Innovative Oncology

We identify, develop and commercialize novel oncology therapeutics with significant commercial potential.

Corporate Presentation | November 2024

Forward Looking Statements

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, including, but not limited to, statements regarding timing of future clinical research catalysts; expectations about market opportunity and U.S. drug treatable cases; expectations about competition; statements about future demand and payer coverage; projections about UDENYCA unit cost, annual capacity and quantity of suppliers; expectations about the resumption of production and product availability for UDENYCA; statements about the timing for a second labeling and packaging CMO to produce final saleable product; and statements about future market share. Such forward-looking statements involve substantial risks and uncertainties that could cause Coherus’ 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 others, 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’ regulatory filings; the risks of Coherus’ reliance on third parties; the risks and uncertainties related to manufacturing and supply of Coherus’ products; the risk that Coherus is unable to complete commercial transactions; risks and uncertainties in executing collaboration agreements and other joint ventures; and the risks and uncertainties of litigation. All forward-looking statements contained in this presentation speak only as of the date on which they were made. Coherus undertakes no obligation to update or revise any forward-looking statements. For a further description of the risks and uncertainties that could cause actual results to differ from those expressed in these forward-looking statements, as well as risks relating to Coherus’ business in general, see Coherus’ Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2024, filed with the Securities and Exchange Commission on November 6, 2024, including the section therein captioned “Risk Factors,” and in other documents Coherus files with the Securities and Exchange Commission. UDENYCA®, UDENYCA® ONBODY™, and LOQTORZI®, whether or not appearing in large print or with the trademark symbol, are trademarks of Coherus, its affiliates, related companies or its licensors or joint venture partners, unless otherwise noted. Trademarks and trade names of other companies appearing in this presentation are, to the knowledge of Coherus, the property of their respective owners.

Agenda

- Corporate Highlights
- Innovative Oncology Pipeline
- Commercial Oncology
- Outlook

End-to-End Innovative Oncology Company

Leveraging Commercial Products Expertise to Identify, Develop and Commercialize Promising Assets

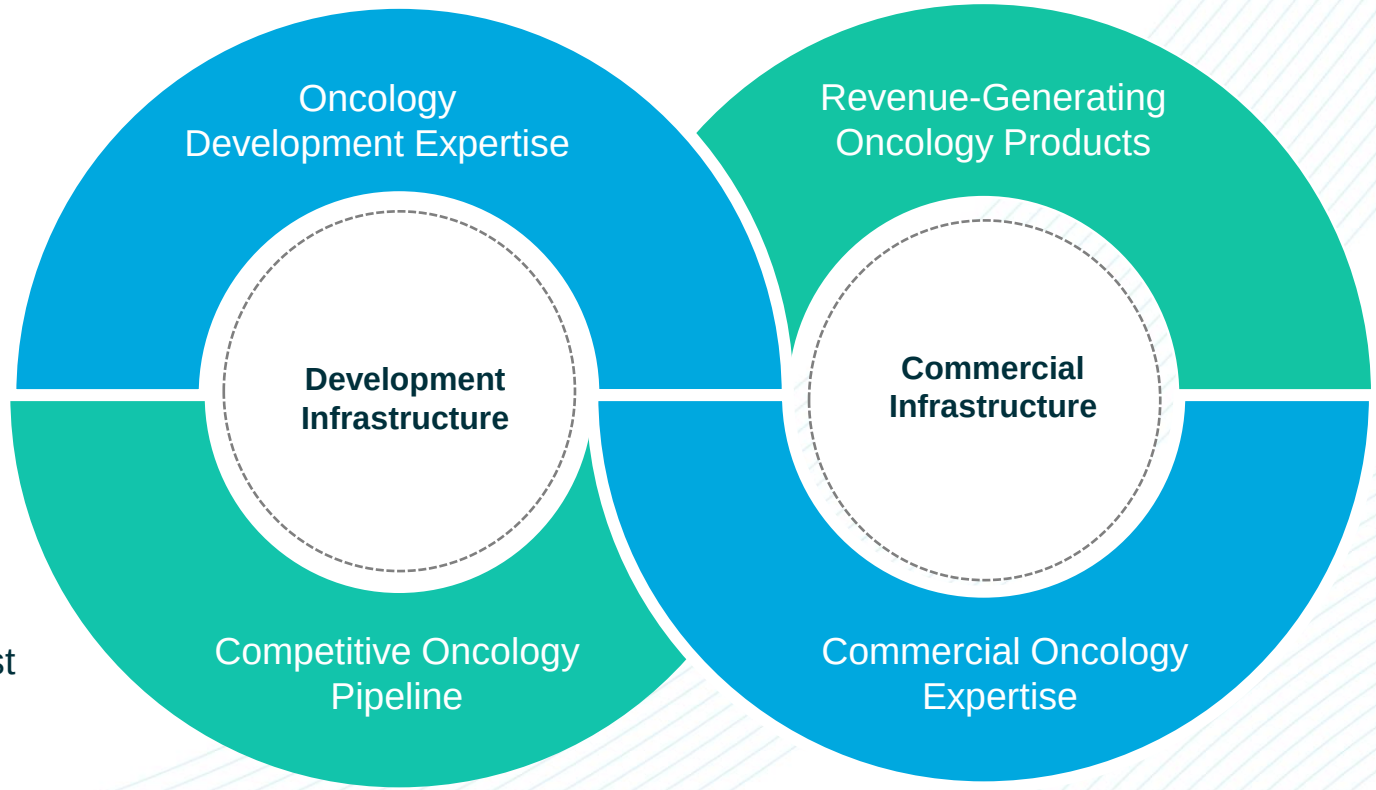
Leadership Has Proven Drug Development Expertise: Discovery of >30 Marketed Products

Demonstrated Regulatory Success: 6 FDA Approvals at Coherus

Antibody Pipeline

- Toripalimab-tpzi (LOQTORZI): next generation PD-1 inhibitor
- Casdozokitug: IL-27 antagonist
- CHS-114: anti-CCR8
- CHS-1000: anti-ILT4

Fully Integrated Model Mitigates Risk



LOQTORZI® (toripalimab-tpzi)injection

UDENYCA® pegfilgrastim-cbqv

Marketed Drugs

- 5 Product Launches
- Highly Experienced Team Has Commercialized 30+ Products

Oncology Clinical Development and Commercialization Expertise

End-to-End Drug Delivery with Commercialization of 30+ Products

Dennis M. Lanfear
Chief Executive Officer

Biopharmaceutical leader with a proven track record of entrepreneurial success and achievement in oncology commercialization.

Commercial + Innovative ONCOLOGY

Theresa LaVallee, Ph.D.
Chief Development Officer

25+ years of drug discovery and development experience in biotech and pharma.

Rosh Dias, M.D., M.R.C.P.
Chief Medical Officer

20+ years leading US and rest of world teams in oncology clinical development and medical affairs.

AMGEN · IPSEN · AstraZeneca · NOVARTIS · ONYX PHARMACEUTICALS · PICI PARKER INSTITUTE FOR CANCER IMMUNOTHERAPY · Celldex therapeutics · Genentech A Member of the Roche Group · Theravance Biopharma

Richard L. Hameister
Chief Technical Officer

30+ years leading both manufacturing and quality organizations.

Paul Reider
Chief Commercial Officer

30+ years of sales and marketing experience across oncology and other therapeutic areas.

Scott Saywell
EVP, Corporate Development

20+ years of corporate development experience. Led commercialization planning and pre-launch activities for a first-in-class personalized cancer vaccine.

Coherus Scientific Advisory Board

Highly Accomplished Scientific Leaders with Deep Expertise in Immunology and Oncology

Theresa LaVallee, PhD (Chair)
Chief Development Officer, Coherus Biosciences

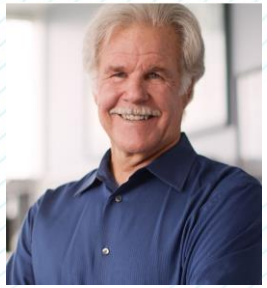
Thomas Graeber, PhD
Professor, Molecular and Medical Pharmacology; Director, UCLA Metabolics Center

Christopher Hunter, PhD
Chair Department of Pathobiology at the University of Pennsylvania School of Veterinary Medicine

Taofeek K. Owonikoko, M.D., PhD
Chief, Division of Hematology/Oncology, University of Pittsburgh Medical Center Hillman Cancer Center

Alexander Rudensky, PhD
Chairman, immunology program and Director, Ludwig Center for Cancer Immunotherapy at Memorial Sloan-Kettering Cancer Center

John Stagg, PhD
Professor, Faculty of Pharmacy at University of Montreal and Principal Investigator, Centre Hospitalier de l'Université de Montréal (CHUM) and its affiliated Cancer Institute of Montreal



Carl F. Ware, Ph.D.
Director, Sanford-Burnham Medical Research Institute

John Wherry, PhD
Director, Penn Institute for Immunology at the Perelman School of Medicine at the University of Pennsylvania

Robust Pipeline with Internally Led Studies

Balanced Oncology-focused Portfolio Creates Long-term Value Creation

Agent	Description	Indication/ Patient Population	Combination	Study Lead	Preclinical	Phase 1	Phase 2	Phase 3	2024/2025 Catalysts
LOQTORZI (toripalimab-tpzi) injection	Anti-PD-1 monoclonal antibody	**1L Nasopharyngeal Carcinoma (NPC)**	Gemcitabine/ Cisplatin		**FDA Approved**				**U.S. Launch January 2024**
		2L+ NPC	Monotherapy		**FDA Approved**				
Casdozokitug	Anti-IL-27 antagonist monoclonal antibody	**Hepatocellular Carcinoma**	Atezolizumab/ Bevacizumab	Coherus					**HCC Triplet Combo Final Data Q1 2025**
		Hepatocellular Carcinoma	Toripalimab/ Bevacizumab	Coherus					**1L HCC Phase 2 Study Initiation Q4 2024**
		Non-Small Cell Lung Cancer	Toripalimab	Coherus					**NSCLC Squamous Subtype Data – SITC 2024 Combo Data 1H 2025**
CHS-114	Anti-CCR8 cytolytic monoclonal antibody	**Solid Tumors including HNSCC**	Monotherapy and Toripalimab Combination	Coherus					**CHS-114 Expanded Phase 1 Data – SITC 2024; HNSCC Data Redouts – 2H 2025**
		Gastric Cancers	Toripalimab	Coherus	**Planning Stages**				**Study Initiation 1Q 2025**
CHS-1000	Anti-ILT4 monoclonal antibody	**Solid Tumors**	Monotherapy and Toripalimab Combination	Coherus	**Planning Stages**				**FDA acceptance of IND in Q2 2024**

Robust Pipeline with Partner Funded and Managed Studies

Balanced Oncology-focused Portfolio Creates Long-term Value Creation

Agent	Description	Indication/ Patient Population	Combination	Study Lead	Preclinical	Phase 1	Phase 2	Phase 3	2024/2025 Catalysts
Toripalimab (Partner Studies)	Anti-PD-1 monoclonal antibody	**Limited Stage SCLC**	Tifcemalimab (BTLA)	Junshi[1,2]					
		Locally Advanced High Risk HPV+ HNSCC	IN0-3112	INOVIO	**Planning Stages**				**Study Initiation 1H 2025**
		Ovarian Cancer	ENB-003	CRI	**Planning Stages**				**Study Initiation**
GSK4381562[3]	Anti-PVRIG monoclonal antibody	**PD-L1 Positive Recurrent/Metastatic HNSCC**	Dostarlimab	GSK					

[1]Junshi multinational study – US, EU, China, ROW, registration enabling. Coherus not contributing to development costs.
[2] Junshi Biosciences is wholly-owned subsidiary of Top Alliance Biosciences Inc. [3]Surface Oncology (acquired by Coherus) granted GSK a worldwide exclusive license to develop, manufacture and commercialize GSK4381562.

Driving the Development of our Diversified Pipeline of Immunotherapies

- Casdozokitug
  - Initiating Phase 2 randomized trial of casdozokitug/toripalimab/bevacizumab in 1L HCC in Q4 2024
  - Final data from Phase 2 trial of casdozokitug/atezolizumab/bevacizumab in 1L HCC in Q1 2025
  - Data from Phase 1 study of casdozokitug/toripalimab in 2L NSCLC in 1H 2025
- CHS-114
  - Phase 1 dose escalation complete establishing safety and proof of mechanism
  - Phase 1 monotherapy biopsy data and CHS-114/toripalimab combination safety data in Q2 2025
  - Initiation of Phase 1b CHS-114/toripalimab combination dose optimization study in 2L HNSCC in Q1 2025 with data readout in Q2 2026
  - Initiation of Phase 1b CHS-114/toripalimab combination dose optimization study in 2L gastric cancer in Q1 2025 with data readout in Q2 2026
- CHS-1000
  - FDA cleared IND for Phase 1 study
  - Proceeding to the first-in-human clinical study is subject to further evaluation in our portfolio prioritization process.

Pipeline Molecules and Lifecycle Access ~$15B of Market Opportunity

Molecule	Setting	US Drug Treatable Cases[1]
Casdozokitug / Toripalimab	1L Advanced HCC (Hepatocellular Carcinoma)	~24K
Casdozokitug / Toripalimab	2L NSCLC (Non-Small Cell Lung Cancer)	~100K
CHS-114 / Toripalimab	2L HNSCC (Non-Nasopharyngeal Head and Neck Squamous Cell Carcinoma)	~15K
CHS-114 / Toripalimab	2L Gastric Cancer	~13K
Toripalimab / BTLA	Limited stage SCLC (Small Cell Lung Cancer)	~5K
Toripalimab / INO-3112	Locally advanced High Risk HNSCC HPV-16/18+[2] (Head and Neck Squamous Cell Carcinoma)	~2K

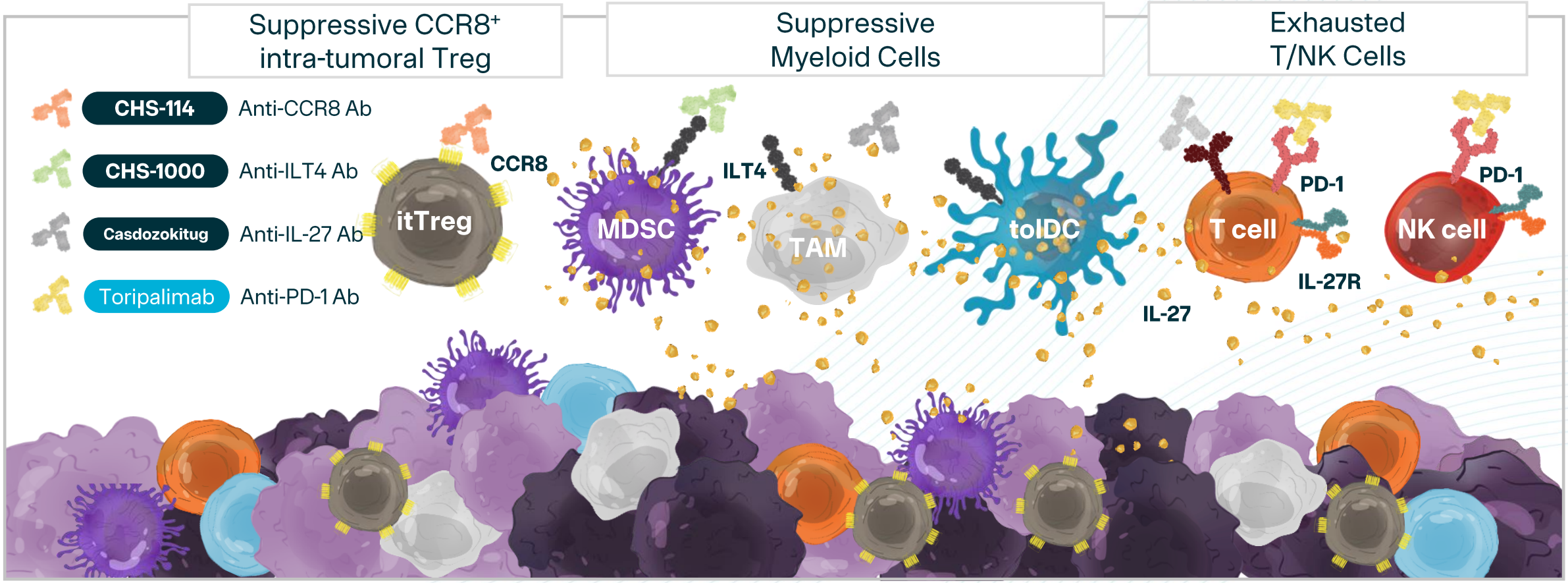
[1] Based on expected drug treated US patient population in 2030. Source: Decision Resources December 2023
[2] Based on locally advanced non-nasopharyngeal carcinoma, 60% HPV+, and 90% with HPV16

Agenda

- Corporate Highlights
- Innovative Oncology Pipeline
- Commercial Oncology
- Outlook

Competitively Positioned, Clinical-stage Oncology Portfolio

Addresses Multiple Pathways to Overcome Immune Suppression in the Tumor Microenvironment



- Relieving T/NK cell exhaustion (toripalimab-tpzi; casdozokitug)
- Targeting/reprogramming major resistance mechanisms (casdozokitug, CHS-114, CHS-1000)

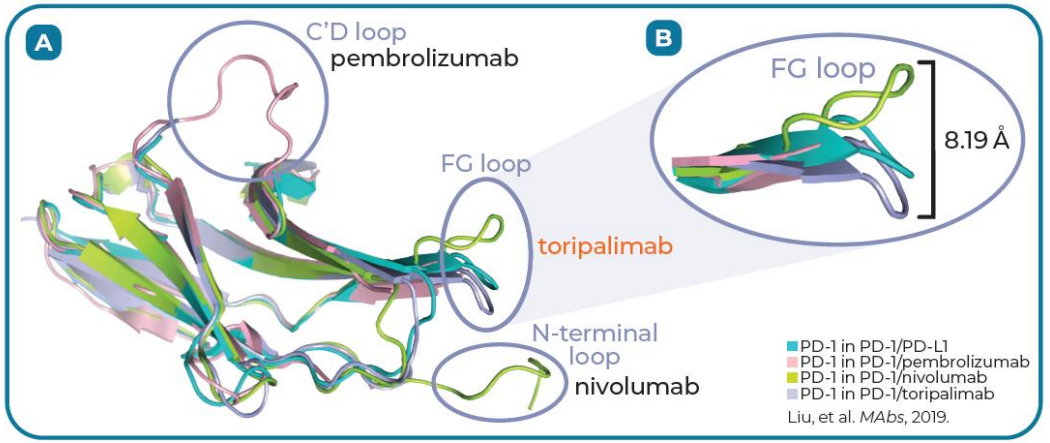
CCR8 = C-C chemokine receptor type 8; IL-27 = interleukin 27; ILT4 = immunoglobulin-like transcript; MDSC = myeloid-derived suppressor cell; NK =Natural Killer; PD-1 = programmed cell death protein 1; TAM = tumor-associated macrophage; tolDC = tolerogenic dendritic cell; Treg = Regulatory T cell

Toripalimab-tpzi: Mechanism of Action

Potent activation of T cells results in antitumor immunity in less inflamed tumors (PD-L1 low) in combo with chemotherapy

- Toripalimab has a unique epitope on PD-1 (FG loop)
- Toripalimab has potent binding affinity for PD-1
- Toripalimab induces strong T cell activation and inflammatory signature in various *in vitro* and *ex vivo* assays.

Epitope drives activity



(A) Comparative structural conformations[1] of PD-1 when bound to either native PD-L1 (blue) or various PD-1 targeting monoclonal antibodies (pembro = pink; nivo = green; tori = lilac) with (B) magnification of the PD-1 FG loop.

Rajasekaran, N., Wang, X., Ravindranathan, S. *et al.* Toripalimab, a therapeutic monoclonal anti-PD-1 antibody with high binding affinity to PD-1 and enhanced potency to activate human T cells. *Cancer Immunol Immunother* **73**, 60 (2024).

LOQTORZI (toripalimab-tpzi) – US FDA Approved PD-1 Inhibitor

Coherus is the Development and Commercial Partner in the U.S. and Canada[1]

- Junshi Biosciences discovered and developed toripalimab
  - Next generation PD-1 designed to bind the FG loop (collaboration with Liepeng Chen)
  - Approvals in China for multiple indications
  - Multiple positive randomized phase 3 studies published in top-tier scientific journals
  - Single country data challenged for US regulatory approval but important for toripalimab contribution of component dataset
  - NPC and ESCC under regulatory review in multiple regions, including the EU
- First and only U.S. FDA-approved I-O treatment in nasopharyngeal carcinoma (NPC)
- Coherus US BLA and development for toripalimab
  - JDC with Junshi and rights to develop outside US
  - Collaborative partnership but also independent toripalimab development
- Junshi continues development of toripalimab
  - Combinations with established SOC regimens
  - Combinations with Junshi's novel and proprietary internal pipeline

ESCC = esophageal squamous cell carcinoma; EU = European Union; JDC = Joint Development Committee; NPC = nasopharyngeal carcinoma; SOC = Standard of Care

[1]In June 2024 Coherus granted an exclusive license to develop toripalimab in Canada to Apotex, Inc.

Toripalimab Demonstrates Survival in a Broad Range of Solid Tumors

Published in Top-tier Journals and Foundational for Contribution of Component

Adj / Neoadj

- **HCC Adjuvant**
  CT16 / JUPITER-04 P3
  Mono vs placebo
- **NSCLC Neoadjuvant**
  CT29 / NEOTORCH / JUPITER-09 P3
  Mono vs placebo
- **ESCC Neoadjuvant**
  CT42 / JUPITER-14
  Combo vs chemo
- **Gastric Adj**
  CT45
  Combo vs chemo
- **Cervical Adj**
  CT49
  Combo vs chemo
- **SCLC Adj**
  P3
  Mono vs IO combo

1st Line

- **NSCLC EGFR(-)**
  CT19 / CHOICE-01 P3
  Chemo combo vs chemo
- **NSCLC EGFR(+)**
  CT25 / JUPITER-07 P3
  Chemo combo vs chemo
- **TNBC**
  CT26 JUPITER-05 P3
  Chemo combo vs chemo
- **SCLC**
  CT28 /JUPITER-08 P3
  Chemo combo vs chemo
- **RCC**
  CT36 JUPITER-12 P3
  Combo w axitinib vs sunitinib
- **UC PD-L1+**
  CT-8
  Chemo combo vs chemo
- **Melanoma**
  CT17 / JUPITER-01 P3
  Mono vs dacarbazine
- **NPC**
  CT15 / JUPITER-02 P3
  Chemo combo vs chemo
- **CT21 / ESCC**
  JUPITER-06 P3
  Chemo combo vs chemo
- **HCC**
  CT-35 / JUPITER-10 P3
  Combo w bevacizumab
  vs sorafenib
- **HCC**
  CT27 / JUPITER-11 P3
  Combo w lenvatinib
  vs lenvatinib
- **Mucosal Melanoma P3**
  CT43
  Combo with axitinib
  vs pembrolizumab
- **IHCC**
  CT39
  Combo vs lenvatinib

≥ 2nd Line

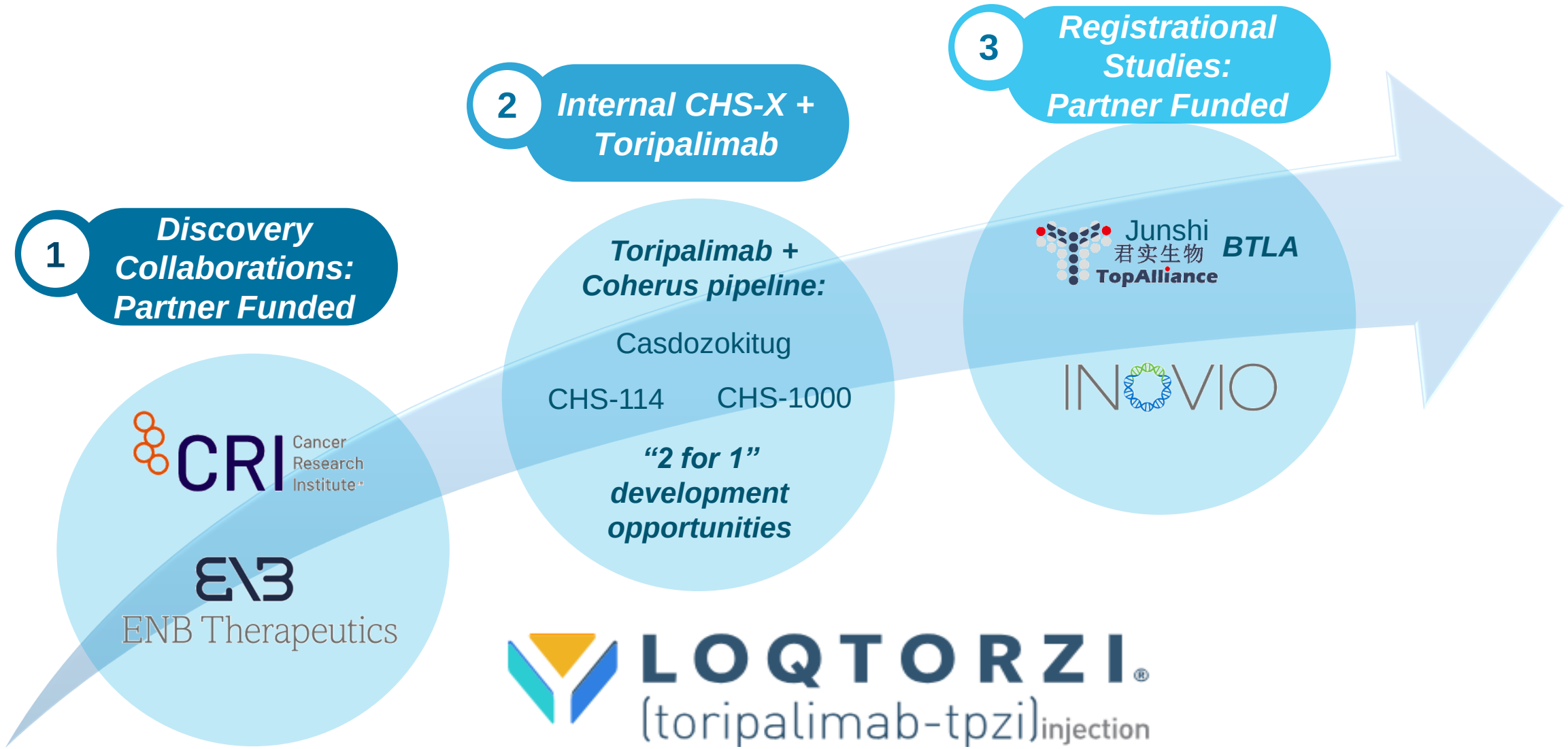
- **Melanoma**
  CT4 POLARIS01 P2
  Mono single arm
- **NPC**
  CT5 POLARIS02 P2
  Mono single arm
- **UC**
  CT12 POLARIS03 P2
  Mono single arm
- **GC**
  CT-3 POLARIS04 P2
  Mono single arm

Published P3 datasets

Adj = adjuvant; EGFR = epidermal growth factor receptor; ESCC = esophageal squamous cell carcinoma; GC = gastric cancer; IHCC = intra-hepatic cholangiocarcinoma; HCC = hepatocellular carcinoma; Neoadj = Neoadjuvent; NPC = nasopharyngeal carcinoma; NSCLC = Non-small cell lung cancer; P2 = Phase 2; P3 = Phase 3; RCC = renal cell carcinoma; SCLC = small cell lung cancer; TNBC = triple negative breast cancer; UC = urothelial cancer

LOQTORZI: Unlocking Additional Value and Expanding Indications

Multiple Opportunities for Registration and Access to Novel Technology through Early to Late-Stage Clinical Studies

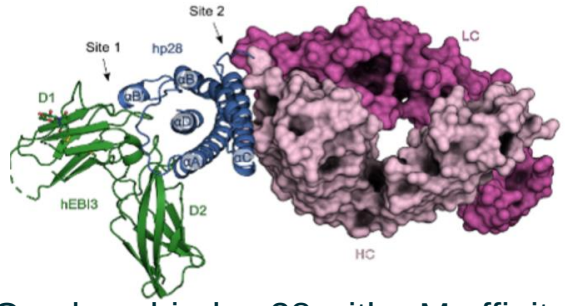


Casdozokitug: First-in-Class IL-27 Antagonist

TME-Targeting Agent; FDA Orphan Drug & Fast Track Designation for HCC

- High-affinity, human IgG1 antibody against IL-27
- IL-27 is an immunoregulatory cytokine that dampens T and NK cell effector function
  - IL-27 is a member of the IL-12/IL-23/IL-6 family, validated targets for modulating the immune response in human disease
- IL-27 is over-expressed in hepatocellular, lung and renal cancers[1]
  - Translational and clinical evidence supports activity in liver & lung[2]
- In early clinical studies casdozokitug demonstrated safety, monotherapy responses and immune activation[2]
- Two ongoing clinical trials:
  - Phase 2 study in hepatocellular carcinoma (HCC)[3]
  - Phase 1/2 study in non-small cell lung cancer (NSCLC)[4]
- Wholly owned asset – data supports partnering with novel immune activators (eg TCE and ADCs)

Casdozokitug: IL-27



Casdozo binds p28 with pM affinity

First and only clinical stage IL-27 antagonist mAb

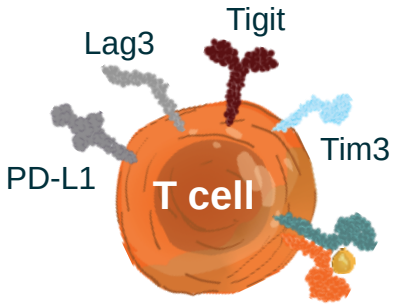
Due to its immune regulatory nature, there is a rationale for inhibiting IL-27 to treat cancer; may influence the activity of multiple types of immune cells that are necessary to recognize and attack a tumor.

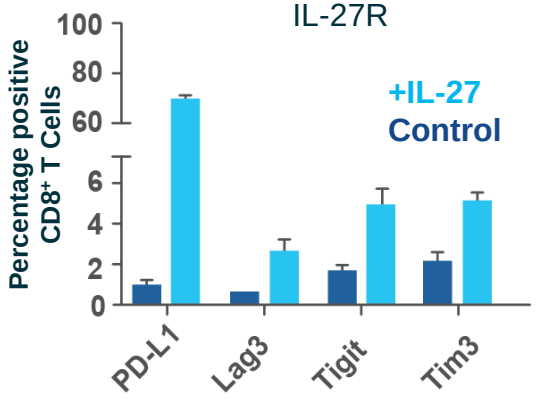
1. Golan, K. et al., 2022 SITC, Poster 1082; 2. Aung Naing et al., JCO 40, 2501-2501(2022); 3. ClinicalTrials.gov ID: NCT05359861; 4. ClinicalTrials.gov ID: NCT04374877

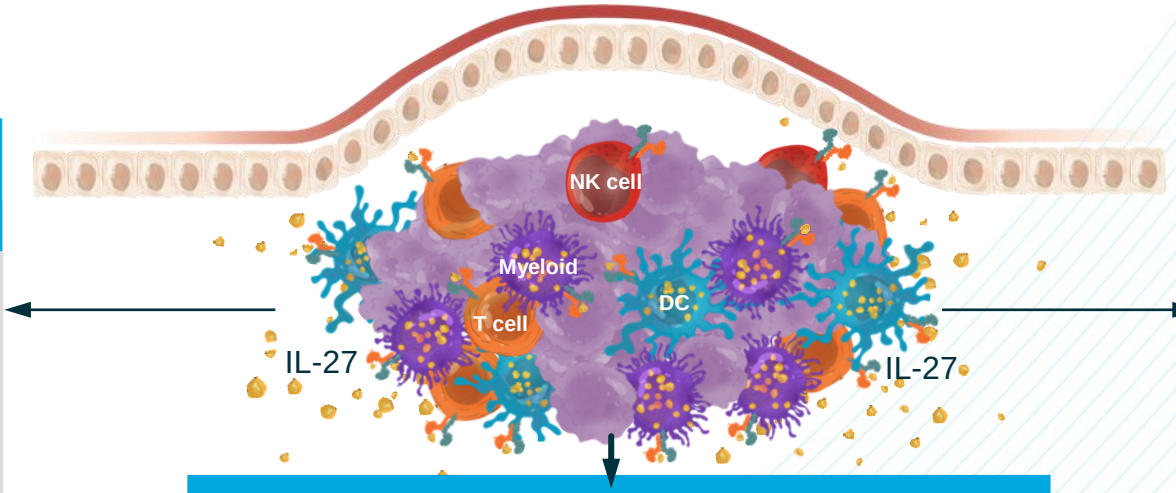
IL-27 Inhibits NK and T Cell Anti-Tumor Response

Immunoregulatory Cytokine Modulates Immune Response, Immune Pathology and Tumor Immune Evasion

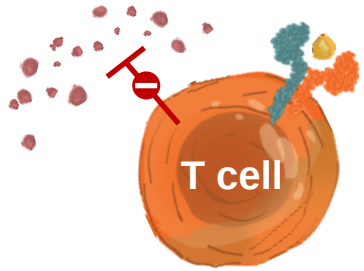
IL-27 upregulates checkpoint receptors

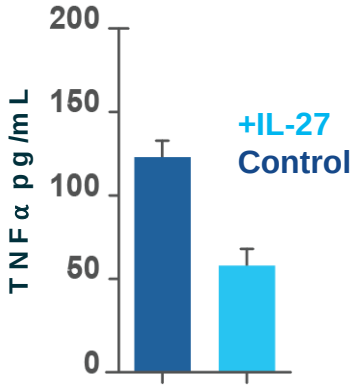




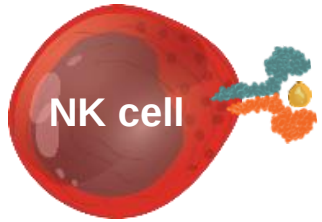


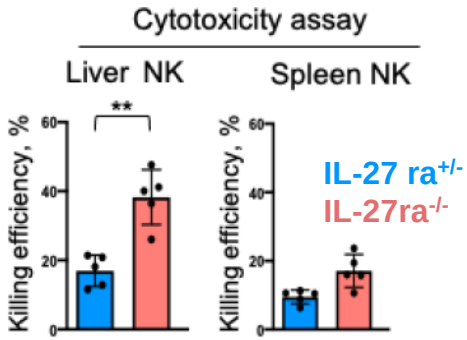
IL-27 downregulates pro-inflammatory cytokines





IL-27 constrains NK cell immunosurveillance





Chihara et al, Nature 558, 2018
DeLong et al, Immunohorizons 3, 2019

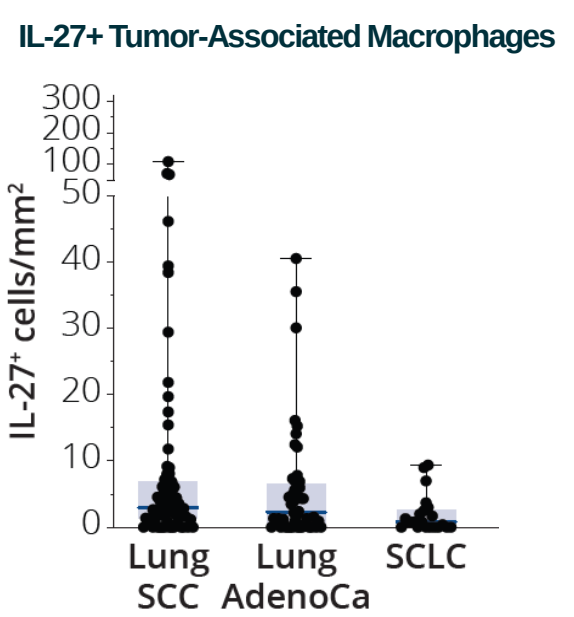
Chihara et al, Nature 558, 2018
DeLong et al, Immunohorizons 3, 2019

Aghayev et al, Cancer Discov, 12, 2022

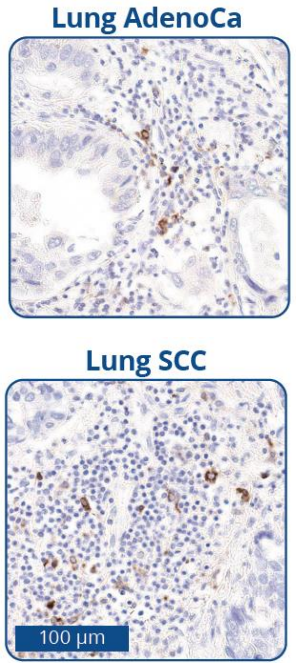
Strong Rationale for Blocking IL-27 in NSCLC

Inhibiting IL-27 in the lung or liver specifically and selectively shows antitumor activity in mouse models

IL-27 is expressed in the majority of NSCLC[1]

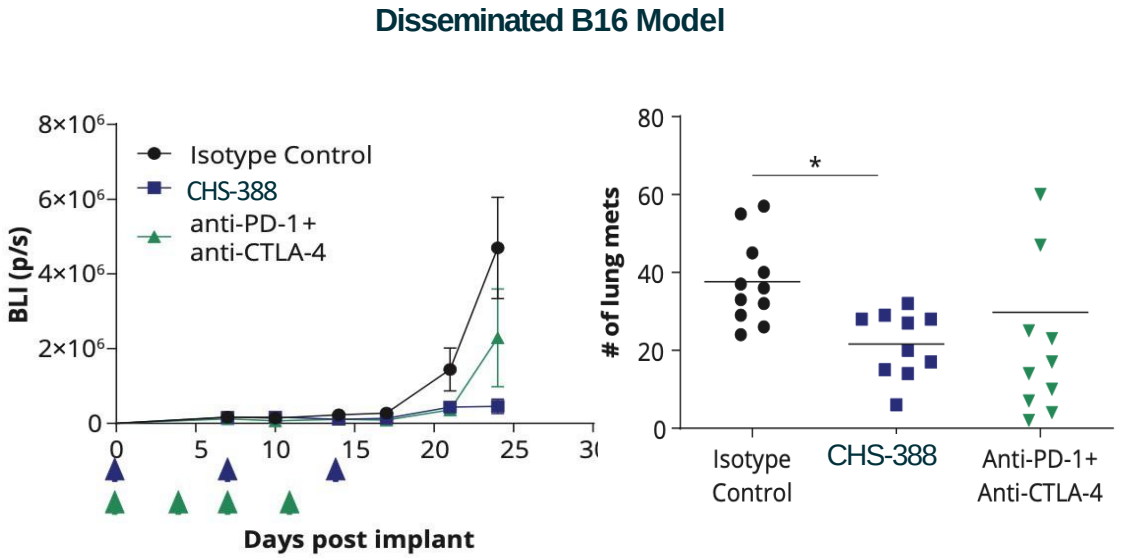


IL-27⁺ macrophages:
81% of squamous
75% of adenoCa



Staining shows positive cells in the tumor microenvironment (TME) that are morphologically consistent with tumor-associated macrophages.

Antitumor activity in mouse models of lung metastases[2]



*indicates P<0.05; unpaired t-test

1.Golan, K. et al., 2022 SITC, Poster 1082; 2. Rausch, M., et al., 2019 SITC, Poster P805

Casdozokitug Phase 1b/2 Clinical Trial

Enrollment Ongoing in Arm Evaluating Casdozo + Toripalimab in NSCLC

Part D (toripalimab NSCLC arm)

Primary endpoint

- Objective Response Rate† (ORR)

Key secondary endpoints:

- Duration of response † (DoR)
- Disease control rate † (DCR)
- Progression-free survival † (PFS)
- Safety
- Pharmacokinetics (PK)

Exploratory endpoints:

- Biomarkers of Interest

† Per RECIST 1.1 based on investigator assessment

NCSLC Expansion Cohorts: Casdozo with and without PD-1 Inhibitor

Part A: Complete

Casdozo Dose Escalation
N=29

- Patients with advanced solid tumors
- Explored 8 dose levels ranging from 0.003 – 20 mg/kg q4w
- Established encouraging safety and tolerability profile up to highest dose tested (20 mg/kg)
- Dose dependent biomarker changes: IL-27 signaling inhibition and immune activation
- No DLTs observed; favorable safety profile to date

Casdozo
10 mg/kg

Part D: 2-4L αPD-(L)1 R/R NSCLC
Casdozo + Toripalimab
Single-arm Simon 2 Stage Phase 2
(N=40)
Enrollment ongoing

Part C: 2-4L αPD-(L)1 R/R NSCLC
Casdozo + Pembro*
Single-arm Simon 2 Stage Phase 2
N=6

Part B: 2-5L NSCLC
Casdozo Monotherapy Expansion
Single-arm Simon 2 Stage Phase 2
N=40

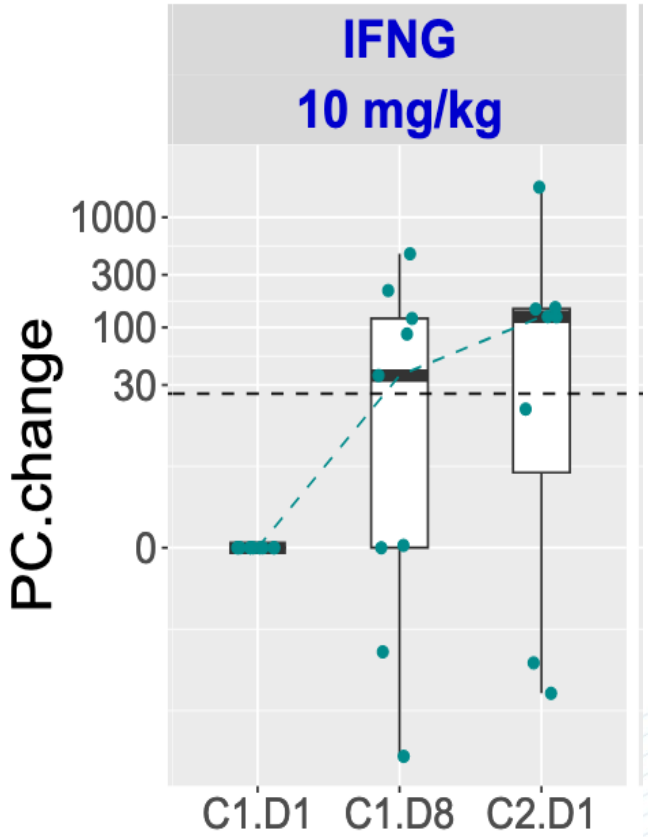
Completed
Ongoing

ClinicalTrials.gov ID: NCT04374877

*Casdozo + pembro arm (Part C) stopped early due to changes in company objectives. A new arm (Part D) of the study is enrolling patients to study casdozo in combination with toripalimab.

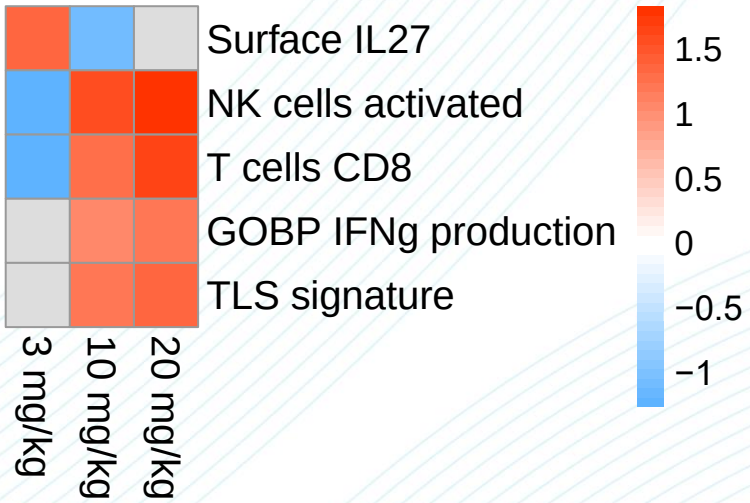
Casdozokitug Completely Inhibits IL-27 Signaling and Activates Immune Responses in Cancer Patients at ≥ 10 mg/kg

Casdozo Rx Increases Serum IFNγ



PC = Percent change
C = Cycle; D = Day
C1D1 = Before treatment

Casdozo Rx at ≥ 10 mg/kg inhibits IL-27 signaling and activates T and NK cells and tertiary lymphoid structures (PBMC)



Surface IL-27 = In house IL-27 gene signature
GOBP = Gene ontology biological process
TLS = Tertiary lymphoid structure

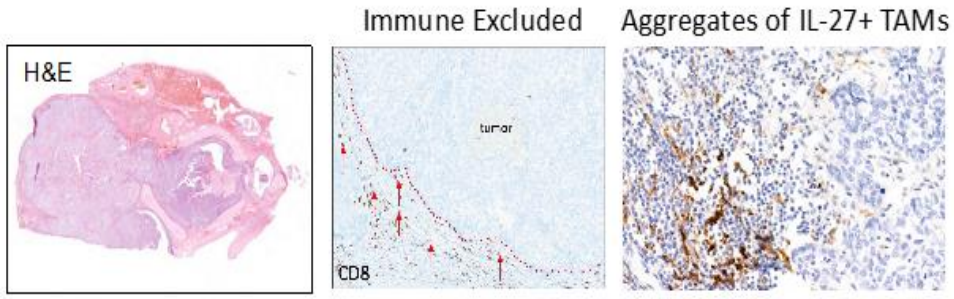
ClinicalTrials.gov ID: NCT04374877

Casdozokitug Demonstrates Monotherapy Activity in NSCLC

Phase 1b/2 Part B Arm in 2L++ Non-Small Cell Lung Cancer Patients

- 2 confirmed PRs in PD-L1 negative or low, squamous NSCLC and 1 durable disease stabilization in adenocarcinoma; all 3 previously treated with PD-(L)1 antibodies
- 22% ORR in squamous subset (n=2/9)
- Clinical demonstration of proof of mechanism – immune activation in cancer patients

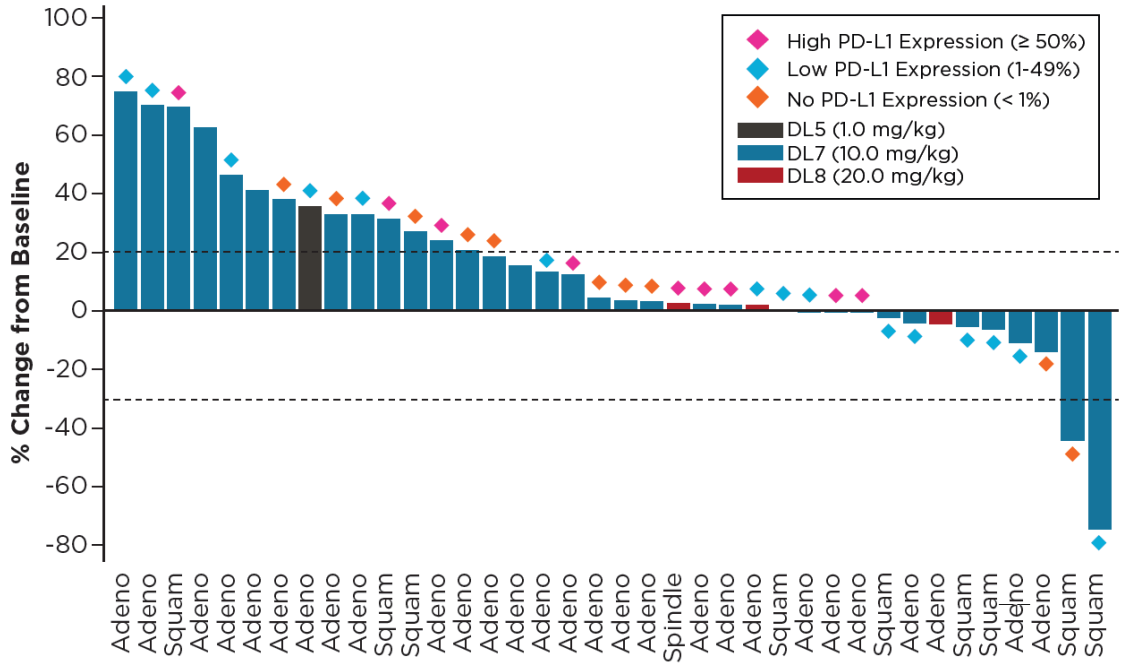
NSCLC partial responder displayed immune excluded tumor microenvironment



Casdozokitug Monotherapy in Non-Small Cell Lung Cancer (NSCLC)

Part B Arm

Best Percent Change from Baseline in Sum of Target Lesions (n=38)

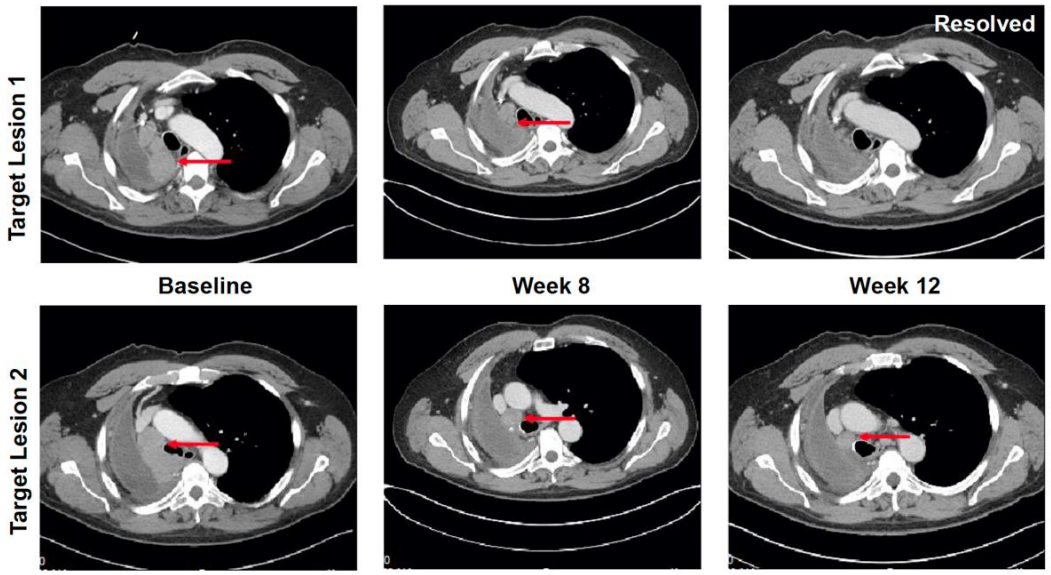


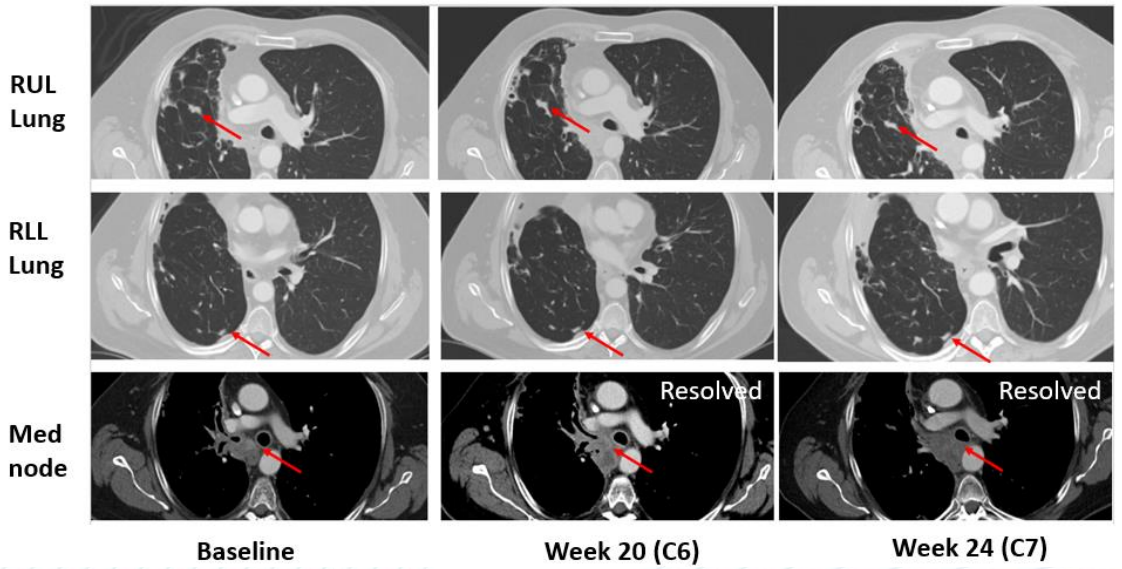
Data cut as of 21 Sept 2023, subject to change

Marron, T., et al., 2023 ESMO Immuno-Oncology Congress, Poster #122P

Casdozo Demonstrates Monotherapy Activity in NSCLC

Patient NSCLC Characteristics: Squamous, PD-1 Experienced and PD-L1 Low Tumors





Responder 1[1]	Responder 2[2]
Squamous histology without actionable driver alterations	
PD-L1 low (10%) or negative disease	
Smokers with metastases to lung, mediastinal nodes and adrenal glands	
Primary resistance to or short-lived disease control on prior αPD-(L)1	
High expression of IL-27+ Tumor Associated Macrophages by IHC	Tumor tissue not available
Rapid PR at 8 weeks (C3)	Delayed PR at 20 weeks (C6)
Post-platinum and docetaxel 3L casdozo; ~3 mo from last αPD-1	Post-platinum, pre-docetaxel 2L casdozo; ~1.5 years from last αPD-L1

1. Patnaik, A., et al., 2021 ASCO Poster 2551; 2. Coherus data on file.

Casdozokitug Phase 2 Trial in 1L HCC

Evaluating Casdozo/PD-(L)1/Bevacizumab Combination in I-O Naive HCC

Primary endpoint

- Safety
- Progression-free survival (PFS)†

Key secondary endpoints:

- Progression-free survival (PFS) †
- PFS according to HCC mRECIST
- Objective Response Rate† (ORR)
- ORR according to HCC mRECIST
- Duration of Response† (DoR)
- DoR according to HCC mRECIST
- Overall Survival

Lead In (N=30)

- Patients with first-line unresectable/metastatic hepatocellular carcinoma
- aPD-(L)1 naive

Casdozokitug 10 mg/kg
Atezolizumab 1200 mg
Bevacizumab 15 mg/kg
IV q3w

ClinicalTrials.gov ID: NCT05359861

Next Steps

Casdozo/Toripalimab/Bevacizumab
Follow-on randomized controlled study will evaluate casdozokitug in combination with toripalimab and bevacizumab in HCC
Planned for Q4 2024

ClinicalTrials.gov ID: NCT06679985

Contribution of Component

Toripalimab/Bevacizumab Phase 3 in China (Junshi Sponsored)
Data expected from Junshi study of toripalimab in combination with bevacizumab vs sorafenib in 1L HCC in Q4 2024

ClinicalTrials.gov ID: NCT04723004

† Per RECIST 1.1 based on investigator assessment

HCC mRECIST = Modified RECIST Assessment for hepatocellular carcinoma

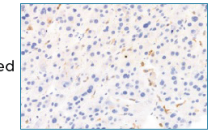
Casdozokitug Demonstrates Combination Efficacy and Safety

1L Liver Cancer Interim Results: 11 Durable Objective Responses including 3 Complete Responses

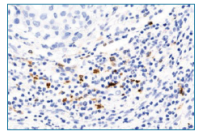
- Study on-going: interim results (data cutoff Nov 9, 2023)
- >60% of patients with tumor shrinkage on initial scans
- 38% ORR to date in response evaluable set
  - 3 Complete Responses
  - 8* Partial Responses
- PFS 8.1 mos.
- Safety profile consistent with atezo/bev alone
- Biomarker data show association of response with IL-27 pathway

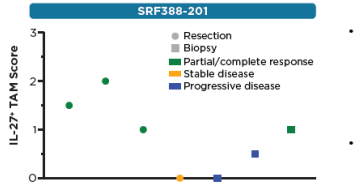
Preliminary Association of Higher Levels of IL-27+ Tumor Associated Macrophages in Archival Tissue Samples With Clinical Response (PR/CR), Small N

Complete responder (RECIST v1.1 and mRECIST) with HBV+HCC with scattered IL-27+ macrophages with Kupffer cell-like pattern



Complete responder (mRECIST) with non-viral HCC with clusters of IL-27+ TAMs



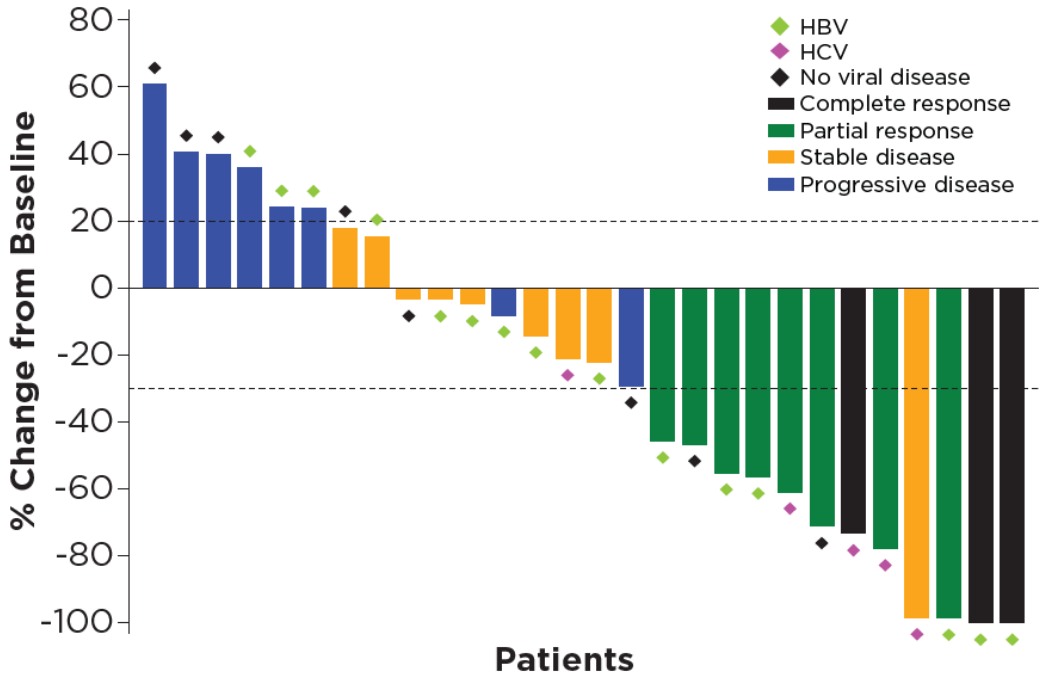


Patient	#1	#2	#3	#4	#5	#6	#7
Site	Liver	Liver	Liver	Liver	Liver	Liver	LN Met
Viral status	Neg	HBV	HBV	HCV	Neg	Neg	HBV
IL-27 score	1.5	2	1	0	0	0.5	1

- Immunohistochemical staining for IL-27 was performed on archival resection and biopsy samples using an independently validated assay
- Samples were scored blindly based on a semi-quantitative scoring system (0-3+) evaluating the abundance of IL-27+ tumor associated macrophages (TAM)

Casdozokitug/Atezolizumab/Bevacizumab in Hepatocellular Carcinoma (HCC)

Best Percent Change from Baseline in Sum of Target Lesions (n=28)



Data cut as of 09 Nov 2023, subject to change

Final Data Expected – Q1 2025

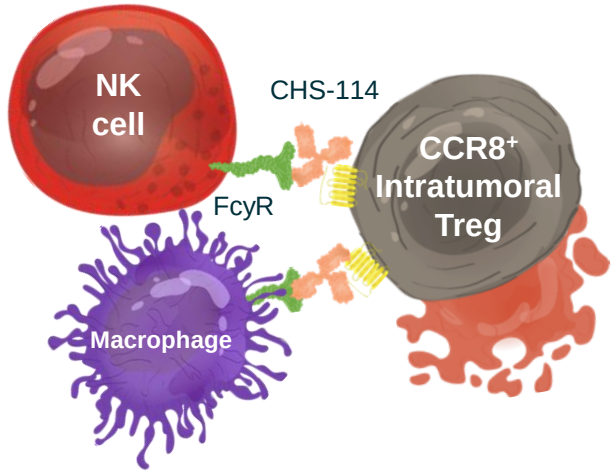
Li, Daneng, et al., 2024 ASCO GI Cancers Symposium, Abstract 470; *Includes 1 patient with an unconfirmed PR at the time of data cut-off

CHS-114: Anti-CCR8 Cytolytic Antibody

A highly selective CCR8 antibody with the potential to relieve Treg mediated tumor immune suppression

- High-affinity, human afucosylated IgG1 antibody
- Specifically binds and preferentially depletes CCR8+ tumor Tregs;
- No off-target binding
- Afucosylation enhances cytolytic activity and promotes killing of intratumoral CCR8+ Tregs
  - Minimal non-specific depletion of circulating Tregs mitigates risk of autoimmunity
  - Minimal depletion of effector T cells improves efficacy
- CHS-114 has the potential to overcome Treg immune suppression by recruiting T cells turning “cold” tumors “hot”
- Coherus asset with global rights

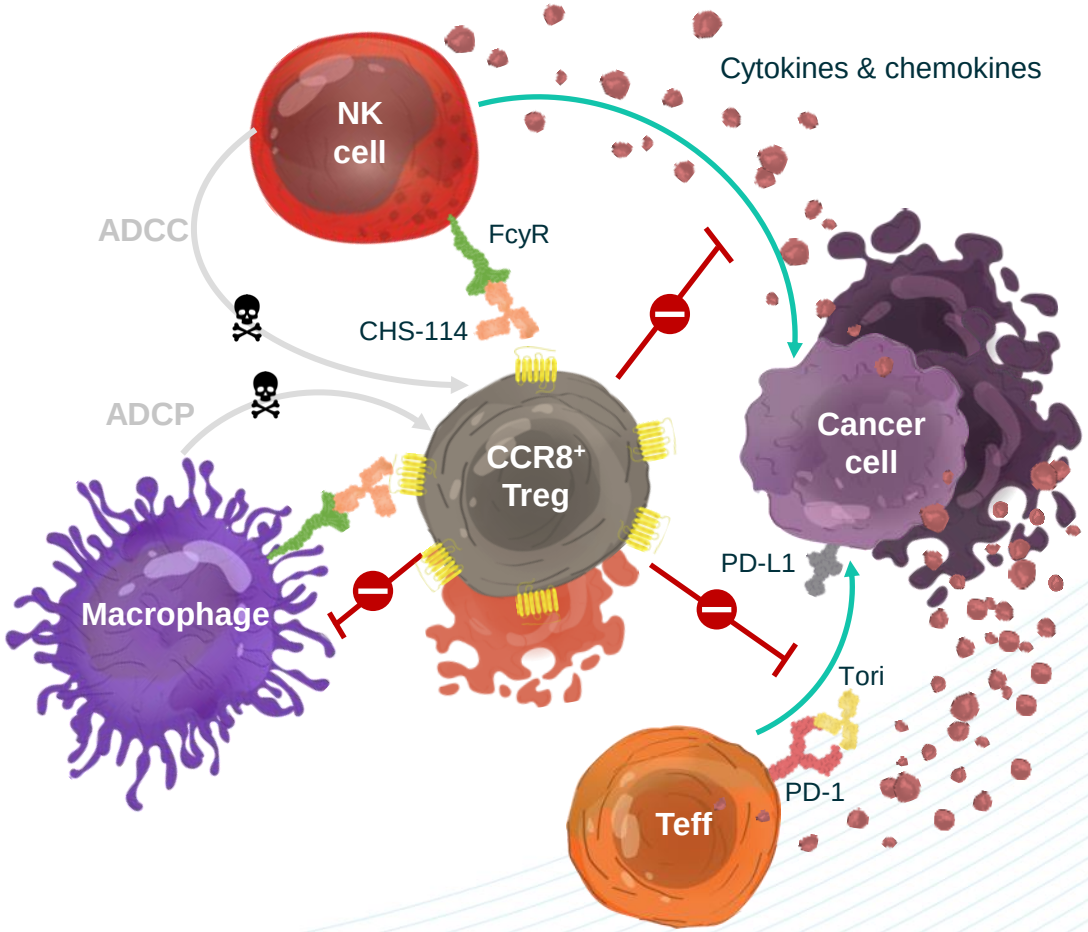
CHS-114: MOA Binds and Kills



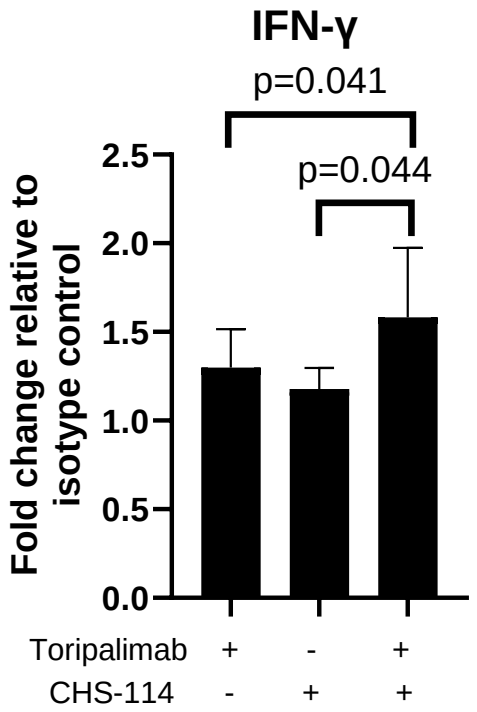
Highly selective and potent Anti-CCR8

CCR8 is a chemokine receptor highly expressed on Treg cells in the TME. CHS-114 is designed as a cytolytic antibody to cause depletion of intra-tumoral Treg cells, important regulators of immune suppression and tolerance, through ADCC, or ADCP or both.

CHS-114 and Toripalimab Combination Treatment Enhances Antitumor Immune Response in *In Vitro* and Murine Models

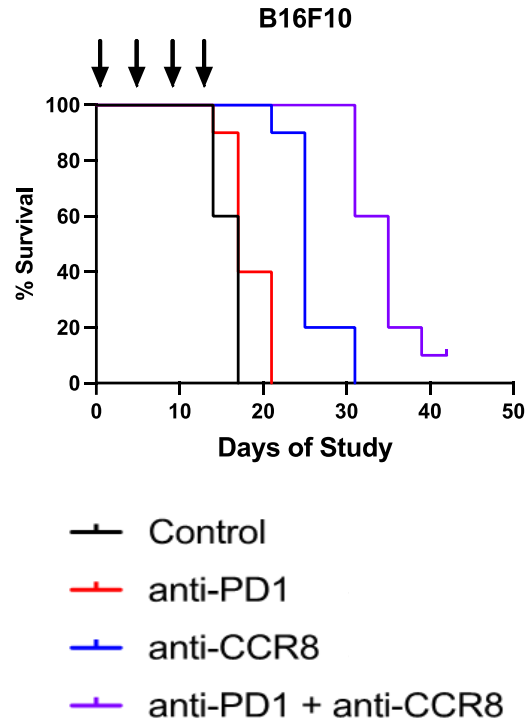


In vitro – immune activation[1]



In vivo – antitumor activity[2]

(PD-1 resistant model)

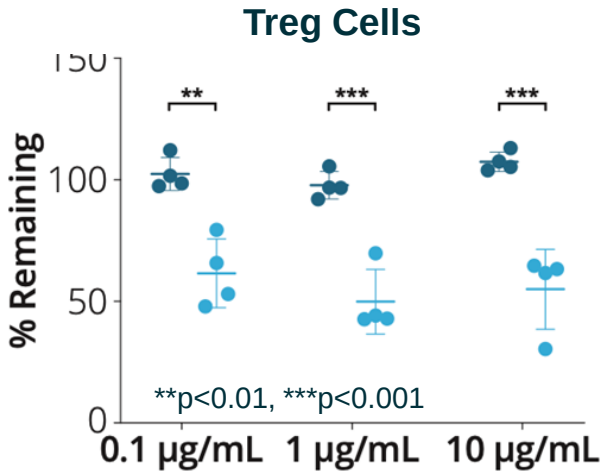


Survival of mice bearing subcutaneous B16F10 tumors treated with anti-murine CCR8.mIgG2a, anti-murine PD-1, or control antibodies

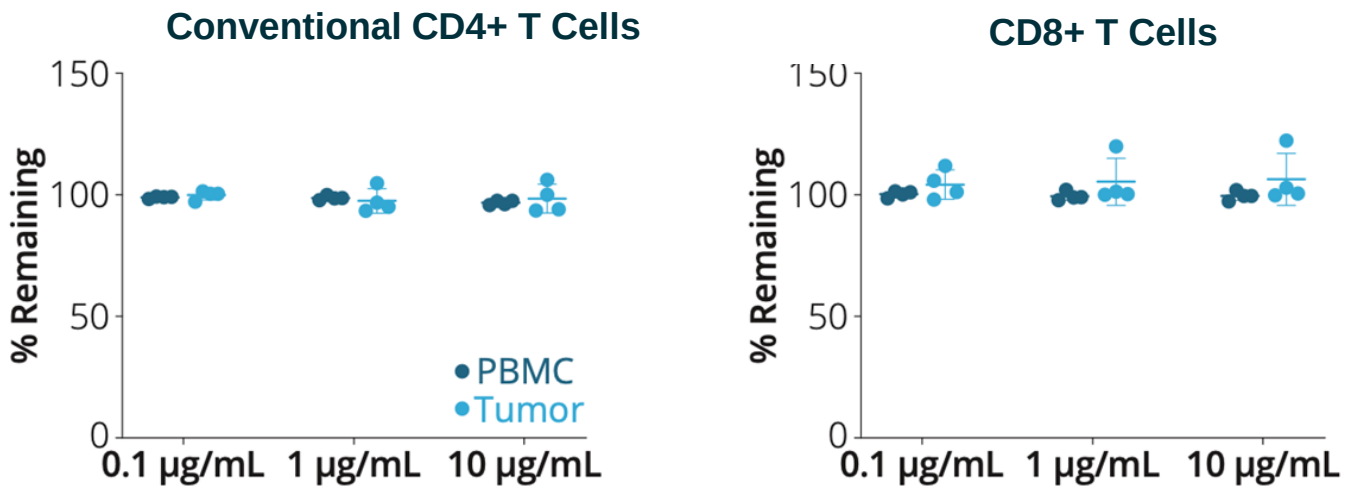
1. Coherus data on file; 2.Panduro, M., et al., 2023 AACR, Poster 5125

CHS-114 Preferentially Depletes Tumor-Infiltrating Treg Cells With No Effect on T Effector Cells

CHS-114 Selectively Depletes Tregs in Tumor and Does Not Deplete Normal T Cells



- CHS-114 selectively targets tumor resident Tregs to mitigate the risk of autoimmune AEs



- No effect on T cells important for anti-tumor immunity

SITC 2022: SRF114, an afucosylated anti-CCR8 antibody, depletes intratumoral Treg cells and reduces tumor growth. Poster 1388

AE = adverse event; PBMC = peripheral blood mononuclear cell; Teff = T effector; Treg = Regulatory T cell

CHS-114 Phase 1 Study Design

Dose Expansion: 2L+ HNSCC (CHS-114 monotherapy and in combination with toripalimab)

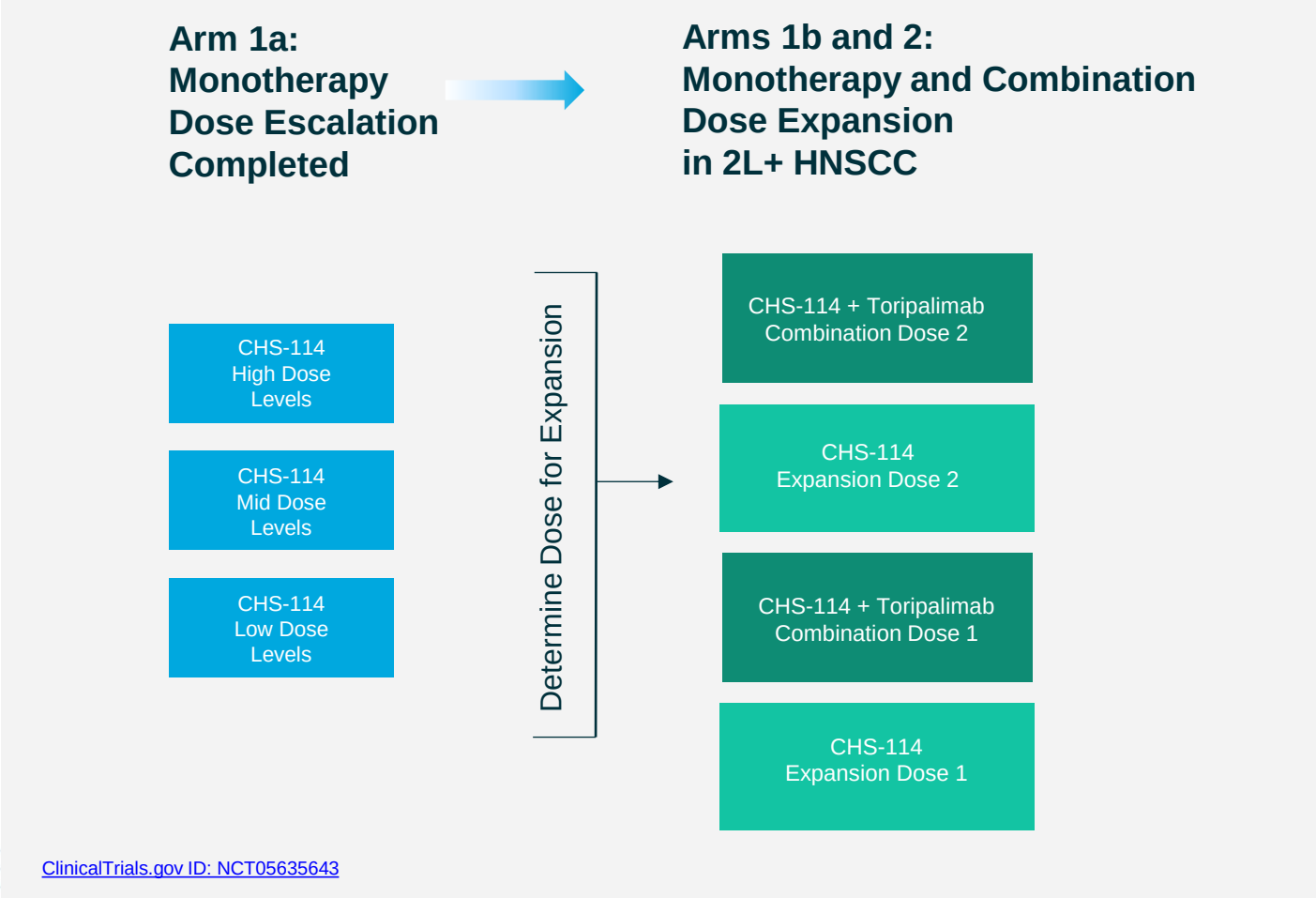
Primary endpoint

- Safety and tolerability

Key secondary endpoints

- Pharmacokinetics (PK)
- Objective Response Rate† (ORR)
- Additional measures of efficacy including:
  - Duration of response† (DoR)
  - Disease control rate† (DCR)
  - Progression-free survival† (PFS)
- Biomarker endpoints
  - Treg depletion in tumor

† Per RECIST 1.1 based on investigator assessment



ClinicalTrials.gov ID: NCT05635643

CHS-114 Phase 1 Study Design Overview

First-in-human open-label single agent and combination treatment dose escalation

- Stage 1 (CHS-114 single-agent dose escalation) employed the Bayesian optimal interval (BOIN) design including accelerated titration and 3+3 run-in
  - Stage 1a enrolled patients with advanced solid tumors who received ≥1 standard treatment
  - Stage 1b, is enrolling an additional 5 patients with advanced/metastatic HNSCC at each of two dose levels (DLs); patients must be willing to undergo pre- and on-treatment biopsies
- Stage 2 (CHS-114 + toripalimab combination dose escalation) is enrolling patients with advanced/metastatic HNSCC and will employ a standard 3+3 design
- CHS-114 is administered intravenously (IV) on day 1 of each Q3W cycle; in Stage 2, CHS-114 will be administered in combination with toripalimab 240mg Q3W
- Dose-limiting toxicities (DLTs) evaluated during Cycle 1 (21 days) using NCI-CTCAE criteria (v5.0 or higher)

J Clin Oncol 42, 2024 (suppl 16; abstr 2664)

CHS-114 Phase 1a Monotherapy Dose Escalation

Baseline Characteristics

Demographics (n=20)		n (%)
Age	Median years (range)	67 (47, 84)
Gender	Female	10 (50)
	Male	10 (50)
Primary Tumor Type	Colorectal	4 (20)
	Endometrial	2 (10)
	HNSCC	2 (10)
	Kidney	1 (5)
	Melanoma	1 (5)
	Non-small Cell Lung Cancer	2 (10)
	Pancreatic	3 (15)
	Other*	5 (25)

Demographics (n=20)		n (%)
ECOG	0	6 (30)
	1	14 (70)
Median time since initial diagnosis, mos. (range)		47 (11, 257)
Lines of Prior Systemic Therapy	0	0
	1 - 2	5 (25)
	3 - 4	6 (30)
	≥ 5	9 (45)
PD-L1 Expression	Positive	6 (30)
	Negative	5 (25)
	Not Done	9 (45)

Data cut as of 16 April 2024; subject to change

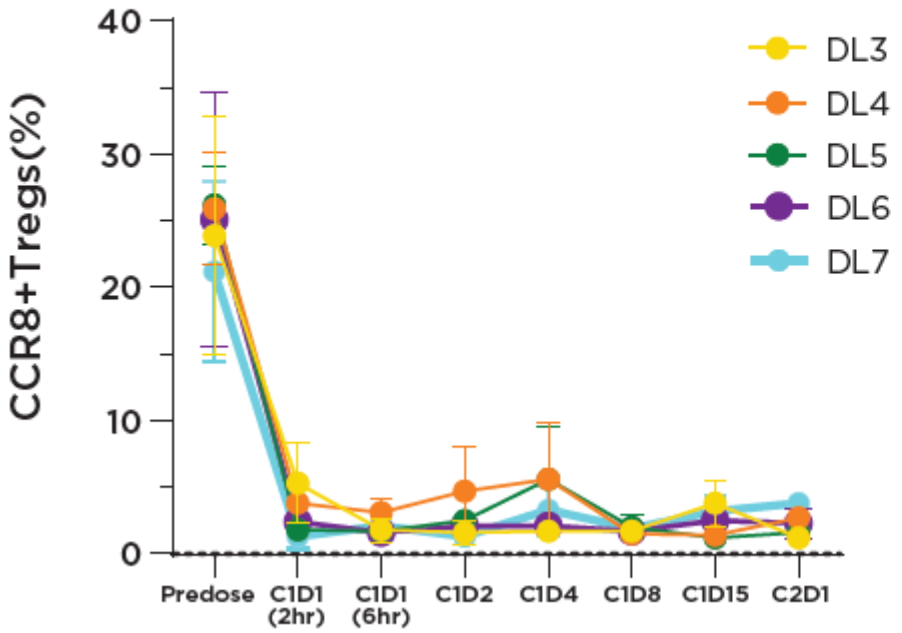
*Other tumor types include biliary tract (n=1), esthesioneuroblastoma (n=1), ovarian (n=3), and rectal (n=1).
HNSCC, Head and Neck Squamous Cell Carcinoma; ECOG PS, Eastern Cooperative Oncology Group Performance Status; PD-L1, programmed death ligand 1

J Clin Oncol 42, 2024 (suppl 16; abstr 2664)

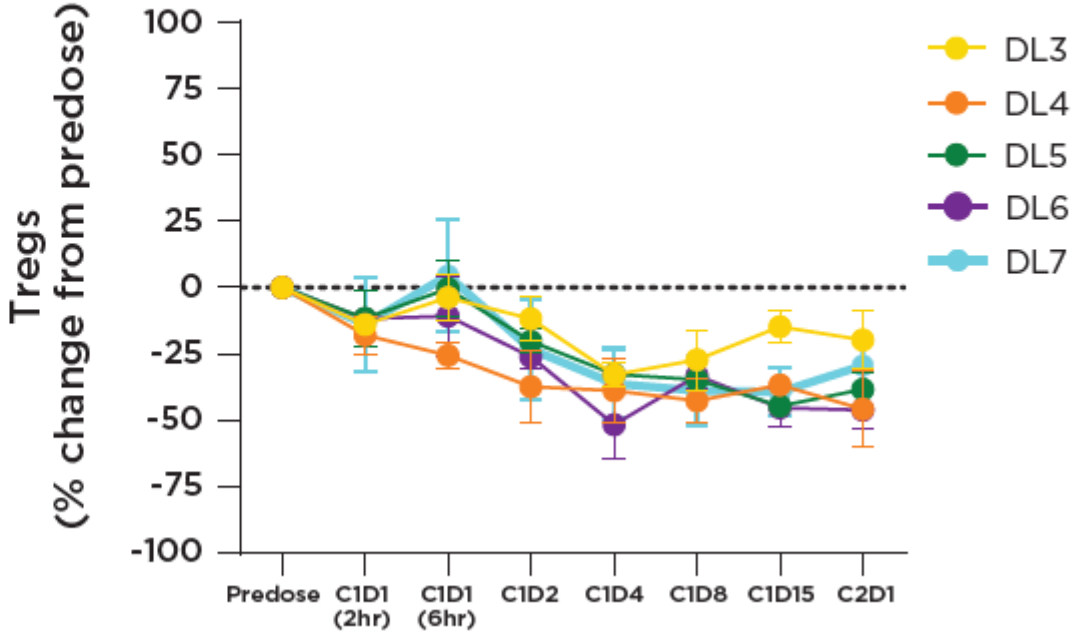
CHS-114 Selectively Depletes CCR8+ Tregs Establishing Proof of Mechanism in Phase 1a Monotherapy Dose Escalation

CHS-114 treatment led to a decrease in subset of total Tregs, while preserving broader Treg population confirming the specificity for CCR8+ Tregs

Frequency of CCR8+ Tregs —
Complete depletion



Percentage decrease total Tregs —
Selectivity for CCR8+ Tregs



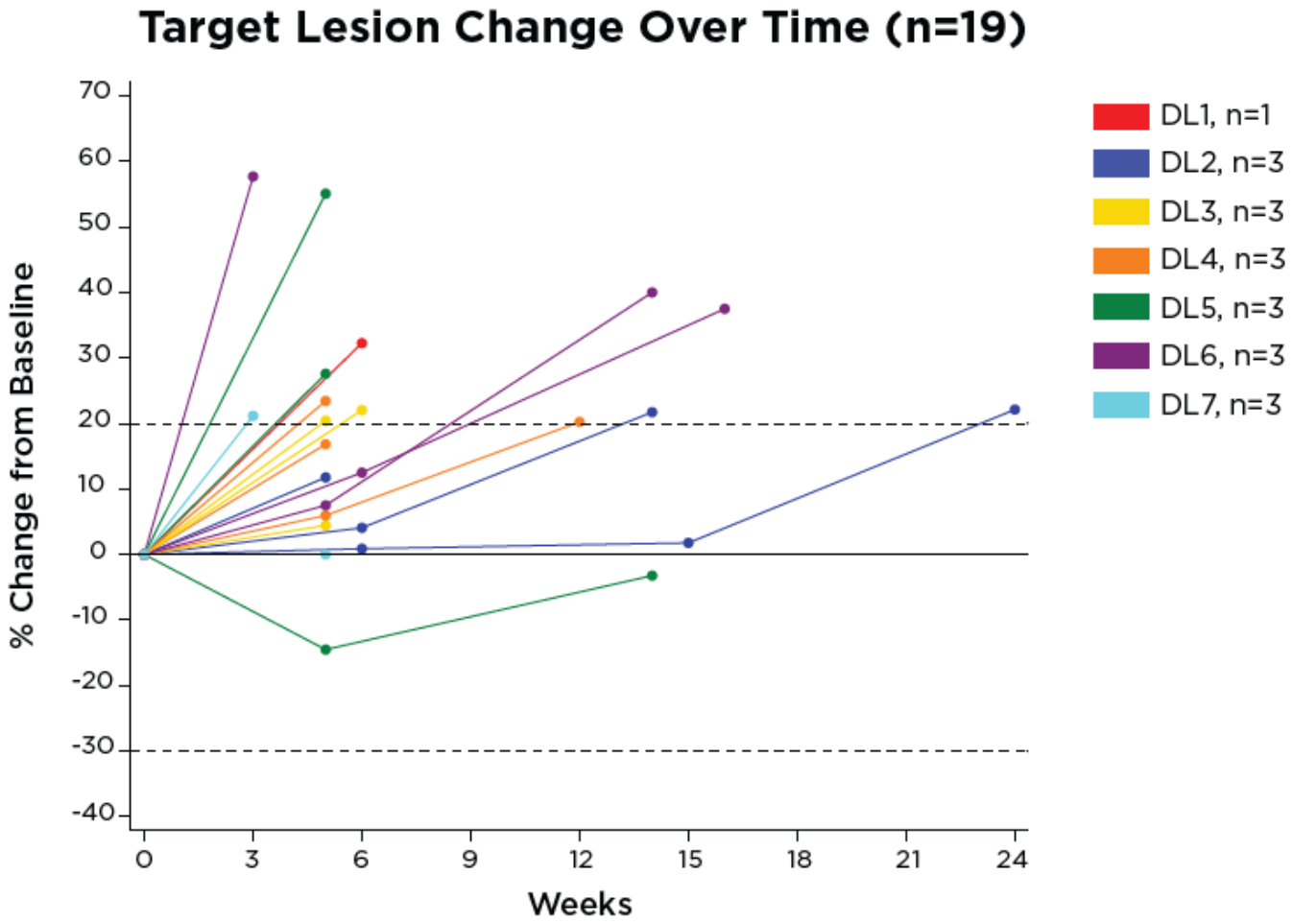
Data cut as of 16 April 2024; subject to change

J Clin Oncol 42, 2024 (suppl 16; abstr 2664)

Total frequency of CCR8+ Tregs from baseline (left) and percent decrease of total Tregs (right) was measured in peripheral blood mononuclear cells (PBMC) by a flow-cytometry assay at DL3-DL7. CCR8+ Treg depletion was stable through cycle 1, with > 85% of CCR8+ Tregs being depleted for all dose levels tested, confirming the proof of mechanism. Additionally, depletion was observed at DL3 (and higher doses), which was lower than predicted dose from in vitro modeling. Furthermore, CHS-114 treatment led to a decrease in subset of total Tregs, while preserving broader Treg population, confirming the specificity of CHS-114 for CCR8+ Tregs. Tregs were defined as CD127low CD25high cells within the CD3+ CD4+ T cell population. Data representative of 3 patients per dose level (n=2-3 samples per timepoint). Error bars = SEM.

Phase 1a Monotherapy Dose Escalation Response Summary

Based on Investigator Assessment per RECIST v1.1



Best Overall Response n (%)	Response Evaluable N = 19
Complete Response	0
Partial Response	0
Stable Disease	9 (47.4%)
Progressive Disease	10 (52.6%)

Disease assessment performed every 9 weeks

Data cut as of 16 April 2024; subject to change

J Clin Oncol 42, 2024 (suppl 16; abstr 2664)

CHS-114 Phase 1a Monotherapy Dose Escalation

Summary of Adverse Events

Adverse Event (AE) Summary	N = 20
Treatment emergent adverse event (TEAE)	19 (95%)
CHS-114-related AE	8 (40%)
Grade ≥3 TEAE	7 (35%)
Grade ≥3 treatment-related AE	0
Serious Treatment Emergent Adverse Event (TESAE)	6 (30%)
Treatment-related SAE	1 (5%)
TEAE leading to CHS-114 discontinuation	1 (5%)
Treatment-related AE leading to CHS-114 discontinuation	0
TEAE leading to death	1 (5%)
Treatment-related AE leading to death	0

Data cut as of 16 April 2024; subject to change

- No DLTs observed to date, across all dose levels tested
- Treatment-related TEAEs were generally low grade, with the most frequent being diarrhea, nausea, chills and pyrexia, each reported in 2 patients
- 1 patient experienced a treatment-related SAE of Grade 2 colitis

J Clin Oncol 42, 2024 (suppl 16; abstr 2664)

CHS-114 Phase 1a Monotherapy Dose Escalation Results

Expansion Phases are Ongoing

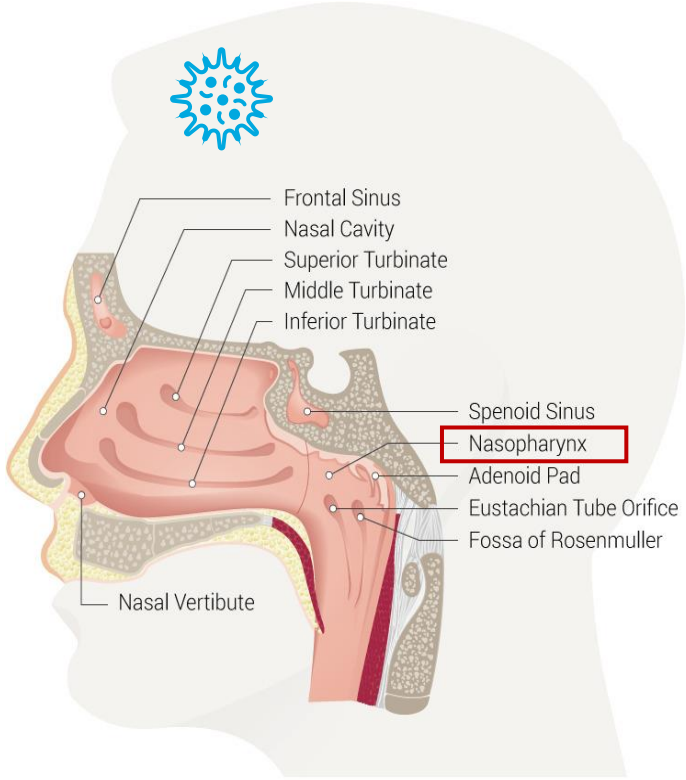
- CHS-114 demonstrated an acceptable safety profile to date in heavily pretreated patients with advanced solid tumors
- Depletion of peripheral CCR8+ Tregs was observed and depletion was maintained over the dosing interval, establishing proof of mechanism
- CHS-114 PK exposure increases with dose, is approximately dose-proportional, and the elimination appears linear with a half-life of about 10 days (range 9-17 days)
- Preliminary results and acceptable safety profile support further evaluation of CHS-114 in combination treatment with the anti-PD-1 antibody, toripalimab, and other IO agents
- Two dose levels of CHS-114 with and without toripalimab expansion phase ongoing in 2L+ HNSCC patients
- Initiation of Phase 1b CHS-114/toripalimab combination dose optimization study in 2L gastric cancer in Q1 2025

J Clin Oncol 42, 2024 (suppl 16; abstr 2664)

Agenda

- Corporate Highlights
- Innovative Oncology Pipeline
- **Commercial Oncology**
- Outlook

Nasopharyngeal Carcinoma (NPC) Is an Uncommon and Distinct Type Of Head and Neck Cancer



Nasopharyngeal Carcinoma

- A rare epithelial carcinoma arising from the nasopharyngeal mucosal lining[1,2]
- In the United States, there is <1 case of NPC per every 100,000 people each year[1]

Viral[3]

Strong association with EBV

Sex[4]

Males have 2-3 times higher risk than females

Age[5]

Median age of 55 years

Image adapted from Mankowski NL and Bordoni B. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan. HNC, head and neck cancer; HNSCC, head and neck squamous cell carcinoma; NPC, nasopharyngeal carcinoma.

1. American Cancer Society cancer facts and figures 2021. Atlanta: American Cancer Society; 2021. 2. Chen YP et al. *Lancet*. 2019;394(10192):64-80.

EBV, Epstein-Barr virus; HNSCC, head and neck squamous cell carcinoma; HPV, human papillomavirus; NPC, nasopharyngeal carcinoma.

3. Johnson DE et al. *Nat Rev Dis Primers*. 2020;6(1):92. 4. Tsao SW et al. *Oral Oncol*. 2014;50(5):330-338. 5 Wu SG et al. *Oral Oncol*. 2017;73:83-87

LOQTORZI®: Establishing a New Standard of Care in NPC

Only FDA-Approved Treatment for Nasopharyngeal Carcinoma* in All Lines of Therapy

Leveraging existing commercial oncology footprint to reach the full NPC patient population in the U.S.

Only I-O treatment with Preferred Category 1 designation under NCCN*
in combination with gemcitabine and cisplatin

Only Preferred NCCN regimen in 2nd Line treatment and later

Establishing position in rare indication with less competition
Strong Clinical evidence (PFS and OS data)

"LOQTORZI is a new treatment option that has demonstrated the ability to significantly improve PFS and OS and should quickly emerge as the new standard of care when used in combination with chemotherapy."

Jong Chul Park, M.D.
Assistant Professor, Harvard Medical School and attending physician at the Center for Head and Neck Cancers at Massachusetts General Hospital Cancer Center

LOQTORZI (toripalimab-tpzi) is indicated in combination with cisplatin and gemcitabine, for the first-line treatment of adults with metastatic or with recurrent, locally advanced nasopharyngeal carcinoma (NPC) and as a single agent, for the treatment of adults with recurrent unresectable or metastatic NPC with disease progression on or after a platinum-containing chemotherapy.

*NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Head and Neck Cancers Version 2.2024 — December 08, 2023

LOQTORZI® + Chemo Extends Overall Survival in 1L NPC

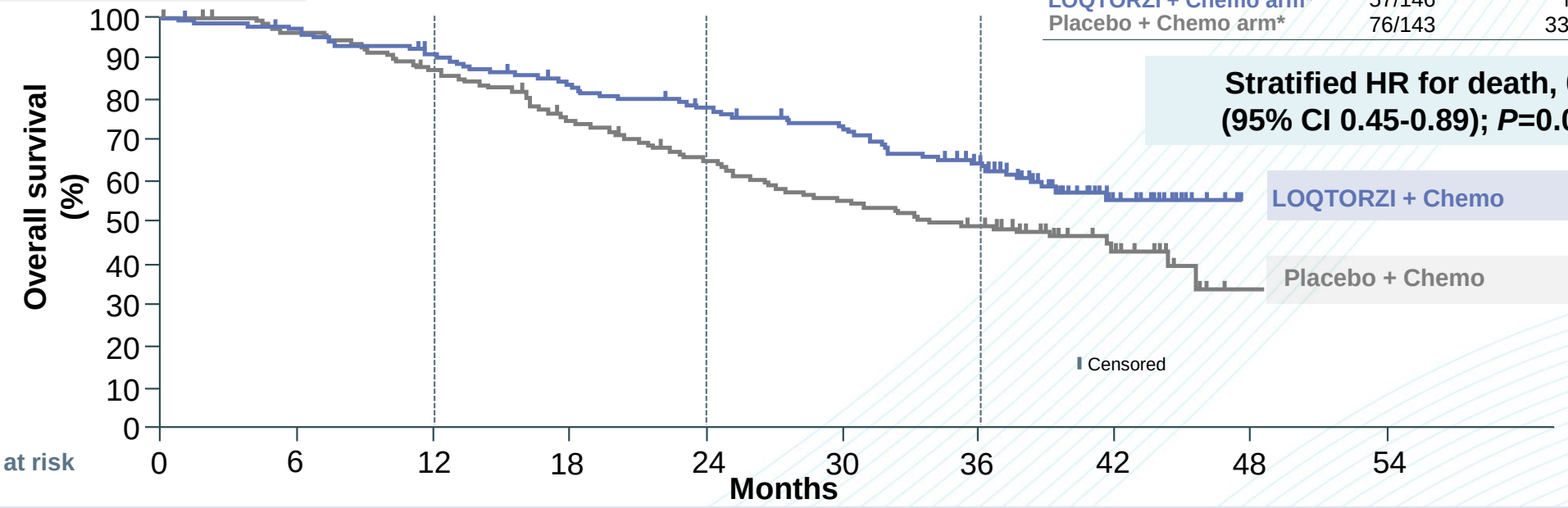
37% Reduction In The Risk Of Death, HR=0.63, Versus Chemotherapy Alone

Data cut-off date: Nov 18, 2022
Median follow-up: 36 months

	1-Yr OS rates[2]	2-Yr OS rates[2]	3-Yr OS rates[2†]
LOQTORZI + Chemo arm*	90.9%	78.0%	64.5%
Placebo + Chemo arm*	87.1%	65.1%	49.2%

	No. Deaths/Total No. of Patients	Median OS mos (95% CI)
LOQTORZI + Chemo arm*	57/146	NR (38.7, NE)
Placebo + Chemo arm*	76/143	33.7 (27.0, 44.2)

Stratified HR for death, 0.63 (95% CI 0.45-0.89); *P*=0.0083



No. at risk										
LOQTORZI + Chemo arm*	146	139	128	116	106	97	79	25	0	0
Placebo + Chemo arm*	143	135	121	102	86	73	64	21	1	0

The JUPITER-02 trial demonstrated statistically significant improvement in BIRC-assessed OS for patients randomized to LOQTORZI (toripalimab-tpzi) in combination with cisplatin/gemcitabine compared to cisplatin and gemcitabine with placebo

*Patients in the LOQTORZI arm were given LOQTORZI + gemcitabine/cisplatin for the first 6 cycles, followed by LOQTORZI maintenance therapy until disease progression, unacceptable toxicity, or completion of 2 years of treatment; patients in the placebo arm were given placebo + gemcitabine/cisplatin for the first 6 cycles followed by placebo maintenance therapy until disease progression, unacceptable toxicity, or completion of 2 years of treatment. †Exploratory analysis.
BIRC, blinded independent review committee; CI, confidence interval; HR, hazard ratio; NE, not estimable; NR, not reached; OS, overall survival; PFS, progression-free survival.
1. LOQTORZI (toripalimab-tpzi) Prescribing Information. Redwood City, CA: Coherus BioSciences, Inc; October 2023. 2. Mai HQ et al. Poster Presentation at ASCO 2023. Abstract 6009.

~2,000 LOQTORZI Treatment Eligible Patients Annually Across Three Patient Segments

LOQTORZI Treatment Patient Segments = ~2,000

Typical NPC Patient Treatment

1. **Recurrent Locally Advanced** — **= 33%** — **Chemo +/- I-O**

   Stage 1-4a with Local or Regional recurrence following initial intervention (generally chemo-radiation, radiation, or surgery)

2. **m1L Drug Treatable** — **= 33%** — **Chemo +/- I-O**

3. **m2L+ Drug Treatable** — **= 33%** — **Chemo or I-O**

I-O use can now be FDA approved LOQTORZI but off-label I-O enabled by NCCN Guidelines listing (current off-label I-O use estimated to be 25%)

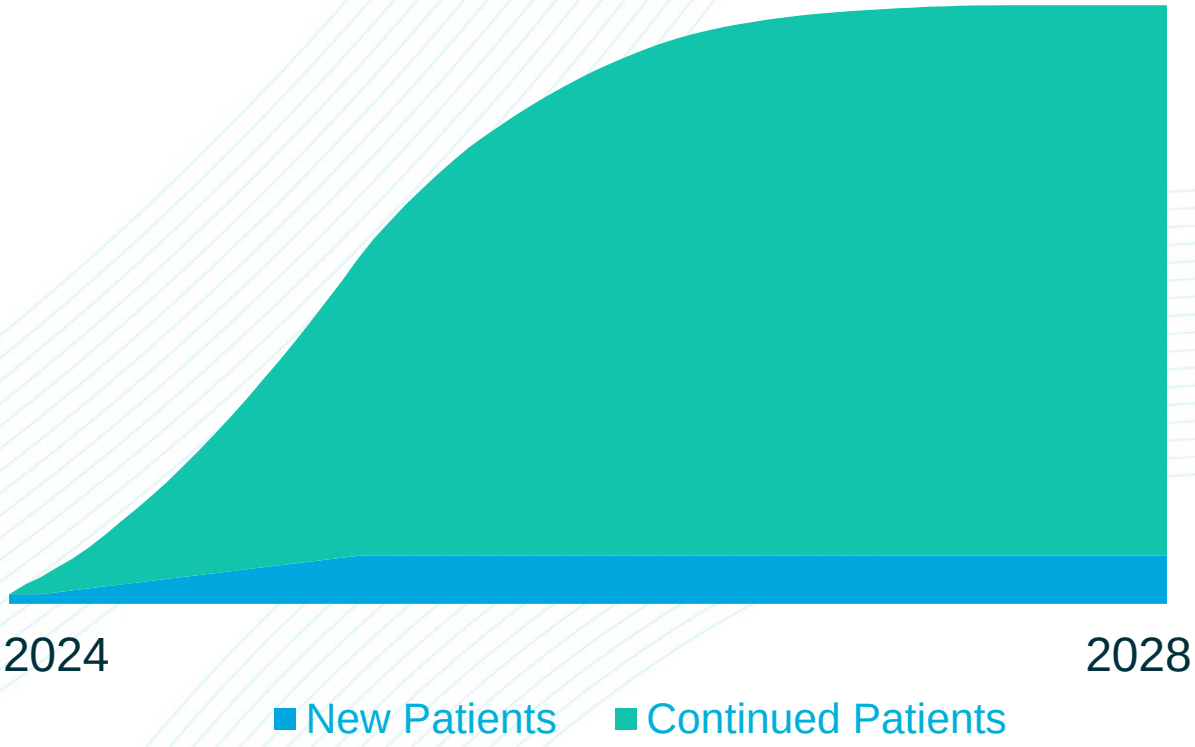
NPC market valued at $150-$200M

Source: Historical data from DRG: Squamous Cell Carcinoma of the Head and Neck-Epidemiology-Mature-Markets-All-Populations-Geographic-Summary & Internal Assumptions on patient growth driven by improved treatment options

Long-Term LOQTORZI Revenue Ramp Driven By Accessing Early-Line Patients Who Have Longer Duration of Treatment

Segment	Revenue Impact	Duration of LOQ Use
Locally Advanced / Regional Recurrent	HIGH	LONGEST
m1L Drug Treatable	HIGH	LONGEST
m2L+ Drug Treatable	LOWER	SHORTEST

ILLUSTRATIVE Revenue Ramp

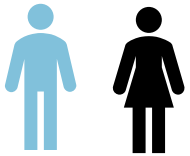


LOQTORZI Launch Achieves Key Milestones for Future Prescribing

Building Momentum as Launch Continues through 2024

90%

of KOLs who state LOQTORZI + Chemo is new 1L SOC[1]



60%

LOQTORZI-Treated Patient Growth Q3 vs. Q2 2024

$5.8M

Q3 2024 Sales[2]

(3rd quarter post launch)

Launch Milestones	Status Launch Through Q3 2024
Payer Coverage	**Nearly 100% of medical benefit lives in health plans** Medicare Fee for Service, Medicare Advantage, and national and regional commercial plans[3]
Treatment Guidelines or Pathways	**Added to NCCN, ASCO, & ClinPath/Elsivier guidelines** as well as treatment pathways with the largest community oncology organizations
Formularies	**Accessible on 100% of NCCN centers and the Veterans Affairs national network[3]**
J-Code	**Product specific, permanent J-code granted and effective July 1, 2024**
Source of Business	**66% of sales from Hospitals; ~30% in Clinics[2]**

Sources

1. Survey of National NPC KOLs at 2024 Multidisciplinary Head and Neck Conference February 2024
2. Coherus Finance; 867/Chargeback through June 30, 2024
3. Coherus Account Team as of September 30, 2024

UDENYCA Brand Milestones Solidify Coherus as a Formidable Oncology Competitor and a Leader in a Mature Market

UDENYCA®
pegfilgrastim-cbqv

MORE CHOICE
MORE CONTROL
MORE CONVENIENCE

$1.7B

Total Net Revenue Launch thru Q3 2024

28%

Franchise Market Share Q3 2024

1.3 Million

Units Sold Launch thru Q3 2024

Coherus Financial Statements 2023;Q2 2024
IQVIA National Sales Perspective; for 2Q2024

UDENYCA Franchise Built for Revenue and Share Growth in 2024

Innovation Establishes Portfolio as Uniquely Differentiated

UDENYCA® pegfilgrastim-cbqv

Full Suite Of Administration Options Reaches More Patients, Drives Long Term Share Growth

Prefilled Syringe Patient

- Prefers next day visit with oncologists
- Likes the confidence of in-office administration

Autoinjector Patient

- Desires control over injection process
- Comfortable with self-injections

On-Body Injector Patient

- Prefers **at home** injection experience
- Prefers device over self administration

Only pegfilgrastim brand with three presentation options

High Customer Demand Will Continue To Be Driven By Four Unique And Differentiated Brand Offerings

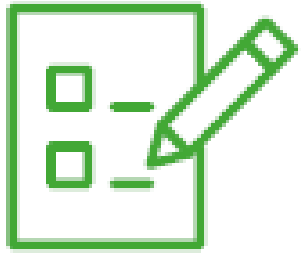
1

MORE CHOICE
MORE CONTROL
MORE CONVENIENCE

Only Brand Offering

3 Presentations

2



Differentiated

Onbody Device

3

Broad Payer

Coverage

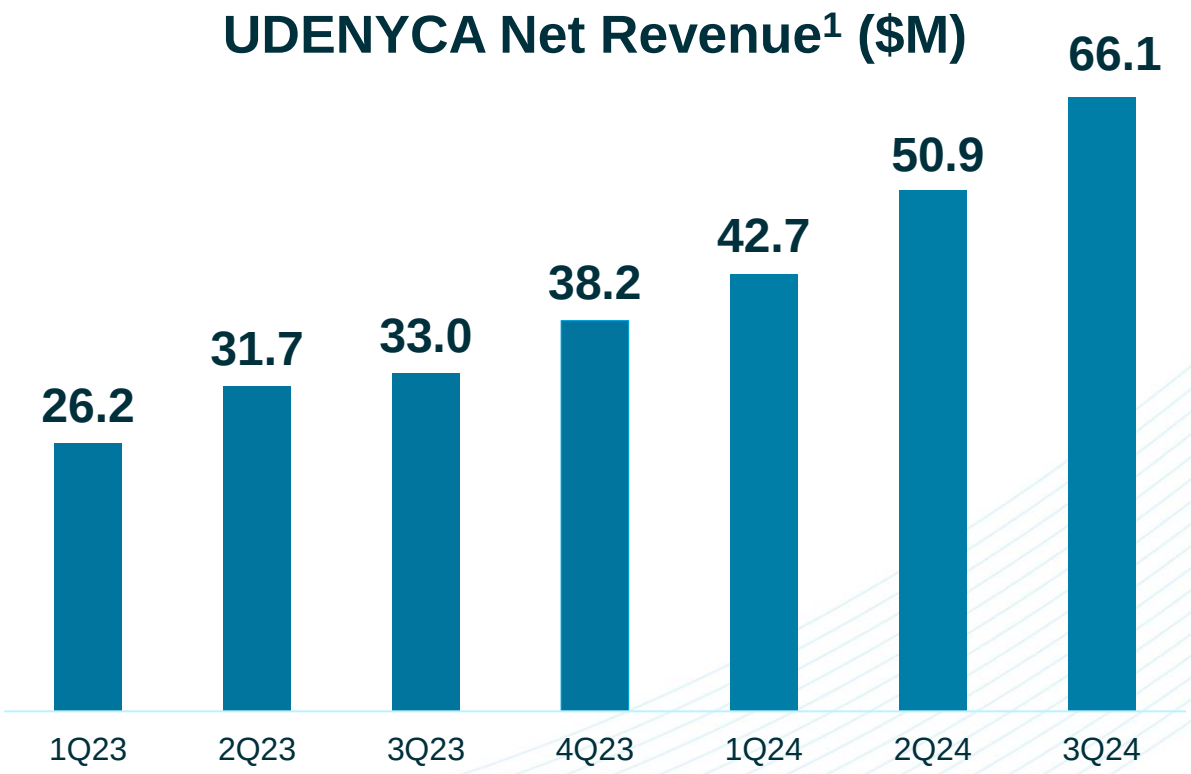
4

Stable

ASP

UDENYCA Franchise Delivering Consistent Revenue Growth

Delivering Consistent Net Revenue Growth



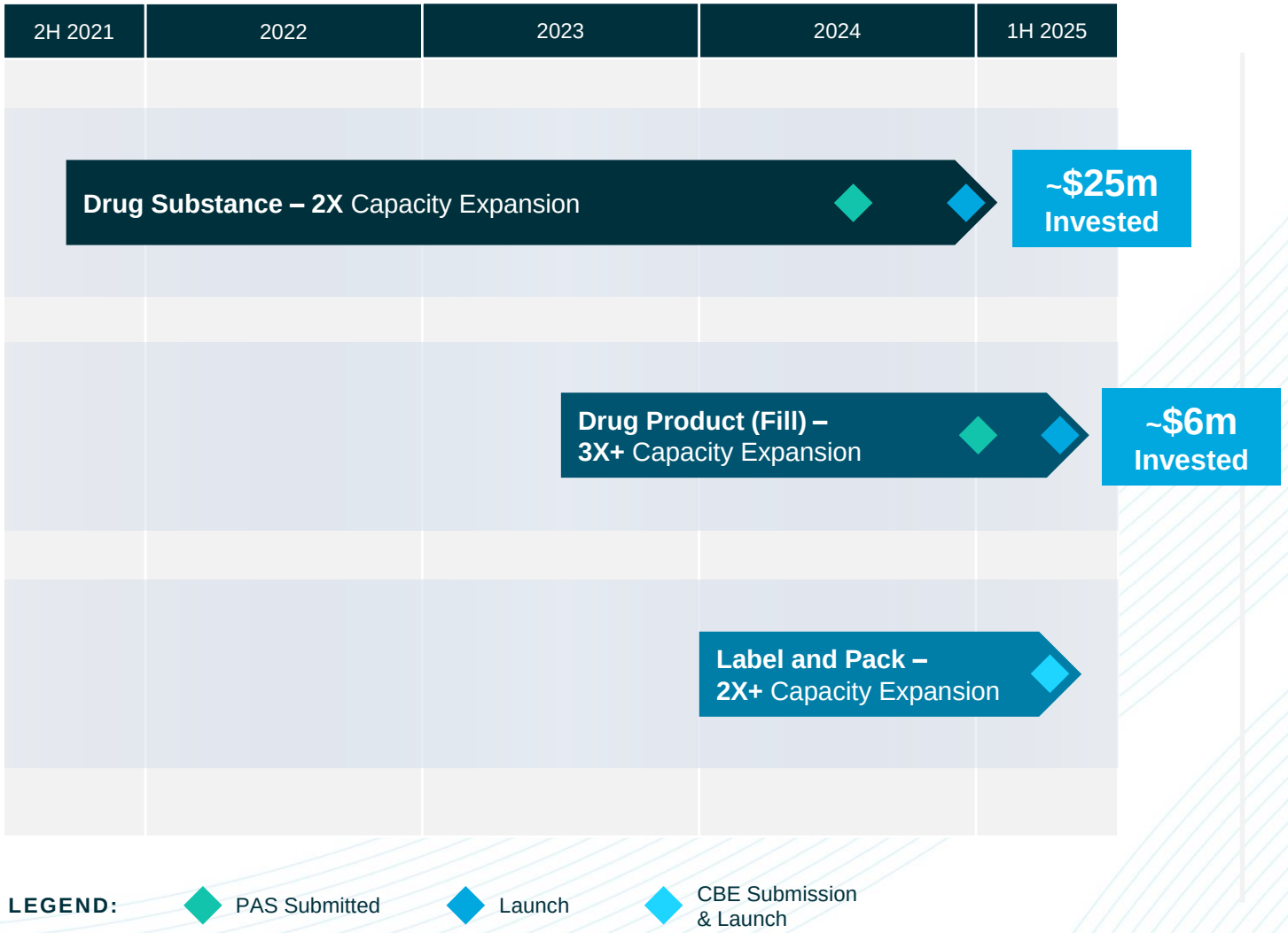
[1]Coherus Financial Statements 2023;Q3 2024
[2]IQVIA National Sales Perspective; for 2Q2024

KPI's & Growth Drivers

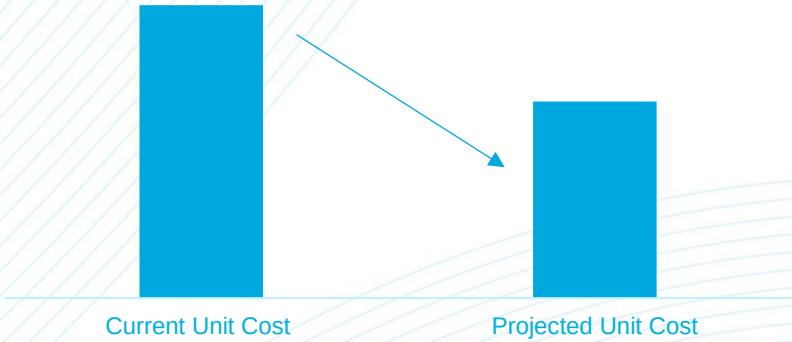
- **Revenue:** 30% increase QoQ and 100% increase Q3'24 vs. Q3'23
- **Franchise market share:** Q3'24 at 28%[2]
- **ONBODY Rapid Adoption:** Q3 revenue driven by 54% increase in demand for ONBODY
- **ONBODY is a Franchise Driver:** 21% of total UDENYCA franchise units sold after only two full quarters representing over 1,200 accounts
- **Payer coverage** for 2025 as good or better than 2024

Strengthening UDENYCA Supply Chain to Support Franchise Growth

Expanding capacity, adding redundancy and reducing costs



Actions expected to collectively reduce the unit cost by approximately one-third from the current unit cost



Annual Capacity & Suppliers

Production Phase	Estimated Max Annual Capacity		Qty. Of Suppliers
	Initial	Final	
Drug Substance (DS)	450K Units	**~1M Units**	Unchanged @ 1
Drug Product (DP) Fill	450K Units	**~1.5M Units**	Increasing from 1 to 2
Label & Packaging	400K Units	**~1M Units**	Increasing from 1 to 2

UDENYCA Supply Update

- Coherus' third-party labeling and packaging contract manufacturing organization (CMO) has resumed the labeling and packaging process for UDENYCA. All backlogged lots are scheduled to be processed without further interruption or delay.
- The backlog comprises thirteen lots totaling about 120,000 UDENYCA units and is expected to be completed over the next few weeks, providing more than enough inventory to meet several months of demand based on historical usage rates. We expect to ship these finished product lots as they are completed, ensuring they get to our customers in an expedited fashion and restocking distribution channels as fast as possible.
- Shipping to our third-party logistics provider will commence the last week of November 2024 with stocking at distributors directly thereafter to fulfill clinic and hospital orders.
- Coherus has made significant progress in bringing an additional final labeling packaging CMO online. Process validation is underway, and process performance qualification is scheduled for December, producing saleable final product by the end of 2024, with commercial supply from that CMO expected to commence in the first quarter of 2025, subject to U.S. Food and Drug Administration (FDA) authorization.
- Once the second CMO is commercially operational, Coherus expects to more than double its UDENYCA packaging and labeling capacity to over one million packaged UDENYCA units annually.

UDENYCA supply update was communicated on November 6, 2024, on Q3 2024 Financial Results press release and conference call and on November 14, 2024, in a UDENYCA Supply Chain Update to Customers.

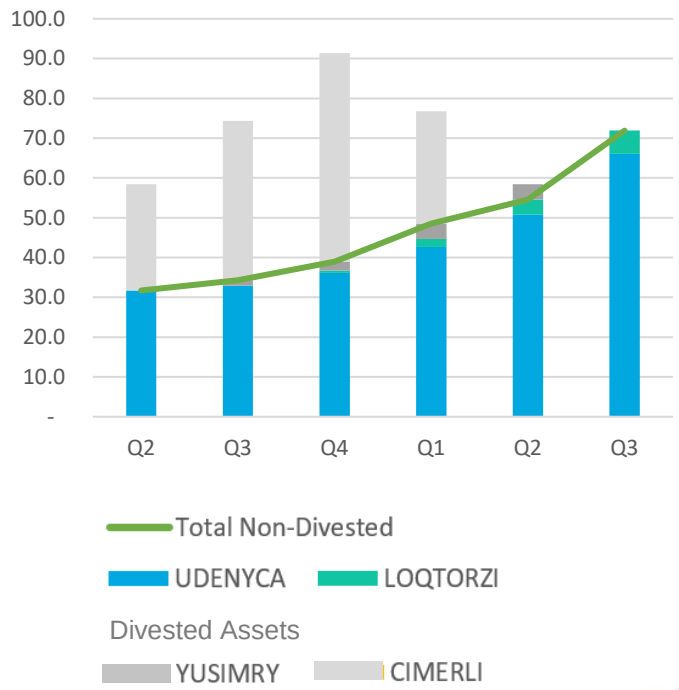
Agenda

- Corporate Highlights
- Innovative Oncology Pipeline
- Commercial Oncology
- Outlook

Q3 2024 Financial Highlights

Sharpened focus on oncology yielding substantial results

Net Revenue
Q2 ’23 – Q3 ‘24



$71.9M Q3 2024 Net Product Sales

32% vs Q2 2024 – Net Product Sales
30% vs Q2 2024 – UDENYCA Net Product Sales
54% vs Q2 2024 – LOQTORZI Net Product Sales
20% vs Q3 2023 – Gross Profit

Controlling Expenses

15%↓ vs Q3 2023 – R&D Expense
20%↓ vs Q3 2023 – SG&A Expense
48%↓ vs Q3 2023 – Interest Expense

Cash, cash equivalents and investments: $97.7M as of September 30, 2024

Q3 2024 Financial Highlights

Growing sales in core products, controlling expenses, improving the balance sheet

- Net sales of non-divested products rose $17.3 million and 32% to $71.9 million in Q3 2024 compared to $54.6 million in Q2 2024
  - UDENYCA® net sales grew $15.2 million and 30% to $66.1 million
  - Second full quarter of sales for UDENYCA ONBODY™ in Q3 2024 and higher net selling price contributed to the momentum
- Cost of goods sold for Q3 2024 was $20.7 million, down $12 million from Q3 2023.
  - Decrease in COGS coupled with only slightly lower net revenue year over year led to a 20% improvement in quarterly gross profit, or $8.2 million.
- R&D expense totaled $21.7 million, a decrease of $4 million, or 15% from Q3 2023.
  - Savings in R&D were partially offset by investments in our pipeline. R&D expenses for the year reflect significant investments in our commercial products and pipeline candidates related to pre-approval costs for expanding supply chain capacity and redundancy and further de-risking inventory supply through on-shore manufacturing.
- SG&A expense in Q3 totaled $34.7 million, a decrease $13.5 million or 28% compared to the prior year.
- Cash, cash equivalents and investments increased to $97.7 million as of September 30, 2024

Delivering on Long-Term Strategy

Increase Revenue, Advance Pipeline, Manage Spend

Multiple 2025 Catalysts in Oncology Pipeline

- Start of RCT Phase 2 Casdozo/Tori/Bev Combo study in HCC in Q4 ’24
- Final data from Phase 2 Casdozo/Atezo/Bev study in HCC in Q1 ‘25
- CHS-114 Gastric Study Initiation in Q1 ’25
- Casdozo + Toripalimab NSCLC Data 1H ’25
- INOVIO Phase 3 study in HPV+ locally advanced HNSCC to begin in 1H ’25
- CHS-114 HNSCC Expansion Data in 2H‘25

Revenue Growth from Commercial Products

LOQTORZI™ (toripalimab-tpzi)injection

Sales Ramp Initiated and Building Momentum

UDENYCA® pegfilgrastim-cbqv

Long-term Market Share Increase Opportunity

Capital Allocation Strategy Centered on Efficiency

- Portfolio prioritization to optimize R&D spend on focused clinical proof of concept
- Improved capital structure via $170 million CIMERLI divestiture, $40 million YUSIMRY divestiture and non-dilutive debt and royalty financing arrangement with Barings
- Pursuing multiple partnerships and collaborations to maximize value

Coherus

Thank You

COHERUS.COM