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American Transplant Congress Data Update

June 22, 2026

Forward-Looking Statements

This presentation contains forward-looking statements that involves substantial risks and uncertainties. Any statements about the company's future expectations, plans and prospects, including statements about its strategy, future operations, development of its product candidates, and other statements containing the words "believes," "anticipates," "plans," "expects," "estimates," "intends," "predicts," "projects," "targets," "could," "may," and similar expressions, constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, although not all forward-looking statements include such identifying words. Forward-looking statements include, but are not limited to statements regarding: expectations regarding the timing for the commencement and completion of product development or clinical trials; the rate and degree of market acceptance and clinical utility of the company's products; the company's commercialization, marketing and manufacturing capabilities and strategy; the company's intellectual property position and strategy; the company's ability to identify additional products or product candidates with significant commercial potential; the company's estimates regarding expenses, future revenue, capital requirements and needs for additional financing; developments relating to the company's competitors and industry; and the impact of government laws and regulations.

Actual results may differ materially from those indicated by such forward-looking statements as a result of various important factors, including: the ability to develop commercially viable product formulations; the sufficiency of the company's cash resources; the ability to obtain necessary regulatory and ethics approvals to commence additional clinical trials; whether data from early clinical trials will be indicative of the data that will be obtained from future clinical trials; whether the results of clinical trials will warrant submission for regulatory approval of any investigational product; whether any such submission will receive approval from the United States Food and Drug Administration or equivalent foreign regulatory agencies and, if we are able to obtain such approval for an investigational product, whether it will be successfully distributed and marketed. These risks and uncertainties, as well as other risks and uncertainties that could cause the company's actual results to differ significantly from the forward-looking statements contained herein, are discussed in our annual report on Form 10-K for the year ended December 31, 2025, and other filings with the SEC which can be found at www.sec.gov. Any forward-looking statements contained in this presentation speak only as of the date hereof and not of any future date, and the company expressly disclaims any intent to update any forward-looking statements, whether as a result of new information, future events or otherwise.

Photo: Gertrude "Trudy" Elion, inventor of azathioprine and recipient of Nobel Prize in Medicine in 1988.

Tegoprubart Offers a Broad Pipeline in a Single Molecule with 5 Transplant Programs in Clinical Trials / EAP

INDICATIONS	DEVELOPMENT STAGE				KEY HIGHLIGHTS	UPCOMING CATALYSTS
	PRE-CLINICAL	PHASE 1 (1)	PHASE 2	PHASE 3		
ALLOTRANSPLANTATION						
Kidney					• Phase 2 BESTOW completed • Phase 1b & Long-Term Extension trials ongoing	• Initiate Phase 3 study • Initiate subcutaneous study
Islet Cell					• U. Chicago investigator sponsored trial • Received US FDA Orphan Drug Designation	• Initiate registrational path studies • Initiate IST in patients with renal dysfunction
Kidney Tolerance Induction					• Mass. Gen. Hospital investigator-led study • 2 patients transplanted	• Continue enrollment
Liver					• IND-ready • Received US FDA Orphan Drug Designation	• Initiate investigator-led study
XENOTRANSPLANTATION						
Kidney					• Performed under U.S. FDA Expanded Access Protocol (EAP) • eGenesis sponsored Phase 1/2/3 study	• FDA regulatory guidance on path to market • Transplant 1st patient ex-US
Adult Heart					• Performed under U.S. FDA Expanded Access Protocol (EAP)	
Pediatric Heart						• FDA pre-IND discussions
Amyotrophic Lateral Sclerosis (ALS) (2)					• Completed Phase 2 trial	• Seeking non-equity dilutive financing to advance program to Phase 3

Note: As of June 2026. Development plans and timelines may change, including based on U.S. and global regulatory interactions.
IST = Investigator Sponsored Trial. EAP = Expanded Access Program.
1. Inclusive of early human trials
2. Seeking non-equity dilutive financing to advance program to Phase 3

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Long-Term Extensions for the Phase 1b & Phase 2 Kidney Transplantation Studies are Ongoing

Phase 2 "BESTOW"

127 participants (2 arms) undergoing kidney transplantation

US, Canada, EU, Brazil, and Australia

Head-to-head, superiority study

ATG induction therapy plus

CNI-free maintenance therapy with tegoprubart or tacrolimus

as part of a maintenance immunosuppressive regimen including mycophenolate and a corticosteroid taper

- 51 tegoprubart and 56 tacrolimus treated patients finished 12 months in initial study
- 49 (96%) tegoprubart and 48 (82%) tacrolimus patients entered long-term extension
- Median time on study of 21 months
- 20 patients at 24 months
- Earliest remaining subject is out ~33 months

Phase 1b

19 participants undergoing kidney transplantation

US, Canada, UK, Brazil, and Australia

Open label, single arm study

ATG induction therapy plus

CNI-free maintenance therapy with tegoprubart

as a replacement for tacrolimus as part of a maintenance immunosuppressive regimen including mycophenolate and a corticosteroid taper

- 19 tegoprubart patients enrolled in 20 mg/kg arm
- 16 (84%) of these tegoprubart treated patients provided long-term data
- 8 patients at 24 months
- Earliest remaining subject is out ~3.5 years

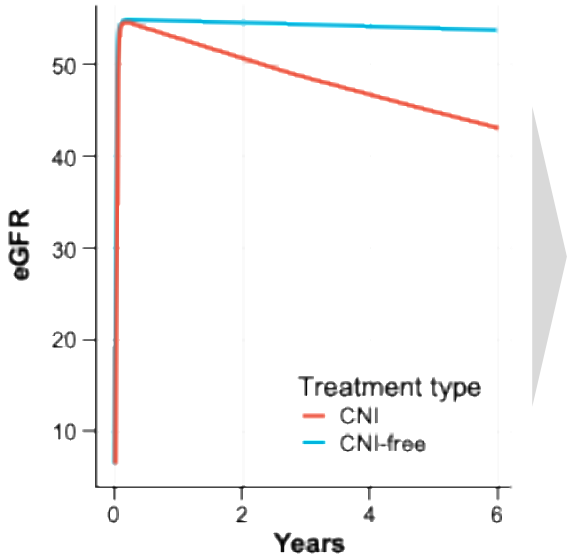
Note: ATG = Antithymocyte globulin.

Key Efficacy Endpoints Examined

Approvable Endpoint: Non-Inferiority Composite

- **Since the 1990's the primary US FDA approvable endpoint has been non-inferiority based on a composite of efficacy failure using:**
  - Biopsy Proven Acute Rejection
  - Graft Loss
  - Death
  - Loss to follow-up
- All transplant immunosuppressants are approved for "prophylaxis of organ rejection"
- Acute rejection is generally treatable and not predictive of long-term graft survival

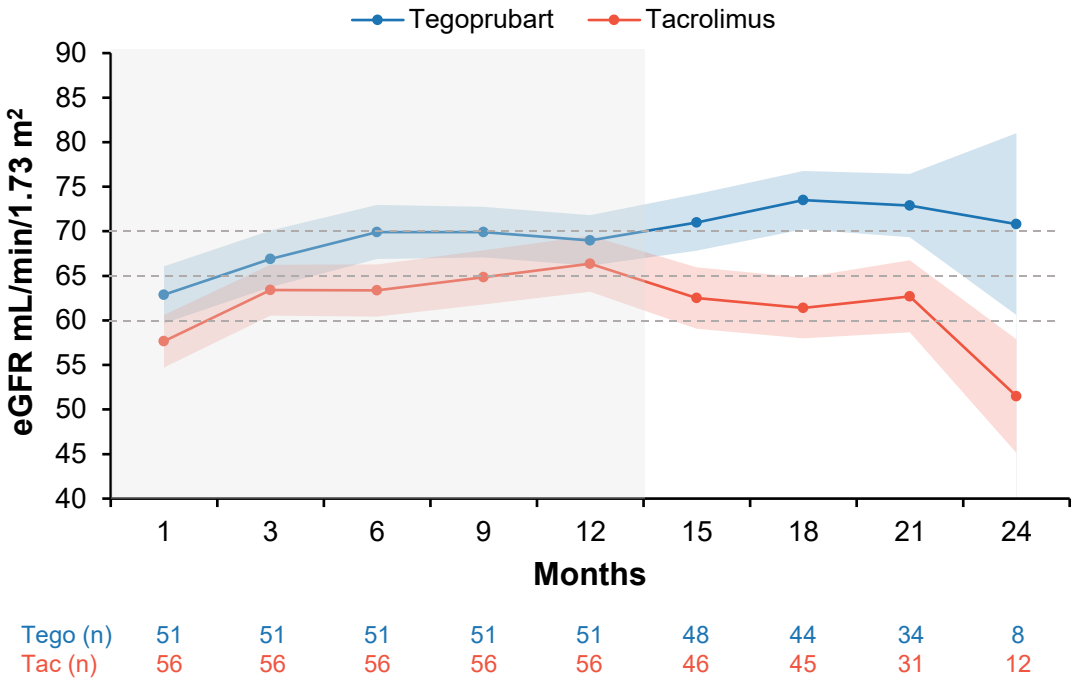
Secondary Endpoint: eGFR as Potential Predictor of Long-Term Graft Function



Historical Mean eGFR of ~53 mL/min/1.73m2 After 12 Months Using CNIs

Note: **n = 4,868 patients**. eGFR estimated using MDRD 4-variable GFR Equation. US FDA, United States Food & Drug Administration..
Source: Kosinski et al. *Clin Transl Sci*. 2023 Nov; 00:1–11.

Tegoprubart Demonstrated Superior Mean eGFR Over Time vs. Tacrolimus in BESTOW Patients

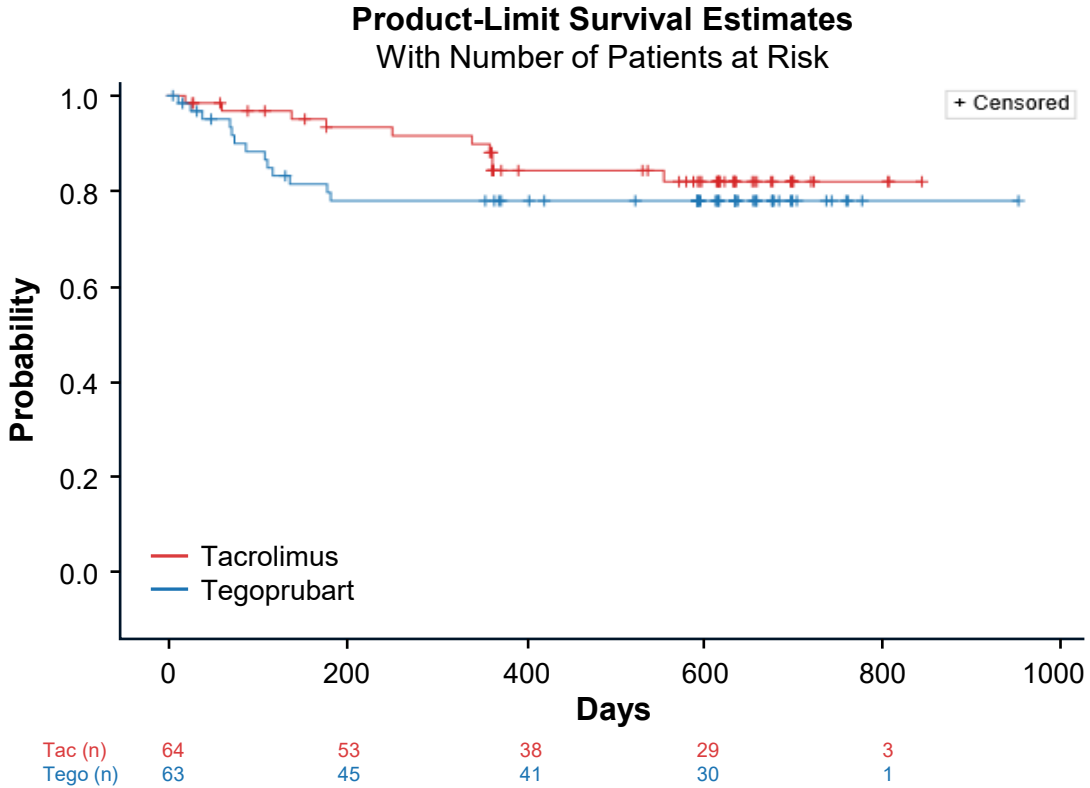


Tego (n)	51	51	51	51	51	48	44	34	8
Tac (n)	56	56	56	56	56	46	45	31	12

- **Statistically significant separation of the eGFR curves achieved at month 18 (p=<0.05) with a ~12 point eGFR difference** for tegoprubart vs. tacrolimus (i.e., approximately 74 vs. 61 mL/min/1.73 m^2)
- Current spread of approximately 10 and 19 points of eGFR at 21 and 24 months, respectively
- Higher kidney function has been associated with improved long-term graft durability, and thus reduced need for re-transplantation or dialysis

Note: Shaded area represents Standard Error of the Mean (SEM). n = patients who have reached each timepoint. Declining n at later timepoints reflects staggered enrollment into trial.
Source: ATC June 2026.

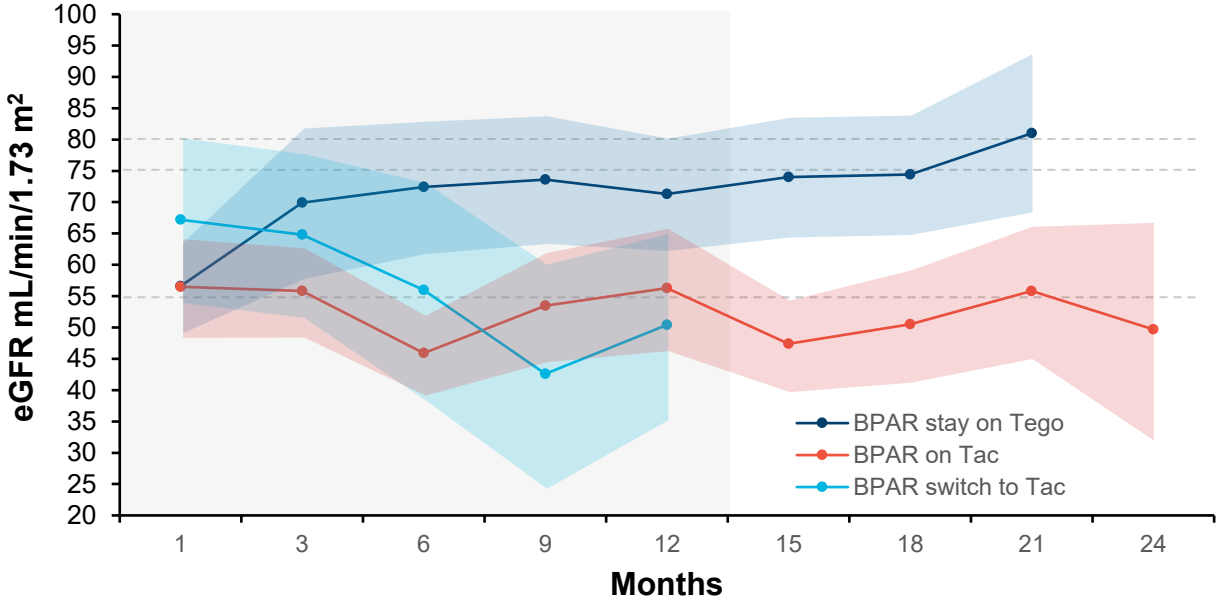
BPAR Rates Over Time Are Similar in BESTOW LTE Patients, but…



- **Tegoprubart:** No BPAR after an initial 13 patients with BPAR during the first 6 months on therapy
- **Tacrolimus:** ~64% of BPAR (7 of 11 cases total) after 6 months on therapy, including 2 cases of BPAR after 12 months on therapy:
  - 1 new case of aAMR
  - 1 recurring case of aTCMR mixed with aAMR

Note: n = BPAR-free patients who have reached each timepoint. Declining n at later timepoints reflects staggered enrollment into trial. Censoring demonstrates latest date patients are post-transplant.
Source: ATC June 2026.

…Patients Who Experienced Rejection While on Tegoprubart Demonstrated Superior Kidney Function vs. Those on Tacrolimus



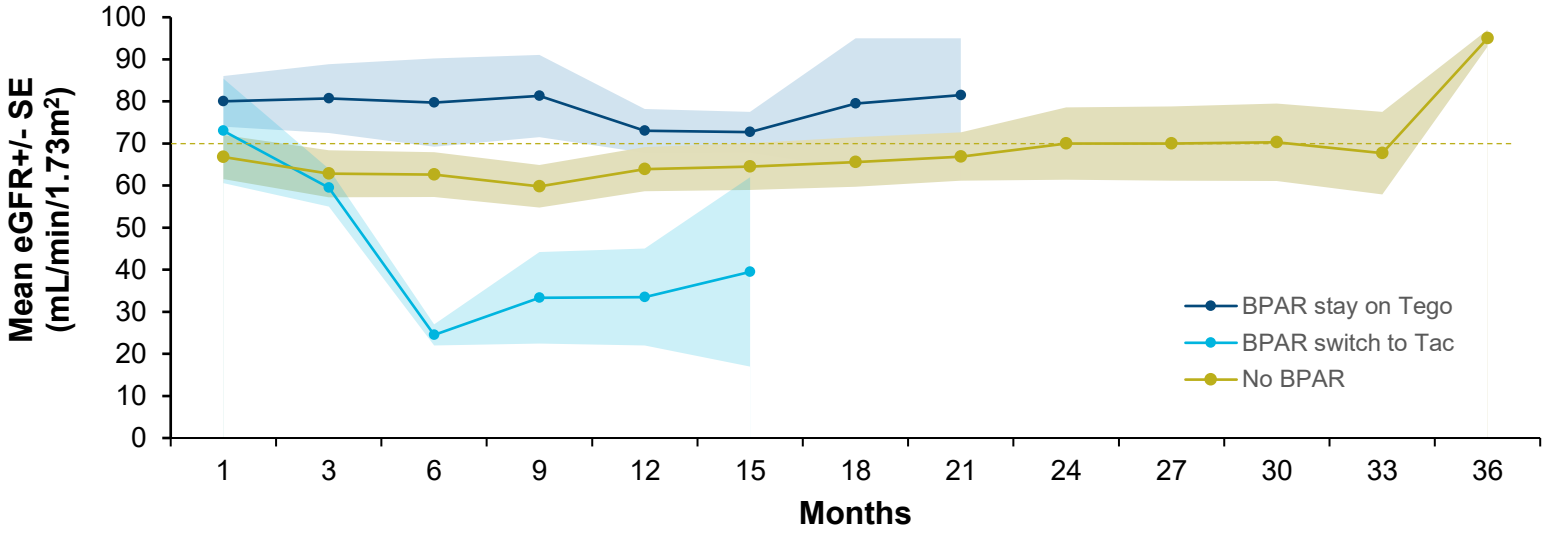
BPAR stay on Tego (n)	7	7	7	7	7	7	7	5	
BPAR on Tac (n)	8	8	8	8	8	8	8	4	3
BPAR switch to Tac (n)	5	5	5	5	5				

- **Benefit in kidney function,** as measured by eGFR, **increased from ~15 at 12 months to ~25 mL/min/1.73 m² at 21 months** between patients treated on tegoprubart who remained on tegoprubart after a rejection episode, and those on tacrolimus who experienced a rejection episode in their 1st year post-transplant
- Patients who were on tegoprubart and were switched to tacrolimus post rejection had lower eGFRs at month 12 vs. those who rejected and remained on their initial therapy

Note: Shaded area represents Standard Error of the Mean (SEM). Included patients all completed at least 1 year of study.
Source: May 2026.

Long Term eGFR Data From Phase 1b Mirrors That of BESTOW's

Phase 1b Patients: eGFR Over Time vs. BPAR



BPAR stay on Tego (n)	3	3	3	3	3	3	2	2					
BPAR switch to Tac (n)	3	3	3	3	2	2							
No BPAR on Tego (n)	11	11	11	11	11	11	11	10	8	7	7	7	2

There have been no BPAR episodes in Phase 1b patients after 6 months on tegoprubart

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Note: Shaded area represents Standard Error of the Mean (SEM). n = patients who have reached each timepoint. Declining n at later timepoints reflects staggered enrollment into trial.
Source: ATC June 2026.

Safety & Tolerability in Year 1: AEs ≥5% with ≥2 Times Risk Observed in One Arm

		Tegoprubart (N=63) n (%)	Tacrolimus (N=64) n (%)	Relative Difference[1]
Opportunistic Infections	**Bacteremia**	**1 (1.6)**	**7 (10.9)**	**6.8x**
	Sepsis	**2 (3.2)**	**5 (7.8)**	**2.4x**
Renal	Proteinuria	10 (15.9)	1 (1.6)	9.9x
Metabolic	**Hyperglycemia**	**6 (9.5)**	**14 (21.9)**	**2.3x**
	New Onset Diabetes (NODAT)	**1 (1.6)**	**7 (10.9)**	**6.8x**
	Hyperkalemia	**7 (11.1)**	**17 (26.6)**	**2.4x**
CNS	**Tremors**	**1 (1.6)**	**16 (25.0)**	**15.6x**
	Muscle Spasms	**3 (4.8)**	**10 (15.6)**	**3.3x**
	Pruritus	**2 (3.2)**	**6 (9.4)**	**2.9x**
Cardiovascular	**Hypertensive Crisis**	**1 (1.6)**	**5 (7.8)**	**4.9x**
Blood	**Lymphopenia**	**4 (6.3)**	**10 (15.6)**	**2.5x**

[1] Tegoprubart rate to Tacrolimus rate.
Note: May exclude select non-specific AEs (e.g., abdominal pain).
Source: Kidney Week, November 2025.

Safety & Tolerability - New Onset Adverse Event in Year 2 & AEs ≥5% with ≥2 Times Risk Observed in One Arm

Event	Tegoprubart n (%)	Tacrolimus n (%)
Any TEAE	39 (80)	41 (85)
Mild	16 (33)	19 (40)
Moderate	16 (33)	13 (27)
Severe	5 (10)	7 (15)
Life Threatening / Urgent Intervention	1 (2)	2 (4)
Death	1 (2)	0

TEAEs		Tegoprubart n (%)	Tacrolimus n (%)
Infection	CMV DNAemia	6 (12)	3 (6)
	BK DNAemia	4 (8)	1 (2)
	Herpes Zoster	**2 (4)**	**4 (8)**
Gastrointestinal	**Diarrhea**	**5 (10)**	**10 (21)**
Renal	**Acute kidney injury**	**1 (2)**	**3 (6)**
CNS	**Headache**	**1 (2)**	**6 (12)**
	Extremity pain	**0**	**5 (10)**
	Fall / loss of balance	**0**	**3 (6)**
Vascular	**Bleeding**	**1 (2)**	**4 (8)**

- **Tegoprubart and tacrolimus both demonstrate good long-term safety in extension study:**
  - 4 discontinuations in each arm
  - 1 death (not attributed to drug) in tego arm
  - No cases of graft loss
  - No PML
  - No PTLD
    - ➢ 1 case of EBV in tacrolimus arm
  - No BK or CMV nephropathy/disease
  - 1 case of proteinuria in tacrolimus arm
  - No new malignancy
- **Potential signals of CNS and kidney effects observed only in the tacrolimus arm**
- **Diarrhea continues to be observed at a higher rate in tacrolimus arm** (after a year 1 rate of 34% with tacrolimus vs. 22% with tego)
- AEs listed here are new (Year 2+) and incremental to the AEs observed in Year 1 post-transplant

PML = Progressive Multifocal Leukoencephalopathy. PTLD = Post-Transplant Lymphoproliferative Disorder. Dyslipidemia includes hypercholesterolemia and hyperlipidemia.
Note: Exclude select non-specific AEs (e.g., abdominal or back pain, upper respiratory infection).
Source: May 2026.

The Patient Perspective:
9 Years Post Kidney Transplant on Tacrolimus

The side effects that infiltrate everything

Tremors	Brain fog	Headaches	GI issues
Difficulty with precise lab work	Affects clarity, career decisions, academic goals	Some severe enough for emergency care	Changed relationship with food and travel
Uncomfortable social situations	Worries about the future – progression	Constant low-level pain affects focus	Work and travel interruptions
Required propranolol and extra practice	Most invisible – hardest to explain	Difficult to fully participate in daily life	Unpredictable – limits spontaneity

GI, gastrointestinal

Dominika Woch
Patient Care America Transplant Recipient and Patient Advocate

Source: ATC, June 2026.

Patient Reported Outcomes Demonstrated Lower & Improving Symptom Burden on Tegoprubart Over 1st Post-Transplant Year

Patient Reported Outcome Scale	Change from Baseline		Treatment Difference[a]: mean (95%CI)
	Tegoprubart	Tacrolimus	
MTSOSD-59R (mean, (SD))			
Week 25	-7.7 (21.3)	-0.2 (12.5)	-7.5 (-15.3, 0.3)
Week 52	**-11.2 (18.1)**	**1.0 (17.9)**	**-12.2 (-19.7, -4.6)**
KDQOL-36 (week 52 mean,(SEM))			
Symptoms and Problems	**9.0 (1.6)**	**3.3 (1.8)**	**5.7 (1.0, 10.5)**
Physical Component (SF-12)	5.7 (1.3)	6.0 (1.4)	-0.4 (-4.1, 3.4)
Mental Component (SF-12)	1.5 (1.4)	-1.6 (1.3)	3.2 (-0.6, 7.0)
Burden of Kidney Disease	27.0 (4.4)	27.2 (3.4)	-0.2 (-11.1, 10.8)
Effects of KD on Daily Life	17.5 (2.8)	17.4 (2.7)	0.1 (-7.5, 7.7)

Statistically superior patient reported outcomes observed in the tegoprubart arm of BESTOW

[A] treatment difference = tegoprubart- tacrolimus. Bolded lines are statistically significant differences. MTSOSD-59R Week 52 P<0.05. KDQOL-36 Symptoms & Problems P<0.05.
Note: KDQOL = Kidney Disease Quality of Life; MTSOSD = Modified Transplant Symptom Occurrence and Symptom Distress Scale.
Source: ATC & company Analysis, June 2026.

Phase 3 Planned Study Assessing Use of Tegoprubart to Prevent Kidney Transplant Rejection in a CNI-free Regimen

DESIGN

- 52-week, prospective, global multicenter, active-controlled, randomized, open-label Phase 3 trial
- ATG induction therapy followed by either tegoprubart or tacrolimus as part of a maintenance immuno-suppressive regimen including mycophenolate and a corticosteroid taper
- Approximately 600 patients randomized 1:1
- Stratification factors include: donor type, recipient age, region

PLANNED DATA GENERATION

- **Primary endpoint:**
  - Non-inferiority of tegoprubart vs. tacrolimus on a composite efficacy failure endpoint at 12 months, defined as a combination of biopsy-proven acute rejection (BPAR), graft loss, and death
- **Select secondary endpoints:**
  - Kidney function as measured by eGFR at 12, 24 and 36 months
  - Safety including: new onset diabetes mellitus (NODAT); delayed graft function; neurotoxicity (tremor, headache, dizziness); hypertension (including crises); and diarrhea
  - Patient reported outcomes (MTSOSD-59R & KDQOL-36)

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Note: Development plans may change, including based on U.S. and global regulatory interactions.

Islet Cell Transplantation

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Severe Type 1 Diabetes Remains a Life-Threatening Unmet Medical Need for 100k-200k US Patients

- Severe T1D remains life-threatening in many T1D patients
  - Despite optimized insulin therapy, ~12% T1D patients experience **recurrent severe hypoglycemic episodes** (SHE), defined as ≥ 2 episodes requiring third-party assistance within 12 months, which is associated with:
    - Risk of seizures, coma, and death
    - Hospitalization and Emergency Services utilization
- Insulin therapy has shown structural limitations for this patient segment: ~35% of patients fail to control their HbA1c on closed loop systems[1] with ~20% of patients experiencing at least one SHE within the prior 12 months, and ~30% reporting impaired awareness of hypoglycemia, regardless of CGM or AID use[6]

Clinical implication of **severe hypoglycemia** in T1D

4–10% of all deaths in individuals with T1D[2]	**~3x** higher all-cause mortality risk compared with patients without severe events[3]
Recurrent severe hypoglycemia that required hospitalization is one of the strongest predictors of premature death in T1D populations[4]	Following a hypoglycemic emergency requiring medical intervention, mortality approaches ~1–2% within 1 year [5]

For patients experiencing recurrent SHE despite optimized insulin therapy, islet transplantation addresses a life-threatening unmet need by restoring endogenous physiologic insulin production, thereby reducing a persistent risk of morbidity and mortality

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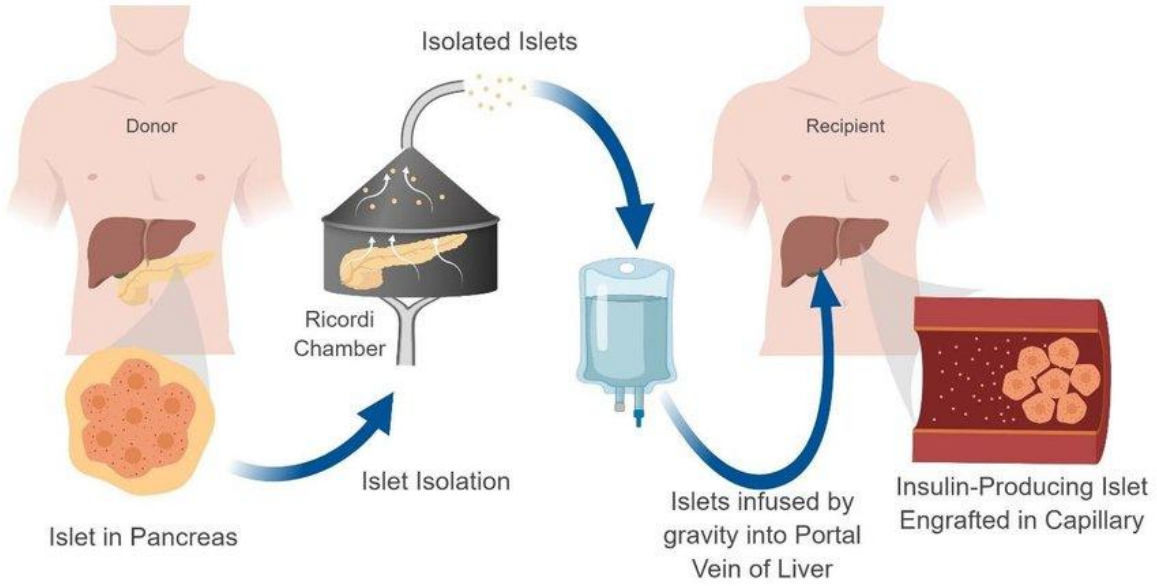
[1] Brown et al., NEJM 2019; [2] Lee et al., Diabetes Care, 2018; [3] McCoy et al., Diabetes Care, 2012; [4] Klein et al., JCEM, 2023; [5] McCoy et al., Diabetes Res Clin Pract, 2023; [6] Sherr et al., Diabetes Care, 2024.

Islet Cell Transplant Procedure & Rationale for Tegoprubart



Tegoprubart may unlock the islet cell transplant market by potentially:

1. Improving islet cell graft survival regardless of cell source (i.e., isolated from deceased donor pancreases or stem-cell derived)
2. Reducing side effects associated with standard of care, tacrolimus based regimens

Source: Quintana et al. *OBM Transplantation*. 2018

Phase 1/2 Study Assessing the Use of Tegoprubart to Prevent Islet Cell Transplant Rejection in Participants with Type 1 Diabetes (T1D)

DESIGN

- 52-week, open label, single dose level study
- Initial group of 12 patients with T1D transplanted in an investigator sponsored trial at the University of Chicago
- Islet cell transplant combined with induction therapy plus tegoprubart and mycophenolate mofetil (MMF) every third week by IV infusion
- Financing principally from Breakthrough T1D (a.k.a. JDRF) and The Cure Alliance

PLANNED DATA GENERATION

- **Safety & tolerability**
- **Graft function**
  - e.g., HbA1C, C-peptide
- **Number of hypoglycemic events**
- **Insulin independence**
- **Need for repeat islet cell transplant(s)**

Anticipated Primary Composite Efficacy Endpoint of:
(i) Insulin Independence (6 out of 12 months off insulin with HbA1C <7%), and
(ii) Absence of severe hypoglycemic events

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Note: Development plans may change, including based on U.S. and global regulatory interactions.

Subject Demographics and Transplanted Islet Dose(s)

Subject	Gender	Age at Transplant	Years of T1D	BMI	Baseline HbA1C	Baseline Insulin (u)	1st Tx (IEQ/Kg)	2nd Tx (IEQ/Kg)
1	F	42	31	30	8.4	80	4,092	5,501
2	F	30	26	21	8.5	60	6,775	
3	M	37	19	30	9.9	90	4,086	4,211
4	F	51	40	19	7.8	35	5,569	
5	F	49	35	25	8.7	65	5,159	
6	M	19	9	29	7.9	90	5,491	7,096
7	F	59	41	26	7.3	40	6,519	
8	M	35	34	25	7.0	35	6,436	6,928
9	F	39	13	22	7.5	40	6,109	
10	F	49	32	24	7.6	40	6,684	
11	F	41	34	23	6.9	55	6,016	6,292
12	M	57	39	25	8.2	35	7,731	
Average	**8F /4M**	**42**	**29**	**25**	**8.0**	**55**	**5,889**	**6,006**

All patients have a history of recurrent severe hypoglycemic events despite standard of care diabetes management and education

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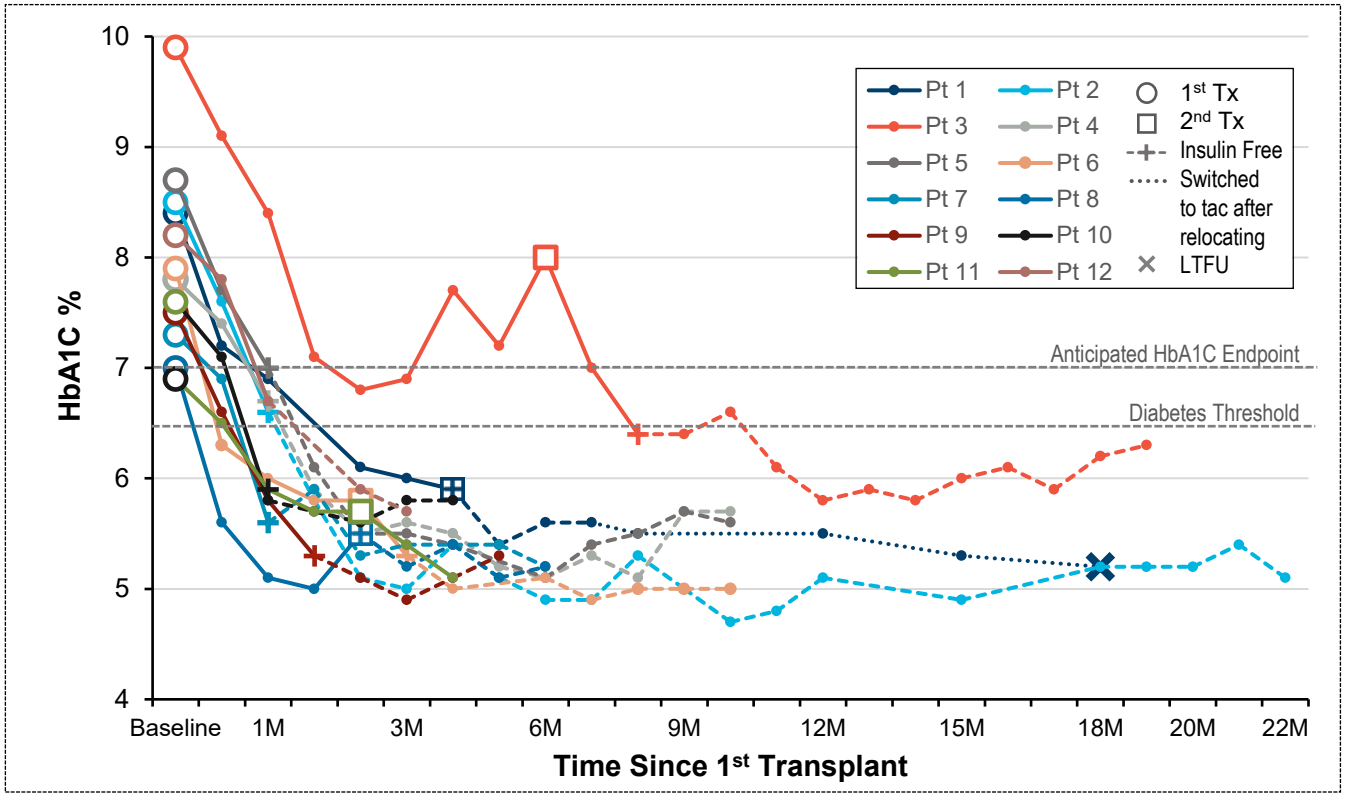
Note: Tx=Transplant; IEQ = Islet Equivalents, at time of transplant, defined per standard as each equaling a single spherical islet of 150 µm in diameter.
Source: Witkowski, ADA, June 2026.

Pre- and Post- Transplant HbA1C Levels & Timing of Independence from Exogenous Insulin



- 12 of 12 patients (100%) achieved insulin independence
- 12 of 12 patients (100%) achieved a non-diabetic HbA1C with an average ~2.6% reduction to date from an average baseline of 8%
- 11 of 12 patients achieved a non-diabetic HbA1c within ~2 months of islet transplant
- No patients experienced a severe hypoglycemic event post-transplant

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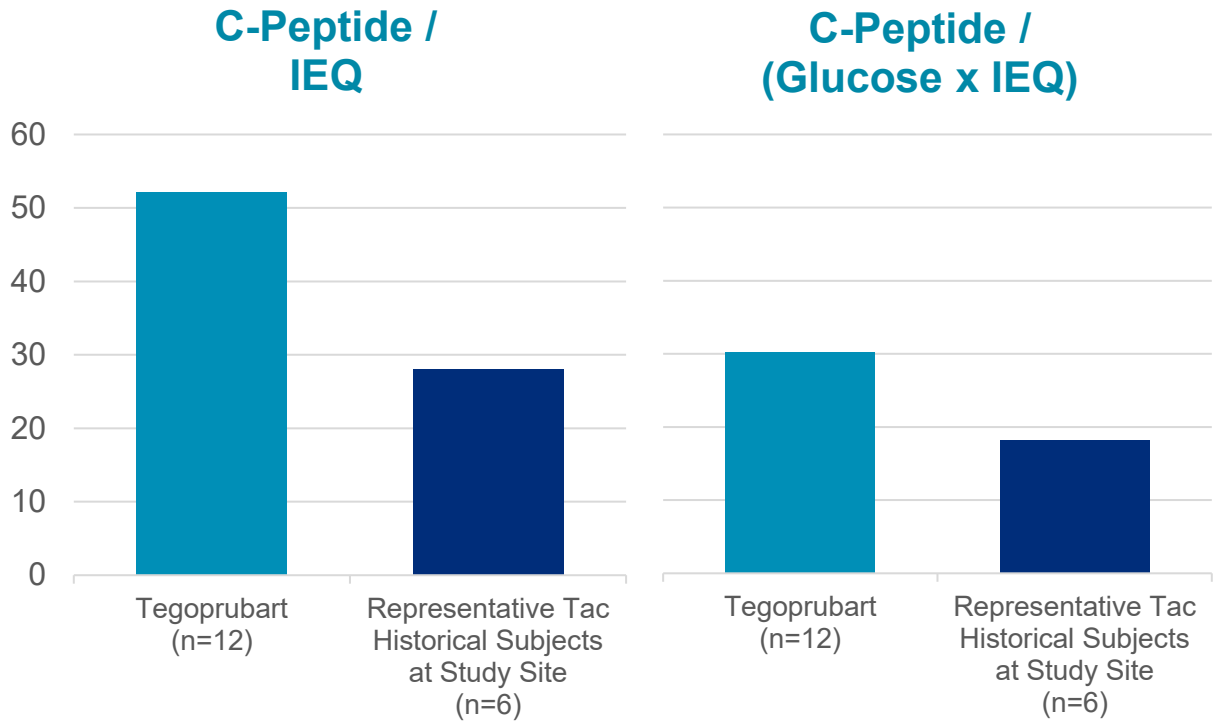
Note: **Patient 1 discontinued tegoprubart after relocating to a geography too distant to continue receiving iv tegoprubart at the University of Chicago**. LTFU = Loss to follow up. Tac = tacrolimus.
Source: Witkowski, ADA, June 2026.

Tegoprubart Demonstrated Higher Levels of Mean Calculated Islet Engraftment at Post-Transplant Day 75 vs. Historical Tacrolimus



- **Average calculated engraftment rates were higher in patients on tegoprubart** vs. historical tacrolimus comps
- **Single donor islet transplants** treated with tegoprubart permitted **lowering insulin requirements by up to ~65u of insulin per day**
- 5 patients who required a second transplant were able to reduce their insulin doses by an average of ~72% after their initial transplant

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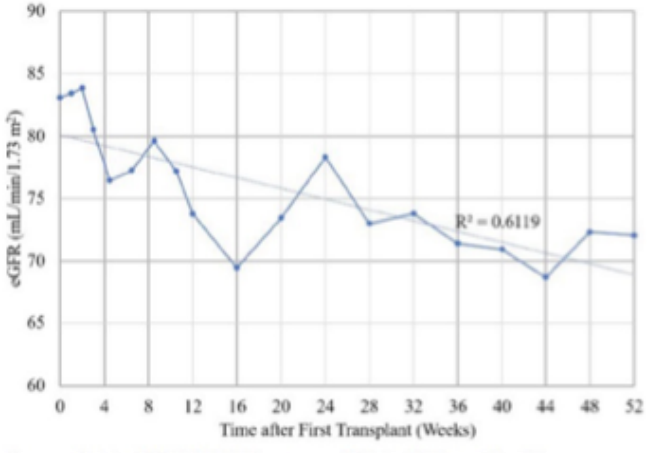
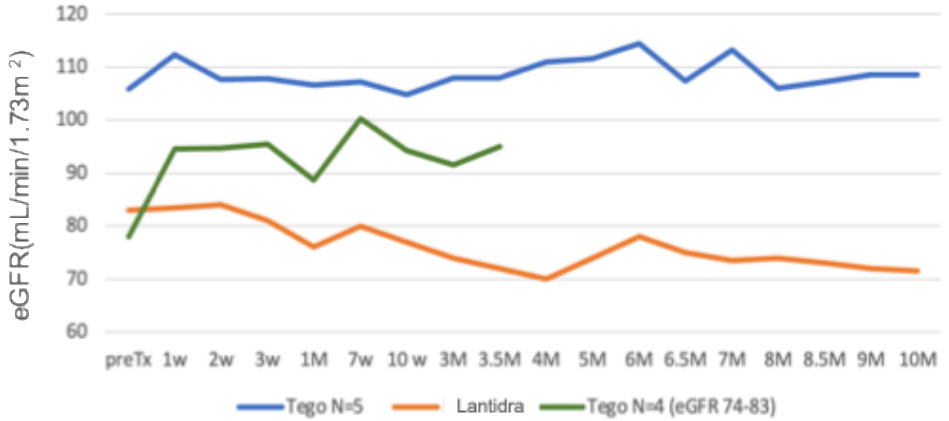
Note: Tac = tarcrolimus treated. Engraftment data is approximate including from Mixed-Meal Tolerance Test.
Source: Witkowski, ADA June 2026.

Tegoprubart Has Not Demonstrated the Negative Impact on eGFR Previously Observed in Tacrolimus Based Regimens



Tacrolimus/Rapamycin



Tegoprubart/MPA vs. Tacrolimus/Rapamycin

Source: Witkowski, ADA 2026; FDA approval documents for Lantidra BLA, 2023.

Tego in Islet Cell Transplant: Safety Profile Summary To Date

- **All 12 patients achieved stable islet graft function with rapidly improved blood glucose control**
- **No severe hypoglycemic events**
- **No signs of rejection or de novo donor specific antibodies (DSAs)**
- **No signs of kidney toxicity, neurotoxicity, GI toxicity, hypertension, or thromboembolic events**
- **No severe infections or WBC changes**
  - 2 patients experienced transient, low titer CMV viremia that responded to lowered MPA and antivirals
  - 1 subject experienced a superficial skin infection that responded to lowered MPA
  - 2 patients experienced episode of norovirus diarrhea that responded to lowered MPA
  - Non-clinically significant anemia & leukopenia that responded to lowered MPA

Source: Witkowski, ADA, June 2026.

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Thank You!

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