

Innovation Driven
Outcomes Focused
October 2022

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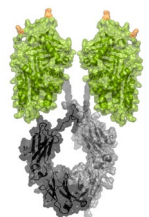
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Four differentiated clinical programs

Rare diseases



INBRX-101
AAT-Fc fusion protein

AATD

- + Potential registration-enabling trial with accelerated pathway to initiate in Q1 2023
- + Favorable safety and tolerability profile w/potential to achieve normal AAT levels with monthly dosing
- + Potential to reach >\$1.3B in U.S. sales within 3 years of launch, \$3B peak sales potential in the U.S.

Acute GvHD

- + De-risked opportunity with promising clinical data with pdAAT
- + Potential to reach >\$600M in U.S. sales within 5 years of launch with upside potential
- + Potential registration-enabling trial to initiate in mid-2023

Cell death pathway



INBRX-109
Tetravalent DR5 agonist

- + Potential path to approval in chondrosarcoma by 2025 with potential profitability in 2026
- + Potential to reach \$600M in U.S. sales within 3 years of launch
- + Initial data in IDH mutant chondrosarcoma at CTOS (Nov '22)
- + Initial combination cohort data starting in mid-2023: mesothelioma, pancreatic adenocarcinoma, colorectal cancer and Ewing sarcoma

Oncology

Immuno-oncology



INBRX-106
Hexavalent OX40 agonist

- + Durable responses in combination with anti-PD-1 in CPI refractory patients
- + Durable single agent activity in patients with prior CPI exposure
- + Potential to combine INBRX-106 with fast-growing IO market
- + Next data readouts in anti-PD-1 combination expansion cohorts in mid-2023



INBRX-105
PD-L1 x 4-1BB tetravalent conditional agonist

- + Potential to be first 4-1BB agonist with a robust therapeutic window
- + Single agent responses in CPI refractory patients including a CR
- + Potential across PD-L1 expressing tumors
- + Data from expansion cohorts in combination with anti-PD-1 in mid-2023

Why invest in Inhibrx?



Four differentiated clinical programs with potentially value-creating readouts in Q4 2022 and 2023



Potential to reach financial sustainability with minimal dilution



Backed by solid institutional investor base with substantial internal ownership



Robust emerging pre-clinical pipeline

KEY FINANCIAL HIGHLIGHTS*

\$176M Cash

\$30+M Average
per Qtr burn rate

39.0M Common stock
outstanding

44.7M Fully diluted
outstanding

* As of 6/30/2022

Inhibrx at a glance



- + Experienced leadership team
- + Proven innovation and execution



All platforms and programs developed in-house with strong patent protection



Inhibrx's modular sdAb platform

- + Ability to precision engineer to specific target biology
- + Smaller than conventional antibodies
- + Antibody-like PK profile
- + Readily manufactured at high yields using standard processes

PARTNERSHIPS WITH INDUSTRY LEADERS



INBRX-101

Recombinant Alpha-1
Antitrypsin Fc-fusion Protein

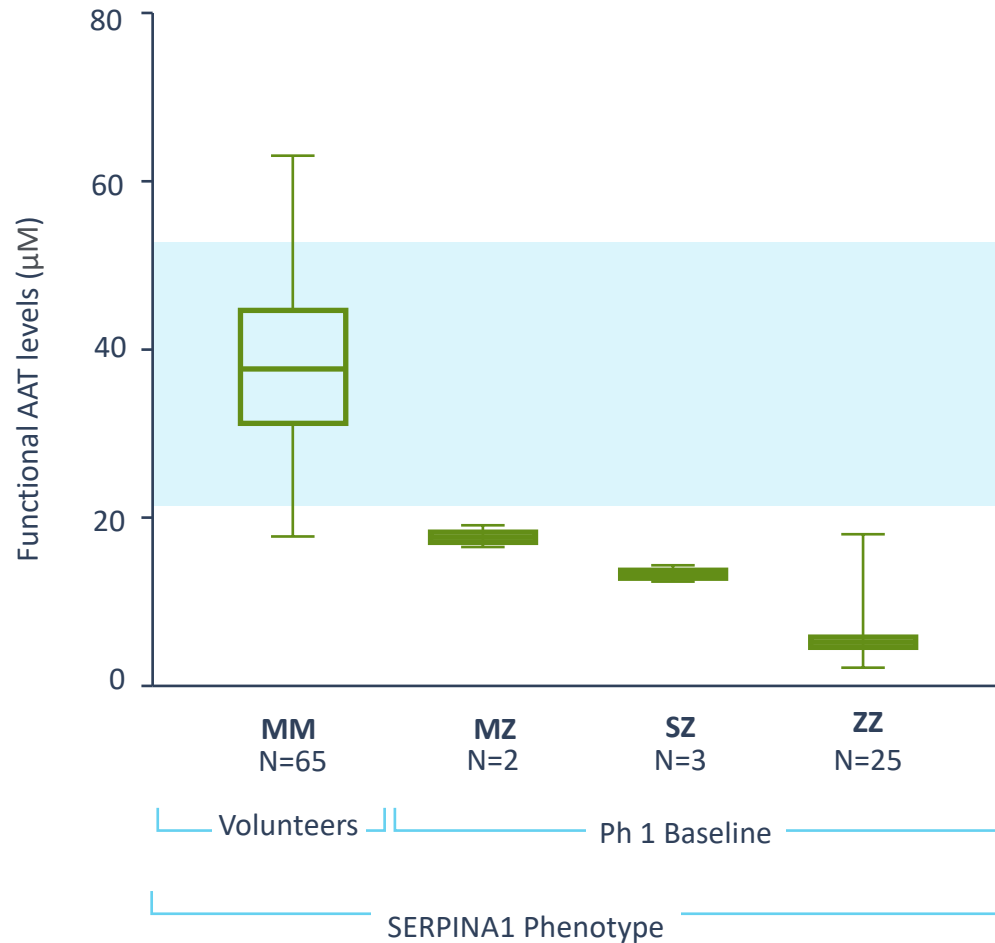
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INBRX-101

Alpha-1 Antitrypsin
Deficiency (AATD)

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Functional AAT levels in healthy individuals vs. AATD patients



Disease history

- + Alpha-1 antitrypsin deficiency (AATD) is an inherited orphan respiratory disease characterized by deficient levels of alpha-1 antitrypsin (AAT)
- + This causes loss of lung function and decreased life expectancy
- + A small percentage of patients also develop liver disease

Study results

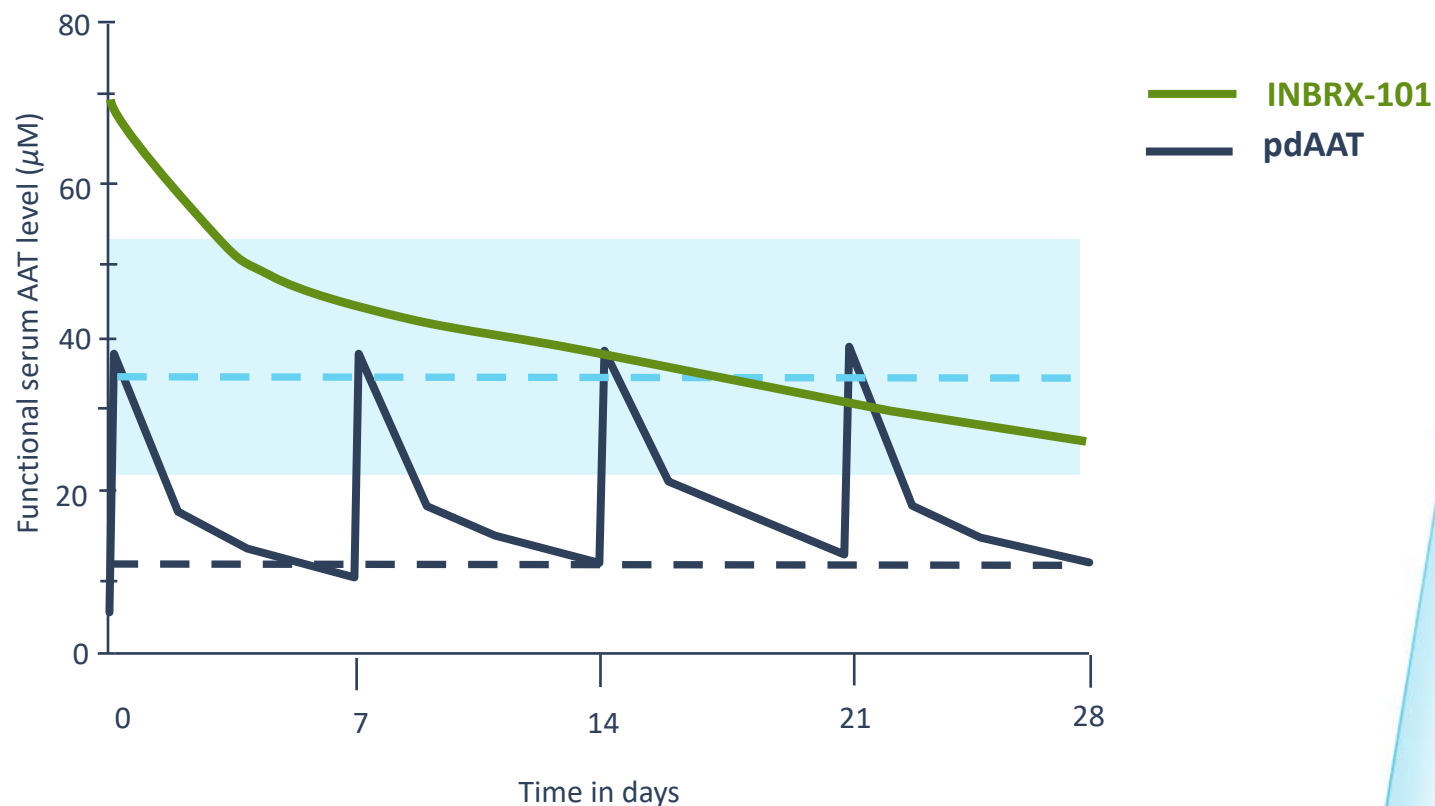
- + Functional AAT levels from 65 MM genotype healthy volunteers ranged from 21 to 54 micromolar (µM), with a mean of 36 µM.
- + Baseline levels of functional AAT for 30 Phase 1 patients prior to dosing of INBRX-101 ranged from 2 to 18 µM, with a median of 4.7 for ZZ genotype patients.

- Box plots show the minimum, lower quartile, median, upper quartile and maximum
- The shaded region represents the 5th-95th percentiles of the normal range of functional AAT in healthy MM genotype adults
- AAT variant determination was conducted by the Mayo Clinic Laboratories using an LC-MS/MS method (A1ALC)
- The Ph 1 baseline data represents the functional AAT levels measured in patients at the beginning of the study prior to dosing INBRX-101

Current standard of care does not maintain normal AAT levels

INBRX-101

Functional AAT serum levels at steady-state (INBRX-101 vs. pdAAT)



— 36 μM mean of functional AAT normal range*

— 11 μM historical putative threshold

+ INBRX-101 dosed **every four weeks** at 120 mg/kg is predicted to maintain patients above the lower threshold of the normal range and achieve an average level (C_{avg}) of functional AAT that approximates that of healthy MM genotype adults.*

+ The current standard of care, plasma-derived AAT (pdAAT)**, dosed **once weekly** at 60 mg/kg, achieves C_{avg} of functional AAT of 17.8 μM over the weekly dosing interval as calculated from steady-state area under the curve (AUC) values***. Due to its short half-life, patients require weekly infusions to achieve target levels, but levels typically fall below the normal range within 1-2 days of infusion.

*Source~ Normal range calculated based on Inhibrx ANEC assay results from 65 healthy MM genotype adults

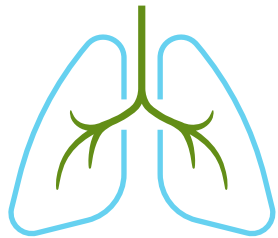
**Current pdAAT therapies include: Aralast, Glassia, Prolastin-C & Zemaira

***Source~ reported in Stocks et al. BMC Clinical Pharmacology 2010, 10:13

Potential advantages of recombinant AAT Fc-fusion protein INBRX-101



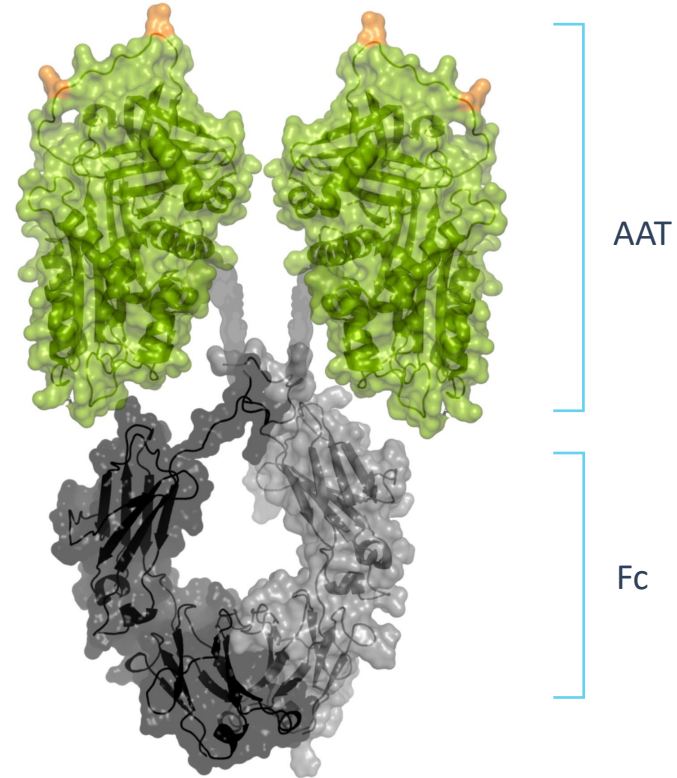
Potential to extend
the dosing interval
from weekly to monthly



Has demonstrated potential to
maintain patients in normal
functional AAT range



Recombinant manufacturing
provides abundant supply
with no pathogen risk



INBRX-101

INBRX-101 - Topline results from Phase 1, Part 2

PART 2



Multiple ascending
dose escalation (MAD)



Complete



N=18



N=6



40 mg/kg



N=6



80 mg/kg*



N=6

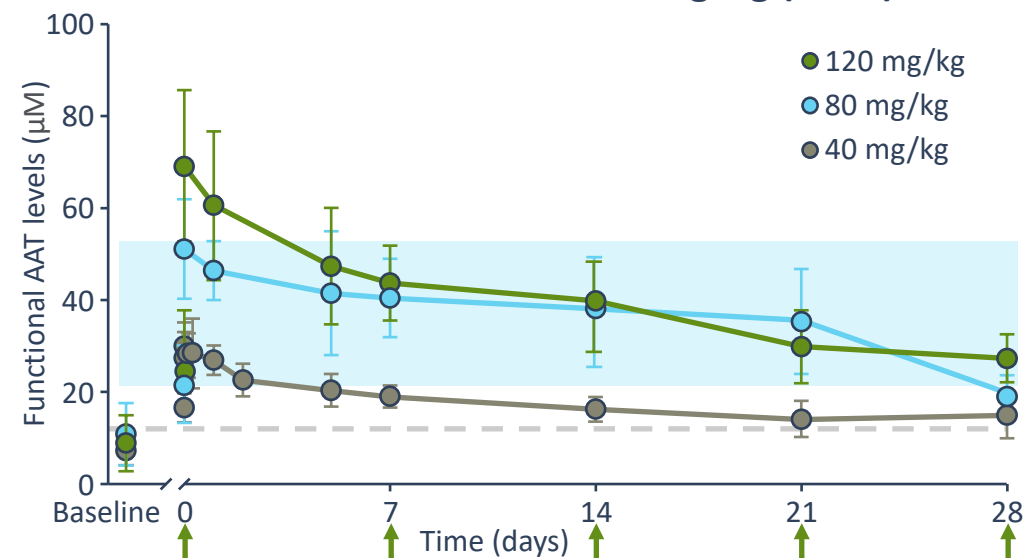


120 mg/kg*

* bronchoalveolar lavage

- + Favorable safety and tolerability profile with only mild and a few moderate AEs that were transient and fully reversible with minimal or no symptomatic care
- + Dose related increases in maximal and total exposure occurred across entirety of SAD and MAD ranges of 10-120 mg/kg
- + Revealed potential to achieve and maintain normal functional AAT levels with monthly dosing

INBRX-101 topline results – 3rd dose of 40, 80 or 120 mg/kg (Q3W)



↑ Indicates timing after third dose

* Baseline values shown at Day 0

- + Significant accumulation observed following each MAD dose in-line with the prolonged terminal elimination half-life of INBRX-101
- + MAD cohorts demonstrate observed C_{avg} of functional AAT of 37.6 µM and 45.4 µM over the 21-day dosing interval following the third 80 mg/kg and 120 mg/kg doses, respectively
- + Functional AAT levels at Day 70 (28 days following the 3rd dose), on average, were within the normal range for the 120 mg/kg dose level

INBRX-101

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INBRX-101 is present in the lung in every patient sampled following IV dosing

Bronchoalveolar lavage fluid (BALF) sample collection and analysis

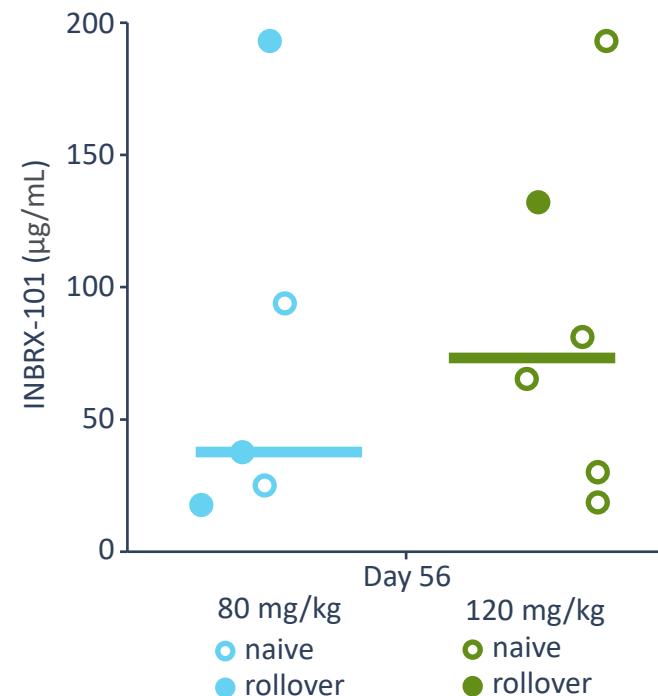
- + BALF samples were collected from 3 lobes of the lung for each patient in the 80 (N = 5)¹ and 120 (N = 6) mg/kg MAD cohorts prior to dosing and two weeks after completion of multiple dosing
- + INBRX-101 concentrations were measured using a proprietary validated mass spectrometry assay specific to INBRX-101

BALF assessment results

- + At baseline, BALF samples from subjects that rolled over from the Part 1 SAD² had measurable INBRX-101 while drug was undetectable in INBRX-101 naïve patients (data not shown)
- + Post-dose, INBRX-101 was present in each lung lobe of every patient for which a bronchoscopy was performed
- + The Phase 1 study data provide emerging evidence of a dose-dependent increase in INBRX-101 lung exposure

¹ One 80 mg/kg patient did not have a post-dose sample collected

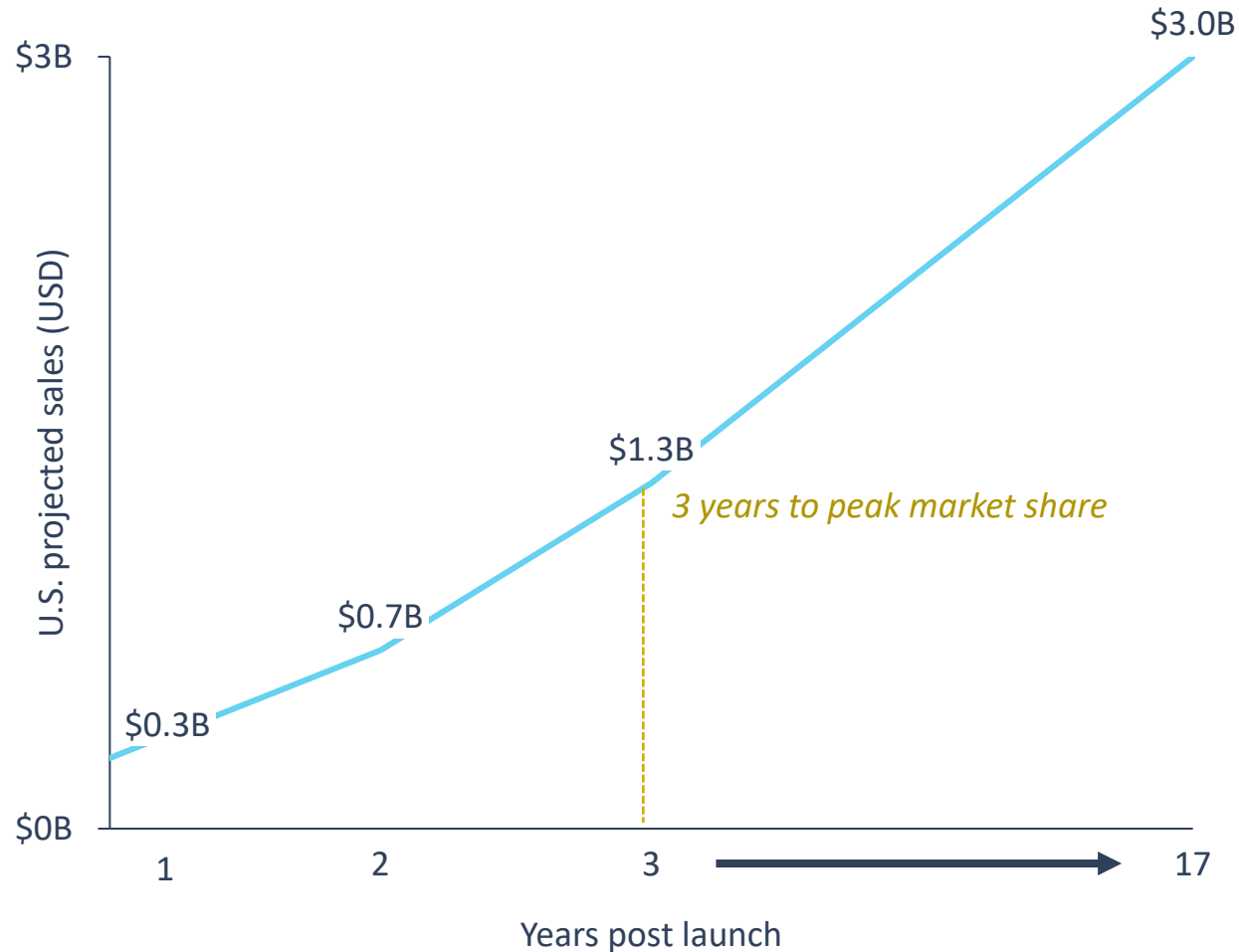
² In rollover patients, baseline collection was at least 84 days after the SAD



- Each point represents the average INBRX-101 concentration measured across three lobes in an individual subject
- Horizontal lines are the median values for each dose level
- Data is preliminary and has not been fully verified

INBRX-101 has the potential to achieve ~\$3B in annual U.S. revenue with expected rapid uptake in patients with severe AATD

INBRX-101 top line projected U.S. sales & key assumptions



Key assumptions

- + “Severe (ZZ/SZ)” AATD patients (same as pdAATs today)
- + 7% CAGR throughout forecast period (conservative estimate given CAGR of ~17% from 2016 to 2020)
- + ~75% peak market share
- + 3-year time to peak share
- + Price parity with current pdAATs* & 2% annual price growth
- + Little to no generic erosion due to high barriers to entry

INBRX-101

INHIBRX

INBRX-101 has the potential to shift the treatment paradigm, expanding augmentation therapy to a broad group of AATD patients in the U.S.

INBRX-101

	TODAY	FUTURE
	PI*ZZ or PI*SZ	PI*ZZ or PI*SZ
U.S. prevalence	~100K	~100K (same as today)
Treatment rate	~8-10%	~40% (driven by increased diagnosis rates)
Total treated U.S. patients	~8K	~40K
Market revenue potential	~\$1 Billion	~\$4 Billion

Key Takeaways for AATD Market:

- + pdAATs only utilized for severe AATD patients and market is still worth ~\$1B today despite only ~8-10% treatment rate
- + PI*ZZ & PI*SZ AATD market is growing at ~17% annually and projected to grow to \$4B due to increased diagnosis
- + Upside market potential from earlier intervention of augmentation therapy, which can help to prevent lung decline
- + Commercial viability and expansion of augmentation therapy use requires abundant supply only available via INBRX-101

“The results of the RAPID trial stress the importance of early intervention. Patients who started augmentation late were unable to regain lung tissue lost during placebo treatment and did not ‘catch up’ to patients who started augmentation early.” – U.S. KOL

INBRX-101

Graft versus Host Disease
(GvHD)

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Strong clinical data and established guidelines exist for AAT therapy in acute GvHD

Existing clinical data for Jakafi: current standard of care

2L (steroid resistant) acute GvHD (aGvHD)

		Ruxolitinib, Incyte ⁴ (n=49)
Efficacy	ORR (%) at day 28 (per CIBMTR)	28/49 (57%)
	CR (%) at day 28	15/49 (31%)
	OS	51% at 6 months
Safety (n=71)	Grade 3+ AEs	97.2%
	Most Frequent AEs	- Anemia: 64% - Thrombocytopenia 62% - Neutropenia 48%
	Incidence of Infection	80%
Dosing		• 5-10 mg twice daily

Existing clinical data for plasma-derived AAT therapies

2L (steroid resistant) aGvHD

		Fred Hutch/Baxalta ¹ Ph1/2 (n=12)	U of Michigan/CSL ² AAT +/- Prednisone Ph2 (n=40)
Efficacy	ORR (%) at day 28 (per CIBMTR)	8/12 (67%)	26/40 (65%)
	CR (%) at day 28	4/12 (33%)	14/40 (35%)
	OS	6/12 alive	45% at 6 months
Safety	Grade 3+ AEs	0%	0%
	Most Frequent AEs	"No clinical apparent toxicity in any patient" 2 d/c due to lack of efficacy	"well tolerated with no infusion reactions or drug-related grade 3 to 4 toxicity"
	Incidence of Infection	0	13/40 (32.5%) Through 30 days
Dosing		90 mg/kg loading dose followed by either 30 or 60 mg/kg every other day	60mg/kg per day every four days

Two active Phase 2/3 studies sponsored by CSL Behring

- + The Safety and Efficacy of Alpha-1 Antitrypsin (AAT) for the Prevention of Graft-Versus-host Disease (GvHD) in Patients Receiving Hematopoietic Cell Transplant (MODULAATE) (NCT03805789)³
- + Treatment of GvHD in Hematopoietic Stem Cell Transplant (HSCT) Recipients Using AAT Plus Corticosteroids (CS) Compared With Corticosteroids Alone (NCT04167514)³

Current guidelines for aGvHD⁵

NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN)	Ruxolitinib (category 1)	Alemtuzumab	Alpha-1 antitrypsin	Anti-thymocyte globulin	Basiliximab	Calcineurin inhibitors	Etanercept
EUROPEAN SOCIETY FOR BLOOD AND MARROW TRANSPLANTATION (EBMT)	Alemtuzumab	Alpha-1 antitrypsin	Basiliximab	Cellular therapies	Daclizumab	Extracorporeal photopheresis	Faecal microbiota transplantation

Sources:

¹ Response of Steroid-Refractory Acute GvHD to a1-Antitrypsin, Marcondes et al, 2016. <http://dx.doi.org/10.1016/j.bbmt.2016.05.011>

² a1-Antitrypsin infusion for treatment of steroid-resistant acute graft-versus-host disease, Magenau et al, 2018. <http://ashpublications.org/blood/article-pdf/131/12/1372/1405639/blood815746.pdf>

³ <https://clinicaltrials.gov/>

⁴ <https://www.jakafi.com/pdf/prescribing-information.pdf>, <https://ashpublications.org/blood/article/135/20/1739/452638/Ruxolitinib-for-the-treatment-of-steroid>

⁵ Listed in alphabetical order and not comprehensive of all consensus recommendations for steroid-refractory GVHD.

INBRX-101 has the potential to achieve >\$1bn in the US market with fast entry into acute GvHD and expansion into prophylaxis setting

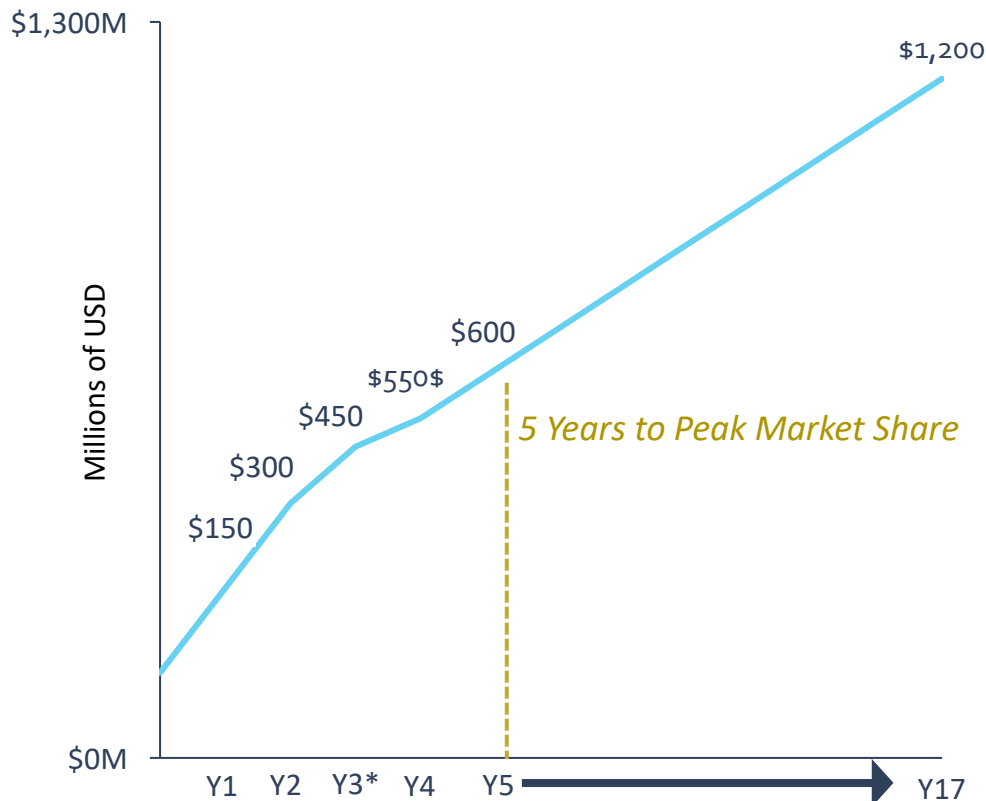
INBRX-101 acute & prophylaxis GvHD top line projected US sales & key assumptions

Potential advantages over pdAAT

- + Potential for sustainable dosing schedule
- + Potential for transformational efficacy at higher dose
- + Ability to price in-line with current standard of care while pdAAT would be more expensive due to COGS and the high dose required
- + Near elimination of pathogenic risk for immunocompromised patients

Potential advantages over standard of care

- + Expected superior safety benefits with potential for greater efficacy



*Launch of prophylaxis indication

Key assumptions:

- + TPP: Superior safety, efficacious in prophylaxis, same efficacy in acute
- + Patients: Allogeneic stem cell transplants (2.3% annual growth), Acute 2L+, high risk prophylaxis (30%)
- + Share: Acute 2L: 50%, 3L: 70%, Prophylaxis: 21%
- + Time to peak: 2 years for acute and prophylaxis (5 years peak total)
- + Price: In-line with approved GvHD branded agents, 2.5% annual growth

Upside potential:

- + Potential for transformational efficacy at high dose
- + Safety profile could enable broad combinability across current and future therapies, including 1L

INBRX-101 GvHD expansion opportunities

U.S. chronic GvHD – progression beyond steroids



- + Less competitive future market landscape
- + Longer therapy duration requires reduced toxicity and steroid-sparing agents
- + Favorable safety profile enables opportunity for combining with standards of care
- + Long half-life enables sustainable long-term utilization of 101 relative to pdAAT therapies

Prophylaxis, acute, & chronic GvHD – EU / Japan



- + Favorable pricing and reimbursement as compared to typical European/Japanese standards due to high mortality and significant unmet medical need
- + There were 9,400¹ allogeneic transplants in the U.S. market; ex-US transplant market represents a large global opportunity

Sources:

¹ 2019 figures from HRSA Blood Stem Cell (<https://bloodstemcell.hrsa.gov/data>)

² 2017 figures for 40 European countries and 10 related countries: <https://www.nature.com/articles/s41409-019-0465-9>

³ 2020 figures from JDCHCT https://drive.google.com/file/d/16Vv8k1aHTMcOKbmOHGiUmEk4rFGwgBEy/view?usp=drive_web

⁴ Qualitative research, third-party analysis and current therapy pricing research, HRSA Blood Stem Cell (<https://bloodstemcell.hrsa.gov/data>).

⁵ Assumes pricing corridor 50% smaller than the US

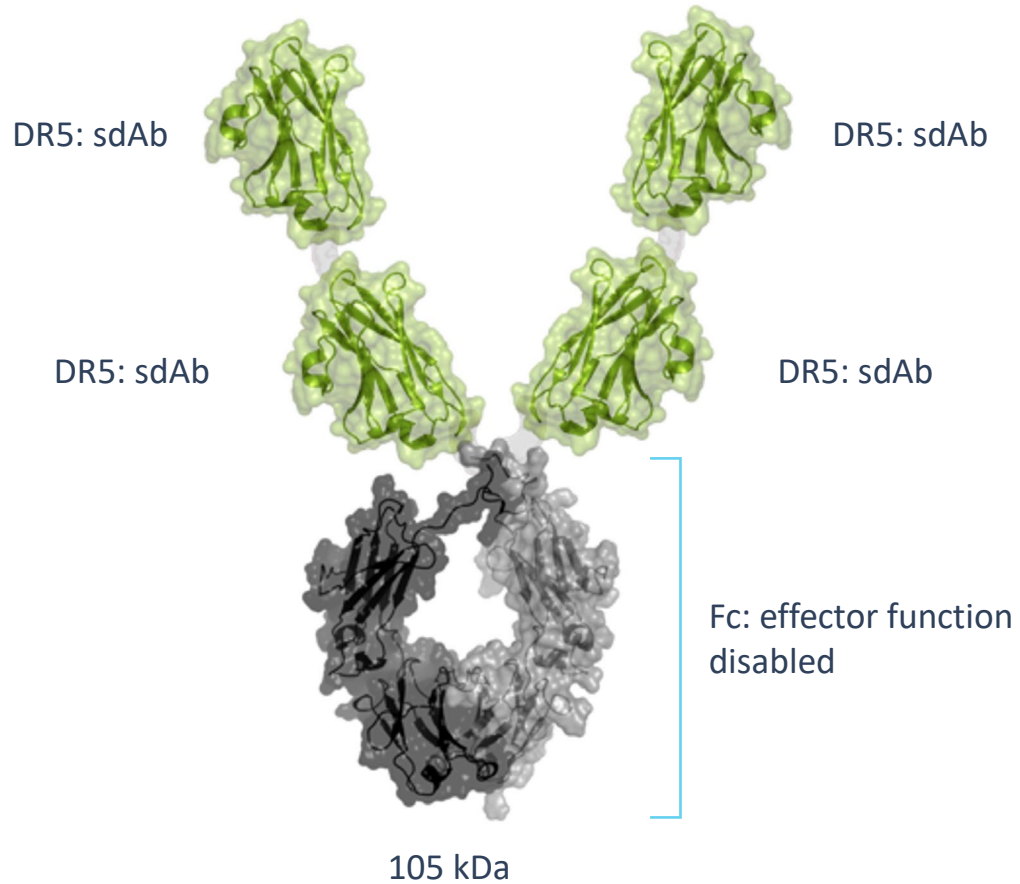
⁶ Epidemiology and Treatment of Chronic Graft-versus-Host Disease Post-Allogeneic Hematopoietic Cell Transplantation: A US Claims Analysis, Bachier, et. al., 2021

INBRX-109

Tetravalent DR5 Agonist

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Tetravalent DR5 agonist



- + Death receptor 5 (DR5) is a receptor for the tumor necrosis factor-related apoptosis-inducing ligand (TRAIL)
- + DR5 activation naturally eliminates damaged and neoplastic cells

INBRX-109 is a best-in-class DR5 agonist

CANDIDATE	VALENCY	SIZE (KDA)
INBRX-109	Tetravalent	105
TAS-266¹	Tetravalent	60
Eftozanermin alpha (TRAIL-Fc fusion)	Hexavalent	167
GEN1029^{1,2}	Dodecavalent	150 ka (2x mAbs)
IGM-8444	Decavalent ³	~950
Dulanermin (recombinant TRAIL)	Trivalent	150
Tigatuzumab	Bivalent	150
LBY-135		
Conatumumab		
Drozitumab		
Lexatumumab		

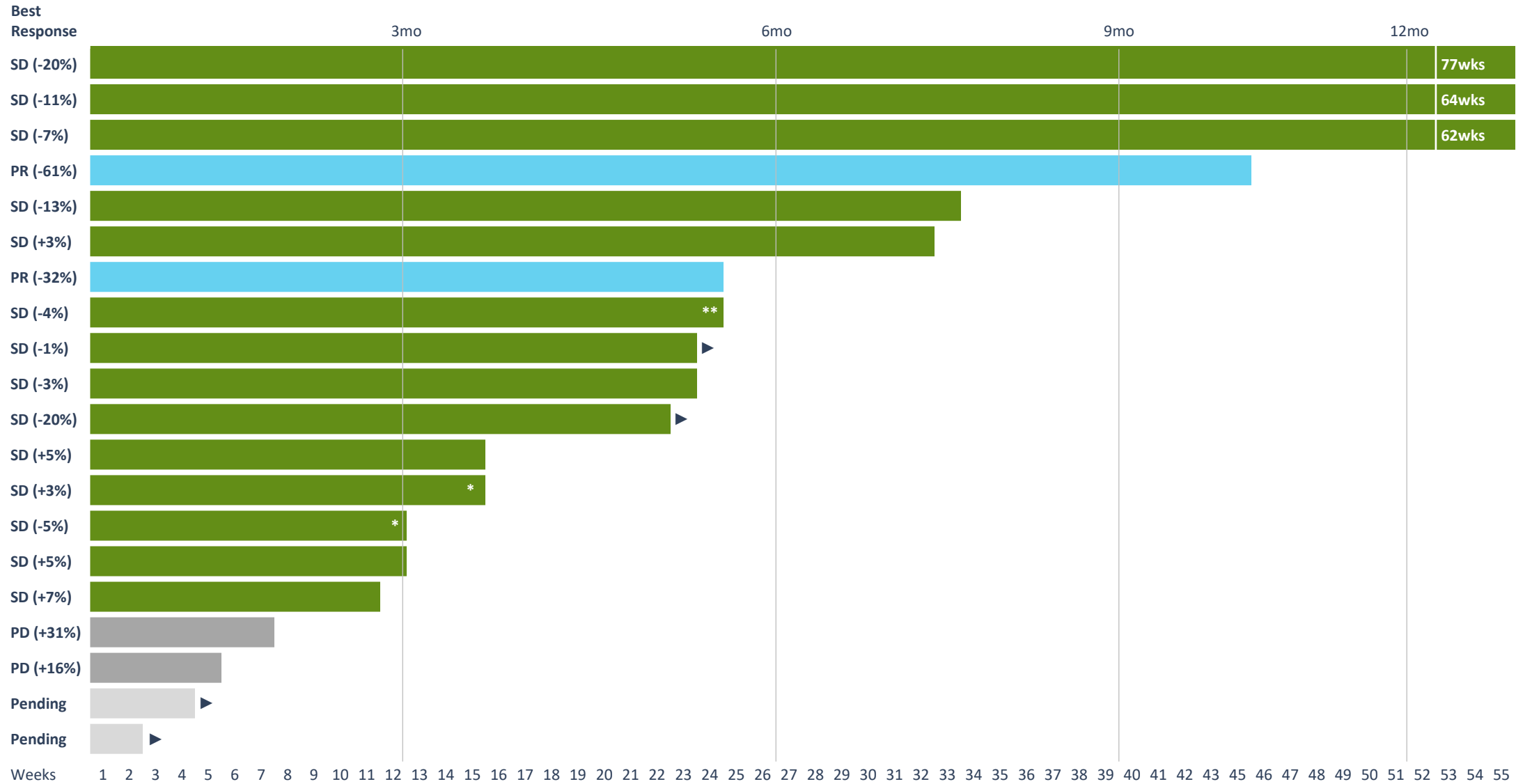
1. Discontinued

2. Two hexamerizing non-competing mAbs

3. Size and rigidity of IgM may prevent effective clustering of DR5

Preliminary Phase 1 data in unresectable or metastatic conventional chondrosarcoma

INBRX-109



+ Data cut point **01-Oct-2021** from Nov 2021 CTOS presentation, study ongoing
 + Response per RECISTv1.1 per Investigator assessment, data subject to change (e.g., some data raw and not verified)

+ PR=Partial Response, SD=Stable Disease, PD=Progressive Disease
 + ▶ Subject ongoing
 + *Off-study per subject request (e.g., resection) or **Investigator discretion

INBRX-109 Phase 2 potentially registration-enabling study design in chondrosarcoma

INBRX-109

Randomization

Conventional chondrosarcoma, Grades 1, 2 and 3, unresectable or metastatic

Stratification

by line of therapy, Grade and IDH1/2 mutation status

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 **N=134***

 3 mg/kg every three weeks



Initiated

Placebo

 **N=67***

 Until PD or toxicity with cross-over to INBRX-109

ENDPOINTS

Primary: Progression free survival

Secondary: Overall survival, quality of life, overall response rate, duration of response, disease control rate, safety, etc.

1H 2024

PFS from other placebo-controlled chondrosarcoma studies

Therapeutic	IPI-926 (HH)
Control arm	Placebo
Subject number	100 (2:1)
Placebo arm	Median PFS 2.9 months

Source~ CTOS 2013 Wagner et al.

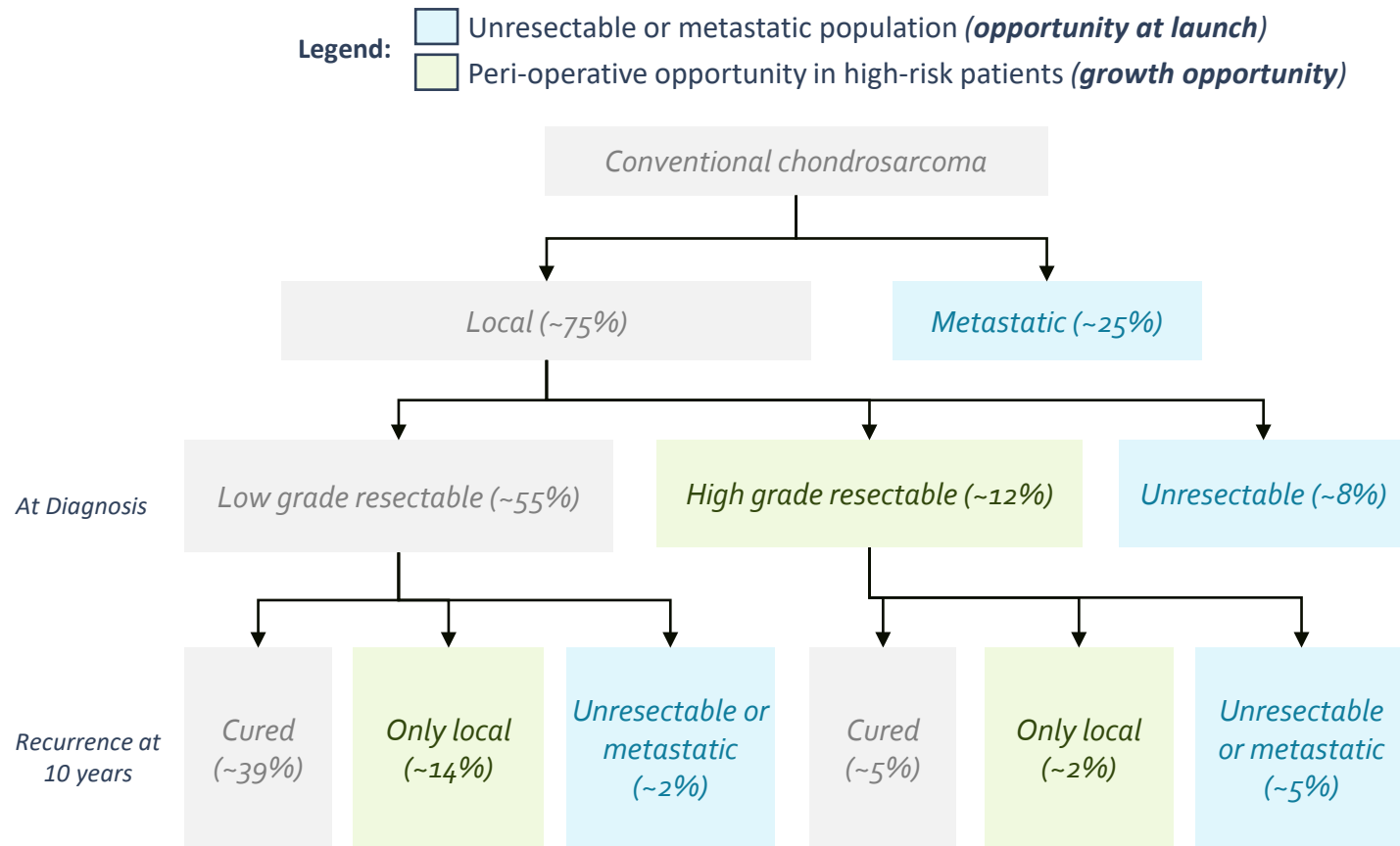
Therapeutic	Regorafenib
Control arm	Placebo
Subject number	46 (2:1)
Placebo arm	Median PFS~ 2 months

Source~ European Journal of Cancer 2021 Florence Duffaud et al.

- + No approved systemic therapeutic for the treatment of chondrosarcoma
- + FDA Fast Track designation and orphan-drug designation in unresectable and metastatic conventional chondrosarcoma

Many patients with local disease eventually progress to unresectable or metastatic chondrosarcoma, providing an annual prevalent patient pool of ~2.5K in the U.S.

Conventional chondrosarcoma patient flow



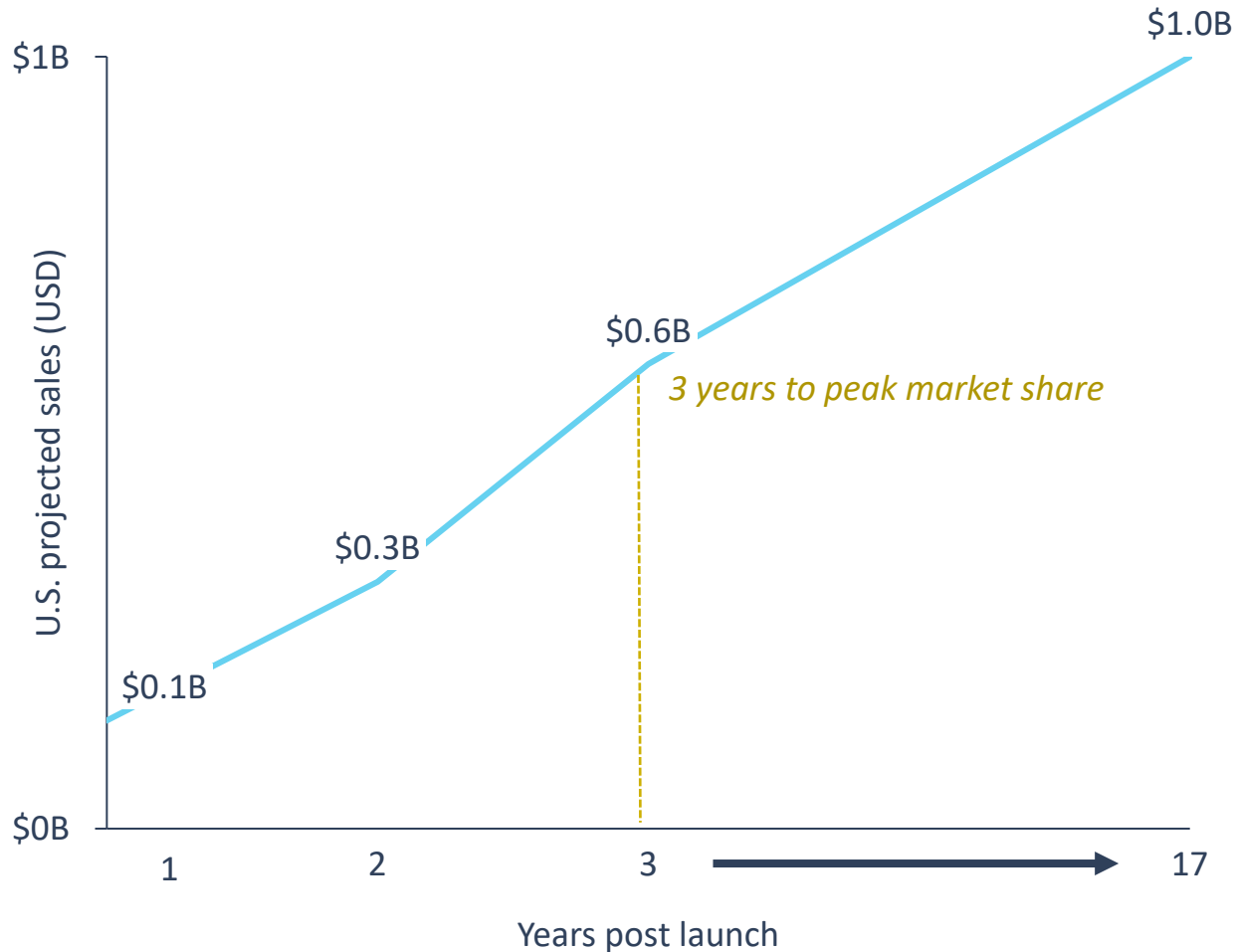
KEY TAKEAWAYS

- + Unresectable or metastatic opportunity estimated at **~2.5K** patients in the U.S. today vs. reported incidence of ~1.5K given tendency for local disease to progress to unresectable or metastatic
- + Longer term growth opportunity in the peri-operative setting for high-risk patients with **~1.6K** prevalent patients in the U.S. today

Based on current trends and lack of approved options, INBRX-109 has the potential to achieve ~\$1B in annual revenue with rapid uptake post launch

INBRX-109

INBRX-109 top line projected U.S. sales in the unresectable/metastatic setting & key assumptions



Key assumptions

- + ~375K* annual price per patient
- + ~85% peak share
- + ~30% 10-year recurrence rate for local, low-grade patients
- + ~65% 10-year recurrence rates for local, high-grade patients

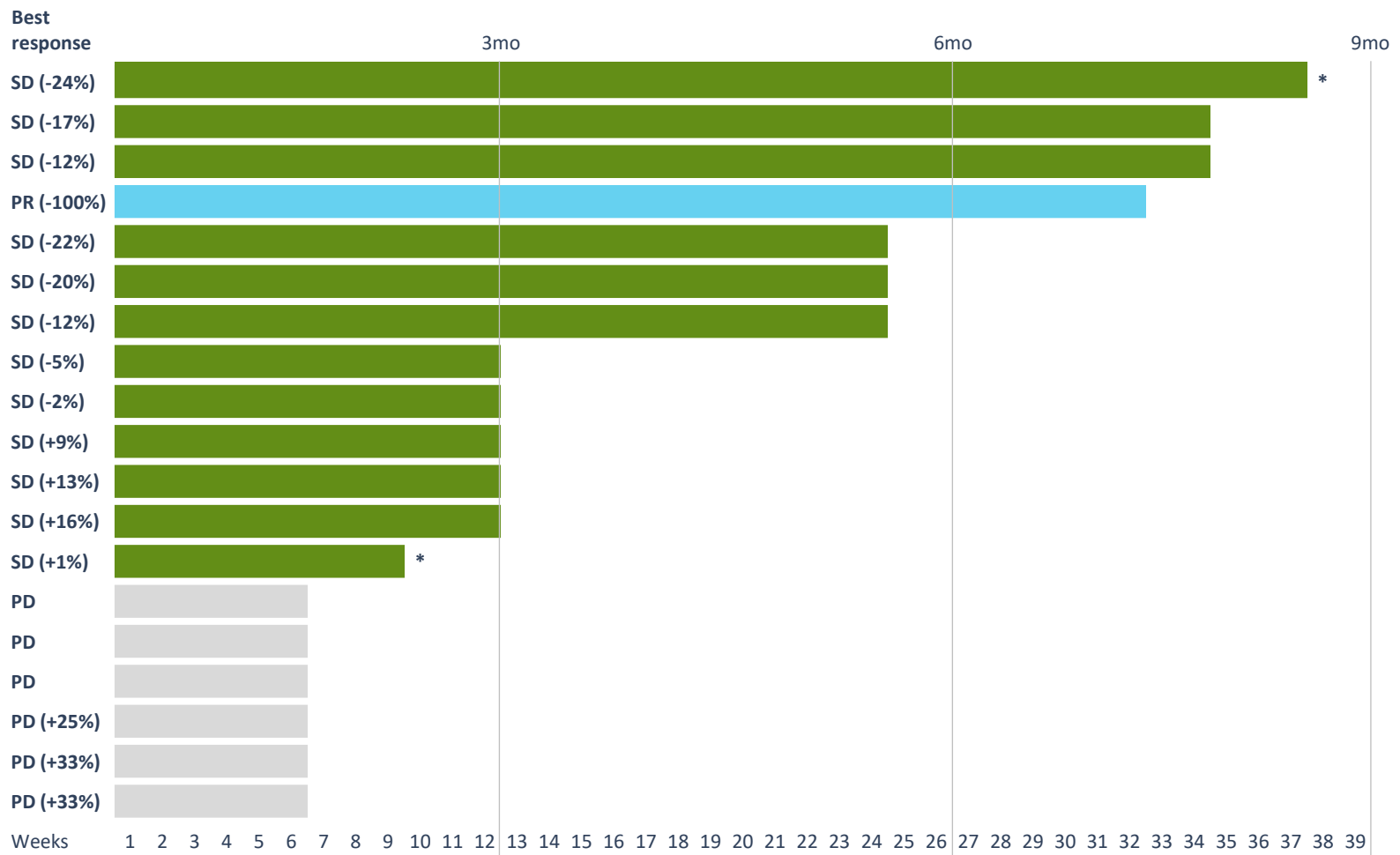
Incremental growth opportunity

- + Peri-operative setting provides an incremental ~\$500M annual opportunity in the U.S. alone

Notes: *Pricing assumption is for modelling purposes only based on analogous market research for oncology products in rare indications; Sources: KOL qualitative interviews (n=~20); Inhibrx secondary research; Hua et al., Treatment Method and Prognostics..., 2020

Phase 1 single agent data in malignant pleural mesothelioma, epithelioid subtype

PARTs 1 & 2



PART 3



Combination study



N=10

Mesothelioma with Cisplatin or Carboplatin



N=10

Mesothelioma with Cisplatin or Carboplatin with Pemetrexed

Mid-2023

- + Time on treatment in weeks
- + Data cut point 24-NOV-2020, data from Ph1 INBRX-109 study, single agent mesothelioma cohort closed
- + Response per RECISTv1.1 or modified RECIST, and per Investigator assessment, data subject to change (e.g., some data raw and not verified)

- + Efficacy population (subjects who completed 2 cycles and had at least one tumor assessment, or discontinued early due to PD); three subjects not evaluable for efficacy were excluded
- + PR=Partial Response, SD=Stable Disease, PD=Progressive Disease
- + * Off-study per subject or Investigator request

INBRX-109 on the horizon

PART 3



Combination studies



N=20

Pancreatic adenocarcinoma
2nd line with mFOLFIRI



Ongoing



N=20

Ewing sarcoma with
Irinotecan + Temozolomide



Ongoing



N=20

Colorectal Cancer with
FOLFIRI



Ongoing



N=20

SDH-deficient GIST with
Temozolomide



Ongoing

Data releases: mid-2023

POTENTIAL FUTURE OPPORTUNITIES

- ✓ **Solid tumors**
+ IAP antagonists
- ✓ **Hematologic tumors**
+ Bcl-2 inhibitors
- ✓ **NSCLC**
+ various combo agents
- ✓ **Additional sarcoma indications**

INBRX-109

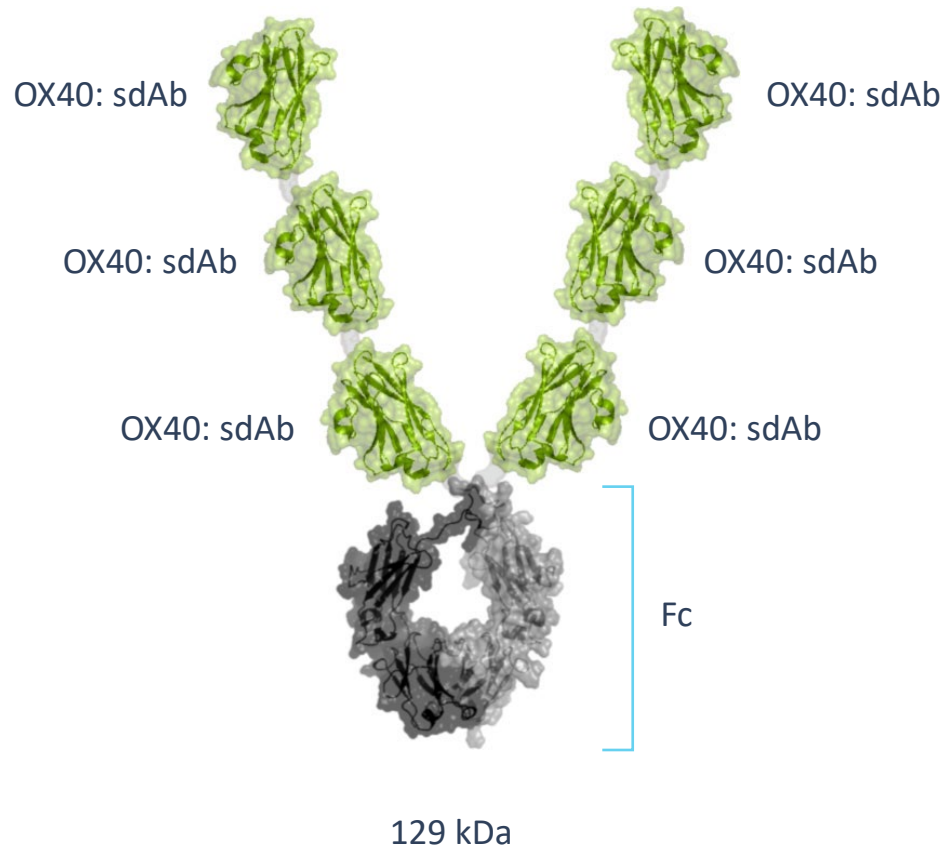
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INBRX-106

Hexavalent OX40 Agonist

INHIBR_X

Hexavalent OX40 agonist

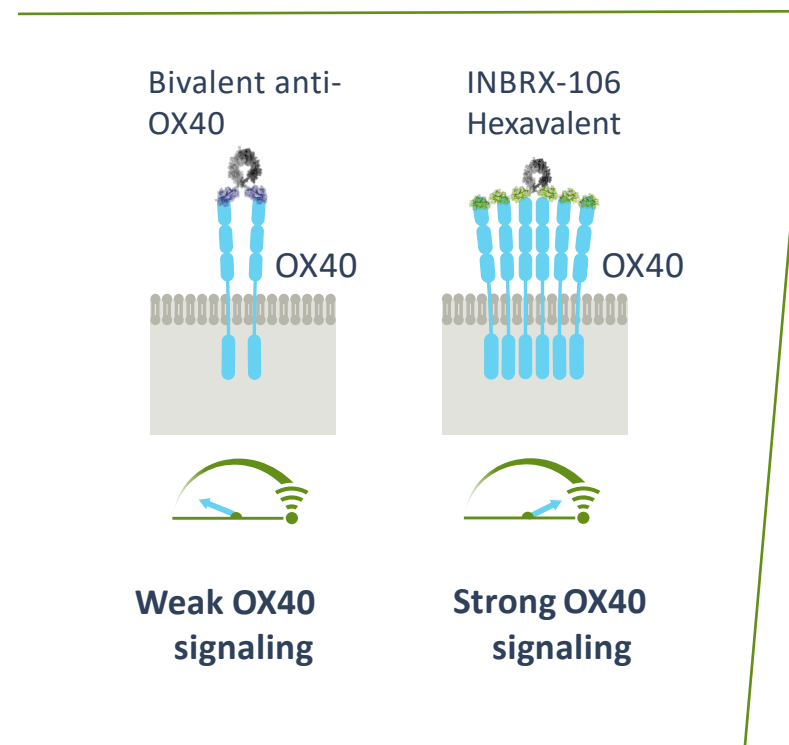


OX40 is a co-stimulatory receptor on activated T-cells designed to:

- + Provide co-stimulation to activated T-cells
- + Reverse regulatory T-cell induced immune suppression
- + Enhance T-cell functionality
- + Provide additional benefit in combination with PD-1 blockade

INBRX-106 is a best-in-class OX40 agonist

CANDIDATES	VALENCY	ISOTYPE	LIGAND BLOCKING
INBRX-106	Hexa-	IgG1	N
MOXR-0916	Bi-	IgG1	Y
GSK-3174998			
BMS-986178			
INCAGN-1949			
ABBV-368			
IBI-101			
MEDI-0562			
PF-04518600	Bi-	IgG2	Y
BGB-A445	Bi-	IgG1	N
BAT6026	Bi-	IgG1 afucosylated mAb	n/a



INBRX-106

INBRX-106 Phase 1 in combination with Keytruda™

INBRX-106

PART 3



Dose
escalation



Complete

N=30

No pre-screening, all-comers

- + Durable responses with anti-PD-1 in CPI refractory patients across multiple tumor types
- + Well-tolerated with mild or moderate immune-related toxicities

PART 4



Dose
expansion



Ongoing

N=80

CPI refractory

N=20 PD-L1+ NSCLC

N=20 PD-L1+ basket

CPI naive

N=10 PD-L1+ cutaneous melanoma

N=10 PD-L1+ uveal melanoma

N=10 PD-L1+ head & neck squamous cell carcinoma

N=10 PD-L1+ nasopharyngeal carcinoma

Mid-2023

INBRX-106 Phase 1 preliminary single agent activity

INBRX-106

PART 1



Dose escalation

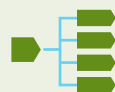


Complete

 N=20

Patients were all-comers

PART 2



Dose expansion



Complete

 N=24

0.03 mg/kg in two different dosing schedules in patients with tumor types responsive to CPIs



- + 4/10 response evaluable NSCLC & melanoma patients with duration of stable disease* greater than 6 months (three CPI-exposed patients and one CPI-naïve uveal melanoma patient)
- + Longest duration of stable disease was 2+ years (NSCLC patient refractory to Keytruda™)**
- + Well-tolerated with mild or moderate immune-related toxicities

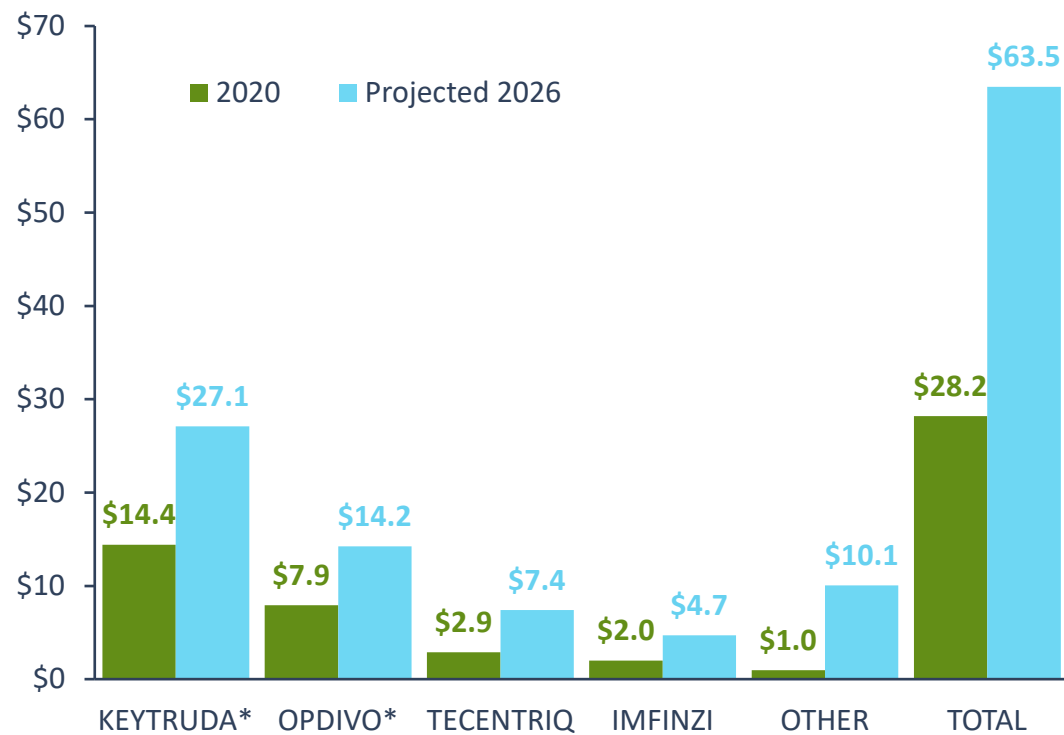
* per investigator assessment

** patient came off study May 12, 2022 after 112 weeks on treatment with INBRX-106

Market opportunity for INBRX-106 and INBRX-105

PD-1/PD-L1 WW Revenue

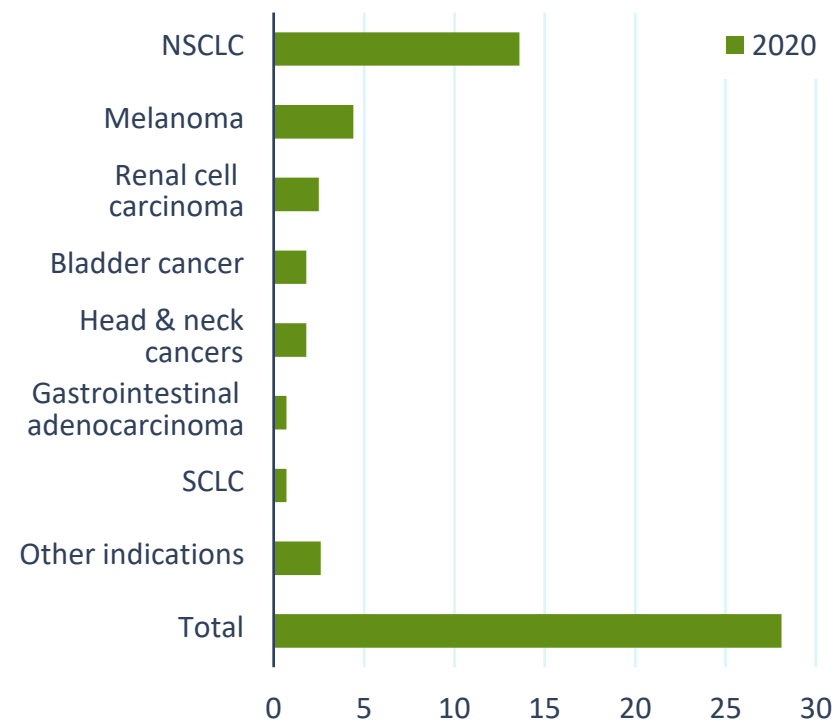
(in \$ billions)



**Keytruda™ and Opdivo® go off patent in 2028*

PD-1/PD-L1 WW Revenue by Indication

(in \$ billions)

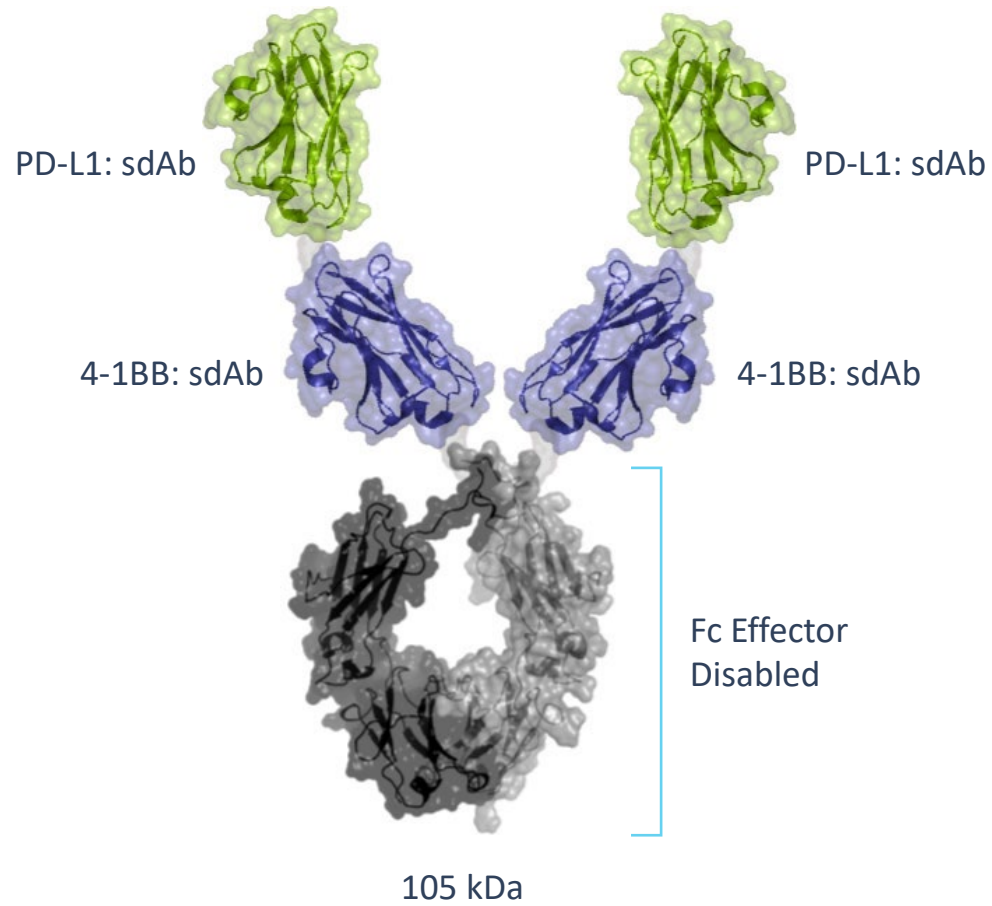


INBRX-105

PD-L1 x 4-1BB Multispecific

INHIBR_X

PD-L1 x 4-1BB multispecific



- + Designed to provide spatially-restricted 4-1BB agonism at sites of PD-L1 expression
- + Highly expressed on tumor infiltrating immune cells, 4-1BB signaling promotes prolonged T-cell survival memory formation
- + Constitutive 4-1BB agonism has achieved anti-tumor responses, but was limited by immune-related toxicities

INBRX-105 is a potential best-in-class 4-1BB agonist

PD-L1 x 4-1BB Bispecifics

CANDIDATE	FORMAT	4-1BBL BLOCKING
INBRX-105	Bivalent/Bivalent	No
Gen-1064	Monovalent/Monovalent	n/a
MCLA-145	Monovalent/Monovalent	Yes
FS222	Bivalent/Bivalent	n/a
PRS-343	Bivalent/Bivalent	No
ND021	Monovalent/Monovalent	n/a

Monoclonal 4-1BB Antibodies

CANDIDATE	IGG SUBCLASS	4-1BBL BLOCKING
Urelumab	IgG4	Yes
Utomilumab	IgG2	No
CTX-471	IgG4	No
ADG106	IgG4	Yes
ATOR-1017	IgG4	Yes
AGEN2373	IgG1	No
LVGN6051	unknown	n/a

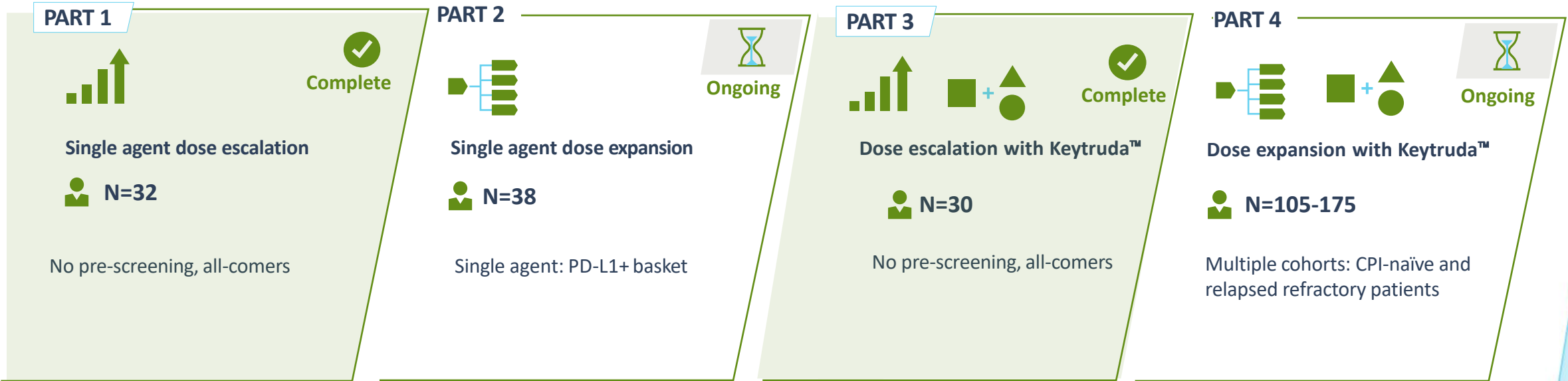
INBRX-105

INHIBRX

INBRX-105 has the potential to be the first 4-1BB agonist with a robust therapeutic window

INBRX-105

Phase 1 trial design



- + Single agent responses observed in CPI-refractory patients
- + Single agent complete response observed

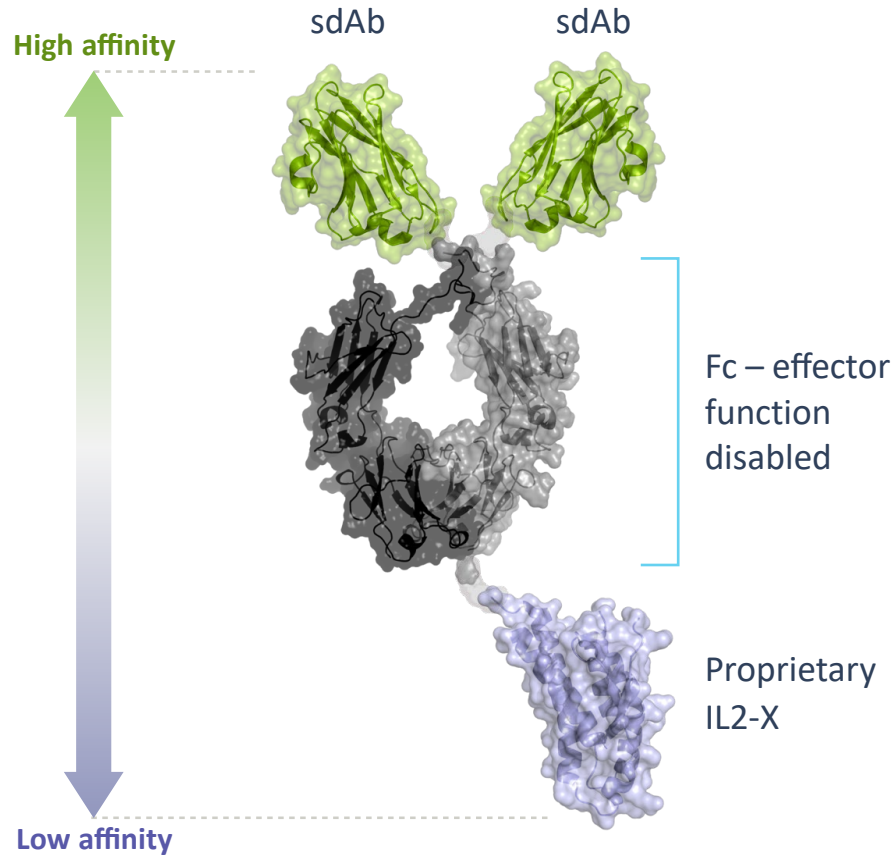
Mid-2023

Molecular Targeted Cytokine (MTC) Platform

A Targeted Detuned
IL-2 Platform

INHIBR_X

Affinity differential enables directed IL-2 expansion/enhancement of specific cell types



High affinity antibody targeting

INHIBRX has developed sdAbs to an extensive number of antigens

- + T-cell or NK cell subsets
- + Activating/co-stimulatory receptors
- + Inhibitory receptors
- + Exhaustion markers

Proprietary IL2-X: affinity detuned cytokine

- + Eliminates CD25 binding
- + Attenuates CD122 binding
- + Targeting allows for potent pinpointed signaling

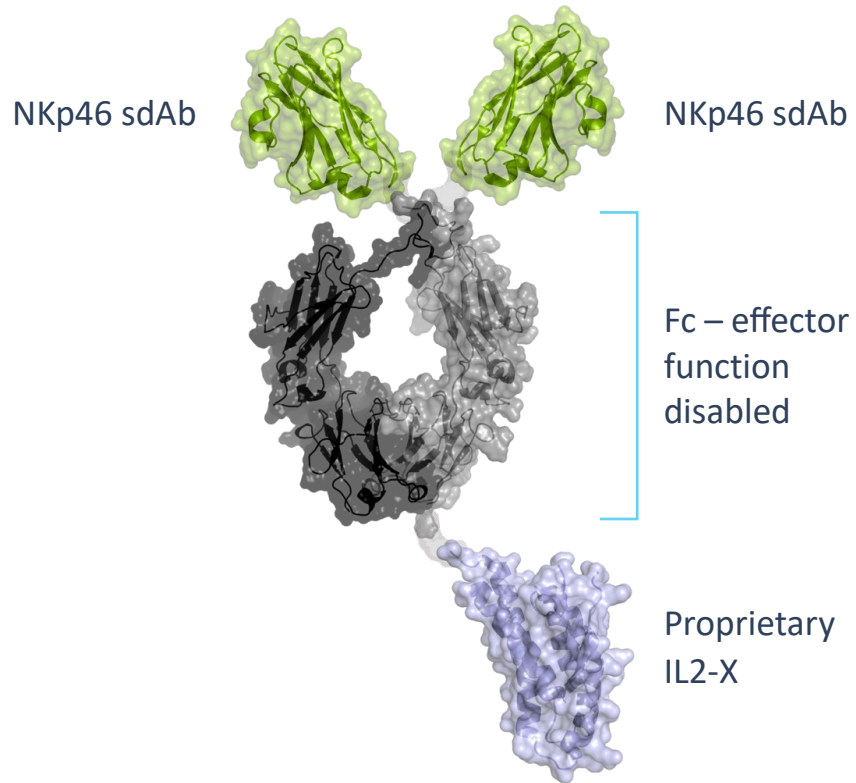
INBRX-121

NKp46 Targeted Detuned IL-2

INHIBR_X

INBRX-121 expanded the NK cell population and enhanced cytotoxicity

INBRX-121

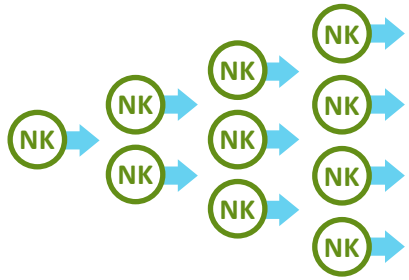


- + NKp46 is an NK-specific marker that maintains expression on tumor-infiltrating NK cells
- + Proprietary IL2-X engineering ensures specific modulation of NK Cells without impacting T-cell subsets (Tcon and Treg)

INBRX-121 is poised to bring NK cells to the forefront of immunotherapy

INBRX-121

Improved NK Activity



- + Expands NK cell numbers
- + Overcomes suppression
- + Enhances cytotoxic capacity

Safety with durability

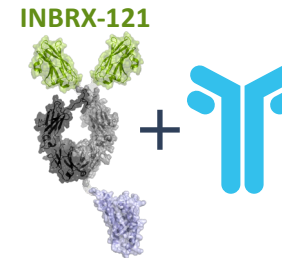


- + Cytokine release syndrome not caused by NK cells
- + Extended exposure drives durability

Multiple potential paths forward



Single agent
Activated NK cells exhibit immediate cytotoxicity

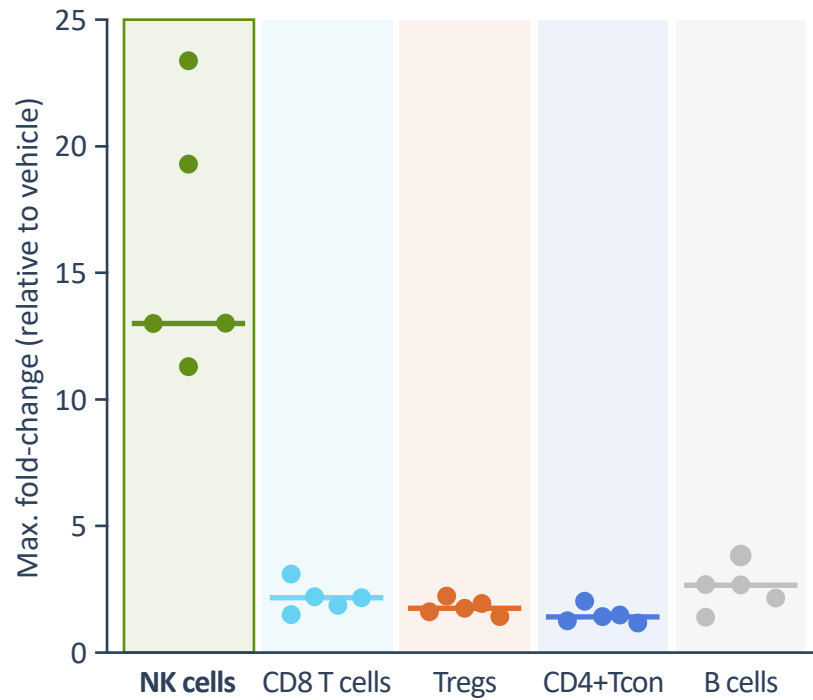


Combination therapy
Enhances the activity of therapeutic antibodies

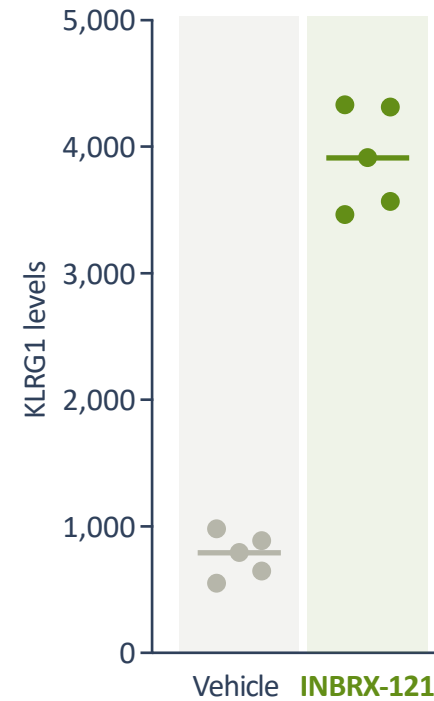
Expanded mouse NK cells and enhanced their cytotoxic potential

INBRX-121

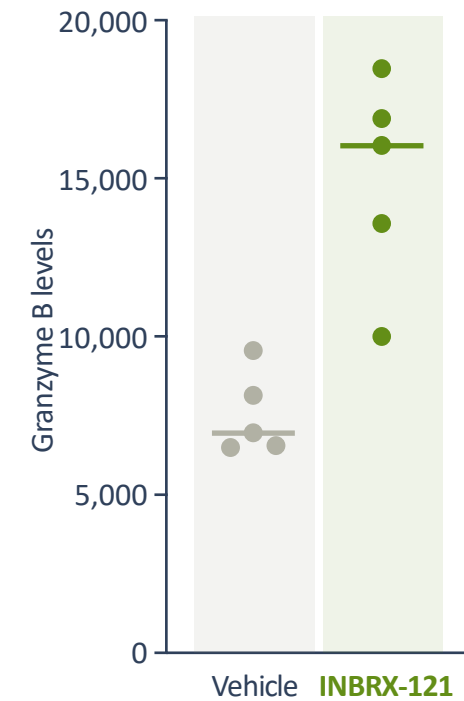
NK cell expansion



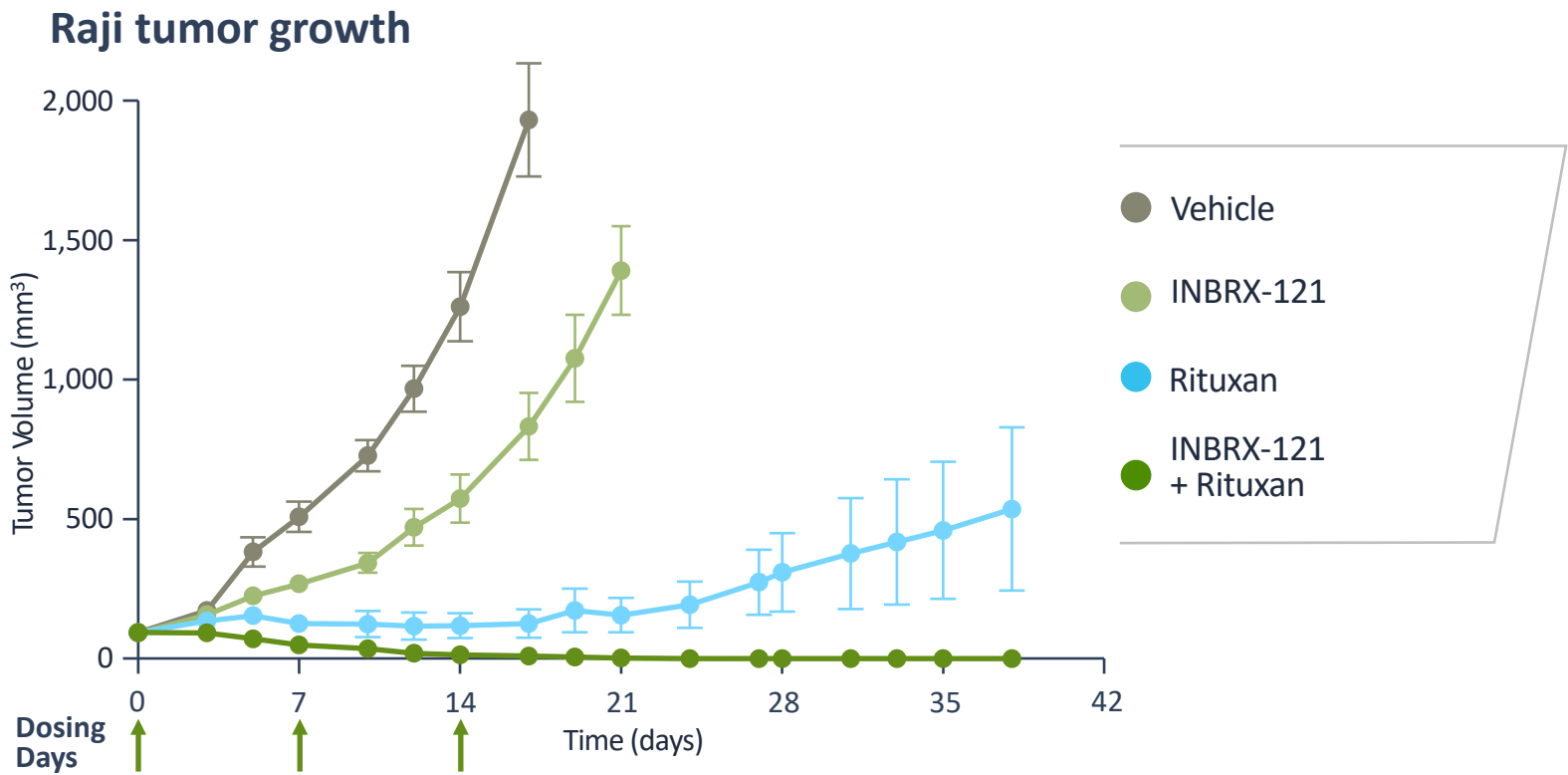
NK cell activation



NK cell cytolytic activity



Synergized with approved therapeutic antibodies

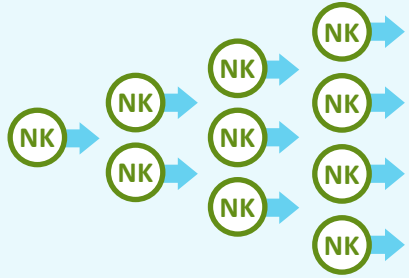


TREATMENT	COMPLETE RESPONSES
Rituxan®	0/10
INBRX-121 + Rituxan®	9/10

INBRX-121

INBRX-121 synergized with Rituxan® in a subcutaneous Raji tumor model resulting in complete tumor regression

INBRX-121 safely expanded NK cells in non-human primates



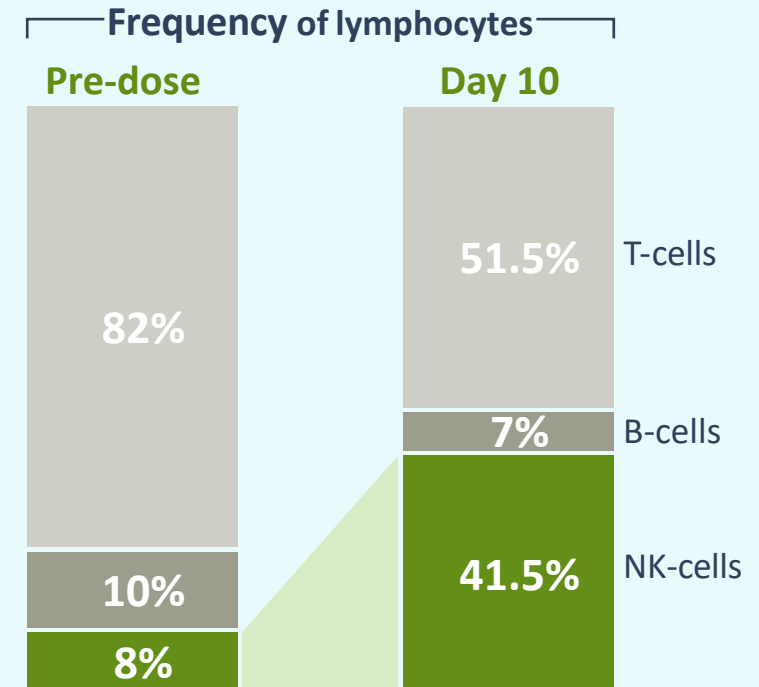
Expanded NK cells
in a dose-dependent
manner (up to 12-fold)
that persists for more than
21 days and can be dosed
multiple times safely



Tolerated in repeat
dose range studies
up to 10 mg/kg

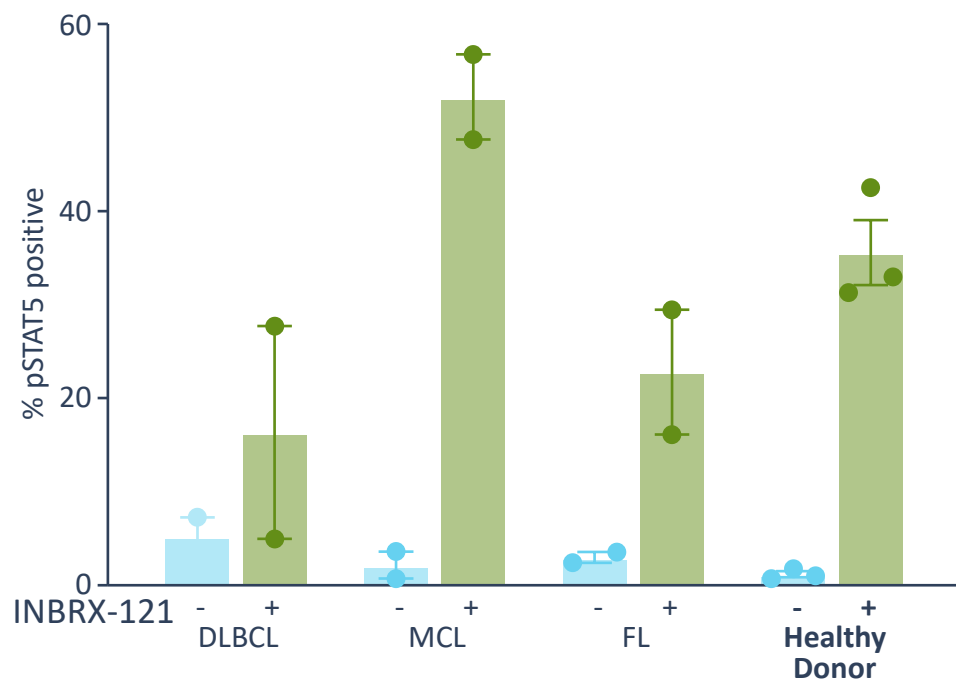
INBRX-121

NK cell expansion in blood after
a single dose of INBRX-121 at 1 mg/kg:



Expanded NK cells from Lymphoma patients

IL-2 signaling in patient NK cells



NK cells from Lymphoma patients expressed NKp46 at levels similar to or above that of healthy donors

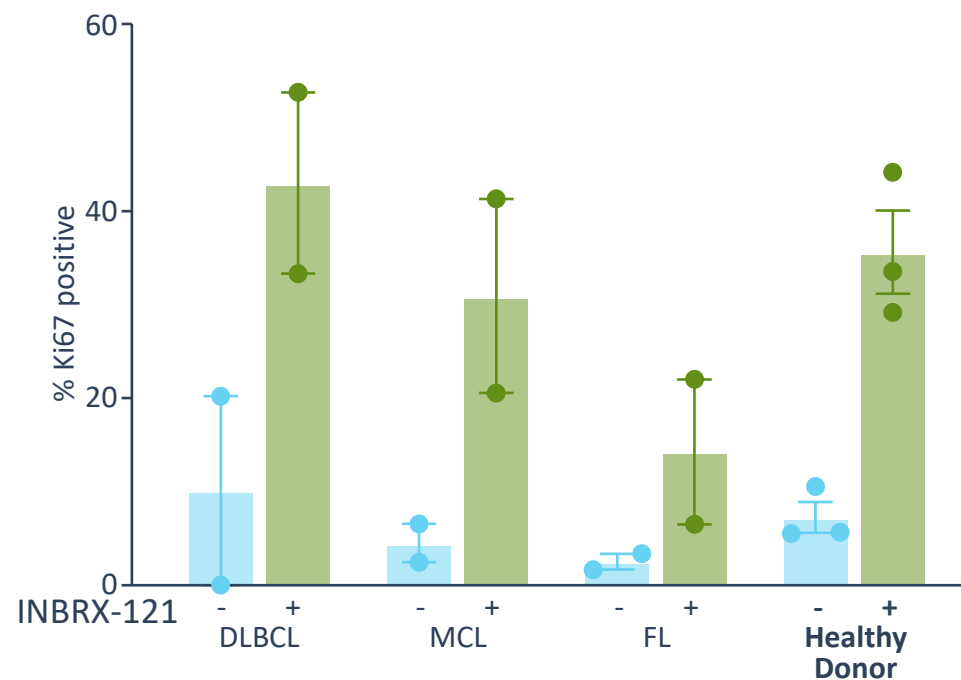
- +: 1 nM INBRX-121

DLBCL: Diffuse large B-cell Lymphoma

MCL: Mantle cell Lymphoma

FL: Follicular Lymphoma

Patient NK cell proliferation

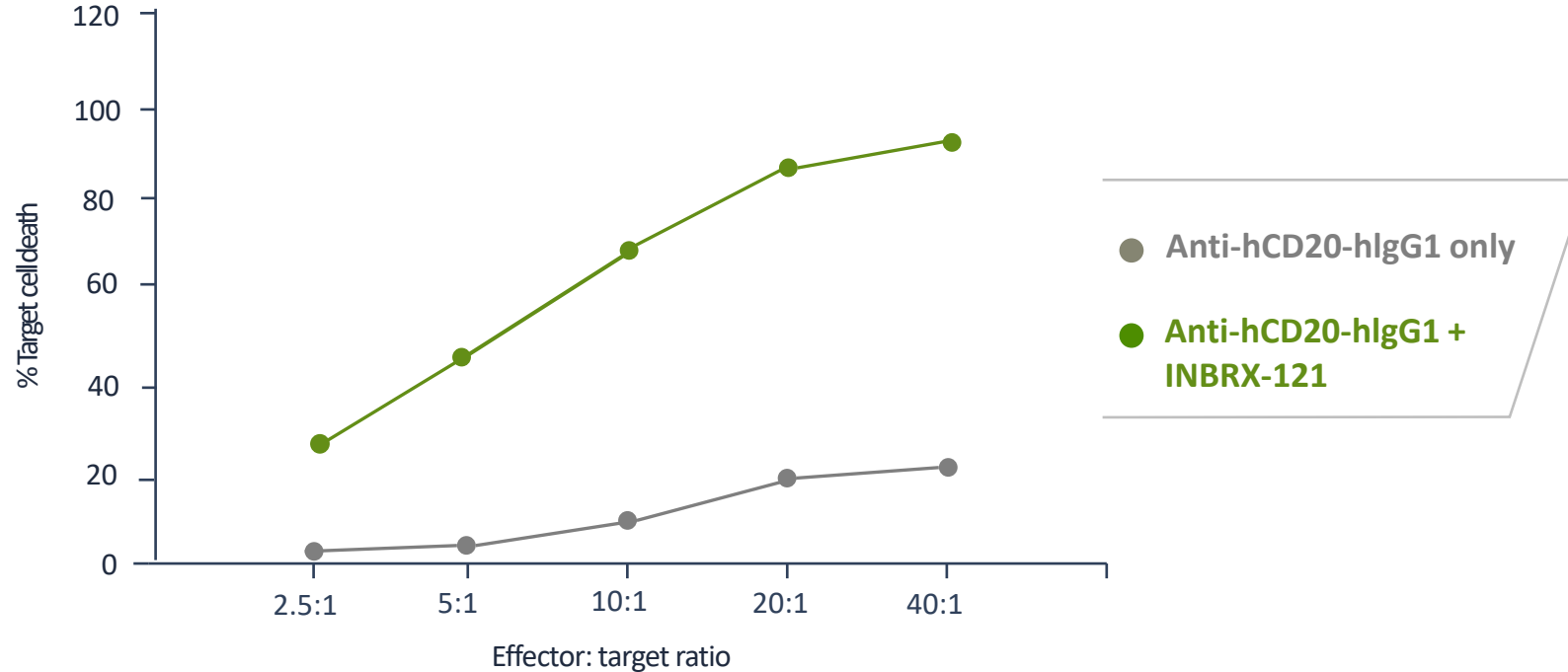


Patient NK cells responded to stimulation with INBRX-121 by upregulating pSTAT5 and showed an increased proliferative potential

INBRX-121

INHIBRX

Expanded the number of NK cells while enhancing their individual cytotoxic capacities

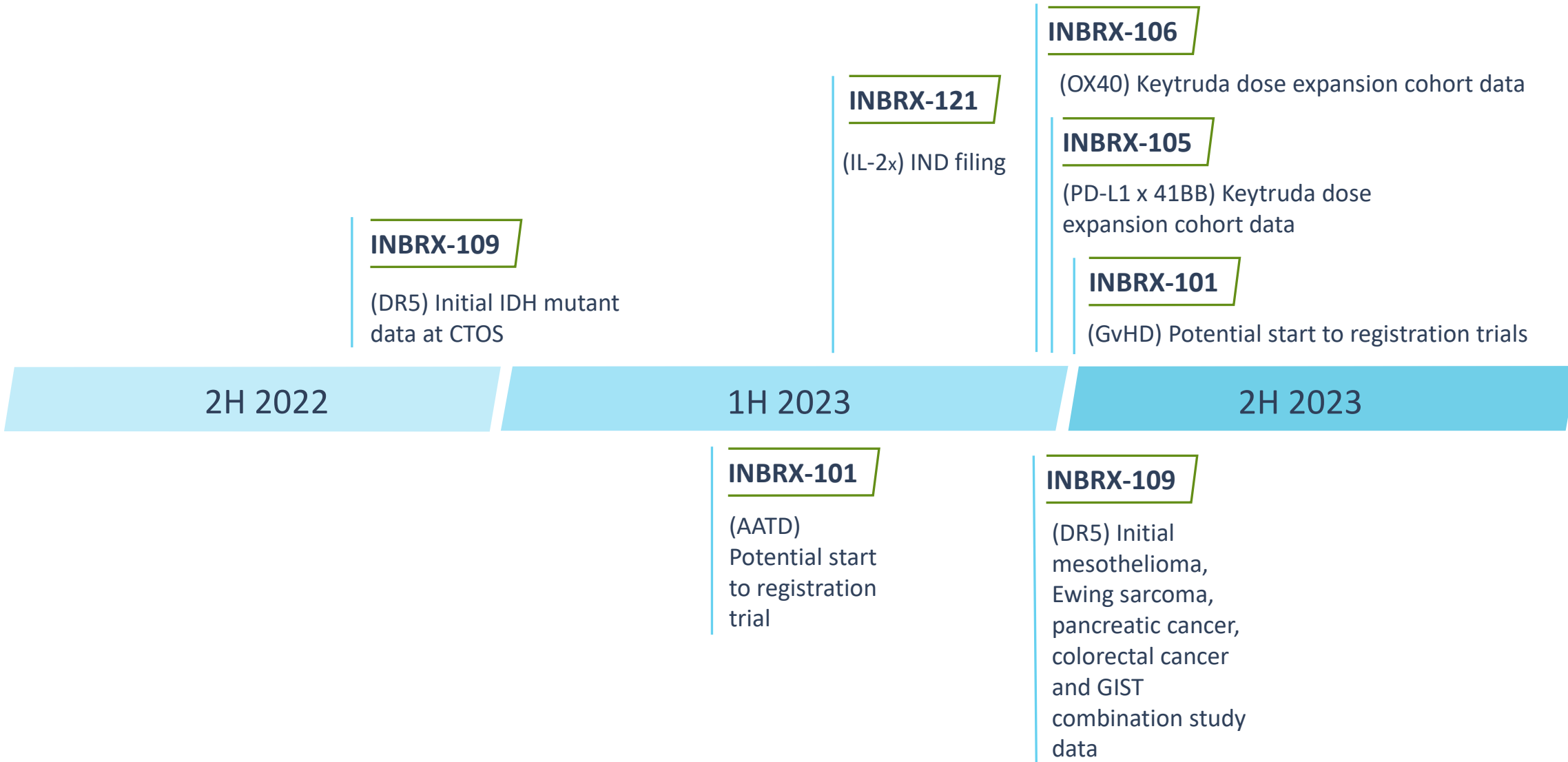


Raji cell killing after INBRX-121 pre-incubation

INBRX-121

INBRX-121 increased NK cell-mediated killing of Raji cells in the presence of a Rituximab sequence analog (Anti-hCD20-hIgG1).

Near term expected clinical milestones



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Ste 200
La Jolla, CA 92037
www.inhibrx.com

INHIBRX

