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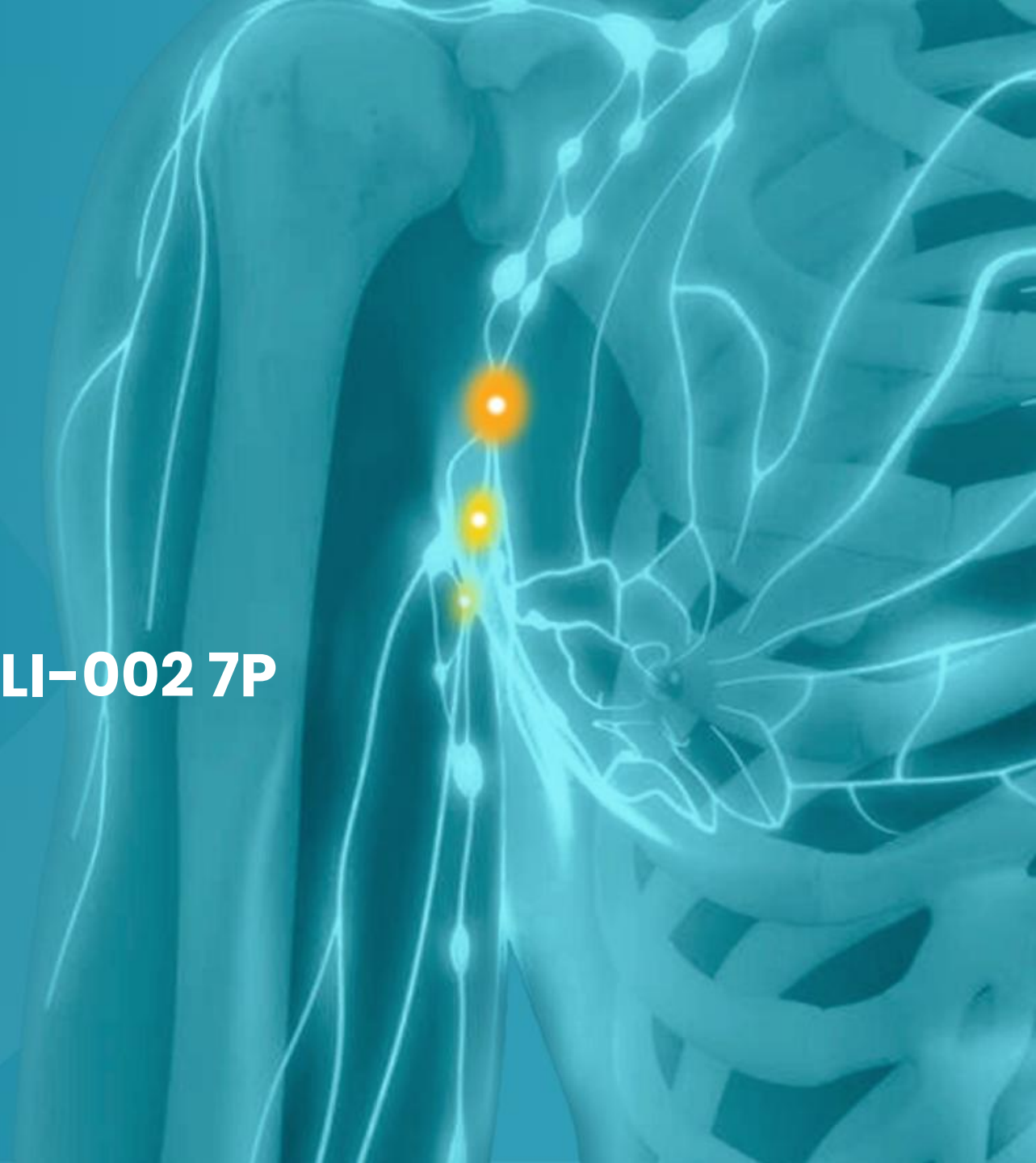
AMPLIFY-7P
Defining the Path Forward for ELI-002 7P in Adjuvant mKRAS PDAC

JUNE 15, 2026



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AMPLIFY-7P Identified a Clear Phase 3 Development Path for ELI-002 7P

Primary endpoint was not met in the ITT population, the study identified a biologically and clinically consistent signal that informs future development

Primary Endpoint was Not Met	Randomized Phase 2 AMPLIFY-7P did not achieve its primary DFS endpoint in the overall ITT population in mKRAS-driven PDAC after locoregional therapy: **adjuvant setting**
Early DFS Benefit Observed	DFS curves separated early during active ELI-002 7P treatment, supporting biological activity in the adjuvant setting
Clear Clinical Signal in Completely Resected (R0) Patients	Strong treatment effect observed in lower residual disease patient populations, supporting a more focused development strategy
Biological Validation and Favorable Safety	Strong mKRAS-specific immune responses correlated with DFS; ELI-002 7P maintained a favorable safety profile

Findings identify a clear development pathway with refined patient selection and extended treatment duration.

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AMPLIFY-7P: Randomized Phase 2 Trial in Adjuvant mKRAS+ PDAC

CLINICAL STUDY OVERVIEW: NCT05726864 (2:1 Randomized)

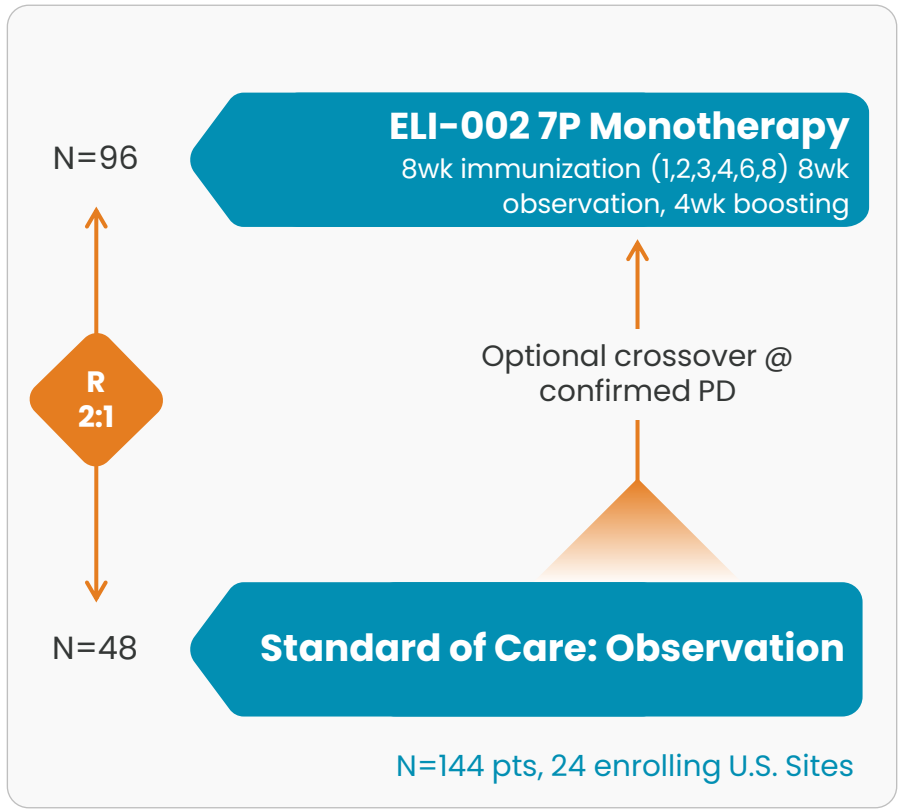
Designed to evaluate whether ELI-002 7P could improve disease-free survival following standard locoregional therapy

ELI-002 7P Monotherapy

- 7 mKRAS peptide antigens

Phase 2: Key Criteria

- Includes: mKRAS G12D/R/V/C/A/S/G13D
- Resected Stage I–III mKRAS PDAC
- Complete R0/R1 resection
- Radiographic NED status within 6 months
- MRD agnostic (biomarker +/- included)
- **Enrollment Completed December 2024**
- 144 patients randomized across 24 U.S. Sites



Endpoints

Primary Endpoint: Disease Free Survival (DFS)

Tumor Biomarker Response (biomarker subset)

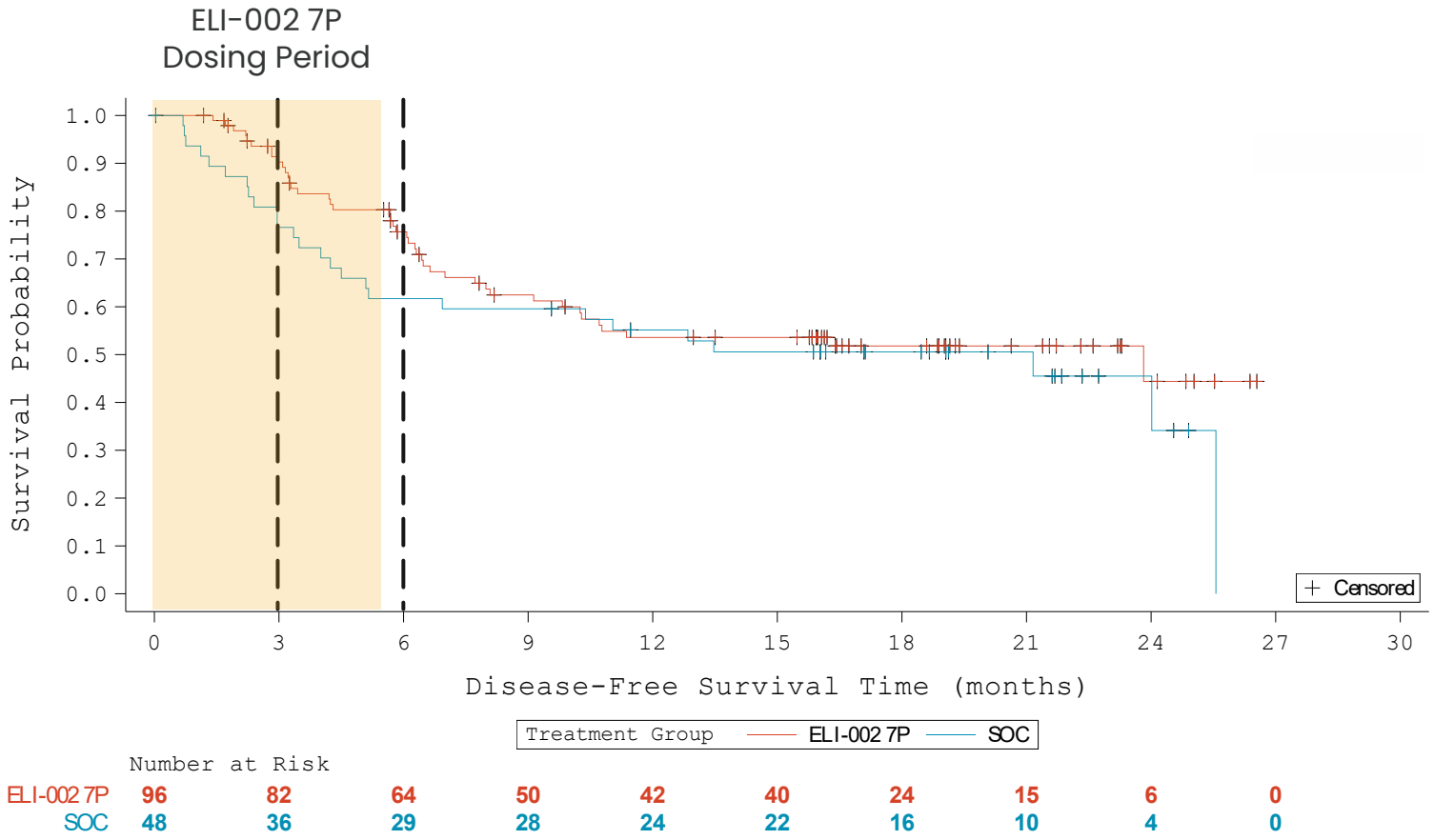
Overall Survival, Safety

Exploratory: Immunogenicity

Note: DFS assessment by iRECIST (new lesions confirmed by biopsy/imaging); R0/R1: Absence or presence of microscopic residual disease; NED: No Evidence of Disease. MRD: Minimal Residual Disease. PD: Progressive Disease

Early DFS Separation Observed Through 9 Months [1]

Post-hoc 3-month and 6-month landmark analyses indicate early clinical activity, with treatment-arm separation persisting through 9 months



ELI-002 7P DFS: ITT Stratified

DCO		20-APR-2026
Median DFS (Months)	ELI-002 7P	23.8 (9.8, NE)
	SOC (Observation)	21.2 (5.1, NE)
	HR (95% CI)	0.85 (0.52 – 1.41)
	P-value	0.5329

ELI-002 7P DFS: Post-hoc Landmark Analysis

Landmark		3 mo	6 mo
DFS Rate	ELI-002 7P	90.3%	75.7%
	SOC (Observation)	76.6%	61.7%
	DFS Rate Difference	**13.7%**	**14.0%**
	P-value	0.0222	0.0557
HR from t_0 to Landmark		0.37	0.55

[1] Primary DFS analyses used specified stratified Logrank test; DCO: Data cut-off

Stronger Treatment Effect Observed in Lower Residual Disease Patient Population [1]

Post-hoc analyses demonstrate stronger treatment effect in lower residual disease

ITT

HR = 0.79

P = 0.2492, N = 144

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R0 Resected

HR = 0.65

P = 0.0484, N = 121

Clear improvement in DFS hazard ratio observed in R0 resected patients (N=121).

While post-hoc, these analyses clearly identify the population Elicio believes is most appropriate for Phase 3 evaluation.

At 84% of the enrolled population, this represents a clinically meaningful and accessible Phase 3 target.

[1] *Unstratified analyses, Wilcoxon*
Primary DFS analyses used specified stratified Logrank test; ITT HR 0.85.

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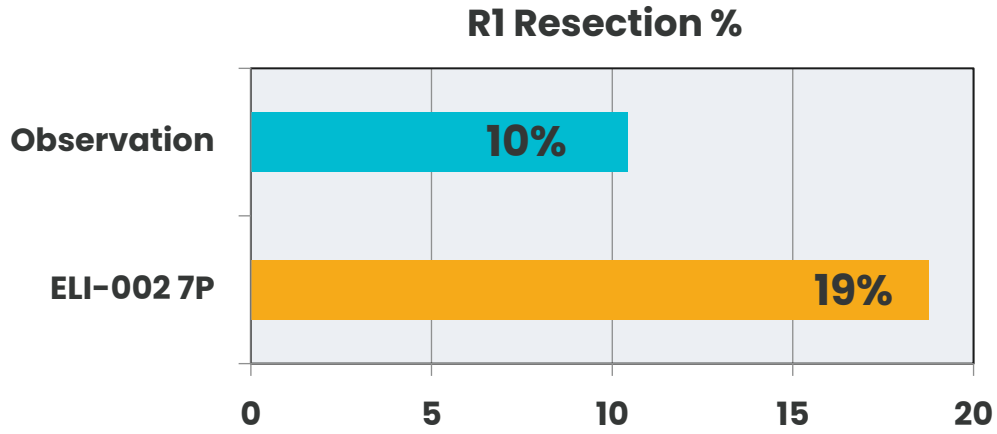
Resection Margin Status Was Imbalanced at Baseline

The ELI-002 7P arm contained more high recurrence-risk R1 patients than the observation arm



Characteristic	ELI-002 7P (N=96)	SOC (N=48)	Total (N=144)
Resection margin R1	18 (19%)	5 (10%)	23 (16%)

R1 resection was disproportionately concentrated in the ELI-002 7P arm, potentially suppressing the ITT treatment effect.

[1] *Multivariate Cox model for DFS-adjusted HR (ITT)*

Stronger Treatment Effect Observed in Lower Residual Disease Patient Population[1]

Post-hoc analyses demonstrate stronger treatment effect in lower residual disease

ITT

HR = 0.79

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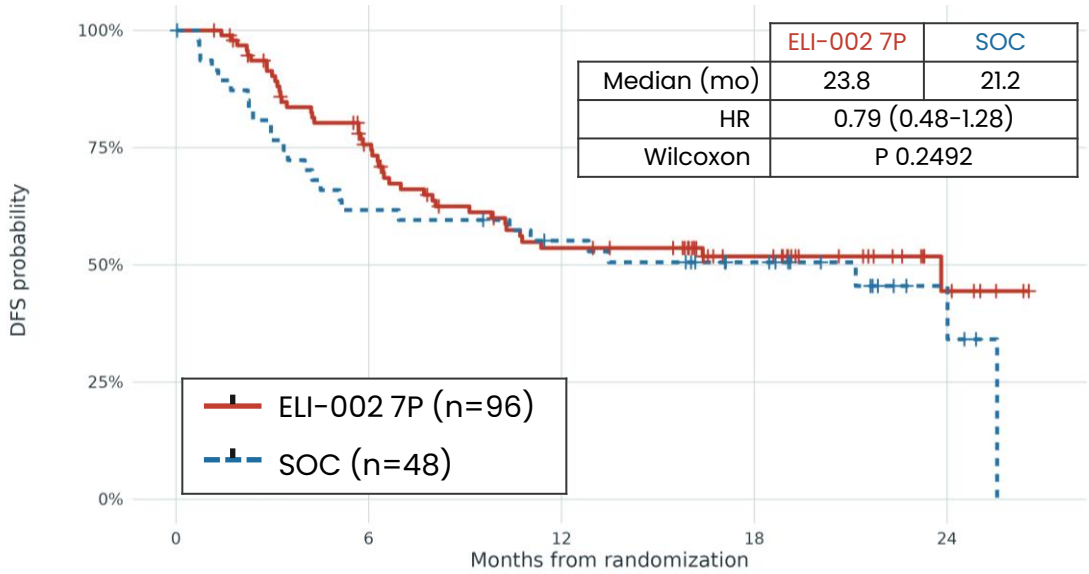

	ELI-002 7P	SOC
Median (mo)	23.8	21.2
HR	0.79 (0.48-1.28)	
Wilcoxon	P 0.2492	

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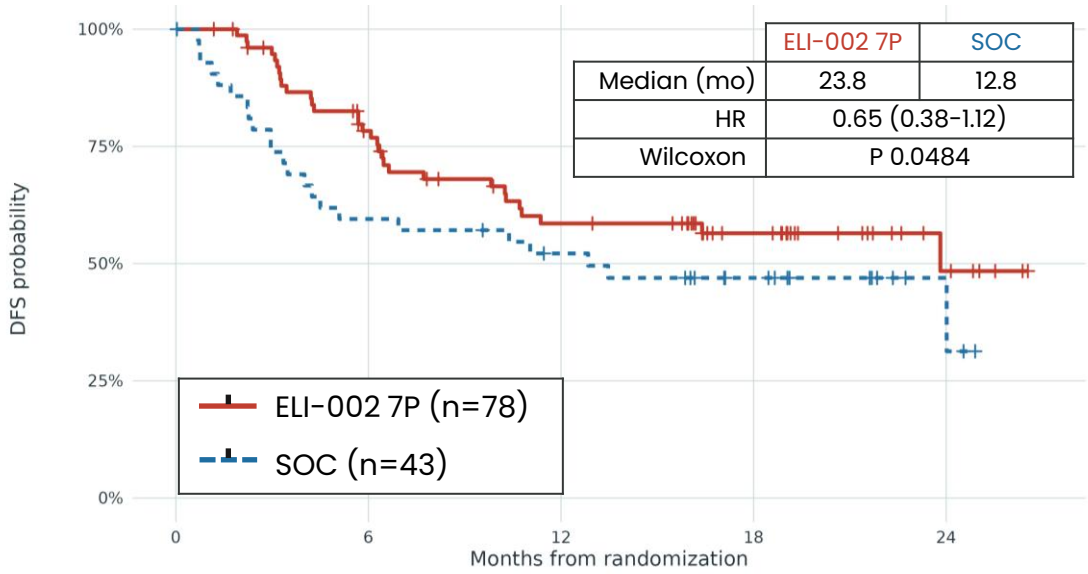
R0 Resected

HR = 0.65

P = 0.0484, N = 121



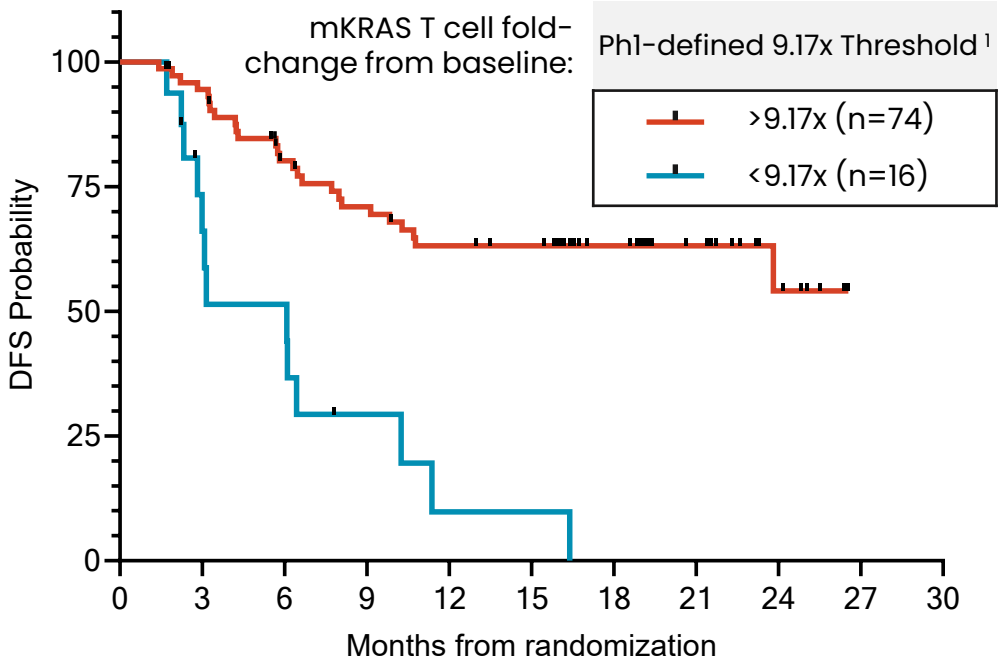
	ELI-002 7P	SOC
Median (mo)	23.8	12.8
HR	0.65 (0.38-1.12)	
Wilcoxon	P 0.0484	

The analyses show the potential for improved treatment effect in lower residual disease, R0 resected population.

[1] *Unstratified analyses, Wilcoxon*
Primary DFS analyses used specified stratified Logrank test; ITT HR 0.85.

mKRAS-Specific T Cell Responses Were Strongly Associated with Improved DFS

Greater mKRAS-specific T cell responses were associated with longer DFS following ELI-002 7P treatment



ELI-002 7P DFS: ITT Supervised by mKRAS-specific T cell Response [2]

DCO		20-APR-2026
Median DFS (Months)	>9.17x	NR
	<9.17x	6.08
	HR (95% CI)	**0.22** (0.08 – 0.63)
	P-value	<0.0001

Immune response to ELI-002 7P was observed to be a strong predictor of DFS benefit.

*[1] Wainberg, O'Reilly, et al. **Nature Medicine**. 2025; [2] mKRAS T cell fold-change assessed among n=90 evaluable patients*

ELI-002 7P Demonstrated a Favorable Safety and Tolerability Profile

Safety profile supports extended treatment and combination strategies

Category	ELI-002 7P n (%)	SOC n (%)
Any TEAE	**70 (72.9)**	**37 (77.1)**
Treatment-related TEAE	23 (24.0)	0 (0.0)
Grade ≥ 3 TEAE	**10 (10.4)**	**7 (14.6)**
Serious TEAE	**6 (6.3)**	**4 (8.3)**
TEAE leading to dose modification	5 (5.2)	0 (0.0)
TEAE leading to withdrawal	0 (0.0)	0 (0.0)
TEAE leading to death	0 (0.0)	0 (0.0)

Proportionally Fewer Adverse Events Observed vs. SOC

- Proportionally fewer ELI-002 7P patients had adverse events (AEs), Grade ≥3 AEs, and Serious AEs
- 5% had ELI-002 7P dose delays
- 0% stopped ELI-002 7P for toxicity
- 0% treatment-related deaths
- AE event terms were similar across groups (e.g. diarrhea, fatigue in both arms reflected prior Whipple surgery)

TEAE: Treatment emergent adverse event

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A Precision Medicine Roadmap to Adjuvant PDAC Pivotal Phase 3

Key Phase 2 findings inform the Phase 3 development strategy

Target R0 Patients	Strong efficacy signal in completely resected R0 patients consistent with lower residual disease
Extend ELI-002 7P Treatment Duration	Robust early efficacy during the dosing period with DFS separation maintained through 9 months

Phase 2 findings support a precision medicine Phase 3 strategy focused on R0 resected patients and additional dosing.

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A Substantial Post-Surgical Treatment Gap Remains in Adjuvant PDAC

Observation remains standard of care despite substantial recurrence risk after surgery and chemotherapy

Current treatment course leaves a major post-surgical recurrence gap

Phase 2:
R0 ~84% (121/144)

No approved treatment following locoregional therapy

>50%
Recurrence within 12-months [1]

~70-80%
Recurrence within 24-months [2,3]

0
Approved immunotherapies for adjuvant PDAC [4]

13%
5-year overall survival all stages [5]

ELI-002 7P is designed to delay recurrence or prevent progression or death after standard locoregional therapy

[1] Leonhardt CS, et al. ***Gastroenterology.*** *2024,* [2] Kleeff J, et al. ***Ann. Surgery****. 2007,* [3] Daamen LA, et al. ***Trials.*** *2024* [4] ***NCCN Clinical Practive Guidelines in Oncology: Pancreatic Adenocarcinoma (latest version), 5. SEER Cancer Statistics Review (Pancreatic Cancer)***

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Selection of R0 Resected Patients Offers a Clear Phase 3 Development Strategy

R0 resected disease setting selects for lower disease burden and slower recurrence kinetics

Feature	R0 Resection	R1 Resection
Surgical Margin Status	Microscopic tumor **not present**	Microscopic tumor **present**
Residual Disease Burden	↓ **Lowest**	↑ **Higher**
Source of Recurrence	Occult micro-metastatic disease	Micro-metastatic disease + **local residual tumor**
Baseline Recurrence Risk	↓ **Lower**	↑ **Higher**
Expected Time to Recurrence	Typically, **longer**	Typically, **shorter**
	▼	▼
Implication for ELI-002 7P Development	Population most likely to benefit from adjuvant ELI-002 7P Phase 3 enrollment in focused R0 population	R1 patients represent a distinct higher-burden disease setting outside the target population Excluded from Phase 3

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Biology of R1 Resected PDAC is Distinct from R0 Resected

R1 margins found in ~20% of PDAC resections indicate unique biology of disease underlying increased recurrence risk

Repeat resection to achieve R0 does not improve outcome [1]

17 patients underwent extended surgery to convert R1 → R0 margins during the operation. Median OS was 11 months for R1 → R0, and 13 months in R1 without extra surgery, indicating that tumor biology beyond the presence of cancer cells at the margin is responsible.

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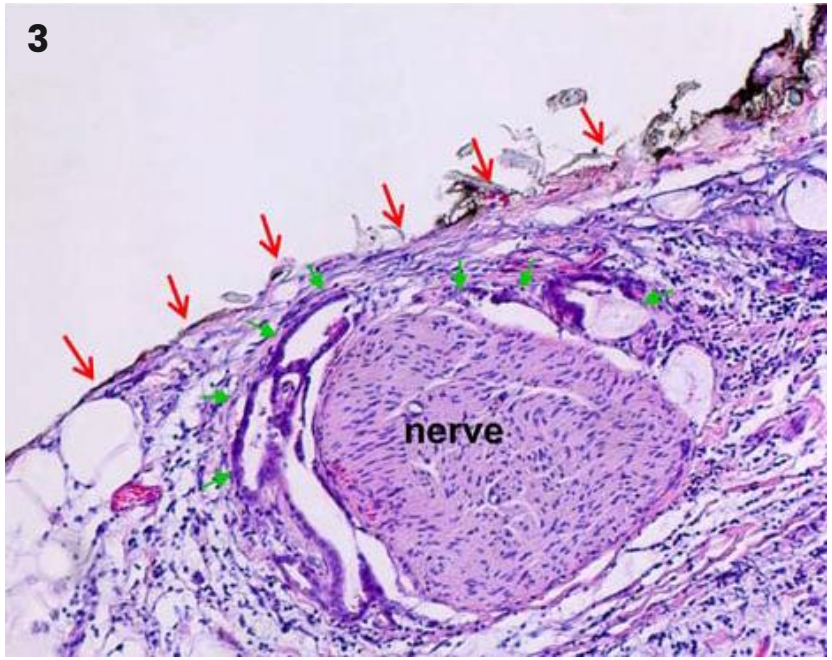

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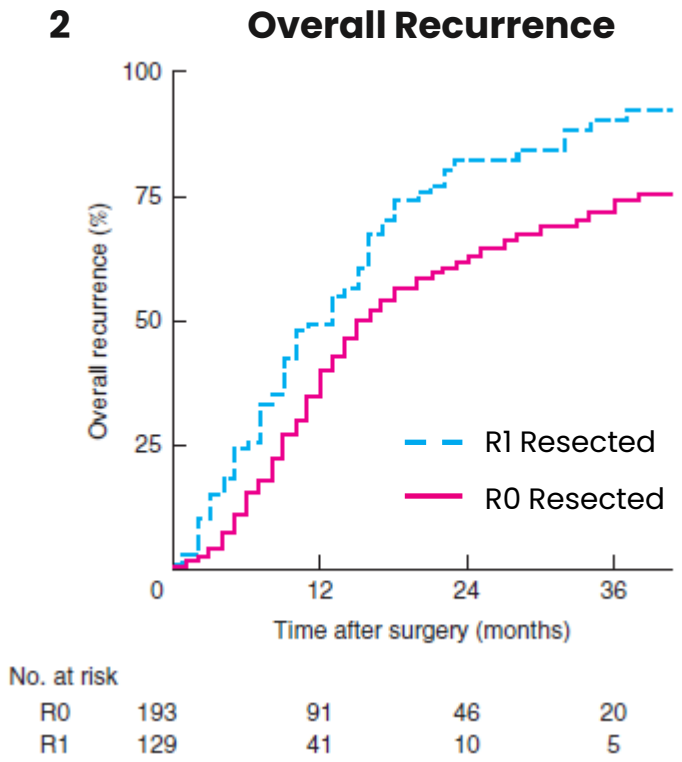

R1 tumors associate with more rapid recurrence

R1 tumors spread along blood/lymph vessels and nerves

[1] Hernandez, et al. ***Annals Surg***. 2009; [2]Tummers, et al. ***Br J Surg.*** 2019; [3] Esposito, et al. ***Annals Surg Oncol.*** 2008

Next Steps

Phase 2 results support continued regulatory, clinical and operational advancement of ELI-002 7P

01

Engage with FDA: End-of-Phase 2 Meeting

Align with FDA on Phase 3 design & regulatory strategy: **ELI-002 7P in R0 resected adjuvant mKRAS PDAC**

02

Initiate Phase 3 Study in Adjuvant PDAC

Post FDA alignment, initiate Phase 3, subject to funding

03

Broaden Pipeline Across Multiple Indications

PDAC provides a clinical foundation for evaluating AMP-enabled immunotherapies **across multiple oncogenic targets,** subject to funding

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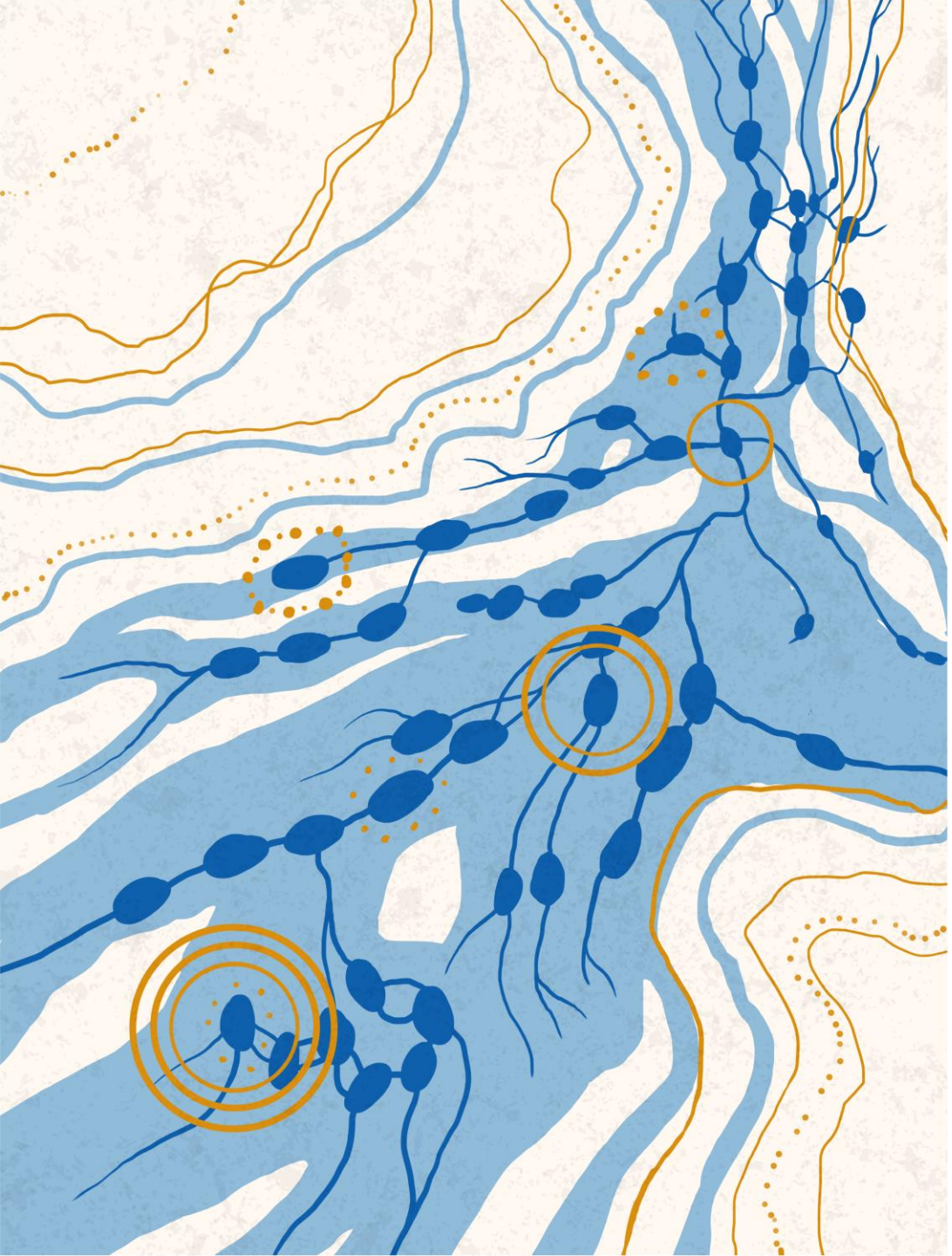

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