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CTMX - CytomX Therapeutics Inc Presents Clinical Data from Probody™ Platform and CX-072 at 2018 ESMO Annual Meeting

EVENT DATE/TIME: OCTOBER 22, 2018 / 12:30PM GMT

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CORPORATE PARTICIPANTS

Christopher S. Keenan *CytomX Therapeutics, Inc. - VP of IR & Corporate Communications*

Debanjan Ray *CytomX Therapeutics, Inc. - CFO & Head of Corporate Development*

Rachel Wallach Humphrey *CytomX Therapeutics, Inc. - Chief Medical Officer*

Sean A. McCarthy *CytomX Therapeutics, Inc. - President, CEO & Director*

CONFERENCE CALL PARTICIPANTS

Biren N. Amin *Jefferies LLC, Research Division - MD and Senior Equity Research Analyst*

Christopher N. Marai *Nomura Securities Co. Ltd., Research Division - MD and Senior Analyst of Biotechnology*

Mohit Bansal *Citigroup Inc, Research Division - VP and Analyst*

Peter Richard Lawson *SunTrust Robinson Humphrey, Inc., Research Division - Director*

Robert Burns

PRESENTATION

Operator

Good morning, and welcome to the CytomX Therapeutics Conference Call to discuss the company's ESMO 2018 clinical presentations. (Operator Instructions) And as a reminder, today's conference call is being recorded.

I would now like to turn the call over to Christopher Keenan, Vice President of Investor Relations at CytomX. Please go ahead.

Christopher S. Keenan - *CytomX Therapeutics, Inc. - VP of IR & Corporate Communications*

Thank you, operator. Good morning, and thank you for joining us today to discuss the company's clinical presentations made this morning at the 2018 ESMO Annual Meeting in Munich, Germany.

I am joined today by CytomX President and Chief Executive Officer, Dr. Sean McCarthy; our Chief Medical Officer, Dr. Rachel Humphrey; and Debanjan Ray, our Chief Financial Officer.

Before we begin, I would like to remind you that we will be making forward-looking statements during this call, including guidance on research and development activities, including preclinical and clinical data pertaining to CX-072, because forward-looking statements relate to the future, they are subject to inherent uncertainties and risks that are difficult to predict and many of which are outside of our control.

Important risks and uncertainties are set forth in our most recent public filings with the SEC at sec.gov. We undertake no obligation to update any forward-looking statements whether as a result of new information, future developments or otherwise. This data is interim, and future results in this trial or future trials may not be consistent with the data discussed today.

A replay of this call and the associated slides will be available on the Investor Relations page at CytomX' website at cytomx.com.

I will now turn the call over to Sean.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Hello, everyone, and thank you for joining us as we review updated clinical results for CX-072, our lead wholly owned Probody therapeutic targeting PD-L1. Updated data represented in 2 posters today at the 2018 ESMO Annual Meeting in Munich.

Today's presentations build on our first clinical data presented at ASCO in June and continue to support our thesis that our platform is as fundamentally new approach to antibody therapeutic drug development and that CX-072 has the potential to be a new and differentiated PD agent for anti-cancer therapy.

Before we get into the main presentation, a reminder that at CytomX we are reinventing therapeutic antibodies for the treatment of cancer. Therapeutic antibodies are a class of drugs that have been very successful in treating many diseases. In 2017, half of the top 10 best-selling drugs were in this class, and this is an enormous market in oncology as well as multiple additional therapeutic areas.

We believe, at CytomX, that a large and fundamental opportunity it is to improve the targeting of therapeutic antibodies to disease tissue. Focusing the activity of antibody therapeutics, specifically to disease tissue, could enable new targets, new mechanisms and reduce toxicities in order to maximize the overall effectiveness of this class of drugs.

Probodies are fully recombinant antibody therapeutics engineered to have masked target binding sites. The mask blocks the ability of the antibody to bind to its target until the mask is removed selectively in the tumor microenvironment by tumor-associated proteases. Mask removal in the tumor allows the antibody to bind to target on cancer cells while maintained masking in the periphery substantially diminishes binding the target in normal healthy tissues potentially reducing systemic side effects.

Probodies are a versatile modality applicable to multiple antibody classes, and they leverage a fundamental property of cancer tissue namely the upregulation of protease activity in tumor cell growth, proliferation, invasion and metastasis. This is an elegant system and we believe, a really big idea that can change the way we think about antibody therapeutics. Our vision at CytomX is to use this technology to bring safer and more effective therapies to patients with cancer.

Our deep and differentiated pipeline of Probody therapeutics has come together really well over the last couple of years and represents a balance of wholly owned imparted programs against both validated and novel targets.

Our lead program is CX-072, an anti-PD-L1 Probody therapeutic, designed to be a best-in-class PD inhibitor and a potentially differentiated center piece of combination cancer therapy moving forward.

We'll be saying a lot more about this program in just a few moments, including a review of the clinical data we presented this morning at ESMO.

Our second wholly owned program, CX-2009, is also at clinical stage. CX-2009 is a Probody drug conjugate directed against the first-in-class high-potential target CD-166, which is one of the most abundant and highly expressed targets on tumor tissue that we know of and a target we think we can uniquely address with our technology.

We'll provide a status update on this program as part of our Q3 financials in early November.

Our third wholly owned program is CX-188, for which we anticipate an IND filing by the end of this year. In addition to our wholly owned programs, our broad platform has attracted major partnerships over the last few years, including alliances with BMS, AbbVie and Amgen, and with these we have received more than $400 million in proceeds from upfront payments and milestones, which has been an important component of our business model.

Partnered Probody therapeutics in the clinic include the anti-CTLA-4 Probody BMS-986249. For which BMS initiated clinical studies earlier this year (technical difficulty)

Probody drug conjugate targeting CD71 the transferrin receptor, another very unique and high (technical difficulty)

The company has a strong cash position. We ended the second quarter with about $335 million into the clinic and in July, we completed our first follow-on offering, resulting in the addition of $134 million of net proceeds to our balance sheet.

Turning now to our vision for CX-072. Our goal for this molecule is for it to become a best-in-class anti-PD-L1 agent as monotherapy and potentially, a centerpiece of combination cancer therapy across a wide range of mechanisms for which combined dosing with a conventional anti-PD antibody has been limited by toxicities. Our ultimate goal is to advance CX-072-based combination therapies with the potential to elicit deep and durable responses in cancer patients.

PROCLAIM-CX-072 is an ambitious clinical program we initiated in 2017 that is now beginning to give us real insights into how our PD-L1 Probody is functioning in patients and also, into how our platform is performing.

Our 2 poster presentations today provided updated safety and efficacy data from the Part A monotherapy dose escalation arm and the Part B combination arm, in which weare evaluating the safety and efficacy of CX-072 with ipilimumab.

Before I hand over to Rachel to review this latest data, here's a brief overview of what we've shared today. First of all, CX-072 monotherapy Part A1 dose escalation, follow-up is largely complete. CX-072 is well tolerated. We observed 3 partial responses, including one confirmed partial response in a patient with triple-negative breast cancer. And we also presented a snapshot of Part A2. This is our mandatory biopsy arm various doses in which we have presented additional safety data. Follow-up is ongoing for efficacy at therapeutic doses. And as I have already mentioned, biopsy data will be presented from this arm at SITC in a couple of weeks.

Regarding the ipilimumab combination, the additional data shows that the combination continues to be well tolerated with a toxicity profile similar to ipilimumab monotherapy, and the clinical activity continues to be encouraging with longer-term follow-up, including confirmation of all 3 responses that were presented at ASCO in June and encouraging and ongoing durability.

So with that, let me hand over to Rachel to review today's data.

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

Thanks, Sean. Good afternoon and morning, depending on where you're joining us from. Today, I'm pleased to share with you our presentations on monotherapy CX-072 and the combination with ipilimumab that we made today here in Munich at the ASCO Annual Meeting.

Here is the protocol design to parts A1 and A2 monotherapy. Part A1 is simple monotherapy dose escalation. Enrollments to that arm was completed in late 2017. These data today reflect additional follow-ups from ASCO. In Part A2, 6 patients in each cohort were enrolled to receive doses that were previously cleared in Part A1. Biopsies were mandatory in Part A2 and all patients were selected for PD-L1 expression of at least 1% by an approved clinical assay.

The primary goals of Part A2 were to explore biomarkers. Additional data on safety and efficacy is also being captured in Part A2.

Turning to safety. Slide 12 shows that at the data cutoff, all 46 patients were valuable for safety. The MTD was not achieved. Most treatment-related AEs were Grade 1/2, with Grade 3/4 treatment-related AEs occurring in 5 of 46 or 11% of patients. This is consistent with the data we presented at ASCO. Narrowing down the safety data to those events most likely to be drug related, we are also presenting here the rate of immune-related adverse events observed in these patients. In this study, immune-related adverse events are culled from a broad list of more than 300 terms. In order to be an irAE, an adverse event must be on the list, be drug related and require systemic steroids. Three patients, or 7%, experienced an immune-related adverse event by that definition in this study. That's 2 patients with thymoma who experienced pneumonitis, one patient, and neutropenia and thrombocytopenia in the other. The third patient is a woman with breast cancer who experienced LFT abnormalities.

Here are the details of the monotherapy antitumor activity. These patients had received no prior PD-1 or PD-L1 inhibitors and had no PD-1 or PD-L1 inhibitor available for their disease at the time of enrollment. That is, the cancers treated here are generally considered weakly immunogenic and not those that are commonly sensitive to PD-1 or PD-L1 inhibitors.

38 patients were available for efficacy and 3 partial responses were observed. That's 1 confirmed and 2 unconfirmed responses. In total, 8% of all evaluable patients or 17% of the subset of the 18 patients treated with a dose of at least 3 mg/kg had some measure of objective response. The confirmed partial response was observed in the PD-L1-negative triple-negative breast cancer patient who received 10 milligrams per kilogram of 072, and who was still on drug for more than 11 months at the time of the data cutoff. The unconfirmed partial responses were observed in the thymic cancer patient who received 3 milligrams per kilogram of 072 and a cervical cancer patient who received 10 milligrams per kilogram of 072. Both patients were off drug at the August 3 data cutoff after 1 and 9 months on study, respectively.

Here's the waterfall plot with an overview of tumor types and responses. This pool of patients is comprised of a longer-term follow-up of patients from the Part A1 arm, which we reported at ASCO. Patients enrolled onto Part A2 entered the study more recently, and as such, these data represent an early snapshot with limited efficacy data available for those enrolled at 3 and 10 milligrams per kilogram, respectively.

In the waterfall plot, patients who were dosed at the lower and subtherapeutic ends of the dose range, that is, 1 mg/kg or lower are shown in gray. Remember that the goal of A2 is the collection of patients' biopsies.As that primary goal of A2 is mature we will be presenting initial translation data from this arm at SITC in a couple of weeks.

As you can see, at doses of 3 mg/kg and above, where we expect to see efficacy, 10 of 17 or 59% of evaluable patients saw a decrease in target lesions per RECIST version 1.1.

The spider plot demonstrates the durability of the anticancer effect. An update on the patient with breast cancer who achieved the confirmed partial response is reviewed in more detail on the next slide.

This patient with metastatic breast cancer was heavily pretreated. Her tumor was microsatellite stable with low tumor-mutational burden and negative PD-L1 expression. The scan on the left was taken at baseline, and the circle on this scan marks a tumor mass just below her right axilla. The scan on the right, taken several months after the start of therapy, shows a meaningful reduction in this lesion and a partial response which was later confirmed. Interestingly, her disease included inflamed skin lesions, which, as you can see from the photos, completely resolved over the first 4 to 5 months of treatment. As of the data cutoff, this patient continues to be treated with 10 mg/kg of CX-072 and has been on treatment for more than 11 months.

Here are preliminary single-dose PK findings from CX-072 as monotherapy. The left-hand panel shows the concentration of CX-072 over time at doses ranging from 0.03 to 30 mg/kg. Separate curves are shown, the amount of masked CX-072 in the blood, which is shown in solid lines, and the amount of total CX-072 in blood representing both masked and unmasked drug that's shown in the dashed lines. These 2 lines are about the same. So these data demonstrate that CX-072 circulates predominantly as the intact masked prodrug species as the Probody therapeutic was designed to do.

For comparison and to provide data that suggests that CX-072 has reduced binding outside of the tumor, we show on the right-hand side of this slide the reported PK of atezolizumab, a marketed anti-PD-L1 antibody. These data demonstrate that at lower doses atezolizumab exhibited rapid clearance and target-mediated drug disposition, while at the same doses CX-072 didn't. So this profile is consistent with our expectations for 072, which reduced bindings to PD-L1 outside of the tumor compared to atezolizumab, and again, it's consistent with the Probody therapeutic design.

In summary, the monotherapy data checks key boxes for the Probody platform. That is, CX-072 demonstrated antitumor activity and remained masked in circulation. So these data suggest that the mask comes off in the tumor but not in the periphery. CX-072 is also generally well tolerated, given the low rate of meaningful adverse events in the PD-1, PD-L1 class of agents in general and the underlying morbidities of patients with cancer, particularly melanoma, that can obscure interpretation of safety data when the rate of events is so low. The real test of the potential for a PD-L1 Probody to improve safety can be found in the safety profile of the combination of CX-072 with full-dose ipi, which we'll highlight next.

Let's now turn to the combination results with ipi. As Sean noted, our vision for the CX-072 program is for the drug to become the combination partner of choice. The first combination that we're evaluating in this study is CX-072 plus ipilimumab, with a goal of maintaining antitumor activity but with an improved safety profile compared to prior experiences with nivo and ipi in combination. The published data on nivo and ipi is shown here and is meant to provide context on the issues with this combination that we're seeking to address with CX-072. On the left-hand side, data

from the well-known Larkin paper show that in patients with advanced melanoma the combination of 3 milligrams per kilogram of ipi administered every 3 weeks and a low dose of 1 mg/kg of nivo is highly effective with nearly 60% of patients with melanoma responding. However, this combination is also highly toxic with nearly as many patients, 55%, developing Grade 3/4 treatment-related adverse events. This is in contrast to ipi alone in this study where 27% of the patients develop Grade 3/4 treatment-related adverse events. These data show that the cost of a dramatic increase in efficacy for the combination is a dramatic increase in toxicity compared to monotherapy. To address this high-rated toxicity, recent studies have decreased the ipi dose and extended the dose schedule but with mixed results. In CheckMate 227, for example, reduced-dosed ipi plus nivo in patients with first-line lung cancer failed to show meaningful improvement over the standard of care in all patients except a small subset of patients with high tumor-mutational burden. We think there are opportunities with CX-072 to realize the full potential of this combination by enabling more optimal doses and schedule.

Now the right-hand side of this slide amplifies the toxicity challenges of the same combination of full-dose ipi with nivo in patients with melanoma in a more real-world clinical setting. The toxicities described in this series are even more significant than the Larkin paper shows with 91% of patients either ending up in ER, being hospitalized or having to take immune-modulating drugs including steroids. Our goal at CytomX with this program is to use the PD-L1 Probody to realize the full potential of this promising immunotherapy combination by improving safety and tolerability with doses of ipi at 3 mg/kg or higher. In this way, more aggressive and longer dosing has the potential to reach more patients and achieve long-term remission in a higher proportion event.

So now let's look at the combination safety data. As noted, 20 patients were evaluable in this ongoing study in which an MTD had not yet been reached at the date of the ESMO cutoff. These patients had received no prior PD-1 or PD-L1 inhibitors and had no PD-1 or PD-L1 inhibitor available for their disease at the time of enrollment. Similar to a monotherapy arm, therefore the majority of patients here had weakly immunogenic tumors.

So let's start with the safety. The details of these patients are listed in this slide. Most treatment-related AEs were Grade 1/2 with Grades 3/4 treatment-related AEs occurring in 4 of 20 patients or 20%, at the time of the data cutoff. This is a rate consistent with ipilimumab monotherapy. We dosed 1 patient with 10 mg/kg of ipi and 10 mg/kg of CX-072. This patient did not experience a dose-limiting toxicity, and we may continue to enroll additional patients at the ipilimumab dose of 10 mg/kg with 10 mg/kg of CX-072. But in the interim, we're enrolling a cohort with 6 mg/kg of ipilimumab and 10 mg/kg of CX-072. These data will be presented at a later date.

So as in the monotherapy presentation, we're presenting immune-related adverse event data as a means to further characterize the safety profile limiting to adverse events that are most likely to be related to these immunotherapies. Here again, the definition of irAE applied here is the same as in the monotherapy presentation. To be an irAE the event must be called from a broad list of 300 terms, be related to the study drug and require steroid intervention.

As you can see in this slide, only 3 types of high-grade irAEs were observed and in 3 patients or 15%, none at the higher doses of CX-072. Recall that all patients in this series received 3 mg/kg of ipi, and the pattern here is reminiscent of that dose of ipi alone. These data suggest that the PD-L1 Probody is working as designed, potentially protecting normal tissue against the synergistic effect of a combination of 2 immunotherapies.

So this slide answers the natural question that we ask. So this slide is a review of the efficacy results among the 14 of those patients. This is a follow-on from the ASCO presentation with 2 additional patients now considered response eligible and with longer follow-up for the 12 valuable patients presented at the time.

At the time of this data cutoff, which is August 3, the durable complete response persists in the patient with anal cell cancer. Her tumor was HPV positive but also PD-L1 negative, microsatellite stable and with intermediate tumor mutational burden. This patient has been on treatment for 58 weeks as of the data cutoff and remains on CX-072 following all 4 planned doses of ipi. The 2 unconfirmed responses that were presented at ASCO are now confirmed. One in a patient with testicular cancer and the second in a patient with cancer of unknown primary suspected to be small bowel. These patients both remained on CX-072 for 39 and 34 weeks, respectively, as of data cutoff.

So here's the waterfall plot demonstrating that among the 13 patients who had at least one follow-up scan, tumor shrinkage from baseline by RECIST version 1.1 was observed in 3 or 23% of patients, and disease control observed in 9 or 69% of patients.

Here's the spider plot. As you can see, all 3 responses are now confirmed with ongoing steady decline of tumor burden over time, a classic pattern for immunotherapy. As of the data cutoff, all 3 patients remain on treatment.

So let's turn to the key takeaways from the combination arm. The data here check an important box for the Probody platform and for CX-072 in particular. CX-072 continues to be well tolerated in combination with the full-label dose of 3 mg/kg of ipi. The safety profile is consistent with ipi monotherapy. As a reminder, the rate of treatment-related adverse events for ipi alone in the Larkin paper, that we showed earlier, was 27%, and the rate of treatment-related AEs with ipi-nivo combination at full dose of ipilimumab was 55%. With CX-072 replacing nivo in the Larkin combination at the same dose of ipi, we're seeing a treatment-related adverse event rate of 20%. Now the observed response rate of 21% in this very difficult-to-treat population that tends not to usually be PD-1 or PD-L1-sensitive, we saw 1 durable confirmed response and 2 durable partial omissions. So the combination is clearly active. These data suggest that the PD-L1 Probody is performing as designed, maintaining synergy of efficacy in the tumor while potentially protecting normal tissue from synergy of toxicity. We believe these data reinforce the opportunity for CX-072 to be a potentially differentiated centerpiece of immunotherapy, and as you'll hear from Sean, provide us with the foundation for our next steps.

With that, I'll turn it back over to Sean.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Thanks, Rachel. In summary, we are very excited about our progress with CX-072 and the Probody platform broadly, and we are now taking steps to explore the full potential of CX-072 monotherapy and combination programs with the goal of advancing towards registrational studies. For monotherapy, we have initiated the Part B expansion arm in 8 undisclosed, high unmet medical need tumor types, with CX-072 at 10 milligrams per kilogram. Our goal is to advance one or more indications into registrational trials depending upon the data. For the ipi combination, we're currently evaluating 6 mg/kg of ipi, and we will guide on our expansion plans at a later date.

Just a word about 2 upcoming events in November, in a couple of weeks at SITC

(technical difficulty) clinical data from the CX-072 Part A2 arm will be presented in a poster and also reviewed at an investor event that will be webcast. And as part of our third quarter financial results, we will be providing a status update on CX-2009.

With that, I would like to open the call up to questions.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) And our first question comes from Mohit Bansal of Citigroup.

Mohit Bansal - *Citigroup Inc, Research Division - VP and Analyst*

If you could help me understand a little bit on the monotherapy data. So how many new patients were treated in the Part A2, the one with the PD-L1 high expressions? How many patients were there? And can you please help me understand how long were they followed?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Yes, Mohit, it's Sean here. Let me hand over to Rachel to take that question.

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

Okay. Thanks, Sean. The number of patients that were treated on A2. Well, I think the best way to answer the question is that the majority of patients were following here that got a second scan is at the lower dose levels. The patients at 10 mg/kg were followed only for a few weeks, and 3 out of 6 of them had no film. The total number of patients in A2 is 6 patients per cohort and we started at 0.3.

Mohit Bansal - *Citigroup Inc, Research Division - VP and Analyst*

Got it. That makes sense. And then the other question I have is regarding the immune-related adverse event in the combination, I mean it is interesting that at the highest -- higher combination doses, even when you are using a 10 milligram ipi dose or even 10 milligram PD-1 dose -- PD-L1 dose, you're not seeing a pretty much any kind of immune-related adverse event. How -- what do you make of that? Compared to ipi monotherapy itself should have seen -- we should have seen some kind of safety issues there or is it something related to these tumors which are -- we -- where you should not see that kind of immune responses? Just trying to understand that part.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Yes, Mohit, it might be worth -- also it is a great question and might be worth just taking a minute or 2 to talk a little more broadly about how we're thinking about immune-related adverse events. This is the first time that we've shared this particular type of analysis of our data, and you'll see more of this from us as time goes on. We see this as an important window into how the Probody is performing. But let me ask Rachel to comment more specifically.

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

Thanks, Sean. So first, let me just remind everybody how we define immune-related adverse events here. The list we picked from was over 300 categories of preferred terms. The patients had to be -- the event had to be drug related and the patient had to be on steroids for -- at the physician's judgment or the clinical protocol-mandated steroids. So that list is relatively narrow, although there are other PD family agents whose immune-related adverse events are similarly defined. The overall rate of irAEs in the population here is about 15% total. They happen to be clustered in the lower dose levels but that may be incidental. A rate of 15% for irAEs Grade 3/4 is -- or 10% of Grade 3/4 and 15% altogether is consistent with ipilimumab. I think the fact that it's clustered in the early dose levels is -- shouldn't be overinterpreted. But it's just notable, I think if we're going to summarize that irAE table that there's no dose effect of those toxicities and you don't see a higher rate with higher doses of CX-072, which argues that this background tier is related to ipi.

Mohit Bansal - *Citigroup Inc, Research Division - VP and Analyst*

Got it. That makes sense. And maybe if I can add the last one. Is there a -- given that you are not seeing lot of toxicities here, at least in the combination arm, but those you are using for PD-L1 is pretty much similar to other PD-L1s. Is there a potential to go up high on the dose as well in subsequent trials?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

It's something that we're certainly considering. The 10 mg/kg dose by multiple measures, including the clinical activity that we've seen, a pretty extensive clinical pharmacology model that we built and preclinical studies, kind of all point to 10 being a potentially optimal dose. But as you saw, in the -- in Part A1, we did escalate to 30. So it's something that we're thinking about Mohit, but at this point the Part B expansions are all at 10 mg/kg. I want to -- by the way, Mohit, just to add one additional comment on the Part A2, it's -- you may recall that when we presented our data at ASCO we had a fairly complete picture of the A1 dose escalation at what we considered at the time to be a snapshot of the very early data for the ipi combo. The way that we think about the data at ESMO is that we now have, obviously, great follow-up on those combo patients, so a more

complete picture of the ipi combo at 3 mg/kg. And the A2 data we see as a snapshot because, of course, we're still collecting efficacy data particularly at the medium to higher doses. So it's really -- it still continues to be early for the A2 patients, which I think is what was underlying your question.

Operator

And our next question comes from Christopher Marai of Nomura.

Christopher N. Marai - *Nomura Securities Co. Ltd., Research Division - MD and Senior Analyst of Biotechnology*

Hello, can you hear me? Hello?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Yes, Chris, we can hear you, just about. Now we can't.

Operator

And our next question comes from Peter Lawson of SunTrust.

Unidentified Analyst

Can you hear me?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Yes.

Unidentified Analyst

So this is his associate [Nin Wong], I'm filling in for Peter Lawson today. I guess, just a couple of quick questions. Yes, I noted the deepening of responses in the combo data. Can you, I guess, quickly comment on how much you think of this attributed to the CX-072 or ipilimumab? And then a follow-up to that, whether we can expect a deepening of responses from the 2 unconfirmed patients that we saw from the monotherapy part?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Let me -- yes, great questions. Let me take the first one and then hand over to Rachel for the second. I guess, the pretty much important consideration around these patients on the ipi combos that these are tumor types that you really wouldn't expect to respond to ipi monotherapy. So it seems unlikely to us that the response will be coming solely from the ipi side. The combination clearly appears to be effective in these particular tumor types. But it's a fair question. It's obviously impossible to unravel in these studies. But we have every reason to believe that both components are contributing to these quite impressive responses. Let me ask Rachel to comment on -- I think the second question, if I got it right, was follow-up on the unconfirmed PRs from the monotherapy. Is that right?

Unidentified Analyst

Yes, that's correct. Yes.

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

Thanks. Let me add one more thing to the first question for just a second, which is, we have 3 confirmed and ongoing responses out of 14 patients in the ipi combo. So while any individual might be super lucky and have a response to ipi, even though these cancer types don't normally respond to ipi, having 3 high quality and durable responses out of 14 is -- in these cancers especially is absolutely not consistent with the history data of ipilimumab. So the other question was, what happened to the -- what's -- what do we know about the unconfirmed responses at ASCO? And the short answer is, we already knew at ASCO that one of them would never be confirmed with the thymoma patient with the deep response that popped right back up when she had to come off drug for an odd neutropenia as a thymoma patient. The second one was a cervical cancer patient that was trending over the response line for close to 9 months before it slowly dipped down. She progressed and is off study. So those will remain unconfirmed partial remissions indefinitely. The breast cancer patient with the confirmed response and the pictures on the slide continues to do well and as of the cutoff remains on study.

Unidentified Analyst

Awesome. Great. Quite helpful. Just one -- just last question then I'll -- do we have any guidance from when we can expect the next update from the combo arm or via the expansion data from Part D?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

I'm sorry, could you repeat the question. You broke up just a little bit.

Unidentified Analyst

Oh, sorry. Yes, I was wondering if we have any guidance for when we can expect the next data readout from the combo arm or the expansion arm.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Yes, great question. No specific guidance at this point issued from the presentation. And you see on the poster, the most important next step for that program now is to evaluate the higher dose of ipi, the 6 mg/kg. That work is ongoing, and we would expect updates in 2019 but nothing more specific than that at this point.

Operator

And our next question comes from Raghuram Selvaraju of H.C. Wainwright.

Robert Burns

This is Robert Burns on for Ram. So 3 questions. First one directed more towards Rachel. I was hoping she could help everyone sort of understand or characterize the frequency with which you see C-3/4 treatment-related adverse events within the thymoma population. And whether that breast cancer patient who had liver mets, whether those liver mets actually responded as well not just the skin lesions and the breast lesion. So that's the first one.

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

Okay. So first we'll talk about the frequency of Grade 3/4 challenges with thymoma and my understanding it's about 30%. Haven't looked at the data very recently, but the most common ones are, especially, myasthenia, which we haven't seen. You can -- but the ones we have seen, pneumonitis and neutropenia, are rare, but they can be associated with thymoma. The big issue with thymoma is that there's an underlying autoimmune fabric already in place from the cancer. So we can't rule out that there's something going on with this particular cancer type. The other question you asked was the liver mets. The breast cancer patient is having responses in all of her visceral lesions.

Robert Burns

Okay, great. So my second question would be, whether you guys have updated your, sort of, go, stop, signals for CX-2009, whether you can discuss that a little further? And then the last question is more for Debanjan in that -- regards to, what exact -- what type of milestone, if you can qualify the milestone for the IND filing, that's coming off? Just around that.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

So let me just comment on 2009, and there's not much to say on this call. We will be providing a status update on the program, as I mentioned, during our Q3 earnings call coming up in a couple of weeks. Let me hand over to Debanjan to follow up on the milestone question.

Debanjan Ray - *CytomX Therapeutics, Inc. - CFO & Head of Corporate Development*

Robert, thanks for the question. So on the milestone, so this year we filed an IND on CX-2029, that's the AbbVie-partnered CD71 Probody drug conjugate. We received a $25 million milestone for that IND filing. We also received a $10 million milestone for an IND filing on the BMF CTLA-4 Probody. That was done late last year that was $10 million. The only other IND filing we have left on the calendar is on CX-188. That's our wholly owned PD-1 Probody. Since that got partnered there's no milestone for that program.

Operator

And our next question comes from Ying Huang of Bank of BofA Merrill Lynch.

Unidentified Analyst

This is [Jian Yang] for Ying. He apologizes for being on his flight at the moment. Just -- I was thinking about the biopsy data to expect at SITC. Obviously, the fact that you have responses and not -- no demasking, and the periphery suggests that there is demasking. But I guess, what can we expect from that data? Will it just be IHC? Will it be similar plots to what you've shown that present demasking versus total? And do you guys have expectations or like, what's this threshold that everybody should be looking for in that data?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Thanks for the question. And obviously, we're looking forward to presenting our translational update at SITC in a couple of weeks. You're right that the ongoing analysis of mask, well, more broadly, a Probody behavior, if you like, in systemic circulation, in particularly, in tumors, there's an important question and one that the team here has been studying now for a few months, quite intensively. And we are -- we have developed methods to detect unmasking in the tumor and we'll be presenting results from several tumor biopsies at SITC looking for exactly that. That's what you all -- I can say at this point.

Unidentified Analyst

Got it. And in terms of the indications for expansion. Will we see indications that we've seen responses so far in these that are patients that typically don't respond to PD-1 or PD-L1 alone. Can you give us any more clarity around those indications?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

You're right. Of course, that the Part D indications include tumor types that we have already demonstrated respond to the Probody. Of course in addition to that, additional tumor types that one might predict based on historical data would respond to a PD agent. We're not in a position to guide on specific indications, but enrollment into the Part D arm continues to progress very well.

Operator

And our next question comes from Biren Amin of Jefferies.

Biren N. Amin - *Jefferies LLC, Research Division - MD and Senior Equity Research Analyst*

Sean, what's the rationale for the choice of the ipi dose of 6 mg/kg? Because it seems in the combo dose escalation you dosed a patient at 10 mg/kg ipi.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Biren, so you're right. And the way the protocol was originally put together, it did call -- actually continues to call for dosing up to 10 mg/kg of ipi. Obviously, based on the really encouraging durability that we've seen of these 3 responses at 3 mg/kg of ipi. We're currently looking at an intermediate dose of 6 mg/kg, which, as you know, is double the label dose. We want to further explore that particular combination dose and then we'll see what happens next. But we continue to -- a little bit as we did with monotherapy over the last year, with the combination we continue to dose range to see what the optimal combination dose would be for subsequent expansion cohorts, which we would guide on at a later date.

Biren N. Amin - *Jefferies LLC, Research Division - MD and Senior Equity Research Analyst*

Got it. And then just on the combo safety data that you presented where you're comparing to ipi-nivo and melanoma. Can you just tell us, I guess, how the combo safety data would compare to ipi-nivo and other solid tumor types? And also, for the combo dose arms, how long was the dose exposure in the higher dose groups relative to the lower dose groups?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

I mean -- like, just a general comment there Biren, it's a great question, it's an important question, then I'll hand over to Rachel for a couple of comments as well. We obviously have been very pleased to see that since ASCO, as the safety profile of the ipi combo is improved. Obviously there were -- all eyes were on that number at ASCO and that's instance of Grade 3/4 AEs has dropped, it's obviously very encouraging. With regards to the -- I think your question really is what's the appropriate historical reference point given that the Larkin paper is in melanoma. And it's an evolving picture for sure, but nonetheless, we're super encouraged by this 20% number at full-dose ipi, and we'll see where it goes as we dose higher. But let me hand over to Rachel just to give her perspective.

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

Yes. So I'll answer the question about safety in melanoma and elsewhere, just to reinforce. At the end of the day if there are differences in the toxicity and other cancer types with ipi-nivo. And I'm not sure that's well defined in larger enough theories, but what I would say is the definitive

choice there would obviously be in an expansion where we could do -- we could work against the more relevant historical data sets. For right now just to reinforce, I think the irAE rate here is so close to ipilimumab alone, and ipilimumab toxicity outside of melanoma is very consistent across the board. So I would say these early signals suggest that because we're pulling it down to the ipilimumab safety profile that we're very much working -- going in the same direction and our expansions will be in multiple cancer types will get more information. The second question was the exposure in the late doses. It's a good question because at ASCO to follow-up in those higher dose levels was very limited, but still it was meaningful, but still, you get more information with longer follow-up. Here we're talking about the data cutoff is 3 months longer and those patients were on for about 2 months at ASCO, so we're talking about 5 months altogether. I would say, it makes the interpretation of the data we're seeing very encouraging because most of the toxicities you expect with ipi-nivo happens within the first 8 weeks.

Operator

And our next question comes from Terence Flynn of Goldman Sachs.

Unidentified Analyst

This is actually [Gaben] on the line for Terence. Sorry if I missed this too. I just wanted an update on the CX-2009. I know it's not a focus on the call but can you just describe that next update, please?

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Sure. The next update will be on our Q3 call. It will be a status update. And what we've been guiding up to this point is that dose escalation continues and we will provide an update in a couple of weeks.

Operator

And our next question comes from Peter Lawson of SunTrust.

Peter Richard Lawson - *SunTrust Robinson Humphrey, Inc., Research Division - Director*

Just a really quick follow-up. The safety and the combination that's improved since ASCO. What drove that improvement? And is there any way of improving it further?

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

Okay. I think I'll just take this one. So there were 5 events we showed at ASCO and there are 4 here, and here's why, the ASCO poster actually explained this but it was in the footnote of the table. Right after the cutoff for ASCO, the -- one of the treatment-related Grade 3/4 events which was lymphadenopathy in a patient with breast cancer post resection, years post resection. The investigator felt that it was no longer related. So we had tumor patients on the program but no more treatment related Grade 3/4 events, and so the overall rate drops. And I can't say any more than that except it's an ongoing study with numbers and follow-up will continue to evolve.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Yes, and it's obviously significant that we think that with -- as Rachel mentioned in an earlier comment, with AP combo -- aPPD combinations. The really serious events tend to happen early. And so the fact that we have followed up these patients now for several additional months with no new events is, we think, quiet encouraging.

Peter Richard Lawson - *SunTrust Robinson Humphrey, Inc., Research Division - Director*

Under the no new events that you're seeing, I guess, with new patients coming on. Is there any way of, kind of, reducing the risk of events?

Rachel Wallach Humphrey - *CytomX Therapeutics, Inc. - Chief Medical Officer*

I don't think so. If I understand your question correctly, there's nothing new about the new patients versus the old. We're just following them at -- whatever dose they've been assigned.

Operator

And that concludes our question-and-answer session for today. I'd like to turn the conference back over to Sean McCarthy for closing remarks.

Sean A. McCarthy - *CytomX Therapeutics, Inc. - President, CEO & Director*

Great. Thank you very much, and thanks, everybody, for joining us today. We're, obviously, very encouraged with the continued performance of CX-072. And I just say, more broadly, what this data tells us about the Probody platform generally. We look forward to sharing additional data coming up at SITC in a few weeks on the transitional analysis of tumor biopsies. And look forward to seeing you all then. We're happy to take additional questions offline. And enjoy the rest of your day. Thank you very much.

Operator

Ladies and gentlemen, thank you for participating in today's conference. This does conclude the program, and you may all disconnect. Everyone, have a great day.