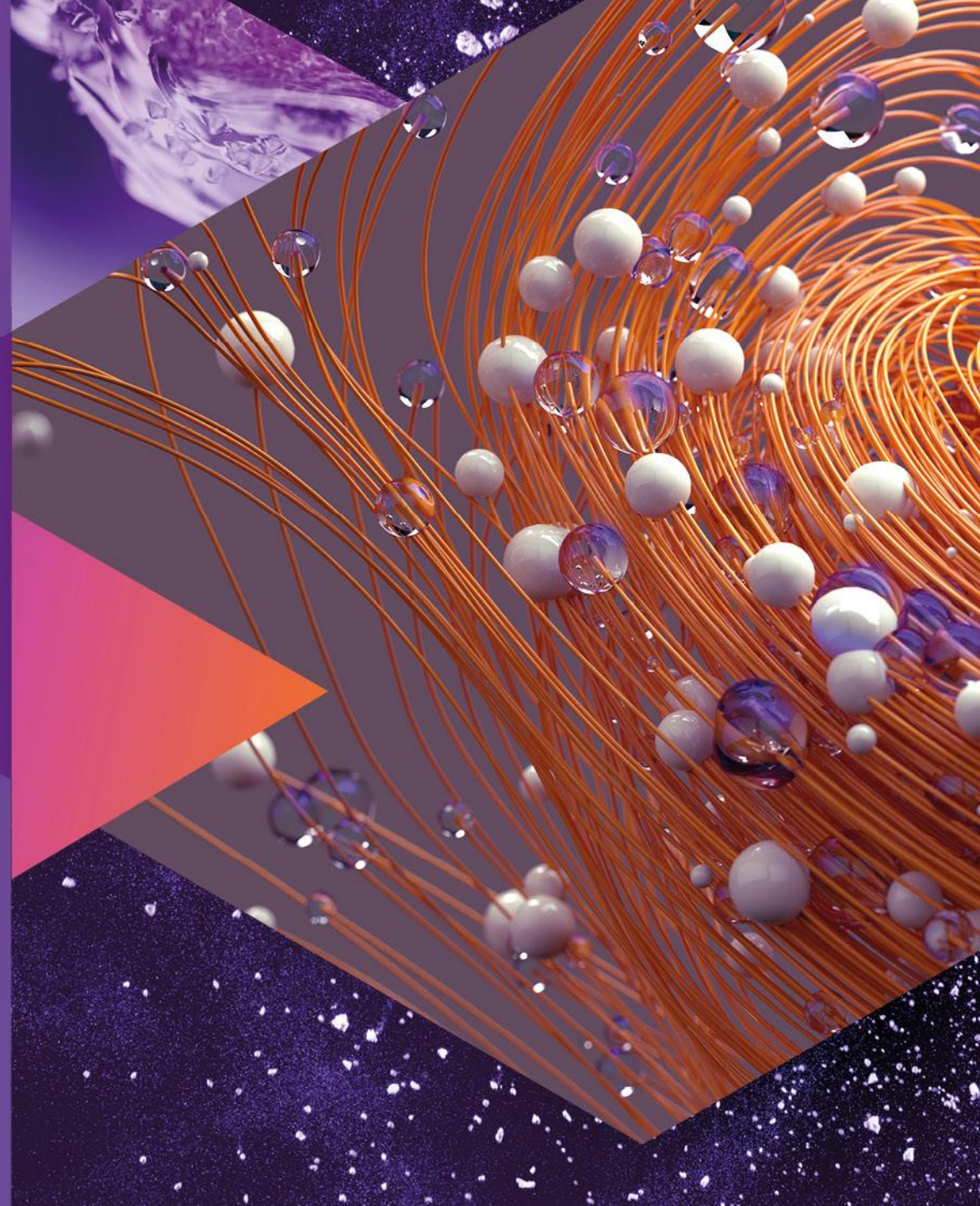
nykode therapeutics

CAPITAL MARKETS DAY

Thompson Central Park New York
September 20, 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.

01 Welcome & opening remarks

Michael Engsig,
Chief Executive Officer

Present today

MICHAEL ENGSIG

Chief Executive Officer

AGNETE FREDRIKSEN

Chief Business Officer & Co-founder

MIKKEL W. PEDERSEN

Chief Scientific Officer

KLAUS EDVARDSEN

Chief Development Officer

HARALD GURVIN

Chief Financial Officer

BRADLEY J. MONK

M.D., Ph.D

Global leader in antigen presenting cell (APC)-targeted immunotherapy technology

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

Differentiated immunotherapies targeting antigens to Antigen-Presenting Cell (APC) to direct tailor-made immune responses with focus on oncology and autoimmune diseases

Strategic partnerships with top tier US biopharma companies[1]

Genentech
A Member of the Roche Group

REGENERON

Oncology Platform validated and de-risked through strong durability and survival data

- Focused strategy to rapidly progress lead asset VB10.16 towards patients and markets in cervical cancer and head & neck cancer. Potential fast to market opportunity in advanced cervical cancer
- Significant further commercial upside in early stage/adjuvant settings supported by Nykode data generated to date

Autoimmune disease constitute a potential new therapeutic vertical

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

1. 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

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.

Modular vaccine technology allows APC-targeting to direct immune responses

DNA plasmid encoding Nykode vaccine

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

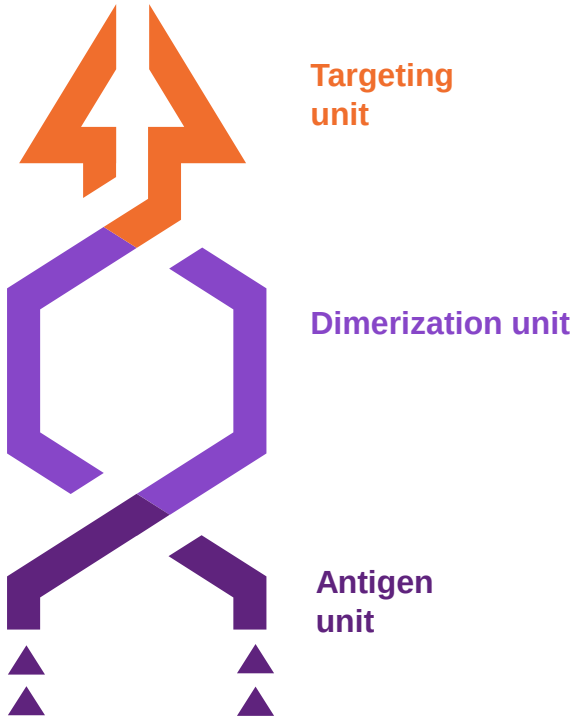
Antigens of choice from cancer, viruses, bacteria, parasites or autoimmune disease

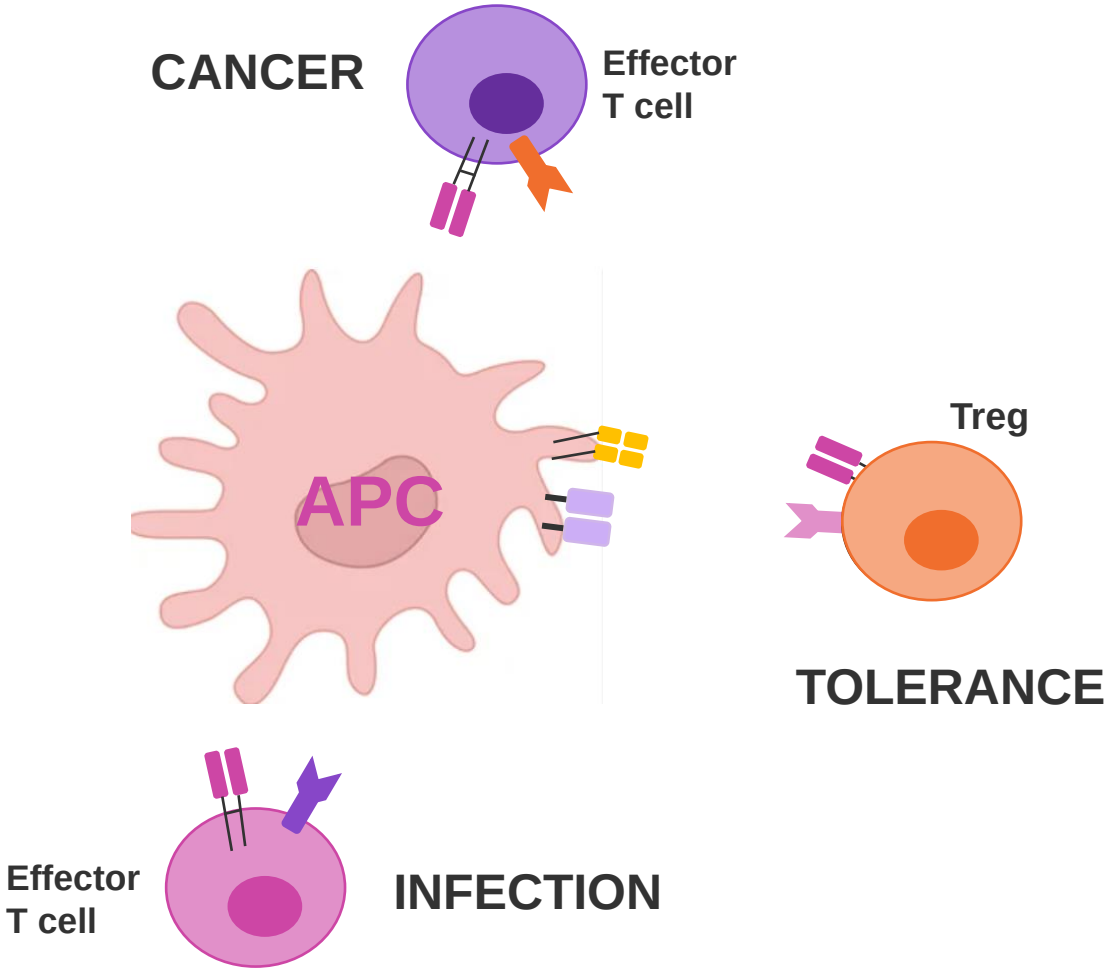
Nykode's immunotherapy candidates may be delivered through DNA, mRNA, viral vectors or as recombinant proteins

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

APCs determines the immune response to the antigen by presenting antigens to different effector T cells

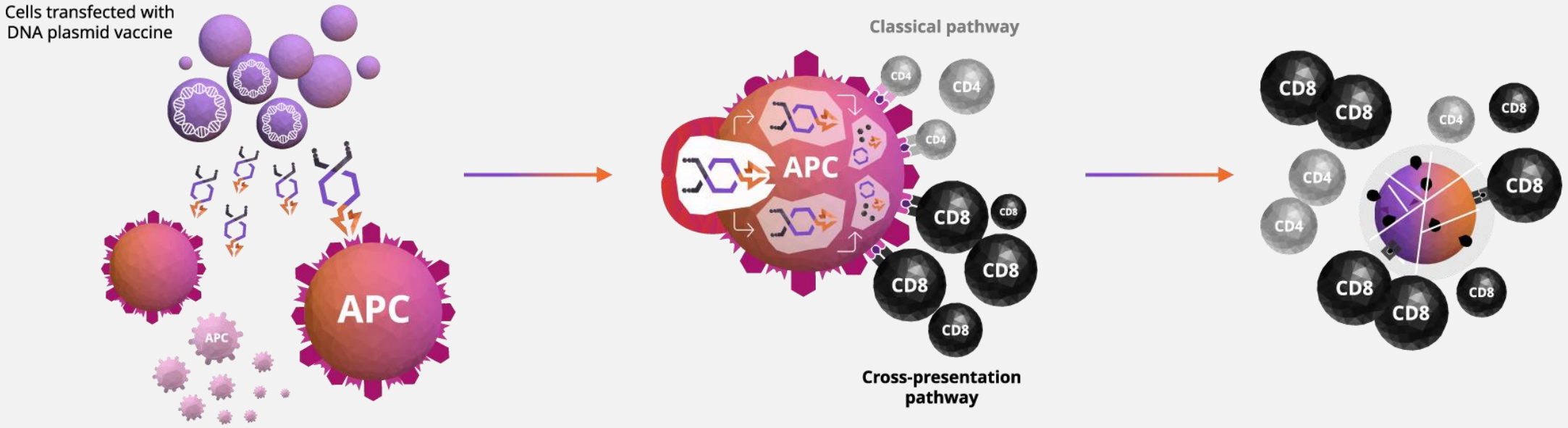
Nykode's APC targeted technology make sure the antigen is delivered to the selected subset of APCs and are presented to the desired T cells





Nykode's cancer vaccine platform 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.

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

On the agenda today

Update on VB10.16 program
- Additional immune response data supporting development strategy
- Layout of ambitious VB10.16 development program

Evolving treatment paradigm for advanced cervical cancer and VB10.16 C-04 trial design conducted in collaboration with GOG

VB10.NEO update
- Additional supportive immune response data

Research and innovation update
- Platform strength and optimization
- Nykode's novel approach to addressing autoimmune disorders
- Discovery pipeline including Regeneron collaboration

Nykode business model
- De-risked and validated oncology platform
- Leveraging Nykode's unique technology developing additional platforms to drive further shareholder value

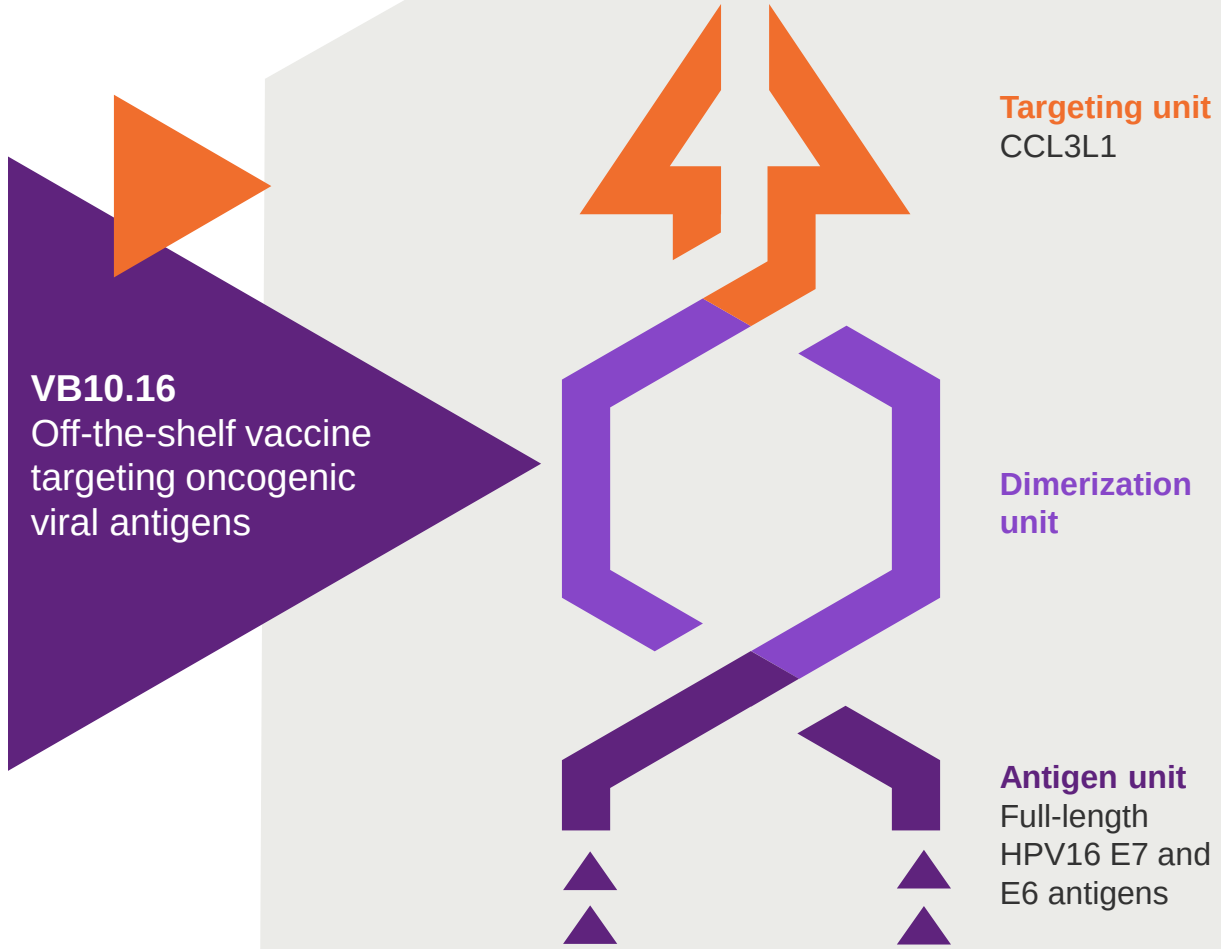
02 VB10.16 program update

Klaus Edvardsen,
Chief Development Officer

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



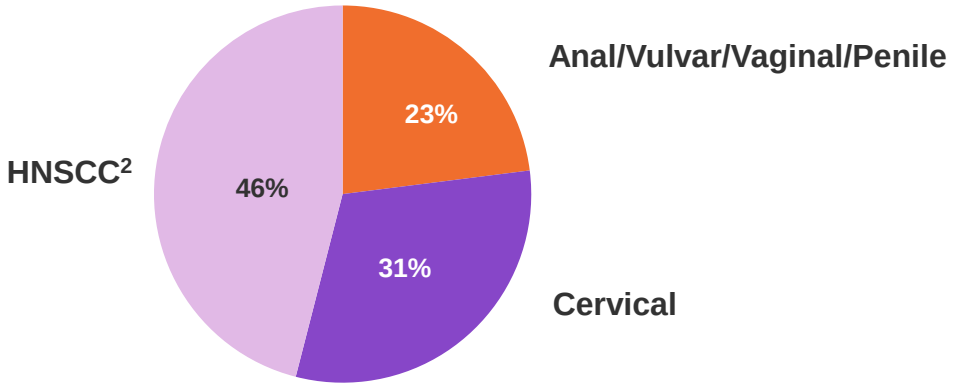
HPV+ cancer incidence is expected to increase despite prophylactic HPV vaccination

HPV16+ cancers are a significant unmet need

HPV+ cervical cancer

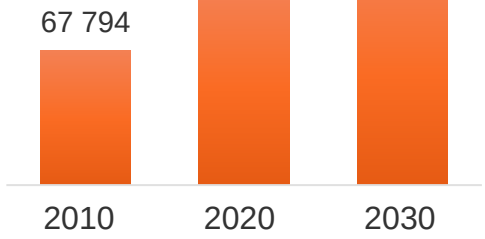
- 4th most common cancer in women worldwide
- 4th leading cause of cancer-related death
- Prognosis is poor for recurrent and/or metastatic (R/M) cervical cancers, 5-year survival <5%

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

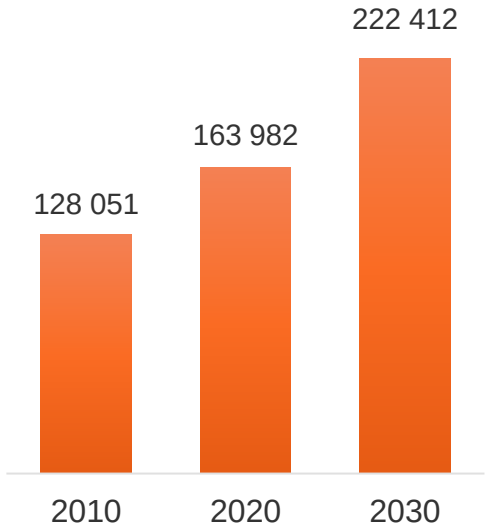


HPV-related cancer incidence is expected to grow

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



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

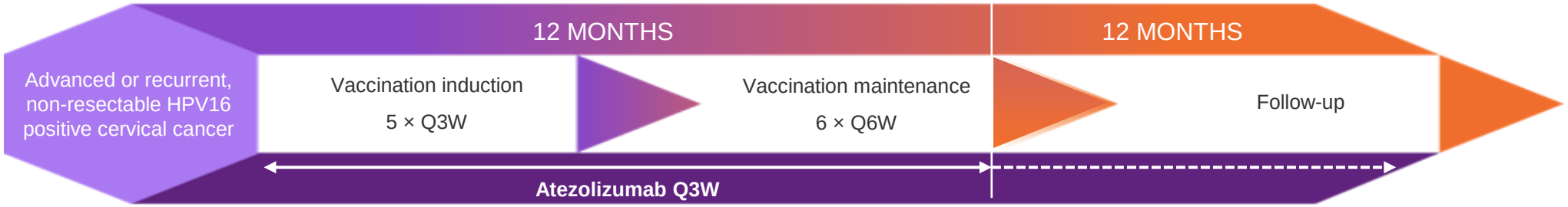


Sources and notes: [1] HPV information centre https://hpvcentre.net/statistics/reports/XEX.pdf?t=1680531103948; American Cancer Society, Cancer Facts & Figures 2020 https://www.cancer.org/; Head Neck Pathol. 2012; 6:55; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3394159/; J Natl Cancer Inst. 2015 Jun; 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

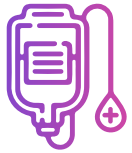
A Multi-Centre, Single Arm, Open-label Phase 2a Trial of the Combination of VB10.16 and atezolizumab in Patients with Advanced or Recurrent, Non-resectable HPV16 Positive Cervical Cancer (NCT04405349)

- **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



Chemotherapy[1]

★

KEYTRUDA® (pembrolizumab) Injection 100 mg

KEYTRUDA® [2]

★

LIBTAYO® (Cemiplimab)

Libtayo[1]

★

TIVDAK[3]

★

Significant unmet need for further improved survival outcomes with well-tolerated treatment alternatives

	Chemotherapy[1]	KEYTRUDA® [2]	Libtayo[1]	TIVDAK[3]
		PD-L1+	PD-L1+	
mOS	8.5mo	11.0mo	13.9mo	12.1mo
mPFS	2.9mo	2.1mo	3.0mo	4.2mo

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 ((TAP > 5%; equals CPS 1)

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

VB10.16 generally well-tolerated

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%)	–

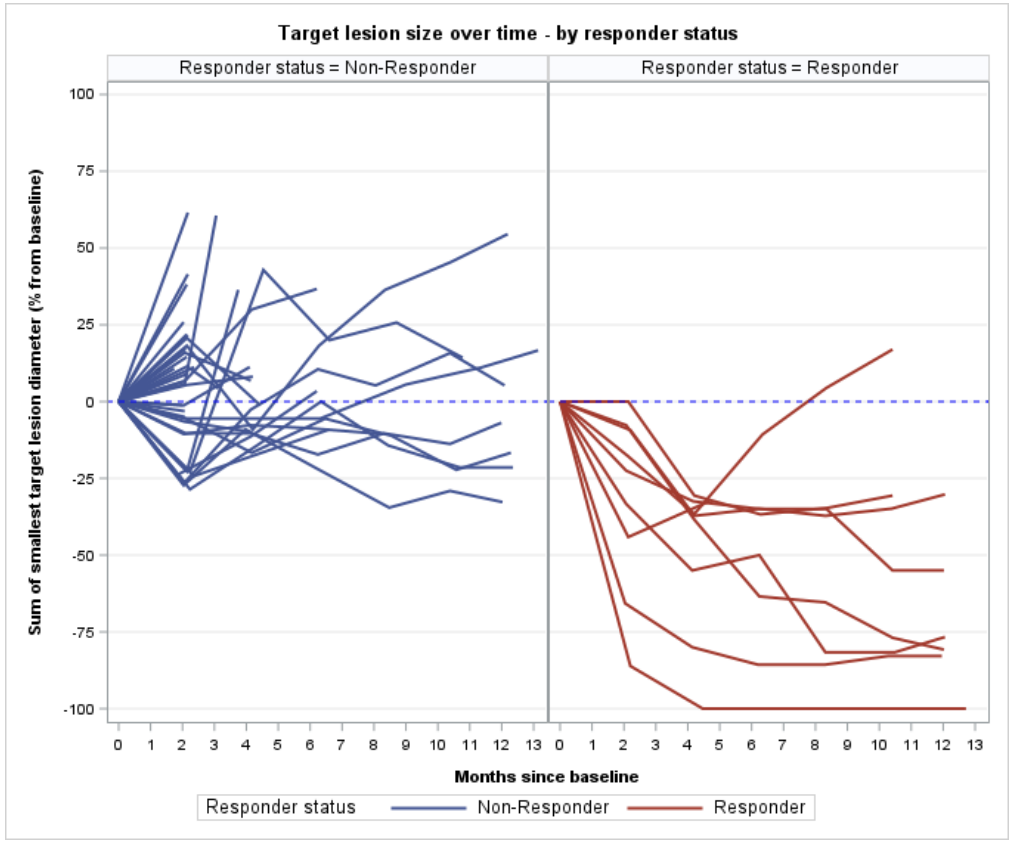
VB10.16 in combination with atezolizumab was generally well-tolerated and showed a favourable tolerability profile

- 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

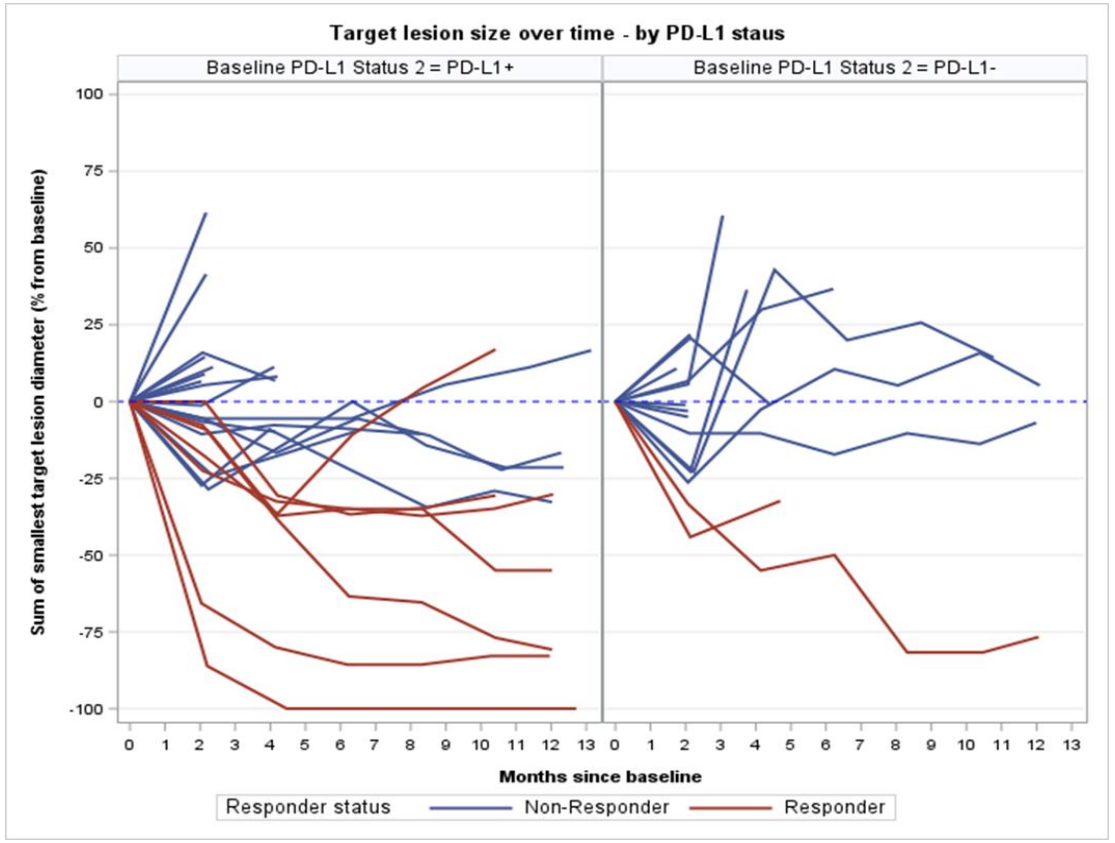
Note: 52 patients were included in the safety population; Median number of VB10.16 doses given was 5 (range 1-11); AE = adverse event; [1] Tabernero et al. Phase II multicohort study of atezolizumab monotherapy in multiple advanced solid cancers. ESMO Open. 2022.

VB10.16 coupled with CPI led to durable 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

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).

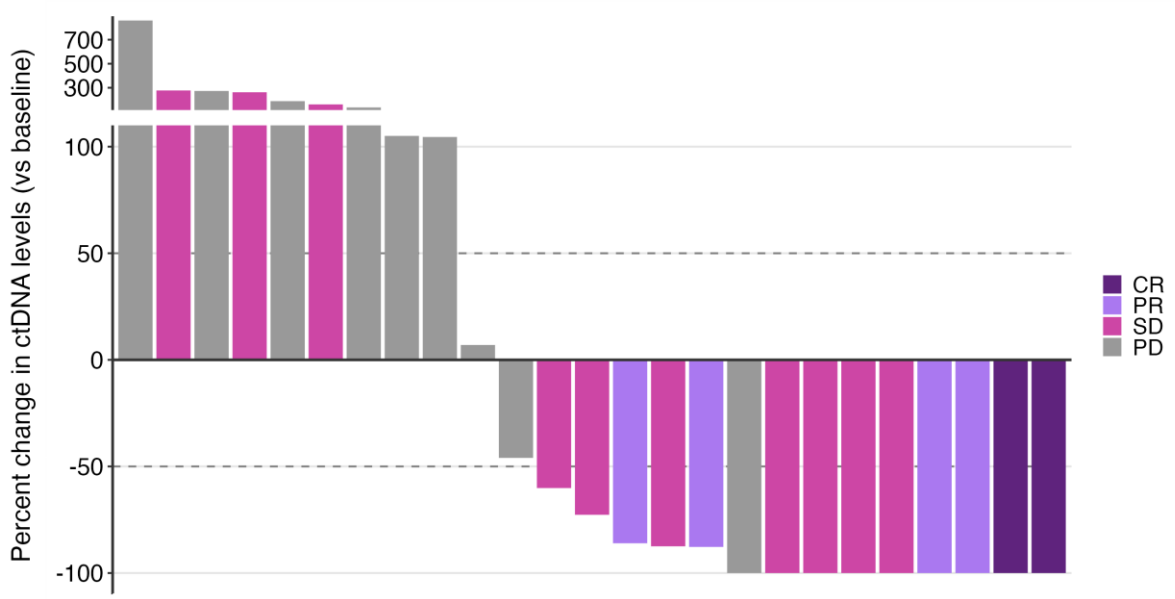
C-02 data supports patient population selection for potentially registrational study

- 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.

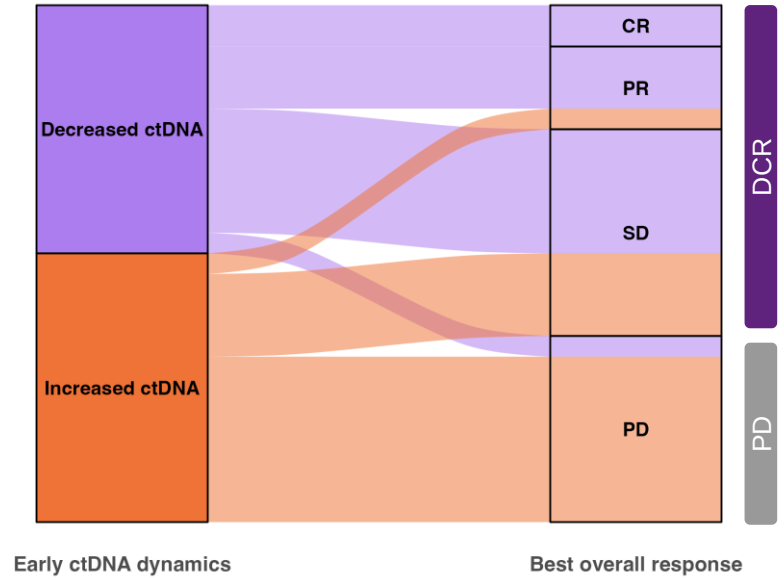
HPV16 circulating tumor DNA dynamics is associated with clinical response

ALL PATIENTS WITH CLINICAL RESPONSE PER RECIST 1.1 HAVE MOLECULAR RESPONSE



All patients with PR and CR have >50% reduction in ctDNA as best molecular response

EARLY CTDNA DYNAMICS (WEEK 9-11) ASSOCIATED WITH IMPROVED CLINICAL OUTCOME



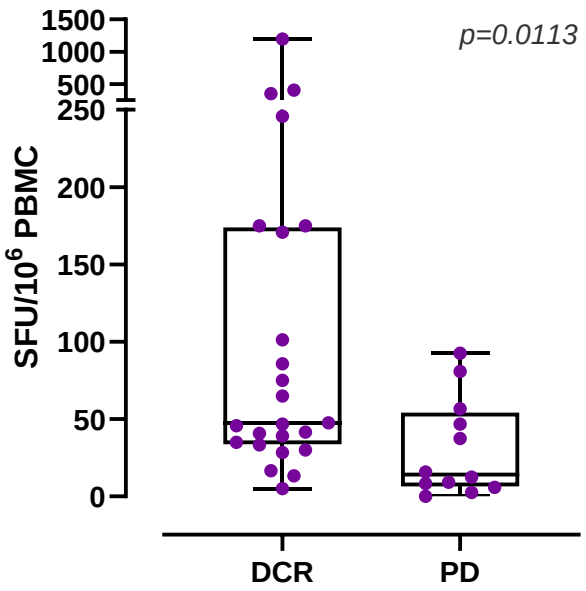
	Increase	Decrease
Disease control N=16	5 (31%)	11 (69%)
PD N=9	8 (89%)	1 (11%)

Fisher's exact test p = 0.011

n=25 patients with detectable ctDNA at baseline and available on-treatment sample
Molecular response defined as >50% decrease in HPV16 ctDNA level
Early ctDNA dynamics is defined as increase or decrease at week 9-11 from baseline

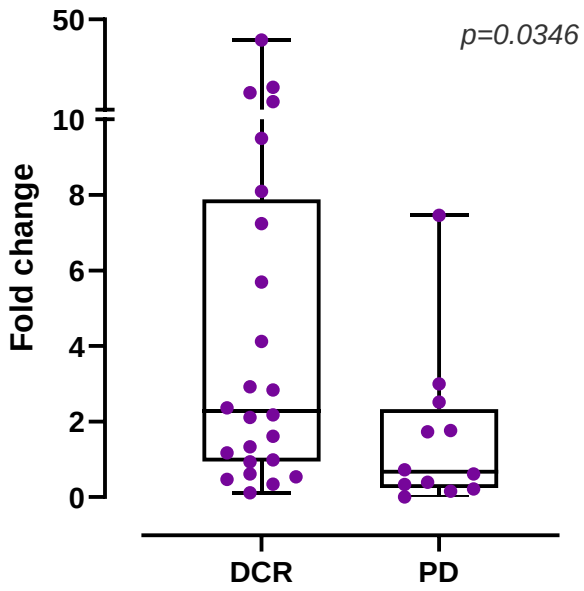
VB10.16 induced HPV16-specific T cell responses that are significantly correlated with clinical response

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



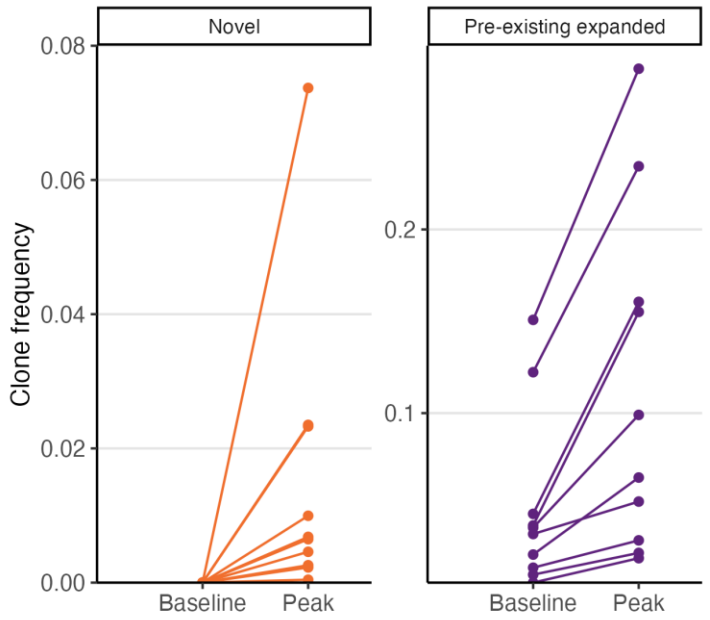
Fold change, baseline to peak count post-treatment

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

T cell responses remain strong and long-lasting

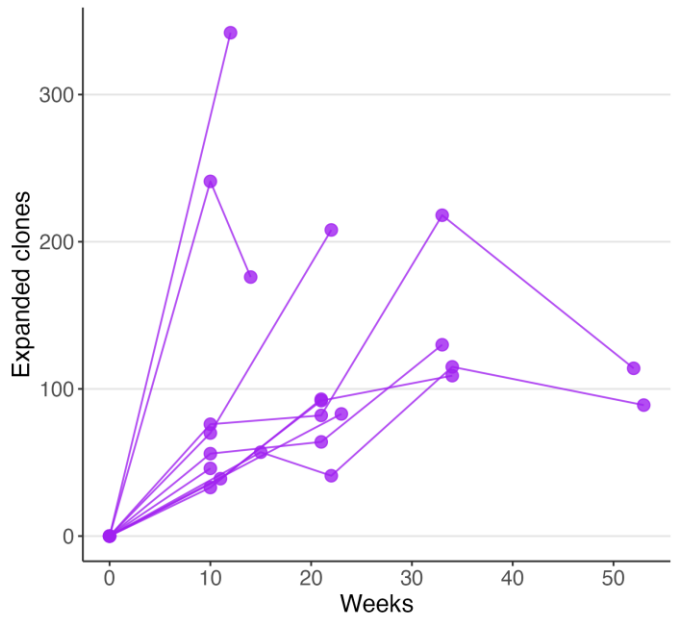
T cell clonotype analysis

EXPANSION OF NOVEL AND EXPANDED CLONES ON TREATMENT



- **Novel expanded clones constituted a median of 0.66% of the peripheral T cell pool at peak, ranging from 0.04% to 7.4 %**

RAPID AND PERSISTENT EXPANSION OF T CELL CLONES



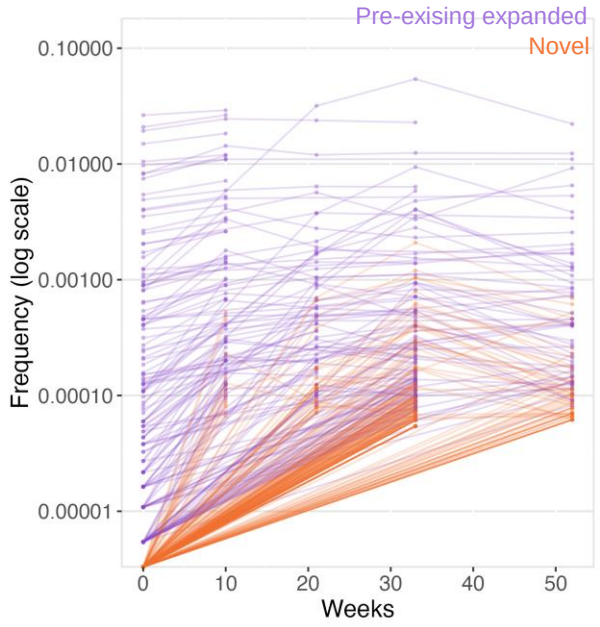
- **Rapid and persistent on-treatment T cell expansion**
- **Peak expansion of 46-342 clonotypes in 10 patients**

Sequencing of T cell receptors in PBMC from 10 patients by ImmunoSEQ. Left: peak was defined as the visit with the highest number of uniquely expanded clones. Summed frequency at peak was calculated by adding up clone frequencies of the expanded clones at this visit. Summed frequency at baseline was calculated for the same clones. Right: line plot shows the number of uniquely expanded clones at each visit in pairwise comparisons versus baseline.

Patient case: longitudinal T cell clonal expansion

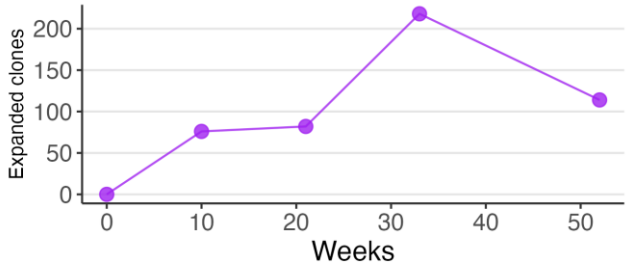
Persistent expansion of novel and pre-existing clones throughout the treatment

FREQUENCY OF EXPANDED CLONOTYPES



Each dot represents a unique T cell clone significantly expanded from baseline

NUMBER OF EXPANDED CLONES



- A persistent expansion of novel and pre-existing clones throughout the treatment period
- Novel and pre-existing HLA class I-restricted clones were identified by the HPV16 TMAP database, verified as HPV16-specific CD8 T cell clones

Sequencing of T cell receptors in PBMC by ImmunoSEQ. Left: the frequency of expanded clones at each visit in pairwise comparisons versus baseline. Only frequencies of significantly expanded clones are shown. Right: the number of uniquely expanded clones in pairwise comparisons versus baseline. HPV16-specific CD8 T cell clones were identified by the HPV16 TMAP database (Adaptive Biotechnologies)

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
- VB10.16 induced HPV-16 specific T cell responses that are significantly correlated with clinical response
- TCR sequencing supports functional assay showing treatment induced expansion of T cells

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.

VB10.16 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

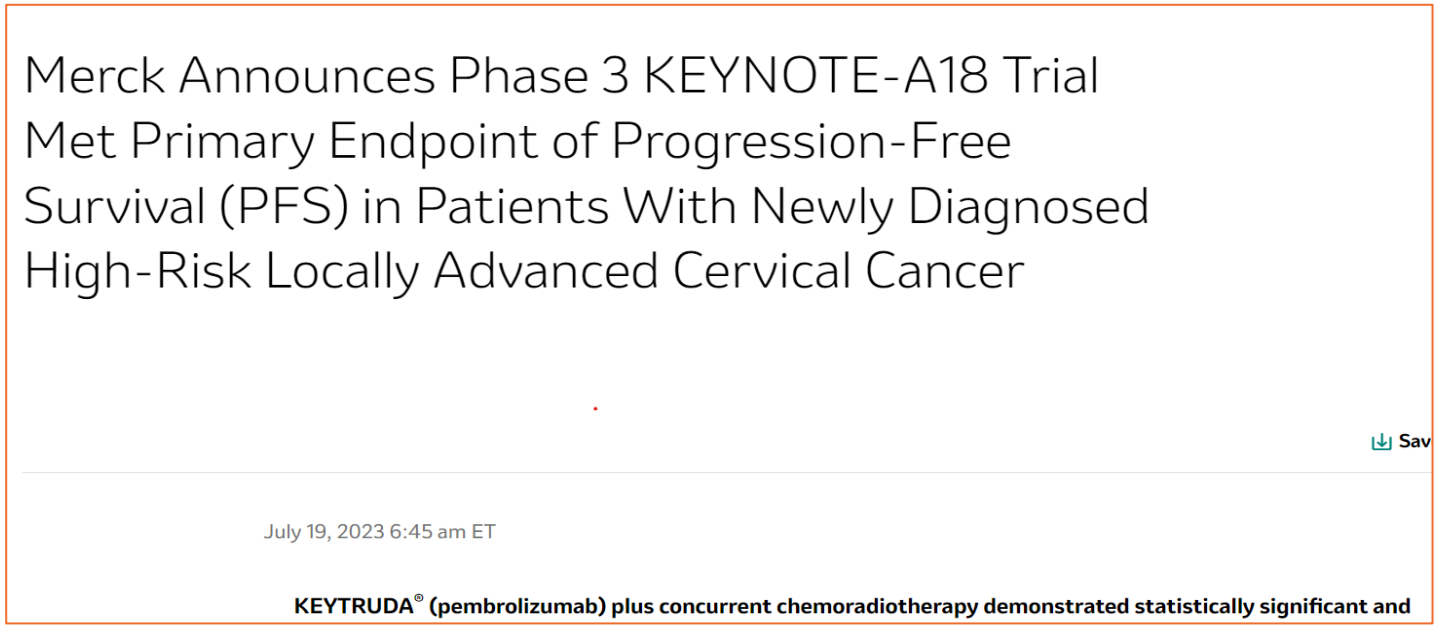
- VB10.16 in combination with immune checkpoint inhibitor
- FDA approval of IND
- Potentially **registrational trial** in the U.S.
- Collaboration with GOG
- Recurrent/ metastatic cervical cancer and PD-L1+ tumors
- First patient dosed, expected Q4 2023

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

Locally advanced cervical cancer represents a new opportunity for immunotherapy



Merck Announces Phase 3 KEYNOTE-A18 Trial Met Primary Endpoint of Progression-Free Survival (PFS) in Patients With Newly Diagnosed High-Risk Locally Advanced Cervical Cancer

Sav

July 19, 2023 6:45 am ET

KEYTRUDA® (pembrolizumab) plus concurrent chemoradiotherapy demonstrated statistically significant and

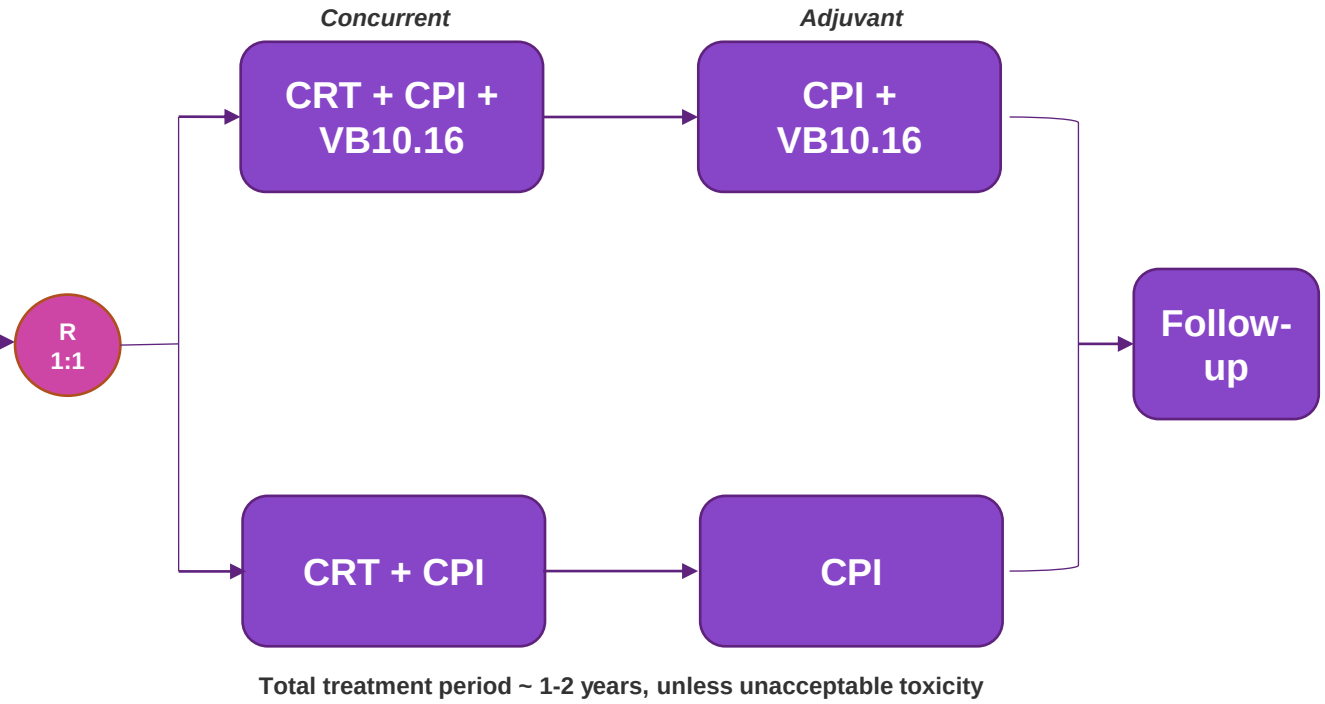
VB C-05: VB10.16+CPI as concurrent treatment to CRT in Locally Advanced Cervical Cancer

Randomized Phase 2 PoC trial in a HPV16+ LACC setting

HPV 16+ High-risk locally advanced cervical cancer (FIGO 2018) defined as stage III-IVA

Histologically-confirmed squamous cell carcinoma, adenocarcinoma, or adenosquamous carcinoma of the cervix

Has not previously received any definitive surgical, radiation or systemic therapy for cervical cancer



Primary endpoint
PFS and OS

Secondary endpoints
Landmark PFS 18mo, OS 36mo. ORR, DCR, PFS/OS PD-L1+, PFS2, DOR
Safety, QoL(ph3)

Exploratory endpoints
ctDNA level changes
HPV T cell response

Potential IA landmark analysis at 12 mo PFS

03 The treatment landscape for cervical

Bradley J. Monk, MD
Director, GOG

Professor, Division of Gynecologic Oncology
University of Arizona College of Medicine
Creighton University School of Medicine
Phoenix, USA

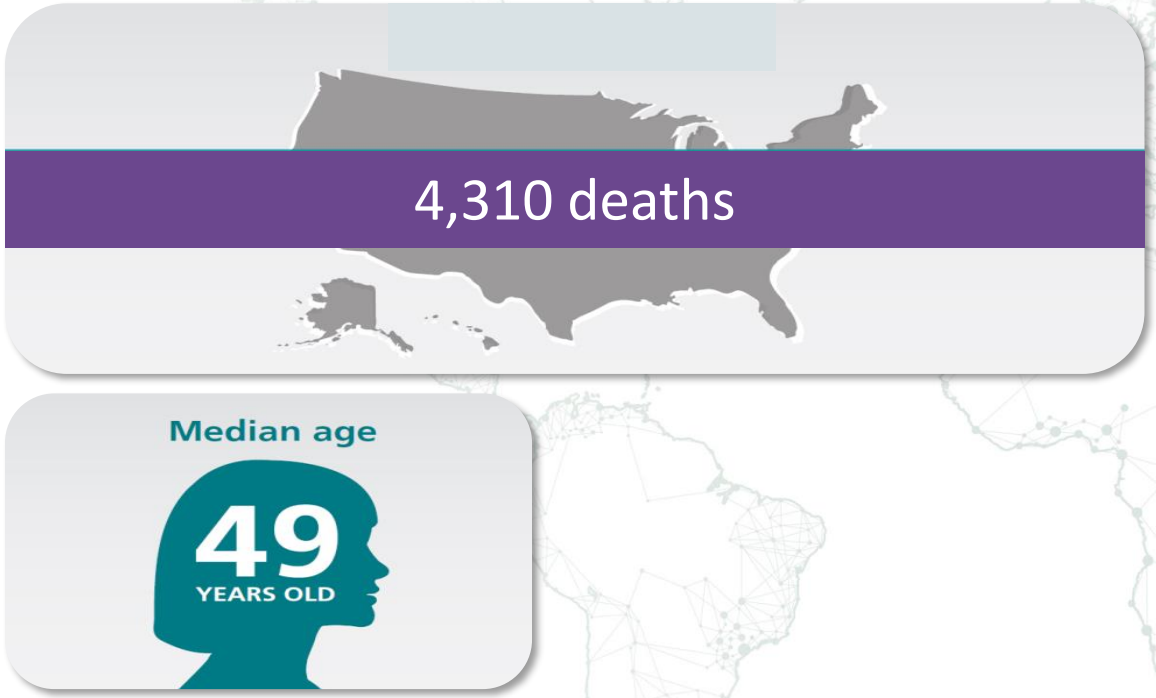
Director, Principal Investigator, Community Research Development, HonorHealth Research Institute

Vice President and Member Board of Directors GOG-Foundation
Director GOG-Partners

I have the following financial relationships with ACCME defined ineligible companies to report over the past 24 months:

Cancer Type	Commercial Interest	What was received	Role
Cervical	Agenus	Honorarium	Consultant
Cervical	Akeso Bio	Honorarium	Consultant
Cervical, uterine, ovarian	AstraZeneca	Honorarium	Speaker/Consultant
Cervical	EMD Merck	Honorarium	Consultant
Cervical, uterine, ovarian	Genmab/Seagen	Honorarium	Consultant
Cervical, uterine, ovarian	GOG Foundation	Honorarium	Consultant
Cervical	Iovance	Honorarium	Consultant
Ovarian	Macrogenics	Honorarium	Consultant
Cervical, uterine, ovarian	Merck	Honorarium	Speaker/Consultant
Cervical	Puma	Honorarium	Consultant
Cervical	Regeneron	Honorarium	Consultant
Cervical, ovarian	Roche/Genentech	Honorarium	Speaker/Consultant
Cervical, uterine, ovarian	TESARO/GSK	Honorarium	Speaker/Consultant
Cervical, uterine, ovarian	US Oncology Research	Honorarium	Consultant and Investigator

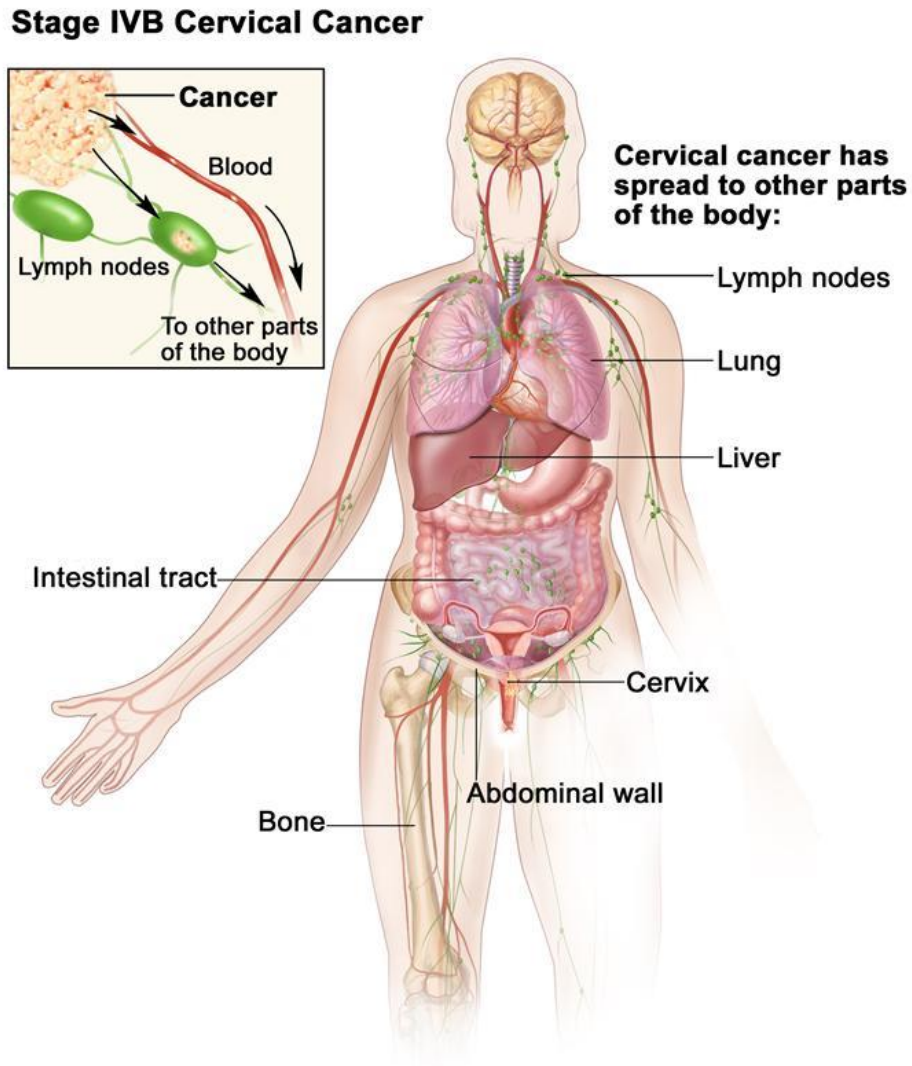
An Estimated 13,960 Cases of Invasive Cervical Cancer in the US in 2023[2]



- ✓ **Death rate in 2016 (2.2 per 100,000) was less than half that in 1975 (5.6 per 100,000)**
- ✓ **From 2007 to 2016, the death rate decreased by about 1% per year in women >50 years of age and older, but was stable in <50**

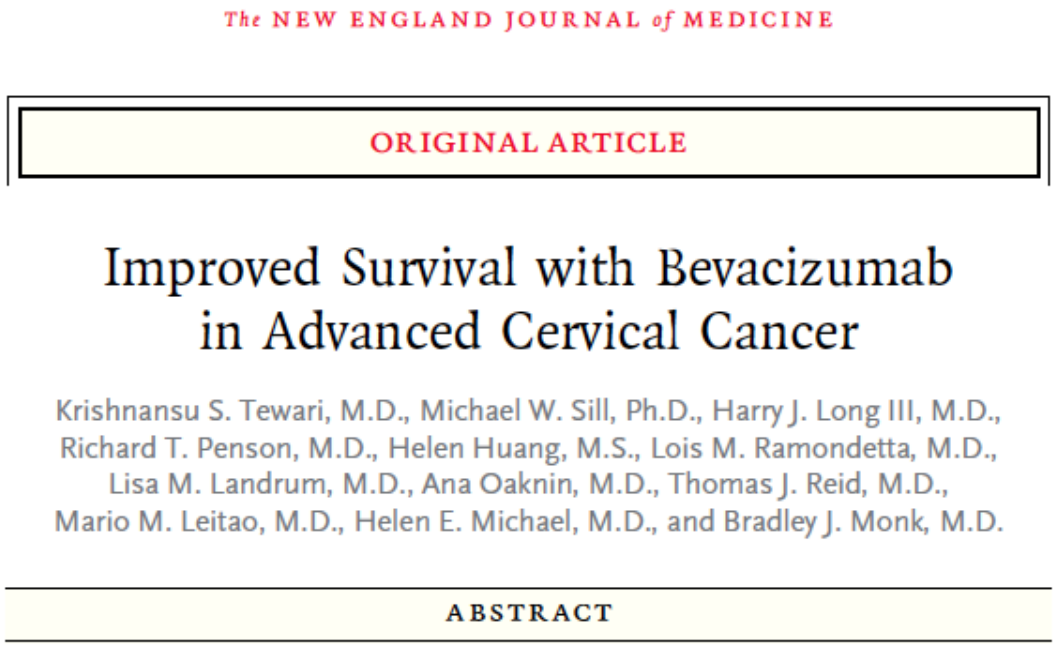
1) Cancer statistics, 2023. Rebecca L. Siegel et al. First published: 12 January 2023. CA: A Cancer Journal for CliniciansVolume 73, Issue 1 p. 17-48
https://doi.org/10.3322/caac.21763

Advanced/Recurrent Cervical Cancer:
A HIGH UNMET CLINICAL NEED!



Winslow T. www.aacrfoundation.org/CancerTypes/Pages/PDQs/Cervical-Cancer-Treatment-PDQ.aspx. Accessed 15 January 2018.

First Targeted Agent Approved in a Gynecologic Cancer: 3rd Landmark Discovery


The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Improved Survival with Bevacizumab in Advanced Cervical Cancer

Krishnansu S. Tewari, M.D., Michael W. Sill, Ph.D., Harry J. Long III, M.D., Richard T. Penson, M.D., Helen Huang, M.S., Lois M. Ramondetta, M.D., Lisa M. Landrum, M.D., Ana Oaknin, M.D., Thomas J. Reid, M.D., Mario M. Leitao, M.D., Helen E. Michael, M.D., and Bradley J. Monk, M.D.

ABSTRACT


THE LANCET

Bevacizumab for advanced cervical cancer: final overall survival and adverse event analysis of a randomised, controlled, open-label, phase 3 trial (Gynecologic Oncology Group 240)

Krishnansu S Tewari, Michael W Sill, Richard T Penson, Helen Huang, Lois M Ramondetta, Lisa M Landrum, Ana Oaknin, Thomas J Reid, Mario M Leitao, Helen E Michael, Philip J DiSaia, Larry J Copeland, William T Creasman, Frederick B Stehman, Mark F Brady, Robert A Burger, J Tate Thigpen, Michael J Birrer, Steven E Waggoner, David H Moore, Katherine Y Look, Wui-Jin Koh, Bradley J Monk

1-L Bevacizumab Approved by FDA on August 14, 2014

Tewari KS et al. *N Engl J Med*. 2014;370(8):734-743.

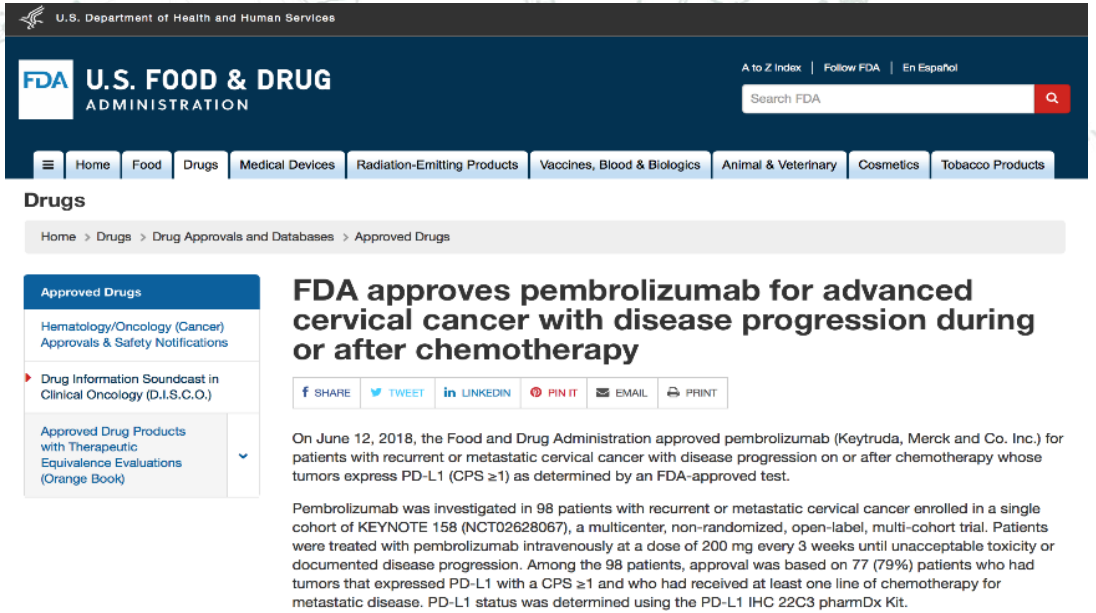
Tewari KS et al. *Lancet*. 2017;390(10103):1654-1663.

Second-Line Approval of Pembrolizumab for CPS ≥1

- US FDA Accelerated Approval of Pembrolizumab

- First Immunotherapy Approval for Cervical Cancer June 12, 2018
- Companion Diagnostic: PD-L1 IHC 22C3

PD-L1+ Cohort (CPS ≥ 1)	
Endpoint	N=77
ORR (95% CI)	14.3% (7.4-24.1)
Complete response	2.6%
Partial response 11.7	11.7
Median duration (mos)	Not reached (4. – 18.6+)
% with duration ≥ 6 mos	91%
Median follow-up (mos)	11.7 (0.6-22.7)



Chung HC, et al. J Clin Oncol 2019;37:1470-8

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Pembrolizumab for Persistent, Recurrent, or Metastatic Cervical Cancer

Nicoletta Colombo, M.D., Ph.D., Coraline Dubot, M.D., Domenica Lorusso, M.D., Ph.D., Valeria Caceres, M.D., Ph.D., Kosei Hasegawa, M.D., Ph.D., Ronnie Shapira-Frommer, M.D., Krishnansu S. Tewari, M.D., Pamela Salman, M.D., Edwin Hoyos Usta, M.D., Eduardo Yañez, M.D., Mahmut Gümüş, M.D., Mivael Olivera Hurtado de Mendoza, M.D., Vanessa Samouëlian, M.D., Ph.D., Vincent Castonguay, M.D., Alexander Arkhipov, M.D., Ph.D., Sarper Toker, M.D., M.B.A., Kan Li, Ph.D., Stephen M. Keefe, M.D., and Bradley J. Monk, M.D., for the KEYNOTE-826 Investigators*

N Engl J Med. 2021 Sep 18. doi: 10.1056/NEJMoa2112435. Online ahead of print.

Full Approval *Pembrolizumab and Line First Line*

FDA Approves Pembrolizumab Combination for the First-Line Treatment of Cervical Cancer

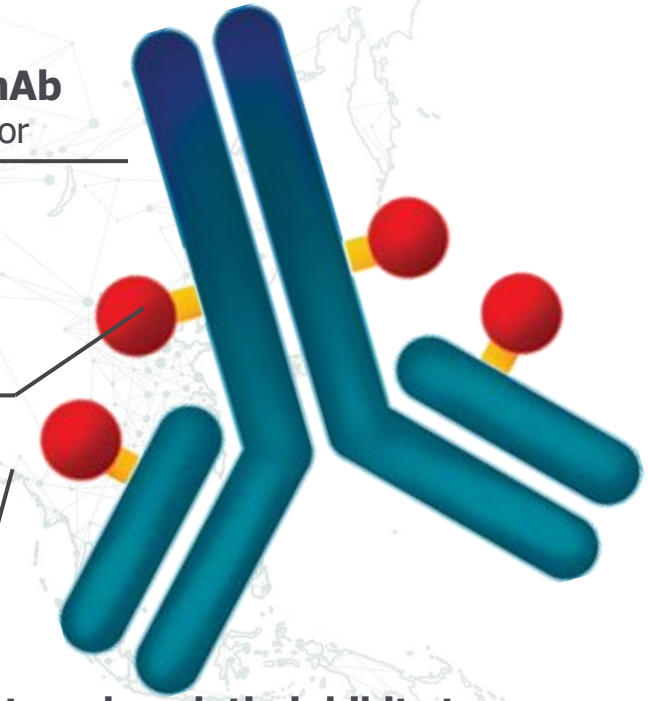
On October 13, 2021, the Food and Drug Administration approved pembrolizumab in combination with chemotherapy, with or without bevacizumab, for patients with persistent, recurrent, or metastatic cervical cancer whose tumors express PD-L1 (CPS≥1), as determined by an FDA-approved test.

https://www.fda.gov/drugs/resources-information-approved-drugs/fda-approves-pembrolizumab-combination-first-line-treatment-cervical-cancer. Accessed March 17, 2022.

1-L Bevacizumab Approved by FDA on October 13, 2021

Tisotumab Vedotin: (5th Landmark Discovery)

- Transmembrane receptor for coagulation factor VII/VIIa[a-c]:
  - Expressed on subendothelial vessel wall cells
- Normal physiological conditions[a-c]:
  - Central role in initiation of the extrinsic pathway of the coagulation cascade
- In oncogenesis[a-c]:
  - Role in tumor angiogenesis, proliferation, metastases, thrombotic events



The human anti-TF antibody of tisotumab vedotin inhibits tumor proliferation pathways with minimal impact on clotting cascade

Antigen[a]	Gynecologic malignancy	Expression frequency
Tissue factor	Ovarian cancer	23.8% to 100%
	Uterine cancer	100%
	Cervical cancer	**94% to 100%**

- mAb, monoclonal antibody; MMAE, Monomethyl auristatin E; TF, tissue factor.
Coleman R, et al. Presented at: ESMO 2020; September 19-21, 2020. Abstract LBA32.

a. Versteeg HH, et al. Semin Thromb Hemost. 2015;41:747-755; b. van den Berg YW, et al. Blood. 2012;119:924-932; c. Chu AJ. Int J Inflam. 2011;2011:367284; d. Forster Y, et al. Clin Chim Acta. 2006;364:12-21; e. Cocco E, et al. BMC Cancer. 2011;11:263; f. Ruf W, et al. J Thromb Haemost. 2011;9(Suppl 1):306-315; g. Jacobs, et al. J Clin Oncol. 2012;30(15_suppl; abstr e16022).

Bringing TV to the Clinic in 2-L

2-L TV Approved by FDA on September 20, 2021

EMPOWER-Cervical 1/GOG-3016/ENGOT-cx9 (2-L) (NCT03257267) Trial

Recurrent and metastatic cervical cancer resistant to platinum-based chemotherapy ≥ 2L

ECOG PS ≤ 1[a,b]

N = 608: 477 SCC, 131 AC

Stratified by:

- **Histology (SCC/AC)**
- **Geographic region**
- **Prior bevacizumab (Y/N)**
- **ECOG PS (0 vs 1)**

R 1:1

Cemiplimab, 350 mg Once every 3 wk via IV

IC chemotherapy

Options*:

- Pemetrexed 500 mg/m^2 Q3W IV
- Gemcitabine 1000 mg/m^2 IV on days 1 and 8 and every 21 days
- Topotecan 1 mg/m^2 daily IV for 5 days, every 21 days
- Irinotecan 100 mg/m^2 IV weekly × 4, followed by 10 to 14 days rest
- Vinorelbine 30 mg/m^2 IV on days 1 and 8 and every 21 days

Primary endpoint: OS

Secondary endpoints: PFS, ORR, DOR, safety, QOL

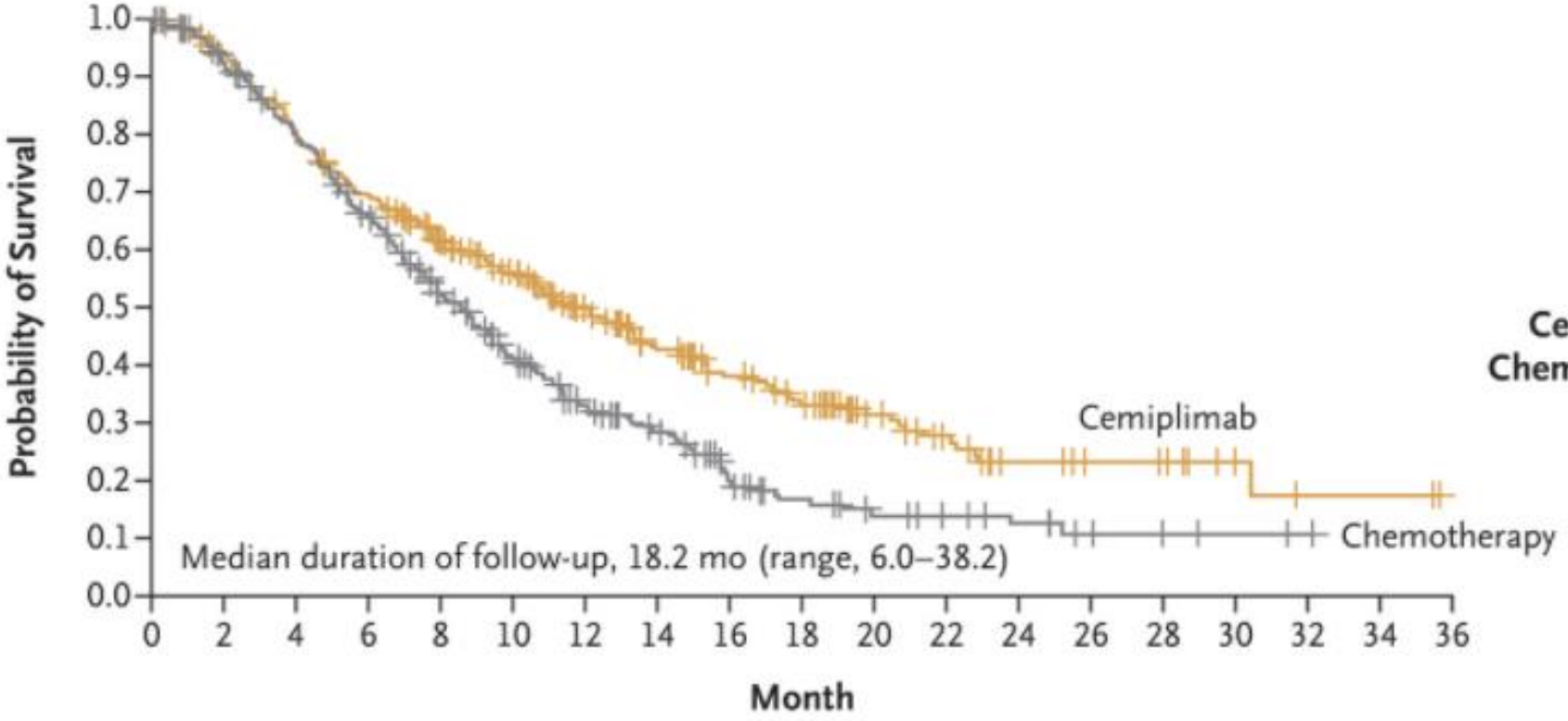
Exploratory endpoints: PK, immunogenicity, biomarkers, PD

- 2 interim analyses were prespecified per protocol
- At first interim analysis, IDMC recommended trial be continued
- At second interim analysis (85% of total OS events), IDMC recommended trial be stopped early for efficacy (presented here)

*Treat up to 96 wk with option for re-treatment; tumor imaging conducted on day 42 (+/- 7 d) of cycles 1 to 4, 6, 8, 10, 12, 14, and 16. Performed according to ENGOT model C.[a]
AC, adenocarcinoma; IDMC, Independent Data Monitoring Committee; IV, intravenous; PK, pharmacokinetics; QOL, quality of life; SCC, squamous cell carcinoma.
a. Vergote I, et al. Int J Gynecol Cancer. 2019;0:1-4; b. Tewari KS, et al. Presented at: ESMO 2021 Virtual congress; May 12-13, 2021. Abstract VP4-2021. N Engl J Med. 2022;386:544-555.

EMPOWER-Cervical 1/GOG-3016/ENGOT-cx9 (2-L) (NCT03257267) Trial

Overall Survival, All Patients



	No. of Patients	Median Overall Survival (95% CI)
		mo
Cemiplimab	304	12.0 (10.3–13.5)
Chemotherapy	304	8.5 (7.5–9.6)

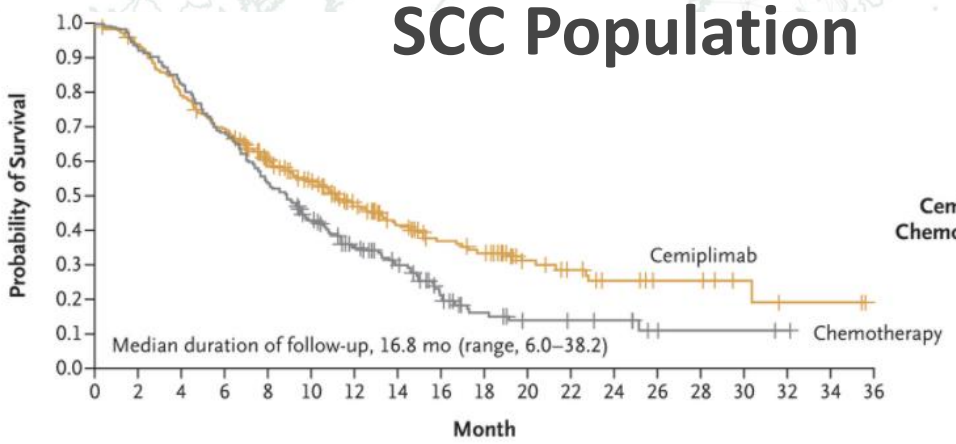
Hazard ratio for death, 0.69 (95% CI, 0.56–0.84)
Two-sided P<0.001

No. at Risk																			
Cemiplimab	304	281	236	206	167	139	110	83	65	52	35	26	13	10	9	4	2	2	0
Chemotherapy	304	264	224	183	132	99	70	54	32	22	15	12	9	5	3	2	1	0	0

Tewari KS, Monk BJ et al. N Engl J Med. 2022;386:544-555.

EMPOWER-Cervical 1/GOG-3016/ENGOT-cx9 (2-L) (NCT03257267) Trial

SCC Population



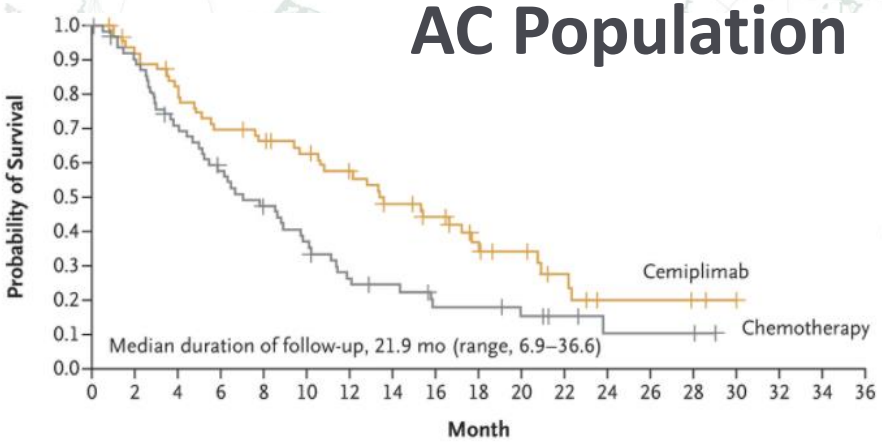
	No. of Patients	Median Overall Survival (95% CI)
		mo
Cemiplimab	239	11.1 (9.2–13.4)
Chemotherapy	238	8.8 (7.6–9.8)

Hazard ratio for death, 0.73 (95% CI, 0.58–0.91)
Two-sided P=0.006

No. at Risk

Cemiplimab	239	223	188	163	127	103	79	58	44	39	24	19	10	7	7	4	2	2	0
Chemotherapy	238	209	182	149	105	78	56	42	24	14	9	8	7	3	2	2	1	0	0

AC Population



	No. of Patients	Median Overall Survival (95% CI)
		mo
Cemiplimab	65	13.3 (9.6–17.6)
Chemotherapy	66	7.0 (5.1–9.7)

Hazard ratio for death, 0.56 (95% CI, 0.36–0.85)

No. at Risk

Cemiplimab	65	58	48	43	40	36	31	25	21	13	11	7	3	3	2	0	0	0	0
Chemotherapy	66	55	42	34	27	21	14	12	8	8	6	4	2	2	1	0	0	0	0

Tewari KS, Monk BJ et al. N Engl J Med. 2022;386:544-555.

EMPOWER-Cervical 1/GOG-3016/ENGOT cx9 (2-L)

Overall response rates

By Investigator Assessment	Overall Population	
	Cemiplimab (n = 304)	Chemotherapy (n = 304)
Response		
ORR (CR + PR), No. (%) 95% CI for ORR	50 (16.4) (12.5, 21.1)	19 (6.3) (3.8, 9.6)
Best overall tumor response, No. (%)		
CR[b]	10 (3.3)	3 (1.0)
PR[b]	40 (13.2)	16 (5.3)
SD[c]	125 (41.1)	148 (48.7)
PD	105 (34.5)	88 (28.9)
Not evaluable	24 (7.9)	49 (16.1)
Stratified CMH test 1-sided *P* value[d]	0.00004	
Odds ratio (95% CI)	2.984 (1.707, 5.215)	
KM estimated median DOR (95% CI),[e] mo	16.4 (12.4, NE)	6.9 (5.1, 7.7)
Median observed time to response (range), mo	2.7 (1.2; 11.4)	1.6 (1.2; 9.0)

ORR of SCC population

- Cemiplimab: 17.6% (95% CI: 13.0, 23.0)
- Chemotherapy: 6.7% (95% CI: 3.9, 10.7)

ORR of AC population

- Cemiplimab: 12.3% (95% CI: 5.5, 22.8)
- Chemotherapy: 4.5% (95% CI: 0.9, 12.7)

Tewari KS, Monk BJ, et al. N Engl J Med. 2022;386:544-555.

Incremental Improvements in Survival (OS) in Treating 1L Metastatic and Recurrent Cervical Cancer with Combinations and Biomarkers

Chemotherapy backbone (platinum + taxane) [2009]

Adding bevacizumab [2014]

Adding pembrolizumab in biomarker positive (PD-L1 22c3) [2023]

GOG 204 established the global standard with a median OS of 12.9 months[1]

ORR = 29%

GOG 240 added bevacizumab in eligible patients with a median OS of 17.5 months[2]

ORR = 48%

KN-826 added pembrolizumab in PD-L1 positive (CPS ≥1%) median OS 28.6 months

ORR = 69%

1. J Clin Oncol. 2009 Oct 1;27(28):4649-55.
2. Lancet. 2017 Oct 7;390(10103):1654-1663.
3. KEYNOTE-826 Final analysis. Presented at ASCO, 2023

GOG-3057/ENGOT-cx12/innovaTV 301: Trial *Study Design*

Genmab and Seagen Announce That TIVDAK® (tisotumab vedotin-tftv) Met its Primary Endpoint of Improved Overall Survival in Patients with Recurrent or Metastatic Cervical Cancer Compared to Chemotherapy

Company Announcement

- **Phase 3 innovaTV 301 confirmatory trial met its primary endpoint of improved overall survival (OS) at predetermined, independent interim analysis**
- **Trial results to be submitted for presentation at a future medical meeting**
- **Genmab and Seagen to engage in discussions with regulatory authorities**

COPENHAGEN, Denmark, and BOTHELL, Wash.; September 4, 2023 – Genmab A/S (Nasdaq: GMAB) and Seagen Inc. (Nasdaq: SGEN) announced today that the Phase 3 innovaTV 301 global trial in recurrent or metastatic cervical cancer patients with disease progression on or after front-line therapy who received TIVDAK® (tisotumab vedotin-tftv), compared with chemotherapy alone, met its primary endpoint of overall survival (OS). An Independent Data Monitoring Committee determined that OS crossed the pre-specified efficacy boundary at interim analysis. The key secondary endpoints of investigator-assessed progression-free survival and objective response rate also demonstrated statistical significance. The safety profile of TIVDAK in innovaTV 301 is consistent with the known safety profile of TIVDAK as presented in the U.S. prescribing information, and no new safety signals were observed.

The results of innovaTV 301/ENGOT cx-12/GOG 3057, a global, randomized, open-label Phase 3 trial, add to the previous results of innovaTV 204, which served as the basis for the accelerated approval of TIVDAK in the United States. Subject to discussions with regulatory authorities, the results from innovaTV 301 are intended to serve as the pivotal confirmatory trial for the U.S. accelerated approval and support global regulatory applications. The innovaTV 301 China extension study has been initiated and continues to enroll patients, in collaboration with Zai Lab Limited.

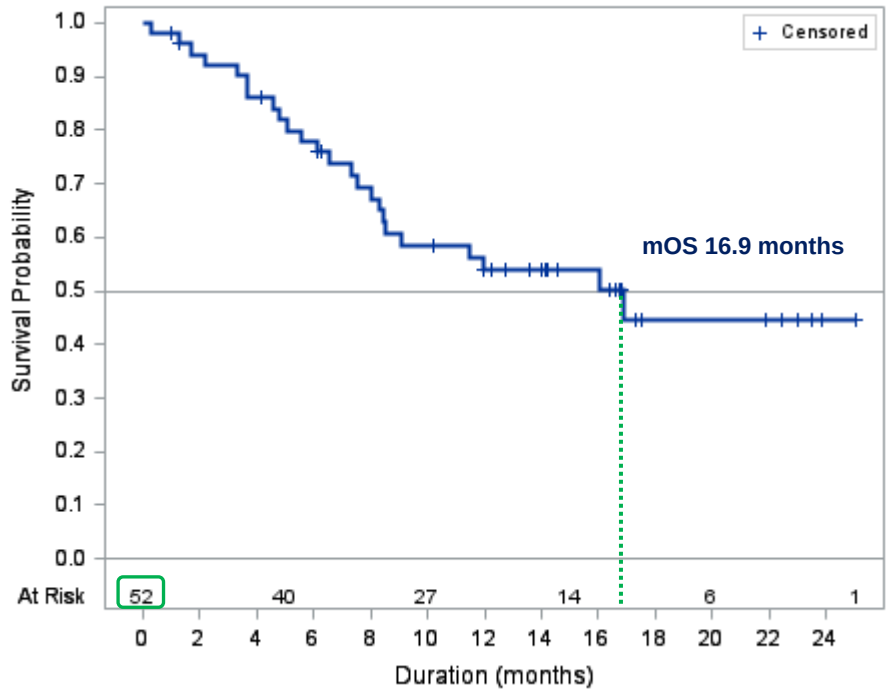
VB-C-04

Randomized Phase 2 selection trial in r/m cervical cancer progressing on 1st line SOC (pembrolizumab + chemotherapy +/- bevacizumab)

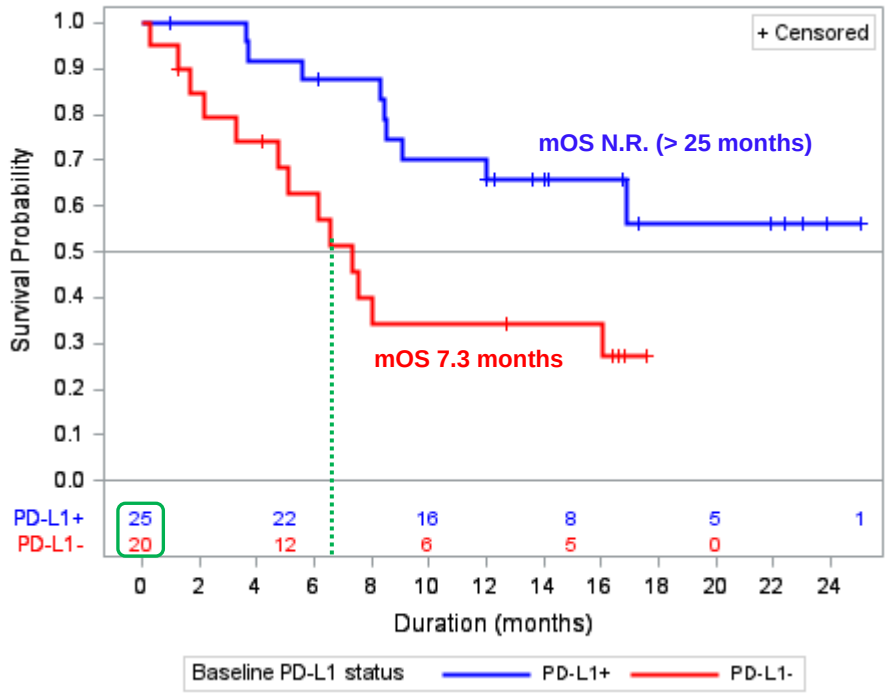
VB10.16 led to prolonged overall survival in advanced cervical cancer patients in VB-C-02

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-)



Nykode committed to progress VB10.16 in recurrent cervical cancer together with GOG Foundation

Company Announcement

Nykode Therapeutics Announces Collaboration with The GOG Foundation, Inc. to Conduct the VB-C-04 Trial in Advanced Cervical Cancer

- *Potentially registrational VB-C-04 trial in the U.S. expected to initiate 4Q 2023*
- *The GOG Foundation, Inc. (GOG) is a U.S. based not-for-profit organization with the purpose of promoting excellence in the quality and integrity in clinical trials; GOG's mission is to transform the standard of care in gynecologic cancers*

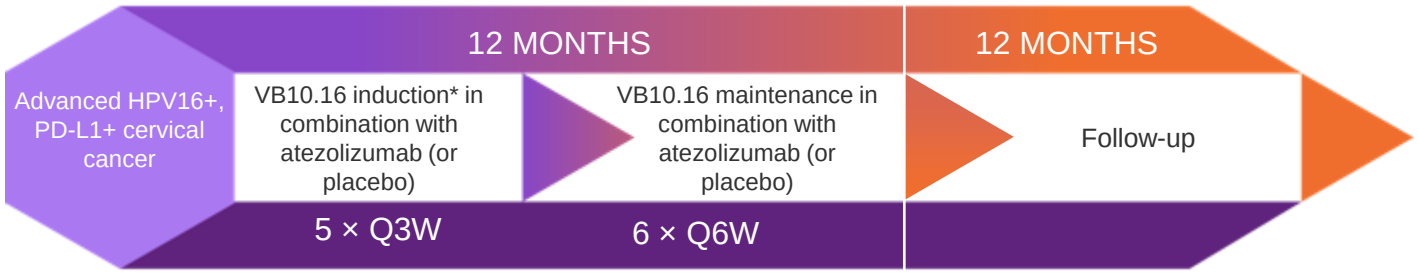
Oslo, Norway, February 10, 2023 – Nykode Therapeutics ASA (OSE: NYKD), a clinical-stage

VB-C-04 trial in advanced HPV16-positive cervical cancer

Randomized Phase 2 selection trial in recurrent cervical cancer progressing on 1st line SOC (pembrolizumab + chemotherapy +/- bevacizumab)

- **Key eligibility criteria**
  - HPV16+
  - PD-L1+ (TAP > 5%; equals CPS 1)
  - 1 prior line of systemic anti-cancer therapy in r/m setting
  - Progression during or after pembrolizumab + chemotherapy +/- bevacizumab
  - Received ≥ 4 cycles of pembrolizumab
  - Measurable disease per RECIST 1.1
- **Key efficacy endpoints**
  - Confirmed objective response rate (ORR) assessed by blinded independent central review (BICR)
  - Duration of response (DOR)wk x 4
  - Disease control rate (DCR)
  - Progression-free survival (PFS)
- **Exploratory endpoints**
  - Biomarkers (e.g. ctDNA) 3

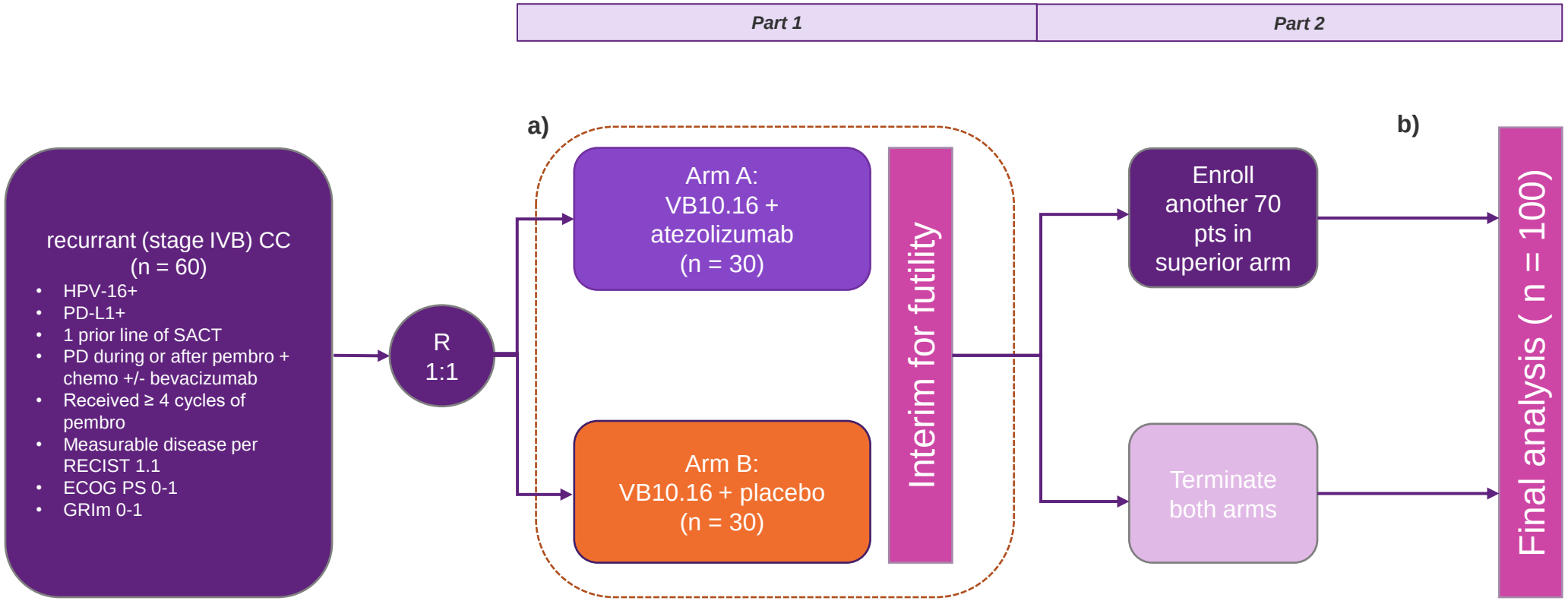
- **Dosing schedule VB10.16 vaccine (i.m.)**
  - Q3W for 5 cycles (induction period) followed by Q6W thereafter (6 cycles in maintenance period)
- **Dosing schedule immune checkpoint inhibitor (i.v.)**
  - Atezolizumab 1200 mg (or placebo) QW3
- **Strategic go/no-go decision and selection of superior intervention (VB10.16 + atezolizumab vs. VB10.16 monotherapy) after 30 + 30 pts (Phase 2a)**
- **Planned enrolment of up to approximately 130 patients (Phase 2a: 60 pts + Phase 2b: 70 pts); ~100 pts for selected intervention**



Atezolizumab will be supplied by Roche

VB-C-04 VB10.16+atezolizumab or placebo in 2L recurrent CC

Overview: randomized Phase 2 selection design



Summary and Conclusions

1. Cervical cancer is a chemo-sensitive solid tumor
2. Cervical cancer is susceptible to antiangiogenic interventions
3. Immunotherapy (IO) is active as a single agent in the 2-L and with chemotherapy in the 1-L
4. Anti-body drug conjugates are active in the 2-L
5. Innovative strategies are needed to impact outcomes post-IO

✓ **VB10.16 (a therapeutic DNA vaccine) plus IO is a novel approach and addresses a high unmet medical need**

04 VB10.NEO Program Update

Klaus Edvardsen,
Chief Development Officer

VB10.NEO: Nykode's individualized cancer vaccine

Targeting antigen presenting cell

Proprietary neoantigen selection method

- Majority of selected neoepitopes are immunogenic
- Frequency of high-quality neoepitopes in vaccine and immune responses correlate with responses

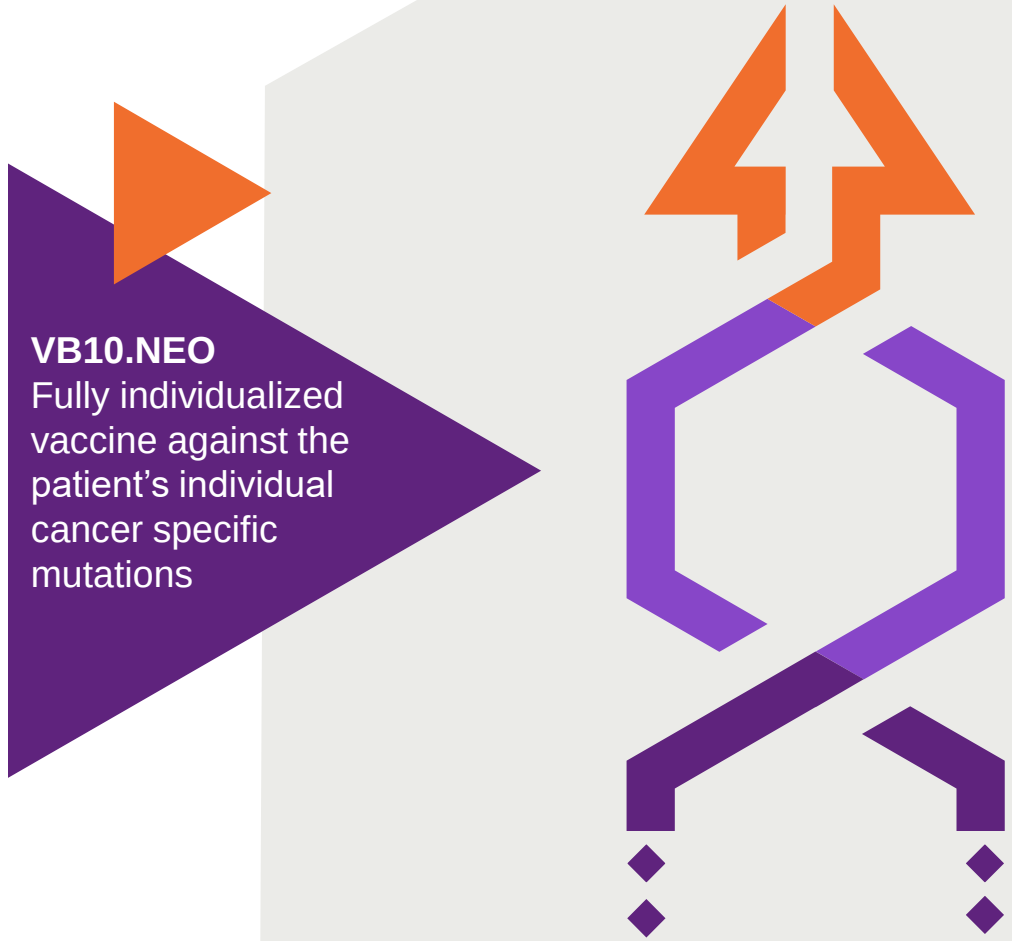
Promising immunogenicity data

- Phase 1/2a in 22 patients with melanoma, NSCLC, SCCHN, RCC or urothelial cancer

Delivered as DNA plasmid

- Flexible, rapid and cost-effective manufacturing. 100% manufacturing success rate

Exclusively out-licensed to Roche and Genentech, 2020



VB-N-02 Phase 1b dose escalation trial

Safety clearance of 9 mg dose with no safety concerns and no dose limiting toxicities observed

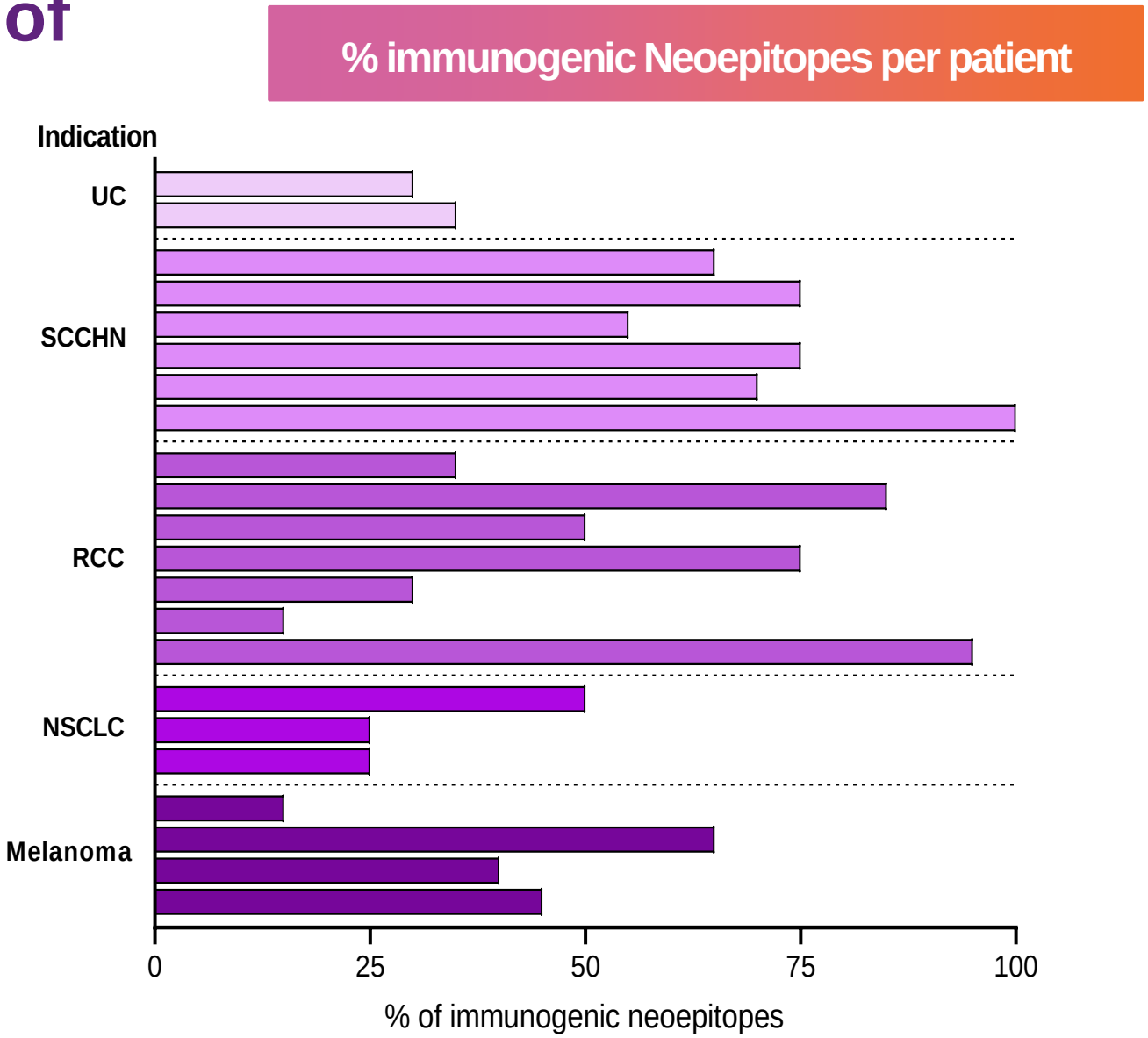
	N-01	N-02
Indication	Melanoma, non-small cell lung cancer (NSCLC), clear renal cell carcinoma, urothelial cancer or squamous cell carcinoma of the head and neck (SCCHN)	Locally advanced and metastatic tumors covering more than ten indications
Dose	3 mg dose in combination with a CPI	3-9 mg dose escalation, in combination with atezolizumab
Phase	1/2a	1b
Status	Fully enrolled (Ph1)	Enrolling
Partnered	Genentech A Member of the Roche Group	

Note: Genentech has an exclusive license to VB10.NEO.

T cell responses to majority of selected neoepitopes

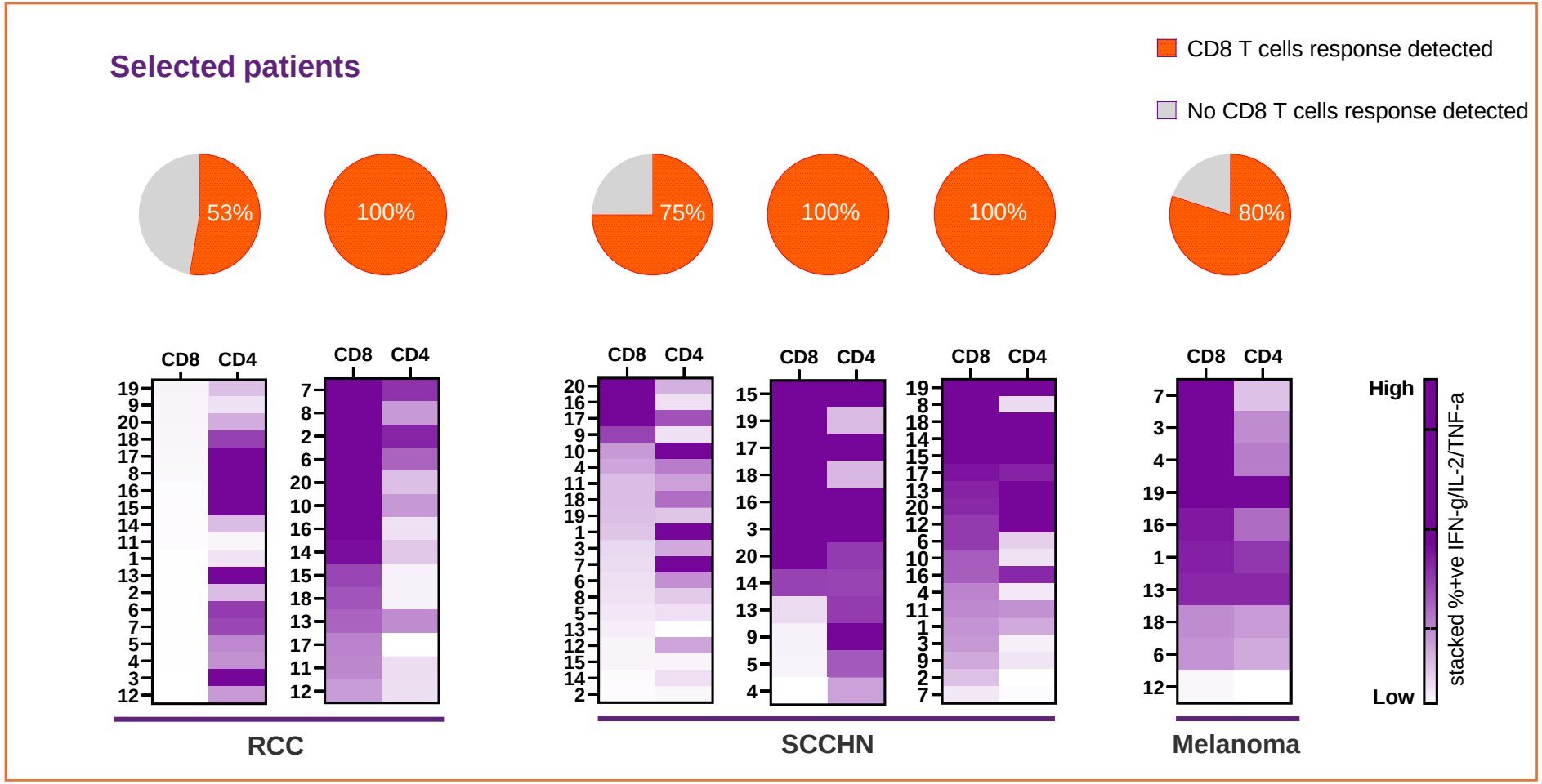
All patients across five indications showed a response to at least one neoepitope

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



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

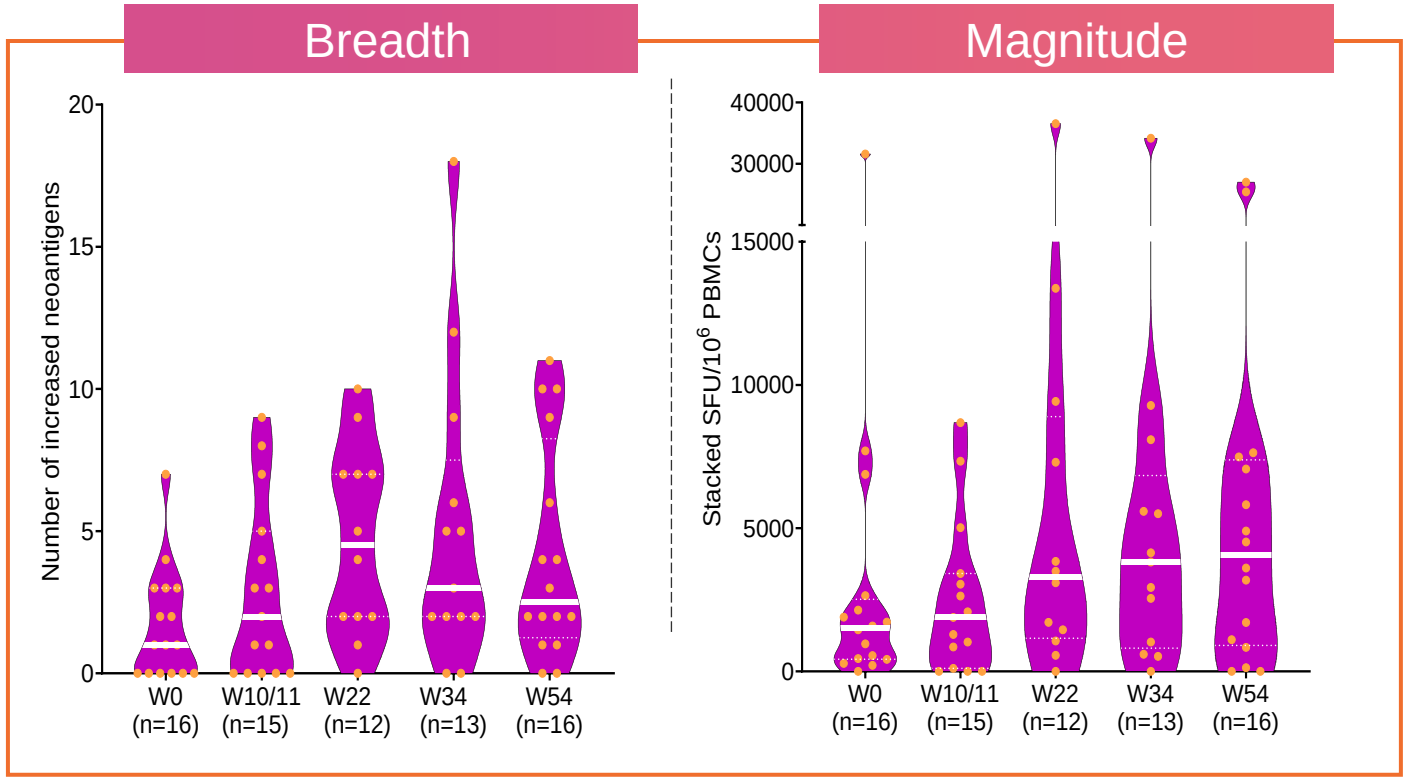
- T cell responses are characterized by both CD8 and CD4 T cells
- The majority of tested neoepitopes activated functional CD8 T cells in all subjects analyzed



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

Multiple vaccinations boost the breadth and magnitude of functional T cell responses

Patients completing 1-Year of treatment



Increase in the **breadth** and **magnitude** of functional T cell responses observed over time.

Breadth: Number of vaccine-induced NeoAg (*de novo* or amplified)

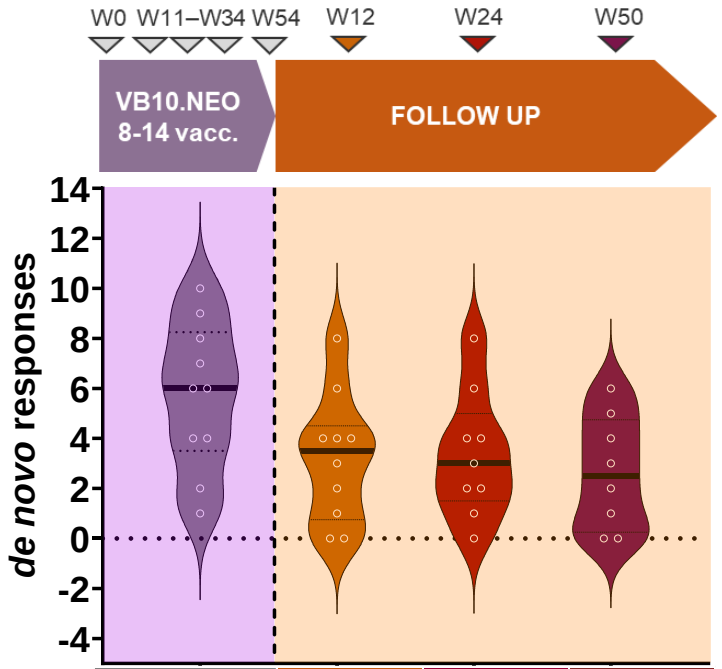
Magnitude: Stacked IFN-γ response of all immunogenic NeoAg

Patients completed and having PBMC collected up to 1-year treatment are included (N=16). Median is shown as horizontal lines.

Vaccine-specific T cells remain functional and immunogenic up to 1-year after last vaccination

VB10.NEO induces a favorable and long-lasting T cell memory phenotype

10 patients were followed for immune responses against the de novo induced neoantigens up to 50 weeks post last vaccination



	OnTx	≤12w	≤24w	≤50w
Patients n (%)	10	8/10 (80%)	8/9 (89%#)	6/8 (75%#*)
NeoAg n (%)	57	32/57 (56%)	30/48 (63%#)	21/44 (48%#*)

48% of the treatment-induced de novo T cell responses were still functionally active 50 weeks post last dose of VB10.NEO

- indicating a long-lasting T cell response

10 patients with de novo responses during treatment and PBMC samples collected after completing 8-14 doses VB10.NEO are included. Vaccine-induced (de novo) T cell responses was analysed by IVS ELISpot. OT = on treatment. #One patient did not have ≤ 24 or ≤ 50 week sample. *One patient did not have ≤50week sample

VB10.NEO Key Differentiators

Solid manufacturing chain

- ✓ 100% successful vaccine production
- ✓ Robust supply chain

Safety

- ✓ Safety profile similar to checkpoint inhibitor monotherapy
- ✓ No increase in immune-related adverse events

NeoSELECT

- ✓ High fraction of immunogenic neoantigens
- ✓ Strong ability to select neoantigens across different tumor entities

Immune response

- ✓ Induces broad and strong T cell responses
- ✓ Long-lived and persistent immune responses

Strong partnership

- ✓ Validated technology
- ✓ Unique targeting module

Competitive player

- ✓ Well-tolerated across trials and in different combinations
- ✓ Within the validated field of personalized vaccines

VB-N-02 Phase 1b dose escalation trial

Safety clearance of 9 mg dose with no safety concerns and no dose limiting toxicities observed

	N-01	N-02
Indication	Melanoma, non-small cell lung cancer (NSCLC), clear renal cell carcinoma, urothelial cancer or squamous cell carcinoma of the head and neck (SCCHN)	Locally advanced and metastatic tumors covering more than ten indications
Dose	3 mg dose in combination with a CPI	3-9 mg dose escalation, in combination with atezolizumab
Phase	1/2a	1b
Status	Fully enrolled (Ph1)	Enrolling
Partnered	Genentech *A Member of the Roche Group*	

Note: Genentech has an exclusive license to VB10.NEO.

Q&A

Klaus Edvardsen, Nykode CDO

Dr. Bradley Monk, GOG

20’ BREAK

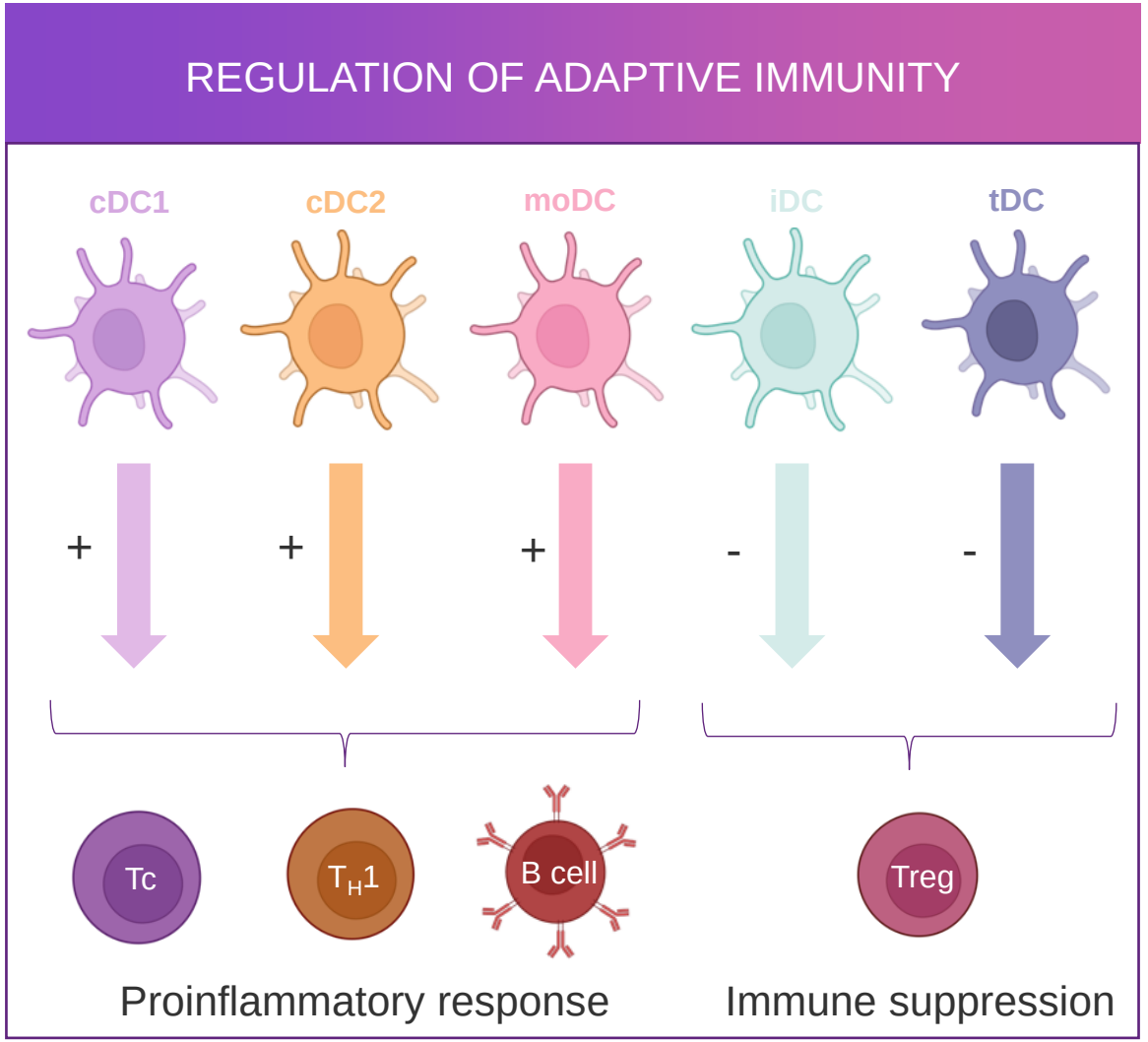
05 Research & innovation update

Mikkel Wandahl Pedersen,
Chief Scientific Officer

Antigen presenting cells - the portal to adaptive immunity

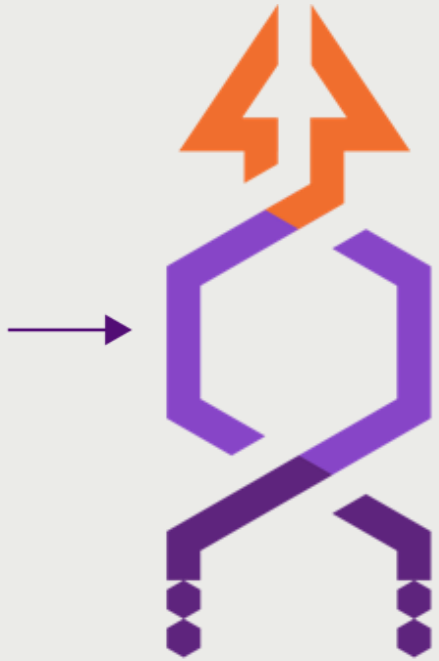
- Activation of the adaptive immune system is key to obtain effective and long-term immune responses
- APCs are the gatekeepers to adaptive immunity
- APCs comes in different “flavors” with specialized immune functions
- Dendritic cells (DCs) are professional APCs
- Targeting antigens and epitopes directly to APCs is a highly effective way of triggering the desired adaptive immune responses

Nykode is a leading APC targeted vaccine Company with a proven platform



Modular vaccine technology allows APC-targeting to direct immune responses

DNA plasmid encoding Vaccibody



Module 1: Targeting unit to attract and bind APCs

Ability to tailor the targeting unit enables induction of different immune response profiles to specific diseases[1]

Module 2: Dimerization unit for crosslinking targeted receptors on the surface of the APC

To facilitate strong bivalent binding

Module 3: Antigenic unit globular antigens or set of T cell epitopes

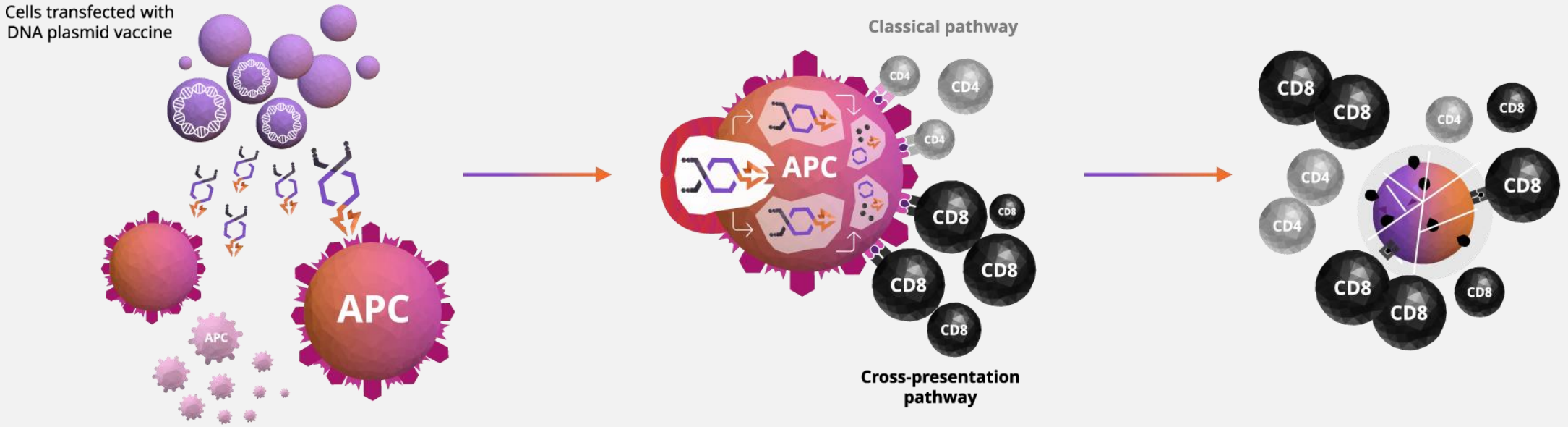
Antigens of choice from cancer, viruses, bacteria, parasites or autoimmune disease

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

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

Nykode vaccines induce 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

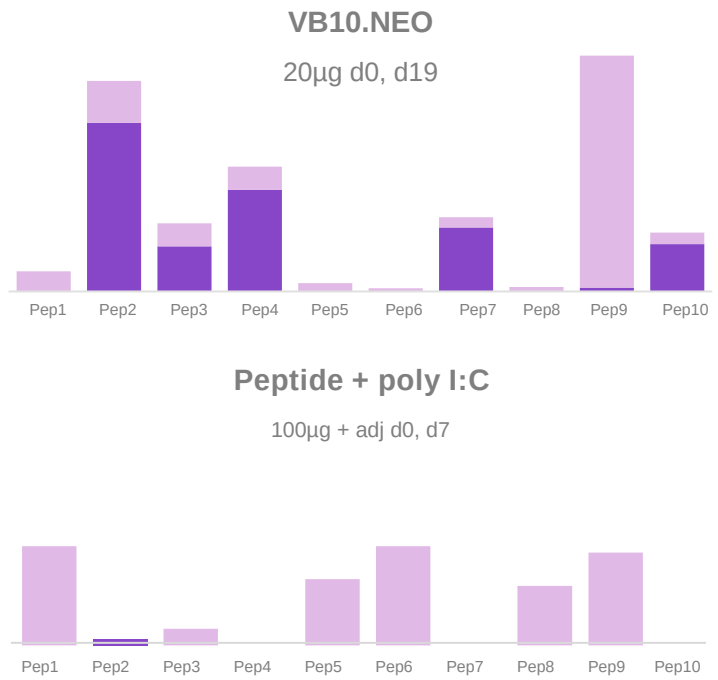
Comparison with peptide and RNA vaccination strategies shows broader CD8 and CD4 responses with Nykode's technology

		Ag1	Ag2	Ag3	Ag4	Ag5	Ag6	Ag7	Ag8	Ag9	Ag10
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



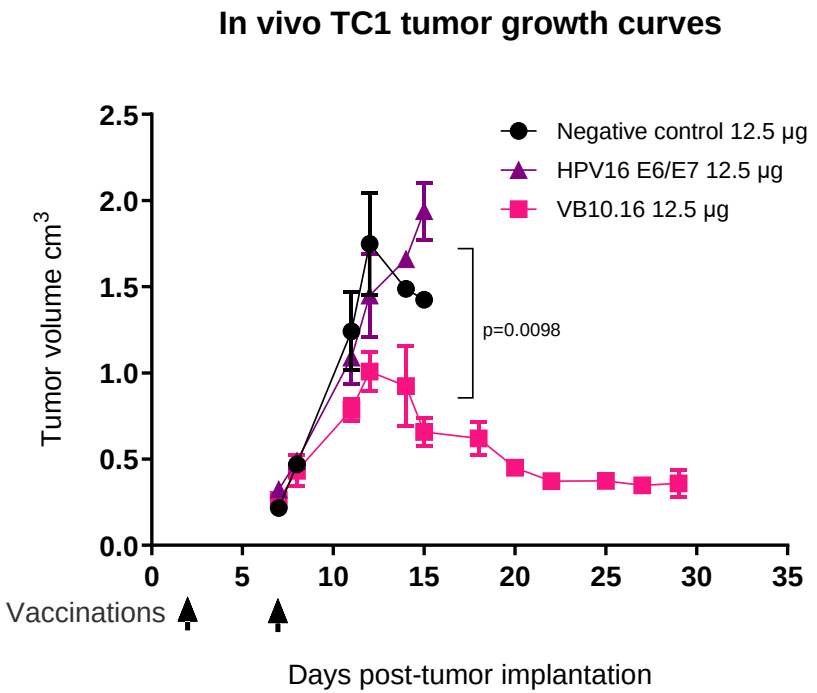
*Castle et al., 2012 and Kreiter et al., 2015

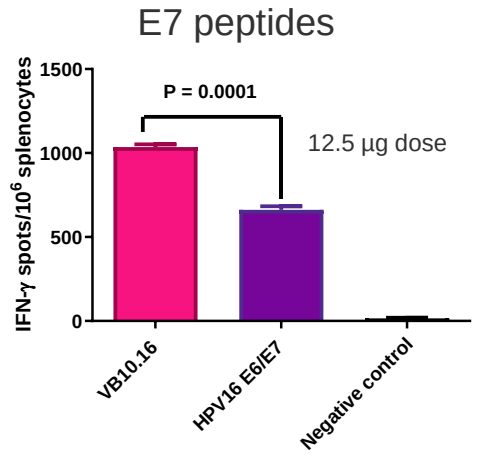
APC targeted HPV16 vaccine drives superior anti-tumor responses in a E6+E7 positive tumor model

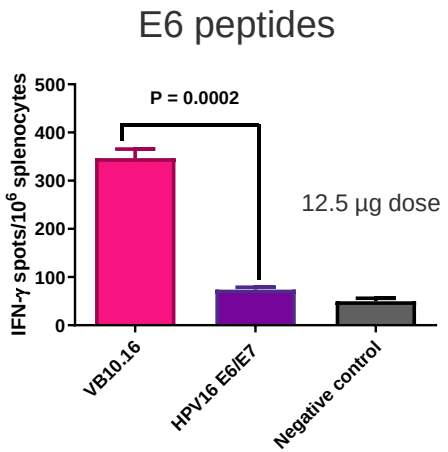
VB10.16 compared to non-targeted vaccine

- Induction of significantly stronger HPV16 specific IFN-γ T cell responses
- Strong anti-tumor efficacy with regression of large established tumors

E6+E7 POSITIVE TC1 TUMOR MODEL



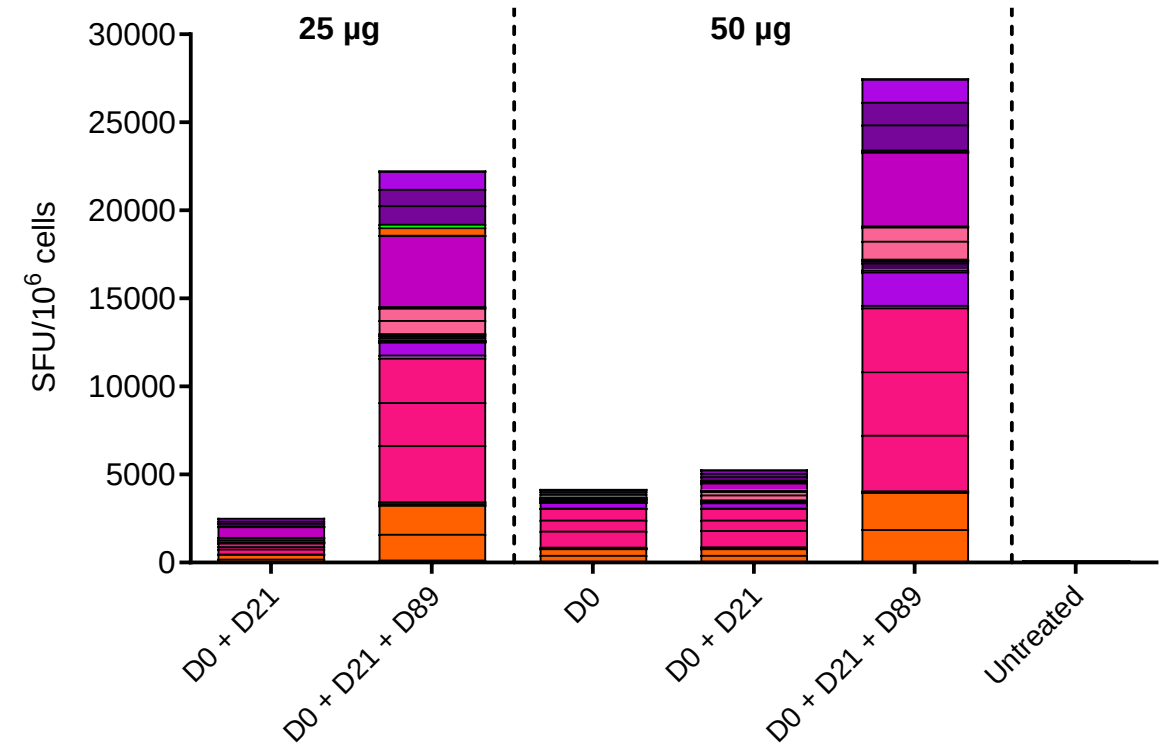




Vaccibody T cell responses are long-lasting and effective memory responses are generated

- Vaccine-induced T cell responses remain strong more than two months after vaccination with a SARS-COV2 RBD vaccine
- An additional boost at day 89 induce a very strong boost in T cell responses demonstrating generation of effective memory responses

PERSISTENCE OF T CELL RESPONSES



Nykode’s research and innovation strategy

The Innovation Strategy encapsulates our vision of finding new ways of coding medicine by breaking down conventional drug design

Creating novel differentiated platform technologies applicable to fuel multiple products and optimize value-creation

CONTINUE TO IMPROVE THE VACCINE PLATFORM

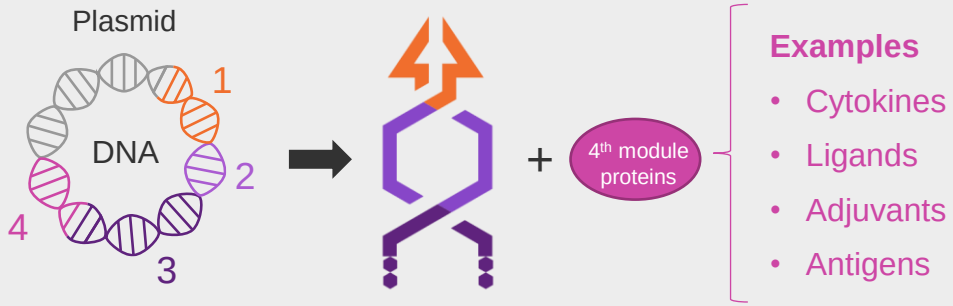
EXPANSION INTO NOVEL THERAPEUTIC AREAS AND NOVEL THERAPEUTIC MOLECULES

BUILD A PIPELINE OF DIFFERENTIATED VACCINE CANDIDATES

Flexibility of DNA platform allows additional modules

- DNA sequences encoding additional polypeptide(s) can be added to vaccines
- Inclusion of ribosome skipping sequence(s) ensure production of separate molecules
- Potential for boosting and directing vaccine induced immune responses
- 4th module constitute a potential significant extension to the platform's proprietary lifetime

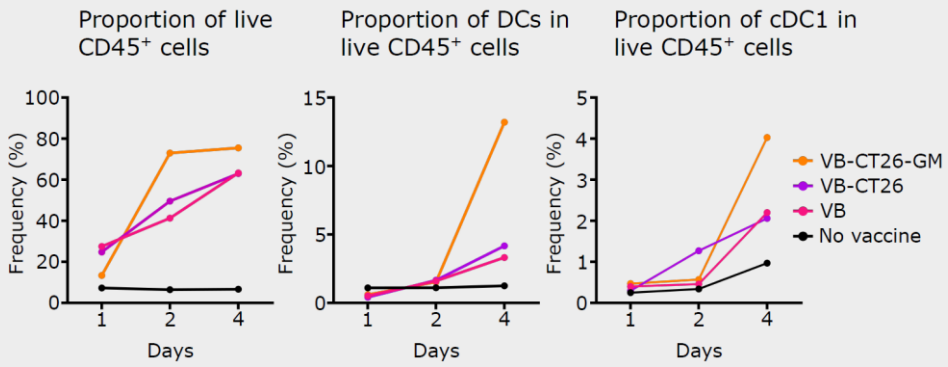
4TH MODULE CONCEPT



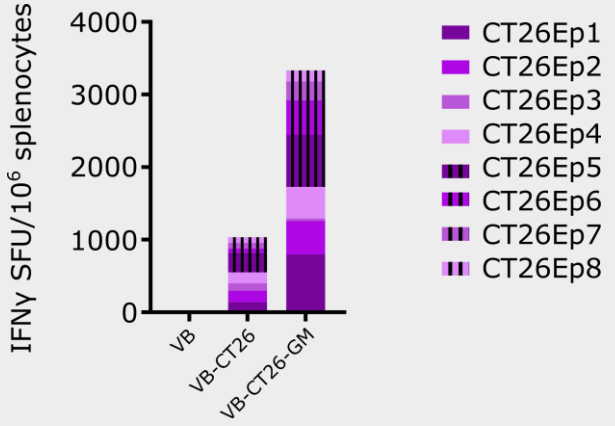
4TH MODULE DATA – GM-CSF

VB CT26 vaccine

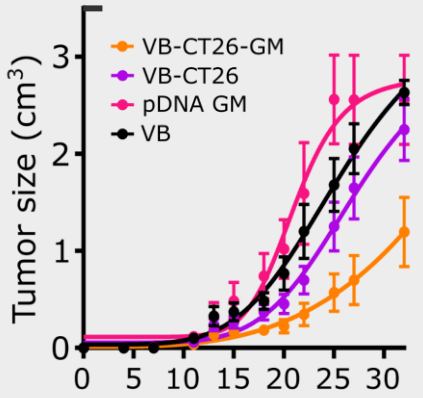
APC infiltration



Fluorospot



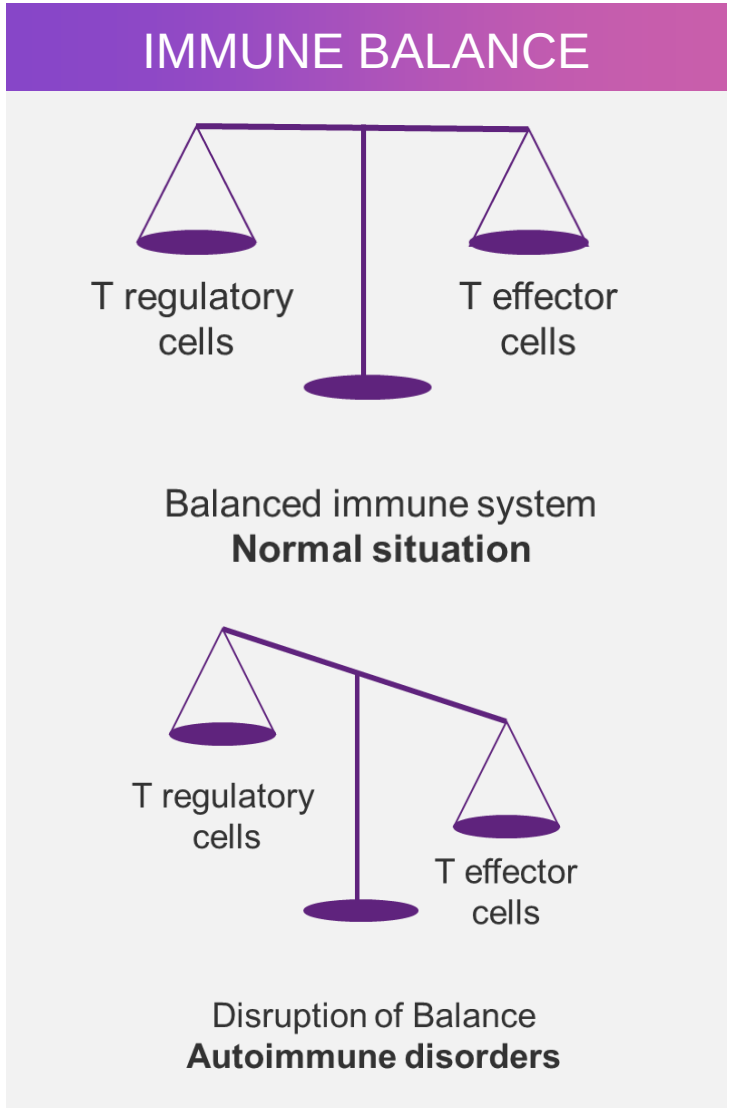
CT26 tumor model



Tolerance
- a new therapeutic focus area

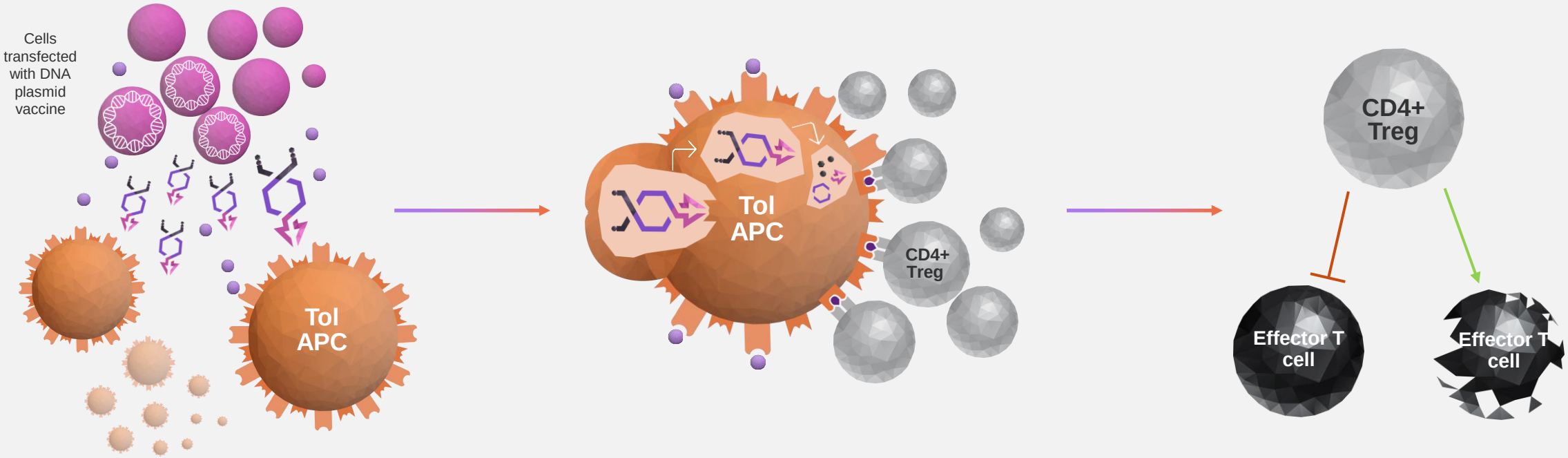
Tolerance induction by inverse vaccination

- Regular vaccines educate the immune system to recognize and attach bacteria, viruses or cancer cells creating immunological memory
- Inverse vaccination aims at doing the opposite by removing the immune system's memory of antigens causing unwanted immune reactions
- Direct targeting of vaccines to specific APC subsets has the potential to dampen disease causing antigen-specific effector responses without impairing protective immunity
- Highly promising approach for allergies, autoimmune diseases and organ transplant rejection
- Nykode's platform uniquely positioned to target antigens to tolerizing dendritic cells stimulating antigen specific T regulatory (Treg) cell activity



Induction of antigen specific tolerance can be achieved by targeting disease causing epitopes to tolerogenic APCs

MECHANISM OF ACTION – TOLERANCE INDUCTION (INVERSE VACCINATION)



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.

Modular design with multiple targeting and 4th modules able to ensure antigen-specific immune tolerance

Module 1: Multiple targeting units for receptors on tolerizing APCs identified including natural ligands and other targeting molecules

Module 3: Auto-antigens or allergens known to elicit unwanted immune responses identified

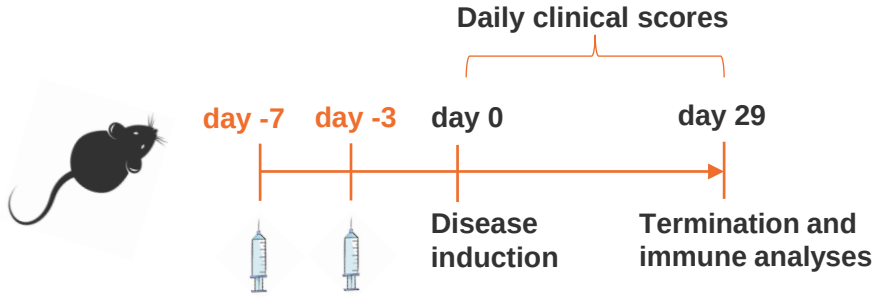
Module 4: Cytokines or modulators playing key roles in mediating anti-inflammatory immune responses

- Numerous exploratory vaccines built on above modules and evaluated experimentally
- Several patent applications covering these concepts filed

Recombinant Vaccibodies targeting tolerogenic DCs prevents serious disease in a MS-like mouse disease model

Multiple sclerosis (MS) is an autoimmune disease of the central nervous system (CNS) where the immune system attacks nerve cells in the brain and spinal cord

The **Experimental Autoimmune Encephalomyelitis** (EAE) model is a widely used animal model for studying MS and other demyelinating diseases in humans



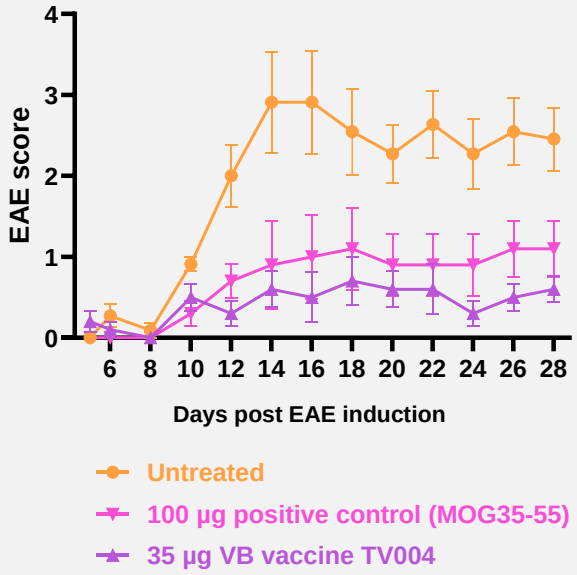
EAE MODEL

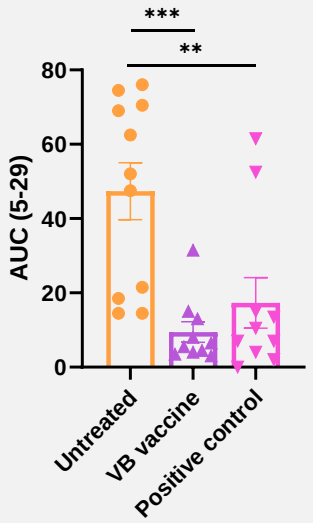
VB vaccine TV004

EAE antigen

EAE antigen: MOG(27-63)

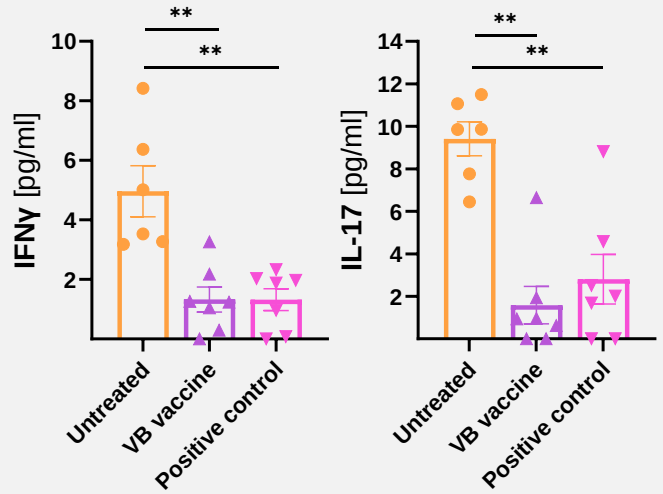
Paralysis





One-way ANOVA with Turkey's multiple comparisons test, ***P < 0.001, **P < 0.01.

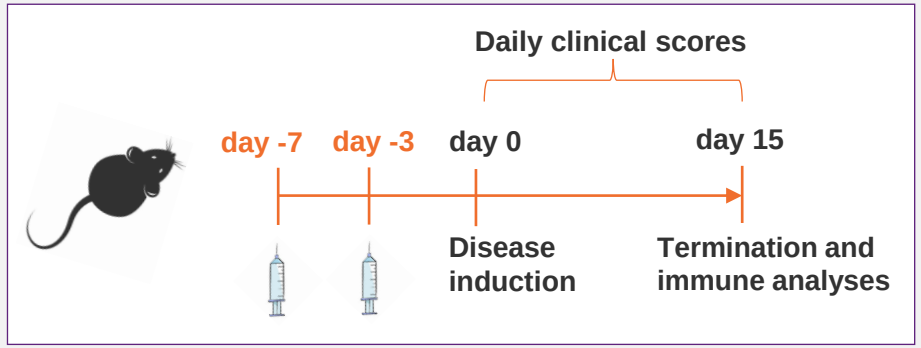
Immune parameter read-out at day 29



Mann-Whitney test on ranks, **P < 0.01, *P < 0.05.

Low dose recombinant Vaccibody vaccine prevent MS disease symptoms with a dose-dependent decrease in disease associated cytokines

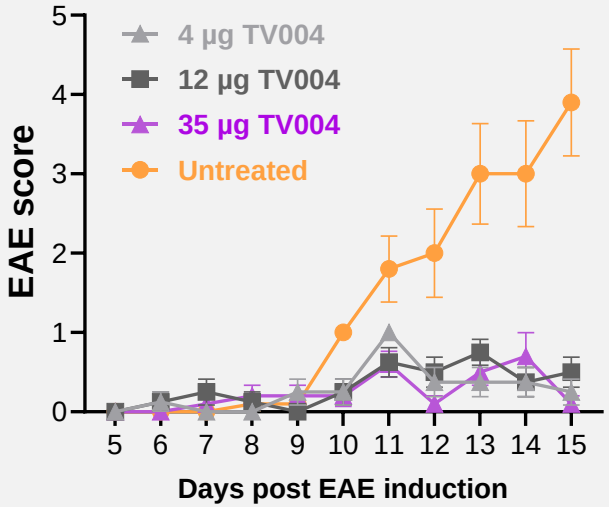
EAE MODEL



VB vaccine TV004

EAE antigen

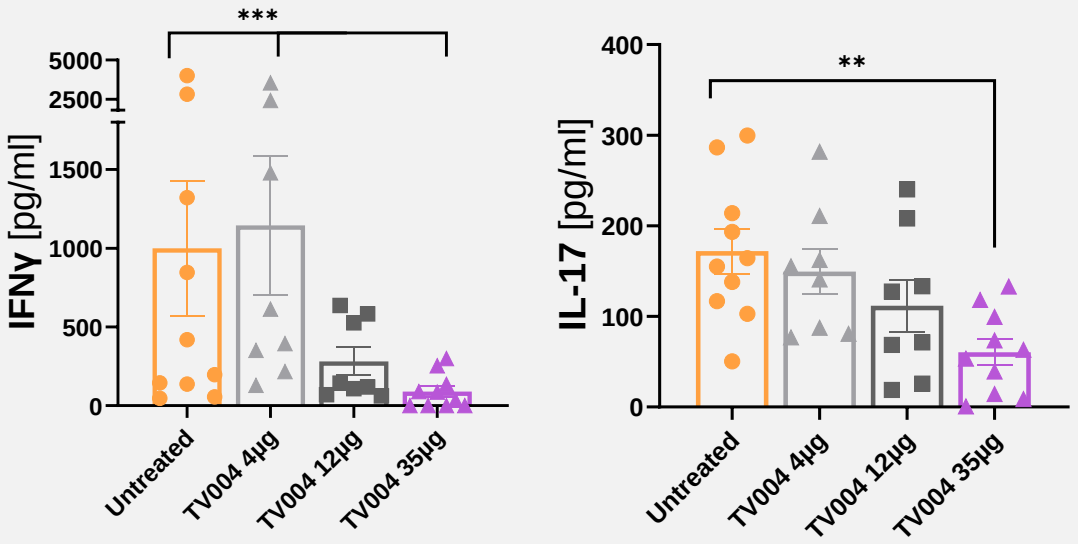
Paralysis



EAE antigen: MOG(27-63)

Immune parameter read-out at day 15 (**at peak of disease**)

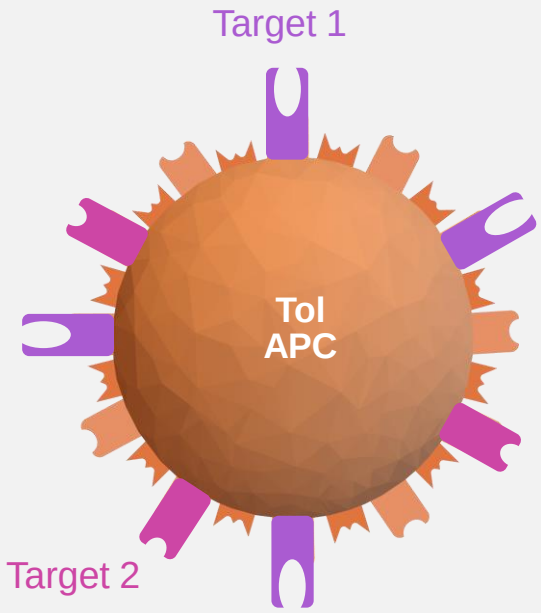
MOG(35-55) recall assay using splenocytes



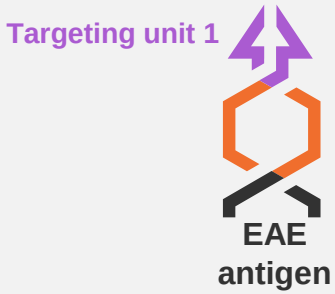
Mann-Whitney test on ranks, **P < 0.01, ***P < 0.005.

Disease prevention in the EAE model can also be achieved by targeting an alternative target on tolerizing APCs

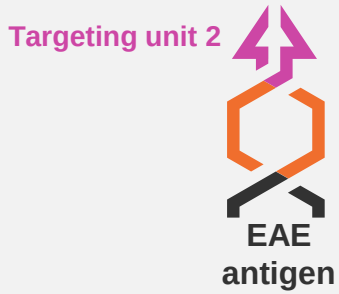
EAE MODEL



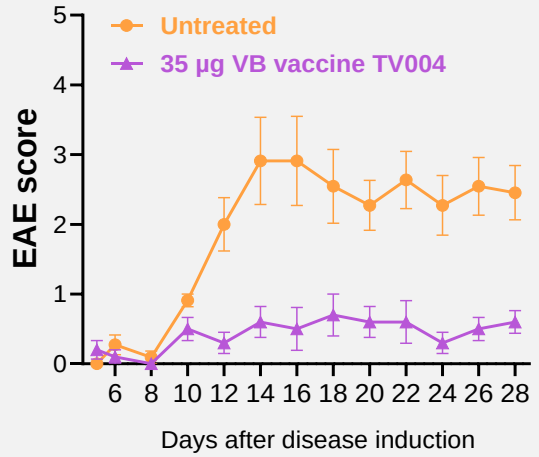
VB vaccine TV004

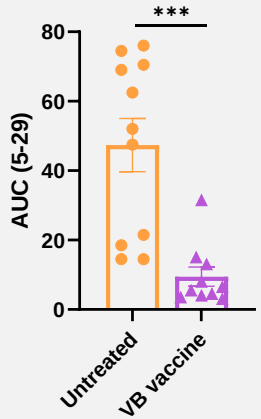


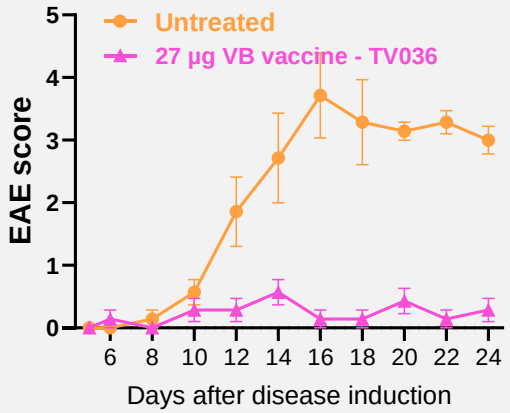
VB vaccine TV036

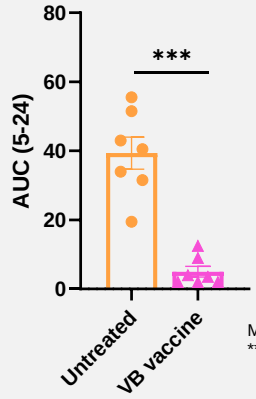


Paralysis









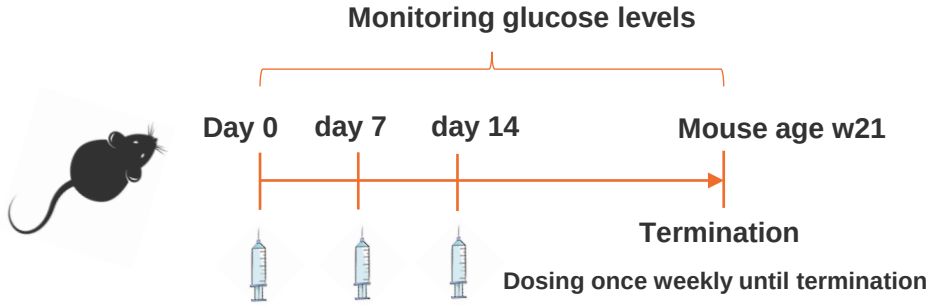
Mann Whitney test on ranks,
***p < 0.001.

EAE antigen: MOG(27-63)

DNA vaccination with Vaccibodies targeting tolerogenic DCs prevents type 1 diabetes in a spontaneous mice model

Type 1 diabetes is an autoimmune disease where the immune system attacks insulin producing cells in the pancreas

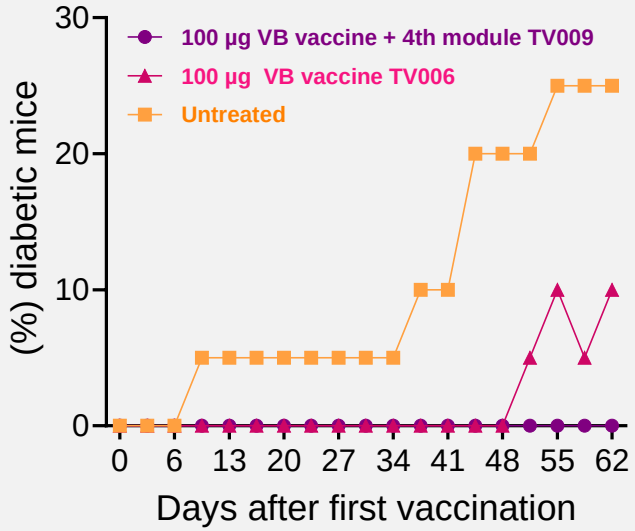
The **NOD diabetes model** is a mouse model that is commonly used in research to study type 1 diabetes. NOD stands for Non-Obese Diabetic, and these mice **spontaneously** develop autoimmune diabetes similar to the human form of the disease



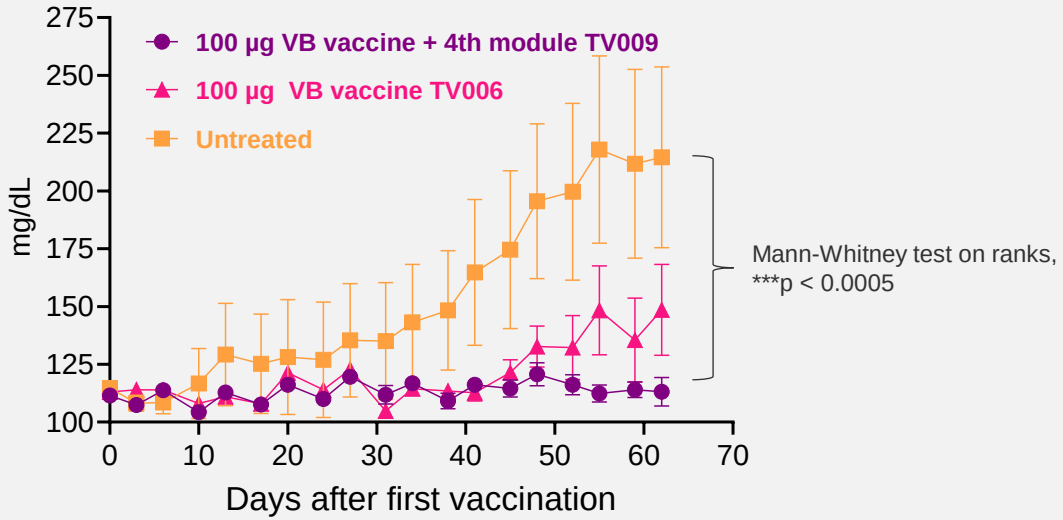
NOD DIABETES MODEL (ONGOING STUDY)

VB vaccine

Incidence of diabetes



Blood glucose levels



Diabetes antigen: PPI

Competition

- ✓ Limited competition within antigen specific tolerance

Opportunities

- ✓ Autoimmune disease
- ✓ Allergies
- ✓ Organ transplantation

Partnership opportunities

- ✓ New platform allows product specific collaborations
- ✓ Early interest from potential Pharma partners

Tolerance Highlights

Medical Need

- ✓ High unmet medical need areas
- ✓ Existing therapies are broadly immune suppressive

Preclinical data

- ✓ Multiple exploratory vaccines designed successfully
- ✓ Positive data in autoimmune disease models of multiple sclerosis and type 1 diabetes

Platform fit

- ✓ Nykode APC targeted platform uniquely positioned to target antigens to tolerizing DCs
- ✓ Addition of immune-inhibitory cytokines (4th module)

Summary and conclusions tolerance

Numerous exploratory “inverse” vaccines built on a diversity of modules and evaluated experimentally

- Works with different targeting units, antigens and 4th modules
- Several patent applications covering these concepts filed

Recombinant Vaccibodies designed to target disease inducing epitopes to tolerogenic antigen presenting cells able to prevent serious disease in the EAE mouse model

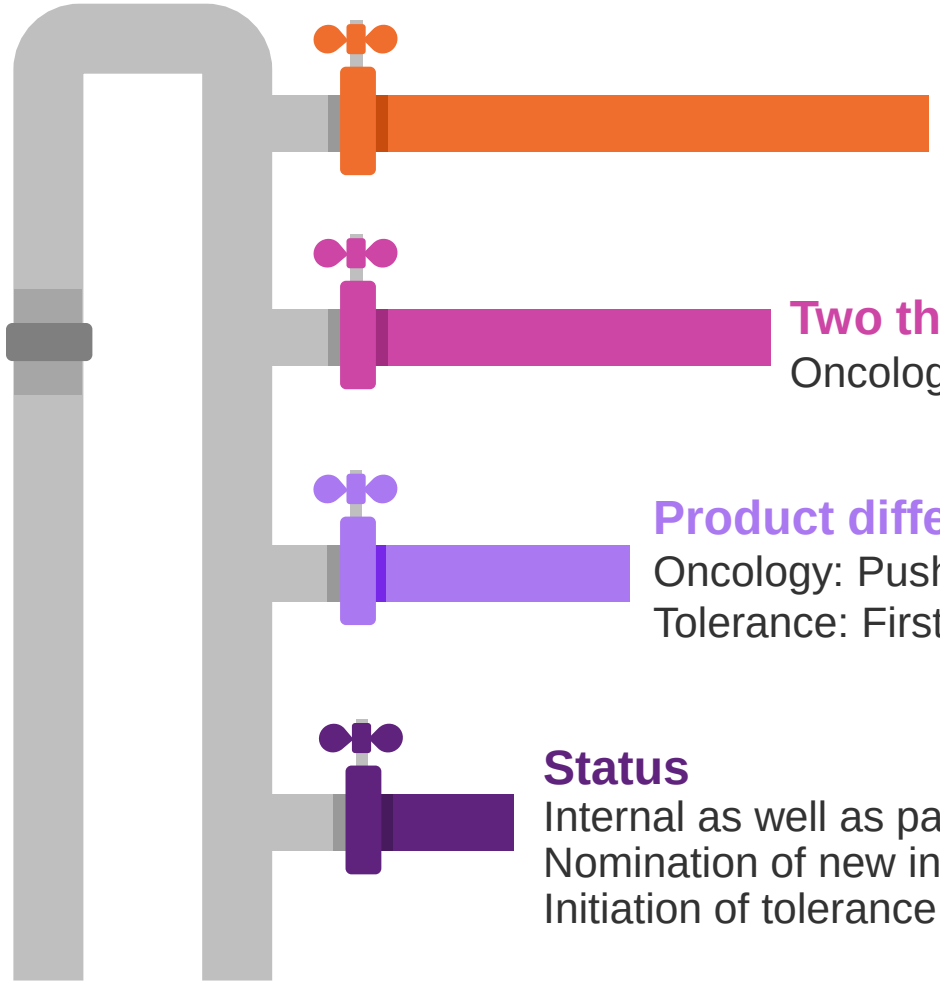
Preliminary data demonstrate that DNA vaccination with Vaccibodies targeting tolerogenic DCs prevents onset of type 1 diabetes in a spontaneous mice model

- The addition of Nykode’s proprietary 4th module technology demonstrated potential to further improve efficacy

Building a new therapeutic area focusing on “Inverse” vaccines for treatment of autoimmune diseases

Expanding the discovery pipeline

Growing a pipeline of differentiated vaccine candidates



Exploit platform

Take advantage of uniqueness and flexibility of our APC targeted vaccine approach and ability to include further modules

Two therapeutic growth areas

Oncology and Tolerance

Product differentiation

Oncology: Push boundaries - opportunities in early and late-stage disease
Tolerance: First in class antigen-specific products

Status

Internal as well as partner discovery projects progressing according to plans
Nomination of new internal oncology development candidate Q4-2023
Initiation of tolerance projects in 2024 to drive further pipeline growth

Update Regeneron collaboration

Multitarget collaboration with the aim of using Nykode's modular vaccine platform combined with Regeneron's unique antigen selection expertise to discover and develop

- Two vaccine programs within infectious diseases
- Three vaccine programs within oncology

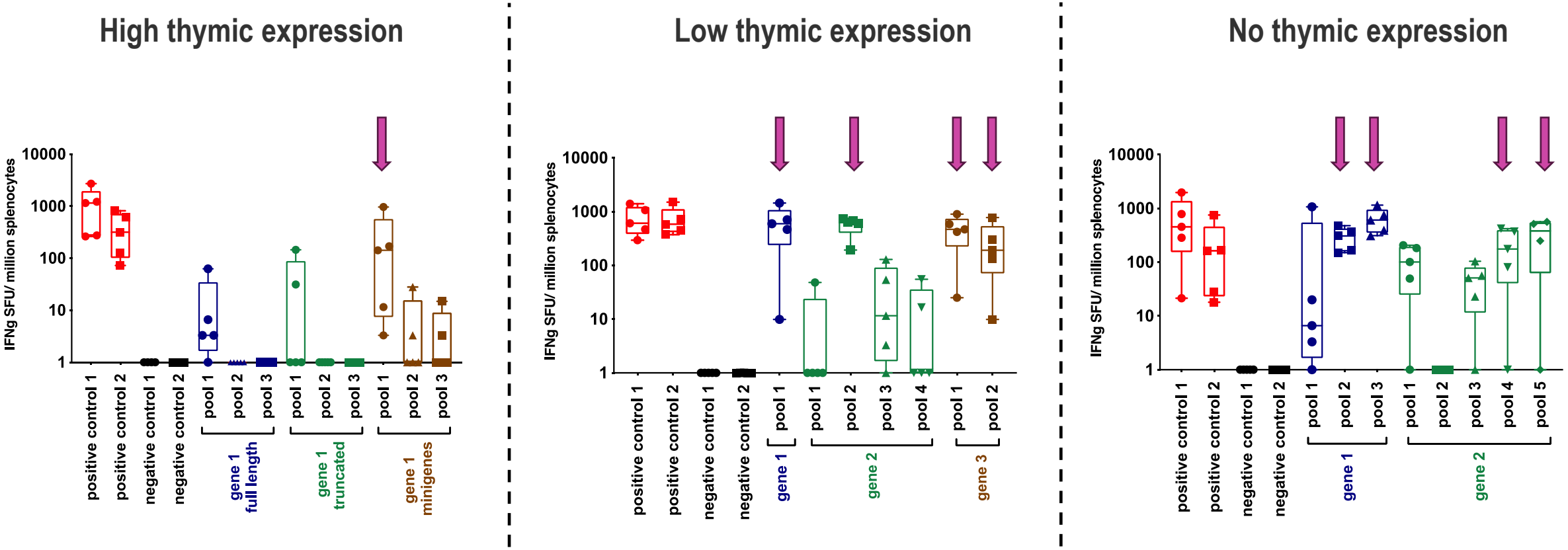
The collaboration moving forward according to plans

- All five programs initiated and progressing
- Multiple vaccine candidates designed for each program
- Next step nomination of lead candidates

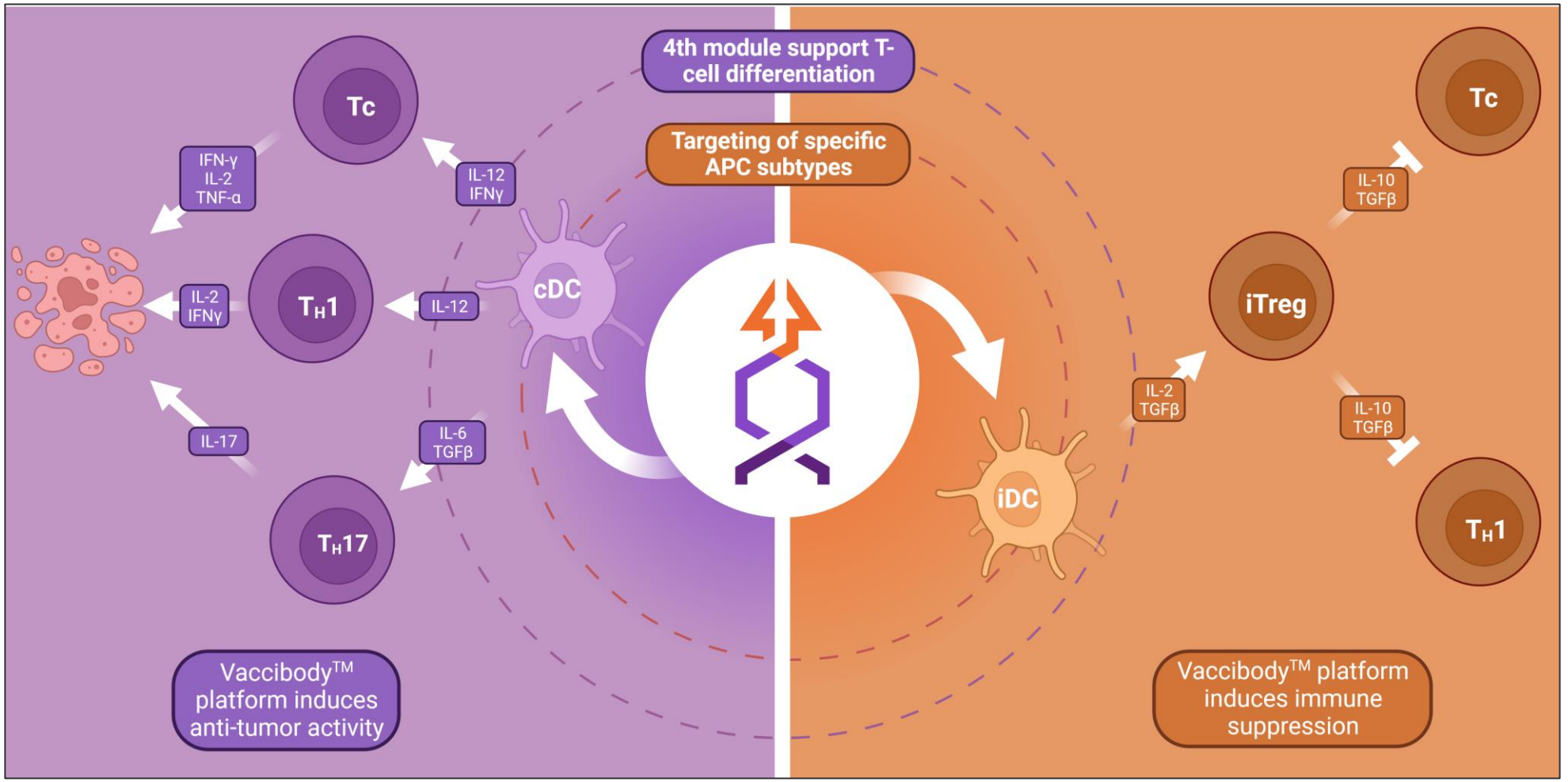
REGENERON®

Vaccibodies induce potent T cell responses against targets subject to various degrees of central tolerance

Potential immunogenicity



Nykode's platform allows tailoring of the immune response by targeting different APC populations



06 Business Model

Agnete B. Fredriksen,
Chief Business Officer & Co-founder

Nykode's Vision and Business Model
Unlocking unlimited possibilities for the future of medicine

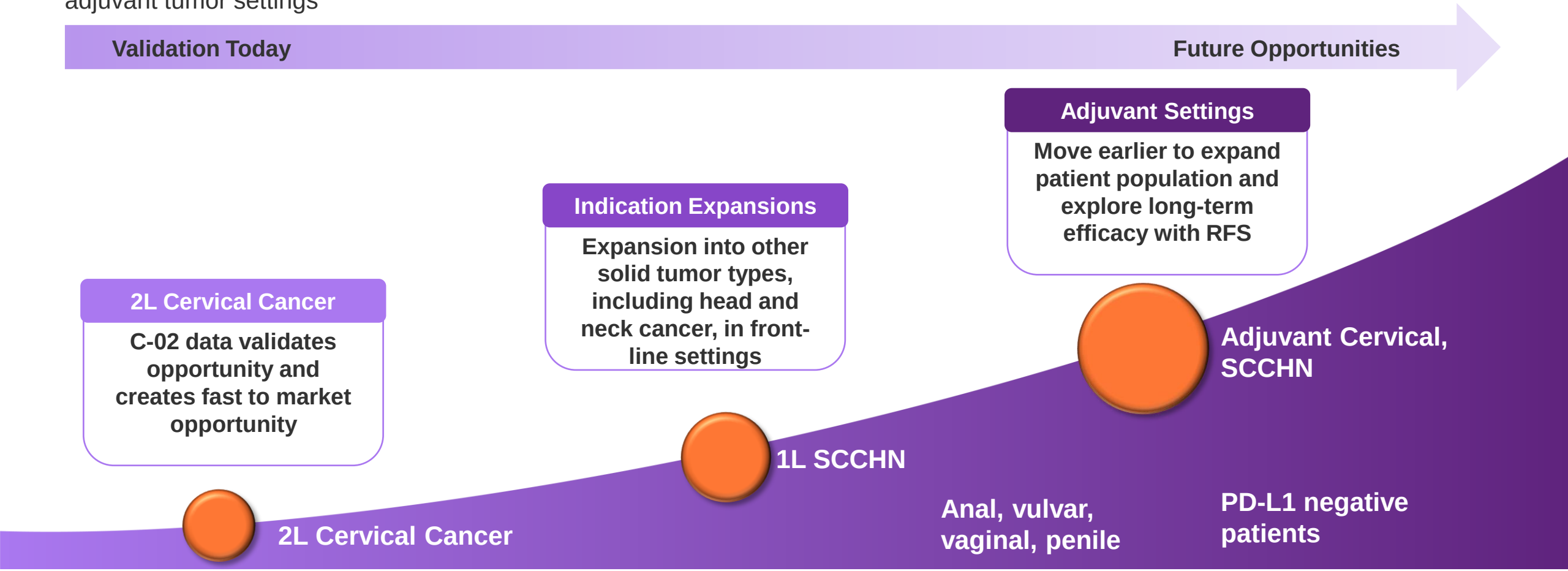
«Building the leading immunotherapy company developing game changing medicine across an expanding range of therapeutic areas.»

- Nykode leverage the unique immunology expertise to create proprietary new codes filling the gap when the immune system fails
  - The Norwegian words for the words new [ny] and code [kode]

- Nykode's business model is focused on maximizing value by:
  - Ensuring differentiated and proprietary platform IP
  - Design and develop products applicable for multiple patient populations
  - Accelerate development by combining in house development and strategic partnerships
  - Oncology platform is well progressing and de-risked through clinical data and partnerships and ready to be further accelerated
  - Addition of novel platform IP for autoimmunity and the 4th module technology

Building a cancer vaccine franchise following strong clinical validation

2L cervical cancer provides near-term validation with an opportunity to significantly expand the addressable patient population in adjuvant tumor settings



Fast to market strategy

Expand indications and into front-line settings

Expand to target the broad addressable patient population

Unlocking possibilities for a future offering all cancer patients a vaccine at diagnosis

Exploring the full range of cancer antigens

INDIVIDUALIZED	OFF-THE-SHELF		
	Viral Antigens	Tumor-specific Neoantigens	Tumor-associated Antigens
VB10.NEO Genentech A Member of the Roche Group	VB10.16	Undisclosed	Undisclosed

Future in house and partnered cancer vaccine opportunity space

Using strategic partnerships to maximize the value of the broader proprietary Nykode platform and products

Platform:

Accelerate and expand the pipeline

REGENERON

$925M

- $30M upfront+ $20M equity
- $875M in milestone payments
- Tiered high single-digit to low double-digit royalties

Products:

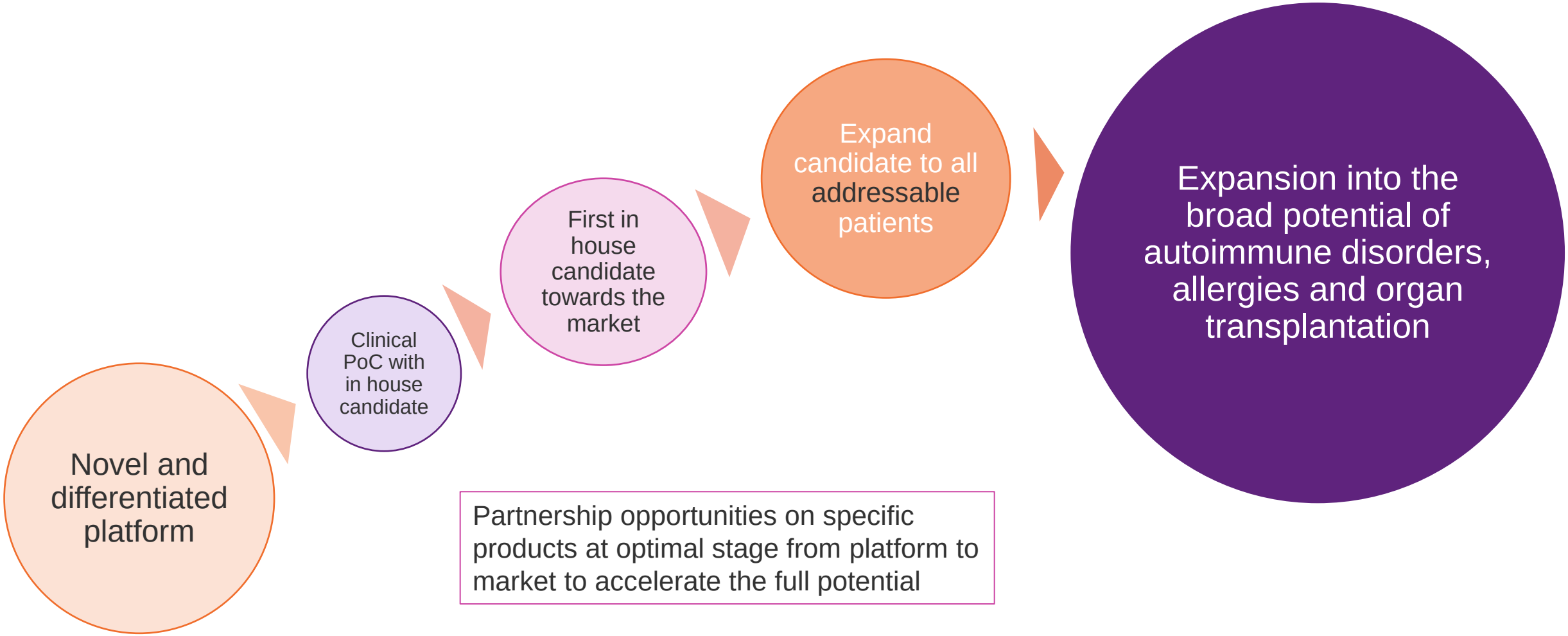
De-risk, accelerate and offload costs

Genentech
A Member of the Roche Group

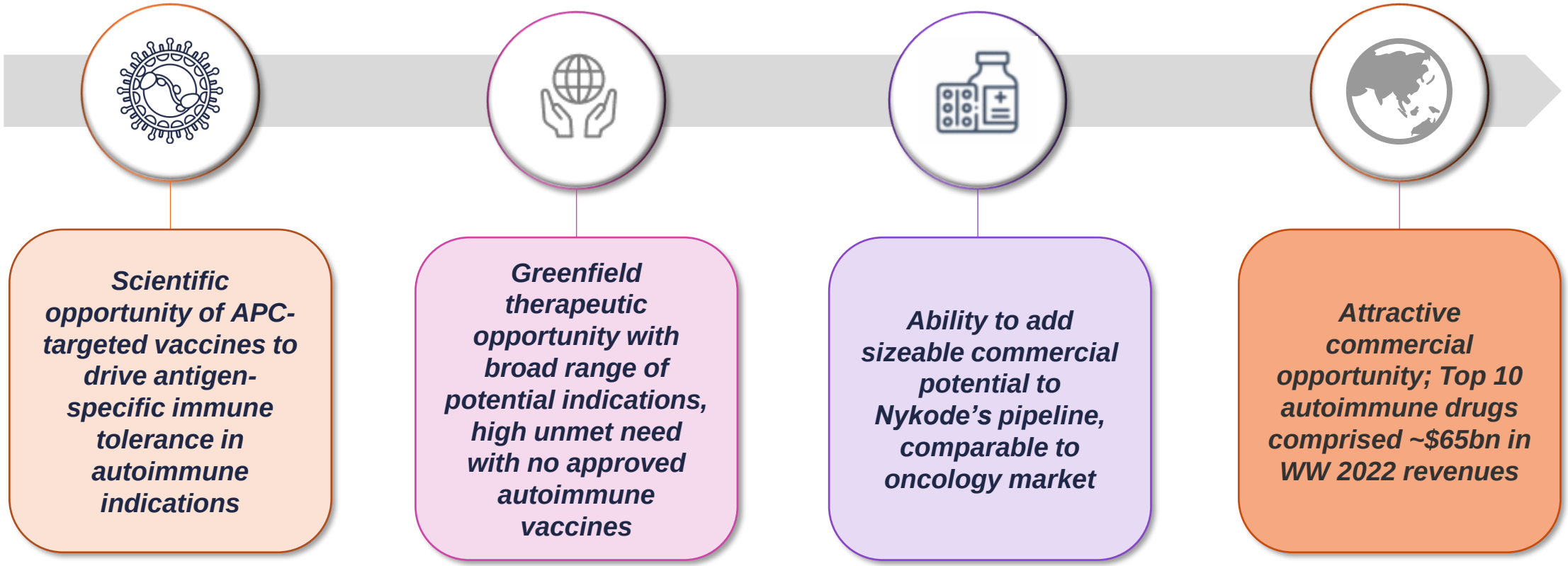
$715M~

- $200M upfront/near term
- $515M in potential payments and milestones
- Tiered low double-digit royalties

Nykode's successful business model validated and ready to accelerate development in autoimmune diseases



Autoimmune indications are an attractive platform expansion category



Dedicated to build on the business model and continue innovation to generate novel platforms and products

Nykode has proven its ability to generate groundbreaking platform technologies

- and leverage this by advancing in house and partnered programs in parallel
- leading to a validated and advanced oncology business ready to be further accelerated

We now see an opportunity to leverage this business model in autoimmunity

Nykode will continue the focus on generating broad «new code» IP protection by creating proprietary platform technologies and maximize value by accelerating both in house and partnered programs

nykode

07 Final remarks

Michael Engsig,
Chief Executive Officer

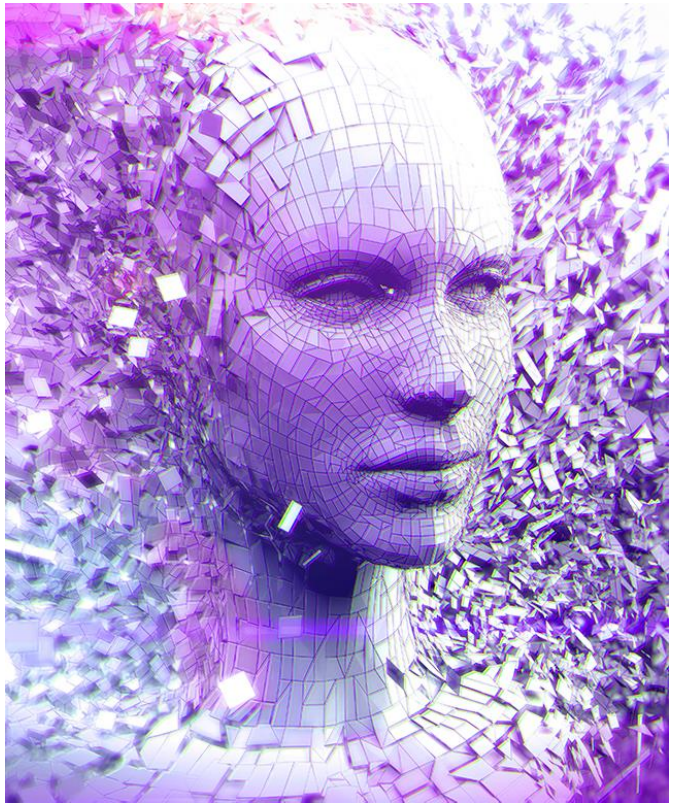
Rich calendar of milestones expected in the next 12 months

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 VB-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 VB-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 VB-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

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

Our conviction in Nykode's platform has never been stronger

Differentiated APC targeting immunotherapy platform validated and de-risked through clinical data and top tier US biopharma partnerships

Clinical durability and survival data further supported today by long lasting immune response with both VB10.16 and VB10.NEO - including differentiated long post-treatment immune responses

- Focused plan to progress VB10.16 towards patients and markets - including a potential fast to market opportunity in recurrent late stage cervical cancer setting
- Early stage cancer setting supported by safety profile, clinical responses and long lasting immune responses presents significant upside potential across our oncology platform
- Our data indicate opportunities for expanding our cancer vaccine platform into a broad range of tumor antigens, supported by today's breaking tolerance data

Unlocking Nykode's autoimmune disease area which could constitute a potential new therapeutic vertical

Well-capitalized to execute growth strategy ($174m in cash at June 30, 2023)

Q&A

- Michael Engsig, CEO
- Agnete Fredriksen, CBO & Co-founder
- Mikkel W. Pedersen, CSO
- Klaus Edvardsen, CDO
- Harald Gurvin, CFO

THANK YOU FOR JOINING US!

UNLOCKING THE FUTURE OF MEDICINE

Contact:
Alexandra Deschner
Head of IR
IR@nykode.com

VB-C-02

Changes in immunosuppressive cells post treatment is associated with clinical outcome

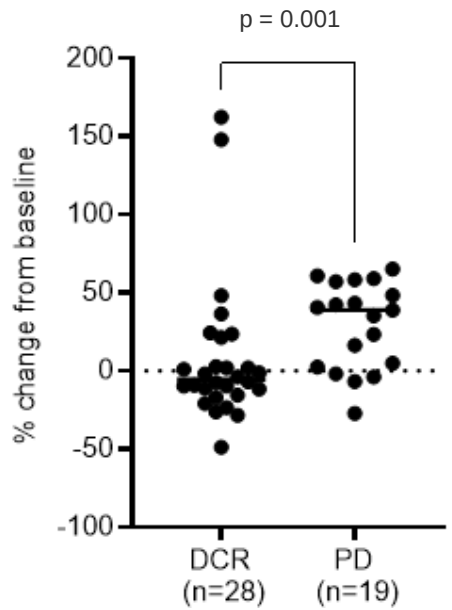
Best Overall Response	Disease control (n=28)	Progressive disease (n=19)
Increase	11 (39%)	15 (79%)
Decrease	17 (61%)	4 (21%)

p = 0.009
Fisher's exact test

Median PFS	Median progression-free survival
Increase	2.1 months
Decrease	8.0 months

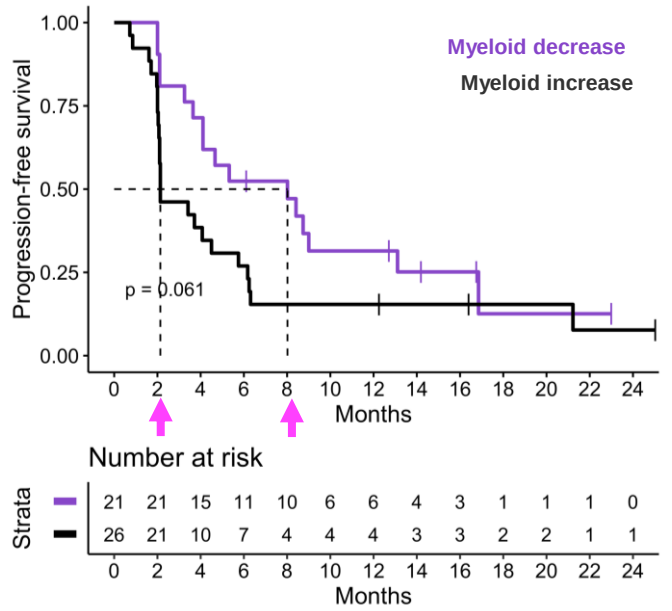
p = 0.061
Log rank test

CHANGE IN MYELOID CELLS IS ASSOCIATED WITH CLINICAL OUTCOME



Mann-Whitney test

PROGRESSION-FREE SURVIVAL



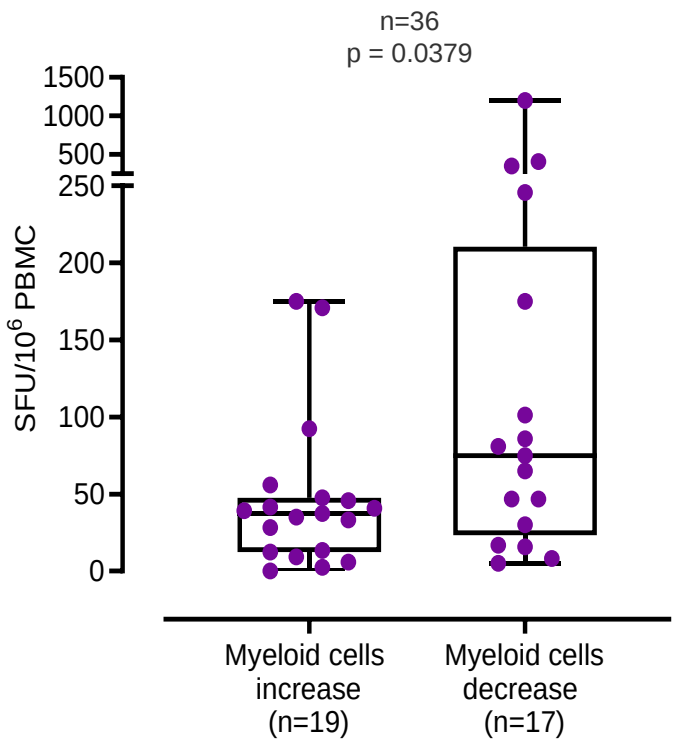
Log rank test

All patients in the efficacy population are included (N=47)

Myeloid cells defined as the sum of absolute neutrophils and monocytes, measured by standard leukocyte diffrentiation at baseline and week 9. Note: A shift in systemic immunosuppression in patients with clincal benefit is verified by NLR and myeloid to lymphoid ratio

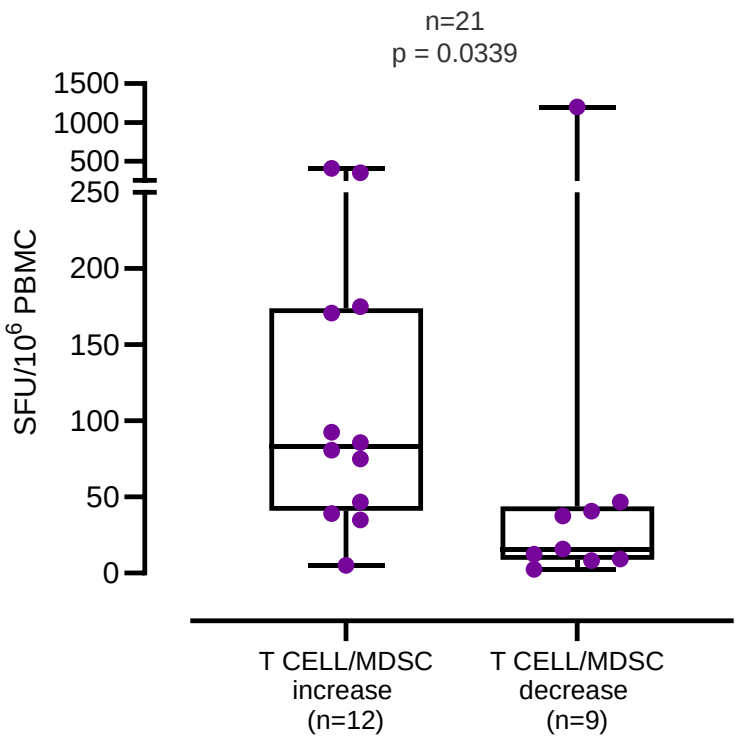
Stronger HPV16-specific T cell responses in patients with a decrease in immunosuppressive cells

DECREASE OF MYELOID CELLS IS ASSOCIATED WITH STRONGER T CELL RESPONSES



Mann-Whitney test

INCREASE OF T CELL/MDSC RATIO CELLS IS ASSOCIATED WITH STRONGER T CELL RESPONSES



Mann-Whitney test

Myeloid cells defined as the sum of absolute neutrophils and monocytes, measured by standard leukocyte differentiation.
ELISpot data not available for 11 subjects.
T CELL/MDSC ratio is the calculated expression of $CD3^+$ T cells relative to PMN-MDSCs by flow cytometry.

VB-C-03

A Phase 1/2a, Open-label, Dose-finding Trial to Evaluate Safety, Immunogenicity, and Anti-tumor Activity of VB10.16 and Pembrolizumab in Patients With Unresectable Recurrent or Metastatic HPV16-positive Head-Neck Squamous Cell Carcinoma (NCT06016920)

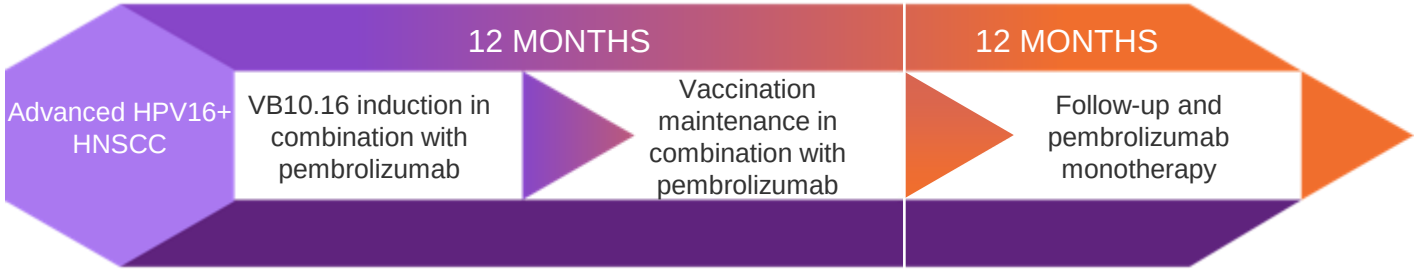
VB-C-03 trial in advanced HPV16+ HNSCC

Combination treatment of VB10.16+pembrolizumab* in 1L HPV16+ R/M HNSCC

Dose-escalation (Phase 1) with randomized dose-expansion (Phase 2a) trial

- **Key eligibility criteria**
  - HPV16+, r/m HNSCC
  - Eligible for standard of care treatment with pembrolizumab monotherapy
- **Approximately 40 patients will be enrolled**
- **Key endpoints**
  - Objective response rate (ORR)
  - Safety/tolerability
  - Antigen-specific immune response
- **Exploratory endpoints**
  - Biomarkers (e.g. ctDNA)
  - Changes in tumor micro-environment

- **Dosing schedule VB10.16 vaccine**
  - Recommended Phase 2 set (RP2S): Randomization (1:2) of 3 mg vs (anticipated) 9 mg in dose-expansion phase
  - Combination treatment administered for up to 1 year
- **Dosing schedule immune checkpoint inhibitor**
  - Pembrolizumab for up to 2 years
- **Phase 1 (dose escalation):** 3, 6 and 9 mg and selection of RP2S
- **Phase 2 (dose expansion):** Assessment of RP2S to determine optimal biologic dose (OBD) for further clinical development

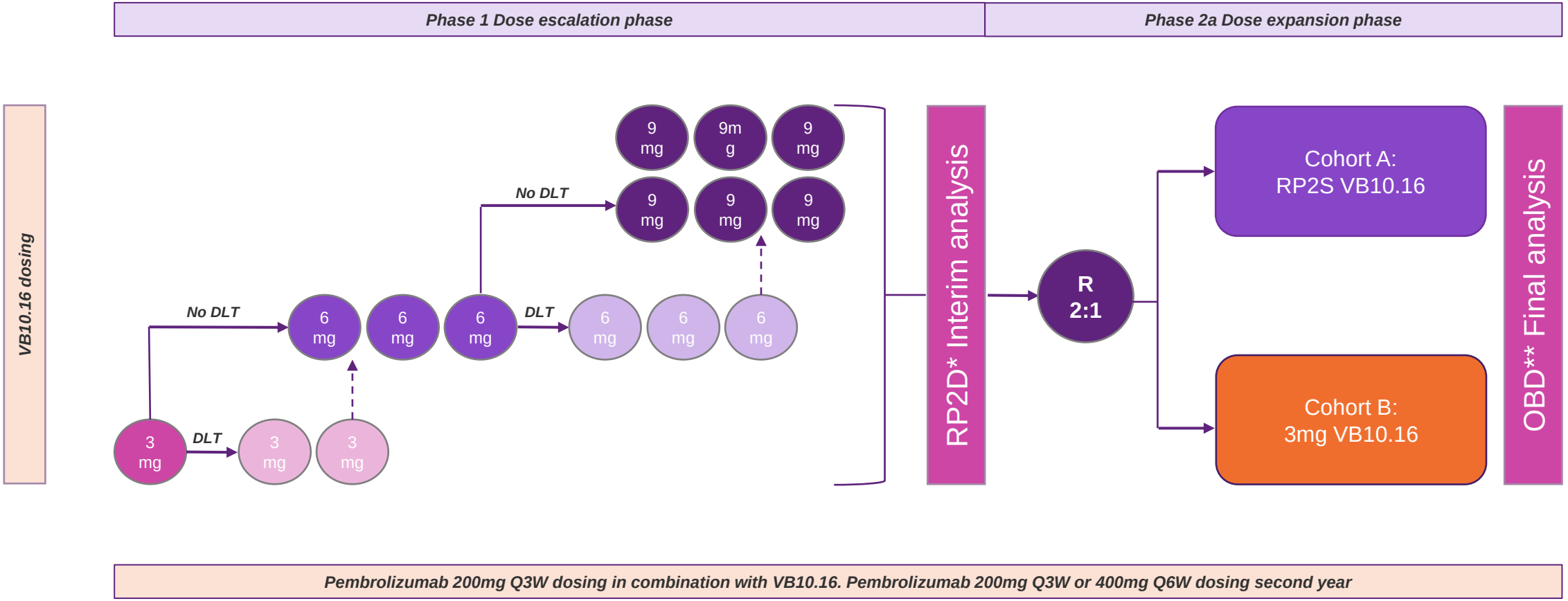


Pembrolizumab will be supplied by Merck in accordance with the clinical collaboration and supply agreement between Nykode and MSD

*KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA.

VB-C-03 Clinical trial design

Combination treatment of VB10.16+pembrolizumab in 1L HPV16+ R/M HNSCC

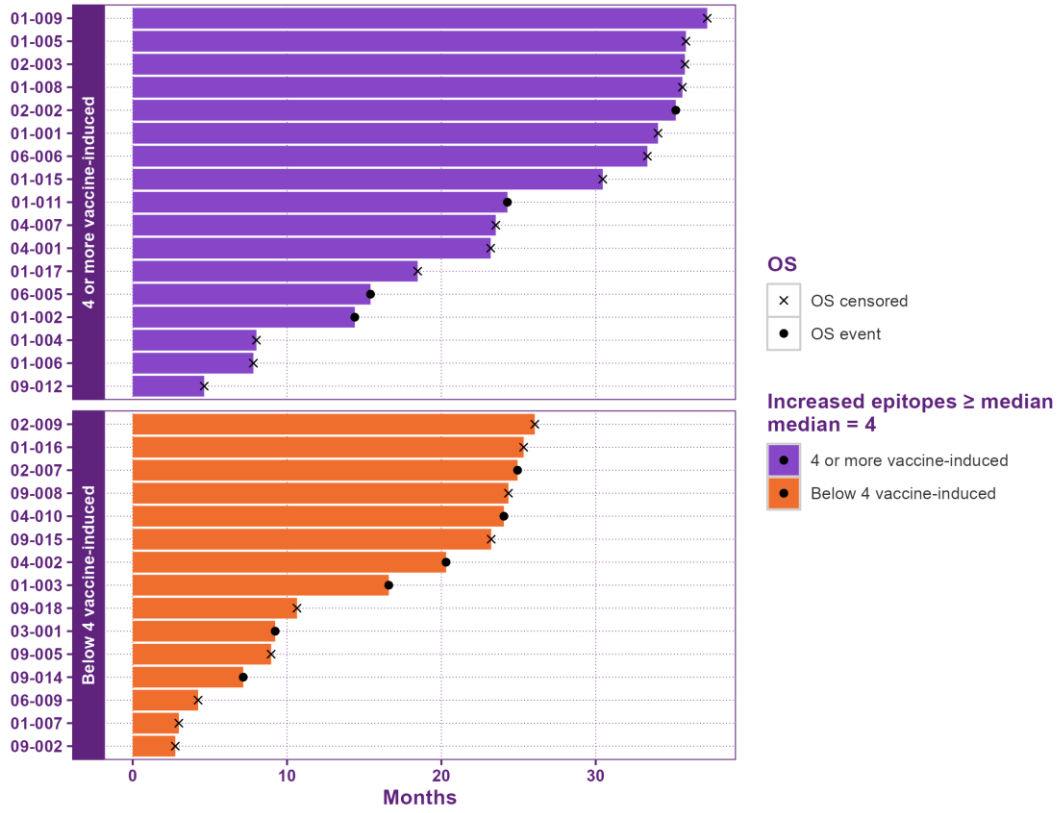


*RP2D=Reccomended Phase 2 Dose
**OBD= Optimal Biological Dose

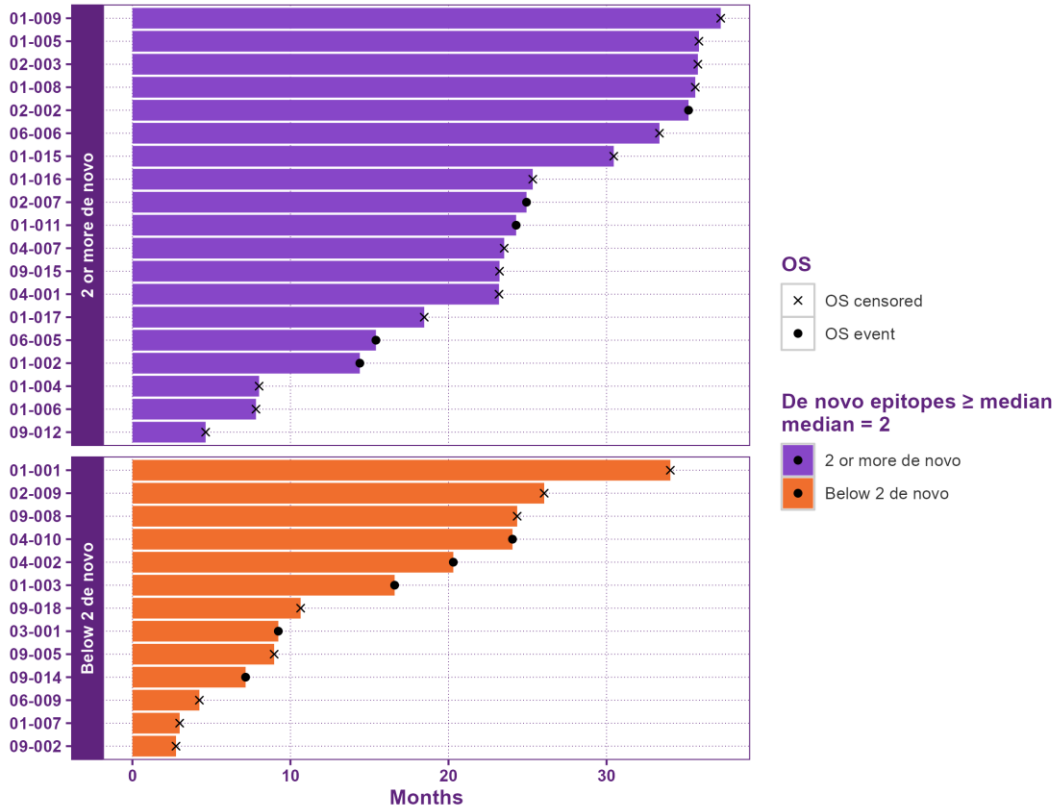
VB-N-01

T cell responses per patient

Total T cell responses



De novo T cell responses



Patients grouped in lower and higher than median immune responses

Patients included are overlapping between EFR and FAS (N=32).