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PRESENTATION

Operator

Good morning, ladies and gentlemen. Thank you for standing by, and welcome to the Agenus Third Quarter 2020 Conference Call and Webcast. (Operator Instructions) Please note, this event is being recorded. I would now like to turn the conference over to Dr. Jennifer Buell, President and Chief Operating Officer of Agenus. Dr. Buell, please go ahead.

Jennifer Buell *Agenus Inc. - President & COO*

Thank you very much, Cheryl. And thank you all for joining us today. Today's call is being webcast and will be available on our website for replay.

Before we start, we'd like to remind you that this call will include forward-looking statements, including statements regarding our clinical development, regulatory and commercial plans and timelines as well as timelines for data release, and partnership opportunities. These statements are subject to risks and uncertainties, and we refer you to our SEC filings for more details on these risks. As a reminder, this call is being recorded for audio broadcast. I'm Jennifer Buell, President and Chief Operating Officer of Agenus. We're really delighted to provide an update today on our business. Joining me are Dr. Garo Armen, Chairman and Chief Executive Officer; and Christine Klaskin, Vice President of Finance.

Now I'll turn the call over to Garo to highlight our key accomplishments and plans.

Garo H. Armen *Agenus Inc. - Founder, Executive Chairman & CEO*

Thank you, Jen, and thank you all for your participation in this call. Today, I will begin with a recognition of our team's resolve and commitment to deliver for our patients and their families. We have made excellent progress in advancing our lead programs balstilimab and zalifrelimab to BLA filings and made important advancements with our next wave of innovations which are in the clinic. This wave of innovations includes AGEN1181, our Fc enhanced next-generation anti-CTLA-4 antibody; our differentiated CD-137 agonist, AGEN2373; AGEN1223, our intra-tumoral T reg depleting bispecific; and allogeneic iNKT cell therapy for patients with cancer and COVID-19.

These achievements have set us up for potentially transformative advances in the treatment and cure of

cancers. In the beginning of this year, we hosted an R&D Day in New York. We outlined plans that would bring us to our first BLA filing for our lead molecules, while also advancing our novel pipeline of differentiated first or best-in-class molecules. We committed to share data readouts from 6 clinical programs this year. As promised, first, having generated positive clinical data from our bali monotherapy trial of 160 patients, we have initiated a rolling BLA filing with the FDA and paid the filing fee of approximately $2.9 million in the third quarter of this year. Second, we presented impressive data from our bali Plus zali, 155-patient combination trial. We are in discussions with the agency regarding a potential BLA filing for this one. Third, we have generated clinical response data in our AGEN1181 Phase I trial. Additional clinical response data will be presented by Dr. Steven O'Day at SITC on November 14. We are particularly excited about this program. Fourth, clinical data from our AGEN2373 dose escalation trial is maturing. We will provide an overview of these data at SITC and expect to present additional data at upcoming conferences. In addition, we expect to start combination trials of AGEN2373 with and without balstilimab soon. Fifth, data from our bispecific antibody AGEN1223 is also maturing, and we expect to present clinical data at upcoming clinical conferences. Sixth, we are delayed in generating clinical data from our very exciting allogeneic iNKT cell program, due to COVID 19, but we are now screening patients for imminent enrollment. We are particularly excited about this program because, one, the ability of iNKT cells to kill cancer cells directly as well as by recruiting other components of the immune army, and also two, the ability of iNKT cells to kill cells that are infected with viruses, such as COVID-19. While also they regulate or modulate immune over-activation. This is a very important property of iNKT cells beyond activating immune response. And unlike many other cell therapies, we expect to deliver potential benefit to both cancer patients and patients with serious viral infections at a much lower cost. It is also important to note that 13 Agenus-discovered clinical stage compounds have cleared through initial safety at multiple doses.

Our next steps will be the rapid advancement of a number of these programs to combination treatments with our own agents, such as bali, and our next-gen CTLA-4 antibody, AGEN1181.

Next, while we are advancing our clinical programs, our innovation engines continue to yield new and exciting products, which are rapidly advancing towards the clinic. This year, we submitted 7 abstracts to SITC, and all 7 were accepted for presentation. Our SITC presentations include 4 clinical and 3 preclinical programs. SITC, as you know, has become one of the most notable immuno-oncology conferences in the world, and we look forward to our presentations between November 11 and November 14. And in a few moments, Jen will provide you with detailed highlights of these presentations. However, please be mindful that the full details from these presentations will only be discussed and disclosed at SITC in compliance with SITC disclosure rules.

Now let me discuss briefly an important driver of our innovation. It is the Agenus proprietary VISION platform which is one of our 7 presentations at SITC this year. A week ago, I took a half a day to work in our VISION laboratories where we do state-of-the-art research with state-of-the-art equipment and with our exceptional team of scientists. Here is VISION's value for us and also what it does. Agenus VISION can investigate stages of various types of immune cells, including T cells. VISION allows us to study these T cells in a simulated human tumor microenvironment. Typically, T cells go from their naive state to their

activated state and then to their efficacious state, otherwise known as tumor-killing state, and ultimately, to their non-efficacious or exhausted state. You may have heard the term T cell exhaustion. That is what this refers to. The VISION platform enables the investigation of the effect of therapeutic drugs and genetic interventions to determine how they can enhance the efficacious state of T cells. So the objective here is to keep T cells in an efficacious state as long as possible or to drive them into that efficacious state. The platform recapitulates known markers of pathology in the tumor microenvironment and helps discover new relevant markers. With all of this, we can investigate new hypotheses in immuno-oncology. Agenus VISION is an individual translational model of multicellular interaction seen in the in vivo tumor microenvironment and, therefore, has potential to direct patient-specific therapy by mimicking the tumor biology seen in patient biopsies.

In brief, we have designed a proprietary platform where, at any given point in time, we can intervene with our molecules and other molecules to modulate a model human system to determine the best therapy option for patients. We believe that our VISION platform has the potential to transform cumbersome and lengthy clinical trials into an agile trial matching platform to meaningfully benefit cancer patients. The platform also has potential utility in studying the immune response to infections.

Also among recent exciting developments, our data presentations by companies who we have out-licensed molecules to. For example, at ESMO last month, Merck provided an update on MK-4830. This is an anti-ILT-4 antibody that Agenus discovered and licensed to Merck several years ago. The data with this myeloid targeting molecule generated quite a bit of attention with 11 objective responses, including 2 complete responses and 9 partial responses in heavily pretreated patients with advanced solid tumors. Agenus is eligible for an additional $85 million in milestone payments plus royalties from commercial sales of this agent.

Also important to note that we have also advanced our own unencumbered myeloid cell targeting programs. We have an undisclosed myeloid cell targeting antibody of our own, which we're targeting to file an IND for next year. In the second quarter of this year, we filed 2 separate cell therapy INDs, both of which were cleared to proceed to the clinic. We made a strategic decision at the time to prioritize our COVID patient enrollment program and having cleared all institutional requirements, we're in the process of screening patients and expect to dose our first patient imminently. iNKT cells, our invariant natural killer T cells, remember, these are T cells, are a unique cell type that combines the features of both innate and adaptive immunity. These lipid ligand binding cells have tumor targeting capabilities without the need for engineering, and they also have a natural ability to suppress graph versus host disease. Together, these features underscore the attractive development attributes of iNKTs with the benefit of scalability, since they are allogeneic.

Finally, turning to our most powerful adjuvant asset in our pipeline. QS-21 Stimulon adjuvant is in GSK's SHINGRIX vaccine, the most effective shingles vaccine with over 90% efficacy and which has achieved blockbuster sales status in its first 2 years after launch. Although there was an interruption in its sales momentum related to COVID-19 this year, sales seem to be on track and rising. And if they continue with this current trend, it will trigger our milestone payment of $25 million, which could be in 2021. QS-21 is

clearly the most powerful adjuvant that we know. However, its supply is limited because of the limited supply of its raw material, which comes from a Chilean soap bark tree. Agenus has been working on a more sustainable supply of feedstock for QS-21 Stimulon since 2015. We have addressed this by developing a proprietary renewable source. And recently, we have validated QS-21 Stimulon quality and biologic activity from this source. Further, we entered a contract this month to scale up the production of QS-21 Stimulon from the source material with Phyton Biotech.

And now a few words about our manufacturing and supply chain. Now to some of you, manufacturing supply may be in the background, but it is critically important in advancing programs. Without it, we certainly could not have achieved the number of IND filings and the advancements in the clinic. On the topic of sustainable supply, this pandemic has heightened everyone's awareness and the importance of access to material. We have now seen, firsthand, the value of independence in manufacturing and supply. While we didn't anticipate this pandemic, we did anticipate the need for fully-integrated capabilities for a sustainable supply of goods and materials to complement our innovations, all for the purpose of benefiting patients with a sense of urgency, which requires speed and innovation. Our research productivity and pipeline has yielded more than 20 novel programs with 15 INDs filed in 4 years. This productivity would not have been possible without our manufacturing and supply team at Agenus West. Especially in this world, when access to manufacturing slots is getting scarcer, timelines are being delayed and material is more difficult to access. Our internal manufacturing and CMC capabilities give us the freedom and flexibility to accelerate our development programs as well as provide access for our current and future partners. And we have done some of this in the past couple of years; that is, manufactured product for our partners. Our Agenus West team has delivered more than 11 GMP batches for our own use and for partners in just the last few years alone.

And lastly, an update on our partnerships. As I mentioned earlier, our innovation engine has given rise to 15 clinical stage programs with 7 of those advancing through strategic collaborations with Merck, Gilead, Urogen, Incyte, and most recently with Betta Pharmaceuticals. Betta is a China-based pharmaceutical company to whom we have licensed greater China rights for our PD-1 and our first-generation CTLA-4, as monotherapy or in combination. These partnerships have generated substantial financial value for us, with the additional value of expanding access to our innovations to patients at an accelerated pace, which would not have been possible with our own capabilities alone. This strategy has allowed us to nearly double the number of molecules advancing in clinical development by leveraging the support and infrastructure of our collaborators. While we ultimately endeavor to retain all rights to our innovations, in the near term, balancing between retaining rights to some of our agents with an emphasis on U.S. rights and out-licensing others with an emphasis on ex-U.S. rights is prudent for us fiscally as well as it's responsible for advancing our innovations into the clinic. Thus, partnering collaborations and innovative transactions are core to our strategy. This strategy has generated more than $575 million of income to us in the past 5 years to help fund our operations. As part of this strategy to maximize the value of our own I-O portfolio, going forward, we will also provide access to others who can advance clinical programs in combination with some of their own agents with our products, such as PD-1 and CTLA-4, while we retain full rights to the commercialization of our products. This will help accelerate the pace of market expansion of our molecules in addition to IO-IO combinations, with also non immuno-oncology agents,

which is a very substantial market.

Today, we announce the first of these collaborations with Rottapharm Biotech. Rottapharm is a leading innovative Italian biotech company dedicated to drug discovery and development with a pipeline of new chemical entities, that is small molecules, as well as biotherapeutics. Through this collaboration with Rottapharm, we'll evaluate the safety and efficacy of CR-6086, Rottapharm's potent EP4 receptor antagonist, with balstilimab, in patients with advanced mismatch repair-proficient and microsatellite stable metastatic colorectal cancer. I realize this is a mouthful, but it's an accurate description of the reality for these cancers. A development area of high unmet need, that is, and where immunotherapy alone has not demonstrated significant clinical benefits so far. The trial is expected to commence this year. Lastly, as of today, we are in active discussions under CDA with 9 major pharma and biotech companies for potential out-licensing transactions. This is the most, by the way, most breadth of companies that we have had ongoing active discussions with. This could result in the infusion of significant amounts of cash. We will update you appropriately if and when some of these transactions come to fruition.

And now I will turn the call over to Jen to provide you with a summary of data from ESMO, our commercial launch readiness plans, and the upcoming data from SITC, without violating the disclosure rule, of course. Jen?

Jennifer Buell *Agenus Inc. - President & COO*
Thank you, Garo. As Garo shared, the productivity of our research and development engine is really profound. We're incredibly proud of what we've accomplished and what our teams continue to accomplish. If you look at our pipeline, you'll see more than 20 discoveries listed with targeting of very novel biology. You'll see that we've brought 15 of those to IND and now into the clinic. These are being advanced now in our own hands and in the hands of our partners, gives us an opportunity to actually expand the breadth and reach of our science and our innovation. Here at Agenus, we're advancing 8 of these programs. And I should highlight that this efficiency is coming out of a company that's just over 200 employees, which is incredibly efficient. And the number of INDs, we've shared this with you before, the number of INDs that we filed in the past 4 years has rivaled our largest competitors, Bristol, Merck, Novartis, others. So again, just to emphasize, all of the capabilities that we have are in-house with a very efficient team, and now we're advancing 8 of these programs in our own hands. We've already provided clinical updates to you on the first 3 of these programs so far this year, most recently at ESMO. Those updates included data on balstilimab, our PD-1, zalifrelimab, our anti CTLA-4, and AGEN1181, our Fc engineered next-gen CTLA-4, and during the upcoming SITC in the next couple of weeks, we're going to present an update on an additional 4 clinical programs and 3 very novel programs and platforms.

I'm going to turn to ESMO and summarize some of the data that many of you may be aware of, but others may not. At the recent European Society for Medical Oncology, that is the ESMO meeting, Dr. David O'Malley, he's a professor of obstetrics and gynecology at the Ohio State University College of Medicine. He's also the Director of the Division of Gynecologic Oncology. He presented results from the largest data set of patients with relapsed/refractory or metastatic cervical cancer treated with anti-PD-1,

our balstilimab alone, or in combination with our anti-CTLA-4, zalifrelimab. The more than 300 patients' worth of data will support our BLA filing, which is now well underway. In fact, we've received confirmation that the FDA has commenced the review of our BLA, starting with our CMC module. The ESMO presentation is available on our Events and Presentations section of our website. I encourage you to have a good look at that, but I'm going to highlight a few resounding messages from David's presentation. Balstilimab has shown activity in both PD-L1 positive and PD-L1 negative tumors. Notably, KEYTRUDA is approved in PD-L1 positive tumors only. And in the data in cervical cancer from Merck, KEYTRUDA has shown no clinical responses in PD-L1 negative tumors. This suggests balstilimab may be a differentiated anti-PD-1. And for 160 patients treated with balstilimab or PD-1 as a monotherapy, we reported response rate of 19% in PD-L1 positive patients and 10% in PD-L1 negative patients. This compares to commercial PD-1 KEYTRUDA with 14% response rates in PD-L1 positive tumors and no response rates in PD-L1 negative tumors. The durability of this trial and of these responses is quite impressive, exceeding 15 months, and patient follow-up continues. When we add zalifrelimab to balstilimab in the same population, refractory metastatic cervical cancer patients, we see an important expansion in response rates into a near doubling in PD-L1 positive tumors of 27%. This represents a benefit that has not yet been observed with any available therapies for patients with cervical cancer. Importantly, we also see an extension in the durability of these responses where the median duration of response has not yet been achieved after 16 months. These data underscore not only the clinical activity of our molecules and the meaningful potential for patients with cervical cancer, including those who have no effective options, such as patients with PD-L1 negative tumors, but it also showcases the details supporting our robust BLA filing for balstilimab, which, as Garo mentioned, is already underway.

We consider PD-1 as being an essential component for use with our own pipeline as well as with the pipelines of others. Although there are several commercially available PD-1s and others in development, there are significant advantages to having our own PD-1. The first is, of course, affordability and flexibility in developing combinations. Our own I-O pipeline is highly synergistic with PD-1. This pipeline includes agents such as our first-generation anti-CTLA-4 agent, zalifrelimab, AGEN1181, our next-generation Fc enhanced multifunctional anti-CTLA-4 antibody, our Fc enhanced bispecific TIGIT antibody, AGEN1777 (this is expected to be in the clinic next year), our differentiated CD-137 antibody, AGEN2373, and our very exciting intra-tumoral T reg depleting bispecific antibody, AGEN1223, also in the clinic, and our allogeneic iNKT cell therapy for patients with cancer, which will be in the clinic this year. This list of compounds are synergistic with our PD-1, and we've presented data at AACR, ESMO, and ASCO, demonstrating the value of the combination of these agents with our PD-1.

Another huge advantage of having a PD-1 in-house is to control pricing of our combinations. Combinations will be required for effective treatment and control of cancer, and pricing will be an important component of the access to these molecules. The advantages offered by having our own PD-1 for our own purposes is becoming clear, and also that other companies who need a PD-1 to combine with their own pipeline of agents or their own commercial products may prefer to use our PD-1, that is balstilimab, versus others for all of the reasons that I've cited above.

We plan to follow the BLA filing of balstilimab with the combination BLA in the same population, so adding zalifrelimab to balstilimab in patients with cervical cancer, within a few months of our filing.

We're preparing for an upcoming pre-BLA meeting with the FDA this year to finalize our plans. We see balstilimab as an important addition to therapies for patients with cervical cancer with clinical responses in both PD-L1 positive and negative tumors. And we believe that the combination has the potential to be the first checkpoint combination in cervical cancer with the potential to bring practice-changing benefits to patients with high response rates that are durable.

The second line cervical cancer market includes approximately 4,000 patients, as you know, about half of which seek treatment, and we're positioning to capture a good proportion of this market. Our commercial and medical plans incorporate a multifaceted approach with 3 major pillars, involving data generation and publication, building awareness of our therapies, and educating the market on the unmet need for patients with cervical cancer. Awareness is a critical component of rapid adoption, and this is a key area of focus for our teams. We've taken several steps to address this in recent months, including detailed presentation of data at ESMO for both monotherapy and the combination and a preparation of this data for rapid publication in high-impact journals. We've already deployed a team of experienced medical science liaisons or MSLs to engage in the community and scientific exchange. Based on our analyses, we plan to hire a nimble and efficient sales force focused on targeting higher volume gynecologic oncology accounts Our fit-for-purpose commercial launch efforts are being managed by an experienced launch team who have led the successful commercial launches for several products in oncology and rare diseases at large pharmaceutical companies, such as BMS.

Our launch preparations will lay the foundation for the innovation to follow. Our pipeline is built for stacking for bringing together optimal combinations for patients in ways that no one else can and delivering robust value reproducibly. As the limitations of PD-1 therapies become more obvious and the obsolescence rates of current therapies increase, we are prepared to meet the growing needs of patients and providers with new therapies that can be combined affordably and accessibly. Now this is a good time to discuss the innovations that are following the launch of balstilimab and zalifrelimab.

First, AGEN1181. AGEN1181 is our next-generation Fc enhanced anti-CTLA-4 antibody. It's poised to be a transformative CTLA-4 asset. It's rationally designed with Fc engineering to optimize its action and overcome the shortcomings of first-generation assets. 1181 has the potential to increase the therapeutic benefit of anti-CTLA-4 therapies and expand responses to a broader population of patients. We previously reported very promising data that we're seeing with this agent, and we'll continue to present additional data. Complete responses are often rare in Phase I studies. For AGEN1181, we've already seen 2 reported complete responses, one of those a complete response by PET scanning, and these patients both have microsatellite stable endometrial cancer, very hard-to-treat endometrial cancer, PD-L1 negative tumors. They also both have a genetic polymorphism in their CD16 allele. These characteristics make them unlikely responders to anti-CTLA-4 therapy or most I-O therapies, but they have seen complete responses from AGEN1181.

And we are thrilled to have Dr. Steven O'Day to present the updates on these additional data and clinical responses as well as some exciting mechanistic findings that have not been observed with first generation anti-CTLA-4 molecules. Dr. O'Day has deep experience with CTLA-4. As a matter of fact, he

was the first to dose patients with ipilimumab. He presented his seminal findings at a plenary session at ASCO in 2009, which exemplified the curative power of anti-CTLA-4 and ignited a field we now call immuno-oncology. 20 years later, Dr. O'Day was the first to dose a patient with our optimized anti-CTLA-4 agent, AGEN1181, a molecule that we believe will be the next major breakthrough in this field. We're looking forward to his presentation.

Now our allogeneic cell therapies, iNKTs. Dr. Burcu Yigit is an expert in the biology of iNKT cells. She's going to be presenting updated data on our program. iNKT cells or invariant natural killer cells are a unique cell type that combines the features of both arms of the immune system, the T cells and the NK cells, both the adaptive and innate immunity. We believe these cells will have an important role in the elimination of tumors and the elimination of viruses such as COVID-19. We previously reported that our clinical trials for iNKT cells, in cancer and in COVID, were cleared by the FDA. We've successfully opened our first site earlier this year at Cornell, and we were just notified that screening has commenced, and we expect to announce the dosing of our patients with allogeneic iNKT imminently. The timing of this trial starting, of course, is in parallel to now another uptick in the spread of the virus, and New York is being hit yet again. We're hoping that we can bring benefit to these patients with COVID. Beyond COVID-19, these cells have great potential in mitigating cancer, and Agenus is also advancing clinical trials for patients with cancer, with plans to start dosing also this year. Those trials are also FDA-cleared to launch and will be initiated at Dana Farber.

Turning to our differentiated anti-CD-137 molecule, AGEN2373. Dr. Claire Galand will be presenting data at SITC. This molecule is designed with important safety and efficacy features as compared to other molecules. AGEN2373 is a fully human monoclonal antibody that boosts the immune response to cancer cells by enhancing CD-137 co-stimulatory signaling in activated immune cells, both adaptive T cells and innate NK cells. Dual targeting of both innate and adaptive immunity makes this molecule a highly attractive target for cancer immune therapy. I'm very happy to report that 2373 has now dosed beyond the 1 mg per kg dose cohort with no observed liver toxicity. Previously, liver toxicity was what hampered or killed one of the competitor molecules. Furthermore, we've observed a durable disease stabilization of patients with ovarian cancer, sarcoma, and non-small cell lung cancer in this early trial. Dr. Galand will provide an update on the preclinical and clinical progress and our upcoming combination plan with this molecule.

Turning to TIGIT, which will also be presented at SITC, it's shaping up, of course, to be the next breakthrough therapy for I-O. We've seen this. This conviction is supported by the launch of multiple late-stage clinical trials by Roche and Merck and others and some recent strategic collaborations. We've learned from data presented at ASCO from Genentech TIGIT that revealed no monotherapy activity. It suggested that Fc silent is a liability and Fc competence at a minimum is necessary. Now there are a couple of components to think about this with respect to the Fc engineering of an antibody. There is an Fc silent. There is an Fc competent, and then there's an Fc enhanced which is the engineering that we've employed into our AGEN1181, we have a lot of experience with this enhancement. We've also employed the same technology and technique into our TIGIT molecules, which include our monospecific antibody as well as our bispecific. We published that Fc enhancement is necessary to optimally target TIGIT. Just

to reiterate, Fc competent and Fc silent molecules are not enough to optimally target TIGIT biology. You need the Fc engineering, the Fc enhancement. We've applied our science to the design of 2 different approaches. This is AGEN1327, our monospecific TIGIT antibody, and our bispecific, AGEN1777. These molecules unleash T cells and NK cells and have demonstrated superior tumor-killing abilities compared to other available TIGIT antibodies. We've shown you that data earlier, and we'll share more at SITC. We have the potential to combine these agents effectively with other I-O agents such as balstilimab, anti-PD-1. Now our bispecific molecule, 1777, has some interesting individual promise, this molecule has shown dramatic tumor control in a PD-1 refractory colon cancer mouse model, and we've designed it to be used as a monotherapy. At SITC Dr. Rebecca Ward will share important data that underscore the importance of these features for potential best-in-class biologic activity in *in vivo* models. We remain on track to advance a novel TIGIT molecule to the clinic in 2021.

Zalifrelimab is our first-generation CTLA-4 showing important activity both as a monotherapy as well as in combination with balstilimab in patients with cervical cancer. We've continued to interrogate a population of patients that are growing. These are populations of patients who have failed PD-1 and have nothing else. We have seen activity with zalifrelimab. We've also seen activity with this molecule in rare tumors, such as angiosarcoma, we presented that data with Dr. Bree Wilky at our last earnings call, who highlighted a couple of key findings related to our anti-CTLA-4 zalifrelimab in angiosarcoma. We're also seeing this activity in other PD-1 refractory tumors. And as the growing population of PD-1 refractory cancers expand, zalifrelimab as a follow-on therapy may provide the immune catalyst for durable responses. We previously reported on 2 responses in angiosarcoma who failed PD-1, and we look forward at SITC to be following up on these promising responders with new reports of single-agent activity in rare tumors.

And finally, adding to our vast body of knowledge on balstilimab and zalifrelimab in refractory metastatic cervical cancer is new data, demonstrating that pseudo-progression, which is somewhat common in immunotherapy. Essentially, it occurs in patients when there's inflammation around the tumor, it actually appears as disease progression. But in fact, it's actually immune attack on the tumor in many cases, sometimes patients are prematurely discontinued from therapy because of the perception that their tumor may have progressed. We are the first to demonstrate in patients with cervical cancer that pseudo-progression is a phenomenon of radiologic growth and tumor size is not due to the spread of cancer. Patients being treated with immunotherapy may discontinue prematurely if this progression or pseudo-progression is not properly identified and delineated. Stopping treatment too early can be detrimental to these patients. Using our knowledge and identification of pseudo-progression patterns in recurrent metastatic cervical cancer, we plan to optimize treatment and care for these patients.

And finishing up with our VISION platform, as Garo has mentioned earlier, our VISION platform is a proprietary platform designed to recapitulate the human tumor microenvironment and a system that allows us or enables us to interrupt with or intervene with therapeutic interventions and reinvigorate T cells to fight cancer. Our data set of responding and nonresponding patients have given rise to improved matching of patients to our clinical trials and dosing protocols, whether it's combination or sequential and information on molecule design to optimally address tumor escape mechanisms or revive immune fighting cells. At SITC, we will be presenting data on how we use the system to identify novel PD-1

biomarkers. The expression of PD-L1 on tumors has been used as a standard predictive biomarker for anti-PD-1 therapies. We've utilized our VISION system by driving T cell dysfunction *in vitro* to identify a biomarker that may call into question the reliability of PD-L1 expression and identify other more reliable predictor response predictive molecules.

We're looking forward to a very exciting SITC program with our 7 programs that will be presented there. And I'm now going to turn the call over to Christine Klaskin to review our financials. Christine?

Christine M. Klaskin ***Agenus Inc. - VP of Finance, Principal Financial Officer & Principal Accounting Officer***

Thank you, Jen. We ended the third quarter of 2020 with a cash balance of $114 million as compared to $62 million at December 31, 2019. This compares to a cash balance of $79 million at the end of the second quarter of this year. For the third quarter ended September 30, 2020, our cash used in operations was $32 million. Net loss for this quarter was $52 million or $0.28 per share and includes certain noncash expenses of $18 million. This compares to cash used in operations for the same period in 2019 of $28 million and a net loss of $46 million or $0.33 per share, which included $9 million of noncash expenses.

Our cash used in operations for the 9 months ended September 30, 2020, was $104 million with a net loss of $145 million or $0.88 per share compared to cash provided by operations of $13 million and a net loss for the same period in 2019 of $81 million or $0.58 per share. For the 9-month period ended September 30, 2020, we recognized revenue of $57 million, which includes revenue related to the upfront license fee from our transaction with Betta, in addition to noncash royalties earned. For the same period in 2019, we recorded revenue of $116 million, which includes revenue related to the upfront license fee from our transaction with Gilead in addition to noncash royalties earned.

I now turn the call back to Garo for his concluding remarks.

Garo H. Armen ***Agenus Inc. - Founder, Executive Chairman & CEO***

Thank you, Christine, and thank you, Jen. So there's a lot, as I've said in my last call, and you are wondering how one will make money with all of this. And we, of course, are determined to embark on our strategy to build a highly, highly successful company in our industry and beyond. And that's based on 5 important pillars. And I will go through them one by one very briefly. Pillar number one, is to manage to continue to manage our cash position relative to our cash requirements. As you can see from this quarter's report and our performance over the last few years, we have done this well. That is until we can bridge to an infusion of a significant amount of cash from either one or more transactions. And that's what we're working on diligently. So that's number one. Number two, very importantly, position our first-generation products with building of a commercial presence in order to optimize the revenues of these products, and I'm talking about specifically bali and zali. And how do we do that? By bringing in a very competent, first-class launch and commercial team, which we have brought in a team from outside now that has provided us with a turnkey operation and are in the process of building our own team for our needs going forward. Now once we launch our first-generation products, we will optimize their

revenue potential for the approved indications but most importantly, beyond approved indications, in combination with our products, and, as I explained before, in combination with other products, including non-IO agents. Thirdly, embarked on our strategy of sprinting towards approval for our pipeline of clinical products that, in our opinion, has very, very exciting potential, in fact, blockbuster potential. Among those included in that category, as Jen described, 1181, our next-gen CTLA-4 molecule, and also importantly, are 2373, our CD-137 antibody that we're starting to see some data on this that we believe will be particularly exciting when we start our combination trials with 2373. And also, very importantly, our iNKT cells. We believe iNKT cells work the way we expect them to work, the commercial potential of this modality is quite significant. Fourthly, we will continue to innovate with our pipeline, soon to be in the clinic. They include AGEN1777, that is our TIGIT bispecific molecule, and also our undisclosed myeloid cell targeting antibody. We expect both of these molecules to be in the clinic next year. And lastly, we believe given the breadth of transactions and the molecules that we have partnered to third parties, we believe by helping them optimize their potential for products that we have licensed them we believe we can generate, over time, a cash annuity to fund our businesses.

So with that, I will stop and turn it to the operator to see if there are any questions we can answer. Cheryl?

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) Your first question is from the line of Mayank Mamtani.

Mayank Mamtani ***B. Riley Securities, Inc., Research Division - Research Analyst***

Great to hear so much progress across the pipeline, including wholly owned and partner programs. And congrats on the interest externally, including from the investigator community at SITC and hopefully, from your future partners. So I have a few questions, obviously, you've a lot going on. So for bali/zali combination filing, Jen, could you speak to what we are sort of waiting there for? Is it duration of response? Or is it a longer-term safety, tolerability data in regards to your BLA filing?

Jennifer Buell ***Agenus Inc. - President & COO***

Mayank, I wasn't -- you said, are we waiting for a duration of response? So we don't yet have the median duration of response achieved, but we -- this may take quite a bit of time. Patients are -- particularly with the combination, are staying on therapy, and they're having really quite lengthy and durable responses so that won't hold us up from any of our regulatory issues with the combinations. That's just something that we will follow and continue to report on.

Garo H. Armen ***Agenus Inc. - Founder, Executive Chairman & CEO***

I mean theoretically and practically, the longer it takes for us to reach duration of response, the better the patients are doing, right?

Mayank Mamtani ***B. Riley Securities, Inc., Research Division - Research Analyst***
Right. Right. Okay. So what would you say then is the next step here? Is it -- you just are taking it sequentially given the agency has a lot going on, ex-oncology, COVID-specific stuff. So are you just taking it sequentially, the 2 BLA filings? Is that it basically?

Jennifer Buell ***Agenus Inc. - President & COO***
That's right. There are a few reasons for that, Mayank. And we have -- as we've mentioned, we have some partnership activity with access to bali. It was -- it's a very straightforward filing. And just technically, there was an opportunity to engage the agency to develop our relationship with them through the monotherapy filing. The trials were run in parallel. The data were collected essentially in parallel. And the submission will be semi parallel. So we're still in the preparation phase for the combination. There are some advantages to just pushing the balstilimab filing in this year as a monotherapy and following. But we expect, and we're in the process of speaking with the agency on the total package requirements, et cetera, that the combination will be just a couple of months behind the monotherapy.

Mayank Mamtani ***B. Riley Securities, Inc., Research Division - Research Analyst***
Right. Great. So my next question kind of cuts across your multiple checkpoint programs for TIGIT and CTLA-4 also. So the importance of Fc engineering, as you highlighted, the Fc depleted version of TIGIT, for example, is being looked at, Gilead and AstraZeneca also started their Phase III study today. Like you said, Merck and Roche has the Fc competent. So maybe just talk to me about how you think about 1181 when we see that clinical data, how much derisking it is to other programs that you have and show the entire concept of Fc enhanced? Again, conceptually makes a lot of sense. We're just in the clinic, as you highlighted, there are different approaches that different companies are taking.

Garo H. Armen ***Agenus Inc. - Founder, Executive Chairman & CEO***
Let me just make a couple of general comments, and I'll let Jen answer the rest of the question. But one thing that I think is important for everyone to realize is that there is a defined strategy of pursuing leads and programs that have an advantage over anybody else's agents. In other words, if we have a TIGIT molecule, the only way we justify advancing that molecule is if we can clearly demonstrate superiority over other molecules that we either internally generate, that is we generate other molecules to test ours against or we procure it to test our molecules against. So unless we can demonstrate that rigorously, we don't take programs forward. And so when we come up with leads such as 2373 or 1777, these have been validated by our systems, including the use of VISION technology, when applicable, in order to justify our further investment to take it forward. We don't do it because a target is fashionable. So Jen?

Jennifer Buell ***Agenus Inc. - President & COO***
And maybe a few points, Mayank. So 1181 why did we choose the route that we chose, and we presented these data, published them in Cancer Cell in 2018. And it was really sort of field shaking and that we're getting -- we've had quite a bit of interest, particularly in this molecule, and the features have played out in the clinic quite well. And the differentiating features of doing the Fc enhancement versus other approaches like the afucosylated approach are a few fold, and I'm just going to highlight, the most

important is that through the Fc engineering, the enhancement, we avoid complement mediated toxicities. These are the hypophysitis and neuroendocrine disorders that actually have hampered treatment. These are irreversible toxicities, we see them in about 15% of patients who are treated with first generation CTLA-4s. And we very much wanted to be able to take advantage of all of the value of CTLA-4, which we know and the data are out there, it was that it's really the only molecule where we see the tail of the curve phenomenon in these long, durable, curative responses. So we wanted to be able to expand and broaden the population who could have that experience without some of these irreversible toxicities. Fc enhancement has allowed us to do that. And we have not seen any neuroendocrine disorders or toxicities in our trial to date. The other features, of course, though, are to broaden the population of responders to those who may have a polymorphism in their CD-16 allele, and that's more than 40% of the population. Those patients do not respond the first generation CTLA-4, these are data presented by us and others, and we are seeing responses with those patients on our trial, patients who have these mutations. So it's acting as designed.

And then finally, of course, and we've presented this, and this is mechanistically driven, it's the enhanced immunogenicity that we see. And we've shown that those data with 1181, with 1181 in combination with balstilimab, as well as with our TIGIT molecule. And these data are all available publicly on our website. And just 2 days ago, Dr. Dhan Chan, Head of our Discovery group here, presented at the TIGIT conference, we've made that publication presentation available for you on our website, and it will showcase that the features that we've leveraged into our 1181 that's given us the benefit that we're seeing right now in patients, we've engineered into TIGIT. The difference in -- the difference in the approaches that we've taken, I believe, may be because of the timing of development some of these earlier TIGIT molecules were designed a few years ago. And did not benefit from some of the science that we know today and that we've published on as well. Now the world is waiting to see how some of these data will play out. And Ira Mellman from Genentech in his own words believes that Fc competence is critical. Silence is going to be problematic. And now we believe that it's one step more than that, that Fc engineering or enhancement will be even better than Fc competence alone. So that's why we pursued the approach that we've pursued. We're following the science here. And the data will continue to play out. But I think that the TIGIT conference is very informative, and I think Dhan's contributions to that will help to better elucidate why we've chosen the path that we've chosen.

Mayank Mamtani ***B. Riley Securities, Inc., Research Division - Research Analyst***
That's great. I really appreciate the detailed explanation. So my last question, if I may, on 2373. As you know, you said you're thinking about combinations there. Could you just kind of share your thoughts based on what you've seen, whether it's going to be a more traditional PD-1 combination? Or are you also thinking CTLA-4? And my -- the second part to that question is, do you also record a payment from Gilead, like you had from Merck for the ILT-4 if this goes on to the next stage of development?

Jennifer Buell ***Agenus Inc. - President & COO***
Okay. So may I'll -- so first, with respect to the combination approach. And you've hit some very important points. And there's some science that's less well adopted by the community, but that we believe is really opportunistic. And that is -- that includes combinations beyond PD-1. Now that said,

what we know with CD-137 molecules that we've seen in the clinic in tumors like melanoma lung cancer and others. We have seen the combinations with CD-137 agonist and PD-1 have great value for patients. The problem has been the liver toxicity that we've seen with those other molecules. So the inability to safely dose or tolerably dose these molecules in combination. The design of our CD-137 molecule allows us to get around that. We have not seen hepatotoxicity. So -- but we're not averse to a traditional -- more traditional combination to start. We have a lot of data on balstilimab, and there's a strong rationale for the combination with PD-1. That said, those combinations will essentially be traditional and base case in your words, and I agree with you, we will add on other very novel compounds that we can deliver and others cannot. And CTLA-4 is one really important complementary agent to CD-137 agonist. And we've got some really impressive preclinical data to support some of the plans that we have for this molecule. And we'll be more public about it as we continue to expand this trial. The protocol amendment is underway. So you'll start to see the updates on what our clinical plans are with CD137 just in the next couple of weeks. With respect to the option programs, these have pre-negotiated financials with Gilead, and I'll turn it over to Garo to highlight a couple of those points.

Garo H. Armen ***Agenus Inc. - Founder, Executive Chairman & CEO***

So with regard to milestones, for the balance of this year, next year and beyond, you can expect perhaps one milestone, we would term that as a minor milestone this year from one of our partners. There will be the most significant milestone expected for next year will be the GSK $25 million royalty milestone. But in terms of transaction income for either balance of this year or next year, those will come from medium or large transactions that will be characterized as new transactions, as opposed to from existing milestones. Those will be the more meaningful components of income for next year.

Operator

Your next question is from the line of Matt Phipps with William Blair.

Matthew Christopher Phipps ***William Blair & Company L.L.C., Research Division - Senior Research Analyst***

Just kind of one for me. Just curious if, in conjunction with the SITC meeting, if you'll be able to start giving some more concrete plans for 1181. You guys have talked about a lot of different ways you can go with the next steps for that molecule and whether it's expansion and individual tumor types in the current trial or kicking off some Phase II trials? And then just again, kind of balancing that versus advance in the zali, which I know you guys just hosted a trial in angiosarcoma. So good to see that, but just kind of the balance of moving those 2 assets forward?

Jennifer Buell ***Agenus Inc. - President & COO***

Matt, thanks very much for your question. 11 -- yes, the answer is yes. We will give more clarity. And I'll tell you a few reasons. We very recently met with our scientific advisory board. And just to reiterate, they're on our website, but these are a really astute group of scientists that we're thrilled to be working with, and it includes Mario Sznol and Kurt Schalper and Pat LoRusso, and David Von Hoff and Manuel Hidalgo, Steven O'Day, real experts in drug development and specifically in immunotherapy development. And we went through all of the data, the preponderance of data that we have to date.

And we've actually agreed on the fact that we have a very active dose and a very active combination dose that we will now pursue with the trial that we believe will be designed to support a very rapid BLA filing. Our next wave -- our clinical expansion for 1181 will be very important for us and will be designed for -- to interrogate activity and a few different targets, tumors of interest, where we believe that we have a differentiated and superior approach in large market opportunities. So we will be disclosing these plans with you this year.

Operator
questions.

Garo H. Armen *Agenus Inc. - Founder, Executive Chairman & CEO*
I respect all the questions, Cheryl. We can properly end the call. We are about 9 minutes over.

Operator
There are no further questions at this time, sir. Are there any closing remarks?

Garo H. Armen *Agenus Inc. - Founder, Executive Chairman & CEO*
Thank you very much, everybody. I think we've covered quite a bit, and we look forward to communicating all the excitement in the coming weeks, months and year.

Operator
Ladies and gentlemen, this concludes today's teleconference. Thank you for your participation. You may now disconnect.
