Interim Data from the Ovarian Cancer Expansion Cohort and Next Steps for UpRi Development Plan

September 10, 2021
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Today’s Agenda

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<td>• Interim Data from the Ovarian Cancer Expansion Cohort of the UpRi Phase 1 Study</td>
<td>Debra L. Richardson, MD, Associate Professor and Section Chief, Division of Gynecological Oncology at OU Health Stephenson Cancer Center and the Sarah Cannon Research Institute</td>
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<td>• UpRi Development Plan:</td>
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<td>• UPLIFT Update</td>
<td>Arvin Yang, MD, PhD, Chief Medical Officer</td>
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UpRi: First-in-Class Dolaflexin ADC Targeting NaPi2b

Interim Data from the Ovarian Cancer Expansion Cohort of the UpRi Phase 1 Study

Debra L. Richardson, MD
Associate Professor and Section Chief, Division of Gynecological Oncology at OU Health Stephenson Cancer Center and the Sarah Cannon Research Institute
Significant Unmet Medical Need in Platinum-Resistant Ovarian Cancer

With PARPi and bevacizumab increasingly used in earlier lines, the current standard of care is single agent chemotherapies

<table>
<thead>
<tr>
<th>Study</th>
<th>Demographics</th>
<th>Control Arm</th>
<th>Control Arm Performance</th>
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<tbody>
<tr>
<td>Forward I ESMO 2019</td>
<td>1 – 3 Prior Median 2 Prior</td>
<td>PLD, Topotecan, Weekly Paclitaxel</td>
<td>ORR 12%</td>
</tr>
<tr>
<td></td>
<td>Prior PARPi: 10% Prior Bev: 47%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Javelin 200 SGO 2019</td>
<td>1 – 3 Prior Median 2 Prior</td>
<td>PLD</td>
<td>ORR 4%</td>
</tr>
<tr>
<td>Corail ESMO 2018</td>
<td>1 – 3 Prior Median 2 Prior</td>
<td>PLD or Topotecan</td>
<td>ORR 12%</td>
</tr>
<tr>
<td></td>
<td>Prior PARPi: 5% Prior Bev: 46%</td>
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</table>
Design for the Ovarian Cancer Expansion Cohort of the UpRi Phase 1 Study

**Ovarian Cancer Cohort**
- 1-3 prior lines in platinum resistant
- 4 prior lines regardless of platinum status
- High grade serous histology
- Archived tumor and fresh biopsy (if medically feasible) for NaPi2b
- Exclusion: primary platinum-resistant defined as lack of response or disease progression within 3 mos after completing front-line platinum containing therapy

**Patient population:** High grade serous ovarian cancer (including fallopian tube and primary peritoneal cancer) progressing after standard treatments

- Measurable disease per RECIST v1.1
- ECOG Performance Status 0 or 1

**Dosing:** IV every 4 weeks until disease progression or unacceptable toxicity

- 36 mg/m² cohort initiated in August 2019 and enrollment closed
- 43 mg/m² cohort initiated in December 2019 and enrollment is closed; 43 mg/m² up to a maximum of ~80 mg total evaluated in EXP*

**Primary Objectives:**
- Evaluate safety and tolerability of MTD or RP2D
- Assess preliminary efficacy (ORR, DCR)

**Secondary Objectives:**
- Association of tumor NaPi2b expression and objective tumor response using an immunohistochemistry (IHC) assay with a broad dynamic range to distinguish tumors with high and low NaPi2b expression
- Further assessment of preliminary anti-neoplastic activity (DOR)

**Assessments:**
- Tumor imaging (MRI or CT): baseline and every 2nd cycle; response assessed per RECIST v1.1

*Maximum Doses are Common in Oncology Drug Development (e.g., ADCETRIS®, PADCEV®, Mylotarg™)

Abbreviations: mos = months; EXP = expansion; RECIST = Response Evaluation Criteria in Solid Tumors; ECOG = Eastern Cooperative Oncology Group; MTD = maximum tolerated dose; ORR = objective response rate; DCR = disease control rate; DOR = duration of response
Expansion Cohort Experience Across a Range of Doses Allows for Further Optimization of UpRi Profile

Doses Studied in Expansion

36 mg/m²
(N=12)

43 mg/m²
(BSA < 1.8 N=39)

43 mg/m²
(BSA > 1.8 N=46)

Higher Dose: 43 mg/m²
Intermediate Dose: ~80 mg
Lower Dose: 36 mg/m²

~30% Of Patients in Exp. Cohort Treated at Doses of ~36 mg/m²*

*Doses from 33 mg/m² to 38 mg/m² (n=29)
### Ovarian Cancer Expansion Patients (N = 97)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Median (range)</th>
<th>N (%)</th>
</tr>
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<tbody>
<tr>
<td><strong>Age; years</strong></td>
<td>68 (33, 87)</td>
<td>97</td>
</tr>
<tr>
<td><strong>ECOG Performance Status; n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>33 (34)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>64 (66)</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline BSA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 1.8 m²</td>
<td>51 (53)</td>
<td></td>
</tr>
<tr>
<td>≥ 2.2 m²</td>
<td>5 (5)</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Tumor Type; n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ovarian</td>
<td>72 (74)</td>
<td></td>
</tr>
<tr>
<td>Fallopian Tube</td>
<td>15 (15)</td>
<td></td>
</tr>
<tr>
<td>Primary Peritoneal</td>
<td>8 (8)</td>
<td></td>
</tr>
<tr>
<td><strong>Prior Lines of Therapy; n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>65 (67)</td>
<td></td>
</tr>
<tr>
<td>4+</td>
<td>32 (33)</td>
<td></td>
</tr>
<tr>
<td><strong>Prior Therapy; n (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bevacizumab</td>
<td>68 (70)</td>
<td></td>
</tr>
<tr>
<td>PARP inhibitor</td>
<td>57 (59)</td>
<td></td>
</tr>
</tbody>
</table>
| **Platinum-free Interval** 
  b; n (%)   |                |       |
| 0-3 mos                                     | 34 (35)        |       |
| >3-6 mos                                    | 46 (47)        |       |
| >6 mos                                    c   | 10 (10)        |       |
| Unknown                                    d  | 7 (7)          |       |
| **BRCA1/2 Mutation; n (%)**                 |                |       |
| Yes                                         | 15 (15)        |       |
| No                                          | 65 (67)        |       |
| Unknown                                        | 17 (18)         |     |
| **NaPi2b TPS**; n (%)                        |                |       |
| Determined                                  | 78 (80)        |       |
| High                                        | 50 (64)        |       |
| Low                                         | 28 (36)        |       |
| Not Yet Determined (ND)                     | 19 (20)        |       |

* Three patients enrolled with ≥5 prior lines of systemic therapy. 
  t Platinum-free interval defined as the time between the last cycle of most recent platinum-containing regimen and evidence of disease progression; determined from treatment dates and/or clinic notes. 
  x All patients had received 4 or 5 lines of prior therapy. 
  y Treatment dates missing/not provided; unable to determine. 
  z BRCA1/2 mutation status not available/not reported. 
  \[High NaPi2b Expression: Tumor Proportion Score (TPS) ≥75; Low NaPi2b Expression: TPS <75; ND = NaPi2b Expression not yet determined or tissue not available\]
UpRi Continues to Have a Consistent Tolerability Profile
No grade ≥ 3 (severe) TRAEs of neutropenia, peripheral neuropathy, or ocular toxicity have been reported

TRAEs Reported in ≥20% of Patients with Ovarian Cancer (N = 97)

- **Fatigue** includes preferred terms of asthenia and fatigue;
- **AST increase** is transient in nature, recovers to baseline or to Grade 1 prior to the next dose, no instances are associated with elevated bilirubin or cases of Hy’s law;
- **Thrombocytopenia** includes preferred terms of platelet count decreased and thrombocytopenia. Thrombocytopenia is transient in nature, nadirs at Day 8 and recovers prior to the next dose;
- **Anaemia** includes preferred terms of anaemia of chronic disease, blood loss anaemia and iron deficiency anaemia

Data Cut: June 10, 2021

Fatigue includes preferred terms of asthenia and fatigue; AST increase is transient in nature, recovers to baseline or to Grade 1 prior to the next dose, no instances are associated with elevated bilirubin or cases of Hy’s law; Thrombocytopenia includes preferred terms of platelet count decreased and thrombocytopenia. Thrombocytopenia is transient in nature, nadirs at Day 8 and recovers prior to the next dose; Anaemia includes preferred terms of anaemia of chronic disease, blood loss anaemia and iron deficiency anaemia
## Decreased Grade 3+ Treatment Related AEs with Lower Dose

<table>
<thead>
<tr>
<th></th>
<th>Lower Dose 36 mg/m²</th>
<th>Intermediate Dose ~80 mg</th>
<th>Higher Dose 43 mg/m²</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; Grade 3 Fatigue</td>
<td>1 (8%)</td>
<td>6 (13%)</td>
<td>9 (23%)</td>
</tr>
<tr>
<td>&gt; Grade 3 Increased AST</td>
<td>1 (8%)</td>
<td>16 (35%)</td>
<td>16 (41%)</td>
</tr>
<tr>
<td>&gt; Grade 3 Pneumonitis</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>4* (10%)</td>
</tr>
</tbody>
</table>

* 2 cases of Grade 5 pneumonitis including 1 previously reported; most recent case was in a 75-year-old 4th line recurrent ovarian cancer patient treated at higher dose of 43 mg/m² (BSA 1.47 m², 105 lb) with past medical history of poor pulmonary reserve: asthma and chronic obstructive pulmonary disease requiring intermittent supplemental oxygen at baseline, coronary artery disease and congestive heart failure.

Data Cut: June 10, 2021
Observed Consistent Tolerability Profile with Limited Discontinuations due to TRAE

Dose modification due to Treatment-Related Adverse Events (TRAEs):
- Of the 97 patients, 43 (44%) had dose delay, reduction, and/or discontinuation due to a TRAE
  - Dose reductions due to TRAEs occurred in 27 (28%) patients
  - Dose delays due to TRAEs occurred in 16 (16%) patients
  - Dose discontinuation (withdrawn) due to TRAEs occurred in 10 (10%) patients

Treatment-Emergent Severe Adverse Events (SAEs) reported in ≥ 5% of Patients:
- Out of 97 patients, 47 (48%) reported Treatment-Emergent SAEs. The most frequent of which were Gastrointestinal Obstruction 7 (7%), 5 (5%) each for Pyrexia, Pneumonitis, and Abdominal Pain
- 22 (23%) of the SAEs were deemed by the investigator to be treatment-related

Data Cut: June 10, 2021
Consistent Activity Observed in Heavily-Pretreated Ovarian Cancer

<table>
<thead>
<tr>
<th></th>
<th>NaPi2b High (TPS&gt;75)</th>
<th>NaPi2b Low (TPS&lt;75)</th>
<th>Not Yet Determined NaPi2b</th>
<th>All Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>38</td>
<td>23</td>
<td>14</td>
<td>75</td>
</tr>
<tr>
<td>CR</td>
<td>2 (5)</td>
<td>0</td>
<td>0</td>
<td>2 (3)</td>
</tr>
<tr>
<td>PR</td>
<td>11 (29)</td>
<td>2 (9)</td>
<td>2 (14)</td>
<td>15 (20)</td>
</tr>
<tr>
<td>uPR</td>
<td>1 (3)</td>
<td>0</td>
<td>2 (14)</td>
<td>3 (4)</td>
</tr>
<tr>
<td>SD</td>
<td>19 (50)</td>
<td>8 (35)</td>
<td>7 (50)</td>
<td>34 (45)</td>
</tr>
<tr>
<td>PD</td>
<td>5 (13)</td>
<td>13 (57)</td>
<td>3 (21)</td>
<td>21 (28)</td>
</tr>
<tr>
<td>Confirmed ORR</td>
<td>13 (34)</td>
<td>2 (9)</td>
<td>2 (14)</td>
<td>17 (23)</td>
</tr>
<tr>
<td>DCR</td>
<td>33 (87)</td>
<td>10 (43)</td>
<td>11 (79)</td>
<td>54 (72)</td>
</tr>
</tbody>
</table>

Data Cut: June 10, 2021
CR = complete response; PR = partial response; uPR = unconfirmed PR; confirmatory scan pending at the time of the data cut
ORR = Objective Response Rate; DCR = Disease Control Rate
22 patients were not evaluable by RECIST 1.1: 10 deaths (4 disease progression, 2 pneumonitis, 2 sepsis, 1 viral pneumonia, 1 unknown); 5 patient withdrawals; 1 enrolled in hospice; 1 clinical progression; 4 discontinued treatment; 1 had not yet reached first scan
Similar Efficacy Across the Three Dose Levels, with Trend to Higher Efficacy with Lower Dose

Confirmed ORR with 95% Confidence Interval
NaPi2b High, RECIST-Evaluable (N=38)

- Lower Dose: 36 mg/m²
  - 50% point estimate
  - 41% lower bound
  - 15% upper bound

- Intermediate Dose: ~80 mg
  - 41% point estimate

- Higher Dose: 43 mg/m²
  - 15% point estimate

• Data trends consistent in the overall population

Data Cut: June 10, 2021
NaPi2b High based on TPS>75
Two-Thirds of Patients Had Reductions in Target Tumor Lesions

Maximum % Change from Baseline in Target Lesions in Evaluable Patients with Ovarian Cancer (n=73*)

49/73 (67%) had reductions in target tumor lesions

Data Cut: June 10, 2021

2 pts excluded as post-baseline tumor measurement shows "Not Measurable", yet "PD" was assigned by Investigator in the response dataset

Abbreviations: CR = complete response; PR = partial response; uPR = unconfirmed PR; H = High NaPi2b Expression; L = Low NaPi2b Expression; ND = NaPi2b Expression not yet determined or tissue not available
Trend to Longer Time on Study with High NaPi2b Expression

Time on XMT-1536 Study in Evaluable Patients with Ovarian Cancer (n=75)

*13/17 (76%) responders with first scan of CR/PR

Abbreviations: CR = complete response; PR = partial response; uPR = unconfirmed PR; High = High NaPi2b Expression; Low = Low NaPi2b Expression; ND = NaPi2b Expression not yet determined or tissue not available
Median Duration of Response Consistent at ~5 Months in Patients with High NaPi2b Expression

Data Cut: June 10, 2021

*The median duration of response for NaPi2b Low and NaPi2b not yet determined expression is 3.9 months and 3.7 months, respectively.
Partial Response in a Patient with Ovarian Cancer Dosed at 36 mg/m² for a Total of 9 Cycles

- 66-year-old patient with BRCA1/2 negative high-grade serous ovarian cancer
- NaPi2b High (TPS≥75)
- 4 prior lines of systemic therapies including carboplatin/taxol/bevacizumab; carboplatin/doxil with PARP inhibitor maintenance; and cisplatin/paclitaxel
- Received 36 mg/m² (maximum dose of approximately 80 mg with a BSA of 2.16 m²)
- Received 9 Cycles of UpRi
- Confirmed PR by RECIST v1.1 with -41.4% tumor reduction
Conclusions: UpRi Expansion in Ovarian Cancer

- In this updated analysis of patients with heavily-pretreated ovarian cancer, UpRi continued to be generally well-tolerated with a consistent profile – no severe neutropenia, peripheral neuropathy, or ocular toxicity

- Consistent antitumor activity observed with UpRi, including patients previously treated with bevacizumab and PARPi
  - Complete response observed in 2 patients with platinum-resistant ovarian cancer at the lower dose
  - Confirmed ORR of 34% and DCR of 87% in NaPi2b High population
  - Median duration of response ~5 months in NaPi2b High population

- This larger data set provides important observations to support the potential of UPLIFT as a registration strategy and to inform next steps in the UpRi development plan
  - Decreased grade 3+ Treatment Related AEs, including pneumonitis, with lower dose
  - Similar efficacy across the three dose levels, with trend toward higher efficacy with lower dose
We thank the patients, their families and caregivers for their contribution to this study

UNITED STATES
Allegheny Health Network, Pittsburgh, PA
Arizona Oncology Associates, Tucson, AZ
Avera Cancer Institute – Sioux Falls, SD
Billings Clinic, Billings, MT
Dana Farber Cancer Institute, Boston, MA
Emory University, Atlanta, GA
Fox Chase Cancer Center, Philadelphia, PA
H. Lee Moffitt Cancer Center, Tampa FL
Henry Ford Medical Center, Detroit, MI
Greenville Hospital System University Medical Center, Greenville, SC
Lahey Clinic, Burlington, MA
Levine Cancer Center, Charlotte, NC
Mary Crowley Cancer Research Center, Dallas, TX
Maryland Oncology and Hematology, Rockville, MD
Massachusetts General Hospital, Boston, MA
Mount Sinai, New York City, NY
NEXT Oncology, San Antonio, TX
Ohio State University Wexner Medical Center, Hilliard, OH
Oncology and Hematology Assoc. of SW VA, Inc., Roanoke, VA
QUEST Research Institute, Royal Oak, MI
Rocky Mountain Cancer Centers, LLP, Denver, CO
Sarah Cannon Research Institute, Nashville, TN
START, San Antonio, TX

UNITED STATES
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Stephenson Cancer Centre, Oklahoma City, OK
Texas Oncology, Austin, TX
Texas Oncology Fort Worth, Fort Worth, TX
Texas Oncology, Tyler, TX
University of Alabama at Birmingham, Birmingham, AL
University of Colorado, Aurora, CO
University of Florida, Gainesville, FL
University of Miami, Miami, FL
University of Pittsburgh Medical Center, Pittsburgh, PA
University of Tennessee, Knoxville, TN
University of Utah Huntsman Cancer Institute, Salt Lake City, UT
Virginia Cancer Specialists, Fairfax, VA
Virginia Commonwealth University Massey Cancer Center, Richmond, VA
Washington University, St. Louis, MO
Willamette Valley Cancer Institute, Eugene, OR
Women’s Cancer Care Associates, LLC – Albany, NY

CANADA
McGill University (Glen-Cedars Cancer Center), Montreal
British Columbia Cancer Agency, Vancouver

AUSTRALIA
Lifehouse Australia as trustee for the Lifehouse Australia Trust, Camperdown
Peter MacCallum Center, Melbourne, Victoria
Austin Health, Heidelberg, Victoria
Next Steps for UpRi Development Plan
Increasing Dose Beyond the Optimal Threshold May Add Incremental Toxicity without Incremental Efficacy

- Further analysis utilizing population PK models confirmed the efficacy and safety findings showing the association between increasing exposure and G3+ adverse events, including pneumonitis.

- Preclinically, ADCs have a well-characterized exposure / response relationship:
  - ADC efficacy increases with payload tumor concentration up to a plateau
  - Beyond this plateau, additional drug can decrease tolerability without improving efficacy
  - Preclinical data confirm relationship appears regardless of target, payload, linker, or platform

The Dose that Optimizes Therapeutic Index May Not be the Maximum Tolerated Dose

Source: Drug Metab Dispos 47:1146–1155, October 2019
Action Plan to Implement Learnings from Expansion Cohort Data Set

- Data set from expansion cohort supports differentiated efficacy and tolerability profile

- Analysis of data combined with population PK modeling identifies the opportunity to further improve UpRi profile

- New UPLIFT Dose: 36 mg/m² up to a maximum of ~80 mg
  - ~15% or less change to dose
  - Potential to improve the therapeutic index of UpRi and the probability of success of UPLIFT
  - Implemented as amendment to the UPLIFT protocol with the support of investigators and cooperative groups
  - Proactively informed FDA

- Amendment is designed to optimize eligibility for management of pneumonitis
  - Exclude patients with severe uncontrolled pulmonary disease or cardiovascular disease, history of or suspected pneumonitis or interstitial lung disease, oxygen saturation or room air below 93%
UP-NEXT: UpRi Monotherapy vs. Placebo as Maintenance in Platinum-Sensitive Recurrent Ovarian Cancer
Despite Bevacizumab and PARPi Options, Significant Unmet Need Remains for New Maintenance Agents

Bevacizumab and PARP Moving into Earlier Lines and Combinations

- A population previously treated with bevacizumab and PARPi maintenance sequentially or in combination is emerging, with no standard of care upon relapse

Watch & Wait Remains a Standard of Care for Some Patients

- Patients poorly served by current maintenance agents need additional options. Watch & wait remains an option in guidelines
  - 80% of patients without BRCA mutation (e.g., HRP, HRD)
  - Co-morbidities (e.g., hypertension, risk for bowel obstruction)
  - Tolerability (e.g., thrombocytopenia)

PARPi Maintenance not Indicated for Stable Disease following Platinum

- PARPi activity is predicted by platinum responsiveness, patients that achieve stable disease to platinum were not included in PARPi maintenance studies
- Emerging evidence of poor outcomes with platinum following PARPi may increase proportion achieving SD

UpRi Differentiation

- Activity against Bev and PARPi Pre-Treated Disease

Optimized Dose with Differentiated Tolerability Profile and Biomarker Enrichment

- Activity, including CRs, in Heavily Pre-Treated Patients

Source: Product labels; KOL interviews; NCCN Guidelines Aug 2021 OV-8; 813 MO ESMO 2020; Abstract 824P ESMO 2020; Abstract 828P ESMO 2020
UP-NEXT/GOG-3049: Phase 3 Study of UpRi Monotherapy Maintenance vs Placebo in Platinum-Sensitive Recurrent OC

Key Enrollment Criteria:
- Platinum-sensitive recurrence, following platinum induction
- NaPi2b High biomarker selection by TPS>75
- 1 – 3 prior platinum-based regimes
- Prior PARPi therapy allowed, but only required for BRCAmut
- SD in addition to CR/PR as best response following platinum induction

Primary Endpoint:
- PFS

Informed by FDA Feedback, Final Design Pending CHMP Scientific Advice
Plans to Initiate in 2022
UP-NEXT Key Differentiators

- **Platinum-Sensitive Population**
  - Earlier in disease than UPLIFT population
  - Opportunity to be first ADC in earlier lines and platinum-sensitive disease

- **UpRi Monotherapy**
  - Randomized vs. placebo, potential for higher probability of success

- **Broader Population than Existing Maintenance Options**
  - Enrolls patients who have achieved stable disease to platinum doublet in addition to patients who achieve partial or complete responses
  - Enrolls patients with prior bevacizumab, prior PARPi, both, or neither

- **Registration Intent**
  - Intended to support global launches
  - If positive, could serve as confirmation of UPLIFT
Closing Remarks
Data Set Supports UpRi Profile and UPLIFT Registration Strategy

**UpRi Profile**

- **Meaningful and Durable Activity in Heavily-Pretreated Patients**
  - >30% ORR with CRs in NaPi2b High Ovarian Cancer

- **Consistent Tolerability Profile**
  - No Severe Neutropenia, Ocular Toxicity, or Peripheral Neuropathy

- **Robust, Predictive, and Reproducible Diagnostic**
  - Tumor Proportion Score > 75 Present in Two-Thirds of Patients Enriches for Improved Outcomes

- **36 mg/m² Up to a Maximum of ~80 mg**
  - Potential to Further Improve Safety while Maintaining Efficacy

Data Cut: June 10, 2021
An Opportunity to Deliver a Potentially Foundational Medicine for Ovarian Cancer

- **UPGRADE**: Umbrella Combo Starting with Platinum
- **UP-NEXT**: Phase 3 Study in Platinum-Sensitive Maintenance
- **UPLIFT**: Single-Arm Registration Strategy in Platinum-Resistant Disease

Increasing Market Potential
Opportunities in Platinum-Sensitive, Platinum-Resistant, Monotherapy, Combination, Treatment, and Maintenance

- 22,000 newly diagnosed ovarian cancer patients annually
- Plus, fallopian tube and primary peritoneal cancers treated in the same algorithm
- With a median survival 5 years from diagnosis
- 80% relapse following frontline therapy
- And 14,000 deaths per year

Source: SEER
Multiple Value-Drivers Across UpRi, Pipeline, and Platforms

Build UpRi as a Foundational Medicine in Ovarian Cancer

Build Out Pipeline

UpRi NSCLC (NaPi2b Dolasynthen)

XMT-1592 (NaPi2b Dolasynthen)

XMT-1660 (B7-H4 Dolasynthen)

XMT-2056 (Immunosynthen)

Build Momentum

Dolaflexin Dolasynthen Immunosynthen

UPLIFT

UP-NEXT

UPGRADE to Enable Combos

UPLIFT

UPLIFT

UPLIFT

UPLIFT

UPLIFT

UPLIFT
Q&A