Disclaimers and forward-looking statements

This presentation and the accompanying discussion contain forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, including, but not limited to, express or implied statements regarding the Company’s plans, progress, and timing relating to the Company’s solid tumor programs and the presentation of data, the Company’s current and future research and development plans or expectations, the structure, timing and success of the Company’s planned preclinical development, submission of INDs, and clinical trials, the potential benefits of any of the Company’s proprietary platforms, multiplexing, or current or future product candidates in treating patients, and the Company’s goals and strategy. TScan intends such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 21E of the Securities Exchange Act of 1934 and the Private Securities Litigation Reform Act of 1995. In some cases, you can identify forward-looking statements by terms such as, but not limited to, “may,” “might,” “will,” “objective,” “intend,” “should,” “could,” “can,” “would,” “expect,” “believe,” “anticipate,” “project,” “target,” “design,” “estimate,” “predict,” “potential,” “plan,” “on track,” or similar expressions or the negative of those terms. Such forward-looking statements are based upon current expectations that involve risks, changes in circumstances, assumptions, and uncertainties. The express or implied forward-looking statements included in this presentation are only predictions and are subject to a number of risks, uncertainties and assumptions, including, without limitation: the beneficial characteristics, safety, efficacy, therapeutic effects and potential advantages of TScan’s TCR-T therapy candidates; TScan’s expectations regarding its preclinical studies being predictive of clinical trial results; the timing of the initiation, progress and expected results of TScan’s preclinical studies, clinical trials and its research and development programs; TScan’s plans relating to developing and commercializing its TCR-T therapy candidates, if approved, including sales strategy; estimates of the size of the addressable market for TScan’s TCR-T therapy candidates; TScan’s manufacturing capabilities and the scalable nature of its manufacturing process; TScan’s estimates regarding expenses, future milestone payments and revenue, capital requirements and needs for additional financing; TScan’s expectations regarding competition; TScan’s anticipated growth strategies; TScan’s ability to attract or retain key personnel; TScan’s ability to establish and maintain development partnerships and collaborations; TScan’s expectations regarding federal, state and foreign regulatory requirements; TScan’s ability to obtain and maintain intellectual property protection for its proprietary platform technology and our product candidates; the sufficiency of TScan’s existing capital resources to fund its future operating expenses and capital expenditure requirements; and the effect of the COVID-19 pandemic, including mitigation efforts and political, economic, legal and social effects, on any of the foregoing or other aspects of TScan’s business or operations; and other factors that are described in the “Risk Factors” and “Management’s Discussion and Analysis of Financial Condition and Results of Operations” sections of TScan’s most recent Annual Report on Form 10-K and any other filings that TScan has made or may make with the SEC in the future.

Any forward-looking statements contained in this presentation represent TScan’s views only as of the date hereof and should not be relied upon as representing its views as of any subsequent date. Except as required by law, TScan explicitly disclaims any obligation to update any forward-looking statements.
Senior leadership team brings an average of 20+ years of experience to TScan

Gavin MacBeath, Ph.D.  
Chief Executive Officer

Debora Barton, M.D.  
Chief Medical Officer

Zoran Zdraveski, J.D., Ph.D.  
Chief Legal Officer

Shrikanta Chattopadhyay, M.D.  
Senior Vice President, Medical, Translational Medicine

Ann Hargraves  
Senior Vice President, Human Resources

Ray Lockard, M.B.A.  
Senior Vice President, Technical Operations & Quality

Leiden Dworak, M.B.A.  
Vice President, Finance

Cagan Gurer, Ph.D.  
Vice President, Discovery

Jim Murray  
Vice President, Clinical Operations

Ken Olivier, Ph.D.  
Vice President, Non-Clinical Development

Heather Savelle  
Vice President, Investor Relations

Gavin MacBeath, Ph.D.  
Chief Executive Officer
TScan: A fully integrated, next-generation TCR-T cell company

- Proprietary discovery platform
  - Rapid discovery of targets and TCRs

- In-house GMP manufacturing
  - Transposon-based T cell engineering

- Rapidly-growing oncology pipeline
  - Clinical-phase programs in heme and solid tumor malignancies

- Broad therapeutic potential
  - Oncology
  - Infectious disease
  - Autoimmune disease
TCR-T therapy builds on the success of immunotherapy

What we have learned from immuno-oncology

Checkpoint inhibitor and TIL therapy

- Unleashing endogenous T cells produces dramatic responses in many solid tumors
- Some patients lack anti-cancer T cells and do not respond

CAR-T therapy

- Genetically reprogramming T cells is highly effective in certain heme malignancies
- Broader use of CAR-T, particularly in solid tumors, has proven challenging

The benefits of TCR-T cell therapy

- Genetically reprogramming T cells with TCRs leverages the body's natural mechanism for fighting cancer
- TCR-T enables access to all anti-cancer protein targets (intra- and extra-cellular)
TScan is targeting the top HLAs to address a broader patient population with TCR-T therapy

Most TCR-T programs target one HLA (up to 40% of people)

**TScan** is working to target the **top 6-8** HLAs (~90% of people)

<table>
<thead>
<tr>
<th>HLA type</th>
<th>United States</th>
<th>Europe</th>
<th>Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>A*02:01</td>
<td>42</td>
<td>47</td>
<td>19</td>
</tr>
<tr>
<td>A*01:01</td>
<td>24</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>A*03:01</td>
<td>22</td>
<td>25</td>
<td>7.0</td>
</tr>
<tr>
<td>B*07:02</td>
<td>20</td>
<td>21</td>
<td>8.1</td>
</tr>
<tr>
<td>C*07:02</td>
<td>24</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>A*24:02</td>
<td>17</td>
<td>19</td>
<td>37</td>
</tr>
</tbody>
</table>

~90% of people in the U.S. are positive for at least one of the top 6 HLA types

<table>
<thead>
<tr>
<th>HLA type</th>
<th>United States</th>
<th>Europe</th>
<th>Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>A*02:01</td>
<td>42</td>
<td>47</td>
<td>19</td>
</tr>
<tr>
<td>A*01:01</td>
<td>24</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>A*03:01</td>
<td>22</td>
<td>25</td>
<td>7.0</td>
</tr>
<tr>
<td>B*07:02</td>
<td>20</td>
<td>21</td>
<td>8.1</td>
</tr>
<tr>
<td>C*07:02</td>
<td>24</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>A*24:02</td>
<td>17</td>
<td>19</td>
<td>37</td>
</tr>
</tbody>
</table>

~90% of people in the U.S. are positive for at least one of the top 6 HLA types

<table>
<thead>
<tr>
<th>HLA type</th>
<th>United States</th>
<th>Europe</th>
<th>Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>A*02:01</td>
<td>42</td>
<td>47</td>
<td>19</td>
</tr>
<tr>
<td>A*01:01</td>
<td>24</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>A*03:01</td>
<td>22</td>
<td>25</td>
<td>7.0</td>
</tr>
<tr>
<td>B*07:02</td>
<td>20</td>
<td>21</td>
<td>8.1</td>
</tr>
<tr>
<td>C*07:02</td>
<td>24</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>A*24:02</td>
<td>17</td>
<td>19</td>
<td>37</td>
</tr>
</tbody>
</table>
Platform delivers broad proprietary pipeline

<table>
<thead>
<tr>
<th>Indications</th>
<th>Programs (target)</th>
<th>HLA type</th>
<th>Discovery</th>
<th>Lead optimization</th>
<th>IND-enabling</th>
<th>Phase 1</th>
<th>Phase 2/3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEMATOLOGIC MALIGNANCIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AML, MDS, ALL</td>
<td>TSC-100 (HA-1)</td>
<td>HLA-A*02:01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TSC-101 (HA-2)</td>
<td>HLA-A*02:01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SOLID TUMORS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head &amp; Neck, Cervical, NSCLC, Melanoma, Ovarian</td>
<td>TSC-200 (HPV16)</td>
<td>HLA-A<em>02:01, HLA-C</em>07:02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TSC-201 (MAGE-C2)</td>
<td>HLA-B<em>07:02, HLA-A</em>02:01, HLA-A*24:02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TSC-202 (undisclosed)</td>
<td>HLA-A*02:01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TSC-203 (PRAME)</td>
<td>HLA-A<em>02:01, HLA-B</em>07:02, HLA-A*24:02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TSC-204 (MAGE-A1)</td>
<td>HLA-A<em>02:01, HLA-C</em>07:02, HLA-A<em>01:01, HLA-A</em>03:01, HLA-B*07:02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Primary solid tumor IND, T-Plex, supports simultaneous use of multiple TCRs
Steady value-generating data flow across clinical programs

**Solid Tumor Program**

- Initiated clinical study
- Preliminary data for singleplexed Rx
- File INDs for 4 TCRs
- Initial data for multiplexed Rx
- Continue to build ImmunoBank
- Long-term duration data for multiplexed therapy

**Heme Program**

- Enrolled patients in all 3 arms of trial
- MRD, donor chimerism, & relapse data
- Establish recommended Phase 2 dose
- Complete Phase 1 dosing
- 6- & 12-month relapse data
- Initiate registration trial
- 2-year relapse data
Heme Malignancies: preventing relapse in patients undergoing HCT
TCR-T uniquely addresses myeloid leukemias

Non-B cell malignancies **AML, MDS, T-ALL** are not addressable by CAR-T therapy

**Allogeneic hematopoietic cell transplant** is considered curative for many and is expected to remain standard of care

Allo-HCT creates a unique opportunity to safely target residual cancer cells

**35,000** cases/year US

**8,000** undergo transplant

- **40%** of patients relapse
- **90%** mortality within 1 year

Source: Independent KOL market research conducted June 2020.
TSC-100/101 prevent relapse by eliminating residual cancer cells following HCT
Multi-arm Phase 1 clinical trial now enrolling final dose level

AML, MDS, ALL
Reduced intensity conditioning
Haploidentical transplant

Patient A*02:01 positive
(~42% US pop)

HA-1 positive
(~60%)

Transplant + TSC-100

Patient A*02:01 negative
(~58% US pop)

HA-2 positive
(~40%)

Transplant + TSC-101

Transplant

Dose Level 21 61

1 5×10^6/kg

2 5×10^6/kg 5×10^6/kg

3 5×10^6/kg 2×10^7/kg

Presented at ASGCT 2023

AML: acute myeloid leukemia; MDS: myelodysplastic syndrome; ALL: acute lymphoblastic leukemia
MRD: minimal residual disease; DL: dose level
Key biomarkers measure residual leukemia or residual patient-derived blood cells as surrogates of efficacy

**Minimal Residual Disease (MRD)**

- High sensitivity
  - MRD by NGS
  - Sensitivity ~0.01%
  - Performed at Columbia University

MRD+ patients post-transplant (~30%) have ~90% chance of relapse.\(^1,2\)

**POST-TRANSPLANT PATIENT**

- Residual Leukemia (HA-1-positive)
- HA-1-negative donor blood cells
- Residual blood cells (HA-1-positive)

**Residual patient derived blood cells**

- Mixed donor chimerism

- High sensitivity
  - NGS-based Alloheme assay
  - Sensitivity ~0.13%
  - Performed by CareDx

Early complete donor chimerism is a favorable indicator of success.\(^3\)

---

1. Craddock, J Clin Oncol 2021
2. Loke, ASH 2021
3. Lindhal, Bone Marrow Transpl 2022
TSC-101 patient: TP53 mutant MDS turned from MRD-positive pre-HCT to MRD-negative post-HCT and post TSC-101

MDS: myelodysplastic syndrome; RIC: reduced intensity conditioning; HCT: hematopoietic cell transplant; PTCy: post-transplant cyclophosphamide; MRD: minimum residual disease; ddPCR: droplet digital polymerase chain reaction; NGS: next generation sequencing; LOD: limit of detection

**Blood Samples:**
- MRD of whole blood by ddPCR (LOD 0.01%)

**Marrow Samples:**
- MRD of whole bone marrow
- CD34+ cells by NGS (LOD 0.05%) or ddPCR (LOD 0.01%)

---

**Marrow Samples:**
- MRD of whole bone marrow
- CD34+ cells by NGS (LOD 0.05%) or ddPCR (LOD 0.01%)
TSC-101 treated patient shows complete donor chimerism compared to control arm patients

<table>
<thead>
<tr>
<th>Day post HCT</th>
<th>TSC-100 DL 1</th>
<th>TSC-101 DL 1</th>
<th>Control patient #1</th>
<th>Control patient #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 21</td>
<td>TCR-T</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 35</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day 42</td>
<td></td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day 56</td>
<td></td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day 63</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 77</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 133</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 180</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Presented at ASGCT 2023

Donor chimerism detected by high-sensitivity NGS-assay (Alloheme) with LOD 0.13%

NGS: next generation sequencing; LOD: limit of detection

TSC-100: T-Cell Survivin Cysteine-ACTivated 100
TSC-101: T-Cell Survivin Cysteine-ACTivated 101

TCR-T: T-Cell receptor T
Near-term opportunity to address the unmet need for thousands of patients

US addressable market could triple with changes in transplant practice and double with additional HLAs and targets

Addressable patients

- Non-HLA-A02
- Non-haplo
- Haplo
- MAC
- RIC
- Eligible patients in clinical trial
- MUD conversion to haplo
- MAC conversion to RIC
- Transplant growth
- New Targets/HLAs

HCT: Hematopoietic Cell Transplant. MAC: Myeloablative Conditioning; MRD: Matched Related Donor; MUD: Matched Unrelated Donor, RIC: Reduced Intensity Conditioning
Source: SEER, CIBMTR, ClearView Analysis
Long-term opportunities to address tens of thousands of patients

Several global expansion and lifecycle management opportunities address additional patient populations with significant unmet needs.

Source: SEER, CIBMTR, ClearView Analysis
Solid Tumors: multiplexed TCR-T to overcome tumor heterogeneity
TScan is learning from nature to understand, exploit, and enhance how T cells recognize and fight cancer

The challenge:
- Heterogeneous target expression
- HLA loss
- Hostile TME (e.g., TGFβ)

Nature’s solution:
- Diverse repertoire of CD4+ and CD8+ T cells
- CD8+
- CD4+

What do T cells naturally recognize and how can we use that information to design better therapeutics?
T cells play a vital role in recognizing tumor antigens

We exploit and amplify natural behavior of T cell receptors to recognize targeted antigens presented by specific HLA types.
TScan is building an ImmunoBank of TCRs to enable enhanced, multiplexed TCR-T cell therapy

- Determine target and HLA expression in patient tumor
- Manufacture and administer customized, multiplexed TCR-T therapy
TScan’s solution for inducing deep and durable responses

**Multiplexed TCR-T to overcome target heterogeneity and HLA loss**

- Singleplexed TCR-T for Target 1
- Multiplexed TCR-T for Target 1 + Target 2
- Relapse
- Targeting long-term remission or cure

**Enhanced TCR-T to combat the hostile tumor microenvironment**

- Co-deliver CD8α/β to engage helper T-cells
- Co-deliver DN-TGFβRII to enhance T-cell expansion/persistence

- Treat patients with multiple TCR-Ts
- Prospectively select patients for target and HLA expression
TScan’s solution for inducing deep and durable responses

**Multiplexed TCR-T addresses target heterogeneity in vitro**

- SCC090
  - HPV16
  - HLA A*02:01
- SW1271
  - MAGE-A1
  - HLA A*02:01 and C*07:02

**CD8α/β enhances cytokine production in vitro**

- With CD8α/β
- Without CD8

**DN-TGFβRII improves responses in mouse models**

- Vehicle
- Untransfected T cells
- TSC-204-A0201 (no DN-TGFβRII)
- TSC-204-A0201 (+ DN-TGFβRII)

**Dead Target Cells (normalized)**

- UTF
- TSC-200-A0201
- TSC-204-A0201
- T-plex-200-A0201/A0201
- T-Plex-200-A0201/204-A0201
- T-Plex-200-A0201/204-C0702

**Tumor volume (mm³)**

- Days post implant
- TSC-204-A0201
- TSC-204-A0201 (+ DN-TGFβRII)
Adding DN-TGFβRII to TCR-T cells enables proliferation in the presence of immunosuppressive TGFβ signaling

Cytokine production

TCR-T without DN-TGFβRII

TCR-T with DN-TGFβRII

TGFβ suppresses IFN-γ production

TGFβ does not impact IFN-γ production

Proliferation

TCR-T without DN-TGFβRII

TCR-T with DN-TGFβRII

TGFβ suppresses proliferation

TGFβ does not impact proliferation

Expansion up to 100-fold and persistence up to 4 years in clinical trials

Programs address targets frequently co-expressed in prevalent solid tumors

Source: American Cancer Society

### Head & Neck
66 K Incident Patients in U.S.

- HPV16: 25%
- MAGE-C2: 25%
- Target 202: 50%
- PRAME: 90%
- MAGE-A1: 45%

### Melanoma
100 K Incident Patients in U.S.

- HPV16: 0%
- MAGE-C2: 50%
- Target 202: 40%
- PRAME: 90%
- MAGE-A1: 50%

### Cervical (Uterine cervix)
15 K Incident Patients in U.S.

- HPV16: 90%
- MAGE-C2: 10%
- Target 202: 25%
- PRAME: 50%
- MAGE-A1: ?

### NSCLC
230 K Incident Patients in U.S.

- HPV16: 0%
- MAGE-C2: 50%
- Target 202: 25%
- PRAME: 50%
- MAGE-A1: 50%
Leveraging ReceptorScan and TargetScan to build ImmunoBank of TCRs

**ReceptorScan**
Identify TCRs against previously validated targets

**TargetScan**
Identify the targets of TCRs that are driving responses to immunotherapy

**ImmunoBank**
A growing collection of potent anti-cancer TCRs that address diverse targets and common HLAs

**Tumor-derived TCRs screened against human peptidome**

**Millions of TCRs screened per target**
TScan is rapidly filling the ImmunoBank to enable multiplexed TCR-T therapy in solid tumors

TCRs covering multiple antigen and HLA alleles will enable 50-75% of patients to receive multiplexed therapy.

INDs
- TSC-200: Q4 2022
- TSC-201: H1 2023
- TSC-202: H2 2023
- TSC-203
- TSC-204

INDs for 6 TCRs by the end of 2023

INDs for 10+ TCRs by the end of 2024
TargetScan and ReceptorScan identify TCRs with potent cytotoxicity

MAGE-A1+ C*07:02+ melanoma
HS936T

In vitro

Non-engineered T cells
TSC-204-C0702

Target Cell Survival (%)
Time (Hours)

MAGE-A1+ A*02:01+ melanoma
NCIH1703

TSC-204-A0201

In vivo

HPV16+ A*02:01+ cervical cancer
CASKI

Non-engineered T cells
TSC-200-A0201

Vehicle

Tumor volume (mm³)
Time (days)

MAGE-A1+ C*07:02+ mouse model
U266B1

In vitro

Non-engineered T cells
TSC-204-C0702

Target Cell Survival (%)
Time (Hours)

MAGE-A1+ A*02:01+ mouse model
U266B1

In vivo

Non-engineered T cells
TSC-204-A0201

Dose

Tumor volume (mm³)
Time (days)

HPV16+ A*02:01+ mouse model
SCC152

TSC-200-A0201

In vitro

Dose

Tumor volume (mm³)
Time (days)
To date, the most impressive TCR-T results in solid tumors were achieved by targeting E7 of HPV16.
TScan’s TSC-200-A0201 shows comparable activity to NCI TCR

**In vitro**

<table>
<thead>
<tr>
<th>Cell Line</th>
<th>E:T</th>
<th>Target Cell Survival</th>
<th>Time (Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaSki</td>
<td>10:1</td>
<td>TSC-200-A0201</td>
<td>0, 50, 100</td>
</tr>
<tr>
<td></td>
<td>5:1</td>
<td>NCI</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cell Line</th>
<th>E:T</th>
<th>Target Cell Survival</th>
<th>Time (Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCC152</td>
<td>5:1</td>
<td>TSC-200-A0201</td>
<td>0, 60, 120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NCI</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cell Line</th>
<th>E:T</th>
<th>Target Cell Survival</th>
<th>Time (Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCC090</td>
<td>10:1</td>
<td>TSC-200-A0201</td>
<td>0, 70, 140</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NCI</td>
<td></td>
</tr>
</tbody>
</table>

**In vivo**

- Tumor volume (mm³)
  - Vehicle
  - NTD
  - TSC-200-A0201

TScan data, following Nagarsheth NB, ..., Hinrichs CS (2021) Nature Medicine, 27, 419-425.
Screening protocol pre-identifies patients for treatment

**Patient journey**

Current therapy → Progression → Leukapheresis → Lymphodepletion → T-Plex D1, 28 days → T-Plex D2 → Follow-up

**Screening protocol:**
- Pre-screens patients for trial eligibility during standard-of-care therapy/before progression
- Germline HLA testing
- Archival tumor sample:
  - Tumor IHC
  - HLA LOH testing

**Treatment protocol:**
- Rapid enrollment
- Vein-to-vein time 25 days
- No IL-2 given
- Endpoints:
  - Primary: Safety
  - Secondary: ORR, DOR
  - Exploratory: T-cell persistence
In-house non-viral manufacturing delivers customized, enhanced TCR-T cells to patients

- Leukapheresis
- Transport to TScan
- Isolate T cells
- Engineer T cells
- Transport to Hospital
- Infuse patient with engineered T cells

Transposon/transposase system enables lower COGs, faster development times, and larger cargo size for enhanced TCR-T cells
Process enables facile manufacturing for multiplexed TCR-T

Patient apheresis product -> PBMCs

Transposase mRNA + TCR #1 transposon = Engineered TCR-T cells #1

Administer sequentially to patient

Transposase mRNA + TCR #2 transposon = Engineered TCR-T cells #2
TSCAN-002: Dose escalation scheme provides a rapid path to multiplexed TCR-T in Phase 1

<table>
<thead>
<tr>
<th>DL1</th>
<th>Singleplexed</th>
<th>DL2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TSC-204-A0201 (MAGE-A1)</td>
<td>0.5E9</td>
</tr>
<tr>
<td></td>
<td>TSC-204-C0702 (MAGE-A1)</td>
<td>0.5E9</td>
</tr>
<tr>
<td></td>
<td>TSC-200-A0201 (HPV16)</td>
<td>0.5E9</td>
</tr>
<tr>
<td></td>
<td>TSC-203-A0201 (PRAME)</td>
<td>0.5E9</td>
</tr>
<tr>
<td></td>
<td>2E9</td>
<td>2E9</td>
</tr>
<tr>
<td></td>
<td>2E9</td>
<td>2E9</td>
</tr>
<tr>
<td></td>
<td>2E9</td>
<td>2E9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DL3</th>
<th>T-Plex</th>
<th>DL4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any two TCR-Ts that have cleared DL2</td>
<td>Any two TCR-Ts that have cleared DL3</td>
</tr>
<tr>
<td></td>
<td>2E9 + 2E9</td>
<td>5E9 + 5E9</td>
</tr>
<tr>
<td></td>
<td>2E9 + 2E9</td>
<td>5E9 + 5E9</td>
</tr>
<tr>
<td></td>
<td>28 days</td>
<td>28 days</td>
</tr>
</tbody>
</table>
Patient eligibility increases rapidly as ImmunoBank grows

Eligible patients include patients who do not require multiplexing (homozygous or hemizygous for targeted HLA type) or are eligible for at least 2 HPV16 TCRs.

Eligible patients include patients who are positive for at least 2 TCR-Ts in the ImmunoBank.
TScan platform technologies can be deployed for target and TCR discovery across many therapeutic areas

**Oncology**
- Novel antigen and clinic-ready TCR discovery
  - Solid tumors and heme malignancies
  - Shared or neoantigens

**Infectious disease**
- Shared T cell antigen ID for vaccine development or TCR-T therapeutics
  - Viruses (COVID-19, flu, etc.)
  - Bacterial infections (e.g., Tb, listeria)

**Autoimmune disease**
- Shared T cell antigen ID for a tolerizing product modality (e.g., TCR-Treg tx, vaccine)
  - T cell driven diseases (e.g., RA, IBD, scleroderma, psoriasis)
Amgen partnership builds value in autoimmune disease

Multi-year collaboration uses TargetScan to identify targets recognized by CD4+ T cells in patients with Crohn’s disease; option to expand collaboration in ulcerative colitis.

Amgen developing modalities to create novel therapeutics using identified antigens.

Financials include:

- $30 million upfront payment.
- Success-based development and commercial milestone payments of over $500 million.
- Covers one HLA type; opt-in for additional HLAs for additional economics.
- Tiered royalties.
TScan highlights

Transformative platform enables rapid discovery of TCRs and targets for engineered T cell therapy
Recent collaboration highlights applicability outside oncology
In-house GMP manufacturing using non-viral vectors

Hematologic malignancies program to prevent relapse with HCT
First patient treated shows complete donor chimerism
No DLTs observed to date
TSC-100 and TSC-101 progressing to third and final dose level

Solid tumor program to deliver enhanced multiplexed TCR-T
INDs cleared for four TCRs in 2023
Two more filings planned by EOY
Patient screening initiated

Q2 2023: $208.8 M
Amgen collaboration proceeds: $30 M
Net cash from 2Q’23, along with Amgen proceeds, funds Company into 2026
THANK YOU