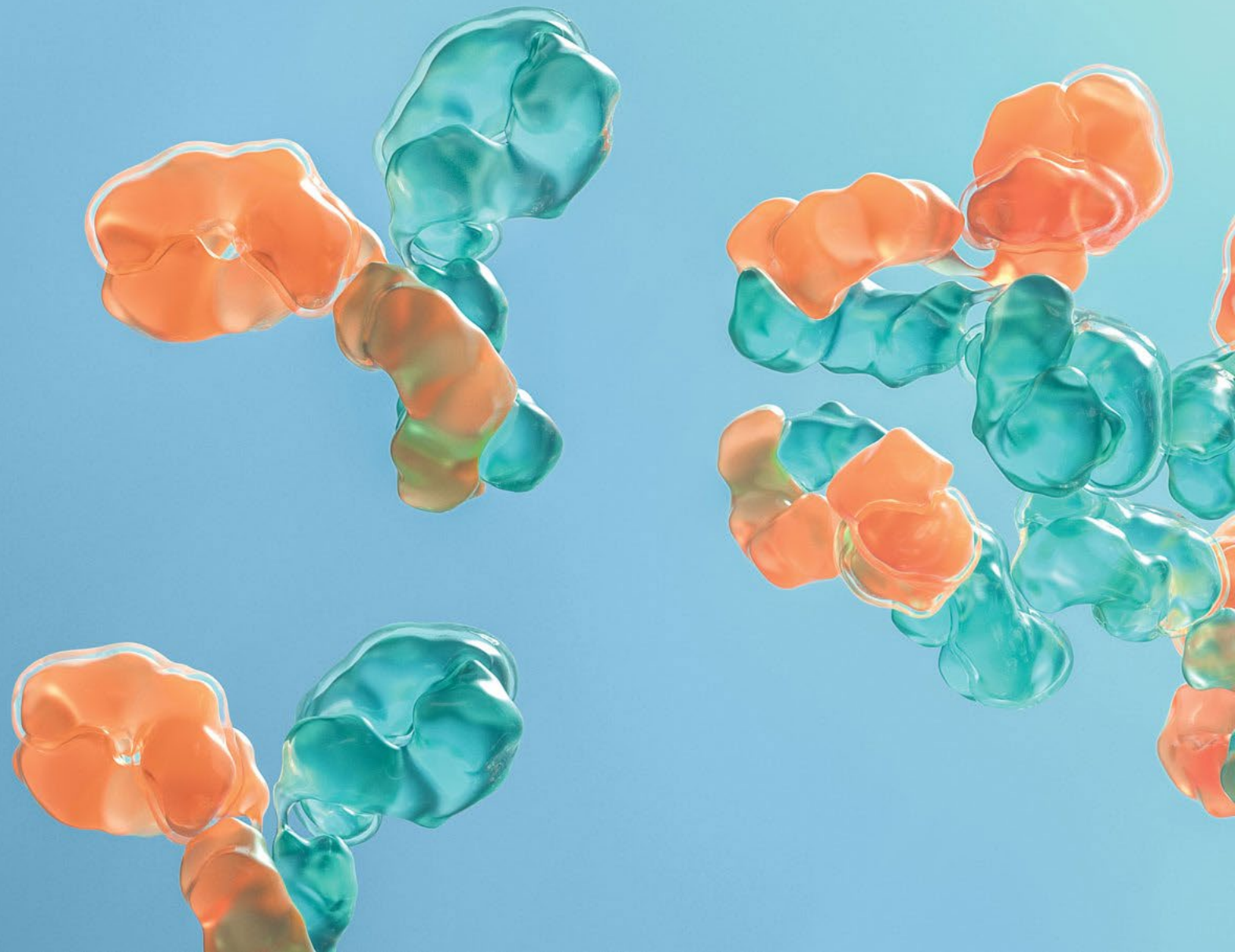
Genmab

2022 R&D Update and ASH Data Review

December 12, 2022

Live in New Orleans and via Webcast



Strategic Partnerships, Collaborations and Licensing Agreements

We will discuss products developed in collaboration with strategic partners or that are the result of product or technology licenses with other companies. This slide is an acknowledgement of those relationships.

- Seagen Inc.: tisotumab vedotin (Tivdak®)
- AbbVie Inc: epcoritamab
- BioNTech SE[1]: HexaBody®-CD27 (GEN1053/BNT313), DuoBody®-PD-L1x4-1BB (GEN1046/BNT311), DuoBody-CD40x4-1BB (GEN1042/BNT312)
- Janssen Biotech, Inc. (Janssen)[2]: HexaBody®-CD38 (GEN3014), daratumumab (DARZALEX®), teclistamab (TECVAYLI®), amivantamab (RYBREVANT®), talquetamab
- Novo Nordisk: Mim8

1. Partnership is based on 50:50 profit/loss share
2. Genmab is developing HexaBody-CD38 in an exclusive worldwide license and option agreement with Janssen Biotech, Inc.

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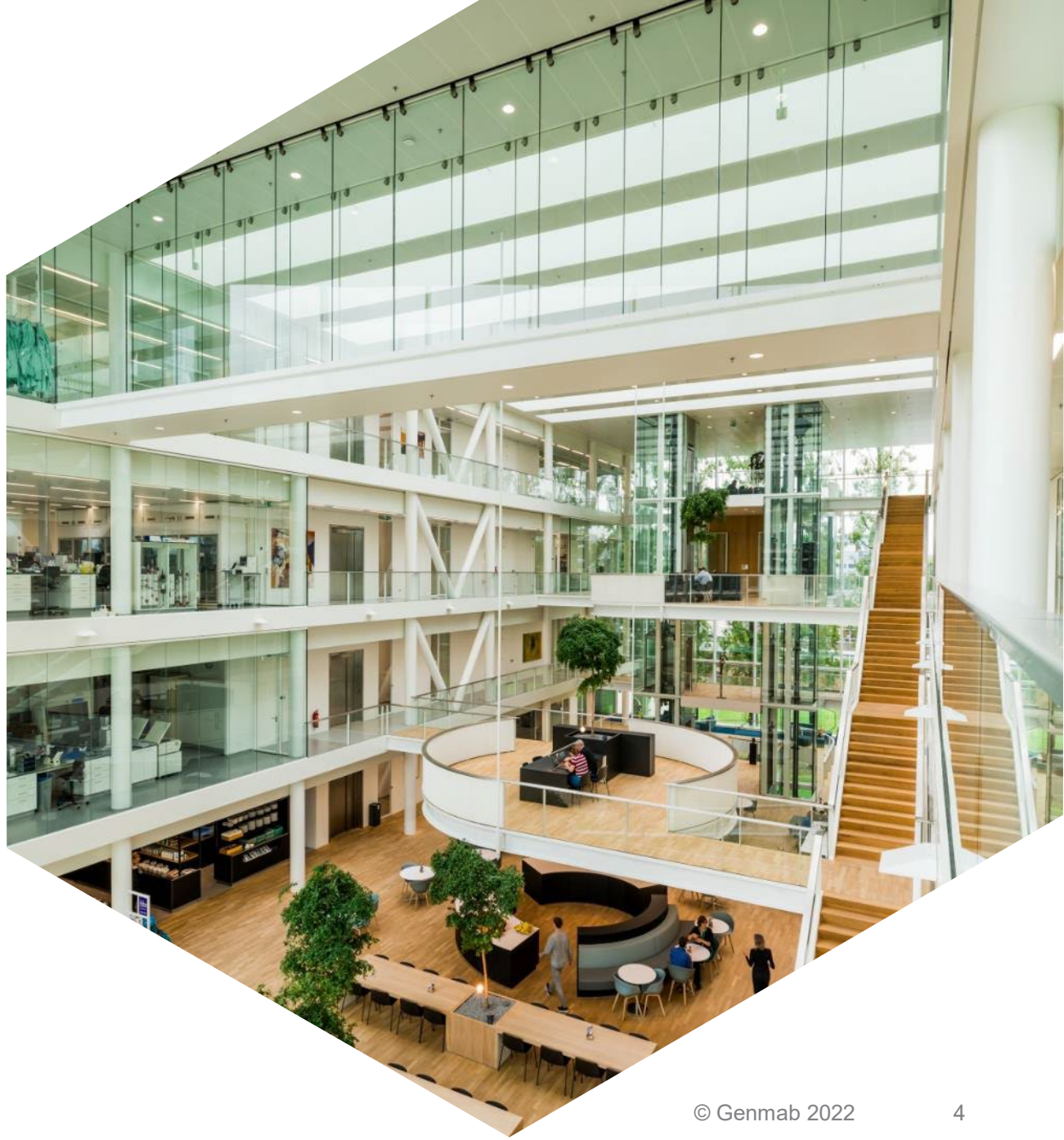
Agenda

7:00 pm	Welcome & Introduction	Dr. Jan van de Winkel, President & CEO
7:10 pm	HexaBody-CD38	Prof. Torben Plesner, Vejle Hospital
7:15 pm	Epcoritamab at ASH	Dr. Lorenzo Falchi, Memorial Sloan Kettering Cancer Center
7:35 pm	GEN1042 at ESMO IO	Dr. Ignacio Melero, Clínica Universidad de Navarra
7:45 pm	2023: Advancing Our Proprietary Pipeline	Dr. Jan van de Winkel
7:50 pm	Live Q&A	

Genmab

Well Positioned for Growth: Solid Track Record and Financial Foundation

- Consistent and solid track record
  - Cumulative INDs since 1999
    - 2019: 33
    - **2022: 40**
  - Approved medicines powered by Genmab's innovation and antibody expertise
    - 2019: 2 - none owned by Genmab
    - **2022: 6 - including Tivdak (tisotumab vedotin-tftv), co-promoted with Seagen in U.S.**
- Innovative proprietary technologies and potential first-in-class / best-in-class pipeline
  - Genmab owned products (≥50%)
    - 2019: 6 - Phase 2 and earlier
    - **2022: 9 - including regulatory submissions for epcoritamab, co-development with AbbVie**
- Sustainably profitable with cash position of ~USD 3B
  - Growing recurring revenue
  - Investing in our capabilities
- Unstoppable team making a difference for patients in need



Driving Towards Our 2030 Vision

Summary of Key 2022 Events: Company Highlights

Our 2030 Vision:
By 2030, our KYSO antibody medicines are fundamentally transforming the lives of people with cancer and other serious diseases.

- Unveiling of 2030 Vision
- First full year of Tivdak on the market
- Growing recurring revenue streams and significant underlying profitability
- Focused and disciplined investment approach incl. continued strategic growth of team
- Business Development deals/expanding our collaborations to accelerate innovation and enhance our pipeline

Genmab

Driving Towards Our 2030 Vision

Summary of Key 2022 Events: Pipeline Highlights

- Epcoritamab
  - New studies initiated/announced
  - Orphan-drug designation (U.S.) for FL
  - Topline results from EPCORE™ NHL-1 study
  - Regulatory submissions – **accepted for Priority Review by U.S. FDA**
- New investigational medicines enter the clinic
  - DuoBody-CD3xB7H4
  - HexaBody-CD27
- Data presentations and publications across portfolio

KYSO

KNOCK YOUR SOCKS OFF

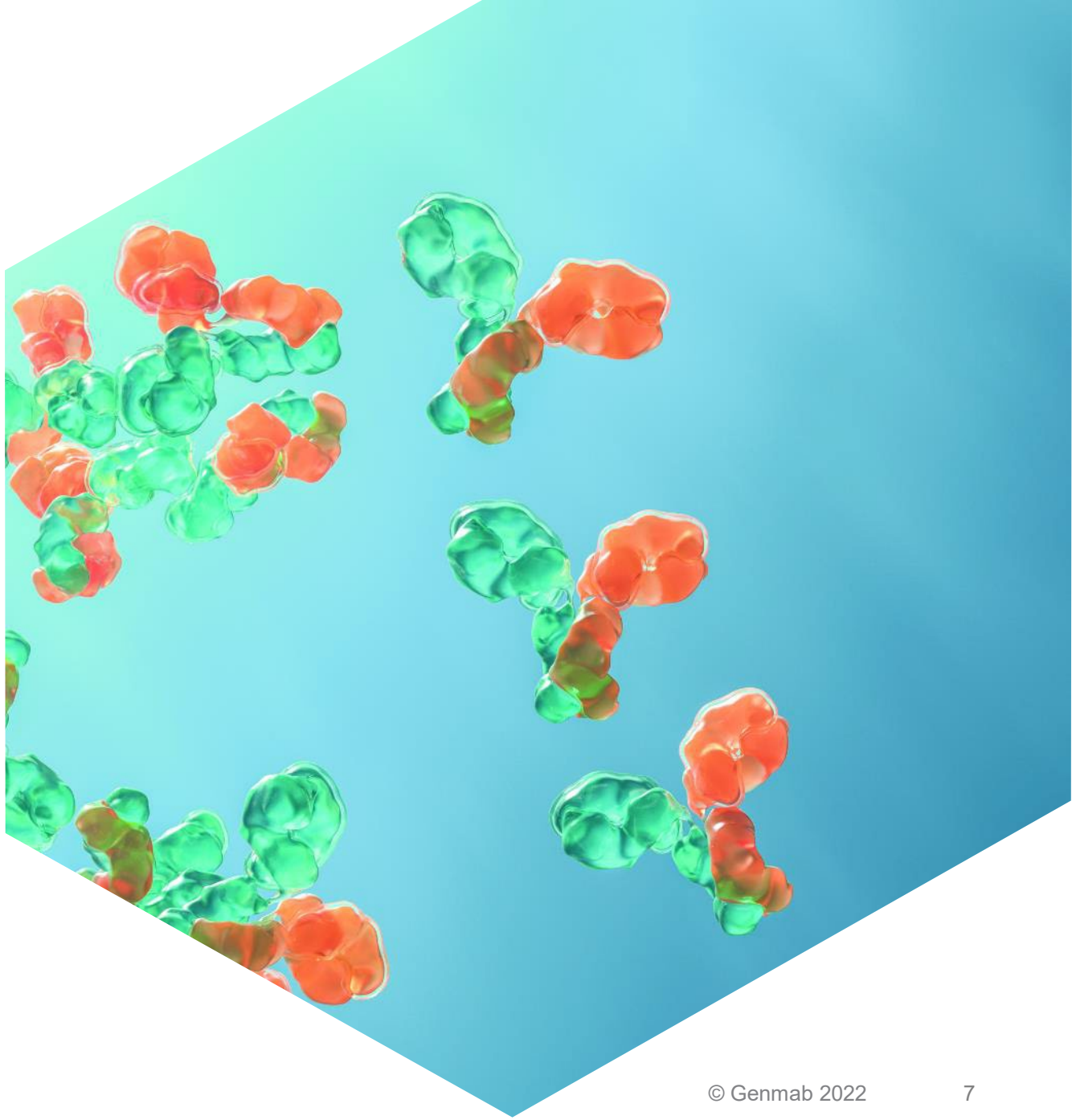
Genmab

Epcoritamab is being co-developed by Genmab and AbbVie; HexaBody-CD27 (GEN1053/BNT313) is being co-developed by Genmab and BioNTech

Innovation in Action

Summary of Key 2022 Events: Programs Powered by Genmab's DuoBody Technology

- Janssen
  - TECVAYLI: EU & U.S. approvals
  - Talquetamab: BTD and BLA filed
  - Multiple new Phase 3 studies initiated/announced including in combination with daratumumab
- Novo Nordisk
  - Mim8: FPD in Phase 3a



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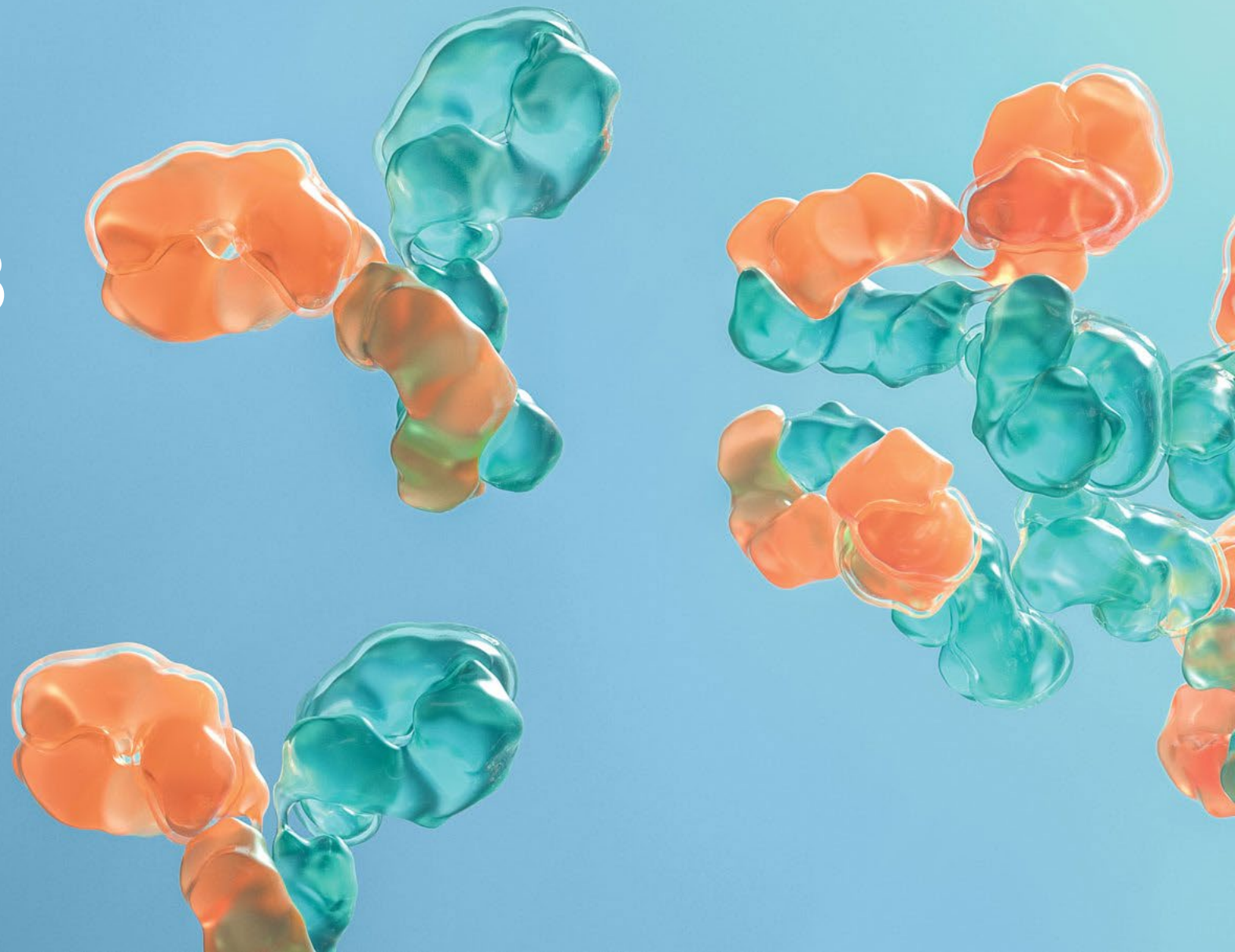
HexaBody-CD38



Presented by Prof. Torben Plesner, Vejle Hospital

Preliminary Dose-Escalation Results from a Phase 1/2 Study of GEN3014 (HexaBody®-CD38) in Patients with Relapsed or Refractory Multiple Myeloma (RRMM)

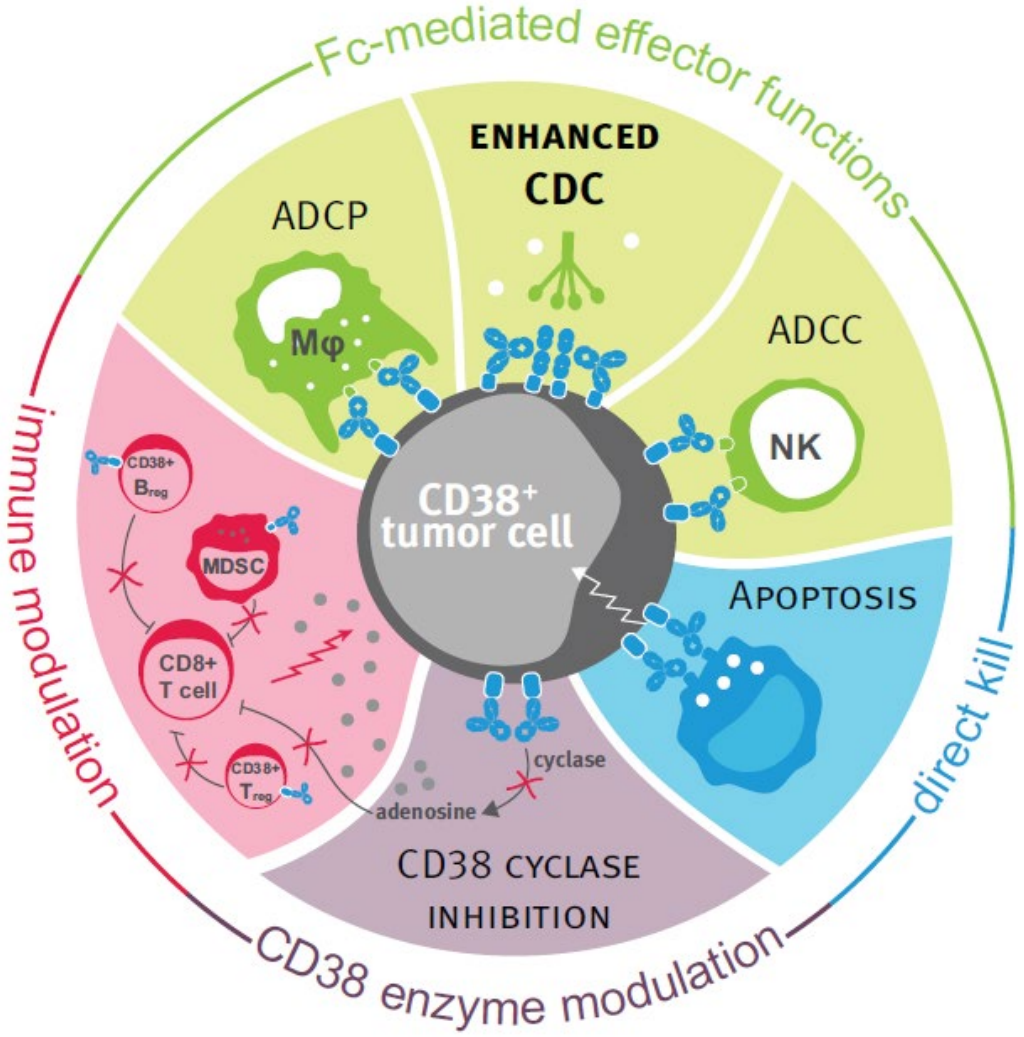
Andrew Spencer, MD,[1] Katrine Fladeland Iversen, MD,[2] Binod Dhakal, MD, MS,[3] Maria Creignou, MD,[4] Jenny Chen, MD, PhD,[5] Ida H. Hiemstra, PhD,[6] Sieto Bosgra, PhD,[6] Avani Badani, MD,[5] Esther C.W. Breij, PhD,[6] Lauren Brady, PhD,[5] Kate Sasser, PhD,[5] Anders Malmberg, PhD,[7] Henrik Gregersen, MD, PhD,[8] Markus Hansson, MD, PhD,[9] Annemiek Broijl, MD, PhD,[10] Maria-Victoria Mateos, MD, PhD,[11] Torben Plesner, MD[2]

[1]Alfred Hospital, Melbourne, Australia; [2]Vejle Hospital, Vejle, Denmark; [3]Medical College of Wisconsin Cancer Center, Milwaukee, WI, USA; [4]Karolinska University Hospital, Stockholm, Sweden; [5]Genmab, Princeton, NJ, USA; [6]Genmab, Utrecht, Netherlands; [7]Genmab, Copenhagen, Denmark; [8]Aalborg University Hospital, Aalborg, Denmark; [9]Skåne University Hospital, Lund, Sweden; [10]Erasmus University Medical Center, Rotterdam, Netherlands; [11]Hospital Universitario de Salamanca, Salamanca, Spain

Presented at the 64th American Society of Hematology Annual Meeting and Exposition; December 10–13, 2022; New Orleans, LA, and virtual
Poster Number 3254

GEN3014 Mechanism of Action

- GEN3014 (HexaBody®-CD38) is a next-generation CD38-specific IgG1 mAb with a hexamerization-enhancing mutation
- GEN3014 is designed to induce antitumor activity through highly potent CDC and other Fc-mediated effector functions
- GEN3014 may relieve immune suppression in the tumor microenvironment by targeting CD38+ immune cells and inhibiting CD38 enzyme activity

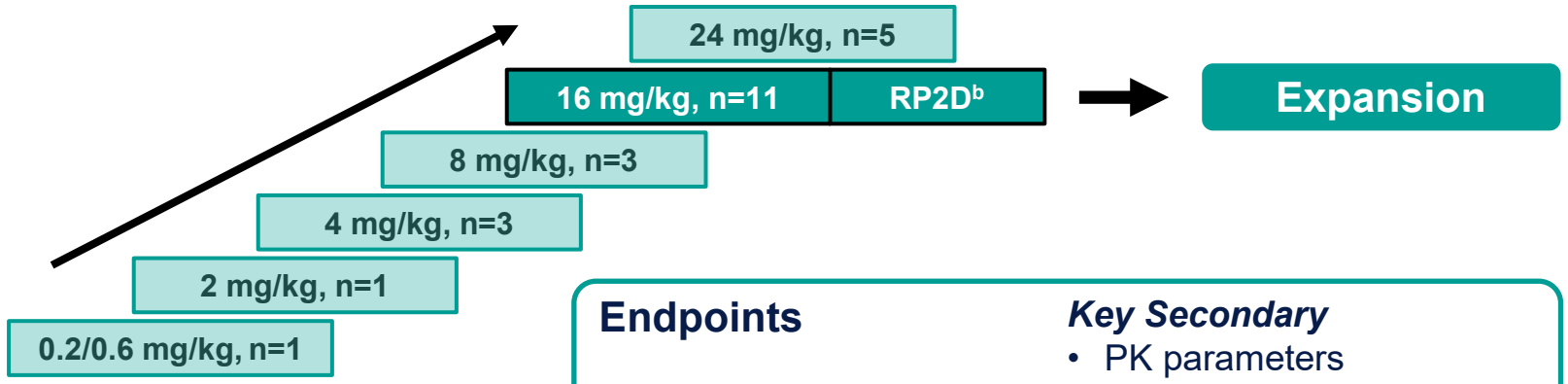


A Phase 1/2, Open-Label, Multicenter Trial of GEN3014 (HexaBody®-CD38) in Adults with RRMM

GEN3014 was administered[a] by IV route in 28-day cycles until disease progression or unacceptable toxicity

Key Inclusion Criteria

- RRMM with disease progression on most recent treatment based on IMWG criteria
- For anti-CD38 mAb–naive: ≥3 prior lines of therapy including PI and IMiD, double refractory to PI and IMiD, or ≥2 prior lines of therapy if 1 included a combination of PI and IMiD
- For anti-CD38 mAb–treated: ≥2 prior lines of therapy, must have discontinued daratumumab or isatuximab ≥4 wk prior to first dose of GEN3014
- Acceptable laboratory test results
- ECOG PS of 0–2



Median (range) follow-up:
7.3 mo (0.3–16.9)
Data snapshot: October 3, 2022

Endpoints

Primary
- DLTs[c]
- Safety and tolerability

Key Secondary
- PK parameters
- Pharmacodynamic markers
- Antitumor activity and clinical efficacy
- Immunogenicity

[a]Premedication (corticosteroids, antipyretics, antihistamines, and a leukotriene receptor antagonist) and postinfusion medications (corticosteroids) were to be given to reduce the risk of infusion-related reactions (IRRs) and systemic administration-related reactions. During cycle 1, all patients were required to remain in the clinic after each GEN3014 infusion for at least 4 h for close observation. Dosing schedule for GEN3014 is as follows: cycle 1 days 1, 2, 8, 15, and 22; cycle 2 days 1, 8, 15, and 22 (QW); cycles 3–6 days 1 and 15 (Q2W); cycles 7+ day 1 (Q4W). [b]Preliminary safety findings from the escalation phase have found the optimal RP2D to be 16 mg/kg with near-complete target saturation, natural killer (NK) cell depletion, and complement consumption. [c]The DLT evaluation period is defined as the first 28 days of GEN3014 treatment (ie, cycle 1). DLT, dose-limiting toxicity; IMiD, immunomodulatory imide drug; PI, protease inhibitor; RP2D, recommended phase 2 dose.

Baseline Demographics and Characteristics

	Total N=24
Median age, y (range)	65 (45–84)
Male, n (%)	16 (67)
Ethnicity, n (%)	
White	19 (79)
Not reported	5 (21)
ECOG performance status, n (%)	
0	11 (46)
1	11 (46)
2	2 (8)
Subtype of measurable MM disease, n (%)	
IgG	15 (63)
IgA	4 (17)
Light chain	5 (21)
Median serum M-protein level, g/L (range)	14.5 (2.7–41.0)
Patients with ≥1 extramedullary plasmacytoma, n (%)	4 (17)
ISS stage category at screening, n (%)	
Stage I	13 (54)
Stage II	6 (25)
Stage III	5 (21)
Median prior lines of therapy, no. (range)	6.5 (3–13)
Anti-CD38 mAb–naive RRMM, n (%)	8 (33)
Anti-CD38 mAb–treated RRMM, n (%)	16 (67)
Daratumumab	16 (67)
<6 mo since prior treatment	5 (21)
≥6 mo since prior treatment	11 (46)
Isatuximab	2 (8)
<6 mo since prior treatment	1 (4)
≥6 mo since prior treatment	1 (4)
Median time since last anti-CD38 treatment, mo (range)	9.5 (1.3–75.5)

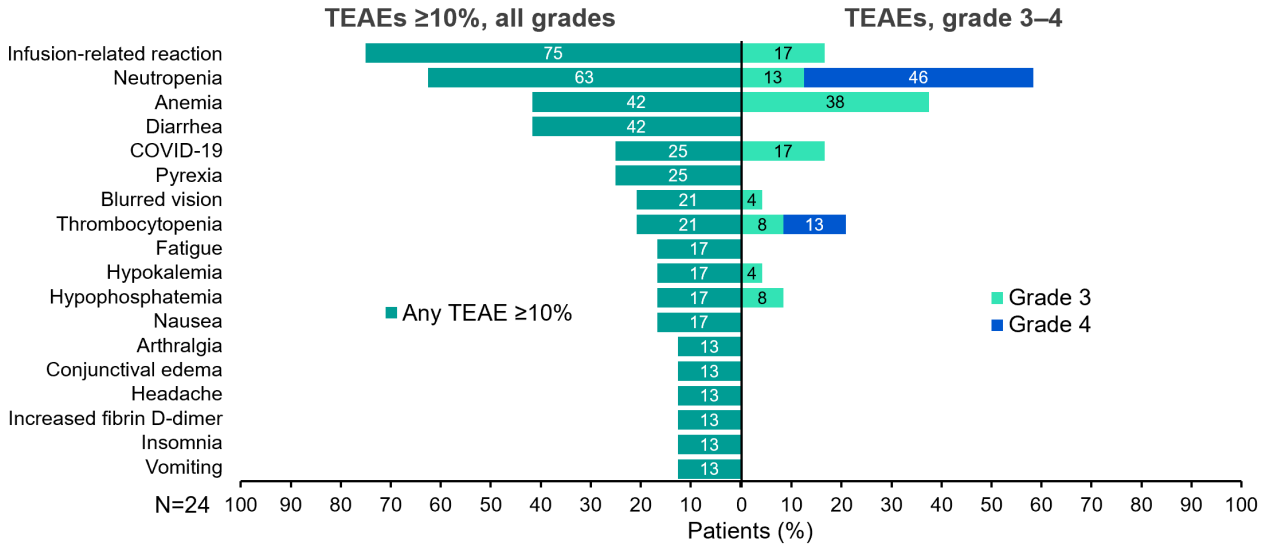
- Overall, patients had exhausted standard therapies, including treatment with anti-CD38 mAbs
- The median time since last anti-CD38 treatment was 9.5 months

Treatment Exposure and Discontinuation

	Total N=24
Treatment exposure	
Median number of cycles initiated, no. (range)	4 (1–17)
Median duration of treatment, mo (range)	3.5 (0.2–14.8)
Dose delay due to TEAE, n (%)	12 (50)
Discontinued treatment, n (%)	21 (88)
Reasons for discontinuation, n (%)	
Disease progression	13 (54)
Adverse event	4 (17)
Clinical progression	3 (13)
Patient request	1 (4)

Safety: Treatment-Emergent Adverse Events

Treatment-Emergent Adverse Events



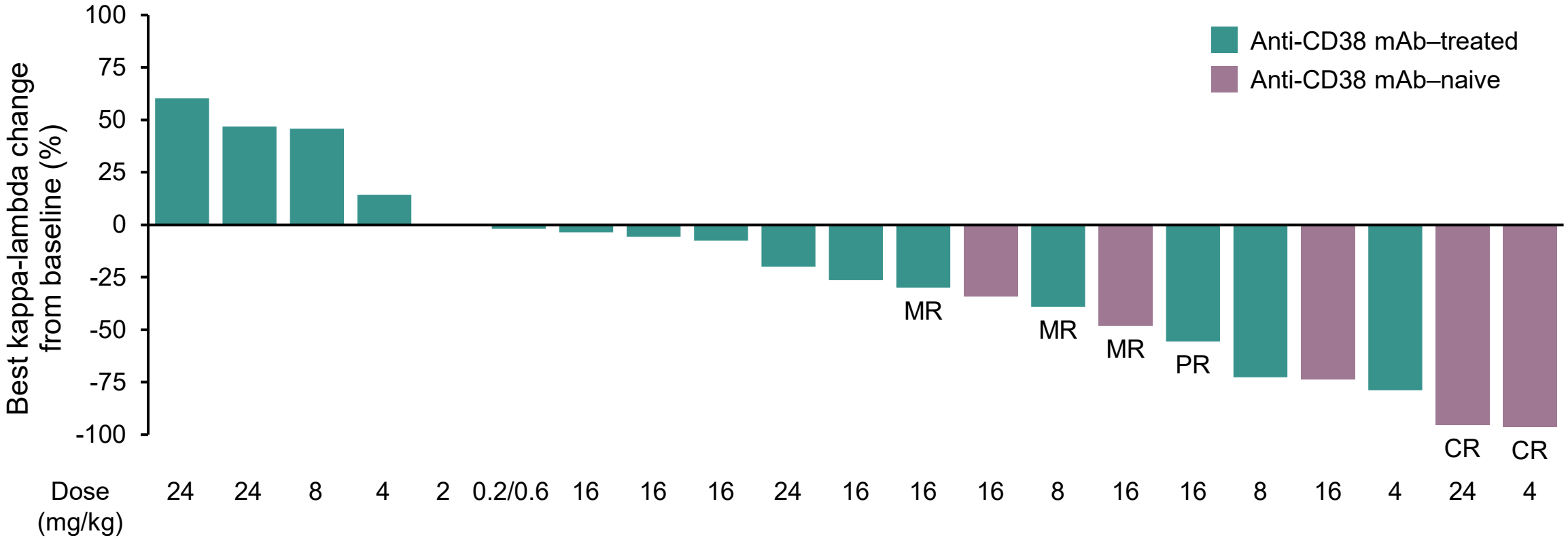
- IRRs were seen at dose levels (DLs) of 4 mg/kg and up, were mostly G2 in severity, and mainly occurred during cycle 1 day 1 (**Figure 1**)
  - IRRs (G2) led to treatment discontinuation in 2 patients
- No DLTs were observed at DLs up to 16 mg/kg, the RP2D
  - 1 patient treated at 24 mg/kg DL reported DLTs of neutropenic sepsis (G3), neutropenia (G4), thrombocytopenia (G4), and appendicitis (G3)
- There were no tumor lysis syndrome (TLS) events at DLs up to 24 mg/kg
- Four patients (17%) experienced treatment-related serious adverse events
  - Two patients had IRRs (G2 and G3), 1 patient had increased fibrin D-dimer (G2), and 1 patient had neutropenic sepsis (G3) and appendicitis (G3), which were classified as DLTs
- There were no treatment-emergent adverse events leading to death
- Of patients evaluated for immunogenicity (n=22), 100% tested negative for antibodies to GEN3014

Treatment Response By Anti-CD38 Treatment History

	Anti-CD38 mAb–naive n=5	Anti-CD38 mAb–treated n=16	Total n=21
Overall response rate[a], n (%) (95% CI)	2 (40) (5–85)	1 (6) (0–30)	3 (14) (3–36)
Clinical benefit[b], n (%) (95% CI)	3 (60) (15–95)	3 (19) (4–46)	6 (29) (11–52)
Stringent complete response, n (%)	0	0	0
Complete response, n (%)	2 (40)	0	2 (10)
Very good partial response, n (%)	0	0	0
Partial response, n (%)	0	1 (6)	1 (5)
Minimal response, n (%)	1 (20)	2 (13)	3 (14)
Stable disease, n (%)	2 (40)	9 (56)	11 (52)
Progressive disease, n (%)	0	4 (25)	4 (19)

Based on response-evaluable population. [a]Overall response includes patients with best response of partial response or better. [b]Clinical benefit includes patients with best response of minimal response or better.

Percentage Change From Baseline in Paraproteins



- Clinical benefit was shown in both anti-CD38 mAb–naive and anti-CD38 mAb–treated patients

Pharmacodynamics

Decreases in complement parameters suggest CDC activity

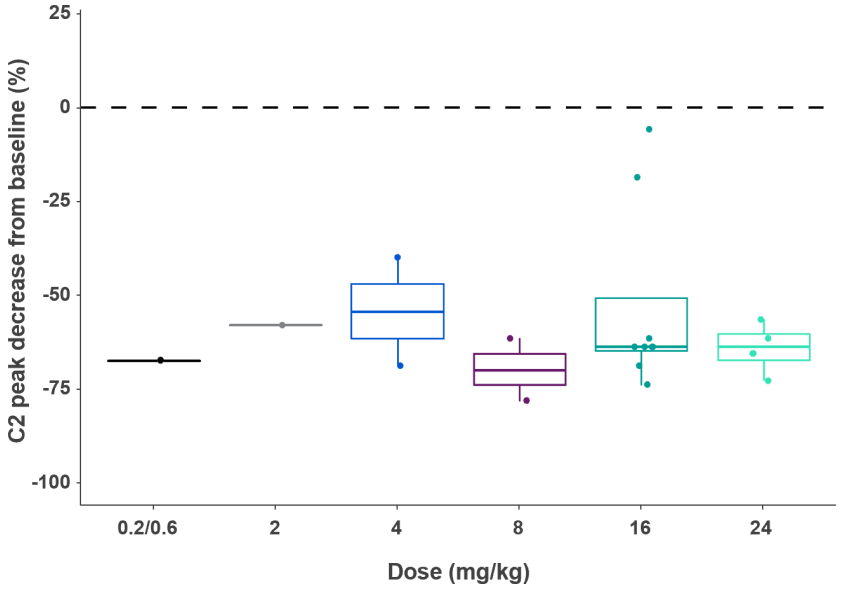
- Reductions in C2 were observed at all dose levels:

  -mean 58% ± 18% peak reduction from baseline, n=18

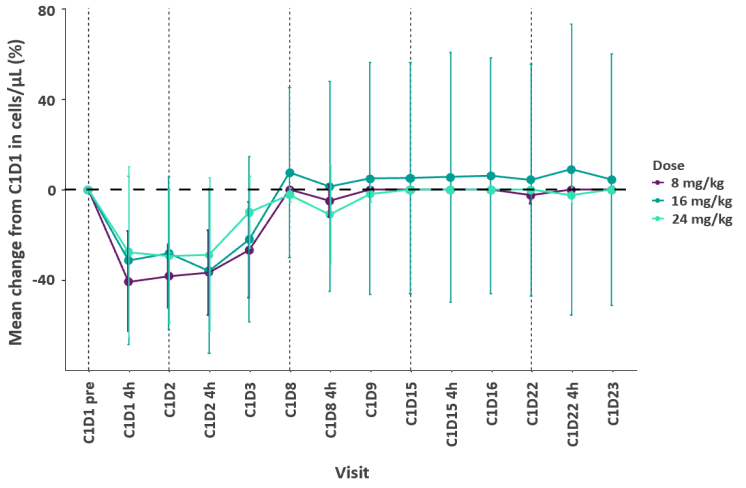
- Decreases in total complement lytic activity were observed

  -CH50 was observed ; mean 48% ± 24% peak reduction from baseline for ≥8 mg/kg, n=11)

C2 change from baseline



CH50 change from baseline



Conclusions

- In this first-in-human study, dose-escalation data show GEN3014 has a tolerable safety profile
  - The most common adverse events were IRRs and hematologic events
  - No TLS was reported at dose levels up to 24 mg/kg
  - No DLTs were observed at dose levels up to the RP2D
- Early clinical activity of GEN3014 in patients with RRMM has been observed in both anti-CD38 mAb–naive and anti-CD38 mAb–treated patients
- Biomarker analyses indicate biological activity in patients with RRMM at all evaluated doses
- The ongoing expansion part of this trial is evaluating GEN3014 at the RP2D of 16 mg/kg in patients with RRMM

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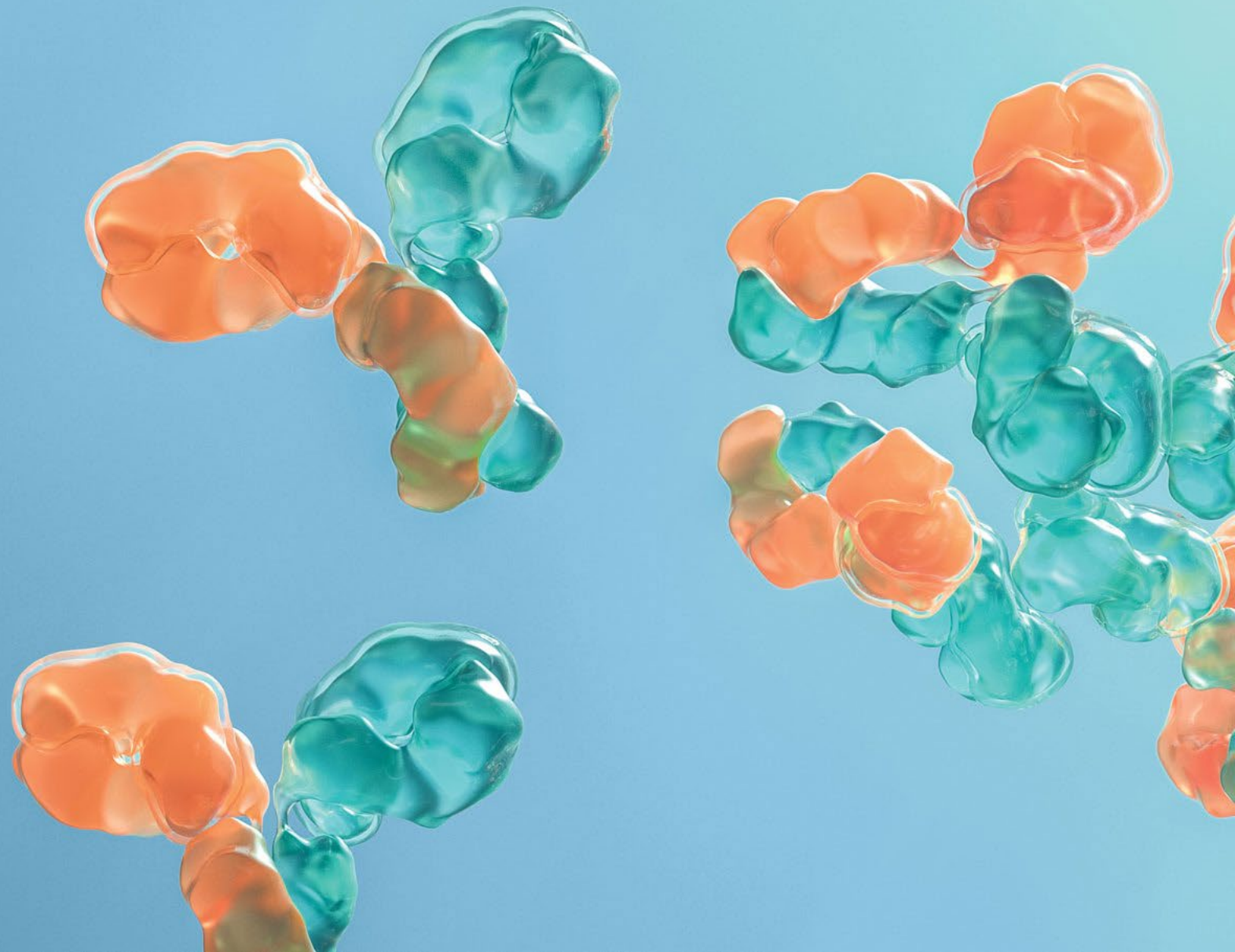
Epcoritamab at ASH



Presented by Dr. Lorenzo Falchi, Memorial Sloan Kettering Cancer Center

Abstract 4251

Epcoritamab Monotherapy Provides Deep and Durable Responses Including Minimal Residual Disease (MRD) Negativity: Novel Subgroup Analyses in Patients with Relapsed/Refractory (R/R) Large B-Cell Lymphoma (LBCL)

Tycel Phillips, MD,[1] et al

[1]University of Michigan Comprehensive Cancer Center, Ann Arbor, MI, USA

Presented at the 64th American Society of Hematology Annual Meeting and Exposition; December 10–13, 2022; New Orleans, LA, and virtual

Study Design: EPCORE NHL-1 LBCL Expansion

Dose escalation

Dose expansion data cutoff: January 31, 2022
Median follow-up: 10.7 mo

B-NHL:

- ✓No DLTs
- ✓MTD not reached
- ✓RP2D identified
- ✓Manageable safety profile
- ✓Encouraging antitumor activity

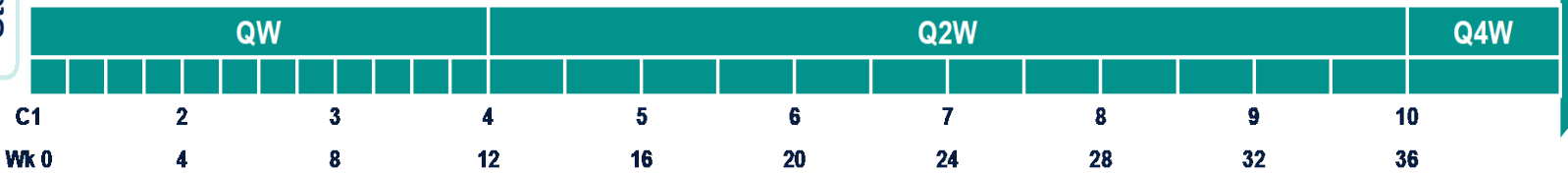
Key inclusion criteria:

- R/R CD20+ mature B-cell neoplasm
- ECOG PS 0–2
- ≥2 prior lines of antineoplastic therapy, including ≥1 anti-CD20 mAb
- FDG PET–avid and measurable disease by CT/MRI
- Prior CAR T allowed

Step-up dosing[a]

Epcoritamab SC RP2D 48 mg
Treatment until PD[b,c] or unacceptable toxicity
LBCL cohort, N=157
DLBCL, HGBCL, PMBCL, and FL G3B

SC injections in minutes



- To ensure patient safety and better characterize CRS, inpatient monitoring was required at first full dose for 24 h in this part of the study; this requirement has since been removed
- **Primary endpoint:** ORR by independent review committee (IRC)
- **Key secondary endpoints:** DOR, TTR, PFS, OS, CR rate, and safety/tolerability

[a]Step-up dosing (priming 0.16 mg and intermediate 0.8 mg dosing before first full dose) and corticosteroid prophylaxis were used to mitigate CRS. [b]Radiographic disease evaluation was performed every 6 wk for the first 24 wk (6, 12, 18, and 24 wk), then every 12 wk (36 and 48 wk), and every 6 mo thereafter. [c]≥2 measurable (by CT/MRI) and FDG PET–positive lesions. ClinicalTrials.gov: NCT03625037. EudraCT: 2017-001748-36.

Patient Demographics

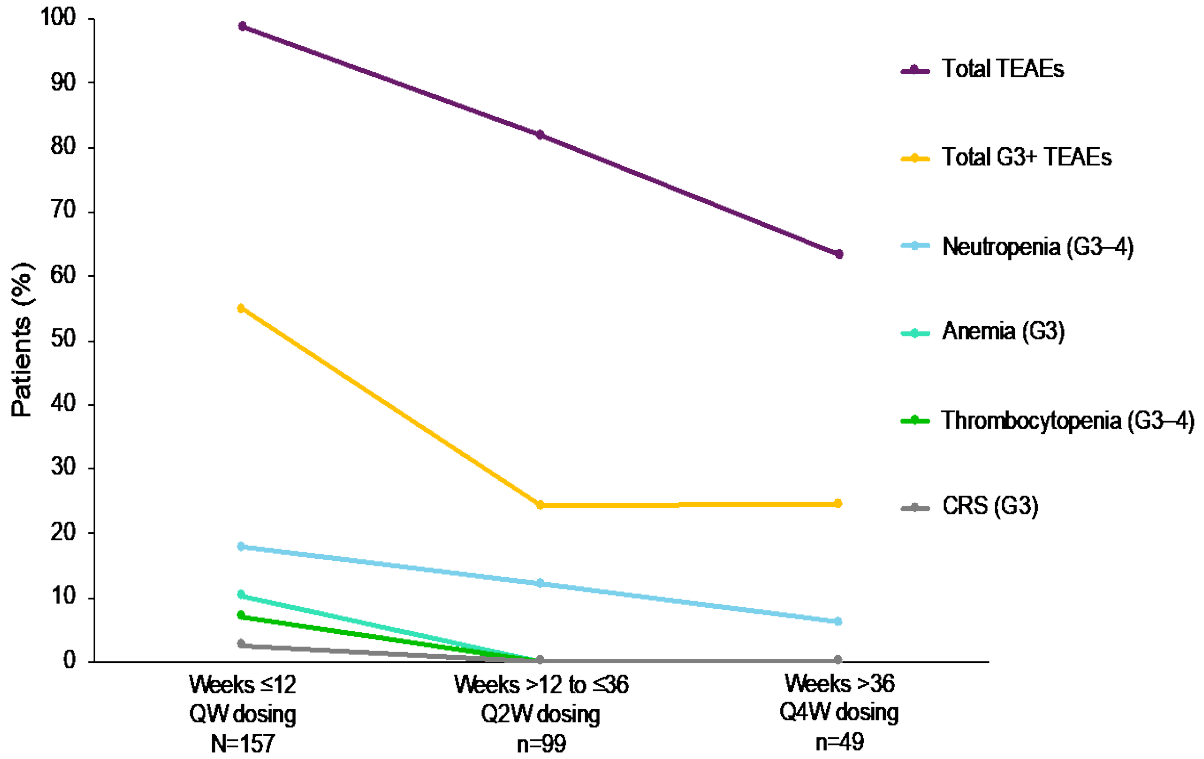
Demographics	LBCL, N=157
Median age (range), y	64 (20–83)
≥75 y, n (%)	29 (18)
ECOG PS, n (%)	
0	74 (47)
1	78 (50)
2	5 (3)
Disease Type, n (%)	**LBCL, N=157**
DLBCL[a]	139 (89)
De novo	97/139 (70)
Transformed	40/139 (29)
DLBCL with DH/TH rearrangements by central FISH[b]	12/88 (14)
HGBCL	9 (6)
PMBCL	4 (3)
FL G3B	5 (3)
Prior Treatments	**LBCL, N=157**
Median time from initial diagnosis to first dose, y	1.6
Median time from end of last therapy to first dose, mo	2.4
Median prior lines of therapy (range)	3 (2–11)
≥3 Lines of therapy, n (%)	111 (71)
Primary refractory[c] disease, n (%)	96 (61)
Refractory[c] to last systemic therapy, n (%)	130 (83)
Refractory[c] to ≥2 consecutive lines of therapy, n (%)	119 (76)
Prior ASCT, n (%)	31 (20)
Prior CAR T therapy, n (%)	61 (39)
Refractory[c] to CAR T therapy	46/61 (75)

[a]De novo versus transformed status of 2 patients with DLBCL was unknown. [b]88 patients with DLBCL were tested using central FISH. [c]Refractory disease is defined as disease that either progressed during therapy or progressed within <6 mo of completion of therapy.

Safety

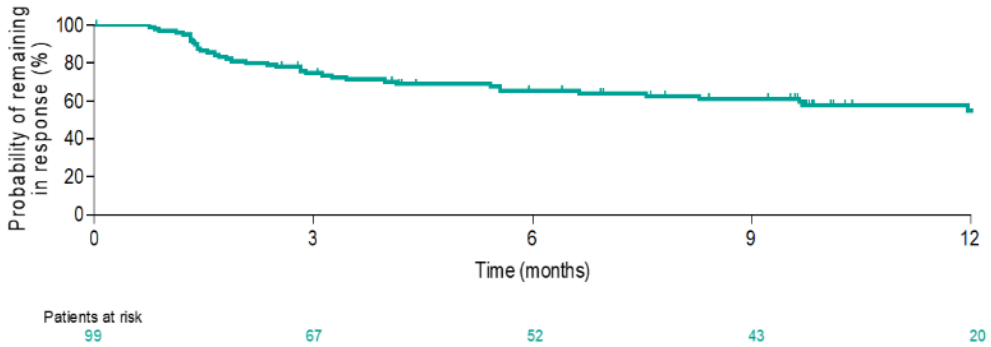
- The most common TEAEs were CRS (49.7%), pyrexia (23.6%), fatigue (22.9%), neutropenia (21.7%), and diarrhea (20.4%)
- CRS primarily occurred after the first full dose on C1D15 and was low grade (47.1% G1–2; 2.5% G3); all but 1 case resolved
- Following first full dose, the median time to CRS onset was 20 h, and median time to resolution was 48 h
- Infections occurred in 45.2% of patients (28.7% G1–2; 13.4% G3; 1.3% G4; 1.9% G5); the most common G3+ infections were COVID-19 (4.5%) and sepsis (2.5%)
- All injection-site reactions were G1–2; these events occurred most frequently in the first 8 weeks of treatment, and 95% resolved
- Ten patients (6.4%) experienced ICANS; 9 (5.7%) had G1–2 events, and 1 patient (0.6%) with several confounding factors experienced a fatal ICANS event

Treatment-Emergent Adverse Events Decreased Over Time



Deep and Durable Responses Were Seen Across Subgroups

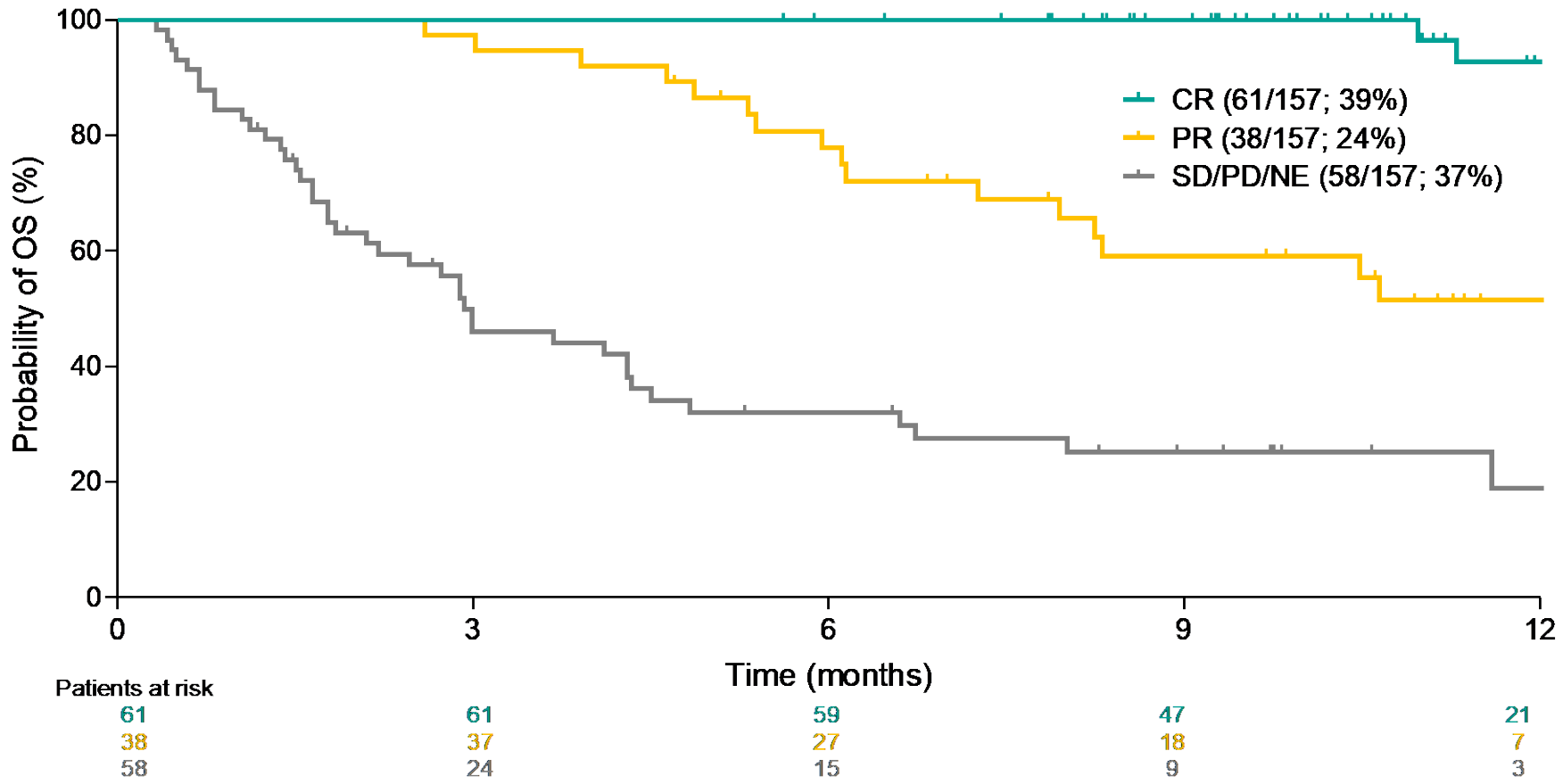
	Overall LBCL N=157	Primary refractory n=96	CAR T–naive n=96	CAR T–exposed n=61	Refractory to prior CAR T n=46	DH/TH n=12	Non–DH/TH n=76	Non–DLBCL subtypes[a] n=30
ORR, %	63	55	69	54	46	50	63	63
CR rate, %	39	30	42	34	28	33	41	37
mDOR, mo	See update[b]	NR	12.0	9.7	NR	12.0	NR	12.0
mDOR in CR patients, mo	NR	NR	NR	NR	NR	12.0	NR	12.0
MRD-negativity rate, % (n/N)[c]	45 (54/119)	40 (29/72)	45 (33/74)	47 (21/45)	40 (14/35)	36 (4/11)	51 (32/63)	36 (9/25)



- As of a more recent data cutoff on June 30, 2022 (median follow-up, 15.7 mo):
  - An estimated 61% and 55% of responders remained in response at 9 and 12 mo, respectively
  - An estimated 89% and 79% of complete responders remained in response at 9 and 12 mo, respectively

[a]Includes DH/TH DLBCL, HGBCL, PMBCL, and FL G3B. [b]See "Updated Duration of Response" section above. All other response data are from January 31, 2022 data cutoff. [c]MRD-negativity rate is as of June 30, 2022.

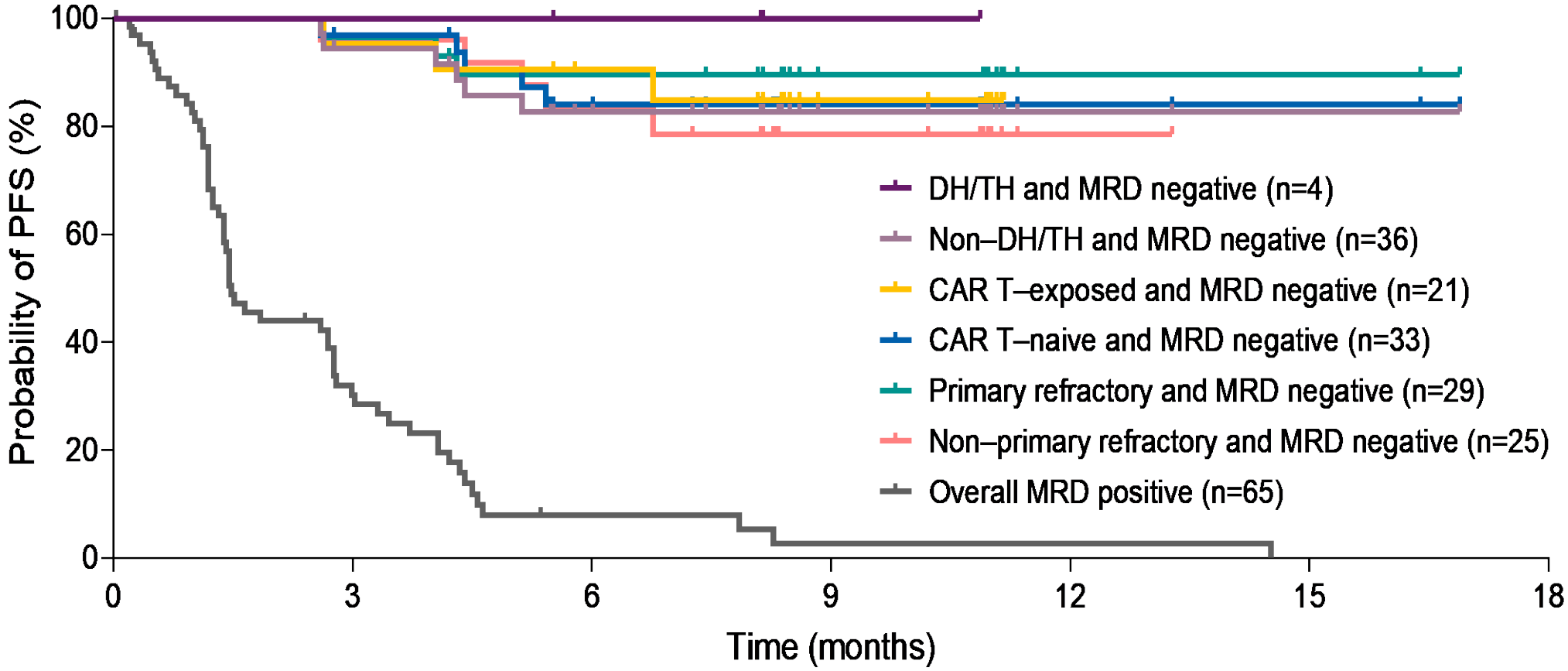
Overall Survival by Best Overall Response



- Median OS was not reached in the overall population (N=157); patients who achieved a CR had robust survival, with median PFS not reached

Data from January 31, 2022

MRD Negativity Was Correlated With Improved PFS



MRD-negativity rate is as of June 30, 2022.

Conclusions

- Epcoritamab is a SC, off-the-shelf T-cell–engaging therapy showing powerful single-agent activity
  in R/R LBCL
- Epcoritamab led to deep and durable responses that correlated with robust PFS and OS
- Subgroup analyses demonstrate high rates of complete response and MRD negativity across standard and poor-prognosis subgroups
- The safety profile was manageable; TEAEs decreased over time
- With longer follow-up, durability of response was reaffirmed; the majority of complete responders
  remain in response

Abstract 443

Subcutaneous Epcoritamab + R-DHAX/C in Patients with Relapsed or Refractory Diffuse Large B-Cell Lymphoma Eligible for Autologous Stem Cell Transplant: Updated Phase 1/2 Results

Pau Abrisqueta, MD, PhD,[1] Raul Cordoba, MD, PhD,[2] Lorenzo Falchi, MD,[3] Sven de Vos, MD, PhD,[4] Marcel Nijland, MD, PhD,[5] Fritz Offner, MD, PhD,[6] Jun Wu, MD, MS,[7] Irina Bykhovski, PharmD,[8] Liwei Wang, PhD,[8] Ali Rana, MD, PhD,[8] Tycel Phillips, MD[9]

[1]Hospital Universitario Vall d'Hebron, Barcelona, Spain; [2]Fundacion Jimenez Diaz University Hospital, Health Research Institute IIS-FJD, Madrid, Spain; [3]Lymphoma Service, Memorial Sloan Kettering Cancer Center, New York, NY, USA; [4]Ronald Reagan University of California Los Angeles Medical Center, Los Angeles, CA, USA; [5]University Medical Center Groningen and University of Groningen, Groningen, Netherlands; [6]Universitair Ziekenhuis Gent, Ghent, Belgium; [7]AbbVie, North Chicago, IL, USA; [8]Genmab, Princeton, NJ, USA; [9]University of Michigan Comprehensive Cancer Center, Ann Arbor, MI, USA

Presented at the 64th American Society of Hematology Annual Meeting and Exposition; December 10–13, 2022; New Orleans, LA, and virtual

Study Design: EPCORE NHL-2 Arm 4

A phase 1b/2, open-label trial evaluating the safety and antitumor activity of epcoritamab + R-DHAX/C in adults with R/R DLBCL who are eligible for transplant

Key inclusion criteria

- R/R CD20+ DLBCL
  - DLBCL, NOS
  - "Double-hit" or "triple-hit" DLBCL[a]
  - FL grade 3B
  - T-cell/histiocyte-rich DLBCL
- Eligible for R-DHAX/C and HDT-ASCT
- ECOG PS 0–2
- Measurable disease by CT or MRI
- Adequate organ function

Data cutoff: September 16, 2022
Median follow-up: 12.6 mo
ClinicalTrials.gov: NCT04663347

Dose escalation, n=8 → **Expansion, n=21**

Step-up dosing

Epcoritamab (SC)
24 mg (n=3) or
48 mg (n=5)
QW C1–4,
Q2W C5–9,
Q4W C10+*

+ R-DHAX/C
C1–3

Primary objectives: DLT/Safety and tolerability
Key secondary objective: Antitumor activity[b]

Step-up dosing

Epcoritamab (SC)
48 mg
QW C1–4,
Q2W C5–9,
Q4W C10+*

+ R-DHAX/C
C1–3

Primary objective: Antitumor activity[b]
Primary endpoint: ORR per Lugano criteria
***Epcoritamab treatment until**
HDT-ASCT or PD (whichever is earlier)

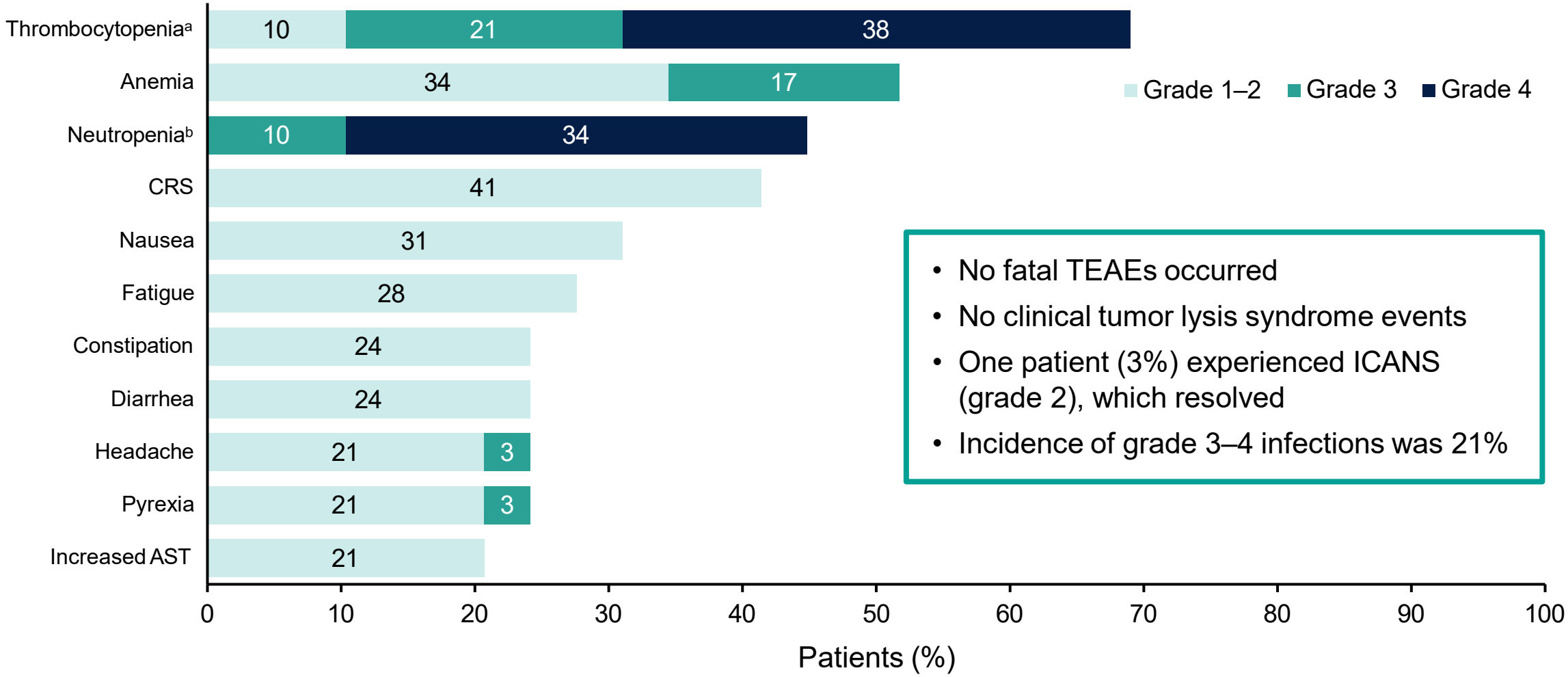
R-DHAX/C regimen in C1–3, 21 d each: rituximab 375 mg/m^2 IV Q3W; dexamethasone 40 mg/d IV or orally on days 1–4; cytarabine 2 g/m^2 IV repeated after 12 h Q3W; carboplatin AUC = 5 mg/mL x min (Calvert formula) or oxaliplatin 100 mg/m^2 IV Q3W. Cycle 4 was 21 d; cycles 5+ were 28 d each. [a]Classified as HGBCL, with *MYC* and *BCL2* and/or *BCL6* translocations. [b]Tumor response was evaluated by PET-CT obtained at 6, 12, 18, 24, 36, and 48 wk, and every 24 wk thereafter, until disease progression.

Patients Were High Risk and Highly Refractory

Characteristic	Total N=29
Median age, y (range)	58 (28–75)
Male, n (%)	24 (83)
Ann Arbor stage, n (%)	
II–III	10 (34)
IV	19 (66)
Transformed from indolent lymphoma, n (%)	10 (34)
Double-/triple-hit lymphoma, n (%)	4 (14)
ECOG PS, n (%)	
0	11 (38)
1	18 (62)
Median time from diagnosis to first dose, mo (range)	11 (0.3–54)
Median number of prior lines of therapy (range)	1 (1–3)
Prior CAR T, n (%)	3 (10)
Progressed within 12 mo of initial therapy, n (%)	19 (66)
Primary refractory[a] disease, n (%)	19 (66)
Relapsed within 6 mo after therapy	14 (48)
No response	5 (17)

Data cutoff: September 16, 2022. [a]Refractory indicates no response or relapse within 6 mo after therapy.

TEAEs (≥20%) by Grade



- No fatal TEAEs occurred
- No clinical tumor lysis syndrome events
- One patient (3%) experienced ICANS (grade 2), which resolved
- Incidence of grade 3–4 infections was 21%

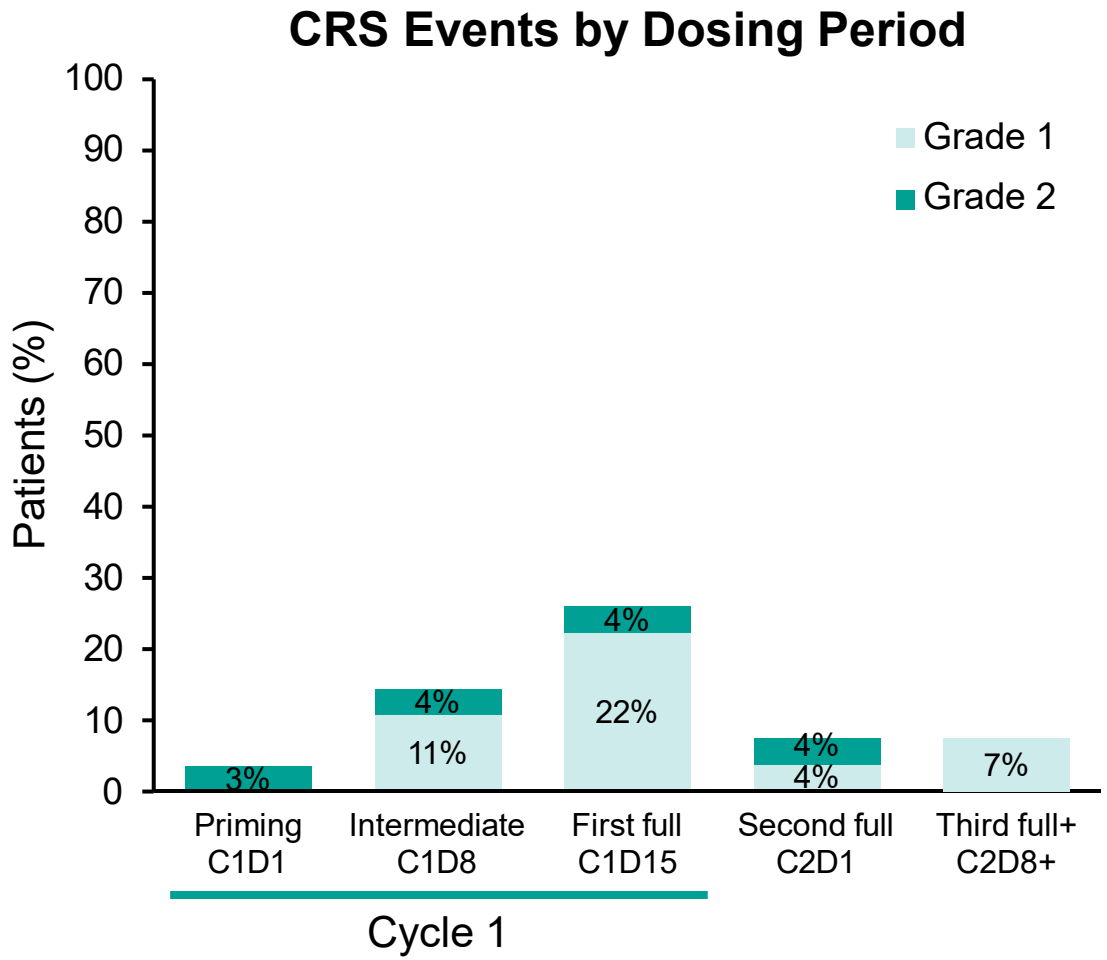
Data cutoff: September 16, 2022. [a]Combined term includes thrombocytopenia and platelet count decreased. [b]Combined term includes neutropenia and neutrophil count decreased; 4 patients (14%) had febrile neutropenia (grade 3).

CRS Was Low Grade; All Events Resolved

	Total, N=29
CRS, n (%)[a]	12 (41)
Grade 1	9 (31)
Grade 2	3 (10)
Grade 3–5	0
CRS resolution, n/n (%)	**12/12 (100)**
Median time to resolution, d (range)[b]	2 (1–8)
Treated with tocilizumab, n (%)	2 (7)
Leading to treatment discontinuation, n (%)	**0**

Data cutoff: September 16, 2022. [a]Graded by Lee et al 2019 criteria. [b]Median is Kaplan–Meier estimate based on longest CRS duration in patients with CRS.

CRS occurrence was predictable, most commonly following the first full dose with a median time to onset of 2 days



Overall and Complete Response Rates Were High

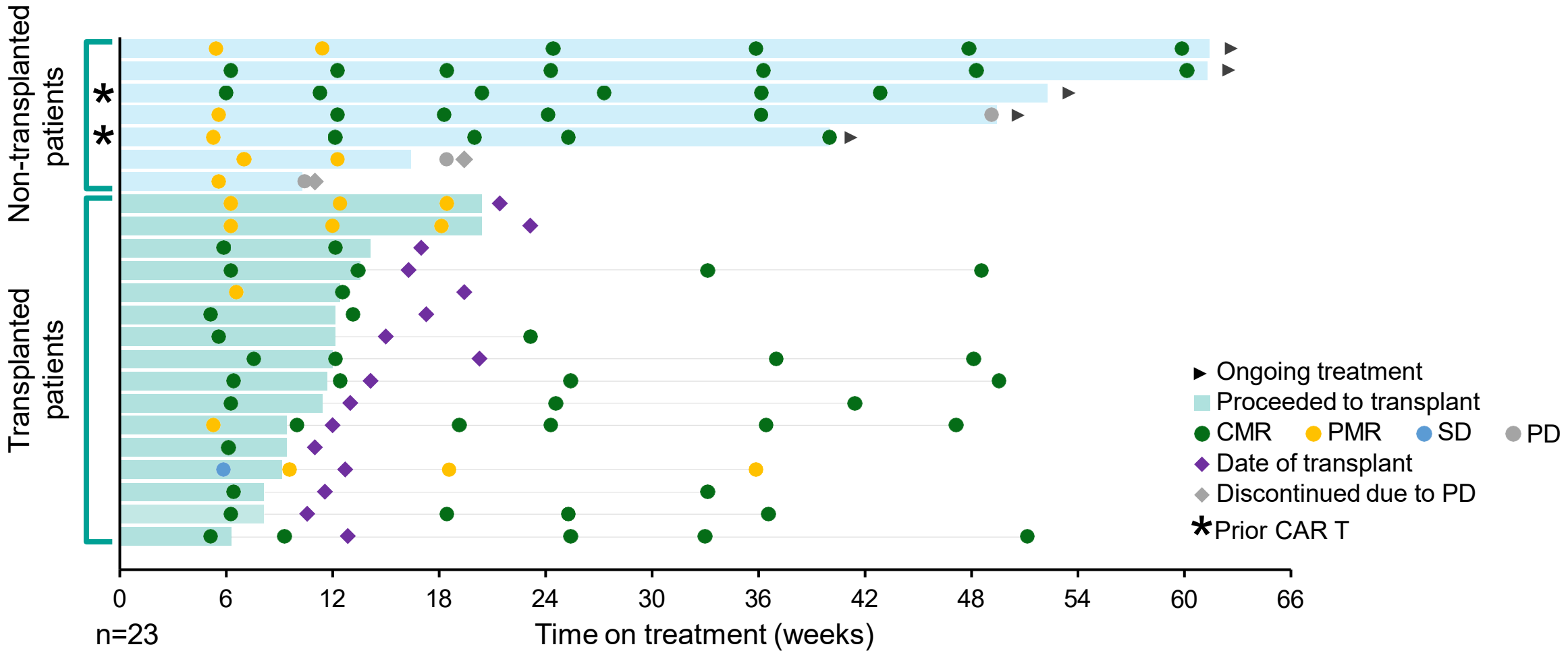
Response, n (%)[a]	Received ASCT n=16	Did not receive ASCT n=11[b]	Total efficacy evaluable n=27
Overall response	**16 (100)**	**7 (64)**	**23 (85)**
CMR	13 (81)	5 (45)	18 (67)
PMR	3 (19)	2 (18)	5 (19)
Stable disease	0	2 (18)	2 (7)
Progressive disease	0	1 (9)	1 (4)

Data cutoff: September 16, 2022. [a]Based on modified response-evaluable population, defined as patients with ≥1 target lesion at baseline and ≥1 postbaseline response evaluation and patients who died within 60 d of first dose. One patient died within 60 d of first dose without assessment. [b]Includes 5 patients who continued epcoritamab monotherapy and 6 patients who discontinued prior to reaching transplant.

- Median* follow-up was 12.6 mo (range, 2.0+ to 17.1)
- Median duration of response and median duration of CMR were not reached
- Median time to response and complete response was 1.4 mo (range, 1.2–2.2 and 1.2–5.6, respectively)
- Efficacy was consistent in primary refractory patients: ORR 82%; CMR 59%

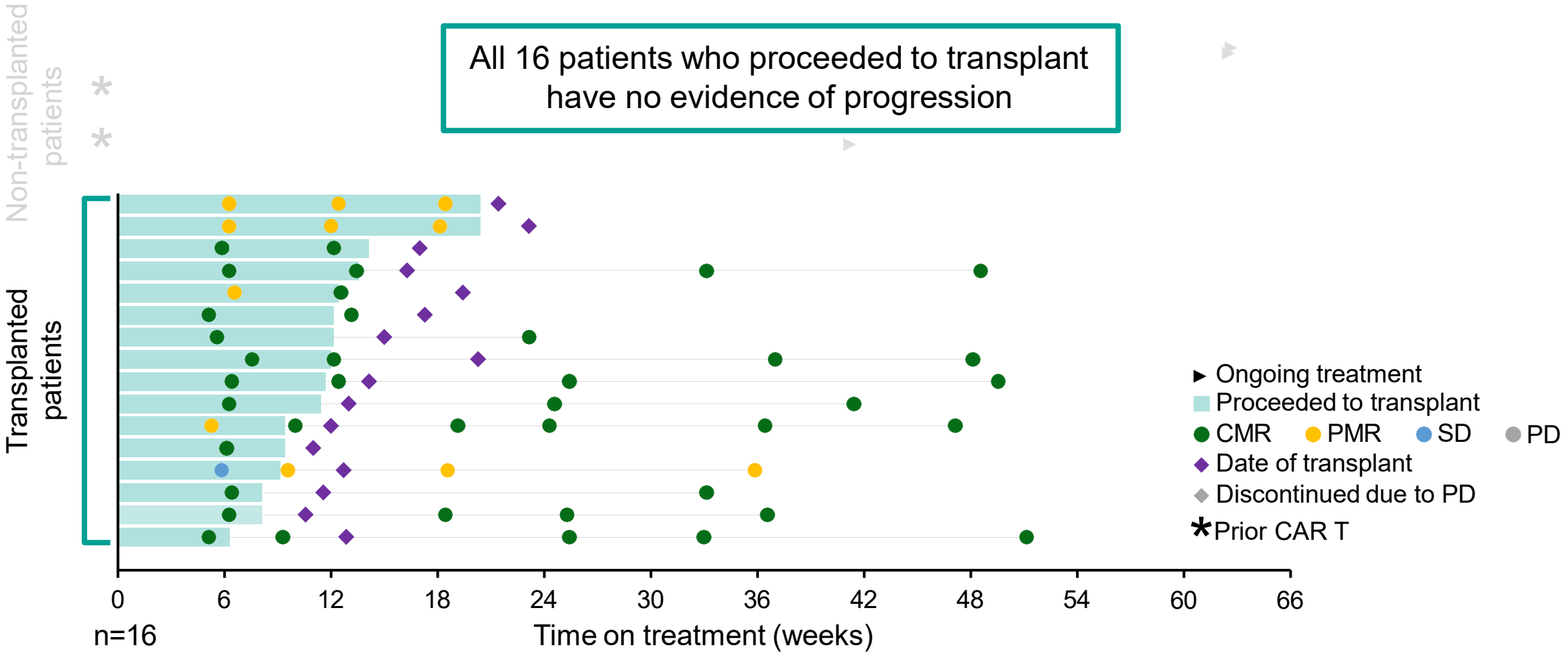
*Median is Kaplan–Meier estimate.

Responses Were Observed Early and Were Deep and Durable



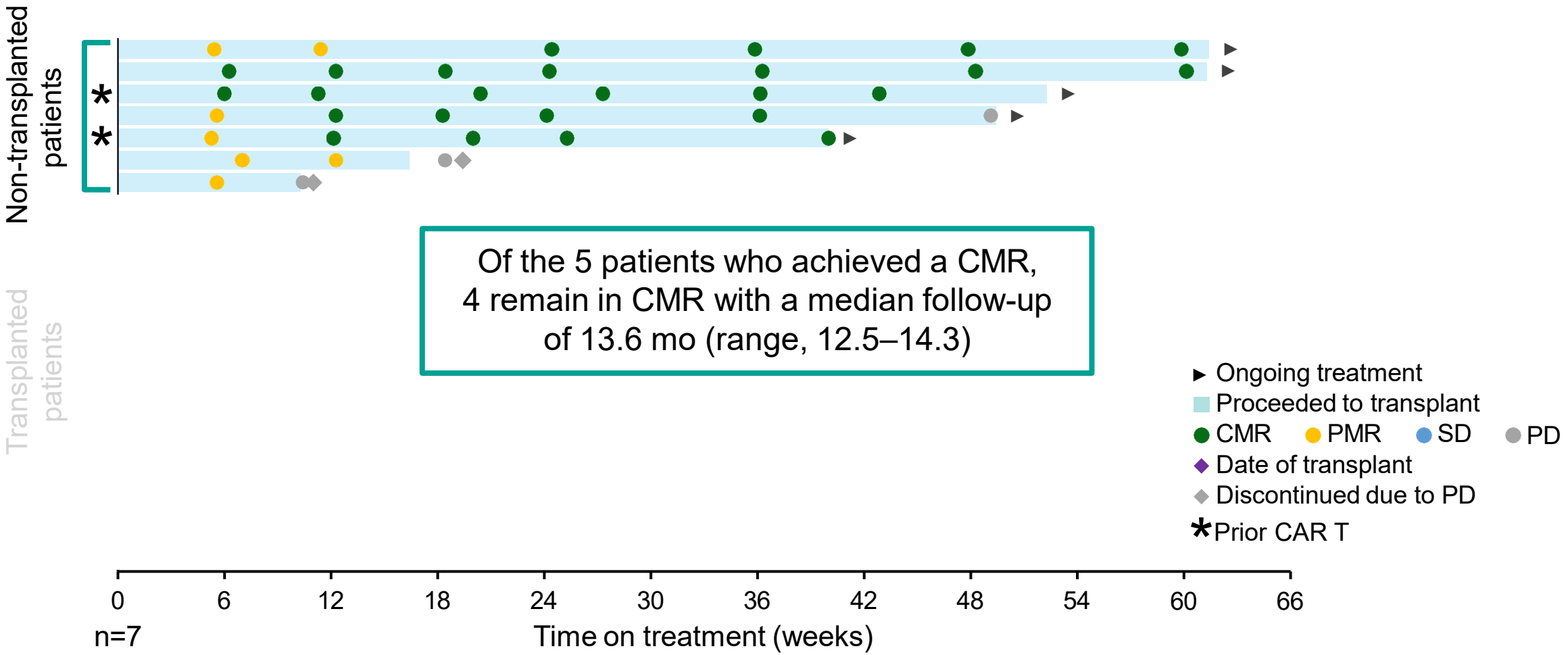
Data cutoff: September 16, 2022.

Responses in Transplanted Patients



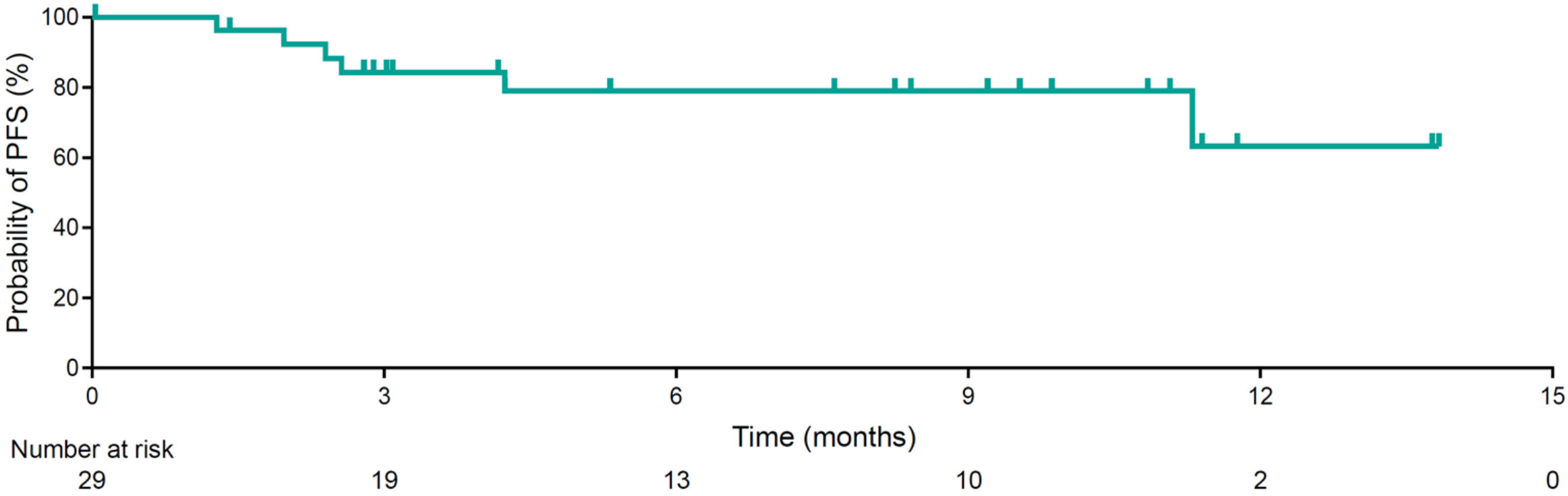
Data cutoff: September 16, 2022.

Responses in Non-Transplanted Patients



Data cutoff: September 16, 2022.

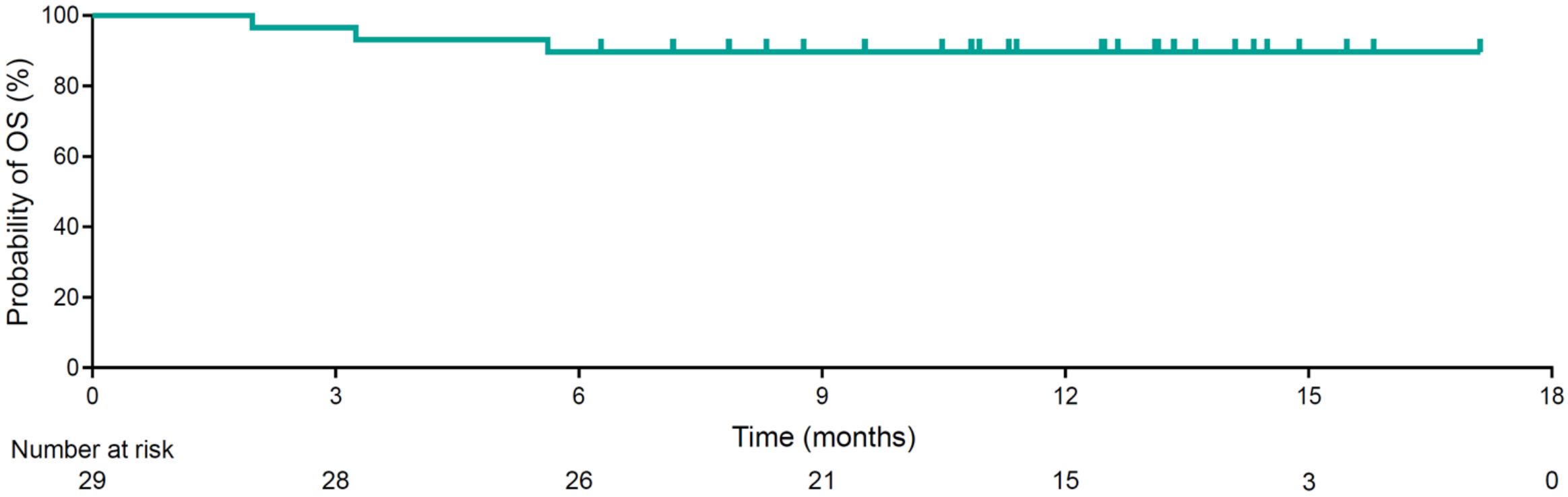
Progression-Free Survival



mPFS not reached at a median follow-up of 12.6 mo

Data cutoff: September 16, 2022. Kaplan–Meier estimated probability of PFS.

Overall Survival



An estimated 90% (95% CI, 71%–97%) of patients remained alive at 12 mo;
mOS not reached at a median follow-up of 12.6 mo

Data cutoff: September 16, 2022. Kaplan–Meier estimated probability of OS.

Conclusions

- In R/R DLBCL, epcoritamab + R-DHAX/C demonstrated high ORRs and CMR rates with a manageable safety profile across both transplanted and non-transplanted patients
  - ORR 85%; CMR 67%
- Responses were deep and durable
  - Among the 16 patients who proceeded to transplant, there is no evidence of progression
  - Four non-transplanted patients remained on treatment and in CMR
- Median duration of response, median PFS, and median OS were not reached
- Epcoritamab is well suited for combination therapy and may improve outcomes of salvage CIT
- These updated data support further exploration of epcoritamab + R-DHAX/C in patients with ASCT-eligible R/R DLBCL

Abstract 609

Subcutaneous Epcoritamab with Rituximab + Lenalidomide in Patients with Relapsed or Refractory Follicular Lymphoma: Phase 1/2 Trial Update

Lorenzo Falchi, MD,[1] Pau Abrisqueta, MD, PhD,[2] Marcel Nijland, MD, PhD,[3] Sirpa Leppä, MD,[4] Martin Hutchings, MD, PhD,[5] Harald Holte, MD, PhD,[6] Reid W. Merryman, MD,[7] Pieternella Lugtenburg, MD, PhD,[8] Sven de Vos, MD, PhD,[9] Chan Y. Cheah, MBBS, FRACP, FRCPA, DMSc,[10] Jacob Haaber Christensen, MD, PhD,[11] Luca Arcaini, MD,[12] Kristina Drott, MD, PhD,[13] Mats Hellström, MD, PhD,[14] Lori A. Leslie, MD,[15] Umberto Vitolo, MD,[16] Ali Rana, MD, PhD,[17] Aqeel Abbas, MS,[17] Liwei Wang, PhD,[17] Minh Dinh, MD,[18] David Belada, MD, PhD[19]

[1]Lymphoma Service, Memorial Sloan Kettering Cancer Center, New York, NY, USA; [2]Hospital Universitario Vall d'Hebron, Barcelona, Spain; [3]University Medical Center Groningen and University of Groningen, Groningen, Netherlands; [4]Helsinki University Hospital Comprehensive Cancer Center and University of Helsinki, Helsinki, Finland; [5]Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark; [6]Oslo University Hospital and KG Jebsen Center for B-cell Malignancies, Oslo, Norway; [7]Dana-Farber Cancer Institute, Boston, MA, USA; [8]On behalf of the Lunenburg Lymphoma Phase I/II Consortium-HOVON/LLPC, Erasmus MC Cancer Institute, University Medical Center, Department of Hematology, Rotterdam, Netherlands; [9]Ronald Reagan University of California Los Angeles Medical Center, Los Angeles, CA, USA; [10]Sir Charles Gairdner Hospital, Nedlands, Australia; [11]Odense University Hospital, Odense, Denmark; [12]Department of Molecular Medicine, University of Pavia and Division of Hematology, Fondazione IRCCS Policlinico San Matteo, Pavia, Italy; [13]Skåne University Hospital, Scania, Sweden; [14]Uppsala University Hospital, Uppsala, Sweden; [15]Hackensack University Medical Center, Hackensack, NJ, USA; [16]Candiolo Cancer Institute, FPO-IRCCS, Candiolo (Turin), Italy; [17]Genmab, Princeton, NJ, USA; [18]AbbVie, North Chicago, IL, USA; [19]4th Department of Internal Medicine – Hematology, University Hospital and Faculty of Medicine, Hradec Králové, Czech Republic

Presented at the 64th American Society of Hematology Annual Meeting and Exposition; December 10–13, 2022; New Orleans, LA, and virtual

Study Design: EPCORE NHL-2, Arm 2b

A phase 1b/2, open-label trial evaluating the safety and antitumor activity of epcoritamab + R² in adults with R/R FL[a]

Key inclusion criteria

- R/R CD20⁺ FL
  - Grade 1, 2, or 3A
  - Stage II–IV
- Need for treatment based on symptoms or disease burden, as determined by GELF criteria[1]
- ECOG PS 0–2
- Measurable disease by CT or MRI
- Adequate organ function

Data cutoff: September 16, 2022
Median follow-up: 6.4 mo

	Treatment Regimen Epcoritamab SC 48 mg + R²						
Agent	**C1**	**C2**	**C3**	**C4**	**C5**	**C6–C12**	**C13+**
Epcoritamab SC 48 mg	QW	QW	Q4W	Q4W	Q4W	Q4W	Q4W Up to 2 years
R² Rituximab IV 375 mg/m²	QW	Q4W	Q4W	Q4W	Q4W		
R² Lenalidomide oral 20 mg	Daily for 21 d (for 12 cycles)						

Primary objective: Safety and antitumor activity[b]

[a]Patients received SC epcoritamab with step-up dosing (ie, priming and intermediate doses before first full dose), corticosteroid prophylaxis to mitigate CRS, and protocol-mandated hospitalization for 24 h after the first full dose. Epcoritamab was administered in 28-d cycles as shown. In arm 2a, epcoritamab schedule was QW in C1–3, Q2W in C4–9, and Q4W in C10+. Dose escalation evaluated 24 and 48 mg epcoritamab + R². [b]Tumor response was evaluated by PET-CT obtained at 6, 12, 18, 24, 36, and 48 wk, and every 24 wk thereafter, until disease progression. **1.** Brice P, et al. *J Clin Oncol*. 1997;15:1110-7.

Patient Characteristics

Demographics and Disease Characteristics	Total N=76
Median age, y (range)	64 (30–79)
Female, n (%)	37 (49)
Ann Arbor stage, n (%)	
II	12 (16)
III	19 (25)
IV	45 (59)
Histologic grade, n (%)[a]	
1	6 (8)
2	37 (49)
3A	24 (32)
FLIPI, n (%)[b]	
0–1	7 (9)
2	24 (32)
3–5	39 (51)
ECOG PS, n (%)	
0	48 (63)
1	25 (33)
2	3 (4)

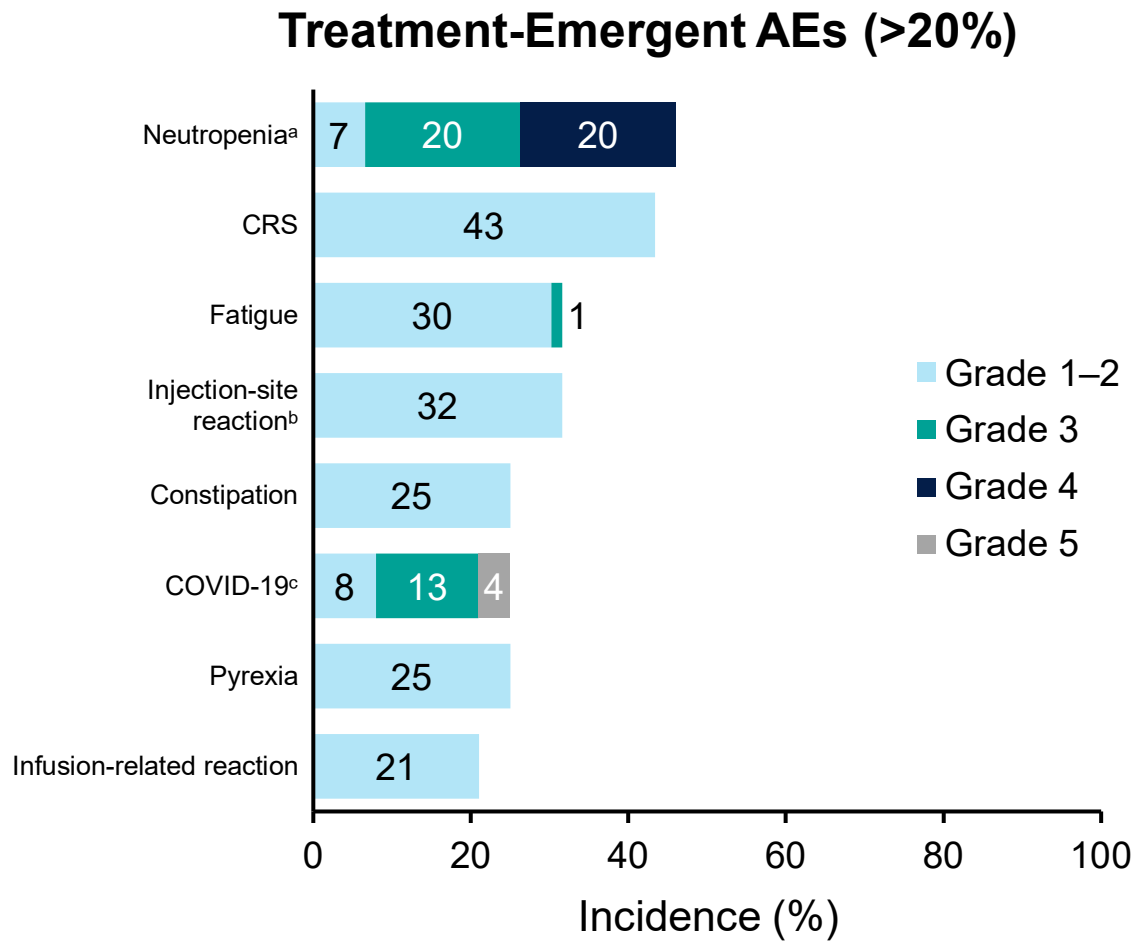
Treatment History	Total N=76
Median time from diagnosis to first dose, mo (range)	59 (4–331)
Median time from end of last line of therapy to first dose, mo (range)	16 (0.2–198)
Median number of prior lines of therapy (range)	1 (1–9)
1 prior line, n (%)	41 (54)
2 prior lines, n (%)	21 (28)
≥3 prior lines, n (%)	14 (18)
Primary refractory[c] disease, n (%)	29 (38)
Double refractory[d] disease, n (%)	30 (39)
POD24[e], n (%)	32 (42)
Refractory[c] to last line of therapy, n (%)	29 (38)
Prior ASCT, n (%)	8 (11)
Prior CAR T, n (%)	2 (3)

[a]Histologic grade was unknown or missing for 9 patients. [b]FLIPI was unknown for 6 patients. [c]Refractory indicates no response or relapse within 6 mo after prior therapy. [d]Double refractory indicates refractory to both anti-CD20 and an alkylating agent. [e]Progression within 2 y of initiating first-line treatment that included immunochemotherapy.

Safety Profile

	Total N=76
Median number of epcoritamab cycles initiated (range)	6 (1–11)
Grade ≥3 TEAE, n (%)	53 (70)
Related to epcoritamab	29 (38)
Fatal TEAE (all COVID-19), n (%)	3 (4)
Epcoritamab dose delay due to TEAE, n (%)	40 (53)
Related to epcoritamab	19 (25)
Epcoritamab discontinuation due to TEAE, n (%)	5 (7)
Related to epcoritamab	0

- No clinical tumor lysis syndrome was observed
- One patient experienced ICANS (grade 1), which resolved in 7 days



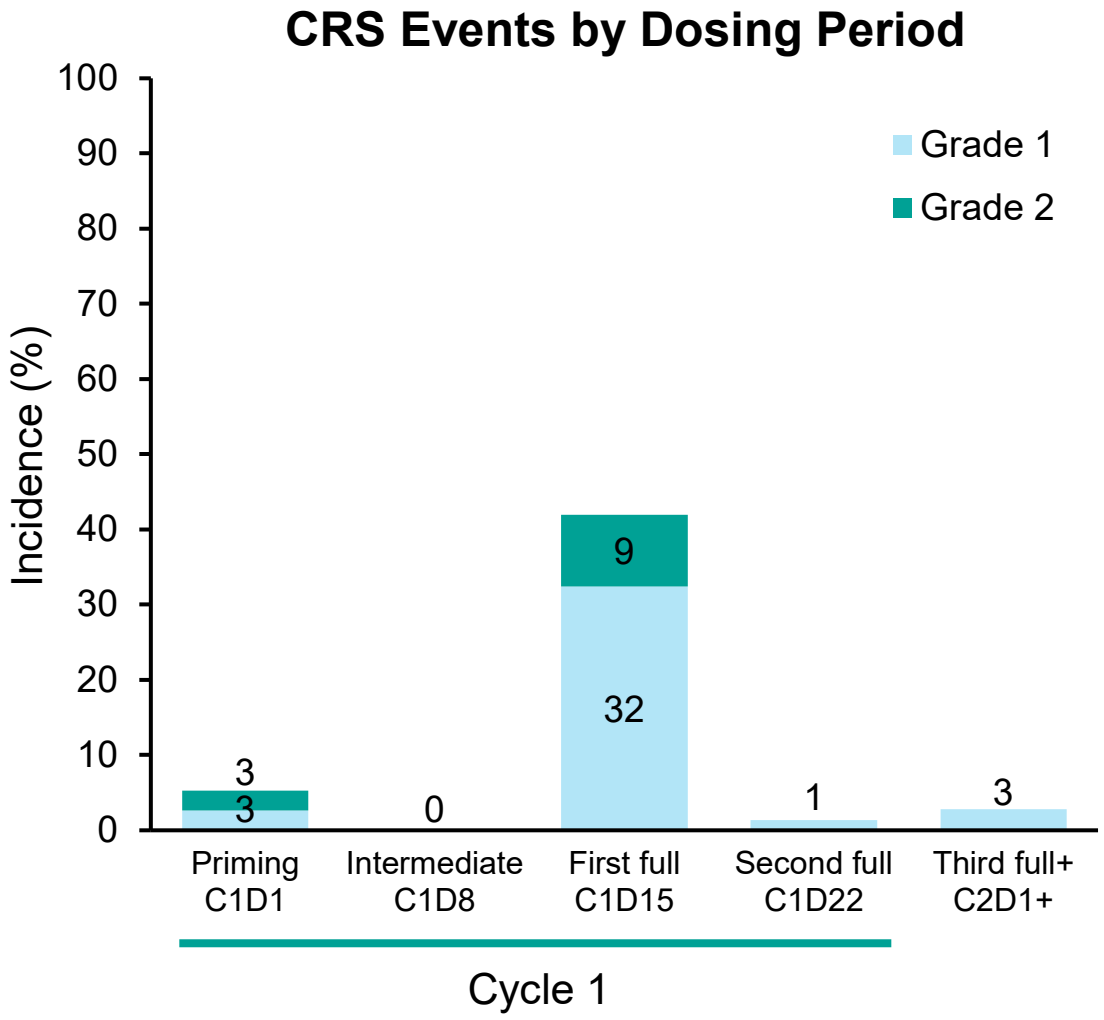
[a]Combined term includes neutropenia and neutrophil count decreased; 3 patients (4%) had febrile neutropenia (grade 3). [b]Combined term includes injection-site reaction and erythema. [c]Combined term includes COVID-19, COVID-19 pneumonia, and post-acute COVID-19 pneumonia.

CRS Events

	Total, N=76
CRS, n (%)[a]	33 (43)
Grade 1	25 (33)
Grade 2	8 (11)
Median time to onset after first full dose, d (range)	2 (1–9)
CRS resolution, n (%)	33 (100)
Median time to resolution, d (range)[b]	2 (1–23)
Treated with tocilizumab, n (%)	8 (11)
Leading to treatment discontinuation, n (%)	**0**

[a]Graded by Lee et al 2019 criteria. [b]Median is Kaplan–Meier estimate based on longest CRS duration in patients with CRS.

- CRS occurrence was predictable, with most cases occurring following the first full dose
- No grade ≥3 CRS events
- These data support fully outpatient administration

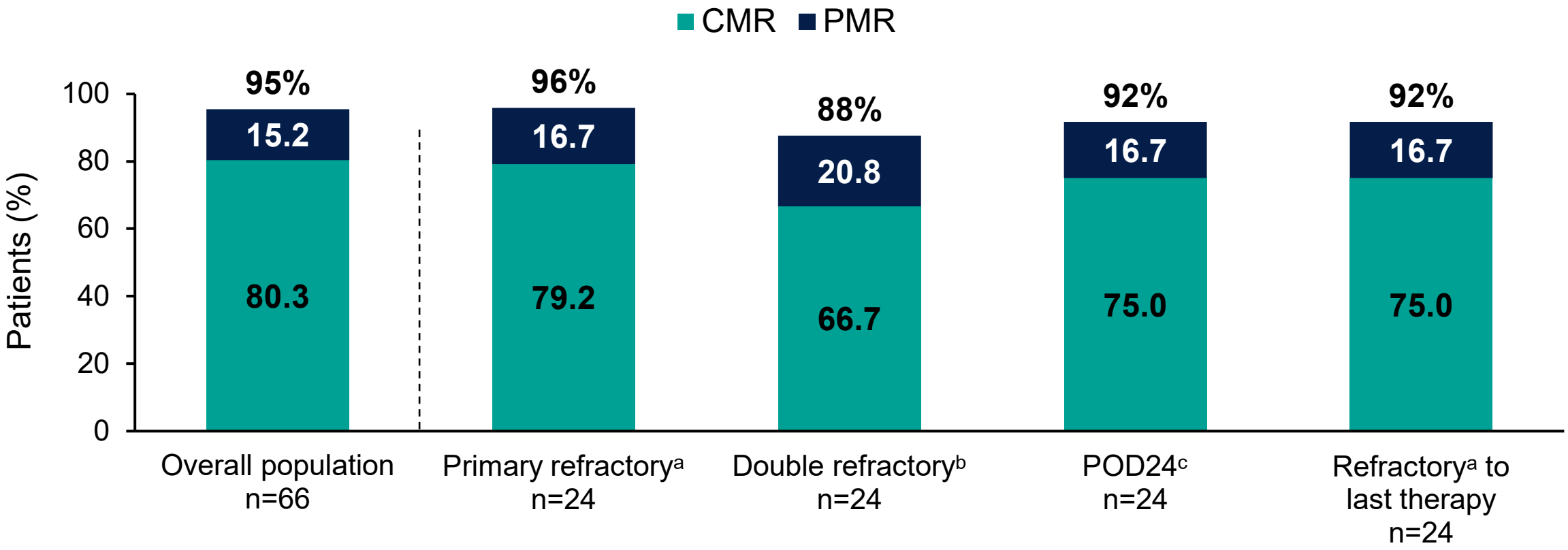


High Overall and Complete Metabolic Response Rates

Response[a]	Efficacy Evaluable n=66
Overall response	**95%**
CMR	80%
PMR[b]	15%
Stable disease	3%
Progressive disease	2%

Data cutoff: September 16, 2022. Median follow-up was 6.4 mo (range, 0.5–9.9). [a]Based on modified response-evaluable population, defined as patients with ≥1 target lesion at baseline and ≥1 postbaseline response evaluation and patients who died within 60 d of first dose. [b]Ongoing PMR in 3 patients.

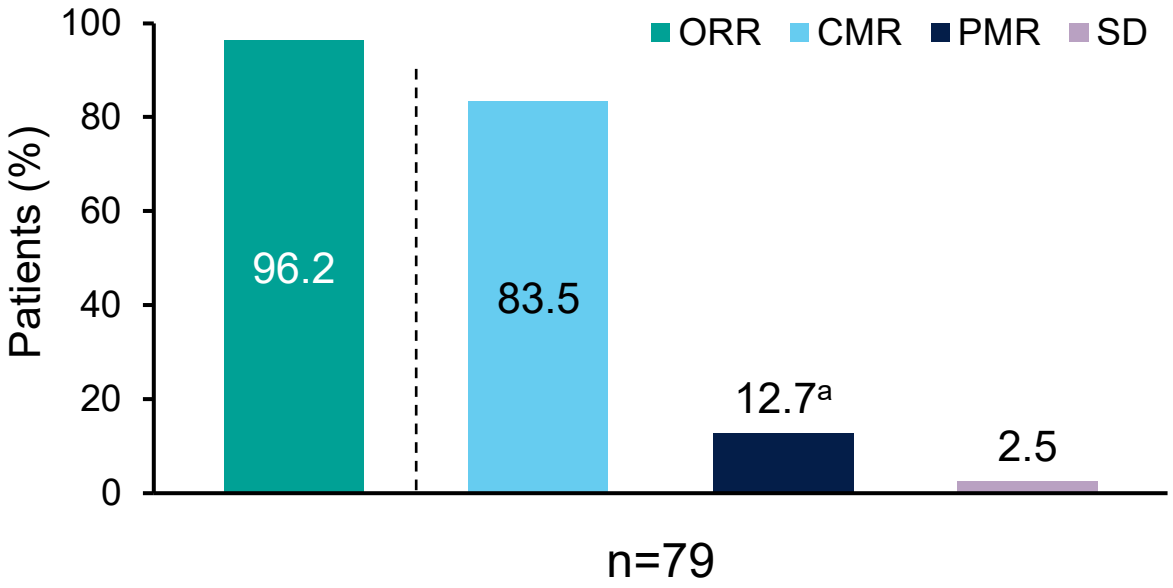
Responses Across High-risk Subgroups

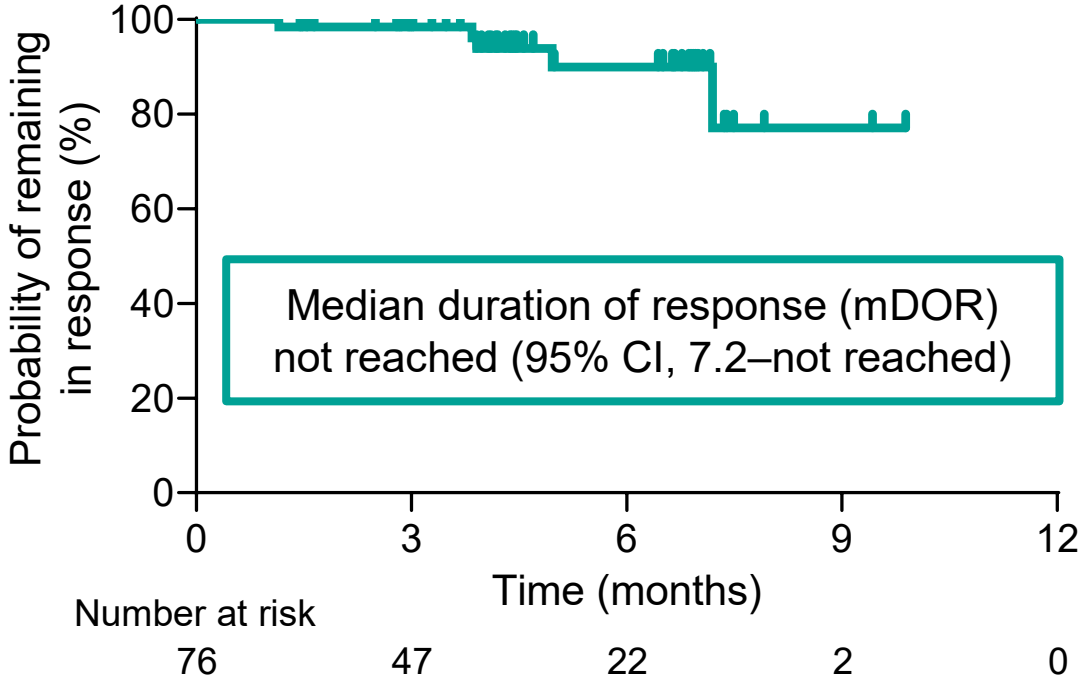


Deep responses consistent across high-risk R/R FL subgroups

Data cutoff: September 16, 2022. [a]Refractory indicates no response or relapse within 6 mo after prior therapy. [b]Double refractory indicates refractory to both anti-CD20 and an alkylating agent. [c]Progression within 2 y of initiating first-line treatment that included immunochemotherapy.

Updated Response Data





Data cutoff: October 31, 2022

Median follow-up: 5.6 mo (range, 1.2+ to 11.5+)

[a]Ongoing PMR in 6 patients.

Conclusions

- **Epcoritamab + R² showed potent antitumor activity**
  - High response rates: ORR 96.2%, CMR 83.5%; majority achieved at first assessment
  - Deep responses observed across high-risk subgroups
  - Durable responses have been observed
- **Safety remained consistent with previous reports**
  - No grade ≥3 CRS observed; CRS events mostly occurred after the first full dose
- **Ongoing phase 3 trial, EPCORE FL-1, is evaluating fully outpatient epcoritamab + R² in patients with R/R FL**
  - Trial-in-progress poster 4206 (Monday, December 12, 2022, 6:00 PM–8:00 PM)

Abstract 611

Subcutaneous Epcoritamab in Combination with Rituximab + Lenalidomide (R^2) for First-Line Treatment of Follicular Lymphoma: Initial Results from Phase 1/2 Trial

Lorenzo Falchi, MD,[1] Lori A. Leslie, MD,[2] David Belada, MD, PhD,[3] Katerina Kopeckova, MD, PhD,[4] Fritz Offner, MD, PhD,[5] Joshua Brody, MD,[6] Miguel Ángel Canales Albendea, MD, PhD,[7] Alejandro Martín García-Sancho, MD, PhD,[8] Marcel Nijland, MD, PhD,[9] Per-Ola Andersson, MD, PhD,[10] Farrukh Awan, MD,[11] Jacob Haaber Christensen, MD, PhD,[12] Kristina Drott, MD, PhD,[13] Mats Hellström, MD, PhD,[14] Catharina Lewerin, MD, PhD,[15] Mayur Narkhede, MD,[16] Sylvia Snauwaert, MD, PhD,[17] Björn E. Wahlin, MD, PhD,[18] Ali Rana, MD, PhD,[19] Aqeel Abbas, MS,[19] Liwei Wang, PhD,[19] Minh Dinh, MD,[20] Joost S.P. Vermaat, MD, PhD,[21] Pau Abrisqueta, MD, PhD[22]

[1]Lymphoma Service, Memorial Sloan Kettering Cancer Center, New York, NY, USA; [2]Hackensack University Medical Center, Hackensack, NJ, USA; [3]4th Department of Internal Medicine – Hematology, University Hospital and Faculty of Medicine, Hradec Králové, Czech Republic; [4]Motol University Hospital, Prague, Czech Republic; [5]Universitair Ziekenhuis Gent, Ghent, Belgium; [6]Icahn School of Medicine at Mount Sinai, New York, NY, USA; [7]Hospital Universitario La Paz, Madrid, Spain; [8]Hospital Universitario de Salamanca, IBSAL, Salamanca, Spain; [9]University Medical Center Groningen and University of Groningen, Groningen, Netherlands; [10]South Älvsborg Hospital, Borås, Sweden; [11]The University of Texas Southwestern Medical Center, Dallas, TX, USA; [12]Odense University Hospital, Odense, Denmark; [13]Skåne University Hospital, Scania, Sweden; [14]Uppsala University Hospital, Uppsala, Sweden; [15]Sahlgrenska University Hospital, Gothenburg, Sweden; [16]O'Neal Comprehensive Cancer Center at the University of Alabama at Birmingham, Birmingham, AL, USA; [17]Department of Hematology, AZ Sint-Jan Hospital, Bruges, Belgium; [18]Karolinska Institutet, Stockholm, Sweden; [19]Genmab, Princeton, NJ, USA; [20]AbbVie, North Chicago, IL, USA; [21]Leiden University Medical Center, Leiden, Netherlands; [22]Hospital Universitario Vall d'Hebron, Barcelona, Spain

Presented at the 64th American Society of Hematology Annual Meeting and Exposition; December 10–13, 2022; New Orleans, LA, and virtual

Study Design: EPCORE NHL-2, Arm 6

A phase 1b/2, open-label trial evaluating the safety and antitumor activity of epcoritamab + R² in adults with previously untreated FL

Key inclusion criteria

- Previously untreated CD20⁺ FL
  - Grade 1, 2, or 3A
- Need for treatment based on symptoms or disease burden, as determined by GELF criteria[1]
- ECOG PS 0–2
- Measurable disease by CT or MRI
- Adequate organ function

Data cutoff: September 16, 2022
Median follow-up, mo (range)[a]: 8.1 (1.4+ to 10.7)

Expansion, N=41

Step-up dosing

Epcoritamab (SC) 48 mg	**Rituximab (IV)**	**Lenalidomide (oral)**
QW C1–2, Q4W C3+	375 mg/m²	20 mg
Treatment up to 2 years	QW C1, Q4W C2–6	QD for 21 d in C1–12

- **Primary objective:** Antitumor activity (ORR)[b] and safety/tolerability
- **Key secondary endpoints:** DOR

Epcoritamab was administered in 28-d cycles as shown. Dose escalation (part of arm 2a, previously reported[2]) evaluated 24 and 48 mg epcoritamab + R². In arm 2a, epcoritamab schedule was QW in C1–3, Q2W in C4–9, and Q4W in C10+. [a]Median is Kaplan–Meier estimate. [b]Tumor response was evaluated by PET-CT obtained Q12W until CMR, and then Q24W, relative to the first study day, until disease progression. **1.** Brice P, et al. *J Clin Oncol*. 1997;15:1110-7. **2.** Falchi L, et al. ASCO 2022. Abstract 7524.

Patient Characteristics

Characteristic	Total N=41
Median age, y (range)	57 (39–78)
Female, n (%)	20 (49)
Median time from diagnosis to first dose, wk (range)	12 (2–352)
Ann Arbor stage, n (%)	
I–II	3 (7)
III	16 (39)
IV	22 (54)
Histologic grade, n (%)	
1	5 (12)
2	29 (71)
3A	7 (17)
FLIPI, n (%)[a]	
0–1	10 (24)
2	14 (34)
3–5	14 (34)
ECOG PS, n (%)	
0	34 (83)
1	6 (15)
2	1 (2)

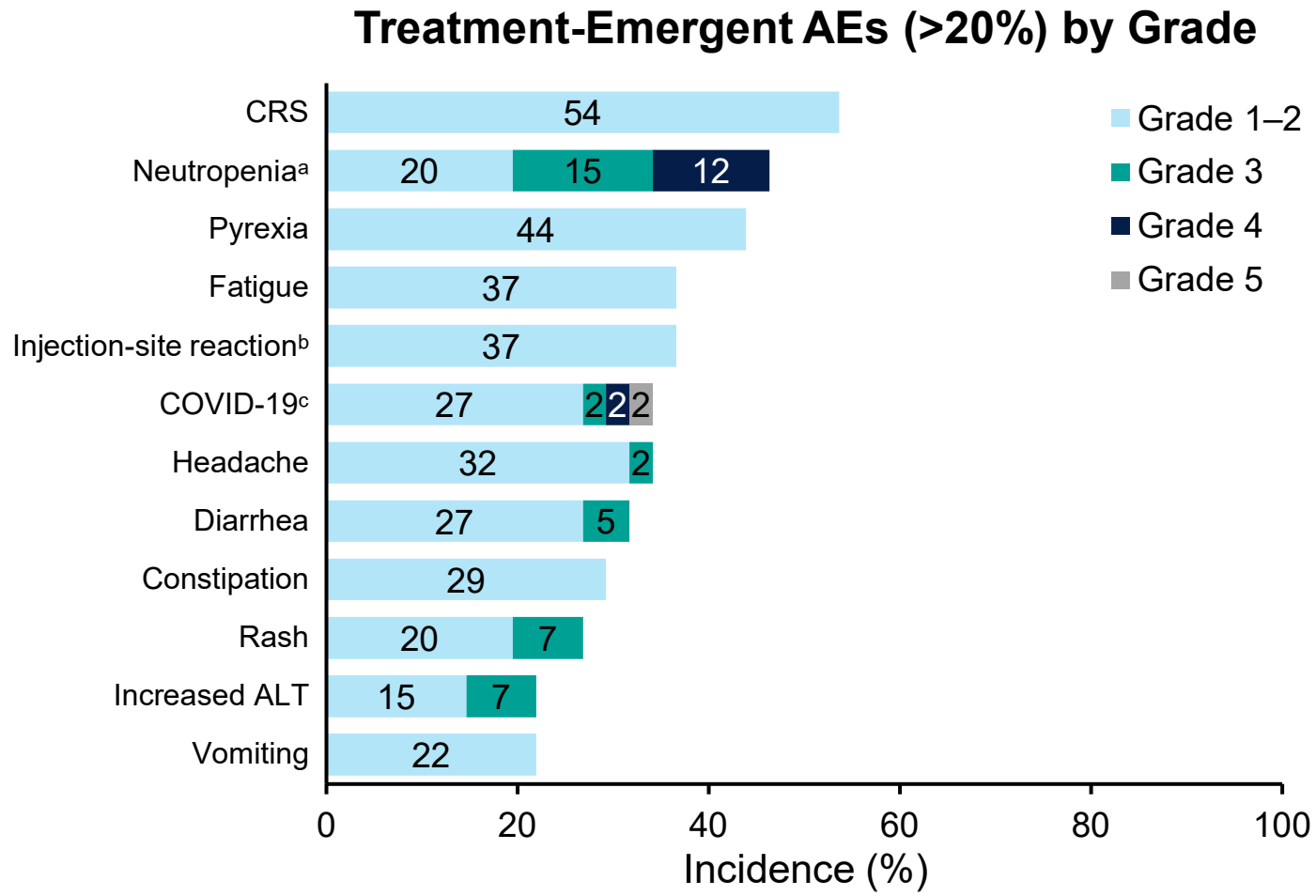
[a]FLIPI was unknown for 3 patients.

Safety Profile

Patients, n (%)	Total N=41
Grade ≥3 TEAE	30 (73)
Related to epcoritamab	14 (34)
Fatal TEAE	2 (5)[a]
Epcoritamab dose delay due to TEAE	22 (54)
Related to epcoritamab	7 (17)
Epcoritamab discontinuation due to TEAE	4 (10)
Related to epcoritamab	3 (7)[b]

[a]COVID-19 pneumonia and septic shock (n=1 each) unrelated to epcoritamab. [b]COVID-19 pneumonia, pneumonitis, and toxic skin eruption (n=1 each).

- No clinical tumor lysis syndrome was observed
- One patient (2%) experienced ICANS (grade 1), which resolved in 2 days



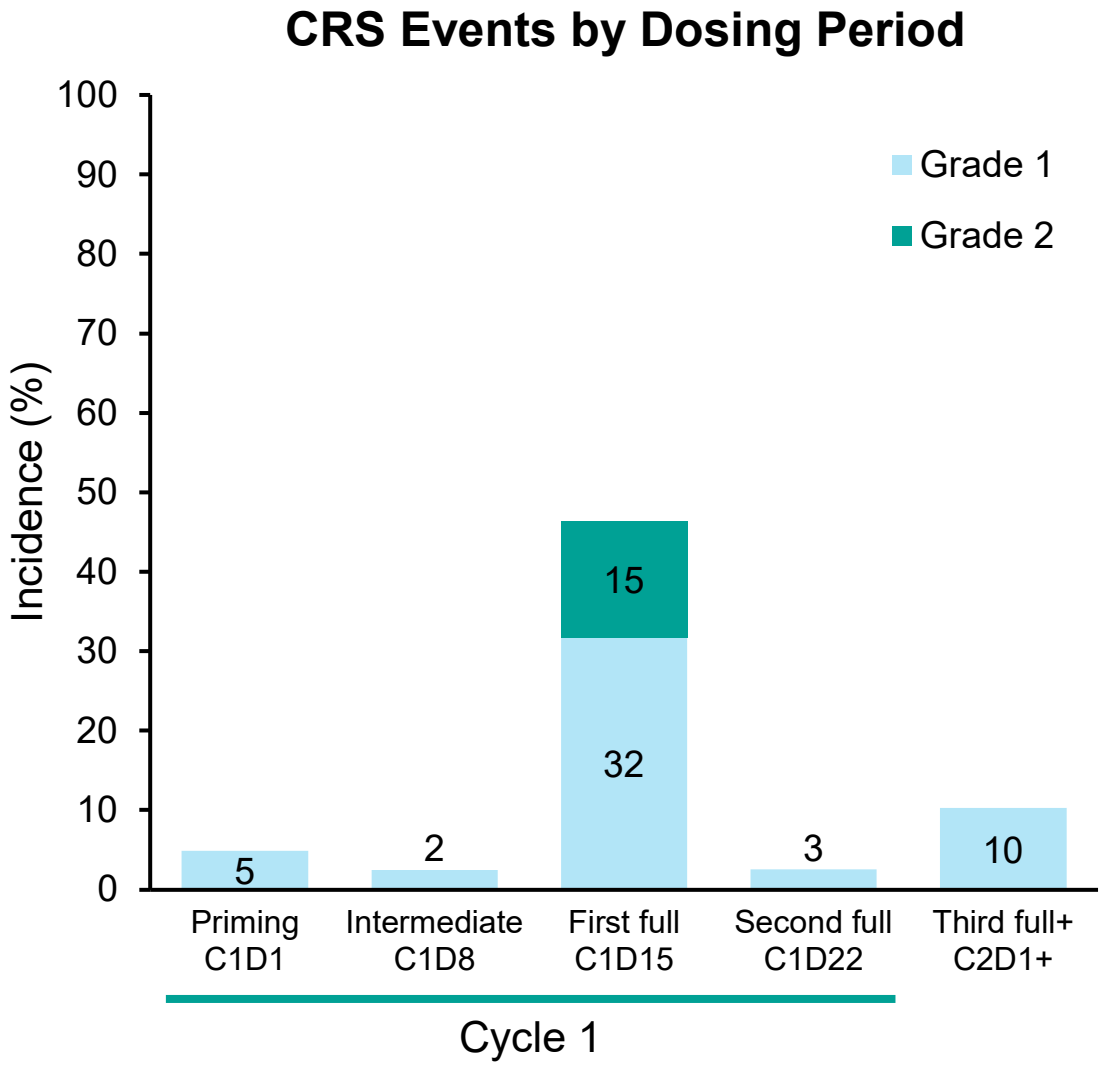
[a]Combined term includes neutropenia and neutrophil count decreased. [b]Combined term includes injection-site reaction, erythema, rash, and hypersensitivity. [c]Combined term includes COVID-19, COVID-19 pneumonia, and post-acute COVID-19 pneumonia.

CRS Events

	Total, N=41
CRS, n (%)[a]	22 (54)
Grade 1	16 (39)
Grade 2	6 (15)
Median time to onset after first full dose, d (range)	3 (1–6)
CRS resolution, n (%)	22 (100)
Median time to resolution, d (range)[b]	4 (1–10)
Treated with tocilizumab, n (%)	4 (10)
Leading to treatment discontinuation, n (%)	**0**

[a]Graded by Lee et al 2019 criteria. [b]Median is Kaplan–Meier estimate based on longest CRS duration in patients with CRS.

- No grade ≥3 events
- All CRS events resolved
- Timing was predictable, with most cases occurring after the first full dose



High Rates of Overall and Complete Metabolic Response

Best Overall Response[a]	Total Efficacy Evaluable n=36
Overall response	**94%**
CMR	86%
PMR	8%
Progressive disease	3%

Median follow-up, mo (range): 8.1 (1.4+ to 10.7). [a]Based on modified response-evaluable population, defined as patients with ≥1 target lesion at baseline and ≥1 postbaseline response evaluation and patients who died within 60 d of first dose. One patient died within 60 d of first dose without assessment (COVID-19).

Conclusions

- **In first-line FL therapy, epcoritamab + R^2 showed promising efficacy**
  - ORR: 94%; CMR: 86%
  - Responses were observed early, with nearly all patients achieving a response at their first assessment
  - Almost all responses were maintained at the time of this analysis
- **Combination therapy showed a consistent safety profile**
  - No new safety findings
  - CRS had predictable timing, was of low grade, and resolved in all cases
  - One ICANS event (resolved)
- **These data support further clinical evaluation of epcoritamab + R^2 as a chemo-free treatment option in previously untreated FL**

Abstract 348

Subcutaneous Epcoritamab in Patients with Richter's Syndrome: Early Results from Phase 1b/2 Trial (EPCORE CLL-1)

Arnon P. Kater, MD, PhD,[1] Jing Christine Ye, MD,[2] Jose Sandoval-Sus, MD,[3] Mar Bellido, MD, PhD,[4] Jacob Haaber Christensen, MD, PhD,[5] Anthony R. Mato, MD, MSCE,[6] Ann Janssens, MD, PhD,[7] Toshihiko Oki, MD, PhD,[8] Daniela Hoehn, MD, PhD,[9] Marcia Rios, MBA,[9] Alexandra Kuznetsova, PhD,[10] Rebecca Valentin, MD, PhD,[10] Herbert Eradat, MD[11]

[1]Amsterdam UMC, Cancer Center Amsterdam, University of Amsterdam, Amsterdam, Netherlands; [2]Rogel Cancer Center, University of Michigan, Ann Arbor, MI, USA; [3]Moffitt Cancer Center at Memorial Healthcare System, Pembroke Pines, FL, USA; [4]University Medical Center Groningen and University of Groningen, Groningen, Netherlands; [5]Odense University Hospital, Odense, Denmark; [6]Memorial Sloan Kettering Cancer Center, Chronic Lymphocytic Leukemia Program, New York, NY, USA; [7]University Hospitals Leuven, Leuven, Belgium; [8]AbbVie, North Chicago, IL, USA; [9]Genmab, Princeton, NJ, USA; [10]Genmab, Copenhagen, Denmark; [11]David Geffen School of Medicine at UCLA, Los Angeles, CA, USA

Presented at the 64th American Society of Hematology Annual Meeting and Exposition; December 10–13, 2022; New Orleans, LA, and virtual

Study Design: EPCORE CLL-1 RS Expansion Cohort

Dose escalation → **Median follow-up: 4.9 mo (range, 0.6–9.3)**

CLL[1]

- ✓ No DLTs
- ✓ MTD not reached
- ✓ RP2D identified
- ✓ Manageable safety profile
- ✓ Encouraging antitumor activity

Key RS inclusion criteria

- Ineligible for or voluntarily declined chemotherapy
- ≤1 prior line of therapy for RS-DLBCL
- Biopsy-proven transformation to CD20^{+} RS-DLBCL
- Prior clinical history of CLL or SLL
- ECOG PS 0–2
- Measurable disease by PET and/or CT/MRI

RS-DLBCL expansion, N=10

Step-up dosing[a]

Epcoritamab (SC) 48 mg

QW C1–3
Q2W C4–9
Q4W C10+

→ Efficacy assessment by PET-CT obtained Q6W until C6, and then Q24W thereafter → Treatment until disease progression

- To ensure patient safety and better characterize CRS, inpatient monitoring was required at first 4 doses of epcoritamab
- **Primary endpoint:** Overall response rate (ORR)
- **Key secondary endpoints:** Complete metabolic response (CMR) rate, time to response (TTR), and safety/tolerability

Data cutoffs: September 8, 2022 (efficacy); September 16, 2022 (safety). Epcoritamab was administered in 28-d cycles as shown. [a]Patients received SC epcoritamab with step-up dosing (ie, 0.16 mg priming and 0.8 mg intermediate doses before first full dose) and corticosteroid prophylaxis as previously described to mitigate CRS.

1. Kater AP, et al. ASH 2021. Abstract 2627.

Patient Characteristics

CLL Characteristic, n (%)	Total N=10
IGHV unmutated[a]	8 (80)
TP53 mutation[b]	5 (50)
NOTCH1 mutation[c]	2 (20)
FISH	
Trisomy 12[d]	1 (10)
Del17p[e]	3 (30)
Del11q[f]	3 (30)
Del13q[g]	4 (40)

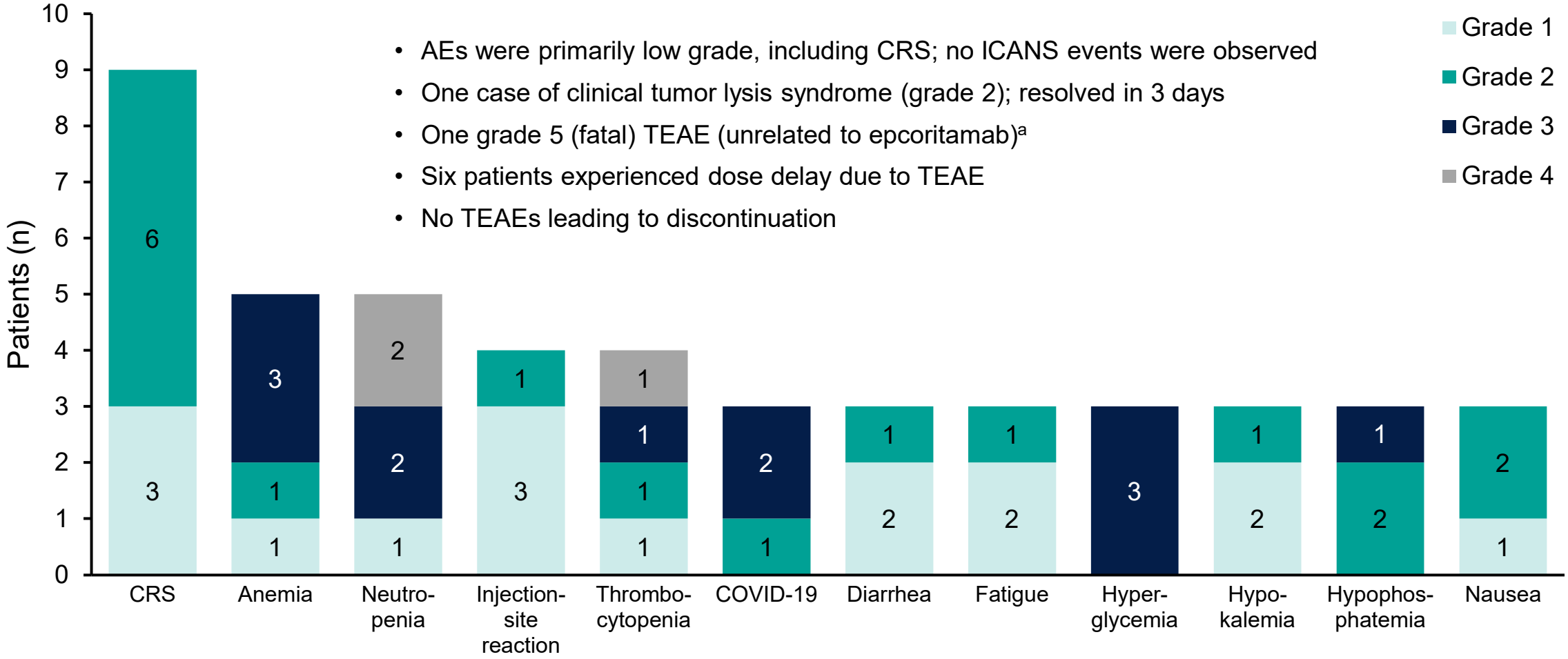
Data for CLL characteristics were obtained from local laboratories. [a]*IGHV* mutation status unknown for 2 patients. [b]*TP53* mutation status unmutated for 4 patients and unknown for 1 patient. [c]*NOTCH1* mutation status unmutated for 4 patients and unknown for 4 patients. [d]Trisomy 12 status negative for 8 patients and unknown for 1 patient. [e]Del17p status negative for 7 patients. [f]Del11q status negative for 7 patients. [g]Del13q status negative for 4 patients and unknown for 2 patients.

RS Characteristic	Total N=10
Median age, y (range)	70 (53–79)
Male, n (%)	7 (70)
Ann Arbor stage, n (%)	
IE	1 (10)
II	1 (10)
III	3 (30)
IV	5 (50)
Elevated lactate dehydrogenase, n (%)	8 (80)
Cell of origin, n (%)[a]	
Germinal center B-cell	1 (10)
Non–germinal center/Activated B-cell	6 (60)

Data cutoff: September 16, 2022. [a]Cell of origin was unknown for 3 patients.

Treatment-Emergent AEs (≥30%)

- AEs were primarily low grade, including CRS; no ICANS events were observed
- One case of clinical tumor lysis syndrome (grade 2); resolved in 3 days
- One grade 5 (fatal) TEAE (unrelated to epcoritamab)[a]
- Six patients experienced dose delay due to TEAE
- No TEAEs leading to discontinuation



Data cutoff: September 16, 2022. Median duration of treatment: 3.5 mo (range, 0.5–9.3). Median cycles (28 d) of epcoritamab: 4 (range, 1–11).

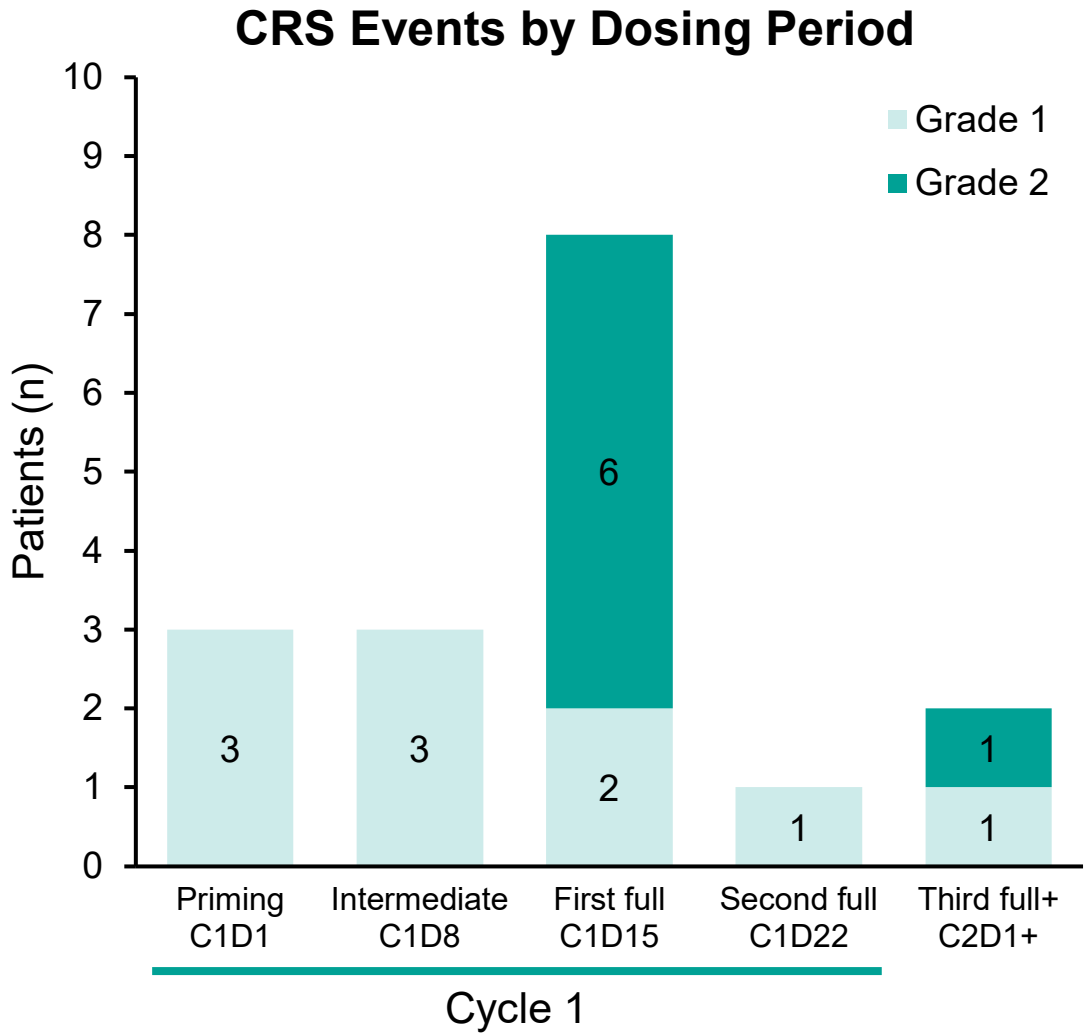
[a]General physical health deterioration in the setting of PD.

CRS Events

	Total, N=10
CRS, n (%)[a]	9 (90)
Grade 1	3 (30)
Grade 2	6 (60)
CRS resolution, n/n (%)	**9/9 (100)**
Median time to onset after first full dose, h (range)	12.5 (8–394)
Median time to resolution, d (range)[b]	3 (2–9)
Treated with tocilizumab, n (%)	7 (70)
Leading to treatment discontinuation, n (%)	**0**

Data cutoff: September 16, 2022. [a]Graded by Lee et al 2019 criteria. [b]Median is Kaplan–Meier estimate based on longest CRS duration in patients with CRS.

- Occurrence was predictable, with most cases following the first full dose
- No grade ≥3 CRS events
- All CRS events resolved, and none led to discontinuation



Data cutoff: September 16, 2022.

Best Overall Response

Response, n (%)[a]	Total Efficacy Evaluable N=10
Overall response[b]	**6 (60)**
Complete metabolic response (CMR)	5 (50)
Partial metabolic response (PMR)	1 (10)
Stable disease	1 (10)
Progressive disease	2 (20)
Not evaluable	1 (10)[c]

Data cutoff: September 8, 2022. Median follow-up: 4.9 mo (range, 0.6–9.3).
[a]Based on modified response-evaluable population, defined as patients with ≥1 target lesion at baseline and ≥1 postbaseline response evaluation and/or patients who died within 60 d of first dose. [b]Response assessment according to Lugano 2014 criteria. [c]Patient stopped treatment on C1D15 due to progression and did not receive any scans.

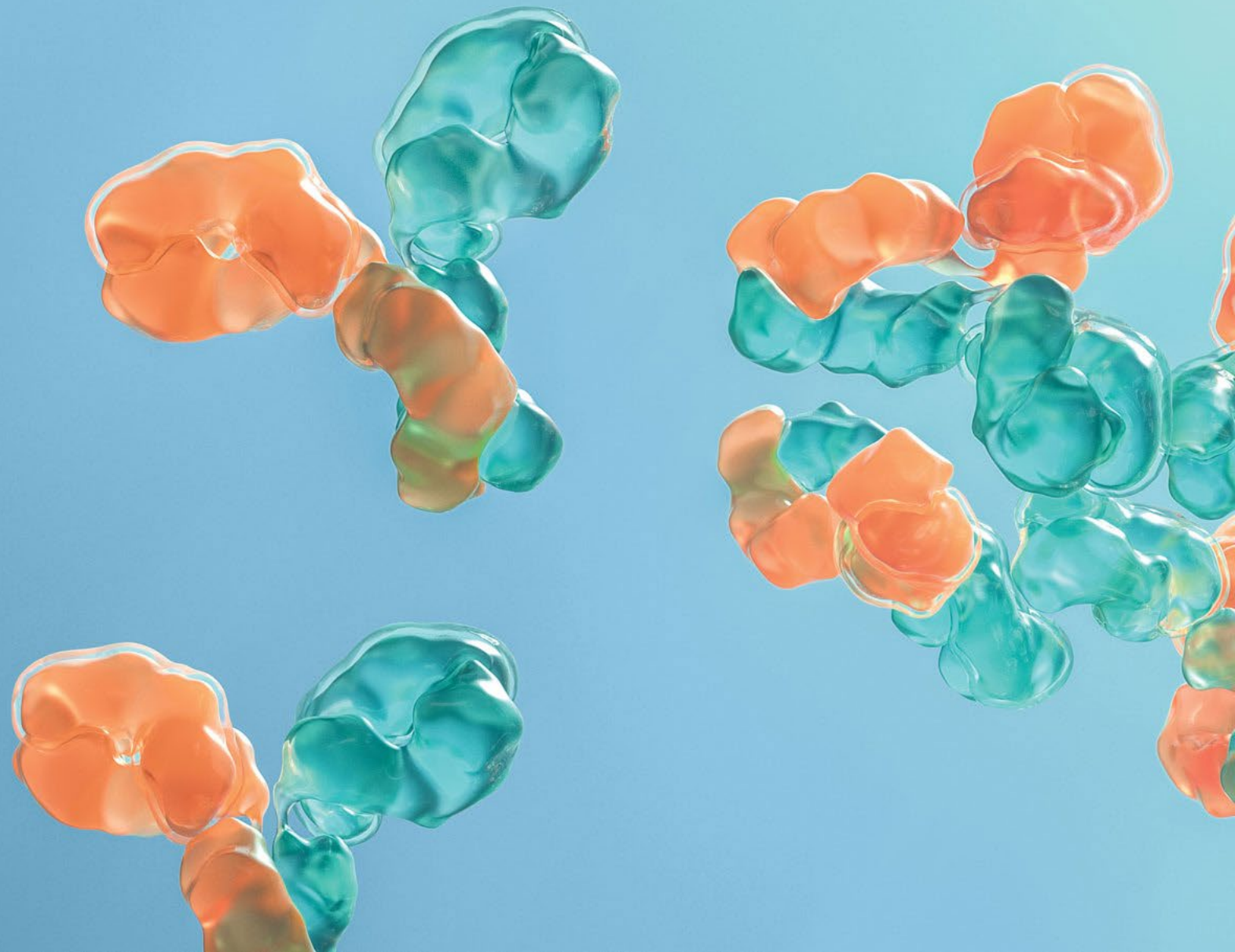
High overall and complete metabolic response rates observed

Conclusions

- In a difficult-to-treat, high-risk RS-DLBCL patient population, single-agent epcoritamab showed promising activity with a tolerable safety profile
  - High response rates: ORR 60%; CMR 50%
  - Only low-grade CRS; all resolved
  - No ICANS events
  - No discontinuations due to TEAEs
- This first standalone dataset for a bispecific antibody in RS supports further clinical exploration of epcoritamab in this aggressive disease with limited treatment options
- The EPCORE CLL-1 study is ongoing and recruiting patients with CLL or RS (NCT04623541)

Genmab

GEN1042 at ESMO IO



Presented by Dr. Ignacio Melero, Clínica Universidad de Navarra

Safety and Preliminary Efficacy of GEN1042 (DuoBody®-CD40x4-1BB) Combination Therapy in Patients With Advanced Solid Tumors

Ignacio Melero, MD, PhD et al.

GEN1042 is a novel, agonistic bispecific antibody that combines targeting and conditional activation of CD40 and 4-1BB on immune cells to enhance priming and (re-)activation of tumor-specific immunity

The distinct and complementary mechanism of action of GEN1042 supports its clinical investigation as a combination partner to improve current standard of care across a range of solid tumors

Presented at the ESMO Immuno-Oncology Congress 2022, Geneva, Switzerland, 7–9 December 2022
Poster Number 175P

Phase 1/2 open-label trial: GEN1042 combination therapy expansion cohorts (GCT1042-01)

Monotherapy dose escalation[1]

- ✓ MTD not reached
- ✓ Manageable safety profile
- ✓ 1 DLT (Gr4 transaminase elevation at 200 mg), resolved with corticosteroids
- ✓ 100 mg Q3W identified as expansion dose
- ✓ Preliminary antitumor activity

Combination therapy expansion (data cut-off: October 3, 2022)

Key Inclusion Criteria

- Selected metastatic or unresectable solid tumors
- Measurable disease (per RECIST v1.1)
- ECOG PS 0–1
- Adequate renal, hepatic, and bone marrow function
- No prior therapy for metastatic diseases and no prior anti-PD(L)1 or other checkpoint inhibitor therapy

Combination 3+3 Safety Run-In

GEN1042 + PEM
Q3W until PD or ≤35 cycles

GEN1042 + Cis or Carbo + 5-FU + PEM
Q3W × 6 cycles[a]

GEN1042 + nab-PAC + GEM ± PEM
Q3W × 8 cycles[b]

Combination Expansion

- 1L Melanoma (n=10–40)
- 1L NSCLC PD-L1+ TPS 1–49% (n=10–40)
- 1L NSCLC PD-L1+ TPS ≥50% (n=10–40)
- 1L HNSCC PD-L1+ CPS ≥1 (n=10–40)
- 1L HNSCC PD-L1+ CPS ≥1 (n=10–40)
- 1L Pancreatic Ductal Adenocarcinoma (n=10–40)

Endpoints

Safety Run-In

- Primary endpoint: DLT

Expansion Phase

- Primary endpoint: ORR per RECIST v1.1
- Secondary endpoints: DOR, DCR, PFS, AEs, PK/PD

[a]Followed by GEN1042 + PEM until PD or ≤29 cycles; [b]Patients in safety run-in stopped after 8 cycles; patients in the combination expansion received GEN1042 + PEM until PD or ≤27 cycles. nab-PAC and GEM given 2Q3W.

5-FU, 5-fluorouracil; AEs, adverse events; Carbo, carboplatin; Cis, cisplatin; DCR, disease control rate; DLT, dose-limiting toxicity; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; GEM, gemcitabine; Gr, grade; HNSCC, head and neck squamous cell carcinoma; MTD, maximum tolerated dose; nab-PAC, nab-paclitaxel; NSCLC, non-small cell lung cancer; ORR, overall response rate; PD, progressive disease; PD-1, programmed cell death protein 1; PD-L1, programmed death-ligand 1; PEM, pembrolizumab; PFS, progression-free survival; PK/PD, pharmacokinetics/pharmacodynamics; Q3W, every 3 weeks; RECIST, Response Evaluation Criteria in Solid Tumours.

1. Muik A, et al. *J Immunother Cancer.* 2022;10(6):e004322.

ClinicalTrials.gov identifier: NCT04083599

Patients were CPI-naive, with select advanced/metastatic solid tumors

	GEN1042 + PEM (N=24)	GEN1042 + PEM + CTx (N=26)
Median age (range), y	70.0 (42–86)	65.5 (30–75)
≥65 years	16 (66.7)	14 (53.8)
Female	9 (37.5)	13 (50.0)
Cancer type		
Non-small cell lung cancer	13 (54.2)	0
Melanoma	4 (16.7)	0
Pancreatic ductal adenocarcinoma	0	19 (73.1)
Head and neck squamous cell carcinoma	7 (29.2)	7 (26.9)
Target/non-target lesion location		
Liver lesions	4 (16.7)	15 (57.7)
Brain lesions	2 (8.3)	0
ECOG performance status		
0	9 (37.5)	13 (50.0)
1	15 (62.5)	13 (50.0)
No. prior systemic anticancer regimens in metastatic or locally advanced settings		
0	22 (91.7)	25 (96.2)
1	2 (8.3)[a]	1 (3.8)[a]
2	0	0

Data are n (%) unless otherwise specified. Data cut-off date: October 3, 2022.

[a]In patients with HNSCC, systemic therapy that was completed >6 months prior to study entry as part of multimodal treatment for locally advanced disease was allowed.

CPI, checkpoint inhibitor; PDAC, pancreatic ductal adenocarcinoma.

54% of patients receiving GEN1042 + PEM + CTx remain on treatment

- The majority of AEs leading to discontinuation were asymptomatic and resolved with a short course of corticosteroids

	GEN1042 + PEM (N=24)	GEN1042 + PEM + CTx (N=26)
Treatment ongoing	9 (37.5)	14 (53.8)
Treatment discontinued	15 (62.5)	12 (46.2)
Treatment discontinuation due to:		
Radiographic disease progression	8 (33.3)	4 (15.4)
Clinical disease progression	1 (4.2)	0
Adverse events	3 (12.5)[a]	4 (15.4)[b]
Death	1 (4.2)[c]	2 (7.7)[c]
Patient request	1 (4.2)	1 (3.8)
Other	1 (4.2)[d]	1 (3.8)[e]

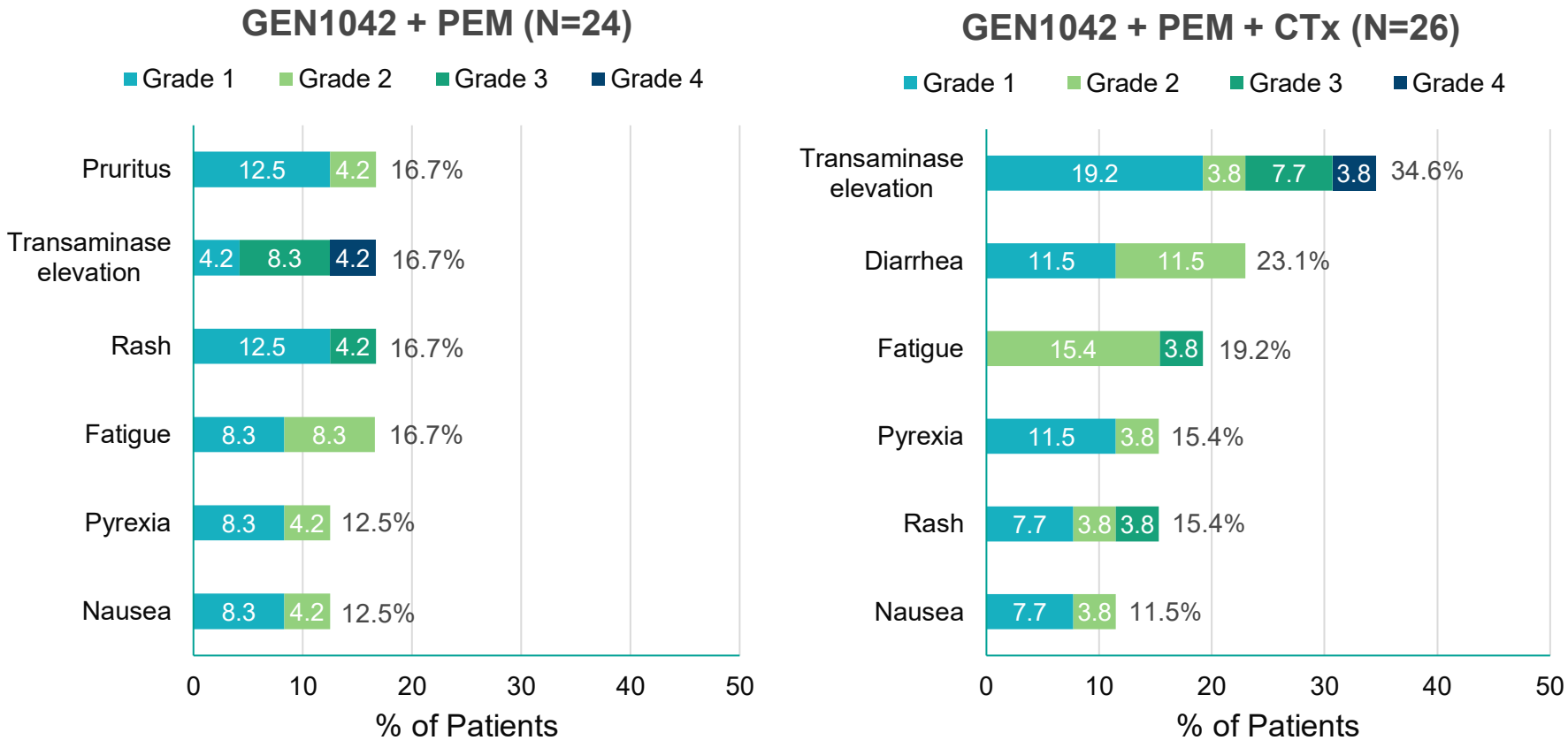
Data are n (%). Data cut-off date: October 3, 2022.

[a]Due to grade 3–4 transaminase elevations (asymptomatic; n=3); [b]Due to treatment-related grade 3 transaminase elevation (n=2), grade 3 hemophagocytic lymphohistiocytosis (n=1), or treatment-related grade 2 thrombocytopenia (n=1); [c]Death not considered related to treatment; [d]Patient voluntarily opted to receive palliative radiation therapy to target mass, which required discontinuation from participation and treatment on-study; [e]Reason for discontinuation changed to grade 4 treatment-related transaminase elevation after data extraction.

GEN1042 + PEM ± CTx was well tolerated with manageable AEs

- No DLTs were observed during the safety run-in
- AEs were primarily grade 1/2
- Immune-related AEs were manageable
- Transaminase elevations resolved with corticosteroids

Treatment-Related Adverse Events (≥10% of Patients) by Grade

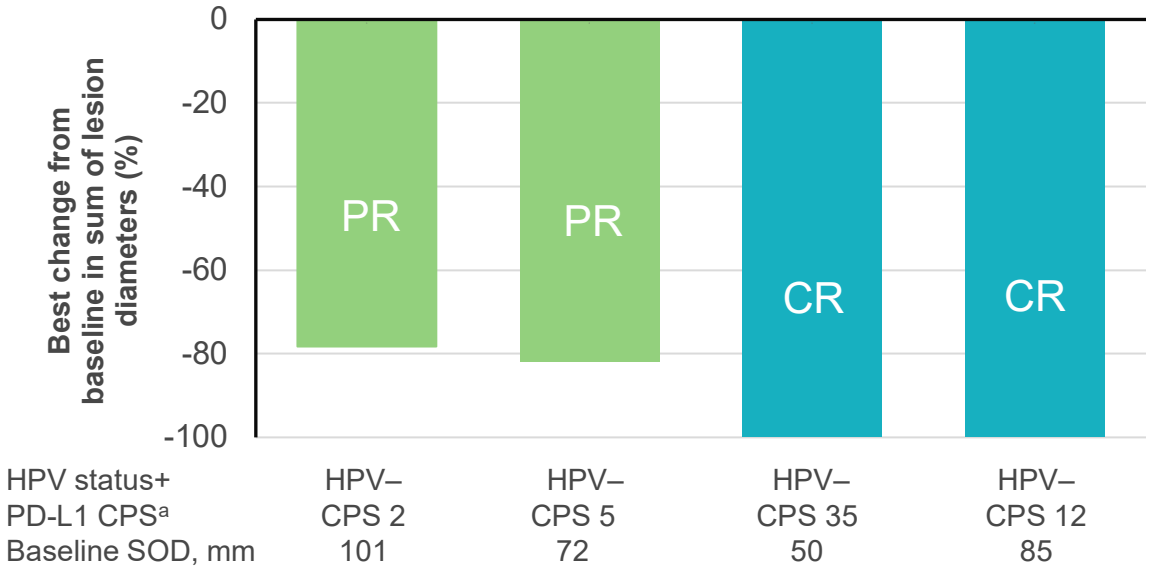


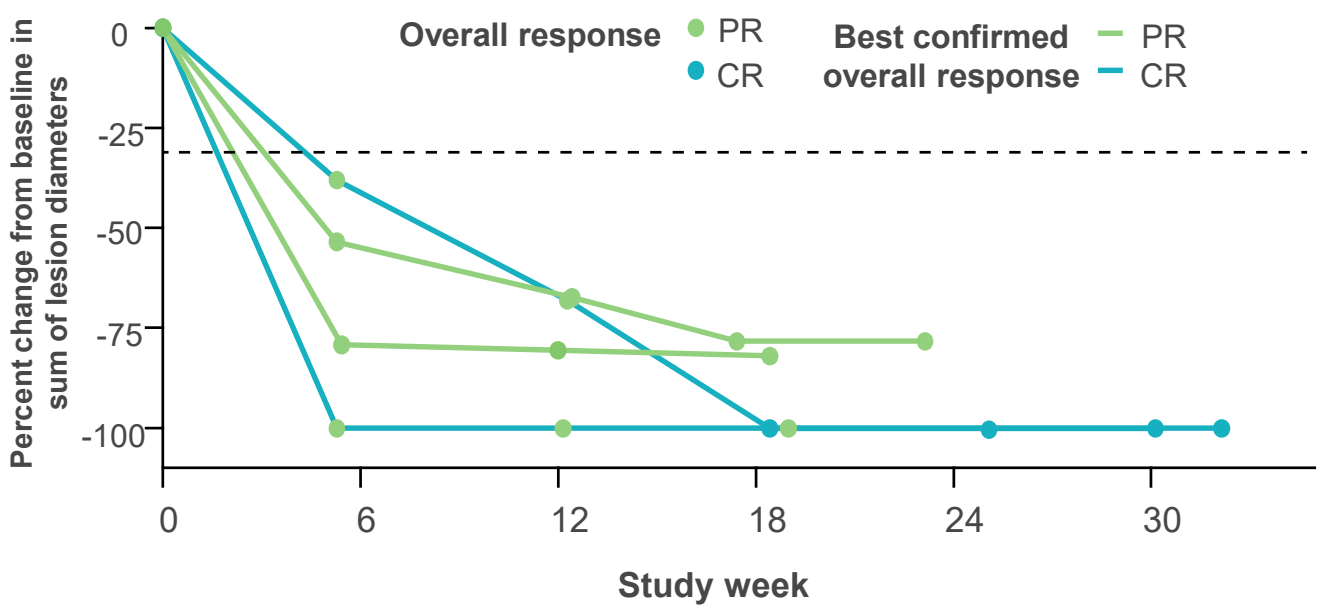
Data cut-off date: October 3, 2022.

Transaminase elevation includes the preferred terms: alanine aminotransferase increased, aspartate aminotransferase increased, transaminases increased, and hypertransaminasemia. Rash includes the preferred terms: rash and rash maculo-papular. Fatigue includes asthenia and fatigue.

Clinical benefit observed in patients with HNSCC receiving GEN1042 + PEM + CTx

- 4 patients with HNSCC treated with GEN1042 + PEM + Cis/Carbo + 5-FU were evaluable by the data cut-off date
- Early preliminary data show that GEN1042 combination therapy induced deep responses in patients with HNSCC at first scan, which were sustained over time
- Responses were seen in tumors with both low and high PD-L1 expression; all 4 patients were HPV negative





Data cut-off date: October 3, 2022. Includes all patients (n=4) who had at least one post-baseline tumor assessment and thus could be assessed for response. [a]Central laboratory CPS shown.
CPS, combined positive score; CR, complete response; HPV, human papillomavirus; PR, partial response; SOD, sum of diameters.

Conclusions

GEN1042 is a novel, agonistic, bispecific antibody that combines targeting and conditional activation of the costimulatory molecules CD40 and 4-1BB on immune cells

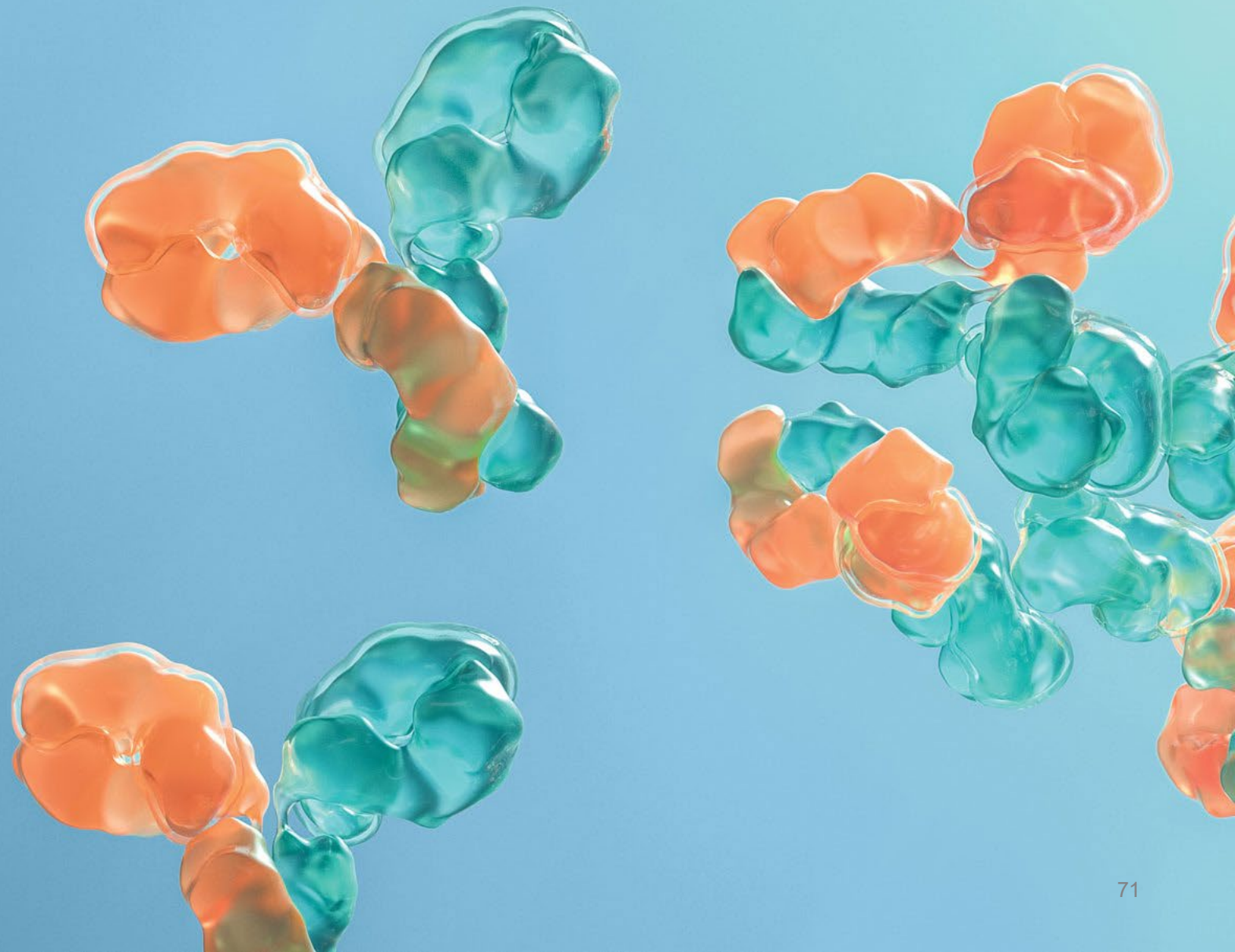
This preliminary dataset from the safety run-in and expansion cohorts of a phase 1/2 study investigating GEN1042 combination therapy shows that:

- GEN1042 + pembrolizumab (PEM) ± chemotherapy (CTx) is well tolerated:
  - No DLTs reported
  - Most AEs were grade 1/2 and manageable
- GEN1042 + PEM + CTx shows encouraging early activity in patients with advanced/metastatic HNSCC, with responses observed in 4/4 evaluable patients
  - GEN1042-mediated immune activation was retained with combination therapy
- Enrollment is ongoing in all cohorts (NSCLC, pancreatic ductal adenocarcinoma, and HNSCC)

Genmab

2023: Advancing Our Proprietary Pipeline

Dr. Jan van de Winkel
President & CEO



2023 Priorities:

Further Advancing Our Differentiated Product Pipeline Towards The Market

KNOCK YOUR SOCKS OFF

Genmab

Bring Our Own Medicines to Patients

Epcoritamab[1]
- Launch in R/R DLBCL[2]
- Submit an sBLA[3]
- Broaden clinical development program

Tivdak[4]
- Progress successful uptake in 2L+ r/m Cervical Cancer patients
- Progress clinical development program

Build World-class Differentiated Pipeline

DuoBody-CD40x4-1BB[5]
- Establish efficacy and safety data in solid tumor indication[6]
- Progress towards late-stage clinical development

DuoBody-PD-L1x4-1BB[5]
- Establish proof of concept data in solid tumor indication

Expand and advance proprietary clinical product portfolio

Invest in Our People & Culture

Further scale organization aligned with differentiated antibody product portfolio growth and future launches

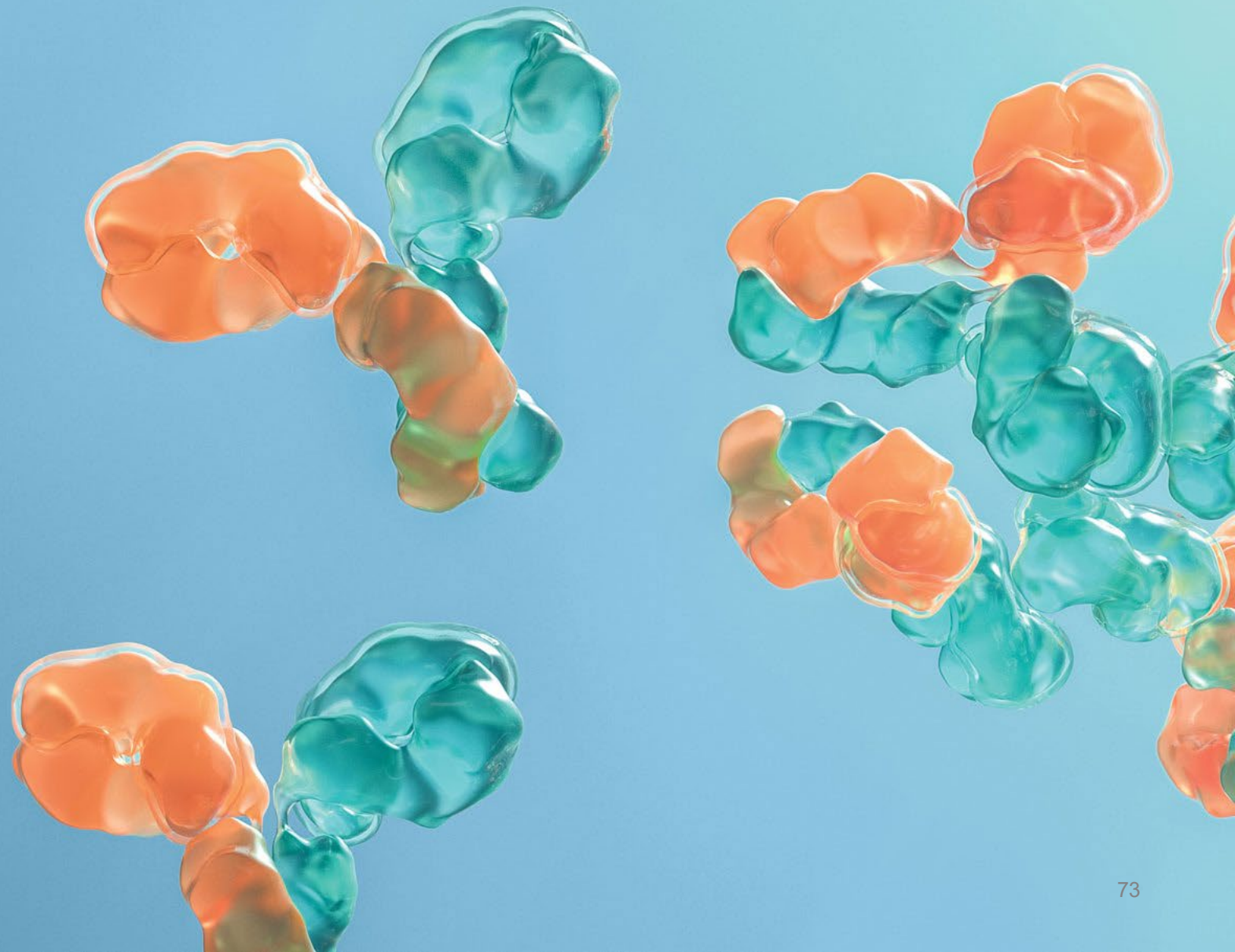
Become a Leading Integrated Biotech Innovation Powerhouse

Use solid financial base to grow and broaden antibody product and technology portfolio

1. Co-development w/ AbbVie; 2. Subject to regulatory approvals; 3. Subject to supportive U.S. FDA feedback; 4. Co-development w/ Seagen; 5. Co-development w/ BioNTech; 6. NCT04083599

Genmab

Q&A



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