triumvira

First in class engineered T cells for safer, more efficacious and durable therapies in solid tumors

Q2 2023

Non-Confidential Overview

Rationally designed T-cell Antigen Coupler (TAC) platform technology

Ability to develop safer & effective T cell medicines for solid tumors

2023

Start of 2 HER2 Phase 2 trials

Start of Claudin18.2 Phase 1 trial

2024

Start of γδ allogeneic clinical program

Clear line of sight to 1st approvable indication in 3L gastric cancers

- Lead HER2 program: strong PRs, remarkable safety profile with no ICU visits for CRS and no neurotox: validation of the TAC platform for the future of T cell medicines
- Phase 2 trial mono and in combination with Keytruda®; opportunity to pursue 3L and 2L gastric cancer indications
- 2nd Program targeting Claudin18.2 adds to building a gastric cancer franchise
- Efficient & scalable autologous manufacturing with 100% success rate to date

Experienced management team

Paul Lammers, MD, MSc
CEO
EMD Serono, Mirna Therapeutics, Organon

Robert Williamson
President & COO
Haya Therapeutics, BioTheryx PharmAkea, Pharmasset, Eos

Andy Bader, PhD
CSO
Asuragen, Mirna Therapeutics, Orros Biotherapeutics

Deyaa Adib, MD
CMO
Bellicum, Baxalta, Astellas, Ariad, Rain Oncology Inc., Sanofi Aventis

Donna Rill
CTO
Cell Medica, Opexa Therapeutics, Baylor College of Medicine

Jon Irvin
SVP of Finance
Esoterix Laboratory Services, Ernst & Young, Bio Numerik

Cynthia Molina
VP, Regulatory Affairs
Cell Medica, Agennix

Chris Murray
VP, Human Resources
Bellicum, Lonza

~70 EMPLOYEES

60% | US
40% | Canada

CORPORATE HQ
Austin, TX

R&D AND MSAT LAB
Hamilton, ON

GMP MANUFACTURING FACILITY
South San Francisco, CA

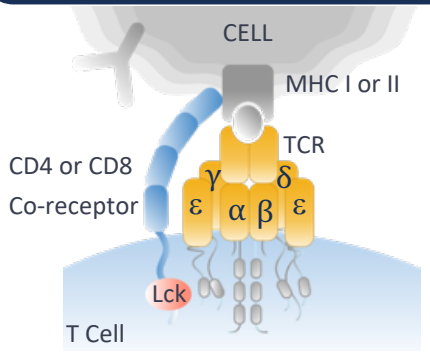
FINANCING
>$102M Series A

leaps by Bayer · Northpond Ventures · B Capital Group

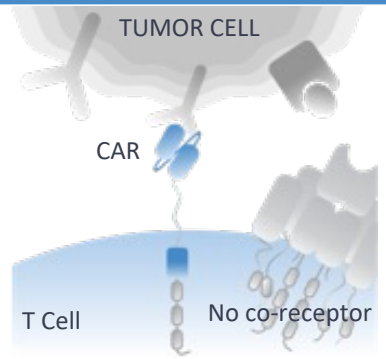
TAC T cells are designed to improve safety, efficacy, and durability over CAR T

Mimic natural T cell activation while maintaining MHC independence

Natural T Cell Biology

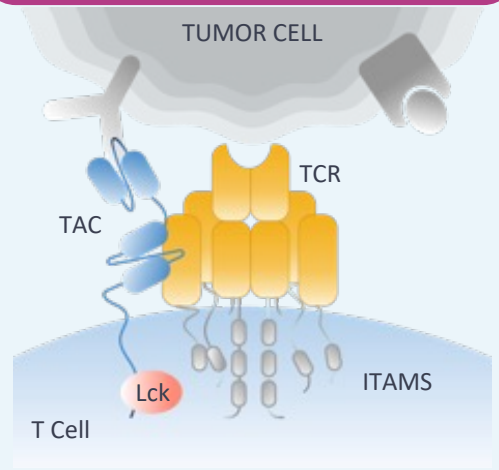


CAR-T Cells



CAR-T cell has “no brakes” which leads to toxicity

TAC-T Cell



Intracellular co-receptor domain of TAC adds key regulatory control and mimics natural T cell activation

No activation nor co-stimulatory domains

Composition of matter patents granted in US, CN, JP, HK, AU, MX, KR

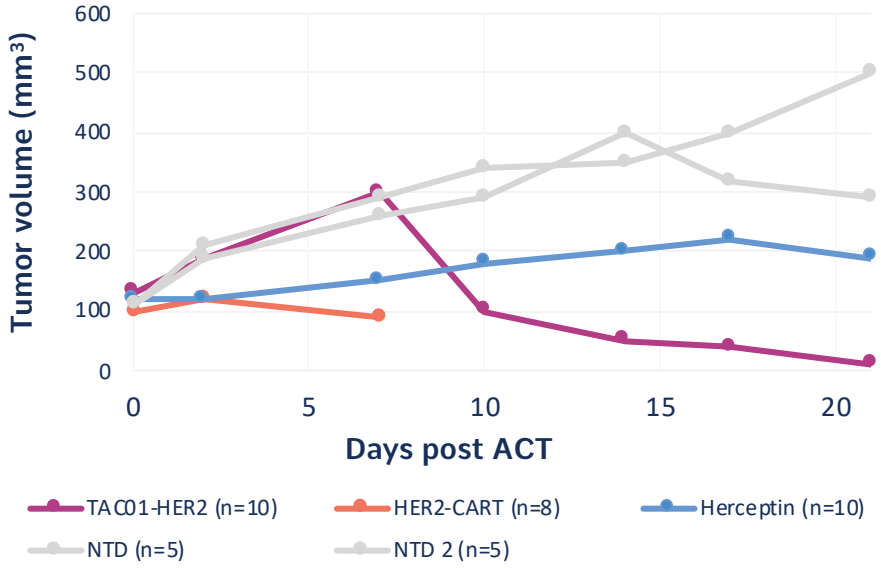
KEY ATTRIBUTES

- No tonic signaling or premature exhaustion
- Normal immune synapse
- Controlled, low & effective cytokine release
- Deep penetration & activation in tumors
- T cell persistence (majority memory CD8 cells)

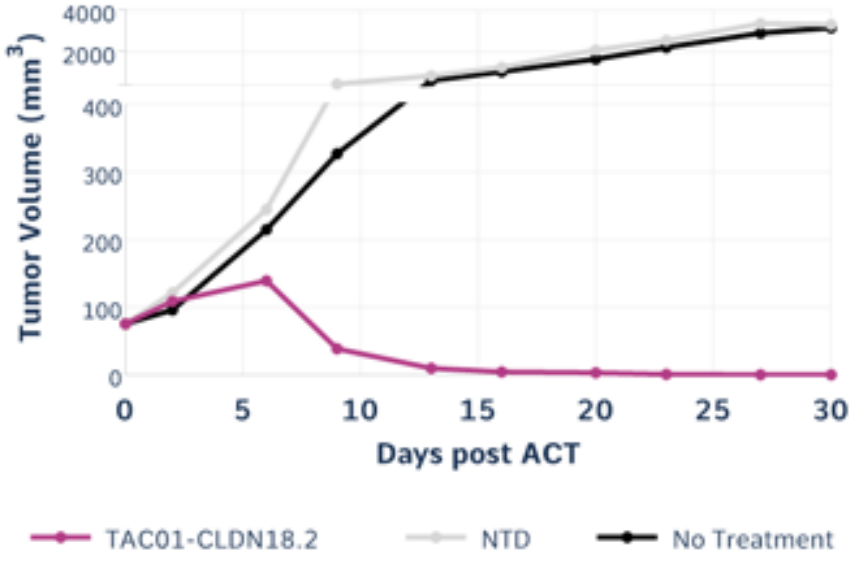
Strong scientific & clinical rationale for gastric cancer franchise

Supported by compelling preclinical and growing clinical data

TAC100-HER2 reduces tumor burden in Herceptin® – sensitive gastric cancer mouse model*



TAC101-Claudin18.2 depletes gastro-esophageal cancer model (n=6/group) **



HER2

Claudin 18.2

1 NTD = Non Transduced

* Study conducted by corporate partner, who considered this 'stunning data"

** Study conducted by external CRO

Triumvira is building a foundation in gastric & gastro-intestinal cancer

Expansion into other tumors and therapeutic areas through existing pipeline and partnerships

Autologous

Allogeneic

Autologous / Allogeneic | TBD

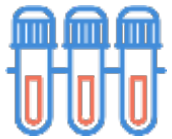
Platform	Target	Indication	Discovery	Preclinical	Phase I	Phase II
TAC100	**HER2** Autologous	Gastric, GEJ				
TAC101	**Claudin18.2** Autologous	Gastric, PDAC				
TAC201	**Claudin18.2** Allogeneic	Gastric, PDAC				
TACX03	**GUCY2C** Auto or Allo	CRC, GEJ, PDAC				
TACX04	**GPC3** Auto or Allo	HCC				
NEXT-GENERATION TAC PROGRAMS		Solid tumors				

CRC=colorectal cancer; GEJ=gastroesophageal junction cancer;
HCC=hepatic cell carcinoma; PDAC=pancreatic ductal adenocarcinoma

Phase 1 study showed differentiated safety profile over CAR T therapy

Zero

neurotoxicity events, and no ICU admissions



Only

One

≥ grade 3 CRS, at dose level 4

Only

One

dose limiting toxicity that was target related

MOST COMMON TOXICITIES

observed in all cohorts were lymphodepletion related

Hematologic toxicities

most resolved in

≤ 24 days

Phase 1 study showed differentiated safety profile over CAR T therapy

No ICANS, no ICU admissions, only 1 grade 3 CRS

Dose Levels 1 (n=4), 2 (n=4), 3 (n=3) & 4 (N=8) Adverse Events

	Adverse Event**	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	
AEs by Severity	Anemia	4	7	4	0	0	Lymphodepletion associated
	WBC Count Decreased	2	4	4	1	0	
	Neutrophil Count Decreased	3	5	2	0	0	
	Lymphocyte Count Decreased	1	1	2	0	0	
	Thrombocytopenia	1	1	2	0	0	
	Hypo-albuminemia	3	1	0	0	0	
	Blood Fibrinogen Increased	2	0	0	0	0	
	ALT increased	4	0	0	0	0	
	Tachycardia	2	0	0	0	0	
	Fatigue	2	0	0	0	0	
	Cytokine Releases Syndrome	5	6	1	0	0	CAR Risks
	ICANS (neuro-toxicity)	0	0	0	0	0	
	Pneumonitis (immune-related toxicity, D15-27 post dose w/o ICU)	0	0	1	0	0	TAC-T Related

	Percent CRS Grade ≥3	Percent Neurotoxicity
Kymriah® USPI	0-48%	43-71%
Yescarta® USPI	8-9%	74-87%
Carvykti® USPI	5%	26%
TAC100-HER2 Ph 1 trial	**5%***	**0%**

* 1/19 patients

1 Grade 3 pneumonitis at Dose Level 4 = only Dose Limiting Toxicity

Drug Safety Monitoring Committee decided on **DL 4 (6-8 X 10^6 TAC+ T cells/kg) as Recommended Phase 2 Dose**

* Across different indications; based on US Package Inserts
** Notes: Safety Data as of 24-Apr-23. Most frequent and relevant AEs are reported

Phase 1 study clinical results viewed very favorably by trial oncologists

83% Disease control rate and 33% ORR across dose levels 2-4 in 3L+ GE cancer

DL1
DL2
DL3
DL4

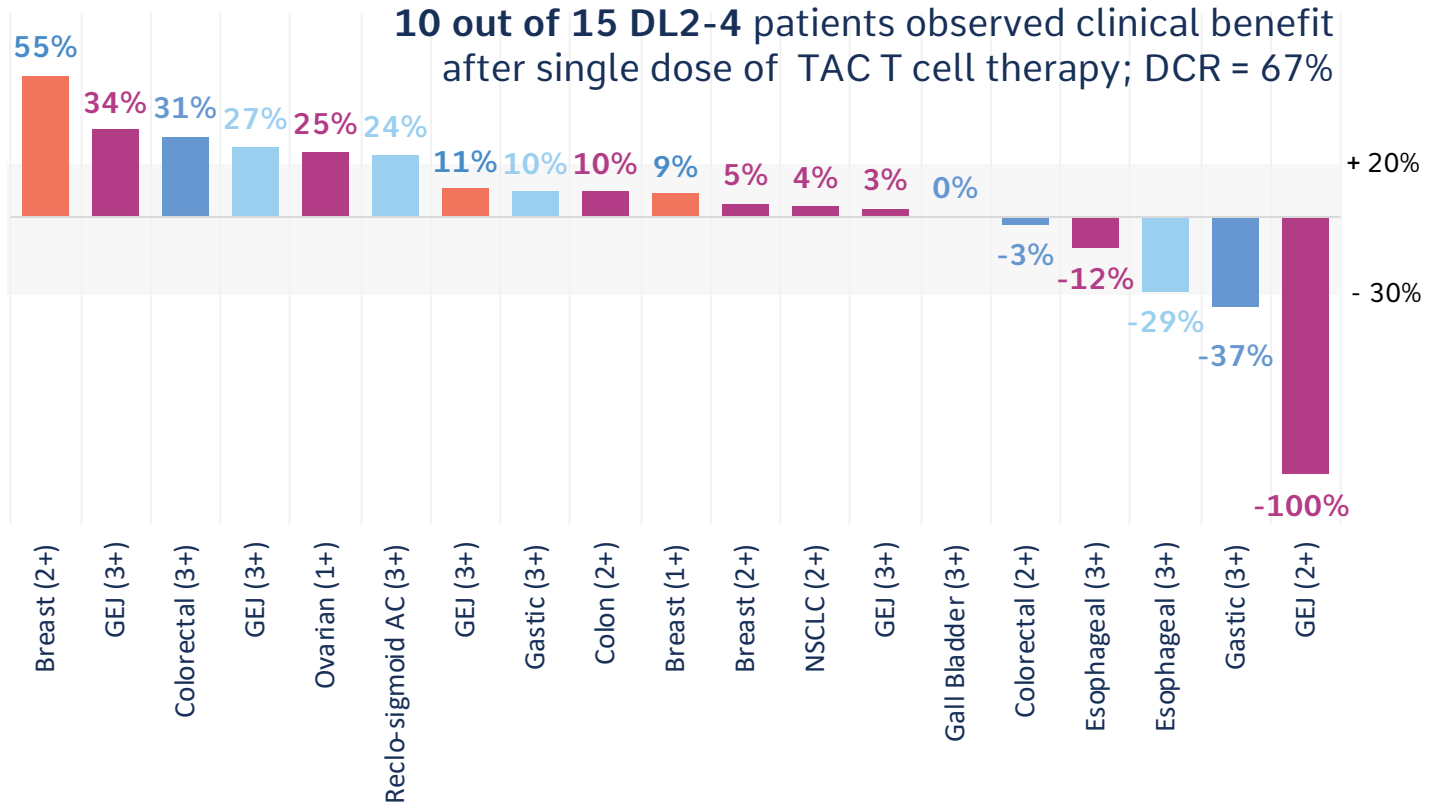
Phase 1 Refractory Cancer Patients
19 patients previously exposed
to a range of **2-12 therapies**

Results in DL2-4 gastric & esophageal cancer patients

DCR 83% at 1st assessment

2 PRs (1 CR of target lesion)

ORR 33% exceeds current SOC of 4% in 3L+ (Shitara et al 2018)

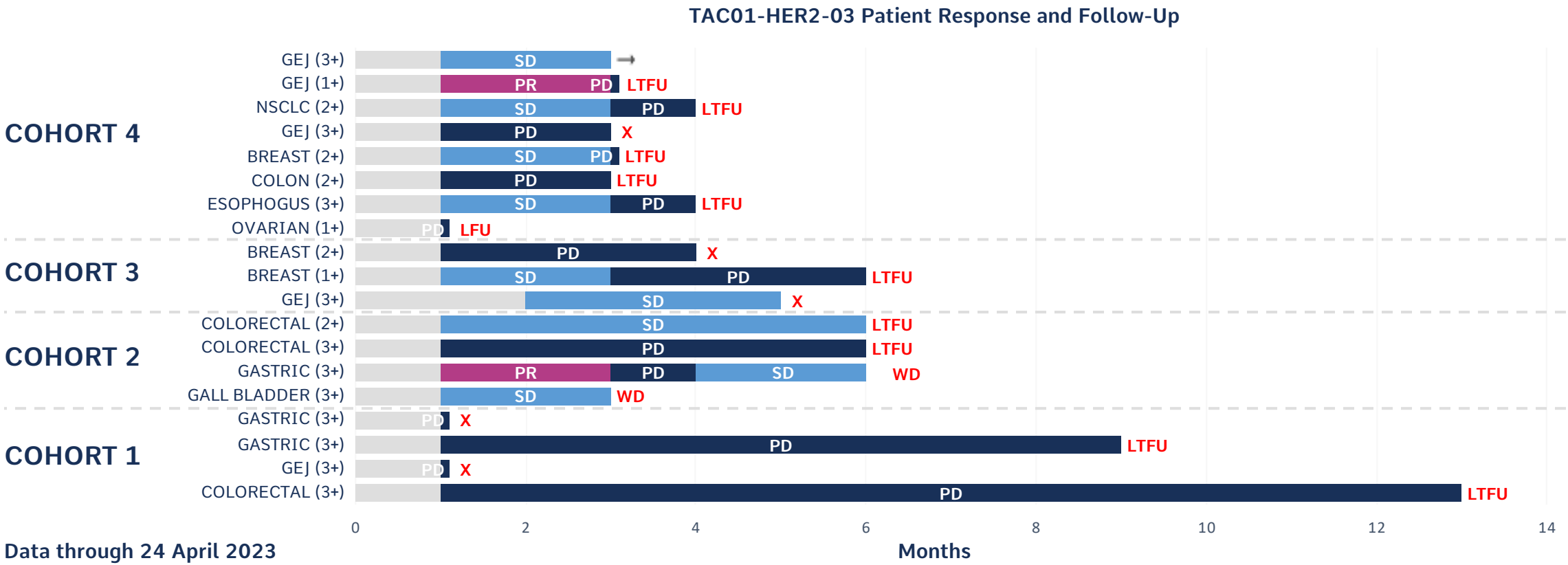


Scan data through 24 Apr 2023

Phase 1 study clinical results viewed very favorably by trial oncologists

83% Disease control rate and 33% ORR across dose levels 2-4 in 3L+ GI cancer

SD
PR
CR
PD
X Death
→ Alive



Data through 24 April 2023

LTFU = Long Term Follow-Up (No Subsequent Scans); X = Death; WC = Withdraw consent;
LFU = Lost to Follow-Up

The first partial response seen in gastric cancer

Underscoring potential of TAC100 in gastric cancers

TREATMENT HISTORY

Diagnosed in 2021

- Chemotherapy + HER2-Bispecific mAb therapy (best response → Partial response)
- Chemotherapy + Herceptin®
- Palliative Radiotherapy (x2)
- Bridging chemotherapy for 3 cycles prior to TAC100-HER2 infusion → patient in progression
- Received DL2 TAC100-HER2 cells after cy/flu LDC

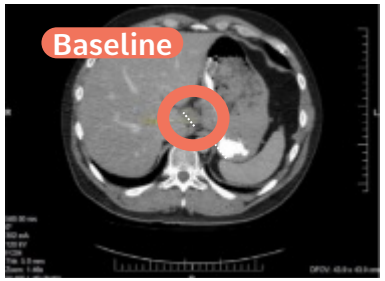
Stage 4b Gastric Adenocarcinoma

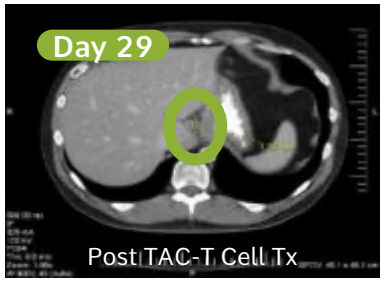
42 year old male; ECOG = 0; Central HER2 Status: 3+ (IHC), + (FISH)

RECIST 1.1 Tumor Response Assessment

(Measurable Disease)

20 MM	Target Lesion	13 MM





CHANGE

- 36.5%

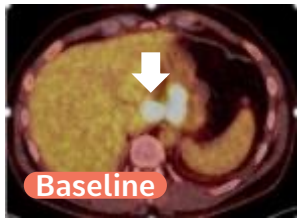
Safety

Infusion well tolerated

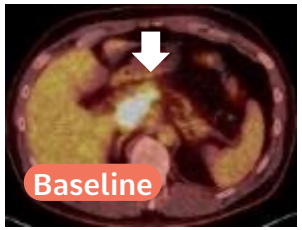
No SAEs, AEs of special interest, or DLTs

PET Scan Results Evaluable Tumor Reduction

Gastrohepatic Node Decrease in Size



Periportal Mass Decrease in Size



TREATMENT HISTORY

De novo metastatic disease in 2017

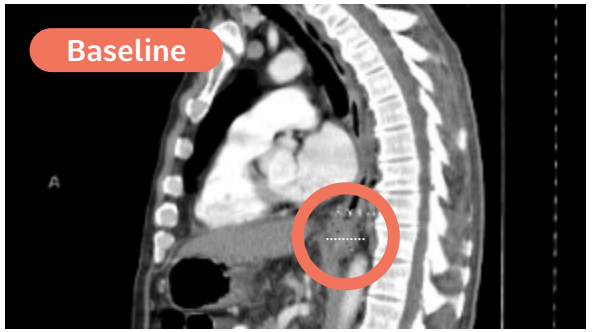
- 1L FOLFOX / Herceptin® → PR → FOLFOX dropped for neuropathy → PD
- 2L FOLFIRI / Herceptin® → PR → PD
- 3L Enhertu® → PD
- 4L taxol/ramucirumab → PR → PD
- Bridging therapy with taxol + ramucirumab + Herceptin®
- Upon progression, received DL4 TAC100-HER2 cells post flu/cy LDC

Second partial response in GEJ with a 100% reduction of target lesion

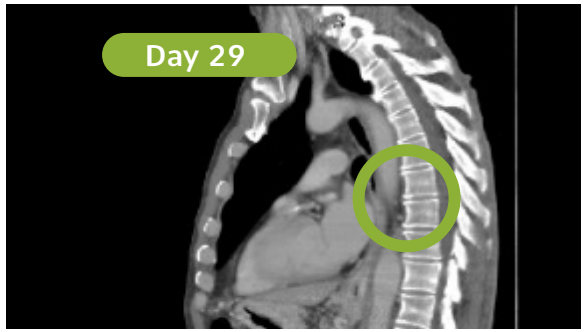
Underscoring potential of TAC100 in gastric cancers

Advanced Gastro-Esophageal Junction Cancer

59 year old male; HER2 Status: 2+ (IHC), + (FISH)



Primary lesion
(3 cm)



100% reduction of Primary lesion (CR), but small increase in pelvic free fluid + new sub-centimeter lymph node lesions

RECIST Score: PARTIAL RESPONSE

Phase 1 results efficacy signals registration-enabling phase 2 trial in gastric & esophageal adenocarcinomas

Key Phase 2 Trial Design Elements

01 **HER2+ (2+; 3+ by IHC/+ve FISH)**
No more than 4 prior therapies, or pts. who cannot tolerate/refuse other options

02 **Redosing option based on pre-set clinical criteria** to extend duration of clinical benefit

03 **Combination arm with Keytruda®** to optimize clinical responses and persistence

04 **Leading cell therapy** academic trial sites

Phase 2 trials to start in Q3 of 2023:

- **TAC100 Mono-therapy (n=36 pts.)**
- **TAC100 Combination therapy with Keytruda® (n=34 pts.)**
- **Simon 3 Stage Design**

Dana-Farber Cancer Institute
THE UNIVERSITY OF TEXAS MD Anderson Cancer Center Making Cancer History®
UHN Princess Margaret Cancer Centre
Northwestern University
THE UNIVERSITY OF CHICAGO

Recognition by GI onc medical community validated the strength of TAC100 data and highlighted the unmet medical need

We anticipate initial approval and launching in underserved gastric & esophageal cancer

ADDRESSABLE POPULATION

48,000

GEA Cases annually in U.S ACS 2023.

10,500

(22%)

HER2+ GEA Cases annually in U.S.

ASCO Gastrointestinal Cancers Symposium

AACR American Association for Cancer Research

sitc Society for Immunotherapy of Cancer

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

WORLD CONGRESS ON Gastrointestinal Cancer

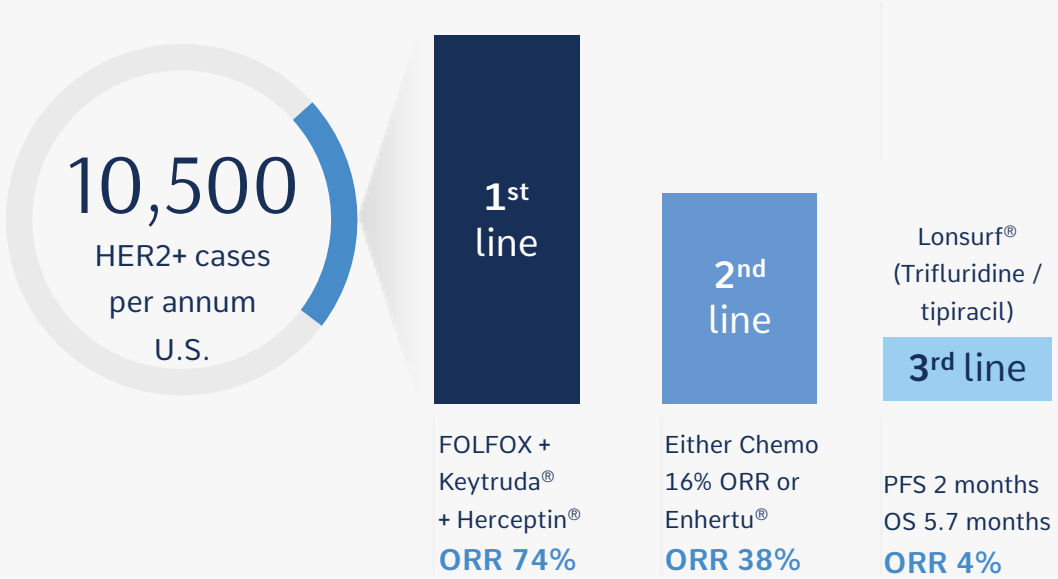
The acceptance for presentation at the most important annual medical & scientific meetings serves as a validation of the interest in our TAC T technology, the phase 1 results to date in solid tumors, and their clinical relevance.

GEA = Gastro-Esophageal Adenocarcinoma

Registrational Phase 2 trial design defines first target indication

3rd Line with upside in 2nd and 1st lines, and potential for chemotherapy sparing regimen

3L GC/GEJ CANCERS POORLY SERVED



TARGET OUTCOME FOR PHASE 2 TRIAL WILL POSITION TAC100 AS SOC IN 3L HER2+ GASTRIC & ESOPHAGEAL CANCERS

Monotherapy Clinically Meaningful Target:

An ORR of ~20% & DOR 4 months

PFS = 4.5 months

OS = 8 months

Combo With Keytruda:

3rd line ORR of 25% & DOR 5-6 months

3rd line results to establish new SOC of Keytruda + TAC in 2nd line setting

Data Driven & Efficient Simon 3 Stage Design for Phase 2

DOR= Duration of Response; ORR=Objective Response Rate; PFS= Progression Free Survival; OS= Overall Survival

Compelling preclinical data supports selection of Claudin18.2

Targeting Claudin18.2 positive cancers expands biomarker-driven gastric franchise

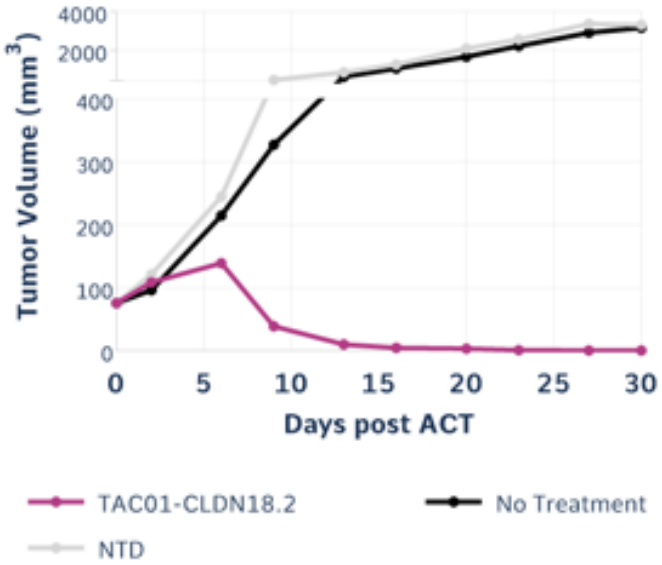
Claudin 18.2 selectively expressed in tight junctions

between normal gastric cells, and not visible to T cells.

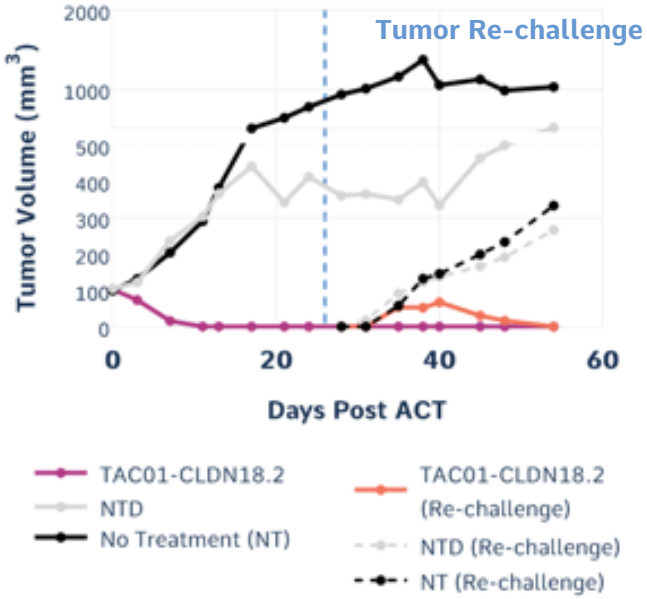
In cancer, Claudin 18.2 expression becomes visible

to T cells, opening up targeting ability

TAC101-Claudin18.2 depletes gastroesophageal cancer model (n=6/group)



TAC101-Claudin18.2 depletes tumors and protects against tumor re-challenge in gastric cancer model (n=4/group)



High expression of Claudin 18.2 seen in 25-40% of gastric cancers, 24-55% in pancreatic cancers (PDAC)

TAC-Claudin18.2 also shows in vivo efficacy in pancreatic cancers

IND submission anticipated in Q2 2023

Claudin18.2 program is on track to dose first patient in Sept 2023

Accelerated path to phase 2 based on HER2 program learnings

FPI Sept 2023

Phase 1 Dose Expansion

ALL comers CLDN18.2+ solid tumors

3+3 dose escalation

DL1
6-8 X 10^5
TAC+ T CELLS / KG

DL2
1-3 X 10^6
TAC+ T CELLS / KG

DL3
6-8 X 10^6
TAC+ T CELLS / KG

RP2D

FPI H2 2024

Phase 2 Dose Expansion

CLDN18.2+ solid tumors **(CLDN status TBD based on Ph 1)**

- **CLDN18.2+ Gastric and GEJ Cohort (n=57) Simon 2 stage**
- **CLDN18.2+ PDAC Cohort (n=10) exploratory**
- **CLDN18.2+ Ovarian and NSCLC Cohort (n=24) Simon 2 stage**

A 2nd dose may be administered if subjects meet clinical response & safety criteria

All patients will receive Lymphodepletion prior to infusion

Simon 2 Stage design for Phase 2 based on anticipated ORR of 40%

Expected RP2D at DL3 = TAC100-HER2 DL4 dose equivalent

GEJ: Gastroesophageal Junction; PDAC: Pancreatic Ductal Adenocarcinoma; NSCLC: Non-Small Cell Lung Cancer

COCOON® TREE

Single

Cocoon® Platform unit

Holds 5 Cocoon® platforms in same footprint as single unit

Quality

100% Success rate to date

High cell yields & option to re-dose

High cell quality/ consistency

Cost

~40% Lower cost at scale

Smaller Facility/ Fewer FTEs

Plug and Play Scalable

Time

9 Days start to finish

Enclosed automated Cocoon

21-24 days vein-to-vein

First mover advantage in automated autologous manufacturing

Three years of experience paying off with reliable clinical supply and commercial-ready products

COCOON® PLATFORM

from Lonza

industrializes and automates autologous cell manufacturing processes

Triumvira's GMP facility in South San Francisco holds

8 **COCOON® PLATFORMS**

Current capacity to manufacture

TAC-T Cells

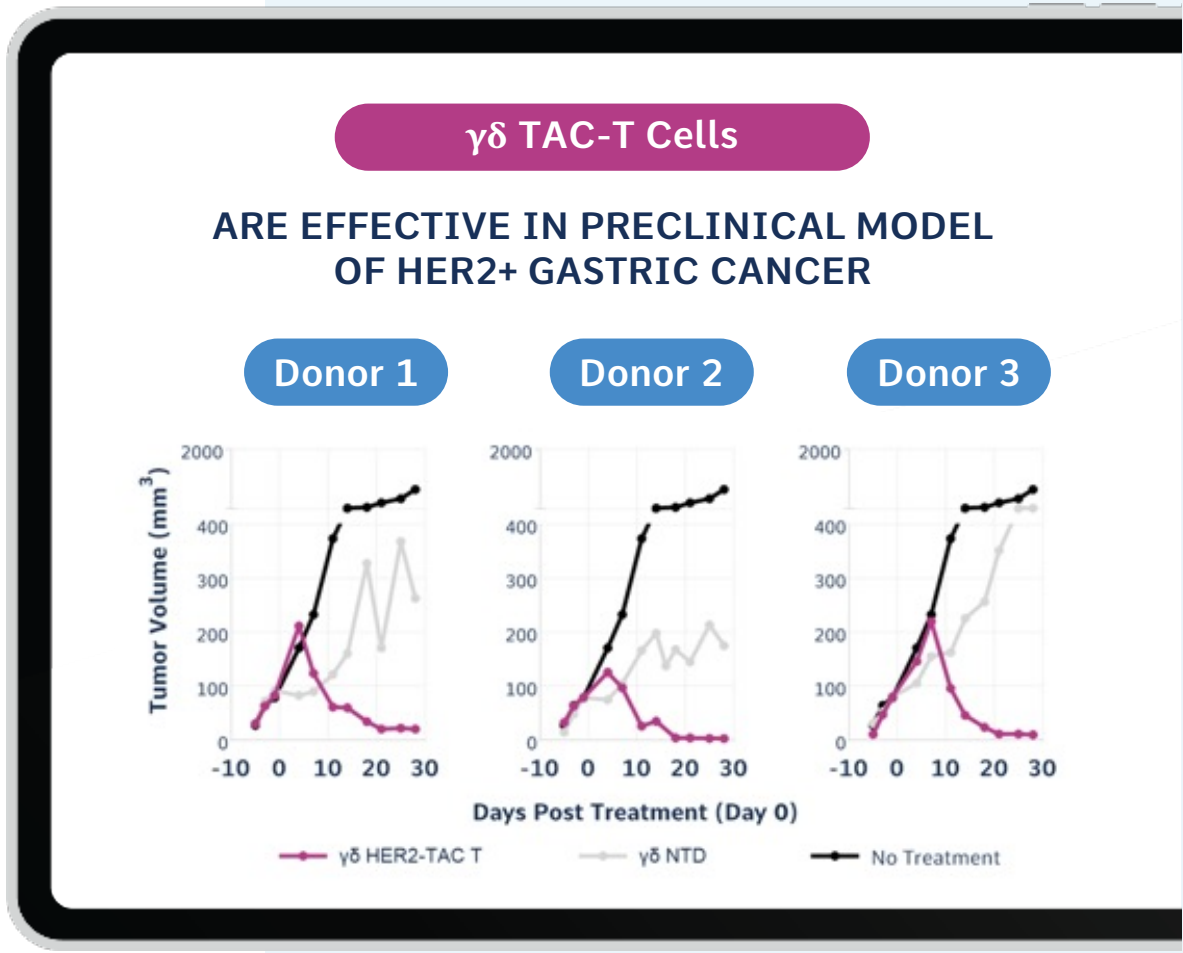
> 200 pts/year

Fast follower allogeneic gamma-delta T cell program enabled by modular TACs

Donor derived Gamma-Delta program on track for IND 1H-2024

Clear benefits for using Gamma-Delta T cells for allogeneic

Unique anti-tumor biology	Naturally primed to penetrate peripheral tissues	Kills via adaptive & innate mechanisms	
Ideal cell source	Relatively abundant	Low/no risk of GvHD	No need for gene editing
Clear Treatment Benefits	Off-the-shelf	Rapid treatment with opportunity for frequent re-dosing	Lower cost of goods



4 INDs & 1 BLA over next 36 months

Autologous
Allogeneic
Autologous / Allogeneic | TBD

Platform	Target	2023	2024	2025	2026
TAC100	HER2 Autologous	Phase 1	Phase 2 registration-enabling trial (GC GEJ) mono-& combination (CPI) therapy		BLA
TAC101	Claudin18.2 Autologous		IND	Phase 1/2 clinical trial (gastric, PDAC, NSCLC, Ovarian)	
TAC201	Claudin18.2 Allogeneic	GMP production; IND-enabling studies	IND	Phase 1/2 clinical trial	
TACX03	GUCY2C Auto or Allo	Lead selection; IND-enabling studies		IND	Phase 1/2 clinical trial (CRC, GEJ, PDAC)
TACX04	GPC3 Auto or Allo	Lead selection; IND-enabling studies			IND
NEXT-GENERATION TAC PROGRAMS		T cell enhancers, dual-TACs			

CRC=colorectal cancer; GEJ=gastroesophageal junction cancer;
HCC=hepatic cell carcinoma; PDAC=pancreatic ductal adenocarcinoma

Significant clinical news flow

2023

CLINICAL

TAC100

HER2 Phase 2 initiation: monotherapy and in combo with Keytruda in GC/GEJ cancers

TAC101

Claudin18.2 IND
Phase 1 initiation and FPI

2024

CLINICAL

TAC100

HER2 Phase 2 fully enrolled

TAC101

Claudin18.2 Phase 1 data & RP2D

TAC201

Claudin18.2 Allo IND and FPI

2025

CLINICAL

TAC100

HER2 Phase 2 completed and BLA initiation EOY

TAC101

Claudin18.2 RP2D, Phase 2 initiation

TAC201

Claudin18.2 Allo Expansion

GUCY2C

IND & FPI

Partnering at Triumvira

Existing agreements

- **Early collaboration for Cocoon® Platform**
- **In-licensed novel binders**
- **PD-1 supply agreement with Merck**

Potential partnerships

Clinical: TAC01-HER2 co-development, other programs

Platform: TAC as backbone for next-gen cell therapies, Autologous and / or Allogeneic, solid / liquid

Enabling: therapeutic combos / other improvements

Regional: program co-development

Rationally designed T-cell Antigen Coupler (TAC) platform technology

Ability to develop safer & effective T Cell medicines for solid tumors

2023

Start of 2 HER2 Phase 2 trials

Start of Claudin18.2 Phase 1 trial

2024

Start of γδ Allogeneic clinical program

Clear line of sight to 1st approvable indication in 3L gastric cancers

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Lead HER2 program with strong PRs, no ICU visits for CRS, no neurotox, and ability to re-dose validate the platform for the future of T cell medicines

Phase 2 trial in combination with Keytruda® will provide opportunity to pursue 2L gastric cancer indication

2nd Program targeting Claudin18.2 adds to building a gastric cancer franchise

Efficient & scalable autologous manufacturing with 100% success rate to date

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First in class engineered T cells for safer, more efficacious and durable therapies in solid tumors

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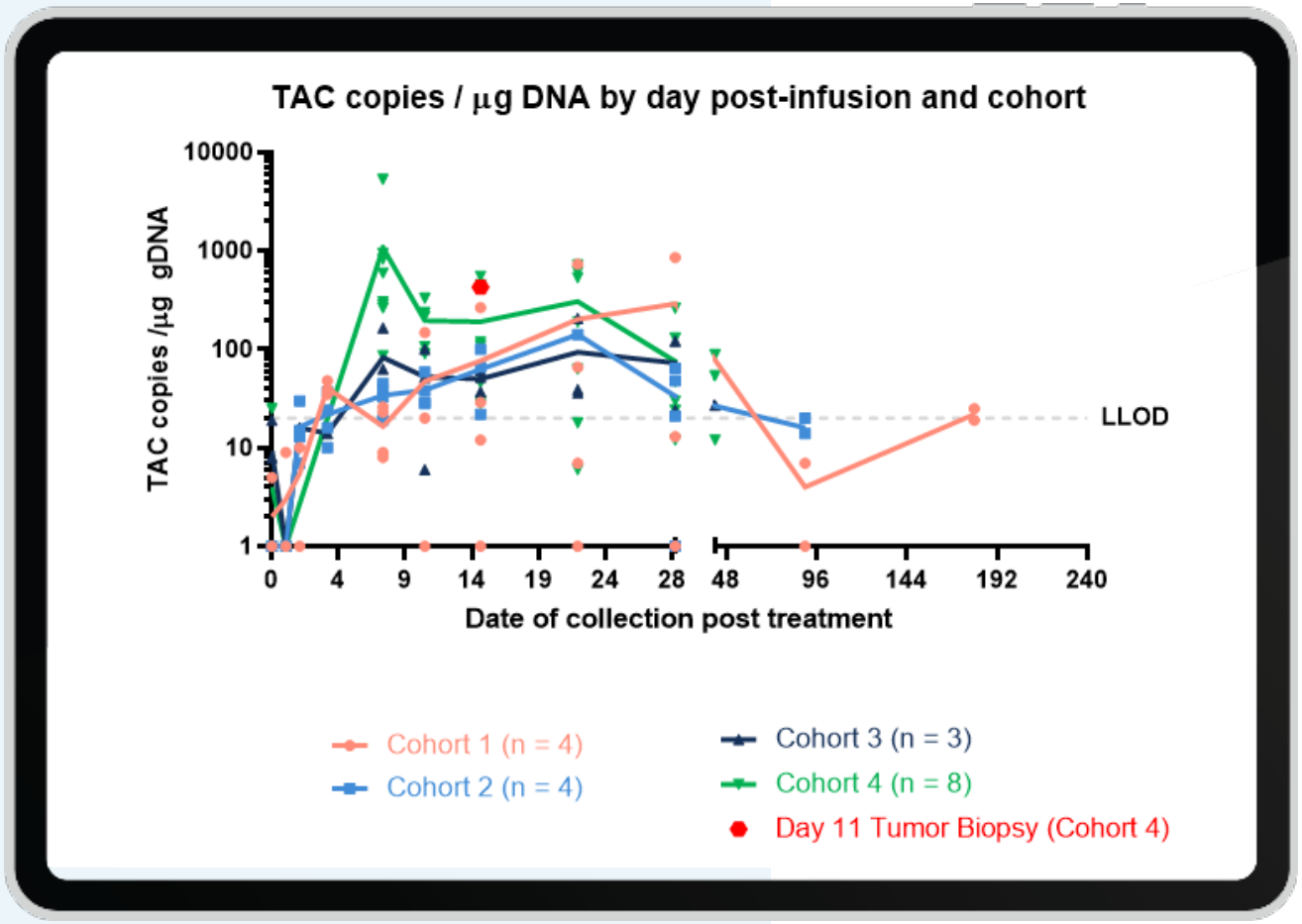

TAC detected in blood and tumor biopsy

PK levels at Dose Level 4 higher than at lower dose levels

BLOOD PK

Unequivocal detection of TAC in blood

Exposure greatest in DL4 (AUC, Cmax)

Tmax earlier in higher dose levels

TUMOR PK

Unequivocal detection of TAC in a Day 11 tumor biopsy

TAC concentrations in tumor are higher than in blood at time of biopsy