Pyxis Oncology
MICVO Clinical Update

November 19, 2026

Forward-Looking Statements

This presentation contains forward-looking statements for the purposes of the safe harbor provisions under the Private Securities Litigation Reform Act of 1995 and other federal securities laws. All statements other than statements of historical facts contained in this presentation, including without limitation statements regarding the plans of Pyxis Oncology, Inc. (the "Company") to develop, manufacture and commercialize its product candidate, including micvotabart pelidotin ("MICVO"); the expected timing and progress of the Company's ongoing and planned clinical trials, including the potential advancement of MICVO into a Phase 3 program; the expected results of the Company's clinical trials; the potential for preliminary, initial and topline clinical data to be confirmed as clinical trials progress, including in larger or later-stage trials, and expectations regarding the safety, tolerability, and potential efficacy of MICVO; the potential differentiation, advantage or effectiveness of MICVO compared to other approved products or products in development; the dosage and treatment potential of MICVO, including the anticipated effects of dose capping on safety and efficacy; the size and future of the market; the plans and objectives of management, and the future results of operations and financial position of the Company, are forward-looking statements. These statements are neither promises nor guarantees, but are statements that involve known and unknown risks, uncertainties and other important factors that are in some cases beyond the Company's control that may cause actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements, including, but not limited to, the following: the risks inherent in drug research and development; the risk that preliminary clinical data from limited patient populations and follow-up may change as additional data become available and further analyses are conducted, and may not be replicated in larger or later-stage trials; the risk that additional or more severe adverse events may emerge with further treatment and follow-up; the Company's projected cash runway and potential needs for additional funding; the lengthy, expensive, and uncertain process of clinical drug development, including potential delays in or failure to obtain regulatory approvals and potential changes to dose selection, trial design or development timelines resulting from clinical findings or regulatory feedback; the Company's reliance on third parties and collaborators to conduct clinical trials, manufacture its product candidate, and develop and commercialize its product candidate; and the Company's ability to compete successfully against other drug candidates. Accordingly, investors should not rely upon forward-looking statements as predictions of future events. Except as required by applicable law, the Company undertakes no obligation to update publicly or revise any forward-looking statements contained herein, whether as a result of any new information, future events, changed circumstances or otherwise. Additionally, investors should read the risk factors in the section titled "Risk Factors" set forth in Part II, Item 1A of the Company's Quarterly Report on Form 10-Q filed on November 5, 2026, and the Company's other filings, each of which is on file with the Securities and Exchange Commission.

MICVO Clinical Update Presenters



Tom Civik, MBA

Chief Executive Officer and Chairman
Pyxis Oncology



Faye Johnson, MD, PhD

The University of Texas MD Anderson Cancer Center, Department of Thoracic/Head and Neck Medical Oncology

Professor in the Department of Thoracic/Head and Neck Medical Oncology at the University of Texas MD Anderson Cancer Center. Dr. Johnson specializes in head and neck cancers, with research focused on translating laboratory discoveries into new treatments. Dr. Johnson has led multiple clinical trials evaluating targeted therapies and immunotherapy combinations.

MICVO is Uniquely Positioned to Become a Meaningful Treatment Option for Patients with Cancer

NEED	**SIGNIFICANT UNMET NEED IN 2L+ HNSCC DRIVEN BY POTENTIAL CHANGE IN 1L** Inadequate options for 2L+ HNSCC; 21K+ US patients by 2030
PROGRAM	**FIRST-IN-CONCEPT ADC** Novel ADC target in the tumor extracellular matrix
STUDY	**EVALUATE MICVO IN 2L+ HNSCC AFTER CURRENT & POTENTIAL FUTURE 1L TREATMENTS** Assess impact of prior therapy and HPV status
RESULTS	**SUBSTANTIAL EFFICACY IMPROVEMENT WITH MANAGEABLE SAFETY** Meaningful survival and response benefit and a safety profile consistent with approved ADCs
PATH FORWARD	**PIVOTAL-READY, ROOM TO EXPAND** Phase 3 initiation planned for mid-2027; potential to develop beyond 2L+ HNSCC

Unmet Need & Opportunity in 2L+ R/M HNSCC

By 2030, an Evolving 1L Landscape and Inadequate Treatment Options in 2L+ Create Significant Unmet Need

Next-gen EGFRi therapies emerging in 1L create significant demand for non-EGFRi mechanism in 2L+

HNSCC: 7th Most Common Oncology Tumor Type[1]

2030 US Incidence

~30K

1L HPV+ ~8K

1L HPV- unrelated ~22K

70% progress to 2L

~21K Significant Unmet Need
HPV+ (6K) and HPV-unrelated (15K)

40% progress to 3L

~8K Significant Unmet Need

2030 US H&N Treatment Evolution

Emerging SoC

EGFRi bi-specifics likely moving to 1L

MICVO Mono Opportunity

Differentiated MOA essential

EGFRi retreatment remains unproven

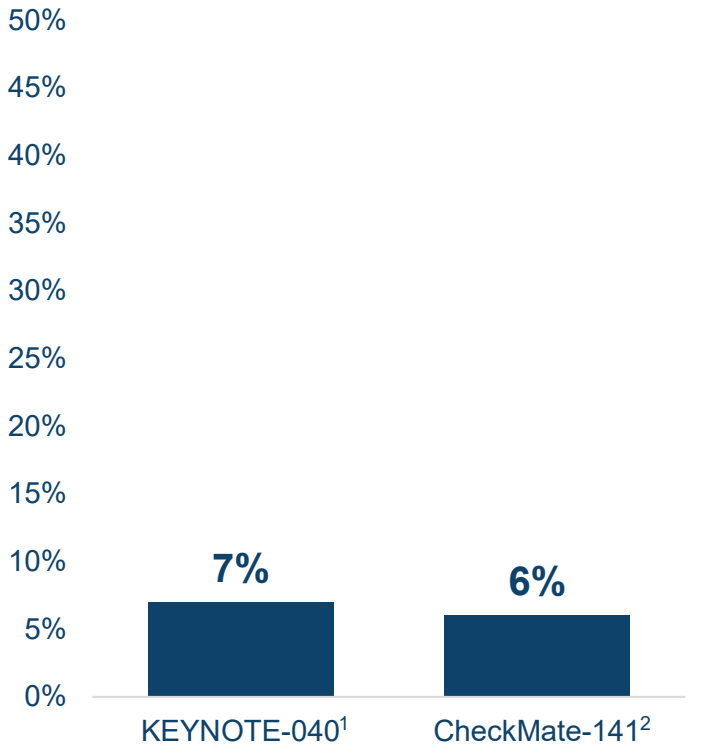
Chemotherapy produces modest benefit

Abbreviations: R/M HNSCC: recurrent or metastatic head and neck squamous cell carcinoma; HPV: human papillomavirus; 1L: first line; 2L: second line; 2L+: second line and beyond; 3L: third line; EGFR: epidermal growth factor receptor.
Note: Opportunity figure and projections and assumptions contained therein are illustrative only and not a forecast.
Sources: DRG Epi Report 2026; Global Data Epi Report 2026; SEER 2026. 1. NIH, 2026

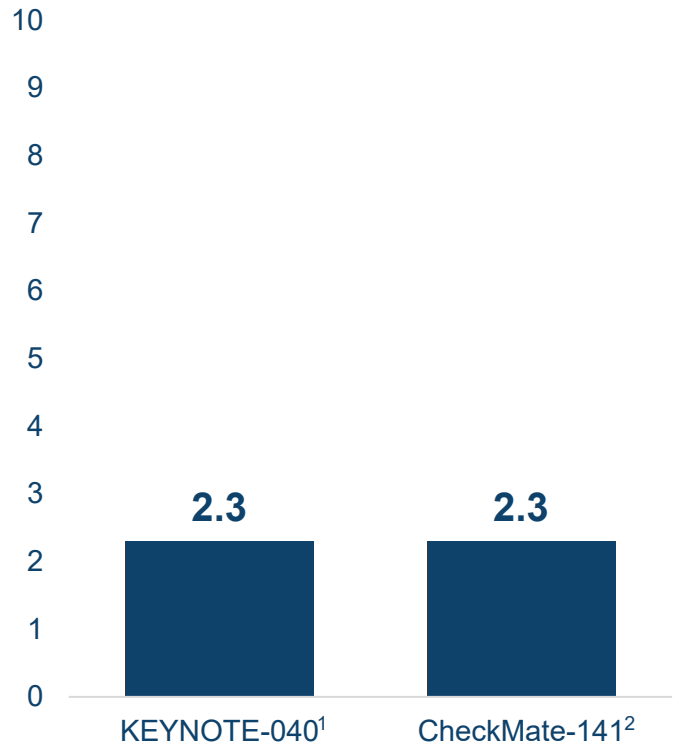
Current Treatment Options Provide Modest Clinical Benefit

Both Keynote-040 and Checkmate-141 trials investigated the impact of investigator choice of cetuximab, docetaxel and methotrexate

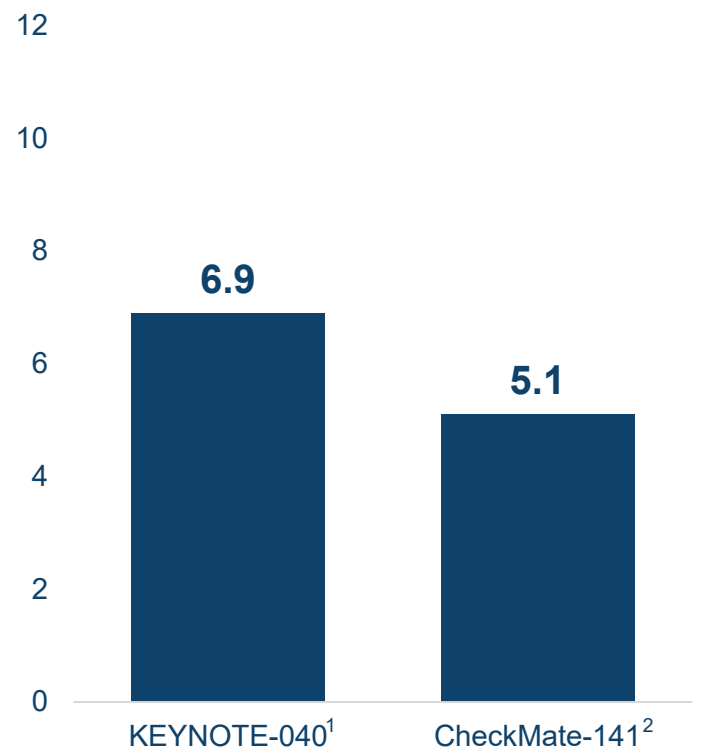
Confirmed ORR (%)



Median PFS (months)



Median OS (months)



Abbreviations: ORR: objective response rate; PFS: progression-free survival; OS: overall survival; N/n: number of patients.
Note: This analysis is the aggregation of results across independent studies. There are risks inherent in conducting cross-trial comparisons. Refer to further disclaimers on slide 2.
Sources: 1. KEYNOTE-040: Control arm (N=248) included Cetuximab/Docetaxel/Methotrexate; Pembrolizumab arm observed cORR=11%; mPFS=2.1 months; mOS=8.4 months (N=247)
2. CheckMate-141: Control arm (N=121) included Cetuximab/Docetaxel/Methotrexate; Nivolumab arm observed cORR=13%; mPFS=2 months; mOS=7.7 months (N=240)

PYXIS ONCOLOGY

MICVO in 2L+ R/M HNSCC

Presented November 19, 2026, at EORTC-NCI-AACR Symposium on Molecular Targets and Cancer Therapeutics in Barcelona, Spain

PYXIS ONCOLOGY

MICVO is a First-in-Concept ADC with a Target in the Tumor Extracellular Matrix, Not on the Cell Surface

Background & Rationale

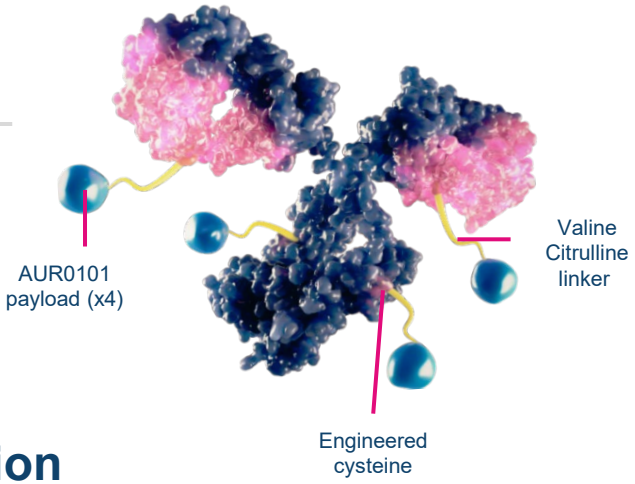
Extradomain-B of Fibronectin (EDB+FN)
- Tumor-specific splice variant of fibronectin

Micvotabart Pelidotin (MICVO)
- Site-specific conjugation, protease-cleavable linker, optimized auristatin payload (DAR 4)

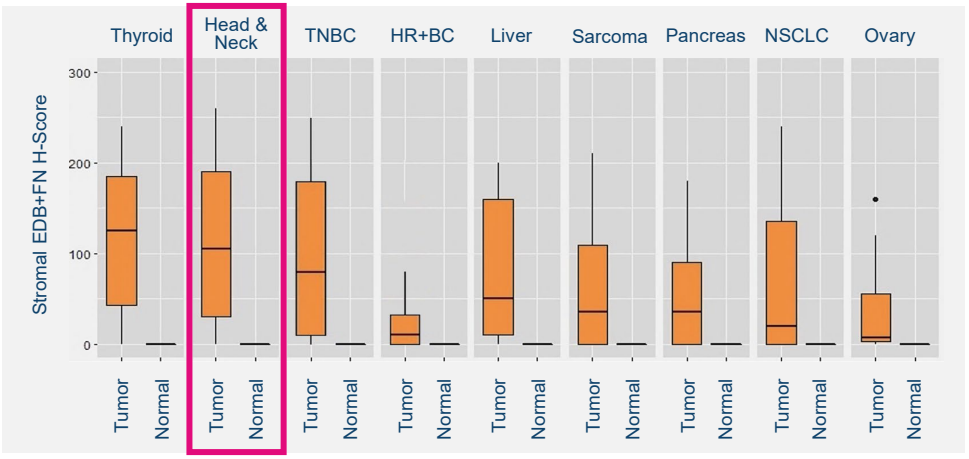
Three-Pronged Mechanism of Action (MOA)
- Directly kills cancer cells, bystander killing, elicits immune response

Unmet Need
- R/M HNSCC post-platinum and anti-PD-1 therapy has limited treatment options and poor prognosis

MICVO Structure



EDB+FN Expression



Lewandowski et al., Cancer Res (2024) 84 (6_Supplement): 2908; Hooper A et al., Mol Cancer Ther. (2022) 21(9):1462-1472; Maderna A et al., J Med Chem (2014) 57: 10527-10543; Shen C et al., Mol Cancer Ther (2025) 24 (10_Supplement): A116; Facklam A et al., Cancer Res (2025) 85 (8_Supplement_1): 3120; Severe N et al., Cancer Res (2024) 84 (6_Supplement): 742; Iovino M et al., Mol Cancer Ther (2025) 24 (10_Supplement): A112; Cote et al., Annals of Oncology (2025) 36, S591-S592.

Abbreviations: ADC: antibody-drug conjugate, EDB+FN: Extradomain-B of Fibronectin, DAR: drug to antibody ratio, AUR0101: auristatin0101, R/M: recurrent/metastatic, HNSCC: head and neck squamous cell carcinoma, PD-1: programmed cell death protein 1, TNBC: triple negative breast cancer, HR+BC: hormone receptor positive breast cancer, NSCLC: non-small cell lung cancer

Phase 1 Study of MICVO Monotherapy in 2L+ R/M HNSCC

Part 1: Dose Escalation
Part 2: Dose Expansion at 5.4 mg/kg Q3W

Key Eligibility Criteria (HNSCC)

- HNSCC: Oropharynx (regardless of HPV status), Hypopharynx, Larynx, or Oral Cavity[1]
- R/M disease progressed on/after a PD-(L)1 inhibitor and additionally a platinum-based therapy or anti-EGFR agent
- RECIST v1.1 measurable disease
- ECOG PS 0-1

Endpoints

- Primary: ORR per RECIST 1.1
- Others: DCR, DOR, PFS, OS, safety

2L+ R/M HNSCC: 5.4 mg/kg Dose Cap Subgroup

Dose Cap Definition:
Males receiving dose ≤ 432mg (80kg);
Females receiving dose ≤ 378mg (70kg)

Safety Analysis	**N = 36**
Efficacy Evaluable	**N = 33[2]**

Efficacy Evaluable Definition: Patients who met all three of the following criteria:

1. Received ≥1 dose of MICVO,
2. Had a baseline disease assessment,
3. Had at least 1 post-baseline disease assessment evaluable per RECIST v1.1 and/or discontinued treatment due to death or disease progression

Median study follow-up, months	**9.2 (95% CI 8.3, 10.4)**
Minimum follow-up, months	**7.4**

Abbreviations: R/M: Recurrent/Metastatic, HNSCC: Head and Neck Squamous Cell Carcinoma, Q3W: Every 3 weeks, HPV: human papillomavirus, PD-(L)1: programmed cell death ligand-1, EGFR: epidermal growth factor receptor, ORR: Objective Response Rate, RECIST: Response Evaluation Criteria in Solid Tumors, DCR: Disease Control Rate, DOR: Duration of Response, PFS: Progression Free Survival, OS: Overall survival, N: number of patients.
Notes: 1. One verrucous subtype patient excluded from dose cap subgroup per protocol. 2. Three patients excluded from efficacy evaluation per definition above. as they discontinued treatment for reasons other than PD or death and had no post-baseline scan.

Data as of 14-Oct-2026

Patient Demographics and Disease Characteristics

Heavily pre-treated and emerging anti-EGFR-experienced population

2L+ R/M HNSCC	5.4 mg/kg Dose Cap (N=36)
Race, n (%)	
White	29 (80.6%)
Black or African American	2 (5.6%)
Asian	2 (5.6%)
Native Hawaiian or Other	1 (2.8%)
Not reported/Unknown	2 (5.5%)
Age (years)	
Median (min-max)	64.5 (41-74)
Gender, n (%)	
Male	30 (83.3%)
Female	6 (16.7%)
Baseline ECOG Performance Status, n (%)	
0	12 (33.3%)
1	24 (66.7%)

2L+ R/M HNSCC	5.4 mg/kg Dose Cap (N=36)
Primary Cancer Site, n (%)	
Oropharynx	23 (63.9%)
Oral cavity	6 (16.7%)
Larynx	7 (19.4%)
HPV Status (local)	
HPV+ Oropharyngeal SCC, n (%)	18 (50.0%)
HPV-Unrelated, n (%)	18 (50.0%)
Prior Systemic Therapy, Median (min-max)	**3 (1-5)**
Prior Systemic Therapy in R/M Setting, Median Lines (min-max)	**2 (1-4)**
Platinum, n (%)	36 (100.0%)
Anti-PD-(L)1 Agent, n (%)	36[1] (100.0%)
Taxane, n (%)	25 (69.4%)
Anti-EGFR, n (%)	21 (58.3%)
Cetuximab	15
Petosemtamab	3
Ficerafusp alfa	3

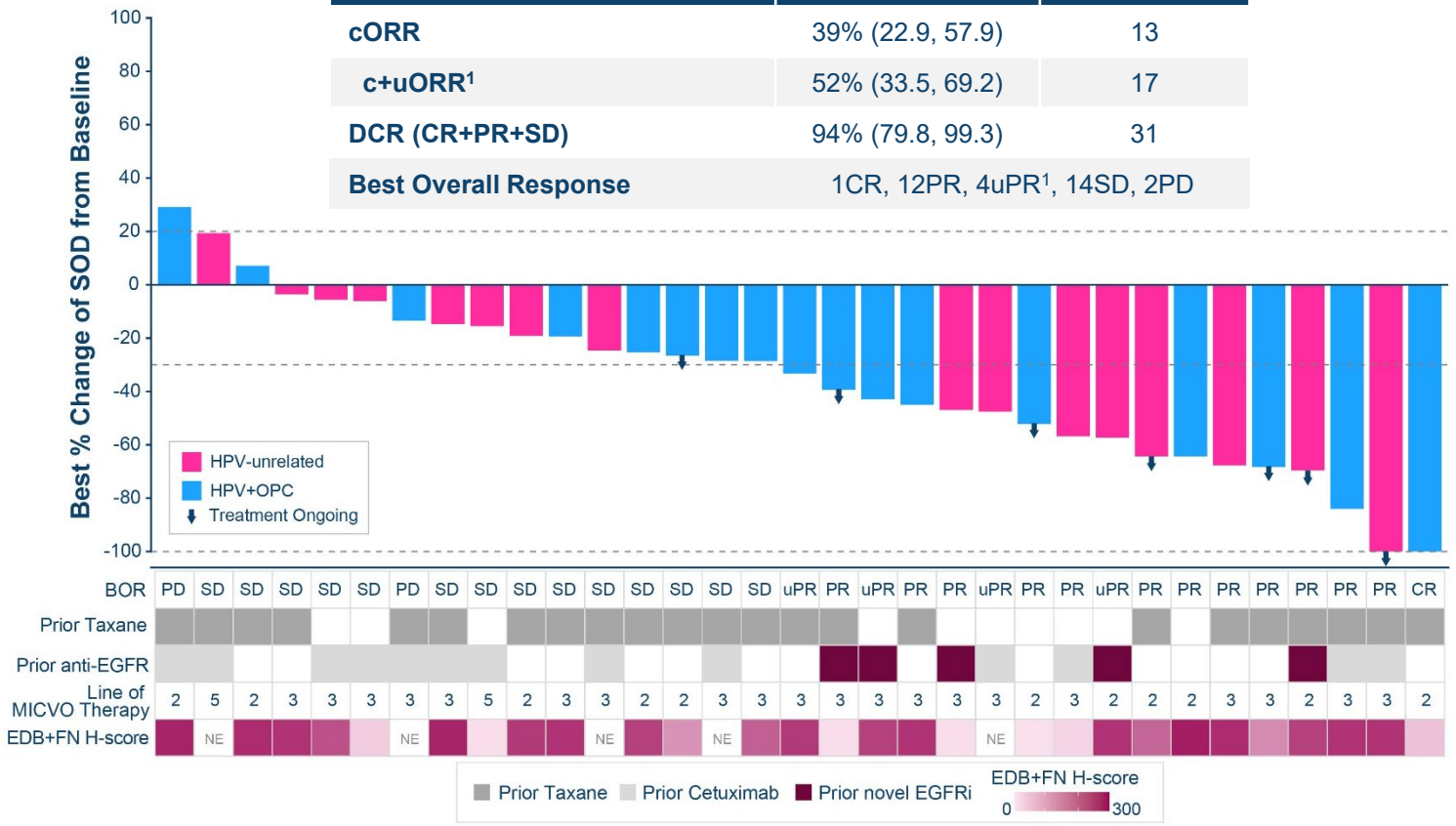
Data as of 14-Oct-2026

Abbreviations: R/M: Recurrent/Metastatic, HNSCC: head and neck squamous cell carcinoma, HPV: human papillomavirus, EGFR: epidermal growth factor receptor, ECOG: Eastern Cooperative Oncology Group, N/n: number of patients.

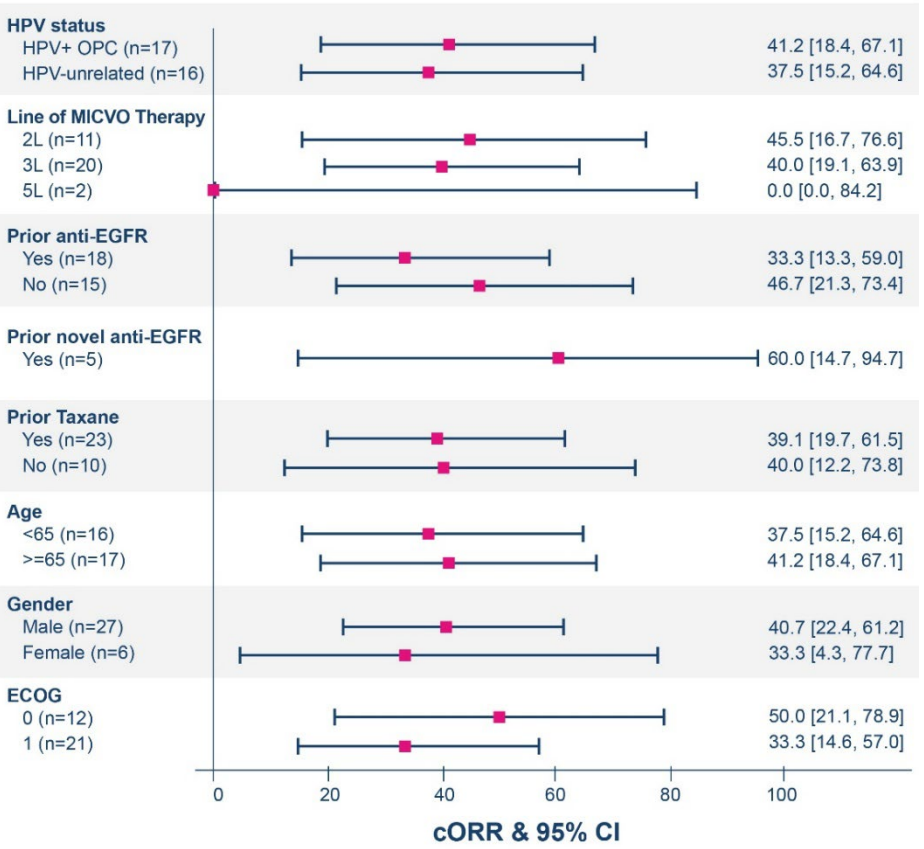
1. One patient's prior anti-PD-1 data was provided after 14-Oct-2026

MICVO Demonstrated Consistent Response Rate Data Across Key Subgroups

5.4 mg/kg Dose Cap (Efficacy Evaluable)		
	%, (95% CI)	N = 33
cORR	39% (22.9, 57.9)	13
c+uORR[1]	52% (33.5, 69.2)	17
DCR (CR+PR+SD)	94% (79.8, 99.3)	31
Best Overall Response	1CR, 12PR, 4uPR[1], 14SD, 2PD	



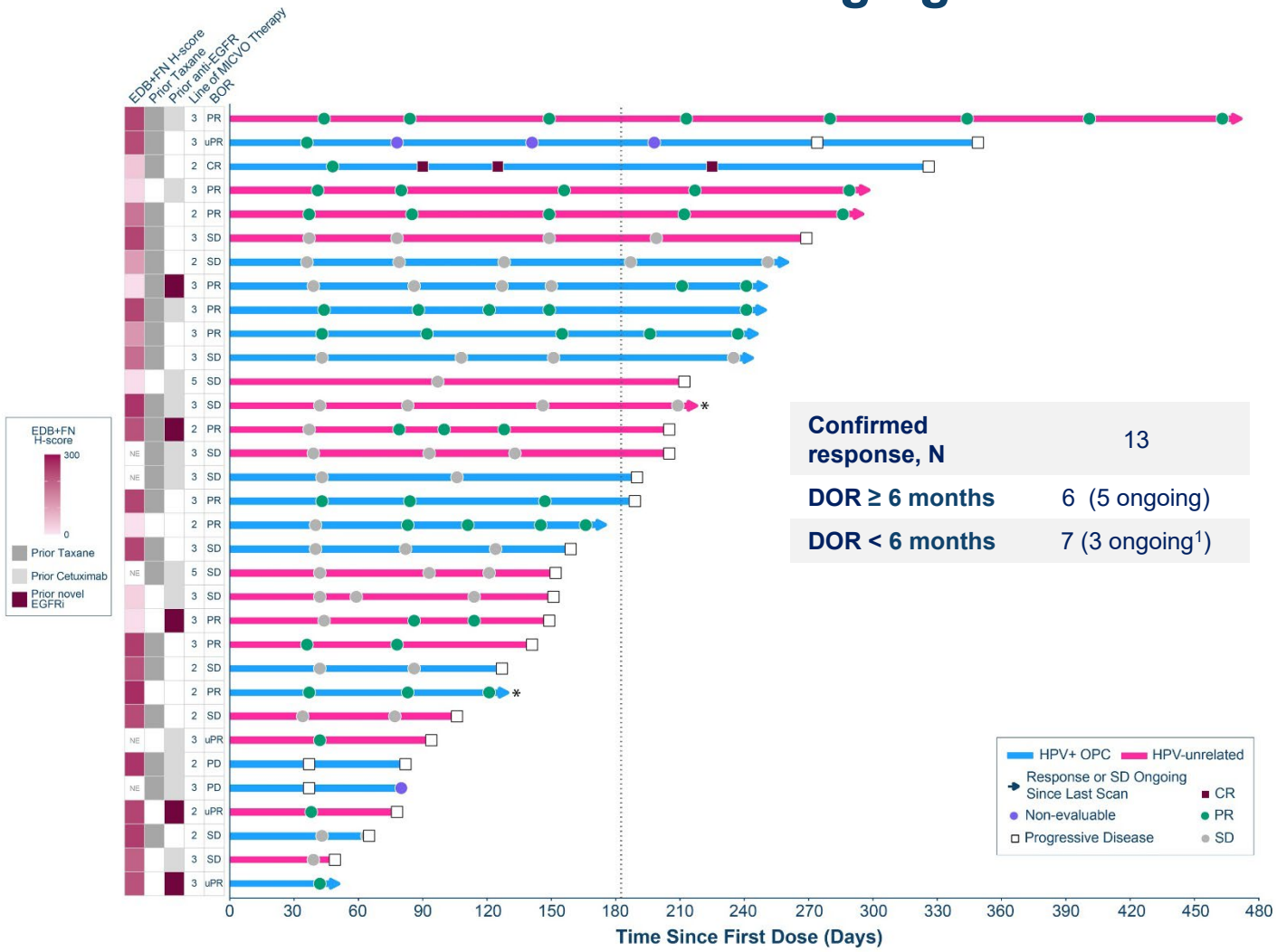
Subgroup cORR



Abbreviations: HPV: human papillomavirus, OPC: oropharyngeal cancer, BOR: best overall response, cORR: confirmed objective response rate, c+uORR: ORR including confirmed and all unconfirmed PR/CR, DCR: disease control rate, CR: complete response, PR: partial response, uPR: unconfirmed partial response, SD: stable disease, PD: progressive disease, EGFR: epidermal growth factor receptor, NE: not evaluable, N/n: number of patients.
Note: [1] 4 patients with uPR include: N=2 patients had PD on the subsequent scan, N=1 lost to follow-up, and N=1 had 3 subsequent tumor assessments as not evaluable and the following scan as PD due to growth of a non-target lesion 216 days after first dose.

Data as of 14-Oct-2026

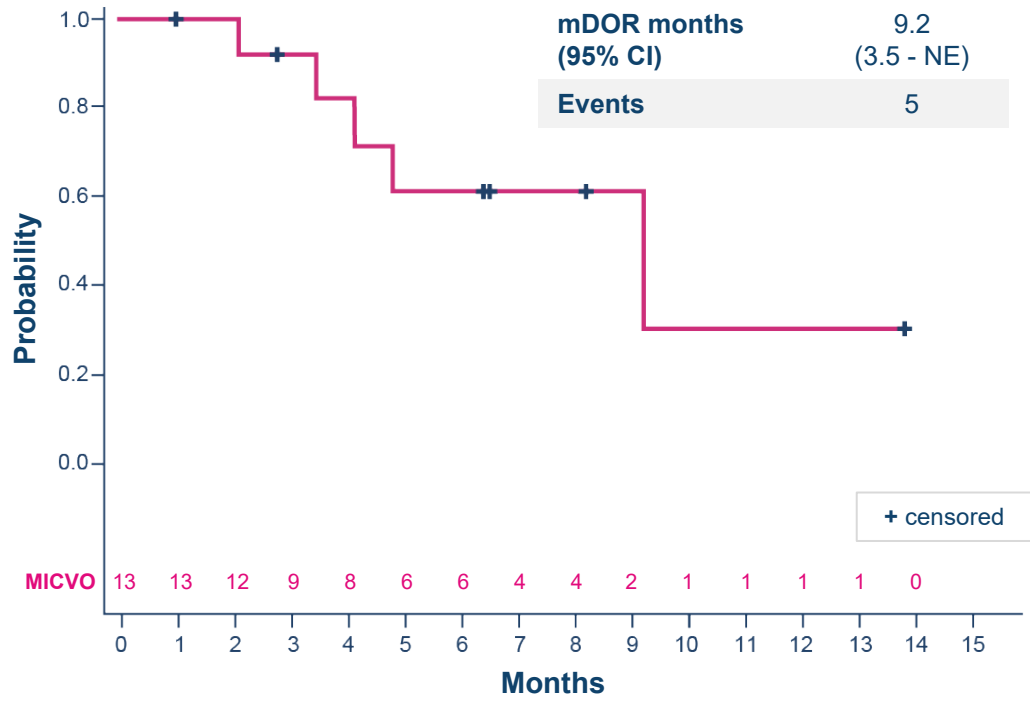
MICVO Data Reflected Encouraging Duration of Response



Confirmed response, N	13
DOR ≥ 6 months	6 (5 ongoing)
DOR < 6 months	7 (3 ongoing[1])

Duration of Response

Confirmed response, N	13
mDOR months (95% CI)	9.2 (3.5 - NE)
Events	5

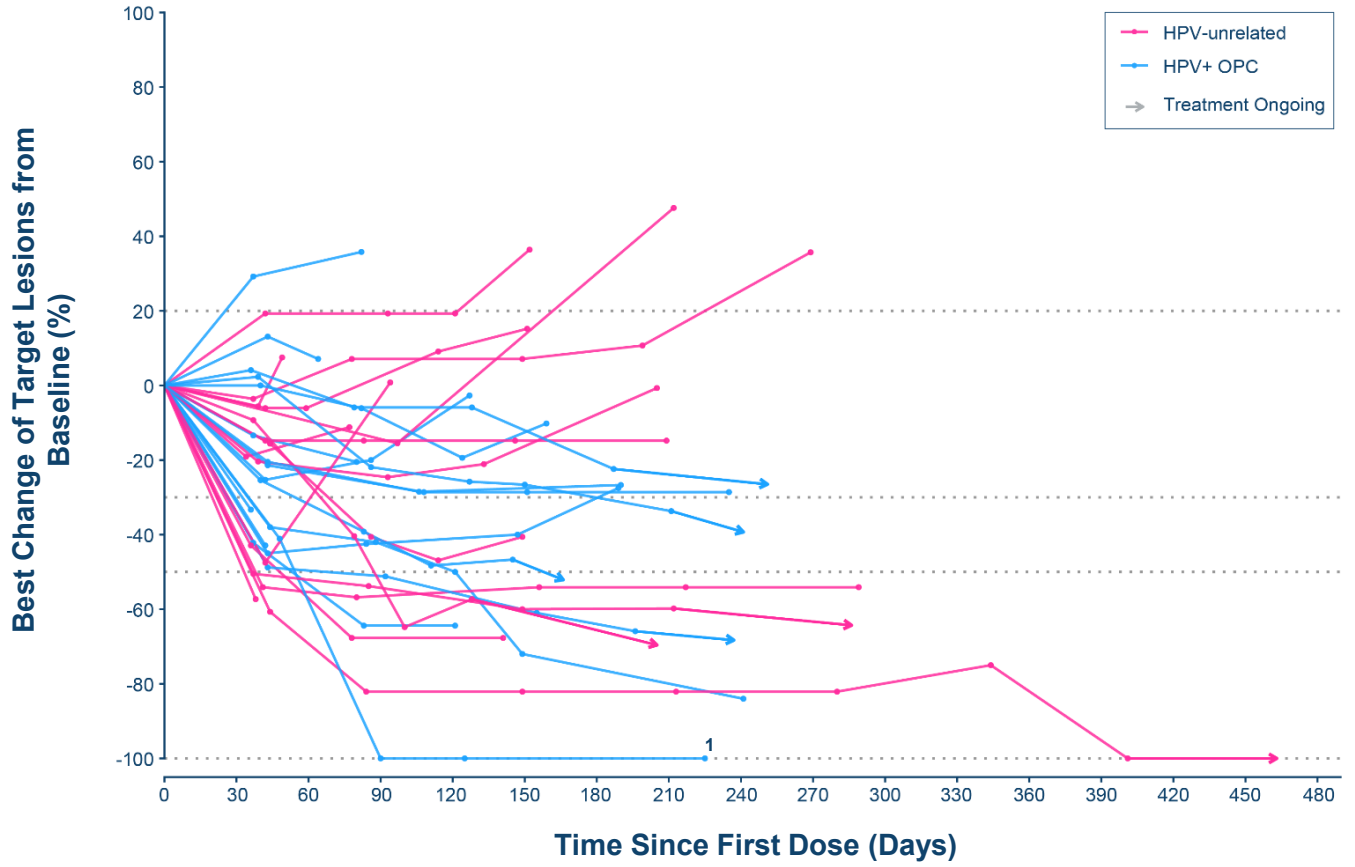


Abbreviations: EDB+FN: Extradomain-B of Fibronectin, BOR: Best overall response, CR: Complete response, DOR: Duration of Response, mDOR: median duration of response, EGFR: epidermal growth factor receptor, OPC: Oropharyngeal cancer, PD: Progressive disease, PR: Partial response, R/M: recurrent/metastatic, SD: Stable disease; uPR: Unconfirmed partial response, CI: confidence interval, NE: Not evaluable, m: months, N: patients
* Patient started subsequent anti-cancer therapy after the last scan and before PD; 1. 1 of 3 patients with ongoing PR as of 14Oct2026 initiated subsequent anti-cancer therapy.

Data as of 14-Oct-2026

MICVO Achieved Rapid and Deep Response Data

MICVO 5.4 mg/kg Dose Cap



Key Takeaways

RAPID RESPONSES

69%

Responses occurred by first scan

DEEP RESPONSES

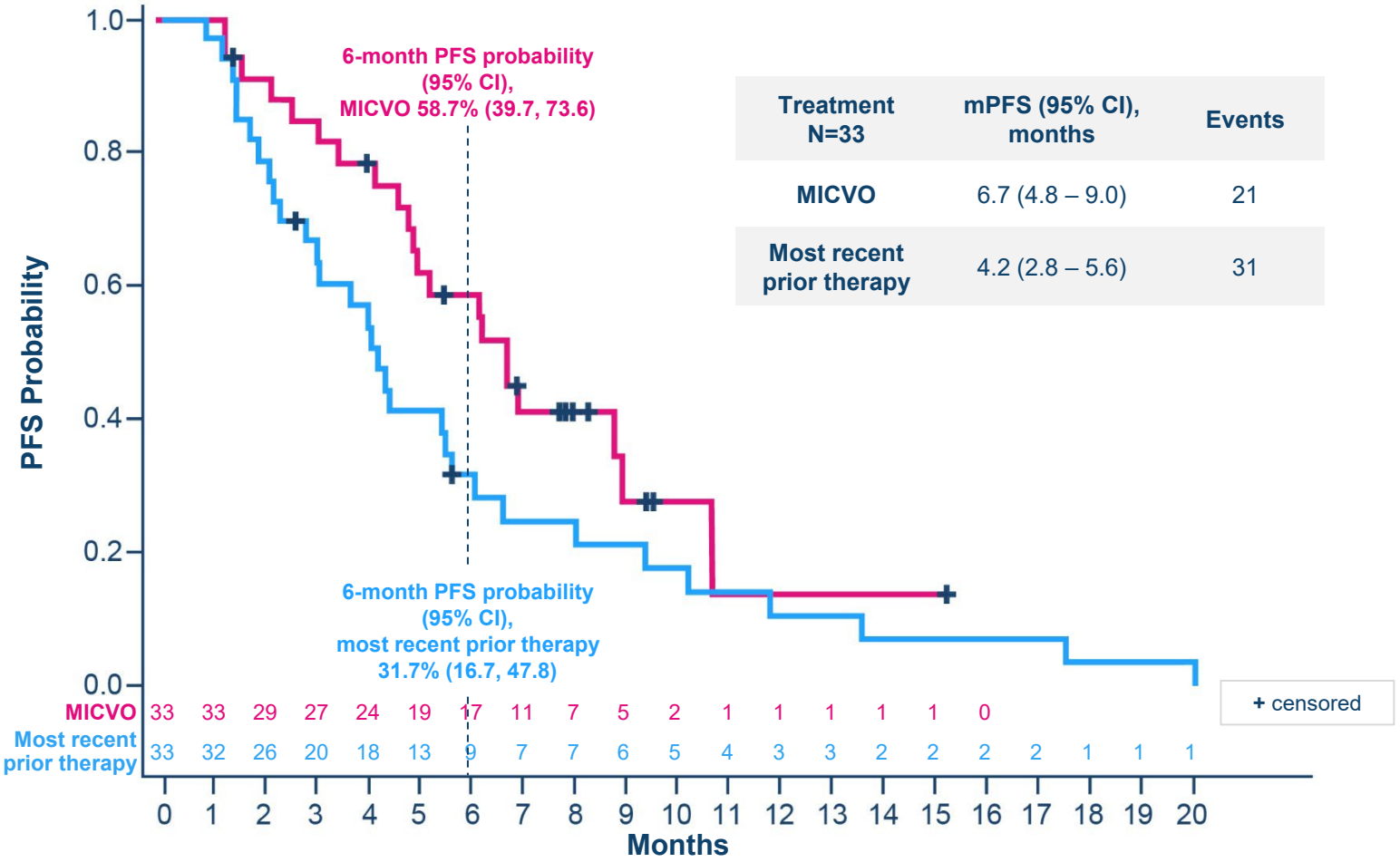
77%

Responders achieved greater than 50% tumor reduction[2]

Data as of 14-Oct-2026

Abbreviations: HPV: human papillomavirus, OPC: oropharyngeal cancer
1. Tumor assessment at Day 326 for target lesions was non-evaluable and not shown on the spider plot.
2. Best percent change of target lesions ≥ 50% from baseline per RECIST v1.1

MICVO Improved PFS as Subsequent Therapy and Consistently Achieved Long PFS Across Key Patient Subgroups



Treatment N=33	mPFS (95% CI), months	Events
MICVO	6.7 (4.8 – 9.0)	21
Most recent prior therapy	4.2 (2.8 – 5.6)	31

MICVO Subgroup mPFS

HPV Status

mPFS: 9.0 HPV+ OPC (N=17)	**mPFS: 5.9** HPV-Unrelated (N=16)

Line of MICVO Therapy

mPFS: 6.7 2L (N=11)	**mPFS: 6.7** 3L (N=20)

2 patients received MICVO in 5L (actual PFS 5.0, 7.0)

Prior anti-EGFR

mPFS: 6.2 Yes (N=18)	**mPFS: 8.8** No (N=15)

Among the 18 patients with prior anti-EGFR, the 5 with a prior novel anti-EGFR experienced **mPFS of 5.8 months**

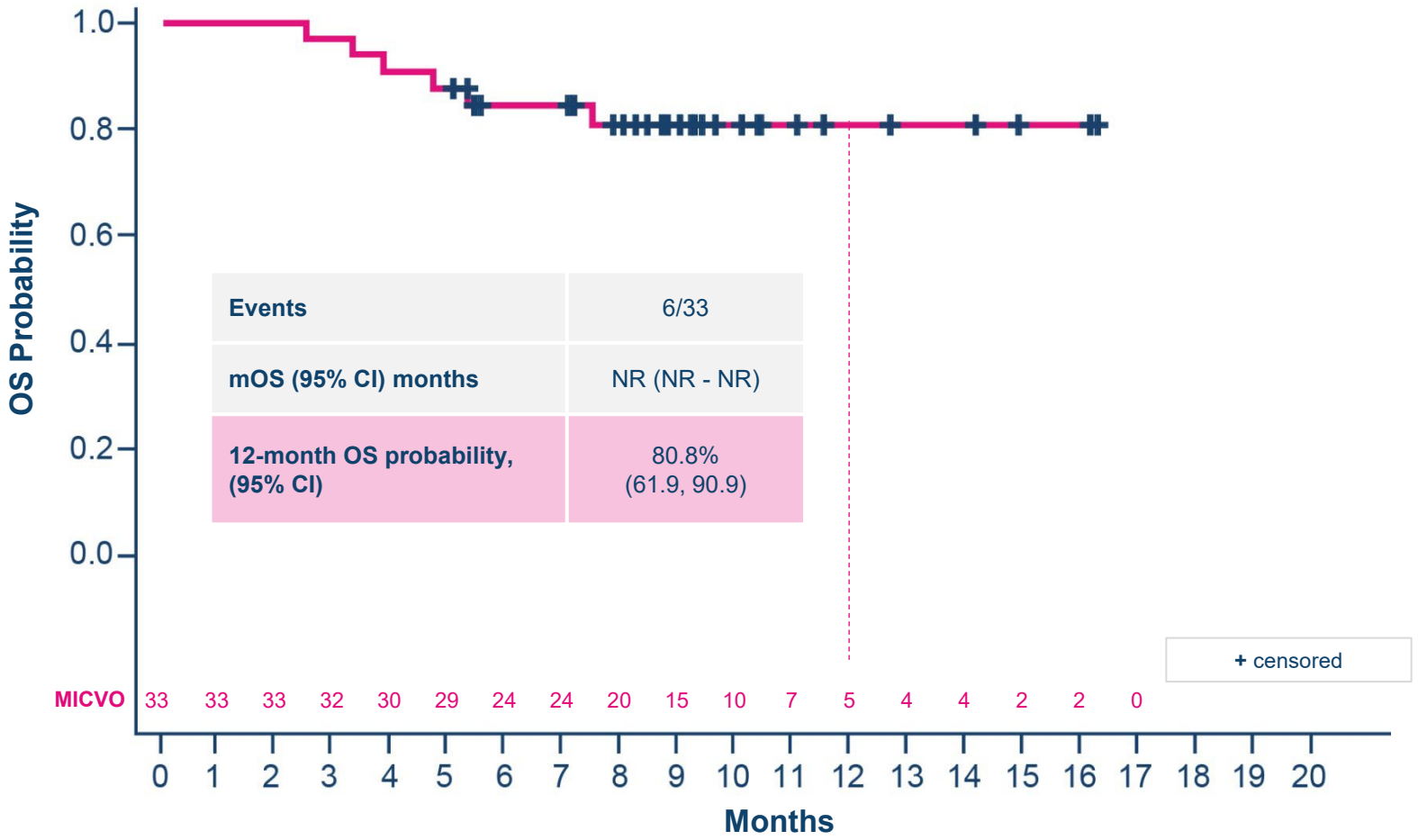
Prior Taxane

mPFS: 6.7 Yes (N=23)	**mPFS: 4.9** No (N=10)

Data as of 14-Oct-2026

Abbreviations: HPV: human papillomavirus, OPC: oropharyngeal cancer, EGFR: epidermal growth factor receptor, mPFS: median progression-free survival, PFS: progression-free survival, CI: confidence interval, Q3W: every 3 weeks, N: number of patients.

MICVO Data Demonstrated Impressive Survival Benefit



Subsequent Therapy post-MICVO	
Treatment Type	**N =11***
Cetuximab	3
Methotrexate	2
Carboplatin	1
Paclitaxel	1
Enfortumab vedotin	1
ADCE-T02: tissue factor targeting ADC with MMAE payload	1
IPH4502: Nectin-4 targeting ADC with TOP1 payload	1
MGC026: B7-H3 targeting ADC with TOP1 payload	1
GS9911: DGK-alpha inhibitor	1
Radiotherapy	2

*Patients may appear in more than one category

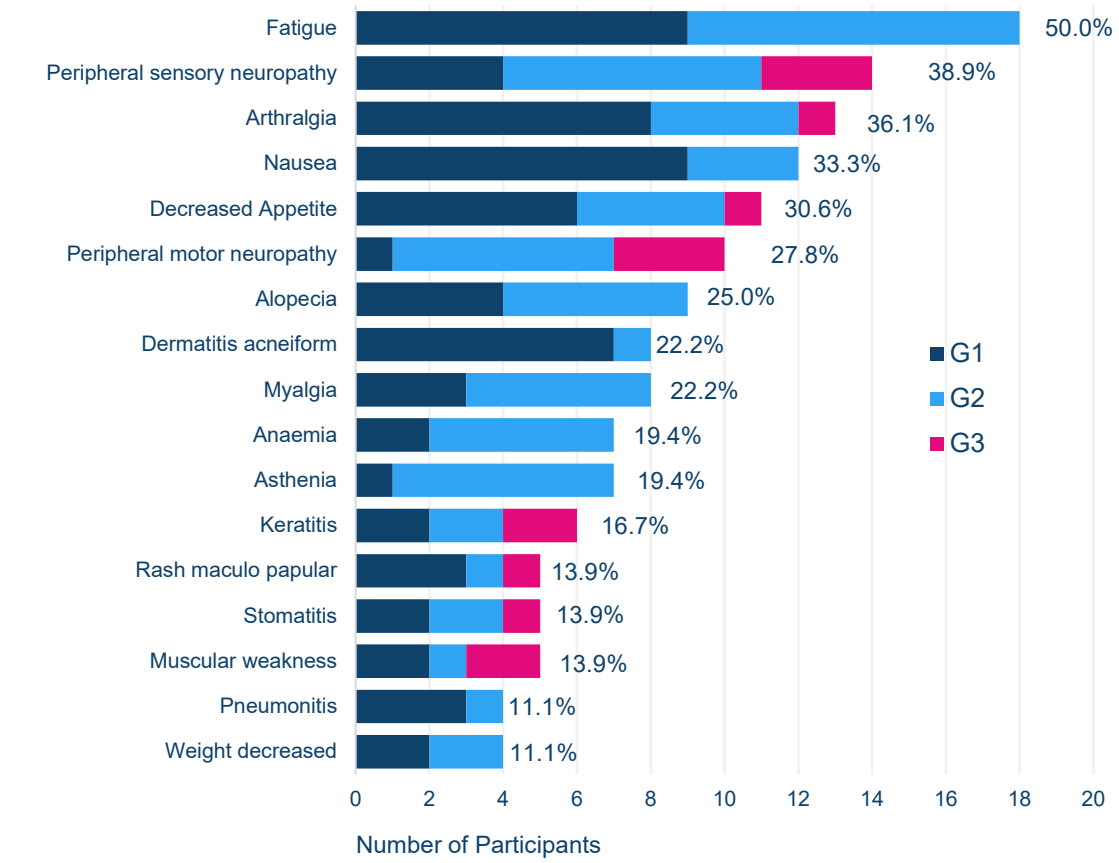
Data as of 14-Oct-2026

Abbreviations: LPFT: last patient first treatment, mOS: median overall survival, CI: confidence interval, Q3W: every 3 weeks, NR: not reached, N: number of patients, ADC: antibody-drug conjugate, MMAE: monomethyl auristatin E, TOP1: topoisomerase-1 inhibitor

MICVO Data Demonstrated an Expected and Manageable Safety Profile

Overall Summary TRAEs 5.4 mg/kg Dose Cap (N=36)	
Treatment duration – median days (range)	122.5 (21-512)
All TRAEs	32 (88.9%)
TRAEs of CTCAE Grade ≥ 3	19 (52.8%)
Non-Hematologic TRAEs of CTCAE Grade ≥ 3	16 (44.4%)
Serious TRAEs	7 (19.4%)
TRAEs leading to treatment discontinuation[1]	5 (13.9%)
TRAEs leading to treatment discontinuation days to onset, median (min-max)	162 (104-212)
TRAEs leading to dose reduction	16 (44.4%)
Treatment related deaths (Grade 5)	0

Most Common TRAEs by Preferred Term (≥10%)



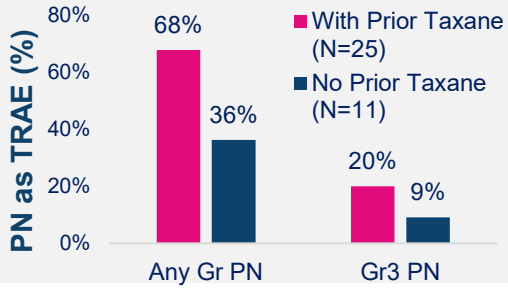
Data as of 14-Oct-2026

Abbreviations: ADC: antibody-drug conjugate, TRAE: treatment-related adverse event, CTCAE: Common Terminology Criteria for Adverse Events, Gr: grade, N: number of patients, PN: peripheral neuropathy.
Notes: 1. TRAEs leading to discontinuation, N=1 Ocular, N=1 Muscle Weakness, N=3 Peripheral Neuropathy

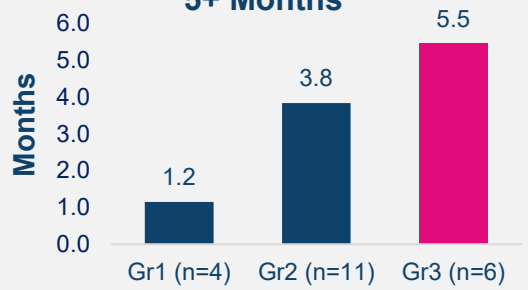
Late-Onset, Often Reversible Peripheral Neuropathy Observed in Patients who Experienced Meaningful Clinical Benefit on MICVO

Clinical benefit preceded onset of neuropathy, providing an opportunity for early detection and timely dose modification to preserve therapeutic activity

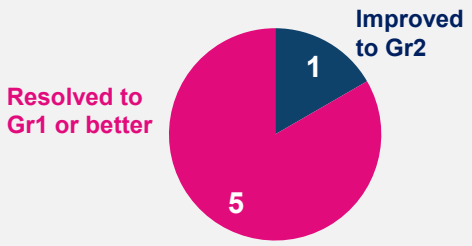
1 Prior Taxane Use Associated with Higher PN Incidence



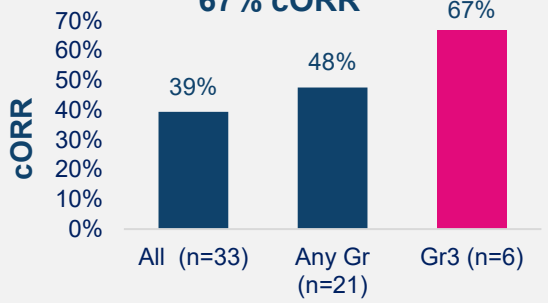
2 Time to Gr3 PN Onset is 5+ Months



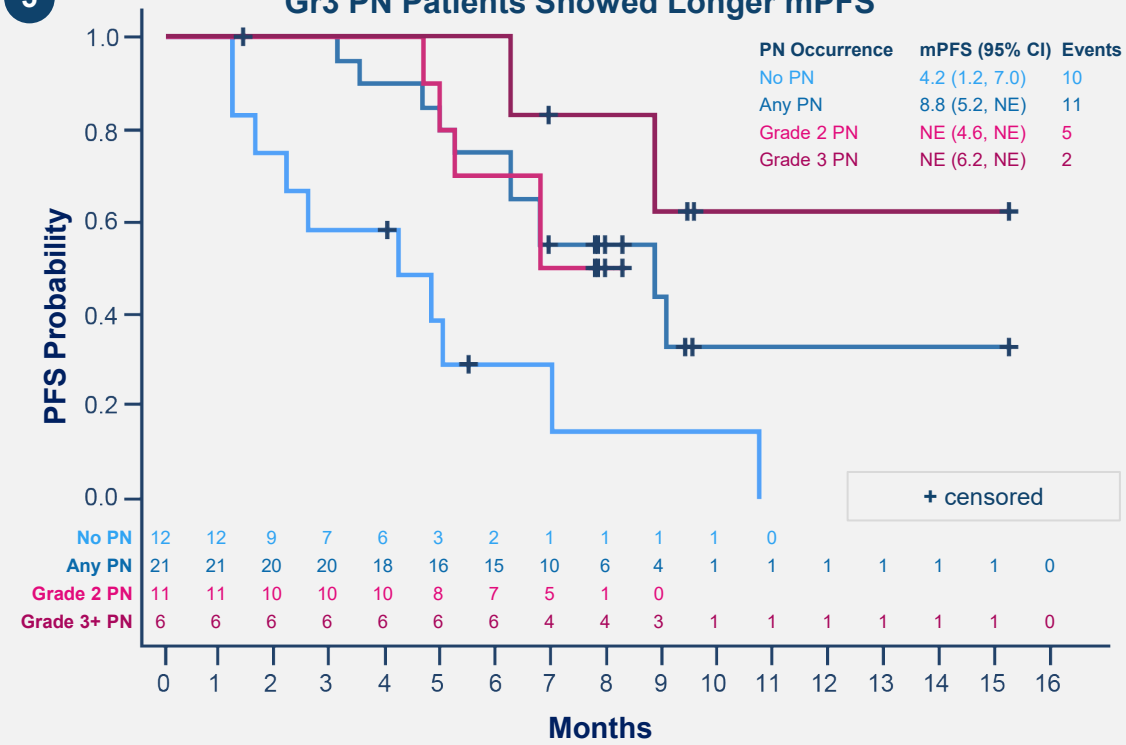
3 Gr3 PN Resolved or Resolving



4 Gr3 PN Patients Showed 67% cORR



5 Gr3 PN Patients Showed Longer mPFS



Abbreviations: PN: peripheral neuropathy; Gr: grade; cORR: confirmed objective response rate; mPFS: median progression-free survival; N/n: number of patients.

Data as of 14-Oct-2026

MICVO Maintained a Deep and Durable Response in a Patient with Grade 3 Neuropathy that Resolved following Dose Delay and Reduction

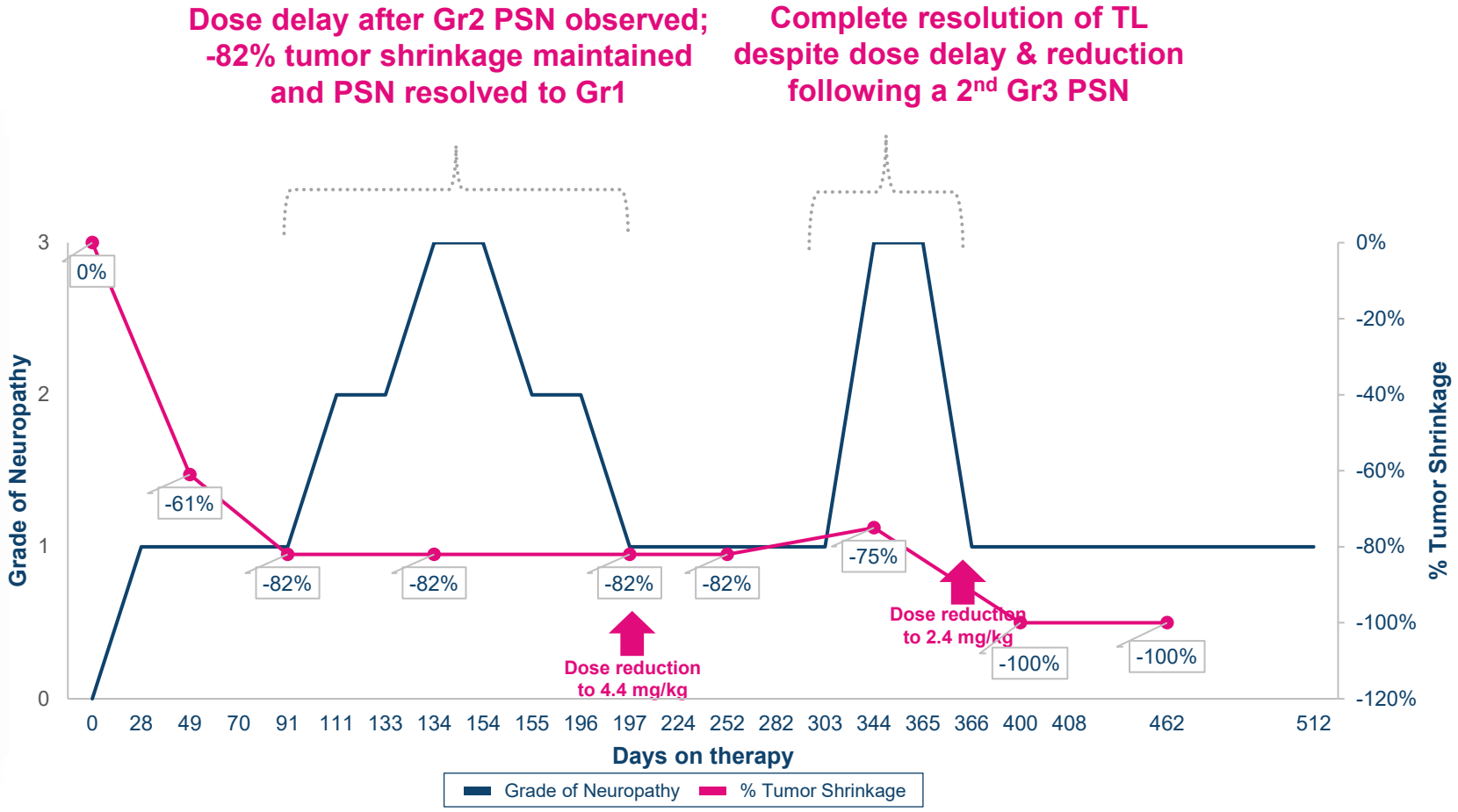
Patient background
5.4 mg/kg Dose Cap

Relevant medical history: HPV unrelated R/M HNSCC; prior hypothyroidism and sensorineural hearing loss

Prior therapy: cisplatin, cetuximab, and docetaxel (N>300 days); nivolumab; and cetuximab monotherapy

Safety: Grade 3 sensory polyneuropathy

Response on MICVO: cPR with 100% resolution of TLs and absence of pulmonary NTL; only one NTL (a lymph node) still present. DOR >14 months



Abbreviations: HPV = human papillomavirus, R/M = Recurrent/Metastatic, HNSCC = Head and Neck Squamous Cell Carcinoma, PR = Partial Response, TL = Target Lesion, NTL= Non-Target Lesion, DOR = duration of response, PSN = Peripheral Sensory Neuropathy; Gr: Grade; N: Number

Data as of 14-Oct-2026

Deep, Sustained Response Observed with MICVO in HPV-Unrelated HNSCC

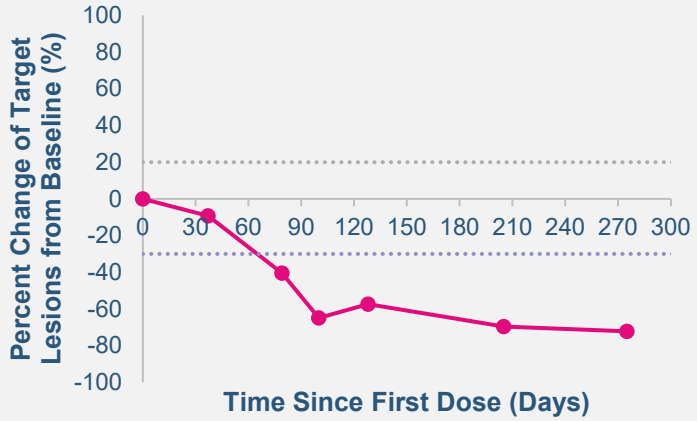
Patient Profile: 70-year-old white male; HPV-unrelated HNSCC; initial diagnosis Jan 2019; Stage IV at enrollment

Prior Therapies:

- Radiation therapy*, surgery, as well as all 4 commonly used systemic therapy classes for HNSCC, including platinum, anti-PD-1, taxane, and anti-EGFR.
- The last treatment prior to study enrollment was a combination of pembrolizumab with a novel anti-EGFR agent, ficerafusp alfa; BOR of SD, followed by disease progression approximately 3.6 m after that treatment

Local regional recurrence with one larger target lesion (58mm, floor of mouth) at enrollment

MICVO Target Lesions Change



MICVO Data

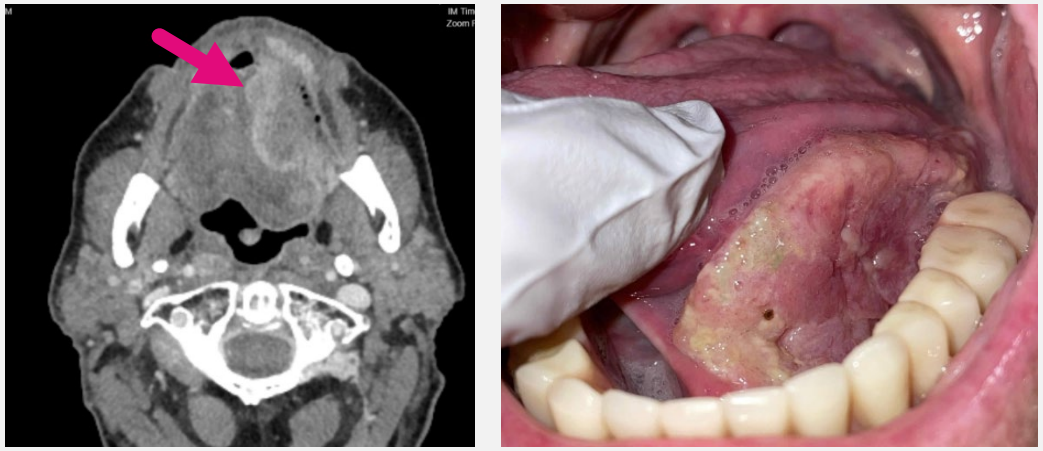
BOR: confirmed PR

Deep Response:
-72% reduction of target lesion**

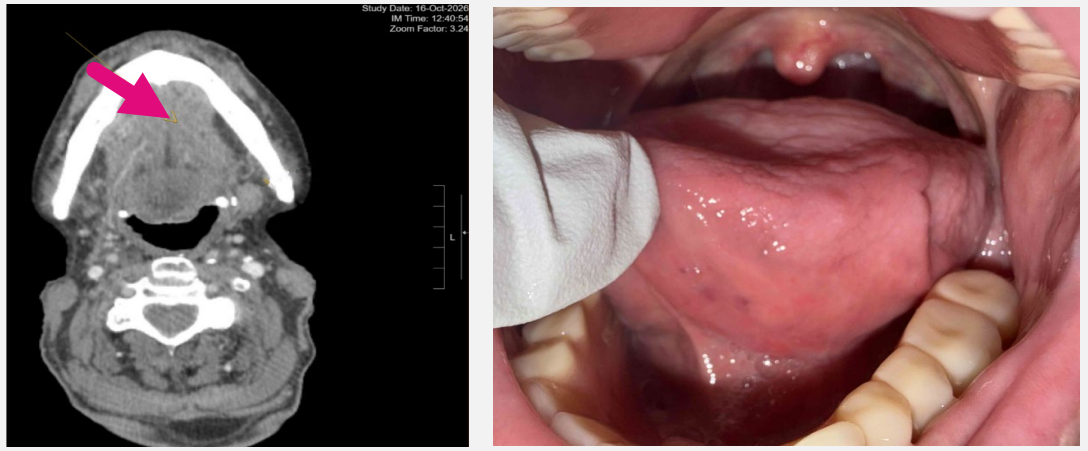
PFS: ~7 Months

Week 30 scan showed -70% reduction of target lesion but reported PD due to minor growth of a non-target lesion which was a lymph node, leading to PFS of ~7m for the patient. Investigator decided to treat beyond PD. Patient ongoing treatment as of Oct 14 data cutoff. Week 39 scan showed sustained PR of target lesion with -72% tumor reduction**

Before MICVO Treatment (Baseline) | 58 mm Target Lesions



After MICVO Treatment (Day 275) | 72% Regression



*Recurrence within 6 months of cCRT in 2021 and treated with salvage cCRT with weekly carboplatin. **Including one scan performed post-Oct 14, 2026 data extract

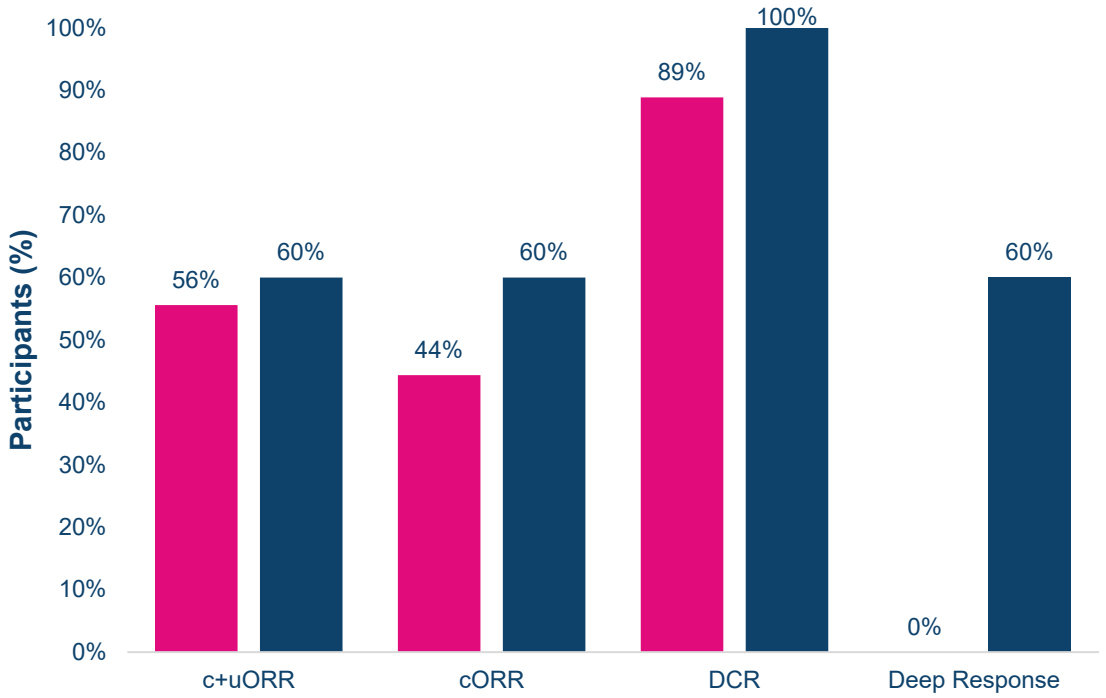
Abbreviations: BOR: Best overall response; cCRT: concurrent chemoradiotherapy; CR: complete response; DOR: duration of response; HNSCC: head and neck squamous cell carcinoma; HPV: human papillomavirus; NA: non-applicable; NE: not evaluable; PR: partial response; RT: radiation therapy; SD: stable disease.

Data as of 14-Oct-2026

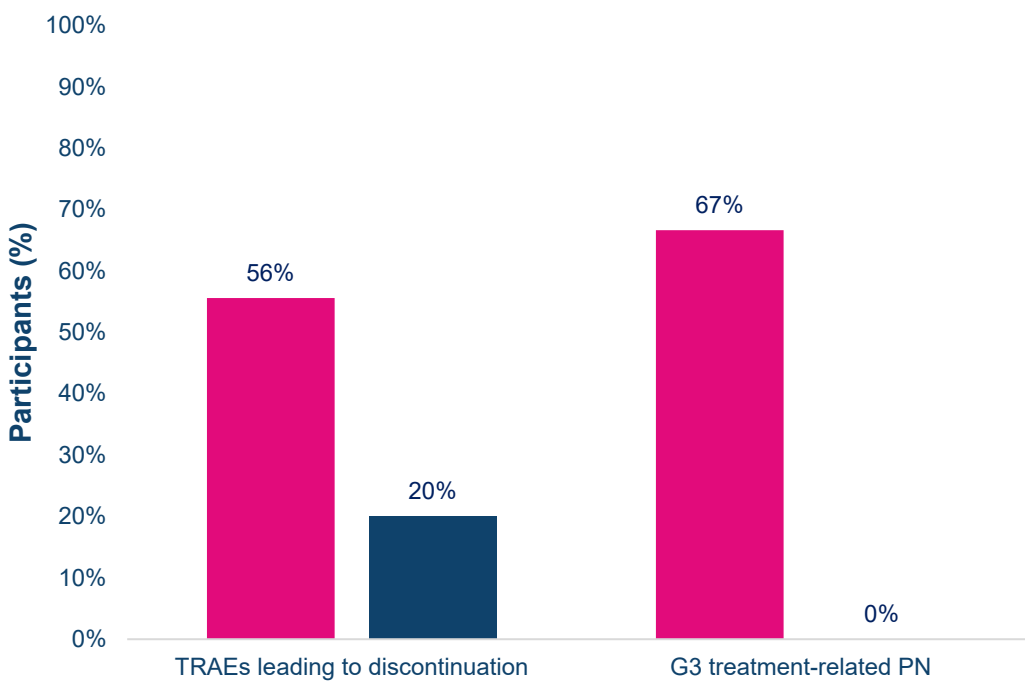
5.4 mg/kg with Dose Cap Maintained Clinical Activity & Improved Safety Profile in High Body Weight Patients

High body weight patients were defined as males >80 kg or females >70 kg

Anti-tumor Activity Maintained



Improved Safety Data



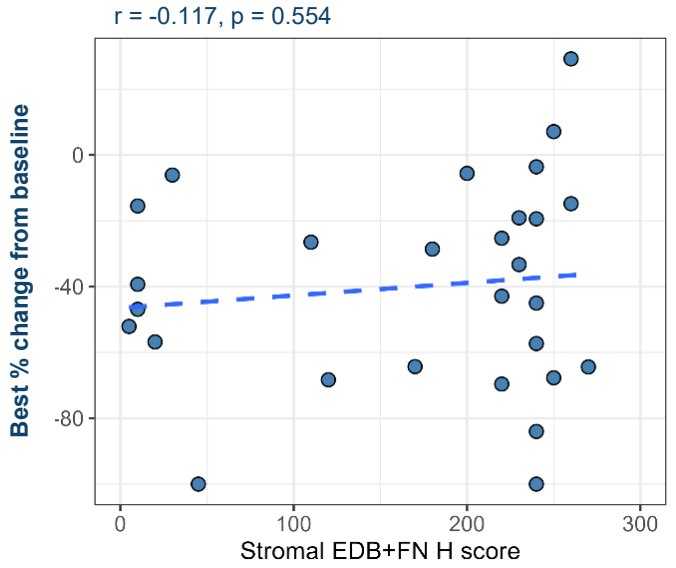
High BW Dosed above the Cap (N=9) High BW Dosed at the Cap (N=5)

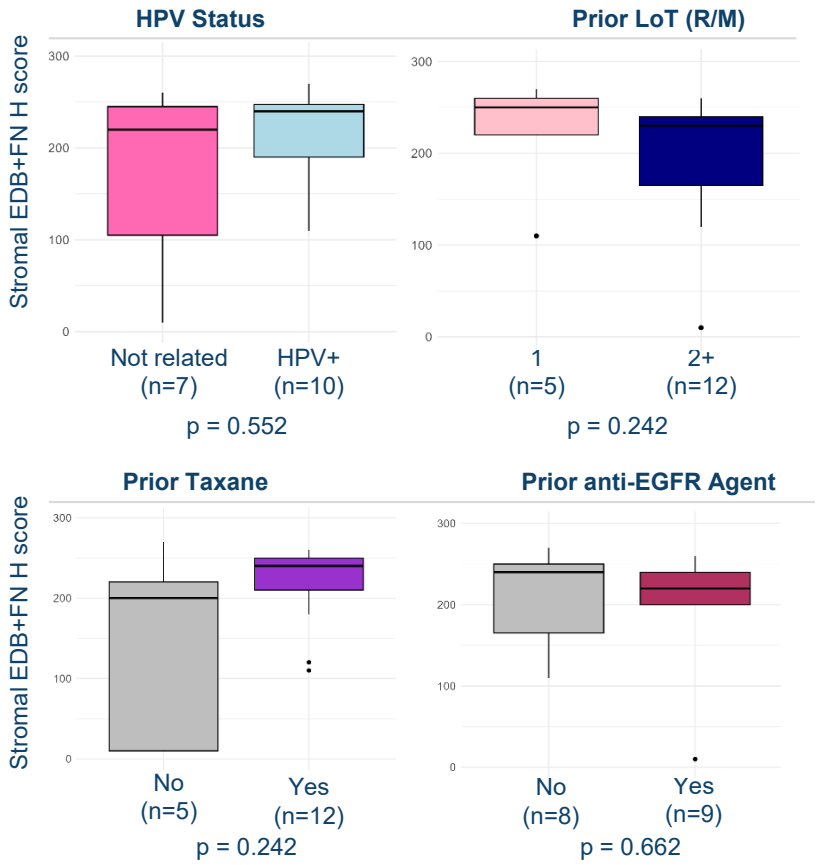
Data as of 14-Oct-2026

Abbreviations: cORR: confirmed objective response rate, c+uORR: ORR including confirmed and all unconfirmed PR/CR, DCR: disease control rate, BW: body weight, PN: peripheral neuropathy, TRAE: treatment related adverse events

EDB+FN Protein Expression in Baseline Tumor Samples Does Not Correlate With MICVO Response, HPV Status or Prior Therapy

EDB+FN is strongly expressed in 2L+ R/M HNSCC and patient selection based on EDB+FN expression is likely not required





Abbreviations: HPV: human papillomavirus; PR: partial response; PD: progressive disease; N: number of patients; LoT: lines of treatment
Correlation analysis includes fresh and archival biopsies. Subgroup analysis includes only biopsy tissue collected within 30 days prior to study enrollment.

Next Steps in Clinical Development

Aligned with FDA and EMA Feedback on Phase 3 Study Design

Phase 3 initiation planned for mid-2027

HEADLINER℠

Randomized, open-label, 2-arm study

MICVO vs. investigator choice in 2L+ HNSCC

ELIGIBILITY

- Histologically or cytologically confirmed 2L+ HNSCC
- R/M disease progressed on/after platinum-based therapy and a PD-(L)1 inhibitor
- Primary tumor location is Oropharynx, Hypopharynx, Larynx or Oral Cavity[1]

RANDOMIZATION

1:1

n ≈ 500

TREATMENT ARMS

MICVO RP3D (Q3W IV)

Investigator choice (Cetuximab, Docetaxel, or Methotrexate)

ENDPOINTS

Primary:

- ORR and OS

Secondary:

- PFS
- DOR
- ORR (FAS)
- DCR
- Safety/tolerability
- PROs

Abbreviations: FDA: US Food and Drug Administration; EMA: European Medicines Agency; PD-(L)1: programmed cell death protein 1/ligand 1; ORR: objective response rate; OS: overall survival; PFS: progression-free survival; DOR: duration of response; FAS: Full Analysis Set; DCR: disease control rate; PROs: patient-reported outcomes; RP3D: recommended Phase 3 dose; Q3W: every 3 weeks; IV: intravenous; mOS: median overall survival; n: number of patients.

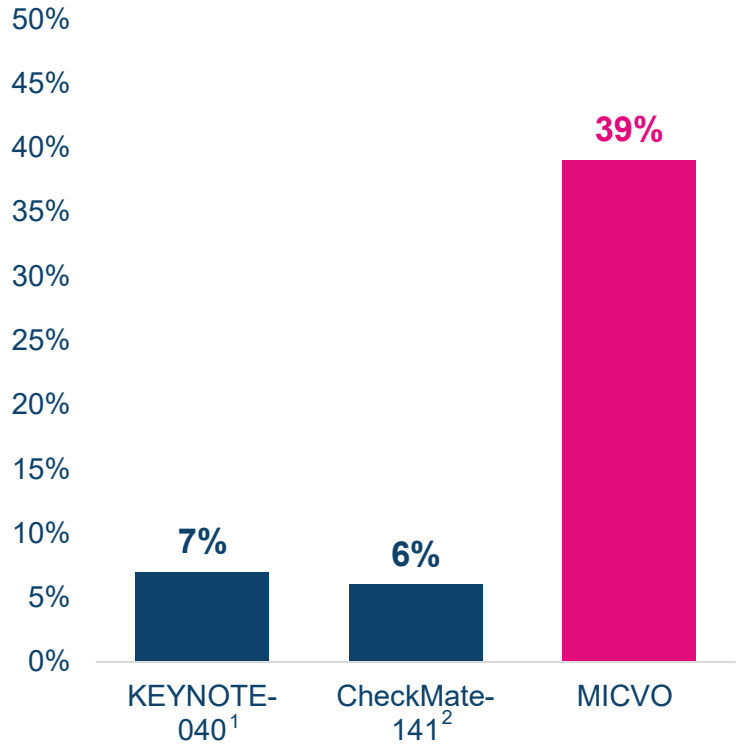
Notes: 1. Excludes verrucous subtype as these patients are typically chemo-resistant and managed by surgical resection – January 2026 amendment excluded verrucous subtype patients from expansion and PYXS plans to exclude verrucous patients from all future 2L+ R/M HNSCC studies.

PYXIS ONCOLOGY

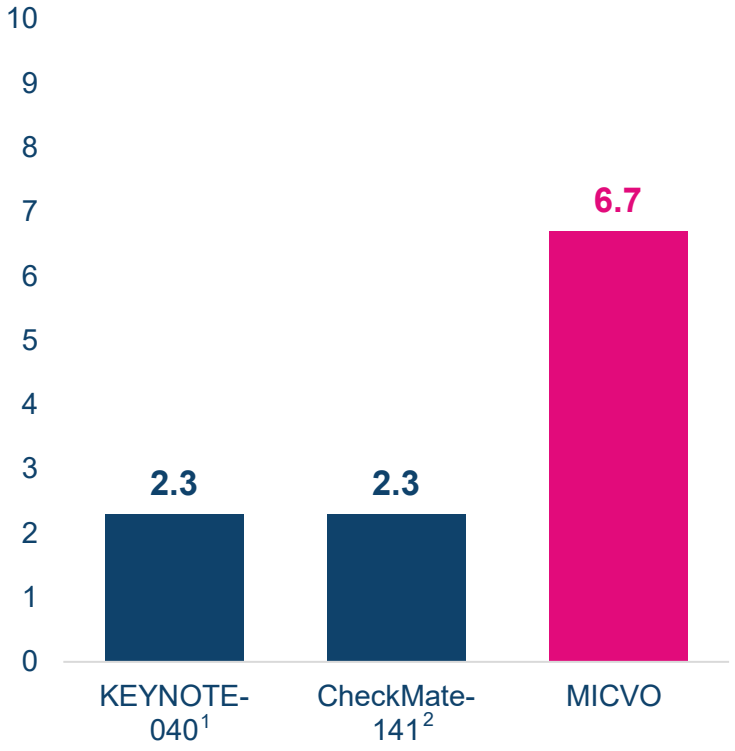
MICVO Response and Survival Benefit Exceeded Benchmarks

MICVO data represented >5X improvement in ORR, >2X improvement on mPFS and significant improvement on mOS compared to historical control arm data in 2L+ R/M HNSCC

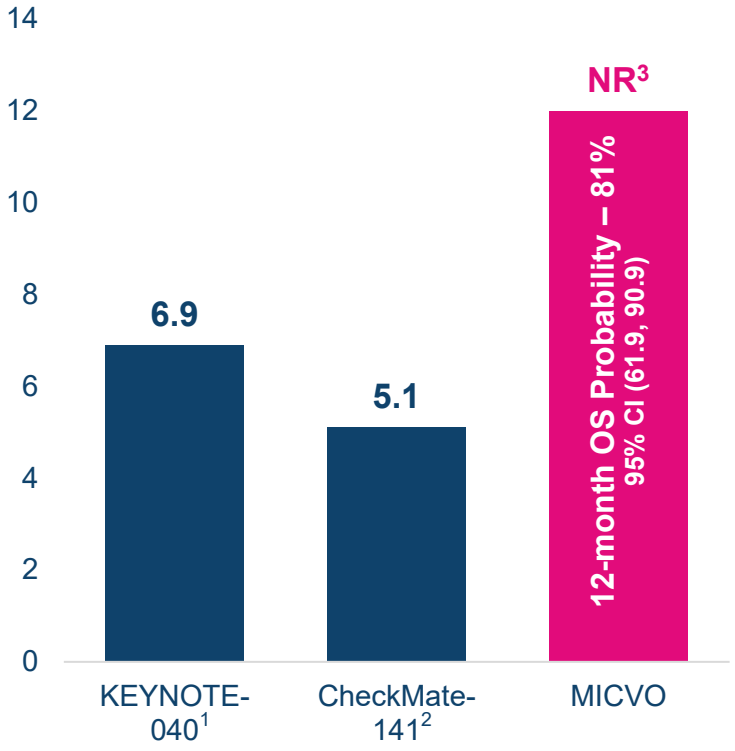
Confirmed ORR (%)



Median PFS (months)



Median OS (months)



Abbreviations: ORR: objective response rate; mPFS: median progression-free survival; PFS: progression-free survival; mOS: median overall survival; OS: overall survival; NR: not reached; N: number of patients.

Note: This analysis is the aggregation of results across independent studies. Cross-trial comparison only; no head-to-head trial of MICVO versus these agents has been conducted. There are risks inherent in conducting cross-trial comparisons. Refer to further disclaimers on slide 2.

References: 1. KEYNOTE-040: Control arm (N=248) included Cetuximab/Methotrexate/Docetaxel; Pembrolizumab arm observed cORR=11%; mPFS=2.1 months; mOS=8.4 months (N=247) 2. CheckMate-141: Control arm (N=121) included Cetuximab/Methotrexate/Docetaxel; Nivolumab arm observed cORR=13%; mPFS=2 months; mOS=7.7 months (N=240); 3. Lower bound of 95% confidence interval for OS at 12 months is 61.9%

PYXIS ONCOLOGY

Data as of 14-Oct-2026

MICVO Key Value Drivers and Anticipated Clinical Data Timeline

Monotherapy and combination highlights, plus five milestones expected from 4Q 2026 through 2H 2027

2L+ R/M HNSCC
MONO: MICVO 5.4 MG/KG WITH DOSE CAP

- Novel MOA required as 1L treatment options change
- Rapid and deep responses
- Substantial survival benefit for entire 2L+ population
- Manageable and well-understood safety profile
- Clear path forward to pivotal start-up

1L HNSCC
COMBO: MICVO + KEYTRUDA® (pembrolizumab)

- Early signs of robust clinical activity in R/M HNSCC
- Preclinical data support synergistic benefit with PD-1 blockade
- Strong global enrollment
- Differentiated MOA with potential to enhance checkpoint inhibition
- Favorable preliminary safety and tolerability

Anticipated Clinical Data Milestones

MONO COMBO

Dec 2026
COMBO
Updated data from 1L combo in R/M HNSCC

1Q 2027
MONO
Optimus Feedback

1H 2027
MONO
Updated OS data

Mid-2027
MONO
Phase 3 first patient first dose

2H 2027
COMBO
Initial durability and RP3D for 1L combo

Abbreviations: 1L: frontline; 2L: second line; MOA: mechanism of action; PD-1: programmed cell death protein 1; OS: overall survival; RP3D: recommended Phase 3 dose.
KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA.
Note: All timing is anticipated and subject to change.

Charting a Course to Therapeutics for Difficult-to-Treat Cancers

November 19, 2026

PYXIS ONCOLOGY

MICVO Data Support Potential To Address Unmet Need Across Entire 21K 2L+ Population

2L+ HPV-positive N=~6k

	MICVO	Methotrexate or Docetaxel or Cetuximab
cORR	**41% (N=17)**	3% (N=29)
mDOR	**9.2 mo[a]**	4.0 mo[a]
mPFS	**9 mo**	2.3 mo (N=121)[a]
OS	**81% 12-mo OS probability[b]**	4.4 mo mOS (N=29)
Peripheral Neuropathy (median days to onset)	42%[c] Gr 1/2 17% Gr 3 **(166 days Gr 3)**	6% Gr 1/2 0% Gr 3 (N=111)[a]
TRAE-D/C Rate (median days to D/C)	14%[c] **(162 days)**	9% (N=111)[a]
Source	Phase 1 data[1]	CheckMate-141[2,3,4]

2L+ HPV-unrelated N=~15k

	MICVO	Methotrexate or Docetaxel or Cetuximab
cORR	**38% (N=16)**	11% (N=36)
mDOR	**9.2 mo[a]**	4.0 mo[a]
mPFS	**5.9 mo**	2.3 mo (N=121)[a]
OS	**81% 12-mo OS probability[b]**	5.8 mo mOS (n=36)
Peripheral Neuropathy (median days to onset)	42%[c] Gr 1/2 17% Gr 3 **(166 days Gr 3)**	6% Gr 1/2 0% Gr 3 (N=111)[a]
TRAE-D/C Rate (median days to D/C)	14%[c] **(162 days)**	9% (N=111)[a]
Source	Phase 1 data[1]	CheckMate-141[2,3,4]

There are risks inherent in conducting cross-trial comparisons. Refer to further disclaimers on slide 2
cORR: confirmed overall response rate; mDOR: median duration of response; mPFS: median progression free survival; mOS: median overall survival; D/C: Discontinuation; mo: months
a. Reported for HPV-agnostic population b. 95% CI: (61.9, 90.9) c. MICVO safety data for N=36 safety population
Source: 1 Pyxis Oncology press release, 19 Nov 2026; 2. Ferris et al., Oral Oncol 2018; 3. Ferris et al., NEJM 2016; 4. Gillison et al., The Oncologist 2018