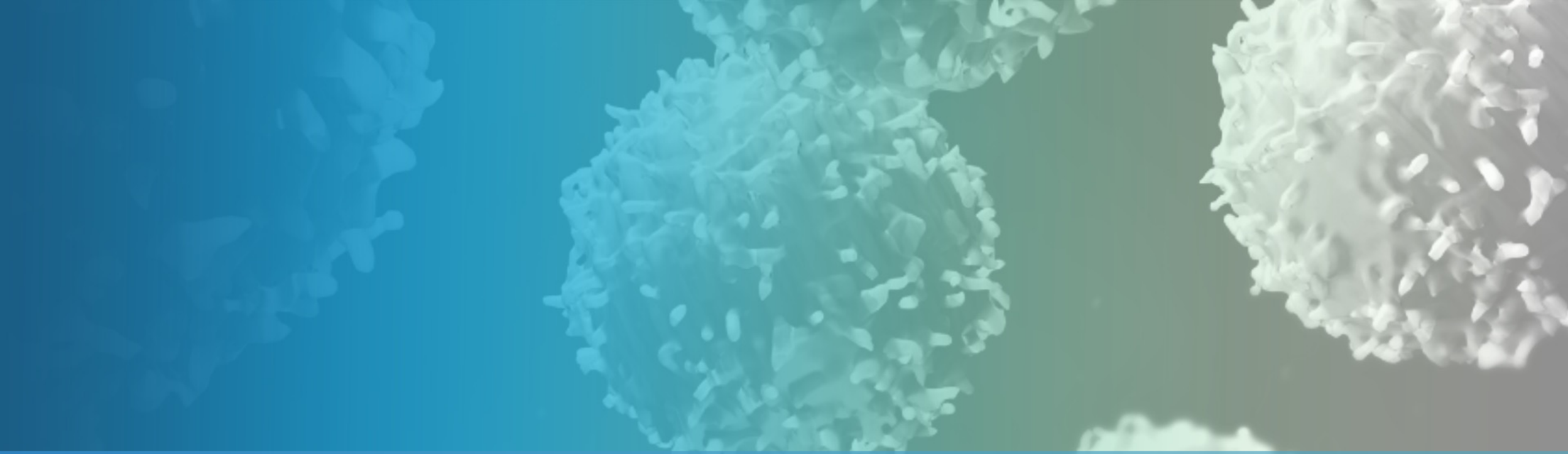

IN8bio

A Leader in Gamma-Delta T Cells

October 2022

Disclaimer

The material in this presentation (this “Presentation”) regarding IN8bio, Inc. (“we,” "us" or the “Company”) is for informational purposes only. This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, that involve substantial risks and uncertainties. All statements, other than statements of historical facts, contained in this presentation, including statements regarding the our capitalization and resources; the adequacy of our capital to support our future operations and our ability to successfully initiate and complete ongoing and planned clinical trials and pre-clinical studies; our strategy and focus; the development and commercial potential of any of our product candidates; the timing and success of our development efforts; the success of any of our trials and our ability to achieve regulatory approval for any product candidate; the entry into or modification or termination of collaborative agreements; the date of filings with the FDA; and the potential market or success for our clinical development programs. The words "may," "should," "expects," "intends," "plans," "anticipates," "believes," "estimates," "predicts," "potential," "continue," and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. The Company may not actually achieve the plans, intentions, or expectations disclosed in these forward-looking statements, and you should not place undue reliance on these forward-looking statements. Actual results or events could differ materially from the plans, intentions and expectations disclosed in these forward-looking statements. In addition, the forward-looking statements included in this presentation represent the Company's views as of the date of this presentation. The Company anticipates that subsequent events and developments will cause its views to change. However, while the Company may elect to update these forward-looking statements at some point in the future, it specifically disclaims any obligation to do so. These forward-looking statements should not be relied upon as representing the Company's views as of any date subsequent to the date of this presentation.

Certain information contained in this presentation relates to or is based on studies, publications, surveys and other data obtained from third-party sources and the Company's own internal estimates and research. While the Company believes these third-party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy or completeness of any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal research is reliable, such research has not been verified by any independent source.

Experienced Leadership

Management

William Ho – Co-Founder, President and Chief Executive Officer

- 21+ years in biotech; launched public investing at New Leaf Venture Partners in 2010 and AlephPoint Capital in 2014; previously FP&A at CuraGen Corporation, equity research at Bank of America and Piper and healthcare investment banking at Cowen

Lawrence Lamb, PhD – Co-Founder and Chief Scientific Officer

- 30 years of clinical and translational research; previously Professor and the Director of the Cell Therapy Laboratory at the University of Alabama Birmingham (UAB) School of Medicine
- Leader in the field of γδ T cells

Patrick McCall, CPA – Chief Financial Officer

- 17+ years of finance, accounting and capital raising experience; previously VP finance at Turnstone Biologics and Controller at Catalyst Biosciences
- CPA and MBA from Cornell University

Trishna Goswami, MD – Chief Medical Officer

- Triple board-certified hematologist oncologist with 10+ years of experience in industry, most recently at Gilead as VP, Clinical Dev. and previously at Immunomedics
- Multiple BLA filings including two approvals for Trodelvy®

Kate Rochlin, PhD – Chief Operating Officer

- 16+ years of science, research and operations experience, most recently Chief Business Officer at Curadigm; co-founder of Immunovent
- PhD in Molecular Biology and Genetics from Weill Cornell

Ken LaMontagne, PhD – SVP, Business Development

- 20+ years of oncology development, commercial and business development experience in both small and large pharma
- Scientific training at Cold Spring Harbor Laboratory and Harvard Medical School

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IN8bio Value Proposition

Gamma-Delta (γδ) T Cell Expertise

DeltEx Platform

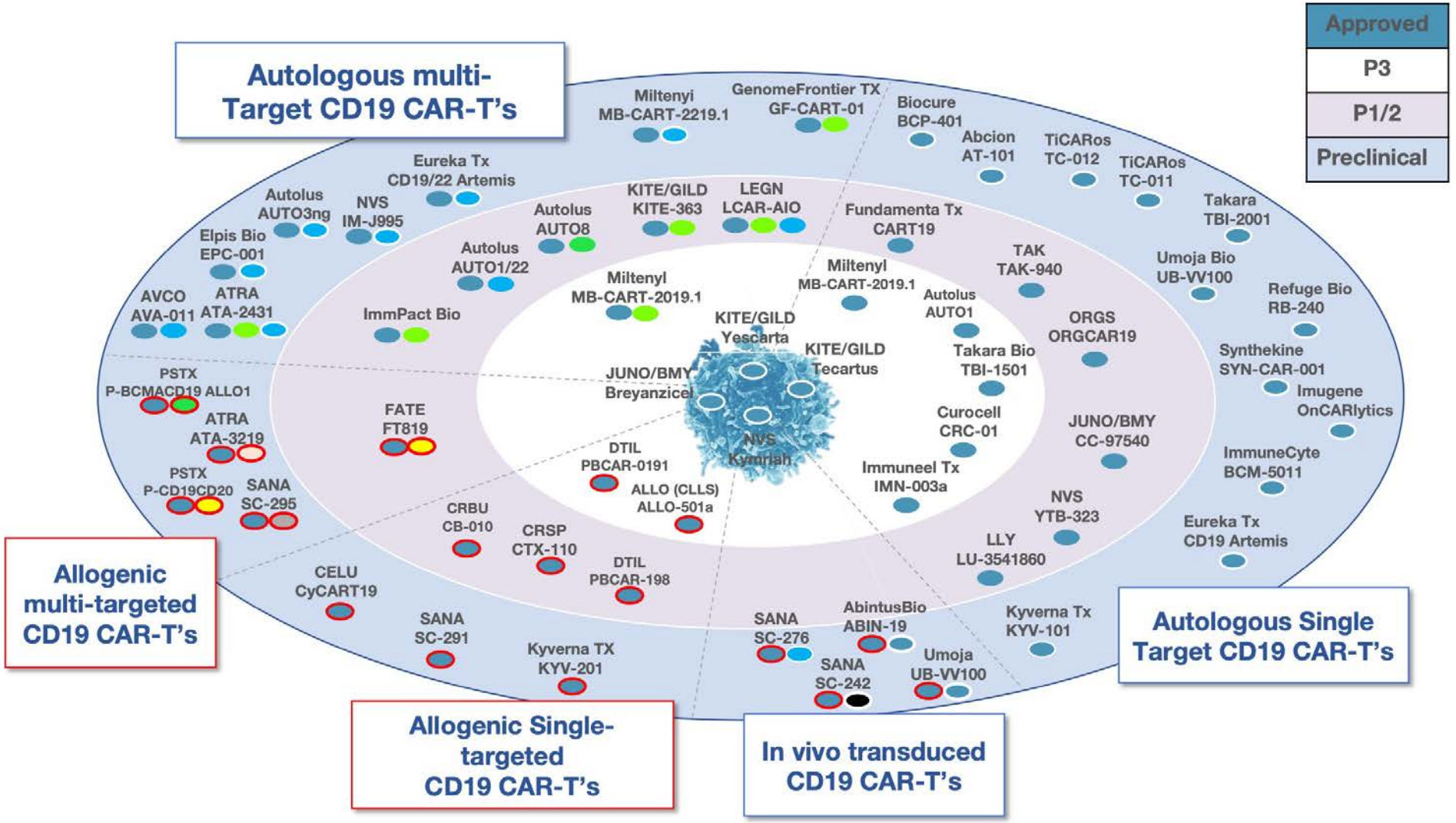
Clinical Pipeline:

INB 100
INB 200

Preclinical Pipeline:

- INB 400 – Allogeneic
- INB 300 – non-signaling CAR-T
- INB 500 – iPSCs

B Cell Targeting CAR-Ts are Crowded

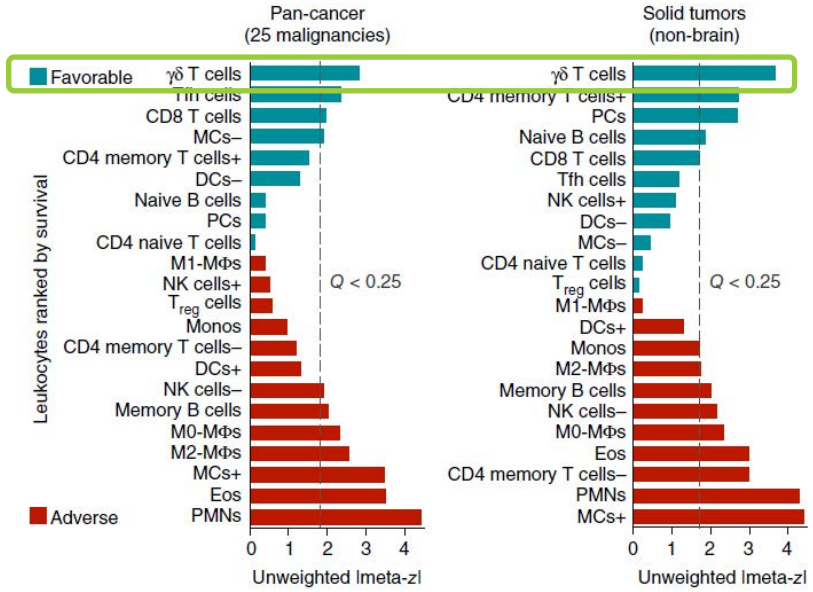


Source: Recreated from Evercore ISI presentation

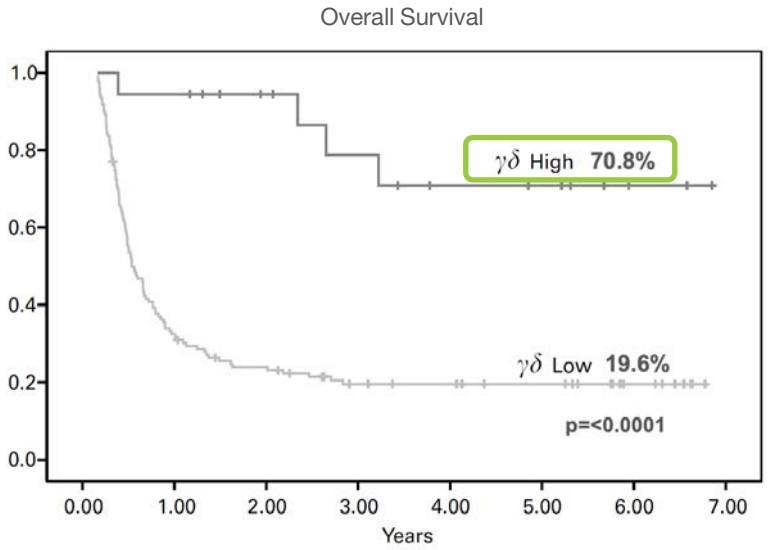
Gamma-Delta (γδ) T Cells are Key to Better Survival

γδ T Cells Observed to Strongly Correlate with Positive Clinical Outcomes

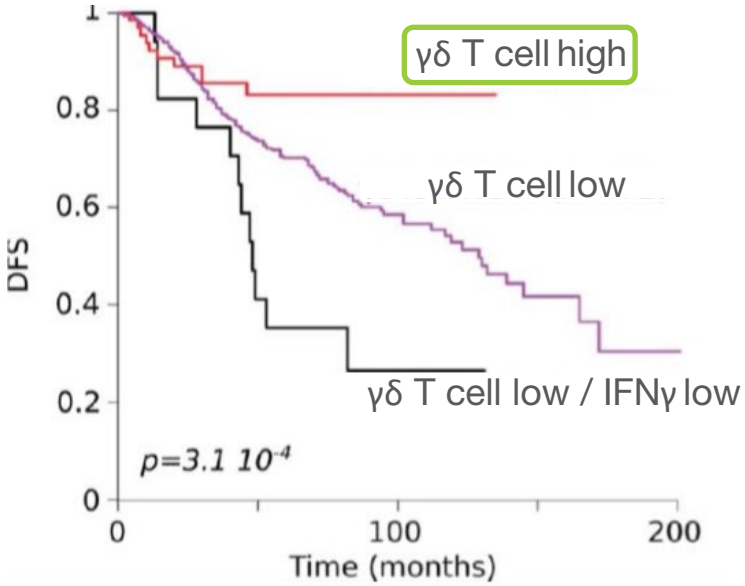
Pan-Cancer: Improved Overall Prognosis



Post-HSCT Improved Survival



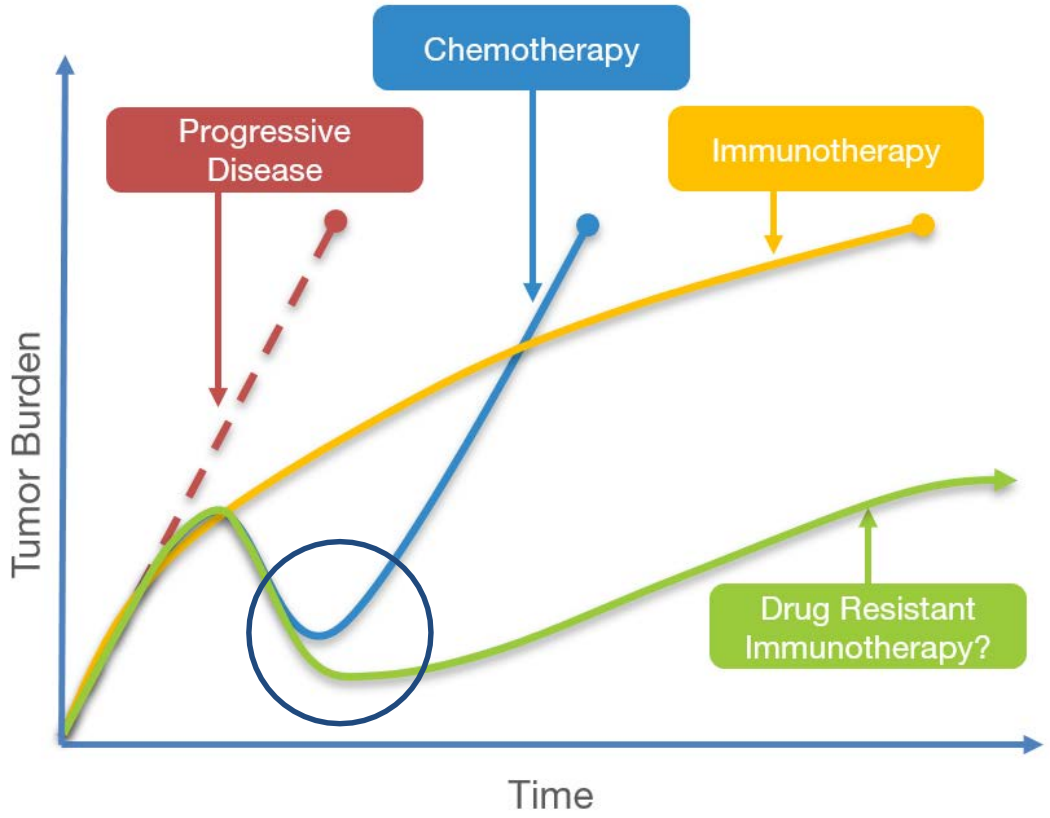
Improved Disease-Free Progression Colorectal Cancer



Source: Gentles et al. 2015, Godder et al. (Lamb), 2007 and Meraviglia et al. 2017

Targeting Cancers by Driving Deeper Responses

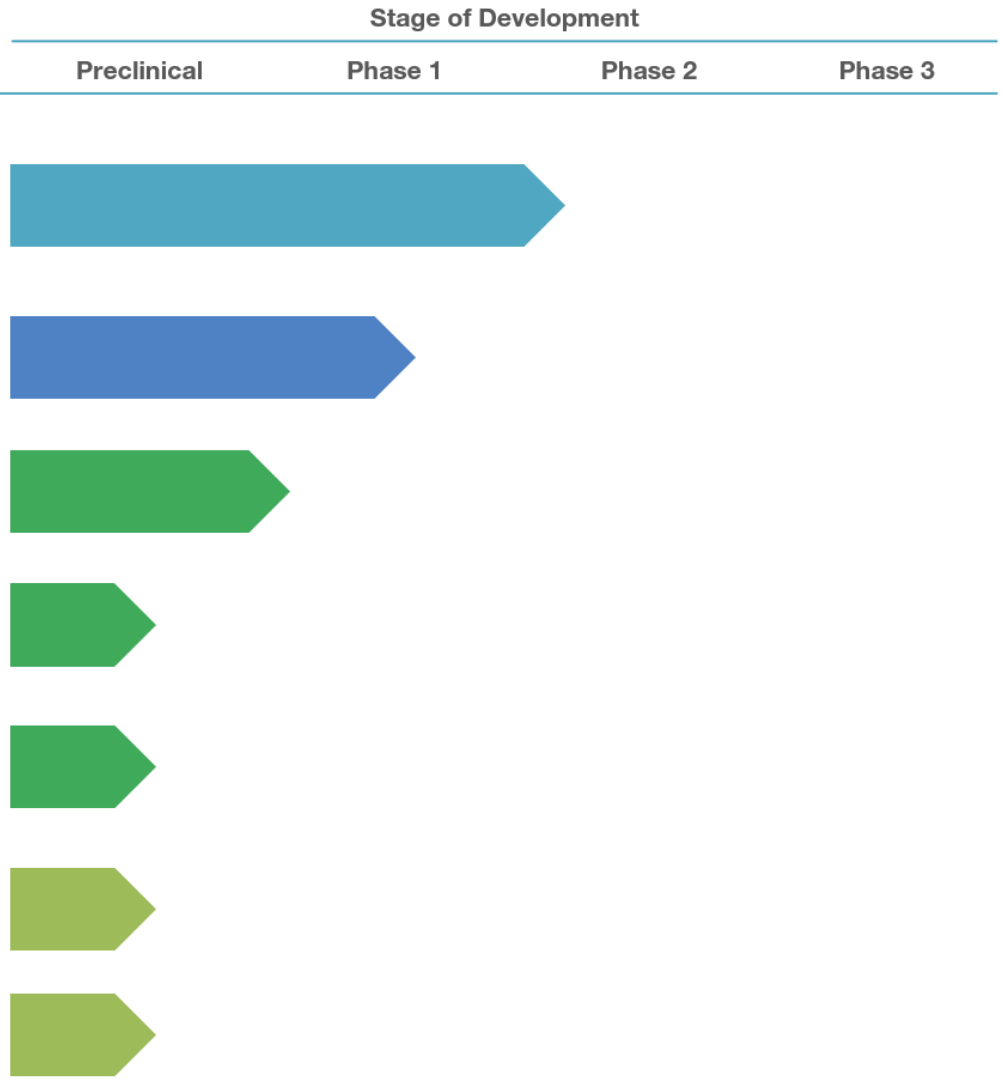
γδ T cells Genetically Engineered to Survive Chemotherapy Induced Cell Death



Source: Adapted from Madan et al. Sem in Onc. 2012, Vol 39, No 3 and Ribas et al. Clin Canc Res, 18(2), Jan. 2012

Our Pipeline

Product Candidate	Approach	Initial Indication
INB-200	DeltEx DRI	Glioblastoma
INB-100	DeltEx Allo	Leukemia
INB-400	DeltEx Allo DRI	Glioblastoma
	DeltEx DRI + Checkpoint	Solid Tumors
	DeltEx DRI + PARP Inhibitor	Solid Tumors
INB-300	Non-signaling CAR-T	Solid Tumors
INB-500	iPSC gamma-delta T cells	TBD



Our DeltEx Platform

Advanced expertise in ex-vivo, expanded gamma-delta T cells	• Significant advantages over *in vivo* expansion, for development of therapeutic candidates
First-in-class proprietary gamma-delta T cell engineering	• DeltEx Drug Resistant Immunotherapy, or DRI protects cells to survive chemotherapy and maintains natural ability to recognize, engage and kill cancer cells • Broadly applicable across multiple solid tumor indications
Advanced next-gen gamma-delta T cell manufacturing	• Automated closed-system manufacturing – operating at clinical-scale • Novel iPSC capabilities provide significant technical and manufacturing advantages

2 CLINICAL PROGRAMS

MULTIPLE PLANNED INDs OVER NEXT 3 YEARS

Manufacturing Primary γδ T Cells

- Automated, robust and scalable cell manufacturing that consolidates entire manufacturing process in a single closed system to reduce risks of contamination
- Allows quick and efficient scaling for clinical trials and commercial capabilities

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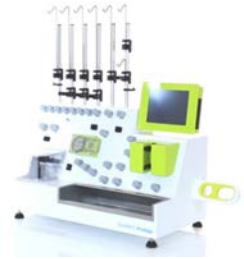
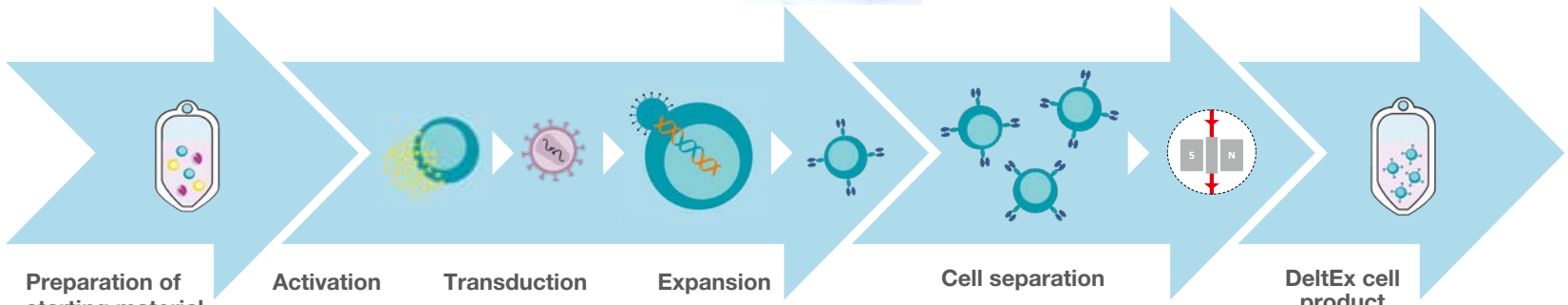
Process Steps:

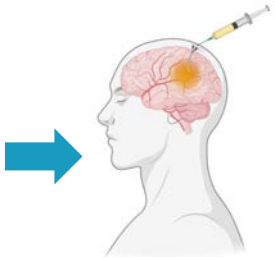


Obtain peripheral blood



Process time: 9-14 days

Cryopreservation



Patient infusion

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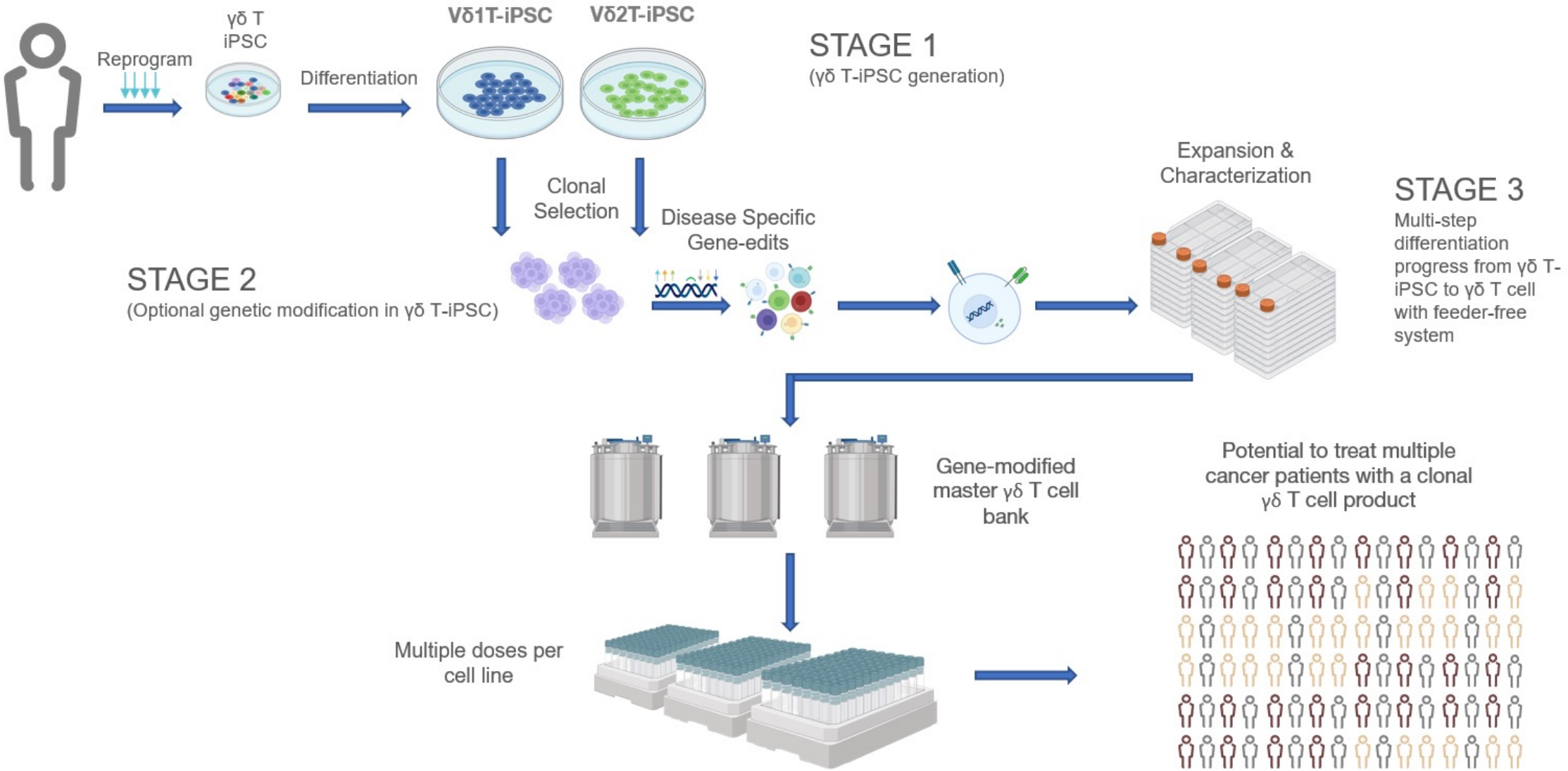
Source: IN8bio

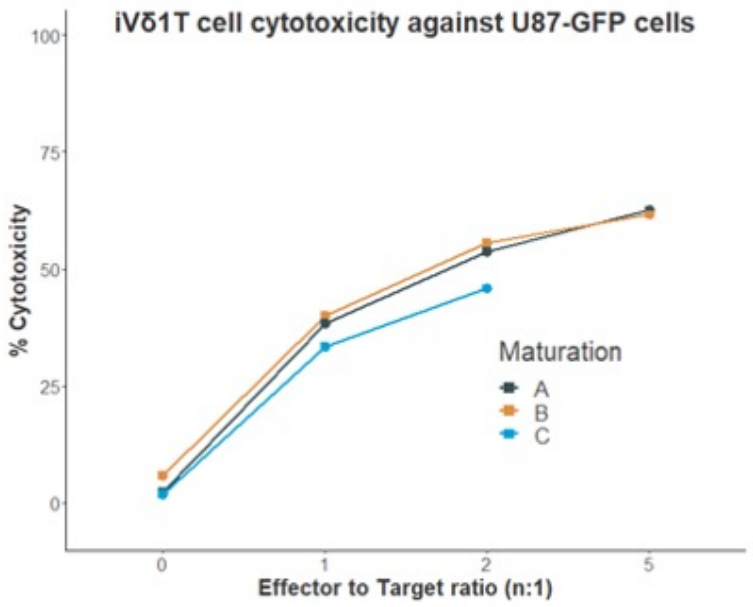
Manufacturing iPSC γδ T Cells

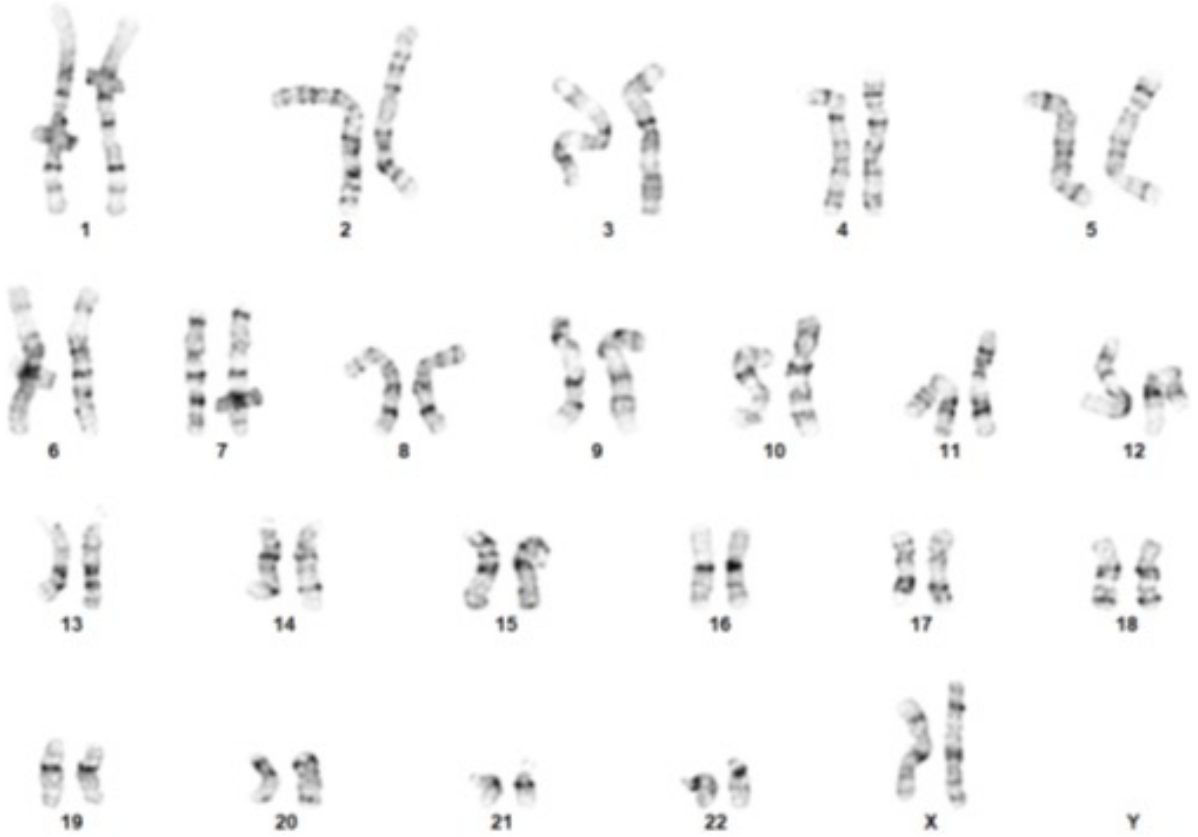


Source: IN8bio; created with biorender.com

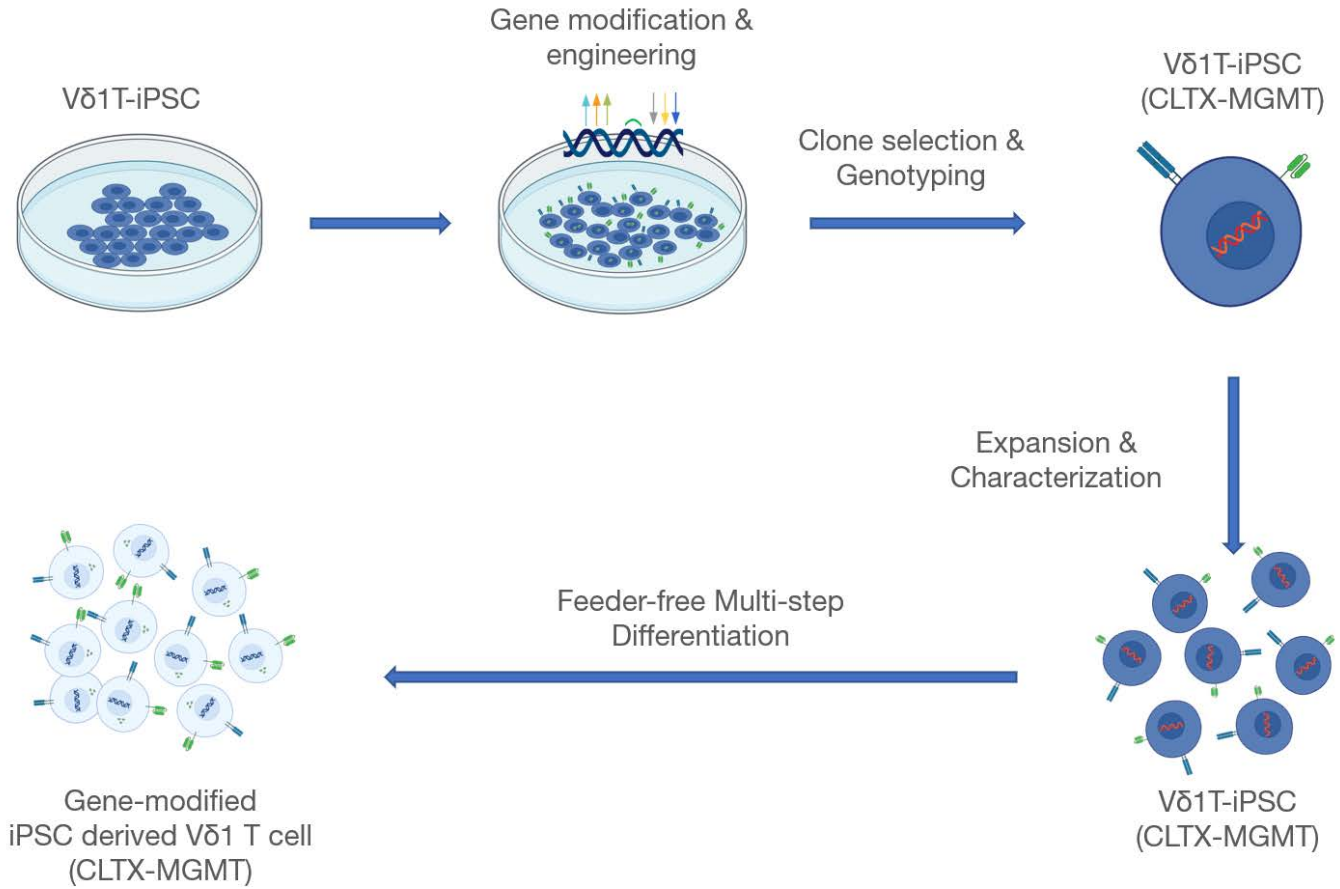
IN8bio iPSC Derived γδ T Cell Generation

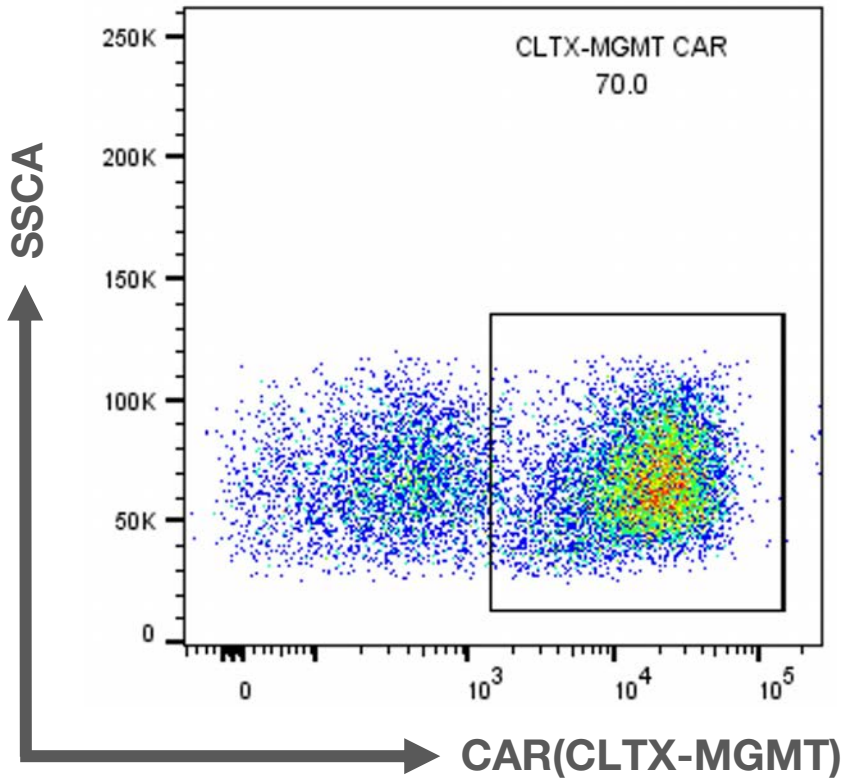
- Dozens of individual γδ T-iPSC colonies were obtained, including both δ1T-iPSC and δ2T-iPSCs
- Normal karyotype with G-band Cytogenetic analysis
- Cell and serum free process demonstrates reproducible linear cytotoxicity



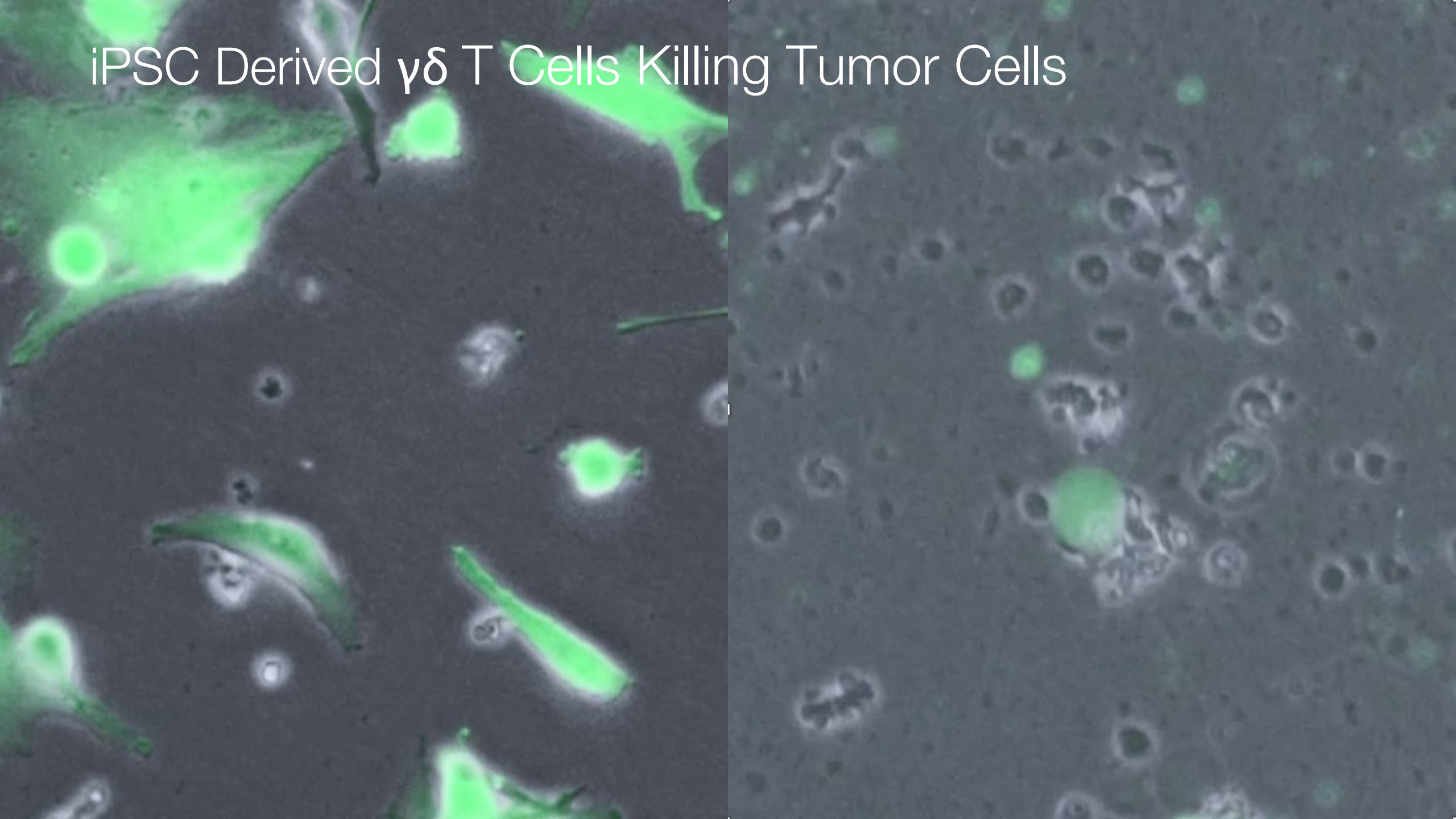


Successful Genetic Modification of iPSC γδ T Cells





iPSC Derived γδ T Cells Killing Tumor Cells



Two Factors to Developing a γδ T Cell Therapy

γδ T Cell Sourcing

Vδ1+

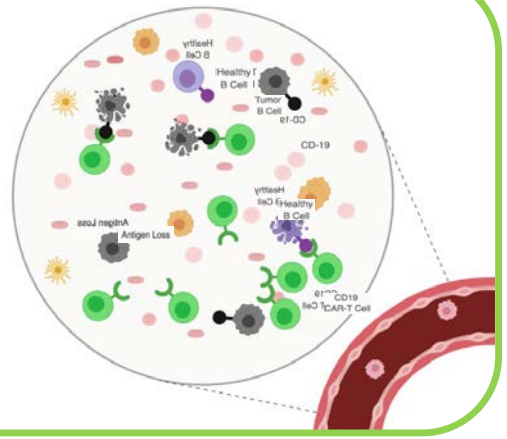
Vδ2+

iPSC

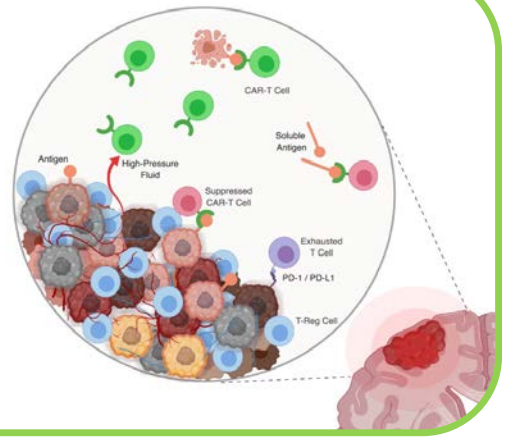
γδ

Tumor Targeting

Hematological Cancers



Solid Tumor Cancers



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Source: IN8bio, image created with Shutterstock and biorender.com

IN8bio Cell Therapy Thesis

IN8bio's three-pronged approach to targeting cancers:

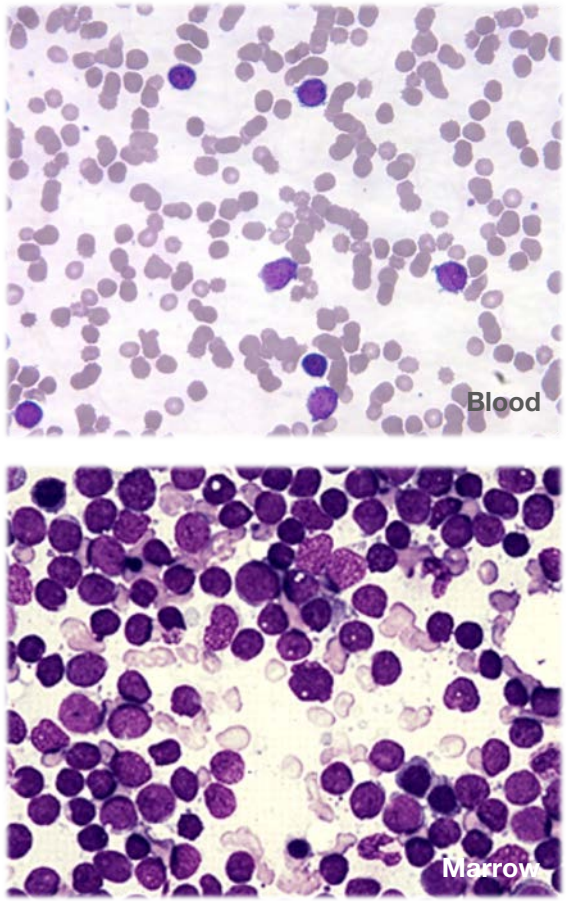
Durability

Tolerability

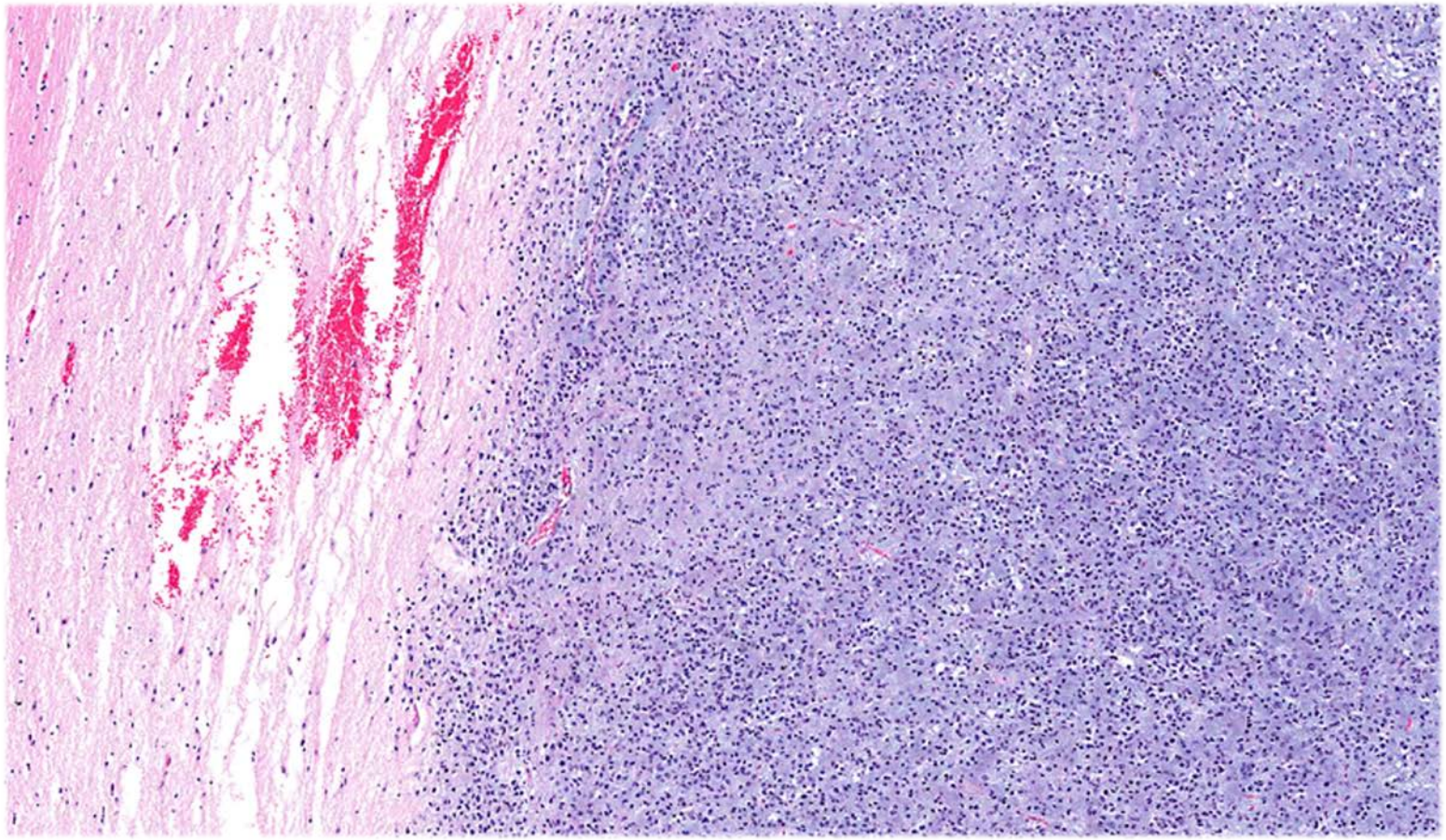
Heterogeneity

Overcoming Challenges to Targeting Solid Tumors

Acute Lymphocytic Leukemia

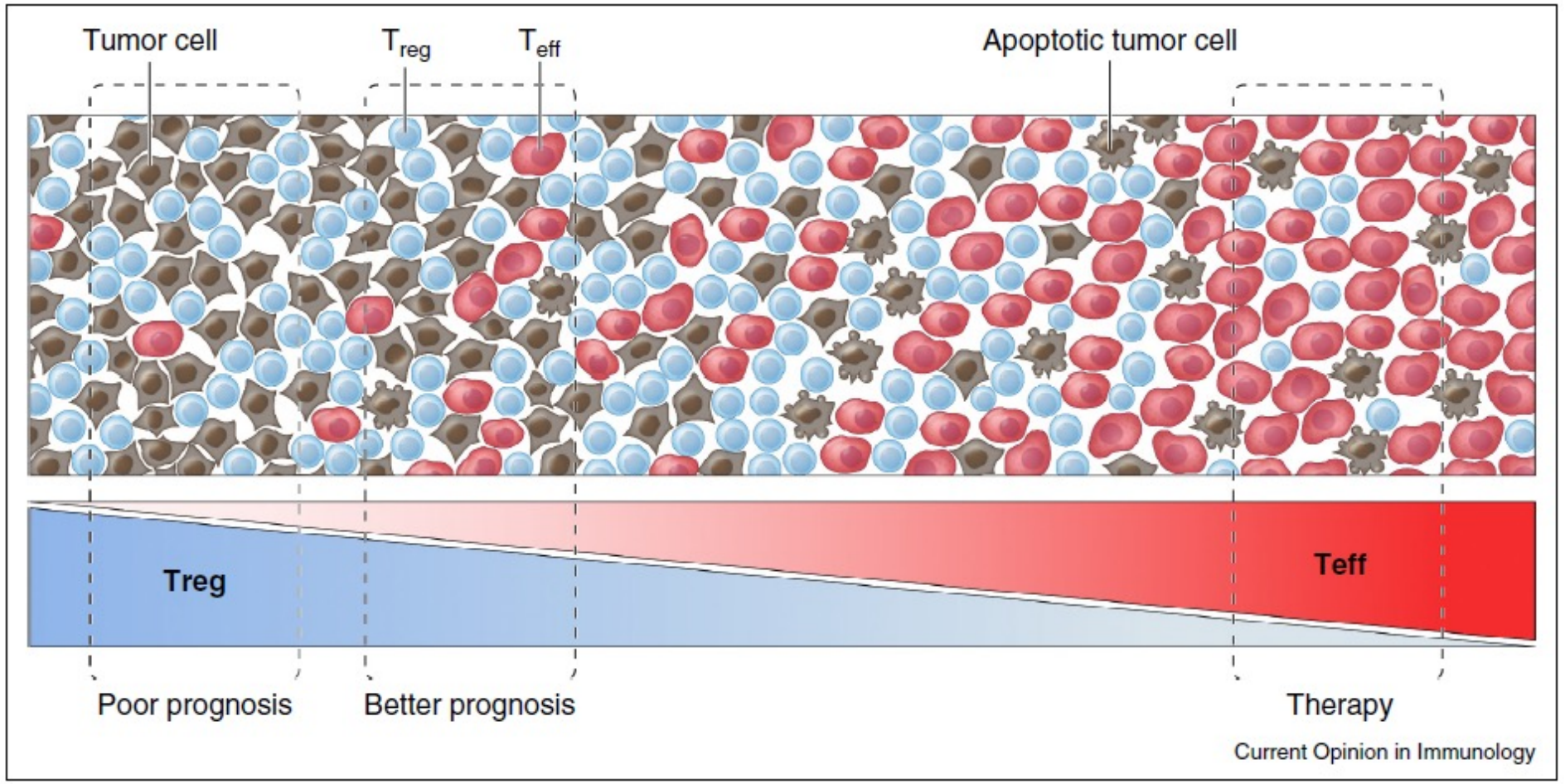


Glioma



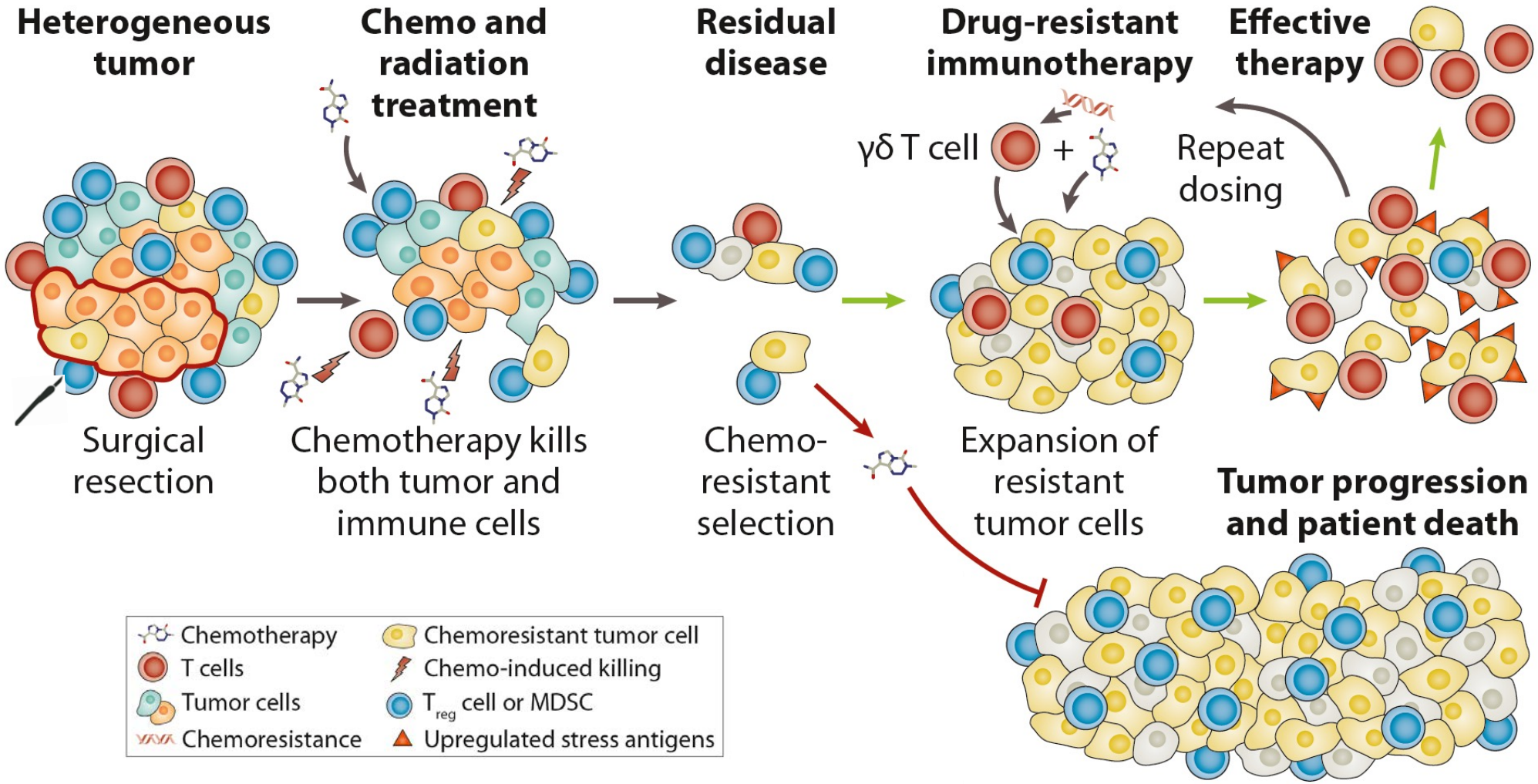
Source: Shutterstock; https://serc.carleton.edu/woburn/overarching/hema_leuk.html

E:T Ratio Matters - We Need to Shift the Balance…



Source: Roychoudhuri et al. Curr Opin Imm, 2015, 33:101–111

IN8bio's DRI Approach to Solid Tumor Therapy

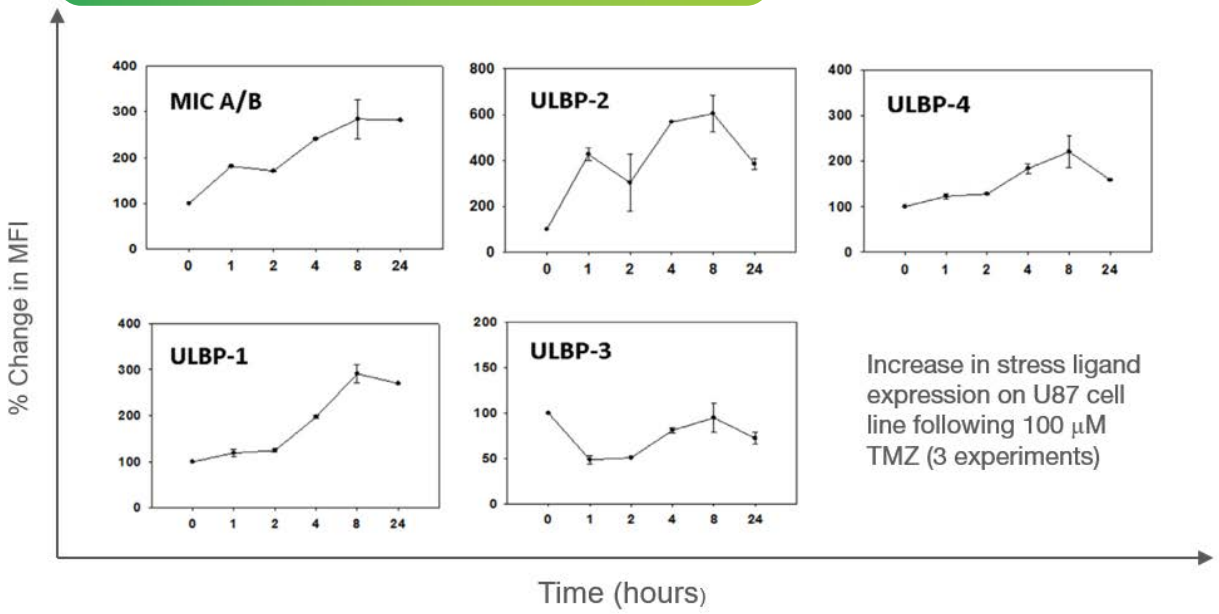


Source: BioPharma Dealmakers, September 2019

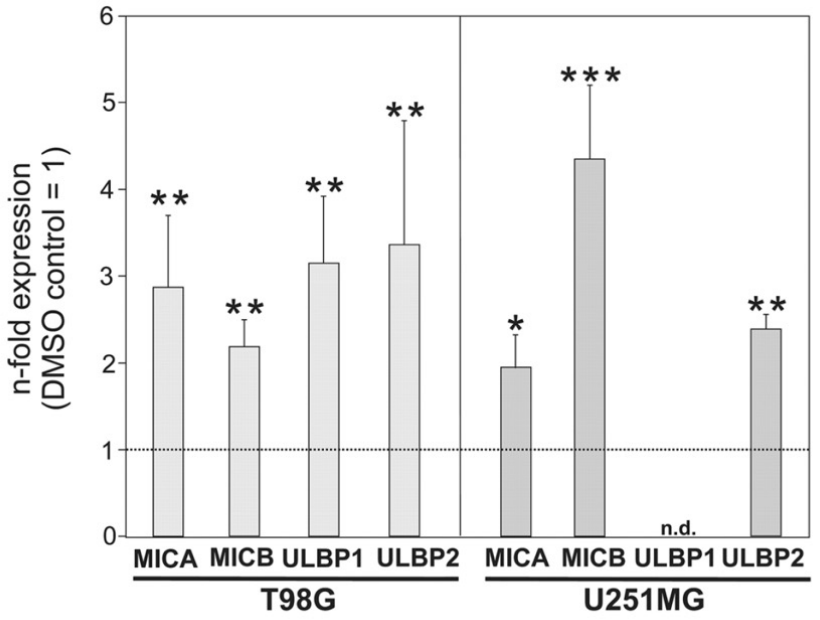
TMZ Increases NKG2D-L Expression

DDR is a biological process that can detect and eliminate resistant cells and cancer stem cells

Versus: Chemo-resistant GBM lines



Versus: Glioma stem-like cells



Source: IN8bio, Lamb et al. Plos One, (2013) Vol 8., Issue 1, Held-Feindt et al. Histochemistry and Cell Biology, (2018) 149: 2019-233; https://doi.org/10.1007/s00418-018-1633-5

The Leading γδ Program for Solid Tumors

INB-200: Single-center, single and multiple dose trial of autologous, DeltEx DRI gamma-delta T cells in combination with maintenance TMZ following surgical resection

Treatment Arms

Fixed dose level (DL) of DRI in a 3+3 design:

1. N = 3 (up to 6) patients, single dose of 1 x 10^7 cells (DL1)
2. N = 3 (up to 6) patients, three doses of 1 x 10^7 cells, one dose every 28 days (DL2)
3. N = 3 (up to 6) patients, six doses of 1 x 10^7 cells, one dose every 28 days (DL3)*

Treatment Regimen & Timing

Surgical resection followed by apheresis → 6 weeks induction TMZ + radiation → 6 cycles maintenance TMZ + DRI*

Primary Endpoints

- Safety
- Maximum tolerated dose (MTD) of DRI in two dose frequencies

Secondary Endpoints

- Time to progression
- Overall survival
- Biologic response

Site

O'NEAL COMPREHENSIVE CANCER CENTER
UAB THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

UAB HEERSINK SCHOOL OF MEDICINE

INBbio

Standard of Care Hasn't Changed in 17 Years!

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Radiotherapy plus Concomitant and Adjuvant Temozolomide for Glioblastoma

Roger Stupp, M.D., Warren P. Mason, M.D., Martin J. van den Bent, M.D., Michael Weller, M.D., Barbara Fisher, M.D., Martin J.B. Taphoorn, M.D., Karl Belanger, M.D., Alba A. Brandes, M.D., Christine Marosi, M.D., Ulrich Bogdahn, M.D., Jürgen Curschmann, M.D., Robert C. Janzer, M.D., et al., for the European Organisation for Research and Treatment of Cancer Brain Tumor and Radiotherapy Groups and the National Cancer Institute of Canada Clinical Trials Group*

- N = 573
- Median age 56 (range 19-71)
- PS 2 only 12%
- RT+TMZ median OS 14.6 months
- RT+TMZ median PFS 6.9 months (95% CI 5.8-8.2)
  - MGMT methylated 10.3 months
  - **MGMT unmethylated 5.3 months**

ORIGINAL ARTICLE

Short-Course Radiation plus Temozolomide in Elderly Patients with Glioblastoma

James R. Perry, M.D., Normand Laperriere, M.D., Christopher J. O'Callaghan, D.V.M., Alba A. Brandes, M.D., Johan Menten, M.D., Claire Phillips, M.B., B.S., Michael Fay, M.B., Ch.B., Ryo Nishikawa, M.D., J. Gregory Cairncross, M.D., Wilson Roa, M.D., David Osoba, M.D., John P. Rossiter, M.B., B.Ch., et al., for the Trial Investigators*

- N = 562
- Median age 73 (range 65-90)
- PS 1 – 54%; PS 2 – 23%
- RT+TMZ median OS 9.3 months
- RT+TMZ median PFS 5.3 months
  - MGMT methylated 7.9 months
  - **MGMT unmethylated 4.8 months**

IN8bio

Source: NEJM 2005; 352:987-996 DOI: 10.1056/NEJMoa043330; NEJM 2017; 376:1027-1037 DOI: 10.1056/NEJMoa1611977

Treatment Emergent Adverse Events (n=7)

Adverse Events	Grade 1/2	Grade 3	Grade 4
WBC decreased	29%	14%	
ALC decreased	29%	14%	
Anemia	14%		
ANC decreased			14%
Platelet count decreased	14%		14%
Nausea	29%		
Vomiting	29%		
Constipation	29%		
Anorexia	29%		
Asthenia	43%		
Headache	43%		
Fever/pyrexia	43%		
Urinary tract infection		14%	
Seizures	14%	14%	

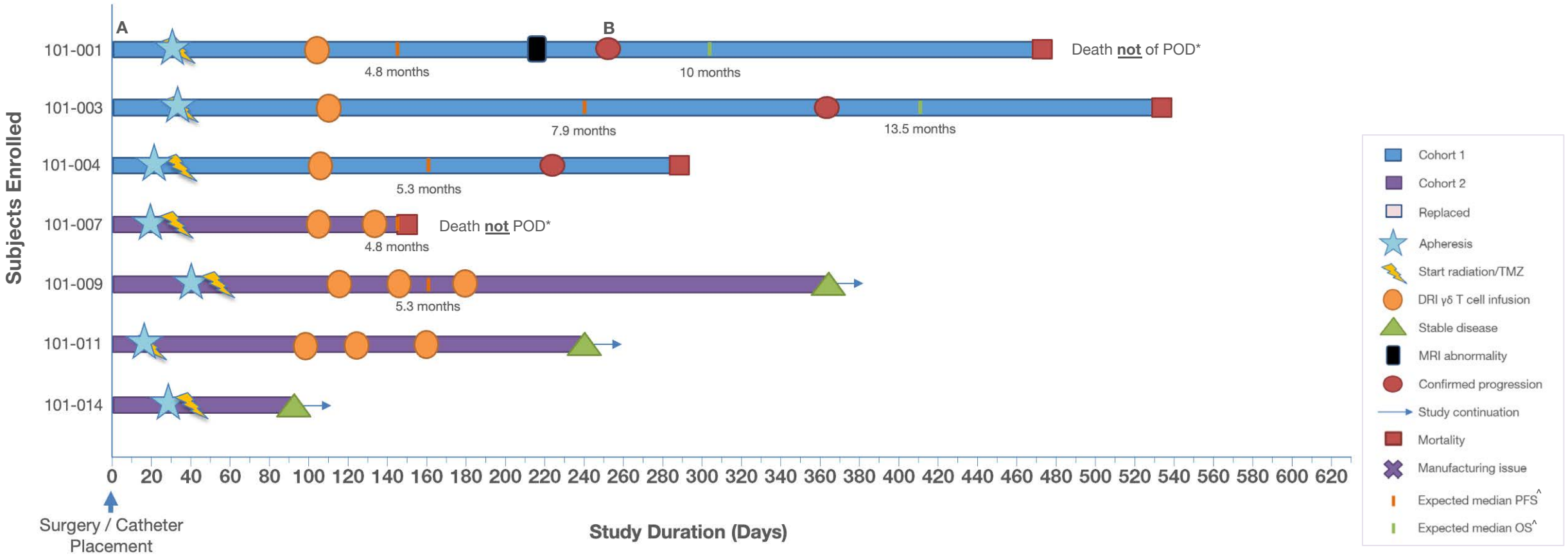
- No DRI related toxicity
- No DLT's to date
- Majority of toxicities are grade 1 or 2
- Unrelated SAE's of seizures, UTI & sudden cardiac death
- No treatment related deaths
- 2 unrelated deaths due to cardiac arrest currently listed as grade 4 and sepsis from a pancreatic cyst
- Repeat dosing DOES NOT demonstrate change in toxicity profile

Note: As of June 3, 2022; Early trial results are not indicative of future results, including the outcome of this trial.

INB-200: Long-term Durability Observed

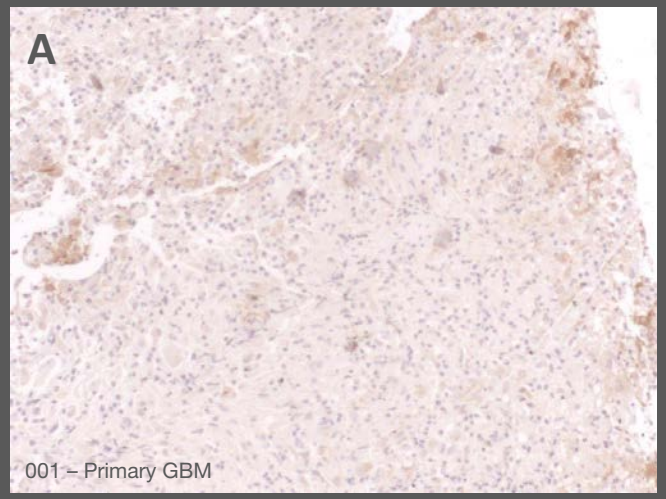
Clinical Results to Date

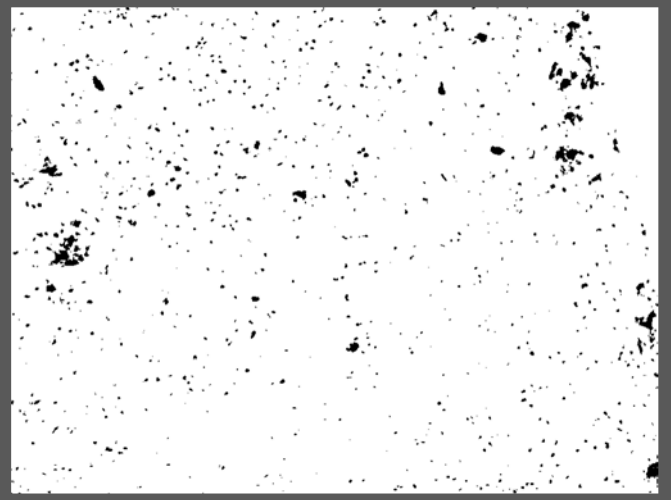
- 6 patients treated
- no DLTs, no CRS or ICANs
- all treated patients exceeded expected PFS based on age and MGMT status as per NEJM data^

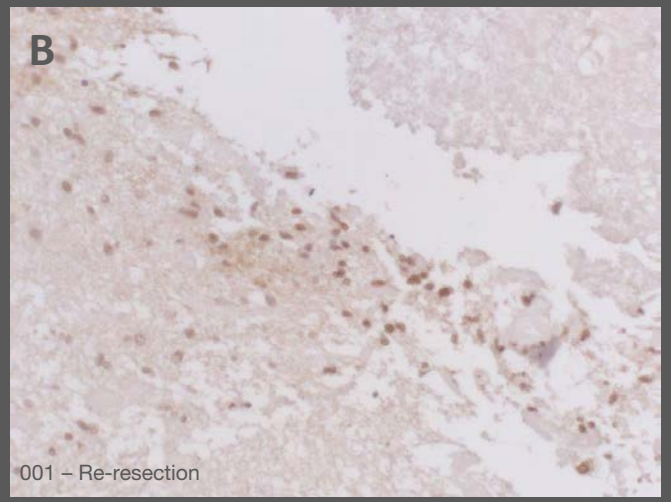


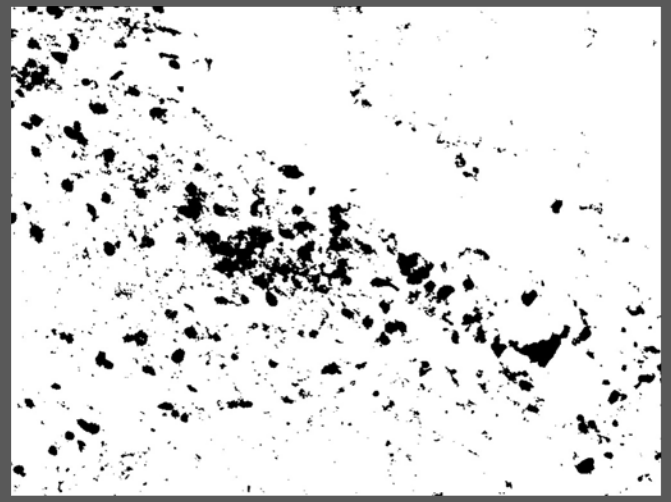
Note: ***POD = progression of disease**; As of June 3, 2022; Source: ^ NEJM 2005; 352:987-996 & 352:997-1003 DOI: 10.1056/NEJMoa043330, DOI: 10.1056/NEJMoa043331; NEJM 2017; 376:1027-1037 DOI: 10.1056/NEJMoa1611977; Early trial results are not indicative of future results, including the outcome of this trial.

γδ T Cells Infiltrating and Persisting in Tumor Tissue









Source: * UAB and IN8bio

An Allogeneic Therapy to Reduce Leukemic Relapse

INB-100: Single-center, dose-escalation trial of DeltEx Allo gamma-delta T cells post-haploidentical HSCT

Treatment Arms

Single, ascending dose levels in a 3+3 design:

1. N = 3 (up to 6) patients, single dose of 1 x 10^6 cells/kg
2. N = 3 (up to 6) patients, single dose of 3 x 10^6 cells/kg
3. N = 3 (up to 6) patients, single dose of 1 x 10^7 cells/kg

Treatment Regimen & Timing

Fludarabine + cyclophosphamide + TBI = 6 days → Haploidentical HSCT* → INB-100 infusion within 5 days after engraftment

*Neutrophil engraftment is ~15-20 days following HSCT

Primary Endpoints

- Safety,
- Maximum tolerated dose (MTD) of DeltEx Allo gamma-delta T cell infusion
- Dose limiting toxicity (DLT)

Secondary Endpoints

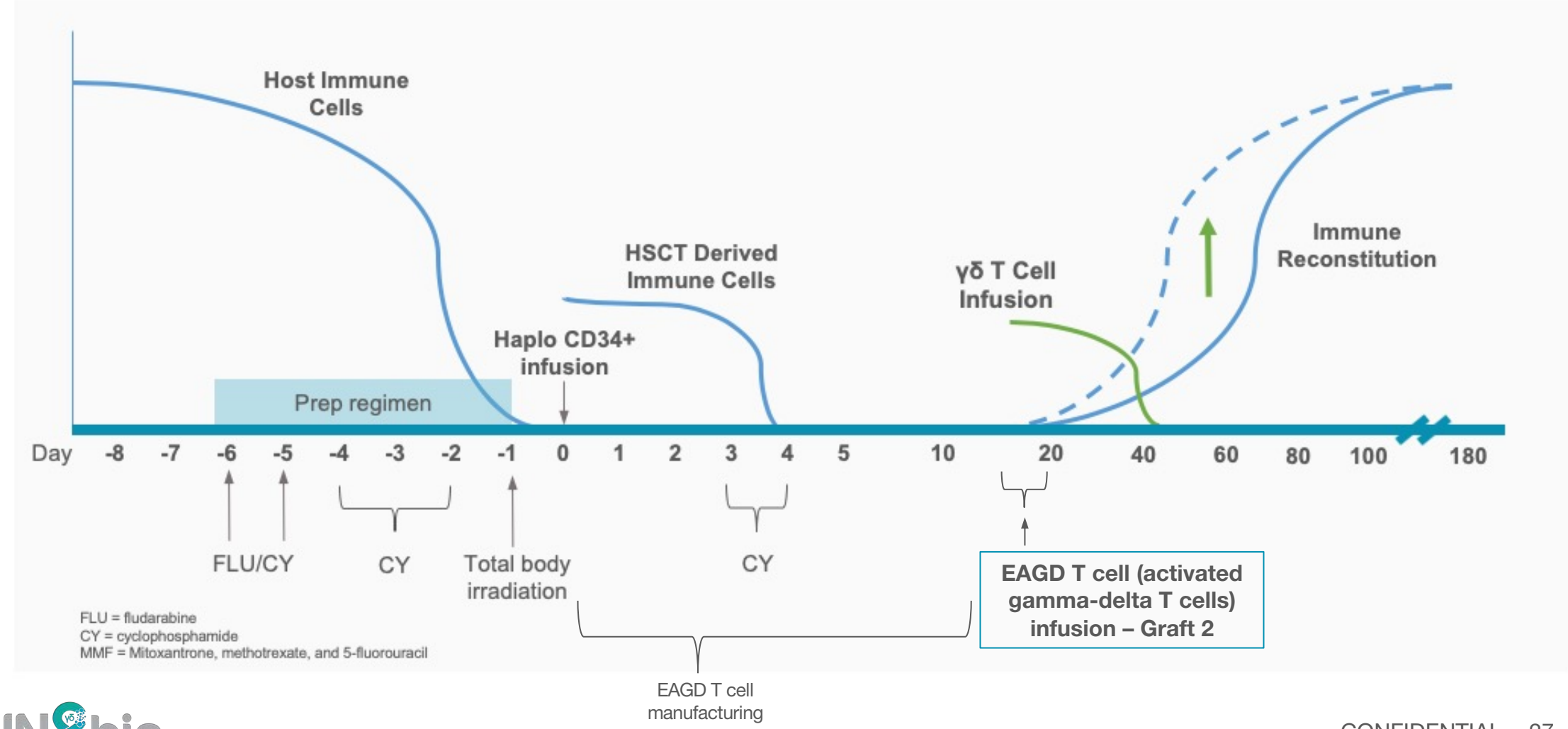
- Rate of acute and chronic graft versus host disease (aGVHD), relapse, and overall survival

Site

THE UNIVERSITY OF KANSAS CANCER CENTER

Potential to Provide Protection During a Vulnerable Period

Gamma-Delta T Cell Expansion + Activation (EAGD) for Prophylaxis Against Leukemic Relapse



Source: IN8bio

The Hopkins Protocol

HLA-Haploidentical Bone Marrow Transplantation for Hematologic Malignancies Using Nonmyeloablative Conditioning and High-Dose, Posttransplantation Cyclophosphamide

Leo Luznik,[1] Paul V. O'Donnell,[2,3]* Heather J. Symons,[1] Allen R. Chen,[1] M. Susan Leffell,[1] Marianna Zahurak,[1] Ted A. Gooley,[2,3] Steve Piantadosi,[1] Michele Kaup,[1] Richard F. Ambinder,[1] Carol Ann Huff,[1] William Matsui,[1] Javier Bolaños-Meade,[1] Ivan Borrello,[1] Jonathan D. Powell,[1] Elizabeth Harrington,[2] Sandy Warnock,[2] Mary Flowers,[2,3] Robert A. Brodsky,[1] Brenda M. Sandmaier,[2,3] Rainer F. Storb,[2,3] Richard J. Jones,[1] Ephraim J. Fuchs[1]*

[1] Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, Maryland; [2] Fred Hutchinson Cancer Research Center, Seattle, Washington; and [3] University of Washington School of Medicine Seattle, Washington

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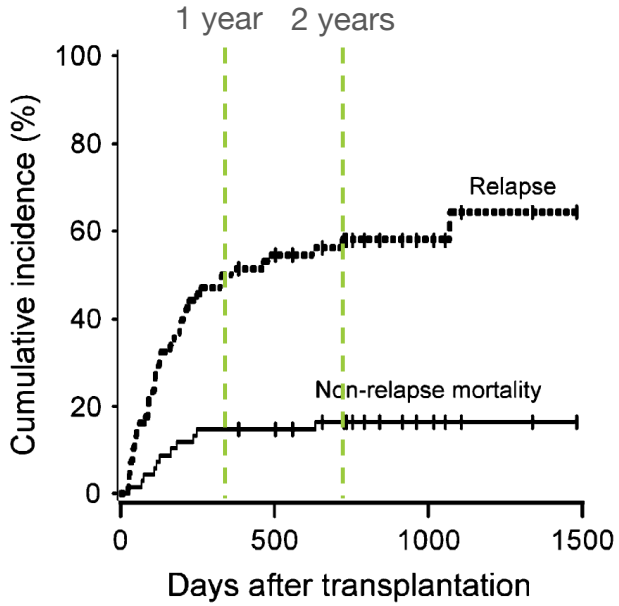
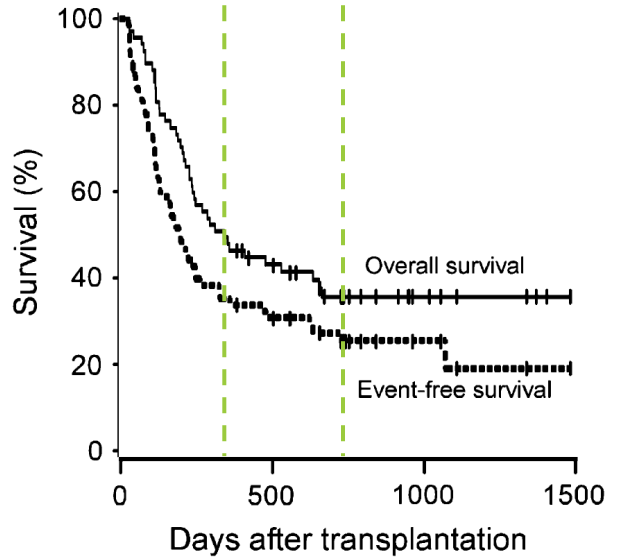
ABSTRACT

We evaluated the safety and efficacy of high-dose, posttransplantation cyclophosphamide (Cy) to prevent graft rejection and graft-versus-host disease (GVHD) after outpatient nonmyeloablative conditioning and T cell-replete bone marrow transplantation from partially HLA-mismatched (haploidentical) related donors. Patients with advanced hematologic malignancies (n = 67) or paroxysmal nocturnal hemoglobinuria (n = 1) received Cy 50 mg/kg i.v. on day 3 (n = 28) or on days 3 and 4 (n = 40) after transplantation. The median times to neutrophil (>500/μL) and platelet recovery (>20,000/μL) were 15 and 24 days, respectively. Graft failure occurred in 9 of 66 (13%) evaluable patients, and was fatal in 1. The cumulative incidences of grades II-IV and grades III-IV acute (aGVHD) by day 200 were 34% and 6%, respectively. There was a trend toward a lower risk of extensive chronic GVHD (cGVHD) among recipients of 2 versus 1 dose of posttransplantation Cy ($P = .05$), the only difference between those groups. The cumulative incidences of nonrelapse mortality (NRM) and relapse at 1 year were 15% and 51%, respectively. Actuarial overall survival (OS) and event-free survival (EFS) at 2 years after transplantation were 36% and 26%, respectively. Patients with lymphoid malignancies had an improved EFS compared to those with myelogenous malignancies ($P = .02$). Nonmyeloablative HLA-haploidentical BMT with posttransplantation Cy is associated with acceptable rates of fatal graft failure and severe aGVHD or cGVHD.





IN8bio INB-100 Patient Summary

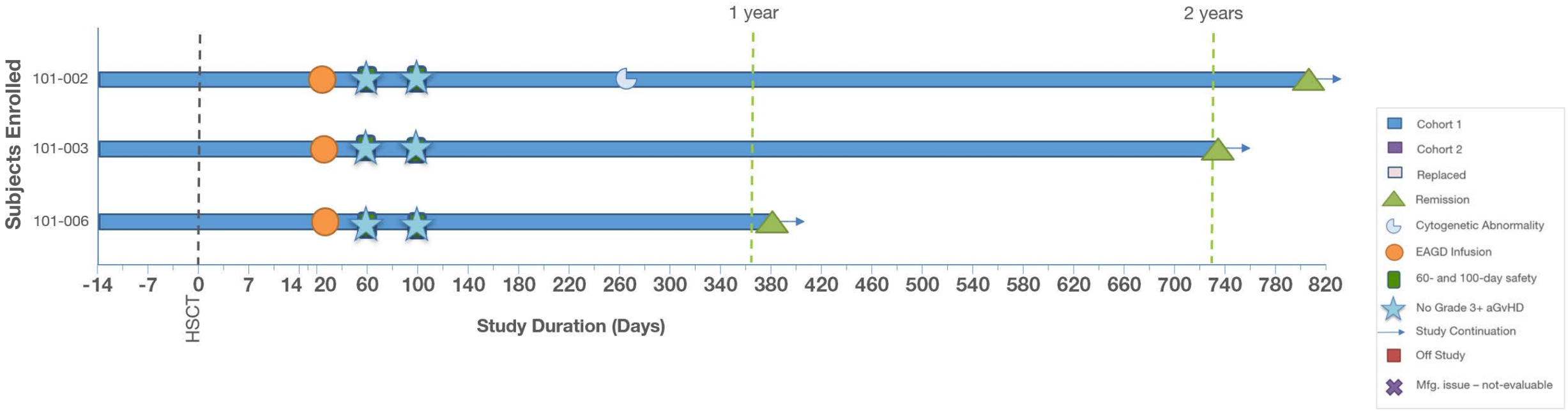
Patient	Age / Sex	Cytogenetics	Prior lines of Treatments	Conditioning	Safety Events
002	54 / female	High-risk AML trisomy 8+ and del7; (NGS: Pathogenic variants detected: M5a, FLT3 TKD, NxPM1, DNMT3A, PTPN11)		RIC	Gr.2 skin GvHD- resolved
003	45 / female	High-risk AML trisomy 8+ and del7 (NGS: Pathogenic variants detected: IDH2, 47,XX,+8[8]/46,sl,-7[9]/48,sl,+8[3])		RIC	Gr.2 GI GvHD and Gr.2 skin GvHD Remains on Jakafi for skin GvHD
006	66 / male	Relapsed AML s/p 7+3, high risk (NGS: Pathogenic variants detected: NF1, ASXL1, DDX41p.R525H)	Cytarabine + daunorubicin	RIC	Gr.2 GvHD-resolved

Note:*As of June 30, 2022; Early trial results are not indicative of future results, including the outcome of this trial.

INB-100: Long-term Durability of Responses

Clinical Results to Date

- 3 patients treated
- no DLTs, no CRS, ICANs or GvHD of grade 3 or greater
- Two of three patients surpassing 2 years and one patient passing 1 year remaining in morphological complete remission



Two patients surpassed 2 years without leukemic relapse and manageable safety profile

Note:*As of June 30, 2022; Early trial results are not indicative of future results, including the outcome of this trial.

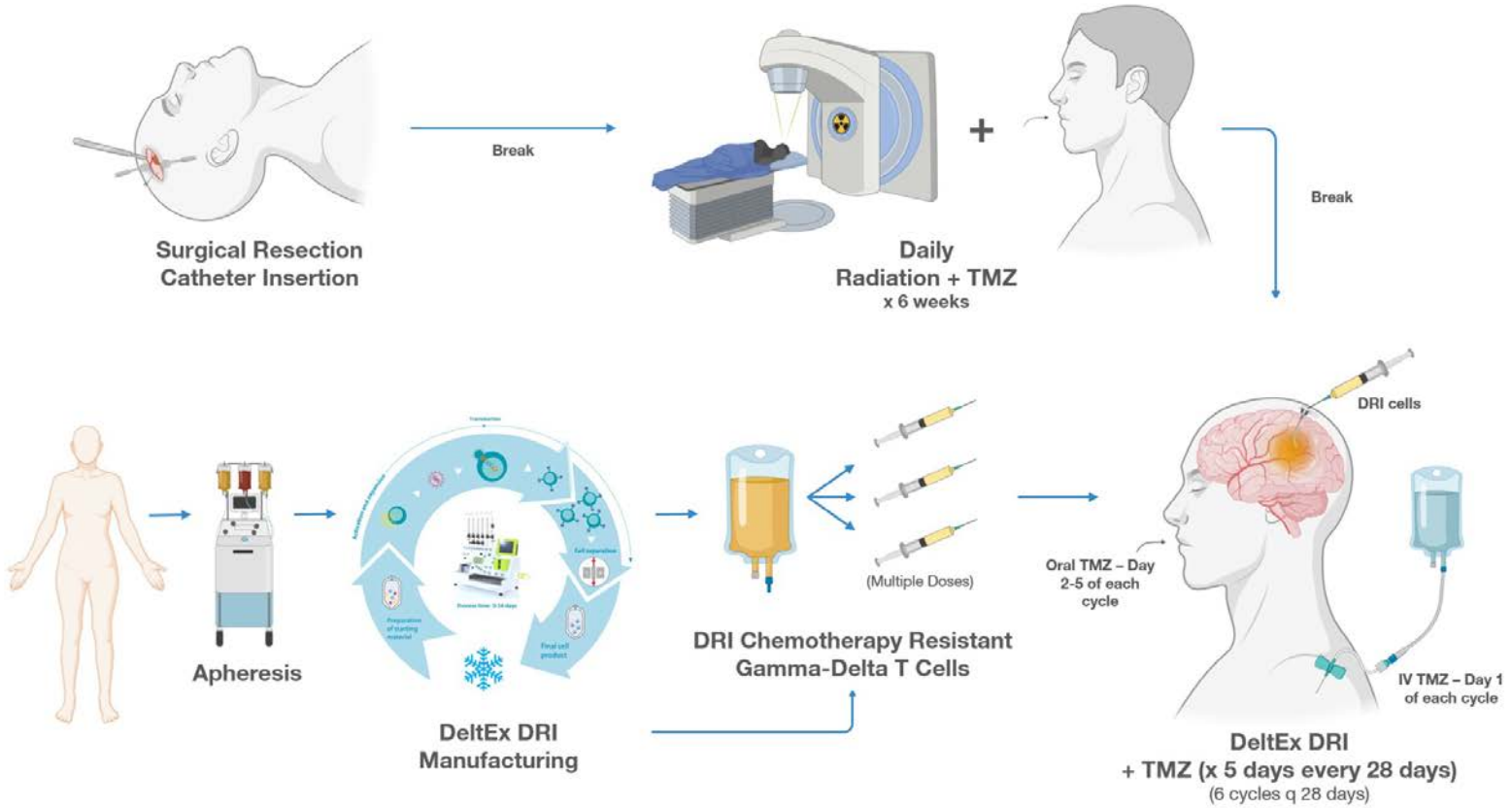
Moving Towards Allogeneic Therapies for Solid Tumors

Allogeneic and Autologous DeltEx DRI

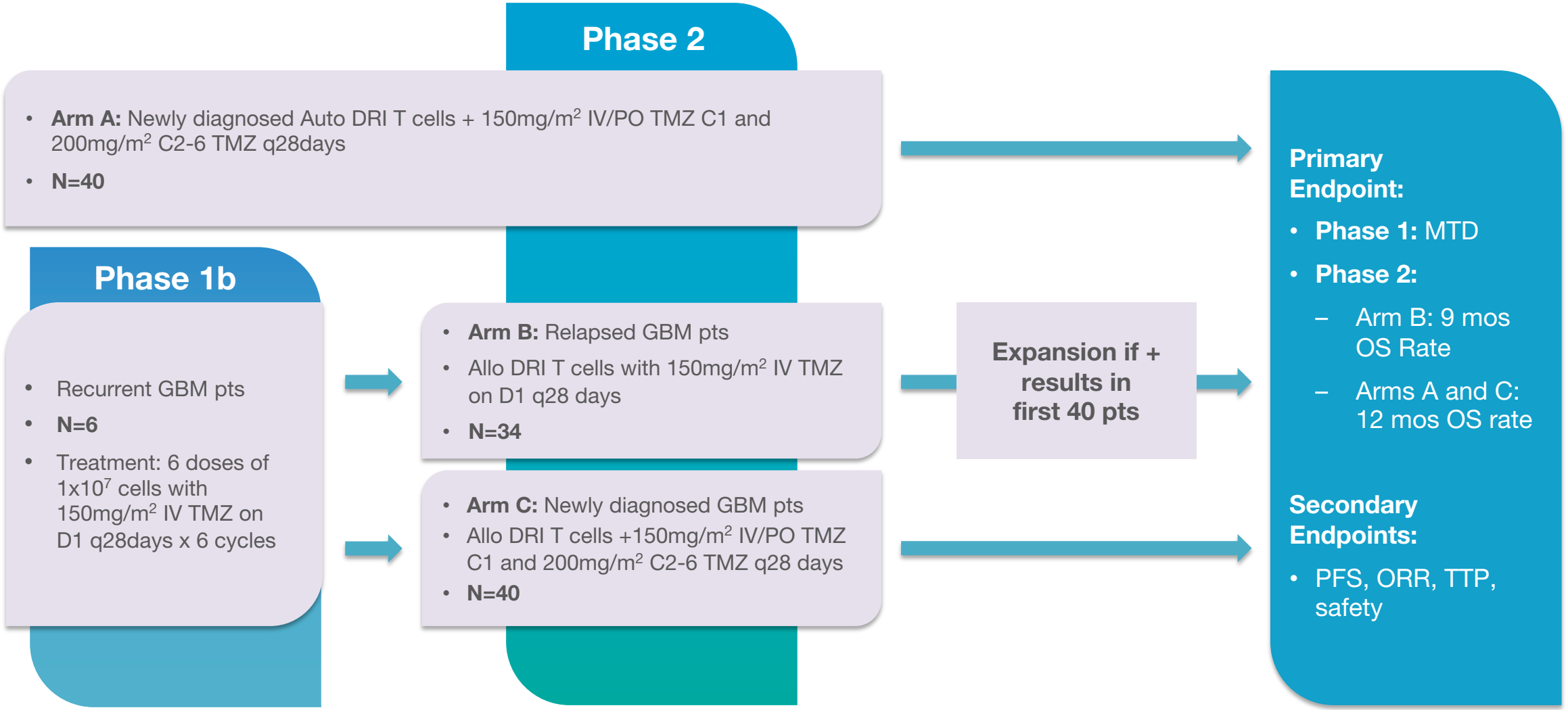
INB-400 Overview

- Initial development plan in GBM with expected IND submission expected in 2H 2022
- Developing INB-400, our allogeneic DeltEx DRI product candidate, following safety data from INB-200 and INB-100 clinical trials
- Based on clinical data from INB-100 to-date, we anticipate a low risk of gamma-delta T cells driving severe dose-limiting acute GvHD
- Further assessing autologous DeltEX DRI product potential in the GBM population

INB-400 Treatment Protocol

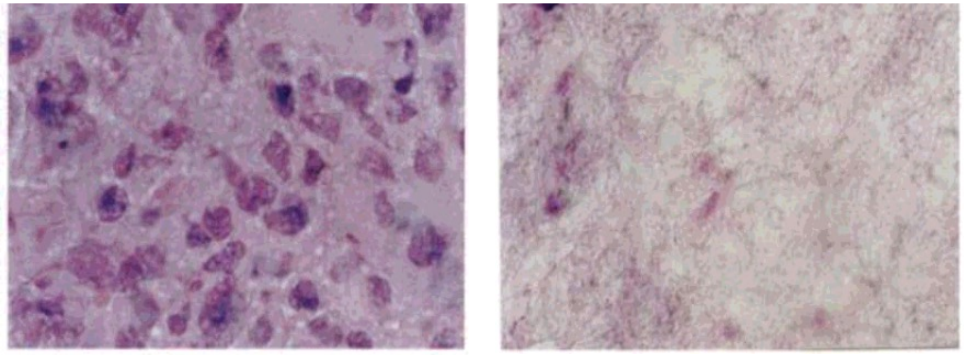


Proposed Clinical Trial Design for INB-400



A Unique CAR-T Platform that Spares Healthy Tissue

Novel Non-Signaling γδ CAR-T Platform

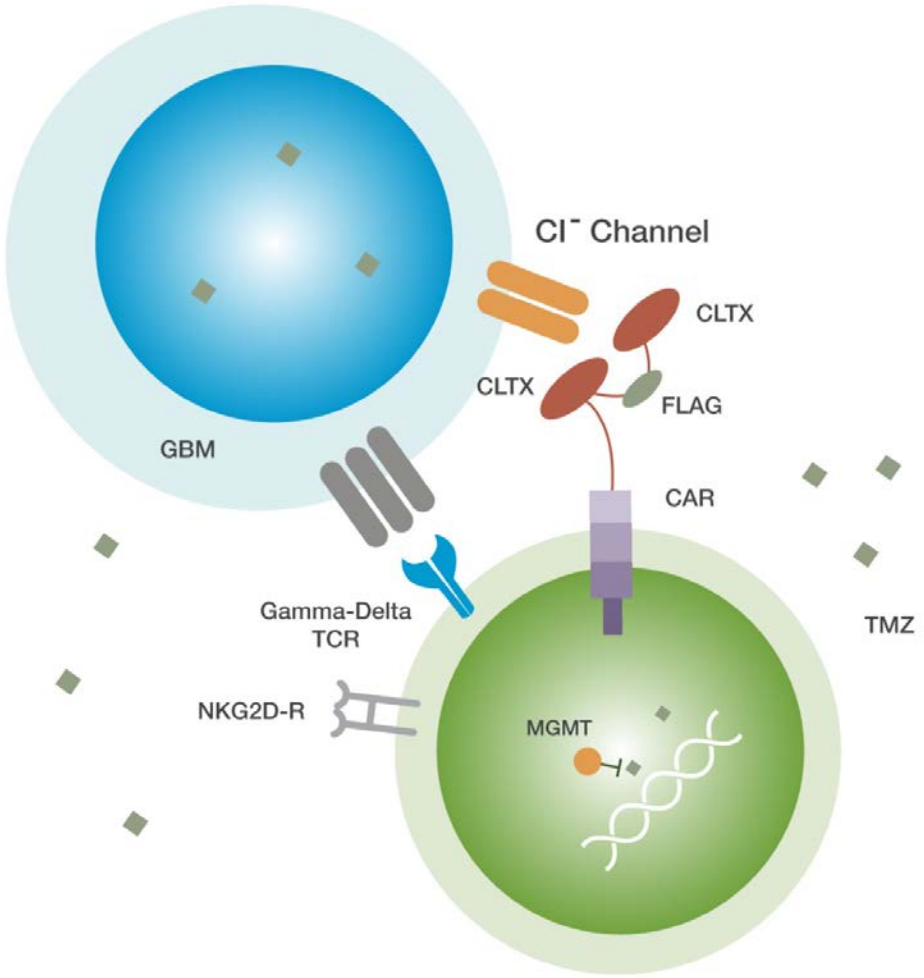


GBM+CLTX Normal+CLTX

CTX stains tumors but not healthy tissue

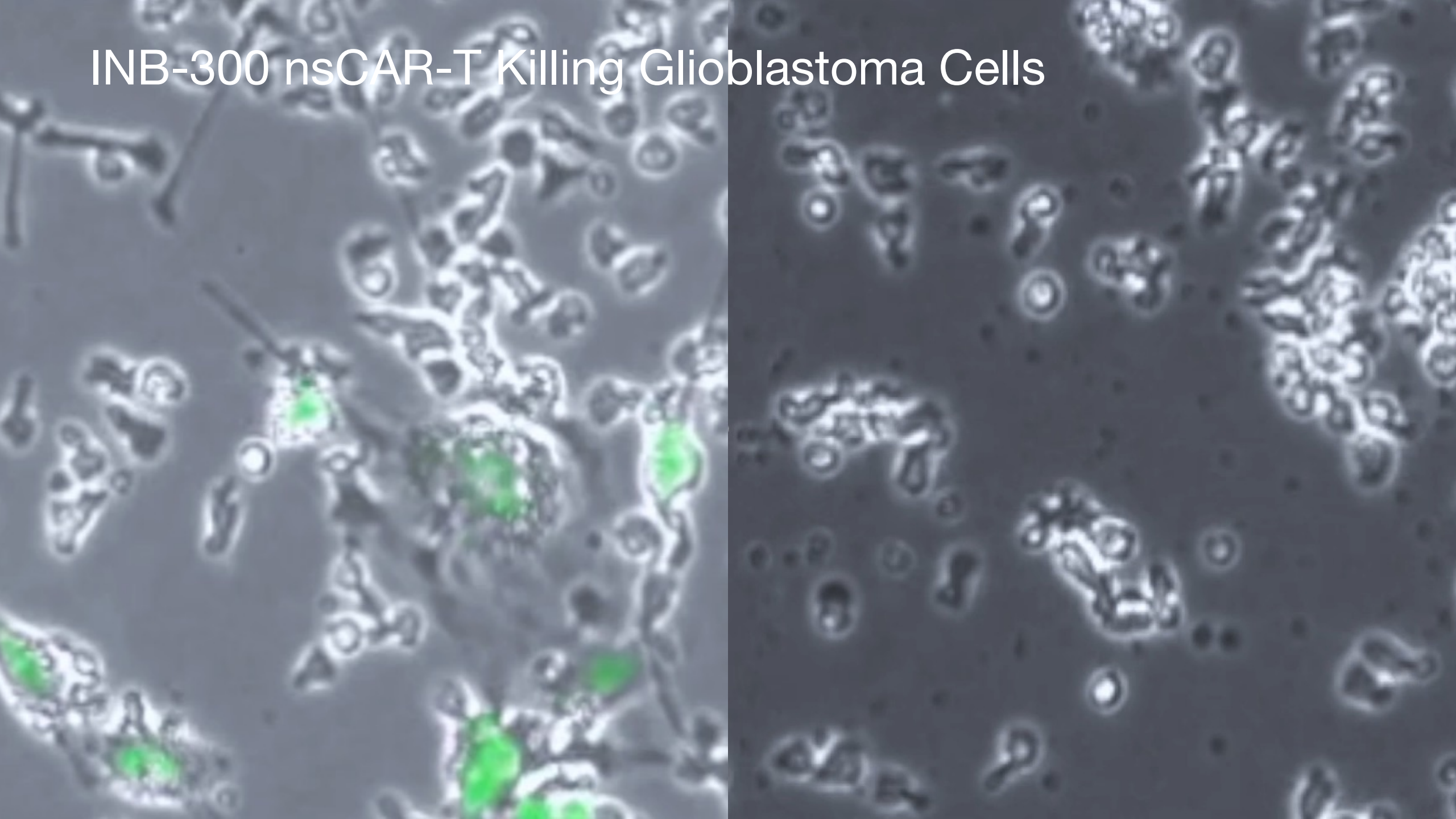
- The venom of Israeli desert scorpion is the source of native neurotoxin peptides
- Chlorotoxin (CLTX) is a 36 amino-acid peptide that binds to tumors
  - CLTX binds glioma and numerous other solid tumor cancers with limited binding to healthy tissues (1)
  - Current applications of CLTX as a tumor paint for surgical resection

Non-Signaling CAR + DeltEx DRI



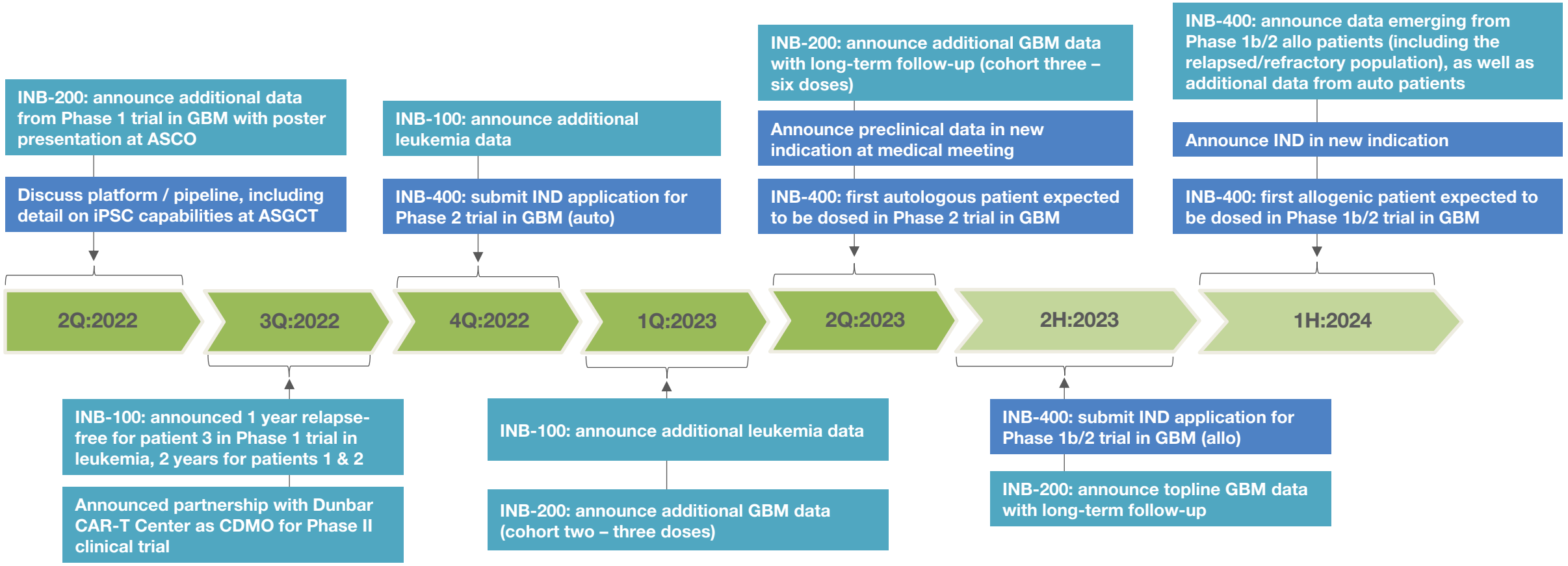
(1) Dardevet et al., Toxins (Basel), 2015 Apr; 7(4): 1079-1101 and Cancer Res November 1 1998 (58) (21) 4871-4879

INB-300 nsCAR-T Killing Glioblastoma Cells



Key Anticipated Newsflow Through First Half of 2024

- Current cash of ~$26mm (as of June 30, 2022) provides runway to mid-2023
- Executed ~$10.8M financing in August (no warrants) provides additional cash runway



Anticipated clinical data event

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IN8bio

Why IN8bio…

We envision a future where cancer patients will have a new lease on life.

With our knowledge and experience we are leading the effort to transform hope into reality.

A recognized leader in gamma-delta T cell biology and development:

Seminal contributions to development and manufacturing of gamma-delta T cells

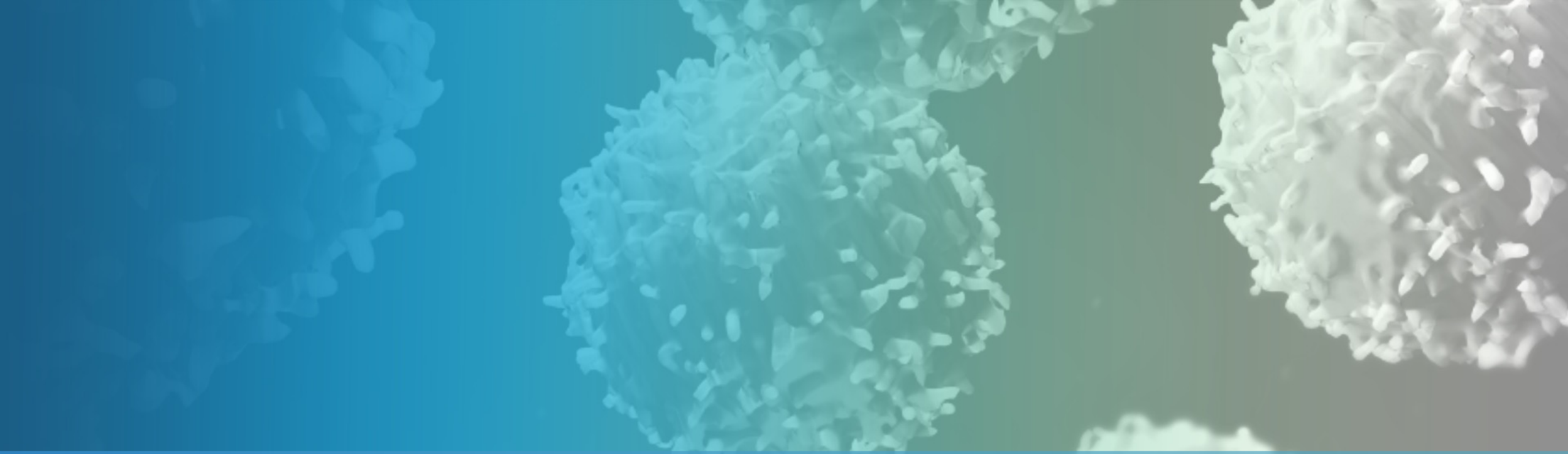
Most advanced and deepest known gamma-delta T cell pipeline:

2 clinical-stage candidates, 4 preclinical programs

- INB-200 – first genetically modified gamma-delta T cell program to enter the clinic
- INB-100 – first allogeneic expanded and activated gamma-delta T cell infusion in the transplant setting in clinical trials

Our DeltEx platform is the most comprehensive in the industry:

Proprietary expansion, iPSC, genetic-engineering and at scale manufacturing capabilities



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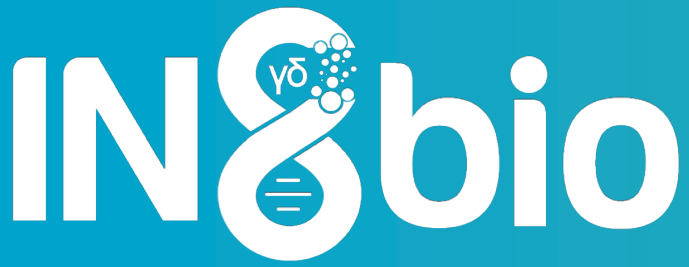
A Leader in Gamma-Delta T Cells

October 2022



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