Building a Differentiated ADC Company

Nasdaq: PYXS
June 2026

PYXIS ONCOLOGY

Forward Looking Statement

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Positioned to be a Differentiated ADC Company

First-in-Concept Extracellular ADC Technology

Clinical focus on significant unmet need in R/M HNSCC

Validated monotherapy & combination efficacy signal in R/M HNSCC

Multiple Clinical Data Catalysts Expected in 2H 2026

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MICVO is a First-in-Concept ADC

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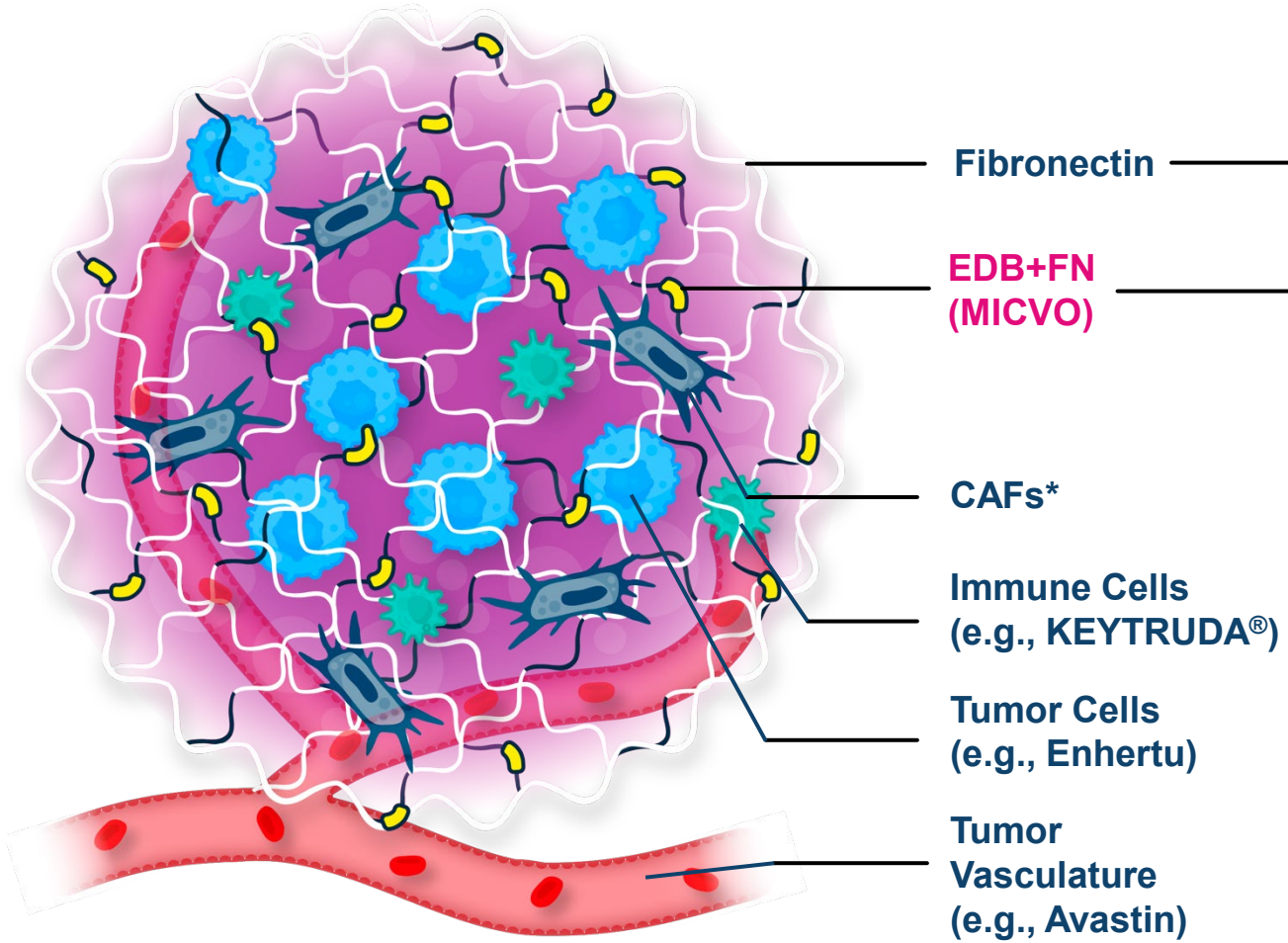
MICVO is the First-in-Concept Extracellular Targeting ADC in Clinical Development

Targets EDB+FN, a splice variant of fibronectin and novel non-cellular ADC target



Fibronectin - non-cellular component of tissue extracellular matrix (ECM), which in tumors acts as a scaffold to support growth

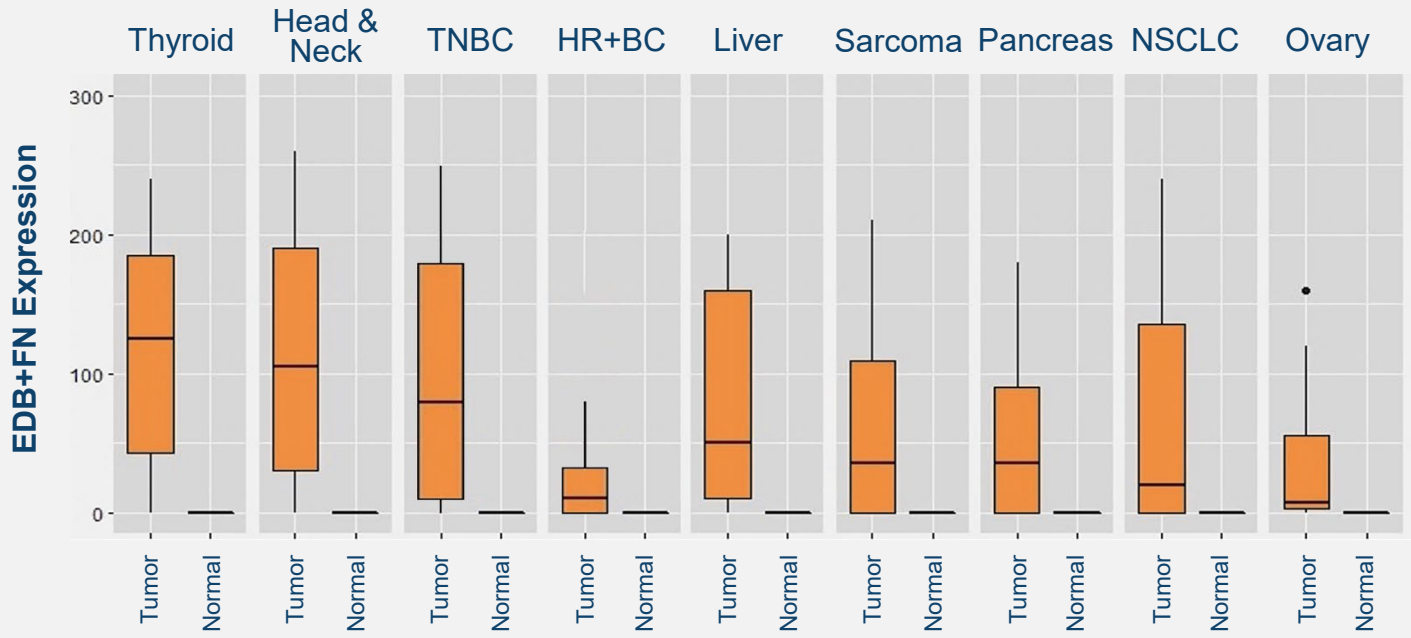
EDB+FN - splice variant of fibronectin abundant in the ECM associated with tumor growth, angiogenesis and metastasis

*CAFs = cancer-associated fibroblasts

EDB+FN is Expressed in ECM of Many Solid Tumors, Negligibly in Normal Tissue

Recent translational findings identify factors in addition to EDB+FN expression driving response

EDB+FN protein shows differential expression between tumor and normal samples, with negligible expression in normal tissues



Key biological drivers of response in addition to EDB+FN expression

- Binding of MICVO to EDB+FN
- Presence of extracellular proteases (cathepsins)
- Low pH to enable cathepsin proteolytic activity
- Stromal architecture (e.g., spatial orientation of ECM fibers)
- Immunogenic tumor microenvironment (TME)[1]

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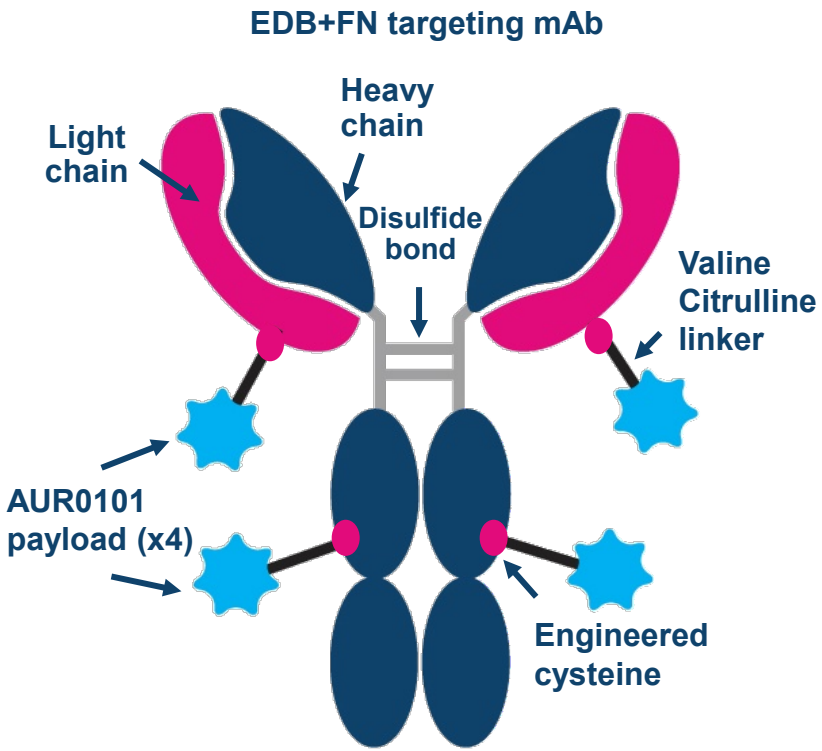
Source: Pyxis Oncology nonclinical data

1. Preclinical data support MICVO has activity in tumors that are immunologically 'cold' as well, so while immunogenic TME can be a driver, it has been shown not to be required

MICVO is an ADC Designed for Optimized Stability, Potency and Permeability in the Tumor ECM

MICVO construct



Key potential advantages

Purpose-Built	• mAb **specifically directed at EDB+FN,** engineered for structural integrity with **high avidity-driven binding** • **Site-specific**, **extracellular protease-cleavable Valine Citrulline linkers**
Predictable	• **Uniform DAR* of 4** provides improved therapeutic window via conjugation with engineered cysteines • **Reduced free payload in serum,** C_{max} ~4 days after administration
Potent	• Four **optimized cytotoxic auristatin 0101 (AUR0101)** microtubule polymerization inhibiting payloads • Potential to maximize **tumor-killing and biological potency** in multiple solid tumor types
Permeable	• Optimized for membrane permeability and diffusion to enable **efficient bystander killing** • **Fast clearance** of optimized AUR0101 payload compared to other auristatins **to reduce off-target effects**

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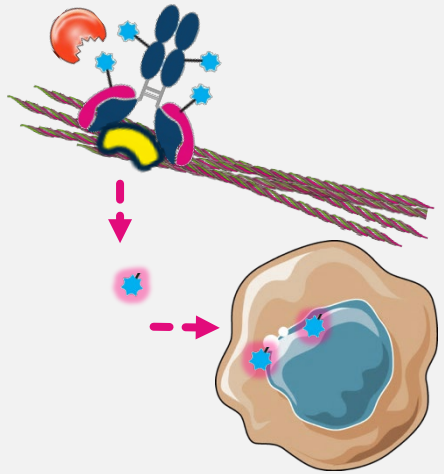
*DAR = Drug Antibody Ratio

MICVO Delivers Potent Anti-Tumor Activity Through a Three-Pronged MOA

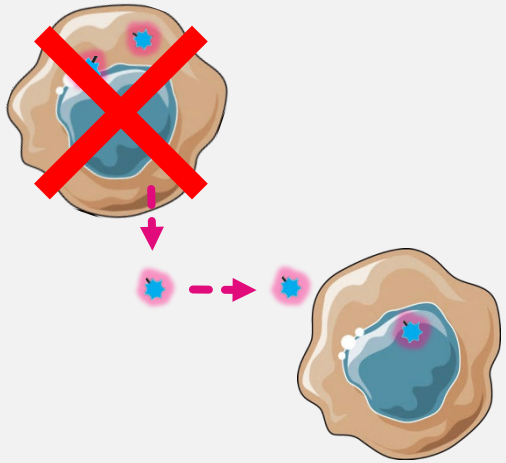
MICVO is designed for extracellular linker cleavage in the TME, which initiates the MOA

1 Payload diffuses into & kills tumors cells



MICVO designed to bind to EDB and releases payload within tumor ECM

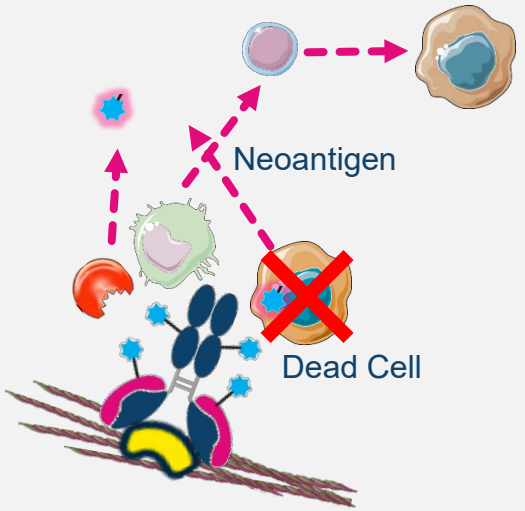
2 Additional bystander killing



Tumor cell dies, releasing payload for additional cycles of tumor cell killing

PAYLOAD DRIVEN

3 Immunogenic cell death



Tumor death and exogenous antibody fragments lead to T-cell activation

IMMUNE DRIVEN

KEY

- CD8⁺ lymphocyte
- Proteases (e.g., cathepsin)
- Cleaved & active payload (auristatin)
- EDB⁺FN
- Dendritic cell
- MICVO
- Tumor cell
- Matrix

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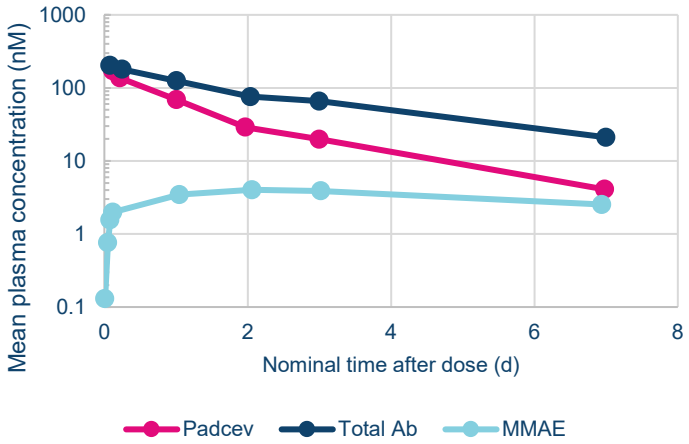
MICVO PK Profile Demonstrates Superior Stability in Circulation Compared to Approved Val-Cit-MMAE ADCs

MICVO linear PK profile across doses demonstrates absence of antigen sink

The site-specific conjugation for MICVO delivers two advantages:

1. **Lower levels of free payload in circulation**
2. **Longer half-life**

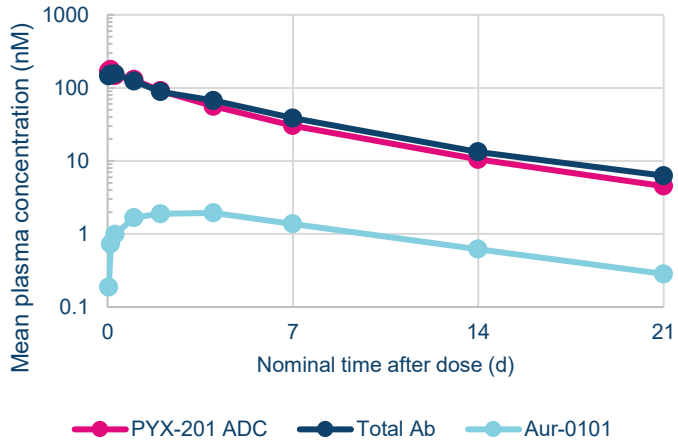
First dose Padcev® PK, 1.25 mg/kg*



Traditional MMAE ADCs with random conjugation have poor stability and high levels of free payload

Half-life = 3.6 days[1]

First dose MICVO PK, 1.2 mg/kg



MICVO uses site-specific conjugation leading to stronger stability and lower levels of free payload

Half-life = 5-7 days

*1.25 mg/kg is recommended monotherapy dose for Padcev

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1. Based on the corresponding FDA label, shown as ADC half-life; Padcev® - Astellas Pharma Inc. and Pfizer Inc.
MMAE: Monomethyl Auristatin E

Initial MICVO Clinical Data Informs Path Forward

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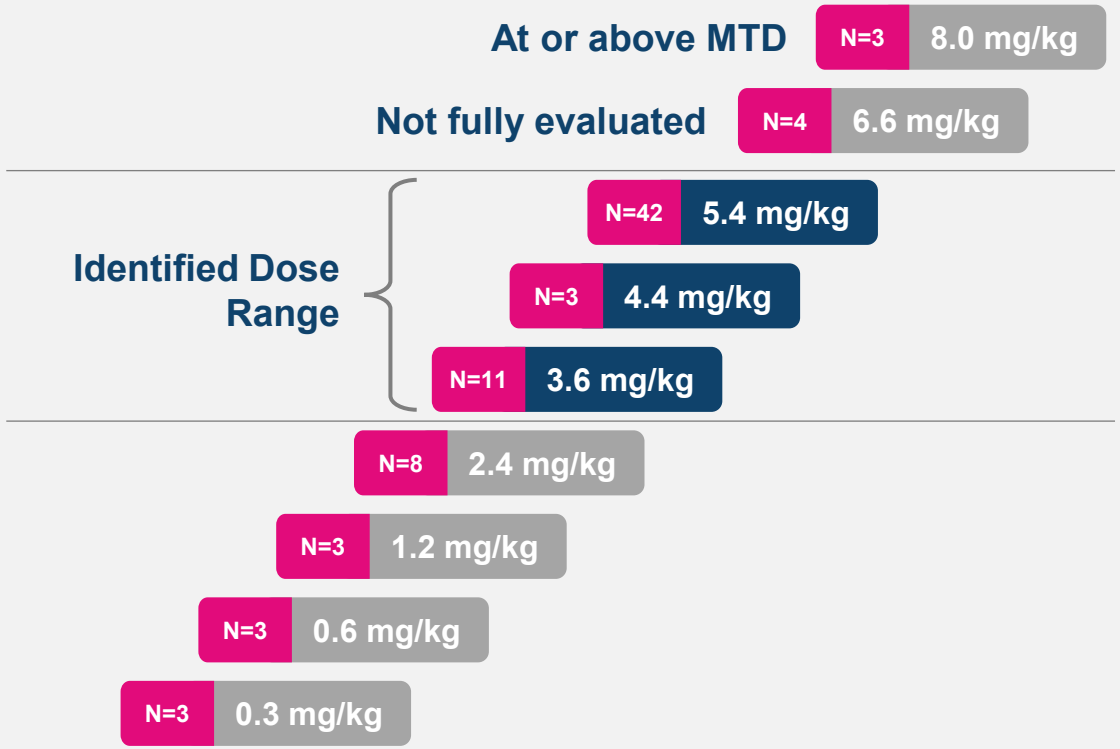
Phase 1 Part 1 Dose Escalation Basket Study with Multiple Tumor Types Identified Range of Potentially Effective Doses

80 patients dosed across 18 global sites[1]

Study explored doses from 0.3 – 8.0 mg/kg Q3W



3.6 - 5.4 mg/kg Q3W focus of Phase 1 Part 1 recruitment

Observed **dose-dependent responses** starting at 3.6 mg/kg

52% of **patients recruited into 5.4 mg/kg dose**

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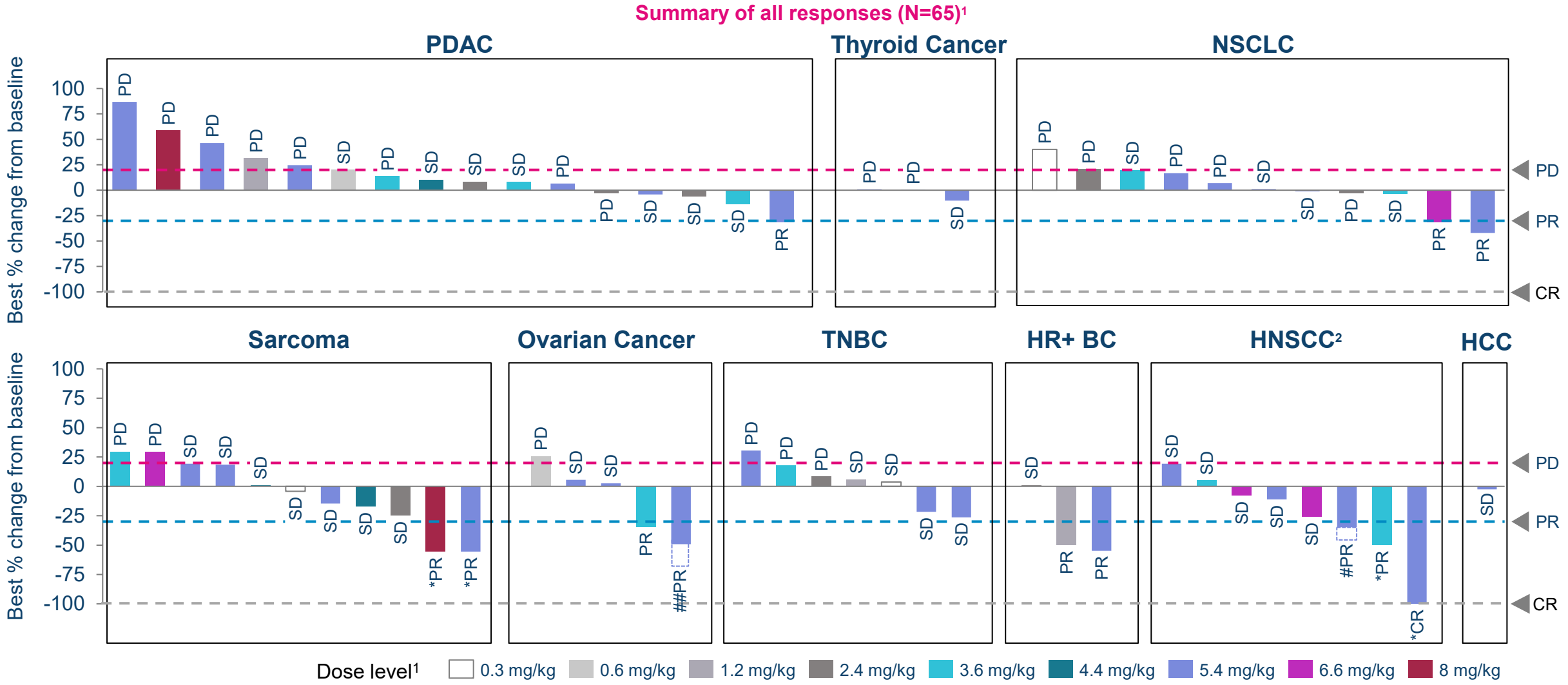
1. As of Oct 4, 2024 data cut off

Nov. 2024: Pronounced Responses Observed in Six Tumor Types In Phase 1 Dose Escalation

Strongest tumor regression observed in R/M HNSCC patients



***Confirmed Response as of Oct 4, 2024 data cutoff; #Confirmed Response after Oct 4, 2024 data cutoff (-47% tumor regression); ##Confirmed Response after Oct 4, 2024 data cutoff (-73% tumor regression)**

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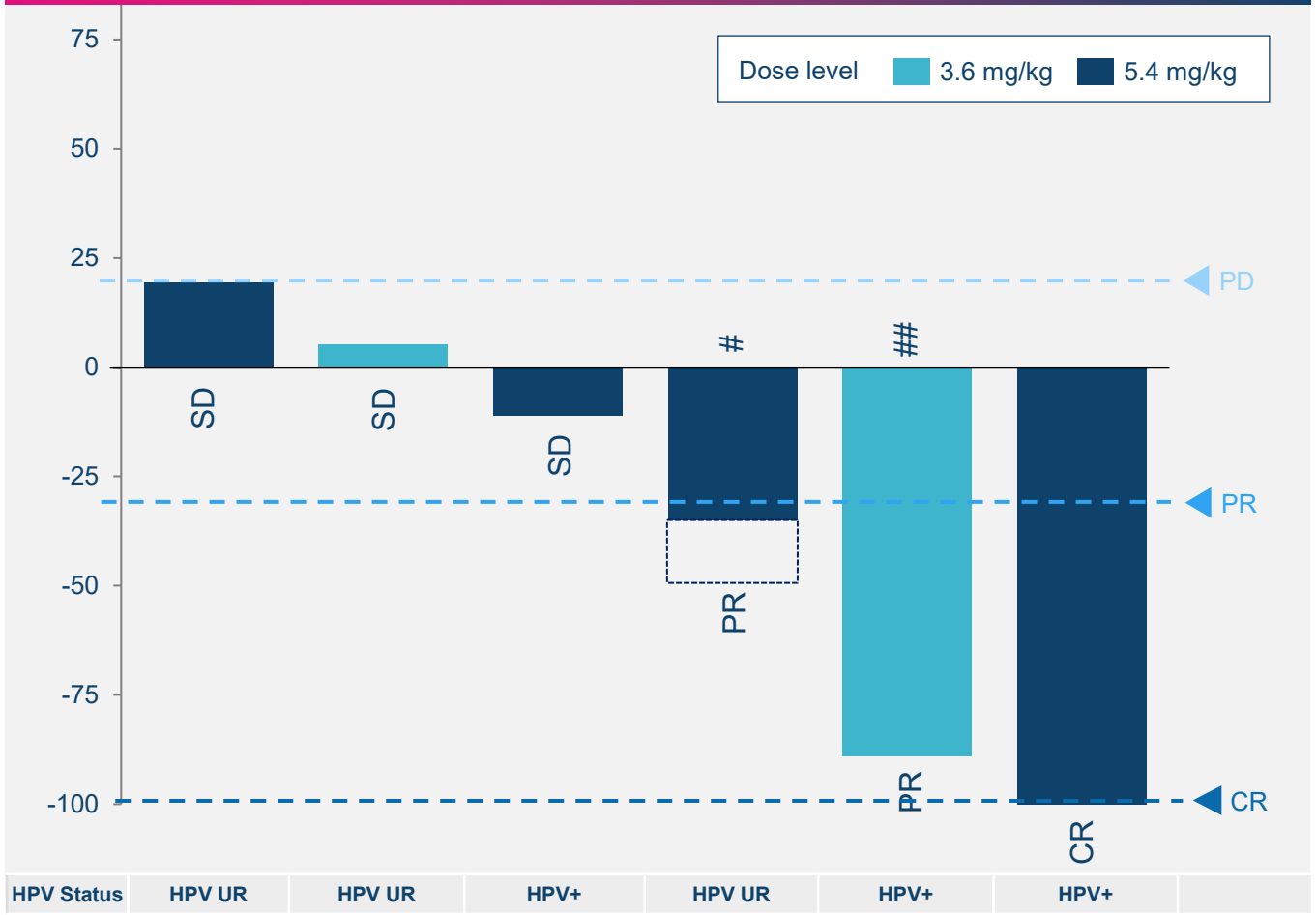
Note: Efficacy population defined by dose received; dose level for patients who escalated or de-escalated = starting dose

1. N=65; 3 patients dosed after 10/4/24 data cutoff and do not yet have scans; 12 patients of the 77 patients included in the safety dataset are not included in the waterfall for the following reasons - > 3 patients scanned after 10/4/24 data cutoff, 1 patient's scan was delayed beyond protocol allowable timeframe, 3 patients discontinued prior to 1st scan due to non-TRAEs, 1 patient withdrew from the study prior to 1st scan and 4 patients discontinued due to Progressive Disease.; 2. Does not include patient dosed at 5.4 mg/kg who received scan on Day 97 after receiving 1 dose and whose scan was disallowed per protocol due to excessive time between dosing and scan

Strong Monotherapy Signal in Heavily Pre-treated R/M HNSCC Patients During Phase 1 Part 1 Dose Escalation

Feb 2025 Part 1 Dose Escalation Update: R/M HNSCC[1]



Part 1 Dose Escalation R/M HNSCC Summary

Multiple doses explored in R/M HNSCC during dose escalation

Responses observed at **3.6 mg/kg and 5.4 mg/kg**

50% Confirmed ORR[1], 100% Disease Control Rate at 3.6 and 5.4 mg/kg

5.4 mg/kg presented an optimal benefit-risk profile and was selected for dose expansion

1. Does not include patient dosed at 5.4 mg/kg who received scan on Day 97 after receiving 1 dose and whose scan was disallowed per protocol due to excessive time between dosing and scan; 2 2 non-evaluable (dose level not cleared) patients dosed at 6.6 mg/kg; # Confirmed Response by RECIST 1.1 after Oct 4, 2024 data cutoff (-47% tumor regression); ## Week 57 Confirmed PR by RECIST 1.1 at Feb 24, 2025 data extraction (-89% tumor regression); 3. HPV UR= HPV status unrelated

Unmet Need in R/M HNSCC

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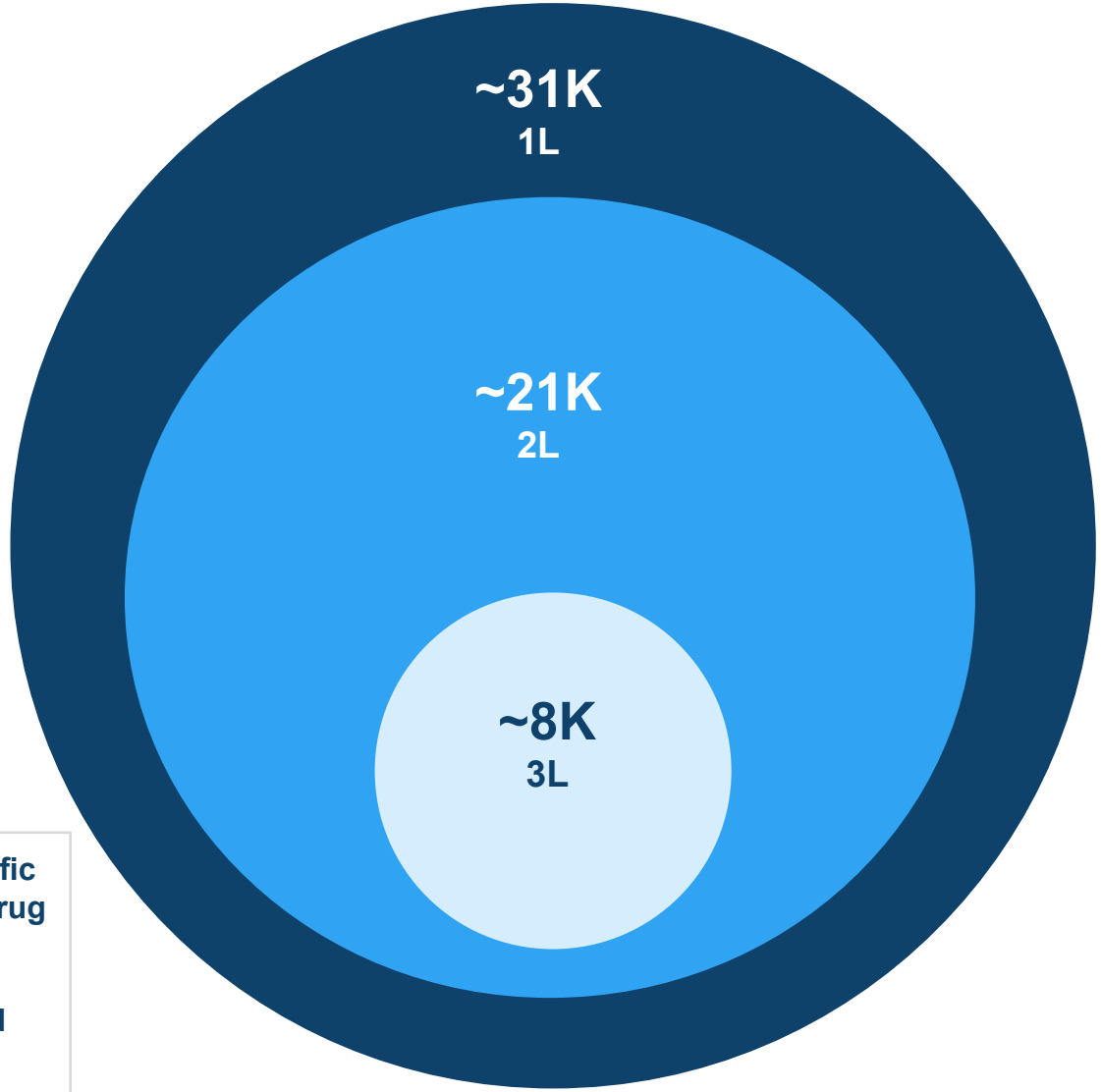
R/M HNSCC is a Large, Growing and Uncrowded Market Ripe for Innovation



US-specific data of drug treatable patients projected to 2029

Key takeaways

- 7th largest oncology market
- High rate of growth propelled by increasing incidence of HPV
- Recent corporate and business development highlights market value
- Innovation driven by a select number of modalities and sponsors

Bispecifics/mABs

BICARA THERAPEUTICS · Genmab | Merus · J&J

ADCs

PYXIS ONCOLOGY · CORBUS PHARMACEUTICALS

Others (Vaccines/TKI etc)

PDS Biotechnology

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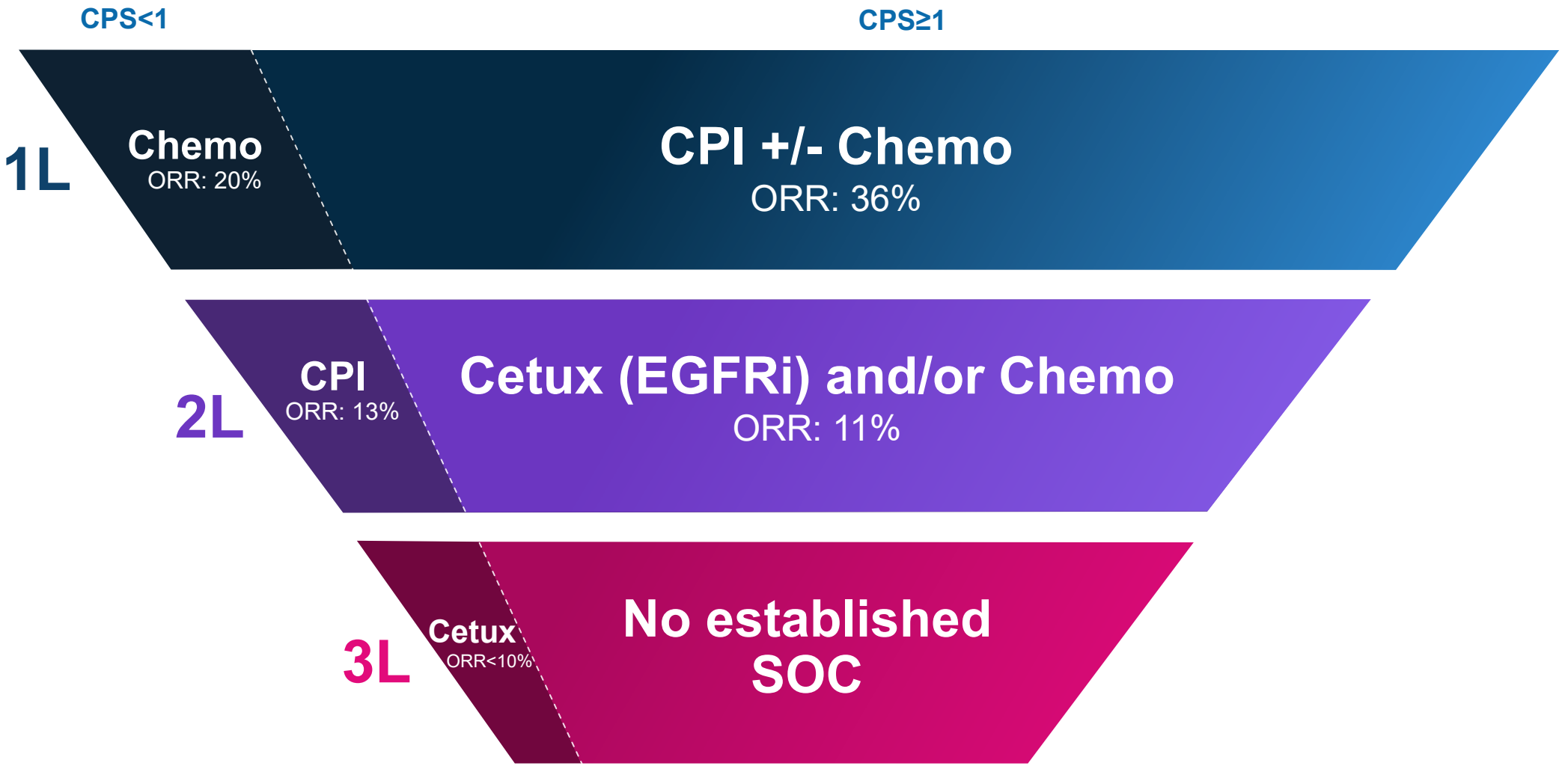
Source: Clarivate/Decision Resources Group: Squamous Cell Carcinoma of the Head and Neck, Epidemiology dashboard, 2022

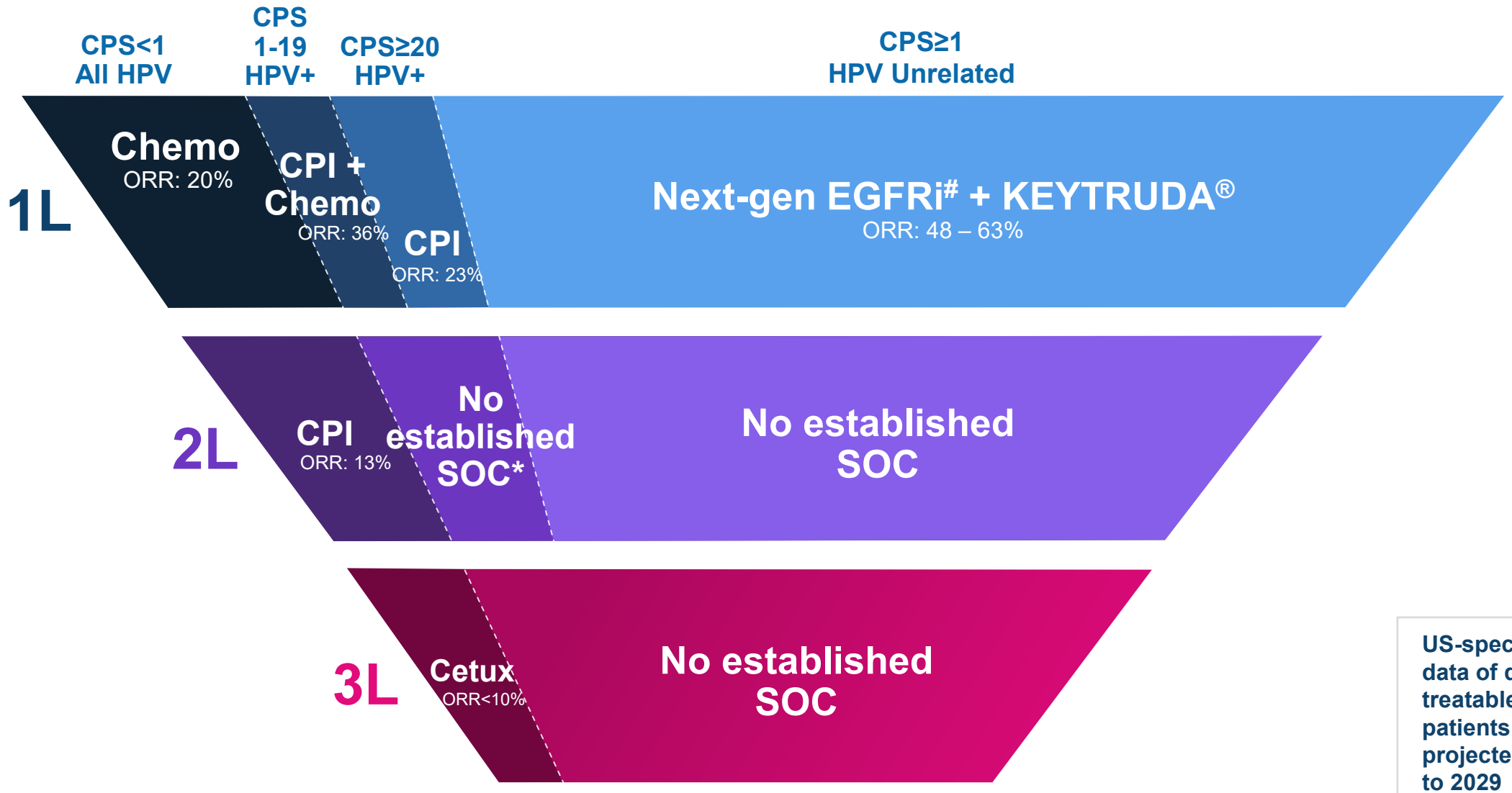
Current US R/M HNSCC Standard of Care Leaves Patients with Few Options and Poor Efficacy



CPI: Checkpoint Inhibitor; Cetux: Cetuximab

Next Gen EGFRi Likely to Become New SOC in HPV unrelated 1L R/M HNSCC

Significant unmet need will remain, both in 1L and in 2L+ R/M HNSCC in particular

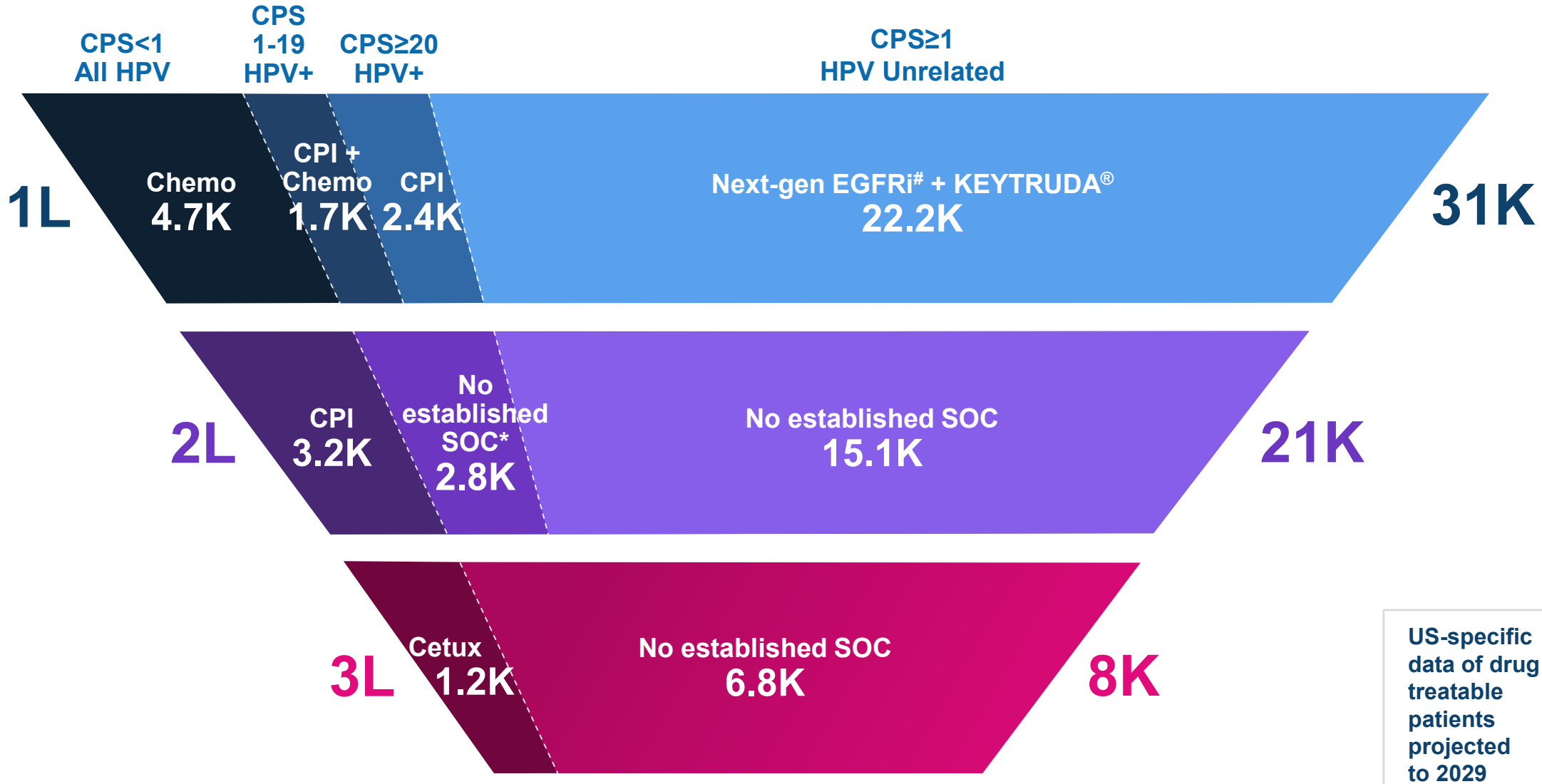


US-specific data of drug treatable patients projected to 2029

CPI: Checkpoint Inhibitor; Cetux: Cetuximab; KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA
*Petosemtamab HPV+ ORR=13% (N=15) per ESMO 2024 presentation and Cetuximab HPV+ ORR=0% per INTERLINK study; #Petosemamtab, Ficerafusp Alfa and Amivantamab studying in 1L

Market Opportunity for MICVO in R/M HNSCC is Substantial

2L+ market (>21K patients) similar in size to 1L EGFR bispecifics market (22K patients)



US-specific data of drug treatable patients projected to 2029

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CPI: Checkpoint Inhibitor; Cetux: Cetuximab
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KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

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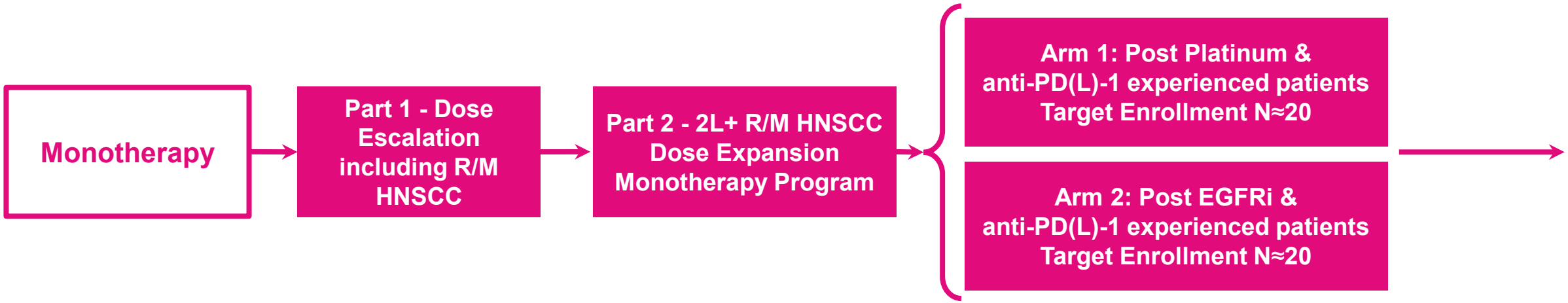
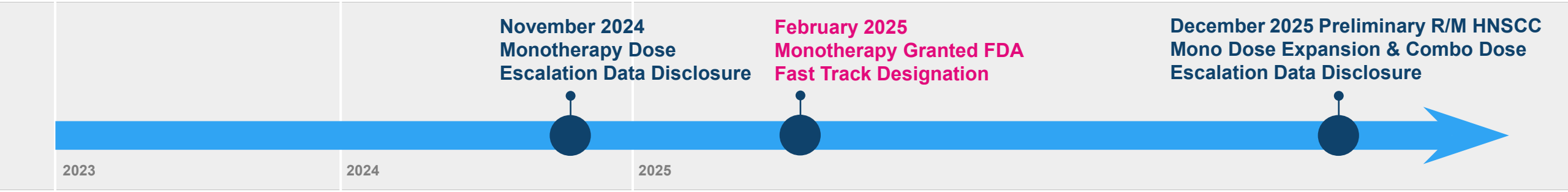
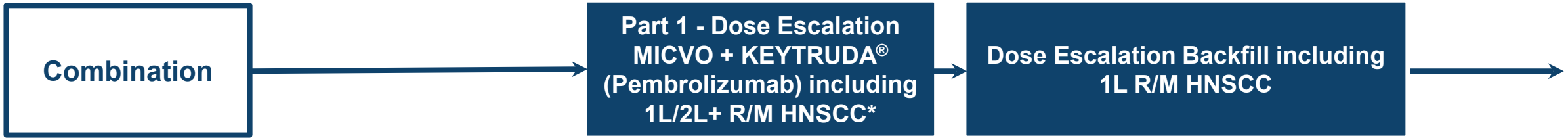
MICVO's Clinical Programs Address the Areas of Highest Unmet Need in R/M HNSCC







*Clinical trial collaboration with Merck to evaluate MICVO in combination with KEYTRUDA® - KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

MICVO Monotherapy in 2L+ R/M HNSCC
December 2025 Preliminary Data

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Dec. 2025: MICVO Preliminary Data Revealed Unsurpassed Efficacy in 2L+ R/M HNSCC

Data as of Nov 3, 2025

Phase 1: 46% Confirmed ORR and 92% Disease Control Rate (N=13, Efficacy Evaluable[1])

Correlation identified between high body weight patients and AEs has been linked to increased drug exposure

Dose capping implemented in December 2025; protocol amendment permitting adjusted ideal body weight (AIBW) has been approved and AIBW dosing has begun

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1. Efficacy evaluable (N=13) does not include N=1 dose escalation patient dosed at 5.4 mg/kg who received scan on Day 97 after receiving 1 dose and whose scan was disallowed per protocol due to excessive time between dosing and scan and N=4 patients in dose expansion who have not yet received 1st scan and are ongoing

MICVO Phase 1 Monotherapy Patient Demographics and Disease Characteristics at 5.4 mg/kg

Data as of Nov 3, 2025

Demographics	Total (N=18)
Age	**Years**
Median (min-max)	63 (41- 72)
Sex	
Male	12 (67%)
Race	
White Black or African American Not Reported	14 (78%) 1 (6%) 3 (16%)
Baseline ECOG Performance Status	
0 1	3 (17%) 15 (83%)
Baseline Weight	**Kg**
Median (min-max)	72 (48, 103)
BMI	
Median (min-max)	25 (19, 32)

Disease Characteristics	Total (N=18)
HPV Status	**n (%)**
HPV +, n (%)	7 (39%)
HPV unrelated, n (%)	11 (61%)

Prior anti-Cancer Therapy	Total (N=18)
Elapsed Time Since Initial Diagnosis (Yr), Median (min-max)	4.0 (1.0-13.2)
Prior Systemic Therapy, Median Lines (min-max)	3 (1-6)
Taxane, n (%)	12 (67%)
Platinum, n (%)	18 (100%)
Checkpoint Inhibitor, n (%)	18 (100%)
EGFR Targeting Agent, n (%)	9 (50%)

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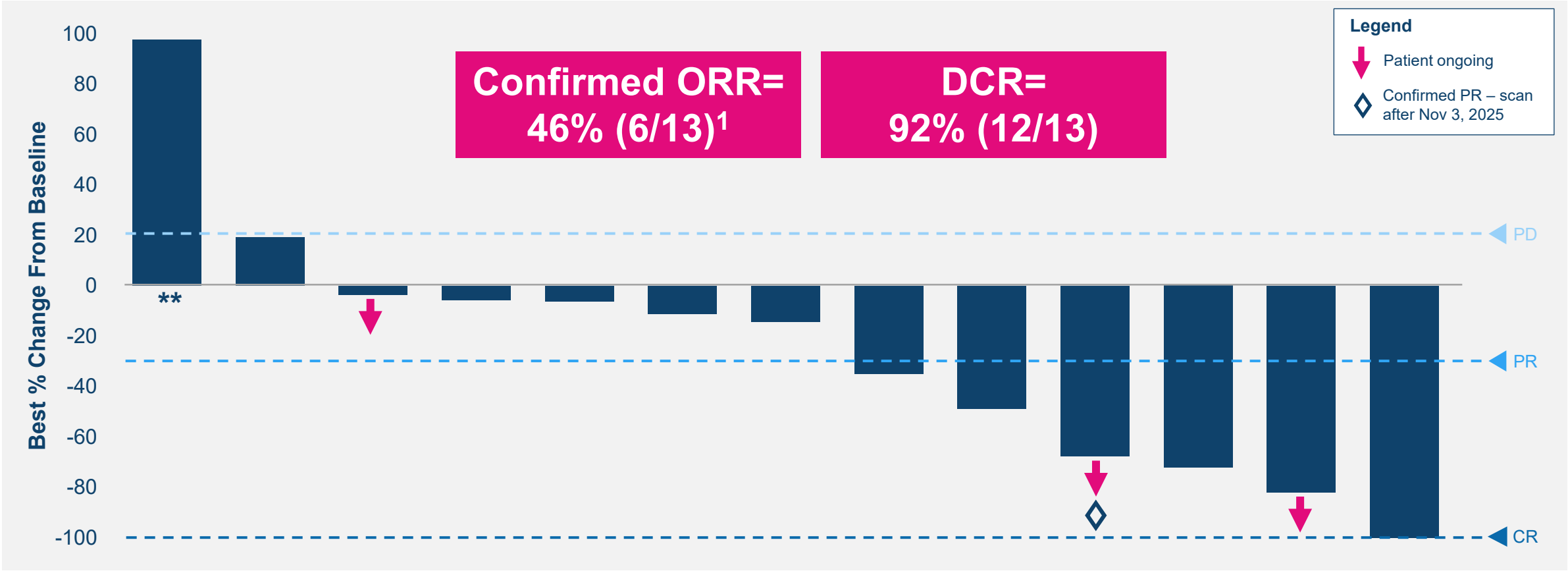
MICVO Monotherapy Demonstrated Clear Activity at 5.4 mg/kg with Deep Responses and Exceptional Disease Control

Data as of Nov 3, 2025



Study*	Arm 2	Esc	Arm 1	Arm 2	Arm 2	Esc	Arm 1	Esc	Arm 1	Arm 1	Arm 1	Arm 2	Esc
HPV Status	HPV unrelated	HPV unrelated	HPV unrelated	HPV unrelated	HPV unrelated	HPV+	HPV unrelated	HPV unrelated	HPV+	HPV unrelated	HPV+	HPV unrelated	HPV+
Baseline Tumor (mm)	41	88	28	149	33	42	35	43	113	133	90	28	16
#Prior tx	5	4	4	2	3	6	2	4	3	2	1	3	1

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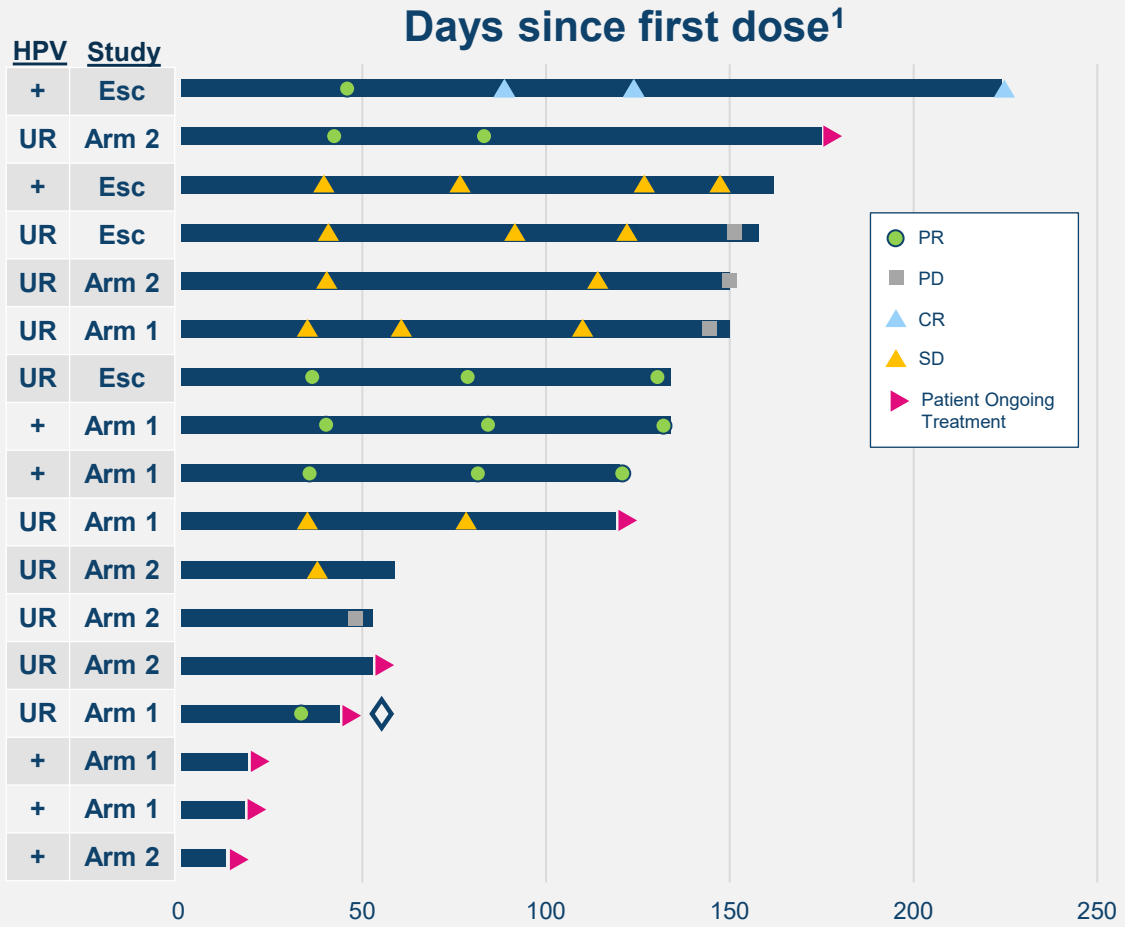
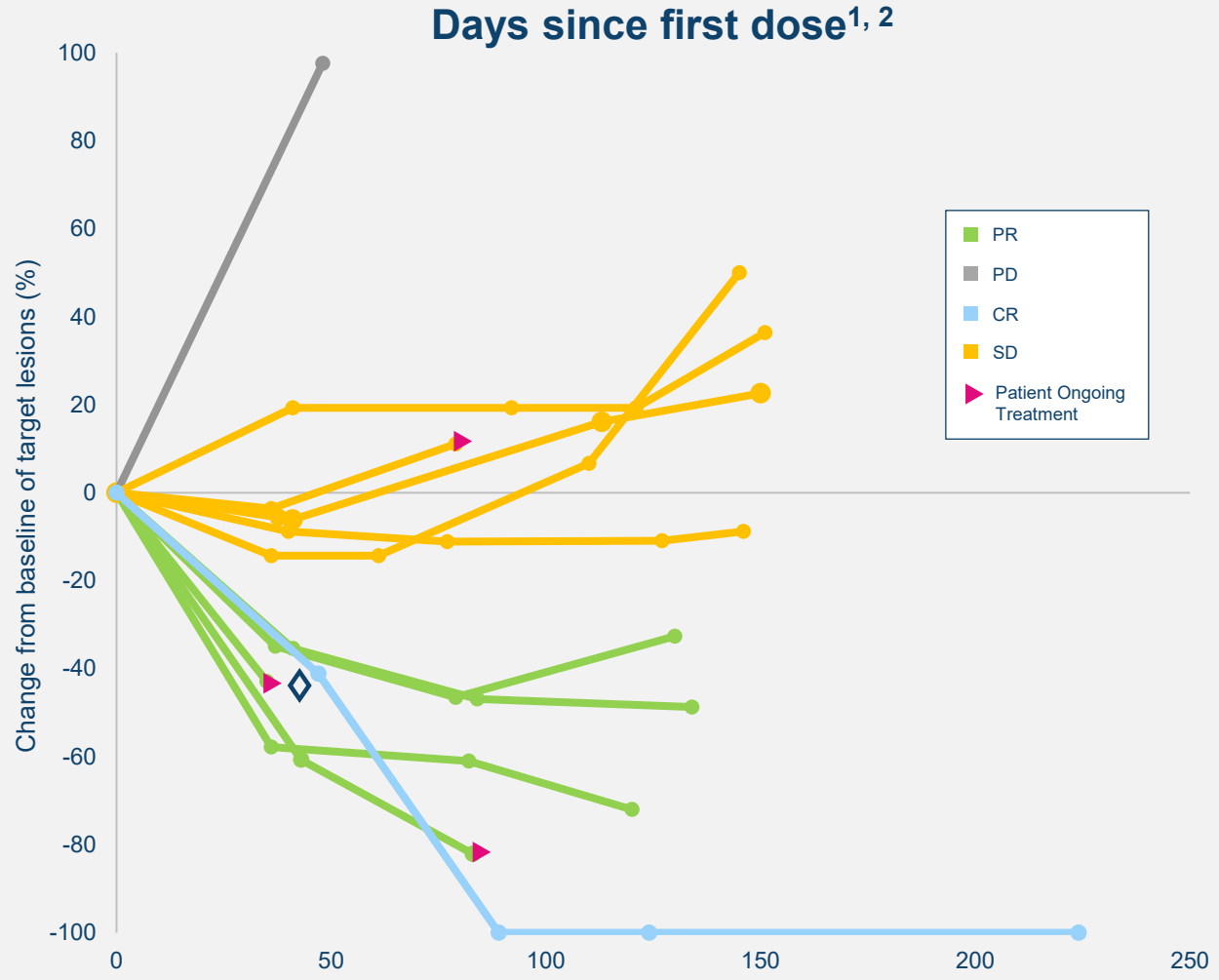
*Arm 1: Post Platinum & anti-PD(L)-1; Arm 2: Post EGFRi & anti-PD(L)-1; Esc: Dose Escalation;
**Patient with loco-regional recurrence, verrucous subtype of HNSCC in oral cavity; progressive disease to prior therapies; this subtype is often resistant to chemotherapy
1. Efficacy evaluable (N=13) does not include N=1 dose escalation patient dosed at 5.4 mg/kg who received scan on Day 97 after receiving 1 dose and whose scan was disallowed per protocol due to excessive time between dosing and scan and N=4 patients in dose expansion that have not received 1st scan and are ongoing; 6th Confirmed PR after data cutoff

MICVO Monotherapy at 5.4 mg/kg Demonstrated Rapid Onset of Response and Disease Control with Emerging Durability Still Maturing

Data as of Nov 3, 2025



Arm 1: Post Platinum & anti-PD(L)-1; Arm 2: Post EGFRi & anti-PD(L)-1; Esc: Dose Escalation
+ = Oropharyngeal HPV+; UR =HPV unrelated
All patients received prior platinum and prior IO therapy
◊ PR confirmed with -68% tumor regression after Nov 3, 2025



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1. Efficacy evaluable (N=13) does not include N=1 dose escalation patient dosed at 5.4 mg/kg who received scan on Day 97 after receiving 1 dose and whose scan was disallowed per protocol due to excessive time between dosing and scan (patient not represented on either figure above), 2. N=4 patients in dose expansion that have not received 1st scan and are ongoing (patients represented on figure to left and not figure on right given lack of scan data

MICVO Safety at 5.4 mg/kg in R/M HNSCC

No Grade 4 or Grade 5 ADC payload TRAEs of interest observed

Data as of Nov 3, 2025[1]

TRAEs	Part 1 Dose Escalation	Part 2 Dose Expansion	Total
N	**5**	**13**	**18**
All TRAEs	5 (100%)	11 (85%)	16 (89%)
Grade 1/2 TRAEs	2 (40%)	4 (31%)	6 (33%)
Grade 3/4 TRAEs	3 (60%)	7 (54%)	10 (56%)
TRAEs leading to **treatment discontinuation**	2 (40%)	3 (23%)	5 (28%)
TRAEs leading to **dose reduction**	2 (40%)	4 (31%)	6 (33%)
TRAEs leading to **dose delay**	1 (20%)	4 (31%)	5 (28%)
Treatment related **Deaths (Grade 5)**	**0**	**0**	**0**

ADC payload TRAEs of interest	Part 1 Dose Escalation		Part 2 Dose Expansion		Total	
	Grade 1/2	**Grade 3**	**Grade 1/2**	**Grade 3**	**Grade 1/2**	**Grade 3**
Cutaneous	1 (20%)	0	7 (54%)	0	8 (44%)	0
Neuropathy	0	2 (40%)	1 (8%)	3 (23%)	1 (6%)	5 (28%)
Neutropenia	0	1 (20%)	2 (15%)	1 (8%)	2 (11%)	2 (11%)
Ocular	1 (20%)	0	1 (8%)	1 (8%)	2 (11%)	1 (6%)
Anemia	0	0	3 (23%)	0	3 (17%)	0%
Pneumonitis	1 (20%)	0	1 (8%)	1 (8%)	2 (11%)	1 (6%)

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1. No prophylactic treatments dictated or administered to-date

MICVO Modified Weight-Based Dosing

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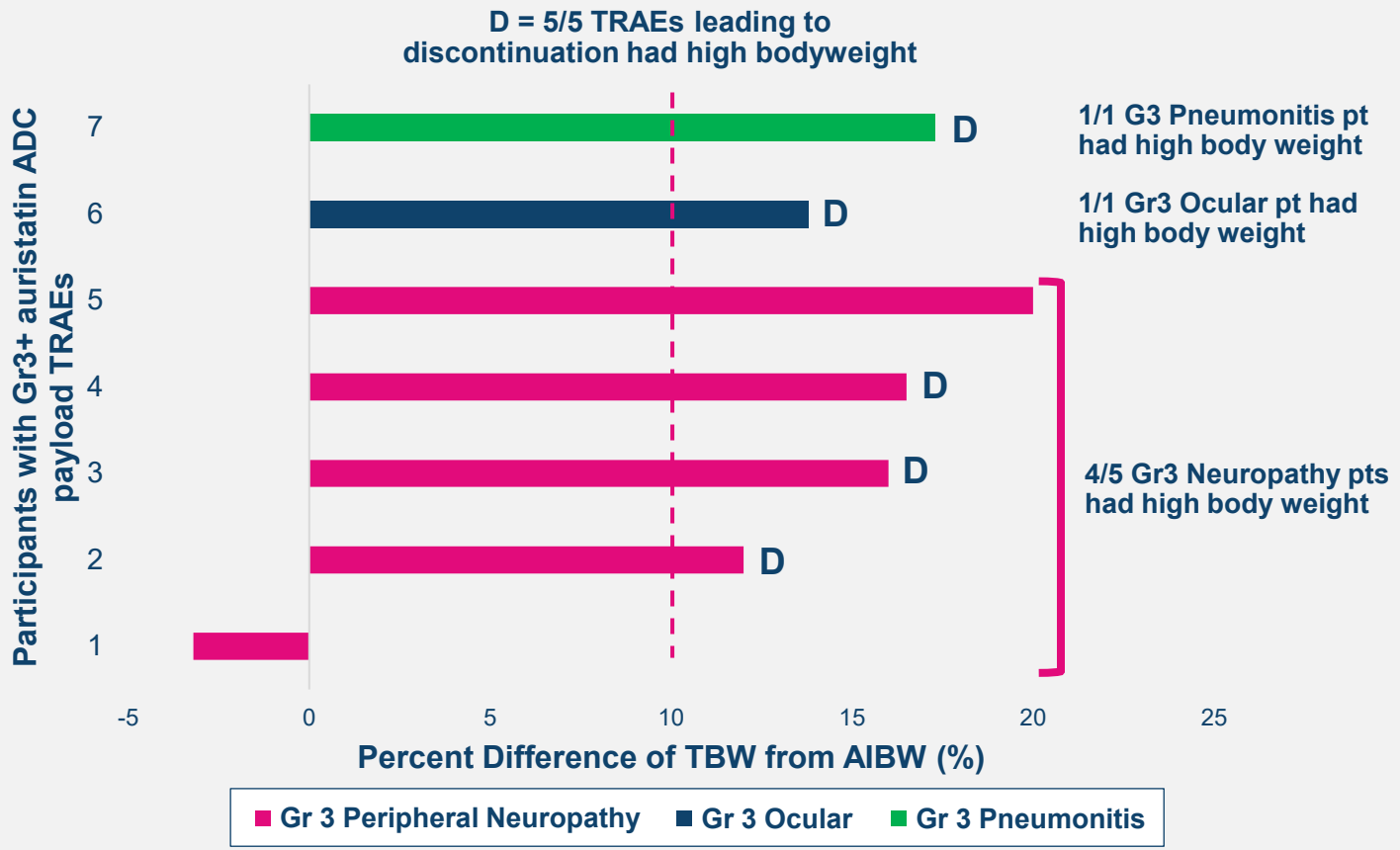
Discontinuations Driven by Overexposure in High Body Weight Patients

Data as of Nov 3, 2025



December 2025 Key Observation

0%

Treatment related discontinuations among patients without high body weight

For males:
IBW=50kg+ 0.91 x (height in cm – 152.4)

For females:
IBW=45.5kg+ 0.91 x (height in cm – 152.4)

AIBW = IBW + 0.4 × (TBW - IBW)
(both male and female)

"High body weight" is defined based on AIBW –
10% difference of TBW from AIBW (%) = (TBW-AIBW)/AIBW.

IBW = Ideal Body Weight; AIBW = Adjusted Ideal Body Weight; TBW = Total Body Weight
AIBW calculated using Devine formula (Devine et al, 1974)

Pyxis Oncology is Actively Exploring Well-Established Modified Weight-Based Dosing Methods with MICVO, Starting with Dose Capping

Padcev[1] and Datroway[2], both auristatin ADC's, leverage dose capping

Elahere[3] and other ADC's in development from Pfizer[4], Immunome[5] and CytomX[6] leverage AIBW

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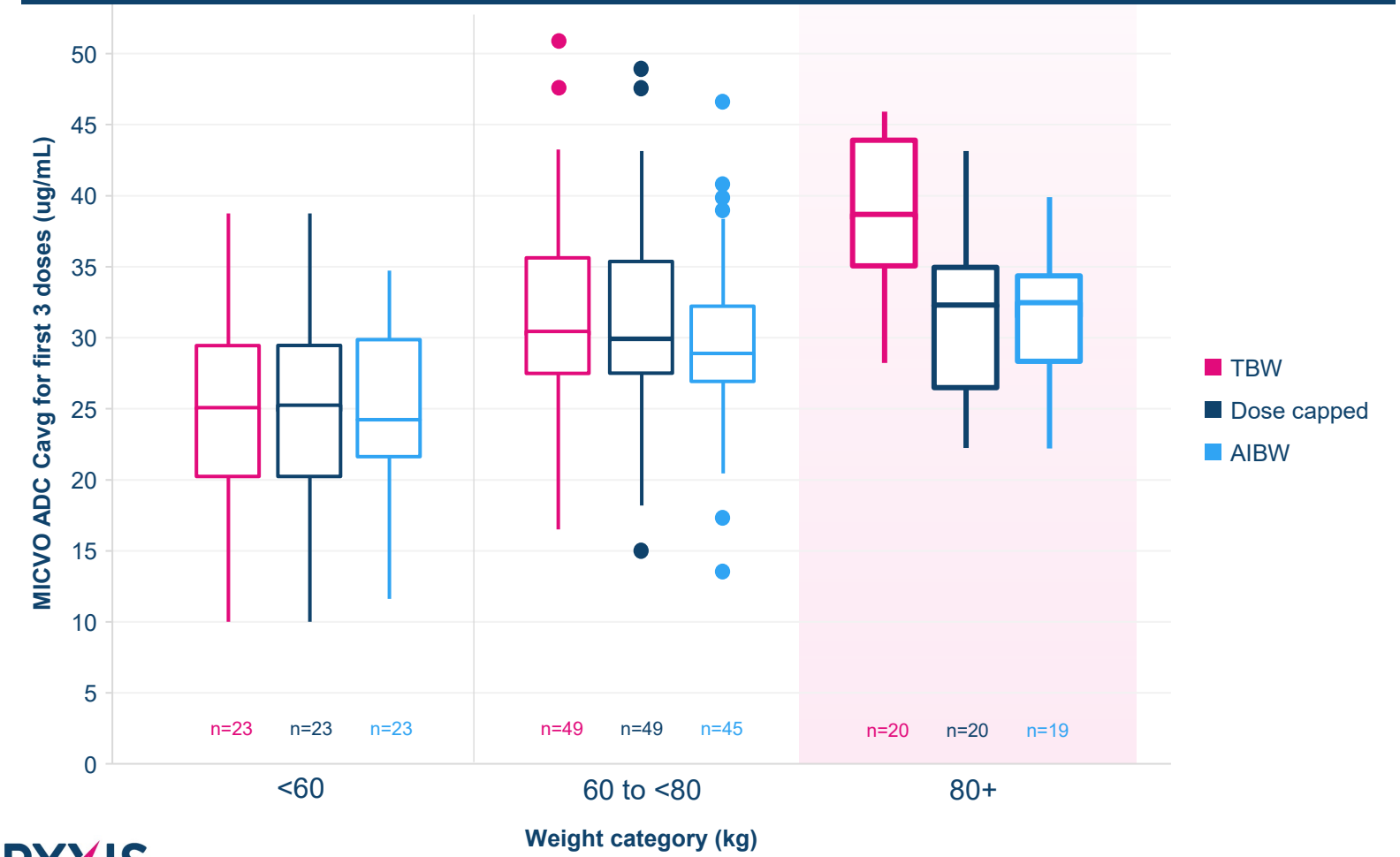
1. PADCEV® label December 2019; 2. DATROWAY label January 2025; 3. ELAHERE® label December 2024; 4. Maura L. Gillison et al. Initial safety and efficacy of PDL1V (PF-08046054), a vedotin-based ADC targeting PD-L1, in combination with pembrolizumab in patients with recurrent or metastatic (R/M) HNSCC. J Clin Oncol 43, 6033-6033(2025). DOI:10.1200/JCO.2025.43.16_suppl.6033; 5. Immunome investor presentation Jan 2026; 6. CytomX investor presentation; Padcev® – Astellas Pharma Inc. and Pfizer Inc., Datroway® – Daiichi Sankyo and Astrazeneca, Tivdak® – Pfizer Inc and Genmab A/S, Emrelis™ – AbbVie, Elahere® – AbbVie

PK Modeling Shows That Overexposure to MICVO in Higher Body Weight Patients Can Be Mitigated Through Modified Weight-Based Dosing

PK Simulation for 5.4 mg/kg Q3W



IBW = Ideal Body Weight; AIBW = Adjusted Ideal Body Weight; TBW = Total Body Weight
AIBW calculated using Devine formula (Devine et al, 1974)

Key Takeaways

- PK simulations predict comparable exposure for patients <60 kg and 60 to <80 kg receiving 5.4 mg/kg of MICVO regardless of dosing approach
- A marked decrease in exposure is predicted for patients weighing 80+ kg using modified weight-based dosing relative to TBW
- Dose Capping and AIBW exposures are comparable for patients across weight categories, including for patients weighing 80+ kg

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Addressing Patient Tolerability Through Modified Weight-Based Dosing with MICVO

Dec. ‘25 Data Observation

- All treatment related discontinuations in high body weight patients
- Non-linear relationship between drug clearance and body weight

External Proof Points

- Overexposure can be mitigated through modified weight-based dosing
- Both dose capping and AIBW have been validated by approved ADCs[1] that demonstrate improved tolerability without sacrificing efficacy

Internal Proof Points

- No treatment related discontinuations among patients at or below AIBW
- PK simulation predicts modified weight-based dosing can mitigate overexposure in high body weight patients

Tolerability in high body weight patients can be mitigated though proven modified weight-based dosing strategies

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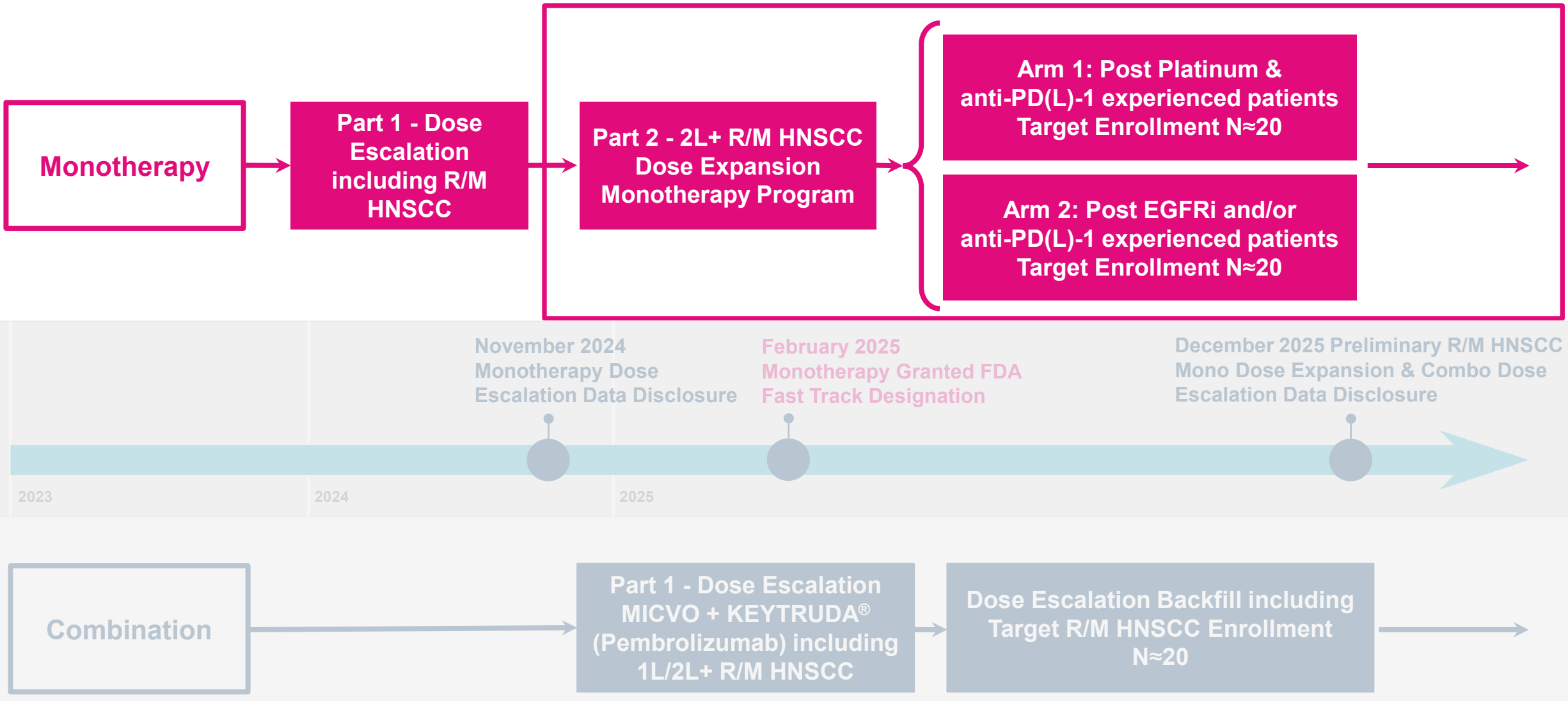
1. Padcev and Adcetris, both auristatin-payload ADC’s, leverage dose caps in their labels; Elahere doses based on adjusted ideal body weight – both dose capping and AIBW have been shown to improve tolerability without sacrificing efficacy; SyBing, Andrew B., and Diane D. Wang. "Optimizing Body Size-Based Dosing Approaches for Antibody–Drug Conjugates." Clinical Pharmacology & Therapeutics (2025).

Updated 2L+ R/M HNSCC Phase 1 Monotherapy Study Data Expected Fall 2026

Update will focus on participants treated at 5.4 mg/kg IV Q3W, with a dose equivalent to or below a dose cap



Clinical trial collaboration with Merck to evaluate MICVO in combination with KEYTRUDA® - KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

Target Enrollment in MICVO Dose Expansion Study Completed

MICVO IV Q3W @ 5.4 mg/kg

Dose Escalation Part 1 N = 5

Key Eligibility Criteria

- **Part 1**: 2L+ R/M HNSCC
- Histologically or cytologically confirmed HNSCC
- R/M disease progressed on/after platinum-based therapy and a PD-1/L1 inhibitor
- RECIST v1.1 measurable disease
- ECOG PS 0-1

Dose Expansion Part 2 N = ~40

Key Eligibility Criteria

- **Part 2**: 2/3L R/M HNSCC
- Histologically or cytologically confirmed HNSCC
- R/M disease progressed on/after platinum-based therapy and a PD-1/L1 inhibitor
- RECIST v1.1 measurable disease
- ECOG PS 0-1

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MICVO + Keytruda® in R/M HNSCC
December 2025 Preliminary Data

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MICVO + KEYTRUDA® Combination Summary in R/M HNSCC

Data as of Nov 3, 2025

Dec. 2025: 71% Confirmed ORR, 100% DCR (n=7, 3.6 mg/kg & 4.4 mg/kg)

Dec. 2025: Initial data support lack of overlapping toxicities observed between MICVO + KEYTRUDA®

Upcoming data in 4Q26 to focus on 1L, with significant potential in underserved patient populations

Anticipated enrollment of HPV unrelated patients provides potential to build on promising HPV+ efficacy signal in 4Q26 update

Future MICVO combinations may provide a further differentiated benefit/risk profile

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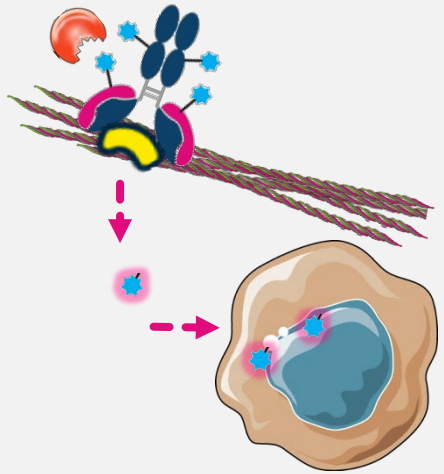
Immunogenic Potential of MICVO Mechanism May Amplify Benefits of KEYTRUDA® in R/M HNSCC

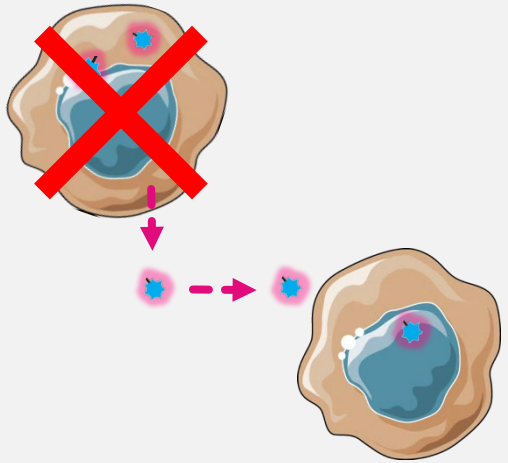
Non-cellular approach remodeling the tumor ECM could address a primary cause of drug resistance

1 Payload diffuses into & kills tumors cells



MICVO designed to bind to EDB and releases payload within tumor ECM

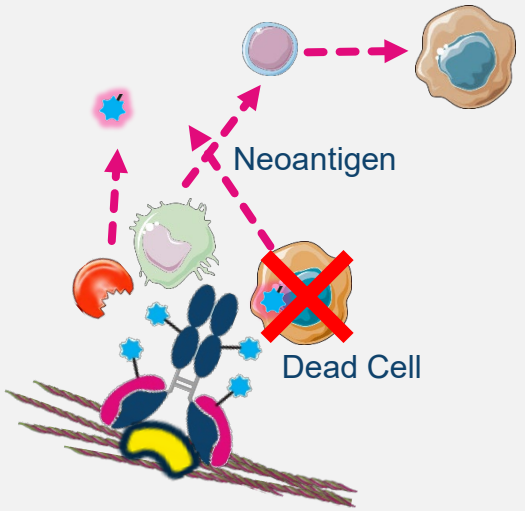
2 Additional Bystander killing



Tumor cell dies, releasing payload for additional cycles of tumor cell killing

PAYLOAD DRIVEN

3 Immunogenic cell death



Tumor death and exogenous antibody fragments lead to T-cell activation

IMMUNE DRIVEN

KEY

- CD8⁺ lymphocyte
- Proteases (e.g., cathepsin)
- Cleaved & active payload (auristatin)
- EDB⁺FN
- Dendritic cell
- MICVO
- Tumor cell
- Matrix

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MICVO 1L/2L+ R/M HNSCC Combo Dose Escalation Patient Demographics

Data as of Nov 3, 2025

Demographics	Total (N=7)
Race	
Asian	0
Black African American	0
White	7 (100%)
Other	0
Age (years)	
Median (min-max)	69 (57 – 76)
Baseline weight (kg)	
Median (min-max)	83 (65 – 107)
Gender	
Male	7 (100%)
Baseline ECOG Performance Status	
0	3 (43%)
1	4 (57%)

Disease Characteristics	Total (N=7)
Line of Disease Setting	**n (%)**
1L HNSCC	4 (57%)
2L+ HNSCC	3 (43%)
HPV Status	N=7 (% of total N=7)
HPV Positive, n (%)	7 (100%)

1L HNSCC Prior anti-Cancer Therapy	Total (N=4)
Elapsed Time Since Initial Diagnosis (Yr), Median (min-max)	1.7 (1.3-3.9)
Prior Systemic Therapy, Median Lines (min-max)	1 (1)
Taxane, n (%)	1 (25%)
Platinum, n (%)	4 (100%)
Checkpoint Inhibitor, n (%)	0
EGFR Targeting Agent, n (%)	0
ADC, n (%)	0

2L+ HNSCC Prior anti-Cancer Therapy	Total (N=3)
Elapsed Time Since Initial Diagnosis (Yr), Median (min-max)	4.3 (2.4-6.8)
Prior Systemic Therapy, Median Lines (min-max)	3 (2-5)
Taxane, n (%)	1 (33%)
Platinum, n (%)	3 (100%)
Checkpoint Inhibitor, n (%)	3 (100%)
EGFRi, n (%)	2 (67%)
ADC, n (%)	0

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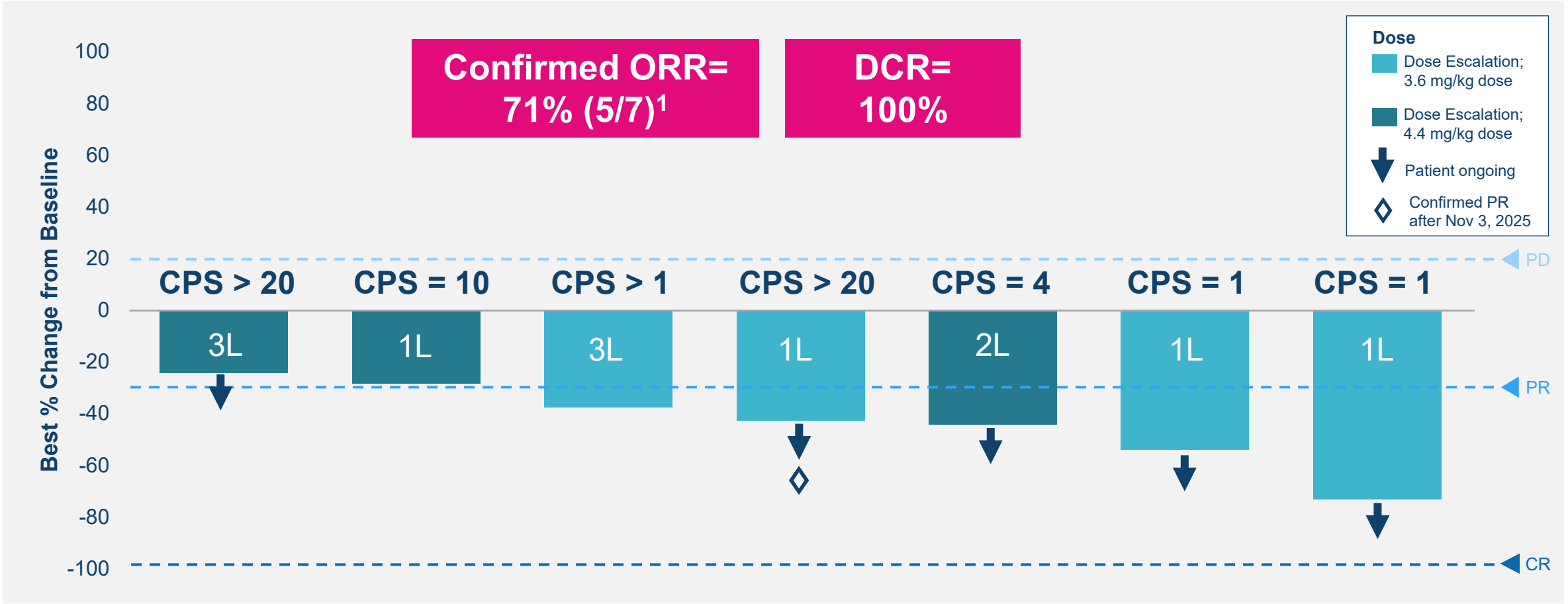
Promising Preliminary Data with MICVO at 3.6 mg/kg and 4.4 mg/kg in Combination with KEYTRUDA®

Data as of Nov 3, 2025



Baseline tumor (mm)	33	21	16	33	18	52	27
Prior IO	✓		✓		✓		
Prior Platinum	✓	✓	✓	✓	✓	✓	✓
#Prior tx	3	**1**	5	1	**2**	**1**	**1**

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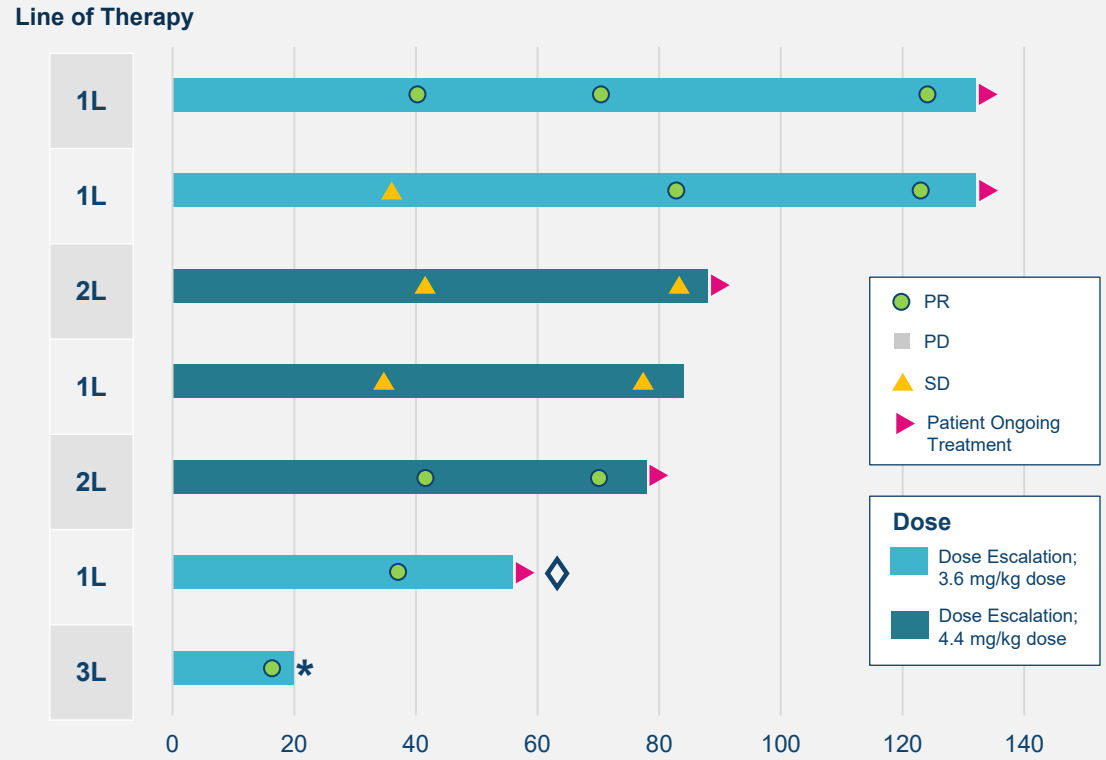
All patients received prior platinum therapy, were HPV positive, with tumor located in Oropharynx; #Prior tx = Number of unique prior systemic therapies

KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA; 1. 5th Confirmed PR after data cutoff

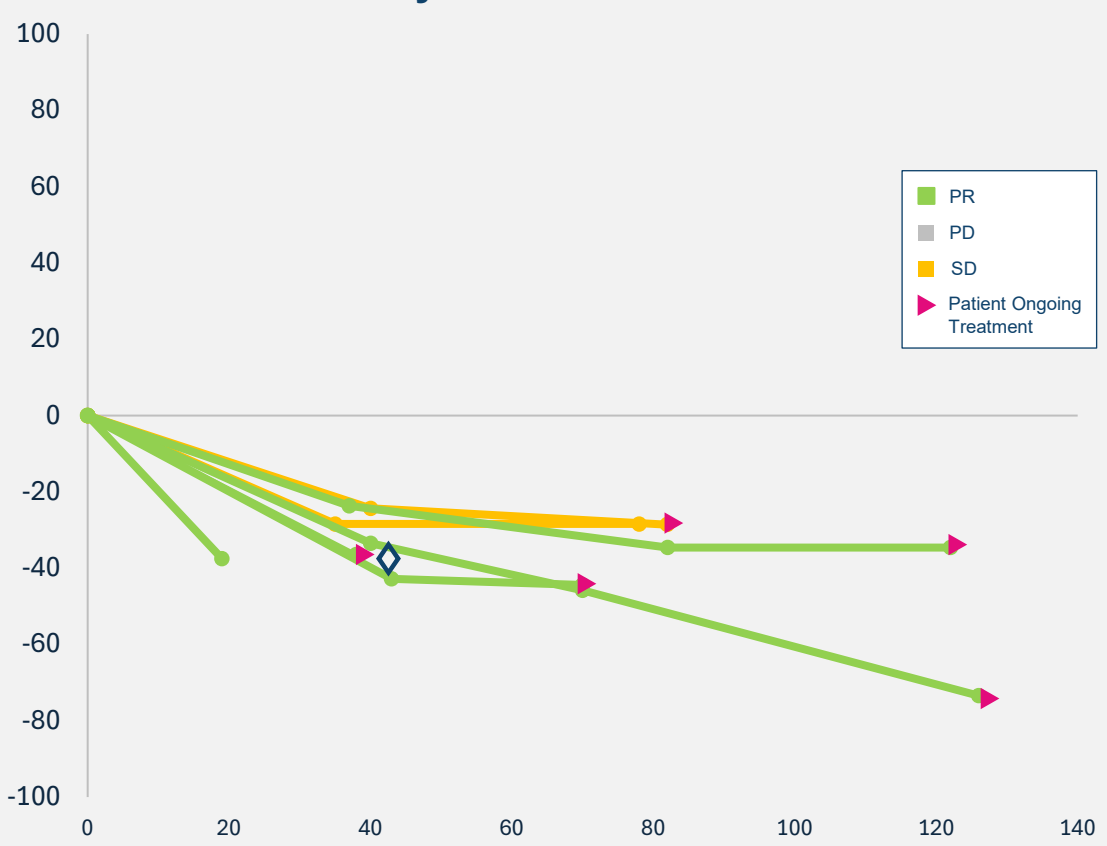
Preliminary MICVO Combination Data with KEYTRUDA® Indicates Rapid Response with Disease Control; Durability Data Maturing

Data as of Nov 3, 2025



* Patient discontinued after one dose of study treatment after enrollment criteria deviation identified; PR was observed after one dose and subsequently confirmed

◊ Confirmed scan received after Nov 3, 2025 data extraction



◊ Confirmed scan received after Nov 3, 2025 data extraction

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MICVO + KEYTRUDA® Dose Escalation Safety in R/M HNSCC

No Grade 3, Grade 4 or Grade 5 ADC payload TRAEs of interest

Data as of Nov 3, 2025

TRAEs	3.6 mg/kg	4.4 mg/kg	Total
N	4	3	7
All TRAEs	3 (75%)	3 (100%)	6 (86%)
Grade 3/4 TRAEs	0	0	0
TRAEs leading to treatment discontinuation	0	0	0
TRAEs leading to dose reduction	0	1 (33%)	1 (14%)
TRAEs leading to dose delay	0	0	0
Treatment related Deaths (Grade 5)	0	0	0

ADC payload TRAEs of interest	3.6 mg/kg			4.4 mg/kg			Total		
	Grade 1/2	Grade 3	Grade 4	Grade 1/2	Grade 3	Grade 4	Grade 1/2	Grade 3	Grade 4
N	4	4	4	3	3	3	7	7	7
Cutaneous	3 (75%)	0	0	2 (67%)	0	0	5 (71%)	0	0
Neuropathy	1 (25%)	0	0	0	0	0	1 (14%)	0	0
Neutropenia	0	0	0	0	0	0	0	0	0
Ocular	0	0	0	0	0	0	0	0	0
Anemia	1 (25%)	0	0	1 (33%)	0	0	2 (29%)	0	0
Pneumonitis	0	0	0	0	0	0	0	0	0

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Multiple MICVO Clinical Data Milestones Expected in 2026

Fall 2026

Updated Data from 2L+ R/M HNSCC Phase 1 Monotherapy Study, including focus on dose cap

4Q 2026

Updated Data from 1L R/M HNSCC Phase 1/2 Dose Escalation Combination Study

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Appendix

Solid Tumor ADC Dosing Approach Summary

Solid Tumor ADC	Dose Cap / AIBW	Highest % Gr3 AE observed at TBW	Target	Payload	Dose (mg/kg)	DAR	Approval Yr	2024 FY Sales
Kadcyla®	TBW	thrombocytopenia	HER2	DM1	3.6; Q3W	4	2013	$2.3B
Enhertu®	TBW	Pneumonitis / ILD	HER2	TOPO1	5.4; Q3W	8	2019	$4.2B
Padcev®	DC - 100kg	Neuropathy and Rash	Nectin-4	MMAE	1.25; D1,8,15 Q4W	4	2019	$1.9B
Trodelvy®	TBW	Neutropenia	TROP2	SN38	10; D1D8 Q3W	8	2020	$1.3B
Tivdak®	DC - 100kg	Neuropathy	Tissue Factor	MMAE	2; Q3W	4	2024	$131M
Elahere®	AIBW	Intestinal obstruction & thrombocytopenia	Folate Receptor α	DM4	6; Q3W	3	2024	$479M
Datroway®	DC - 90kg	Pneumonitis / ILD	TROP2	TOPO1	6; Q3W	4	2025	N/A
Emrelis™	DC - 100kg	Pneumonitis / ILD & Neuropathy	C-MET	MMAE	1.9; Q2W	4	2025	N/A

Not Approved / In Development

MICVO	DC & AIBW	Neuropathy	EDB+FN	AUR0101	5.4; Q3W	4
Varsetatug masetecan (Cytomx)	AIBW	Diarrhea	EpCAM	TOPO1	8.6 and 10; Q3W	8
IM-1021 (Immunome)	AIBW	TBD	ROR-1	TOP1	TBD	8
Sigvotatug vedotin (Pfizer)	AIBW	Pneumonitis / ILD	IB6	MMAE	1.8; Q2W	4

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DC = Dose Cap; AIBW = Adjusted Ideal Body Weight; TBW = Total Body Weight

Kadcyla® – Roche, Enhertu® – Daiichi Sankyo and Astrazeneca, Padcev® – Astellas Pharma Inc. and Pfizer Inc., Trodelvy® – Gilead, Inc., Tivdak® – Pfizer Inc and Genmab A/S, Elahere® – AbbVie, Datroway® – Daiichi Sankyo and Astrazeneca, Emrelis™ – AbbVie

Recent Translational Posters Build on Previous Publications to Further Support Three-Pronged MOA of MICVO

1 Payload diffuses into & kills tumors cells | 2 Additional Bystander killing

- **Highly specific and avidity driven binding to EDB+FN** [1, 2]
  - Lack of drug sink and no off-target binding support minimal off target effects
  - Strong binding strength to EDB+FN fibrils predicts the prolonged drug retention in TME for heightened clinical efficacy
- **Extracellular payload release** mediated by **tumor-specific cathepsins** [2]
- **Improved membrane permeability** for cancer cell diffusion and efficient bystander killing [2,3,4,5]
- **Optimized payload potency** by rational structure-based drug design (SBDD) to increase tumor cell killing [6]
- **pH-dependency favors linker cleavage in acidic TME** to minimize off-target toxicity [2]
- **Observed changes to tumor stromal architecture indicate potential for extracellular mechanism** to lead to unique TME remodeling and improve tumor response [7,8]

Payload Driven

3 Immunogenic cell death

- **MICVO acts as a driver for the cancer-immunity cycle,** inducing immunogenic cell death, activating immune cells and allowing tumor infiltration of T cells [4]
- **Preclinical data support complementary potential with immune checkpoint inhibitors**
  - Mouse analog of MICVO showed immune response in tumors that had been refractory to anti-PD1 [9]
  - Synergistic antitumor activity when combined with anti-PD1 [9]

Immune Driven

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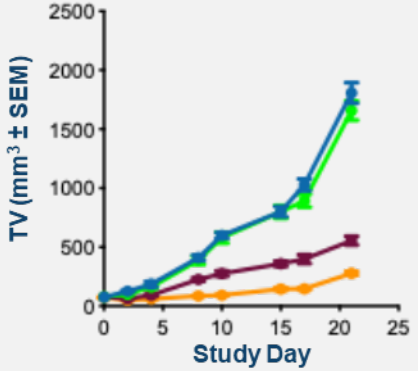
[1] Hooper A et al., Mol Cancer Ther (2022) 21(9):1462-1472 [2] Shen C & Iovino M et al., AACR-NCI-EORTC (2025) [3] Graziani EI et al., Mol Cancer Ther (2020) 19: 2068-78 [4] Iovino M et al., AACR-NCI-EORTC (2025) [5] Lewandowski S et al, AACR (2025). [6] Maderna A et al., J Med Chem (2014) 57: 10527-10543 [7] Trickett J et al, AACR-NCI-EORTC (2025) [8] Lewandowski S et al, AACR-NCI-EORTC (2025) [9] Rodriguez A et al, AACR-NCI-EORTC (2025)

AACR 2026 Poster[1] - maMICVO Demonstrates Anti-Tumor Efficacy in an Immunotherapy-Refractory Syngeneic HNSCC Model

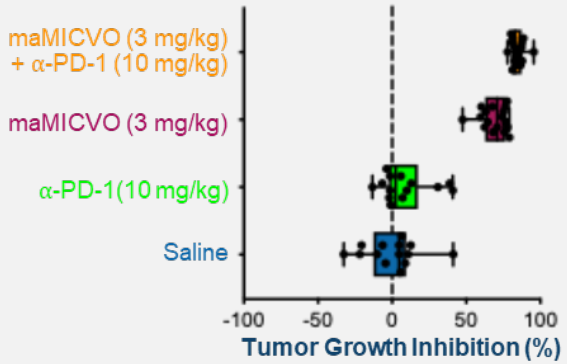
Findings support the clinical development of MICVO as both a monotherapy and in combination with pembrolizumab for R/M HNSCC

MOC2 – HNSCC Anti-PD-1 refractory

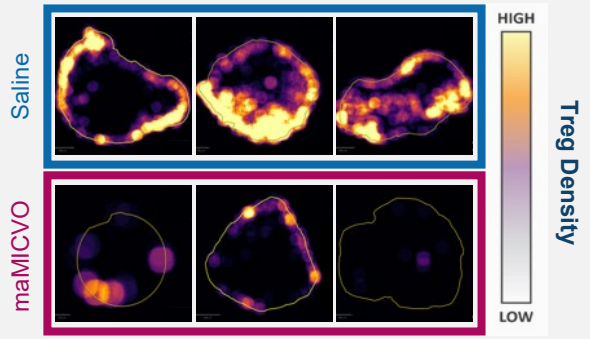
Tumor Efficacy Combination Therapy

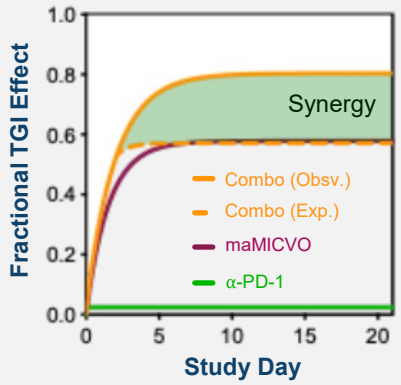


Tumor Growth Inhibition (%) Day 21



MOC2 – Day 10





- Strengthens the evidence for MICVO's anti-tumor activity in HNSCC
- Promotes a more favorable immune microenvironment in HNSCC
- Supports its potential to enhance responses to anti-PD-1
- Highlights MICVO's potential to synergize with pembrolizumab and provide clinical benefit in patients with HNSCC who do not respond to checkpoint blockade

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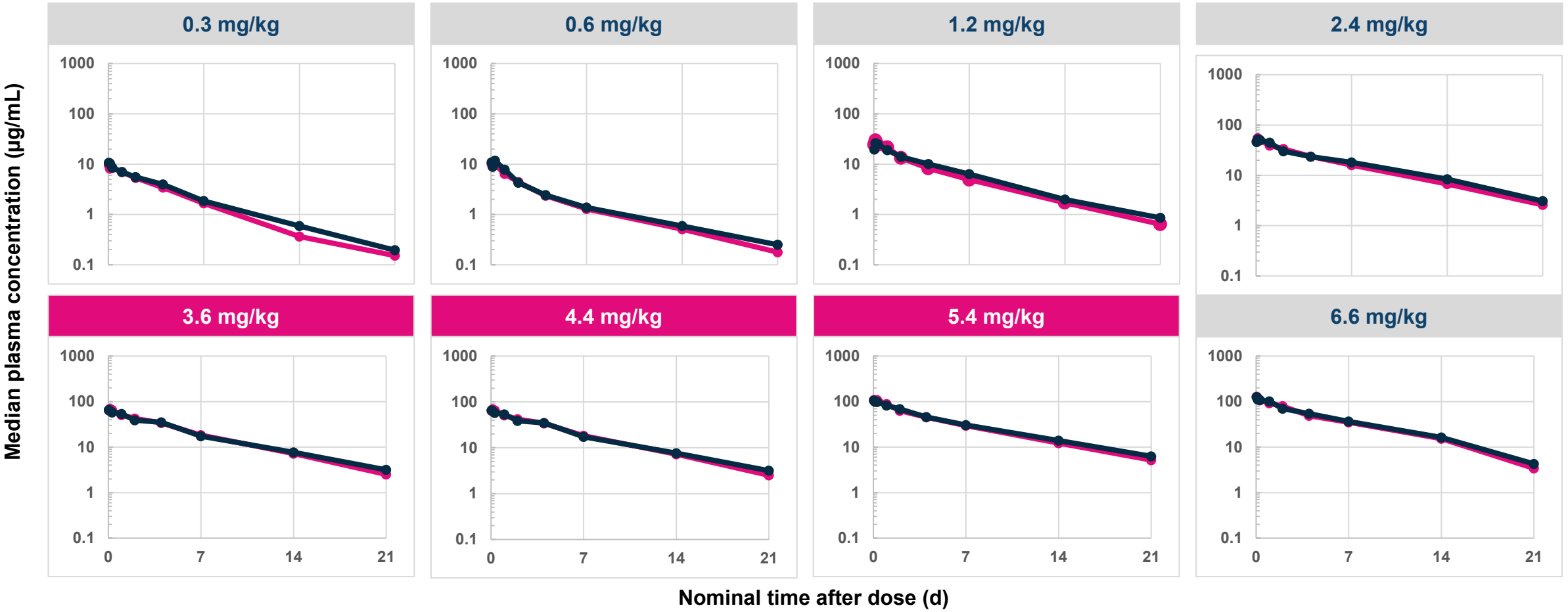
maMICVO = mouse analog of MICVO (mouse IgG2a), HNSCC = Head & Neck Squamous Cell Carcinoma, PD-1 = Programmed Cell Death-1, TV = Tumor Volume, SEM = Standard Error of the Mean

1. Rodriguez et al., Cancer Res (2026) 86 (7_Supplement): 4406 (https://pyxisoncology.com/wp-content/uploads/Rodriguez_AACR2026_MICVO_FINAL.pdf)

MICVO Dose Linear PK Demonstrates No Antigen Sink (Q3W Dosing)

Consistent with differentiated EDB+FN target expression in tumor ECM and negligible expression in normal tissue



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