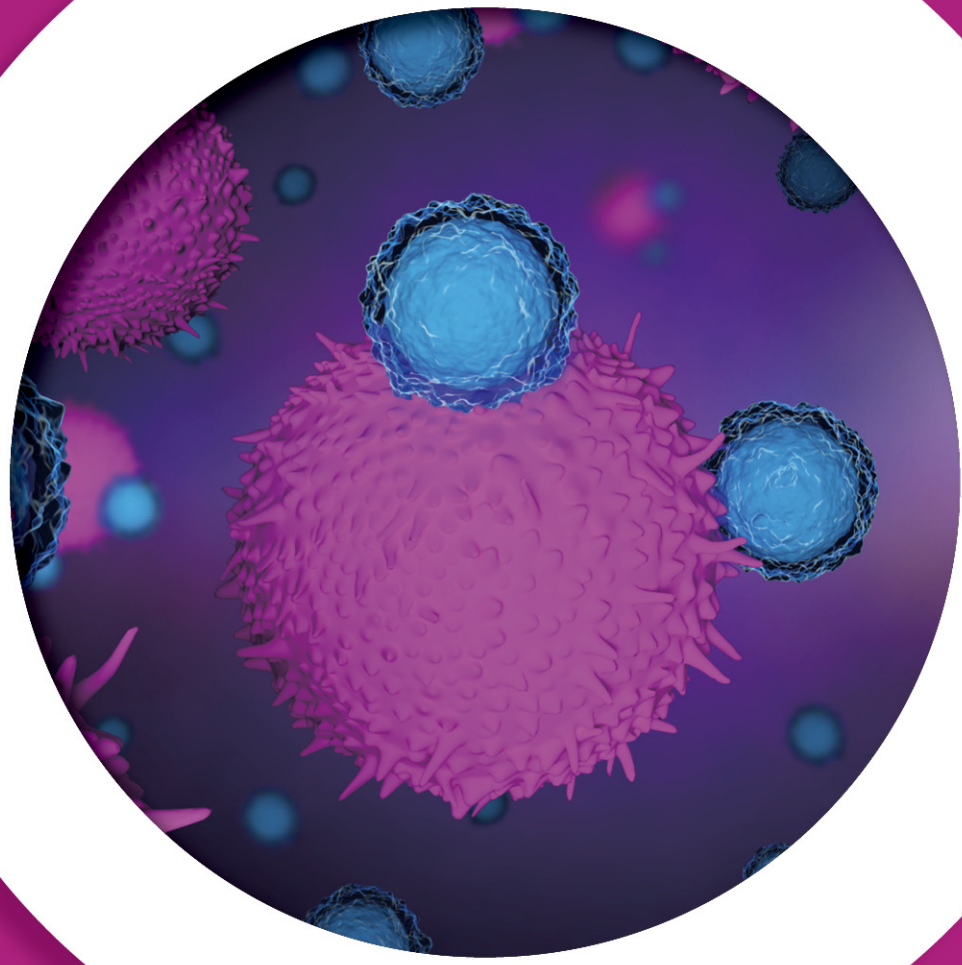
INVESTOR RELATIONS 2021

NeoImmuneTech

Expanding the Horizon of Immuno-Oncology and Enhancing Immunity to Infectious Diseases



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Poster Presentation at 2021 ASCO ANNUAL MEETING

1. **NIT-107 (IIT) -** *CR-7 Program (Combo with Chemoradiotherapy)*
   - Phase 1 (Dose Escalation) part
   - Newly diagnosed high grade gliomas
   - Combo therapy: Concurrent treatment of chemoradiation + NT-I7

2. **NIT-110 (SIT)** - *Check-7 Program (Combo with Checkpoint inhibitor)*
   - Phase 1b (Dose Escalation) part
   - Relapsed/refractory advanced solid tumors
   - Combo therapy: Checkpoint inhibitor(Pembrolizumab) + NT-I7

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01 Background of Study

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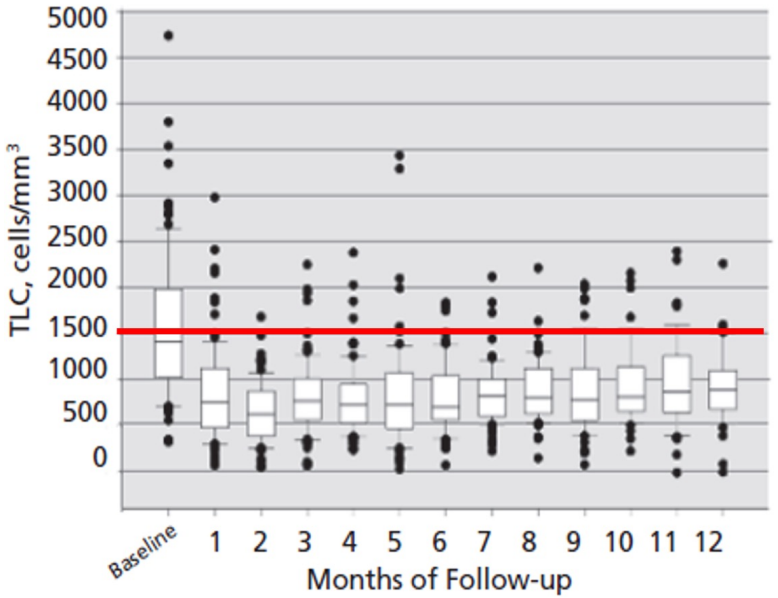
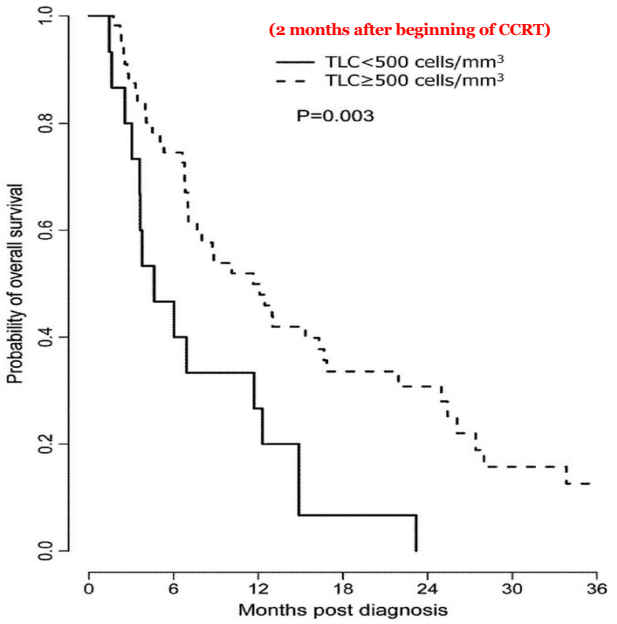
Survival of HGG Patients is strongly correlated with TLC levels. The higher TLC levels are, the higher survival rates are.

- High grade glioma (HGG) patients tend to have chronic lymphopenia after CCRT
- TLC (Total Lymphocyte Count) deficiency noted for 1 year



J Natl Compr Cancer Network 2015;13:1225-1231

- Survival of HGG patients, highly correlated with TLC levels
- After 2 months of treatment with combo therapy, patients with low TLC tend to have low survival rates



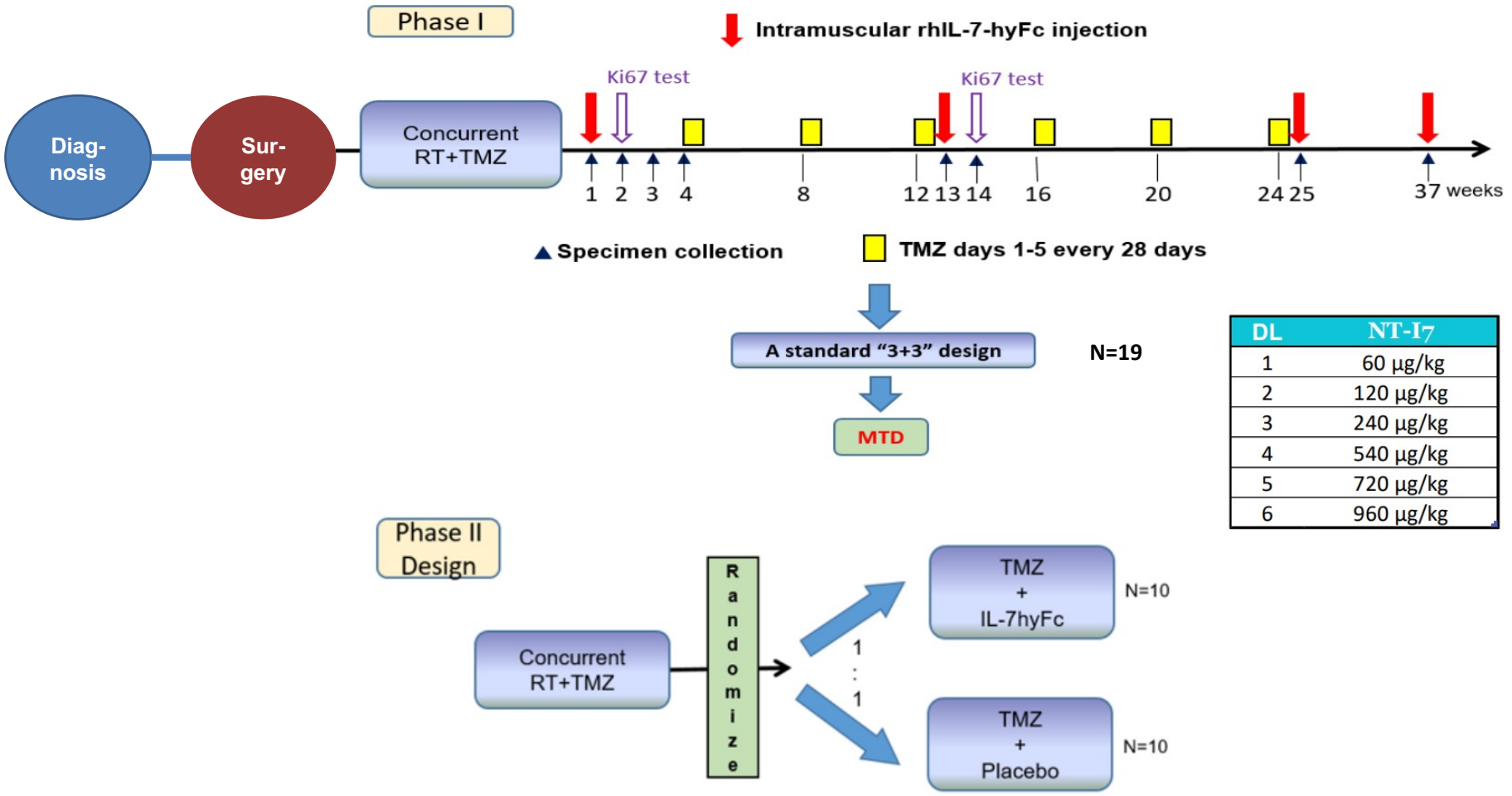
J Neurooncol. 2016 Apr;127(2):329-35.

Study Hypothesis

1. Can NT-I7 amplify T cells that were lowered after CCRT (Concurrent chemoradiotherapy)?

2. Can NT-I7 contribute to improved survival of patients with HGG (High Grade Glioma)?

Study Schema



DL	NT-I7
1	60 μg/kg
2	120 μg/kg
3	240 μg/kg
4	540 μg/kg
5	720 μg/kg
6	960 μg/kg

04 Dose dependent increase of lymphocyte

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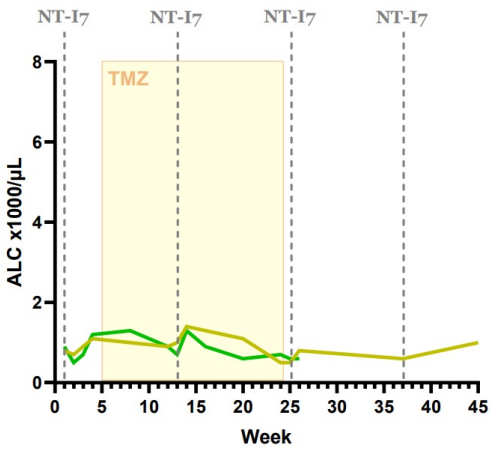
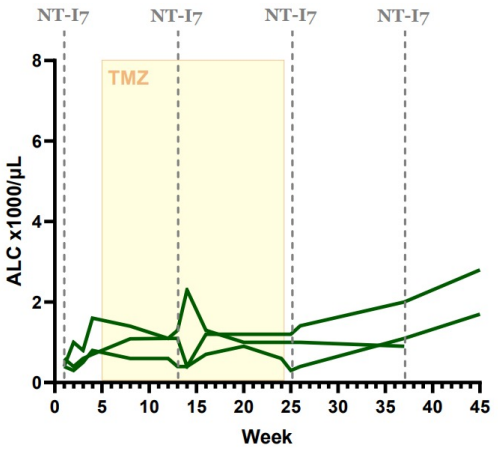
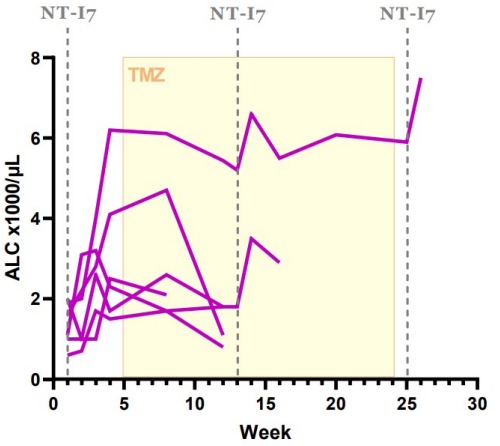
60ug/kg, 120ug/kg



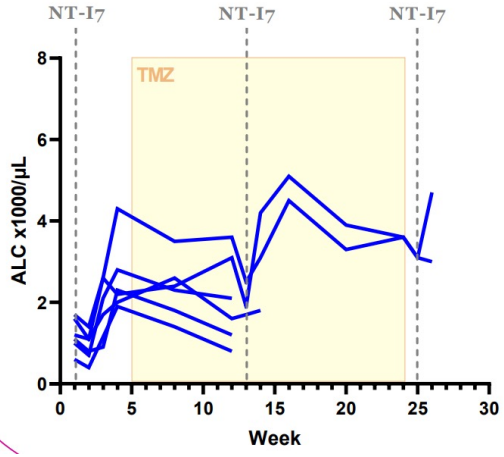
240ug/kg



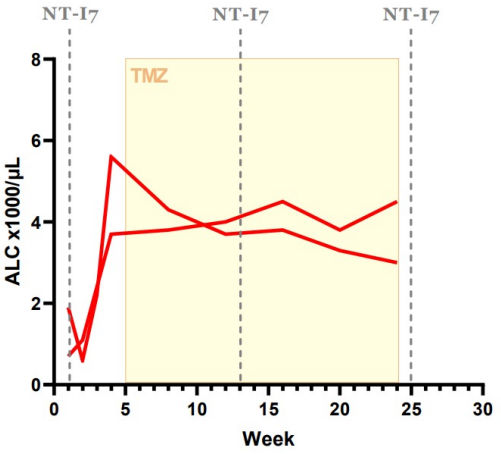
540ug/kg



720ug/kg



960ug/kg



- ALC(Absolute Lymphocyte Count) increased in all patients
- Higher than 2,000/μl increase observed from 540μg/kg

05 Functionality of newly produced T cells

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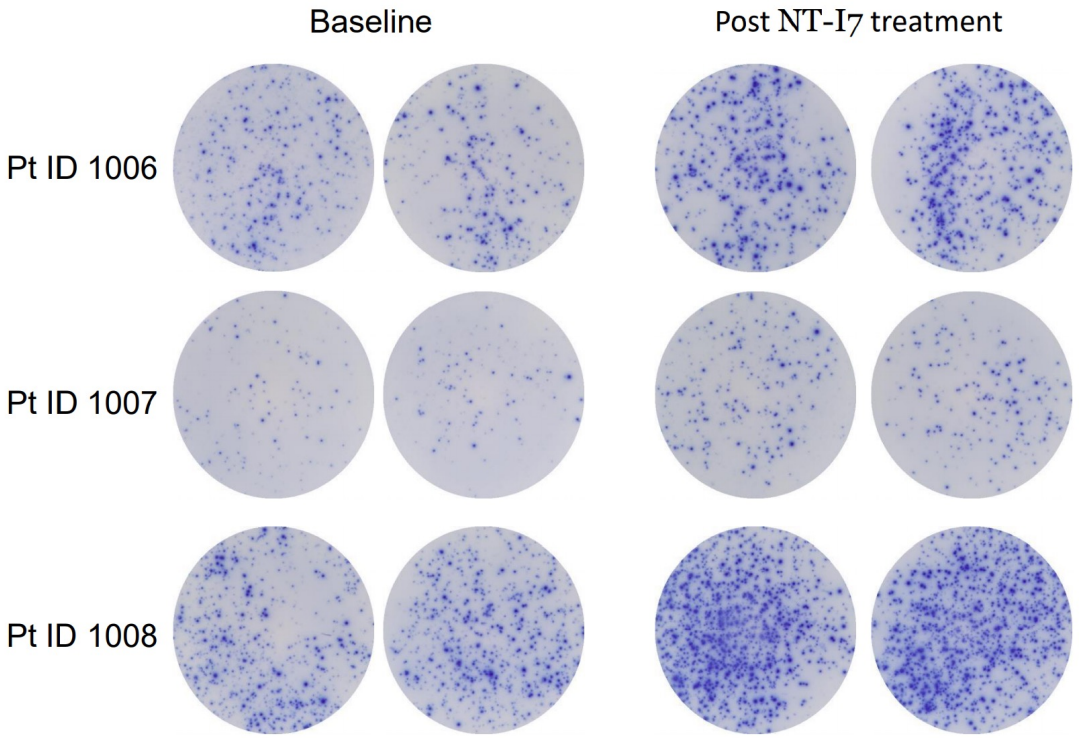
T cell functionality



- Evaluation of new T cells post NT-I7 injection
  - IFN-γ measured (as indication of T cell production)

- **# of spots before/after treatment**

→ Functioning T cell numbers increased

Adverse Event	60 μg/kg n=1 (%)		120 μg/kg n=1 (%)		240 μg/kg n=3 (%)		540 μg/kg n=6 (%)		720 μg/kg n=6 (%)		960 μg/kg n=2 (%)	
	Any grade	≥Grade 3	Any grade	≥Grade 3	Any grade	≥Grade 3	Any grade	≥Grade 3	Any grade	≥Grade 3	Any grade	≥Grade 3
Injection site reaction	1 (100)	0	1 (100)	0	1 (33)	0	2 (33)	0	1 (17)	0	2 (100)	0
Pyrexia	0 (0)	0	0	0	0	0	1 (17)	0	0	0	1 (50)	0
Flu like symptoms	0	0	0	0	0	0	2 (33)	0	2 (33)	0	1 (50)	0
Rash	1 (100)	0	0	0	0	0	0	0	0	0	2 (100)	0
Fatigue	0	0	0	0	1 (33)	0	1 (17)	0	0	0	2 (100)	0
ALT increased	0	0	0	0	0	0	2 (33)	0	0	0	1 (50)	1 (50)*
AST increased	0	0	0	0	0	0	2 (33)	0	0	0	0	0
Nausea	0	0	1 (100)	0	0	0	1 (17)	0	1 (17)	0	1 (50)	0
Muscle weakness	0	0	0	0	0	0	1 (17)	1 (17)	2 (33)	0	1 (50)	0
Back pain	0	0	0	0	0	0	0	0	0	0	0	1 (50)*

*** DLTs noted in 960 μg/kg dose level. Thus 720 μg/kg is selected as the phase 2 dose.**

- Safety and tolerability was confirmed without serious AE. RP2D was decided at 720μg/kg
- ALT increase was tentative response and not serious, Back muscle pain is subjective and not serious AE as well
- Rationale for RP2D: Instead of additional recruiting of patients at 960μg/kg and have RP2D upgrade to 960μg/kg, for faster and effective Ph2 initiation, RP2D was decided to be 720μg/kg

07 Analysis on Patients

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Pt. ID	NT-I7 Dose (μg/kg)	Age	Sex	Diagnosis	MGMT	IDH
1	60	58	M	GBM	Methylated	WT
2	120	32	M	GBM	Un-Methylated	WT
3	240	45	M	AO	Unknown	Mutated
4	240	46	M	GBM	Un-Methylated	WT
5	240	67	M	GBM	Methylated	WT
6	540	63	M	AO	Unknown	Mutated
7	540	67	M	GBM	Un-Methylated	WT
8	540	65	M	GBM	Un-Methylated	WT
9	540	40	F	GBM	Un-Methylated	WT
10	540	64	M	GBM	Un-Methylated	WT
11	540	25	M	GBM	Un-Methylated	WT
12	720	30	M	GBM	Un-Methylated	WT
13	720	58	F	GBM	Un-Methylated	WT
14	720	58	F	GBM	Un-Methylated	WT
15	720	58	M	GBM	Methylated	WT
16	720	78	F	GBM	Methylated	WT
17	720	66	M	GBM	Un-Methylated	WT
18	960	30	M	GBM	Methylated	Mutated
19	960	38	F	GBM	Un-Methylated	WT
	Median (Range)	**58 (25-78)**				

1. Diagnosis

- GBM: Glioblastoma multiforme (Negative Prognosis)
- AO: Anaplastic oligodendroglioma (Relatively good prognosis)

2. MGMT: O6-methylguanine-DNA methyl-transferase (Enzyme)

- Un-Methylated shows worse prognosis
- Of GBM pts, un-methylated is 71% (12/17 pts)

3. IDH: Isocitrate Dehydrogenase(Enzyme)

- Wild type shows worse prognosis
- Of GBM pts, WT is 94% (16/17 pts)

08 Survival ratio over 1 year: higher by 3-fold than SoC

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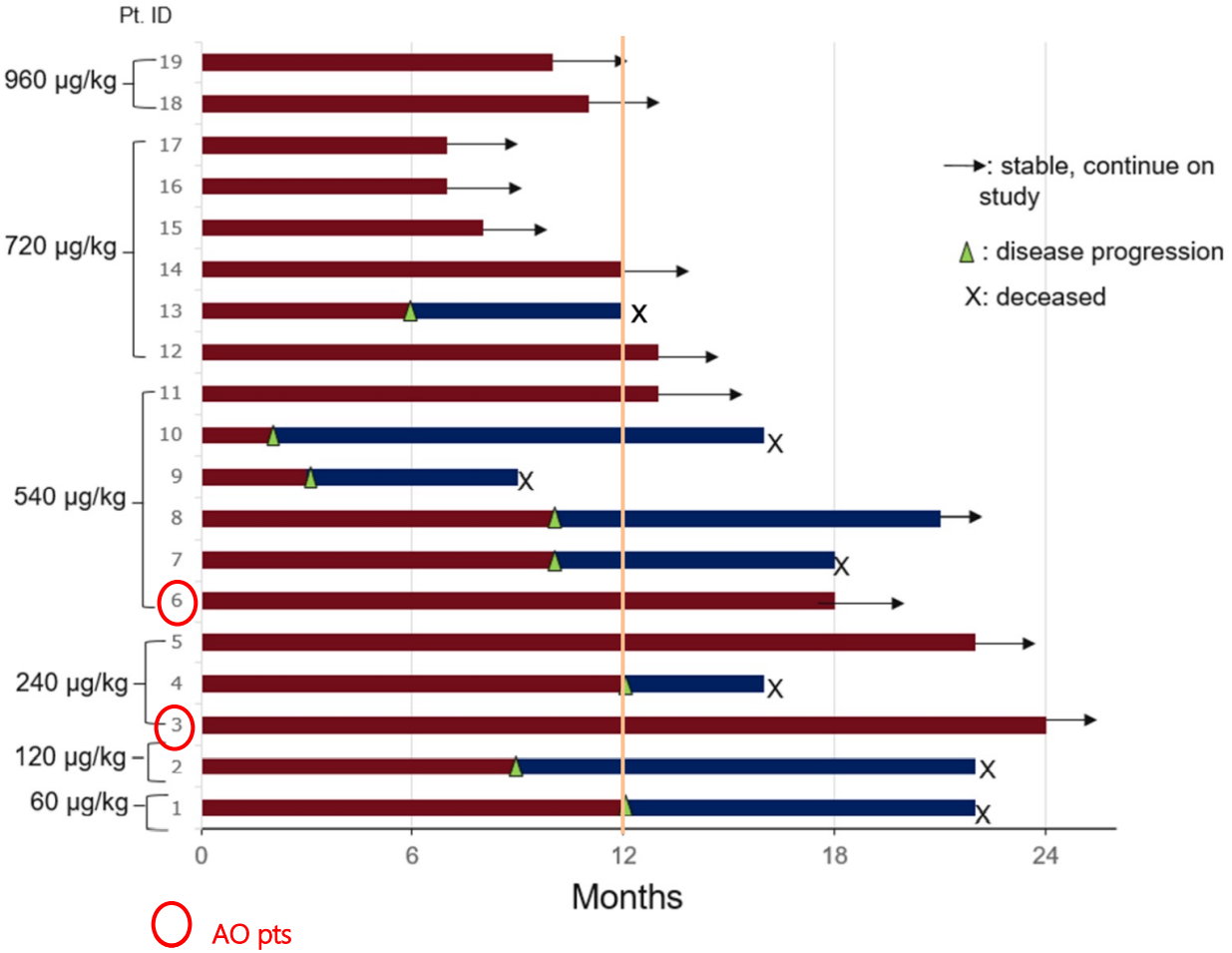


1. Pts with over 1 year data :14
   > GBM pts: 12 (a)
   > Of GBM pts, survival over 1 yr :10(b)

2. Survival Comparison (As-is)
- NIT-107 (b/a) → 83.3%
- GBM Standard of Care * → 25%

➔ Phase 1 data shows survival ratio over 1 yr is higher than that of standard of care by 3-fold

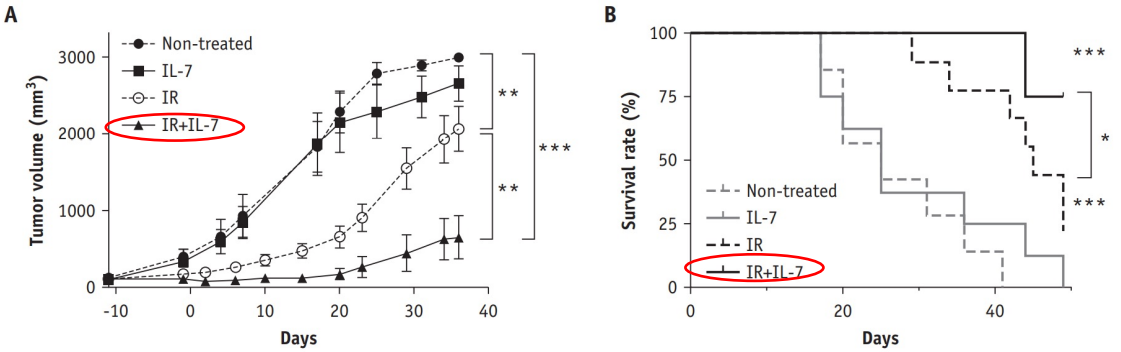
* https://www.braintumourresearch.org/info-support/types-of-brain-tumour/glioblastoma-multiforme

* CCRT followed by adjuvant TMZ

CR-7 Program: Pre-clinical Study

With CCRT + NT-I7, cancer size is reduced, and survival is improved.

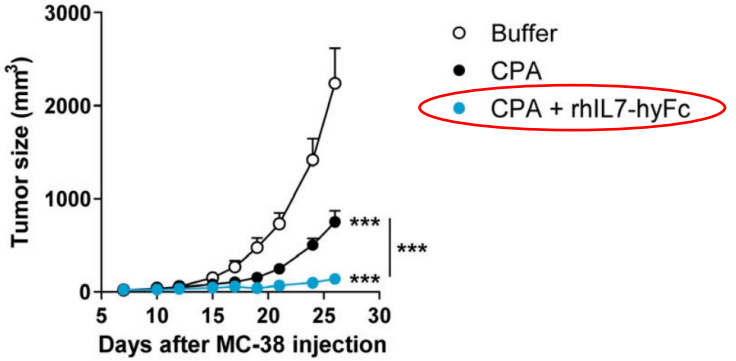
Radiation + NT-I7



- Combo Therapy:
IL-7; NT-I7 (GX-I7) + IR (Irradiation)

International J. of Radiation Oncology, 2020
(POSTEC)

Chemotherapy + NT-I7



- Combo Therapy:
rhIL-7-hyFc; NT-I7 (GX-I7) + CPA (Cyclophosphamide)

Clinical & Translational Immunology, 2020
(POSTEC)

Results

1. Can NT-I7 amplify T cells that were lowered after CCRT (Concurrent chemoradiotherapy)? YES

   - Functioning T cells were amplified.

2. Can NT-I7 contribute to improved survival of patients with HGG (High Grade Glioma)? YES

   - The Ph1 data cut showed the survival ratio over 1 year is higher than that of standard of care by 3-fold.
   - However, it is a Ph1 dose escalation study based on small sample size.
   - The first patient in the Ph2(dose expansion) part was dosed in March and is in the process of getting more data for further analysis

Going Forward

1. Ph1 dose escalation showed NT-I7 was safe and tolerable. RP2D was declared as 720μg/kg.
2. Ph2 dose expansion part started, with first patient dosed in March 2021. Ph2a interim results are estimated to be released around mid-2022.
3. Upon finding significant data in 2022, Ph2 for fast-track approval could be initiated as an SIT.

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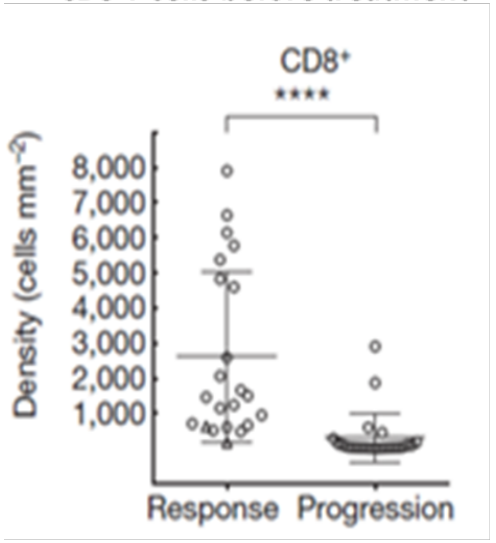
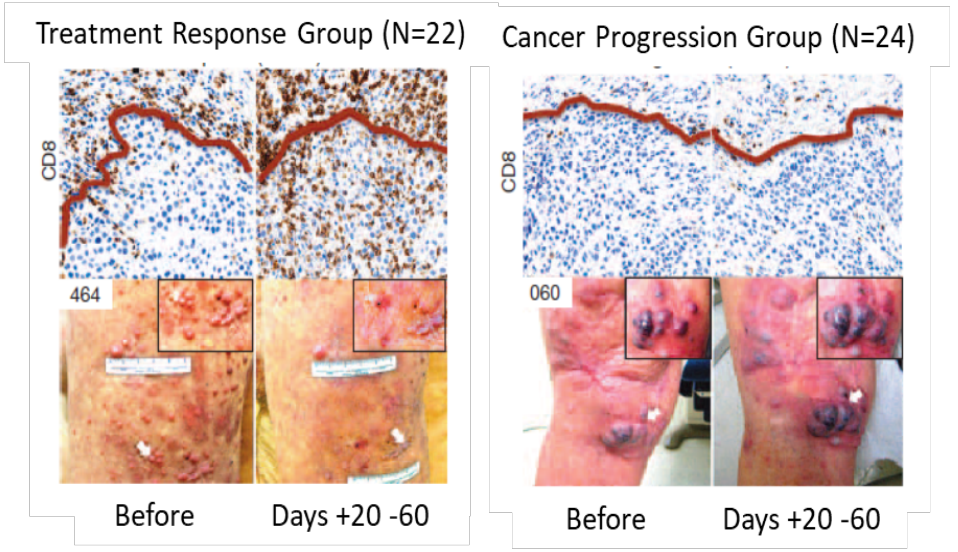
Background of Study

- Before CPI, patients with higher ALC responded better
- Before CPI, patients with higher TIL (Tumor Infiltrating Lymphocyte) responded better

CD8 T cells before treatment



Staining of CD8 T-cells in tumors before/after anti-PD1 treatment



Nature 2014, 515; 568-571

Study Hypothesis

1. Can NT-I7 increase the ALC in the peripheral blood and TIL in the TME?

2. Can the combo therapy of NT-I7 and a CPI improve responses of R/R solid tumor patients?

Study Protocol

Relapsed/Refractory Advanced Solid Tumors.

Phase 1b

Dose Escalation*
3 + 3 Design
(n=up to 18) N=12

Dose Level (n=3/6 / DL)	NT-I7 IM Q6W	Pembrolizumab IV Q3W
DL 1	480 μg/kg	200 mg
DL 2	960 μg/kg	
DL3	1200 μg/kg	

RP2D

Phase 2a

Dose Expansion
Simon's two-stage minimax design
(n=25$^{\Delta}$/arm)

NT-I7: RP2D IM Q6W
Pembrolizumab: 200 mg IV Q3W

- **Arm I: CPI-treated R/R TNBC$^{\#}$** n=up to 17 (stage 1)/ 8 (stage 2) (25 total)
- **Arm II: CPI-treated R/R NSCLC$^{\#}$** n=up to 17 (stage 1)/ 8 (stage 2) (25 total)
- **Arm III: CPI-treated R/R SCLC$^{\#}$** n=up to 17 (stage 1)/ 8 (stage 2) (25 total)
- **Arm IV: CPI-naive R/R MSS-CRC$^{\#}$** n=up to 17 (stage 1)/ 8 (stage 2) (25 total)
- **Arm V: CPI-naive R/R PC$^{\#}$** n=up to 17 (stage 1)/ 8 (stage 2) (25 total)

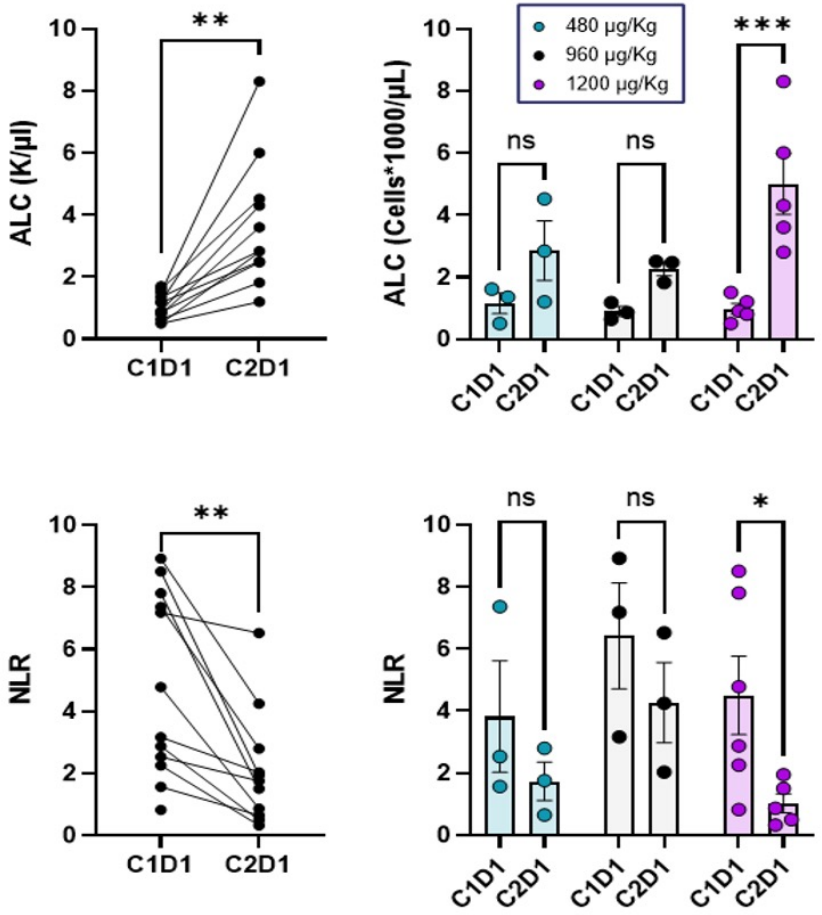
**Patients with advanced solid tumors who can provide mandatory pre- and on-treatment biopsies*

$^{\#}$Selected tumor types for Dose Expansion

$^{\Delta}$Evaluable patients

+ Bio marker study :
CPI naïve R/R
Ovarian Cancer
(+ N=10)

04 Increased Lymphocyte & Decreased NLR



1. ALC (Absolute Lymphocyte Count) change

- Increased in all patients
- 1,200*μ*g/kg group increased the most

2. NLR (Neutrophil Lymphocyte Ratio) change

- Decreased in all patients
- It is well known that high NLR is correlated with poor survival

05 Increase of Tumor Infiltrating Lymphocyte (TIL)

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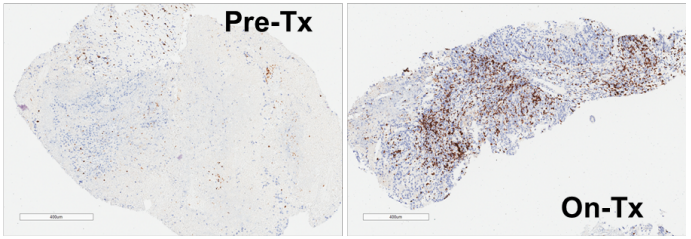
Patient ID	ORR	Lymphocytes (Tumor)		Lymphocytes (Stroma)	
		Pre-Tx	On-Tx	Pre-Tx	On-Tx
102-10101	SD	1	<1	3	20
102-10102	SD	<1	<1	13	16
102-10103	SD	6	20	15	20
101-10106	PD	0	<1	2	7

102-10103 (Clear cell ovarian cancer)



1. **Tumor Biopsy before/after NT-I7 injection**

- Post NT-I7 injection, TIL was up by all 4 pts
- Intratumoral & Stromal TILs(iTILs & sTIL) both increased

2. Response

- SD: all 3 showed increase
- PD: sTIL increased, absolute number is not high enough

3. Cold tumor showed more notable responses

- Ovarian cancer, a cold tumor showed a notable response
- Decided to add 10 ovarian cancer pts for biomarker study

Table 2. Summary of Adverse Events

n (%)		DL1 = 480 μg/kg (n = 3)	DL2 = 960 μg/kg (n = 3)	DL3 = 1200 μg/kg (n = 6)	Total (n = 12)
Any TEAE		3 (100)	3 (100)	6 (100)	12 (100)
ADR		0	0	0	0
ADR by severity	Grade 1	1 (33.3)	1 (33.3)	2 (33.3)	4 (33.3)
	Grade 2	2 (66.7)	2 (66.7)	4 (66.7)	8 (66.7)
	Grade 3	0	0	0	0
	Grade 4-5				
Most frequently reported ADR					
Injection site reaction		3 (100)	3 (100)	6 (100)	12 (100)
Chills		2 (66.7)	-	5 (83.3)	7 (58.3)
Pyrexia		3 (100)	-	3 (50.0)	6 (50.0)
Fatigue		-	1 (33.3)	4 (66.7)	5 (41.7)
Oedema peripheral		2 (66.7)	1 (33.3)	2 (33.3)	5 (41.7)
ADR resulting in drug discontinuation		0	0	3 (50.0)	3 (25.0)
DLT events		0	0	1 (16.7)	1 (8.3)

ADR: Adverse Drug Reaction; DLT: Dose Limiting Toxicity; TEAE: Treatment-Emergent Adverse Event

- Maximum tolerable dose(MTD) was not reached. NT-I7 was tolerable up to 1,200μg/kg Q6W
- ADR (Adverse Drug Reaction) was found, but no serious AE was found
- RP2D is the highest dose of 1,200μg/kg and first Ph.2a patient was dosed in January 2021
- NT-I7 was tolerable and safe not only in mono therapy but also in combo therapy with CPI

Target Patients : Heavily pretreated

Table 1. Baseline characteristics

Characteristics	Categories	DL1 = 480 μg/kg (n = 3)	DL2 = 960 μg/kg (n = 3)	DL3 = 1200 μg/kg (n = 6)	Total (n = 12)
Age, year, median (range)	-	58.0 (43, 64)	60.0 (59, 77)	53.0 (46, 69)	58.0 (43, 77)
Gender, n(%)	Male	2 (66.7)	1 (33.3)	3 (50.0)	6 (50.0)
ECOG Performance Status, n(%)	0 1	1 2	- 3	5 1	6 6
Sum of TL, mm, median (range)	-	81.0 (45, 144)	87.0 (68, 106)	102.5 (28, 127)	85.0 (28, 144)
No. of previous lines of therapy for recurrent/metastatic disease, n(%)	1-2 3-4 >4	1 (33.3) 1 (33.3) 1 (33.3)	1 (33.3) - 2 (66.7)	- 2 (33.3) 4 (66.7)	2 (16.7) 3 (25.0) 7 (58.3)

DL: dose level; ECOG: Eastern Cooperative Oncology Group ; TL: target lesion

- All patients have relapsed or refractory advanced solid tumors.
- All patients received more than 1 prior treatment, and more than 58% of pts had 4 or more prior treatments.

08 Previous data of pts diagnosed with same indications

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Indication (NIT-110, number of subjects)	Checkpoint inhibitor (Keynote Studies)			
	ORR	PFS	OS	Source
Malignant Melanoma (1)	26%	6m PFS, 45%	13.4 months	KEYNOTE-001
MSS-CRC (4)	**0%**	**5m PFS, 11%**	**5 months**	KEYNOTE-016
Esophageal cancer (2)	11.6%	6m PFS, 14.1%	5.8 months	KEYNOTE-059
Ovarian Cancer (1)	9.9%	6m PFS, 22% Median PFS 2.1m	17.6 months	KEYNOTE-100
Metastatic Pancreatic Cancer (MSI-H) (1)	**18.2%**	**6m PFS, N/D Median PFS 2.1m**	**4 months**	KEYNOTE-158
Metastatic Breast Cancer (1)	12%	6m PFS, 16.7%	8.6 months	KEYNOTE-028
Soft-tissue sarcoma (1)	18%	3m PFS, 55%	11.4 months	SARC028

- All 12 pts showed fast progression → negative prognosis
- Post Keytruda mono therapy, all cancer types showed low ORR except melanoma. Particularly, PFS and OS were very short

  → Fast cancer progression up to decease
- Listed indications leave big medical unmet needs for PFS and OS

09 Anticancer activities that suppress progression

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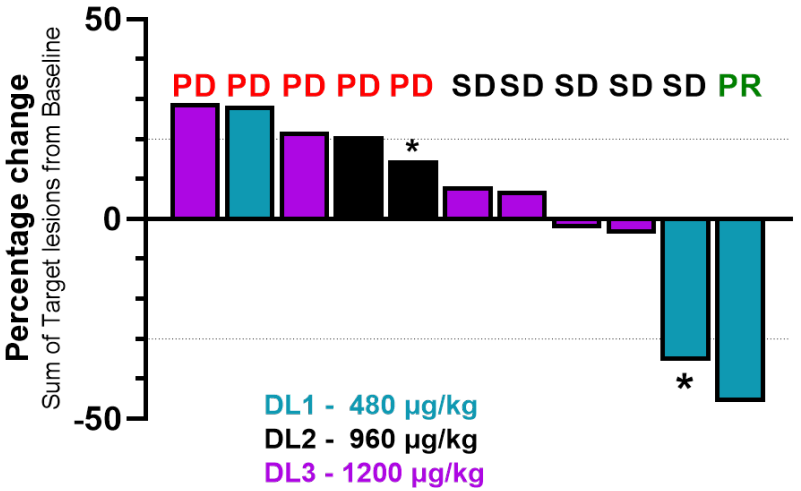
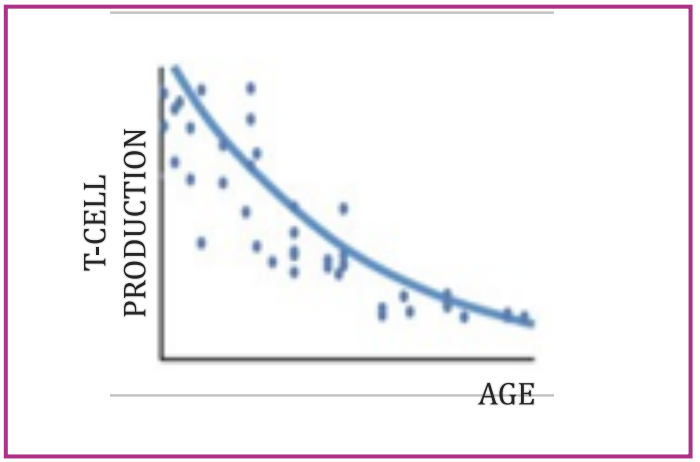
Subject ID	Dose Level	Best Overall Response	Best Overall Change
101-1001	480 µg/kg	**Partial response (PR)**	**- 45.8%**
101-1002	480 µg/kg	Progressive Disease (PD)	+ 28.4%
101-1003	480 µg/kg	**Stable Disease (SD)**	**- 35.6%**
101-1004	960 µg/kg	Progressive Disease (PD)	+ 20.7%
101-1005	960 µg/kg	Progressive Disease (PD)	N/D
101-1006	960 µg/kg	Progressive Disease (PD)	+ 14.7%
102-1001	1200 µg/kg	**Stable Disease (SD)**	**+ 7.0%**
102-1002	1200 µg/kg	**Stable Disease (SD)**	**- 2.4%**
102-1003	1200 µg/kg	**Stable Disease (SD)**	**+ 8.2%**
102-1004	1200 µg/kg	Progressive Disease (PD)	+ 21.8%
102-1005	1200 µg/kg	**Stable Disease (SD)**	**- 3.6%**
102-1006	1200 µg/kg	Progressive Disease (PD)	+ 28.9%



* Pt had reduction in initial lesion, but cancer found in another lesion ; SD -> PD, PR -> SD

- Of the 11 evaluated, 6 pts showed controlled progression (DCR: 55%)
  - > 1) a malignant melanoma patient responded very fast to the combo therapy, in spite of the two failed prior treatments with Nivolumab (aPD1) and Ipilimumab (aCTLA4)
- Of the 5 SD pts, 4 pts remained in SD for more than 6 weeks
- Increased mPFS can be estimated

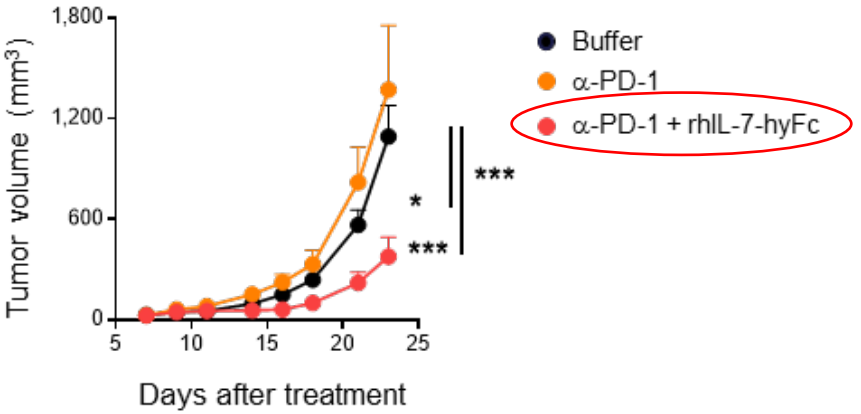
Check-7 Program: Pre-clinical study



IMMUNOLOGY DATA

Source: Protein Cell (2018), NIT analysis

Thymectomy Mouse Model



Clinical & Translational Immunology, 2020 (POSTEC)

- As we age, the Thymus shrinks and produces less T cells
- With a lower number of T cells, there is a higher chance of cancer developing and a lower response to a checkpoint inhibitor
- To build a similar clinical setting, adult mice with Thymectomy were used
- In this model, CPI (aPD1) mono therapy did not show significant anticancer activity
- But in the combo treatment cohort (CPI + NT-I7), suppression of cancer progression was observed

1. Can NT-I7 increase the ALC and TIL? YES

   - T cells were increased in all patients with NT-I7

   - Neutrophil-lymphocyte ratio (NLR) was decreased in all patients

   - All pts with evaluable tumor biopsies showed increase TILs (4 pts)

2. Can NT-I7+ CPI (aPD1, pembrolizumab) contribute to improve responses in R/R advanced solid tumor? YES

   - It was only limited number of patient-based Ph.1b dose escalation study

   - Ph.2a part started in Jan.2021 to get more data for further analysis including OS and PFS.

Going forward

1. Ph.1b demonstrated that the combo therapy(NT-I7 1200 μg/kg IM Q6W + pembrolizumab 200 mg IV Q3W) was safe and tolerable. RP2D was determined to be 1,200μg/kg

2. Some patients who failed in the prior treatments showed PR and SD.

3. In Ph.2a with 5 solid tumor types, cold tumors (CPI not approved for) such as MSS-CRC and Pancreatic cancer are in fast progress.
   - It is estimated that interim data release on selected tumor types in the Ph.2a could be available 4Q21 at the earliest.

4. In 2022, indication related strategy for accelerated approval can be initiated

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01 Clinical Trial Development Plan (USA)

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Program	Study	Combo Trial	Indications	2020	2021	2022	2023	2024+	Data Release
CR-7	NIT-104 NIT-107	CCRT	Glioblastoma, GBM		Ph1b/2a		Ph2		2021 ASCO
CAR-7	NIT-112	CAR-T (Novartis [4])	Relapsed or refractory large B-cell lymphoma, DLBCL		Ph1b/2a		Ph2		
Check-7	NIT-106	CPI (Roche)	3 Skin caners [1]		Ph1b/2a		Ph2		2021 SITC(E)
	NIT-110	CPI (Merck)	5 Solid cancers [2]		Ph1b/2a		Ph2		2021 ASCO/ SITC (E)
	NIT-109	CPI (BMS)	3 Gastro cancers [3]			Ph2			
	NIT-119	CPI (Roche)	NSCLC (1L)			Ph2	Ph3		
VAX-7	NIT-105	-	Infectious disease for elderly subjects		Ph1b		Ph2		
Mono-7	NIT-116 NIT-118	-	COVID-19		Ph1	Ph2		Ph3	
	NIT-114	-	Idiopathic CD4 lymphopenia, ICL			Ph1/2a	Ph2		
	NIT-113	-	Progressive multifocal leukoencephalopathy, PML			Ph1	Ph2		

Note) 1. Melanoma, Merkel Cell Carcinoma(MCC), Cutaneous Squamous Cell Carcinoma(cSCC). 2. Triple Negative Breast Cancer(TNBC), Non-small Cell Lung Cancer(NSCLC), Small Cell Lung Cancer(SCLC), Pancreatic Cancer, Colorectal. 3. Gastric Cancer, Gastro-Esophageal Junction Cancer, GEJ , Esophageal Adenocarcinoma, EAC. 4. Combined therapy is going on without collaboration agreement

* Clinical plan and data presentation schedule may be changed depending on internal and external environment

Upcoming Major Events

	2H2021	1H2022
Trial Starts	✓ NIT-112: CAR-T combo trial ✓ NIT-119: 1st Line NSCLC CPI combo ✓ NIT-106: Skin Cancer CPI combo (Ph2 part)	✓ NIT-109: Gastric/GEJ/EA CPI Combo (Ph2 part)
Data Read-Outs	✓ NIT-106 - Skin Cancer CPI combo (DE phase) ✓ NIT-110 - Basket Study CPI combo (Certain Tumor Types - Ph2a part)	✓ NIT-110 - Basket Study CPI combo (Additional Tumor Types, Ph2a part)

- Multi journal publications are under review and in preparation
- All schedules are subject to change

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