

# Innovation Driven Outcomes Focused

November 2022

**INHIBR<sub>x</sub>**



# Presentation disclaimer

This presentation contains forward-looking statements. In some cases, you can identify forward-looking statements by the words “will,” “expect,” “intend,” “plan,” “objective,” “believe,” “estimate,” “potential,” “continue” and “ongoing,” or the negative of these terms, or other comparable terminology intended to identify statements about the future. These statements are based on management’s current beliefs and expectations. These statements include but are not limited to statements regarding Inhibrx, Inc.’s (the “Company”) business strategy, the Company’s plans to develop and commercialize its product candidates, the safety and efficacy of the Company’s product candidates, the Company’s plans and expected timing with respect to clinical trials and regulatory filings and approvals, manufacturing matters, strength of intellectual property protection, and the size and growth potential of the markets for the Company’s product candidates, and any implication that pre-clinical data or preliminary or topline results will be representative of the results of later trials. This presentation also contains certain projections and estimates regarding the Company’s future financial performance, namely potential future revenue for certain of the Company’s product candidates. This information also constitutes forward-looking information and is for illustrative purposes only and should not be relied upon as necessarily being indicative of any future results. The assumptions and estimates underlying this estimated financial information are inherently uncertain and subject to a wide variety of significant business, economic competitive and other risks and uncertainties that could cause actual results to differ materially from those contained in the prospective financial information. These potential financial information and other forward-looking statements involve substantial known and unknown risks, uncertainties and other factors that may cause the Company’s actual results, levels of activity, performance or achievements to be materially different from the information expressed or implied by these forward-looking statements.

Additional information regarding the Company’s risks and uncertainties are described from time to time in the “Risk Factors” section of our Securities and Exchange

Commission filings, including those described in our Annual Report on Form 10-K as well as our Quarterly Reports on Form 10-Q, and supplemented from time to time by our Current Reports on Form 8-K.

The Company may not actually achieve the plans, intentions or expectations disclosed in its forward-looking statements, and you should not place undue reliance on the Company’s forward-looking statements. Actual results or events could differ materially from the plans, intentions and expectations disclosed in the forward-looking statements the Company makes. The forward-looking statements in this presentation represent the Company’s views as of the date of this presentation. The Company anticipates that subsequent events and developments will cause its views to change. However, while the Company may elect to update these forward-looking statements at some point in the future, the Company has no current intention of doing so except to the extent required by applicable law. You should, therefore, not rely on these forward-looking statements as representing the Company’s views as of any date subsequent to the date of this presentation.

The investigational product candidates discussed in this presentation have not been approved or licensed by the U.S. Food and Drug Administration or by any other regulatory authority, and they are not commercially available in any market. This presentation also contains estimates and other statistical data made by independent parties and by the Company relating to market size and growth and other data about its industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such estimates. In addition, projections, assumptions, and estimates of the Company’s future performance and the future performance of the markets in which it operates are necessarily subject to a high degree of uncertainty and risk.

This presentation shall not constitute an offer to sell or the solicitation of an offer to buy securities.

# THE CANDIDATES

PRECLINICAL

PHASE 1

REGISTRATION-  
ENABLING

## INBRX-109

*Our Tetravalent DR5 Agonist*



Pivotal Trial Enrolling

- + Potential path to approval in chondrosarcoma by 2025 with potential profitability in 2026; potential for \$600M in U.S. sales within 3 years of launch
- + Initial combination cohort data starting in mid-2023: mesothelioma, pancreatic adenocarcinoma, colorectal cancer and Ewing sarcoma

## INBRX-105

*Our Tetravalent PD-L1 targeted 4-1BB Agonist*



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

## INBRX-106

*Our Hexavalent OX40 Agonist*



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

## INBRX-101- AATD

*Our Recombinant Alpha-1-Anti-trypsin Fc-Fusion Protein (AAT-Fc)*



Pivotal Trial to start  
1H 2023

- + Potential registration-enabling trial with accelerated pathway to initiate in April 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 w/in 3 years of launch, \$3B peak sales potential in the U.S.

Trial to start  
mid 2023

## INBRX-101- GvHD

*Our Recombinant Alpha-1-Anti-trypsin Fc-Fusion Protein (AAT-Fc)*



- + 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

# Anchored by innovation and protein-engineering expertise

## Expertise



Experienced leadership team with proven innovation and execution

## Technology

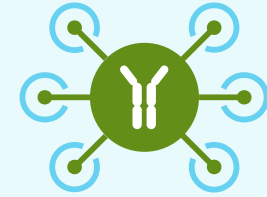


All platforms and programs developed in-house with strong patent protection

## Strategy



To pursue clinically validated pathways with a high unmet medical need where prior attempts have been suboptimal or ineffective



## 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

| PARTNER                                                                                                                                   | FOCUS                                                                                                                     | ECONOMICS                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
|  Bristol Myers Squibb™                                    | CD47 checkpoint inhibitor                                                                                                 | Development and regulatory milestones of up to \$934 million + royalties                           |
|  Chiesi<br>People and ideas for innovation in healthcare | Option to Ex-North America rights to INBRX-101 AATD                                                                       | Option exercise fee \$12.5M                                                                        |
|  2seventybio™                                             | Use of INBX sdAb platform for certain cell therapy products for up to 13 programs                                         | Developmental milestones of up to \$51.5M per therapeutic + royalties                              |
|  MERCK                                                   | Merck-supplied Keytruda for INBRX-106 Phase 1 combo trial                                                                 | Joint development committee and Merck access to real-time data                                     |
|  ARROWMARK<br>PARTNERS                                  | Joint venture with ArrowMark affiliate, Phylaxis Bioscience, LLC: license of IP and know-how to develop certain compounds | Up to 15% ownership interest; Development and commercial milestones of up to \$400M + % of profits |
|  Elpiscience                                           | Greater China rights to INBRX-105 and INBRX-106                                                                           | Development and commercialization milestones of up to \$200M + royalties                           |

## Key financial highlights



**\$290M** Cash

**> 30%** Internal ownership

**43.5M** Common stock outstanding

**49.1M** Fully diluted outstanding

**~130** Employees

\* As of 10/31/2022

**INHIBRX**

## Near term expected clinical milestones

### INBRX-101

(AATD) Potential start to registration trial

1H 2023

### INBRX-101

(GvHD) Potential start to registration trials

2H 2023

### INBRX-109

(DR5) Initial mesothelioma, Ewing sarcoma, pancreatic cancer, colorectal cancer and GIST combination study data

### INBRX-109

(DR5) Registration-enabling Phase 2 Chondrosarcoma data

1H 2024

### INBRX-121

(IL-2x) IND filing

### INBRX-105

(PD-L1x41BB & OX40) Keytruda dose expansion cohort data

### INBRX-106

### INBRX-105

(PD-L1x41BB) Potential start to first registration trial

# INBRX-101

Recombinant Alpha-1  
Antitrypsin Fc-fusion Protein

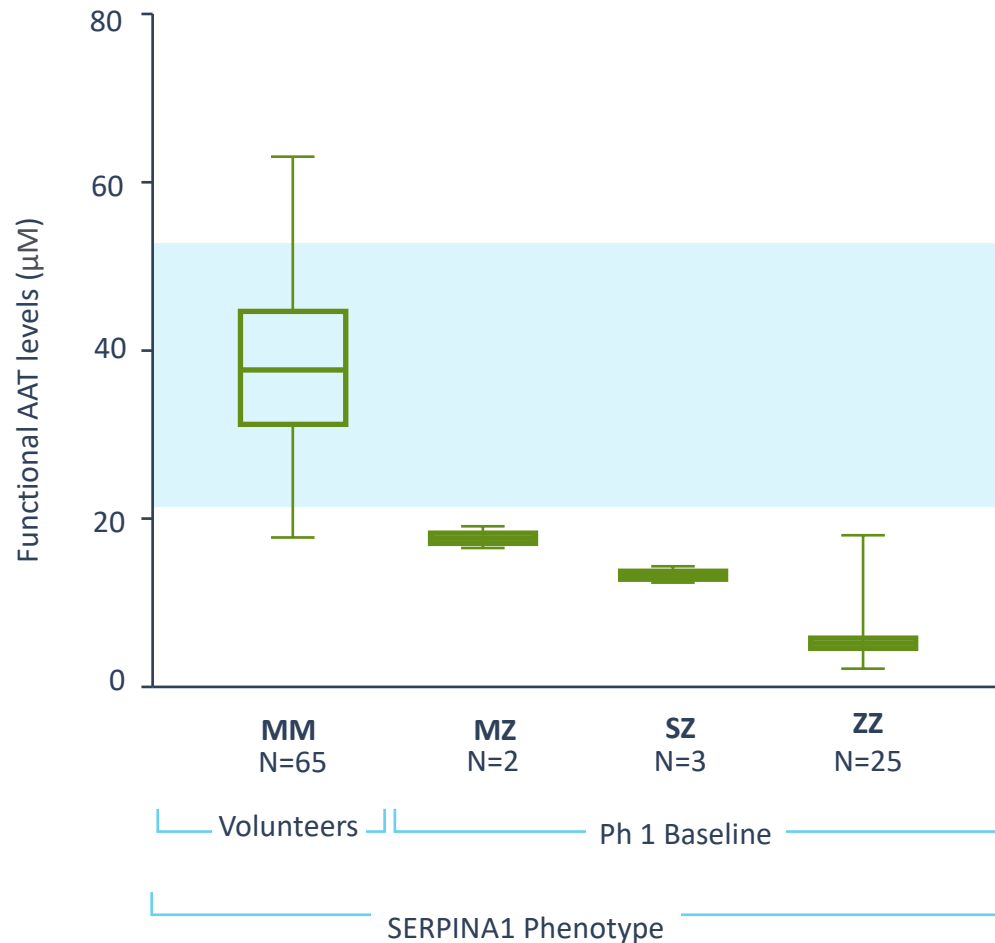
**INHIBR<sub>X</sub>**

# INBRX-101

Alpha-1 Antitrypsin  
Deficiency (AATD)

**INHIBR<sub>X</sub>**

# 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

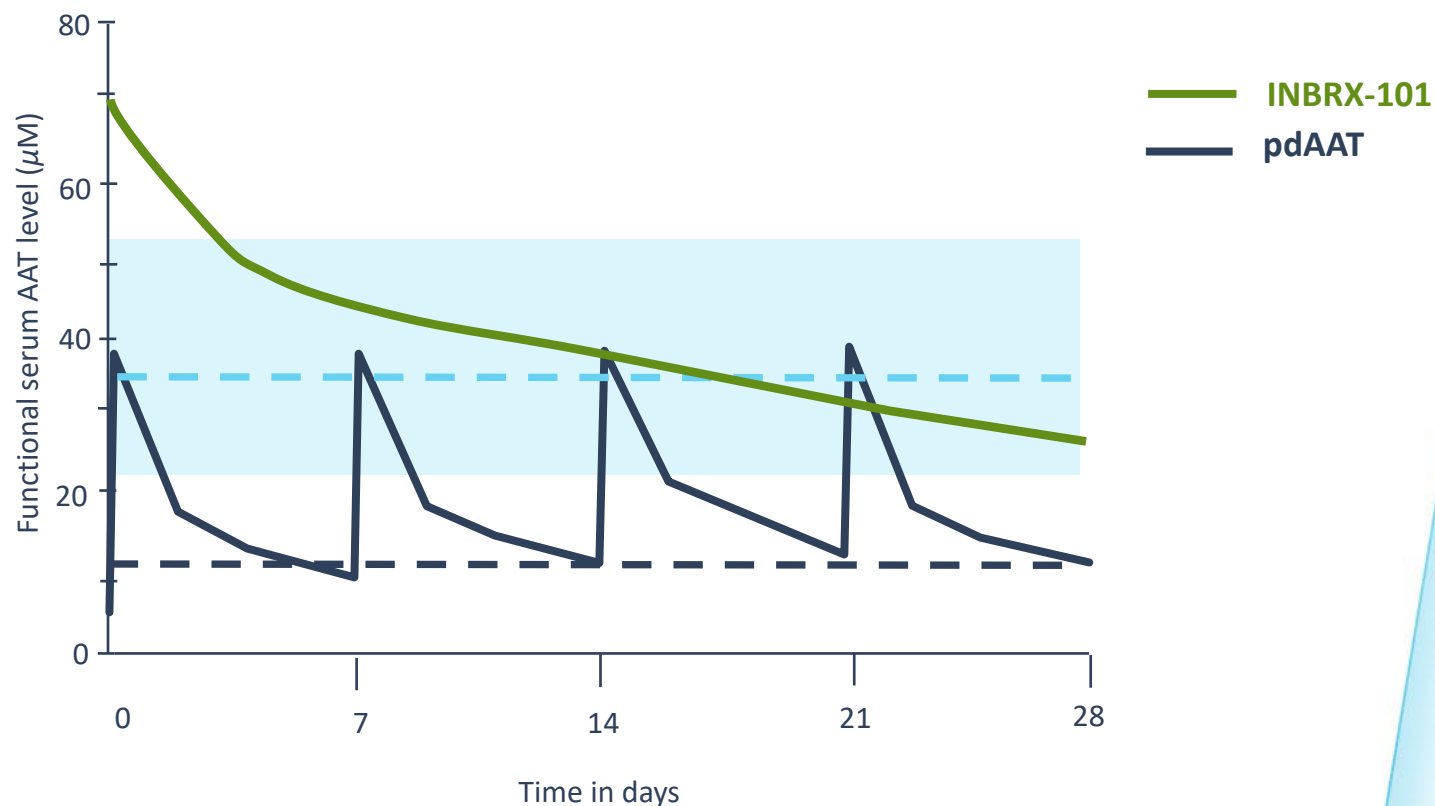
- + Functional AAT levels from 65 MM genotype healthy volunteers ranged from 21 to 54 micromolar (µM), with a mean of 36 µM.
- + Baseline levels of functional AAT for 30 Phase 1 patients prior to dosing of INBRX-101 ranged from 2 to 18 µM, with a median of 4.7 for ZZ genotype patients.

- Box plots show the minimum, lower quartile, median, upper quartile and maximum
- The shaded region represents the 5<sup>th</sup>-95<sup>th</sup> 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

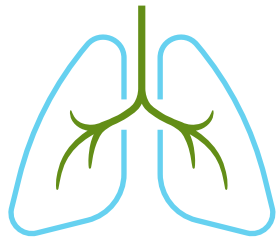
\*\*Current pdAAT therapies include: Aralast, Glassia, Prolastin-C & Zemaira

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

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



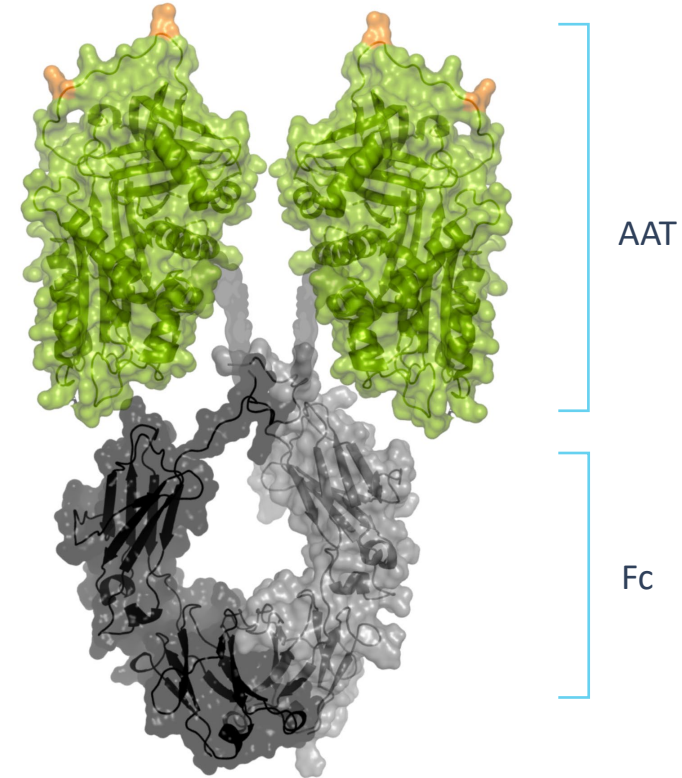
Potential to extend  
the dosing interval  
from weekly to monthly



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

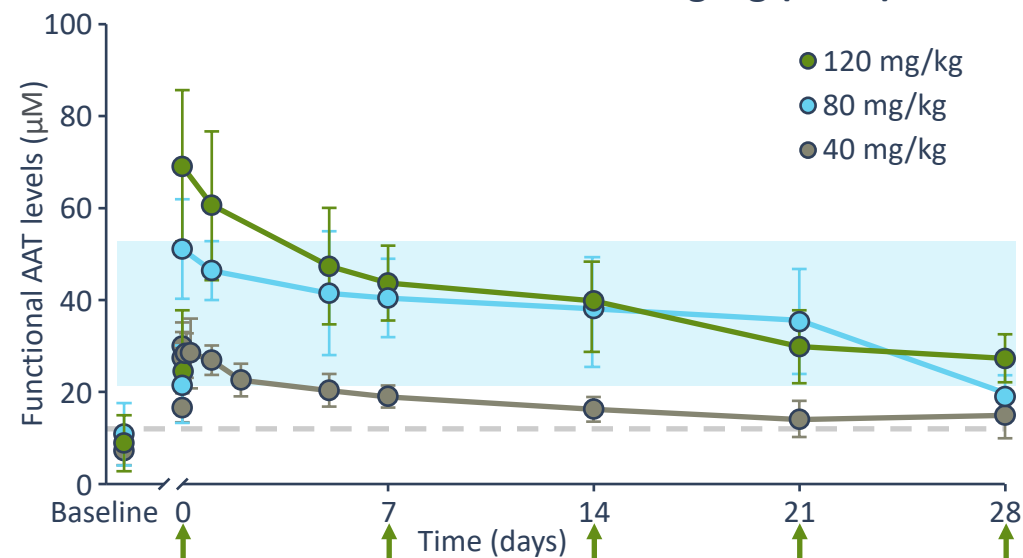


120 mg/kg\*

\* 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 – 3<sup>rd</sup> 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 3<sup>rd</sup> dose), on average, were within the normal range for the 120 mg/kg dose level

INBRX-101

INHIBRX

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

## Bronchoalveolar lavage fluid (BALF) sample collection and analysis

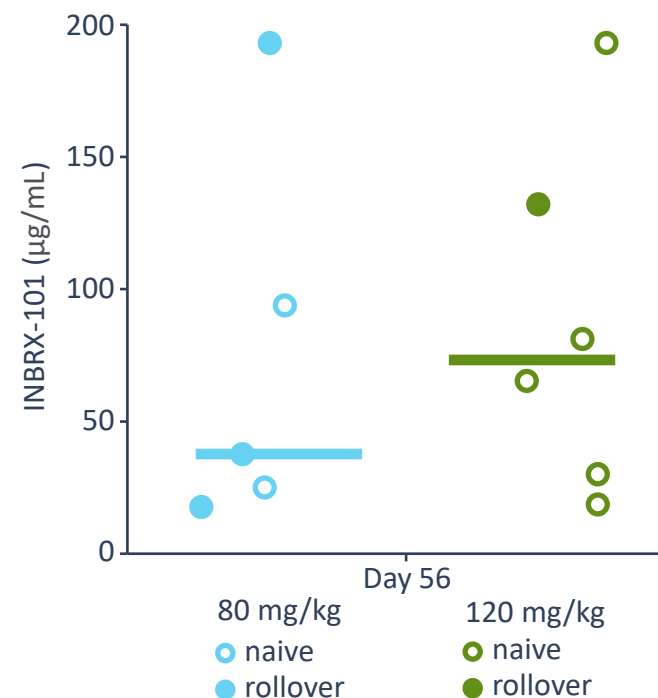
- + BALF samples were collected from 3 lobes of the lung for each patient in the 80 (N = 5)<sup>1</sup> and 120 (N = 6) mg/kg MAD cohorts prior to dosing and two weeks after completion of multiple dosing
- + INBRX-101 concentrations were measured using a proprietary validated mass spectrometry assay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

## BALF assessment results

- + At baseline, BALF samples from subjects that rolled over from the Part 1 SAD<sup>2</sup> 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

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

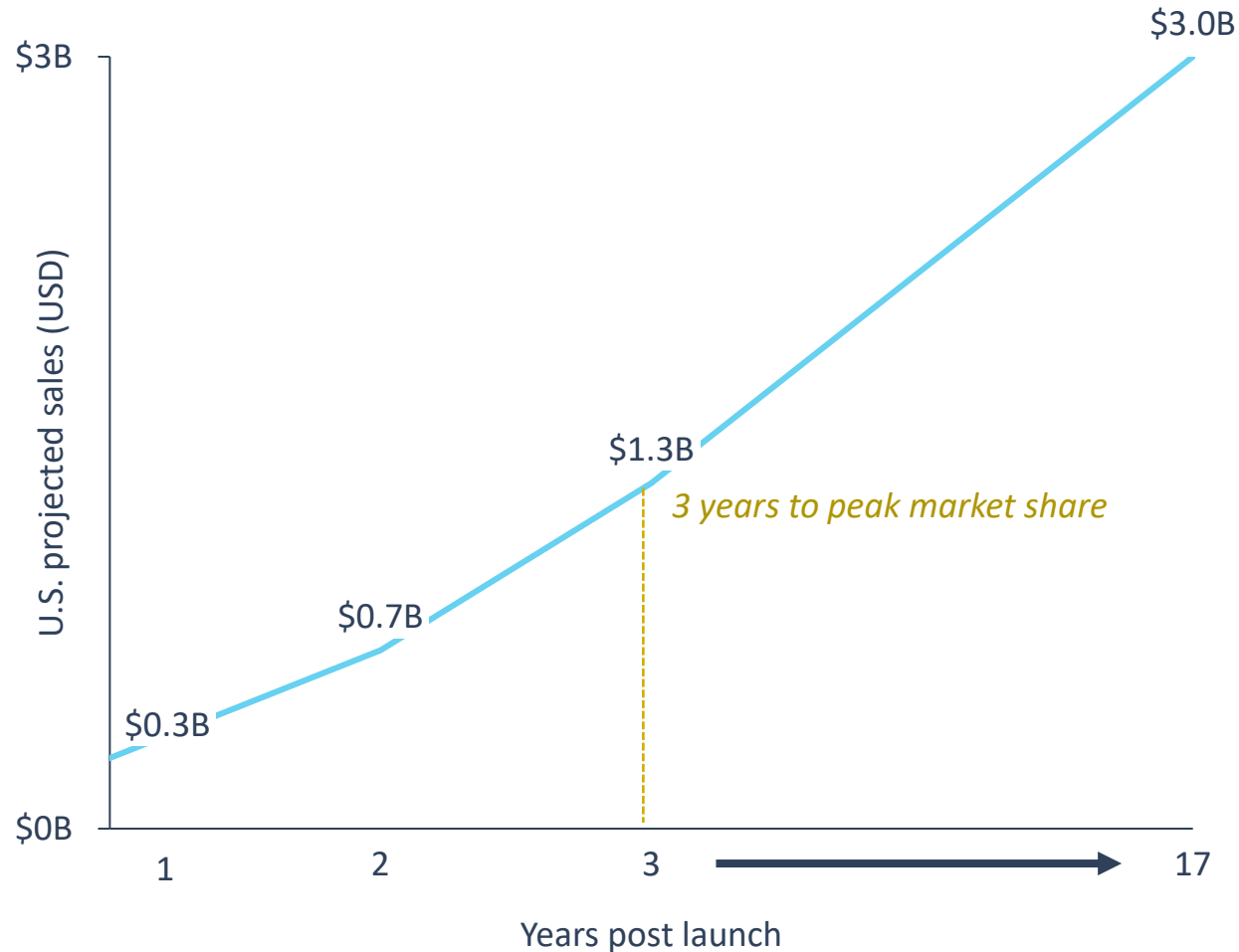
<sup>2</sup> In rollover patients, baseline collection was at least 84 days after the SAD



- 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

Notes: \*Pricing assumption is for modelling purposes only

Source: KOL Qualitative Interviews (n=~25); EvaluatePharma, Datamonitor, IQVIA, Fortune Business Insights, Analog analysis of other recombinant products

# 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                             |
| <b>U.S. prevalence</b>             | ~100K          | ~100K (same as today)                      |
| <b>Treatment rate</b>              | ~8-10%         | ~40% (driven by increased diagnosis rates) |
| <b>Total treated U.S. patients</b> | ~8K            | ~40K                                       |
| <b>Market revenue potential</b>    | ~\$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)

**INHIBR<sub>X</sub>**

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

## Existing clinical data for plasma-derived AAT therapies 2L (steroid resistant) aGVHD

|          | Fred Hutch/Baxalta <sup>1</sup><br>Ph1/2 (n=12)                         | U of Michigan/CSL <sup>2</sup> AAT +/-<br>Prednisone Ph2 (n=40)                   |
|----------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Efficacy | ORR (%) at day 28 (per CIBMTR)                                          | 26/40 (65%)                                                                       |
|          | CR (%) at day 28                                                        | 14/40 (35%)                                                                       |
|          | OS                                                                      | 45% at 6 months                                                                   |
| Safety   | Grade 3+ AEs                                                            | <b>0%</b>                                                                         |
|          | Most Frequent AEs                                                       | “well tolerated with no infusion reactions or drug-related grade 3 to 4 toxicity” |
|          | Incidence of Infection                                                  | 13/40 (32.5%)<br>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                                                   |

## Current guidelines for aGVHD<sup>5</sup>

| National comprehensive cancer network (nccn)                 | Ruxolitinib (category 1) | Alemtuzumab                | <b>Alpha-1 antitrypsin</b> | Anti-thymocyte globulin | Basiliximab | Calcineurin inhibitors       | Etanercept                        |
|--------------------------------------------------------------|--------------------------|----------------------------|----------------------------|-------------------------|-------------|------------------------------|-----------------------------------|
| European society for blood and marrow transplantation (ebmt) | Alemtuzumab              | <b>Alpha-1 antitrypsin</b> | Basiliximab                | Cellular therapies      | Daclizumab  | Extracorporeal photopheresis | Faecal microbiota transplantation |

INBRX-101

## 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)<sup>3</sup>
- + Treatment of GVHD in hematopoietic stem cell transplant (HSCT) recipients using AAT plus corticosteroids (CS) compared with corticosteroids alone (NCT04167514)<sup>3</sup>

Sources:

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

<sup>2</sup> 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>

<sup>3</sup> <https://clinicaltrials.gov/>

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

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

# INBRX-101 has the potential for fast entry into Acute GVHD, expanding to Prophylaxis, achieving >\$1bn in the US Market

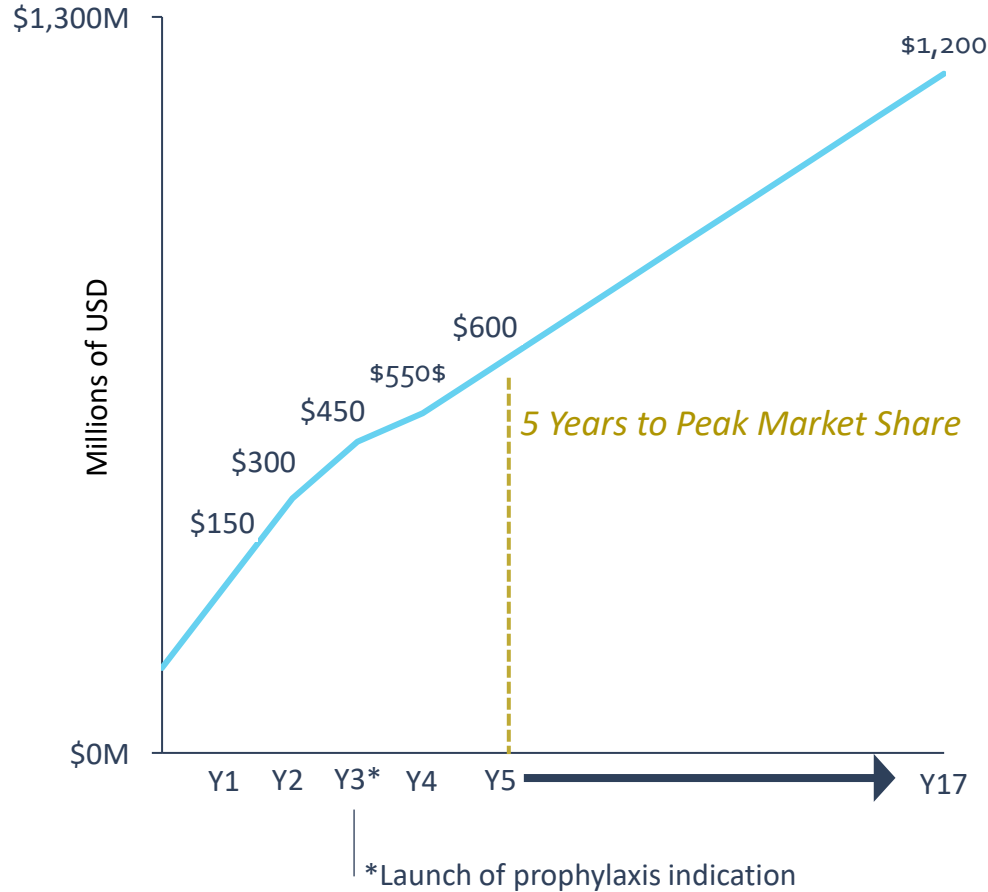
INBRX-101 acute & prophylaxis GvHD top line projected US sales & key assumptions

## 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



## 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

|                                                        |                      |                                                                                                                                         |
|--------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| US Prevalence (2022)                                   | ~16,000 <sup>6</sup> | <br><b>~\$2bn</b><br><b>2030 US Market Opportunity</b> |
| Extensive disease requiring therapy (50%) <sup>4</sup> | 8,000                |                                                                                                                                         |
| Progression beyond Steroids (71%) <sup>4</sup>         | 5,700                |                                                                                                                                         |

- + 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

|                                          |                        |                                                                                                                                                                    |
|------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Europe & Japan<br>Allogeneic Transplants | 21,000 <sup>2, 3</sup> | <br><b>&gt;\$3bn</b><br><b>2030 EU &amp; JP Market Opportunity <sup>5</sup></b> |
|------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|

- + Favorable pricing and reimbursement as compared to typical European/Japanese standards due to high mortality and significant unmet medical need
- + There were 9,400<sup>1</sup> allogeneic transplants in the U.S. market; ex-US transplant market represents a large global opportunity

Sources:

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

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

<sup>3</sup> 2020 figures from JDCHCT [https://drive.google.com/file/d/16Vv8k1aHTMcOKbmOHGiUmEk4rFGwgBEy/view?usp=drive\\_web](https://drive.google.com/file/d/16Vv8k1aHTMcOKbmOHGiUmEk4rFGwgBEy/view?usp=drive_web)

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

<sup>5</sup> Assumes pricing corridor 50% smaller than the US

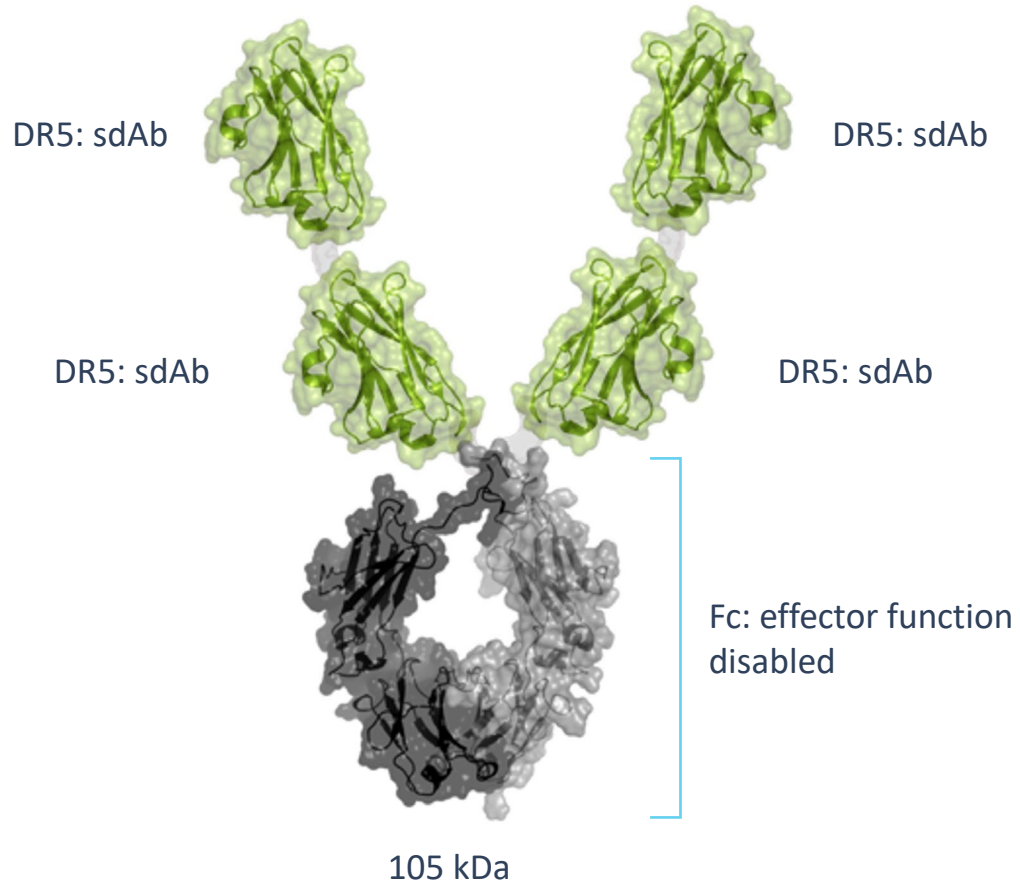
<sup>6</sup> Epidemiology and Treatment of Chronic Graft-versus-Host Disease Post-Allogeneic Hematopoietic Cell Transplantation: A US Claims Analysis, Bachier, et. al., 2021

# INBRX-109

Tetravalent DR5 Agonist

**INHIBR<sub>X</sub>**

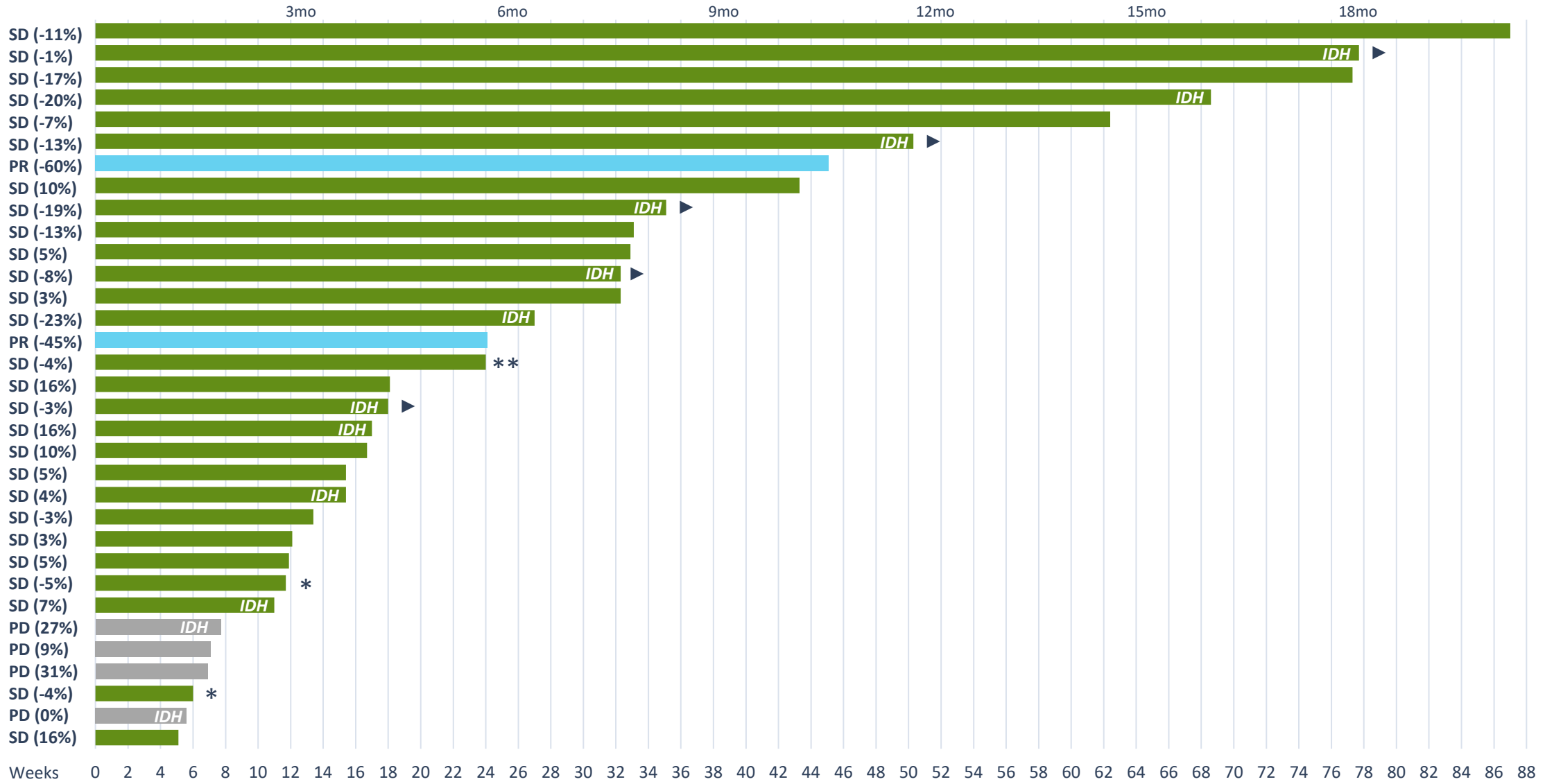
# Tetravalent DR5 agonist



- + 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

# Preliminary Phase 1 data in unresectable or metastatic conventional chondrosarcoma

INBRX-109



+ Data cut point **8-Nov-2022**, 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  
 + ▶ Patient still on treatment **IDH**- isocitrate dehydrogenase (IDH1/IDH2) mutant  
 + \*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

## INBRX-109

 **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.

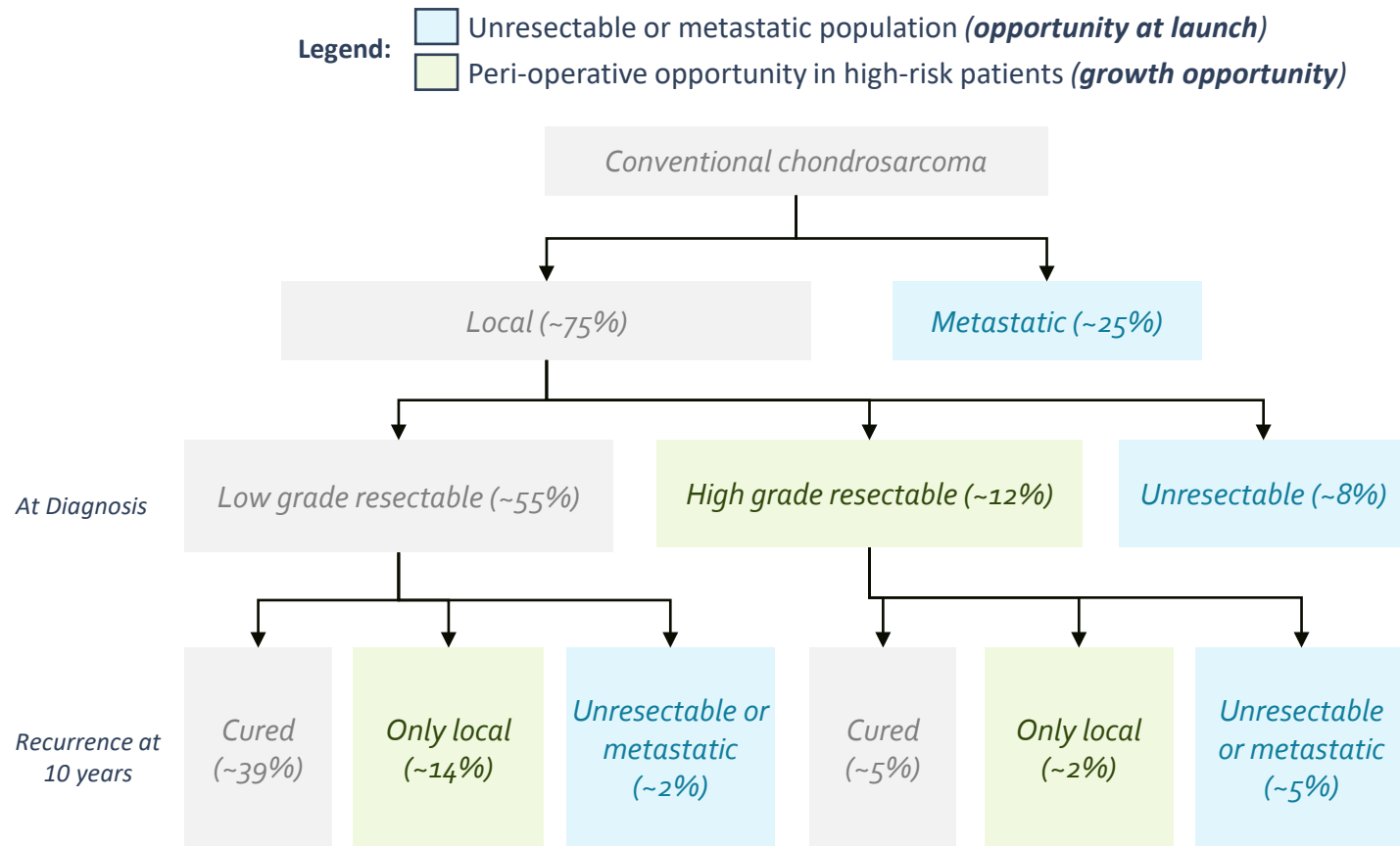
|                |                      |
|----------------|----------------------|
| Therapeutic    | Regorafenib          |
| Control arm    | Placebo              |
| Subject number | 46 (2:1)             |
| Placebo arm    | Median PFS~ 2 months |

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



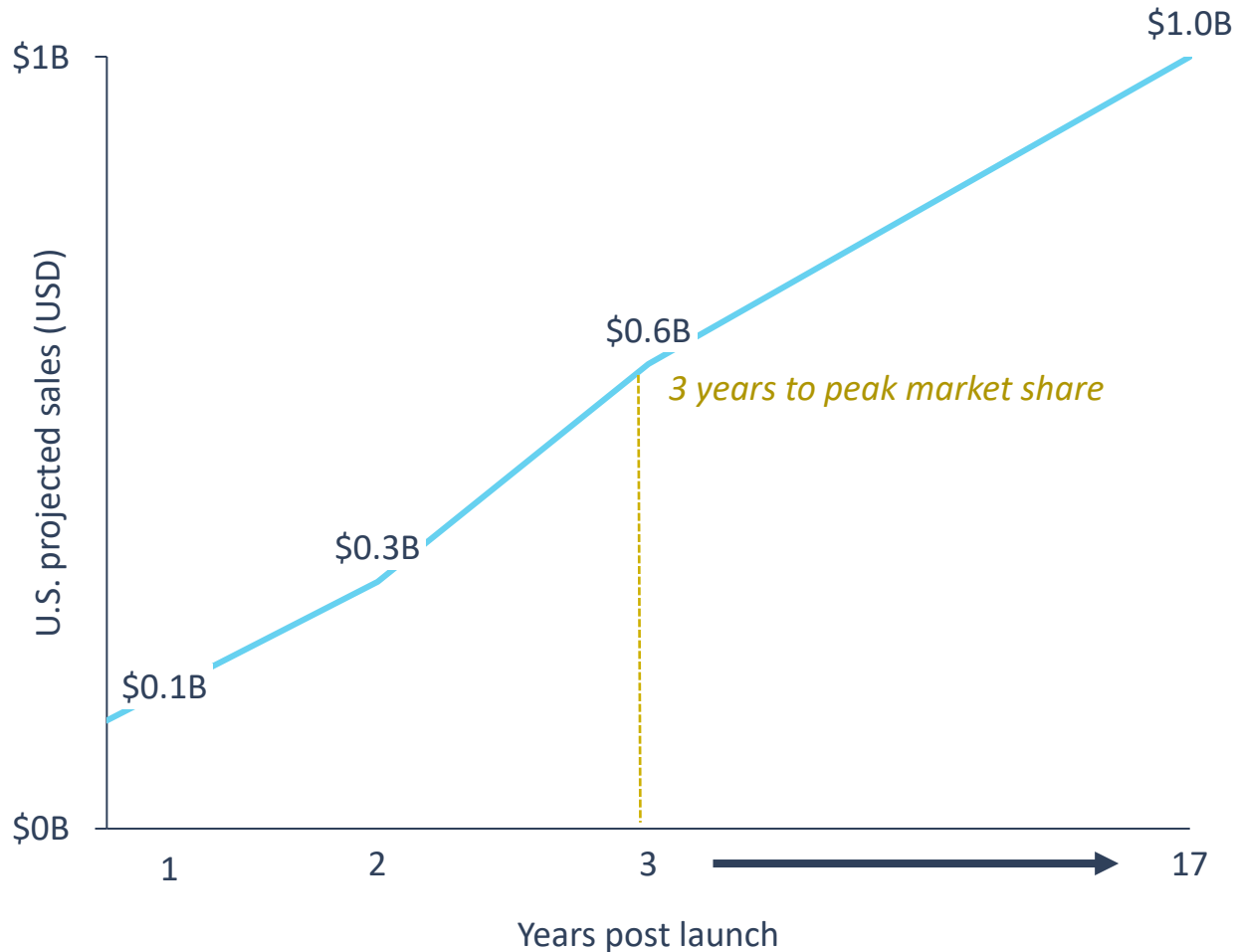
### KEY TAKEAWAYS

- + 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

# INBRX-109 on the horizon

## PART 3



### Combination studies



Ongoing



N=20

Pancreatic adenocarcinoma  
2<sup>nd</sup> line with mFOLFIRI



N=20

Ewing sarcoma with  
Irinotecan + Temozolomide



N=20

Colorectal Cancer with  
FOLFIRI



N=20

SDH-deficient GIST with  
Temozolomide

Data releases: mid-2023

## POTENTIAL FUTURE OPPORTUNITIES



**Solid tumors**

+ IAP antagonists



**Hematologic tumors**

+ Bcl-2 inhibitors



**NSCLC**

+ various combo agents



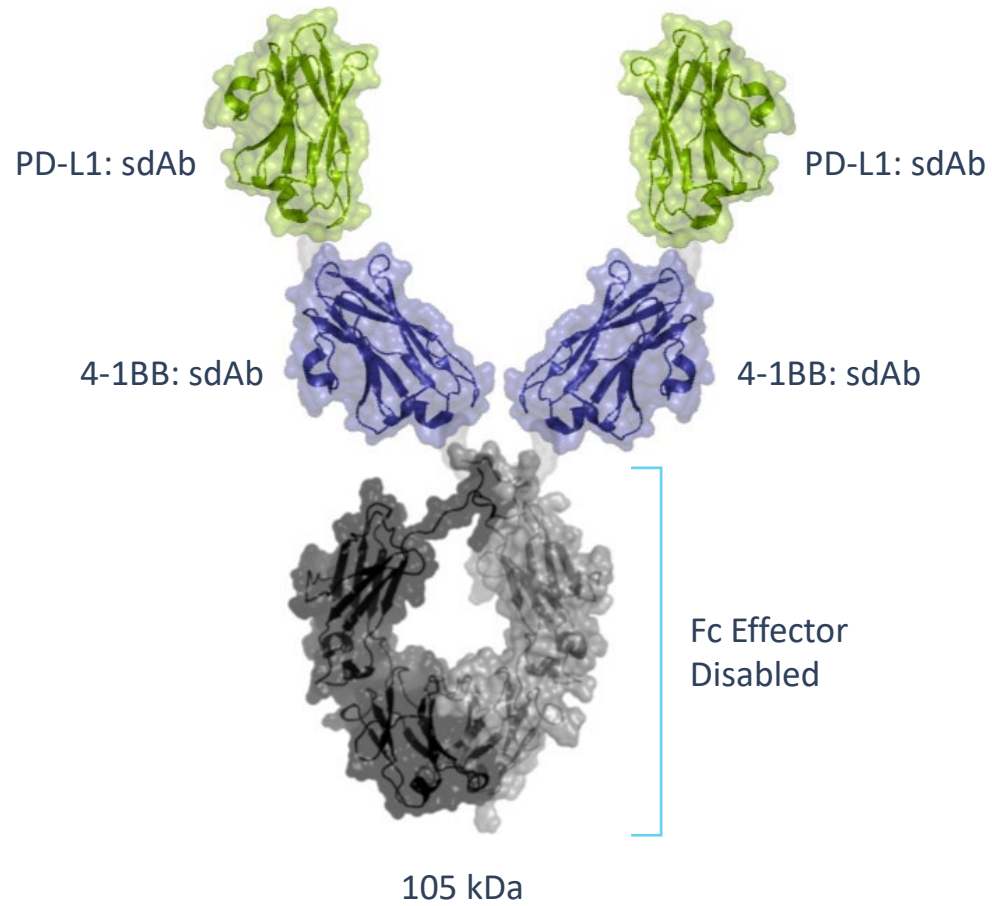
**Additional sarcoma indications**

# INBRX-105

PD-L1 x 4-1BB Multispecific

**INHIBRX**

## 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 |
|------------------|--------------------------|-----------------|
| <b>INBRX-105</b> | <b>Bivalent/Bivalent</b> | <b>No</b>       |
| 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             |

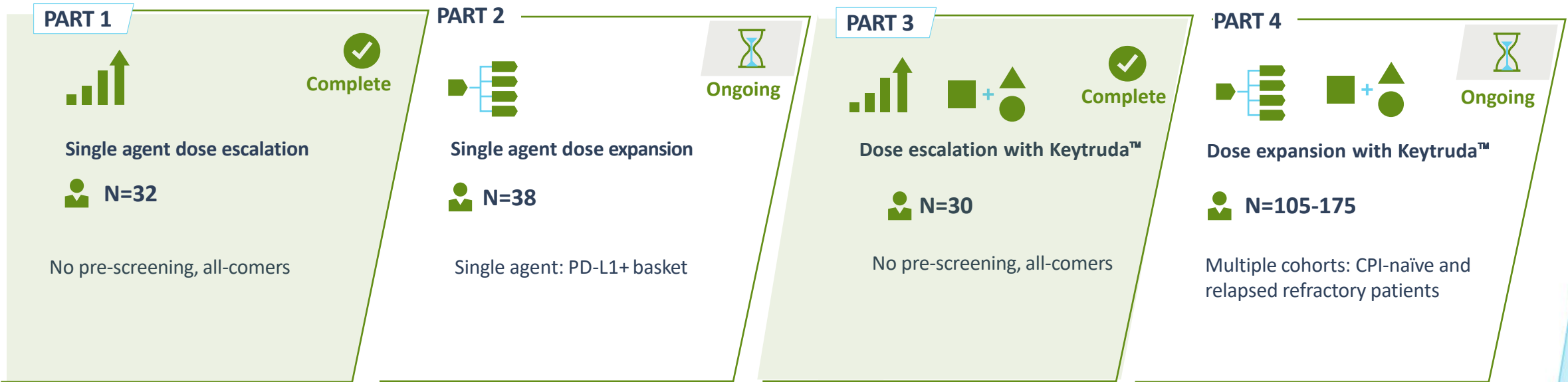
INBRX-105

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

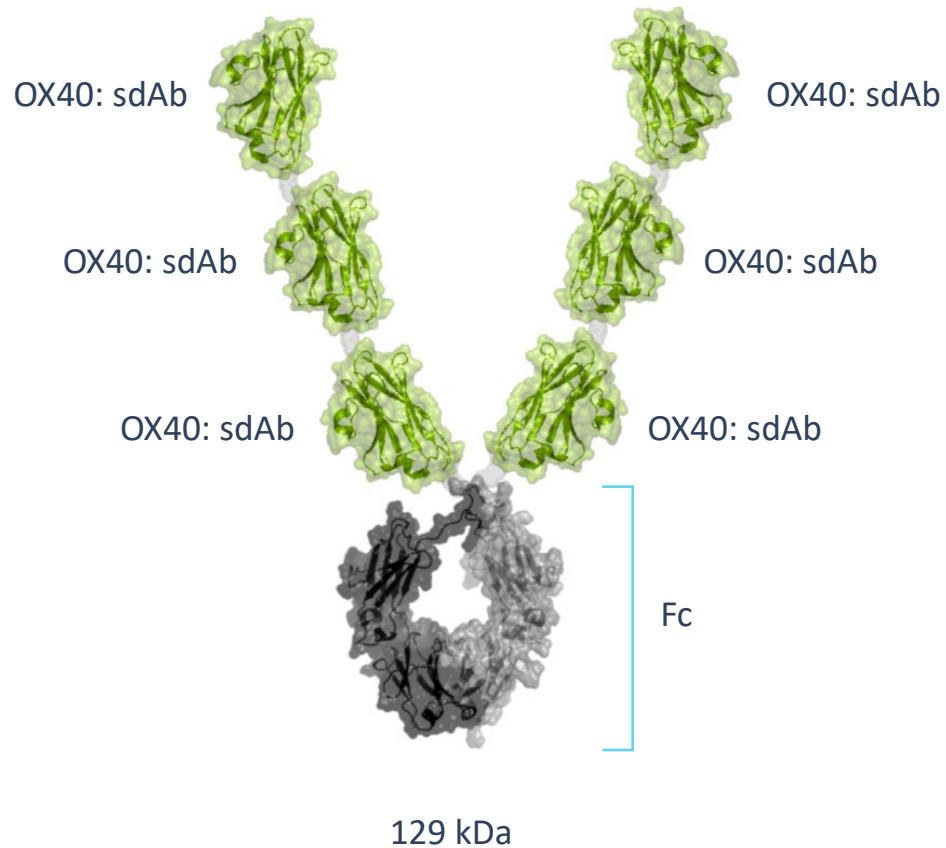
Mid-2023

# INBRX-106

Hexavalent OX40 Agonist

**INHIBR<sub>X</sub>**

# Hexavalent OX40 agonist

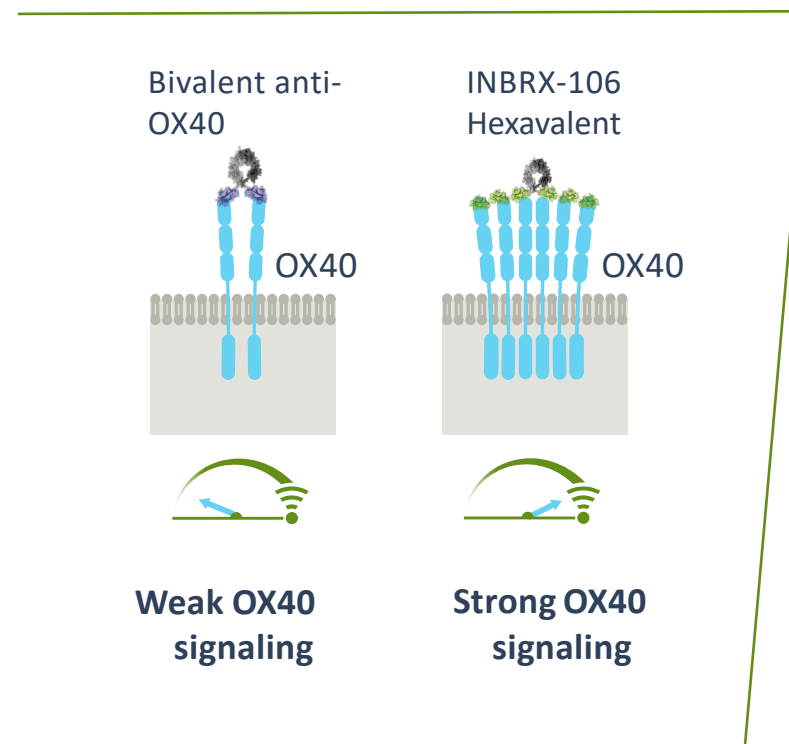


OX40 is a co-stimulatory receptor on activated T-cells designed to:

- + 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 |
|------------------|--------------|-----------------------|-----------------|
| <b>INBRX-106</b> | <b>Hexa-</b> | <b>IgG1</b>           | <b>N</b>        |
| 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

# Phase 1 INBRX-106 trial as a single agent and in combination with Keytruda

INBRX-106

## Single agent

### PART 1



INBRX-106 single-agent dose escalation

**N=20**

- + 3+3 design
- + Locally advanced or metastatic solid tumors
- + All-comers



Complete

### PART 2



INBRX 106 single-agent dose expansion

**N=24**

- + 0.03 mg/kg (RP2D) at 2 dosing schedules (Q3W or Q9W) in tumor types responsive to CPIs

**N=4** NSCLC

**N=4** Melanoma

**N=4** HNSCC

**N=4** G/GEA

**N=4** RCC



Complete

## In combination

### PART 3



Dose escalation with Keytruda

**N=30**

- + Locally advanced or metastatic solid tumors
- + mTPI design
- + >3 subjects per dose level:
  - 0.01, 0.03, 0.1 and 0.3 mg/kg (Q3W)
- + No prescreening; all-comers



Complete

### PART 4



Dose expansion with Keytruda

**N=80**

- + Relapsed or refractory to CPI
- + PDL1 TPS ≥ 1% (NSCLC)
- + PDL1 CPS ≥ 1% (PD-L1 basket)

**N=20** PDL1+ NSCLC r/r

**N=20** PDL1+ basket

**N=10** PDL1+ cutaneous melanoma

**N=10** PDL1+ uveal melanoma

**N=10** PDL1+ HNSCC

**N=10** PDL1+ nasopharyngeal carcinoma



Ongoing

## Single agent

- + 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

## In combination

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



CPI r/r

CPI naïve

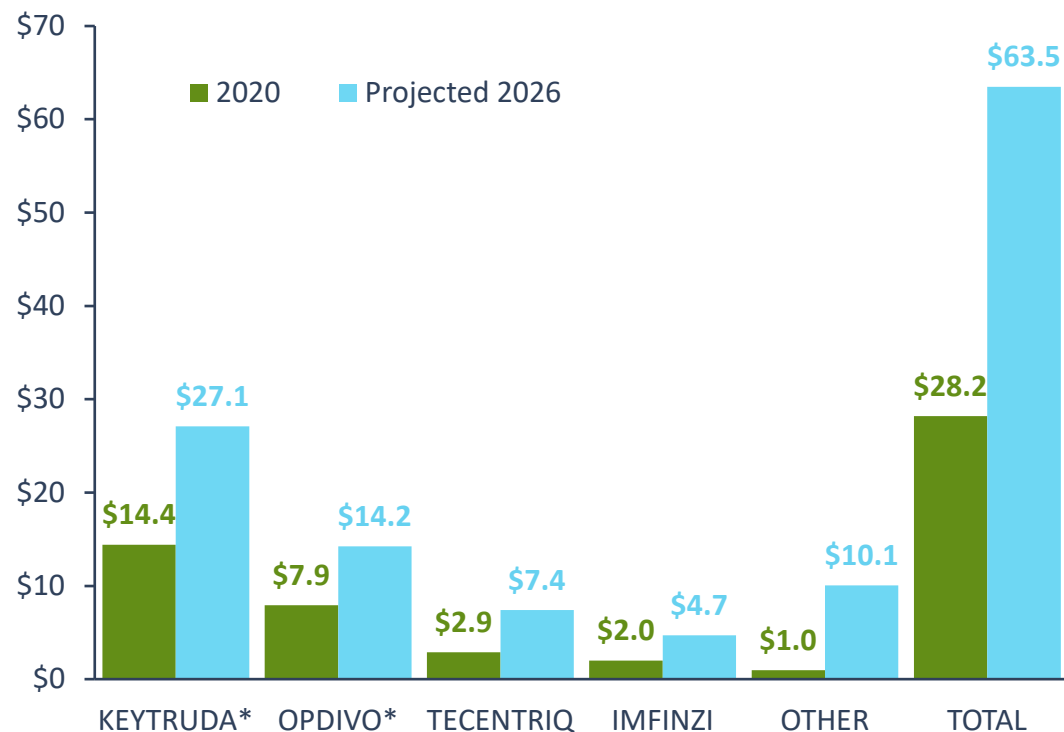
\*per investigator assessment

\*\*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

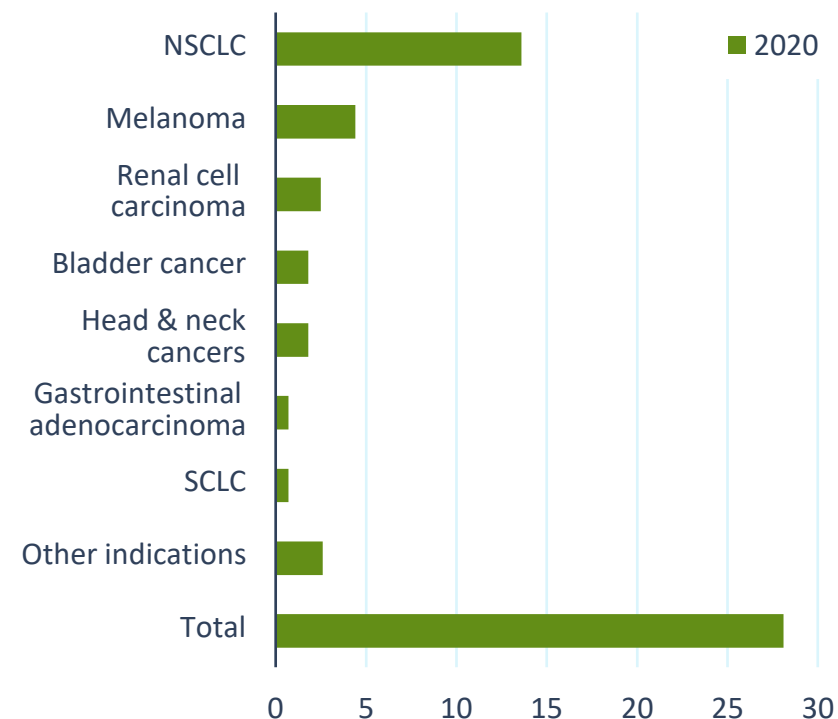
(in \$ billions)



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

## PD-1/PD-L1 WW Revenue by Indication

(in \$ billions)

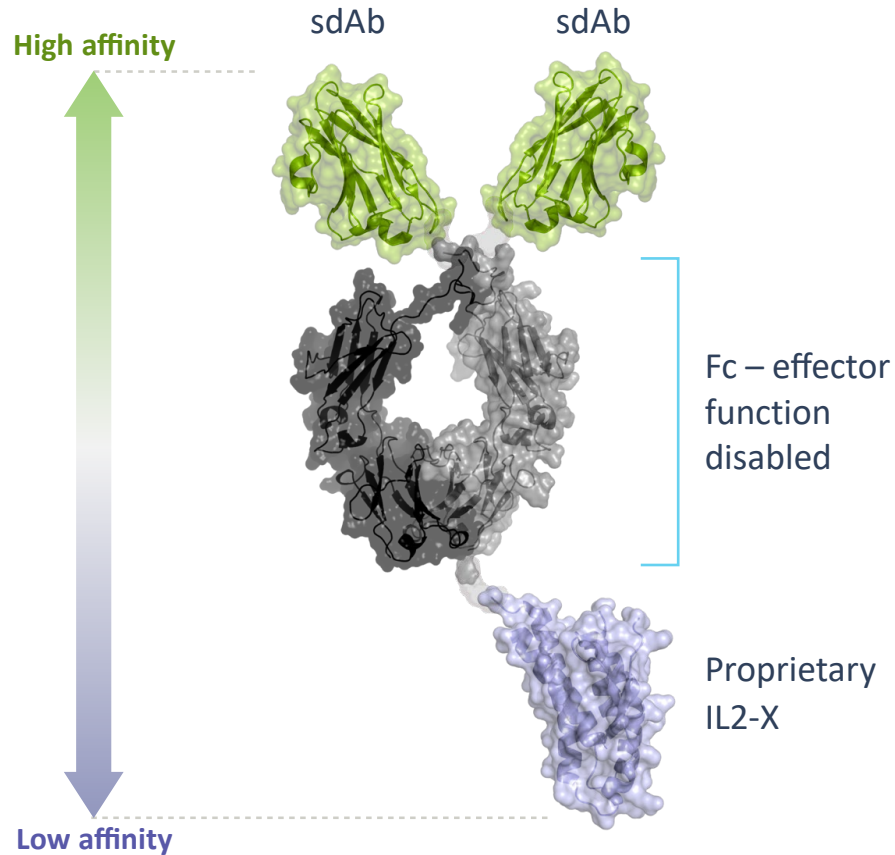


# INBRX-121

NKp46 Targeted Detuned IL-2

**INHIBR<sub>X</sub>**

# 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

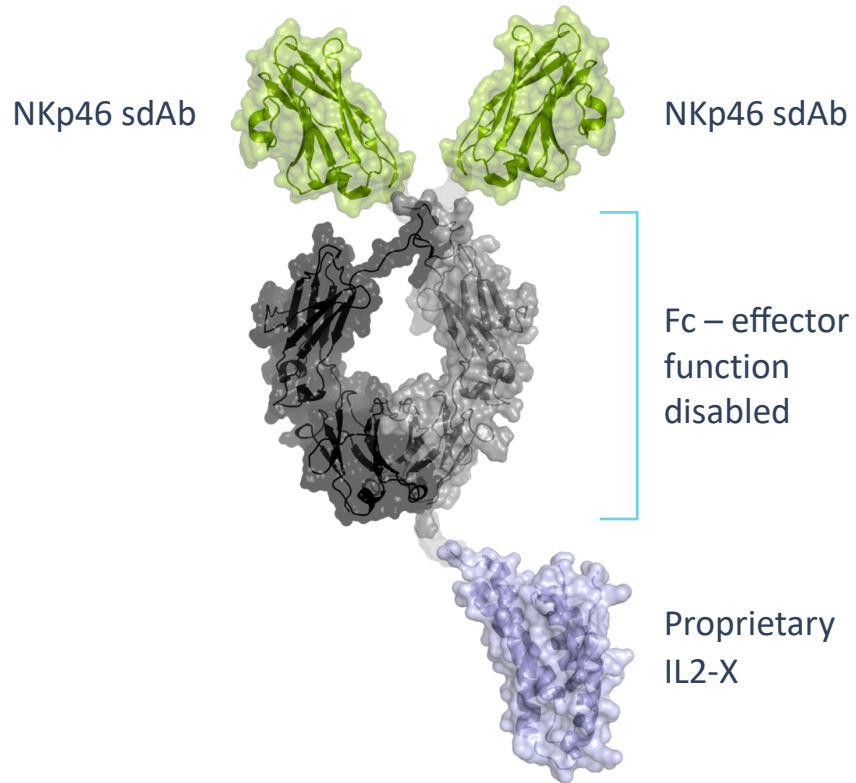
# Molecular Targeted Cytokine (MTC) Platform

A Targeted Detuned  
IL-2 Platform

**INHIBR<sub>X</sub>**

# INBRX-121 expanded the NK cell population and enhanced cytotoxicity

INBRX-121

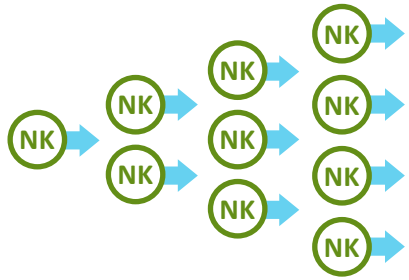


- + NKp46 is an NK-specific marker that maintains expression on tumor-infiltrating NK cells
- + Proprietary IL2-X engineering ensures specific modulation of NK Cells without impacting T-cell subsets (Tcon and Treg)

# 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

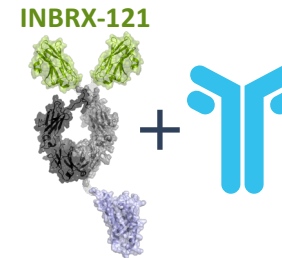


- + Cytokine release syndrome not caused by NK cells
- + Extended exposure drives durability

## Multiple potential paths forward



**Single agent**  
Activated NK cells exhibit immediate cytotoxicity

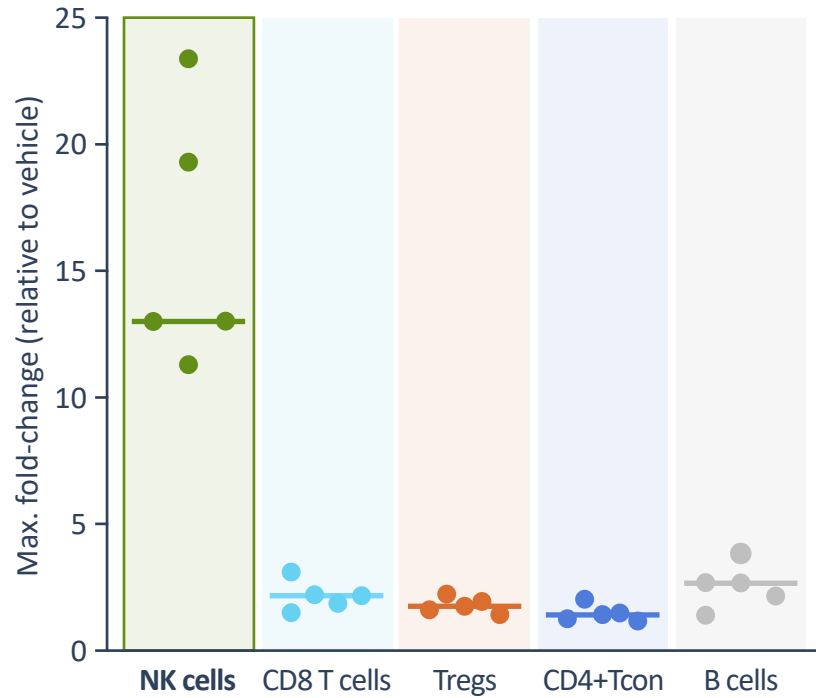


**Combination therapy**  
Enhances the activity of therapeutic antibodies

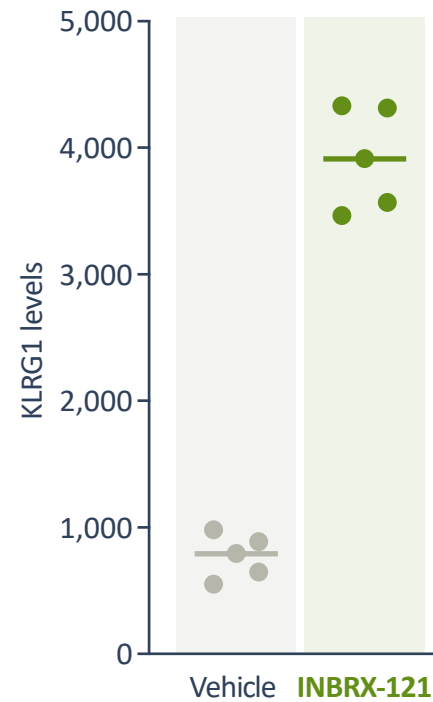
# Expanded mouse NK cells and enhanced their cytotoxic potential

INBRX-121

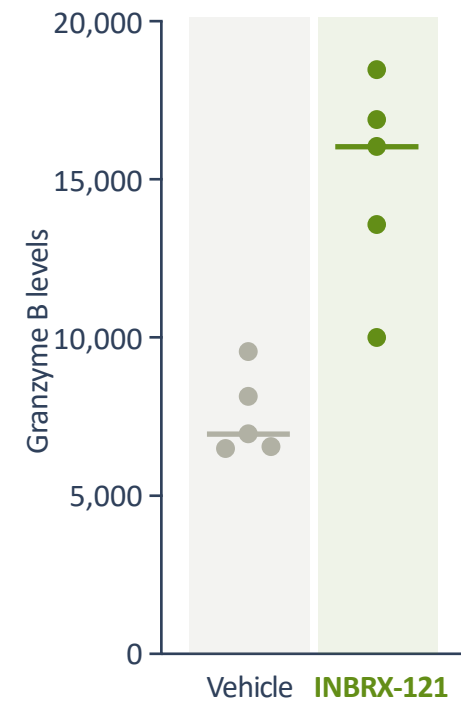
## NK cell expansion



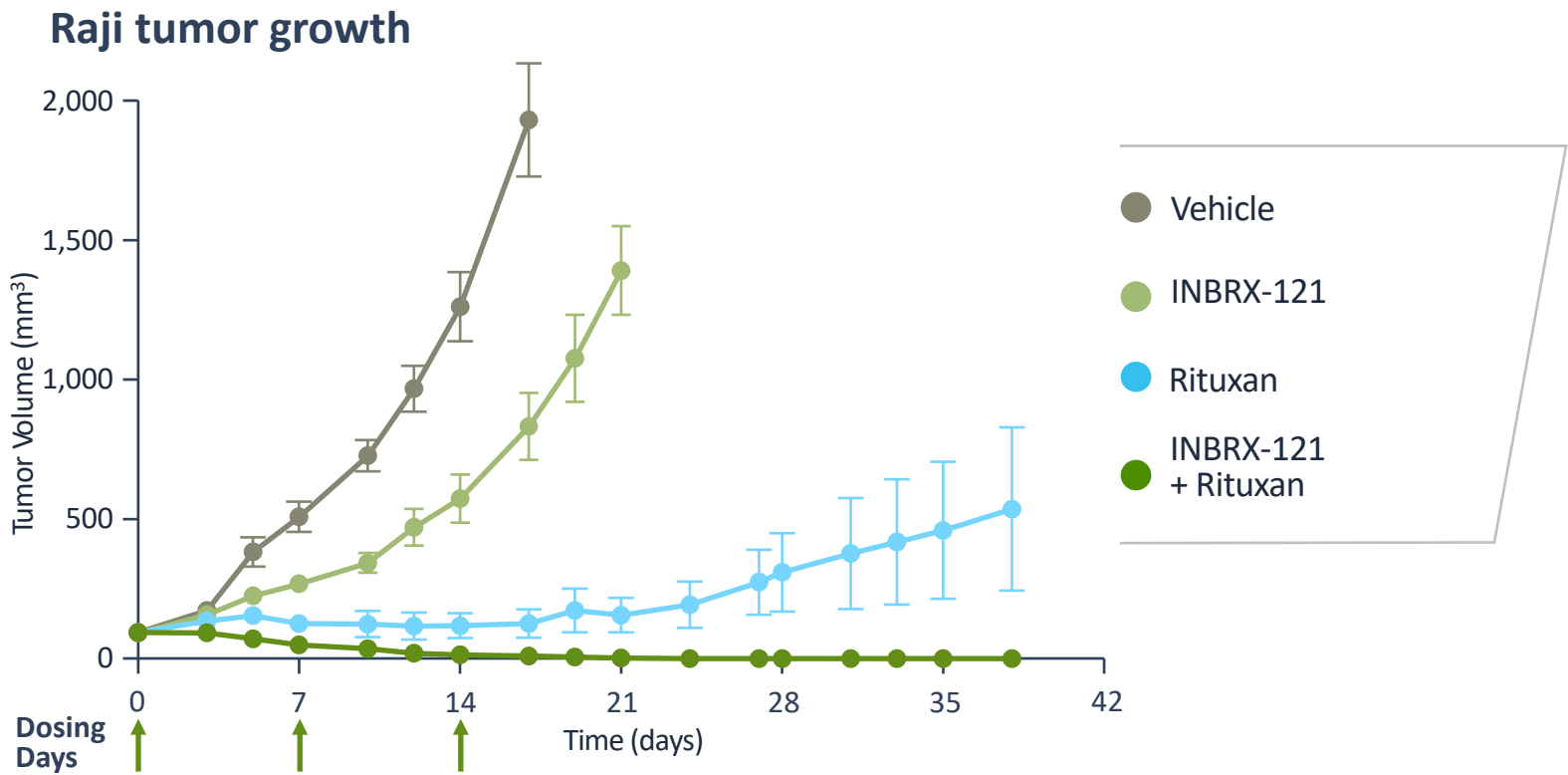
## NK cell activation



## NK cell cytolytic activity



# Synergized with approved therapeutic antibodies

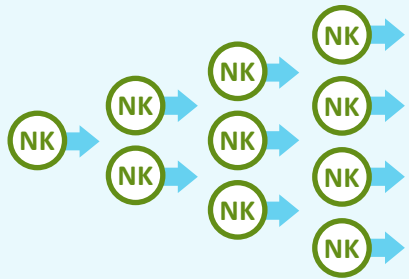


| TREATMENT            | COMPLETE RESPONSES |
|----------------------|--------------------|
| Rituxan®             | 0/10               |
| INBRX-121 + Rituxan® | 9/10               |

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



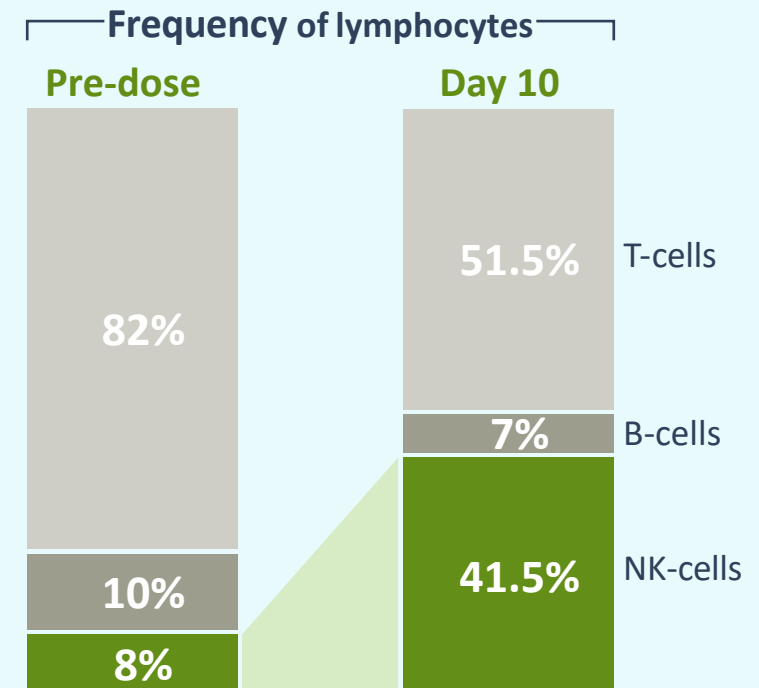
Expanded NK cells  
in a dose-dependent  
manner (up to 12-fold)  
that persists for more than  
21 days and can be dosed  
multiple times safely



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

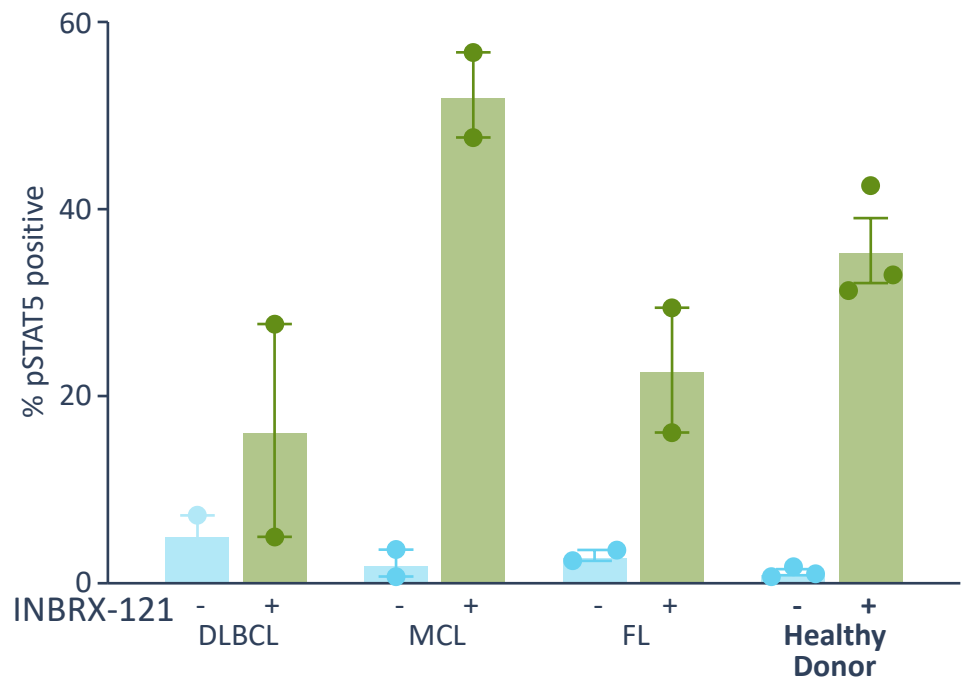
INBRX-121

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



# Expanded NK cells from Lymphoma patients

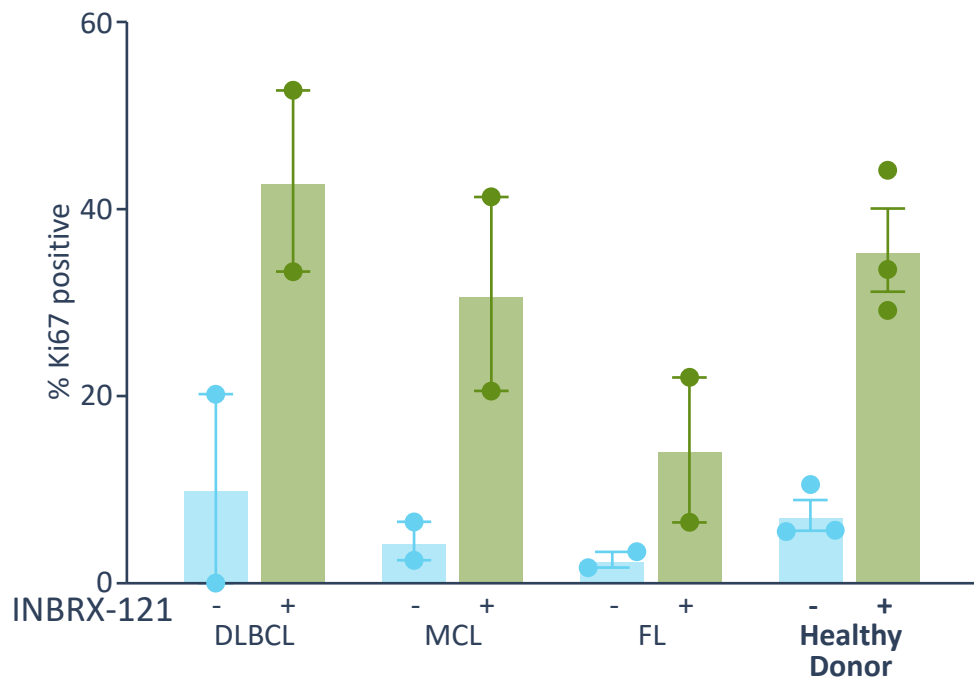
## IL-2 signaling in patient NK cells



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

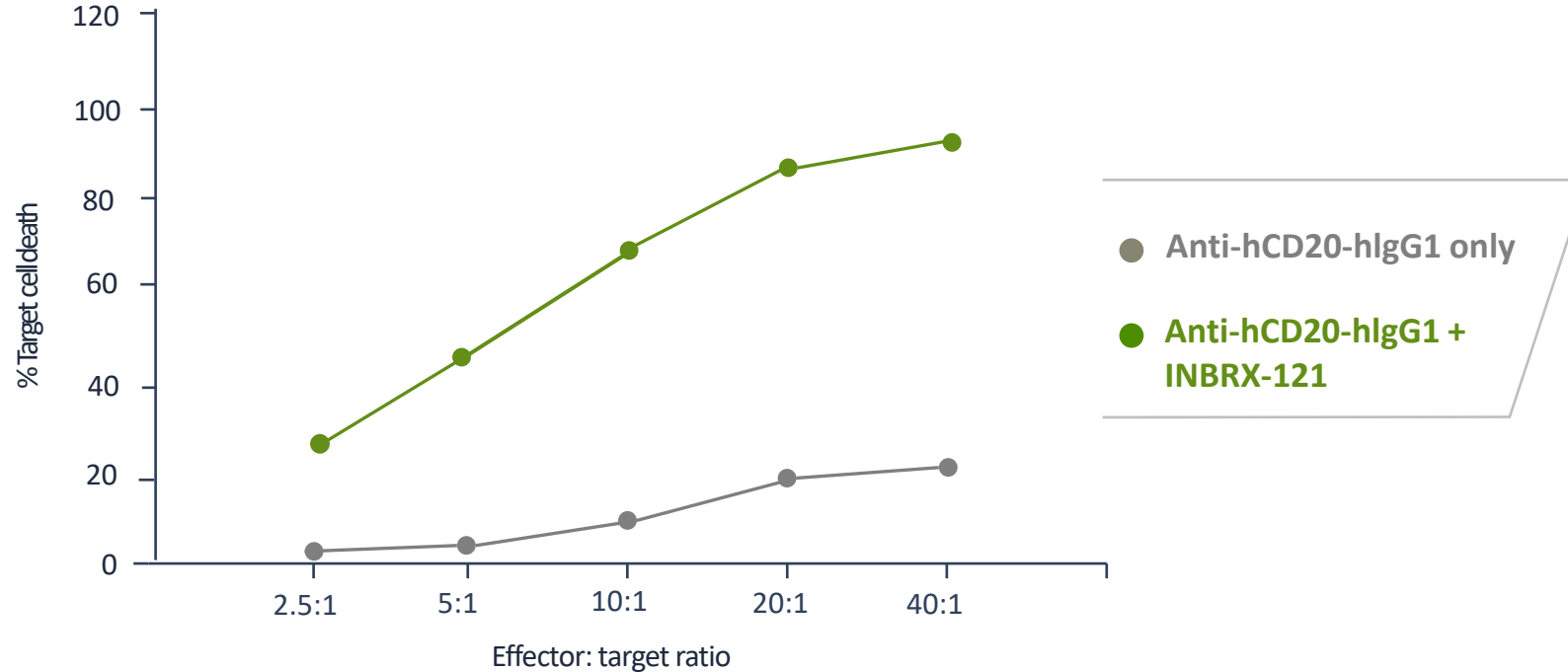


Patient NK cells responded to stimulation with INBRX-121 by upregulating pSTAT5 and showed an increased proliferative potential

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).

11025 N. Torrey Pines Rd  
Ste 200  
La Jolla, CA 92037  
[www.inhibrx.com](http://www.inhibrx.com)

**INHIBRX**

