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HMBD-002
Phase I Clinical Trial

Final Results

7 October 2025

Forward-Looking Statements

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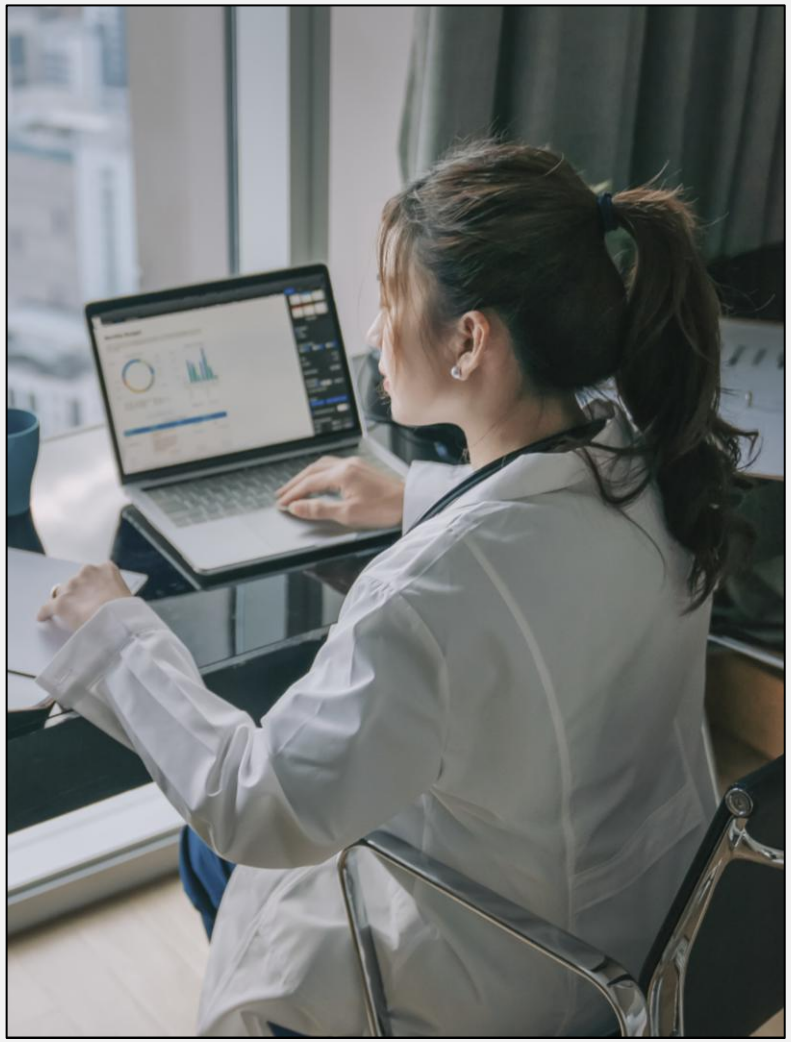
Introduction

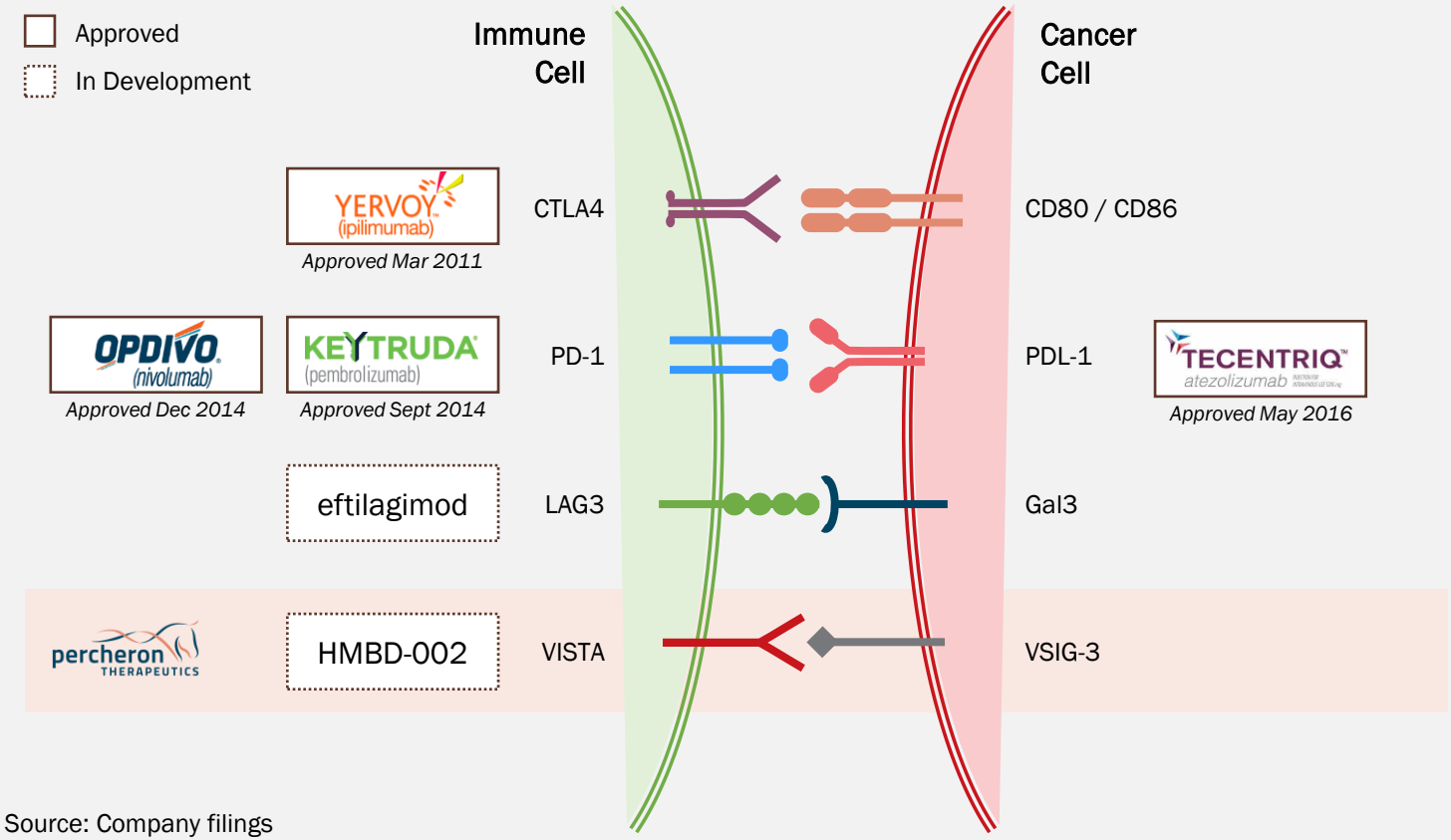
- HMBD-002 is an IgG4 monoclonal antibody that inhibits VISTA (v-domain immunoglobulin suppressor of T-cell activation). VISTA is a novel immune checkpoint, expressed on both tumour cells and immune cells.
- Expression and activation of VISTA is associated with a suppression of immune function, including an increase in myeloid-derived suppressor cells and a decrease or inactivation of natural killer cells and T-lymphocytes.
- HMBD-002 inhibits VISTA with picomolar affinity and with very high specificity.
- In a wide range of animal models of diverse tumour types, HMBD-002 has shown consistent ability to inhibit tumour growth, both as monotherapy and, synergistically, in combination with PD-1 inhibition.
- Percheron's licensor, Hummingbird Bioscience, conducted a phase I clinical trial of HMBD-002 in patients with advanced cancer. The trial recruited 48 patients at six hospitals across the United States.
- The company has previously reported high-level qualitative data confirming that HMBD-002 was well tolerated at weekly doses up to 1,400mg, both as monotherapy and in combination with pembrolizumab.



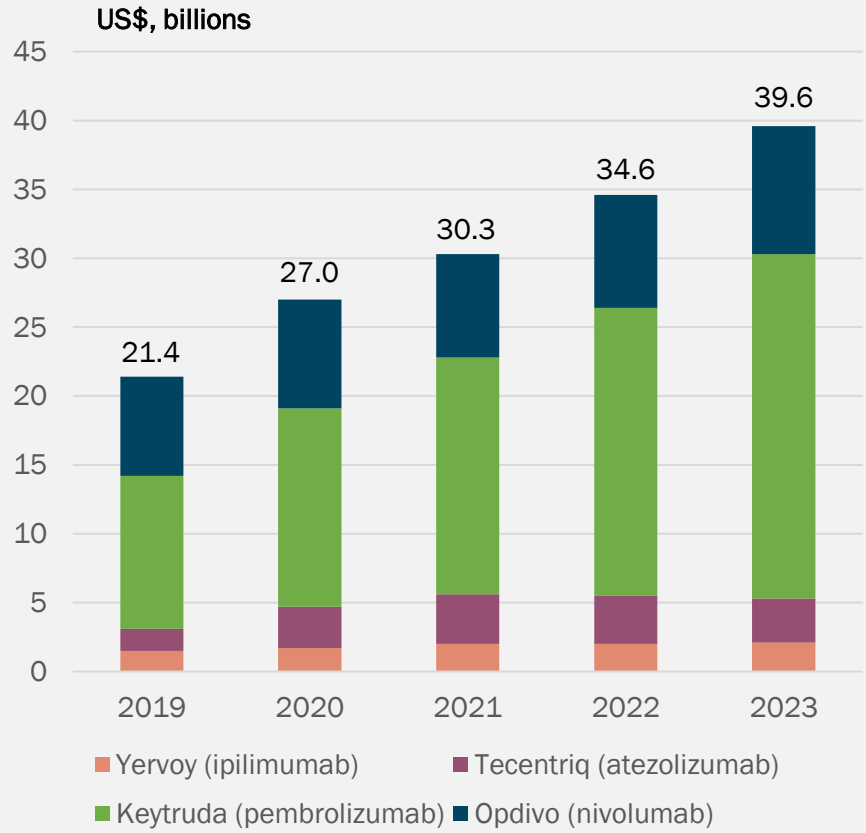
Background

Immuno-oncology has emerged in the past decade as one of the most important new fields in the treatment of cancer

Immuno-oncology therapies target the interaction between tumours and the immune system to enhance the immunological response to cancer



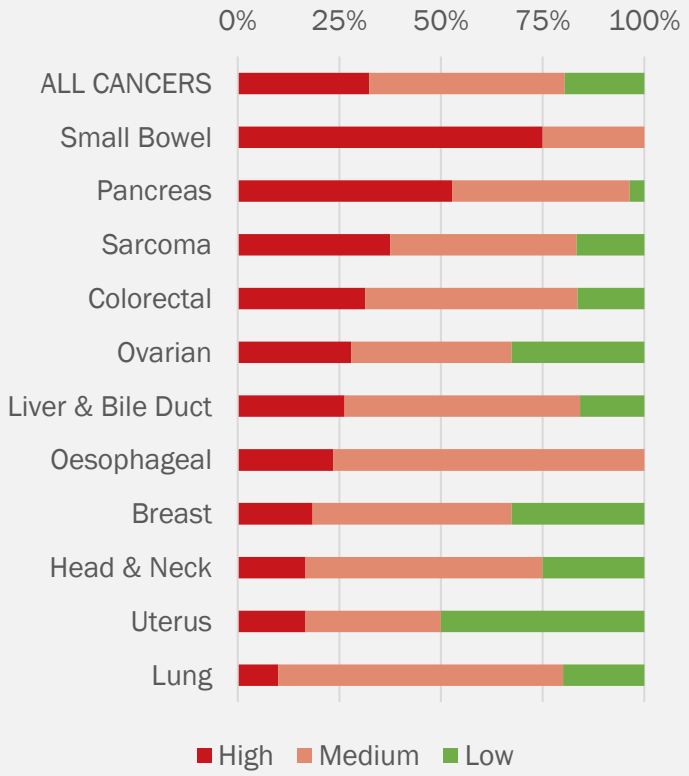
Immuno-oncology has grown to a ~US$ 40+ billion market



Source: Company filings
Note: list of approved products and available targets is non-exhaustive

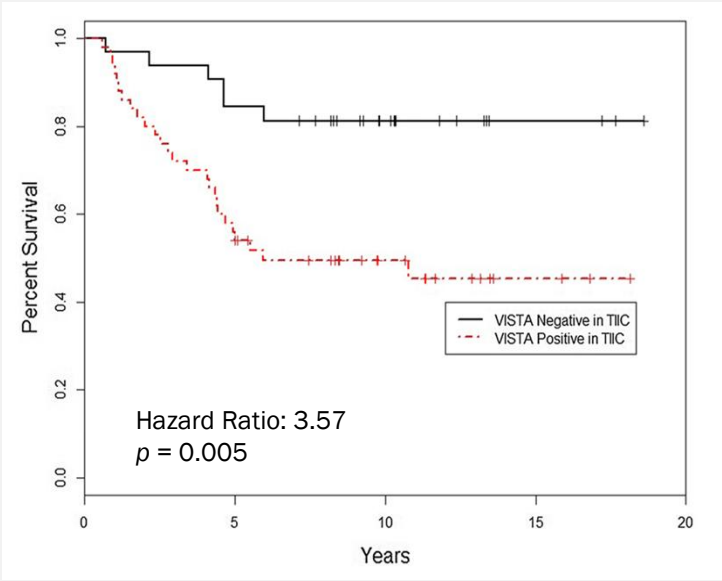
VISTA is a compelling target for novel oncology therapies, showing high expression on many tumours and clear correlation with prognosis

VISTA is expressed on a wide range of tumours



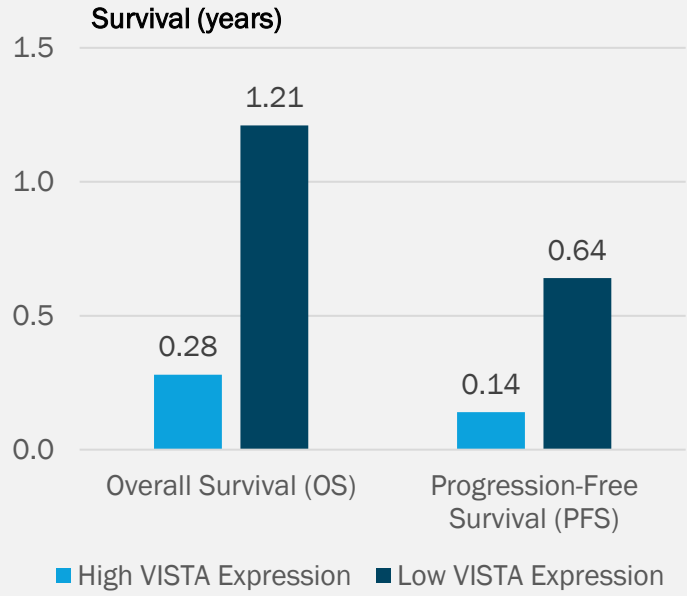
High expression of VISTA is associated with worse prognosis

Survival of 85 melanoma patients comparing those with VISTA positive tumour-infiltrating inflammatory cells (TIICs) and those with VISTA negative TIICs



High VISTA expression is associated with resistance to PD-1 inhibition

Survival of 16 pancreatic cancer patients, all treated with immunotherapy, comparing those with high and low VISTA expression



Sources: D Nishizaki et al. (2024) *ESMO Open* 9(4):102942 (panels 1 & 3); LF Kuklinski et al. (2018) *Cancer Immunol. Immunother.* 67:1113-1121 (panel 2)

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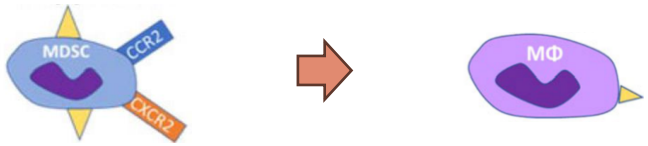
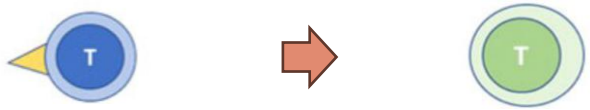
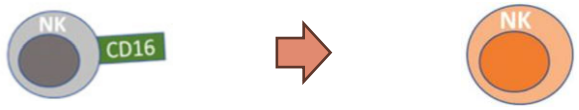
HMBD-002 is a potent inhibitor of VISTA, a well-validated immune checkpoint inhibitor

Tumours suppress immune function in their local environment; inhibition of VISTA reactivates immune function via multiple pathways

1	Reduces myeloid-derived suppressor cell suppression and enhances myeloid activation	
2	Brings T-cells out of a quiescent state	
3	Activates Natural Killer (NK) cells to attack tumour	
4	Enhances antigen presentation to potentiate immune response	
5	Expands and transforms activated and exhausted T-cells into effector cells	

HMBD-002 is a recombinant humanized IgG4 monoclonal antibody

HMBD-002 inhibits VISTA at picomolar concentrations and with very high specificity

HMBD-002 has completed a phase I trial in patients with advanced cancer (all types) in the US under IND

HMBD-002 has composition-of-matter IP protection to 2038, with potential for patent term extensions

HMBD-002 has been reliably manufactured at 500L scale with high yield and recovery, and viable COGS

Source: AS Martin et al. (2023) *Front. Immunol.* 14:1086102

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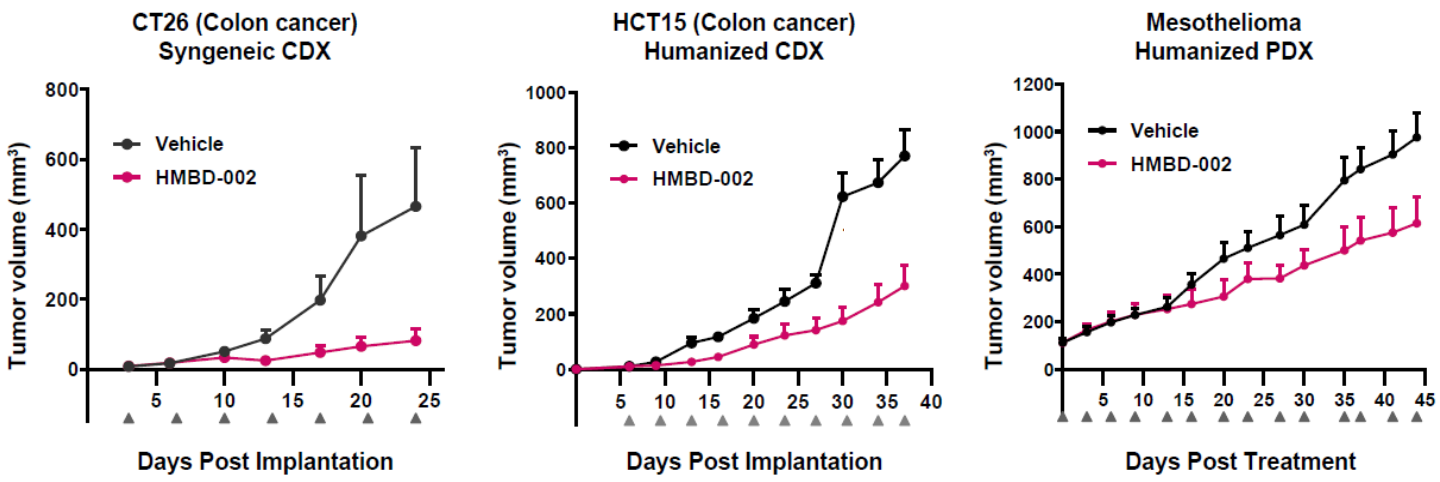
HMBD-002 has shown compelling evidence of activity in a range of preclinical tumour models, and is synergistic with PD-1 inhibition

Monotherapy administration yields up to 80% tumour growth inhibition, depending on tumour type

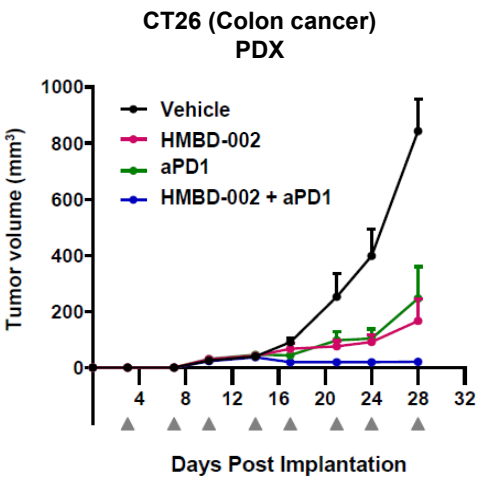


Tumour Growth Inhibition (TGI): ~84%

Tumour Growth Inhibition (TGI): ~65%

Tumour Growth Inhibition (TGI): ~40%

Combination with PD-1 inhibition provides substantial synergy



Tumour Growth Inhibition (TGI): ~94%

Source: B Dharmadhikari et al. (2022) *J Immunother. Cancer* 10(Suppl 2):A558-A558 (poster presentation to SITC 37th Annual Meeting)

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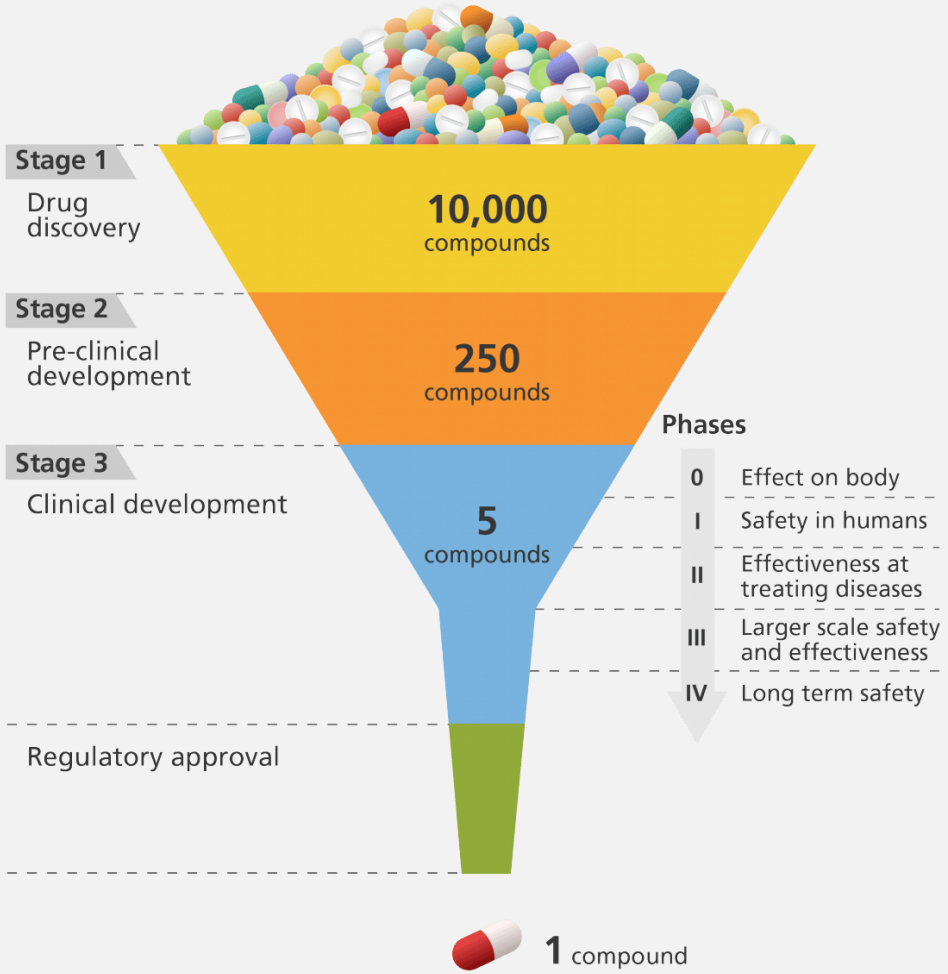
Phase I studies are initial safety studies, designed to determine the appropriate dose of an investigational drug and identify key toxicities



HMBD-002 has completed phase I

- Phase I studies are safety studies – they are primarily intended to determine the 'maximum tolerated dose' (MTD) of a new drug
- In most cases, phase I studies are performed in healthy volunteers and so provide no indication of efficacy. In oncology, phase I studies are often performed in patients, and sometimes provide a signal of clinical activity
- Even in oncology, phase I studies typically recruit very late-stage patients, who are often very resistant to treatment, and they do not have the statistical power to properly measure efficacy
- The most common phase I design is a 'dose escalation' study, in which a small group of patients (commonly, three) initially receive a very low dose of the drug. Providing they do not experience significant toxicity, the next group of patients receive a higher dose. The process continues until dose-limiting toxicities are seen. Typically, only the last few cohorts receive a therapeutic dose of the drug
- For cancer drugs, the probability of successfully completing phase I trials and transitioning to phase II is approximately 50%

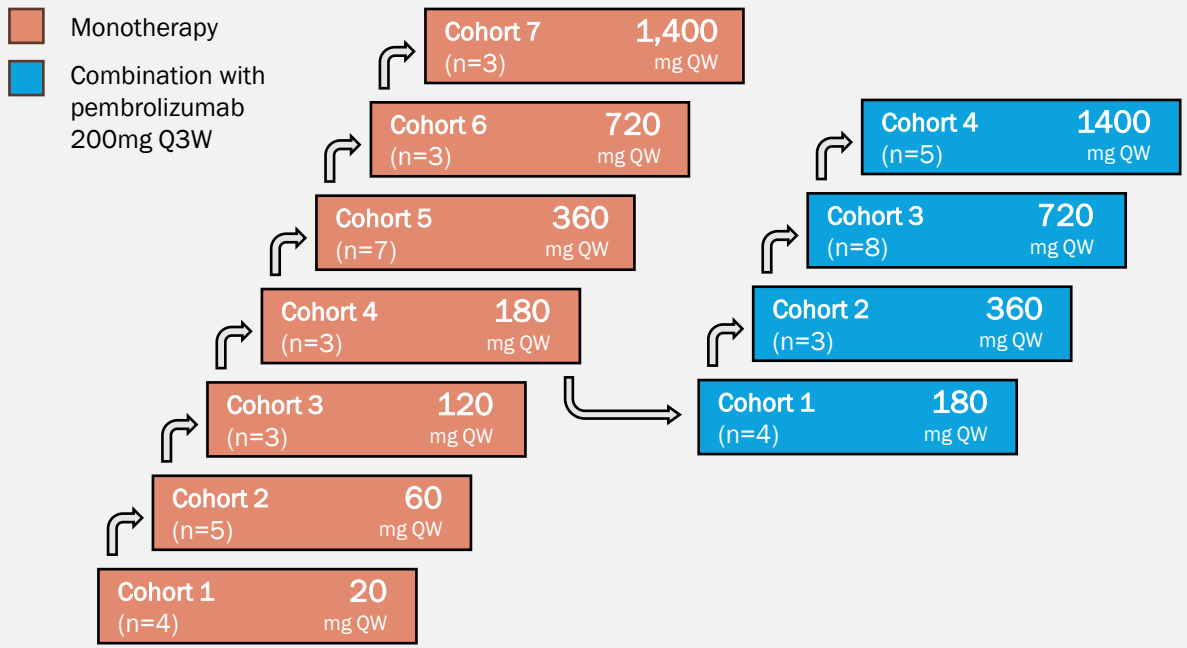
Study Design & Baseline Characteristics

The HMBD-002 phase I study adopted a standard '3+3' design, with an initial monotherapy group (*n*=28) followed by a pembrolizumab combination therapy group (*n*=20)

Patient Population & Study Design

- Advanced cancer patients with no available treatment options known to confer clinical benefit
- ECOG performance status ≤ 1
- 3+3 dose escalation design, with a 21-day observation period for dose limiting toxicities
- HMBD-002 administered weekly via 60-minute iv infusion
- 28 patients on monotherapy and 20 patients in combination with pembrolizumab

Dose Escalation



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Baseline Characteristics

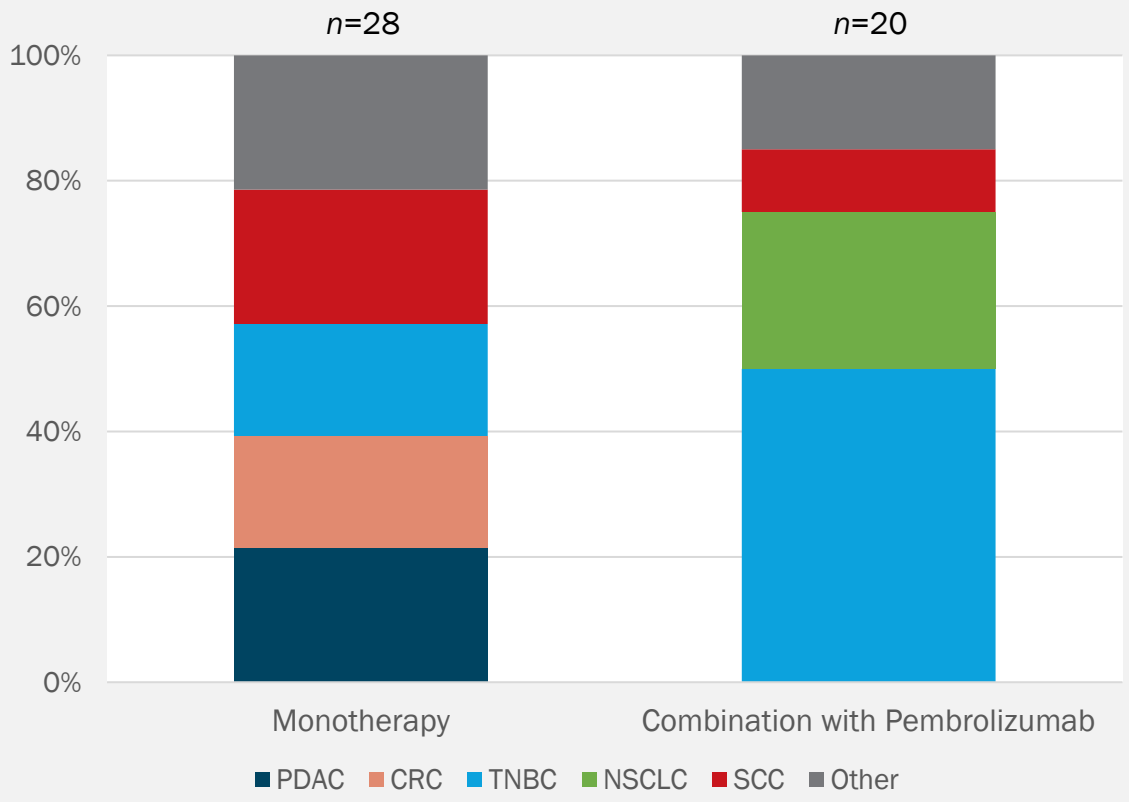
	Monotherapy	Combination Therapy	Overall
Sample size, n	28	20	48
Age, years, mean (SD)	57.7 (12.7)	55.0 (11.0)	56.6 (12.0)
Age range, min – max	27 – 81	30 – 71	27 – 81
Sex, M/F (%M)	15 / 13 (54%)	6 / 14 (30%)	21 / 27 (44%)
ECOG Performance Status, 0/1	10 / 18	8 /12	18 / 30
Time since initial diagnosis, years, mean (SD)			4.1 (3.6)
Time since metastasis, years, mean (SD)			2.6 (2.4)
Prior lines of systemic therapy, median	4	5	4
Prior surgical treatments, median	1	1	1

Commentary

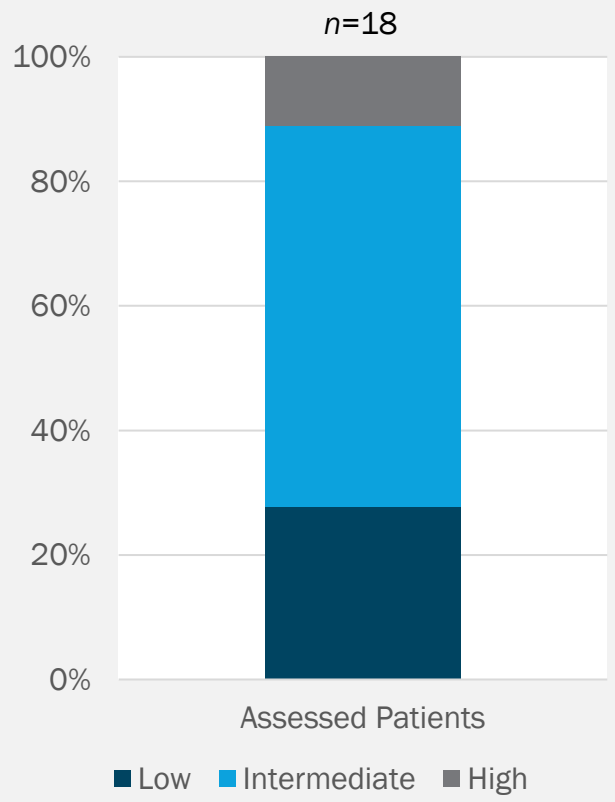
- The study population was generally typical of a phase I oncology study
- This was not a randomised study, and so it is not expected that monotherapy and combination therapy groups were statistically identical

The study population was highly mixed in terms of tumour type, with a weighting towards low to intermediate tumour mutational burden

Breakdown of tumour Types



Assessment of tumour Mutational Burden



High TMB
(>20 mutations/MB)

Typically associated with better response to immunotherapy

Intermediate TMB
(5 – 20 mutations/MB)

Typically associated with variable response to immunotherapy

Low TMB
(<5 mutations/MB)

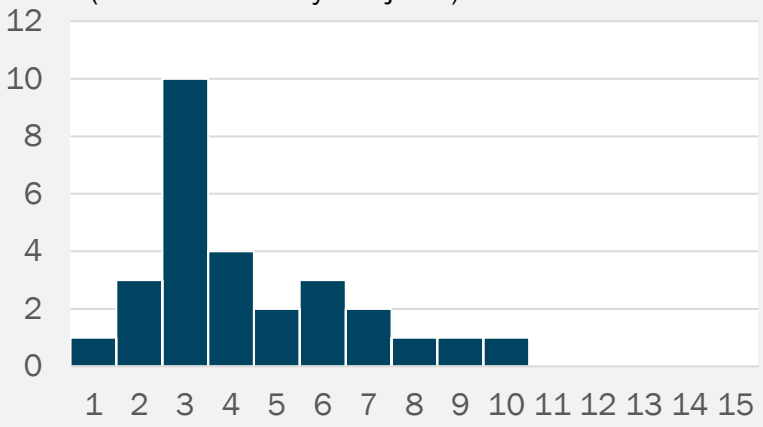
Typically associated with poor response to immunotherapy

Notes: PDAC = pancreatic ductal adenocarcinoma; CRC = colorectal carcinoma; TNBC = triple-negative breast cancer; SCC = squamous cell carcinoma
TMB is usually only assessed in certain tumour types, so was not available for all patients

Patients were heavily pre-treated, with up to 13 prior lines of drug therapy prior to study entry

Monotherapy Cohort

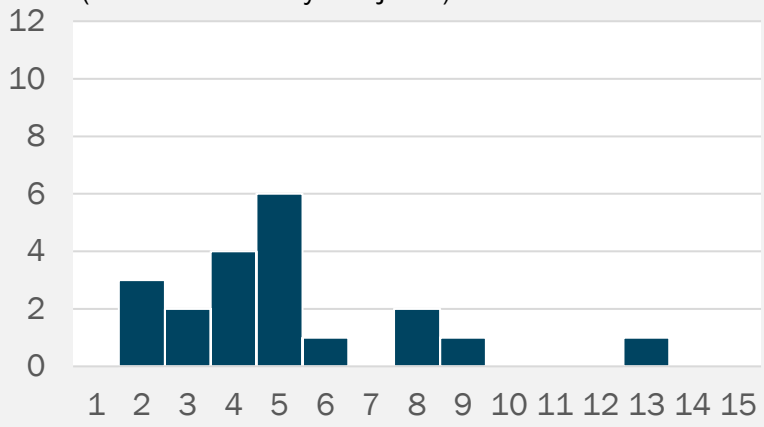
Number of Prior Lines of Treatment
(Number of Study Subjects)



Median Number of Prior Lines of Systemic Cancer Therapy	4
Median Number of Prior Cancer Surgeries (excl. biopsies)	1
Proportion of Patients with Prior Immune Checkpoint Therapy	64%

Combination Therapy Cohort

Number of Prior Lines of Treatment
(Number of Study Subjects)



Median Number of Prior Lines of Systemic Cancer Therapy	5
Median Number of Prior Cancer Surgeries (excl. biopsies)	1
Proportion of Patients with Prior Immune Checkpoint Therapy	75%

Commentary

- Patients in this study were very heavily pre-treated, with an average of between four and five prior lines of systemic therapy. On average, patients in the study had undergone at least one surgical procedure for their cancer, and between two-thirds and three-quarters of patients had previously failed at least one immune checkpoint inhibitor.

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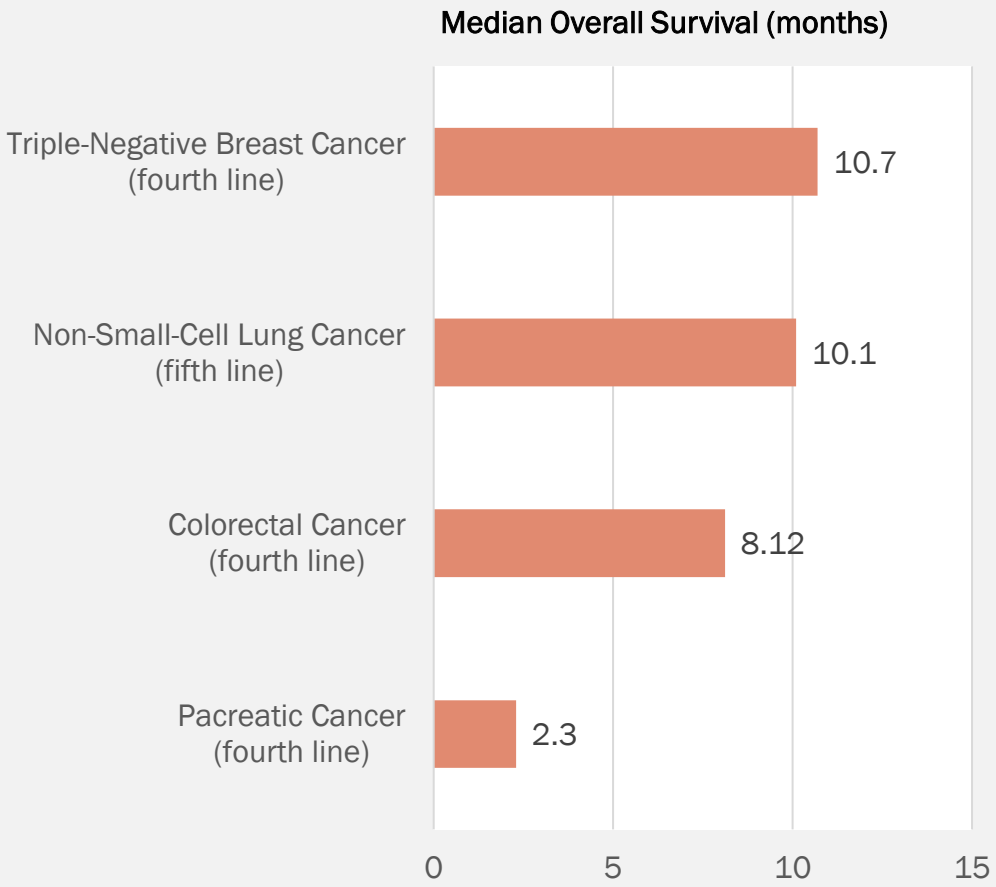
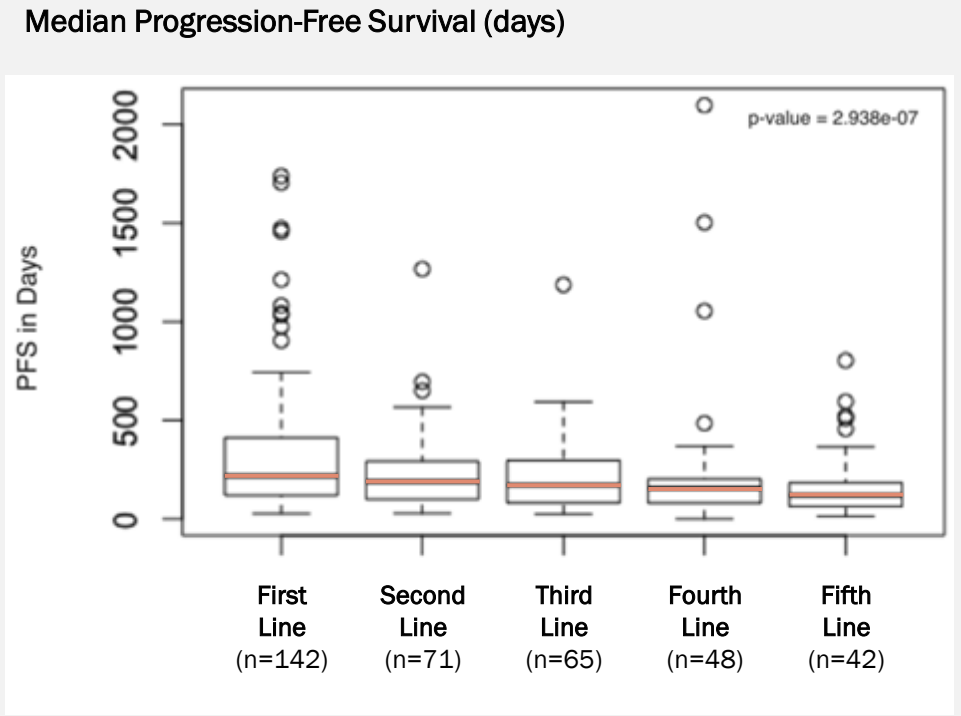
In general, heavily pre-treated patients typically have overall survival <12 months and progression-free survival <4 months





Analysis of 165 patients with advanced cancer enrolled to 6 phase I trials at a single trial center in the United States

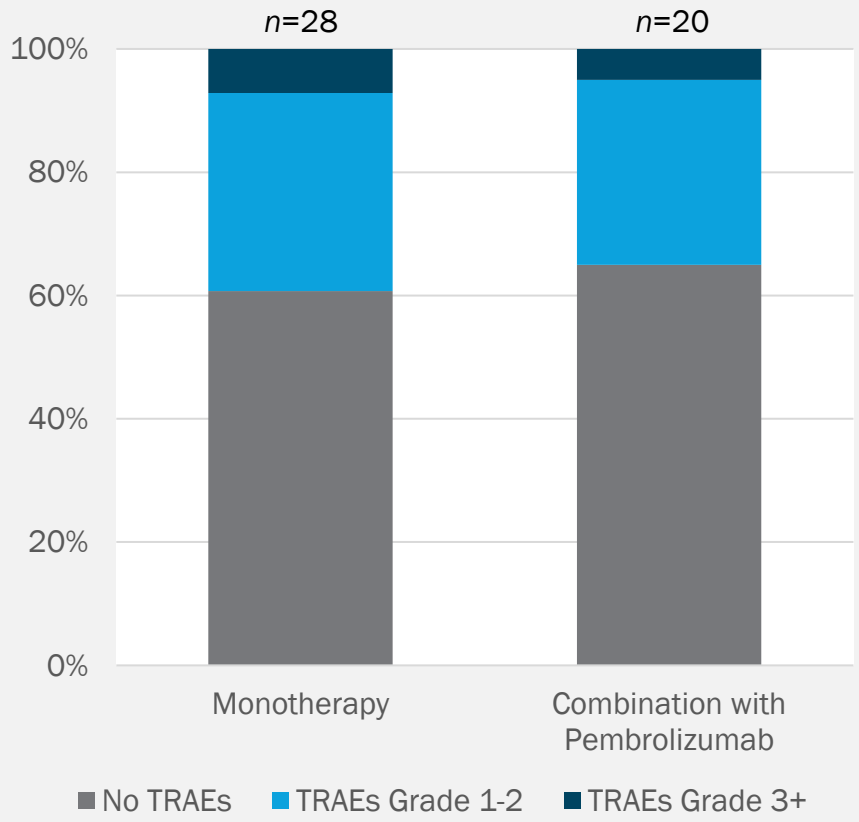
Median PFS

Source: JP Willey et al. (2020) *J Clin Oncol*. 38(15 Suppl); XF Wang et al. (2014) *Zhongguo Fei Ai Za Zhi* 17(2):839-44; Y Liu et al. (2023) *Cell Res* 33:389-402; AF Montes et al. (2021) *Sci Reports* 11; CH Bailey et al. (2012) *J Cancer* 3:7-13

Safety Data

Common treatment-related adverse events (TRAEs) included infusion reactions, gastrointestinal disorders, fatigue, and rash

Few patients with TRAEs at Grade ≥3; no incremental toxicity in combination

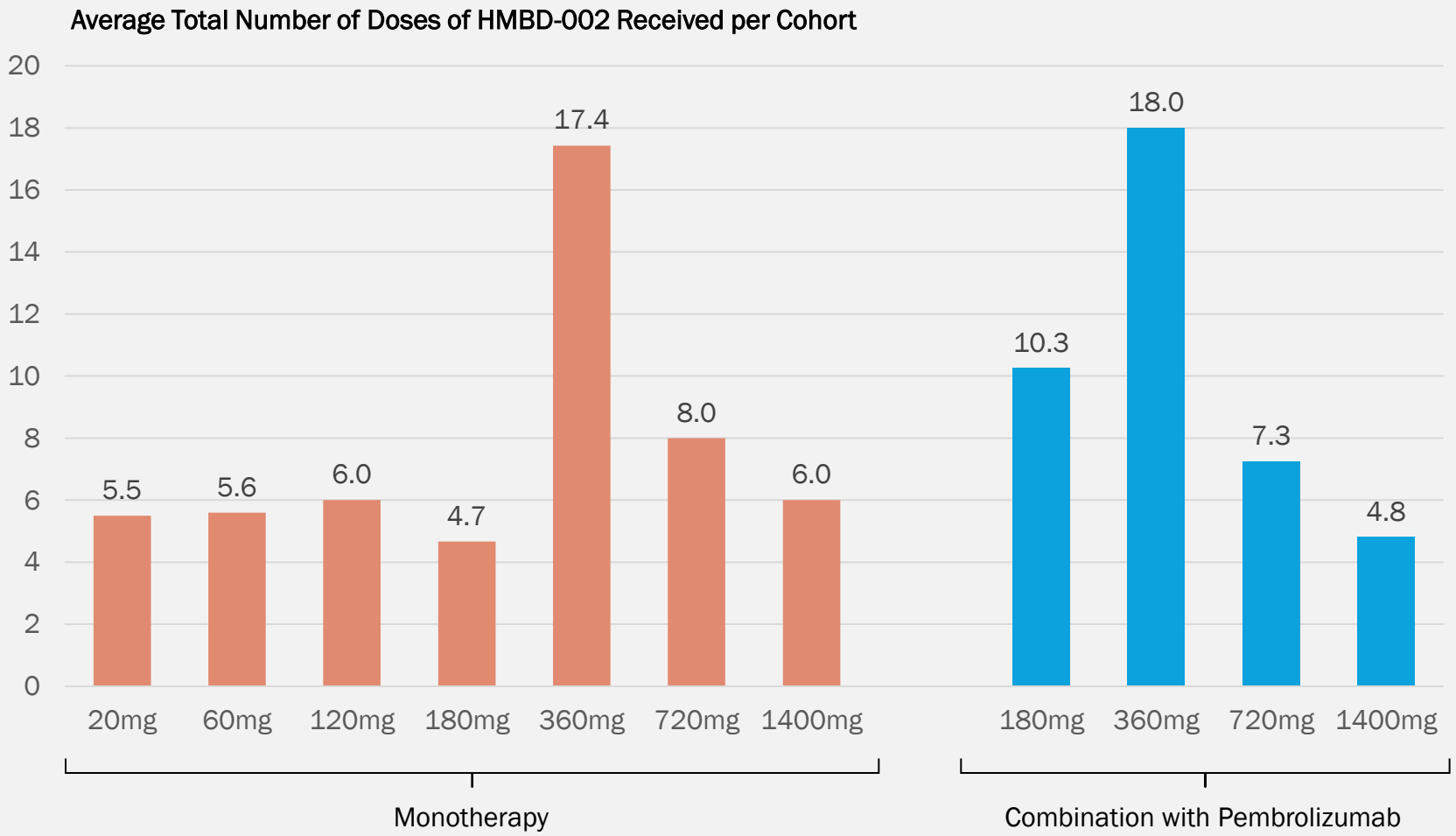


- Clinical experience comprises 48 patients receiving doses up to 1,400mg QW, for up to ~1 year, as monotherapy or in combination
- Most common TRAEs were infusion reactions, gastrointestinal disorders (e.g. nausea, diarrhea), fatigue, and rash
- 1 dose-limiting toxicity (DLT) observed at 360mg dose: a patient with grade 3 hepatitis which resolved with corticosteroids
- Only one treatment-related discontinuation: a combination therapy patient with pneumonitis (a common side effect of PD-1 inhibition)
- **No cases of cytokine release syndrome (CRS) seen in monotherapy or combination therapy cohorts**

Commentary

- The safety profile of HMBD-002 appears very favourable in the context of a drug intended for use in advanced cancer. Only a handful of patients experienced treatment-related adverse events ≥ grade 3 in severity, and less than half of patients in the study experienced any treatment-related adverse events at all.
- Combination of HMBD-002 with pembrolizumab appeared in general to be associated with no additional toxicity and no potentiation of anti-PD1 toxicity.

On average, patients in the study received 8.8 weekly doses of HMBD-002 (~2 months of treatment)



Commentary

- The most common reason for treatment cessation was disease progression, reflecting the advanced condition of patients in the study.

No cases of cytokine release syndrome were seen, likely reflecting the IgG4 phenotype of HMBD-022

Program	HMBD-002	CI-8993	JNJ-61610588	SNS-101	W0180
Company	Hummingbird Bioscience / percheron THERAPEUTICS	CURIS / ImmuNext	janssen	sensei BIO	Pierre Fabre
Isotype	IgG4	IgG1	IgG1	IgG1	IgG1
Stage	Phase I Complete	Phase I Complete	Phase I Terminated	Phase I Ongoing	Phase I Terminated
Exposure to Date	48 patients	26 patients	12 patients	-	33 patients
Combination Data Available	Monotherapy & Combination with Pembrolizumab	Monotherapy	Monotherapy	Monotherapy & Combination with Cemiplimab	Monotherapy & Combination with Pembrolizumab
Status	**Ongoing**	Inactive	Discontinued	**Ongoing**	Discontinued
Notes				pH-sensitive antibody	

In general, IgG1 antibodies activate antibody-dependent cellular cytotoxicity (ADCC), recruiting immune cells such as natural killer (NK) cells to destroy the target.

This can be a very effective approach in cancer, but can also lead to significant toxicity, including cytokine release syndrome (CRS).

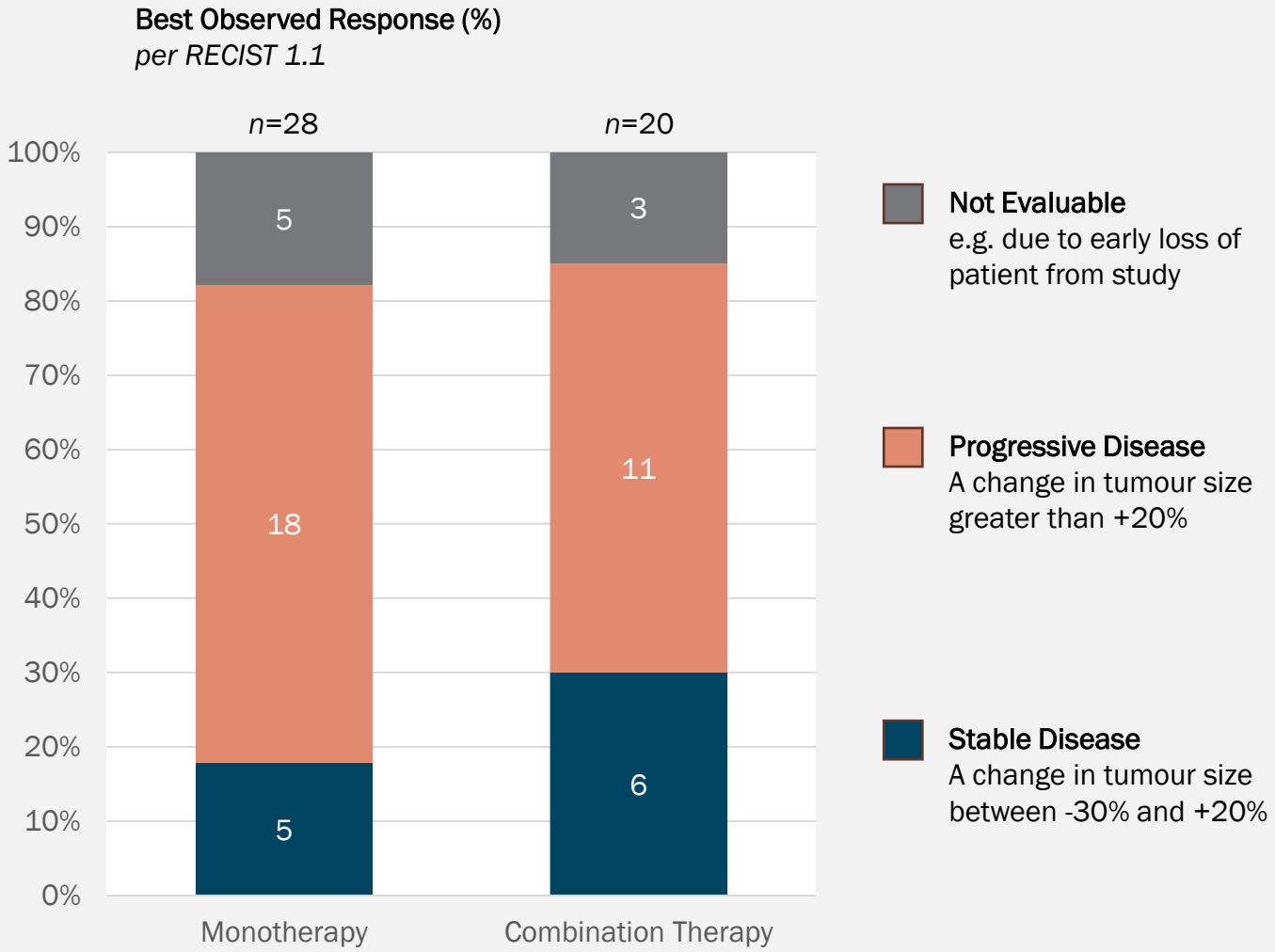
Expert feedback indicates that the key challenge with other VISTA antibodies, which are almost exclusively IgG1, is that they have often proven toxic in clinical trials.

HMBD-002 is an IgG4 antibody, so it blocks VISTA signalling, but does not necessarily destroy VISTA-positive cells. This is likely to make it significantly less toxic in clinical use.

Sources: Company filings; Clinicaltrials.gov

Efficacy Data

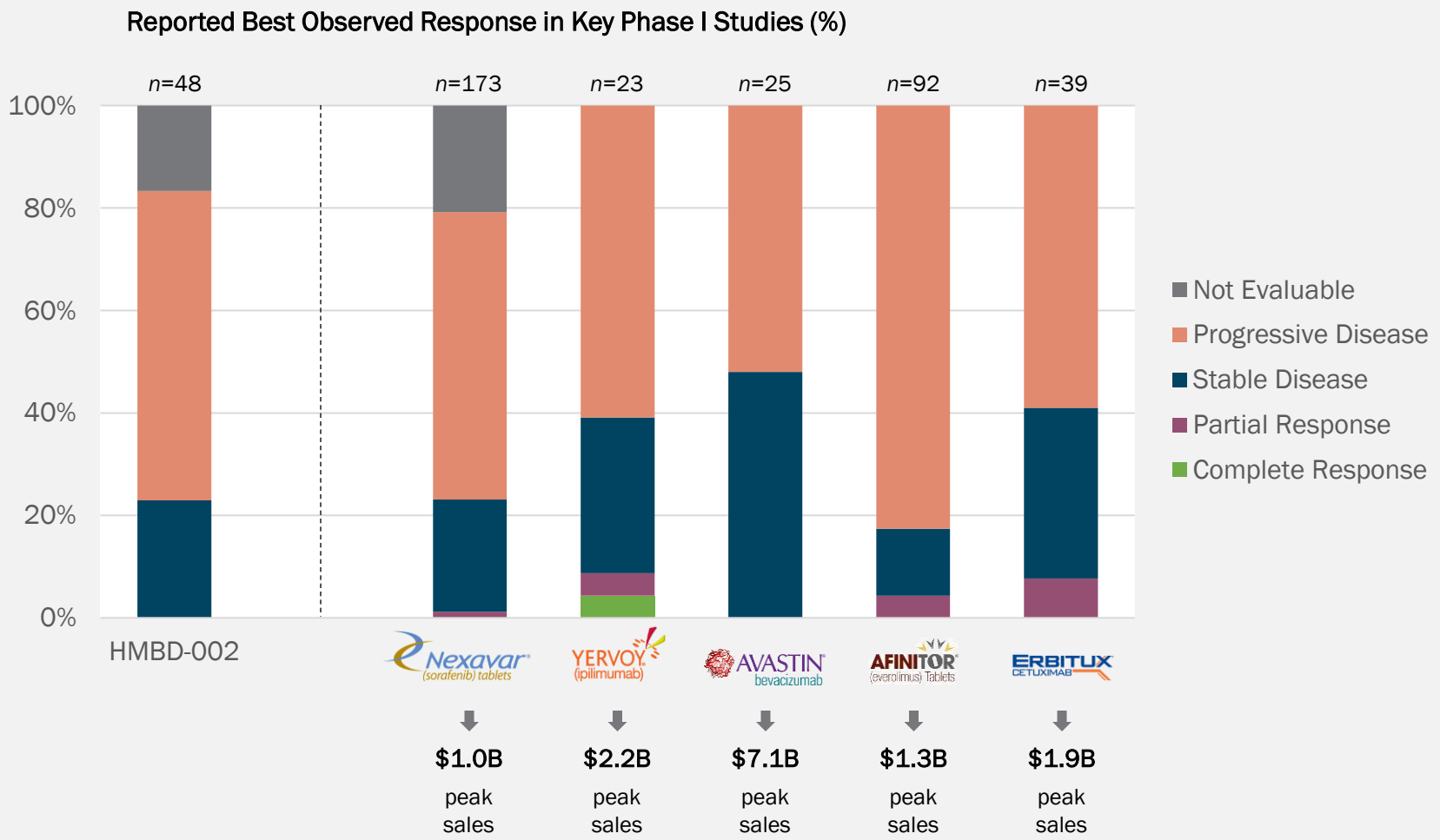
28% of patients in the study showed a best observed response of ‘stable disease’ (SD)



Commentary

- No patients in either group demonstrated a complete response (CR) or partial response (PR).
- 18% of patients in the monotherapy group and 30% of patients in the combination therapy group had a best observed response of stable disease (SD).

Overall response rates such as were seen in this study are common for targeted and cytostatic therapies



Commentary

- Many targeted therapies have shown low overall response rate (ORR) in early-phase studies. This has not precluded some drug candidates from becoming blockbuster commercial products.
- There are several reasons why ORR in phase I is sometimes poorly predictive of eventual clinical benefit:
  1. Phase I studies are typically performed in very advanced patients, who may be resistant to almost any therapeutic intervention.
  2. ORR can be a reasonable measure of cytotoxicity and is therefore more useful in the context of cytotoxic chemotherapy, but it often performs less well when measuring the primarily cytostatic effects of targeted therapies.
  3. Immunotherapies in particular can take longer to show benefit, whereas ORR is typically a relatively early-focused measure.

Sources: D Strumberg et al. (2007) *Oncologist* 12(4):426-437; MS Gordon et al. (2001) *J Clin Oncol.* 19(3); A O'Donnell et al. (2008) *J Clin Oncol.* 26(10); JS Weber et al. (2008) *J Clin Oncol.* 26(36); PM Fracasso et al. (2007) *Clin Cancer Res* 13(3):986-993; company and analyst reports

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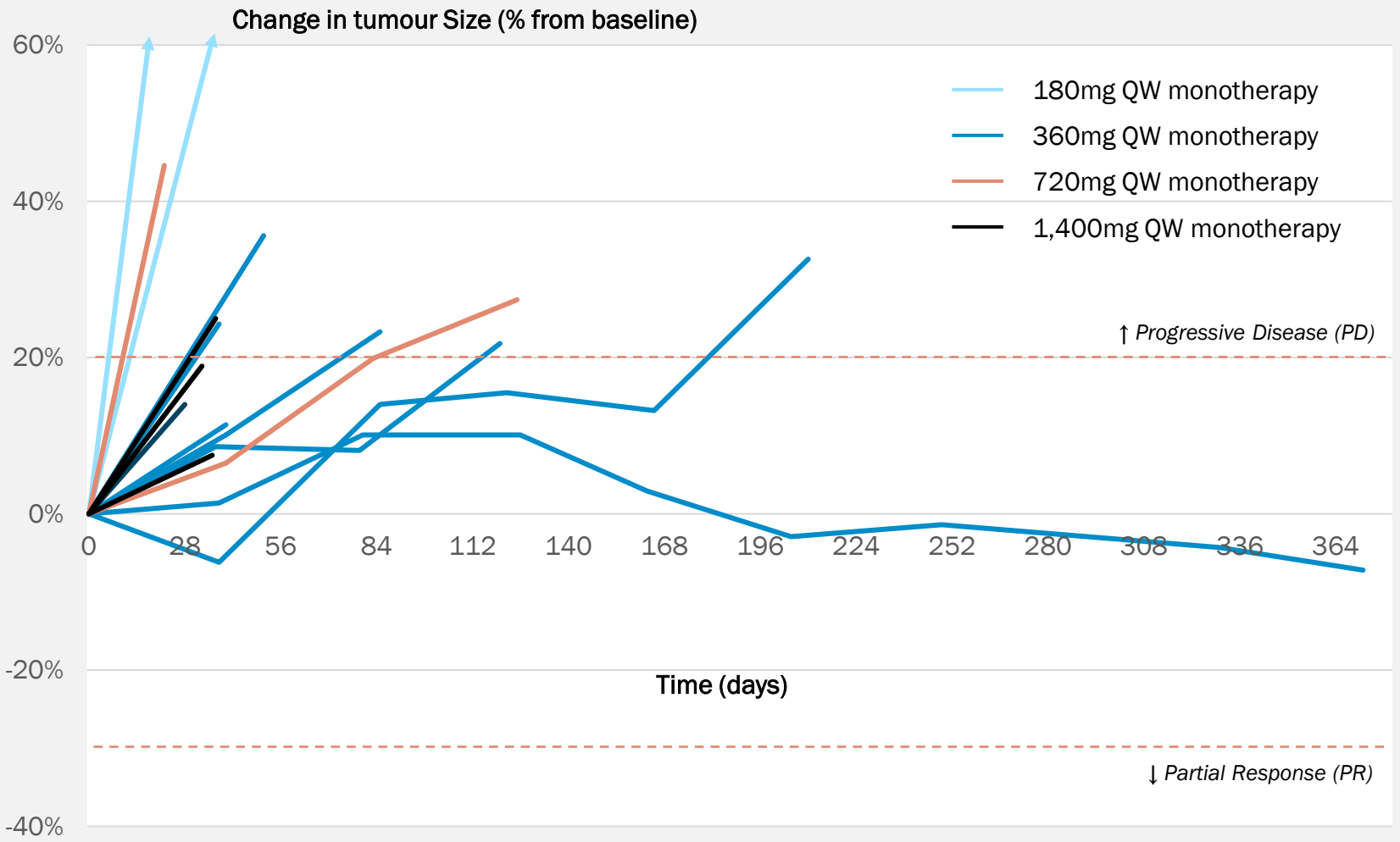
In the monotherapy group, there is a loose association between dose, tumour response, and time on treatment



Commentary

- Patients in the 180mg monotherapy dose group all progressed rapidly. (20, 60, and 120mg doses are not shown for clarity – all patients in these groups progressed rapidly)
- A number of patients in the higher dose groups remained on drug for extended periods of time, including one patient in the 360mg dose group who remained stable for more than one year on treatment.
- The study was not designed to formally assess efficacy, much less to quantify differences between dose cohorts, but the data suggests a trend towards activity in the higher doses.

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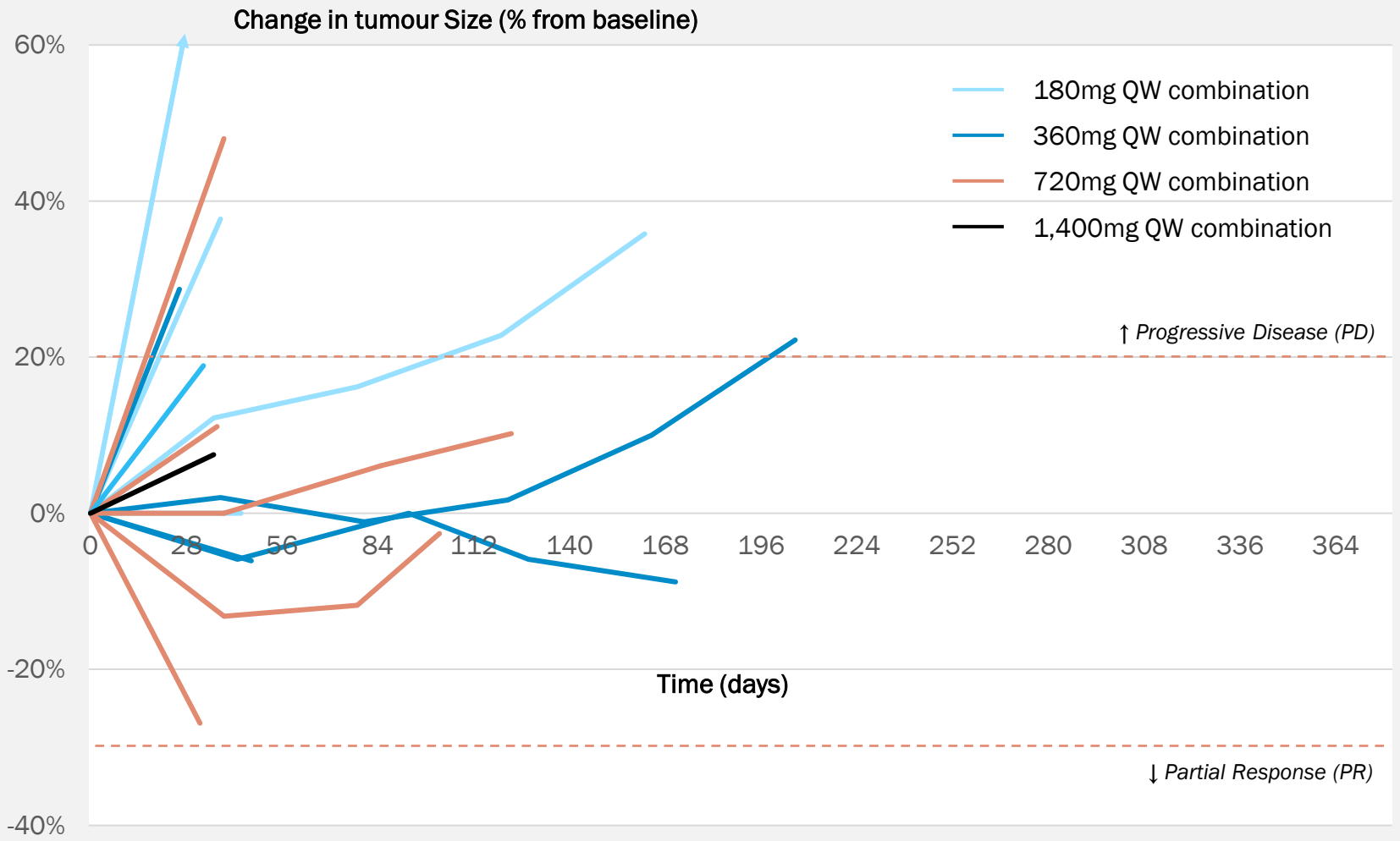
In the combination therapy group, there is a similarly loose association between dose, tumour response, and time on treatment



Commentary

- The 180mg dose again showed limited evidence of activity.
- Higher doses were associated, in some patients, with prolonged periods of stable disease and, in once, case a reduction in tumour size of 27%, which approaches the threshold for a partial response.

Dose Cohort
360mg Monotherapy

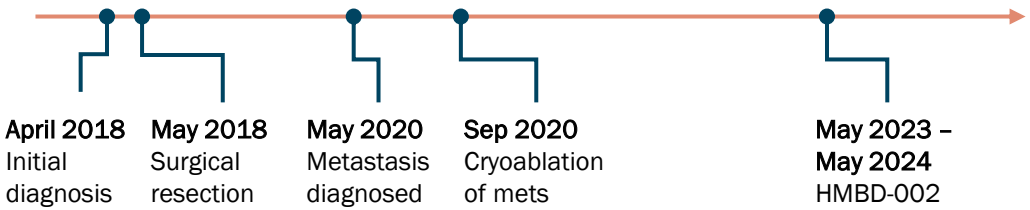
Illustrative Clinical Vignette #1

27-year-old male with metastatic dedifferentiated liposarcoma

Liposarcomas

- tumours originating from fat cells (lipoblasts)
- A type of soft-tissue sarcoma (STS)
- Usually poorly responsive to chemotherapy and immunotherapy
- Dedifferentiated liposarcoma (DD-LPS) accounts for ~25% of liposarcoma cases
- Approximately 700 new cases of DD-LPS per annum are diagnosed in the US
- DD-LPS has a worse prognosis than most other types of LPS, with 5-year survival of approximately 55%

Cancer History



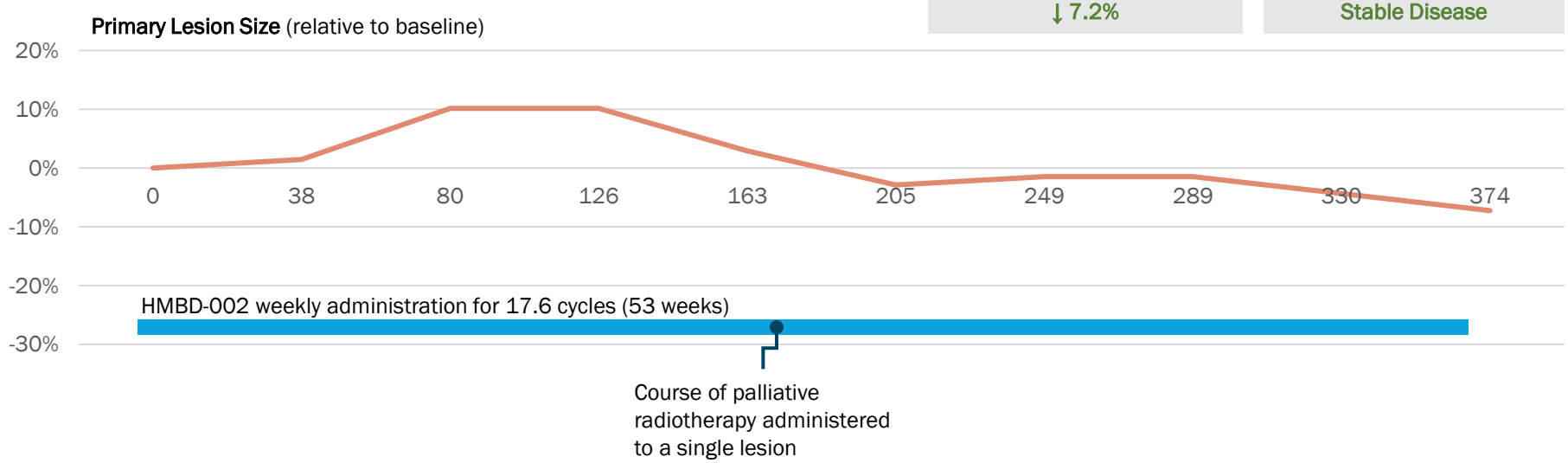
Prior Systemic Cancer Therapies

1	Adriamycin + Ifosfamide	3 months	(adjuvant)
2	Nivolumab + Ipilimumab	2 months	No Response
3	Palbociclib	3 months	No Response

tumour Measurements on Study

Maximum tumour Reduction
↓ 7.2%

Best Observed Response
Stable Disease



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Dose Cohort
360mg Monotherapy

Illustrative Clinical Vignette #2

67-year-old female with metastatic triple-negative breast cancer

Breast Cancer

- The most common cancer in women, with >300,000 new cases pa in the United States
- Triple-negative breast cancer (TNBC) lacks estrogen or progesterone receptors, or HER2 expression, which are the most common targets for treatment
- TNBC represents about 15-20% of breast cancer cases
- TNBC is resistant to many therapies and has a worse prognosis, with more aggressive patterns of metastasis

Cancer History

Aug 2020 Initial diagnosis

Jan 2021 Surgical resection

Mar 2023 Metastasis diagnosed

May 2023 – Dec 2023 HMBD-002

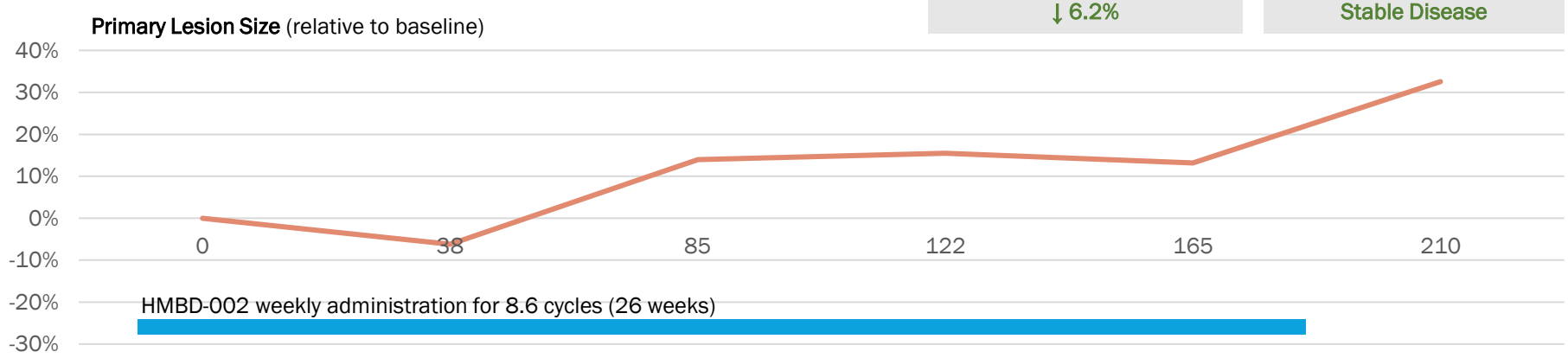
Prior Systemic Cancer Therapies

1	Cyclophosphamide + Doxorubicin + Paclitaxel	3 months	Partial Response
2	Capecitabine	2 months	Toxicity
3	Pembrolizumab	11 months	Stable Disease

tumour Measurements on Study

Maximum tumour Reduction
↓ 6.2%

Best Observed Response
Stable Disease



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Dose Cohort
360mg Combination

Illustrative Clinical Vignette #3

49-year-old male with metastatic non-small-cell lung adenocarcinoma

Lung Cancer

- Most common cancer in the world, with more than 2 million cases diagnosed per annum
- ~85% are non-small-cell cancers (NSCLC) and almost half of those are adenocarcinoma
- Median survival for metastatic NSCLC has historically averaged 12-15 months
- Pembrolizumab has roughly doubled survival in appropriate patients, but almost all eventually develop resistance

Cancer History

April 2021 Initial diagnosis

May 2021 Surgical resection

May 2021 PD-L1 status negative

Oct 2023 – May 2024 HMBD-002

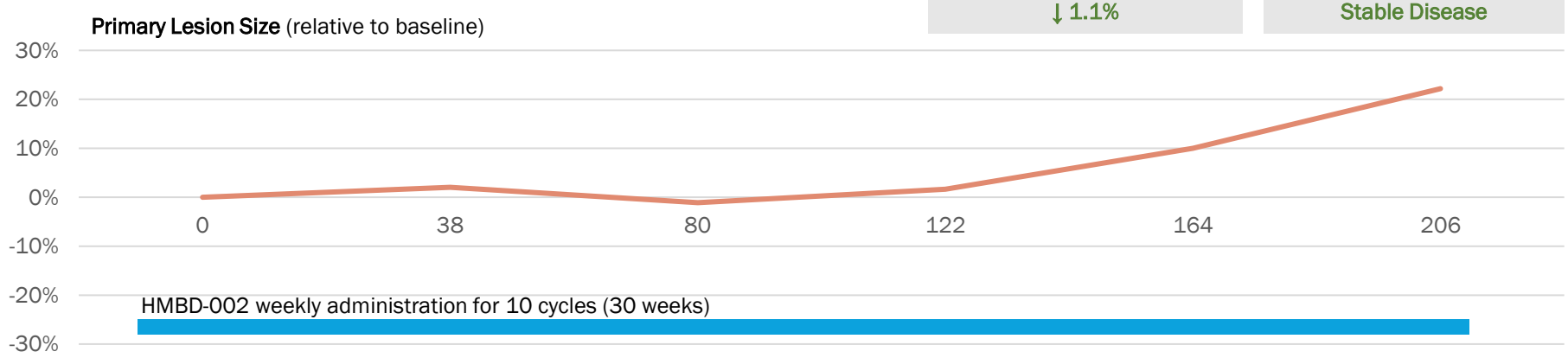
Prior Systemic Cancer Therapies

1	Carbo. + Pem. + Pembro.	1 month	(adjuvant)
2	Bemcentinib + Docetaxel	7 months	Partial Response
3	Pembro. + Pemetrexed	12 months	Partial Response
4	(investigational drug)	4 months	Stable Disease
5	Nivolumab + Ipilimumab	2 months	No Response

tumour Measurements on Study

Maximum tumour Reduction
↓ 1.1%

Best Observed Response
Stable Disease



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Dose Cohort
720mg Combination

Illustrative Clinical Vignette #4

45-year-old female with metastatic triple-negative breast cancer

Breast Cancer

- The most common cancer in women, with >300,000 new cases pa in the United States
- Triple-negative breast cancer (TNBC) lacks estrogen or progesterone receptors, or HER2 expression, which are the most common targets for treatment
- TNBC represents about 15-20% of breast cancer cases
- TNBC is resistant to many therapies and has a worse prognosis, with more aggressive patterns of metastasis

Cancer History

May 2021 Initial diagnosis

June 2021 Metastatic diagnosis

Jan 2024 – Feb 2024 HMBD-002

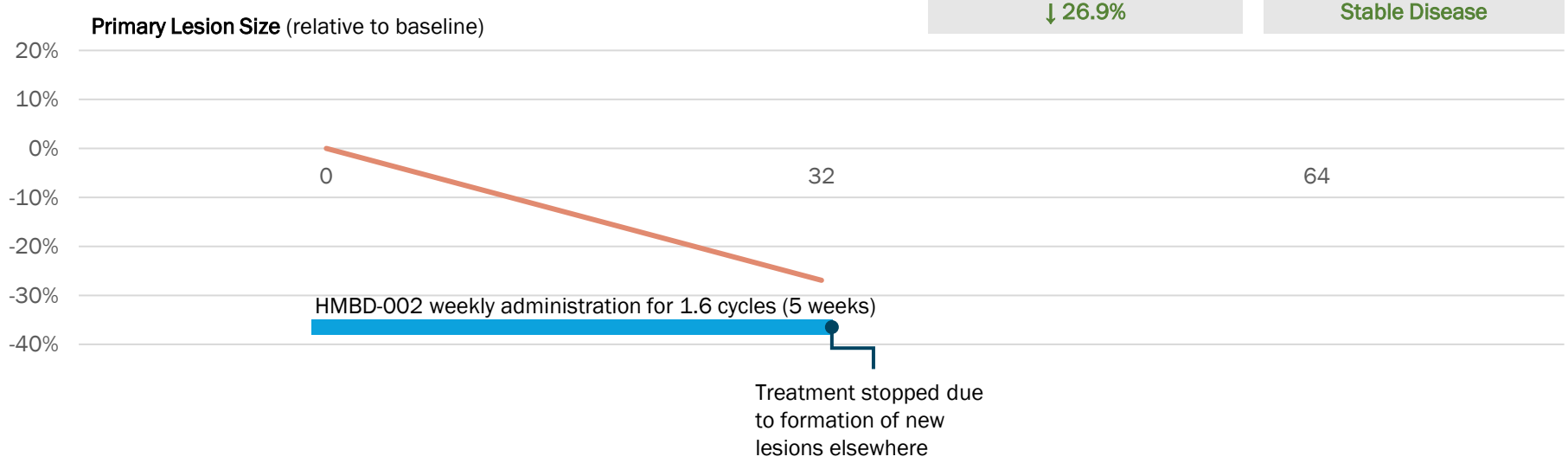
Prior Systemic Cancer Therapies

1	Carbo. + Pem. + Pembro.	1 month	(adjuvant)
2	Bemcentinib + Docetaxel	7 months	Partial Response
3	Pembro. + Pemetrexed	12 months	Partial Response
4	(investigational drug)	4 months	Stable Disease
5	Nivolumab + Ipilimumab	2 months	No Response

tumour Measurements on Study

Maximum tumour Reduction
↓ 26.9%

Best Observed Response
Stable Disease



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Dose Cohort
720mg Combination

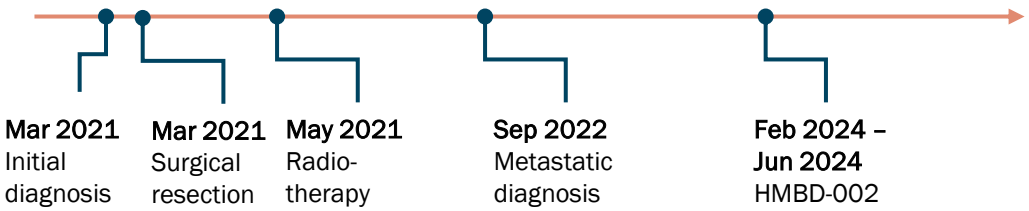
Illustrative Clinical Vignette #5

59-year-old male with metastatic squamous cell cancer of the head & neck

Head & Neck Cancer

- A catch-all term which mainly includes tumours of the mouth and pharynx
- 90-95% of head & neck cancers are of the squamous cell type (SCCHN)
- SCCHN accounts for about 3% of all cancers diagnosed in US, or about 50,000 cases pa
- SCCHN is typically treated with surgery and radiotherapy in the first line

Cancer History



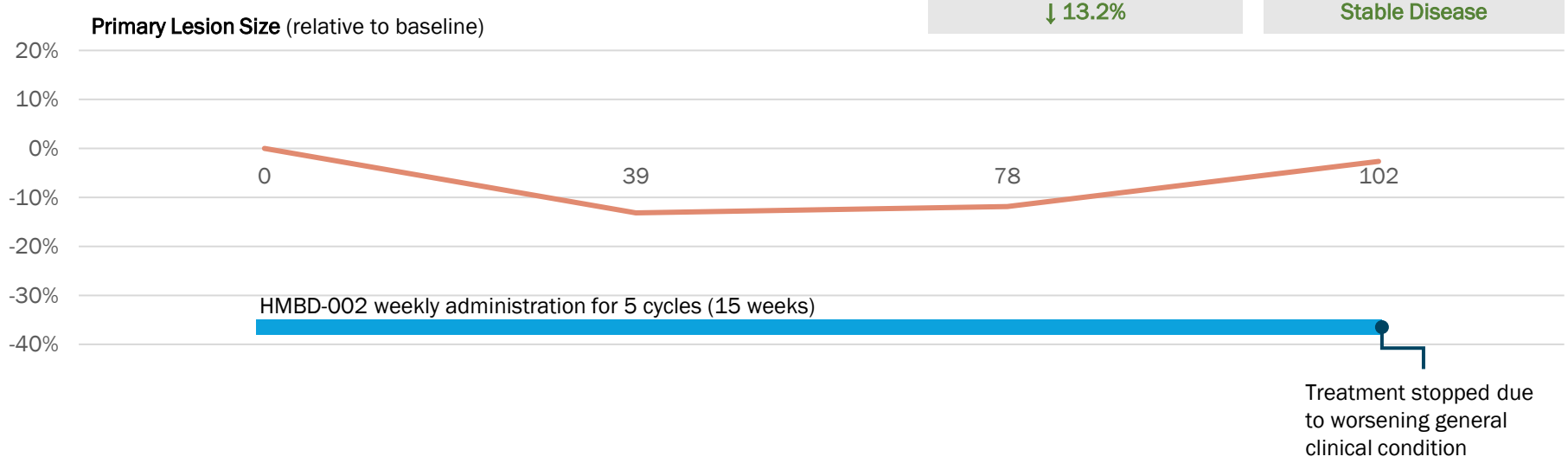
Prior Systemic Cancer Therapies

1	Carbo. + 5FU + Pembro.	4 months	(adjuvant)
2	Magrolimab + Docetaxel	3 months	No Response
3	Cetuximab	12 months	Stable Disease
4	Methotrexate	1 month	No Response

tumour Measurements on Study

Maximum tumour Reduction
↓ 13.2%

Best Observed Response
Stable Disease



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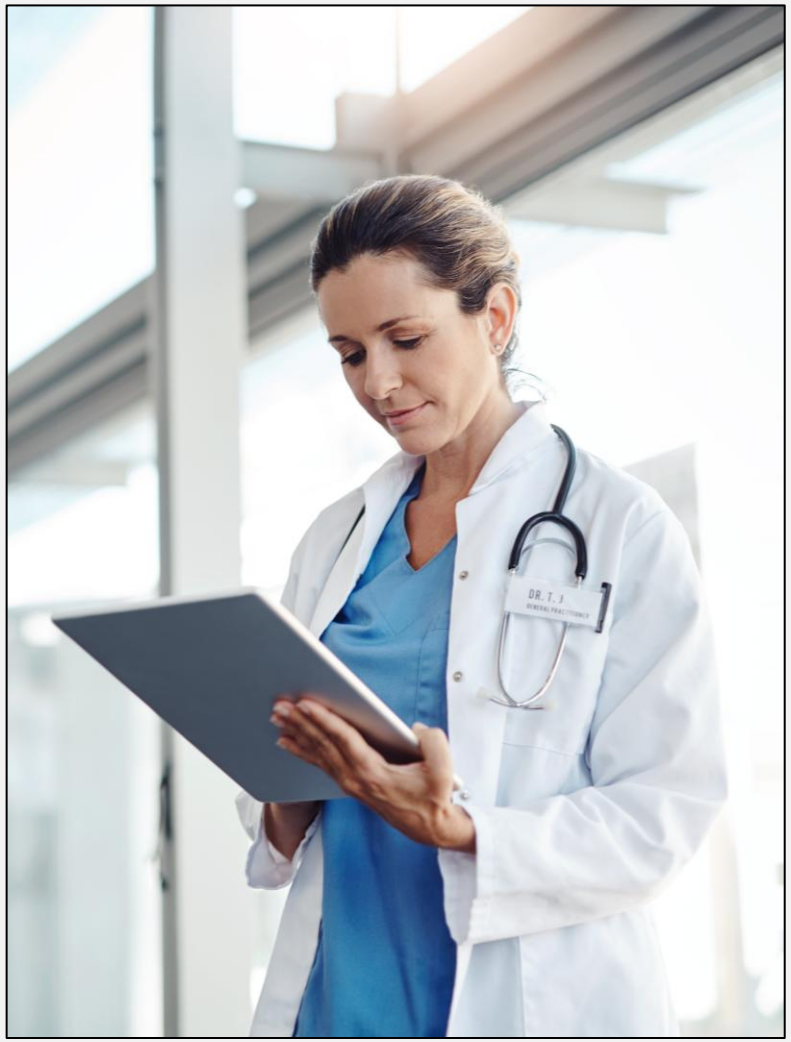
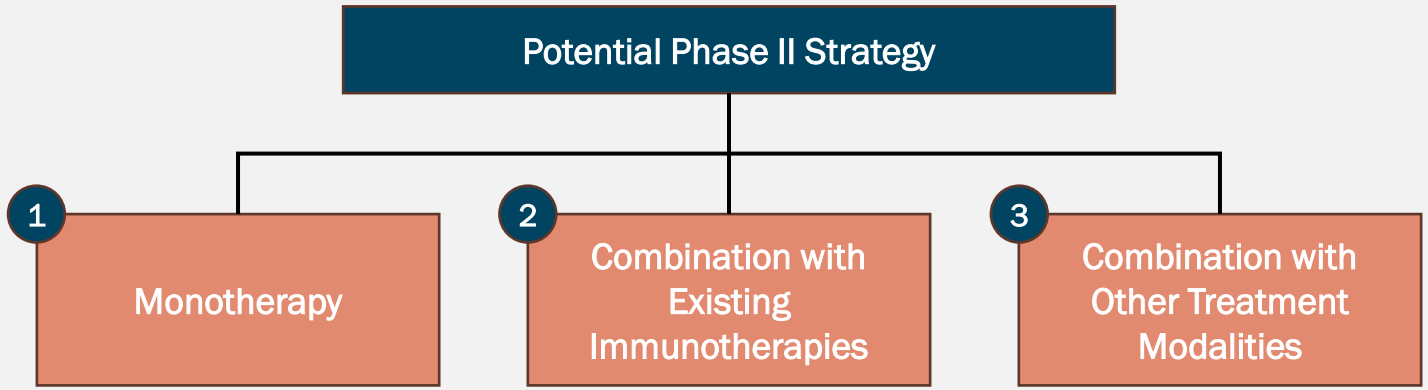
Conclusions & Next Steps

Conclusions

- HMBD-002 appears safe and well-tolerated at doses up to 1,400mg, both as monotherapy and in combination with pembrolizumab.
- The study recruited 48 patients with advanced cancer, most of whom were late-stage and heavily pre-treated, a challenging population in which to demonstrate potential efficacy.
- Nevertheless, a number of patients show disease stabilisation for prolonged periods and / or substantial tumour shrinkage, suggestive of potential clinical benefit.
- Percheron will use the results of this study to inform a planned phase II study, which it aims to commence in CY2026.



Percheron will consult clinicians and advisors in 2H CY2025 to determine the optimal path forward for phase II



- Opportunity to 'enrich' the target population by enrolling patients with high VISTA expression and /or with particular biomarker signatures relating to tumour microenvironment

- Potential to combine with immunotherapies (e.g. Keytruda, Opdivo) during initial treatment or after failure

- Some rationale for combination with, e.g., EGFR inhibitors in NSCLC or SCCHN

Potential to deploy more than one phase II study to explore different 'use cases' of HMBD-002

In oncology, phase II studies are sometimes designed with registrational intent via FDAs 'accelerated approval' pathway

Percheron is focused on moving its pipeline forward expeditiously, with potential for rich, value-generating news flow over FY2026

CY2025		
Release of full phase I data	2H CY2025	✓
Initiate manufacture of new batch of drug substance for clinical trial use	2H CY2025	✓
Publication of new preclinical data in head & neck cancer and in triple-negative breast cancer	2H CY2025	✓
Clinician consultation to determine optimal path(s) forward for HMBD-002 in phase II	2H CY2025	
Disclosure of phase II study design and target tumours	2H CY2025	
CY2026		
Initiation of phase II trial(s) for HMBD-002	CY2026	
Potential application for orphan drug designation with FDA	CY2026	
Potential application for international non-proprietary name for HMBD-002	CY2026	
Potential licensing or acquisition of further pipeline expansion opportunities	CY2026 - 27	

Note: All timelines are indicative and subject to ongoing review

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