Coherus ONCOLOGY

OVERCOMING IMMUNE RESISTANCE IN CANCER

44TH ANNUAL J.P. MORGAN Healthcare Conference

Denny Lanfear, Chairman and CEO

Forward Looking Statements

Except for the historical information contained herein, the matters set forth in this presentation are forward-looking statements within the meaning of the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995. Forward-looking statements contained in this presentation may be identified by the use of words such as "may," "will," "should," "expect," "could," "intend," "target," "estimate," "predict," or "potential" or the negative of these terms or other similar expressions. These statements include, but are not limited to statements about growth in sales or revenues; ability of any of our pipeline product candidates to be first-to-market, first-to-data or first-in-class in the future; expectations about being able to secure funding or to secure non-dilutive funding in future periods; statements about multiplying value; future data readouts or catalysts based on the clinical trials of Coherus Oncology, Inc. ("Coherus Oncology"); market size, market value, addressable market or opportunity and the number of patients or incidence for particular indications; ability for a product candidate to disrupt a market; standard of care expectations; projections for cash runway; future collaborations; the degree of unmet need for particular indications; and the assumptions underlying or relating to such statements.

Such forward-looking statements involve substantial risks and uncertainties that could cause Coherus Oncology's actual results, performance or achievements to differ significantly from any future results, performance or achievements expressed or implied by the forward-looking statements. Such risks and uncertainties include, among other things, the risks and uncertainties inherent with clinical research and commercialization; the risks and uncertainties of the clinical development and regulatory approval process, including the timing of Coherus Oncology's regulatory filings; the risk that Coherus Oncology is unable to complete commercial transactions in a timely manner or at all; risks and uncertainties in executing collaboration agreements and other joint ventures, including particular risks of working with international partners; the risk of Coherus Oncology's dependence on an ability to raise funds, which may not be available on acceptable terms or at all; the risks and uncertainties of the degree of market acceptance for Coherus Oncology's product by physicians, healthcare providers and patients; and the risks and uncertainties of litigation. For a further discussion of these and other factors that could cause Coherus Oncology's future results to differ materially from any forward-looking statements see the section entitled "Risk Factors" in Coherus' Quarterly Report on Form 10-Q for the period ended September 30, 2025, filed with the Securities and Exchange Commission ("SEC") on November 6, 2025, as updated by Coherus Oncology's subsequent reports filed with the SEC. Any forward-looking statements speak only as of the date of this presentation and are made based on the current, plans, estimates, good faith beliefs and judgments of Coherus Oncology management, and the reader is cautioned not to rely on any forward-looking statements made by Coherus Oncology. Unless required by law, Coherus Oncology is not under any duty and undertakes no obligation to publicly update or revise any forward-looking statement to reflect changes in underlying assumptions or factors, of new information, data or methods, future events or other changes. Coherus Oncology's past performance should not be considered to be a guarantee of future results.

COHERUS ONCOLOGY

Overcoming Immune Resistance in Cancer

- Commercial Stage Innovative Oncology Company
- LOQTORZI®: Revenue Multiplier Backbone PD-1
- Tagmokitug: Highly-Selective, Potentially Best-in-Class Treg Depleter
- Casdozokitug: First-in-Class IL-27 Antagonist
- 2026 is a Data-Rich Year with Multiple Value Drivers

Coherus Oncology: Completed Transformation to Innovative Oncology

Overcoming Immune Resistance in Cancer

Oncology Pipeline Acquisition September 2023

SURFACE Oncology Acquisition—
$65M in stock, ~$29M in cash & investments

- **SURF, a scientifically renowned biotech, invested over $300M in its pipeline**
- **Peak valuation of ~$1 billion in 2021**
- **Coherus Oncology acquired full global rights to tagmokitug and casdozokitug**

Acquired novel and potential best-in-class and first-in-class clinical-stage IO pipeline

Biosimilar Divestitures 2024-2025

CIMERLI® Divestiture—$170M upfront— June 2024

- **Originally in-licensed for €10M upfront**
- **Second to market, leading biosim at divestiture**
- **Sold to Sandoz for $170M upfront in 2024**

UDENYCA® Divestiture—up to $558M—April 2025

- **Developed in-house**
- **Second to market, leading pegfilgrastim**
- **Sold to Intas/Accord for $483M upfront**

Total divestitures for ~$800M

Paid-off ~$480M in debt and added ~$250M to balance sheet

Coherus Oncology Value Proposition
Shareholder Value Creation Focused on Drugs, Data and Deals

DRUGS

Commercial Stage

LOQTORZI® (toripalimab-tpzi)injection

Clinical Stage

Tagmokitug

anti-CCR8 cytolytic antibody

Casdozokitug

IL-27 antagonist

DATA

Tagmokitug

- HNSCC – Mid 2026
- GC, GEJ, EAC – Mid 2026
- CRC – H2 2026
- ESCC – H2 2026
- Additional indications starting in 2026

Casdozokitug

- HCC – Mid 2026

DEALS

- Tagmokitug novel combinations
- Ex-US licensing
- LOQTORZI® US supply agreements

$172.1M in cash, cash equivalents and investments at the end of Q4 2025, expected to support operations through end of 2026*

* Cash, cash equivalents and investments as of December 31, 2025, inclusive of Transition Service Agreement (TSA)-related collections that will be applied to associated TSA payables and accrued liabilities. The preliminary fourth quarter and full year 2025 financial information presented herein has not been audited and is subject to change

NPC = Nasopharyngeal Carcinoma; HNSCC = Head and Neck Squamous Cell Carcinoma; GC = Gastric Cancer; GEJ = Gastro-esophageal-junction; EAC = Esophageal Adenocarcinoma; ESCC = Esophageal Squamous Cell Carcinoma; HCC = Hepatocellular Carcinoma; sqNSCLC = squamous Non-Small Cell Lung Cancer

Coherus Oncology Pipeline: Targeting Resistance to Cancer Treatment

LOQTORZI® (toripalimab-tpzi) Revenue Generator, Revenue Multiplier

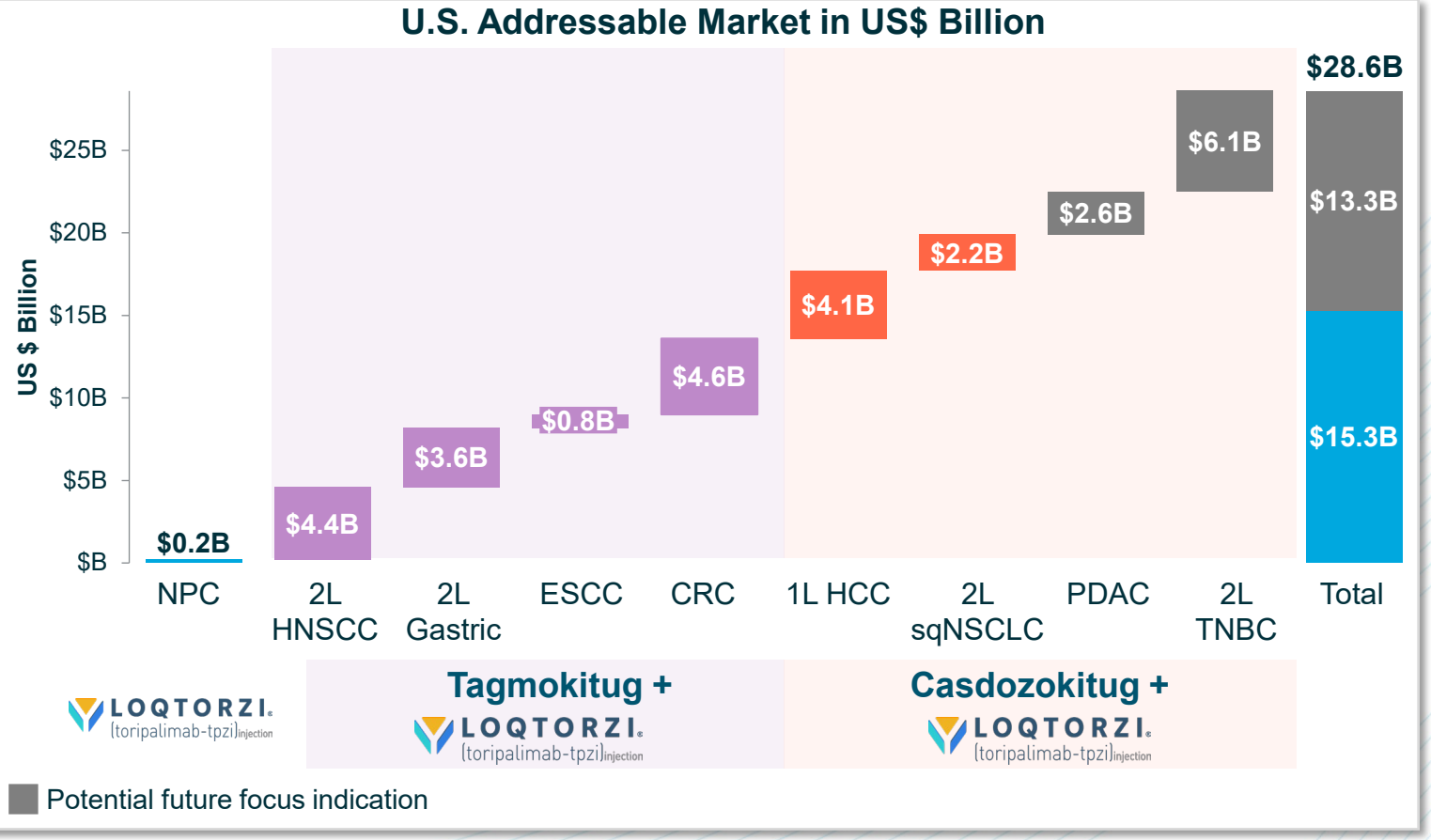
	Target	Indication	Combo	Pre-Clinical / Phase 1 / Phase 2 / Phase 3 / Marketed	Upcoming Data Readouts
LOQTORZI (toripalimab-tpzi) injection	Anti-PD-1 monoclonal antibody	1st Line NPC	Gemcitabine/ Cisplatin		From combination studies
		2nd Line+ NPC	Monotherapy		
Tagmokitug	Anti-CCR8 cytolytic monoclonal antibody	4th Line+ CRC	LOQTORZI		H2 2026
		2nd Line HNSCC	LOQTORZI		Mid 2026
		2nd Line GC, GEJ, EAC	LOQTORZI		Mid 2026
		1st Line/2nd Line ESCC	LOQTORZI		H2 2026
Casdozokitug	IL-27 antagonist monoclonal antibody	1st Line HCC	LOQTORZI + Bevacizumab		Mid 2026

NPC = Nasopharyngeal Carcinoma; HNSCC = Head and Neck Squamous Cell Carcinoma; GC = Gastric Cancer; GEJ = Gastro-esophageal-junction; EAC = Esophageal Adenocarcinoma; ESCC = Esophageal Squamous Cell Carcinoma; HCC = Hepatocellular Carcinoma

LOQTORZI® Potential Combination Indications are a Value Multiplier

Pipeline Addresses ~$29 billion of Market Opportunity in the U.S.

Coherus Pipeline U.S. Market Opportunity



- **LOQTORZI Revenue Multiplier** – each pipeline product approval represents a label expansion for LOQTORZI
- **Partnered indications** represent additional upside from indications/ trials funded by third parties
- **Significant ex-US opportunity** for our wholly owned pipeline (tagmokitug and casdozokitug)
- **Potential to further expand market opportunity** leveraging potential growth in LOQTORZI revenues

1 TAM: Total Addressable Market for PDCA and TNBC based on US sales in 2030 by tumor, Datamonitor and EvaluatePharma; Internal assumptions based on Incidence for HCC and SqNSCLC

NPC = Nasopharyngeal Carcinoma; HNSCC = Head and Neck Squamous Cell Carcinoma; GC = Gastric Cancer; ESCC = Esophageal Squamous Cell Carcinoma; CRC = Colorectal Cancer; HCC = Hepatocellular Carcinoma; sqNSCLC = squamous Non-Small Cell Lung Cancer; PDAC - Pancreatic Ductal Adenocarcinoma

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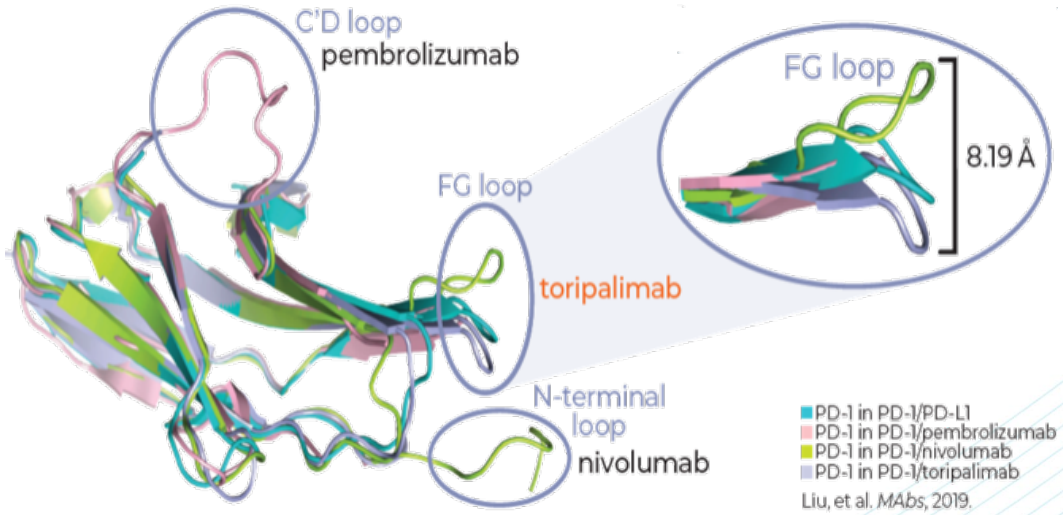
LOQTORZI® is a Next-Generation PD-1 Inhibitor

Demonstrated Clinical Differentiation

LOQTORZI binds to a unique epitope and with higher affinity than first-generation PD-1s

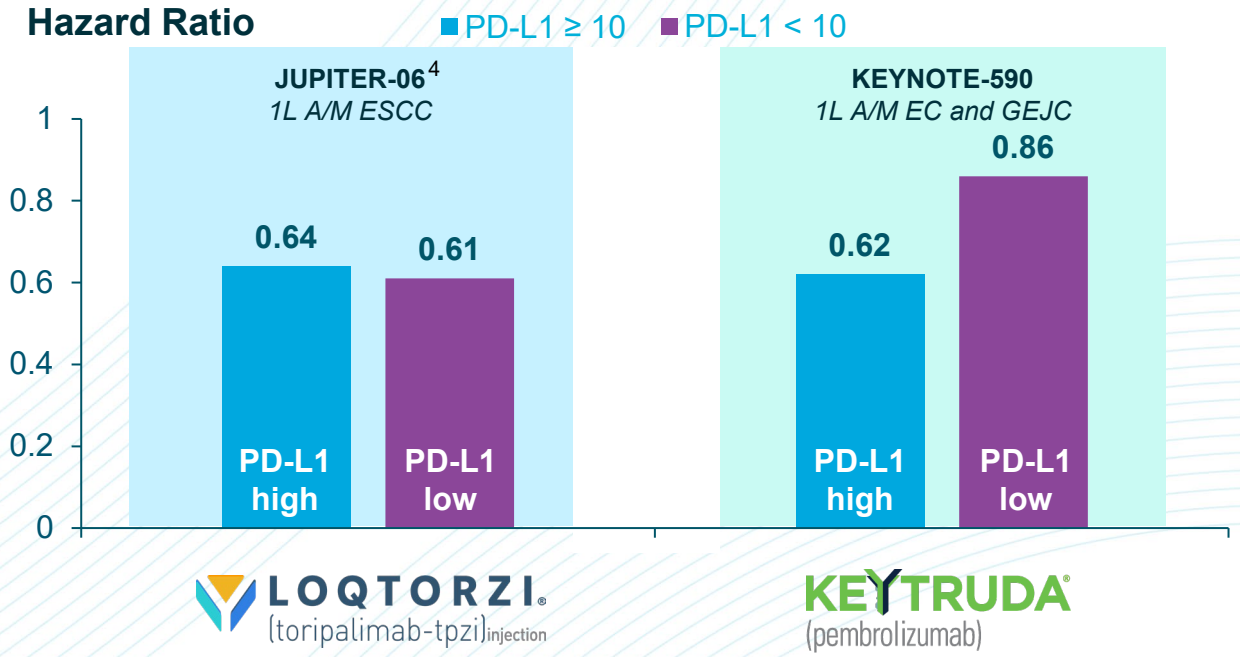
Binding sites of approved PD-1s



Affinity of approved PD-1s

Antibody	K_D (nM)*
toripalimab	0.3[1]
pembrolizumab	3.9[2]
nivolumab	7.2[2]

LOQTORZI demonstrated activity irrespective of PD-L1 status in 1L ESCC



Low-PD-L1 ESCC indication approved in the EU by EMA

Efficacy and approval limited to high PD-L1 (PD-L1 > 1)

KD: Dissociation constant

1 Liu H, et al. MAbs. 2019;11(4):681-690; 2 Brown et al. PLoS One. 2020;15: e0229206; 3. Rajasekaran et al. Cancer Immunol ImmunotherPY. 2024;73(3):60. 4. Zi-Xian Wang, et al. Cancer Cell. 2022; 40(3): 277-288

LOQTORZI® Continues to Deliver Meaningful Clinical Evidence

Only Preferred Regimen in NCCN NPC Guidelines

LOQTORZI long term OS; data readout at ESMO Asia 2025 strengthens clinical evidence

SINGAPORE 2025 ESMO ASIA

SINGAPORE
5-7 DECEMBER 2025

5-YEAR OVERALL SURVIVAL WITH LOQTORZI + CHEMO

Long-term observed median OS[6]

5-year post hoc analysis‖

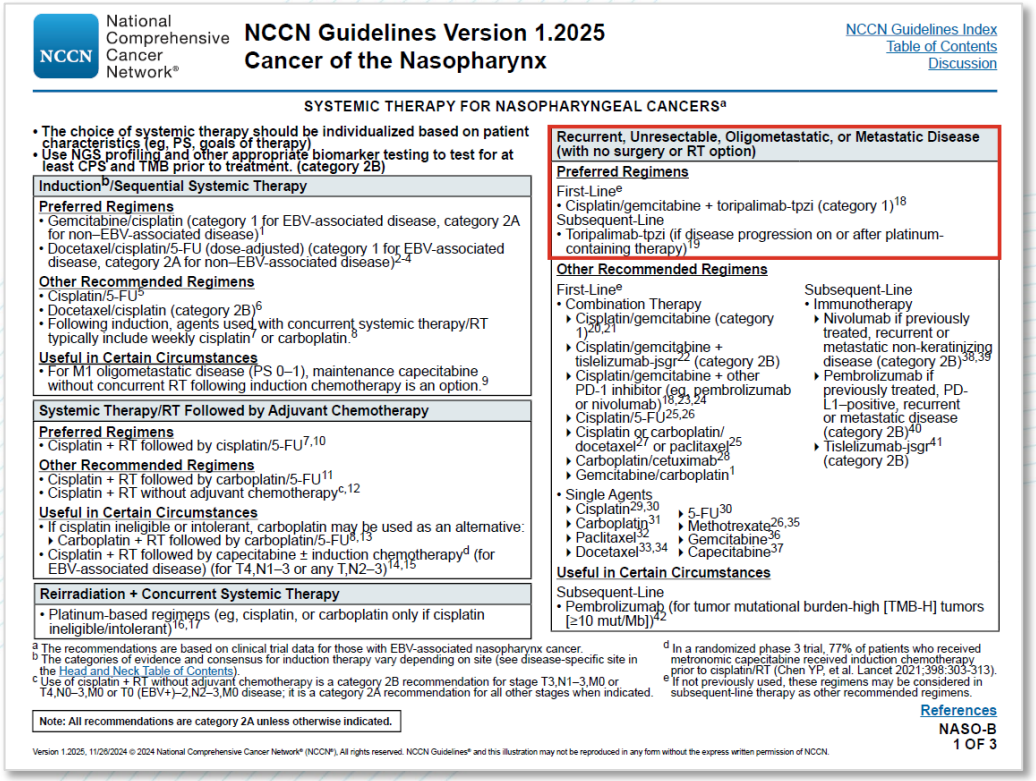
64.8 months (95% CI, 38.8–NE) vs **33.7 months** (95% CI, 26.7–44.2)

HR=0.62 (95% CI, 0.45-0.85)

38% reduction in risk of death

This 5-year post hoc analysis was exploratory in nature and occurred after the protocol-specified final analysis.

LOQTORZI is the only preferred regimen established in NCCN NPC guidelines



National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2025
Cancer of the Nasopharynx

NCCN Guidelines Index
Table of Contents
Discussion

SYSTEMIC THERAPY FOR NASOPHARYNGEAL CANCERS[a]

- The choice of systemic therapy should be individualized based on patient characteristics (eg, PS, goals of therapy)
- Use NGS profiling and other appropriate biomarker testing to test for at least CPS and TMB prior to treatment. (category 2B)

Induction[b]/Sequential Systemic Therapy

Preferred Regimens
- Gemcitabine/cisplatin (category 1 for EBV-associated disease, category 2A for non–EBV-associated disease)[1]
- Docetaxel/cisplatin/5-FU (dose-adjusted) (category 1 for EBV-associated disease, category 2A for non–EBV-associated disease)[2-4]

Other Recommended Regimens
- Cisplatin/5-FU[5]
- Docetaxel/cisplatin (category 2B)[6]
- Following induction, agents used with concurrent systemic therapy/RT typically include weekly cisplatin[7] or carboplatin.[8]

Useful in Certain Circumstances
- For M1 oligometastatic disease (PS 0–1), maintenance capecitabine without concurrent RT following induction chemotherapy is an option.[9]

Systemic Therapy/RT Followed by Adjuvant Chemotherapy

Preferred Regimens
- Cisplatin + RT followed by cisplatin/5-FU[7,10]

Other Recommended Regimens
- Cisplatin + RT followed by carboplatin/5-FU[11]
- Cisplatin + RT without adjuvant chemotherapy[c,12]

Useful in Certain Circumstances
- If cisplatin ineligible or intolerant, carboplatin may be used as an alternative:
  - Carboplatin + RT followed by carboplatin/5-FU[8,13]
- Cisplatin + RT followed by capecitabine ± induction chemotherapy[d] (for EBV-associated disease) (for T4,N1–3 or any T,N2–3)[14,15]

Reirradiation + Concurrent Systemic Therapy
- Platinum-based regimens (eg, cisplatin, or carboplatin only if cisplatin ineligible/intolerant)[16,17]

Recurrent, Unresectable, Oligometastatic, or Metastatic Disease (with no surgery or RT option)

Preferred Regimens

First-Line[e]
- Cisplatin/gemcitabine + toripalimab-tpzi (category 1)[18]

Subsequent-Line
- Toripalimab-tpzi (if disease progression on or after platinum-containing therapy)[19]

Other Recommended Regimens

First-Line[e]
- Combination Therapy
  - Cisplatin/gemcitabine (category 1)[20,21]
  - Cisplatin/gemcitabine + tislelizumab-jsgr[22] (category 2B)
  - Cisplatin/gemcitabine + other PD-1 inhibitor (eg, pembrolizumab or nivolumab)[18,23,24]
  - Cisplatin/5-FU[25,26]
  - Cisplatin or carboplatin/docetaxel[27] or paclitaxel[25]
  - Carboplatin/cetuximab[28]
  - Gemcitabine/carboplatin[1]
- Single Agents
  - Cisplatin[29,30]
  - Carboplatin[31]
  - Paclitaxel[32]
  - Docetaxel[33,34]
  - 5-FU[30]
  - Methotrexate[26,35]
  - Gemcitabine[36]
  - Capecitabine[37]

Subsequent-Line
- Immunotherapy
  - Nivolumab if previously treated, recurrent or metastatic non-keratinizing disease (category 2B)[38,39]
  - Pembrolizumab if previously treated, PD-L1–positive, recurrent or metastatic disease (category 2B)[40]
  - Tislelizumab-jsgr[41] (category 2B)

Useful in Certain Circumstances

Subsequent-Line
- Pembrolizumab (for tumor mutational burden-high [TMB-H] tumors [≥10 mut/Mb])[42]

[a] The recommendations are based on clinical trial data for those with EBV-associated nasopharynx cancer.
[b] The categories of evidence and consensus for induction therapy vary depending on site (see disease-specific site in the Head and Neck Table of Contents).
[c] Use of cisplatin + RT without adjuvant chemotherapy is a category 2B recommendation for stage T3,N1–3,M0 or T4,N0–3,M0 or T0 (EBV+)–2,N2–3,M0 disease; it is a category 2A recommendation for all other stages when indicated.
[d] In a randomized phase 3 trial, 77% of patients who received metronomic capecitabine received induction chemotherapy prior to cisplatin/RT (Chen YP, et al. Lancet 2021;398:303-313).
[e] If not previously used, these regimens may be considered in subsequent-line therapy as other recommended regimens.

Note: All recommendations are category 2A unless otherwise indicated.

References

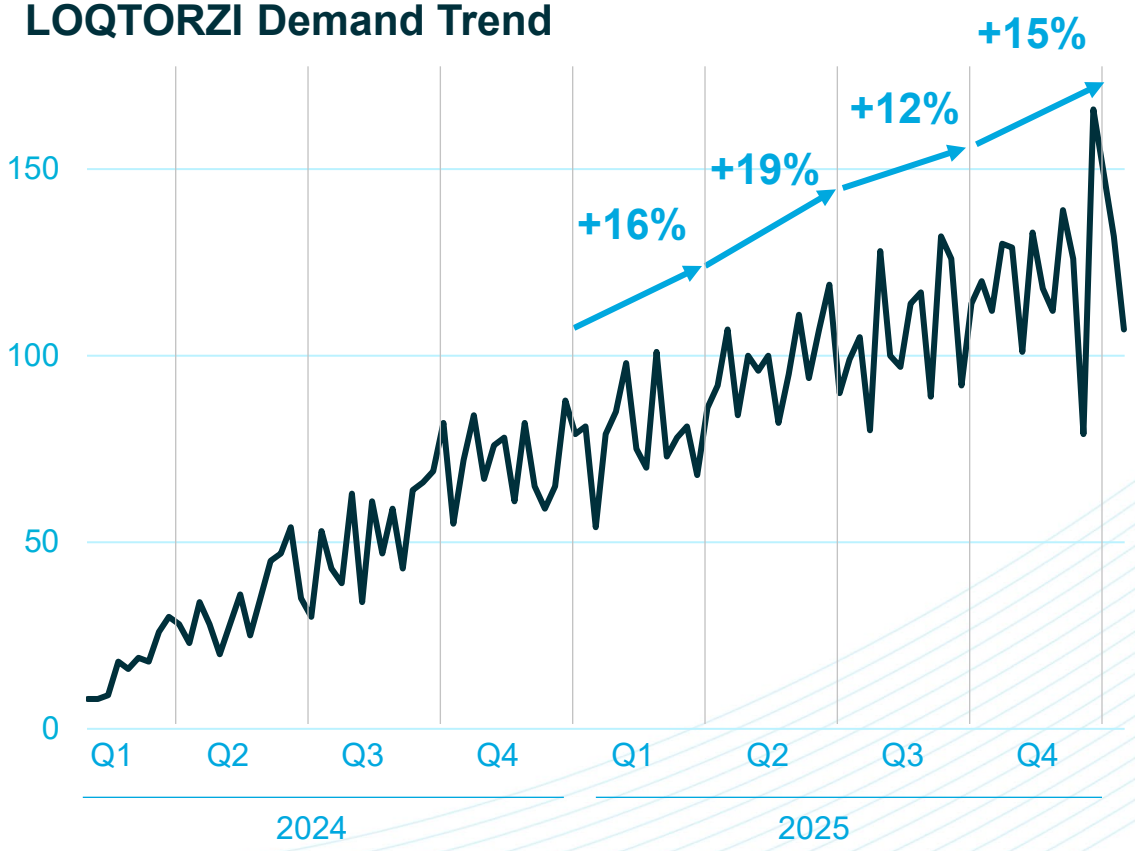
NASO-B
1 OF 3

LOQTORZI® Delivering Steady Demand and Revenue Growth

Projected to Reach $150-200M in Revenues by 2028 in $250M Market

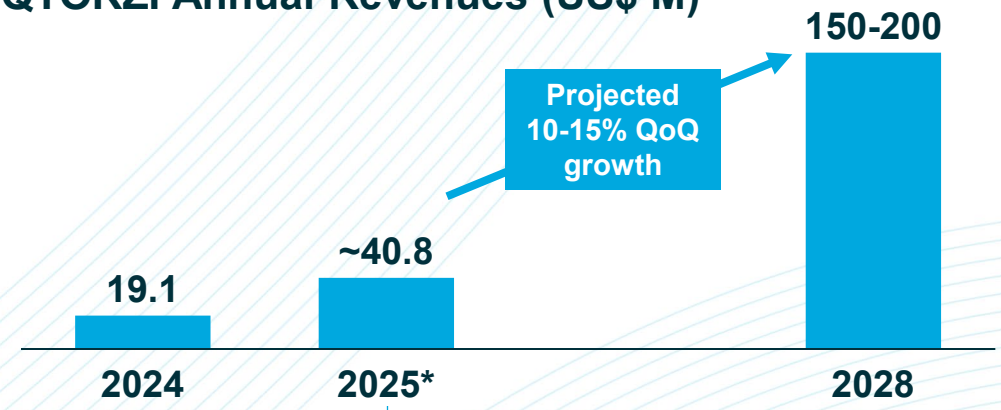
Strong demand growth for LOQTORZI supported by data strength and commercial efforts

LOQTORZI Demand Trend

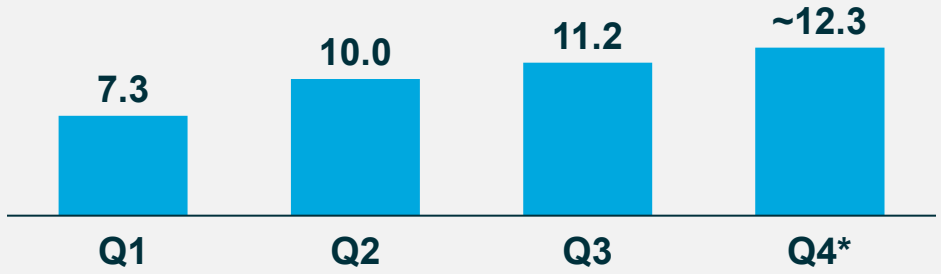


Resulting in steady revenue growth, projected to ~$150-200 million by 2028

LOQTORZI Annual Revenues (US$ M)



2025 Quarterly LOQTORZI Revenues (US$ M)



* Q4 and full year 2025 financial information presented herein is preliminary and has not been audited and is subject to change

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Overcoming Immune Resistance in Cancer through Treg Depletion

Large Unmet Need where PD-1 Therapies are not Effective

~70%

Cancer Patients Not Addressable by Anti-PD-1 Inhibitors

- Low or absent PD-L1 expression
- High infiltration of suppressive Tregs
- Low T cell infiltration (cold tumors)

T-Cell Desert

Anti-PD1s Ineffective

Liver

Colorectal

Pancreatic

Prostate

Endometrial/ Ovarian

CCR8+ Treg Depletion

Treg depletion key to turning cold tumors hot

Backbone Potential

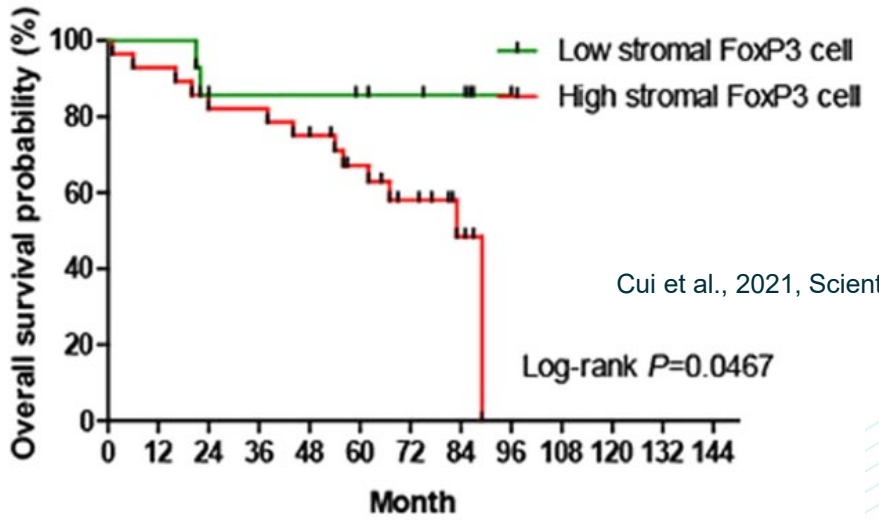
Han Y, Liu D, Li L. PD-1/PD-L1 pathway: current researches in cancer. Am J Cancer Res. 2020 Mar 1; Haslam A, Prasad V. Estimation of the Percentage of US Patients With Cancer Who Are Eligible for and Respond to Checkpoint Inhibitor Immunotherapy Drugs. JAMA Netw Open. 2019 May 3

CCR8+ Tregs Presence Predictive of Lower Survival in Solid Tumors

Treg Depletion Modulates the tumor microenvironment to Support Anti-Tumor Responses

Presence of CCR8+ Tregs is prognostic for lower survival outcomes in several solid tumors

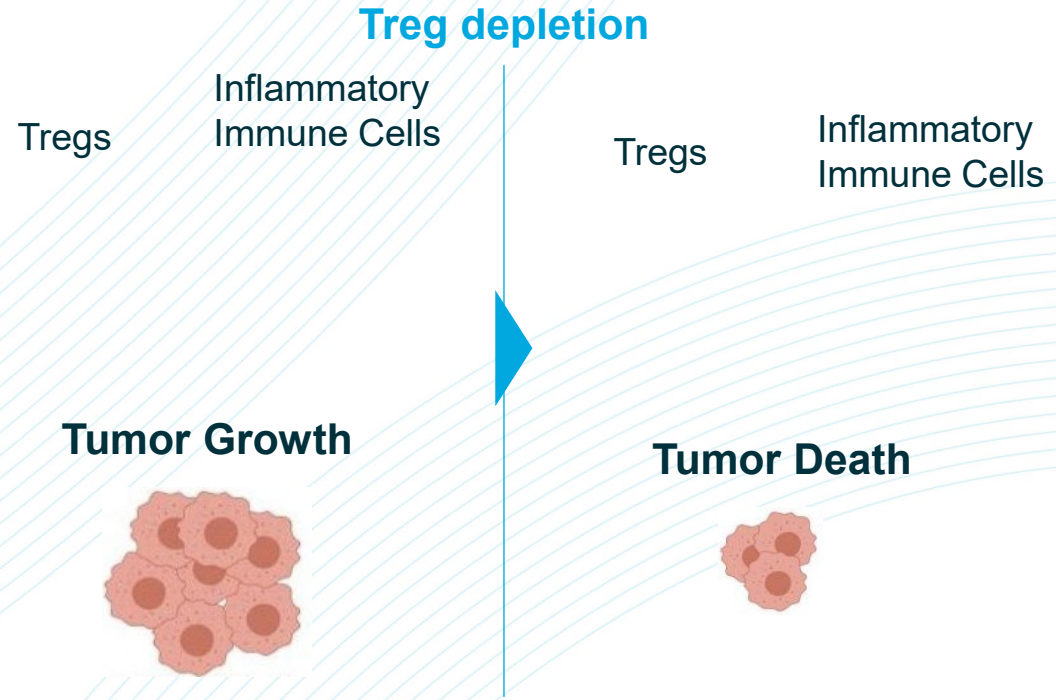
Kaplan-Meier survival curves CRC patients (n=102)



Cui et al., 2021, Scientific Reports

Note: FoxP3 (transcription factor) defines **regulatory T cells (Tregs)**

Selectively depleting CCR8+ Tregs in tumors primes the immune system for responses

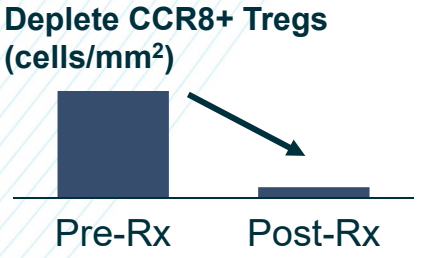


The potential therapeutic importance of Tregs was recognized by the 2025 Nobel Prize in Medicine

Requirements for Treg Depletion-Driven Anti-Tumor Response

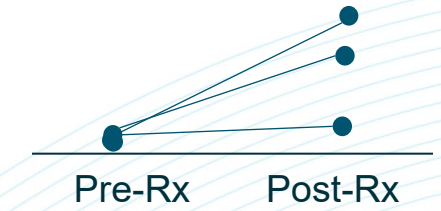
Significant Treg depletion from TME and not normal tissue

Treg depleting agent (e.g., CCR8 or next-gen CTLA4 mAb)



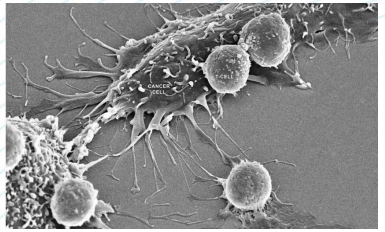
Infiltration of CD8+ T cells to attack tumors

Remodeling of TME required post-depletion



Activate T cells

Right indication / Right combination
PD-1s, T cell engagers (TCE), CAR-T, other

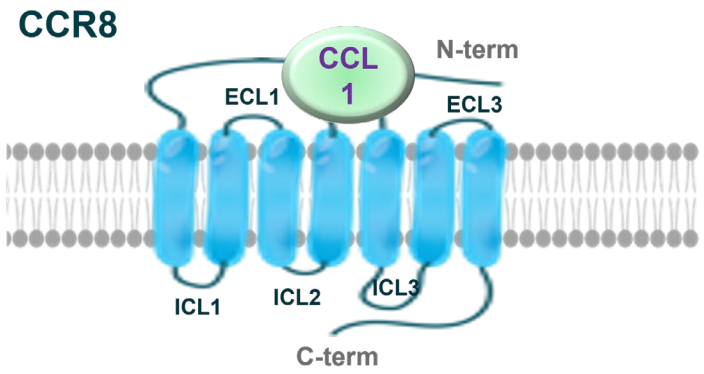


Tagmokitug is a Potential Best in Class CCR8+ Treg Depleter

Only Known Selective mAb Known to Date

GPCRs are difficult mAb targets - often have off-target binding

Only ~25% of the receptor is exposed on the cell surface



Tagmokitug binds only to CCR8 - only selective mAb identified to date

Selected Antibodies	# of non-CCR8 Targets Identified
tagmokitug	0
mAb2	1
mAb3	8
mAb4	15
mAb5	20
Comparator Antibodies	**"Off Target" Binding**
Comparator 1	ANGPTL7
Comparator 2	J chain
Comparator 3	SEMA4B

Tagmokitug Best In-Class Potential

Proof of Mechanism

- ✓ Significant depletion of tumor CCR8+ Tregs
- ✓ Only CCR8 mAb to show strong immune remodeling

Selectivity

- ✓ Only known selective CCR8 mAb, showing no off-target binding

Pharmacology

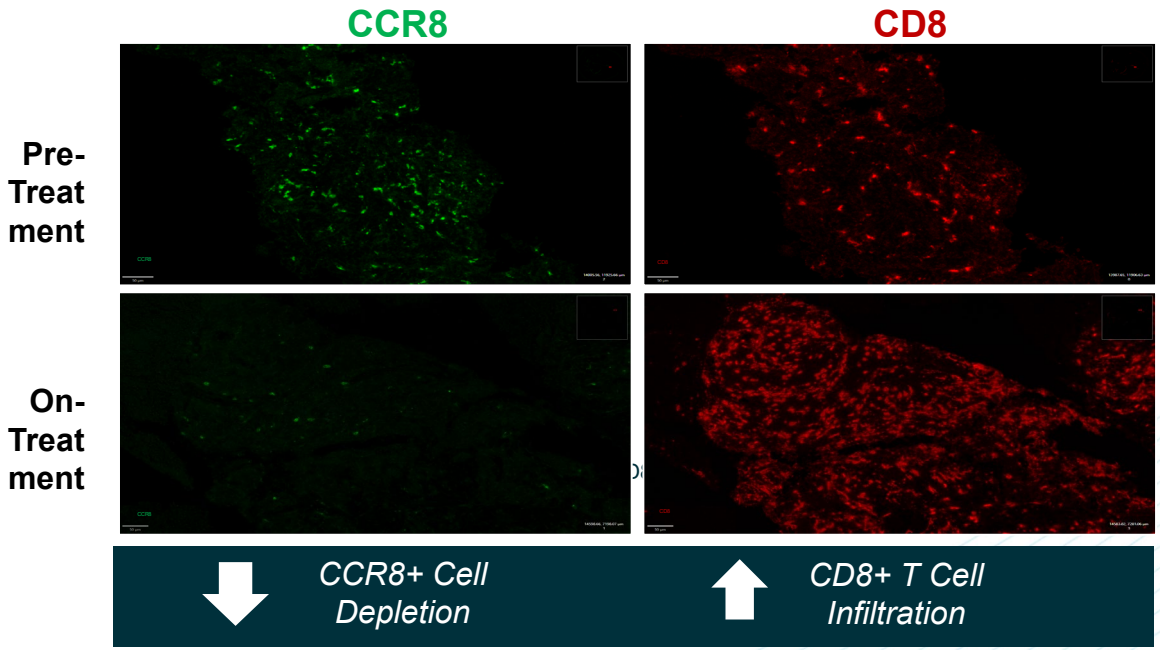
- ✓ High affinity (pM)
- ✓ High potency with enhanced ADCC/ADCP
- ✓ Excellent human PK profile (IgG1-like)

CCR8 Antibody screen: Ab specificity profiling using cell microarray to uncover extracellular antibody targets; Assay screens across 5,528 cell surface and secreted proteins using cell microarray technology; 293T cells transfected and fixed prior to binding; IgG antibodies bound to Fc gamma receptors

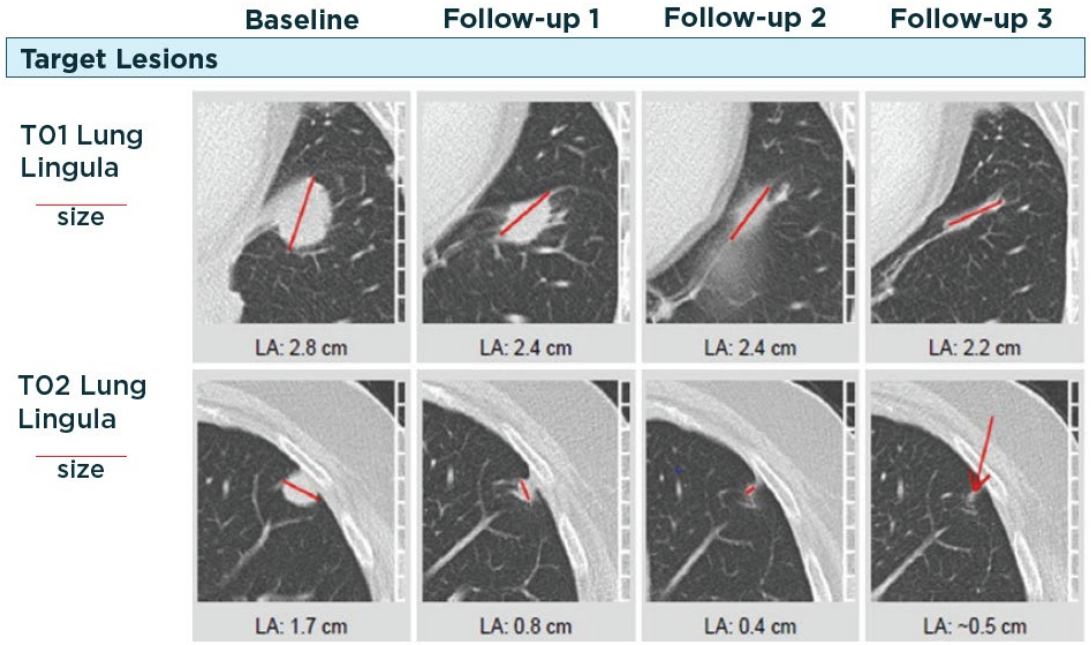
Tumor Response in the Tagmokitug + Toripalimab Combination

Tumor Shrinkage with Confirmed Partial Response in a 4L Anti-PD-1 Refractory Patient

Tumor biopsy from HNSCC patients (tagmokitug alone – proof of MOA)



Confirmed partial response in 4L PD-1 refractory patient with combination tagmokitug/toripalimab



Responder received tagmokitug/toripalimab as 4th line treatment (~5 months from 3rd line docetaxel treatment and ~12 months from 1st line PD-1 plus chemo)

Worden F, et al. Phase 1 study of anti-CCR8 antibody tagmokitug with and without anti-PD-1 antibody toripalimab in patients with advanced solid tumors. Presented at American Association for Cancer Research Annual Meeting 2025; Apr 25-30, 2025; Chicago, IL.

Ongoing Tagmokitug/Toripalimab Studies Provide Multiple Shots on Goal while Addressing Large Market Opportunities

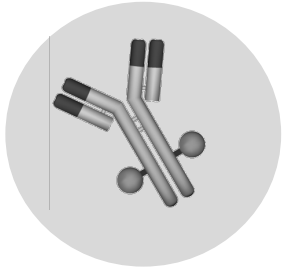
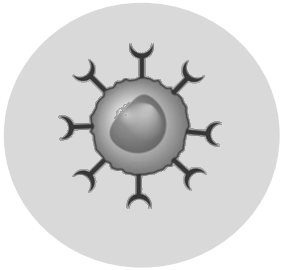
	Gastric	Esophageal	Colorectal	HNSCC
	2L GC, GEJ, EAC	**2L ESCC**	**4L+ MSS CRC**	**2L HNSCC**
	Tagmo & Tori	Tagmo & Tori	NLM MSS CRC Tagmo & Tori	Tagmo & Tori
		1L ESCC	LM MSS CRC Tagmo & Tori	
		Tagmo & Tori + 5FU + cisplatin		
Rationale	*Positive clinical data by competing CCR8 program*	*LOQ data in ESCC high unmet need*	*Positive clinical data with next-gen CTLA4*	*Promising activity in tagmo 2L+ Phase 1 study*
Interim Data	**MID '26**	**MID '26**	**H2 '26**	**MID '26**
U.S. Market	***$3.6B***	***$800M***	***$4.6B***	***$4.4B***

Worden F, et al. Phase 1 study of anti-CCR8 antibody tagmokitug with and without anti-PD-1 antibody toripalimab in patients with advanced solid tumors. Presented at American Association for Cancer Research Annual Meeting 2025; Apr 25-30, 2025; Chicago, IL.

DL = Dose Level; RP2D = Recommended Phase 2 Dose

ClinicalTrials.gov ID: NCT05635643

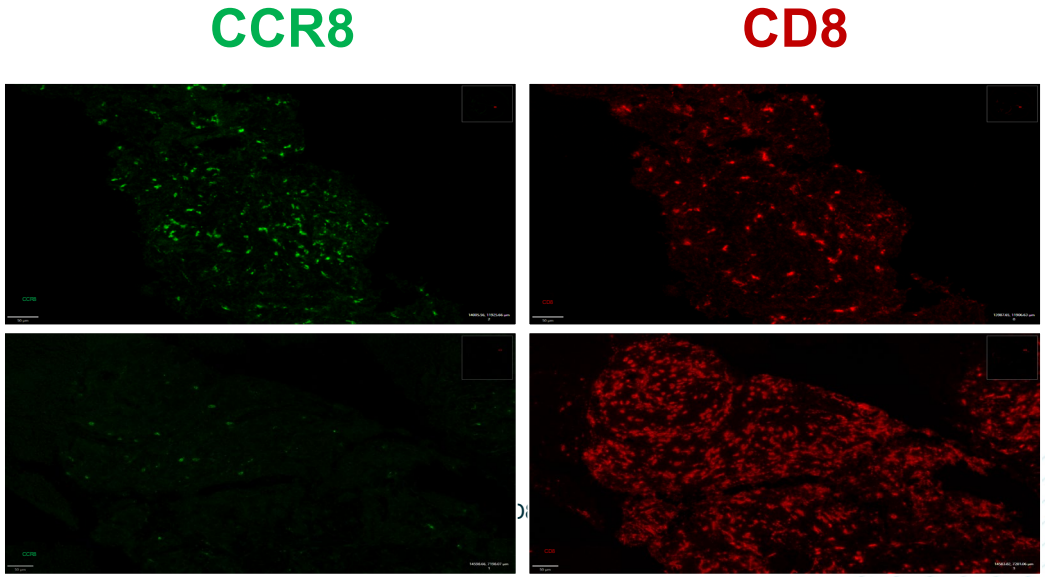
Our Strategy is to Broadly Develop Tagmokitug as the CCR8+ Treg Depleter of Choice with Partners, and Across Treatments

	Rationale	Potential Indications	# of Eligible Patients (U.S.)
 **Targeted Therapies (e.g., ADCs)**	***Enabling immune activation in "cold" tumors***	• **HNSCC** • **Breast** • **Colorectal**	***~200K***
 **T Cell Engagers and CAR-T**	***Remodeling the TME for T Cell activation***	• **Solid tumors (SCLC)** • **Blood cancer (TCL)**	***~50K***
 **Radiation**	***Overcome Treg resistance induced by radiation therapy***	• **Advanced solid tumors (e.g., HNSCC, NSCLC, gynecologic cancer)**	***>900K***

Tagmokitug May Enhance the Activity Broadly for IO Treatments

TCE, CAR-Ts: Relieve Immune Suppression and Promote T Cells in the Tumor

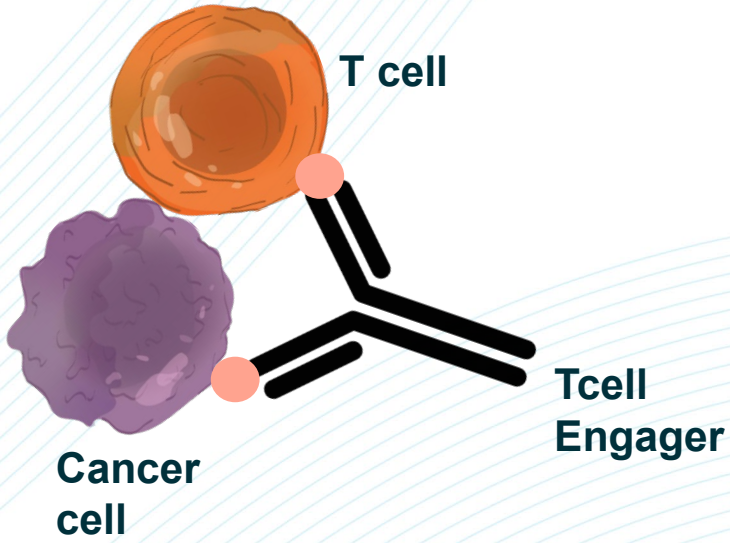
Tagmokitug remodeled the TME – turns tumors "hot"



↓ *CCR8+ Cell Depletion*

↑ *CD8+ T Cell Infiltration*

TCE/CAR-T cells require T cells in the tumor to activate and kill tumor cells



- Tagmokitug depletes immunosuppressive Tregs and increases T cells to improve antitumor immune response
- T cell engagers bind to the tumor on one end and activate the T cell on the other end, so both need to be in proximity

CCR8+ Tregs (CCR8+ FOXP3+): Wilcoxon paired test (left); Mann Whitney non-parametric (right); N=10 CHS-114 monotherapy Arm1b

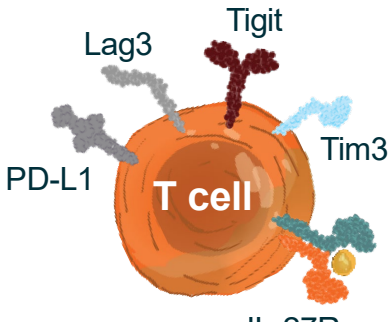
COHERUS ONCOLOGY

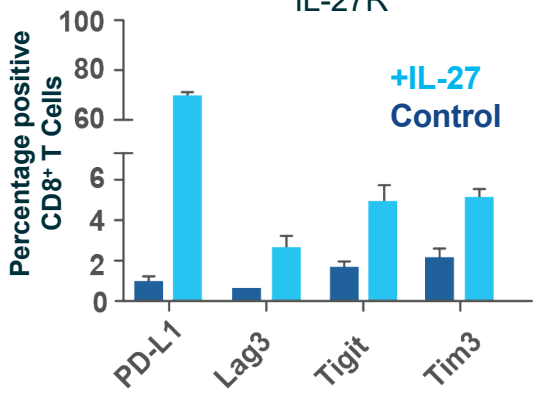
- Commercial Stage Innovative Oncology Company
- LOQTORZI®: Revenue Multiplier Backbone PD-1
- Tagmokitug: Highly-Selective, Potentially Best-in-Class Treg Depleter
- **Casdozokitug: First-in-Class IL-27 Antagonist**
- 2026 is a Data-Rich Year with Multiple Value Drivers

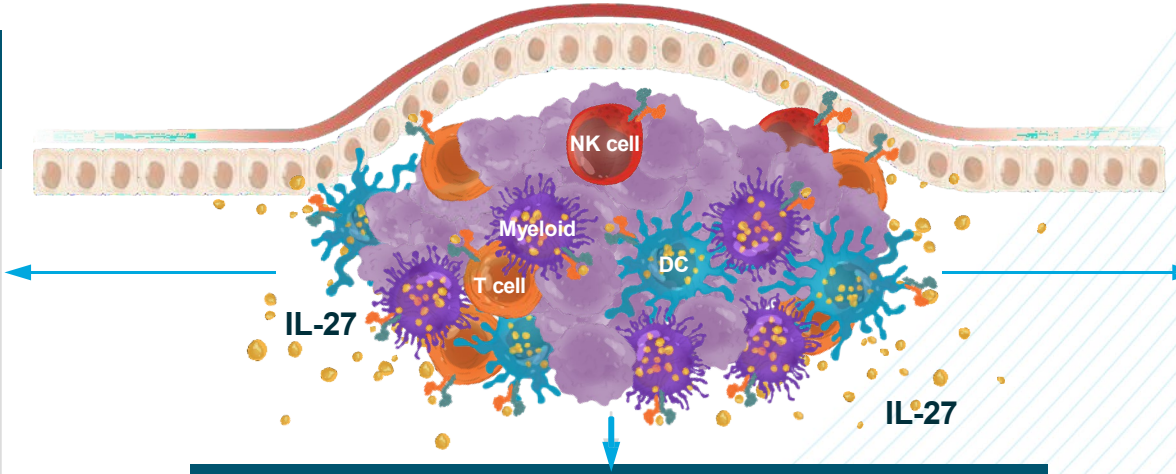
IL-27 Inhibits Natural Killer (NK) and T Cell Antitumor Response

Modulates Immune Response, Immune Pathology, and Tumor Immune Evasion

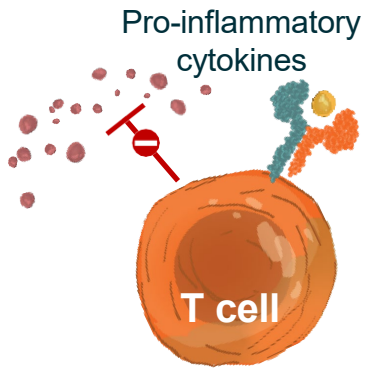
IL-27 upregulates checkpoint receptors[1,2]

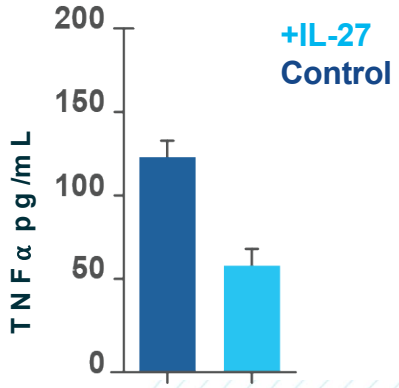




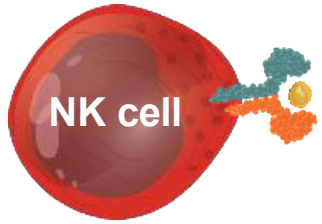


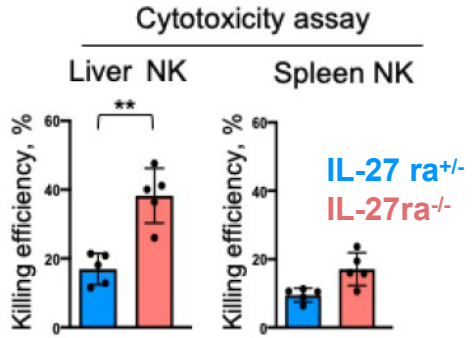
IL-27 downregulates pro-inflammatory cytokines





IL-27 constrains NK cell immunosurveillance[3]



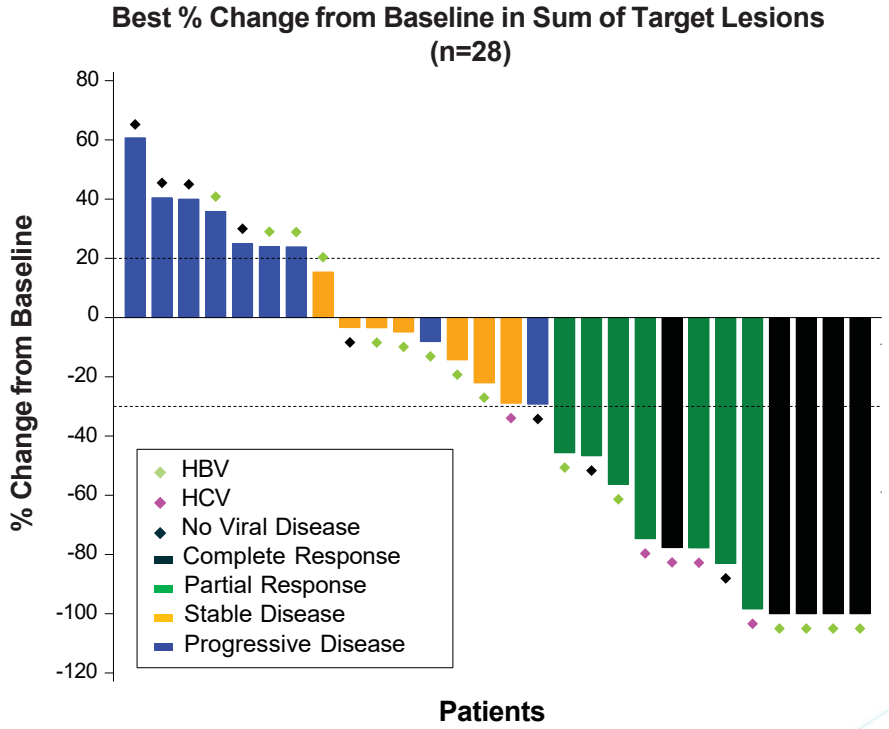


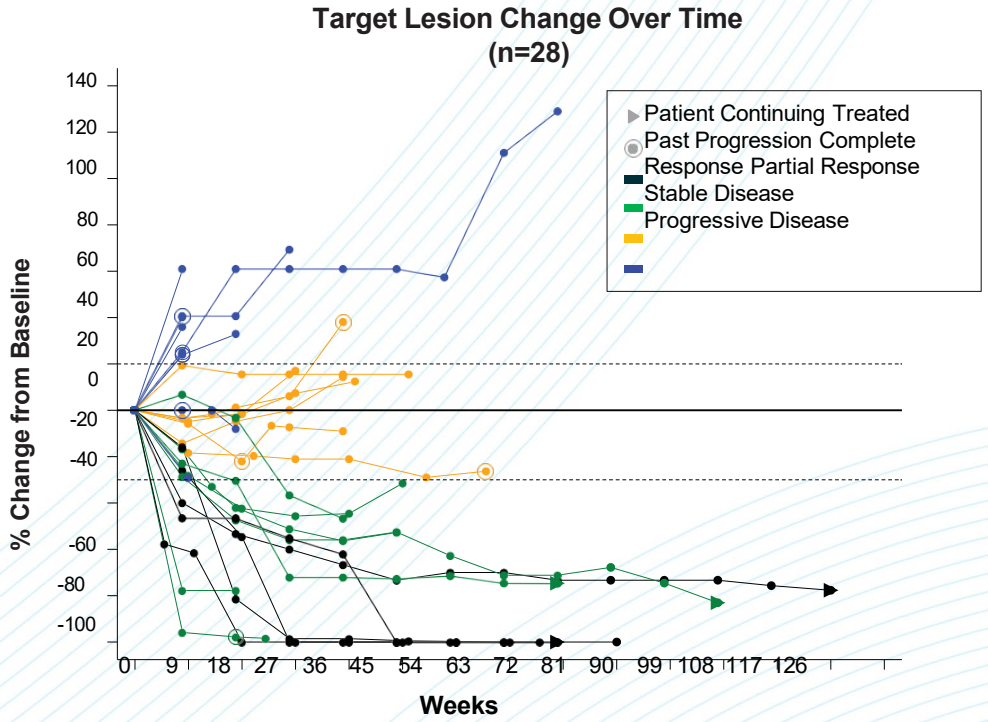
IL-27 Represents A Novel Immune Target Complementary to PD-1

1. Chihara et al., Nature 558, 2018; 2. DeLong et al., ImmunoHorizons 3, 2019; 3. Aghayev et al., Cancer Discov., 12, 2022

Casdozokitug Combination Demonstrated Strong Clinical Activity

Phase 2 Study Results - Durable Responses: 11 Objective Responses, 5 CRs





- 38% ORR / 17% CR to date in response evaluable set (viral and nonviral patients)
- Safety profile consistent with atezo/bev alone
- Biomarker data demonstrate association with IL-27 pathway

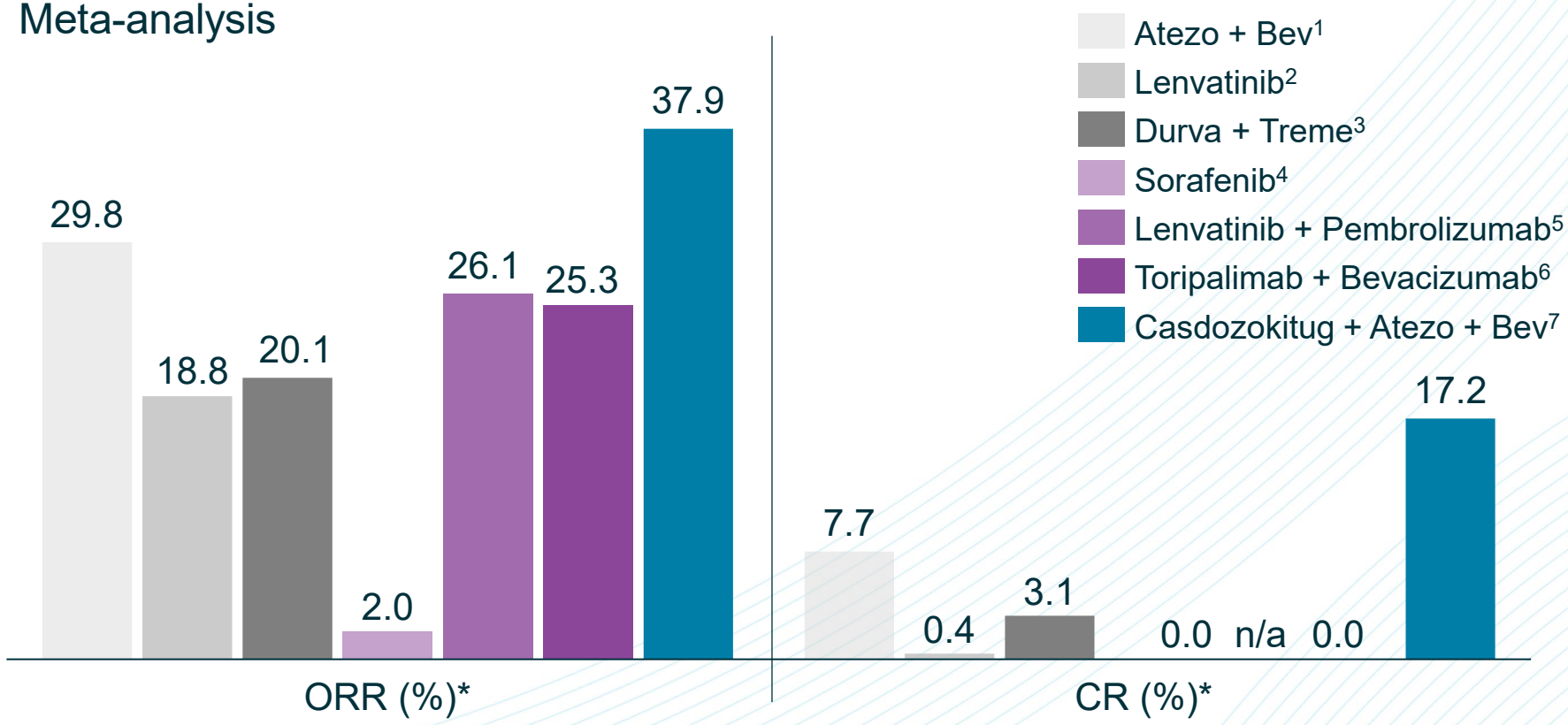
- Casdozo + atezo/bev demonstrated deep, durable responses in 1st-Line HCC

Li D, et al. Results from a phase 2 study of triplet blockade of the IL-27, PD-(L)1, and VEGF pathways with casdozokitug (casdozo, CHS-388) in combination with atezolizumab and bevacizumab in patients with unresectable, locally advanced or metastatic hepatocellular carcinoma (uHCC). Presented at 2025 American Society of Clinical Oncology (ASCO) Gastrointestinal Cancers Symposium; January 23-25, 2025; San Francisco, CA.

Casdozokitug has the Potential for Significant Improvement of the Standard of Care in 1st-Line HCC

Casdozo + atezo/bev demonstrated a higher ORR and CR than standard of care in 1st-Line HCC

Meta-analysis



- Opportunity to improve efficacy in combination with next-gen anti-PD-1 (LOQTORZI®) in ongoing randomized phase 2 trial
- Opportunity to expand into other tumor types where IL-27 orchestrates immune resistance (sqNSCLC, pancreatic, breast cancer, others)

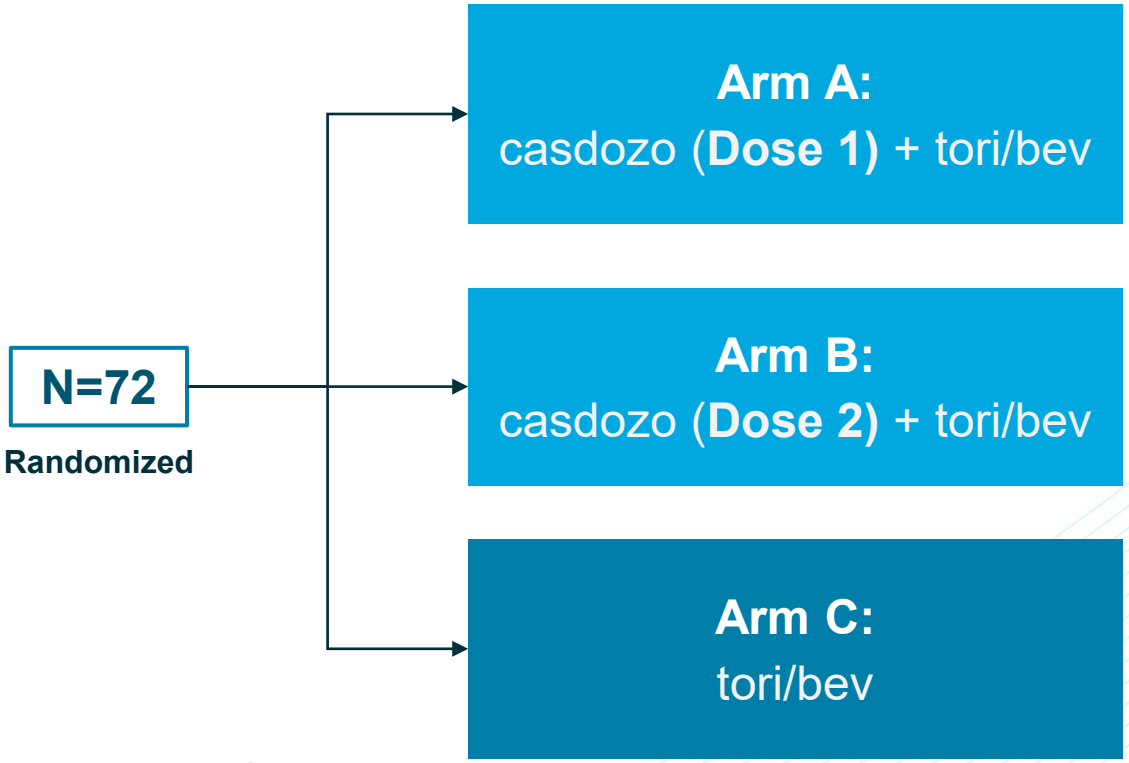
*ORR and CR in % per RECIST v1.1

NSCLC = Non-Small Cell Lung Cancer 1. IMbrave150 trial (Finn et al., NEJM 2020); 2. REFLECT trial (Kudo et al., Lancet 2018); 3. HIMALAYA trial (Abou-Alfa et al., NEJM 2022); 4. SHARP trial (Llovet et al., NEJM 2008); 5. LEAP-002 trial (Finn et al., Lancet Oncol 2023); 6. HEPATORCH trial (Junshi, OncLive 2025); 7. SRF388-201 (casdozokitug Triplet, Coherus ASCO GI 2025)

Ongoing Casdozokitug Phase 2 Clinical Study in 1L HCC

In Combination with LOQTORZI and Bevacizumab with Aim to Advance 1L SOC

Interim data readouts in mid 2026 with data maturation through 2026



ClinicalTrials.gov ID: NCT06679985

- **First patient dosed in Q2 2025**
- **Toripalimab phase 3 HEPATORCH* data to support contribution of component**
- **Casdozo has Orphan Drug Designation in HCC**

***1L HCC - HEPATORCH**
Combo with bevacizumab vs sorafenib; Approved in China

HCC mRECIST = Modified RECIST Assessment for hepatocellular carcinoma; 1. FAN, J. (2024) *HEPATORCH: A randomized, open-label, multicenter, phase III clinical study of the safety and efficacy of toripalimab combined with bevacizumab versus sorafenib as first-line treatment for advanced hepatocellular carcinoma* presented at the 2024 Annual Meeting of Chinese Society of Clinical Oncology

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Coherus Oncology Value Proposition
Shareholder Value Creation Focused on Drugs, Data and Deals

DRUGS

Commercial Stage

LOQTORZI® (toripalimab-tpzi)injection

Clinical Stage

Tagmokitug

anti-CCR8 cytolytic antibody

Casdozokitug

IL-27 antagonist

DATA

Tagmokitug

- HNSCC – Mid 2026
- GC, GEJ, EAC – Mid 2026
- CRC – H2 2026
- ESCC – H2 2026
- Additional indications starting in 2026

Casdozokitug

- HCC – Mid 2026

DEALS

- Tagmokitug novel combinations
- Ex-US licensing
- LOQTORZI® US supply agreements

$172.1M in cash, cash equivalents and investments at the end of Q4 2025, expected to support operations through end of 2026*

Cash, cash equivalents and investments as of December 31, 2025, inclusive of Transition Service Agreement (TSA)-related collections that will be applied to associated TSA payables and accrued liabilities. The preliminary fourth quarter and full year 2025 financial information presented herein has not been audited and is subject to change

NPC = Nasopharyngeal Carcinoma; HNSCC = Head and Neck Squamous Cell Carcinoma; GC = Gastric Cancer; GEJ = Gastro-esophageal-junction; EAC = Esophageal
ESCC = Esophageal Squamous Cell Carcinoma; HCC = Hepatocellular Carcinoma; sqNSCLC = squamous Non-Small Cell Lung Cancer

Coherus ONCOLOGY

OVERCOMING IMMUNE RESISTANCE IN CANCER

44TH ANNUAL J.P. MORGAN Healthcare Conference

Denny Lanfear, Chairman and CEO

January 13, 2026