ABIVAX

From Evolution to Revolution: New Mechanisms of Action in Ulcerative Colitis

6 October 2025

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- This satellite symposium is sponsored by Abivax and is not accredited for continuing education by any organization
- This program is for educational purposes only and includes investigational agents not currently approved by any health regulatory authorities
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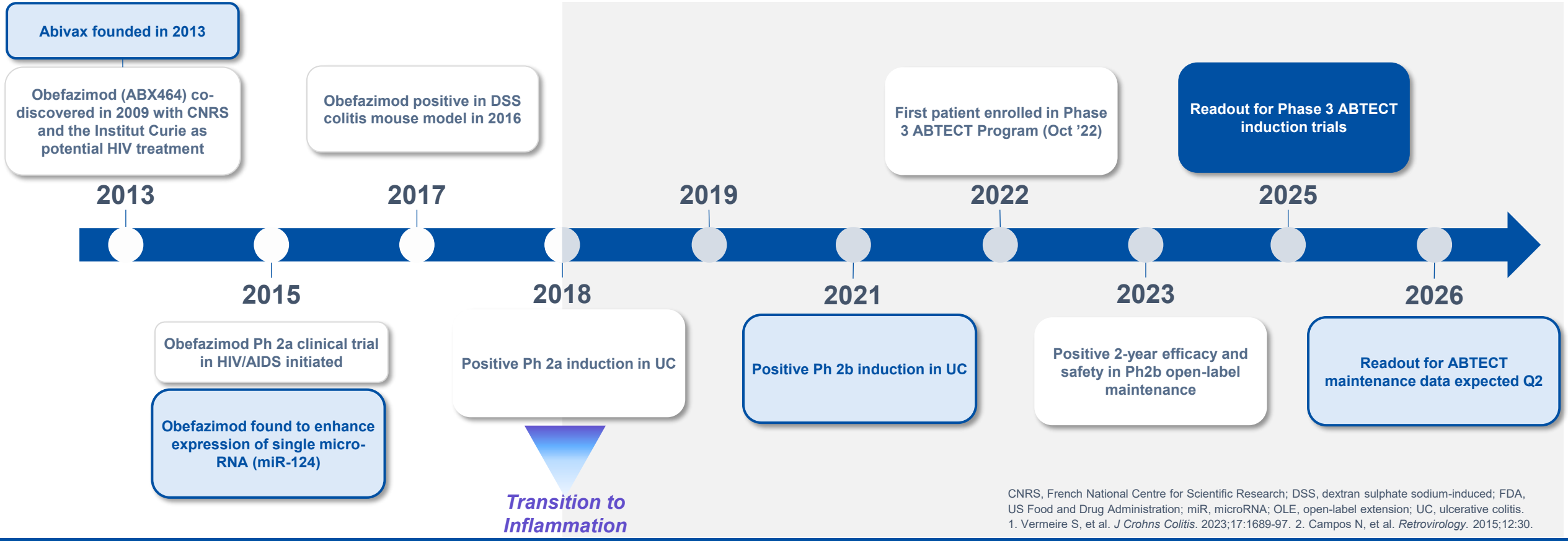
About Abivax

- Abivax is a clinical-stage biotechnology company focused on developing therapeutics that harness the body's natural regulatory mechanisms to help stabilize the immune response in patients with chronic inflammatory diseases
- Abivax is headquartered in Paris, France



CNRS, French National Centre for Scientific Research; DSS, dextran sulphate sodium-induced; FDA, US Food and Drug Administration; miR, microRNA; OLE, open-label extension; UC, ulcerative colitis.

1. Vermeire S, et al. *J Crohns Colitis*. 2023;17:1689-97. 2. Campos N, et al. *Retrovirology*. 2015;12:30.

Faculty

Prof Bruce Sands, MD, MS

Mount Sinai Health System
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Prof Silvio Danese, MD, PhD

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Disclosures

Prof Raja Atreya, MD, served as a speaker or consultant or received research grants from AbbVie, Abivax, AstraZeneca, Bristol Myers Squibb, Celltrion Healthcare, Galapagos, Johnson & Johnson, Eli Lilly, MSD, Pfizer, and Takeda Pharma

Prof Silvio Danese, MD, PhD, received consultancy fees from AbbVie, Abivax, Alimentiv, Allergan, Amgen, Applied Molecular Transport, AstraZeneca, Athos Therapeutics, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Celltrion, Dr Falk Pharma, Eli Lilly, Enthera, Ferring, Gilead, Hospira, Inotrem, Janssen, Johnson & Johnson, Morphic, MSD, Mundipharma, Mylan, Pfizer, Roche, Sandoz, Sublimity Therapeutics, Takeda, Teladoc Health, TiGenix, UCB, Vial, and Vifor and received lecture fees from Abbvie, Amgen, Ferring, Gilead, Janssen, Mylan, Pfizer, and Takeda

Prof Bruce Sands, MD, MS, reports consulting fees from Abbvie, Alimentiv, Adiso Therapeutics, Agomab, Amgen, AnaptysBio, Astra Zeneca, Biolojic Design, Biora Therapeutics, Boehringer Ingelheim, Celltrion, Equillium, Ensho Therapeutics, Enthera, Enveda Biosciences, Evommune, Ferring, Fzata, Galapagos, Genentech (Roche), Gilead Sciences, GlaxoSmithKline, Gossamer Bio, Imhotex, Immunyx Therapeutics, Index Pharmaceuticals, Innovation Pharmaceuticals, Kaleido, Kallyope, Merck & Co., Microba, Microbiotica, Mirador Therapeutics, Mitsubishi Tanabe Pharma, Mobius Care, Morphic Therapeutics, MRM Health, Nexus Therapeutics, Nimbus Discovery, Odyssey Therapeutics, Palisade Bio, Prometheus Biosciences, Prometheus Laboratories, Protagonist Therapeutics, Q32 Bio, Rasayana Therapeutics, Recludix Therapeutics, Reistone Biotherapeutics, Sanofi, Sorriso Pharmaceuticals, Surrozen, Target RWE, Teva, TLL Pharmaceutical, TR1X, Union Therapeutics; consulting and speaking fees from Abivax; consulting and speaking fees and other support from Lilly; research grants, consulting and speaking fees and other support from Bristol Myers Squibb, Janssen/J & J Innovative Medicine, Pfizer, Takeda; research grants and consulting fees from Theravance Biopharma; and consulting fees, stock and stock options from Ventyx Biopharma.

Agenda

Prof Raja Atreya, MD

University Hospital of Erlangen
Erlangen, Germany

The Evolution of UC Drug Development

17:35–17:45

Prof Bruce Sands, MD, MS

Mount Sinai Health System
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A New Chapter: Phase 3 Induction Results With Obefazimod

17:45–18:00

Prof Silvio Danese, MD, PhD

IRCCS San Raffaele Hospital
Milan, Italy

Exploring Subgroup Outcomes and Potential for Combination Therapy

18:00–18:20

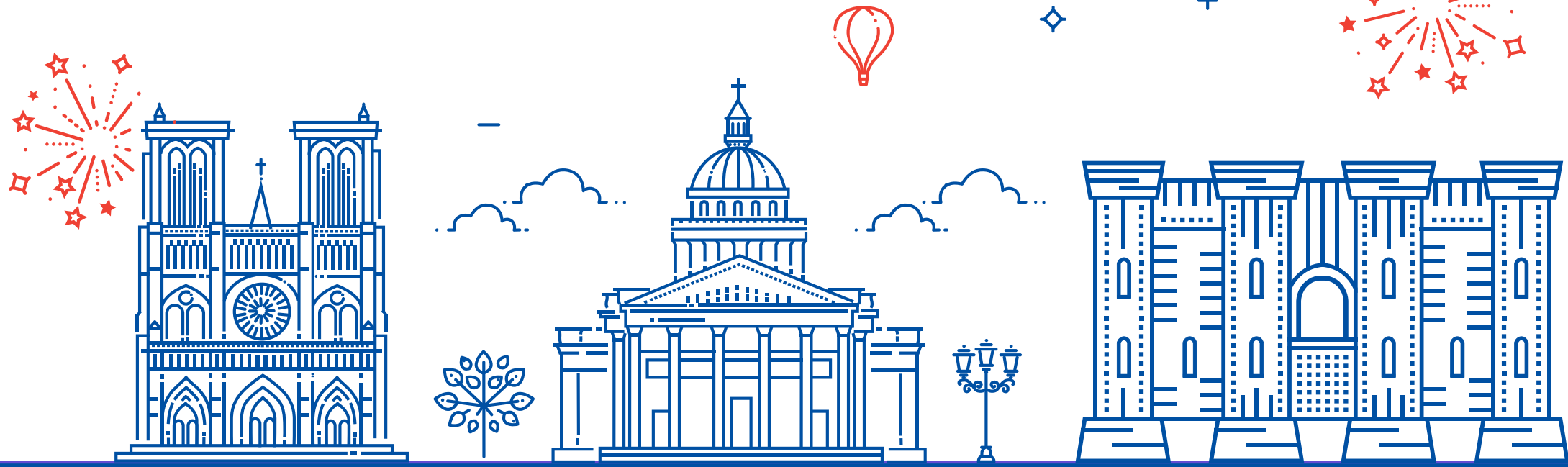
All

FAQ

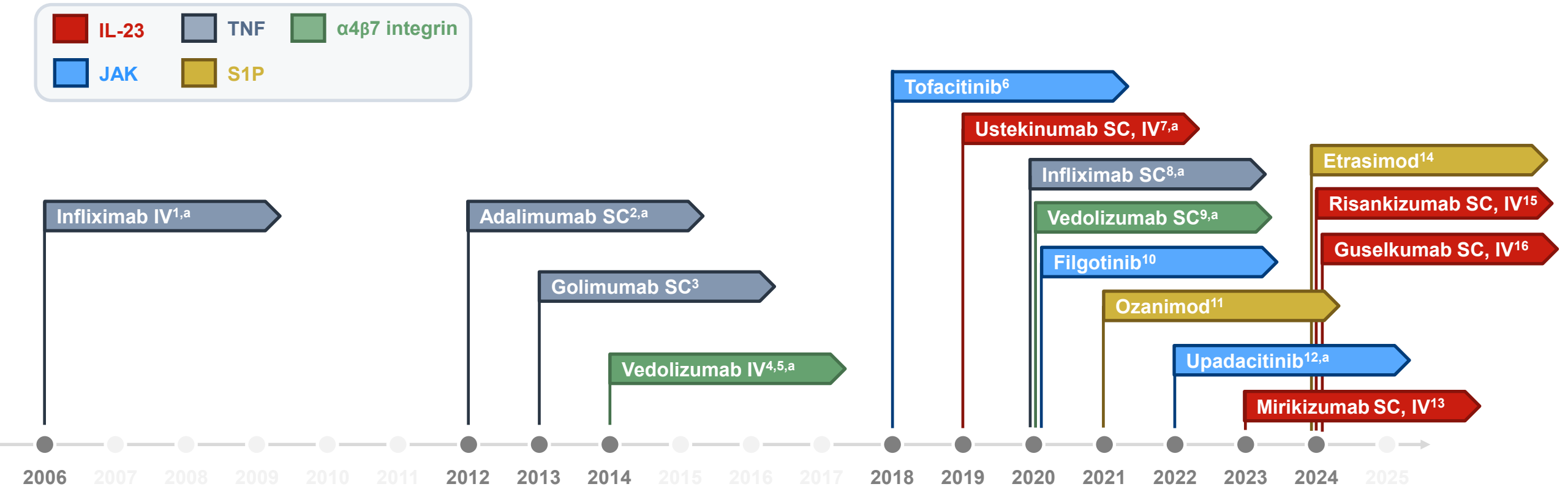
18:20 – 18:30

The Evolution of UC Drug Development

Raja Atreya, MD
University Hospital of Erlangen
Erlangen, Germany

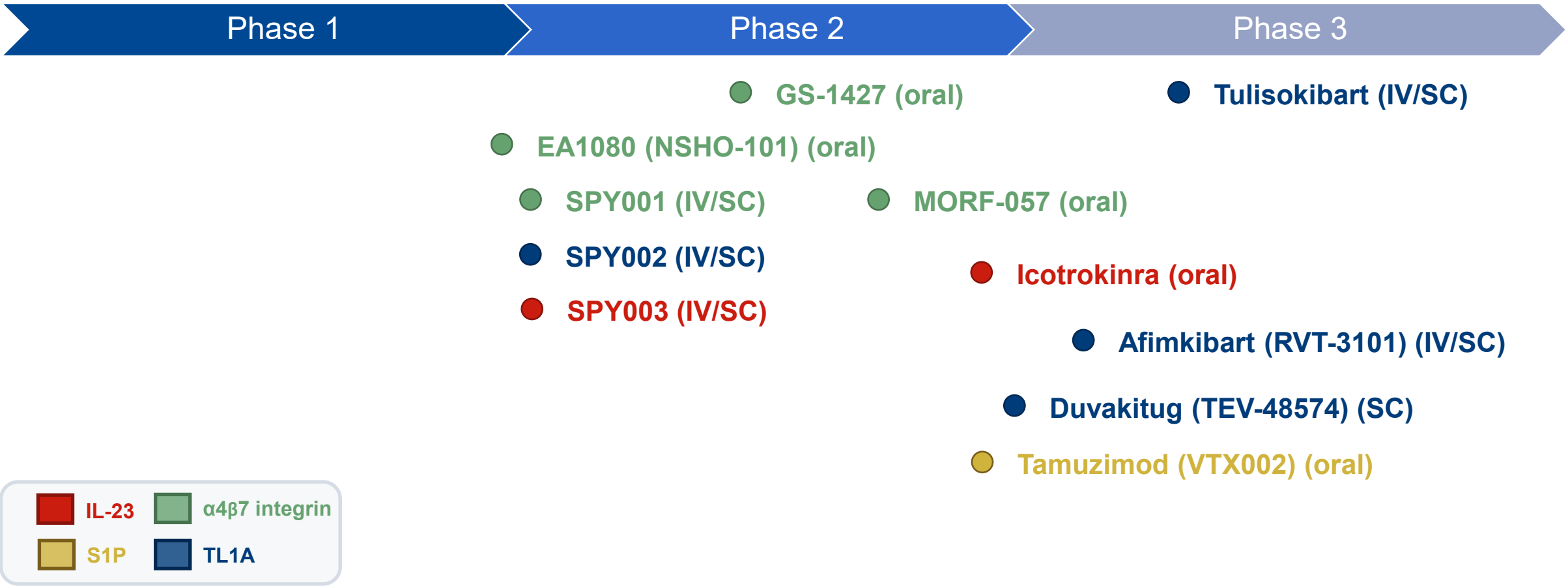


Advanced Treatment Options Approved for UC Have Been Expanding in Recent Years



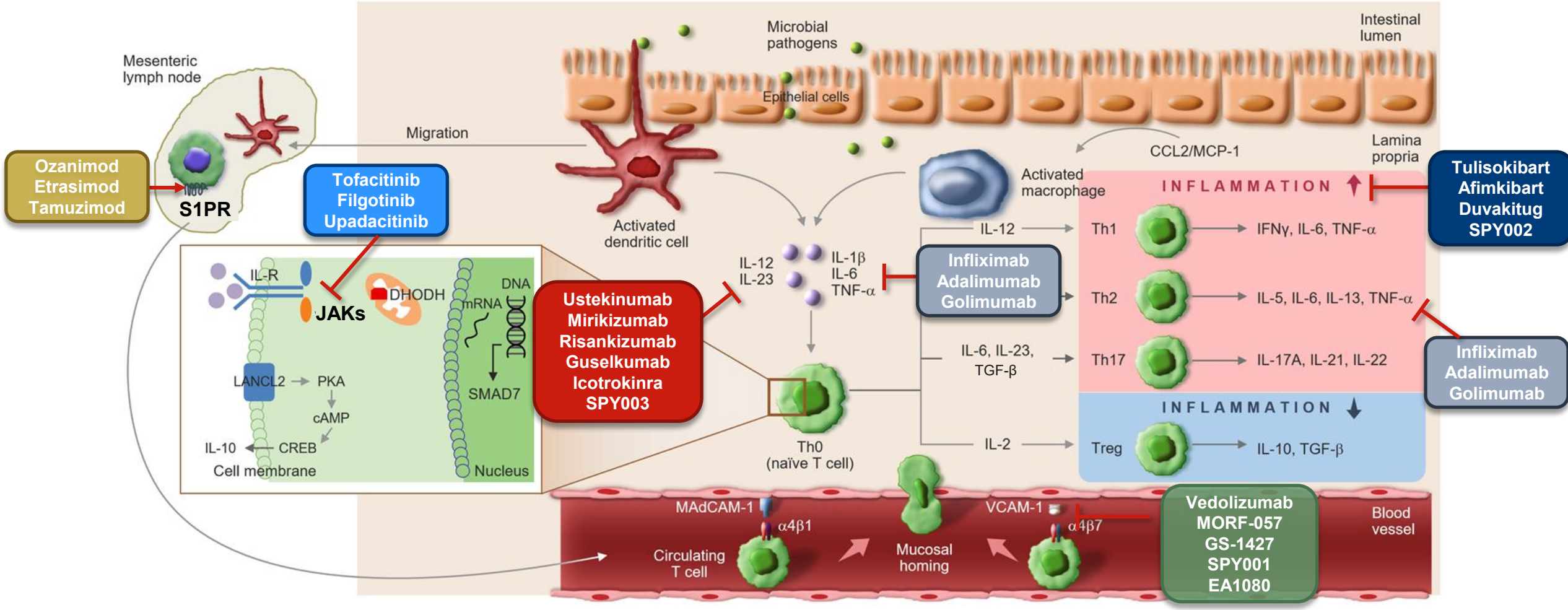
[a]Approved for Crohn's disease as well (EMA 1999/infliximab IV[17]; 2007/adalimumab[18]; 2014/vedolizumab IV[4]; 2016/ustekinumab[19]; 2020/infliximab subQ[8]; 2020/vedolizumab subQ[10]; 2023/upadacitinib[20]). EMA, European Medicines Agency; IV, intravenous; SC, subcutaneous; UC, ulcerative colitis. **1.** Hisa EC, et al. *APLAR J Rheumatol.* 2006;9:107-118. **2.** Abbott. Press release. April 11, 2012. **3.** Johnson & Johnson. Press release. September 23, 2013. **4.** Takeda. News release. May 28, 2014. **5.** EPAR. Entyvio. **6.** Pfizer. Press release. August 1, 2018. **7.** BusinessWire. September 4, 2019. **8.** European Pharmaceutical Review. News article. July 29, 2020. **9.** Takeda. Press release. May 8, 2020. **10.** EPAR. Jyseleca. **11.** BMS. Press release. November 23, 2021. **12.** AbbVie. Press release. July 26, 2022. **13.** EPAR. Omvoh. **14.** Pfizer. Press release. February 19, 2024. **15.** AbbVie. Press release. June 18, 2024. **16.** Johnson & Johnson. Press release. September 11, 2024. **17.** Melsheimer R, et al. *Biologics*. 2019;13:139-178. **18.** PharmaTimes. June 8, 2007. **19.** Johnson & Johnson. Press release. November 11, 2016. **20.** AbbVie. Press release. April 17, 2023.

The Therapeutic Pipeline Includes Many Investigational Drugs With the Same Mechanism of Action



IL, interleukin; IV, intravenous; S1P, sphingosine-1-phosphate; SC, subcutaneous; TL1A, TNF-like cytokine 1A.

The Pathogenesis of UC Provides Many Therapeutic Targets



cAMP, cyclic adenosine monophosphate; CCL, C-C motif chemokine ligand; CREB, cAMP response element binding protein; DHODH, dihydroorotate dehydrogenase; IFN, interferon; IL, interleukin; JAK, Janus kinase; LANCL2, lanthionine synthetase C-like 2; MAdCAM, mucosal addressin cell-associated molecule; MCP-1, monocyte chemoattractant protein-1; PKA, protein kinase; S1PR, sphingosine-1-phosphate receptor; STAT3, signal transducer and activator of transcription 3; TGF, transforming growth factor; Th0, naive T cell; Th1, T-helper 1 cell; Th2, T-helper 2 cell; Th17, T-helper 17 cell; TNF, tumor necrosis factor; Treg, regulatory T cell; UC, ulcerative colitis; VCAM-1, vascular cell adhesion molecule.

There Is an Increasing Number of Drugs in Development With the Same Target

Remission Rates

- A substantial number of patients do not respond to or lose response to current treatments.[1-8]
- **One-year net remission rates,** defined as the actual percentage of patients enrolled during induction who are in remission at the end of maintenance in Ph3 clinical trials:
  - In **anti-TNF/biologic-naive** patients: 21.5% – 43.9%[9]
  - In **anti-TNF/biologic-exposed** patients: 10.2% – 33.0%[9]

Drug Development

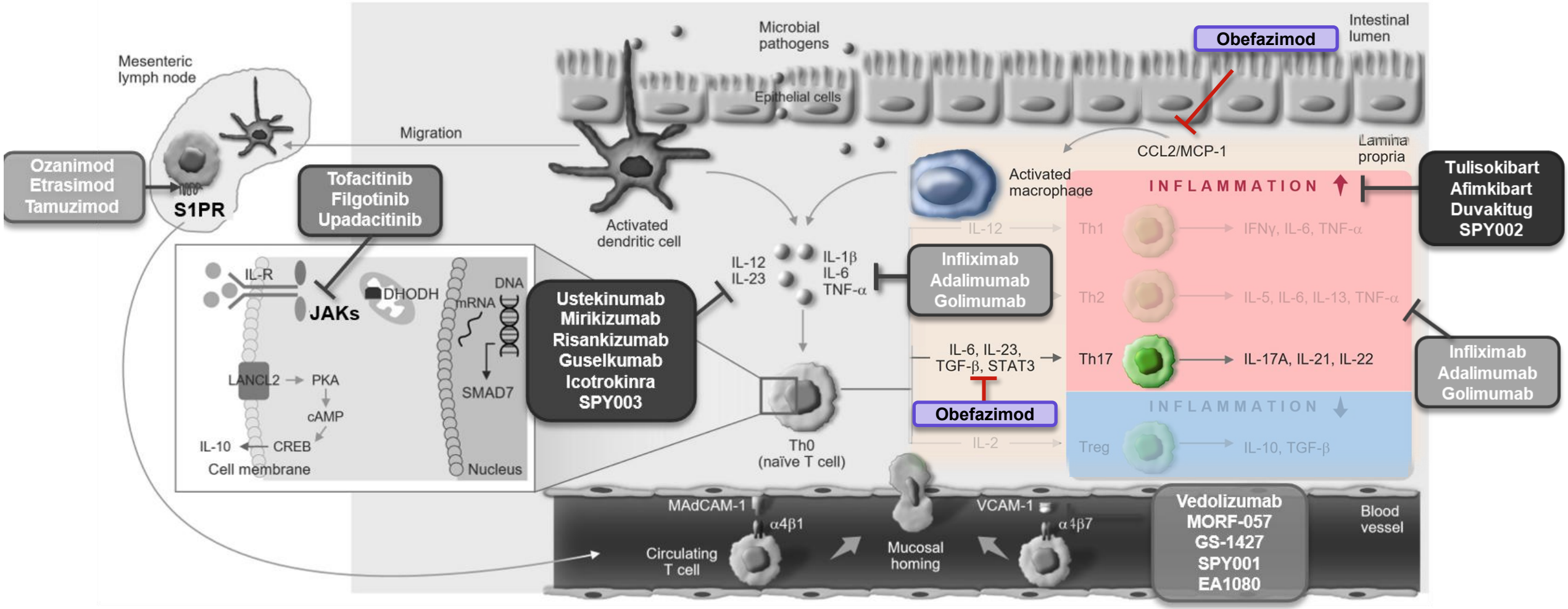
- With the expansion of the therapeutic pipeline for UC, there are an increasing number of drugs with the same molecular target

Unmet Need

- Therefore, an unmet clinical need remains for additional agents with a novel mechanism of action or combination therapy strategies

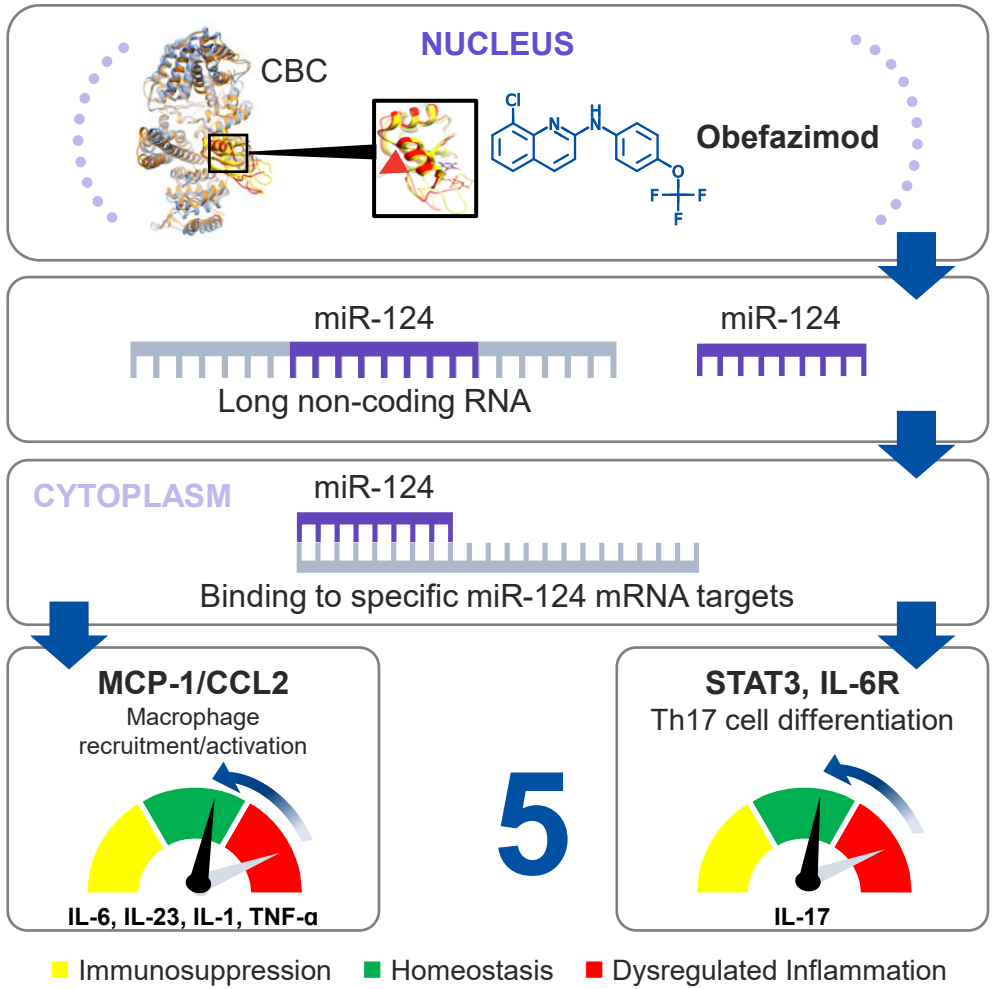
1. Danese S, et al. *Lancet Gastroenterol Hepatol.* 2021;7:118-127. **2.** Hibi T, et al. *J Gastroenterol.* 2017;52:1101-1111. **3.** Jyseleca. Summary of product characteristics. 2020. https://www.ema.europa.eu/en/documents/product-information/jyseleca-epar-product-information_en.pdf. Accessed Sep 2025. **4.** Rubin DT, et al. *Lancet Gastroenterol Hepatol.* 2022;7:17-27. 5. Sandborn WJ, et al. *N Engl J Med.* 2017;376:1723-1736. **6.** Sandborn WJ, et al. *Gastroenterology.* 2020;158:562-572. **7.** Sands BE, et al. *N Engl J Med.* 2019;381:1201-1214. **8.** Sandborn WJ, et al. *N Engl J Med.* 2016;374:1754-1762. **9.** Kayal M, et al. Clin Gastroenterol Hepatol. 2023;21(13):3433-3436.e1.
UC, ulcerative colitis.

Obefazimod – a Novel Therapeutic Mechanism



cAMP, cyclic adenosine monophosphate; CCL, C-C motif chemokine ligand; CREB, cAMP response element binding protein; DHODH, dihydroorotate dehydrogenase; IFN, interferon; IL, interleukin; JAK, Janus kinase; LANCL2, lanthionine synthetase C-like 2; MAdCAM, mucosal addressin cell-associated molecule; MCP-1, monocyte chemoattractant protein-1; PKA, protein kinase; S1PR, sphingosine-1-phosphate receptor; STAT3, signal transducer and activator of transcription 3; TGF, transforming growth factor; Th0, naive T cell; Th1, T-helper 1 cell; Th2, T-helper 2 cell; Th17, T-helper 17 cell; TNF, tumor necrosis factor; Treg, regulatory T cell; UC, ulcerative colitis; VCAM-1, vascular cell adhesion molecule.
Image adapted from Ben Ghezala I, et al. *Pharmaceuticals*. 2021;14(7):637. Reprinted and licensed under Creative Commons Attribution License 4.0 (CC BY; https://creativecommons.org/licenses/by-nc/4.0/).

Obefazimod enhances expression of miR-124, resulting in regulation of inflammatory response, restoring mucosal homeostasis in UC[1-3]



1. Obefazimod binds to CBC within the nucleus (demonstrated by cryo-electron microscopy)[a]
2. Induces selective splicing of a single, long, non-coding RNA, leading to enhanced expression of miR-124
3. miR-124 binds to its specific mRNA targets in the cytoplasm, reducing translation into their respective proteins
4. Reduced translation of MCP-1/CCL2 stabilizes macrophage activation and recruitment to the gut
5. Reduced translation of STAT3 and IL-6R stabilizes Th17 differentiation and related cytokines

[a]Cryo-electron microscopy is a technique for determining protein structure.
CBC, cap binding complex; CCL2, C-C motif chemokine ligand 2; IL, interleukin; MCP-1, monocyte chemoattractant protein-1; miR, microRNA; R, receptor; STAT3, signal transducer and activator of transcription 3; Th, T-helper cell; TNF, tumor necrosis factor; UC, ulcerative colitis.
1. Vermeire S, et al. *Lancet Gastroenterol Hepatol*. 2022;7(11):1024-1034. **2.** Apolit C, et al. *Clin Transl Gastroenterol.* 2023;14:e00560. **3.** Data on file. Abivax.

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A New Chapter: Phase 3 Induction Results With Obefazimod

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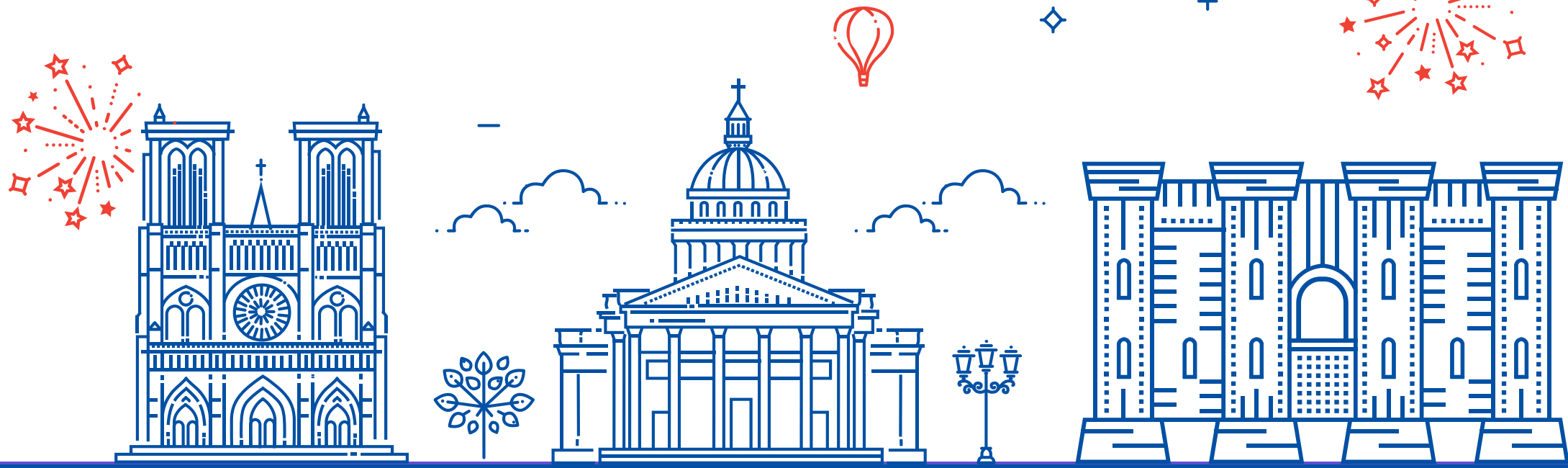


ABTECT Phase 3 Program: Obefazimod in Ulcerative Colitis

2 Induction Trials and 1 Maintenance Trial

Screening

- ❑ Moderately to severely active UC defined by:
  - MMS 5-9, ES≥2, RB≥1
- ❑ Prior failure of conventional and/or biologic/JAKi/S1P
- ❑ No limit on number of prior treatment failures

Induction Trials

ABTECT 1

ABX464-105 (n=639*)

Randomization

- Obe 50 mg (n=318)
- Obe 25 mg (n=160)
- Placebo (n=158)

ABTECT 2

ABX464-106 (n=636)

Randomization

- Obe 50 mg (n=318)
- Obe 25 mg (n=159)
- Placebo (n=159)

Assessment at Week 8

Week 8

FDA Primary Endpoint: Clinical Remission

Maintenance Trial

ABX464-107

Active Drug Responders

Randomization 1:1:1

- Obe 50 mg
- Obe 25 mg
- Placebo

Assessment at Week 52

Week 52

FDA Primary Endpoint: Clinical Remission

Long-Term Extension Offered Up to 4 years or Until Commercialization

Relapsers

Assigned to 50mg

Placebo Responders → **Placebo Induction Responder Arm** *(Stay on Placebo Until Relapse)*

Placebo and Active Drug Non-Responders → **Non-responder Treatment Arm**

This presentation will focus on the safety and efficacy results of patients from ABTECT 1 & 2 induction trials

ABX464-105, ABX464-106, ABX464-107; Placebo responders from induction are not re-randomized and do not contribute to the primary endpoint in the maintenance study.*3 patients in ABTECT 1 were randomized but not treated
Clinical remission is defined as SFS = 0 or 1, and RBS = 0 and MES = 0 or 1 (MES of 1 modified to exclude friability).

Baseline Characteristics: Generally Well Balanced

- Slightly more severe and refractory population randomised to 25mg group in ABTECT 2 vs. ABTECT 1

	Pooled ABTECT 1 & 2			ABTECT 1 (105)			ABTECT 2 (106)		
	Placebo (N=317)	Obe 25 mg (N=319)	Obe 50 mg (N=636)	Placebo (N=158)	Obe 25 mg (N=160)	Obe 50 mg (N=318)	Placebo (N=159)	Obe 25 mg (N=159)	Obe 50 mg (N=318)
Age (years), mean (SD)	42.3 (14.1)	41.4 (13.2)	42.1 (14.0)	43.1 (13.6)	41.5 (13.5)	42.7 (14.3)	41.6 (14.7)	41.3 (12.8)	41.4 (13.6)
Disease duration (years), mean (SD)	7.6 (7.1)	7.9 (7.0)	7.9 (7.3)	7.5 (7.8)	7.8 (7.2)	8.0 (7.4)	7.8 (6.5)	7.9 (6.8)	7.7 (7.2)
Baseline MMS, mean (SD)	6.9 (1.0)	6.9 (1.0)	6.9 (1.1)	6.9 (1.0)	6.8 (1.0)	6.9 (1.1)	6.8 (1.0)	7.0 (1.0)	6.9 (1.1)
Endoscopic subscore 3, n (%)	189 (59.6)	194 (60.8)	378 (59.4)	94 (59.5)	91 (56.9)	190 (59.7)	95 (59.7)	103 (64.8)	188 (59.1)
Extensive Colitis	130 (41.0)	131 (41.1)	236 (37.1)	59 (37.3)	63 (39.4)	110 (34.6)	71 (44.7)	68 (42.8)	126 (39.6)
Fecal Calprotectin (µg/g), median	1902	1762	1564	1969	1499	1581	1792	2041	1499
Concomitant Corticosteroids	126 (39.7)	120 (37.6)	262 (41.2)	61 (38.6)	61 (38.1)	132 (41.5)	65 (40.9)	59 (37.1)	130 (40.9)

Data on File ABX464-105 & ABX464-106

Baseline Characteristics: Generally Well Balanced

- Slightly more severe and refractory population randomised to 25mg group in ABTECT 2 vs. ABTECT 1

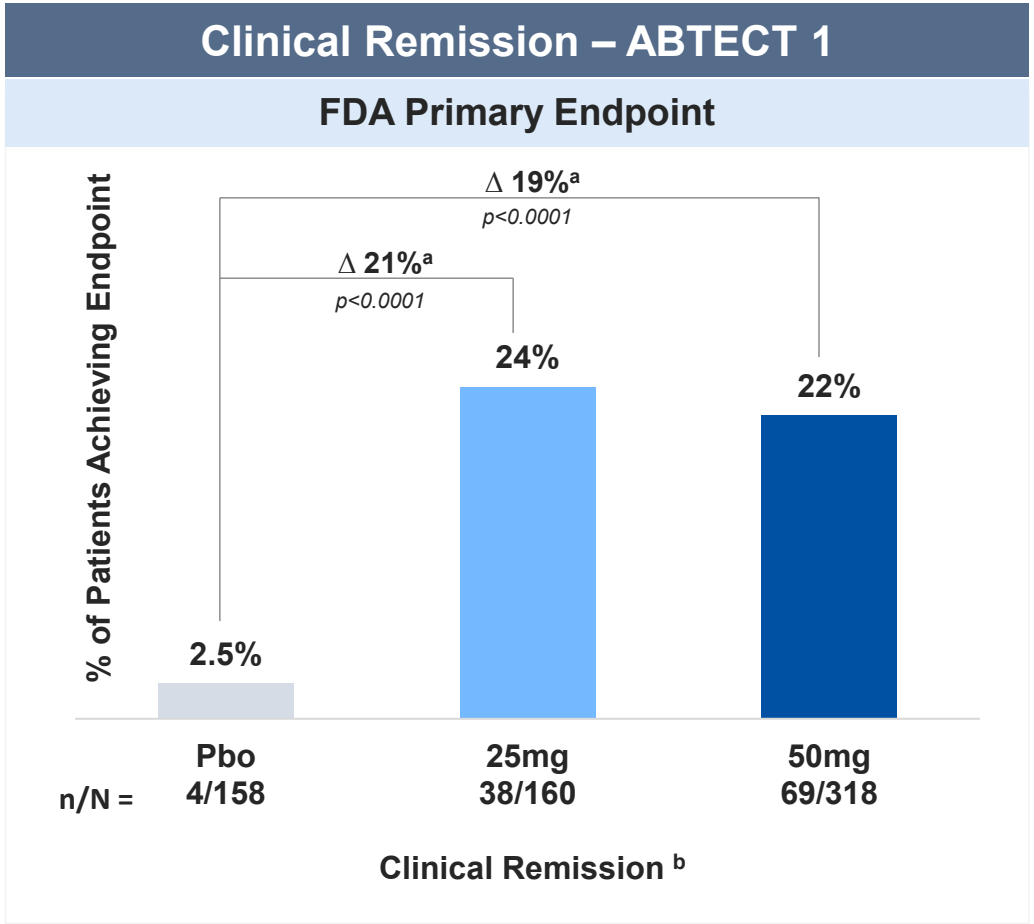
	Pooled ABTECT 1 & 2			ABTECT 1 (105)			ABTECT 2 (106)		
	Placebo (N=317)	Obe 25 mg (N=319)	Obe 50 mg (N=636)	Placebo (N=158)	Obe 25 mg (N=160)	Obe 50 mg (N=318)	Placebo (N=159)	Obe 25 mg (N=159)	Obe 50 mg (N=318)
AT-IR Yes	148 (46.7)	146 (45.8)	308 (48.4)	69 (43.7)	70 (43.8)	149 (46.9)	79 (49.7)	76 (47.8)	159 (50.0)
Number of prior JAK-IR (% of AT-IR Yes Patients)	35 (23.6)	34 (23.3)	55 (17.9)	15 (21.7)	15 (21.4)	22 (14.8)	20 (25.3)	19 (25.0)	33 (20.8)
Number of prior AT-IR by medication name†, n (%)									
1	62 (19.6)	45 (14.1)	150 (23.6)	31 (19.6)	23 (14.4)	70 (22.0)	31 (19.5)	22 (13.8)	80 (25.2)
2	34 (10.7)	45 (14.1)	64 (10.1)	16 (10.1)	20 (12.5)	35 (11.0)	18 (11.3)	25 (15.7)	29 (9.1)
3	28 (8.8)	33 (10.3)	52 (8.2)	12 (7.6)	18 (11.3)	25 (7.9)	16 (10.1)	15 (9.4)	27 (8.5)
4+	24 (7.6)	23 (7.2)	42 (6.6)	10 (6.3)	9 (5.6)	19 (6.0)	14 (8.8)	14 (8.8)	23 (7.2)

Highly refractory population with ~21% of AT-IR failing a JAK inhibitor

† Medication name results in each individual advanced therapy being counted as a unique medication; e.g. infliximab + adalimumab would be counted as 2
Data on File ABX464-105 & ABX464-106

ABTECT 1: Obefazimod Met the FDA Primary Endpoint of Clinical Remission

- 25mg and 50mg doses demonstrated statistically significant and clinically meaningful improvement



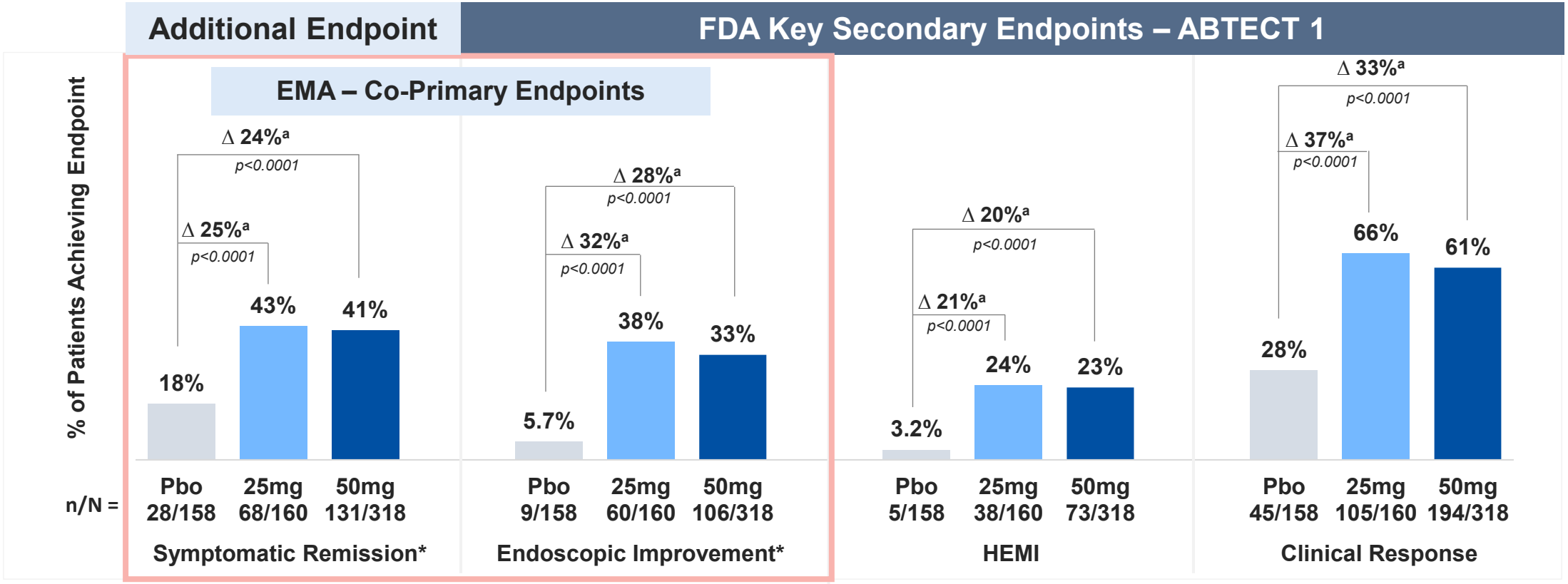
Data on File ABX464-105

[a] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

[b] Clinical remission is defined as SFS = 0 or 1, and RBS = 0 and MES = 0 or 1 (MES of 1 modified to exclude friability).

ABTECT 1: Both doses met all key secondary endpoints

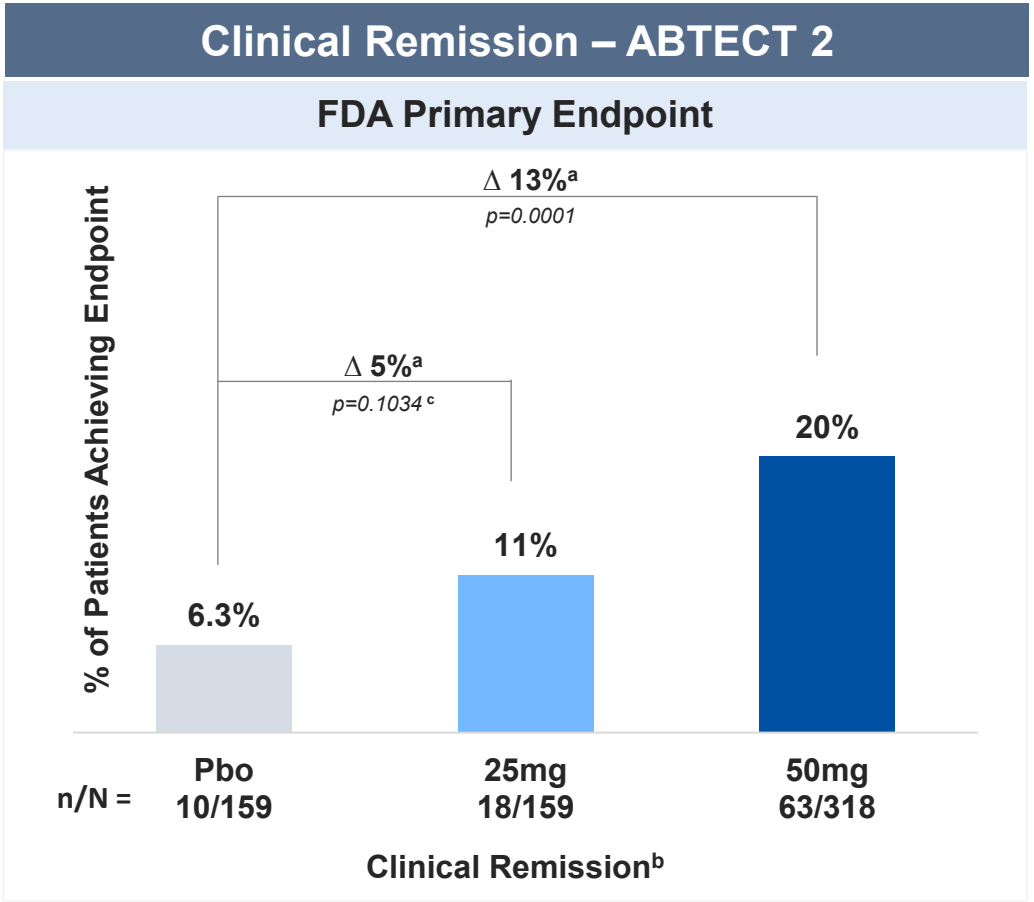
- EMA co-primary endpoints met for 25mg and 50mg



Data on File ABX464-105
[a] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.
Endoscopic improvement is defined as MES = 0 or 1 (MES of 1 modified to exclude friability).
Clinical response is defined as a reduction from Baseline in MMS >= 2 points and a relative reduction from Baseline in MMS >= 30%, and a reduction from Baseline in RBS >= 1 point and/or RBS = 0 or 1.
HEMI is defined as MES = 0 or 1 and Geboes Index score $\leq$3.1
Symptomatic remission is defined as RBS=0 and SFS= 0 or 1
*Co-Primary Endpoints for EMA

ABTECT 2: 50 mg met the FDA primary endpoint of clinical remission

- Statistically significant and clinically meaningful improvement observed



Data on File ABX464-106

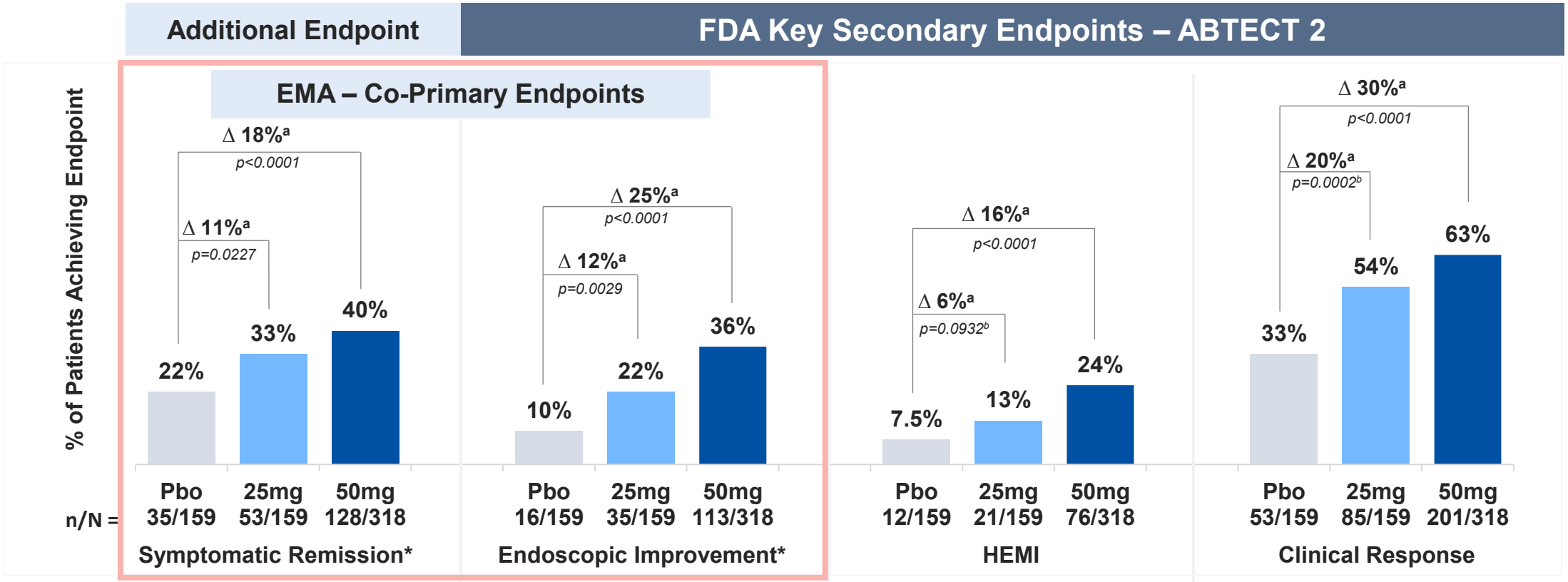
[a] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no), and region (Japan/rest of world). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

[b] Clinical remission is defined as SFS = 0 or 1, and RBS = 0 and MES = 0 or 1 (MES of 1 modified to exclude friability).

[c] 25mg did not achieve statistical significance at 8 weeks

ABTECT 2: 50mg met all key secondary endpoints

- EMA co-primary endpoints met for both 25mg and 50mg



Data on File ABX464-106

[a] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no), and region (Japan/rest of world). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

Endoscopic improvement is defined as MES = 0 or 1 (MES of 1 modified to exclude friability).

Clinical response is defined as a reduction from Baseline in MMS >= 2 points and a relative reduction from Baseline in MMS >= 30%, and a reduction from Baseline in RBS >= 1 point and/or RBS = 0 or 1.

HEMI is defined as MES = 0 or 1 and Geboes Index score $\leq$3.1

Symptomatic remission is defined as RBS=0 and SFS= 0 or 1

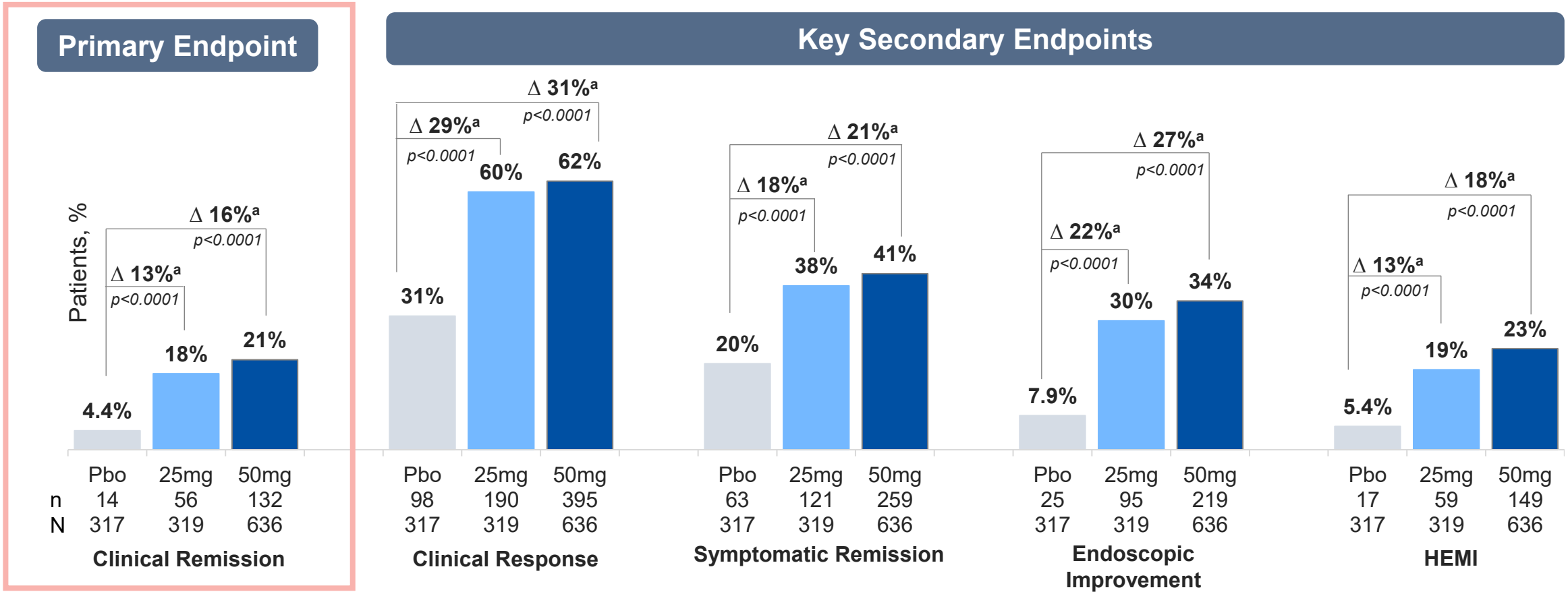
[b] p values for 25mg are nominal on key FDA secondary endpoints of HEMI and Clinical Response

*Co-Primary Endpoints for EMA

ABTECT-1
ABTECT-2

Pooled ABTECT 1 & 2: Both doses achieved clinically meaningful improvements across all efficacy endpoints

- Modest dose response appears across efficacy endpoints in pooled data set
- All p-values are nominal



Data on File ABX464-105 & ABX464-106;
[a] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no), and region (Japan/rest of world for ABTECT 2 only) . P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.
Clinical remission is defined as SFS = 0 or 1, and RBS = 0 and MES = 0 or 1 (MES of 1 modified to exclude friability). **Endoscopic improvement** is defined as MES = 0 or 1 (MES of 1 modified to exclude friability).
Clinical response is defined as a reduction from Baseline in MMS >= 2 points and a relative reduction from Baseline in MMS >= 30%, and a reduction from Baseline in RBS >= 1 point and/or RBS = 0 or 1.
HEMI is defined as MES = 0 or 1 and Geboes Index score ≤3.1. **Symptomatic remission** is defined as RBS=0 and SFS= 0 or 1

Safety Summary – ABTECT 1 & 2 – Pooled Full Data Set

	ABTECT 1 & 2 – Pooled Full Data Set		
Treatment Emergent Adverse Events (TEAE), n (%)	**Placebo (N=317)**	**Obefazimod 25 mg (N=319)**	**Obefazimod 50 mg (N=636)**
Any TEAE	161 (50.8)	156 (48.9)	383 (60.2)
TEAE leading to study drug discontinuation	15 (4.7)	8 (2.5)	32 (5.0)
Serious TEAE	10 (3.2)	7 (2.2)	20 (3.1)
Death	0	0	0
Malignancy	0	0	1 (0.2)†
Serious/severe (grade ≥3) infections and opportunistic infections	1 (0.3)‡	1 (0.3)¥	4 (0.6)§

†Prostate cancer stage I
‡Bronchopulmonary aspergillosis; ¥Appendicitis; §Pneumonia (2), anal abscess, COVID-19

Treatment-Emergent Adverse Events (≥1% and greater than placebo)

	ABTECT 1 & 2 – Pooled Full Data Set		
	Placebo (N=317)	**Obefazimod 25 mg (N=319)**	**Obefazimod 50 mg (N=636)**
Headache*	19 (6.0)	51 (16.0)	153 (24.1)
Headache leading to study **discontinuation** (per subject), n (%)	0	1 (0.3)	7 (1.1)
Time to onset of first TE headache per subject (days), median	7.0	1.0	1.0
Duration of headache for all TE headaches, days, median (range)	2.0	3.0	2.0
Nausea	4 (1.3)	16 (5.0)	46 (7.2)
Lipase increased	7 (2.2)	9 (2.8)	27 (4.2)
Abdominal pain	2 (0.6)	2 (0.6)	24 (3.8)
Vomiting	1 (0.3)	7 (2.2)	18 (2.8)
Upper abdominal pain	2 (0.6)	5 (1.6)	18 (2.8)
Back pain	0	4 (1.3)	13 (2.0)
Alanine aminotransferase increased	2 (0.6)	5 (1.6)	10 (1.6)
Hypertriglyceridaemia	0	3 (0.9)	12 (1.9)
Dyslipidaemia	2 (0.6)	1 (0.3)	9 (1.4)
Pyrexia	1 (0.3)	3 (0.9)	8 (1.3)
Amylase increased	1 (0.3)	4 (1.3)	7 (1.1)
Hyperlipidaemia	1 (0.3)	0	7 (1.1)
Hypertension	2 (0.6)	1 (0.3)	7 (1.1)

Data on File ABX464-105 & ABX464-106
*Headache Custom MedDRA Query includes the following Preferred Terms (PT): headache, tension headache, procedural headache, cluster headache, cervicogenic headache, migraine.
All other TEAEs are shown by individual Preferred Term.

Conclusions

ABTECT 1 Efficacy

- Both doses met FDA and EMA primary and all key secondary endpoints

ABTECT 2 Efficacy

- 50 mg met FDA and EMA primary and all key secondary endpoints
- 25 mg met EMA primary endpoint

Safety

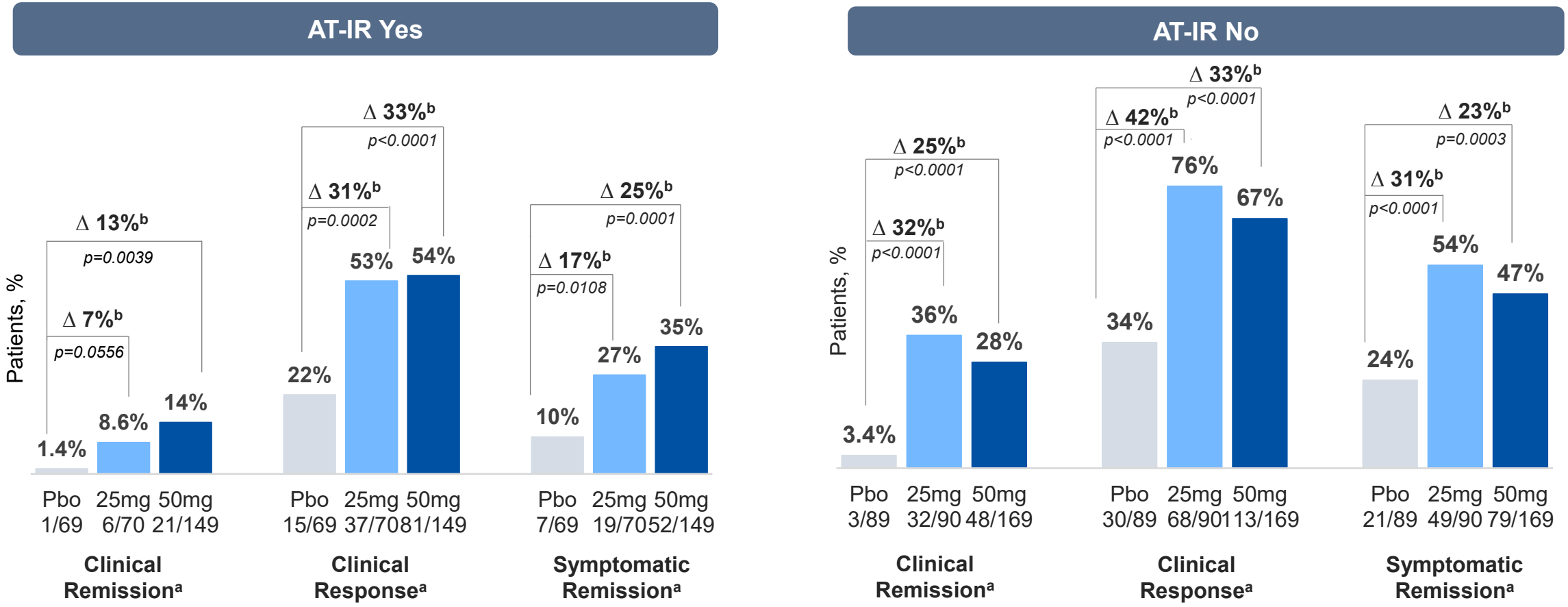
- No new safety signal identified
- No signal for serious or opportunistic infections or malignancies

Exploring Subgroup Outcomes and Potential for Combination Therapy

Silvio Danese, MD, PhD
IRCCS San Raffaele Hospital
Milan, Italy

ABTECT 1: 50 mg achieved clinically meaningful improvements in all clinical endpoints regardless of prior AT-IR

- Both doses performed well in subgroup with no prior AT-IR



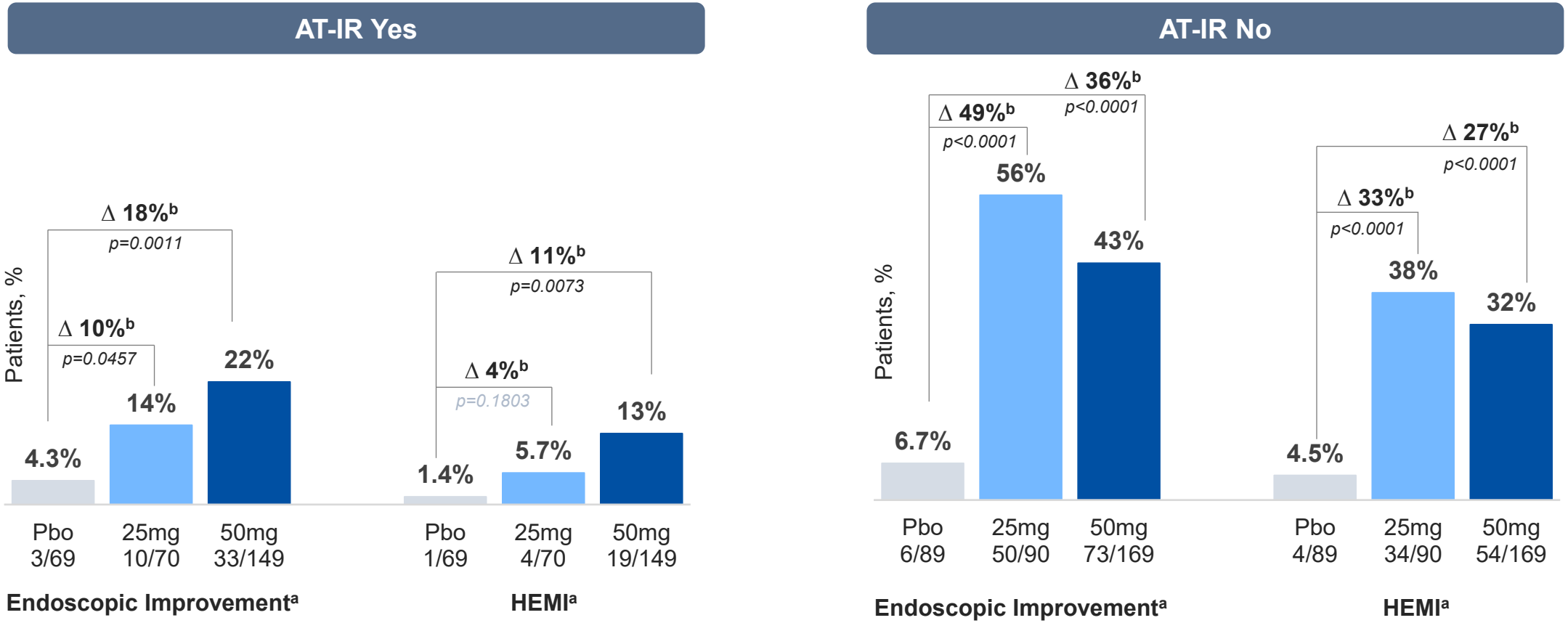
Data on File ABX464-105 & ABX464-106; All p-values are nominal

[a] **Clinical remission** is defined as SFS = 0 or 1, and RBS = 0 and MES = 0 or 1 (MES of 1 modified to exclude friability). **Clinical response** is defined as a reduction from Baseline in MMS >= 2 points and a relative reduction from Baseline in MMS >= 30%, and a reduction from Baseline in RBS >= 1 point and/or RBS = 0 or 1. **Symptomatic remission** is defined as RBS=0 and SFS= 0 or 1

[b] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

ABTECT 1: 50 mg achieved clinically meaningful improvements in endoscopic and histologic endpoints regardless of prior AT-IR

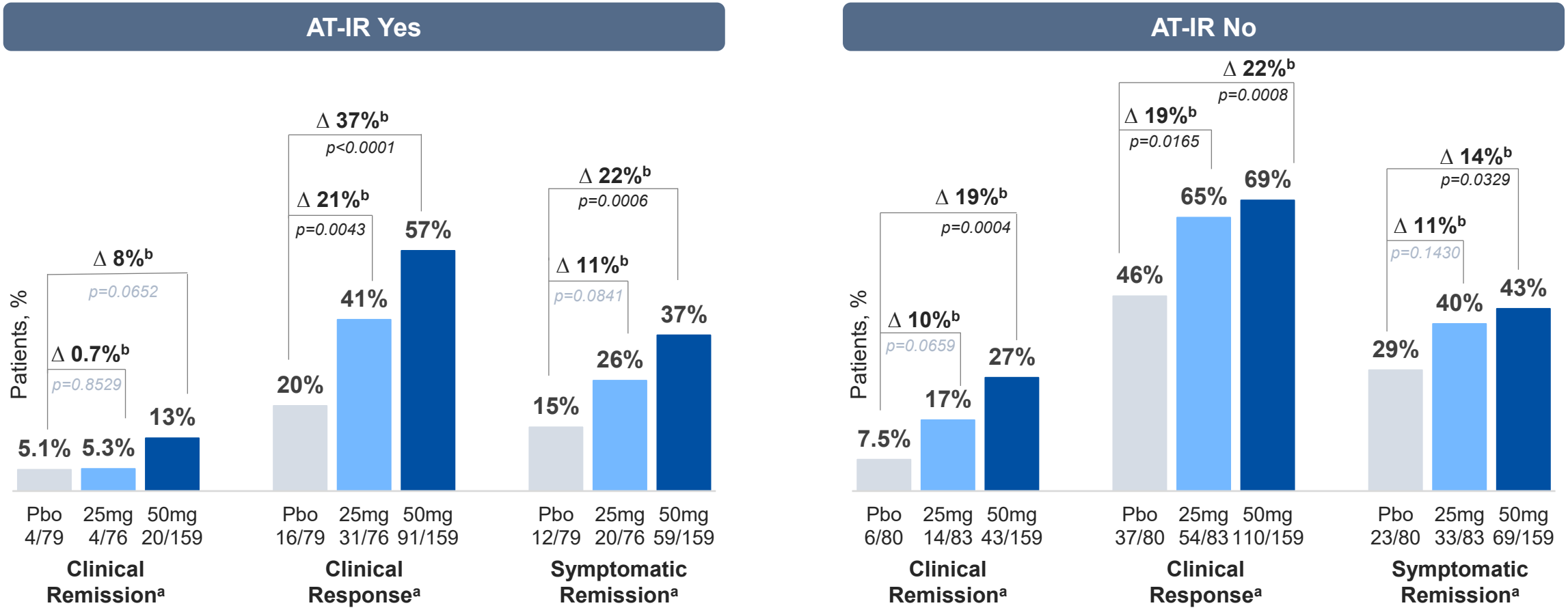
- Both doses performed well in subgroup with no prior AT-IR



Data on File ABX464-105 & ABX464-106; All p-values are nominal
[a] Endoscopic improvement is defined as MES = 0 or 1 (MES of 1 modified to exclude friability). HEMI is defined as MES = 0 or 1 and Geboes Index score ≤3.1
[b] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

ABTECT 2: 50 mg achieved clinically meaningful improvements in clinical endpoints regardless of prior AT-IR

- 50mg appears more effective than 25mg in both subgroups, especially in subgroup with prior AT-IR



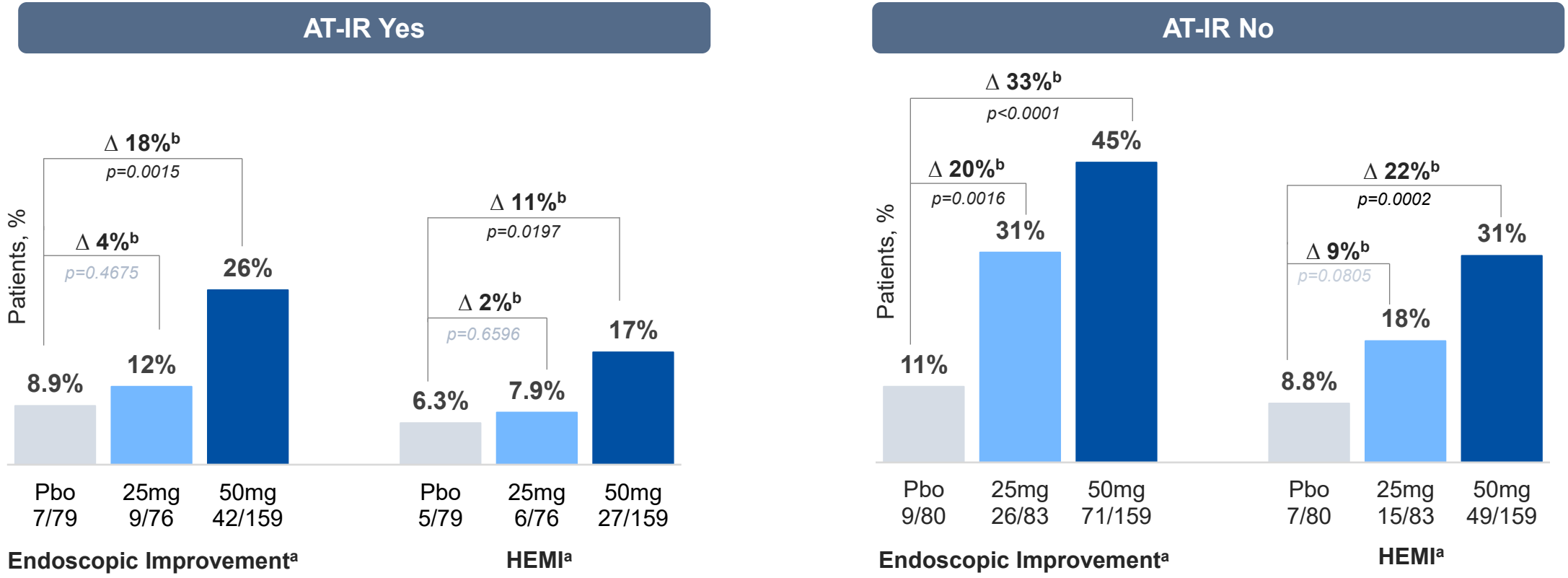
Data on File ABX464-105 & ABX464-106; All p-values are nominal

[a] **Clinical remission** is defined as SFS = 0 or 1, and RBS = 0 and MES = 0 or 1 (MES of 1 modified to exclude friability). **Clinical response** is defined as a reduction from Baseline in MMS >= 2 points and a relative reduction from Baseline in MMS >= 30%, and a reduction from Baseline in RBS >= 1 point and/or RBS = 0 or 1. **Symptomatic remission** is defined as RBS=0 and SFS= 0 or 1

[b] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no) and region (Japan/rest of world). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

ABTECT 2: 50 mg achieved clinically meaningful improvements in endoscopic and histologic endpoints regardless of prior AT-IR

- 50mg appears more effective than 25mg in both subgroups; clearly in subgroup with prior AT-IR



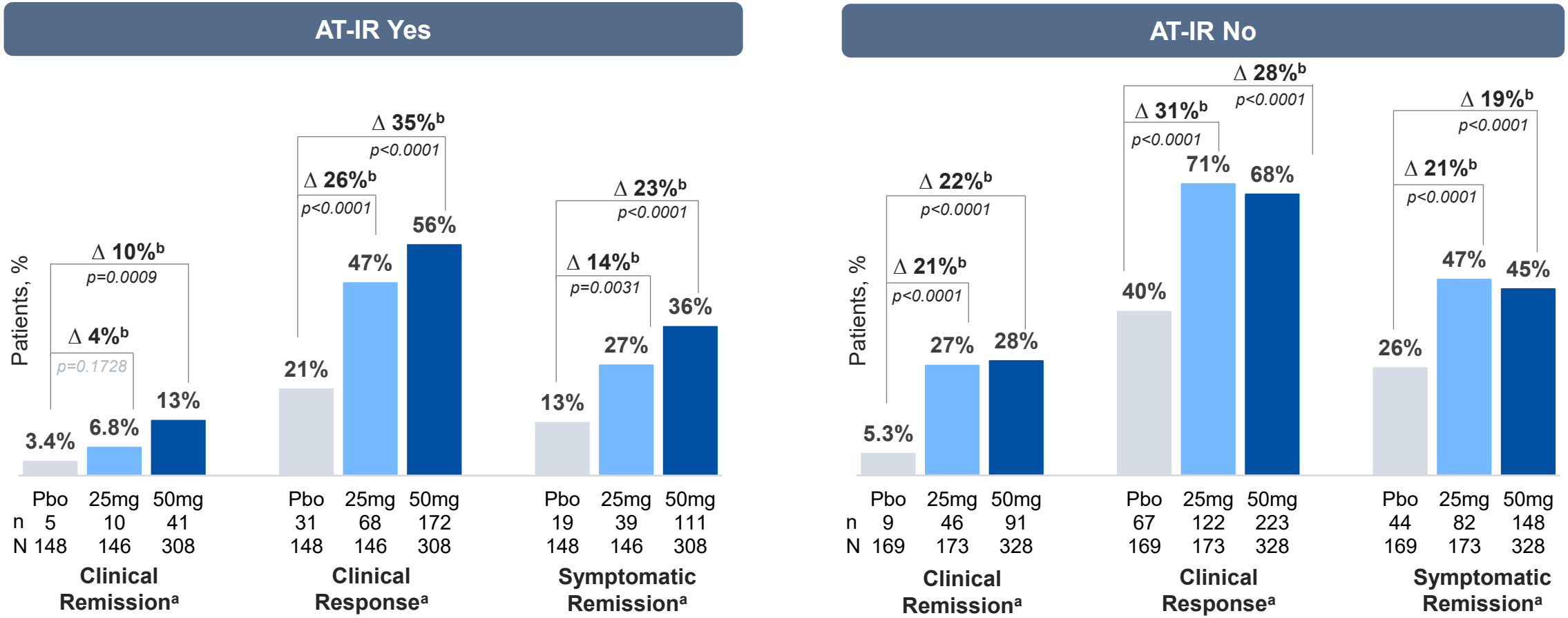
Data on File ABX464-105 & ABX464-106; All p-values are nominal
[a] Endoscopic improvement is defined as MES = 0 or 1 (MES of 1 modified to exclude friability). HEMI is defined as MES = 0 or 1 and Geboes Index score ≤3.1
[b] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no) and region (Japan/rest of world). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

ABTECT-1

ABTECT-2

Pooled ABTECT 1 & 2: 50 mg dose achieved clinically meaningful improvements in all clinical endpoints regardless of prior AT-IR

- 25mg and 50mg perform similarly in subgroup with no prior AT-IR in pooled data set



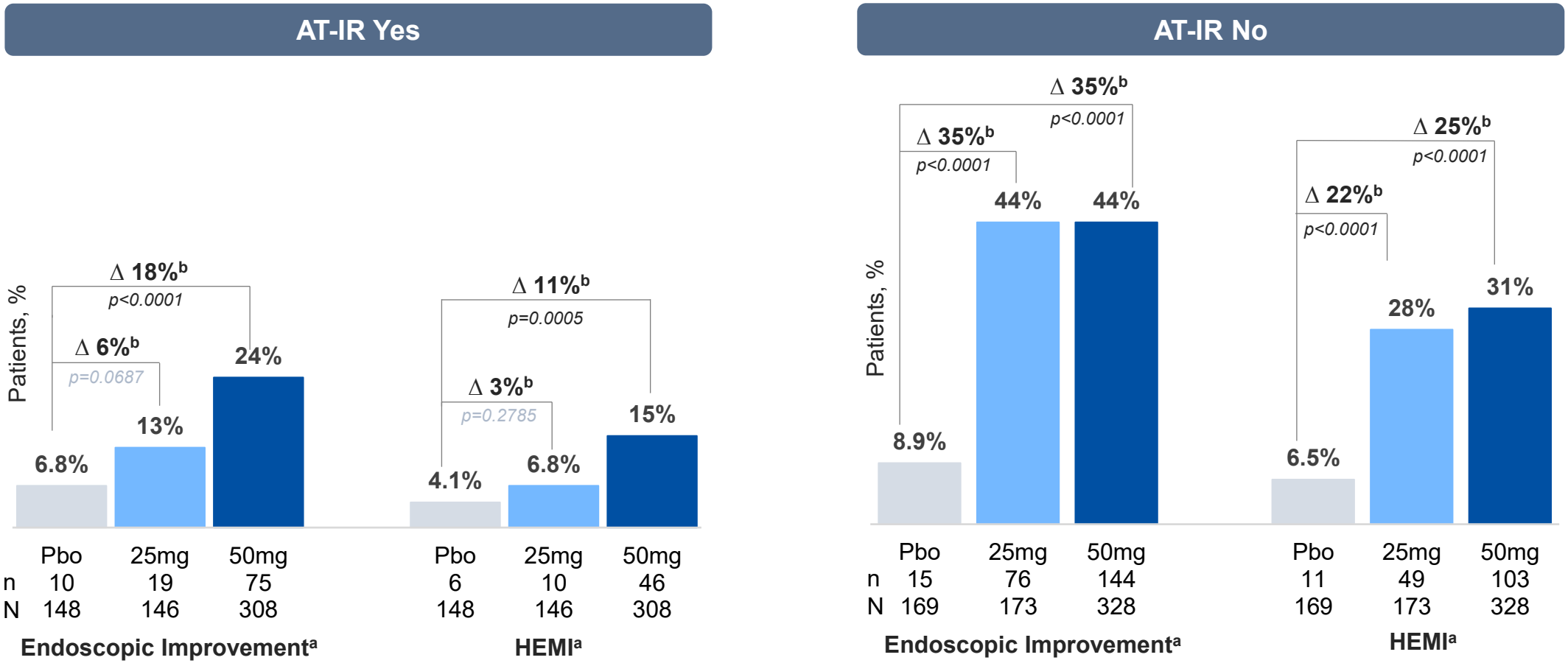
Data on File ABX464-105 & ABX464-106; All p-values are nominal

[a] **Clinical remission** is defined as SFS = 0 or 1, and RBS = 0 and MES = 0 or 1 (MES of 1 modified to exclude friability). **Clinical response** is defined as a reduction from Baseline in MMS >= 2 points and a relative reduction from Baseline in MMS >= 30%, and a reduction from Baseline in RBS >= 1 point and/or RBS = 0 or 1. **Symptomatic remission** is defined as RBS=0 and SFS= 0 or 1

[b] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

Pooled ABTECT 1 & 2: 50 mg achieved clinically meaningful improvements in endoscopic & histologic endpoints regardless of prior AT-IR

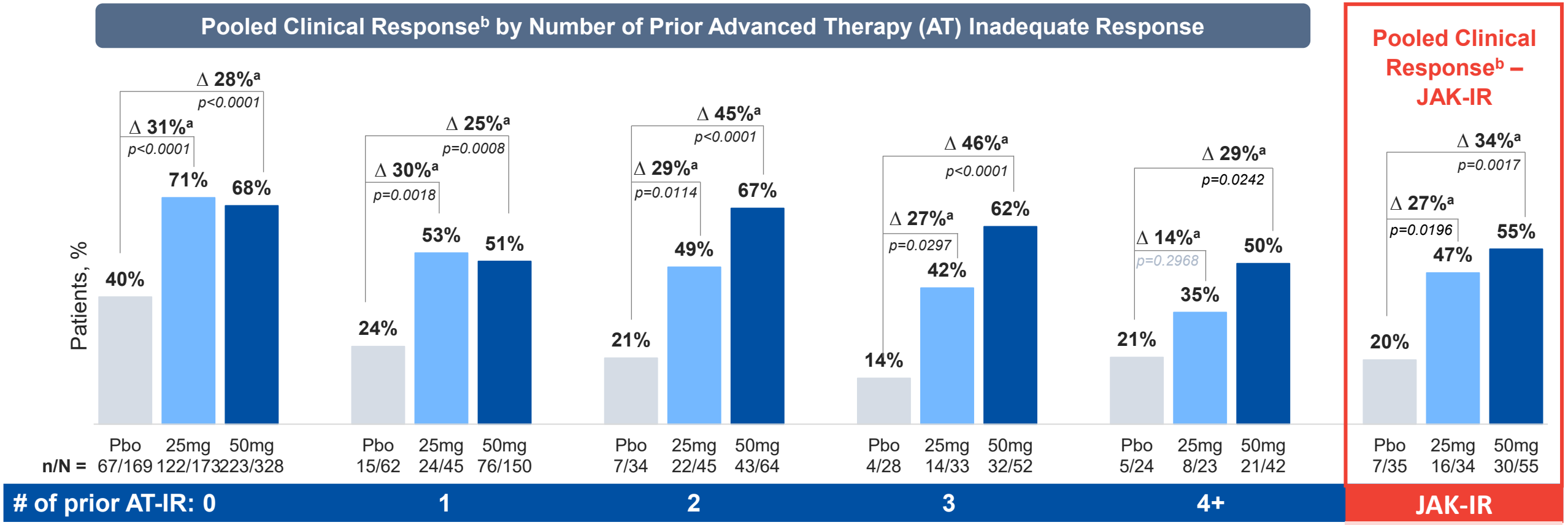
- 50mg outperformed 25mg in subjects with prior AT-IR; 25mg and 50mg performed similarly with no prior AT-IR



Data on File ABX464-105 & ABX464-106; All p-values are nominal
[a] Endoscopic improvement is defined as MES = 0 or 1 (MES of 1 modified to exclude friability). HEMI is defined as MES = 0 or 1 and Geboes Index score ≤3.1
[b] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.

Clinical Response by Number of Prior AT Inadequate Responses and Prior JAKi

- 50mg clinical response consistent in subgroups with no prior AT-IR through 4+ AT-IR or JAK-IR

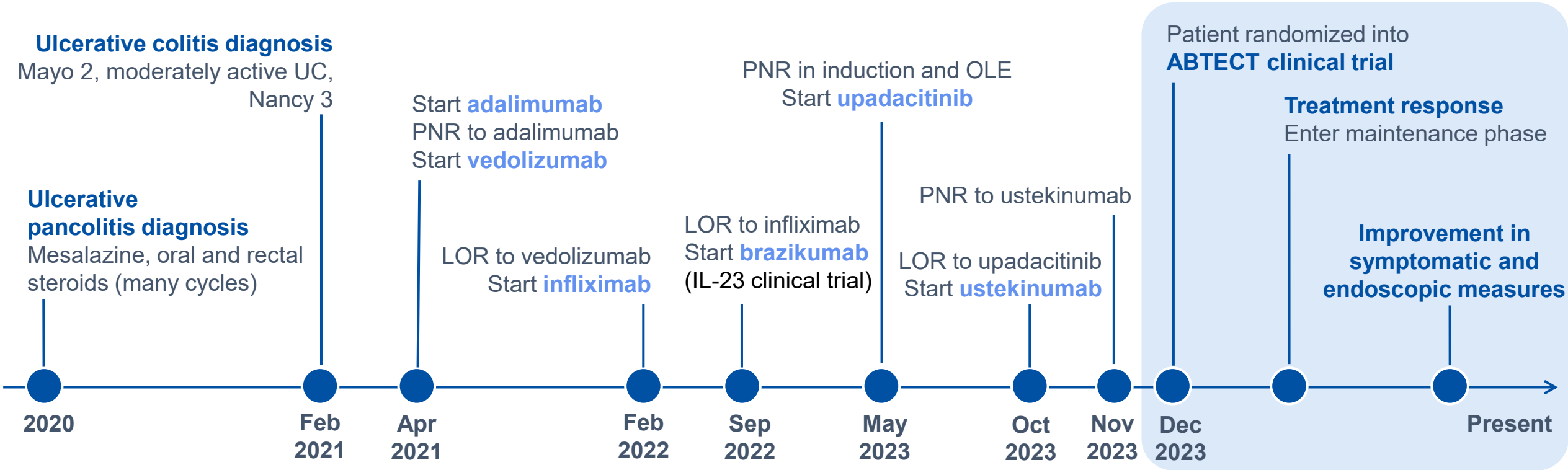


~21% of AT-IR population had JAK-IR

Data on File ABX464-105 & ABX464-106; All p-values are nominal
[a] % Difference is for ABX464 minus placebo and is based on estimated common risk difference using the Mantel-Haenszel weights adjusting for the randomization stratification factors: inadequate response to advanced therapies (yes/no), Baseline oral corticosteroids usage (yes/no). P-values are two sided. NRI is used for subjects with missing outcome at Week 8 and subjects reporting any IE prior to Week 8.
[b] Clinical response is defined as a reduction from Baseline in MMS >= 2 points and a relative reduction from Baseline in MMS >= 30%, and a reduction from Baseline in RBS >= 1 point and/or RBS = 0 or 1.

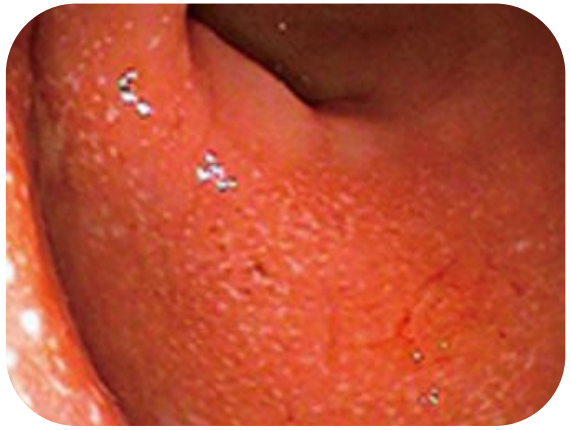
Patient With UC Participated in ABTECT (obefazimod vs placebo)

Male patient with UC, 53 years old
No family history of IBD, colon cancer, or rheumatological disease
Former smoker, no alcohol consumption

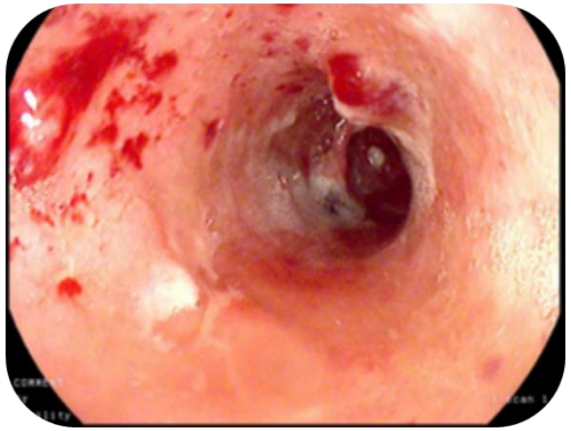


IBD, inflammatory bowel disease; LOR, loss of response; PNR, primary nonresponse; UC, ulcerative colitis.

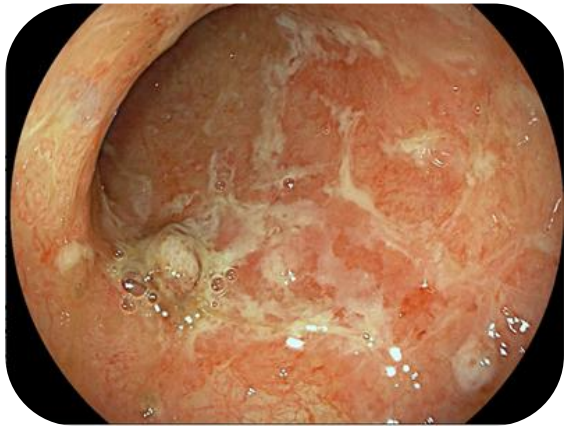
Patient With UC Participated in ABTECT (obefazimod vs placebo): Endoscopy Results Over Time



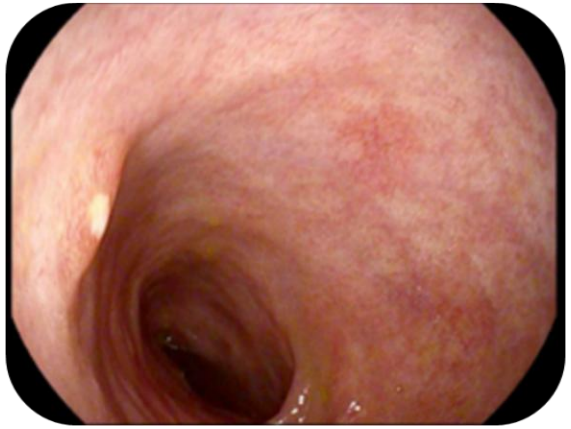
2021
After mesalazine, steroids
(Mayo score 2, Nancy 3)



2022
After adalimumab, vedolizumab,
(Mayo score 3, Nancy 3)



2023
After brazikumab trial,
upadacitinib, ustekinumab
(Mayo score 3, Nancy 4)



2024
~1 year in **ABTECT**
(Mayo score 1)

Potential for Obefazimod Combination Therapy

Complementary MOA

- With obefazimod's distinct mechanism of action, complementary pathways may be targeted through combination approaches

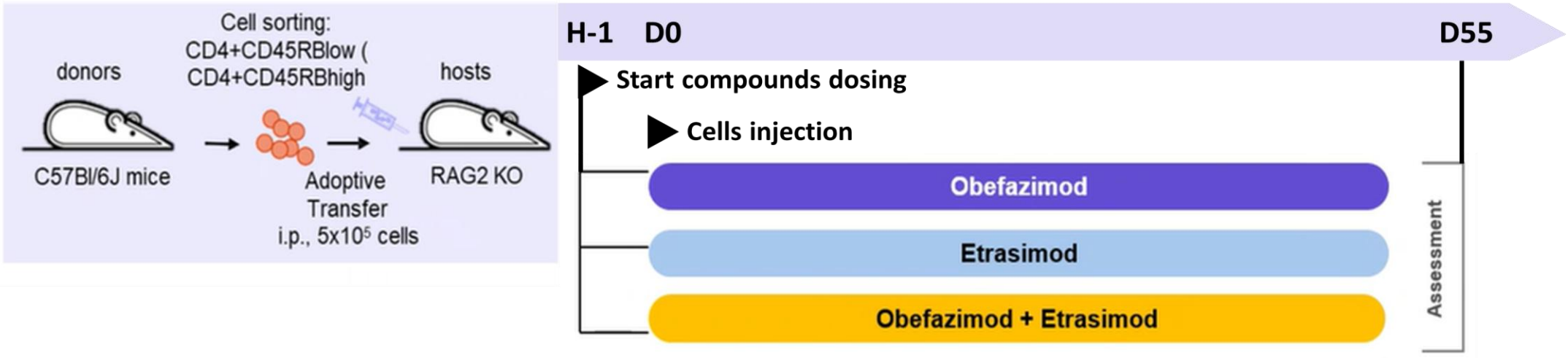
Efficacy and Safety

- Obefazimod had promising efficacy data from ABTECT induction trials and no new safety signals
- The objective is to explore whether efficacy can go beyond additive effects of monotherapy and potentially address the observed 'clinical remission ceiling' without sacrificing safety

Convenience

- Obefazimod is an oral, once daily investigational drug
- A fixed-dose oral combination could be a convenient option

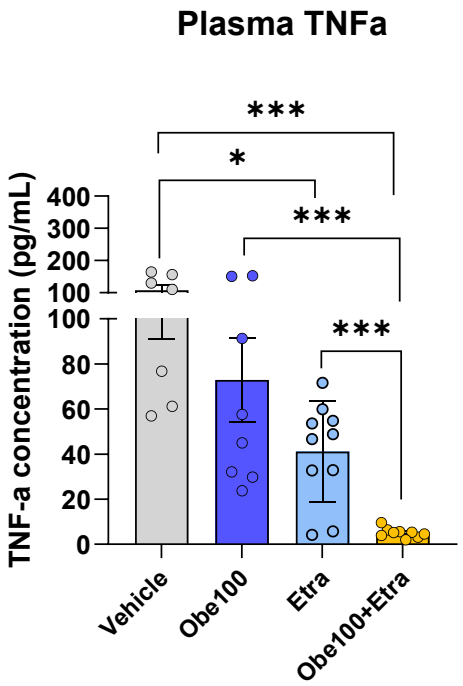
Obefazimod and etrasimod in combination treatment vs. either monotherapy in an experimental colitis model



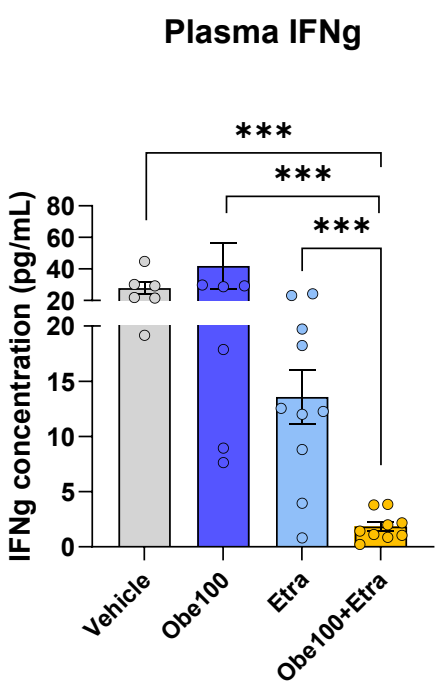
- CD4+CD45high T-cells from immunocompetent C57Bl/6J mice were transferred into RAG2 knockout mice
- Treatments were administered daily (10 ml/kg, p.o.) from Day 0 (1h before cell transfer) until Day 55: vehicle (0.5% methylcellulose), obefazimod (40 or 100 mg/kg, Obe40, Obe100), etrasimod (Etra, 3 mg/kg), Obe40 + Etra, Obe100 + Etra.
- Levels of cytokines in the colon and blood were measured to assess disease severity and inflammation

Combination of obefazimod and etrasimod improved cytokine reduction in the blood with synergistic effect

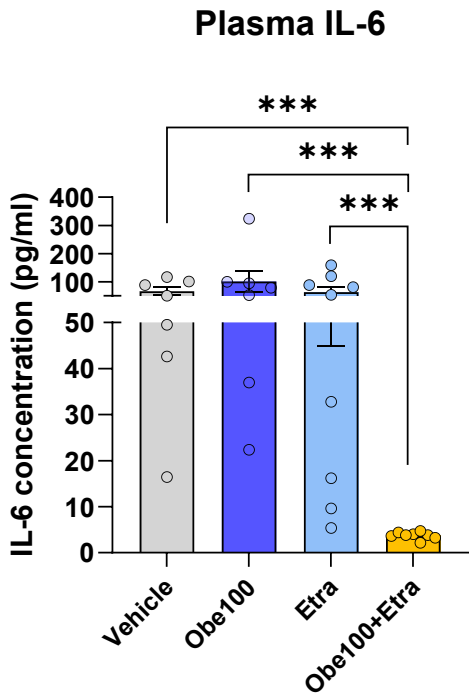
Obefazimod 100mg/kg and Etrasimod 3 mg/kg



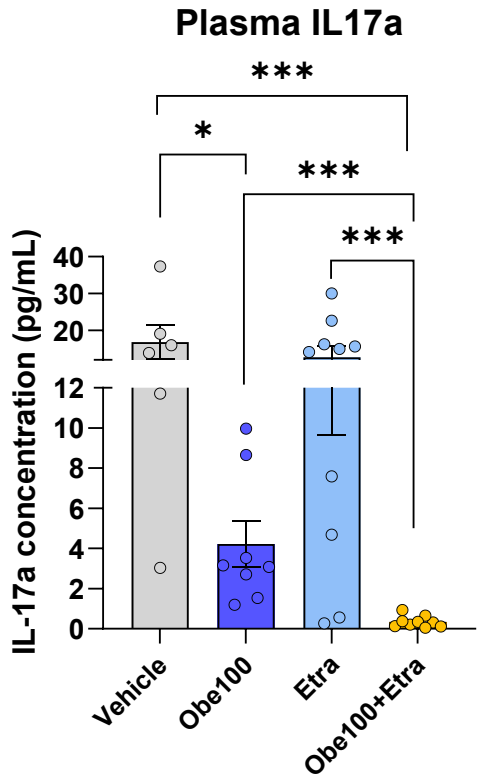
* Synergy : p=0,0165



** Synergy: p=0,0033



*** Synergy: p=0,0004



* Synergy : p=0,0313

Mean +/- SD, analyses of the effect of each treated group versus the vehicle were performed with a Dunnett's T3 test, comparisons of combinations versus each compound alone were performed with a Holm-Sidak adjustment for multiplicity and synergy evaluation of each combination involved comparing the combination effect versus vehicle with the sum of compounds alone effects versus vehicle with a Holm-Sidak adjustment for multiplicity. *P<0.05, **P<0.01, ***P<0.001, ****P<0.0001
Scherrer, D., & et al. *Synergistic reduction of inflammatory cytokines with obefazimod and etrasimod in combination treatment vs. either monotherapy in a mouse model of inflammatory bowel disease.* Oral Presentation presented at: Digestive Disease Week (DDW) 2025; May 5, 2025.

Conclusion

AT-IR Yes

- 50 mg dose achieved clinical meaningful improvements regardless of prior AT-IR
- 50 mg outperformed 25 mg in subgroup with prior AT-IR
- Consistent clinical response in subjects with no prior AT-IR through 4+ AT-IR or JAK-IR

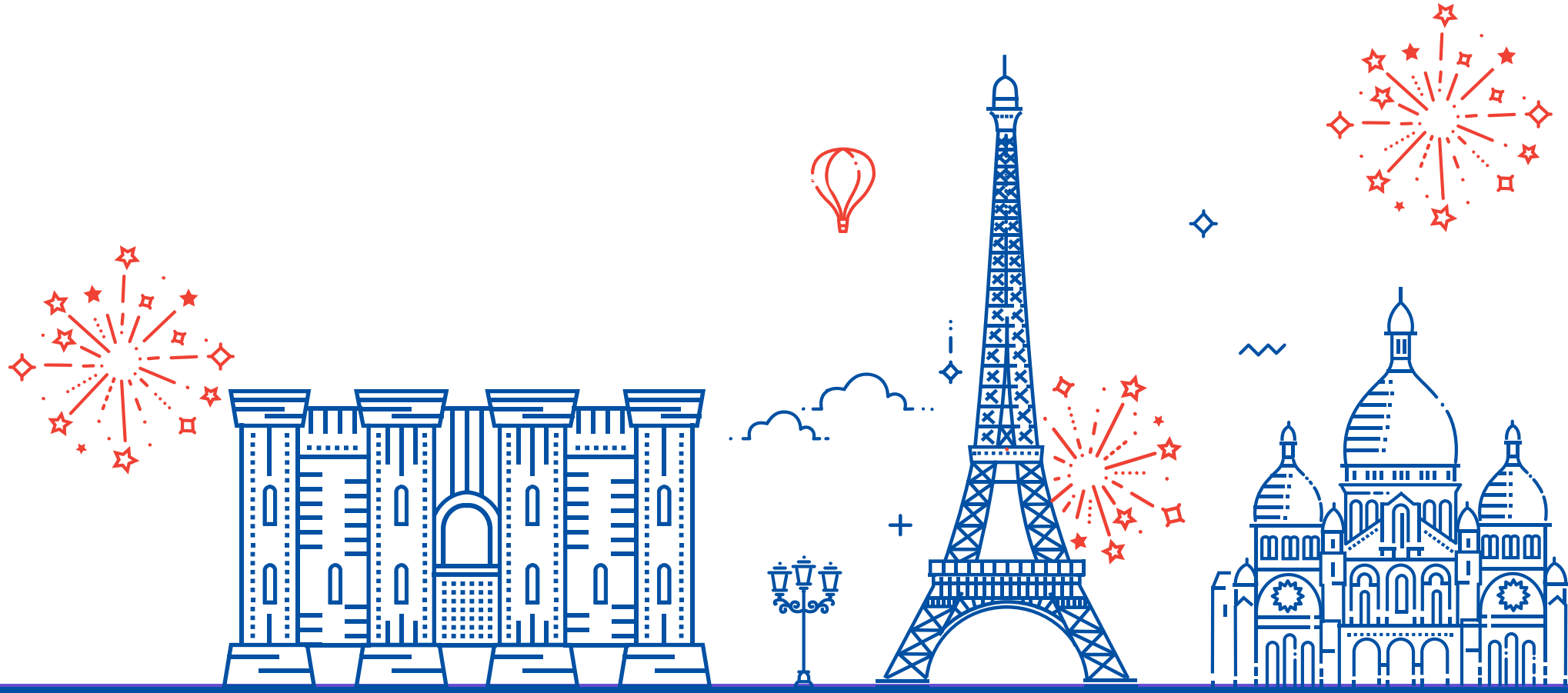
AT-IR No

- Both doses performed similarly in subgroup with no prior AT-IR

Combination Partner

- An optimal combination partner might have a complementary mechanism of action, potential for synergistic efficacy, and a favorable safety and tolerability profile.

Merci!



Q&A