Making hematopoietic stem cell transplantation (HSCT) safer and more effective

Cell-based immunotherapy products for the treatment of blood cancers and inherited blood disorders

Company presentation, April 2017
Amsterdam, The Netherlands
Euronext (KDS)
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Every three minutes one person is diagnosed with blood cancer.

Sixty years after the first successful bone marrow transplantation, hematopoietic stem cell transplantation (HSCT) is still a risky procedure.
## Kiadis: company at a glance

### TEAM
- New CEO and COO as of April add business and supply chain capabilities
- Strong team, ex Crucell, J&J, Organon, Wyeth, McKinsey, DSM, Sanquin
- Based in Amsterdam, The Netherlands

### SHAREHOLDERS
- Euronext Amsterdam/Brussels, listed in 2015 raising €35M
- Major shareholders: LSP, Draper Esprit, Alta
- Analyst coverage: KBC Securities, Kempen, Edison, Roth Capital

### FINANCIALS
- Market cap: €117M (13 April 2017)
- YE 2016 cash: €14.6 million
# Kiadis management: industry experience, all functions

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arthur Lahr</strong> (April 2017)</td>
<td>Chief Executive Officer</td>
<td>• Chief Strategy Officer Crucell (NASDAQ/Euronext); head BD, M&amp;A and M&amp;S US/EU</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Board Sanquin (Dutch blood bank)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• McKinsey &amp; Co, Unilever</td>
</tr>
<tr>
<td><strong>Robbert van Heekeren</strong></td>
<td>Chief Financial Officer</td>
<td>• Head Global Finance &amp; Control Organon</td>
</tr>
<tr>
<td><strong>Jan Feijen</strong> (April 2017)</td>
<td>Chief Operations Officer</td>
<td>• Head operations &amp; supply chain J&amp;J vaccines, Crucell and Avebe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Development at Gist-Brocades</td>
</tr>
<tr>
<td><strong>Jeroen Rovers</strong></td>
<td>Chief Medical Officer</td>
<td>• Chief Medical Officer Ceronco Biosciences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Director Clinical Development Organon</td>
</tr>
<tr>
<td><strong>Margot Hoppe</strong></td>
<td>General Counsel</td>
<td>• 20+ years in corporate legal affairs, including Gist-Brocades and DSM</td>
</tr>
<tr>
<td>UNIQUE PLATFORM</td>
<td>• Elegant and proprietary cell therapy immunotherapy platform, no genetic engineering</td>
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<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>LARGE POTENTIAL</td>
<td>• Orphan drug (US/EU) for high unmet need with thousands of stem-cell transplantation patients in blood cancers and inherited blood disorders</td>
<td></td>
</tr>
<tr>
<td>STRONG PHASE II DATA</td>
<td>• Phase II 1 year data superior to literature for PTCy/Baltimore: higher Overall Survival (OS) and higher GVHD and relapse free survival (GRFS)</td>
<td></td>
</tr>
<tr>
<td>COMMERCIAL IN 2019</td>
<td>• Filing for (conditional) EU approval soon, preparing for EU launch 2019; Phase III against PTCy/Baltimore initiated (US, Canada, EU)</td>
<td></td>
</tr>
<tr>
<td>EFFICIENT SUPPLY CHAIN</td>
<td>• Efficient 5 day manufacturing, easily integrated into existing routine transplantation center processes</td>
<td></td>
</tr>
</tbody>
</table>
Allogeneic hematopoietic stem cell transplantation (HSCT)

Patient → Conditioning of patient to destroy diseased immune and blood system → Donor

Donor → Harvest stem cells and mature immune cells from donor → Patient
Issue with HSCT: need to give mature T-cells, yet avoid GVHD

**Highest risk during reconstitution of immune system from donor stem cells (6-12 months)**

- Mature donor T-cells attack patient tissue (skin, GI, liver); Often debilitating and lethal

**Immunosuppression needed to control alloreactive T-cells**

**Potent mature T-cells needed for immediate protection**

**Trade off**

**RELAPSE AND INFECTION**

- Graft vs Host Disease (GVHD)
  - GVHD & Relapse Free Survival*: 30%

*Solh 2016: 1 year GFRS for MRD/MUD/HID (survival without acute Grade III/IV GVHD, chronic GVHD requiring systemic immunosuppression or relapse)

** 30% of GVHD is acute Grade III/IV; 70% of acute Grade III/IV GVHD die
Haploidentical can address donor shortage, if GVHD controlled

**Historical standard:**
matched related/unrelated donors, to limit risk of GVHD

- **Availability**
  - 65%
  - 37,000 waiting (13,000 US), many never find donor

**Emerging alternative:**
Half-matched haploidentical donors, yet high inherent GVHD risk

- **Availability**
  - 95%
  - All parents and children can be donor

Source: Lancet 2015; Defined Health 2013
<table>
<thead>
<tr>
<th>Depletion of GVHD causing T-cells:</th>
<th>In patient</th>
<th>Ex vivo / In patient</th>
<th>Ex vivo</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCT</td>
<td>Adjunctive mature T-cells (after HSCT)</td>
<td>GVHD treatment/ prophylaxis</td>
<td></td>
</tr>
<tr>
<td>PTCy/Baltimore protocol</td>
<td>T-cell replete (unmanipulated, all T-cells)</td>
<td>None</td>
<td>Post-Transplant Cyclophosphamide &amp; immunosuppressant to control alloreactive T-cell response</td>
</tr>
<tr>
<td>Zalmoxis (MolMed), BPX-501 (Bellicum)</td>
<td>T-cell depleted</td>
<td>All T-cells, engineered with suicide switch</td>
<td>Trigger suicide switch upon GVHD</td>
</tr>
<tr>
<td>ATIR</td>
<td>T-cell depleted (‘Safe’ stem cells)</td>
<td>Depleted of GVHD causing T-cells (‘Safe’ T-cells)</td>
<td>No prophylactic immunosuppressant needed</td>
</tr>
</tbody>
</table>
ATIR: Adjunctive infusion of ‘safe’ T-cells, 28 days post HSCT

Mix patient &
donor immune cells,
alloreactive
T-cells activated
(Mixed Lymphocyte
Reaction)

Add TH9402*, which
is retained only in
activated
alloreactive T-cells

Expose to green light,
only TH9402
containing
alloreactive T-cells are
killed

Know how;
Issued patents
(till 2021);
Pending patents
(estimated till
2036)

Infused on day 28
after HSCT

GVHD causing T-cells depleted by causing GVHD ex vivo,
reactivity against tumor and infections retained

*TH9402 – proprietary selective cytotoxic compound
## Pipeline: ATIR101 acute leukemia, ATIR201 thalassemia

<table>
<thead>
<tr>
<th>ATIR101 Blood cancers (acute leukemia)</th>
<th>ATIR201 Inherited blood disorders (beta thalassemia)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCT procedure</td>
<td></td>
</tr>
<tr>
<td>- Myeloablative conditioning</td>
<td>- Myeloablative conditioning</td>
</tr>
<tr>
<td>- CD34+ stem cell only</td>
<td>- αβ T-cell depleted</td>
</tr>
<tr>
<td>Phase I/II</td>
<td>Phase I/II</td>
</tr>
<tr>
<td>- CR-GVH-001 (dose finding)</td>
<td>- CR-BD-001 (dose finding)</td>
</tr>
<tr>
<td>Phase II</td>
<td>Phase II</td>
</tr>
<tr>
<td>- CR-AIR-006 (historic control)</td>
<td>- CR-AIR-007 (efficacy)</td>
</tr>
<tr>
<td>- CR-AIR-008 (2nd dose)</td>
<td>- CR-AIR-009 (randomized, controlled)</td>
</tr>
<tr>
<td>Phase III</td>
<td></td>
</tr>
<tr>
<td>- CR-AIR-009 (randomized, controlled)</td>
<td></td>
</tr>
</tbody>
</table>
ATIR101: potent mature T-cells, yet low GVHD (1 yr)

- 007: CD34+ HSCT and single dose ATIR
  - Open label single arm, AML/ALL
  - 23 patients
  - 8 sites Canada and EU

- 006: CD34+ HSCT
  - Matched historical observational cohort
  - 34 patients
  - Matched indications, patients, sites
  - Based on EMA scientific advice

Improved Overall Survival (OS) versus matched historical control

- 61% with ATIR (007)
- 21% without ATIR (006)

Low GVHD related to ATIR

- no acute Grade III/IV
- 3 acute Grade II (13%)
- 1 chronic severe (4%)
ATIR101: superior vs literature for other haplo HSCT (1 yr)

Higher Survival

<table>
<thead>
<tr>
<th>1 Year data (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Survival</td>
</tr>
<tr>
<td>ATIR</td>
</tr>
<tr>
<td>PTCy/Baltimore*</td>
</tr>
<tr>
<td>Zalmoxis**</td>
</tr>
</tbody>
</table>

Lower Relapse and GVHD

<table>
<thead>
<tr>
<th>1 Year data (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapse</td>
</tr>
<tr>
<td>ATIR</td>
</tr>
<tr>
<td>PTCy/Baltimore*</td>
</tr>
<tr>
<td>Zalmoxis**</td>
</tr>
<tr>
<td>Acute GVHD III/IV</td>
</tr>
<tr>
<td>ATIR</td>
</tr>
<tr>
<td>PTCy/Baltimore*</td>
</tr>
<tr>
<td>Zalmoxis**</td>
</tr>
<tr>
<td>Chronic GVHD</td>
</tr>
<tr>
<td>ATIR</td>
</tr>
<tr>
<td>PTCy/Baltimore*</td>
</tr>
<tr>
<td>Zalmoxis**</td>
</tr>
<tr>
<td>Non Relapse Mortality</td>
</tr>
<tr>
<td>ATIR</td>
</tr>
<tr>
<td>PTCy/Baltimore*</td>
</tr>
<tr>
<td>Zalmoxis**</td>
</tr>
</tbody>
</table>

Note: NOT randomized controlled trials: differences in patient population, indications, disease risk
* Weighted average 6 studies with at least 50% AML/ALL: Ciurea 2012; Ciurea 2015; Esquirol 2016 (2x); Greco 2016; Santoro 2016
** CHMP Assessment report (except for aGVHD III/IV); Matched control 34% OS, 21% relapse, NRM 46%, chronic GVHD 23%
ATIR101: superior GRFS vs literature for PTCy/Baltimore (1 yr)

Superior GRFS**

1 Year data (%)

- ATIR Phase II (n=23)
- PTCy/Baltimore Solh 2016* (n=128)

- 57% vs 30%

GRFS gap potentially larger: patients in Solh 2016 better prognosis then patients in ATIR Phase II

<table>
<thead>
<tr>
<th>Patient population</th>
<th>Distribution ATIR101 (n=23)</th>
<th>Distribution Solh (PTCy/MUD/MRD, n=531)</th>
<th>1 yr GRFS Solh (PTCy/MUD/MRD, n=531)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Risk index</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>15%</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>43%</td>
<td>49%</td>
<td>31%</td>
</tr>
<tr>
<td>High/Very High</td>
<td>57%</td>
<td>36%</td>
<td>26%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AML</td>
<td>70%</td>
<td>37%</td>
<td>28%</td>
</tr>
<tr>
<td>ALL</td>
<td>30%</td>
<td>13%</td>
<td>34%</td>
</tr>
<tr>
<td>MDS/MPS/CML</td>
<td>21%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>NHL/HD/CLL</td>
<td>25%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

*Solh et al, Biol Blood Marrow Transplant 22 (2016) 1403-1409

** GVHD and Relapse Free Survival: survival without acute Grade III/IV GVHD, chronic GVHD requiring systemic immunosuppression or relapse
ATIR101: superior vs literature for MMUD/cord (1 yr)

Higher Survival

<table>
<thead>
<tr>
<th></th>
<th>ATIR 101</th>
<th>MMUD*</th>
<th>UCB**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Survival</td>
<td>61/48/51</td>
<td>30/19/17</td>
<td>30/22</td>
</tr>
</tbody>
</table>

Lower relapse and GVHD

<table>
<thead>
<tr>
<th></th>
<th>Relapse</th>
<th>Acute GVHD III/IV</th>
<th>Chronic GVHD</th>
<th>Non Relapse Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATIR</td>
<td>9/30/44</td>
<td>19/17/25</td>
<td>30/32</td>
<td></td>
</tr>
<tr>
<td>MMUD*</td>
<td>61/48/51</td>
<td>30/19/17</td>
<td>30/32</td>
<td></td>
</tr>
<tr>
<td>UCB**</td>
<td>30/22</td>
<td>17/25</td>
<td>32/22</td>
<td></td>
</tr>
</tbody>
</table>

Note: NOT randomized controlled trials, differences in patient population, indications, disease risk
ATIR101: superior GRFS vs matched control MMUD/cord (1 yr)

Superior GRFS**

1 Year data (%)

<table>
<thead>
<tr>
<th></th>
<th>OS</th>
<th>GRFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATIR Phase II (n=23)</td>
<td>61</td>
<td>57</td>
</tr>
<tr>
<td>MMUD* (9/10) (n=37)</td>
<td>64</td>
<td>31</td>
</tr>
<tr>
<td>Cord Blood* (n=22)</td>
<td>55</td>
<td>23</td>
</tr>
</tbody>
</table>

* Historical observational cohort 2010-2012; matched indications, patients and sites
** GRFS: survival without acute Grade III/IV GVHD, chronic GVHD requiring systemic immunosuppression or relapse
ATIR101: filing EMA Marketing Authorization Application

- ATMP certificate April 2015 for quality and non-clinical data
- Orphan Drug Designation (all HSCT indications)
- Pediatric Investigation Plan agreed with EMA

Preparation for EMA MAA submission in final stages; Approval to be expected 2nd half 2018
ATIR101 Phase III (009) initiated: ATIR versus PTCy/Baltimore

Objectives: demonstrate superior clinical benefit and collect pharmacoeconomical data (cost, days in hospital, incidence of severe infections and quality of life)

Kiadis protocol:
CD34+ HSCT + single dose ATIR101

PTCy/Baltimore protocol:
post-HSCT cyclophosphamide & immunosuppressant

Randomized Controlled (1:1)

195 patients* with acute leukemia
45 sites in US, Canada and EU

Primary endpoint:
GRFS

Secondary endpoints:
OS, Progression Free Survival, Relapse Related Mortality, Transplant Related Mortality

Event driven

Protocol and GRFS as endpoint aligned with EMA and FDA; Phase III initiated; Trial approved in several countries

* Designed and powered for 20% difference in 1 yr GRFS, will reach statistical significance at 15% difference in 1 yr GRFS
ATIR: efficient central manufacturing

Efficient manufacturing process:
- 5 day process; only 2 operating days
- Disposable bags

Modest facility requirements, no/low capex:
- Simple clean room (class C/D)
- One site for US/Canada and Europe each

Significantly lower COGS and manufacturing footprint than genetically engineered cell therapy products
ATIR: easy fit into routine transplantation center procedures

Patient & donor material 42 hour hold time (HypoThermosol) → Final product frozen in liquid nitrogen (>12 month stability)

Apheresis → Ship to Kiadis → Central Kiadis manufacturing → Ship to hospital → Dose at bedside

14 days before HSCT conditioning → 28 days after HSCT

Routinely done for bone marrow transplants and patient specific cell products from blood banks
## ATIR201 Phase I/II initiated: thalassemia

| Trial design | • Pediatric patients with β-thalassemia major  
|             | • Adjunctive to a αβ T-cell depleted haploidentical HSCT  
|             | • Optimized manufacturing for pediatric setting |
| Status      | • Centers: Regensburg, Tubingen, Manchester, Birmingham, London  
|             | • Trial initiated, approved by authorities in UK & Germany |
| Collaboration with TIF | • Awareness on haploidentical HSCT  
|             | • Access to families and to HSCT |
Kiadis 2017 clinical and regulatory milestones

- MAA submission to EMA for (conditional) approval ATIR101
- Opening new EU, US and Canadian clinical sites
- Enrollment updates on ATIR101/leukemia and ATIR201/thalassemia
- Updates on regulatory progress in EU and USA
Annual potential for improved haploidentical HSCT

*some sources not EU but Europe
# Kiadis: Make HSCT safer and more effective

## LARGE VALUE
- Large unmet need in blood cancers and inherited blood disorders
- Unique orphan drug

## CLOSE TO MARKET
- Strong Phase II results, superior to average literature for alternatives
- Filing EMA MAA soon, EU market launch 2019
- Phase III initiated (US, Canada and EU)
- Efficient manufacturing and supply chain

## STRONG LEADERSHIP
- Experienced team with business and supply chain capabilities
...so that many more patients with otherwise incurable diseases will have a reasonable chance of long survival and cure

— Dr. E. Donnall Thomas

established bone marrow transplantation as a treatment for leukemia

*Nobel Lecture / 1990*
Additional information

ATIR product characteristics

Clinical trial information (April 2018)

• CR-GVH-001
• CR-AIR-007
• CR-AIR-008

HSCT market data
ATIR101: alloreactive T-cells depleted, potency retained

- **Donor**: Cells from the donor/starting material
- **ATIR**: Final product manufactured from donor

### Functional release assay

Based on Quality Target Product Profile & Critical Quality Attributes
ATIR101: T-cells reactive against infections & tumor retained

Collaboration with Prof. Angela Krackhardt, Medizinische Klinik III, Klinikum Rechts der Isar, TU Munich, Munich, Germany
Examples of two patients in clinical study with ATIR:

EBV reactivation triggered response of (viral specific) T-cells in several patients

- Increase in CD3+ T-cells detected in peripheral blood
- EBV copy numbers reduced after increase in CD3+ T-cells, indicating effective immunological T-cell response.
Phase I CR-GVH-001: Overall Survival (5 year)

Patients:
19 with advanced hematological malignancies (15 not in remission at transplant)

ATIR doses:
10k cells/kg to 5 mln cells/kg; 30 days after HSCT

Results:
• 67% Overall Survival at middle dose level after 5 years
• No acute Grade III/IV GVHD related to ATIR at any dose

Note: Unmanipulated haplo-identical Donor Lymphocyte Infusion can cause Grade III/IV GVHD at 50k cells/kg.
Phase II CR-AIR-007: trial characteristics & endpoints

Design:
open-label, single arm, multi-center study

Patient population:
• AML or ALL in first remission with high-risk features or in second or higher remission
• No suitable matched donor
• Haploidentical family

Locations: CA, BE, DE, UK (8 sites in total)

Primary endpoint:
• Transplant Related Mortality (TRM) at 6 months

Secondary endpoints:
• Acute and chronic GVHD
• Immune reconstitution
• Infections
• TRM, relapse, Overall Survival (OS)

Patient follow-up (per 28 November 2016):
• Median 485 days (range 110 – 742)
Phase II CR-AIR-007: patient & donor characteristics

Patient and donors
- N=23 patients \((HSCT + ATIR101)\)
- Median patient age (range): 41 years (21-64)
- Gender: 13 female, 10 male
- Median donor age (range): 33 years (21 - 61)

Diagnosis
- AML: n=16 (70%):
  - 11 in CR1
  - 5 in CR2
- ALL: n=7 (30%):
  - 4 in CR1
  - 3 in CR2

Risk classification
- Cytogenetic risk profile\(^1\):
  - Favorable 0
  - Intermediate 9 (39 %)
  - Adverse 14 (61 %)
- Disease-risk index\(^2\):
  - Low risk index 0
  - Intermediate risk index 10 (43 %)
  - High risk index 13 (57 %)

\(^1\) Mrozek K, et al. JCO 2012, 30 (36): 4515-4523
Phase II CR-AIR-007: HSCT characteristics

Myeloablative conditioning

- TBI (1200 cGy; n=11) or melphalan (120mg/m²; n=12)
- Thiotepa (10 mg/kg), fludarabine (30 mg/m² x 5d) and ATG (2.5mg/kg x 4d)

HSCT

- CliniMACS® CD34 isolation system (Miltenyi Biotec)
- Target: 8-11x10⁶ CD34+ cells/kg, with max. of 3x10⁴ CD3+ cells/kg

Prophylaxis

- No GVHD prophylaxis
- CMV/EBV monitoring
- Prophylactic ganciclovir/foscarnet (CMV + recipient/donor)

ATIR101 infusion

- Day 28 post HSCT (median)
### Phase II CR-AIR-007: causes of death (April 2017)

<table>
<thead>
<tr>
<th>Period post HSCT</th>
<th>Classification</th>
<th>No. of pts</th>
<th>Classification of cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 6 months</td>
<td>Relapse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TRM – Infections</td>
<td>2</td>
<td>Adenovirus and JC virus infections</td>
</tr>
<tr>
<td></td>
<td>TRM – Other</td>
<td>1</td>
<td>Pulmonary embolism</td>
</tr>
<tr>
<td>6-12 months</td>
<td>Relapse</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TRM – Infections</td>
<td>3</td>
<td>Respiratory/pulmonary infections/distress</td>
</tr>
<tr>
<td></td>
<td>TRM – Other</td>
<td>1</td>
<td>Multi-organ failure</td>
</tr>
<tr>
<td>12-24 months (ongoing)</td>
<td>Relapse</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TRM – Infections</td>
<td>3*</td>
<td>Pneumonia/Sepsis/Septic shock</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

* Patients immunosuppressed for GVHD, that subsequently contracted infections, leading to death: Two patients who received un-manipulated DLI’s and subsequently developed severe GVHD; One patient with chronic GVHD
### Phase II CR-AIR-008: study with second dose (April 2017)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Extend the length of protection (further improve TRM); investigate flexibility for physicians (instead of un-manipulated DLI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design:</td>
<td>HSCT followed with ATIR at day 30, and additional dose of ATIR at day 72</td>
</tr>
<tr>
<td>Enrollment:</td>
<td>11 out of 15 patients enrolled and treated with ATIR: 5 patients received one dose of ATIR and 6 patients received two doses</td>
</tr>
<tr>
<td>Results:</td>
<td>Confirming safety/efficacy findings in 001/007 with a single dose, not with two doses</td>
</tr>
<tr>
<td></td>
<td>- Single dose: no Grade III/IV GVHD (median 137 days follow up)</td>
</tr>
<tr>
<td></td>
<td>- Two doses: Grade III/IV GVHD in some patients</td>
</tr>
<tr>
<td>Continuation:</td>
<td>Remaining 4 patients to be enrolled and treated with a single dose, according to protocol</td>
</tr>
</tbody>
</table>
Relapse and GVHD main risks, with all donor sources

**Causes of death (MUD*)**
- Relapse: 37%
- GVHD: 20%
- Infections: 19%
- Other: 17%
- Organ Failure: 6%
- New Malignancy: 1%

**GRFS**

(MRD/MUD/HID***)

- MRDT (N=198)
- MUDT (N=205)
- HIDT (N=128)

* CIBMTR summary 2014
** GVHD and Relapse Free Survival: survival without acute Grade III/IV GVHD, chronic GVHD requiring systemic immunosuppression or relapse
*** Solh 2016 (acute/chronic leukemia and NHL/HD)

Acute Grade III/IV GVHD leads to death in 70% of cases.
Growth in HSCT: MRD, MUD, cord, Haplo

US | no. HSCT recipients

- Matched related MRD
- Matched Unrelated MUD
- Cord blood
- Haploidentical HID

EU | no. HSCT recipients

- Matched related MRD
- Haploidentical HID
- Matched unrelated MUD
- Cord blood