anixa BIOSCIENCES

NASDAQ:ANIX

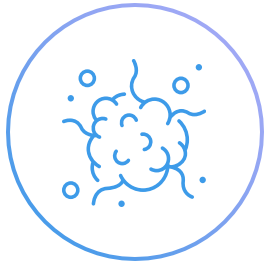
November 2025

Forward-Looking Statements

Statements that are not historical fact may be considered forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are not statements of historical facts, but rather reflect Anixa Biosciences' current expectations concerning future events and results. We generally use the words "believes," "expects," "intends," "plans," "anticipates," "likely," "will" and similar expressions to identify forward-looking statements. Such forward-looking statements, including those concerning our expectations, involve risks, uncertainties and other factors, some of which are beyond our control, which may cause our actual results, performance or achievements, or industry results, to be materially different from any future results, performance, or achievements expressed or implied by such forward-looking statements. These risks, uncertainties and factors include, but are not limited to, those factors set forth in "Item 1A – Risk Factors" and other sections of our most recent Annual Report on Form 10-K as well as in our Quarterly Reports on Form 10-Q and Current Reports on Form 8-K. We undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise, except as required by law. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented herein.

Anixa Snapshot

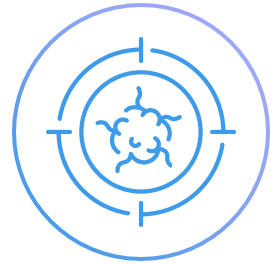
Clinical-stage company developing first-in-class products to treat & prevent cancer



Robust Pipeline

Strong Clinical Data

Key Partnerships



Significant TAM Opportunity

Strong Balance Sheet

Clean Capital Table

Strong Consistent Insider Buying

Capital Efficient Business Model

Capital Efficient Business Model

NASDAQ:ANIX

$16M Cash and short-term investments as of July 31, 2025

~$5-7M Approximate annual cash burn since 2017

33M Common shares outstanding as of July 31, 2025

⊘ No debt

⊘ No warrants, no preferred stock

- **Develop programs with partners**
  - ✓ **Leverage existing infrastructure of partner**
  - ✓ **Maintain low overhead and cash burn**
  - ✓ **Allows for multiple orthogonal projects**
- **Out-license or sell programs to pharma for late-stage clinical development and commercialization**

Total Burn Last Fiscal Year was $7 Million

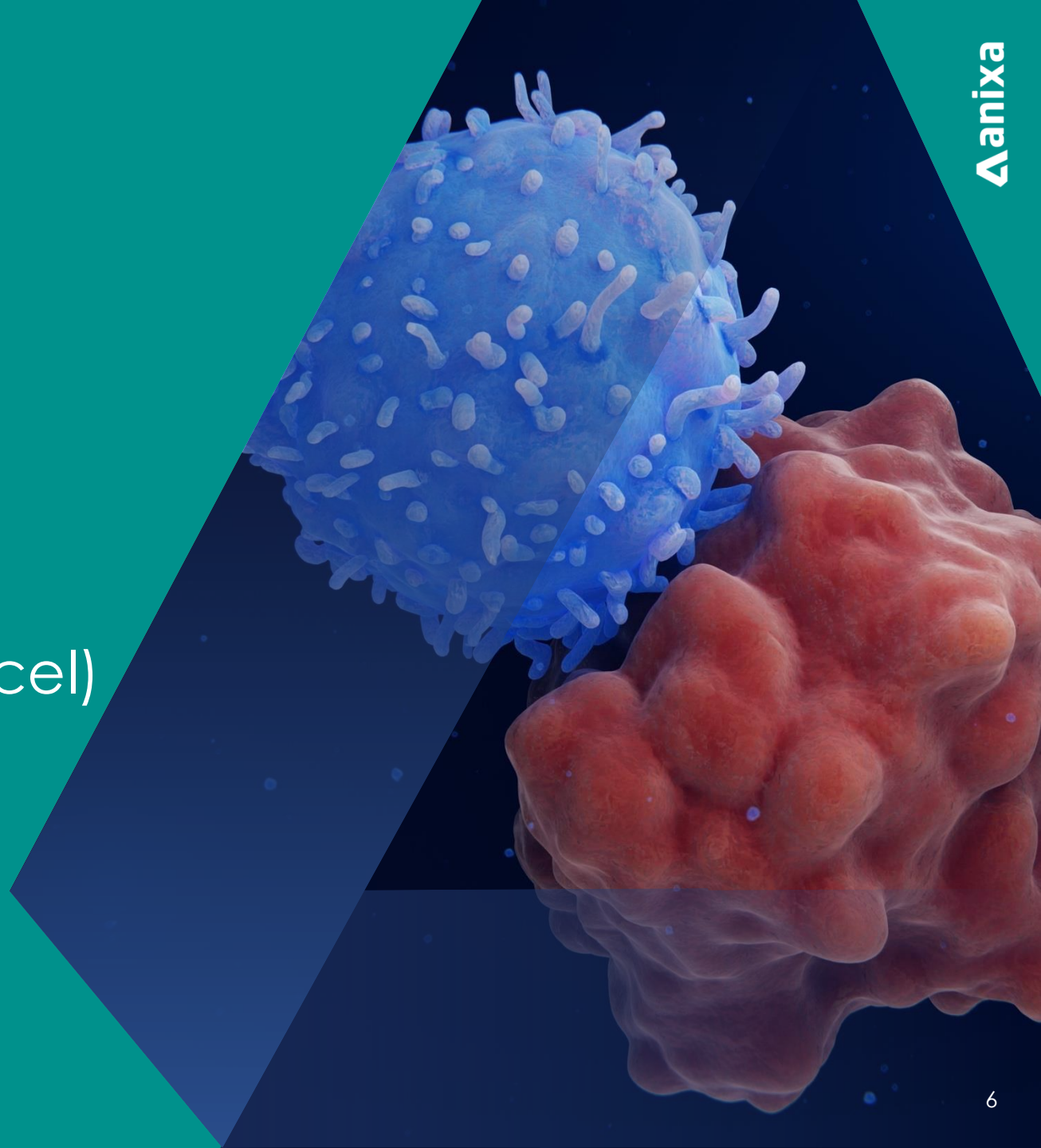
anixa

Clinical Programs & Development Partnerships

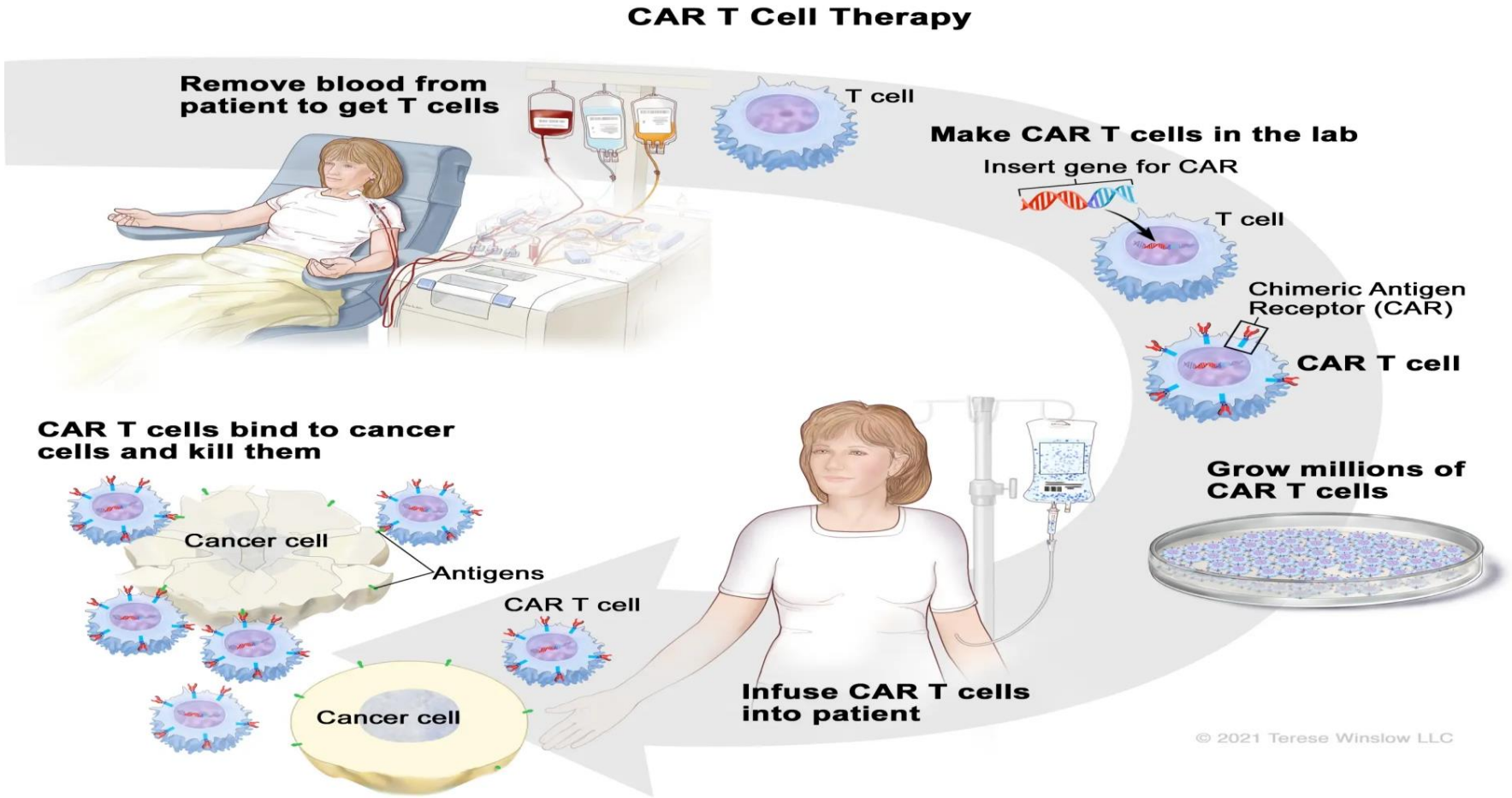
THERAPEUTIC AREA	MECHANISM OF ACTION	INDICATION	GEOGRAPHIC RIGHTS	STAGE	UPCOMING MILESTONES	PARTNERS
Oncology	**CAR-T Therapeutic**	Ovarian Cancer / Other Solid Tumors	Global	Phase 1	Periodic data releases (enrollment based)	MOFFITT CANCER CENTER; THE WISTAR INSTITUTE
Oncology	**Vaccine Therapeutic**	Breast Cancer	Global	Phase 1	Final Phase 1 data release	Cleveland Clinic; Department of Defense
Oncology	Vaccine	Ovarian Cancer	Global	Pre-clinical	Initiate IND enabling studies	Cleveland Clinic; NIH National Cancer Institute
Oncology	Vaccine	Lung, Colon, Prostate	Global	R&D	Pre-clinical Data	Cleveland Clinic

CAR-T Program

Ovarian Cancer Therapy
Liraltagene autoleucel (Lira-cel)



CAR-T Procedure- Chimeric Antigen Receptor T cell



CAR-T Technology

Background & opportunity

Chimeric Antigen Receptor T cell

CAR- T has made great inroads in B-Cell cancers

- High Overall Response Rates and Durable responses (50-80% of patients)
- Multi-billion-dollar valuations and big pharma deals
  - Novartis - First approved product by FDA
    - Kymriah for Acute Lymphoblastic Leukemia (ALL)
    - Second approval for Diffuse large B-cell Lymphoma (DLBCL)
  - KITE - $12BB acquisition by GILD
  - JUNO - $9BB acquisition by CELG

Our Opportunity

- CAR-T in solid tumors has failed

Our Unique Approach

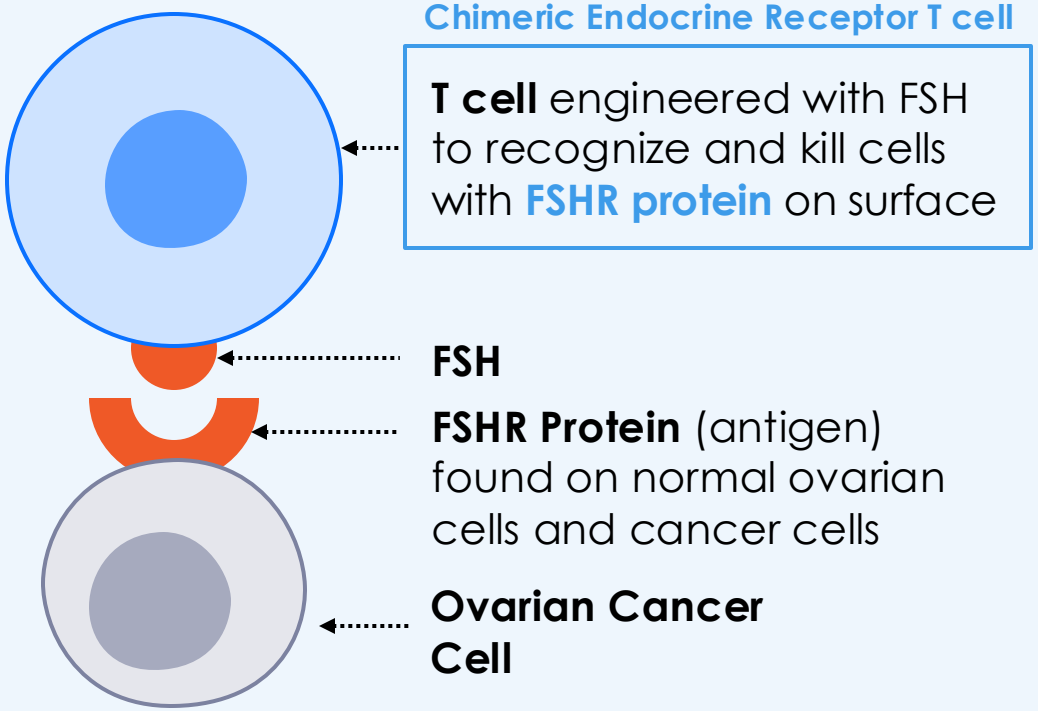
- Anixa's novel tech has three unique attributes:
- Unique target antigen that is primarily found on ovaries in women
- Anti-angiogenesis effect of our T cells
- Intraperitoneal delivery

Anixa's Unique & Targeted CAR-T Approach for Solid Tumors- Lira-cel

Exclusive worldwide license from The Wistar Institute

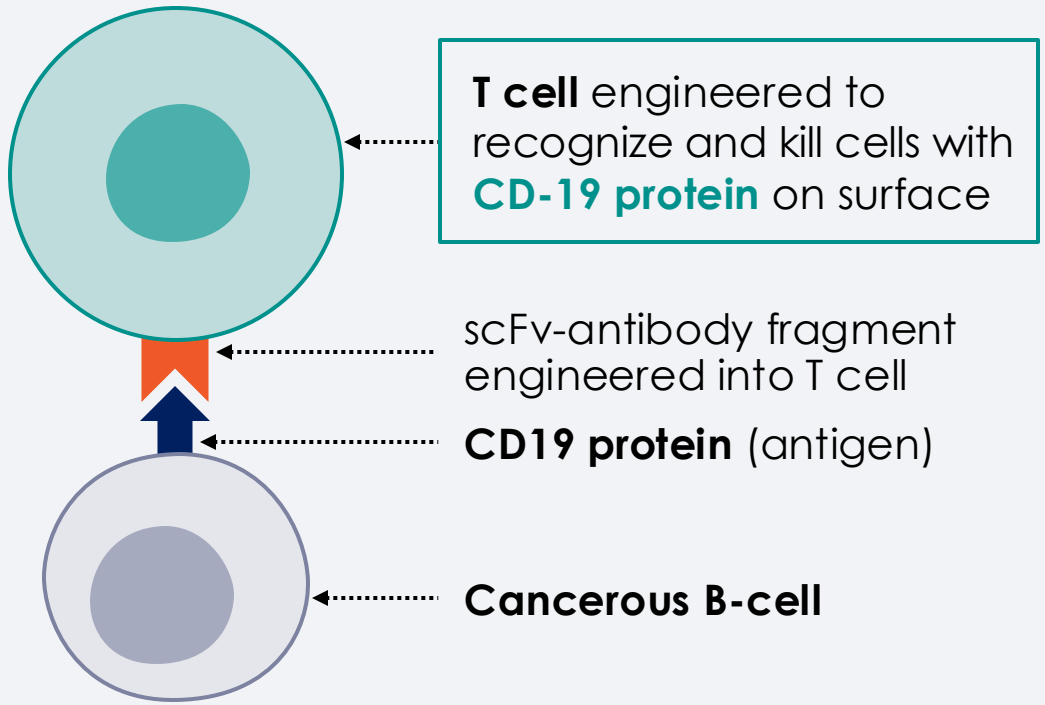
Lira-cel for Ovarian Cancer

Follicle Stimulating Hormone Receptor ("FSHR")-mediated CAR-T Technology



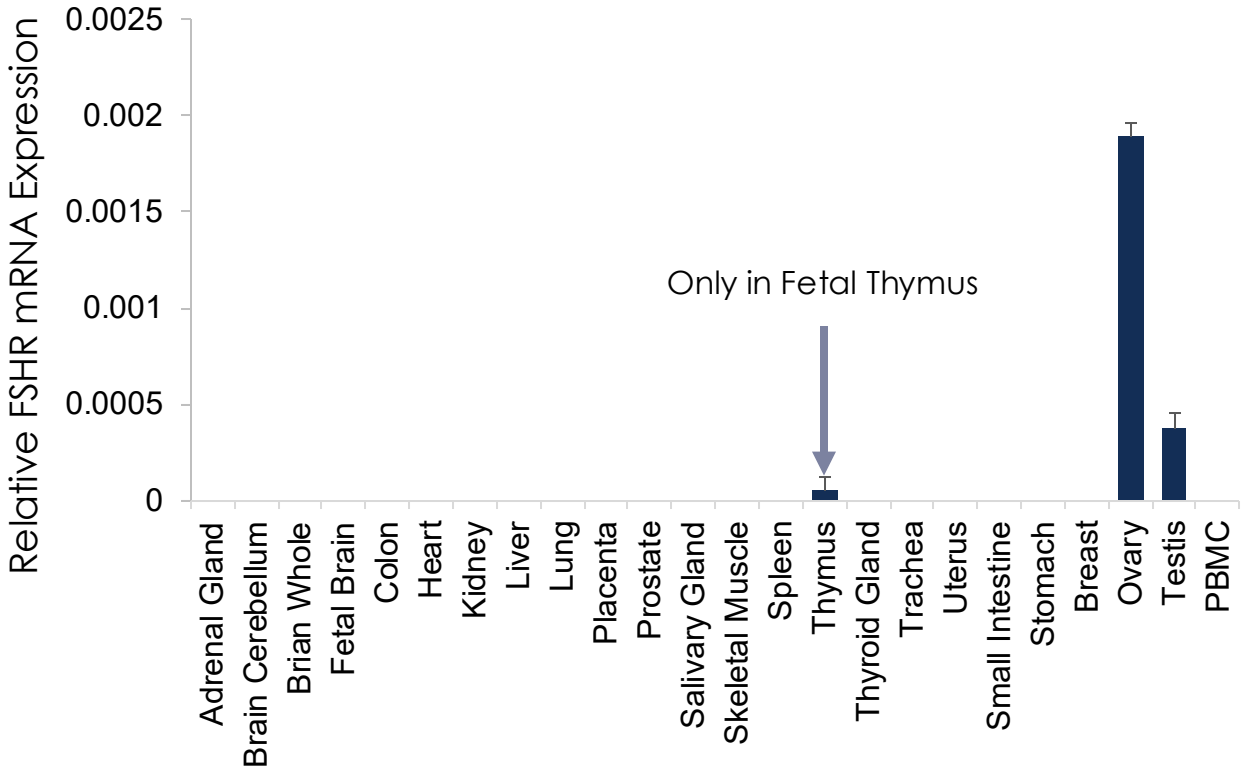
Other CAR-T Programs

Novartis, JUNO, KITE and others working on B-Cell cancers



FSHR ONLY Expressed in Ovaries, Testes and Tumor Blood Vessels

In Healthy Humans



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Expression of Follicle-Stimulating Hormone Receptor in Tumor Blood Vessels

Aurelian Radu, Ph.D., Christophe Pichon, Ph.D., Philippe Camparo, M.D., Martine Antoine, M.D., Yves Allory, M.D., Anne Couvelard, M.D., Gaëlle Fromont, M.D., Mai Thu Vu Hai, Ph.D., and Nicolae Ghinea, Ph.D.

ABSTRACT

BACKGROUND

In adult humans, the follicle-stimulating hormone (FSH) receptor is expressed only in the granulosa cells of the ovary and the Sertoli cells of the testis. It is minimally expressed by the endothelial cells of gonadal blood vessels.

METHODS

We used immunohistochemical and immunoblotting techniques involving four separate FSH-receptor-specific monoclonal antibodies that recognize different FSH receptor epitopes and in situ hybridization to detect FSH receptor in tissue samples from patients with a wide range of tumors. Immunoelectron microscopy was used to detect FSH receptor in mouse tumors.

RESULTS

In all 1336 patients examined, FSH receptor was expressed by endothelial cells in tumors of all grades, including early T1 tumors. The tumors were located in the prostate, breast, colon, pancreas, urinary bladder, kidney, lung, liver, stomach, testis, and ovary. In specimens obtained during surgery performed to remove tumors, the FSH receptor was not expressed in the normal tissues located more than 10 mm from the tumors. The tumor lymphatic vessels did not express FSH receptor. The endothelial cells that expressed FSH receptor were located at the periphery of the tumors in a layer that was approximately 10 mm thick; this layer extended both into and outside of the tumor. Immunoelectron microscopy in mice with xenograft tumors, after perfusion with anti–FSH-receptor antibodies coupled to colloidal gold, showed that the FSH receptor is exposed on the luminal endothelial surface and can bind and internalize circulating ligands.

CONCLUSIONS

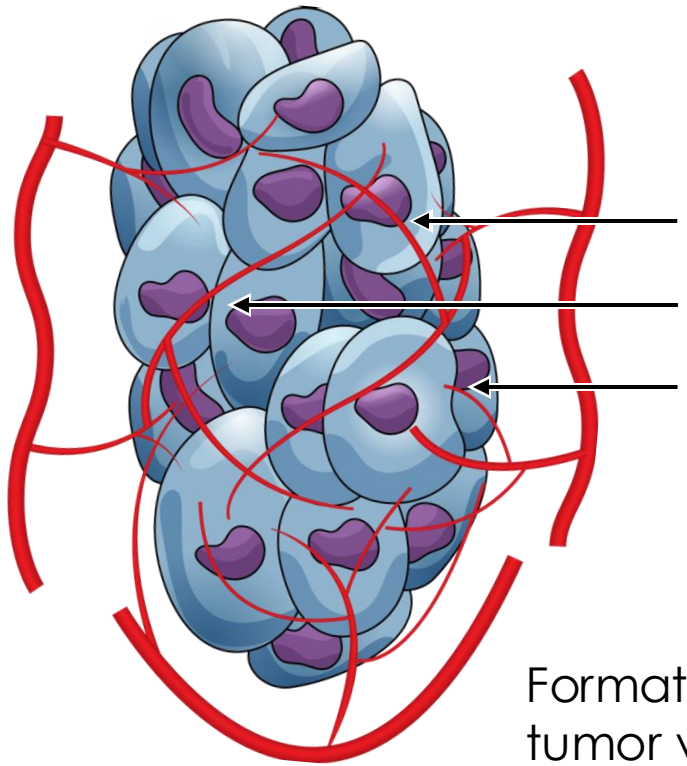
FSH receptor is selectively expressed on the surface of the blood vessels of a wide range of tumors. (Funded by INSERM.)

From Mount Sinai School of Medicine, New York (A.R.); and INSERM Unité 753, Villejuif (C.P.), Val-de-Grâce Hospital, Paris (P.C.), Tenon Hospital, Paris (M.A.), INSERM Unité 955-Eq 07, Université Paris-Est, Créteil (Y.A., M.T.V.H., N.G.), Beaujon Hospital, Clichy (A.C.), and Centre Hospitalier Universitaire de Poitiers, Poitiers (G.F.) — all in France. Address reprint requests to Dr. Ghinea at INSERM Unité 955-Eq 07, 8 rue du Général Sarrail, Université Paris-Est, Créteil, France, or at nicolae.ghinea@inserm.fr.

N Engl J Med 2010;363:1621-30.

Lira-cel: Dual Mechanism of Action

Angiogenesis
Tumors induce rapid blood vessel growth to nourish themselves



These blood vessels are positive for **FSHR**

Formation of new tumor vasculature

- Many tumors have blood vessels where FSHR is expressed even though healthy tissue does not show such expression
- Anti-angiogenesis drugs are a multi-billion-dollar class of drugs, with Avastin the leader with 2021 sales of $3 billion
- Enables Dual Mechanism of Action

Lira-cel may destroy tumor vasculature and starve or shrink the tumor, disrupting FSH from both the inside and outside

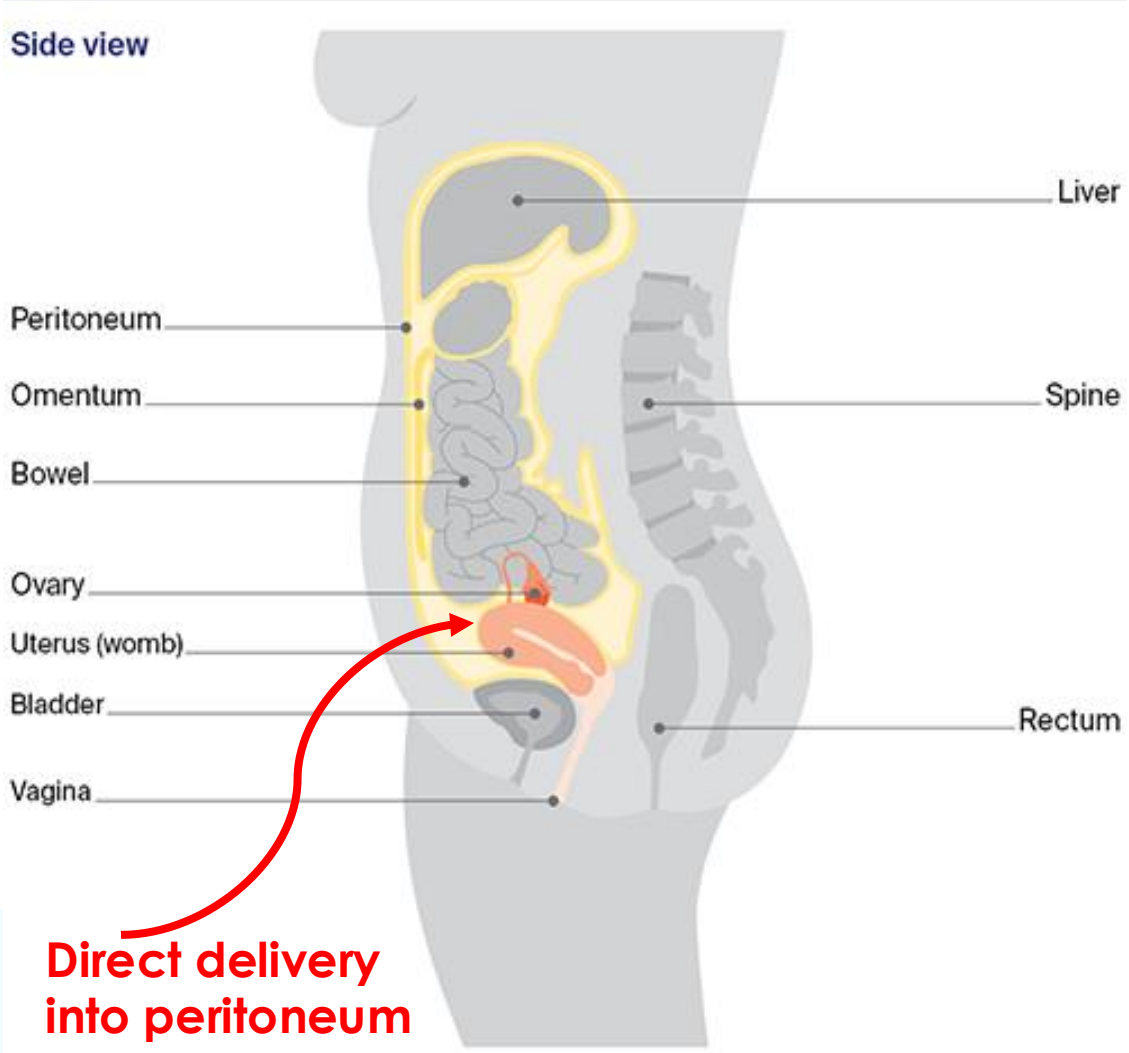
Combination therapy utilizes dual mechanisms of action. Lira-cel operates a dual mechanism with a single agent

Tumors expressing FSHR on vasculature:
Lung, Breast, Prostate, Colon, Head & Neck, Pancreatic, Liver, Renal, Ovarian and others

Intraperitoneal Delivery (IP) Is Another Key Advantage

- Most, if not all, ovarian cancer lesions remain within the peritoneal cavity
- By delivering through an IP catheter, the engineered T cells will largely remain in the peritoneal cavity
- Very few, if any, engineered T cells escape into blood stream
  - Minimizes side effects like CRS
  - Better trafficking to tumor lesions
  - May enable us to go to much higher concentrations than available with IV administration

We plan to test IV delivery, but to date all patients have been treated via IP delivery



Dose-escalation first-in-human clinical trial in recurrent/chemoresistant ovarian cancer

- PI: R. Wenham, MD Chair, Gynecologic Oncology Program Moffitt Cancer Center
- I.P. *vs.* I.V.→ Comparative safety and effectiveness

Table 1. Dose-escalation scheme.

Cohort	Dose Level	Cyclophosphamide dose	FSHCER T-cell Dose	Number of Patients
1	1	None	1×10^5 cells/kg	3-6 patients
2	2	None	3×10^5 cells/kg	3-6 patients
3	3	None	1×10^6 cells/kg	3-6 patients
4	4	None	3×10^6 cells/kg	3-6 patients
6	5	None	1×10^7 cells/kg	3-6 patients
5	3	Cyclophosphamide 500 mg/m^2 and fludarabine (30 mg/m^2) × 3 days	1×10^6 cells/kg	3-6 patients
5b	4	Cyclophosphamide 500 mg/m^2 and fludarabine (30 mg/m^2) × 3 days	3×10^6 cells/kg	3-6 patients
5c	5	Cyclophosphamide 500 mg/m^2 and fludarabine (30 mg/m^2) × 3 days	1×10^7 cells/kg	3-6 patients

Current dosage

Clinical Results to Date: Excellent Safety Profile and Preliminary Findings of Clinical Activity

- **Current Status**
  - **12 patients treated to date, 3 in each of the first 4 dose cohorts (Conventional 3+3 Phase 1 oncology trial design)**
  - **Patients in most recent cohort received 3 x 10^6 CAR+ T cells/kg**
- **Safety**
  - **No dose limiting toxicities (DLT), CRS (cytokine release syndrome) or ICANS (immune effector cell-associated neurotoxicity syndrome)**
- **Clinical Activity**
  - **One patient survived 28 months after treatment- received 2 CAR-T doses, 2nd dose delivered approximately 18 months after 1st dose***
  - **Multiple patients survived 10 or more months after treatment**
  - **Most patients surpassed the median expected overall survival of 3-4 months**

*FDA has approved a second CAR-T dose if warranted for patients in trial

In clinical trial, we are treating patients who have failed 2-6 approved therapies

The preliminary results on these terminally ill patients is very promising and has exceeded our expectations for the low doses

Vaccine Program

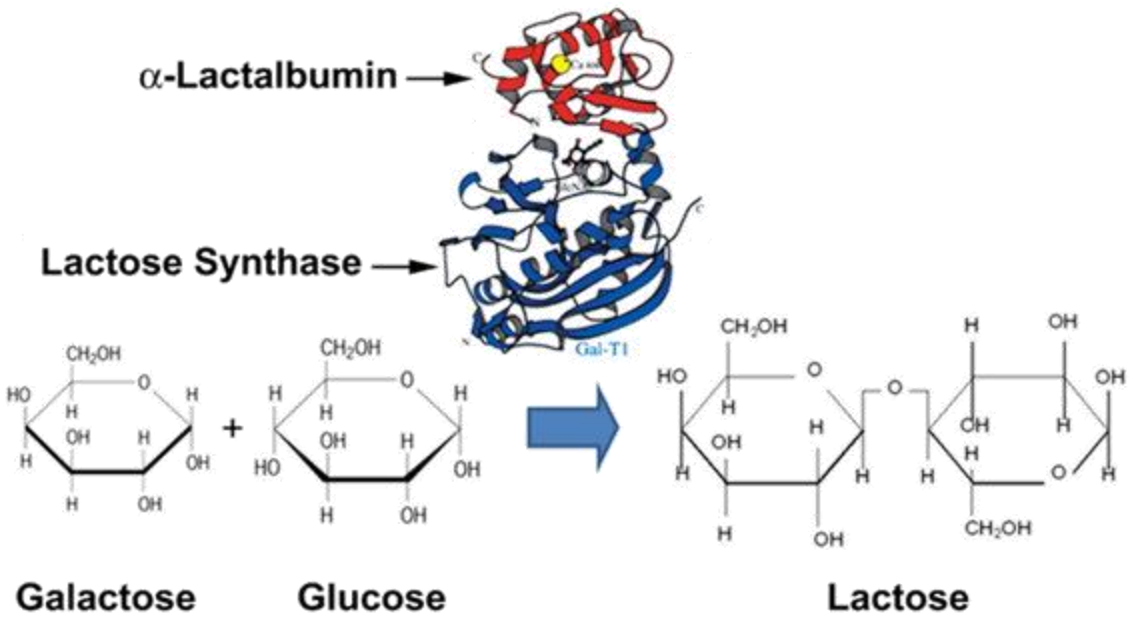
Breast Cancer

Breast Cancer Vaccine: Retired Tissue-Specific Protein

Exclusive worldwide license from Cleveland Clinic

Retired Tissue-Specific Protein

Expressed at periods of life, but no longer expressed as we age



α-LACTALBUMIN

- Expressed ***only*** in the breast and ***only*** during lactation
- Expressed in tumor cells, especially Triple Negative Breast Cancer **("TNBC")**
- Our vaccine targets this retired protein
  - Once vaccinated, the patient's immune system is ready to destroy cells expressing the protein as they arise, disallowing cancer to gain critical mass

TNBC Overview

- Most aggressive form of breast cancer
- Prevalent cancer in patients with breast cancer gene ("BRCA") mutations

Proof of Concept* -Published in 2012

Vaccinated mouse

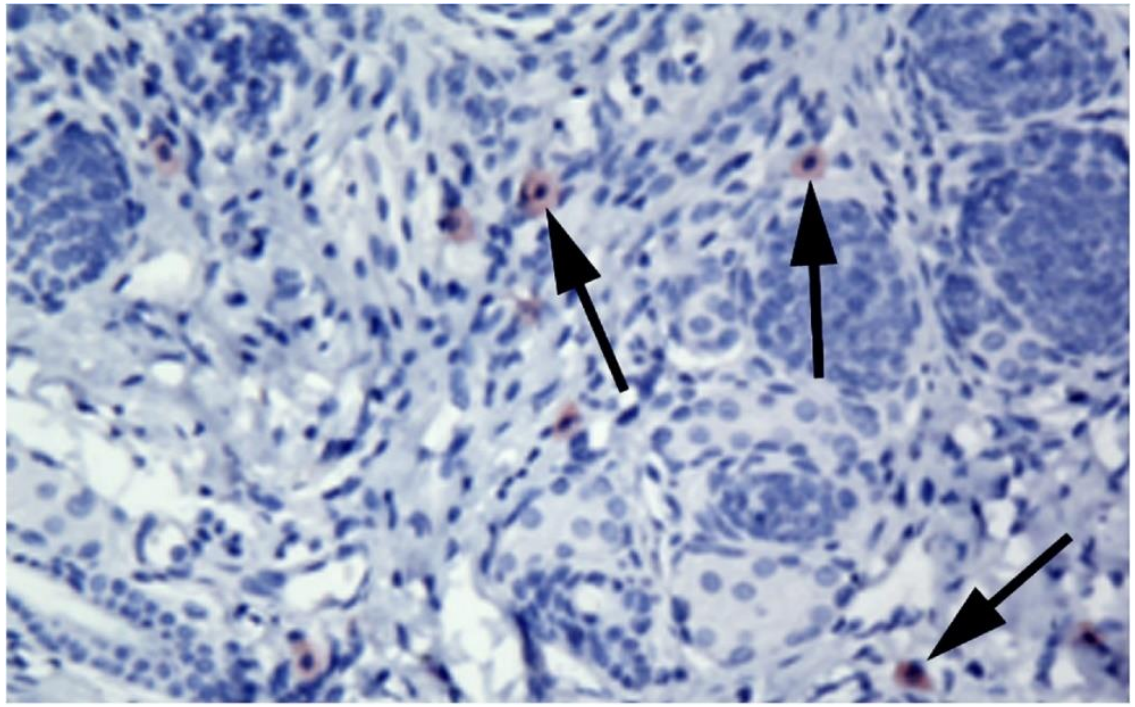
- After vaccination mice were mated and allowed to have a litter.
- The pups were perfectly normal at birth.
- **Mothers were unable to produce milk.**

This proves that vaccination targeting a-lactalbumin enables the immune system to destroy all cells producing that protein.

*SOURCE: AMERICAN J. OF PATHOLOGY, **181**, SEPTEMBER 2012, 775-783.

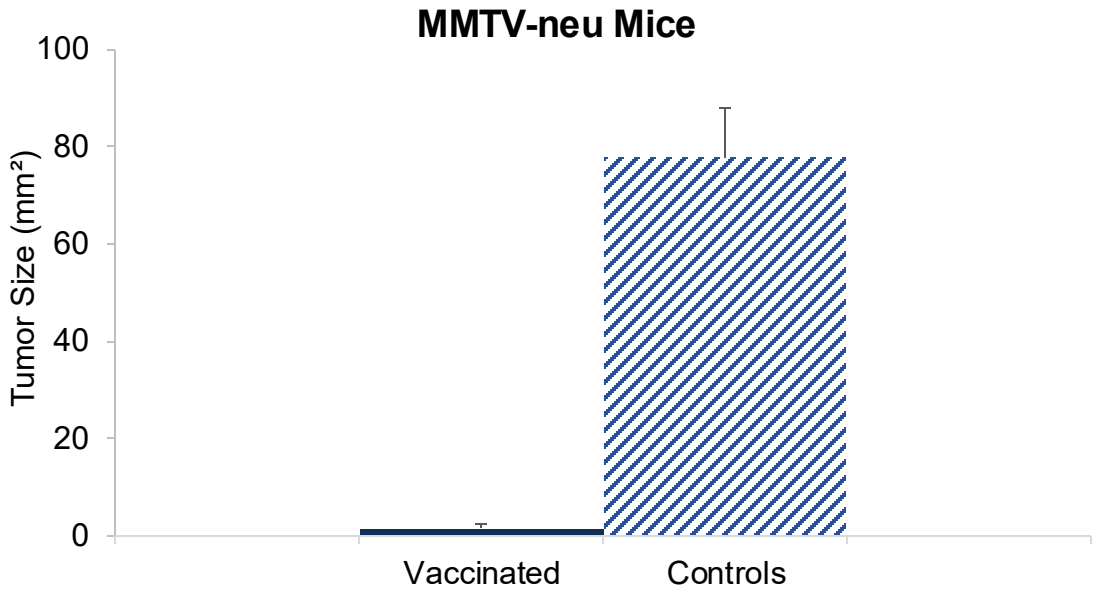
Pre-Clinical Studies: Vaccination Prevents Breast Cancer

Well-Tolerated



Vaccinated mice did not exhibit autoimmune damage, while single T-cell infiltrates were seen in non-lactating breast tissue (arrows)

Robust Pre-Clinical Response



100% of α-LACTALBUMIN vaccinated mice did not develop breast cancer

80% of un-vaccinated mice developed breast cancer

Data published: Nature Medicine, 2010, 16(7), 799-803

Phase 1 Trial

Conducted by Cleveland Clinic, funded by U.S. Department of Defense (DOD)

An open-label Phase 1 dose-escalation trial

Design	Cohort 1a (Recurrence Group)	Cohort 1b (Prevention Group)	Cohort 1c (Treatment Group)
Participants will receive three vaccinations, each two weeks apart, and will be closely monitored for side effects and immune response	▪ 24-36 Patients who have been treated for TNBC ▪ Safety will be monitored ▪ Immune Response will be monitored ▪ Maximum Tolerated Dose ("MTD") determined	▪ Healthy women w/mutations ▪ Chosen to undergo prophylactic mastectomy ▪ Vaccinate before surgery and evaluate immune response and resected tissue ▪ **Unique opportunity to garner supplemental data after studying breast tissue to determine if T cells are surveilling the tissue without any visible cancer tumors**	▪ **Additional cohort combining vaccine with Keytruda** ▪ Patients treated for TNBC ▪ Combine Keytruda w/ vaccine to evaluate if there is synergy

Cleveland Clinic

DOD

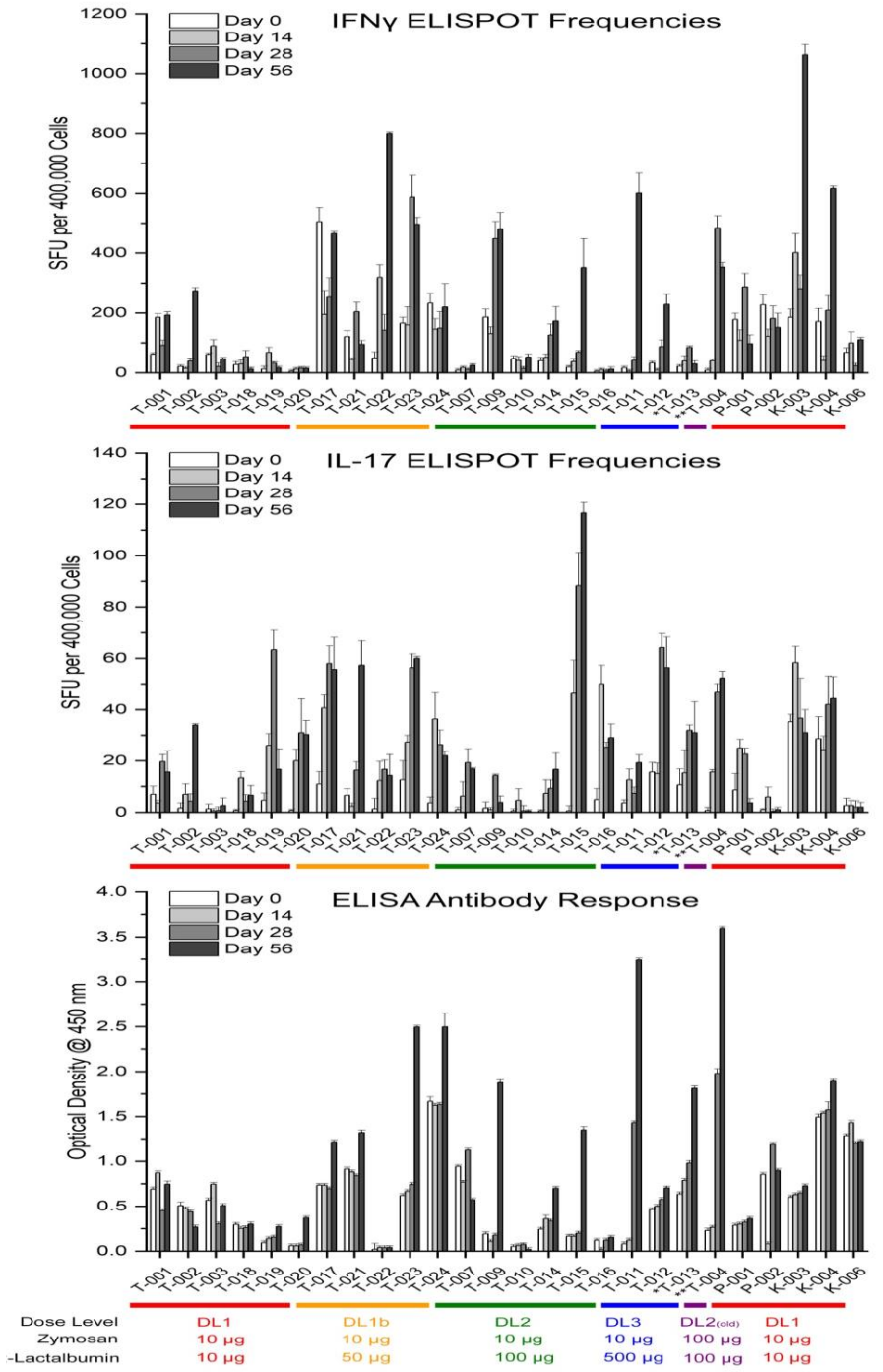
Positive Phase 1 Clinical Results

- **35 patients**
  - TNBC patients who have undergone standard of care, but are at risk of recurrence (40-80% recur in 5 years)— cohort 1a
  - Genetic risk patients choosing prophylactic mastectomies— cohort 1b
  - Patients with residual disease taking Keytruda— cohort 1c

- **Key Findings Presented on November 8, 2024 at Society of Immunotherapy of Cancer (SITC)**
  - MTD reached
  - No safety concerns
  - Immune responses observed at all dose levels
  - 70% had protocol specified immune response
  - Intensity of other responses varied
  - Keytruda plus vaccine exhibited no additional adverse side effects, enabling combination use

- **Phase 1 Status**
  - Final patient visits complete
  - Final data to be presented on December 11, 2025 at San Antonio Breast Cancer Symposium

First 26 Patients



Phase 2 Breast Cancer Vaccine Trial

Near Term- Therapeutic Approach

Phase 2 trial in neo-adjuvant setting – before surgery

- Faster evaluation of efficacy
- Multiple types of Breast Cancer
- Faster data, enabling earlier alliance with big Pharma

Two Arms

- Standard of Care + Vaccine
- Standard of Care only (chemotherapy and/or immunotherapy, such as Keytruda)

Breast Cancer Vaccine Development Plan and Market Opportunity

Clinical Trials and Launches will occur in stages

- **Neo-Adjuvant Therapeutic treatment**
- **Adjuvant-therapeutic treatment**
- **Recurrence Prevention**
- **Prophylactic Vaccination-**
  - **Cancer free individuals for primary prevention**

Market Opportunity

- 2023- $38.35 billion[1]
- 2030- $89.67 billion, projected CAGR of 12.9%[1]

Market Opportunity

- Over 3.8 MM breast cancer survivors in the U.S.[2]
  - Tens of millions outside of U.S.
- Millions harbor mutations creating high risk
- More than 80 million women are currently 40 or older in the U.S.
  - 1.4 billion outside the U.S.
  - Millions more age into this group annually

1) Maximize Market Research
2) National Cancer Institute

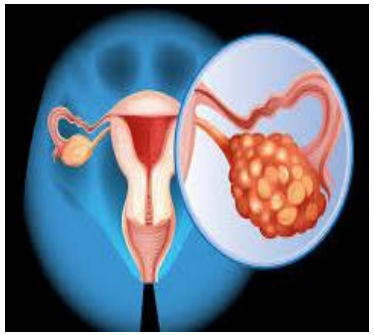
Pre-Clinical Pipeline

Ovarian, Lung, Prostate, Colon

Collaboration with Cleveland Clinic and the National Cancer institute

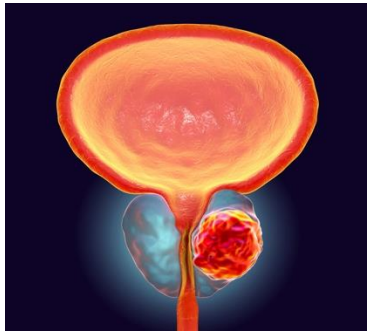
Driven by current promising data from Breast Cancer Vaccine Clinical Trial

Maintain our Lead in Prophylactic Cancer Vaccine Development

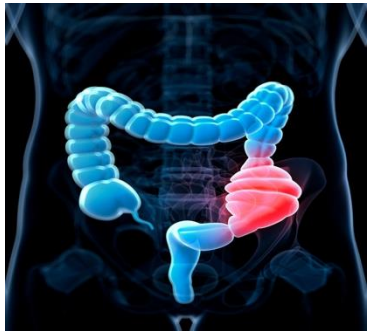


Ovarian

Lung



Prostate



Colon

Development of Additional Cancer Vaccines

- Bioinformatic analysis utilizing advanced AI and supercomputing capabilities
- Pre-clinical studies to verify and validate antigen targets
- Animal studies to establish proof of concept
- Clinical Development

Thank you

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