POINT BIOPHARMA

Next Generation Radioligands™

NASDAQ: PNT

# Investor Presentation

September 2023

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# POINT Biopharma: discovering, developing, & supplying **next-generation radioligands™**

## VERTICALLY INTEGRATED PLATFORM

- Demonstrated capabilities include the rapid development of next-generation radioligands (PNT2004) from concept to clinic, as well as clinical development of late-stage programs (PNT2002)

## INDUSTRY LEADING PIPELINE

- Pan-cancer ligand currently in human trials (PNT2004, phase 1), next-generation $^{225}$Ac PSMA program (PNT2001, preclinical) first patient in Q1 2024

## PROVEN RADIOPHARMA EXPERTS

- Leadership team has the rare advantage of decades of experience in radiopharmaceutical discovery, development, and manufacturing

## ROBUST SUPPLY CHAIN

- State-of-the-art GMP manufacturing facility operational and currently supplying drug product to clinical trials
- Medical isotopes supply in-place with multiple suppliers ($^{177}$Lu & $^{225}$Ac)

## SIGNIFICANT NEAR-TERM REVENUE

- Anticipating robust margin on manufacturing and supply of commercial product for Lantheus
- Up to $1.8B in milestone & royalty payments on PNT2002 (prostate cancer) & PNT2003 (neuroendocrine tumors) expected to begin in 2025

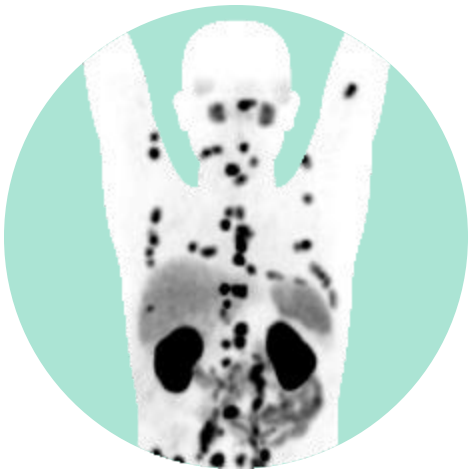
## FISCALLY STRONG

- $435M in cash, cash equivalents, and investments, as of June 30, 2023
- Cash runway into 2026
- 114.4M fully diluted shares outstanding

# Targeted radioligand therapy is an ideal platform for precision oncology

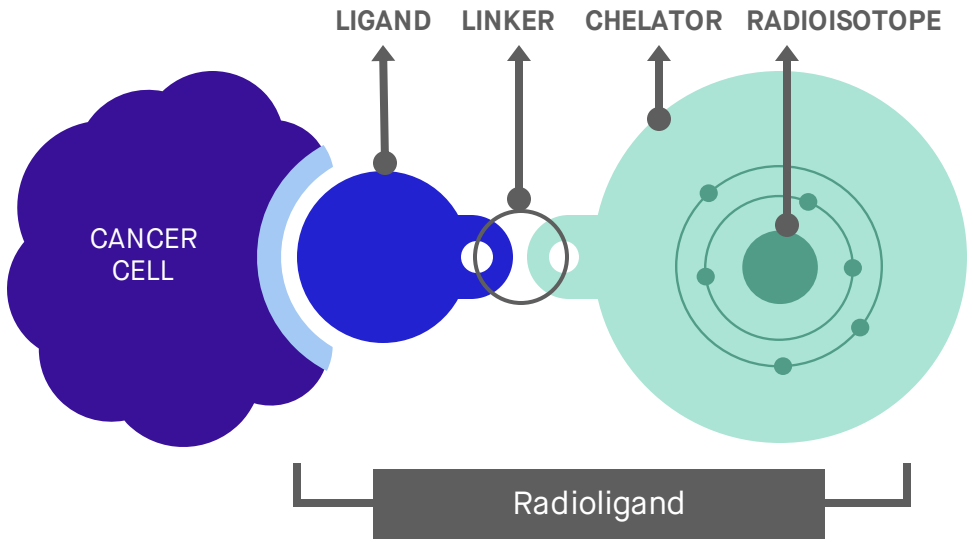
**Radioligands** enable the precise targeting of cancer by combining a radioisotope, a linker, and a targeting moiety that seeks cancer cells

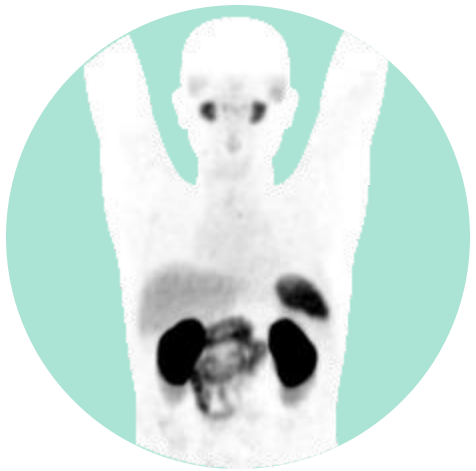
PSMA is overexpressed on prostate cancer cells + A PSMA-specific ligand seeks out cancer cells + The radioisotope emits ionizing radiation = Ionizing radiation kills the tumor cell, while minimizing damage to healthy tissue



PSMA-PET Scan Before Treatment[1]

*PSMA = Prostate Specific Membrane Antigen*



PSMA-PET Scan After 3 $^{177}$Lu-PSMA Treatments[1]

*1. Baum et al. J Nucl Med 2016*

# The radiopharmaceutical industry is overcoming its historical bottlenecks

| | Past Issues | Evolving Innovation |
|---|---|---|
| **Isotope Supply Chain** | Government-funded entities are the main source of novel isotope supply chains, creating bottlenecks | New, isotope-specific, private sector commercial suppliers have built businesses to capitalize on the market opportunity |
| **Manufacturing & Production** | Drug developers didn't plan for success, supply chains weren't mature, scale and geography mattered | Radiopharmaceutical companies are focusing specifically on manufacturing excellence along with logistics and redundancy |
| **RLT Treatment Site Access** | Strong gamma from previous generation isotopes required lead-lined rooms in the basements of hospitals | Next-generation isotopes can be administered in outpatient settings, and next-generation PET scanners have been developed to improve throughput |
| **Drug Development** | Limited commercial uptake lowered incentive for heavy investment in R&D | Currently approved RLT for prostate cancer trending towards blockbuster status,<br>>$1.5B invested into RLT companies since Jan 2022 |

# POINT Biopharma has built the platform for **next-generation radioligands™**

As one of the few companies that have demonstrated competency in the discovery, clinical development, and supply of radioligands, POINT is well positioned to be a leader in this exciting emerging modality.

**Robust isotope supply chain**

Fortified supply chain, safeguarded from disruptions

**Radiochemistry & preclinical expertise**

Experience engineering optimized combinations of ligands, linkers, and isotopes

**Next-generation clinical programs**

Currently in the clinic in indications of high unmet need

**Commercial scale manufacturing**


Internal manufacturing capabilities, ensuring patients needs are consistently met

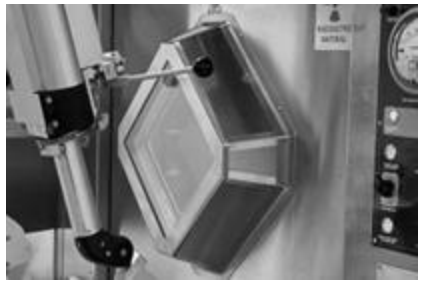
# CORE is POINT's 180,000 ft² commercial manufacturing campus in Indianapolis, Indiana

POINT BIOPHARMA CENTER OF RADIOLIGAND EXCELLENCE


**Aerial View**

# POINT Biopharma Institute for Radioligand Innovation (PIRI): Driving the development of novel programs from discovery to the clinic

POINT BIOPHARMA INSTITUTE FOR RADIOLIGAND INNOVATION



Fully operational; currently licensed for alpha, beta, gamma, and positron emitters

State of the art 7,700 ft$^2$ GMP facility with PETtrace™ 800 cyclotron and hot cells

Located in Toronto, Canada, in a translational institute & research hospital network

*PETtrace is a trademark of General Electric Company.*

# POINT's lutetium-177 and actinium-225 supply chains are industry-leading

71 Lu Lutetium (177)

## Internal $^{177}$Lu production capability will provide a COGS advantage and supply chain redundancy

- itm — No-carrier-added $^{177}$Lu partner
- isotopia — No-carrier-added $^{177}$Lu partner
- Eckert & Ziegler — No-carrier-added $^{177}$Lu partner
- POINT BIOPHARMA — No-carrier-added $^{177}$Lu manufactured internally *
- $^{176}$Yb input material secured in North America
- Nuclear reactor irradiation network assembled
- Technology to purify $^{177}$Lu at a significant scale

89 Ac Actinium (225)

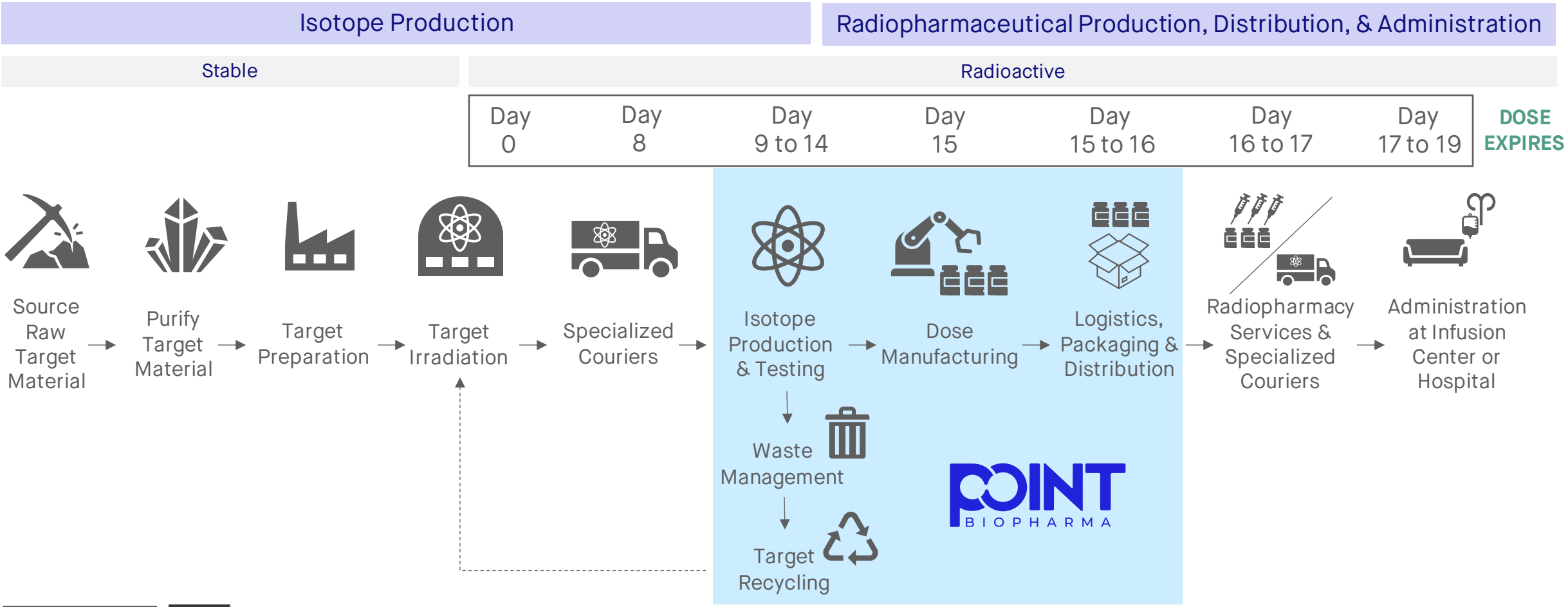
## Redundant $^{225}$Ac supply from partners with access to rare Thorium and Radium inputs

| U.S. Department of Energy | TerraPower (A Nuclear Innovation Company) | Eckert & Ziegler | IONETIX | NorthStar Medical Radioisotopes, LLC |
|---|---|---|---|---|
| Thorium-229 | | | Radium-226 | |
| $^{225}$Ac "milked" from Thorium "cows" | | | $^{225}$Ac via proton accelerator | $^{225}$Ac via electron accelerator |

POINT's Facility

* *Expected to commence by the end of 2023*

# POINT has established redundancies in a complex, just-in-time supply chain to enable the reliable scale-up and manufacturing of no-carrier-added $^{177}$Lu RLT




**Announced Partnerships**

KINECTRICS

sck cen MURR

sck cen itm isotopia Eckert & Ziegler

LANTHEUS

*Example shown for n.c.a. $^{177}$Lu*

*Next Generation Radioligands™*

# Our next-generation early-stage pipeline is focused on patient indications of high unmet need

| Program | Target | Clinical Candidate | Discovery | Preclinical | Phase 1 | Phase 2 | Phase 3 | Commercial Rights |
|---|---|---|---|---|---|---|---|---|
| PNT2002 | PSMA | $^{177}$Lu-PNT2002 | Metastatic Castration-Resistant Prostate Cancer, Pre-Chemo[1] | | | | | LANTHEUS* |
| PNT2003 | SSTR | $^{177}$Lu-DOTATATE | Neuroendocrine Tumors (NETs)[2] | | | | | LANTHEUS* |
| PNT2004 | FAP-α | $^{177}$Lu-PNT6555 | Solid Tumors Expressing FAP[3] | | | | | POINT BIOPHARMA |
| PNT2004 | FAP-α | $^{225}$Ac-PNT6555 | Solid Tumors Expressing FAP | | | | | POINT BIOPHARMA |
| PNT2001 | PSMA | $^{225}$Ac-PSMA-62 | Prostate Cancer | | | | | POINT BIOPHARMA |

| Discovery Programs | |
|---|---|
| Ligands | Multiple programs are underway assessing the CanSEEK™ platform with novel ligands, as well as other novel small and large molecule candidates |
| Radioisotopes | Assessment of alpha, beta, and auger emitters to match the right isotope with the specific disease state and target characteristics |
| Combinations | Combination testing of RLT with existing and novel IO, DDRi, and chemotherapy products for identification of compelling opportunities for clinical testing |

** partnered with Lantheus Holdings Inc. for exclusive worldwide rights excluding certain territories of : Japan, South Korea, China (including Hong Kong, Macau and Taiwan), Singapore, and Indonesia*
***1.*** *SPLASH (NCT04647526),* ***2.*** *Trial sponsored by the University Health Network (NCT02743741),* ***3.*** *FRONTIER (NCT05432193)*

# Key strategic near-term priorities

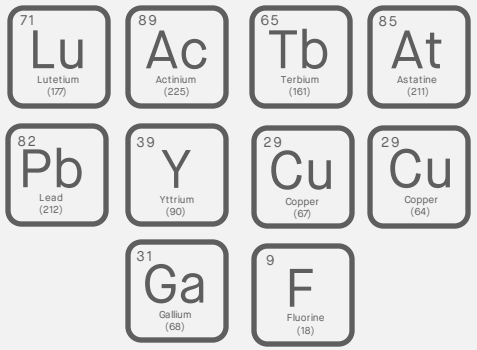
Strategic investment in current and additional programs, new isotopes, and opportunistic partnerships

## Programs

| Discovery | Preclinical | Phase 1 | Phase 2 | Phase 3 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Expand clinical trials to include novel approaches and continue to increase investment in discovery

## Isotopes




Expand isotope "tool chest" to include new, high potential isotopes

## Partnerships

Engage in new partnerships and in-licensing opportunities synergistic with POINT's platform

# POINT is well positioned to become the leader in next-generation radioligands™

**Chemistry, Radiochemistry, and Biology**

**GMP Process Development and CMC**

POINT BIOPHARMA

**Clinical Development and Regulatory**

**Manufacturing and Supply Chain**

## EXECUTIVE TEAM:

**DR. JOE McCANN PhD**
CEO & Co-Founder

**DR. NEIL FLESHNER, MD**
Chief Medical Officer & Co-Founder

**ALLAN SILBER**
Executive Chairman & Co-Founder

**BILL DEMERS, FCPA**
Chief Financial Officer

**JUSTYNA KELLY, MSc**
Chief Operating Officer

**ARI SHOMAIR**
Chief of Staff

**DR. MYRA ROSARIO HERRLE, PhD**
EVP, Regulatory Affairs

**JESSICA JENSEN, MPH**
EVP, Clinical Development

**CHRIS HORVATH, MSc, MBA**
EVP, Commercial

## 170+ TEAM MEMBERS WITH EXPERIENCE FROM COMPANIES INCLUDING:

cpdc Centre for Probe Development and Commercialization · Advanced Accelerator Applications · BAYER · abbvie · NOVARTIS · gsk · AstraZeneca · Progenics Pharmaceuticals · Avacta · EY · Northern Biologics · GlycoMimetics · ENDOCYTE · Dana-Farber Cancer Institute · UHN · SGS · GILEAD · SANOFI GENZYME · CardinalHealth™ · OICR Ontario Institute for Cancer Research

# Anticipated Milestones & Financial Summary

Meaningful near-term value creation milestones with a long-term goal of introducing **five new programs in humans** by the end of 2028

| Program | Clinical Candidate | Indication | Timing (Est.) | Milestone |
|---|---|---|---|---|
| PNT2002 | $^{177}$Lu-PNT2002 | mCRPC | **Q4 2023** | Topline data |
| PNT2001 | $^{225}$Ac-PSMA-62 | Prostate cancer | **Q4 2023** | Health authority submission |
| PNT2001 | $^{225}$Ac-PSMA-62 | Prostate cancer | **Q1 2024** | First patient in phase 1 |
| Discovery Program A | Undisclosed | Undisclosed | **1H 2024** | Disclose new development candidate |
| PNT2004 | $^{177}$Lu-PNT6555 | Solid tumors expressing FAP | **1H 2024** | Phase 1 data |
| PNT2001 | $^{225}$Ac-PSMA-62 | Prostate cancer | **EOY 2024** | Clinical data update |
| Discovery Program B | Undisclosed | Undisclosed | **EOY 2024** | Disclose new development candidate |
| **Manufacturing & Isotope Supply** | | **Location** | **Timing (Est.)** | **Milestone** |
| In-house n.c.a $^{177}$Lu production | | CORE Campus | **EOY 2023** | Online |

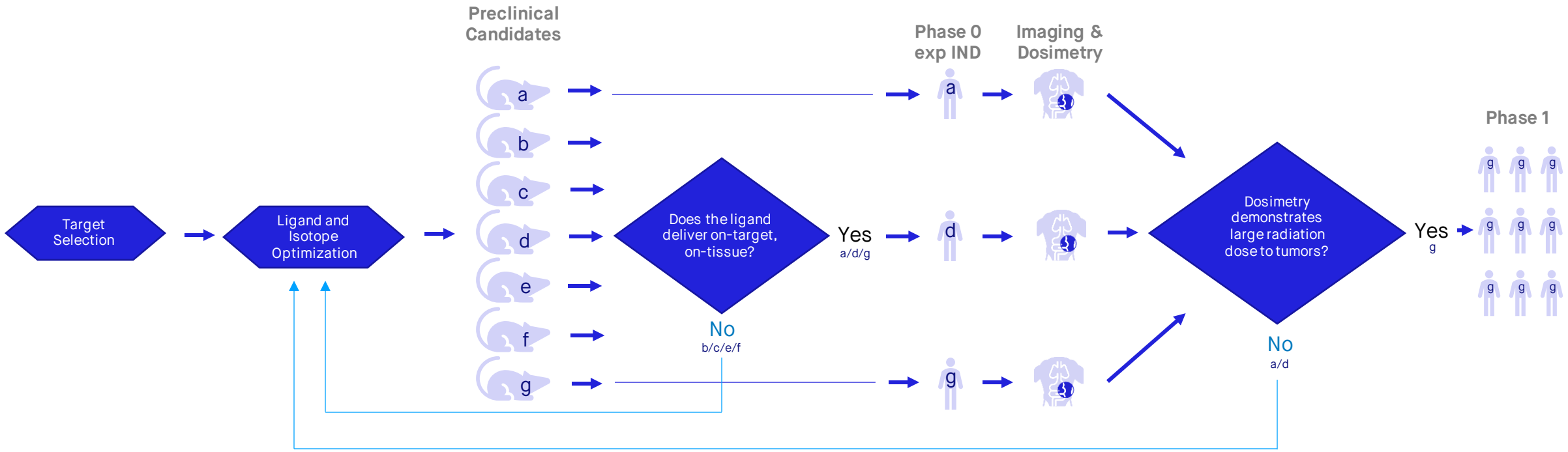
| | |
|---|---|
| **Balance Sheet** | **$435M** in cash, cash equivalents, and investments, as of June 30, 2023 |
| **Projected Runway** | Cash runway into 2026 |
| **Capital Structure** | **105.8M** Common Shares + **8.6M** Options |


# Programs:
# **Phase 1:** $^{177}$Lu-PNT2004 Fibroblast Activation Protein-α Targeting Ligand for Multiple Tumor Types

# Radioligand therapies have the unique advantage of being able to use imaging and dosimetry to shorten the path to human proof-of-concept

The radiation emitted by radioligands can be used to produce images to estimate the variables that impact efficacy and safety: where the ligand goes, how much radiation is delivered, and for how long.

Imaging data can therefore be used to efficiently screen multiple preclinical candidates in parallel.

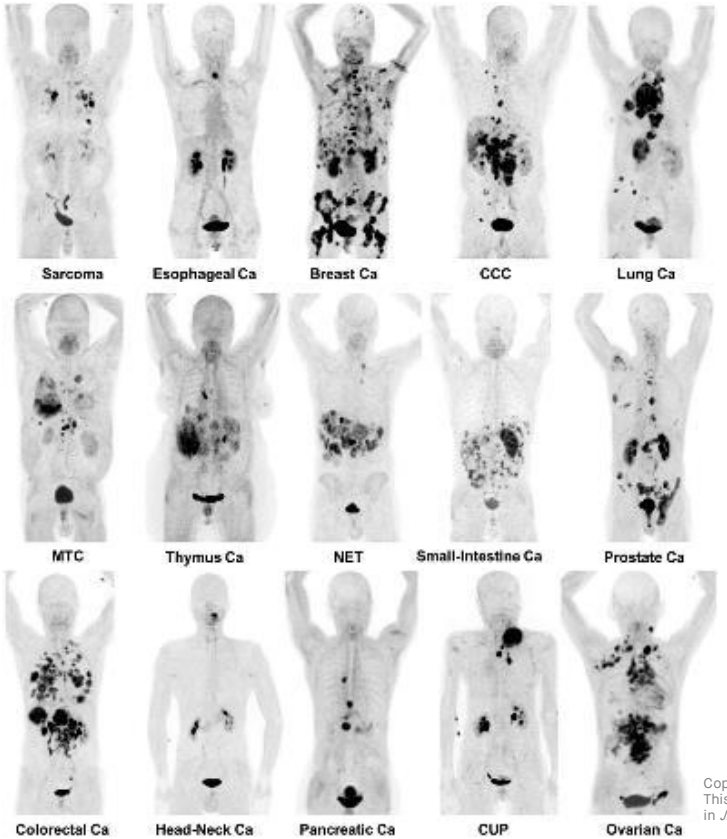



*exp IND, exploratory IND.*

# FAP-α is a compelling pan-cancer target for imaging and therapy that is found in >90% of epithelial tumors[1,2,3]

In cancer, fibroblast activation protein-α (FAP) is highly expressed on cancer associated fibroblasts (CAFs)[3,4], which drives tumor progression and resistance to chemo and immunotherapy[5,6,7]:

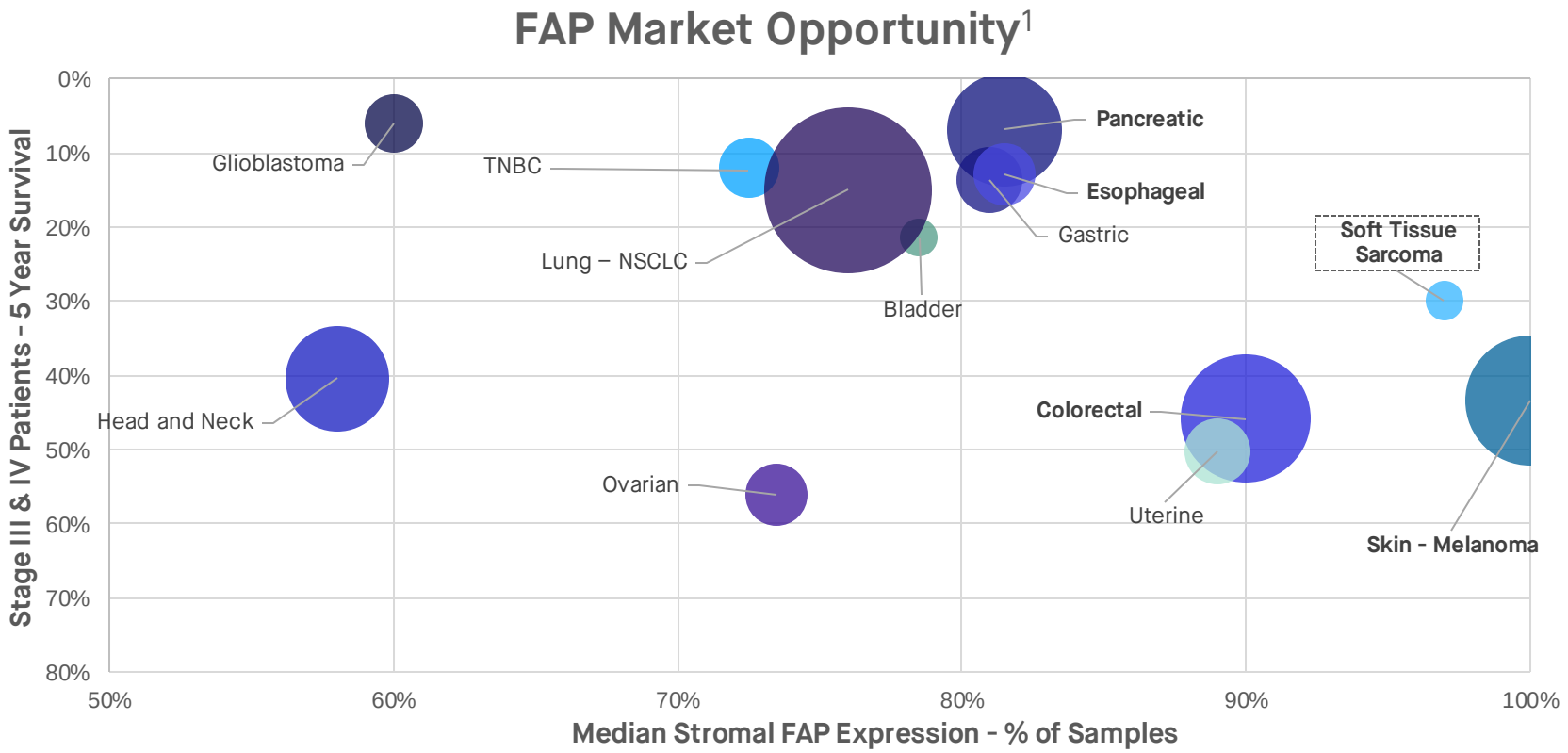
- FAP is a 170kDa membrane bound prolyl endopeptidase[8]
- FAP is expressed during development[9] but rarely in healthy adult tissues[1,3]
- FAP is upregulated at sites of active tissue remodeling, such as during wound healing[10]
- FAP is highly upregulated in cancer by overexpression on CAFs[1,2,3,4] and by some mesenchymal origin tumors (sarcoma, mesothelioma)[11]
- **PNT2004** is a proprietary D-ala-boroPro warhead platform developed by Dr. William Bachovchin at Tufts that is highly specific for FAP-α over other dipeptidyl peptidases ubiquitously expressed in the body
- **PNT6555 (clinical lead)** is a potent DOTA-conjugated FAP-targeting compound built with the D-ala-boroPro warhead technology






***1.*** *Rettig WJ, et al. Proc Natl Acad Sci USA. 1988;85(9):3110-3114.* ***2.*** *Garin-Chesa P, Old LJ, Rettig WJ. Proc Natl Acad Sci USA. 1990;87:7235–7239.* ***3.*** *Dolznig H, et al. Cancer Immun. 2005;5:10.* ***4.*** *Scanlan MJ, et al. Proc Natl Acad Sci USA. 1994;91:5657–5661.* ***5.*** *Mhawech-Fauceglia P, et al. Cancer Microenviron. 2015;8(1):23-31.* ***6.*** *Domen A, et al. Cancers (Basel). 2021;13(5):987.* ***7.*** *Joshi RS, et al. Cancers (Basel). 2021;13(6):1399.* ***8.*** *NCBI (nih.gov). Gene. Gene ID: 2191, updated 8-Dec-2022, accessed 11-Jan-2023. https://www.ncbi.nlm.nih.gov/gene?Db=gene&Cmd=ShowDetailView&TermToSearch=2191.* ***9.*** *Niedermeyer J, et al. Int J Dev Biol. 2001;45(2):445-447.* ***10.*** *Jacob M, Chang L, Puré E. Curr Mol Med. 2012;12(10):1220-1243.* ***11.*** *Dohi O, et al. Histopathology. 2009;55(4):432-440.* ***12.*** *Kratochwil C, et al. J Nucl Med. 2019;60(6):801-805.*

# As a pan-cancer RLT, PNT2004 has an extremely broad market opportunity: FAP-α expression has been demonstrated in **the most common solid tumor types**




**Bubble Size represents the number of US Stage III & IV Patients.**

**Cancers in the top right quadrant represent ideal cancer targets due to high FAP expression + high unmet need.**

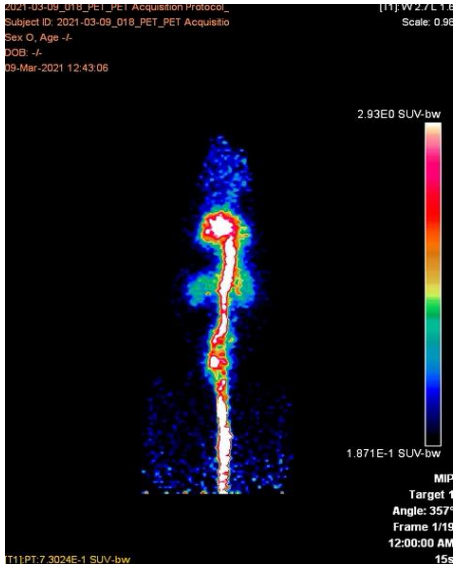
*Indicates FAP expression on cancer cells as well as stroma*

***1.*** *Management Estimates*

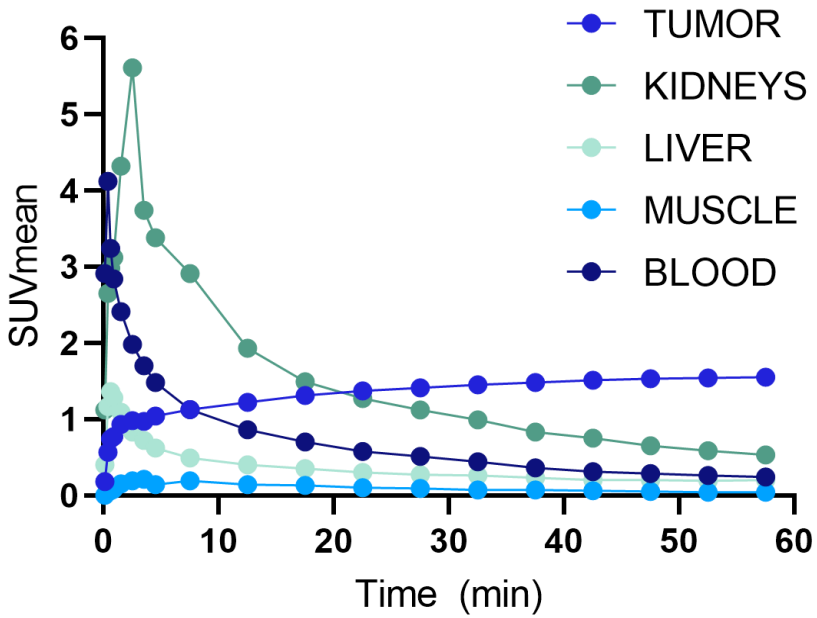
# PNT6555 is the lead of the PNT2004 program. $^{68}$Ga-PNT6555 biodistribution studies demonstrate fast tumor targeting with little accumulation in normal tissues.

Rapid and sustained tumor retention with fast clearance from organs and tissues is an ideal profile for molecular imaging.

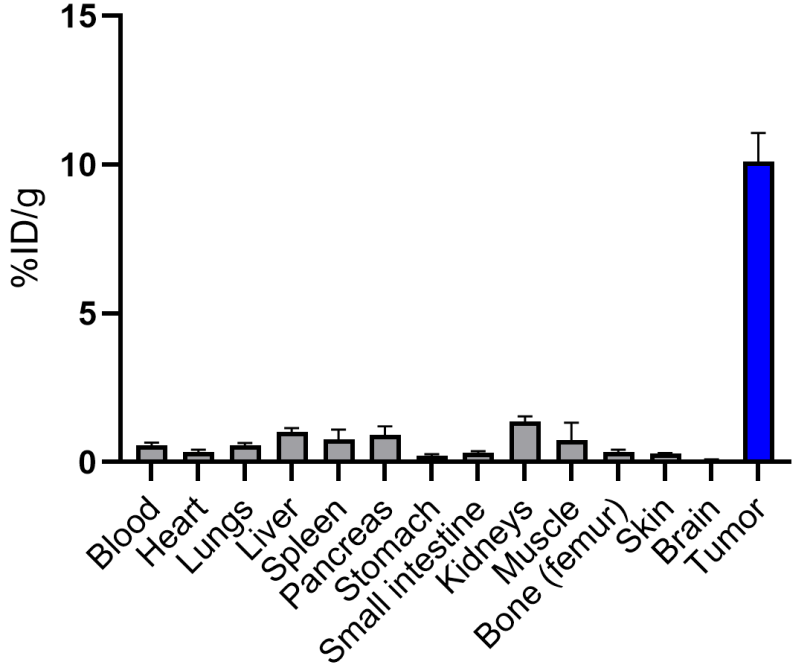
## Dynamic Imaging




## $^{68}$Ga-PNT6555 Biodistribution




## $^{68}$Ga-PNT6555 Biodistribution at 60 min

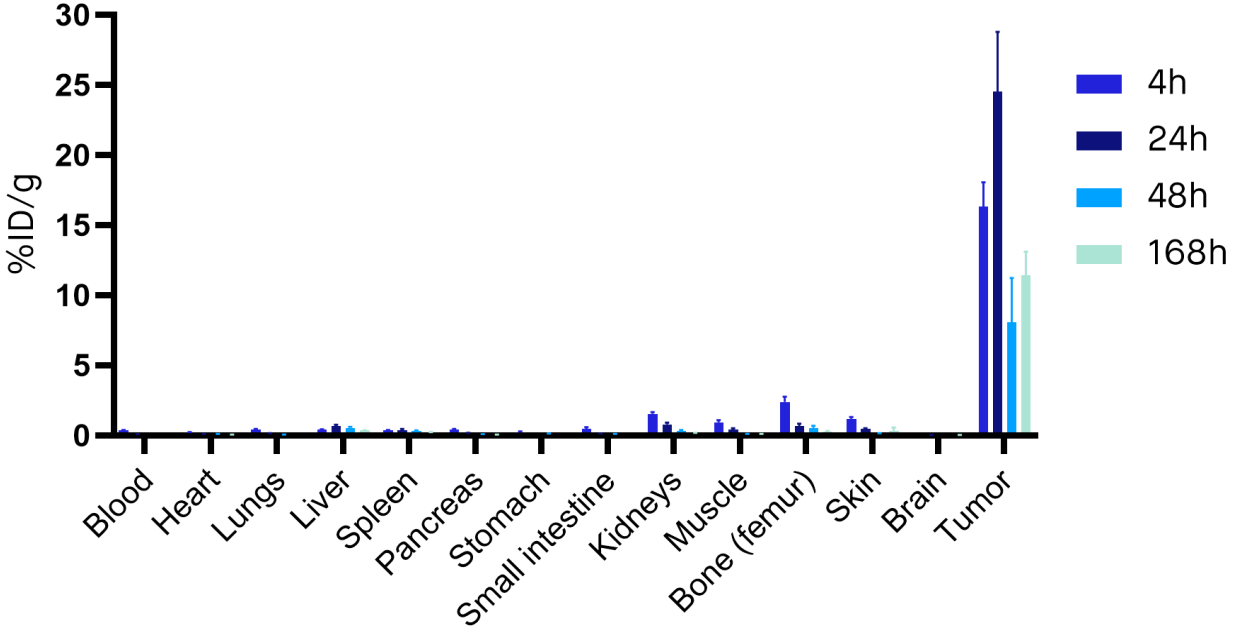



*HEK-mFAP tumor bearing Fox Chase SCID, n=3/timepoint. Hallet R, et al. Pre-clinical characterization of the novel fibroblast activation protein (FAP) targeting ligand PNT6555 for the imaging and therapy of cancer. Presented at SNMMI Annual Meeting April 2022; Vancouver, BC, Canada.*

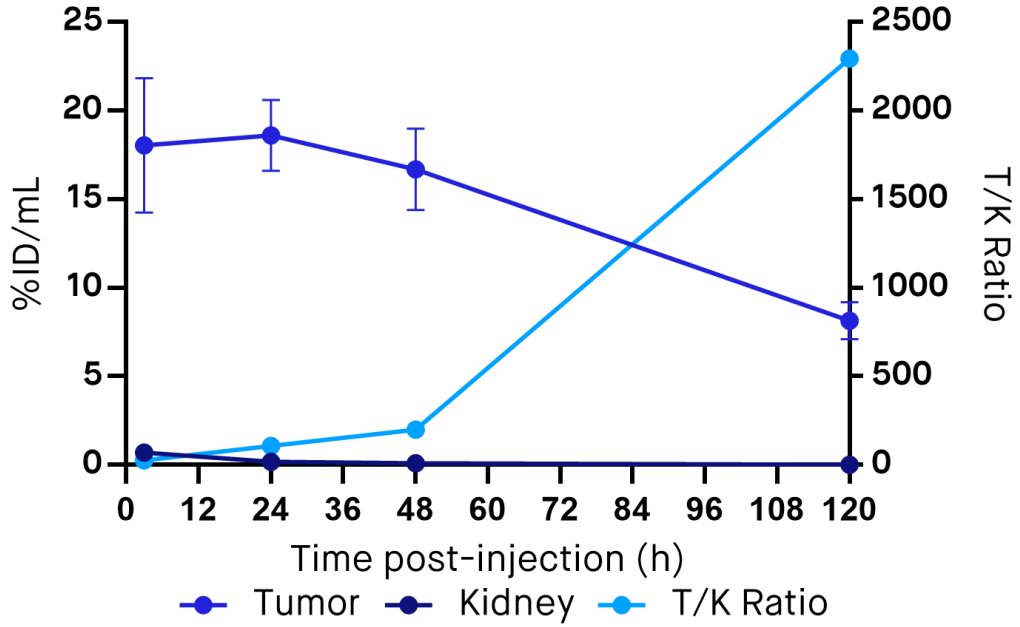
# $^{177}$Lu-PNT6555 biodistribution studies demonstrate prolonged tumor retention and rapid normal tissue clearance

Sustained retention in the tumor beyond 7 days with low retention in organs and tissues, including the kidney and bone, highlights the potential of PNT6555 as an RLT.

$^{177}$Lu-PNT6555 Biodistribution



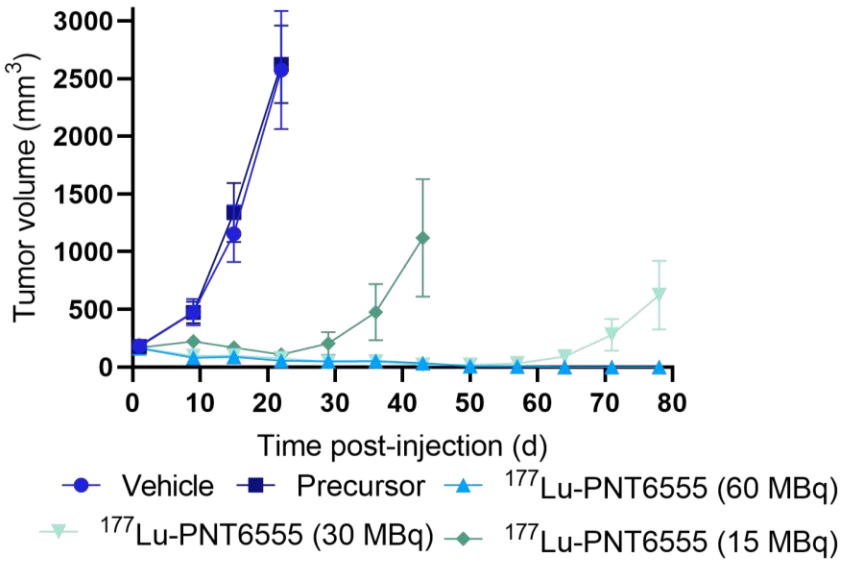

Organ Uptake $^{177}$Lu-PNT6555 SPECT



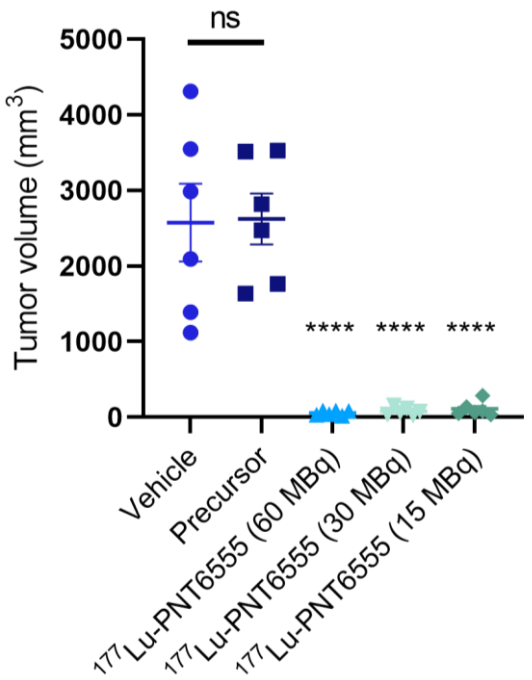

*HEK-mFAP tumor bearing Fox Chase SCID, n=3/timepoint. Hallet R, et al. Pre-clinical characterization of the novel fibroblast activation protein (FAP) targeting ligand PNT6555 for the imaging and therapy of cancer. Presented at SNMMI Annual Meeting April 2022; Vancouver, BC, Canada.*

# $^{177}$Lu-PNT6555 shows compelling anti-tumor activity, with mice experiencing long-term survival

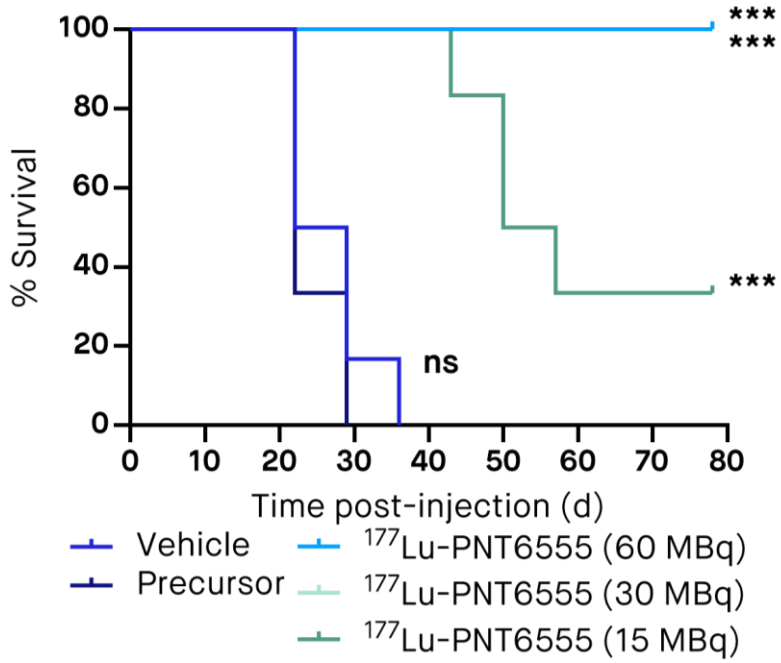
## Tumor Volumes




## Tumor Volumes on Day 22




## Kaplan-Meier Survival Curves



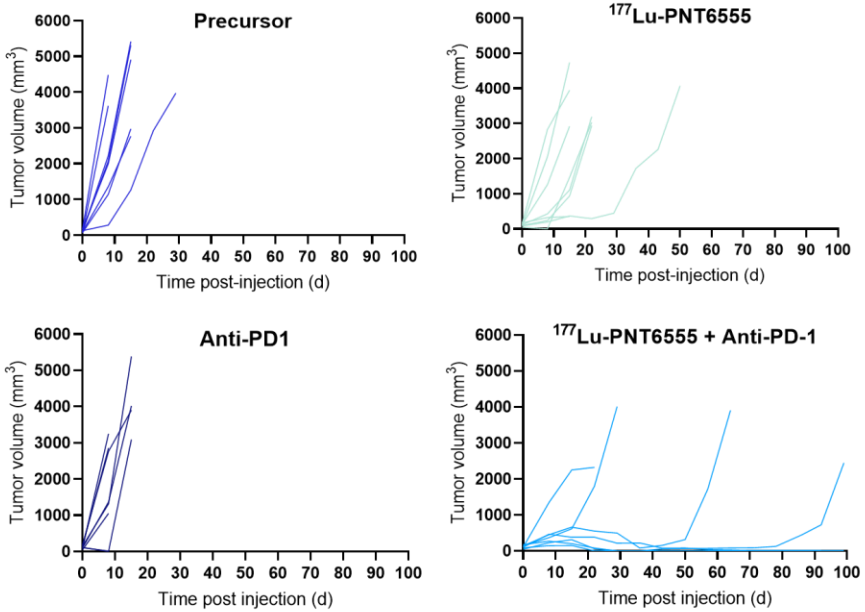

**Similar results have been shown with $^{225}$Ac-PNT6555**
**Additional studies in syngeneic and PDX models are underway**

*HEK-mFAP model, n=6/group, single dose treatment in mice with tumors (~200mm $^3$), ns=not significant, *p<0.05, **p<0.01, ***p<0.001, **** p<0.0001. Hallet R, et al. Pre-clinical characterization of the novel fibroblast activation protein (FAP) targeting ligand PNT6555 for the imaging and therapy of cancer. Presented at SNMMI Annual Meeting April 2022; Vancouver, BC, Canada.*

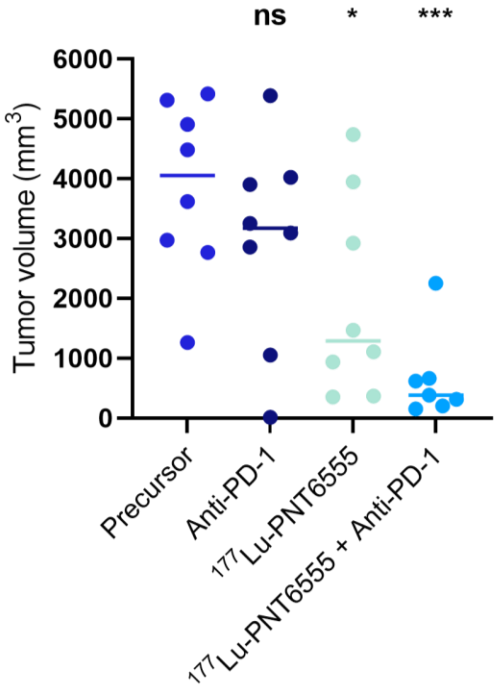
# Preclinical data demonstrate $^{177}$Lu-PNT6555 acts synergistically with immunotherapy; anti-PD-1 insensitive tumors become responsive to anti-PD-1 when used in combination with $^{177}$Lu-PNT6555

$^{177}$Lu-PNT6555 and anti-PD-1 combination treatment resulted in a large survival benefit in mice relative to either treatment alone. The CT26-mFAP tumor model used for the study is a low FAP expressing model that grows aggressively and is insensitive to anti-PD-1 immunotherapy.

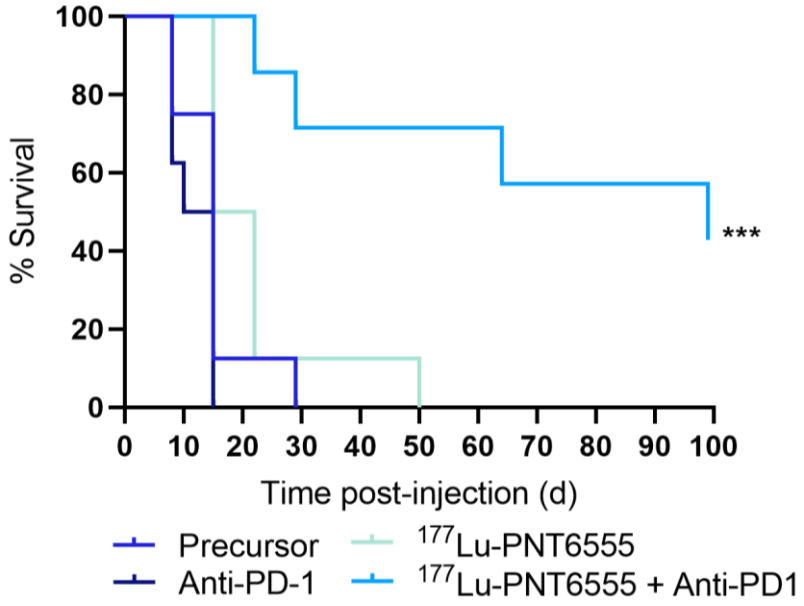
## Individual Tumor Growth Plots




## Tumor Volumes on Day 15




## Kaplan-Meier Survival Curves




*CT26-mFAP model; n=8/group; treatment started at ~120mm $^3$; $^{177}$Lu-PNT6555 60MBq (days 1&8), Anti-PD-1 (250 µg IP 3x/week x 3 weeks, clone RMP1.14); Day 15 tumor volumes analyzed by ANOVA; survival curves analyzed by Mantel-Cox Log-Rank comparing against precursor: ns=not significant, *p<0.05, **p<0.01, ***p<0.001; data on file; study ongoing*

# **FRONTIER**: **F**APi **R**adioligand **O**pe**N**-label, phase 1 study to evaluate safety, **T**olerability and dos**I**metry of $^{177}$Lu-PNT6555—A dose **E**scalation study for t**R**eatment of patients with select solid tumors.

## Imaging & Therapy

$^{68}$Ga-PNT6555

120 - 220 MBq
(3.2 - 5.9 mCi)

**≥50% of lesions with $SUV_{max}$ ≥1.5x liver $SUV_{mean}$**

$^{177}$Lu-PNT6555

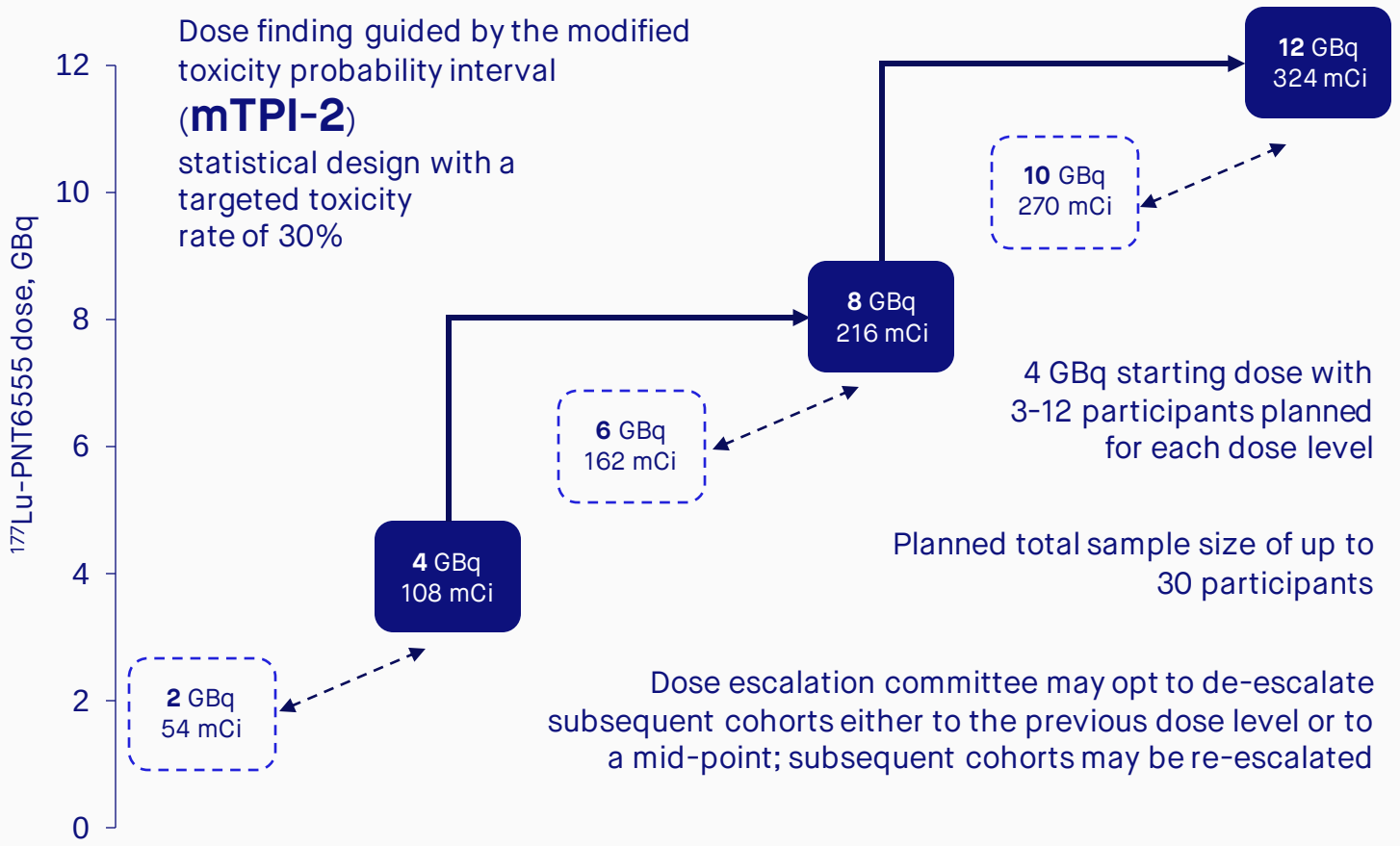
Once every 6 weeks for up to **6 cycles**

**Advanced or Metastatic**

- Esophageal Cancer
- Cholangiocarcinoma
- Melanoma Skin Cancer
- Colorectal Cancer
- Head & Neck Cancer
- Adenocarcinoma of the Pancreas
  *Squamous Cell Carcinoma or Adenocarcinoma*
- High-grade Soft Tissue Sarcoma
  *excluding Chordoma*

## Dose Escalation

Dose finding guided by the modified toxicity probability interval (**mTPI-2**) statistical design with a targeted toxicity rate of 30%




4 GBq starting dose with 3-12 participants planned for each dose level

Planned total sample size of up to 30 participants

Dose escalation committee may opt to de-escalate subsequent cohorts either to the previous dose level or to a mid-point; subsequent cohorts may be re-escalated

*DLT, dose limiting toxicity; GBq, gigabecquerel; MBq, megabecquerel; mCi, millicurie.*

# **FRONTIER**: **F**APi **R**adioligand **O**pe**N**-label, phase 1 study to evaluate safety, **T**olerability and dos**I**metry of $^{177}$Lu-PNT6555—A dose **E**scalation study for t**R**eatment of patients with select solid tumors.

## Primary Objective

**RP2D** for $^{177}$Lu**-PNT6555**

Determine the recommended phase II dose (RP2D) for $^{177}$Lu-PNT6555

## Exploratory Objectives

$^{177}$Lu**-PNT6555**

- Tumor response
- Biomarker changes
- Tumor immune response
- Tumor dosimetry

## Secondary Objectives

$^{68}$Ga**-PNT6555**

Safety and tolerability

Biodistribution and radiation dosimetry to normal organs

Qualitative tumor lesion detection

Quantitative tumor lesion uptake

$^{177}$Lu**-PNT6555**

Safety and tolerability

Biodistribution and radiation dosimetry to normal organs

**Current Status:** Enrollment to dose level cohort 3 (12 GBq) began in May 2023 with data anticipated 1H 2024

# Data from the full phase 1 FRONTIER study is expected to be available in the first half of 2024

**Preclinical activities underway to inform phase 2 opportunities**

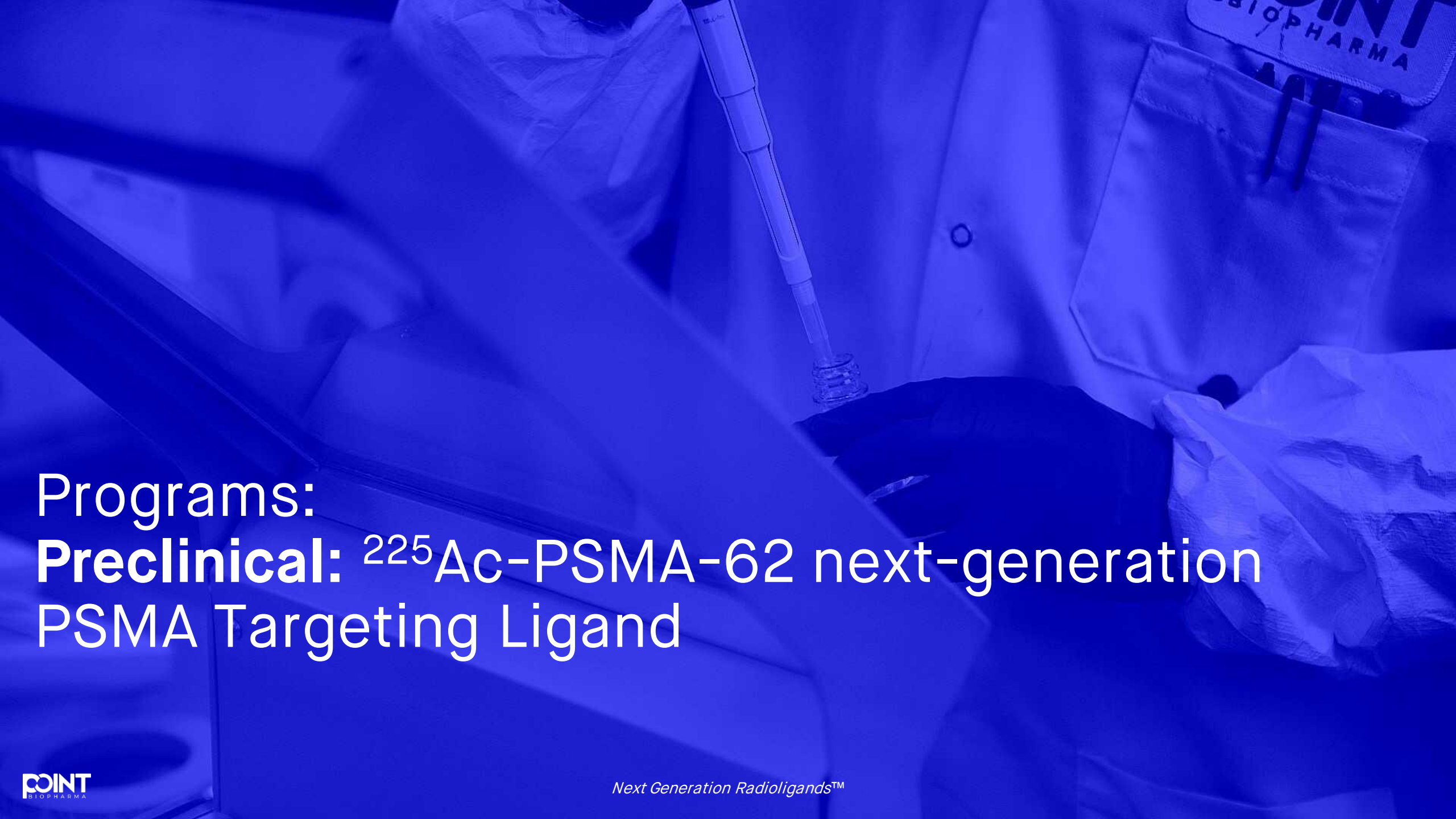
Additional studies in syngeneic and PDX models underway.

**Actively expanding access to gallium-68 imaging agent**

Technology transfers of imaging agent to multiple sites to expand phase 1 recruitment and plan for phase 2 are underway.

**Phase 1 trial proceeding as planned**

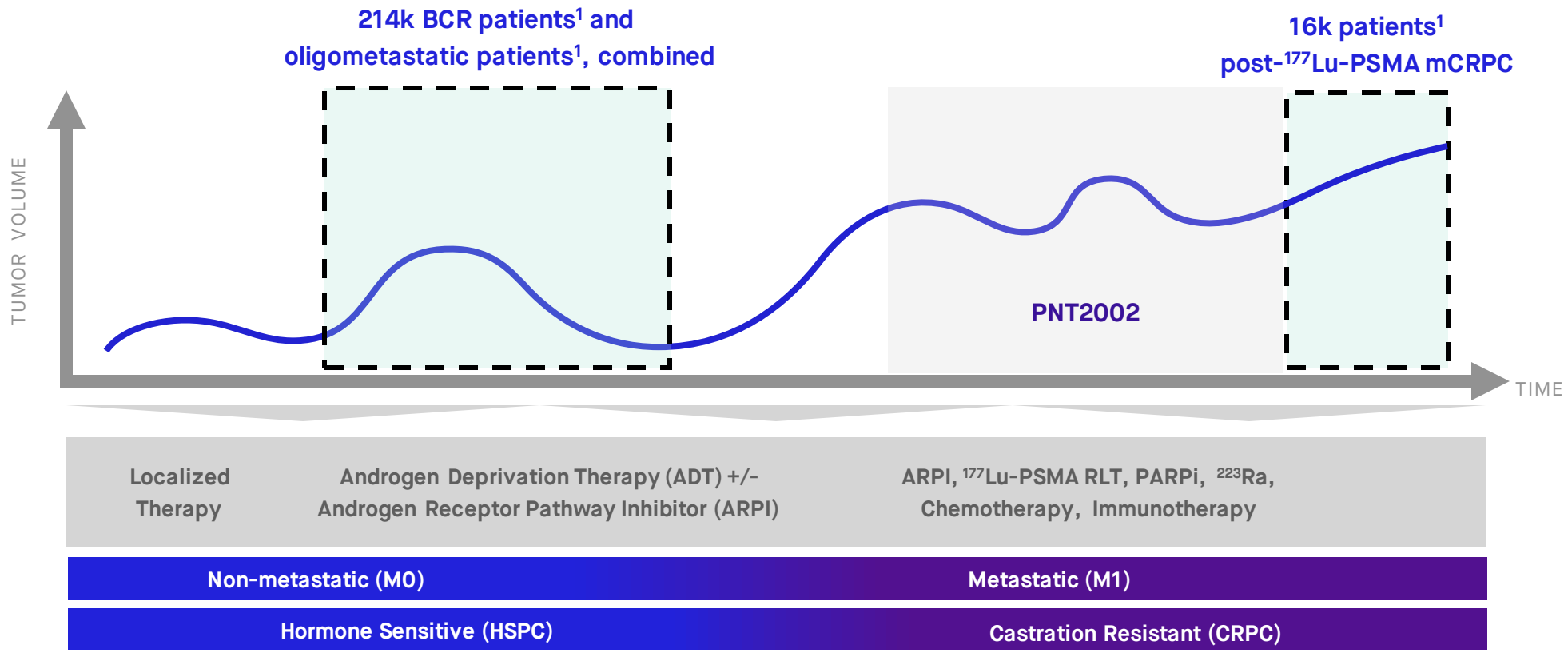
Enrollment in cohort 2 of FRONTIER began in December 2022. Enrollment in cohort 3 began in May 2023.



# Programs:
# **Preclinical:** $^{225}$Ac-PSMA-62 next-generation PSMA Targeting Ligand

# PSMA-62 is a next-generation PSMA radioligand optimized for delivery of $^{225}$Ac

The clinical development plan is to evaluate the clinical lead in the biochemically recurrent, oligometastatic, and post-$^{177}$Lu-PSMA mCRPC settings.




*1. US patients; Management Estimates*

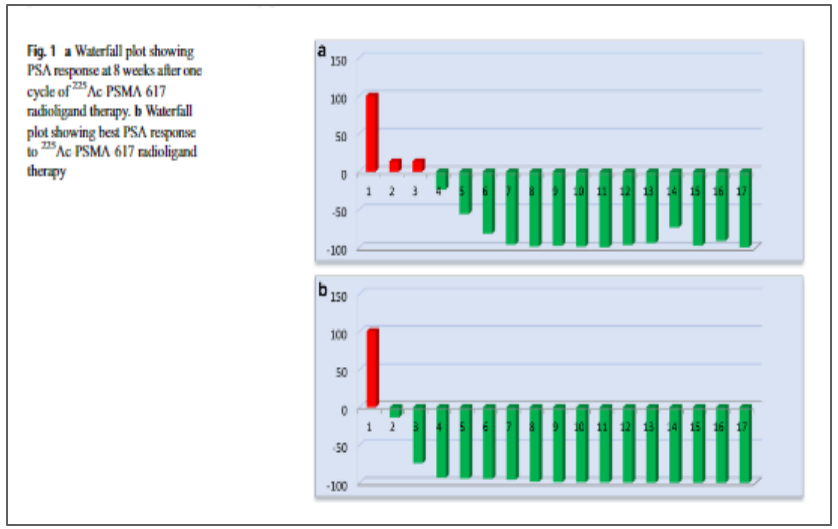
# $^{225}$Ac-PSMA has shown clinical activity in treatment-naïve patients as well as those previously treated with ADTs or who failed $^{177}$Lu-PSMA

Moving targeted radioligand therapy earlier in the treatment pathway creates an opportunity to potentially avoid the hypogonadal state and associated toxicities

$^{225}$Ac combined with 1$^{st}$ generation ligands has shown preliminary clinical activity in patients who were:

- Previously treated with $^{177}$Lu-PSMA[1]
- Previously treated with ADTs[2,3]
- Treatment-naïve[3]

**$^{225}$Ac-PSMA post-ADT & in treatment naïve patients[3]**

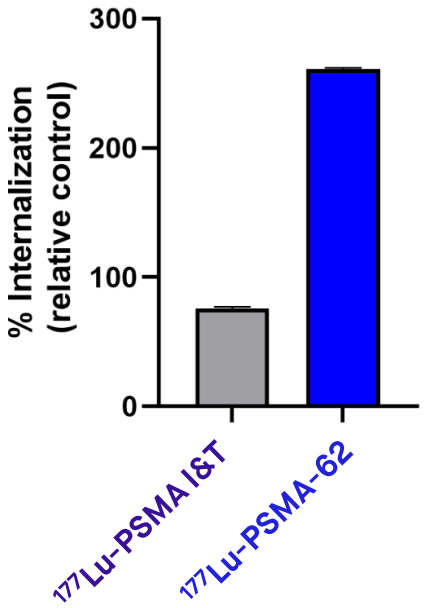




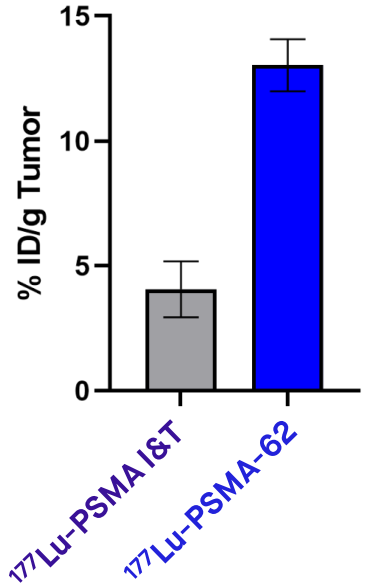

***1.*** *Sanli Y, et al. Clin Nucl Med. 2021;46(12):943-951.* ***2.*** *Sathekge M, et al. J Nucl Med. 2022;63(10):1496-1502.* ***3.*** *Sathekge M, et al. Eur J Nucl Med Mol Imaging. 2019;46(1):129-138.*

# PSMA-62 has linker technology that allows for increased internalization into cells, resulting in increased tumor uptake

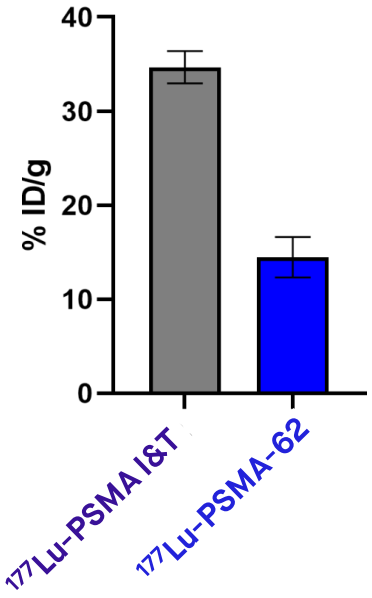
## Improved Internalization



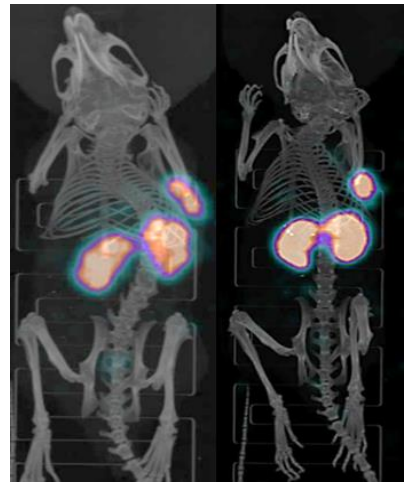

## Improved Tumor Uptake




## Reduced Kidney Uptake




## $^{177}$Lu-PSMA-62



T: 14.3%ID/g
K: 13.7%ID/g

T: 12.4%ID/g
K: 11.3%ID/g

$^{177}$Lu-PSMA-62, LNCaP tumor bearing , CB17-SCID mice (n = 4, t=24 h)
Internalization in LNCaP cells (n = 3) relative to [$^{125}$I]I-BAKuE reference compound

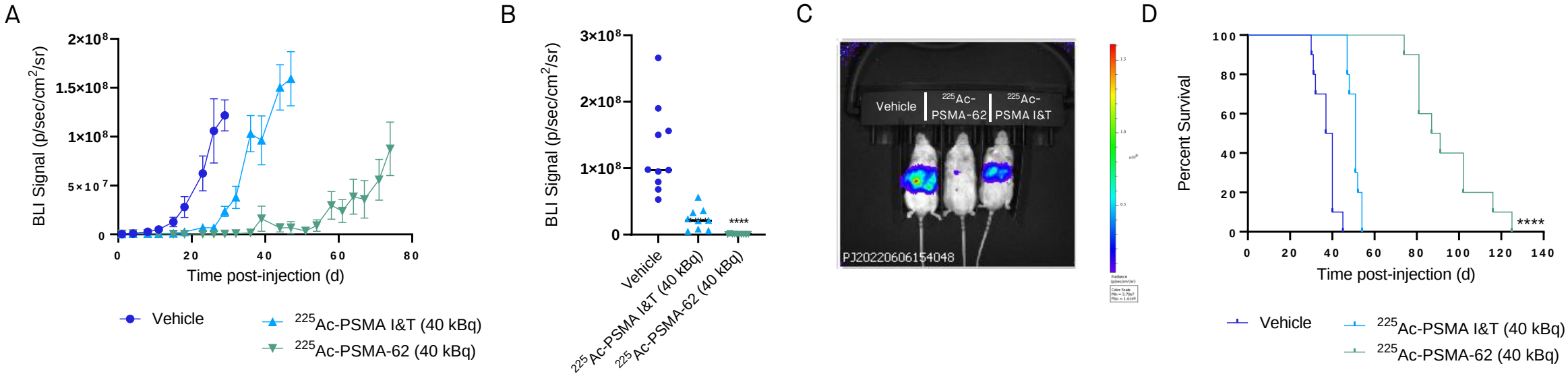
µSPECT/CT Imaging
*LNCaP tumor-bearing CB17-SCID mice, 24 h p.i., 160 pmol each, n = 2*

*Vito A. et al. EP-039. Presented at EANM Congress Oct 2022, Barcelona, Spain.*

# $^{225}$Ac-PSMA-62 shows robust efficacy as a single dose in a PSMA$^{+}$ metastatic prostate tumor model (C4.2) versus $^{225}$Ac-labelled PSMA I&T

Single dose $^{225}$Ac-PSMA-62 treated mice showed significant improvement in tumor burden and survival compared to both control and $^{225}$Ac-PSMA-I&T.

Intracardiac injection of C4.2 leads to metastatic disease (liver, brain, bone marrow mets) and metastatic burden is monitored using bioluminescence.




*A single dose of $^{225}$Ac-PSMA-62 or $^{225}$Ac-PSMA I&T slows tumor growth and improves survival outcomes. NSG mice bearing metastatic C4.2 tumors were treated with vehicle, $^{225}$Ac-PSMA-62 (40 kBq), or $^{225}$Ac-PSMA I&T (40 kBq). Tumor cells expressed luciferase an could therefore be imaged to assess tumor burden based on the correlative bioluminescence (BLI) signal. (**A**) Average BLI signal for each group. Graphing stops when the first mouse from a group reaches endpoint. (**B**) Average BLI signal for each mouse on day 29. Each symbol represents an individual mouse within the group. (**C**) Representative BLI images on day 29 for each group. (**D**) Kaplan-Meier survival curves of each group. ****p<0.0001*

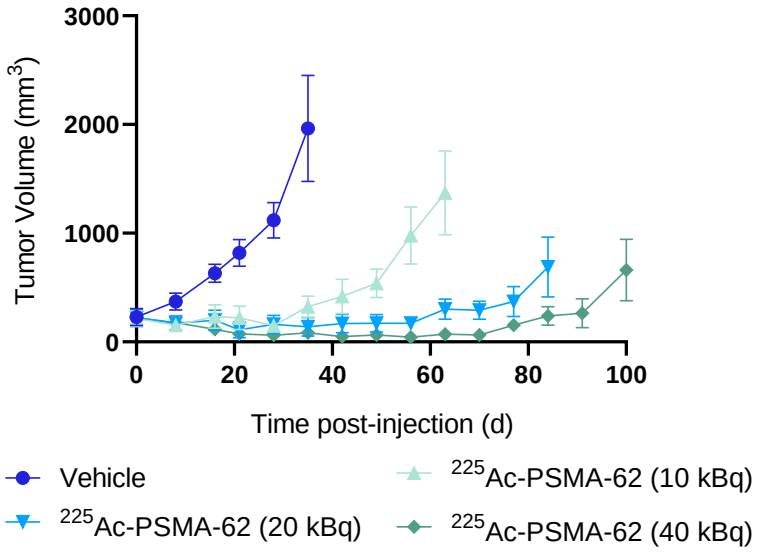
*Vito A. et al. EP-039. Presented at EANM Congress Oct 2022, Barcelona, Spain.*

# $^{225}$Ac-PSMA-62 also shows robust and dose responsive efficacy as a single dose in a PSMA$^{+}$ tumor model (LNCaP model)

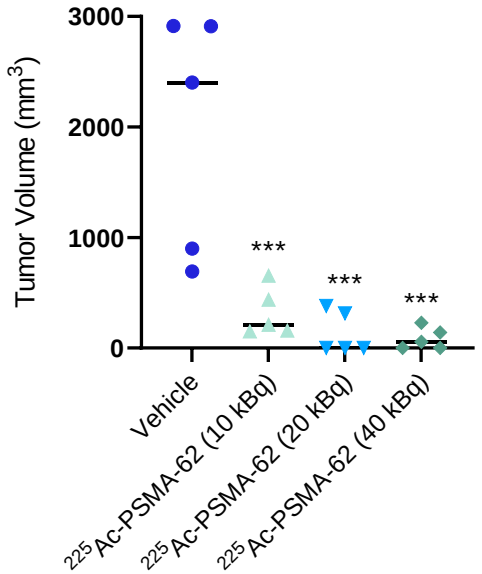
Single dose $^{225}$Ac-PSMA-62 dose responsively inhibits the growth of LNCaP tumors.

Nearly 100% of mice treated with $^{225}$Ac-PSMA-62 at the intermediate and high dose levels survived until end of study (100 days).

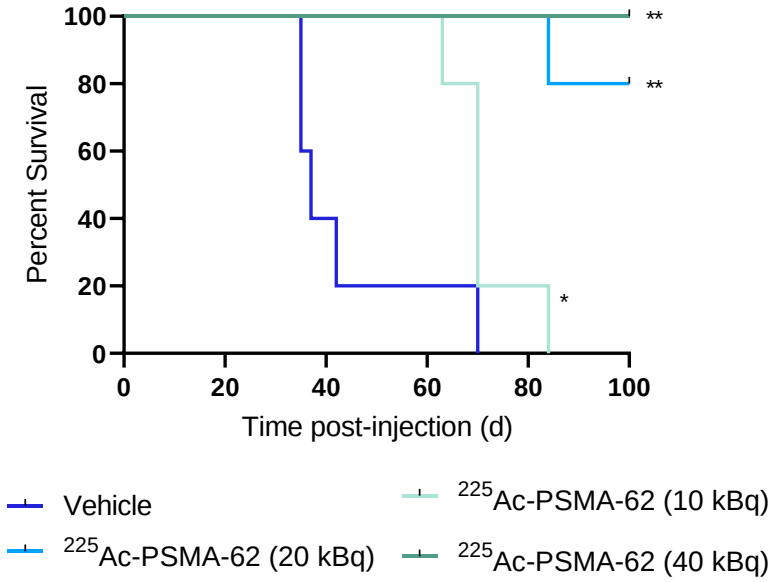
## Tumor Volumes




## Tumor Volumes on Day 35




## Kaplan-Meier Survival Curves



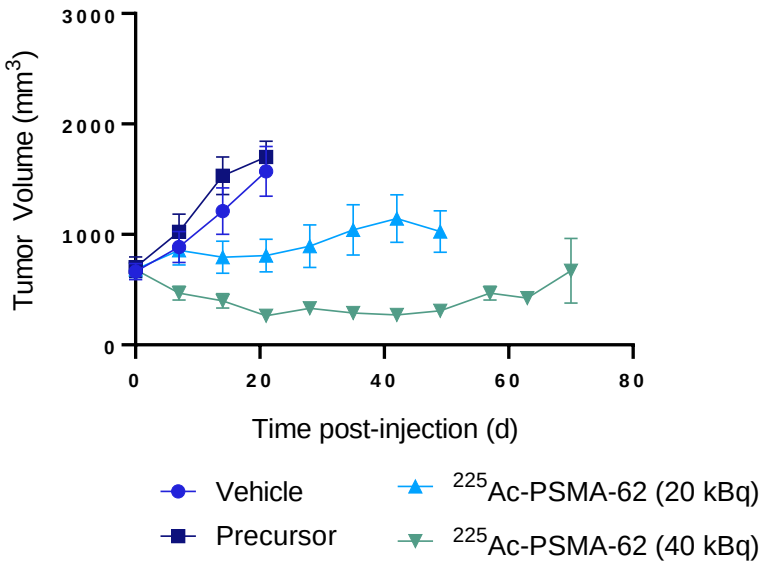

*NSG mice bearing subcutaneous LNCaP tumors on the flank (n=5/group) were treated with vehicle, $^{225}$Ac-PSMA-62 (10 kBq), $^{225}$Ac-PSMA-62 (20 kBq) or $^{225}$Ac-PSMA-62 (40 kBq). **p<0.01; ***p<0.001.*

*Vito A. et al. EP-039. Presented at EANM Congress Oct 2022, Barcelona, Spain.*

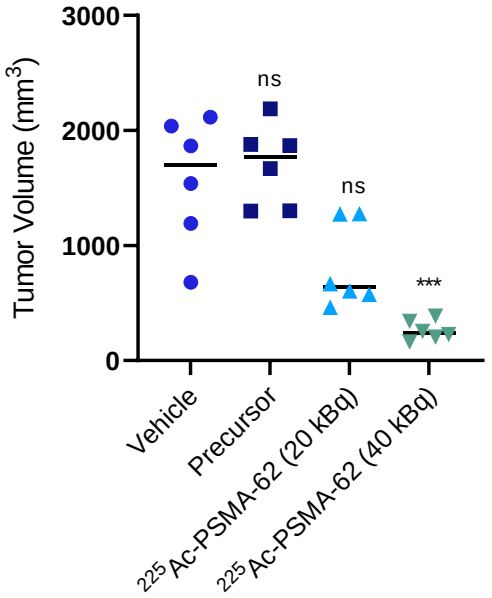
# Single dose efficacy is also seen with $^{225}$Ac-PSMA-62 in large PSMA$^{+}$ prostate tumors in an LNCaP model

Single dose $^{225}$Ac-PSMA-62 inhibits the growth of large LNCaP tumors, a difficult setting to observe monotherapy efficacy.

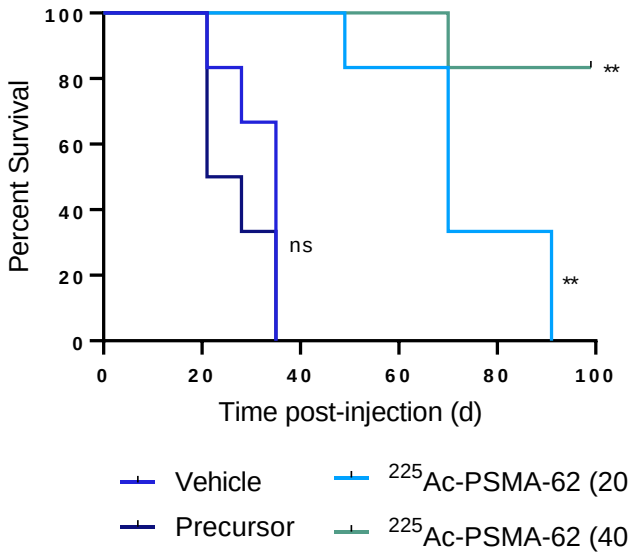
## Tumor Volumes




## Tumor Volumes on Day 21




## Kaplan-Meier Survival Curves

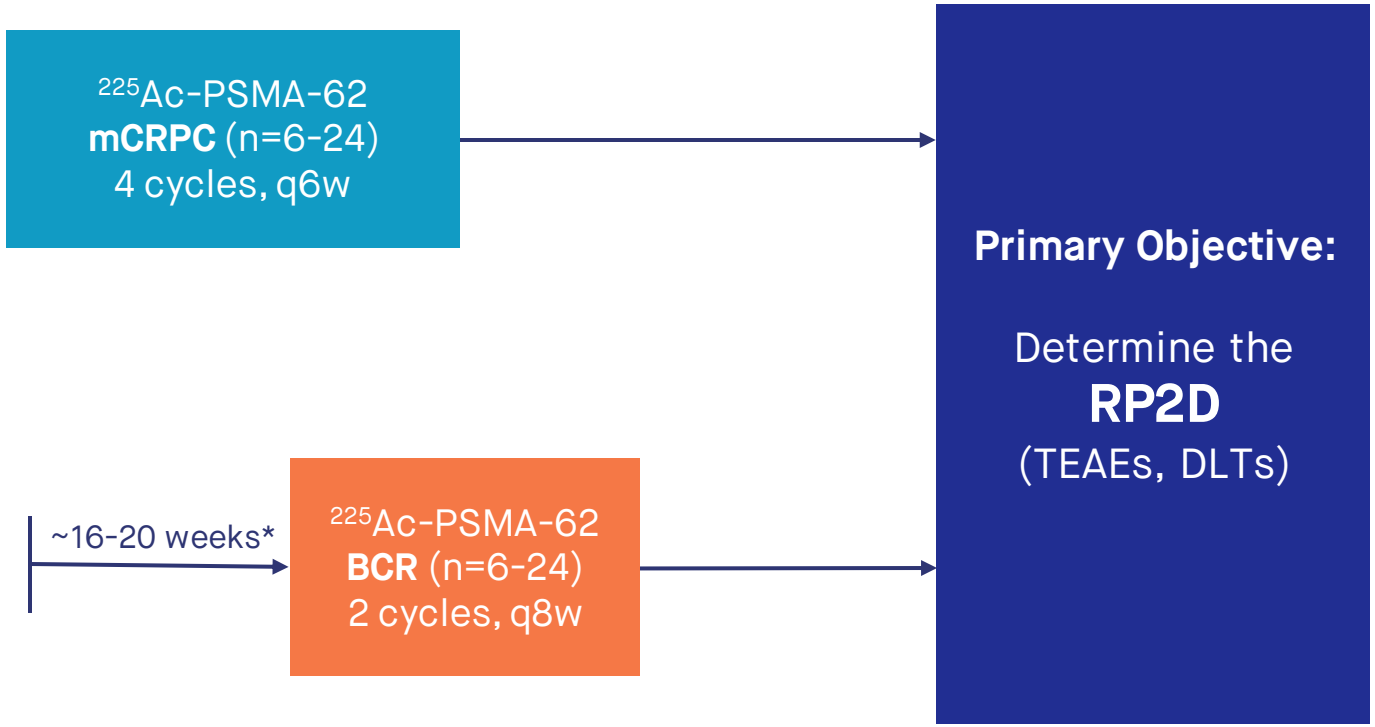



*NSG mice bearing subcutaneous LNCaP tumors on the flank (n=6/group) were treated with vehicle, precursor, $^{225}$Ac-PSMA-62 (20 kBq) or $^{225}$Ac-PSMA-62 (40 kBq). **p<0.01; ***p<0.001; ns, not significant.*
*Vito A. et al. EP-039. Presented at EANM Congress Oct 2022, Barcelona, Spain.*

# ACCEL first-in-human study will separately investigate $^{225}$Ac-PSMA-62 in both mCRPC and BCR prostate cancer

mCRPC & BCR Bayesian Optimal Interval (BOIN) Dose Escalation

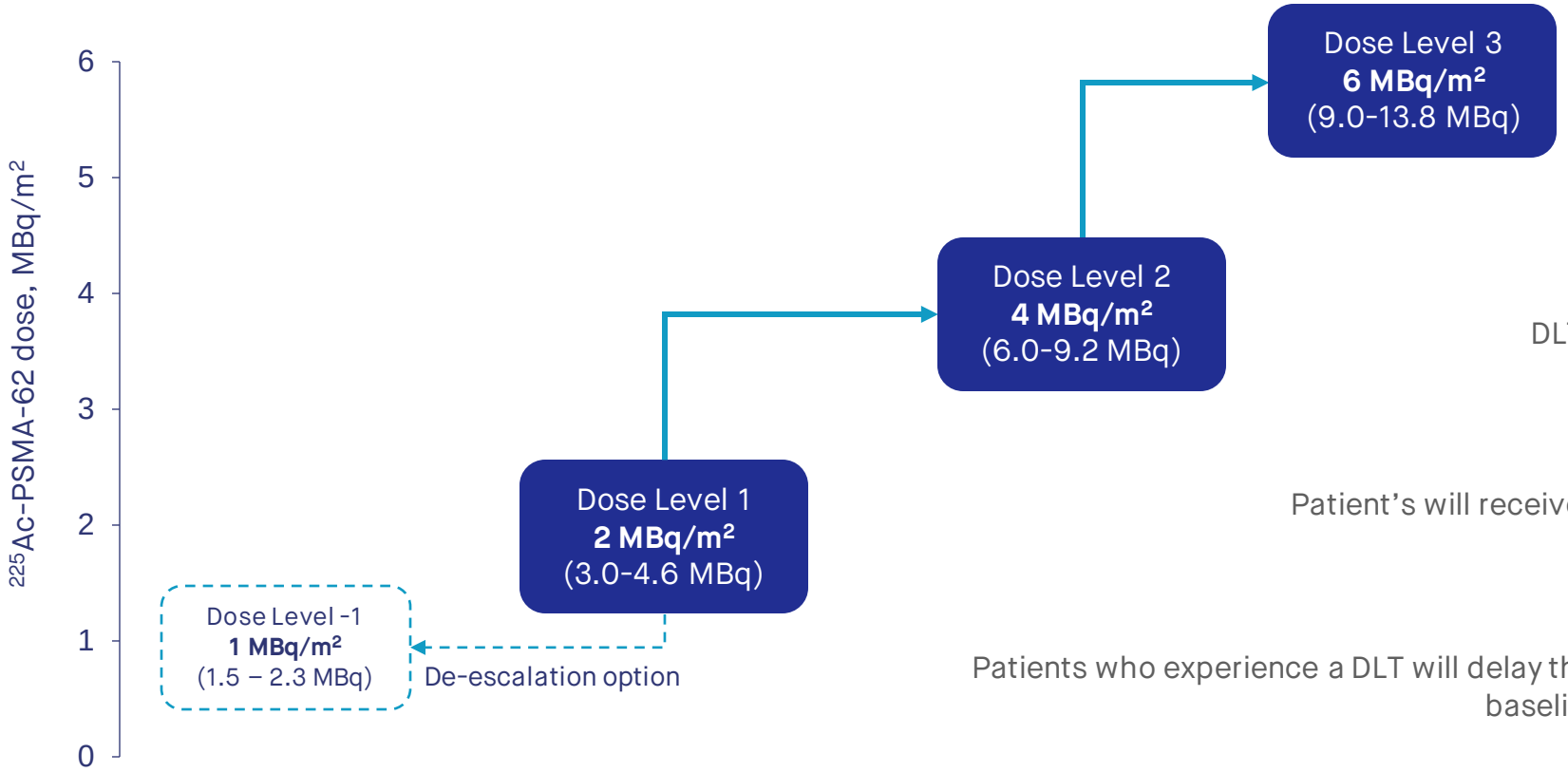
- **mCRPC:** Patients refractory to prior therapy who have exhausted all satisfactory or available approved treatment options. PSMA PET positive.
- **BCR with molecularly defined metastasis:** Patients with biochemical recurrence (BCR) of prostate cancer after surgery or radiation therapy. PSMA PET oligometastatic: 1-5 positive lesions identified outside the prostate bed or remaining gland.




**Enrollment of BCR patients will be opened after initial safety data are generated and reviewed for the mCRPC population (~16-20 weeks). BCR, biochemical recurrence; DLT, dose-limiting toxicity; mCRPC, metastatic castration-resistant prostate cancer; PET, positron emission tomography; PSMA, prostate-specific membrane protein; RP2D, recommended phase 2 dose; TEAE, treatment-emergent adverse event.*

# ACCEL dose escalation strategy: reducing suboptimal dosing in prostate cancer

mCRPC & BCR BOIN Dose Escalation




Cohort size will be 3-6 and utilize the BOIN statistical model to guide DEC decisions

DLTs will be assessed during a 4-week observation period post Cycle 1

Patient's will receive $^{225}$Ac-PSMA-62 at the same dose level for each cycle, precluding intra-patient dose escalation

Patients who experience a DLT will delay their next cycle until toxicity resolves to Grade 1 or baseline, with subsequent doses reduced by 1 MBq/m$^2$

*BOIN, Bayesian optimal interval; DEC, dose escalation committee; DLT, dose-limiting toxicity; MBq, megabecquerel; PSMA, prostate-specific membrane protein.*

# $^{225}$Ac-PSMA-62 targeting health authority submission in Q4 2023, first patient in phase 1 in Q1 2024

**Non-clinical work is ongoing**

IND / CTA enabling studies initiated.

**cGMP process development underway**

Radiochemistry, formulation, and process optimization are ongoing.

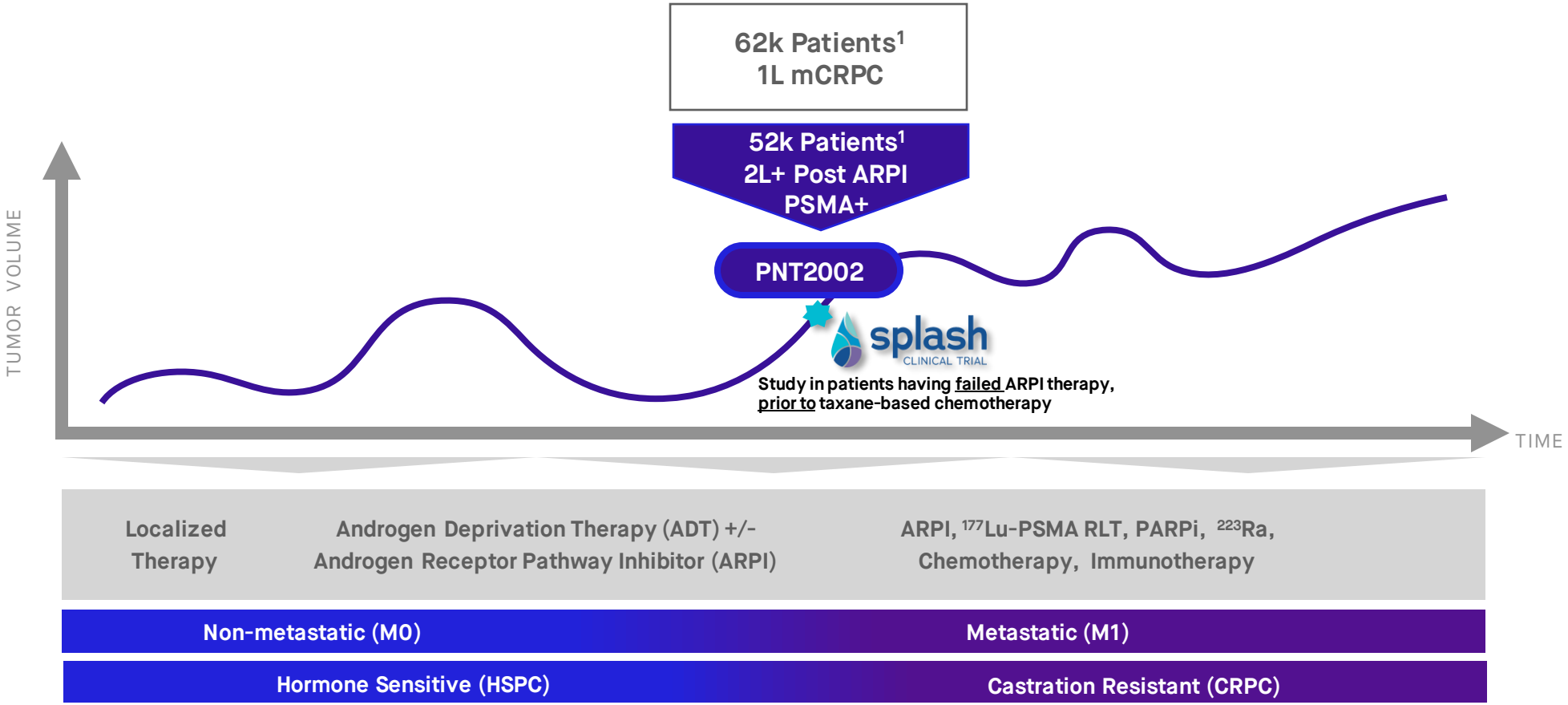
**Anticipating first patient dosed in Q1 2024**

Engagement with KOLs underway to define clinical protocol.

# Programs:
# **Phase 3:** $^{177}$Lu-PNT2002 PSMA-Targeted Ligand for mCRPC

## Topline Data: Anticipated Q4 2023

# PNT2002 is a PSMA-targeted therapy for metastatic castration-resistant prostate cancer (mCRPC), an indication with 52,000 post-ARPI, PSMA-positive patients annually in the US




*1. US patients; Management Estimates*

# POINT has executed a collaboration agreement with Lantheus to commercialize PNT2002

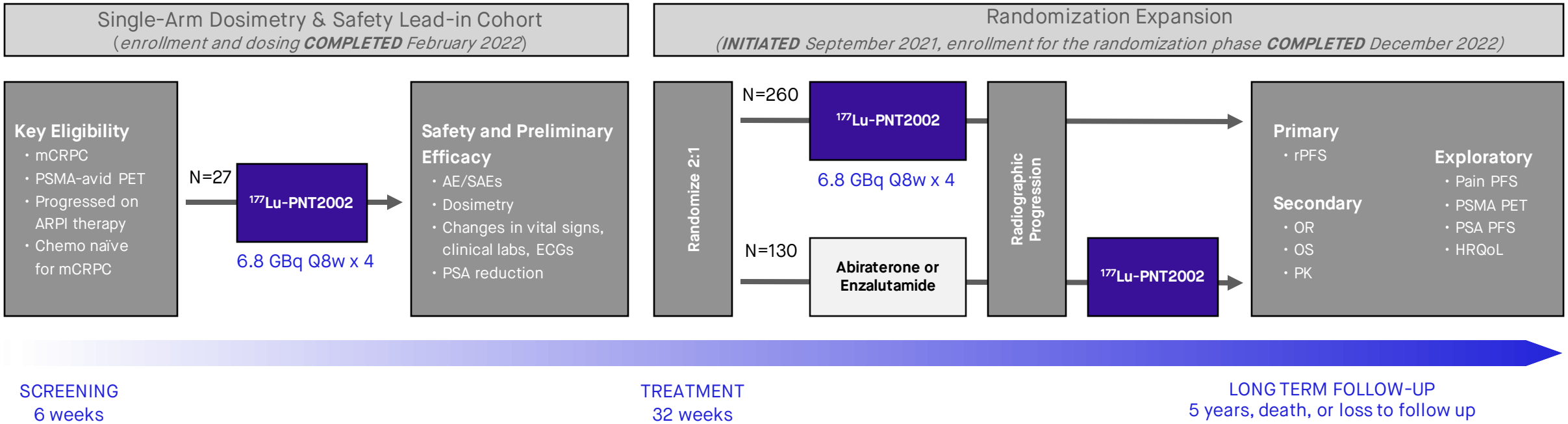
Under the agreements, POINT will fund and complete the phase 3 SPLASH trial for PNT2002, following which Lantheus will file the New Drug Application (NDA) in collaboration with POINT.

| | PNT2002 | |
|---|---|---|
| **Geography** | Exclusive worldwide rights excluding certain territories[1] | |
| **Upfront Payment** | $250M | |
| **U.S. Regulatory Milestone** | Range: $150M - $250M<br>(Based on timing of FDA approval and number of competing $^{177}$Lu-radioligand therapies on market at time of approval) | |
| **Commercial Sales Milestones:**<br>**(One-time Calendar Year Net Sales)** | $50M at $150M net sales<br>$50M at $300M net sales<br>$280M at $500M net sales | $150M at $600M net sales<br>$250M at $1,000M net sales<br>$500M at $2,000M net sales |
| **Royalties** | 20% net sales[2] royalty<br>(Following commercial launch, Lantheus will pay POINT Royalties of 20% of "Eligible Net Sales" i.e., from direct sales, after the point that Lantheus has realized $500M in cumulative Gross Profit) | |
| **Sublicense Income Sharing** | POINT receives 40% of Sublicensing Income<br>(income not otherwise subject to royalty payments to POINT) | |
| **Product Cost** | PNT to supply Lantheus with commercial product at COGS + markup | |

***1.*** *POINT retains the following territories: Japan, South Korea, China (including Hong Kong, Macau and Taiwan), Singapore, and Indonesia*
***2.*** *Net Sales by Lantheus in Territory and Net Sales by Lantheus/Sublicensee in US*

# PNT2002's phase 3 SPLASH trial for mCRPC began with a dosimetry & safety lead-in; Randomization began in Sept 2021 and completed recruitment for randomization in Dec 2022

Designed to evaluate $^{177}$Lu-PNT2002* **earlier in the treatment pathway** and using **fewer and lower doses**, as compared to other currently approved radioligand therapies for prostate cancer.




**S**tudy Evaluating Metastatic Castrate Resistant **P**rostate Cancer Using $^{177}$**L**u-PNT2002 PSMA Therapy versus Abiraterone or Enzalutamide **A**fter **S**econd-Line **H**ormonal Treatment (NCT04647526), a multi-center, open label, randomized study.

** US Patent #'s: 11,129,912 (Sep 28, 2021), 11,491,246 (Nov 8, 2022)*

# SPLASH single arm 27 patient dosimetry & safety lead-in data: **In-line with previously published literature**

## Median rPFS of 11.5 months

Median radiographic progression free survival exceeds control arm historical benchmarks[1] & **SPLASH success criteria assumptions**

## Median OS not yet reached at 11.7 mo

Median overall survival has not been reached based on a 11.7-month median duration of follow-up

## Radiographic objective response rate of 60% (n = 10)

Among participants with evaluable disease at baseline (target and/or non-target lesions), n = 10

## PSA50 Response of 42%

Prostate-specific antigen 50 response (42%) superior to control arm historical benchmarks[1]

## Safety

PNT2002 was well tolerated with no treatment-related deaths

## Eligibility

84.8% of patients met PSMA-avidity criteria using either $^{68}$Ga-PSMA-11 or $^{18}$F-DCFPyL

## Treatment Exposure

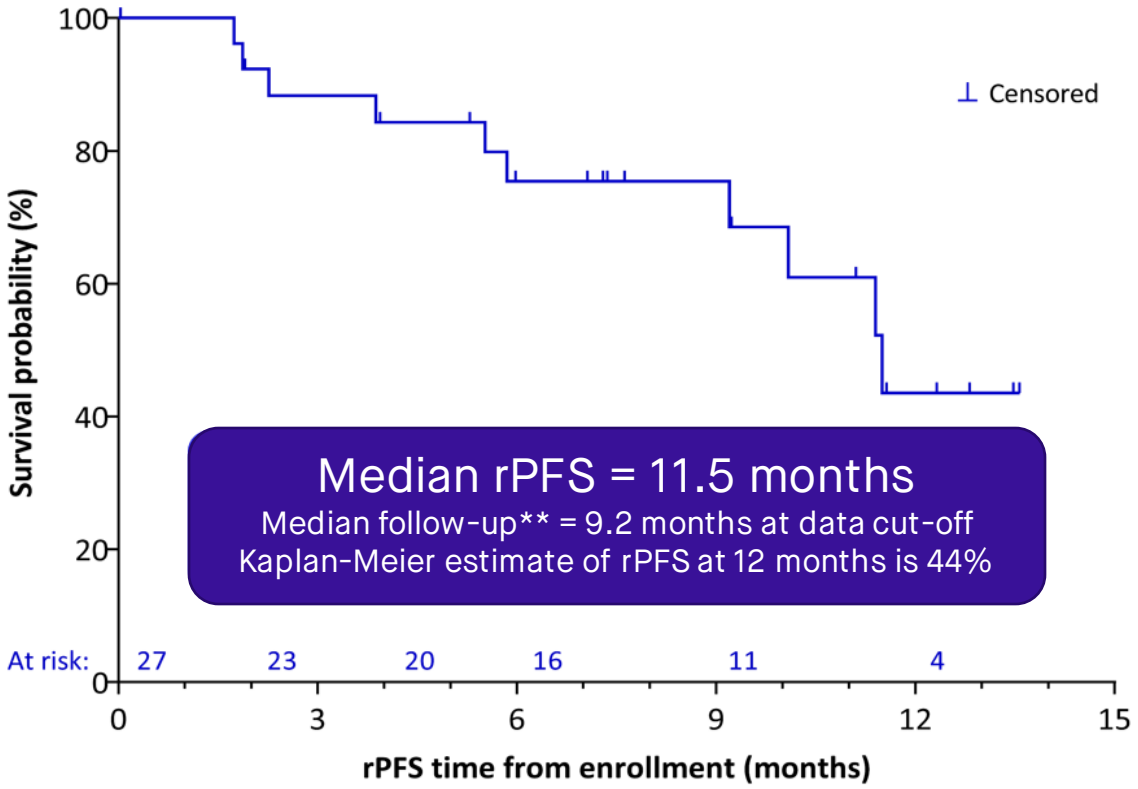
70% of patients completed all 4 cycles with median (range) 6.89 (6.2, 7.5) GBq dose per cycle

## Biodistribution & Dosimetry

Aligned with previously published literature demonstrating a favorable dosimetry profile for combination potential

*1. De Bono et al. N Engl J Med 2020; 382:2091-2102 and Powles T, et al. Nature Med 2022; 28:144-153*

# SPLASH lead-in cohort* had a median rPFS of 11.5 months
# Median overall survival has not been reached based on a 11.7-month median duration of follow-up



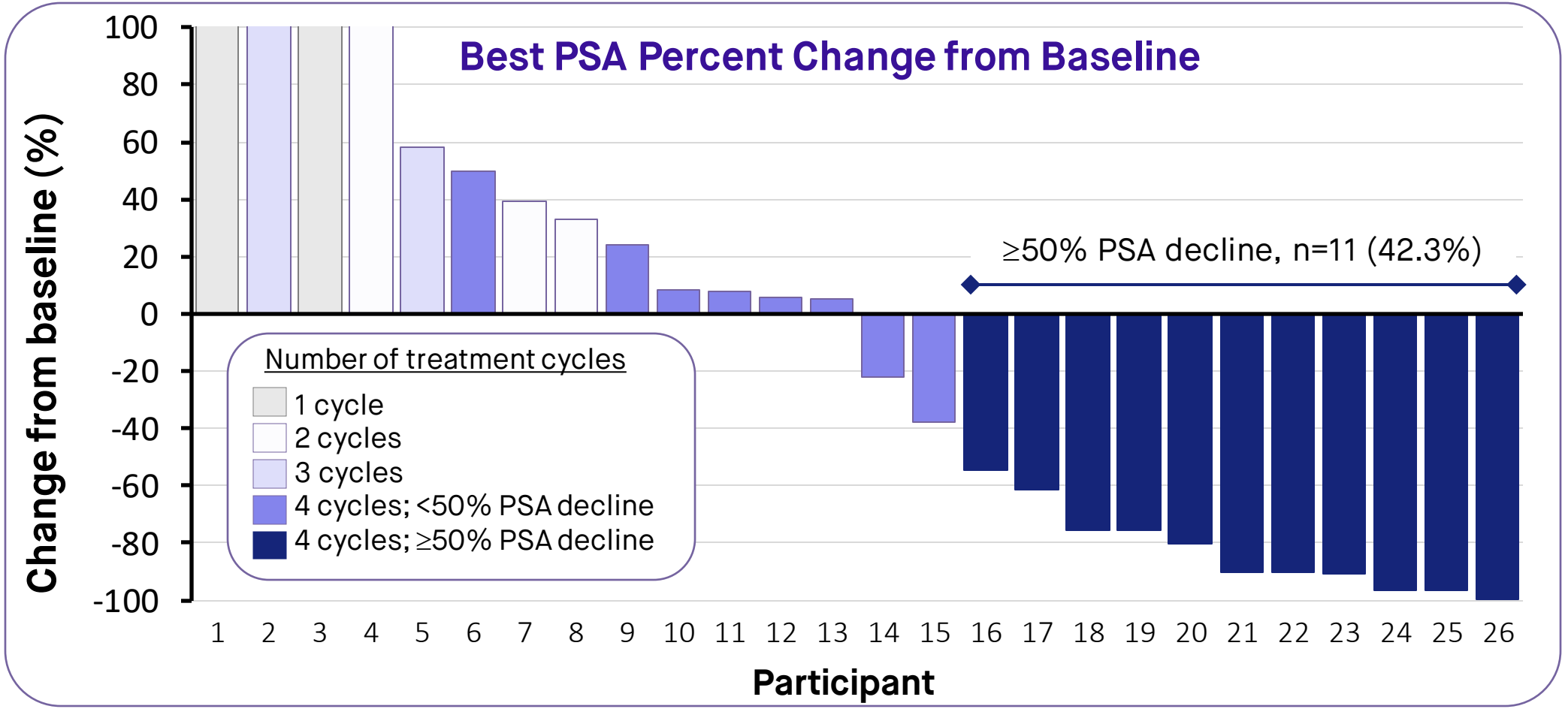

**SPLASH control arm (ARPI switch) assumptions were based on two phase 3 mCRPC trials (PROfound[1] and IMbassador250[2])**

**ARPI switch has been reported to prolong rPFS by 3.5[1] – 4.2[2] months**

*1. de Bono J, et al. N Engl J Med 2020; 382:2091-102. 2. Powles T, et al. Nature 2022;28:144–53. *No head-to-head trials have been conducted; illustrative comparison. **Radiographic progression-free survival (rPFS) follow-up calculated as time in months from date of enrollment to date of last available imaging (conventional) prior to the data cut-off for all enrolled participants.*
*Hansen et al. Poster #1400P. Presented at ESMO Congress Sep 2022, Paris, France.*

# 42.3% of patients in PNT2002 SPLASH lead-in cohort achieved ≥50% PSA decline*

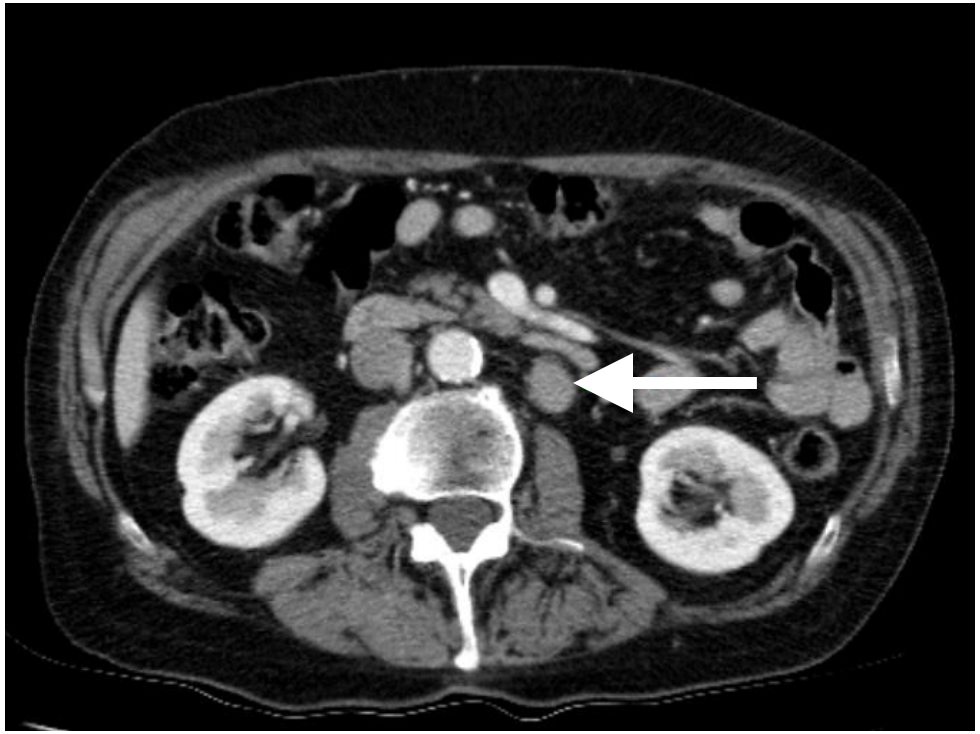
Participants had **low PSA at baseline**, relative to other trials in mCRPC[1,2], as SPLASH is designed to evaluate PNT2002 earlier in the treatment pathway.



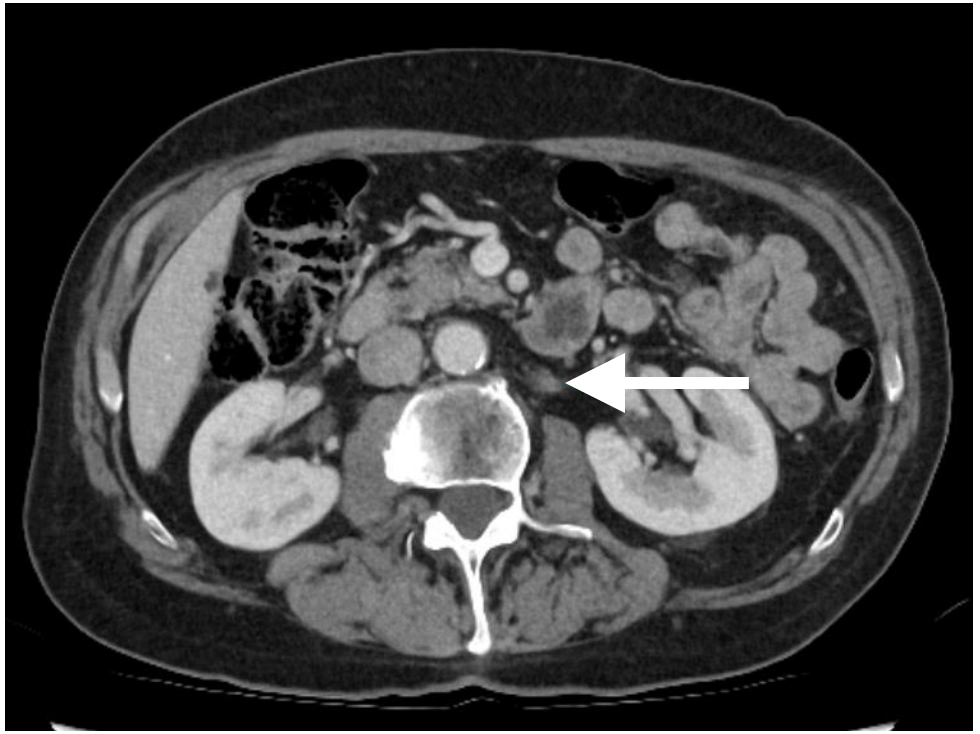

*1. Sartor O, et al. N Engl J Med. 2021;385(12):1091-1103. 2. Hofman MS, et al. Lancet. 2021;397(10276):797-804.*
**One participant is excluded due to absence of post-baseline PSA data; this participant received 1 cycle. PSA, prostate-specific antigen*

# Case study from the SPLASH lead-in cohort: radiological complete response participant

**Baseline, PSA 30.6 ng/mL**



**Month 11, PSA <0.03 ng/mL**



Retroperitoneal lymph node target lesion (indicated by arrows) with a short axis measurement of 2.1 cm at baseline, and the complete response of the lesion imaged at month 11.

**This example is provided for illustrative purposes only, is from a single participant, and is not meant to be representative of the outcomes for any other participant.*

# Dosimetry data from the PNT2002 SPLASH trial lead-in cohort met pre-defined criteria

Radiation dosimetry of PNT2002 was calculated in 27 patients with mCRPC based on biodistribution data post injection of their first cycle of PNT2002.

Organs receiving the largest absorbed doses were the lacrimal glands at 1.2 Gy/GBq, followed by the kidneys at 0.73 Gy/GBq.

For a cumulative administered activity of 27.2 GBq (4 cycles of 6.8 GBq), the kidneys would receive a cumulative absorbed dose of 19.9 Gy and the red marrow 0.91 Gy.

**PNT2002 (PSMA-I&T)**

| Cumulative Administered Activity | **SPLASH Trial Lead-In[1] (N=27)** |
|---|---|
| **Median Dose** | 6.8 GBq / 4 cycles |
| **Total Kidneys** | 19.9 Gy |
| **Total Red Marrow** | 0.91 Gy |
| **Total Lacrimal Gland** | 33.7 Gy |
| **Total Salivary Gland** | 9.15 Gy |

| | **Baum[2]** |
|---|---|
| **Median Dose** | 5.8 (3.6-8.7) GBq / 2 (1-5) cycles |
| **Safety** | 0% AEs led to death or discontinuation |
| **Patients with >50% PSA decline** | 59% |
| **Median Radiographic Progression-Free Survival** | 13.7 months (N=56) |
| **Median Overall Survival** | Not reached at 28 months (N=56) |

*1. Beauregard et al. SNMMI Mid-Winter Meeting Feb 2022 2. Baum et al. J Nucl Med 2016;57:1006-1013*

# PNT2002: Treatment-related adverse events occurring in >10% of participants in the lead-in cohort were limited to dry mouth, fatigue, nausea, and anaemia

Incidence of treatment-related adverse events by preferred term and maximum grade.

| | Grade 1 | | Grade 2 | | Grade 3 | | Grade 4/5 | | Cumulative |
|---|---|---|---|---|---|---|---|---|---|
| | # of pts | % | # of pts | % | # of pts | % | # of pts | % | |
| **Treatment-related AEs that occurred in >10%** | | | | | | | | | |
| Dry mouth | 7 | 25.9 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 7 (25.9%) |
| Fatigue* | 3 | 11.1 | 3 | 11.1 | 0 | 0.0 | 0 | 0.0 | 6 (22.2%) |
| Nausea | 3 | 11.1 | 2 | 7.4 | 0 | 0.0 | 0 | 0.0 | 5 (18.5%) |
| Anaemia | 1 | 3.7 | 1 | 3.7 | 2 | 7.4 | 0 | 0.0 | 4 (14.8%) |
| **Additional treatment-related AEs of interest** | | | | | | | | | |
| Thrombocytopenia | 1 | 3.7 | 0 | 0.0 | 1 | 3.7 | 0 | 0.0 | |
| Neutropenia | 0 | 0.0 | 1 | 3.7 | 1 | 3.7 | 0 | 0.0 | |
| Lymphopenia | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | |
| Leukopenia | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | |
| Acute kidney injury | 0 | 0.0 | 0 | 0.0 | 1† | 3.7 | 0 | 0.0 | |
| Vomiting | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | |
| **Laboratory abnormalities** | | | | | | | | | |
| Lymphocyte count decreased | 1 | 3.7 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | |
| Neutrophil count decreased | 0 | 0.0 | 1 | 3.7 | 0 | 0.0 | 0 | 0.0 | |
| Red blood cell count decreased | 1 | 3.7 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | |
| Blood creatinine increased | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | |

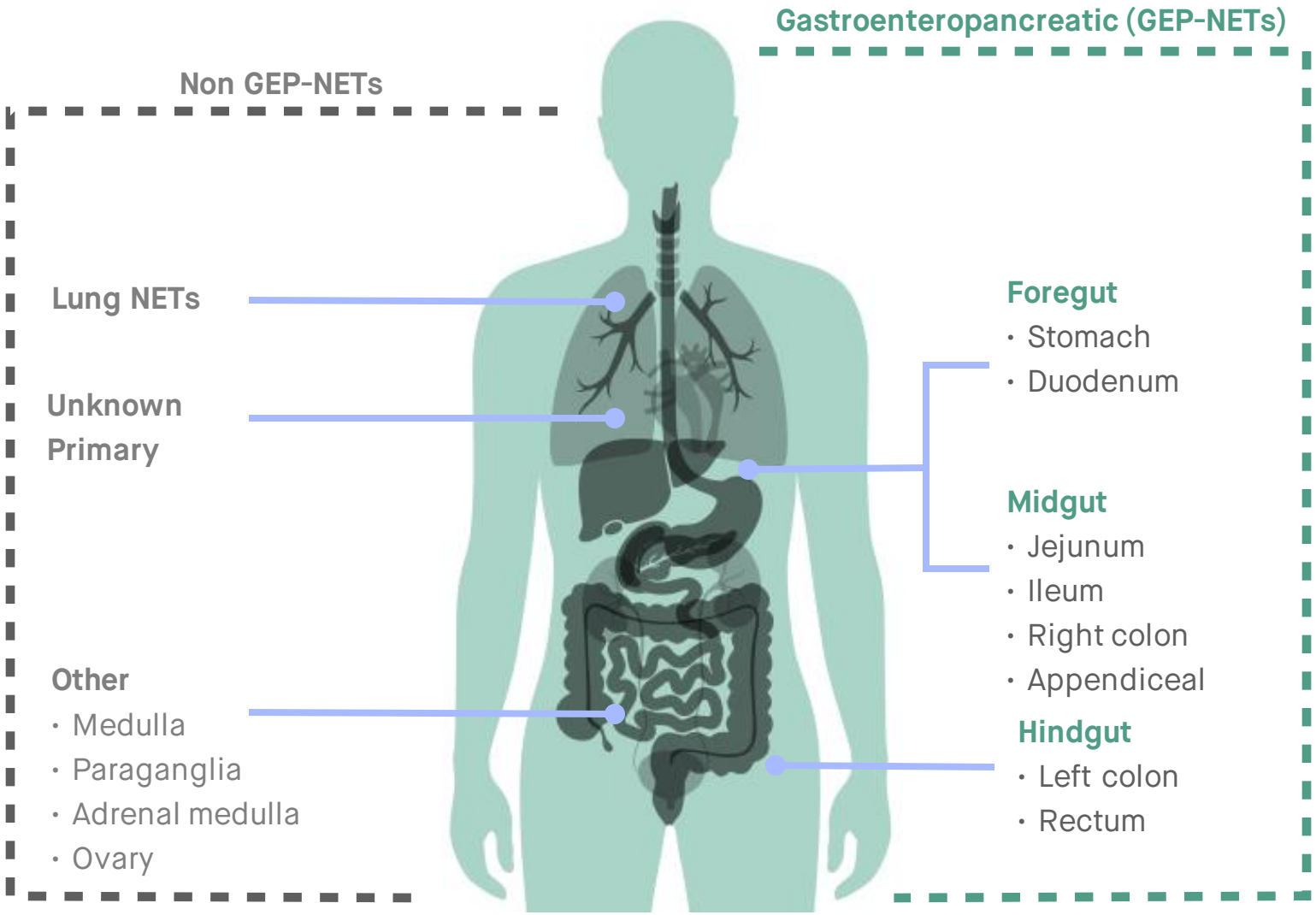
**Includes fatigue and asthenia. †Acute kidney injury leading to hospitalization resolved the following day; this event was attributed to several factors including dehydration as definitely related and $^{177}$Lu-PNT2002 deemed possibly related.*

# Programs:
# **Phase 3:** $^{177}$Lu-PNT2003 SSTR Targeting Ligand for Neuroendocrine Cancer

# PNT2003 is a somatostatin receptor targeted treatment for neuroendocrine cancer (NETs)

**NETs are heterogeneous tumors that originate in neuroendocrine cells[1].**

- PNT2003 uses the SSTR-targeted DOTA-TATE ligand, also utilized in the currently approved radiopharmaceutical product for the GEP-NETs indication.
- POINT has licensed both trial data as well as unique intellectual property from CanProbe which enables the formulation of DOTA-TATE while remaining fully outside of competitors' patent space.




*1. Oronsky B. et al. Neoplasia. 2017;19(12):991-1002. US Patent # :11,439,714*

# POINT has executed a collaboration agreement with Lantheus to commercialize PNT2003

POINT will facilitate the analysis of the OZM-067 clinical trial data sets received from the trial sponsor.

| | PNT2003 |
|---|---|
| **Geography** | Exclusive worldwide rights excluding certain territories[1] |
| **Upfront Payment** | $10M |
| **U.S. Regulatory Milestone** | Up to $30M in the aggregate |
| **Commercial Sales Milestones:** (One-time Calendar Year Net Sales) | $25M at $200M net sales<br>$100M at $500M net sales<br>$150M at $1,000M net sales |
| **Royalties** | 15% net sales[2] royalty |
| **Sublicense Income Sharing** | POINT receives 40% of Sublicensing Income<br>(income not otherwise subject to royalty payments to POINT) |
| **Product Cost** | PNT to supply Lantheus with commercial product at COGS + markup |

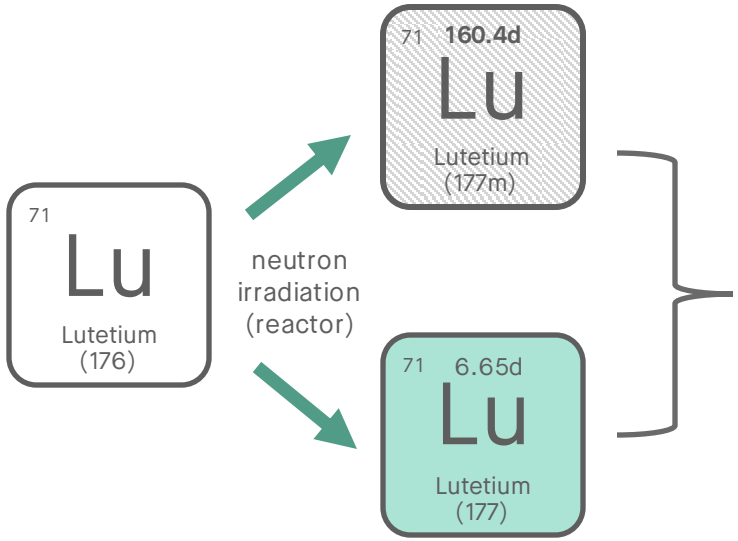
***1.*** *POINT retains the following territories: China (inclusive of Taiwan, Hong Kong and Macau), Japan, South Korea, Indonesia and Singapore*
***2.*** *Net Sales by Lantheus in Territory and Net Sales by Lantheus/Sublicensee in US*

# PNT2003's reduced radiation safety burden offers a significant opportunity for differentiation from the currently approved radiopharmaceutical product for the GEP-NETs indication

The $^{177}$Lu in PNT2003 does not contain long-lived radioactive impurities, simplifying administration of the drug product.

## Carrier-added $^{177}$Lu

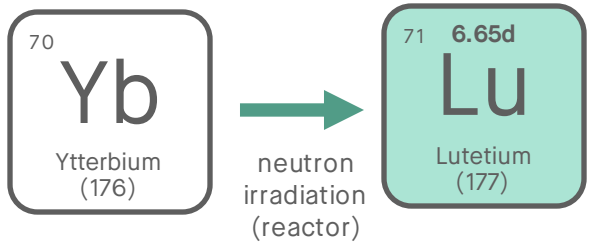
Contains up to 0.01% metastable $^{177m}$Lu, a radionuclide with a half-life of 5+ months, **forcing clinics to create a costly specialized waste stream** required by the NRC[1] for disposing waste with a physical half-life >120 days




Both $^{177m}$Lu and $^{177}$Lu incorporated in drug product

## PNT2003: **No-carrier-added $^{177}$Lu**

**Contains no $^{177m}$Lu;** infrastructure requirements are minimal, same as for PNT2002




Only $^{177}$Lu in drug product

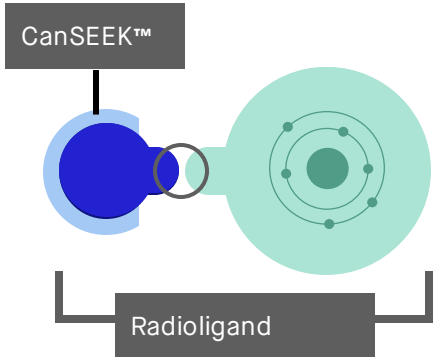
*1. NRC Part 35.92 Decay-in-storage*

# Programs:
# **Preclinical:** CanSEEK™ FAP-α Activated Prodrug Technology Platform

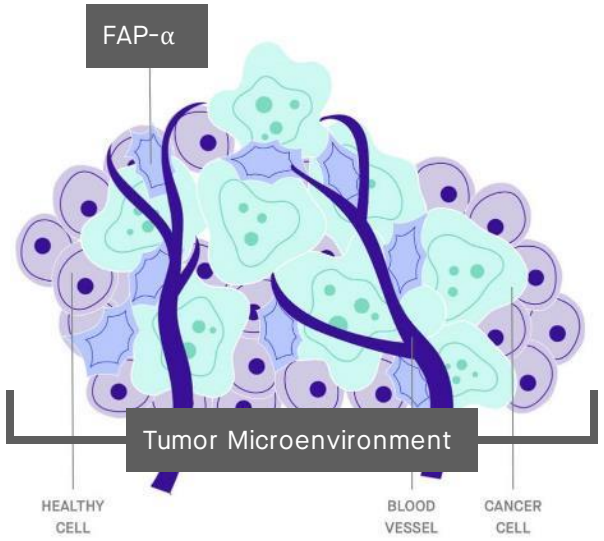
# The goal of the CanSEEK™ prodrug technology platform is to improve precision, efficacy, and safety of all radioligands

CanSEEK™, currently in preclinical development, prevents a radioligand from binding to receptors until it has been activated by FAP-α in the tumor microenvironment (TME), potentially preventing off-target delivery, improving therapeutic index, and enabling usage of new isotopes.

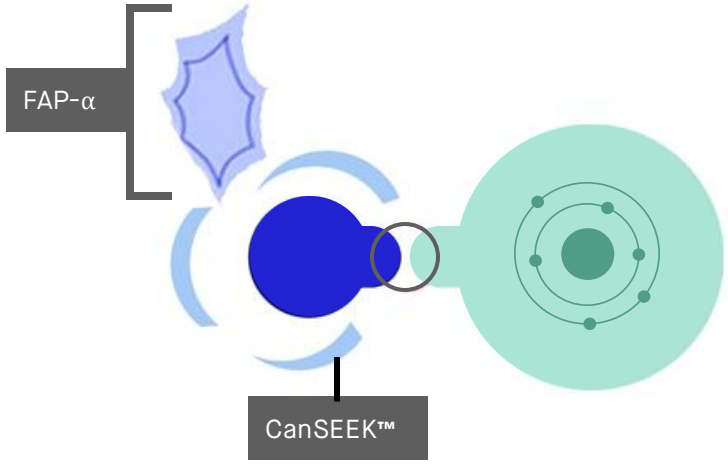
CanSEEK™ blocks a radioligand's ability to bind to receptors...




...until it reaches FAP-α, which is present in >90% of epithelial TMEs[1,2,3]...




... then **FAP-α cleaves CanSEEK™ away, allowing the radioligand to bind to the tumor's receptors**




*POINT's CanSEEK™ technology is the subject of licenses from both Bach Biosciences and Avacta Life Sciences*

*1. Rettig WJ, et al. Proc Natl Acad Sci USA. 1988;85(9):3110-3114. 2. Garin-Chesa P, Old LJ, Rettig WJ. Proc Natl Acad Sci USA. 1990;87:7235–7239. 3. Dolznig H, et al. Cancer Immun. 2005;5:10.*

# Milestones Summary

# Anticipated Milestones & Financial Summary

Meaningful near-term value creation milestones with a long-term goal of introducing **five new programs in humans** by the end of 2028

| Program | Clinical Candidate | Indication | Timing (Est.) | Milestone |
|---|---|---|---|---|
| PNT2002 | $^{177}$Lu-PNT2002 | mCRPC | **Q4 2023** | Topline data |
| PNT2001 | $^{225}$Ac-PSMA-62 | Prostate cancer | **Q4 2023** | Health authority submission |
| PNT2001 | $^{225}$Ac-PSMA-62 | Prostate cancer | **Q1 2024** | First patient in phase 1 |
| Discovery Program A | Undisclosed | Undisclosed | **1H 2024** | Disclose new development candidate |
| PNT2004 | $^{177}$Lu-PNT6555 | Solid tumors expressing FAP | **1H 2024** | Phase 1 data |
| PNT2001 | $^{225}$Ac-PSMA-62 | Prostate cancer | **EOY 2024** | Clinical data update |
| Discovery Program B | Undisclosed | Undisclosed | **EOY 2024** | Disclose new development candidate |
| **Manufacturing & Isotope Supply** | | **Location** | **Timing (Est.)** | **Milestone** |
| In-house n.c.a $^{177}$Lu production | | CORE Campus | **EOY 2023** | Online |

| | |
|---|---|
| **Balance Sheet** | **$435M** in cash, cash equivalents, and investments, as of June 30, 2023 |
| **Projected Runway** | Cash runway into 2026 |
| **Capital Structure** | **105.8M** Common Shares + **8.6M** Options |

POINT BIOPHARMA

Accelerating Precision Medicine™

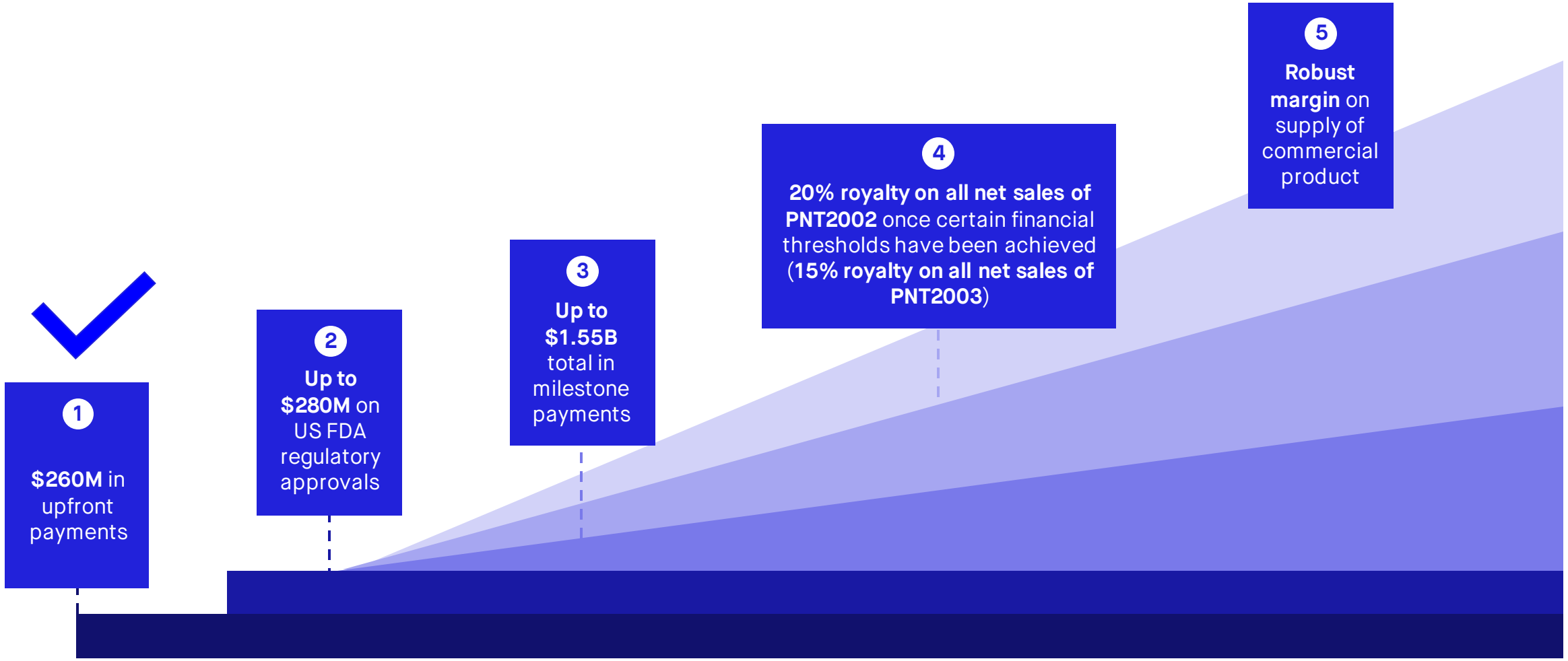
NASDAQ: PNT

# POINTBiopharma.com

investors@pointbiopharma.com

# Appendix

# The Lantheus collaboration affirms the value of POINT's platform




*Graphic not to scale*

# The collaboration strengthens POINT's balance sheet, creates a robust margin manufacturing unit, and facilitates expansion of its pipeline of next-generation radioligands

## Bolsters cash runway into 2026

**+ the opportunity to further extend runway**

Through FDA regulatory approval and commercial milestone payments, as well as royalties

## Establishes business unit with robust margins

**+ preserves commercial supply and manufacturing capabilities**

By retaining manufacturing operations within POINT while funding commercial scale-up through non-dilutive capital

## Expansion of next-generation pipeline

**+ the opportunity to bring RLT to new indications**

Leveraging unique expertise in manufacturing, discovery, and clinical development

# POINT evaluated multiple strategic pathways prior to identifying Lantheus (NASDAQ: LNTH) as the ideal partner to license both PNT2002 & PNT2003

| | PNT2002 | PNT2003 |
|---|---|---|
| **Geography** | Exclusive worldwide rights excluding certain territories[1] | |
| **Upfront Payment** | $250M | $10M |
| **U.S. Regulatory Milestone** | Range: $150M - $250M<br>(Based on timing of FDA approval and number of competing $^{177}$Lu-radioligand therapies on market at time of approval) | Up to $30M in the aggregate |
| **Commercial Sales Milestones:**<br>**(One-time Calendar Year Net Sales)** | $50M at $150M net sales<br>$50M at $300M net sales<br>$280M at $500M net sales<br>$150M at $600M net sales<br>$250M at $1,000M net sales<br>$500M at $2,000M net sales | $25M at $200M net sales<br>$100M at $500M net sales<br>$150M at $1,000M net sales |
| **Royalties** | 20% net sales[2] royalty<br>(Following commercial launch, Lantheus will pay POINT royalties of 20% of "Eligible Net Sales"; after Lantheus has realized $500M in cumulative Gross Profit, Lantheus will pay POINT royalties of 20% of "Net Sales") | 15% net sales[2] royalty |
| **Sublicense Income Sharing** | POINT receives 40% of Sublicensing Income<br>(Income not otherwise subject to royalty payments to POINT) | POINT receives 40% of Sublicensing Income<br>(Income not otherwise subject to royalty payments to POINT) |
| **Product Cost** | PNT to supply Lantheus with commercial product at COGS + markup | |

*1. POINT retains the following territories: Japan, South Korea, China (including Hong Kong, Macau and Taiwan), Singapore, and Indonesia*
*2. Net Sales by Lantheus in Territory and Net Sales by Lantheus/Sublicensee in US*