Corporate Presentation

October 2025

Forward-Looking Statements

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Certain information contained in this presentation relates to or is based on studies, publications, surveys, and other data derived from third-party sources and our own internal estimates and research. While we believe these third-party sources to be reliable as of the date of this presentation, we have not independently verified, and we make no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involve a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, although we believe our own internal research is reliable, such research has not been verified by any independent source.

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A Pioneer and Leader in ADCs

Capability **Commercial-stage pioneer** in the field of ADCs, with specialized **capabilities** from clinical through commercialization

Pipeline **Seeking** expansion of **FDA-approved ZYNLONTA®** while pursuing **early-stage PSMA-targeting ADC** towards IND

Corporate Delivering on our strategy supported by an **accomplished and multidisciplinary team** and with cash runway expected **into 2028**

Focused Portfolio with ZYNLONTA and PSMA-targeting ADC

ZYNLONTA

- Currently commercialized program in 3L+ DLBCL is self-funded
- Potential expansion into earlier lines of therapy and with new indications
  - LOTIS-5: rituximab combination
  - LOTIS-7: bispecific combinations
  - Indolent lymphomas (FL and MZL)

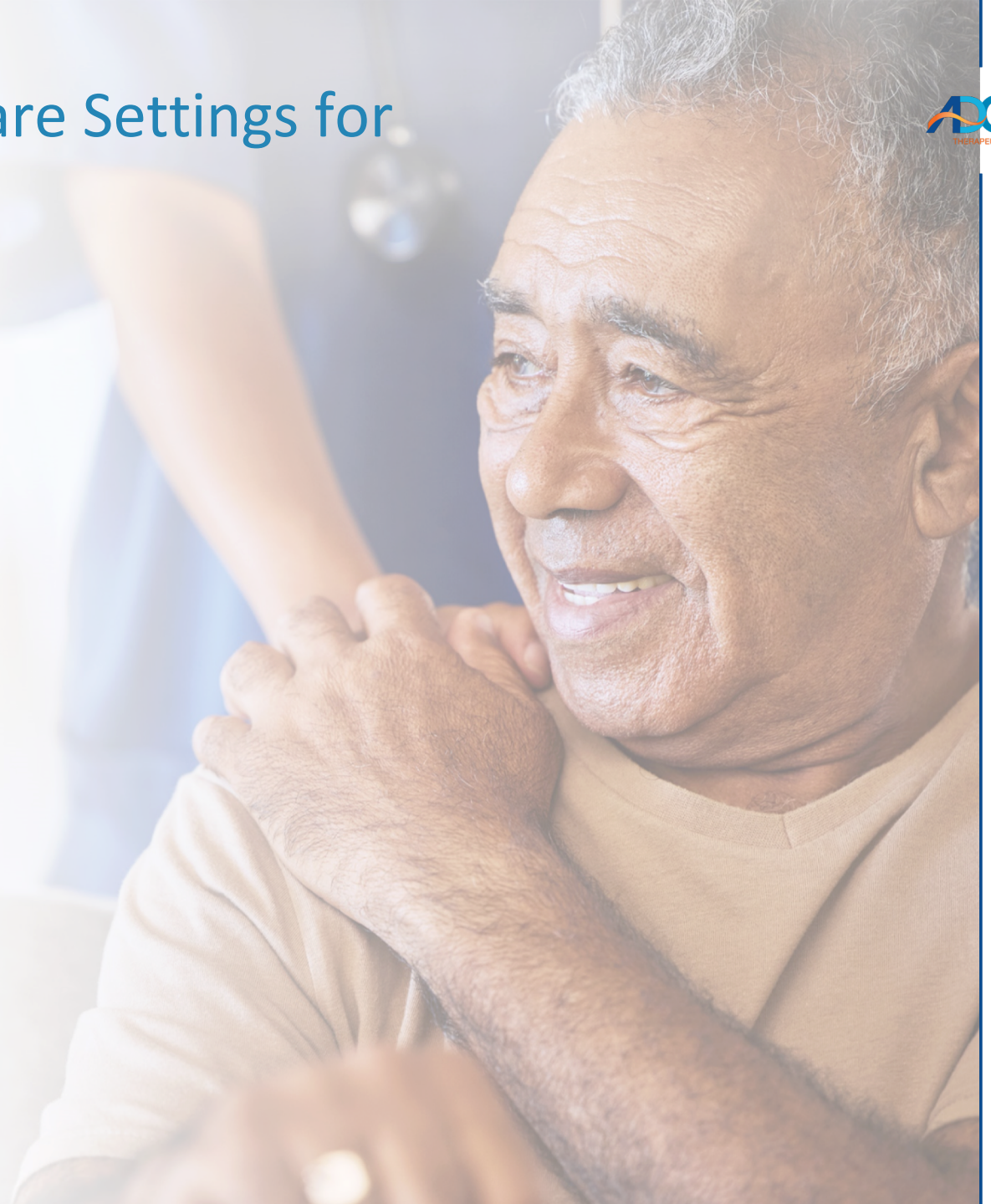
PSMA-targeting ADC

- Advancing IND-enabling activities for next-generation ADC candidate
  - Differentiated exatecan-based payload with novel hydrophilic linker
  - Seeking research collaborations

DLBCL: Diffuse Large B-Cell Lymphoma; FL: Follicular Lymphoma; MZL: Marginal Zone Lymphoma; NSCLC: Non-Small Cell Lung Cancer; ALL: Acute Lymphoblastic Leukemia

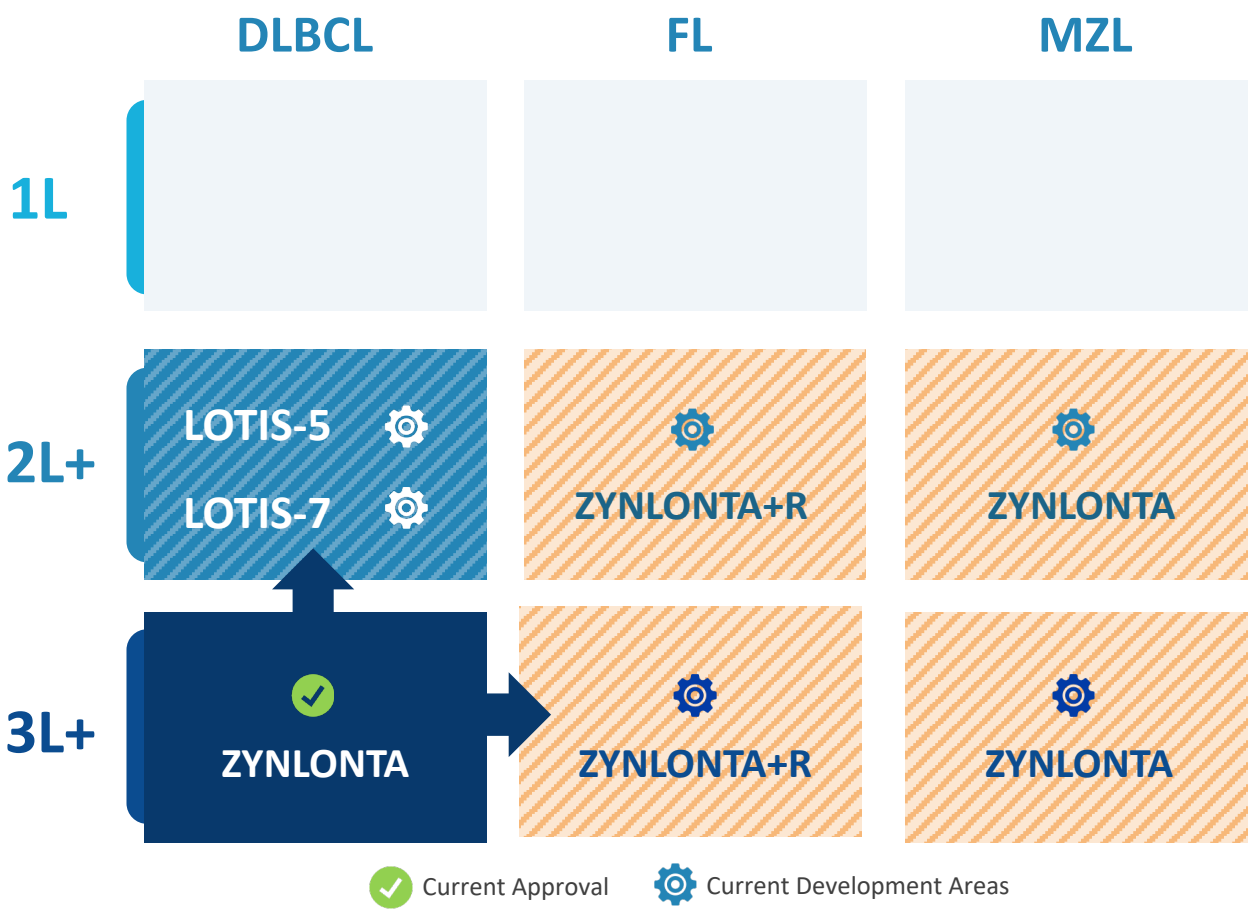
ZYNLONTA is Ideally Suited Across Care Settings for Patients with r/r DLBCL

- ZYNLONTA is a CD19-directed ADC indicated as monotherapy for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy
- Rapid, deep, and durable efficacy
  - Median time to CR 1.5 months
  - 48.3% ORR and 24.8% CR
  - Median duration of response not yet reached for patients in CR at 2-year follow-up
- Manageable safety profile
  - No CRS or ICANS and no cumulative irreversible toxicities
- Accessibility
  - Simple Q3W dosing with no REMS or inpatient stay requirements



Please visit ZYNLONTA.com for complete prescribing information including indication, warnings and precautions.

Advancing ZYNLONTA Development Into 2L+ B-Cell Lymphomas



Potential To Move Into 2L+ DLBCL

	Overall Response Rate	Complete Response Rate
LOTIS-5		
ZYNLONTA + rituximab[1] *(N=20)*	**~80%**	**~50%**
LOTIS-7		
ZYNLONTA + glofitamab[2] *(N=30)*	**~93%**	**~87%**

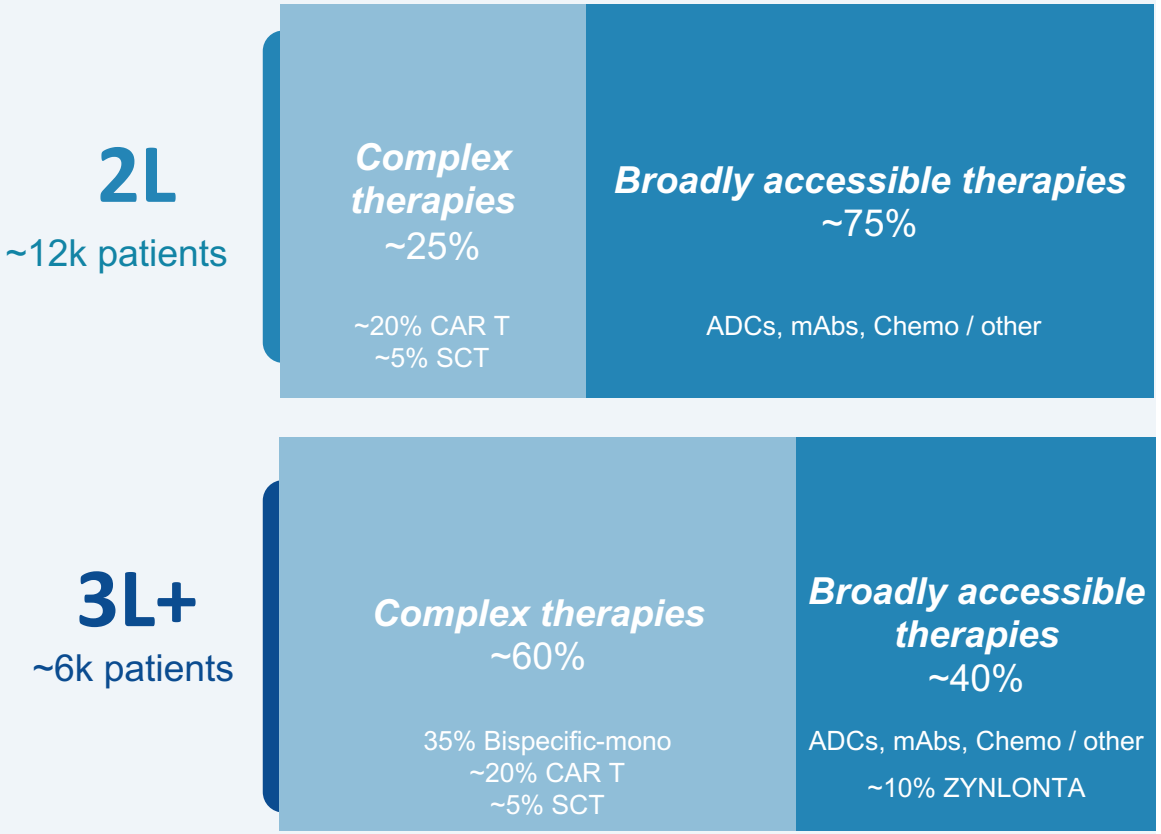
Potential Benefit In Indolent Lymphomas

	Overall Response Rate	Complete Response Rate
High-risk r/r FL		
ZYNLONTA + rituximab[3] *(N=39)*	**~97%**	**~77%**
r/r MZL		
ZYNLONTA[4] *(N=27)*	**~85%**	**~69%**

1 Safety run-in study as detailed in SOHO 2023 poster presentation
2 As detailed in EHA 2025 poster presentation scheduled for June 14, 2025
3 As detailed in ASH 2024 oral presentation; Alderuccio, PJ. Loncastuximab tesirine with rituximab in patients with relapsed or refractory follicular lymphoma: a single centre, single arm Phase 2 trial. The Lancet Haematology. January 2025; Volume 12 (Issue 1): E23-E34.
4 As detailed at ICML in June 2025

Two Distinct Segments in r/r DLBCL Treatment Options

Current r/r DLBCL U.S. Market



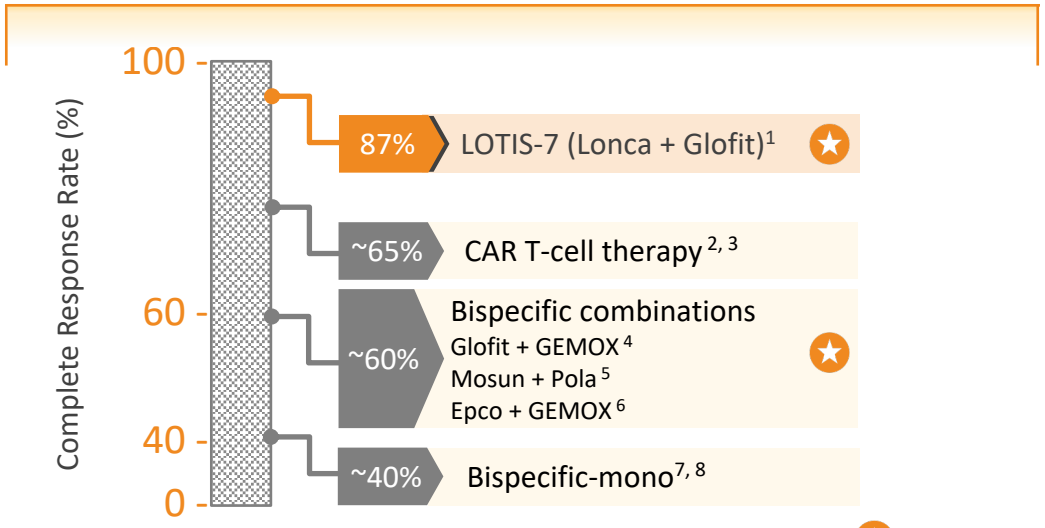
Based on internal market research conducted July to August 2024 (n=160 US Hem/Oncs), and glofitamab ODAC briefing book

2L+ treatment choice based on efficacy, safety and accessibility in context of individual patient need

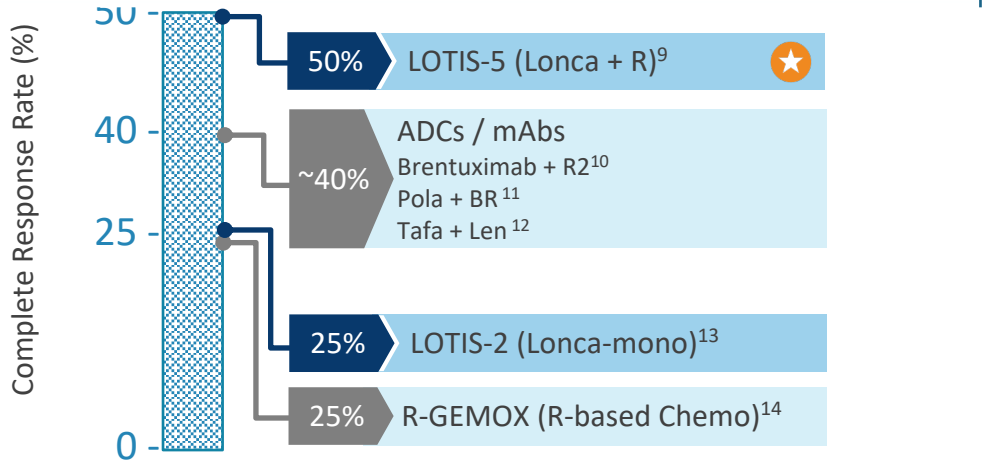
- **Complex** therapies with unique patient management and infrastructure requirements
- **Broadly accessible** outpatient therapies

ZYNLONTA Has Potential to Disrupt r/r DLBCL Market and Unlock Significant Growth Opportunity in Both Segments

Complex therapies
(CAR T-cell therapy, Bispecifics)



Broadly accessible therapies
(ADCs, mAbs, Chemo / other)



Emerging data - not FDA approved

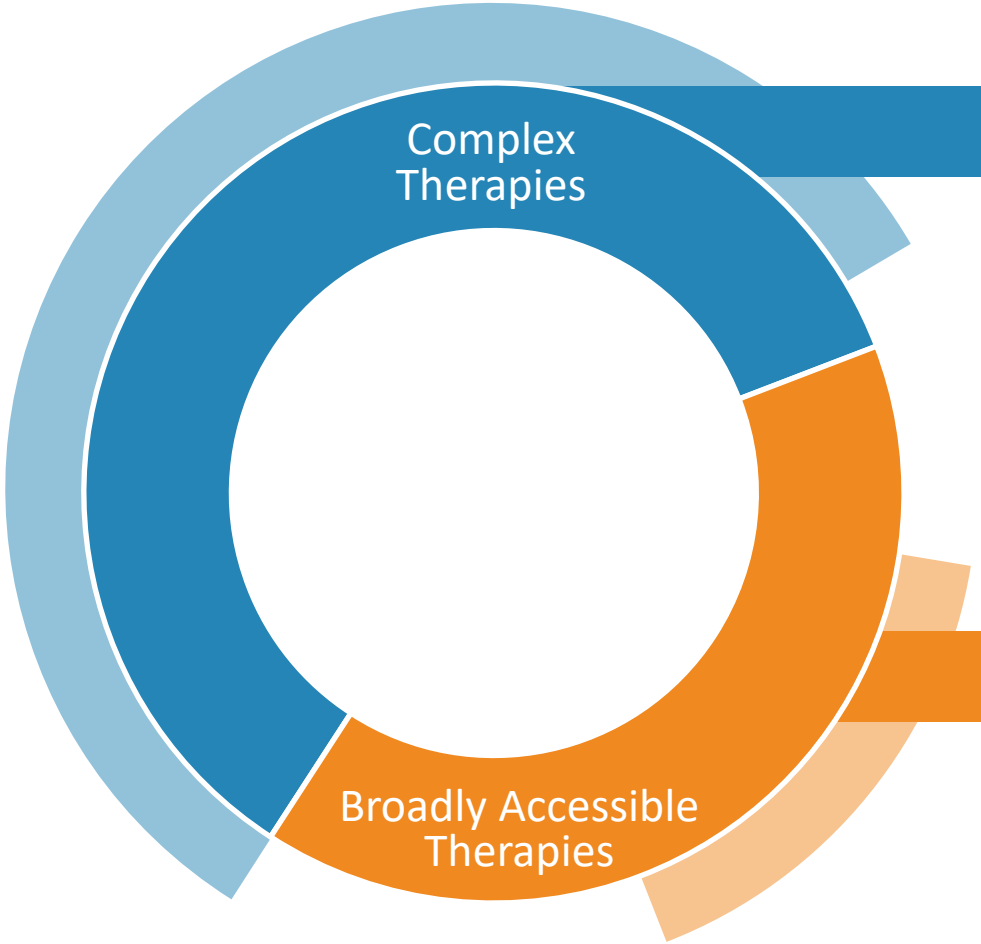
ZYNLONTA combinations have the potential to unlock significant growth through:

- → Doubling the addressable patient population (2L)
- → Capturing higher market share with leading efficacy
- → Increasing average duration of therapy (3 cycles with mono to 5-6 with combo)

1. LOTIS-7 (loncastuximab + glofitamab) – EHA 2025 poster presentation - 87% CR as of data cutoff of April 14, 2025; 2. Yescarta (axi-cel) – USPI, ZUMA-7 study – 65% CR; 3. Breyanzi (liso-cel) – USPI, TRANSFORM study – 66% CR; 4. Columvi (glofitamab) + GEMOX – STARGLO study, Lancet 2024 – 59% CR; 5. Mosunetuzumab + Polatuzumab – Phase 1/2b ASH Presentation 2024 – 58% CR; 6. Epkinly (Epcoritamab) + GEMOX – EPCORE NHL-2 study ASH Poster 2024 – 61% CR; 7. Epkinly (epcoritamab) – USPI, EPCORE-NHL-1 study – 38% CR; 8. Columvi (Glofitamab) – USPI, Study NP30179 – 43% CR; 9. LOTIS-5 (loncastuximab + Rituximab) – SOHO 2023 safety run-in poster – 50% CR; 10. Adcetris (Brentuximab) + R2 – USPI, ECHELON-3 study, JCO 2025 – 45% CR; 11. Polatuzumab + BR – USPI, Study GO29365 – 40% CR; 12. Monjuvi (Tafasitamab + Lenalidomide) – USPI, L-MIND study – 37% CR; 13. LOTIS-2 (loncastuximab) – 2 year follow up, LOTIS-2 study – 25% CR; 14. R-GEMOX – control arm of STARGLO study, Lancet 2024 – 25% CR

Note: No head-to-head trials have been conducted among the results shown. Comparing the results from different trials may be unreliable due to different protocol designs, trial design, patient selection and populations, number of patients, trial endpoints, trial objectives and other parameters that may not be the same between trials.

ZYNLONTA Combinations Potentially Raising the Bar on Efficacy in r/r DLBCL



87% CR

LOTIS-7 (ZYNLONTA + glofitamab) **Opportunity**

- We believe LOTIS-7 has the potential to be the leading bispecific combination regimen for patients with access to complex therapies
- Leading CR rate that rivals CAR T-cell therapy with a manageable toxicity profile and improved accessibility
- LOTIS-7 provides a unique combination for r/r DLBCL without repeat exposure to polatuzumab and chemo

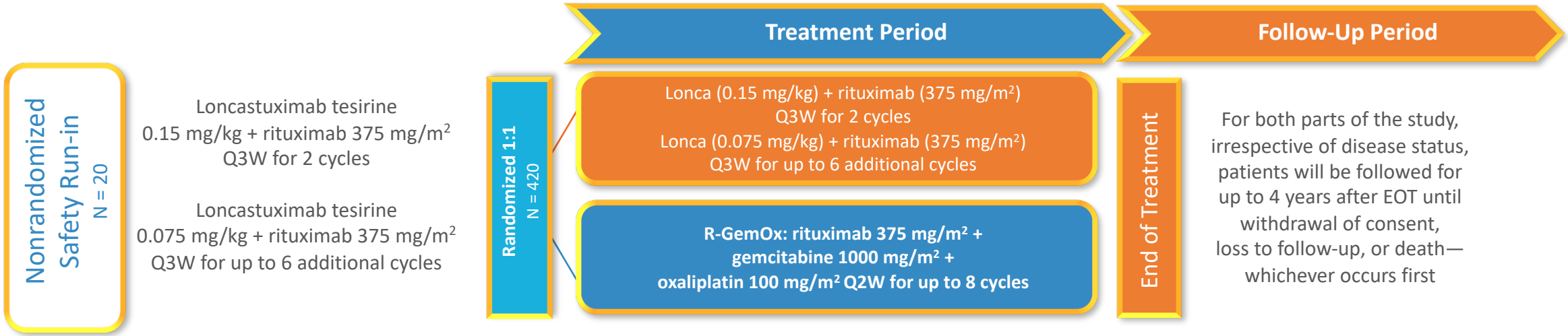
50% CR

LOTIS-5 (ZYNLONTA + rituximab) **Opportunity**

- We believe LOTIS-5 has the potential to be the leading regimen for patients who will not receive complex therapies
- High CR rate among broadly accessible therapies (ADCs, mAbs, chemo/other) in r/r DLBCL
- Manageable safety with reversible toxicities

Illustrative depiction of potential market share based on internal market research Conducted July to August 2024 (n=160 US Hem/Oncs)

LOTIS-5: Phase 3 Confirmatory Trial of ZYNLONTA in Combination with Rituximab in 2L+ DLBCL



LOTIS-5 Overview

- **Patient Population:** 420 randomized 1:1 2L+ DLBCL patients, ASCT ineligible
- **Primary endpoint:** PFS; **Secondary endpoints** include OS; ORR; CRR; DoR; frequency and severity of adverse events
- **Initial data:** 20 patient safety run-in, **resulting in 80% ORR and 50% CR (mDOR not reached for CR), with no new safety signals**[1]

Status and Next Steps

- Full enrollment completed in 2024
- After the prespecified number of PFS events is reached and data are available, the Company expects to provide topline data in 1H 2026
- sBLA submission and potential approval to follow

Initial data demonstrates that this combination has the potential to provide competitive 2L+ efficacy with a favorable safety profile allowing broad accessibility

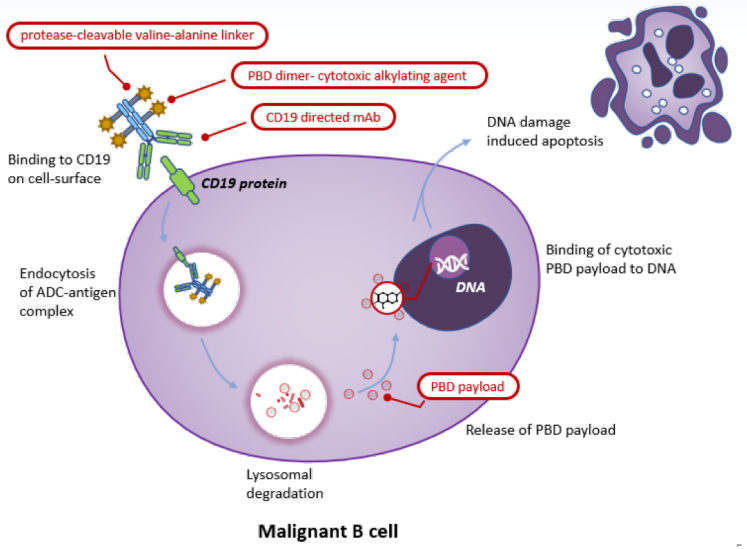
1 – Initial data from SOHO 2023 poster presentation; updated data from EHA 2025 poster presentation

LOTIS-7 Combination Rationale and Biological Hypothesis

Potent, single agent drugs with distinct and complementary MOAs

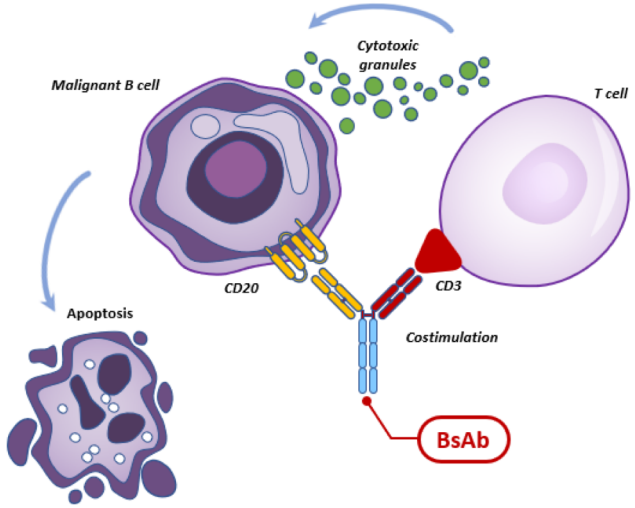
ZYNLONTA

ANTI-CD19 ADC



GLOFITAMAB

ANTI-CD20/CD3 T-Cell engaging bispecific antibody



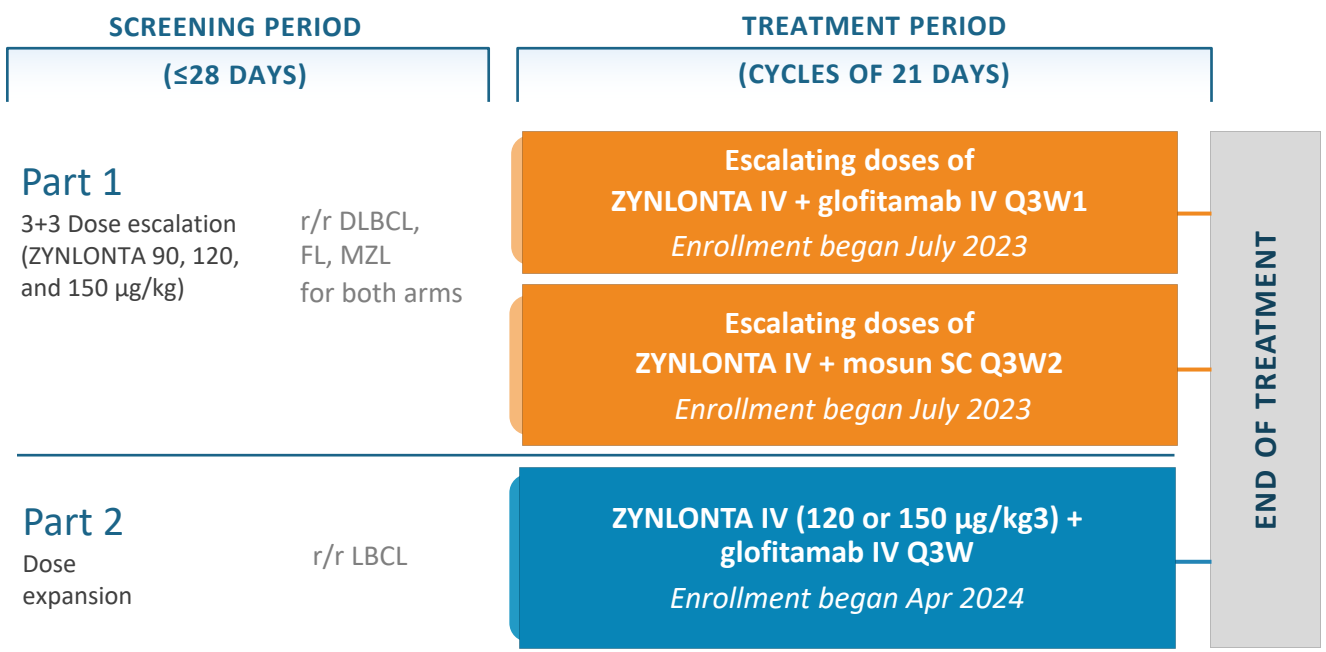
EFFICACY

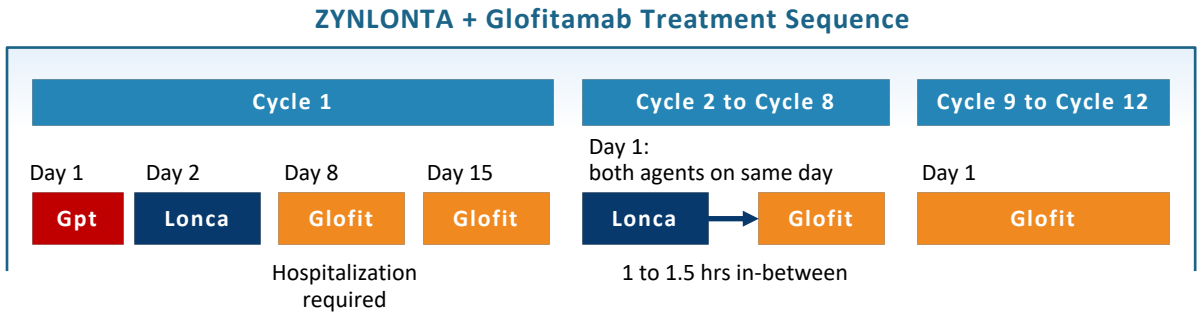
- Expected to have additive or synergistic efficacy

SAFETY

- No overlapping non-hematologic toxicities expected to yield manageable safety profile
- Potentially lower CRS rates/grades given ZYNLONTA use prior to glofitamab may debulk the tumors and reduce peripheral B cells

LOTIS-7: Phase 1b Trial of ZYNLONTA in Combination with Glofitamab





Study Population

- Relapsed or Refractory B-NHL patients, ECOG PS 0 – 2, and have received:
  - Part 1: >2 systemic treatment regimens
  - Part 2: >1 systemic treatment regimens
- Prior autologous SCT or CAR-T (>100 days) is allowed
- Measurable disease per 2014 Lugano Classification
- Excludes patients with clinically significant 3rd space fluid accumulation

Endpoints

- Primary: Safety and tolerability; MTD and/or RD
- Secondary:
  - Efficacy: ORR, DOR, CRR, PFS, RFS, OS
  - Pharmacokinetics and Immunogenicity

Trial Status

- Dose escalation complete with no DLTs, no high-grade CRS or ICANS and early signs of anti-tumor activity
- Dose expansion of 40 patients completed in ZYNLONTA (120 or 150 µg/kg) + glofitamab
- 150 µg/kg dose selected; expanding to 100 patients

Obinutuzumab pretreatment 1000mg on C1D1; ZYNLONTA administered on C1D2; administration of 1st and 2nd step-up dose(s) of IV glofitamab (2.5mg on C1D8 & 10mg on C1D15); ZYNLONTA plus glofitamab 30mg on C2D1 and beyond (reduce ZYNLONTA to 75 ug/kg at C3 if starting dose is 120 ug/kg or higher)

ZYNLONTA plus subcutaneous mosunetuzumab 1st step-up dose of 5 mg on C1D1, followed by mosunetuzumab 2nd step-up & target dose of 45 mg for C1D8 & C1D15; ZYNLONTA plus 45mg of subcutaneous mosunetuzumab on C2D1 and beyond (reduce ZYNLONTA to 75 µg/kg at C3 if starting dose is 120 ug/kg or higher)

ZYNLONTA dose reduced to 75 µg/kg at C3

LOTIS-7 Phase 1b Trial: Baseline Patient Characteristics

r/r Large B-Cell Lymphoma Treated Population (N=41) as of data cutoff of April 14, 2025

All patients enrolled in US & Europe with majority in US

	120 µg/kg N=20	150 µg/kg N=21	N=41
Median age [years (range)]	70 (50, 82)	74 (26, 85)	71 (26, 85)
Male	11 (55%)	12 (57.1%)	23 (56.1%)
ECOG Performance Status			
0	9 (45%)	14 (66.7%)	23 (56.1%)
1	10 (50%)	7 (33.3%)	17 (41.5%)
2	1 (5%)	0	1 (2.4%)
Large B-Cell Lymphoma Histology			
de novo DLBCL	13 (65%)	17 (81%)	30 (73.2%)
trFL	2 (10%)	2 (9.5%)	4 (9.8%)
HGBCL	4 (20%)	2 (9.5%)	6 (14.6%)
FL Grade 3b	1 (5%)	0	1 (2.4%)
DLBCL Subtype			
GCB	10 (50%)	11 (52.4%)	21 (51.2%)
non-GCB	5 (25%)	8 (38.1%)	13 (31.7%)
Double/Triple hit	3 (15%)	5 (23.8%)	8 (19.5%)

	120 µg/kg N=20	150 µg/kg N=21	N=41
IPI Score			
0/1/2	9 (45%)	10 (47.6%)	19 (46.3%)
3/4/5	11 (55%)	11 (52.4%)	22 (53.7%)
LDH Level High	11 (55%)	10 (47.6%)	21 (51.2%)
Ann Arbor stage			
I/II	3 (15%)	3 (14.3%)	6 (14.6%)
III/IV	17 (85%)	18 (85.7%)	35 (85.3%)
Bulky Disease (≥10 cm)	2 (10%)	2 (9.5%)	4 (9.8%)
Median prior lines of therapy (range)	2 (1,4)	2 (1,5)	2 (1,5)
Number of prior lines of therapy			
1	10 (50%)	10 (47.6%)	20 (48.8%)
≥2	10 (50%)	11 (52.4%)	21 (51.2%)
Prior Stem Cell Transplant	3 (15%)	1 (4.8%)	4 (9.8%)
Prior CAR-T Therapy	4 (20%)	4 (19%)	8 (19.5%)
Refractory to primary therapy	8 (40%)	13 (61.9%)	21 (51.2%)
Refractory to last prior therapy	7 (35%)	13 (61.9%)	20 (48.8%)

LBCL = large B-cell lymphoma, DLBCL= diffuse large B-cell lymphoma, HGBCL= high grade B-cell lymphoma, NOS = not otherwise specified, trFL= transformed follicular lymphoma, GCB, germinal center B-cell
Data cutoff: 14Apr2025 Note: Data extracted from live clinical database. Data is subject to change.

LOTIS-7 Phase 1b Trial: Safety Summary

r/r Large B-Cell Lymphoma Treated Population (N=41) as of data cutoff of April 14, 2025

	120 µg/kg n=20	150 µg/kg n=21	All n = 41
Grade 3/4 TEAEs (> 5% of patients)[a]	**11 (55%)**	**12 (57.1%)**	**23 (56.1%)**
Neutropenia	4 (20%)	6 (28.6%)	10 (24.4%)
Anemia	1 (5%)	3 (14.3%)	4 (9.8%)
AST increased	2 (10%)	1 (4.8%)	3 (7.3%)
GGT increase	1 (5%)	2 (9.5%)	3 (7.3%)
Thrombocytopenia	2 (10%)	1 (4.8%)	3 (7.3%)
Grade 3/4 AESI (all patients)[a]			
Febrile neutropenia	0	1 (4.8%)	1 (2.4%)
Thrombocytopenia	2 (10%)	1 (4.8%)	3 (7.3%)
GGT increase	1 (5%)	2 (9.5%)	3 (7.3%)
Generalized oedema	1 (5%)	1 (4.8%)	2 (4.9%)
Rash	1 (5%)	0	1 (2.4%)
Photosensitivity reaction	0	1 (4.8%)	1 (2.4%)
Sepsis	1 (5%)	0	1 (2.4%)
Upper respiratory infection	1 (5%)	0	1 (2.4%)
Pneumonia	1 (5%)	0	1 (2.4%)
Serious TEAE	**11 (55%)**	**9 (42.9%)**	**20 (48.8%)**

[a]*As per Investigator reported adverse events* *TEAE = treatment emergent adverse event; AESI = adverse event of special interest*

Data cutoff: 14 Apr 2025. Data extracted from live clinical database. Data is subject to change.

LOTIS-7 Phase 1b Trial: Safety Summary

r/r Large B-Cell Lymphoma Treated Population (N=41) as of data cutoff of April 14, 2025

Patients with TEAEs leading to study drug discontinuation[a]	120 µg/kg n=20	150 µg/kg n=21	All n = 41
TEAE leading to loncastuximab discontinuation only	**1 (5%)**	**2 (9.5%)**	**3 (7.3%)**
Pericardial effusion	1 (5%)	0	1 (2.4%)
Generalized oedema and GGT increased	0	1 (4.8%)	1 (2.4%)
Pleural effusion and erythema	0	1 (4.8%)	1 (2.4%)
TEAE leading to glofitamab discontinuation only	**0**	**3 (14.3%)**	**3 (7.3%)**
ICANS	0	1 (4.8%)	1 (2.4%)
Polyneuropathy	0	1 (4.8%)	1 (2.4%)
Febrile Neutropenia	0	1 (4.8%)	1 (2.4%)

[a]*As per Investigator reported adverse events*

TEAE = treatment emergent adverse event; AESI = adverse event of special interest

Data cutoff: 14 Apr 2025. Data extracted from live clinical database. Data is subject to change.

LOTIS-7 Phase 1b Trial: CRS/ICANS Profile & Management

r/r Large B-Cell Lymphoma Treated Population (N=41) as of data cutoff of April 14, 2025

	120 µg/kg n=20	150 µg/kg n=21	All n = 41
Cytokine Release Syndrome[a]			
Any grade	11 (55%)	5 (23.8%)	16 (39.0%)
Grade 1	7 (35%)	5 (23.8%)	12 (29.3%)
Grade 2	3 (15%)	0	3 (7.3%)
Grade 3	1 (5%)	0	1 (2.4%)
Grade 4/5	0	0	0
ICANS[a]			
Any grade	2 (10%)	1 (4.8%)	3 (7.3%)
Grade 1	1 (5%)	0	1 (2.4%)
Grade 2	1 (5%)	1 (4.8%)	2 (4.9%)
Grade $\geq$ 3	0	0	0

- Grade 1 and 2 CRS cases managed with tocilizumab, corticosteroids, acetaminophen, and/or fluid bolus, without ICU admittance or pressor support
- Grade 3 CRS case managed with tocilizumab, acetaminophen, dexamethasone, norepinephrine. ICU admittance

- All patients with ICANS had complete resolution of symptoms
  - Two patients resumed treatment and ultimately achieved a CR
  - One patient elected to discontinue treatment
- ICANS managed primarily with corticosteroids

[a]*Number of patients who experienced at least 1 event per ASTCT Consensus Grading for Cytokine Release Syndrome and Neurologic Toxicity Associated with Immune Effector Cells; worst grade reported if applicable*
Data Cutoff 14 Apr 2025. Note: Data extracted from live clinical database. Data is subject to change.

LOTIS-7 Phase 1b Trial: Overall Response Rate (ORR)

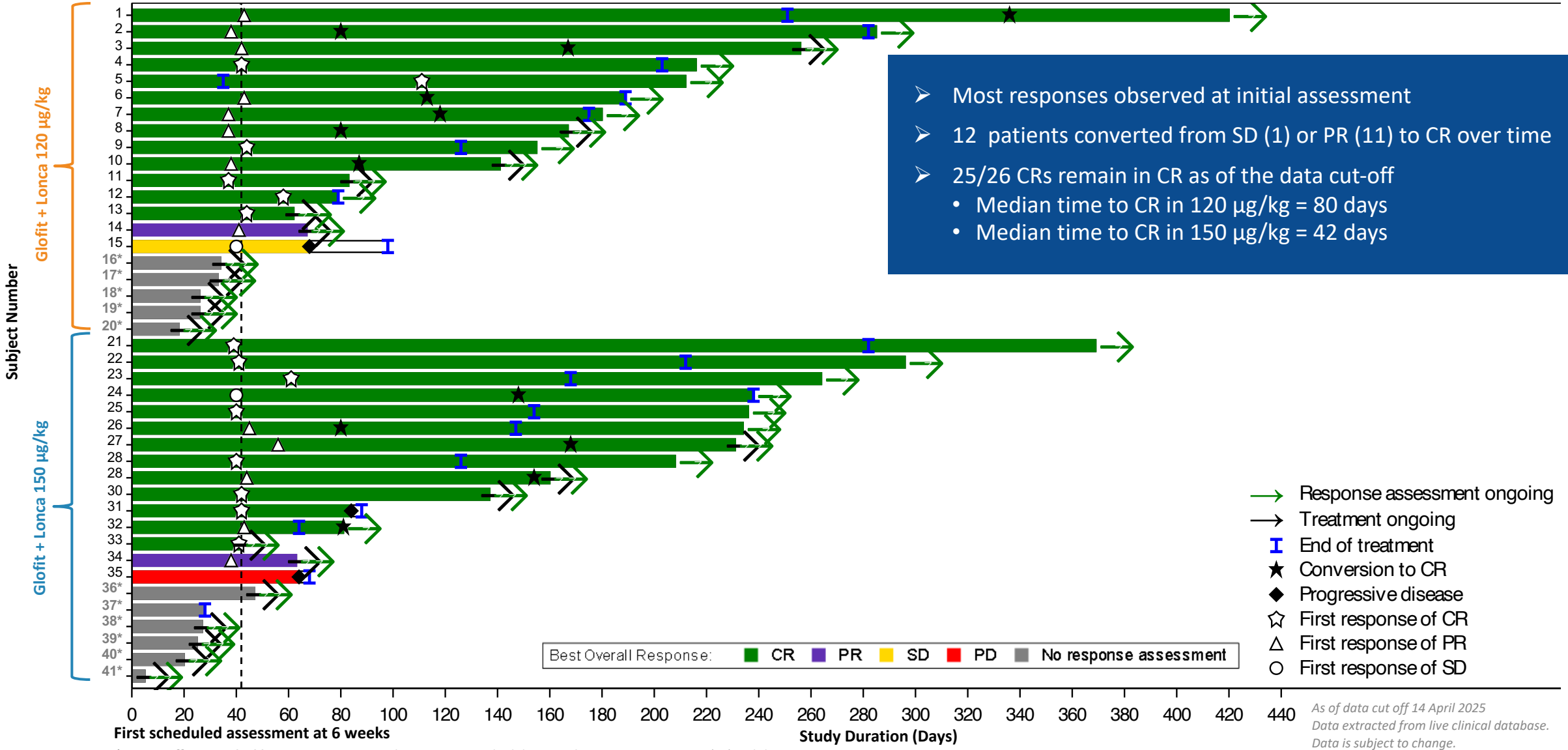
r/r Large B-Cell Lymphoma Efficacy Evaluable Population (N=30) as of April 14, 2025

	120 µg/kg		150 µg/kg		Total	
	n=15	%	**n=15**	%	**n=30**	%
ORR (CR + PR)	**14**	93.3%	**14**	93.3%	**28**	93.3%
Complete Response (CR)	**13**	86.7%	**13**	86.7%	**26**	86.7%
Partial Response (PR)	**1**	6.7%	**1**	6.7%	**2**	6.7%
Stable Disease	**1**	6.7%	**0**	0%	**1**	3.3%
Progressive Disease	**0**	0%	**1**	6.7%	**1**	3.3%

As of data cut off 14 Apr 2025. Note: Data extracted from live clinical database. Data is subject to change.

LOTIS-7 Phase 1b Trial: Efficacy Over Time

r/r Large B-Cell Lymphoma Treated Population (N=41) as of April 14, 2025



- Most responses observed at initial assessment
- 12 patients converted from SD (1) or PR (11) to CR over time
- 25/26 CRs remain in CR as of the data cut-off
  - Median time to CR in 120 µg/kg = 80 days
  - Median time to CR in 150 µg/kg = 42 days

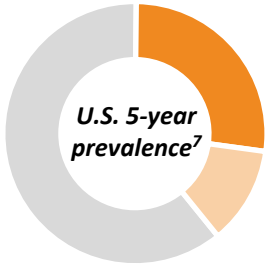
As of data cut off 14 April 2025
Data extracted from live clinical database.
Data is subject to change.

***Not Yet Efficacy Evaluable Patients:** 10 patients have not yet reached the 6-week assessment; 1 patient (37) withdrew prior to any assessment

ZYNLONTA Phase 2 IIT Data Showed 69.2% CR Rate in r/r MZL

r/r MZL Patient Population

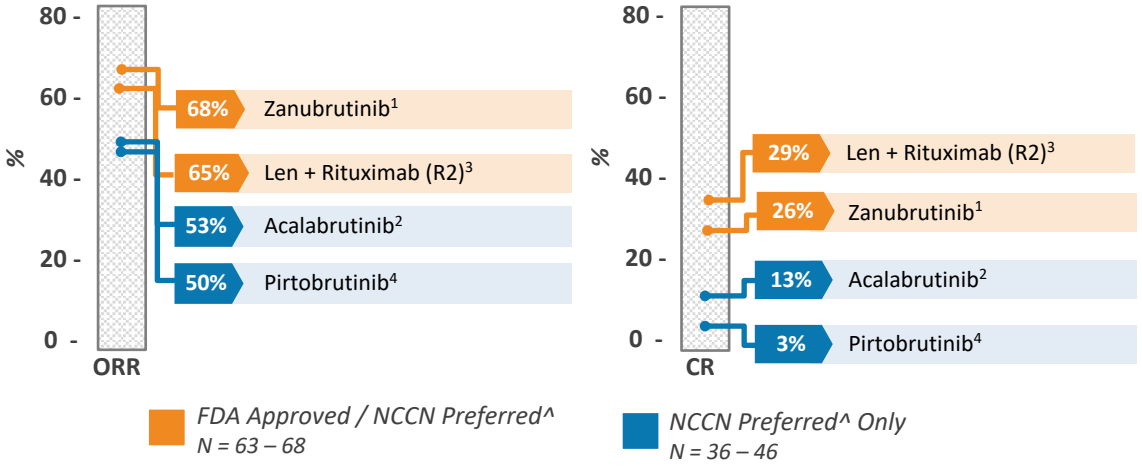
- **Estimated 3–4k 2L+ MZL patients are drug-treated** in the US annually[5-7]; despite patients achieving durable responses, **high unmet medical need** remains with <30% CR for 2L NCCN preferred treatments[1-4]



~15 K *2L+ MZL patients*

Key: *1L* *2L* *3L+*

Current FDA Approved / 2L NCCN Preferred Regimens with r/r MZL Data



University of Miami phase 2 IIT in r/r MZL*

- Highlights of ICML 2025 abstract by Dr. Izidore Lossos on study of ZYNLONTA in patients with r/r MZL:
  - **N = 27 patients enrolled** (as of Feb 10, 2025) from Univ of Miami Sylvester Comprehensive Cancer Center & City of Hope, with **26 efficacy evaluable**
  - **ORR of 84.6%** (22 of 26); **CR of 69.2%** (18 of 26)
    - POD24 patients (N = 13): 61.5% CR
    - CR maintained in 17 out of 18 CR patients, with longest duration of CR of 27 months from the start of treatment
  - **Safety consistent with known profile of ZYNLONTA**
    - Adverse events (AE) were most commonly grade 1 or 2. Grade 3 and 4 AEs were observed in 16 and 2 patients, respectively, including neutropenia, RSV lung infection, and hyponatremia (with 2 AEs in the same patient)
    - Three patients needed dose reduction and one patient discontinued treatment after cycle 4 due to cholestatic hepatitis that fully recovered

Next Steps

- The study was recently expanded to Emory Winship Cancer Institute and Vanderbilt-Ingrim Cancer Center to accelerate enrollment to 50 r/r MZL patients
- ADCT plans to potentially pursue regulatory pathway and compendia in parallel as soon as sufficient data are available

^ Data do not include all 2L MZL regimens such as B+O, R-CHOP, R-CVP, or B-R because inclusion based on either front-line data or studies in mixed histologies; 1. MAGNOLIA Trial (single arm, multicenter ph 2; n = 68) – Best Response; 2. ACE-LY-003 study (part 2 of multicenter, ph 1/2b; n = 43) – Best Response; 3. AUGMENT study (randomized ph3 of R2 vs. R; total n = 358, total MZL n = 63, R2 MZL n = 31, R mono MZL n = 32) – Best Response; 4. BRUIN study (ph 1/2 of pirtobrutinib in CLL/SLL and NHL, total estimated n = 860, total MZL n = 36) - . 5. Clarivate DRG (2022); 6. Global Data (2017); 7. Cerner Enviza CancerMPact (2023), distribution by line of therapy is based on the incident, drug-treated population.

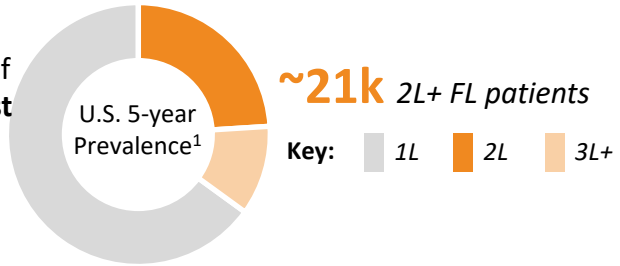
**This data reflects abstract data published at ICML on June 15, 2025 followed by a poster on June 18, 2025 based on the same data cutoff of February 10, 2025*

Note: No head-to-head trials have been conducted among the results shown. Comparing the results from different trials may be unreliable due to different protocol designs, trial design, patient selection and populations, number of patients, trial endpoints, trial objectives and other parameters that may not be the same between trials.

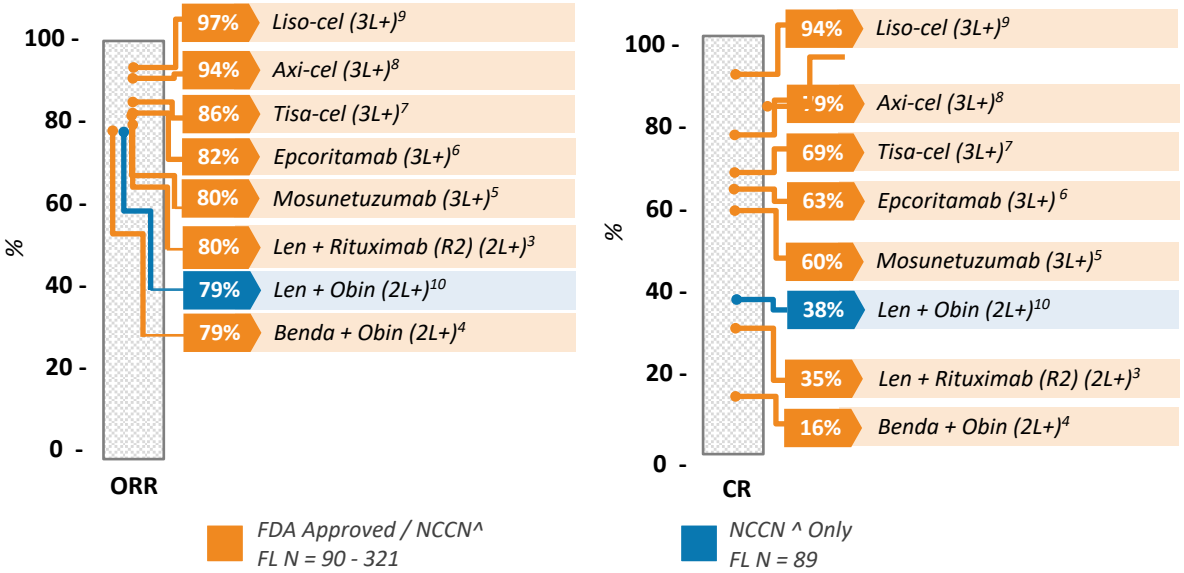
ZYNLONTA + Rituximab Phase 2 IIT Data Show 77% CR Rate in r/r FL

2L+ FL Patient Population

→ **Estimated 6k 2L+ FL patients are drug-treated** in the US annually[1], of which **~20% relapse within the first 24 months of frontline therapy (POD24)** and are characterized by an **unfavorable prognosis**[2]



2L+ FL Treatment Landscape



University of Miami phase 2 IIT in 2L+ FL ASH 2024 presentation & Lancet Haem publication highlights[11]

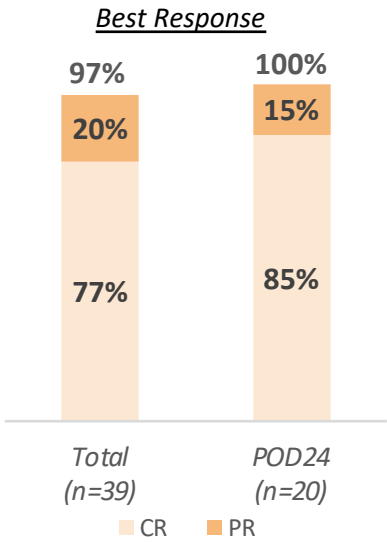
→ N = 39 patients (all of which were evaluated for safety and for efficacy)

→ Best ORR of 97.4% (n=38); CR rate of 76.9% (n=30)

→ After median follow-up of 15.6 months, median PFS was not reached, and the 12-month PFS was 94.6%

→ Safety consistent with known profile of ZYNLONTA

- The most common TEAEs were hyperglycemia (n=17; 43.6%), increased alkaline phosphatase (n=16; 41%) and neutropenia, fatigue and increased aspartate aminotransferase and alanine aminotransferase (n=15; 38.5%)
- The most common grade ≥3 TEAE were lymphopenia (n=8; 20.5%) followed by neutropenia (n=5; 12.9%)
- No Grade 5 TEAEs occurred



Next Steps

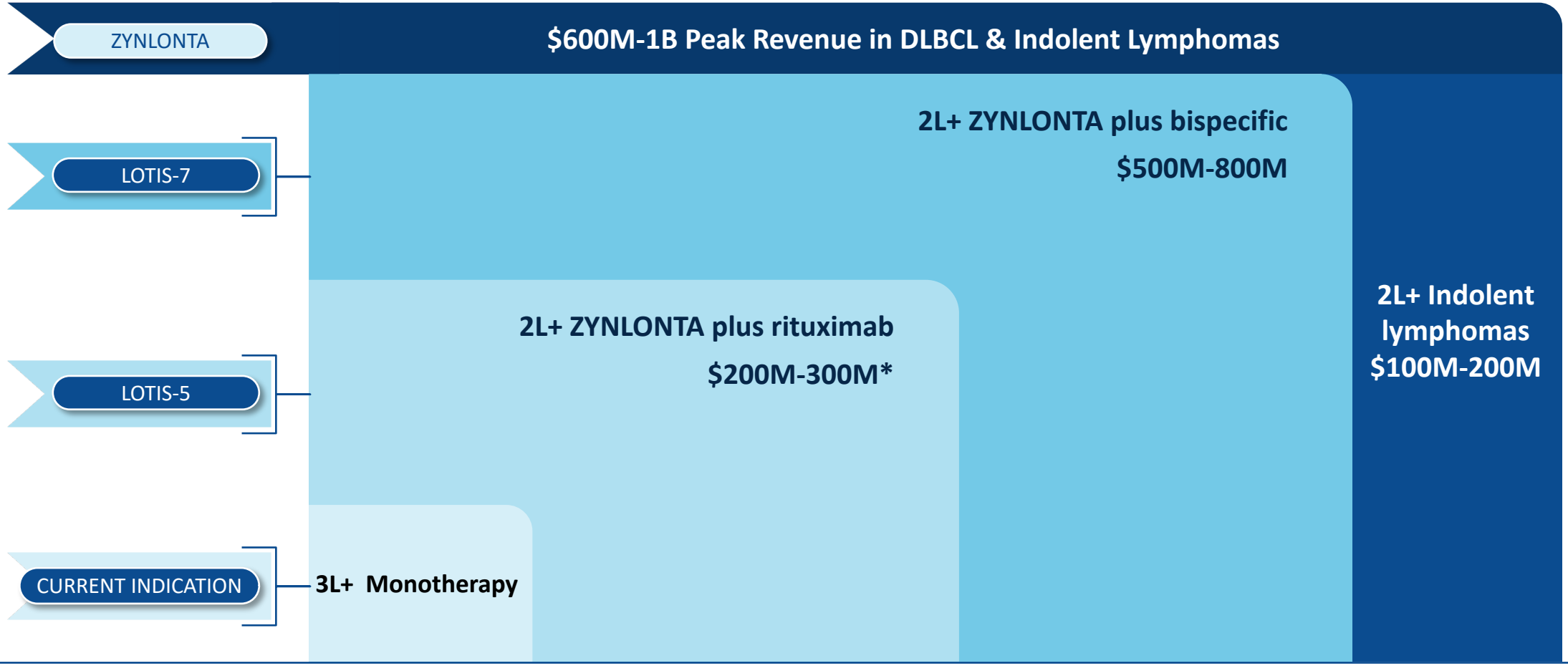
→ University of Miami expanding the trial by increasing target enrollment to 100 high-risk r/r FL patients and opening the study at additional US cancer research centers

→ ADCT plans to potentially pursue regulatory pathway and compendia in parallel as soon as sufficient data are available

^Data do not include all FL FDA approved or NCCN regimens (including R-mono, Obin-mono, Len-mono, B-R, R/Obin-CHOP, or R/Obin- CVP) 1. Cerner Enviza CancerMPact (2023), distribution by line of therapy is based on the incident, drug-treated population; 2. Casulo et al., J Clin Oncol (2015), Casulo et al., Blood (2022); 3. AUGMENT study (randomized ph 3 of R² vs. R; total n = 358, total FL n = 295, R² FL n = 147, R mono FL n = 148) – Best Response; 4. GADOLIN study (randomized ph3 of B + O vs. B; total n = 396, total FL n= 321, B+O FL n = 155) – Best Response in Label; 5. GO29781 study (single-arm, ph 1/2, n = 90); 6. EPCORE NHL-1 (single-arm, ph 1/2, n = 128); 7. ELARA (single-arm, ph 2, n = 98); 8. ZUMA-5 (single-arm, ph 2, FL n = 123); 9. TRANSCEND-FL (single-arm, ph 2, FL n = 114); 10. GALEN study (single arm, multicenter ph 2; n = 89) – Response at end of induction; 11. Alderuccio, Lancet Haem (2024)

Note: No head-to-head trials have been conducted among the results shown. Comparing the results from different trials may be unreliable due to different protocol designs, trial design, patient selection and populations, number of patients, trial endpoints, trial objectives and other parameters that may not be the same between trials.

ZYNLONTA U.S. Peak Revenue Potential of $600M-1B



Peak revenue projection assumes both compendia listing and regulatory approval

Note: ZYNLONTA Monotherapy is FDA approved under accelerated approval; other potential indications in development
**Based on quantitative market research study of 150 physicians*
Note: The Company does not promote ZYNLONTA for unapproved uses

Developing Differentiated PSMA-Targeting ADC With a High Therapeutic Index

A novel hydrophilic, highly stable, protease-cleavable linker conjugated to exatecan

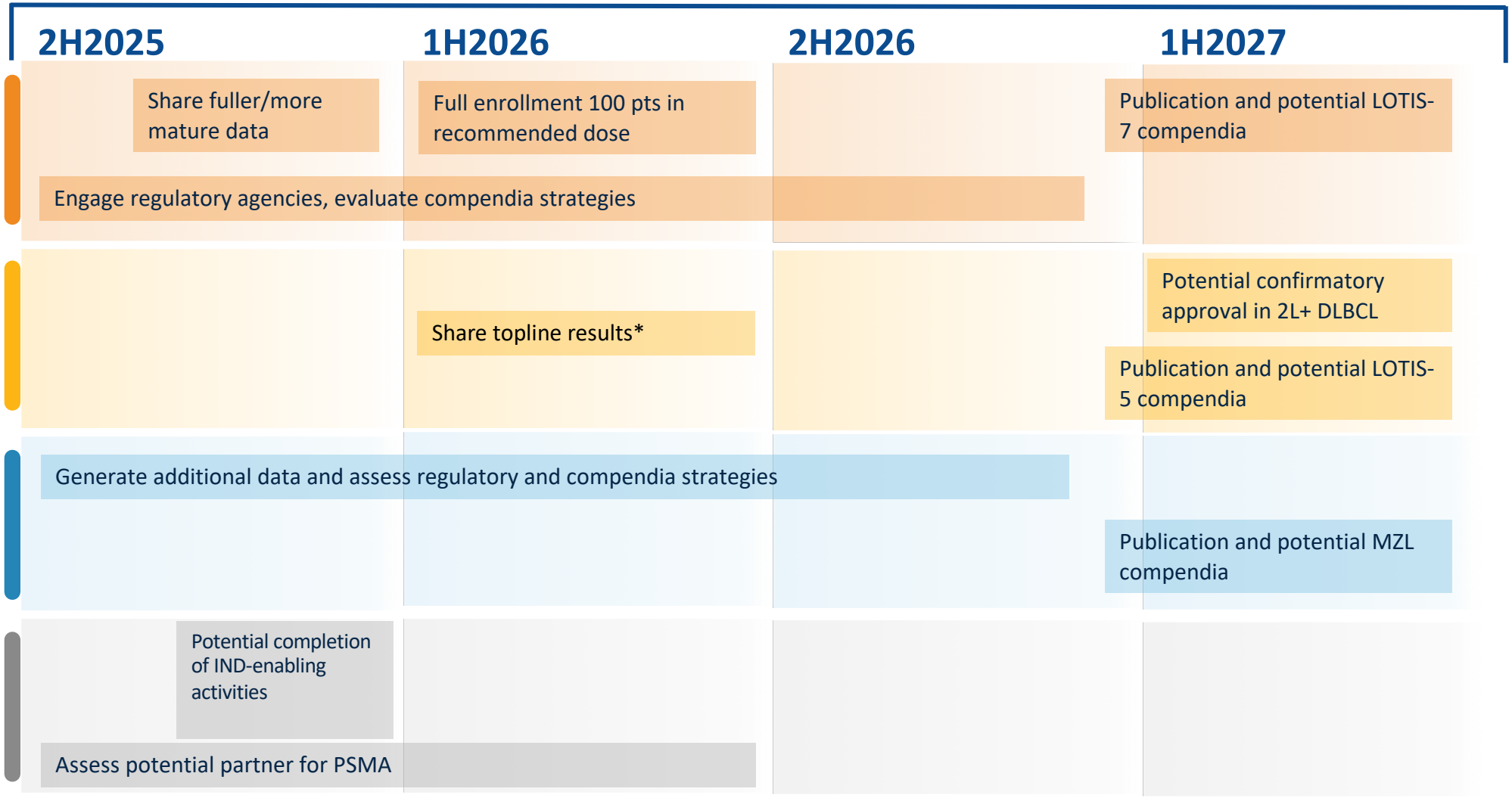
		PSMA
Target description		**Enzymatic glycoprotein**
Tumor types of interest		Prostate cancer
Payload	**Toxin**	Exatecan
	Linker	Novel, hydrophilic, protease cleavable
Preclinical data		*in vitro* characterization *in vivo* efficacy NHP toxicology – Repeat-dose (Q3Wx2)
Stage		IND-enabling

Company moving forward with IND-enabling activities and seeking research collaboration to advance

Note: 1. IND enabling studies have typically averaged approximately 18 months (13 – 24 months) after selection of the candidate; NHP: Non-human primate.

Delivering On Our Strategy

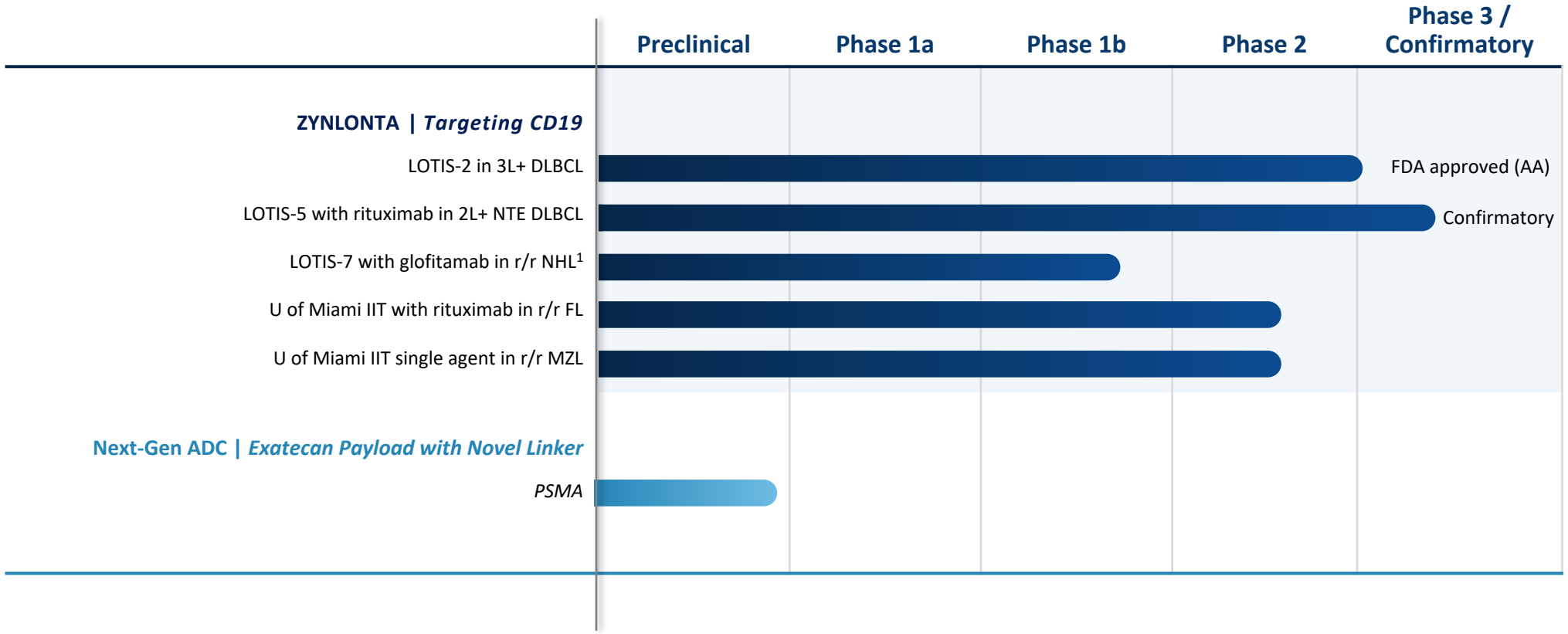
Upcoming Expected Milestones



** Company expects to provide updated data once the pre-specified number of PFS events is reached and data are available*

Thank You

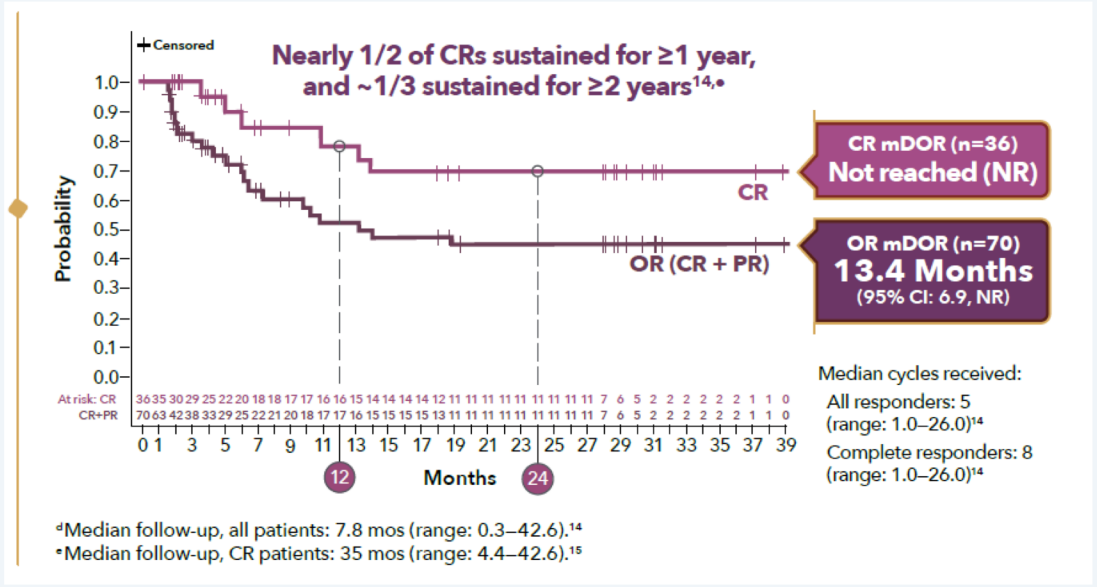
Focused Pipeline with ZYNLONTA and PSMA-targeting ADC



Anticipated milestones set forth in this chart are subject to further future adjustment. NTE: Non-Transplant Eligible. 1. DLBCL, FL, MZL AA: Accelerated Approval.

Both Lonca and Glofit Have Demonstrated Durable Complete Responses as Single Agents in Heavily Pretreated 3L+ Patients

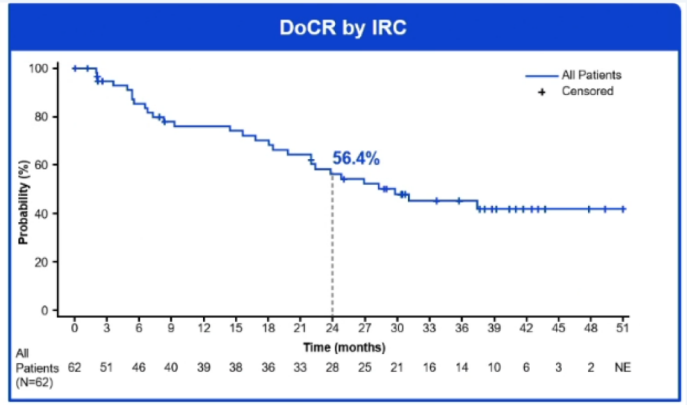
LOTIS-2 (Lonca monotherapy) 2-Yr Follow-up Analysis[1]



LOTIS-5 Phase 3, the mDOR for CRs (50% CRR) has not been reached after 2 years of follow-up[2] (20-patient safety run-in)

Glofitamab (monotherapy) 3-Yr Follow-up Analysis[3]

	(N=155)*
CR rate, n (%) [95% CI]	62 (40) [32.2–48.2]
ORR, n (%) [95% CI]	80 (52) [43.5–59.7]
Median DoCR, months (95% CI)	29.8 (22.0–NE)
24-month DoCR, % (95% CI)	56.4 (42.9–69.8)
Ongoing CRs, n/N (%)	33/62 (53.2)
Median CR follow-up, months (range)	37.7 (0–51)



- Median time on study: 41.0 months (range: 0–52)

An estimated 56.4% of patients with a CR at any time remained in remission at 24 months

All responses in the table are based on the best overall response; *Intention-to-treat population; CI, confidence interval; NE, not estimable.

CRs remained durable following fixed-duration glofitamab treatment

- Pre-clinical studies point to complimentary mechanisms of action that elicit immune activation of T-cell mediated anti-tumor activity that may underlie the observed Lonca+Glofit anti-tumor efficacy overall (initial responses and durability of responses)
- Loncastuximab tesirine mechanism of action is immunogenic cell death via intracellular delivery to CD19 expressing tumor cells its pyrrolobenzodiazepine (PBD) warhead that exerts persistent covalent cross-linking of DNA that may contribute to the prolonged duration of CRs observed in LOTIS-2 monotherapy

1. LOTIS-2 2-yr analysis, 2. LOTIS-5 EHA abstract, 3. ASH 2024 oral presentation

LOTIS-7 Clinical Trial: Rationale for Expansion of 150 µg/kg

Early safety and efficacy data support the ongoing expansion of ZYNLONTA 150 µg/kg + glofitamab in 2L+ LBCL, which has been endorsed by the study DSMC*

150 µg/kg is the approved dose of ZYNLONTA for the treatment of adult patients with relapsed or refractory (r/r) LBCL after two or more lines of systemic therapy

Safety

- Manageable safety profile observed in 150 µg/kg and 120 µg/kg
- Lower rate of CRS (any grade) observed at 150 µg/kg vs 120 µg/kg
- No Gr 3 or higher CRS events observed in 150 µg/kg vs one Gr 3 CRS observed in 120 µg/kg

Efficacy

- Median time to CR in 150 µg/kg (42 days) is shorter compared to 120 µg/kg (80 days)

Pharmacokinetics

- Higher ZYNLONTA exposure during the first two cycles was associated with an increased predicted probability of objective response, as measured by CR at Week 6 and ORR
  - Model-predicted response probabilities were higher at 150 µg/kg compared to 120 µg/kg

**DSMC, data safety monitoring committee*
ORR, overall response rate; CR, complete response; SD, stable disease; PR, partial remission; DLT, dose limiting toxicity; TEAE, treatment emergent adverse event; CRS, cytokine release syndrome; ICANS, Immune Effector Cell-Associated Neurotoxicity Syndrome.
Data cutoff: 14Apr2025 Note: Data extracted from live clinical database. Data is subject to change.