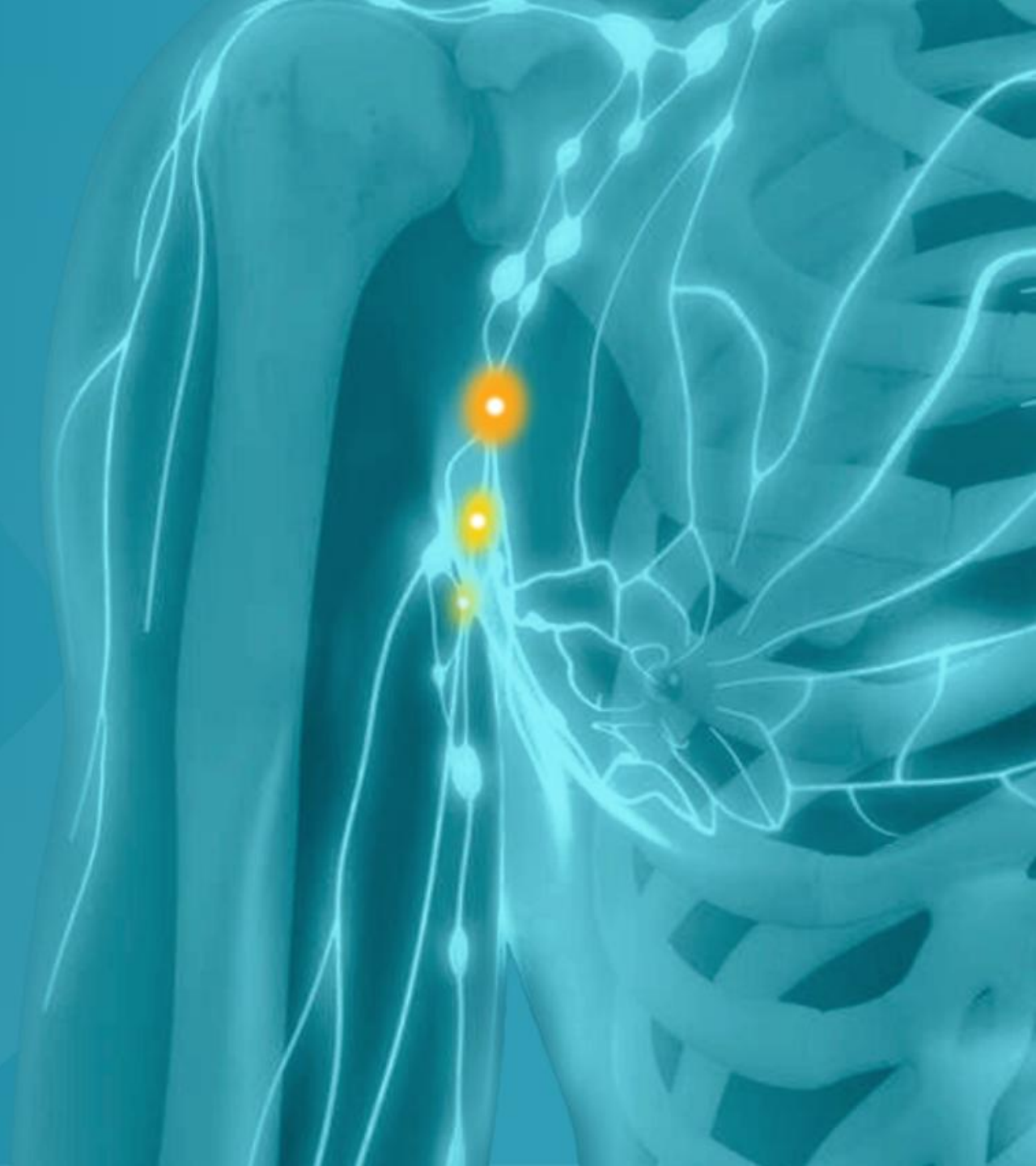




## Targeting the Lymph Nodes to AMPlify Immunotherapy

Nasdaq: ELTX

January 2026



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# Disclaimers

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## Forward-Looking Statements

This presentation contains forward-looking statements as that term is defined in Section 27A of the Securities Act of 1933, as amended, Section 21E of the Securities Exchange Act of 1934, as amended, and the Private Securities Litigation Reform Act of 1995, known as the PSLRA. Statements in this presentation that are not purely historical are forward-looking statements. Such forward-looking statements include, among other things, statements regarding the sufficiency of our existing cash to support planned operations through the second quarter of 2026, our planned clinical programs, including planned clinical trials and the potential of our product candidates, including the potential durable clinical benefits, potential broad application of our product candidates, and potential future growth catalysts, the unmet need and potential addressable market for our product candidates, the potential clinical utility, potential benefits and market acceptance of our product candidates, the potential advantages of our product candidates over those of existing therapeutics and/or those of our competitors, the expected receipt of clinical data, the timing of initiation of our planned clinical trials, the potential for any correlation between the immunogenicity data from the ELI-002 7P Phase 2 trial and clinical efficacy outcomes, and the advancement of and funding for our developmental programs generally. No forward-looking statement can be guaranteed, and actual results may differ materially from those projected. We undertake no obligation to publicly update any forward-looking statement, whether as a result of new information, future events or otherwise, except to the extent required by law. We use words such as “anticipates,” “believes,” “plans,” “expects,” “projects,” “future,” “intends,” “may,” “will,” “should,” “could,” “estimates,” “predicts,” “potential,” “continue,” “guidance,” and similar expressions to identify these forward-looking statements that are intended to be covered by the safe-harbor provisions of the PSLRA. Such forward-looking statements are based on our expectations and involve risks and uncertainties; consequently, actual results may differ materially from those expressed or implied in the statements due to a number of factors, including, but not limited to our financial condition, including our anticipated cash runway; our ability to obtain the funding necessary to advance the development of ELI-002 and any other future product candidates; our ability to continue as a going concern; our plans to develop and commercialize our product candidates, including ELI-002; the timing of initiation of our planned clinical trials, including advancing ELI-007 BRAF and ELI-008 p53 vaccines for Phase 1 readiness; the timing and initiation of investigator-sponsored trials, including studies of ELI-002 7P plus checkpoint inhibitors in pancreatic ductal adenocarcinoma (“PDAC”) and colorectal cancer (“CRC”) and other combinations; the potential timing and outcome of our anticipated ELI-002 7P End of Phase 2 U.S. Food and Drug Administration (“FDA”) meeting; the potential timing and ability to finalize our Phase 3 trial protocol in adjuvant PDAC for ELI-002 7P; the timing of the availability of data from our clinical trials, including the disease-free survival final analysis from the ELI-002 7P Phase 2 trial; the timing of any planned investigational new drug application or new drug application; our plans to research, develop and commercialize its current and future product candidates; and our estimates regarding future revenue, expenses, capital requirements and need for additional financing.

New factors emerge from time to time, and it is not possible for us to predict all such factors, nor can we assess the impact of each such factor on the business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements. These risks are more fully discussed in our Annual Report on Form 10-K filed with the SEC on March 31, 2025, under the heading “Risk Factors”, and any subsequent reports and other documents filed from time to time with the SEC. Forward-looking statements included in this release are based on information available to us as of the date of this release. We do not undertake any obligation to update such forward-looking statements to reflect events or circumstances after the date of this release, except to the extent required by law.

# Investment Highlights

## Clinical-stage Biotech Developing Novel Lymph Node-targeted “off the shelf” Cancer Immunotherapies

### Leveraging proprietary Amphiphile (“AMP”) Technology

- Our proprietary AMP platform is designed to generate robust, functional, and durable immune responses by targeting lymph nodes- the “brain center” of the immune response
- AMP technology delivers antigen-specific payloads directly to lymph nodes to educate, activate, and expand tumor-eliminating T cell populations with broad applicability across cancer immunotherapy
- Proof-of-concept has been demonstrated in two completed Phase 1 trials; a randomized Phase 2 monotherapy study in pancreatic cancer is expected to read out in 1H ‘26

### ELI-002 Lymph Node Targeted mKRAS Cancer Vaccine

- Off-the-shelf immunotherapy candidate targeting the most common KRAS mutations that drive 25% of solid tumors
- Potential monotherapy adjuvant treatment in high relapse-risk mKRAS<sup>+</sup> cancers: pancreatic (PDAC), colorectal (CRC)
- In the ongoing Phase 2 trial ELI-002 7P elicited mKRAS-specific T cell response >44x increased over baseline at the Phase 2 dose without any dose limiting toxicities (DLTs) or serious adverse events (SAEs)
- ELI-002 2P Update in Nature Medicine 2025: full cohort (n=25) **mOS of 28.9 months; mRFS of 16.3 months**

### Value-creating catalysts and capitalization

- ELI-002 7P Phase 2 trial: Disease-free survival interim analysis completed in Q3 ‘25; final analysis expected in 1H ‘26
- ELI-002 7P end of Phase 2 FDA meeting to be requested upon final DFS analysis
- Investigator-sponsored trials of ELI-002 + checkpoint inhibitors (CPI) in PDAC and CRC and other combinations
- Cash runway expected to support operations through Q2 2026 beyond Phase 2 final data analysis expected in 1H ‘26

# Seasoned Management Team



**Robert Connelly**

Chief Executive Officer



**Peter DeMuth, PhD**

Chief Scientific Officer



**Christopher Haqq, MD, PhD**

Executive Vice President, Head of Research and Development, Chief Medical Officer



**Preetam Shah, MBA, PhD**

Chief Strategy and Financial Officer



**Megan Filoon, JD**

General Counsel, Secretary and Compliance Officer



**Marc Wolfgang, MS**

Chief Technology Officer



# Company Pipeline

Innovative Pipeline of Cancer Immunotherapies Addressing Critical Unmet Needs

Candidate	Target	Indication	Setting	Preclinical	IND Ready	Phase 1	Phase 2	Phase 3
ELI-002 7P	mKRAS	PDAC	Adjuvant					
ELI-002 7P	mKRAS	CRC	Adjuvant					
ELI-002 7P	mKRAS	CRC	Metastatic					
ELI-002 7P + CPI	mKRAS	PDAC	Neoadjuvant PDAC					
ELI-004 + Radiation	Soft Tissue Sarcoma	Metastatic						
ELI-007	mBRAF	GI Tumors						
ELI-008	mTP53	GI Tumors						



CRC: colorectal carcinoma | PDAC: pancreatic ductal adenocarcinoma

mKRAS: mutant Kirsten rat sarcoma | mBRAF: mutant homolog B of the Rapidly Accelerated Fibrosarcoma | mTP53: mutant tumor protein p53

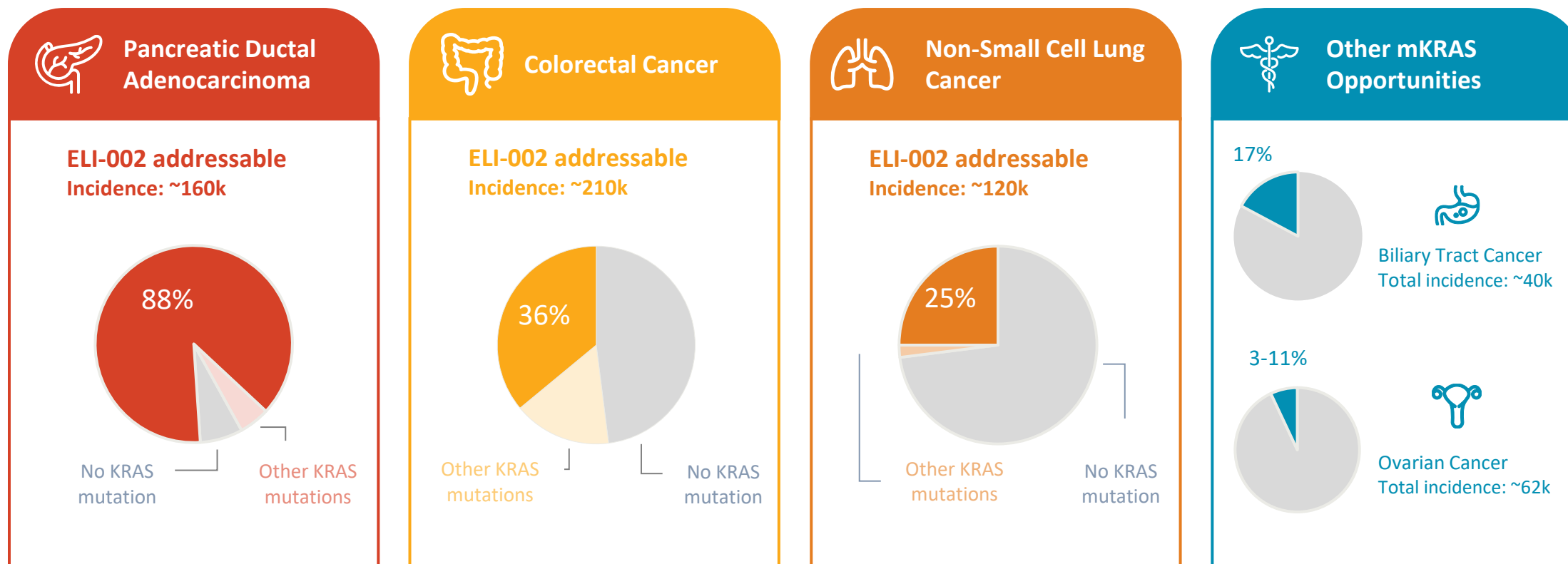
IIT: Investigator initiated trial

<sup>1</sup> Planned and Advancing programs are subject to funding

# The Annual Addressable KRAS-mutant Market – A Significant Opportunity

ELI-002 7P Targets the 7 Most Common KRAS Mutations Driving 25% of Solid Tumors

## The Annual Incidence of KRAS mutated cancers in US, EU5 and Japan:



Incidence for the 7 Major Markets (MM): US, France, Germany, Italy, Spain, UK, and Japan; [Pancreatic cancer statistics | World Cancer Research Fund](#); [Lung cancer statistics | World Cancer Research Fund](#); [Colorectal cancer statistics | World Cancer Research Fund](#)

PDAC: 90% of pancreatic cancers (O'Reilly, 2021), NSCLC 84.3% of lung cancers (SEER, 2021), BTC: 15% of liver cancers + gallbladder

Sources for KRAS mutation data: Waters & Der, 2018; Ji Luo, 2021, Meng 2021; Hofmann 2022, AACR Project GENIE Registry; Froesch et al, 2022, Gordon et al, 2023



# ELI-002's Differentiated Approach to mKRAS Therapy

Validated mKRAS Target | Differentiated Vaccine Approach | Clinical Stage



## Small Molecules Inhibiting Mutant KRAS

- > FDA approvals for LUMAKRAS® & KRAZATI® validate target
- > Mirati: \$4.8B acquisition by BMS
- > Revolution Medicine: \$2B for future royalties on P3 Daraxonrasib program

**BUT**

- > • Approved agents only affect 1 mutation (G12C), subject to multiple resistance mechanisms
- Limited duration of clinical benefit



## Personalized Cancer Vaccines Targeting Private Tumor Neoantigens

- > Significant progress and investment in vaccine product development:
  - Moderna / Merck: KeyNote-942
  - BioNTech / Roche: Autogene Cevumeran
- > Validates clinical utility of cancer vaccines in adjuvant settings

**BUT**

- > • Manufacturing is long + costly
- Targets non-essential mutations
- Combination with CPI needed

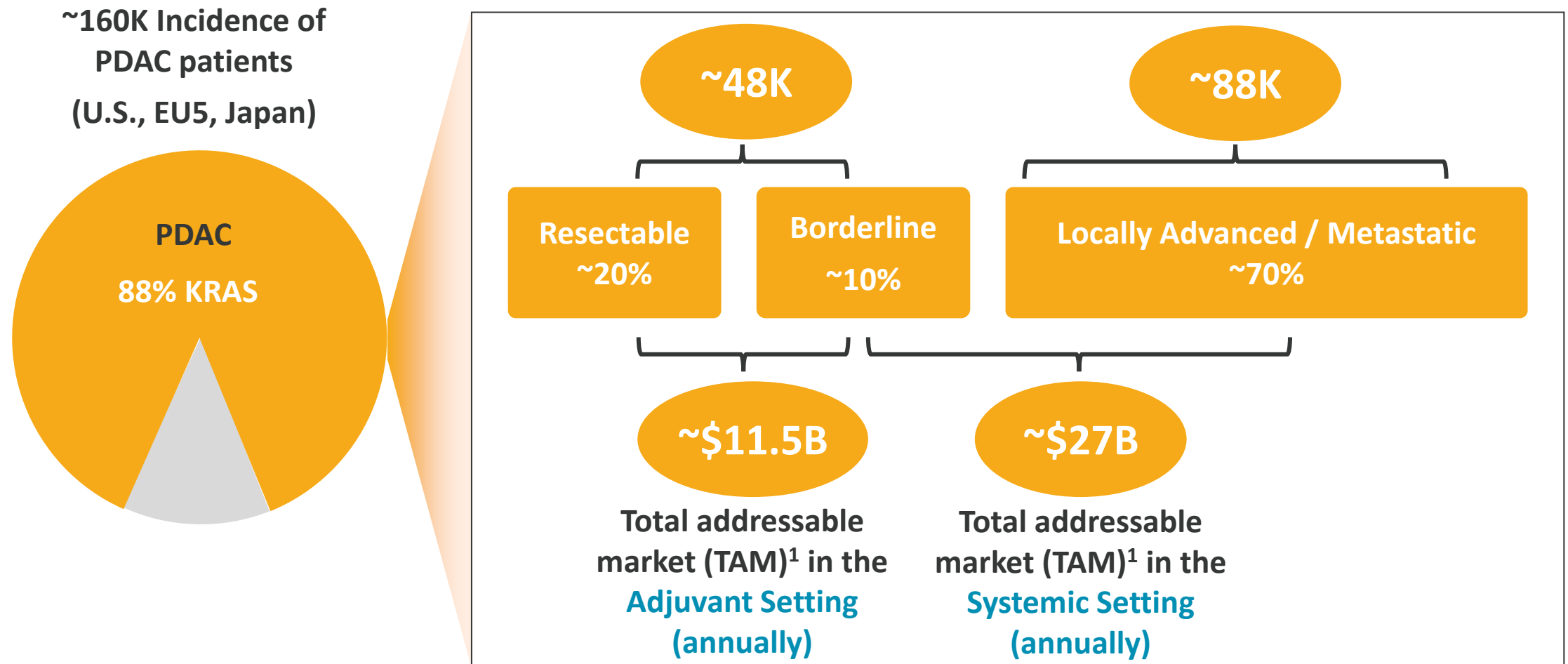


## Lymph Node Targeted Vaccine Targeting Mutant KRAS

- ✓ Promising P1 data in PDAC and CRC
- ✓ Targeting 7 mKRAS driver mutations
- ✓ Lymph Node Targeting MoA
- ✓ Off-the-shelf simplicity, COGs
- ✓ Robust T cell Response (CD4 + CD8)
- ✓ Monotherapy activity
- ✓ Potential durable clinical benefit
- ✓ Potential broad application for ~25% of human solid cancers expressing mKRAS

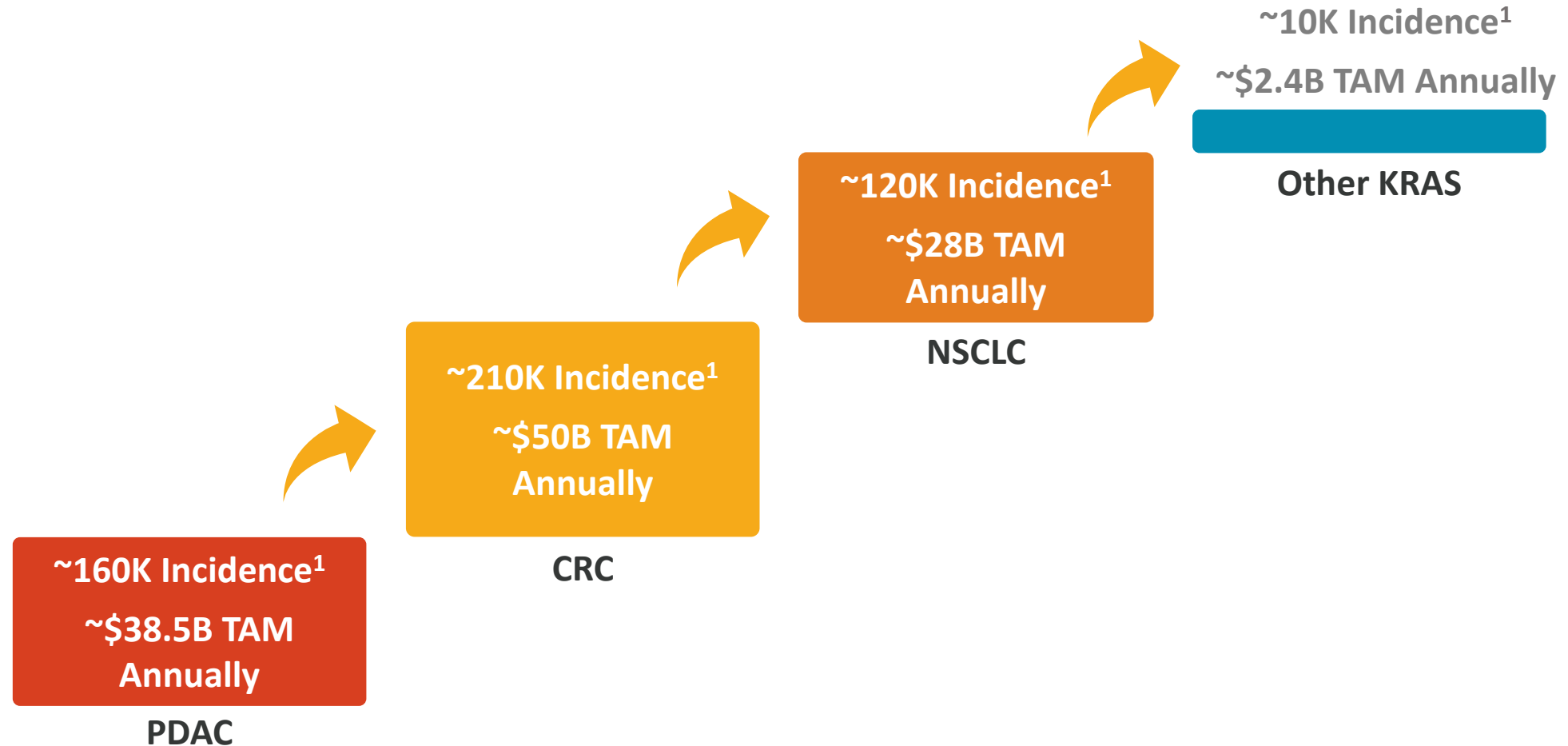


# Annually ELI-002 7P has a Potential to Address ~48K PDAC Patients with its Initial Indication, and an Additional ~88K Patients with Subsequent Indications



<sup>1</sup>Assumes \$240K overall cost of therapy per patient. Benchmark for KRAS therapy: Lumakras monthly cost of therapy ~\$20K/month annualized ~\$240K (<https://tinyurl.com/s8s6wfcj>); Average cost of cancer immunotherapy ~\$250K (<https://tinyurl.com/ymvzft5f>)  
Incidence for the 7 Major Markets (MM): US, France, Germany, Italy, Spain, UK, and Japan; Sources for tumor incidence obtained from GLOBOCAN (2020). PDAC: 90% of pancreatic cancers (O'Reilly, 2021), NSCLC 84.3% of lung cancers (SEER, 2021), BTC: 15% of liver cancers + gallbladder; Sources for KRAS mutation data: Waters & Der, 2018; Ji Luo, 2021, Meng 2021; Hofmann 2022, AACR Project GENIE Registry; Froesch et al, 2022, Gordon et al, 2023. TAM = Total Addressable Market; CRC: colorectal carcinoma, PDAC: pancreatic ductal adenocarcinoma, NSCLC: Non small cell lung cancer, KRAS: Kirsten rat sarcoma. % of PDAC patients in each category: Soweid et.al., 2017; Park et. Al. 2021; Audlin et. al, 2021.  
Incidence for the 7 Major Markets (MM): US, France, Germany, Italy, Spain, UK, and Japan; [Pancreatic cancer statistics | World Cancer Research Fund](#); [Lung cancer statistics | World Cancer Research Fund](#); [Colorectal cancer statistics | World Cancer Research Fund](#)

# Beyond PDAC, ELI-002 7P has Significant Potential to Transform the Care of KRAS Mutant Cancers



<sup>1</sup>Assumes \$240K overall cost of therapy per patient. Benchmark for KRAS therapy: Lumakras monthly cost of therapy ~\$20K/month annualized ~\$240K (<https://tinyurl.com/s8s6wfcj>); Average cost of cancer immunotherapy ~\$250K (<https://tinyurl.com/ymvzft5f>) Incidence for the 7 Major Markets (MM): US, France, Germany, Italy, Spain, UK, and Japan; Sources for tumor incidence obtained from GLOBOCAN (2020). PDAC: 90% of pancreatic cancers (O'Reilly, 2021), NSCLC 84.3% of lung cancers (SEER, 2021), BTC: 15% of liver cancers + gallbladder; Sources for KRAS mutation data: Waters & Der, 2018; Ji Luo, 2021, Meng 2021; Hofmann 2022, AACR Project GENIE Registry; Froesch et al, 2022, Gordon et al, 2023. TAM = Total Addressable Market; CRC: colorectal carcinoma, PDAC: pancreatic ductal adenocarcinoma, NSCLC: Non small cell lung cancer, KRAS: Kirsten rat sarcoma. % of PDAC patients in each category: Soweid et.al., 2017; Park et. Al. 2021; Audlin et. al,2021. Incidence for the 7 Major Markets (MM): US, France, Germany, Italy, Spain, UK, and Japan; [Pancreatic cancer statistics | World Cancer Research Fund](#); [Lung cancer statistics | World Cancer Research Fund](#); [Colorectal cancer statistics | World Cancer Research Fund](#)

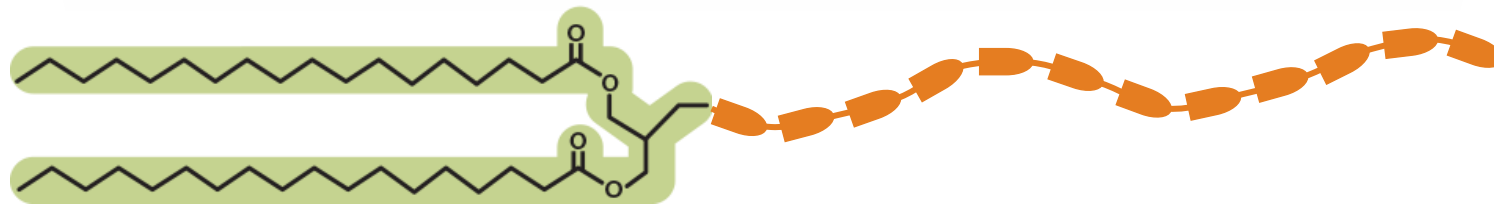
The background is a solid blue color with several large, overlapping, organic shapes in a lighter shade of blue, creating a layered, abstract effect.

# Targeting the Lymph Nodes to Orchestrate Immunity

## Amphiphile (AMP) Platform

# Amphiphile (AMP) Platform Enables Lymph Node Delivery with Simple and Versatile Application

**AMP: A Modular Chemical Conjugation Approach for Delivery of Immune Therapeutics to the Lymph Nodes**



1

Albumin Binding Lipid

- ✓ Lymph Node Delivery
- ✓ Lymph Node Retention

2

Polymeric Linker

- ✓ Improved Solubility
- ✓ Controlled Payload Release

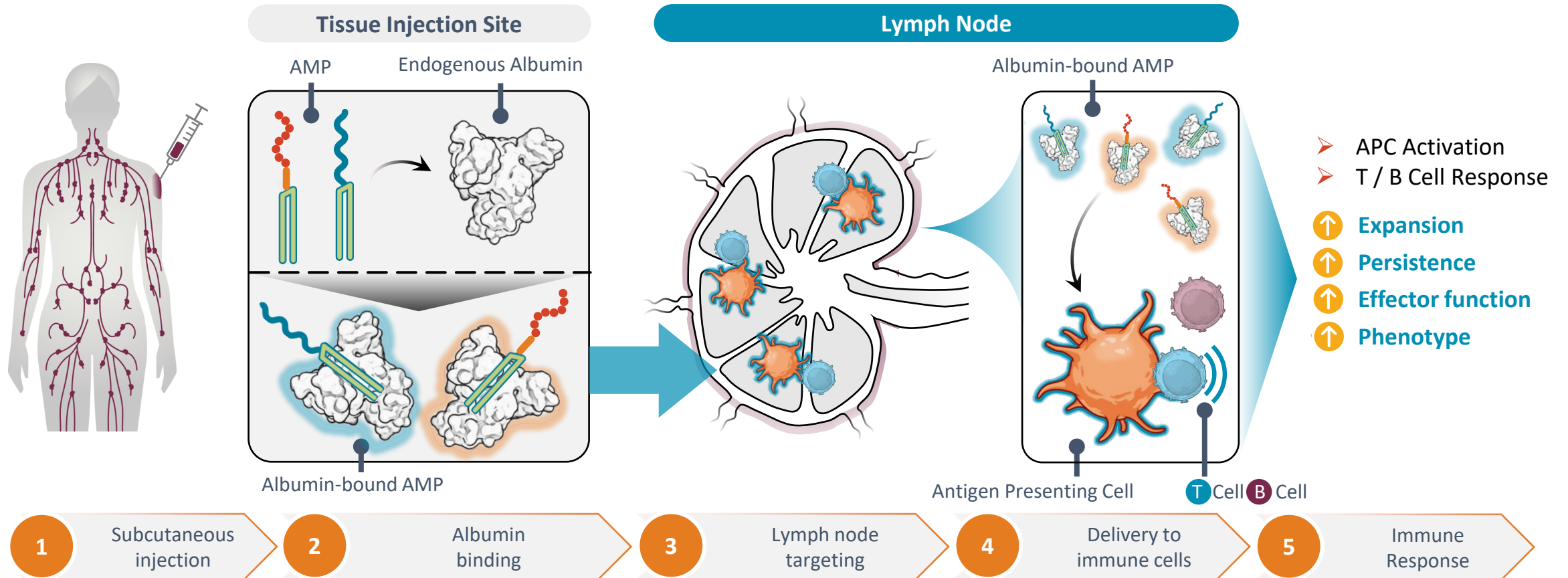
3

Payload

- ✓ Antigens
- ✓ Adjuvants

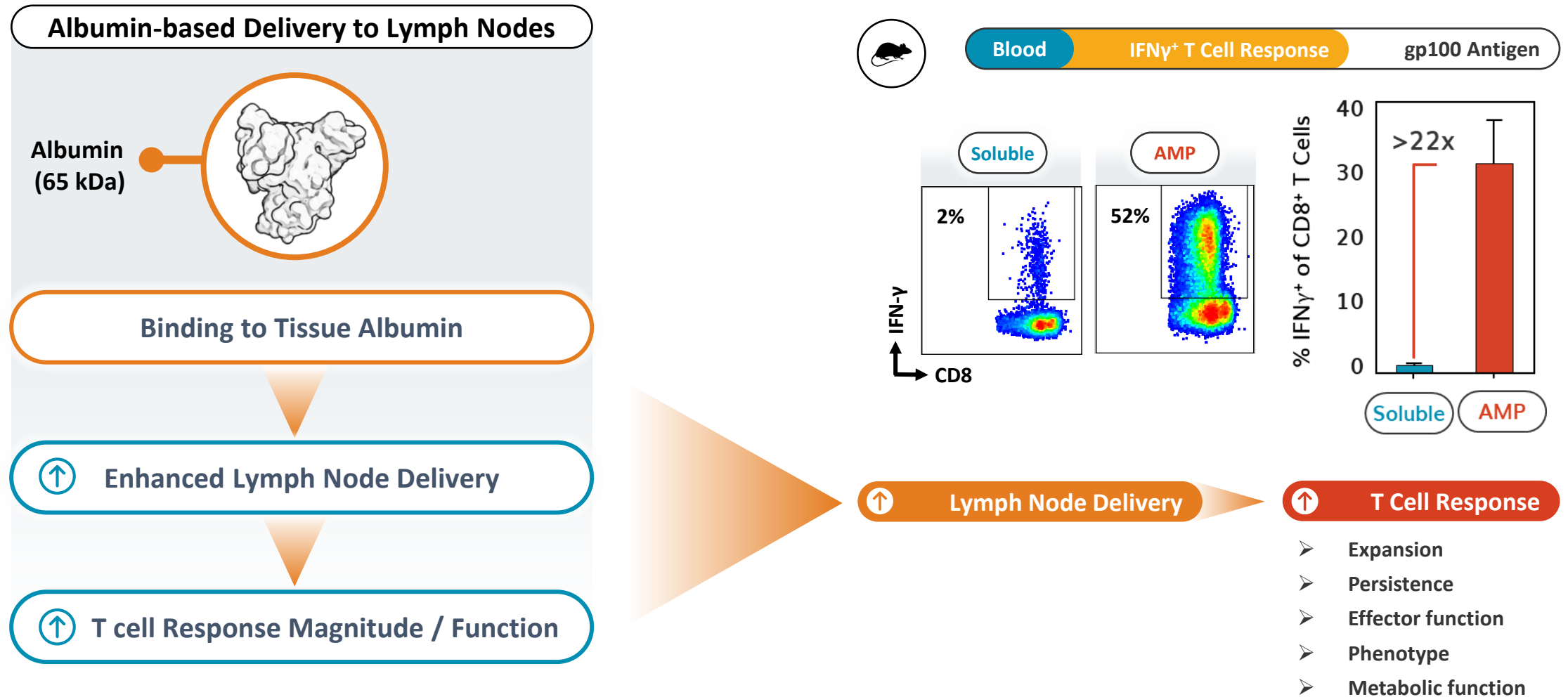
- Immune Modulating
- Small Size (<50 kDa)
- Validated Activity

# MOA: Targeting the Lymph Nodes with AMP to Orchestrate Immunity



# AMP-vaccination Induces Coordinated Immune Activation in Lymph Nodes

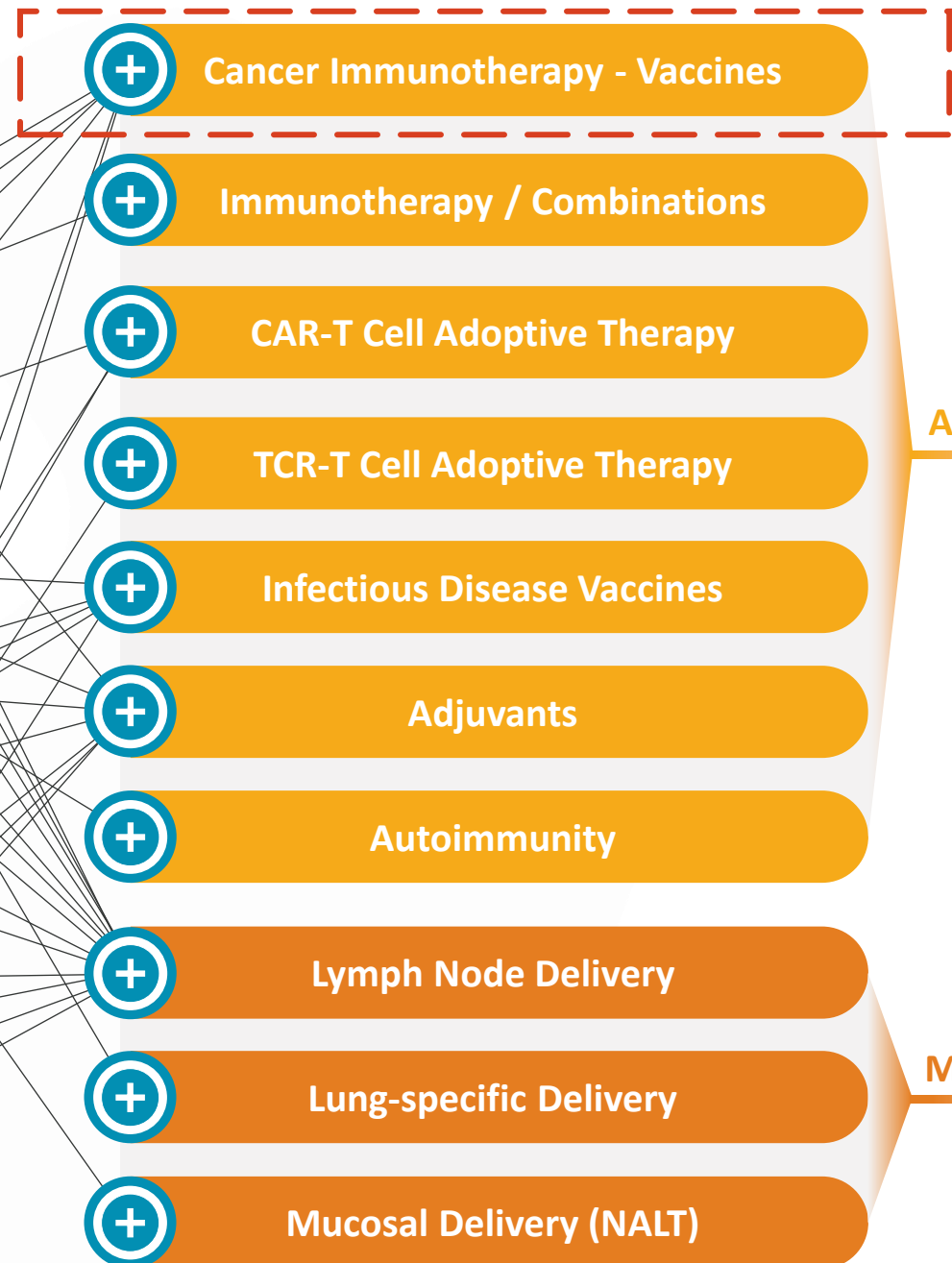
Enhanced Antigen-specific T cell Response Magnitude and Functional Quality



# AMP Platform Technology

Versatile | Simple | Clinical Stage

	2014	Liu	Nature	---	●
	2016	Moynihan	Nature Medicine	---	●
	2018	Moynihan	Cancer Immunology Research	---	●
	2019	Ma	Science	---	●
	2021	Rakhra	Science Immunology	---	●
	2021	Steinbuck	Science Advances	---	●
	2021	Li	J Immunology	---	●
	2023	Dasari	Nature Communications	---	●
	2022	Hartwell	Science Translational Medicine	---	●
	2022	Seenappa	NPJ Vaccines	---	●
	2023	Ma	Cell	---	●
	2023	Zhang	Nature Biomedical Engineering	---	●
	2024	Drakes	Cancer Immunology Research	---	●
	2024	Pant	Nature Medicine	---	●
	2024	Steinbuck	BioRxIV	---	●
	2025	Wainberg	Nature Medicine	---	●



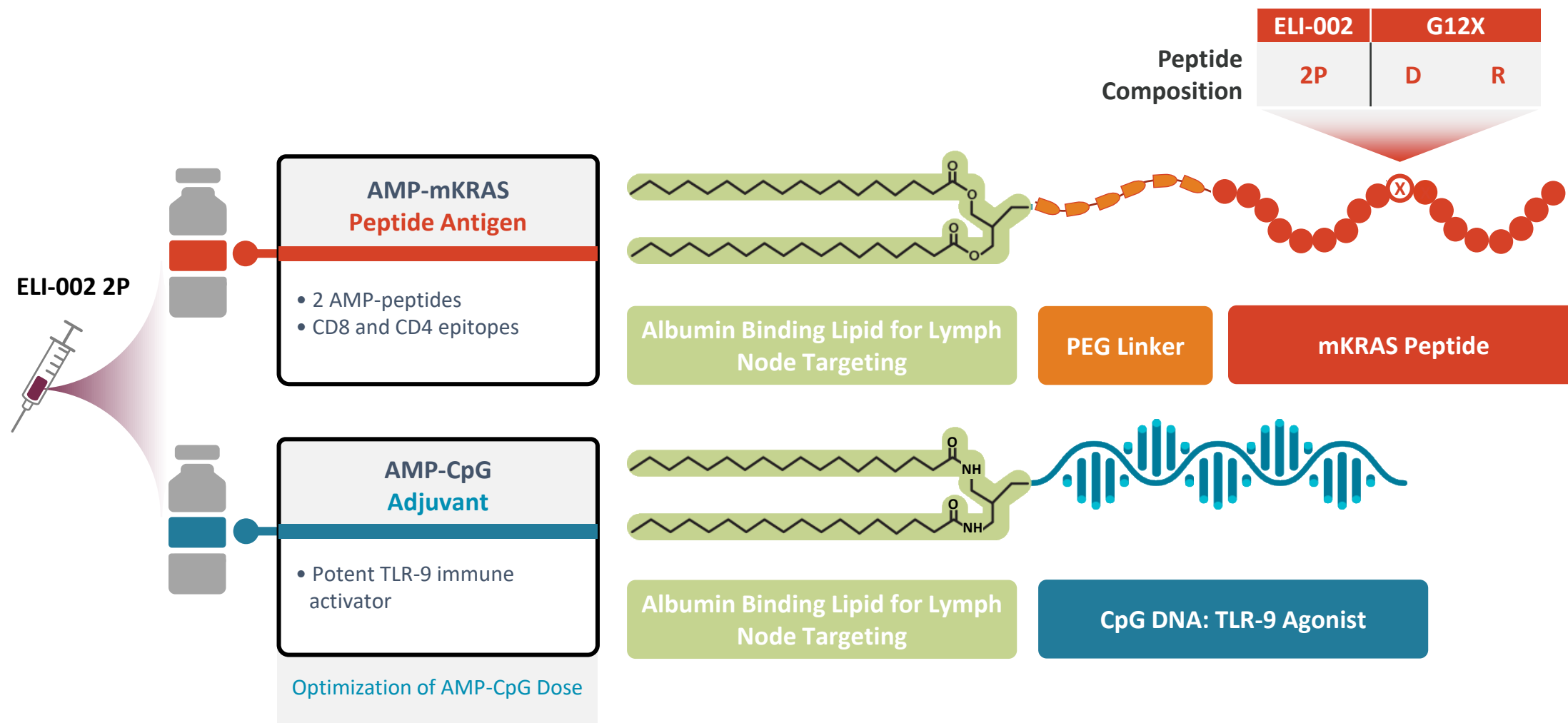


Boosting Endogenous Anti-tumor Immunity Targeting  
mKRAS

ELI-002 2 Peptide (2P) Formulation

# ELI-002 2 Peptide (2P) Is a Lymph Node Targeted mKRAS Vaccine

Proprietary AMP-CpG Adjuvant Shown to Enhance Immunogenicity in Early-Stage Trials



# ELI-002 2 Peptide Phase 1 Study Overview

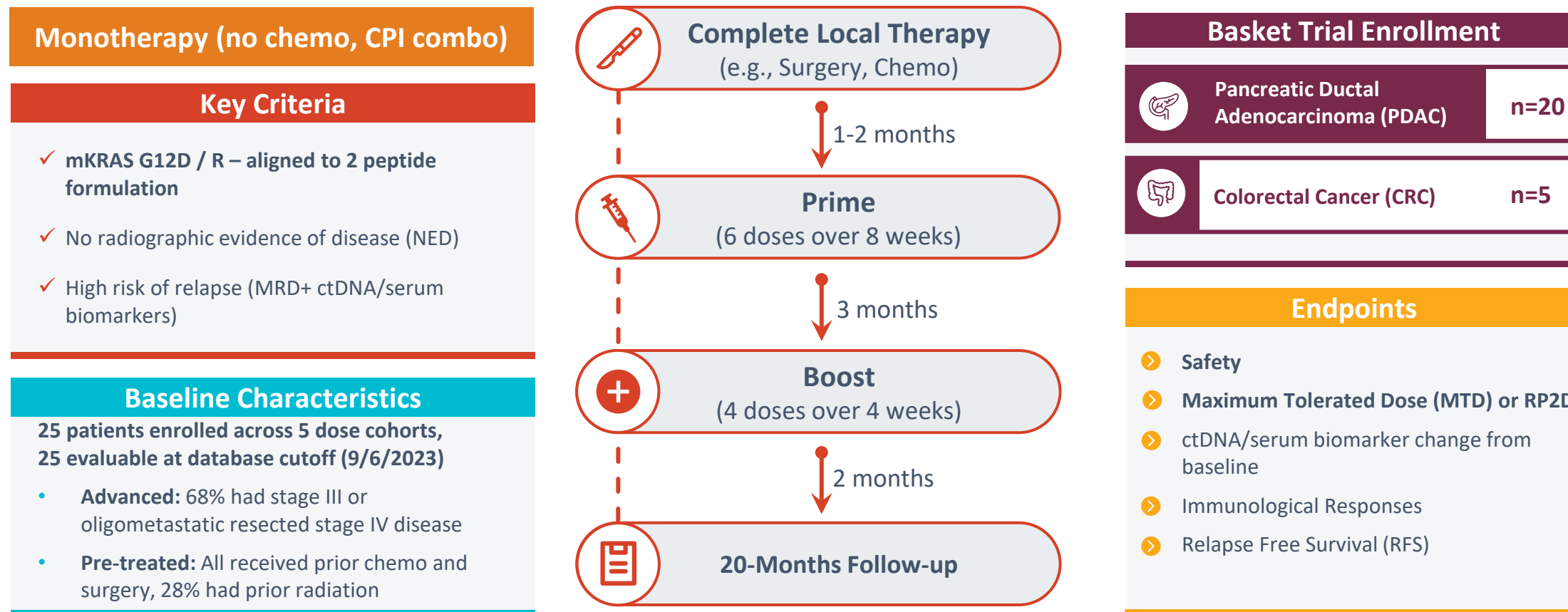
\*Published in Nature Medicine

ELI-002 2P

Phase 1A

Phase 1 adjuvant dose-ranging study to assess safety and efficacy of ELI-002 2P in patients who completed standard therapy and have molecular disease

## ELI-002 MONOTHERAPY: NCT04853017



Phase 1 (AMPLIFY-201) study of ELI-002 2P published in Nature Medicine January 2024 and August 2025

Pant, O'Reilly, et al. Nature Medicine. 2024; Wainberg, O'Reilly, et al. Nature Medicine. 2025

# ELI-002 2P Induces Tumor Biomarker Declines in Majority of Phase 1a Patients

ELI-002 2P

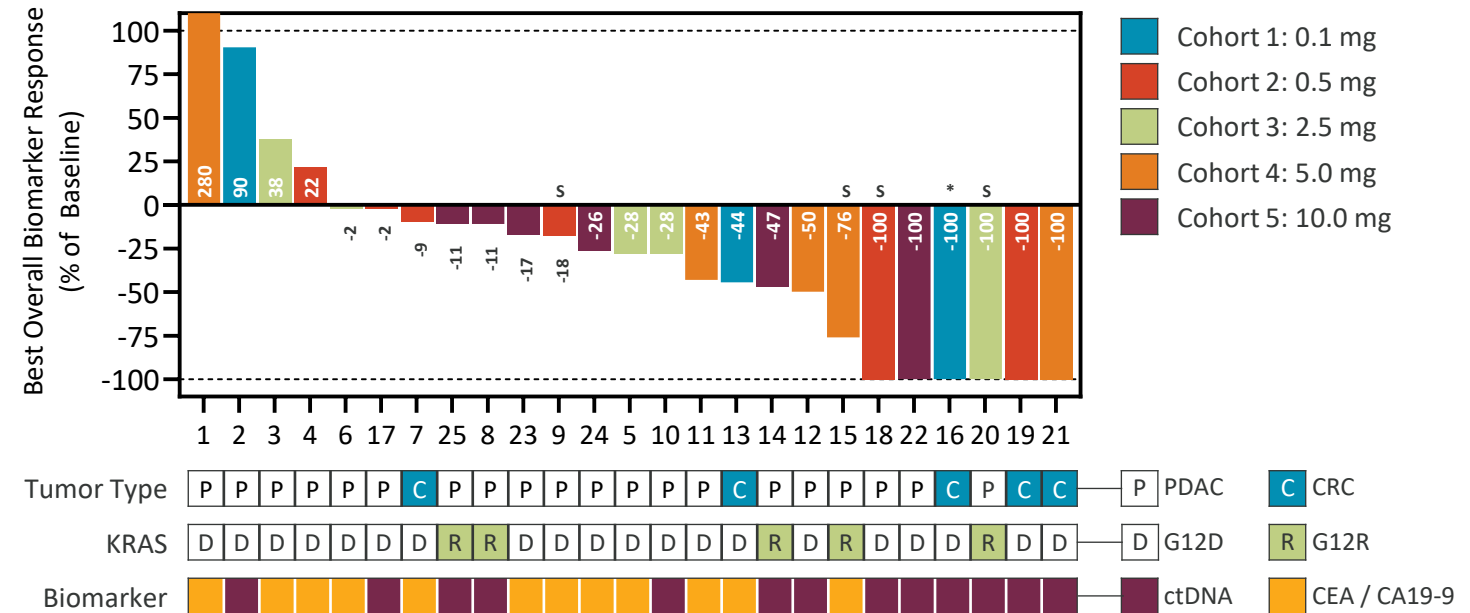
Phase 1A

Robust responses observed across tumor types and KRAS mutations with ELI-002 monotherapy

## Tumor Biomarker Responses

- Waterfall displays best response of ctDNA or serum tumor biomarker
- Most patients (84%, 21/25) showed decline from baseline in ctDNA or CEA/CA19-9 levels
- 24% of patients (6/25) showed complete clearance of ctDNA
- Responses observed in PDAC and CRC, mKRAS G12D and G12R
- Responses observed despite prior splenectomy (S annotated)

ELI-002 2P Waterfall Plot: Biomarker Reduction/Clearance



\* Patient biopsied, exhibited T cell infiltration and continued study treatment

S Patient underwent splenectomy

Data cutoff 6-Sept-23

# ELI-002 2P Elicits Robust Immune Responses in Majority of Phase 1a Patients

ELI-002 2P

Phase 1A

84% of patients generated mKRAS-specific T cells directly ex vivo; 100% at RP2D

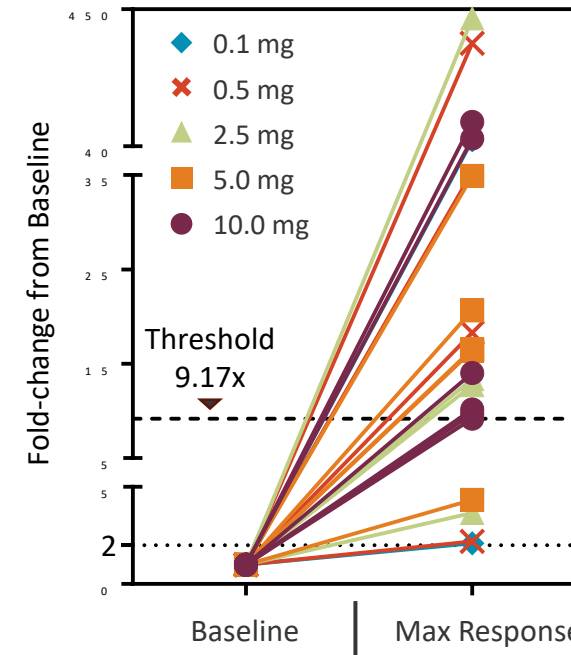
## mKRAS T Cell Responses

- T cells detectable by standard direct ex vivo FluoroSpot and flow cytometry, with no expansion required
- 84% of patients showed T cell responses; 100% at the RP2D (10 mg)
- 58.6x average fold-change in T cell numbers from baseline (median 13.38; range 2-423x)
- 71% of patient responses included both CD4 and CD8 T cells
- De novo T cell priming and memory cell expansion
- Responses were observed across diverse HLA backgrounds

**Increasing adjuvant concentrations were tested:**  
10.0 mg adjuvant was identified as the optimal adjuvant concentration.

## ELI-002 2P T Cell Fold-Changes

### Direct Ex Vivo T Cell Response



Responses shown are best overall responses vs baseline for each patient at any timepoint during the assessment period; Data cutoff 24-Sept-24

# ELI-002 2P: T cell Response Magnitude Correlates with Tumor Biomarker Response

ELI-002 2P

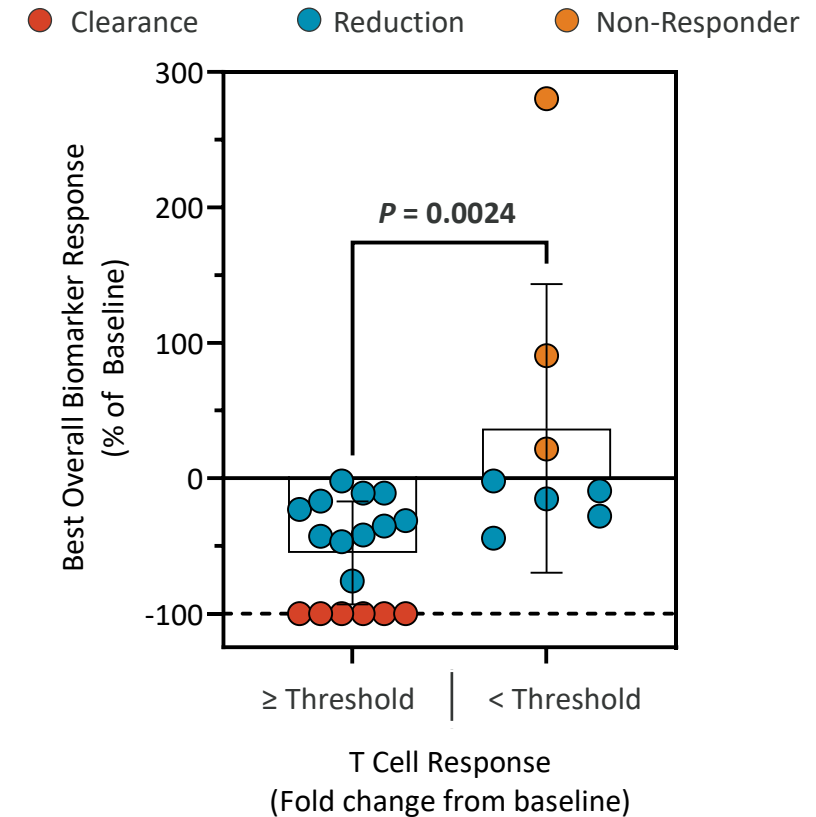
Phase 1A

All patients with T cell responses over the threshold 9.17x showed tumor biomarker response

## mKRAS T Cell Response ➔ Tumor Biomarker Response

- Strength of T cell response to ELI-002 is strongly correlated to tumor biomarker response
- **100% of patients in the above-threshold T cell group responded to ELI-002, compared to 62.5% (5/8) in the below-threshold group**
- All (100%) of the observed tumor biomarker clearances (6/6) are in the above threshold T cell group
- Statistically significant per Mann Whitney Test ( $P < 0.0024$ )

## Best Overall Tumor Biomarker Response



Data cutoff 24-Sept-24

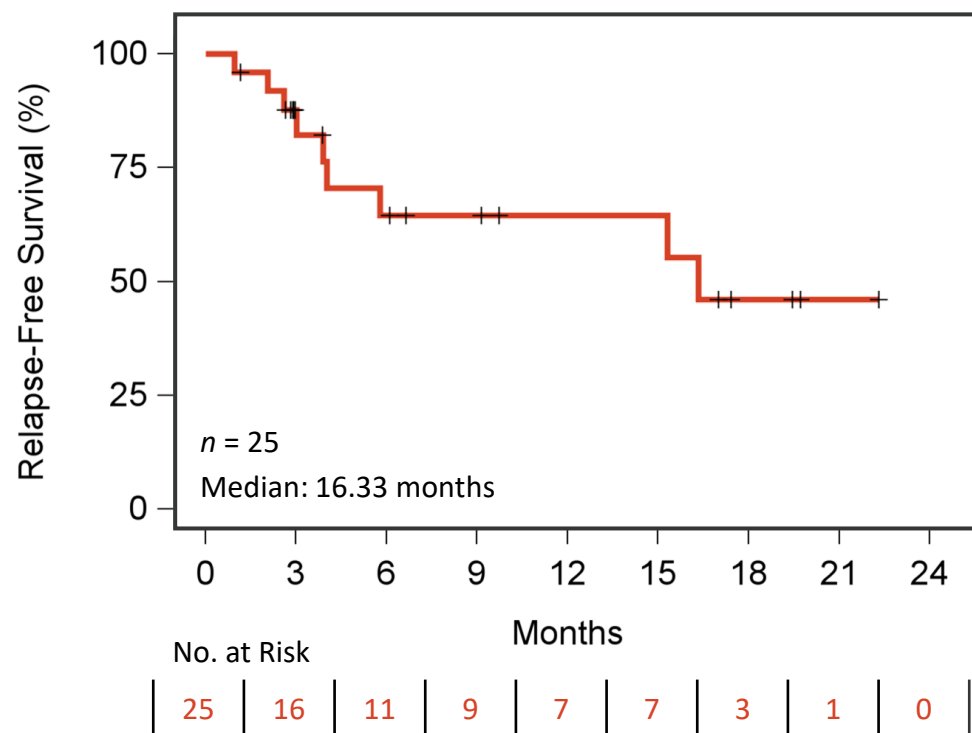
## RFS in Full Cohort vs PDAC Subgroup

Median follow up has increased to 19.7 months vs 8.5 months in Pant et al., 2024 Nature Med

Median RFS times similar for the full cohort and PDAC subgroup: Data cut-off Sept 24, 2024

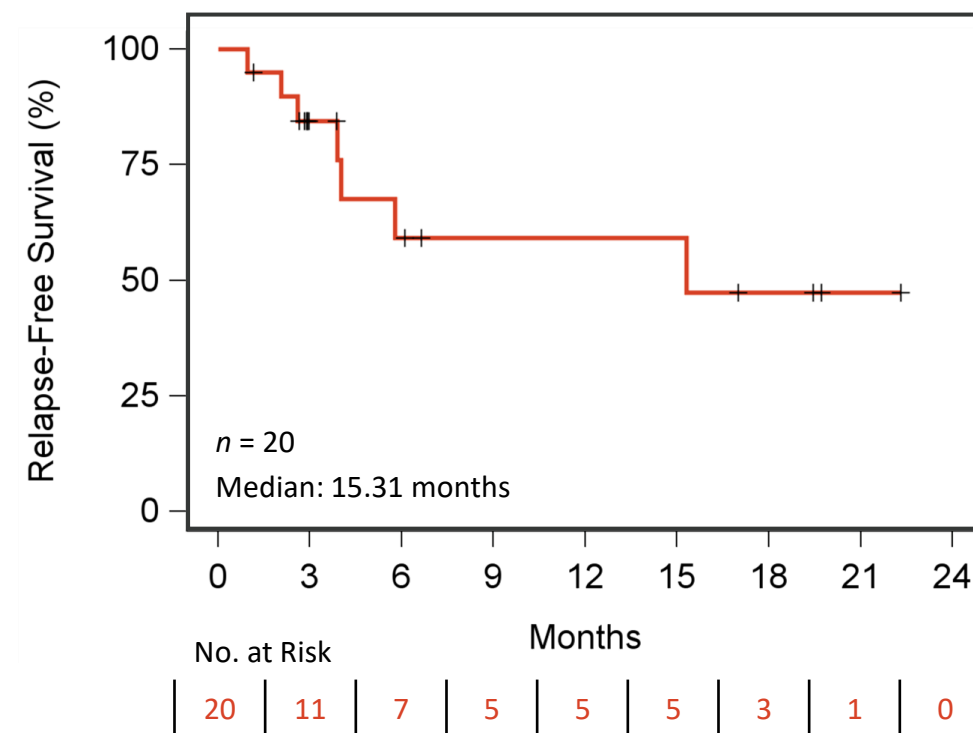
### Relapse-free Survival:

### Full Cohort (n=25)



### Relapse-free Survival:

### PDAC Subgroup (n=20)



ELI-002 2P demonstrated compelling median RFS in the full cohort (~16 months), including the PDAC subgroup (~15 months), which is particularly important given the significant unmet need—only ~10% of patients survive without relapse beyond one year.



# Final Analysis Shows Strong Correlation between RFS and T Cell Response

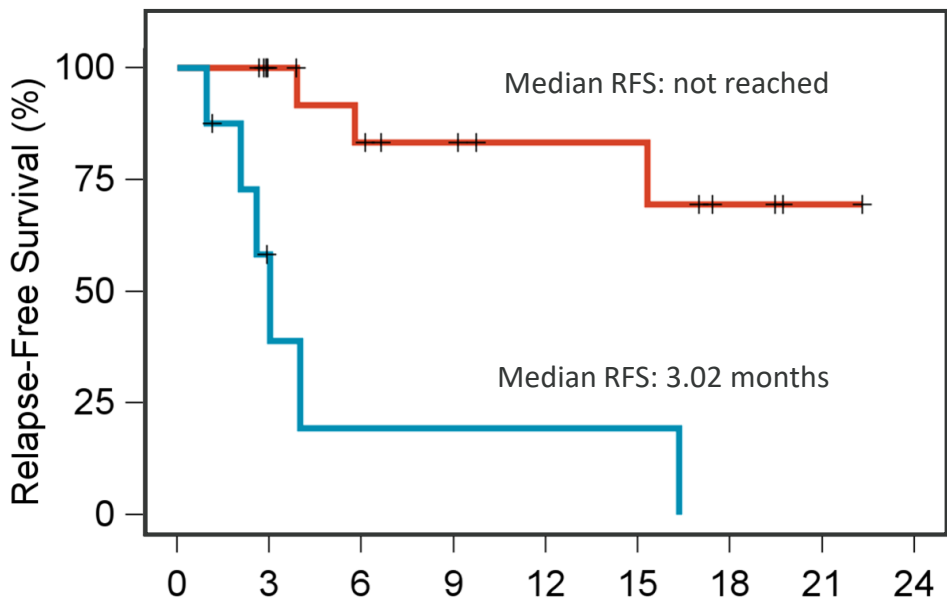
ELI-002 2P

Phase 1A

88% Reduced Risk of Relapse or Death in Patients with T cell Responses above Threshold 9.17x

Relapse-free Survival:

DCO September 24, 2024



At risk

≥ Threshold

< Threshold

17	13	10	8	6	6	3	1	0
8	3	1	1	1	1	0		

- ≥ Threshold T Cell Response (n = 17)
- < Threshold T Cell Response (n = 8)

ELI-002 2P Relapse-free Survival

	DCO	06-Sept-2023	24-Sept-2024
Median RFS (Months)	≥ Threshold T Cell	Not Reached	Not Reached
	< Threshold T Cell	4.01	3.02
HR (95% CI)		0.142	0.12
		(0.032 - 0.628)	(0.022 - 0.615)
P-value		0.0167	0.0002

Data cut-off (DCO): September 24, 2024

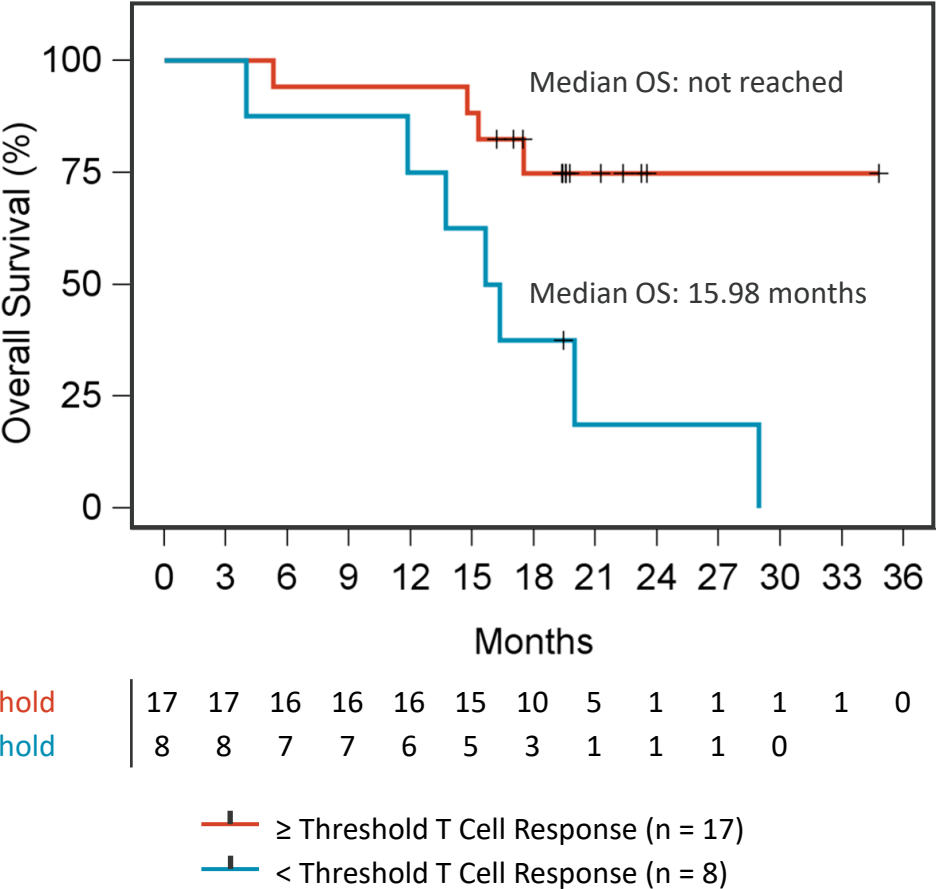
- 10/17 in the above threshold T cell group have not relapsed or died
- Favorable RFS stratified by T cell response was maintained relative to prior analysis:
  - Median RFS not reached for above threshold T cell Responders
  - Median RFS 3.02 months for below threshold T cell Responders
  - **HR 0.12, P = 0.0002**
- **88% reduction in Risk of Progression or Death** due to any cause in above threshold T cell Responders to ELI-002

# Final Analysis Shows Strong Correlation between OS and T Cell Response

77% Reduced Risk of Death in Patients with T cell Responses above Threshold 9.17x

Overall Survival:

DCO September 24, 2024



ELI-002 2P Overall Survival

DCO		06-Sept-2023	24-Sept-2024
Median OS (Months)	≥ Threshold T Cell	Not Assessed	Not Reached
	< Threshold T Cell		15.98
HR (95% CI)		Not Assessed	0.23
P-value			(0.063 - 0.854)
			0.0099

Data cut-off (DCO): September 24, 2024

- 10/17 in the above threshold T cell group have not relapsed or died
- Favorable OS stratified by T cell response was observed:
  - Median OS not reached for above threshold T cell Responders
  - Median OS 15.98 months for below threshold T cell Responders
  - HR 0.23, P = 0.0099**
- 77% reduction in Risk of Death** due to any cause in above threshold T cell Responders to ELI-002 2P

# Final Analysis of ELI-002 2P Phase 1: mKRAS T cell Response Correlated To Clinical Activity

ELI-002 2P

Phase 1A

Risk of Relapse and Death Reduced in 68% of Patients with T cell Responses Above 9.17x Threshold

	Pant et al. Nature Medicine. 2024	Wainberg, et al. Nature Medicine. 2025	
Data Cut-off	6 Sept 2023	24 Sept 2024	
Median Follow-up	8.5 months	19.7 months	Historic MRD+ PDAC
Median RFS (n=25)	16.33 months	16.33 months	5.0 – 6.4 months
Median OS (n=25)	16.33 months	28.94 months	17 months
mKRAS T Cell Response Threshold	12.75x (median)	9.17x (ROC-defined)	
Patients ≥ mKRAS T Cell Response Threshold	13 / 25	17 / 25	
mKRAS T Cell Response	P = 0.0014	P = 0.0024	
Correlation to: RFS	HR 0.14, P = 0.0167	HR 0.12, P = 0.0002	
OS	NR	HR 0.23, P = 0.0099	

RFS: Relapse-free survival; OS: Overall survival; ROC: Receiver-operating curve; NR: Not reported

# Enhancing Endogenous Anti-tumor Immunity by Using Additional Peptides Targeting mKRAS

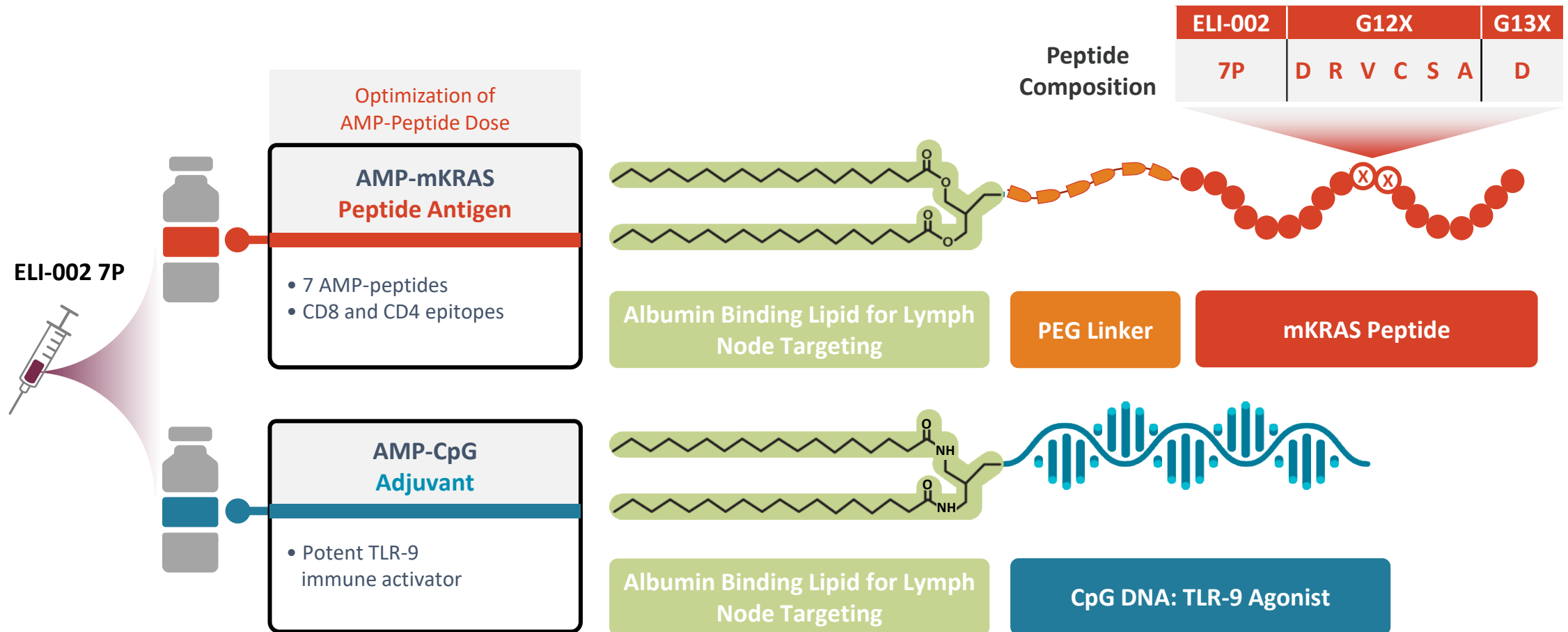
**ELI-002 7P:**

**Phase 1a Trial of ELI-002 7-Peptide Formulation**

First-in-human Study: mKRAS G12x or G13D-expressing, Adjuvant treatment of MRD+ PDAC and CRC

# ELI-002 7 Peptide (7P) Is a Lymph Node Targeted mKRAS Vaccine

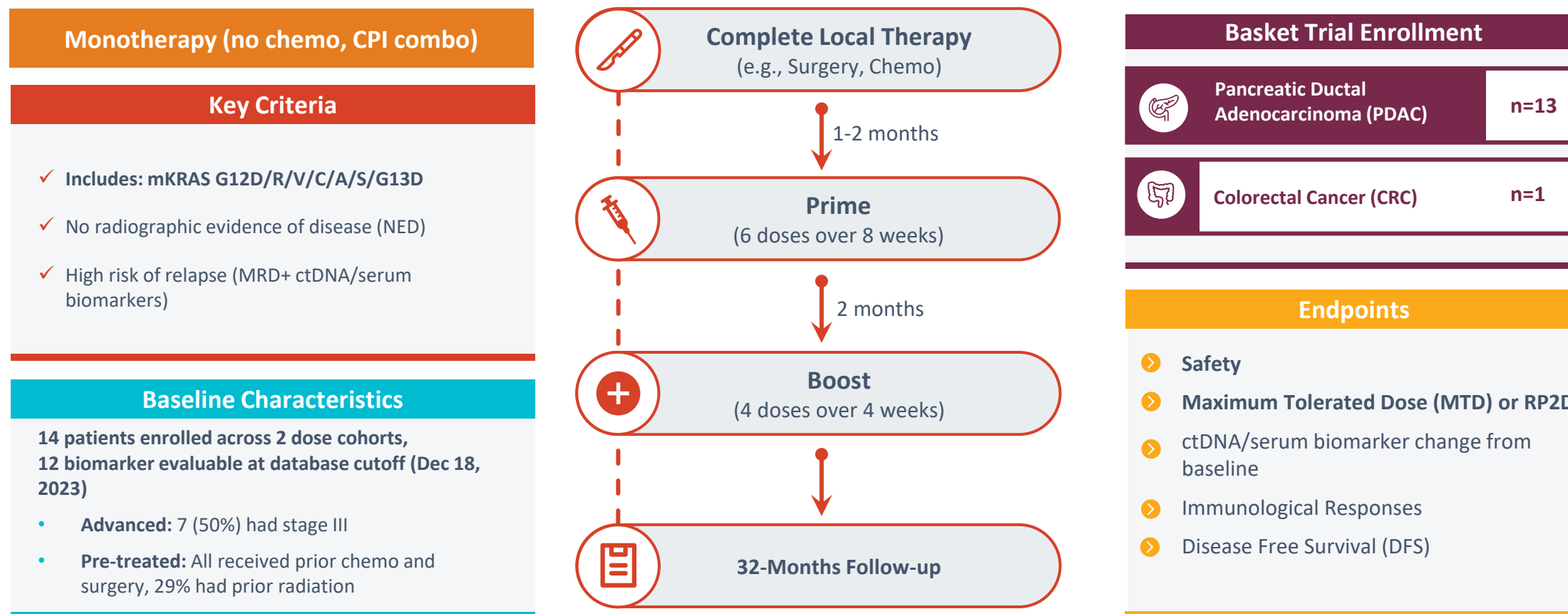
Proprietary AMP-CpG Adjuvant Shown to Enhance Immunogenicity in Early-Stage Trials



# ELI-002 7P Phase 1A Study Overview

Phase 1 peptide dose-ranging study to assess safety and efficacy of ELI-002 7P in patients who completed standard therapy and have minimal residual disease

## ELI-002 MONOTHERAPY: NCT05726864



# ELI-002 7P Elicits Immune Responses in all Phase 1a Patients

ELI-002 7P

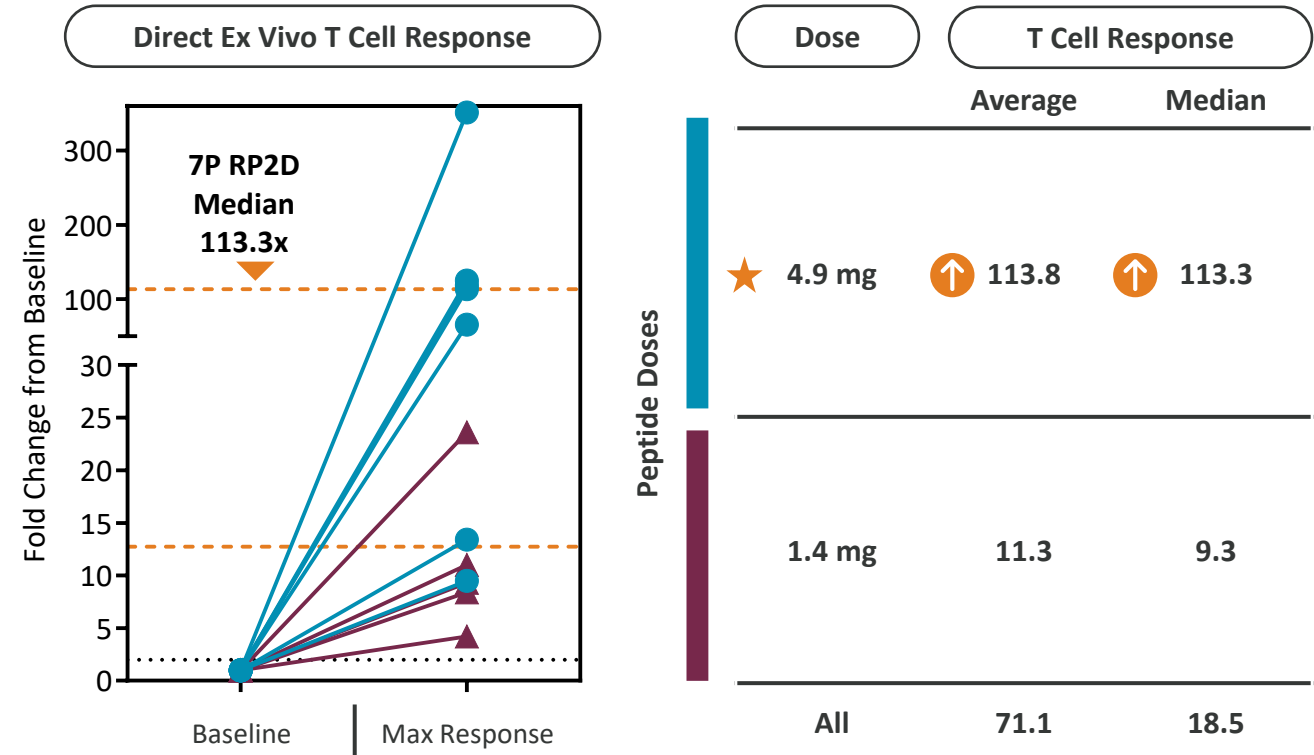
Phase 1A

100% of patients with robust T cell response

## mKRAS T Cell Responses

- **100% of patients showed T cell responses**
- 4.9 mg dose group selected for Phase 2
  - Median fold change = **113.3x**
  - 85.7% with CD4 and CD8 T cells
- T cells detectable by standard direct ex vivo FluoroSpot and flow cytometry, with no expansion required

## ELI-002 7P T Cell Fold-Changes by Dose Level



Responses shown are best overall responses relative to baseline for each patient at any timepoint during the assessment period.

ELI-002 7P: Data cutoff 24-Sep-24

★ = Phase 2 Dose



# ELI-002 7P: T Cell Response Magnitude Correlates with Dose

ELI-002 7P

Phase 1A

Phase 2 Dose generates higher immune response than seen with ELI-002 2P

## ELI-002 2P vs ELI-002 7P 4.9 mg

- ELI-002 7P data based on n=12 Patients (1.4 mg, n=5; 4.9 mg, n=7)
- 100% T cell Response Rate (n=12)
- ELI-002 7P 4.9 mg shows increased:
  - ↑ Median Fold Change
  - ↑ CD4 + CD8 Response Rate
  - ↑ Response Rate for all 7 mKRAS Antigens
  - ↑ Response Rate to Patient Tumor Antigen

	ELI-002 2P (Nat Med)	ELI-002 7P (All)	ELI-002 7P (4.9 mg)
Response Rate	84%	100%	100%
Median Fold Change	13.4	18.5	↑ 113.3
CD4 + CD8 T cells	70.6%	75.0%	↑ 85.7%
Response to 7 mKRAS Antigens	57.1%	50.0%	↑ 71.4%
Response to Tumor Antigen	80.9%	83.3%	↑ 100%
Responses shown are best overall responses vs baseline for each patient at any timepoint during the assessment period.			Phase 2 Dose

ELI-002 2P: Data cutoff 24-Sept-24  
ELI-002 7P: Data cutoff 24-Sept-24

★ = Phase 2 Dose

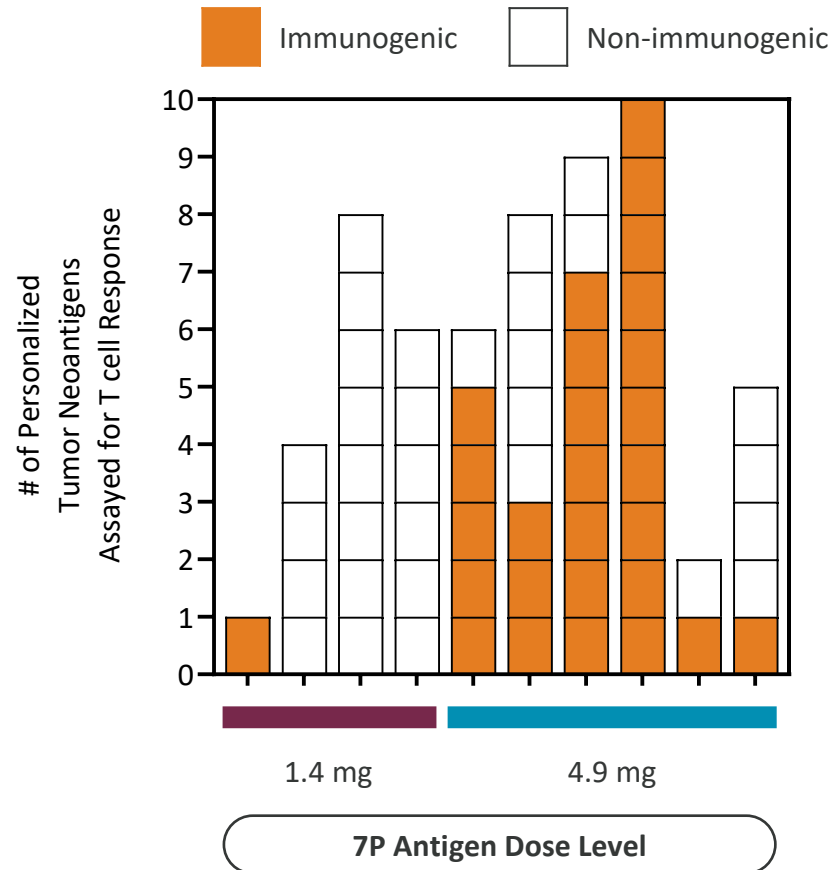
The ELI-002 7P formulation demonstrated robust T cell activation in patients.

# ELI-002 7P: ELI-002 Stimulates Antigen Spreading

ELI-002 7P

Phase 1A

Expansion of T cells specific to personalized tumor antigens not targeted by vaccination



## Antigen Spreading to Personal Tumor Neoantigens

- ELI-002 7P vaccination led to expansion of T cell responses targeting passenger mutations alongside mKRAS driver mutations in a majority of evaluable patients
- T cells detectable by standard direct ex vivo FluoroSpot and flow cytometry, with no expansion required
- 70% of evaluated patients (7/10) developed increased T cell responses targeting personalized tumor neoantigens
  - 100% at RP2D 4.9 mg peptide antigen dose
- Polyfunctional CD4 and CD8 T cells

# ELI-002 7P Induces Tumor Biomarker Declines in Majority of Phase 1A Patients

ELI-002 7P

Phase 1A

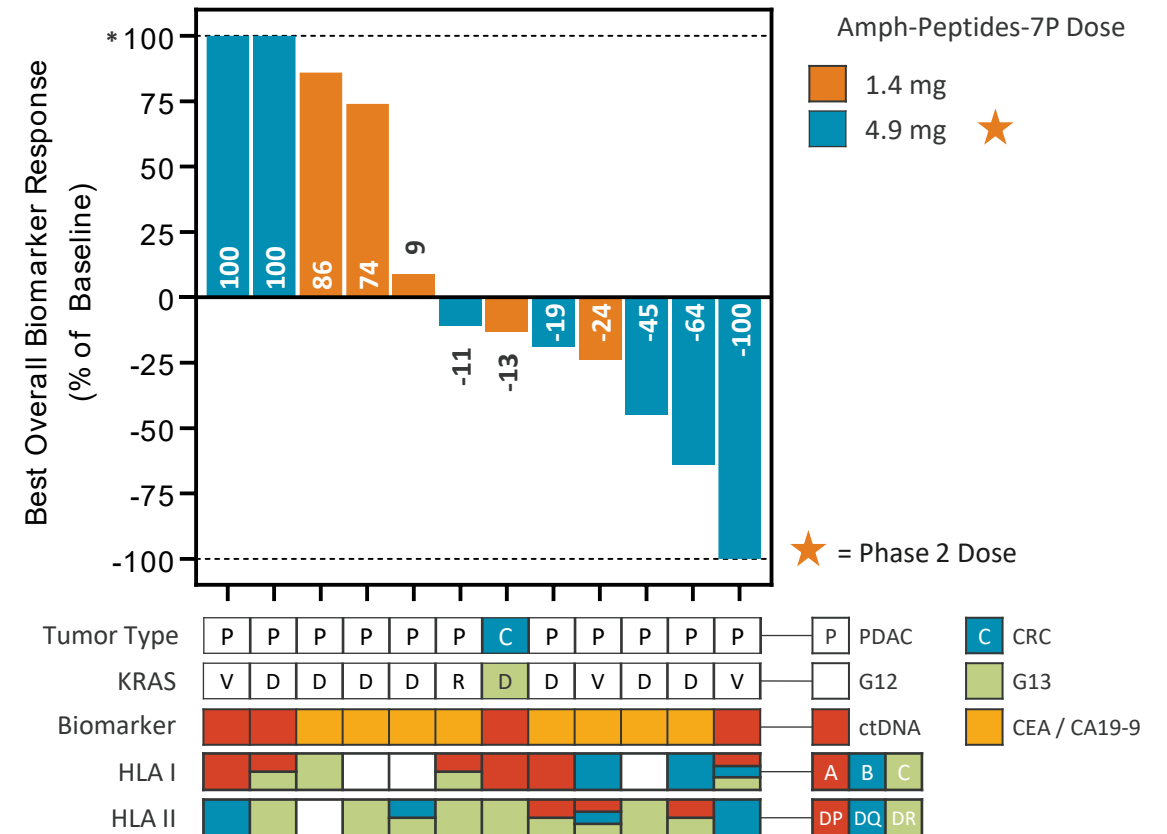
Waterfall reflects superiority of 4.9 mg AMP-Peptide 7P dose level

## Tumor Biomarker Responses

- 71% (5/7) of patients in the 4.9 mg dose had biomarker decline
- 40% (2/5) of patients in the 1.4 mg dose had biomarker decline
- 14% (1/7) PDAC patients at 4.9 mg dose had complete clearance
- Response may deepen over time (some patients not yet finished boosters)

Data cutoff 18-Dec-23

## ELI-002 7P Waterfall Plot: Biomarker Reduction / Clearance



# ELI-002 7P: T Cell Response Drives Tumor Biomarker Response

ELI-002 7P

Phase 1A

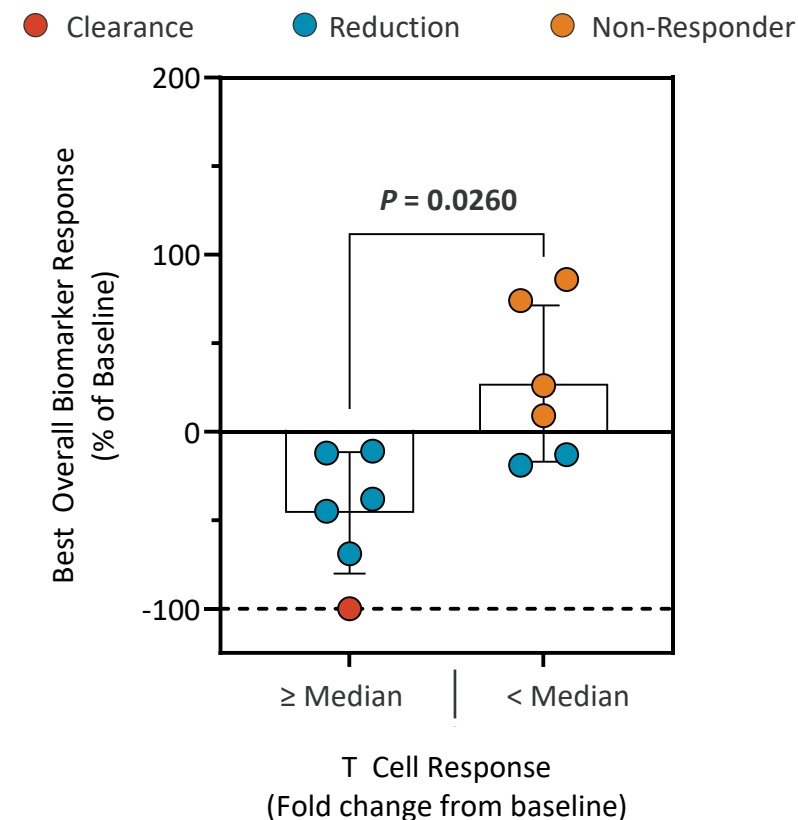
All patients with T cell responses above median showed tumor biomarker response

## mKRAS T Cell Response ➔ Tumor Biomarker Response

- **Strength of T cell response to ELI-002 is correlated to tumor biomarker response**
- 100% (6/6) of the above median T cell group respond to ELI-002; in the below median group 33% (2/6) respond to ELI-002\*
- 71.4% (5/7) of the 4.9 mg dose cohort are in the above median T cell group, including a complete responder
- Statistically significant per Mann Whitney Test ( $P = 0.0260$ )

\*10 patients had both immunogenicity and biomarker data available at data cutoff.

## Best Overall Tumor Biomarker Response



Tumor Biomarker data cutoff 18-Dec-23;  
T cell biomarker data cutoff 24-Sep-24

# ELI-002 7P: DFS Strongly Correlates with T Cell Response

ELI-002 7P

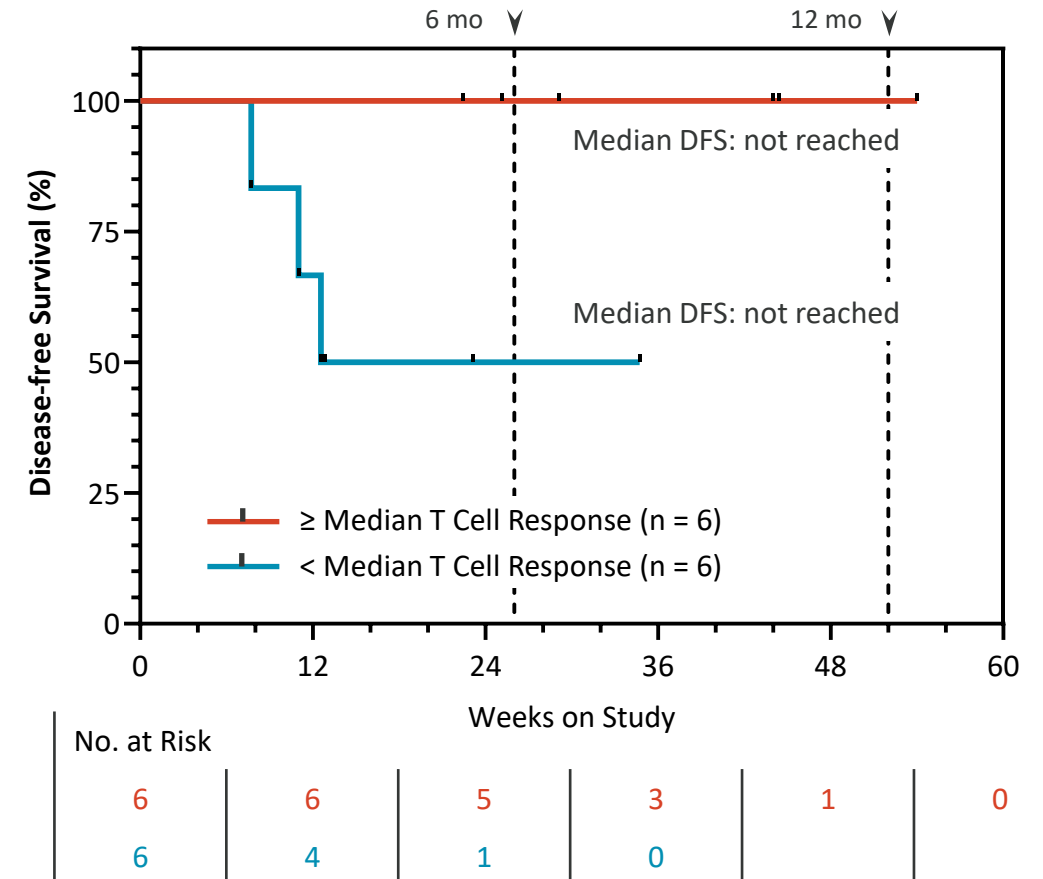
Phase 1A

Improved DFS associated with above median T cell response

## ELI-002 7P Disease-free Survival

- Induction of above median mKRAS-specific T cell responses by ELI-002 7P associated with decreased risk of disease progression and death compared to below median T cell response
- All patients with above median T cell responses were free from disease progression as of the data cutoff date

## Supervised by Median T cell Fold Change



## ELI-002 7P: Safety

ELI-002 7P

Phase 1A

ELI-002 7P was well tolerated at all dose levels with no DLTs observed

### ELI-002 7P Safety / Tolerability

- No DLT observed, No CRS or T cell Toxicities
- Most common TRAE (>20%) were Fatigue (28.6%; all Gr1) and Malaise (21.4%; all Gr1)
- One (1) pt had SAE (107-002) 1.4 mg dose non-treatment related intestinal obstruction resulted in hospitalization and w/d from treatment
- No dose modification
- No TRAE leading to death

ELI-002 7P Dose	1.4 mg	4.9 mg	Overall
	n=6	n=8	n=14
Adverse Event Term <sup>a</sup>			
Patients with Any Related TEAE, n (%)	5 (83.3)	6 (75.0)	11 (78.6)
Fatigue	3 (50.0)	3 (37.5)	6 (42.9)
Malaise	1 (16.7)	2 (25.0)	3 (21.4)
Diarrhea	1 (16.7)	2 (25.0)	3 (21.4)
Abdominal Distension	2 (33.3)	0	2 (14.3)
Abdominal Pain	1 (16.7)	1 (12.5)	2 (14.3)
Patient Summary			
KRAS Mutation	DDDDV 13D	DDDDR VVV	
Dose Limiting Toxicity	0	0	0
Biomarker Reduction / Clearance	2 / 5 (40)	5 / 7 (71)	7 / 12 (58) <sup>b</sup>
T cell Response	6 / 6 (100)	5 / 5 (100)	11 / 11 (100) <sup>c</sup>

TEAE: Treatment Emergent Adverse Event

<sup>a</sup> Preferred terms per the Medical Dictionary for Regulatory Activities, version 25.0

<sup>b</sup> Measured among 12 evaluable patients as of the data cut off: December 18, 2023

<sup>c</sup> Measured among 11 evaluable patients as of the data cut off: December 18, 2023

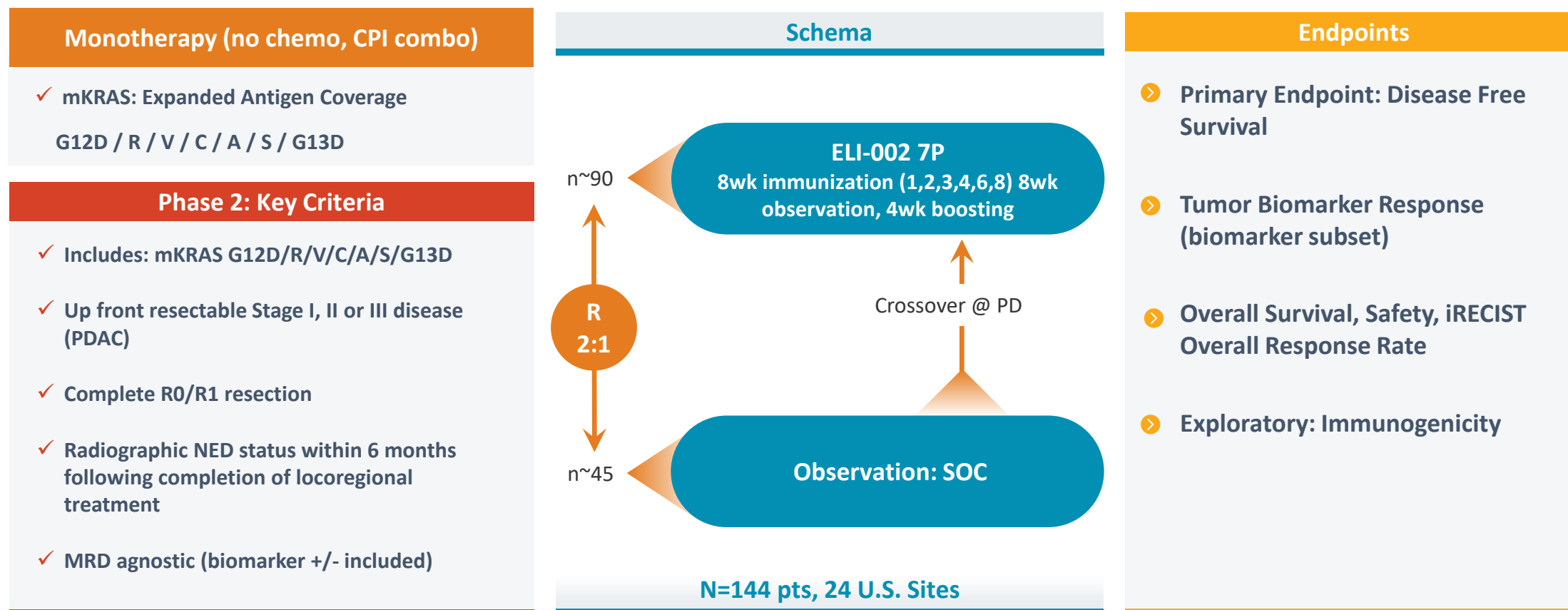
# Enrollment Complete for ELI-002 7P Randomized Phase 2 PDAC

ELI-002 7P

Phase 2

Event Driven Interim DFS Analysis Completed: Preliminary Signals of Efficacy, IDMC Confirmed Safety  
Final Analysis Expected 1H 2026 for 2:1 Randomized, Open Label Study

## CLINICAL STUDY OVERVIEW: NCT05726864



ELI-002 7P Phase 2 trial in PDAC patients: Disease-free survival final analysis expected in 1H 2026

Phase 3 Design aligned in FDA meeting

Randomized, blinded trial; primary endpoint investigator assessed DFS using modified RECIST (new lesions confirmed by biopsy/imaging)



# ELI-002 Summary of Phase 1 Clinical Trials

39 patients treated in two Phase 1A trials: ELI-002 2P and ELI-002 7P

- MRD+ PDAC (n=33) and CRC (n=6) patients treated after local surgery and chemotherapy (adjuvant setting)
- Phase 1 trials included dose-ranging for both peptide and adjuvant components of ELI-002
- Data from both trials have shown:
  - ELI-002 was well tolerated at all dose levels, with no DLTs or SAEs observed
  - RP2D established: 10 mg AMP-CpG with 4.9 mg AMP-peptide mix (elicited median 113-fold T cell increase)
  - ELI-002 elicited a robust mKRAS-specific T cell response (CD4+ and CD8+) in a majority of patients
  - ELI-002 elicited T cell response correlating with a reduction in tumor biomarker levels
  - Evidence of Antigen Spreading at RP2D with immune response targeting personal tumor neoantigens
  - **Strength of ELI-002 T cell response correlates with a reduction in the risk of progression or death**
- Preliminary Phase 1 study of ELI-002 2P including RFS outcome published in Nature Medicine January 2024
- Long-Term Follow-up Phase 1 (ELI-002 2P) data highlighting durable RFS and OS published in Nature Medicine, August 2025

Pant, et al.  
Nature Medicine. 2024



Wainberg, O'Reilly, et al.  
Nature Medicine. 2025



# ELI-002 7P Generated Robust T Cell Responses In Ongoing Phase 2

Response Consistent with Observations in Phase 1 Trials of ELI-002 that Correlated with Clinical Activity

## Phase 2: mKRAS-specific T cell Responses to ELI-002 7P were Consistent with Previous Phase 1 Observations

- ELI-002 7P data based on n = 90 evaluable Patients (4.9 mg AMP-Peptides)
  - **Robust expansion of mKRAS-specific T cells (median fold change from baseline):**
    - 99% mKRAS-specific T cell Response Rate (n = 89/90); 44.3x median increase over baseline; 145.3x average increase over baseline
    - Responses above ~9x over baseline correlated with clinical activity in two previous Phase 1 trials<sup>1</sup>
  - **Consistent CD4 + CD8 T cell Responses:**
    - 85% CD4 + CD8 Response Rate (compared to 75.0% in Phase 1)
    - Induction of combined CD4 and CD8 responses correlated with clinical activity in previous Phase 1 trial
  - **Consistent Responses to all included mKRAS antigens:**
    - 67.4% Response Rate for all 7 mKRAS Antigens (compared to 50.0% in Phase 1)
    - >80% Response Rate for each individual mKRAS antigen
  - **Consistent Responses to Patient-specific mKRAS Tumor antigen:**
    - 87.6% Response Rate to Patient Tumor Antigen (compared to 83.3% in Phase 1)
  - **Consistent Overall Vaccine Immunogenicity:**
    - Positive T cell Responses to 85.7% of vaccine antigens (compared to 66.7% in Phase 1)

<sup>1</sup> The response threshold correlated with clinical activity has not been determined for Phase 2

# ELI-002 7P Generated Robust T Cell Responses In Phase 2

Immune Response Consistent with Observations in Phase 1 Trials of ELI-002 that Correlated with Clinical Activity

	ELI-002 2P (Nature Medicine) Phase 1 (n=25)	ELI-002 7P (4.9 mg) Phase 1 (n=7)	ELI-002 7P All (1.4 mg & 4.9 mg) Phase 1 (n=12)	ELI-002 7P (4.9 mg) Phase 2 (n=90)
<b>Patients</b>	MRD+ only	MRD+ only	MRD+ only	MRD+ & MRD-
<b>mKRAS T Cell Response</b>				
T cell Response Rate (% , n)	84% (21/25)	100% (7/7)	100% (12/12)	99% (89/90)
Average Fold Change <sup>1</sup>	58.6x	113.8	71.1x	145.3x
Median Fold Change <sup>1</sup> (range)	16.4x (2.1x to 423x)	113.3x (9.5x to 351x)	18.5x (4.2x to 351x)	44.3x (2.13x to 1310x)
<b>Threshold Above Which Clinical Activity was Correlated (% of Patients Above Threshold)</b>	<b>9.17x (68% above 9.17x) 12.75x (52% above 12.75x)</b>	<b>ND</b>	<b>9.5x (75% above 9.5x)</b>	<b>TBD (80% above 9.5x)</b>
CD4 + CD8 T cell Response <sup>2</sup>	70.6%	85.7%	75.0%	85.0%
Response to 7 mKRAS Antigens <sup>1</sup>	57.1%	71.4%	50.0%	67.4%
Response to Patient Tumor Antigen <sup>1</sup>	81.0%	100%	83.3%	87.6%
Overall Antigen Response Rate (% , n) <sup>3</sup>	74.0% (37/50)	79.6% (39/49)	66.7% (56/84)	85.7% (540/630)

<sup>1</sup> Responses shown are best overall responses vs baseline for assessable patients at any timepoint during the assessment period, measured among T cell Responders; ND = Not Determined; TBD = To be Determined; MRD = Minimal Residual Disease

<sup>2</sup> Measured among evaluable patients with samples assessable by Ex Vivo Intracellular Cytokine Staining assay; <sup>3</sup> Overall Antigen Response Rate calculated as the percentage of positive mKRAS-specific T cell responses among all evaluated patients against all vaccine antigens

**The Company remains blinded to the trial efficacy outcomes and the correlation of T cell responses to antitumor response;** ELI-002 2P: Data cutoff 24-Sept-24; ELI-002 7P Phase 1: Data cutoff 24-Sept-24; ELI-002 7P Phase 2: 22-Aug-25

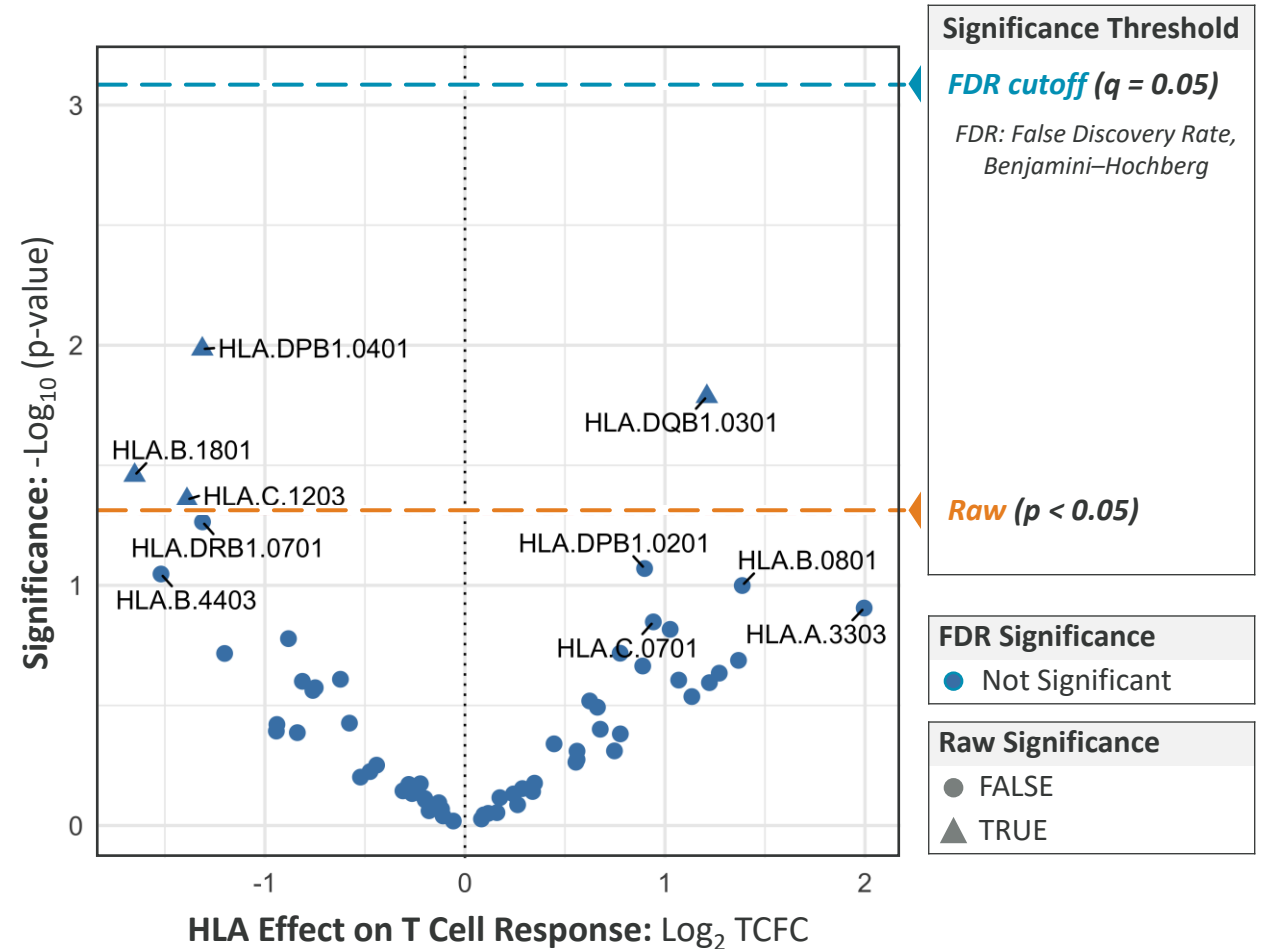
**ELI-002 7P demonstrated robust T cell activation in patients in Phase 2 AMPLIFY Trial**

# ELI-002 7P Generated Robust T Cell Responses In Phase 2

## Robust mKRAS-specific Immune Responses Induced Across Diverse HLA Backgrounds

### mKRAS T Cell Response in Diverse Patient HLA Backgrounds

- High resolution HLA typing of evaluable Phase 2 patients treated with ELI-002 7P (n = 89) showed high diversity: 1,132 unique HLA types
- No significant associations were observed between HLA allele and the strength of mKRAS-specific T cell responses (TCFC: T cell fold-change over baseline)
- Robust response across varied HLA Class I and Class II indicates the potential for broad use of ELI-002 among a diverse patient population



# ELI-002 7P Generated Robust T Cell Responses In Phase 2

Robust Antigen Spreading Responses Induced Targeting Personalized Tumor Antigens

	ELI-002 2P (Nature Medicine) Phase 1 (n=25)	ELI-002 7P All (1.4 mg & 4.9 mg) Phase 1 (n=12)	ELI-002 7P (4.9 mg) Phase 2 (n=90)
<b>Patients</b>	MRD+ only	MRD+ only	MRD+ & MRD-
<b>mKRAS T Cell Response</b>			
T cell Response Rate (% , n)	84% (21/25)	100% (12/12)	99% (89/90)
<b>Antigen Spreading T cell Response</b>			
Patients tested for Antigen Spreading (n)	9	10	15
Median number of non-mKRAS antigens tested per patient (range)	8 (6 – 10)	6 (1 – 10)	10 (5 – 12)
T cell Response Rate (% , n)	67% (6/9)	70% (7/10)	87% (13/15)
Median fold change <sup>1</sup>	3.4x	2.7x	10.6x
Responses in both CD4 + CD8 T cells <sup>2</sup>	33.3%	50%	90%

<sup>1</sup> Responses shown are best overall responses vs baseline for assessable patients at any timepoint during the assessment period, measured among T cell Responders; MRD = Minimal Residual Disease

<sup>2</sup> Measured among evaluable patients with samples assessable by Ex Vivo Intracellular Cytokine Staining assay

**The Company remains blinded to the trial efficacy outcomes and the correlation of T cell responses to antitumor response;** ELI-002 2P: Data cutoff 24-Sept-24; ELI-002 7P Phase 1: Data cutoff 24-Sept-24; ELI-002 7P Phase 2: 22-Aug-25

**Increased T cell responses targeting mKRAS and personalized tumor antigens observed in evaluated patients in Phase 2 AMPLIFY Trial**

# Key Milestones Achieved and Future Growth Catalysts

## ELI-002 Clinical Development

- ✓ Preliminary Phase 1 T Cell and biomarker response (ASCO)
- ✓ T cell and Antigen Spreading (SITC)
- ✓ Complete Phase 2 enrollment with 144 patients enrolled (4Q 2024) for ELI-002 7P in PDAC
- ✓ FDA Type B Meeting (4Q 2024)
- ✓ ELI-002 7P Phase 2 DFS Interim Analysis (completed Q3 2025)
- ☐ ELI-002 7P Phase 2 DFS Final Analysis (expected 1H 2026)
- ☐ End of Phase 2 FDA Meeting to be requested after final DFS analysis

## Future Growth Catalysts

- ☐ Initiate ELI-002 7P + CPI investigator-sponsored clinical combination study in neo-adjuvant PDAC and potential other ELI-002 7P combination studies, subject to funding
- ☐ Select Sponsor and potentially initiate ELI-004 + radiation investigator-sponsored clinical study in solid tumors, subject to funding
- ☐ Select Sponsor and potentially initiate ELI-002 7P + CPI investigator-sponsored clinical study in metastatic micro-satellite stable CRC, subject to funding
- ☐ Advance ELI-007 BRAF and ELI-008 p53 vaccines for Phase 1 readiness, subject to funding
- ☐ Finalize Phase 3 trial protocol in adjuvant PDAC setting for ELI-002 7P

# Investment Highlights

## Clinical-stage Biotech Developing Novel Lymph Node-targeted “off the shelf” Cancer Immunotherapies

### Leveraging proprietary Amphiphile (“AMP”) Technology

- Our proprietary AMP platform is designed to generate robust, functional, and durable immune responses by targeting lymph nodes- the “brain center” of the immune response
- AMP technology delivers antigen-specific payloads directly to lymph nodes to educate, activate, and expand tumor-eliminating T cell populations with broad applicability across cancer immunotherapy
- Proof-of-concept has been demonstrated in two completed Phase 1 trials; a randomized Phase 2 monotherapy study in pancreatic cancer is expected to read out in 1H ‘26

### ELI-002 Lymph Node Targeted mKRAS Cancer Vaccine

- Off-the-shelf immunotherapy candidate targeting the most common KRAS mutations that drive 25% of solid tumors
- Potential monotherapy adjuvant treatment in high relapse-risk mKRAS<sup>+</sup> cancers: pancreatic (PDAC), colorectal (CRC)
- In the ongoing Phase 2 trial ELI-002 7P elicited mKRAS-specific T cell response >44x increased over baseline at the Phase 2 dose without any dose limiting toxicities (DLTs) or serious adverse events (SAEs)
- ELI-002 2P Update in Nature Medicine 2025: full cohort (n=25) **mOS of 28.9 months; mRFS of 16.3 months**

### Value-creating catalysts and capitalization

- ELI-002 7P Phase 2 trial: Disease-free survival interim analysis completed in Q3 ‘25; final analysis expected in 1H ‘26
- ELI-002 7P end of Phase 2 FDA meeting to be requested upon final DFS analysis
- Investigator-sponsored trials of ELI-002 + checkpoint inhibitors (CPI) in PDAC and CRC and other combinations
- Cash runway expected to support operations through Q2 2026 beyond Phase 2 final data analysis expected in 1H ‘26

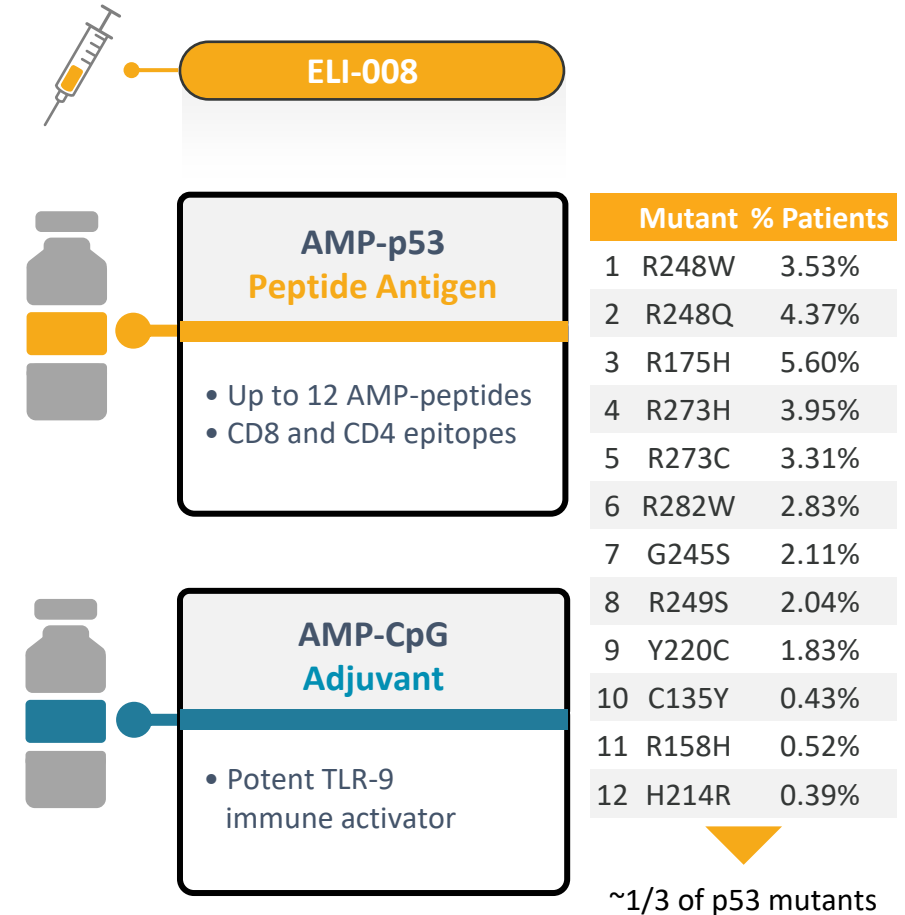
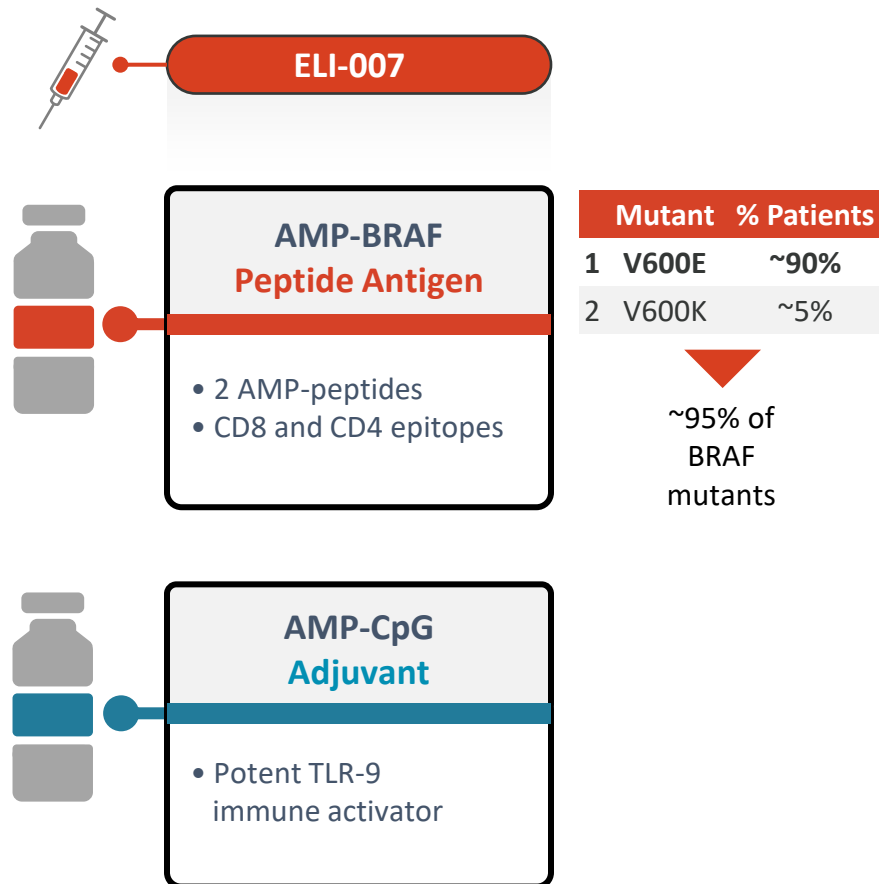
**Appendix:**

Other Pipeline Assets



# ELI-007 (BRAF) and ELI-008 (p53)

Designing an AMP-Vaccine Targeting Mutant BRAF and p53

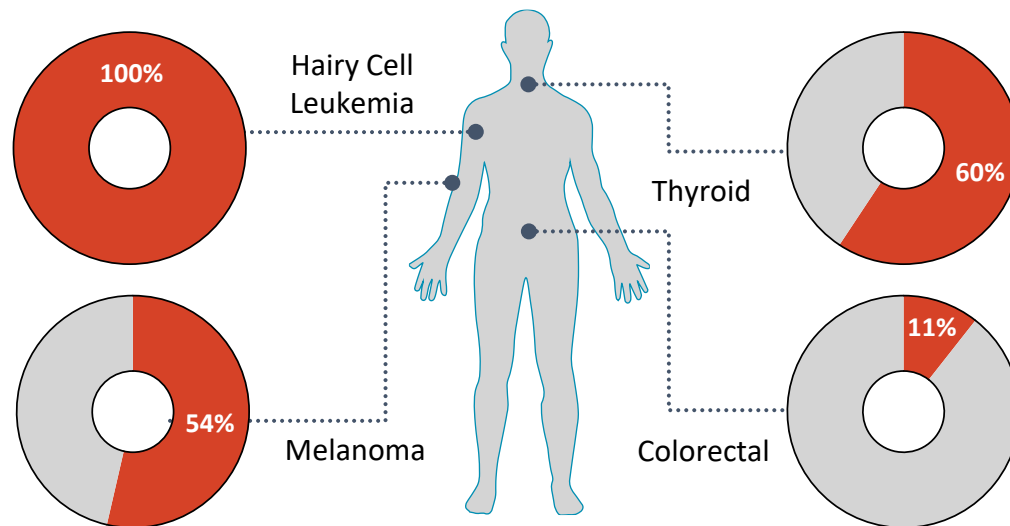


# ELI-007: Why Target mutant BRAF with Vaccine Immunotherapy?

## Mutant BRAF is a Common Cancer Driver

- **Prevalent** among numerous tumor types
- Overall **poor clinical prognosis**
- **Limited therapeutic options**

### Most Frequently BRAF-Mutated Cancer Types



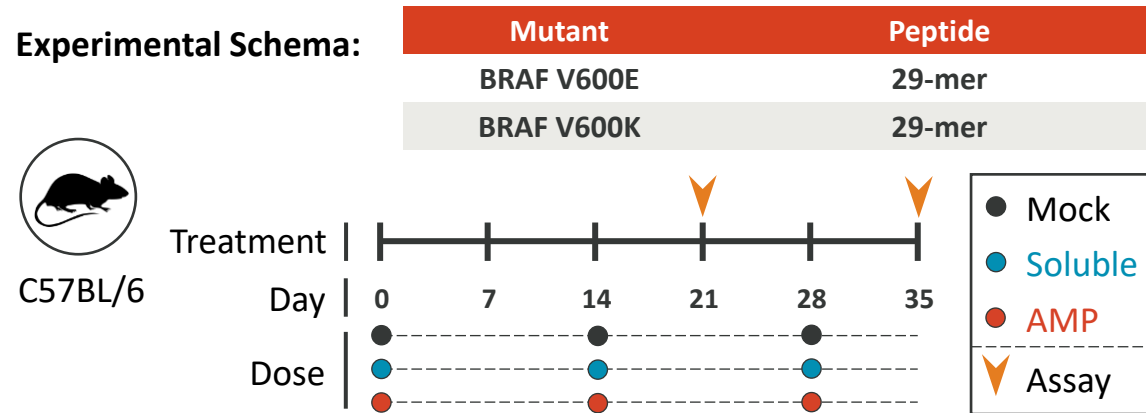
## Mutant BRAF is a Promising Tumor Antigen

- **Truncal:** mutations occur early, expressed uniformly in tumor cells
- **Driver:** mBRAF signaling is required for tumor growth and survival
- **Highly prevalent:** frequently mutated across tumor types
- **Public neoantigen:** not centrally tolerized, cognate TCRs present in naïve repertoire
- **Broad HLA presentation:** potential off-the-shelf use in diverse patient population
- **Demonstrated Clinical MOA:** mBRAF-specific T cells known to mediate anti-tumor efficacy
- **Multi-targeting potential:** broad recognition of mBRAF variants to prevent escape

# ELI-007 Is a Lymph Node Targeted mBRAF Vaccine Immunotherapy

AMP-modification enhances BRAF V600E-specific T cell responses

## Experimental Schema:

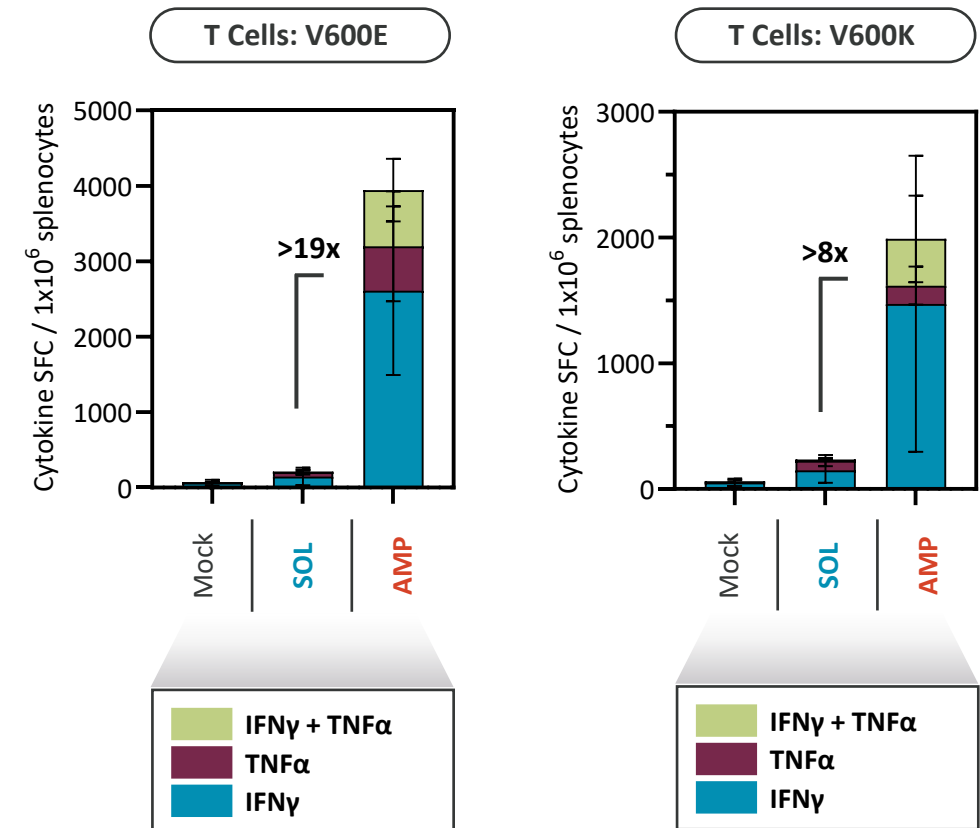


## AMP Generates Potent Polyfunctional T Cell Response

- Soluble peptide + CpG is completely inactive
- AMP-vaccine generates potent functional T cell response
- Responses are specific to V600E and V600K mutations
- T cells exhibit polyfunctional effector phenotype
- Cytolytic granzyme production

## T Cell Response: BRAF V600 Spleen Day 35

Stim: V600E or V600K Peptide Pool

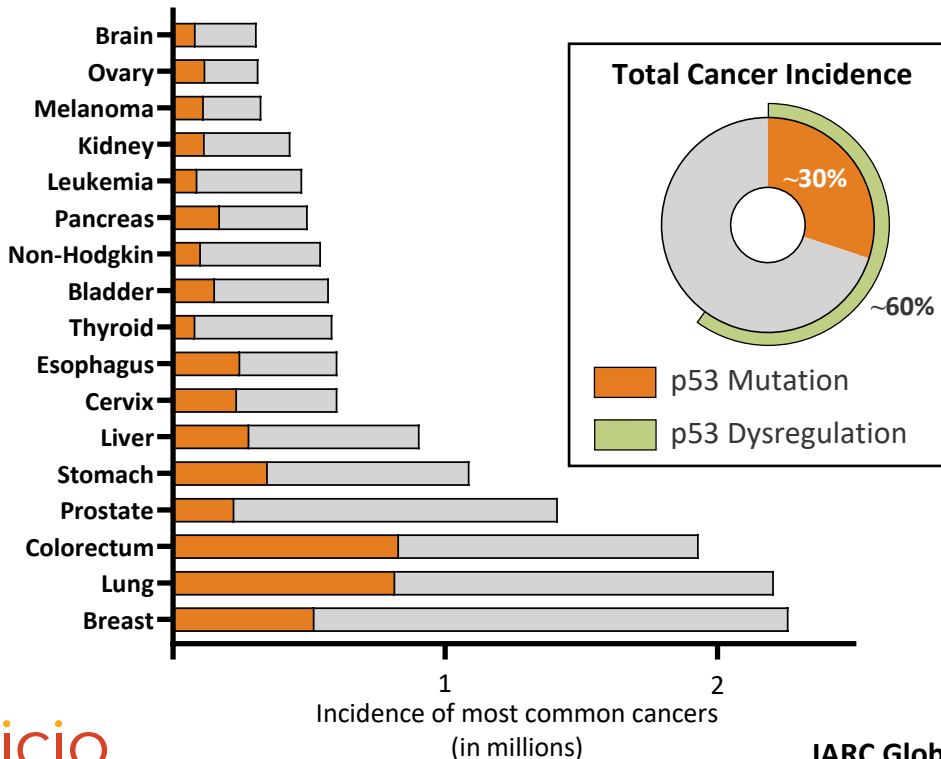


# ELI-008: Why Target mutant p53 with Vaccine Immunotherapy?

## Mutant p53 Drives ~30% of Human Cancers

- **Prevalent** among numerous tumor types
- **Limited therapeutic options**

Estimated Worldwide Annual Incidence



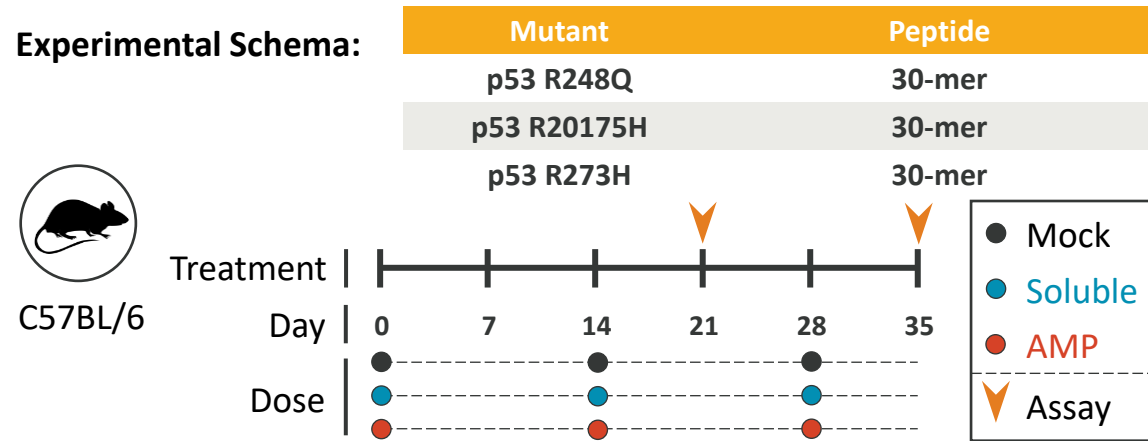
## Mutant p53 is a Promising Tumor Antigen

- **Truncal**: mutations occur early, expressed uniformly in tumor cells
- **Driver**: mp53 signaling is required for tumor growth and survival
- **Highly prevalent**: frequently mutated across tumor types
- **Public neoantigen**: not centrally tolerized, cognate TCRs present in naïve repertoire
- **Broad HLA presentation**: potential off-the-shelf use in diverse patient population
- **Demonstrated Clinical MOA**: mp53-specific T cells known to mediate anti-tumor efficacy
- **Multi-targeting potential**: broad recognition of mp53 variants to prevent escape

# ELI-008 Is a Lymph Node Targeted mp53 Vaccine Immunotherapy

AMP-modification enhances p53 hot-spot mutant-specific T cell responses

## Experimental Schema:

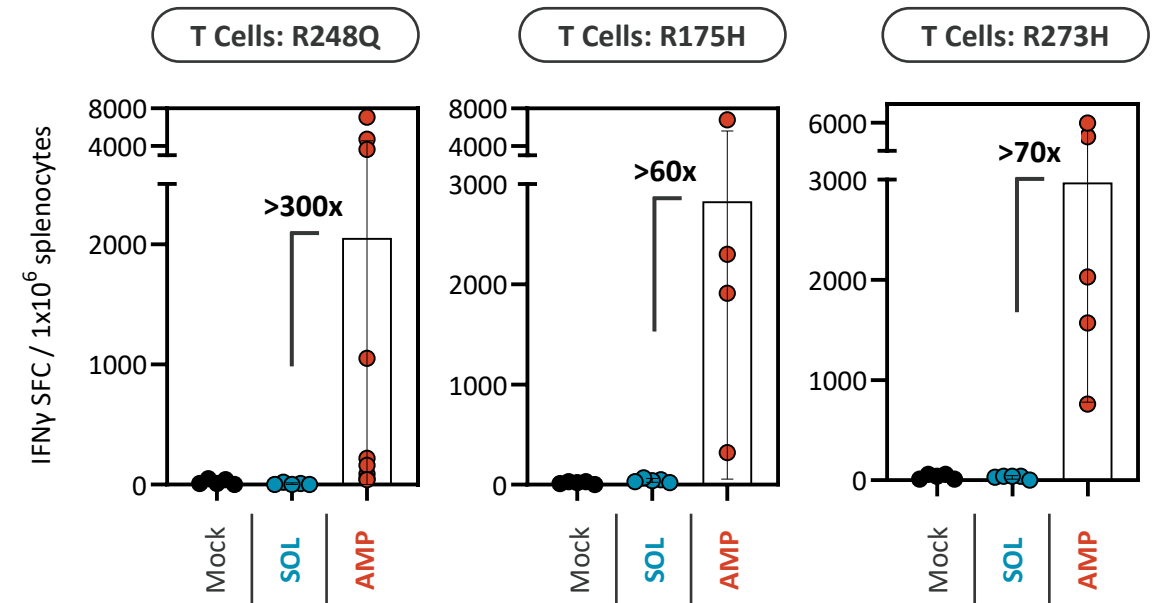


## AMP Generates Potent Polyfunctional T Cell Response

- Soluble peptide + CpG is inactive
- AMP-vaccine generates potent functional T cell response
- Polyfunctional effector cytokine secretion
- Cytolytic granzyme production

## T Cell Response: p53 Spleen Day 35

Stim: p53 R248Q, R175H, or R273H OLPs



## ELI-004: AMP-CpG Combination with Radiation to Induce Tumor-specific Immunity *In Situ*

