LISATA THERAPEUTICS

Targeted Therapy *Delivered*

Corporate Presentation | November 6, 2025

Nasdaq: LSTA

www.lisata.com

Forward-looking statements advisory

This presentation contains “forward-looking statements” that involve substantial risks and uncertainties for purposes of the safe harbor provided by the Private Securities Litigation Reform Act of 1995. All statements, other than statements of historical facts, included in this communication regarding strategy, future operations, future financial position, future revenue, projected expenses, prospects, plans and objectives of management are forward-looking statements. In addition, when or if used in this communication, the words “may,” “could,” “should,” “anticipate,” “believe,” “estimate,” “expect,” “intend,” “plan,” “predict”, “target” and similar expressions and their variants, as they relate to Lisata or its management, may identify forward-looking statements. Examples of forward-looking statements include, but are not limited to, statements relating to Lisata’s continued listing on the Nasdaq Capital Market; expectations regarding the capitalization, resources and ownership structure of Lisata; the approach Lisata is taking to discover, develop and commercialize novel therapeutics; the adequacy of Lisata’s capital to support its future operations and its ability to successfully initiate and complete clinical trials; and the difficulty in predicting the time and cost of development of Lisata’s product candidates. Actual results could differ materially from those contained in any forward-looking statement as a result of various factors, including, without limitation: the safety and efficacy of Lisata’s product candidates, decisions of regulatory authorities and the timing thereof, the duration and impact of regulatory delays in Lisata’s clinical programs, Lisata’s ability to finance its operations, the likelihood and timing of the receipt of future milestone and licensing fees, the future success of Lisata’s scientific studies, Lisata’s ability to successfully develop and commercialize drug candidates, the timing for starting and completing clinical trials, rapid technological change in Lisata’s markets, the ability of Lisata to protect its intellectual property rights and legislative, regulatory, political and economic developments. The foregoing review of important factors that could cause actual events to differ from expectations should not be construed as exhaustive and should be read in conjunction with statements that are included herein and elsewhere, including the risk factors included in Lisata’s Annual Report on Form 10-K filed with the SEC on February 27, 2025, and in other documents filed by Lisata with the Securities and Exchange Commission. Except as required by applicable law, Lisata undertakes no obligation to revise or update any forward-looking statement, or to make any other forward-looking statements, whether as a result of new information, future events or otherwise.

Lisata at a Glance

Company Overview

Lisata Therapeutics (Nasdaq: LSTA)

OVERVIEW

Clinical stage pharmaceutical company developing innovative therapies for the treatment of cancer and other serious diseases.

MISSION

To rapidly develop and commercialize innovative treatments that improve outcomes for patients with cancer or other serious diseases.

Lisata Therapeutics (Nasdaq: LSTA): Key attributes

Seasoned management with successful international drug development experience and expertise

Proprietary field-leading technology with global IP protection extending beyond 2040

Multiple product and business milestones projected over the next 12 months

Platform technology validated by existing partnerships with potential for many others

Cash runway extending into 1Q 2027 with no debt

Seasoned leadership with proven history of drug approvals worldwide

David J. Mazzo, PhD

President and Chief Executive Officer, Member of the Board of Directors

With >40 years of experience, Dr. Mazzo is a global pharmaceutical executive noted for his strategic prowess and his vast experience developing and launching new products across all therapeutical areas. He recently was recognized as a *2024 PharmaVoice Top 100 Standout Leader*.

RegadoBiosciences · ÆTERNA ZENTARIS · CHUGAI (Roche Group) · Schering-Plough · Hoechst Marion Roussel · RHÔNE-POULENC RORER

Kristen K. Buck, MD

Executive Vice President of R&D and Chief Medical Officer

Dr. Buck is a board certified and licensed physician with >20 years of strategic global drug development, drug/device safety/epidemiology, FDA, and clinical practice experience.

ICON · IQVIA · FDA · OPTUMInsight · AstraZeneca · B|BRAUN

Gregory Berkin
Chief Information Officer and Data Protection Officer

James Nisco
SVP of Finance and Treasury and Chief Accounting Officer

Tariq Imam
SVP of BD and Operations and General Counsel

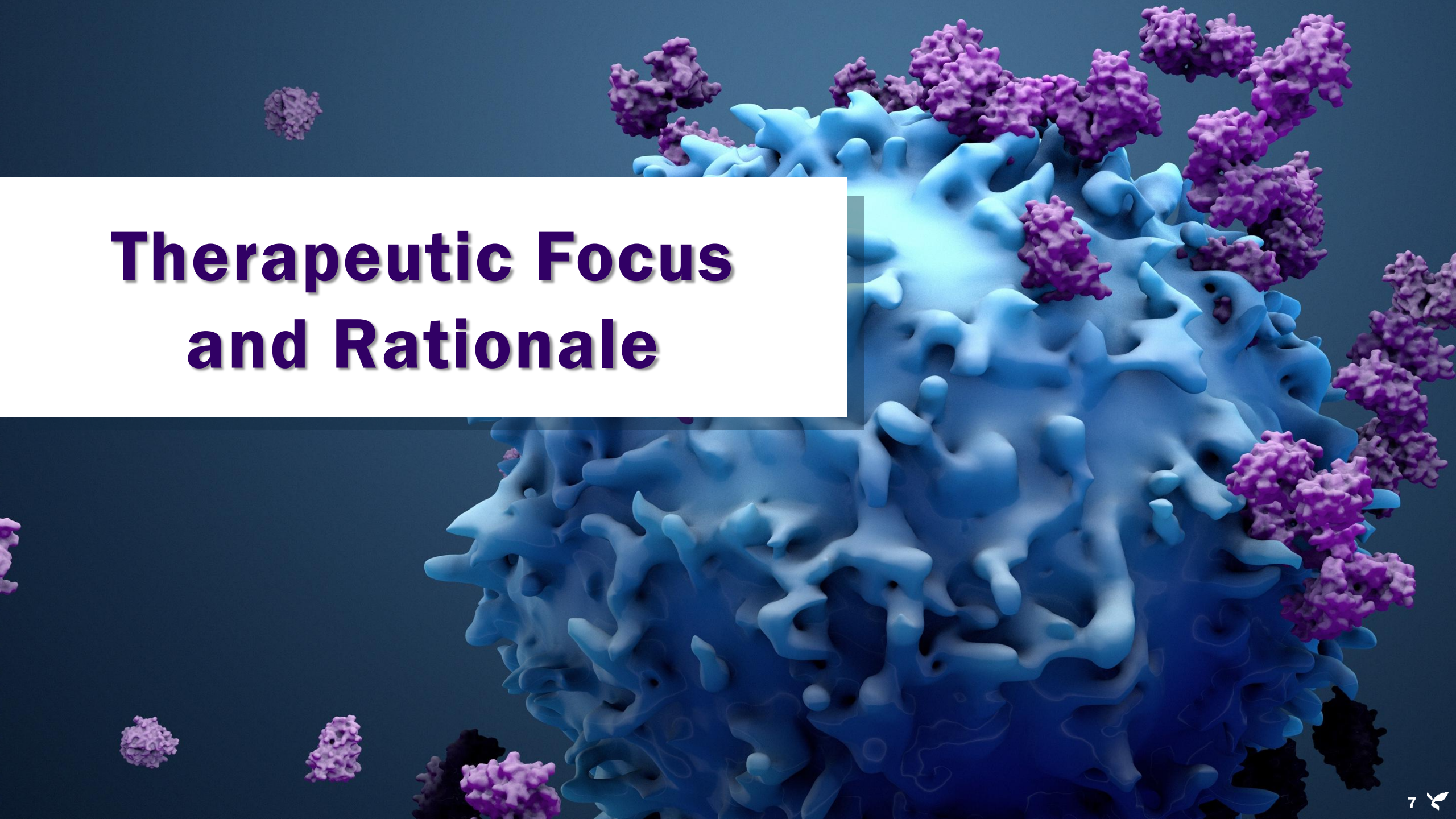
John Menditto
VP of Investor Relations and Corporate Communications

Bill Sietsema, PhD
VP of Global Regulatory Affairs

Ryan Quick
VP of Chemistry, Manufacturing and Controls

Detailed management bios can be found at www.lisata.com

Therapeutic Focus and Rationale



Improved solid tumor treatment remains a vital, growing global need

Worldwide Cancer Incidence

2022

20 million new cases with **10 million** deaths[1-2]

2050

35 million new cases with **18.5 million** deaths[3]

Solid tumors account for more than 90% of all diagnosed cancers

Pancreatic Cancer Incidence

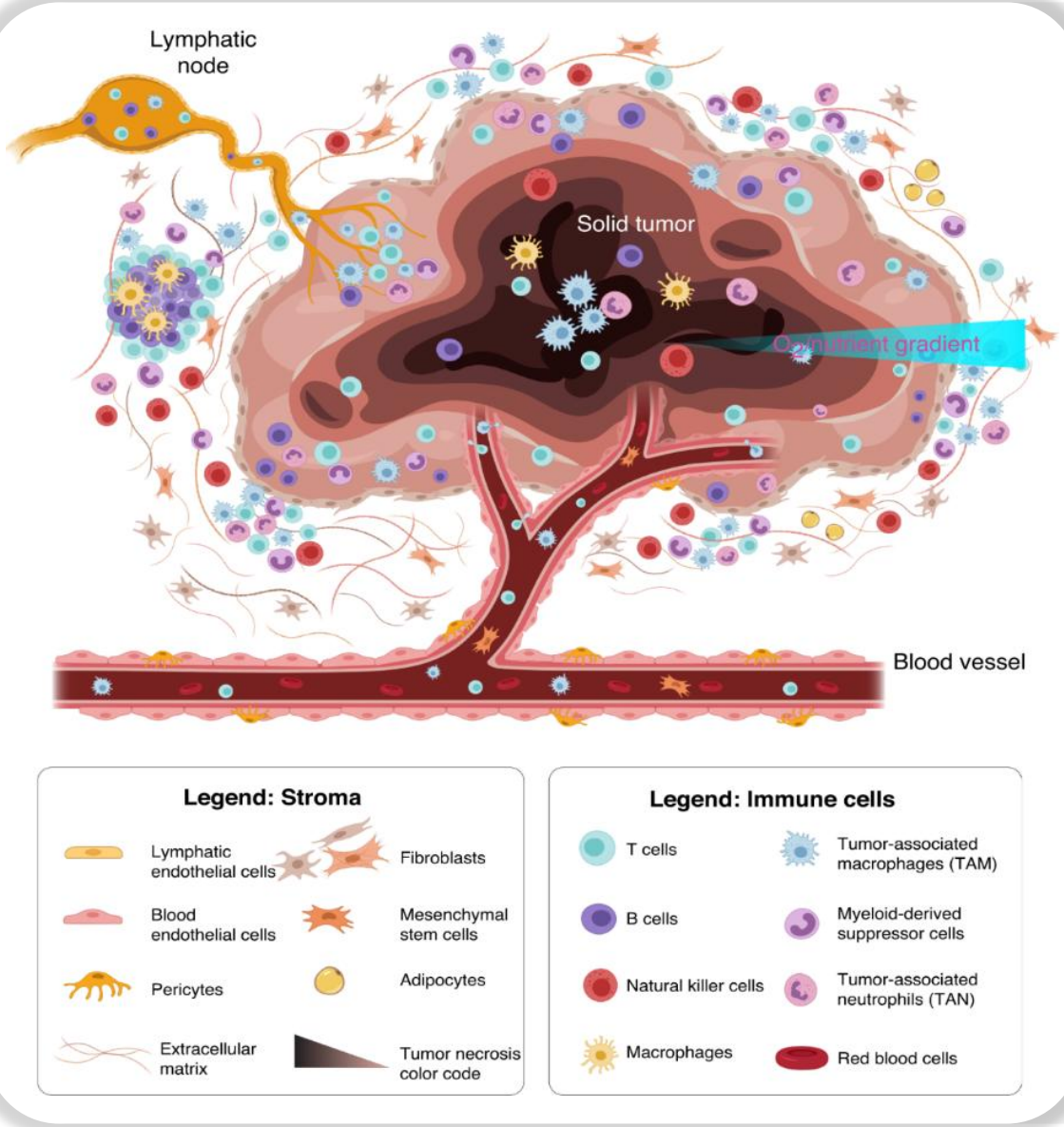
By 2030, PDAC* is predicted to be the second most common cause of cancer mortality[4]

Immunotherapy is generally ineffective in improving outcomes

**Pancreatic ductal adenocarcinoma (PDAC)*

[1] https://gco.iarc.who.int/tomorrow/en/dataviz/tables?mode=population&years=2050&types=1&populations=903_904_905_908_909_935_900; data retrieved Feb 12, 2024.
[2] https://seer.cancer.gov/statfacts/html/common.html; data retrieved Nov 2, 2023.
[3] https://www.who.int/news/item/01-02-2024-global-cancer-burden-growing--amidst-mounting-need-for-services; data retrieved Oct 14, 2024.
[4] Europe Is Facing a Pancreatic Cancer Emergency - Medscape - January 25, 2024.

Current solid tumor treatments & patient outcomes are suboptimal



Challenging tumor morphology and tumor microenvironment (TME) pose significant barriers to effective treatment and outcomes

Tumor stroma acts as a physical barrier to anti-cancer agents

An immunosuppressive TME contributes to tumor resistance and/or metastases

Prolonged or escalated dosing of non-targeted anti-cancer therapies generally leads to intolerable off-target side effects

Diagram source: Abizanda-Campo, S. et al, *Microsyst Nanoeng* **9**, 154 (2023)

Certepetide is designed to optimize solid tumor treatment

Certepetide: a proprietary internalizing RGD* (iRGD) cyclic peptide adjuvant with tumor specific targeting & penetration activity and tumor microenvironment modifying properties

- Converts tumor stroma from a barrier to a conduit for anti-cancer drugs
- Selectively reduces TME immunosuppressive T cells and recruits cytotoxic T cells[1]
- Inhibits the metastatic cascade[2]
- Applicable with any modality of anti-cancer therapeutic
  - Via co-administration or molecular tethering
- Poised for Phase 3 in mPDAC**
  - In mid-stage clinical development in multiple solid tumors

internalizing RGD: arginyl-glycyl-aspartic acid or iRGD
****mPDAC: metastatic pancreatic ductal adenocarcinoma***

[1] Sugahara, et al. Mol Cancer Ther; 14(1) January 2015; Hamilton, et al., J MolMed. April 2015; and Miyamura, et al., bioRxiv. May 2023.
[2] Yuan, D., Duda, D., et al. CCA Foundation Conf. 2024 Poster. *Enhancing the efficacy of standard therapy in intrahepatic cholangiocarcinoma using LSTA1, a novel tumor targeting and penetration agent.*

Certepetide possesses a strong Intellectual Property portfolio

- Eight families, comprising 25 granted patents (6 U.S.), 26 pending patents, and two families in PCT phase
- Orphan Drug Designations provides for 7 and 10 years of market exclusivity post-approval in the U.S. and EU, respectively
- Composition of matter patent through March 2040, with subsequent opportunity for patent term extension
- Claims cover composition of matter, method of use, and therapeutic combinations
- Pending claims cover methods of making certepetide (via peptide synthesis), specific combinations in the treatment of PDAC, and combinations with immunotherapies, specifically, durvalumab, resulting from the iLSTA study data
- Exclusive option to granted patent relating to the ability of certepetide altering the immune cell landscape, thus better sensitizing cancers to use of checkpoint inhibitors

Partnerships

Noteworthy existing relationships and potential for many more

Existing partnerships support certepetide's promise and broad applicability

R&D alliances contribute resources with minimal commercial interest in certepetide

- *Australasian Gastro-Intestinal Trials Group* - Clinical Trialists Consortium (Australia & New Zealand) and *WARPNINE* - Foundation (Australia)

Existing strategic partnerships

Catalent, Inc.

- Lisata granted Catalent a worldwide non-exclusive license to develop and commercialize antibody-drug conjugate (ADC) products containing certepetide and its analogs
- Catalent will evaluate certepetide as a SMARTag® payload with multiple ADCs targeting difficult-to-treat diseases
- Lisata is eligible to receive >$10 million in tiered development milestone payments, plus revenue sharing on future sales and partnerships

GATC Health Corp.

- Lisata & GATC formed a strategic alliance to develop GATC's AI-derived drug candidates, including combinations with certepetide
- Lisata will receive an upfront payment and increasing asset equity upon development milestone achievement
- Lisata will have an option to license future AI-derived assets for a nominal fee

Kuva Labs

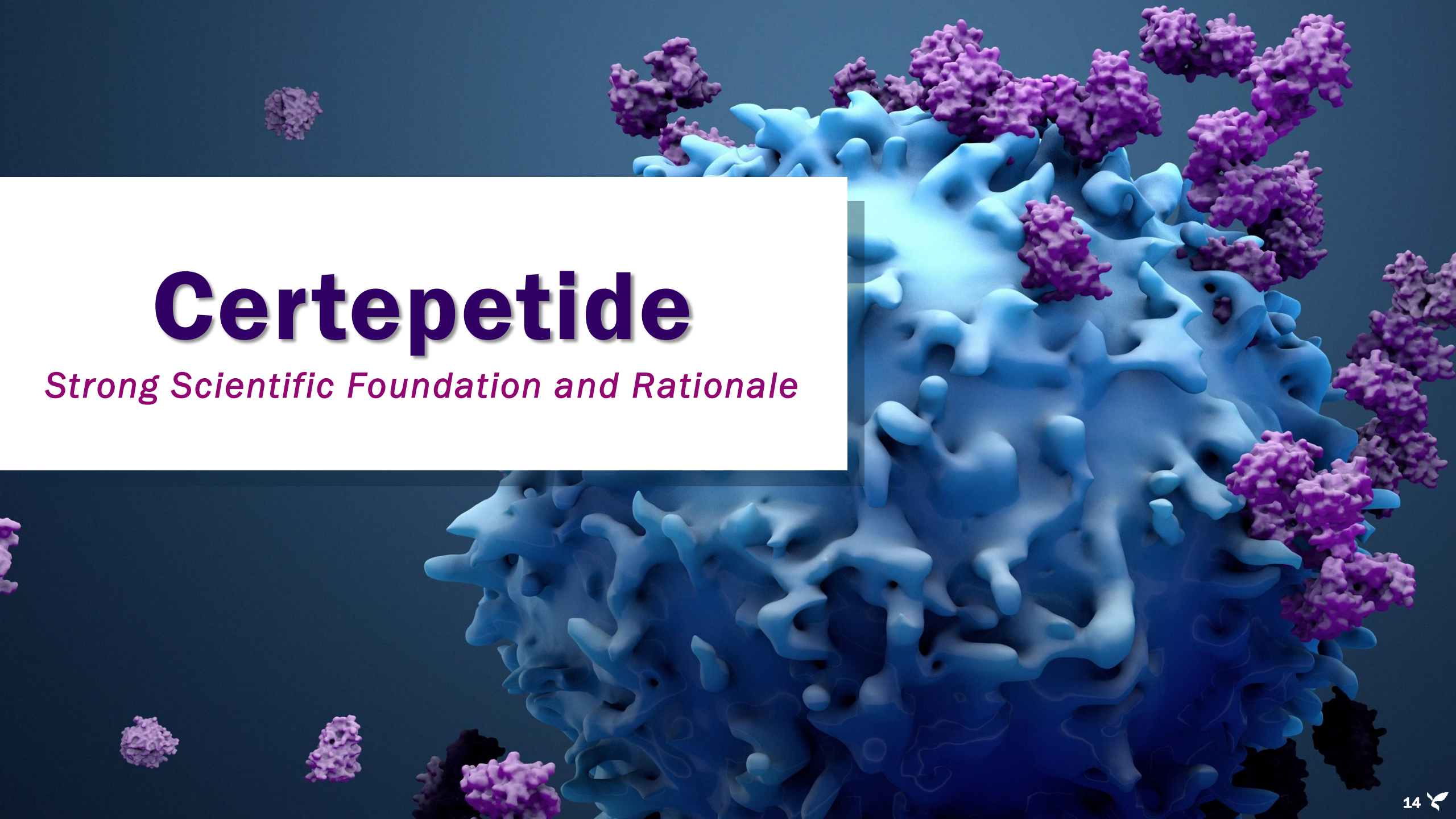
- Lisata granted Kuva exclusive worldwide rights to certepetide for use with Kuva's NanoMark technology for diagnostic tumor imaging
- Kuva assumes all development and commercialization responsibilities/costs
- Includes a $1 million upfront fee and potential ~$20 million in milestones plus royalties on sales

Qilu Pharmaceutical

- Lisata granted Qilu exclusive rights in China, Taiwan, Hong Kong and Macau
- Qilu assumes all development and commercialization responsibilities/costs in licensed territories
- Potential for additional $221 million in milestones plus royalties on sales ($15 million collected to date)

Additional partnership opportunities exist for many combinations with certepetide

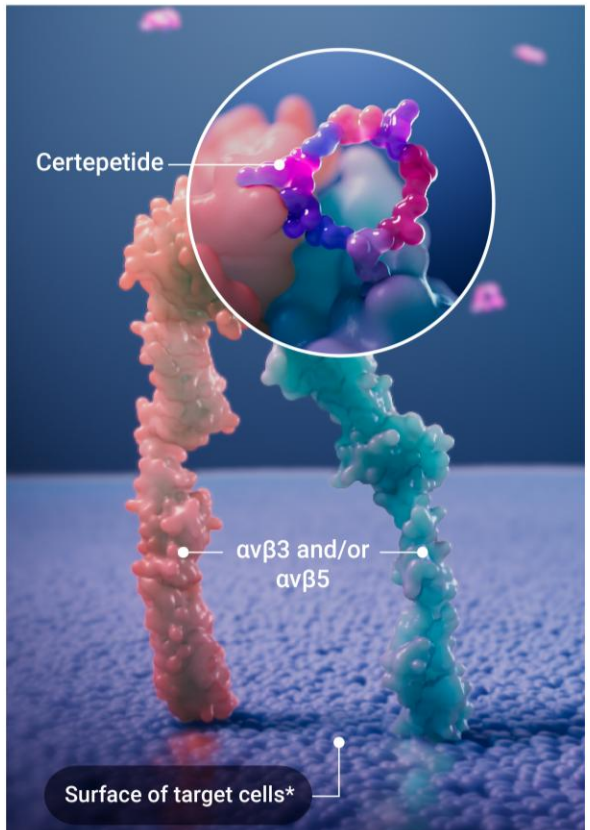
- By indication, modality of co-administered drug(s), and/or geography



Certepetide

Strong Scientific Foundation and Rationale

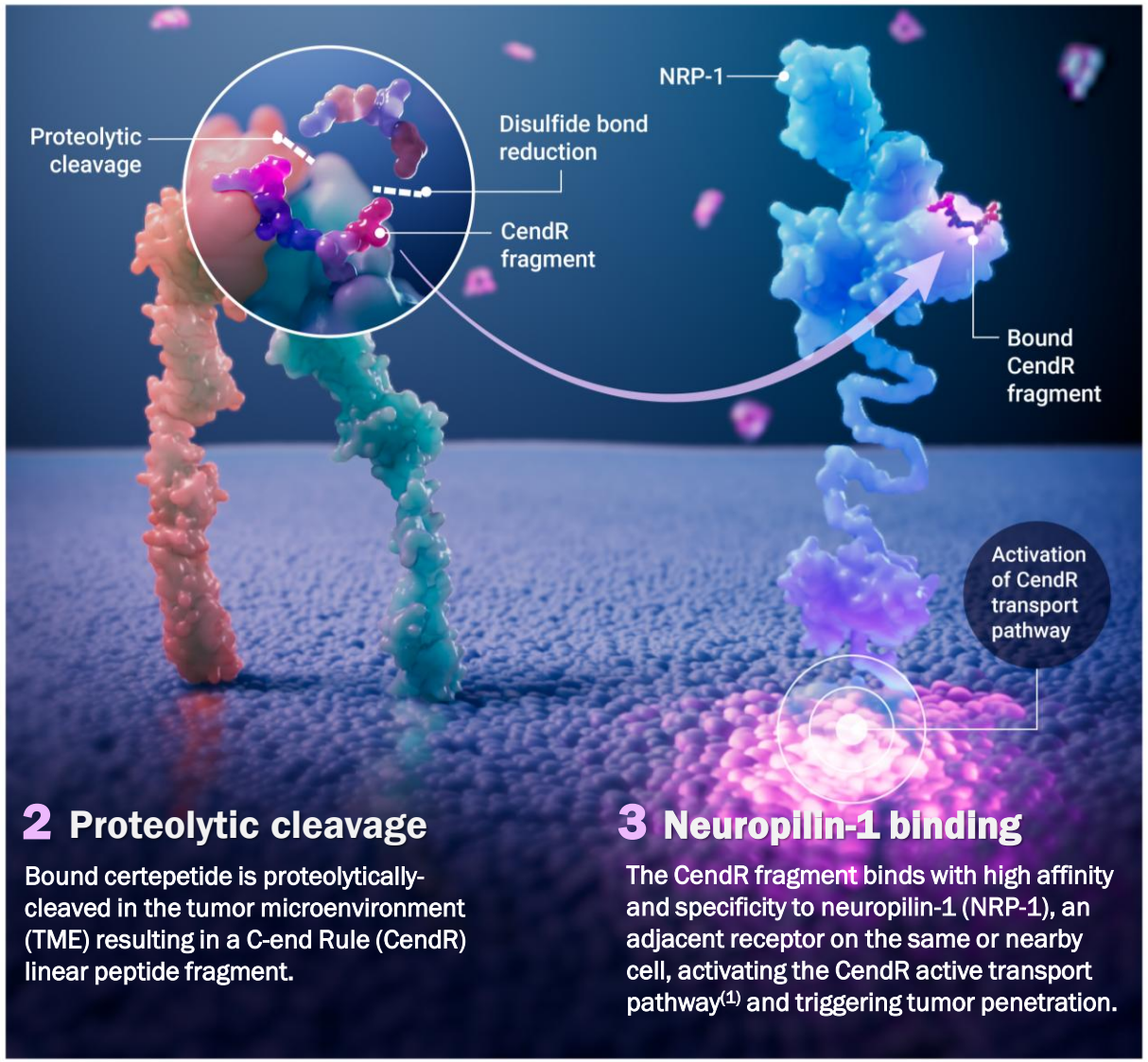
Certepetide mechanism of action: Unique, multi-step approach



1 Integrin binding

Certepetide is a 9-amino acid cyclic iRGD peptide with high binding specificity and affinity for αvβ3 and/or αvβ5 integrins that are upregulated on target cells.

**Tumor cells and tumor vascular endothelial cells (components of the tumor stroma)*

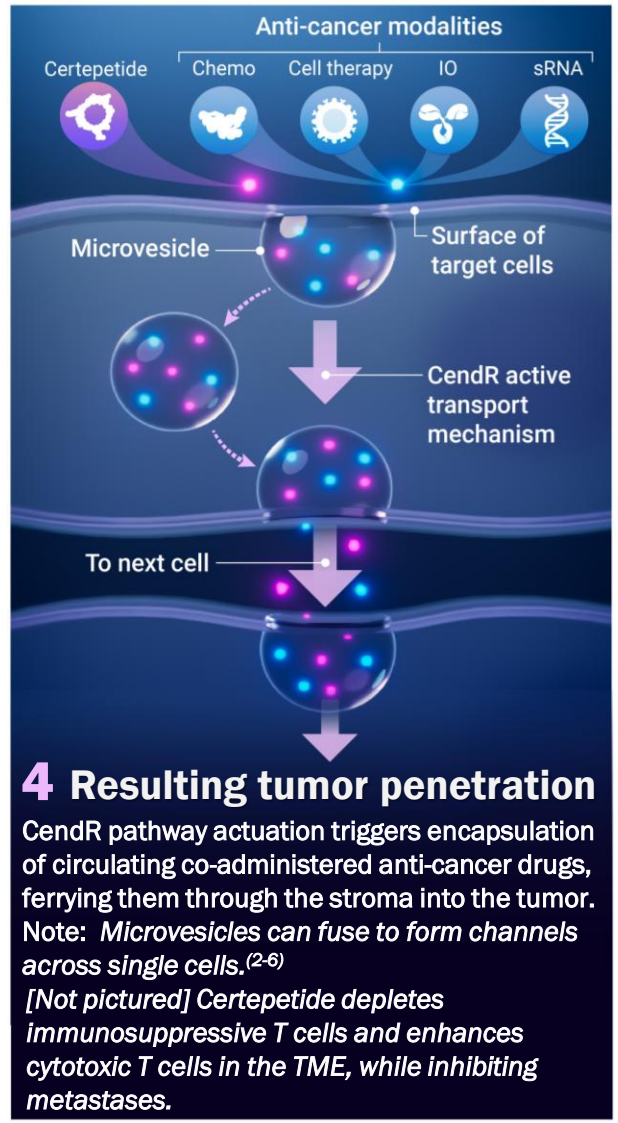


2 Proteolytic cleavage

Bound certepetide is proteolytically-cleaved in the tumor microenvironment (TME) resulting in a C-end Rule (CendR) linear peptide fragment.

3 Neuropilin-1 binding

The CendR fragment binds with high affinity and specificity to neuropilin-1 (NRP-1), an adjacent receptor on the same or nearby cell, activating the CendR active transport pathway(1) and triggering tumor penetration.



4 Resulting tumor penetration

CendR pathway actuation triggers encapsulation of circulating co-administered anti-cancer drugs, ferrying them through the stroma into the tumor.
Note: *Microvesicles can fuse to form channels across single cells.*(2-6)
[Not pictured] Certepetide depletes immunosuppressive T cells and enhances cytotoxic T cells in the TME, while inhibiting metastases.

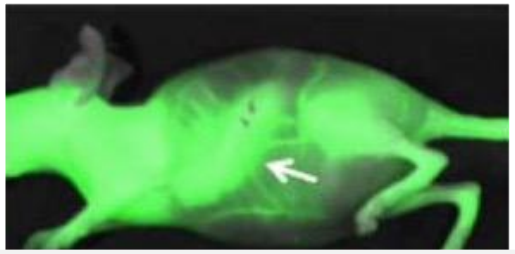
Illustration is a simplified rendition of MOA

[1] Ding et al., *Nature Comm*, 2019.
[2] Ruoslahti E. *The Journal of clinical investigation.* 2017;127(5), 1622–1624.
[3] Liu, X., et al. *J Clin Invest.* 2017;127(5):2007-2018.
[4] De Mendoza, T. H., Suzuki, K., et al. *Nature Comm,* 2021;12, 1541.
[5] Wang, C., et al. *International Journal of Nanomedicine,* 2024;19, 12633–12652.
[6] Saifi, M. A., et al. *Biochimica Et Biophysica Acta (BBA) - Reviews on Cancer*, 2023; 1878(3), 188895.

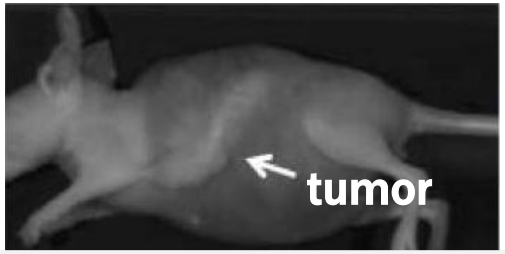
Certepetide/iRGD selectively promotes intratumoral penetration

Whole body imaging of mice with pancreatic ductal adenocarcinoma (arrow) dosed with Fluorescent Quantum Dots (FQDs) with and without certepetide[1],[2]

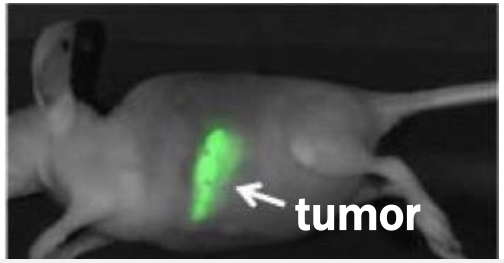
- Circulating FQDs result in whole body fluorescence
- Etching solution quenches fluorescence in circulation



FQDs

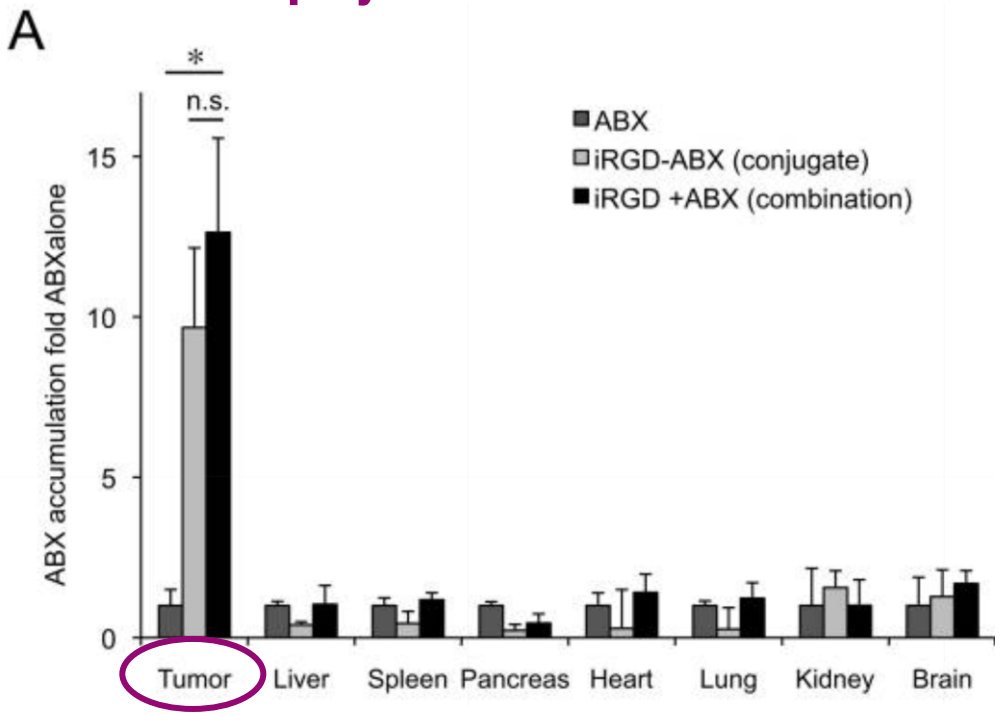


FQDs + Etching solution



Certepetide + FQDs + Etching solution

When co-administered with iRGD, nab-paclitaxel (Abraxane or ABX) is preferentially taken up by tumor tissue in mice[3]



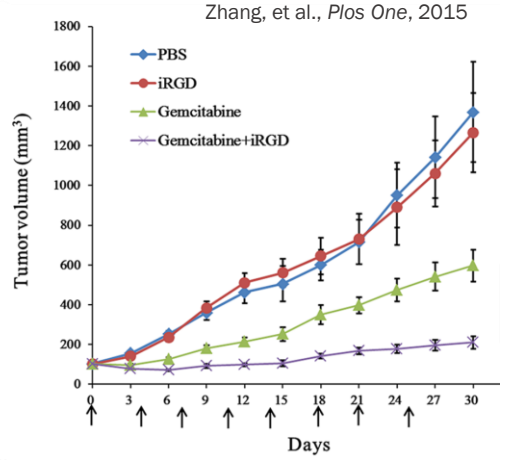
[1] Braun et al., Nature Mater. 2014.
[2] Liu, Braun et al., Nature Comm. 2017.
[3] Sugahara et al 2010.

Broad applicability & activity of certepetide/iRGD consistently demonstrated

Sampling extensive scientific literature showing improved survival

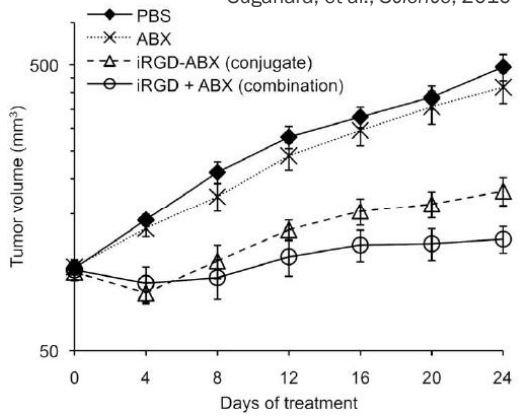
Lung cancer + gemcitabine

Zhang, et al., *Plos One*, 2015



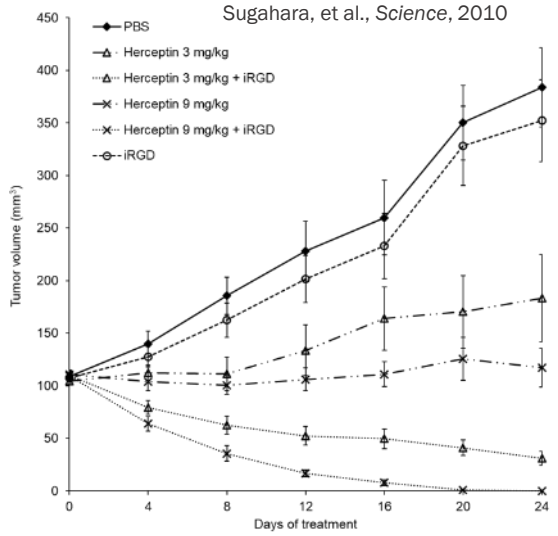
Breast cancer + nanoparticle nab-paclitaxel

Sugahara, et al., *Science*, 2010



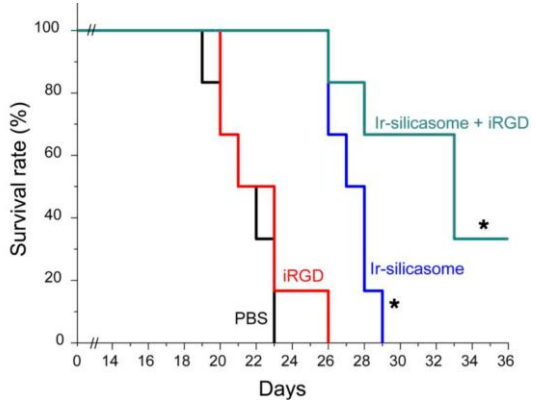
Breast cancer + Herceptin®

Sugahara, et al., *Science*, 2010



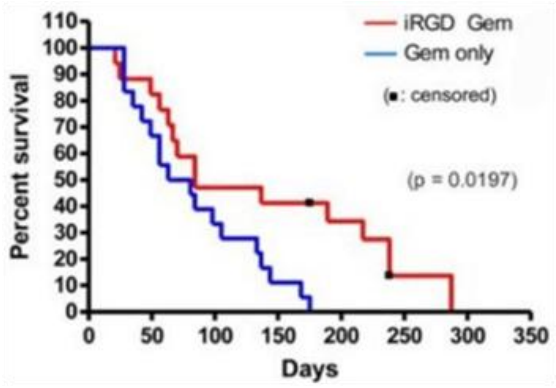
PDAC + irinotecan nanoparticles

Liu X et al., J Clin Invest, 2017



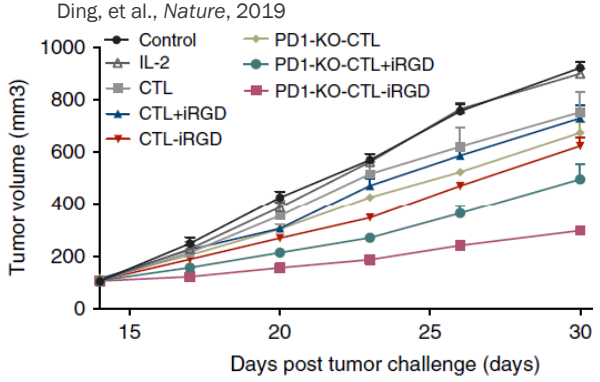
PDAC + gemcitabine

Hurtado de Mendoza et al, Nature Comms, 2021



GI cancer + adoptive cell therapy

Ding, et al., *Nature*, 2019



Certepetide/iRGD consistently improves *immunotherapy* efficacy in multiple preclinical solid tumor models

Solid Tumor Types

- Intrahepatic cholangiocarcinoma
- Pancreatic adenocarcinoma
- Prostate cancer
- Breast cancer
- Non-Small Cell Lung Cancer
- Gastric cancer
- Hepatocellular carcinoma

Preclinical Observations

- Improved overall survival
- Reduced tumor size
- Reduced and/or inhibited metastases

AACR 2025 Abstracts:

- Kim, M., Sugahara, K., et al. *iRGD peptide therapy transforms immunosuppressive microenvironment to immune-favorable state in pancreatic ductal adenocarcinoma* (https://www.abstractsonline.com/pp8/#!/20273/presentation/5422).
- Miyamura, N., Sugahara, K., et al. *A cytotoxic peptide designed for tumor-targeted delivery of co-injected molecules* (https://www.abstractsonline.com/pp8/#!/20273/presentation/3881).
- Kuroda, Y., Sugahara, K., et al. *The iRGD tumor-penetrating peptide inhibits TGF-β activation mediated by an αvβ5 integrin-rich tumor microenvironment in pancreatic cancer* (https://www.abstractsonline.com/pp8/#!/20273/presentation/5404).
- Choi, Y., Sugahara, K., et al. *Altered collagen morphology in pancreatic cancer treated with the iRGD tumor-penetrating peptide* (https://www.abstractsonline.com/pp8/#!/20273/presentation/5419).

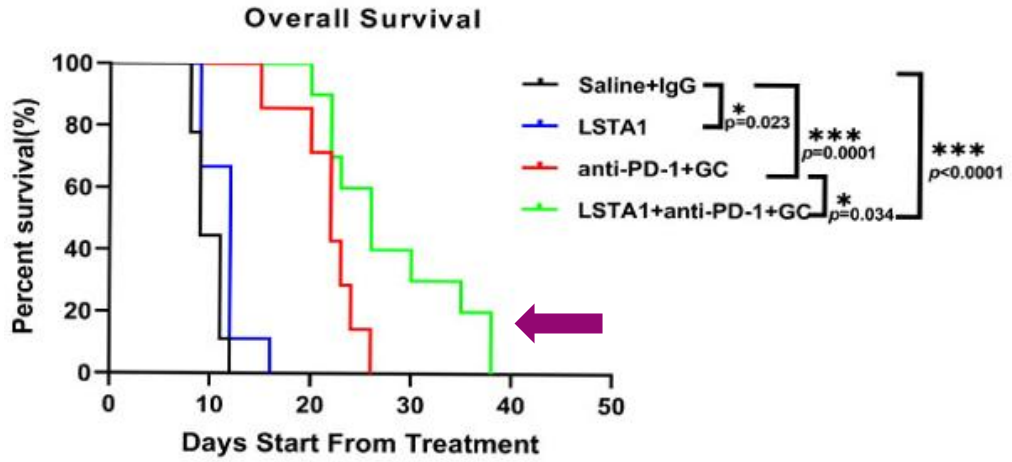
Sugahara, K., et al. bioRxiv 2023.05.24.542137; doi: https://doi.org/10.1101/2023.05.24.542137
Yuan, D., Duda, D., et al. 2024 CCA Foundation Conference. Poster: *Enhancing the efficacy of standard therapy in intrahepatic cholangiocarcinoma using LSTA1, a novel tumor targeting and penetration agent.*

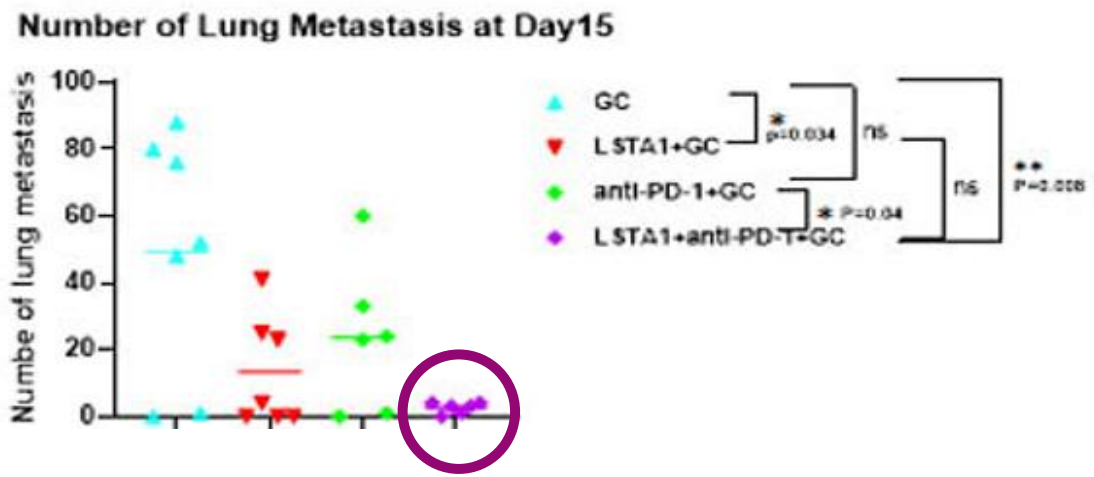
Sugahara, et al. 2015; Sugahara, et al. 2010
Yang, et al. 2019a; Yang, et al. 2019b
Zhang et al 2016b
Dong, et al. 2023

Certepetide improves immunotherapy impact in cholangiocarcinoma

- Intrahepatic cholangiocarcinoma (ICC) has an immunosuppressive TME and a dense desmoplastic stroma with abnormal vasculature which together impede anti-cancer agent efficacy
- Lung metastases often lead to a significant decline in survival
- Human ICC SoC (gemcitabine/cisplatin/durvalumab) efficacy improved with certepetide in murine model

ICC mouse model





**Certepetide was formerly known as LSTA1*

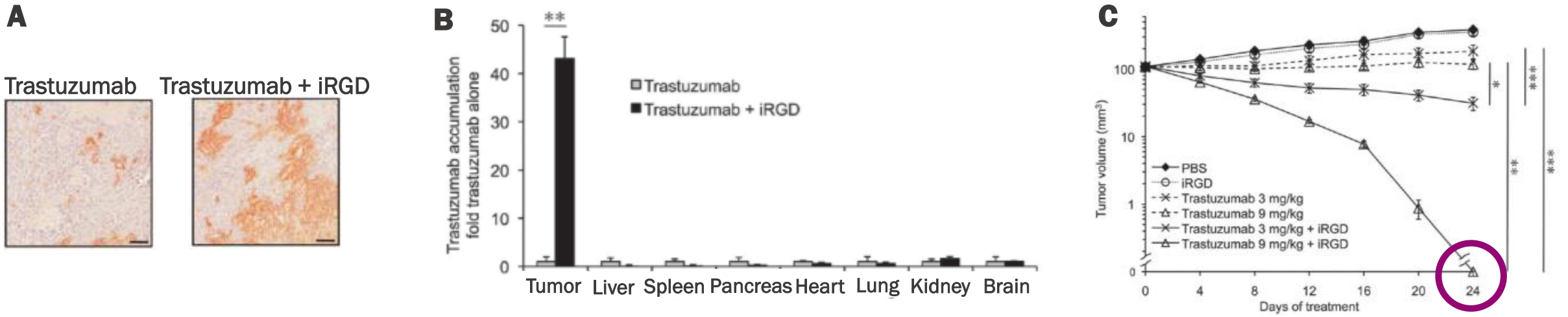
Certepetide combined with chemo- and immunotherapy improves survival, reduces morbidity and inhibits metastasis in cholangiocarcinoma mouse model

Yuan, D., Duda, D., et al. CCA Foundation Conf. (2024) Poster. *Enhancing the efficacy of standard therapy in intrahepatic cholangiocarcinoma using LSTA1, a novel tumor targeting and penetration agent*

iRGD enhances selective tumor penetration of trastuzumab

Mouse model injected with human BT474 breast tumors

Trastuzumab is a monoclonal Ab that inhibits HER2



- Panel A shows greater staining for trastuzumab in breast cancer tissue with iRGD
- Panel B shows remarkable selectivity for tumor tissue with iRGD
- Panel C shows iRGD co-administered with trastuzumab leads to **tumor shrinkage**

Sugahara, et al. 2010

Certepetide is a proprietary iRGD; experiments denoting iRGD use a non-proprietary certepetide analog with differs in structure by a single acetyl group.

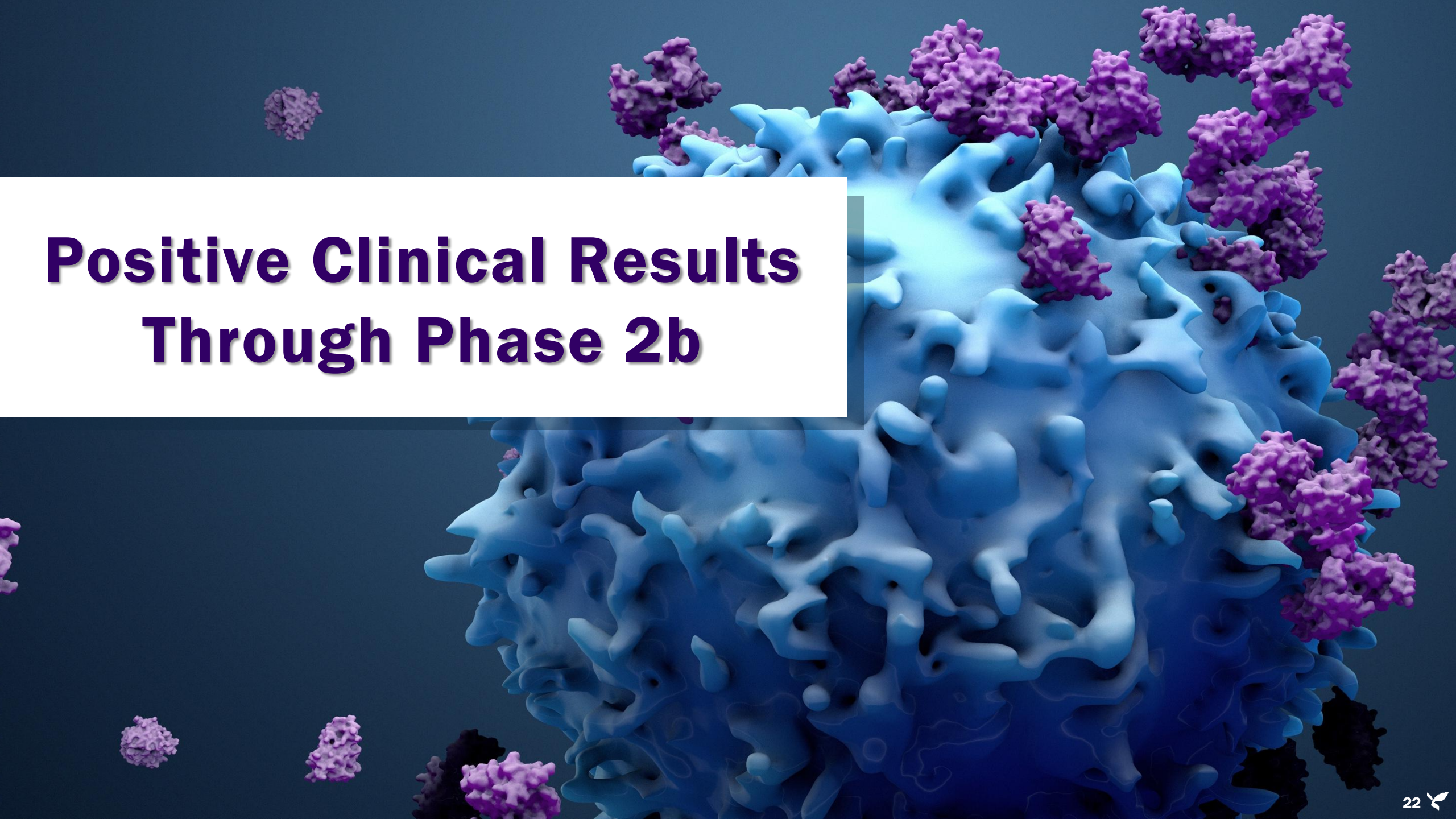
Certepetide development strategy: A two-pillar approach

Pursue rapid global registration in mPDAC, initially combined with gemcitabine/nab-paclitaxel standard-of-care (SoC)

- *Positive ASCEND Phase 2b preliminary results*
- *End-of-Phase 2 FDA meeting completed*
  - *Phase 3 study protocol and development plan agreed*
- *Phase 3 preparations underway*

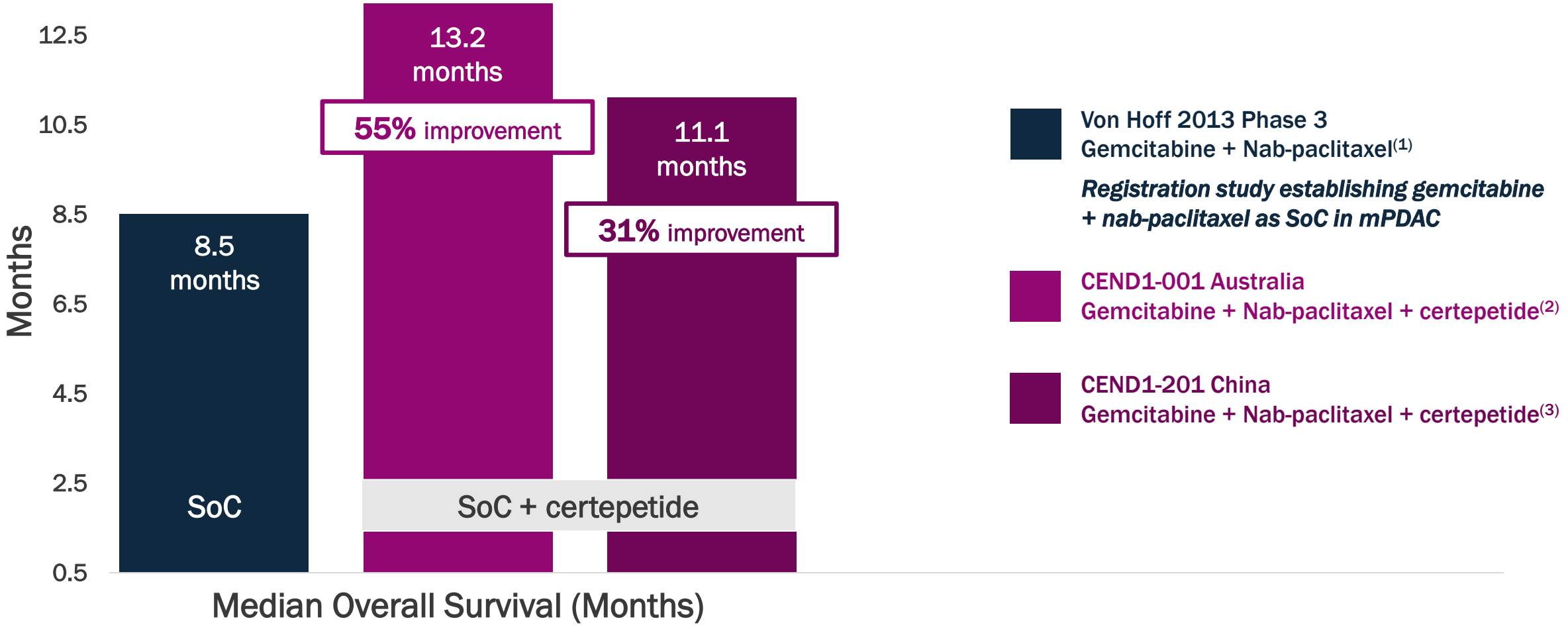
Demonstrate certepetide effectiveness when combined with a variety of other SoC regimens (e.g., chemotherapy, immunotherapy, etc.) in a variety of solid tumors

- *Multiple Phase 2a studies underway*



Positive Clinical Results Through Phase 2b

Certepetide improved survival in mPDAC in two independent, multicenter Phase 1b/2a trials



[1] Von Hoff D, et al., *New England Journal of Medicine*, 2013.
[2] Dean A, et al., *The Lancet Gastroenterology & Hepatology*, 2022
[3] QILU Pharmaceutical

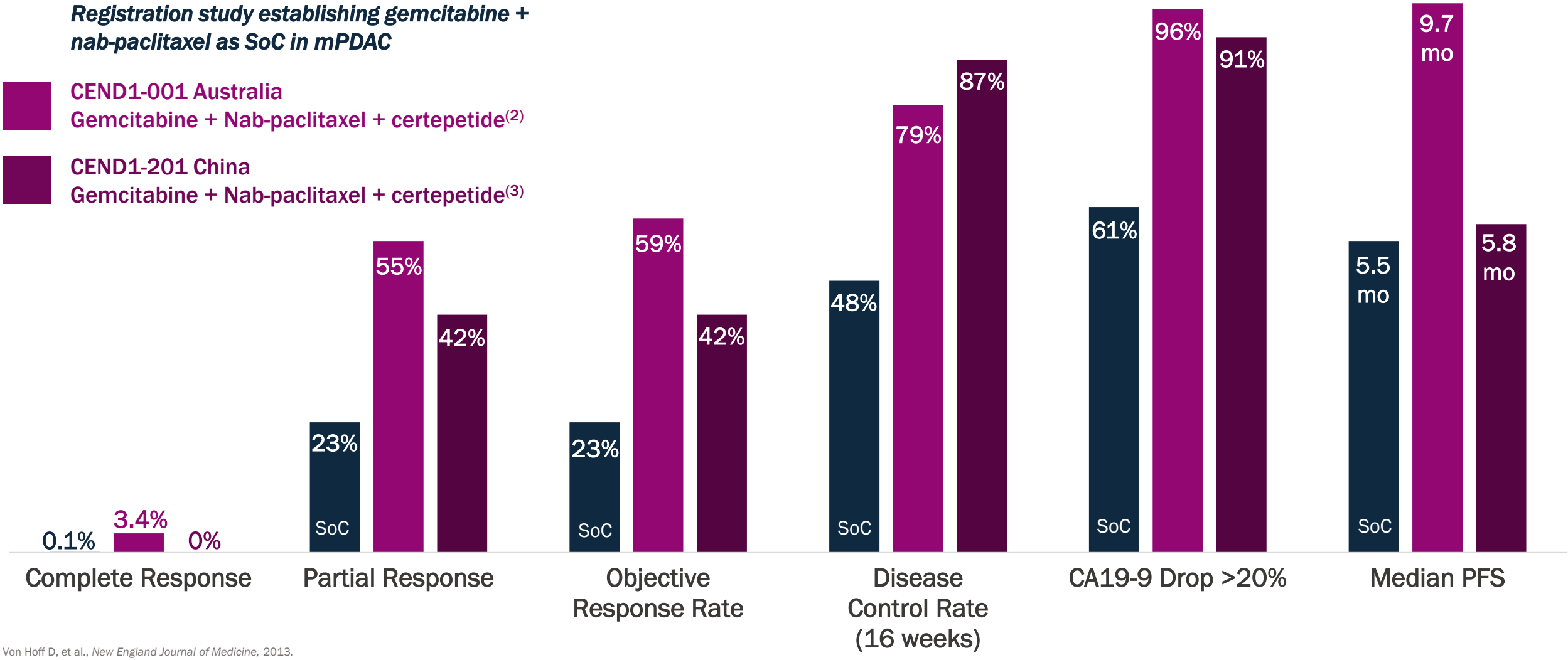
Certepetide demonstrated internal consistency in two Phase 1b/2a trials

Von Hoff 2013 Phase 3
Gemcitabine + Nab-paclitaxel[1]

Registration study establishing gemcitabine + nab-paclitaxel as SoC in mPDAC

CEND1-001 Australia
Gemcitabine + Nab-paclitaxel + certepetide[2]

CEND1-201 China
Gemcitabine + Nab-paclitaxel + certepetide[3]



[1] Von Hoff D, et al., *New England Journal of Medicine*, 2013.
[2] Dean A, et al., *The Lancet Gastroenterology & Hepatology*, 2022
[3] QILU Pharmaceutical

ASCEND: Phase 2b study of certepetide in mPDAC

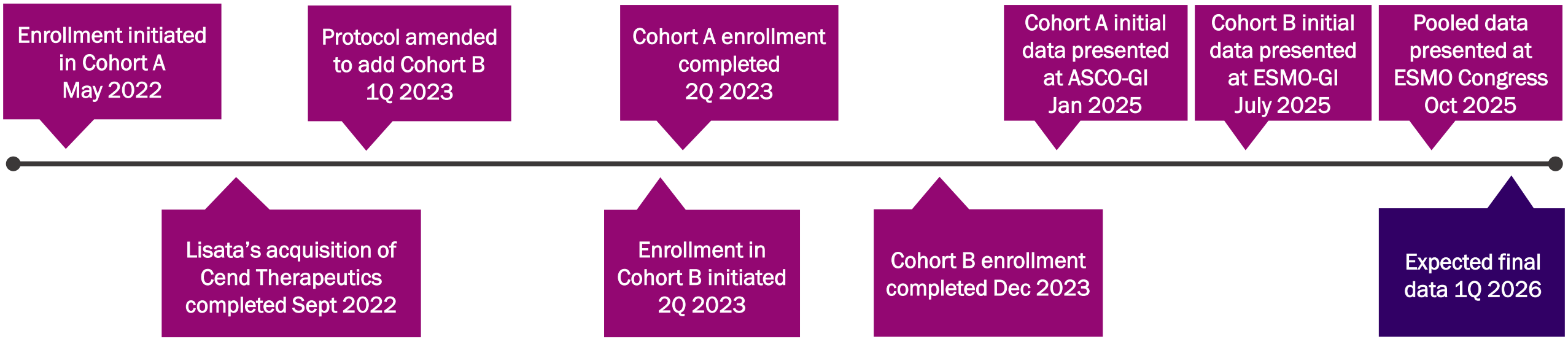
Investigator initiated trial *inherited* through acquisition of Cend Therapeutics

- **Sponsor:** Australasian Gastro-Intestinal Trials Group (AGITG) and NHMRC Clinical Trials Centre of University of Sydney (Australia)
  - Lisata-funded, data contractually sponsor-controlled
    - Restricts initial public announcement of results to scientific meetings or publications
- **'Academic design'** overlooked global regulatory standards supporting eventual approval
  - **Powered for 6-mos. PFS primary endpoint**
    - **Not a standard regulatory endpoint**
  - **Single cohort with one IV push of certepetide 3.2 mg/kg + SoC vs. SoC alone**

Lisata *amended* protocol to ensure trial data will support global registration strategy

- **Lisata** clinical trial data rights defined/expanded
- **'Product development design'** considers eventual regulatory review and approval
  - **Median overall survival (precedent registration endpoint)** added for both cohorts
  - **Second cohort (Cohort B) added with two IV pushes of certepetide 3.2 mg/kg administered 4 hours apart** to further evaluate pharmacodynamics of certepetide consistent with FDA Project Optimus

ASCEND: Phase 2b study chronology



ASCEND: Cohort A Progression-Free Survival data

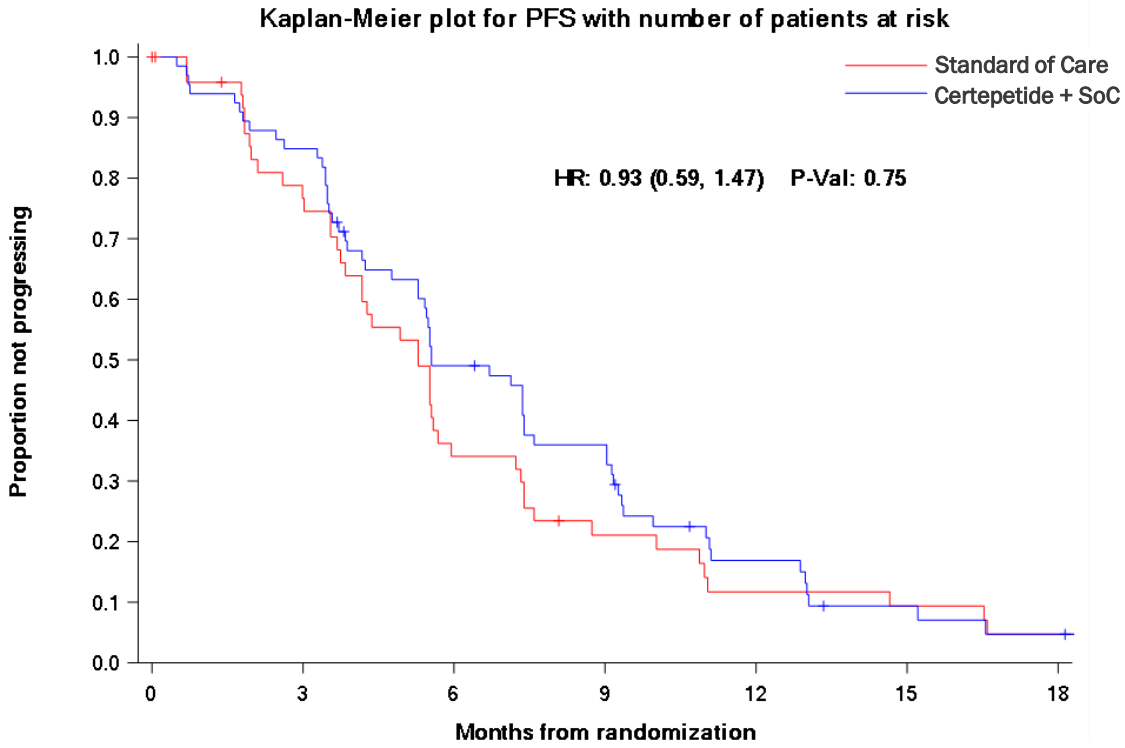
Data cut-off date: February 28, 2025

Cohort A

ONE IV PUSH OF CERTEPETIDE + SoC

- Cohort A ***powered*** for 6-month PFS
- No statistically significant improvement shown with certepetide
- *Data mature* - 91% (86 out of 95 patients with Progressive Disease or Death)

Cohort A: Progression-Free Survival (PFS) Data



Treatment arm	N	Median PFS in months (95% CI)
Certepetide	66	5.55 (5.29, 7.39)
Standard of Care*	50	5.29 (3.84, 5.68)

*Combined placebo participants from both cohorts

ASCEND: Cohort A Overall Survival data

Data cut-off date: February 28, 2025

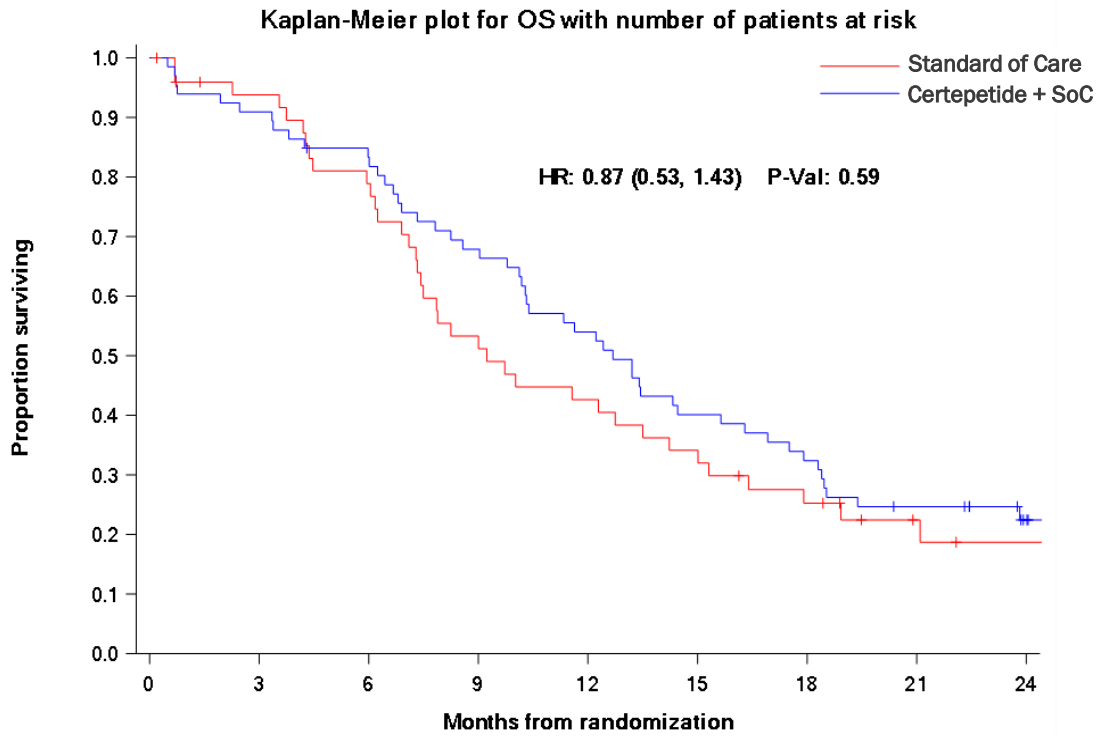
Cohort A

ONE IV PUSH OF CERTEPETIDE + SoC

- Cohort A ***not powered*** for OS
- *Data mature* - 76% (72 deaths out of 95)
- mOS numerically favors certepetide (12.68 vs. 9.23 months); separation occurs at 7 months similar to NAPOLI-3
- Cohort A ORR* data favors certepetide
  - Certepetide – 4 complete responses
  - Placebo – 0 complete responses

*ORR: Objective Response Rate

Cohort A: Overall Survival (OS) Data



Treatment arm	Participants	Median OS in months (95% CI)
Certepetide	66	12.68 (10.18, 16.30)
Standard of Care*	50	9.23 (7.33, 13.50)

*Combined placebo participants from both cohorts

ASCEND: Cohort B Progression-Free Survival data

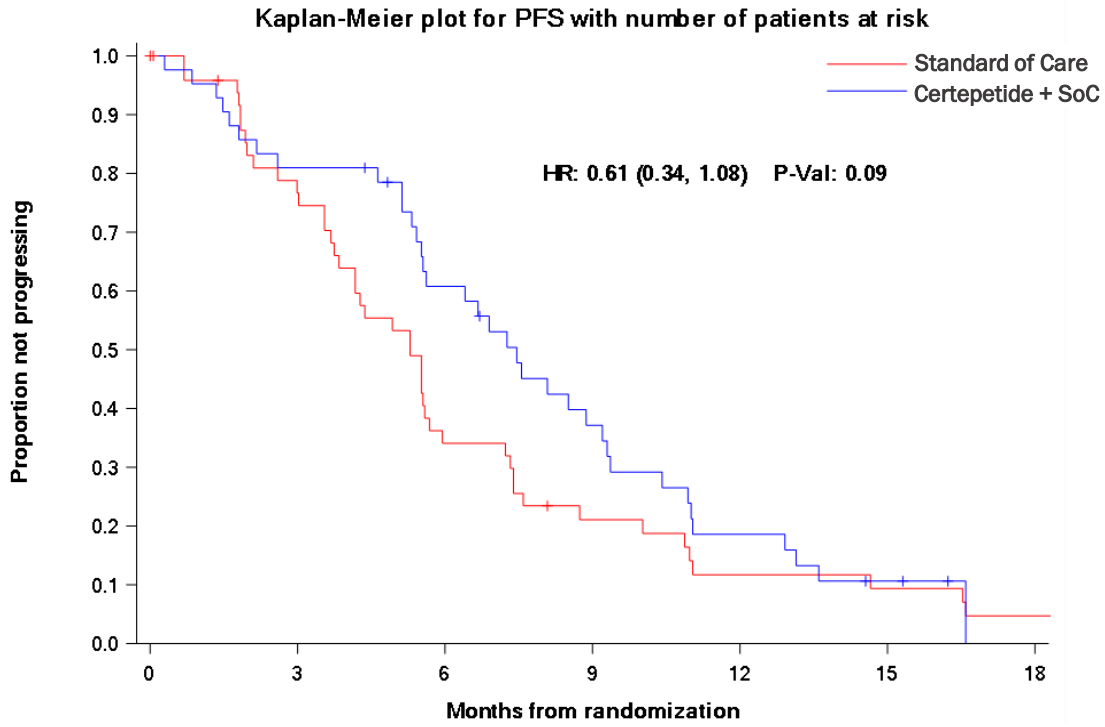
Data cut-off date: February 28, 2025

Cohort B

TWO IV PUSHES OF CERTEPETIDE 4 HOURS APART + SoC

- Cohort B ***not powered*** for PFS
- Data mature
- **Despite not being powered, mPFS in Cohort B *nears statistical significance* favoring certepetide over placebo (7.46 vs 5.29 months) HR 0.61, p=0.09**

Cohort B: Progression-Free Survival (PFS) Data



Treatment arm	N	Median PFS in months (95% CI)
Certepetide	42	7.46 (5.52, 9.20)
Standard of Care*	50	5.29 (3.84, 5.68)

**Combined placebo participants from both cohorts*

ASCEND: Cohort B Overall Survival data

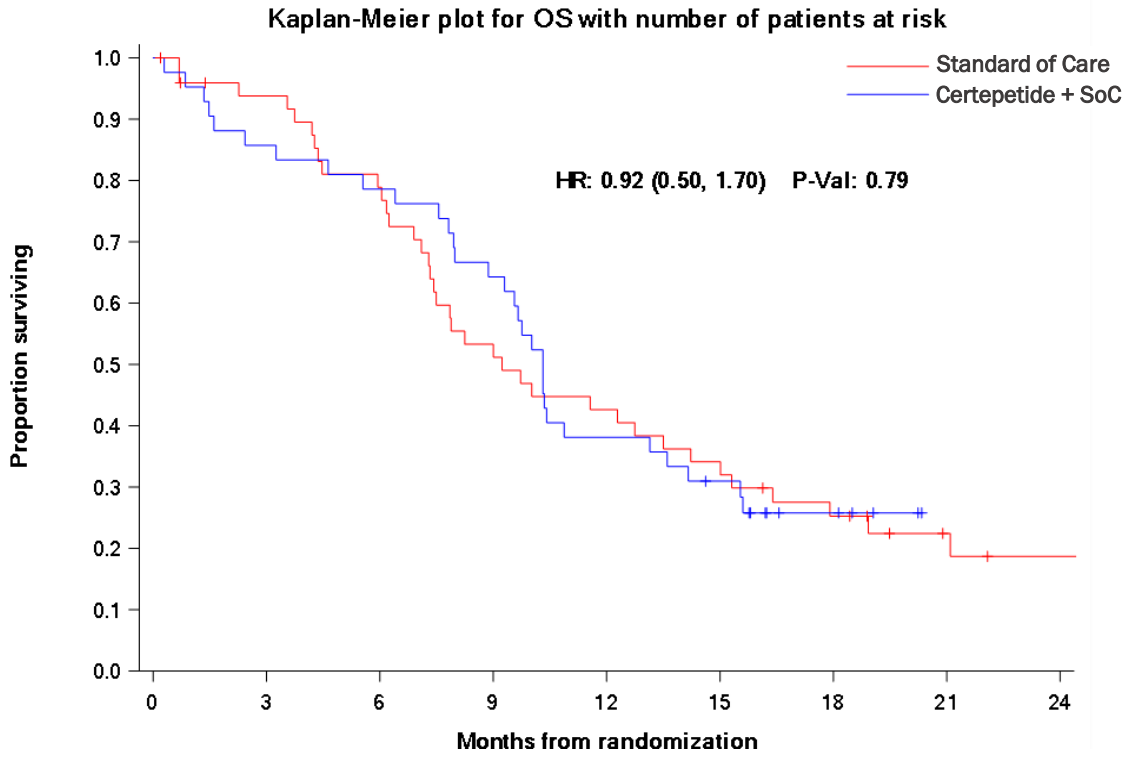
Data cut-off date: February 28, 2025

Cohort B

TWO IV PUSHES OF CERTEPETIDE 4 HOURS APART + SoC

- Cohort B ***not powered*** for OS
- *Data mature* - 71% (45 deaths out of 63)
- **mOS favors certepetide (10.32 vs. 9.23 months)**
  - Separation occurs at 7 months similar to NAPOLI-3 NALIRIFOX Phase 3 study data
- Cohort B ORR favors certepetide (see next slide)
  - (CR + PR) 45% vs 19% certepetide vs placebo; 1 CR certepetide, 0 CR placebo group

Cohort B: Overall Survival (OS) Data



Treatment arm	Participants	Median OS in months (95% CI)
Certepetide	42	10.32 (8.87, 13.14)
Standard of Care*	50	9.23 (7.33, 13.50)

**Combined placebo participants from both cohorts*

Cohort B Time to Treatment Failure (TTF) and Duration of Treatment

Data cut-off date: December 30, 2024

Cohort B

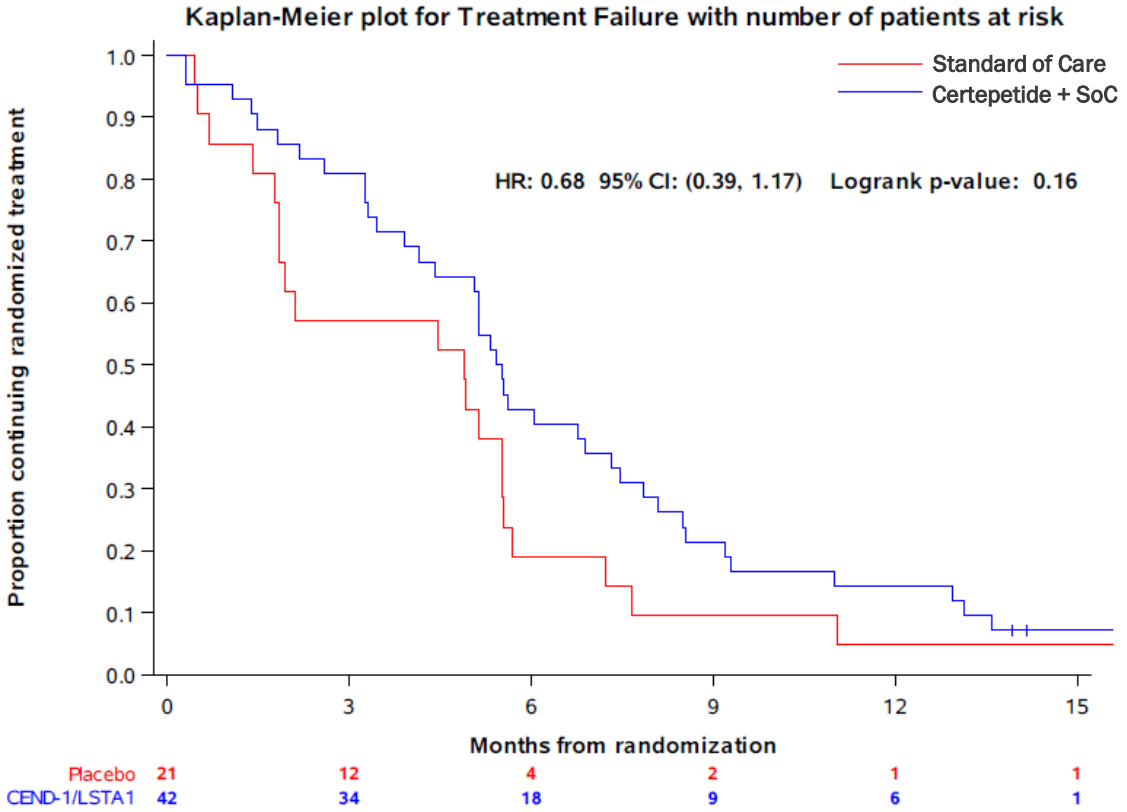
TWO IV PUSHES OF CERTEPETIDE 4 HOURS APART + SoC

- TTF and Treatment duration favor certepetide

Treatment arm	Treatment Failures	Median TTF months (95% CI)
Certepetide	40/42	5.47 (4.47, 6.90)
Standard of Care	20/21	4.90 (1.90, 5.52)

Treatment arm	Average Treatment Duration months (95% CI)
Certepetide	5.00 (3.77, 6.65)
Standard of Care	3.32 (2.09, 4.96)

Cohort B: Time To Treatment Failure and Treatment Duration



ASCEND: Most Common Adverse Events (All Grades)

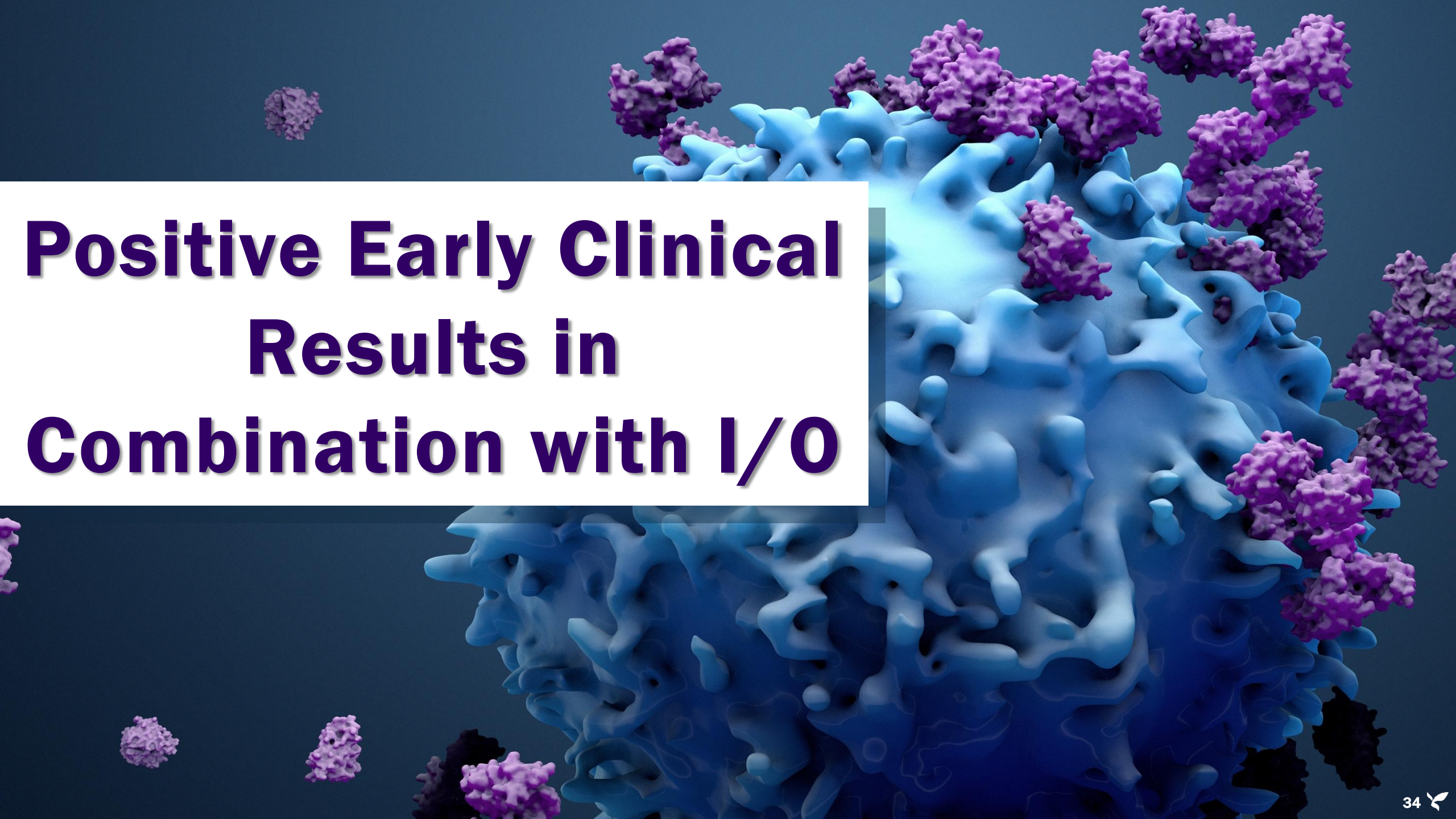
Adverse Event (AE)	Pooled Standard of Care n=49	Cohort A CERT n=65	Cohort B CERT n=42
Fatigue	29 (59.18%)	48 (73.85%)	34 (80.95%)
Peripheral sensory neuropathy	22 (44.90%)	35 (53.85%)	24 (57.14%)
Neutrophil count decreased	22 (44.90%)	23 (35.38%)	21 (50.00%)
Nausea	21 (42.86%)	35 (53.85%)	26 (61.90%)
Anemia	21 (42.86%)	30 (46.15%)	24 (57.14%)
Diarrhea	20 (40.82%)	25 (38.46%)	21 (50.00%)
Vomiting	18 (36.73%)	10 (15.38%)	10 (23.81%)
Constipation	17 (34.69%)	29 (44.62%)	21 (50.00%)
Alopecia	17 (34.69%)	30 (46.15%)	18 (42.86%)
Fever	15 (30.61%)	29 (44.62%)	11 (26.19%)
Edema limbs	15 (30.61%)	20 (30.77%)	16 (38.10%)
Platelet count decreased	14 (28.57%)	25 (38.46%)	21 (50.00%)
Abdominal pain	14 (28.57%)	20 (30.77%)	11 (26.19%)
ALT increased	13 (26.53%)	20 (30.77%)	14 (33.33%)
Rash maculo-papular	11 (22.45%)	18 (27.69%)	14 (33.33%)

**Top 15 AEs, greater than 30% in any column*

Certepetide improves clinical outcomes in mPDAC with benign safety profile

Certepetide Clinical Data Summary to Date

- Two Phase 1b/2a clinical trials (CEND1-001 in Australia and CEND1-201 in China) demonstrate that **certepetide plus SoC chemotherapy improves overall survival in *metastatic* PDAC akin to the recently FDA approved NALIRIFOX triplet therapy**
- Certepetide is well tolerated with cumulative adverse events reflecting companion therapy
- mOS in Cohort A numerically favored certepetide as did ORR (4 CRs vs 0)
- mPFS in Cohort B nears statistical significance favoring certepetide over placebo 7.46 vs 5.29 months) HR 0.61, p=0.09
- Cohort B mOS favored certepetide (10.32 vs 9.23 months) corroborating clinical benefit
- Cohort B ORR favored certepetide
  - Excluding unknown/early withdrawal/death, ORR *statistically significant* favoring certepetide
  - 50.0% certepetide treated patients had complete or partial response vs 21.1% placebo
  - 1 Complete Response in the certepetide group compared to zero in the placebo group
- Certepetide treated subjects stayed on treatment longer (5.00 vs 3.22 months)



Positive Early Clinical Results in Combination with I/O

iLSTA: Phase 1b/2a trial in locally advanced PDAC with chemo & IO

Phase 1b/2a proof-of-concept safety and early efficacy study of LSTA1 in combination with durvalumab, gemcitabine and nab-paclitaxel, as first-line treatment in *locally advanced non-resectable* pancreatic ductal adenocarcinoma

Randomize

Cohort 1
Gemcitabine + nab-paclitaxel + Placebo LSTA1 + Placebo durvalumab
N=5

Cohort 2
Gemcitabine + nab-paclitaxel + LSTA1 + Placebo durvalumab
N=5

Cohort 3
Gemcitabine + nab-paclitaxel + LSTA1 + durvalumab
N=up to 20

EUS Biopsy
Screening

12 weeks

Primary Endpoint

8 weeks tumor burden assessments until 24 months or recurrence

12 month
Follow-up

24 months
Follow-up completion

EUS & Biopsy
At weeks 12-16

Tumor burden assessment at screening, cycle 2, and then 8-weekly thereafter. Patients are treated with 28-day cycles until surgery, definitive radiotherapy, unacceptable toxicity, progression or death
Endpoints: safety, DLT, ORR, PFS, OS, DoR, immune profiling

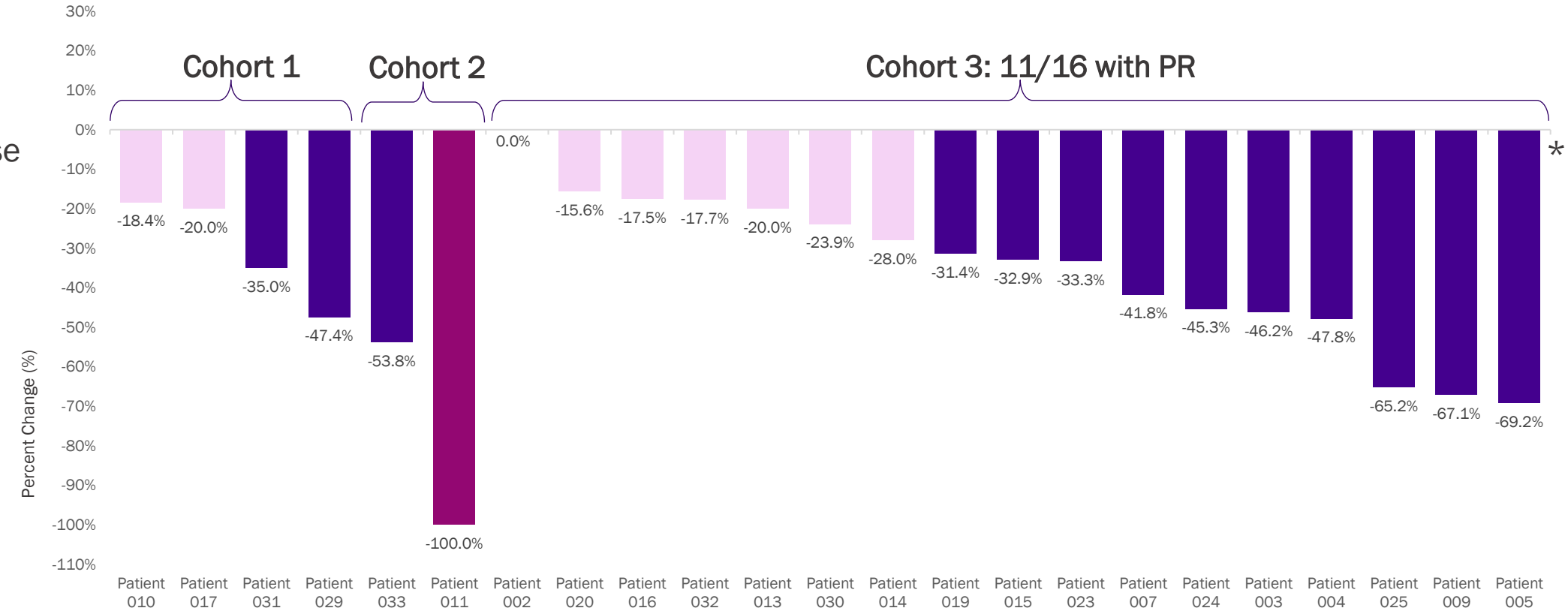
- **Sponsor:** WARPNINE, Inc. - funding trial
- **Timing:** Final 6-month PFS/OS data expected 1Q 2026

gemcitabine 1000mg/m^2 : Days 1, 8, 15 in 28-day cycles
nab-paclitaxel 125mg/m^2: Days 1, 8, 15 in 28-day cycles
durvalumab 750mg: Days 1 and 15 in 28-day cycles
certepetide 3.2 mg/kg/ Placebo: Days 1, 2, 8, 15, 16 in 28-day cycles

Preliminary Efficacy as of May 2025 – Best Overall Response Rate

Cohort 3: Overall Response Rate 69%
Disease Control Rate 100%

Key:
- Stable disease
- Partial response
- Complete response



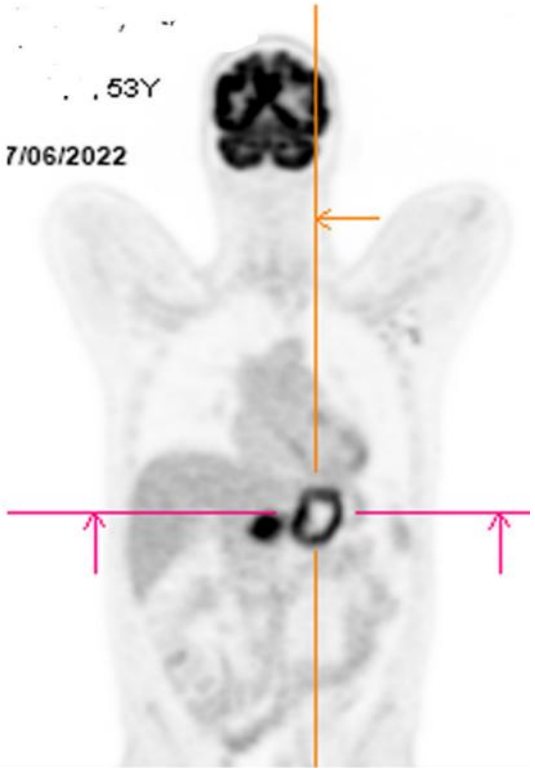
*N=20 patients treated: N=1 patient (032) without baseline measurement

Remarkable evidence of certepetide activity in other solid tumors

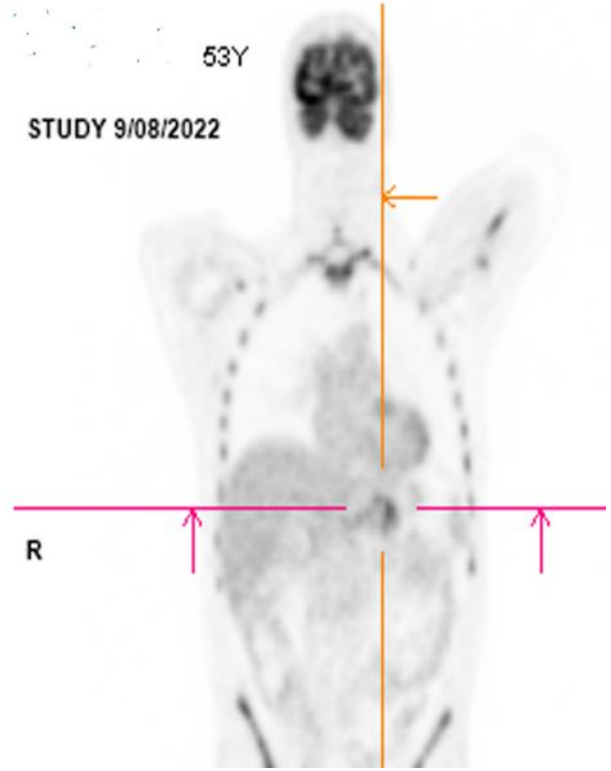
Certepetide potentiated a complete response in metastatic gastroesophageal adenocarcinoma (mGEAC)

- 53-year-old male with mGEAC with significant (> 5cm) nodal metastases (June 2022)
- SoC combination chemotherapy (FOLFIRINOX) and radiotherapy, with immunotherapy (pembrolizumab) later added, resulting in partial response
- Certepetide added to above regimen at cycle 7 and exploratory laparoscopy after cycle 18 (September 2022) showed **no discernable disease**
- **37+ months with sustained <u>complete response</u>**

FDG-PET* scan June 2022



FDG-PET scan Sept. 2022



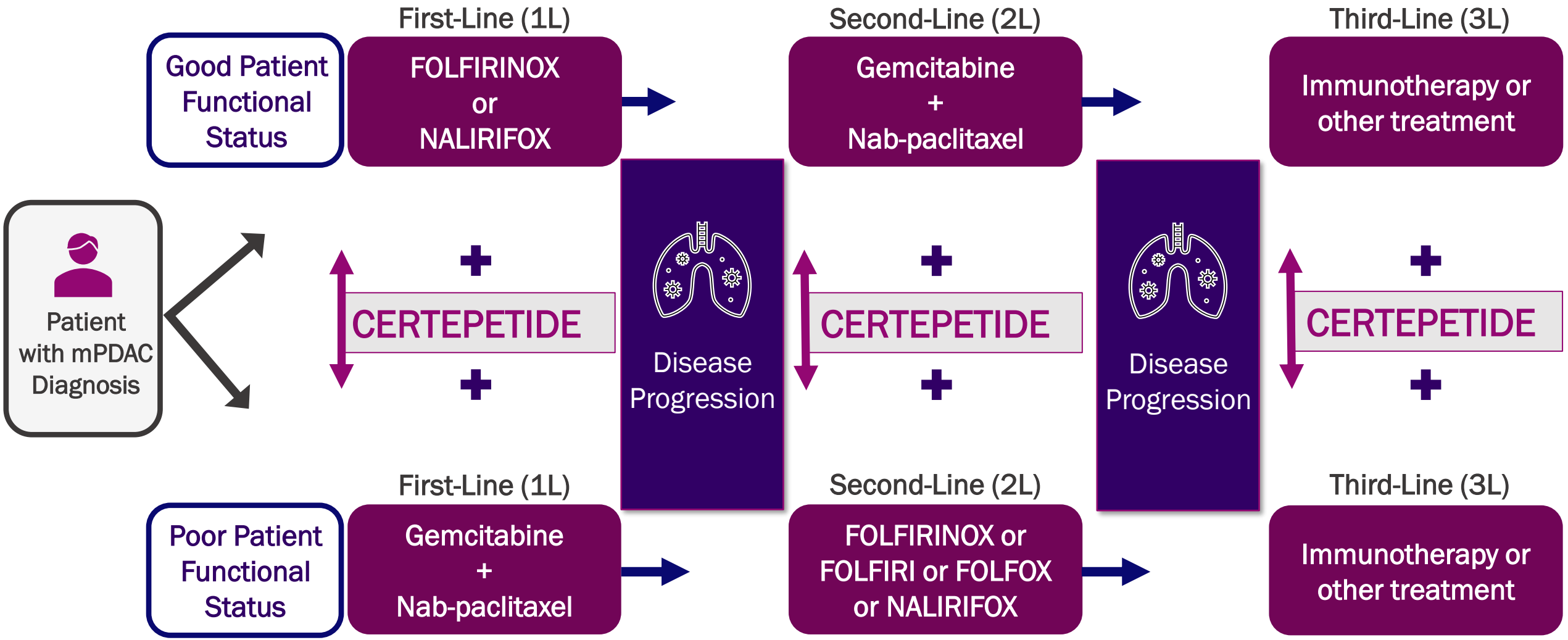
Reduction in FDG activity demonstrated(1)

**Fluorodeoxyglucose (FDG)-positron emission tomography (PET)*

[1] Buck, K.K, Dean, A., McSweeney, T. LSTA1 Potentiates Complete Response in Metastatic Gastroesophageal Adenocarcinoma. Oncol Cancer Case Rep. 2023, 9(6), 001-003

Attractive Commercial Opportunity

Certepetide can be used throughout the mPDAC treatment paradigm



Certepetide's broad value proposition beyond mPDAC

Breadth of Applicability

Oncologic applications:

- *Locally advanced* PDAC - a population recognized as non-responsive to checkpoint inhibition - Improved clinical outcomes demonstrated
- **Metastatic gastroesophageal cancer** - a sustained **complete response shown**
- Other tumor types (**cholangiocarcinoma, GBM, CRC, appendiceal**) – clinical tolerance demonstrated
- Preclinical study ongoing in combination with an oncolytic virus + checkpoint inhibitor in **melanoma**

Non-oncologic applications:

- Cancer diagnostics
- Black Lung Disease

Certepetide's Commercial Prospects

- Well-characterized, de-risked, in later stage development
- Capital efficient, rational & broad clinical development plan
- Efficacy agnostic to co-administered treatment
  - Combination therapy complementary not competitive with existing and/or emerging anti-cancer agents Existing commercial partnerships
- Additional commercial partnership opportunities exist
  - By region
  - By combination product
  - By indication

Certepetide special regulatory designations and benefits

FDA Fast Track Designation

- ***Pancreatic cancer (FDA)***

- Eligible for *Accelerated Approval, Priority Review and Rolling Review*
- Provides for program-specific guidance from and frequent communication with FDA

FDA Rare Pediatric Disease Designation

- ***Osteosarcoma (FDA)***

- Eligible for *Priority Review Voucher* upon approval; redeemable for a priority review for any subsequent marketing application, or may be sold or transferred
- Vouchers have sold recently for $75-$100 million and, historically, for up to $350 million

Orphan Drug Designations

- ***Pancreatic cancer (FDA & EMA)***
- ***Malignant glioma (FDA)***
- ***Osteosarcoma (FDA)***
- ***Cholangiocarcinoma (FDA)***

- Eligible for tax credits, marketing exclusivity, fee waivers and development grants
- Provides for specialized regulatory assistance from FDA's Office of Orphan Products Development

**Priority Review Voucher program expires September 2026 and may not be renewed*

Poised for Global Phase 3 Initiation

Requisite clinical development steps completed in preparation for Phase 3 trial

- ☑ Full NDA-ready preclinical toxicology package
- ☑ Phase 1 dose ranging study in 1L mPDAC
  - No DLTs observed; safety profile consistent with co-administered SoC
  - Certepetide improved all efficacy endpoints compared to SoC
- ☑ Second independent Phase 1 study in in 1L mPDAC in different geography
  - Improvement in mOS effect corroborated
- ☑ FDA end-of-Phase 1 meeting completed: agreement on tox package, comparator, endpoints, and patient population for NDA
- ☑ Large Phase 2b (ASCEND) study in 1L mPDAC completed
  - Effect size for Phase 3 estimated
- ☑ FDA end-of-Phase 2 meeting held; agreement reached on Phase 3 program and development plan
- ☑ Clinical operations and CMC readiness for Phase 3 underway

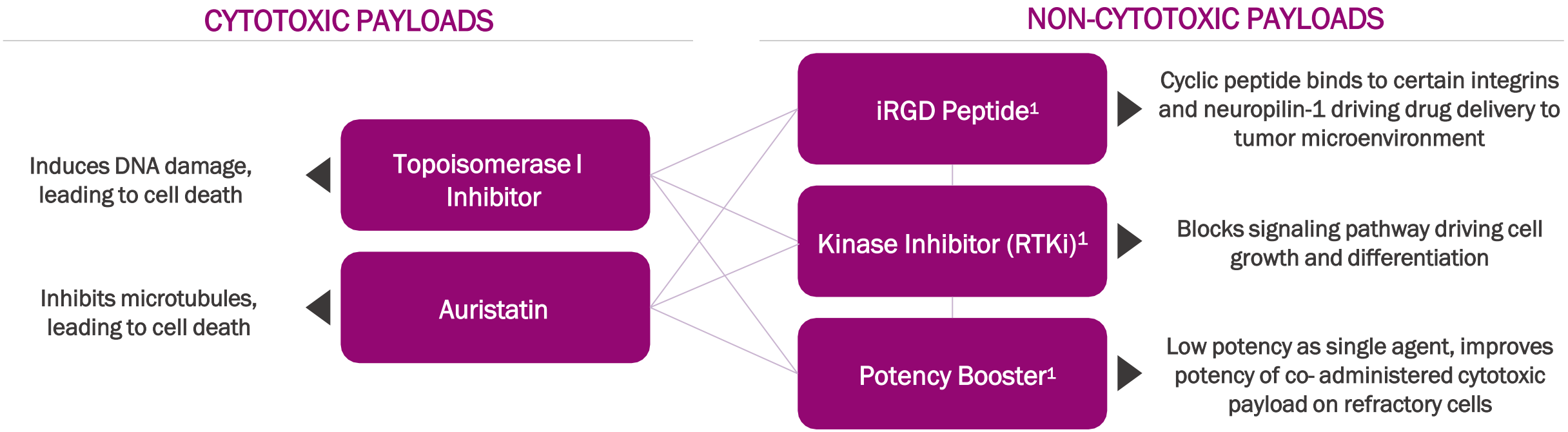
mPDAC Phase 3 study design agreed with FDA

- Global Phase 3, open-label, randomized clinical trial evaluating the efficacy and safety of certepetide in combination with standard of care (gemcitabine and nab-paclitaxel) vs. standard of care alone in patients with 1L mPDAC
- N=657 patients (+/- 50 depending on event rate)
  - Primary endpoint: Overall Survival
  - 90% Power, HR of 0.75
  - 18 months accrual (assuming 0.2 patients/site/month), 16 months observation period
  - 183 clinical sites in ~15 countries
- Open-label study acceptance precedent with global health authorities (e.g., NAPOLI-3)
- End-of-Phase 2 FDA meeting held May 21, 2025 – FDA agreement with study key elements
- FDA amenable to addition of multiple dosing arms (e.g., continuous infusion)

Catalent Preclinical Data

SMARTag® Enhanced Conjugates

SMARTag® Enhanced Conjugates Feature Multiple Payload MOAs on a Single ADC



- SMARTag platform enables the **combination of these 5 different mechanisms of action** as duets or triplets in different formats depending on the indication to generate **completely new classes of ADCs**
- SMARTag-enabled novel payload combinations **yield greater potency with a lower dose of cytotoxic payload**
- As most payload classes are compatible with the SMARTag platform, the **payload panel can be readily expanded**

1. First-in-Class Payload MOA

Current ADC Delivery Challenges Relate to Limitations of Passive Antibody Tumor Penetration

CURRENT ADC DELIVERY CHALLENGE

Inherent limitations of vascular permeability and/or binding site barrier set upper limit to % of injected antibody- based drugs reaching the tumor

IRGD-CONJUGATE VALUE PROPOSITION

Increasing the % injected ADC dose delivered to the tumor would widen the therapeutic index by delivering more payload to the tumor without increasing the total ADC dose

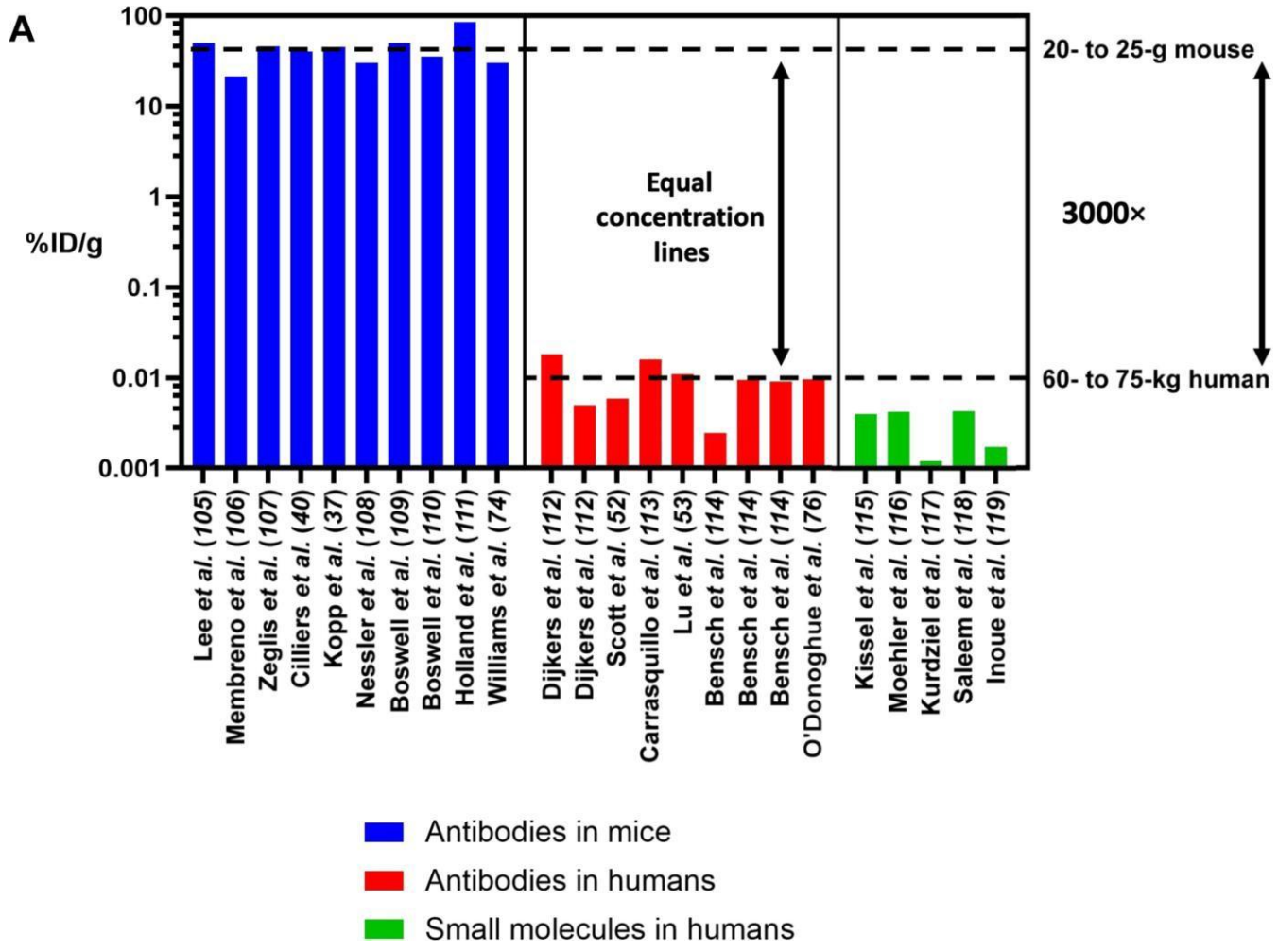
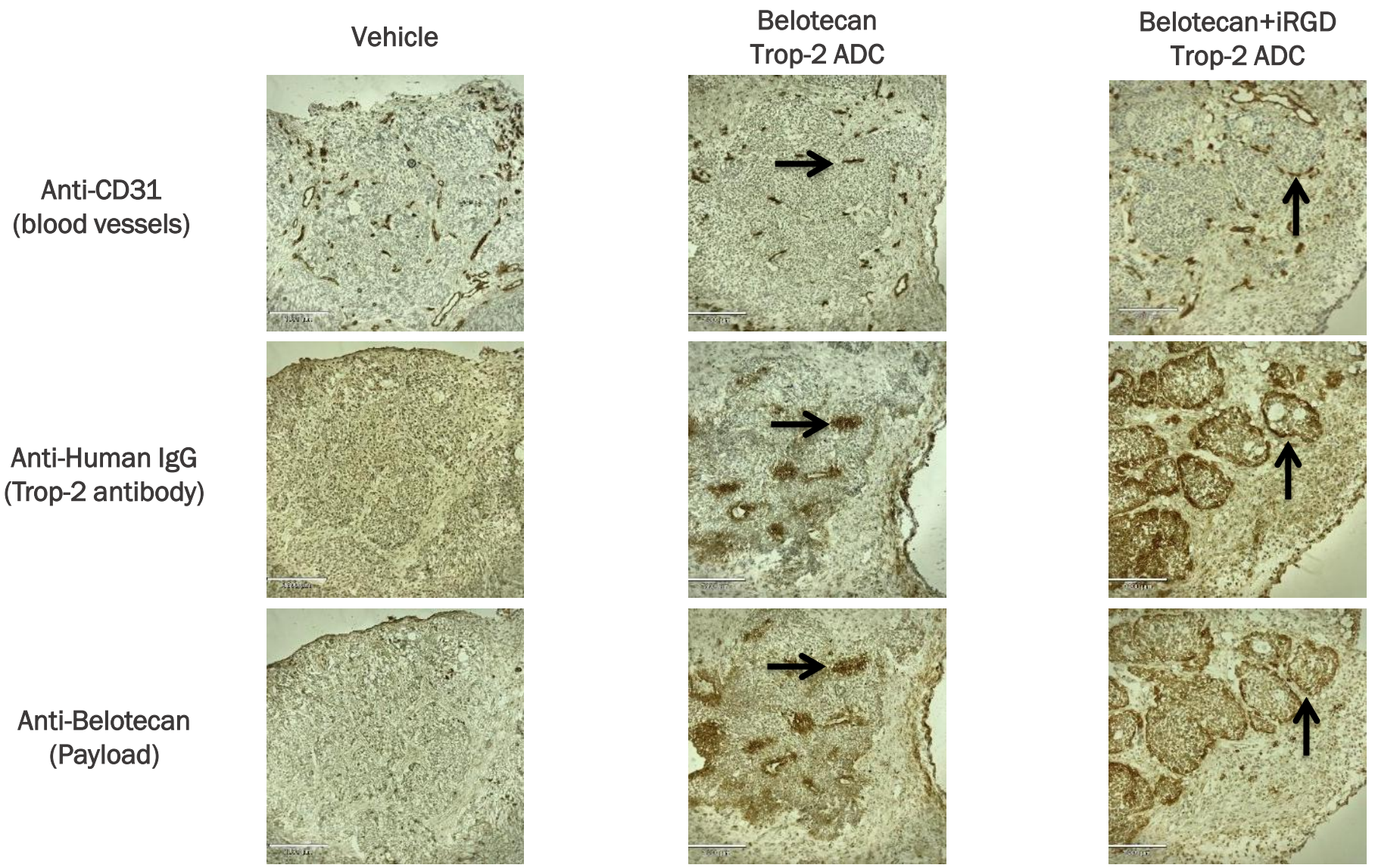


Figure from Clinical translation of antibody drug conjugate dosing in solid tumors from preclinical mouse data
Baron Rubahamya https://orcid.org/0000-0002-9116-0848, Shujun Dong, and Greg M. Thurber
Science Advances, 31 May 2024, Vol 10, Issue 22

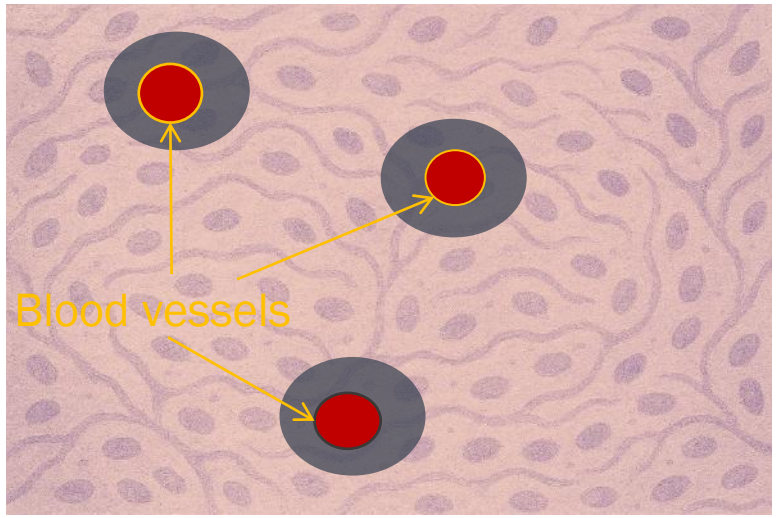
ADC Incorporating iRGD Payloads Demonstrates Altered Intra-Tumor Distribution



- BxPC-3 tumors from Day 4 post-dose
- ADCs dosed at 3 mg/kg
- Arrows indicate CD31+ blood vessels and the same areas in adjacent tumor sections

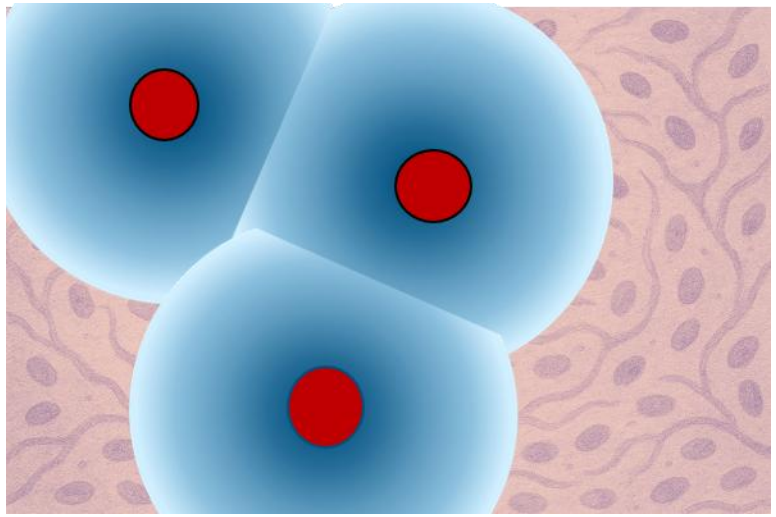
iRGD/Certepetide* can Alter the Distribution of ADC Payload Within a Tumor

Without iRGD/Certepetide

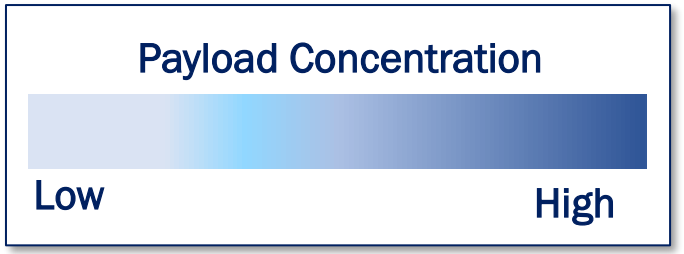


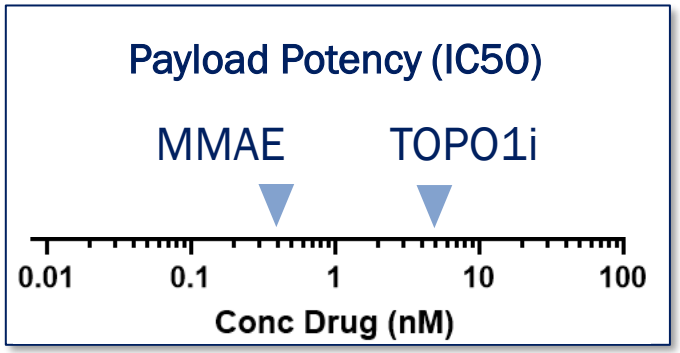
Limited ADC penetration beyond vasculature; denser payload distribution per cell

With iRGD/Certepetide



ADC penetrates deeper into the tumor; lower payload distribution per cell

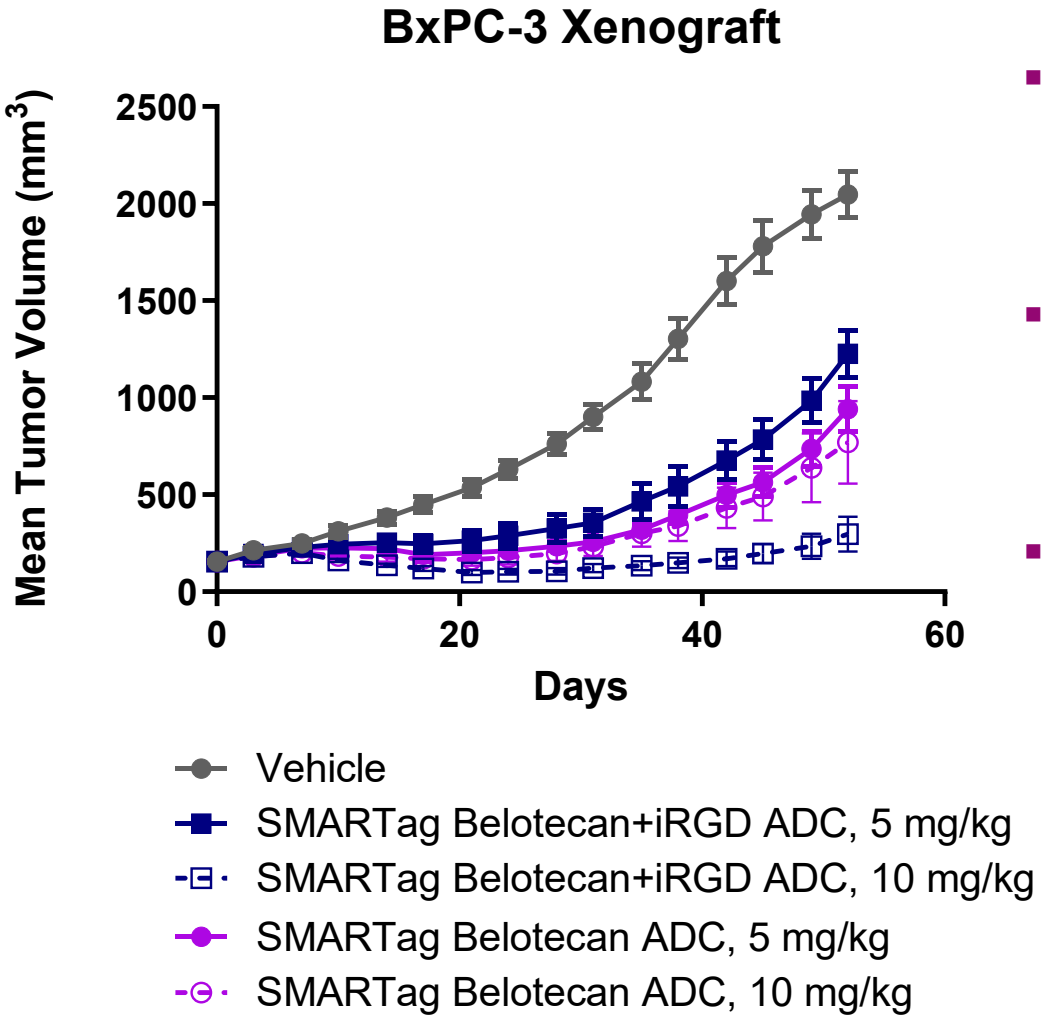




- Payload potency and distribution determine efficacy
- ADC DAR and dosing can be adjusted to optimize outcomes

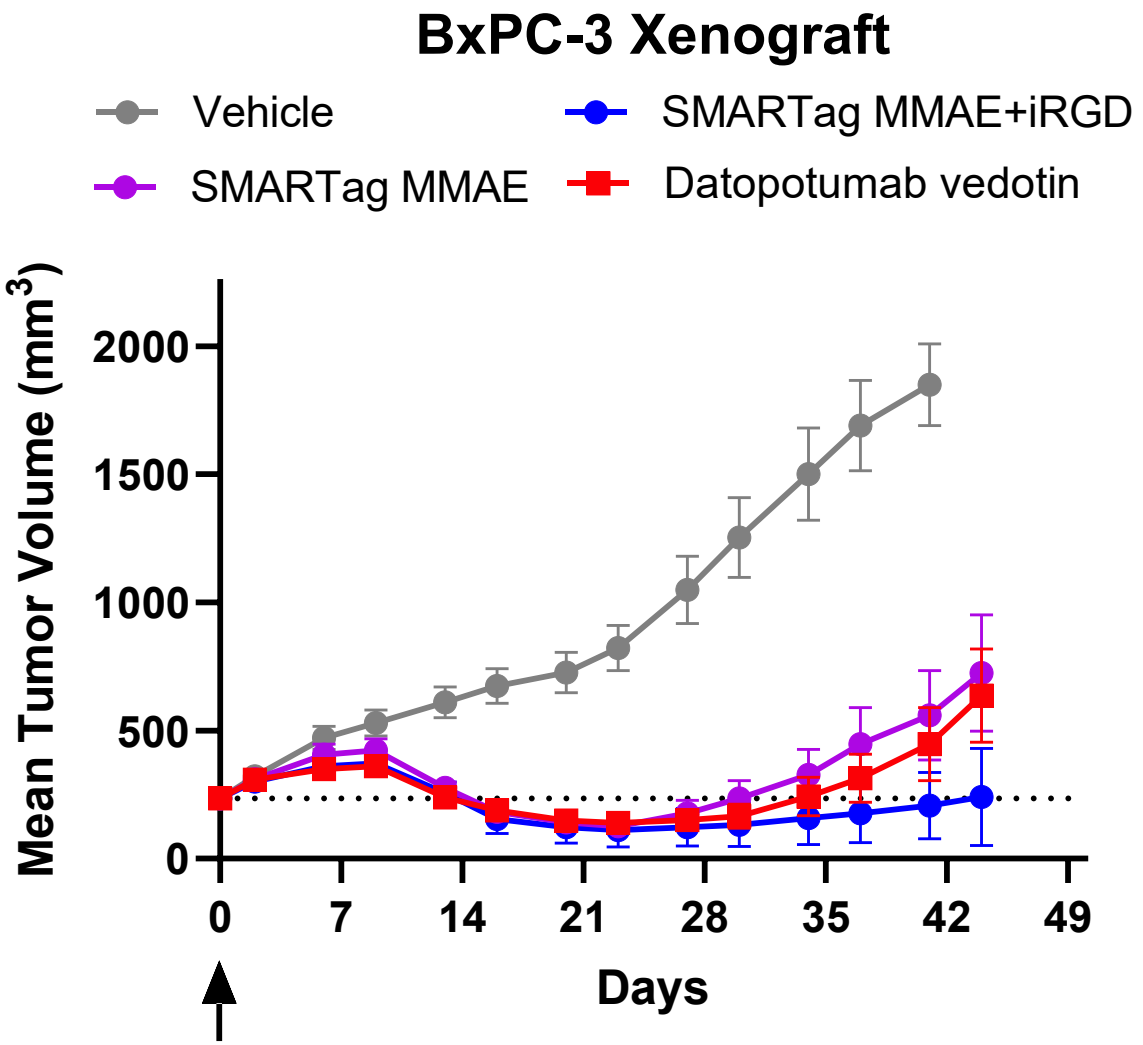
*Catalent licensed worldwide, non-exclusive rights to develop and commercialize bioconjugate products containing certepetide and its analogs from Lisata Therapeutics

TOPOi + iRGD DAR[4+4] ADC Demonstrates Dose Responsive Efficacy Not Observed With TOPOi DAR4 ADC



- Single-payload TOPOi (belotecan) ADCs (no iRGD enhancement) show no dose response, suggesting failure to deliver additional payload to the tumor at higher dose
- By contrast, enhanced DAR[4+4] ADCs incorporating both TOPOi and iRGD demonstrate a clear dose response, with enhanced efficacy at the higher dosages
- Together, the results support iRGD as an additional mechanism for driving TOPOi ADC payload delivery to the tumor

SMARTag® MMAE + iRGD DAR[2+2] ADC Demonstrates Enhanced Efficacy Compared to MMAE ADCs

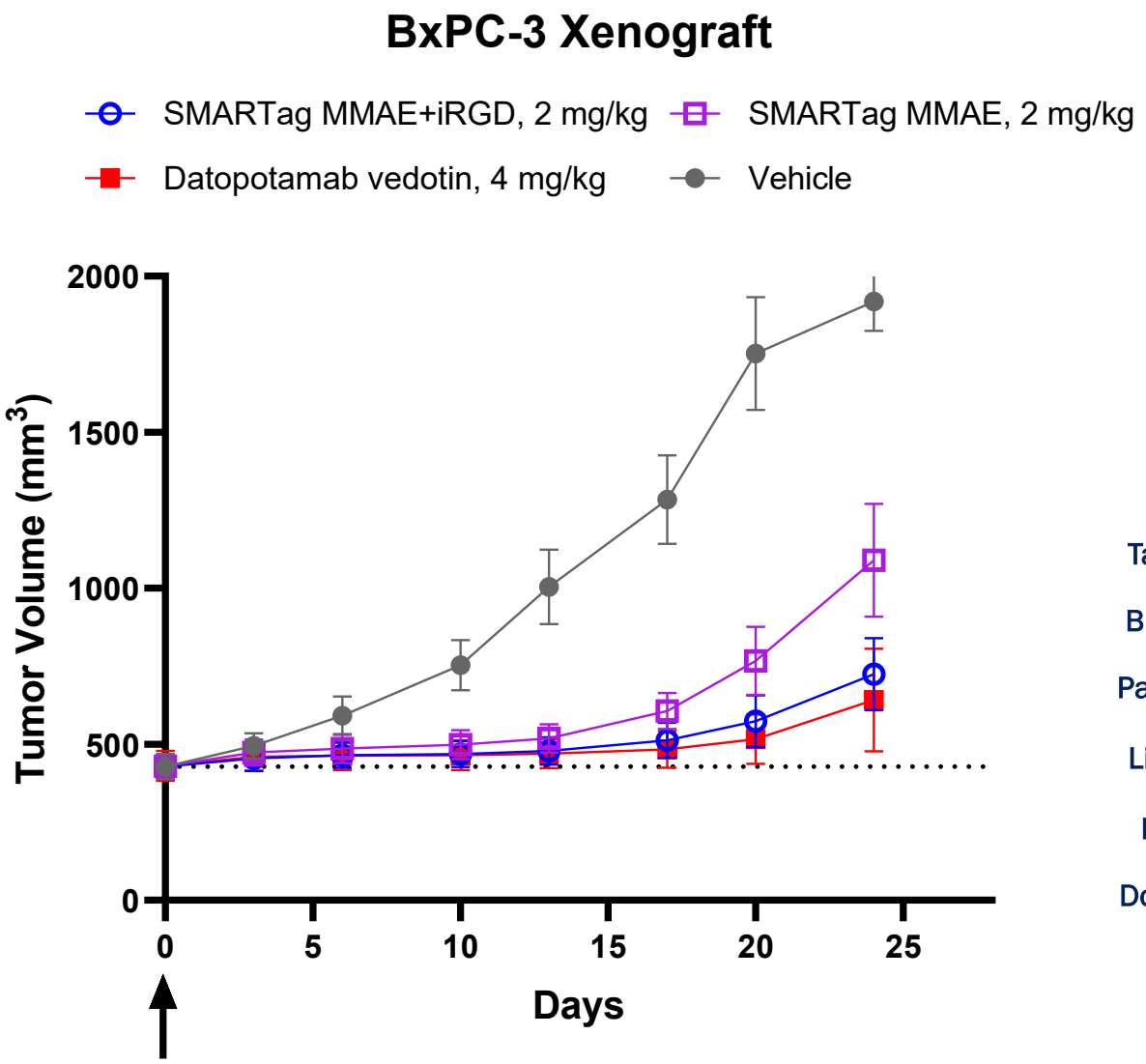


- Enhanced ADCs feature two different MOAs: **tumor delivery and microtubule inhibition**
- **SMARTag technology enables equal efficacy at a lower MMAE DAR** compared to conventional technology; **iRGD further boosts the response**

	SMARTag MMAE+iRGD ADC	SMARTag MMAE ADC	Datopotamab Vedotin
Target	Trop-2	Trop-2	Trop-2
Binder	1D4	1D4	Datopotamab
Payload	MMAE+ iRGD	MMAE	MMAE
Linker	HIPS-Tandem-Cleavage	HIPS-Tandem-Cleavage	Mal-ValCit-PABC
DAR	[2+2]	2	4
Dosage	3 mg/kg	3 mg/kg	3 mg/kg

6: clinical dosing level

Adding iRGD Yields Equal Efficacy at a Lower ADC and Cytotoxic Payload Dose



- SMARTag® ADCs incorporating MMAE+iRGD enable enhanced efficacy at both a lower MMAE DAR and a lower dosage compared to vedotin
- The SMARTag® MMAE+iRGD treatment group received only 25% of the MMAE dose contained in the vedotin treatment group yet delivered equal efficacy

	SMARTag® MMAE+iRGD ADC	SMARTag® MMAE ADC	Datopotamab Vedotin
Target	Trop-2	Trop-2	Trop-2
Binder	1D4	1D4	Datopotamab
Payload	MMAE+iRGD	MMAE	MMAE
Linker	HIPS-Tandem-Cleavage	HIPS-Tandem-Cleavage	Mal-ValCit-PABC
DAR	[2+2]	2	4
Dosage	2 mg/kg	2 mg/kg	4 mg/kg

Certepetide

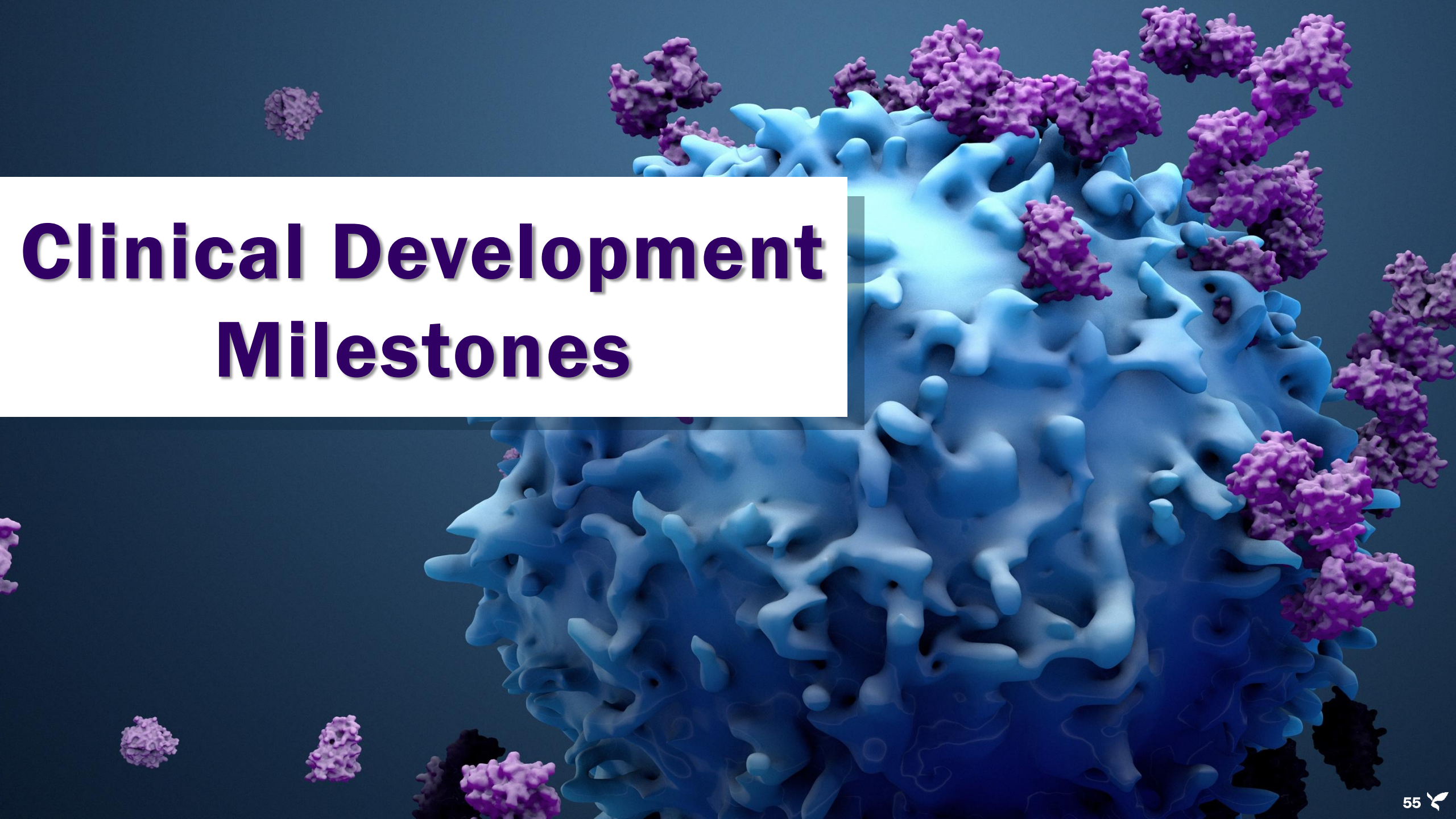
Development Portfolio

Certepetide capital efficient clinical development plan

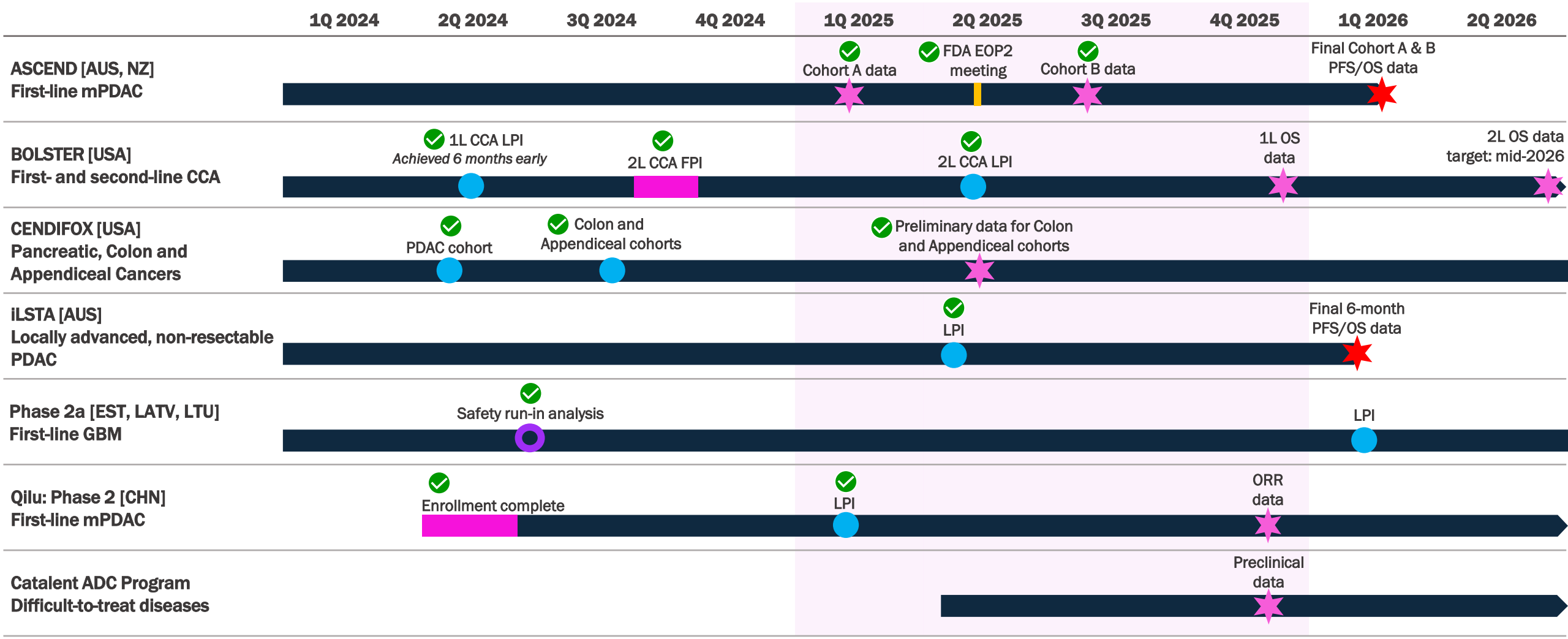
Sponsor(s)	Indication	Description	Current Phase		
			Phase 1	Phase 2	Phase 3
AGITG/Lisata	*First-line mPDAC*	▪ **ASCEND:** Phase 2b, placebo-controlled trial (N=158) ▪ *Gemcitabine/nab-paclitaxel + certepetide or placebo* ▪ Australia/New Zealand	Cohort A data announced Cohort B data announced		
Lisata	*First- and Second-line Cholangiocarcinoma (CCA)*	▪ **BOLSTER:** Phase 2a, placebo-controlled trial ▪ *1L: Gemcitabine/cisplatin/durvalumab + certepetide or placebo* (N=47) ▪ *2L: FOLFOX with certepetide or placebo* (N=22) ▪ United States	1L CCA Enrollment complete 2L CCA Enrollment complete		
KUCC/Lisata *Investigator-initiated trial*	*Pancreatic, Colon, and Appendiceal Cancers*	▪ **CENDIFOX:** Phase 1b/2a, open-label trial (N=50) ▪ *FOLFIRINOX + panitumumab** + certepetide* ▪ United States	Enrollment complete		
WARPNINE/Lisata	*Locally advanced, non-resectable PDAC*	▪ **iLSTA:** Phase 1b/2a, open-label trial (N=30) ▪ *Gemcitabine/nab-paclitaxel/durvalumab + certepetide* ▪ Australia	Enrollment complete		
Tartu University/Lisata *Investigator-initiated trial*	*First-line Glioblastoma Multiforme (GBM)*	▪ Phase 2a, placebo-controlled trial (N=30) ▪ *Temozolomide +/- certepetide* ▪ Estonia/Latvia	Enrolling		
Qilu/Lisata	*First-line mPDAC*	▪ Phase 2, placebo-controlled trial (N=96) ▪ *Gemcitabine/nab-paclitaxel + certepetide* ▪ China	Enrollment complete		

**Panitumumab may be added for colorectal or appendiceal patients without Ras mutation*

Clinical Development Milestones

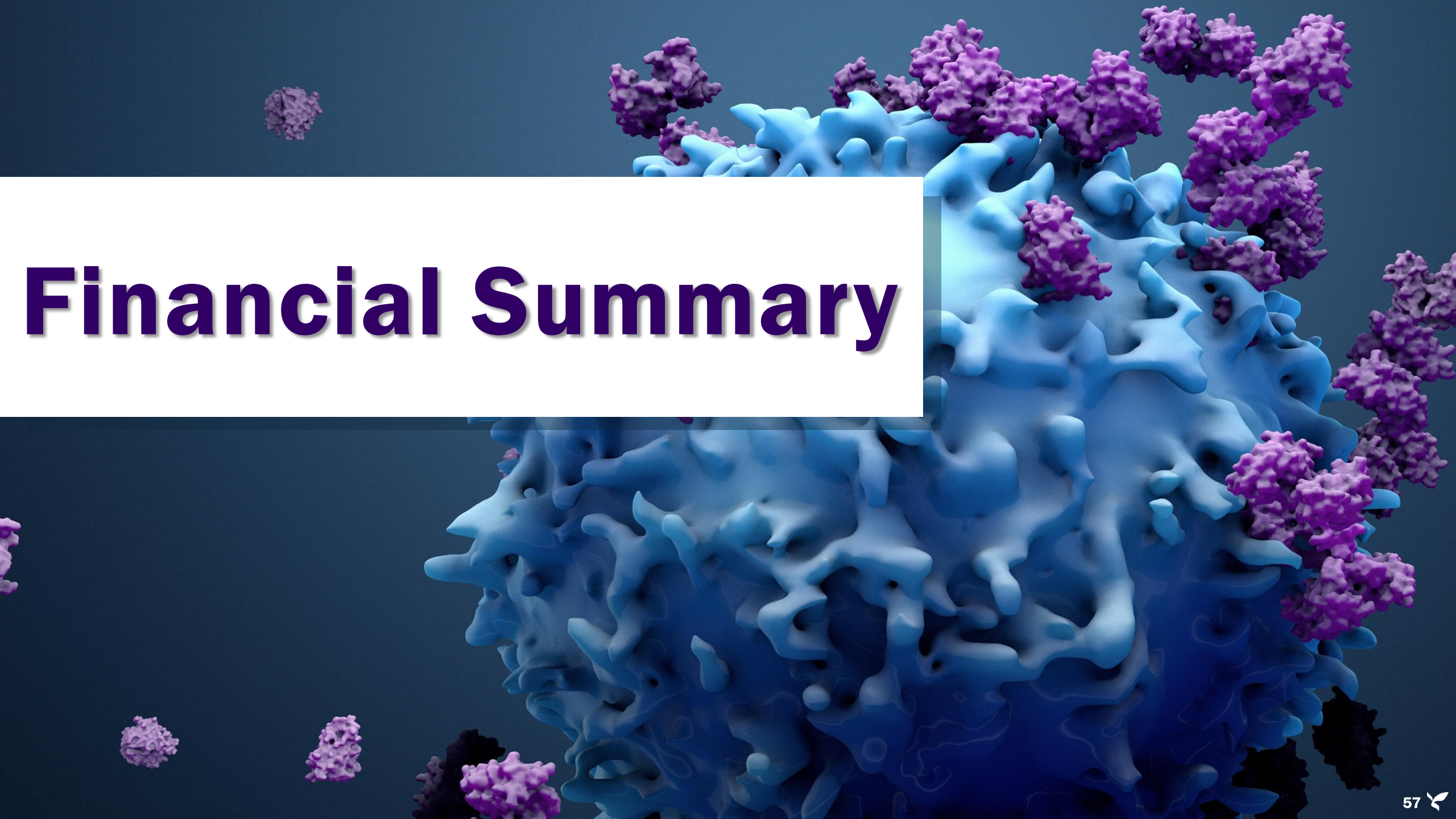


A wealth of key certepetide clinical milestones



**Several of these studies are investigator-initiated trials. Lisata has limited control and thus, timelines and expectations may be subject to change.*

- PFS: Progression-free Survival
- OS: Overall Survival
- ORR: Objective Response Rate
- EOP2: End-of-Phase 2



Financial Summary

Capital projected to fund all clinical programs to data

Cash & Investments As of 9/30/2025	Debt	Projected Cash Runway into
$19.0M	**$0**	**1Q 2027**

Common Shares Outstanding (9/30/2025):	8.8 million shares
Options Outstanding (9/30/2025): Exercise Price: $0.02 - $4.22 = 1,286,200 shares Exercise Price: > $4.22 = 216,700 shares	1.5 million shares
Warrants Outstanding (9/30/2025): Weighted Average Exercise Price: $40.52	1.5 million shares

Key factors supporting investment in Lisata Therapeutics

PEOPLE

Seasoned management with successful international drug development experience and expertise

INTELLECTUAL PROPERTY

Proprietary field-leading technology with global IP protection extending beyond 2040

MILESTONES

Multiple product and business milestones projected over the next 12 months

CAPITAL

$19.0 million cash*- no debt; Funds to support advancement of current clinical programs

PARTNERING

Platform technology validated by existing partnerships with potential for many others

* As of 9/30/2025; includes investments

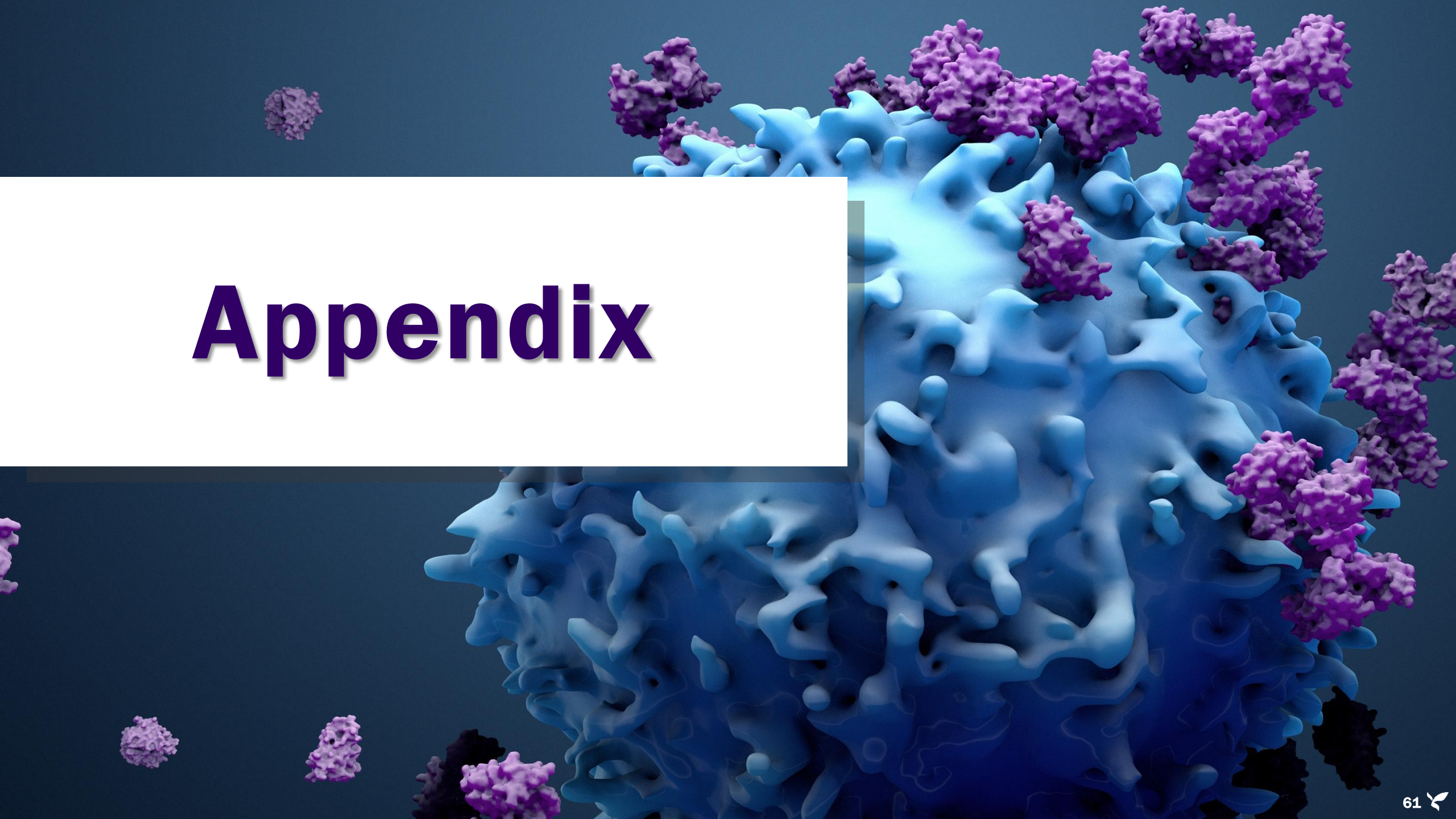
LISATA THERAPEUTICS

Targeted Therapy *Delivered*

Investor Relations Contact:
John D. Menditto
VP, IR & Corporate Communications
Tel: (908) 842-0084 | Email: jmenditto@lisata.com

Nasdaq: LSTA | *www.lisata.com*

Appendix



Certepetide capital efficient clinical development plan

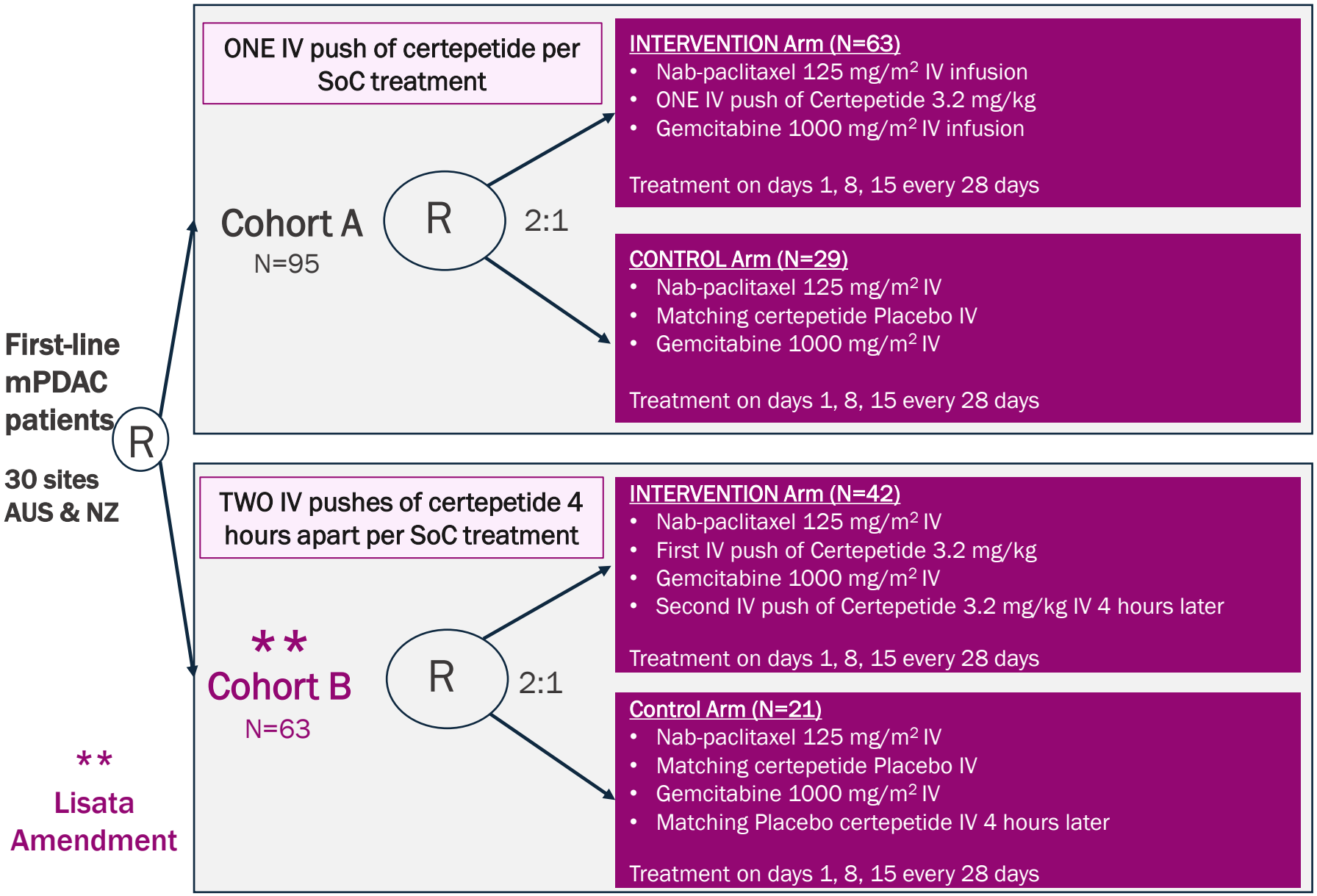
Development Partner(s) [Development Venue]	Indication and Trial Product/Comparator	Stage of Development	Strategic Rationale
Lisata/AGITG [Australia/New Zealand]	**First-line mPDAC;** Gemcitabine/nab-paclitaxel with certepetide or placebo	**Phase 2b (ASCEND)**	Corroborate Phase 1b results in a placebo-controlled trial and evaluate 2 dose regimens of certepetide for dose optimization
Lisata [United States]	**First- and Second-line Cholangiocarcinoma (CCA);** 1L CCA: Gemcitabine/cisplatin/durvalumab + certepetide or placebo 2L CCA: FOLFOX + certepetide or placebo	**Phase 2a (BOLSTER)**	Assess certepetide safety and effectiveness in cholangiocarcinoma in a placebo-controlled trial (proof-of-concept)
KUCC/Lisata* [United States]	**Pancreatic, Colon & Appendiceal Cancers;** FOLFIRINOX + panitumumab** with certepetide	**Phase 1b/2a (CENDIFOX)**	Tumor immuno-profiling pre- & post- treatment and certepetide effectiveness assessment in combination with chemo and an EGFR inhibitor (open-label)
WARPNINE/Lisata [Australia]	**Locally Advanced, Non-Resectable PDAC;** Gemcitabine/nab-paclitaxel/durvalumab + certepetide	**Phase 1b/2a (iLSTA)**	Assess certepetide safety and effectiveness in combination with IO & Chemo in locally advanced PDAC; determine if inoperable tumors can become operable (open-label)
Tartu University/Lisata* [Estonia/Latvia]	**First-line Glioblastoma Multiforme (GBM);** Temozolomide +/- certepetide	**Phase 2a**	Assess certepetide safety and effectiveness in additional tumor type (GBM) in a placebo-controlled trial
Qilu [China]	**First-line mPDAC;** Gemcitabine/Nab-paclitaxel + certepetide	**Phase 2b**	Continue development of certepetide in China (placebo controlled)

**Investigator-initiated trial*
***Panitumumab may be added for colorectal or appendiceal patients without Ras mutation*

ASCEND: Phase 2b, blinded, randomized trial in mPDAC

Sponsor/Partner	▪ Australasian Gastro-Intestinal Trials Group (AGITG) in collaboration with the NHMRC Clinical Trials Centre at the University of Sydney ▪ Lisata funded (LSTA eligible for ~43% rebate on all qualified R&D expenses in AUS)
Objective	▪ Corroborate Phase 1b results in a placebo-controlled study ▪ Determine if a second dose of certepetide further improves patient outcomes
Design	▪ Phase 2b randomized, double-blind study in mPDAC testing gemcitabine + nab-paclitaxel SoC with one of two certepetide dose regimens or placebo
Study Size	▪ N=158 (~30 sites in Australia and New Zealand)
Endpoints	▪ Primary: Progression Free Survival ▪ Secondary: AEs, SAEs, Overall Survival, Objective Tumor Response Rate
Timing	▪ Enrollment completed December 2023 ▪ Preliminary Cohort A data was presented at ASCO-GI in January 2025 ▪ Preliminary Cohort B data was presented at ESMO-GI in July 2025

ASCEND Phase 2b trial design



Phase 2b randomized, double-blind study in mPDAC testing gemcitabine + nab-paclitaxel SoC with one of two certepetide dose regimens or placebo

Endpoints

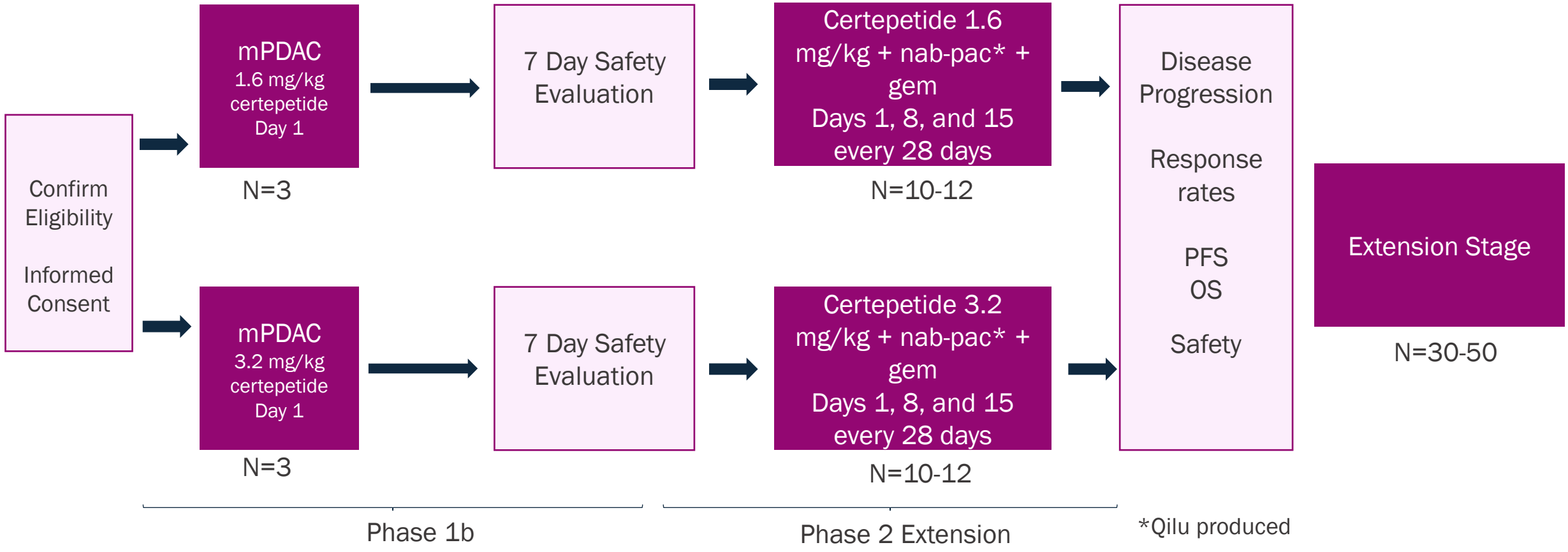
- PFS: Progression Free Survival
- ORR: Objective Response Rate
- OS: Overall Survival
- Safety (Adverse Events)
- QoL: Quality of Life
- Exploratory Endpoints

Phase 1b/2a open-label trial in mPDAC in China (CEND1-201)

Sponsor/Partner	▪ Qilu Pharmaceutical (funds all development in China)
Objective	▪ Evaluate safety, pharmacokinetics and preliminary efficacy of certepetide added to SoC in Chinese patients with mPDAC
Design	▪ Phase 1b/2a open-label study in advanced mPDAC patients of Chinese ethnicity testing SoC chemotherapy (gemcitabine + Qilu-produced nab-paclitaxel) in combination with certepetide
Study Size	▪ N=55 (~15 sites)
Endpoints	▪ Primary: AEs, SAEs, Objective Response Rate, Duration of Response, Disease Control Rate, Overall Survival, and Progression Free Survival ▪ Secondary: Pharmacokinetic parameters
Timing	▪ Preliminary data was presented at the 2023 ASCO Annual Meeting

Qilu Phase 1b/2a trial design

Phase 1b/2a study evaluating the safety, pharmacokinetics, and preliminary efficacy of certepetide for injection in Chinese patients with advanced metastatic pancreatic ductal adenocarcinoma

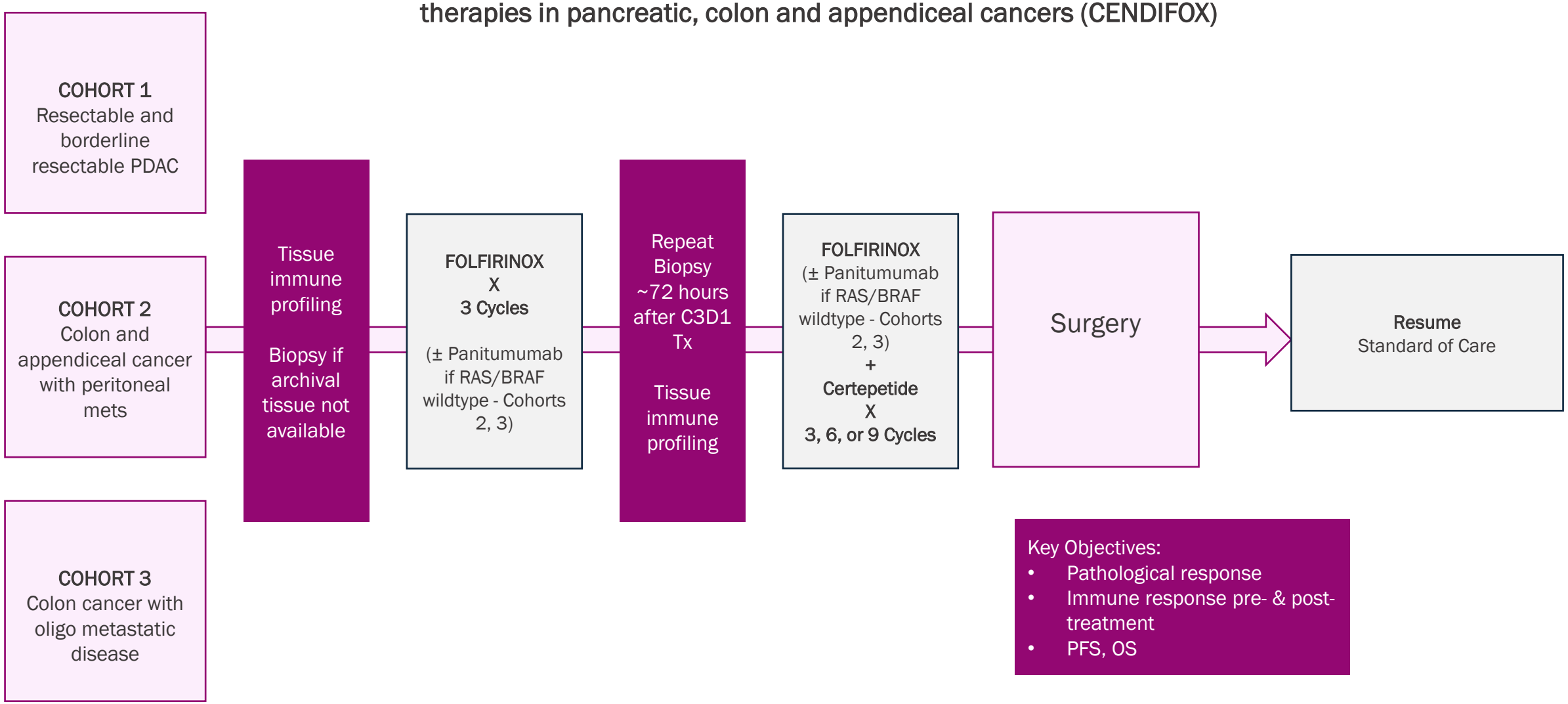


CENDIFOX: Phase 1b/2a open-label trial in PDAC and other cancers

Sponsor/Partner	▪ University of Kansas Medical Center (Investigator initiated trial in U.S.) ▪ KUCC funded; Lisata provides certepetide
Objective	▪ Evaluate the safety and therapeutic effect of certepetide in combination with neoadjuvant FOLFIRINOX-based therapies and an EGFR inhibitor for the treatment of pancreatic, colon and appendiceal cancers and determine immuno-profiling in tumor pre- & post- treatment
Design	▪ Phase 1b/2a open-label study in resectable pancreatic, colon with oligo metastases and appendiceal with peritoneal metastases cancers testing SoC chemotherapy (neoadjuvant FOLFIRINOX-based therapies) with certepetide ± panitumumab
Study Size	▪ N=50 (24 PDAC, 15 colon, and 11 appendiceal)
Endpoints	▪ Primary: Drug Safety ▪ Secondary: Overall Survival, Disease-free Survival, Overall Response Rate, RO Resection Rate, Pathological Response Rate
Timing	▪ Enrollment completed 4Q24

CENDIFOX Phase 1b/2a trial design

Phase 1b/2a open-label trial of certepetide in combination with neoadjuvant FOLFIRINOX based therapies in pancreatic, colon and appendiceal cancers (CENDIFOX)



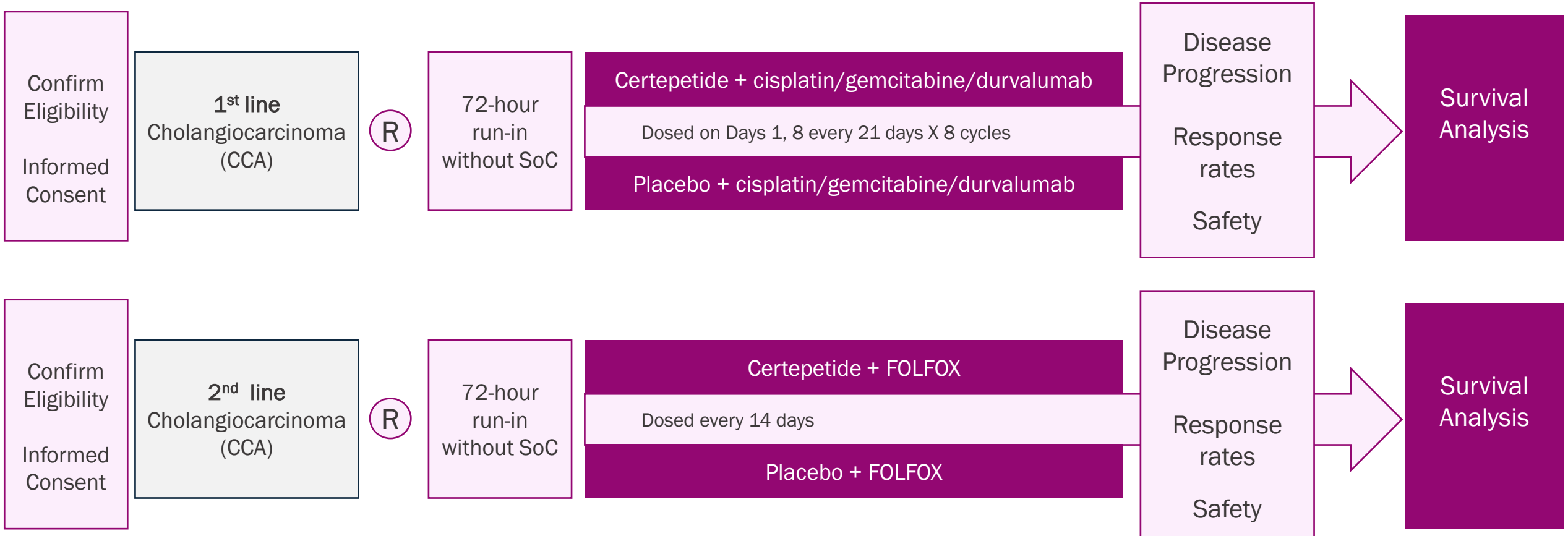
Key Objectives:
- Pathological response
- Immune response pre- & post-treatment
- PFS, OS

BOLSTER: Phase 2 blinded, randomized trial in cholangiocarcinoma

Sponsor/Partner	▪ Lisata (U.S.)
Objective	▪ Evaluate the preliminary efficacy, safety and tolerability of certepetide in combination with standards of care in subjects with first- and second-line cholangiocarcinoma
Design	▪ Phase 2 randomized, double-blind, placebo-controlled, proof-of-concept trial in first- and second-line cholangiocarcinoma testing corresponding SoC with certepetide or placebo
Study Size	▪ N=69 (1L: N=47, 2L: N=22) ▪ 1:1 SoC + certepetide or SoC + placebo
Endpoints	▪ Primary: OS ▪ Secondary: Safety, ORR, PFS
Timing	▪ Patient treatment has been completed

BOLSTER Phase 2a trial design

Phase 2a, double-blind, placebo-controlled, multi-center, randomized study evaluating certepetide when added to standard of care (SoC) versus standard of care alone in subjects with first- and second-line cholangiocarcinoma

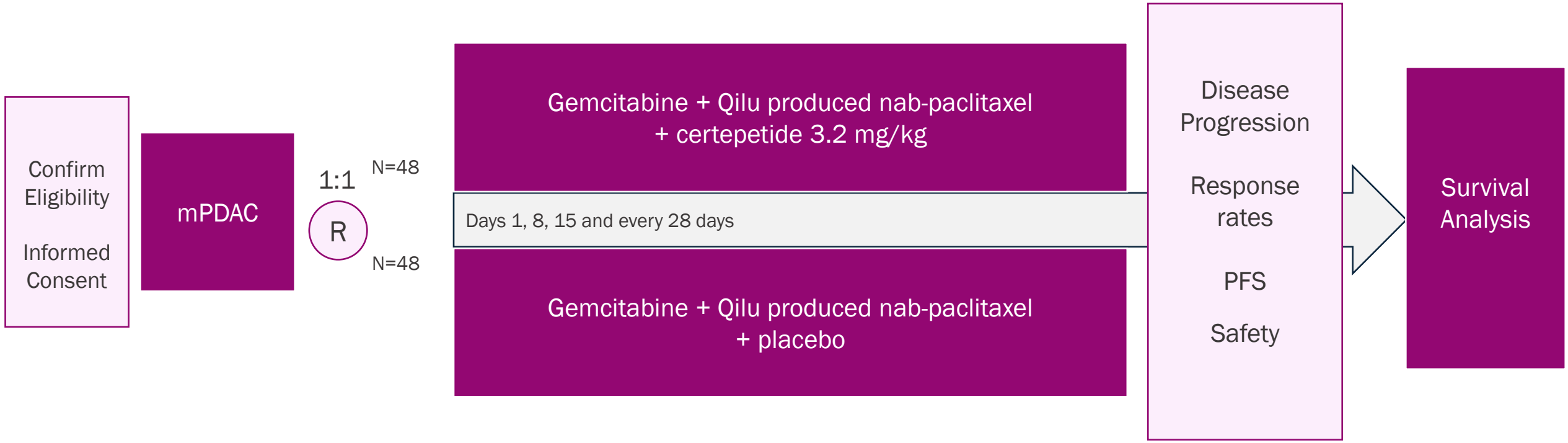


Phase 2 double-blind, placebo-controlled trial in mPDAC in China

Sponsor/Partner	▪ Qilu Pharmaceutical (funds all development in China)
Objective	▪ Further evaluate safety and therapeutic efficacy of certepetide when added to SoC in Chinese patients with locally advanced unresectable mPDAC
Design	▪ Phase 2b, double-blind, placebo-controlled, randomized study evaluating certepetide + SoC (Qilu-produced nab-paclitaxel and gemcitabine) vs. placebo + SoC
Study Size	▪ N=96 (1:1 SoC + certepetide or SoC + placebo)
Endpoints	▪ Objective response rate, progression free survival, duration of response, disease control rate, overall survival ▪ Safety
Timing	▪ Enrollment completed 1Q25

Qilu Phase 2b trial design

Phase 2b, double-blind, placebo-controlled, randomized, multicenter study evaluating the safety and efficacy of certepetide when added to standard of care (nab-paclitaxel and gemcitabine) vs. standard of care alone and placebo in Chinese subjects with locally advanced unresectable mPDAC

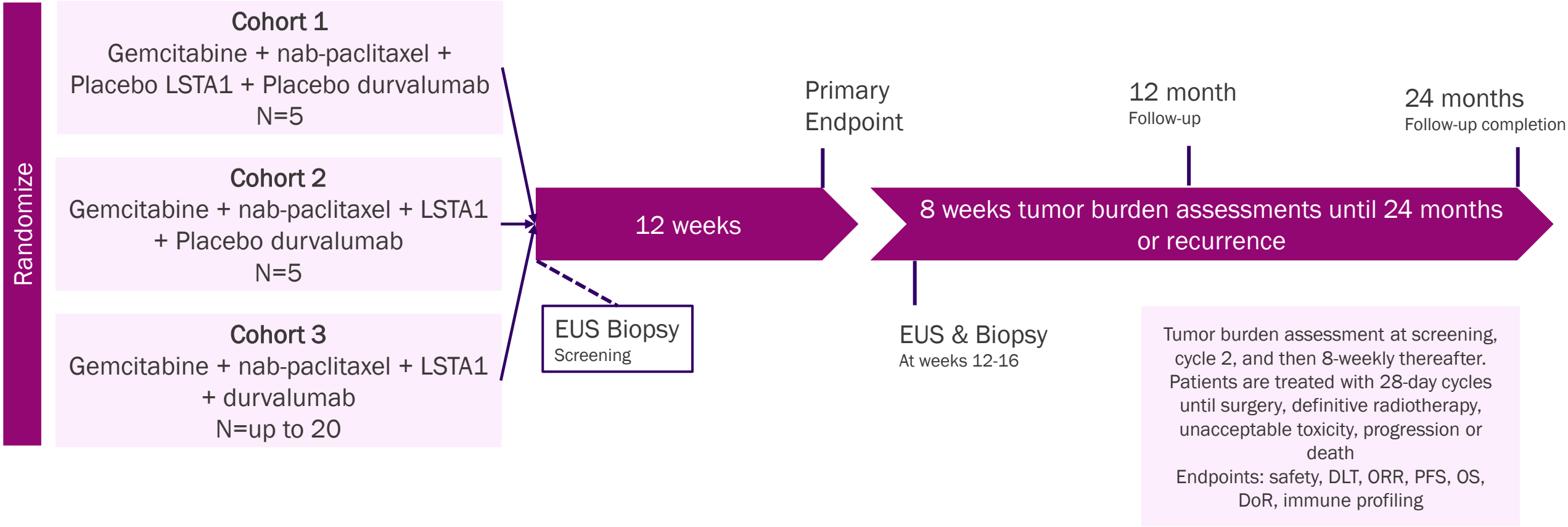


iLSTA: Phase 1b/2a trial in locally advanced PDAC with chemo & IO

Sponsor/Partner	▪ WARPNINE, Inc. (registered charity in Australia) is funding trial ▪ Lisata providing study drug
Objective	▪ Evaluate safety and therapeutic effect of LSTA1 in combination with IO & Chemo in locally advanced non-resectable pancreatic ductal adenocarcinoma (PDAC); determine if inoperable tumors can become operable
Design	▪ Phase 1b/2a proof-of-concept safety and early efficacy study of LSTA1 in combination with durvalumab, gemcitabine and nab-paclitaxel, as first-line treatment in *locally advanced* non-resectable pancreatic adenocarcinoma
Study Size	▪ N=30
Endpoints	▪ Safety and tolerability; 28-day DLTs ▪ Objective response rate, PFS, OS, duration of response, immune cell infiltration
Timing	▪ Final 6-month PFS/OS data expected 1Q 2026 ▪ Preliminary data presented at ASCO-GI (January 2025), with updated data consistent with previous findings presented at ESMO-GI (July 2025)

iLSTA Phase 1b/2a trial design

Phase 1b/2a proof-of-concept safety and early efficacy study of LSTA1 in combination with durvalumab, gemcitabine and nab-paclitaxel, as first-line treatment in *locally advanced non-resectable* pancreatic ductal adenocarcinoma



gemcitabine 1000mg/m^2 : Days 1, 8, 15 in 28-day cycles
nab-paclitaxel 125mg/m^2: Days 1, 8, 15 in 28-day cycles
durvalumab 750mg: Days 1 and 15 in 28-day cycles
certepetide 3.2 mg/kg/ Placebo: Days 1, 2, 8, 15, 16 in 28-day cycles

Preliminary iLSTA trial results poster at 2025 ASCO-GI Symposium

ASCO
American Society of Clinical Oncology

Authors:
Andrew Peter Dean[1], Mikael Johansson[2], Ian Yusoff[2], Samarth Rao[2], Susan Sparrow[3], Priyanthi Kumarasinghe[3], Suresh Navadgi[1], Yuki Watanabe[2], Laurence Webber[1], Jenny Grew[3], Alice Talbot[1], Olivia Rose Comito[4].

Affiliations:
1. St John of God Hospital, Subiaco, WA.
2. Sir Charles Gairdner Hospital, Nedlands, WA.
3. Australian Clinical Labs, Subiaco, WA.
4. WARPNINE Incorporated.

iLSTA: Trial in Progress

A safety and early efficacy study of LSTA-1 in combination with durvalumab, gemcitabine and nab-paclitaxel, as first-line treatment in locally advanced pancreatic ductal adenocarcinoma (PDAC)

ASCO Gastrointestinal Cancers Symposium

Background

Pancreatic ductal adenocarcinoma (PDAC) is characterised by a dense, extracellular, matrix-rich stroma, which creates a physical barrier against drug penetration.

It is estimated that less than 1% of the administered chemotherapeutic agent can penetrate the stroma to reach the tumour.

LSTA-1 (formerly known as CEND-1) is an investigational drug that penetrates the dense outer stroma of PDAC, which leads to improved intratumoural delivery of therapeutic drugs, thus, enhancing their effect.

LSTA-1 is a cyclic peptide which selectively binds to αvβ3/β5 integrins that are overexpressed on a tumour's vascular endothelium, and once bound, it is cleaved by proteases into a linear peptide.

This peptide goes on to bind with neuropilin-1 (NRP-1) to increase vascular permeability and activate endocytic/exocytic uptake transport pathways. This leads to enhanced uptake of co-administered drugs.

Regulatory T cells (Tregs) are T cells that suppress immune response and are expressed in high levels in PDAC, further contributing to its resistance to treatment. Specifically, resistance to immunotherapy.

Tregs in PDAC express αvβ5 integrin and NRP-1 thus making them a target for LSTA-1.

Recent studies showed that LSTA-1 leads to a depletion of Tregs in mice, thereby enhancing the effects of immune checkpoint inhibitors such as durvalumab.

Finally, LSTA-1 increases the CD8+ to CD4+ T cell ratio, thus priming the tumour immune landscape. This study will assess the effect of adding immunotherapy to LSTA-1 and standard chemotherapy as first-line treatment in locally advanced PDAC.

Inclusion Criteria

1. Have histologically confirmed, locally advanced pancreatic ductal adenocarcinoma
2. Capable of giving signed informed consent.
3. Age > 18 years.
4. Eastern Cooperative Oncology Group (ECOG) score of 0 or 1.
5. Have either adequate archival tissue from prior biopsy or willingness to undergo tumour biopsy before treatment starts and willing to have tumour biopsy during treatment at 12-16 weeks.
6. Have a negative serum pregnancy test (if premenopausal female). Men and women of child-bearing potential must use effective barrier contraceptive methods during the study.
7. Adequate normal organ and marrow function:
   i. Haemoglobin ≥9.0 g/dL, absolute neutrophil count (ANC) ≥1.5 × 109 /L,
   ii. Platelet count ≥100 × 109/L,
   iii. Serum bilirubin ≤1.5 x institutional upper limit of normal (ULN),
   iv. AST (SGOT)/ALT (SGPT) ≤ 2.5 x institutional upper limit of normal,
   v. Measured creatinine clearance (CL) >60 mL/min/1.73m2 or Calculated creatinine CL>40 mL/min by the Cockcroft-Gault formula (Cockcroft and Gault 1976) or by 24-hour urine collection for determination of creatinine clearance
8. Patient is willing and able to comply with the protocol for the duration of the study including undergoing treatment and scheduled visits and examinations including follow up.
9. Minimum life expectancy of 12 weeks.
10. No significant abnormalities in urinalysis.
11. Have acceptable coagulation status.
12. At least 1 lesion, not previously irradiated, that qualifies as a Response Evaluation Criteria in Solid Tumours (RECIST) 1.1 target lesion (TL) at baseline. Tumour assessment by computed tomography (CT) scan or magnetic resonance imaging (MRI) must be performed within 28 days prior to randomisation, and subsequent imaging should use the same modality.
13. Must be eligible for treatment with nab-paclitaxel and gemcitabine

Method

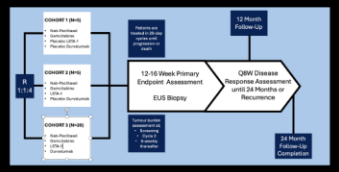
This is a phase I, randomised, single-blind, single-centre, safety and pharmacodynamics study evaluating the safety and tolerability of LSTA-1 in combination with durvalumab, nab-paclitaxel and gemcitabine versus standard of care chemotherapy in patients with locally advanced PDAC.

A total of 30 participants are randomised 4:1:1 in favour of cohort 3.

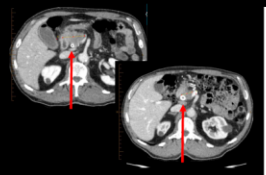
- Cohort 1 (N=5) will receive nab-paclitaxel 125mg/m2 and gemcitabine 1000mg/m2 on days 1, 8, and 15 with placebo durvalumab D1 and 15 and placebo LSTA-1 D1, 2, 8, 15 and 16 in 28-day cycles.
- Cohort 2 (N= 5) will receive nab-paclitaxel 125mg/m2, gemcitabine 1000mg/m2 and LSTA1 3.2mg/kg on days 1, 8, and 15 with placebo durvalumab D1, 15 and placebo LSTA-1 D2 and 16 in 28-day cycles.
- Cohort 3 (N=20) will receive nab-paclitaxel 125mg/m2 and gemcitabine 1000mg/m2 on days 1, 8, and 15 with durvalumab D1, 15 and LSTA1 3.2mg/kg D1, 2, 8, 15 and 16.

An EUS biopsy will be taken at 12-16 weeks and compared to diagnostic samples to ascertain the degree of immune cell infiltration of the tumour in each cohort.

Schema



CT Scan Images



Translational Research

Background: Recent research has identified that bacteria in the human gut microbiome may influence treatment response in patients with PDAC. These bacteria are present in faeces, and are thought to be representative of the bacteria in the pancreatic ductal system. Many bacteria in the *Firmicutes* phylum produce Butyrate, which is known to have several anti-cancer effects. Additionally, *gammaproteobacteria*, which belong to the *Proteobacteria* phylum, secrete the enzyme cytidine deaminase, which is capable of metabolising and deactivating gemcitabine.

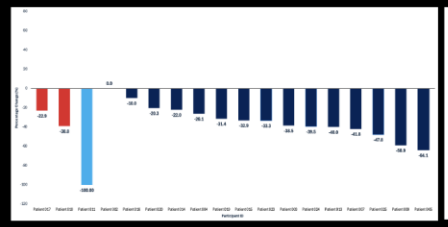
Aim: This study aimed to investigate the relationship between gut microbiome composition and patient response to PDAC anti-cancer therapy, and the effect of anti-cancer treatment on the gut microbiome.

Method: This study involved 14 individuals with locally advanced PDAC from the iLSTA trial. Participants received anti-cancer treatment, with patient response determined through analysis of CA19-9 levels and RECIST guidelines.

Results:
- 9 patients demonstrated strong treatment outcomes with high levels of Firmicutes (>80%) and low levels of Proteobacteria (<0.54%).
- 5 patients demonstrated a reduced treatment response with had low levels of Firmicutes (>44%) and high levels of Proteobacteria (<27%).
- 9/14 had an increase in Firmicutes (8 in C3).
- 10/14 had a decrease in Proteobacteria (9 in C3).
- 8/14 had both an increase in Firmicutes and a decrease in Proteobacteria (7 in C3).

Conclusion: This study revealed a trend towards shifting microbial composition and treatment response. High levels of Firmicutes and low levels of Proteobacteria were associated with improved treatment outcomes. Patients who received immunotherapy developed a more favourable microbiome composition during treatment.

Results: RECIST Classification After 4 Cycles of Treatment



Cohort 1
- 1 PR, 1 SD

Cohort 2
- 1 CR

Cohort 3
- 10 PR, 5 SD

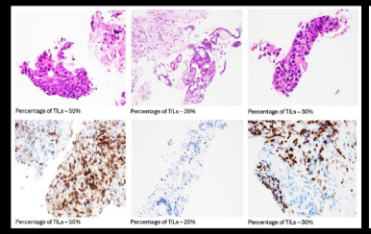
Response Rate: 67%
Disease Control Rate: 100%

6 of the first **7** participants had a major RECIST response after 2 cycles.

Toxicity

- Of the 20 participants on study, 16 participants have received immunotherapy
- 7 participants have experienced immune-related adverse events (irAEs).
- Examples of toxicities that have been observed:
  - Grade 2 hepatitis
  - Grade 2 myositis
  - Grade 2 autoimmune diabetes
  - Grade 2 pancreatitis
  - Grade 3 dermatitis
  - Grade 3 hepatitis
  - Grade 3 colitis (biopsy confirmed)
  - 2 participants discontinued immunotherapy due to toxicity (one of which withdrew consent from the trial following colitis)

Results: Tumour Infiltrating Lymphocytes



Patient biopsies were assessed for 'Tumour Infiltrating Lymphocytes' (TILs).

Of the 8 participants who had their baseline and secondary biopsies analysed for the presence of TILs;
- 6 patients had an increase in TILs (5% to 45%)
  - i. 5 patients had a partial response (4 in C3)
  - ii. 1 patient had stable disease (C3)
- 1 patient had no change in TILs
  - i. Patient had stable disease (C3)
- 1 patient had a decrease in TILs (5%)
  - i. Patient had stable disease (C3)

Objectives

Primary Objectives
1. To determine the safety and tolerability of adding LSTA-1 to the combination of durvalumab, gemcitabine, and nab-paclitaxel in subjects with locally advanced pancreatic ductal adenocarcinoma.

Secondary Objectives
1. Disease control rate (DCR).
2. The best overall response rate (ORR).
3. Median progression-free survival (mPFS) and mPFS at 6 months.
4. Duration of response for responding participants.
5. To determine levels of immune cell infiltration in tumour biopsies (pre-treatment and on treatment at 12-16 weeks) in each cohort.

Study Update

- Study Sponsor: WARPNINE Incorporated, Subiaco, WA 6008, Australia
- Contact: admin@warpnine.org.au
- Study Chair: Dr Andrew Dean
- Trial Identifier: ACTRN12623000223639
- Participating site(s): St John of God Subiaco Hospital, 12 Salvado Rd, Subiaco WA 6008
- Anticipated recruitment end date: End of first quarter 2025

Recruitment details:
- 20 participants enrolled
- 3 participants randomised to Cohort 1
- 1 participant randomised to Cohort 2
- 16 participants randomised to Cohort 3
- 4 participants underwent surgery after study

Results: Tumour Markers

		Participant ID																			
	Cycle	003-002	003-003	003-004	003-005	003-007	003-009	001-010	002-011	003-013	003-014	003-015	003-016	001-017	003-019	003-020	003-023	003-024	003-025
CA19-9	Screening	163	251	8435	<2	30208	30	8572	42	1567	3620	409	3008	23	3	8	1347	3106	54
	C1D1	179	-	8223	-	31916	-	-	33	627	-	553	3390	-	8	-	-	3813	6
	C2D1	290	61	6675	1	7835	27	5649	19	169	1102	273	1786	15	6	13	252	2059	12
	C3D1	271	33	3635	<2	948	15	1685	16	55	653	245	919	11	8	7	62	492	14
	C4D1	205	96	1625	4	137	12	411	19	28	1486	112	230	7	32	13	27	167	8
	C5D1	495	187	497	4	244	12	346	19	28	2862	101	148	11	7	11	13	131	15
	C6D1	-	1259	213	<2	220	14	541	15	17	4203	81	90	10	6	6	13	151	-

Summary

Notable early RECIST response rate in combination arms. 10/15 participants in C3 have demonstrated a RECIST partial response (PR) to treatment, 6 of whom had a PR after just 2 cycles.

An encouraging signal of immune engagement has been observed as 6/8 participants demonstrated an increase in TILs during treatment (5 in C3).

Early results suggest a a relationship between gut microbiome composition and response to anti-cancer treatment. Further analysis is ongoing.

Immune related toxicities have been observed in 7 of the 16 participants who received immunotherapy, all of which are recognised as irAEs .

4 participants proceeded to surgery having previously been deemed inoperable.

An abstract with a detailed summary of the poster presentation is also available on the ASCO GI website: https://meetings.asco.org/abstracts-presentations/241611

Updated preliminary iLSTA trial results poster at 2025 ESMO-GI

267P

ESMO

Authors:

Andrew Peter Dean[1], Mikael Johansson[2], Ian Yusoff[2], Samarth Rao[2], Susan Sparrow[3], Priyanthi Kumarasinghe[3], Jenny Grew[3], Yuki Watanabe[2], Maclain Robinson[1], Alice Talbot[1], & Olivia Rose Comito[4].

Affiliations:

1. St John of God Hospital, Subiaco, WA.
2. Sir Charles Gairdner Hospital, Nedlands, WA.
3. Australian Clinical Labs, Subiaco, WA.
4. WARPNINE Incorporated.

iLSTA

Provisional results of immunotherapy combined with LSTA1 plus nab-paclitaxel and gemcitabine for locally advanced pancreatic ductal adenocarcinoma

ESMO GASTROINTESTINAL CANCERS Annual Congress

BARCELONA SPAIN 2-5 JULY 2025

Background

Pancreatic ductal adenocarcinoma (PDAC) is characterised by a dense, extracellular, matrix-rich stroma, which creates a physical barrier against drug penetration.

This leads to less than 1% of the administered chemotherapeutic agent being able to penetrate the stroma to reach the tumour.

LSTA-1 (formerly known as CEND-1) is an investigational drug that can penetrate the dense outer stroma of PDAC tumours, which leads to improved intratumoural delivery of therapeutic drugs, thus, enhancing their effect.

LSTA-1 is a cyclic peptide that selectively binds to αvβ3/β5 integrins expressed on the tumour's vascular endothelium and intratumorally. Once bound, a protease cleavage event occurs to activate the peptide.

This peptide then goes on to bind with neuropilin-1 (NRP-1) to increase vascular permeability and activate an endocytic uptake transport pathway, known as the CENDR pathway. This leads to enhanced uptake of co-administered drugs.

Regulatory T cells (Tregs) suppress the immune response and are expressed in high levels in PDAC tumours, further contributing to resistance to anti-cancer treatment. Specifically, resistance to immunotherapy.

Tregs in PDAC tumours also express αvβ5 integrins and NRP-1, thus, making them a target for LSTA-1. Recent studies in mouse models showed that LSTA-1 leads to the depletion of Tregs, thereby enhancing the effect of immune checkpoint inhibitors such as durvalumab.

Finally, LSTA-1 increases the CD8+ to CD4+ T cell ratio, priming the tumour immune landscape.

Therefore, this study will assess the effect of adding LSTA-1 and/or immunotherapy to standard chemotherapy as first-line treatment for locally advanced PDAC.

Objectives

Primary Objectives

1. To determine the safety and tolerability of adding LSTA-1 to the combination of durvalumab, gemcitabine, and nab-paclitaxel in subjects with locally advanced pancreatic ductal adenocarcinoma.

Secondary Objectives

1. Disease control rate (DCR).
2. The best overall response rate (ORR).
3. Median progression-free survival (mPFS) and mPFS at 6 months.
4. Duration of response for responding participants.
5. To determine levels of immune cell infiltration in tumour biopsies (pre-treatment and on treatment at 12-16 weeks) in each cohort.

Inclusion Criteria

1. Histologically confirmed, locally advanced PDAC.
2. Eastern Cooperative Oncology Group (ECOG) score of 0 or 1.
3. Minimum life expectancy of 12 weeks.
4. Adequate archival tissue from prior biopsy or willingness to undergo tumour biopsy before treatment starts
5. Willing to have tumour biopsy at 12-16 weeks.
6. Adequate normal organ and marrow function
7. No significant abnormalities in urinalysis.
8. Have acceptable coagulation status.
9. At least 1 lesion, not previously irradiated, that qualifies as a RECIST 1.1 target lesion at baseline. Tumour assessment by CT scan or MRI.
10. Must be eligible for treatment with nab-paclitaxel and gemcitabine.

Study Update

Recruitment details:

- 29 participants enrolled
- 23 currently evaluable participants
  - 4 participants randomised to Cohort 1
  - 2 participant randomised to Cohort 2
  - 17 participants randomised to Cohort 3

Method

This study was conducted as a phase I, randomised, single-blind, single-centre, safety and pharmacodynamics study evaluating the safety and tolerability of LSTA-1 in combination with durvalumab, nab-paclitaxel and gemcitabine versus standard of care chemotherapy in patients diagnosed with locally advanced PDAC.

30 participants were randomised in a 4:1:1 ratio;

- Cohort 1/C1 (N=5) received nab-paclitaxel 125mg/m2 and gemcitabine 1000mg/m2 on days 1, 8, and 15 with placebo durvalumab on D1 and 15 and placebo LSTA-1 on D1, 2, 8, 15 and 16.
- Cohort 2/C2 (N= 5) will receive nab-paclitaxel 125mg/m2, gemcitabine 1000mg/m2 and LSTA1 3.2mg/kg on D1, 8, and 15 with placebo durvalumab D1 and 15 and placebo LSTA-1 D2 and 16.
- Cohort 3/C3 (N=20) will receive nab-paclitaxel 125mg/m2 and gemcitabine 1000mg/m2 on D1, 8, and 15 with durvalumab on D1 and 15 and LSTA1 3.2mg/kg D1, 2, 8, 15 and 16.

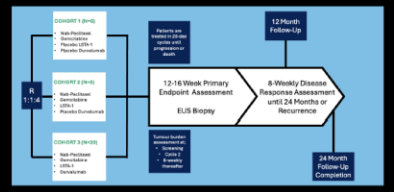
Participants received treatment in 28-day cycles.

An EUS biopsy was conducted between weeks 12 and 16 and compared to the diagnostic samples to determine the degree of tumour immune cell infiltration in each cohort.

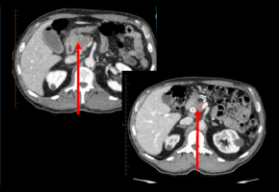
Toxicity

- Of the 29 participants recruited, 17 participants have received immunotherapy.
- 7 participants have experienced immune-related adverse events (irAEs).
- Examples of toxicities that have been observed: Grade 2 hepatitis, Grade 2 myositis, Grade 2 autoimmune diabetes, Grade 2 pancreatitis, Grade 3 dermatitis, Grade 3 hepatitis, Grade 3 colitis (biopsy confirmed).
- 2 participants discontinued immunotherapy due to toxicity (one of which withdrew consent from the trial following colitis).

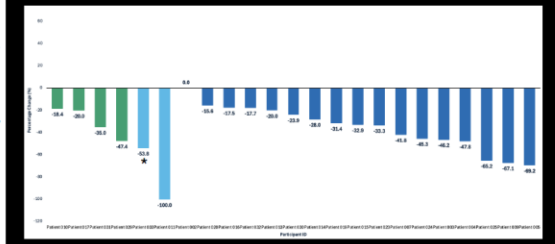
Schema



CT Scan Images



Results: RECIST Classification After Completing Treatment



Cohort 1
- 2 PR, 2 SD

Cohort 2
- 1 CR, 1 PR

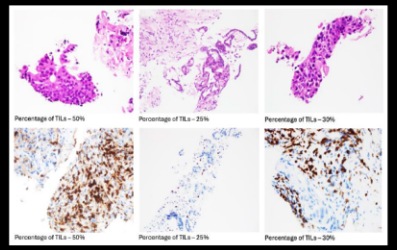
Cohort 3
- 10 PR, 7 SD

Response Rate: 61%

Disease Control Rate: 100%

* Cycle 4 Measurement

Results: Tumour Infiltrating Lymphocytes



Patient biopsies were assessed for 'Tumour Infiltrating Lymphocytes' (TILs). Of the 14 participants who had their baseline and secondary biopsies analysed for TILs;

- 8 patients had an increase in TILs (5% to 45%)
  - i. 7 patients had a partial response (6 in C3)
  - ii. 1 patient had stable disease (C3)
- 4 patients showed nil (2) or minimal (2) residual adenocarcinoma (isolated tumour cells)
- 1 patient had no change in TILs
  - i. Patient had stable disease (C3)
- 1 patient had a decrease in TILs (5%)
  - i. Patient had stable disease (C3)

Translational Research

Background: Recent research has identified that bacteria in the human gut microbiome may influence treatment response in patients with PDAC. Specifically, these studies have revealed the gut microbiome may impact the tumour microenvironment, metabolism, and sensitivity to therapeutic drugs. Many bacteria in the *Firmicutes* phylum produce Butyrate, which is known to have several anti-cancer properties. Additionally, *gammaproteobacteria*, a class of bacteria that belongs to the *Proteobacteria* phylum, secrete the enzyme cytidine deaminase, which is capable of metabolising gemcitabine into its inactive isoform.

Aim: This study aimed to investigate the relationship between gut microbiome composition and patient treatment response, as well as the effect of treatment on microbiome composition.

Method: This study involved 14 participants with locally advanced PDAC from the iLSTA trial. Stool samples were collected from participants at baseline and 12 weeks into treatment. Patient treatment response was determined through analysis of CA19-9 levels and RECIST analysis.

Results:

- 9 patients demonstrated strong treatment outcomes with high levels of Firmicutes (>80%) and low levels of Proteobacteria (<0.54%).
- 5 patients demonstrated a reduced treatment response with low levels of Firmicutes (>44%) and high levels of Proteobacteria (<27%).
- 9/14 showed an increase in Firmicutes (8 in C3).
- 10/14 showed a decrease in Proteobacteria (9 in C3).
- 8/14 showed both an increase in Firmicutes and a decrease in Proteobacteria (7 in C3).

Conclusion: This study revealed a trend towards shifting microbial composition and treatment response. High levels of Firmicutes and low levels of Proteobacteria were associated with improved treatment outcomes. Patients who received immunotherapy developed a more favourable microbiome composition during treatment.

Results: Tumour Markers

	Participant ID																									
	Cycle	003-002	003-003	003-004	003-005	003-007	003-009	001-010	002-011	003-013	003-014	003-015	003-016	001-017	003-019	003-020	003-023	003-024	003-025	001-029	003-030	001-031	003-032	002-033
CA19-9	Screening	163	251	8435	<2	30208	30	8572	42	1567	3620	409	3008	23	3	8	1347	3106	54	329	2651	<2	424	3268
	C1D1	179	251	8223	<2	31916	30	8572	33	627	3620	553	3390	23	8	8	1347	3813	6	401	2733	<2	424	3268
	C2D1	290	61	6675	1	7835	27	5649	19	169	1102	273	1786	15	6	13	252	2059	12	411	3727	3	254	2420
	C3D1	271	33	3635	<2	948	15	1685	16	55	653	245	919	11	8	7	62	492	16	72	2789	3	138	196
	C4D1	205	96	1625	4	137	12	411	19	28	1486	112	230	7	32	13	27	167	14	31	1425	8	88	38
	C5D1	495	187	497	4	244	12	346	19	28	2862	101	148	11	7	11	13	131	8	21	659	<2	64	-
	C6D1	-	1259	213	<2	220	14	541	15	17	4203	81	90	10	6	6	13	151	15	22	560	2	-	-

Disclosure

- Sponsor: WARPNINE Inc.
- Contact: admin@warpnine.org.au
- Study Chair: Dr Andrew Dean.
- Trial Identifier: ACTRN12623000223639
- Participating site: St John of God Subiaco Hospital, 12 Salvado Rd, Subiaco WA 6008.
- DOI: Dr. Dean is on the board of WARPNINE Incorporated with no financial interests.
- Durvalumab provided by AstraZeneca.
- LSTA-1 provided by Lisata Therapeutics.

Summary

- Notable early RECIST response rate in combination arms - 12/19 participants in C2 + C3 demonstrated a RECIST partial response (PR) to treatment, 7 of whom had a PR after 2 cycles.
- An encouraging signal of immune engagement was observed as 8/14 participants demonstrated an increase in TILs during treatment (7 in C3), and 4 participants showed nil or minimal residual tumour cells.
- Early results suggest a a relationship between gut microbiome composition and response to anti-cancer treatment. Analysis is ongoing.
- Immune related toxicities have been observed in 7/17 participants who received immunotherapy. All were recognised as irAEs.
- 4 participants proceeded to surgery having previously been deemed inoperable.

Phase 2a trial of certepetide with SoC in first-line GBM

Sponsor/Partner	▪ Tartu University Hospital (Investigator initiated trial in Estonia, Latvia and Lithuania) ▪ Lisata providing study drug and funding trial
Objective	▪ Evaluate safety, tolerability, and therapeutic effect of certepetide in combination with standard-of-care (temozolomide) in patients with previously untreated Glioblastoma Multiforme
Design	▪ Phase 2a proof-of-concept, double-blind, placebo-controlled, randomized study evaluating certepetide when added to standard of care (temozolomide) versus SoC and placebo in subjects with newly diagnosed Glioblastoma Multiforme (GBM)
Study Size	▪ N=30 total (N=3 safety run-in, N=27 in main study schema)
Endpoints	▪ Safety, tolerability ▪ ORR, PFS, OS, disease control rate
Timing	▪ Enrollment commenced December 2023

GBM Phase 2a trial design

Phase 2a proof-of-concept double-blind, placebo-controlled, randomized, proof-of-concept study evaluating certepetide when added to standard of care (temozolomide) versus temozolomide and matching certepetide placebo in subjects with newly diagnosed GBM