Corporate Presentation

July 2026

TSCAN THERAPEUTICS

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TSCAN THERAPEUTICS

TScan is a fully integrated, next-generation TCR-T cell therapy company

Clinical

HEME MALIGNANCY PROGRAM

- Designed to treat residual disease and prevent relapse in patients undergoing bone marrow transplant
- TSC-101 continues to be well-tolerated
- **Durable long-term data for TSC-101: 100% (2/2) of patients 3-years post-HCT** and **71% (5/7) of patients 2-years post-HCT** show **detectable TSC-101 cells** and **no evidence of disease** vs. 0% (0/3) and 43% (3/7), respectively, on the control arm[(1)]
- **Treated 14 patients** using commercial-ready manufacturing process in Cohort C of ALLOHA™ trial with promising initial data
- **First patient dosed** in ALLOHA-2™ Phase 3 trial with topline readout expected in **2H 2028**
- **INDs** for **TSC-102-A01** and **TSC-102-A03 cleared** providing path to double addressable market. Phase 1 study expected to begin in **Q4 2026**

Preclinical

SOLID TUMOR PROGRAM

- TCR-Ts for PRAME and MAGE-A4 in preclinical development using an ***in vivo*-engineering** platform
- Recent FDA INTERACT feedback established a roadmap for filing **INDs by mid-2027**

Discovery

AUTOIMMUNITY PROGRAM

- Targets identified for systemic sclerosis, ulcerative colitis, ankylosing spondylitis, and birdshot uveitis[(2)]
- Novel targets leveraged to generate first-in-class T-cell depleting therapies
- Lead program in preclinical development for AS & spondyloarthropathies

$128.1M as of March 31, 2026 funds operations into H2 2027

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(1) Data as of June 8. 2026; (2) Weinheimer et al, and Pryor et al, presented at ACR Convergence 2025, abstracts 0888, 0997; IND: investigational new drug; AS = ankylosing spondylitis

Advancing focused hematology pipeline with emerging preclinical programs

	Indications	Targets	HLA type	Discovery/Preclinical	IND-enabling	Phase 1	Pivotal
	Engineered TCR-T cell therapies						
HEMATOLOGIC MALIGNANCIES	AML, MDS	**TSC-101** (HA-2)	HLA-A*02:01	***ALLOHA-2™***			
		TSC-102 (CD45)	HLA-A*03:01			*Phase 1 launch Q4 2026*	
			HLA-A*01:01				
			HLA-A*24:02				
SOLID TUMORS		*In vivo*-engineered TCR-Ts					
	Target-directed therapeutics						
AUTOIMMUNITY	Systemic sclerosis Ulcerative colitis Ankylosing spondylitis Birdshot uveitis						
	Crohn's	AMGEN					

TSCAN THERAPEUTICS

2026 will be a transformational year for TScan

	2025	H1 2026	H2 2026
Heme Program	Opened expansion cohorts at DL3 ✓	INDs for TSC-102 (A*03:01 and A*01:01) cleared ✓	Updated data on pts with commercial-ready process
	Aligned on final pivotal design for TSC-101 ✓	Early data on ~10 pts with commercial-ready process* ✓	Initiate Phase 1 for TSC-102
	Two-year relapse data from initial TSC-101 patients ✓	Launch pivotal trial for TSC-101 in Q2 ✓	
Solid Tumor Program	Dose escalation completed for singleplex TCR-T tx ✓	Initiated preclinical development of *in vivo* TCR-T ✓	
	First patients treated with multiplex TCR-T therapy ✓		
Auto-immunity	Identified novel autoantigens ✓		Proof-of-concept for therapeutic approach
	Presented preclinical data for lead programs ✓		

*Expansion Cohort C

Heme Malignancies

Targeting residual disease to prevent relapse in patients undergoing allogeneic HCT

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TScan is working to treat residual disease and prevent relapse in heme malignancies

Current Standard of Care	Allogeneic hematopoietic cell transplant (Allo-HCT) is the only potential cure for patients with AML and MDS
Unmet Medical Need	38-44% of patients relapse within two years following Allo-HCT with reduced intensity conditioning (RIC)*
TScan Approach	TCR-T cell therapy that targets antigens on patient cells, but not donor cells, to prevent relapse after transplant

TSC-101 is a TCR-T cell therapy designed to **eliminate residual cancer** and **prevent relapse** following Allo-HCT in HLA-A*02:01-positive patients

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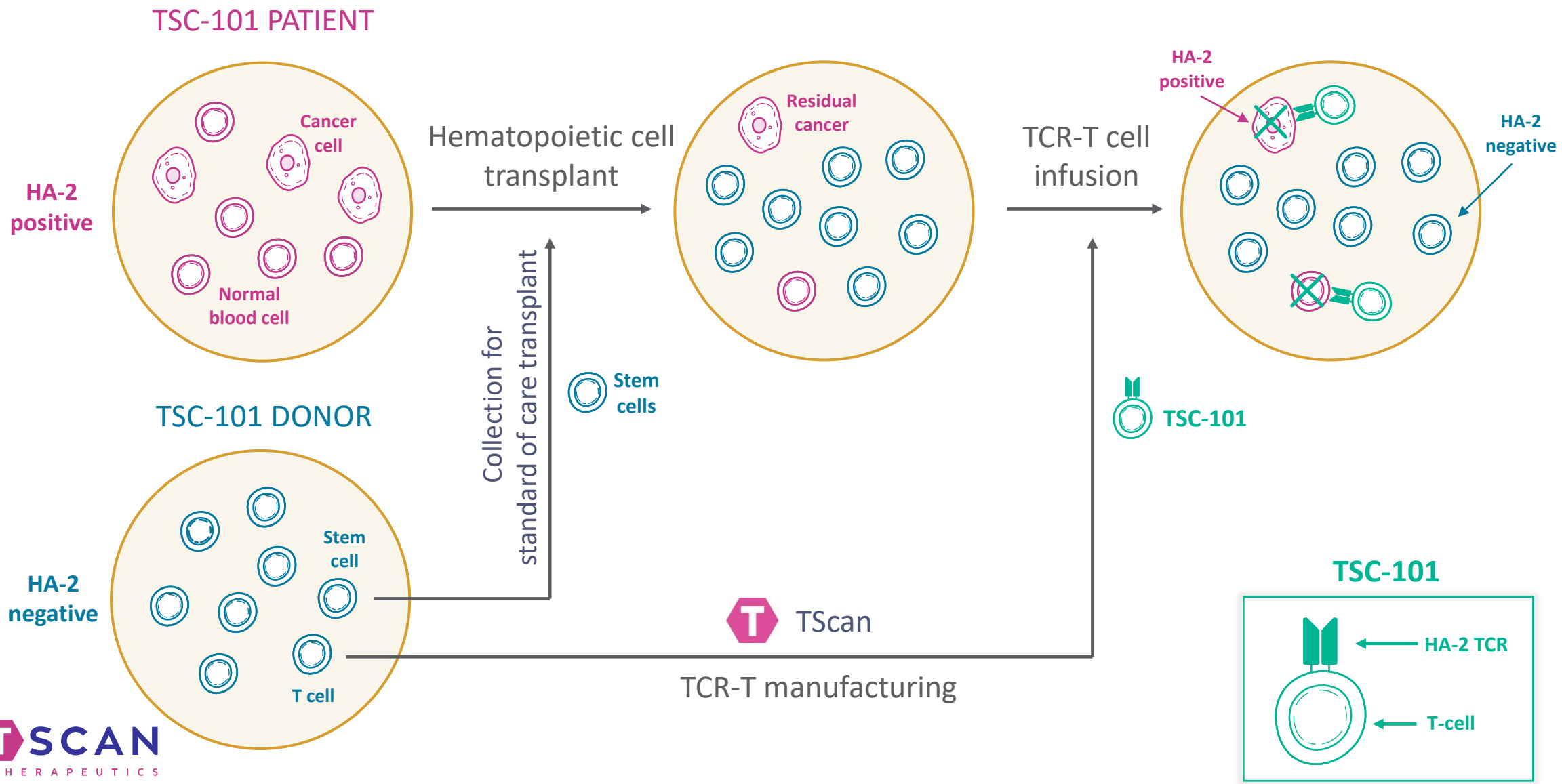
* CIBMTR analysis of AML, ALL, MDS allogeneic transplants with reduced intensity conditioning (RIC) between 2017-2019 with 2-year follow-up

TSC-101 is a TCR-T cell therapy designed to eliminate residual cancer and prevent relapse following Allo-HCT



Heme Clinical Development Strategy: TSC-101

Targeting residual disease to prevent relapse in patients undergoing allogeneic HCT

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Patients are generally well balanced across TSC-101 Cohort A and control arms

		TSC-101 Cohort A	Control
Evaluable Subjects*		19	19
Age, Median years (Range)		65 (52-74)	66 (23-77)
Sex, Male		13 (68%)	9 (47%)
Underlying Disease	ALL	2 (11%)	1 (5%)
	AML	13 (68%)	10 (53%)
	MDS	4 (21%)	8 (42%)
TP53 mutated		6 (32%)	4 (21%)
MRD-positive pre-HCT		12 (63%)	10 (53%)
Donor type	Haplo	19 (100%)	18 (95%)
	MMUD	--	1 (5%)

Mixed chimerism post-HCT (~D21)	11 of 18 (61%)	13 of 17 (76%)

*Subjects on the treatment arm who received ≥1 infusion of TSC-101 and on the control arm who reached Day 21 post-HCT; ALL, acute lymphoblastic leukemia; AML, acute myeloid leukemia; MDS, myelodysplastic syndromes; Pre-HCT MRD, pre-hematopoietic cell transplantation minimal residual disease; Haplo, haploidentical donor; MMUD, mismatched unrelated donor

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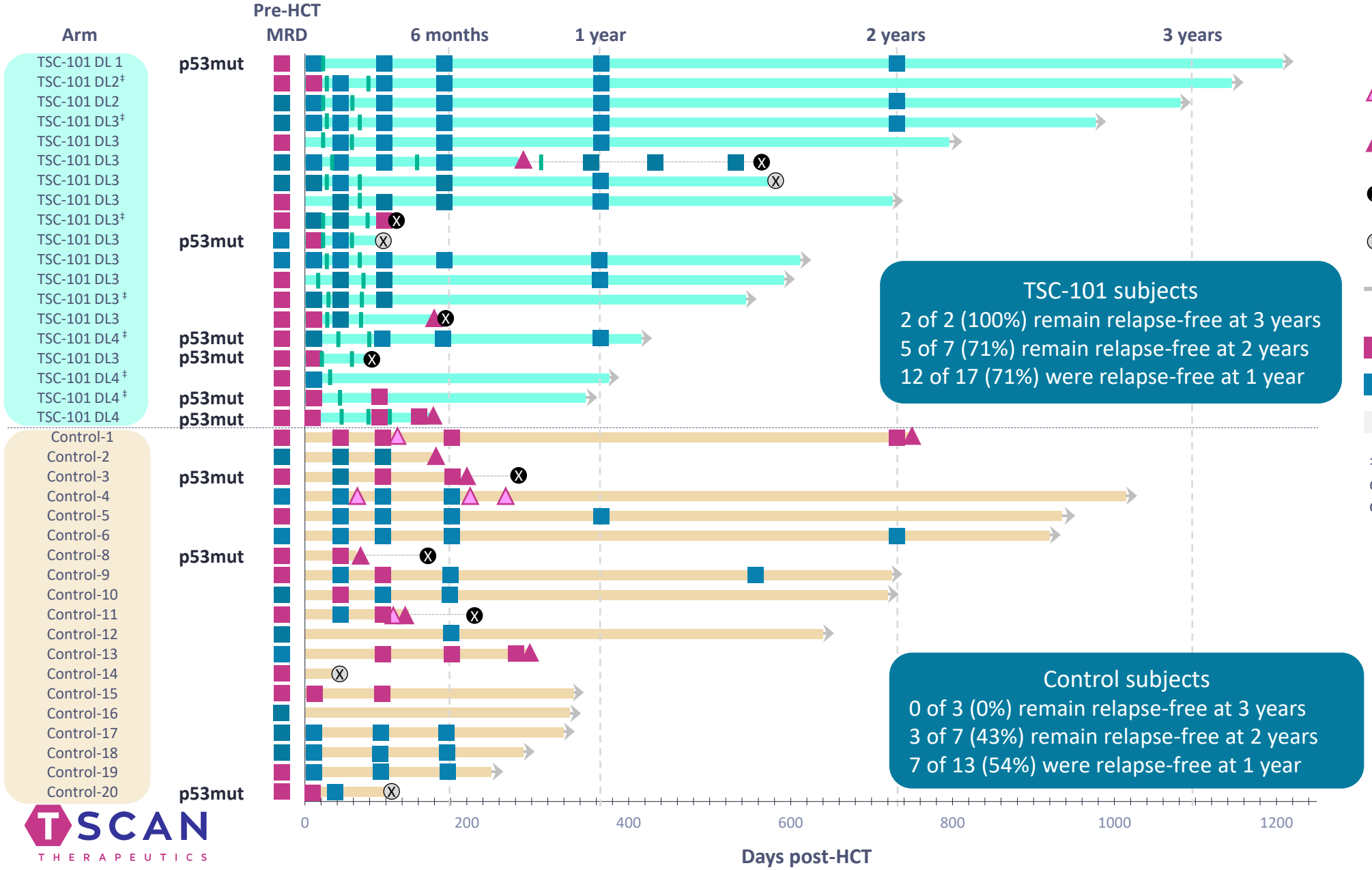
Data as of May 20, 2026

Patients treated with TSC-101 have more durable remissions than control patients



TSC-101 subjects
2 of 2 (100%) remain relapse-free at 3 years
5 of 7 (71%) remain relapse-free at 2 years
12 of 17 (71%) were relapse-free at 1 year

Control subjects
0 of 3 (0%) remain relapse-free at 3 years
3 of 7 (43%) remain relapse-free at 2 years
7 of 13 (54%) were relapse-free at 1 year

TSC-101 infusion
Clinical intervention for concern for relapse
Relapse
Death from relapse
Death unrelated to relapse or TSC
Ongoing follow-up
MRD-positive
MRD-negative
MRD pending

‡Dose did not meet target dose criteria in supplemental cohorts

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Data as of June 8, 2026

TSC-101 is well tolerated with no dose-limiting toxicity

	TSC-101 n=19	Control n=18
Treatment-emergent aGvHD (MAGIC)	12 (63%)	10 (56%)
Grade I	8 (42%)	5 (28%)
Grade II	3 (16%)	4 (22%)
Grade III	1 (5%)	1 (6%)
Grade IV	0 (0%)	0 (0%)
Any Treatment-emergent cGvHD (NIH)	1 (5%)	2 (11%)
Mild	1 (5%)	1 (6%)
Moderate	0 (0%)	1 (6%)
Severe	0 (0%)	0 (0%)
Any CRS	14 (74%)	7 (39%)
Grade 1 - 2	14 (74%)	6 (33%)
Grade 3 - 4	0 (0%)	1 (6%)
Treatment-emergent CRS	3 (16%)	0 (0%)
Grade 1 - 2	3 (16%)	0 (0%)
Grade 3 - 4	0 (0%)	0 (0%)
Any ICANS	1 (5%)	0 (0%)

- No DLTs reported
- No moderate or severe chronic GvHD (cGVHD) with TSC-101
  - One case of mild cGVHD seen in both arms
- Three cases of CRS reported after TSC-101 infusions
  - Two Grade 1 events and one Grade 2 event; all resolved
- One case of ICANS reported after a TSC-101 infusion
  - Depressed consciousness (Grade 2) reported following infusion #2 in a patient with relapsing disease. Treated with tocilizumab and steroids; resolved within 24 hours

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Sept 19, 2025 data cut; Al-Malki et al, abstract ID 2391, presented at ASH Annual Meeting December 2025; GvHD, graft-versus-host disease; ICANS, Immune Effector Cell Associated Neurotoxicity Syndrome; CRS, Cytokine Release Syndrome

ALLOHA™ Phase 1 data support launch of pivotal trial in Q2 2026

Attractive safety profile

Infusions with TSC-101 were **well-tolerated with no DLTs** and adverse events following HCT + TSC-101 were consistent with HCT alone*

Meaningful long-term benefit

More TSC-101-treated patients remain relapse-free >1-year post-HCT vs control arm#

- **100% (2/2)** vs 0% (0/3) on control arm **at 3-years**
- **71% (5/7)** vs 43% (3/7) on control arm **at 2-years**
- **71% (12/17)** vs 54% (7/13) on control arm **at 1-year**

Commercial-ready manufacturing process

- Streamlined manufacturing process developed and transferred to CDMO
- Additional 14 patients (Cohort C) enrolled and treated with commercial-ready process

Reached agreement with FDA on pivotal trial design

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DLTs, dose-limiting toxicities; HCT, hematopoietic cell transplantation; #Data as of June 8, 2026; CDMO, contract development and manufacturing organization

14 Patients enrolled and treated in Cohort C in ~4 months

- Patients generally well balanced across arms, although Cohort C included a higher percentage of patients with MRD-positive disease prior to transplant

		TSC-101 Cohort C	Control
Evaluable Subjects*		14	19
Age, Median years (Range)		68 (28-79)	66 (23-77)
Sex, Male		9 (64%)	9 (47%)
Underlying Disease	ALL	1 (7%)	1 (5%)
	AML	8 (57%)	10 (53%)
	MDS	5 (36%)	8 (42%)
TP53 mutated		3 (21%)	4 (21%)
MRD-positive pre-HCT		9 of 12 (75%)	10 (53%)
Donor type	Haplo	9 (64%)	18 (95%)
	MMUD	5 (36%)	1 (5%)

Mixed chimerism post-HCT (~D21)	12 of 14 (86%)	13 of 17 (76%)

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*Subjects on the treatment arm who received ≥1 infusion of TSC-101 and on the control arm who reached Day 21 post-HCT; ALL, acute lymphoblastic leukemia; AML, acute myeloid leukemia; MDS, myelodysplastic syndromes; Pre-HCT MRD, pre-hematopoietic cell transplantation minimal residual disease; Haplo, haploidentical donor; MMUD, mismatched unrelated donor

Data as of May 20, 2026

TSC-101 continues to be well-tolerated in Cohort C

	TSC-101 Cohort C n=14	Control* n=19
Treatment-emergent aGvHD (MAGIC)	2 (14%)	12 (63%)
Grade I	1 (7%)	6 (32%)
Grade II	1 (7%)	5 (26%)
Grade III	0	1 (5%)
Any Treatment-emergent cGvHD (NIH)	1 (7%)	2 (11%)
Mild	1 (7%)	1 (5%)
Moderate	0	1 (5%)
Any CRS	8 (57%)	7 (37%)
Grade 1 - 2	8 (57%)	6 (32%)
Grade 3 - 4	0	1 (5%)
Treatment-emergent CRS	1 (7%)	0
Grade 1 - 2	1 (7%)	0
Grade 3 - 4	0	0
Any ICANS	0	0
Treatment-emergent ICANS	0	0

- Safety has been consistent with Cohort A
- One case of acute respiratory distress syndrome (ARDS) with TSC-101
  - G4 ARDS 13 days after infusion #1 in patient with G4 kidney injury and HHV6 encephalitis after transplant. Case reviewed by SRC and no changes recommended
- Two cases of acute graft vs host disease (aGvHD)
  - 1 Grade I and 1 Grade II events
- One case of CRS reported after TSC-101 infusions
  - Grade 1 event and resolved

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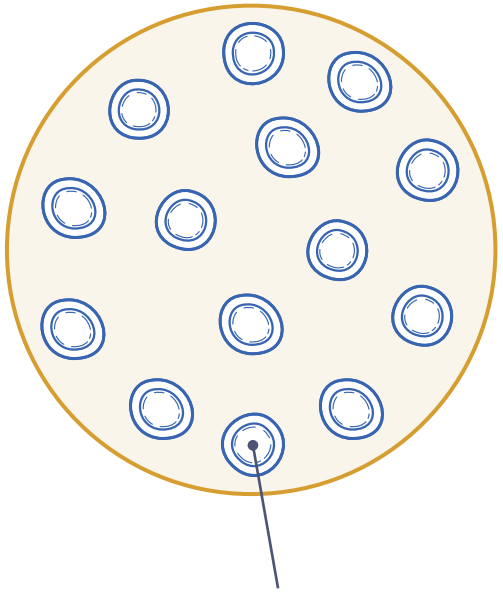
* Control-arm patients enrolled concurrently with Cohort A and therefore with longer duration on study vs Cohort C; GvHD, graft-versus-host disease; ICANS, Immune effector cell-associated neurotoxicity syndrome; CRS, Cytokine release syndrome

Data as of May 20, 2026

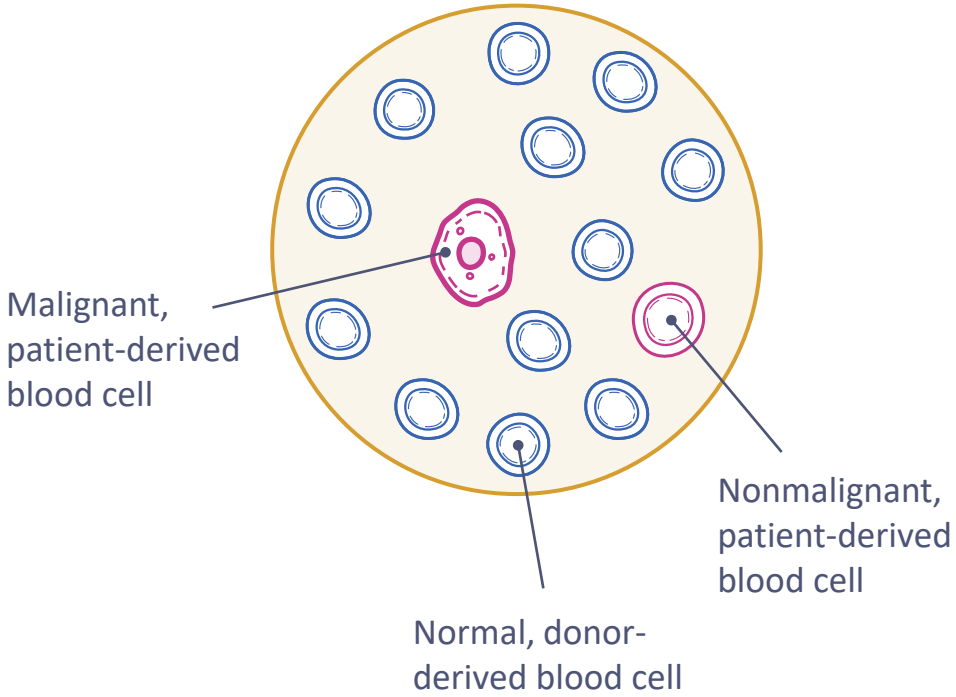
Donor chimerism serves as an early surrogate of efficacy

Post-transplant patient

Complete donor chimerism
(low risk of relapse[1,2])

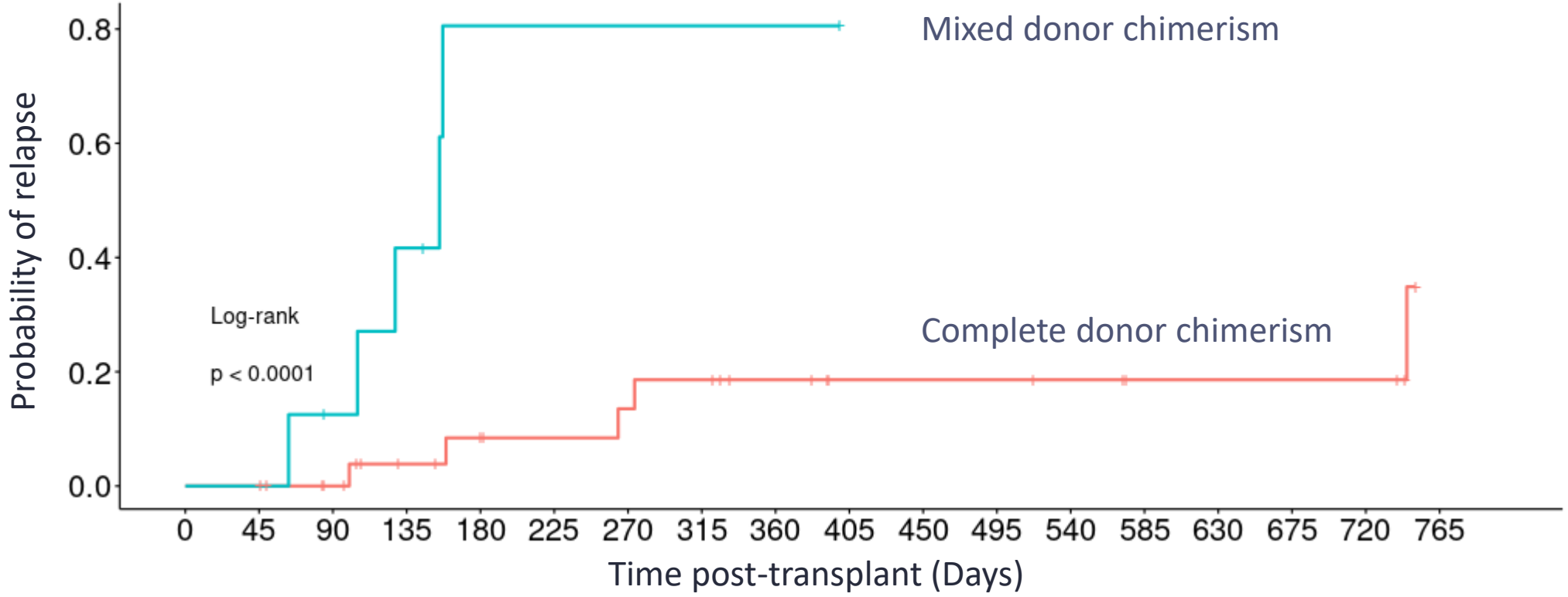


Mixed donor chimerism
(increased risk of relapse[1,2])



1. Lindhal, Bone Marrow Transpl, 2022
2. Ciurea, Al Malki, Blood Rev, 2023

Patients with complete donor chimerism using NGS assay at two months post-transplant have a low probability of relapse



Chimerism status of initial ALLOHA patients at 2 months post-transplant predicts probability of relapse (HR 10.2)

NGS, investigational next-generation sequencing assay (Alloheme)

Data on file; Data as of May 19, 2026

11 of 14 patients achieved complete donor chimerism within ~3 weeks of receiving first infusion of TSC-101

Time post HCT#	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	DL4	DL4	DL3	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4
	Haplo	Haplo	MMUD	Haplo	Haplo	MMUD	Haplo	MMUD	MMUD	Haplo	Haplo	Haplo	MMUD	Haplo
	AML-p53	MDS	AML	AML	ALL-p53	MDS-p53	AML	MDS	AML	MDS	AML	AML	MDS	AML
Prior to infusion	✕	✕	✕	✓	✕	✕	✕	✕	✕	✕	✕	✕	✕	✓
	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Day 35/42	✓	✕	✓	✓	✕	✓	✓	✓	✓	✕	✓	✕	✓	✓
Day 56/63	✓	✕	✓	✓		✓	✓	✓	✓					
	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆			
Day 77/84	✓	✓	✓		✕	✓	✓	✓						
					◆									
Day 105	✓	●	✕											
			◆											
Day 133	✓		✕											
Day 180	✓													

- 2 of the remaining 3 patients had improving chimerism following infusion with TSC-101, approaching complete donor chimerism
- Patient who received dose level 3 showed stabilization of chimerism following third infusion

◆ TSC-101 infusion
✓ Complete donor chimerism
✕ Mixed donor chimerism
▲ Relapse
● Non-relapse death
● Relapse death

Donor chimerism results using investigational NGS assay (Alloheme) with data cut-off of 0.2% at indicated times post-HCT (#± 3 days); ALL, acute lymphoblastic leukemia; AML, acute myeloid leukemia; MDS, myelodysplastic syndromes; Haplo, haploidentical donor; MMUD, mismatched unrelated donor

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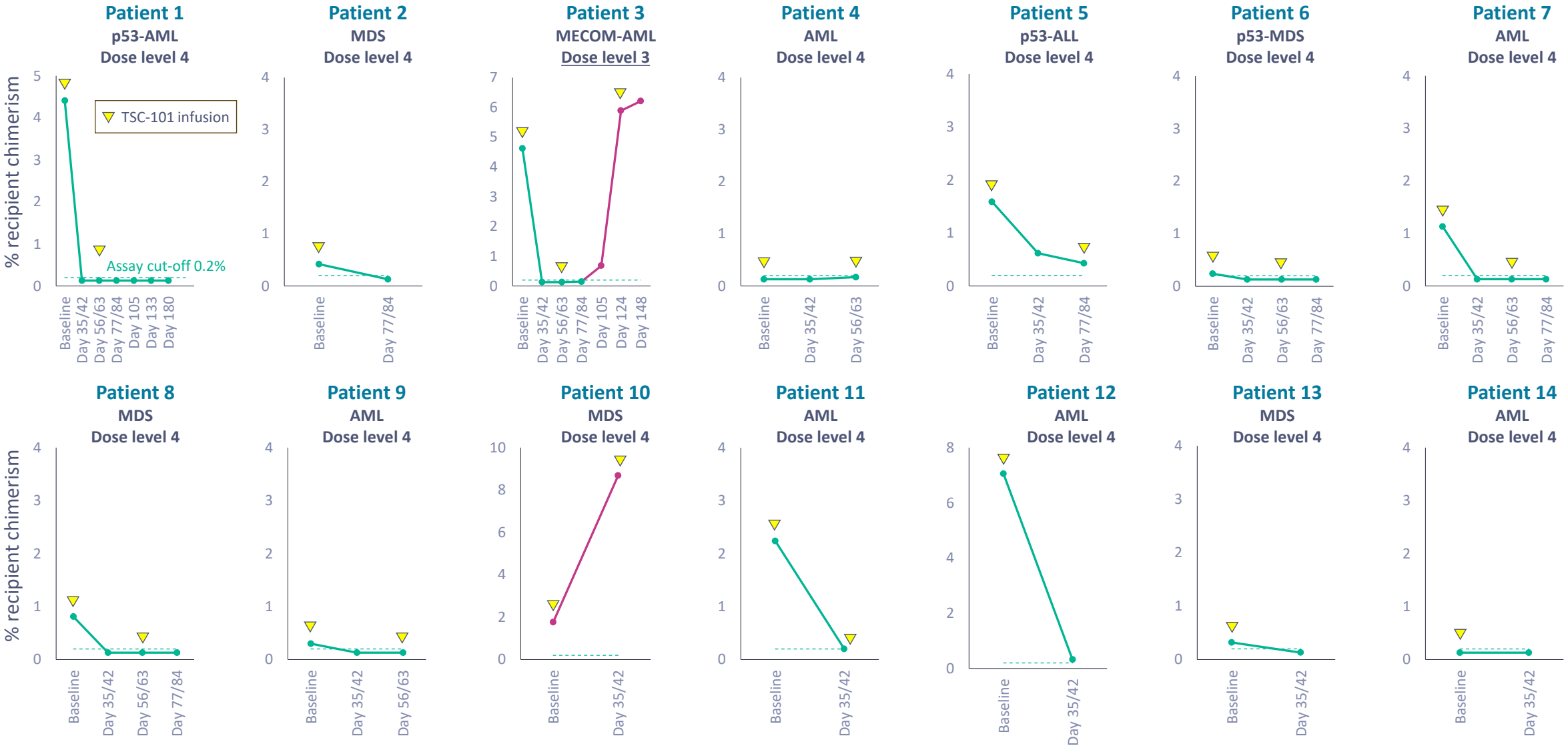
Data as of June 8, 2026

All but one patient in Cohort C (93%) responded to TSC-101 with decreasing recipient chimerism



Donor chimerism results using investigational next-generation sequencing assay (Alloheme) with data cut-off of 0.2% at indicated times post-transplant (# ± 3 days)

No patients in Cohort C have relapsed to date, with higher rates of complete donor chimerism compared to control-arm patients

% Patients with complete donor chimerism

	Cohort A	Cohort C	Control
Immediately post-HCT	37% (7/19)	14% (2/14)	24% (4/17)
~3 weeks after infusion 1	79% (15/19)	79% (11/14)	61% (11/18)#
~3 weeks after infusion 2	73% (11/15)†	100% (5/5)*	53% (9/17)#

† 15/19 patients received two or more infusions of TSC-101; Of the 4 patients that only received one infusion, 3 achieved and maintained complete donor chimerism within 3 weeks of receiving their infusion

* Patient receiving dose level 3 subsequently showed mixed donor chimerism

For the control arm, day 35/42 and day 77/84 were deemed the comparable time points to ~3 weeks post first and second infusions of TSC-101

Post-HCT, post-hematopoietic cell transplant

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Data as of June 8, 2026

Pivotal trial design for TSC-101 uses a biologically-assigned control arm to support relapse-free survival as the primary endpoint

- Agreement reached with the FDA to use a **pivotal trial design that mirrors the ALLOHA™ Phase 1 trial**
- All patients that are eligible for TSC-101 will be assigned to the investigational arm
- Trial **powered at 85% for a Hazard ratio of 0.52** with readout at 25 months (no interim analysis), **n= ~150/arm**

Study Population

- AML or MDS
- Age ≥ 18 years
- Undergoing first allo-HCT
- Eligible for reduced intensity conditioning (RIC)

Key Endpoints

- **Primary Endpoint**: RFS
- Key Secondary Endpoint: OS, EFS

Biological assignment

Investigational Arm

A*02:01-positive subject with A*02-negative donor

Control Arm

A*02:01-negative subject
or
A*02:01-positive subject with no available mismatched donor

RIC-based transplant

Two infusions of TSC-101

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AML: Acute myeloid leukemia; MDS: Myelodysplastic syndromes; Allo-HCT: Allogeneic hematopoietic cell transplantation; RIC: Reduced intensity conditioning; RFS: Relapse-free survival; OS: Overall survival

Heme Clinical Development Strategy: TSC-102

HLA and Indication expansion

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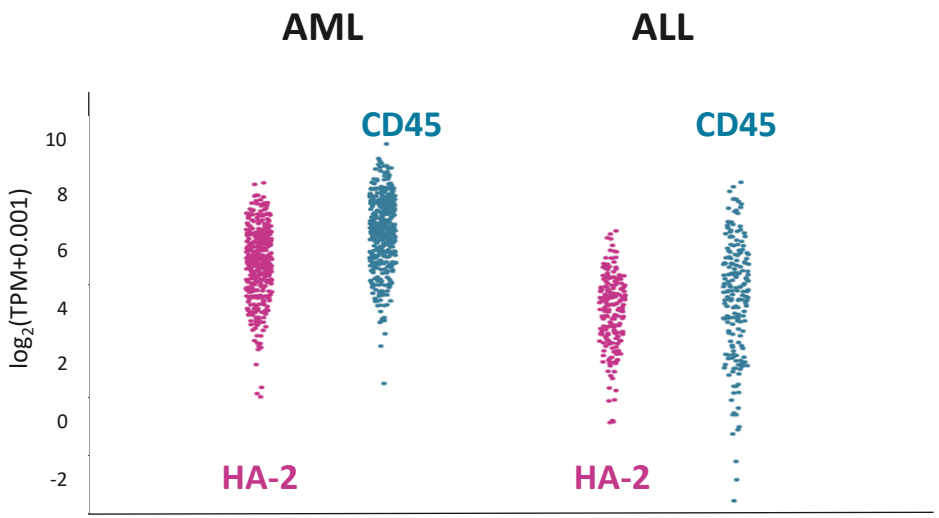
TCRs for additional HLA types target epitopes derived from CD45, a universal source of antigens for heme malignancies

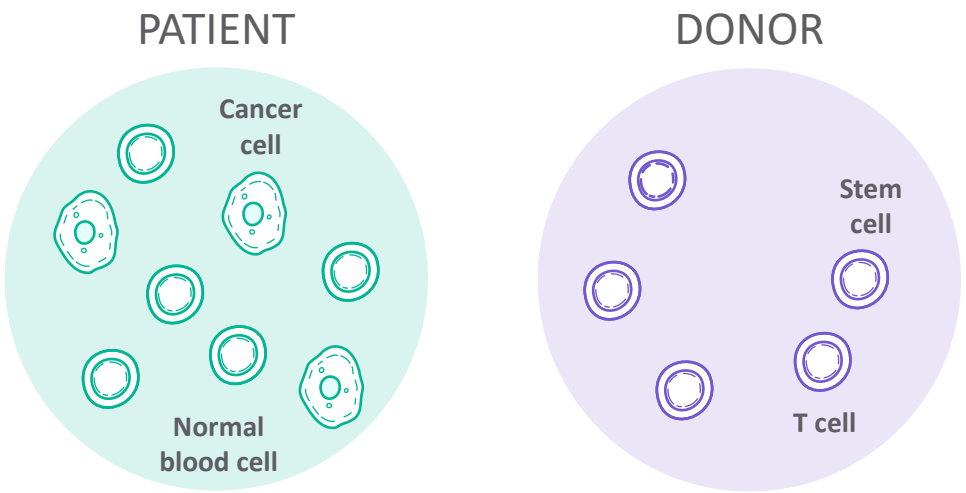
- CD45 is a lineage-specific protein with expression in all hematopoietic cells, including HSCs
- CD45 is a large protein with many well-known epitopes for high frequency HLAs
- Antigen-negative donors will be selected by mismatching on HLA (using haploidentical and MMUD donors)

CD45 has high and uniform expression in AML and ALL



Source: TCGA

TSC-102 TCRs target CD45 antigens presented on patient but not donor HLAs



CD45 antigen
HLA-A*03:01 positive

CD45 antigen
HLA-A*03:01 negative

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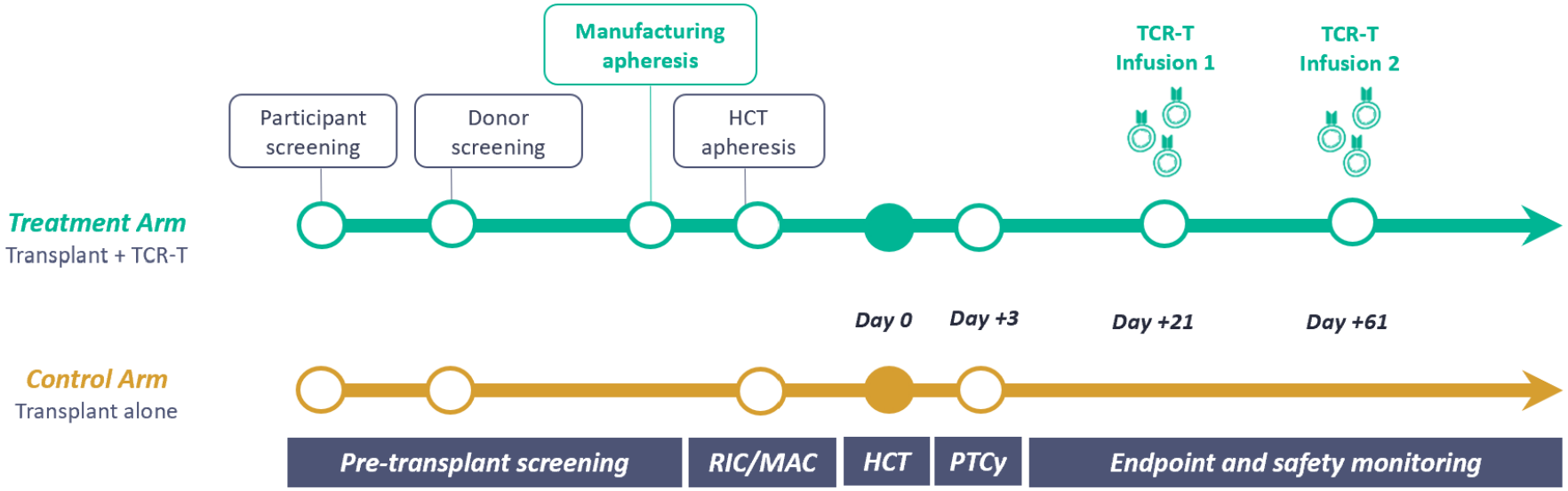
Data on file

INDs cleared for TSC-102-A03 and TSC-102-A01; Phase 1 planned for Q4 2026

- Study expands the heme program
  - Two additional HLA types
  - MAC conditioning
  - ALL and Non-Hodgkin Lymphoma in addition to AML and MDS



Indications
- AML, ALL, MDS
- Non-Hodgkin Lymphoma

Study Characteristics
- Dose escalation
- RIC or MAC
- Haplo or MMUD

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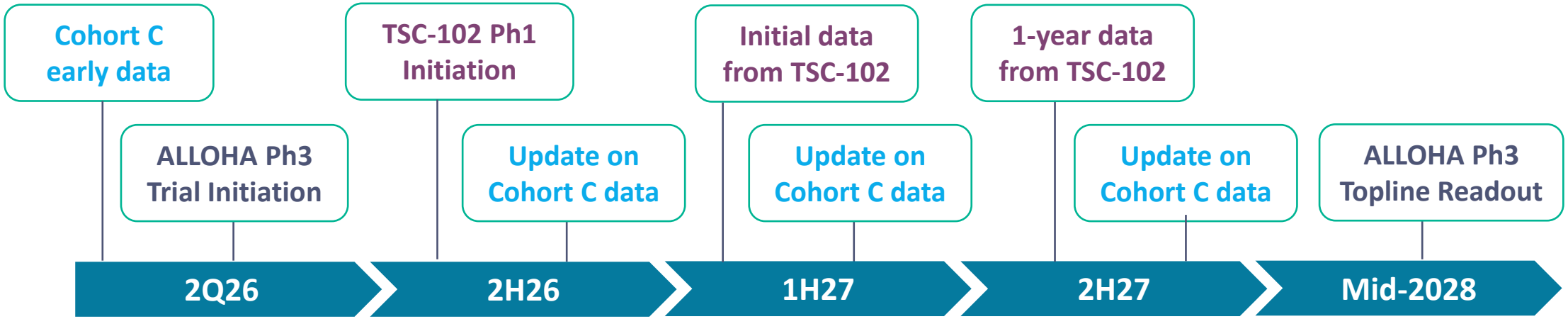
Continuous data read-outs over the next two years provides clinical de-risking

- ALLOHA Phase 3 will take ~2 years, with a topline readout targeted for the second half of 2028
- Cohort C is the same manufacturing process and patient population as our Phase 3, and is expected to provide clinical de-risking throughout the duration of the pivotal study
- TSC-102 will also be ongoing and is expected to provide insight to safety and efficacy



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Heme Program Progress and Anticipated Milestones

- ✓ Reached agreement with FDA on pivotal trial design
- ✓ Transferred commercial-ready manufacturing process to external CDMO
- ✓ Two-year relapse data from initial TSC-101 patients Dec 2025
- ✓ Cleared INDs for TSC-102-A01 and TSC-102-A03 Q1 2026
- ✓ Share data from Cohort C patients with commercial-ready manufacturing process in **Q2 2026**
- Launch pivotal study for TSC-101 in **Q2 2026**
- Initiate Phase 1 study of TSC-102-A01 and TSC-102-A03 in **Q4 2026**

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Market Opportunity and Market Access Strategy

Clear unmet need with concentrated market and a broad range of expansion opportunities

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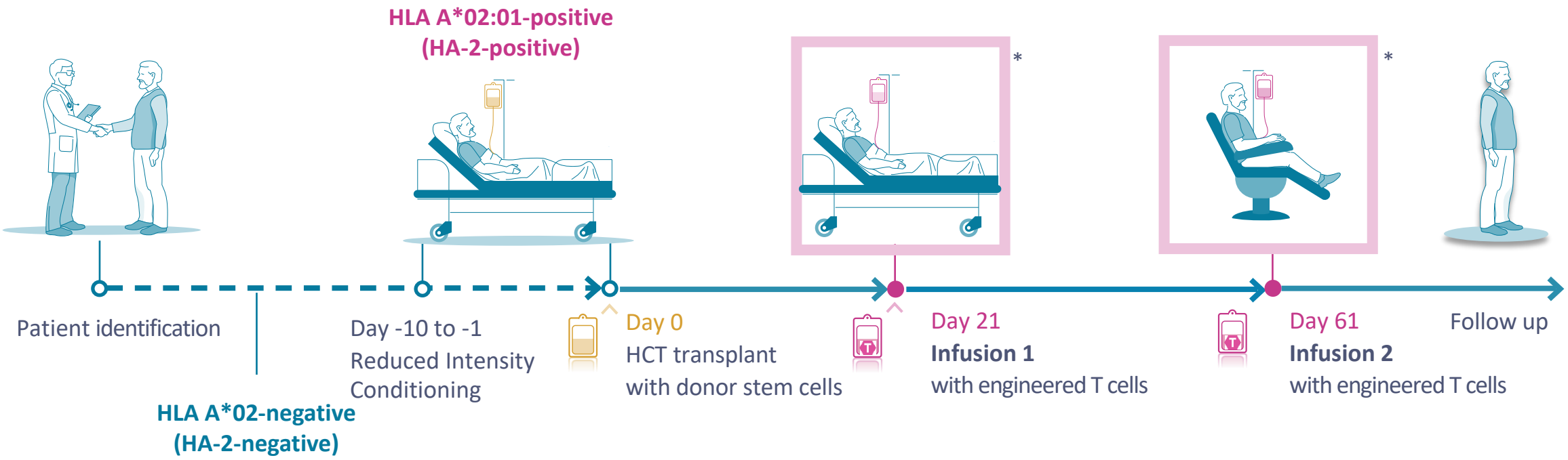
TSC-101 is incorporated seamlessly into current transplant journey



Donor apheresis 1: T-cells
Donor apheresis 2: Stem cells

- Referral to existing transplant centers is current standard of care
- Patient and donor pairing conducted through standard HLA testing
- Flexibility for inpatient/outpatient infusion(s)
- Product manufacturing is completed well before planned infusion on Day 21

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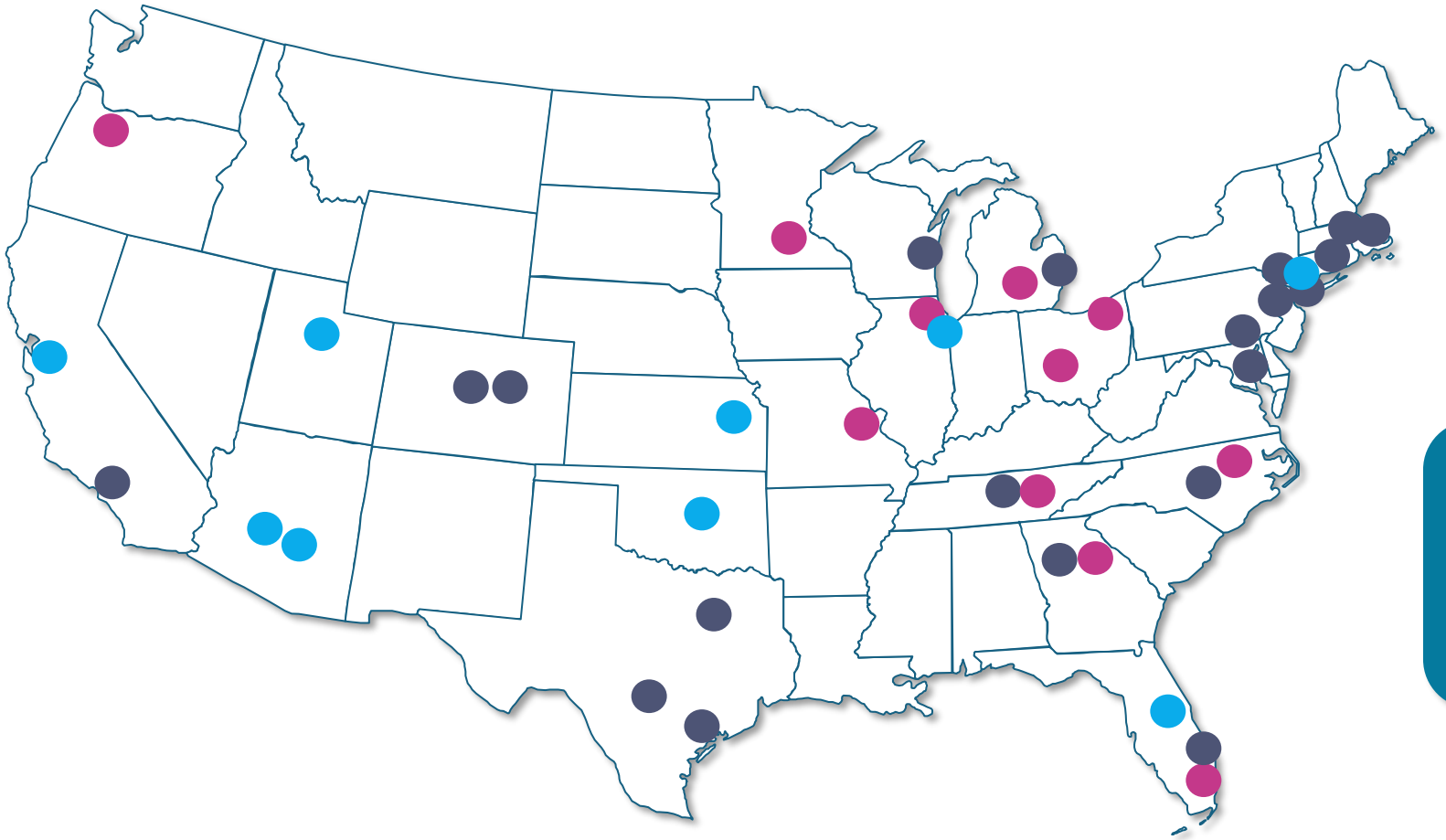
* Infusion 1 & 2 site of care (inpatient vs outpatient) determined by administering physician. Infusion 1 may be given upon engraftment and between days 14-35 post transplant, infusion 2 would be administered about 40 days after infusion 1.

US geographical footprint ensures appropriate patient access to treatment



ATCs Color Coded by Category:

- Current clinical trial sites
- Potential additional sites for pivotal
- Potential additional sites for commercial

- **~120** centers conduct allo-HCT
- **21** sites in Phase 1 clinical trial
- **30** sites in Phase 3 trial
- Targeting **40** ATCs at launch

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90% of addressable patients will have access to an ATC within 250 miles of home

At launch, ~2,350 patients will qualify for TSC-101 in the U.S. based on HLA type

Addressable U.S. Patient Population

~7,000 AML/MDS patients estimated to undergo Allo HCT in **2029***

2,940 HLA-A*02:01 positive patients (42%)

2,350 with A*02-negative donor (80%)

Requires transplant with reduced intensity conditioning and haplo/MMUD donor

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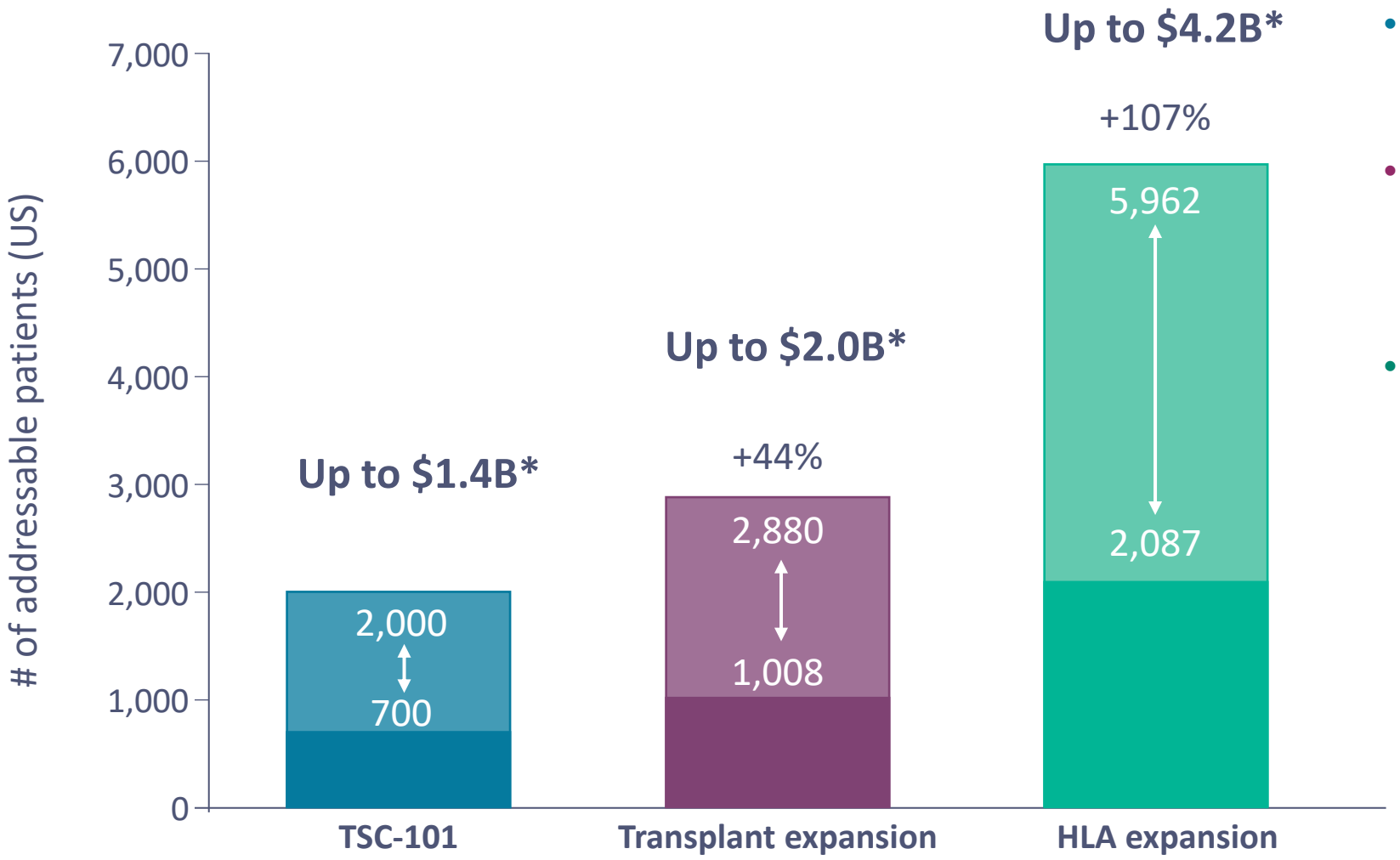
Sources: Spellman SR, et al. Transplant Cell Ther., 2025, 31:505-532; Analyses from NMDP, allelefrequencies.net, ClearView Independent Analysis; Addressable patient estimates based on 4% annual growth in allo-HCT; Haplo: haploidentical donor; MMUD: mismatched unrelated donor.

Heme franchise represents a substantial commercial opportunity



- Positive data expected to increase use of RIC and haplo/MMUD donors
- Increased use of transplant provides a way to reach over 2,800 AML and MDS patients per year in the U.S. with TSC-101
- Addition of TSC-102 will expand the addressable patient population to include additional HLA types

Candidate	HLA type	Frequency
TSC-101	A*02:01	42%
TSC-102-A01	A*01:01	24%
TSC-102-A03	A*03:01	22%
TSC-102-A24	A*24:02	17%
Total	**HLA total**	**82%**

- Accounts for overlap in addressable patient populations
- Assumes 85% probability of finding a mismatched donor

Source: SEER, CIBMTR, EBMT, APBMT; HLA, human leukocyte antigen; *Based on pricing of ~$700K

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Solid Tumors

Developing multiplex TCR-T therapy to overcome tumor heterogeneity

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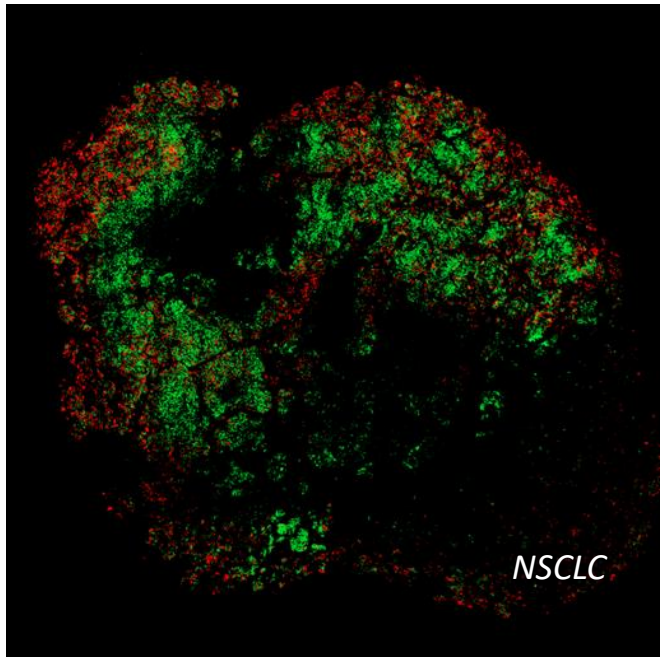
Multiplex TCR-T therapy designed to overcome the heterogeneity of solid tumors

Unmet Medical Need

Solid tumors remain difficult to treat and cure, representing a large unmet medical need

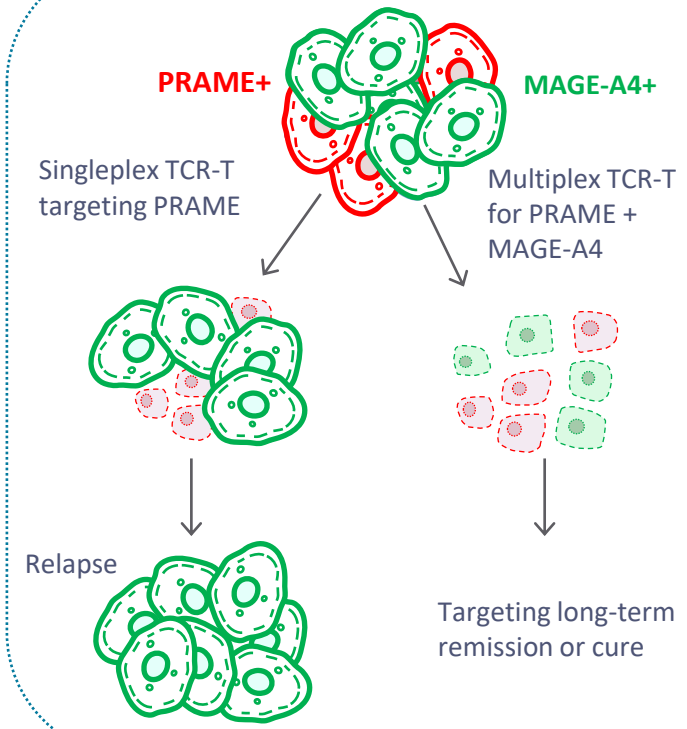
Only 10-35%* of patients diagnosed with metastatic solid tumors survive more than 5 years

Many solid tumors exhibit heterogeneity of target expression



Single solid tumor expression of **PRAME** and **MAGE-A4**

Durable responses may require TCR-T therapy for multiple targets



In vivo engineering platform currently being developed to enable **off-the-shelf multiplex TCR-T therapy**

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Source: SEER; * Across HNSCC, NSCLC, sarcoma, cervical, and anal cancer; Data on file

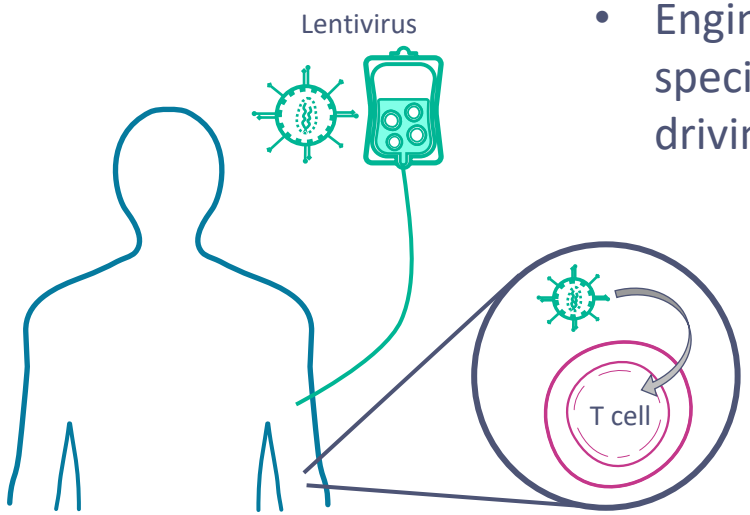
Lentiviral *in vivo* technology addresses the key challenges of autologous TCR-T

In vivo engineering solves the key challenges of autologous TCR-T approaches

- Lymphodepletion is not required
- Off-the-shelf (no patient-specific manufacturing); lentivirus prepared in large batches with significantly reduced COGS
- No vein-to-vein time
- Promising early clinical data from *in vivo* CAR-T therapy

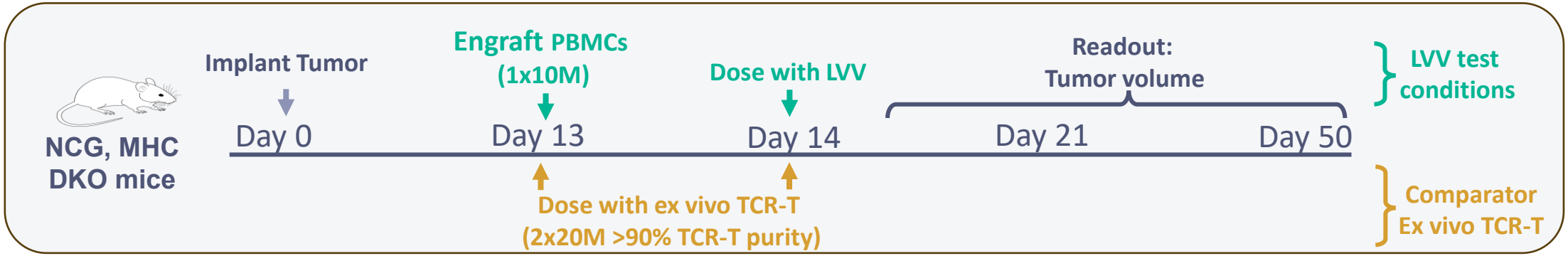
In vivo lentiviral approach offers potential for long-term response

- Modified lentiviruses specifically target T-cells *in vivo* and enable permanent integration of genetic cargo
- Engineered T-cells express a cancer-specific TCR and form memory cells, driving long term anti-cancer activity

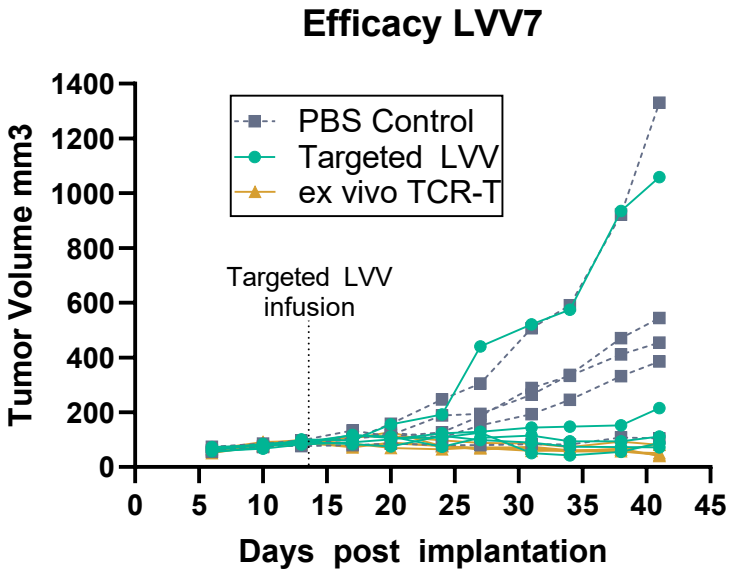


COGS, cost of goods

MAGE-A4 TCR delivered in vivo with targeted LVVs illustrate tumor clearance in PBMC engrafted mice implanted with NSCLC solid tumor cell line



- MAGE-A4-expressing NSCLC tumor model was adapted for human PBMC co-engraftment
- In vivo engineered TCR-T cells illustrate tumor clearance in NSCLC tumor model



LVV, lentiviral vector; NSCLC, non-small cell lung cancer; PBS, phosphate buffered saline; PBMC, peripheral blood mononuclear cells

Data on file

Autoimmunity

Deploying TargetScan platform to discover novel T-cell targets in autoimmune disorders

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TScan's target discovery platform provides a way to identify targets in autoimmune disease, unlocking the development of targeted therapeutics

Current therapies typically provide general immune suppression, leading to complications (e.g., increased risk of infection)

Target-specific therapies provide a way to address the cause, rather than the symptoms, of autoimmunity

Many autoimmune disorders have a substantial T-cell component, but the targets of these pathogenic or protective T-cells are largely unknown

Identified targets for systemic sclerosis, ulcerative colitis, ankylosing spondylitis, and birdshot uveitis using proprietary platform

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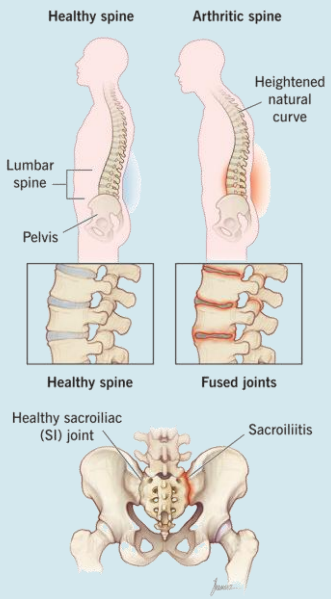
Multi-year collaboration using TargetScan to identify targets for T cells in patients with Crohn's disease

AMGEN

Ankylosing spondylitis (AS) is a debilitating autoimmune disorder strongly driven by T-cells but with a poorly characterized autoantigen target landscape

- Primarily affects **young males** (Male-to-Female ratio: 2:1); ~6 million cases globally (2018), including ~550,000 in North America
- Common symptoms include **low back pain, stiffness, and loss of spinal mobility**
- **No cure is available**, current AS treatments rely on TNF, IL-17, and JAK inhibitors
- AS etiology is unclear, but the presence **of HLA-B*27:05 in more than 90% of patients** suggests involvement of **common antigenic targets**



- After four decades of research, concrete **CD8$^+$ T cell targets <u>remained</u> elusive**
- **TargetScan enabled us to discover multiple biologically relevant targets capable of inducing AS-like disease in mice**

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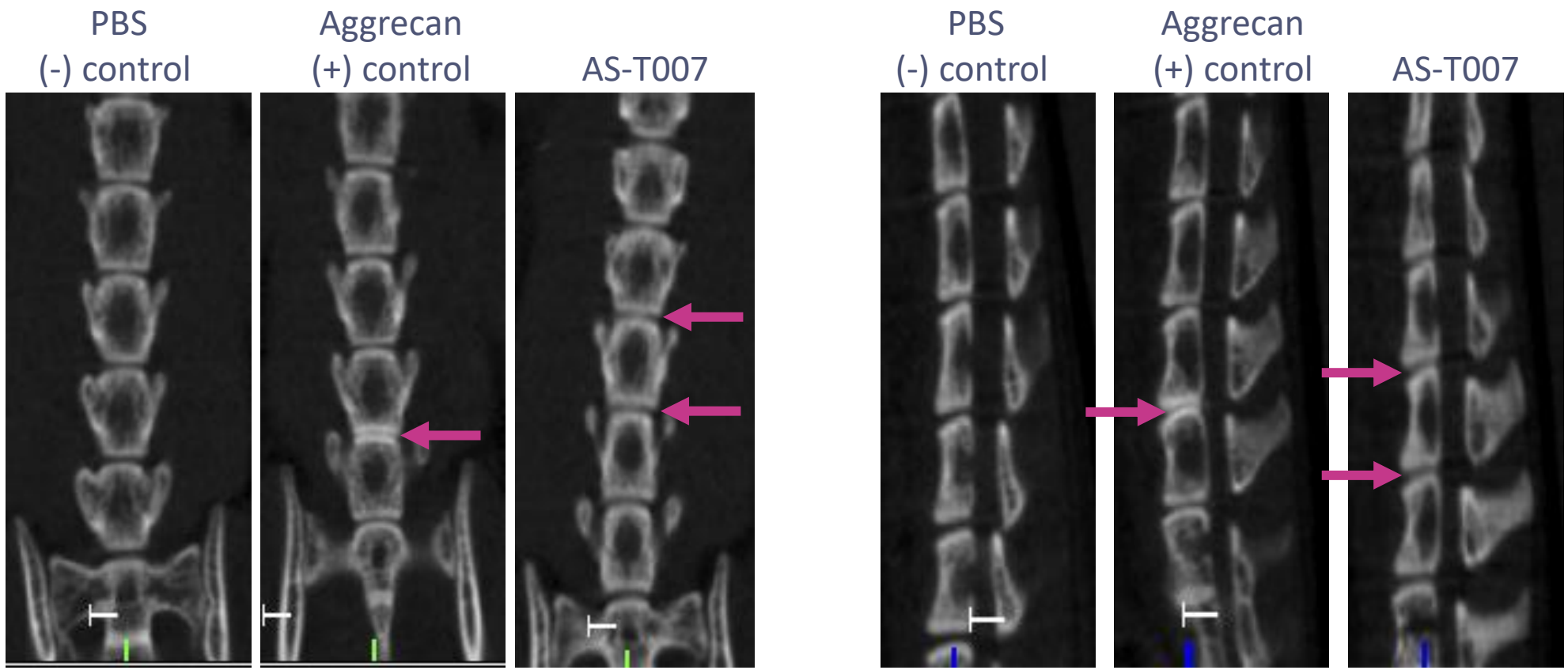
JAMA 2025; 333(5):408-420. doi:10.1001/jama.2024.20917; *Bone Research* 2019; 7:22. doi:10.1038/s41413-019-0057-8; *Curr Opin Rheumatol* 2018; 30:137–143. doi:10.1097; AS, ankylosing spondylitis; TNF, tumor necrosis factor; JAK, Janus kinase

Micro-CT reveals bone remodeling in the spine of mice immunized with TScan-identified targets



Data presented at the Antigen-Specific Immune Tolerance (ASIT) Summit (March 5, 2026; Boston)

- Screening of additional AS patient PBMCs for reactivity to putative targets in progress

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Micro-CT, micro-computed tomography; AS, ankylosing spondylitis; PBMC, peripheral blood mononuclear cells

Data on file

2026 will be a transformational year for TScan

	2025	H1 2026	H2 2026
Heme Program	Opened expansion cohorts at DL3 ✓	INDs for TSC-102 (A*03:01 and A*01:01) cleared ✓	Updated data on pts with commercial-ready process
	Aligned on final pivotal design for TSC-101 ✓	Early data on ~10 pts with commercial-ready process* ✓	Initiate Phase 1 for TSC-102
	Two-year relapse data from initial TSC-101 patients ✓	Launch pivotal trial for TSC-101 in Q2 ✓	
Solid Tumor Program	Dose escalation completed for singleplex TCR-T tx ✓	Initiated preclinical development of *in vivo* TCR-T ✓	
	First patients treated with multiplex TCR-T therapy ✓		
Auto-immunity	Identified novel autoantigens ✓		Proof-of-concept for therapeutic approach
	Presented preclinical data for lead programs ✓		

*Expansion Cohort C

THANK YOU

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