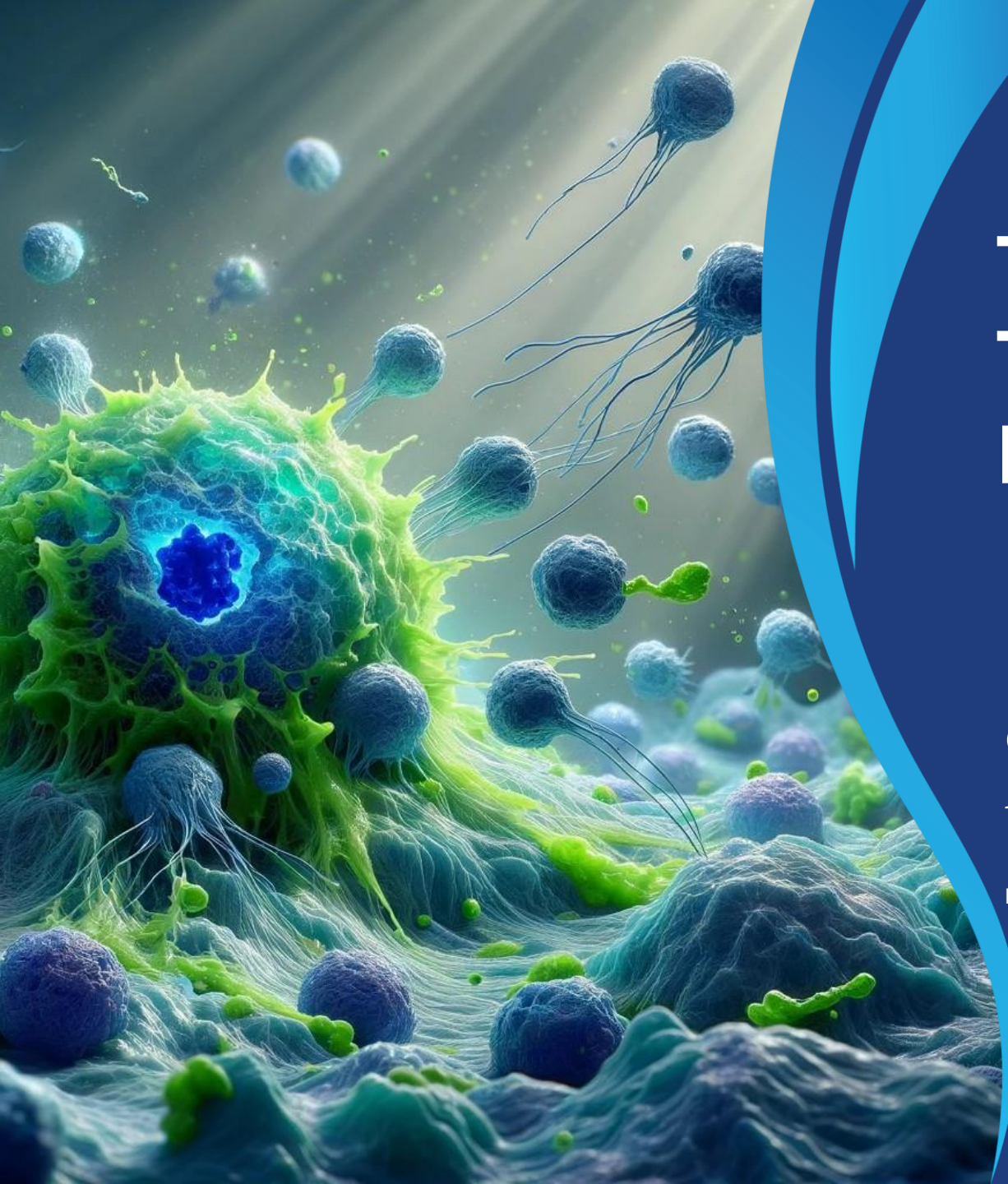

Two Late-Stage Platforms Targeting Inflammation-Driven Disease

Corporate Presentation

July 2026

NASDAQ: INMB

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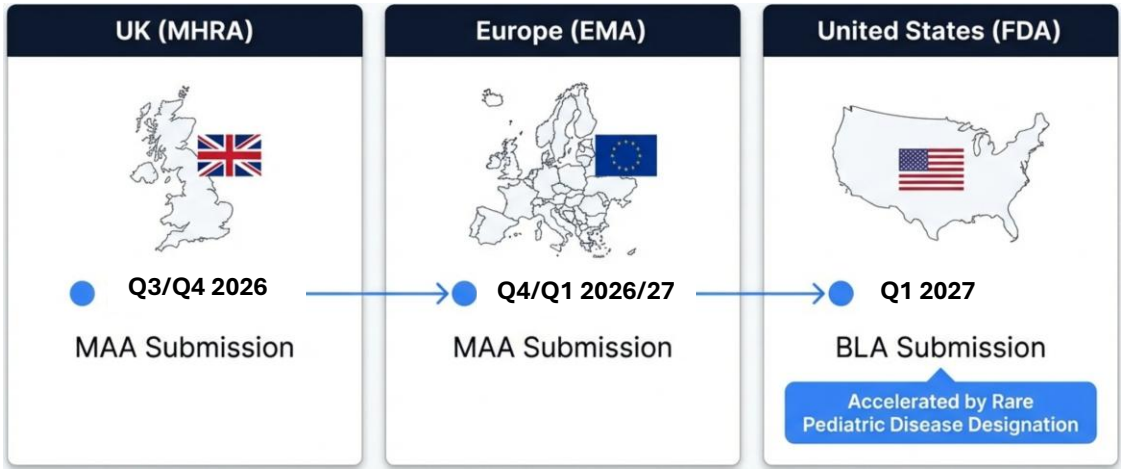
Clinical trials are in early stages and there is no assurance that any specific outcome will be achieved. Any statements contained herein related to the development or commercialization of product candidates and other business and financial matters, including without limitation, trial results and data, including the results of the Phase 2 MINDFuL trial, the timing of key milestones, future plans or expectations for the treatment of XPro™, and the prospects for receiving regulatory approval or commercializing or selling any product or drug candidates may constitute forward-looking statements as that term is defined in the Private Securities Litigation Reform Act of 1995. Any forward-looking statements contained herein are based on current expectations but are subject to several risks and uncertainties. Actual results and the timing of certain events and circumstances may differ materially from those described by the forward-looking statements because of these risks and uncertainties. CORDstrom™, XPro1595 (XPro™, pegipanermin), and INKmune®™ have either finished clinical trials, are still in clinical trials or are preparing to start clinical trials and have not been approved by the US Food and Drug Administration (FDA) or any regulatory body and there cannot be any assurance that they will be approved by the FDA or any regulatory body or that any specific results will be achieved. The factors that could cause actual future results to differ materially from current expectations include, but are not limited to, risks and uncertainties relating to the Company’s ability to produce more drug for clinical trials; the availability of substantial additional funding for the Company to continue its operations and to conduct research and development, clinical studies and future product commercialization; and, the Company’s business, research, product development, regulatory approval, marketing and distribution plans and strategies. These and other factors are identified and described in more detail in the Company’s filings with the Securities and Exchange Commission, including the Company’s Annual Report on Form 10-K, the Company’s Quarterly Reports on Form 10-Q and the Company’s Current Reports on Form 8-K. The Company assumes no obligation to update any forward-looking statements to reflect any event or circumstance that may arise after the date hereof.

Two Late-Stage Platforms Across Inflammation & Immunology

- **Two Late-Stage Assets:** Leading with CORDStrom™ (RDEB) and XPro1595™ (Alzheimer's), both entering regulatory/pivotal phases.
- **Near-Term Commercialization:** CORDStrom™ targeting MAA filing (UK/EU) in Q3/Q4, 2026 and BLA (US) in late 2026.*
- **Regulatory-De-Risking:** RPDD + ODD received (RDEB). FDA alignment on XPro Phase 2b/3 design confirmed with Fast Track granted.
- **Focused Capital Efficiency:** Priority to CORDStrom approval for potential Priority Review Voucher (PRV) monetization to fund further XPro and CORDStrom platform expansion.
- **Substantial Platform Upside:** CORDStrom™ + XPro™ address large, unmet needs across rare disease and neurodegeneration.

CORDStrom™



XPro1595™

Program	Indication / Patient Pop (US&EU)	Pre-clinical	Phase 1	Phase 2	Phase 2b/3
XPro™ / Neuro	Early Alzheimer's Disease with Infl. (9M)	→	→	→	FDA Alignment on Phase 2b/3 Clinic Ready in 2027

*Estimated dates subject to change – See "Forward-Looking Statements"

Key Patents & Exclusivity Position

CORDStrom™

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International Bureau

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WIPO | PCT

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Published:
— *with international search report (Art. 21(3))*

(54) Title: THERAPEUTIC COMPOSITIONS COMPRISING POOLED, CULTURE-EXPANDED HUMAN UMBILICAL CORD DERIVED MESENCHYMAL STROMAL CELLS

Ideal Surface Marker Expression in a Pooled, Culture-Expanded hucMSCs Composition for General Therapeutic Use

Surface Marker	Function	Ideal Expression (%)
CD73 (5′-ectonucleotidase)	Defines MSC identity; regulates extracellular adenosine production for immunosuppression	≥97%
CD90 (Thy-1)	Supports cell adhesion, migration, and immune modulation	≥97%
CD105 (Endoglin)	Involved in TGF-β signaling, angiogenesis, and immunosuppression	≥97%
CD146 (MCAM)	Enhances MSC homing, migration, pericyte-like function, and vascular interaction	30–75%
CD166 (ALCAM)	Promotes MSC adhesion, retention, and extracellular matrix (ECM) stabilization	85–95%
CD44 (Hyaluronate receptor)	Regulates MSC trafficking, adhesion, and anti-inflammatory responses	≥95% (optimally ≥97%)
CD29 (Integrin β1)	Facilitates MSC attachment to extracellular matrix proteins	≥95% (optimally ≥97%)
CD54 (ICAM-1)	Enhances MSC immune interactions; T-cell suppression	optimally ≥80%
HLA-DR (MHC Class II)	Associated with allogeneic immune activation (should be absent in naïve MSCs)	≤3%
CD133 (Prominin-1, Nes-1)	Marked lineage marker (exclusion criterion)	≤3%
CD34 (Hematopoietic stem cell marker)	Indicates hematopoietic progenitors (should be absent in MSCs)	≤3%
CD38 (Poly-ADP-ribose-cyclase)	Involved in lipid metabolism, oxidative stress response, and immune modulation	≤3%
CD45 (Leukocyte common antigen)	Hematopoietic marker (excludable criterion for pure MSC populations)	≤2%
CD19/CD79a (B-cell markers)	Indicate presence of B cells (should be absent)	≤2%
CD14/CD11b (Monocyte/Macrophage markers)	Indicate presence of contaminating monocytes/macrophages	≤3%

FIG. 15

(57) Abstract: The disclosure provides a therapeutic composition comprising pooled, culture-expanded human umbilical cord-derived mesenchymal stromal cells (hucMSCs) derived from at least four and up to twelve donors, which can be reproduced with batch to batch consistency. These cells exhibit consistent marker expression profiles, enhanced and consistent secretion of therapeutic factors, and potent immunomodulatory activities after at least ten to thirty population doublings. The composition, formulated with a pharmaceutically acceptable carrier, is designed for clinical applications addressing inflammatory, immune, and degenerative conditions.

WO 2025/179269 A1

International PCT Stage
USPTO (ISA)
Favorable Written
Opinion on Patentability
(all claims)
-CoM
-Formulation
-MoT

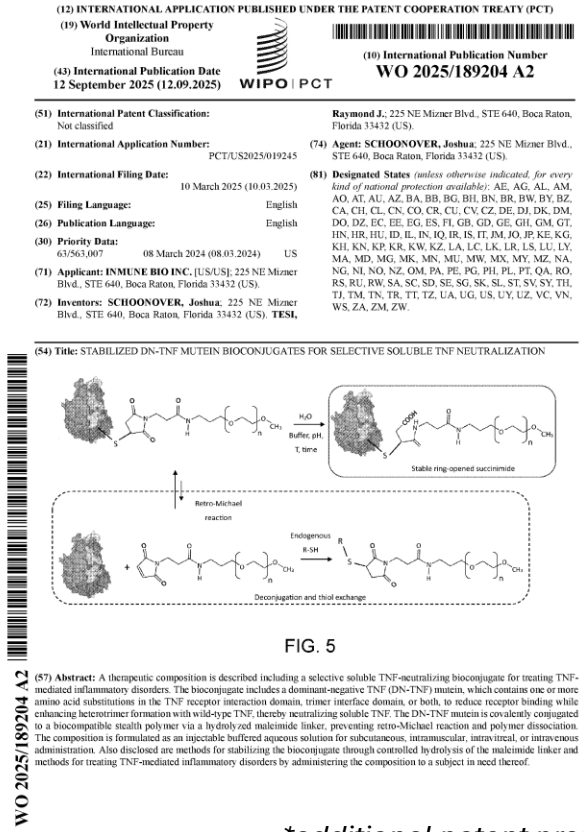
Nominal Patent Coverage thru 2045

Eligible for PTE up to +5years on approval

**additional patent properties pending*

Eligible for Ref. Biol. Product Exclusivity (~12 years)
ODD Exclusivity (RDEB) ~7years

XPro1595™



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(54) Title: STABILIZED DN-TNF MUTEIN BIOCONJUGATES FOR SELECTIVE SOLUBLE TNF NEUTRALIZATION

FIG. 5

(57) Abstract: A therapeutic composition is described including a selective soluble TNF-neutralizing bioconjugate for treating TNF-mediated inflammatory disorders. The bioconjugate includes a dominant-negative TNF (DN-TNF) mutein, which contains one or more amino acid substitutions in the TNF receptor interaction domain, trimer interface domain, or both, to reduce receptor binding while enhancing heterotrimer formation with wild-type TNF, thereby neutralizing soluble TNF. The DN-TNF mutein is covalently conjugated to a biocompatible stealth polymer via a hydrolyzed maleimide linker, preventing retro-Michael reaction and polymer dissociation. The composition is formulated as an injectable buffered aqueous solution for subcutaneous, intramuscular, intravitreal, or intravenous administration. Also disclosed are methods for stabilizing the bioconjugate through controlled hydrolysis of the maleimide linker and methods for treating TNF-mediated inflammatory disorders by administering the composition to a subject in need thereof.

WO 2025/189204 A2

International PCT Stage
USPTO (ISA)
Favorable Written
Opinion on Patentability
(all claims)
-CoM
-Formulation
-MoT

Nominal Patent Coverage thru 2045

Eligible for PTE up to +5years on approval

US 11,365,229 B2 Expires 2033
-MoT (Neurologic Diseases)

**additional patent properties issued/pending*

Eligible for Ref. Biol. Product Exclusivity (~12 years)

INmuneBio

CORDStrom™ (*Ebstrocel*)

for EB

Beyond Topical Care: Disease-Modifying Systemic Therapy

The Progressive Nature of Recessive Dystrophic EB (RDEB)

18 Months to 10 Years: The Critical Therapeutic Window

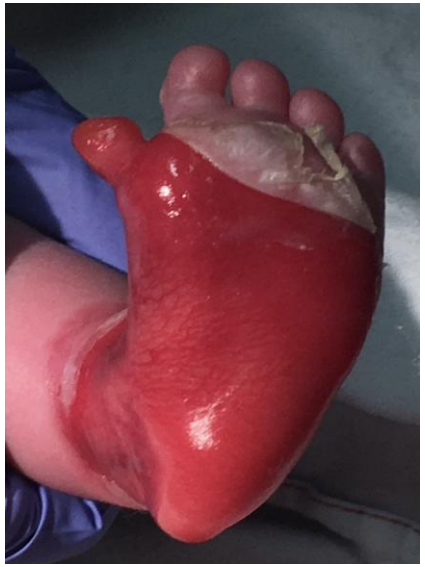
Journal of
Dermatology and Venereology

ScienceAssist International

Prospective | Open Access

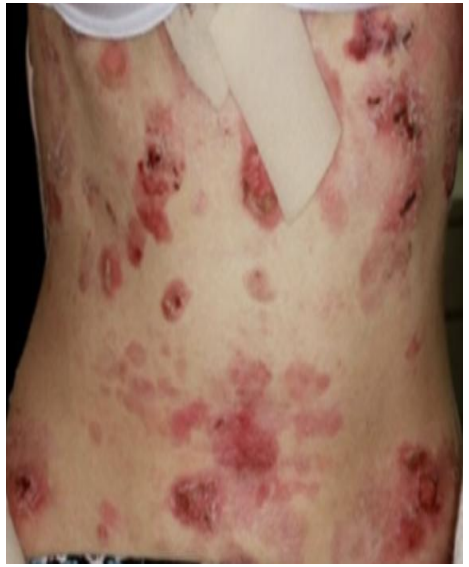
The Natural History of Severe Recessive Dystrophic Epidermolysis Bullosa – 4 Phases Which May Help Determine Different Therapeutic Approaches

Bageta ML[1]*, Yerlett N[2], McGrath JA[3], Mellerio JE[4], Petrof G[1], Martinez AE[1]

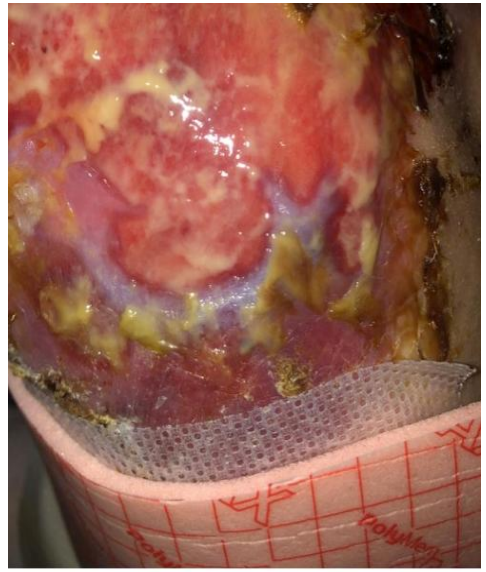


0-18 months

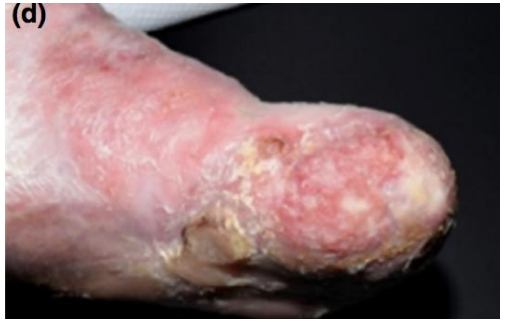
18 months-10 years



10-20 years



Over 20 years



Squamous cell carcinoma (SCC)

What Treatments do People Living with DEB Want Right Now?

Prioritisation survey
865 members EB global community
2024-Top 5 issues

1. Pain relief
2. Itch relief
3. Mental health children/YP
4. Impact of inflammation
5. GI issues e.g., dysphagia

Global EB Priority Setting Partnership

identifies research priorities for the four main types of epidermolysis bullosa

Source: FDA Patient-Focused Drug Development Meeting
https://www.youtube.com/live/Ids1WAe5Czo

Pruritus is a Clinically Meaningful Endpoint in RDEB

Evidence from Danial et al. (2015) and the PEBLES Prospective Registry (2023)

Danial et al. (2015)

- 146 EB patients
- Itch ranked the most bothersome complication
- Healing wounds produced greatest itch
- Major impact on sleep and quality of life
- Defined key itch triggers

PEBLES Registry (2023)

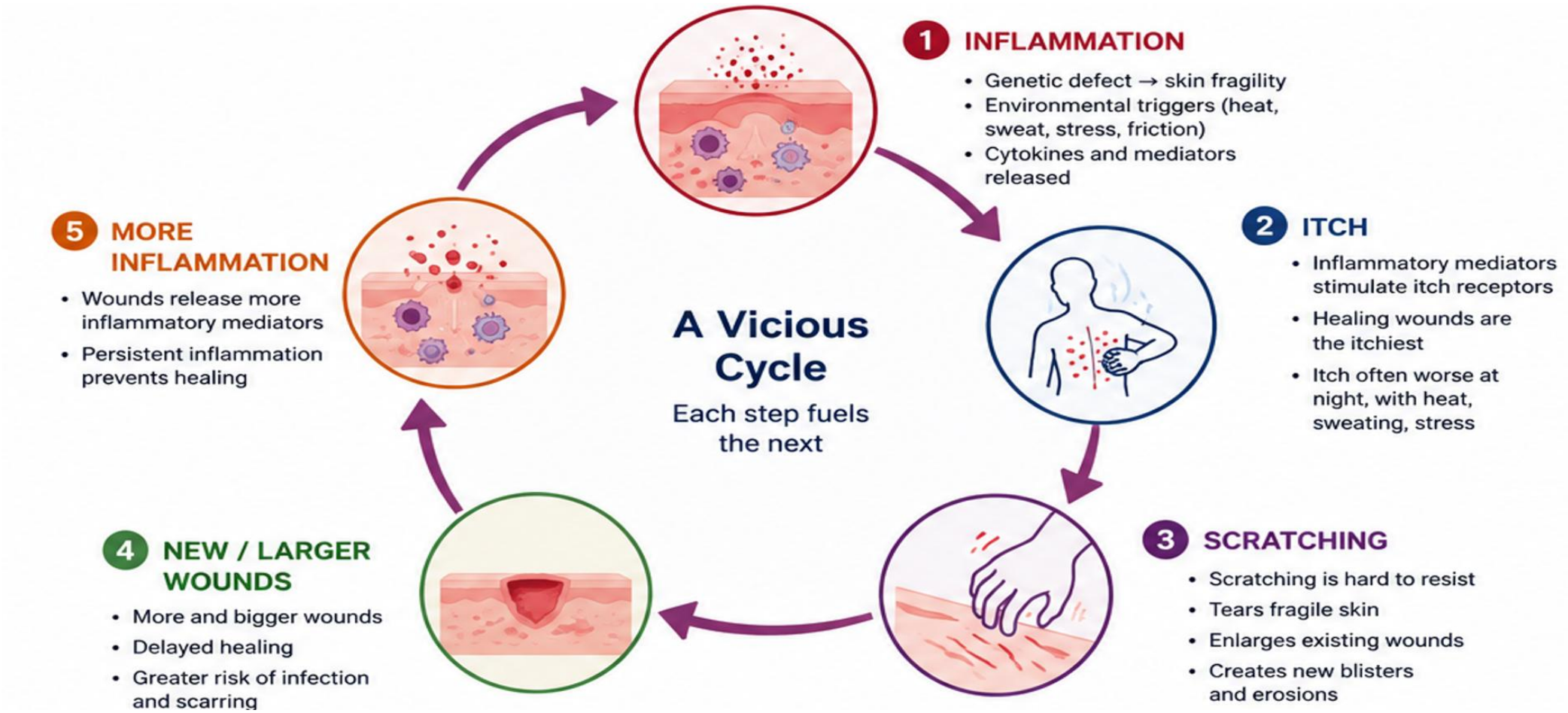
- 50 RDEB patients
- 243 longitudinal assessments over 7 years
- Itch present in 93% of assessments
- Severe RDEB had highest itch burden
- Supports itch as endpoint in future trials

Key Clinical Findings

- ✓ Itch is nearly universal in RDEB (93% prevalence) and in wider EB (~85% prevalence)
- ✓ Patients describe itch as deep, painful and difficult to control
- ✓ Severity increases with disease severity
- ✓ Patients rank itch among the most burdensome symptoms
- ✓ Itch drives the itch–scratch–wound–inflammation cycle
- ✓ Healing wounds produce the greatest itch
- ✓ **Current therapies provide inadequate relief**
- ✓ Night-time itch causes significant sleep disruption
- ✓ Heat, sweating, stress and dry skin worsen symptoms
- ✓ Global disease severity scores do not adequately capture itch
- ✓ **Both studies support itch as a clinically meaningful endpoint in RDEB and in wider EB**

The Itch-Scratch-Wound-Inflammation Cycle in RDEB

A self-perpetuating cycle that drives diseases disease burden



Why Reducing Puritus May Reduce Wounds and Long-Term SCC Risk in RDEB

Evidence

- Scratching tears fragile skin, enlarges wounds and creates new blisters.
- Healing wounds are the itchiest wounds.
- Larger wounds are associated with greater itch burden.
- MSC and calcipotriol studies showed wound improvement together with itch reduction.
- Current evidence strongly supports: ↓ itch → ↓ scratching → ↓ wound burden.
- ***Ebstrocel reduced systemic inflammatory cytokines which drive itch leading to clinically meaningful reduction***

Implications

- Chronic non-healing wounds are the principal substrate for SCC in RDEB.
- Persistent inflammation drives repeated tissue injury and malignant transformation.
- No study has yet proven that reducing itch lowers SCC incidence.
- However, the biological rationale is strong: interrupting the itch–scratch cycle may reduce chronic wounds and, over time, could reduce SCC risk.

"Treatment with Ebstrocel infusions in RDEB patients is likely to be disease-modifying, improving itch, skin healing, quality of life and reducing the risk of squamous cell carcinoma later in life" –

Professor Anna Martinez, UK clinical lead for paediatric RDEB.

Mission EB Phase III: Randomized, Placebo-Controlled Crossover Trial

2012 - Cure EB Charity funded **EBSTEM** an open label study 10 children with RDEB from Great Ormond Street treated with 3 infusions of bone derived stem cells with promising results lasting up to 6 months

2019 – NIHR / NHS England / CureEB funded a **Double blind, placebo controlled, *crossover*** trial at GOSH and BCH for children with RDEB

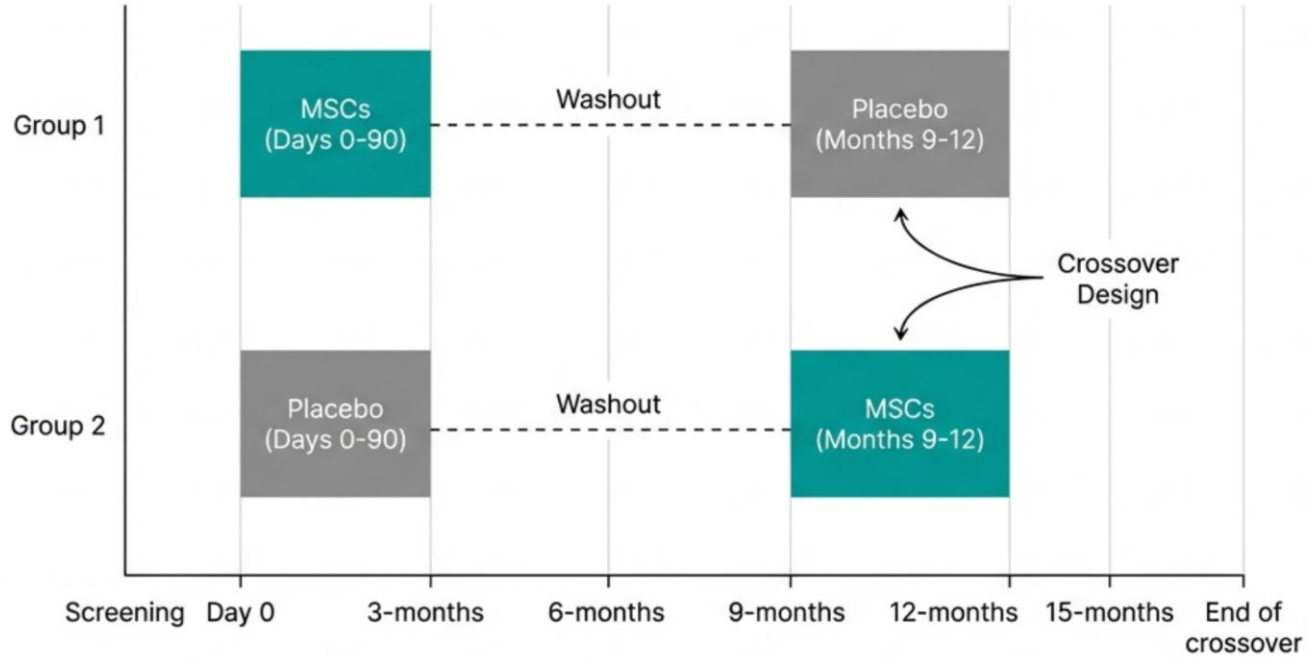
MissionEB

Mesenchymal Intravenous Stromal cell Infusions in children with recessive dystrophic Epidermolysis Bullosa

Both UK National centres, 33 enrolled, 31 evaluable –

all crossed over from drug to placebo or placebo to drug

all remained double blind through treatment and follow-up



Mission EB Clinical Trial Summary

Month-3 Data

- **RDEB-Severe** patients across all ages (9/30)
  - No improvement in their skin scores
  - **25% reduction in ITCH**

Month-6 Data

- Itch reduction **maintained** 6 months post cell infusions across **all** of the itch-man scale cohort
- The largest itch reduction was seen in the **RDEB-S** group at month 6 post cell infusion of **27.5%**
- **IscorEB scores** improved in all **RDEB patients**
- There is large improvement in **all iscorEB** scores in RDEB-S cohort **not seen** at month 3
  - overall score 9.3%
  - patient score 9.6%
  - clinician score 6.4%
  - skin score 2.8%

Conclusion From Month 6 Data

- There is **large improvement** in **all iscorEB scores** in **RDEB-S** cohort not seen at month-3
- The observed **skin improvement** and **wound closure** is likely to be **disease modifying, improving pain and quality of life** and **reduce** the long-term **risk of squamous cell carcinoma**

Qualitative Results

- 13 participants (reporting on 9 cases)
  - 8 parents
  - 5 children

- Completed blinded interview at two time points
  - 3 months post UC-MSCs
  - 3 months post placebo

- 12/13 reported benefits on Ebstrocel
- 3/13 reported benefits on placebo
  - 2 post Ebstrocel
  - 1 treatment naive

- **10/13 correctly identified order of treatment**

ID	Patient details	Role	UC-MSCs	Placebo
A	Under 6 years* RDEB intermediate Order of infusions: UC-MSC/Placebo	Parent	• Parent described that wound healing was quicker and had changed in form and this reduced the frequency of dressing changes. • It was difficult to monitor whether the treatment had made a difference to some symptoms.	• Positive changes such as fewer blisters on the feet, fewer open wounds and as a result, less dressing changes. • Seemed to be talking about improvement since the start of the trial, rather than since the most recent infusion.
B	Under 6 years* RDEB intermediate Order of infusions: UC-MSC/Placebo	Parent	• Reported a huge improvement all round: Improvements in energy, eating, wound healing and recovery time from illness was quicker.	• Reported no change this time, compared to 1st infusion where there was a great improvement.
C	Over 10 years RDEB intermediate Order of infusions: UC-MSC/Placebo	Patient	• Reported a significant decrease of wounds and blisters, less pain and that new wounds healed faster. Improved sleep and general activities have become easier to do.	• Said there was no impact of this infusion, and compared to the first infusion where they thought it had helped.
		Parent	• Felt that there was significant positive change since the infusion, skin was less sensitive, wound healing was quicker and less itchiness and pain.	• Reported eye pain and itchiness was worse after the 2nd infusion. • Compared this time to last time by saying that the 1st infusion was much better.
D	Over 10 years RDEB severe Order of infusions: UC-MSC/Placebo	Patient	• Reported having one positive experience where their skin had improved on holiday but that this returned to normal when he came back to the UK. • Nothing else had changed in relation to his EB symptoms.	• Reported a small positive change in pain and itchiness, wounds on their legs had decreased but when they returned, this was more difficult to deal with. • No impact on dressings, bathing or sleep.
		Parent	Was not interviewed at this time due to illness.	• Noticed improvement in wound healing; these improvements lasted two months and their legs were 'clear' for three weeks. • These changes had improved their social life as they were able to walk more and being abroad was easier due to fewer complications.
E	Under 10 years RDEB intermediate Order of infusions: Placebo/UC-MSC	Patient	• Reported positive changes such as fewer blisters, quicker wound healing, less pain during bathing and EB activities took less time due to the decrease in pain. • Positive impact on quality of life e.g., able to socialise more with peers.	• Positive impact on their regular activities and playing with friends, and some reference to less pain. • No impact on wound healing or itching. •
		Parent	• Described less pain and that wounds had healed quicker. This made bath times easier and impacted positively on their mental wellbeing. • They felt that the participant was more positive now because of the improvement and more willing to be engaged in activities.	• Reported no change in any symptoms or quality of life.
F	Over 10 years RDEB intermediate Order of infusions: Placebo/UC-MSC	Patient	• A bit less pain and itchiness since the infusion. Did not last long. Improved school and sleep.	• Reported no change in any symptoms or quality of life.
		Parent	• Reported improvements in itchiness, pain and activities at school and sleep.	• Reported no change in any symptoms or quality of life.
G	Over 10 years RDEB intermediate Order of infusions: Placebo/UC-MSC	Patient	Withdrawn	• Improvement in skin, fewer cuts and they have healed quicker, less itchiness and were able to write longer at school because of the positive changes.
		Parent	Withdrawn	• Highlighted positive improvement in wound healing and formation of blisters.
H	Under 6 years* RDEB severe Order of infusions: Placebo/UC-MSC	Parent	• Reported improved sleep, energy, and mood. • No impact on skin and wounds.	• No change, stated everything is still the same.
I	Under 6 years* RDEB severe Order of infusions: Placebo/UC-MSC	Parent	• Unclear but thinks there may have been some improvement in the healing of wounds. Noticed less scratching but thought this could just be them growing up. • Childminder thought the skin had improved.	• Reported no change in any symptoms or quality of life, some more itching reported.
J	Under 10 years RDEB severe Order of infusions: Placebo/UC-MSC	Patient	• Reported that pain reduced a little, itchiness improved slightly and they had played with their sibling more since treatment. • No impact on sleep, their eyes or dressings.	• Initially said pain and itch had improved a little but later in the interview said it had not improved, no impact on activities.
		Parent	• Wounds are healing quicker. • Reported less waking but not certain if this is due to infusion or getting used to it.	• Reported no change in any symptoms or quality of life, except more itching.

*Patients under 6 years were too young to be interviewed.

Table 3: Summary of qualitative interviews.

Comprehensive Organ System Improvements

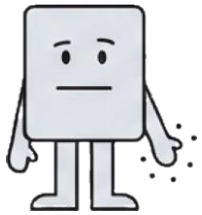
Itch Man

"I don't sleep because of the itch. I just wait for the sun to come up."

"The itch is just a different form of pain."

"The itch is a monster... an itch that feels like it's inside my bones."

"I just wait for the sun to come up so I can start the cycle of bandaging the damage I did in my sleep."



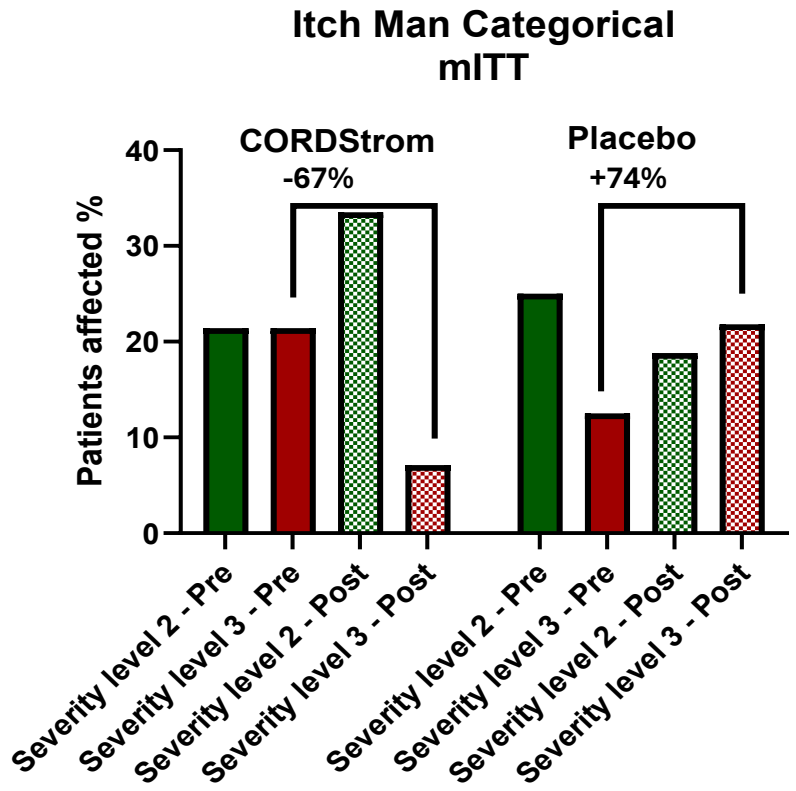
Level 2: Itches more; sometimes interferes with activity

Level 3: Itches a lot; difficult to be still, concentrate

Month 3 - Itch Man Scale improved 17%

Month 6 - Itch Man Scale improved **27.5%**

CS switches 2/3 of pts with grade 3 to grade 2
1/4 of pts on placebo who were grade 2 progress to grade 3



Comprehensive Organ System Improvements

ISCOREB Improvement Scores

Period 1 at 3 and 6 months

Ebstrocel is potentially the first systemic therapy with itch and pain relief benefits as key differentiation factors in quality of life.

Overall Summary

- Ebstrocel has proven to be beneficial treatment with **no safety signals** in children with RDEB from the age of 6 months
- **Intermediate and younger patients** under the age of 10 years saw earlier effects with **improvement of their skin, pain and itch**
- Although the **most severe and older patients** did not show changes in their skin at 3 months, by 6 months their **itch and skin scores had improved greatly**
- ***"Treatment with Ebstrocel infusions in RDEB patients is likely to be disease-modifying improving itch, skin healing, quality of life and reduce the risk of squamous cell carcinoma later in life"*** – Professor Anna Martinez, UK clinical lead for paediatric RDEB

Standards for Conditional Drug Approval

- **Core Efficacy Requirements (MHRA, EMA & Similar Frameworks)**
  - **Positive Benefit-Risk Balance:** Data must indicate that the ***drug's benefits outweigh its risks***, even if the data are less comprehensive than required for standard marketing authorisation.
  - **Proof of Concept/Partial Data:** Evidence must demonstrate a "reasonable prospect" of efficacy and safety, ***often based on early Phase II or Phase III trial results***.
  - **Unmet Medical Need:** The medicine must address a condition where ***no satisfactory treatment***, prevention, or diagnosis exists, or offer a "major therapeutic advantage" over existing methods.
  - **Substantial Evidence Expected:** Although data are ***"less" comprehensive, it must still be robust enough to support a positive benefit-risk assessment***.

Ebstrocel – Complex Mechanisms of Action Validated

The Mechanism of Systemic Resolution: M1 to M2 Shift

CORDStrom Infusion

The Inhibition Path (Blocking Destruction)

- Inhibits IL-6, IFN-G, and TNF-α secretion by M1 macrophages.
- Secretes IL-8 to enhance neutrophil function and lower infection risk.
- M2 cells secrete IL-10 to suppress Th2/Th17 activation.

Systemic Itch & Pain Reduction

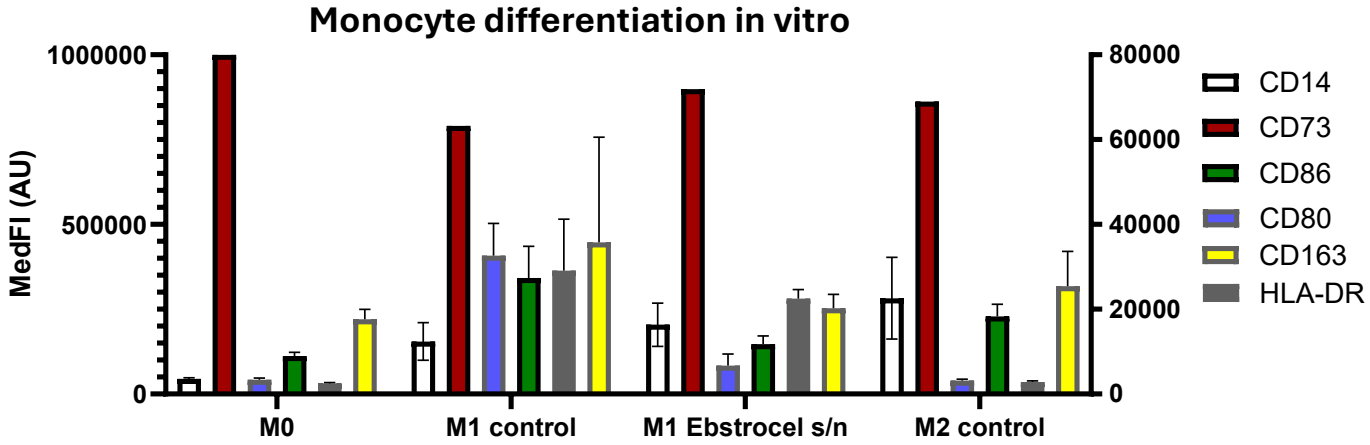
The Activation Path (Inducing Healing)

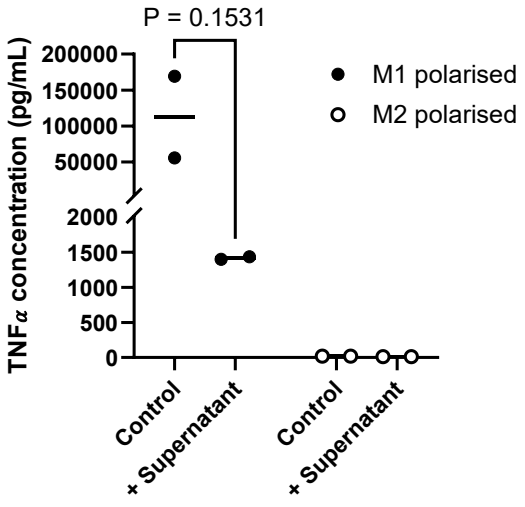
- Drives M1 to M2 differentiation.
- Secretes PGE2 and induces IL-13 secretion as M1 cells transition to M2.
- Induces M2 migration directly to wounds, releasing healing factors (TGF-b, VEGF, IGF-1).

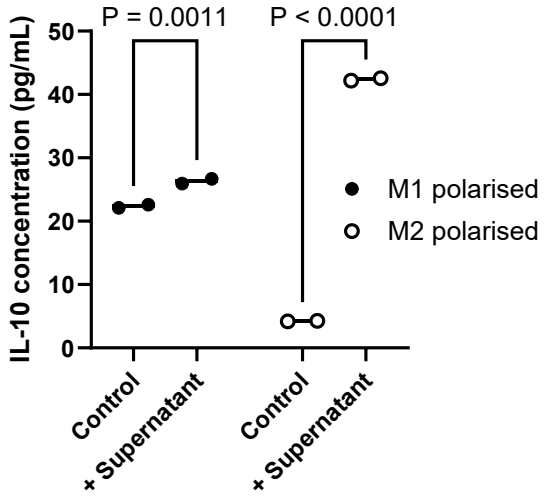
Enhanced Continuous Wound Healing

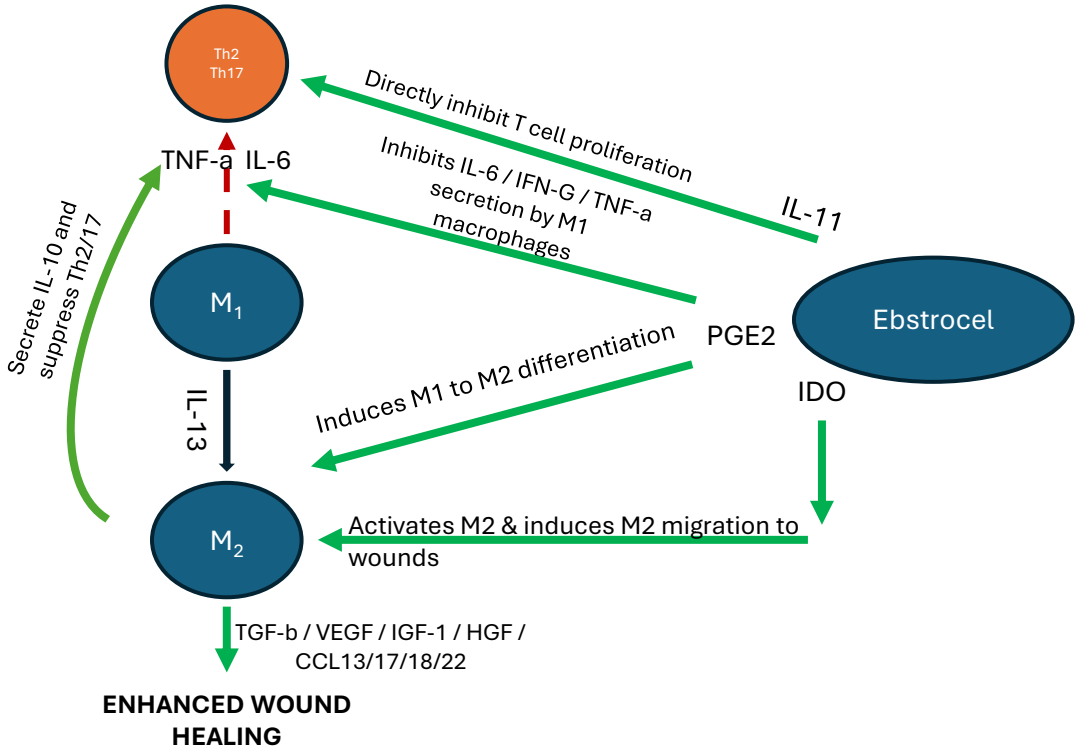
Ebstrocel Mechanisms of Action - Details

M1 to M2 differentiation *in vitro*



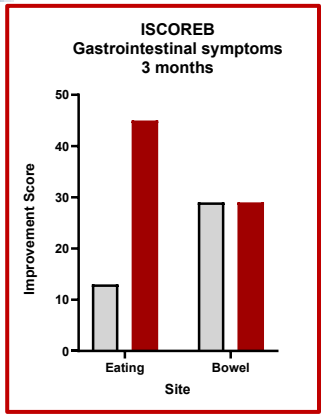


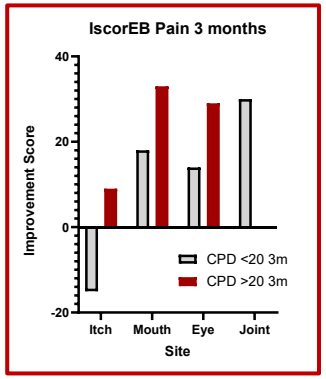


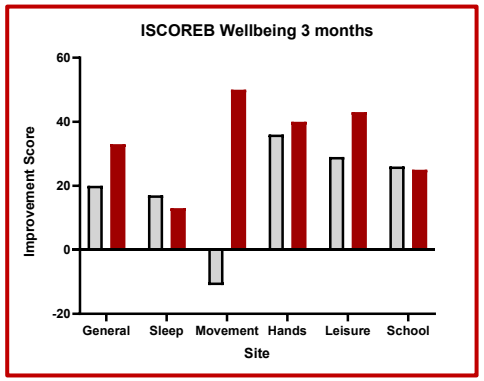


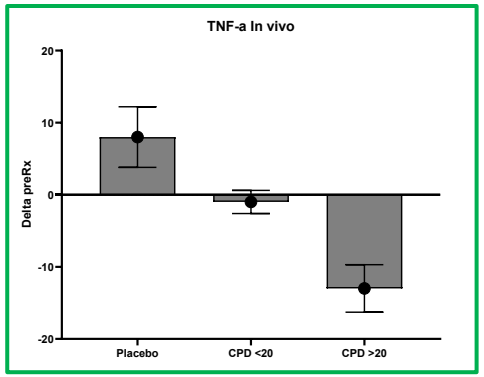
Ebstrocel Mechanisms of Action

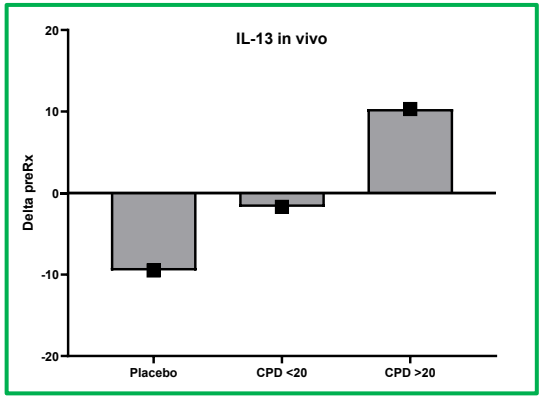
Proof of MoA *in vivo*

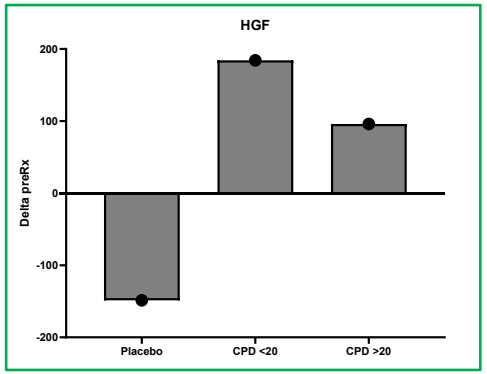


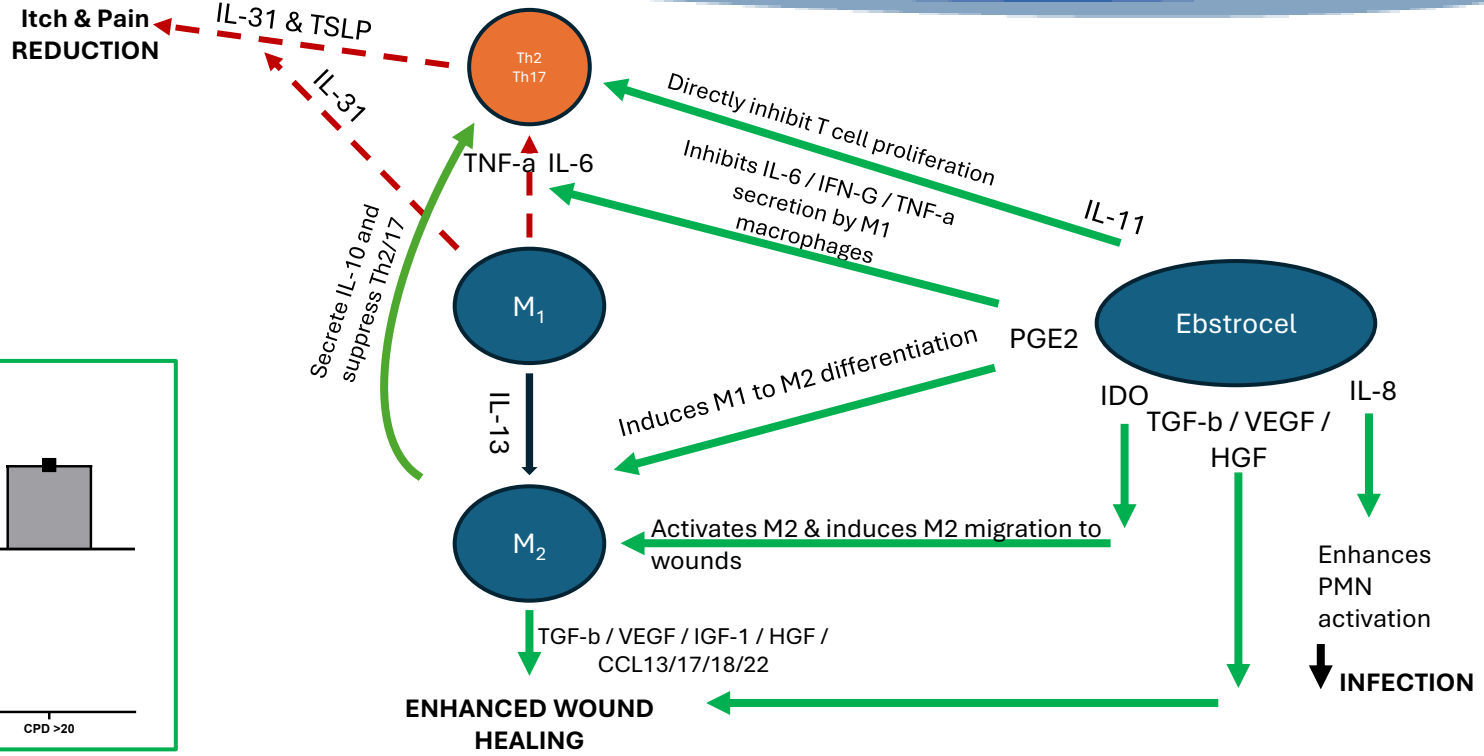


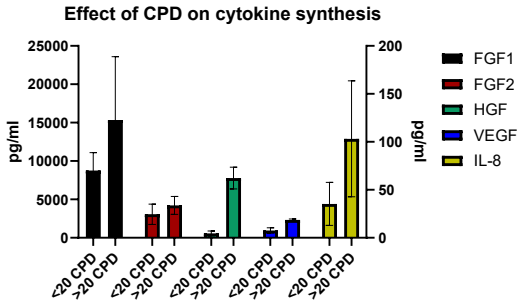


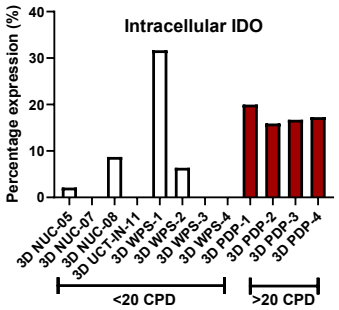






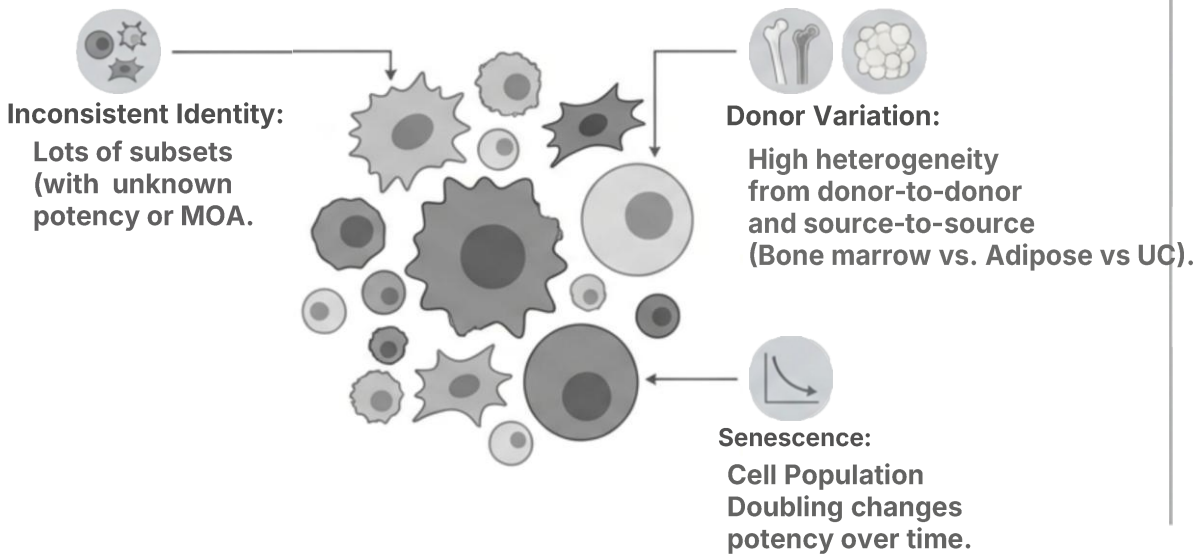






Why Historical MSC Development Failed: The Problem of Heterogeneity

The Heterogeneity issue



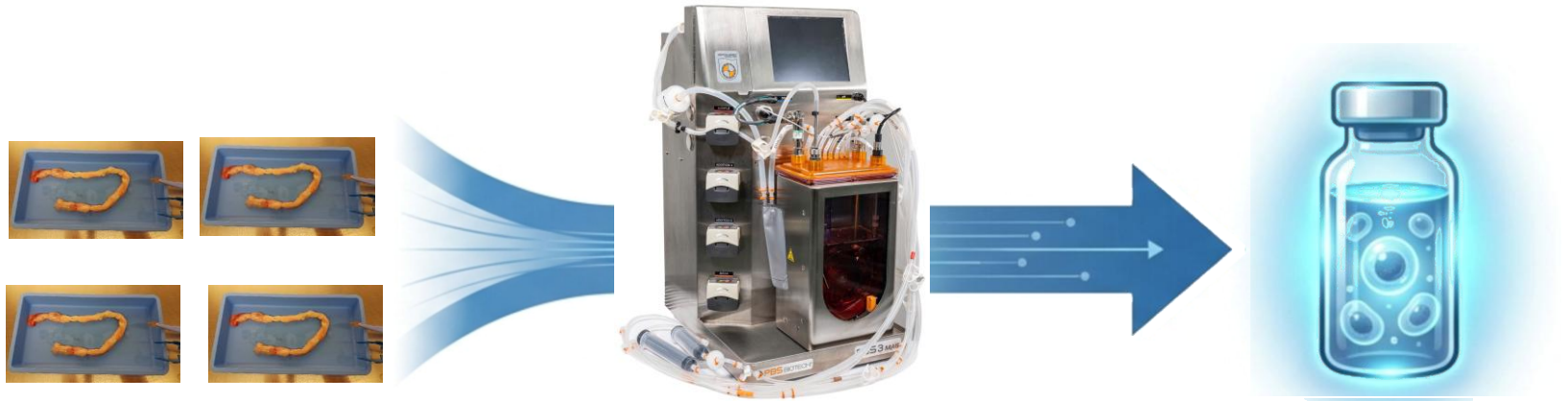
The Consequence

Clinically Naive Assumptions.

The assumption that "all MSCs are the same" led to few successful trials and only one approval.

Past failures were not always due to a lack of therapeutic potential, but mostly lack of product consistency and understanding of the mechanisms of action in the disease

The CORDStrom™ Solution: Engineered Homogeneity Through Identity Selection and Pooling



Minimum
4 *"selected"* UC Donors

Proprietary
Pooling Process

High Potency
High Reproducibility
Master Cell Stock

Source

Umbilical Cord Tissues
(Superior expansion potential and lower heterogeneity vs. adult tissue).

Identity

Characterized by standard markers (CD73/90/105) PLUS potency-specific markers (CD10, CD29, CD44,MSCA-1, and others).

Advantage

Pooling minimizes donor variation, creates a highly reproducible product, and enables massive scalability.

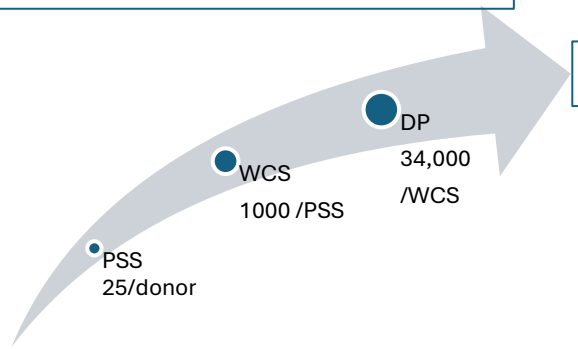
Commercial-scale manufacture complete and future-proofed

Supply Reliability

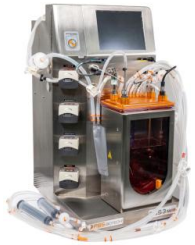
Available = 80L

~100 patients in UK
4 doses/year
45 years from same 4xdonor stock

1. Phase-dependent, scalable



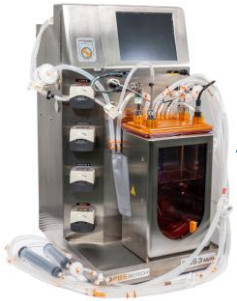
Current scale = 3L



In development = 15L

2. Closed Bioprocessing

Closed from MCB to Final Drug Product



0.5L to 80L

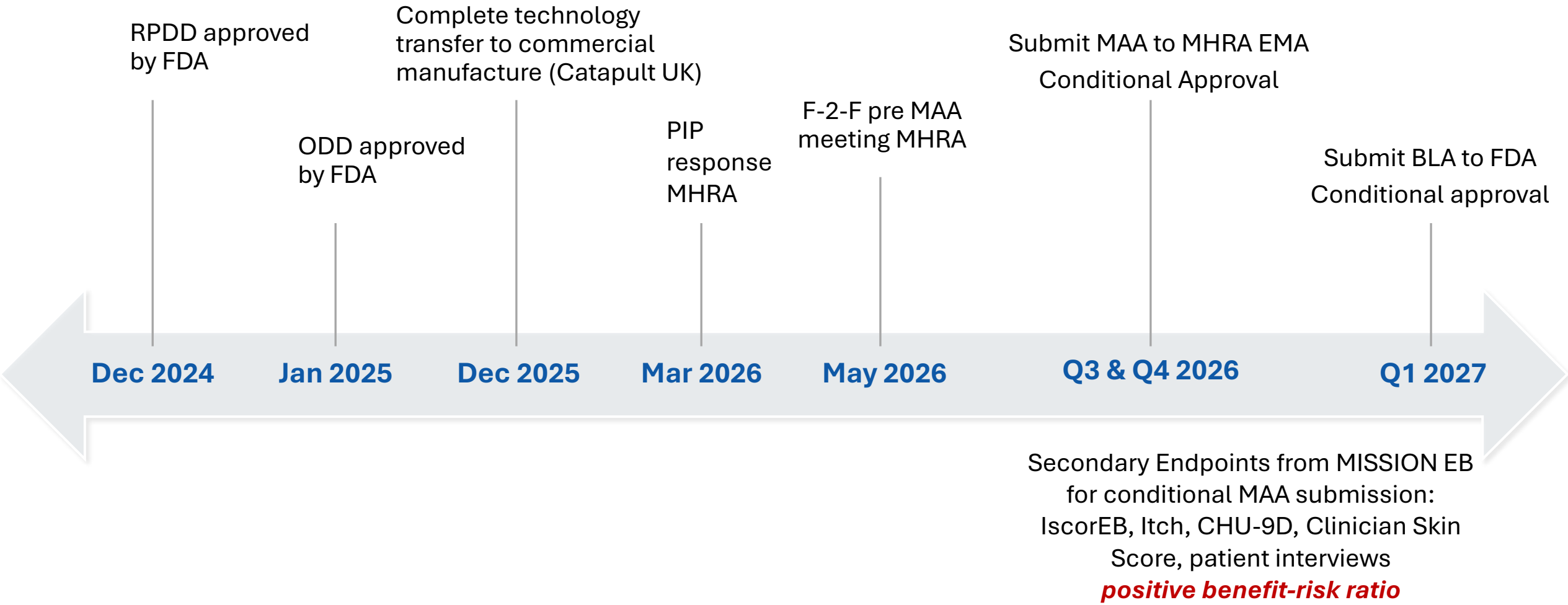
0.2L to 2000L

Automated formulation & bag filling x21 per manifold

High-capacity (75) controlled rate freezers

Stable long-term storage

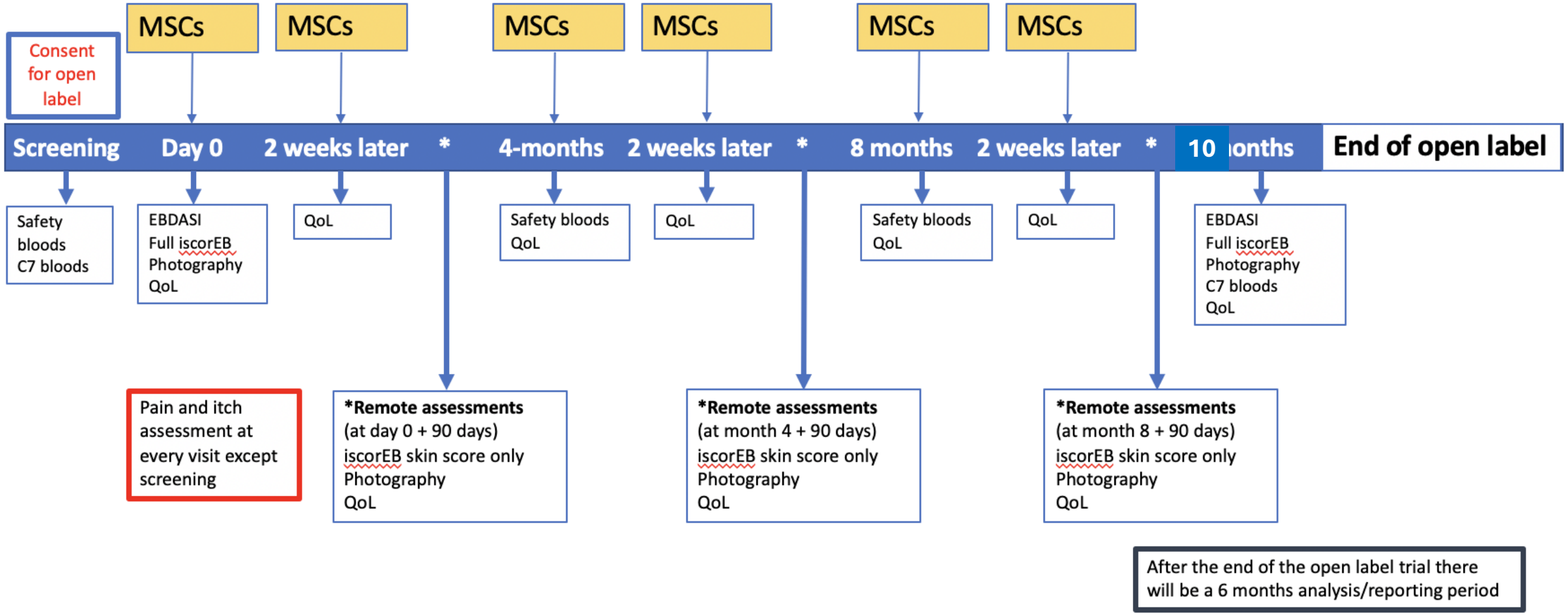
Ebstrocel for RDEB: Path To Market



FDA = Food and Drug Administration; MHRA, EMA = regulatory agencies in UK and EU; ODD = Orphan Drug Designation; MAA = Market Authorization Application; BLA = Biologics Licensing Application; RPDD = Rare Pediatric Disease Designation

*Estimated dates subject to change – See "Forward-Looking Statements"

Phase 3 Open Label Trial – 18 Months
MISSION EB-DELIVER



Market Landscape: Comparison of Therapeutic Approaches

	Vyjuvek (Krystal Biotech, ~$8B Cap)	Zevaskyn (Abeona)	Filsuvez (Chiesi)	CORDStrom
Mechanism of Action	Gene therapy, topical application	Autologous gene-modified epidermal sheets	Topical gel	Allogeneic mesenchymal stromal cells, intravenous infusion
Route of Administration	Localized topical application to wounds	Surgical grafting to specified wounds	Localized topical application to wounds	Systemic intravenous infusion
Systemic Efficacy	None (Localized effect)	None (Localized effect)	None (Localized effect)	Significant systemic reduction in pruritus and pain
Estimated Cost	~$750k annually	>$3M (One-time treatment)	~$27k (Per treatment course, variable)	~$700k annually (Estimated)

Vyjuvek = Product of Krystal Biotech, Inc.; Filsuvez = Product of Chiesi Farmaceutici S.p.A.; Zevaskyn = Product of Abeona Therapeutics Inc.

The TAM is an estimate based on internal assumptions and third-party sources, is a forward-looking statement and does not guarantee any future performance. Actual TAM may differ materially. See "Disclaimer" and "Forward-Looking Statements"

Parent Quotes

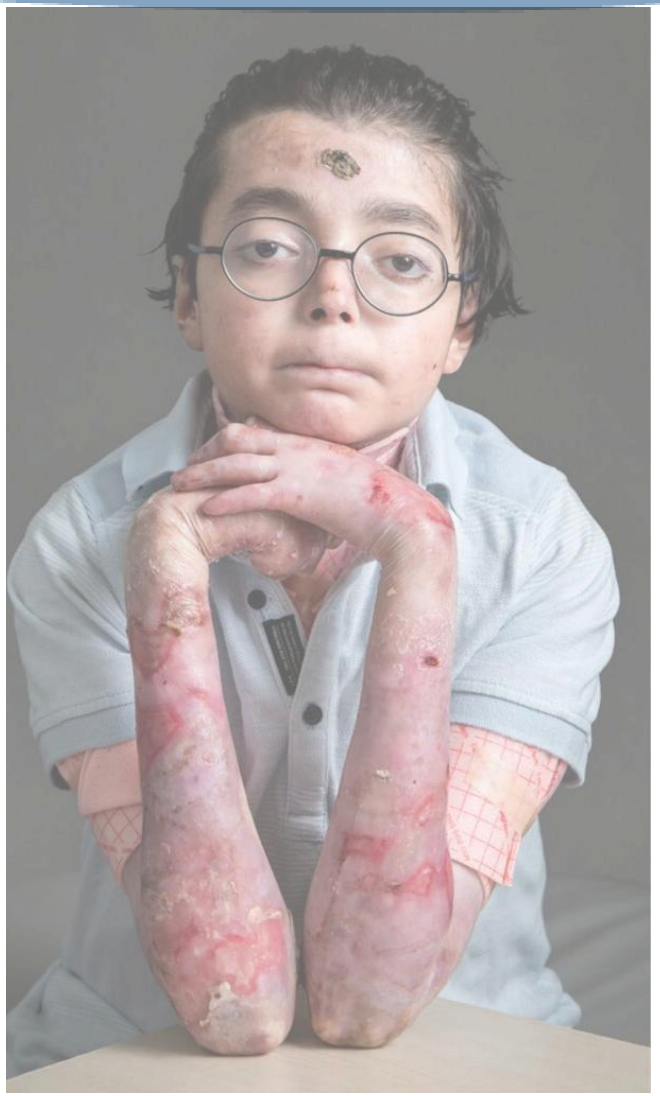
When she has been getting ill she has just been recovering in the same time as her brother, normally illness affects her much more because it causes inflammation. We have just been able to cope with everything so much better and have lots of energy and I suppose ***life has felt normal***

I think it's just been lovely to see him having energy and having an appetite , I suppose actually that's the one thing we've noticed as well, ***she has put on weight***

Children's Quotes

It was less painful, when I itch it's painful so obviously that's not comfortable, but ***I had less pain****, my* ***skin was less itchy****, my hands were less hot and when they are hot I itch. That was not happening that much.*

Normally it would hurt when I have a bath but lately it hasn't been hurting



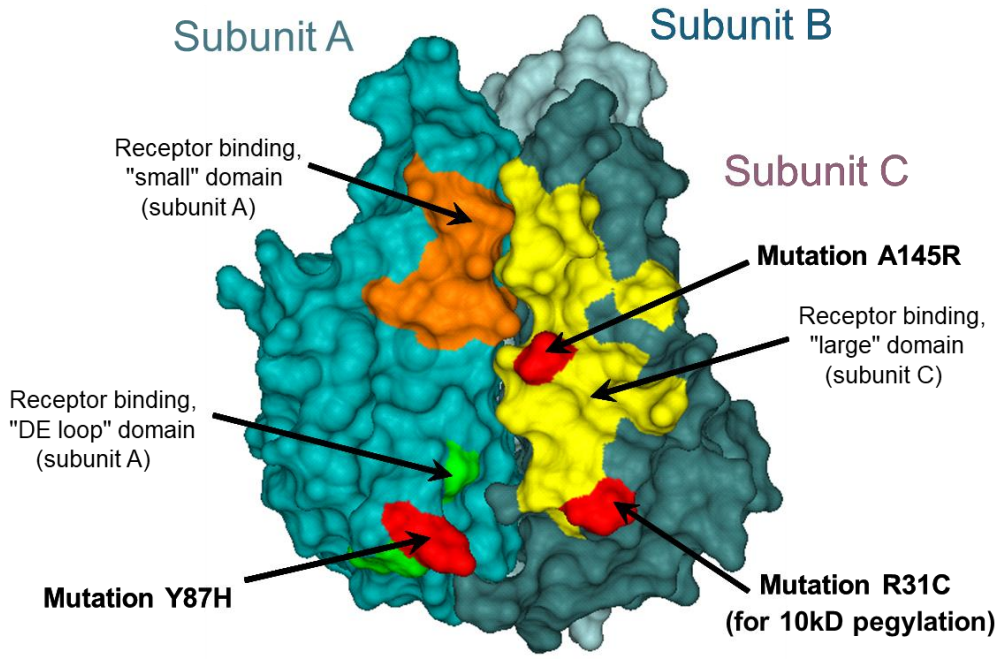
Quote from a parent:

"If it makes only one per cent difference, then I'm happy to come whenever they call us *for the trial because that one per cent isn't a lot I know, maybe it's nothing for somebody, but* ***it's a lot for him, one per cent less pain for him is one per cent more real life-*** *that's a lot"*

MISSION EB Team 2024


XPro™
Approaching Alzheimer's as an Immunologic Disease

XPro1595 (XPro): Neutralize TNF while Preserving Immune Function



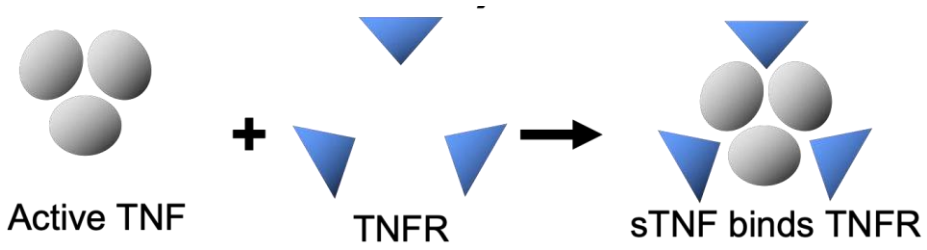
XPro1595 is identical to the human soluble TNF monomer with the exception of mutations in the receptor binding domain and another for pegylation.

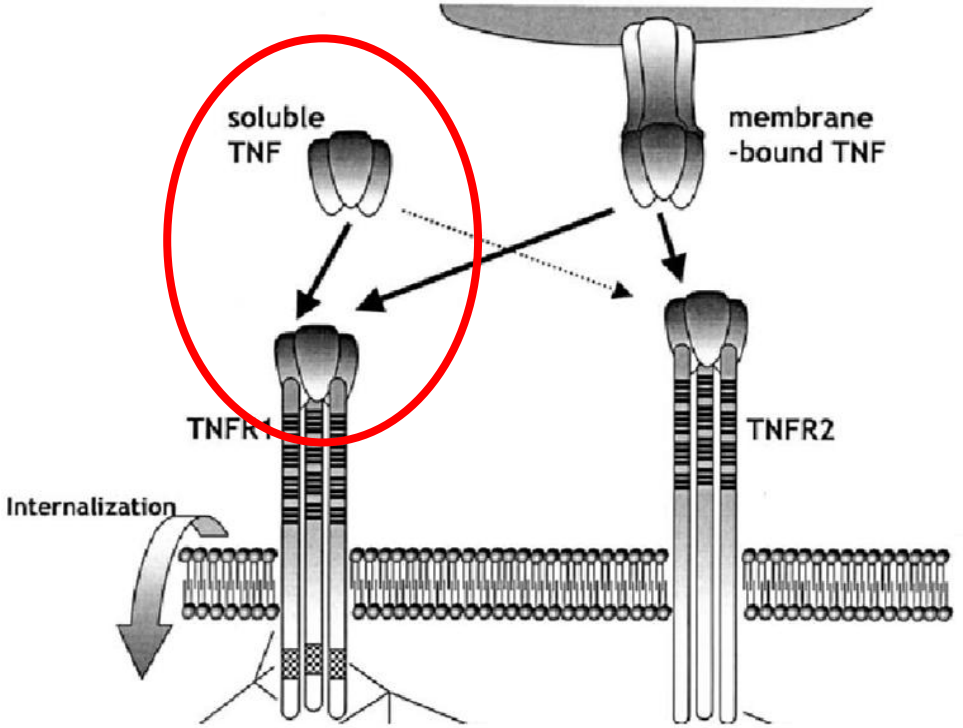
Dominant-Negative in genetics:
"A mutation producing a rogue protein that interferes with the function of the native protein."

see Steed et al., *Science*, 301, 2003

Normal Soluble TNF activity

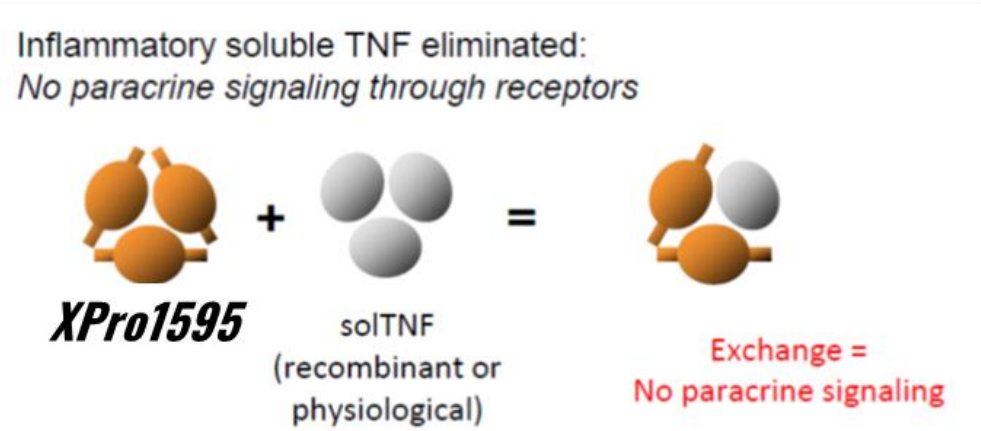
solTNF monomers form active heterotrimers that bind to TNF receptor. Each monomer in the trimer contacts one TNFR subunit



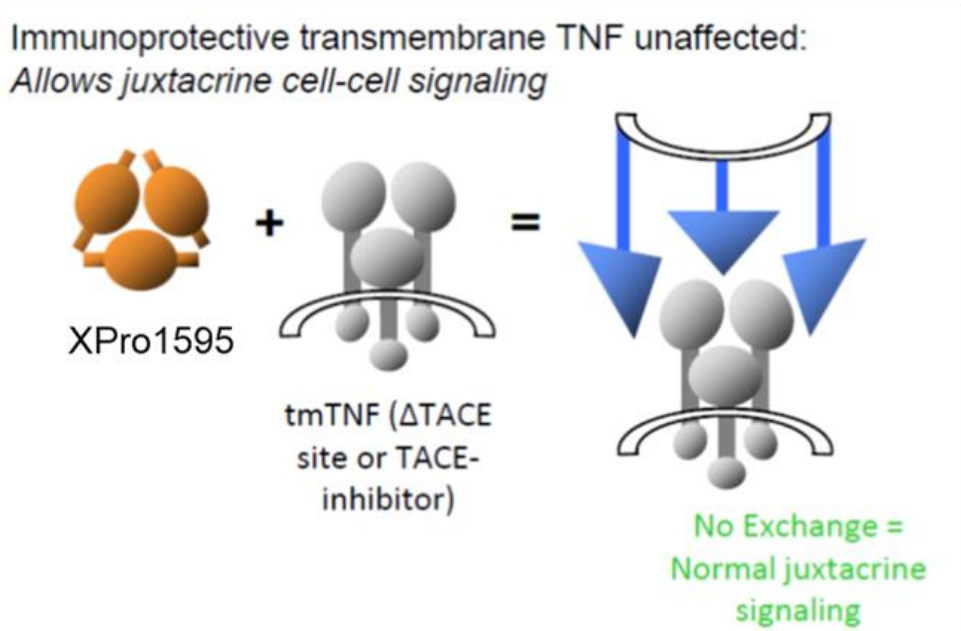


XPro1595 MOA

Xpro1595 freely exchanges with solTNF monomers to form inactive heterotrimers

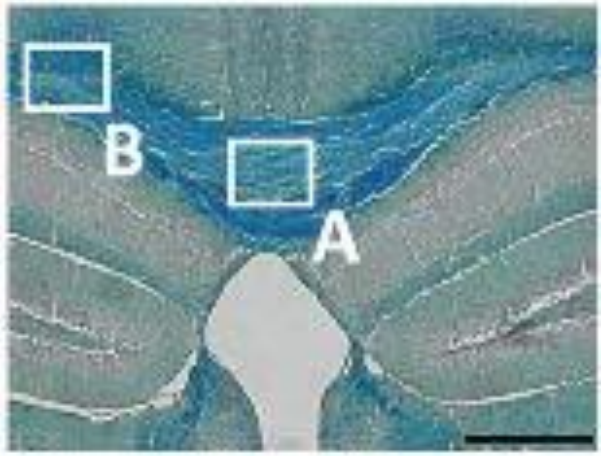


tmTNF homotrimers are anchored to the cell membrane, *XPro1595* cannot exchange



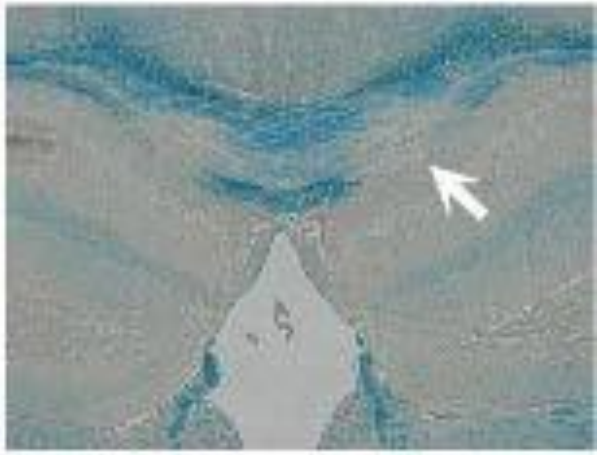
XPro1595 is Neuroprotective

Normal



Cuprizone

(Model of Multiple Sclerosis)



Etanercept

Anti-inflammatory AND immunosuppressive

Exacerbated demyelination

XPro1595

Anti-inflammatory NOT immunosuppressive

Remyelination

Adapted from: Karamita et al., 2017

XPro1595 Peer-Reviewed Publications: Breadth of Scientific Validation

More Than A Decade of Research Excellence

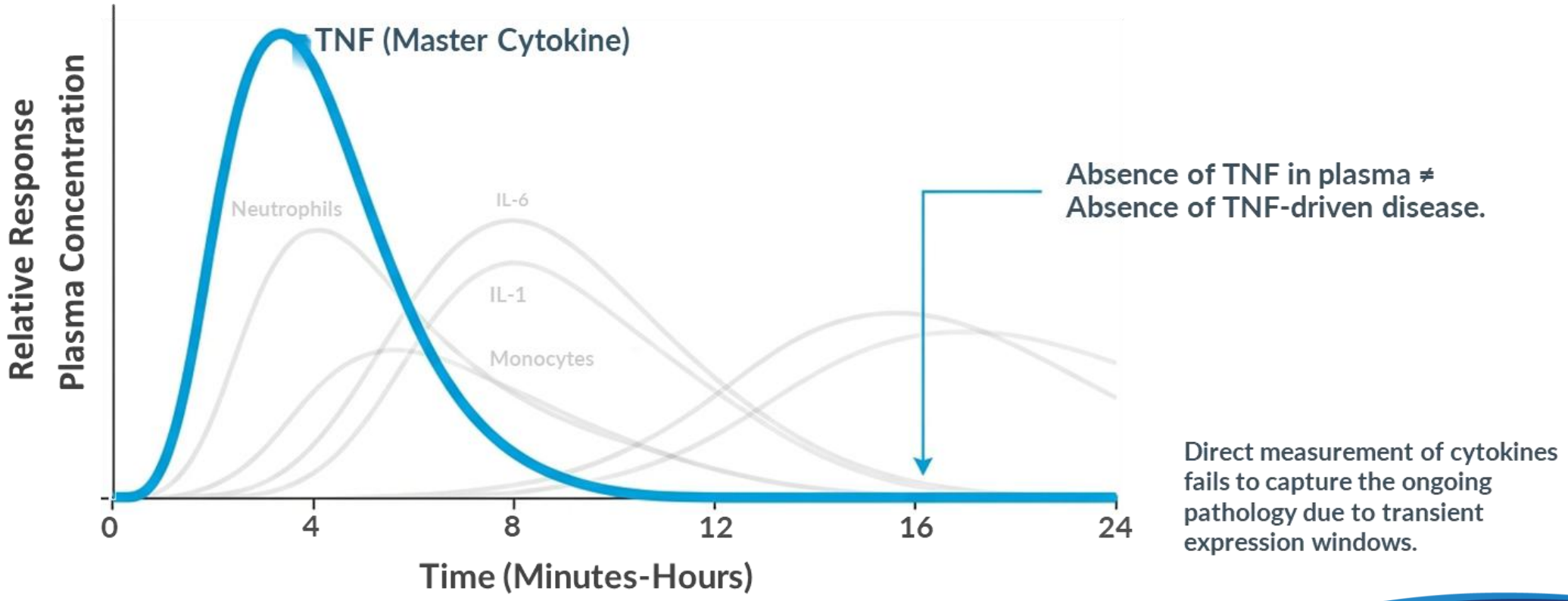
XPro1595's therapeutic potential has been rigorously validated across more than 90 peer-reviewed publications spanning 24 therapeutic areas, 2 dozen independent laboratories, and 3 continents. This extensive body of evidence demonstrates consistent neuroprotective, anti-inflammatory, and disease-modifying effects across diverse pathologies. (See appendix)

>90 Publications

24 therapeutic areas
2 dozen laboratories
3 continents

	Non-selective TNF inhibitors	XPro1595
Decreases inflammation	yes	yes
Immunosuppression	yes	No
Demyelination	yes	No
Neuroprotective	no	yes
Enhances neuroplasticity	no	yes

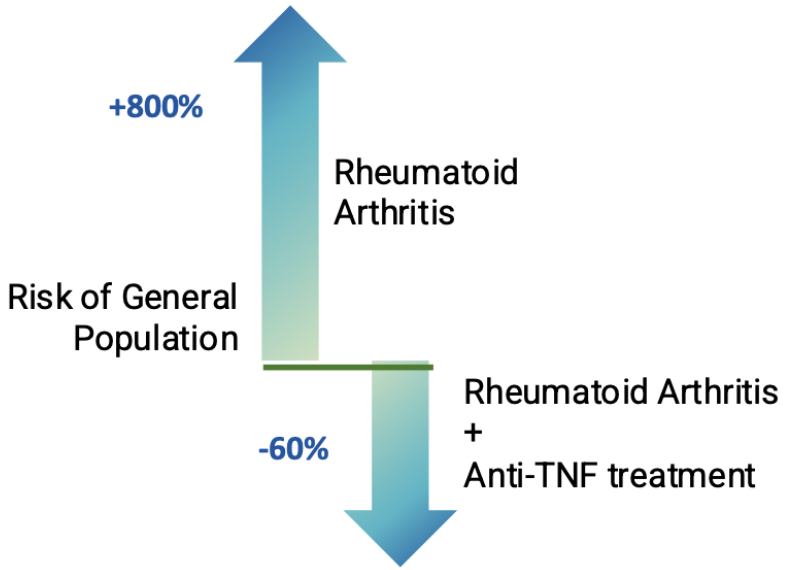
Cytokines are not informative biomarkers of chronic inflammation (Immune Dysfunction)



Adapted from PMID: 27994591 and 18673219

Strong Evidence for anti-TNF to Treat Alzheimer's Disease

TNF Inhibitors Reduce Risk of Developing AD



Epidemiological studies including a meta-analysis of more than 60 million cases linking **TNF Blocking Agents** to reduced risk of AD

Adapted from PMID: 27470609, 33016914

Evidence linking TNF to AD

TNF increases with Age	TNF levels increase beginning the 3rd or 4th decade of life and correlate with age[6]
TNF increased in AD Patients	Plasma and CSF TNF levels increased in AD patients[2,3] TNF co-localizes with amyloid plaques[4] TNF levels correlate with disease progression[5]
TNF causes AD pathology in animals	TNF increases amyloid[7,8] and Tau[9-12] TNF causes cell loss and cognitive impairment[13]
TNF inhibitors reduce risk of AD	Anti-TNF therapies[1] reduce the risk of AD in humans by up to:

60%

1. Torres-Acosta N, et al. J Alzheimer's Dis. 2020;78:619–626
2. Fillit H, et al. *Neurosci Letters*. 1991;129:318-320
3. Tarkowski E, et al. J Clin Immunol. 1999, 19(4):223-230
4. Dickson DW. J Neuropathol Exp. Neurol 1997;56:321-339
5. Paganeli R, et al. *Experimental Gerontology*. 2002;37:257-263
6. Parker et al. The Journals of Gerontology (2019) 74(3):283
7. Lahiri et al. J Alzheimer's Dis. 2003;5(2): 81-90
8. Blasko et al. FASEB Journal. 1999, 13(1):63-68
9. Gorlovoy et al. FASEB Journal. 2009, 23(8):2502-2513
10. Montgomery et al. Am Journal Pathology. 2013, 182(6):2285-2297
11. Janelsins et al. Am Journal Pathology. 2008, 173(6):1768-1782
12. Lee et al. Molecular Med Rep. 2014, 10(4):1869-1874
13. He et al. J Cell Biol. 2007, 178(5):829-841

Biomarker Enrichment Rationale

Matching drug biology to patient · Predictive enrichment using downstream indicators of TNF-driven biology

The Challenge

TNF is the therapeutic target
but cannot serve as the enrichment biomarker.

Ultra-short half-life
TNF peaks in minutes–hours and resolves rapidly. Circulating levels don't reflect tissue or CNS inflammation.

Solution
Measure downstream biomarkers that integrate TNF-associated biology over stable timeframes.

hsCRP — Days to Weeks

TNF → IL-6 → hepatic CRP production

Delayed but stable systemic marker of TNF-driven acute-phase response

ESR — Weeks to Months

TNF → fibrinogen → rouleaux formation

Slow rise, prolonged elevation reflecting chronic inflammatory burden

HbA1c — Weeks to Months

TNF → insulin resistance (JNK/IKKβ) → glycemic load

Integrates metabolic consequences of chronic TNF signaling

APOE ε4 — Constant

Amplifies TNF production in microglia and astrocytes

Genetic variants (Arg112/Arg158) drive lifelong glial inflammatory priming

≥2 of 4 Composite Design

Captures Multidimensionality · Accommodates Biological Heterogeneity · Reduces Misclassification

11 distinct qualifying biomarker combinations — built-in redundancy against single-assay failure

Enrichment is predictive — *identifying patients with TNF-driven disease biology most likely to benefit from XPro1595.*
hypothesis-driven precision medicine.

ADi = Alzheimer's Disease with Inflammation. Cutoffs: hsCRP >1.5 mg/L, ESR >10 mm/hr, HbA1c >6%, APOE ≥1 ε4 allele. Enrichment requires ≥2 of 4.

References available upon request

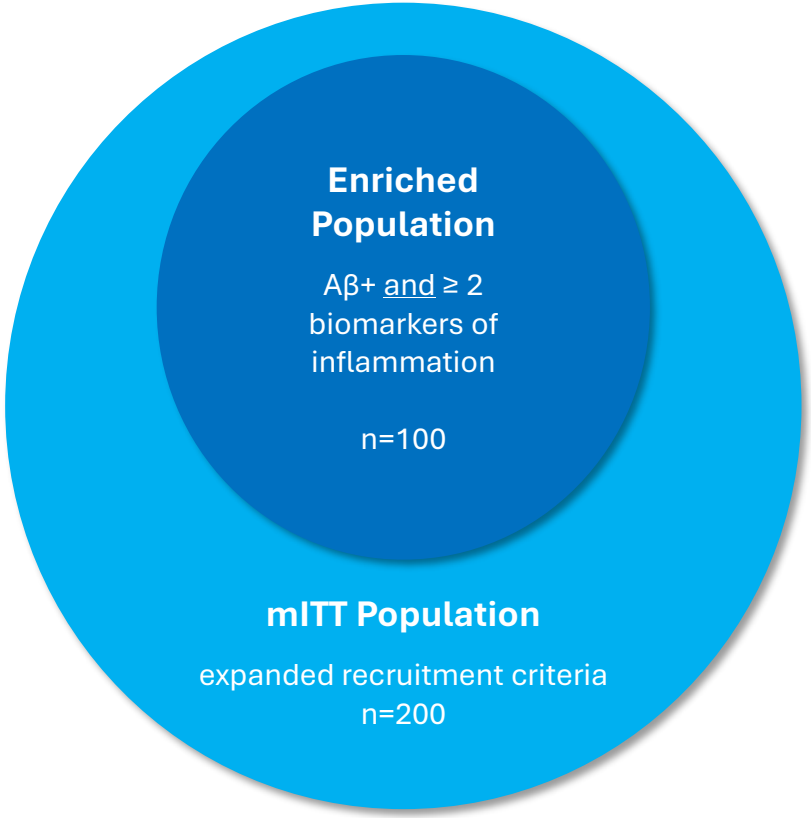
Phase 2: Why Did We Miss P-Value in Cognition (EMACC)? No Placebo Decline in mITT

Original Key Inclusion Criteria: Enriched Protocol

- Age (60 - 85 years)
- Diagnosis of mild AD (NIA-AA stage-4)[1]
- Amyloid-beta positive (Aβ+)
- MMSE ≥ 22
- ≥ 2 blood biomarkers of inflammation

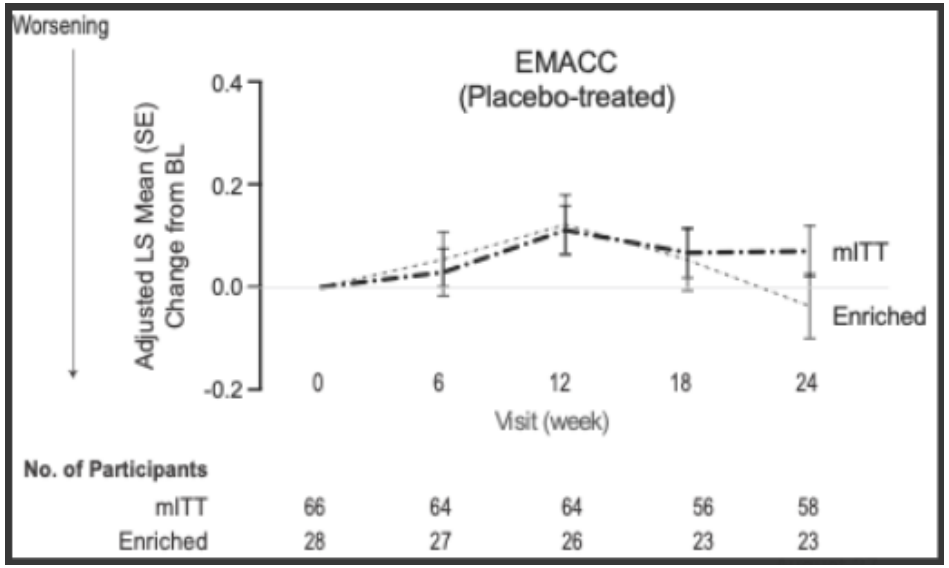
Expanded Inclusion Criteria: Revised Protocol

- Age (50 - 85 years)
- Diagnosis of MCI or mild AD (NIA-AA stages 3-4)[1]
- ~~Amyloid-beta positive (Aβ+)~~
- MMSE ≥ 22
- **≥ 1 blood biomarker of inflammation**



To assess a possible treatment effect of XPro1595 compared to placebo, a decrease in cognition within the placebo-treated group over the study period is necessary.

No such decline is observed in the placebo group within the mITT population, but a decline is present in the placebo group among the Enriched population.



Phase 2: Consistent Signal in AD Inflammation Enriched Population

6-month RCT · N = 206 (mITT: XPro n=139, placebo n=67) · ADi enrichment: ≥2 of 4 biomarkers AND amyloid positive (n=100)

Overall Population (mITT)

72 yrs median age · 51% female · 45% MCI

68.5% APOE4 carriers — highest ARIA risk population

75% amyloid positive — confirmed AD pathology

62.5% ADi population (≥2 inflammatory biomarkers)

ADi = Alzheimer's Disease with Inflammation. Requires ≥2 of 4 biomarkers: hsCRP >1.5 mg/L, ESR >10 mm/hr, HbA1C >6%, or ≥1 APOE ε4 allele, in addition to confirmed amyloid positivity

Key Findings: ADi Enriched Population

Endpoint	Effect Size	Signal
EMACC (primary) Cognitive composite	d = 0.27	Clinically meaningful
***Chi-separation** myelin (imaging)	d = 0.59	Clinically meaningful
Cortical Disarray (PerpPD+) Gray matter (imaging)	d = 0.32	Clinically meaningful
NPI Total Score Neuropsychiatric symptoms	d = 0.23	Clinically meaningful
GFAP (plasma) Astrocyte reactivity	d = 0.19	Directionally supportive
pTau-217 (plasma) Tau accumulation	d = 0.18	Directionally supportive
Goal Attainment Scale Patient-reported outcome	d = 0.18	Directionally supportive
ISRL Delayed recall / memory	d = 0.16	Directionally supportive

**** Statistically significant (p=0.0098).*** *Positive Cohen's d favors XPro1595. d ≥ 0.2 = small, d ≥ 0.5 =med-large; but clinically meaningful signal threshold; d < 0.2 = directionally supportive. ADi population (amyloid positive AND ≥2 of 4 inflammatory biomarkers, n ≈ 100).*

Dose-compliant analyses show increased effect sizes for NPI, pTau-217, and GFAP, Chi-separation — effects attributable to greater XPro1595 exposure

Differentiated Safety Profile

No ARIA · Immune Function Preserved · SAEs Lower on Drug

0

ARIA Events

Despite a high-risk population:
68.5% APOE4+ · 34% with microbleeds
27% on antithrombotic

Placebo infection rates

2× higher

XPro1595 preserves systemic immune function — selectively inhibiting inflammatory TNF (sTNF) while preserving protective TNF (tmTNF)

Serious & Severe AEs Lower on Drug

Both serious and severe events were less frequent on XPro1595 than placebo. Severe events 3× more frequent on placebo. Zero fatal events across 206 patients.

ISR & Blinding Considerations

ISR rates higher on drug (79%) — majority were mild and transient, characterized by an independent safety board as "more nuisance than safety." Blinding strategy addressed in Phase 3 design.

Safety profile supports Phase 3 advancement — predictable, manageable, with no unexpected signals

Phase 2b/3 Adaptive Trial Design — FDA Aligned

FDA End-of-Phase 2 Meeting Completed Q1 2026; Fast Track Granted Q2 2026

Study Population
Patients with Early Alzheimer's disease and Inflammation (ADI).

Study size *
Phase 2b will target ~300
Phase 3 will target ~1000

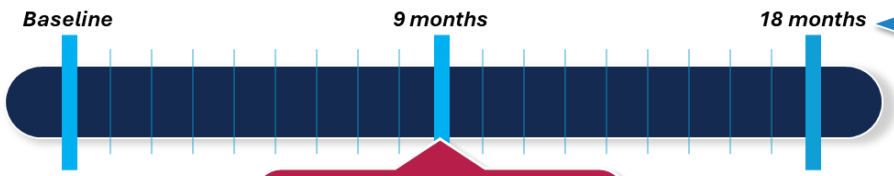
Enrichment Biomarkers
ADi is defined by ≥ 2 (of 4) of the following biomarkers: hsCRP, ESR, HbA1C, APOE4

Timeline & Treatment Arms

1:1 Randomization

XPro1595 Arm
Weekly subcutaneous injections of 1.0 mg/kg XPro1595

Placebo Arm
Matching subcutaneous placebo injection



Go/No-Go Decision Gate
Requires success on EMACC or pTau217; includes Phase 3 sample size re-estimation

Phase 2b Decision Point
Assessment of co-primary endpoints: Cognitive Performance (**EMACC**) and plasma biomarker (**pTau-217**).

Phase 3
(Registration Endpoint)
Cognition and function measured by **CDR-SB**

Secondary Metrics include additional **Clinical** (cognitive, function, Patient reported outcomes) and **Biomarker** assessments (blood and imaging)

FDA Alignment

- **Enrichment**
  ADi biomarker strategy endorsed
- **Design**
  Adaptive 2b/3 with decision gate accepted
- **Endpoint**
  CDR-SB as sole Phase 3 primary
- **Exploratory**
  Non-enriched cohort recommended

Summary represents sponsor interpretation of FDA feedback.

CDR-SB Confidence: Why 18 Months Will Work

EMACC detects subtle cognitive changes- CDR-SB measures the consequences.

- Phase 2b: 3 more months + 3× sample → more time for placebo decline
- Anti-amyloid precedent: CDR-SB separation emerged at 18 months
- We have the early signal. Now we need the time.

EMACC — Cognitive Sensitivity

What it measures

Measures subtle cognitive changes — word recall, fluent speech, processing speed — too subtle for conventional clinical scales

Why it detects change early

Captures early changes such as slower performance or fewer words recalled in individuals that remain independent - A "***Stress Test for the brain***"

MINDFuL Phase 2 (ADi, 6 months)

d = 0.27

CDR-SB — Functional Impact

What it measures

Clinician and caregiver-rated assessment of whether cognitive deficits interfere with daily activities — appointments, finances, conversations

Why it requires more time

Broad scoring categories (none, slight, mild) don't reflect small changes. Requires observable change in day-to-day activities.

Phase 3 Registration (ADi, 18 months)

Primary endpoint for FDA approval

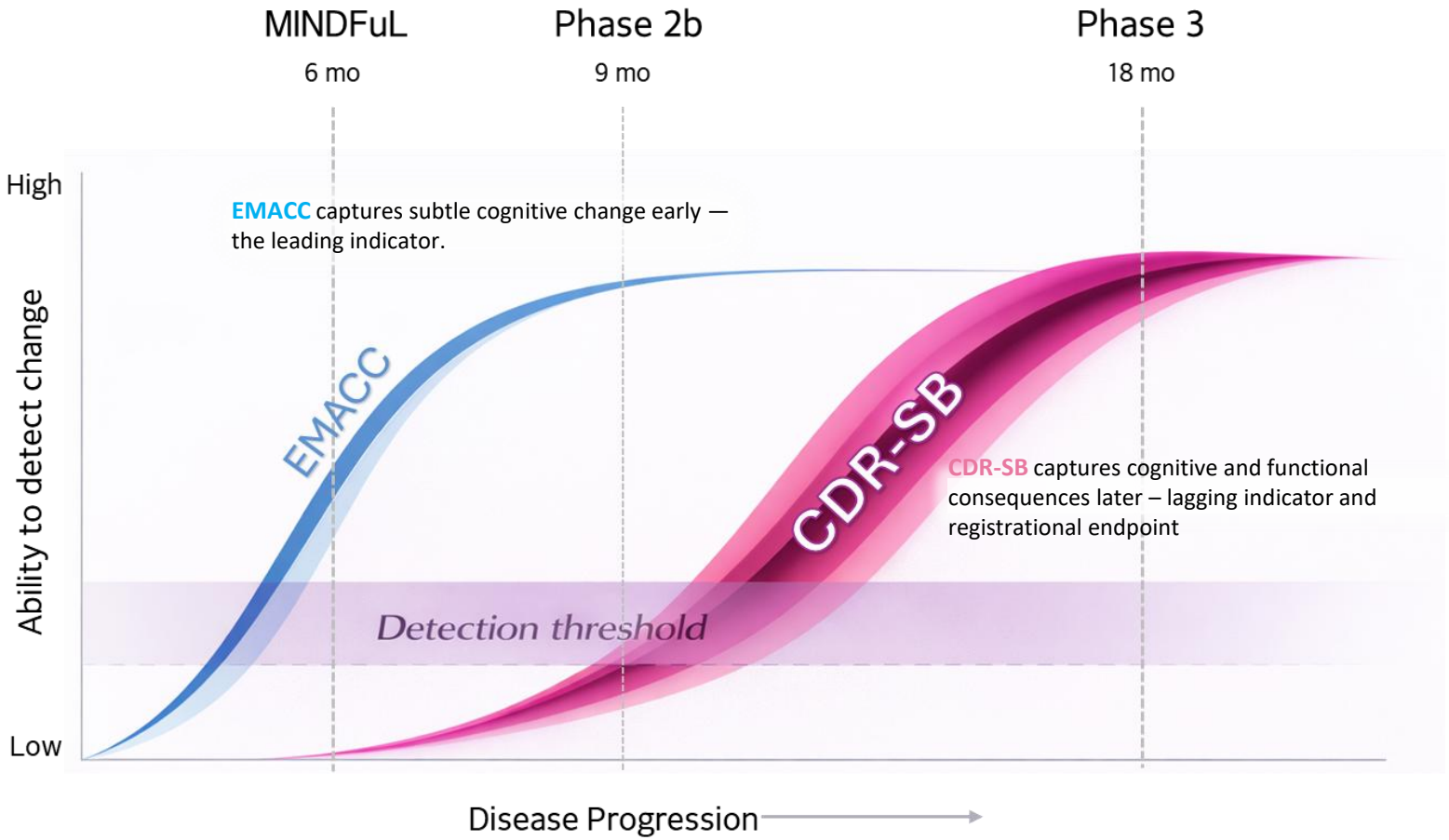
The Confidence Bridge: In external AD cohorts, correlation between cognitive composites and CDR-SB strengthens over time:

r = 0.41 (early) → r = 0.65 (18 months).

Cognition precedes function — the same temporal pattern seen in lecanemab and donanemab.

Why CDR-SB Requires More Time: Evidence from External AD Cohorts

Enough Cognitive Change Must Occur to Measure Functional Change



How to Read This Chart

Y-axis: Ability to reliably separate drug from placebo.
X-axis: Time / disease progression.
Horizontal band: Detection threshold — where enough signal accumulates to measure a difference.

EMACC (blue curve)
Cognitive composite measured on a continuous scale. Crosses threshold early — detected treatment signal at 6 months (d = 0.27).

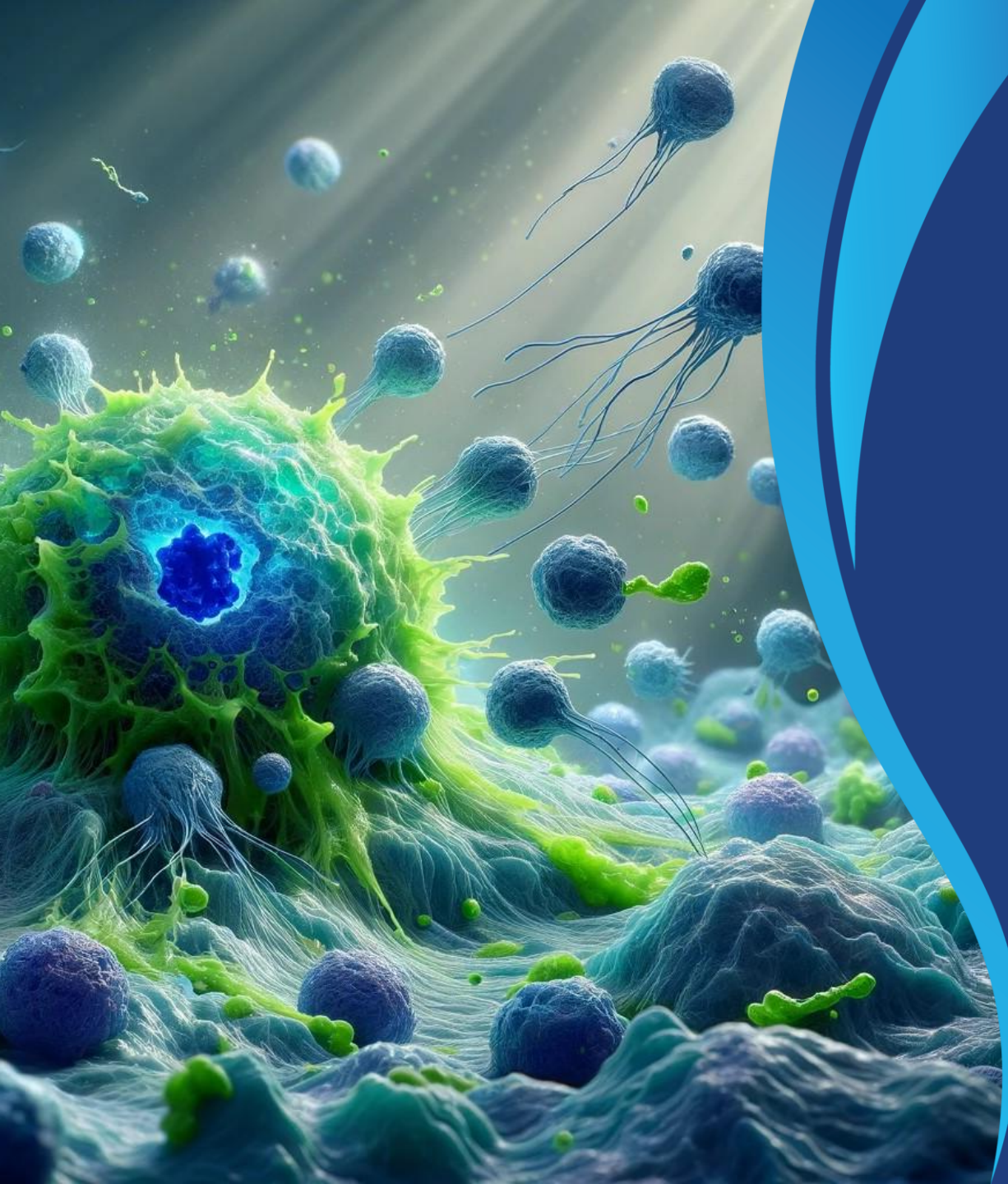
CDR-SB (magenta curve)
Broad scoring categories need larger functional change to register. Crosses threshold much later when daily activities are impacted.

Key: Same pattern as lecanemab and donanemab — cognitive separation first, functional later.

Conceptual framework. Curves are illustrative — not derived from trial data.

XPro1595 Path to Execution

- **Staged Investment:** The Phase 2b/3 design stages the capital commitment. The Phase 2b serves as a de-risking milestone with a built-in go/no-go decision before full Phase 3 expenditure.
- **Capital Markets:** As catalysts mature across our pipeline, including CORDStrom, we expect improved access to capital markets on favorable terms.
- **CORDStrom Optionality:** A successful CORDStrom program generates both revenue potential and a Priority Review Voucher, either of which strengthens our financial position for XPro development.
- **Advancing Now:** Protocol development is underway. CMC scale-up planning has been initiated. Site feasibility assessments are in process. Our intent is to be clinic-ready in 2027.



Thank You!

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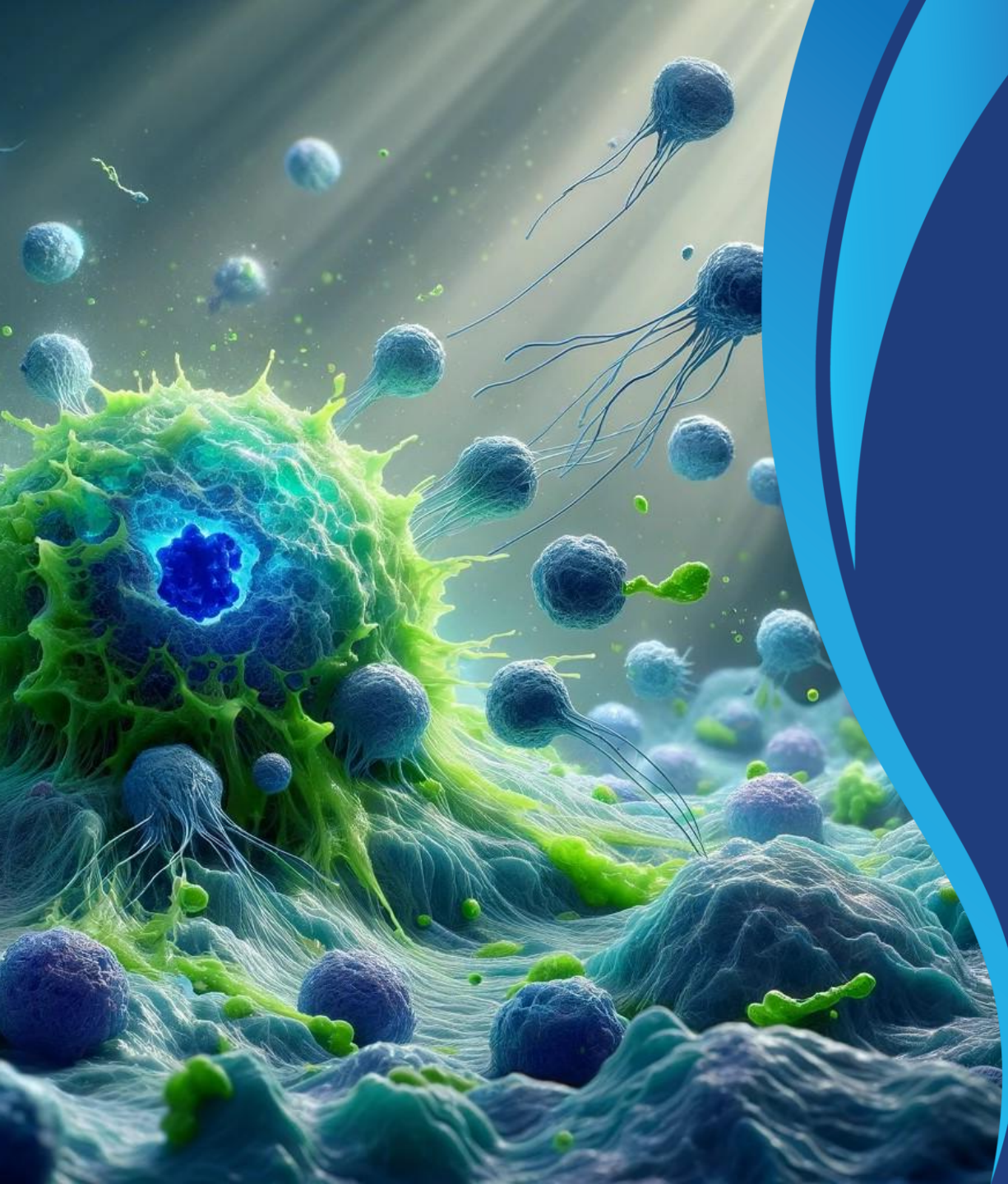
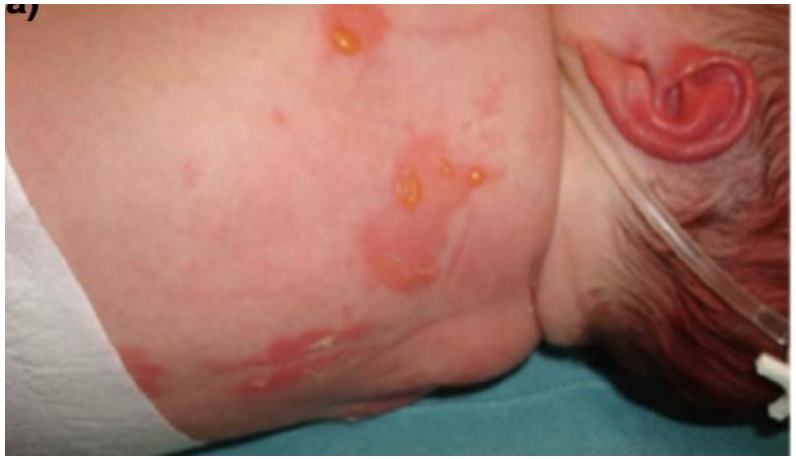
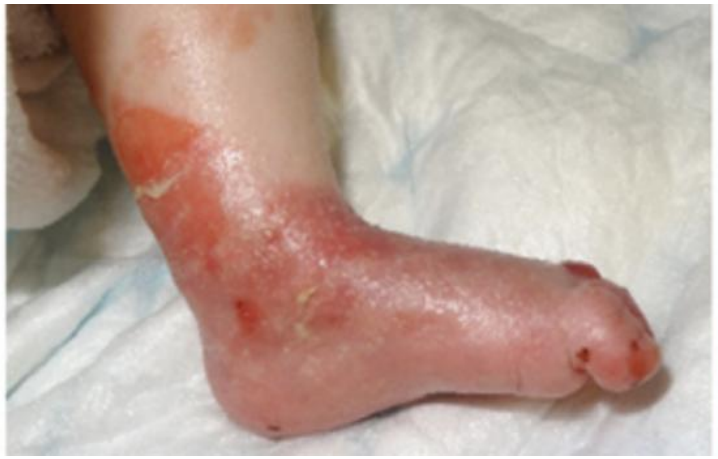
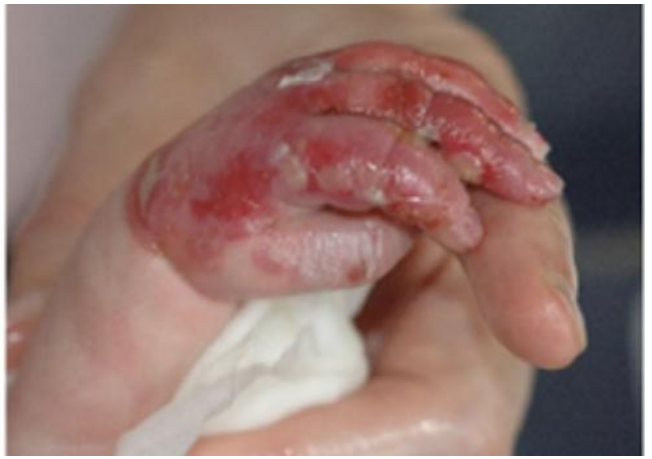


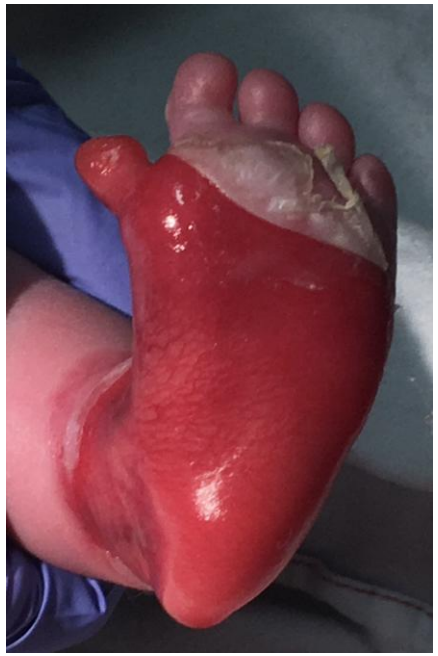
Appendix

Phase 1: 0 to 18 months









- Cutis aplasia-months to heal
- Wounds heal
- Weight gain satisfactory
- Relatively stable period

Consensus **reclassification** of inherited epidermolysis bullosa and other disorders with skin fragility.

Has C, Bauer JW, Bodemer C, Bolling MC, Bruckner-Tuderman L, Diem A, Fine JD, Heagerty A, Hovnanian A, Marinkovich MP, Martinez AE, McGrath JA, Moss C, Murrell DF, Palisson F, Schwieger-Briel A, Sprecher E, Tamai K, Uitto J, Woodley DT, Zambruno G, Mellerio JE.

Br J Dermatol. 2020 Feb 4. doi: 10.1111/bjd.18921. Online ahead of print.

PMID: 32017015 Review.

Phase 2: 18 months to 10 years

- Wound burden & skin colonization advances
- Wounds heal within 21 days
- They are recurrent & reoccurring wounds but not chronic

- First signs of internal involvement
    - inflammatory markers elevated
    - weight faltering
    - the onset of anemia
    - first signs of esophageal involvement and scaring

Phase 1 and 2

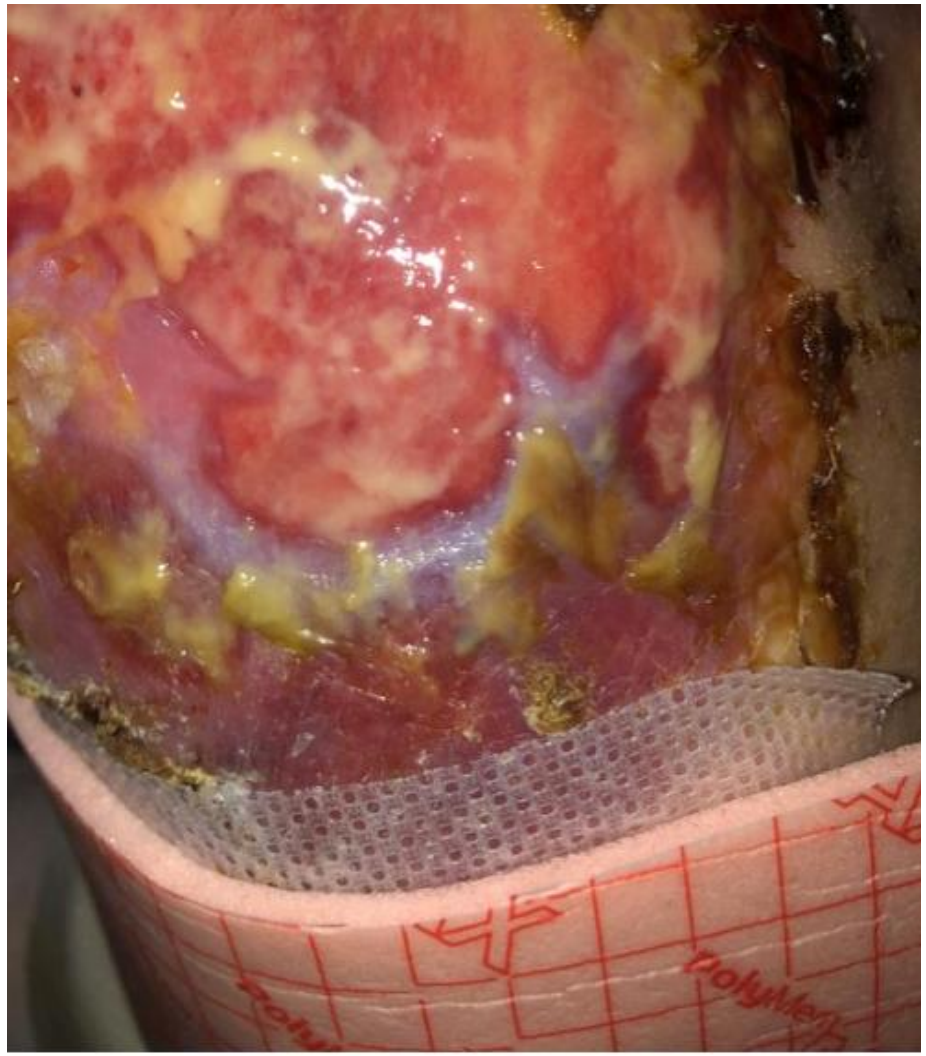
- Window of opportunity for anti-inflammatory therapy such as CORDStrom for systemic disease pathology

Therapeutic Requirements:
Anti-inflammatory cytokines
Reprogramming pro-inflammatory macrophages (M1) to anti-inflammatory (M2)

Phase 3: 10 to 20 years

- Skin involvement continues to increase
  - chronic wounds over 21 days
  - bacterial colonisation
  - multiple co morbidities
- Dramatic reduction in the ability to heal

Therapeutic Requirements:
Wound healing cytokines
Increased innate immune activity against bacteria/fungi

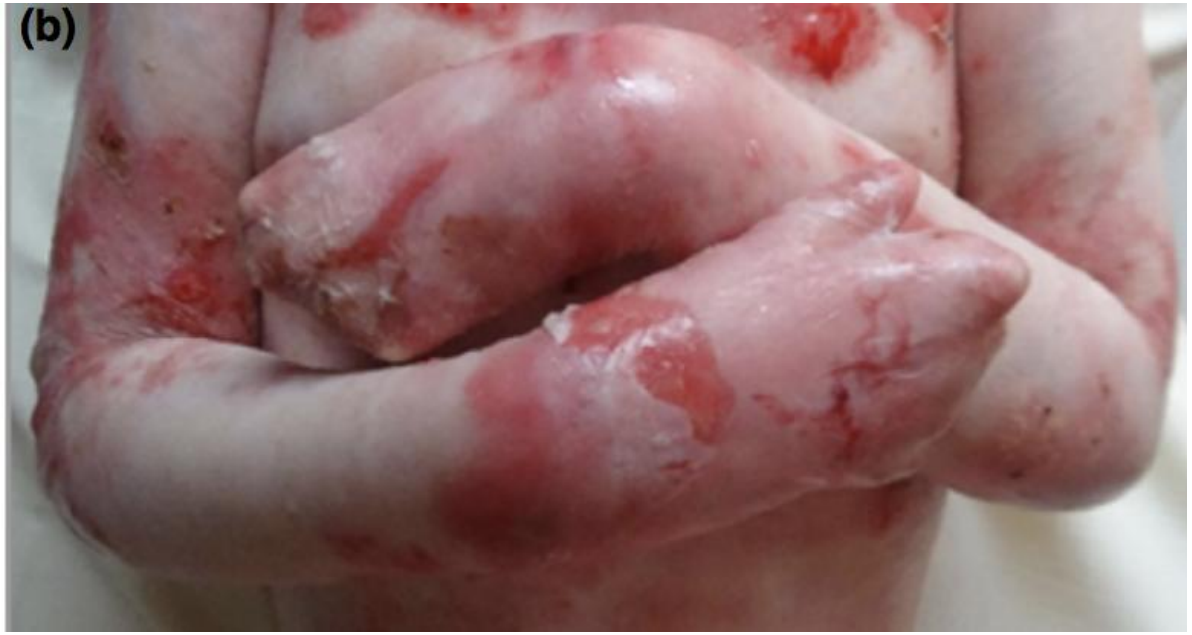


Phase 3: 10 to 20 years

- Massive levels of chronic inflammation
  - affects 4 major pathways

- Hypothalamic-pit-gonadal axis → pubertal delay
- GH/IGF-1 axis → growth delay
- Bone regulatory pathway → osteoporosis & fractures
- Iron metabolism → anaemia

- **Anti-inflammatory therapy much less effective**

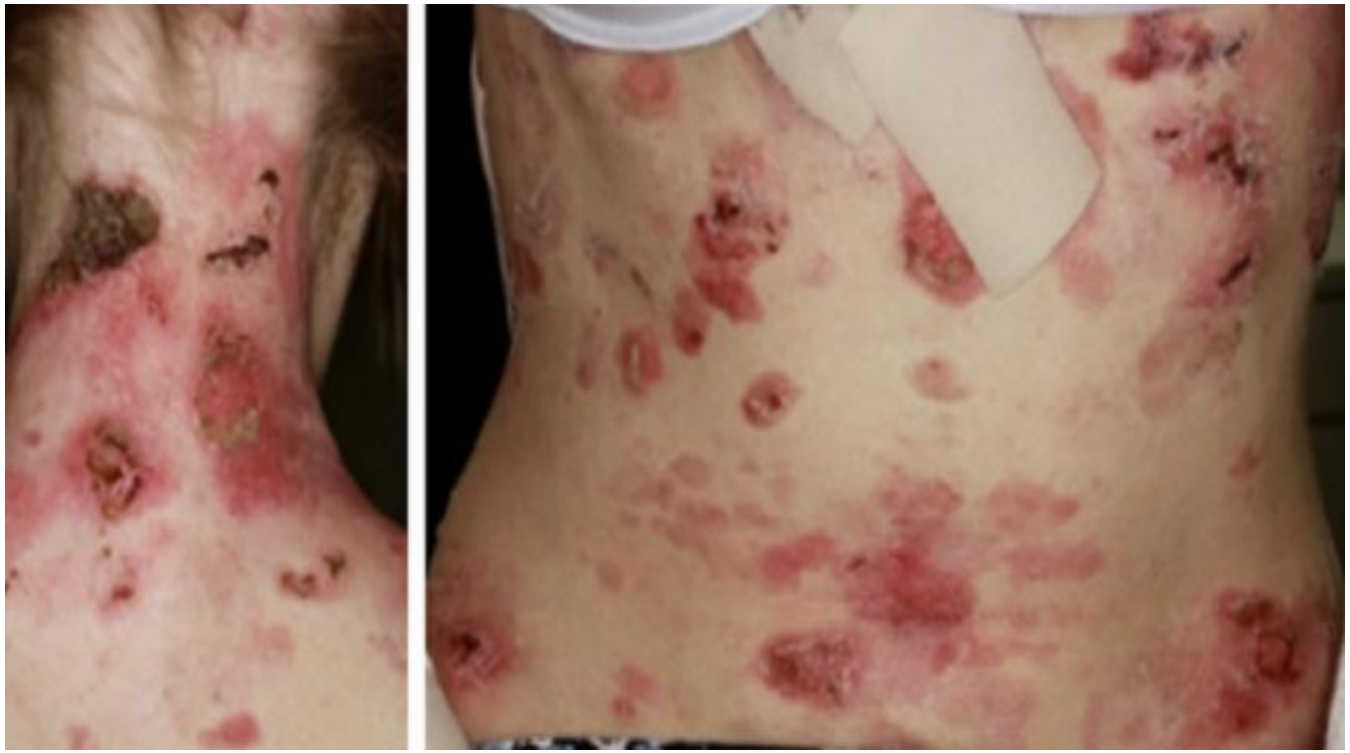


Therapeutic Requirements:
Wound healing cytokines
Increased innate immune activity against bacteria/fungi

Phase 4: From 20 years onwards

- Steady progression of the severity
- Chronic wounds very rarely heal

Therapeutic Requirements:
Symptom control



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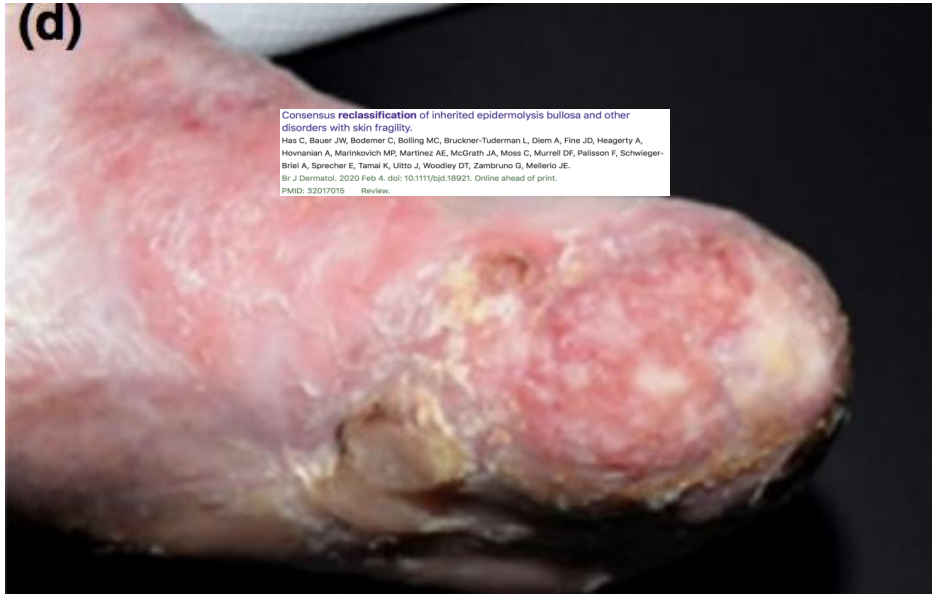
Br J Dermatol. 2020 Feb 4. doi: 10.1111/bjd.18921. Online ahead of print.
PMID: 32017015 Review.

Phase 4: From 20 years onwards

- Patients are at high risk for developing squamous cell carcinoma, a life-threatening complication of severe RDEB
- Tumors are usually well differentiated and rapidly-growing, often on the extremities with a median survival of 2.4 years for this EB subtype
- Anti-inflammatory and antifibrotic therapies are now unlikely to help much

Therapeutic Requirements:
Symptom control



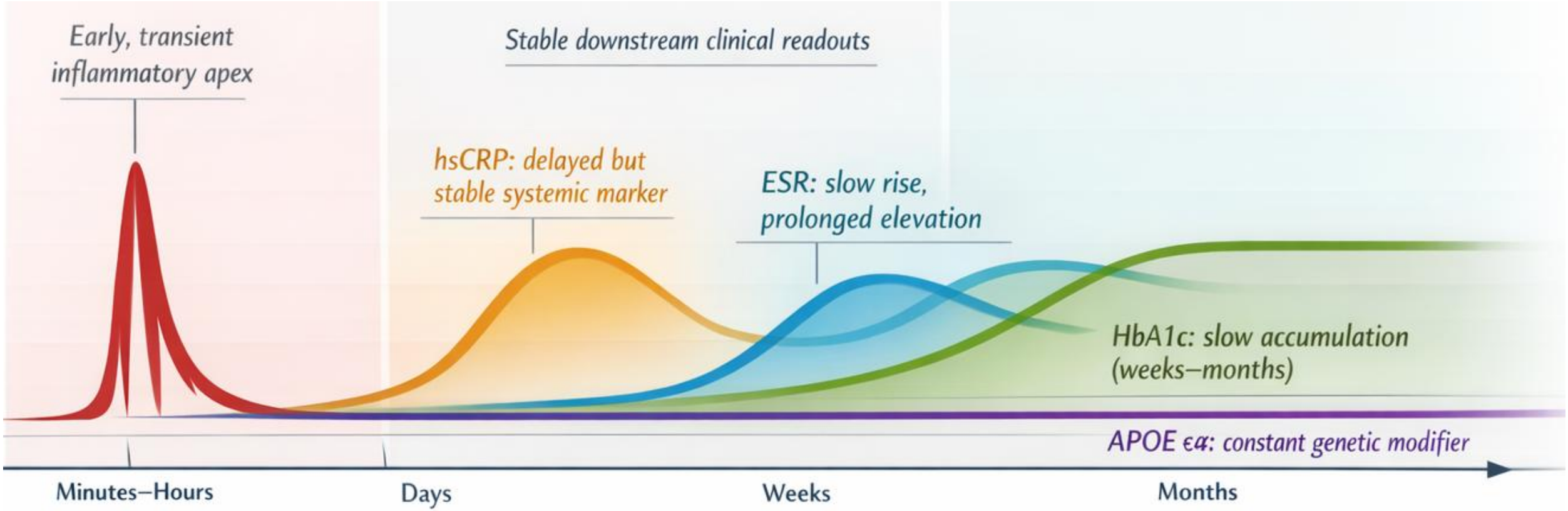
Cutaneous Squamous Cell Carcinoma in Epidermolysis Bullosa: a 28-year Retrospective Study

Susan J. ROBERTSON[1], Elizabeth ORRIN[1], Manpreet K. LAKHAN[1], Gavin O'SULLIVAN[1], Jessie FELTON[2], Alistair ROBSON[3], Danielle T. GREENBLATT[1], Catina BERNARDIS[4], John A. MCGRATH[1,5], Anna E. MARTINEZ[6] and Jemima E. MELLERIO[1,5]
[1]St John's Institute of Dermatology, Guy's and St Thomas' NHS Foundation Trust, London, [2]Department of Dermatology, Brighton and Sussex University Hospitals NHS Trust, Brighton, UK, [3]Department of Pathology, Instituto Português de Oncologia de Lisboa, Lisboa, Portugal, [4]Department of Plastic Surgery, Guy's and St Thomas' NHS Foundation Trust, [5]Genetic Skin Disease Group, King's College London and [6]Department of Dermatology, Great Ormond Street Hospital for Children NHS Foundation Trust, London, UK

Accepted Jul 6, 2021; Epub ahead of print Jul 7, 2021

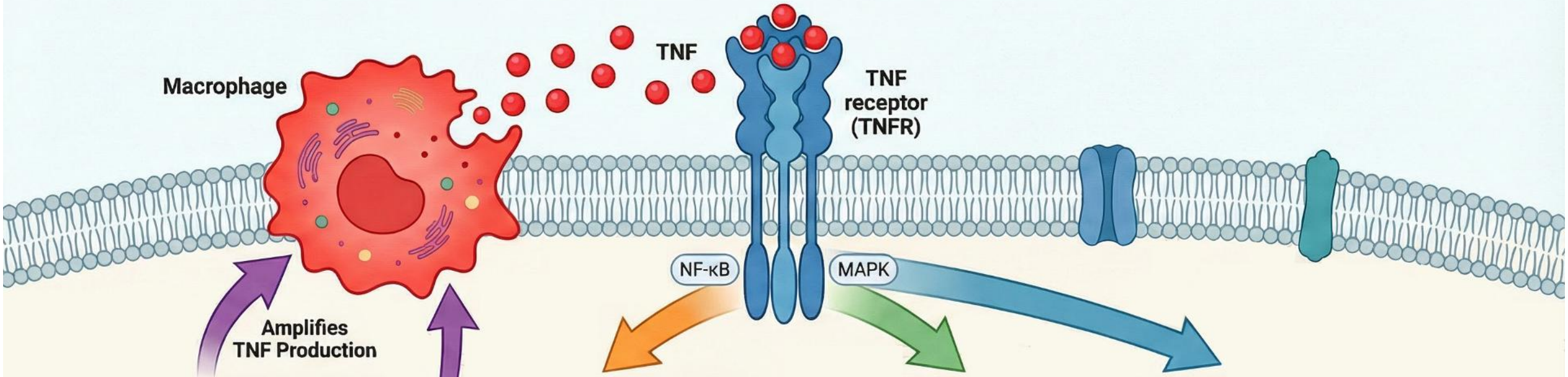
Acta Derm Venereol 2021; 101: adv00523.

Capturing Stability: from Minutes to Lifelong Predisposition

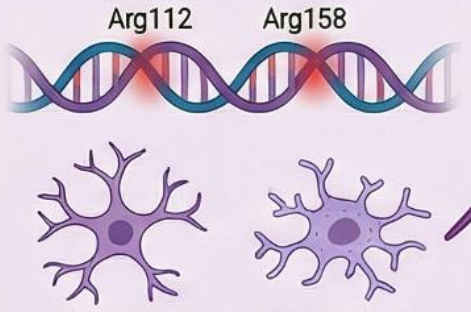


Xu et al., 2020; Resi et al., 2021

Mechanistic Links Between TNF and Downstream Biomarkers

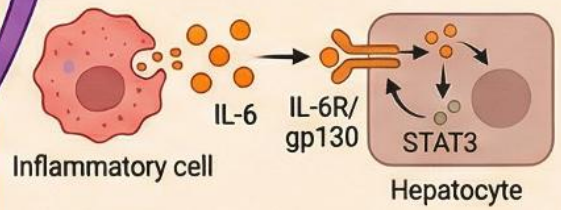


APOE ε4 Constitutional Amplification



Genetic variants Arg112/Arg158 trigger lifelong glial inflammation, increasing TNF production in microglia and astrocytes.

IL-6 to CRP Acute-Phase Cascade

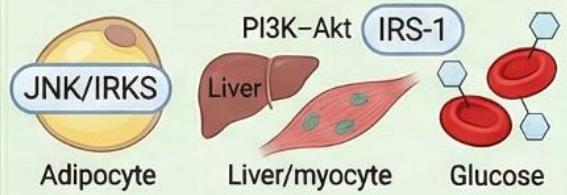


TNF-activated hepatocytes utilize STAT3 signaling to produce C-reactive protein over days to weeks.

C-reactive protein (CRP)

Typical Time Scale: Days to Weeks

Insulin Resistance and HbA1c Elevation

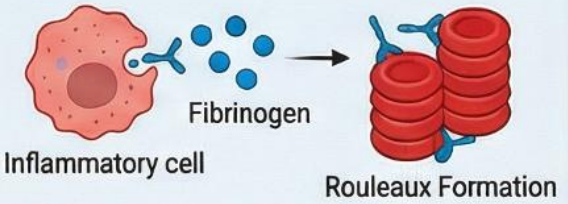


TNF-driven inflammation impairs PI3K–Akt signaling in liver/myocytes, increasing chronic glycemic load over months.

HbA1c

Typical Time Scale: Weeks to Months

Chronic Inflammation and ESR Readout



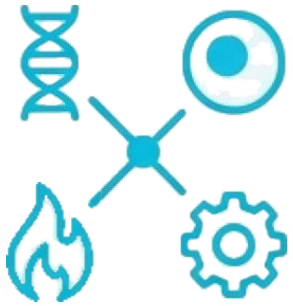
Increased fibrinogen production causes red blood cells to form rouleaux, elevating the Erythrocyte Sedimentation Rate.

Erythrocyte Sedimentation Rate (ESR)

Typical Time Scale: Weeks to Months

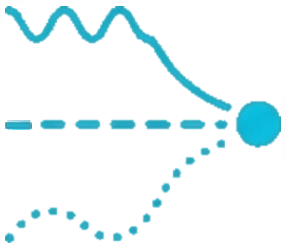
The "≥2 of 4" Composite Design: High-Confidence Identification of a TNF-Driven Phenotype

Requiring positivity on at least two independent biomarkers substantially increases specificity for TNF-driven biology and reduces misclassification arising from single-marker noise or non-TNF-related inflammatory processes.



Captures Multidimensionality

TNF signaling exerts pleiotropic effects across multiple biological domains, including genetic susceptibility, metabolic state, acute inflammatory activity, and chronic inflammatory burden. The composite framework integrates signals across these axes rather than relying on a single biological dimension.



Accommodates Biological Heterogeneity

The design identifies patients with TNF-driven disease regardless of the specific biological manifestation. Patients may qualify through different combinations of genetic, metabolic, acute, and chronic biomarkers, allowing for 11 distinct qualifying biomarker combinations.

Reduces Misclassification Risk

Built-in redundancy ensures that failure of a single assay or transient suppression of an individual biomarker is less likely to incorrectly exclude a truly TNF-responsive patient.