Designing Proteins
Delivering Medicines™

Updated Results from Dose Expansion Cohorts in the Phase 1 Study of XmAb819

October 26, 2026

Today's Speakers

Xencor Management



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President & Chief Executive Officer



John Desjarlais, Ph.D.
Executive Vice President & Chief Scientific Officer



Dane Leone
Executive Vice President & Chief Strategy Officer



Jeff Chou
Senior Vice President, Head of Oncology
Clinical Development

Guest Speaker



Sumanta Pal, M.D., F.A.S.C.O.
Professor, Department of Medical Oncology & Therapeutics Research

Vice Chair of Academic Affairs

Co-director, Kidney Cancer Program

City of Hope Comprehensive Cancer Center

Today's Agenda

- Overview & XmAb® 2+1 T-cell Engagers  
- Updated Phase 1 results of XmAb819, a novel ENPP3 x CD3 bispecific, in advanced clear cell renal cell carcinoma (ccRCC) 
- Additional results 
- XmAb819 development strategy 
- Summary and Q&A   

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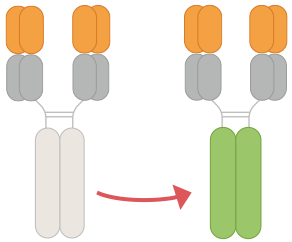
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Xencor is at the forefront of bispecific T-cell engagers in solid tumors with the 3rd late-stage XmAb® program expected in 2027

XmAb® toolkits enable rapid prototyping and lead optimization

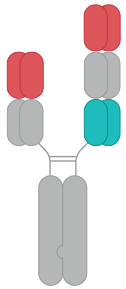
XmAb® Fc Domains

Augment native immune functions in molecules and/or control their structure, while preserving desired attributes (e.g., Xtend™ extended half-life or heterodimeric Fc domain for bispecific antibodies).



XmAb® 2+1 Formats

Designed to enable antibodies to bind more avidly and selectively kill cells with higher antigen density, potentially sparing normal cells



XmAb® 2+1 programs in solid tumor oncology advancing internally and with leading pharmaceutical partners

XmAb819

ENPP3 x CD3

Planned, potential registration-enabling study start in 2027

Advanced ccRCC and ENPP3+ tumors

100% Wholly Owned

ASP2138

CLDN18.2 x CD3

Phase 3

Gastric/GEJ cancer, Pancreatic cancer

High single- to low double-digit royalty and up to $232.5 million in milestone payments[1]

Xaluritamig

STEAP1 x CD3

Phase 3

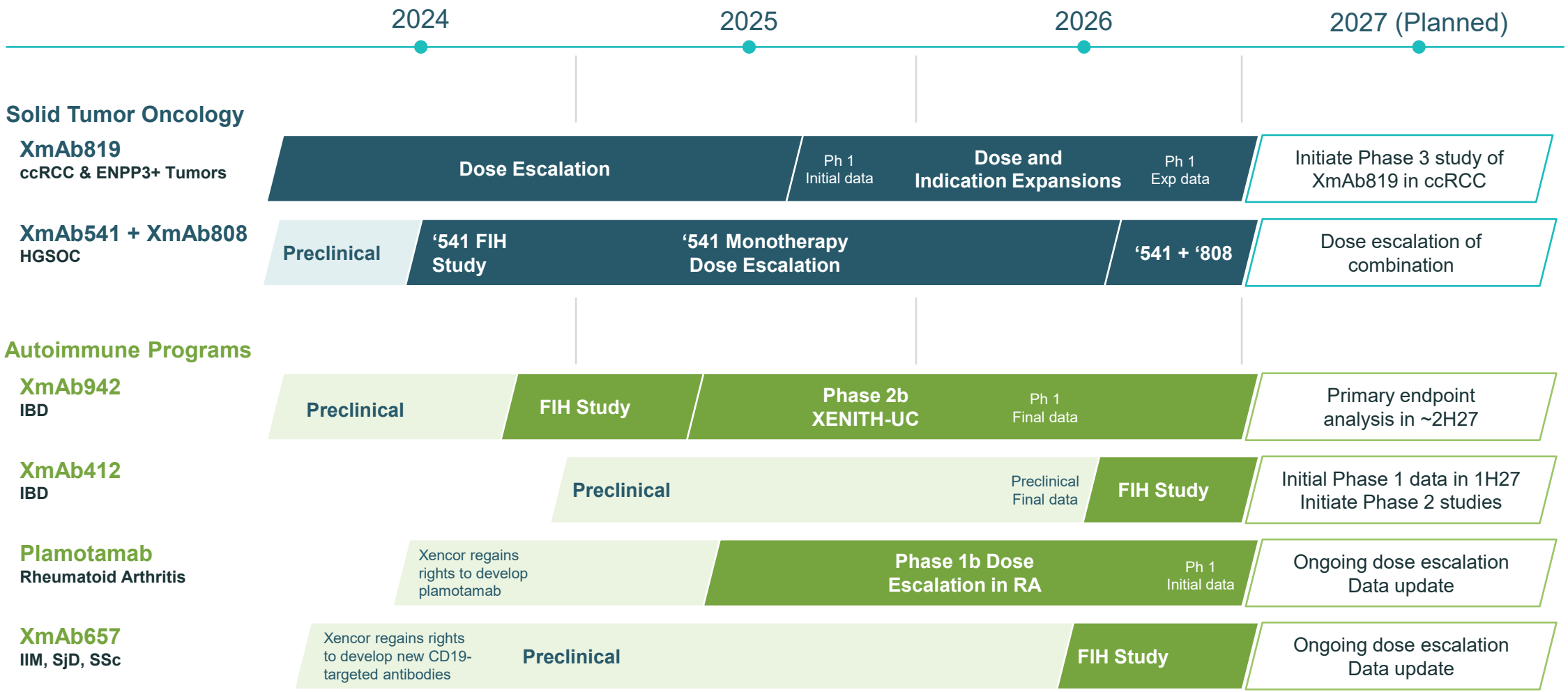
Prostate cancer, Ewing sarcoma

Mid- to high-single digit royalty and up to $225 million in milestone payments[1]

1 Remaining as of June 30, 2026 **ccRCC** clear cell renal cell carcinoma **GEJ** gastro-esophageal junction

Our focus on clinical excellence to realize value from XmAb® platform

Cash runway into 2029



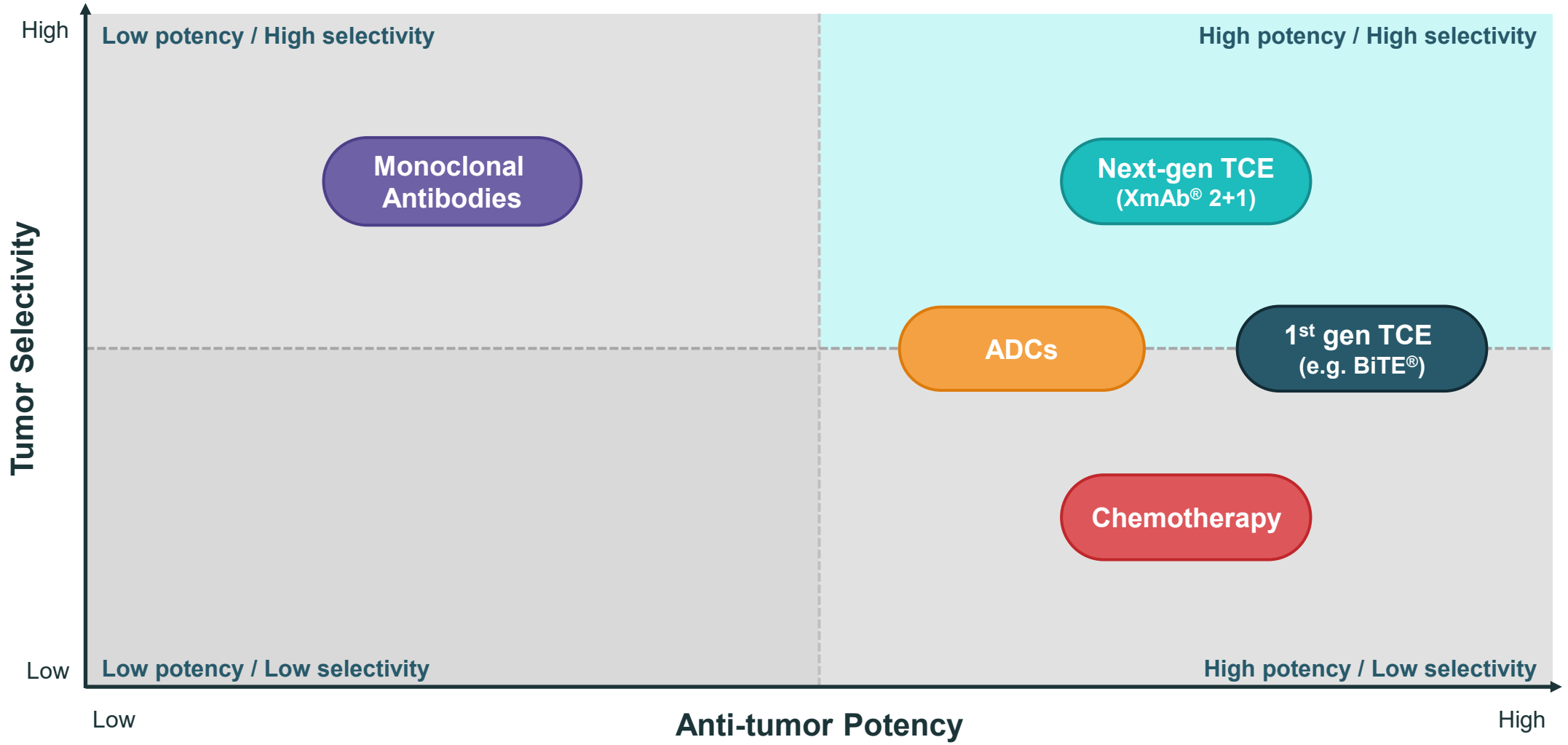
ccRCC clear cell renal cell carcinoma **Exp** expansion **FIH** first-in-human **HGSOC** high-grade serous ovarian carcinoma
IBD inflammatory bowel disease **IIM** idiopathic inflammatory myopathies **SjD** Sjögren's disease **SSc** systemic sclerosis
RA rheumatoid arthritis

XmAb® 2+1 T Cell Engagers



Solid tumor targeting challenge: target expression on normal tissues

XmAb® 2+1 format aims to combine tumor selectivity with high potency to treat aggressive cancers



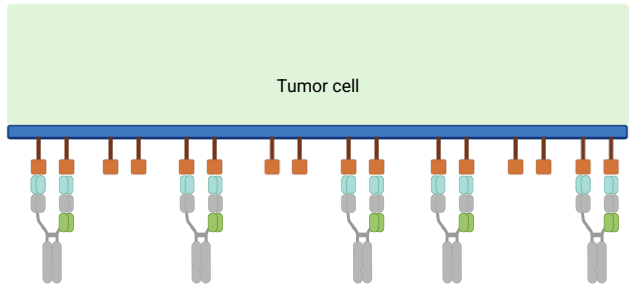
ADC antibody drug conjugate **BiTE®** is a registered trademark of Amgen Inc. **TCE** T-cell engager

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Tuned XmAb® 2+1 formats potentially improve selectivity of T-cell engagers in solid tumors

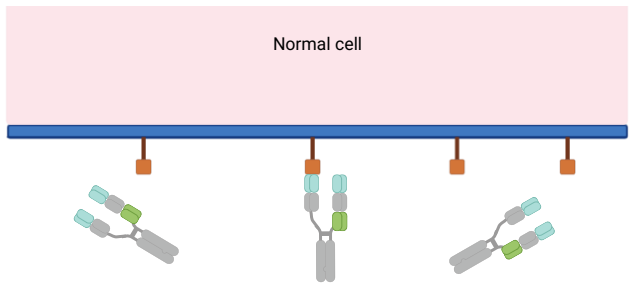
XmAb 2+1 format

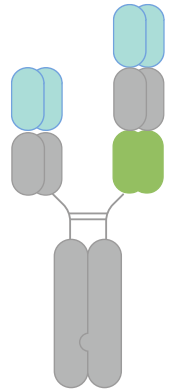
High density tumor cell



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Low density normal cell

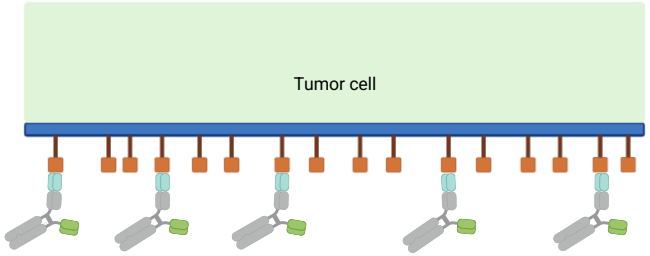




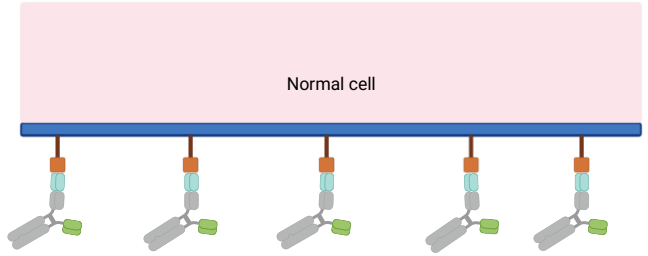
XmAb 2+1 format

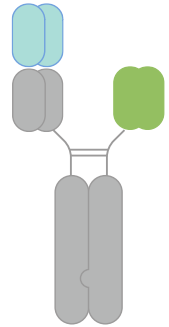
XmAb 2+1 high avidity/low affinity target binding
Selective for tumor cells

1+1 format



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1+1 format

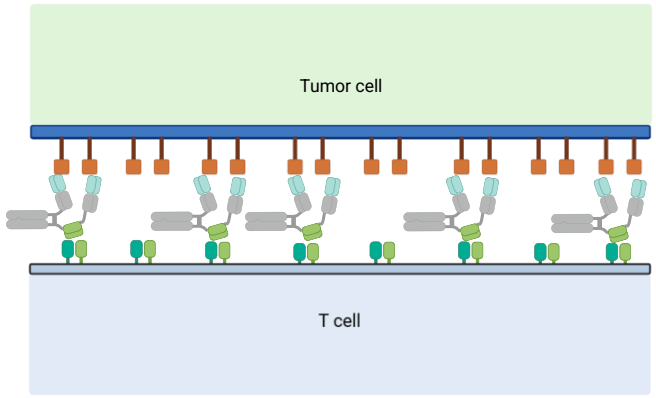
1+1 high affinity needed to bind tumor cells
Also binds normal cells

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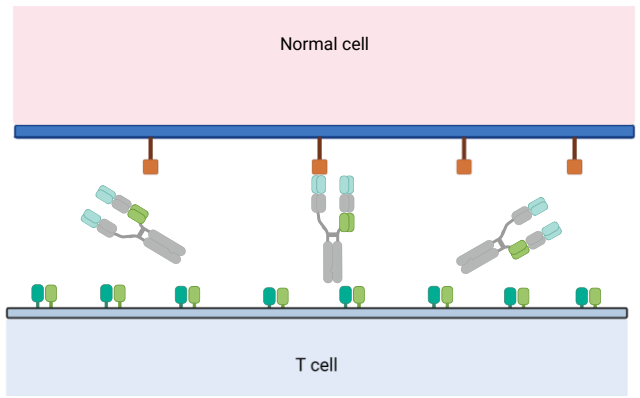
Tuned XmAb® 2+1 formats potentially improve selectivity of T-cell engagers in solid tumors

XmAb 2+1 format

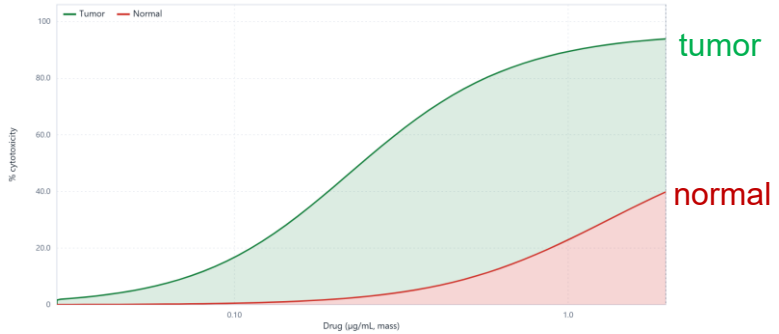
High density tumor cell



Low density normal cell

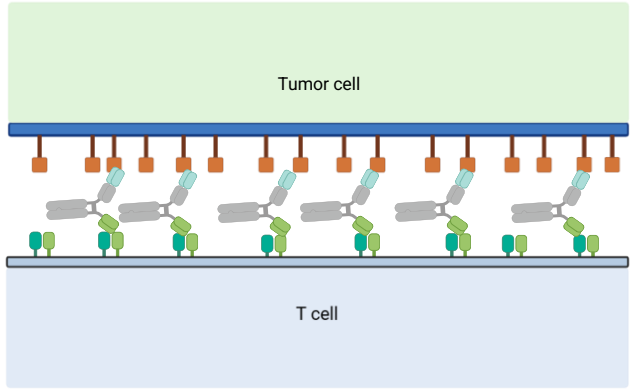


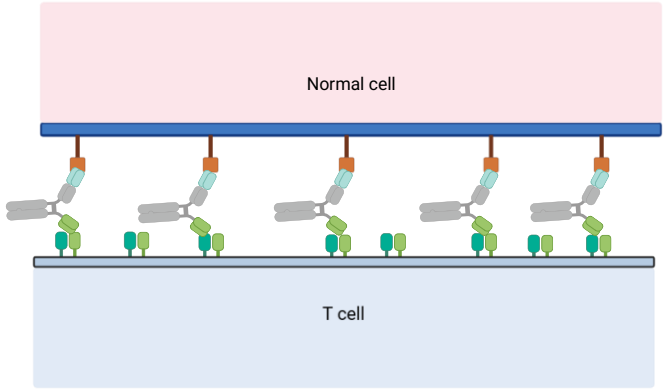
2+1 kills tumor cells, spares normal cells



XmAb 2+1 high avidity/low affinity target binding
Selective for tumor cells

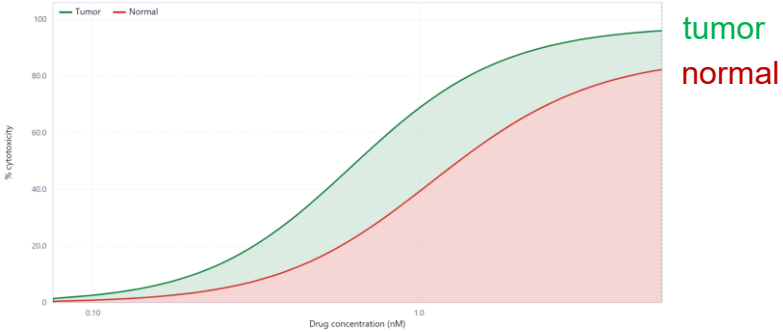
1+1 format





QSP cytotoxicity models

1+1 kills both tumor and normal cells



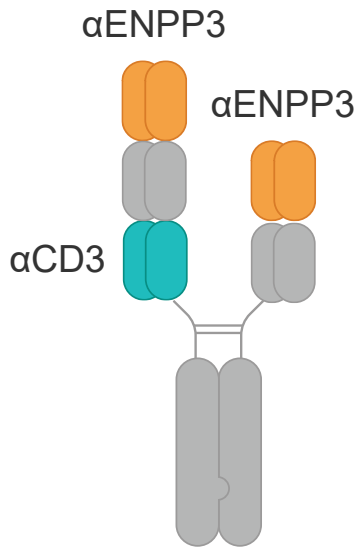
1+1 high affinity needed to bind tumor cells
Also binds normal cells

QSP quantitative systems pharmacology

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XmAb819 is an XmAb® 2+1 ENPP3 x CD3 bispecific antibody in development for ccRCC

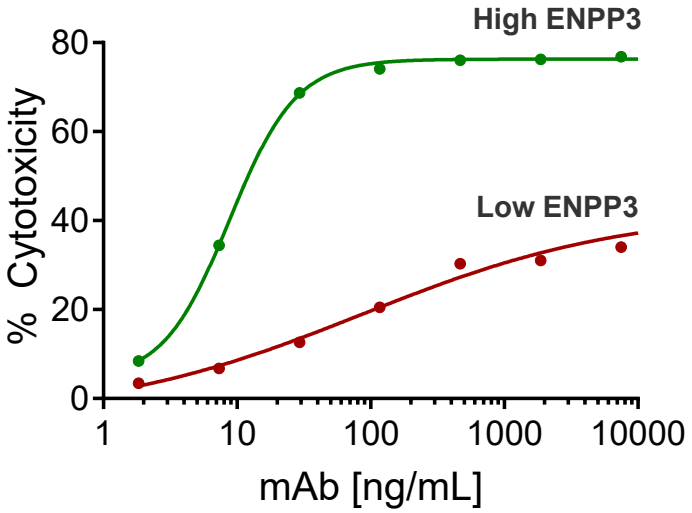
Full length 2+1 antibody-like format



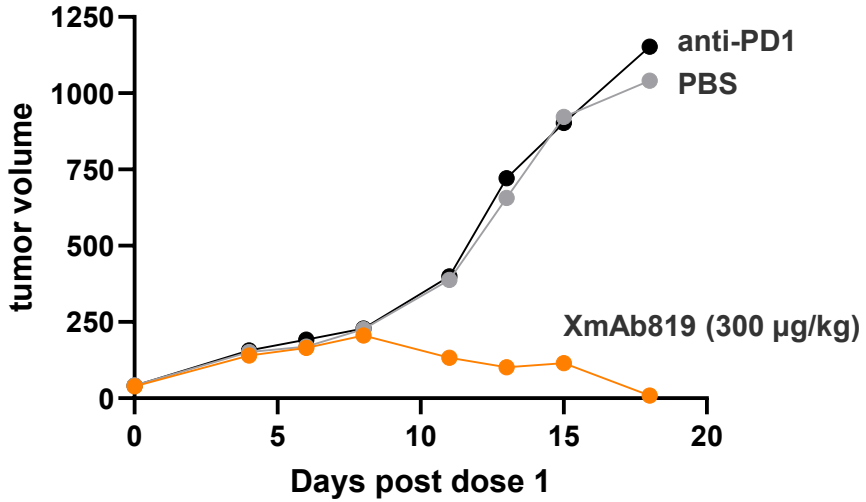
Affinity/avidity tuned

High tumor/normal selectivity

Preferential killing of ENPP3^{high} cells *in vitro*



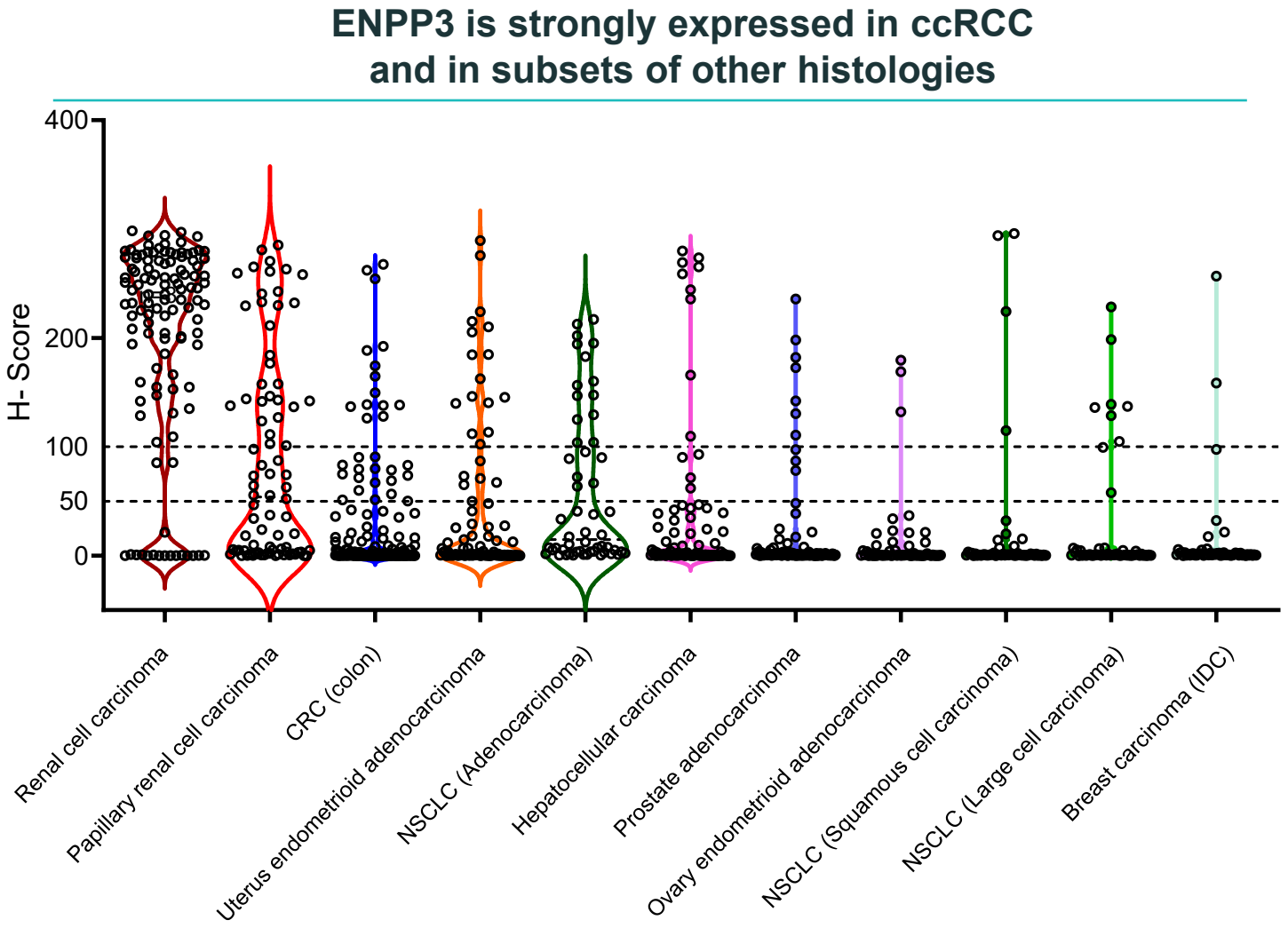
Strong *in vivo* activity in PD1-refractory model

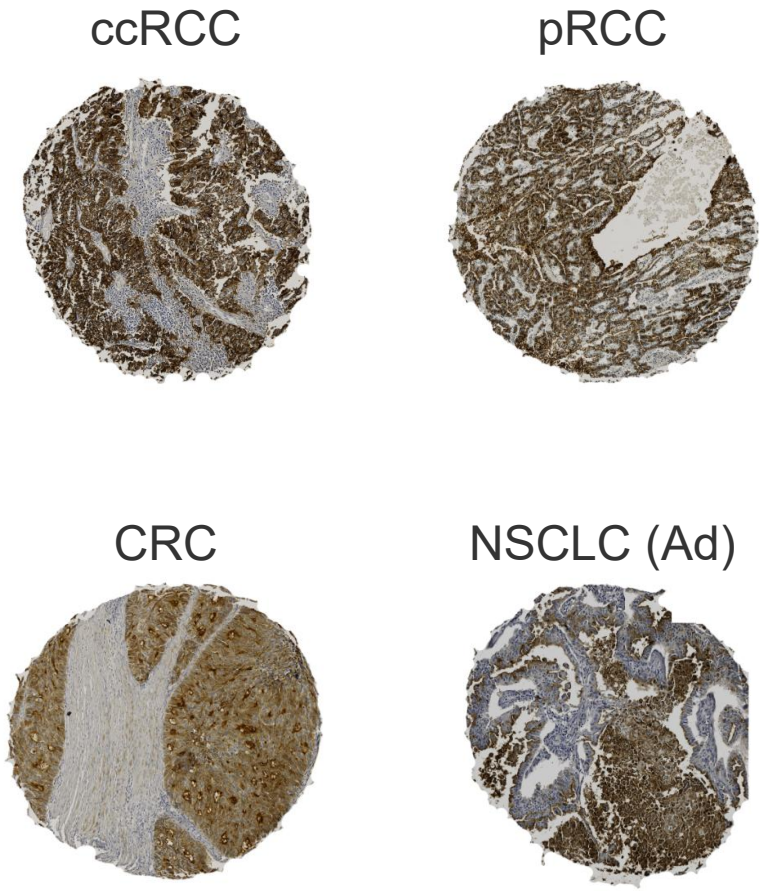


ccRCC clear cell renal cell carcinoma

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XmAb819 targets ENPP3 for treatment of renal cell carcinoma and other solid tumors

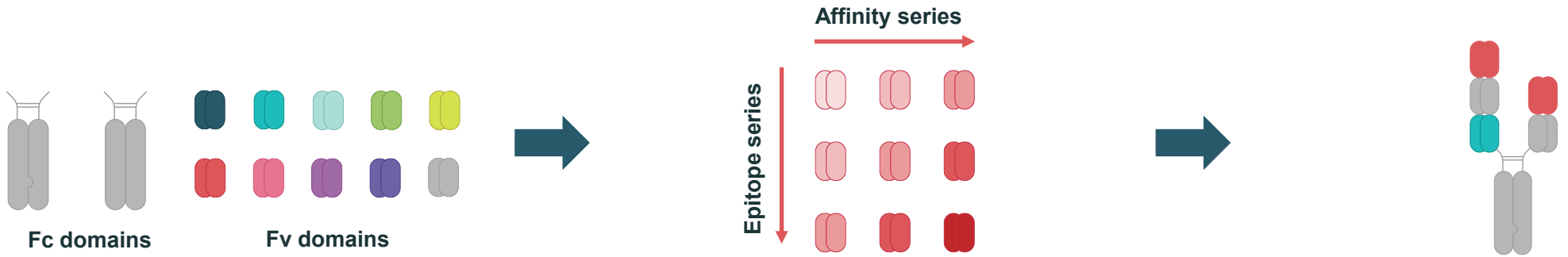




ccRCC clear cell renal cell carcinoma **CRC** colorectal cancer **IDC** invasive ductal carcinoma **NSCLC** non-small cell lung cancer **pRCC** papillary renal cell carcinoma **RCC** renal cell carcinoma

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XmAb® engineering: modular, stable and tuned for purpose



Engineer robust, soluble, variable and Fc domain modules

Tune affinity and other properties for specific use

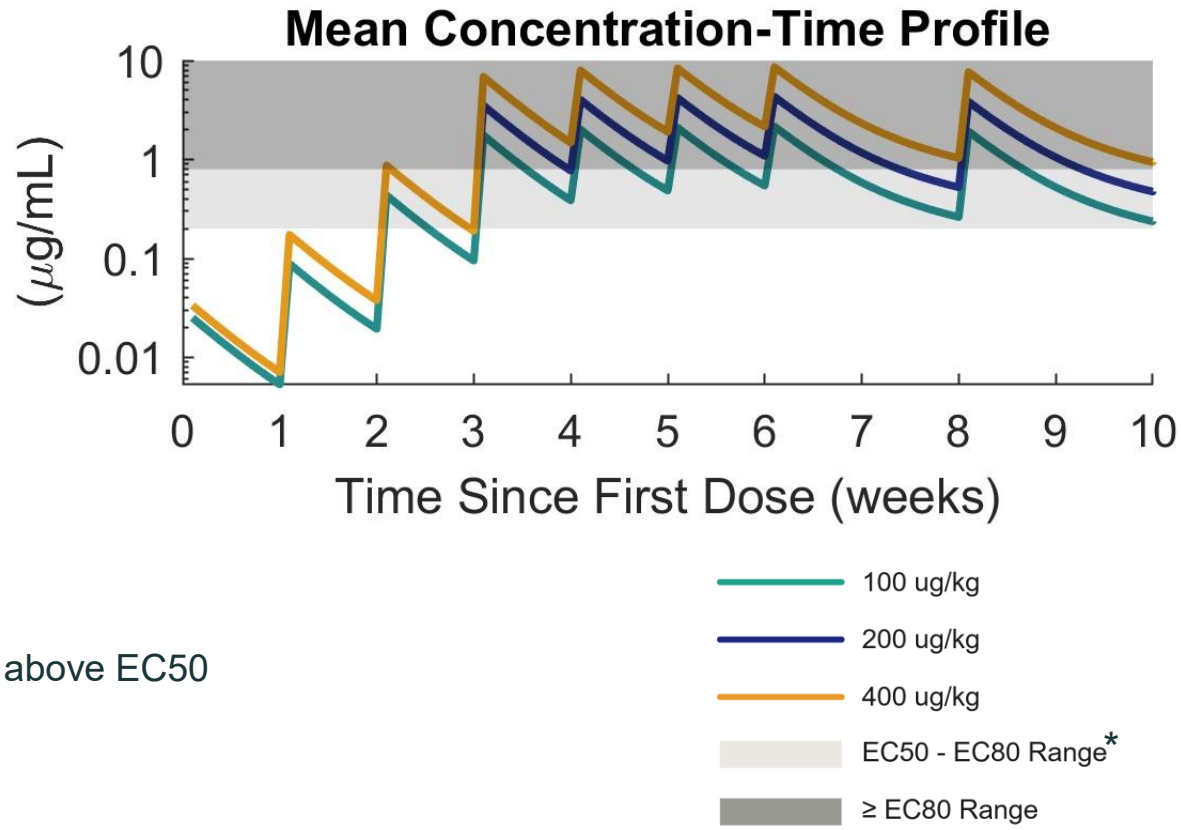
Assemble modules into required format

Highly stable – Long half-life – Standard manufacturing

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XmAb819 PK profile supports Q2W+ dosing schedule

- Well characterized by a two compartment PopPK model
- Linear clearance and dose proportional exposure
  - ~1000x range of doses
- Terminal half life ~ 8 days



- Quantitative Systems Pharmacology (QSP) Model
  - 100 µg/kg and 200 µg/kg doses maintained drug concentration above EC50
  - 400 µg/kg maintained drug concentration above EC80

* QSP modeled cytotoxicity range

PK pharmacokinetic(s) **popPK** population PK **Q2W** every two weeks

XmAb819 late-phase manufacturing activities initiated

Modular XmAb design and expert CMC execution create scalable process and stable product

Robust process	Cell bank – well characterized, high titer Drug substance (DS) – Xencor platform process 2000L scale Drug product (DP) – Multiple presentations for flex across IV/SC dose range
Highly stable	DS – 60 months (anticipate 60+) DP – 60 months (anticipate 60+) Liquid formulation 5 ºC
Supply chain	U.S. manufacturing at validated commercial CDMOs

CDMO contract development and manufacturing organization **CMC** chemistry, manufacturing and control(s) **IV** intravenous **SC** subcutaneous

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Phase 1 results of XmAb819, a novel ENPP3 x CD3 bispecific, in advanced clear cell renal cell carcinoma (ccRCC)

Sumanta K. Pal[1], Benjamin Garmezy[2], Randy F. Sweis[3], Mehmet A. Bilen[4], Scott S. Tykodi[5], Yuanquan Yang[6], Karie Runcie[7], David A. Braun[8], David J. VanderWeele[9], Claud M. Grigg[10], Christopher Hoimes[11], Adanma Ayanambakkam[12], Joseph J. Maly[13], Robert A. Franklin[14], Biren Saraiya[15], Chet Bohac[16], Jitendra Kanodia[16], Nicholas Rinella[16], Ritesh R. Kotecha[17], Laurence Albiges[18]

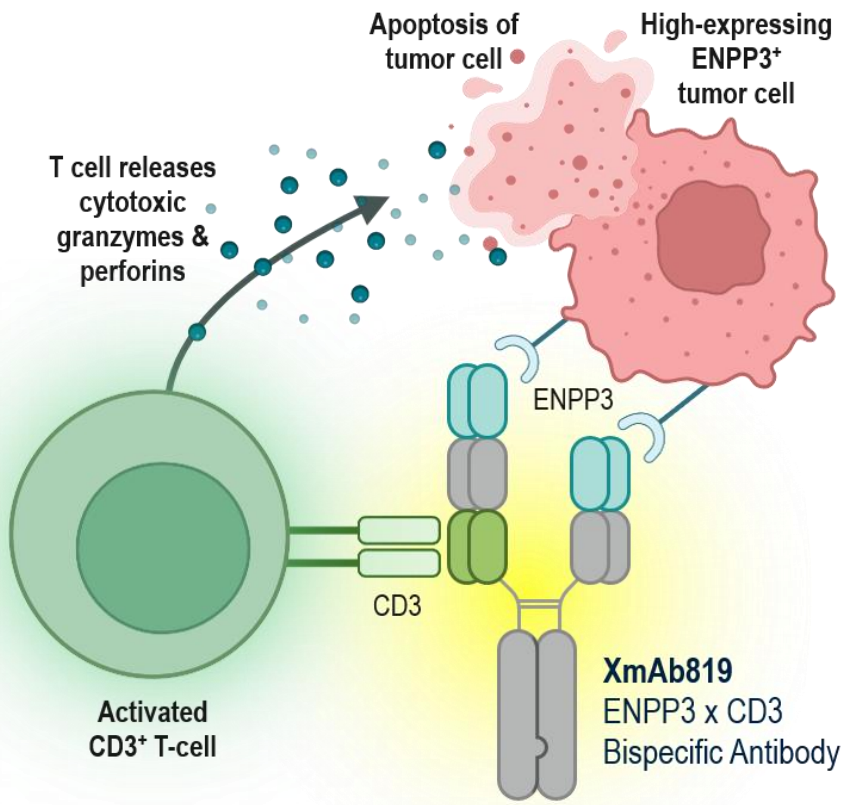
[1]City of Hope Comprehensive Cancer Center, Duarte, USA; [2]Sarah Cannon Research Institute, Nashville, USA, [3]University of Chicago, Chicago, USA, [4]Winship Cancer Institute of Emory University, Atlanta, USA, [5]University of Washington and Fred Hutchinson Cancer Center, Seattle, USA, [6]The Ohio State University Comprehensive Cancer Center, Columbus, USA, [7]Columbia University, New York, USA, [8]Yale School of Medicine, New Haven, USA, [9]Northwestern University, Chicago, USA, [10]Atrium Health Wake Forest Baptist Comprehensive Cancer Center, Charlotte, NC, USA, [11]Duke University Medical Center, Durham, USA, [12]University of Oklahoma Health Sciences Center, Oklahoma City, USA, [13]Norton Cancer Institute - St Matthews Campus, Louisville, USA, [14]University of Cincinnati Medical Center, Cincinnati, OH, USA, [15]Rutgers Cancer Institute, New Brunswick, USA, [16]Xencor, Inc., Pasadena, California, USA, [17] Memorial Sloan Kettering Cancer Center, New York, USA, [18]Institut Gustave Roussy, Villejuif, France

25 October 2026

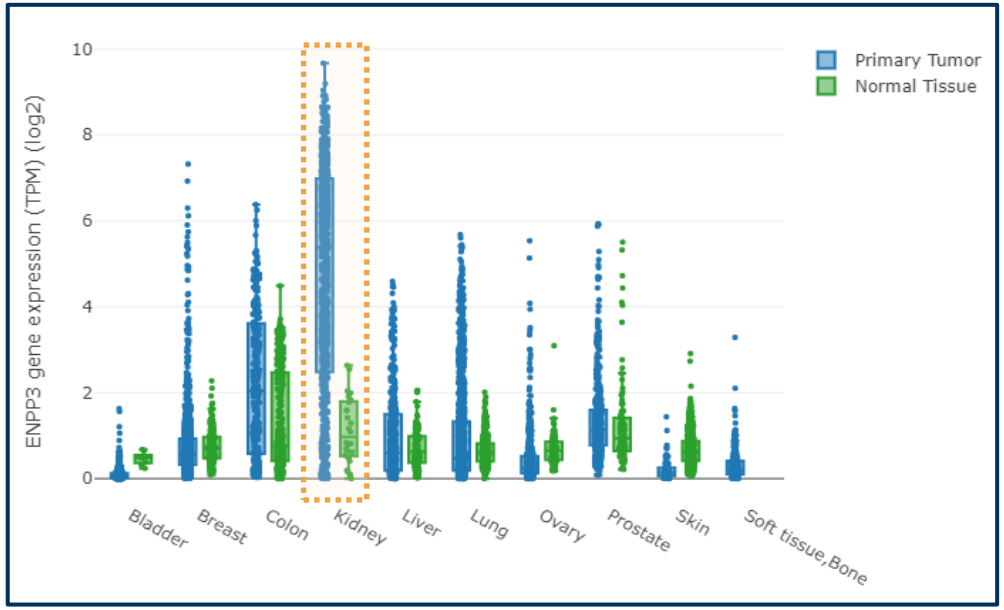
Abstract 2684

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XmAb819, ENPP3 x CD3 bispecific antibody in development for ccRCC



- ENPP3 is an extracellular nucleotide metabolizing enzyme with high expression in RCC and other solid tumors, and low expression in normal tissues[1]
- XmAb819 targets T cells for potent lysis of ENPP3+ tumor cells
- XmAb 2+1 format selectively binds and kills high density ENPP3 tumor cells, but spares low density normal tissue



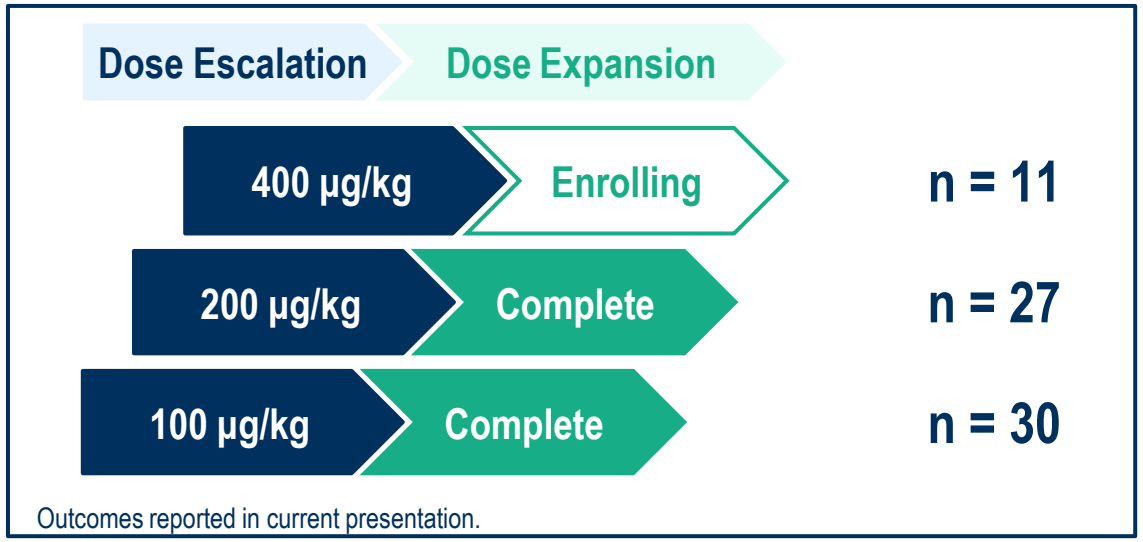
ENPP3 ectonucleotide pyrophosphatase / phosphodiesterase family member 3

[1]Doñate, Fernando, et al. Clinical Cancer Research 22.8 (2016)

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XmAb819-01: Phase 1 study design in advanced ccRCC

Study Schema – IV Administration



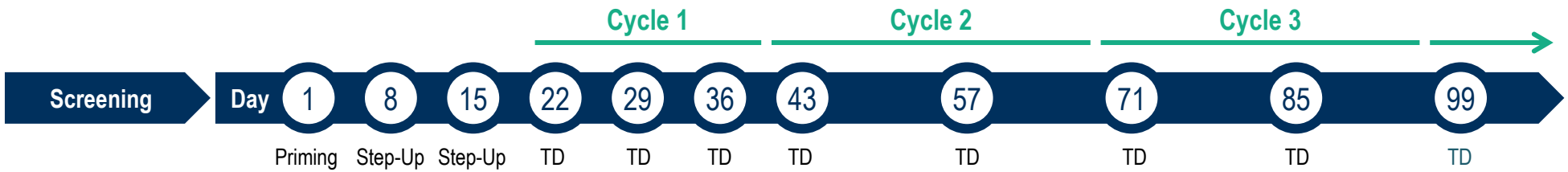
Key Eligibility Criteria

- R/R ccRCC – prior ICI & VEGFR-TKI
- Measurable disease by RECIST v1.1
- No prior anti-ENPP3 therapy

Endpoints

- Primary: Safety & Tolerability
- Secondary:
  - ORR, DOR, PFS per RECIST 1.1
  - Pharmacokinetics

NCT05433142. US & EU sites.



DOR, duration of response; **ICI**, immune checkpoint inhibitor; **IV,** intravenous; **ORR,** objective response rate; **PFS**, progression free survival; **R/R,** relapsed / refractory; **TD**, target dose; **TKI,** tyrosine kinase inhibitor; **VEGFR,** vascular endothelial growth factor receptor

Pal SK, et al.

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Patient characteristics

Baseline Characteristic	All IV Doses (n=119)	Expansion Doses (n=68)
Median Age, Years (range)	61 (34, 78)	62 (34, 78)
Male, n (%)	97 (81.5)	58 (85.3)
Race – White, n (%)	101 (84.9)	56 (82.4)
Time Since Disease Diagnosis, mo. (range)	52.5 (7, 287)	49.5 (7, 287)
IMDC Risk Score at Baseline[1], n (%)		
Favorable	8 (6.7)	4 (5.9)
Intermediate	81 (68.1)	46 (67.6)
Poor	30 (25.2)	18 (26.5)
Sarcomatoid Features, n (%)	16 (13.4)	13 (19.1)
≥3 Metastatic Sites, n (%)	84 (70.6)	46 (67.6)
Bone metastasis, n (%)	58 (48.7)	32 (47.1)
Liver metastasis, n (%)	48 (40.3)	27 (39.7)
Target Lesions SOD (mm), Median	90.0	90.5
ENPP3 Positive From Cases With Tissues[2] (%)	83/89 (93.3)	50/52 (96.2)

Prior Therapy	All IV Doses (n=119)	Expansion Doses (n=68)
# Prior Regimens, Median (Min, Max)	3 (1, 10)	3 (1, 10)
1, n (%)	7 (5.9)	4 (5.9)
2	35 (29.4)	22 (32.4)
3	30 (25.2)	18 (26.5)
≥4	47 (39.5)	24 (35.3)
Prior Treatments, n (%)		
Any Immune Checkpoint Inhibitor	119 (100)	68 (100)
Any VEGFR-TKI	119 (100)	68 (100)
2 or More VEGFR-TKIs	76 (63.9)	43 (63.2)
HIF2α Inhibitor	42 (35.3)	23 (33.8)
Nephrectomy, n (%)	81 (68.1)	46 (67.6)

Subjects who received ≥1 protocol-specified dose of XmAb819 were included in the baseline characteristics analysis. Data cut-off: **01 September 2026**. Excludes 1 participant who experienced approximately 10-fold higher exposure than intended at the first and only dose administered, and who subsequently developed Grade 4 CRS and discontinued treatment.

[1]IMDC risk derived at study baseline using central laboratory values; KPS <80% defined as ECOG ≥2.
[2]Tumor ENPP3 positivity was defined as a tumor proportion score (TPS) ≥1, regardless of expression intensity, by a clinical trial IHC assay (Roche Diagnostics).

HIF2α, hypoxia-inducible factor 2-alpha; **IMDC,** International Metastatic RCC Database Consortium; **IHC,** immunohistochemistry; **SOD,** sum of diameters; **TKI,** tyrosine kinase inhibitor; **VEGFR,** vascular endothelial growth factor receptor

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Adverse events

Summary of Adverse Events

Number of Subjects With, n (%)	All IV Doses (N=119)	Expansion Doses (n=68)
Grade ≥ 3	95 (79.8)	56 (82.4)
Related TEAE Grade ≥ 3	75 (63.0)	49 (72.1)
Serious TEAE	74 (62.2)	42 (61.8)
Related Serious TEAE	64 (53.8)	37 (54.4)
TEAE Leading to Dose Reduction	7 (5.9)	1 (1.5)
Did Not Reach Target Dose	9 (7.6)	3 (4.4)
TEAE Leading to Discontinuation	8 (6.7)	5 (7.4)
Related TEAE Leading to Discontinuation	7 (5.9)	4 (5.9)
Leading to Death	0	0

Subjects who received ≥1 protocol-specified dose of XmAb819 were included in the safety analysis. Data cut-off: **01 September 2026.** Excludes 1 participant who experienced approximately 10-fold higher exposure than intended at the first and only dose administered, and who subsequently developed Grade 4 CRS and discontinued treatment. Reported TEAEs were defined per MedDRA and CTCAE; CRS graded per ASTCT[2].

[1]Combined rash term includes 10 preferred terms: rash (unspecified, maculo-papular, erythematous, macular, morbilliform, pustular, pruritic, anal), erythema, dermatitis acneiform.

[2]Lee DW, et al. Biol Blood Marrow Transplant. 2019;25:625-638.

ALT, alanine aminotransferase; **ASTCT**, American Society for Transplantation and Cellular Therapy; **AST,** aspartate aminotransferase; **CTCAE,** Common Terminology Criteria for Adverse Events; **MedDRA,** Medical Dictionary for Regulatory Activities; **SAE,** serious adverse event; **TEAE,** treatment-emergent adverse event

- Low rate of dose reductions and treatment discontinuation due to TEAEs
- Events were predominately confined to the priming dose period
- Most common Grade ≥3 TEAEs were asymptomatic, transient transaminase increases

TEAEs reported in >25% Subjects by Maximum Severity Grade

Expansion Doses (n=68)	Any Incidence		>Day 29 Onset	
Preferred Term, n (%)	**All grades**	**Grade ≥3**	**All grades**	**Grade ≥3**
Rash (combined term)[1]	62 (91.2)	15 (22.1)	20 (29.4)	2 (2.9)
Cytokine release syndrome	46 (67.6)	4 (5.9)	12 (17.6)	1 (1.5)
ALT increased	36 (52.9)	23 (33.8)	12 (17.6)	7 (10.3)
Nausea	35 (51.5)	-	9 (13.2)	-
AST increased	33 (48.5)	24 (35.3)	10 (14.7)	6 (8.8)
Oedema peripheral	31 (45.6)	-	11 (16.2)	-
Vomiting	30 (44.1)	-	7 (10.3)	-
Diarrhoea	28 (41.2)	2 (2.9)	9 (13.2)	2 (2.9)
Fatigue	27 (39.7)	-	11 (16.2)	-
Headache	23 (33.8)	-	10 (14.7)	-
Hypophosphataemia	20 (29.4)	1 (1.5)	8 (11.8)	-
Hypotension	20 (29.4)	5 (7.4)	3 (4.4)	1 (1.5)
Pruritus	19 (27.9)	-	7 (10.3)	-
Chills	18 (26.5)	-	11 (16.2)	-
Cough	18 (26.5)	-	10 (14.7)	-

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Adverse events

Summary of Adverse Events

Number of Subjects With, n (%)	All IV Doses (N=119)	Expansion Doses (n=68)
Grade ≥ 3	95 (79.8)	56 (82.4)
Related TEAE Grade ≥ 3	75 (63.0)	49 (72.1)
Serious TEAE	74 (62.2)	42 (61.8)
Related Serious TEAE	64 (53.8)	37 (54.4)
TEAE Leading to Dose Reduction	7 (5.9)	1 (1.5)
Did Not Reach Target Dose	9 (7.6)	3 (4.4)
TEAE Leading to Discontinuation	8 (6.7)	5 (7.4)
Related TEAE Leading to Discontinuation	7 (5.9)	4 (5.9)
Leading to Death	0	0

Subjects who received ≥1 protocol-specified dose of XmAb819 were included in the safety analysis. Data cut-off: **01 September 2026.** Excludes 1 participant who experienced approximately 10-fold higher exposure than intended at the first and only dose administered, and who subsequently developed Grade 4 CRS and discontinued treatment. Reported TEAEs were defined per MedDRA and CTCAE; CRS graded per ASTCT[2].

[1]Combined rash term includes 10 preferred terms: rash (unspecified, maculo-papular, erythematous, macular, morbilliform, pustular, pruritic, anal), erythema, dermatitis acneiform.

[2]Lee DW, et al. Biol Blood Marrow Transplant. 2019;25:625-638.

ALT, alanine aminotransferase; **ASTCT**, American Society for Transplantation and Cellular Therapy; **AST,** aspartate aminotransferase; **CTCAE,** Common Terminology Criteria for Adverse Events; **MedDRA,** Medical Dictionary for Regulatory Activities; **SAE,** serious adverse event; **TEAE,** treatment-emergent adverse event

- Low rate of dose reductions and treatment discontinuation due to TEAEs
- Events were predominately confined to the priming dose period
- Most common Grade ≥3 TEAEs were asymptomatic, transient transaminase increases

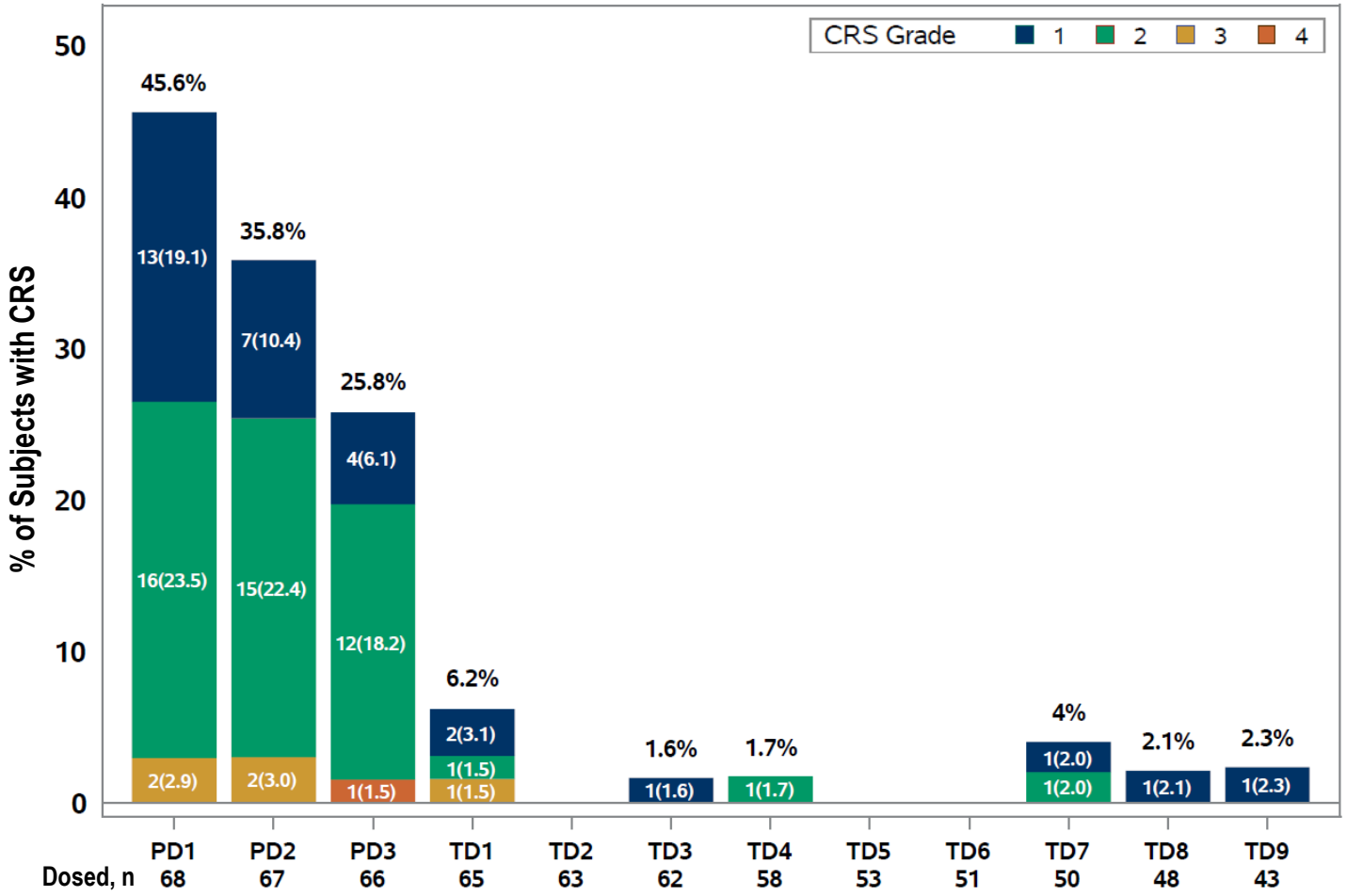
TEAEs reported in >25% Subjects by Maximum Severity Grade

Expansion Doses (n=68)	Any Incidence		>Day 29 Onset	
Preferred Term, n (%)	**All grades**	**Grade ≥3**	**All grades**	**Grade ≥3**
Rash (combined term)[1]	62 (91.2)	15 (22.1)	20 (29.4)	2 (2.9)
Cytokine release syndrome	46 (67.6)	4 (5.9)	12 (17.6)	1 (1.5)
ALT increased	36 (52.9)	23 (33.8)	12 (17.6)	7 (10.3)
Nausea	35 (51.5)	-	9 (13.2)	-
AST increased	33 (48.5)	24 (35.3)	10 (14.7)	6 (8.8)
Oedema peripheral	31 (45.6)	-	11 (16.2)	-
Vomiting	30 (44.1)	-	7 (10.3)	-
Diarrhoea	28 (41.2)	2 (2.9)	9 (13.2)	2 (2.9)
Fatigue	27 (39.7)	-	11 (16.2)	-
Headache	23 (33.8)	-	10 (14.7)	-
Hypophosphataemia	20 (29.4)	1 (1.5)	8 (11.8)	-
Hypotension	20 (29.4)	5 (7.4)	3 (4.4)	1 (1.5)
Pruritus	19 (27.9)	-	7 (10.3)	-
Chills	18 (26.5)	-	11 (16.2)	-
Cough	18 (26.5)	-	10 (14.7)	-

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Cytokine release syndrome (CRS)

CRS by Max Grade & Dose (n=68)



- CRS was predominately low-grade and occurred during priming
- No dose delays and one treatment discontinuation due to CRS
- Premedications for XmAb819:
  - Acetaminophen, diphenhydramine, and IV normal saline
  - Dexamethasone prior to priming doses
  - Tocilizumab prior to priming dose 1 (PD1)
- Graded per ASTCT consensus criteria; managed per institutional standards, or NCCN guidelines when local standards were absent

Subjects who received ≥1 protocol-specified dose of XmAb819 were included in the safety analysis. Data cut-off: **01 September 2026.** Excludes 1 participant who experienced approximately 10-fold higher exposure than intended at the first and only dose administered, and who subsequently developed Grade 4 CRS and discontinued treatment. Reported TEAEs were defined per MedDRA and CTCAE; CRS graded ASTCT[1]. Per-protocol PK samples were not collected for subject in plot (left) with reported Grade 4 CRS at priming dose 3; drug exposure could not be determined. Two subjects each experienced 2 events of Grade ≥3 CRS.

[1]Lee DW, et al. Biol Blood Marrow Transplant. 2019;25:625-638.

ASTCT, American Society for Transplantation and Cellular Therapy; **CRS,** cytokine release syndrome, **CTCAE,** Common Terminology Criteria for Adverse Events; **MedDRA,** Medical Dictionary for Regulatory Activities; **NCCN,** National Comprehensive Cancer Network; **PD**, priming dose, **TEAE,** treatment-emergent adverse event; **TD**, target dose

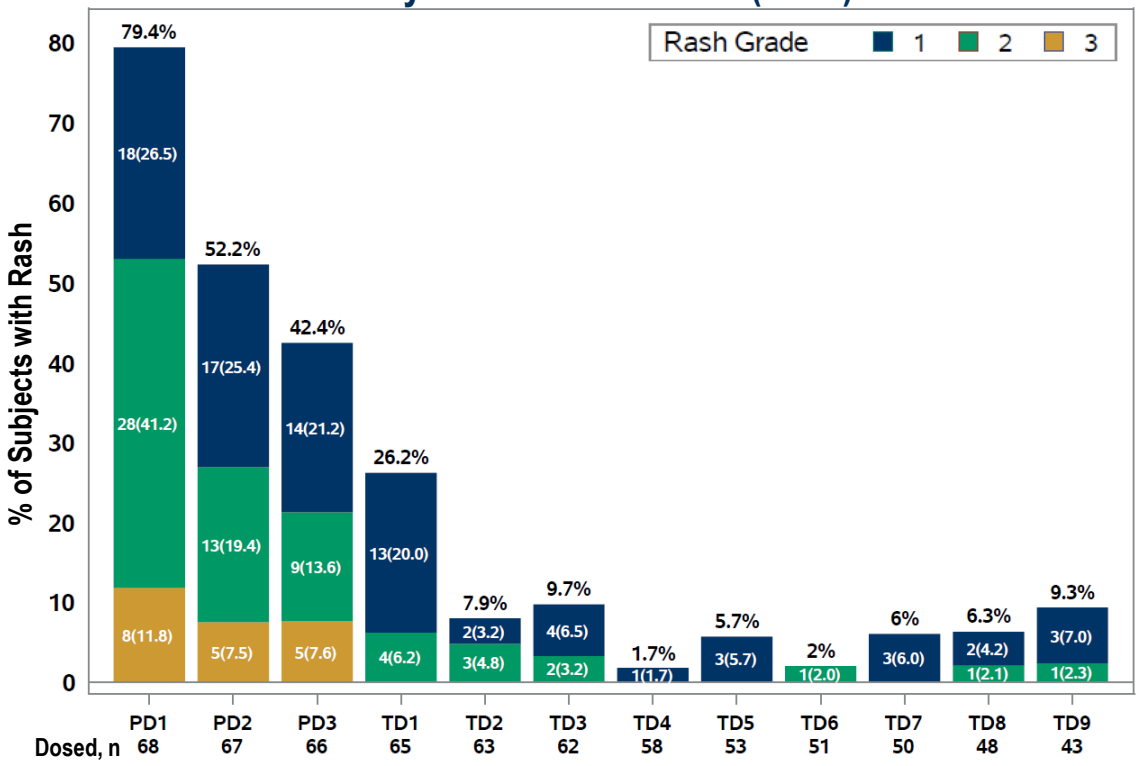
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Cytokine-driven adverse events

- Rash, an on-target effect due to ENPP3 expression on basophils and mast cells, is well managed with daily antihistamine (oral) and steroids (topical & oral).
- Dose delays due to rash occurred in 4.4% of subjects, with no treatment discontinuations.

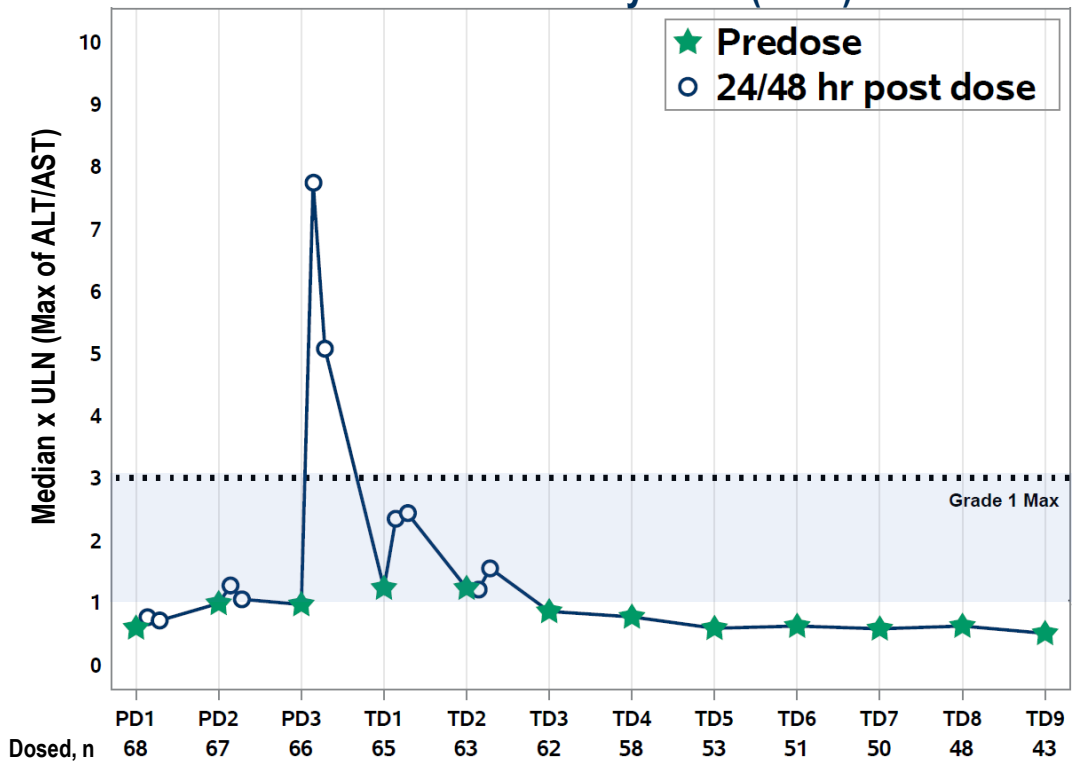
- Transaminase elevations were asymptomatic, transient, and self-limited, with a median time to resolution of 7 days and no clinical sequelae.
- Dose delays due to transaminase elevations occurred in 14.7% of subjects, with no treatment discontinuations.

Rash by Max Grade & Dose (n=68)



Combined rash terms (10 PTs): rash (unspecified, maculo-papular, erythematous, macular, morbilliform, pustular, pruritic, anal), erythema, dermatitis acneiform. Reported TEAEs were defined per MedDRA and CTCAE. Data cut-off: **01 September 2026.**

Transaminase kinetics by Dose (n=68)

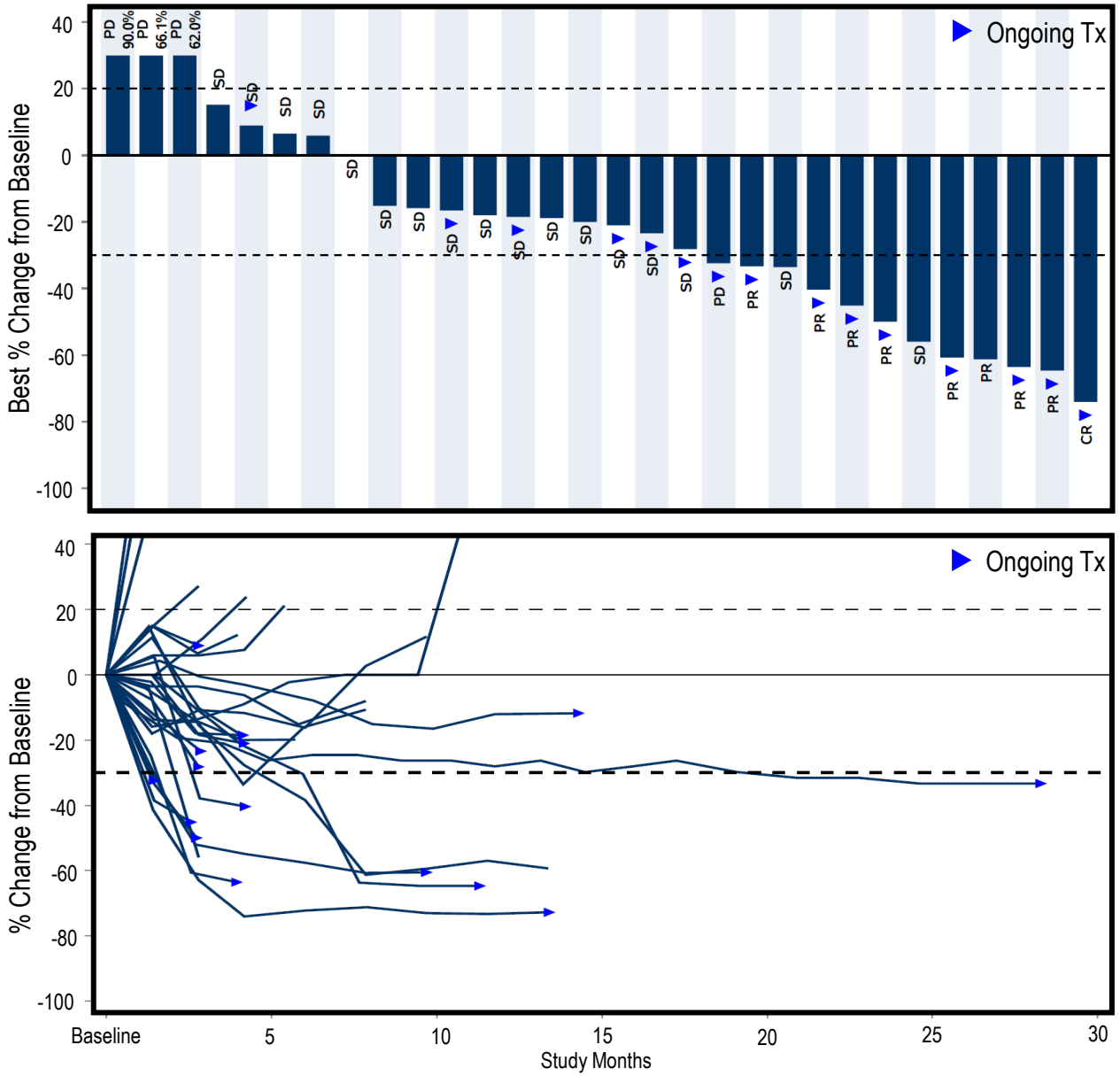


Median of the per-subject maximum of ALT and AST (central laboratory), expressed as ×ULN, among subjects with an available result at each timepoint. Data cut-off: **01 September 2026.**

PD, priming dose; **TD**, target dose

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Antitumor activity at target dose of 100 µg/kg



Efficacy Evaluable	100 µg/kg (n = 30)
Confirmed ORR, % (95% CI)	**30.0 (14.7, 49.4)**
BOR, n (%)	
CR	1 (3.3)
PR	8 (26.7)
SD	17 (56.7)
PD	4 (13.3)
DCR, % (95% CI)	86.7 (69.3, 96.2)
Median follow-up, months (range)	4.1 (1.1, 28.3)

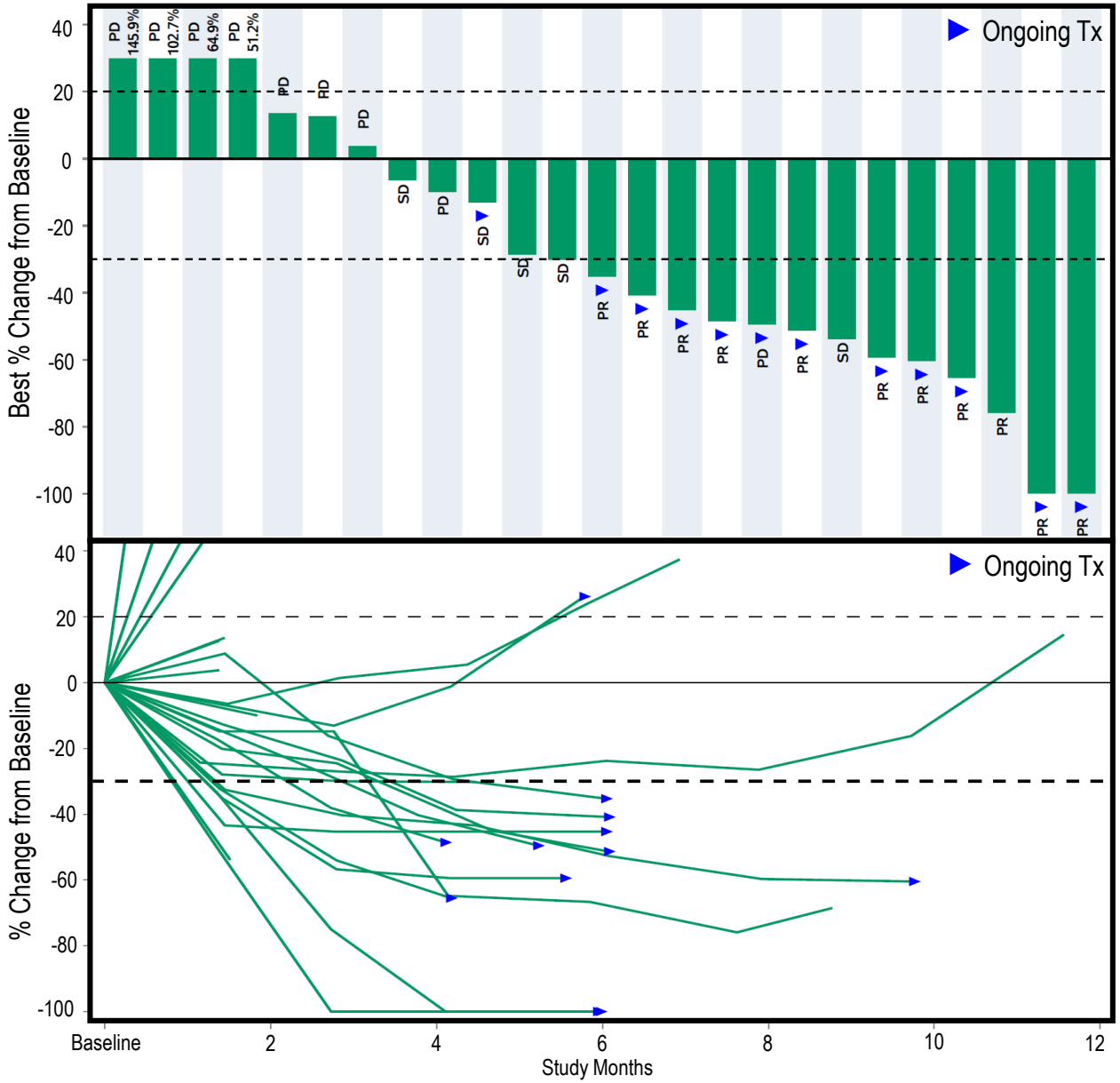
Efficacy analysis includes subjects with ≥1 protocol-specified dose of XmAb819 and ≥1 post-baseline tumor assessment. Confirmed responses per investigator assessment, RECIST v1.1. Data cut-off: **01 September 2026.** CR subject has two resolved lymph node target lesions with residual mass <10 mm.

BOR, best overall response; **CR**, complete response; **DCR,** disease control rate; **ORR,** objective response rate; **PD**, progressive disease; **PR**, partial response; **SD**, stable disease; **Tx**, treatment

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Antitumor activity at target dose of 200 µg/kg



Efficacy Evaluable[1]	200 µg/kg (n = 25)
Confirmed ORR, % (95% CI)	**44.0 (24.4, 65.1)**
BOR, n (%)	
CR	-
PR	11 (44.0)
SD	5 (20.0)
PD	9 (36.0)
DCR, % (95% CI)	64.0 (42.5, 82.0)
Median follow-up, months (range)	4.5 (0.8, 11.6)

Efficacy analysis includes subjects with ≥1 protocol-specified dose of XmAb819 and ≥1 post-baseline tumor assessment. Confirmed responses per investigator assessment, RECIST v1.1. Data cut-off: **01 September 2026.**

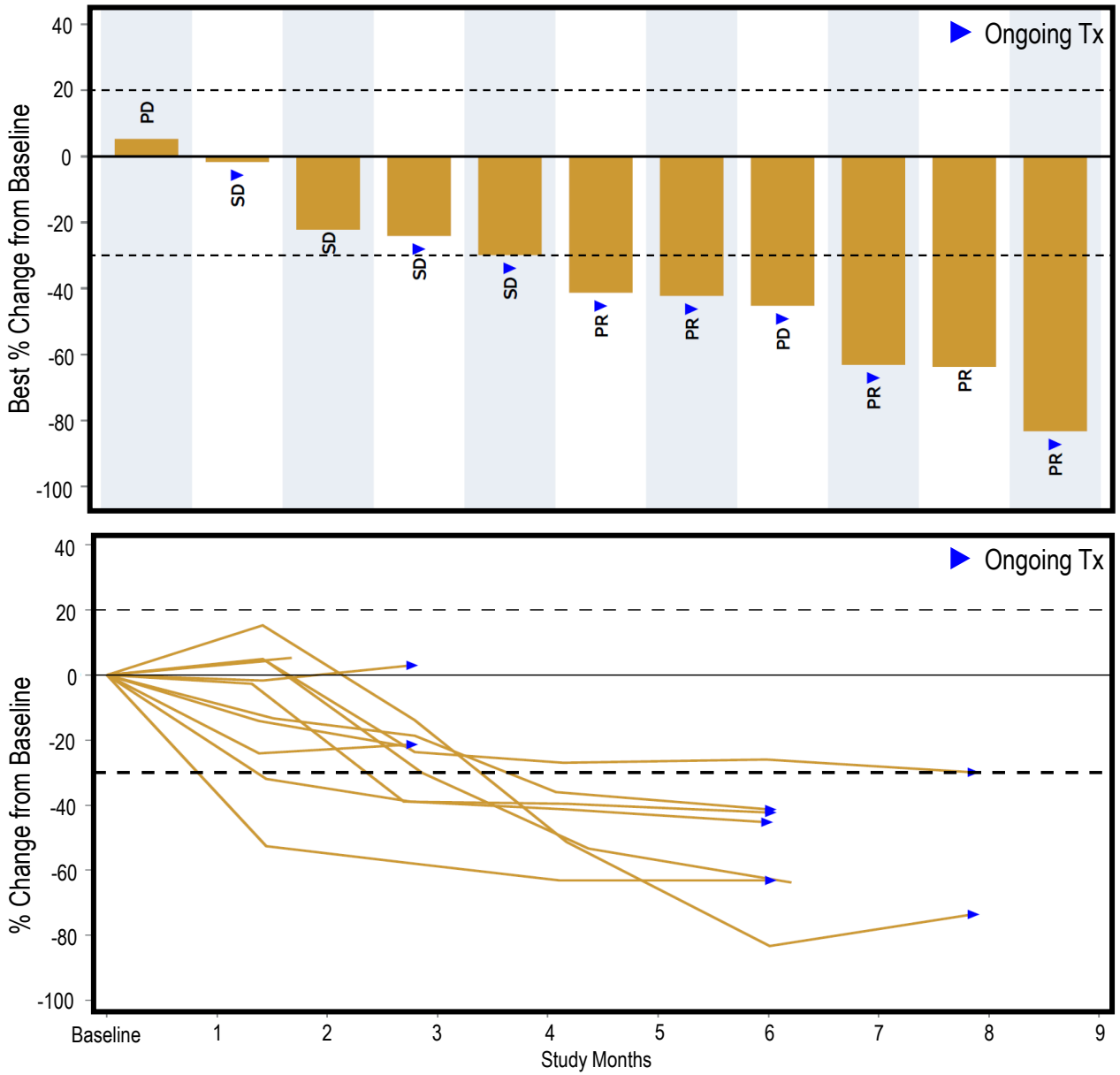
[1]Two subjects at 200 µg/kg discontinued treatment without a post-baseline response assessment and without documented progression.

BOR, best overall response; **CR**, complete response; **DCR,** disease control rate; **ORR,** objective response rate; **PD**, progressive disease; **PR**, partial response; **SD**, stable disease; **Tx**, treatment

Pal SK, et al.

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Antitumor activity at target dose of 400 µg/kg



Efficacy Evaluable	400 µg/kg (n = 11)
Confirmed ORR, % (95% CI)	**45.5 (16.8, 76.6)**
BOR, n (%)	
CR	-
PR	5 (45.5)
SD	4 (36.4)
PD	2 (18.2)
DCR, % (95% CI)	81.8 (48.2, 97.7)
Median follow-up, months (range)	6.0 (1.4, 7.9)

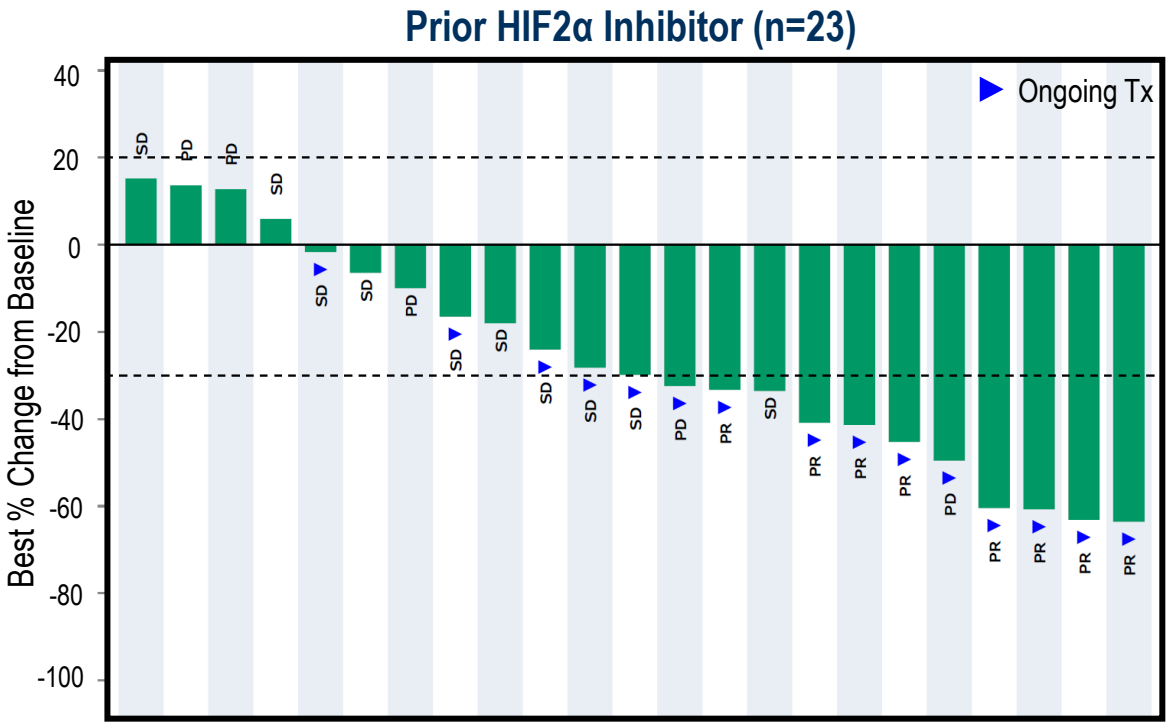
Efficacy analysis includes subjects with ≥1 protocol-specified dose of XmAb819 and ≥1 post-baseline tumor assessment. Confirmed responses per investigator assessment, RECIST v1.1. Data cut-off: **01 September 2026.**

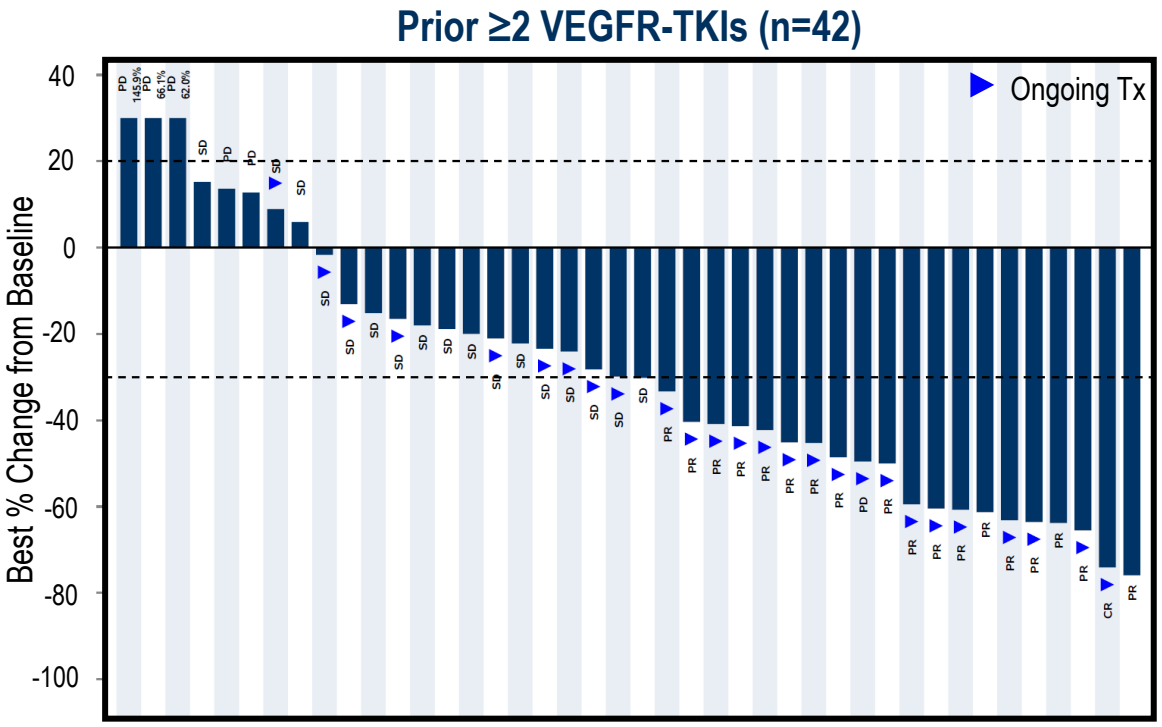
BOR, best overall response; **CR**, complete response; **DCR,** disease control rate; **ORR,** objective response rate; **PD**, progressive disease; **PR**, partial response; **SD**, stable disease; **Tx**, treatment

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Antitumor activity of 100-400 µg/kg doses in prior therapy subgroups





Expanded Doses	Prior HIF2α (n = 23)	≥2 VEGFR-TKIs (n=42)
Confirmed ORR, % (95% CI)	**34.8 (16.4, 57.3)**	**45.2 (29.9, 61.3)**
DCR, % (95% CI)	78.3 (56.3, 92.5)	85.7 (71.5, 94.6)

Efficacy analysis includes subjects with ≥1 protocol-specified dose of XmAb819 and ≥1 post-baseline tumor assessment. Confirmed responses per investigator assessment, RECIST v1.1. Data cut-off: **01 September 2026.** CR subject has two resolved lymph node target lesions with residual mass <10 mm.

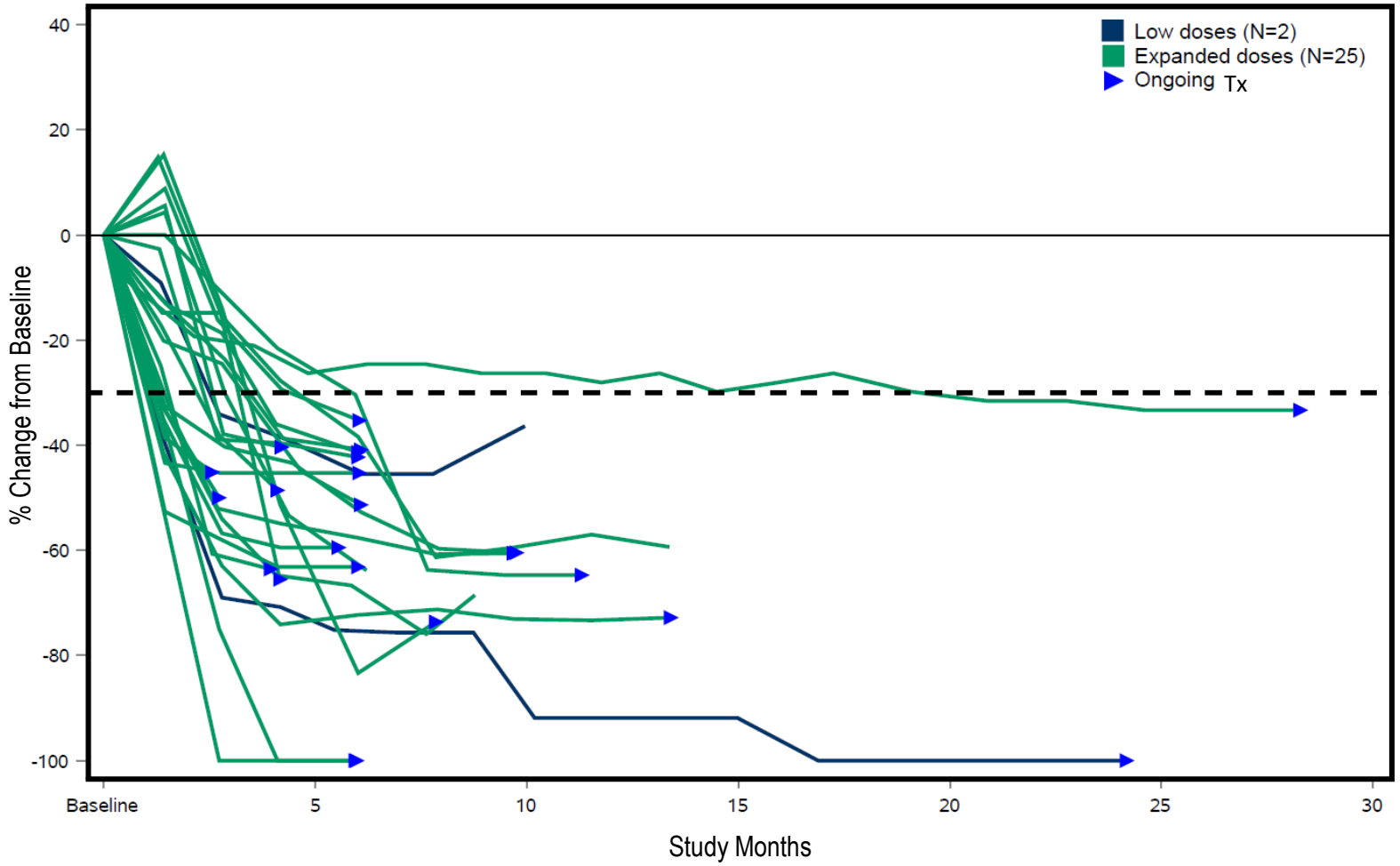
DCR, disease control rate; **HIF2α,** hypoxia-inducible factor 2-alpha; **ORR,** objective response rate; **TKI,** tyrosine kinase inhibitor; **Tx**, treatment; **VEGFR,** vascular endothelial growth factor receptor

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Depth and duration of responses

Spider Plot of Confirmed Responders Across All IV Doses (n = 27)



Responders	Expansion Doses (n=25)
Ongoing Responses, n (%)	19 (76.0)
Median TTR, months (range)	2.7 (1.3, 20.9)
Median time on treatment, months (range)	7.0 (3.4, 28.3)

Efficacy analysis includes subjects with ≥1 protocol-specified dose of XmAb819 and ≥1 post-baseline tumor assessment. Confirmed responses per investigator assessment, RECIST v1.1. Data cut-off: **01 September 2026.**

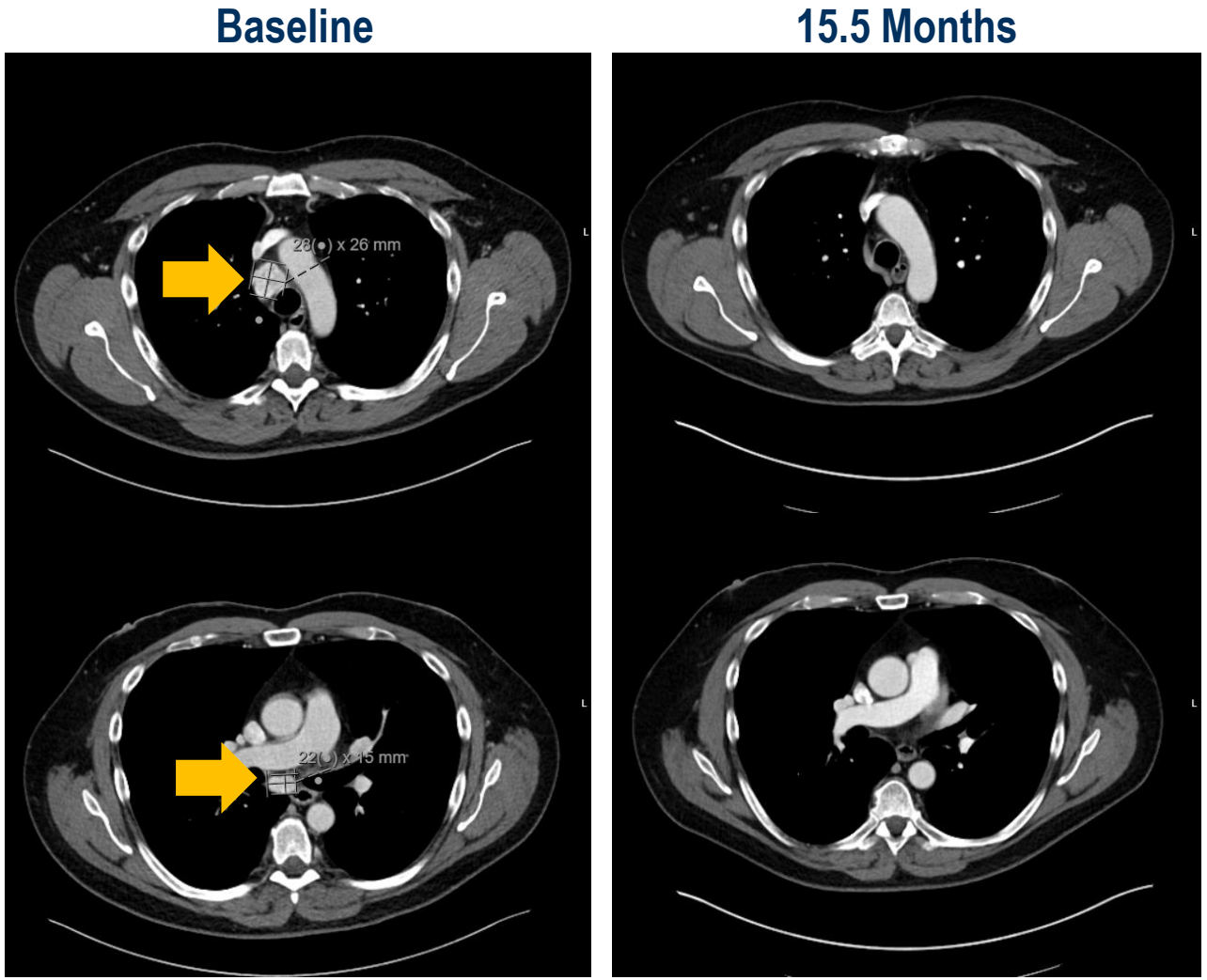
TTR, time to response; **Tx**, treatment

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Patient case study: Deepening of response over time

- **Background:** Male, 57 years old, RCC diagnosed 10 years ago, metastatic disease ~5 years ago
- **Prior therapy:** 2 prior therapy lines
  cabozantinib + nivolumab (1 mo) → progression
  & lenvatinib + everolimus (3 yrs) → progression
- **Baseline:** Two enlarged mediastinal lymph nodes
  both > 2 cm longest diameter
  multiple small lung and pancreas lesions
  membrane ENPP3+ <25% tumor cells
- **Response:** PR week 6, deepened to CR week 42
  normalization of lymph nodes
  disappearance of lung and pancreas lesions
- **Treatment and response ongoing at month 16**



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Conclusions

- XmAb819 (ENPP3 x CD3) showed meaningful antitumor activity in patients with advanced ccRCC.
- Antitumor activity was observed in a dose-dependent manner, with a cORR of 30% at 100 µg/kg, 44% at 200 µg/kg, and 45% at 400 µg/kg, and a majority of responses ongoing at data cut.
- Consistent activity in subgroups with prior exposure to HIF2α inhibitors (cORR 35%) and ≥2 VEGFR-TKIs (cORR 45%).
- These data support continued development of XmAb819 as a monotherapy for advanced clear cell RCC and evaluation of rational combination strategies in earlier lines of treatment.

cORR, confirmed objective response rate; **HIF2α,** hypoxia-inducible factor 2-alpha; **TKI,** tyrosine kinase inhibitor; **VEGF,** vascular endothelial growth factor receptor

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Additional Results

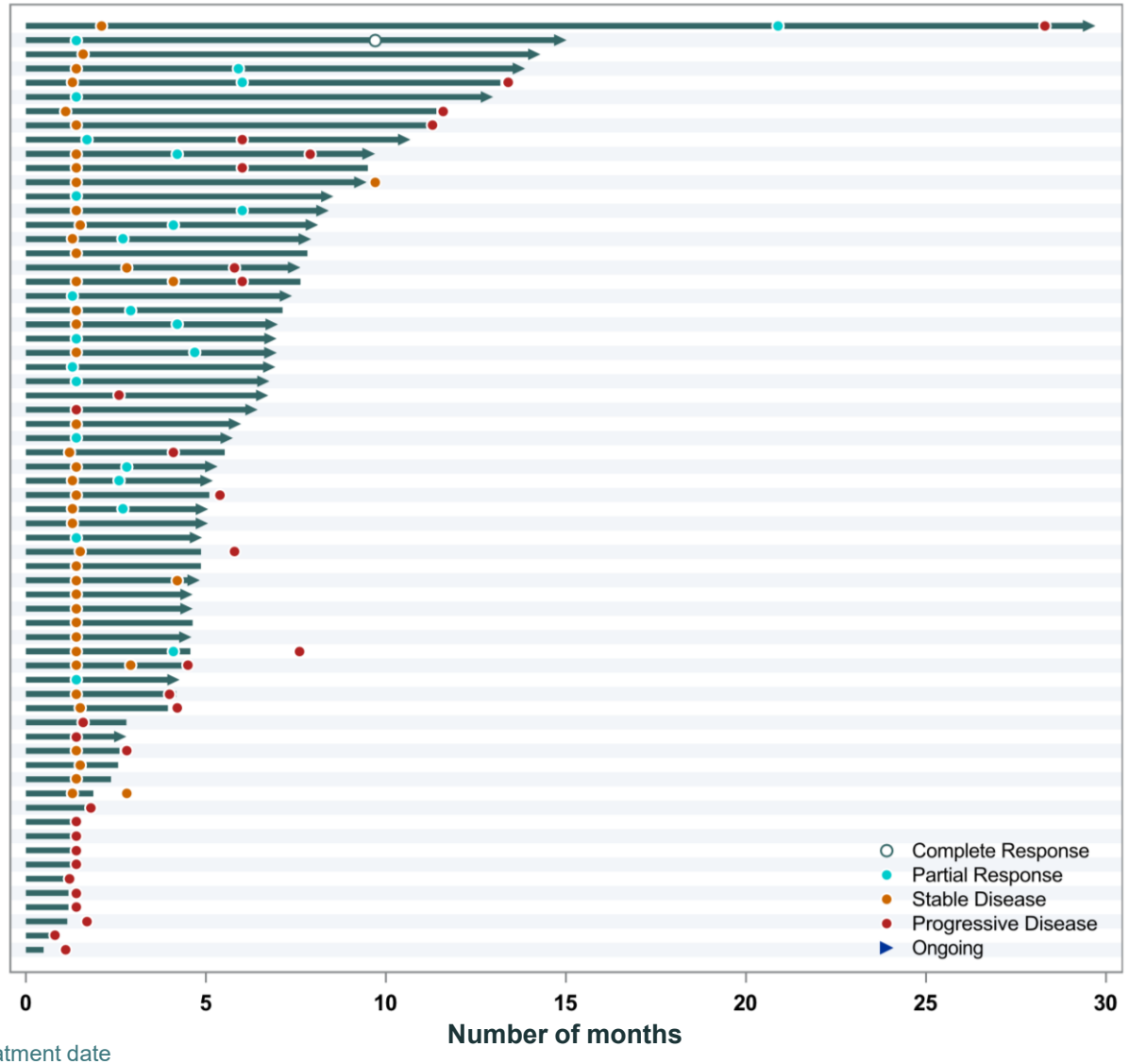


Durable disease control observed in heavily pre-treated advanced ccRCC population

7.9 month
median time-on-treatment[1]

Current follow-up for the consolidated IV target dose patient population (expanded doses: 100, 200 and 400 µg/kg)

n=66; 95% CI: 5.8, 13.4

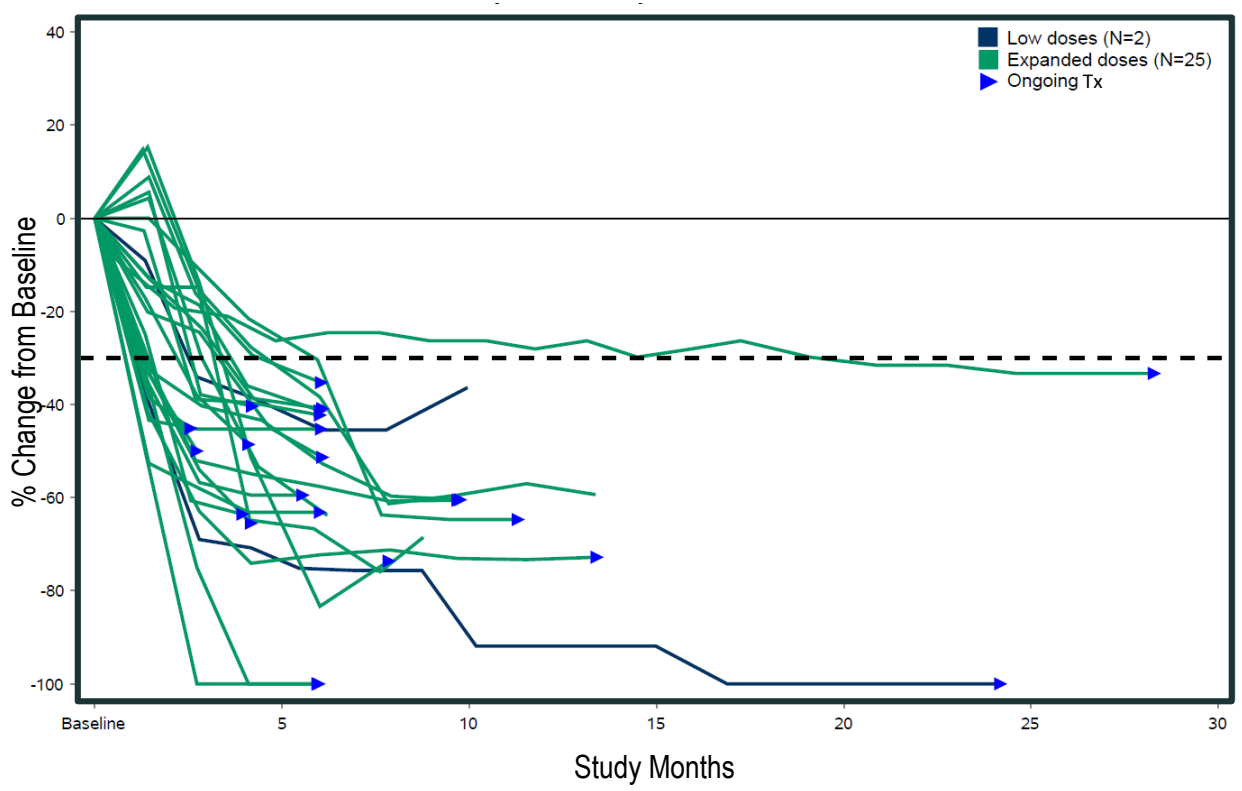


Data-cut: 01-Oct-2026 **1** Kaplan-Meier estimate of time-on-treatment defined as censor as of last treatment date or first event of progressive disease or death **ccRCC** clear cell renal cell carcinoma **CI** confidence interval

Deepening of response and new responses over time were common

- Consistent with sustained T-cell activation and low adverse event rate after priming period
- Combination of rapid disease control with potential for longer term deepening of response
- Response profile matured over several cycles: 25% of responders >4.2 months TTR

Spider Plot of Confirmed Responders Across All IV Doses (n = 27)

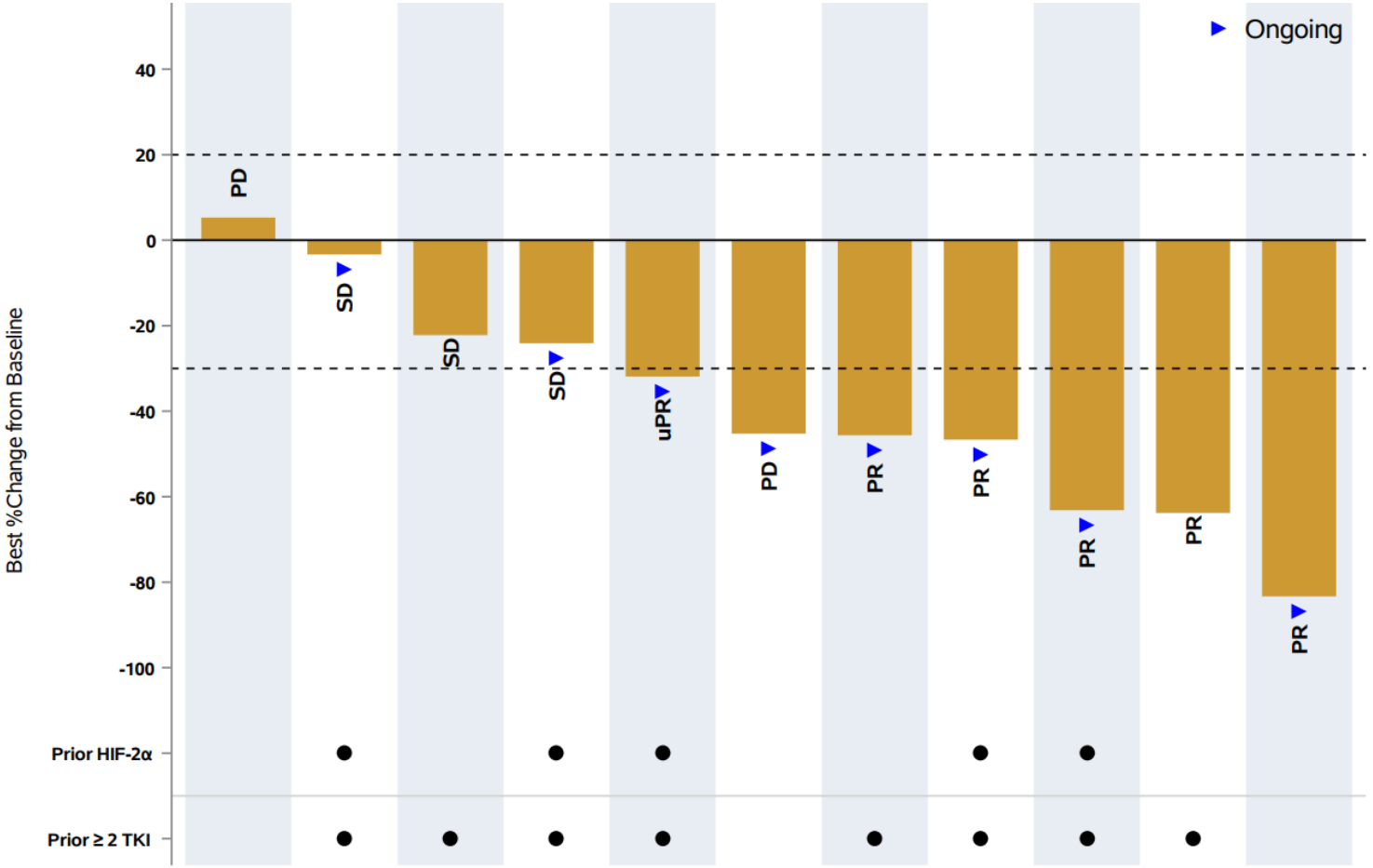


Time to Response (TTR)	% of Responders
>1.4 mo	75
>2.7 mo	50
>4.2 mo	25

TTR analysis for n=25 patients in Expanded Doses.
Data cut-off: **01 September 2026.**

400 µg/kg target dose is the proposed IV RP3D for XmAb819

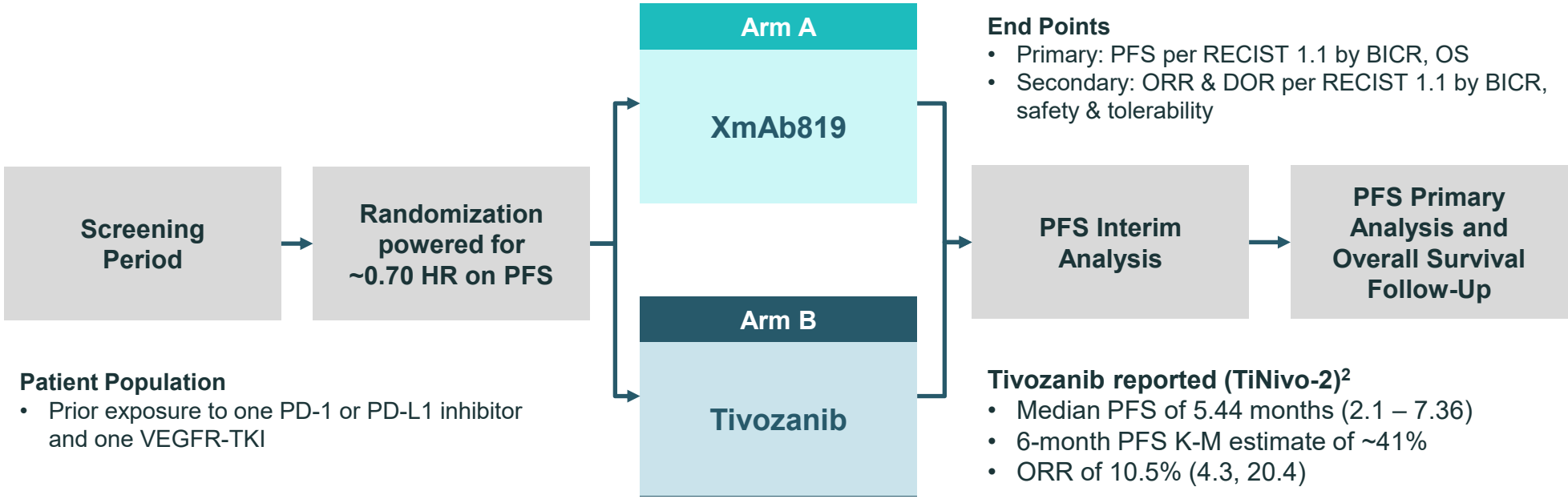
- 45% cORR plus additional week 42 conversion of a stable disease patient to uPR (uORR 55%)
- >80% DCR, low rate of primary progressive disease
- >70% of patients with treatment ongoing
- ~82% 6-month PFS K-M estimate at follow-up
- Median PFS is Not Reached
- Safety results: 400 µg/kg consistent with 200 µg/kg and 100 µg/kg target dose cohorts
- Enrollment complete in 400 µg/kg expansion cohort
- Data from the full 400 µg/kg IV analysis set expected during 1H2027 (20+ patients)



Data-cut: 01-Oct-2026 **cORR** confirmed objective response rate **DCR** disease control rate **IV** intravenous **K-M** Kaplan-Meier **PFS** progression free survival **RP3D** recommended Phase 3 dose **uORR** unconfirmed objective response rate **uPR** unconfirmed partial response

Global randomized control trial with a tivozanib control arm could potentially support BLA submission seeking a post IO-TKI label[1]

Proposed Phase 3 study design to evaluate XmAb819 compared to tivozanib in post IO-TKI patient population



End Points
- Primary: PFS per RECIST 1.1 by BICR, OS
- Secondary: ORR & DOR per RECIST 1.1 by BICR, safety & tolerability

Patient Population
- Prior exposure to one PD-1 or PD-L1 inhibitor and one VEGFR-TKI

Tivozanib reported (TiNivo-2)[2]
- Median PFS of 5.44 months (2.1 – 7.36)
- 6-month PFS K-M estimate of ~41%
- ORR of 10.5% (4.3, 20.4)

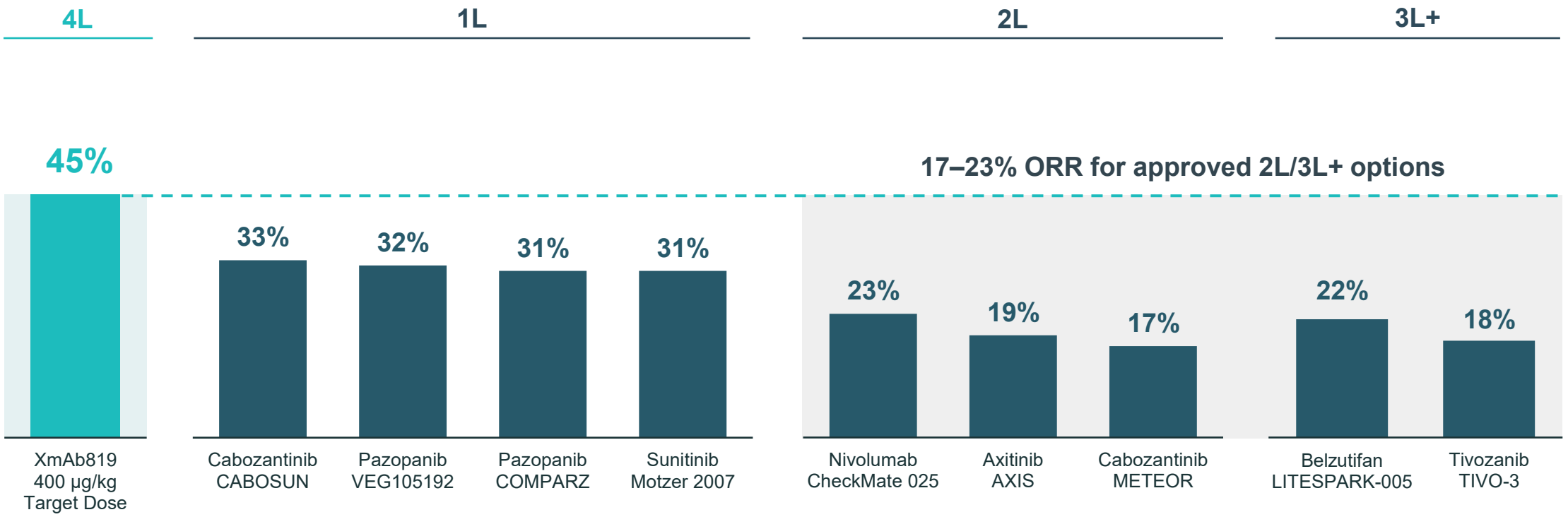
3L sub-group analysis of TiNivo-2 provides a basis for expectations of standard dose tivozanib outcomes in a contemporary post IO-TKI patient population

1 Study design and registrational potential subject to further interactions with FDA **2** Final analysis of the TiNivo-2 phase 3 trial: Long-term outcome of Tivozanib (Tivo) in patients with metastatic renal cell carcinoma (mRCC); Motzer and Choueiri et al; ASCO 2026. **BICR** blinded independent central review **BLA** biologics license application **DOR** duration of response **HR** hazard ratio **IO** immuno-oncology **K-M** Kaplan-Meier **ORR** objective response rate **OS** overall survival **PFS** progression free survival **QD** every day **RECIST** response evaluation criteria in solid tumors **TKI** tyrosine kinase inhibitor **VEGFR** VEGF receptor

XmAb819 Development Strategy

45% cORR in advanced ccRCC exceeds monotherapy benchmarks despite a more heavily pre-treated patient population

ORR for XmAb819 compared to NCCN guideline recommended monotherapy treatments for advanced ccRCC[1]



1 Cross-trial comparison for illustration only and is not based on head-to-head studies; trials differ in design, population and response assessment, and strong caution should be exercised when comparing data across unrelated trials. Comparators: **AXIS** Rini Lancet 2011 **CABOSUN** Choueiri JCO 2017; investigator-assessed, 20% by IRC **CheckMate 025** Motzer Cancer 2020 **COMPARZ** Motzer NEJM 2013; Motzer NEJM 2007 **LITESPARK-005** Choueiri NEJM 2024; 1–3 prior regimens **METEOR** Choueiri Lancet Oncol 2016 **TIVO-3** Rini Lancet Oncol 2020 **VEG105192** Sternberg JCO 2010, treatment-naïve subgroup **ccRCC** clear cell renal cell carcinoma **XmAb819** XmAb819-01 Phase 1, 400 µg/kg IV target dose (**Data cut Oct 01, 2026**) **cORR** confirmed objective response rate **NCCN** National Comprehensive Cancer Network **ORR** objective response rate

XmAb819 demonstrated favorable balance of response to primary progressive disease despite enrolling a poorer prognosis patient population

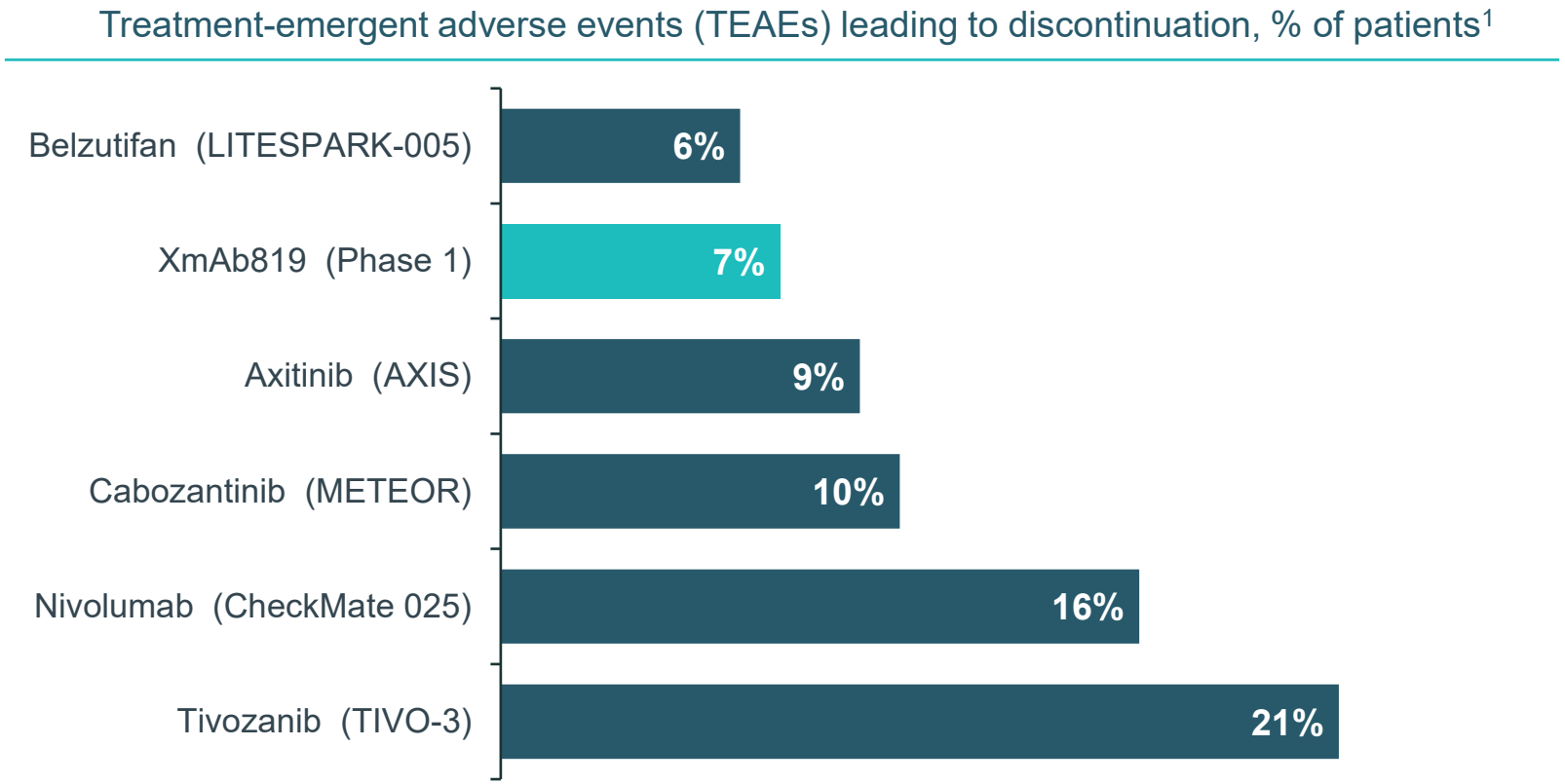
Agent / trial[1]	Intermediate-to-poor risk[2]	◄ Primary progression	Objective response ►	Net (ORR − PD)
XmAb819 Phase 1 study, 400 µg/kg IV	**82%**	18%	45%	**+27%**
Cabozantinib METEOR	57%	14%	17%	**+3%**
Axitinib AXIS	70%	22%	19%	**-3%**
Tivozanib TIVO-3	80%	22%	18%	**-4%**
Belzutifan LITESPARK-005	78%	34%	22%	**-12%**
Nivolumab CheckMate 025	65%	35%	23%	**-12%**

XmAb819 high objective response rate relative to primary progression supports earlier line development as a monotherapy treatment

1 Cross-trial comparison for illustration only and is not based on head-to-head studies; trials differ in design, population and response assessment, and strong caution should be exercised when comparing data across unrelated trials **2** Risk group per IMDC or MSKCC as reported by each trial Comparators: **AXIS** Rini Lancet 2011 **CheckMate 025** Motzer NEJM 2015 **LITESPARK-005** Choueiri NEJM 2024 **METEOR** Choueiri NEJM 2015 **TIVO-3** Rini Lancet Oncol 2020 **XmAb819** XmAb819-01 Phase 1, all treated patients (**Data-cut 01-Oct-2026**)

xencor

XmAb819 was well tolerated with a low rate of discontinuations due to adverse events compared to third party studies of approved monotherapy ccRCC therapies

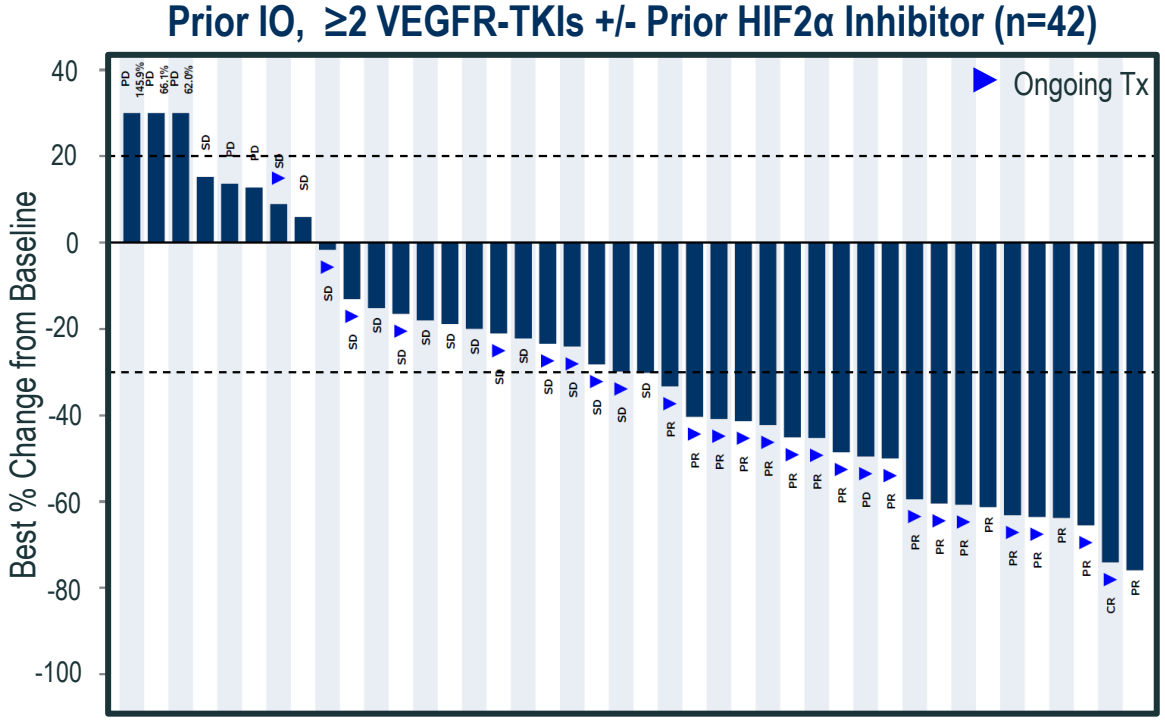


Fewer discontinuations compared with those reported in certain studies of most approved later-line therapies, with no dose reductions required for toxicity management at target dose

1 Cross-trial comparison for illustration only and is not based on head-to-head studies; trials differ in design, population, exposure duration and AE attribution (any-cause vs. treatment-related), and strong caution should be exercised when comparing data across unrelated trials. Comparators: **AXIS** Rini Lancet 2011 **CheckMate 025** Motzer NEJM 2015 **LITESPARK-005** Choueiri NEJM 2024 **METEOR** Choueiri NEJM 2015 **TIVO-3** Rini Lancet Oncol 2020 **XmAb819** XmAb819-01 Phase 1, all treated patients (**Data-cut 01-Oct-2026**) **ccRCC** clear cell renal cell carcinoma

Xencor plans to discuss accelerated approval pathway for XmAb819 based on efficacy results in key sub-groups

- No guideline-recommended treatments exist post PD-1/PD-L1 inhibitor plus ≥2 VEGFR-TKIs, or post PD-1/PD-L1 inhibitor, VEGFR-TKI, and HIF2α inhibitor (triple-class exposed)
- Estimated addressable population of ~9,200 US patients who were treated post PD-1/PD-L1 inhibitor and ≥2 prior VEGFR-TKIs in 2025[1]
- Triple-class exposed population is smaller but growing, driven by approval of belzutifan + lenvatinib post PD-1/PD-L1 inhibitor (LITESPARK-011)



Expanded Doses	Prior HIF2α (n = 23)	≥2 VEGFR-TKIs (n=42)
Confirmed ORR, % (95% CI)	**34.8 (16.4, 57.3)**	**45.2 (29.9, 61.3)**
DCR, % (95% CI)	78.3 (56.3, 92.5)	85.7 (71.5, 94.6)

Efficacy analysis includes subjects with ≥1 protocol-specified dose of XmAb819 and ≥1 post-baseline tumor assessment. Confirmed responses per investigator assessment, RECIST v1.1. Data cut-off: **01 September 2026.** CR subject has two resolved lymph node target lesions with residual mass <10 mm.

DCR, disease control rate; **HIF2α,** hypoxia-inducible factor 2-alpha; **ORR,** objective response rate; **TKI,** tyrosine kinase inhibitor; **Tx**, treatment; **VEGFR,** vascular endothelial growth factor receptor

1 Komodo Health claims data; nationally weighted U.S. patient estimates for 2025

Development plan for XmAb819 to become the backbone of ccRCC treatment

Establish XmAb819 Monotherapy Post IO-TKI

Phase 1 Part	Description	Patient population	U.S. Patient opportunity[1]	Status	Expected Milestone or Readout
A & B	IV monotherapy	**Post-IO + TKI**	**~23.9K**	Ongoing	End of Phase 1 meeting 1H 2027

Post Front-line IO-IO for IMDC Intermediate – Poor Risk Patients

Phase 1 Part	Description	Patient population	U.S. Patient opportunity[1]	Status	Expected Milestone or Readout
D	2L ccRCC	**Post-1L nivolumab/ipilimumab (TKI-naïve)**	**~9.4K**	Ongoing	Proof of concept data 2027

PD-1 Proof-of-concept Combination for Future 1L study

Phase 1 Part	Description	Patient population	U.S. Patient opportunity[1]	Status
F	Nivolumab combination	**1L opportunity for novel IO-TCE combination**	**~30.1K**	Planned

Increase Clinical Convenience

Phase 1 Part	Description	Patient population	Status	Expected Milestone or Readout
A & B	SC monotherapy	Post-IO + TKI	Ongoing	End of Phase 1 meeting 1H 2027
A & E	Q3W IV / reduced hospitalization	Post-IO + TKI	Planned	–

1 Komodo Health claims data; nationally weighted U.S. patient estimates for 2025 **ccRCC** clear cell renal cell carcinoma **IO** immuno-oncology **IV** intravenous **TCE** T-cell engager **TKI** tyrosine kinase inhibitor **SC** subcutaneous **Q3W** every 3 weeks **1H** first-half

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Global RCC drug market is an estimated ~$11.7B annualized opportunity

TKI Class	IO Class	HIF2α Class
~$5B[1]	~$5.6B[2]	~$1.1B[3]
cabozantinib, lenvatinib, axitinib, sunitinib, pazopanib, tivozanib	nivolumab, pembrolizumab, ipilimumab, avelumab	belzutifan



1 Estimate based on 2025 cabozantinib net product revenue and RCC market share internal estimates from Xencor **2** Estimate based on annualized Q2'26 global nivolumab sales and Komodo RCC market claims data **3** Estimate based on annualized Q2'26 global belzutifan sales **IO** immuno-oncology **RCC** renal cell carcinoma **TKI** tyrosine kinase inhibitor

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ENPP3+ expansion programs add significant development opportunities

U.S. 2030 TAM in ENPP3+[1] papillary RCC, MSS colorectal cancer and NSCLC **+$4.5B**



2L/3L Papillary RCC

U.S. 2030 TAM

~$0.5B

> 50% ENPP3+[1]

SoC: cabozantinib



3L MSS Colorectal Cancer

U.S. 2030 TAM

+$1B

> 50% ENPP3+[1]

SoC: regorafenib, fruquintinib or FTD/TPI + bevacizumab



2L/3L NSCLC

U.S. 2030 TAM

+$3B

> 30% ENPP3+[1]

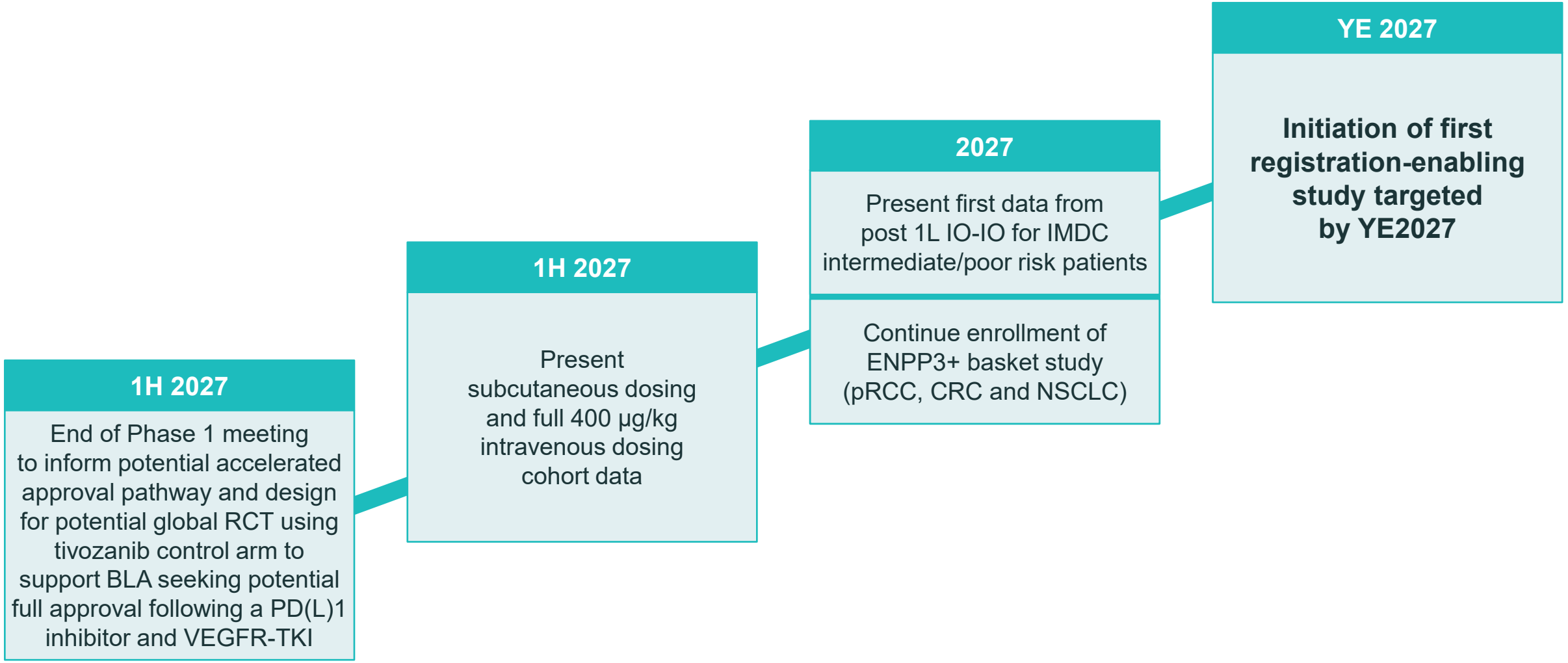
SoC: docetaxel post IO and/or targeted therapy for actionable mutations

Enrolling patients with pRCC, MSS CRC and NSCLC in Part C of the ongoing Phase 1 study

1 Estimates for U.S. ENPP3+ population based on H-Score of ≥25 cutoff **CRC** colorectal cancer **FTD/TPI** trifluridine/tipiracil **IO** immuno-oncology **MSS** microsatellite stable **NSCLC** non-small cell lung cancer **SoC** standard of care **TAM** total addressable market

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Expected 2027 plans include first potential registration-enabling study in ccRCC and further data from ongoing Phase 1 study cohorts



ccRCC clear cell renal cell carcinoma **CRC** colorectal cancer **IMDC** International mRCC Database Consortium **IO** immuno-oncology **NSCLC** non small cell lung cancer
pRCC papillary renal cell carcinoma **RCT** randomized control trial **TKI** tyrosine kinase inhibitor **VEGFR** VEGF receptor **YE** year-end **1H** first-half

Focus on clinical excellence is expected to deliver an accelerating pace of readouts across Xencor's pipeline through 2027

XmAb® Drug Candidate		Indication	2H2026	2027 (Planned)
Oncology Portfolio				
XmAb819	ENPP3 x CD3	ccRCC	Present RP3D monotherapy data at ESMO 2026 ✓	Initiate registration-enabling study
		Additional ENPP3+ tumors	Initiate tumor expansion cohorts for CRC, NSCLC and pRCC ✓	Safety and early assessment of efficacy
XmAb541 + XmAb808	CLDN6 x CD3 + B7-H3 x CD28	CLDN6+ HGSOC	Ongoing dose escalation ✓	Safety and early assessment of efficacy
Autoimmune Portfolio				
XmAb942	Xtend™ TL1A	IBD+	Update on progress achieved in Phase 2b XENITH-UC study ~YE26	Primary endpoint analysis in ~2H27
XmAb412	TL1A x IL23p19	IBD+	Initiate first-in-human study ✓	Phase 1 data Initiate Phase 2 Studies
Plamotamab	CD20 x CD3	Rheumatoid arthritis	Initial dose-escalation data from ongoing Phase 1b in RA at ACR	Updated data from ongoing escalation
XmAb657	CD19 x CD3	IIM, Sjögren's disease, Systemic sclerosis	Update on progress achieved in FIH dose-escalation study	Updated data from ongoing escalation

As of 26-Oct-2026 **ACR** American College of Rheumatology (Convergence 2026) **ccRCC** clear cell renal cell carcinoma **CRC** colorectal cancer **FIH** first-in-human **HGSOC** high-grade serous ovarian carcinoma **IBD** inflammatory bowel disease **IIM** idiopathic inflammatory myopathies **NSCLC** non-small cell lung cancer **pRCC** papillary renal cell carcinoma **RA** rheumatoid arthritis **RP3D** recommended Phase 3 dose

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Q&A



Designing Proteins
Delivering Medicines™

Updated Results from Dose Expansion Cohorts in the Phase 1 Study of XmAb819

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