nykode therapeutics

Company Presentation

March 2024

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 antigen presenting cell (APC)-targeted immunotherapy technology

nykode therapeutics

NYKODE THERAPEUTICS (NYKD-OL, MKT CAP ~$555M[1])

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

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
- mRNA vaccine having demonstrated preclinical differentiation vs. existing 'antigen-alone' approaches

Autoimmune disease constitute a potential new therapeutic vertical in high-unmet need indications (e.g., MS, T1D)

Strategic partnerships with top tier US biopharma companies[2]

Genentech
A Member of the Roche Group
Up to ~$715M

REGENERON
Up to ~$925M

Well-capitalized with a cash position of $162.6m at December 31, 2023
Completed private placement of $45m in October with primarily new international specialist investors

1. Based on closing share price of NOK 17.90 on February 23, 2024 and USD/NOK exchange rate of 10.53.
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 Genentech to subsequently conduct clinical, regulatory, manufacturing and commercialization activities

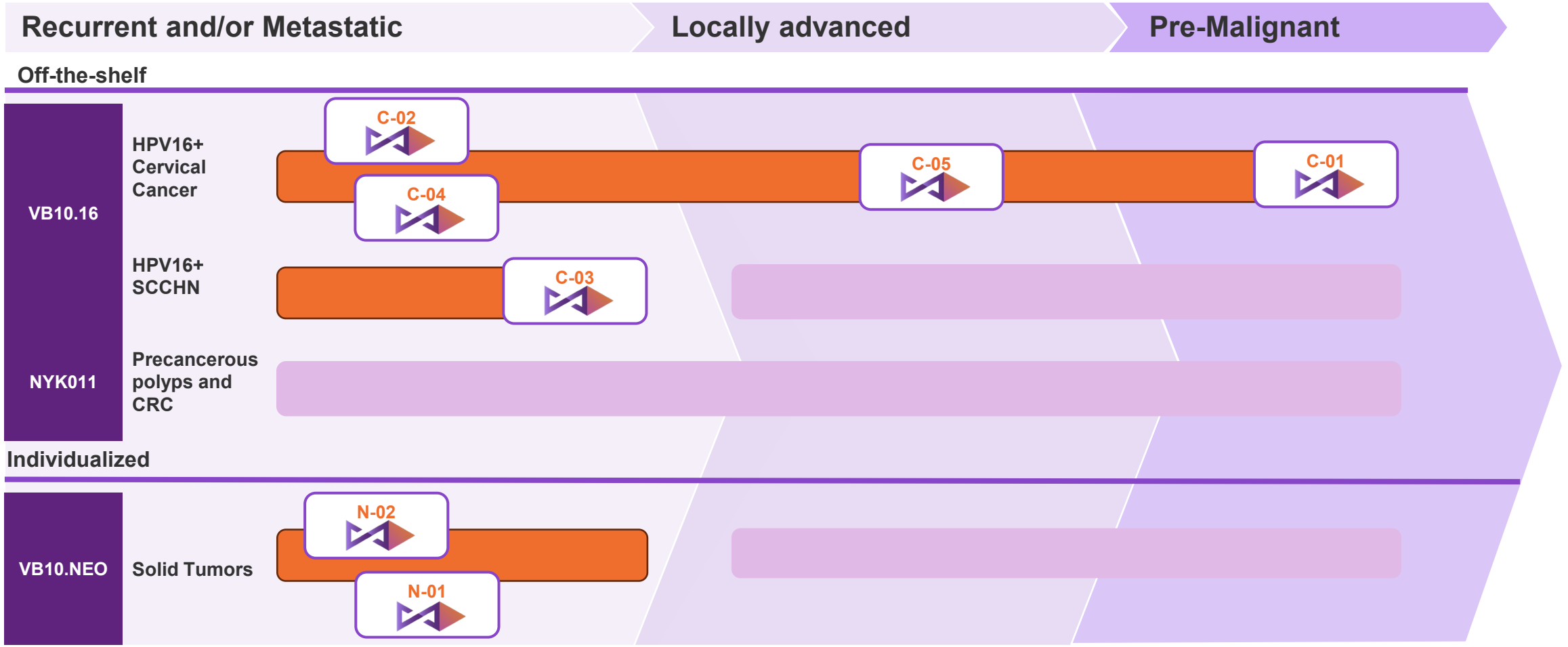
Broad pipeline targeting early to late-stage cancer treatment

	Asset	Indication	Rights	Preclinical	Phase 1	Phase 2	Phase 3	Upcoming Catalyst
Oncology								
Off-the-shelf	VB10.16	HPV16+ cervical cancer	nykode [1]				C-02, C-04	Initiate trial (Q1 2024)
		HPV16+ head and neck cancer	nykode [2]			C-03		Dose level recommendation (H2 2024)
		HPV16+ locally advanced cervical cancer	nykode [2]				C-05	Protocol in development
	Regeneron programs	Undisclosed	nykode REGENERON [3]					Selection of lead candidate
	NYK011	Colorectal: pre-cancerous polyps to cancer	nykode					Update (H2 2024)
Individua-lized	VB10.NEO	Melanoma, lung, bladder, renal, head and neck cancer; locally advanced and metastatic tumors	nykode Genentech [4]				N-01	
		Locally advanced and metastatic tumors	nykode Genentech [4]			N-02		
Infectious Disease								
Regeneron programs		Undisclosed	nykode REGENERON					
Autoimmune								
Internal		Undisclosed	nykode					Update (H1 2024)

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.

Balanced portfolio designed to adress all stages of disease from pre-malignant to late-stage cancer treatment

Strategic expansion of vaccine candidate portfolio



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

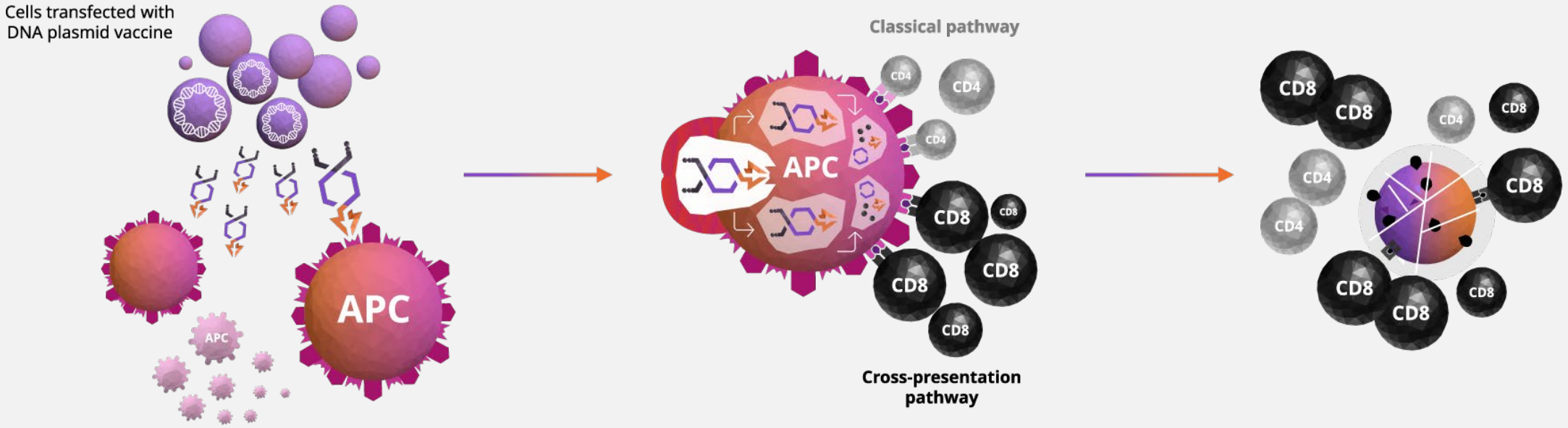
Antigens of choice from cancer, viruses, bacteria, parasites or autoimmune disease

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

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.

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

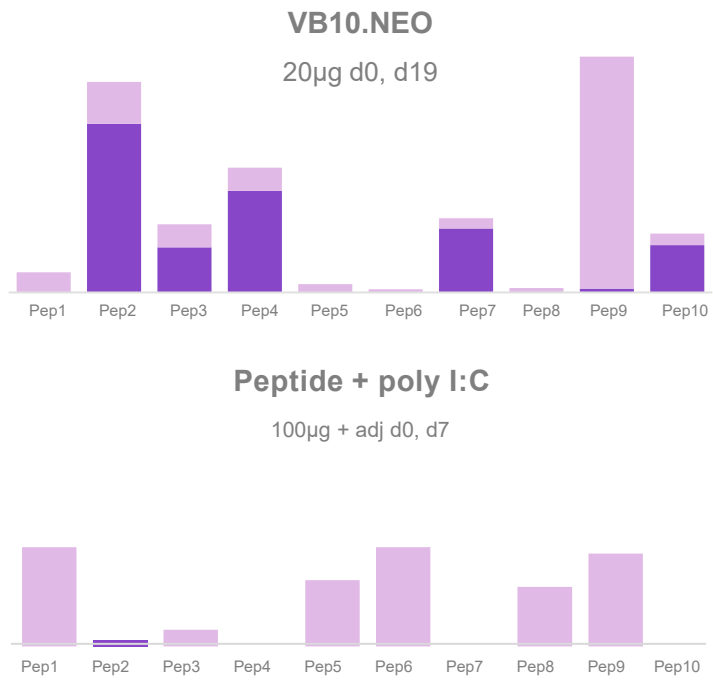
Comparison with peptide and RNA vaccination strategies shows broader CD8 and CD4 responses with Nykode's technology

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

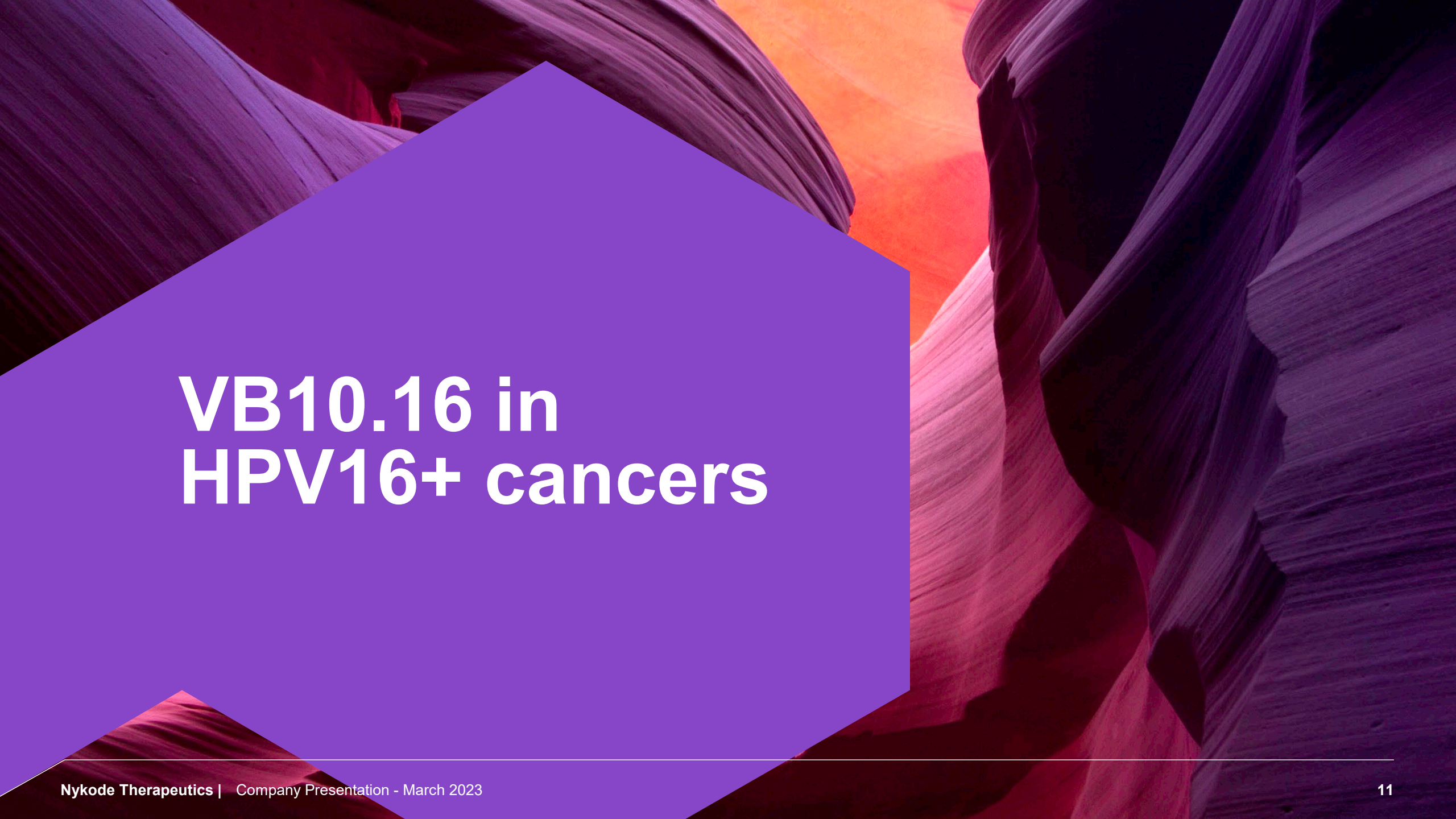
B16 melanoma model

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

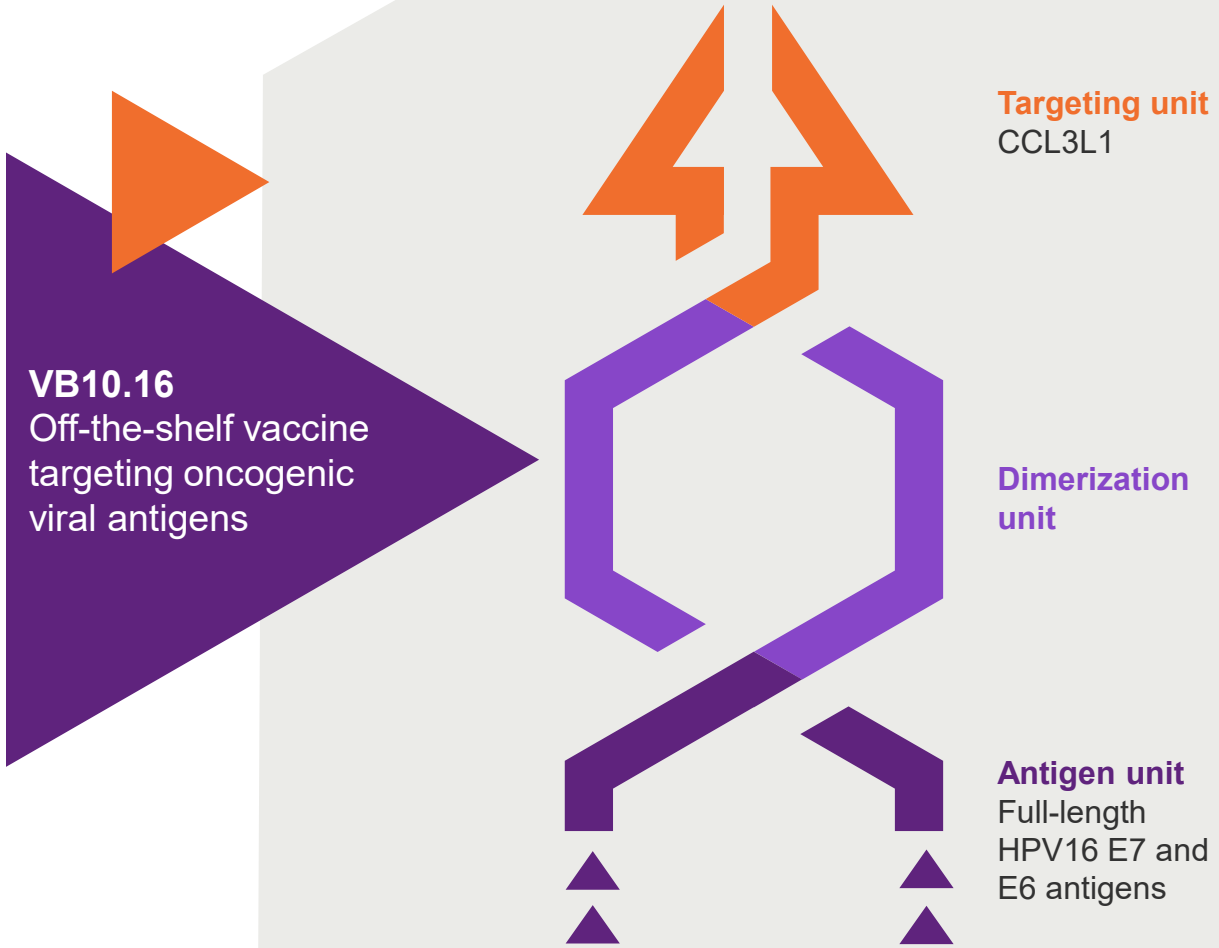


VB10.16 in HPV16+ cancers

VB10.16: Therapeutic vaccine candidate for HPV16+ cancers

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

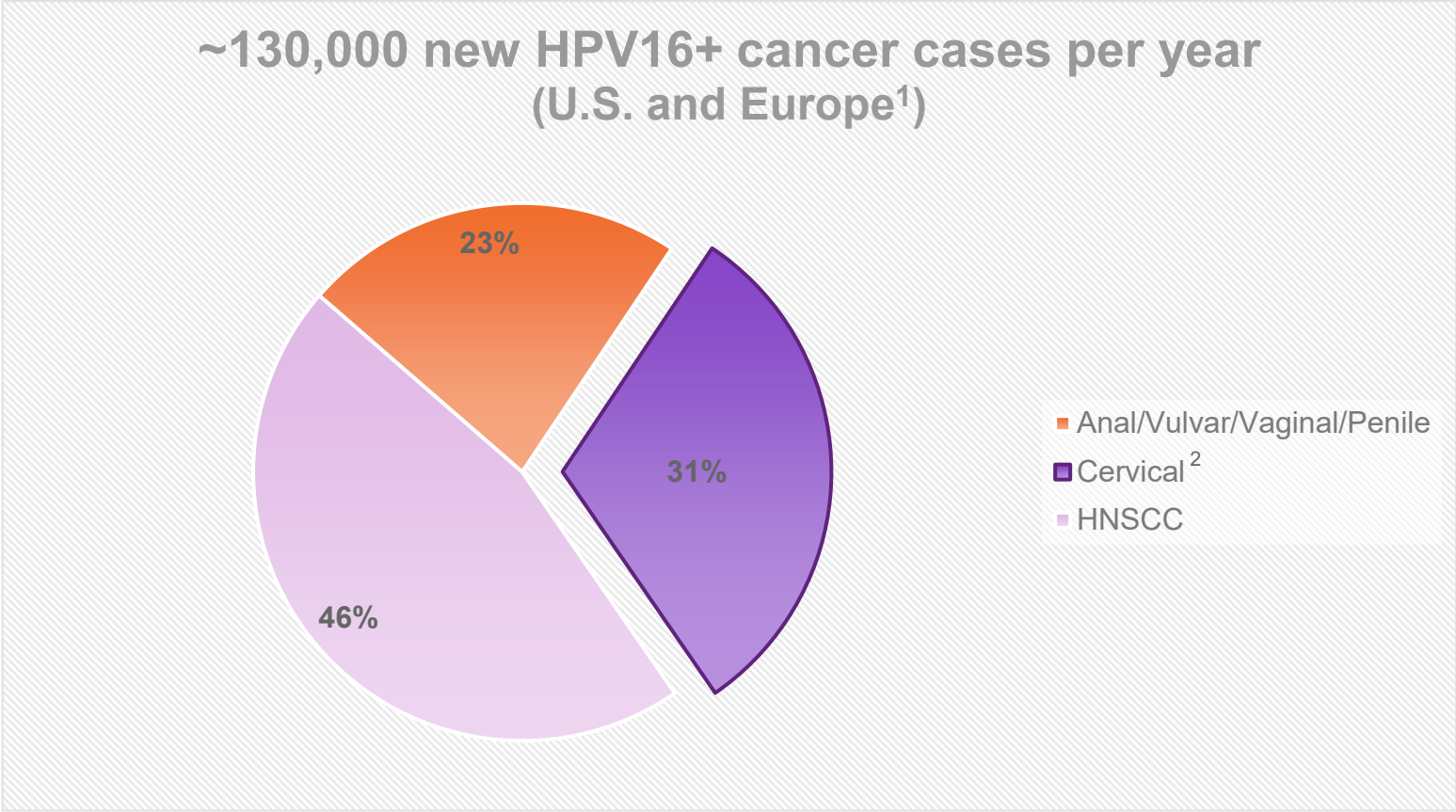
- HPV16 is the most prevalent oncogenic HPV strain
- Targeting the cancer-specific full-length HPV16 E7 and E6 antigens
- Promising Phase 2a data demonstrating strongly competitive efficacy vs. existing standards of care
- Wholly-owned by Nykode



HPV16+ cervical cancer is a significant unmet need

Cervical cancer incidence worldwide

- 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%

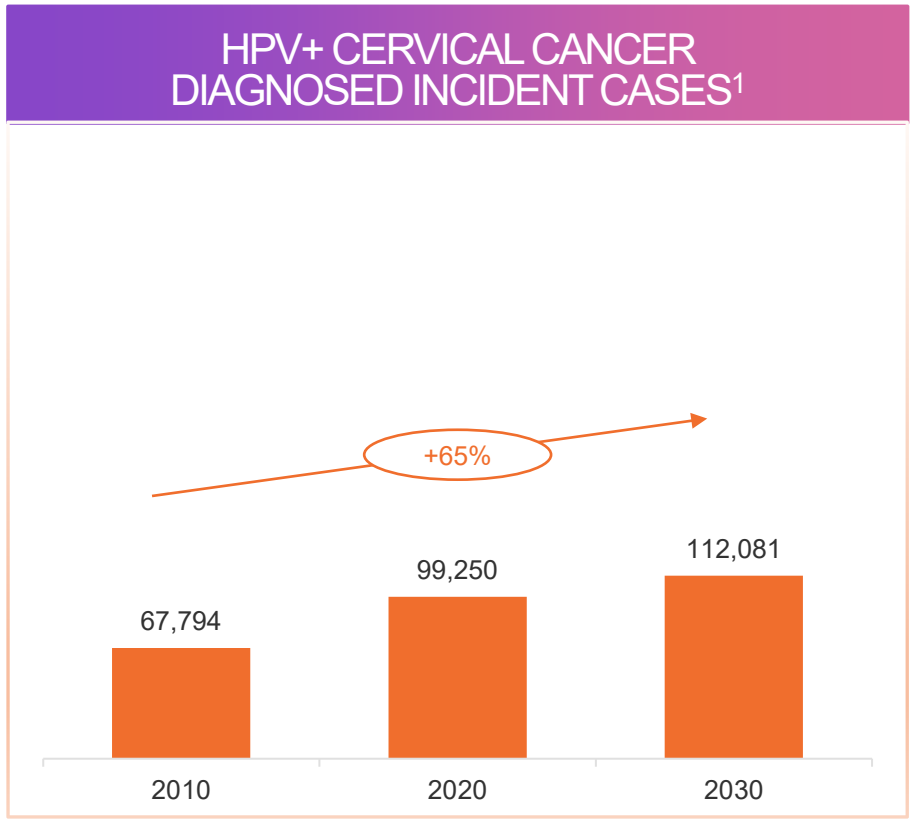


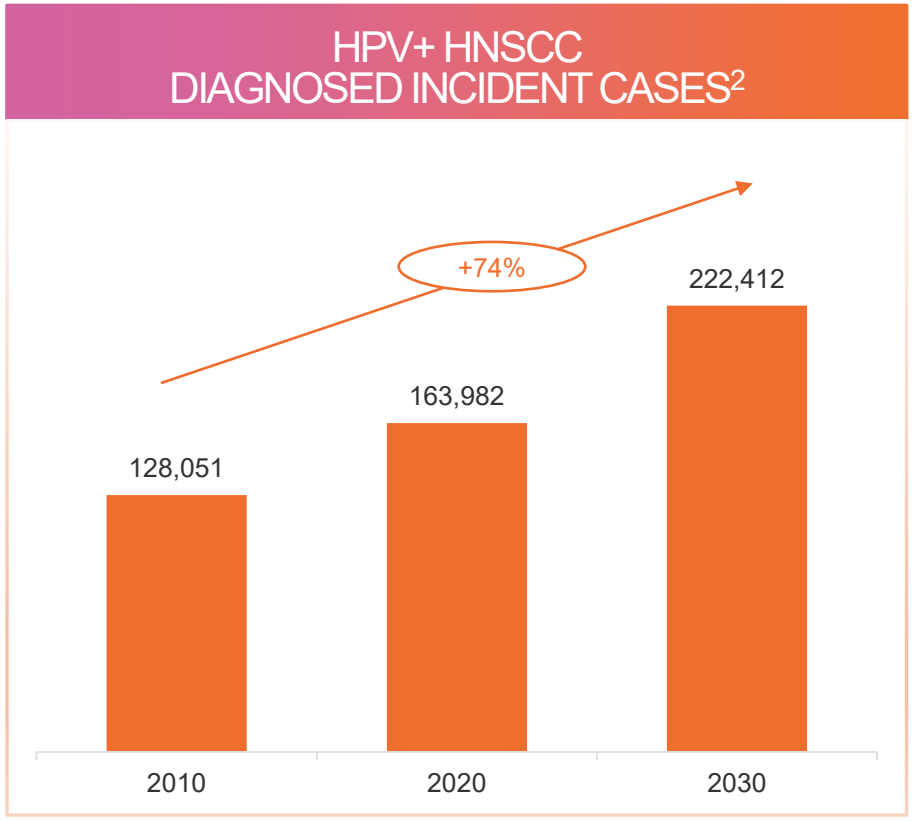
[1] HPV information centre https://hpvcentre.net/statistics/reports/XEX.pdf?t=1680531103948; American Cancer Society, Cancer Facts & Figures 2020 https://www.cancer.org/; Head Neck Pathol. 2012; 6:55; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3394159/; J Natl Cancer Inst. 2015 Jun; 107(6): djv086 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4838063/; Internal analysis

[2] Head and neck squamous cell carcinoma

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

U.S. + EU5 + China + Japan



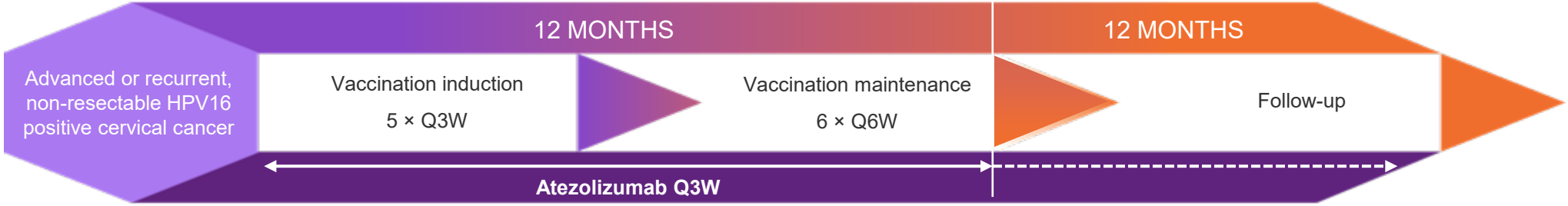


[1] GlobalData Cervical Cancer. 8 main markets (U.S., France, Germany, UK, Italy, Spain, Japan, China)
[2] GlobalData HNSCC. 8 main markets (U.S., France, Germany, UK, Italy, Spain, Japan, China). Head Neck Pathol. 2012; 6:55; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3394159

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

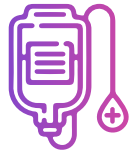
A Multi-Centre, Single Arm, Open-label Phase 2a Trial of the Combination of VB10.16 and atezolizumab in Patients with Advanced or Recurrent, Non-resectable HPV16 Positive Cervical Cancer (NCT04405349)

- **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 .

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 (estimated 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 C-02 data compare strongly to CPI monotherapy as well as expected SoC in ≥2L r/m cervical cancer

	VB10.16 plus atezolizumab in PD-L1+	CPI Monotherapy in r/m CC			
		Atezolizumab in PD-L1+†††	Pembrolizumab in PD-L1+**	Cemiplimab in PD-L1+ ††	Tisotumab vedotin (PD-L1 agnostic) ‡‡
Trial name	**C-02**	Skyscraper-04, atezolizumab arm	Keynote-158	Empower-Cervical 1, cemiplimab arm	InnovaTV 301, tisotumab vedotin arm
ORR	**29%**	16%	17%	18%	18%
mPFS	**6.3 mo**	1.9 mo	2.1 mo	3.0 mo	4.2 mo
mOS	**Not reached (25.0+ mo)**	10.6 mo	11.0 mo	13.9 mo	11.5 mo

Median OS not yet reached (last update August ‘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

††† Salani et al. Efficacy and safety results from Skyscraper-04: An open-label randomized phase 2 trial of tiragolumab plus atezolizumab for PD-L1-positive recurrent cervical cancer. IGCS 2023.

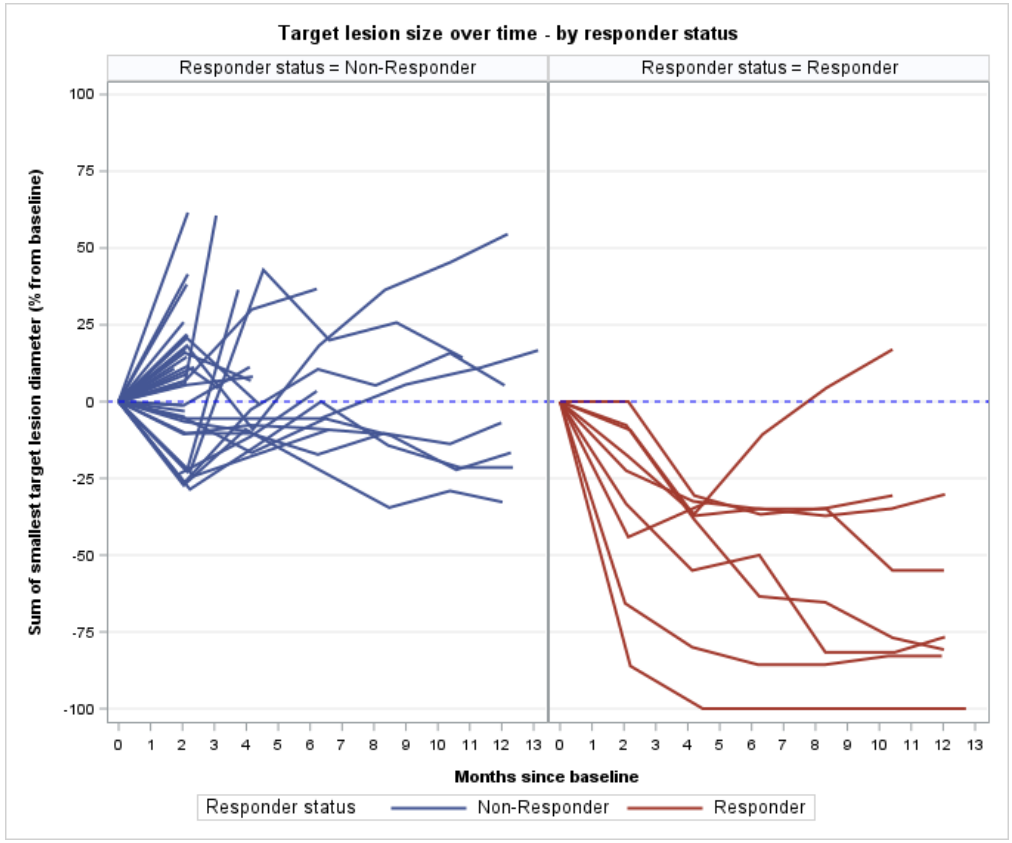
** Chung et al. Efficacy and safety of pembrolizumab in previously treated advanced cervical cancer: Results from the phase II KEYNOTE-158 study. J Clin Oncol 2019

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

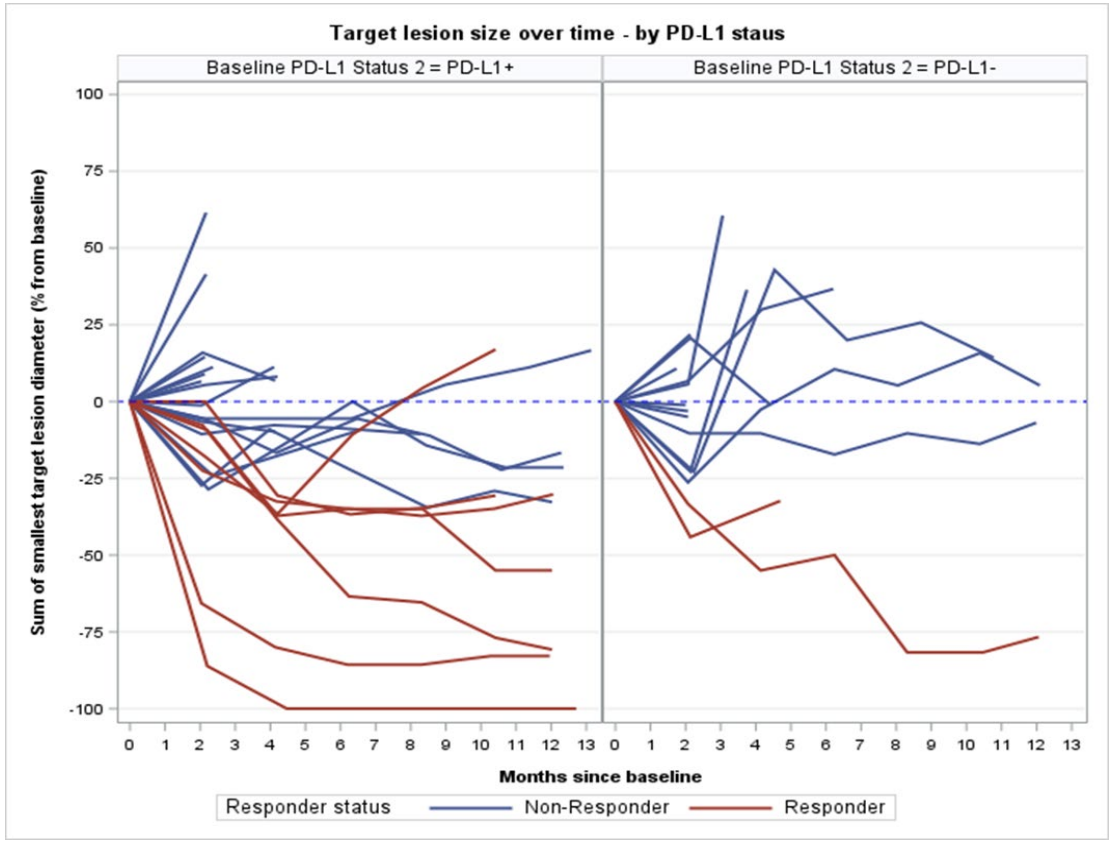
‡‡ Confirmatory phase 3 RCT evaluating tisotumab vedotin vs. investigator’s choice chemotherapy (topotecane, vinorelbine, gemcitabine, irinotecan, or pemetrexed). Ignace Vergote: innovaTV 301/ENGOT-cx12/GOG-3057: A Global, Randomized, Open-Label, Phase 3 Study of Tisotumab Vedotin vs Investigator’s Choice of Chemotherapy in 2L or 3L Recurrent or Metastatic Cervical Cancer. ESMO 2023.

VB10.16 coupled with CPI led to lasting responses

All (n = 47)



By PD-L1 status (n = 40)

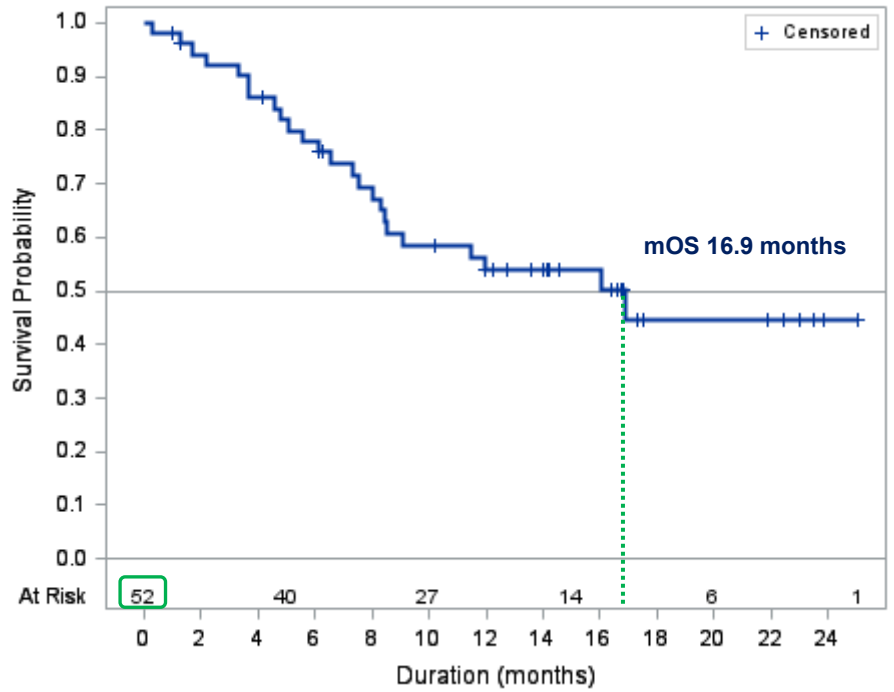


Note: 7 out of 47 responders had PD-L1 unknown status, 40 out of 47 had known PD-L1 status

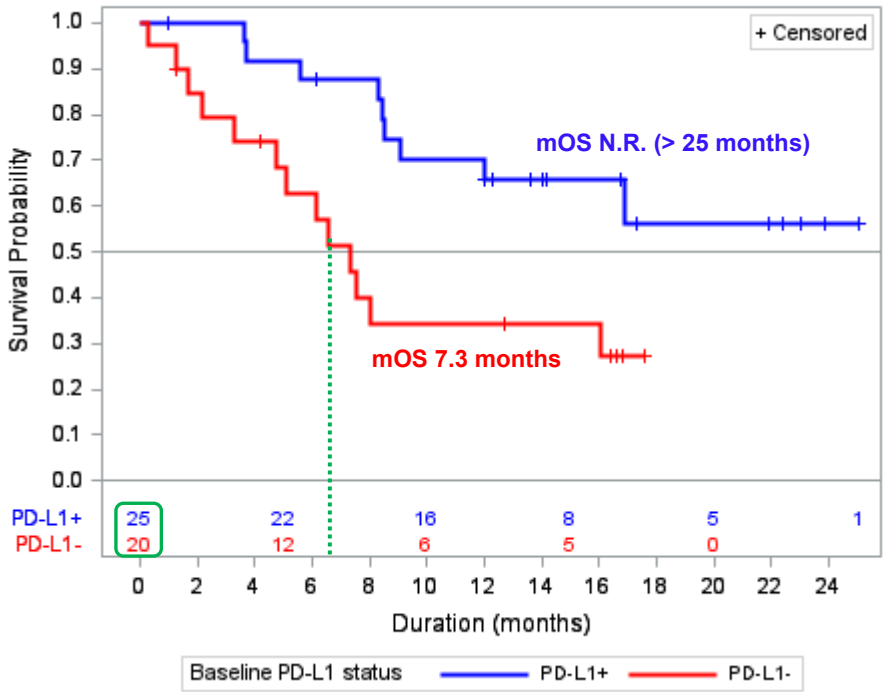
VB10.16 led to prolonged overall survival in advanced cervical cancer patients

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

Overall survival



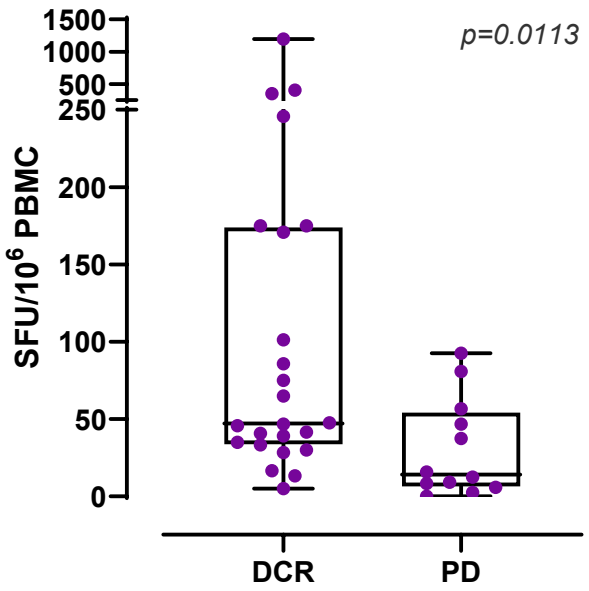
Overall survival (PD-L1+ vs. PD-L1-)



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

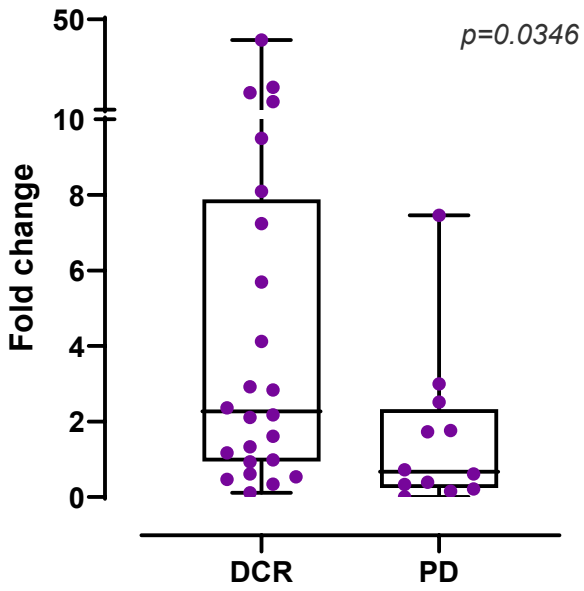
VB10.16 induced HPV16-specific T cell responses that are significantly correlated with clinical response

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

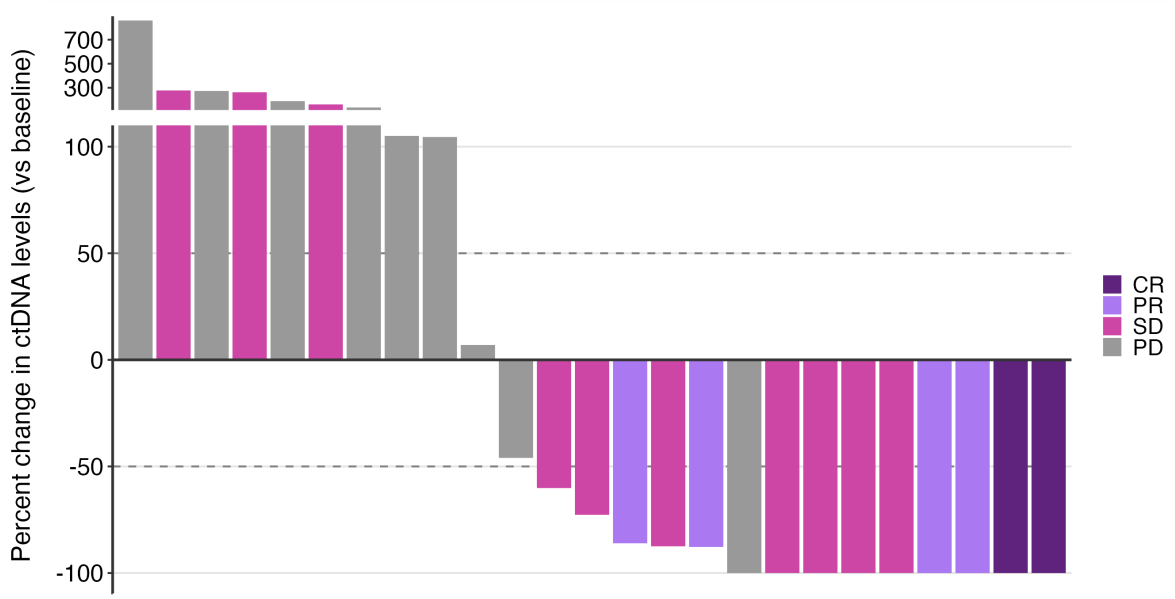


Fold change, baseline to peak count post-treatment

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

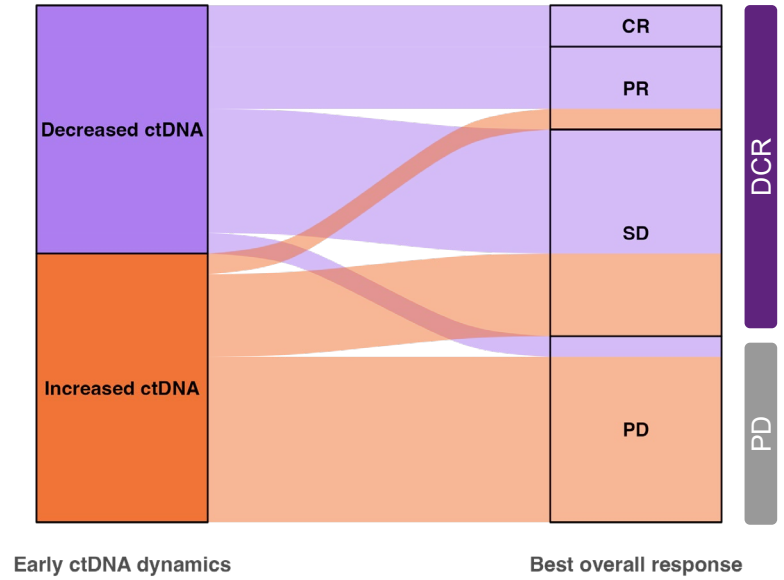
HPV16 circulating tumor DNA dynamics is associated with clinical response

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%)

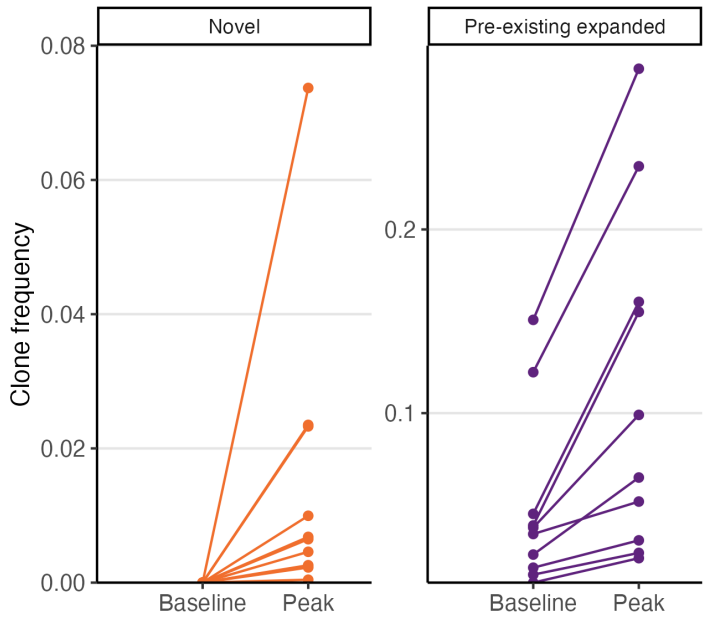
Fisher's exact test p = 0.011

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

T cell responses remain strong and long-lasting

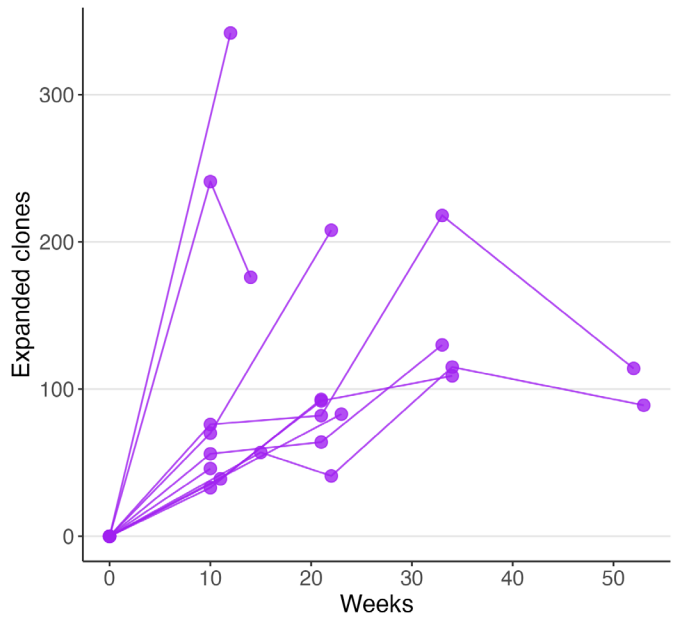
T cell clonotype analysis

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



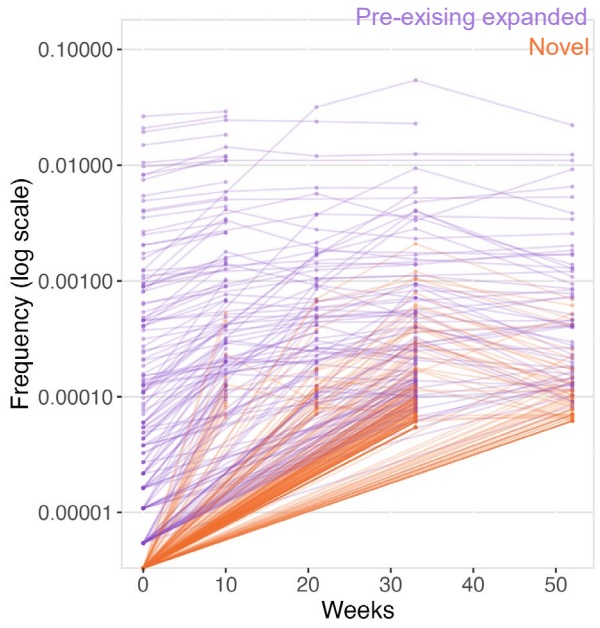
- **Rapid and persistent on-treatment T cell expansion**
- **Peak expansion of 46-342 clonotypes in 10 patients**

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

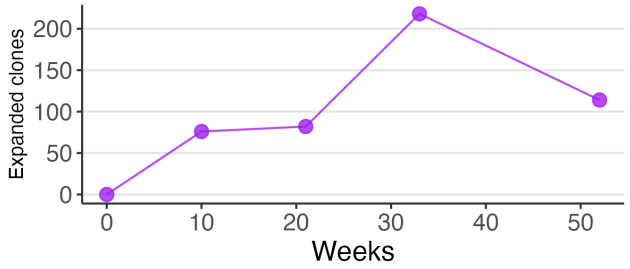
Persistent expansion of novel and pre-existing clones throughout the treatment

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)

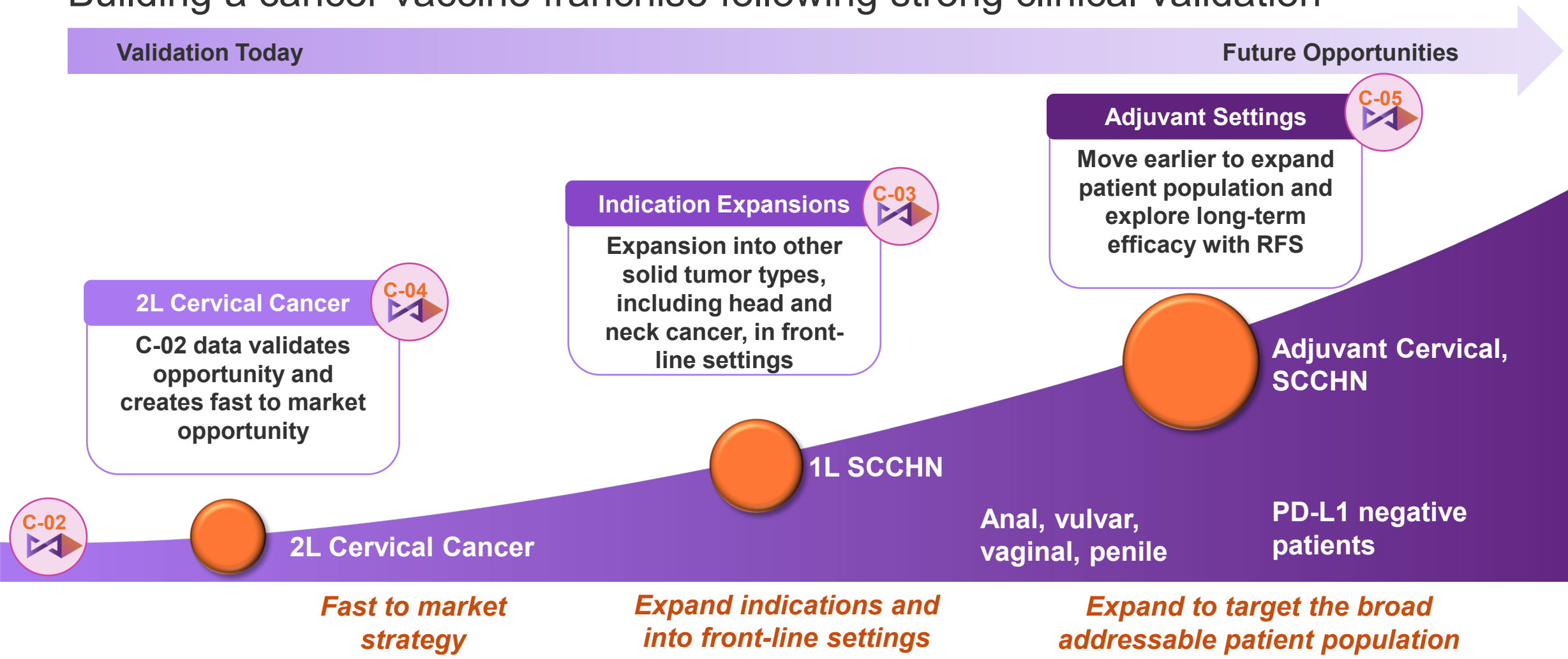
C-02 data supports patient population selection for potentially registrational study

- 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.

Maximizing addressable patient populations by diversifying offerings and broadening therapeutic scope

Building a cancer vaccine franchise following strong clinical validation



Creating a portfolio of targeted vaccines for HPV16+ cancers
VB10.16 portfolio

	C-02	C-03	C-04	C-05
Indication	r/m Cervical Cancer, ≥2L	r/m head and neck cancer (HNSCC), PD-L1+, 1L	r/m Cervical Cancer, PD-L1+, 2L	Locally Advanced Cervical Cancer (LACC)
Dose	3 mg in combination with atezolizumab (Tecentriq®)	Up to 9 mg in combination with pembrolizumab (Keytruda®[1])	9 mg in combination with atezolizumab (Tecentriq®)	TBD
Phase	2a	1/2a	2	2
Status	Finalized	Enrolling second dose level (6 mg); 11 out estimated 22 sites activated in 8 countries	Enrolment to start. Currently 36 US sites in process of activation	Protocol in development
Next catalyst(s)	Updated survival data Q1 2024	Recommended Ph2 dose for Part 2 in H2 2024	Initiate potentially registrational trial (U.S.) Q1 2024; finalize enrolment of Part 1 in Q4 2024	

VB10.16 is wholly owned by Nykode

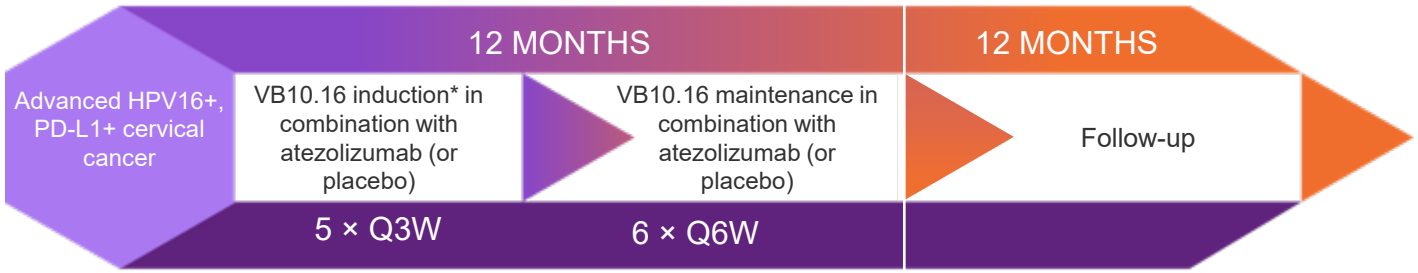
1. Note: KEYTRUDA® is a registered trademark of Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA

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

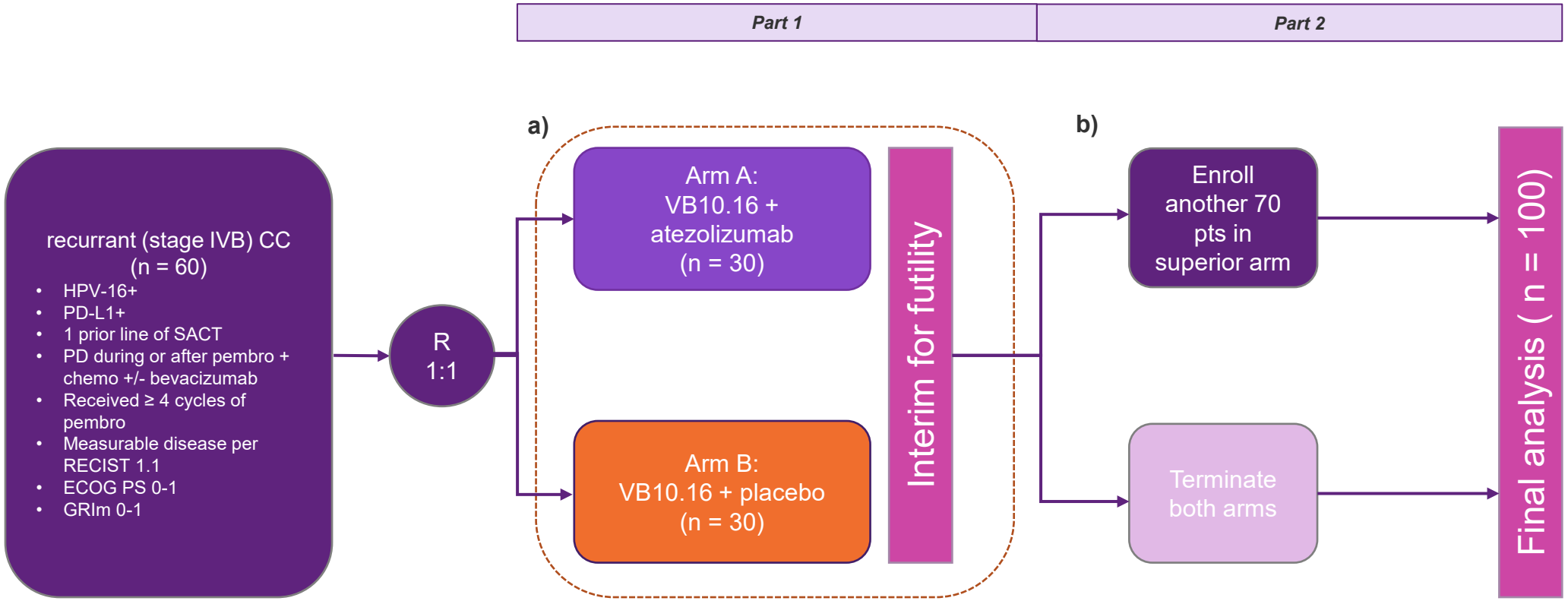
- **Dosing schedule VB10.16 vaccine (i.m.)**
  - Q3W for 5 cycles (induction period) followed by Q6W thereafter (6 cycles in maintenance period)
- **Dosing schedule immune checkpoint inhibitor (i.v.)**
  - Atezolizumab 1200 mg (or placebo) QW3
- **Strategic go/no-go decision and selection of superior 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**



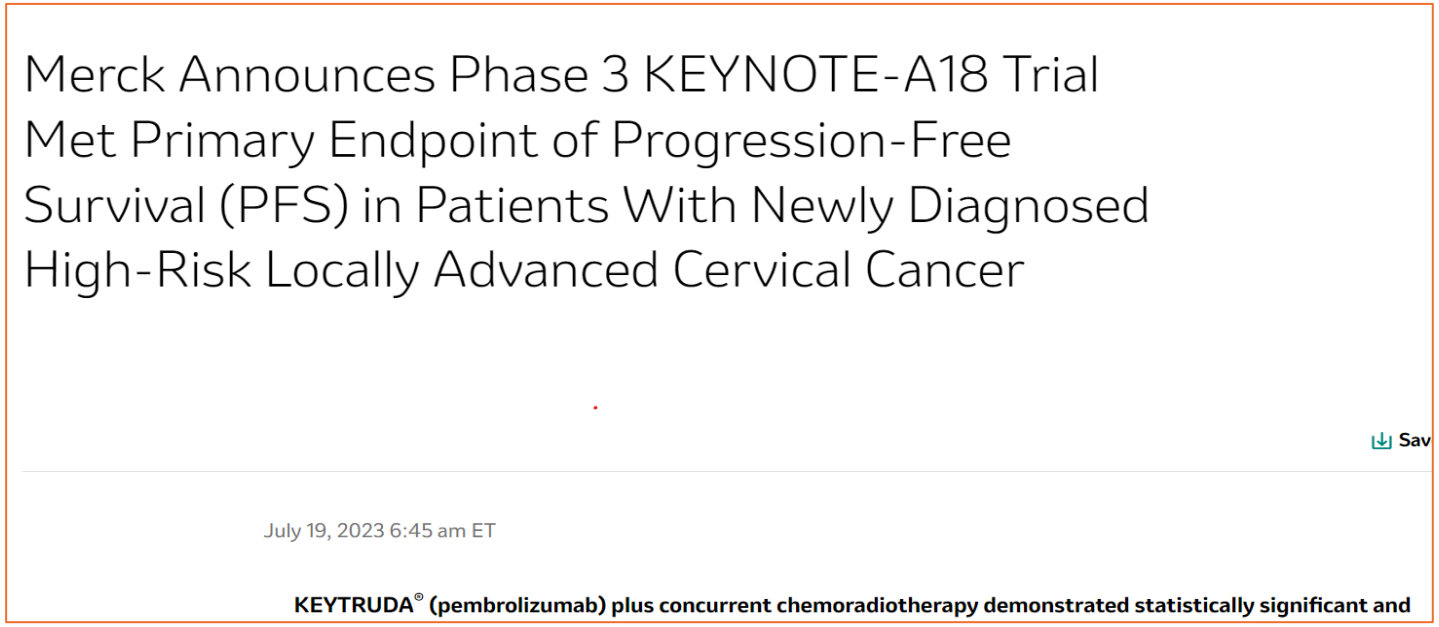
Atezolizumab will be supplied by Roche

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

Overview: randomized Phase 2 selection design



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

Press release

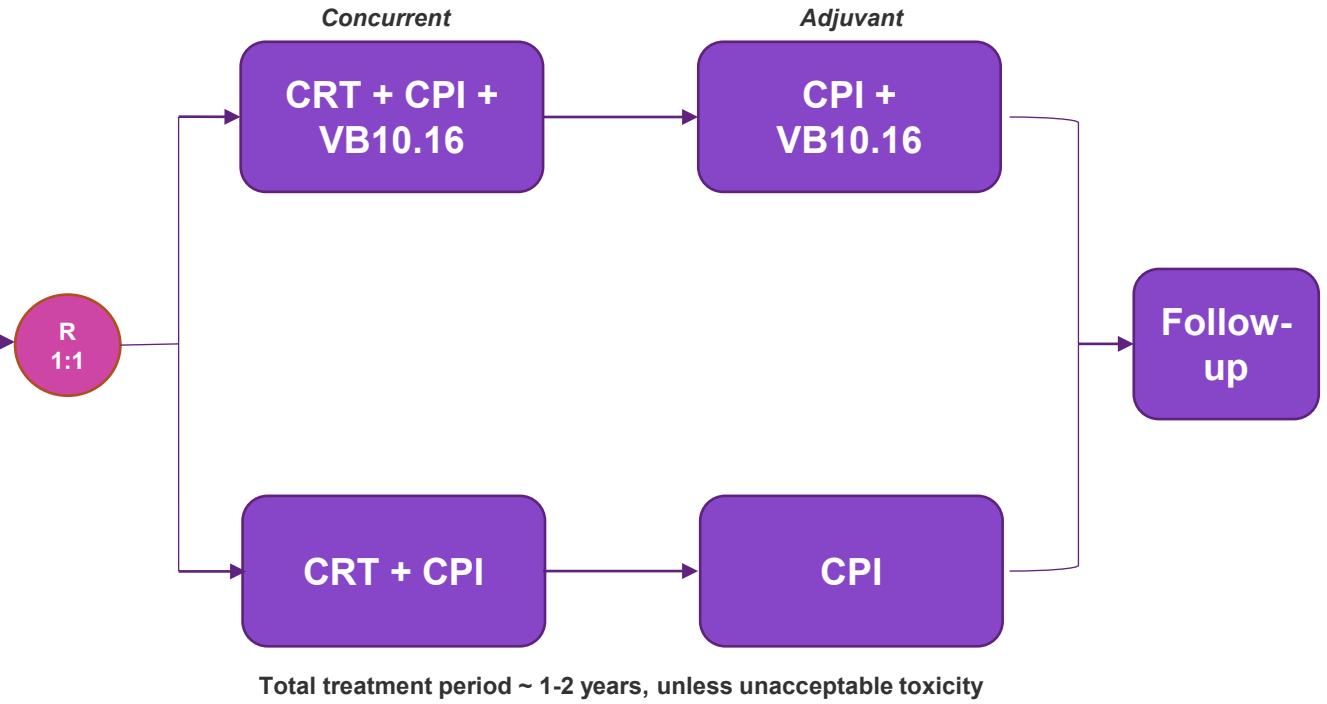
VB C-05: VB10.16+CPI as concurrent treatment to CRT in Locally Advanced Cervical Cancer

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

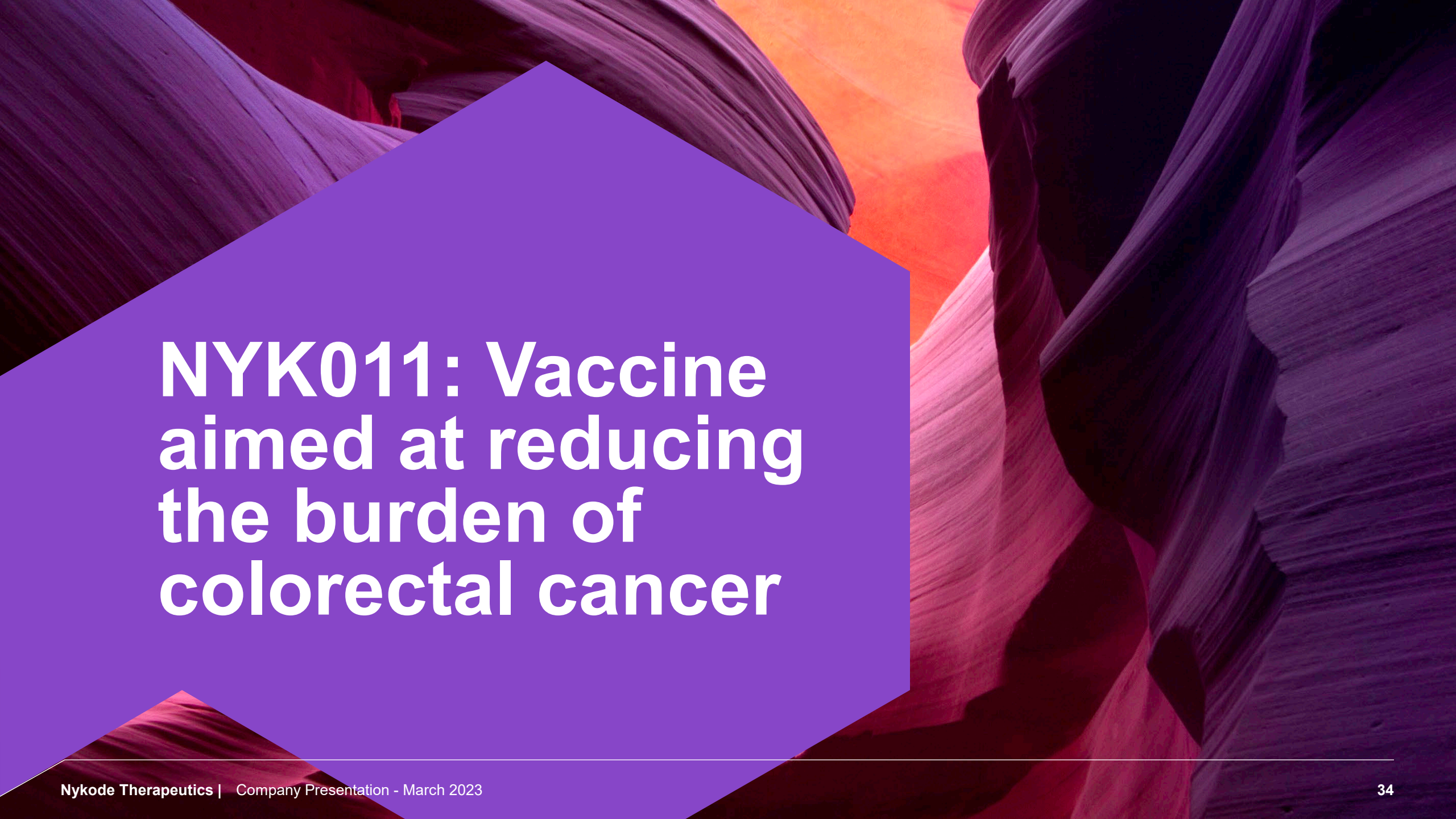


Primary endpoint
PFS and OS

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

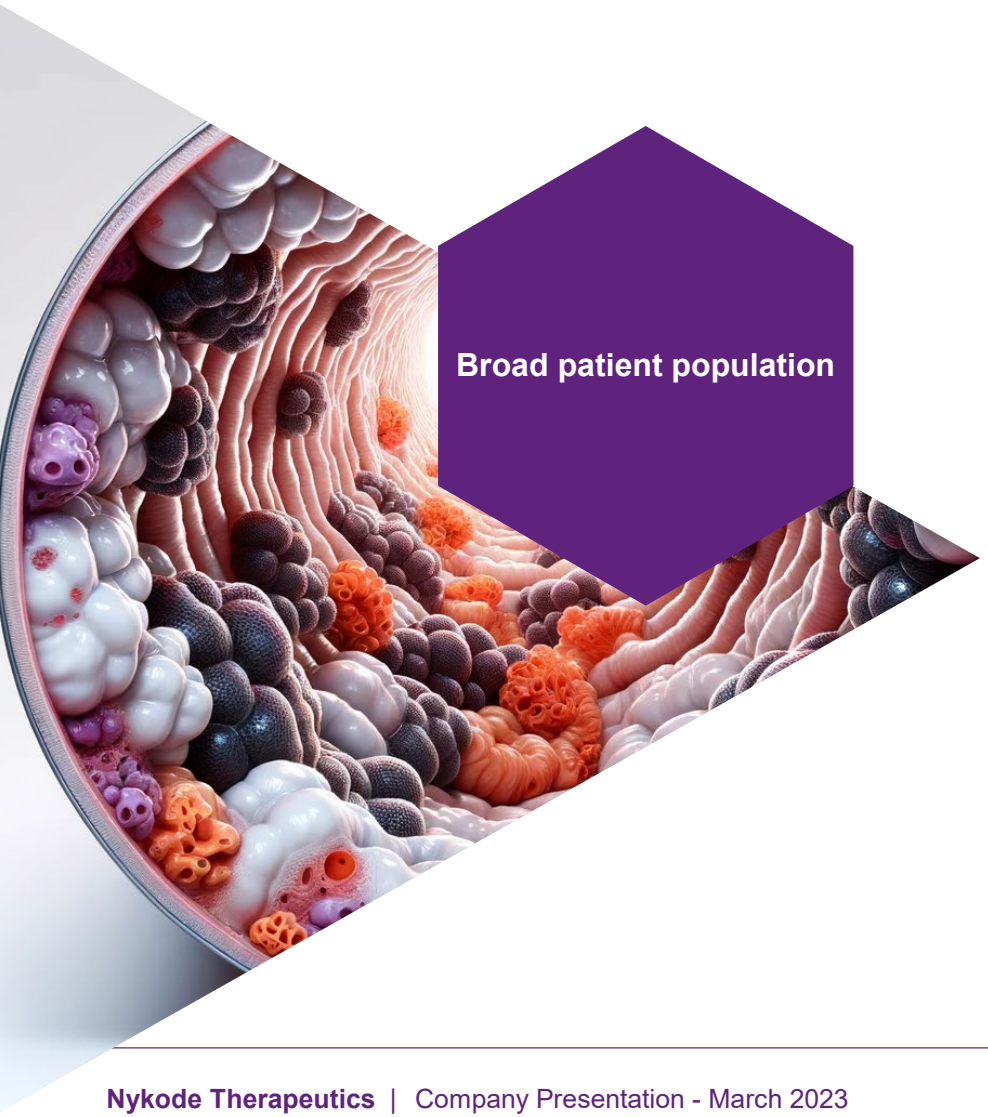
Exploratory endpoints
ctDNA level changes
HPV T cell response

Potential IA landmark analysis at 12 mo PFS



NYK011: Vaccine aimed at reducing the burden of colorectal cancer

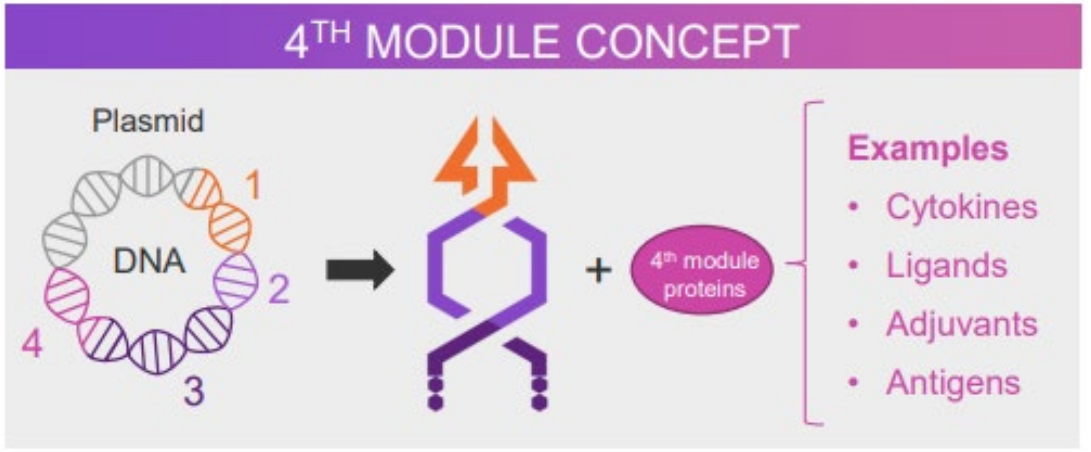
Pipeline expansion aims at addressing patients ranging from high-risk pre-cancerous polyps to colorectal cancer

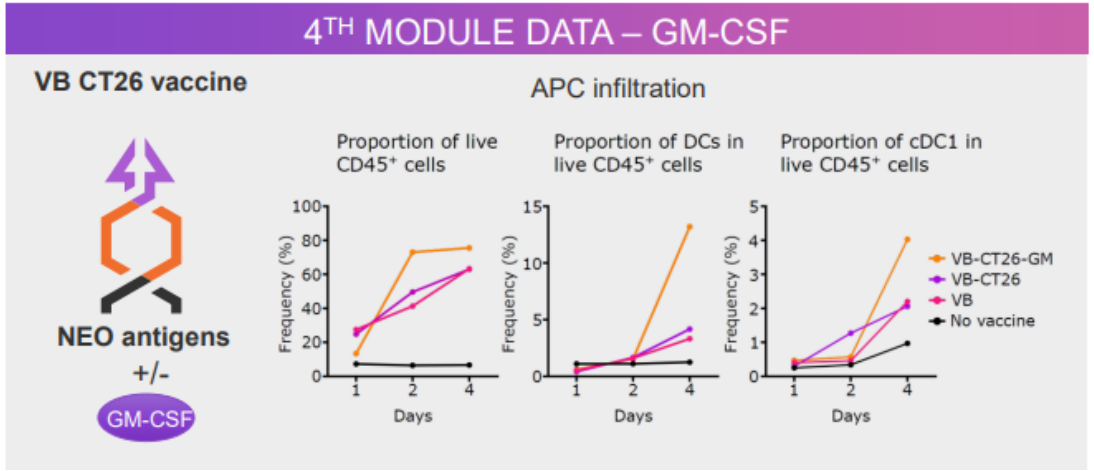


- Colorectal cancer develops from premalignant polyps on the colon or rectum's mucosal surface
- Disease development and screening programs represent an opportunity to identify and treat high-risk patients
- Nykode's latest pipeline expansion introduces a preclinical program aimed at targeting patient populations ranging from high-risk pre-cancerous colonic polyps to colorectal cancer
- In line with Company's strategic vision of a comprehensive cancer vaccine portfolio addressing all cancer stages

Potential first-in-class program including Nykode's 4th module 2nd generation technology

- NYK011 is a potential first-in-class oncology vaccine program based on careful selection and novel combination of tumor-associated antigens (TAA)
- Leverages Nykode's expertise to elicit strong and broad CD8 T cell responses by targeting antigens to APC, capable of breaking tolerance against TAA's
- Incorporates Nykode's 4th module 2nd generation technology to further improve and customize the immune responses

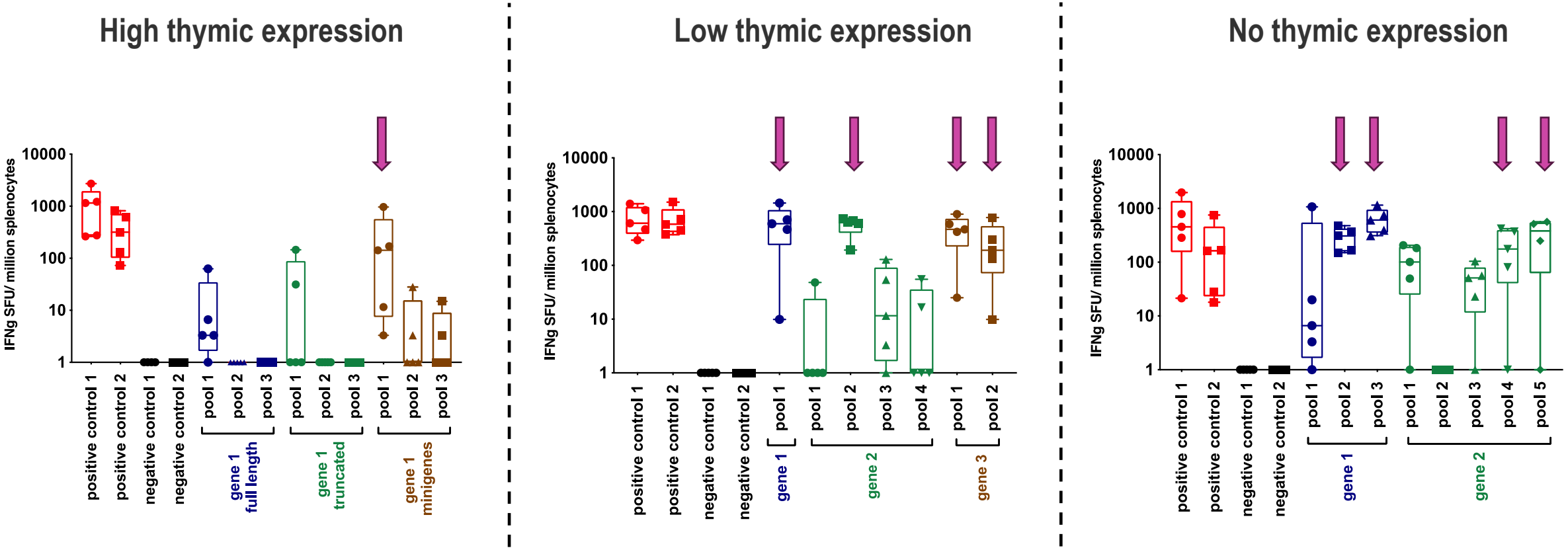




Note: GM-CSF data illustrative; does not reflect construct of NYK011

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

Potential immunogenicity



REGENERON

VB10.NEO- Individualized cancer immunotherapy

Nykode's individualized cancer vaccine is designed to target a broad range of tumours

Vaccine design

- APC-targeted vaccine technology leverages targeting unit to enhance CD8+ response
- Induces immune response in hard-to-treat patients with low TMB

Sequencing of biopsy tissue

- Proprietary neoantigen selection algorithm optimizes predicted immune response profile
- Strong & broad antigen-specific response, with ~53% immunogenic neoepitopes per patient

Manufacture one vaccine per patient

- pDNA fast and robust manufacturing with high success rate and cost-effective manufacturing
- Rapid turnaround time from biopsy to vaccination

Clinical site

- Broad applicability across tumor types, including CPI-refractory and 'cold' tumors
- Safe and well-tolerated in combination with CPI

Key clinical results

- 2 clinical trials in more than 10 indications in recurrent / metastatic setting
- Broad and durable T cell responses in clinic, with neoantigen-specific T-cell clones sustained over 1 year
- Polyfunctional T-cell response predominated by CD8+ T-cells
- Immune responses correlate with clinical responses

*Exclusively out-licensed to Roche and Genentech (2020)

VB10.NEO programs

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

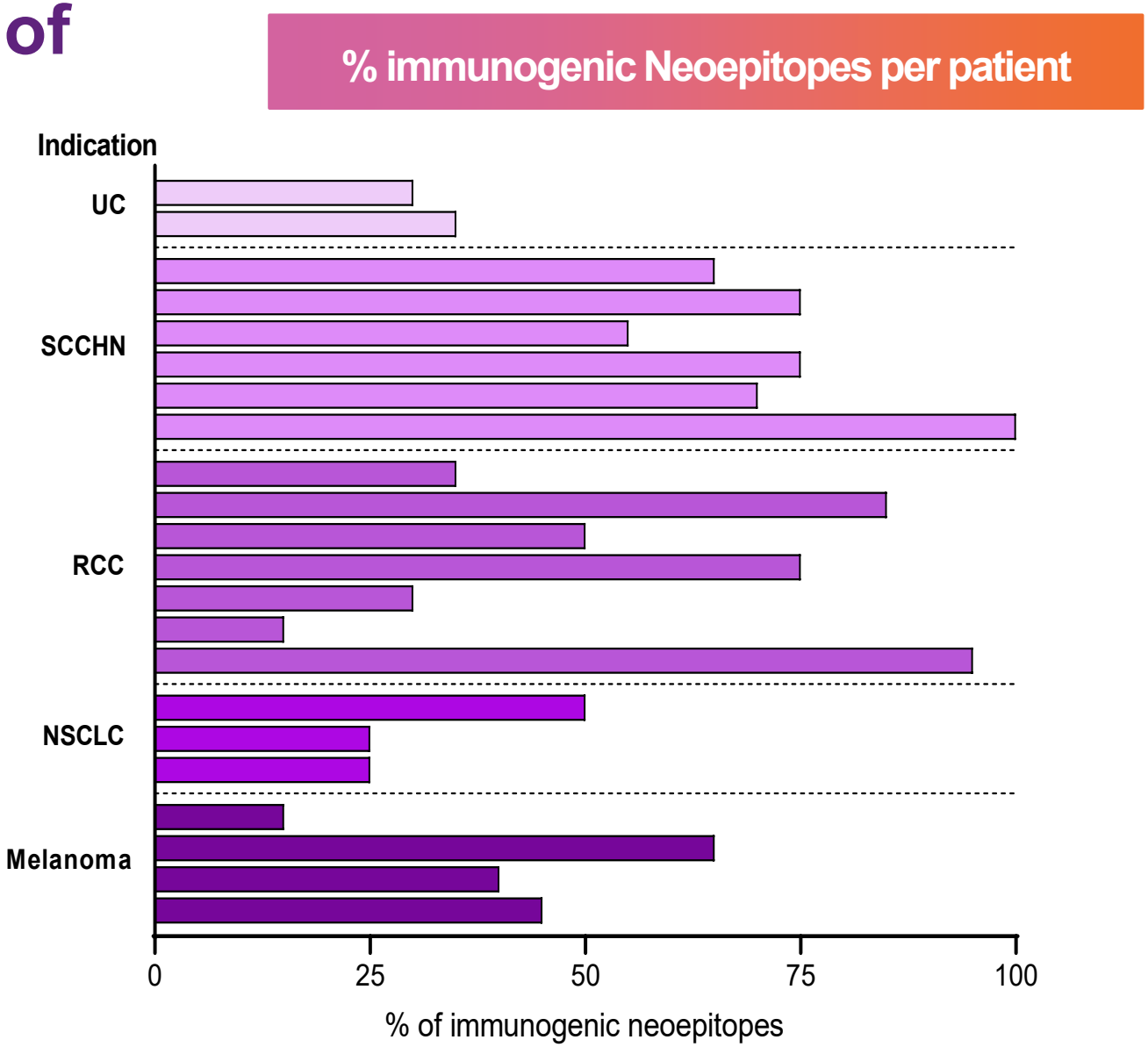
	N-01	N-02
Indication	r/m Melanoma, non-small cell lung cancer (NSCLC), clear renal cell carcinoma, urothelial cancer or squamous cell carcinoma of the head and neck (SCCHN)	r/m cancer, covering more than ten indications
Dose	3 mg dose in combination with a CPI	3-9 mg dose escalation, in combination with atezolizumab
Phase	1/2a	1b
Status	Finalized	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

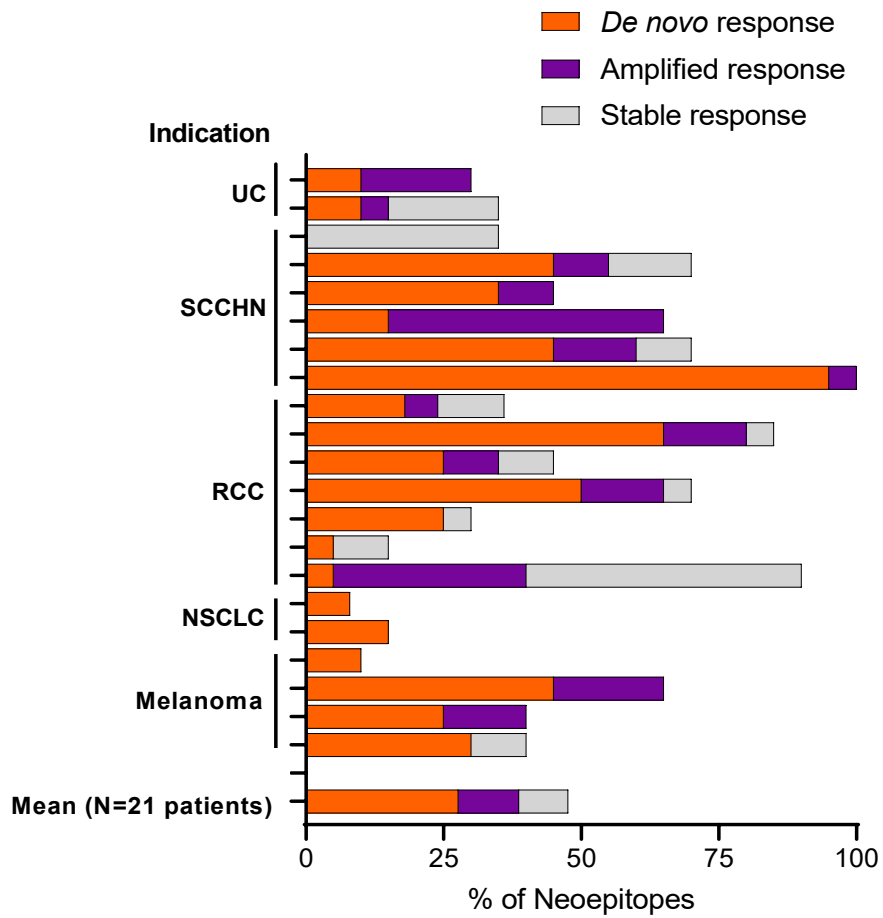


VB10.NEO amplifies pre-existing T-cell responses and induces multiple novel T-cell specificities

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

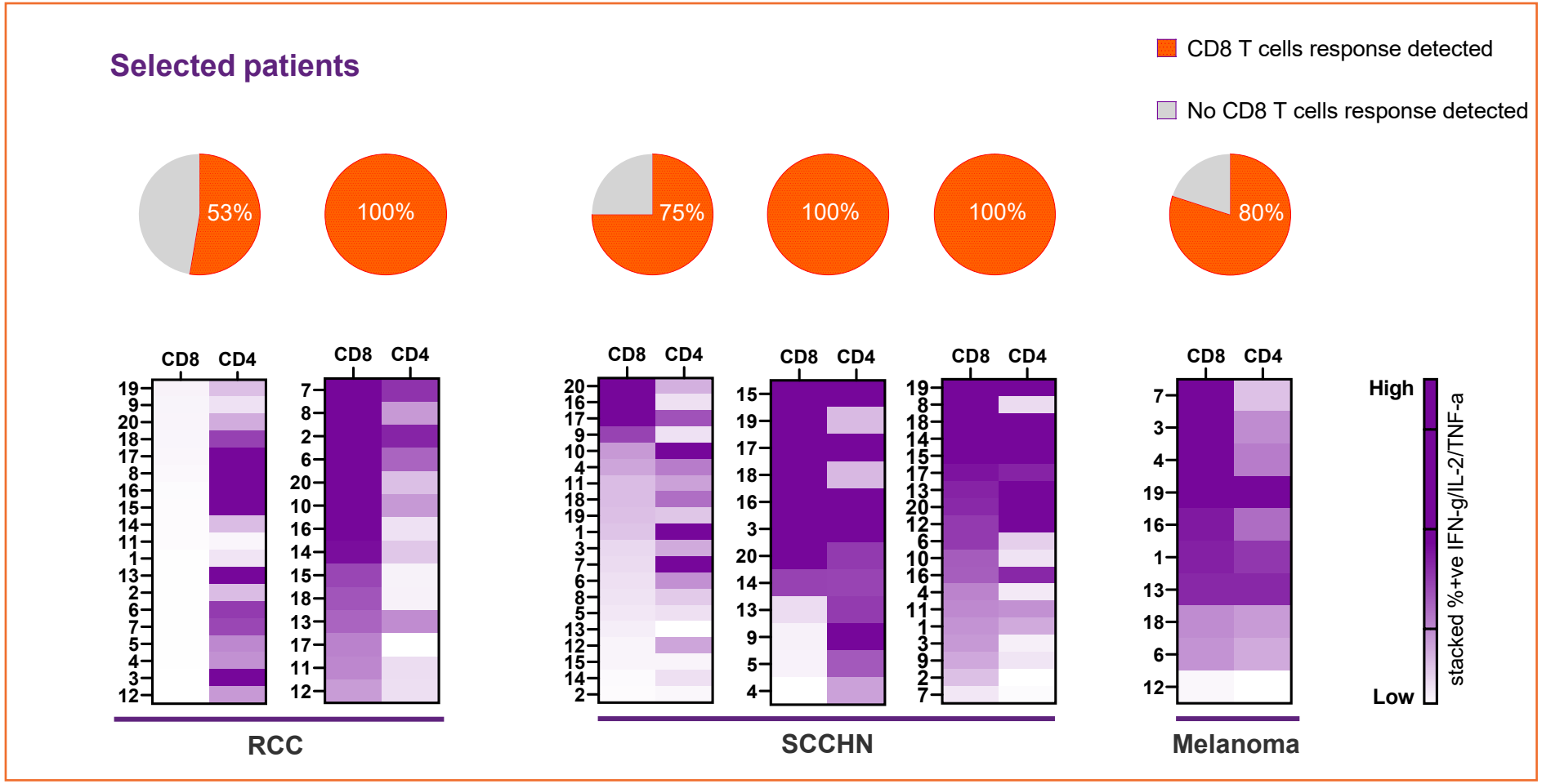
Expansion of pre-existing and induction of novel T cells



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 activates CD8 T cells

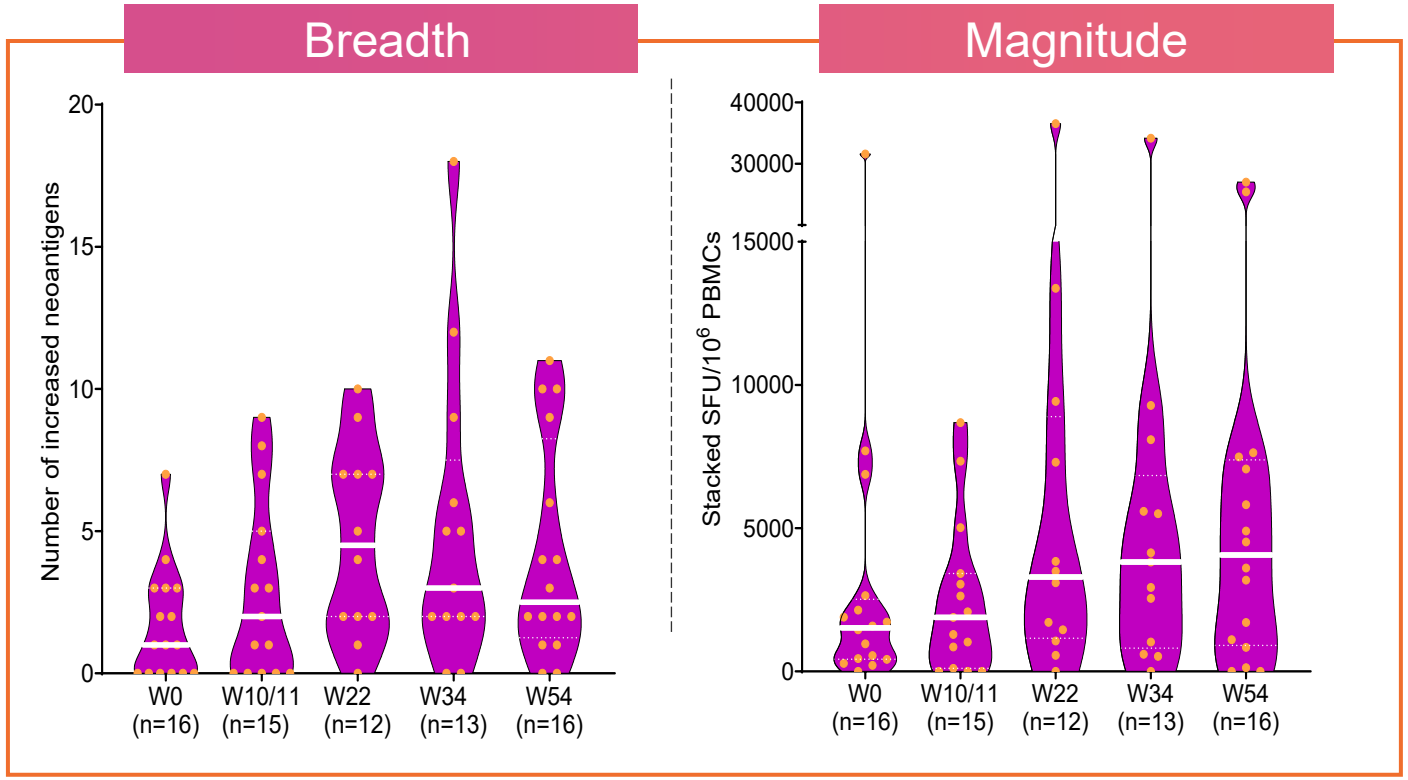
- T cell responses are characterized by both CD8 and CD4 T cells
- The majority of tested neoepitopes activated functional CD8 T cells in all subjects analyzed



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.

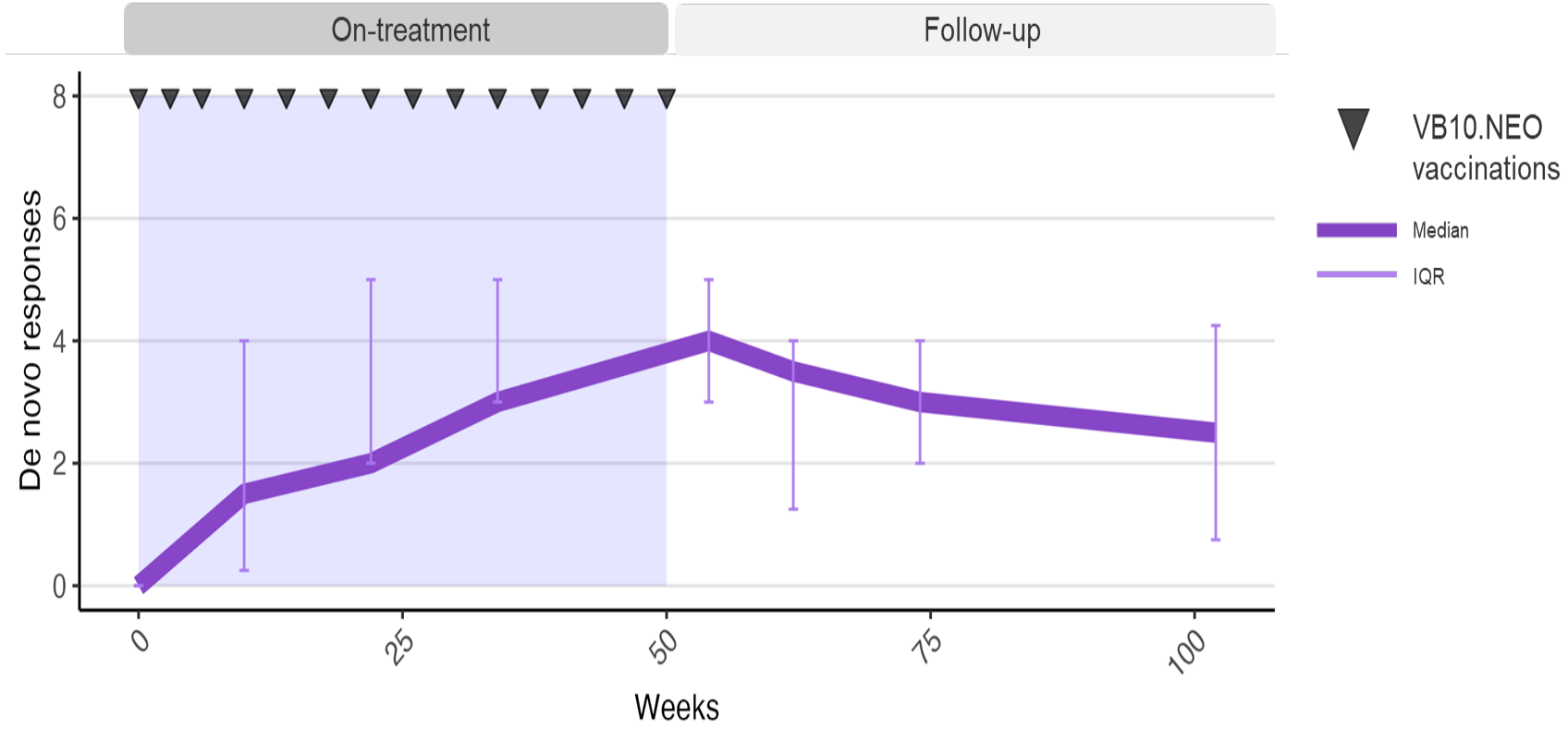
Breadth: Number of vaccine-induced NeoAg (*de novo* or amplified)

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

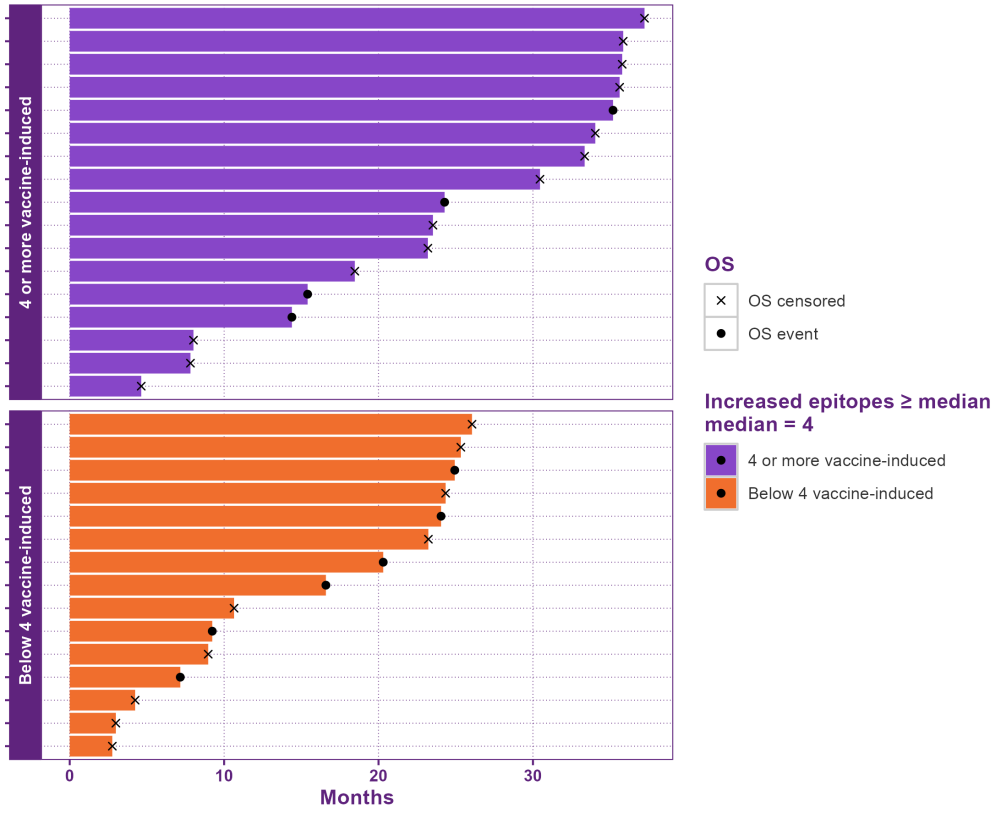
VB10.NEO induces a favorable and long-lasting T cell memory phenotype



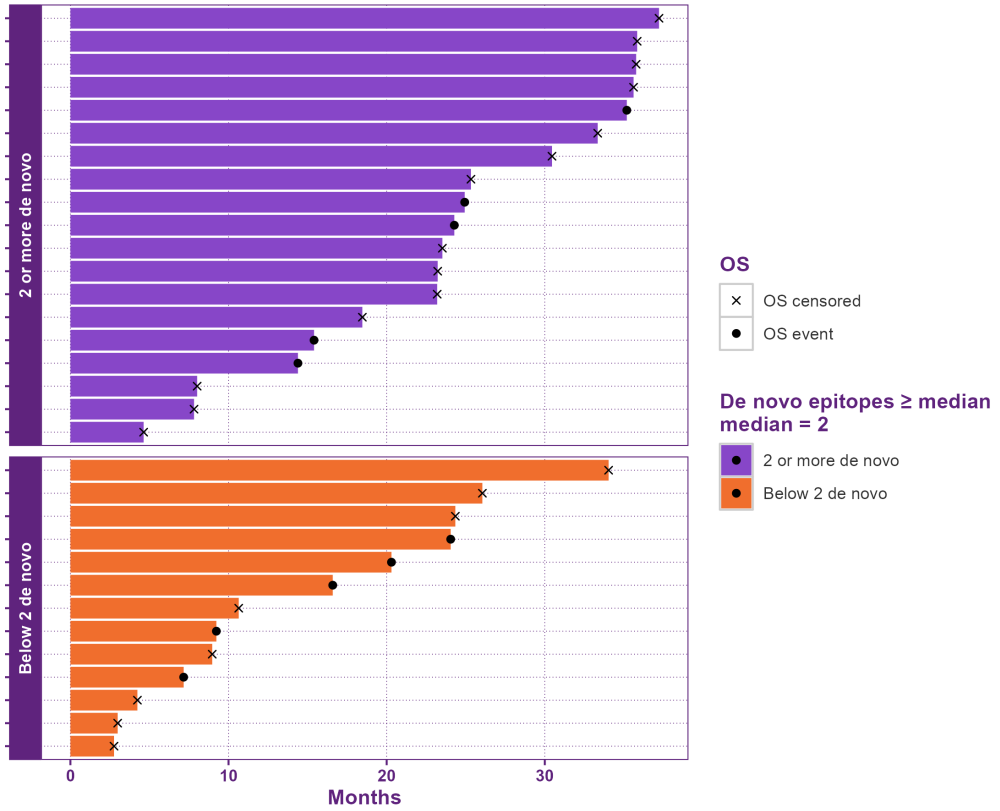
N=10 patients with on-treatment (OT) and follow-up (FU) samples. IQR: Interquantile range. OT data: actual *de novo* responses at weeks 10/11, 22, 34, 54. FU data: The latest positive timepoint defined the persistence of response (i.e. neoantigens were called positive at earlier FU timepoints if positive at later FU timepoint(s)).

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).

VB10.NEO Key Differentiators

Solid manufacturing chain

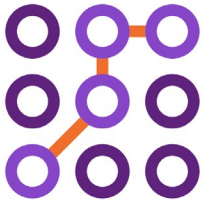
- ✓ 100% successful vaccine production
- ✓ Robust supply chain

Safety

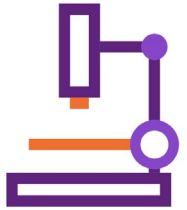
- ✓ Safety profile similar to checkpoint inhibitor monotherapy
- ✓ No increase in immune-related adverse events

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

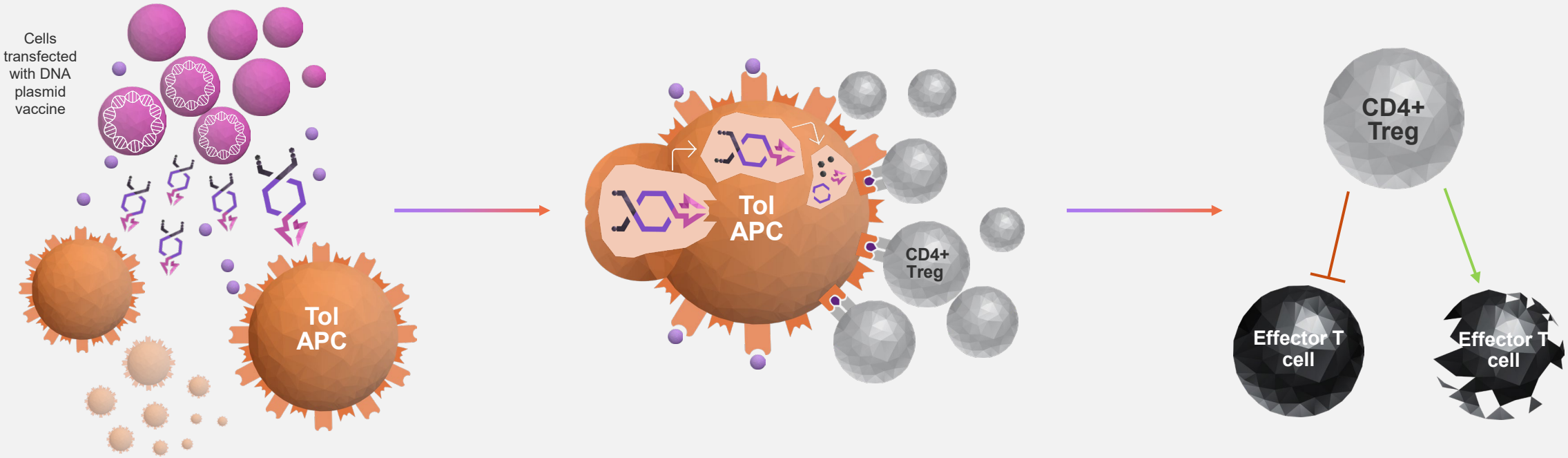
Competitive player

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

Autoimmunity and further platform potential

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

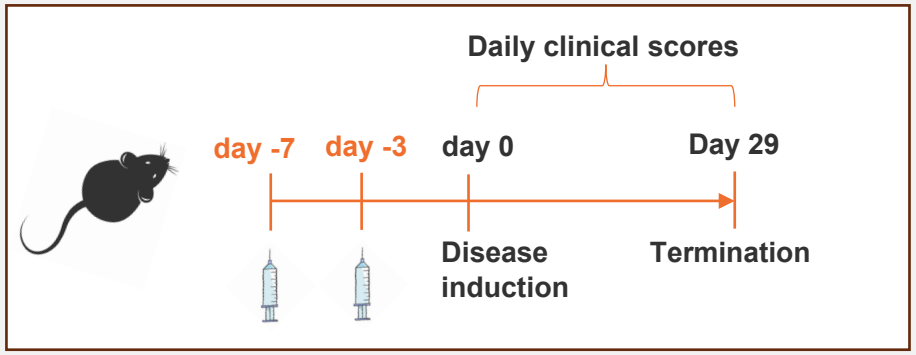
Module 3: Auto-antigens or allergens known to elicit unwanted immune responses identified

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

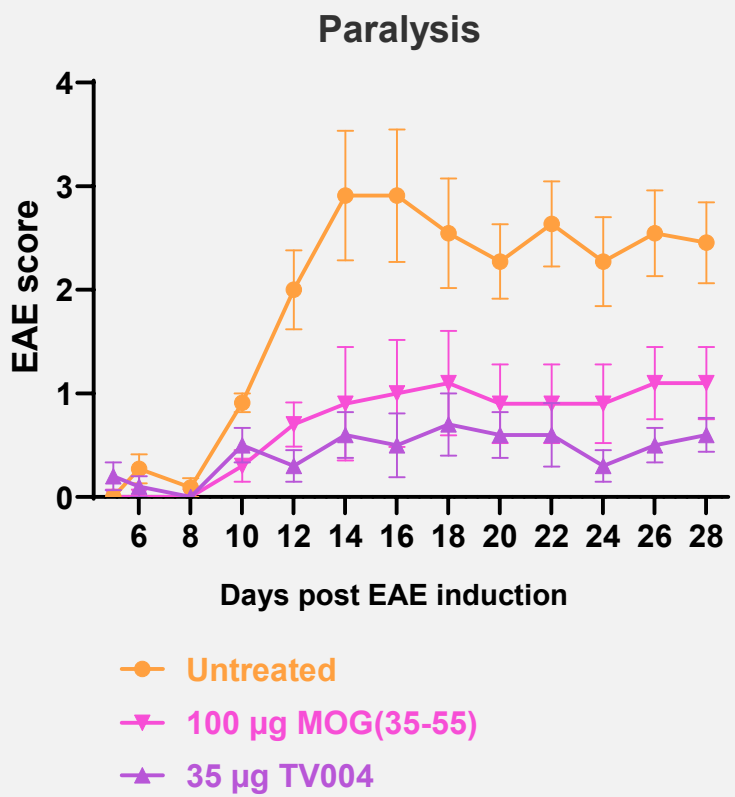
Recombinant Vaccibodies targeting tolerogenic DCs prevents serious disease in a mouse model of multiple sclerosis

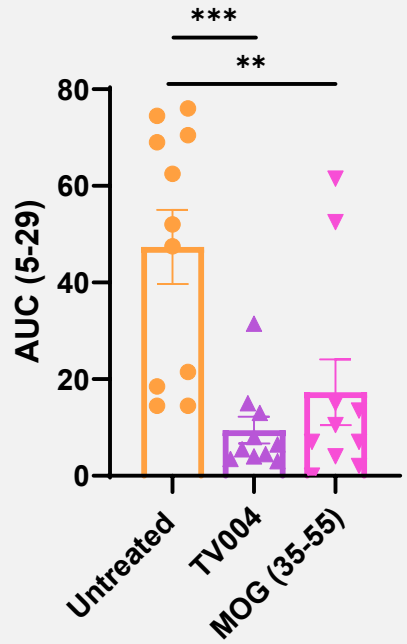
EXPERIMENTAL AUTOIMMUNE ENCEPHALOMYELITIS (EAE) MODEL



Vaccibody design

MS antigen: MOG(27-63)



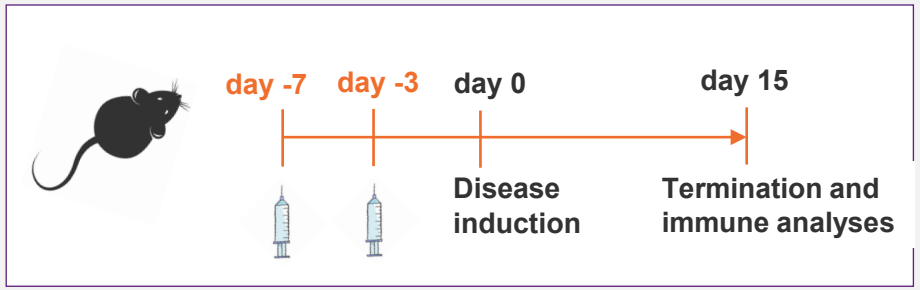


One-way ANOVA with Turkey's multiple comparisons test, ***P < 0.001, **P < 0.01.

52x more MOG antigen delivered in **100 µg MOG(35-55)** vs. **35µg TV004**

Dose-dependent decrease in disease associated cytokines induced by Nykode's inverse vaccines, differentiated from Ag alone

EAE MODEL



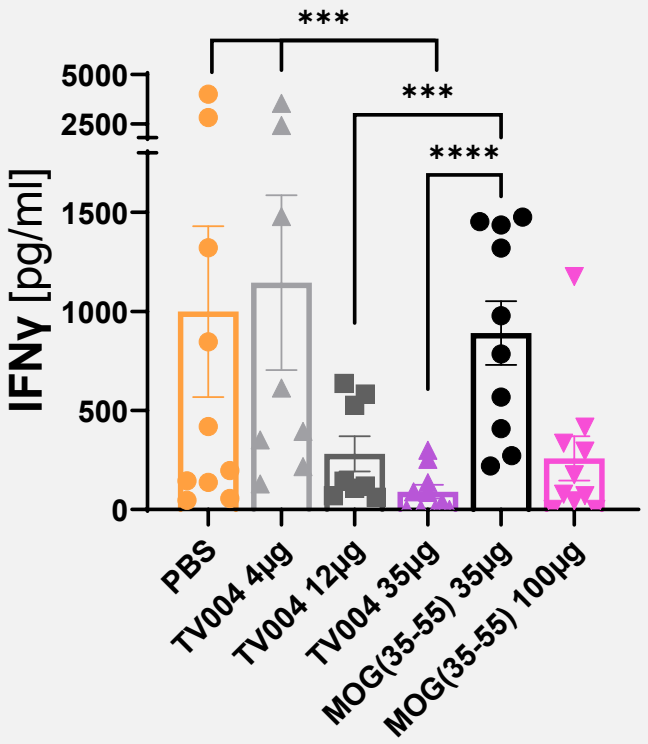
VB vaccine TV004

EAE antigen

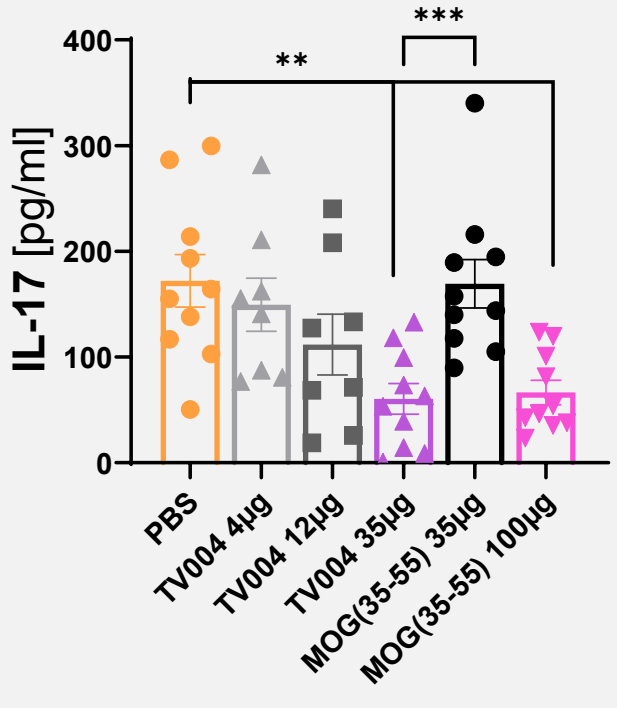
EAE antigen: MOG(27-63)

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

MOG(35-55) recall assay using splenocytes



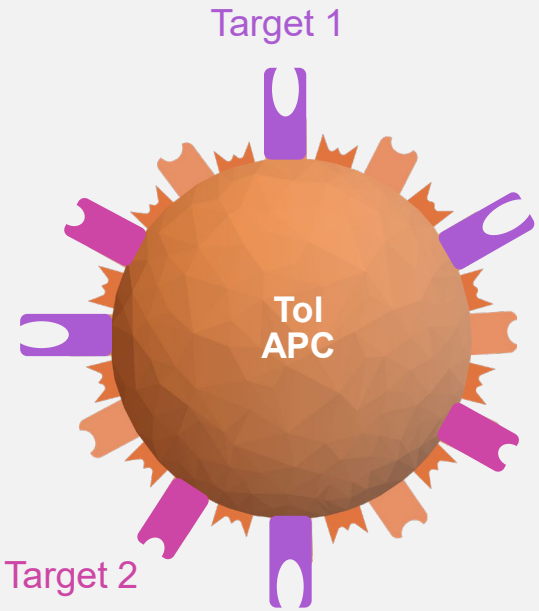
Mann-Whitney test on ranks, **P < 0.01, ****P < 0.0001.



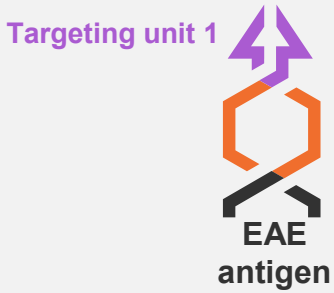
Mann-Whitney test on ranks, **P < 0.01, ***P < 0.0005.

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

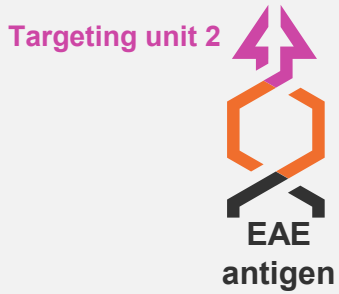
EAE MODEL



VB vaccine TV004

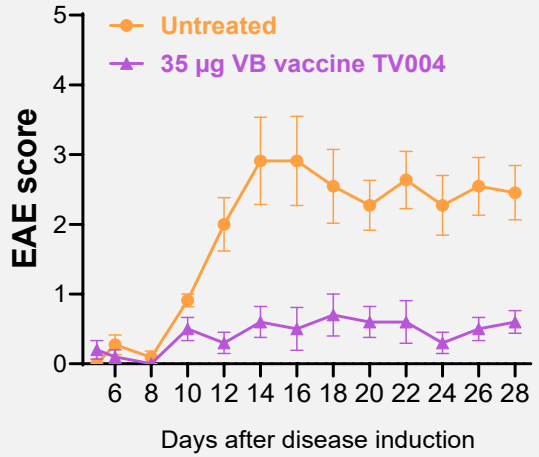


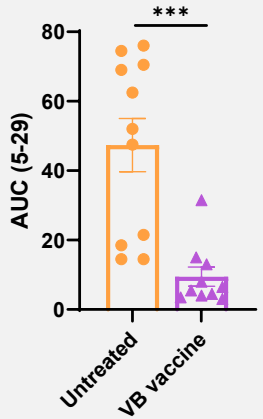
VB vaccine TV036

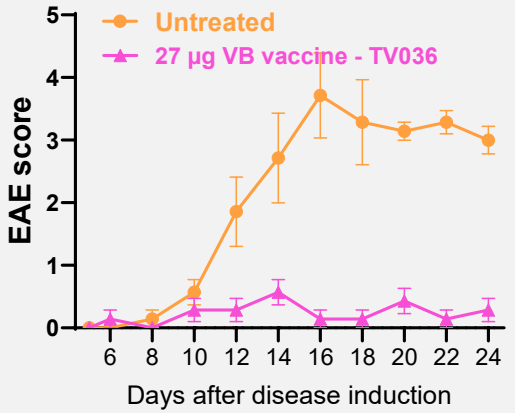


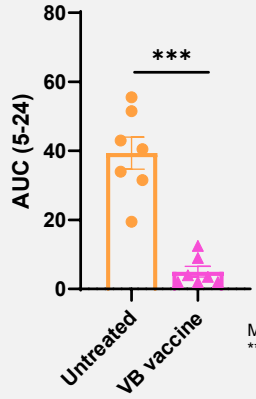
EAE antigen: MOG(27-63)

Paralysis







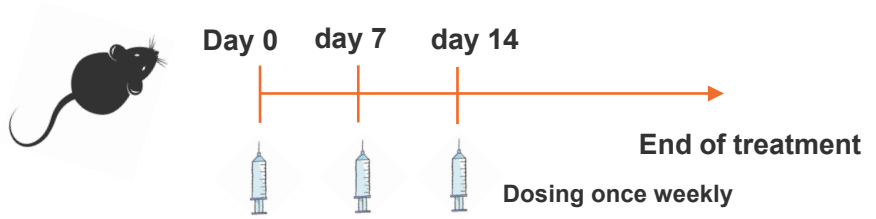


Mann Whitney test on ranks,
***p < 0.001.

DNA vaccination with Vaccibody targeting tolerogenic APCs 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 Non-Obese Diabetic (**NOD)** model is a **mouse diabetes model** that is commonly used in research to study type 1 diabetes. These mice **spontaneously** develop autoimmune diabetes similar to the human form of the disease

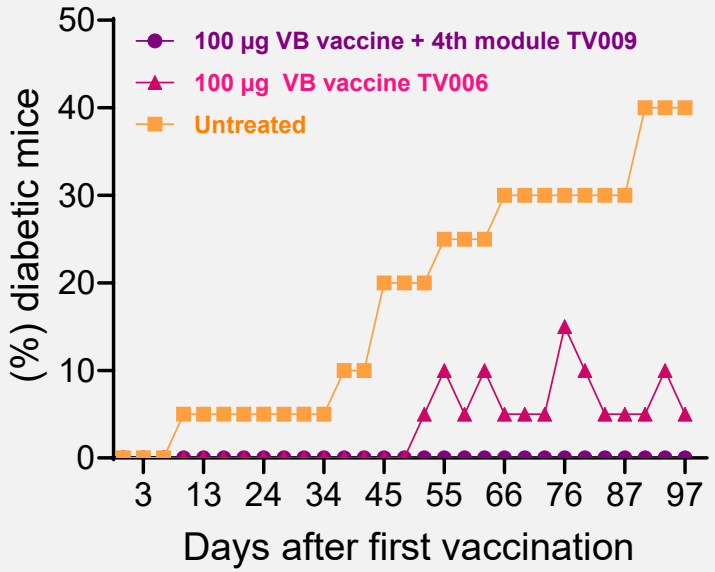


NOD DIABETES MODEL (ONGOING STUDY)

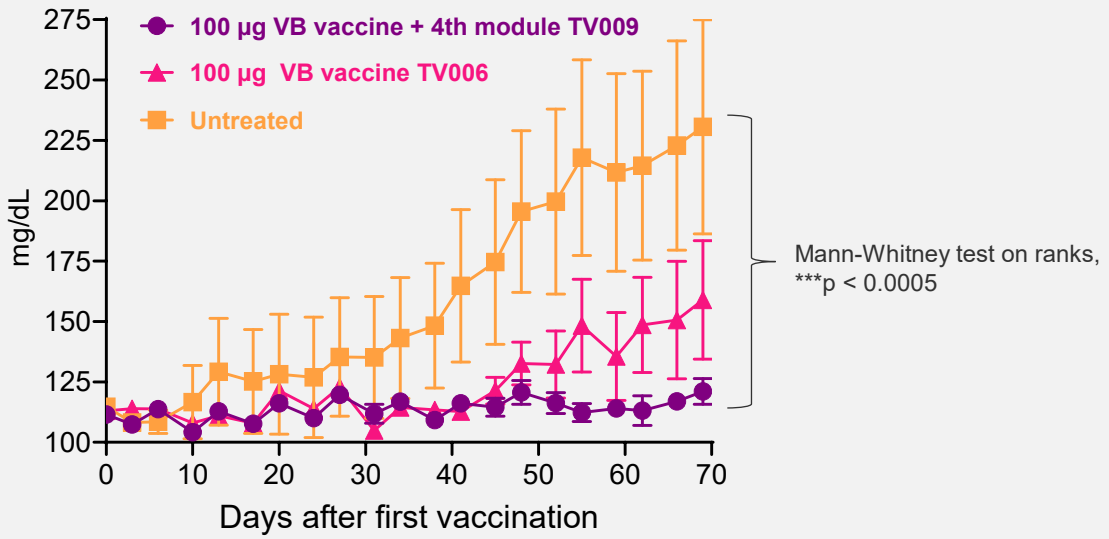
VB vaccine

Diabetes antigen: PPI

Incidence of diabetes



Blood glucose levels

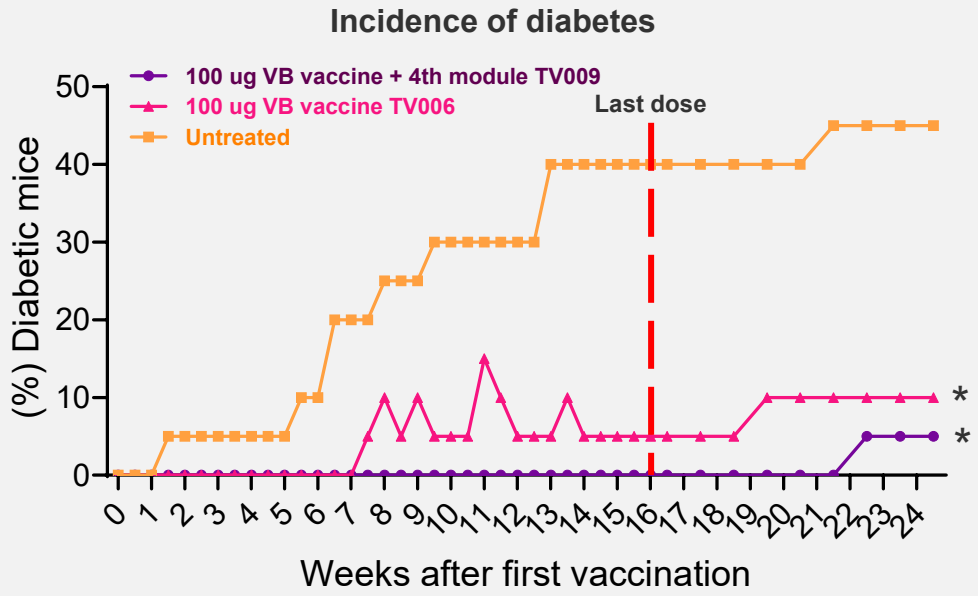


PPI antigen alone is not protective in this model. Grönholm J et al.,2017, Pagni PP et al (2022), Pham MN et al, 2016, Daniel C et al. 2011

DNA vaccination with Vaccibody induces long-lasting efficacy post treatment

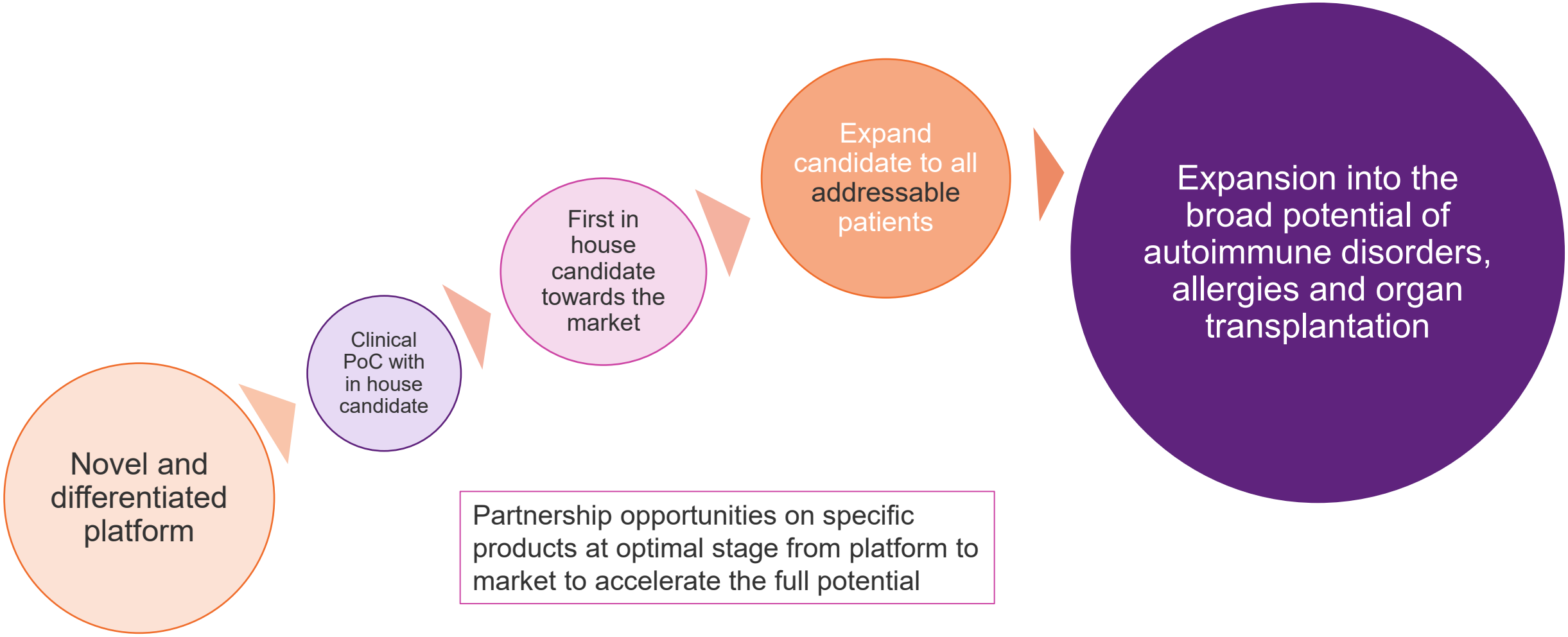
NOD DIABETES MODEL (ONGOING STUDY)

Diabetes antigen: PPI



PPI antigen alone is not protective in this model. Grönholm J et al.,2017, Pagni PP et al (2022), Pham MN et al, 2016, Daniel C et al. 2011

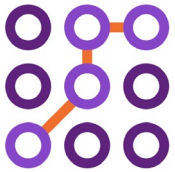
Nykode's successful business model validated and ready to accelerate development in autoimmune diseases



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)

mRNA oncology vaccine

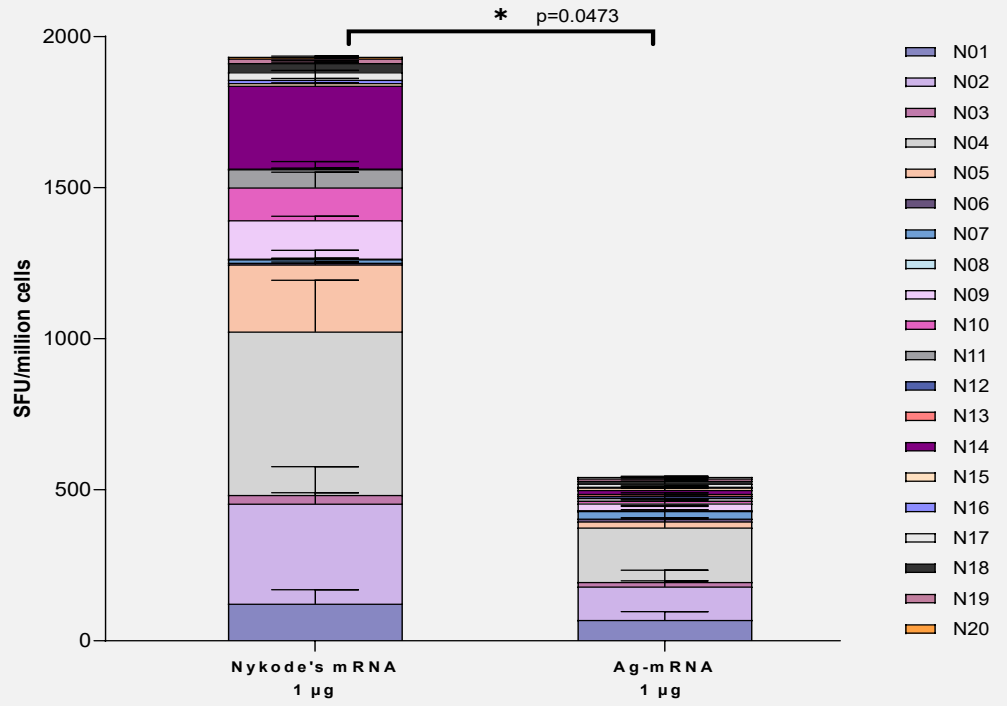
Nykode’s APC targeting technology can leverage mRNA vaccines and presents opportunity for platform expansion

- Targeted delivery via APCs using Nykode’s technology has been shown to induce broader and stronger CD8+ immune responses vs. existing ‘antigen-alone’ approaches.
- Preclinical studies have demonstrated that Nykode’s APC-targeted vaccines delivered as mRNA improves the number of immunogenic antigens vs. ‘antigen-alone’ approaches
- The potential to leverage Nykode’s APC targeted approach across vectors and formulations into an expanding range of indications presents a significant growth opportunity for Nykode’s broad oncology platform

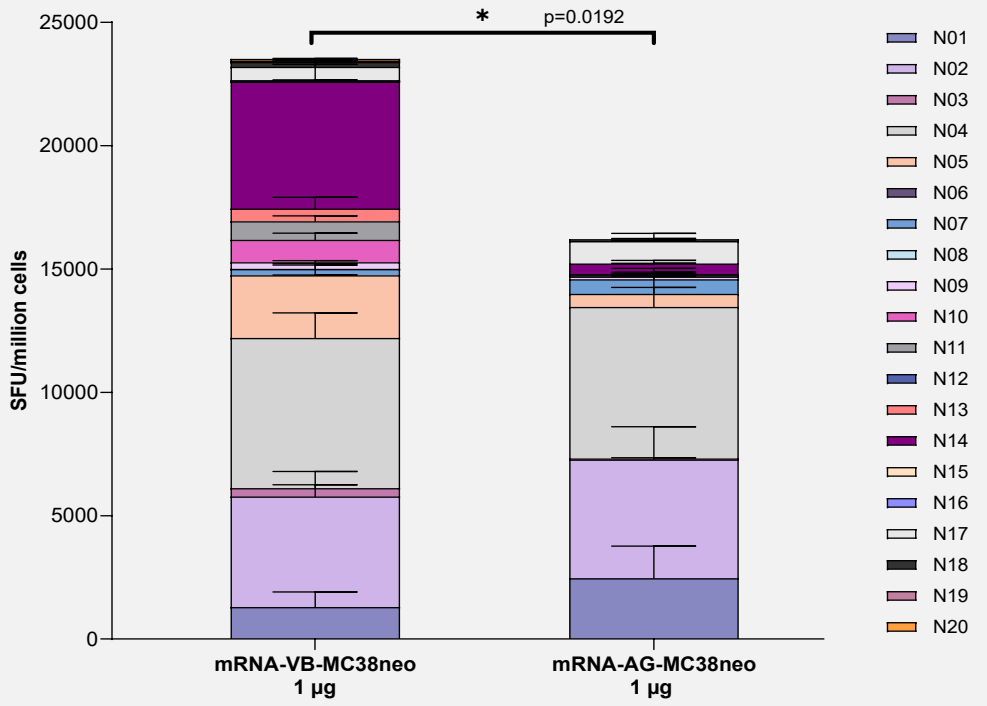
Nykode's APC-targeted technology offers improvement of mRNA based vaccines

Stronger T cell responses to a wider variety of MC38 T cell epitopes

Prime vaccination only (D14)



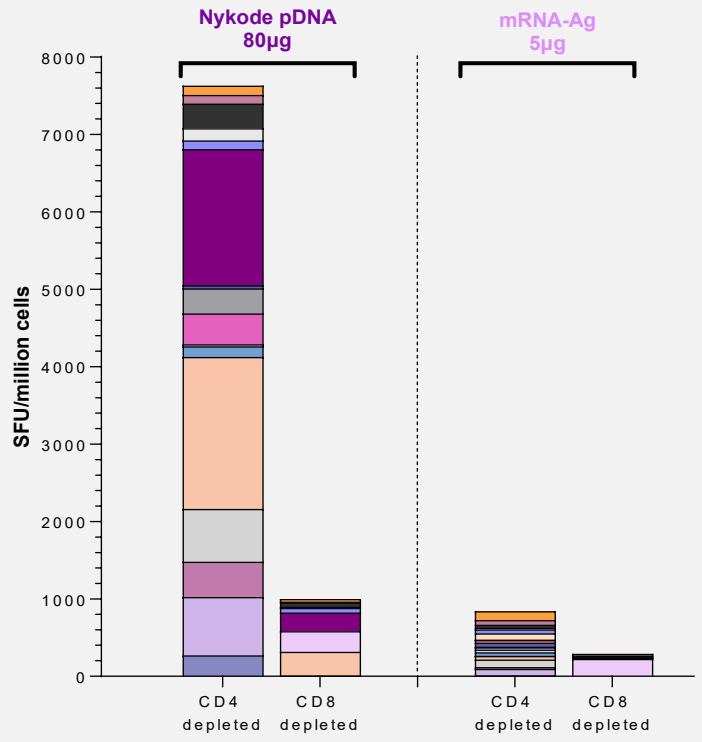
Prime + boost vaccination (D28)



The strong responses by Nykode's APC-targeted technology is primarily driven by broad CD8 T cell specificity

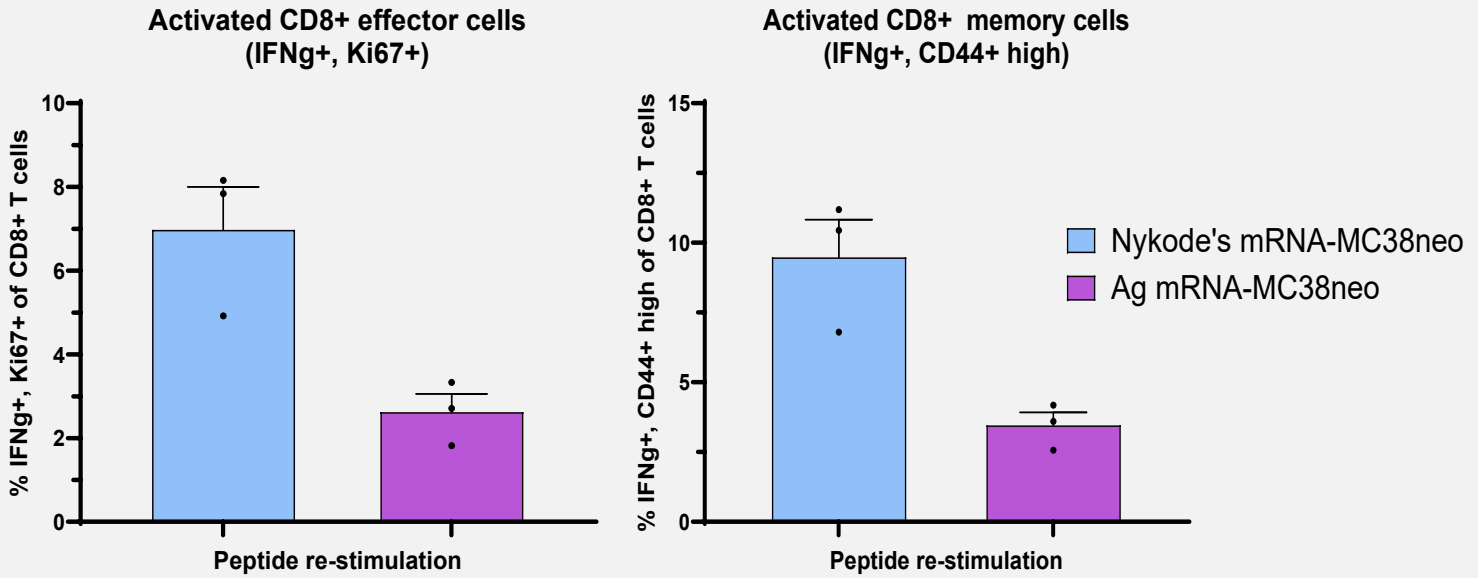
The strong responses by Nykode's vaccine are primarily CD8 driven and includes both effector and memory subtypes

Nykode pDNA vs Ag mRNA



d14

Nykode mRNA vs Ag mRNA



d28

Unlocking the full potential of cancer vaccines

Nykode is dedicated to fill the gaps and offer a sustainable cancer vaccine platform

CONTROL OF WHICH CELLS THAT TAKE UP THE ANTIGEN AND HOW IT IS PRESENTED TO T CELLS THROUGH APC-TARGETING

- **Superior immunogenicity**
  - Broad response to multiple epitopes and reduced risk of tumor escape
  - Proven ability to break tolerance against tumor-associated antigens
  - Strong and broad CD8 T cell responses
- **Favorable kinetics**
  - Fast onset
  - Long durability
  - No sign of exhaustion of T cells
  - No restrictions for repetitive dosing

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	**VB10.16**	**Undisclosed**	**Undisclosed**

Genentech
A Member of the Roche Group

Future in house and partnered cancer vaccine opportunity space

Opportunities for DNA, mRNA, viral vector or protein delivery

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

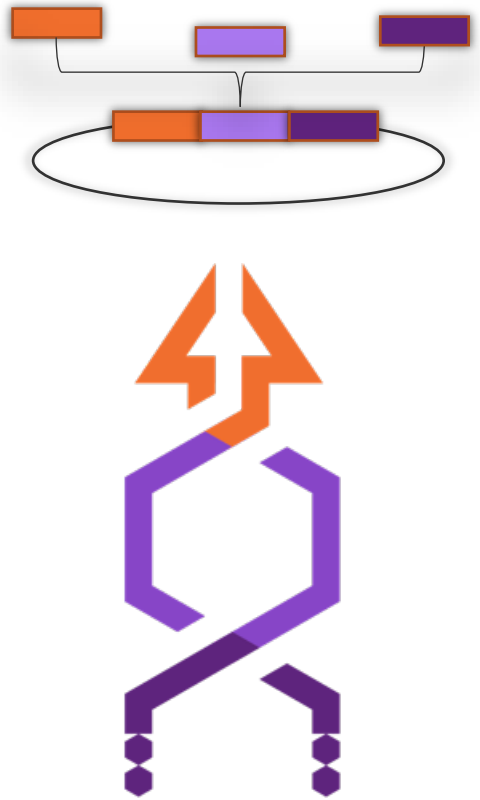
APC-specific Ag delivery and stimulation

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 & outlook

Upcoming milestones

Oncology	Q1 '24	**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
Oncology	Q1 '24	**VB10.16 Cervical Cancer**	Updated survival data from VB-C-02 Phase 2 trial
Oncology	H2 '24	**VB10.16 Head and Neck Cancer**	Recommended Phase 2 dose for Part 2 of the VB-C-03 trial in PD-L1+ patients with 1st line recurrent/metastatic advanced head and neck cancer
Oncology	Q4 '24	**VB10.16 Cervical Cancer**	Finalized enrollment for Part 1 of the VB-C-04 trial
Oncology	H2 '24	**NYK011 CRC**	Update on preclinical oncology vaccine program
Auto-immune	H1 '24	**Autoimmunity and Allergy**	Update on Nykode's inverse vaccine technology platform
Other	H1 '24	**Platform**	Update on Nykode's APC targeted vaccine technology delivered by mRNA

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

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 ($162.5m in cash at Dec. 31, 2023)
Completed private placement of $45m in October with primarily new international specialist investors

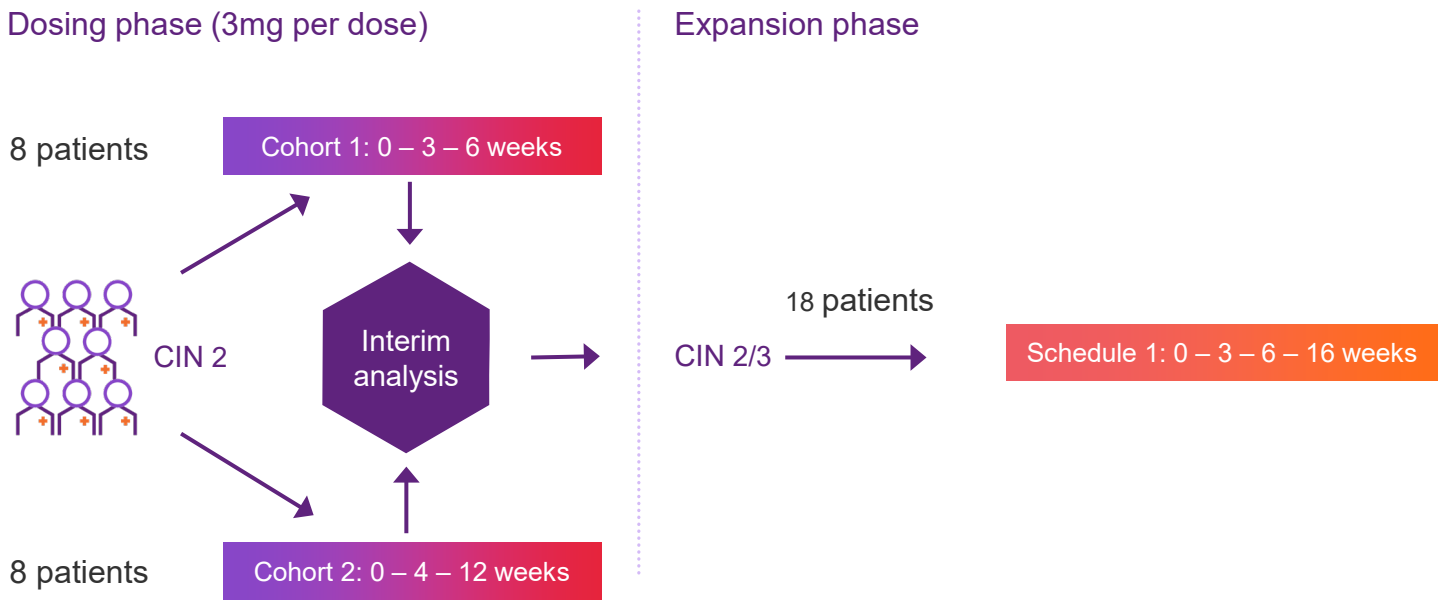
UNLOCKING THE FUTURE OF MEDICINE

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

VB-C-01

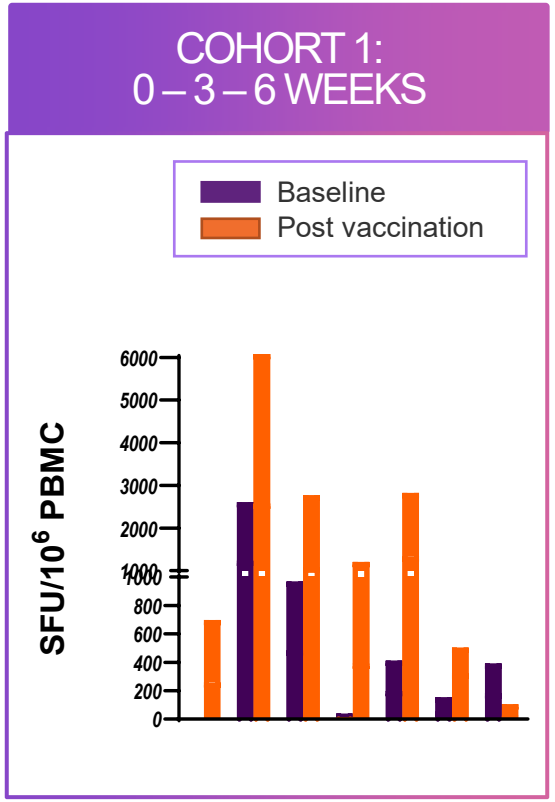
VB C-01: First trial with VB10.16 as monotherapy for treatment of HPV16+ precancerous lesions

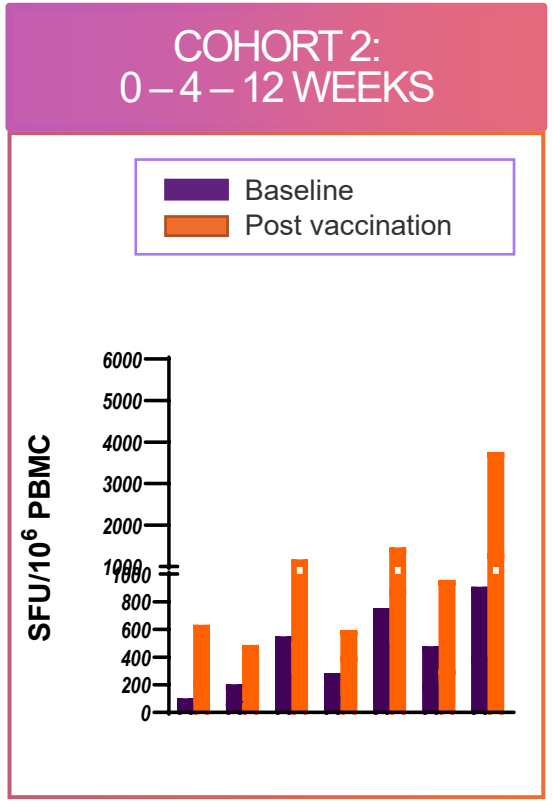
VB C-01
Exploratory, open labelled, multi-centre study in patients with HPV16+ High Grade Cervical Intraepithelial Neoplasia (HSIL, CIN 2/3)

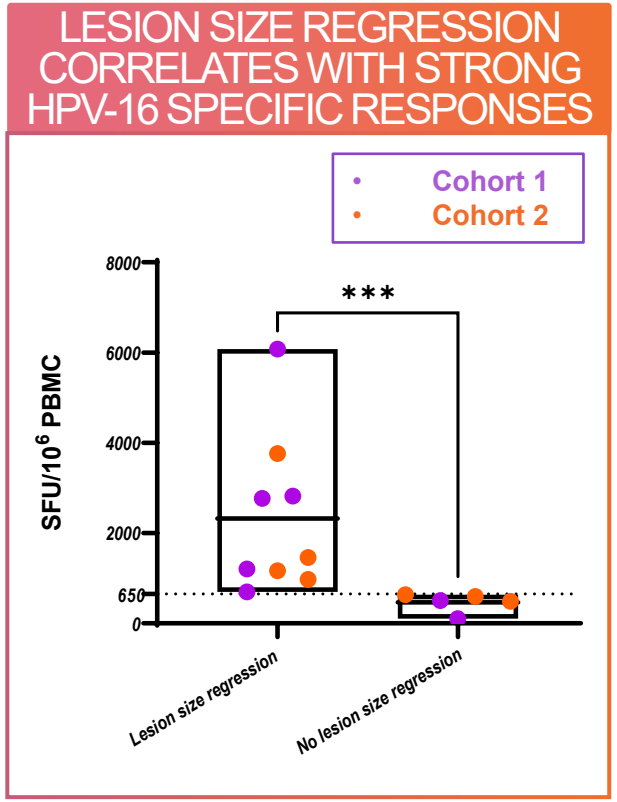


VB10.16: Strong correlation with strength of induced HPV16-specific immune response and lesion size reduction

- 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



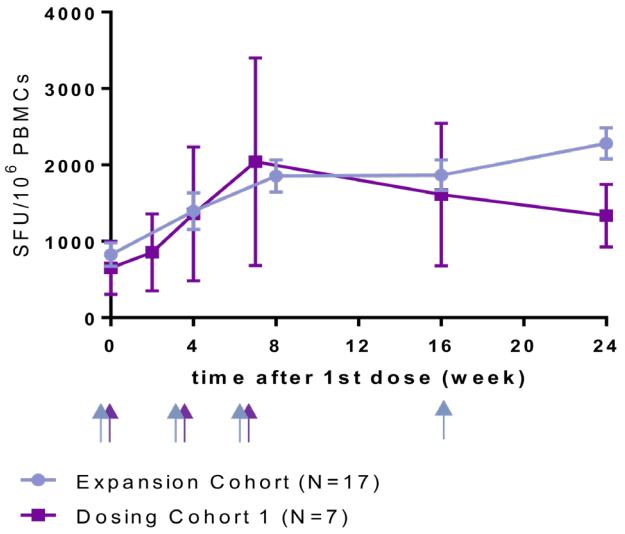




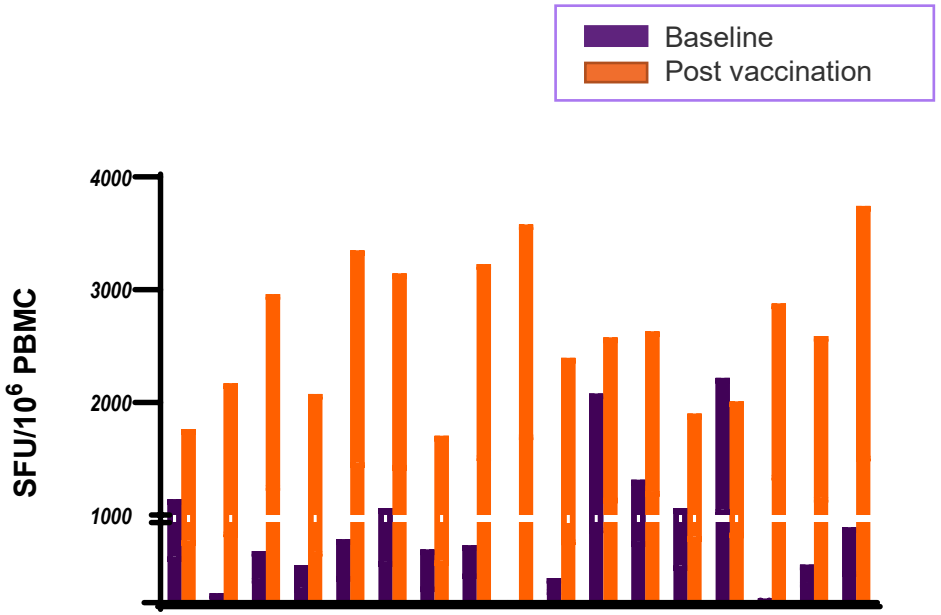
VB10.16: homologous booster dose induced strong T cell responses in all patients in the expansion cohort

- 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

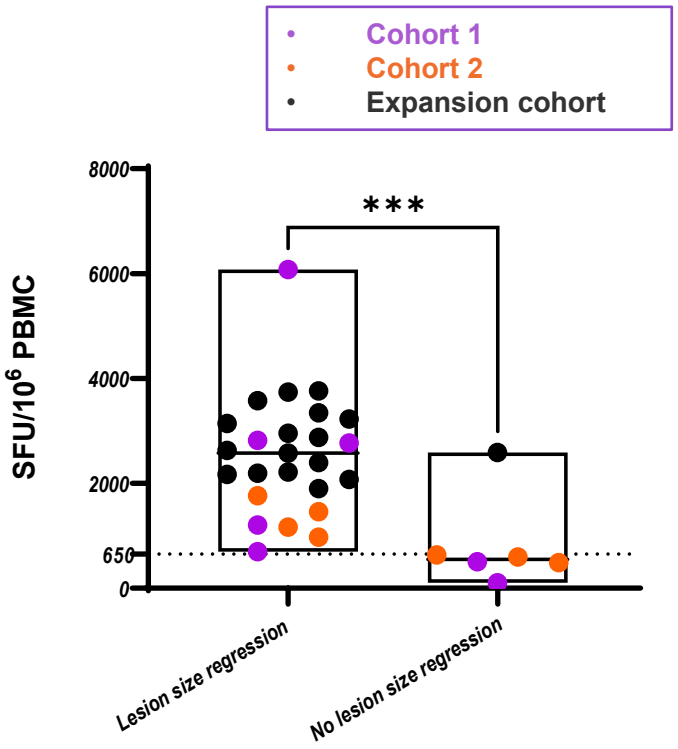


STRONG HPV16-SPECIFIC T CELL REPSONSES IN ALL PATIENTS IN THE EXPANSION COHORT

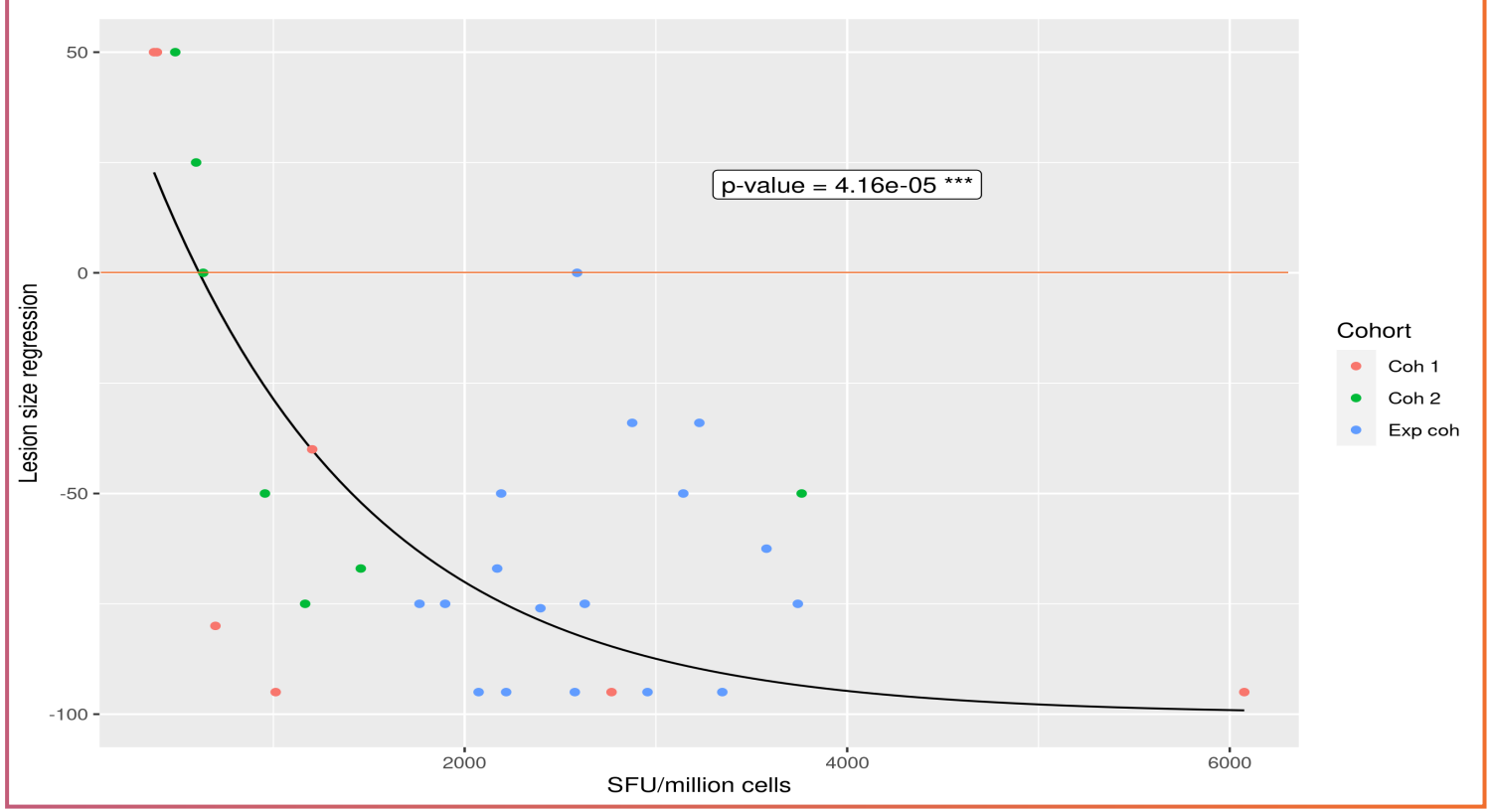


VB10.16: highly significant correlation between vaccine induced HPV16-specific T cell responses and lesion size across all cohorts

LESION SIZE REGRESSION CORRELATES WITH HPV-16 SPECIFIC RESPONSES



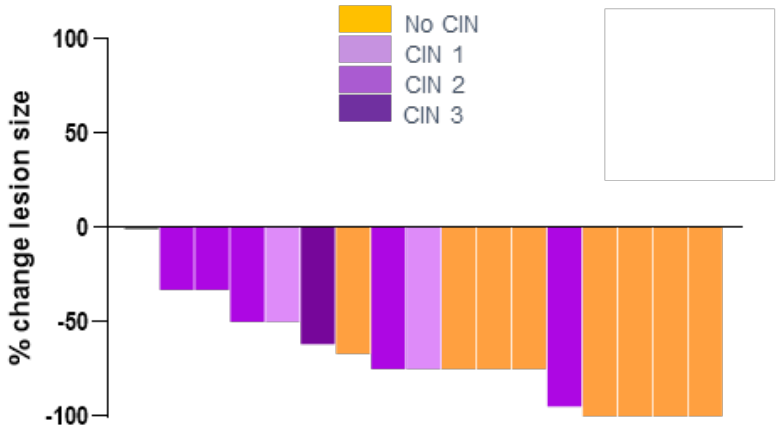
SIGNIFICANT CORRELATION OBSERVED WITH % LESION SIZE REDUCTION AND # SFU/MILL



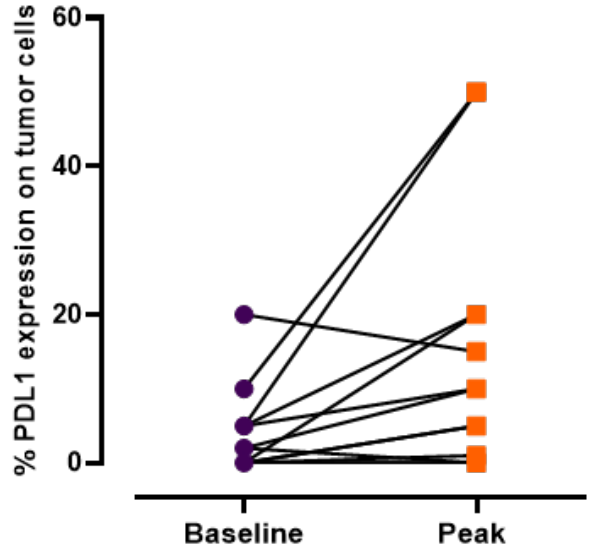
Promising clinical data as monotherapy in pre-cancerous lesions

- 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

VB-C-03

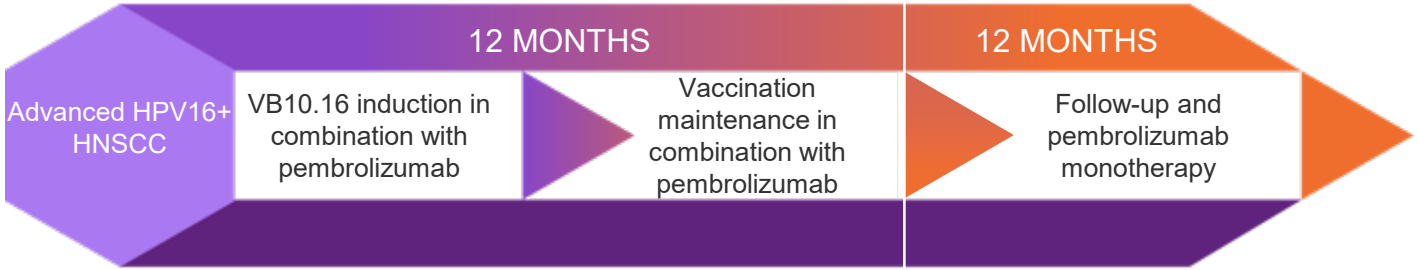
VB-C-03 trial in advanced HPV16+ HNSCC

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

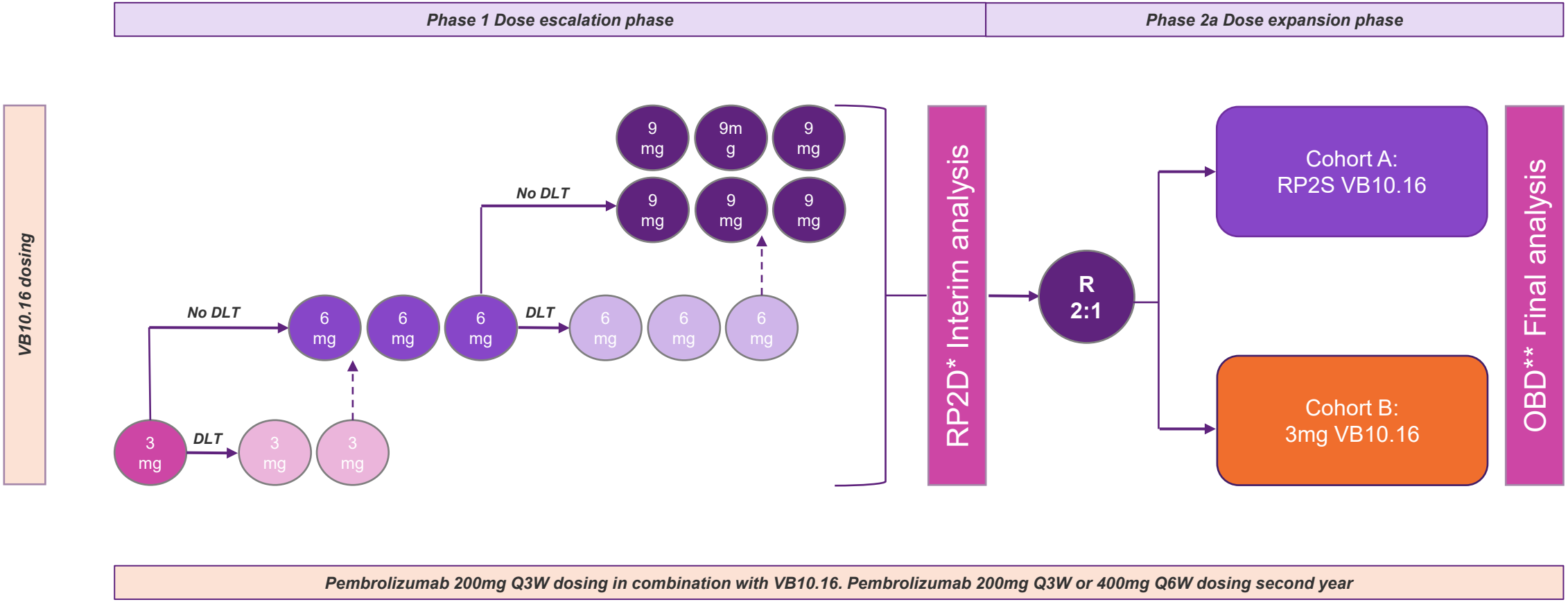


Pembrolizumab will be supplied by Merck in accordance with the clinical collaboration and supply agreement between Nykode and MSD

*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