Making bone marrow transplantations safer and more effective

Patient specific cell-based immunotherapy product, as adjunctive treatment to haploidentical hematopoietic stem cell transplantation (HSCT), for the treatment of blood cancers and inherited blood disorders

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

**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 (April 2017)</strong></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 (April 2017)</strong></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>• Proprietary patient specific cell therapy product as adjunctive treatment to haploidentical hematopoietic stem cell transplantation (HSCT)</td>
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<tr>
<td>LARGE POTENTIAL</td>
<td>• Orphan Drug Designations (US/EU); high unmet need with thousands of 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 other haploidentical HSCT PTCy/Baltimore and Zalmoxis</td>
<td></td>
</tr>
<tr>
<td>COMMERCIAL IN 2019 (EU)</td>
<td>• Filed for (conditional) EU approval based on Phase II; approval expected H2 2018; Phase III against PTCy/Baltimore initiated for FDA</td>
<td></td>
</tr>
<tr>
<td>EFFICIENT SUPPLY CHAIN</td>
<td>• Efficient 5 day manufacturing, without genetic engineering; easily integrated into existing transplantation center processes</td>
<td></td>
</tr>
</tbody>
</table>
Allogeneic HSCT: blood cancers & inherited blood disorders

Conditioning of **patient** to destroy diseased blood system

Harvesting of **donor** stem cells and immune cells to engraft new blood system

Passweg BMT 2017 (Europe)
Trade-off with HSCT: need mature T-cells, yet avoid GVHD

Reconstitution of immune system from donor stem cells:
- NK/B-cells: 1-2 months
- T-cells: 6-12 months

Infusion of HSCT graft
Graft Versus Host Disease (GVHD)

**Acute GVHD (within 100 days)**
- Grade I/II: manageable
- Grade III/IV: lethal in 70% of cases

**Chronic severe GVHD**
- Severely debilitating, can persist years
- Increased risk of infections and relapse

Mature alloreactive T-cells from donor attack antigenically foreign epithelial tissues of patient (MHC class II proteins)

- Affected organs: skin, mouth, eyes, liver, gastrointestinal tract, lungs
- Manifestations: rash, scleroderma, ulceration, erythema, cirrhosis, immunodeficiency
- Treatment: immunosuppression (e.g. corticosteroids), anti-infectives
Haploidentical HSCT: donors available, if GVHD controlled

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

- **Availability:** 65%
  - 37,000 waiting, of which 13,000 in 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
Recent haploidentical growth due to adoption of PTCy/Baltimore protocol, at expense of matched unrelated and cord blood

Source: EBMT, CIBMTR
Annual potential for (improved) haploidentical HSCT

*some sources not EU but Europe
** Calculation based on 35% of patients not finding a matched donor
### Enabling haploidentical HSCT: deplete T-cells that cause GVHD

<table>
<thead>
<tr>
<th></th>
<th>Haploidentical HSCT</th>
<th>Adjunctive dose of T-cells (after HSCT)</th>
<th>GVHD treatment/prophylaxis</th>
<th>Strategy towards GVHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTCy/Baltimore (physician protocol)</td>
<td>T-cell replete (stem cells and all immune cells)</td>
<td>None</td>
<td>Post-Transplant Cyclophosphamide &amp; immunosuppressant to control alloreactive T-cell response</td>
<td>Treatment (in patient)</td>
</tr>
<tr>
<td>Zalmoxis (MolMed) BPX-501 (Bellicum)</td>
<td>T-cell depleted (CD34+/αβ-TCD) ('Safe' HSCT)</td>
<td>All T-cells, engineered with suicide switch</td>
<td>If GVHD occurs suicide agent infused (ganciclovir, rimiducid) to eliminate T-cells</td>
<td>Treatment (ex vivo/in patient)</td>
</tr>
<tr>
<td>ATIR (Kiadis)</td>
<td>T-cell depleted (CD34+/αβ-TCD) ('Safe' T-cells)</td>
<td>Subset of T-cells: depleted of GVHD causing T-cells ('Safe' T-cells)</td>
<td>No prophylactic immunosuppressant needed</td>
<td>Prevention (ex vivo)</td>
</tr>
</tbody>
</table>
**ATIR: adjunctive infusion of ‘safe’ T-cells, 28-32 days post HSCT**

- **Mix patient & donor immune cells:** alloreactive T-cells become activated *(Mixed Lymphocyte Reaction - MLR)*

- **Add TH9402*, which accumulates only in activated (and thus alloreactive) T-cells, due to lack of PgP pump function**

- **Expose to green light, TH9402 becomes toxic: only TH9402 containing (and thus alloreactive) T-cells are killed**

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*TH9402 – proprietary selective rhodamine derivative, modified to become cytotoxic under green light*
### Trials: ATIR101 blood cancers, ATIR201 thalassemia

<table>
<thead>
<tr>
<th>Trial designs to date</th>
<th>Phase I/II</th>
<th>Phase II</th>
<th>Phase III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATIR101</strong>&lt;br&gt;Blood cancers&lt;br&gt;- Adult acute leukemia&lt;br&gt;- Myeloablative conditioning&lt;br&gt;- CD34+ stem cell</td>
<td><strong>CR-GVH-001</strong>&lt;br&gt;(dose finding)</td>
<td><strong>CR-AIR-006</strong>&lt;br&gt;(historic control)</td>
<td><strong>CR-AIR-009</strong>&lt;br&gt;(randomized, controlled)</td>
</tr>
<tr>
<td><strong>ATIR201</strong>&lt;br&gt;Inherited blood disorders&lt;br&gt;- Pediatric β thalassemia&lt;br&gt;- Myeloablative conditioning&lt;br&gt;- αβ T-cell depleted</td>
<td><strong>CR-BD-001</strong>&lt;br&gt;(dose finding)</td>
<td><strong>CR-AIR-007</strong>&lt;br&gt;(efficacy)</td>
<td><strong>CR-AIR-008</strong>&lt;br&gt;(2nd dose)</td>
</tr>
</tbody>
</table>

**Future additional trials for ATIR101 in blood cancers:**
- As adjunctive to PTCy/αβ T-cell depleted HSCT
- Pediatric
ATIR101: potent mature T-cells, yet low GVHD (1 yr)

- Improved Overall Survival with ATIR
  - 61% with CD34+ plus single dose ATIR (007)
  - 21% without ATIR (006)

- Low GVHD related to ATIR
  - No acute grade III/IV
  - 3 acute grade II (13%)
  - 1 chronic (4%)

ATIR depletion effective: potent T-cells providing protection, yet low GVHD

007: CD34+ plus single dose ATIR
- Open label single arm 2013-16
- 23 patients: 70% AML, 30% ALL
- 8 sites Canada and EU

006: CD34+
- Historical observational cohort 2006-13
- 34 patients, matched indications/sites
- Based on EMA scientific advice
ATIR101: superior vs EMA approved product Zalmoxis (1 yr)

**Superior Survival**

<table>
<thead>
<tr>
<th>1 Year data (%)</th>
<th>Overall Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ATIR</td>
</tr>
<tr>
<td></td>
<td>61%</td>
</tr>
</tbody>
</table>

**Superior Relapse**

<table>
<thead>
<tr>
<th>1 Year data (%)</th>
<th>Relapse</th>
<th>Acute GVHD III/IV</th>
<th>Chronic GVHD</th>
<th>Non Relapse Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9%</td>
<td>0%</td>
<td>4%</td>
<td>30%</td>
</tr>
<tr>
<td>ATIR</td>
<td>42%</td>
<td>7%</td>
<td>6%</td>
<td>20%</td>
</tr>
</tbody>
</table>

- **ATIR**
  - Phase II (007), n=23
- **Zalmoxis (Molmed)**
  - Phase II data in EMA filing, n=36*

**Zalmoxis**: Conditionally approved June 2016, based on Phase II data and matched historical control

**ATIR101**: More potent T-cells, providing more protection against relapse, with similar GVHD

*Note: NOT randomized controlled trials: differences in patient population, indications, disease risk*

*CHMP Assessment report (except for aGVHD III/IV); CD34+ HSCT; 74% AML/10% ALL/16%MDS/NHL/HD,*
ATIR101: filing EMA Marketing Authorization Application (MAA)

ATMP certificate April 2015 for quality and non-clinical data

Orphan Drug Designation (all HSCT indications)

Pediatric Investigation Plan agreed with EMA

Rapporteurs accepted Phase II data with historical control for filing and review

EMA MAA submitted April 2017 based on Phase II and matched historical control (like Zalmoxis); Approval to be expected 2nd half 2018
ATIR101: superior GRFS vs literature for PTCy/Baltimore (1 yr)

**Superior GVHD and Relapse Free Survival (GRFS)**

<table>
<thead>
<tr>
<th>1 Year data (%)</th>
<th>ATIR Phase II (n=23)</th>
<th>PTCy/ Baltimore Solh 2016* (n=128)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Survival without:**
- Chronic GVHD requiring immunosuppression
- Acute grade III/IV GVHD
- Relapse

**Composite endpoint: survival, quality of life, future prognosis**

**Note:** NOT randomized controlled trials: differences in patient population, indications, disease risk

*Solh et al, Biol Blood Marrow Transplant 22 (2016) 1403-1409; patient population with better prognosis than in ATIR101 Phase II (25% NHL/HD/CLL, 15% low disease risk index)
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

Primary endpoint:
GRFS

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

Event driven

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

Protocol and GRFS as endpoint aligned with EMA and FDA (End of Phase II meeting); Trial approved in several countries, lining up sites

* Designed and powered for 20% difference in 1 yr GRFS, will reach statistical significance at 15% difference in 1 yr GRFS
ATIR101: superior relapse and GVHD vs literature for PTCy (1 yr)

**Similar Survival**

| Overall Survival | ATIR101: 61% | PTCy/Baltimore*: 64% |

**Superior Relapse and GVHD**

<table>
<thead>
<tr>
<th>Condition</th>
<th>ATIR101 (007), n=23</th>
<th>Average literature, n=215-325</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapse</td>
<td>9%</td>
<td>35%</td>
</tr>
<tr>
<td>Acute GVHD III/IV</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>Chronic GVHD</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
<td>Non Relapse Mortality</td>
<td>13%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Note:** NOT randomized controlled trials: differences in patient population, indications, disease risk

* Weighted average 6 publications (adult; at least 50% AML/ALL): Ciurea 2012; Ciurea 2015; Devilier 2015; Di Stasi 2014; Esquirol 2016; Salomon 2012

ATIR101: more potent T-cells, providing more protection against relapse, yet lower GVHD
### Improvements: ATIR101 as adjunctive to αβ-TCD and PTCy

<table>
<thead>
<tr>
<th></th>
<th>Overall Survival</th>
<th>Relapse</th>
<th>Chronic GVHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD34+ (Phase II 006/007)</td>
<td>21% + ATIR</td>
<td>61%</td>
<td>9%</td>
</tr>
<tr>
<td>αβ-TCD (literature*)</td>
<td>56% + ATIR</td>
<td>TBD</td>
<td>40%</td>
</tr>
<tr>
<td>PTCy (literature**)</td>
<td>64% + ATIR</td>
<td>TBD</td>
<td>35%</td>
</tr>
</tbody>
</table>

* Improve Overall Survival... by lowering relapse... with low impact on GVHD

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* EBMT 2017, Preziosa et al (adult AML/ALL)
** Weighted average 6 publications (adult; at least 50% AML/ALL): Ciurea 2012; Ciurea 2015; Devilier 2015; Di Stasi 2014; Esquirol 2016; Salomon 2012
**ATIR201 Phase I/II initiated: thalassemia**

| HSCT | • Adjunctive to a αβ T-cell depleted haploidentical HSCT  
<table>
<thead>
<tr>
<th></th>
<th>• Optimized manufacturing for pediatric setting</th>
</tr>
</thead>
</table>
| Trial design | • Pediatric patients with β-thalassemia major  
|      | • 10 patients |
| Status | • Centers: Regensburg, Tubingen, Manchester, Birmingham, London  
|      | • Trial approved by authorities in UK & Germany |
| Collaboration with TIF | • Awareness on haploidentical HSCT  
|      | • Access to families and to HSCT |
ATIR: efficient central manufacturing

Efficient manufacturing process:
- 5 day process; only 2 operating days
- No genetic engineering
- Disposable bags

Modest facility requirements, no/low capex:
- Simple clean room with LAF cabinets, no viral vectors
- 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  
5 day process  
28 - 32 days after HSCT

Routinely done for bone marrow grafts and blood products supplied by blood banks
## Kiadis key expected milestones

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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</thead>
</table>
| 2017 | Submission to EMA of ATIR101 for marketing authorization approval *(done)*  
Updates on enrollment and on opening new clinical sites |
| 2018 | Marketing authorization approval ATIR101 in EU  
Initiate ATIR101 as adjunctive to PTCy/αβ T-cell depleted HSCT  
Updates on enrollment and on opening new clinical sites |
| 2019 | Commercial launch ATIR101 in EU  
(Interim) data various Phase I/II/III clinical trials ATIR101 and ATIR201 |
### Kiadis: make HSCT safer and more effective

<table>
<thead>
<tr>
<th><strong>HUIGE NEED</strong></th>
<th>• Large unmet need in blood cancers and inherited blood disorders</th>
</tr>
</thead>
</table>
| **CLOSE TO MARKET** | • Strong Phase II results, superior to literature for alternatives  
• Filed MAA with EMA April 2017 (based on Phase II), approval expected H2 2018, EU launch expected 2019  
• Phase III initiated (based on GRFS) in US/Canada/EU for FDA approval |
| **UNIQUE POSITION** | • Elegant/proprietary orphan drug, efficient manufacturing & supply chain  
• Opportunities to further improve overall survival and GRFS |
| **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 2017)
• CR-GVH-001
• CR-AIR-007
• CR-AIR-008

Literature data: Solh 2016
ATIR101: alloreactive T-cells depleted, potency retained

**Control:** no donor reactivity

**Safety:** depleted allo-reactivity

**Potency:** other reactivity retained

Functional release assay based on Quality Target Product Profile & Critical Quality Attributes
ATIR101: T-cells reactive against infections & tumor retained

Donor

ATIR

Collaboration with Prof. Angela Krackhardt, Medizinische Klinik III, Klinikum Rechts der Isar, TU Munich, Munich, Germany
ATIR101: T-cells reactive against EBV retained – examples

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)

ATIR101 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 ATIR101 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 profile¹:
• Favorable
• Intermediate  9 (39 %)
• Adverse  14 (61 %)

Disease-risk index²:
• Low risk index
• 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>

* All 3 patients immunosuppressed for GVHD, subsequently contracted infections, leading to death: 2 patients who received un-manipulated DLI’s and subsequently developed severe GVHD; 1 patient with chronic GVHD
### Phase II CR-AIR-008: study with second dose (April 2017)

| **Objective:** | Extend the length of protection (further improve TRM); investigate flexibility for physicians (instead of un-manipulated DLI) |
| **Design:** | HSCT followed with ATIR101 at day 30, and additional dose of ATIR101 at day 72 |
| **Enrollment:** | 11 out of 15 patients enrolled and treated with ATIR101: 5 patients received one dose of ATIR101 and 6 patients received two doses |
| **Results:** | Confirming safety/efficacy findings in 001/007 with a single dose, not with two doses  
- Single dose: no grade III/IV GVHD (median 137 days follow up)  
- Two doses: grade III/IV GVHD in some patients |
| **Continuation:** | Remaining 4 patients to be enrolled and treated with a single dose, according to protocol |
Comparison ATIR101 Phase II versus Solh 2016*

<table>
<thead>
<tr>
<th>Disease Risk index</th>
<th>Distribution of patients in ATIR101 (n=23)</th>
<th>Distribution of patients in Solh (PTCy/MUD/MRD, n=531)</th>
<th>1 yr GRFS** in Solh (PTCy/MUD/MRD, n=531)</th>
</tr>
</thead>
<tbody>
<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><strong>Diagnosis</strong></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>25%</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
** Survival without acute grade III/IV GVHD, chronic GVHD requiring systemic immunosuppression or relapse

Patients in Solh 2016 better prognosis than patients in ATIR Phase II
Relapse and GVHD remain risks with haploidentical PTCy

**Causes of death (MUD*)**

- Relapse: 37%
- GVHD: 19%
- Infections: 17%
- Other: 20%
- Organ Failure: 6%
- New Malignancy: 1%

Acute grade III/IV GVHD leads to death in 70% of cases

**GVHD and Relapse Free Survival (GRFS**) (MRD/MUD/HID***)**

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