nykode therapeutics

Company Presentation

September, 2023

Forward-looking statement

This announcement and any materials distributed in connection with this presentation may contain certain forward-looking statements. By their nature, forward-looking statements involve risk and uncertainty because they reflect the company's current expectations and assumptions as to future events and circumstances that may not prove accurate.

A number of material factors could cause actual results and developments to differ materially from those expressed or implied by these forward-looking statements.

Global leader in APC-targeted immunotherapy technology

NYKODE THERAPEUTICS (NYKD-OL, MKT CAP ~$800M)

Proprietary immunotherapies targeting antigens to Antigen-Presenting Cell (APC) and generating strong CD8 killer T cell responses correlated with clinical responses in solid tumors

Modular, versatile platform

- Easily incorporate new antigens and adapt to new diseases with focus on oncology and autoimmunity

Rapidly advancing wholly owned lead asset, VB10.16, immunotherapy for HPV16+ cancers

- Final data from phase 2 VB-C-02- unprecedented long lasting survival benefit in advanced cervical cancer
- Potentially registrational study in advanced cervical cancer to initiate 2023
- Dose escalation study with KEYTRUDA®[1] in head and neck cancer to initiate 2H2023

Strategic partnerships to advance clinical programs and commercialize assets worldwide[2]

Genentech – A Member of the Roche Group | REGENERON | Adaptive biotechnologies | Roche | MSD

Well-capitalized with a cash position of $174m at June 30, 2023

1. Note: KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA
2. Note: Genentech has an exclusive license to VB10.NEO. Collaboration and license to 5 programs with Regeneron. Collaboration and license with Adaptive Biotechnologies on SARS-CoV-2 T cell vaccine. Roche supplies atezolizumab; . Merck (MSD) supplies pembrolizumab

Nykode executive management
Experienced and international management team

MICHAEL ENGSIG

Chief Executive Officer

Takeda

NYCOMED

PPD

KLIFO

AGNETE FREDRIKSEN

Chief Business Officer & Co-founder

Affitech

Medinnova

MIKKEL W. PEDERSEN

Chief Scientific Officer

SERVIER

symphogen

KLAUS EDVARDSEN

Chief Development Officer

CUREVAC

MERCK

AstraZeneca

gsk

Genmab

HARALD GURVIN

Chief Financial Officer

SFL

FLEX LNG

Top-tier collaborations for cancer and infectious disease vaccines valued potentially more than $1.64 billion plus royalties

Partner	Collaboration	Terms	Clinical Development
REGENERON	Multi-target license and collaboration agreement to develop 3 oncology and 2 novel infectious disease programs	$925M~ ◆ $30M upfront ◆ $20M equity investment ◆ Potentially more than $875M in milestone payments ◆ Tiered high single-digit to low double-digit royalties	Regeneron to develop and potentially commercialize products Nykode to supply technology and product supply through Phase 1 trials
Genentech A Member of the Roche Group	Worldwide, exclusive license and collaboration agreement to develop VB10.NEO, Nykode's individualized neoantigen cancer vaccine	$715M~ ◆ $200M upfront/near term ◆ $515M in potential payments and milestones ◆ Tiered low double-digit royalties	Nykode to conduct clinical trials through Phase 1b study Genentech to subsequently conduct clinical, regulatory, manufacturing and commercialization activities
Adaptive biotechnologies	Worldwide, exclusive rights to Adaptive's clinically validated SARS-CoV-2 T cell epitopes	◆ Undisclosed	Nykode to design and develop T cell vaccines to specifically address SARS-CoV-2 variants of concern

Rich and diversified pipeline

	Asset	Indication	Preclinical	Phase 1	Phase 2	Phase 3	Rights
Oncology							
Off-the-shelf	VB10.16	HPV16+ cervical cancer					[1] nykode
	VB10.16	HPV16+ head and neck cancer					[2] nykode
	Regeneron programs	Undisclosed					[3] nykode REGENERON
	Internal	Undisclosed					nykode
Individualized	VB10.NEO	Melanoma, lung, bladder, renal, head and neck cancer; locally advanced and metastatic tumors					[4] nykode Genentech A Member of the Roche Group
	VB10.NEO	Locally advanced and metastatic tumors					[4] nykode Genentech A Member of the Roche Group
Infectious Disease							
	Regeneron programs	Undisclosed					[3] nykode REGENERON
	Internal	Undisclosed					nykode
Autoimmune							
	Internal	Undisclosed					nykode

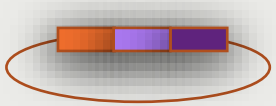
1. Wholly-owned by Nykode. Potentially registrational. Roche supplies atezolizumab; 2. Wholly-owned by Nykode. Merck (MSD) supplies pembrolizumab; 3. Collaboration with Regeneron; 4. Genentech has an exclusive license to VB10.NEO.

Unique antigen presenting cell (APC) targeted modular immunotherapy Vaccibody technology

MODULAR IMMUNOTHERAPY INCLUDES THREE DISTINCT COMPONENTS

Nykode's immunotherapy candidates may be delivered through DNA, mRNA, viral vectors or as recombinant proteins

DNA plasmid encoding Vaccibody

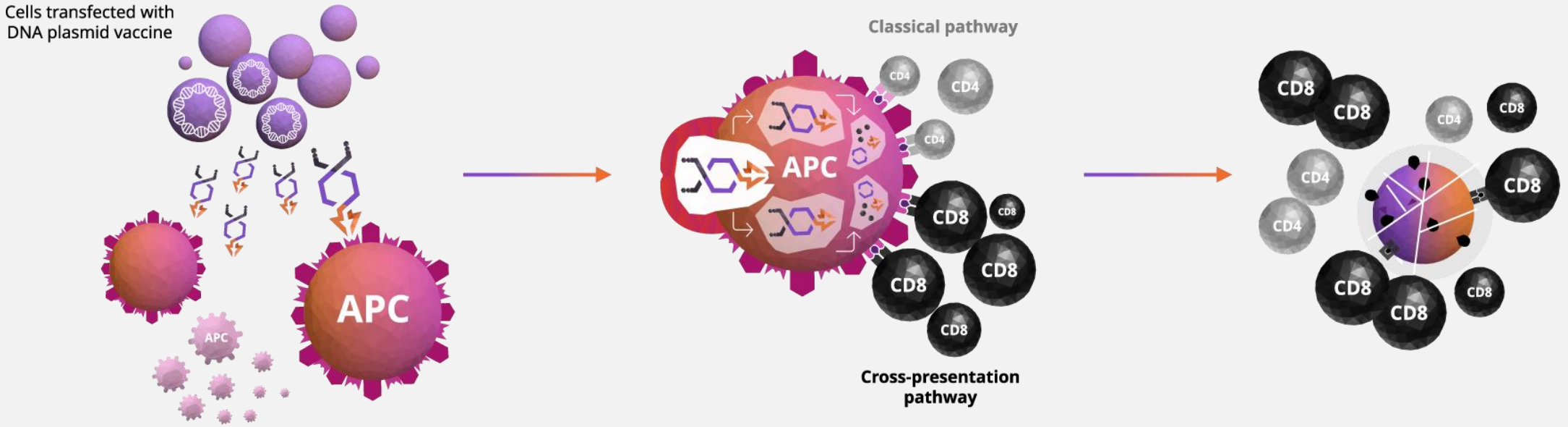


- **Targeting unit** to attract and bind APCs
  Ability to tailor the targeting unit enables induction of different immune response profiles to specific diseases[1]
- **Dimerization unit** for crosslinking targeted receptors on the surface of the APC
  To facilitate strong bivalent binding
- **Antigenic unit** presents globular antigens or set of T cell epitopes
  Antigens of choice from cancer, viruses, bacteria, parasites and autoimmune disease

Note: [1] Targeting unit can consist of natural ligands, including cytokines/chemokines; bacterial proteins; scFv

Vaccibody vaccine induces a rapid, robust and long-lasting CD8 T cell response against cancer cells

MECHANISM OF ACTION – T CELL INDUCTION



1 Cells encode and secrete Vaccibody proteins, which attract a high concentration of APCs.

2 The APCs process and present the vaccine antigens to T cells and effectively activate CD8 killer T cells via cross-presentation.

3 The T cells attack cancer cells or pathogen-infected cells expressing the antigens.

Controlled cross-presentation by specific APC receptor targeting induces broader & stronger CD8 responses than non-targeted technologies such as mRNA- and peptide vaccines

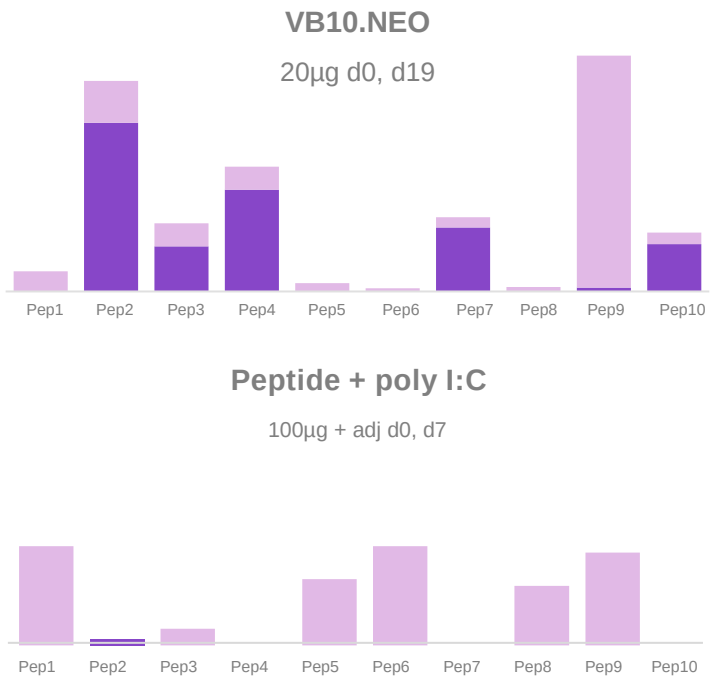
Comparison with peptide and RNA vaccination strategies shows broader CD8 and CD4 responses with Nykode's technology

		Pep1	Pep2	Pep3	Pep4	Pep5	Pep6	Pep7	Pep8	Pep9	Pep10
Peptide*	CD4										
	CD8										
mRNA*	CD4										
	CD8										
VB10.NEO	CD4										
	CD8										

B16 melanoma model

CD8 + T cells CD4 + T cells

Addition of strong CD8 responses to epitopes non/weakly-immunogenic with other strategies



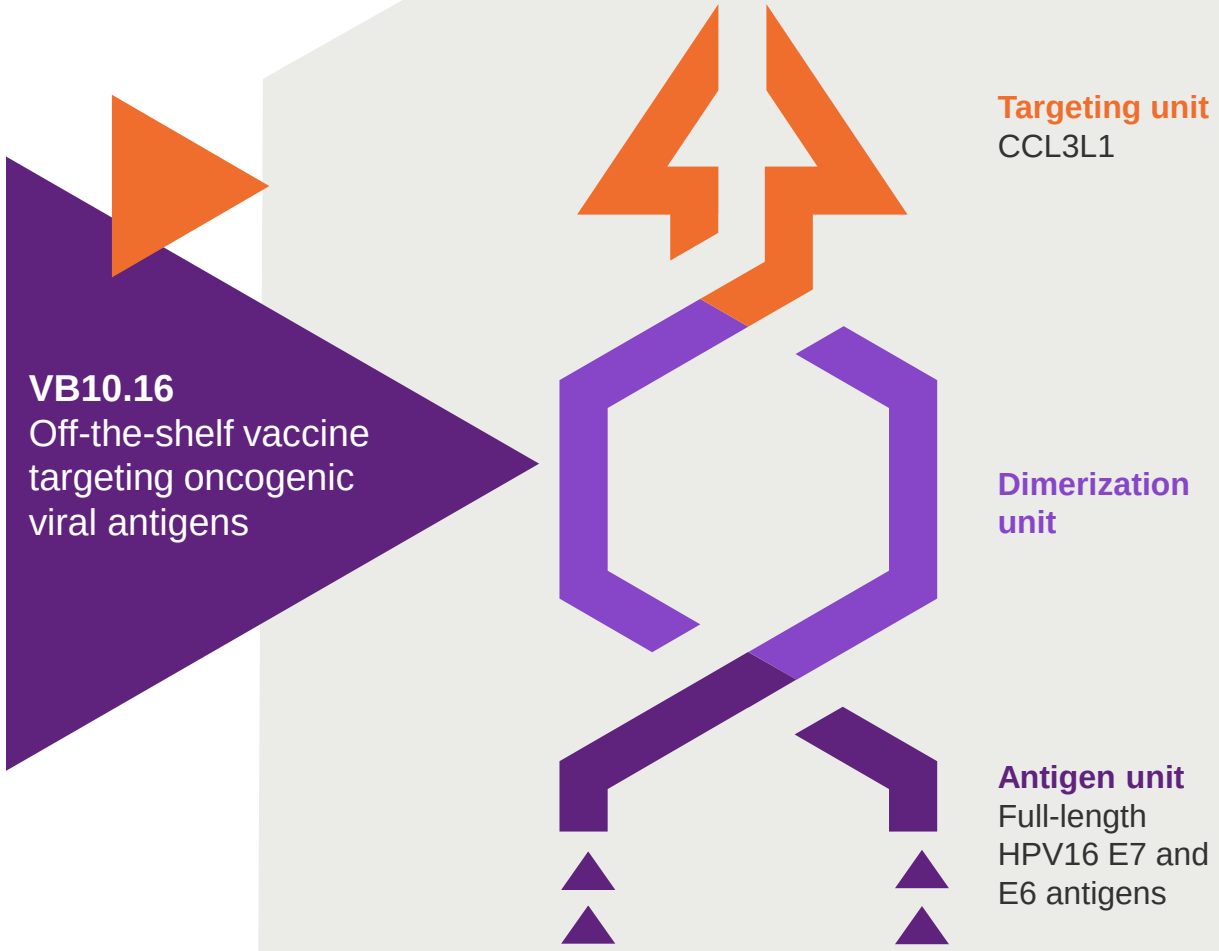
*Castle et al., 2012 and Kreiter et al., 2015

VB10.16 in HPV16+ cancers

VB10.16: Therapeutic vaccine candidate for HPV16+ cancers

Off-the-shelf therapeutic cancer DNA vaccine against HPV16 induced malignancies

- HPV16 is the most prevalent oncogenic HPV strain
- Targeting the cancer-specific full-length HPV16 E7 and E6 antigens
- Wholly-owned by Nykode



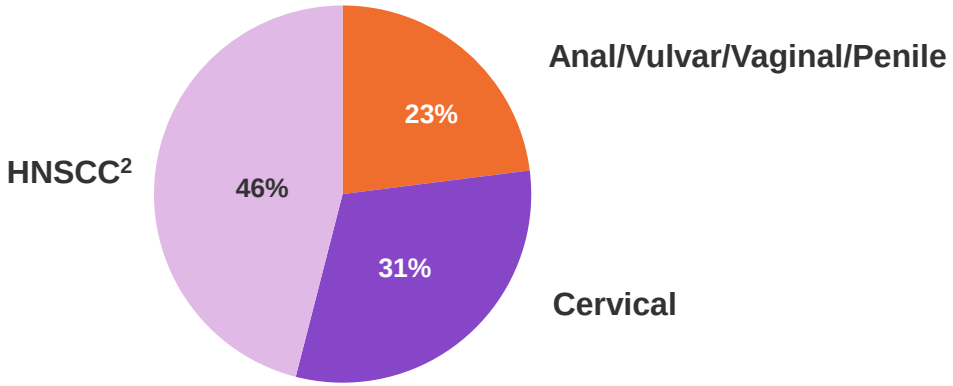
HPV16+ cancers are a significant unmet need

Despite prophylactic HPV vaccination, HPV+ cancer incidence is expected to increase

HPV+ cervical cancer

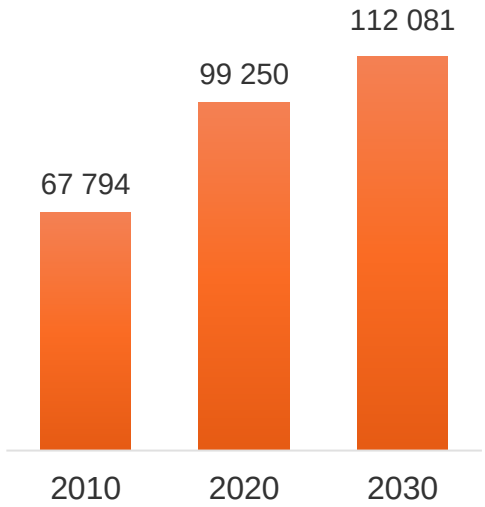
- 4th most common cancer in women worldwide
- 4th leading cause of cancer-related death
- Prognosis is poor for recurrent and/or metastatic (R/M) cervical cancers, 5-year survival <5%

~130,000 new HPV16+ cancer cases per year (U.S. and Europe[1])

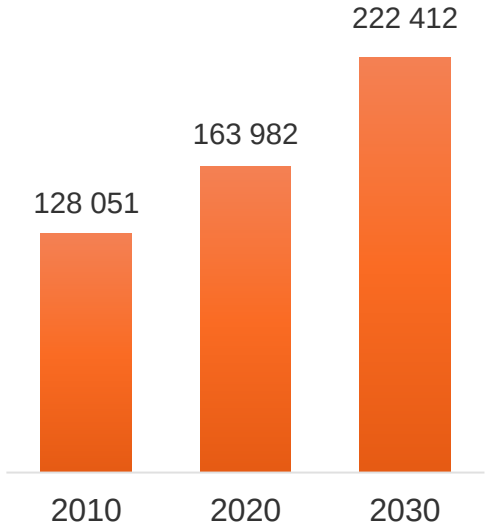


HPV-related cancer incidence is expected to grow

HPV+ cervical cancer diagnosed incident cases[3]
(U.S. + EU5 + China + Japan)



HPV+ HNSCC diagnosed incident cases[4]
(U.S. + EU5 + China + Japan)

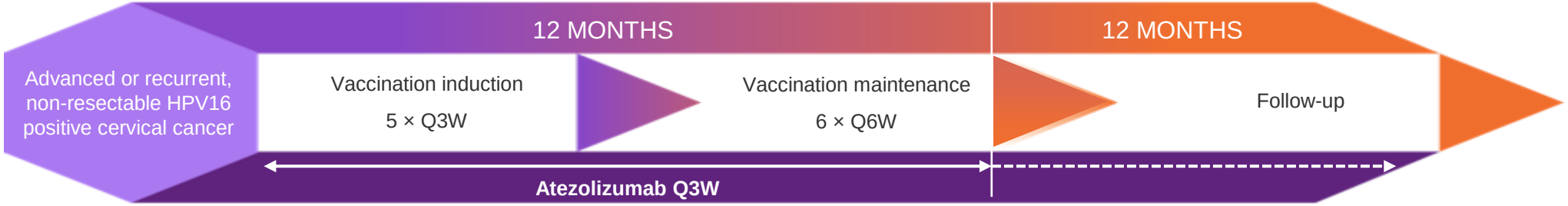


Sources and notes: [1] HPV information centre https://hpvcentre.net/statistics/reports/XEX.pdf?t=1680531103948; American Cancer Society, Cancer Facts & Figures 2020 https://www.cancer.org/; Head Neck Pathol. 2012; 6:55; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3394159/; J Natl Cancer Inst. 2015 Jun; 107(6): djv086 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4838063/; Internal analysis; [2] Head and neck squamous cell carcinoma; [3] GlobalData Cervical Cancer. 8 main markets (U.S., France, Germany, UK, Italy, Spain, Japan, China); [4] GlobalData HNSCC. 8 main markets (U.S., France, Germany, UK, Italy, Spain, Japan, China). Head Neck Pathol. 2012; 6:55; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3394159;

VB C-02: VB10.16 plus atezolizumab (Tecentriq®) in advanced cervical cancer

A Multi-Centre, Single Arm, Open-label Phase 2a Trial of the Combination of VB10.16 and atezolizumab in Patients with Advanced or Recurrent, Non-resectable HPV16 Positive Cervical Cancer (NCT04405349)

- **Objectives:** Safety/tolerability, immunogenicity and efficacy
- **Primary endpoints:** Incidence/severity of AEs, overall response rate (ORR) as per RECIST 1.1 by blinded independent central review (BICR)
- **Secondary endpoints:**
  - Duration of response (DOR)
  - Progression-free survival (PFS)
  - Overall survival (OS)
  - Evaluate immunogenicity of VB10.16 in combination with atezolizumab by analysing HPV16 E6/E7-specific cellular immune responses
- Conducted in Europe in 6 countries (Germany, Belgium, Bulgaria, Czech Republic, Poland and Norway)
- Fully enrolled with 52 patients
- Enrolled patients received treatment with 3 mg VB10.16 in combination with 1200 mg atezolizumab up to 48 weeks, with atezolizumab monotherapy dosed every 3 weeks, and a follow up period of up to 12 months



Recent clinical progress has increased survival outcomes in advanced cervical cancer patients, but room for significant improvement remains

Patients that have failed 1 or more line of systemic treatment have limited Progression Free Survival and Overall Survival with current approved treatments

mPFS of >4 months and mOS of >14 months combination with a favourable safety profile regarded as highly competitive / best-in-class

Notes: [1] Tewari et al. Survival with cemiplimab in recurrent cervical cancer. N Engl J Med 2022. Chemotherapy at investigator choice as control arm; [2] Keynote-158 study update (Chung et al. Efficacy and safety of pembrolizumab in previously treated advanced cervical cancer: Results from the phase II KEYNOTE-158 study. J Clin Oncol 2019; Chung et al. Pembrolizumab treatment of advanced cervical cancer: Updated results from the phase II KEYNOTE-158 study. Gynecol Oncol 2021); [3] Coleman et al. Efficacy and safety of tisotumab vedotin in previously treated recurrent or metastatic cervical cancer (innovaTV 204/GOG-3023/ENGOT-cx6): A multicentre, open-label, single-arm, phase 2 study. Lancet Oncol 2021. (Tabernero et al. Phase II multicohort study of atezolizumab monotherapy in multiple advanced solid cancers. ESMO Open. 2022 did not report PD-L1+ patient data).

VB10.16 evaluated in pretreated advanced cervical cancer patients, with ~40% PD-L1 negative

Baseline characteristics

PATIENT CHARACTERISTICS[1]		SAF[2] (n = 52)
Median age, years (range)		47.5 (27-83)
Histology	◆ Squamous cell carcinoma	81% (42/52)
	◆ Adenocarcinoma	15% (8/52)
	◆ Adenosquamous carcinoma	2% (1/52)
	◆ Unknown	2% (1/52)
Prior lines of SACT (range 0-5)[3]	◆ 0	4% (2/52)
	◆ 1	50% (26/52)
	◆ ≥ 2	46% (24/52)
ECOG PS	◆ 0	56% (29/52)
	◆ 1	44% (23/52)
PD-L1 expression[4]	◆ PD-L1+	48% (25/52)
	◆ PD-L1-	39% (20/52)
	◆ Unknown	14% (7/52)

ECOG PS: Eastern Cooperative Oncology Group performance status; SACT: systemic anticancer therapy.

Note: [1] Total may not sum to 100% due to rounding; [2] Safety analysis set; [3]Prior lines of therapy did not include CPI. [4]PD-L1 expression was evaluated using Ventana clone SP263 .

VB10.16 was generally well-tolerated

VB10.16 plus atezolizumab tolerability profile was consistent with checkpoint inhibitor monotherapy[1]

Treatment-related Adverse Events assessed as related to VB10.16 (n = 52)

System Organ Class Preferred Term	Grade 1-2 n (%)	Grade 3-4 n (%)
All AEs related to VB10.16	**15 (31%)**	**1 (2%)**
General disorders and adm. site conditions.	**10 (19%)**	**–**
◆ Administration site pain	2 (4%)	–
◆ Fatigue	1 (2%)	–
◆ Injection site bruising	2 (4%)	–
◆ Injection site discomfort	3 (6%)	–
◆ Injection site haematoma	1 (2%)	–
◆ Injection site pain	2 (4%)	–
Injury, poisoning and procedural complications	**1 (2%)**	**–**
◆ Infusion related reaction	1 (2%)	–
Metabolism and nutrition disorders	**1 (2%)**	**–**
◆ Decreased appetite	1 (2%)	–
Musculoskeletal and connective tissue disorders	**2 (4%)**	**1 (2%)**
◆ Arthralgia	–	1 (2%)
◆ Myalgia	2 (4%)	–
Skin and subcutaneous tissue disorders	**4 (8%)**	**–**
◆ Erythema	1 (2%)	–
◆ Pruritus	2 (4%)	–
◆ Rash	2 (4%)	–

VB10.16 in combination with atezolizumab was generally well-tolerated and showed a favourable tolerability profile

- Treatment-related AEs of any grade related to either VB10.16 or atezolizumab were seen in 67% of patients
- Most treatment-related AEs were mild or moderate (gr. 1-2)
  - Five patients (10%) experienced treatment-related AEs of gr. 3 related to atezolizumab
  - Of these, 1 event of gr. 3 arthralgia was additionally reported as related to VB10.16
- **No serious AEs were reported related to VB10.16**
- No deaths were related to either VB10.16 or atezolizumab

Note: 52 patients were included in the safety population; Median number of VB10.16 doses given was 5 (range 1-11); AE = adverse event; [1] Tabernero et al. Phase II multicohort study of atezolizumab monotherapy in multiple advanced solid cancers. ESMO Open. 2022.

Strong anti-tumor effect leading to prolonged overall survival (compared to CPI alone)[1]

High mOS of >25 months (not reached) and mPFS 6.3 months in PD-L1+ patients

Endpoint	All patients[2]		PD-L1+ [3]	
	Value	**95% CI**	**Value**	**95% CI**
ORR	19%	(9%-33%)	29%	(13%-51%)
CR	6%	(1%-18%)	8%	(1%-27%)
DCR	60%	(44%-74%)	75%	(53%-90%)
MR	19%	(9%-33%)	17%	(5%-37%)
mDOR, months	**17.1**	(2.6-n.r.)	**17.1**	(2.2-n.r.)
mPFS, months	**4.1**	(2.1-6.2)	**6.3**	(3.6-16.9)
mOS, months	**16.9**	(8.3-n.r.)	**n.r. (> 25)**	N.A

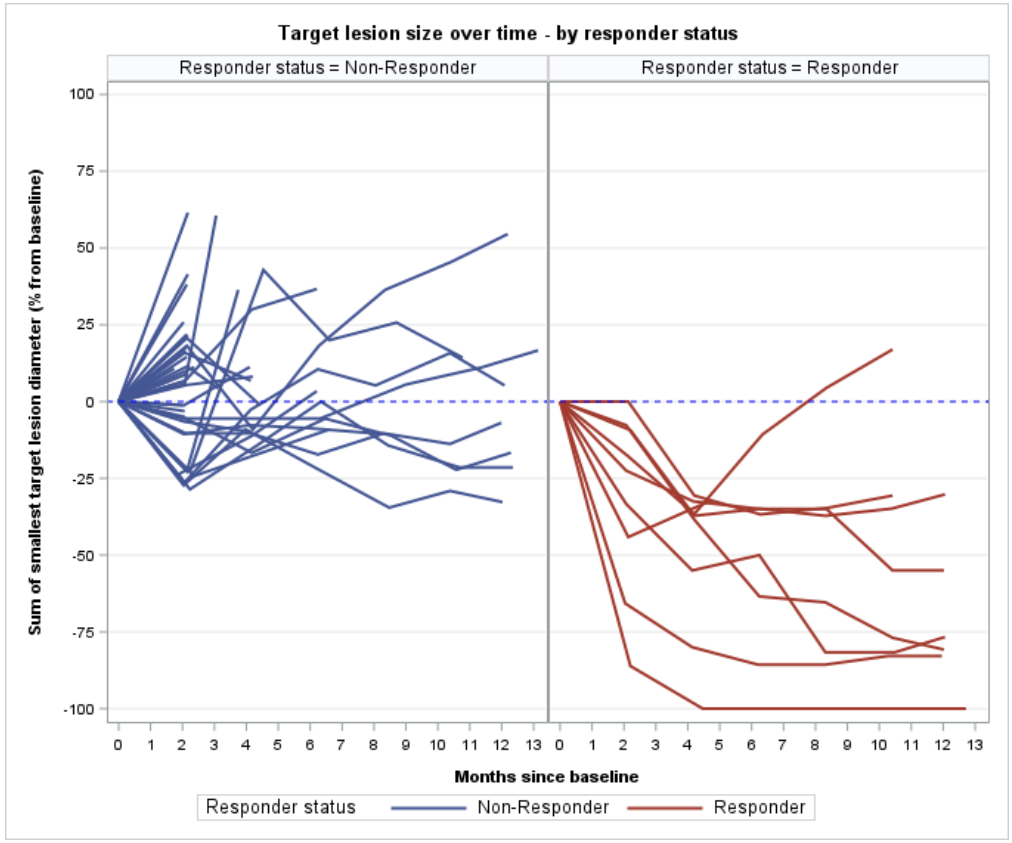
- Strong and durable anti-tumor efficacy across all patients with 16.9 months mOS
- Even stronger signal in PD-L1+ sub-population with mOS not reached (25+ months) and mPFS 6.3 months

Note: [1]Chung et al. Efficacy and safety of pembrolizumab in previously treated advanced cervical cancer: Results from the phase II KEYNOTE-158 study. J Clin Oncol 2019; Tewari et al. Survival with cemiplimab in recurrent cervical cancer. N Engl J Med 2022; Tabernero et al. Phase II multicohort study of atezolizumab monotherapy in multiple advanced solid cancers. ESMO Open. 2022.

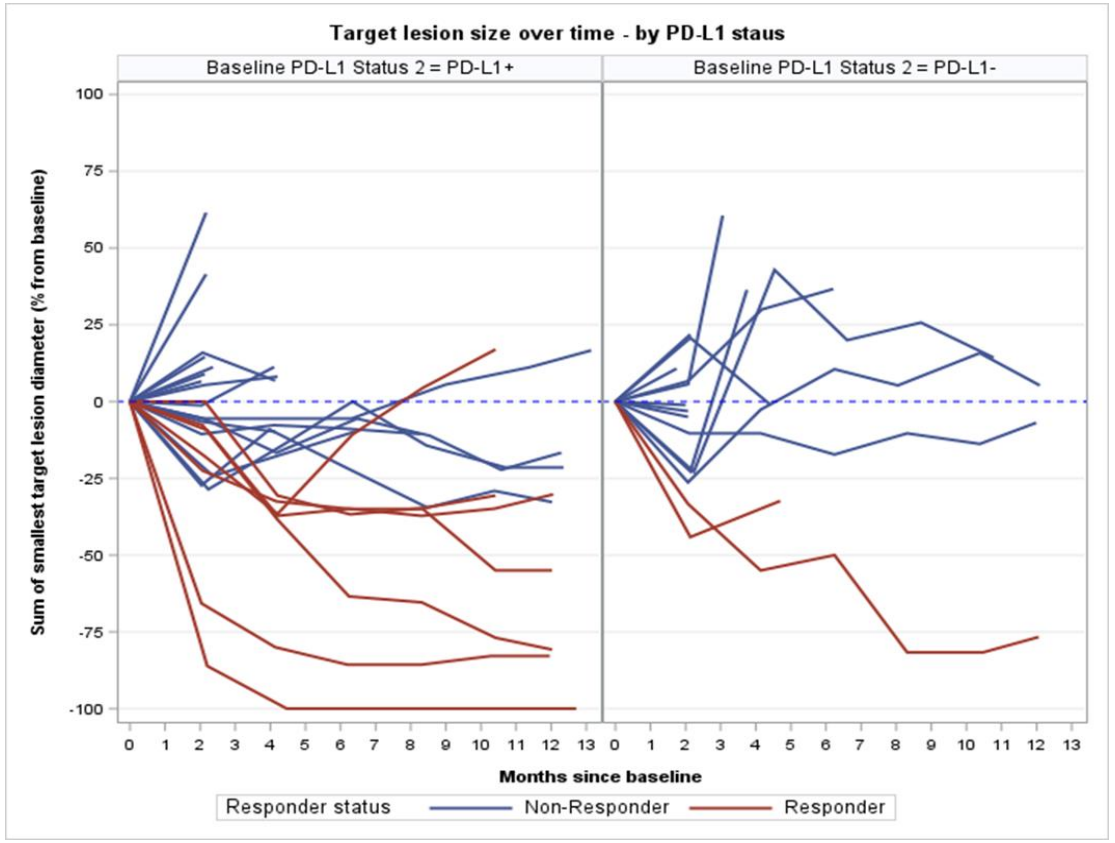
[2] The number of patients evaluable for a response is 47 (the Efficacy Analysis Set, EAS), mOS on all 52 patients; [3] 24 efficacy evaluable patients with PD-L1+ marker, n=25 PD-L1+ for mOS; CI: Confidence interval; CR: Complete response; MR: Minimal response (SD with tumor shrinkage ≥ 10% to < 30%); ORR: overall response rate

VB10.16 coupled with CPI led to lasting responses

All (n = 47)



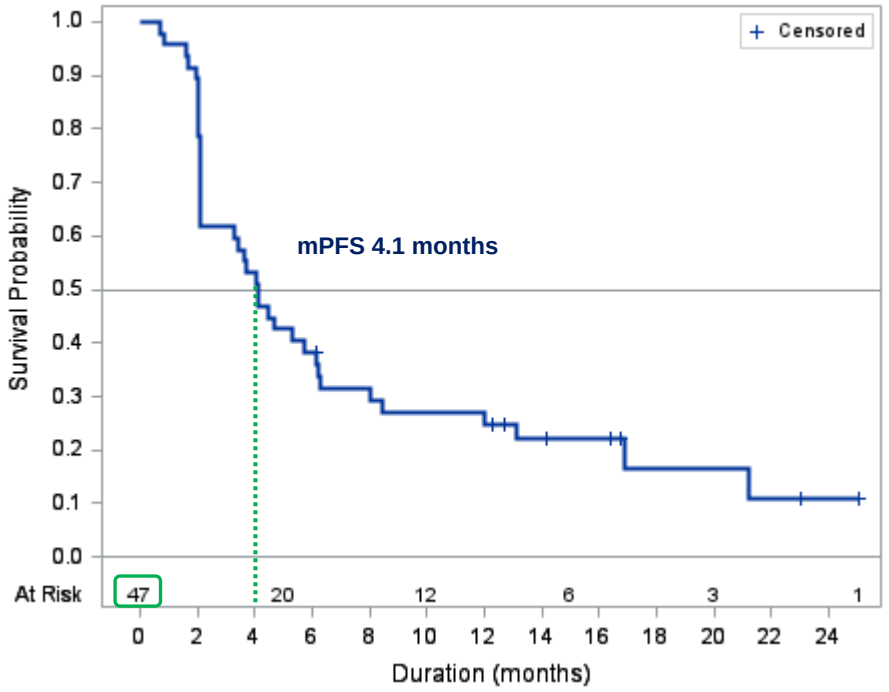
By PD-L1 status (n = 40)



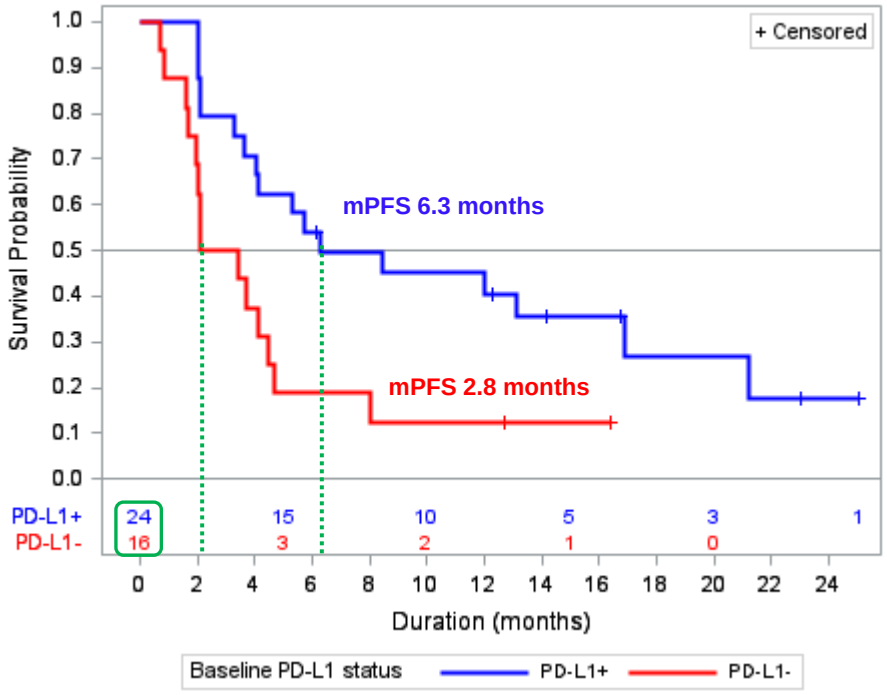
Note: 7 out of 47 responders had PD-L1 unknown status, 40 out of 47 had known PD-L1 status

Progression free survival reached 6.3 months to date in PD-L1+ patients irrespective of prior number of treatments

Progression-free survival



Progression-free survival (PD-L1+ vs. PD-L1-)

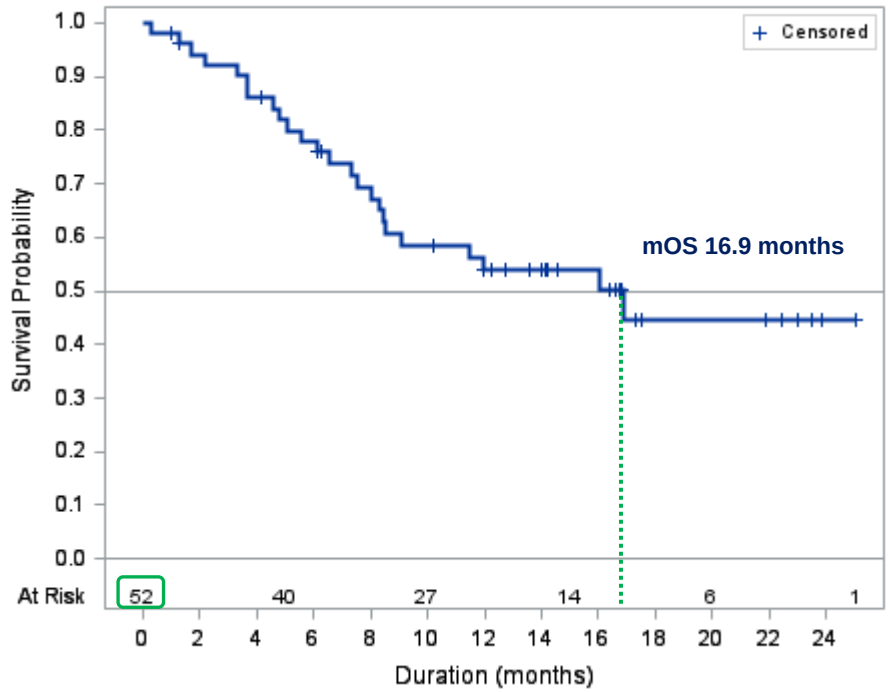


Note: 7 out of 47 patients had PD-L1 unknown status

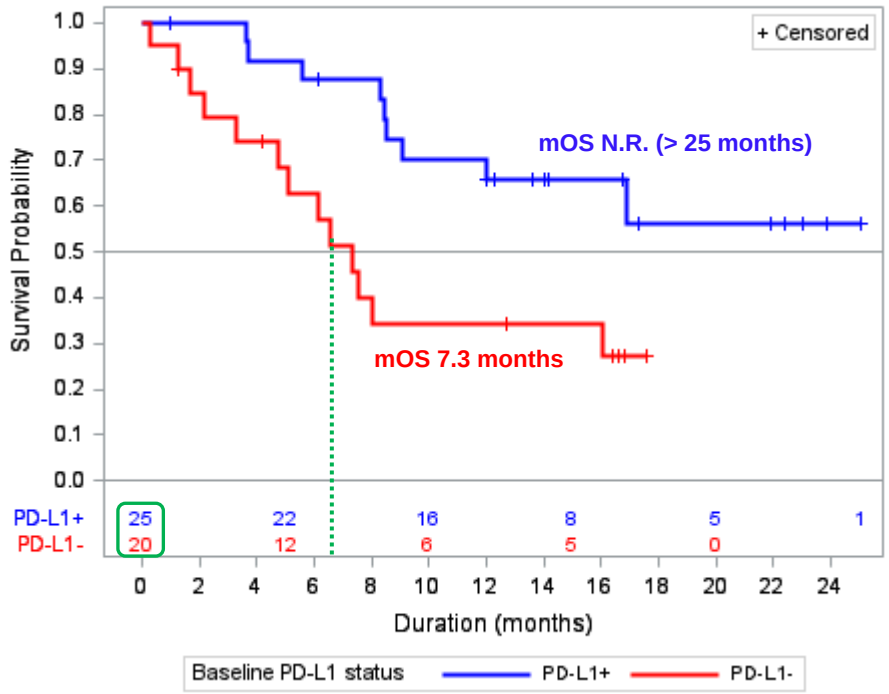
VB10.16 led to prolonged overall survival in advanced cervical cancer patients

Median overall survival of 16.9 months in overall population, mOS not reached (> 25 months) in PD-L1+ patients

Overall survival



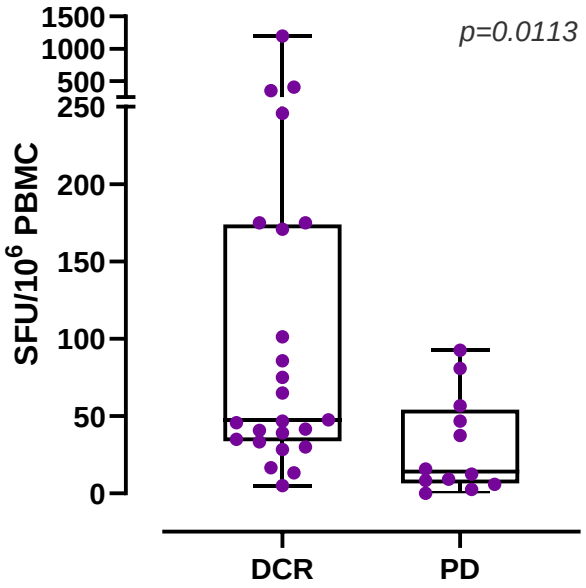
Overall survival (PD-L1+ vs. PD-L1-)



Note: All patients evaluated for OS, n = 7 where PD-L1 status unknown

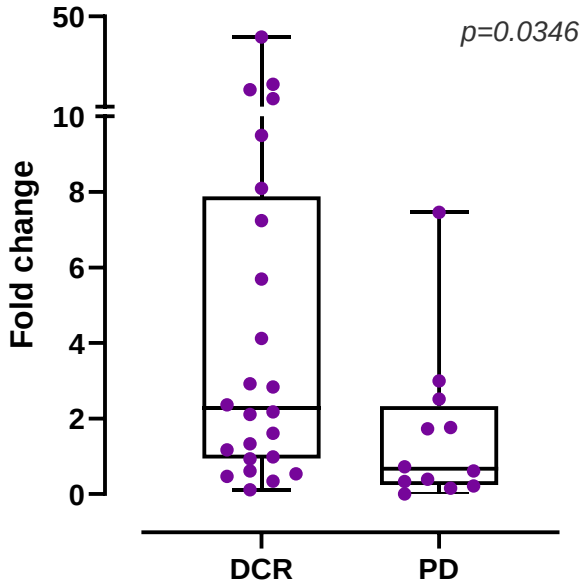
VB10.16 induced HPV16-specific T cell responses that are significantly correlated with clinical response

HIGHER PEAK T CELL RESPONSES IN PATIENTS WITH DISEASE CONTROL



Absolute count at peak visit post-treatment

HIGHER FOLD INCREASED T CELL RESPONSES IN PATIENTS WITH DISEASE CONTROL



Fold change, baseline to peak count post-treatment

Note: Ex vivo ELISpot analysing HPV16 E6 and E7 responses with background subtracted n = 36 (n = 24 DCR, n = 12 PD). Data not available for 11 subjects

Data from the VB10.16 Ph2 trial compared with relevant current and future SoC as evaluated in third-party trials

Endpoint	VB10.16 plus atezolizumab in PD-L1+ (n = 24)	Pembrolizumab in PD-L1+ (Keynote-158, n = 82)**	Cemiplimab in PD-L1+ (Empower-Cervical 1, n = 82, cemiplimab arm) ††	Tisotumab vedotin (PD-L1 agnostic) (InnovaTV 204, n = 101) ‡‡
ORR	**29%***	17%	18%	24%
mPFS	**6.3 mo‡**	2.1 mo	3.0 mo	4.2 mo
mOS	**Not reached (25.0+ mo)**	11.0 mo	13.9 mo	12.1 mo

Median OS had not yet been reached (Aug ’23)

Notes: The data shown on this slide represents third-party clinical trials involving different trial designs and patient populations. These trials are not head-to-head evaluations of VB10.16 against standard of care
NA = not available in publication / presentation / abstract

* 40% (6/15) in PD-L1+ with **1 prior line** of systemic anticancer therapy (SACT)

† 80% (12/15) in PD-L1+ with **1 prior line** of SACT

‡ 16.9 mo in PD-L1+ with **1 prior line** of SACT (n = 15)

** Chung et al. Efficacy and safety of pembrolizumab in previously treated advanced cervical cancer: Results from the phase II KEYNOTE-158 study. J Clin Oncol 2019

†† Tewari et al. Survival with cemiplimab in recurrent cervical cancer. N Engl J Med 2022

‡‡ Coleman et al. Efficacy and safety of tisotumab vedotin in previously treated recurrent or metastatic cervical cancer (innovaTV 204/GOG-3023/ENGOT-cx6): A multicentre, open-label, single-arm, phase 2 study. Lancet Oncol 2021

(Tabernero et al. Phase II multicohort study of atezolizumab monotherapy in multiple advanced solid cancers. ESMO Open. 2022 did not report PD-L1+ patient data).

C-02 data supports patient population selection for potentially registrational study

- Clinical activity observed across all endpoints, with strongest results in PD-L1+ patients with 1 prior line of systemic therapy
- Duration of response data in PD-L1+ patients show potential for competitive positioning in this patient population

Endpoint	All	PD-L1+ and 1 prior line of SACT
ORR	19%	40%
CR	6%	13%
DCR	60%	80%
mDOR, months	17.1	17.1
mPFS, months	4.1	16.9
mOS, months	16.9	>25 N.R.

VB10.16 has broad potential across HPV-driven cancers

FINALIZED. REPORTED POSITIVE DATA

C-01
Ph 1/2a Pre-cancerous Cervical Lesions

- Monotherapy of VB10.16, 3 mg
- CIN2/3 (HSIL) patients
- Well tolerated and strong antigen specific immune responses correlating with potential clinical efficacy

ONGOING. REPORTED POSITIVE INTERIM DATA

C-02
Ph 2a Cervical Cancer

- VB10.16, 3 mg in combination with atezolizumab (Tecentriq®)
- Advanced cervical cancer
- Positive interim analysis, Q2 2022

EXPANSION PLANNED FOR 2023

C-03
Ph 1/2a Head and Neck Cancer

- VB10.16, up to 9 mg in combination with pembrolizumab (Keytruda®)
- 1st line unresectable recurrent or metastatic head and neck cancer (HNSCC) and PD-L1+
- MHRA and EC approval received for UK as first country, Q2 2023
- First patient dosed, expected Q3 2023

C-04
Ph 2 Cervical Cancer

- VB10.16 in combination with immune checkpoint inhibitor
- Potentially **registrational trial** in the U.S.
- Collaboration with GOG
- Recurrent/ metastatic cervical cancer and PD-L1+ tumors
- First patient dosed, expected Q4 2023

FURTHER POTENTIAL

Earlier lines and other HPV+ driven cancers

- Adjuvant/locally advanced HPV16+ cervical and HNSCC
- Additional HPV16+ cancers (anal, penile, vaginal)
- PD-L1- HPV16+ tumors

VB10.16 in combination with atezolizumab showed promising clinical profile with favorable tolerability in patients with advanced HPV16+ cervical cancer, an area of high unmet medical need

- Clinically relevant endpoint mPFS was 4.1, 6.3 and 16.9 months for all, PD-L1+ and PD-L1+ with one prior treatment line, respectively
- Clinically relevant endpoint mOS was 16.9 months and not reached (> 25 months) for all patients and PD-L1+ patients, respectively
- VB10.16 plus atezolizumab demonstrated ORR 19% with median duration of response 17.1 months and DCR of 60%
- In the PD-L1+ and PD-L1+ plus one prior treatment line subgroups, overall response rates were **29%** and **40%**, respectively

Together these findings indicate a potentially differentiated and lasting anti-tumor response pattern of the combination treatment compared to checkpoint inhibitor monotherapy[1]

The subgroup analyses support the planned studies with VB10.16 in PD-L1+ patients who have received max 1 prior line of systemic anticancer treatment in the advanced disease setting

Note:[1]Chung et al. Efficacy and safety of pembrolizumab in previously treated advanced cervical cancer: Results from the phase II KEYNOTE-158 study. J Clin Oncol 2019; Tewari et al. Survival with cemiplimab in recurrent cervical cancer. N Engl J Med 2022; Tabernero et al. Phase II multicohort study of atezolizumab monotherapy in multiple advanced solid cancers. ESMO Open. 2022.

VB10.NEO- Individualized cancer immunotherapy

VB10.NEO: Individualized neoantigen immunotherapy for the treatment of broad range of solid tumor indications

ONGOING. REPORTED POSITIVE INTERIM DATA.

N-01

- VB10.NEO in combination with CPI
- Melanoma, lung, bladder, renal, head and neck
- Recruitment finalized
- Positive interim data: broad and long-lasting polyfunctional CD8 T cell responses

ONGOING IN >10 INDICATIONS, COLLABORATION WITH GENENTECH

N-02

- Dose escalation 3-9 mg VB10.NEO in combination with atezolizumab (Tecentriq®)
- >10 indications
- Initiated 2021. Planned enrollment up to 40 patients
- Safety clearance of 9 mg dose with no safety concerns and no dose limiting toxicities

Exclusively out-licensed to Roche and Genentech, 2020

VB10.NEO: leading technology for individualized cancer neoantigen immunotherapy

Strong in-house bioinformatic competences and proprietary neoantigen selection method

- Trained on Vaccibody's data and unique broad CD8 dominated immune response
- Focus on clonal and clinically relevant epitopes
- High quality immunogenic neoepitopes shown to correlate with clinical responses

Optimal manufacturing for individualized

- DNA plasmid manufacturing is an intermediate in mRNA and viral vector productions and thus will be more rapid, cost-effective and robust
- 100% manufacturing success rate to date

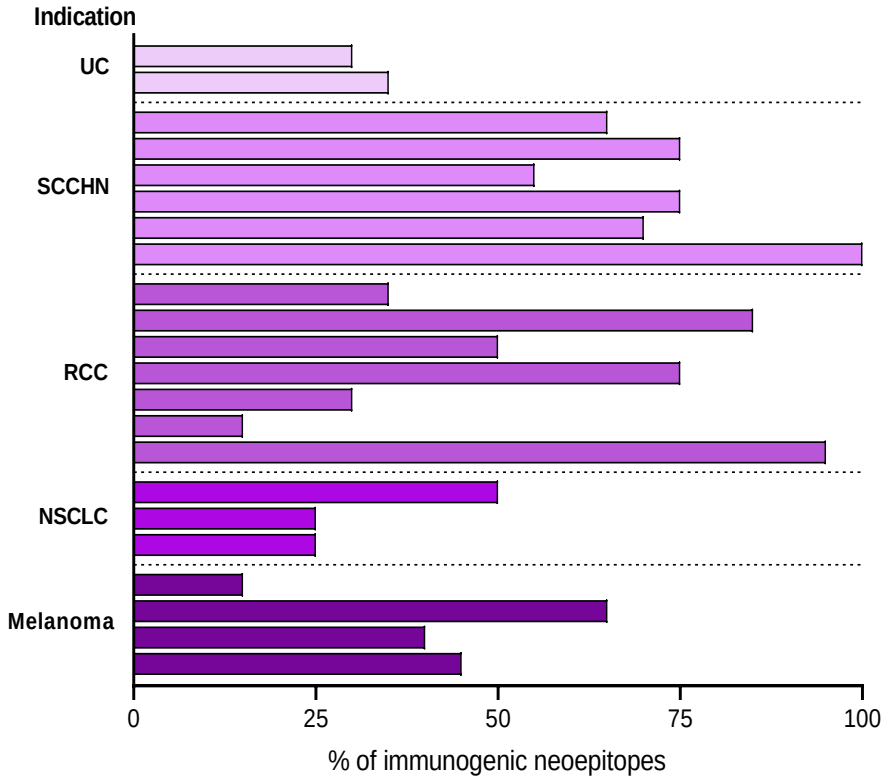
Safe and well tolerated platform

T-cell responses to the majority of selected neoepitopes

100% of patients across five indications showed a response to at least three neoepitopes (at least one time point)

On average, 53% of selected neoepitopes were immunogenic, ranging from 3 to all 20 neoepitopes in the VB10.NEO immunotherapy demonstrating a broad response

% immunogenic Neoepitopes per patient

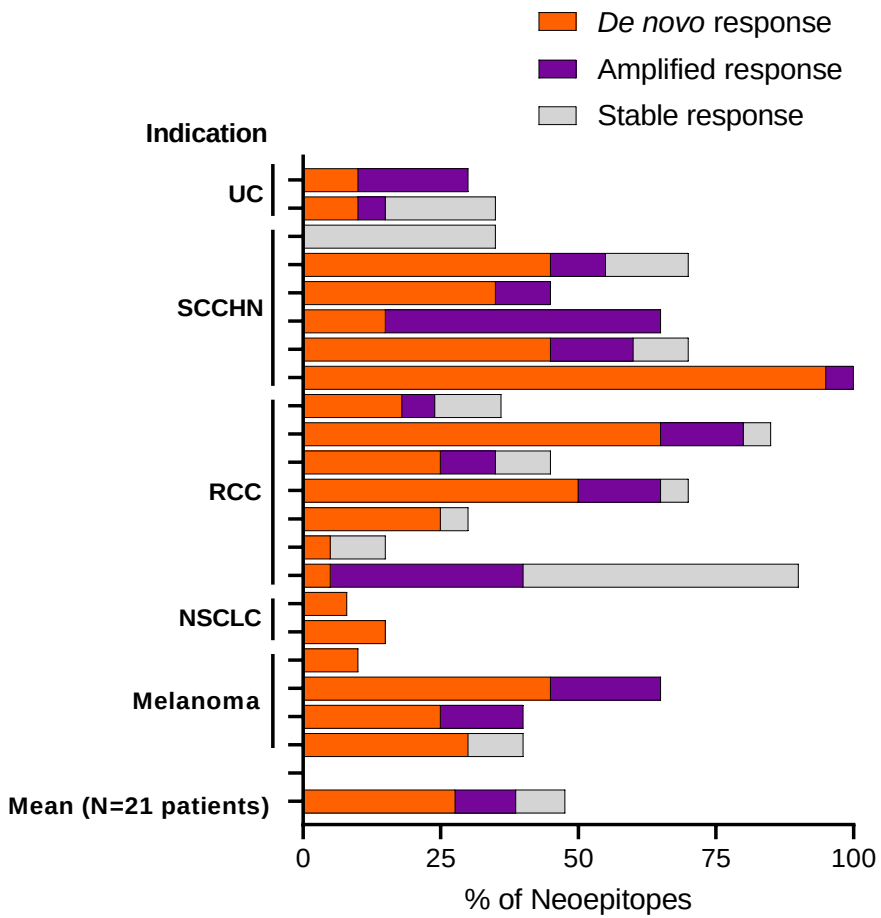


VB10.NEO amplifies pre-existing T-cell responses and induces multiple novel T-cell specificities

Expansion of both pre-existing and novel T-cell responses in most patients (at least one time point post vaccination)

- 20/21 (95%) *de novo* expanded
- 14/21 amplification of pre-existing

Expansion of pre-existing and induction of novel T cells

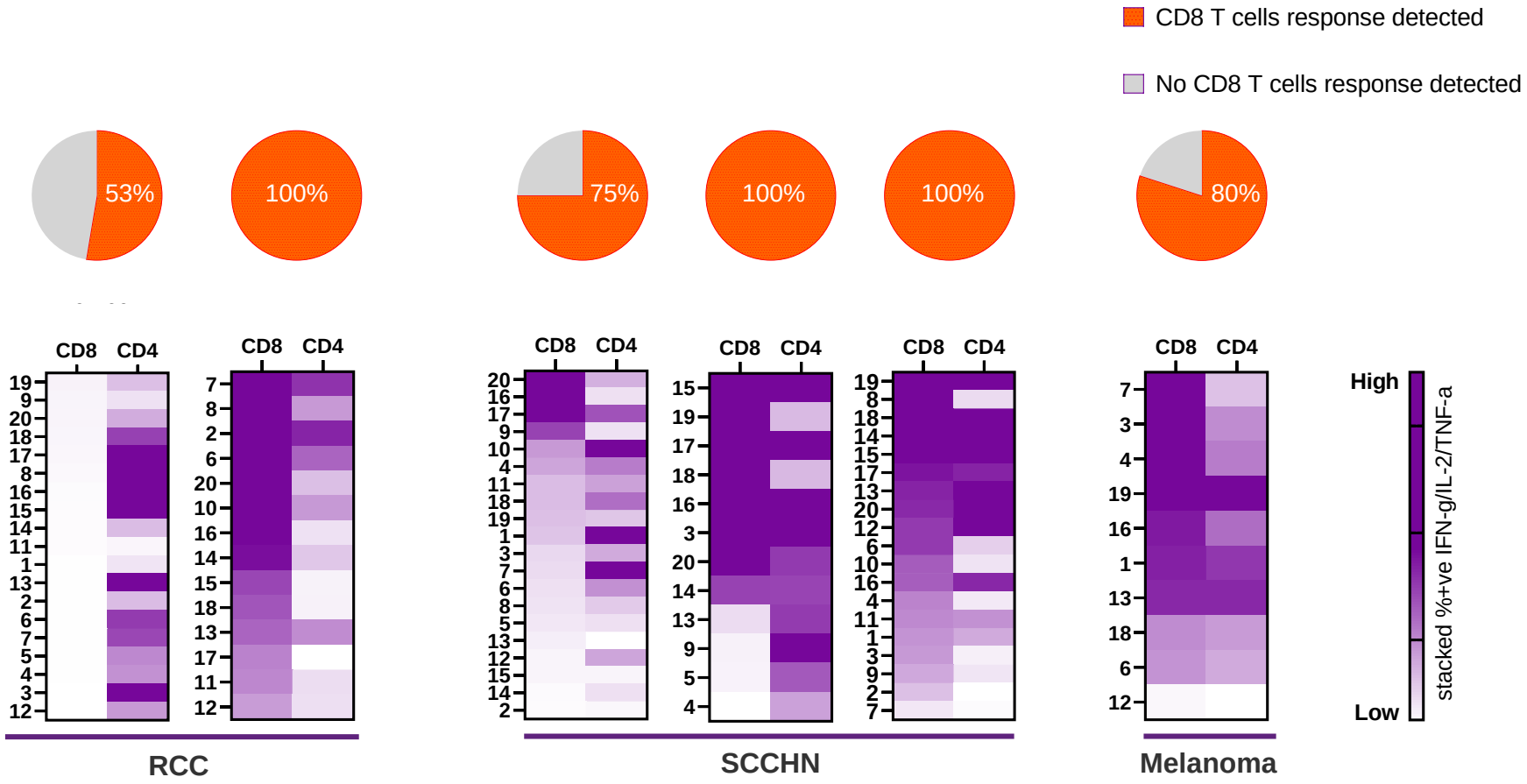


Analysis reported for patients with available PBMC, data missing for 1 or more neoepitopes for 1 patient (N=21)

Preliminary immune phenotyping shows that the majority of neoepitopes activate CD8 T cells

T cell responses are characterized by both CD8 and CD4 T cells (at week 22)

The majority of tested neoepitopes activated functional and strong CD8 T cell responses in all subjects analyzed



CD8 response defined as ≥ 0.2% above DMSO background.
Phenotyping was performed by IVS ICS using PBMC from week 22 for 6 subjects. Number indicate neoepitope in VB10.NEO

Autoimmunity and Further platform potential

Building a new therapeutic area focusing on Autoimmunity

Opening up a new therapeutic market with high unmet medical need

- Differentiated platform technology, IP protected
- Building on the unique APC-targeted competence for cancer vaccines
- Focusing on dampening the antigen-specific immune responses by targeting to specific receptors on selected subset of APC
- Established dedicated Autoimmune research group, effective from September 1, 2023 led by Henrik Søndergaard

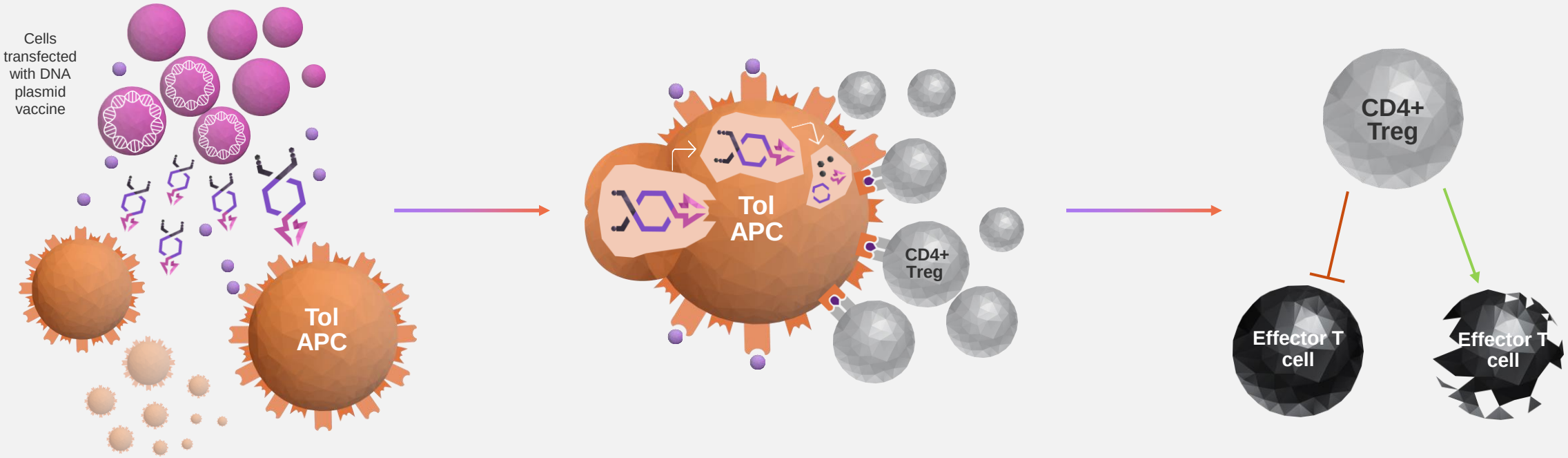
Update on recent data and future plans to be presented at Capital Market Day in September

Henrik Søndergaard
Head of Tolerance

- 15+ years of drug development experience
- Prior leadership and operational roles at Novo Nordisk and Roche's RNA molecule research unit at Roche Innovation Center Copenhagen

Tolerance induction

MECHANISM OF ACTION – TOLERANCE INDUCTION



1 Cells encode and secrete Tol APC-targeted Vaccibody proteins together with immunosuppressive molecules/modulators to enhance tolerogenic APC function.

2 The Tol APCs present vaccine antigens in a tolerogenic milieu supported by the vaccine co-encoded suppressive molecules, and prime regulatory T cell (Treg) activation and expansion.

3 The Tregs inhibit or delete disease-specific effector T cells.

Nykode's modular platform is designed to unlock multiple applications across targets and therapeutic areas

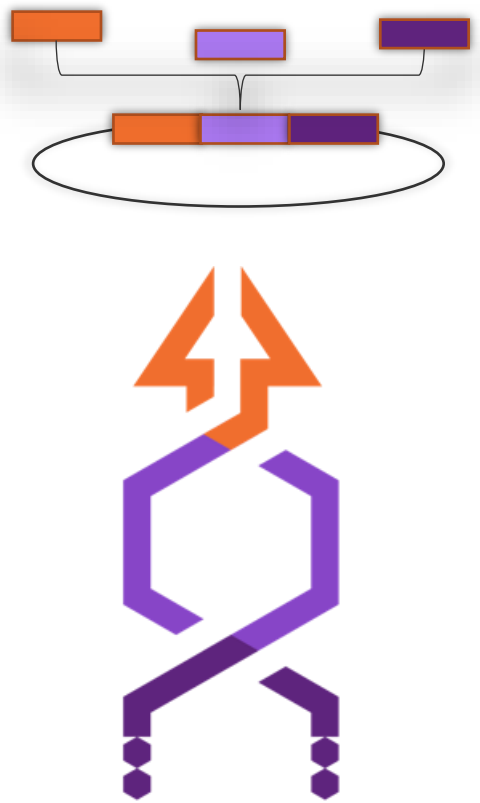
APC-specific Ag delivery and stimulation

Cancer immunotherapies

Infectious disease immunotherapies

Immunotherapies against autoimmunity and allergy

APC-specific Ag delivery and inhibition



Expanded use of modularity

Building additional modules

Novel combinations and structures

Novel therapeutics beyond vaccines

Fully exploit product opportunities building on competence with modular and targeted platform

Financial overview

Rich calendar of milestones expected in the next 12 months

Oncology	H1 2023	**VB10.16 Cervical Cancer**	Final results from VB-C-02 Phase 2 study; 12 month treatment follow-up ✓
	Q3 2023	**VB10.16 Head and Neck Cancer**	First patient dosed in C-03 trial with KEYTRUDA® in patients with PD-L1 positive 1st line unresectable recurrent or metastatic disease. MHRA and EC approval for UK as first country has been received
	Q4 2023	**VB10.16 Cervical Cancer**	Initiate potentially registrational C-04 trial in the U.S. in patients with recurrent/metastatic disease and PD-L1 positive tumors
	Q4 2023	**Undisclosed Oncology**	Nomination of an additional oncology development candidate for a new internal oncology program
	Q1 2024	**VB10.16 Cervical Cancer**	Updated survival data from C-02 trial
Autoimmune	Q3 2023	**Autoimmunity and Allergy**	Update on Nykode's Ag-specific immune tolerance platform

Note: The news flow from the collaboration with Genentech and Regeneron is at their discretion, respectively

Global leader in APC-targeted immunotherapy technology

NYKODE THERAPEUTICS (NYKD-OL, MKT CAP ~$800M)

Proprietary immunotherapies targeting antigens to Antigen-Presenting Cell (APC) and generating strong CD8 killer T cell responses correlated with clinical responses in solid tumors

Modular, versatile platform

- Easily incorporate new antigens and adapt to new diseases with focus on oncology and autoimmunity

Rapidly advancing wholly owned lead asset, VB10.16, immunotherapy for HPV16+ cancers

- Final data from phase 2 VB-C-02- unprecedented long lasting survival benefit in advanced cervical cancer
- Potentially registrational study in advanced cervical cancer to initiate 2023
- Dose escalation study with KEYTRUDA®[1] in head and neck cancer to initiate 2H2023

Strategic partnerships to advance clinical programs and commercialize assets worldwide[2]

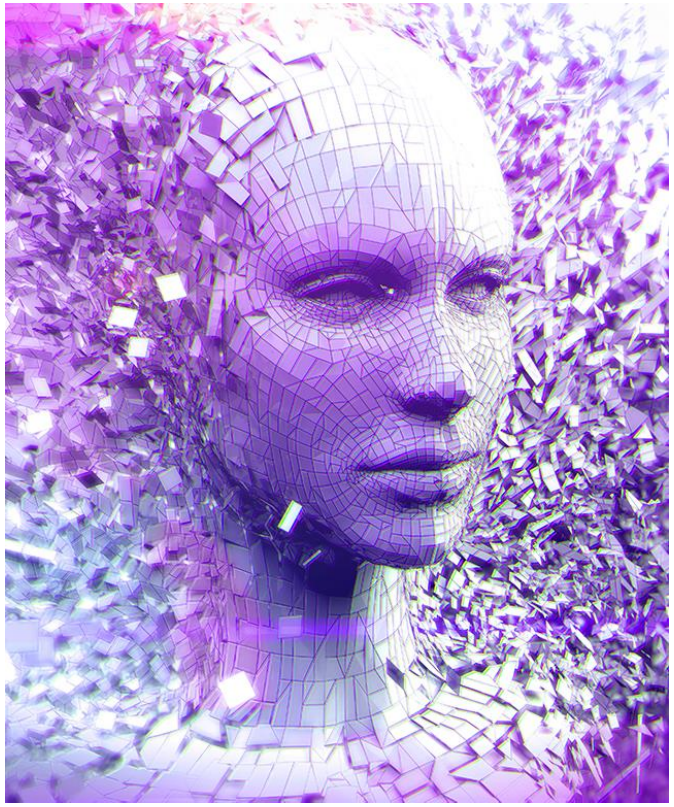
Genentech A Member of the Roche Group · REGENERON · Adaptive biotechnologies · Roche · MSD

Well-capitalized with a cash position of $174m at June 30, 2023

1. Note: KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA
2. Note: Genentech has an exclusive license to VB10.NEO. Collaboration and license to 5 programs with Regeneron. Collaboration and license with Adaptive Biotechnologies on SARS-CoV-2 T cell vaccine. Roche supplies atezolizumab; . Merck (MSD) supplies pembrolizumab

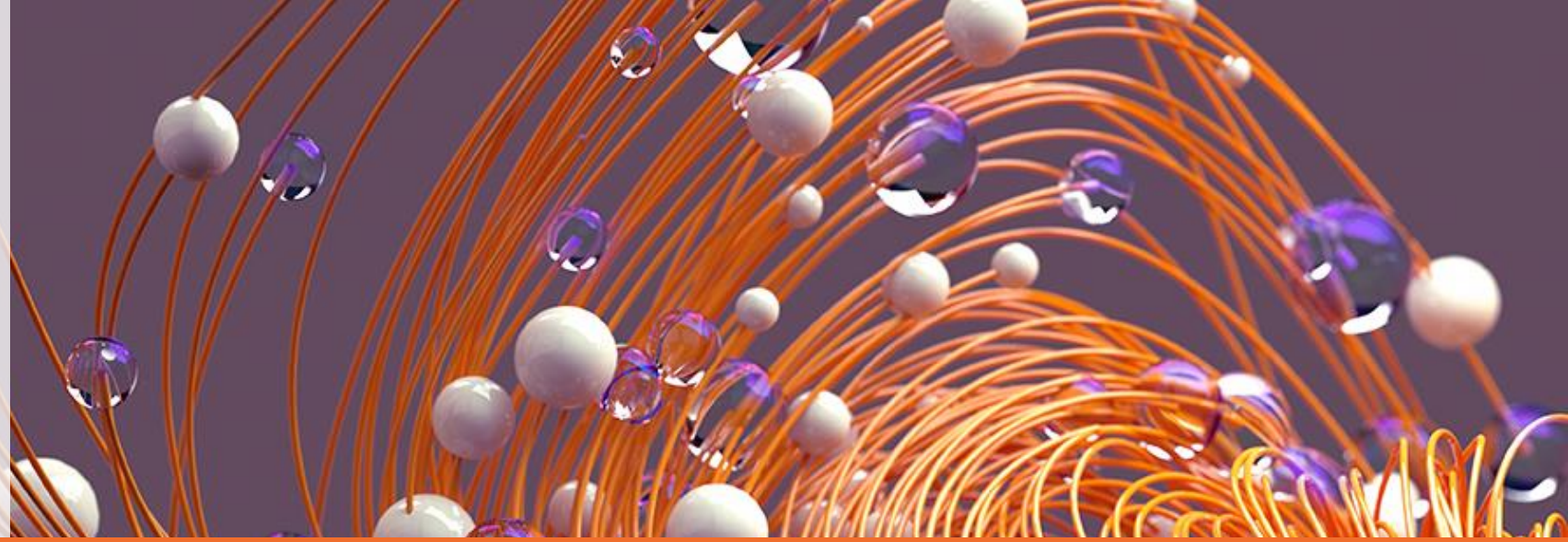
Strong financial foundation for achieving our vision

Cash position of $174m end Q2 2023



- Financially well positioned to execute the Company's strategy over the next years
- Nykode continues to explore a potential listing on the Nasdaq Global Market in the United States

SAVE THE DATE!



Nykode to a host a **Capital Markets Days in NYC and Oslo**.
Members of the Management Team and a Key Opinion Leader will present latest updates on the Vaccibody platform and its clinical programs:

- **NYC - September 20, 2023**
- **Oslo - September 27, 2023**

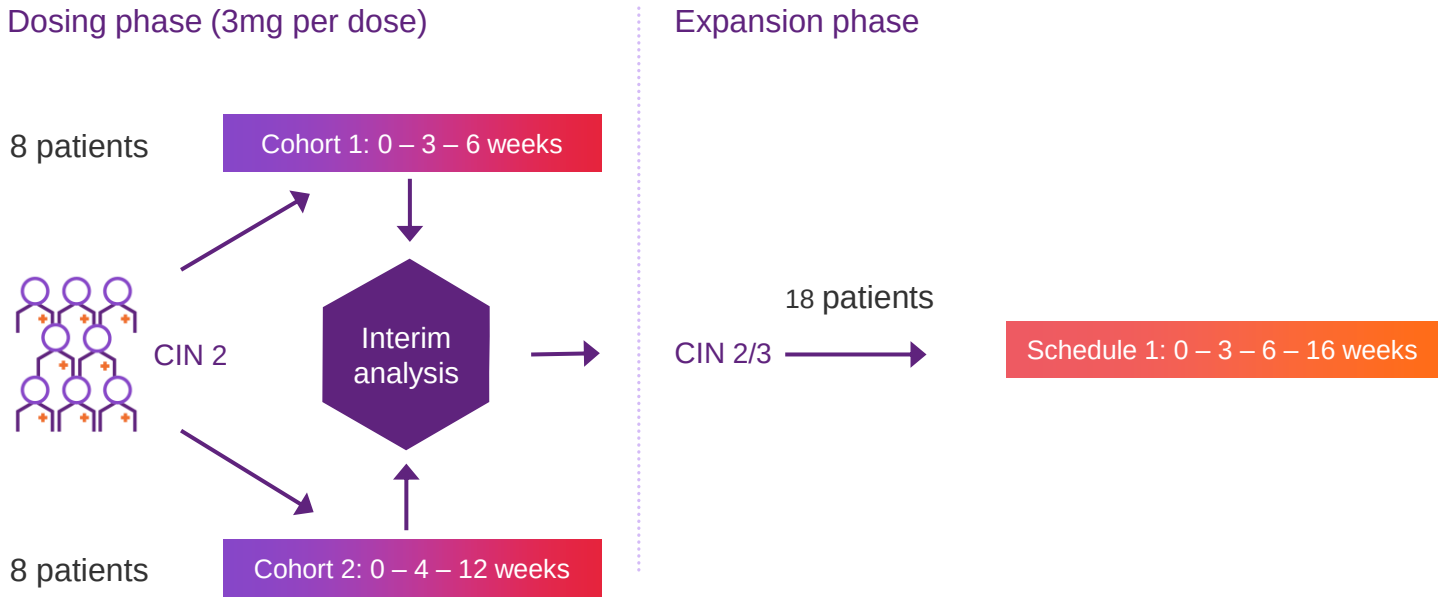
Stay tuned!

UNLOCKING THE FUTURE OF MEDICINE

Contact:
Agnete Fredriksen
CBO
IR@nykode.com

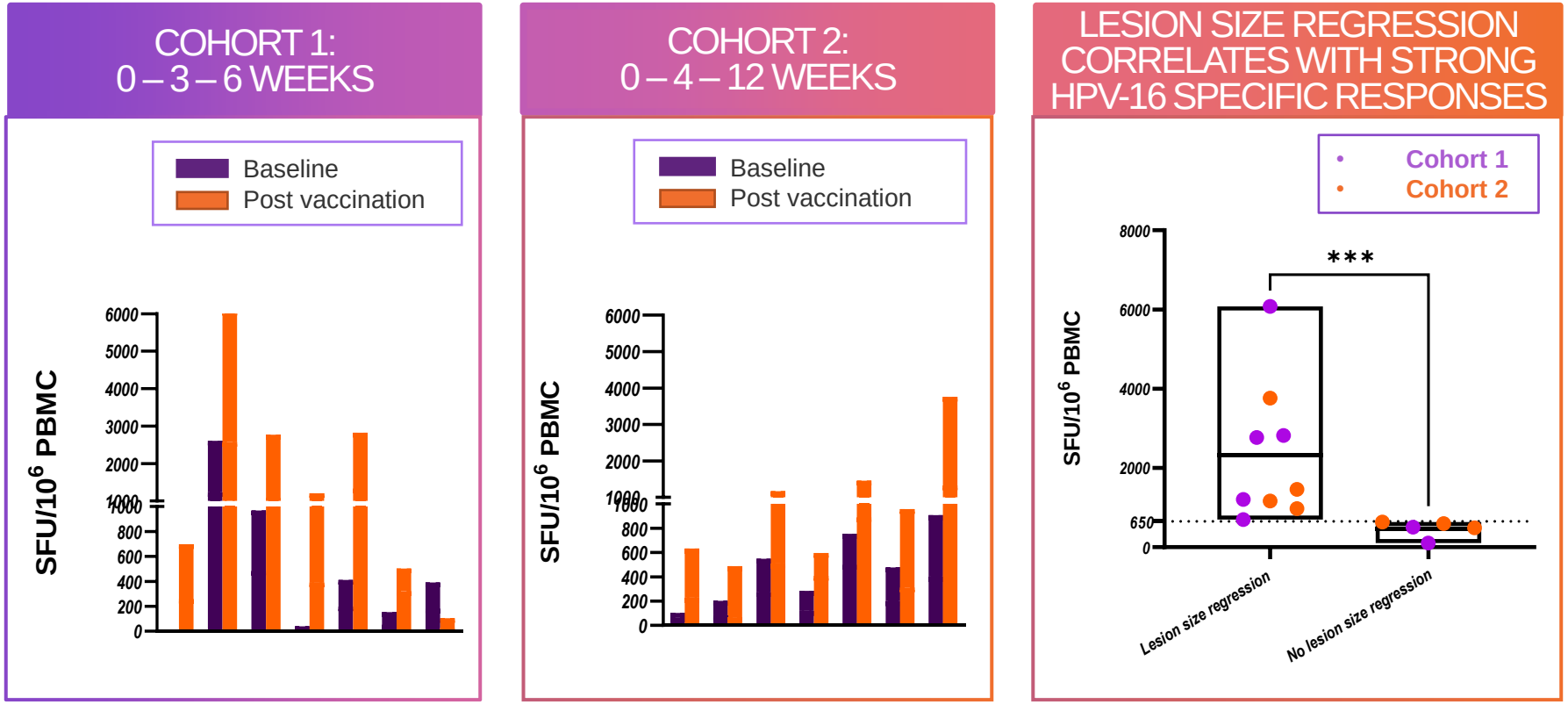
VB C-01: First trial with VB10.16 as monotherapy for treatment of HPV16+ precancerous lesions

VB C-01
Exploratory, open labelled, multi-centre study in patients with HPV16+ High Grade Cervical Intraepithelial Neoplasia (HSIL, CIN 2/3)



VB10.16: Strong correlation with strength of induced HPV16-specific immune response and lesion size reduction

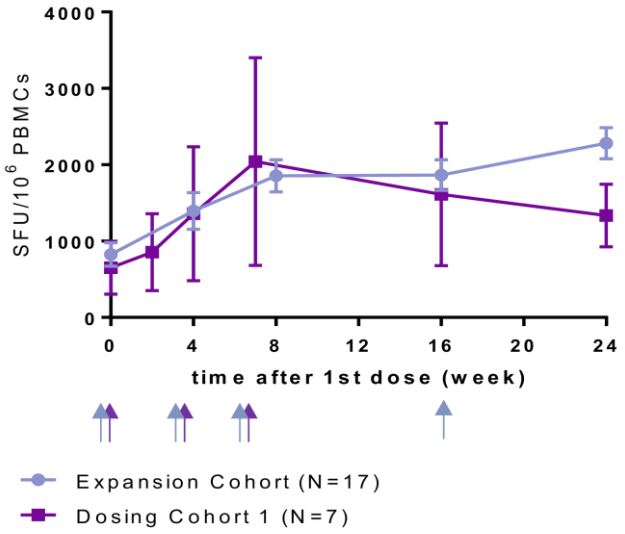
- 13 of 14 patients showed increased T cell responses after vaccination with VB10.16
- Strong correlation between strength of T cell responses (>650 SFU/mill) and lesion size reduction



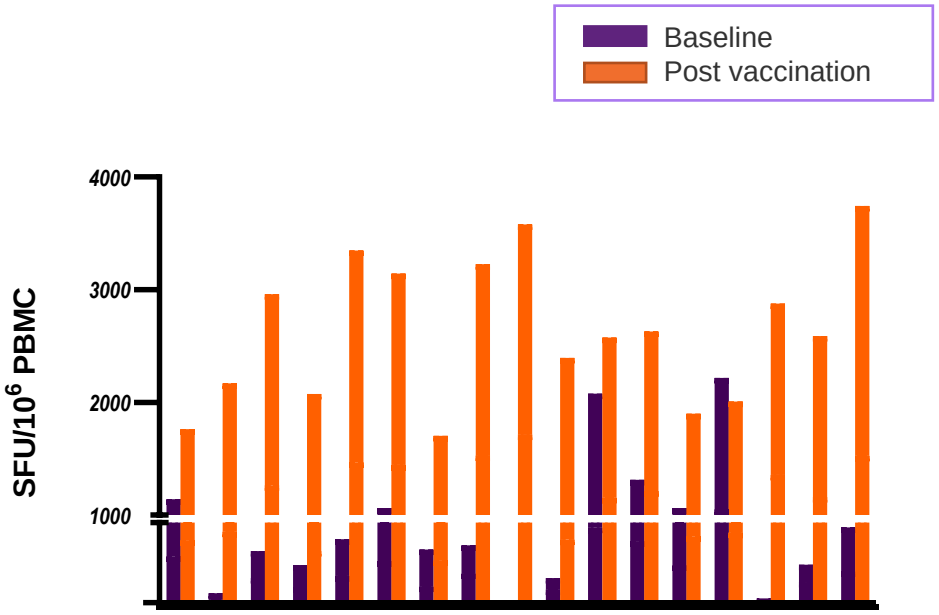
VB10.16: homologous booster dose induced strong T cell responses in all patients in the expansion cohort

- The vaccination regimen from cohort 1 (Q3W) plus a booster vaccination at W16 was introduced in the Expansion Cohort to make sure at patients could have a strong T cell response
- All patients in the expansion cohort achieved a strong T cell response (>650 SFU/mill)

HOMOLOGOUS BOOST ENSURE STRONG AND LONG-LASTING T CELL RESPONSE

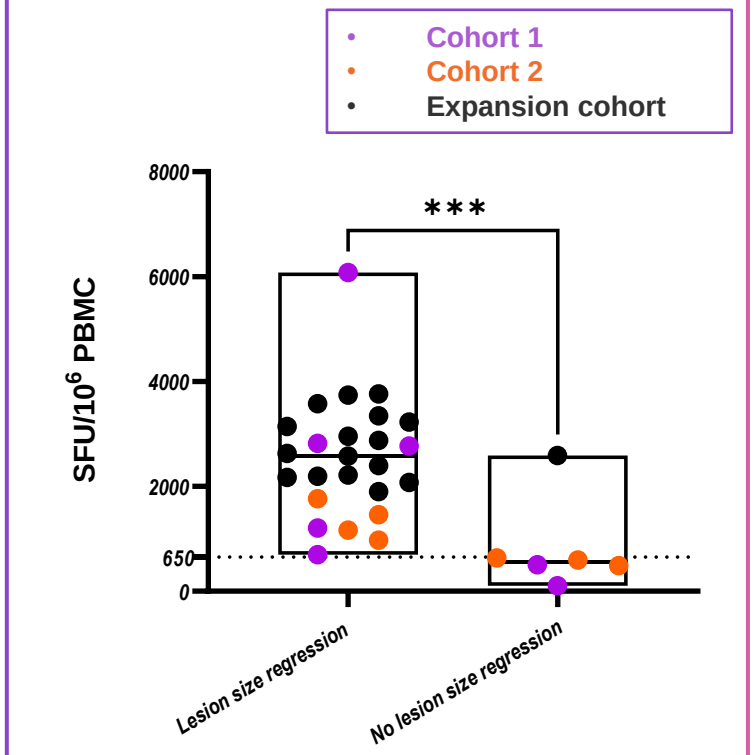


STRONG HPV16-SPECIFIC T CELL REPSONSES IN ALL PATIENTS IN THE EXPANSION COHORT

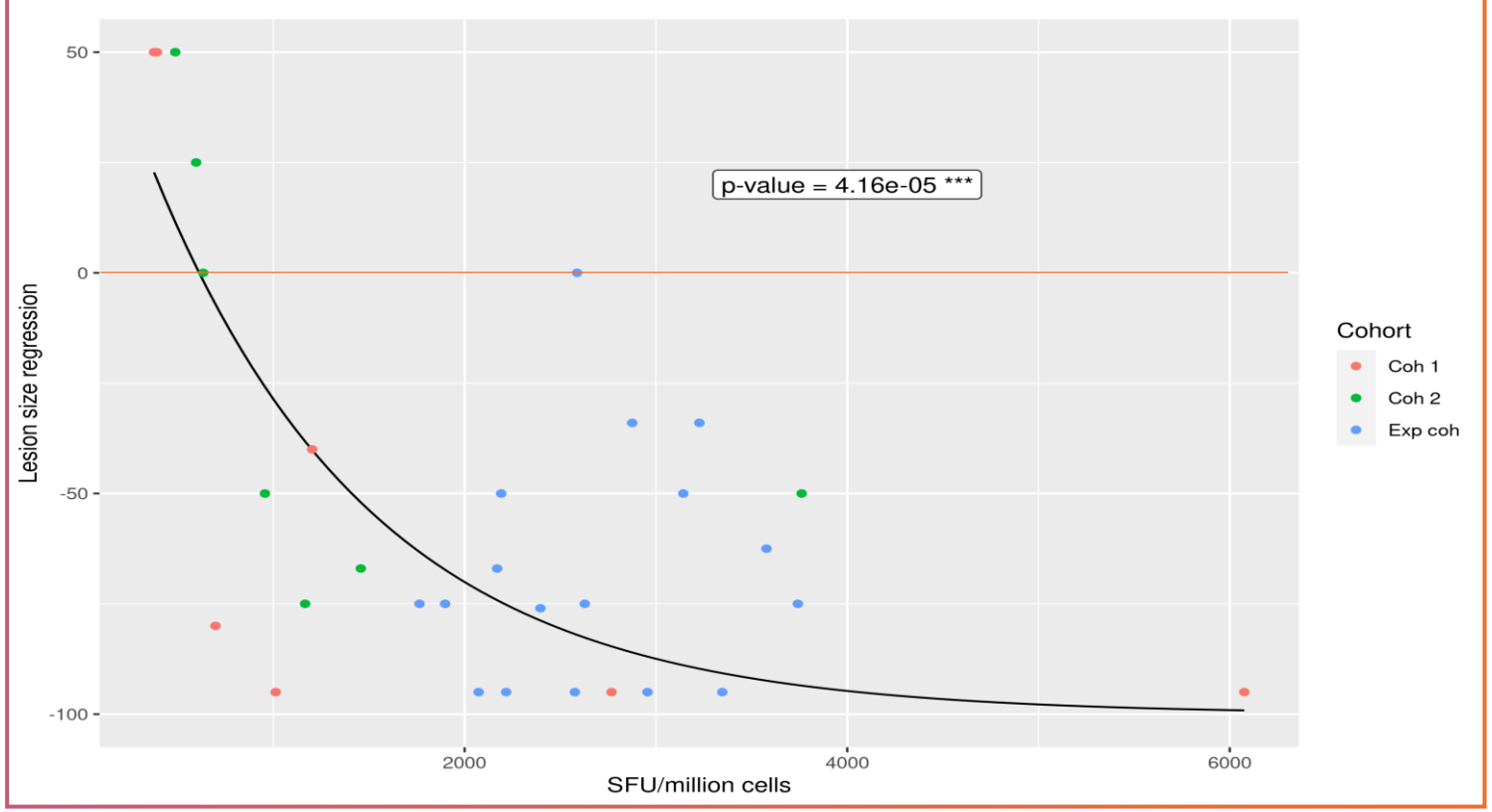


VB10.16: highly significant correlation between vaccine induced HPV16-specific T cell responses and lesion size across all cohorts

LESION SIZE REGRESSION CORRELATES WITH HPV-16 SPECIFIC RESPONSES



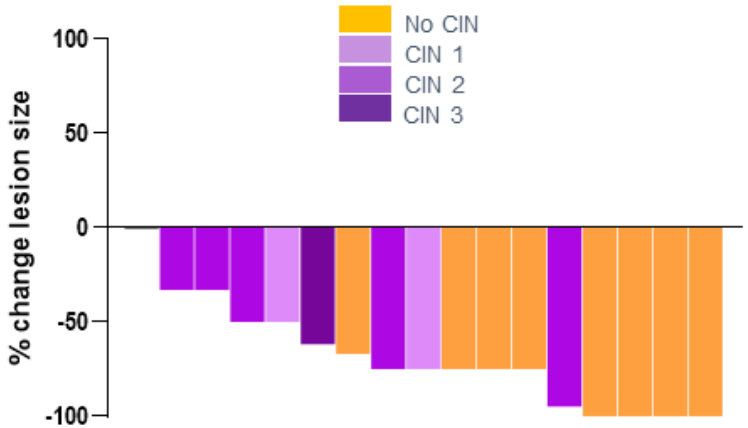
SIGNIFICANT CORRELATION OBSERVED WITH % LESION SIZE REDUCTION AND # SFU/MILL



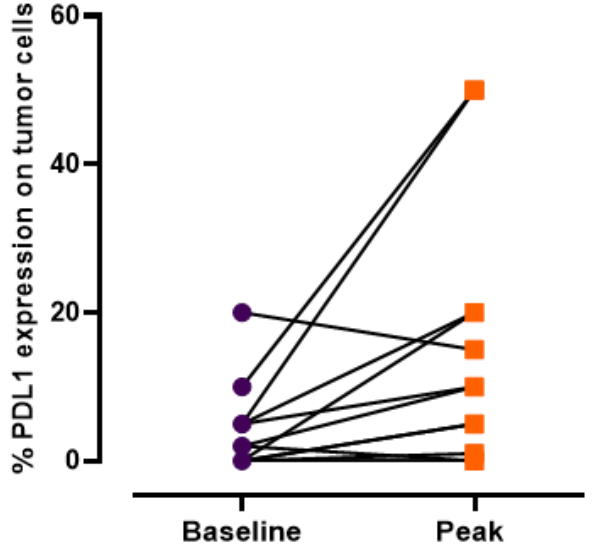
Promising clinical data as monotherapy in pre-cancerous lesions

- Lesion size reduction observed in majority of subjects (16 of 17) in the Expansion cohort
- CIN regression to CIN1 or no CIN in 10 subjects
- HPV16 and/or p16 clearance in 8 subjects
- Upregulation of PD-L1 in lesions post-vaccination - scientific rationale for combination with anti-PD(L)1 inhibitor in HPV16+ cancers

LESION SIZE REDUCTION AND CIN REGRESSION



UPREGULATION OF PD-L1 POST VACCINATION



Peak indicate PD-L1 expression at 16 or 24 weeks after first vaccination