context therapeutics

# Advancing T Cell Engagers for Solid Tumors


Corporate Presentation

June 2026

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# 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

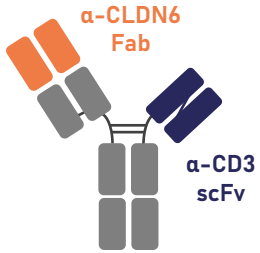
### Strong financial position with high quality investor base

- Expected cash runway into mid-2027

# Pipeline Overview

| PROGRAM | TARGET | ADDRESSABLE MARKET (U.S. ONLY) | PRECLINICAL | PHASE 1 | PHASE 2 | ANTICIPATED MILESTONES |
|---|---|---|---|---|---|---|
| **CTIM-76** | Claudin 6 (CLDN6) | > 50,000 patients | | | | **Q4 2026**: QW updated data<br>**Q2 2027**: Q3W dosing data |
| **CT-95** | Mesothelin (MSLN) | > 100,000 patients | | | | **Sept 2026**: Preliminary Ph 1a data |
| **CT-202** | Nectin-4 | > 125,000 patients | | | | **Q3 2026**: Ph 1 FPI |

## CTIM-76: CLDN6 x CD3

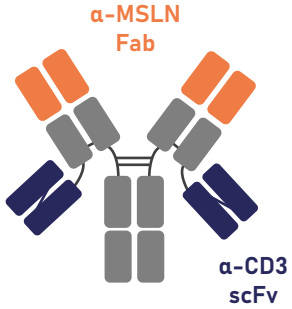



**Product differentiation:** highly selective for CLDN6 over CLDN3/4/9

**Safety:** potent CD3 induction without broad cytokine activation

**Potential Indications:** ovarian, endometrial, lung

## CT-95: MSLN x CD3

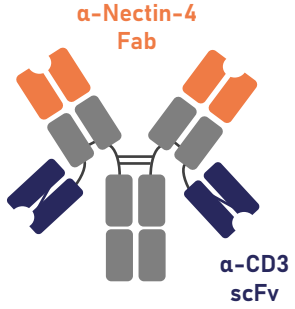



**Product differentiation:** avidity optimized to avoid mesothelin (MSLN) fragments

**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



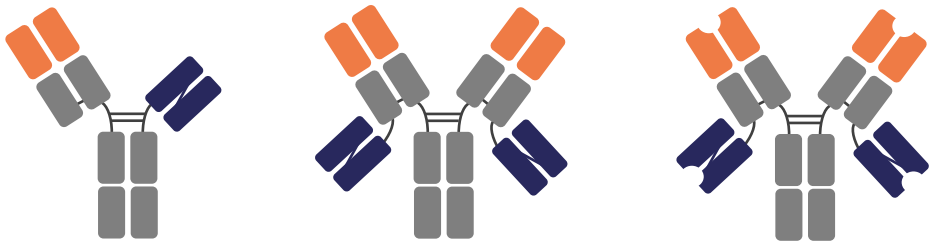
Addressable market is the estimated patient population derived from tumor antigen positive population multiplied by Relapsed/Refractory (R/R) incident population.

# 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**

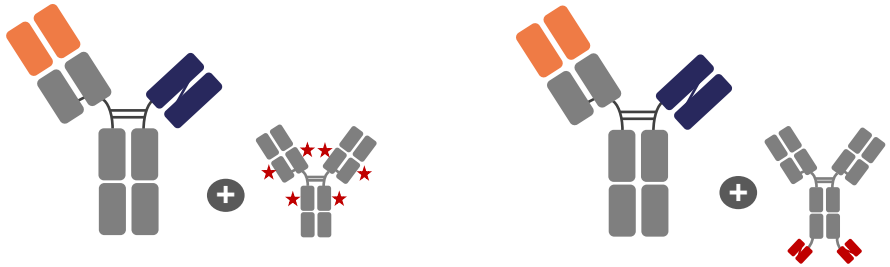


**Bispecific TCE Engineered for:**

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

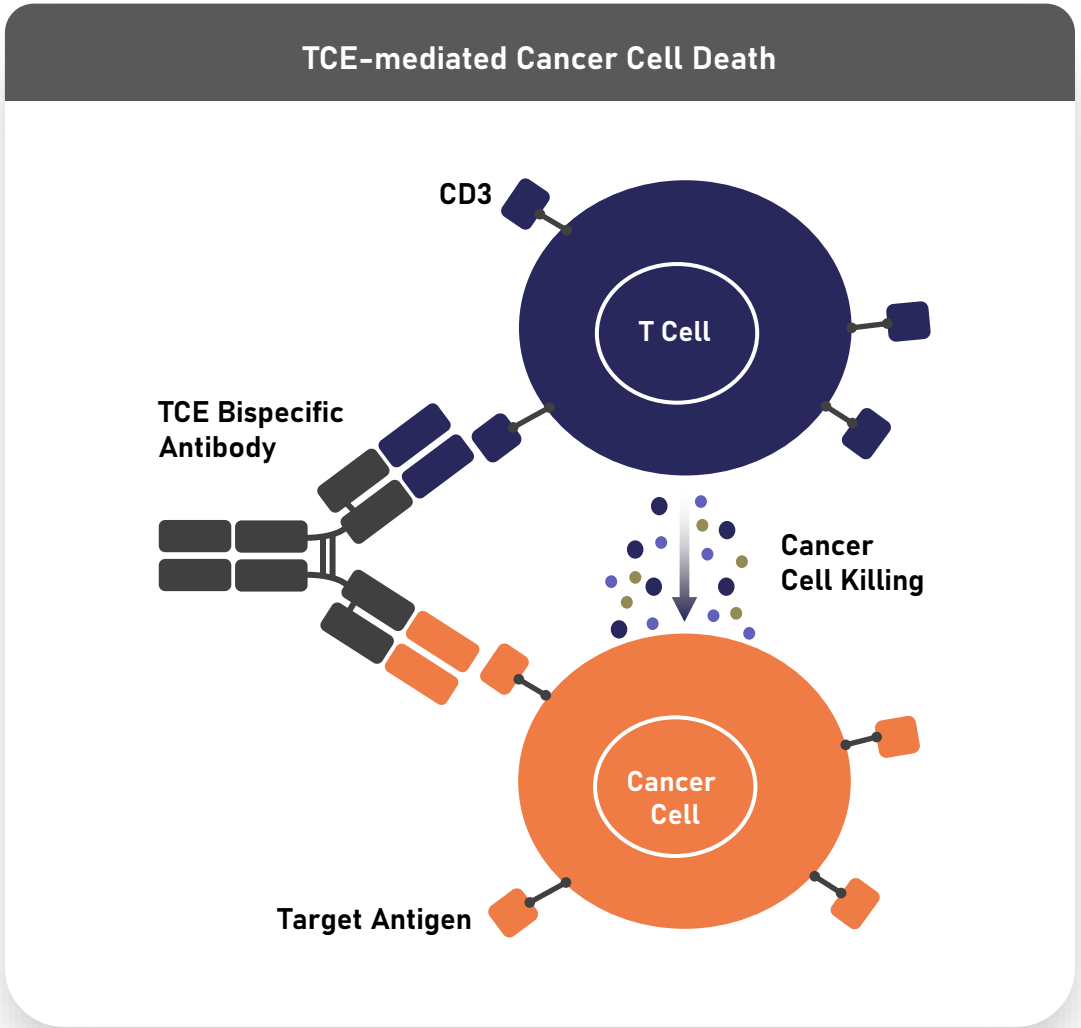
# T Cell Engaging (TCE) Bispecific Antibodies

## Mechanism of Action

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

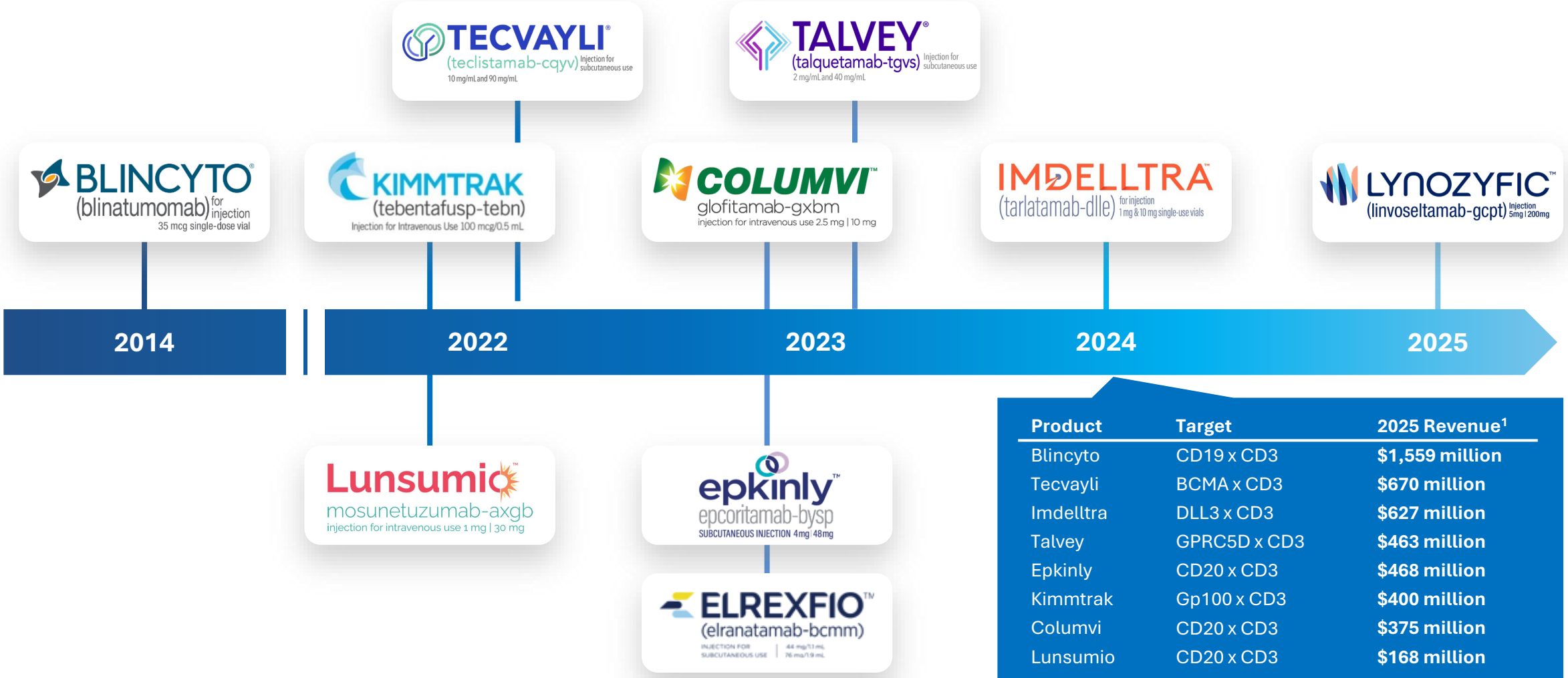
These molecules simultaneously bind to a tumor-associated antigen on the cancer cell and to CD3, a component of the T-cell receptor complex.

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



# 10 FDA Approvals for TCE for Solid and Liquid Tumors

## Recently approved TCE have had strong initial commercial launches




| Product | Target | 2025 Revenue[1] |
|---|---|---|
| Blincyto | CD19 x CD3 | **$1,559 million** |
| Tecvayli | BCMA x CD3 | **$670 million** |
| Imdelltra | DLL3 x CD3 | **$627 million** |
| Talvey | GPRC5D x CD3 | **$463 million** |
| Epkinly | CD20 x CD3 | **$468 million** |
| Kimmtrak | Gp100 x CD3 | **$400 million** |
| Columvi | CD20 x CD3 | **$375 million** |
| Lunsumio | CD20 x CD3 | **$168 million** |



**1** Information from 2025 earnings filings and other public disclosures. Information provided is for illustrative purposes only and is not indicative of future performance.

# TCE Success in Solid Tumors

| | AMGEN | HARPOON Therapeutics | 齐鲁制药 QILU PHARMACEUTICAL | Innovent | VIR™ | Janux | Johnson & Johnson | AMGEN | REGENERON |
|---|---|---|---|---|---|---|---|---|---|
| **Asset** | **Tarlatamab (AMG757)** | **HPN328** | **QLS31905** | **IBI389** | **VIR-5500** | **JANX007** | **JNJ-78278343** | **Xaluritamig (AMG509)** | **Ubamatamab (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%<br>PFS: 4.9 mos.** | **ORR: 55%<br>DoR: 10.8 mos.** | **ORR: 25%<br>PFS: 3.9 mos.** | **ORR: 38%** | **PSA50: 100%<br>ORR: 36%<br>PFS: ~6 mos.** | **PSA50: 100%<br>ORR: 13%<br>PFS: 7.9 mos.** | **PSA50: 42%<br>ORR: 8%<br>PFS: 7.9 mos.** | **PSA50: 50%<br>ORR: 20%<br>PFS: 7.8 mos.** | **ORR: 31%** |
| **Grade ≥ 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)**



Information provided in the table above as of March 1, 2026. Information provided is for illustrative purposes only and is not a head-to-head comparison. Differences exist between study or trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

# 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** | 21,010 | 19,500 | 75%[1] | 35%[1] | **14,625** |
| **Endometrial** | 68,270 | 17,000 | 50%[1] | 22%[1] | **8,500** |
| **Testicular** | 9,810 | 750 | 100%[3] | >95%[3] | **750** |
| **Non-Small Cell Lung** | 199,586 | 122,500 | 26%[2] | 6%[2] | 31,850 |
| **Colon** | 158,850 | 36,600 | 43%[3] | 0%[3] | 15,738 |
| **Breast** | 321,910 | 66,000 | 40%[3] | 0%[3] | 26,400 |

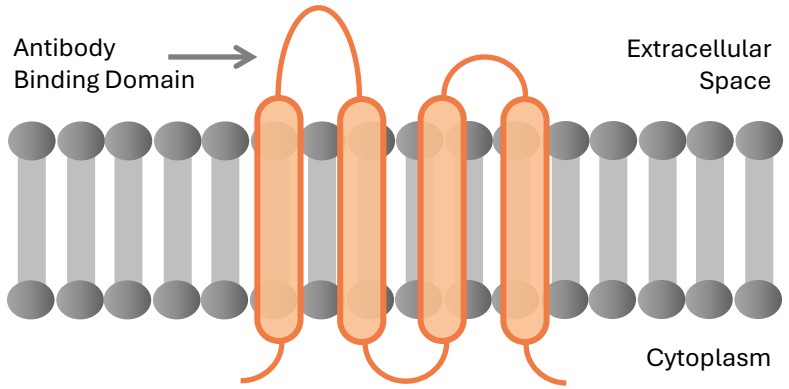


**1** Context internal Phase 1 data; **2** Context internal biopsy prevalence screen data; **3** Mackensen, Nature Medicine, 2023. Incidences based on public estimates; Relapsed/refractory (R/R) or last-line patient population approximated by annual mortality; CLDN6 target prevalence is based on IHC 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

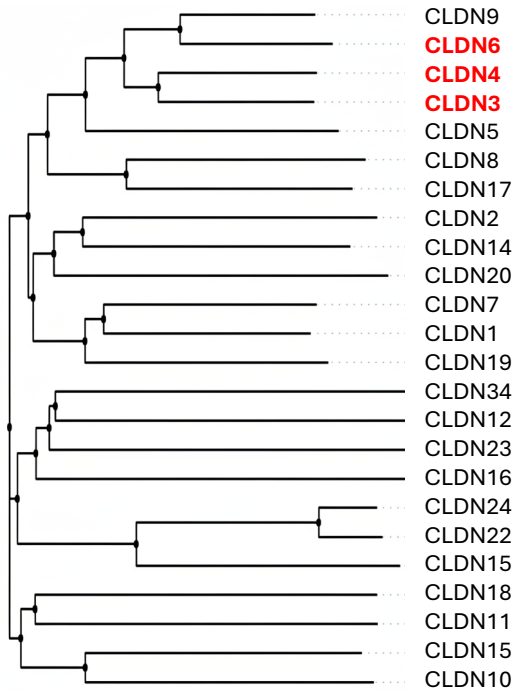
## CLDN6 is an Ideal TCE Target

- 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




CLDN6 Protein

## Avoiding CLDN3 and CLDN4 is a Critical Safety Determinant




Claudin Gene Family

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

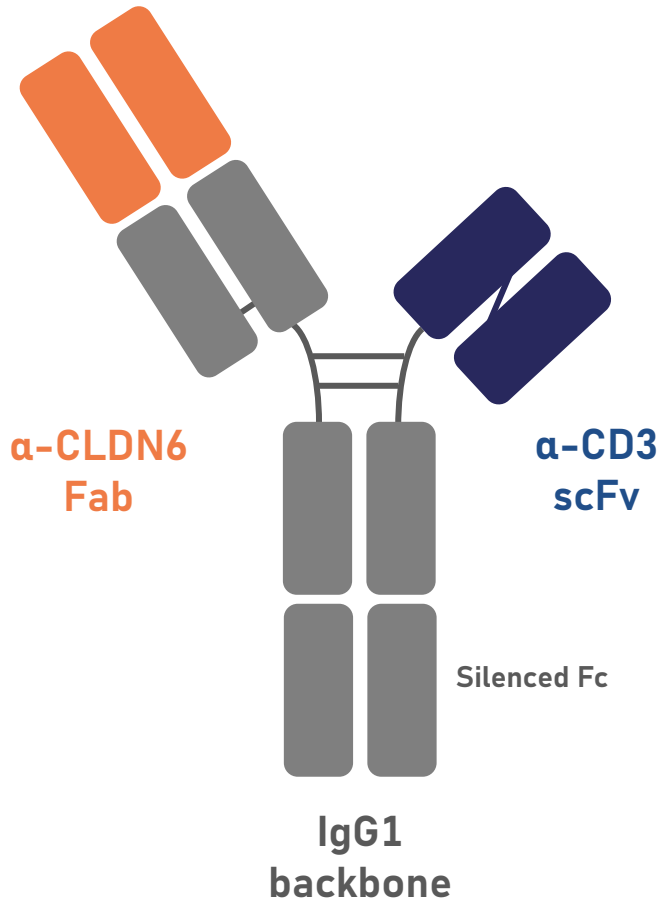
The CLDN6 antibody binding region is **highly conserved** with CLDN3 and CLDN4 – differing by only 3 amino acids[1]

CLDN3 and CLDN4 are enriched in the liver and antibody binding may result in **liver enzyme elevations**[2,3]



**1** Screnci, Cancer Res, 2022; **2** Tanaka, J Hepatol, 2018; **3** Cordat, Physiology, 2019; Li, FEBS Open Bio, 2020

# 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

# Positive Phase 1a Clinical Data Observed for CTIM-76

## CTIM-76 has been granted FDA Fast Track Designation

### Pan-PROC Target

~75% of platinum resistant ovarian cancer (PROC) patients are CLDN6+

**Potential for Rapid Clinical Enrollment**

### Clinical Activity in Late Line PROC

7 (5-16) prior lines of therapy

29% confirmed ORR

57% confirmed DCR

66% of patients on therapy

**Potential to Address ADC Resistance in PROC**

### Low Rate of CRS in PROC

11% Grade 1 CRS at target dose levels

**Potential for Outpatient Dosing**

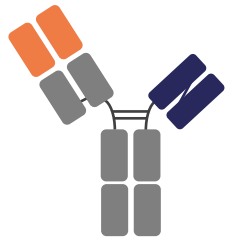
CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. RECIST-evaluable PROC population (n=9 patients at target doses) is defined as having measurable disease documented at baseline according to RECIST v1.1 criteria and at least one follow-up tumor assessment after a full cycle of treatment. Disease Control Rate: Patients achieving confirmed stable disease, partial response, or complete response. Data as of May 29, 2026

# Significant Market Opportunity in High Unmet Need CLDN6+ Post-ADC PROC

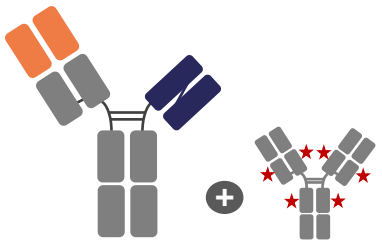
- **~75%** of PROC patients are CLDN6+
- **No approved treatment option** specifically for this biomarker selected PROC population
- **~42,000** CLDN6+ PROC patients globally (US, EU7, JP)
- CLDN6 has **significant target overlap** with promising ADC targets, including FRα, CDH6, NaPi2b – opening the door to potential combination opportunities
- **Additional opportunities** in earlier lines of ovarian cancer and other tumor types with CLDN6 overexpression, including non-small cell lung (NSCLC) and endometrial cancer

## Broad Use Case as Monotherapy or Combination

**CTIM-76**



**CTIM-76 + ADC**



**Potential Opportunities for:**

- Monotherapy development post-ADC
- Combination development with ADC, VEGF, or chemotherapy

Patient population based on multiplying NIH SEER 2026 ovarian cancer estimates in United States and prevalence estimates for EU7 and Japan by ~80% of all PROC (based on internal data)

# CTIM-76 Phase 1a Dose Escalation Trial

### Target population

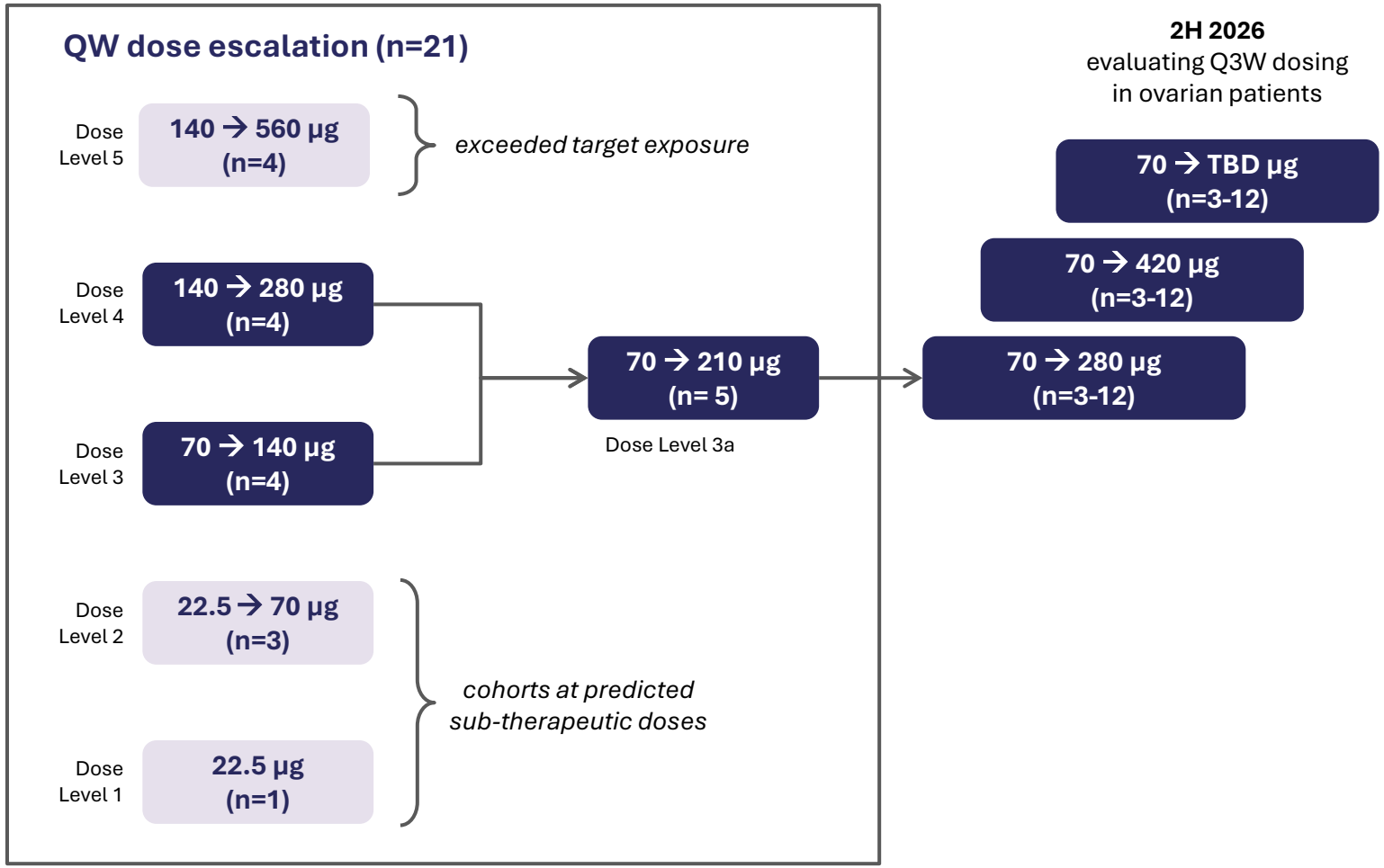
- Ovarian, endometrial and testicular cancer relapsed to standard of care (all comers)
- CLDN6+ positive via IHC (≥10% 1+ staining)

### Trial objectives

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

### Dosing and Administration

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




**Path to the identification of optimal prime dose, full dose, and dosing schedule**



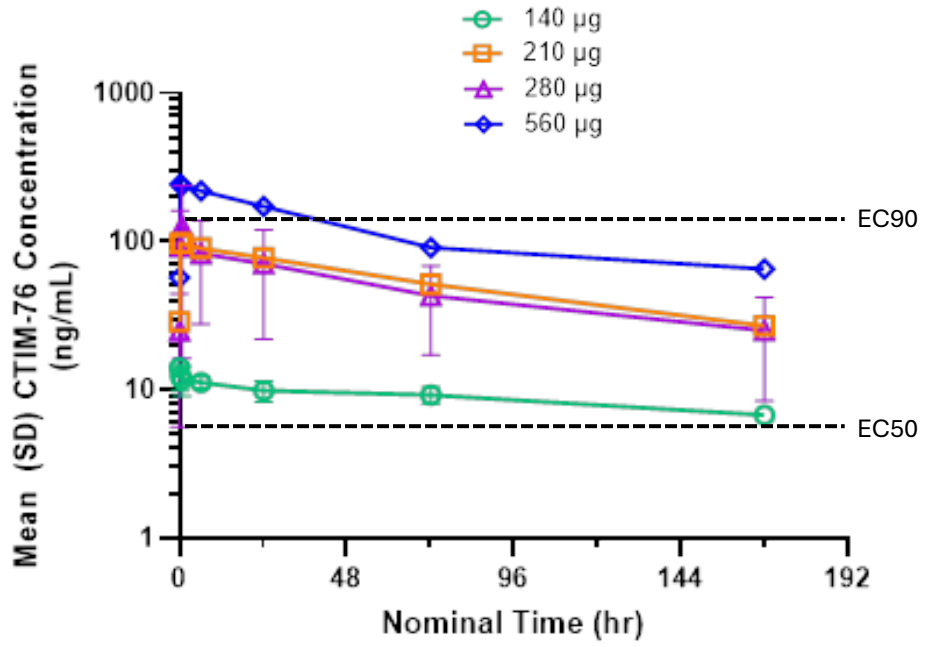
CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. Data as of May 29, 2026

# CTIM-76 Exhibits Compelling Pharmacokinetic (PK) Properties

## Weekly Dosing (QW)

210 and 280µg doses displayed optimal PK properties, including Cmax below target saturation (EC90) and Cmin above activity threshold (EC50)

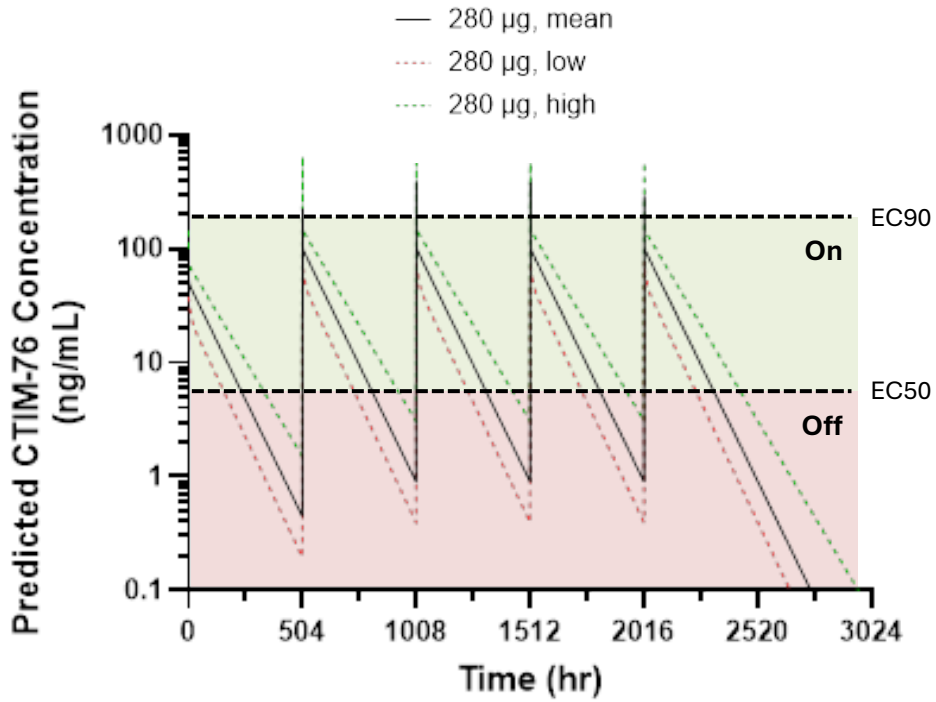
560µg resulted in target saturation and was associated with rapid T cell exhaustion




## Every Three Week (Q3W) PK Simulation

Reducing TCE dose frequency has been shown to reduce T cell exhaustion, resulting in improved treatment response and durability[1]

Q3W dosing of CTIM-76 may optimize T cell activation and recovery through on/off cycling






CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. Data as of May 29, 2026. 1 Pasritamig: Autio ESMO 2025 . Q3W = every three weeks.

# Patient Demographics at Target Doses of 140 to 280 µg

## CTIM-76 evaluated in heavily pre-treated patients with high tumor burden

| Baseline Characteristics | All Comers |
|---|---|
| **N** | 13 |
| **Age, n (range)** | 61 (29-72) |
| **ECOG, n (range)** | 1 (0-1) |
| **Ovarian, n (%)** | 9 (69) |
| **Testicular, n (%)** | 3 (23) |
| **Endometrial, n (%)** | 1 (8) |
| **Prior therapies, median (range)** | 6 (3-16) |
| **1, n (%)** | 0 (0) |
| **2** | 0 (0) |
| **3** | 3 (23) |
| **4** | 1 (7) |
| **≥5** | 9 (69) |

| Baseline Characteristics | Ovarian |
|---|---|
| **N** | 9 |
| **Age, n (range)** | 63 (53-74) |
| **ECOG, n (range)** | 0 (0-1) |
| **Sum of longest dimension (mm)** | 71 (39-114) |
| **Liver metastases, n (%)** | 4 (44) |
| **H-Score, median (range)** | 145 (25-300) |
| **Prior therapies, median (range)** | 7 (5-16) |
| **Checkpoint Inhibitor, n (%)** | 5 (55) |
| **ADC** | 8 (89) |
| **DNA Repair** | 7 (78) |
| **VEGF** | 9 (100) |

CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. Data as of May 29, 2026. ADC = antibody drug conjugate; DNA Repair = PARP, WEE1, or Chk1/2 inhibitor; VEGF = bevacizumab or PD-1xVEGF. Because the trial permits use of archival biopsy specimens, some samples may reflect earlier stages of disease and prior treatment history rather than contemporaneous tumor biology at study entry.

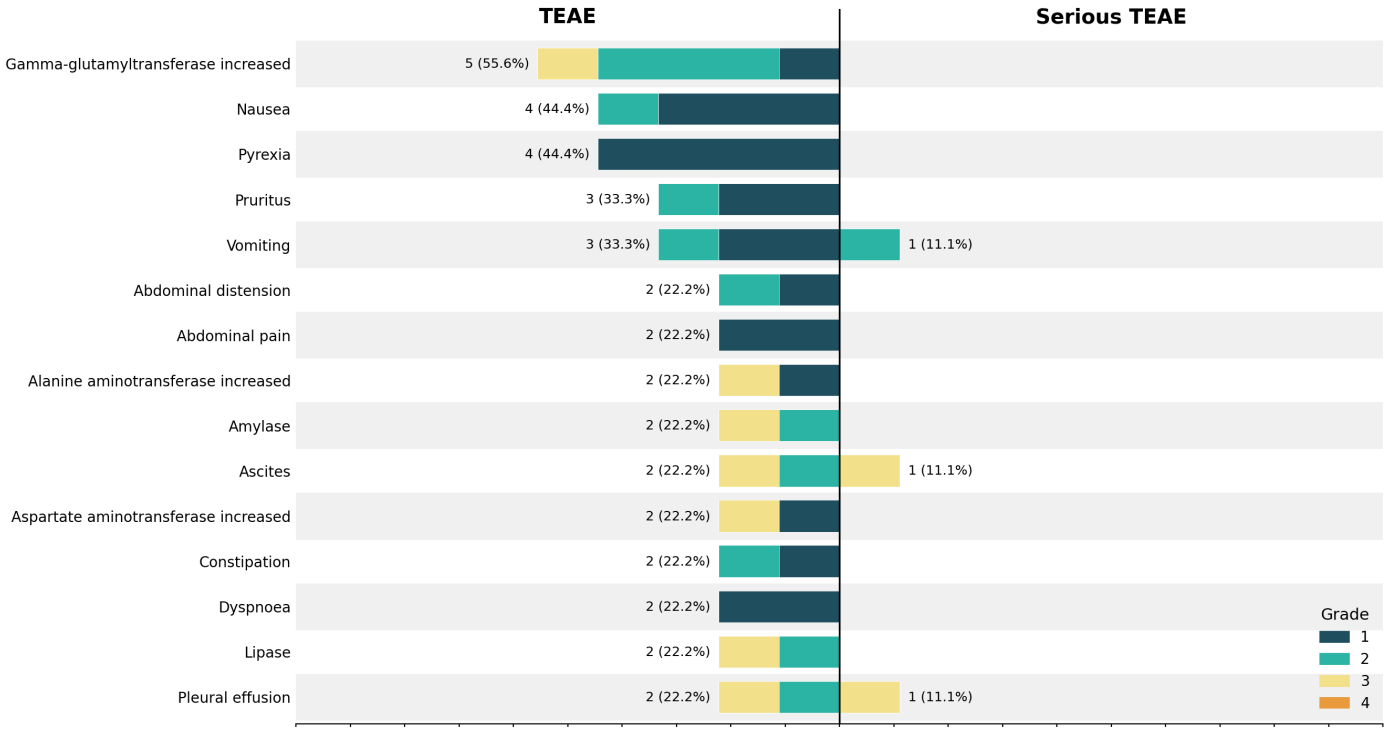
# Safety Analysis at Target Doses of 140 to 280 µg

**Observed to be well-tolerated with a favorable safety profile**

- Adverse events (AE) generally occurred during the first or second dose
- Most events were low grade, of short duration, and were reversible with standard management
- Low rate of cytokine release syndrome (CRS)

| Treatment Emergent Adverse Events (TEAE) | All Comers | Ovarian |
|---|---|---|
| **N (%)** | 13 | 9 |
| **Any** | 13 (100) | 9 (100) |
| **Related** | 13 (100) | 9 (100) |
| **Serious** | 5 (39) | 3 (33) |
| **Related Serious** | 2 (15) | 1 (11) |
| **Grade 1 CRS** | 2 (15) | 1 (11) |
| **Grade ≥2 CRS** | 0 (0) | (0) |
| **Dose Reduction** | 0 (0) | 0 (0) |
| **Discontinuation** | 0 (0) | 0 (0) |

**Ovarian: overall TEAE and Serious TEAE for by Maximum Severity Grade (N=9)**

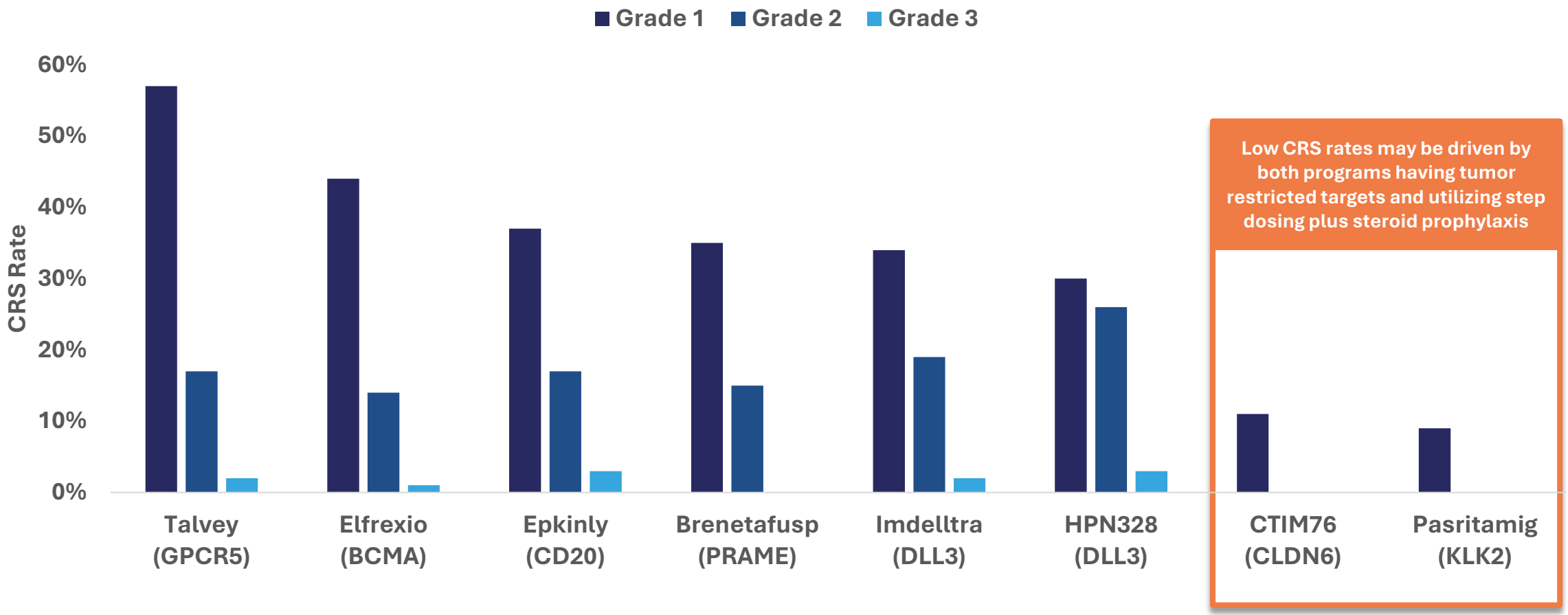





CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. Data as of May 29, 2026. All comers = ovarian, testicular, and endometrial patients at target dose levels. TEAE ≥15% in patients.

# CRS in PROC Patients at Target Dose Levels

## Benchmarking CRS profiles across approved and experimental TCE



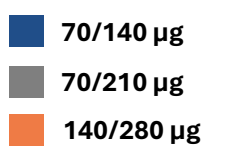

CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. Data as of May 29, 2026. CTIM-76 CRS derived from 16% Grade 1 CRS in all comers patients (n=13). Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, sample size, inclusion and exclusion criteria and many other factors. Imdelltra; Epkinly; Elrexfio; Talvey: Prescribing label. HPN329: Beltran ASCO 2024. Brenetafusp: Freidman ESMO 2024. Pasritamig: Autio ESMO 2025, Stein ASCO 2025

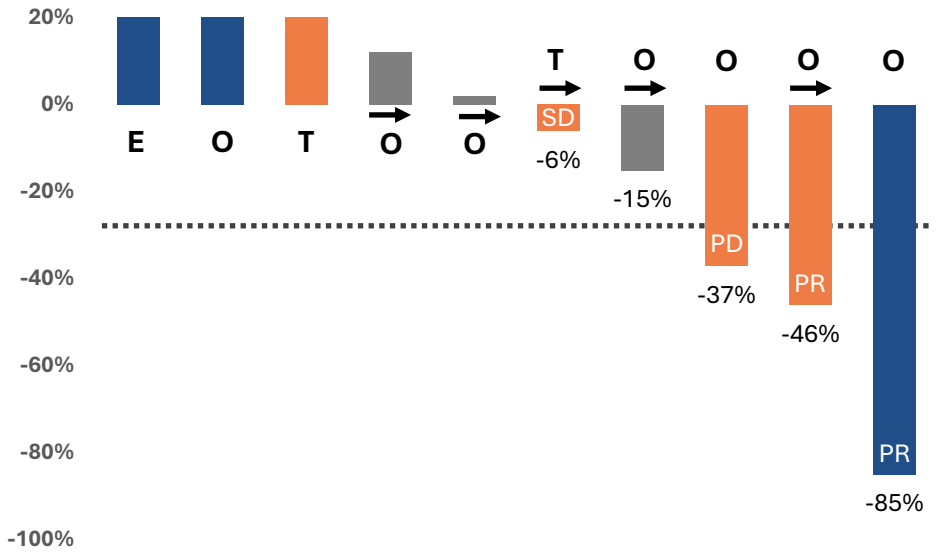
# CTIM-76 Interim Phase 1a Data at Target Doses

## Tumor reduction combined with manageable CRS profile supports continued clinical development

**Efficacy**

**Best Overall % Change in Tumor Size From Baseline***



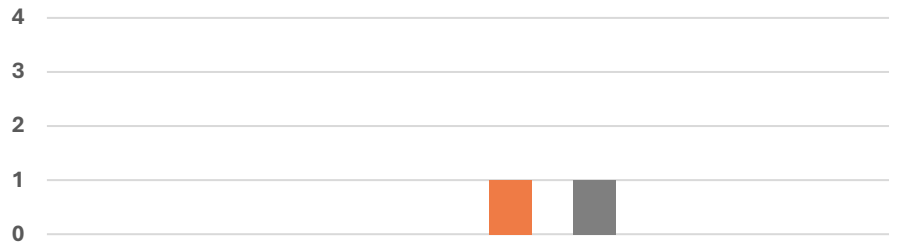




- Dose proportional anti-tumor activity
- Tumor shrinkage across multiple lesions and patients, providing evidence of effective T cell engagement

→ On treatment
**E** Endometrial cancer
**O** Platinum-resistant ovarian cancer
**T** Testicular cancer

**Safety**

**CRS Grade**



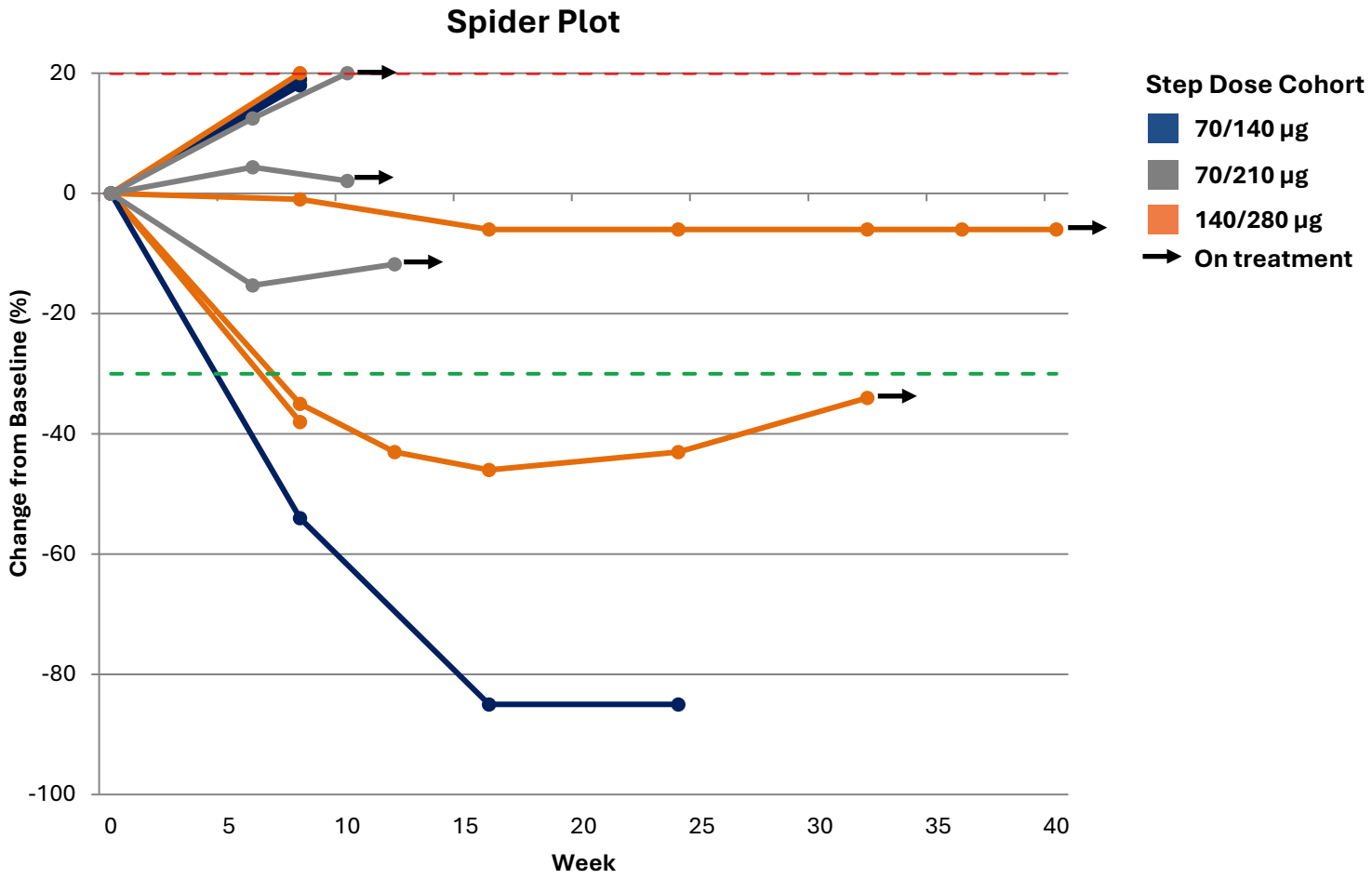

- Limited CRS to date



CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. RECIST-evaluable population (n =10 patients at target doses) is defined as having measurable disease documented at baseline according to RECIST v1.1 criteria and at least one follow-up tumor assessment after a full cycle of treatment. *Best tumor reduction at any time point in evaluable patients. Data as of May 29, 2026.

# CTIM-76 Anti-tumor Activity at Target Dose Levels

## Emerging durability signal, despite weekly dosing during escalation phase

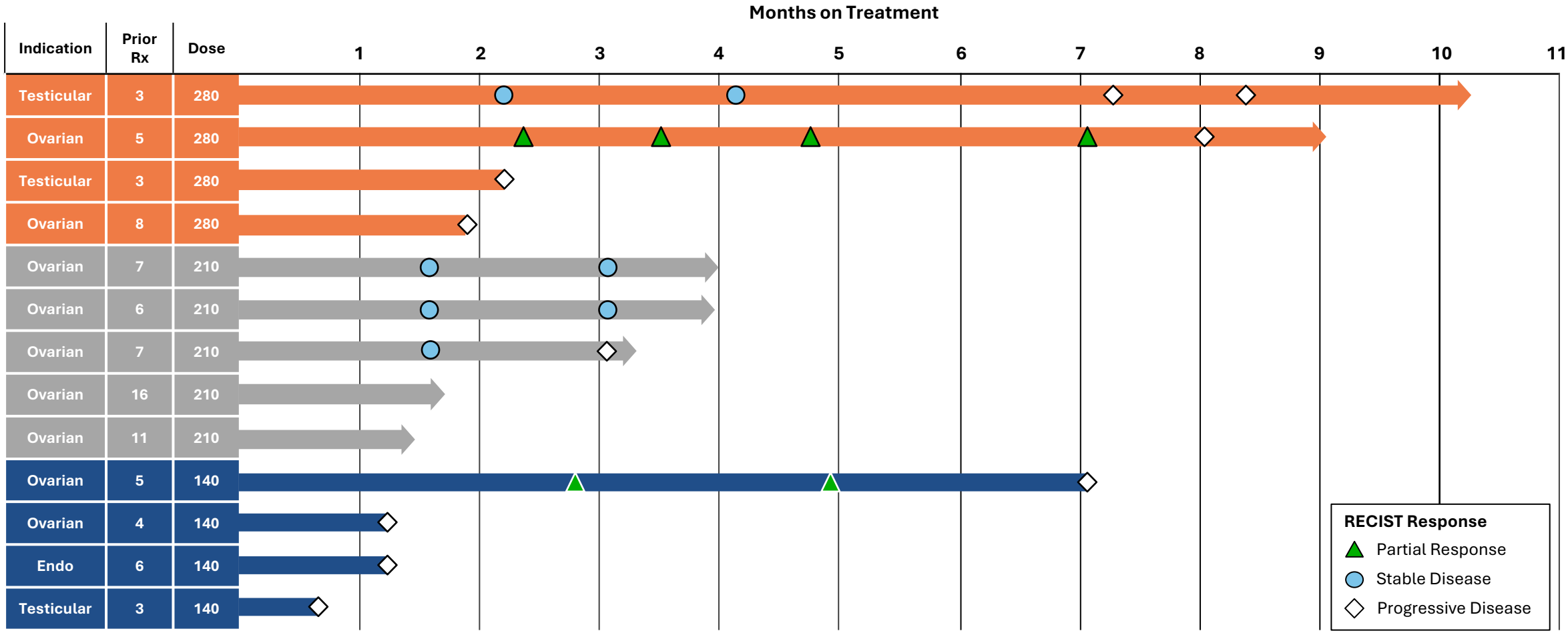



| | All Comers | Ovarian |
|---|---|---|
| **Patient enrolled, n** | 13 | 9 |
| **RECIST evaluable, n** | 10 | 7 |
| **Not RECIST evaluable, n** | 1 | 0 |
| **Pending 1st Scan** | 2 | 2 |
| **Overall Response Rate (ORR), n (%)** | 2 (20) | 2 (29) |
| **Stable Disease (SD), n (%)** | 3 (30) | 2 (29) |
| **Disease Control Rate (DCR), n (%)** | 5 (50) | 4 (57) |

CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. RECIST-evaluable population (n =10 patients at target doses) is defined as having measurable disease documented at baseline according to RECIST v1.1 criteria and at least one follow-up tumor assessment after a full cycle of treatment. Disease Control Rate: Patients achieving confirmed stable disease, partial response, or complete response. Data as of May 29, 2026.

# CTIM-76 Anti-tumor Activity at Target Dose Levels

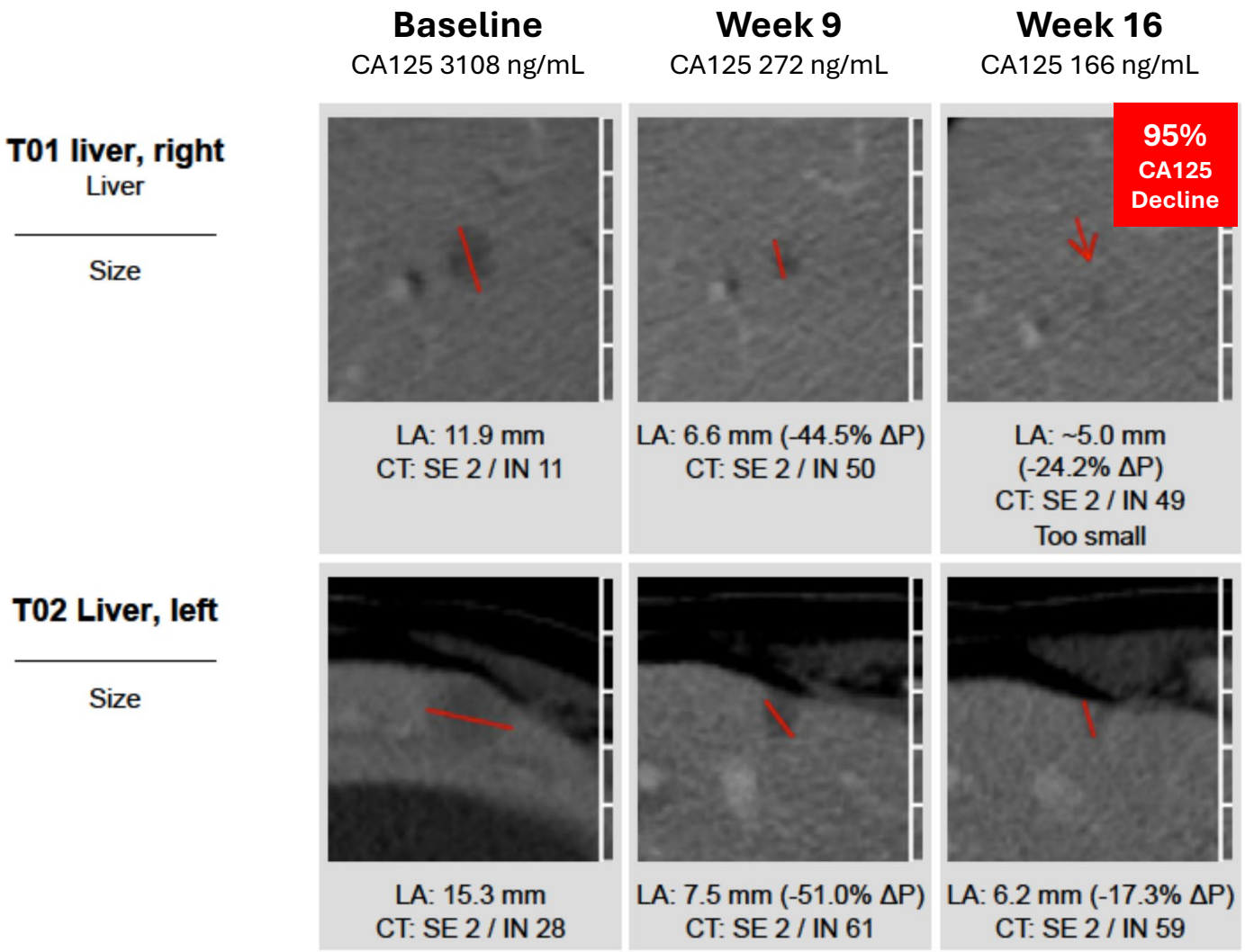
**Emerging durability signal with the potential to further improve with less frequent CTIM-76 dosing**






CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. Swimmer plot includes all comers at target dose levels (n=13). Data as of May 29, 2026.

# Significant RECIST Response in Ovarian Patient with Liver Lesions




## Patient Case Study Detail

- PROC patient administered 140µg
- 53-year-old female
- High disease burden; liver and peritoneum
- 5 prior lines of treatment and treatments included mirvetuximab, pembrolizumab, olaparib, VLS-1488
- Rapid progression on two prior therapies
- Confirmed PR, 85% decrease in tumor diameter
- Disappearance of peritoneal target lesion
- On treatment for 162 days; progression due to new lesions

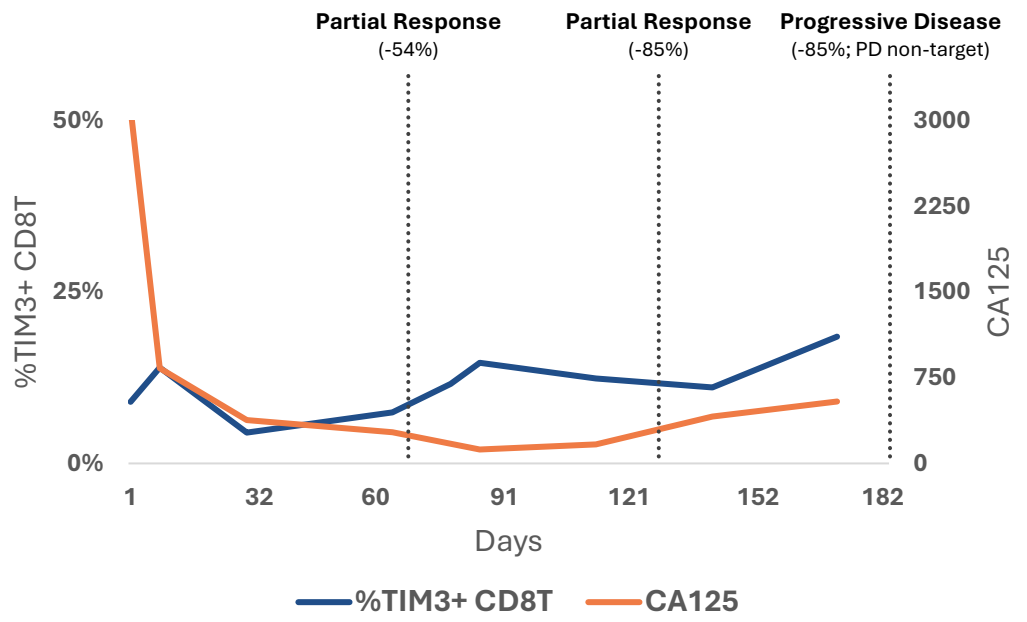


Context Internal Data. CTIM-76-101. Study Patient Biopsy.

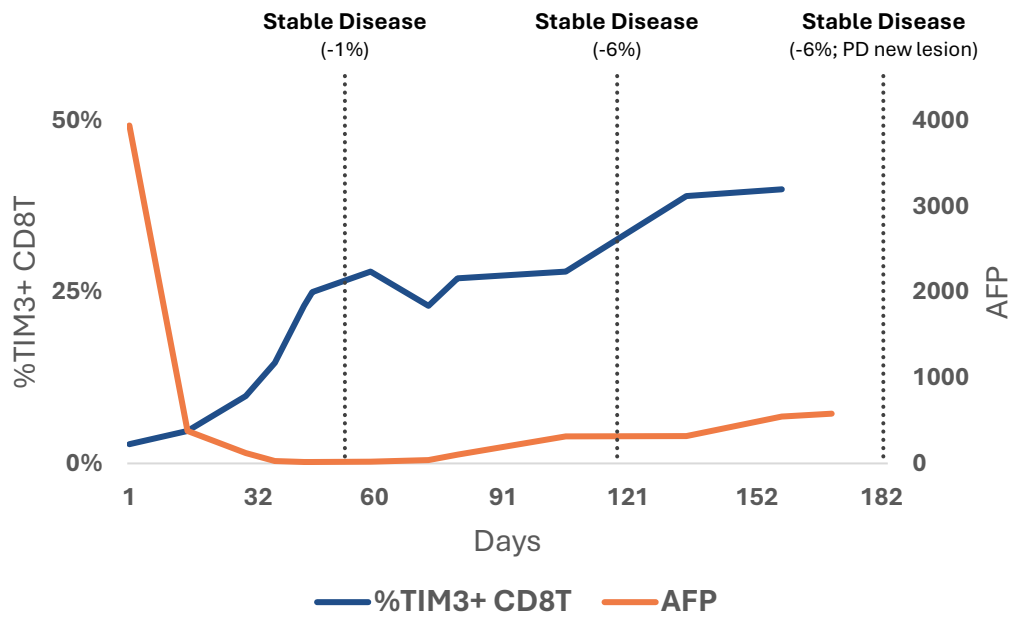
# T Cell Exhaustion is a Critical Determinant of Tumor Response Durability

## Q3W dosing may delay T cell exhaustion, improve treatment durability, and be more convenient for patients[1]

### Ovarian Patient @ 70/140 µg




### Testicular Patient @ 140/280 µg




- Response profiles for two patients with similar tumor burden and H-scores were compared
- Markers of T cell exhaustion (%TIM3+ CD8T) were dose proportional



Context Internal Data. CTIM-76-101. Study Patient correlative data. 1 Autio, Pasritamig in mCRPC, ESMO2025

# Competitive Profile for CTIM-76 in PROC

## Encouraging tumor response and safety profile in heavily pretreated / ADC-experienced patient population

| | CTIM-76 | Multiple | Nab-Paclitaxel | Azenosertib | Brenetafusp |
|---|---|---|---|---|---|
| **Target** | CLDN6 | CDH6, FRα, NaPi2b | Microtubule | Wee1 (CCNE1 amplified) | PRAME |
| **Format** | TCE | ADC | Chemotherapy | Small Molecule | TCE |
| **Prior ADC (%)** | **89** | 3-20 | 3 | 15 | 11 |
| **Prior Lines, median** | **7** | 3-5 | 2 | 3 | 4 |
| **ORR (%)** | **29** | 46-55 | 30 | 33 | 6 |
| **Trial** | NCT06515713 | REJOICE Ovarian-01, Rainfol-01, NAPISTAR | ROSELLA | DENALI Part 1b | ESMO 2024 |

Data are not from head-to-head studies. Cross-trial data interpretation should be considered with caution as it is limited by differences in study population, sample size, inclusion and exclusion criteria and many other factors. CTIM-76-101 ClinicalTrials.gov Identifier: NCT06515713. Data as of May 29, 2026.

# 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**

**Initial indications of interest based on:**

- MSLN prevalence
- Patient population size
- MSLN target validation

| 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** | 199,586 | 122,500 | 55% | 36% | **67,375** |
| **Pancreatic** | 67,530 | 47,850 | 80% | 61% | **38,280** |
| **Colon** | 158,850 | 36,600 | 41% | 17% | **15,006** |
| **Ovarian** | 19,900 | 19,500 | 90% | 80% | **17,550** |
| **Mesothelioma** | 3,000 | 2,500 | 70% | 60% | **1,750** |
| **Esophageal** | 22,530 | 16,290 | 41% | 26% | 6,679 |
| **Endometrial** | 68,270 | 17,000 | 45% | 23% | 7,650 |
| **Gastric** | 31,510 | 11,200 | 49% | 23% | 5,488 |

Incidences based on public estimates; Relapsed/refractory (R/R) or last-line patient population approximated by annual mortality; MSLN target prevalence is based on Simon et al, Biomedicines, 2021. Patient population derived from MSLN positive population multiplied by R/R incident population.

# MSLN Target Biology

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

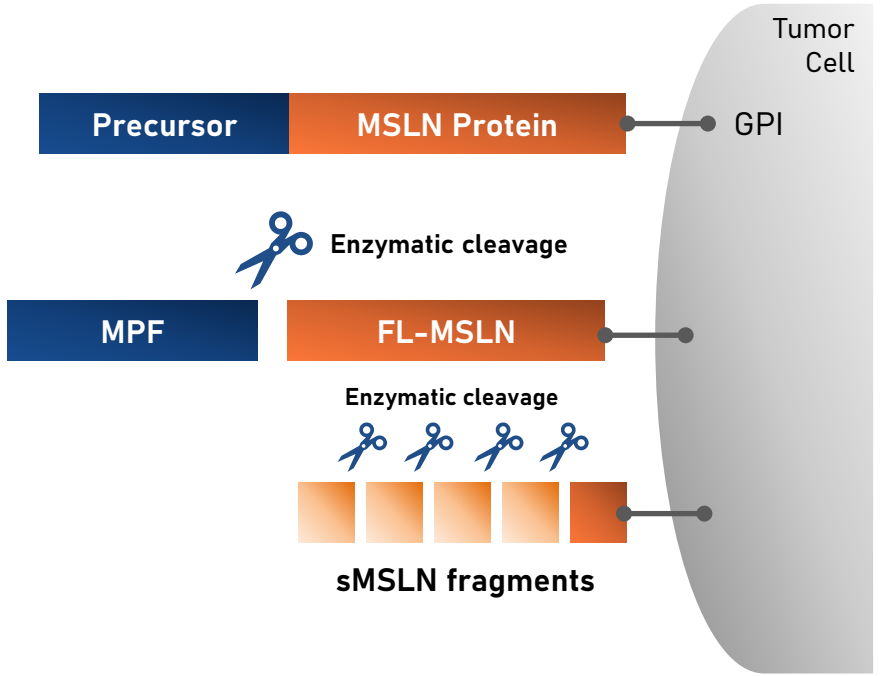
### Overcoming Fragmented MSLN in the Tumor Microenvironment

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)

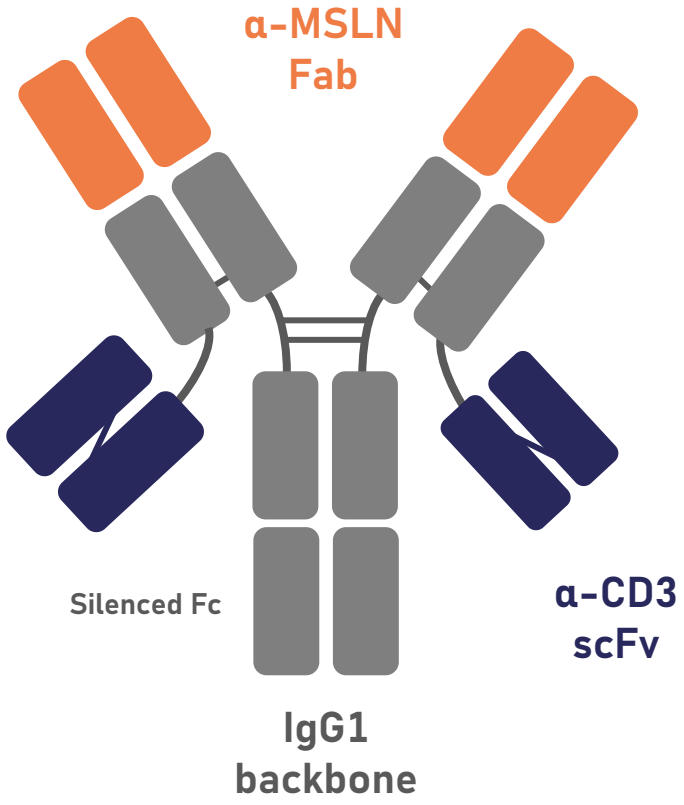
sMSLN serves as a competitive sink, preventing antibodies from binding to the tumor, which can lead to suboptimal drug exposure and efficacy






**1** Zhang, Transl Oncol, 2022; **2** Liu, Commun Biol, 2020; **GPI** = Glycosylphosphatidylinositol

# 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

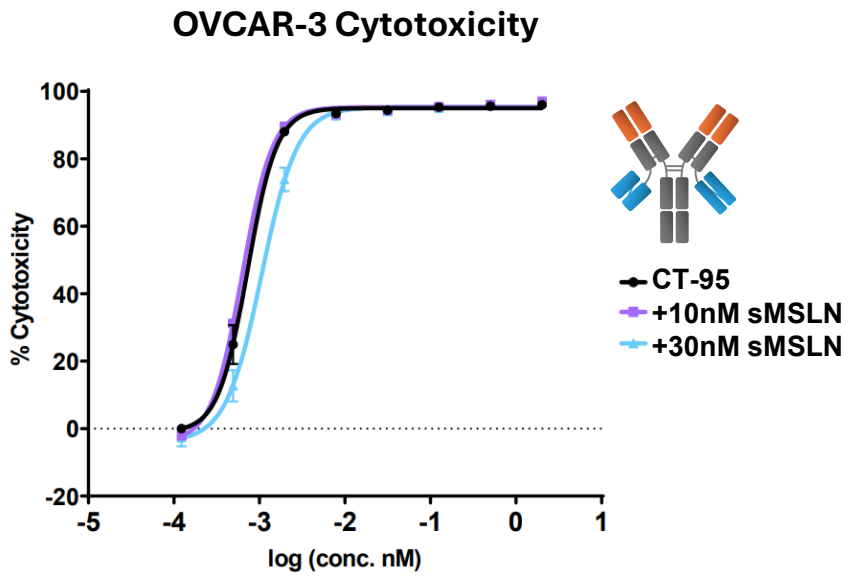
- IgG1 backbone is highly stable and enables high yield

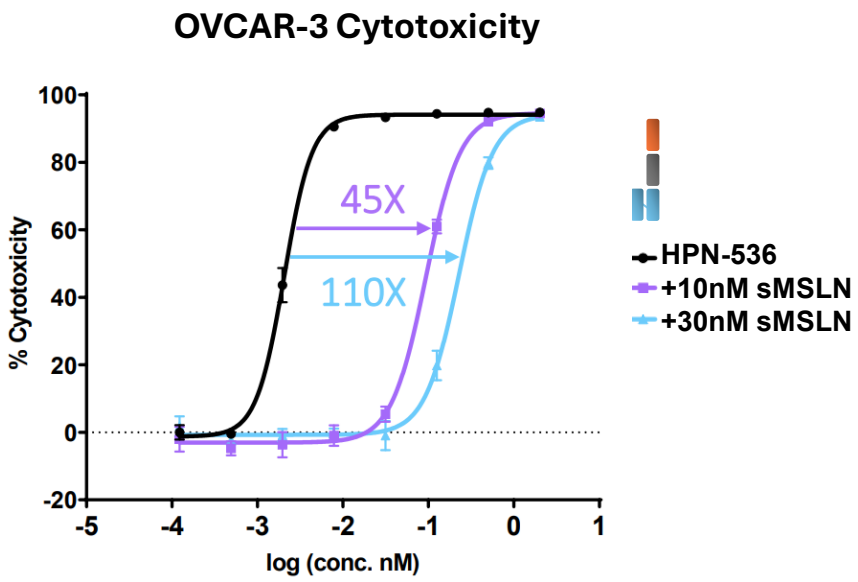
Anticipate Preliminary Phase 1a Data in September 2026

# 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**






HPN-536 clones are not derived from the original manufacturer and were produced for this research study based on the published sequence of their antibody variable chains; thus, the clones used in this study are biosimilars and may not be identical to the antibodies formulated for clinical development.

# 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 (≥10% 1+ staining)

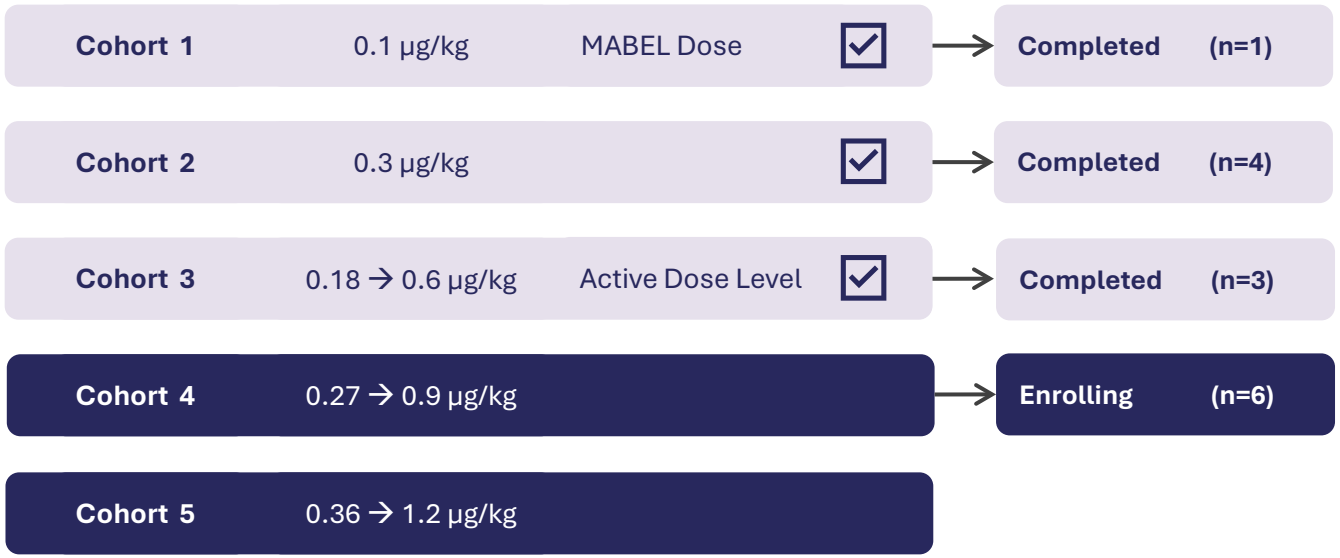
### Trial objectives

- 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**






Trial status information provided as of March 20, 2026

# 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<br>CDH3 + MSLN dBiTE | TriTAC | 1+1 | 2 + 1 |
| **Avoids sMSLN** | ✓ | ✗ | ✗ | ✓ | ✗ |
| **Affinity Tuned** | ✓ | ✗ | ✗ | ✗ | ✗ |
| **High Affinity CD3** | ✓ | ✗ | ✓ | ✗ | ✗ |
| **Program Status** | Phase 1<br>FPI Apr 2025 | Phase 1<br>FPI Oct. 2023 | Phase 1<br>Discontinued | Phase 1<br>Discontinued | Phase 1<br>Discontinued |

Clinical trials.gov accessed on October 30, 2025 **1** Harpoon Therapeutics Corporate Presentation, 4 November 2021; **2** Piscitelli, PEGS Boston, 2023; **3** Zymeworks R&D Day, 2022; **4** WO2022096716A2. Information provided in the table above is for illustrative purposes only and is not a head-to-head comparison. Differences exist between study or trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

# 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

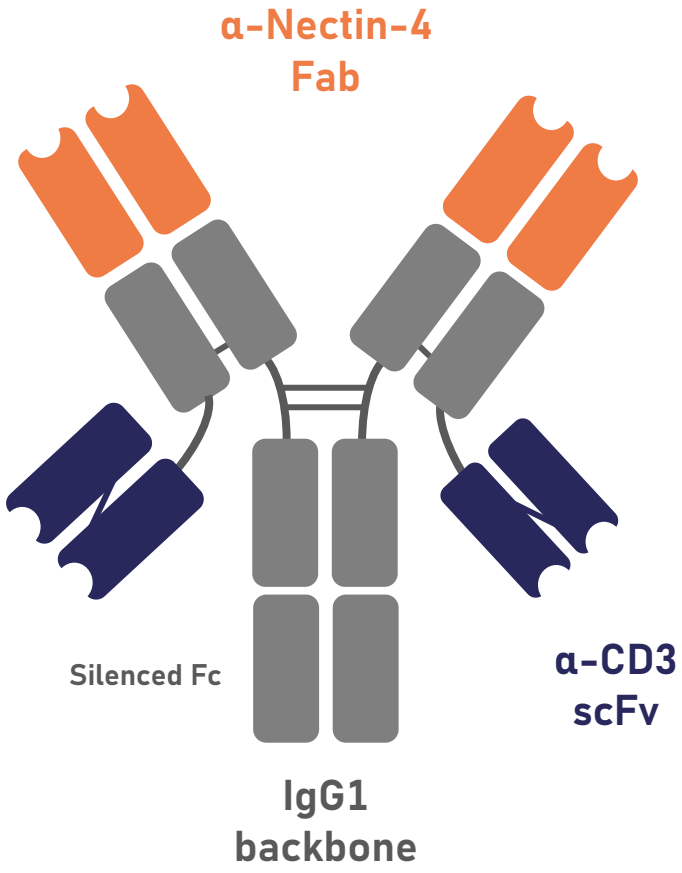
**Initial indications of interest based on:**

- 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** | 158,850 | 36,600 | 87%[1] | 78%[2] | **31,842** |
| **Bladder (urothelial)** | 84,530 | 18,765 | 83%[3] | 60%[3] | **15,575** |
| **Breast (TNBC)** | 56,334 | 11,550 | 78%[3] | 58%[5] | **9,009** |
| **Non-Small Cell Lung** | 199,586 | 122,500 | 64%[3] | 58%[6] | 78,400 |
| **Pancreatic** | 67,530 | 47,850 | 71%[3] | 37%[3] | 33,974 |
| **Head and Neck** | 72,680 | 12,000 | 59%[3] | 18%[3] | 7,080 |
| **Esophageal** | 22,530 | 16,290 | 55%[3] | 24%[3] | 8,960 |
| **Gastric** | 31,510 | 11,200 | 94%[7] | 60%[4] | 10,528 |

Incidences 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** Kobecki, 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

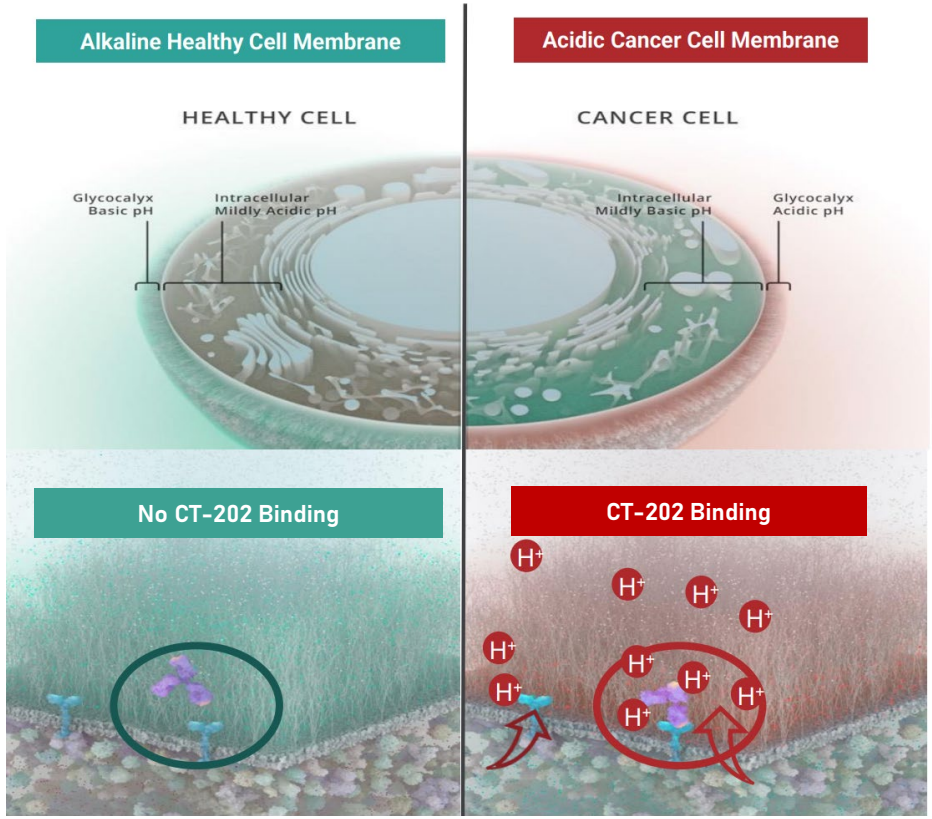
- IgG1 backbone is highly stable and enables high yield

Anticipate Phase 1 First Patient Dosed in Q3 2026

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

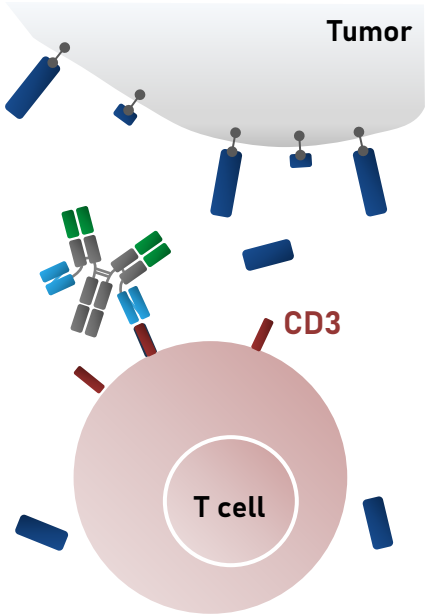
## Logic Gating Through pH Dependency

30x gain of activity in acidic tumor microenvironment versus healthy cells[1]



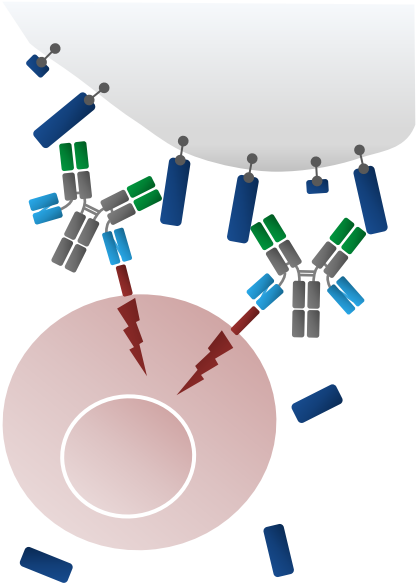

## Increased Target Selectivity Through Avidity

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




No T cell activation

Avidity-enhanced Nectin-4 binding



Potent T cell activation



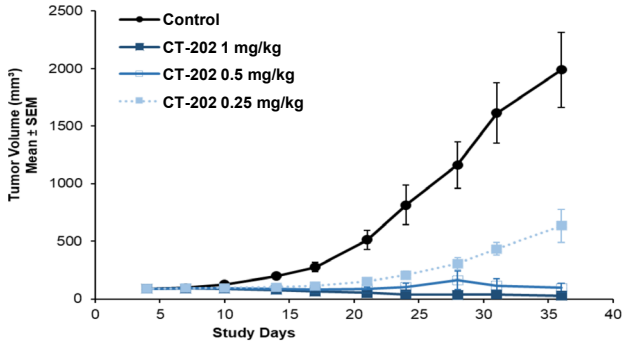
1 Chang, PNAS, 2021

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

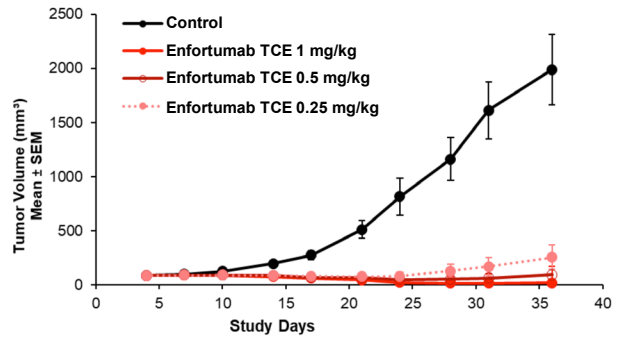
## Complete Tumor Regressions

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

CT-202



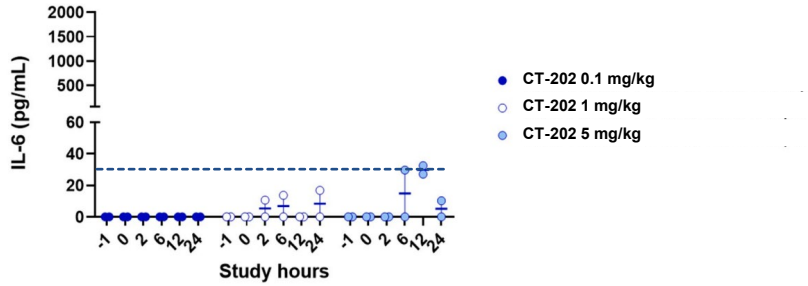

Enfortumab TCE



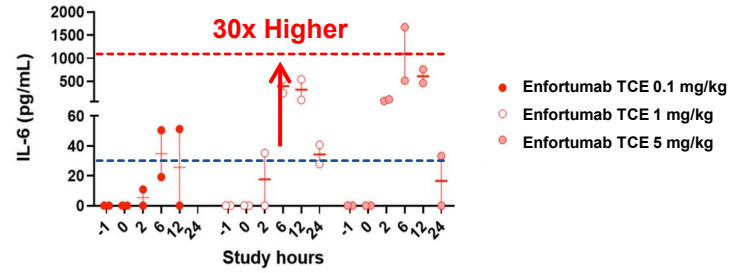

## Reduced Cytokine Release

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

CT-202




Enfortumab TCE






**Padcev** = enfortumab vedotin

# CT-202 Competitive Landscape

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

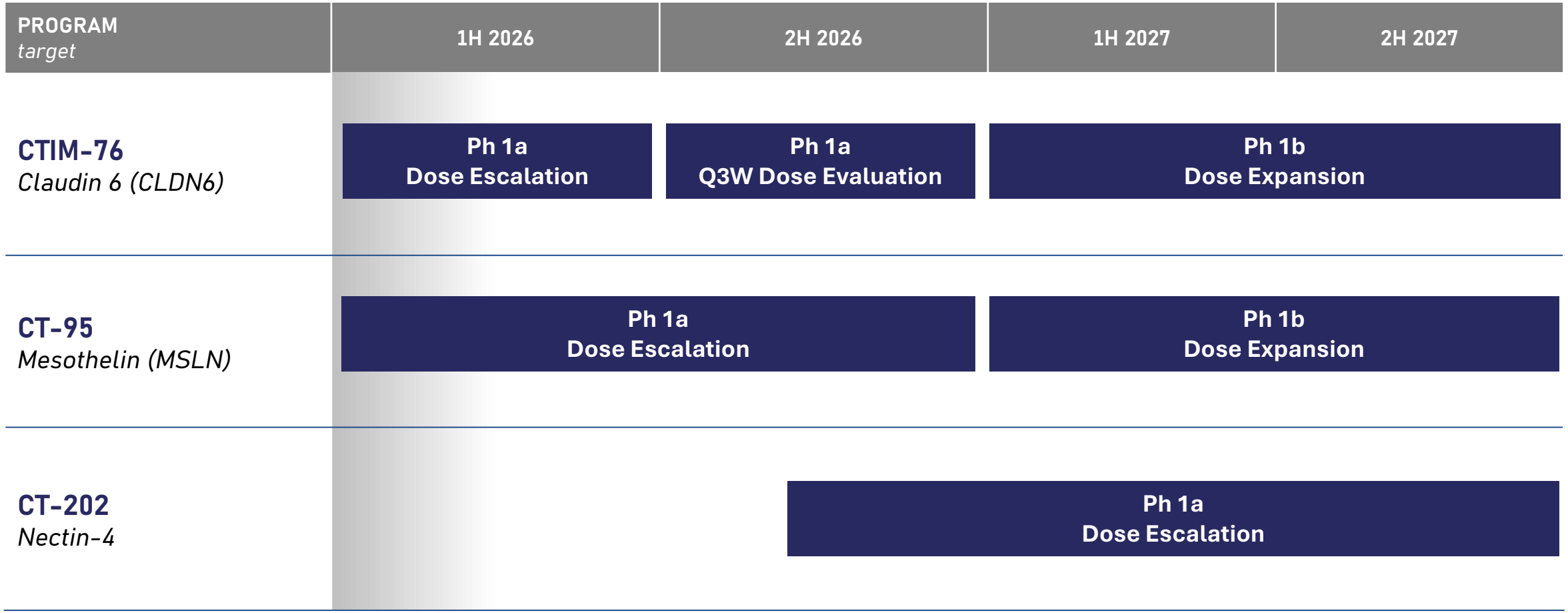
| Company | Context Therapeutics | Bicycle Therapeutics | Rondo Therapeutics |
|---|---|---|---|
| **Asset** | CT-202 | BT7480[1,2] | RNDO-564[3] |
| **Format** | 2 + 2 (pH dependent) | 1 + 2 (Bicycle) | 1 + 1 (Fixed light chain) |
| **Conditionally active** | ✓ | ✗ | ✗ |
| **Avidity enhanced** | ✓ |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

**1** Bicycle Therapeutics R&D Day, Dec 2023; **2** Hurov, J Immunother Cancer, 2021; **3** PEGS Boston 2024. Information provided in the table above is for illustrative purposes only, is not exhaustive and is not a head-to-head comparison. Differences exist between study or trial designs and subject characteristics, and caution should be exercised when comparing data across studies.

# Corporate

# Anticipated Key Milestones in 2026-2027

- Multiple data inflection points over the next 12 months
- Current cash runway into mid-2027






Reflects current expectations, subject to change

# Experienced Leadership Team

**Martin Lehr**
CEO and Director

Praesidia BIOLOGICS
Cure Duchenne
OSAGE UNIVERSITY PARTNERS

**Karen Chagin, MD**
Chief Medical Officer

Adaptimmune
TMUNITY
GSK

**Jennifer Minai**
Chief Financial Officer

MILLENDO THERAPEUTICS
parexel
EY

**Alex Levit, Esq**
Chief Legal Officer

optinose
teva
ReedSmith

**Jennifer Dashnau, PhD**
SVP Technical Operations

CENTURY THERAPEUTICS
MERCK

**Chris Beck, MBA**
SVP Operations

Galera Therapeutics, Inc
Shire
MERCK

## 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

context therapeutics

# Advancing T Cell Engagers for Solid Tumors



# 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 |
| **QW** | Every week |
| **Q3W** | Every three weeks |
| **scFv** | Single chain variable fragment |
| **SD** | Stable Disease |
| **TCE** | T cell engager |
| **YE** | Year End |