



Advancing T Cell Engagers for Solid Tumors

Corporate Presentation

March 2026



Forward Looking Statement

Except for statements of historical fact, any information contained in this presentation may be a forward-looking statement that reflects the Company's current views about future events and is subject to risks, uncertainties, assumptions and changes in circumstances that may cause events or the Company's actual activities or results to differ significantly from those expressed in any forward-looking statement. In some cases, you can identify forward-looking statements by terminology such as "may", "will", "should", "plan", "predict", "expect", "estimate", "anticipate", "intend", "goal", "strategy", "believe", "could", "would", "potential", "project", "continue" and similar expressions and variations thereof.

Forward-looking statements may include statements regarding the Company's business strategy, cash flows, cash runway and funding status, potential growth opportunities, clinical development activities, the timing and results of preclinical research, clinical trials and potential regulatory approval and commercialization of product candidates.

Although the Company believes that the expectations reflected in such forward-looking statements are reasonable, the Company cannot guarantee future events, results, actions, levels of activity, performance or achievements.

Any forward-looking statements are subject to a number of risks, uncertainties and assumptions, including those described under the heading "Risk Factors" in documents the Company has filed with the SEC. Any forward-looking statements speak only as of the date of this presentation and the Company undertakes no obligation to revise or update any forward-looking statements to reflect events or circumstances after the date hereof.

Important Notice and Disclaimers

Certain information contained in this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company's own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions.

This presentation discusses product candidates that are under preclinical and clinical study, and which have not yet been approved for marketing by the U.S. Food and Drug Administration. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied. While the Company believes its internal research is reliable, such research has not been verified by any independent source. All the scientific, preclinical and clinical data presented within this presentation are – by definition prior to completion of the clinical trial and a clinical study report – preliminary in nature and subject to further quality checks including customary source data verification.

The trademarks included herein are the property of the owners thereof and are used for reference purposes only. Such use should not be construed as an endorsement of such products.

Building a Leading T cell Engager (TCE) Pipeline

Strategy



Developing potentially best-in-class TCE for solid tumors

- Tumor antigens that are clinically validated by antibody drug conjugates (ADC) or chimeric antigen receptor T cell therapy (CAR-T)
- Limited or weak competition addressing large market opportunities
- High affinity CD3 to maximize solid tumor response

Pipeline



CTIM-76: Claudin 6 (CLDN6) x CD3 bispecific antibody

- CLDN6 is overexpressed in ovarian, endometrial, lung, testicular, and other solid tumors
- CTIM-76 was designed to bind selectively to CLDN6 over similar claudin family members, including CLDN3/4/9

CT-95: Mesothelin (MSLN) x CD3 bispecific antibody

- MSLN is overexpressed in pancreatic, lung, colorectal, and other solid tumors
- CT-95 was designed to bind selectively to membrane-bound MSLN to enhance drug exposure and activity

CT-202: Nectin-4 x CD3 bispecific antibody

- Nectin-4 is overexpressed in bladder, lung, breast, colorectal, and other solid tumors
- CT-202 was designed to be conditionally active within the tumor microenvironment

Capitalization



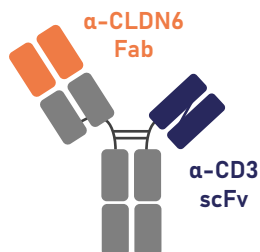
Strong financial position with high quality investor base

- Expected cash runway into mid-2027

Pipeline Overview

PROGRAM	TARGET	ADDRESSABLE MARKET (U.S. ONLY)	DISCOVERY	DEVELOPMENT	PHASE 1	PHASE 2
CTIM-76	Claudin 6 (CLDN6)	> 50,000 patients			Ph 1a interim data expected June 2026	
CT-95	Mesothelin (MSLN)	> 100,000 patients			Ph 1a interim data expected Sept 2026	
CT-202	Nectin-4	> 125,000 patients			Ph 1 FPI expected Q3 2026	

CTIM-76: CLDN6 x CD3

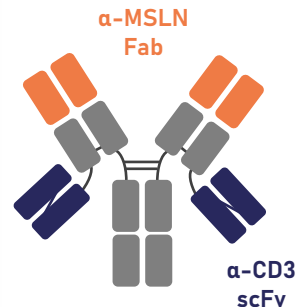


Product differentiation: highly selective for CLDN6 over CLDN3/4/9

Safety: potent CD3 induction without broad cytokine activation

Potential Indications: ovarian, endometrial, lung

CT-95: MSLN x CD3

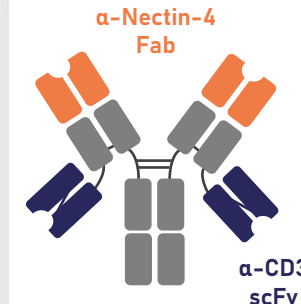


Product differentiation: avidity optimized to avoid mesothelin (MSLN) fragments

Safety: sterically hindered CD3 to avoid T cell crosslinking

Potential Indications: lung, pancreatic, ovarian, colorectal

CT-202: Nectin-4 x CD3



Product differentiation: conditionally activate in the tumor microenvironment

Safety: sterically hindered CD3 to avoid T cell crosslinking

Potential Indications: bladder, colorectal, breast, lung

Context is Positioned to Develop the Next Generation of Transformative T Cell Engagers

Potential to expand into early treatment lines through synergistic drug combinations

Optimized Novel Monotherapies

CTIM-76 **CT-95** **CT-202**

Engineered for:

- Best-in-class efficacy
- Target selectivity
- Reduced CRS risk
- Pharmacokinetics

Synergistic Combination Approaches

TCE + ADC **TCE + PD-1xVEGF**

Potential Opportunities for:

- Complementary mechanisms to enhance activity
- Improved safety due to non-overlapping toxicities
- Synergistic immunologic effects

T Cell Engager Strategy



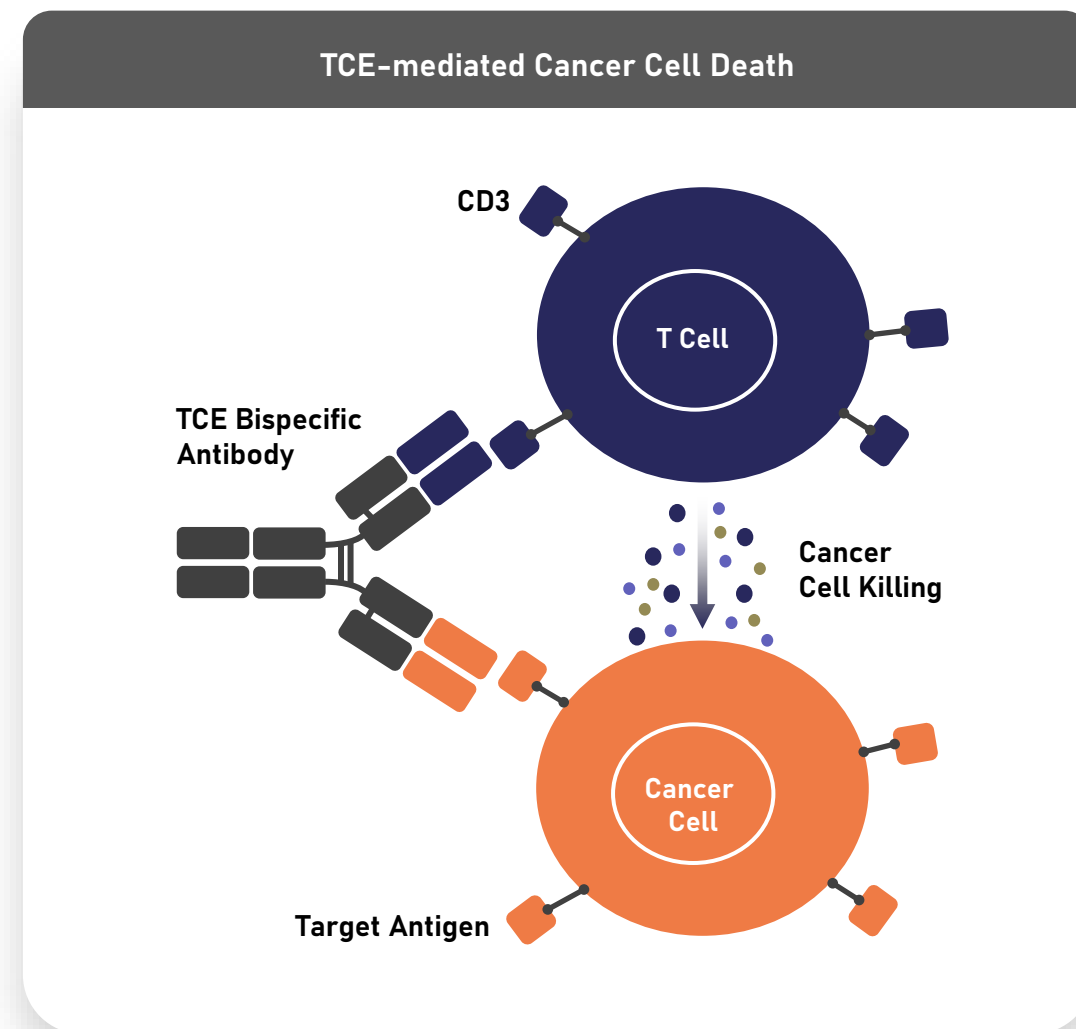
T Cell Engaging (TCE) Bispecific Antibodies

Mechanism of Action

T-cell engagers (TCEs) are bispecific antibodies designed to redirect cytotoxic T lymphocytes toward malignant cells.

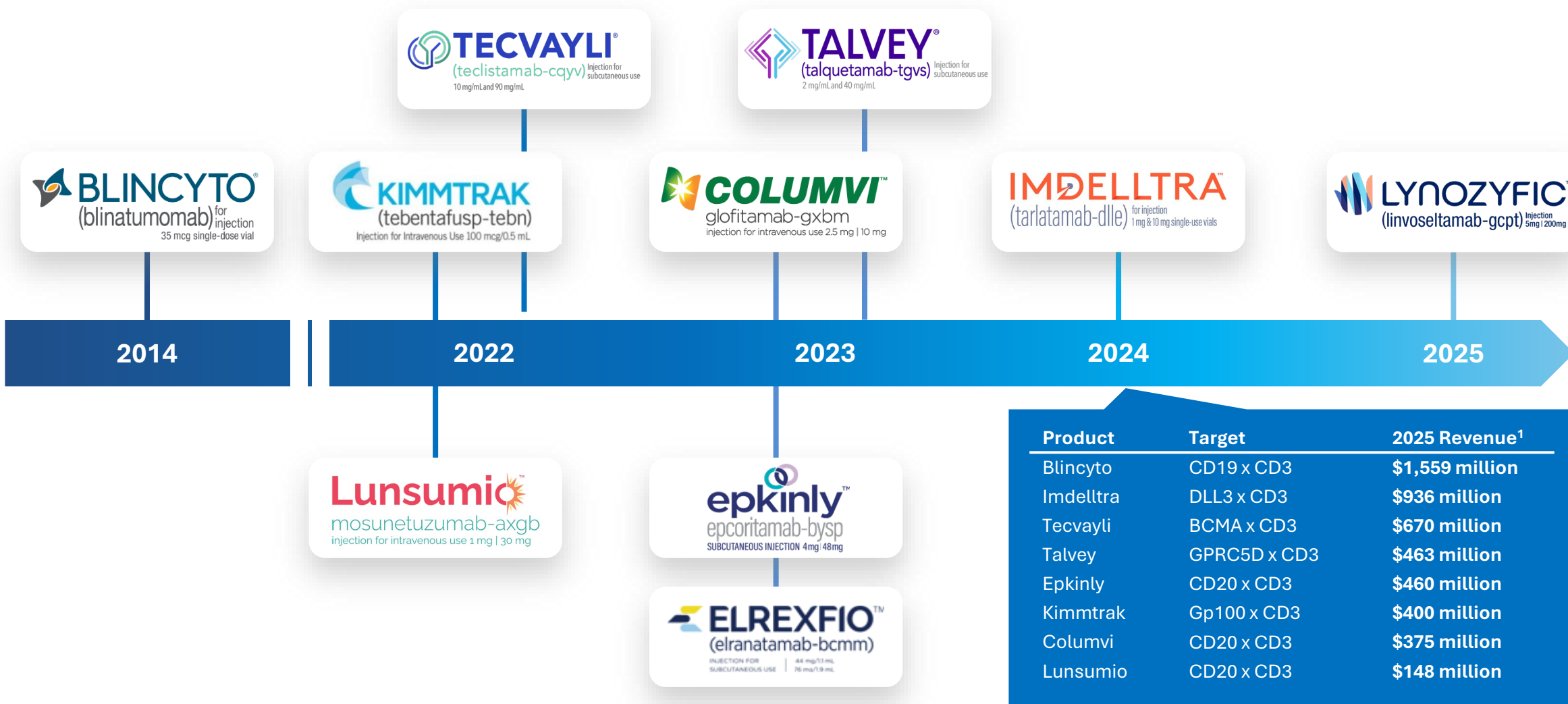
These molecules simultaneously bind to a tumor-associated antigen on the cancer cell and to CD3, a component of the T-cell receptor complex.

This dual engagement facilitates T-cell activation, immune synapse formation, and targeted cytotoxicity of tumor cells.












10 FDA Approvals for TCE for Solid and Liquid Tumors

Recently approved TCE have had strong initial commercial launches



TCE Success in Solid Tumors

									
Asset	Tarlatamab (AMG757)	HPN328	QLS31905	IBI389	VIR-5500	JANX007	JNJ-78278343	Xaluritamig (AMG509)	Ubatamab (REGN4018)
Target x Effector	DLL3 x CD3	DLL3 x CD3	CLDN18.2 x CD3	CLDN18.2 x CD3	PSMA x CD3	PSMA x CD3	KLK2 x CD3	STEAP1 x CD3	MUC16 x CD3
Cancer Indication	Small Cell Lung	Small Cell Lung	Pancreatic	Pancreatic	Prostate	Prostate	Prostate	Prostate	Ovarian
Patients (n)	100	73	12	27	11	8	33	21	13
Efficacy	ORR: 40% PFS: 4.9 mos.	ORR: 55% DoR: 10.8 mos.	ORR: 25% PFS: 3.9 mos.	ORR: 38%	PSA50: 100% ORR: 36% PFS: ~6 mos.	PSA50: 100% ORR: 13% PFS: 7.9 mos.	PSA50: 42% ORR: 8% PFS: 7.9 mos.	PSA50: 50% ORR: 20% PFS: 7.8 mos.	ORR: 31%
Grade \geq 3 CRS	1%	1%	3%	0%	2%	8%	0%	2%	0%
Reference	Ahn 2023	ESMO 2025	ASCO 2025	ASCO 2024	ASCO GU 2026	Dec 2025 data cutoff	ASCO 2025	ESMO 2024	ESMO 2022

TCE efficacy in cold tumors with a low rate of cytokine release syndrome (CRS)

CTIM-76

CLDN6 x CD3 bispecific antibody



CLDN6 Therapies Have the Potential to Reach a Large Patient Population

>50,000 patients per year in the United States in Relapse/Refractory (R/R) Setting

Initial indications of interest based on:

- CLDN6 prevalence
- Patient population size
- CLDN6 target validation

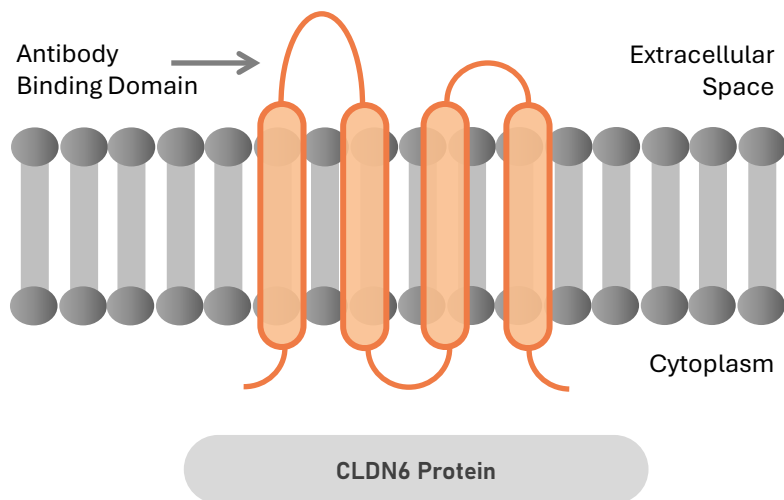
Selected Cancer indications	Incidence (US Only)	R/R Incidence	CLDN6 Positive	CLDN6 Med/High	Patient Population Based on R/R Incidence
Ovarian	19,900	12,800	75% ¹	35% ¹	9,600
Endometrial	65,900	14,000	50% ¹	22% ¹	7,000
Testicular	9,910	400	100% ³	>95% ³	400
Non-Small Cell Lung	201,229	110,653	26% ²	6% ²	28,769
Colon	152,810	53,010	43% ³	0% ³	22,794
Breast	290,600	43,800	40% ³	0% ³	17,520

¹ Context internal Phase 1 data; ² Context internal biopsy prevalence screen data; ³ Mackensen, Nature Medicine, 2023. Incidences based on public estimates; Relapsed/refractory (R/R) or last-line patient population approximated by annual mortality; CLDN6 target prevalence is based on IHC or RNAseq from published reports. Patient population derived from midpoint of CLDN6 positive population multiplied by R/R incident population.

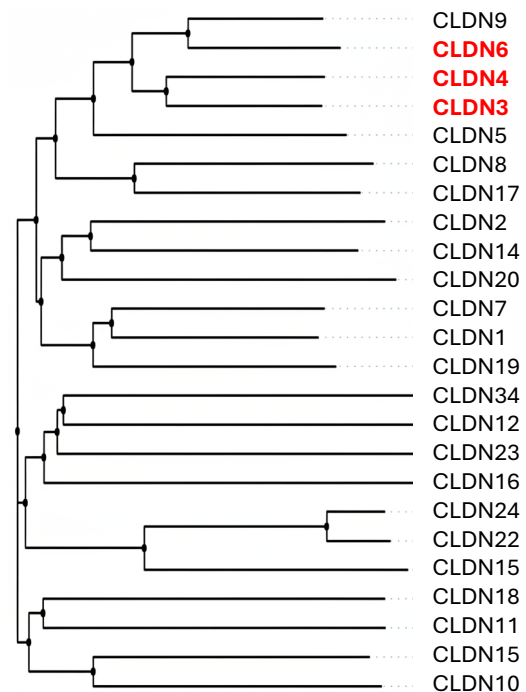
CLDN6 is an Attractive Target for Immunotherapy

CLDN6 is an Ideal TCE Target

- CLDN6 is an oncofetal protein. Normally present at higher levels during embryonic development
- Turned off or have low levels of expression in adult tissues
- Expression increases with cancer disease stage
- Tetraspan protein; does not readily internalize



Avoiding CLDN3 and CLDN4 is a Critical Safety Determinant



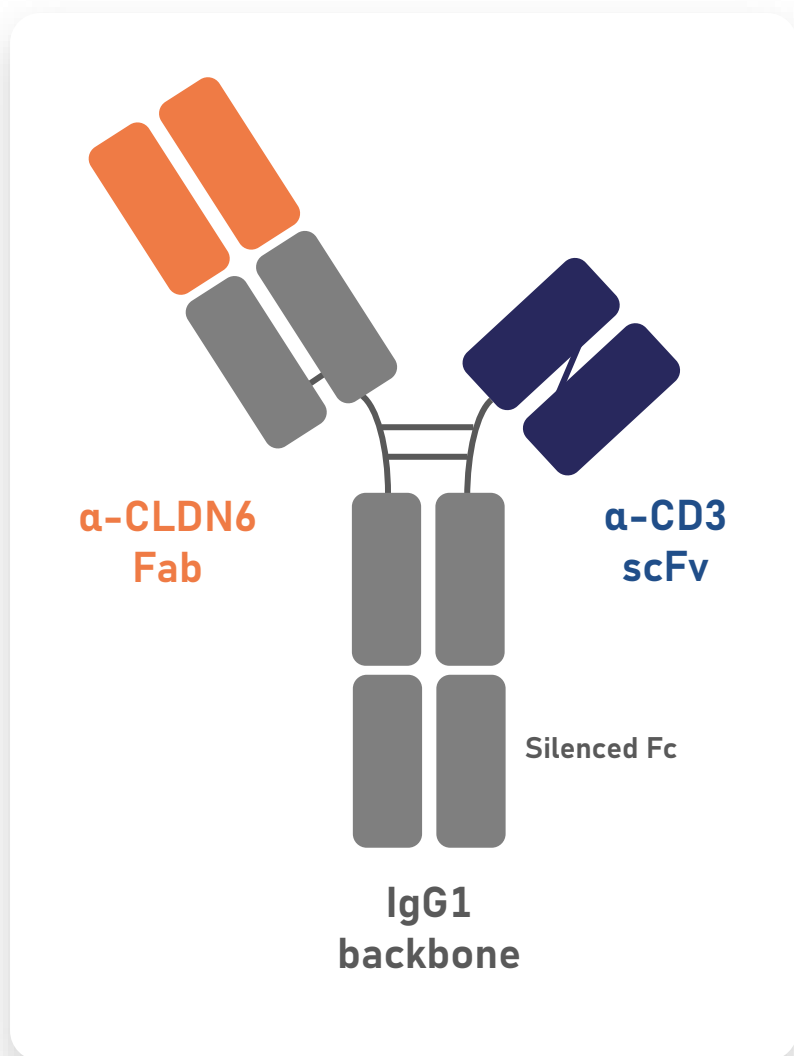
CLDN6 **selectivity is required** to avoid off-target liabilities

The CLDN6 antibody binding region is **highly conserved** with CLDN3 and CLDN4 – differing by only 3 amino acids¹

CLDN3 and CLDN4 are enriched in the liver and antibody binding may result in **liver enzyme elevations**^{2,3}

Claudin Gene Family

CTIM-76: Claudin 6 x CD3 T cell Engaging (TCE) Bispecific Antibody



Optimized structure for CLDN6 selectivity, potency, and manufacturability

- Highly selective CLDN6 binding fragment antibody-binding (Fab) arm
- Immunostimulatory CD3 binding single-chain fragment variable (scFv) domain is functionally monovalent to avoid aberrant T cell activation
- Silenced Fc domain to avoid off target immune cell activation

Potentially wide therapeutic window

- T cell dependent cellular cytotoxicity with no or minimal activation of circulating cytokines
- Humanized CLDN6 and CD3 binding domains

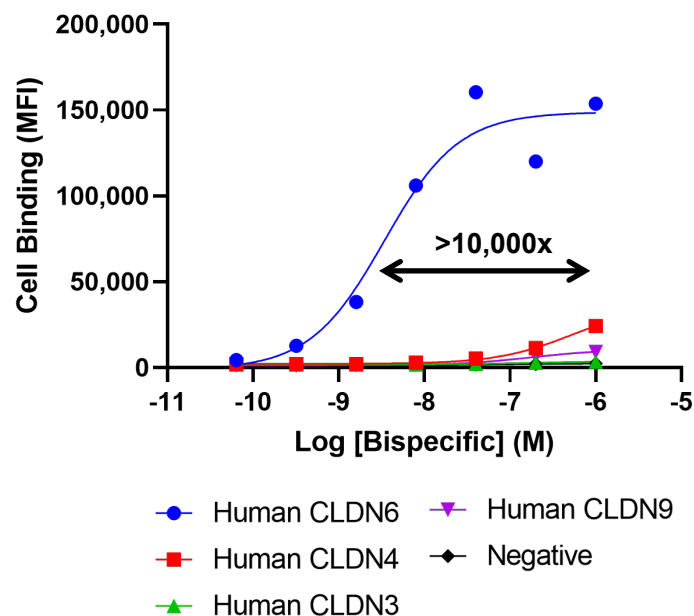
Ease of manufacturing

- IgG1 backbone is highly stable and enables high yield

Anticipate Interim Phase 1a Data in June 2026

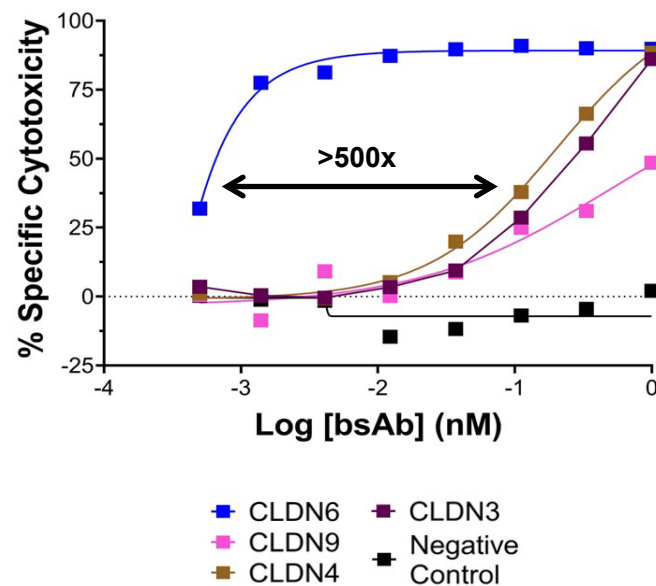
CTIM-76 is a Highly Selective and Potent CLDN6 x CD3 Bispecific Antibody

Selectivity



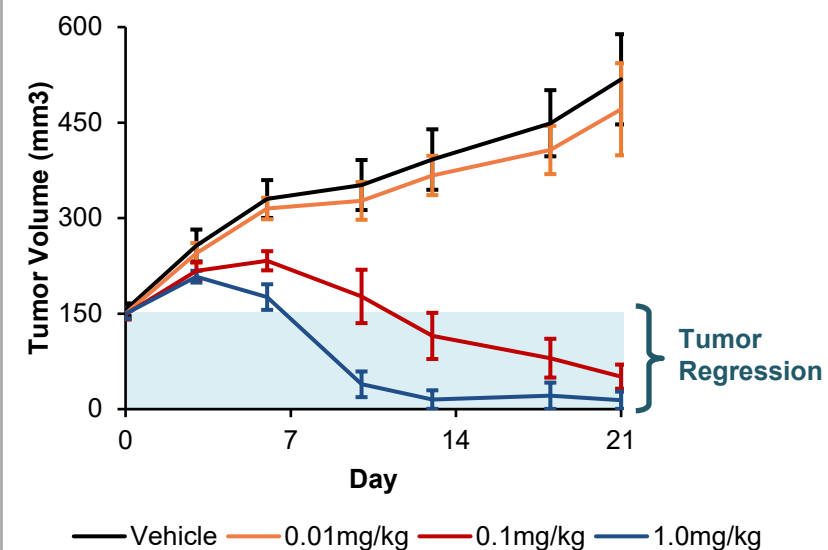
- CTIM-76 CLDN6 EC50 of 3.41 nM (binding)
- CTIM-76 preferentially binds to CLDN6 over CLDN3/4/9
- CLDN3/4/6/9 were transiently transfected in HEK-293F cells

Potency



- Potency assay provides a better assessment for a TCE bispecific than binding assays for off-target liabilities associated with CLDN3, CLDN4, or CLDN9
- CTIM-76 CLDN6 EC50 of 0.0004 nM (cytotoxicity)
- CTIM-76 preferentially targets CLDN6, with minimal binding and cytotoxicity against CLDN9-expressing cells

In Vivo Efficacy



- CTIM-76 effectively engaged systemically administered human PBMC cells to promote significant tumor regression and complete responses in OVCAR3 (~96,000 CLDN6 copies per cell) ovarian xenograft models in mice
- CTIM-76 was well tolerated in OVCAR3 xenograft study
- NSG-b2m knockout mice (n=14/arm) engrafted with human PBMCs and bearing advanced subcutaneous OVCAR3 tumor xenografts were treated twice per week

CTIM-76 Phase 1a Dose Escalation Trial

Target population

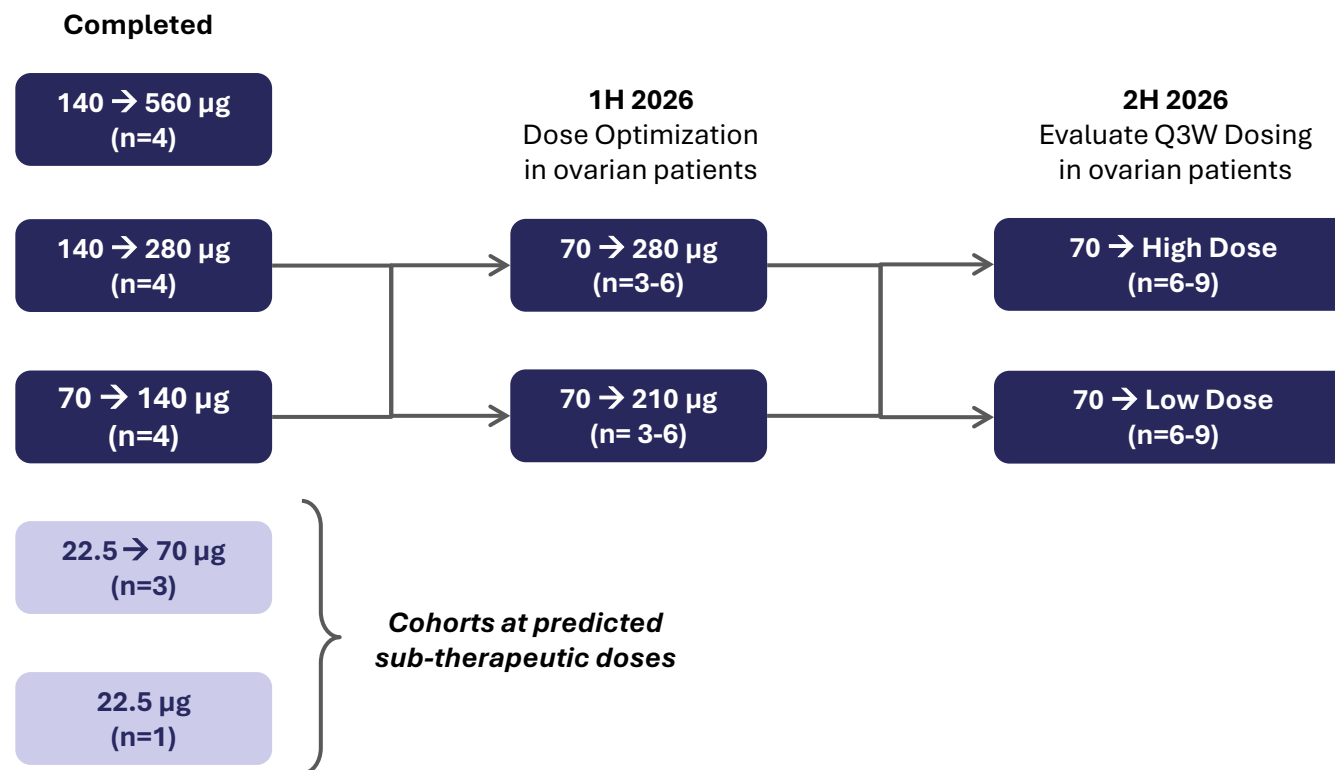
- Ovarian, endometrial and testicular cancer relapsed to standard of care
- CLDN6+ positive via IHC ($\geq 10\%$ 1+ staining)

Trial objectives

- Assess safety and tolerability
- Pharmacokinetic and pharmacodynamic data
- Evaluate preliminary anti-tumor activity

Dosing and Administration

- Weekly IV infusion
- Step dosing
- Pretreat patients with 16 mg dexamethasone 1 hour prior to C1D1 and C1D8 doses



Anticipated path to the identification of optimal prime dose, full dose, and dosing schedule

Summary of Preliminary Data from Ongoing Phase 1a Trial of CTIM-76 as of October 2025

Context anticipates providing updated interim Phase 1a data in June 2026

Patient Demographics

12 patients enrolled: ovarian (7); testicular (3); endometrial (2)
Median of 4 previous lines of therapy (range: 3-8)
5 patients are currently on treatment



Dose Response Relationship

Linear and dose proportional pharmacokinetics (PK)
Potential to explore Q2W and/or Q3W dosing in future trials
Dose responsive T cell migration and cytokine induction



Efficacy

Confirmed partial response (cPR) with an 85% reduction in tumor size is ongoing in Cohort 3 patient with platinum-resistant ovarian cancer (PROC) who progressed on prior FRα ADC
Cohort 4 patients were not response evaluable at the time of data cutoff¹



Safety

No cytokine release syndrome (CRS) greater than Grade 1
No dose limiting toxicities (DLT) have been observed
A maximum tolerated dose (MTD) has not been reached



CTIM-76 Competitive Landscape

CTIM-76 incorporates a highly selective CLDN6 binder and high affinity CD3

	Clinical Programs				Discontinued	
	CTIM-76	XmAb541	ARC101	BGB-B455	AMG794	SAIL66
Company	Context	Xencor	Third Arc	BeOne	Amgen	Chugai
Stage	Ph 1	Ph 1	Ph 1	Ph 1	Ph 1 ¹	Ph 1
Bispecific Format	1 + 1	2 + 1	1 + 1	1 + 1	HLE Bite	Dual Specific Fab
CLDN3/4/9 Selectivity	High ¹	Moderate ²	High ³	Not Disclosed ⁴	High ⁶	Moderate ⁵
High Affinity CD3	✓	X	X	✓	X	X
Preclinical Tolerability	Well tolerated	Well tolerated	Well tolerated	Moderate tolerability	Poor tolerability	Poor tolerability

CT-95

MSLN x CD3 bispecific antibody



MSLN Therapies Have the Potential to Reach a Large Patient Population

>100,000 patients per year in the United States in Relapse/Refractory (R/R) Setting

Selected Cancer indications	Incidence (US Only)	R/R Incidence	MSLN Positive	MSLN Med/High	Patient Population Based on R/R Incidence
Non-Small Cell Lung	201,229	110,653	55%	36%	60,859
Pancreatic	66,440	51,750	80%	61%	41,400
Colon	152,810	53,010	41%	17%	21,734
Ovarian	19,900	12,800	90%	80%	11,520
Mesothelioma	3,000	2,500	70%	60%	1,750
Esophageal	22,370	16,130	41%	26%	6,613
Endometrial	65,900	14,000	45%	23%	6,300
Gastric	26,380	11,090	49%	23%	5,434

Initial indications of interest based on:

- MSLN prevalence
- Patient population size
- MSLN target validation

MSLN Target Biology

Shed mesothelin (sMSLN) in tumor microenvironment requires a creative solution to overcome

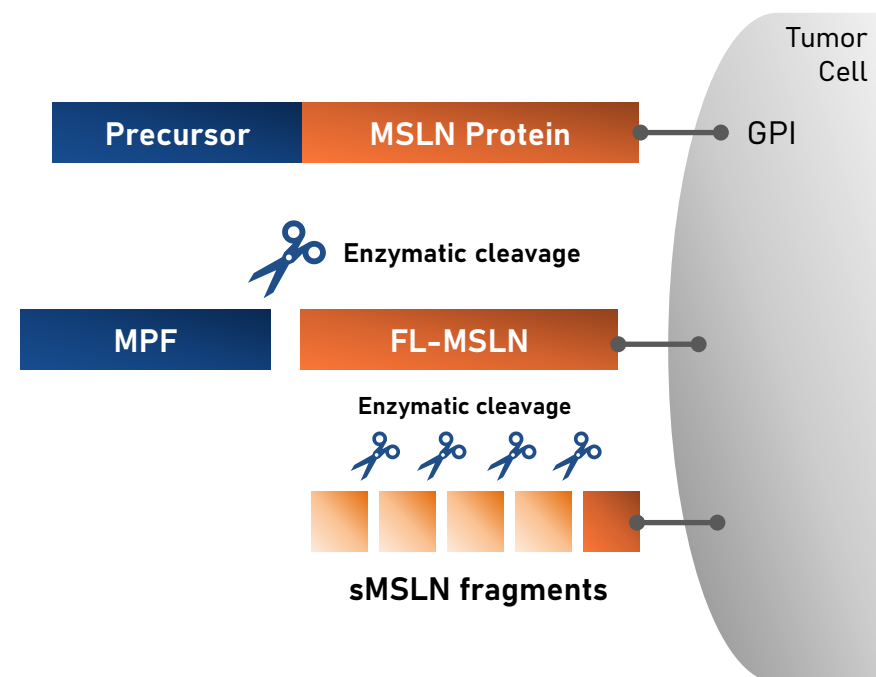
Overcoming Fragmented MSLN in the Tumor Microenvironment

MSLN is bound to tumor cells via a GPI-anchor

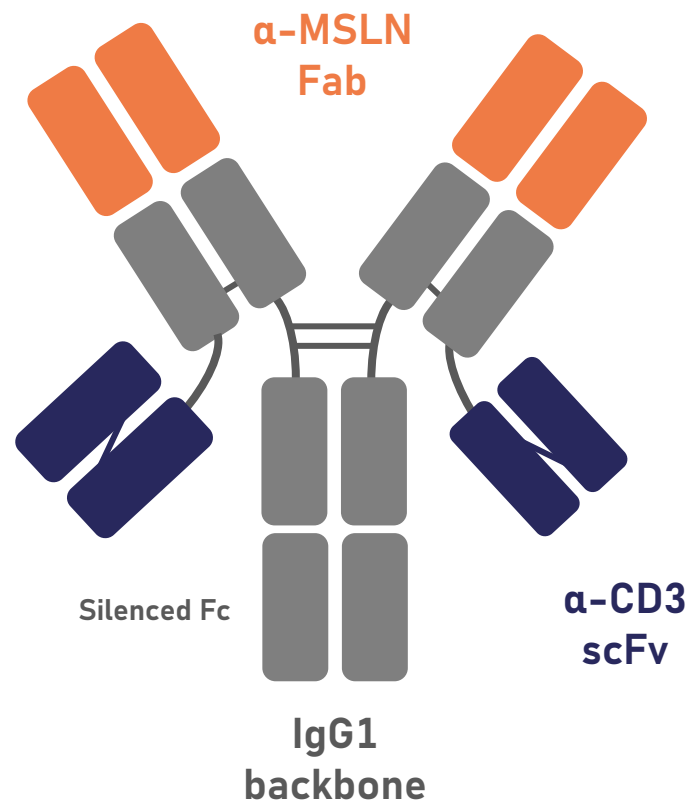
Like many GPI-anchored proteins, MSLN can be cut into smaller fragments^{1,2}

The MSLN gene encodes a precursor that is cleaved into two products: a soluble N-terminal protein called megakaryocyte potentiating factor (MPF), and a membrane-bound fragment called full length mesothelin (FL-MSLN)

sMSLN serves as a competitive sink, preventing antibodies from binding to the tumor, which can lead to suboptimal drug exposure and efficacy



CT-95: MSLN x CD3 T cell Engaging (TCE) Bispecific Antibody



Novel design to overcome mesothelin (MSLN) sink

- Binds to membrane-proximal MSLN epitope
- Affinity tuned MSLN binding
- Cooperative binding results in high affinity binding of CT-95 to tumor

Potentially wide therapeutic window

- No crosslinking by shed MSLN, mitigating off-tumor T cell activation
- Cooperative binding of MSLN on tumor surface crosslinks CD3, activating T cells

Ease of manufacturing

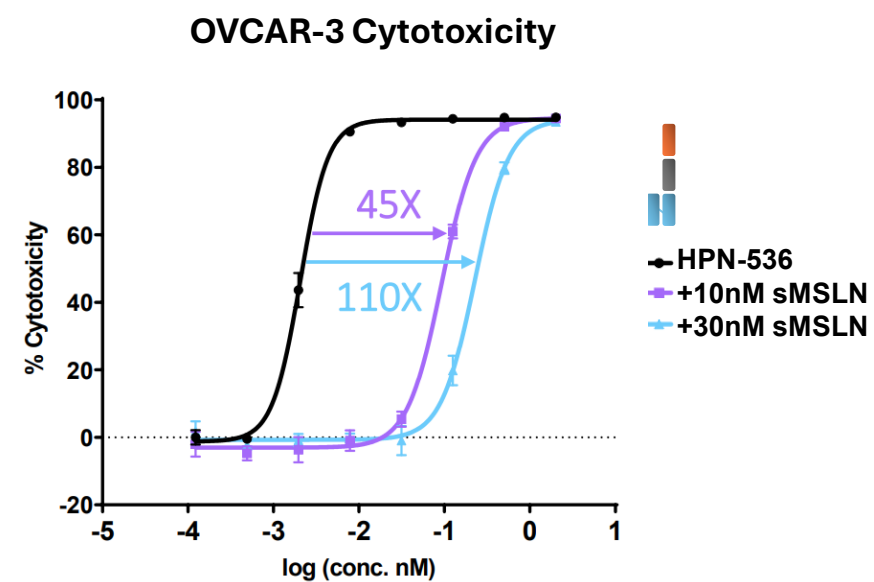
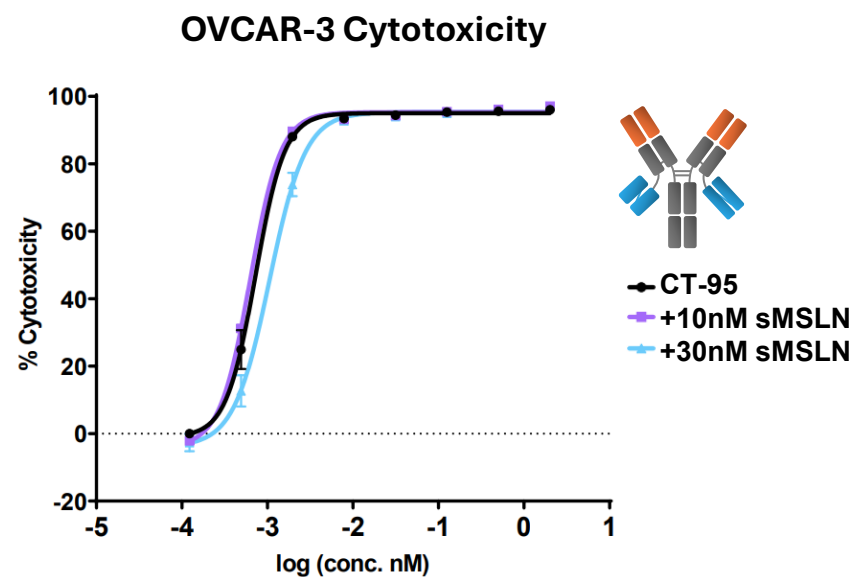
- IgG1 backbone is highly stable and enables high yield

Anticipate Interim Phase 1a Data in September 2026

CT-95 Intended to Overcome MSLN Sink

HPN-536 (Harpoon Therapeutics) binds to soluble MSLN (sMSLN) in a dose proportional manner, limiting therapeutic exposure

Cytotoxicity in the Presence of Soluble MSLN



CT-95 Phase 1a/b Study

An open-label, multi-center, dose escalation / expansion, safety, and PK study (NCT06756035)

Biomarker stratification

- Ovarian, pancreatic, and mesothelioma do not require prospective screening
- All other indications require prospective MSLN screening via IHC ($\geq 10\%$ 1+ staining)

Trial objectives

- Assess safety and tolerability at increasing dose levels
- Pharmacokinetic and pharmacodynamic data
- Evaluate preliminary anti-tumor activity

Dosing and Administration

- Weekly IV infusion
- Single step dose
- Pretreat patients with 10 mg dexamethasone 1 hour prior to C1D1 and C1D8 doses

Phase 1a Dose Escalation

Cohort 1	0.1 $\mu\text{g}/\text{kg}$	MABEL Dose	<input checked="" type="checkbox"/>	→	Completed (n=1)
Cohort 2	0.3 $\mu\text{g}/\text{kg}$		<input checked="" type="checkbox"/>	→	Completed (n=4)
Cohort 3	0.18 \rightarrow 0.6 $\mu\text{g}/\text{kg}$	Active Dose Level	<input checked="" type="checkbox"/>	→	Completed (n=3)
Cohort 4	0.27 \rightarrow 0.9 $\mu\text{g}/\text{kg}$			→	Enrolled (n=6)
Cohort 5	0.36 \rightarrow 1.2 $\mu\text{g}/\text{kg}$				
Cohort 6	0.48 \rightarrow 1.6 $\mu\text{g}/\text{kg}$				

CT-95 Competitive Landscape

CT-95 is avidity enhanced, affinity tuned, and binds to membrane-bound MSLN

	CT-95	AMG-305	HPN-536	JNJ-79032421	ZW171
Company	Context	Amgen ⁴	Harpoon ¹	JNJ	Zymeworks ^{2,3}
Format	2 + 2	1 + 1 + 2 CDH3 + MSLN dBiTE	TriTAC	1+1	2 + 1
Avoids sMSLN	✓	X	X	✓	X
Affinity Tuned	✓	X	X	X	X
High Affinity CD3	✓	X	✓	X	X
Program Status	Phase 1 FPI Apr 2025	Phase 1 FPI Oct. 2023	Phase 1 Discontinued	Phase 1 Discontinued	Phase 1 Discontinued

CT-202

Nectin-4 x CD3 bispecific antibody



Nectin-4 Therapies Have the Potential to Reach a Large Patient Population

>125,000 patients per year in the United States in Relapse/Refractory (R/R) Setting

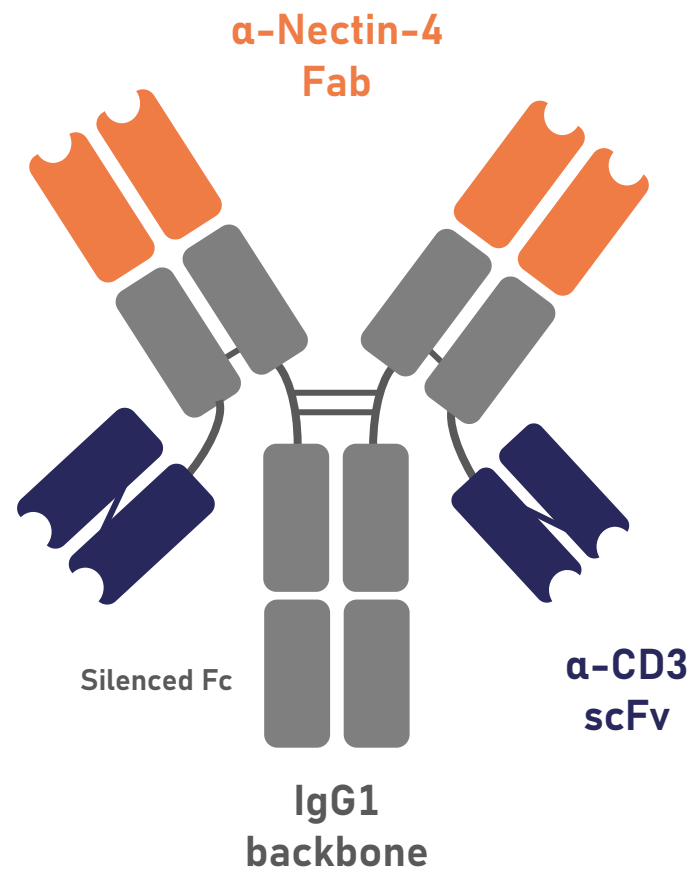
Initial indications of interest based on:

- Nectin-4 prevalence
- Patient population size
- Target validation via antibody-drug conjugates (ADCs)

Selected Cancer indications	Incidence (US Only)	R/R Incidence	Nectin-4 Positive	Nectin-4 Med/High	Patient Population Based on R/R Incidence
Colon	152,810	53,010	87% ¹	78% ²	46,119
Bladder (urothelial)	83,190	20,000	83% ³	60% ³	16,600
Breast (TNBC)	62,054	15,500	78% ³	58% ⁵	12,090
Non-Small Cell Lung	201,229	110,653	64% ³	58% ⁶	70,818
Pancreatic	66,440	51,750	71% ³	37% ³	36,743
Head and Neck	54,000	12,000	59% ³	18% ³	7,080
Esophageal	22,370	16,130	55% ³	24% ³	8,872
Gastric	26,890	12,000	94% ⁷	60% ⁴	11,280

Incidence based on public estimates; Relapsed/refractory (R/R) or last-line patient population approximated by annual mortality; Patient population derived from Nectin-4 positive population multiplied by R/R incident population. ¹ Koberki, Int J Mol Sci, 2023; ² Nikanjan, Can Let, 2025; ³ Challita, Can Res, 2016; ⁴ Zhang, Oncol Lett, 2018; ⁵ Zeindler, Front Med, 2019; ⁶ Takano, Mol Bio, 2009; ⁷ Muro, ESMO Open, 2025

CT-202: Nectin-4 x CD3 T cell Engaging (TCE) Bispecific Antibody



Novel design incorporating logic gating to spare Nectin-4 in normal tissue

- Because of its expression in healthy epidermal keratinocytes, sweat glands, and hair follicles, Nectin-4 targeted treatments are associated with dermatological side effects
- CT-202 uses pH dependent binding to both Nectin-4 and CD3 to minimize binding to healthy tissues and maximize binding and T cell activation within the tumor microenvironment

Avidity optimized to mitigate CRS risk

- Bivalent Nectin-4 binding to reduce T cell crosslinking in the absence of target
- Steric hindrance of CD3 binding by Fc domain prevents T cell crosslinking by single CT-202 molecules

Ease of manufacturing

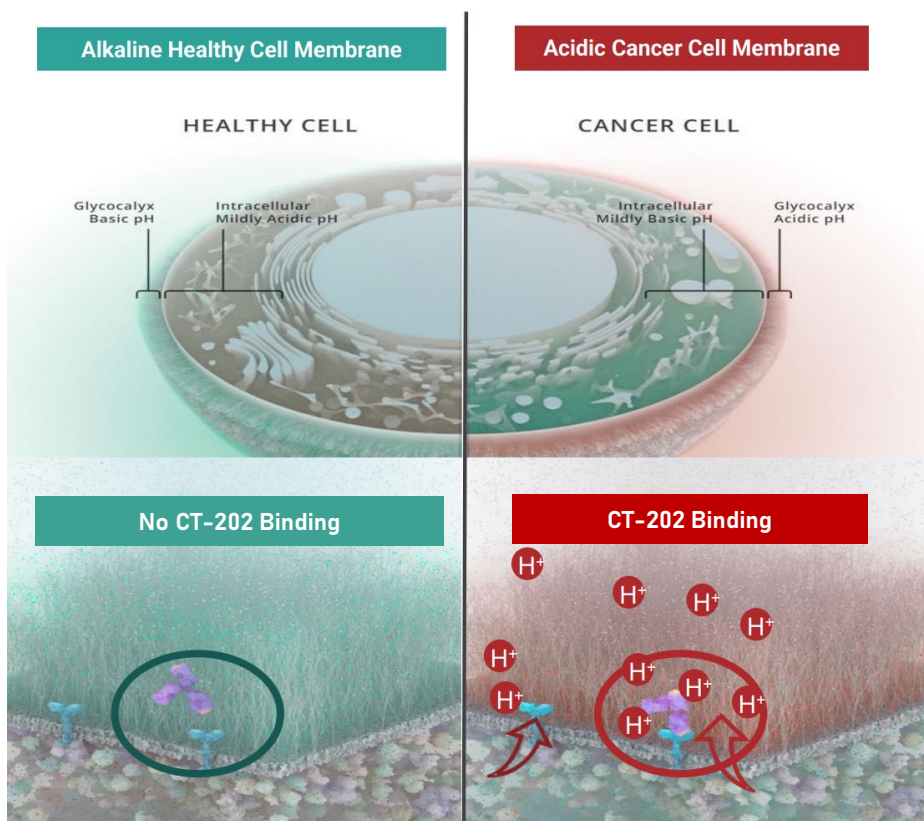
- IgG1 backbone is highly stable and enables high yield

Anticipate Phase 1 First Patient Dosed in Q3 2026

Two-Pronged Approach to Overcoming Nectin-4 Expression in Skin

Logic Gating Through pH Dependency

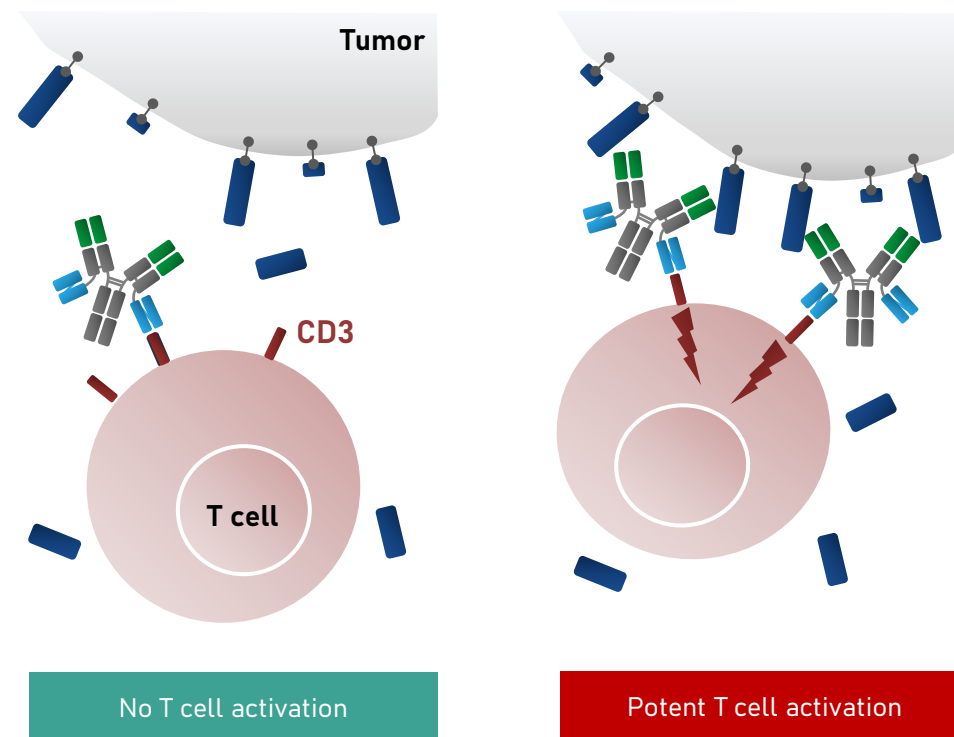
30x gain of activity in acidic tumor microenvironment versus healthy cells¹



Increased Target Selectivity Through Avidity

High on-/off-rate when bound to Nectin-4 monomer

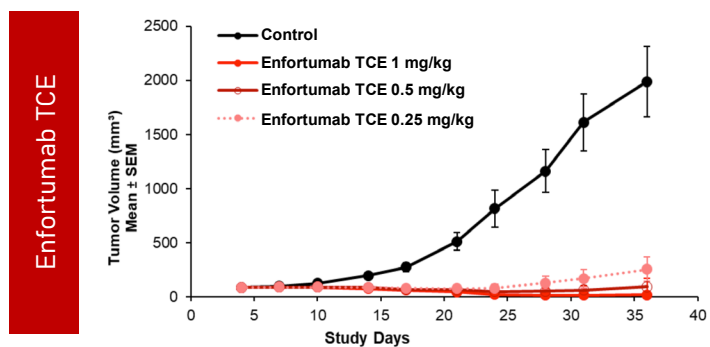
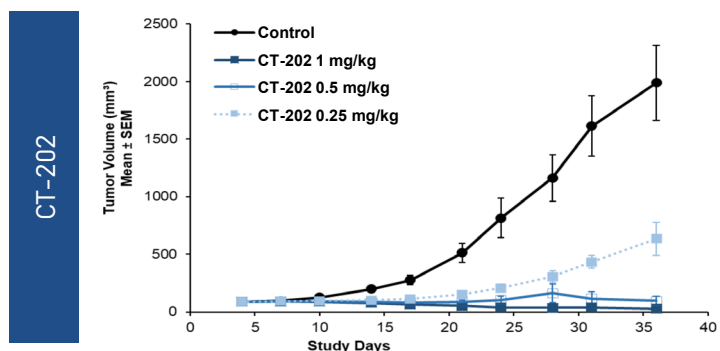
Avidity-enhanced Nectin-4 binding



CT-202 is Highly Active and Well Tolerated Across In Vivo Models

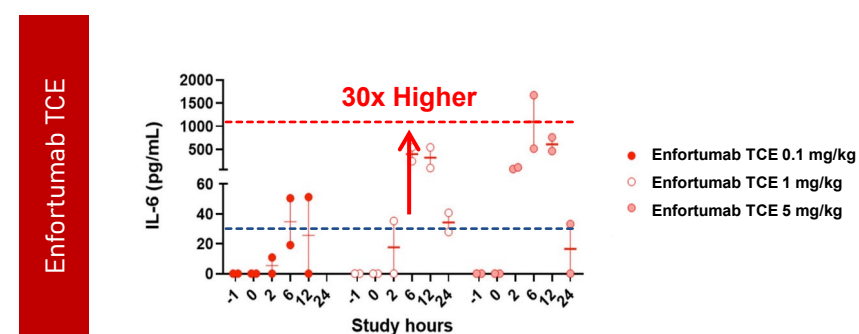
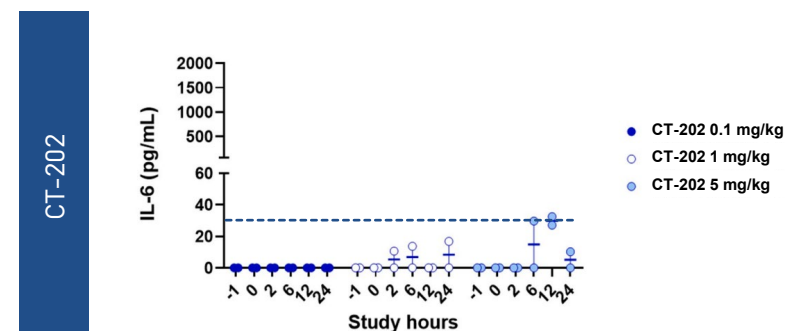
Complete Tumor Regressions

CT-202 demonstrated similar efficacy in BT474 breast cancer xenograft compared to enfortumab TCE control antibodies in mice



Reduced Cytokine Release

CT-202 treatment resulted in significantly lower IL-6 induction compared to enfortumab TCE benchmark antibodies in NHP



CT-202 Competitive Landscape

Competitor TCE programs lack conditional activation, avidity enhancement, and high potency immune activator

Company	Context Therapeutics	Bicycle Therapeutics	Rondo Therapeutics
Asset	CT-202	BT7480 ^{1,2}	RNDO-564 ³
Format	2 + 2 (pH dependent)	1 + 2 (Bicycle)	1 + 1 (Fixed light chain)
Conditionally active	✓	✗	✗
Avidity enhanced	✓	✗	✗
High Affinity CD3	✓	✗	✗
Program Status	Preclinical (Ph 1 FPI expected Q3 2026)	Phase 1 (completed)	Preclinical (Ph 1 late 2025)



Corporate

Anticipated Key Milestones in 2026-2027

- Multiple potential data inflection points over the next 18 months
- Anticipated cash runway into mid-2027

PROGRAM <i>target</i>	1H 2026	2H 2026	1H 2027	2H 2027
CTIM-76 <i>Claudin 6 (CLDN6)</i>	Ph 1a Dose Escalation	Ph 1a Q3W Dose Evaluation	Ph 1b Dose Expansion	
CT-95 <i>Mesothelin (MSLN)</i>	Ph 1a Dose Escalation		Ph 1b Dose Expansion	
CT-202 <i>Nectin-4</i>	Ph 1a Dose Escalation			

Experienced Leadership Team



Martin Lehr
CEO and Director



Karen Chagin, MD
Chief Medical Officer



Jennifer Minai
Chief Financial Officer



Alex Levit, Esq
Chief Legal Officer



Jennifer Dashnau, PhD
SVP Technical Operations



Chris Beck, MBA
SVP Operations



Focus on Execution

Experienced management team

Clinical team has developed T cell therapies

Our management team is supported by a Board with deep oncology experience



Advancing T Cell Engagers for Solid Tumors

© Context Therapeutics 2026



Glossary

ADC	Antibody drug conjugate
AE	Adverse event
CAR-T	Chimeric antigen receptor T cell therapy
CD3	Cluster of differentiation 3
CLDN	Claudin
CRS	Cytokine release syndrome
DLT	Dose limiting toxicity
Fab	Fragment antigen-binding region
FIH	First-in-human
FPI	First Patient In (dosed)
FRα	Folate receptor alpha
GPI	Glycosylphosphatidylinositol
IHC	Immunohistochemistry
IND	Investigational new drug
IV	Intravenous
Mabel	Minimum anticipated biologic effect level
MoA	Mechanism of action
MSLN	Mesothelin
MTD	Maximum tolerated dose

N.D.	Not disclosed
ORR	Overall response rate
PFS	Progression free survival
PK	Pharmacokinetic
PR	Partial Response
PROC	Platinum resistant ovarian cancer
Q2W	Every two weeks
Q3W	Every three weeks
RP2D	Recommended Phase 2 dose
TCE	T cell engager
scFv	Single chain variable fragment