THE FUTURE OF VACCINES

NOVEMBER 2015
This presentation contains forward-looking statements. All statements other than statements of historical facts contained in this presentation constitute forward-looking statements, including statements regarding future results of operations, financial position, strategy and plans of Bavarian Nordic A/S (the “Company”), and the Company’s expectations for future operations.

These forward-looking statements include, but are not limited to, statements about: the timing of data from our ongoing Phase 3 PROSPect Trial of PROSTVAC and the ongoing Phase 3 trial of IMVAMUNE/IMVANEX; our receipt of future milestone payments from our collaboration partners, and the expected timing of such payments; our expectations regarding the potential market size and the size of the patient populations for our product candidates, if approved for commercial use; our expectations regarding the potential advantages of our product candidates over existing vaccines or immunotherapies; our potential to enter into new collaborations; our expectations with regard to the ability to develop additional product candidates using our MVA-BN platform and file INDs for such product candidates; our expectations with regard to our current and future collaboration partners to pursue the development of our product candidates; our development plans with respect to our product candidates; our ability to develop, acquire and advance product candidates into, and successfully complete, clinical trials; the timing or likelihood of regulatory filings and approvals for our product candidates; the commercialization of our product candidates; our commercialization, marketing and manufacturing capabilities; the implementation of our business model and strategic plans for our business, product candidates and technology platform; the scope of protection we are able to establish and maintain for intellectual property rights covering our product candidates; estimates of our expenses, future revenue, capital requirements, our needs for additional financing and our ability to obtain additional capital; our financial performance; and developments and projections relating to our competitors and our industry. Moreover, the Company operates in a very competitive and rapidly changing environment. New risks emerge from time to time. It is not possible for the Company’s management to predict all risks, nor can the Company assess the impact of all factors on its business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statement. In light of these risks, uncertainties and assumptions, the forward-looking events and circumstances discussed in this presentation may not occur and actual results could differ materially and adversely from those anticipated or implied.

Except as required by law, neither the Company nor any other person assumes responsibility for the accuracy and completeness of the forward-looking statements. The Company undertakes no obligation to update publicly any forward-looking statements for any reason after the date of this presentation to conform these statements to actual results or to changes in the Company’s expectations.
MULTIPLE LAYERS OF VALUE

1 approved product
7 active programs

Validated Platform Technology
(NIH, BARDA, BMS, Janssen)

2 focus areas
Infectious Disease & Oncology

Expertise in T-Cell Stimulation & Antibody Response

3 Phase 3 Products
Multiple near-term milestones

Broad Pipeline & Late-Stage Candidates

$1.2B in US government contracts
$900M in revenues over past 10 years
$975M BMS deal - PROSTVAC
$187M Janssen deal - Ebola

Strong Revenue Base to Re-Invest in Clinical Pipeline
LIVE VIRUS PLATFORM TECHNOLOGY
VALIDATED AND MODULAR APPROACH EMPLOYING POXVIRUSES

Wide Variety of Target Diseases

Antigenic Complexity
Low
High

Recombinant Poxviruses

Vectors
Antigens
Promoters
Co-Stimulatory Molecules (TRICOM)

Customized Immunogenicity
Simple
Complex

Target Multiple Antigens for a Single Disease

Widely Applicable Technology for Infectious Disease and Cancer Immunotherapy
### MULTIPLE ASSETS DRIVING VALUE

#### PRODUCT CANDIDATE INDICATION COMMERCIAL RIGHTS PRIMER / BOOSTER PHASE 1 PHASE 2 PHASE 3 APPROVED STATUS / EXPECTED MILESTONES

**Infectious Disease**

**IMVAMUNE / IMVANEX (LIQUID FROZEN)**
- Smallpox
  - **IMVAMUNE**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 1: Approved in Canada and the European Union
  - **IMVANEX**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 1: Complete enrollment in 2017

**IMVAMUNE (FREEZE DRIED)**
- Smallpox
  - **IMVAMUNE**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 2: Phase 3 in US (non-inferiority)
  - **IMVANEX**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 2: Manufacturing validation

**MVA-BN Filo**
- Ebola / Marburg
  - **IMVAMUNE**
    - PRIMER: AdVac
    - BOOSTER: MVA-BN
    - PHASE 2: Data from multiple trials in 2016
  - **IMVANEX**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 2: Phase 1 trial data in 1H16

**MVA-BN RSV**
- RSV
  - **IMVAMUNE**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 3: Approved in Canada and the European Union (non-inferiority)
  - **IMVANEX**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 3: Fully enrolled

**Cancer Immunotherapy**

**PROSTVAC**
- mCRPC
  - **PROSTVAC**
    - PRIMER: Vaccinia
    - BOOSTER: Fowlpox
    - PHASE 1: PROSPECT fully enrolled
  - **PROSTVAC**
    - PRIMER: Vaccinia
    - BOOSTER: Fowlpox
    - PHASE 1: Three interim analyses starting in 2016 with top-line data in 2017

**Localized Prostate Cancer**
- **PROSTVAC**
  - PRIMER: Vaccinia
  - BOOSTER: Fowlpox
  - PHASE 1: NCI enrolling Phase 2 trial

**Localized Prostate Cancer (neoadjuvant)**
- **PROSTVAC**
  - PRIMER: Vaccinia
  - BOOSTER: Fowlpox
  - PHASE 1: NCI Phase 2 trial data in 2016

**Non-Metastatic Prostate Cancer**
- **PROSTVAC**
  - PRIMER: Vaccinia
  - BOOSTER: Fowlpox
  - PHASE 1: NCI Phase 1 trial enrollment complete

**Prostate Cancer**
- **PROSTVAC**
  - PRIMER: Vaccinia
  - BOOSTER: Fowlpox
  - PHASE 1: NCI enrolling Phase 2 trial

**CV 301**
- Bladder Cancer
  - **CV 301**
    - PRIMER: Vaccinia
    - BOOSTER: Ipilimumab
    - PHASE 1: NCI enrolling Phase 2 NCI trial

**MVA-BN Brachyury**
- Solid Tumors
  - **MVA-BN**
    - PRIMER: MVA-BN
    - BOOSTER: MVA-BN
    - PHASE 1: Phase 1 trial data in 4Q15

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(a) An adenovirus primer from Janssen.
(b) BMS would have complete commercial rights to PROSTVAC, regardless of treatment setting, should they exercise their licensing agreement.
(c) Anticipated transition to MVA primer.
(d) Anticipated transition to Fowlpox booster.
COMMERCIAL MANUFACTURING CAPABILITIES

Commercial Production Facility
- Inspected by the EMA and the FDA
- 28M doses of IMVAMUNE delivered to US national stockpile
- 1.3M doses of MVA-BN Filo (Ebola) delivered to Janssen

Multi-Product Facility
- Highly scalable, fully integrated, reduces dependency on sub-contractors
- Fill/Finish established to support commercial launch of PROSTVAC
- Production of all clinical trial material

Poxvirus Manufacturing Expertise
- Commercial partnerships in place with Janssen & BMS
- All manufacturing performed by BN
- Company has developed IP and extensive know-how in the production of poxvirus based vaccines
<table>
<thead>
<tr>
<th>PRODUCT CANDIDATE</th>
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<th>PHASE 3</th>
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<th>STATUS / EXPECTED MILESTONES</th>
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</thead>
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</tr>
<tr>
<td>IMVAMUNE / IMVANEX (FREEZE DRIED)</td>
<td>Smallpox</td>
<td>Phase 3 in US (non-inferiority)</td>
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<td></td>
<td></td>
<td></td>
<td>• Complete enrollment in 2017</td>
</tr>
<tr>
<td>MVA-BN Filo</td>
<td>Ebola / Marburg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• EU Phase 2 trial initiated in 1Q15; Africa Phase 3 trial initiated in 4Q15; Data from multiple trials in 2016</td>
</tr>
<tr>
<td>MVA-BN RSV</td>
<td>RSV</td>
<td>Fully enrolled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Phase 1 trial data in 1H16</td>
</tr>
</tbody>
</table>

 Pipeline Driven by Live Virus Vaccine Platform
<table>
<thead>
<tr>
<th>Status</th>
<th>Revenue Generation</th>
<th>Freeze Dried</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Only non-replicating smallpox vaccine approved in the European Union</td>
<td>• Awarded ~$1.2B in contracts from the US government, of which more than $900M has been received</td>
<td></td>
</tr>
<tr>
<td>• Commercialized in liquid frozen formulation</td>
<td>• Recognized $126M and $154M in revenue in 2013 and 2014, respectively</td>
<td>• Demonstrated bioequivalence</td>
</tr>
<tr>
<td>• Stockpiled by the US government (EUA)</td>
<td></td>
<td>• Potential 10+ year shelf life</td>
</tr>
<tr>
<td>• Phase 3 trial ongoing to support FDA approval</td>
<td></td>
<td>• Potentially no storage limitations</td>
</tr>
<tr>
<td>• 7,600 patients dosed</td>
<td></td>
<td>• Supports US government’s long-term stockpiling goals</td>
</tr>
</tbody>
</table>

Our Freeze Dried Formulation Represents a Significant Market Opportunity

(a) Emergency Use Authorization.
SUCCESSFUL PARTNERSHIP WITH THE US GOVERNMENT
CONTRACTS AWARDED OF ~$1.2B TO DATE, OF WHICH MORE THAN $900M HAS BEEN RECEIVED

Developing, producing, supplying liquid frozen IMVAMUNE

- **RFP-1**
  - IMVAMUNE Smallpox Vaccine
  - $14M
  - NIH

- **RFP-2**
  - IMVAMUNE Smallpox Vaccine
  - $100M
  - NIH

- **RFP-3**
  - IMVAMUNE Smallpox Vaccine
  - $500M
  - BARDA

- **RFP-2 Expansion**
  - IMVAMUNE Smallpox Vaccine
  - $16M
  - NIH

- **RFP-3 Expansion**
  - IMVAMUNE Smallpox Vaccine
  - $49M
  - BARDA

- **Delivery Contract**
  - IMVAMUNE Smallpox Vaccine
  - $228M
  - BARDA

Developing freeze dried vaccine

- **RFP Freeze Dried**
  - IMVAMUNE Smallpox Vaccine
  - $40M
  - BARDA

- **RFP Freeze Dried Expansion**
  - IMVAMUNE Smallpox Vaccine
  - $55M
  - BARDA

- **Bulk Order**
  - IMVAMUNE Smallpox Vaccine
  - $133M
  - BARDA

Expanding MVA-BN platform

- **MVA-BN Marburg**
  - $18M
  - NIH

- **MVA-BN Foot-and-Mouth Disease**
  - $1M
  - DHS

- **MVA-BN Burkholderia**
  - $500K
  - DOD DTRA

- **MVA-BN Marburg Expansion**
  - $15M
  - NIH
NEW CONTRACT SIGNALS THE BEGINNING OF FREEZE DRIED IMVAMUNE ORDERS

RECENT EVENTS CONTINUE TO DRIVE CONFIDENCE

• $22M expansion to higher capacity line for freeze dried (April 2014)
• 2016 presidential budget lists freeze dried IMVAMUNE (Feb 2015)
• Phase 2 freeze dried met primary endpoint of equivalence to liquid frozen (May 2015)
  • Meeting clinical criteria for EUA stockpiling
• $133M Bulk order of IMVAMUNE by BARDA (July 2015)
  • Allows for transition to freeze dried once RFP occurs and freeze dried pricing can be established
• Phase 3 lot-to-lot trial complete (May 2015)
• $6.4M order of IMVAMUNE by PHAC (October 2015)

FREEZE DRIED POTENTIAL

• 20M doses expire starting in 2017 (liquid frozen)
• Long-term stated goal of US government calls for non-replicating vaccine for 66M US citizens (132M doses)
  • Supplied liquid frozen doses at $29 per dose

(a) Public Health Agency of Canada
IMVAMUNE FREEZE DRIED & LIQUID FROZEN FORMULATIONS INDUCE EQUIVALENT IMMUNE RESPONSES

Pivotal Phase 2 randomized, double-blind in 650 healthy vaccinia-naïve volunteers

Antibody responses induced by freeze dried and liquid frozen formulations were equivalent

Similar data have also been generated in the various animal efficacy models
First of two Phase 3 trials to support a BLA for liquid frozen IMVAMUNE

Placebo-controlled lot consistency trial in 4,000 vaccinia-naïve subjects
- 3,000 IMVAMUNE subjects (three arms) compared to 1,000 placebo subjects

Primary endpoint met: The three lots induced equivalent antibody responses

No cardiac events reported among IMVAMUNE vaccinated subjects

ACAM2000® (approved in the United States) has recorded high rates of cardiac complications in healthy vaccinees (5.73 events per 1000 immunizations)\(^{(a)}\)

Second Phase 3 trial ongoing in military personnel with enrollment completion expected in 2017

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MVA-BN FILO: OUR PHASE 3 EBOLA VACCINE PARTNERED WITH JANSSEN

<table>
<thead>
<tr>
<th>Janssen Deal</th>
<th>Clinical Status</th>
<th>Additional Commercial Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>• $45M licensing agreement grants Janssen full commercialization rights</td>
<td>• Janssen presented preliminary Phase 1 data in May 2015</td>
<td>• Three undisclosed commercial infectious disease targets also being explored</td>
</tr>
<tr>
<td>• BN eligible to receive royalties outside of Africa</td>
<td>• Multicenter Phase 2 clinical trial initiated in July 2015 in the United Kingdom and France</td>
<td>• MVA-BN is a promising booster to existing Janssen technology (AdVac from Crucell)</td>
</tr>
<tr>
<td>• Additional supply agreement of $99M</td>
<td>• Phase 2 trial (n=1,200) and a Phase 3 trial have been initiated in Africa</td>
<td></td>
</tr>
<tr>
<td>• Equity investment of $43M (~5% of BN)</td>
<td>• Data expected in 2016</td>
<td></td>
</tr>
</tbody>
</table>

Advanced from Phase 1 to Phase 3 in < 12 Months
FIRST IN HUMAN DATA FOR THE BAVARIAN NORDIC/JANSSEN EBOLA PRIME-BOOST VACCINE

- 72 healthy volunteers randomized into four groups receiving prime-boost vaccine regimen or placebo at intervals of 28 or 56 days
- An open-label arm with 15 healthy volunteers is also investigating a shorter prime-boost interval of 14 days for Ad26.ZEBOV prime and MVA-BN Filo boost

AdVac + MVA-BN Provides Durable Response

Phase 2 & 3 Clinical Trials Ongoing in the US, EU and Africa
• Subsequent to the Ebola collaboration, BN and Janssen have agreed to collaborate on three additional infectious disease targets

• BN will develop MVA-BN constructs for scientific evaluation

• Janssen will have an exclusive window to decide if they wish to enter into licensing agreements (to be separately negotiated)

MVA/ADVAC - PRIME-BOOST RATIONALE

• All adenoviruses require a separate boost to be an effective vaccination regime
  • One of the best boost platforms that has been used in combination with adenoviruses (of all species, human or chimp) is MVA

• As it relates to Ebola, the combination of adenovirus and MVA improves the induction of strong immune responses in the short term (due to the highly immunogenic adenovirus), and provides long-term protection (due to the properties of MVA-BN)
RSV: Respiratory Syncytial Virus
• No approved vaccine; high unmet medical need
• Responsible for a similar number of deaths as the flu in children up to 14, as well as in the elderly population
• Results in a high number of hospitalizations

MVA-BN RSV vaccine candidate
• Demonstrated strong immune response
• Blood and mucosal protection (*key differentiator*)
• Protection against both RSV subtypes (A&B) in preclinical models
• Received NIH funding (*preclinical efficacy*)

DEVELOPMENT STRATEGY

<table>
<thead>
<tr>
<th>Year</th>
<th>Phase 1</th>
<th>Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Fully Enrolled</td>
<td>Initiate 2H</td>
</tr>
<tr>
<td>2016</td>
<td>1/2</td>
<td></td>
</tr>
</tbody>
</table>

Elderly + Adults at risk
Children <5yrs
MVA-BN RSV BOOSTS PRE-EXISTING MEMORY RESPONSES

MVA-BN Boosts Pre-Existing Responses

IgG in Serum

Anti-RSV Antibodies in blood (GMT)

Weeks

10,000
20,000
30,000
40,000
50,000

0 2

Mucosal IgA

Anti-RSV Antibodies in the mucosa (GMT)

Weeks

10,000
20,000
30,000
40,000
50,000

0 2

Neutralizing Antibodies Boosted in Blood and Mucosa (Lung), as well as T-Cells
MVA-BN RSV PHASE 1 INITIATED IN THE UNITED STATES

- Fully enrolled Phase 1, randomized, single-blind, monocenter, placebo controlled
- Healthy subjects, 18 - 65 years of age, N = 63
- **Primary objective**: Safety and reactogenicity of MVA-mBN294B (MVA-BN RSV vaccine)
- **Secondary objective**: RSV-specific (ELISA, PRNT, ELISPOT/ICS) and vaccinia-specific immune response to MVA-BN-RSV vaccine

<table>
<thead>
<tr>
<th>Groups</th>
<th>N</th>
<th>Age (years)</th>
<th>Vaccine</th>
<th>Dose per 0.5 ml (nominal titers)</th>
<th>Schedule (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18+3</td>
<td>18-49</td>
<td>MVA-BN RSV / placebo</td>
<td>1 x 10^7 TCID&lt;sub&gt;50&lt;/sub&gt;</td>
<td>0-28</td>
</tr>
<tr>
<td>2</td>
<td>18+3</td>
<td>18-49</td>
<td>MVA-BN RSV / placebo</td>
<td>1 x 10^8 TCID&lt;sub&gt;50&lt;/sub&gt;</td>
<td>0-28</td>
</tr>
<tr>
<td>3</td>
<td>18+3</td>
<td>50-65</td>
<td>MVA-BN RSV / placebo</td>
<td>1 x 10^8 TCID&lt;sub&gt;50&lt;/sub&gt;</td>
<td>0-28</td>
</tr>
<tr>
<td>Total</td>
<td>54+9</td>
<td>50-65</td>
<td></td>
<td>1 x 10^8 TCID&lt;sub&gt;50&lt;/sub&gt;</td>
<td>0-28</td>
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Data Expected 1H 2016
## INFECTIOUS DISEASE MILESTONES

<table>
<thead>
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<th>Product Candidate</th>
<th>Expected Milestone</th>
</tr>
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<tr>
<td>IMVAMUNE (liquid frozen)</td>
<td>Complete enrollment by 2017</td>
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<td>IMVAMUNE (freeze dried)</td>
<td>Manufacturing validation</td>
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<td>MVA-BN Filo</td>
<td>Data from multiple trials in 2016</td>
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<td>MVA-BN RSV</td>
<td>Phase 1 data by 1H16</td>
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### CANCER IMMUNOTHERAPY PIPELINE

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<td>mCRPC</td>
<td>Bristol-Myers Squibb&lt;sup&gt;(a)&lt;/sup&gt;</td>
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<td>Bristol-Myers Squibb&lt;sup&gt;(a)&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td>• NCI Phase 2 trial enrolling</td>
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<tr>
<td></td>
<td>Localized Prostate Cancer (neoadjuvant)&lt;sup&gt;(b)&lt;/sup&gt;</td>
<td>Bristol-Myers Squibb&lt;sup&gt;(a)&lt;/sup&gt;</td>
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<td></td>
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<td></td>
<td>mCRPC</td>
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<td>+ XTANDI (enzalutamide)</td>
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<td>Bristol-Myers Squibb&lt;sup&gt;(a)&lt;/sup&gt;</td>
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<td>MVA-BN Brachyury</td>
<td>Solid Tumors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Phase 1 trial data in 4Q15</td>
</tr>
</tbody>
</table>

<sup>(a)</sup> BMS would have complete commercial rights to PROSTVAC, regardless of treatment setting, should they exercise their licensing agreement.

<sup>(b)</sup> Treatment given to shrink the tumor before the main treatment.
### BMS Collaboration
- Up to $975M in upfront and milestone payments
  - $60M upfront payment
  - $420M in pre-commercial milestones
- Entitled to tiered double-digit royalties on future sales
- BN to retain all commercial production responsibilities

### Monotherapy
- Phase 3 PROSPECT trial fully enrolled (n=1,298)
- 3 interim analyses starting in 2016
- Top-line data expected in 2017

### PROSTVAC & Checkpoint Inhibitors Combination Therapy
- Induces antigen cascade, indicating promise with checkpoint inhibitors
- Demonstrated benefit with ipilimumab in NCI trial
- Five ongoing trials with the NCI
- BMS will initiate trial with a checkpoint inhibitor by early 2016

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**Phase 3 “Off-The-Shelf” Vaccine for Prostate Cancer**
PROSTVAC
PRIME/BOOST PSA TARGETED CANCER VACCINE

Heterologous prime/boost regimen

Vaccinia or MVA + Fowlpox

Subcutaneous administration

P.S.A.
CEA, MUC-1
HER-2
Brachyury

Tumor antigens with epitopes enhanced for HLA binding

Prostate, lung, head & neck, bladder, colorectal, breast, ovarian and renal cancers

TRICOM (TRIad of COstimulatory Molecules)

Enhance T-Cell activation in synergistic manner

Strengthen the anticancer immune response

Safe and well tolerated (11 clinical trials)

Injection site reactions and flu-like symptoms
PROSTVAC INDUCES AN ANTIGEN CASCADE AGAINST PROSTATE CANCER CELLS

Summary of T-cell responses from six PROSTVAC clinical trials

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA-Specific Immune response</td>
<td>56.7% (59/104)</td>
<td>28 days after last vaccine</td>
</tr>
<tr>
<td>Median fold increase in PSA-specific immune response</td>
<td>5X</td>
<td>PSA response 30 / 10^6 cells</td>
</tr>
<tr>
<td>Antigen Cascade</td>
<td>67.9% (19/28)</td>
<td></td>
</tr>
<tr>
<td>Anti-PSA Ab</td>
<td>0.57% (2/349)</td>
<td></td>
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</tbody>
</table>

PROSTVAC PHASE 2 DATA
MOST PRONOUNCED SURVIVAL TO DATE IN PROSTATE CANCER

Overall Survival Analysis of a Phase 2 Randomized Controlled Trial of a Poxviral-Based PSA-Targeted Immunotherapy in Metastatic Castration-Resistant Prostate Cancer
Kantoff et al., Journal of Clinical Oncology, January 2010

Significantly extended overall survival

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Deaths</th>
<th>Median OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>40</td>
<td>37</td>
<td>16.6</td>
</tr>
<tr>
<td>PROSTVAC</td>
<td>82</td>
<td>65</td>
<td>25.1</td>
</tr>
</tbody>
</table>

Δ 8.5 months improvement in OS

Hazard ratio
0.56 (95% CI 0.37–0.85)
p=0.0061

Pivotal data of approved agents:
Provenge®: ΔOS = 4.1 mo (AS/MS mCRPC)
Zytiga®: ΔOS = 5.2 mo (pre-chemo mCRPC)
Xtandi®: ΔOS = 2.2 mo (pre-chemo mCRPC)

Reference
Package insert Sipuleucel-T, enzalutamide and abiraterone
ADDITIONAL PROSTVAC PHASE 2 DATA

32 mCRPC patients enrolled with median age 65.6

Improvement of 9.2 months compared to Halabi Score

# Predicted Survival (Halabi) Versus Actual

<table>
<thead>
<tr>
<th></th>
<th>All patients</th>
<th>Patients with Halabi Predicted Survival &lt; 18 months</th>
<th>Patients with Halabi Predicted Survival ≥ 18 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine PROSTVAC (n=32)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median survival predicted by Halabi score (months)</td>
<td>17.4</td>
<td>12.3</td>
<td>20.9</td>
</tr>
<tr>
<td>Actual median overall survival (months)</td>
<td>26.6</td>
<td>14.6</td>
<td>≥ 37.3 (not reached)</td>
</tr>
<tr>
<td>Patients surviving longer than predicted by Halabi nomogram</td>
<td>22 of 32 (69%)</td>
<td>10 of 17 (59%)</td>
<td>12 of 15 (80%)</td>
</tr>
<tr>
<td>Difference (months)</td>
<td>9.2</td>
<td>2.3</td>
<td>≥ 16.4</td>
</tr>
</tbody>
</table>


<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Median survival predicted by Halabi score (months)</td>
<td>16.5</td>
<td>13.0</td>
<td>21.0</td>
</tr>
<tr>
<td>Actual median overall survival (months)</td>
<td>15.5</td>
<td>15.4</td>
<td>16.9</td>
</tr>
<tr>
<td>Patients surviving longer than predicted by Halabi nomogram</td>
<td>11 of 22 (50%)</td>
<td>8 of 13 (62%)</td>
<td>3 of 9 (33%)</td>
</tr>
<tr>
<td>Difference (months)</td>
<td>(-1.0)</td>
<td>2.4</td>
<td>(-4.1)</td>
</tr>
</tbody>
</table>

## ENTRY CRITERIA

<table>
<thead>
<tr>
<th>Randomized Phase 2</th>
<th>PROSPECT Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECOG &lt; 2</strong></td>
<td></td>
</tr>
<tr>
<td>No visceral metastases</td>
<td></td>
</tr>
<tr>
<td>Asymptomatic (no cancer-related pain requiring narcotics)</td>
<td></td>
</tr>
<tr>
<td>No prior chemotherapy</td>
<td></td>
</tr>
</tbody>
</table>

- **Gleason score ≤ 7 (from original biopsy)**
  - **Removed Gleason score exclusion**
    - Gleason grade not associated with treatment effect in other phase 3 mCRPC trials (sip-T, ipilimumab)

- **No alkaline phosphatase exclusion**
  - Changed to exclude patients with alk phos ≥ 2 times ULN
    - Excludes more advanced metastatic disease

- **No LDH exclusion**
  - Changed to exclude patients with LDH ≥ 2 times ULN
    - Excludes more advanced metastatic disease

- **No PSA doubling time (PSA-DT) exclusion**
  - Added exclusion for patients with PSA-DT < 1 month
    - Excludes patients with fast growing tumors

- **Minimum PSA value for determination of CRPC = 5 ng/mL (PCWG1)**
  - Minimum PSA value for determination of CRPC lowered to 2 ng/mL (PCWG2)
Primary endpoint is overall survival

Either one of the treatment arms must be superior to placebo

Each comparison between active and placebo requires 534 deaths for the final analysis

Interim analysis plan
  - Pre-specified interim data analyses will evaluate whether the trial should continue as planned or potentially be stopped early for efficacy or futility

Phase 2 results:
Demonstrated hazard ratio 0.56 = 44% reduction in risk of death

SPA terms for Phase 3:
Required hazard ratio 0.82 or less = 18% reduction in risk of death

PROSPECT
A Randomized, Double-blind, Global Phase 3 Efficacy Trial of PROSTVAC in Metastatic Castration-Resistant Prostate Cancer

1,298 patients

Enrolled at 214 sites in 15 countries: Australia, Belgium, Canada, Denmark, Estonia, France, Germany, Iceland, Israel, Netherlands, Poland, Russia, Spain, United Kingdom & United States

3 trial arms

PROSTVAC + GM-CSF
PROSTVAC
Placebo
Randomization by region
N=1,298

- **25.7%** Rest of World (n=333)
- **38.2%** Western Europe (n=497)
- **18.4%** North America Oncology (n=239)
- **17.7%** North America Urology (n=229)

Injections

- Average was **6.1 injections**
- Randomized Phase 2 trial (n=122) had average of 5.4 injections
- An increased number of injections is expected to improve the clinical outcome for patients receiving the active drug.

---

1) Subjects who have completed study treatment phase or have completed 7th dosing visit. N=1,279
2) Kantoff et al., Journal of Clinical Oncology, January 2010
DEMONSTRATED POTENTIAL AS A COMBINATION THERAPY WITH BMS’ IPILIMUMAB

PROSTVAC Phase 2 Trial

PROSTVAC + Ipilimumab Phase 1 Trial

Patients in 10mg/kg dose cohort (N=15) reported 37.2 months median overall survival

~20% of 10mg/kg patients remain alive at 80 months

BMS to Initiate Combination Trial with a Checkpoint Inhibitor In Early 2016


Further investigation of PROSTVAC in collaboration with BMS

- Two new investigator-sponsored trials planned for initiation

### Phase 2

<table>
<thead>
<tr>
<th>Phase 2 (n=75)</th>
<th>Open label combination trial in localized prostate cancer using PROSTVAC and ipilimumab as neoadjuvant therapy.</th>
<th>Randomization 1:1:1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PROSTVAC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ipilimumab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROSTVAC + ipi</td>
</tr>
</tbody>
</table>

Sponsor: UCSF  
Clinicaltrials.gov  
NCT02506114

### Phase 2

<table>
<thead>
<tr>
<th>Phase 2 (n=28)</th>
<th>Open label combination trial in prostate cancer using PROSTVAC, ipilimumab and nivolumab as neoadjuvant therapy</th>
<th>PROSTVAC + ipi + nivo</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PROSTVAC + ipi</td>
</tr>
</tbody>
</table>

Sponsor: NCI
<table>
<thead>
<tr>
<th>Stage</th>
<th>Indication</th>
<th>Trial design</th>
<th>Key endpoints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 2 (n=38)</td>
<td>Non-metastatic castration sensitive prostate cancer</td>
<td>PROSTVAC + enzalutamide vs. enzalutamide alone</td>
<td>Decrease in tumor re-growth rate (PSA kinetics) after three months of enzalutamide</td>
</tr>
<tr>
<td>Phase 2 (n=76)</td>
<td>Metastatic castration sensitive prostate cancer</td>
<td>PROSTVAC + enzalutamide vs. enzalutamide alone</td>
<td>Time to progression</td>
</tr>
<tr>
<td>Phase 2 (n=27)</td>
<td>Patients undergoing treatment with radical prostatectomy</td>
<td>PROSTVAC as neoadjuvant therapy</td>
<td>Effect on immune cells (measured by CD4 and CD8 cell infiltrate response) in the prostate</td>
</tr>
<tr>
<td>Phase 2 (n=62)</td>
<td>Non-metastatic prostate cancer</td>
<td>PROSTVAC + flutamide vs. flutamide alone</td>
<td>Time to treatment failure</td>
</tr>
<tr>
<td>Phase 2 (n=90)</td>
<td>Localized prostate cancer, active surveillance</td>
<td>PROSTVAC</td>
<td>Immune response</td>
</tr>
</tbody>
</table>
TRIALS SPAN PROSTATE CANCER DISEASE LANDSCAPE

- **Active surveillance (NCI)**
- **enza combo (NCI)**
- **flutamide combo (NCI)**
- **enza combo (NCI)**
- **Phase 3 (BN)**

**Mechanism of action**
- Immune infiltration to tumor, immune response, biomarkers, and PSA kinetics

**Use in combination**
- With currently approved therapies for mCRPC, and with checkpoint inhibitors

**Use in earlier prostate cancer to support future label expansion**
- More trials planned in early disease indications
CV 301 IMMUNOTHERAPY VACCINE CANDIDATE

TRICOM (TRIad of COstimulatory Molecules)
- Enhance T-Cell activation in synergistic manner
- Strengthen the anticancer immune response

Heterologous prime/boost regimen
- Vaccinia or MVA + Fowlpox
- Subcutaneous administration

Vaccinia or MVA + Fowlpox

Tumor antigens with epitopes enhanced for HLA binding
- PSA
- CEA, MUC-1
- HER-2
- Brachyury

Prostate, lung, head & neck, bladder, colorectal, breast, ovarian and renal cancers

Safe and well tolerated (six clinical trials)
- Injection site reactions and flu-like symptoms

Injection site reactions and flu-like symptoms

Injection site reactions and flu-like symptoms

Injection site reactions and flu-like symptoms
CV 301 IMMUNOTHERAPY CANDIDATE FOR MULTIPLE CANCERS

High unmet need remains for patients with PD-L1 low/negative tumors

- Scientific rationale for CV 301 combination:
  - Inducing antigen-specific tumor-infiltrating CD8 T-Cells provoke up-regulation of tumor PD-L1 expression in patients
  - Combination CV 301 + PD blockade therapy more likely to achieve efficacy in patients with PD-L1 low/negative tumors
  - CV 301 is believed to convert non-expressing PD-L1 tumors in immune-responsive tumors by inducing PD-L1 expression, potentially resulting in a higher overall therapeutic response
  - Poxvirus-based immunotherapy induces high IFNγ-producing CD8 TILs
  - PD-L1 tumor expression is up-regulated in response to CD8 TILs and IFNγ
UPREGULATION OF PD-L1 AFTER PANVAC TREATMENT
MC38-MUC1 MOUSE CRC MODEL

Tissue harvest: day 25
1E7 Inf.U PANVAC-V on day 4
5E7 Inf.U PANVAC-F on day 11 and 18
COMPLETE TUMOR REGRESSION FROM POXVIRUS-BASED IMMUNOTHERAPY COMBINED WITH PD-1 & LAG-3 BLOCKADE

CT26-HER2 solid tumor model:

MVA-BN-HER2 immunotherapy (s.c.) and/or anti-PD1 + anti-LAG3 antibody (i.p.)

Q2wks x2 (d1 and 15)

Durable Response After Mice Were Re-Challenged
## OVEREXPRESSION OF CEA AND MUC-1 IN HUMAN CARCINOMAS

<table>
<thead>
<tr>
<th>Carcinoma</th>
<th>CEA</th>
<th>MUC-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Pancreatic</td>
<td>&gt;95%</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>Lung(^1)</td>
<td>70%</td>
<td>&gt;80%</td>
</tr>
<tr>
<td>Bladder</td>
<td>70%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Breast</td>
<td>50%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Ovarian</td>
<td>15%</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>

\(^1\) Expression higher in Adenocarcinoma than in Squamous

Initiate Phase 2 in 2016

Currently being evaluated
## Indications
- Chordoma (ultra-orphan disease)
- Triple negative breast cancer
- NSCLC
- Multiple solid tumors

## Development Strategy
- NCI Phase 1 and Phase 2 trials
- NCI Phase 2 chemotherapy combination trial(s)
- NCI erlotinib combination trial(s)
- NCI and BN immune checkpoint inhibitor combinations

Brachyury expression is highly correlated with metastatic disease, and multi-drug resistance.

Brachyury is not expressed in most normal tissue.

Brachyury is responsible for epithelial to mesenchymal transition (EMT), which is a major driver of metastasis.
BRACHYURY IS ABERRANTLY OVEREXPRESSED IN LUNG TUMORS

Collaboration with Drs. Guadagni and Roselli, Rome, Italy

<table>
<thead>
<tr>
<th>Lung tumor</th>
<th>% Brachyury positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenocarcinoma</td>
<td>10/21 (48%)</td>
</tr>
<tr>
<td>Squamous carcinoma</td>
<td>3/12 (25%)</td>
</tr>
<tr>
<td>Other</td>
<td>3/6 (50%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16/39 (41%)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Normal Adjacent to Tumor</th>
<th>% Brachyury positive</th>
</tr>
</thead>
</table>
|                         | 7/24 (29%)           

<table>
<thead>
<tr>
<th>Normal Tissue</th>
<th>% Brachyury positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>0/3 (0%)</td>
</tr>
<tr>
<td>Brain</td>
<td>0/3 (0%)</td>
</tr>
<tr>
<td>Liver</td>
<td>0/3 (0%)</td>
</tr>
<tr>
<td>Kidney</td>
<td>0/3 (0%)</td>
</tr>
<tr>
<td>Spleen</td>
<td>0/3 (0%)</td>
</tr>
<tr>
<td>Adrenal Gland</td>
<td>0/1 (0%)</td>
</tr>
<tr>
<td>Lung</td>
<td>0/3 (0%)</td>
</tr>
<tr>
<td>Skin</td>
<td>0/1 (0%)</td>
</tr>
<tr>
<td>Skeletal Muscle</td>
<td>0/3 (0%)</td>
</tr>
<tr>
<td>Testis</td>
<td>3/3 (100%)</td>
</tr>
<tr>
<td>Thyroid</td>
<td>4/6 (67%)</td>
</tr>
</tbody>
</table>

Brachyury Expression in Lung Cancer Correlates with Tumor Stage

<table>
<thead>
<tr>
<th></th>
<th>Brachyury / GAPDH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NORMAL ADJACENT TO TUMOR</td>
</tr>
<tr>
<td><strong>Adenocarcinoma</strong></td>
<td>2/16 (12.5%)</td>
</tr>
<tr>
<td><strong>Squamous CA.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16/39 (41%)</td>
</tr>
</tbody>
</table>

Roselli et al., Clin Can Res. 2012

Fernando et al., J Clin Invest. 2010
These findings show for the first time that advanced cancer patients can be safely immunized with an MVA-based vaccine targeting brachyury, and can develop brachyury-specific T-cell immune responses. ¹

¹Heery, Donahue, et al.
# Cancer Immunotherapy Milestones

<table>
<thead>
<tr>
<th>Product Candidate</th>
<th>Expected Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROSTVAC in mCRPC</td>
<td>Three interim analyses starting in 2016 with top-line data in 2017</td>
</tr>
<tr>
<td>PROSTVAC in Localized Prostate Cancer (neoadjuvant)</td>
<td>Phase 2 data in 2016</td>
</tr>
<tr>
<td>PROSTVAC in Non-Metastatic Prostate Cancer</td>
<td>Phase 2 data in 1H16</td>
</tr>
<tr>
<td>MVA-BN Brachyury</td>
<td>Phase 1 data in 4Q15</td>
</tr>
</tbody>
</table>
FINANCIAL OVERVIEW

<table>
<thead>
<tr>
<th>FACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Founded 1994, IPO 1998</td>
</tr>
<tr>
<td>• Listed on Nasdaq Copenhagen: BAVA</td>
</tr>
<tr>
<td>• Level 1 ADR: BVNRY</td>
</tr>
<tr>
<td>• 27.8m shares outstanding/~29.3m fully diluted</td>
</tr>
<tr>
<td>• Market cap DKK 7.3bn / $1.1B*(2)</td>
</tr>
<tr>
<td>• ~27,000 registered shareholders</td>
</tr>
</tbody>
</table>

(1) For the twelve months ended September 30, 2015.
(2) As of September 30, 2015.
APPENDIX
PROSTVAC - PATIENT CASE HISTORY (“FRANK”)  
PUBLISHED 2013 CASE REPORT IN CLINICAL GENITOURINARY CANCER

Gleason grade: 4 + 3 = 7

- Trend before radical prostatectomy (■): 5.8 months DT (doubling time)
- Trend after radical prostatectomy: External beam radiation (■): 9.6 months DT
- Trend after first vaccine trial (■): 28.6 months DT
- Trend after second vaccine trial (■):

Radical Prostatectomy
External Beam Radiation
Vaccine Treatment
Second Vaccine Treatment
INCREASED LAG-3 STAINING AFTER COMBINATION TREATMENT

MVA-BN-HER2

Anti-PD1

MVA-BN-HER2 + anti-PD1

Tissue harvest: day 16

MVA-BN-HER2 immunotherapy (s.c.) and/or anti-PD1 mAb 10mg/kg (i.p.), Q2wks x 2 (d1 and d15)
PSA Waterfall Plot: Ipi/Prostvac

Figure: Best PSA response after treatment
14 (58%) of 24 patients who were chemotherapy-naive had PSA declines; six (25%) had PSA declines greater than 50%. PSA = prostate specific antigen.
Patients with a strong PSA specific T-cell response responded better ($p = 0.0055$)

The median survival of placebo mCRPC patients from several Phase 3 trials reported in the same period ranged from 12.2 to 21.7 \(^{1-8}\)

---

**Table 1. Summary of Overall Survival and Time to Disease Progression in D9901, D9902A, and the Integrated Analysis**

<table>
<thead>
<tr>
<th></th>
<th>D9901</th>
<th></th>
<th>D9902A</th>
<th></th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sipuleucel-T, n=82</td>
<td>Placebo, n=45</td>
<td>Sipuleucel-T, n=65</td>
<td>Placebo, n=33</td>
<td>Sipuleucel-T, n=147</td>
</tr>
<tr>
<td>Median survival (CI), mo</td>
<td>25.9 (20.0-32.4)</td>
<td>(21.4) (13.3-25.8)</td>
<td>19.0 (13.6-31.9)</td>
<td>(15.7) (12.8-25.4)</td>
<td>23.2 (19.0-31.0)</td>
</tr>
<tr>
<td>Hazard ratio* (CI)</td>
<td>1.71 (1.13-2.58)</td>
<td>(P=0.010)</td>
<td>1.27 (0.78-2.07)</td>
<td>(P=0.31)</td>
<td>1.50 (1.10-2.05)</td>
</tr>
<tr>
<td>Overall survival, log-rank test</td>
<td>1.45 (0.99-2.11)</td>
<td>(P=0.052)</td>
<td>1.09 (0.69-1.70)</td>
<td>(P=0.719)</td>
<td></td>
</tr>
<tr>
<td>Median time to progression (CI), wk</td>
<td>11.7 (9.1-16.6)</td>
<td>9.1 (8.7-13.1)</td>
<td>10.9 (9.3-17.7)</td>
<td>9.9 (8.4-18.0)</td>
<td>11.1 (10.0-16.3)</td>
</tr>
<tr>
<td>Hazard ratio* (CI)</td>
<td>1.45 (0.99-2.11)</td>
<td>(P=0.052)</td>
<td>1.09 (0.69-1.70)</td>
<td>(P=0.719)</td>
<td></td>
</tr>
<tr>
<td>Overall TTP, log-rank test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

WHY DO SOME PATIENTS RESPOND BETTER TO PROSTVAC?

All patients could mount and immune response to the vaccine backbone

Less T regulatory cell activity in responders

Antibody titer to fowlpox

% change in suppressive function

Predicted Survival by Halabi Nomogram

> predicted survival  < predicted survival
SYNERGY OF POXVIRUS-BASED IMMUNOTHERAPY COMBINED WITH PD-1 AXIS BLOCKADE

MVA-BN-HER2 immunotherapy (s.c.) and/or anti-PD1 mAb 10mg/kg (i.p.)

Q2wks x 2 (d1 and d15)

Very strong synergy
Chou-Talalay: CI < 0.031

** p < 0.01
**** p < 0.0001
TUMOR INFILTRATION BY HIGHLY ACTIVATED CYTOTOXIC T-CELLS

Lung/Tumors (day 25)

Antigen-specific CTL Activity

Activated phenotype:
CD44⁺, ICOS⁺, PD-1mid
KLRG1⁺, CD127⁺/-

Foy et al. (2014) ASCO poster; Manuscript submitted
BRACHYURY IS ABERRANTLY OVEREXPRESSED IN BREAST TUMORS

<table>
<thead>
<tr>
<th>Breast tissue type</th>
<th>% Brachyury positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Invasive Ductal Ca.</td>
<td>27/30 (90%)</td>
</tr>
<tr>
<td>Benign Breast disease</td>
<td>2/16 (12.5%)*</td>
</tr>
<tr>
<td>Breast Ca. Metastases</td>
<td>6/6 (100%)</td>
</tr>
</tbody>
</table>

(*) focal staining

Brachyury expression correlates with high risk recurrence in breast cancer patients treated with Tamoxifen only

Data provided by Kim Lyerly, Duke Univ.
## COMMERCIAL LICENSE WITH BMS

<table>
<thead>
<tr>
<th>Elements</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upfront payment</td>
<td>$60M</td>
</tr>
<tr>
<td>License</td>
<td>$80M</td>
</tr>
<tr>
<td>Phase 3 data</td>
<td>$50M</td>
</tr>
<tr>
<td>Data-driven milestones</td>
<td>$180M*</td>
</tr>
<tr>
<td>Regulatory milestones</td>
<td>$110M</td>
</tr>
<tr>
<td>Sales milestones</td>
<td>$495M</td>
</tr>
<tr>
<td>Tiered royalties on future sales</td>
<td>Double-digit</td>
</tr>
</tbody>
</table>

* Based on Phase 2 data