AXL inhibitors as a cornerstone of combination cancer therapy

Corporate Update
April 2018
Richard Godfrey, CEO
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Corporate snapshot

Background
Leaders in developing therapeutics that target AXL, a protein that makes cancers and their environment highly aggressive and which is associated with poorer outcomes across many cancers.

Diversified pipeline. Lead drug is tested in several indications of high unmet medical need and large market potential.

Companion diagnostic supported by biomarker tests.

Bemcentinib (BGB324)
First-in-class highly selective small molecule AXL inhibitor.

Broad phase II clinical programme
Confirmed favourable safety profile
Durable responses:
- NSCLC
- AML / MDS

Pipeline
Bemcentinib
AXL antibody
AXL ADC (partnered)
Immunomodulatory small molecules
Companion Dx

Corporate
35 staff
Headquarters and research in Bergen, Norway; Clinical Trial Management in Oxford, UK

OSE:BGBIO
Raised USD 50m in IPO on OSE in April ’17
USD 270m market cap (April 5th 2018)
Management
Presenting team

Richard S. Godfrey, Chief Executive Officer
- Pharmacist / MBA – joined BerGenBio in 2008 as CEO
- 28 years industry experience, led and managed multiple international drug development and commercialization partnerships
- Previous international executive roles with Eli Lilly, Reckitt Benckiser, Catalent, DDC and SwissCaps
- Developed and launched many drugs in different classes: Adalat, Noctura, Feldene, Imodium, Pepcid, Zyprexa Zofran, Subutex

Prof. James Lorens, Founder and Chief Scientific Officer
- Professor University of Bergen Medical School
- 30 years biotech research experience, academic biomedical research positions at Stanford University and University of Bergen
- Former Director Oncology R&D, Rigel Inc. (San Francisco, CA)
- The first to recognize that Axl kinase is an essential mediator of cancer development (EMT)

Murray Yule MD, PhD, Clinical Development Officer
- MD Oncologist – joined BerGenBio in 2011
- 17 years industry experience with Roche, Eisai and Astex Pharmaceuticals
- Developed and launched several cancer drugs: Velcade, Eribulin

Rune Skeie, Chief Financial Officer
- 20 years of financial management, corporate development, corporate governance and advisory experience across multiple industry sectors. – Joined BerGenBio in 2018
- Previously Executive Director at EY and CFO of REMA Franchise Norge AS, the multinational supermarket business.
- Registered Accountant and a State Authorized Public Accountant
Advancing a broad clinical development pipeline

<table>
<thead>
<tr>
<th>Discovery Pipeline – small molecule inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BGB002/ BGB003</strong> oncology</td>
</tr>
<tr>
<td>Small molecule</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antibody programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BGB149</strong> oncology</td>
</tr>
<tr>
<td>Anti-Axl mAb</td>
</tr>
<tr>
<td><strong>BGB601</strong> metastatic cancer</td>
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<tr>
<td>ADC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discovery</th>
<th>Preclinical</th>
<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bemcentinib – AXL kinase inhibitor</strong></td>
<td></td>
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<tr>
<td>adenocarcinoma Phase II Combination with KEYTRUDA® (pembrolizumab)</td>
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<tr>
<td>NSCLC mutation driven Phase I Combination with TARCEVA® (erlotinib)</td>
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<tr>
<td>adenocarcinoma Phase I Combination with docetaxel</td>
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<tr>
<td>TNBC Phase II Combination with KEYTRUDA® (pembrolizumab)</td>
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<tr>
<td>Melanoma Phase II Combination with SoC therapies, incl. CPIs</td>
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<tr>
<td>AML / MDS Phase I Combination with docetaxel</td>
<td></td>
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</tr>
</tbody>
</table>

**Patients:** >350

**Sites in Europe and North America:** 50

**Key read-outs:** 2018

(1): Clinical trial collaboration, no preferential rights (2): outlicensed
Bemcentinib Phase II clinical trials
AXL inhibition as a cornerstone for cancer therapy

- BGBC008: NSCLC
- BGBC007: TNBC
- BGBIL006: Melanoma
- BGBIL004: NSCLC
- BGBIL005: NSCLC
- BGBIL003: AML
- BGBC003: AML/MDS

+ checkpoint inhibitors  
+ targeted therapy  
+ chemotherapy  
monotherapy

Bemcentinib foundation therapy
**Aggressive cancers**

Strong AXL expression correlates with poor survival rate

- **Breast carcinoma**
  - AXL expression log rank test, P=0.035
- **Lung adenocarcinoma (NSCLC)**
  - X: AXL IHC low (n=59)
  - P <0.001
  - X: AXL IHC high (n=29)
- **Acute Myeloid Leukaemia**
  - X: AXL < median
  - X: AXL > median
- **Pancreatic ductal adenocarcinoma**
  - X: AXL IHC low (n=16)
  - P=0.02
  - X: AXL IHC high (n=38)

Broad evidence of AXL linked with poor prognosis

- **Astrocytic brain tumors**
- **Breast cancer**
- **Gallbladder cancer**
- **GI**
  - Colon cancer
  - Esophageal cancer
  - Gastric cancer
- **Gynaecological**
  - Ovarian cancer
  - Uterine cancer
- **HCC**
- **HNC**
- **Haematological**
  - AML
  - CLL
  - CML

**Additional notes:**

- **Melanoma**
- **Mesothelioma**
- **NSCLC**
- **Pancreatic cancer**
- **Sarcomas**
  - Ewing Sarcoma
  - Kaposi sarcoma
  - Liposarcoma
  - Osteosarcoma
- **Skin SCC**
- **Thyroid cancer**
- **Urological**
  - Bladder cancer
  - Prostate cancer
  - RCC

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1 Gjerdrum, 2010; 2 Ishikawa, 2012; 3 Ben-Battala, 2013; 4 Song, 2010, 5 supported by > 100 publications
AXL drives majority of aggressive cancers

Most common tumours express high AXL levels

<table>
<thead>
<tr>
<th>Tumour</th>
<th>New incidences in 2017 (U.S.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>222,500</td>
</tr>
<tr>
<td>Breast</td>
<td>255,180</td>
</tr>
<tr>
<td>AML</td>
<td>21,380</td>
</tr>
<tr>
<td>Melanoma</td>
<td>87,110</td>
</tr>
<tr>
<td>Prostate</td>
<td>161,360</td>
</tr>
<tr>
<td>Colon</td>
<td>95,520</td>
</tr>
<tr>
<td>Renal cancer</td>
<td>63,990</td>
</tr>
<tr>
<td>Head &amp; neck</td>
<td>61,760</td>
</tr>
<tr>
<td>Thyroid</td>
<td>56,870</td>
</tr>
<tr>
<td>Pancreatic</td>
<td>53,670</td>
</tr>
<tr>
<td>Ovarian</td>
<td>22,440</td>
</tr>
<tr>
<td>CML</td>
<td>8,950</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% AXL positive vs AXL negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  20  40  60  80  100</td>
</tr>
</tbody>
</table>

AXL low = Higher survival; AXL high = Poor survival

Companion diagnostic in development to identify AXL positive patients

AXL on tumour tissue

AXL on tumour adjacent immune cells
Bemcentinib, a selective AXL inhibitor, is intended to restore sensitivity to immune cell attack and therapy and prevent spread
Bemcentinib, first in class highly selective AXL inhibitor

Most advanced selective, orally bioavailable, small molecule AXL kinase inhibitor in phase II clinical development

26kg API manufactured
Size 0 100mg HPMC capsules
3 years stability confirmed
Strong patent position

Once daily dosing
Well tolerated
Safely combined with chemo, targeted and IO drugs

IC$_{50}$ = 14 nM
50-100 fold selective cf. TAM kinases
Axl inhibitors - competitive landscape

- BerGenBio
- Daiichi-Sankyo
- BGB149
- aravive
- Genmab

- IND / Phase I
- Phase II
- Phase III
- Approved
Pre-clinical data guides bemcentinib’s broad clinical utility

AXL inhibition as a cornerstone of therapy in NSCLC

BGBC004, BGBIL005, BGBC008
Potential for bemcentinib to become a cornerstone therapy for NSCLC

- Lung cancer is the most frequent cause of cancer-related death in developed countries
- More than 220,000 new cases of lung cancer will be diagnosed in the US in 2018 - 65% of NSCLCs are adenocarcinoma
- Existing treatments curtailed by acquired resistance to therapy
- Strategy to position bemcentinib as a cornerstone of treatment for NSCLC by combining with standard of care therapies
The BGBC004 trial is designed to test the hypothesis whether AXL inhibition can

- **Reverse** and / or
- **Prevent** resistance to EGFRm targeted therapies

when given in combination with erlotinib in EGFRm NSCLC patients who have either progressed on or have just started EGFRm targeted therapy.
BGBC004: Phase Ib/II trial in NSCLC of bemcentinib with TARCEVA® (erlotinib)

Stage IIIb or IV disease EGFR mutation positive

33 enrolled as of March 15th 2018

**Phase Ib**
- Arm A1: bemcentinib safety as monotherapy
- Arm A2: Dose finding in combination

**Phase II**
- Arm B: 2nd line
  - Resistance reversal
  - bemcentinib 200mg daily + erlotinib daily

**Phase II**
- Arm C: 1st line
  - Resistance prevention
  - bemcentinib 200mg daily + erlotinib daily

Dose escalation (completed) & expansion (ongoing)

**Expected readout**
- Safety
- Efficacy, PK, biomarkers

Read-out expected 2H 2018

Source: NCT02424617
BGBC004 arm A1: Phase Ib trial in NSCLC of bemcentinib as monotherapy – safety as single agent

**Part A1 patient population**

- All comor patient population
- Median 5 lines (2 – 10) prior therapy
- 6 pts stage IV, 2 pts stage IIIB
- Average age: 65 (58-77)

**Outcome:**
- Safety: Very well tolerated
- RP2D bemcentinib: 200 mg/d
- 2/8 patients with durable benefit

**Duration of treatment (months)**

- MR: minor response (19% shrinkage)

Source: Byers et al World Conference on Lung Cancer
BGB04 arm A2: Phase Ib trial in NSCLC of bemcentinib with TARCEVA (erlotinib)

- Full dose bemcentinib (200 mg daily) was well tolerated with 150 mg erlotinib
- Median # prior therapies: 1 (1-3)

Source: Byers et al World Conference on Lung Cancer
BGBC004: Phase II arm B, erlotinib resistance reversal

- **Arm B patient population**
  - Progressed on 1st line approved EGFR TKI therapy (erlotinib, afatinib, gefitinib)
  - Median 3 lines (2 – 12) prior therapy
  - Typical EGFRm population
    - 5 of 9 pts are Asian, 6 females

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### No targeted therapy available for 2nd line T790M negative patients*

- T790M Negative
- No targeted therapy
- T790M Positive
- Osimertinib

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### Duration of treatment (weeks)

- PR
- SD

- T790M negative patients
- T790 positive patients

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* Astra Zeneca press release Sep 8th 2017: »Tagrisso shows potential as a new standard of care in 1st-line EGFR-mutated lung cancer at ESMO 2017 Congress*
Phase II (arm B & C): Designed to evaluate the potential of bemcentinib to reverse and prevent acquired resistance to EGFR targeted therapy:

Arm B successfully completed first stage

Arm B
Resistance reversal
NSCLC pts who progressed on prior approved EGFR TKI

Initial EGFR targeted therapy

Emergence of EGFRi resistance

AXL inhibition + erlotinib

First efficacy endpoint met: 1PR + 2SD

Arm C
Resistance prevention
NSCLC pts who are stable on erlotinib monotherapy

Initial EGFR targeted therapy (erlotinib)

AXL inhibition + erlotinib

Ongoing & recruiting: 1 PR reported to date

Time to progression

10.2 months*

Emergence of EGFRi resistance?

* FLAURA trial comparator arm, SoC erlotinib or gefitinib
The BGBIL005 trial is designed to test the hypothesis whether AXL inhibition can

- Enhance responses to chemotherapy

when given in combination with docetaxel in previously treated (last line) NSCLC patients.
Docetaxel is last line treatment option in heavily pre-treated NSCLC patients
(85,000* NSCLC patients receive docetaxel in later line therapy)

Published results in previously treated NSCLC with docetaxel ORR 0% - 14%

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>ORR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single agent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CheckMate 057: Borghaei et al(^1) 582 patients randomised Pt chemo failures</td>
<td>Nivolumab vs Docetaxel</td>
<td>19%  12%</td>
</tr>
<tr>
<td>OAK trial: Marinis et al(^2) 850 patients randomised Pt chemo failures</td>
<td>Atezo vs Docetaxel</td>
<td>14%  14%</td>
</tr>
<tr>
<td><strong>KEYNOTE 010(^3) ≥ 1% PDL1</strong></td>
<td>Pembro Docetaxel</td>
<td>19%  9%</td>
</tr>
<tr>
<td><strong>Combination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levy et al(^4) 95 patients randomised</td>
<td>Docetaxel + PX-866 (PI3K inhibitor) vs Docetaxel alone</td>
<td>6%   0%</td>
</tr>
<tr>
<td>Ramlau et al(^5) 913 patients randomised</td>
<td>Docetaxel + Aflibercept (anti-VEGF) vs Docetaxel alone</td>
<td>23%  9%</td>
</tr>
</tbody>
</table>

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* company estimates – 7MM
BGBIL005: Phase I/II trial in NSCLC, bemcentinib with docetaxel – ongoing

**Sponsor Investigator: Dr David Gerber, UTSW Dallas**

“The vast majority of my lung cancer patients progress onto chemotherapy, combining this with bemcentinib may significantly improve the performance of the chemo and could lead to meaningful disease modification in some patients.”

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**Source:** NCT02424617
BGBIL005: Phase I/II trial in NSCLC, bemcentinib with docetaxel – ongoing

Duration of treatment (days)

- PR: Partial response
- SD: Stable disease

Heavily pre-treated patient population:
- All failed at least 1 line of chemo
- Most received prior immunotherapy without sustained benefit
- Most patients are metastatic, no more treatment options remain
- 2 out of 6 had response + 2 SD

**Status December 2017**

Duration of treatment:
- 75 mg/m² docetaxel + 100 mg bemcentinib
- 60 mg/m² docetaxel + 100 mg bemcentinib
AXL inhibition as a cornerstone of therapy in combination with Immune Oncology (checkpoint inhibitors)

BGBC008, BGBC007, BGBIL006
Combination with bemcentinib to increase efficacy of anti-PD1 therapy

- A significant proportion of patients do not respond to checkpoint inhibitor therapy
- Non-responders to checkpoint therapy have been shown to express AXL at higher rates
- Inhibiting AXL may increase the number of patients responding to checkpoint therapy
- Comprehensive biomarker programme analysing AXL, PD-L1 and immune signature

**Source:** Gay et al, British Journal of Cancer (2017)
Favourable safety and tolerability reported for bemcentinib/KEYTRUDA combo across three indications
Nature of SAE profile of combination similar to KEYTRUDA alone

<table>
<thead>
<tr>
<th>SOC</th>
<th>TNBC NCT03184558</th>
<th>NSCLC NCT03184571</th>
<th>Melanoma* NCT02872259</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin and subcutaneous tissue disorders</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>General disorders and administration site conditions</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Investigations</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Blood and lymphatic system disorders</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cardiac disorders</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hepatobiliary disorders</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory, thoracic and mediastinal disorders</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Combo well tolerated over extended periods:
Ongoing treatment durations of over 6 months on KEYTRUDA / bemcentinib combo reported at World Melanoma (Oct 2017)

Source: Yule et al ASCO-SITC Clinical IO Symposium (January 2018)
* Investigator led study
BGBC008 trial in NSCLC

KEYTRUDA monotherapy showed 18% response rate in previously treated NSCLC patients. PD-L1 negative patients remain particularly challenging.

The BGBC008 trial is designed to test the hypothesis whether AXL inhibition can

- Enhance responses to immunotherapy

when given in combination with pembrolizumab in previously treated, immunotherapy-naïve NSCLC patients.

Clinical collaboration with Merck & Co. (MSD)
**BGBC008: Phase II trial in NSCLC of bemcentinib in combination with KEYTRUDA**

<table>
<thead>
<tr>
<th>NSCLC Adenocarcinoma of the lung</th>
<th>Simon two stage (interim after 22 pts)</th>
<th>Expected readout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously treated, unresectable adenocarcinoma of the lung</td>
<td>Single arm</td>
<td>Initial read-out expected 2H 2018</td>
</tr>
<tr>
<td>up to 48 pts any PD-L1 expression any AXL expression no prior IO</td>
<td>bemcentinib 200mg/d KEYTRUDA 200mg/3w</td>
<td>ORR</td>
</tr>
<tr>
<td></td>
<td>Safety, DoR, TtP, OS at 12 mo, response by biomarker expression</td>
<td></td>
</tr>
</tbody>
</table>
KEYTRUDA monotherapy showed 4% response rate in previously treated TNBC patients.

The BGBC007 trial is designed to test the hypothesis whether AXL inhibition with bemcentinib can enhance responses to immunotherapy when given in combination with pembrolizumab in previously treated, immunotherapy-naïve TNBC patients.

Clinical collaboration with Merck & Co. (MSD)
BGBC007: Phase II trial in TNBC of bemcentinib in combination with KEYTRUDA

<table>
<thead>
<tr>
<th>Metastatic TNBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously treated, unresectable or metastatic TNBC</td>
</tr>
<tr>
<td>up to 56 pts any PD-L1 expression any AXL expression no prior IO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Simon two stage (interim after 28 pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single arm</td>
</tr>
<tr>
<td>bemcentinib 200mg/d</td>
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<tr>
<td>KEYTRUDA 200mg/3w</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expected readout</th>
</tr>
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<tbody>
<tr>
<td>ORR</td>
</tr>
<tr>
<td>Safety, DoR, TtP, OS at 12 mo, response by biomarker expression</td>
</tr>
</tbody>
</table>

| Initial read-out expected 2H 2018 |
BGBIL006 trial in melanoma

Although responses to TKIs are rapid, resistance ultimately emerges. Monotherapy checkpoint inhibitor responses can be further improved.

The BGBIL006 trial is designed to test the hypothesis whether AXL inhibition can

- **Enhance** responses to immunotherapy
- **Enhance** responses to targeted therapy

when given in combination with pembrolizumab or dabrafenib/trametinib in treatment naïve melanoma patients
BGBIL006: Randomised Phase II trial of bemcentinib in combination with targeted and I/O therapies in Melanoma

Melanoma, randomised SoC (KEYTRUDA or BRAF/MEKi) +/- bemcentinib

<table>
<thead>
<tr>
<th>First Line</th>
<th>Second Line</th>
<th>Endpoints</th>
<th>Expected readout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment naïve, BRAF mutant (high tumour burden)</td>
<td>Dabrafenib+ trametinib +/- bemcentinib 200mg/d</td>
<td>Dabrafenib+ trametinib +/- bemcentinib 200mg/d</td>
<td>ORR</td>
</tr>
<tr>
<td>up to 40 pts BRAF mutation driven any AXL expression</td>
<td>BRAFm pts only</td>
<td>Safety, DoR, TiP, OS at 12 mo, response by biomarker expression</td>
<td></td>
</tr>
<tr>
<td>Treatment naïve, BRAF mutant (low tumour burden), BRAF-</td>
<td>KEYTRUDA 200mg/3w +/- bemcentinib 200mg/d</td>
<td>KEYTRUDA 200mg/3w +/- bemcentinib 200mg/d</td>
<td></td>
</tr>
<tr>
<td>up to 40 pts any AXL expression any PD-L1 expression</td>
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</tbody>
</table>

Source: Straume et al World Conference on Melanoma (October 2017)
AML and high-risk MDS patients unfit for high intensity chemotherapy remain a very challenging patient population with no treatment options when driver mutations are absent.

The BGBC003 trial is designed to test the hypothesis whether AXL inhibition with bemcentinib can:

- Elicit *single agent* effect and/or
- Enhance responses to low dose chemotherapy

when given as a single agent in relapsed/refractory AML and high risk MDS or in combination with azacitidine or decitabine in treatment naïve AML patients.
R/R AML patients have no approved treatment options
Experimental agents report ORR 0-11%

Clinical trial data for R/R AML patients from ASH December 2017

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>ORR</th>
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<tbody>
<tr>
<td><strong>Single agent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pratz <em>et al</em></td>
<td>TAK-659 investigational FLT-3 and SYK inhibitor</td>
<td>9%</td>
</tr>
<tr>
<td>31 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daver <em>et al</em></td>
<td>FLX925 Dual FLT3 and CDK4/6</td>
<td>0%</td>
</tr>
<tr>
<td>51 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dawson <em>et al</em></td>
<td>GSK525762 BET inhibitor</td>
<td>11%</td>
</tr>
<tr>
<td>46 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DiNardo <em>et al</em></td>
<td>Ivosidenib (AG-120) mutant IDH1 (mIDH1) inhibitor</td>
<td>30%</td>
</tr>
<tr>
<td>258 patients – selected for mIDH1 mutation</td>
<td></td>
<td></td>
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<tr>
<td><strong>Combination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goldberg <em>et al</em></td>
<td>Venetoclax* + hypomethylating agent (HMA) or low dose cytarabine (LDAC)</td>
<td>28%</td>
</tr>
<tr>
<td>24 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rausch <em>et al</em></td>
<td>Venetoclax + HMA or LDAC</td>
<td>22%</td>
</tr>
<tr>
<td>27 patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Venetoclax + LDAC received breakthrough designation in 1st line AML (July 2017)

(1) ASH 2017 abstract 2622 (2) ASH 2017 abstract 1353 (3) ASH 2017 abstract 1356 (4) ASH 2017 abstract 1343 (5) ASH 2017 abstract 725 (6) ASH 2017 abstract 1377
### BGB003: Phase Ib/II trial in AML & MDS

**AML/high risk MDS as monotherapy and in combination with decitabine or azacitidine**

<table>
<thead>
<tr>
<th>Dose escalation (completed)</th>
<th>Expected readout</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd line monotherapy</td>
<td></td>
</tr>
<tr>
<td>1st line combo</td>
<td></td>
</tr>
<tr>
<td>bemcentinib +</td>
<td></td>
</tr>
<tr>
<td>decitabine / azacitidine</td>
<td></td>
</tr>
<tr>
<td>Safety &amp; efficacy</td>
<td></td>
</tr>
<tr>
<td>PK, biomarkers</td>
<td>Initial read-out expected 2H 2018</td>
</tr>
<tr>
<td>2nd line monotherapy</td>
<td></td>
</tr>
</tbody>
</table>

**Relapsed/refractory AML & high-risk MDS**

- up to 75 pts

**Source:** NCT02424617

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Source: NCT02424617
Bemcentinib single agent reported 19% ORR in R/R AML & high risk MDS patients

19% Response Rate

- (CRi + PR)
  - 2 CRi
  - 5 PRs

Correlation with predictive biomarker candidates
- Proprietary predictive and PD biomarkers identified

Well tolerated

Early efficacy and favourable safety

- Time of first response. * patients with MDS

Status: Jan 2017, ASCO-SITC
Companion diagnostic immunohistochemistry (IHC) method developed and validated

AXL can be detected in patient tumour and immune cells

- AXL expression in NSCLC patient tumour sample
- AXL expression in tumour adjacent alveolar macrophages

IHC assays:
- Widely used diagnostic method
- Standard for PD-1 directed and other targeted therapies
- Provide spatial information

Shown are squamous cell carcinoma FFPE patient samples stained for AXL (brown) as per BerGenBio’s proprietary AXL IHC assay

Source: Yule et al ASCO-SITC Clinical IO Symposium (January 2018)
Bemcentinib recently reported Proof of Concept Phase II data

- **BGBC008**: NSCLC
- **BGBC007**: TNBC
- **BGBIL006**: Melanoma

**Silencing of CDK7 in various cancer types**

- **BGBC004**: NSCLC
- **BGBC003**: AML
- **BGBIL005**: NSCLC
- **BGBIL006**: Melanoma
- **BGBIL005**: NSCLC
- **BGBIL003**: AML/MD

**Therapy Approaches**

- + checkpoint inhibitors
- + targeted therapy
- + chemotherapy

**Bemcentinib foundation therapy**
BGB149: First-in-class AXL functionally blocking antibody

- IgG1 fully humanised
- GMP manufacturing complete
- GLP tox ongoing
- FiM H2 2018

Highly selective to human AXL
High affinity ($K_D$: 500pM)

Patent position on CDR sequences

Opportunities in oncology and non-oncology

Potent anti-tumour effect in vivo (AML)$^1$

Enhances effect of erbitux in vivo (NSCLC)$^2$

(1) MV4-11 Nude model; in house data (2) A549 Nude model; in house data
AXL inhibition as a potential therapy in fibrotic diseases

Idiopathic Pulmonary Fibrosis

Serum AXL elevated in Idiopathic Pulmonary Fibrosis, selective AXL inhibition superior to SoC in vivo¹

Non Alcoholic Steatohepatitis (NASH)

Serum AXL elevated in NASH, selective AXL inhibition active in vivo²

HFCD = high-fat, choline deficient diet
Leads to NASH in animal models

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¹ Espindola, 2018 (1) Barcena EASL 2018
² (2)
Significant milestones expected in 2018 & 2019

Significant milestones expected over the next 12 months:

- **Interim clinical data** from 6 phase II trials H1’18
- **Final readout** from 4 phase 2 trials in H2
- **Initiation of AXL antibody BGB149 clinical trials in H2**

NB: Progression of ongoing and start-up of new clinical trials are subject to customary regulatory reviews and approvals
Key financials (Q4 / YE 2017)

Key Figures (NOK million) | Q4 2017 | Q4 2016 | FY2017 | FY2016
--- | --- | --- | --- | ---
Operating revenues | - | - | - | -
Operating expenses | 47.5 | 28.0 | 183.7 | 131.6
Operating profit (loss) | -47.5 | -28.0 | -183.7 | -131.6
Profit (loss) after tax | -47.6 | -27.9 | -182.2 | -129.8
Basic and diluted earnings (loss) per share (NOK) | -0.96 | -82.81 | -4.01 | -419.68
Net cash flow in the period | -28.8 | -25.4 | 208.5 | 87.8
Cash position end of period | 370.3 | 161.8 | 370.3 | 161.8

- OPEX sequentially increased as recruitment to our clinical studies is ramping up which triggers milestone payments
- Net cash flow is NOK 18.8 million below operating loss due to non dilutive cash grants and favourable working capital development
- Robust cash position gives runway to deliver key clinical read outs on our ongoing clinical studies.

http://www.bergenbio.com/investors/reports/quarterly-reports/
Thank you.

For further information please visit www.bergenbio.com

Developing first-in-class Axl inhibitors to treat aggressive cancer