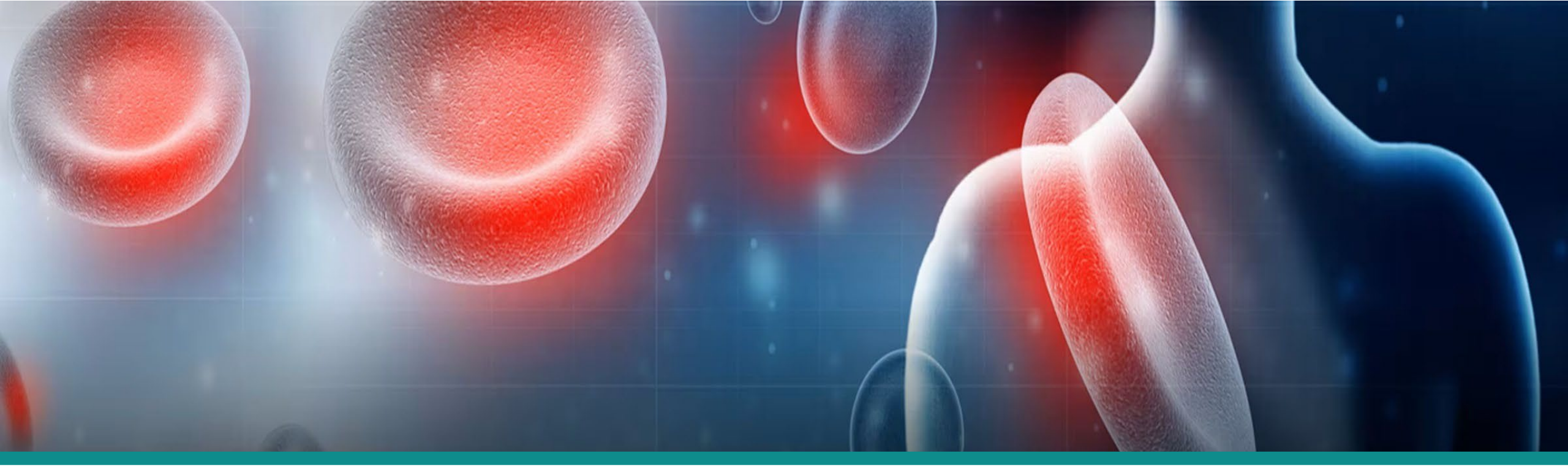

JUBILANT THERAPEUTICS

Transforming Treatment for Myeloproliferative Neoplasms

Oral, first-in-class epigenetic therapies for ET, PV and other myeloproliferative diseases

Corporate Presentation
November 2026

Non-confidential

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Jubilant Therapeutics: Private Subsidiary of Jubilant Bhartia Group

Jubilant Bhartia Group (founded 1978)
Over $10B enterprise value
~2000 US employees | ~43,000 global employees

Jubilant Ingrevia	Jubilant Agri & Consumer Products	Jubilant FoodWorks	Jubilant Pharmova	Jubilant Therapeutics	Jubilant Enpro	Jubilant Beverages	Jubilant MotorWorks
Specialty chemicals and life science ingredients	Agri, consumer and industrial products	Food service brands	Global pharmaceuticals, CDMO and radiopharma	Clinical-stage hematology and oncology therapeutics	Business aviation and oil-field services	Bottling and distribution of Coca-Cola	Luxury car dealerships, e.g., Audi

PUBLICLY LISTED COMPANIES

UNLISTED COMPANIES

Jubilant Bhartia Group

- Multibillion-dollar international corporation
- Indian licensee for Domino's, Dunkin' and Popeyes
- Strategic partner for Coca-Cola in India

Jubilant Therapeutics

- Private drug discovery and pipeline-focused subsidiary
- Leverages group-wide preclinical, CMC and regulatory expertise

CDMO: contract development and manufacturing organization; CMC: chemistry, manufacturing and controls.

Internally Discovered, Potential Best-in-Class Therapies

Targeting large unmet medical needs in hematology, oncology and inflammation

Target	Molecule	Indication	Discovery	Preclinical (IND)	Phase 1	Phase 2	Status
Dual LSD1 & HDAC6 CoREST inhibitor	**JBI-802**	**Essential thrombocythemia (ET) / MPNs**					• Phase 1 dose escalation complete • 15 mg emerging as RP2D
		mSTK11 IO-resistant NSCLC					Phase 2 IIT ongoing
		SCLC					Planned Phase 2 IIT with SWOG
PAD4 inhibitor	**JBI-3041**	Severe inflammation-mediated diseases					IND-enabling studies in progress

AML: acute myeloid leukemia; CoREST: co-repressor of RE1-silencing transcription factor; ET: essential thrombocythemia; IIT: investigator-initiated trial; IO: immuno-oncology; MPN: myeloproliferative neoplasm; MSK: Memorial Sloan Kettering; NSCLC: non-small cell lung cancer; PAD4: peptidylarginine deiminase 4., LSD1: Lysine demethylase, HDAC6: Histone deacetylase 6

CoREST Inhibitors: Two Is Better Than One

JBI-802 inhibits LSD1 and HDAC6 in a single integrated small molecule

LSD1 *lysine-specific demethylase 1*

Critical for self-renewal of malignant cells and proliferation of blood stem cells; essential for differentiation of mature megakaryocytes and granulocytes

+

HDAC6 *histone deacetylase 6*

Primarily cytoplasmic; increases megakaryocyte differentiation and proplatelet formation. Progressively expressed in ET, PV and PMF, driving increased, activated and dysfunctional platelet production

JBI-802
Dual LSD1/HDAC6 CoREST inhibitor in one molecule

Mechanism

- Small molecule designed to inhibit the CoREST complex
- CoREST regulates gene expression through histone deacetylation and demethylation
- Inhibition alters chromatin structure and gene expression, potentially reversing immune evasion and cancer-cell proliferation
- Enables broad transcriptional reprogramming

Opportunity

- Single-target agents (LSD1 only) may deliver incomplete transcriptional reprogramming and a narrow therapeutic index
- Legacy agents' PK (long half-life, wide tissue distribution) challenges safety management
- Several companies developing single-target CoREST inhibitors
- LSD1 validated as a CoREST target via Merck's bomedemstat

Why JBI-802

Next-generation **dual-targeting (LSD1 & HDAC6) CoREST inhibitor designed as a single integrated small molecule** (not two separate molecules)

- Designed for durable, multi-lineage hematologic control across molecular subtypes
- Short half-life (~1.5–2 h) with no accumulation supports continuous once-daily dosing

ET: essential thrombocythemia; PMF: primary myelofibrosis; PV: polycythemia vera. Sources: Ismail et al., *Sci Adv* 2025;11:eads6556; *Cell Death Dis* 2025;16:619; Xu et al., *Haematologica* 2024;109(10); *Cancers* 2022;14:6014.

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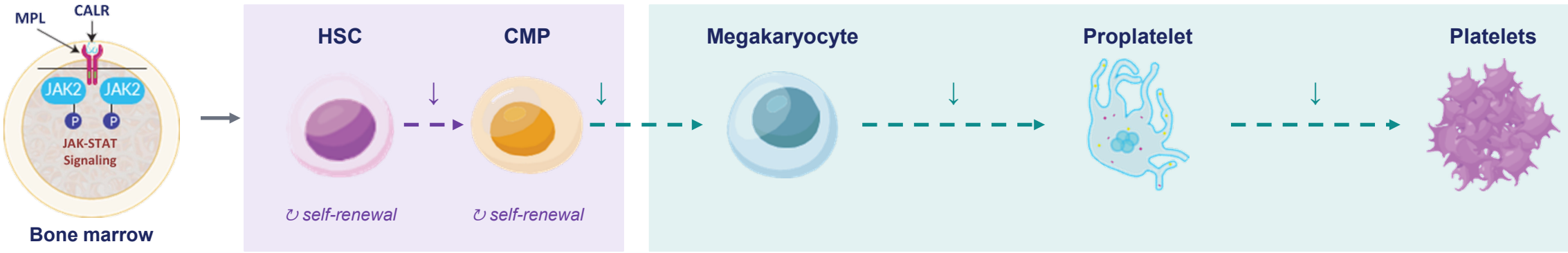
JBI-802 Targets Both the Malignant Clone and Platelet Production

Dual LSD1 / HDAC6 inhibition acts at two distinct points in megakaryopoiesis

JBI-802

LSD1 inhibition | **HDAC6 inhibition**



LSD1 activity ↓

↓ HSC / CMP self-renewal

↓ Malignant clone maintenance

HDAC6 activity ↓

↑ Acetylated α-tubulin (target engagement)

↓ MK maturation and proplatelet formation

~ Modulates platelet activation kinetics

Hematologic Control

↓ Platelets and WBCs

LSD1 targets malignant hematopoiesis and clonal disease biology; **HDAC6** targets megakaryocyte maturation and platelet production

CALR: calreticulin; CMP: common myeloid progenitor; HSC: hematopoietic stem cell; JAK-STAT: Janus kinase–signal transducer and activator of transcription; MK: megakaryocyte; MPL: thrombopoietin receptor.

HDAC6 Inhibition Drives JBI-802's Rapid Platelet Decline

What HDAC6 inhibition does

Blocks new platelet release

HDAC6 inhibition impairs megakaryocyte maturation and proplatelet formation through cytoskeletal disruption (↑ acetylated cortactin / α-tubulin) → replacement of circulating platelets falls

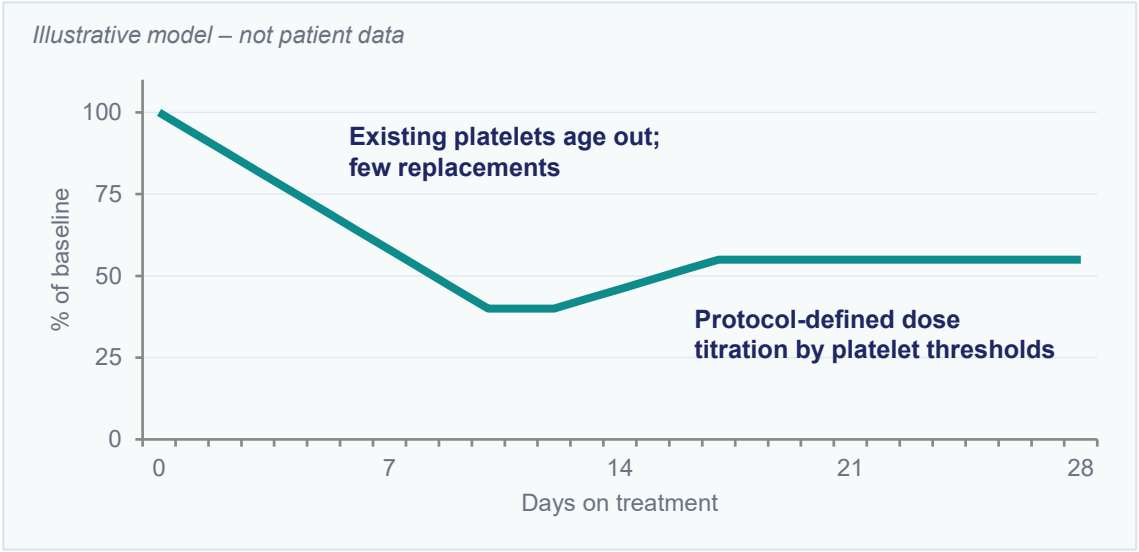
Spares the megakaryocyte reservoir

HDAC-inhibitor thrombocytopenia reflects blocked platelet shedding, not marrow suppression: no anti-mitotic or pro-apoptotic effect on progenitors; MK numbers maintained → platelet output adjusts with dose

Modulates platelet function

HDAC6 deacetylates platelet microtubules during activation and tunes the speed of platelet activation and spreading → potential additional effect on thrombotic biology (under investigation)

Why the decline is fast: platelet lifespan sets the clock



7–10 days
Normal circulating platelet lifespan

~10–14%/day
Platelets cleared daily as they age

Titration
Intra-patient titration by platelet and hemoglobin thresholds after Cycle 1

Predictable kinetics: circulating platelets keep clearing on schedule while HDAC6 inhibition curtails replacement, so counts can fall within days, not months; protocol-defined titration by platelet thresholds manages the decline

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MK: megakaryocyte. Chart assumes ~10-day platelet lifespan, ~60% reduction in platelet release at starting dose and smaller reduction after dose titration; for illustration only. Sources: Bishton MJ et al., Blood 2011; Iancu-Rubin C et al., Exp Hematol 2012; Messaoudi K et al., Nat Commun 2017; Sadoul K et al., Blood 2012; Aslan JE et al., Am J Physiol Cell Physiol 2013.

01

Essential Thrombocythemia



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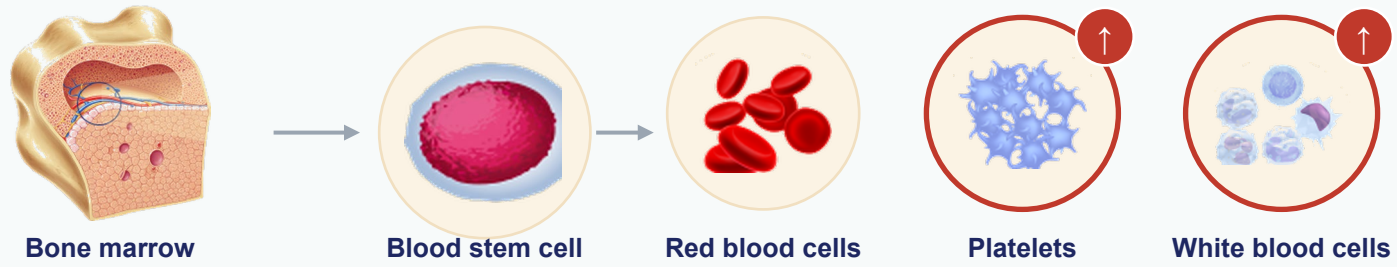
Essential Thrombocythemia: A Chronic Disease With Serious Risks

Characterized by thrombosis, thrombocytosis and risk of progression to MF and AML

Prevalence	Up to 150,000 patients in the U.S., characterized by platelet overproduction
Clinical risks	Thrombosis (clots), hemorrhage, impaired organ perfusion, and progression to MF or AML
Diagnosis	Platelet count ≥450,000/µL* plus molecular and bone marrow findings; absence of other myeloid neoplasm
Treatment goal	Lower platelet count to reduce the risk of thrombosis or hemorrhage
Unmet need	**Existing therapies reduce platelets but have limitations, including boxed warnings**



JBI-802

Dual LSD1/HDAC6 inhibition targets the root biology and clinical consequences of ET

AML: acute myeloid leukemia; MF: myelofibrosis; WBC: white blood cell. *Per WHO diagnostic criteria; normal platelet range 150–400 ×10⁹/L. Sources: Yacoub et al., *Clin Lymphoma Myeloma Leuk* 2021; *N Engl J Med* 2017;376:2168–81.

Clinical Presentation Varies: ~70% of ET Patients Receive Cytoreduction

ET risk stratification, NCCN-recommended therapy and JBI-802 target population

Disease risk	Risk factors	Current therapy (NCCN; aspirin for all)	JBI-802 target population
High risk **45–50%** of patients	• History of thrombosis, or • Age >60 years with JAK2 mutation	**Cytoreductive therapy (CR)** 1L: hydroxyurea 2L: peginterferon or anagrelide	**100%** of high-risk patients
Intermediate risk **15–20%** of patients	• No history of thrombosis • Age >60 years, no JAK2 mutation	CR considered for CV risk factors, symptomatic thrombocytosis, extreme platelet counts or disease burden	**~50%** of intermediate-risk patients
			CORE TARGET POPULATION
Low risk **20–25%** of patients	• No history of thrombosis • Age ≤60 years with JAK2 mutation	Low-dose aspirin daily; manage CV risk CR for significant symptoms or extreme thrombocytosis	**~25%** of low-risk patients
Very low risk **~10%** of patients	• No history of thrombosis • Age ≤60 years, no JAK2 mutation	Monitor	**~10%** of very-low-risk patients

High- and intermediate-risk patients (~60–70% of ET) are the primary candidates for cytoreductive therapy

ASA: aspirin; CR: cytoreductive therapy; CV: cardiovascular; 1L/2L: first/second line. Sources: Tefferi et al., *Am J Hematol* 2024; Gangat et al., *Blood* 2024; NCCN Guidelines v1.2026; Alvarez-Larrán et al., EHA 2023.

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Current ET Treatments: One New Approval, Persistent Unmet Need

BESREMi is the first new FDA-approved ET therapy in ~30 years, but it is injectable, carries a boxed warning and has slower onset

Therapy	Mechanism / evidence	Limitations / unmet need
Low-dose aspirin Oral, once daily	• Blocks microvascular clots (headache, erythromelalgia); prevents TIA/stroke • Modest effect on platelet count	• Acquired von Willebrand syndrome: bleeding risk at high platelet counts • No effect on underlying disease
Hydroxyurea (1L) Oral, once daily **BOXED WARNING**	• Reduces megakaryocyte proliferation and platelet production • Only therapy proven in randomized trials to prevent major thrombosis in ET	• Cytopenias, dermatologic and mucosal toxicity; possible long-term AML risk • Cannot be used in pregnancy; no effect on underlying disease
BESREMi (ropeginterferon alfa-2b) Subcutaneous, every 2 weeks **FDA-APPROVED FOR ET AUG 2026** **BOXED WARNING**	• Long-acting interferon; suppresses megakaryocyte progenitors and malignant clone • Durable modified ELN response 37.4% vs 3.6% anagrelide (SURPASS-ET)	• Boxed warning: neuropsychiatric, autoimmune, ischemic, infectious disorders • Slower onset: median 8.4 wks to hematologic response (EXCEED-ET); injection and titration; contraindicated with severe psychiatric history, Child-Pugh B/C
Anagrelide (2L) Oral, 2–4 times daily	• Inhibits megakaryocyte maturation and platelet release • Approved ~30 years ago	• Inferior thrombotic protection vs hydroxyurea; CV toxicity • No effect on underlying disease
Ruxolitinib (off-label) Oral, twice daily	• JAK/STAT inhibition; “rescue” use in patients intolerant of other therapies	• Only modest platelet and symptom reductions; no clear disease modification in ET • Myelosuppression and infection risk

JBI-802: oral, once daily; all 8 patients starting at 15 mg reached >50% platelet reduction or <400 ×10^9/L by week 3 (median 15 days)

BESREMi approved by FDA for adults with ET on Aug 31, 2026 (SURPASS-ET, N=174, HU-resistant/intolerant ET vs anagrelide; responders met blood-count remission, spleen and no thrombosis/bleeding criteria at Months 9 and 12). EXCEED-ET: single-arm study. Cross-trial comparisons are illustrative only. 1L/2L: first/second line; CV: cardiovascular; ELN: European LeukemiaNet; TIA: transient ischemic attack. Sources: FDA labels; FDA BESREMi ET approval notice (Aug 2026).

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ET: Limited Treatment Options and Poor Long-Term Outcomes

Real-world data from patients treated with cytoreductive therapy

Current treatment

~90%
Hydroxyurea first line (high/intermediate risk)

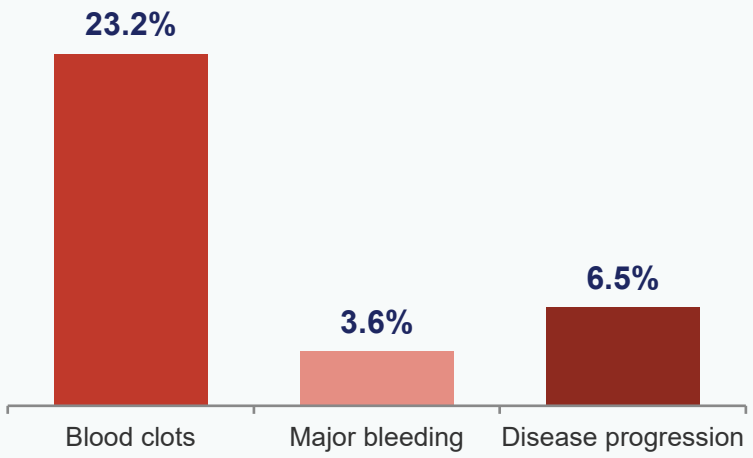
Other therapies rarely used:

- **1.8%** Interferon-α
- **1.5%** Ruxolitinib
- **1.3%** Anagrelide
- **0.3%** Busulfan

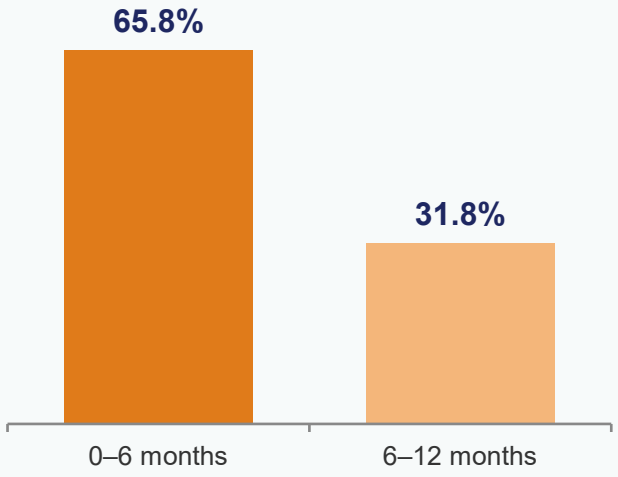
Poor outcomes with current standard of care

- **~30%** Experience disease-related complications (blood clots, bleeding, or progression)
- **~50%** Interrupted or discontinued treatment
- **31.8%** Persistent platelet counts >600 ×10⁹/L after 6 months

Complications of ET (% of patients)



Platelets persistently very high (%)



Better treatment options are needed to improve the long-term health of patients with ET

SoC: standard of care. Very high platelet count: >600 ×10⁹/L. Source: Real-World Treatment Patterns and Clinical Outcomes in Patients With Essential Thrombocythemia Treated With Cytoreductive Therapy: A Retrospective Analysis of Electronic Health Records Data. ASH 2025.

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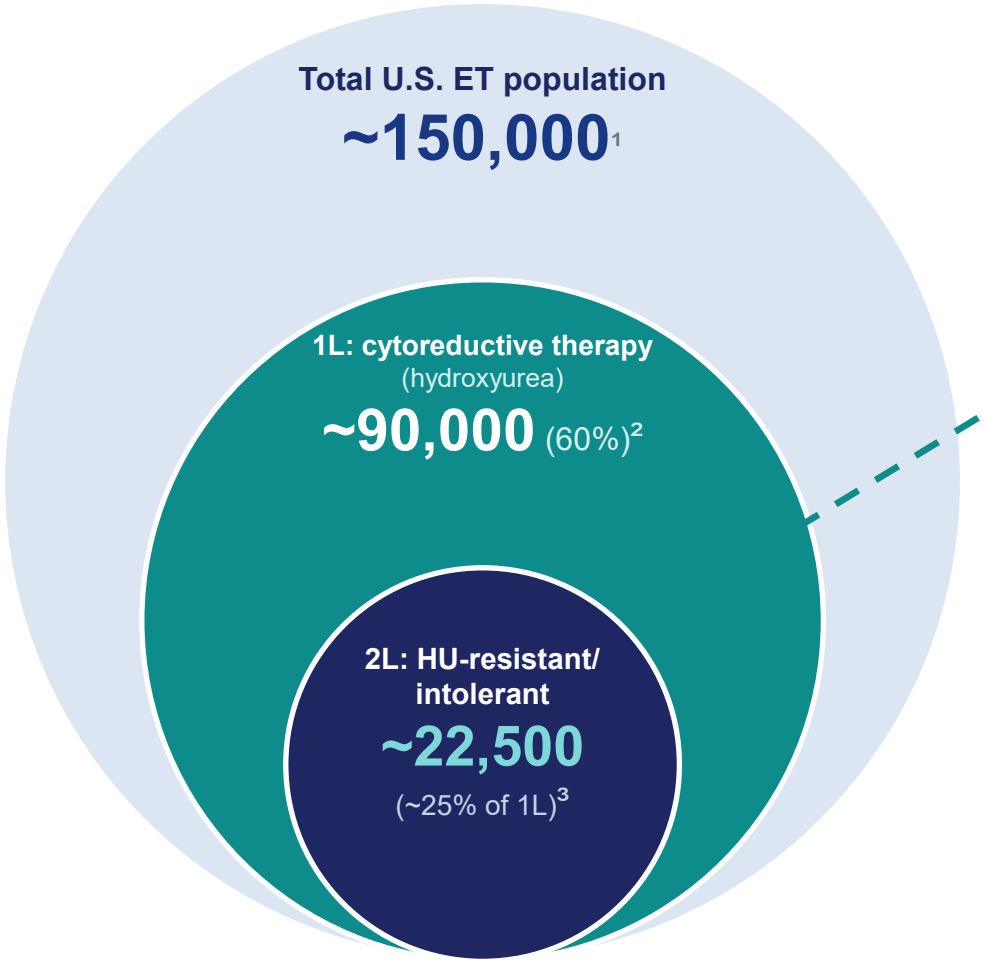
ET: Potential Blockbuster U.S. Opportunity in 1L and 2L Settings

~$5B U.S. TAM in the 2L hydroxyurea-resistant/intolerant segment alone



2L HU-resistant/intolerant U.S. TAM

~$5B[4]

~22,500	×	~$224K	=	~$5.0B
patients		annual cost*		TAM

Upside beyond 2L ET

- Potential to move to 1L ET (~90,000 patients on cytoreduction)
- Broader MPN segments, including PV and MF

HU: hydroxyurea; MF: myelofibrosis; PV: polycythemia vera; TAM: total addressable market; 1L/2L: first/second line. *Company estimate; pricing benchmarked to Jakafi annual cost (~$224K; GlobalData, Myelofibrosis Report). 1. Yacoub et al., *Clin Lymphoma Myeloma Leuk* 2021. 2. Larsson et al., *Eur J Haematol* 2026; Gangat et al., *Blood* 2024. 3. *Lancet Haematol* 2025;12(11):e862–e875. 4. TAM based on company estimate.

Commercial Validation: Merck Acquired Imago for $1.3B

Acquisition driven by Imago's LSD1 inhibitor, bomedemstat



$1.35B

Acquisition value

Merck acquired Imago BioSciences and its LSD1 inhibitors (announced Nov 2022)

Bomedemstat

LSD1 inhibitor (MK-3543)

Lead asset driving the acquisition

Phase 3

Ongoing in 1L and 2L ET

Phase 3 clinical trials of bomedemstat ongoing

Strong validation of LSD1 as a target, confirming the mechanism and commercial opportunity in the LSD1 space; JBI-802 adds HDAC6 inhibition in a single molecule

1L/2L: first/second line; ET: essential thrombocythemia; LSD1: lysine-specific demethylase 1. Source: Keown A, "Merck Acquires Imago and its LSD1 Inhibitors in $1.3B Deal (Updated)," *BioSpace*, Nov 21, 2022.

02

JBI-802 Clinical Data

Phase 1/2 study in MPN with thrombocytosis

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JBI-802 Selected for an Oral Presentation at ASH

68th ASH Annual Meeting and Exposition · December 12–15, 2026 · New Orleans

ORAL PRESENTATION · ABSTRACT 1036

Safety and preliminary efficacy results from a Phase 1/2 multicenter open-label study evaluating JBI-802, a first-in-class oral CoREST inhibitor, in myeloproliferative and myelodysplastic/myeloproliferative neoplasms

Presenter: Andrew McQuillan, MBBS, FRACP, FRCPA
Session: Myeloproliferative Syndromes: Clinical and Epidemiological
Monday, December 14, 2026 · 5:15 p.m. CT

POSTER PRESENTATION · ABSTRACT 5540

Pharmacokinetics, active-metabolite contribution and PK/PD correlation of JBI-802 in MPN and MDS/MPN

Sridharan Rajagopal, Ph.D. · December 14, 2026 · 6:00–8:00 p.m. CT

SCIENTIFIC AND CORPORATE EVENT

Dual LSD1/HDAC6 Inhibition with JBI-802 in Thrombocytosis-Predominant MPN: Clinical Data and Emerging Perspectives

December 14, 2026, following the oral presentation · livestreamed, with replay at jubilanttx.com

Abstract data: all 8 patients starting at 15 mg reached >50% platelet reduction or <400 ×10⁹/L by week 3

CT: Central Time. Abstract data cutoff 30 Jun 2026; data are preliminary and subject to change. Sources: ASH 2026 abstracts; Jubilant Therapeutics press release, Nov 10, 2026.

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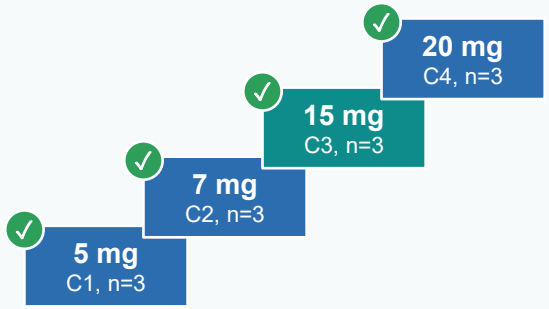
JBI-802: Ongoing Phase 1 Study in 2L MPN With Thrombocytosis

Open-label, multicenter study of oral JBI-802 in MPN with thrombocytosis (MPN-t)

Part 1a: Dose escalation (3+3) — COMPLETE

Population: ET, PV, pre-MF and MDS/MPN



Based on the totality of safety, PK and efficacy data in these 12 patients, backfill cohorts were enrolled at starting doses of 10 mg

Part 1b: Backfill — ENROLLING

Population: ET and PV only

Cohort 6 ~10 patients
15 mg continuous dosing

Cohort 5 ~10 patients
10 mg continuous dosing

Part 2: Expansion — PLANNED

Population: ET and PV only

JBI-802 RP2D ~50 patients

Part 1

Inclusion criteria

- MPN with thrombocytosis
- Relapsed/refractory to, or intolerant of, standard-of-care therapy
- No available therapy known to provide clinical benefit (per investigator)

Endpoints

- Safety and tolerability
- MTD and/or recommended Phase 2 dose regimen(s)
- Preliminary efficacy at RP2D (platelet count reduction)

Part 2

Inclusion criteria

- MPN with thrombocytosis
- Relapsed/refractory to, or intolerant of, standard-of-care therapy
- No available therapy known to provide clinical benefit (per investigator)

Endpoints

- CHR: platelets ≤400 ×10⁹/L and WBC ≤10 ×10⁹/L (PV: hematocrit <45% without phlebotomy)
- Durable CHR (dCHR) and time to response
- Change in variant allele frequency (VAF)

2L: second line; CHR: complete hematologic response; ET: essential thrombocythemia; MDS/MPN: myelodysplastic/myeloproliferative neoplasm; MF: myelofibrosis; MTD: maximum tolerated dose; PV: polycythemia vera; RP2D: recommended Phase 2 dose. Source: ANZCTR ACTRN12624000478516.

JBI-802 at ASH 2026: Rapid, Durable Hematologic Control

Phase 1 results from the ASH 2026 abstract (data cutoff 30 Jun 2026)

8/8
Platelet response at 15 mg
>50% reduction or <400 ×10⁹/L by wk 3

15 days
Median time to response
5 of 8 started above 1,000 ×10⁹/L

4/4
CHR
ET/PV Patients with leukocytosis at 15 mg

84%
Max driver VAF reduction
JAK2V617F or CALR, at 15 mg (n=3)

Rapid and broad

- Responses across ET, PV, post-ET MF and MDS/MPN
- Responses regardless of driver mutation, incl. extreme thrombocytosis
- Escalation to 15 mg (n=3): median 57.2% platelet reduction in 28 days

Durable control

- Platelet normalization maintained at 33, 44 and 46 wks (15 mg starters)
- Control up to 88 wks in patients escalated from lower doses
- WBC and platelets fell together, often in Cycle 1

Molecular signal

- All molecularly evaluable pts starting at 15 mg, treated ≥6 months (n=3), had driver mutation reductions (42–84%)
- One JAK2V617F pt at 5 mg: 50% VAF reduction
- Suggests potential disease-modifying activity

Safety

- 17 pts dosed at 5, 7, 15 and 20 mg
- No DLTs at 5, 7 or 15 mg; DLT of thrombocytopenia at 20 mg, managed per protocol
- Most TEAEs Grade 1/2; Grade 3 in 5 pts (29.4%), Grade 4 in 1

15 mg emerging as RP2D: rapid, durable, mutation-agnostic multi-lineage control in the ASH 2026 abstract

Sources: ASH 2026 abstracts 1036 (oral; clinical) and 5540 (poster; PK), data cutoff 30 Jun 2026. CHR: complete hematologic response; DLT: dose-limiting toxicity; RP2D: recommended Phase 2 dose; TEAE: treatment-emergent adverse event; VAF: variant allele frequency. Data are preliminary and subject to change.

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03

JBI-802 Development Plans



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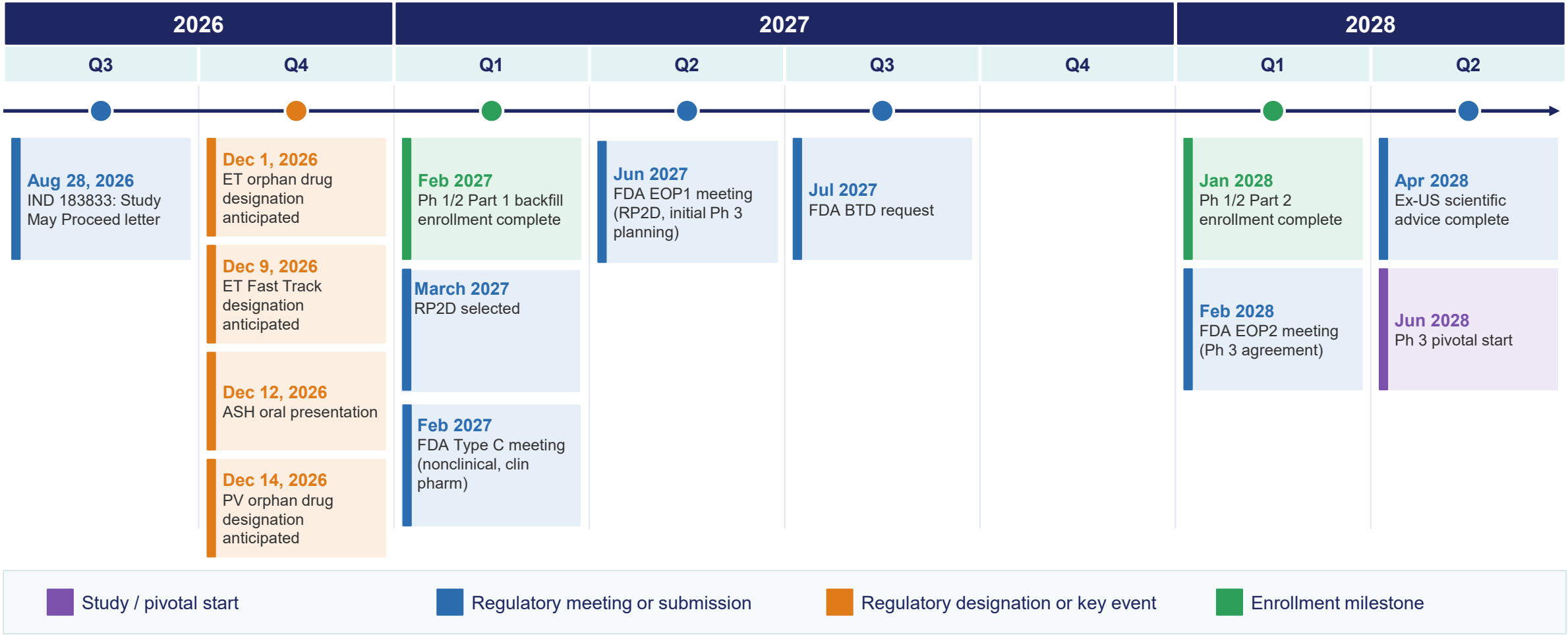
JBI-802: Planned/Estimated Development Timeline

Anticipated key milestones from Phase 1/2 through registration-enabling study



Planned / estimated timeline as of 2 Nov 2026 and subject to change. ASH: American Society of Hematology; EOP1/EOP2: End-of-Phase 1/2; ET: essential thrombocythemia; IND: Investigational New Drug; pBTD: breakthrough therapy designation; PV: polycythemia vera; RP2D: recommended Phase 2 dose.

04

JBI-802 Intellectual Property



JBI-802: IP Portfolio Supports Protection Into 2046

Composition of matter, isomer and method-of-use filings support long-term protection across key markets

Patent type	Coverage	Status / geography	Expected expiry
Composition of matter	Novel dual LSD1/HDAC inhibitors	Granted Granted in U.S. and major global markets	2042*
Composition of matter (isomers)	Pharmaceutically active dual LSD1/HDAC inhibitors	Granted / pending Granted in Eurasia; pending in U.S. and other major markets	2043
Method of use	Dual LSD1/HDAC inhibitors for the treatment of myeloproliferative neoplasms	Filed U.S. provisional filed	2046
Method of use	Dual LSD1/HDAC inhibitors for the treatment of cancers with STK11 mutations	Filed U.S. provisional filed	2046



100% owned: Global IP developed in-house (not in-licensed) and wholly owned by Jubilant Therapeutics

Layered IP strategy extends coverage from core composition claims to follow-on isomer and indication-specific filings

*Expiry date includes potential Patent Term Extension, which may extend patent life by up to 5 years. Bars show protection from today through expected expiry.

05

JBI-802 Leadership



Leadership and Advisors

Experienced team with track record across biotech and large pharma



Daniel J. O'Connor
President & Chief Executive Officer

AMBRX · ADVAXIS IMMUNOTHERAPIES · ImClone Systems Incorporated



Sandra Aung
Chief Development Officer

AMBRX · oncosec IMMUNOTHERAPIES · NEKTAR THERAPEUTICS



Shyam Pattabiraman
Chief Financial Officer

pwc



Sridharan Rajagopal
Head, Research

JUBILANT BIOSYS · AURIGENE Accelerating Discovery · OrchidPharma



Megan Schaeffer
Head, Clinical Operations

context Therapeutics · geron · GSK



Adair Turner
Executive Director, Regulatory Affairs

AMBRX · J&J · C



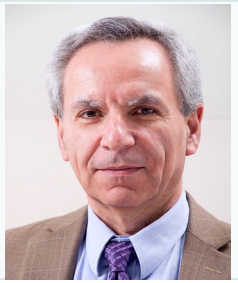
Quan Hong
Head, Biometrics

AMBRX · ADVAXIS IMMUNOTHERAPIES · Immunomedics



Agunan Krishnan
Senior Director, Business Development

JUBILANT BIOSYS



Hagop Youssoufian
Medical Advisor

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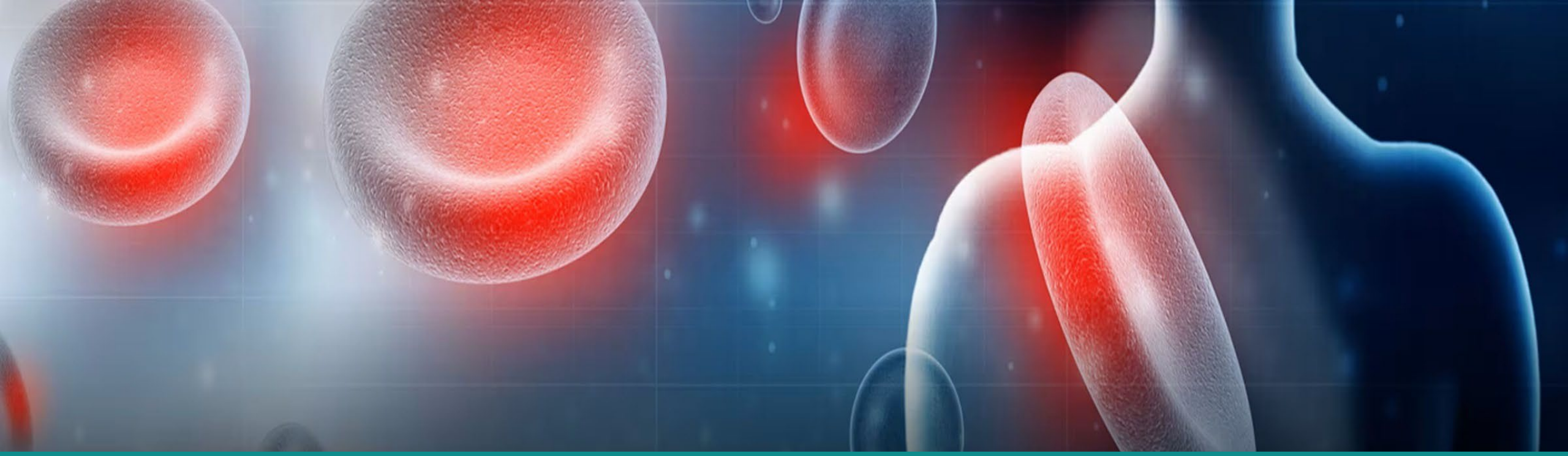
JUBILANT THERAPEUTICS



Thank You

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