iTEOS THERAPEUTICS

Cancer Immunotherapies *by design*™

Nasdaq: ITOS November 2024

Forward-Looking Statements

This presentation contains forward-looking statements. Any statements that are not solely statements of historical fact are forward-looking statements. Words such as "believe," "anticipate," "plan," "expect," "will," "may," "intend," "prepare," "look," "potential," "possible" and similar expressions are intended to identify forward-looking statements. These forward-looking statements include statements relating to the potential benefits of our product candidates and combinations, including the potential of EOS-984 to revive T cell proliferation and offer large combination opportunity broadly across cancer therapies; our clinical, data generation and data presentation plans for 2024, including having data readouts from GALAXIES Lung-201, A2A-005, and EOS-984; our market opportunities and number of patients potentially eligible for our product candidates; the potential benefits of our collaboration with GSK; intentions around trial enrollment and recruitment; and our expected cash runway through 2027.

These forward-looking statements involve risks and uncertainties, many of which are beyond iTeos' control. Actual results could materially differ from those stated or implied by these forward-looking statements as a result of such risks and uncertainties. Known risk factors include the following: success in preclinical testing and early clinical trials does not ensure that later clinical trials will be successful, and early results or interim data from a clinical trial may change as more patient data become available and are subject to audit verification procedures; the data for our product candidates may not be sufficient to support regulatory approval; iTeos may encounter unanticipated costs or may expend cash more rapidly or more slowly than currently anticipated due to challenges and uncertainties inherent in product research and development and biologics manufacturing; the expected benefits and opportunities related to the agreement between iTeos and GSK may not be realized or may take longer to realize than expected due to a variety of reasons, including challenges and uncertainties inherent in product research and development and manufacturing limitations; iTeos may not be able to execute on its business plans, including meeting its expected or planned regulatory milestones and timelines, research and clinical development plans, and bringing its product candidates to market, for various reasons, some of which may be outside of iTeos' control, including possible limitations of company financial and other resources, manufacturing limitations that may not be anticipated or resolved for in a timely manner, negative developments in the field of immuno-oncology, such as adverse events or disappointing results, including in connection with competitor therapies, and regulatory, court or agency decisions such as decisions by the United States Patent and Trademark Office with respect to patents that cover our product candidates; and those risks identified under the heading "Risk Factors" in iTeos' Quarterly Report on Form 10-Q for the period ended September 30, 2024 filed with the Securities and Exchange Commission (SEC) as well as other SEC filings made by the Company which you are encouraged to review. Statements regarding the Company's cash runway do not indicate if and when the Company may access the capital markets.

Any of the foregoing risks could materially and adversely affect iTeos' business, results of operations and the trading price of iTeos' common stock. We caution investors not to place undue reliance on the forward-looking statements contained in this press release. iTeos does not undertake any obligation to publicly update its forward-looking statements based on events or circumstances after the date hereof.

Deep Pipeline with Clinical Readouts in 2024

Innovative molecules and compelling combinations

	Preclinical	Phase 1	Phase 2	Phase 3	Status
Belrestotug: IgG1 antibody targeting TIGIT					iTEOS GSK
+ dostarlimab | 1L NSCLC PDLI ^{high}				**GALAXIES Lung-301**	Enrolling
+ dostarlimab | 1L NSCLC PDL1 ^{high}			**GALAXIES Lung-201**		Data Anticipated 2025
+ dostarlimab | 1L HNSCC PDL1 $^{high/low}$			**TIG-006**		Data Anticipated 2025
+ dostarlimab + CD96 | 1L HNSCC PDL1 ^{high}			**GALAXIES H&N-202**		Data Anticipated 2025
+ dostarlimab + chemotherapy | 1L mNSCLC		**TIG-006**			Enrollment Complete
+ dostarlimab + CD96 | Advanced Malignancies		**NCT03739710**			Enrollment Complete
+ dostarlimab + PVRIG | Advanced Malignancies		**NCT05277051**			Enrollment Complete
Inupadenant: Small molecule targeting A_{2A} receptor					iTEOS
+ chemotherapy | Post-IO Chemo-naïve NSCLC			**A2A-005**		Data Anticipated ESMO-IO 2024
EOS-984: Small molecule targeting ENT1					iTEOS
Monotherapy | Advanced Malignancies		**Data Anticipated 2025**			

ENT1, Equilibrative Nucleoside Transporter 1; (m)NSCLC, (metastatic) non-small cell lung cancer; HNSCC, head and neck squamous cell carcinoma

Belrestotug

EOS-448 / GSK4428859A

iTeos and GSK are uniquely positioned to leverage the TIGIT/CD226 axis

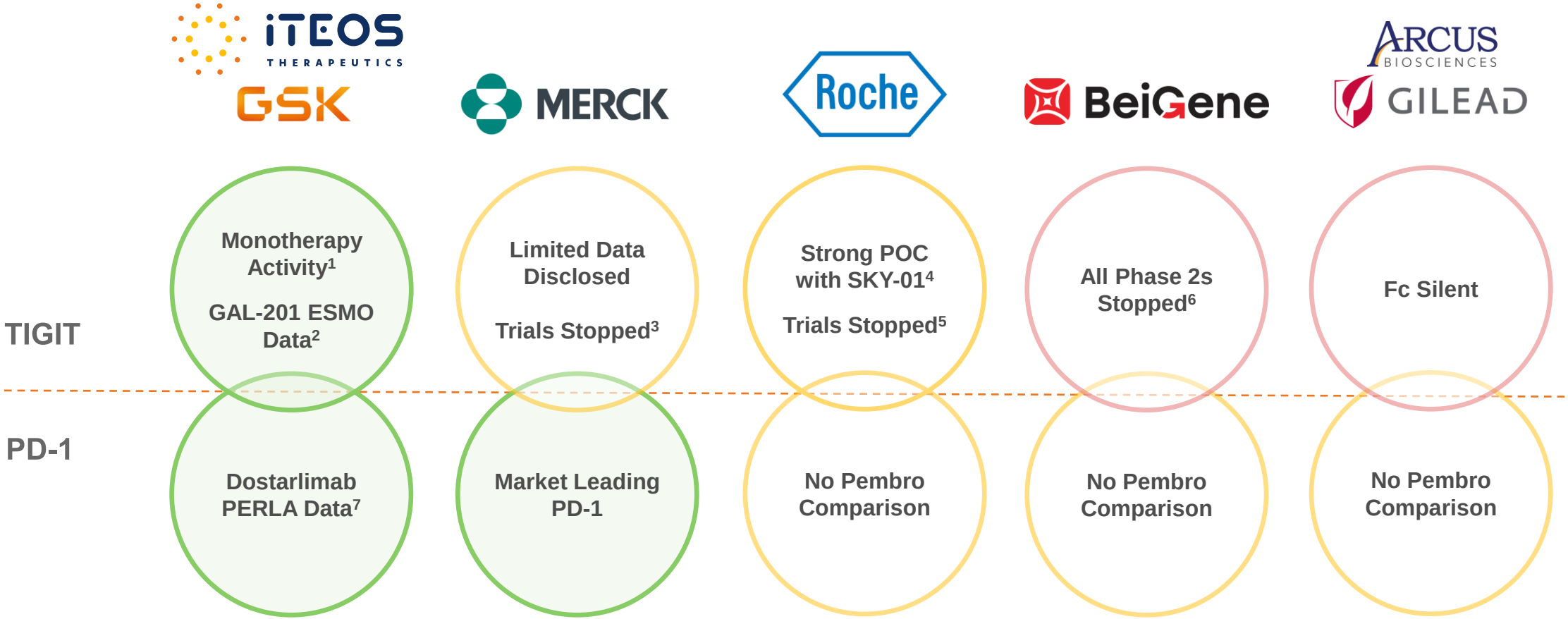
We Hold An

Advantageous Field Position

Significant momentum in 2024

The Need for a Transformative TIGIT:PD-1 Doublet

Belrestotug + dostarlimab represent potentially differentiated, high-quality therapies



POC, proof of concept; Pembro, pembrolizumab

1. iTeos AACR 2021, 2. iTeos ESMO 2024, 3. Merck Phase 3 Keyvibe-008 + Keyvibe-010 Updates, 4. Roche Phase 3 Skyscraper-01 Study - August 22, 2023 Release, 5. Roche 2Q24 Earnings Update, 6. BeiGene Goldman Sachs Conference 2024, 7. ESMO 2023 – Phase 2 GSK-sponsored PERLA study in 1L NSCLC

Belrestotug: The First And Only TIGIT to Demonstrate Robust Target Engagement

Unique Epitope Binding

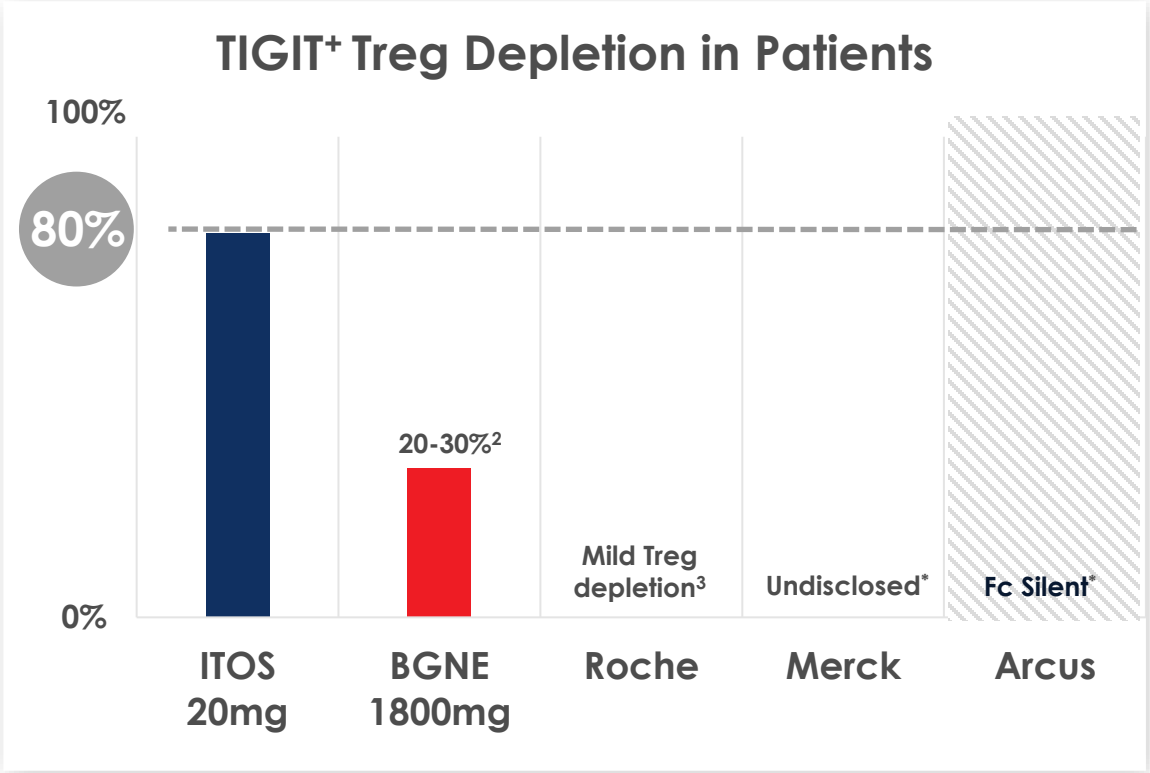
High Affinity + Potency

First and only TIGIT with proven

Treg depletion at all doses[1]

Only TIGIT to Demonstrate Phase 1

Monotherapy Activity[1]

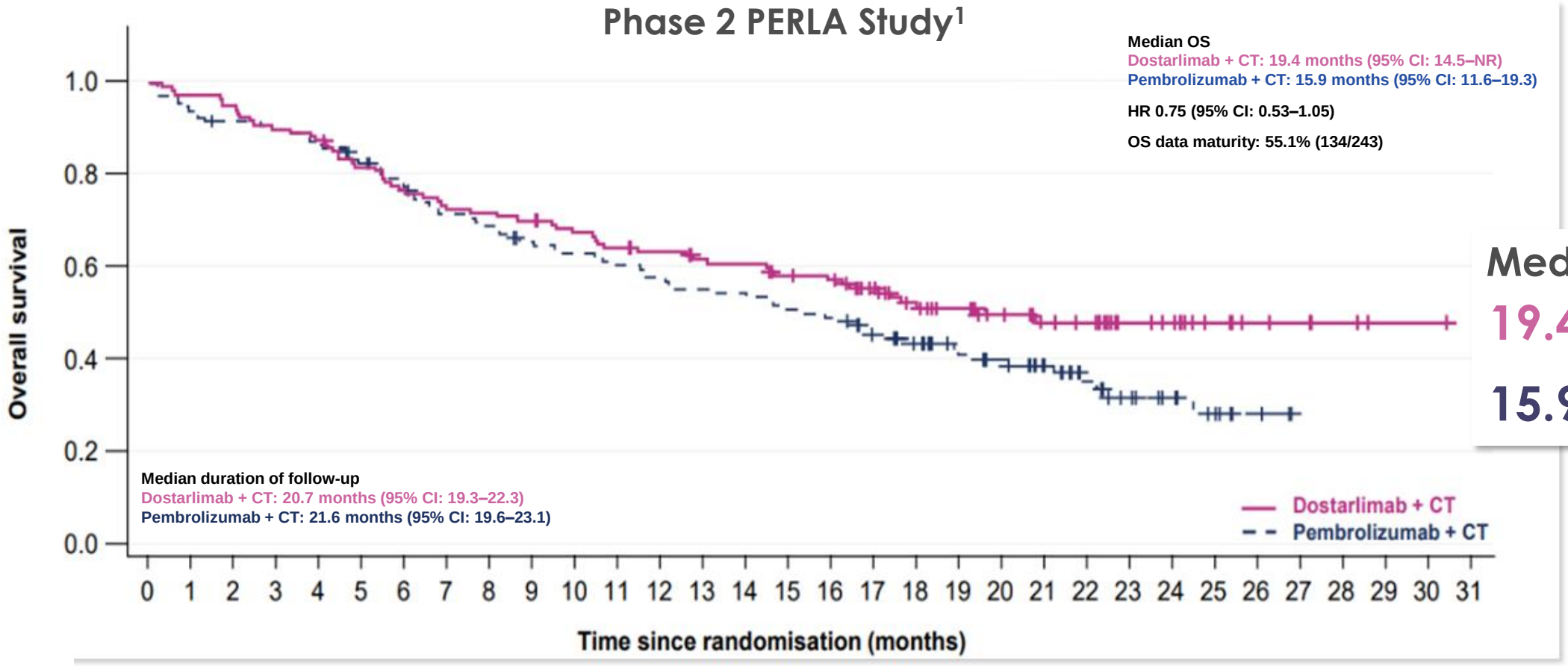


*Merck vibostolimab has yet to publicly show Treg depletion data; Arcus' domvanalimab is an Fc silent TIGIT and not capable of Treg depletion

1. iTeos AACR 2021
2. doi: 10.1136/jitc-2022-SITC2022.0768
3. doi: 10.1038/s41586-024-07121-9

PERLA: Dostarlimab Is A Quality Anti-PD-1 Backbone

Positive numerical OS trend in 1L NSCLC favoring dostarlimab + CT vs. pembrolizumab + CT



Median OS

19.4 Months

15.9 Months

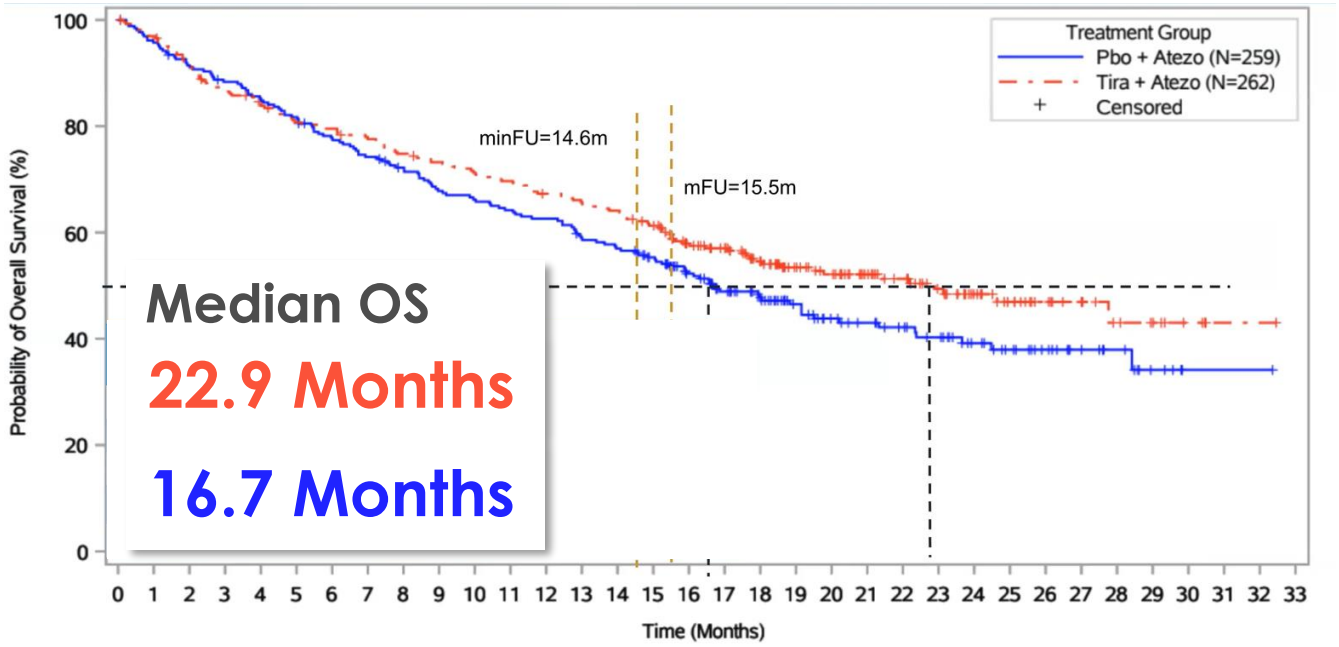
[1]Phase 2 GSK-sponsored PERLA study in 1L NSCLC. Peters S, et al. Annals of Oncology (2023) 34 (suppl_2): S1254-S1335. 10.1016/annonc/annonc1358.
NB: Safety profiles in the secondary analysis of OS were similar and consistent with those previously reported in the primary analysis for the PERLA trial.

CT, chemotherapy; NSCLC, non-small cell lung cancer; OS, overall survival; dMMR, mismatch repair–deficient

SKY-01: Meaningful Separation of Curves Validates TIGIT

Potential for enhancement of quality of components and clinical trial design

Phase 3 SKY-01 IA2[1] in 1L NSCLC



Key Insights

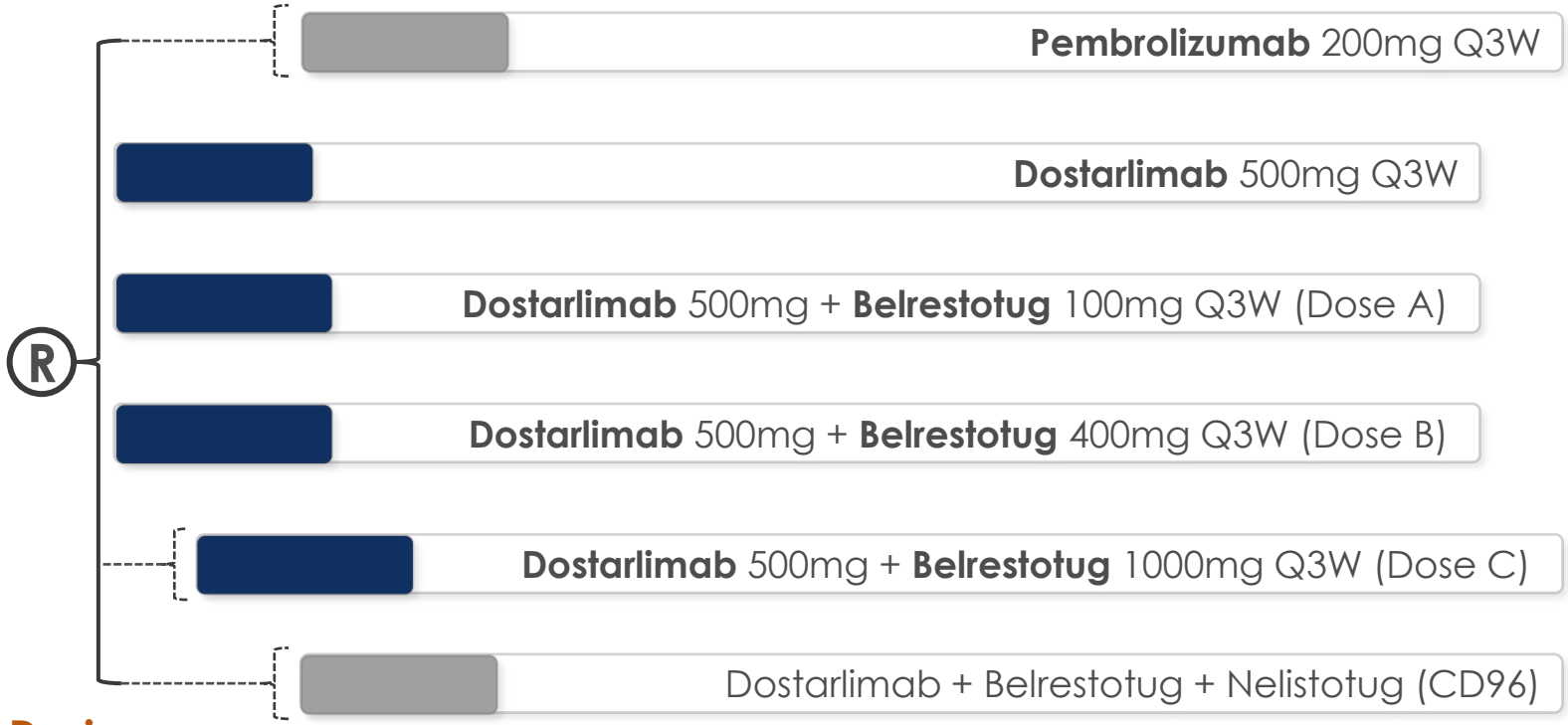
1. **Validated TIGIT as a target** with mOS extended by ~6 months
2. **Robust study design** could provide meaningful efficacy and safety evaluation
3. **Incorporation of pembrolizumab** as SoC control arm

1. Genentech Phase 3 Skyscraper-01 Study - August 22, 2023 Release

SoC, standard of care; OS, overall survival; NSCLC, non-small cell lung cancer

GALAXIES Lung-201 - Phase 2 in 1L NSCLC

The largest TIGIT Phase 2 in PD-L1 high 1L NSCLC



Key

R Subjects Randomization

Study Design

Estimated Enrollment 300

Status	Enrolling	**Objectives**	Evaluate belrestotug + dostarlimab safety, efficacy, PK/PD
Masking	Open label	**Primary Endpoint**	ORR
PDL1 Expression	≥50%	**Secondary Endpoint**	PFS, OS, DOR
Lines of Therapy	No prior systemic therapy	**Clinical Trials Listing**	NCT05565378
Delivery	IV Infusion		

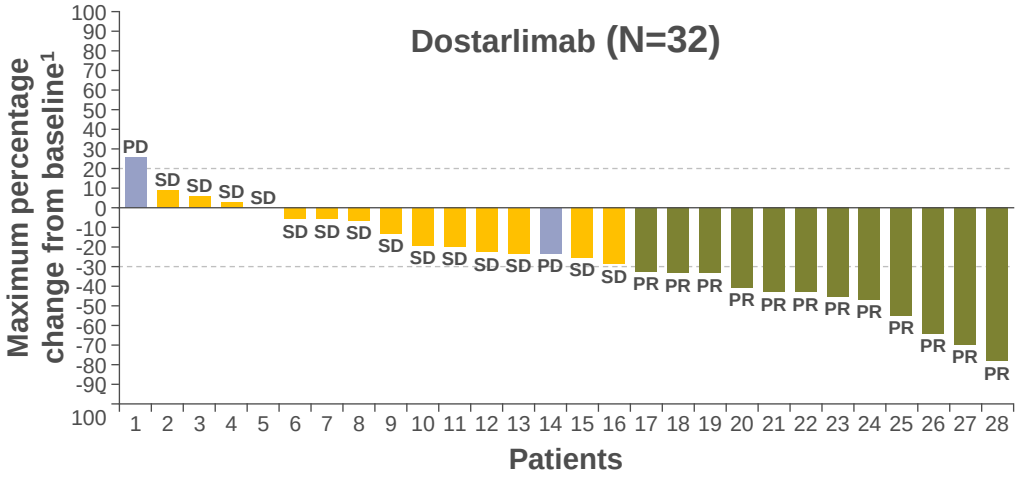
NSCLC, non-small cell lung cancer; Q3W, every 3 weeks; ORR, overall response rate; PFS, progression free survival; OS, overall survival; DOR, duration of response

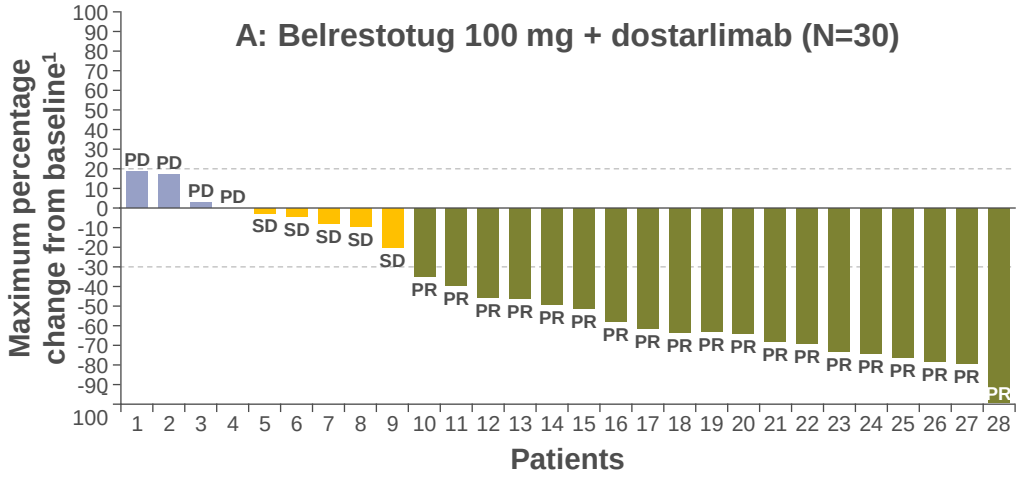
Clinically Meaningful ORR Observed at Every Dose vs Dostarlimab Monotherapy

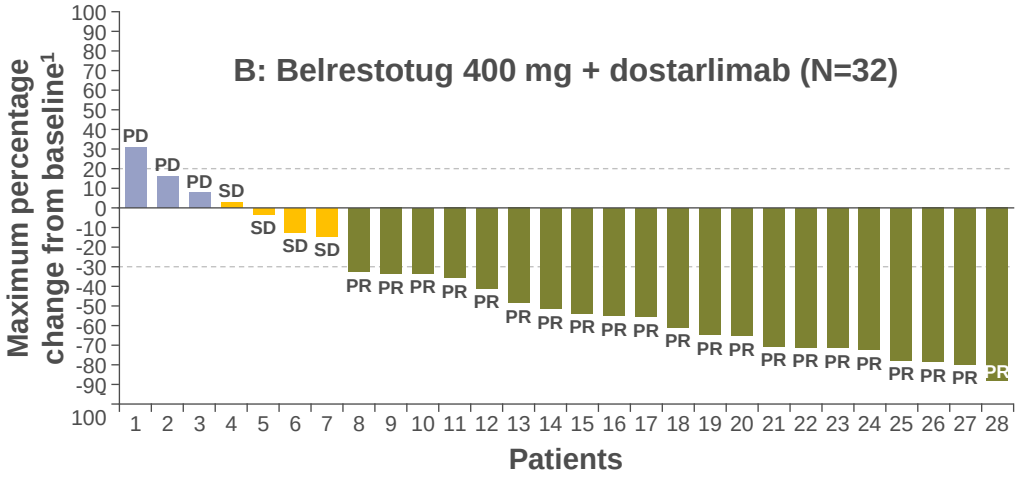
Response measure in mITT	Dostarlimab N=32	A: Belrestotug 100 mg + dostarlimab N=30	B: Belrestotug 400 mg + dostarlimab N=32	C: Belrestotug 1000 mg + dostarlimab N=30
Median follow-up, months (range)[1]	7.0 (0.2–16.6)	8.5 (0.3–14.3)	8.5 (0.4–16.2)	6.7 (2.4–9.7)
ORR,[2,3] % n (95% CI)	**37.5%** n=12 (21.1–56.3)	**63.3%** n=19 (43.9–80.1)	**65.6%** n=21 (46.8–81.4)	**76.7%** n=23 (57.7–90.1)
Complete response, n (%)	0	0	0	0
Partial response, n (%)	12 (37.5%)	19 (63.3%)	21 (65.6%)	23 (76.7%)
Stable disease, n (%)	14 (43.8%)	5 (16.7%)	4 (12.5%)	5 (16.7%)
Progressive disease, n (%)	2 (6.3%)	4 (13.3%)	3 (9.4%)	2 (6.7%)
Not evaluable/no assessment,[4] n (%)	4 (12.5%)	2 (6.7%)	4 (12.5%)	0
Confirmed ORR,[3,5] % n (95% CI)	**28.1%** n=9 (13.7–46.7)	**60.0%** n=18 (40.6–77.3)	**59.4%** n=19 (40.6–76.3)	**63.3%** n=19 (43.9–80.1)

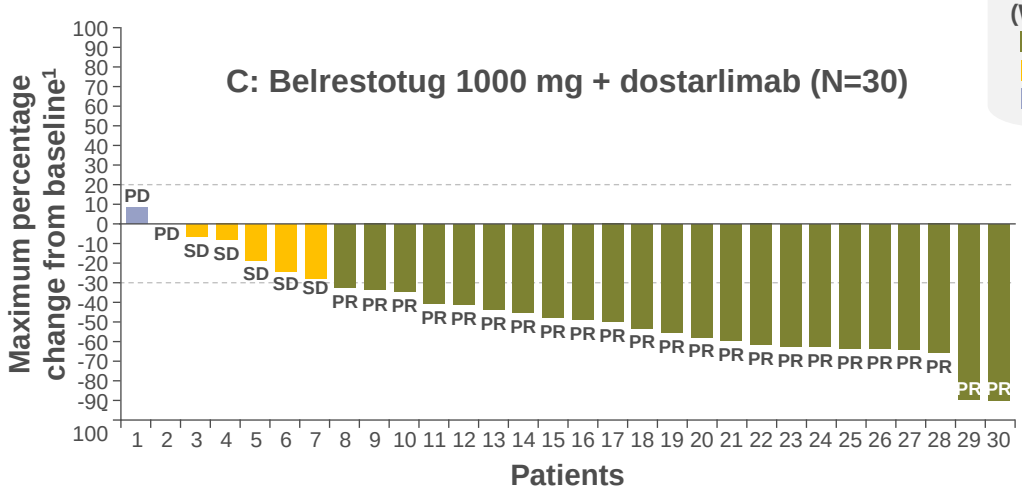
[1]As of data cut 7 Jun 2024, 65% of patients remained in ongoing follow-up; [2]unconfirmed ORR; [3]PD-L1 high (TPS ≥50%) was determined locally or centrally by DAKO 22C3 or VENTANA SP263 assay; [4]patients who only had "not evaluable" post-baseline assessments, those who had a best response of "not evaluable" per RECIST 1.1 by investigator assessment, or those where no post-baseline tumour assessment was performed; [5]complete or partial response confirmed by repeat imaging ≥4 weeks after response criteria first met. CI, confidence interval; mITT, modified intention-to-treat; ORR, objective response rate; PD-L1, programmed death ligand-1; RECIST, Response Evaluation Criteria in Solid Tumours; TPS, tumour positive score.

Belrestotug + Dostarlimab Consistently Increased Depth of Response vs Dostarlimab Monotherapy





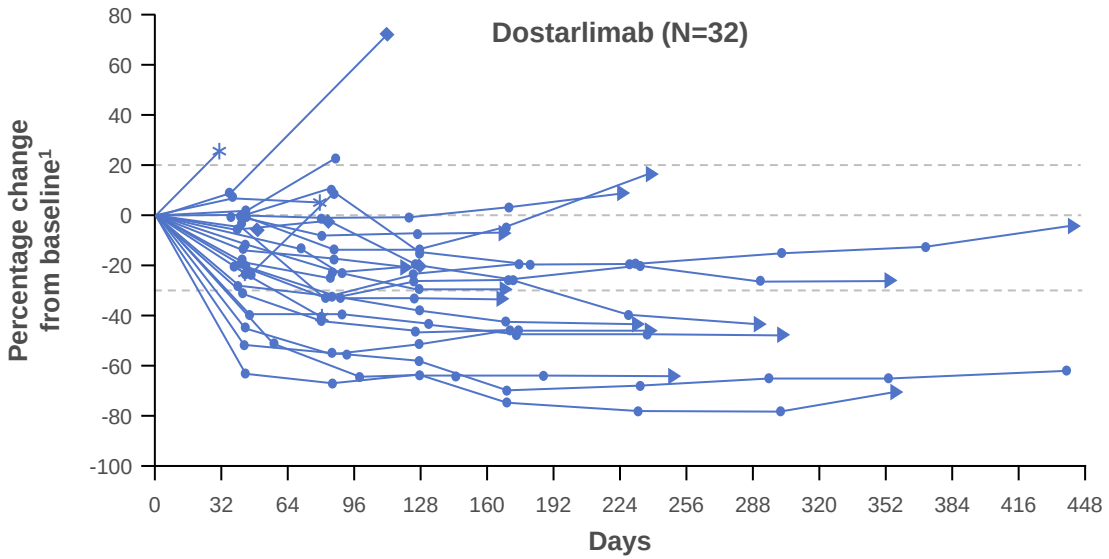


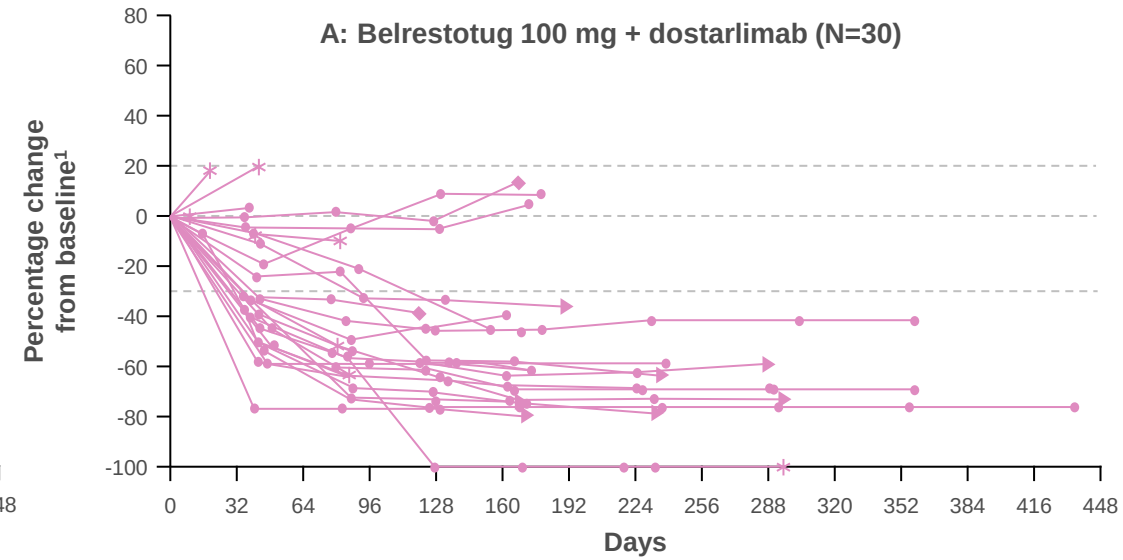


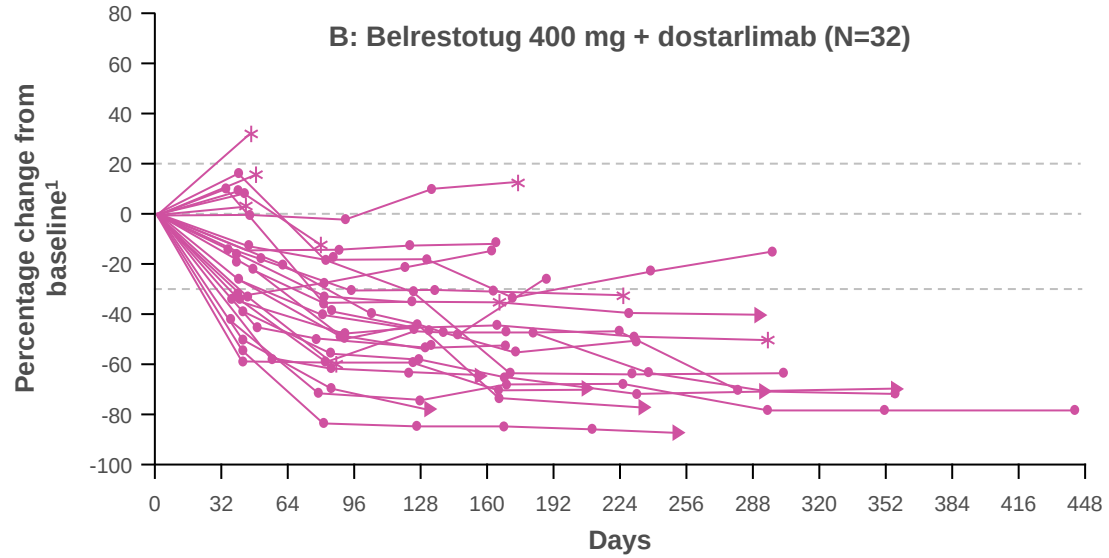
Best Observed Response (Without Confirmation):
- PR
- SD
- PD

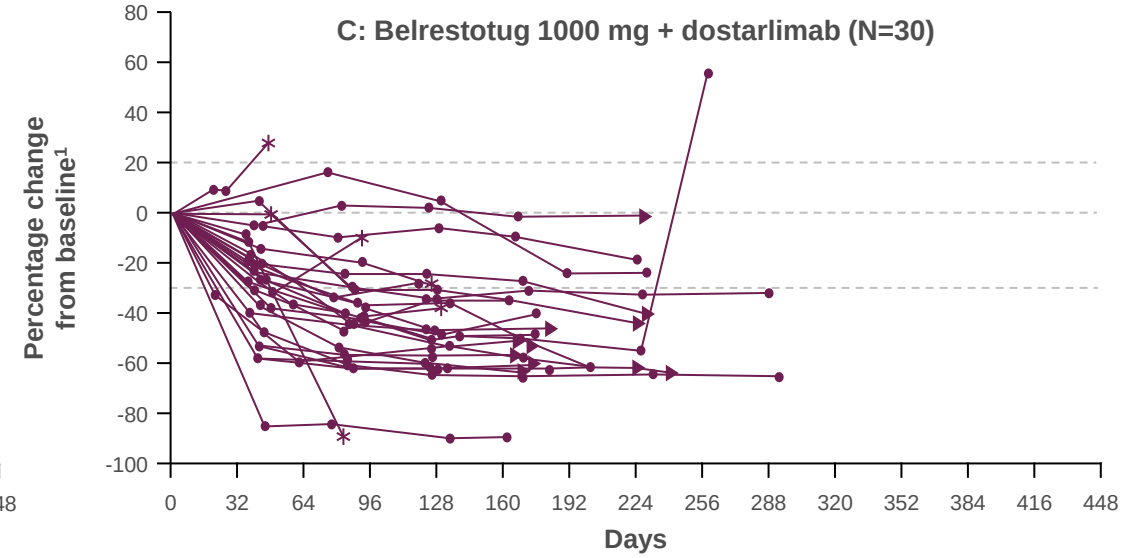
[1]Numerically lowest percent change from baseline that is on or prior to date of first radiological PD and start of follow-up anticancer therapy (excluding radiotherapy and surgery); patients without assessable post-baseline scans or where all baseline target lesions are not measured at subsequent visits are not included in figure; responses shown are per RECIST 1.1 by investigator assessment without confirmation. PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumours; SD, stable disease.

Consistent Deep Tumor Reduction with Ongoing Responses by Belrestotug + Dostarlimab vs Dostarlimab Monotherapy





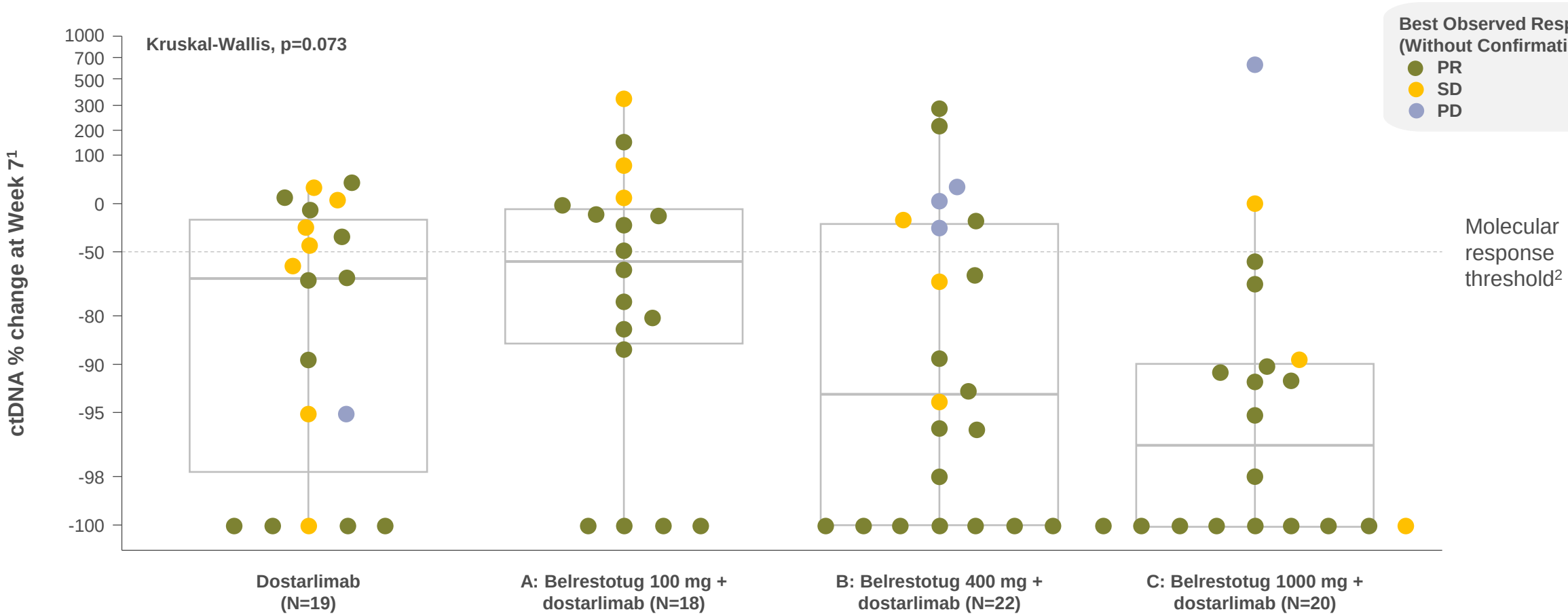




- ▶ Ongoing – on study treatment
- ● Ongoing – in follow-up
- ✱ Died
- ◆ Withdrawn

[1]Investigator assessed percentage change from baseline per RECIST 1.1 by investigator assessment. RECIST, Response Evaluation Criteria in Solid Tumors.

Numerically Greater Reduction of ctDNA Associated with Belrestotug 400mg and 1000mg + Dostarlimab Cohorts



	Dostarlimab (N=19)	A: Belrestotug 100 mg + dostarlimab (N=18)	B: Belrestotug 400 mg + dostarlimab (N=22)	C: Belrestotug 1000 mg + dostarlimab (N=20)
Molecular Response Rate (>-50% from Baseline)	11/19 (58%)	9/18 (50%)	15/22 (68%)	18/20 (90%)
Median ctDNA % Change	-65%	-55%	-94%	-97%

[1]Mean variant allele frequency change from baseline to Week 7; [2]molecular response threshold defined as having at least 50% reduction of ctDNA levels. Responses shown are per RECIST 1.1 by investigator assessment without confirmation. ctDNA, circulating tumour DNA; PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumours; SD, stable disease.

Belrestotug + Dostarlimab Is Broadly Consistent with Known Safety Profile of Checkpoint Inhibitor Combinations

Increase in immune-related adverse events with belrestotug + dostarlimab vs dostarlimab

Event, n (%)	Dostarlimab (N=32)	A: Belrestotug 100 mg + dostarlimab (N=30)	B: Belrestotug 400 mg + dostarlimab (N=32)	C: Belrestotug 1000 mg + dostarlimab (N=30)
TEAE	29 (91%)	29 (97%)	31 (97%)	30 (100%)
Grade 3+ TEAE	14 (44%)	19 (63%)	16 (50%)	16 (53%)
TRAE	19 (59%)	24 (80%)	27 (84%)	29 (97%)
Grade 3+ TRAE	5 (16%)	10 (33%)	7 (22%)	13 (43%)
Serious TRAE	3 (9%)	10 (33%)	8 (25%)	11 (37%)
Grade 5 serious TRAE	0	2 (7%)	1 (3%)	0
TRAE leading to discontinuation	2 (6%)	7 (23%)	5 (16%)	12 (40%)
Grade 1/2 TR-irAE leading to discontinuation	0 (0%)	2 (7%)	3 (10%)	2 (7%)
TR-irAE[1]	6 (19%)	20 (67%)	18 (56%)	22 (73%)
Grade 3+ TR-irAE	4 (13%)	9 (30%)	5 (16%)	11 (37%)
Infusion-related reactions[2]	4 (13%)	8 (27%)	3 (9%)	7 (23%)

- The most common TRAEs overall (≥15%) were skin and subcutaneous tissue disorders (50%) and endocrine disorders (26%)
- The most common TEAEs leading to discontinuation were skin and subcutaneous tissue disorders (6%) and respiratory, thoracic and mediastinal disorders (6%)
- Fatal serious TRAEs include immune-mediated pneumonitis (N=1), immune-mediated hepatitis (N=1) and immune-mediated myocarditis (N=1)

[1]Immune-related AEs are events of potential immunologic aetiology, including irAEs; irAEs are identified as any Grade 2+ AEs (or AEs of unknown grade) based on a prespecified search list of preferred terms using the most recent MedDRA version identified by a custom MedDRA query (CMQ) using GSK Terms of Interest codes; [2]infusion-related reactions are drug component–related AEs which occurred ≤1 day after drug component infusion and are identified based on a prespecified search list of preferred terms and most recent MedDRA version. AE, adverse event; irAE, immune-related AE; MedDRA, Medical Dictionary for Regulatory Activities; TEAE, treatment-emergent adverse event; TR, treatment-related; TRAE, treatment-related treatment-emergent adverse event.

Belrestotug + Dostarlimab Is Broadly Consistent with Known Safety Profile of Checkpoint Inhibitor Combinations

Most common TR-irAE were skin and subcutaneous tissue disorders

Event, n (%)	Dostarlimab N=32	A: Belrestotug 100 mg + dostarlimab (N=30)	B: Belrestotug 400 mg + dostarlimab (N=32)	C: Belrestotug 1000 mg + dostarlimab (N=30)
TR-irAE[1] by preferred terms (≥10% incidence in any cohort[2]), Grade 2+				
Grade 3+				
Immune-mediated dermatitis	0 0	5 (17%) 1 (3%)	0 0	6 (20%) 3 (10%)
Pruritus	0 0	3 (10%) 0	5 (16%) 0	4 (13%) 0
Rash	0 0	2 (7%) 0	4 (13%) 0	2 (7%) 1 (3%)
Immune-mediated hypothyroidism	1 (3%) 0	1 (3%) 0	3 (9%) 0	4 (13%) 0
ALT increase	1 (3%) 1 (3%)	3 (10%) 2 (7%)	0 0	1 (3%) 1 (3%)
Immune-mediated lung disease	0 0	1 (3%) 0	1 (3%) 0	3 (10%) 1 (3%)
Immune-mediated myocarditis	0 0	1 (3%) 1 (3%)	0 0	3 (10%) 1 (3%)

- The majority of Grade 2+ irAEs were skin and subcutaneous tissue disorders across all combination cohorts and were considered generally manageable with steroids (topical or oral). Adaptions to skin toxicity management are ongoing.
- Immune-mediated lung disease and myocarditis were more frequent in the belrestotug 1000 mg + dostarlimab cohort

[1]Immune-related AEs are events of potential immunologic aetiology, including irAEs; irAEs are identified as any Grade 2+ AEs (or AEs of unknown grade) based on a prespecified search list of preferred terms using the most recent MedDRA version identified by a custom MedDRA query (CMQ) using GSK Terms of Interest codes; [2]infusion-related reactions are drug component–related AEs which occurred ≤1 day after drug component infusion and are identified based on a prespecified search list of preferred terms and most recent MedDRA version. AE, adverse event; irAE, immune-related AE; MedDRA, Medical Dictionary for Regulatory Activities; TEAE, treatment-emergent adverse event; TR, treatment-related; TRAE, treatment-related treatment-emergent adverse event.

GALAXIES Lung-301 - Phase 3 in 1L NSCLC

Key

R Subjects Randomization

Study Design

Estimated Enrollment 1,000

Status	Enrolling
Masking	Double-blind
PDL1 Expression	≥50%
Lines of Therapy	No prior systemic therapy
Delivery	IV Infusion

Objectives	Evaluate belrestotug + dostarlimab safety, efficacy vs placebo + pembrolizumab
Primary Endpoint	PFS, OS
Secondary Endpoint	ORR, MRR, DOR

NSCLC, non-small cell lung cancer; PFS, progression free survival; OS, overall survival; ORR, overall response rate; MRR, molecular response rate; DOR, duration of response

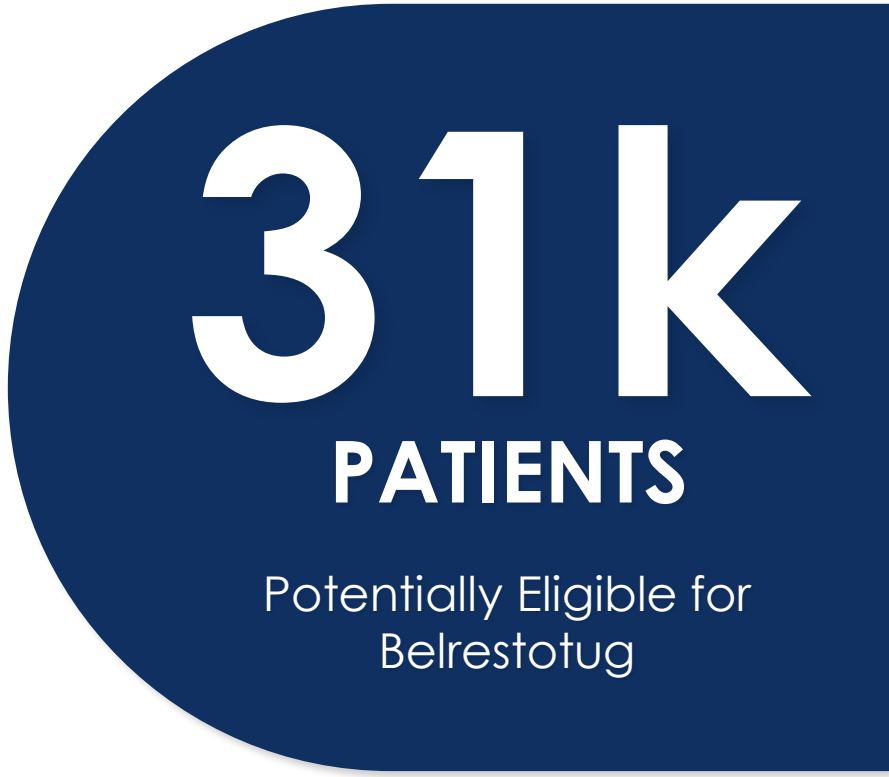
1L NSCLC: Building A Meaningful Position

Evolving competitive landscape favoring a high-quality TIGIT:PD-1 doublet

Strong scientific rationale with high levels of TIGIT+ Tregs, high infiltration of T cells, and highly amenable to IO therapies

The right Phase 3 strategy with right dose, right combination, right trial design, and right commercial approach

1L NSCLC strategic launch point and clinical POC enables future exploration of other NSCLC settings and indications beyond lung



Source: Kantar, internal iTeos analysis

NSCLC, non-small cell lung cancer; IO, immuno-oncology; POC, proof of concept

PD-1 Therapy Remains Primary Treatment for 1L NSCLC Patients

No major shift in 1L NSCLC treatment trend in last two years

- **PD-1 treatment alone remains SOC in 1L NSCLC PD-L1 high patients**, followed by platinum-doublet in 2L NSCLC[1,2,3]
  - PD-1 + chemo failed to improve OS vs PD-1 alone
  - PD-1 alone viewed as sufficient for most patients while reducing toxicity
  - Chemotherapy option still available in 2L NSCLC
- **PD-1 + chemo typically used for high burden disease** to provide rapid control/symptom relief[2]
- **No difference in mOS or rwPFS between PD-1 alone vs chemo + PD-1** in retrospective cohort study examining 1L NSCLC treatment[3]

Patients that Receive PD-(L)1 without Chemotherapy in 1L NSCLC PD-L1 High in US

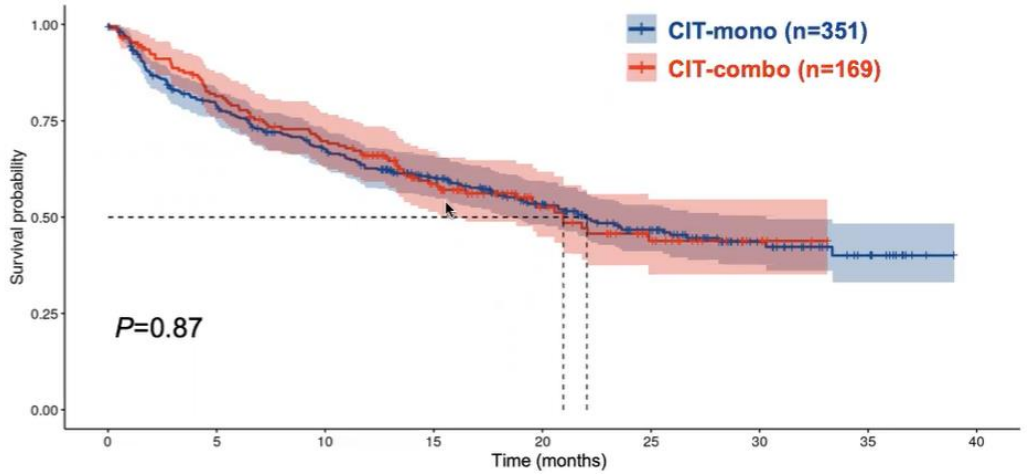
72%

Ipsos Oncology Monitor
Chart data for 12 months ending June 2023

68%

iTeos US Oncologist Survey
(n=50; 16 academic, 34 community; 124 patient charts)

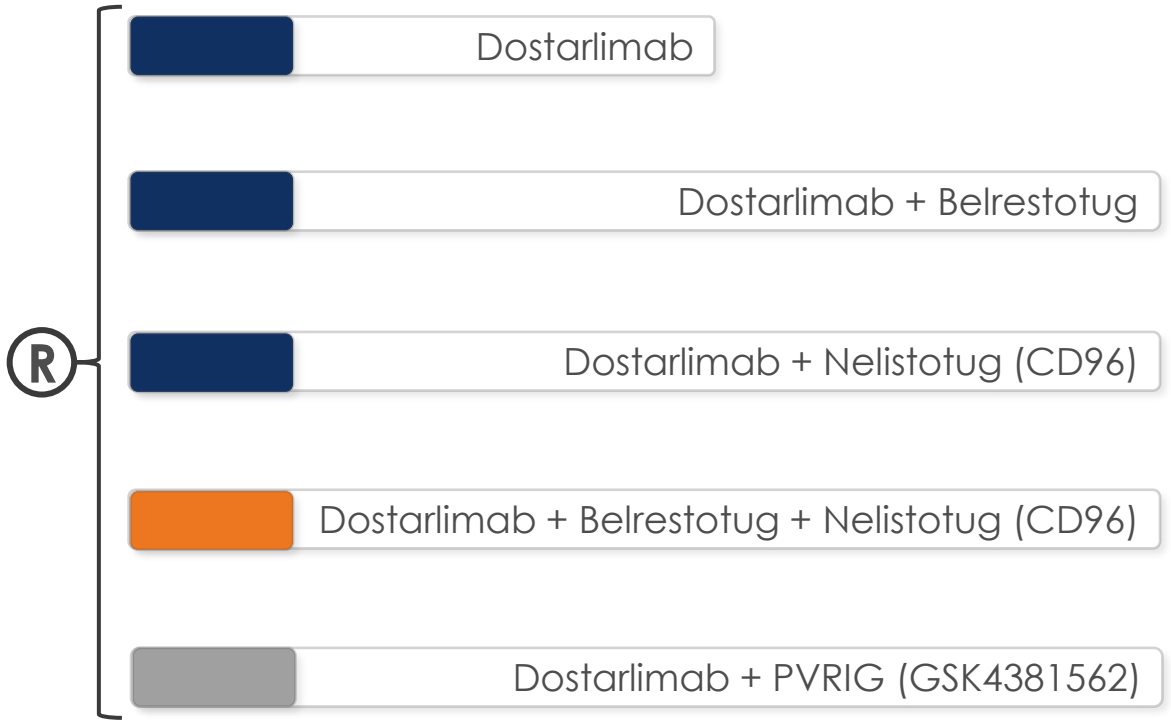
Effectiveness of PD-(L)1 Inhibitors Alone or in Combination with Platinum Doublet Chemo in 1L NSCLC with PD-L1 High Expression Using Real World Data[2]



1. Ipsos Oncology Monitor
2. iTeos US Oncologist Survey
3. ESMO Virtual Plenary: Effectiveness of PD-(L)1 Inhibitors Alone or in Combination with Platinum Doublet Chemo in 1L NSCLC with PD-L1 High Expression Using Real World Data

NSCLC, non-small cell lung cancer; SOC, standard of care; (m)OS, (median) overall survival; rwPFS, real world progression free survival

GALAXIES H&N-202: Phase 2 in 1L HNSCC



Key

R Subjects Randomization

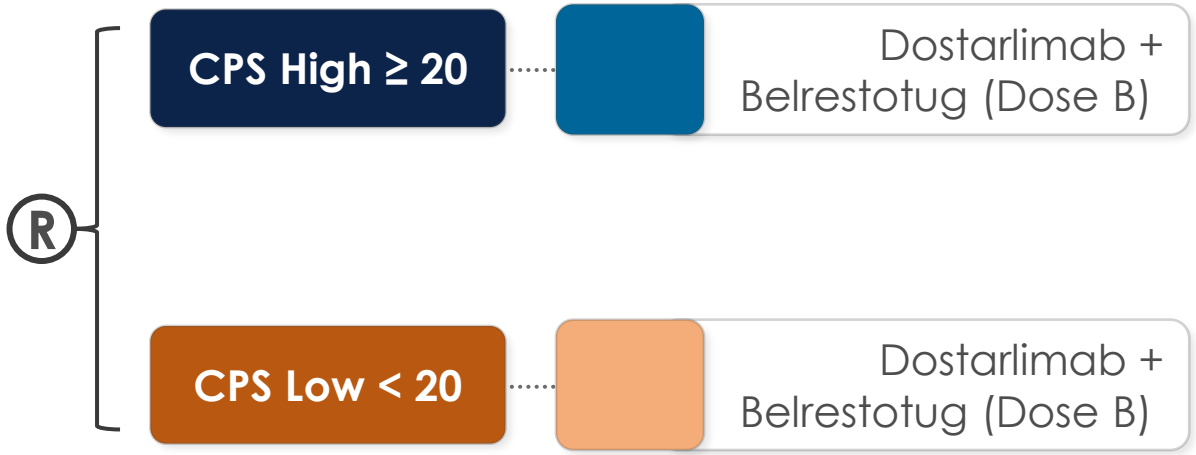
Study Design

Estimated Enrollment 360

Status	Enrolling	**Objectives**	Evaluate antitumor activity, safety of dostarlimab + novel IOs
Masking	Open label	**Primary Endpoint**	ORR
PDL1 Expression	PDL1+	**Secondary Endpoint**	PFS, OS, DOR
Lines of Therapy	No prior systemic therapy	**Clinical Trials Listing**	NCT06062420
Delivery	IV Infusion		

HNSCC, head and neck squamous cell carcinoma; ORR, overall response rate; PFS, progression free survival; OS, overall survival; DOR, duration of response

TIG-006 – Phase 2 in 1L HNSCC PDL1 High/Low



Study Design

Estimated Enrollment 40

Status	Enrolling
Masking	Open label
PDL1 Expression	PDL1+
Lines of Therapy	No prior systemic therapy
Delivery	IV Infusion
Objectives	Evaluate belrestotug + dostarlimab in two CPS populations
Primary Endpoint	ORR
Secondary Endpoint	PFS, OS, DOR
Clinical Trials Listing	NCT05060432

1L HNSCC: Potential First-to-Market Opportunity

Under-served market with strong biological rationale seeking advances

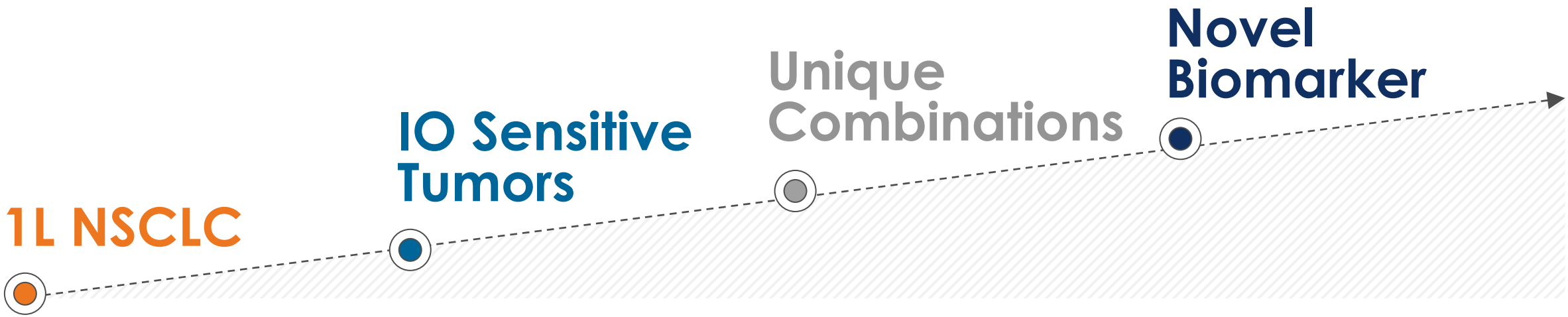
Strong scientific rationale with high levels of TIGIT+ Tregs, high infiltration of T cells and the indication being amenable to PD-1 therapy

Significant market opportunity due to no ongoing Phase 3 studies, potential to be first-to-market, and the opportunity to expand to the locally advanced setting

Source: Kantar, internal iTeos analysis

HNSCC, head and neck squamous cell carcinoma; mOS, median overall survival

Belrestotug + Dostarlimab Are Uniquely Positioned to Fully Exploit TIGIT Pathway



Foundation

1L NSCLC to serve as launch point for TIGIT:PD-1 doublet

Expansion

Target clinically validated indications and improve tumor activity with TIGIT:PD-1 doublet

Design

Utilize doublets beyond PD-1 and unique triplets to target complementary mechanisms or drugs limited by exhaustion

Implementation

Integrate promising TIGIT biomarker to precisely target sensitive indications and subpopulations

An Empowering, Strategic Collaboration with GSK

Data-driven approach to unlock potential of high-quality regimens

Success Factors

Quality TIGIT

Proven PD-1

Right Partner

Strategic Approach

Payments
$625M upfront,
up to **$1.45B** milestones

Territories
US: co-commercialization and **50/50 profit share**

Ex-US: double digit royalties **up to 20%**

Developmental expenses
40% iTeos / **60%** GSK

PFS, progression free survival; OS, overall survival; dMMR, mismatch repair deficient

Adenosine Pathway

Unlocking one of the most promising targets responsible for immunosuppression

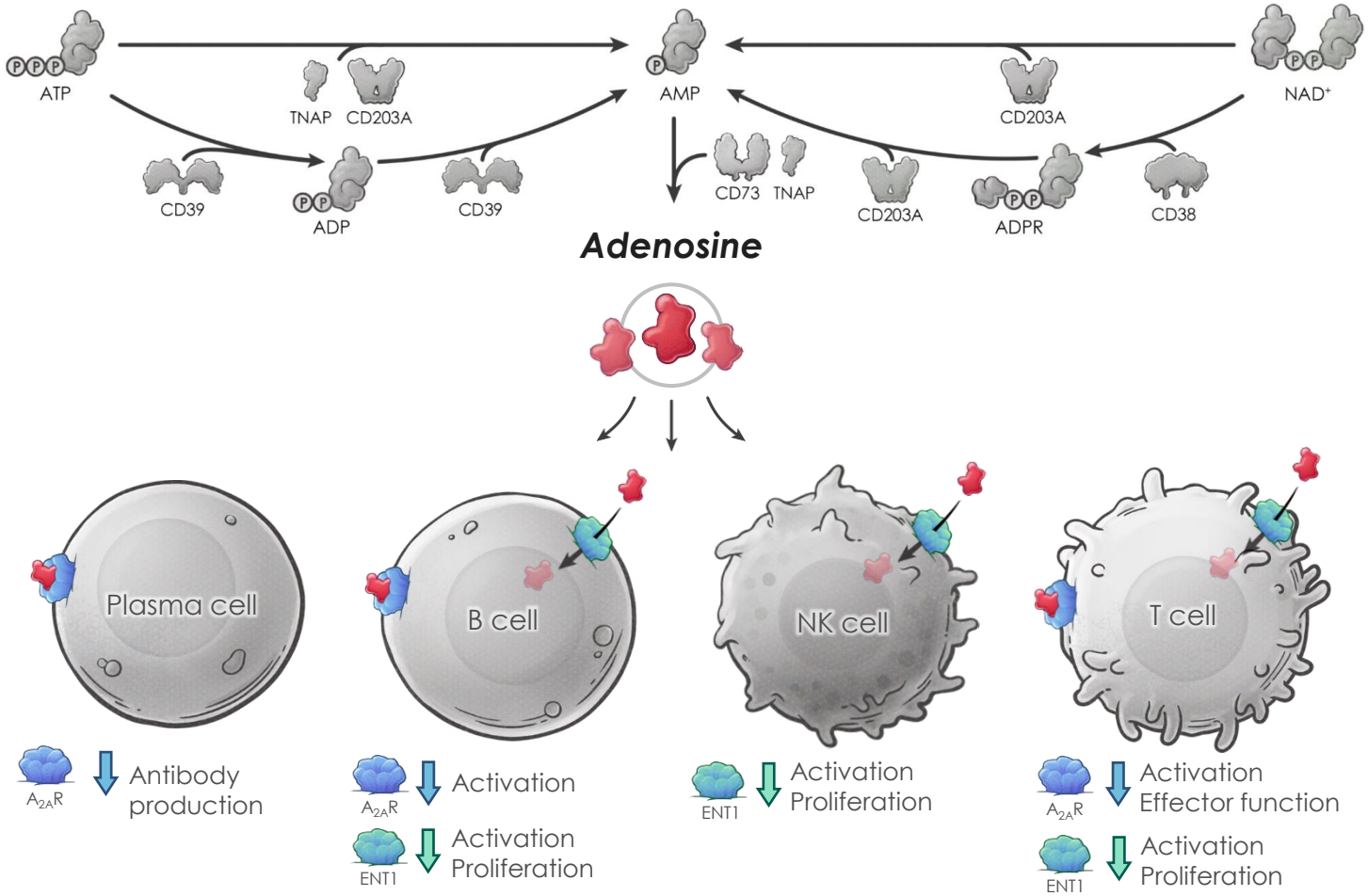
Supraphysiological Adenosine Synthesis in TME Broadly Suppresses Immune System

ATP/Adenosine created in response to proinflammatory stimuli, like cell stress from hypoxia and cell necrosis in the tumor

Difficult to stop adenosine production due to multiple mechanisms involved, including enzymes CD39 and CD73

$A_{2A}R$ engagement with adenosine impairs multiple immune cell activities

ENT1 engagement with adenosine impairs immune cell metabolism, effector function, and proliferation



Inupadenant: A Class of Its Own

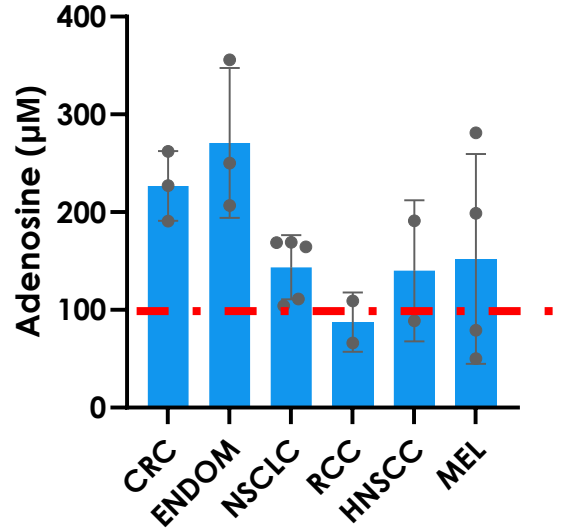
Best-in-class, highly selective $A_{2A}R$ antagonist optimized for hostile solid TME

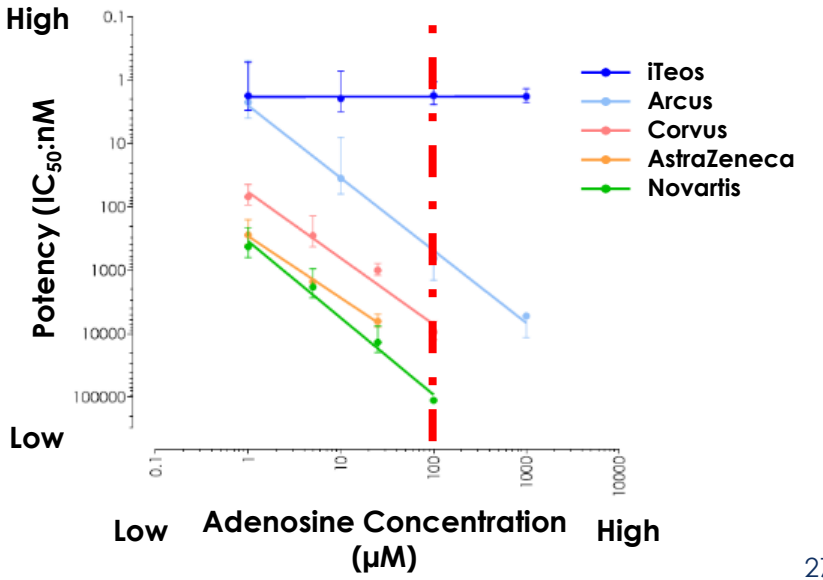
Targeting $A_{2A}R$

- $A_{2A}R$ activation by adenosine suppresses immune cell responses, inhibiting anti-tumor response
- Inupadenant targets $A_{2A}R$, the final endpoint of the adenosine production pathway, circumventing the multiple ways adenosine is created

The Insurmountable Profile of Inupadenant

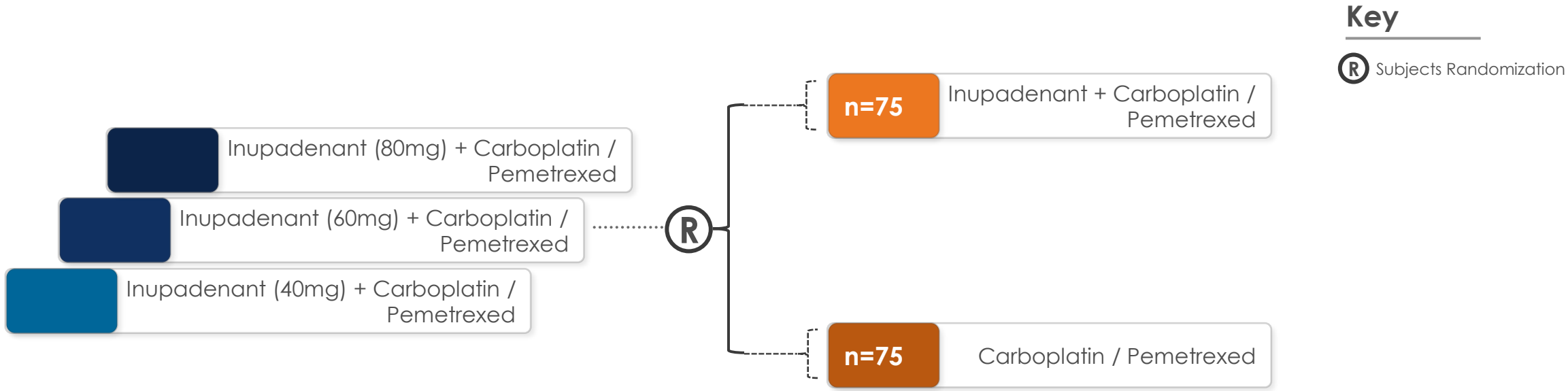
- First company to demonstrate TME adenosine concentration is supraphysiological and varies depending on indication
- First and only $A_{2A}R$ antagonist to maintain activity at high adenosine concentrations





TME, tumor microenvironment

A2A-005: Phase 2 in 2L NSCLC (Post-IO) Chemo-Naïve



Study Design

Estimated Enrollment 192

Status	Enrolling
Masking	Double Blind
PDL1 Expression	PDL1+ (all %)
Lines of Therapy	1; PD-1 Inhibitors
Delivery	Oral
Objectives	Evaluate clinical benefit of inupadenant + chemotherapy
Primary Endpoint	ORR
Secondary Endpoint	PFS, OS, DOR
Clinical Trials Listing	NCT05403385

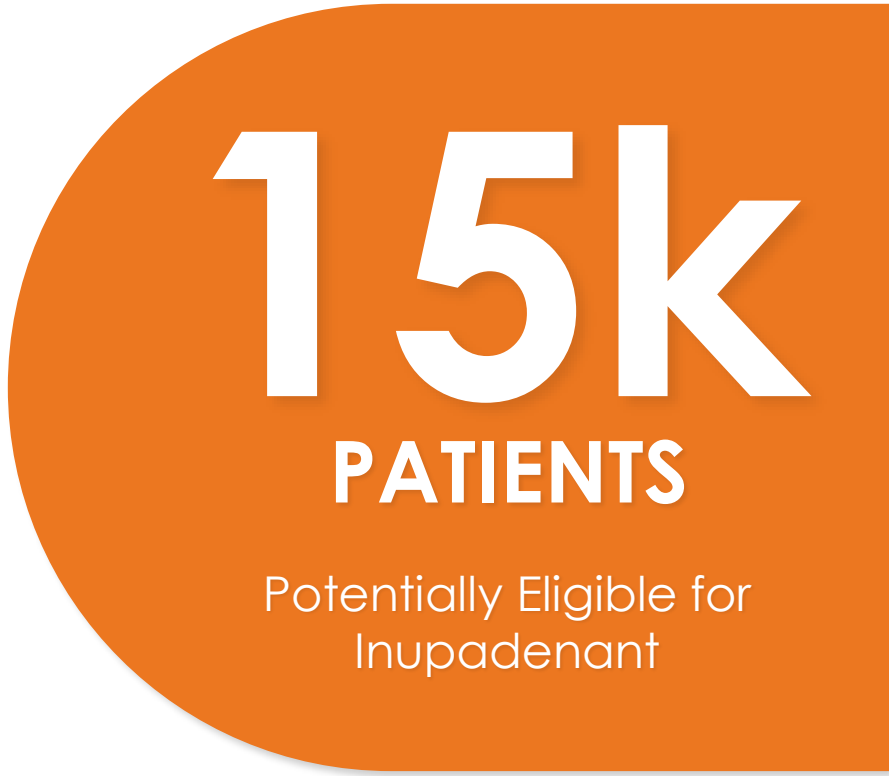
Inupadenant Counteracts Chemotherapy's Key Downfall

2L NSCLC is an under-served population with strong biological rationale seeking advances

Chemotherapy increases adenosine levels via cell death, hindering the immune system and plasma cell activity

Inupadenant maintains potency + function at high adenosine levels, potentially enhancing chemotherapy therapeutic response

Currently only clinical trial in 2L NSCLC platinum-naïve setting



Source: Kantar, internal iTeos analysis

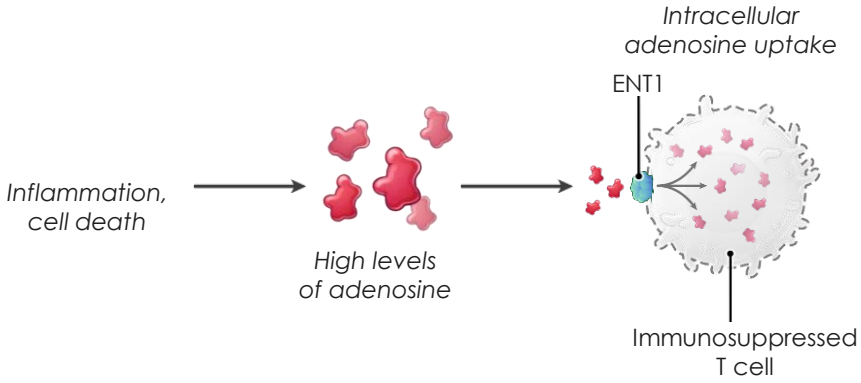
NSCLC, non-small cell lung cancer; TME, tumor microenvironment

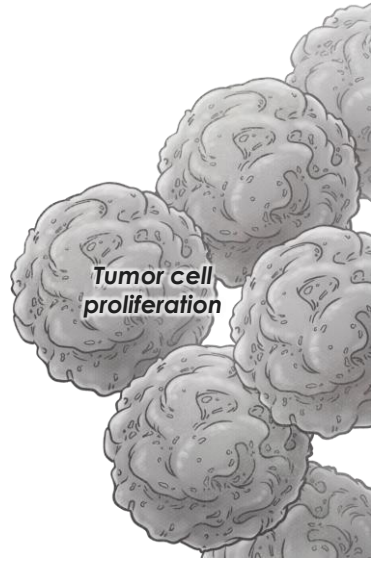
EOS-984: Enhancing T Cell Proliferation in the Hostile TME

One of the most meaningful discoveries in the adenosine pathway

The Role of ENT1

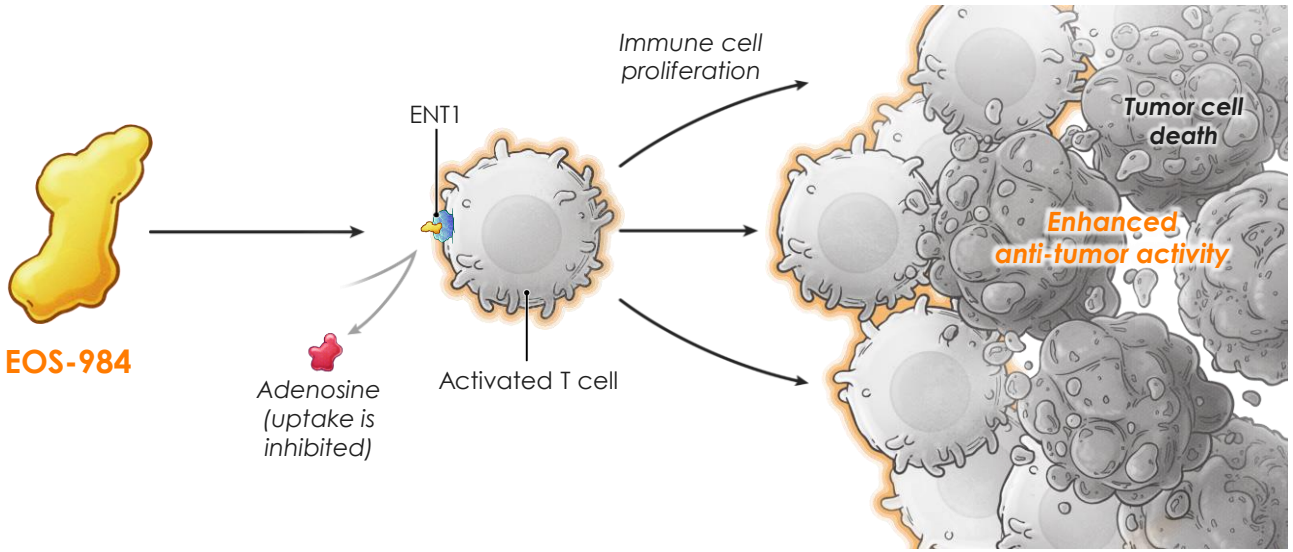
- Dominant transporter of adenosine on lymphocytes effecting:
  - T cell metabolism
  - T cell expansion
  - T cell effector function
  - T cell survival





The Opportunity to Revive T Cell Proliferation

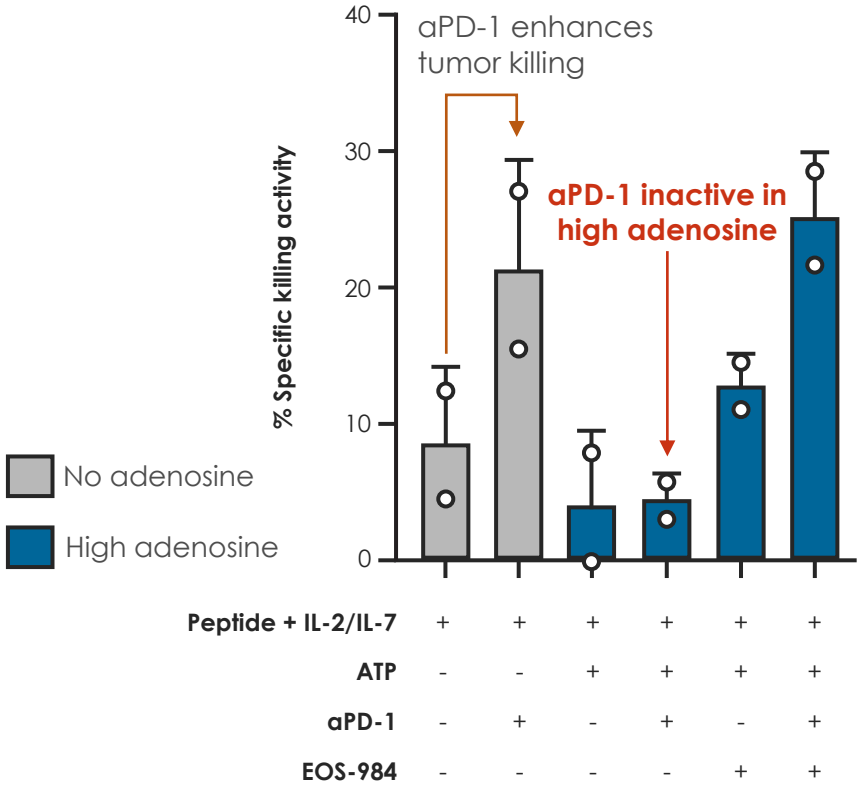
- First company to understand how adenosine transports into T cells and inhibits proliferation
- EOS-984 offers large combination opportunity broadly across cancer therapies



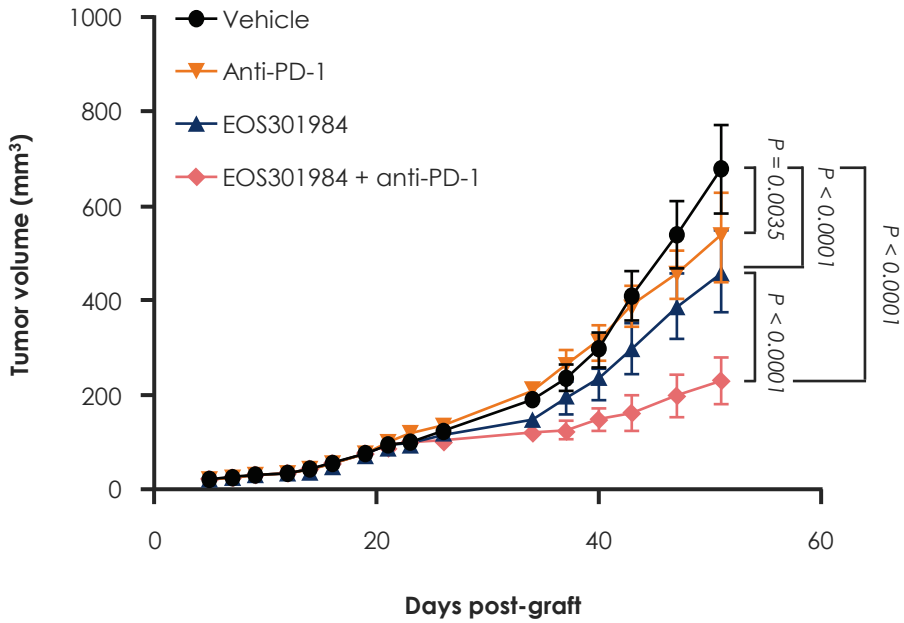
TME, tumor microenvironment; ENT1, Equilibrative Nucleoside Transporter 1

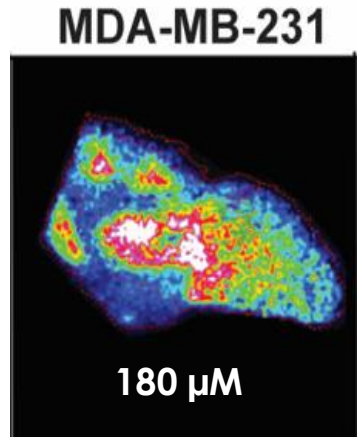
Anti-PD-1 Activity Enhanced by Restoration of T Cell Proliferation by EOS-984

EOS-984 + aPD-1 combination maximizes tumor killing by functional memory T cells



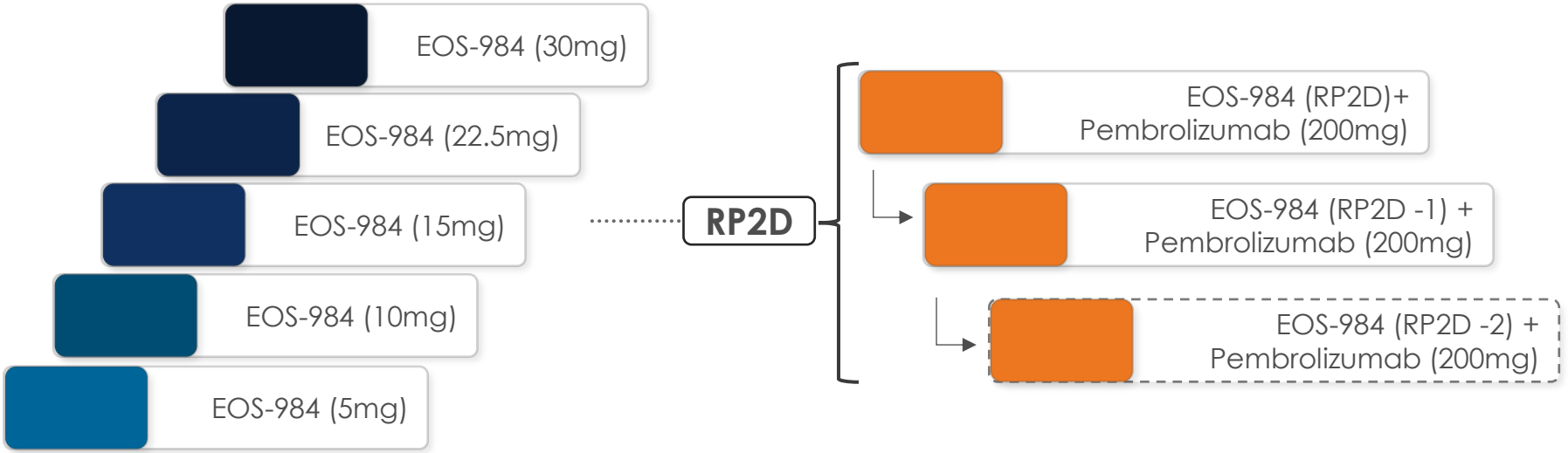
Humanized TNBC model (MDA-MB-231) containing high adenosine





EOS-984: Phase 1 in Advanced Solid Tumors

Evaluation of target engagement and impact on T cells in TME



Study Design

Estimated Enrollment 84

Status	Enrolling
Masking	Open Label
PDL1 Expression	PDL1+ (all %)
Lines of Therapy	All-comers
Delivery	Oral

Objectives	Evaluate safety/tolerability of EOS-984 as a monotherapy and in combination with pembrolizumab
Primary Endpoint	Safety/tolerability, PK/PD
Secondary Endpoint	ORR, PFS, OS, DOR

TME, tumor microenvironment; RP2D, recommended Phase 3 dose; PK/PD, pharmacokinetic/pharmacodynamic; ORR, overall response rate; PFS, progression free survival; OS, overall survival; DOR, duration of response

2024: Pivotal Year of Data Generation

Innovative portfolio leveraging deep tumor immunology expertise

TIGIT

1L NSCLC

(Phase 2 GALAXIES LUNG-201)

Adenosine Pathway

$A_{2A}R$ - 2L NSCLC

(Phase 2 A2A-005)

ENT1 - MOA

(EOS-984 Preclinical)

Funded Through Significant Milestones

As of Sept. 30, 2024

~$684M

Pro forma cash, cash equivalents and short-term investments

Runway through 2027

NSCLC, non-small cell lung cancer; HNSCC, head and neck squamous cell carcinoma; ENT1, Equilibrative Nucleoside Transporter 1; MoA, Mechanism of Action

Cancer Immunotherapies *by design™*

Nasdaq: ITOS November 2024