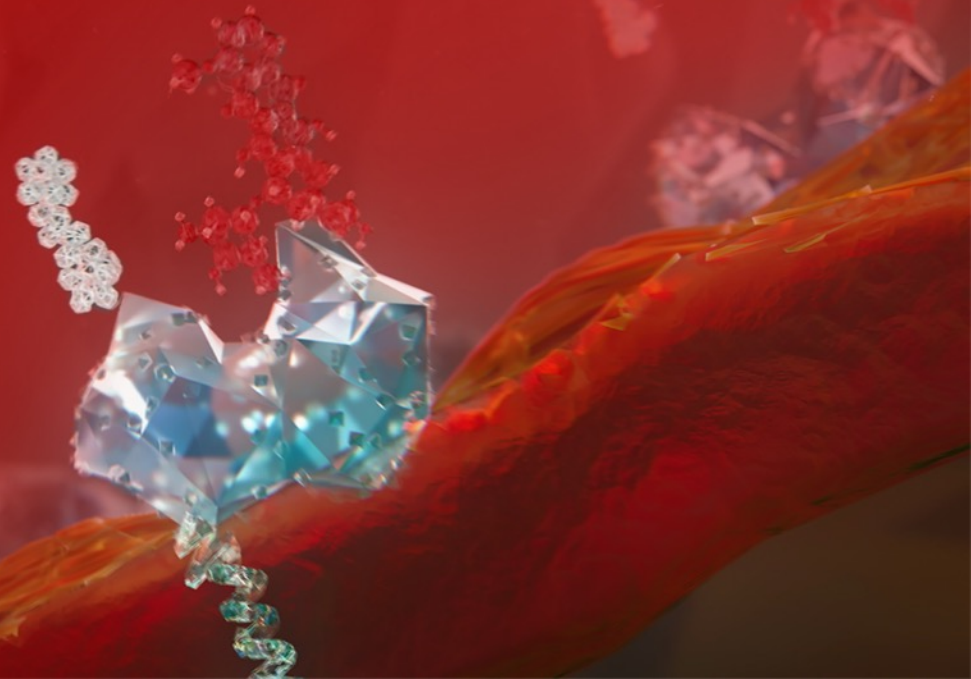
Preliminary Results for the Year Ending December 31st, 2023

and

Business Update

30th April 2024



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Avacta Appoints Christina Coughlin, MD, PhD as CEO

“I am confident that Chris is the right person to lead Avacta’s next chapter. Her deep understanding of drug development and the urgent unmet needs in oncology, her extensive scientific and clinical experience and her many years in leadership roles in this industry make her the ideal person to drive our strategy and present the Company’s truly innovative technology to the specialist healthcare investor audience”

Eliot Forster, PhD., Chairman of the Avacta Board of Directors

Avacta®

Leadership Team

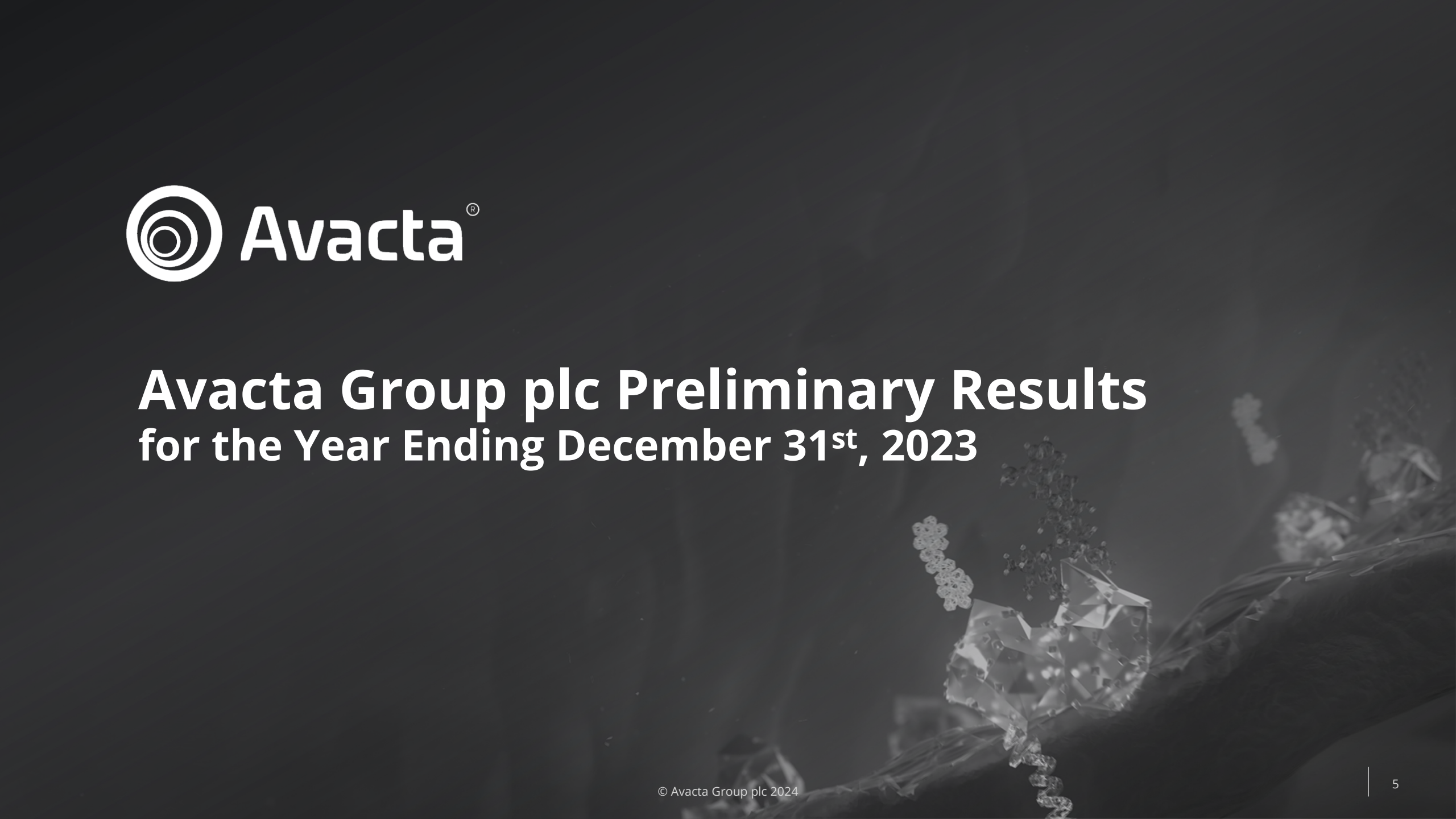
Christina Coughlin, MD, PhD
CEO

- Over 18 years' experience of oncology drug development in both biotech and large pharmaceutical companies
- Former CEO of CytoImmune Therapeutics and prior to that Chief Medical Officer of Rubius Therapeutics Tmunity and Immunocore
- Held other leadership roles in the pharmaceutical and biotechnology fields including at Pfizer and Novartis
- Oncologist and immunologist, having received her M.D. and Ph.D. from the University of Pennsylvania.

Tony Gardiner
CFO

- Over 25 years' senior financial and operational experience across multiple sectors
- Joined Avacta in 2016
- Prior to that Tony spent five years at AHR, an international architecture and building consultancy practice, where he held the role of Finance Director and he spent four years as CFO of AIM listed Fusion IP plc which was acquired by IPG Group plc
- Tony has also held senior finance roles within Eversheds LLP, KCOM Group Plc, Eldon Electric Ltd and Hickson International Plc

Avacta Group plc Preliminary Results
for the Year Ending December 31st, 2023



Preliminary Results for Year Ending 31st December 2023

Income Statement

- Launch Dx acquired October 2022; Coris BioConcept acquired June 2023.
- Increased gross profit from Dx of £7.3m, partially offset by reduction in Tx milestone payments from (£3.3m)[1]
- Pipeline progress driving increase in Tx R&D of £4.3m, offset by reduction in Dx R&D
- Excluding acquisitions SG&A down 3.5% versus FY22.
- Dx Adjusted EBITDA improving by £3.9m versus FY22. Expected to be EBITDA positive in 2H24.

	2023 (£m)	2022 (£m)	FY23 vs FY22 (£m)
Revenue	**23.3**	**9.7**	**+13.6**
Gross profit	**11.2**	**7.2**	**+4.0**
Research costs	(14.5)	(11.1)	(3.4)
S, G & A costs	(16.9)	(11.2)	(5.7)
Adjusted EBITDA	**(20.1)**	**(15.1)**	**(5.0)**
Amortisation and Depreciation	(4.2)	(8.2)	+4.0
SBP/Share of AffyXell losses	(4.0)	(9.4)	+5.4
Operating loss	**(28.4)**	**(32.6)**	**+4.2**
Financing/Taxation	3.5	(4.0)	+7.5
Retained loss	**(24.9)**	**(36.6)***	**+11.7**
Loss per share	9.15p	14.34p*	+5.19p

[1] FY22 Included Affyxell and LG Chem milestones.

* FY22 has been restated to reflect the recognition of a £2.6m deferred tax asset following the acquisition of Launch Diagnostics in 2022.

Preliminary Results for the Period Ending 31st December 2023

Operating Segment Analysis

	2023 (£m)				2022 (£m)			
	Tx	Dx	Central	Total	Tx	Dx	Central	Total
Revenue	**2.06**	**21.19**	**-**	**23.25**	**5.48**	**4.17**	**-**	**9.65**
Gross profit	**2.04**	**9.20**	**-**	**11.24**	**5.35**	**1.89**	**-**	**7.24**
Research costs	(13.11)	(1.42)	-	(14.53)	(8.79)	(2.31)	-	(11.10)
S, G & A costs	(2.49)	(8.96)	(5.40)	(16.85)	(2.40)	(4.71)	(4.12)	(11.23)
Adjusted EBITDA[1]	**(13.56)**	**(1.18)**	**(5.40)**	**(20.14)**	**(5.84)**	**(5.13)**	**(4.12)**	**(15.09)**
Amortisation/Depreciation	(1.28)	(2.89)	(0.01)	(4.18)	(1.28)	(6.88)	(0.02)	(8.18)
SBP[2]/Share of AffyXell losses	(2.59)	(0.36)	(1.09)	(4.04)	(3.86)	(1.44)	(4.08)	(9.38)
Operating loss	**(17.43)**	**(4.43)**	**(6.50)**	**(28.36)**	**(10.98)**	**(13.45)**	**(8.22)**	**(32.65)**

1 Adjusted EBITDA (before non-cash and non-recurring items)
2 SBP – Share based payments

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Preliminary Results for the Year Ending 31st December 2023

Cash Flow

- **Investing activities** - relates to the Coris acquisition (£6.9m), deferred acquisition payment re Launch tax receipt (£0.9m) and capex (£1.1m).
- **Financing activities -** reflects the receipts from employee option exercises £0.4m and lease/finance payments (£1.7m).
- **Cash at 31 March 2024 circa £38.0m** following the completion of the fundraise in March 2024 which generated £31.1m gross proceeds (£29.4m net proceeds).

	2023 (£m)	2022 (£m)
Cash/short term deposits at 1 January	**41.78**	**26.19**
Operating cash outflows	(14.87)	(16.43)
Investing activities	(9.00)	(25.04)
Financing activities	(1.30)	56.90
Other	0.01	0.16
Cash/short term deposits at 31 December	**16.63**	**41.78**

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Preliminary Results for the Year Ending 31st December 2023

Balance Sheet

- **Non-current assets** include PPE, IFRS16 leases re Avacta facilities, goodwill on the Launch and Coris acquisitions and investment in AffyXell.
- **Current assets** include FY23 R&D tax credit and Launch/Coris debtors/inventories.
- **Current liabilities** are predominately trade payables and accruals.
- **Non-current liabilities** are IFRS16 leases liabilities and asset finance liabilities.
- Unsecured convertible bond has 2 components – a debt value of £16.1m and a derivative value of £18.3m.
- Convertible bond outstanding following 6th amortisation on 22 April is now reduced to £35.7m (£55m at inception).

	2023 (£m)	2022 (£m)
Non-current assets	45.16	37.37
Current assets (exc. cash/deposits)	11.41	13.77
Cash/deposits	16.63	41.78
Current liabilities (exc. bond)	(10.69)	(9.78)
Convertible bond (debt & derivative)	(34.42)	(57.83)
Non-current liabilities	(6.28)	(4.31)
Net assets	**21.81**	**21.00**

Business Update

The Avacta Therapeutics Research and Development Team

Christina Coughlin, MD, PhD

Chief Executive Officer and Head of R&D

Chris is an oncologist and immunologist, trained at the University of Pennsylvania

She has >18 years of industry experience including >30 oncology INDs and approvals across small molecules to cell therapy in oncology

Simon Bennett, DPhil

Chief Business Officer

Simon is a biochemist with more than 26 years' commercial experience in biopharmaceuticals, supporting business development and corporate development. Simon has been involved in over 80 commercial deals across geographies

Karen Harrison, MBA

Chief Operating Officer

Karen has >30 years' experience in building successful teams and delivering all operational aspects of her teams Karen's focus is on value creation and global reach of companies, delivering transformational operational planning

David Jones, DPhil

VP and Head of Biology

David trained at the University of Birmingham in the science of oncology modeling with expertise in both *in vitro* and *in vivo* modeling of cancer biology

David has worked in models of human disease with more than 15 years' industry experience

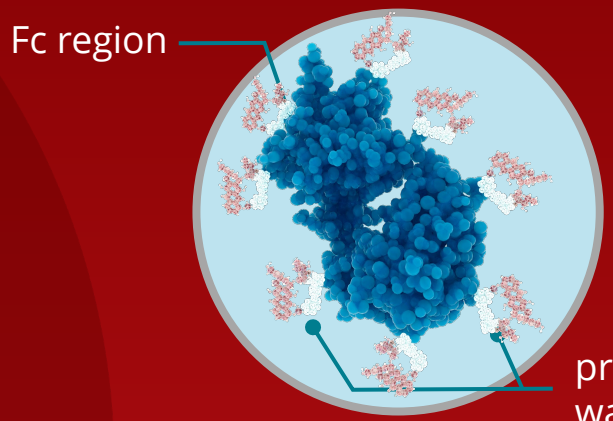
Francis Wilson, DPhil

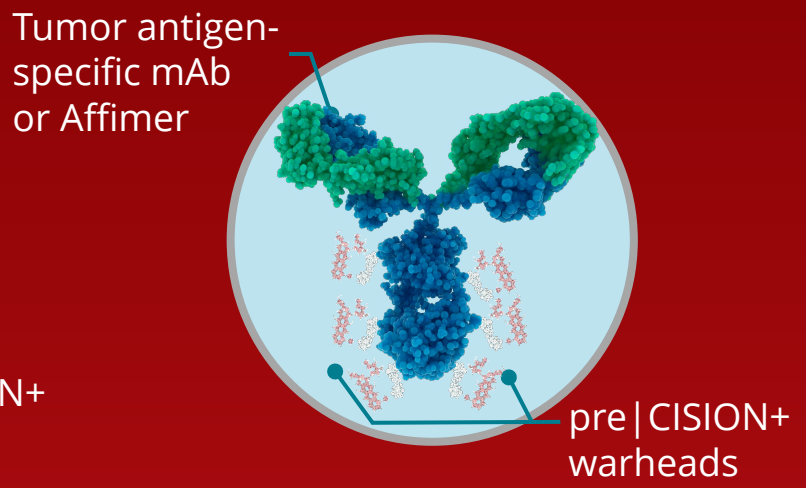
VP and Head of Chemistry

Francis trained in medicinal chemistry at Oxford University

He has >30 years' experience in industry with multiple companies and programs advanced across multiple therapeutic areas including the science of biologic-small molecule conjugations

Avacta is Targeting Highly Toxic Warheads to the TME by Leveraging Tumor-Selective FAP Expression





pre|CISION
peptide drug conjugate (PDC)

$t_{1/2}$: minutes to hours

The warhead is linked to a **peptide specifically cleaved by FAP** which prevents cell entry until released by FAP in the extracellular TME

Lead program: AVA6000

pre|CISION +
Half-life optimized drug conjugate

$t_{1/2}$: ~hours - days

The peptide-warhead conjugate is **linked to the Fc region**, producing a pre|CISION™ molecule with **prolonged half-life and DAR~10**

pre|CISION ADC
antibody/Affimer drug conjugate (AffDC)

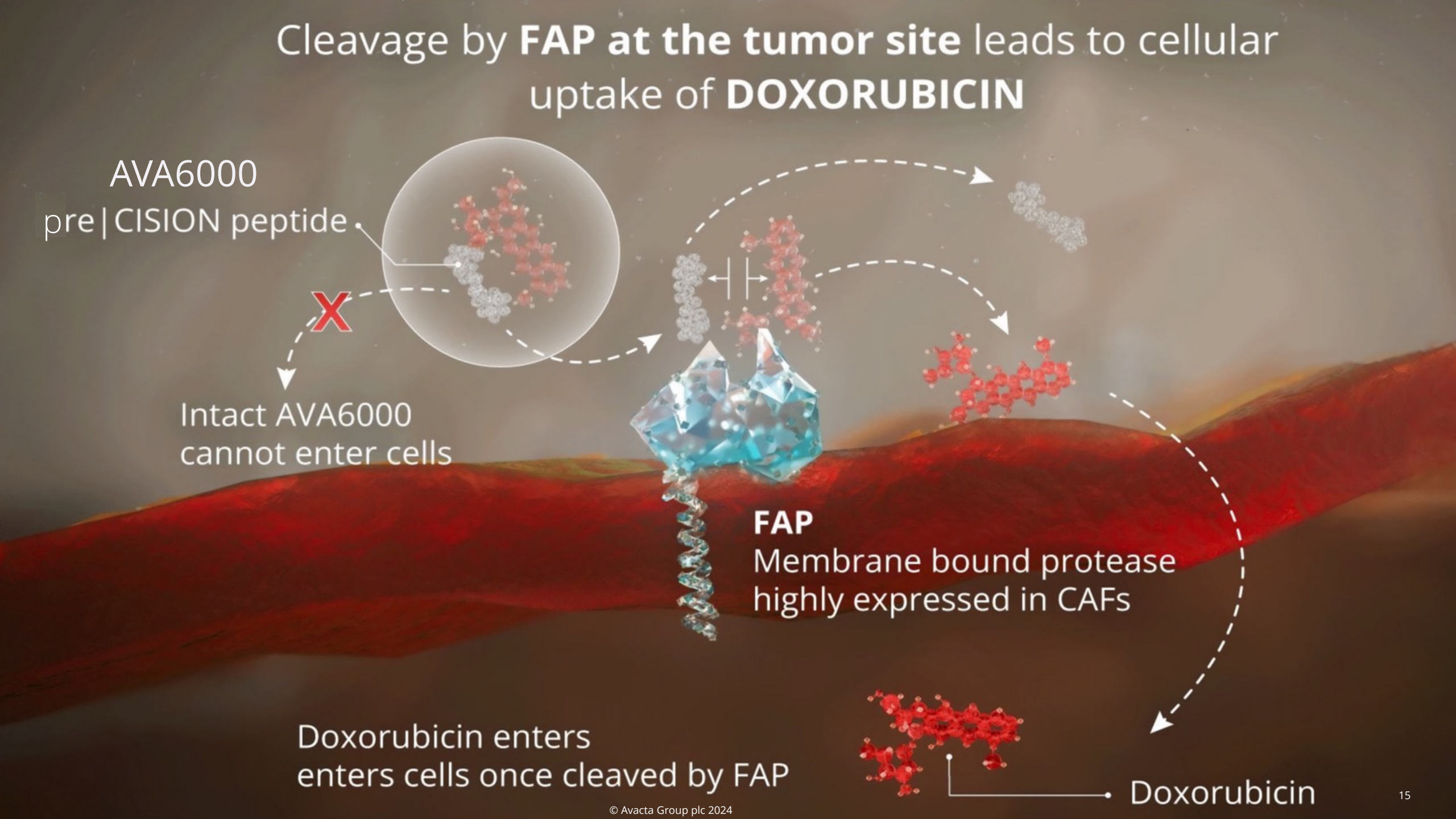
$t_{1/2}$: ~days - weeks

The peptide-warhead conjugate is linked to a tumour antigen-targeted **monoclonal antibody or Affimer**, creating a highly **tumor-specific ADC**

PDC and Affimer-DC Have Key Advantages Over Traditional ADC Approaches

	PDC	AffDC	ADC
	Avacta **Peptide Drug Conjugate** v.	Avacta **Affimer Drug Conjugate** v.	Traditional **Antibody Drug Conjugate**
Mechanism of action	***Extracellular warhead release*** with limited systemic exposure Rapid internalization in FAP+ and FAP- cells		Warhead released ***intracellularly after internalization*** Antigen negative tumour cell killing relies on the bystander effect
Location of warhead activation	Extracellular release optimizing the ***bystander effect***		Intracellular with internalization of the ADC complex necessary
Linker	***Tumour-specific warhead release*** by FAP peptide cleavage		Non-specific release where proteases available contributes to warhead toxicity (e.g. lung toxicity)
Drug-to-Antibody/ Affimer ratio	**1:1** Drug : Peptide	**3-6:1** Drug : Affimer	**4-8** Drug : Antibody needed to deliver quantity of warhead
Manufacturing	Small molecule timelines and costs of manufacturing	Thermally stable, low mW Affimer molecules (~14 kDa) with simpler manufacturing and conjugation, shorter timelines and lower cost	Complex conjugations methods and costs of manufacture of both mAb (~150 kDa) and drug-linker complex

AVA6000 PHASE 1:
INTERIM CLINICAL AND PK/PD RESULTS



KEY FINDINGS IN PHASE 1

AVA6000 delivers **high concentrations of doxorubicin to the TME** relative to plasma, resulting in significant antitumor activity in patients whose tumours have over-expression of FAP

PK/PD modeling suggests that released doxorubicin is **generated primarily by cleavage in the TME** v. soluble FAP in the bloodstream leading to a distinctly favorable safety profile

pre|CISION-enabled doxorubicin in AVA6000 results in a **robust widening of the therapeutic index**

The AVA6000 Phase 1 Trial is Ongoing with Q2W Dosing Based on Low Toxicity

PHASE 1: ARM 1

Q3W iv*
[dox equivalent]
(mg/m²)

80 [54]	120 [81]	160 [108]	200 [135]	250 [169]	310 [209]	385 [260]
N=4	N=6	N=8	N=7	N=9	N=4	N=4

low/standard dose doxorubicin — *escalated dose doxorubicin*

Disease surveillance every 6 weeks

Cohorts included in the AACR data analysis

PHASE 1: ARM 2

Q2W iv*
(mg/m²)

160	200	250	310
N=3	N=X	N=X	N=X

escalated dose doxorubicin

Disease surveillance every 8 weeks

EXPANSION COHORTS

Recommended dose
(mg/m²)

PHASE 1: PATIENT POPULATION

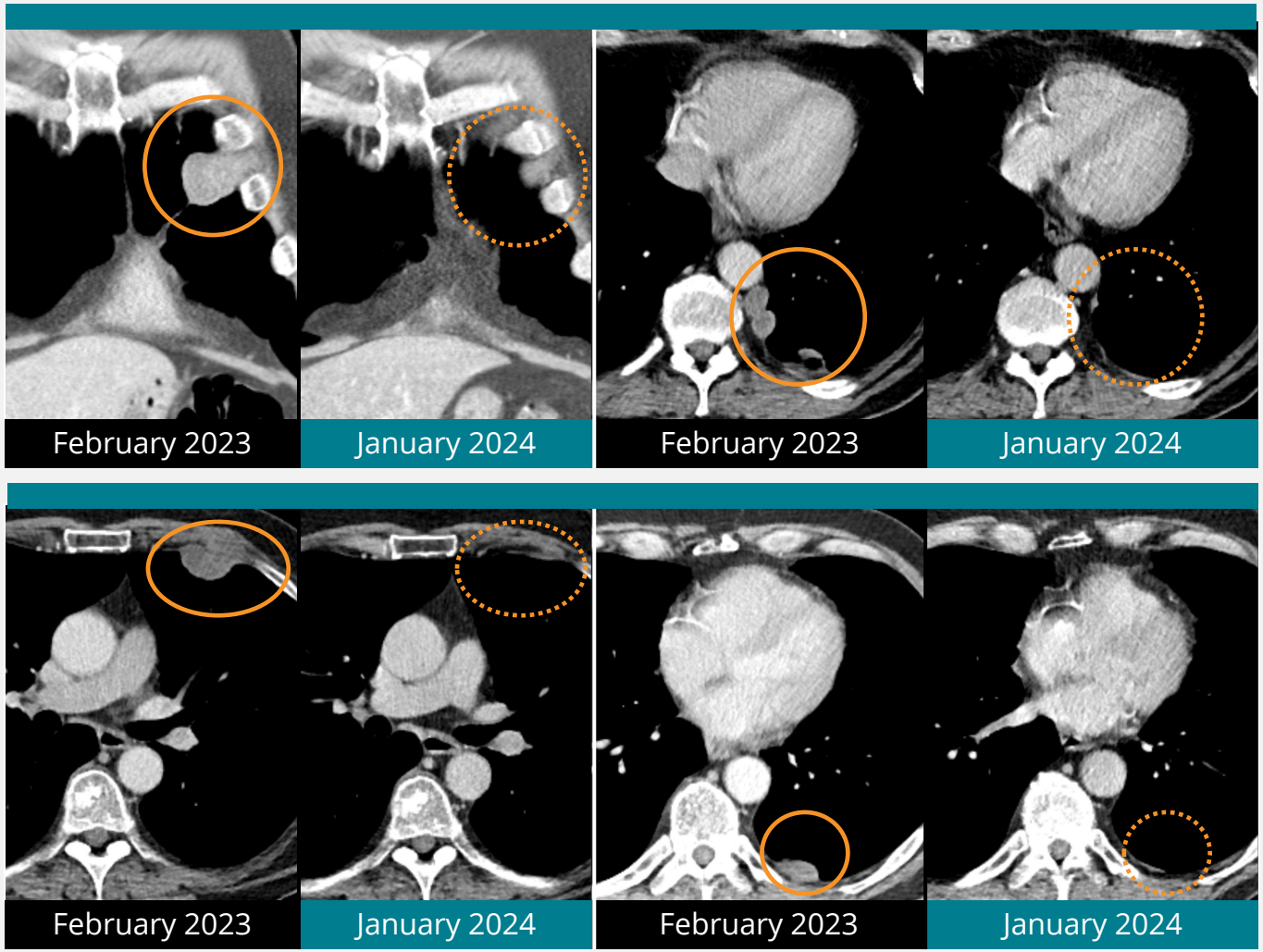
- Patients with a diagnosis of known FAP-positive cancers, including sarcoma, pancreatic cancer, colorectal cancer, head and neck cancers
- Acceptable performance status (ECOG 0 or 1), adequate organ function and recovery from prior therapy
- Prior therapy with any anthracycline was limited to total cumulative dose of less than 350 mg/m²

AVA6000 Reduces Severe Toxicities and Improves the Quality of Life for Patients

Observations compared with standard dose (75 mg/m^2) doxorubicin	What are the implications of this improvement in safety and tolerability?
Observation One: A significant reduction in the **severe toxicities** such as neutropenia which **limit dosing of doxorubicin**.	It is possible to consider higher and/or more frequent dosing (“optimise the dosing schedule”) in order to improve the efficacy of the treatment.
Observation Two: A reduction in the **mild to medium toxicities**, including multiple toxicities that contribute to the **patient’s quality of life**	The quality of life of patients whilst on the treatment is significantly improved with improvements in toxicities such as (such as nausea, loss of appetite, constipation, mouth sores and musculoskeletal pain)

First AVA6000 Responder Demonstrates Ongoing Dramatic Tumour Reduction

Near complete resolution of the multiple pleural metastases

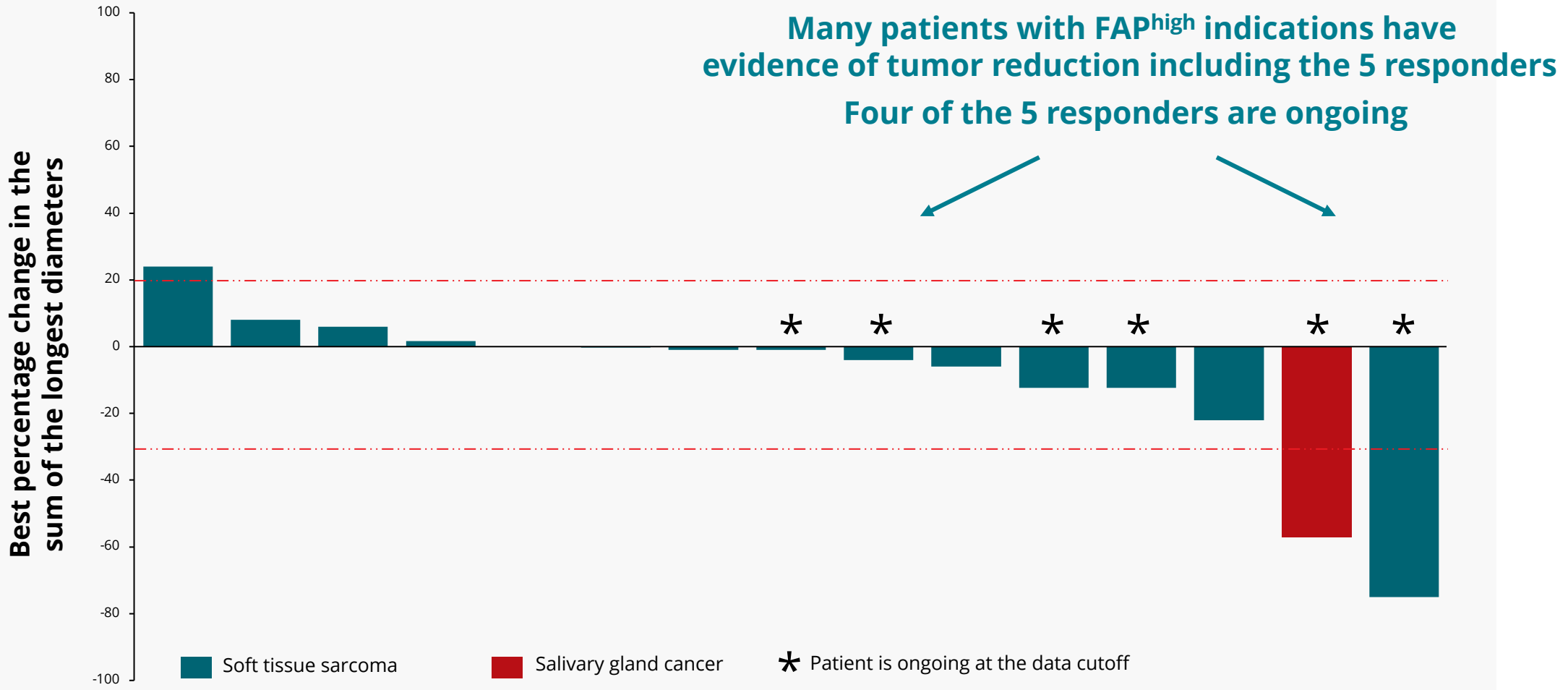


Case Study:

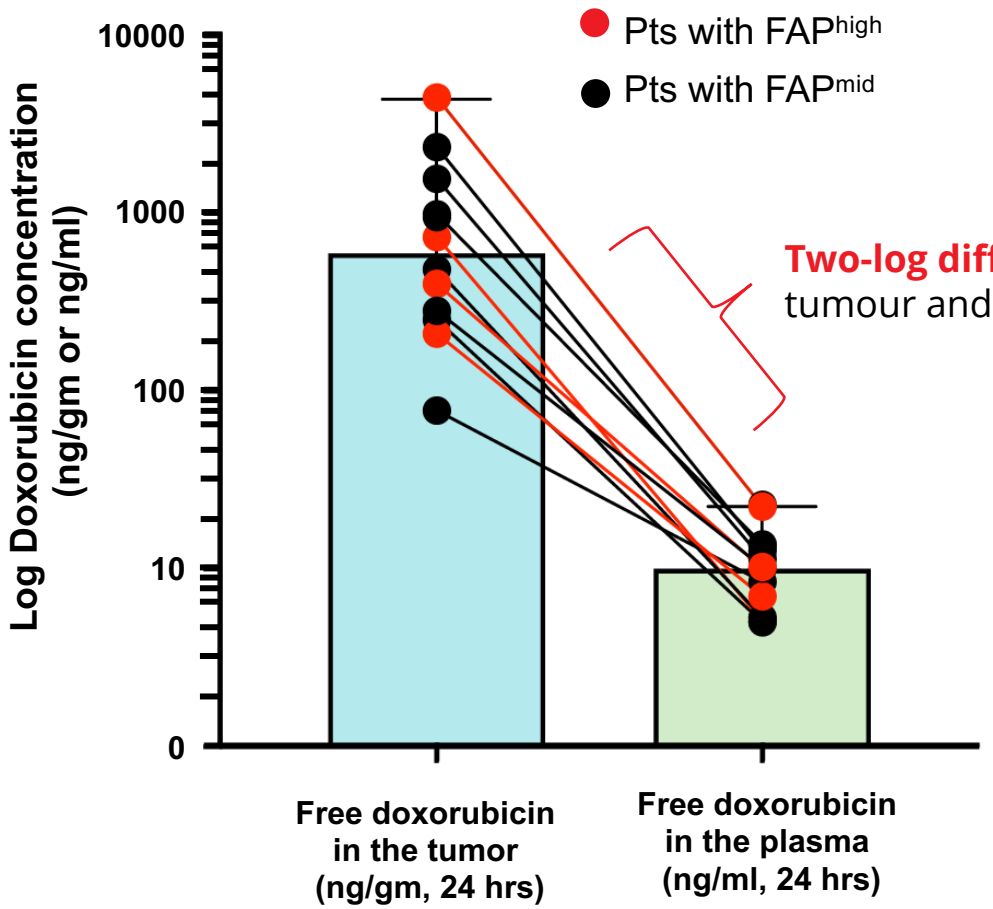
60-year-old male patient with a right-side popliteal mass biopsy diagnosed with a grade 3 undifferentiated pleomorphic sarcoma (UPS). Prior cancer therapy radiotherapy (May-Jul 2021) followed by surgery (Sept 2021)

Stage IV (metastatic) diagnosis (March 2022) with pleural metastases, enrolled in etigilimab + nivolimab (clinical trial June 2022-Jan 2023) with disease progression prior to enrolling in the AVA6000 Phase 1 trial

AVA6000 Leads to Tumour Responses in Patients with FAP^{high} Indications



Robust Warhead Concentration in the TME Due to Tumour-Specific Cleavage



[1] FAP^{high} indications were categorized by FAP expression in literature review and archival tumor tissue IHC. FAP^{high} indications include soft tissue sarcoma and salivary gland cancer

[2] FAP^{mid} diseases include colorectal carcinoma, pancreatic cancer, ovarian cancer, biliary tract cancer, transitional cell cancer of the urethra and lung cancer

AVA6000 cleavage occurs in the TME, with **concentration of doxorubicin in the TME** of approximately ~ 2-log difference between tumor and plasma concentrations

pre|CISION™ : A Highly Precise Tumor Targeting Mechanism of Action

1

Data show that the pre|CISION™ platform works as designed

AVA6000 delivers **high concentrations of doxorubicin to the TME** relative to plasma, resulting in significant antitumor activity in patients whose tumors have over-expression of FAP

2

AVA6000 has improved the safety and tolerability of doxorubicin

The preliminary observed safety and efficacy of pre|CISION-enabled doxorubicin in AVA6000 results in a **robust widening of the therapeutic index**

3

Preliminary signs of AVA6000 clinical activity are encouraging

Preliminary results indicate clinical activity of AVA6000 in patients with tumors with high FAP expression further **validating the pre|CISION™ mechanism of action**

4

Optimizing dose and schedule should increase efficacy of AVA6000

Given the favourable safety data, a two-weekly dosing arm will assist in **optimizing the schedule and dose for further clinical development** in patients with high FAP indications

Diagnostics Division Update

Supporting healthcare professionals and improving access to high quality diagnostics

Centralised Testing	Decentralised Testing
LAUNCH	CORIS BioConcept
Distributor of medical diagnostics Active in UK, France, Ireland, Belgium. Planned Germany. "Solutions", "Wide range", "Service excellence" Main specialisms microbiology and autoimmune	**Developer of rapid tests** Active in 90+ countries through distributors "Fast to market", "AMR" World-leading AMR tests
FY 23 financial results Revenue: £17,872m EBITDA: £851k	**FY 23 financial results (7 months)** Revenue: £3,270m EBITDA: £194k
Avacta Diagnostics expected to be overall EBITDA positive in second half of 2024 and cash generative 2025	
Growth Initiatives • Expand product portfolio • Geographical expansion into Germany (MD appointed and building portfolio/team)	**Growth Initiatives** • Improve distributor network and management • Expand AMR product portfolio • Global product partnering (India)

Summary

Avacta's preICISION™ platform is a highly tumour-specific drug release mechanism capable of concentrating anti-cancer drugs to the tumour microenvironment v. the plasma and can be leveraged in different formats

Our clinical data released at AACR provide clinical proof of concept for AVA6000 and proof of mechanism that the preICISION™ platform works as designed

PK/PD modelling supports the ongoing exploration of a Q2W dosing schedule to assist in defining the recommended Phase 2 dose and we remain on track to begin the expansion cohorts in 2H 2024

Ongoing work in the Diagnostics Division to integrate and plan for the future, maximizing value for shareholders and patients alike

Avacta: Upcoming Milestones and Catalysts in 2H 2024

Initiate Expansion Cohorts

Completing the Phase 1 dose escalation and advancing the AVA6000 program to expansion cohorts

Updated AVA6000 Clinica Data

Updating the AVA6000 clinical data to support the next stage of development in the expansion cohorts

Release Pipeline Update

Release of the updated pipeline of Avacta Tx assets with stage and timing to the clinic

www.avacta.com

Glossary

FAP – Fibroblast activation protein
TME – Tumour micro environnent
PREP – Prolyl endopeptidase – a protein coding gene
HEK– Human embryonic kidney
HEK model - human embryonic kidney model, a cell line created for use in generating data
Xenograft - tissues transplanted from one species to another
PDX – Patient Derived Xenograft, which are models of cancer where the tissue or cells from a patient's tumour are implanted into a mouse.
HPAF-IIP – Human Pancreatic Adenocarcinoma cell line.
WBC count – White blood cell count
PK - Pharmacokinetics
CAF – Cancer associated fibroblast
Cleave – remove
Peptide – chain of amino acids that can bind to a warhead
D-Ala-Pro - a peptide sequence providing exquisite selectivity for cleavage by FAPa
CGP-DOX - carboxybenzyl- Gly-Pro-doxorubicin, another modified version of doxorubicin
Osteosarcoma - a tumour of the bone
Cytotoxic - a substance or process that can damage cells or cause them to die
Anthracyclines - a class of drugs used in cancer chemotherapy
Topoisomerases - enzymes that play essential roles in DNA replication
Neutropenia - a low number of white blood cells called neutrophils in the blood
Mucositis – when the mouth or gut is sore and inflamed
Leukopenia – when the body doesn't have enough disease-fighting leukocytes in the blood
Febrile neutropenia - the development of a fever, alongside other signs of infection such as feeling unwell, shivers and shakes in a patient with neutropenia
Thrombocytopenia – a deficiency of platelets in the blood.
Cmax – maximum concentration
AUC – area under the curve (in this case showing overall exposure)
Undifferentiated pleomorphic sarcoma (UPS) - a type of cancer that begins mostly in the soft tissues of the body
Angiosarcoma - a type of cancer that forms in the lining of the blood vessels and lymph vessels
Solitary fibrous tumours (SFT) - growths of cells that can form in almost any part of the body.
Minor response – a 10-29% decrease in the sum of the target lesions.
Partial response - at least a 30% decrease in the sum of the target lesions.