

Corporate Presentation

September 2026



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Strategic prioritization to focus on *in vivo* cell therapy for solid tumor indications

TScan today

Strategy

Value inflection points

SOLID TUMORS

- *In vivo* lentivirus platform developed
- Two product candidates advanced to IND-enabling

- Focus on advancing PRAME and MAGE-A4 TCR-Ts with *in vivo* engineering platform

- Preclinical data and regulatory updates – Q1 2027
- File first IND – Q3 2027
- Launch P1 clinical trial – Q4 2027

HEME

- Strong clinical data with commercial-ready process
- Agreement with FDA on Phase 3 study; first 7 patients enrolled

- Pause Phase 3 for data to mature
- Establish external manufacturing
- Actively seek strategic partnership

- 6-month data (14 pts) – Q4 2026
- 1-year data (21 pts) – Q2 2027
- Strategic partnership or funding

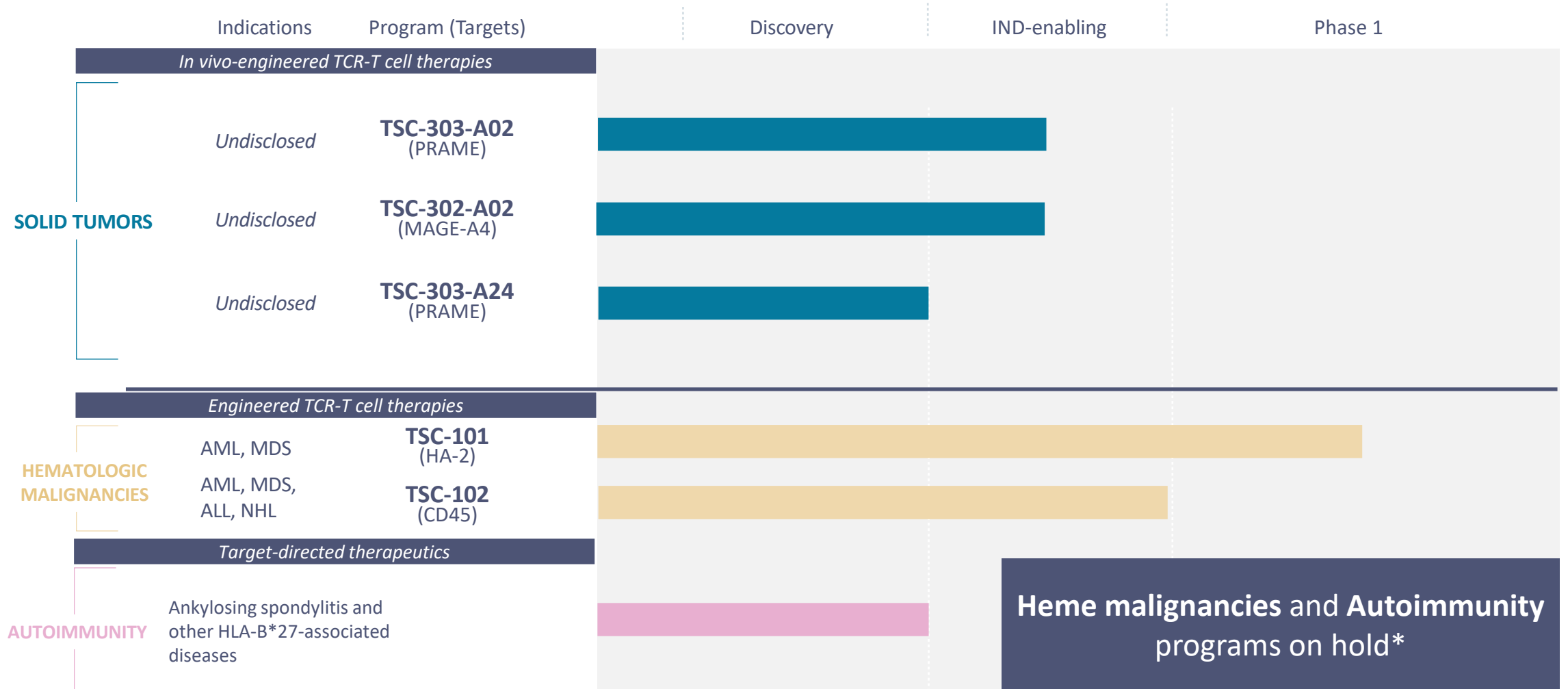
AUTO- IMMUNITY

- Targets discovered in HLA-B*27-associated autoimmunity

- Halt further development pending partnership

- Strategic partnership

Focus on *in vivo*-engineered TCR-T cell therapies for solid tumors



Solid Tumors

*Developing in vivo-engineered TCR-T
cell therapy for solid tumor indications*

Solid tumors represent a large unmet medical need

THE UNMET NEED

High mortality persists in solid tumor indications despite approved therapies



550,000 deaths from solid tumor indications are expected in the U.S. in 2026



8,500 deaths occur annually from melanoma despite ~20 approved therapies



125,000 deaths occur annually from non-small cell lung cancer despite ~50 approved therapies



TARGETABLE BIOLOGY

TScan's TCR-T therapies target prevalent cancer-specific antigens in major solid tumor indications



Intracellular cancer-specific targets are uniquely addressable by TCR-T cell therapies



>90% of melanomas express PRAME*



14-24% of non-small cell lung cancer, head & neck cancer, and ovarian cancer express MAGE-A4*

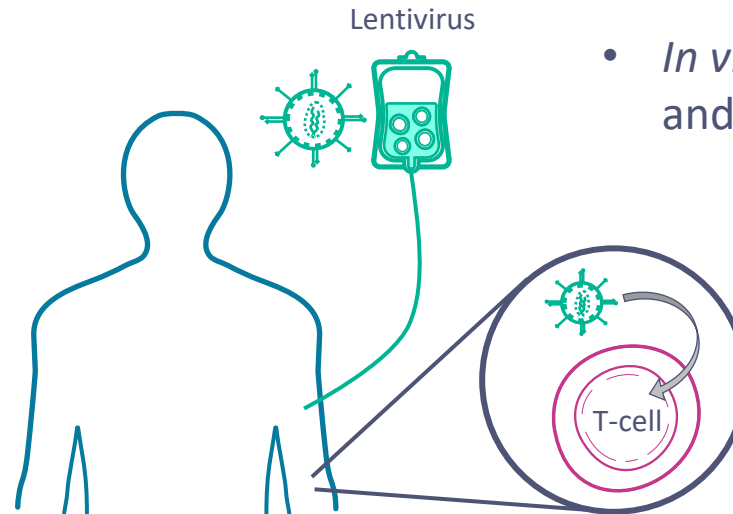
Lentiviral-based *in vivo* engineering technology addresses the key challenges of autologous TCR-T cell therapy

In vivo engineering solves the key challenges of autologous TCR-T

- No patient-specific manufacturing, eliminating out-of-spec issues and significantly reducing cost of goods
- No vein-to-vein time issues for treating patients
- No need for lymphodepletion

In vivo lentiviral approach offers potential for long-term responses

- T cell-targeted lentiviruses enable permanent genetic integration
- Engineered T-cells form memory cells, driving long term anti-cancer activity
- *In vivo* delivery enables higher levels and expansion of engineered T-cells



Early data from *in vivo* CAR-T programs in heme malignancies show remarkable response rates



PROOF-OF-CONCEPT IN HEME MALIGNANCY SPACE

In vivo-engineered CAR-T programs are showing deep responses and durable T-cell persistence



BCMA CAR-T

Relapsed/refractory
multiple myeloma

100%

MRD-negative responses
at 1 month (n=18)



BCMA CAR-T

Relapsed/refractory
multiple myeloma

100%

MRD-negative responses
at 1 month (n=4)



CD19xCD20 CAR-T

Relapsed/refractory B cell
non-Hodgkin lymphoma

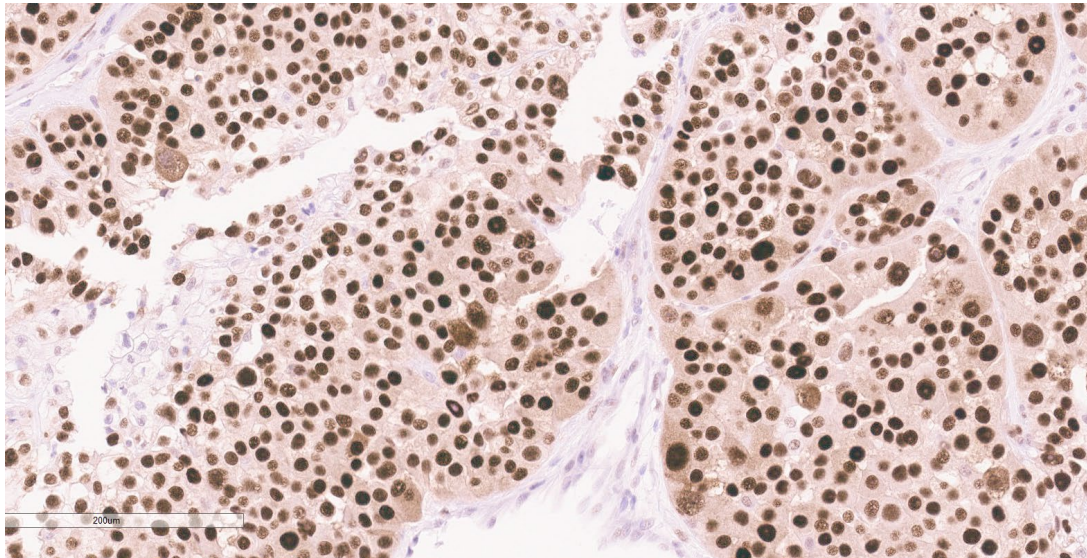
100%

ORR at highest dose level
including 83% CR (n=6)

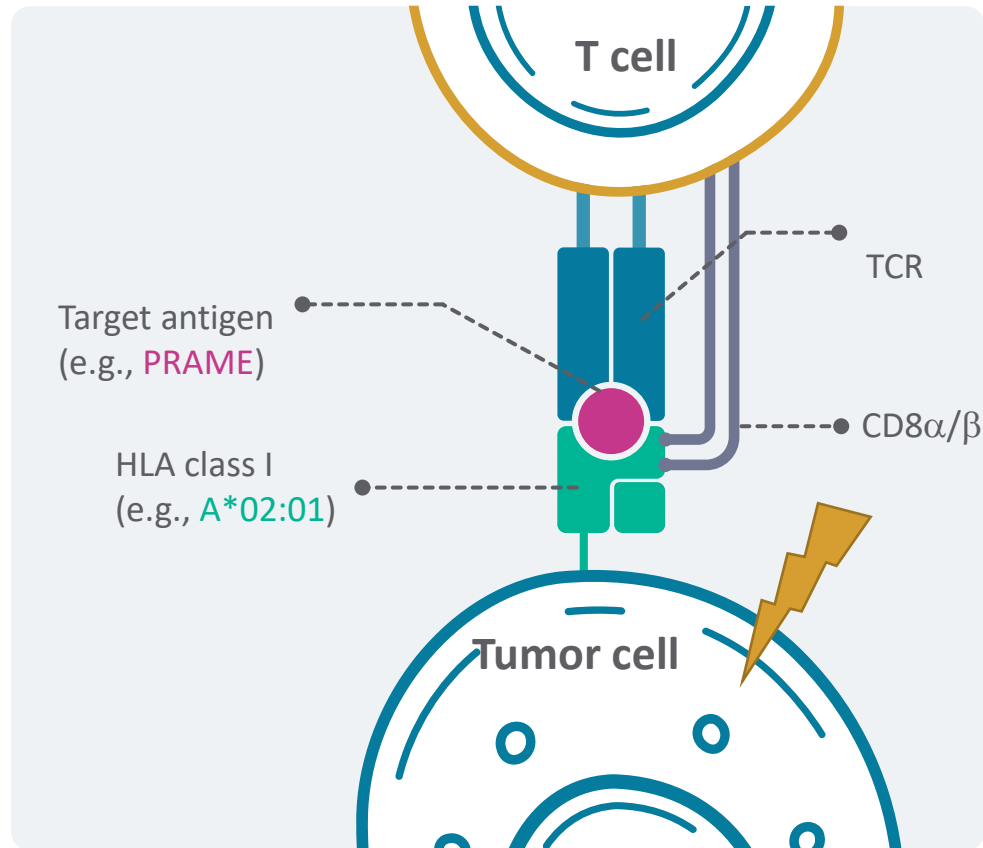
Sources: Kelonia ASH 2025 / ASCO 2026 (inMMMyCAR Ph1, n=18); EsoBiotec/AstraZeneca ESO-T01, The Lancet 2025; Legend Biotech EHA 2026 (Ph 1, n=6 at DL2)

In vivo-engineered TCR-T provide a promising way to address solid tumor indications

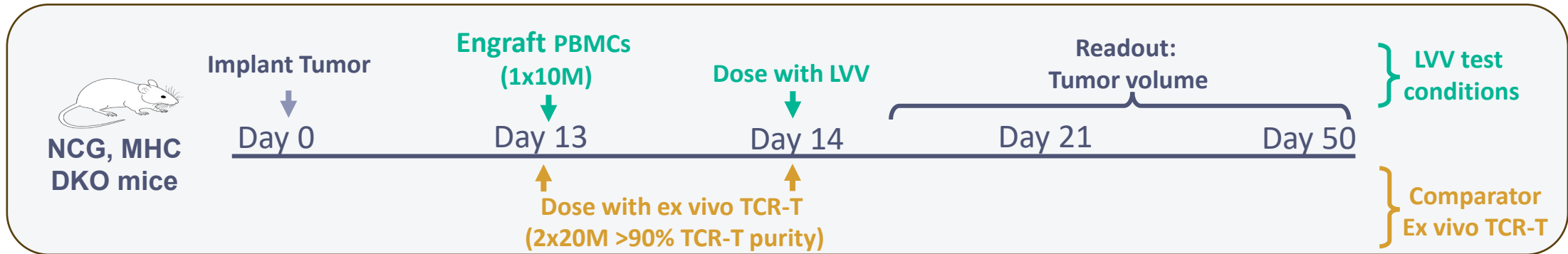
PRAME is expressed at high levels in cutaneous melanoma*



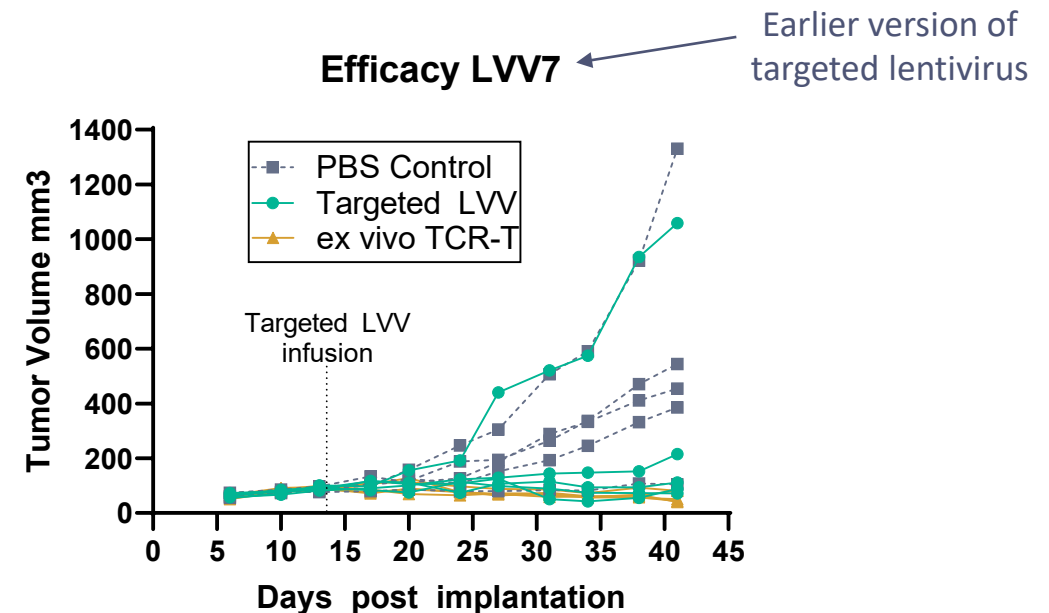
TCR-T cells recognize cancer-specific antigens presented on HLA Class I



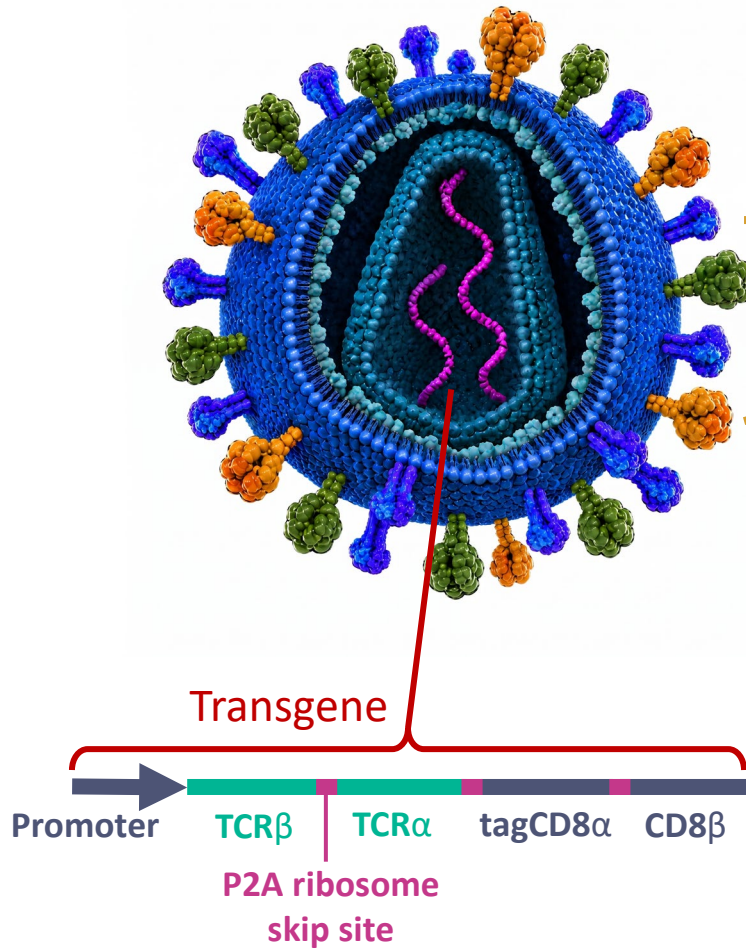
MAGE-A4 TCR delivered *in vivo* with an early version of a targeted lentivirus shows tumor clearance in PBMC-engrafted mice implanted with NSCLC tumor model



- MAGE-A4-expressing NSCLC tumor model was adapted for human PBMC co-engraftment
- *In vivo* engineered TCR-T cells illustrate tumor clearance in NSCLC tumor model



TScan's third generation lentiviral vector enables *in vivo* generation of TCR-T cells



Proprietary elements

- Non-targeting fusogen
- Dual targeting antibodies

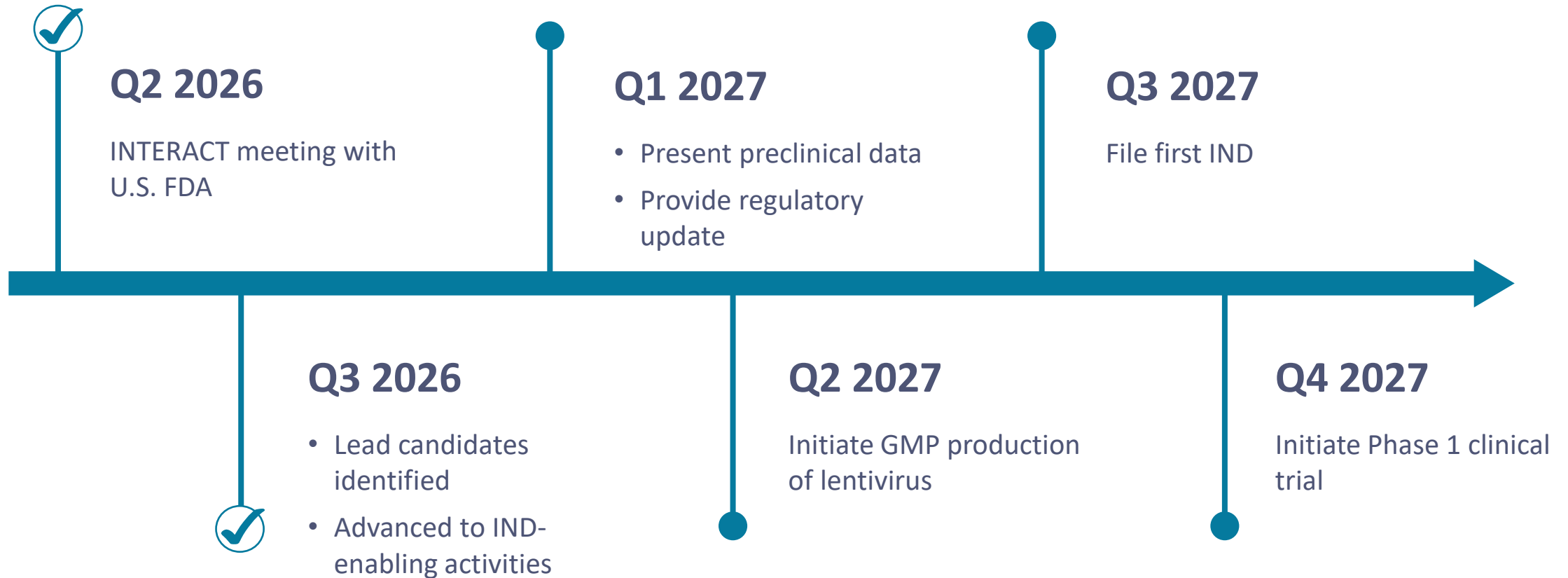
- T-cell targeting antibodies direct the virus to cytotoxic and helper T-cells
- Antibodies simultaneously target and activate T-cells, enabling rapid expansion *in vivo*
- Non-targeting fusogen mediates entry exclusively to T-cells

TScan's product candidates

- Dual-targeting product candidates efficiently transduce human PBMCs in mouse models and induce expansion *in vivo*
- *In vivo*-engineered TCR-Ts control tumor growth in mice at <10% of the equivalent dose of *ex vivo*-engineered TCR-T cells
- Preclinical data will be presented at a major medical meeting in Q1 2027

Solid tumor program on track to initiate Phase 1 development in Q4 2027

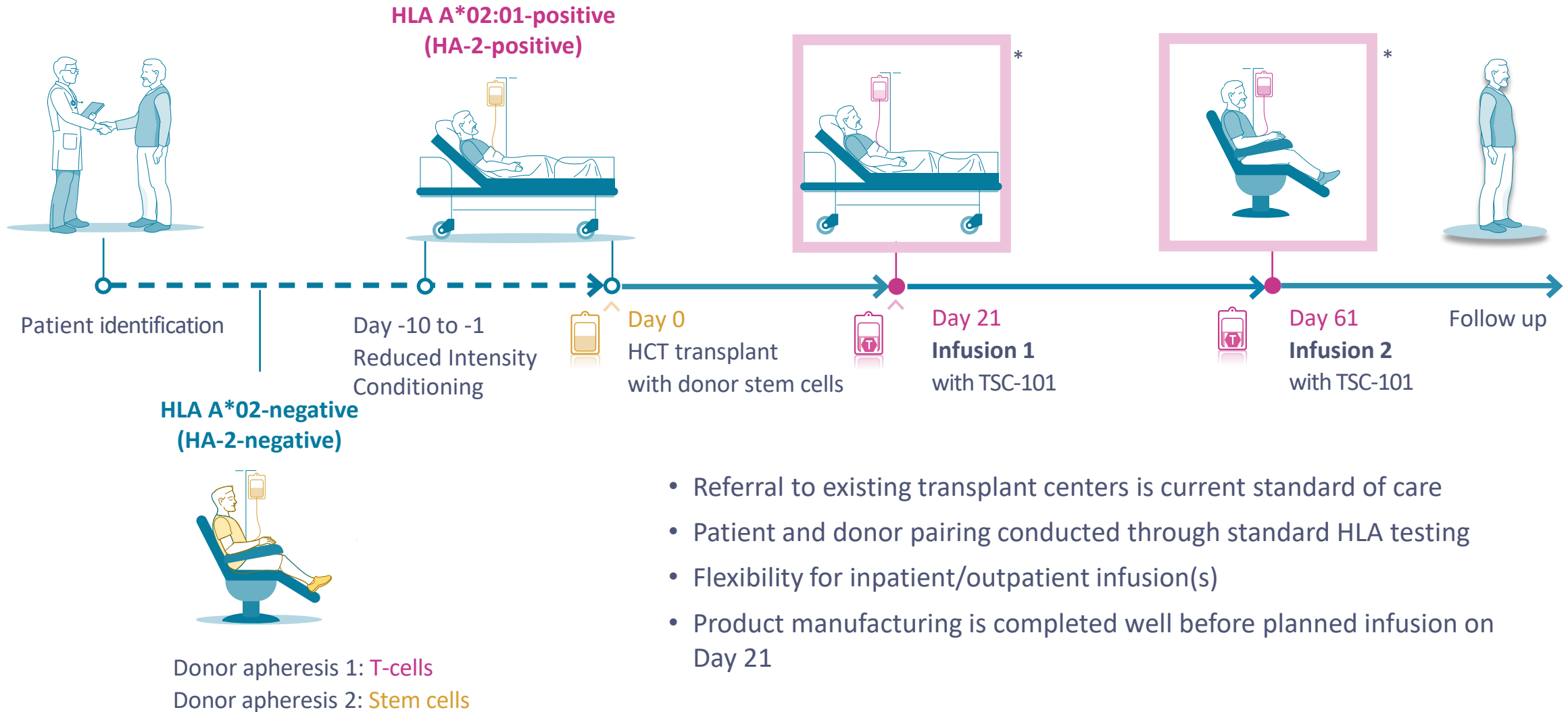
UPCOMING MILESTONES



Heme Malignancies

*Targeting residual disease to prevent relapse
in patients undergoing allogeneic HCT*

TSC-101 is designed to target residual disease and prevent relapse in patients undergoing hematopoietic cell transplantation



- Referral to existing transplant centers is current standard of care
- Patient and donor pairing conducted through standard HLA testing
- Flexibility for inpatient/outpatient infusion(s)
- Product manufacturing is completed well before planned infusion on Day 21

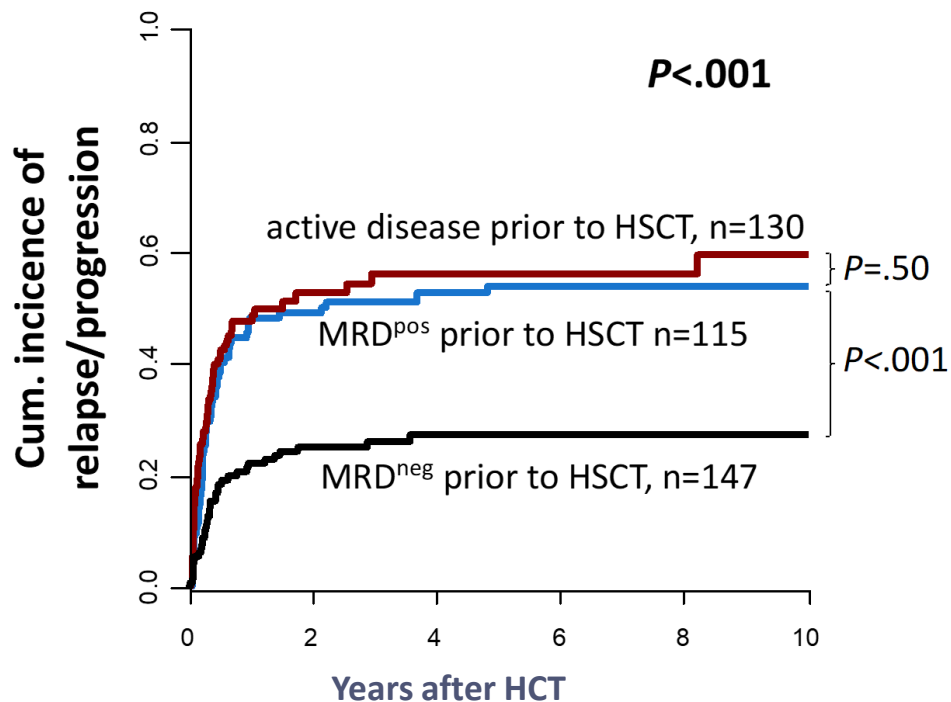
Patients generally well balanced across TSC-101 and control arms although Cohort C included a higher percentage of high-risk patients

		TSC-101 Cohort A	TSC-101 Cohort C	Control
Evaluable Subjects*		19	14	19
Age, Median years (Range)		65 (52-74)	68 (28-79)	66 (23-77)
Sex, Male		13 (68%)	9 (64%)	9 (47%)
Underlying Disease	ALL	2 (11%)	1 (7%)	1 (5%)
	AML	13 (68%)	8 (57%)	10 (53%)
	MDS	4 (21%)	5 (36%)	8 (42%)
TP53 mutated		6 (32%)	4 (29%)	4 (21%)
MRD-positive pre-HCT		13 (68%)	12 (86%)	10 (53%)
Donor type	Haplo	19 (100%)	9 (64%)	18 (95%)
	MMUD	--	5 (36%)	1 (5%)
Mixed chimerism post-HCT (~D21)		11 of 18 (61%)	12 of 14 (86%)	13 of 17 (76%)

Pre-transplant MRD is associated with a very high risk of relapse in AML patients

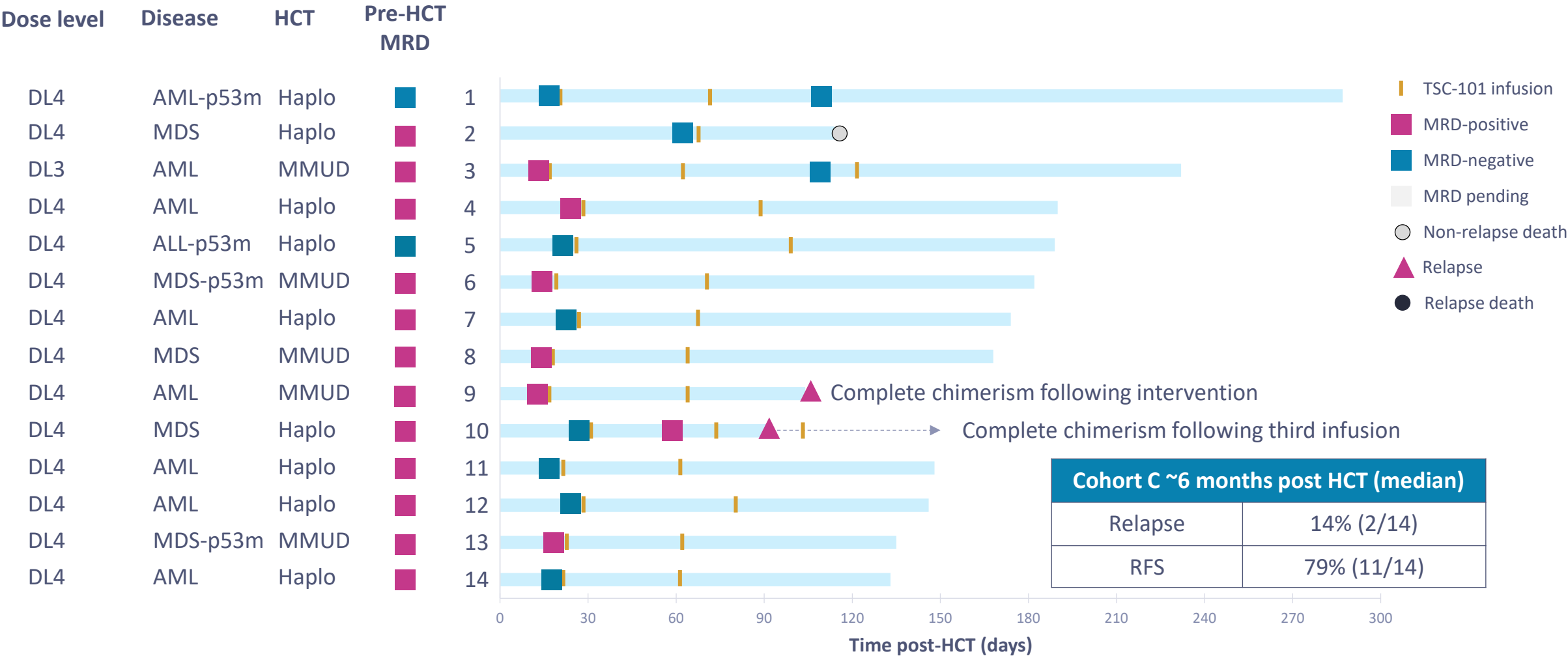
- Retrospective analysis of 392 patients with AML⁽¹⁾
- All patients received NMA- or RIC-HCT
- 75% of patients had intermediate or high-risk genetics
- Cumulative incidence of relapse was 50-60% for patients that were MRD-positive prior to HCT, similar to those with active disease

- Retrospective analysis of adults with AML (n = 1,114) who received their first allo-transplant between April 2006 and March 2023⁽²⁾
- MRD-positive patients had much higher rates of relapse than MRD-negative patients



Outcome	AML n=1,114	AML MRD- negative n=907	AML MRD- positive n=207
Relapse at 1 year	24%	17%	55%
RFS at 1 year	65%	73%	32%

All 14 Cohort C patients were at high risk of relapse: 12 were MRD-positive and remaining 2 were p53m

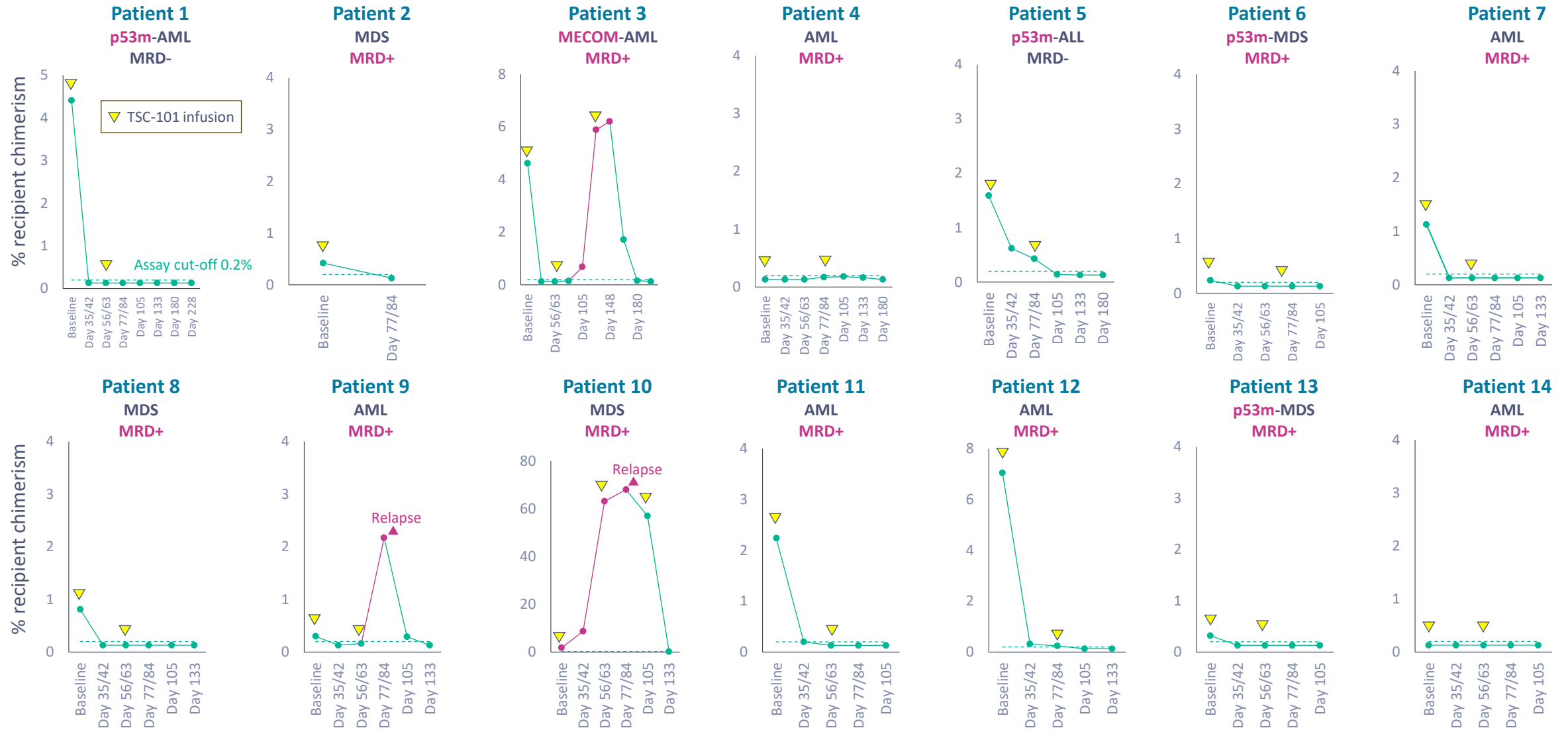


Despite being at high risk of relapse, all patients in Cohort C had complete donor chimerism at their last assessment, including both patients who relapsed

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	DL4	DL4	DL3	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4	DL4
Time post HCT#	Haplo	Haplo	MMUD	Haplo	Haplo	MMUD	Haplo	MMUD	MMUD	Haplo	Haplo	Haplo	MMUD	Haplo
	AML-p53m	MDS	AML	AML	ALL-p53m	MDS-p53m	AML	MDS	AML	MDS	AML	AML	MDS-p53m	AML
Prior to infusion	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓
	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Day 35/42	✓	✗	✓	✓	✗	✓	✓	✓	✓	✗	✓	✗	✓	✓
Day 56/63	✓	✗	✓	✓		✓	✓	✓	✓	✗	✓		✓	✓
	◆	◆	◆			◆	◆	◆	◆	◆	◆		◆	◆
Day 77/84	✓	✓	✓		✗	✓	✓	✓	✗	✗	✓	✗	✓	✓
				◆	◆							◆		
Day 105	✓	●	✗	✓	✓	✓	✓	✓	▲	▲	✓	✓	✓	✓
			◆							◆				
Day 133	✓		✗	✓	✓		✓	✓	✓	✓		✓		
Day 180	✓		✓		✓									
Day 228	✓		✓											

- ◆ TSC-101 infusion
- ✓ Complete donor chimerism
- ✗ Mixed donor chimerism
- ▲ Relapse
- Non-relapse death
- Relapse death

Despite being at high risk of relapse, all patients in Cohort C had complete donor chimerism at their last assessment, including both patients who relapsed



Donor chimerism results using investigational next-generation sequencing assay (Allohome) with data cut-off of 0.2% at indicated times post-transplant (# ± 3 days)

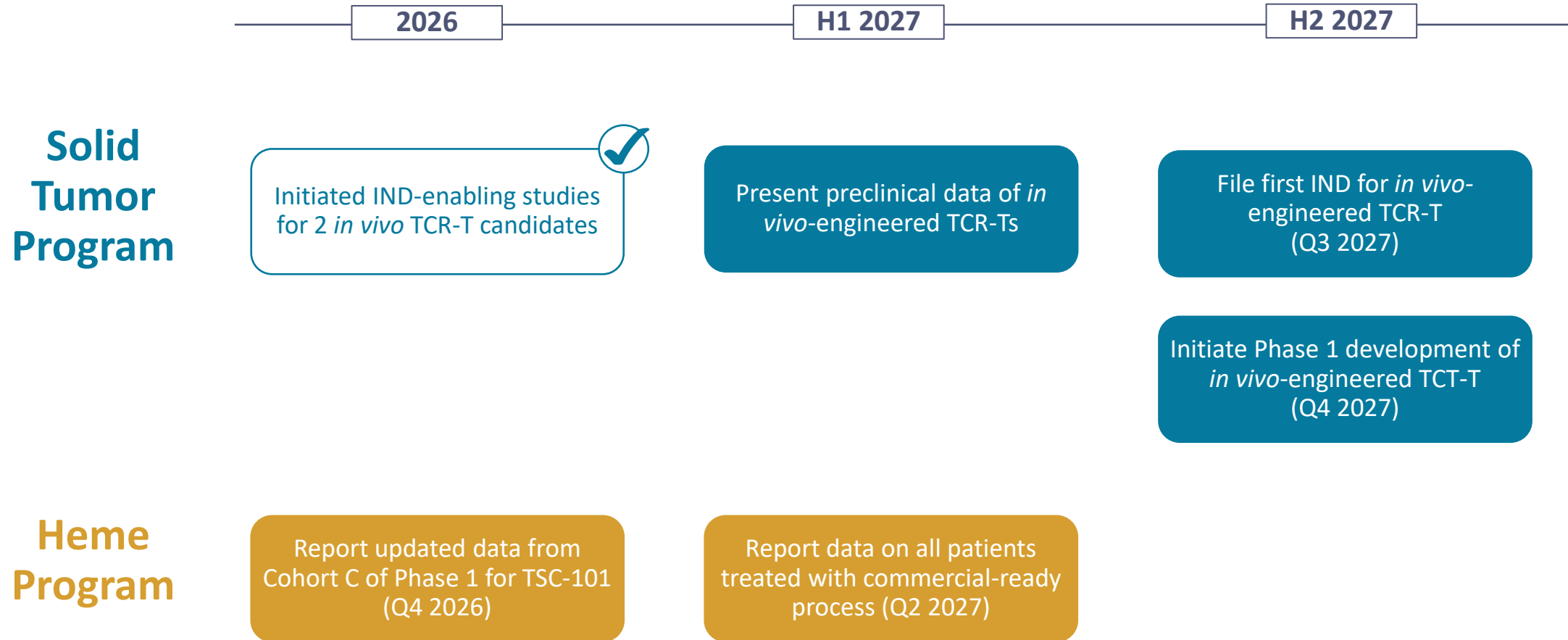
Data as of Aug 27, 2026

TSC-101 is well tolerated with no dose-limiting toxicity

	Cohort A n=19	Cohort C n=14	Control n=19
Treatment-emergent acute GvHD (MAGIC)	14 (73.7%)	5 (35.7%)	12 (63.2%)
Grade I	8 (42.1%)	3 (21.4%)	6 (31.6%)
Grade II	5 (26.3%)	2 (14.3%)	5 (26.3%)
Grade III	1 (5.3%)	0 (0%)	1 (5.3%)
Grade IV	0 (0%)	0 (0%)	0 (0%)
Treatment-emergent chronic GvHD (NIH)	2 (10.5%)	1 (7.1%)	2 (10.5%)
Mild	2 (10.5%)	1 (7.1%)	1 (5.3%)
Moderate	0 (0%)	0 (0%)	1 (5.3%)
Severe	0 (0%)	0 (0%)	0 (0%)
Any CRS	13 (68.4%)	8 (57.1%)	7 (36.8%)
Grade 1 - 2	13 (68.4%)	8 (57.1%)	6 (31.6%)
Grade 3 - 4	0 (0%)	0 (0%)	1 (5.3%)
Treatment-emergent CRS	3 (15.8%)	1 (7.1%)	0 (0%)
Grade 1 - 2	3 (15.8%)	1 (7.1%)	0 (0%)
Grade 3 - 4	0 (0%)	0 (0%)	0 (0%)
Any ICANS	1 (5.3%)	0 (0%)	0 (0%)
Any TLS	0 (0%)	0 (0%)	0 (0%)
Any Graft Failure	0 (0%)	0 (0%)	0 (0%)

- No dose-limiting toxicities were observed across either treatment cohort
- Treatment-emergent acute GvHD occurred in most patients, mainly Grade I–II
 - 74% Cohort A, 36% Cohort C, 63% Control; only 1 Grade III event each in Cohort A and Control, and no Grade IV events
- No moderate or severe chronic GvHD occurred with TSC-101 (Cohort A or C)
 - Two mild events in Cohort A, one mild event in Cohort C, and one moderate event in Control
- CRS occurred more frequently with TSC-101 but stayed low-grade
 - No treatment-emergent Grade ≥3 CRS in either treatment cohort
- One TEAE of ICANS reported in Cohort A
 - Depressed consciousness (Grade 2) reported following infusion #2 in a patient with relapsing disease. Treated with tocilizumab and steroids; resolved within 24 hours
- No events of TLS or graft failure were reported in any cohort

Upcoming milestones



THANK YOU

