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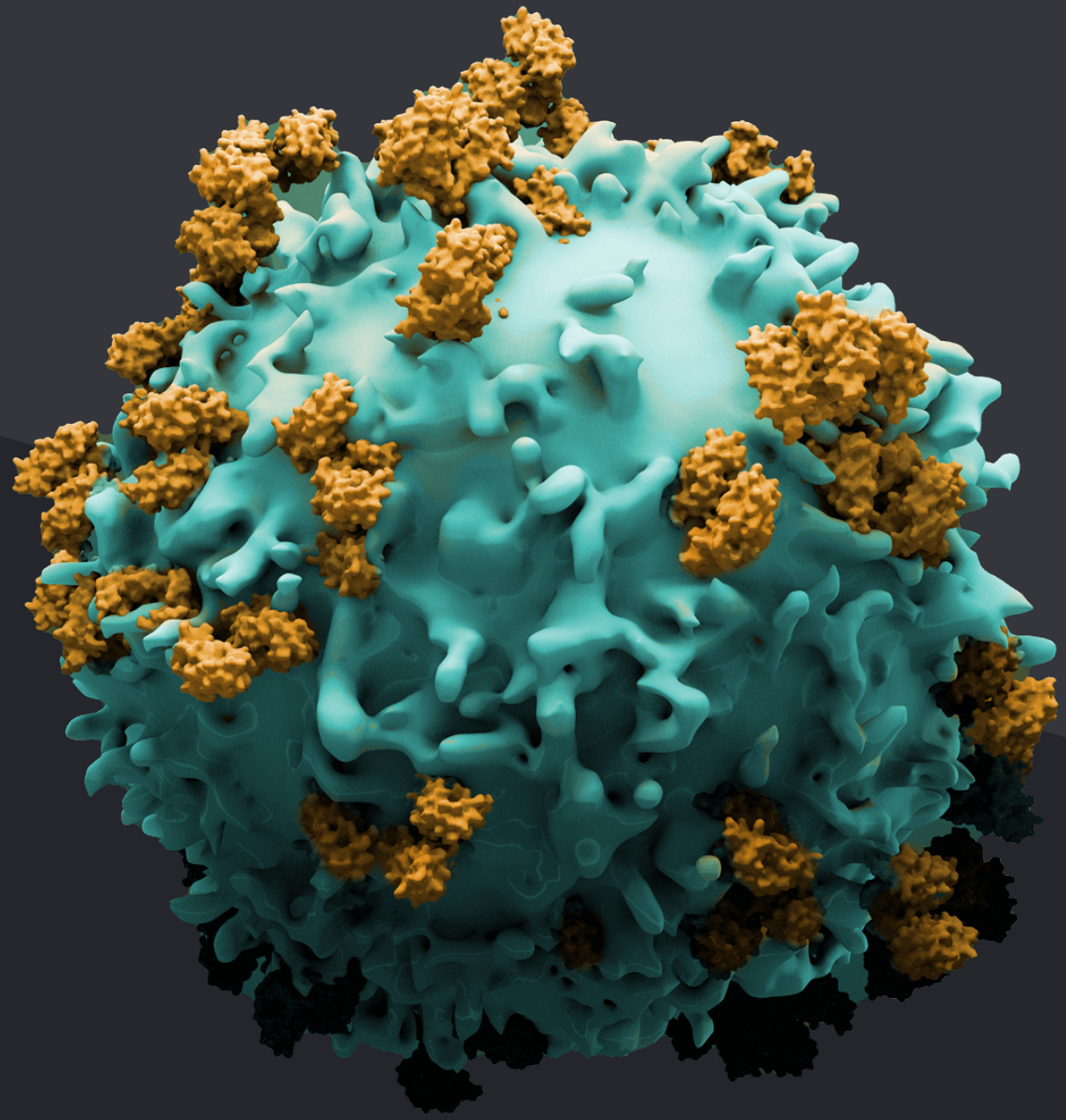

Corporate Presentation

July 2026

Active Immunotherapy
Ready For Prime Time

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Investment Highlights

Phase 3 ready, pipeline diversity, near term catalysts

iSCIB1+: Novel, Phase 3-Ready DNA Therapeutic Vaccine for Melanoma

Compelling clinical benefit across multiple endpoints:

- Highlight of 77% PFS at 22 mths vs 43% SoC* with CPIs in adv melanoma in ongoing Phase 2b trial

Favorable safety profile

Defined regulatory path for global Phase 3 with accelerated approval surrogate endpoint (PFS)

Phase 1 **Monotherapy** activity in adjuvant setting **expansion opportunity**

Multi-billion-dollar market potential

Validated Platform, Robust, Diversified Pipeline with Partnership Opportunities

ImmunoBody™ **platform focuses on hard to drug tumors** beyond melanoma such as PDAC, NSCLC, MSS CRC

MODITOPE® **platform generates off-the-shelf peptide vaccines**

GlyMab Therapeutics, a wholly owned subsidiary, focuses on **developing high affinity IgG1 antibodies** targeting tumor-specific glycans. Two antibodies partnered with Genmab

Solid Financials Through Multiple Milestones

Multiple Milestones Ahead, including the Phase 3 iSCIB1+ primary readout in H2 2028[1]

Near-term catalysts:

Advanced melanoma:

- **Phase 3 initiation of ISCIB1+ in H2 2026[1]**
- **Additional Phase 2 PFS & early OS in advanced melanoma in H1 2027**

Neo/adjuvant melanoma:

- **Phase 2 initiation in H1 2027[1] with interim data in H2 2027**

CPI=checkpoint inhibitors (Nivolumab and Ipilimumab); CRC=colorectal cancer; MSS=microsatellite stable cancer; NSCLC= non-small cell lung cancer; PDAC=Pancreatic ductal adenocarcinoma .
1. Subject to financing. * Checkmate 067 study. Data from ipi+nivo arm of study

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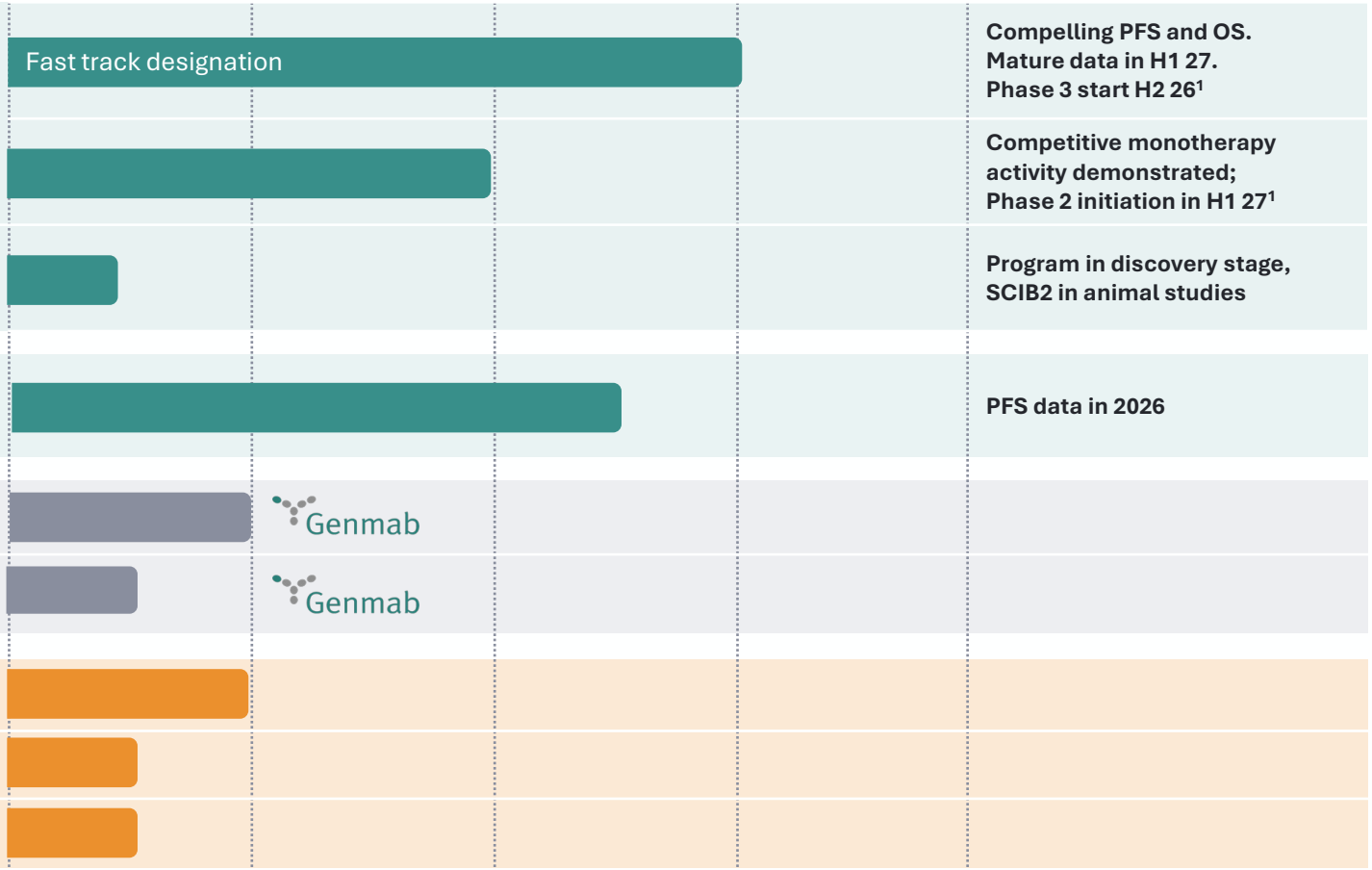
Robust, Diversified Pipeline with Partnership Opportunities

Lead asset iSCIB1+ ready to enter phase 3 trial

	Product	Modality	Indication	Target	Recent & Upcoming Milestones
Scancell Clinical	SCIB1/ iSCIB1+	DNA Plasmid encoding In vivo antibody	Advanced Melanoma (+ipi/nivo)	GP100 & TRP2	**Compelling PFS and OS. Mature data in H1 27. Phase 3 start H2 26[1]**
Scancell Clinical	SCIB1	DNA Plasmid encoding In vivo antibody	Adjuvant Melanoma (monotherapy)	GP100 & TRP2	**Competitive monotherapy activity demonstrated; Phase 2 initiation in H1 27[1]**
Scancell Clinical	ImmunoBody®	DNA Plasmid encoding In vivo antibody	PDAC, NSCLC, MSS CRC	NY-ESO-1, KRAS, cMET, FAP	**Program in discovery stage, SCIB2 in animal studies**
Scancell Clinical	Modi-1 **(ModiFY study)**	Peptide	Head & Neck and Renal	Combination with CPIs[1]	**PFS data in 2026**
Partnered	SC129	ADC	Solid Tumours	-	
Partnered	SC2811	ADC	Solid Tumours	-	
GlyMab Tx	SC134	TCE	SCLC	Fucosyl GM1	
GlyMab Tx	SC27	TCE/ADC	Various	Lewis^{Y}	
GlyMab Tx	GT200	TBC	Ovarian	SLAN	



ADC=antibody-drug conjugate; CPI=checkpoint inhibitors; CRC=colorectal cancer; Ipi=Ipilimumab; MSS=microsatellite stable cancer; Nivo= Nivolumab; NSCLC= non-small cell lung cancer; PDAC=Pancreatic ductal adenocarcinoma; SCLC=small cell lung cancer; TCE=T cell engager. 1. Subject to financing.

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SCIB/iSCIB1+ Program in First Line Advanced Melanoma

Despite Advent of Checkpoint Inhibitors, Significant Unmet Need in Melanoma

Melanoma is the deadliest form of skin cancer

Melanoma cases are rapidly rising

Cases of melanoma **have tripled in the last 30 years** and continue to rise, especially in young people[1]

~330,000 global incidence[2] with 104,960 new cases of invasive melanoma in the U.S. alone[3]

~60,000 deaths per year globally[2]

Many patients do not respond to CPI and have limited treatment options in the post-CPI settings

50% of patients treated are **refractory or relapse within 1 year** of treatment

5-year survival of Stage IV melanoma is **<23%**

Post-progression treatment options remain limited and non-durable

There is a substantial unmet need for therapies that can provide robust and long-lasting response

CPI=checkpoint inhibitors.

1. Melanoma Research Alliance. https://www.curemelanoma.org/about-melanoma/melanoma-101. 2.WHO (2022) https://www.iarc.who.int/cancer-type/skin-cancer/#summary. 3. CDC (2025). https://seer.cancer.gov/statfacts/html/melan.html

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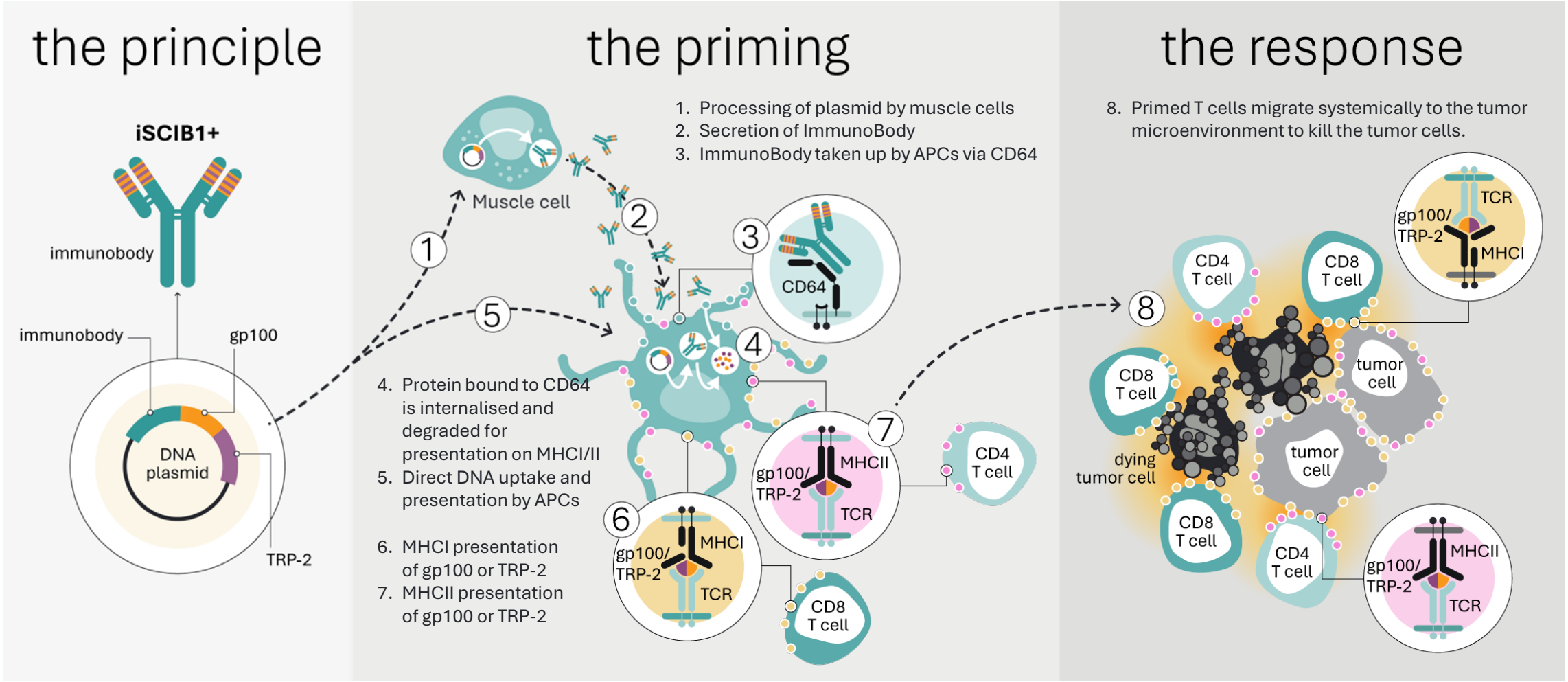
iSCIB1+'s Novel Dual Presentation MoA: Robust and Durable Anti-Tumor Response

Cross-presentation increases potency 100-fold



In combination, checkpoint inhibitors unleash high-avidity iSCIB1^{+} T-cell–driven tumor killing

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Stratis® Allows for Patient-friendly Administration

Minimal training required, similar workflow to needle and syringe

- Intramuscular delivery
- Needle-free (high velocity fluid jet)
- Hand-held with separate charging station
- Delivers injectables in ~1/10 of a second
- Broad global regulatory approval
- Development & Commercialization agreement

SCOPE Phase 2b Trial of SCIB/iSCIB1+ in Combination with Checkpoints in 1L Advanced Melanoma

132 patients across 16 sites in the UK

Objective: select product, target population, dosing schedule and endpoints for Ph 3 trial

Key inclusion Criteria

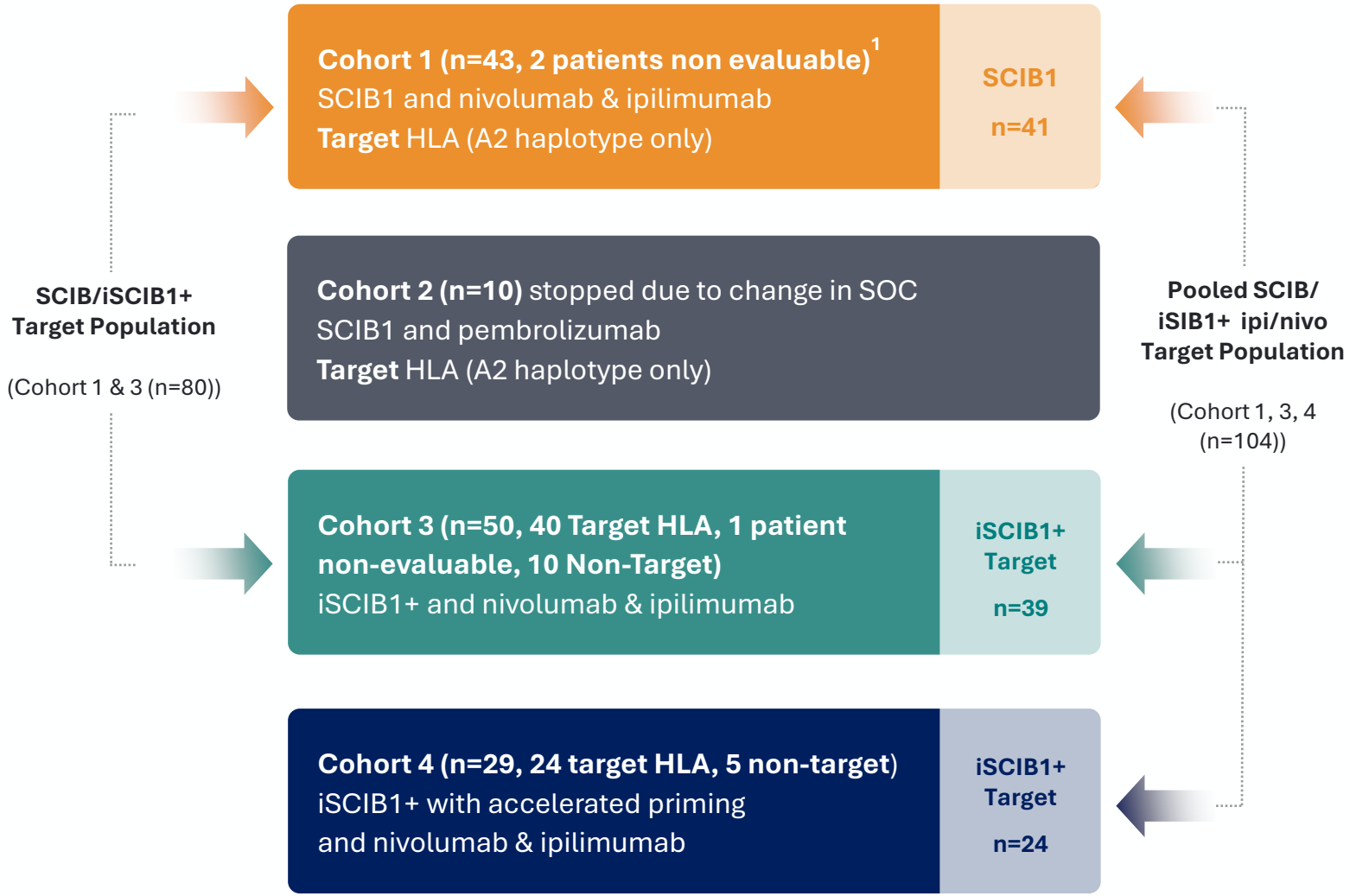
- Histologically confirmed, unresectable Stage III or Stage IV Melanoma
- Not received prior systemic treatment for advanced disease.
- ECOG Performance Status 0 or 1.
- ≥ 1 measurable lesion per RECIST 1.1
- Known HLA status

Key Exclusion Criteria:

- Acral, Ocular & Mucosal Melanoma
- CNS Metastases
- Exposure to CPI as adjuvant treatment in previous 6 months

Phase 2b SCOPE trial

Designed to improve on reported outcomes with SOC:
ipi/nivo PFS: 46% at 12m; Pembro: 35% at 12m



1. Two patients non-evaluable,. 2. One patient considered non-evaluable (Brain mets, acral melanoma)

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Phase 2b SCOPE trial

Trial Population Highly Aligned with 1L Melanoma Studies

Baseline patient characteristics

	SCIB1 (n=43)	iSCIB1+ (n=50)
Gender		
Male	65%	42%
Female	35%	58%
Age		
<65	47%	66%
≥65 - <75	25%	30%
≥75	28%	4%
Stage of Disease at Study Entry IIIB/IIIC/IV	1 IIIB / 42 IV	1 IIIC / 49 IV
M0, M1a or M1b	64%	58%
M1c, M1d	36%	42%
BRAF		
Mutation	49%	50%
Wildtype	51%	50%
Lactate Dehydrogenase		
>Upper limit of normal (ULN)	33%	38%
≤ULN	67%	62%
Prior treatment in the adjuvant setting		
Anti-PD-1	26%	10%
Baseline Tumor Burden		
<100mm/>100mm	19/81%	
Liver mets	27.5%	

	ipi + nivo Checkmate 067	Nivo+rela Relativity 047	IO102/103-pembro
Gender			
Male	65%	59%	67%
Female	35%	41%	33%
Age			
<65	60%	59%	38%
≥65 - <75	28%	29%	26%
≥75	13%	12%	36%
Stage of Disease at Study Entry IIIB/IIIC/IV	1 IIIB / 42 IV	1 IIIC / 49 IV	
M0, M1a or M1b	42%	59%	60%
M1c, M1d	58%	41%	40%
BRAF			
Mutation	32%	39%	41%
Wildtype	68%	61%	59%
Lactate Dehydrogenase			
>Upper limit of normal (ULN)	36%	36%	35%
≤ULN	64%	64%	65%
Prior treatment in the adjuvant setting			
Anti-PD-1	0	8.4%	10.3%
Baseline Tumor Burden			
<100mm/>100mm			16/84%
Liver mets	28%	40%	18.1%

Trial population is representative with:
More BRAF mutant, lower M1c/d; similar tumor burden and liver mets; and more prior anti PD-1

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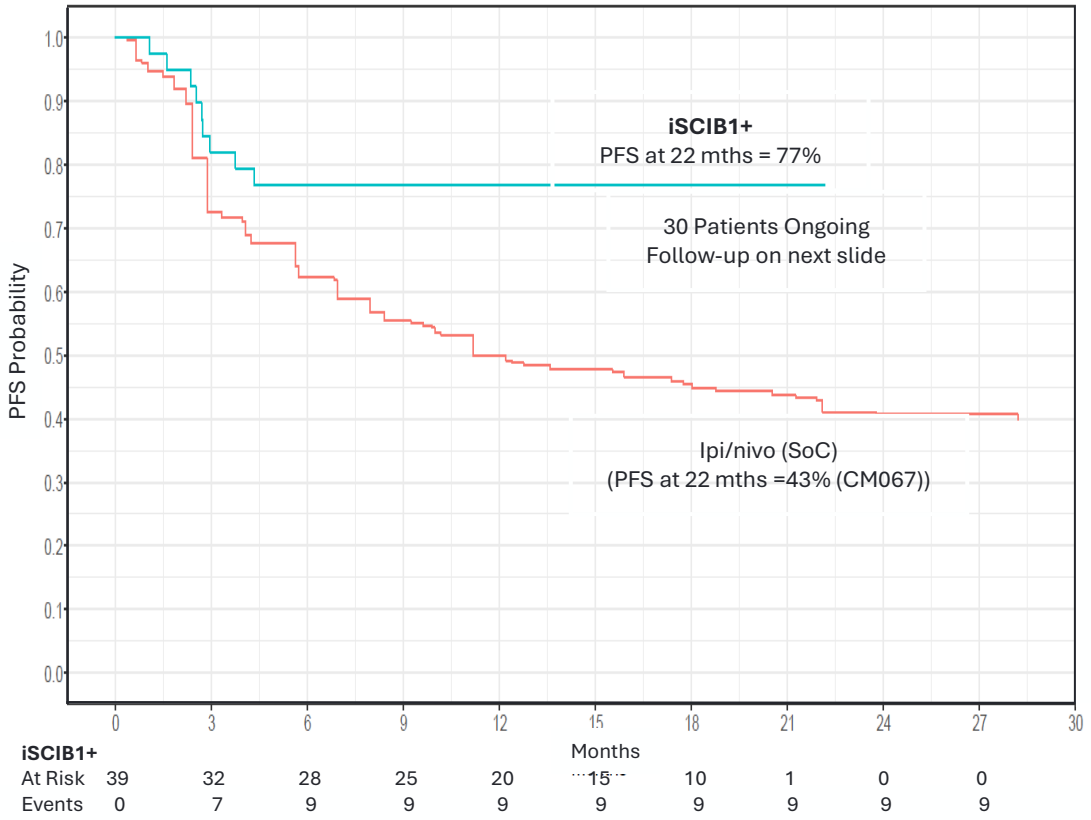
Phase 2b SCOPE trial

Compelling Clinical Benefit Observed Across Multiple Endpoints

	Scancell	Scancell	BioNTech	IO Biotech	BMS	BMS	Real World
Study[1]	SCOPE (combined)	SCOPE (iSCIB1+ accel dosing)	IMCODE-001 (control arm)	Phase 3 NCT05155254	Relativity 047	Checkmate 067	NA
No of Patients	104	24	41	203	355	314	NA
Agent	iSCIB1+ / SCIB1 Nivolumab + Ipilimumab	iSCIB1+ Nivolumab + Ipilimumab	Pembro	IO102-IO103 + Pembro	Anti-LAG-3 + nivo	Nivo + ipi	Nivo + ipi
ORR	**62%**	**70%**	49%	44.8%	43.9%	50% (confirmed)	48%
DCR	**81%**	**83%**		65.5%		63%	58%

iSCIB1+ with ipi/nivo (SCOPE) vs ipi/nivo (Checkmate 067))



More Mature PFS and early OS data expected in H1 2027

DCR=disease control rate; ORR=overall response rate
IMCODE001: 2024 ASCO Annual Meeting, Relativity 047: N Engl J Med 2022;386:24-34, Checkmate 067: N Engl J Med 2017;377:1345-1356, IO Biotech: Annals of Oncology May 2026, RWE European Journal of Cancer, 2022; 176, 121-132
Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in study design, phase, population, sample size, inclusion and exclusion criteria and many other factors.

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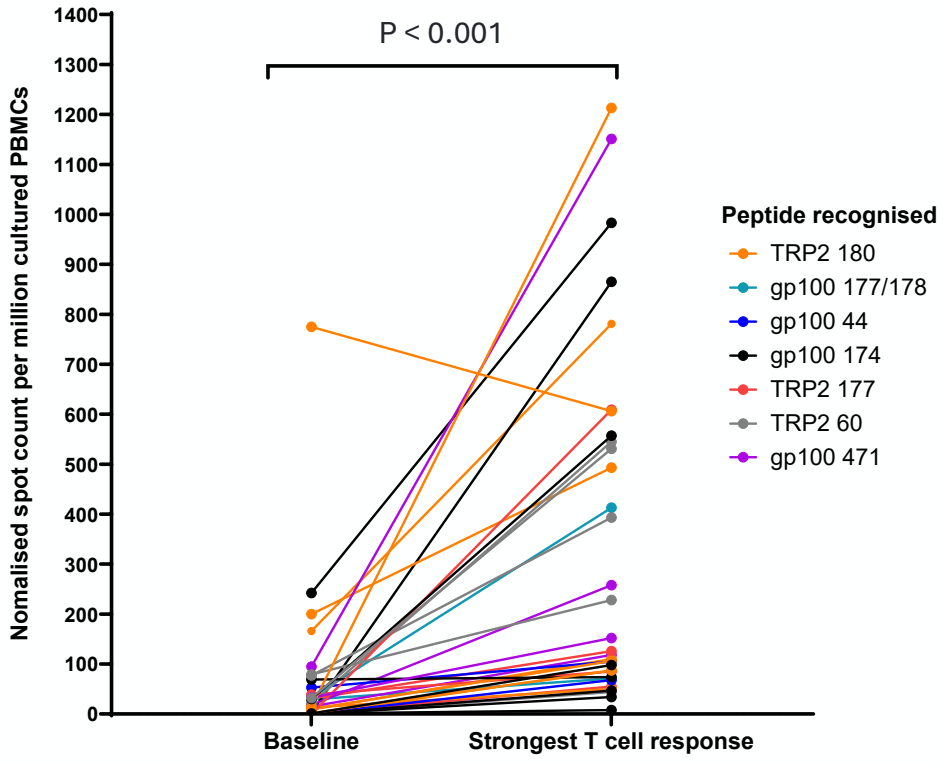
Strong Anti-tumor T Cell Responses Generated by iSCIB1+ Correlated with ORR

High statistical significance in increased T-cell response post-SCIB1+ administration observed in patients



Patients with broad T-cell responses had better clinical responses

Clinical response	Number of patients	High magnitude T cell response (n=30)*	Response to both gp100 and TRP2 (n=39)
CR/PR	**41**	**22/30 (73%)**	**28/39 (72%)**
SD	17	5/30 (17%)	7/39 (18%)
PD	8	3/30 (10%)	4/39 (10%)
Overall:	66*	30	39

**94% patients generated T-cell responses to the iSCIB1+ peptides*

Cells with CD8 SCIB1/iSCIB1+ specific TCRs have:

- Strong signal of tumor cell killing and immune cell recruitment (cytotoxic and chemokine signature)
- Tumor-specific stem-like T cells that **can be reactivated and expand to mount an anti-tumor response** (Tpex phenotype)

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SCIB1 & iSCIB1+ Well Tolerated with No Increase in CPI-Related Toxicities

Treatment-Emergent Adverse Events amongst HLA matched, evaluable patients in C1, 3 & 4 (n=104)

TEAEs, n(%)	Related to: SCIB1/iSCIB1+		Related to CPI		Dually Related (CPI + IMP)	
	All grades	Grade ≥3	All grades	Grade ≥3	All grades	Grade ≥3
Endocrine disorders						
Hypophysitis	5 (4)	3 (3)	11 (10)	5 (5)	5 (4)	3 (3)
Adrenal Insufficiency	5(5)	0 (0)	13(13)	1(1)	3(3)	0(0)
Thyroid Disorders	2 (2)	0(0)	18 (14)	2(1)	0(0)	0(0)
Eye disorders						
Dry Eye*	1 (1)	0 (0)	5 (5)	0 (0)	1 (1)	0 (0)
Uveitis*	2 (2)	0 (0)	2 (2)	0 (0)	0 (0)	0 (0)
Vision Blurred*	3 (2)	0 (0)	2 (2)	0 (0)	1 (1)	0 (0)
Gastrointestinal disorders						
Colitis	5 (3)	1 (1)	22 (21)	15 (14)	5 (3)	1 (1)
Diarrhoea	9 (8)	0 (0)	50 (32)	6 (5)	9 (8)	0 (0)
Decreased Appetite	5 (5)	0 (0)	21 (14)	1 (1)	5 (5)	0 (0)
Nausea	10 (5)	1 (1)	32 (20)	2 (2)	9 (4)	1 (1)
Injection Site Reactions	42 (16)	0 (0)	3 (3)	0 (0)	0 (0)	0 (0)
Fatigue	22 (20)	0 (0)	56 (44)	1 (1)	18 (16)	0 (0)
Headache	7 (5)	0 (0)	22 (17)	0 (0)	6 (4)	0 (0)
Hepatitis	3 (3)	1 (1)	24 (11)	6 (6)	3 (3)	1 (1)
Transaminases Increased	29 (11)	6 (4)	76 (4)	18 (15)	28 (11)	6 (4)
Arthralgia	0 (0)	0 (0)	19 (9)	0 (0)	0 (0)	0 (0)
Vitiligo*	5 (2)	0 (0)	13 (13)	0 (0)	4 (4)	0 (0)
Pruritus	5 (5)	0 (0)	37 (23)	1 (1)	5 (5)	0 (0)
Rash	22 (16)	2 (2)	91 (54)	6 (6)	21 (15)	2 (2)

- Low grade AEs for iSCIB1+ and SCIB1
- No potentiation of the toxicities associated with ipilimumab & nivolumab observed
- One patient discontinued treatment due to posterior uveitis, which fully resolved following discontinuation
- Grade ≥3 TEAEs were infrequent overall
- TEAEs were predominantly manageable through standard supportive care and without treatment discontinuation

*Possibly related to mechanism of action.

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iSCIB1+ Defined Regulatory Path Forward

Accelerated Approval Trial Design of ISCIB1+ in Advanced Melanoma

Phase 3 double blinded randomized registrational study cleared with FDA

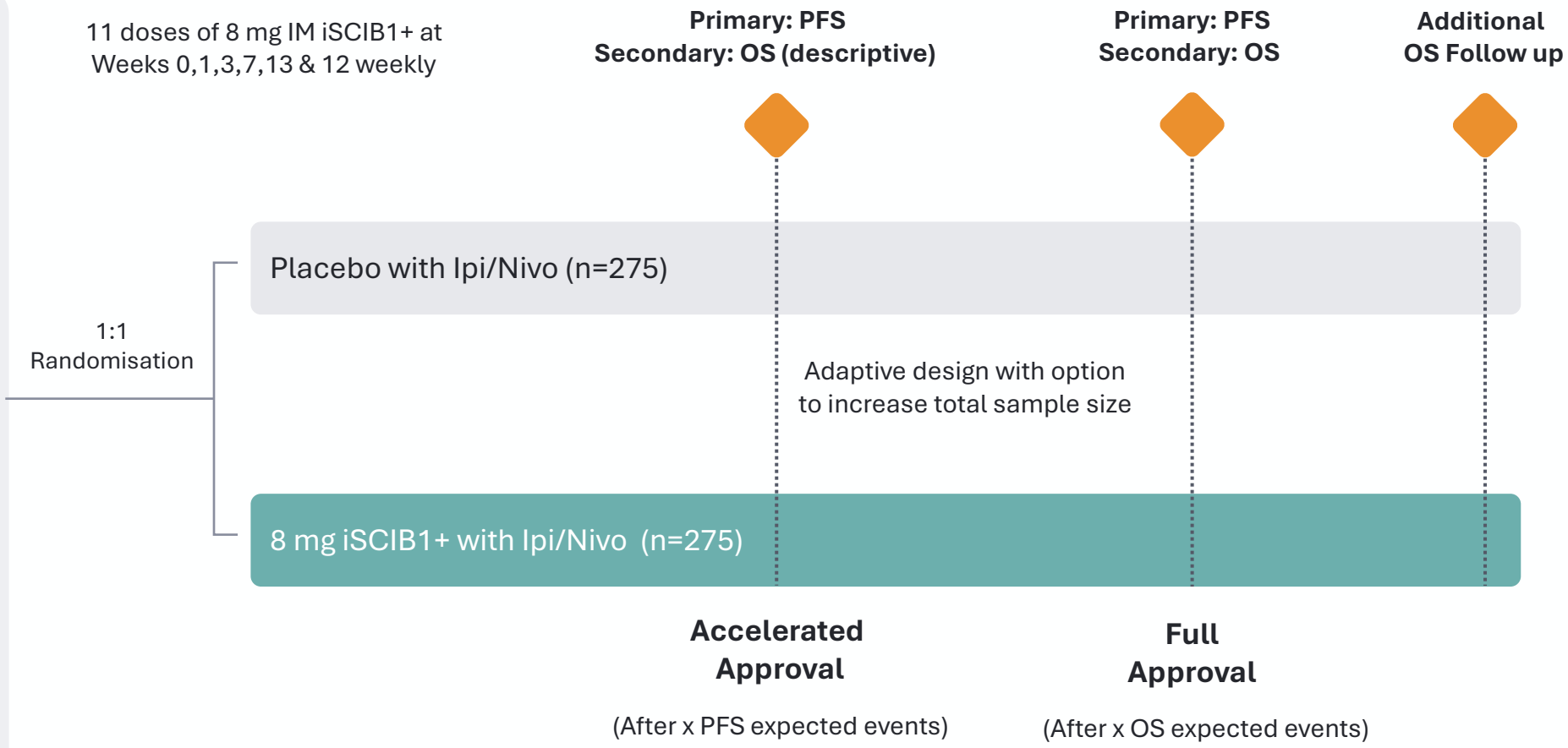
N = 550 at ~90 global sites

Target Population:

- Stage III & IV unresectable melanoma
- HLA Haplotypes: A2, A3, A31, B35, B44, Bw4
- Exclude acral melanoma & active brain metastases

Stratification Factors:

1. BRAF status: WT / M
2. Previous adjuvant therapy: Y vs N
3. No of metastatic lesions: <3 or >3



iSCIB1+ has FDA fast track designation

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Defined Regulatory Path Forward for iSCIB1+

Building positive momentum through solid regulatory strategy

Jan 2026	Received **IND clearance** from FDA for the Phase 3 of iSCIB1+ in advanced melanoma
Apr 2026	FDA **Fast Track** Designation Received **CTA submitted** to MHRA
May 2026	**Anticipated regulatory submissions** EMA, Canada, Australia
H2 2026	**Initiate Phase 3** in Q3 2026
H2 2028	**PFS data with potential for accelerated approval** in advanced melanoma

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iSCIB1+ Program in Neoadjuvant/ adjuvant melanoma

Phase 1 SCIB1 Monotherapy study in Resectable Melanoma

In partially and fully resected stage III & IV patients

Partially or Fully Resected Stage III & IV Adjuvant Patients

15 patients with some **tumor(s) at baseline**

- 0.1 -8mg dose (n=10)
- 8mg dose (n=5)

20 patients **with fully resected disease**

- 4mg dose (n=15)
- 8mg dose (n=4)

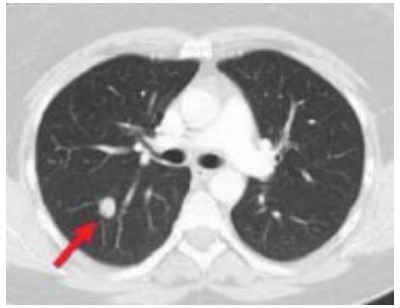
Patient Demographics

Number	35	%
Age		
Range	25–75	
Median	60	
Sex		
Male	18	51.4
Female	17	48.6
Stage at study entry[1]		
III	13	37.1
IV	22	62.8
M1a	7	31.8
M1b	8	36.4
M1c	7	31.8
Primary site		
Head	5	14.3
Neck	2	5.7
Upper extremity	2	5.7
Lower extremity	10	28.6
Trunk	10	28.6
Mucosal	1	2.9
Other	5	14.3
Unknown	1	2.9
History		
Superficial spreading	17	48.6
Nodular	10	28.6
Lentigo maligna	2	5.7
Acral lentiginous	1	2.9
Other	5	14.3
Lactose dehydrogenase (LDH)		
≥ 450 IU/L	6	17.1
< 450 IU/L	29	82.9

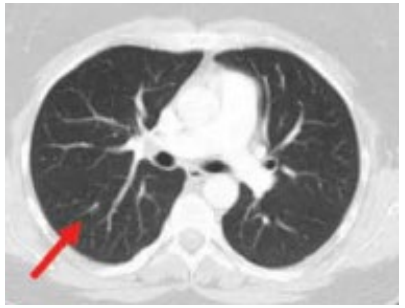
1 PR & 3 SDs Observed at 8mg Dose

Lung lesions before and after treatment with SCIB1

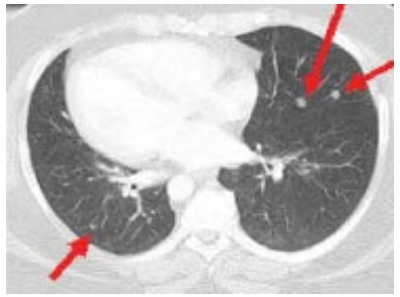
Patient A: Pre Treatment



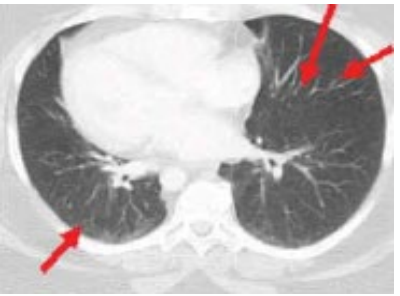
Patient A: Post Treatment (6 months)



Patient B: Pre Treatment



Patient B: Post Treatment (9 months)



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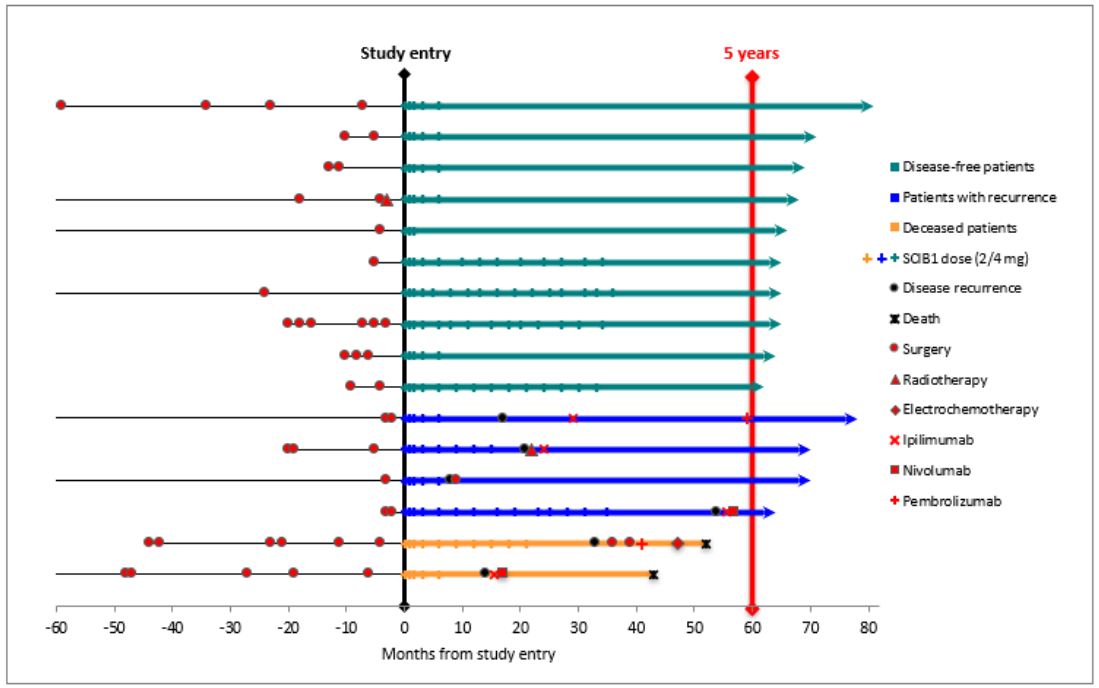
Phase 1 trial

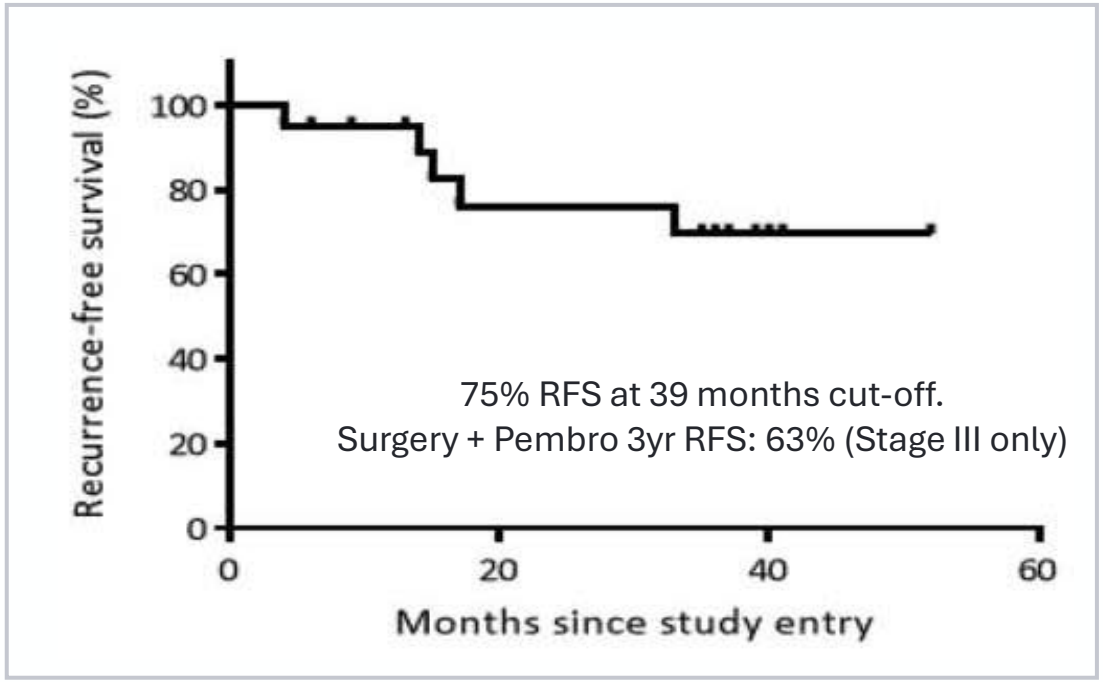
Compelling SCIB1 Monotherapy Activity in Neoadjuvant/ Adjuvant Melanoma

Data supports advancement to Phase 2

10 of 16 Patients remained disease-free at 60 months



RFS: All patients alive at 39 months cut-off



T cell responses in 88% of patients
No serious AEs or DLTs

Phase 2 initiation planned for H1 2027

Patel et al, ONCOIMMUNOLOGY 2018 VOL. 0, NO. 0, e1433516

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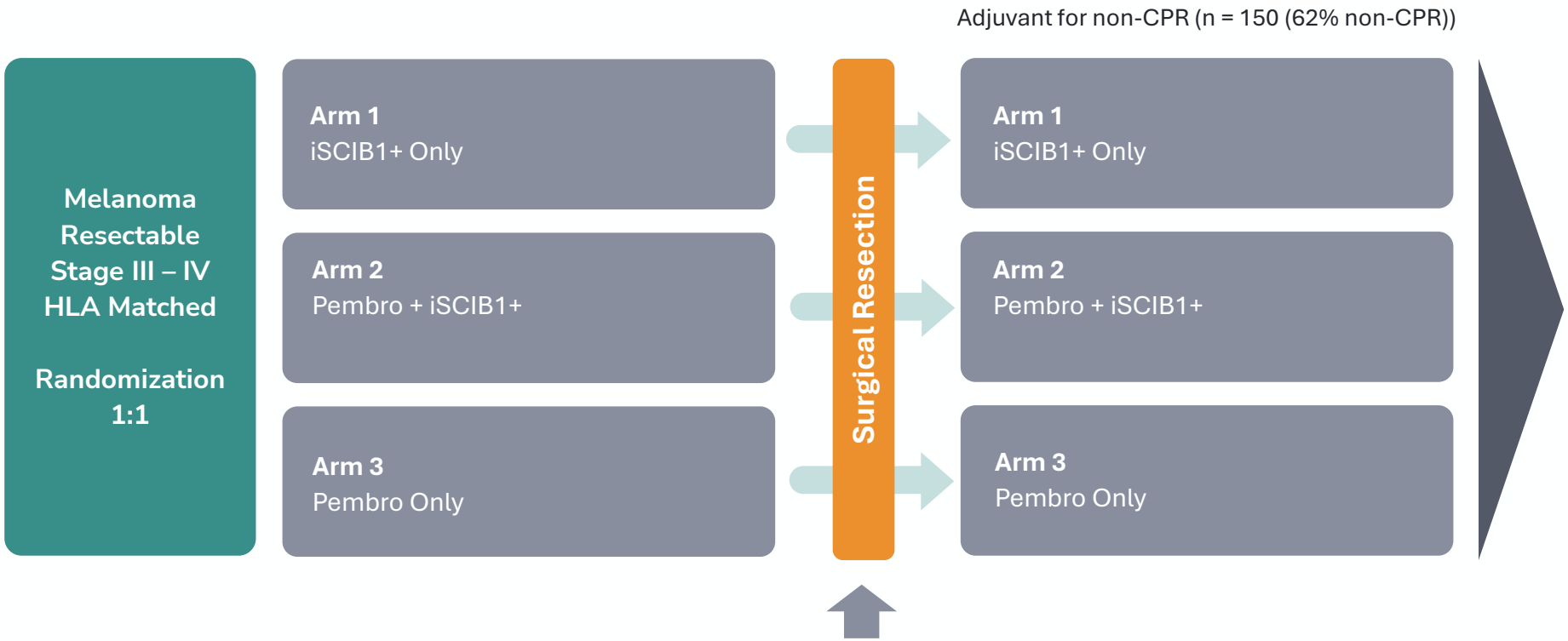
Proposed PoC Open-label, Randomized Study in Neoadjuvant/Adjuvant Setting

Study builds on demonstration of monotherapy



Neoadjuvant-adjuvant pembrolizumab vs adjuvant pembrolizumab (n=345) – SWOG 1801

- 3-y EFS: 68% vs 56%
- 3-y OS: 84% vs 73%
- Grade 3–4 TRAEs: 21% vs 18%

EFS at 12, 18 & 24 months

Primary Endpoint: 1st Read-out: Complete Pathological Response pCR

Phase 2 initiation planned for H1 2027

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iSCIB1+ Commercial Opportunity

iSCIB1+ Demonstrates Deep and Durable Responses Across Multiple Endpoints in Broad Patient Population

	Scancell (Investigational)		Immunocore (Investigational)	Iovance (Investigational)	BMS (Approved, now SoC)	
Therapy	SCIB1/iSCIB1+ + ipi/ nivo	iSCIB1+ accel dosing + ipi/ nivo	Brenetafusp	Lifileucel + pembro	Relatlimab + nivo	Ipi + nivo
MOA	Therapeutic vaccine		Engineered TCR	Ex vivo TIL expansion	Anti-LAG-3 + anti-PD-1	Anti-CTLA-4 + anti-PD-1
Study	Phase 2b SCOPE		NA	Phase 2**	Ph3 Relativity 047	Ph3 Checkmate 067
Patient selection	Broad HLA+ (80% Stage IIIB & IV)		HLA-A2 restricted	1L	1L	1L
No of Patients	104	24	NA	23	355	314
ORR	**62%**	**70%**	NA	65%	43.9%	50% (confirmed)
DCR	**81%**	**83%**	NA	NA		63%

DCR=disease control rate; ORR=overall response rate.

IMCODE001: 2024 ASCO Annual Meeting, Relativity 047: N Engl J Med 2022;386:24-34, Checkmate 067: N Engl J Med 2017;377:1345-1356, IO Biotech: Annals of Oncology May 2026, RWE European Journal of Cancer, 2022; 176, 121-132

Data above are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in study design, phase, population, sample size, inclusion and exclusion criteria and many other factors.

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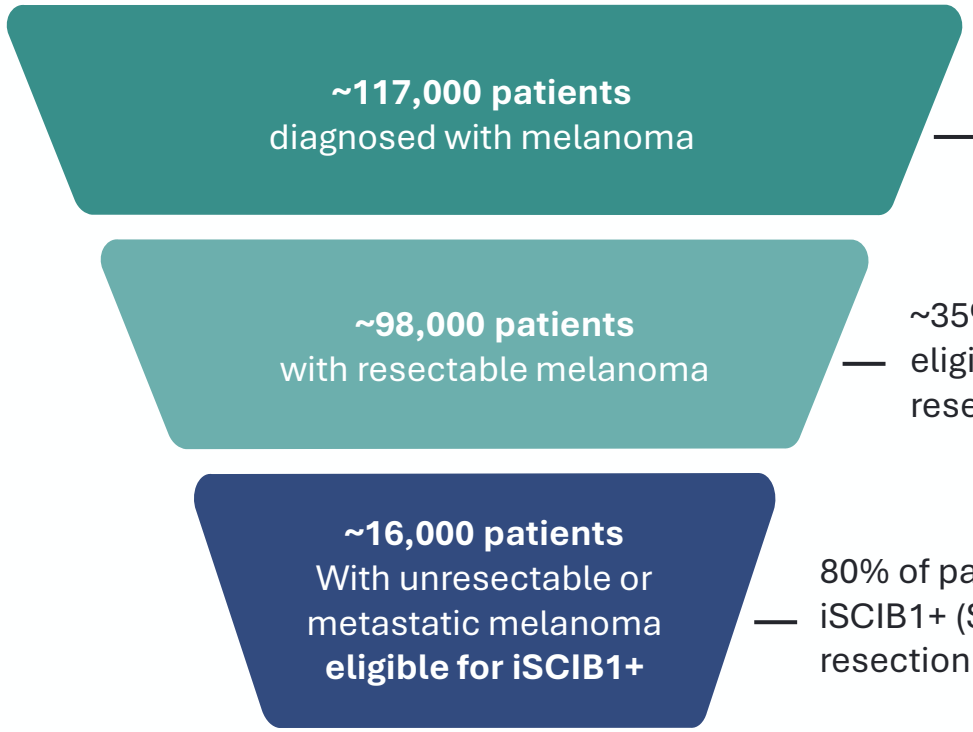
Significant Commercial Opportunity for iSCIB1+

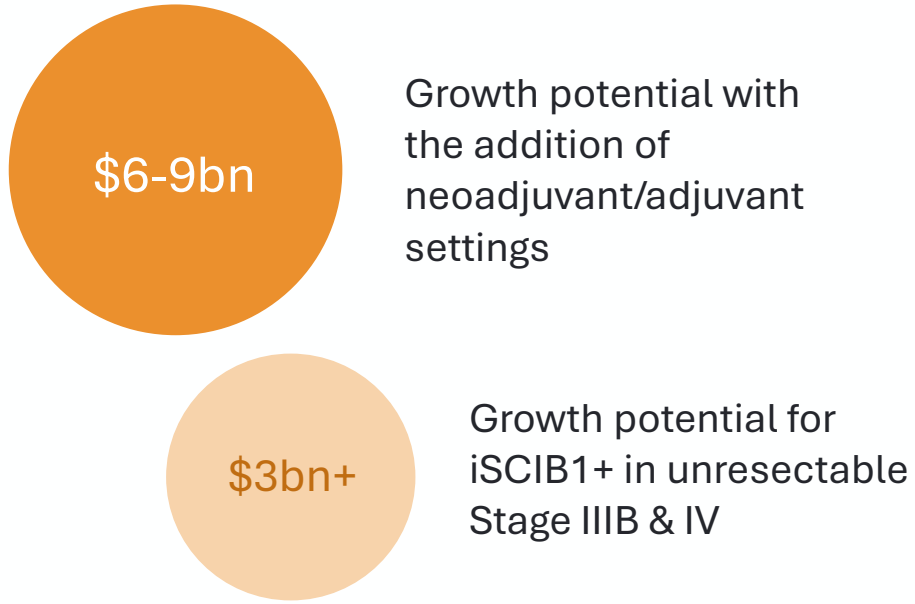
Global peak sales potential up to $9bn in both advanced and earlier settings

Cutaneous melanoma addressable market in the U.S.

(forecasted 2028)



Global peak sales potential for iSCIB1+



Bloomberg Melanoma Market Analysis 2026 | Peak sales based on predicted valuation of iSCIB1+ treatment and global addressable patient population

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Strong Execution

Experienced leadership executing with pace and precision

Focus and execution drive value

Phil L'Huillier
Chief Executive Officer

Professor Lindy Durrant
Chief Scientific Officer & Founder

Nermeen Varawalla
Chief Medical Officer

David Schilansky
interim Chief Financial Officer

Mandeep Sehmi
Head of Business Development

Callum Scott
SVP of Development

Key Milestones and Development Plans

2025	H1 2026	H2 2026	H1 2027	H2 2027	H1 2028	H2 2028	H1 2029
NHS CVLP Partnership ✓	iSCIB1+ IND clearance ✓	iSCIB1+ Ph3 Trial initiation	iSCIB1+ Neoadjuvant / adjuvant trial start	iSCIB1+ Neoadjuvant / adjuvant trial interim readout	iSCIB1+ Neoadjuvant / adjuvant trial readout	iSCIB1+ Ph3 primary readout	iSCIB1+ Regulatory filing
SCOPE study enrolment completed ✓	iSCIB1+ FTD ✓	Modi RCC and H&N data read out	iSCIB1+ SCOPE Study mature PFS & OS readout	SCIB2 -4 Preclinical development	iSCIB1+ fully enrolled	SCIB2 -4 Clinical development	
Data update ESMO IO ✓							
Modi RCC enrolment completed ✓							
New IP Glymab and TCEs ✓							

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iSCIB1+ Has the Potential to Transform The Treatment of Advanced Melanoma

Deep and durable responses with solid safety profile

- **Broad clinical benefit across multiple endpoints** with **competitive efficacy** vs approved and investigational treatments
- **Clinical benefit correlates with T-cell responses** and supports novel MOA
- **Favourable safety profile** for iSCIB1+; combinable with other existing or new therapies

Defined regulatory path to accelerated approval

- **Phase 3 initiation** in the U.S. anticipated **in H2 2026**
- CTA submitted to MHRA (UK), with imminent submissions to EMA, Canada and Australia regulatory agencies

Significant commercial opportunity

Multibillion dollars market opportunity:

- iSCIB1+ **initial peak sales of $3bn+** in advanced melanoma globally
- **Additional expansion potential to $6-9bn** in peak sales in the neoadjuvant/adjuvant setting
  - **Phase 2 initiation in** neoadjuvant/adjuvant melanoma expected in **H1 27**

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Additional Pipeline

Moditope® Off-the-shelf Peptide Vaccine

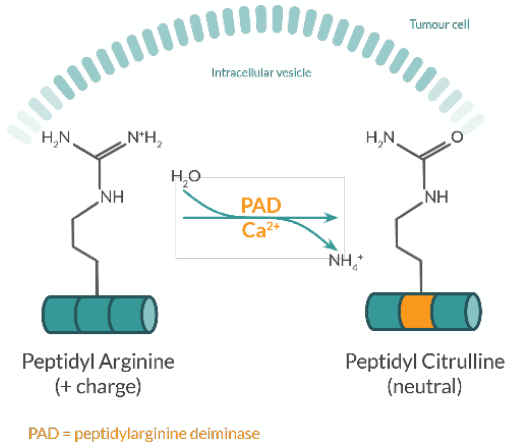
Targeting stress-induced post translational modifications

- Citrullination occurs due to autophagy induced in stressed cells, including cancer cells
- Citrullination protects from proteolytic cleavage and creates neo-epitopes
- Inflammation induces MHC class II expression and presentation of the citrullinated epitopes

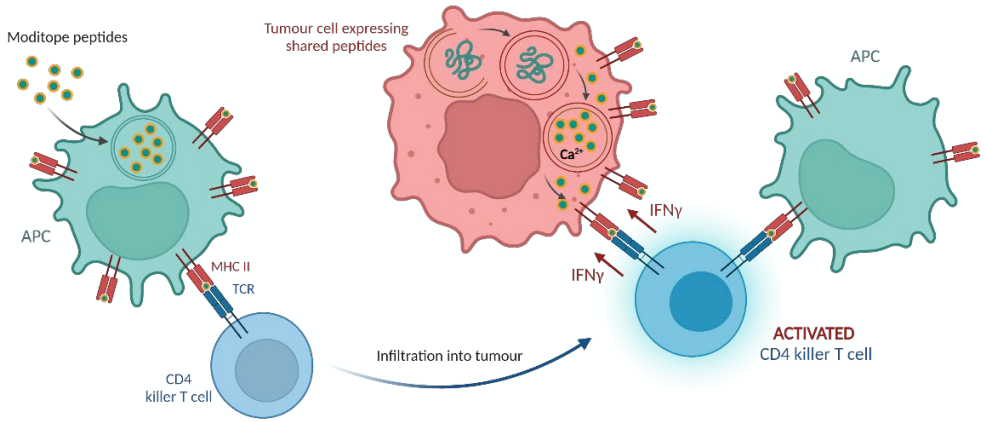
Modi-1 product consists of:

- Two citullinated vimentin and one enolase peptide
- Conjugated to amplivant® adjuvant immune response booster
- Several solid tumours undergoing autophagy express vimentin, enolase & citrullinated proteins PAD2, PAD4
- Tumour types: ovarian, triple negative breast, renal and head & neck cancers

Citrullination



Mode of action



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Modi-1 Pipeline & Clinical Development

- Multi-cohort basket study conducted at 16 UK clinical sites enrolling over 120 patients
- Safety and dose selection confirmed in over 50 patients
- Ongoing cohorts evaluating Modi-1 in combination with SOC checkpoint inhibitors
- Modi-1 shows strong early efficacy in HPV negative head and neck (HNSCC) cancer
  - Partial response demonstrated in 3/7 patients as determined by RECIST 1.1 at their 25-week scan
  - Modi-1 shows ORR of 43% at week 25 in 7 patients with Head & Neck cancer
  - Compared to historical ORRs of 19% for pembrolizumab and 13% for nivolumab
- Translational data demonstrates T cell responses (double screening response) which correlates to clinical responses

Product	Indication	Therapy Type	Preclinical	Phase I	Phase II	Phase III	Milestones
Modi-1	Multiple	Monotherapy					Complete
Modi-1 **(ModiFY study)**	Head & Neck	Pembrolizumab					PFS data in 2026
Modi-1 **(ModiFY study)**	Renal	Ipilimumab + Nivolumab					PFS data in 2026

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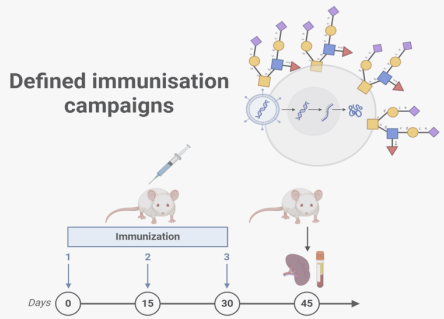
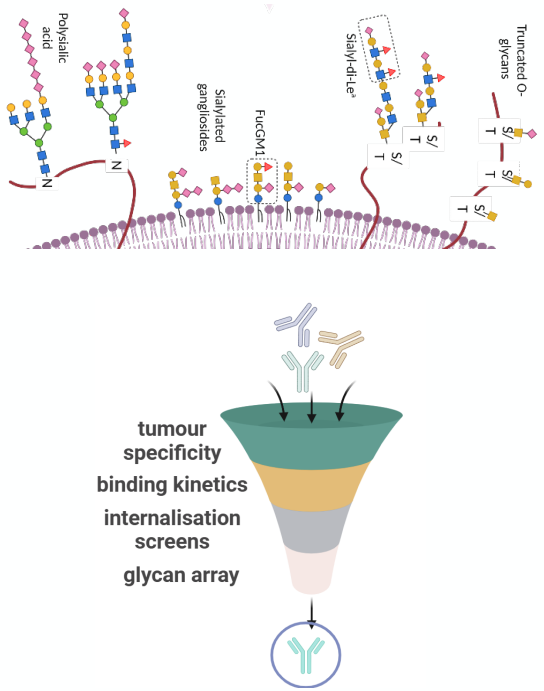
Glymab® Therapeutics Ltd

Platform and pipeline generating tumor glycan specific antibodies

Demonstrated production of high affinity glycan-specific IgG1 antibodies in cancers, improved binding kinetics and functional attributes, to be developed into novel T cell engagers.



DEFINED IMMUNIZATION STRATEGIES



TARGETING THE GLYCOPROTEOME

Sialylation, Sulfation,
Fucosylation
Glycopeptides

NOVEL INTRACTABLE TARGETS:

SLAN
Protein + glycan combinations

COMPREHENSIVE ANALYSIS

Extensive characterisation using high density glycan arrays, IHC; SPR binding kinetics, target internalisation screens, ADCC

HIGHER SPECIFICITY TARGETS:

Sialyl-di-Lewis A
Fucosyl GM1
Lewis Y

Genmab

2 Licenses agreed demonstrating industry validation. Each upto $630m in development millstones and low single digit royalties

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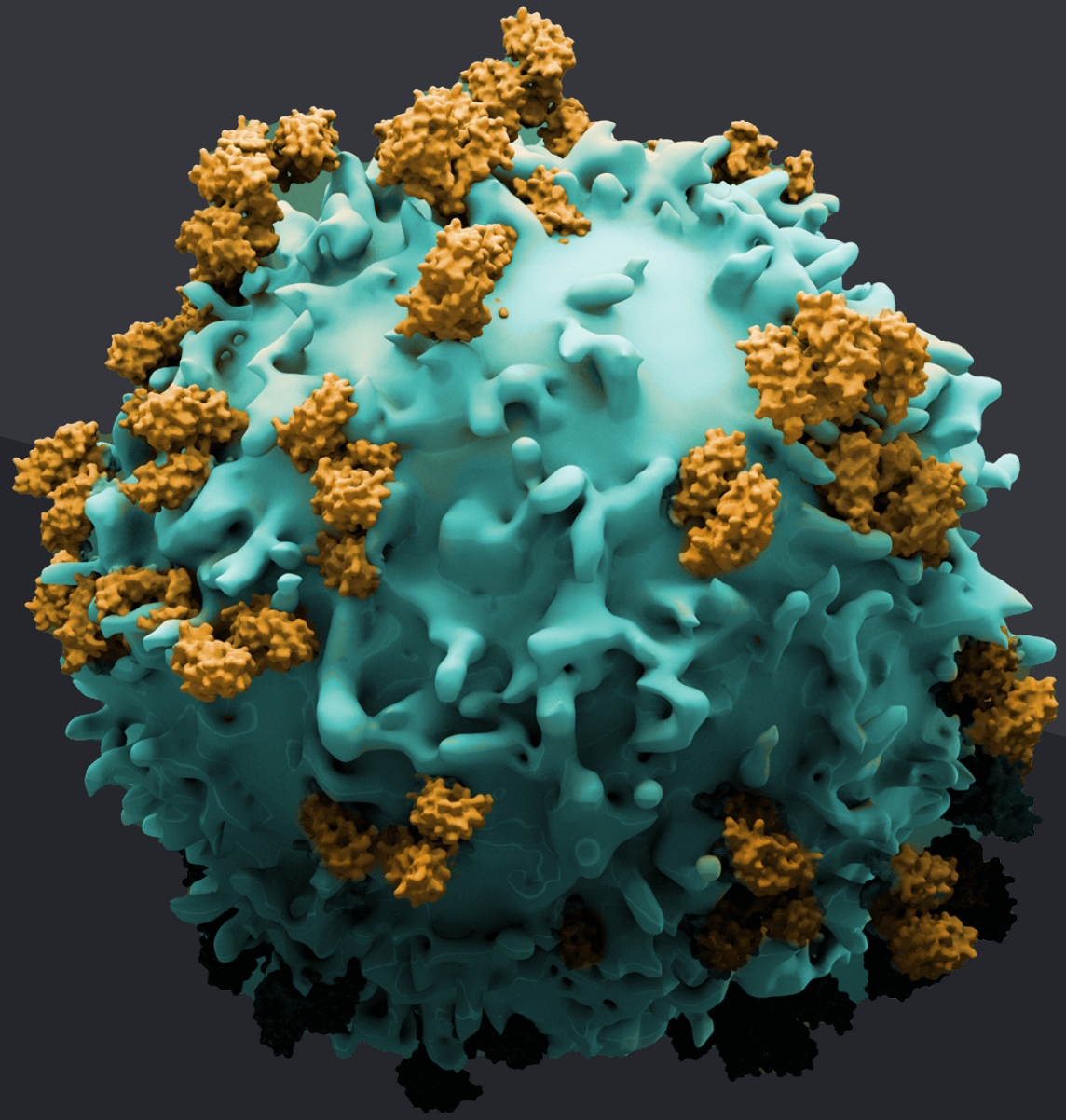
Thank You



Appendices

Experienced Board with Expertise In Biotechnology

Dr Jean-Michel Cosséry
Chairman

Lilly kymab IMMUNOCORE GE Healthcare MALIN

Susan Clement Davies
Director

citi TORREYA A Stifel Company MiNA Therapeutics

Martin Diggle
Director

VULPES INVESTMENT MANAGEMENT

Dr Ursula Ney
Director

CELLTECH ANTISOMA genkyotex the nox company UNIVERSITY OF PLYMOUTH

Phil L'Huillier
Director and Chief Executive Officer

MSD CATALYM artios PsiOxus THERAPEUTICS CANCER RESEARCH TECHNOLOGY

Dr Florian Reinaud
Director

Redmile Group

Prof Lindy Durrant
Director and Chief Scientific Officer

University of Nottingham UK | CHINA | MALAYSIA

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Leveraging a Strong Advisory Board

Purposefully mixing KOLs and Industry leaders

Pippa Corrie
Consultant Medical Oncologist, Cambridge Cancer Centre, Addenbrooke's Hospital, Cambridge

Dirk Shadendorf
Professor & Director of Department of Dermatology, University Hospital, Essen, Germany

Alexander Eggermont
Director & Professor of Immunology, Prinses Máxima Center for Pediatric Oncology, Utrecht, Netherlands

Georgina Long
Chair of Melanoma Medical Oncology, Royal North Shore Hospital, St. Leonards, Australia

Eric Rubin
Strategic Advisor to the Board
Former SVP IO Development
Merck & Co.

Sapna Patel
Professor of Medical Oncology, University of Colorado Cancer Center

Michael Postow
Chief of Melanoma Oncology Service, Memorial Sloan Kettering Cancer Center, New York

Heather Shaw
Consultant Medical Oncologist, University College Hospital, London

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Mike Holmes
Strategic Advisor to the Board
Former SVP IO Development
Merck & Co.