Immunomedics

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Nick Abbott: Good afternoon. Thank you for joining us. My name is Nick Abbott. I'm on Jim's biotech team here at Wells Fargo. We're delighted to have Immunomedics with us and Behzad Aghazadeh who's the chairman of the board at my immediate left and Michael Garone who's the interim CEO and CFO on my far left. Mike, actually you and I were sitting here this time last year. Quite a chance since then. So maybe if you can talk a little bit about the changes that have occurred in the company over the last 12 months?

Behzad Aghazadeh: Sure. Nick, thank you very much for inviting us to your conference. We're pleased to be here with you. There's been quite a few changes. Obviously perhaps not to go all the way back to 12 months ago but to go back just five months because that's enough to fill the 29 minutes effectively. As of early March the Chancery court of Delaware has seated the new board, comprised of the venBio slate, my slate of four directors and three incumbents directors that received the plurality vote from the shareholders, the 7 member board, Cynthia Sullivan, David Goldenberg with the respective former CEO and chairman of the company remain on the board. So Cynthia stepped down from the role of CEO at the end of July and Mike to my left has assumed the role of interim CEO as we conduct our search for a permanent CEO.

Since taking control of the company, we've brought in a number of expert consultants in various areas including clinical, regulatory, and manufacturing to do a complete assessment in particular on 132 and with the focus on the triple negative indication given that that's our late stage indication we're pursuing extended approval in. And having completed that about two, three months ago and have announced the intention of filing a BLA and bringing that to market by ourselves.

And in order to accomplish that we have raised $125 million in a secondary offering back in May and the team of consultants who helped us in the evaluation phase are mostly retained as permanent contract employees or consultants to the organization and are helping us navigate that and to wrap up the stated goals as far as the BLA for accelerated approval by the end of this year or by the end of the first quarter next year. We can get into that a little later on but the delta there is really a function of key inputs from the FDA

that will further allow us to accelerate and finalize the timeline.

Nick Abbott: Great. Thank you. Obviously, the Seattle Genetics deal, it was quite controversial when it was announced, so just in terms of the valuation that you placed on the company and the asset, just sort of tell us briefly what your thoughts were around that and as you think about re-partnering potentially outside of the US?

Behzad Aghazadeh: So the deal, just from a headline standpoint was $250 million up front and significant milestones beyond that for a total deal value of $2 billion subject to all sorts of metrics, be it approval of various indications we're pursuing, alongside double-digit royalties. In this capacity as a former shareholder of Seattle Genetics, I have a high opinion of that organization but if in the end 132, at the time Seattle licensed the drug and we were entering the picture had shown dramatic benefits in the setting that we are pursuing an indication for and as a result and upon completion of our diligence with our internal team that we brought to the table, we realized there was a lot of shareholder value that could be unleashed if the asset were to be maintained in-house.

And we really felt that given the path towards approval being available to us and the potential for us to commercialize it would probably unleash a lot more value for Immunomedics shareholders, that was really principle. Seattle certainly would've succeeded I believe and given their expertise would've done tremendously well in the lead indications rather than follow on but I think from a shareholders' standpoint, the Immunomedics' shareholders probably stand to benefit fully if we are able to successfully execute and we feel we're on a pretty good path so far.

Nick Abbott: Excellent. And obviously your bread and butter, antibody drug conjugates and that's been something that as long as I've been in the industry people have been talking about this. There have been an awful lot that have gone into the clinic, very few have made it out the other side. What is it that you think Immunomedics does very well in terms of ADCs and in some ways itôs a more straight forward approach than many have taken?

Behzad Aghazadeh: Sure. That's interesting because I remember the days when I was in the lab and thinking how elegant this solution is. I think what's played out in terms of the first-generation technologies of ADCs which is essentially a three component product, the antibodies which target the tumor, the linker that links the payload to it and the payload that is really the focus of the cytotoxicity.

The first-generation focused on building a very robust linker, a tight linker that really holds on to the toxin and only releases it upon internalization. The idea was to load it up with the highest potential potency toxin in order to get the maximum result. Potentially and what we've seen in some instances is that it has brought with it profound toxicity and it has a very limited therapeutic window.

In the case of Immunomedics and 132 in particular, the design behind this molecule, the product is for the antibody that targets 12-2 but the linker is a less tight linker, if you will. It's more Ph sensitive and the toxin as well as being an ultra-high potency or moderate potency toxin and what that allows us to do is to deliver a more total delivery of this toxin which is the active metabolizer and potentially more active. It does provide a targeted

delivery but beyond just the intracellular internalization and release, we also get some release into the micro environment and acidic and the low Ph environment and as a result we seem to have found a bit of a broader therapeutic window where we're able to deliver more drug for a prolonged period of time without hitting the DLTs that others encountered in the same setting.

Furthermore, the traditional depression ratio of ADCs is typical up two or three toxins per antibody. We're loading on average I believe the quoted number is 7.5 toxins per antibody. So we are delivering a higher amount of drug per antibody into the micro environment and that I think in aggregate has allowed us to penetrate in these solid tumors where in general historically we've not had the same success that they have and the good rates.

Nick Abbott: In terms of 132, in terms of the target, why triple-negative breast cancer? And maybe something a little bit about the safety and tolerability? Obviously irinotecan is associated with diarrhea as a DLT and a lot of neutropenia and you're not seeing a great deal of that?

Behzad Aghazadeh: I'll elaborate on that latter point just a little bit in a moment. But to the point, it's 12-2. 12-2 has been a biomarker that's been elevated in a number of cancer settings. It's been reported in breast tissue in prostate and lung and it's shown activity in a number of these settings already in our Phase 2 trial. The safety profile as you pointed out is it's generally very well tolerated. Some people have spoken to the clinicians that have used it. They do point out that it's drastically than irinotecan. Again, SN-38, the active metabolizer which is a payload here is related to irinotecan but the local delivery or the targeted delivery does allow us to give more drug for a long period of time without hitting these toxicities. Now our DLT ultimately is also neutropenia. But, first of all, it's very manageable. We don't have very meaningful if any discontinuations as a result of it. it's generally always been managed medically or via dose reductions. Beyond that, the diarrhea which is also present, it's substantially less severe that the diarrhea with irinotecan and the clinicians absolutely distinguish it from a irinotecan-based regimen. For those who have followed the story for longer, they will notice that over time the toxicities do accumulate and as we interrogated that, what we hear is that these are toxicities that often you would see early on with irinotecan that would essentially hit the DLT and prevent the patient from continuing on therapy. In the case of 132, they tend to come up over time as a function of cumulative toxicity and the clinicians welcome that because it suggests that those patients are staying on drug long enough to even reach those points in time. And so it is profoundly different than irinotecan toxicities in the clinic and physicians attest to that.

Nick Abbott: And in terms of the data we've seen in triple-negative breast, can you briefly just review what we've seen?

Behzad Aghazadeh: Yes. So the last update, and just backing up, the FDA requirement for approval is to enroll about 100 patients in the triple-negative setting, the third-line setting of metastatic disease where at least two prior regimens have been administered, one of which has been Abraxane. So that's the indication that we're pursuing. The last updates that the company provides was in January, which was 85 patients. We've gone on since to complete the Phase 2 enrollment and announce that we have exceed 100 target but ultimately what makes it into the final package is subject to clean up of the data. But that be that as it

may, we've reported on 85 patients a response rate of 29%, a PFS which again is subject to all the qualified maturity and over time that will all zero in on the final number. But at the time was about six months of PFS, both of which are, I guess compared to historic substantially higher than we've seen in that today.

Nick Abbott: There has been no data if I recall correlated outcome with level of Trop-2 depression?

Behzad Aghazadeh: So the company has previously reported some Trop-2 breakdown. You're right. There is no discernable difference between the Trop-2 level. Having said that, Trop-2 is rather broadly expressed in triple-negative I think over 90% of tissue if I'm not mistaken has dropped too. So as a result, breast or triple-negative breast in particular may not be the right place to determine whether a Trop-2 population or classification is required. In other settings that we might be interested in exploring their role in the presence of Trop-2 would have to elucidate a little bit more and there we might actually have situations where you want to preset the final preselect for the Trop-2 levels but in triple-negative there doesn't seem to be a need for that and to the extent there is a follow-up question with regards to the FDA, that conversation essentially has not come up as a requirement to add a diagnostic because they've acknowledged the efficacy that we've shown is broadly applicable in that setting.

Nick Abbott: In terms of a response rate, do you think that captures the clinical benefit or is there some long-term stable disease that is underlying of a broader clinical benefit than just response rates?

Behzad Aghazadeh: No, Nick. Good question. And I think it's really too early to judge that definitely but obviously the response rate is quite impressive and if that holds up we'd be very pleased. I think the agency sort of gave the company the breakthrough designation in recognition of that value. Having said that there's likely to be some quite long duration responses to the drug, quite deep responses in some incidences and the stable disease, also as you pointed out, is as the word suggests, stable now. All of that again one has to sort of qualify with a single Phase 2 study. But again it's a very refractory population, a very late stage population. To show a six month DFS as of last update where the stable population contributing to that is actually quite impressive compared to what we've seen historically. Ultimately that all has to get elucidated in the randomized Phase 3 study that we're about to open or enroll patients. But so far it doesn't promise anything beyond just the responders.

Nick Abbott: And since you're got the breakthrough designation, how has that helped you with interactions with the FDA and thoughts about how many boxes need to be fully checked or half-checked as you march your way to approval?

Behzad Aghazadeh: I think it's certainly very apparent that the FDA is playing a true role of the partner here and working with us to solve any problems or address any questions in a very expeditious fashion to the extent they're able to accommodate our needs with respect to timelines or prioritization of certain activities. To your point, which box needs to get checked in what sequence and what needs to get checked today versus what can be checked maybe in a month or in three months or potentially during the review period in particular is one of

the key questions. There it's really hard to point out in any instance a situation where the FDA has not really been accommodating. Again I think it speaks to the high unmet need of the triple-negative setting, the data that has been generated so far. As long as that holds up I think we have a true partner in the FDA. But as a small company with limited resources, it's pretty remarkable how much attention the FDA has provided us and how much collaboration and interaction we have. It truly is in some ways on an on-demand basis. We can have questions answered. Now we're trying to go about it rather more formally given that we're now on a path towards a BLA we do want to go about it the way it's intended to be done. But despite that it's rather helpful to be able to answer the questions on a more expedited fashion rather than going through the appropriate channels of scheduling a meeting with 30 day advanced notice and a follow-up period. We find in some incidences and have commented on some meetings one on one, that the situation is the FDA essentially calls us 3 days before meeting and cancels the meeting on us with the question of why are you even showing up? We can answer these questions electronically. You don't really have to come, please don't, we can handle this. So again I'm going back - this is the first time. But it's a good experience.

Nick Abbott: Right. On recent earnings calls you've provided a window December to March for the BLA filing. Do you have any more clarity in terms of - is it still December to March? Or do you feel like it's - ?

Behzad Aghazadeh: The guidance is that we're going to file the BLA sometime between the end of December and the end of March next year. We believe the gating factor continues to be - or one of the key steps during the manufacturing, actually the validation once the manufacturing stuff, that's a pretty robust method that's been developed. It's just the validation of the process that needs to be documented. It's just a bit of a block and tackle documenting. It takes time. And the question there is do we need to have it complete before submission or could we complete that work in parallel to submitting the dossier and in some regards consider it as a rolling CMC package although it's not a rolling submission. And that clarity will be hopefully gained at an upcoming FDA meeting although the meeting has not yet occurred since our earning call so we really don't have anything since the earnings call to report. But that's only been ten days, two weeks now.

Nick Abbott: Only ten days?

Behzad Aghazadeh: Yes. But as soon as we have it and there's something meaningful to report we will certainly update.

Nick Abbott: Did you request that particular meeting?

Behzad Aghazadeh: Yes. Again, as part of the breakthrough we have a number of meetings lined up and formally scheduled but this particular topic may not even make it to one of those meetings. It may be one of those - can we just sort it out over the phone conversations. It's a very dynamic interaction and relationship.

Nick Abbott: And presumably this is a high priority for you to get this figured out.

Behzad Aghazadeh: The manufacturing bit?

Nick Abbott: Yeah. The requirements.

Behzad Aghazadeh: I know everyone's so focused on and probably I have to blame myself for being entirely up front about it but it's one that I'm entirely not worried about because I'm told repeatedly by the people overseeing it that it's just a question of time. Now would I like it to happen today rather than tomorrow? Absolutely. But it will get done and it's not something that will derail us. I think the much more important issues that we are working and looking forward to sort of solving and breaking new ground, new indications, that's what's really keeping us sort of energized. This is something that is in some ways, frankly, mundane. Other than everyone's anxiously awaiting that event to happen. It's going to happen. And it's going to happen when the timeline is announced, plus or minus. So it's not really critical. It's critical to get the BLA in or reviewed. It's not critical to the ultimate success because that's going to happen with no questions.

Nick Abbott: Before we leave triple-negative and talk about other achievements, in the Phase 3 trials, briefly review that for us, what the assumptions are and what you think the timeline is for that trial.

Behzad Aghazadeh: So the Phase 3 trial is a one to one randomized trial of 328 patients. I'm zeroing in on - it's between 326 and 330. So 328 patients under the policy the FDA established in December 2015 and there is really no meaningful changes to that protocol. We have signed a CRL as of the second quarter and we are in the process of generating the randomization which shocked me. It takes two months to build the database. But that trial is set to open and have the first patient enrolled in the first quarter of 2017. It's going to be a global study, opening up initially sites in the US with the idea that once approved it's going to be very difficult for us to enroll additional patients in that study in the US and so we need to shift the focus to Europe. We have sites already selected both in the US and in Europe. It's going to be about 80 to 100 sites and in Europe we're going to focus principally on the Western European market. So France, Germany, Spain, England, Italy if I didn't mention that. Standard PFS as a primary endpoint, 132 versus one of four regimens typically used in that setting. Other than that, just safety, duration, overall survival, secondaries, but the primary endpoint is PFS.

In terms of power, I believe we haven't exactly established what the power is other than to say that it's way over power to show PFS and to some extent it's over power to demonstrate the benefit beyond just PFS and get a good handle on the duration and survival and what not.

Nick Abbott: And what do you think of the timing of that?

Behzad Aghazadeh: We haven't really commented on the enrollment timeline but again, 330 or so odd patients, we have to narrow that down.

Nick Abbott: Do you think you need that? Is that what's required for a European filing?

Behzad Aghazadeh: Yes. In fact we've had that conversation some time ago. We are going to go back to the

European agencies so that in the near-term now that we have the US path sort of up and running and on a good autopilot to some extent. But at the time when we approach a European, they do consider the PFS as the primary end point for a randomized trial as appropriate for the registration in Europe as well. The question that we have with the European agency is that now that we have more patients in hand with a benefit that as of last January will be 29% and a single arm PFS of around six months, is that potentially sufficient for an accelerated approval or conditional approval as it's called in Europe. We just want to explore that before we make any further decision on Europe with respect to our licensing and partnering strategy. The phase 3 as it's been developed we believe should be sufficient if we can get to a similar outcome as we are in the US. Hopefully the Phase 3 will be the registration file for Europe.

Nick Abbott: And just quickly on the competitive landscape in triple-negative breast, is there anything you're looking at on the horizon that you see as competitive or potentially offers you an opportunity for combination therapy?

Behzad Aghazadeh: Yes. So I think in timeline we should be able to file and gain approval in the US. It's really hard to foresee anyone, even if they have the data to be able to get their - but the technologies that are being studied, the products in that setting on one hand, the checkpoints are being explored in that setting and we talk someday that ASCO unfortunately for patients not very strong as single agent. On the other hand the parts are all being studied in that setting. We saw some day that ASCO again, in small numbers, didn't look for the applicable but I think we're going to get an update on the parts and they're all pursuing combinations of the parts and the checkpoints in triple-negative. Again, I think on the timelines that we're talking about I don't really see competition on the horizon. Having said that, from a mechanism standpoint we are a DNA damaging agent and the parts are obviously a DNA repair inhibiting mechanism. So the double hit concept there on paper should work potentially quite well and in fact we have shown preclinically tremendous synergy between the two product classes. And so that would be a natural place to think about ultimately expanding our benefits and potentially if they are to succeed also their benefits. And that don't just apply to triple-negative obviously. We can talk about other tumor settings as well but I think on the combination with checkpoints again, they're all looking for ways to differentiate and improve on their efficacy and it would be natural in this day and age to study our product at the checkpoints and in the urothelial setting and for example in the non-small cell lung cancer setting we have shown activity in the checkpoint refractory setting. So it does look like we have a different mechanism of action and an orthogonal one to the checkpoint. And so maybe the synergy there could give a bigger benefit to both products. So that would be another place to think about a combination.

Nick Abbott: So you mentioned this is a product that leads to a franchise across a number of tumors. Do you have any bandwidth to be really considering what the next steps are outside of triple-negative?

Behzad Aghazadeh: Absolutely. Especially now. For the past three months we've been really hunkering down on the triple-negative and in particular the BLA filing for the triple-negative and getting the Phase 3 up and running. We're now coming up for air and we're coming up for air in two different areas that we're focusing on. One is expanding beyond triple-negative, what

indications we want to pursue and potentially what combinations we want to study, back to the former question. The other area that we're re-engaging is with potential partnering and licensing arrangements, particularly in markets that are not a focus for us. So think Asia, Japan. Those could be sources of non-dilutive capital. With respect to bandwidth, our product in Phase 2 is already in a basket study where we are continuing to accumulate data from other tumor settings. This weekend we'll publish our update and you'll see a little bit on 41 patients and I believe that's going to be pretty good data to look at and that obviously lends itself to what are we going to do in the urothelial setting that we're going to explore and have a BST around that. And the outcome of that will then determine next steps and we're absolutely in a position to drive that program as well. In particular now that the CRO is taking over all clinical development in triple-negative. That opens up our organization and then beyond that there are other indications that we have protocols lined up to start exploring growth settings and so we should be - you'll be hearing about some of the other programs as well. But absolutely we are on the road to expand it. And then beyond 132 we've had some very interesting data from 113 in colorectal cancer.

Nick Abbott: What are your thoughts about resurrecting -- ?

Behzad Aghazadeh: Oh, yeah. So absolutely. And we did receive some feedback from the medical community, particularly on the heels of that data, very favorable feedback. And so the question is just with respect to our policies and frankly that goes to that extent from resources, meaning humans, to capital resources to manufacturing capacity as we would need to wrap up our manufacturing for additional product as well. But it's not lost on us that the activity was rather -- despite being early but quite striking and there is appetite. The question is how do we fit that in now? Do we really have the bandwidth to manage that ourselves or should we be seeking a partner? But that's sort of next on the list once we hack off the former two being the business integration and indication expansion of 132. But that certainly looks like another interesting product.

Nick Abbott: So let's just sum up with cash runway and maybe what are the key events that you'll be looking out for in the next 12 months before we sit down again?

Michael Garone: We have $150 million approximately in cash as of June 30 and that's sufficient to file the BLA, continue manufacturing commercial supply, begin enrollment of the Phase 3 confirmatory study and also to begin preparations for commercialization later in the year.

Nick Abbott: All right. In our last couple of minutes, if there's any questions out there, please feel free to raise a hand and skewer the two gentlemen sitting next to me. If there are no further questions, thank you very much, gentlemen for the update.

Behzad Aghazadeh: Thank you.