

INB-200: Phase I study and characterization of gene-modified autologous gamma delta ($\gamma\delta$) T cells in newly diagnosed glioblastoma multiforme (GBM)

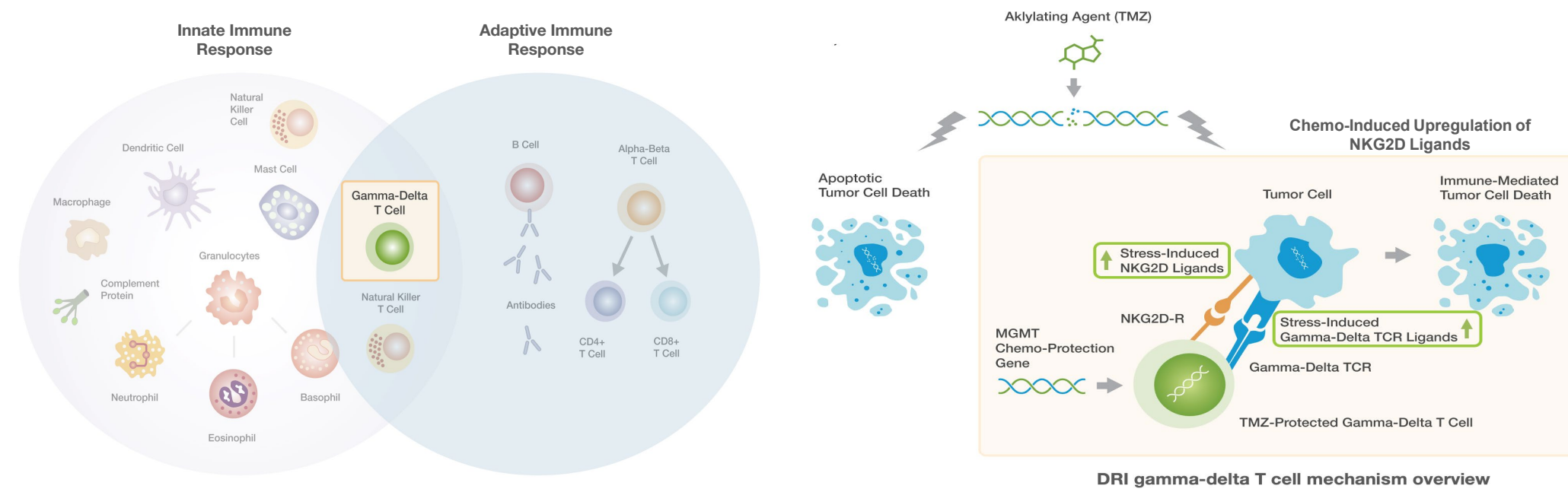
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Abstract # 2077
Poster # 442

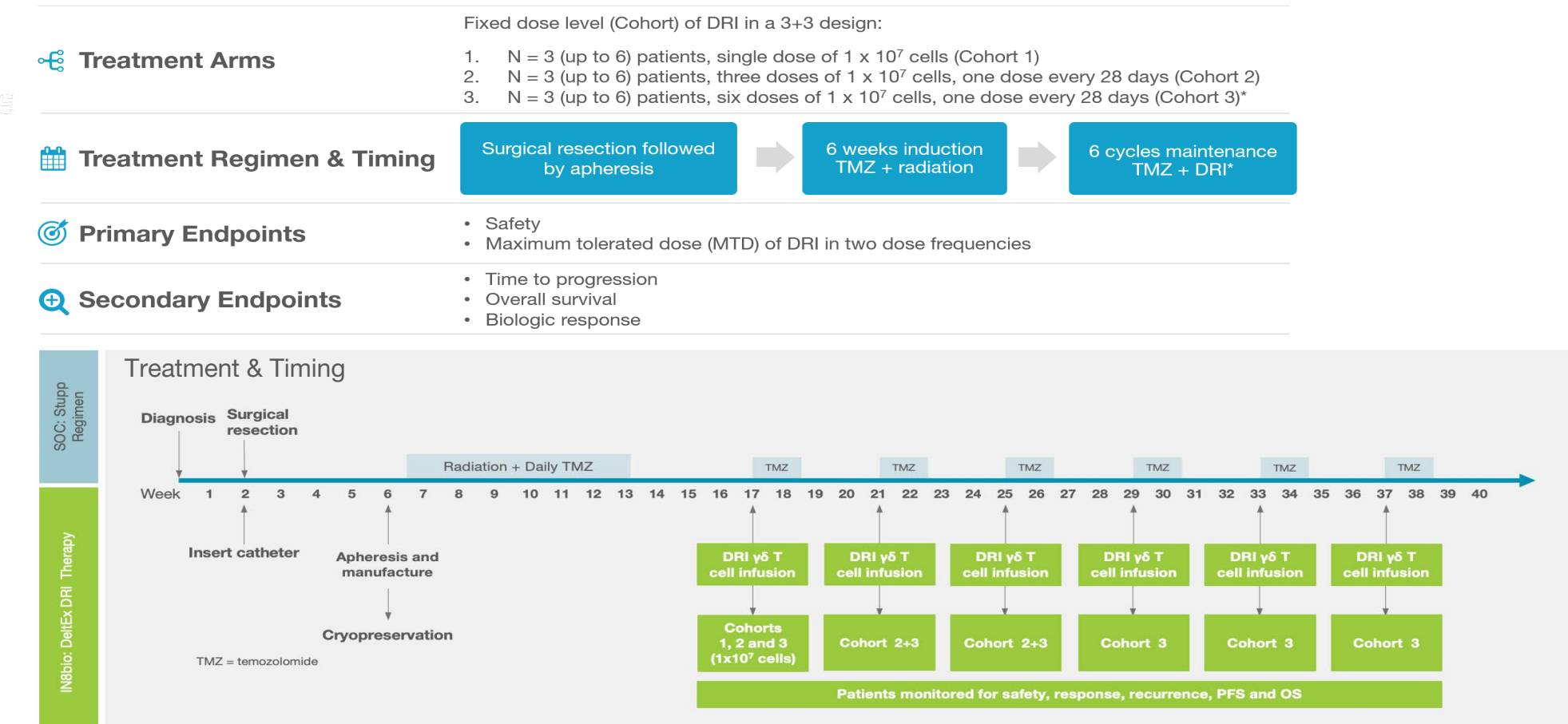
Background

Glioblastoma (GBM) is an aggressive brain tumor that has a high unmet need, an upfront treatment regimen that has remained unchanged for 20+ years, and a one-year overall survival (OS) of only 53.7%¹ (mPFS 6.9m, mOS 14.6m)². Gamma-delta ($\gamma\delta$) T cells are innate immune cells that directly recognize and kill malignant tissue through the recognition of Natural Killer Group 2D Ligands (NKG2D-L) that are highly expressed on cancer cells. Alkylating chemotherapies such as Temozolomide (TMZ) force significant upregulation of NKG2D-L expression on tumor cells and tumor stem-cells but are also strongly lymphodepleting. The NKG2D-L increase makes them susceptible to $\gamma\delta$ T cell mediated killing. In the trial of INB-200/400, DeltEx Drug Resistant Immunotherapy (DeltEx DRI), genetically modified $\gamma\delta$ T cells with a methylguanine-DNA methyltransferase (MGMT) expressing lentivector that renders them TMZ resistant, are given concomitantly with TMZ. This allows for greater elimination of residual GBM cells, including TMZ-resistant GBM cells, which also upregulate stress ligands when combined with standard-of-care (SOC). Here we present consolidated data from 17 treated patients enrolled in the INB-200 Phase 1 study and INB-400 Phase 2 study. SOC control data from contemporaneously enrolled consented subjects that did not receive DeltEx DRI are also presented.



Sources: ¹Ostrom, et al Neuro-Onc 2013; ²Stupp, et al NEJM 2005; Hottinger, et al Neuro-Oncology 2016, * adapted with permission from Dranoff et al. Nature Rev. Can., Jan. 2004, fig 1, IN8bio, image created with biorender.com

INB-200: Study Design and Treatment Schema



Newly diagnosed GBM patients are enrolled and treated with DeltEx DRI in combination with the SOC Stupp regimen. A Rickham catheter is placed during surgical resection, the DeltEx DRI product is manufactured and patients received 1 (Cohort 1), 3 (Cohort 2), or up to 6 doses (Cohort 3) of DeltEx DRI, delivered intrathecally during maintenance TMZ cycles. INB-400 treatment followed the same schema as Cohort 3.

Demographics of Treated (N= 17) and Control (N= 10) Patients

Patients were enrolled in the INB-200 (Phase 1 single-center) and INB-400 (Phase 2 multi-center) trial

Treatment Arm	N	Methylation Status	Resection Type		Median Age	Gender
			Subtotal	Total		
INB-200 DL1 Patients	3	66% Unmethylated	0%	100%	69	33% Male
All Control (SOC) Patients	10	60% Unmethylated	20%	80%	67	60% Male
DL1 + Control (SOC) Patients	13	62% Unmethylated	15%	85%	67	54% Male
INB-200 Repeat Dose Patients	10	50% Unmethylated	60%	40%	62	70% Male
INB-400 Repeat Dose Patients	4	50% Unmethylated	50%	50%	66	0% Male
All Repeat Dose Patients	14	50% Unmethylated	57%	43%	64	50% Male

- 34 patients were enrolled
- 17 patients were treated with DeltEx DRI, with 14 patients receiving from 3 to 6 doses (**Repeat Dose Patients**)
- 10 patients received only SOC Stupp protocol, and consented to be tracked (**Control (SOC) Patients**)
- Across all patient groups there were similar methylation status distribution, gender distribution and median age; one single patient (009) enrolled before 2021 was a grade 4, IDH-mutant glioma
- Interestingly, in the SOC Control patients, the number of Total resections was much higher (80% total) compared to the Repeat Dose patients (43% total). Patients with Total resections are generally expected to have better outcomes

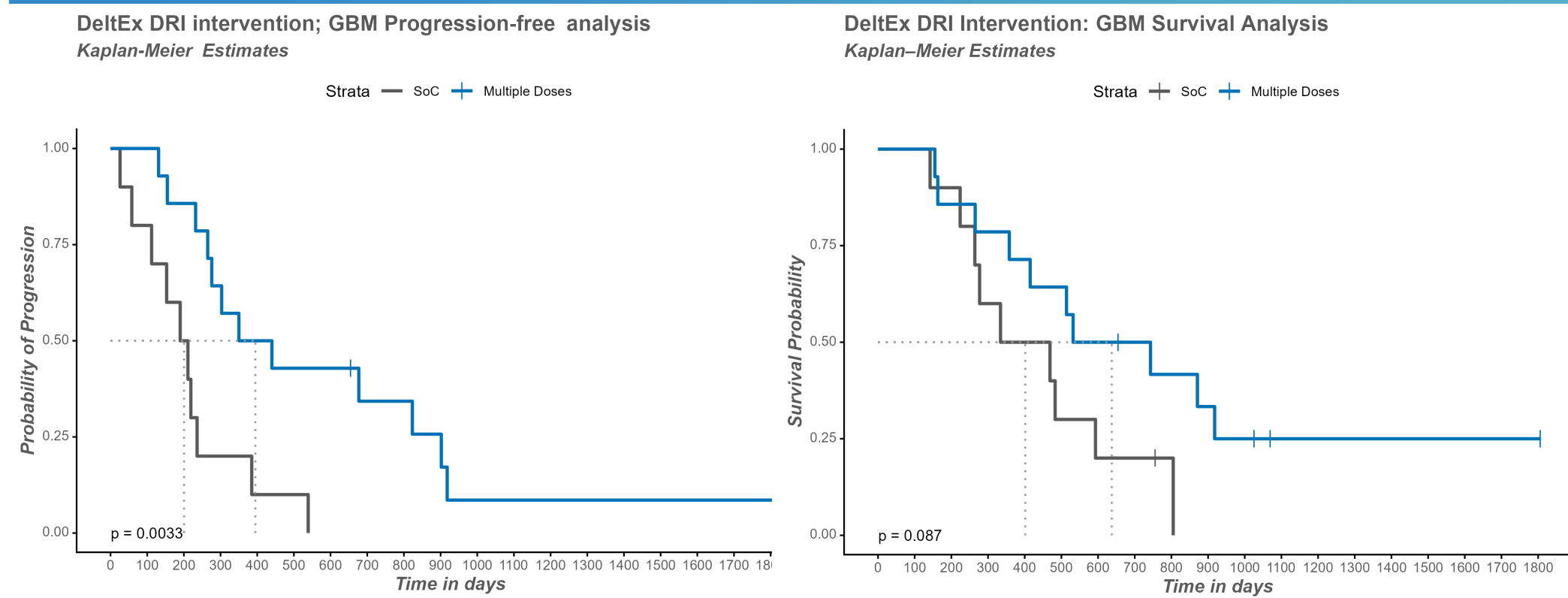
Strong Treatment Effect Observed in Repeat Dose Patients

Treatment Arm	Median PFS (m)	Median OS (m)	Pts without progression or PFS Exceeding Expected OS (%)
Historical NEJM Data	6.9	14.6	NA
INB-200 DL1 Patients	8.0	15.7	(0/3) 0%
All Control (SOC) Patients	6.6	13.2	(1/10) 10%
DL1 + Control (SOC) Patients	7.2	15.4	(1/13) 8%
INB-200 Repeat Dose Patients	16.1	21.1	(5/10) 50%
INB-400 Repeat Dose Patients	13.0	NR (19.5+)	(3/4) 75%
All Repeat Dose Patients	13.0	NR (19.5+)	(8/14) 57%

Patients that received repeat doses of DeltEx DRI in INB-200/400 show a significant improvement in median progression-free survival (mPFS = 13.0m) over enrolled SOC control patients from the same centers who only received the Stupp Regimen (mPFS = 6.6m), which is inline with historical Stupp controls (mPFS 6.9m). INB-200/400 repeated dose patients have not reached (NR) mOS which is at 19.5+m and still climbing while SOC control have reached a final mOS of 13.2m.

Note: As of May 15, 2026; Source: Early trial results are not indicative of future results, including the outcome of this trial.

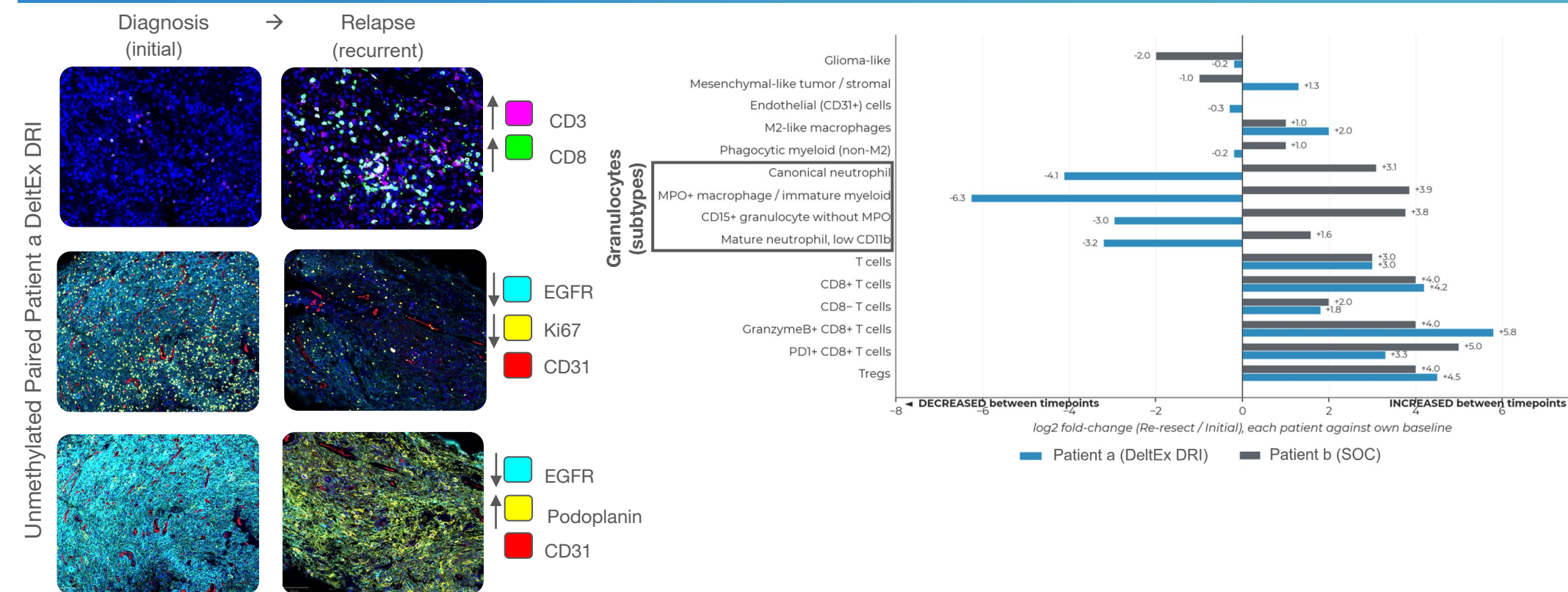
Multiple-Dose DeltEx DRI Improves GBM Outcomes



Repeat-dose DeltEx DRI significantly improved PFS over SOC ($p = 0.0033$), with mPFS approximately doubling (~13m vs. ~6.6m). No SOC patients remained progression-free beyond 17.7m, while ~40% of the repeat-dose patients passed this timeframe. A meaningful survival trend in mOS was also observed from repeat-dose DeltEx DRI patients vs. SOC ($p = 0.087$; n=14 vs. n=10) 19.5+m vs. 13.2m. Approximately 43% of repeat-dose patients remained alive at 24.0m vs. only 20% SOC; late censoring suggests this benefit may be underestimated. The data demonstrate encouraging durable responses and a significant PFS and OS trend for DeltEx DRI. These findings support advancing DeltEx DRI into larger, pivotal trials.

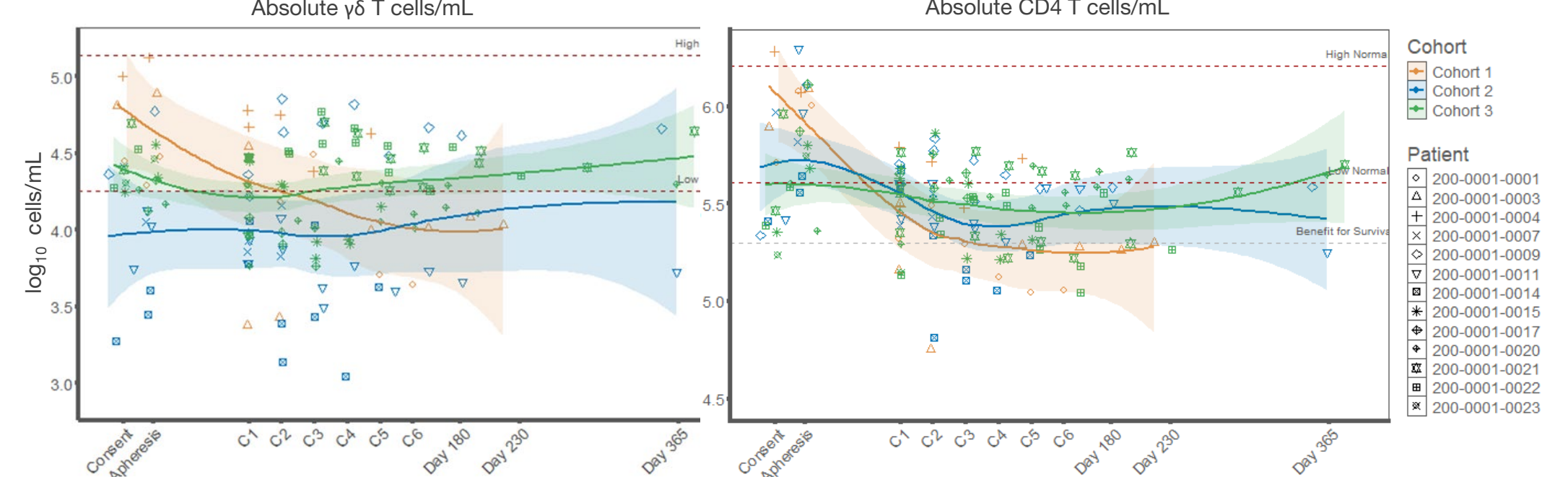
Note: As of May 15, 2026; Source: Early trial results are not indicative of future results, including the outcome of this trial, limited late at-risk numbers

DeltEx DRI Drives a Cold-to-Hot TME Shift with Granulocyte Clearance



Paired tumor biopsies (initial diagnosis vs. recurrence) from two unmethylated GBM patients were analyzed by spatial proteomics and transcriptomics. The SOC patient relapsed at 7.5m (gross total) while the DeltEx DRI patient relapsed at 9.9m (partial) despite the difference in resection type. In the DeltEx DRI-treated patient, the tumor microenvironment shifted markedly, with broad T cell infiltration, including cytotoxic GranzymeB+ and PD1+ CD8 T cells, alongside a substantial reduction in all granulocyte subtypes. This granulocyte clearance was not observed in the SOC patient, suggesting it may be specific to DeltEx DRI treatment and may be mediated by $\gamma\delta$ T cells. Both patients ultimately showed mesenchymal-like stromal expansion at relapse, consistent with progressive tumor evasion and suggesting that similar mechanisms presented in both patients. This could suggest that dose intensification or additional cycles of DeltEx DRI may be beneficial and could continue to provide tumor control.

Repeat Doses Reconstitutes and Sustains Immune Cell Levels



Absolute $\gamma\delta$ and CD4 T cell counts were tracked consent through Day 365. Single-dose patients (Cohort 1) showed progressive decline, falling below clinically meaningful levels, which is typical in TMZ treated GBM patients. Repeat dose patients (Cohort 2 & 3), demonstrated sustained immune reconstitution, which was most pronounced in Cohort 3 with $\gamma\delta$ T cell levels trending above the low-normal threshold and CD4+ counts above the survival-benefit threshold (~200 cells/ μ L; $-5.3 \log_{10}$ cells/mL), a level associated with improved outcomes in GBM patients on TMZ (Grossman et al., 2011; Ellsworth et al., 2013). This suggests DeltEx DRI dosing supports immune recovery during & after chemotherapy.

DeltEx Dosing Preserves the T cell Compartment During Chemo

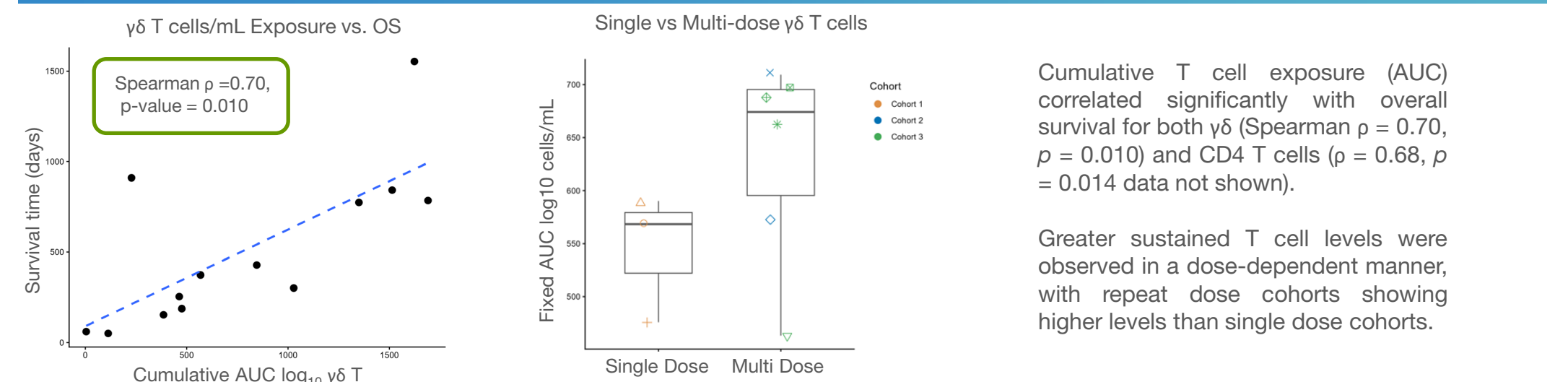


Mean T cell levels (CD3+, CD4+, CD8+, and $\gamma\delta$ subsets) were monitored across six TMZ maintenance cycles (pre- and post-dose). Patients receiving a single DeltEx DRI dose (Cohort 1) showed a progressive decline across all T cell compartments, consistent with TMZ-induced lymphodepletion.

In contrast, repeat DeltEx DRI dosing (Cohorts 2&3) stabilized T cell counts throughout treatment, with levels remaining broadly maintained across all subsets.

This pattern suggests that repeat dosing may mitigate treatment-related lymphodepletion, which may lead to fewer TMZ treatment breaks or delays, more consistent TMZ delivery which is known to influence patient outcomes.

Repeat Dosing Improves Immunity and correlates to Survival



Cumulative T cell exposure (AUC) correlated significantly with overall survival for both $\gamma\delta$ (Spearman $\rho = 0.70$, $p = 0.010$) and CD4 T cells ($\rho = 0.68$, $p = 0.014$ data not shown).

Greater sustained T cell levels were observed in a dose-dependent manner, with repeat dose cohorts showing higher levels than single dose cohorts.

Conclusions

- Intracranially delivered DeltEx DRI gamma-delta T cell therapy was well-tolerated in patients, showing no dose-limiting toxicities (DLTs), no neurotoxicities (ICANS) and no cytokine release syndrome (CRS)
- Patients receiving repeat doses achieved a mPFS of 13.0m and have not reached mOS (19.5+m) versus 6.6m and 13.2m in SoC controls. Notably, in 57% repeat-dose patients their PFS exceeded their expected OS, compared to only 10% in the SOC group based on age and MGMT status.
- Paired biopsy analysis integrating AI and histopathology revealed that DeltEx DRI treatment drove a cold-to-hot microenvironment shift, with broad T cell infiltration and reduction in immunosuppressive granulocytes not seen in the SoC patient, pointing to a $\gamma\delta$ T cell-mediated local mechanism with systemic reach.
- Repeat dosing drove a dose-dependent systemic immune response, preserving T cell counts (CD3+, CD4+, CD8+, $\gamma\delta$) through maintenance TMZ administration and restoring CD4+ levels above the survival-benefit threshold. This demonstrates that local DeltEx DRI administration promotes broader systemic immune reconstitution, critical in the context of lymphodepleting chemotherapy.
- Cumulative $\gamma\delta$ T cell and CD4+ exposure both correlated significantly with overall survival, linking sustained immune reconstitution to improved outcomes and was dose-dependent.
- This data demonstrates the power of using $\gamma\delta$ T cell based cellular therapy (DeltEx DRI) synergistically with the SOC in frontline GBM and provide meaningful time to newly diagnosed GBM patients