NEKTAR®

NEW PATHWAYS TO SMARTER MEDICINE™

European Society for Medical Oncology Immuno-Oncology (ESMO IO) Congress 2021

Investor & Analyst Call

December 6, 2021

This presentation includes forward-looking statements regarding Nektar's proprietary drug candidates, the timing of the start of and plans for ongoing or planned clinical trials with partners, the therapeutic potential of our drug candidates, the timing and outcome of regulatory decisions, and future availability of clinical trial data. Actual results could differ materially, and these statements are subject to important risks detailed in Nektar's filings with the SEC including the Form 10-Q filed on November 5, 2021. Nektar undertakes no obligation to update forward-looking statements as a result of new information or otherwise.

Today's Speakers

Jonathan Zalevsky, PhD

Chief Research & Development Officer at Nektar Therapeutics

Dimitry Nuyten, MD, PhD

Chief Medical Officer at Nektar Therapeutics

Daniel Johnson, MD

Medical Oncologist, Gayle and Tom Benson Cancer Center; Deputy Director, Precision Cancer Therapies (Phase I) Research Program Ochsner Medical Center

Mehmet Altan, MD

Assistant Professor in the Department of Thoracic-Head and Neck Medical Oncology, Division of Cancer Medicine at The University of Texas MD Anderson Cancer Center

Daniel Johnson, M.D. – Ochsner Medical Center

Daniel Johnson, M.D. is a medical oncologist and the deputy director of the Precision Cancer Therapies (Phase 1) Research Program at Ochsner Medical Center. He specializes in treating patients with melanoma, lung cancer, and head & neck cancer. His specific research interests include strategies to overcome immunotherapy resistance and prevent immunotherapy related toxicities. He has published multiple peer-reviewed articles and presented at various national meetings pertaining to the management and underlying mechanisms of immune toxicity. Dr. Johnson is also a clinical investigator focusing on designing and implementing clinical trials intended to optimize the safety and efficacy of immune checkpoint inhibitors.

Mehmet Altan, M.D. – MD Anderson Cancer Center

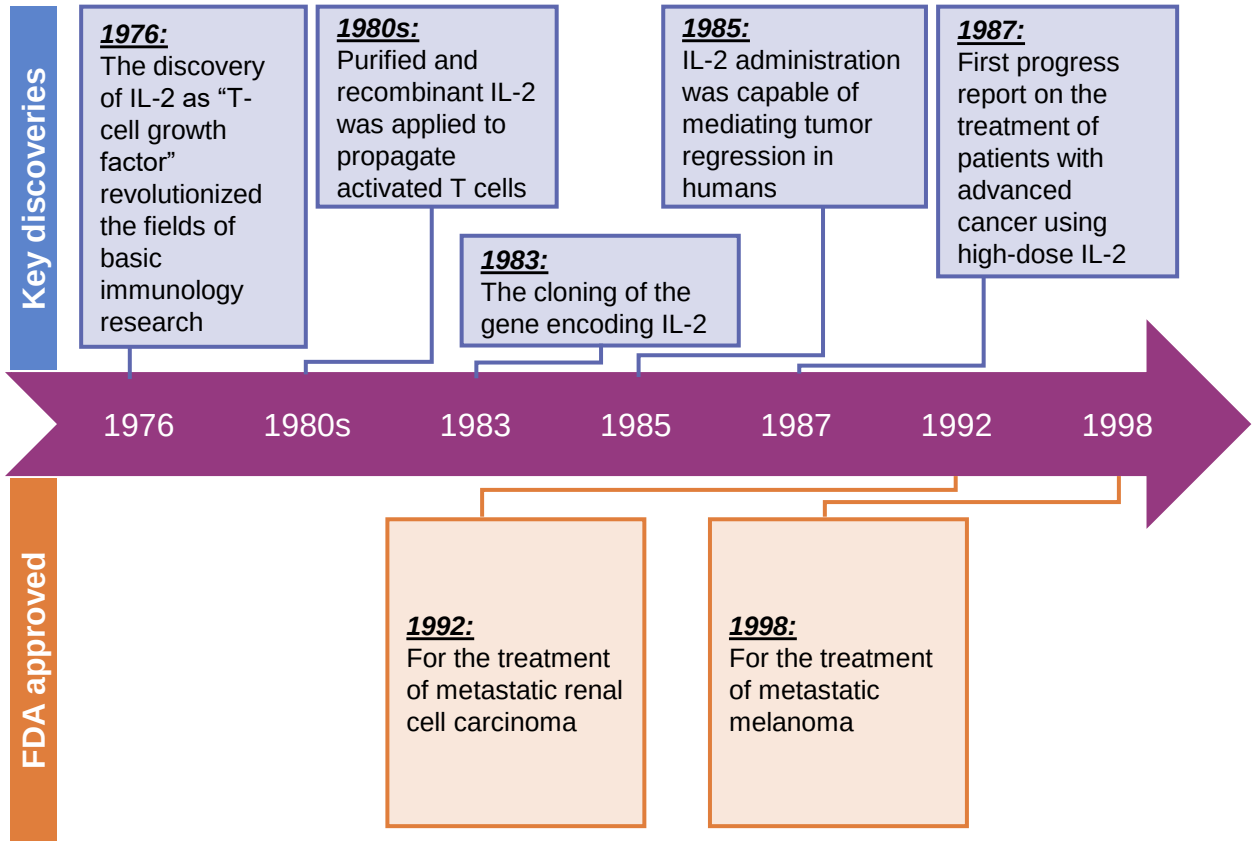
Mehmet Altan, M.D., is an Assistant Professor in the Department of Thoracic-Head and Neck Medical Oncology, Division of Cancer Medicine at The University of Texas MD Anderson Cancer Center. His current research areas include identification of mechanisms for primary and secondary resistance to immunotherapies and predictive markers for immunotherapy toxicities. He also works on translational research projects for identification of spatiotemporal dynamics of the tumor microenvironment in response to immunotherapy to define potential therapeutic targets.

Agenda

Bempegaldesleukin (BEMPEG; NKTR-214): an IL-2 pathway agonist

- ***IL-2: The Central Immuno-Stimulatory Cytokine***
  - *Jonathan Zalevsky, Ph.D., Nektar Therapeutics*
- ***ESMO-IO 2021: "Preliminary results from PROPEL: A phase 1/2 study of bempegaldesleukin (BEMPEG: NKTR-214) plus pembrolizumab (PEMBRO) with or without chemotherapy in patients with metastatic NSCLC"***
  - *Dimitry Nuyten, M.D., Ph.D., Nektar Therapeutics*
- ***Depth of Response and Correlation to PFS and OS in NSCLC with Patient Case Studies from PROPEL***
  - *Daniel Johnson, M.D., Ochsner Medical Center*
- ***Remarks and Q&A Session***
  - *Mehmet Altan, M.D., MD Anderson Cancer Center, Daniel Johnson, M.D., Ochsner Medical Center*

IL-2: The Central Immuno-Stimulatory Cytokine
A Pathway With Untapped Potential



Jiang et al OncoImmunology (2016)

- High-Dose IL-2 has been associated with complete responses and "durable cancer regression" since its first approvals
- Interleukin-2 (IL-2) was historically one of the few treatments for adults with stage IV solid tumors that could produce complete responses (CRs) that were often durable for decades without further therapy
- The majority of complete responders with metastatic renal cell carcinoma (mRCC) and metastatic melanoma (mM) could probably be classified as "cures"

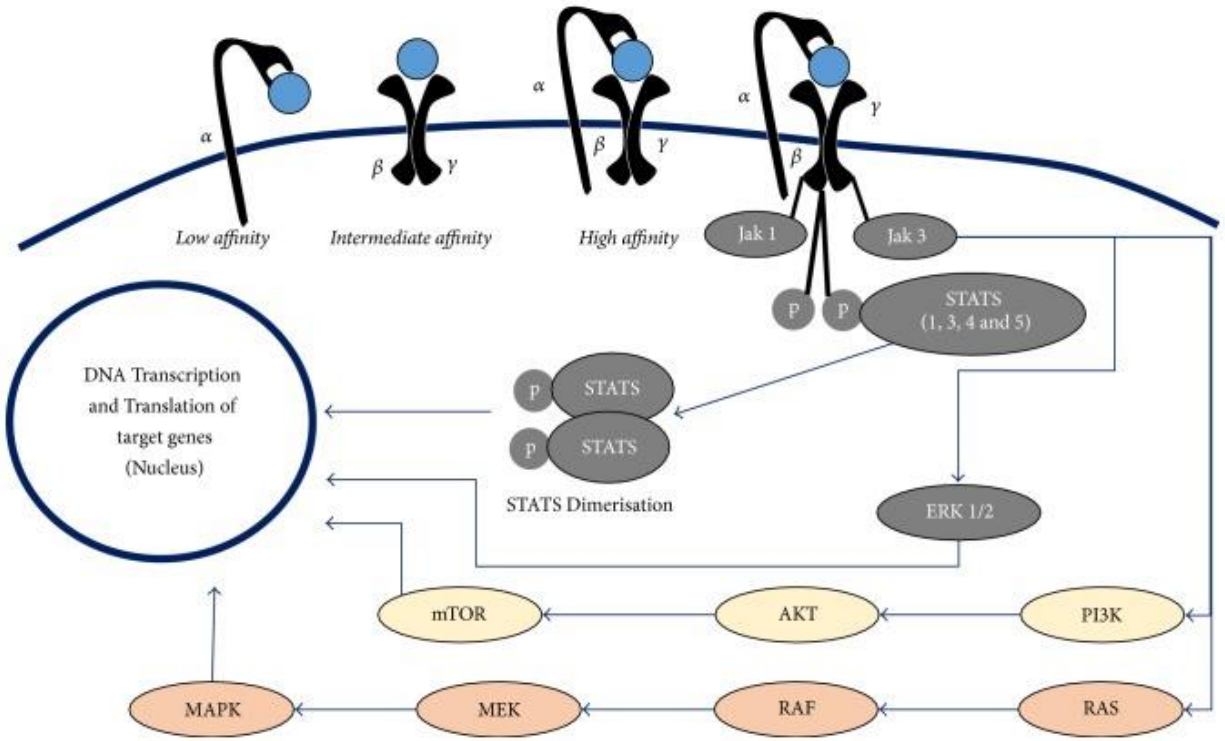
NEKTAR Rosenberg et al J Immunol (2014); Dutcher et al Journal for Immunotherapy of Cancer (2014)

IL-2 Pathway: Proven Efficacy in Melanoma and Renal Cell Carcinoma

		HD IL-2[1] in Melanoma	HD IL-2[2] in RCC
Overall response rate (CR+PR)		14-16%	15-34%
CR rate		6-9%	9%
Median duration of response	**All responders (CR+PR)**	9 months	54 months
	CR Only	59+ mos.	80+ months
Grade 3+ AEs		80 – 90%	

NEKTAR [1]Package insert PROLEUKIN; Payne R et al., J Immunother Cancer 2014, 2:13; [2]Package insert PROLEUKIN; McDermott DF et al., Clin Cancer Res 2015 21:561-568

IL-2: The Central Immuno-Stimulatory Cytokine
A Pathway With Untapped Potential



Choudhry et al BioMed Research International (2018)

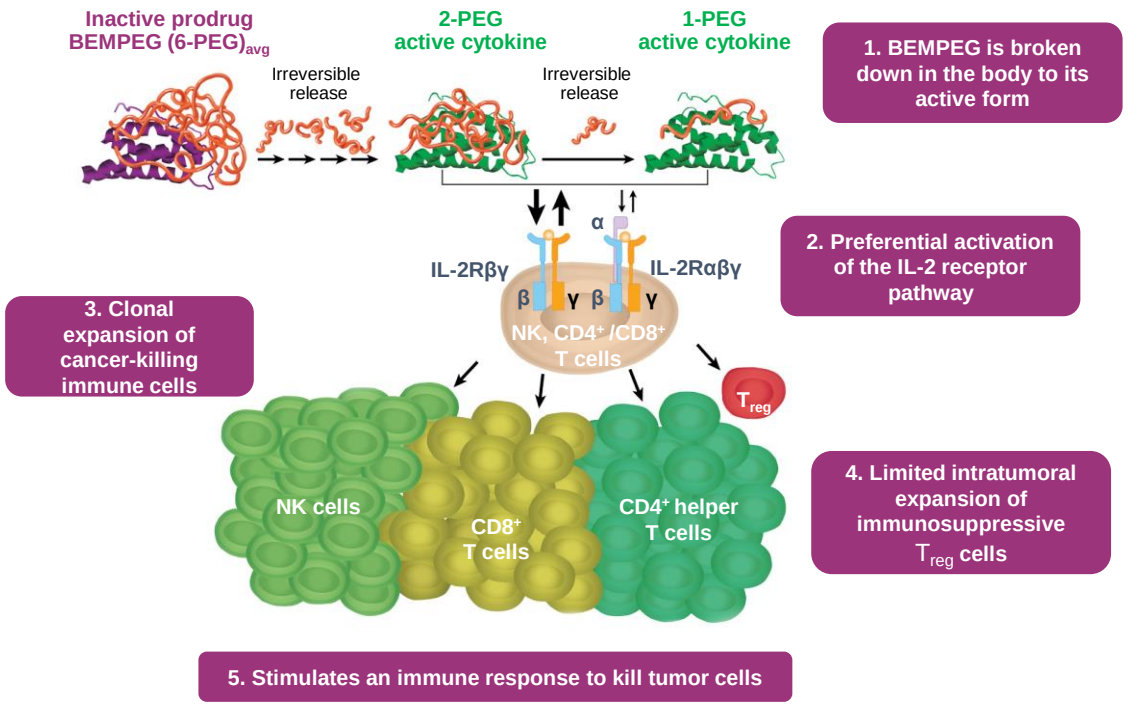
- IL-2 has dual functional properties that it can act on both Tregs as well as effector T cells
- To achieve an optimal immune-stimulatory effect and overcome short half-life, IL-2 is given in a high dose in 8-hour intervals which results in severe toxicities of HD IL-2 therapy and requirement for hospitalization.
- HD IL-2-induced severe toxicities including vascular leak syndrome (VLS), pulmonary edema, hypotension, and heart toxicities.

NEKTAR Rosenberg et al J Immunol (2014); Dutcher et al Journal for Immunotherapy of Cancer (2014)

BEMPEG: Develop a New Medicine that Both Harnesses and Tames the IL-2 Pathway

- Bias signaling to favor the IL-2Rβγ complex
  - Increase the CD8 T cells over the Tregs in the tumor
- Deliver controlled, sustained signal to the IL-2 pathway by designing a pro-drug which releases biased, active species
  - Mitigate over-activation of the IL-2 pathway
- Widen the therapeutic window between efficacy and safety
  - Allow significant tumor exposure after a single dose to achieve antibody-like dosing schedule (q3week)
  - Goal of an outpatient medicine

BEMPEG: Preferential Signaling Via the IL-2R Pathway



- BEMPEG is an immunostimulatory IL-2 cytokine prodrug, which has been engineered to deliver a controlled, sustained, and preferential IL-2 pathway signal[1,2]
- BEMPEG plus a CPI has been shown to convert baseline tumors from PD-L1 negative to PD-L1 positive[3-6]
- BEMPEG plus either nivolumab or pembrolizumab is being evaluated in patients with:
  - metastatic NSCLC (NCT03138889),
  - metastatic or recurrent HNSCC (NCT04969861),
  - metastatic melanoma (NCT03635983),
  - adjuvant melanoma (NCT04410445),
  - advanced renal cell carcinoma (NCT03729245),
  - metastatic urothelial carcinoma (NCT03785925), and
  - muscle-invasive bladder cancer (NCT04209114)

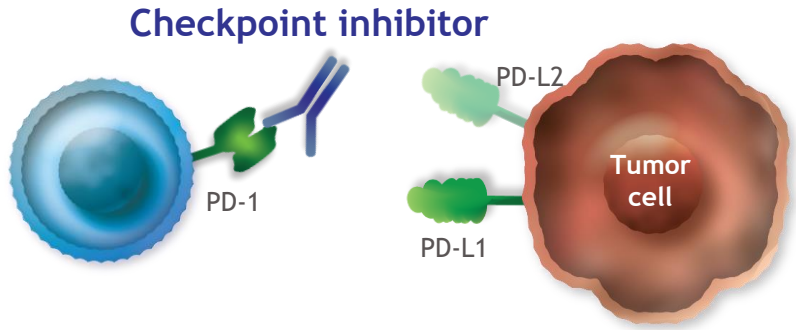
CD, cluster of differentiation; IL-2(R), interleukin-2 (receptor); NK, natural killer; PEG, releasable polyethylene glycol; Treg, regulatory T cell.; NSCLC: Non-small Cell Lung Cancer; HNSCC: Head and Neck Squamous Cell Carcinoma;
1. Charych D, et al. PLoS One 2017;12:e0179431; 2. Bentebibel SE, et al. Cancer Discov 2019;9:711–721; 3. Diab A, et al. SITC 2018. Abstract O4; 4. Siefker-Radtke AO, et al. ASCO GU 2019. Abstract 388; 5. Hurwitz M, et al. ASCO 2019. Abstract 2623; 6. Tolaney S, et al. CICON 2019. Poster A001

Combining an IL-2 Mechanism with Checkpoint Inhibition: Release the Brakes, Hit the Gas

CHECKPOINT INHIBITION:

Release the brakes

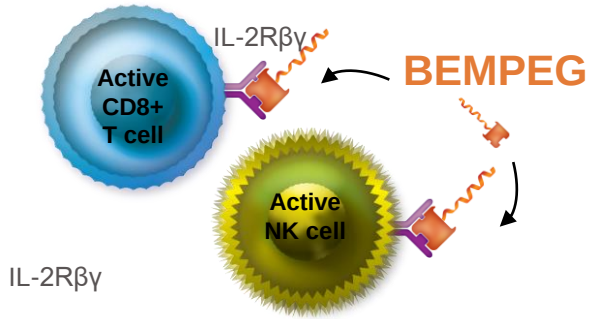
Anti-PD-1 blocks PD-1 on T cells, restoring their cytotoxic function in the TME[1]



IL-2 AGONISM:

Hit the gas

Bempeg preferentially binds IL-2Rβγ, activating and expanding effector CD8+ T cells and NK cells over immunosuppressive Tregs in the TME[1-4]



[1]Ribas A, Wolchok JD. *Science*. 2018;359(6382):1350-1355., [2]Bernatchez C et al. Poster presentation at ASCO 2017. Abstract 2545., [3]Bernatchez C et al. Poster presentation at SITC 2016. Poster 387., [4]Boyman O, Sprent J. *Nat Rev Immunol*. 2012;12(3):180-190.

Scientific and Biological Rationale Supporting BEMPEG + Checkpoint Inhibitors in Solid Tumors

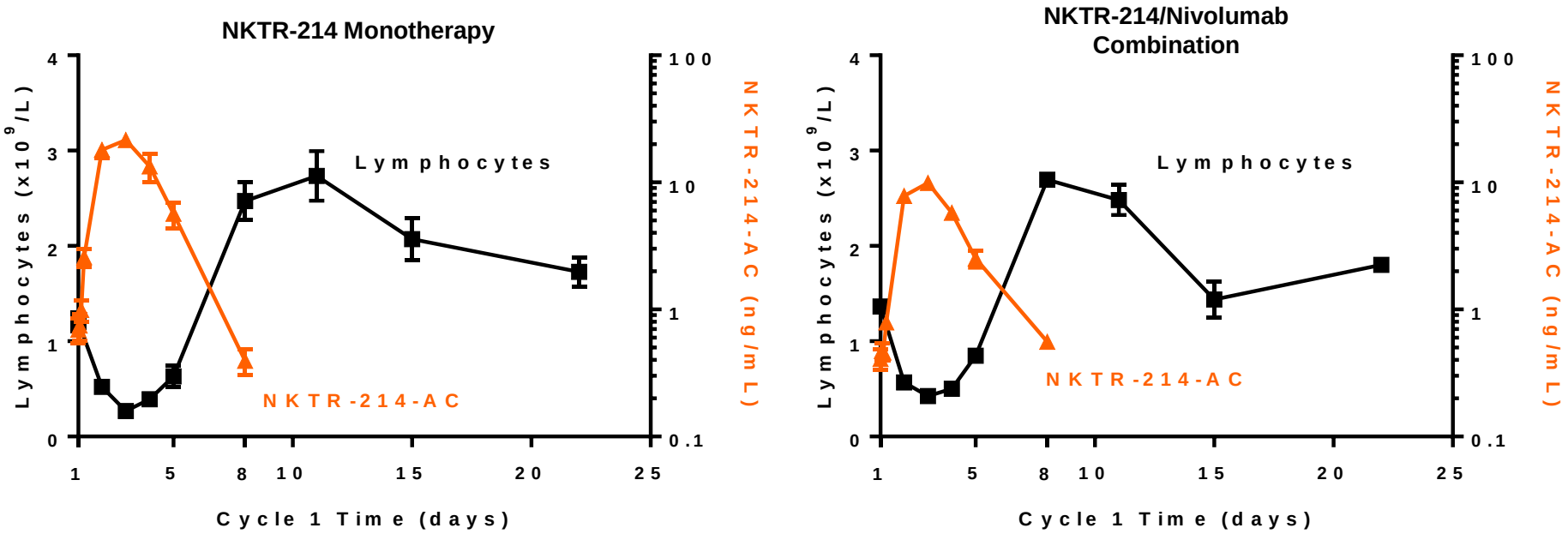
T cells and PD-L1 expression are prognostic

IL-2 is a clinically validated target in multiple solid tumors with approvals in RCC and melanoma

BEMPEG:

- induces strong T cell proliferation and activation after each treatment cycle
- increases activated T cells and PD-L1 expression in tumor tissue
- synergizes with anti-PD-1 in other tumors that are sensitive to T cells and to anti-PD-1 (MM, mUC, RCC, NSCLC)
- converts tumor tissue from PD-L1 negative to positive as a single agent and in combination with checkpoint
- increases favorable anti-tumor gene expression and interferon gamma
- in combination with nivolumab, BEMPEG yielded an unprecedented CR rate in metastatic melanoma and has a well-tolerated safety profile and BEMPEG's AE profile does not overlap with checkpoint inhibitors

Transition of NKTR-214 Prodrug to Active NKTR-214 Related Molecules Correlates with Number of Lymphocytes in Blood

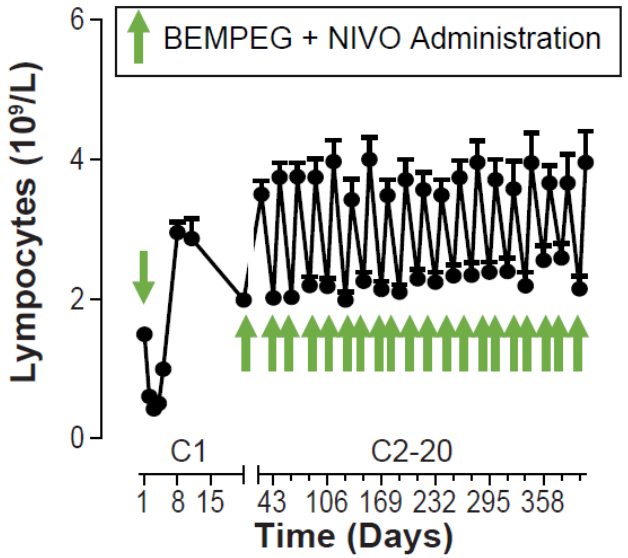


- NKTR-214 prodrug releases Active NKTR-214 related molecules (NKTR-214-AC) over time
- Days 2-4: Peak of NKTR-214-AC coincides with transient lymphopenia
- Day 8-10: Transient lymphocytosis and the presence of proliferating (Ki67+) cells [not shown] are observed as NKTR-214-AC clears circulation
- Lymphocyte effects are driven by NKTR-214 since effects were observed with NKTR-214 monotherapy, with little contribution from Nivolumab

NEKTAR Lymphocyte levels were obtained from standard hematology analysis (N=17 EXCEL and N=328 PIVOT-02). NKTR-214-AC (NKTR-214 active cytokine, 2-PEG and 1-PEG IL-2) measured by a qualified method (N=17 EXCEL and N=48 PIVOT-02).

BEMPEG Increases Lymphocytes in the Peripheral Blood which Corresponds to Increases in CD8+ Tumor Infiltrating Lymphocytes (TILs)

Increase in Lymphocytes with Every Treatment Cycle*

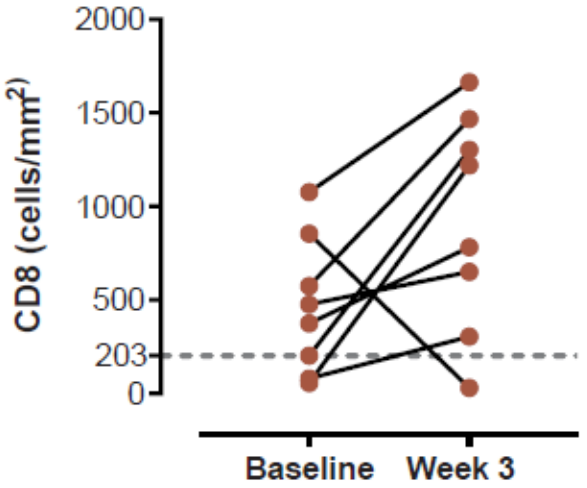


Lymphocyte effects of the BEMPEG + NIVO combination are driven by BEMPEG, as a similar pattern is observed with monotherapy[2]

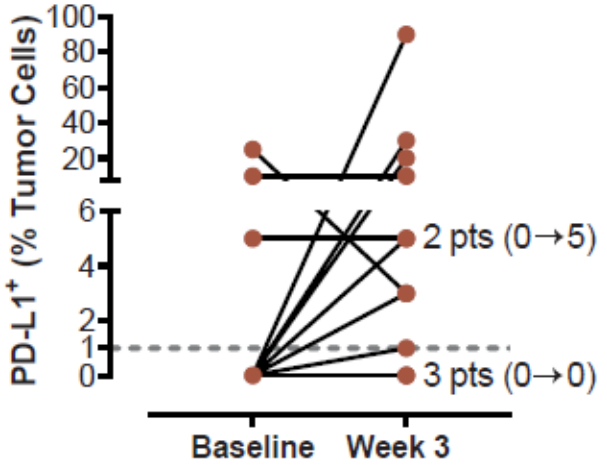
*Lymphocyte levels were obtained from standard hematology analyses. All efficacy evaluable melanoma (n=38) and mUC (n=27) in the BEMPEG + NIVO combination enrolled in PIVOT-02 (n=65, Mean+SD) were included in the analyses.

On-Treatment Increase in TIL and PD-L1

Change in CD8 Infiltrate in MEL[3,^]



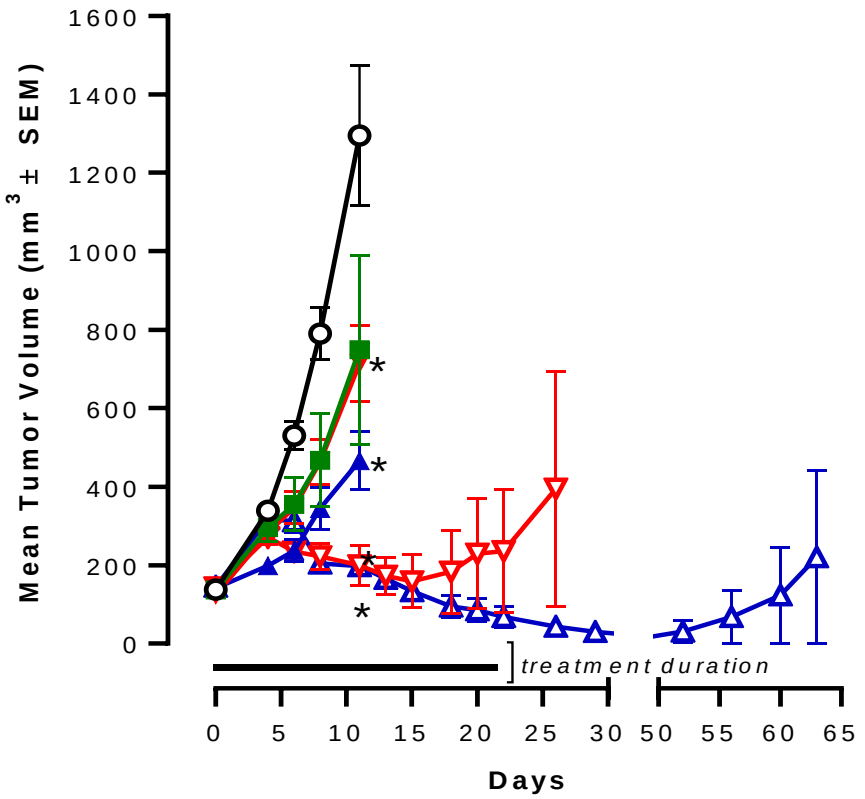
PD-L1 Conversion in UC[4,#]

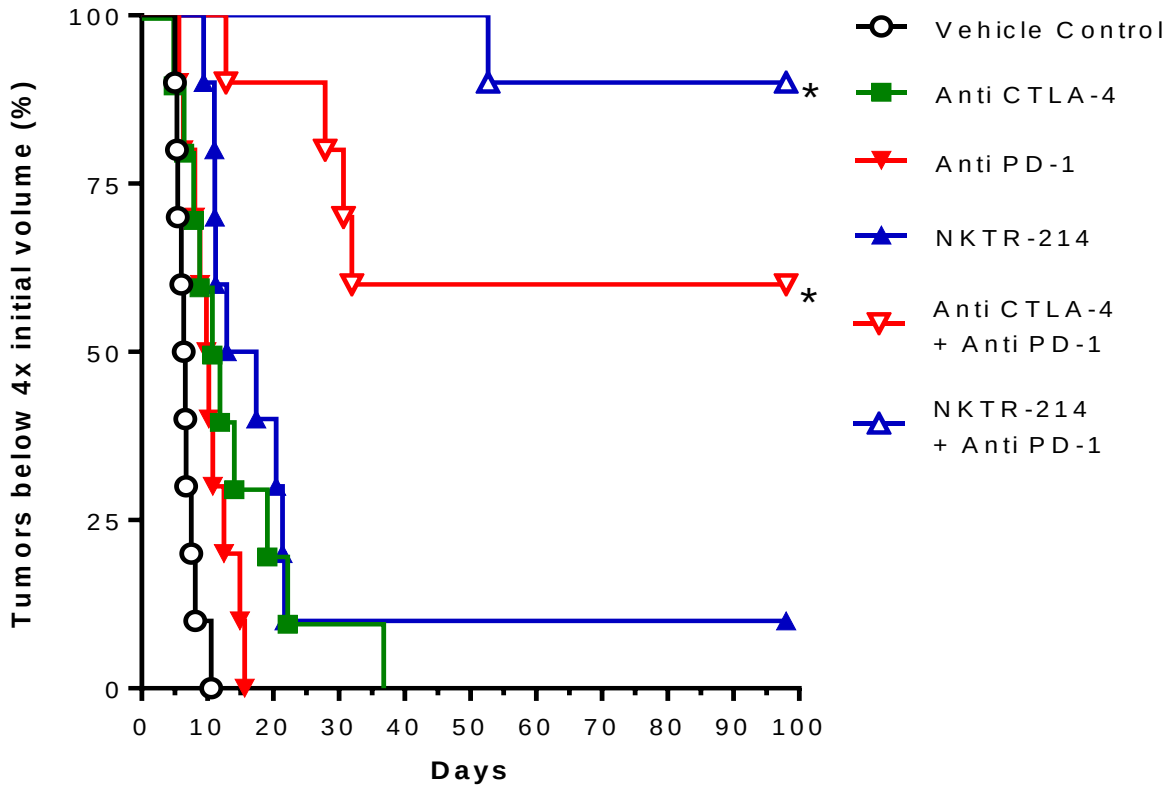


^IHC for CD8 was obtained by standard methods. All patients with first-line melanoma (1L MEL) with matched Baseline and Week 3 biopsy (n=8) were included in the analyses.
#All patients with 1L urothelial carcinoma (UC) with matched Baseline and Week 3 biopsy (n=13) at time of data cut were included and assessed for PD-L1 expression (DAKO PD-L1 IHC 28-8 pharmDx).

Hurwitz et. al, ASCO 2019

In Preclinical Models, Bempeg is a Natural 'Accelerant' for Durable Response to Checkpoint Inhibition

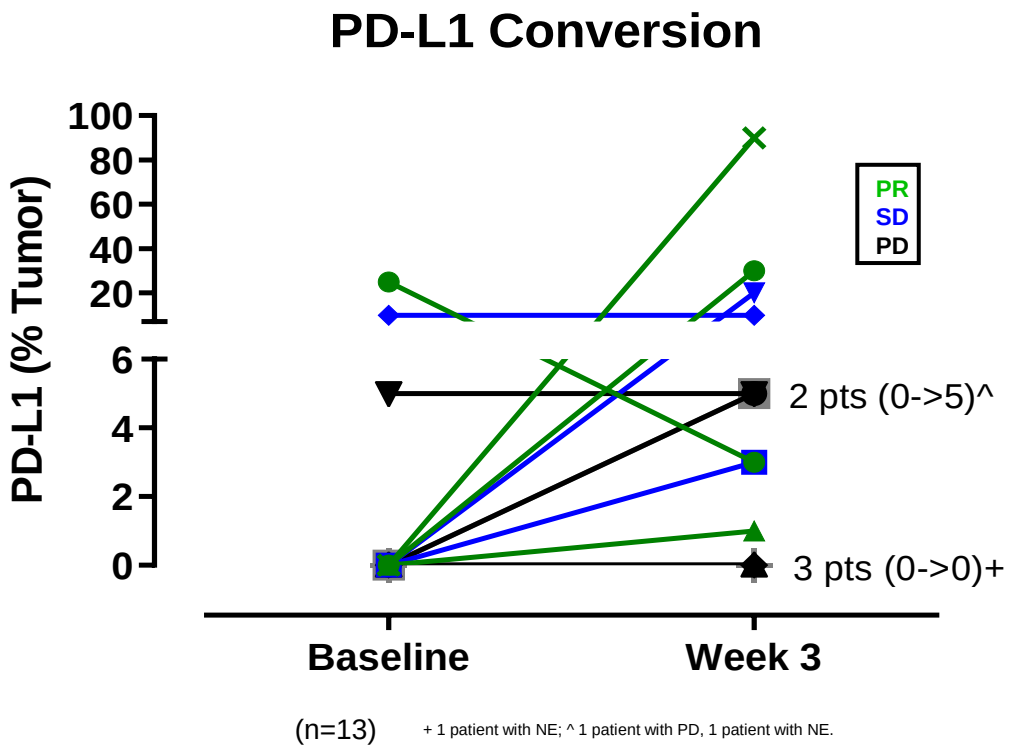


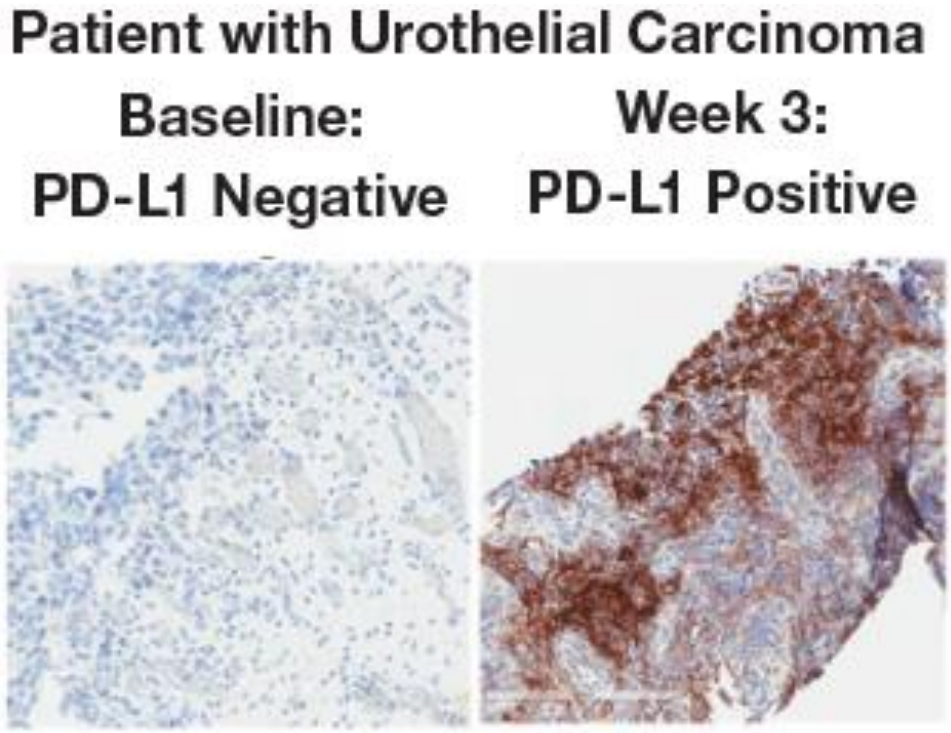


CT26 murine colon tumor model, NKTR-214 0.8mg/kg q9dx3, CPI 200ug/mouse 2x/week

NEKTAR Charych D, et al. Clin Cancer Res; 22(3) February 1, 2016

BEMPEG in Combination with Nivo Demonstrates On-Treatment PD-L1 Conversion from PD-L1 Negative to Positive



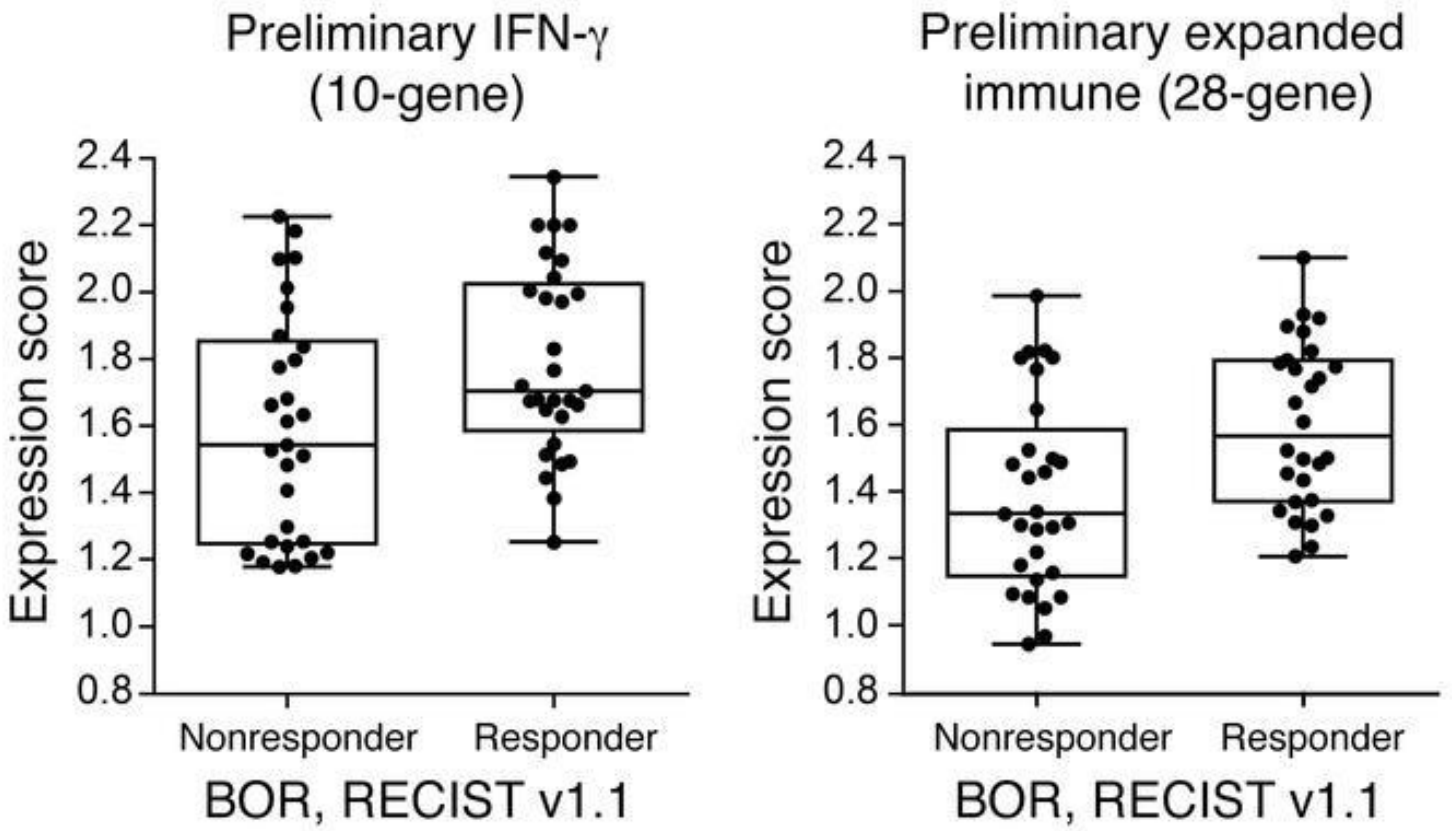


- 13 paired tissue samples were evaluated for changes in PD-L1 expression (28-8 Assay)
- 7 of 10 (70%) patients who were PD-L1 negative at Baseline converted to PD-L1 positive by Week 3
- 3 of 3 patients who were PD-L1 positive at Baseline remained PD-L1 positive

NEKTAR Siefker-Radtke et. al, ASCO-GU 2019

Interferon Gamma Activation at Baseline Predicts Response to Pembrolizumab in Melanoma, SCCHN and NSCLC

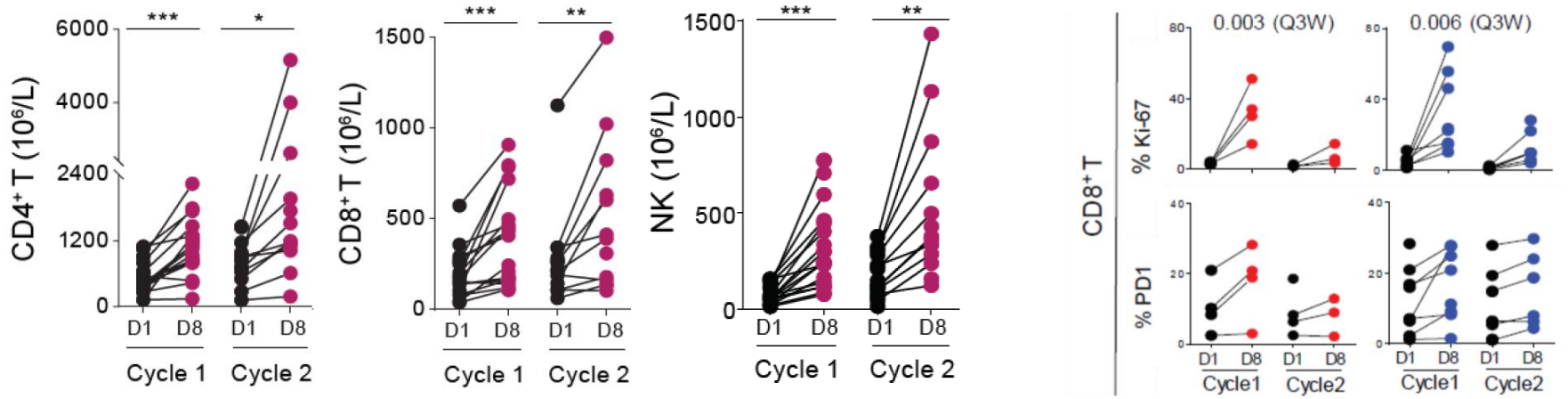
Box plots for the IFN-γ 10-gene and 28-gene expanded immune signatures and best overall response with clinical outcomes under anti–PD-1 therapy



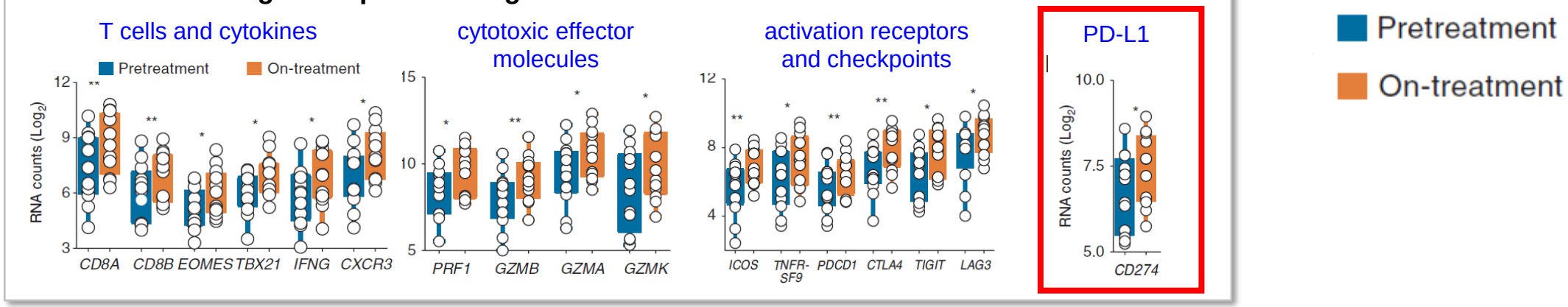
NEKTAR Ayers, J Clin Invest; 2017 DOI: 10.1172/JCI91190

Bempeg Monotherapy Expands Lymphocytes and Activates Genes Associated with T cells, Effector Cells and PD-L1

Systemic expansion of lymphocyte subsets driven by proliferation and accompanied by activation/PD-1 upregulation



Broad gene expression signatures of _intratumoral_ immune activation

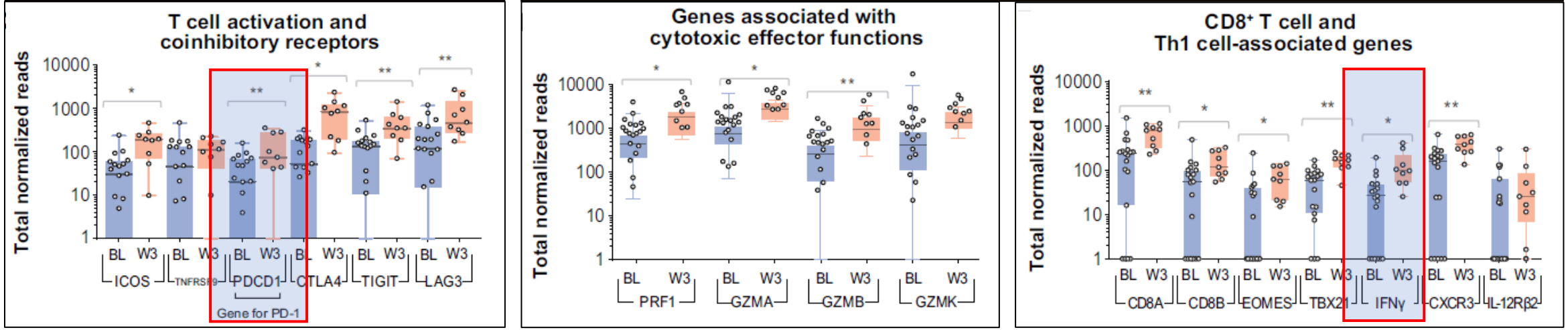


Bentebibel et al., Cancer Discovery 2019.

PIVOT-02: BEMPEG + Nivo Enhanced Intratumoral Expression of Immune-Related Genes, Including the Gene Encoding PD-L1

Increased expression of genes relating to immune activation, including the PD-L1 gene

Stimulation of gene expression relating to cytotoxicity and CD8+ T cell function



Transcriptional analysis of tumor biopsies at baseline (blue) and after 3 weeks of combination treatment (orange). Unpaired t-test (one-tailed): ** P≤0.01; * P≤0.05.

BL, baseline; W, week.

Treatment with BEMPEGaldesleukin in combination with nivolumab led to enhanced expression of genes associated with CD45+ lymphocytes, CD8+ T cells, macrophages, and cytotoxic cells

Adi Diab, Nizar M. Tannir, Salah-Eddine Bentebibel, et al. *Cancer Discov* 2020

Scientific and Biological Rationale Supporting BEMPEG + Checkpoint Inhibitors in Solid Tumors

T cells and PD-L1 expression are prognostic

IL-2 is a clinically validated target in multiple solid tumors with approvals in RCC and melanoma

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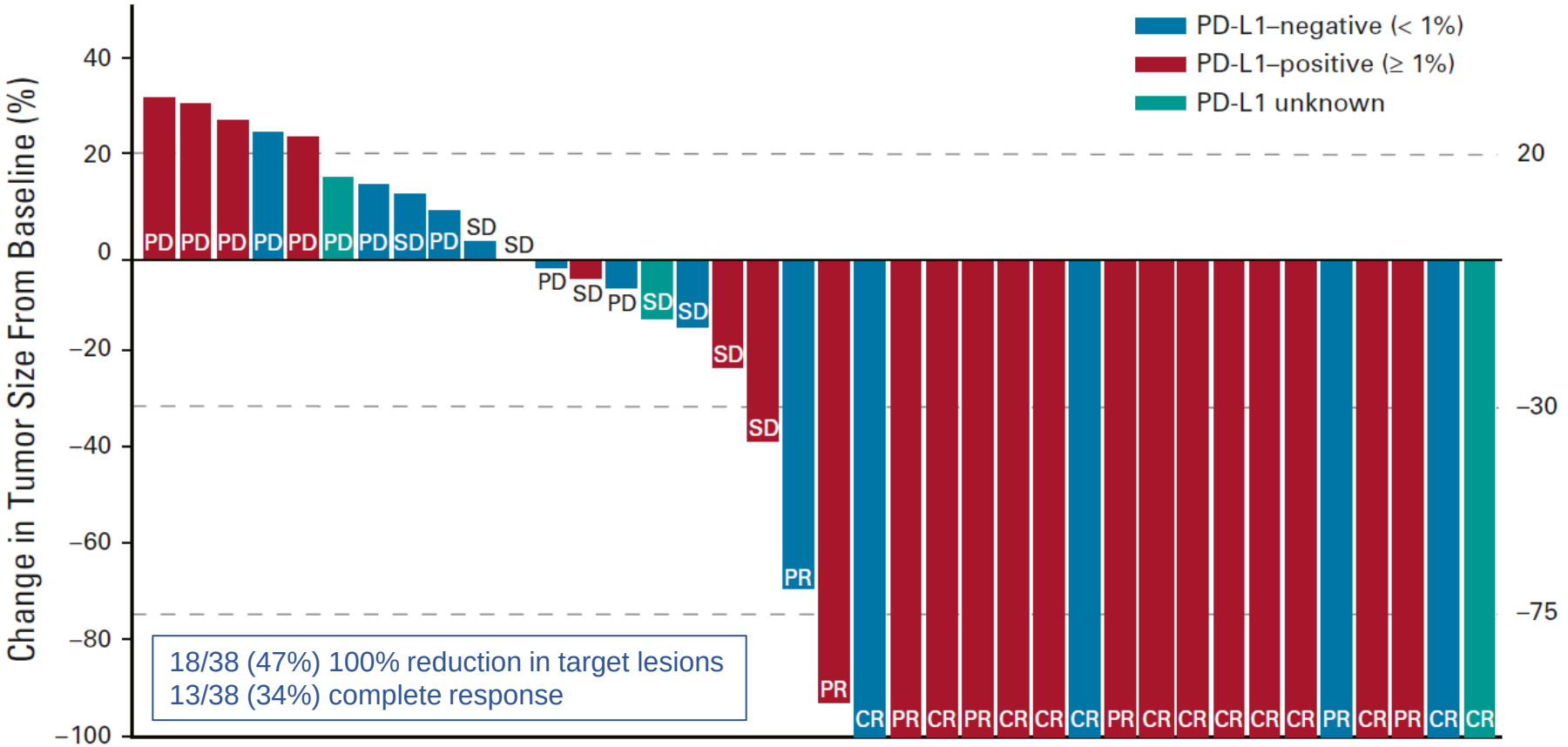
Stage IV 1L Melanoma: Best Overall Response by Independent Radiology



1L Melanoma (n=38 Efficacy Evaluable) Median 29.0 Months of Follow-up	ORR
Confirmed ORR (CR+PR)	20 (53)
CR	13 (34)
PD-L1 negative (n=13)	5 (39)
PD-L1 positive (n=22)	14 (64)
PD-L1 unknown (n=3)	1 (33)
LDH >ULN (n=11)	5 (46)
Liver metastases (n=10)	5 (50)
Median % reduction from baseline	–78.5
Median time to response (months)	2.0
Median time to CR (months)	7.9

All 5 responses in patients with liver metastases were CRs

1L Melanoma (n=38 Efficacy Evaluable)	
Median duration of follow-up (months)	29.0
Median number of cycles (range)	9 (1–35)
Number of cycles ≥6, n (%)	29 (70.7)
Pts with ongoing responses, n (%)	16 (80.0)
Median duration of response (months)	NE

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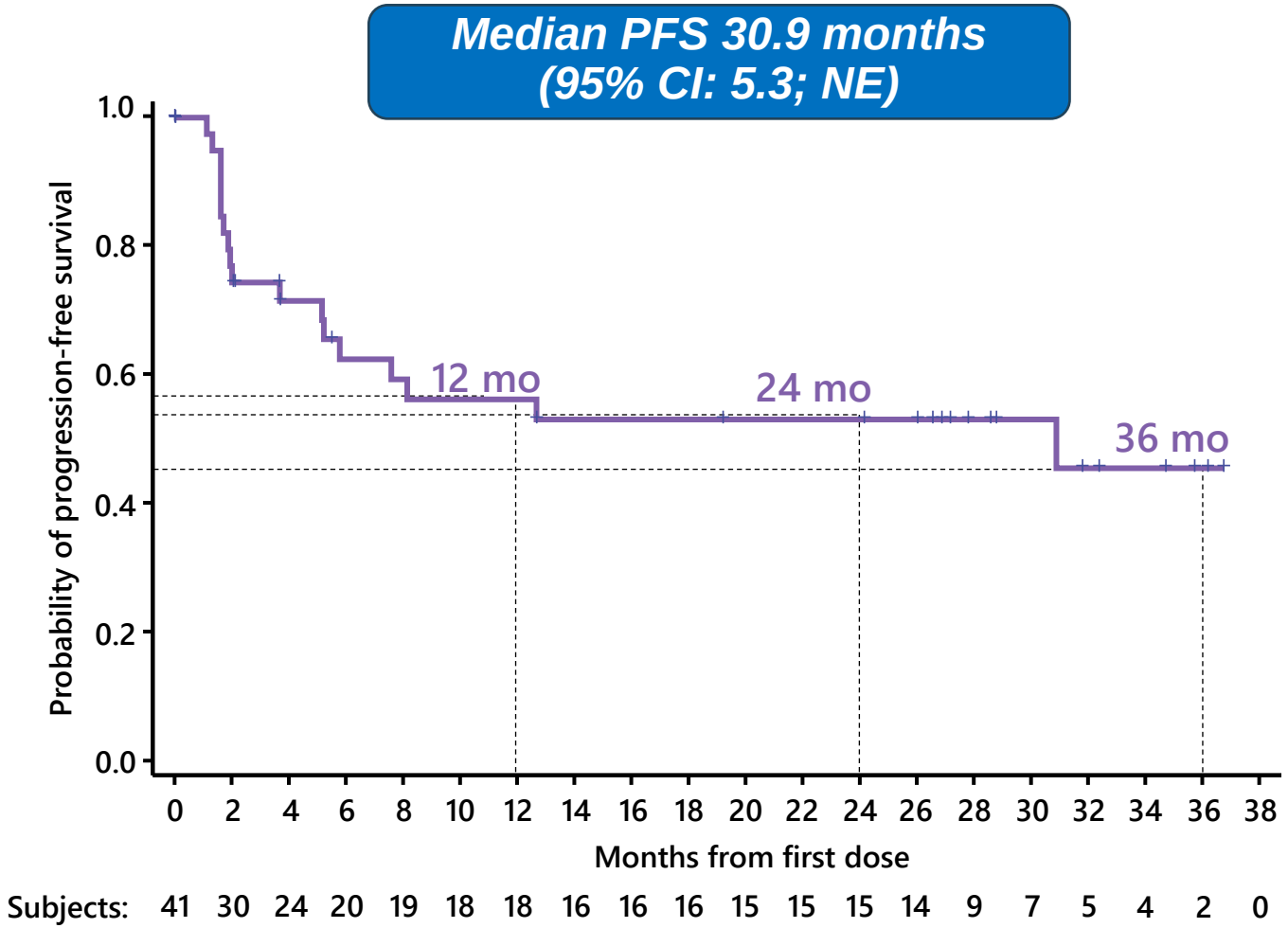
Diab A, et al. *Journal of Clinical Oncology* 2021

CR complete response; LDH, lactate dehydrogenase; ORR, objective response rate; PD-L1, programmed death-ligand 1; PR, partial response; SD, stable disease

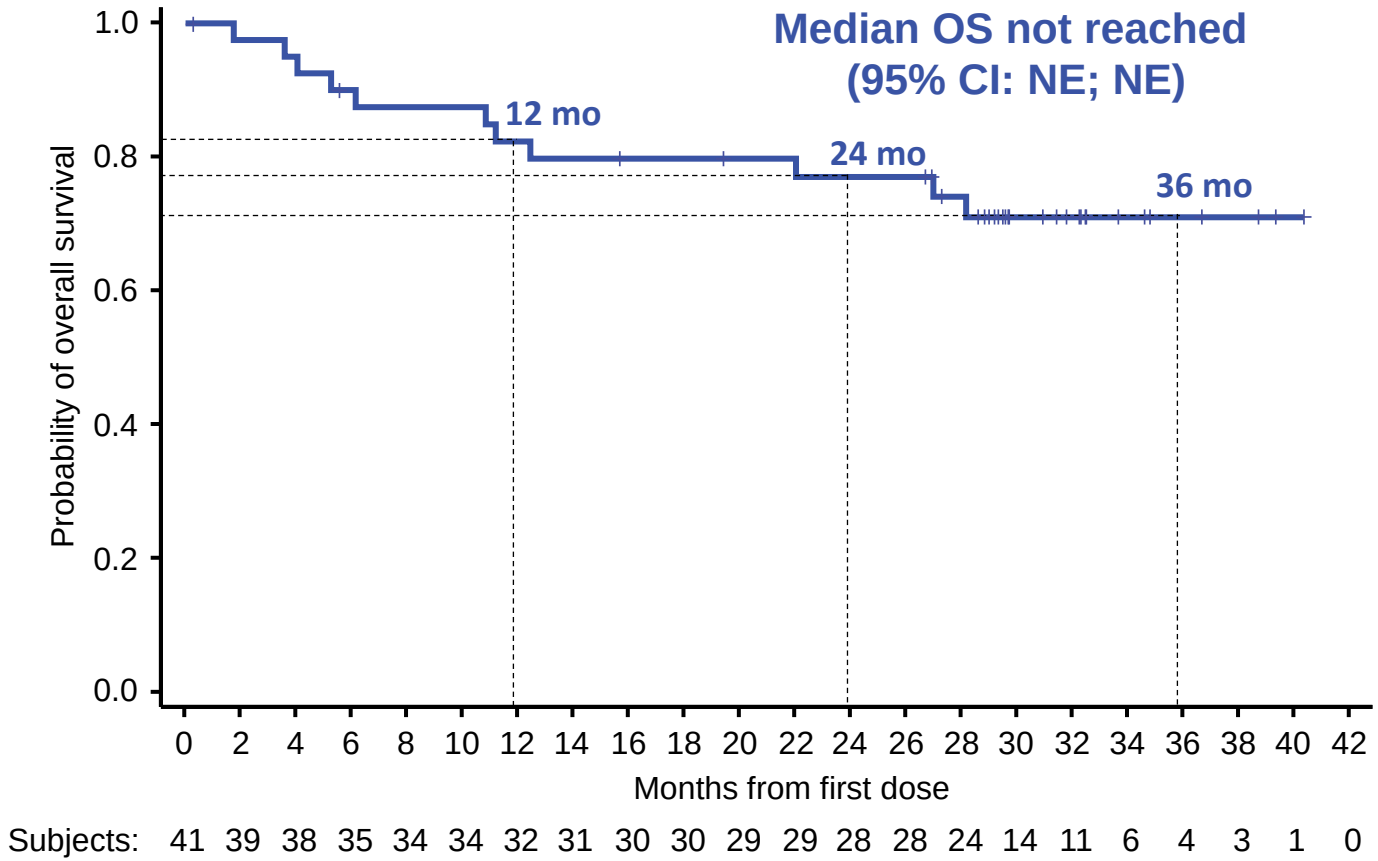
SITC 2020: BEMPEG plus NIVO Demonstrated mPFS 30.9 Months at Median Follow-up of 29.0 Months



Historical Comparisons	
Median PFS Nivolumab (CM-067)	6.9 months
Median PFS Ipilimumab+Nivolumab (CM-067)	11.5 months

NEKTAR Sources: SITC 2020 (BEMPEG plus NIVO); CHECKMATE-067 Sources: NEJM Larkin et. al, 2015. NEJM Wolchok et. al., 2017.

mOS Not Reached (95% CI: NE, NE) at Median Follow-up of 29.0 Months[1]



Kaplan–Meier Estimate of Overall Survival	Total (N=41)
Rate at 12 months, % (95% CI)	82.3 (66.4; 91.1)
Rate at 24 months, % (95% CI)	77.0 (60.4; 87.3)
Rate at 36 months, % (95% CI)	70.9 (53.5; 82.8)

Data cutoff: 1SEPT2020.
NE, not estimable; mOS, median overall survival.
1. Diab A, et al. *J Immunother Cancer* 2020;8(Suppl 3):A446: Abstract 420.
The BEMPEG compound and the combination of agents and their uses have not been approved.

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Depth of Response (DpR) Correlates with Longer PFS/OS in Melanoma

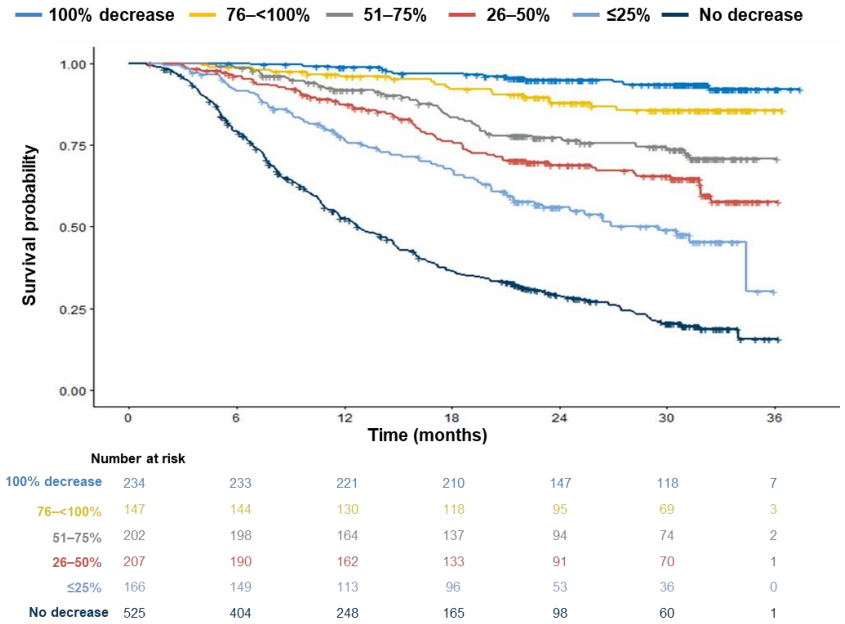
Two studies have shown that depth of response correlates with a longer PFS and OS in melanoma, regardless of therapy type

One study has shown that early tumor size changes (Week 12) are predictive of survival

Study	Patient population	Number of studies	Treatments	Analysis method	Association between depth of response and:	
					OS	PFS
Osgood, 2019	Previously treated advanced or metastatic melanoma	10 RCTs	TKI (BRAF, MEK inhibitors)	Cox proportional hazards model	Yes	Yes
			Immunotherapy (antibodies targeting PD-1 or CTLA-4)		Yes	Yes
			Chemotherapy		Yes	Yes
Lewis, 2019	BRAFV600-mutated metastatic melanoma	4 trials	MEK inhibitor/ BRAF inhibitor	Cox proportional hazards model	Yes	Yes
Wang, 2019	Previously treated and treatment naïve advanced or metastatic melanoma	3 trials	Pembrolizumab and ipilimumab	Cox proportional hazards model – early tumor size changes (12 weeks)	Yes	Not Reported

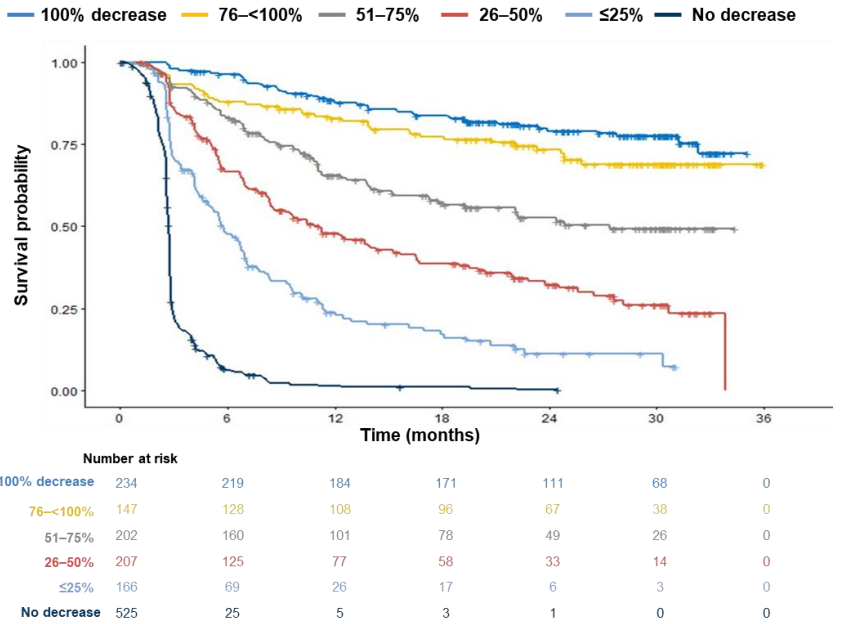
OS and PFS by Depth of Response in Melanoma – Immunotherapy

OS



Immunotherapy (n=1481)	Patients; n (%)	HR (95% CI)
100% decrease*	234 (16)	0.14 (0.09–0.20)
76–<100%*	147 (10)	0.22 (0.16–0.31)
51–75%*	202 (14)	0.33 (0.26–0.43)
26–50%*	207 (14)	0.49 (0.38–0.64)
≤25%*	166 (11)	0.61 (0.46–0.82)
No decrease	535 (35)	–

PFS



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≤25%*	166 (11)	0.60 (0.40–0.92)
No decrease	535 (35)	–

NEKTAR Osgood C, et al. J Clin Oncol 2019;37 (15_suppl):9508.

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- in combination with nivolumab, BEMPEG yielded an unprecedented CR rate in metastatic melanoma and has a well-tolerated safety profile and BEMPEG's AE profile does not overlap with checkpoint inhibitors

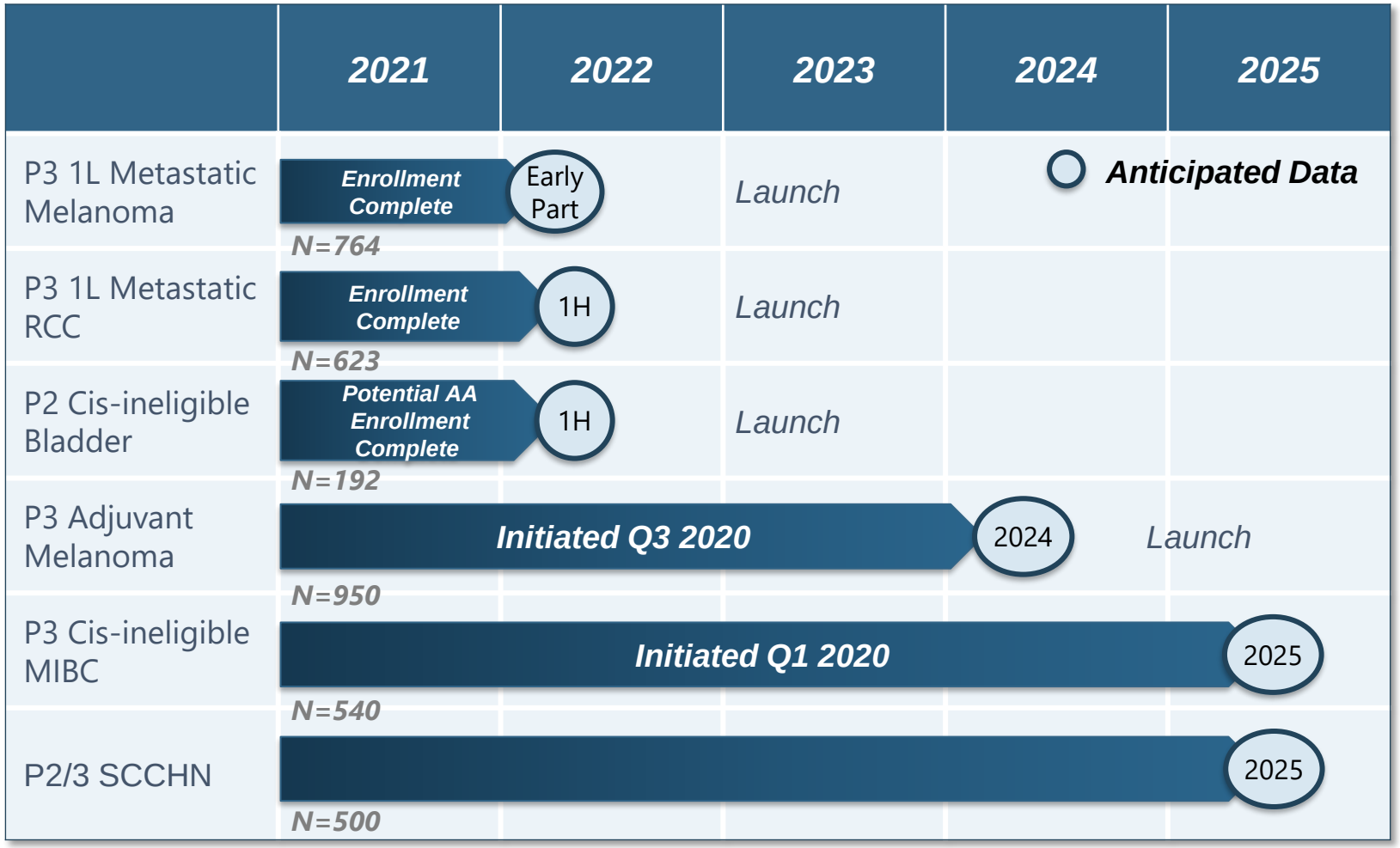
In melanoma, depth of response is associated with longer PFS and OS with CPIs and other agents

BEMPEG Development Program

Program	Indication	Study	Preclinical	Phase 1	Phase 2	Phase 3	
1L Metastatic Melanoma	BEMPEG + OPDIVO® vs. OPDIVO®	Registrational Study					Bristol Myers Squibb
1L Renal Cell Carcinoma	BEMPEG + OPDIVO® vs. TKI	Registrational Study					Bristol Myers Squibb
Muscle-invasive Bladder Cancer	BEMPEG + OPDIVO® vs. OPDIVO®	Registrational Study					Bristol Myers Squibb
Adjuvant Melanoma	BEMPEG + OPDIVO® vs. OPDIVO®	Registrational Study					Bristol Myers Squibb
Cis-Ineligible Bladder Cancer	BEMPEG + OPDIVO®	AA Registrational Study					Bristol Myers Squibb
1L Head & Neck Cancer	BEMPEG + KEYTRUDA®	Planned Registrational Study					SF | MERCK
1L Renal Cell Carcinoma	BEMPEG + OPDIVO® + TKI						Bristol Myers Squibb
1L NSCLC	BEMPEG + KEYTRUDA® +/- chemotherapy						
R/R Head & Neck Cancer	BEMPEG + VB10.NEO						vaccibody

NEKTAR AA: Accelerated Approval

BEMPEG Poised for Multiple Potential Approvals in 2023-2025



Estimated current PD-1/PD-L1 sales in these indications **exceed $5B**

- **~$3-4B** *Melanoma*
- **~$1-2B** *Renal Cell Carcinoma*
- **~$500M-1B** *Bladder Cancer**
- **~$500M-1B** *Head and Neck Cancer*

2019 PD-1/PD-L1 WW Sales**

AA: Accelerated Approval

*Bladder cancer sales WW represent indications of Non-Muscle Invasive Bladder Cancer, PD-L1 high expression patient populations, and second-line indications, as there are no approvals in 1L low PD-L1 expressing populations in bladder cancer setting currently or in MIBC setting.

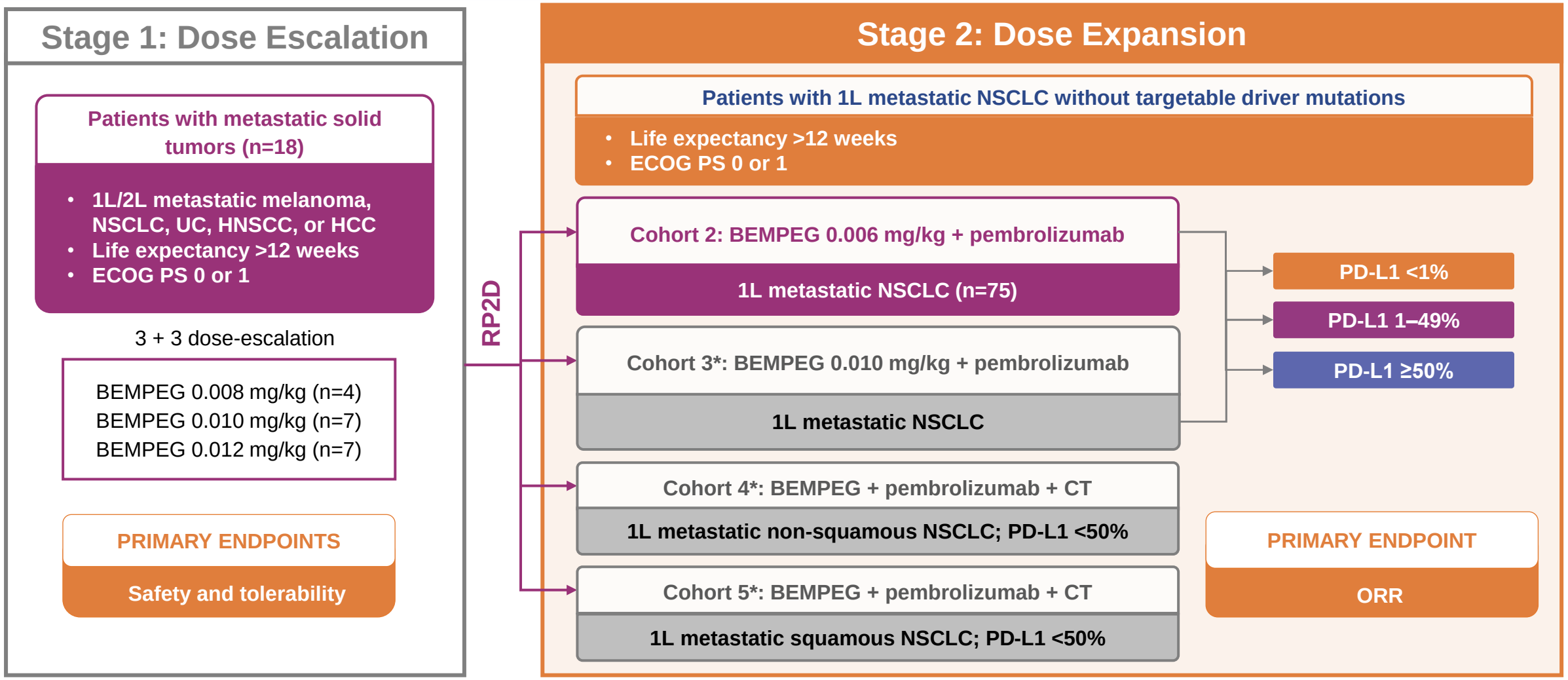
**Source for 2020 PD-1/PD-L1 (Opdivo, Keytruda, Tecentriq, Imfinzi, Bavencio) WW Sales: Evaluate Pharma; Referenced 7 January 2021. Represents sales ranges across all lines of therapy

Agenda

Bempegaldesleukin (BEMPEG; NKTR-214): an IL-2 pathway agonist

- ***IL-2: The Central Immuno-Stimulatory Cytokine***
  - *Jonathan Zalevsky, Ph.D., Nektar Therapeutics*
- ***ESMO-IO 2021: "Preliminary results from PROPEL: A phase 1/2 study of bempegaldesleukin (BEMPEG: NKTR-214) plus pembrolizumab (PEMBRO) with or without chemotherapy in patients with metastatic NSCLC"***
  - *Dimitry Nuyten, M.D., Ph.D., Nektar Therapeutics*
- ***Depth of Response and Correlation to PFS and OS in NSCLC with Patient Case Studies from PROPEL***
  - *Daniel Johnson, M.D., Ochsner Medical Center*
- ***Remarks and Q&A Session***
  - *Mehmet Altan, M.D., MD Anderson Cancer Center, Daniel Johnson, M.D., Ochsner Medical Center*

PROPEL: A Phase 1/2 Study



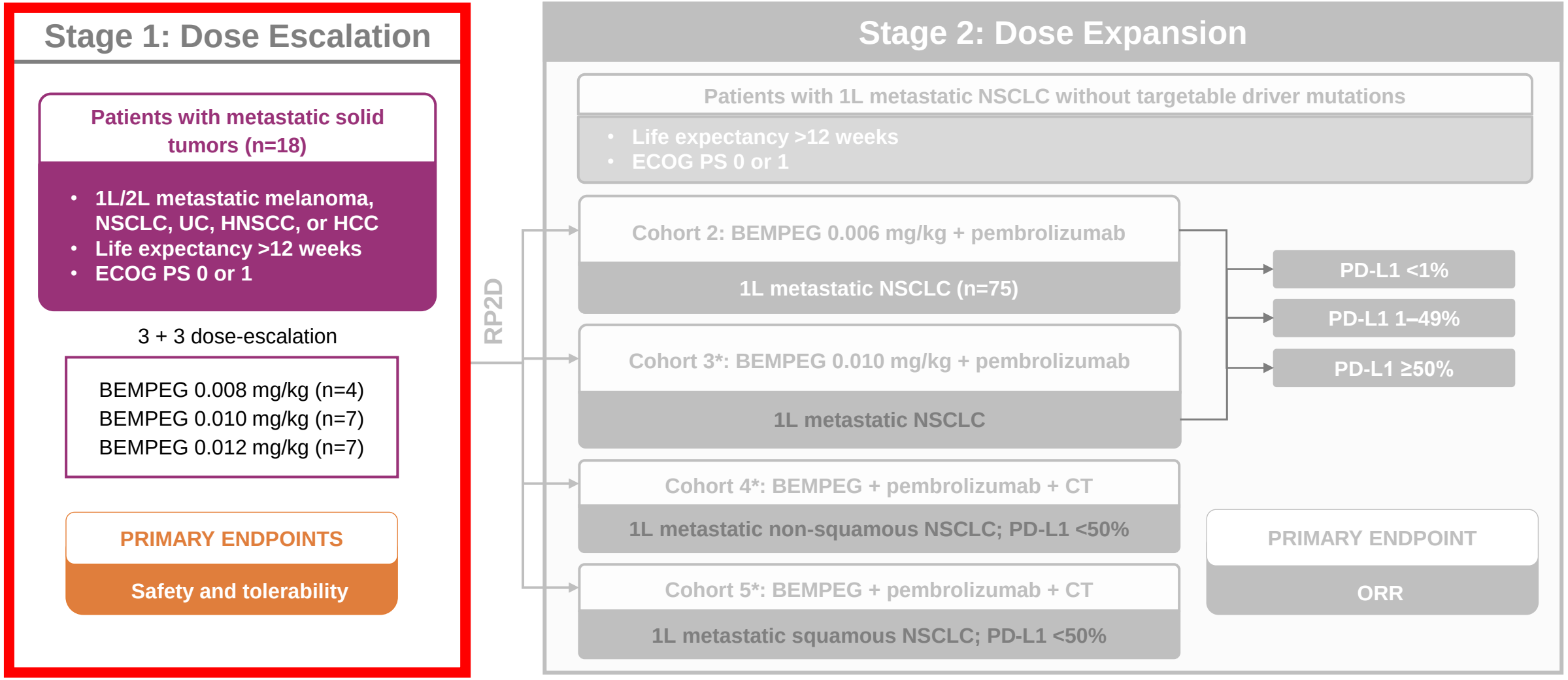
NCT03138889. *Enrollment ongoing. Pembrolizumab 200 mg IV q3w was administered across all cohorts. Study medications were administered until disease progression, death, unacceptable toxicity, symptomatic deterioration, lost to follow-up, investigator or patient decision to discontinue treatment, withdrawal of consent or termination of the study by the sponsor. Patients in Cohorts 4 and 5 received SOC platinum doublet chemotherapy in addition to the study medications noted for Cohort 2. In France, patients in subgroup PD-L1 <50% were excluded from Cohorts 2 and 3. 1L, first-line; 2L, second-line; BEMPEG, bempegaldesleukin; CT, chemotherapy; ECOG PS, Eastern Cooperative Oncology Group performance status; HCC, hepatocellular carcinoma; IV, intravenous; HNSCC, head and neck squamous cell carcinoma; NSCLC, non-small cell lung cancer; ORR, objective response rate; PD-L1, programmed death ligand-1; q3w, every 3 weeks; SOC, standard of care; UC, urothelial cancer.

Study Procedures and Assessments

Safety and tolerability	Efficacy	PD-L1 status (Cohort 2)
▪ AEs were assessed by CTCAE v5.0 ▪ Safety population: all patients who received ≥1 dose of treatment	▪ Objective response per RECIST 1.1 by BICR targeting scans every 9 (±1) weeks ▪ Efficacy-evaluable population: patients with ≥1 post-baseline, on-treatment radiographic scans	▪ Local assessment was used for enrolment ▪ Central assessment available for 91% of patients and was utilized for PD-L1 subgroup analyses when available

Data cut-off: October 29, 2021. Median follow-up for the dose-expansion Cohort 2: 12 months.
AE, adverse event; BICR, blinded independent central radiology; CTCAE, Common Terminology Criteria for Adverse Events; PD-L1, programmed death ligand-1; RECIST, Response Evaluation Criteria in Solid Tumors.

PROPEL: A Phase 1/2 Study



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Patient Demographics and Disease Characteristics in the Dose-Escalation Cohort

		BEMPEG 0.008 mg/kg + pembrolizumab (n=4)	BEMPEG 0.010 mg/kg + pembrolizumab (n=7)	BEMPEG 0.012 mg/kg + pembrolizumab (n=7)
Median age, years (range)		59.5 (49–72)	68.0 (43–76)	65.0 (53–74)
Male sex, n (%)		2 (50.0)	3 (42.9)	2 (28.6)
ECOG PS, n (%)	0	3 (75.0)	2 (28.6)	5 (71.4)
	1	1 (25.0)	5 (71.4)	2 (28.6)
Cancer diagnosis, n (%)	Melanoma (1L-3L)	2 (50.0)	3 (42.9)	4 (57.1)
	NSCLC (1L-3L)	1 (25.0)	3 (42.9)	2 (28.6)
	UC (2L)	1 (25.0)	0	1 (14.3)
	HNSCC (1L)	0	1 (14.3)	0

BEMPEG, bempegaldesleukin; ECOG PS, Eastern Cooperative Oncology Group performance status; HNSCC, head and neck squamous cell carcinoma; NSCLC, non-small cell lung cancer; UC, urothelial cancer.

All patients enrolled in dose escalation had Stage IV metastatic disease excepted for one patient with recurrent Stage III NSCLC

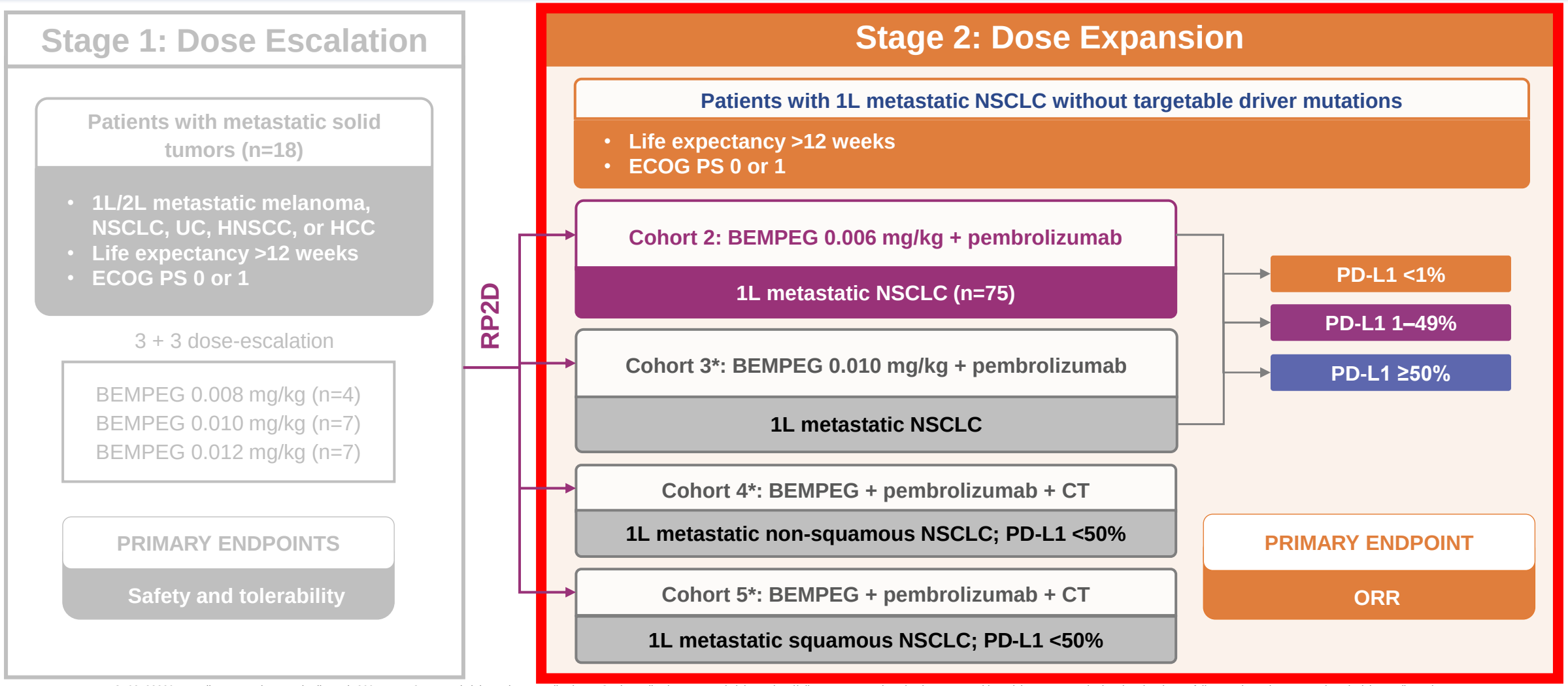
Safety for the Dose-Escalation Cohorts

- **No Grade 5 TRAEs were reported. One DLT (Grade 3 hypotension) was noted at the 0.010 mg/kg dose level within the first treatment cycle**
- **28% of patients (4/14) at the highest dose levels required a dose reduction due to TRAEs (2/7 BEMPEG 0.010 mg/kg; 2/7 BEMPEG 0.012 mg/kg)**
- **BICR RECIST 1.1 responses were observed for 3 patients in the BEMPEG 0.010 mg/kg + pembrolizumab cohort (1L HNSCC [CR], 1L melanoma [PR], and 2L [refractory to pembrolizumab monotherapy] melanoma [PR])**

TRAEs reported in >3 patients; n (%)	BEMPEG 0.008 mg/kg + pembrolizumab (n=4)		BEMPEG 0.010 mg/kg + pembrolizumab (n=7)		BEMPEG 0.012 mg/kg + pembrolizumab (n=7)	
	Any Grade	Grade ≥3	Any Grade	Grade ≥3	Any Grade	Grade ≥3
Any	4 (100.0)	2 (50.0)	7 (100.0)	4 (57.1)	7 (100.0)	4 (57.1)
Chills	2 (50.0)	0	2 (28.6)	0	6 (85.7)	0
Fatigue	2 (50.0)	0	6 (85.7)	3 (42.9)	3 (42.9)	0
Nausea	2 (50.0)	0	7 (100.0)	1 (14.3)	2 (28.6)	0
Pruritus	2 (50.0)	0	2 (28.6)	0	2 (28.6)	0
Diarrhea	1 (25.0)	0	4 (57.1)	2 (28.6)	1 (14.3)	0
Hypotension	1 (25.0)	0	2 (28.6)	1 (14.3)	2 (28.6)	0
Influenza-like illness	1 (25.0)	0	2 (28.6)	0	2 (28.6)	0
Pyrexia	1 (25.0)	0	7 (100.0)	0	4 (57.1)	0
Rash maculo-papular	1 (25.0)	0	1 (14.3)	0	2 (28.6)	1 (14.3)
Vomiting	1 (25.0)	0	4 (57.1)	0	1 (14.3)	0
ALT increased	0	0	2 (28.6)	0	2 (28.6)	0
Arthralgia	0	0	4 (57.1)	0	1 (14.3)	1 (14.3)
AST increased	0	0	2 (28.6)	0	2 (28.6)	0

ALT, alanine aminotransferase; AST, aspartate aminotransferase; BEMPEG, bempegaldesleukin; TRAE, treatment-related adverse event.

PROPEL: A Phase 1/2 Study



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Patient Demographics and Disease Characteristics in the Dose-Expansion Cohort

		PD-L1 status			All
		<1% (n=28)	1–49% (n=28)	≥50% (n=19)	(n=75)
Median age, years (range)		65.5 (46–83)	65.5 (51–80)	62.0 (40–79)	65 (40–83)
Male sex, n (%)		20 (71.4)	20 (71.4)	11 (57.9)	51 (68.0)
ECOG PS, n (%)	0	14 (50.0)	10 (35.7)	8 (42.1)	32 (42.7)
	1	14 (50.0)	18 (64.3)	10 (52.6)	42 (56.0)
Histology, n (%)	Squamous	13 (46.4)	13 (46.4)	4 (21.1)	30 (40.0)
	Non-squamous	15 (53.6)	15 (53.6)	15 (78.9)	45 (60.0)
Smoking status, n (%)	Current	9 (32.1)	8 (28.6)	6 (31.6)	23 (30.7)
	Former	17 (60.7)	18 (64.3)	11 (57.9)	46 (61.3)
	Non-smoker	2 (7.1)	2 (7.1)	2 (10.5)	6 (8.0)
Metastases, n (%)	Brain	4 (14.3)	1 (3.6)	1 (5.3)	6 (8.0)
	Liver	6 (21.4)	1 (3.6)	3 (15.8)	10 (13.3)
Stage at diagnosis, n (%)*	I–II	4 (14.3)	3 (10.7)	2 (10.5)	9 (12.0)
	III	2 (7.1)	6 (21.4)	0	8 (10.7)
	IV	21 (75.0)	19 (67.9)	17 (89.5)	57 (76.0)
Prior chemotherapy, n (%)		2 (7.1)	7 (25.0)	1 (5.3)	10 (13.3)

*One patient (PD-L1 status <1%) had missing stage at diagnosis.

ECOG PS, Eastern Cooperative Oncology Group performance status; PD-L1, programmed death ligand-1.

Safety for the Dose-Expansion Cohort in NSCLC

TRAEs reported in >10% of patients; n (%)	All (n=75)	
	Any Grade	Grade ≥3
Any	69 (92.0)	30* (40.0)
Pyrexia	25 (33.3)	0
Fatigue	19 (25.3)	3 (4.0)
Asthenia	15 (20.0)	1 (1.3)
Influenza-like illness	13 (17.3)	1 (1.3)
Pruritus	13 (17.3)	0
Nausea	12 (16.0)	0
AST increased	11 (14.7)	1 (1.3)
ALT increased	10 (13.3)	1 (1.3)
Arthralgia	10 (13.3)	1 (1.3)
Diarrhea	10 (13.3)	1 (1.3)
Hyperthyroidism	10 (13.3)	2 (2.7)
Lymphocyte count decreased**	10 (13.3)	7 (9.3)
Rash	10 (13.3)	2 (2.7)
Chills	8 (10.7)	0
Hypotension	8 (10.7)	1 (1.3)

Nine subjects (12%) reported ≥1 serious TRAE.
*One Grade 5 TRAE of myasthenic syndrome was reported that was considered related to pembrolizumab only by the investigator.
**Transient lymphocyte count decrease within the first 72 hours is a known result of BEMPEG treatment and is followed by lymphocytosis by Day 8.
ALT, alanine aminotransferase; AST, aspartate aminotransferase; TRAE, treatment-related adverse event.

ORR by RECIST 1.1 per Blinded Independent Central Radiology

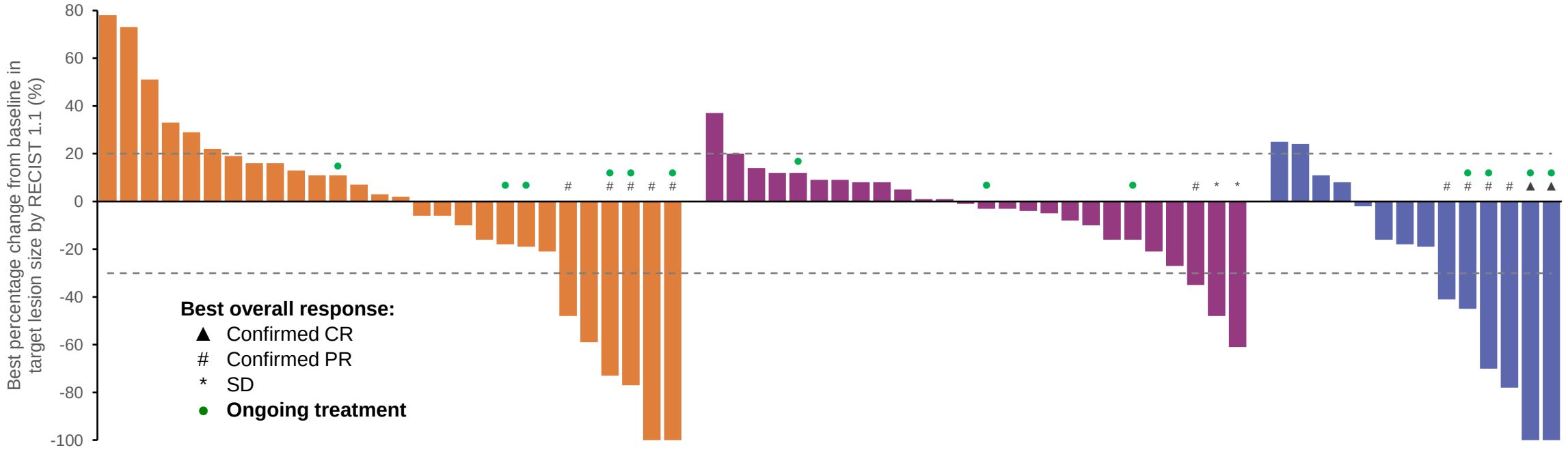
- **Median duration of response was not reached for patients with an objective response**
- **Median time to response is 2.1 months (1.4 – 4.2)**

Efficacy-evaluable population*		PD-L1 status			All
		<1% (n=28)	1–49% (n=27)	≥50% (n=15)	(n=70)
ORR, n (%)		5 (18)	1 (4)	6 (40)	12 (17)
Best response, n (%)	CR	0 (0)	0 (0)	2 (13)	2 (3)
	PR	5** (18)	1 (4)	4 (27)	10 (14)
	SD	6 (21)	14 (52)	4 (27)	24 (34)
	PD	16 (57)	11 (41)	4 (27)	31 (44)
	NE	1 (4)	1 (4)	1 (7)	3 (4)
DCR (CR + PR + SD), n (%)		11 (39)	15 (56)	10 (67)	36 (51)

*Five patients were not included in the efficacy-evaluable population; one patient (PD-L1 status 1–49%) had no post-baseline imaging due to an SAE of pulmonary embolus (investigator deemed it unrelated to either BEMPEG or pembrolizumab) and four patients (all PD-L1 status ≥50%) had no post-baseline imaging due to an SAE of Lambert–Eaton syndrome (n=1) (investigator deemed it related to both BEMPEG and pembrolizumab), AEs of fatigue (n=1) (investigator deemed it related to both BEMPEG and pembrolizumab) and infusion reaction (n=1) (investigator deemed it related to BEMPEG), or death due to myasthenic syndrome (n=1) (investigator deemed it related to pembrolizumab).
**Two patients with a PR had a 100% reduction in target lesions from baseline.
AE, adverse event; CR, complete response; DCR, disease control rate; NE, not evaluable; ORR, objective response rate; PD L1, programmed death ligand 1; PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SAE, serious adverse event; SD, stable disease.

NEKTAR

Best Overall Response by PD-L1 Status per Blinded Independent Central Radiology

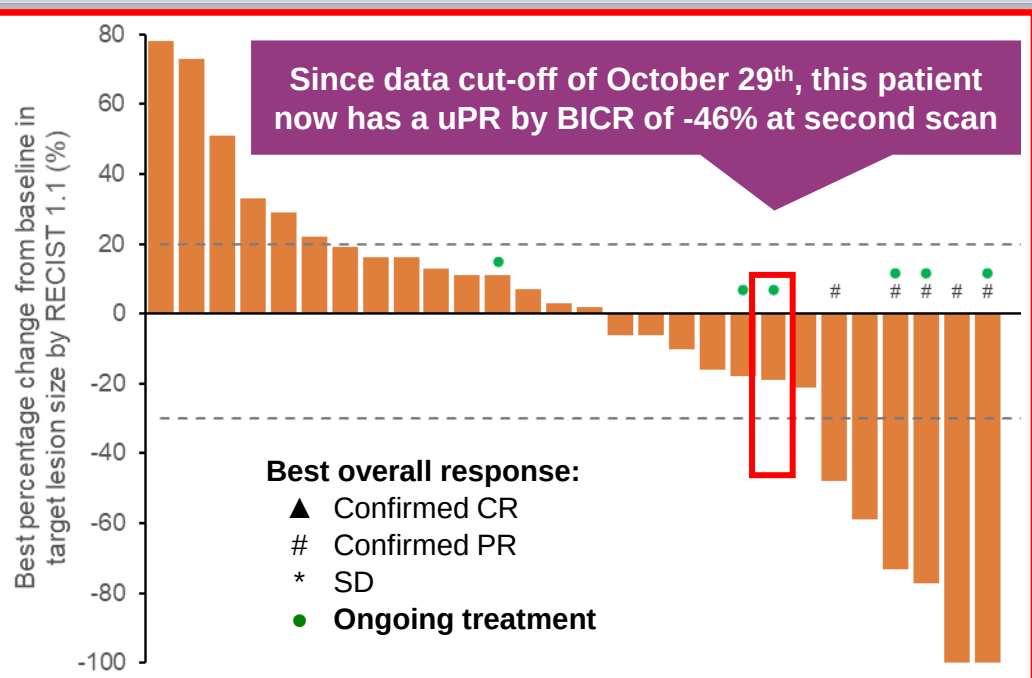


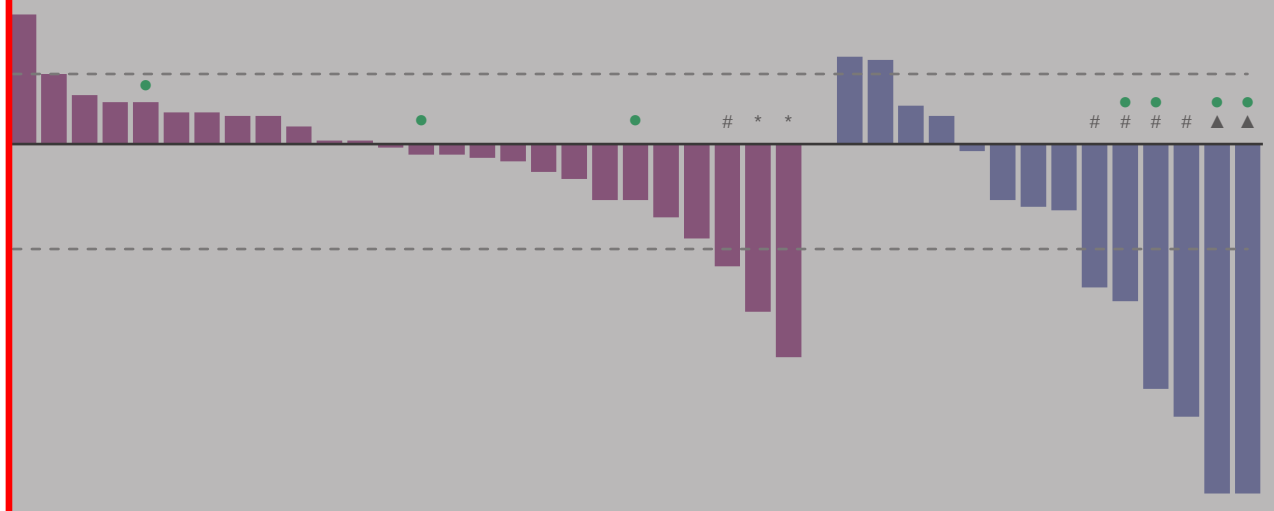
	PD-L1 status: <1% (n=28)	PD-L1 status: 1–49% (n=26)	PD-L1 status: ≥50% (n=14)
Baseline sum of target lesions			
Mean (standard deviation)	69.4 (43.9)	90.0 (43.8)	78.5 (39.7)
Median (range)	64.0 (10–208)	83.0 (15–220)	74.5 (26–166)

75% median reduction in baseline target lesions for patients with a RECIST 1.1 response

Two efficacy-evaluable patients (PD-L1 status 1–49%, n=1 [NE] and PD-L1 status ≥50%, n=1 [best response PD]) are not shown due to missing post-baseline target lesion measurements.
CR, confirmed RECIST complete response; NE, not evaluable; PD, progressive disease; PD-L1, programmed death ligand-1; PR, confirmed RECIST partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease.

Best Overall Response by PD-L1 Status per Blinded Independent Central Radiology





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Two efficacy-evaluable patients (PD-L1 status 1–49%, n=1 [NE] and PD-L1 status ≥50%, n=1 [best response PD]) are not shown due to missing post-baseline target lesion measurements.
CR, confirmed RECIST complete response; NE, not evaluable; PD, progressive disease; PD-L1, programmed death ligand-1; PR, confirmed RECIST partial response; uPR, unconfirmed RECIST partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease.

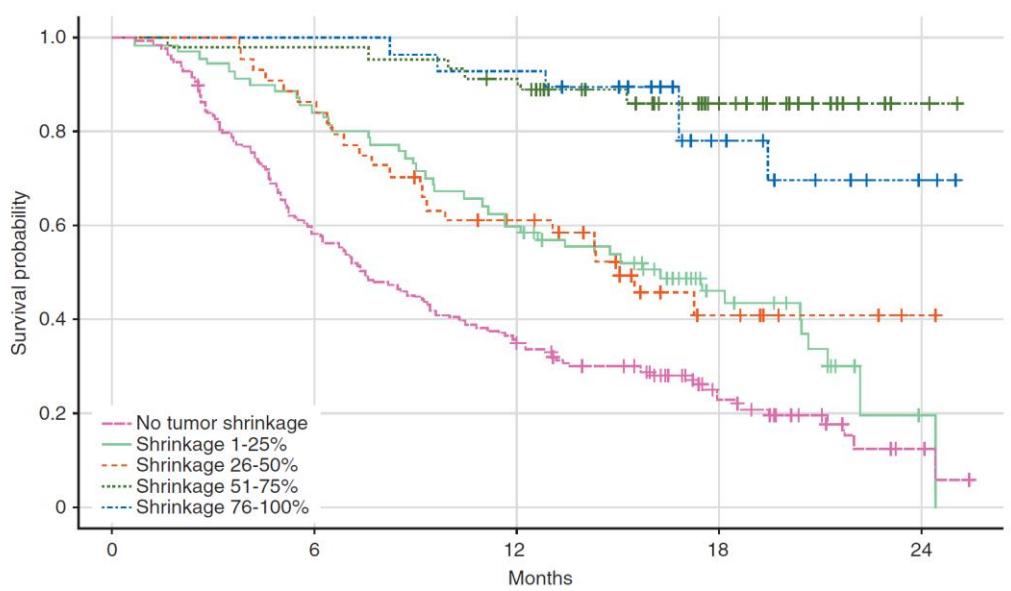
Key Takeaways from PROPEL Data

- **BEMPEG 0.006 mg/kg + pembrolizumab was well tolerated in the 1L NSCLC setting**
- **Compelling ORR (18%) by BICR for patients with PD-L1 negative (<1%) disease compared to historical data for pembrolizumab monotherapy[1]**
  - Two patients with 100% reduction in target lesions
  - One patient with an unconfirmed PR and two patients with SD remain on treatment
- **Notable CR rate (13%) by BICR for patients with PD-L1 high (≥50%) disease compared to historical data for pembrolizumab ±CT[2-4]**
  - Two patients with PRs remain on treatment
- **75% median reduction in baseline target lesions was observed in patients with a RECIST 1.1 response and a deepening reduction in target lesions over time**
- **Median duration of response has not been reached for the patients with an objective response**
- **Assessment of BEMPEG 0.006 mg/kg + pembrolizumab + CT is ongoing in patients with 1L NSCLC and PD-L1 status <50%**

NEKTAR **1.** Hui R, et al. *Ann Oncol* 2017;28:874–81; **2.** Gadgeel S, et al. *J Clin Oncol* 2020;38:1505–1517; **3.** Mok TSK, et al. *Lancet* 2019;393:1819–1830; **4.** Gandhi L, et al. *New Engl J Med* 2018;378:2078–2092.

OS by Depth of Response – PD-1 Inhibitors in NSCLC

PD-1 inhibitor depth of response in 2L NSCLC post-chemotherapy subgroups (n=355)



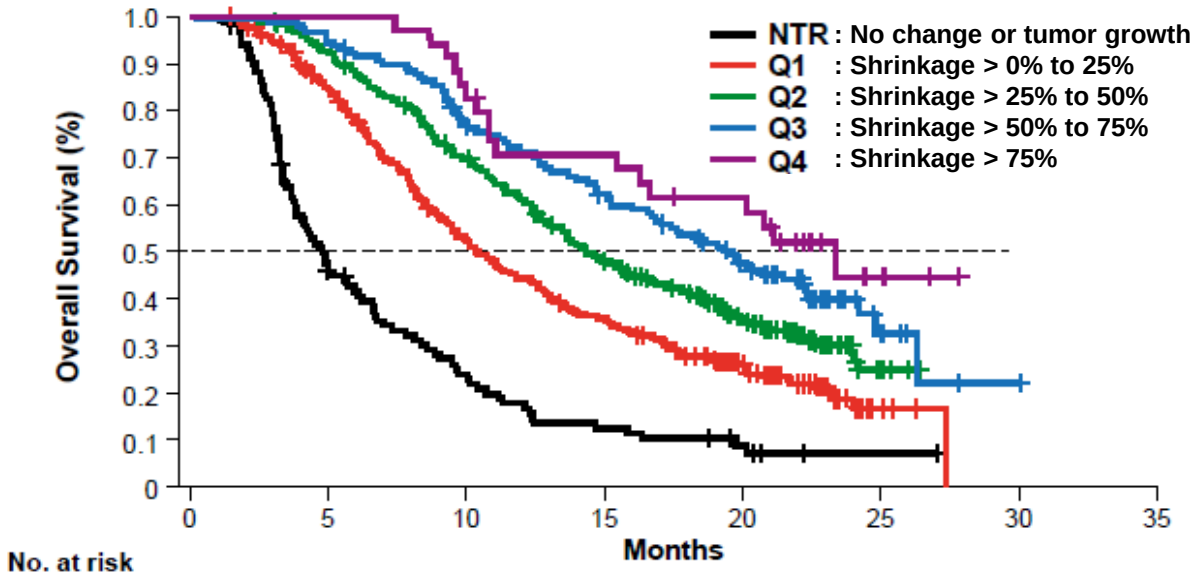
No tumor shrinkage	168	97	58	22	3
Shrinkage 1-25%	70	59	42	17	1
Shrinkage 26-50%	44	38	24	8	1
Shrinkage 51-75%	45	44	39	18	2
Shrinkage 76-100%	28	28	26	11	2

Depth of response has been shown to correlate with a longer OS with PD-1 inhibitors in NSCLC

NEKTAR McCoach CE, *et al*. *Ann Oncol* 2017; **28**: 2707–14

OS by Depth of Response – Chemotherapy in NSCLC

Chemotherapy depth of response in 1L NSCLC (n=1052)



No. at risk							
NTR	102	44	22	11	5	1	0
Q1	365	298	183	121	67	4	0
Q2	327	301	224	152	90	6	0
Q3	131	124	98	78	55	7	1
Q4	34	34	29	23	19	4	0

Depth of response has been shown to correlate with a longer OS with chemotherapy in NSCLC

NEKTAR Morgensztern D, *et al*. *Cancer* 2019; **125**: 2394–9.

Agenda

Bempegaldesleukin (BEMPEG; NKTR-214): an IL-2 pathway agonist

- ***IL-2: The Central Immuno-Stimulatory Cytokine***
  - *Jonathan Zalevsky, Ph.D., Nektar Therapeutics*
- ***ESMO-IO 2021: "Preliminary results from PROPEL: A phase 1/2 study of bempegaldesleukin (BEMPEG: NKTR-214) plus pembrolizumab (PEMBRO) with or without chemotherapy in patients with metastatic NSCLC"***
  - *Dimitry Nuyten, M.D., Ph.D., Nektar Therapeutics*
- ***Depth of Response and Correlation to PFS and OS in NSCLC with Patient Case Studies from PROPEL***
  - *Daniel Johnson, M.D., Ochsner Medical Center*
- ***Remarks and Q&A Session***
  - *Mehmet Altan, M.D., MD Anderson Cancer Center, Daniel Johnson, M.D., Ochsner Medical Center*

Patient Case Studies from PROPEL

- **Case Study #1:**
  - 61-year-old former smoker with non-squamous NSCLC achieved a confirmed PR (-77%)
- **Case Study #2:**
  - 55-year-old former smoker with widespread non-squamous NSCLC achieved a confirmed PR (-76%)
- **Case Study #3:**
  - 62-year-old current smoker with non-squamous NSCLC achieved a confirmed CR
- **Case Study #4:**
  - 64-year-old current smoker with squamous NSCLC achieved a confirmed PR (-48%)
- **Case Study #5:**
  - 59-year-old non-smoker with widespread non-squamous NSCLC achieved a confirmed PR (-73%)
- **Case Study #6:**
  - 76-year-old former smoker with HNSCC achieved a confirmed CR

Case Study #1 – 1L Stage IV NSCLC patient achieved a confirmed PR (-77%) by RECIST 1.1 (BICR)

PD-L1 <1%

Case Study #1:

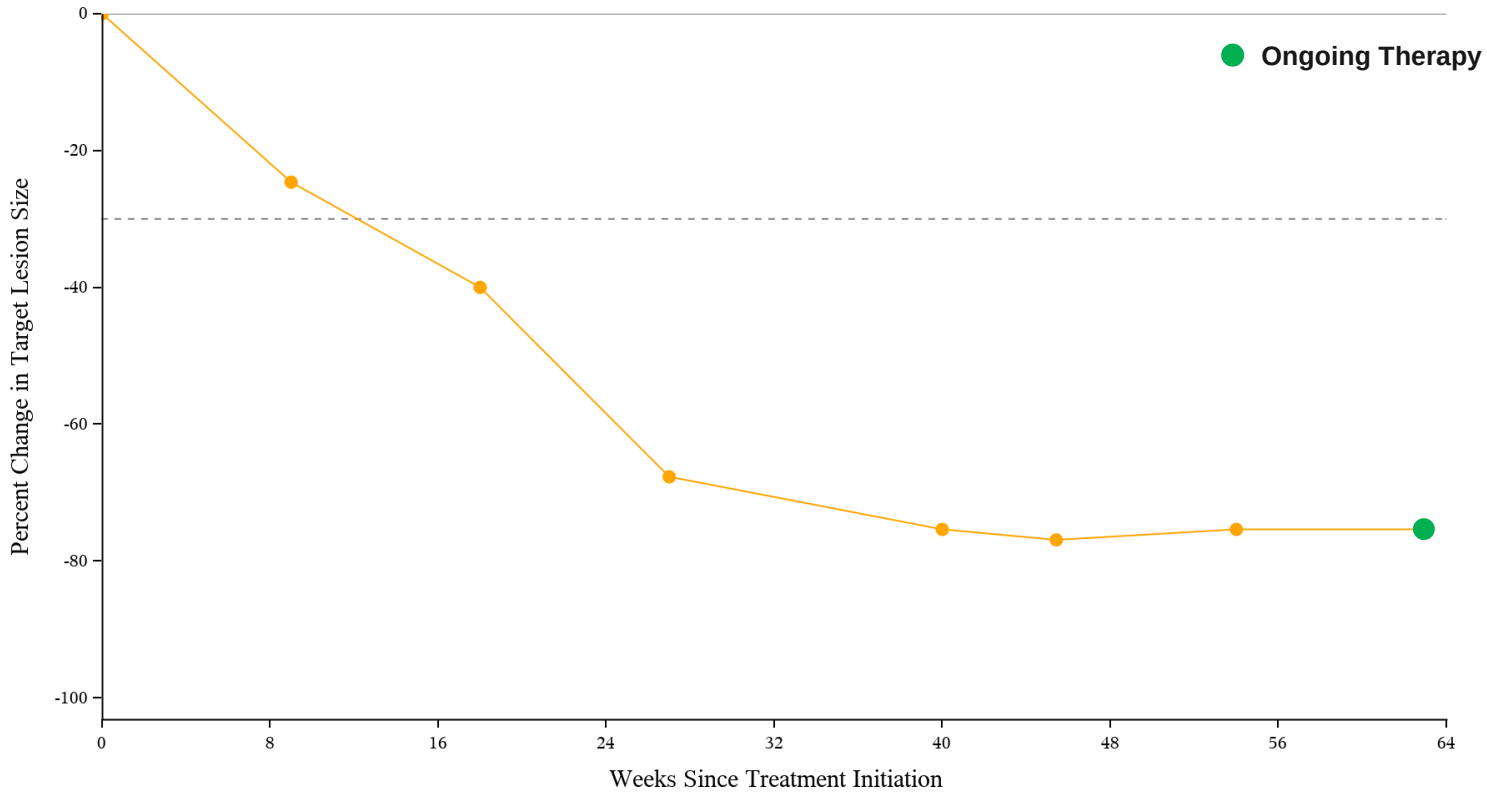
Medical History:

- 61-year-old, Female
- Non-squamous NSCLC
- ECOG Performance Status: 1
- Former Smoker
- Baseline Tumor Burden: 65 mm

Treating PI:

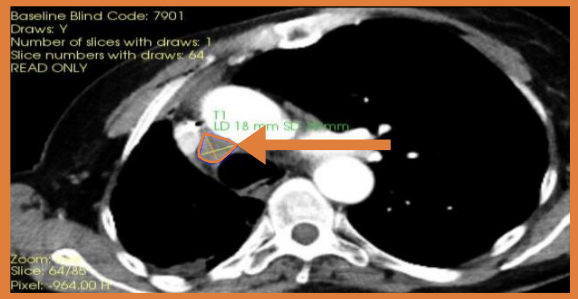
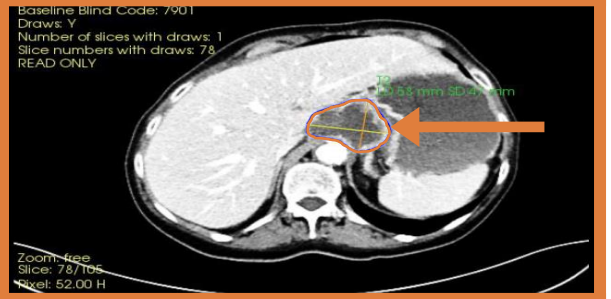
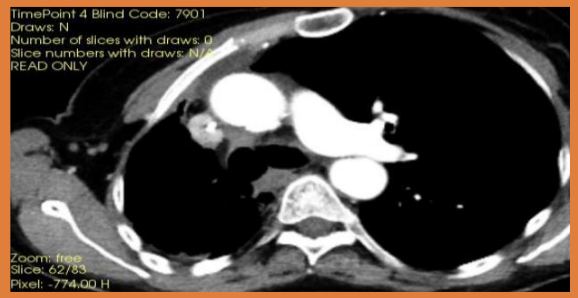
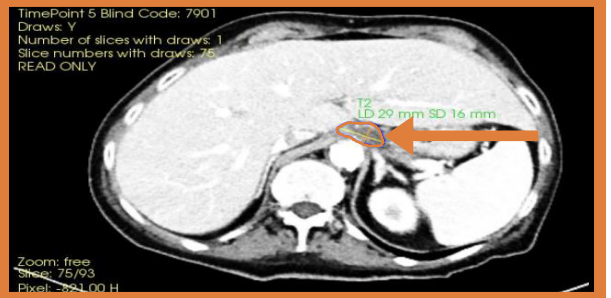
Dr. Ernst Späth-Schwalbe
Vivantes Klinikum Spandau
(Berlin, Germany)

Percent Change in Target Lesion by BICR:



PD-L1, programmed death ligand-1; PR, partial response; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment

Case Study #1 – 1L Stage IV NSCLC patient achieved a confirmed PR (-77%) by RECIST 1.1 (BICR)

Lesion:	Mediastinal lymph node, 18 mm short axis	Abdominal lymph node, 47 mm short axis
Baseline		
Day 281		
	CR of lesion	16 mm short axis *Day 319 scan showed 15 mm short axis*

New abdominal lesion noted on Day 319 by central assessment. Patient continued study treatment and target lesions remain stable (Day 442+)

CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; PR, partial response; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment

Case Study #2 – 1L Stage IV NSCLC patient achieved a confirmed PR (-76%) by RECIST 1.1 (BICR)

PD-L1 ≥50%

Case Study #2:

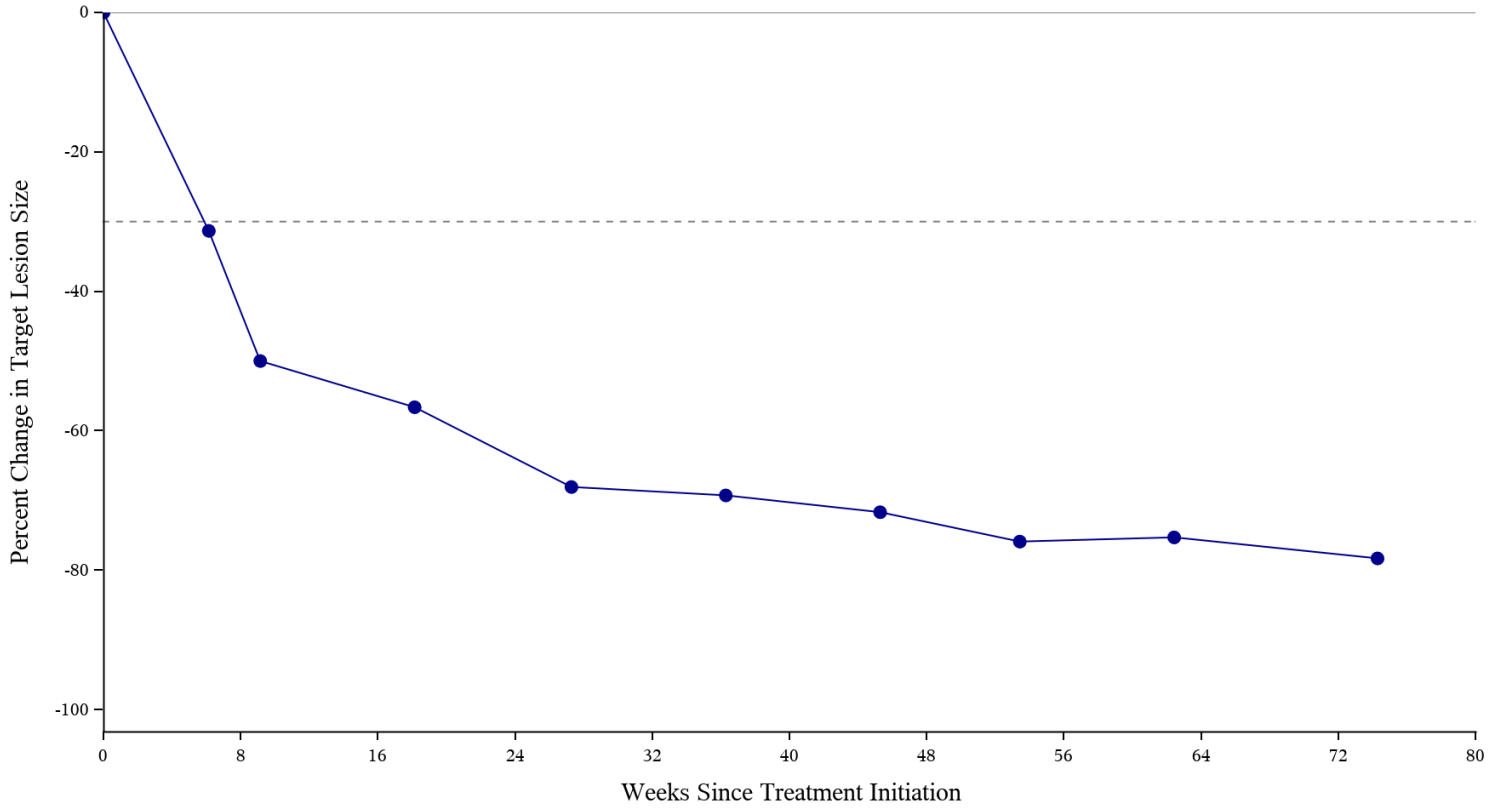
Medical History:

- 55-year-old, Male
- Widespread non-squamous NSCLC, including liver metastases
- ECOG Performance Status: 0
- Former Smoker
- Baseline Tumor Burden: 166 mm

Treating PI:

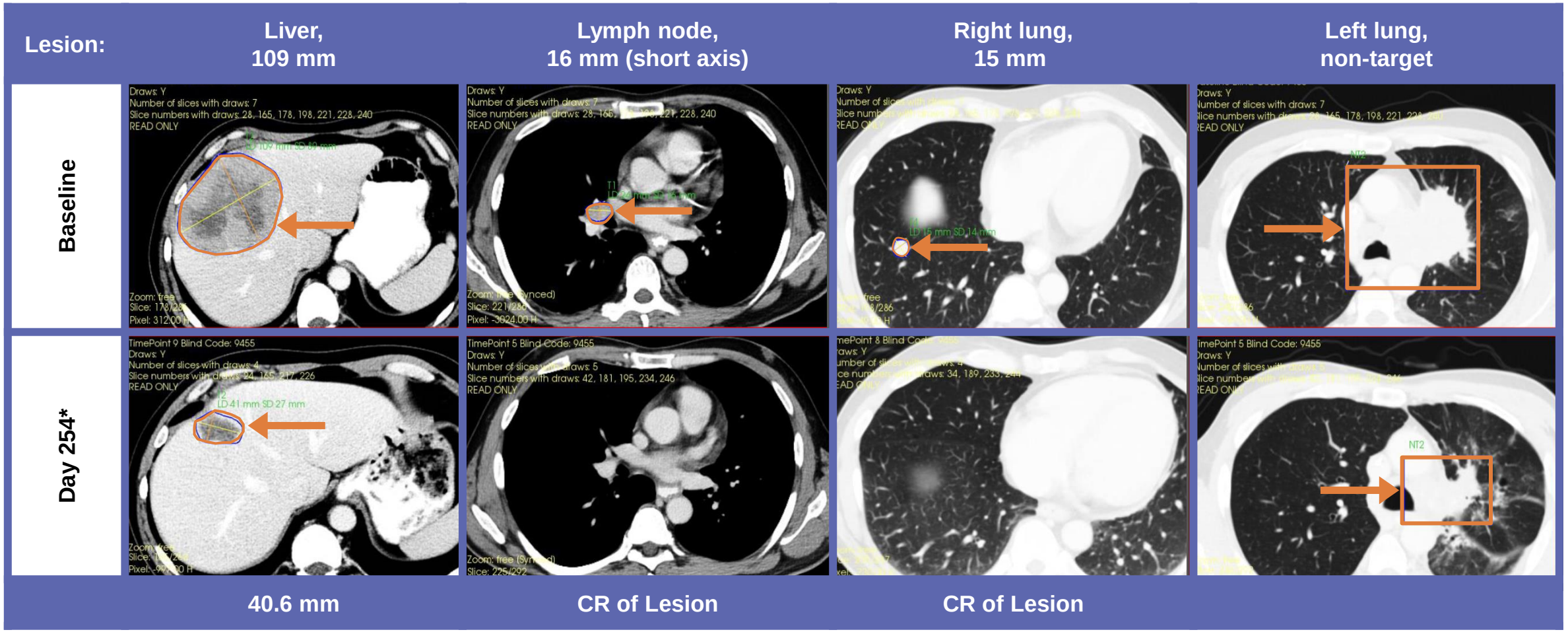
Dr. Apar Ganti
University of Nebraska

Percent Change in Target Lesion by BICR:



NEKTAR CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; PR, partial response; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment; Patient had 16 cycles of BEMPEG + pembrolizumab and, at cycle 17, continued on pembrolizumab alone due to a BEMPEG related AE (G2 Arthralgia)

Case Study #2 – 1L Stage IV NSCLC patient achieved a confirmed PR (-76%) by RECIST 1.1 (BICR)



*Scan of right lung lesion is from Day 374; Scan of liver lesion is from Day 437; All other scans are Day 254; Final BICR report showed a 78% reduction as of Day 520

CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; PR, partial response; Patient had an additional 26 mm baseline right adrenal target lesion (not shown here) noted to have a CR.

Case Study #3 – 1L Stage IV NSCLC patient achieved a confirmed CR by RECIST 1.1 (BICR)

PD-L1 ≥50%

Case Study #3:

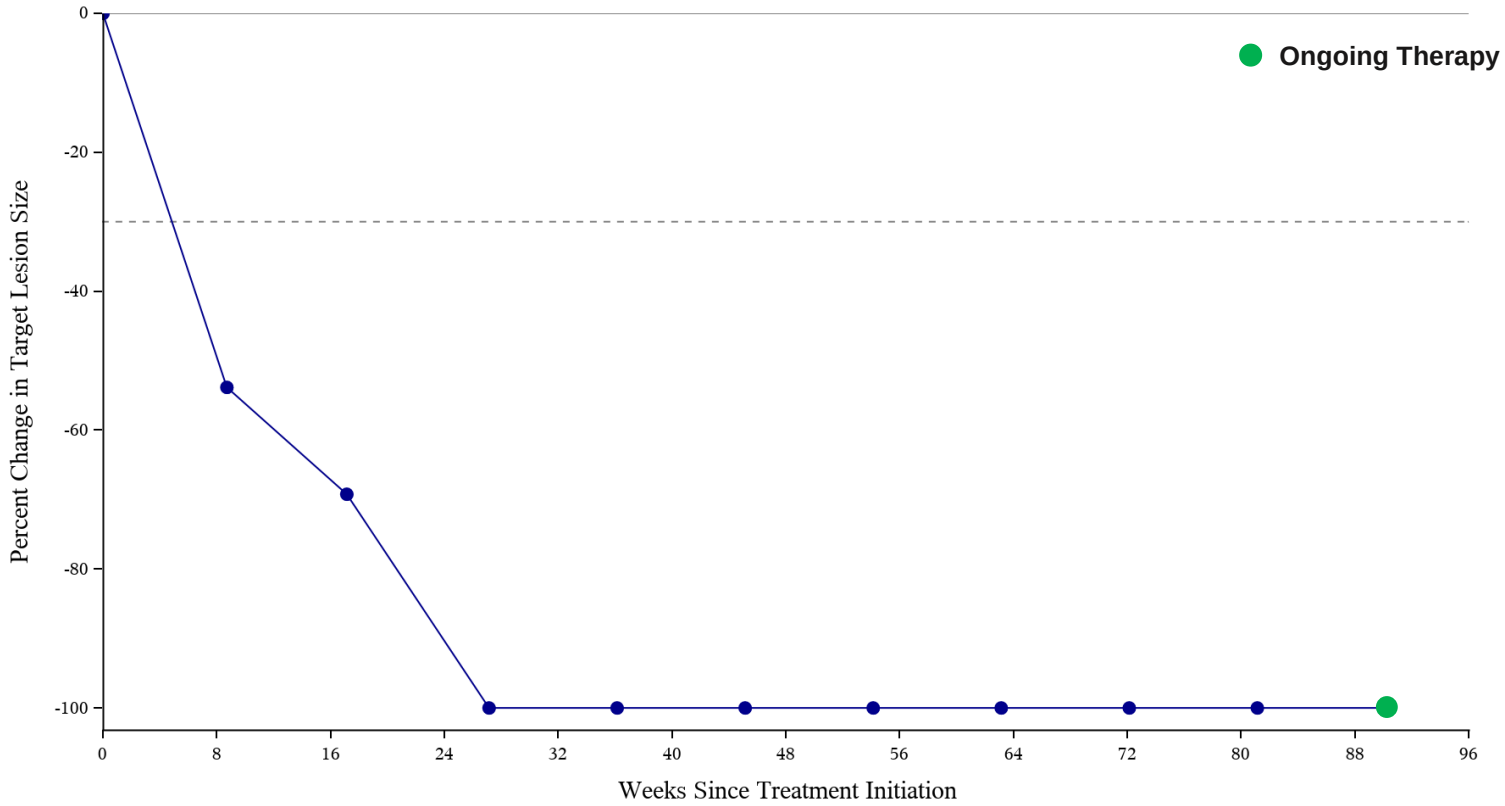
Medical History:

- 62-year-old, Female
- Non-squamous NSCLC with liver metastases
- ECOG Performance Status: 1
- Current Smoker
- Baseline Tumor Burden: 26 mm

Treating PI:

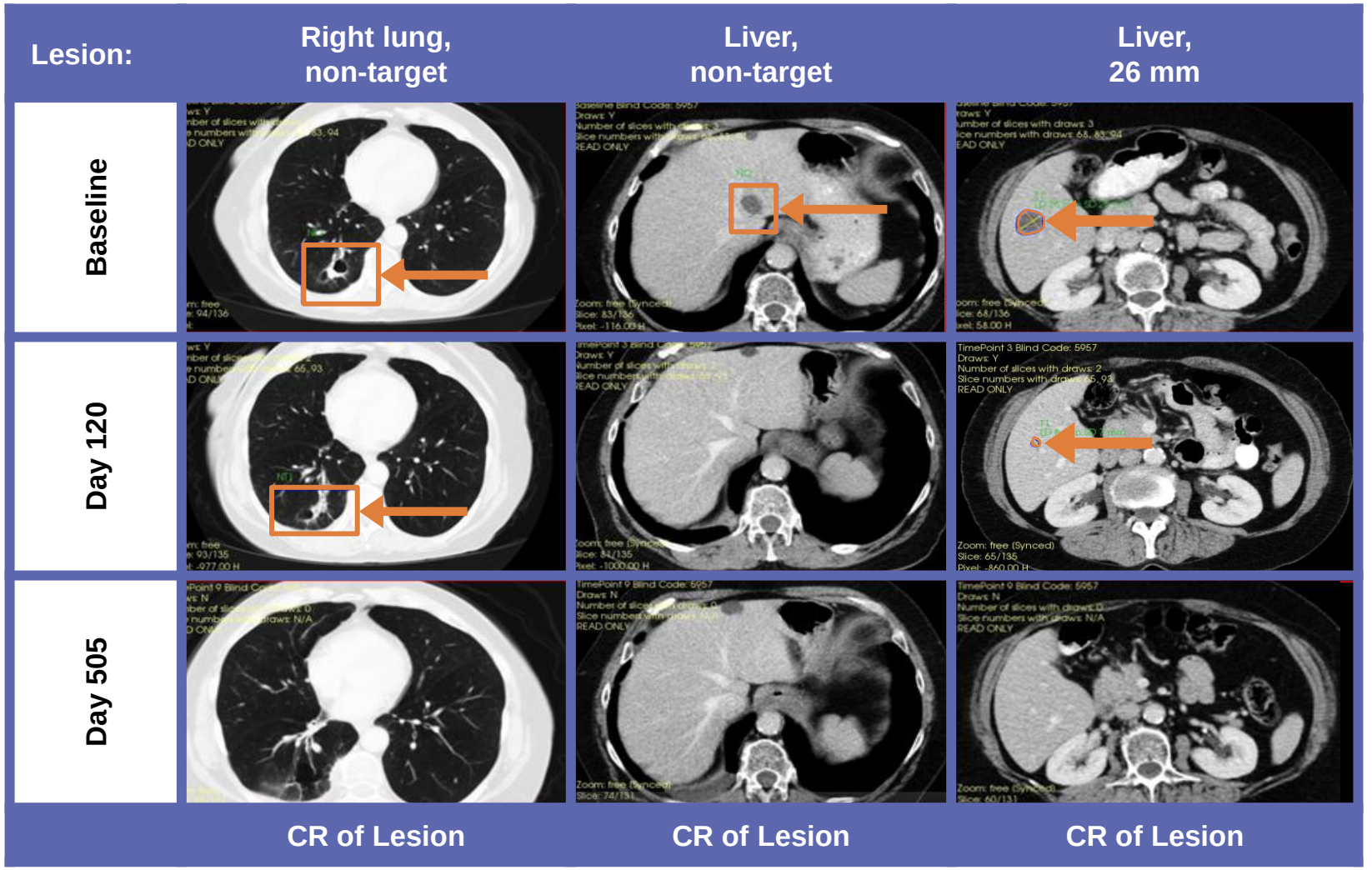
Dr. Rachel Lerner
Park Nicollet - Frauenshuh Cancer Center
St. Louis Park, Minnesota

Percent Change in Target Lesion by BICR:



CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment; Patient had 10 cycles of BEMPEG + pembrolizumab and, at cycle 11, continued on pembrolizumab alone due to a BEMPEG related AE (Flu-like Symptoms)

Case Study #3 – 1L Stage IV NSCLC patient achieved a confirmed CR by RECIST 1.1 (BICR)



CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1;
Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment

Case Study #4 – 1L Stage IV NSCLC patient achieved a confirmed PR (-48%) by RECIST 1.1 (BICR)

PD-L1 <1%

Case Study #4:

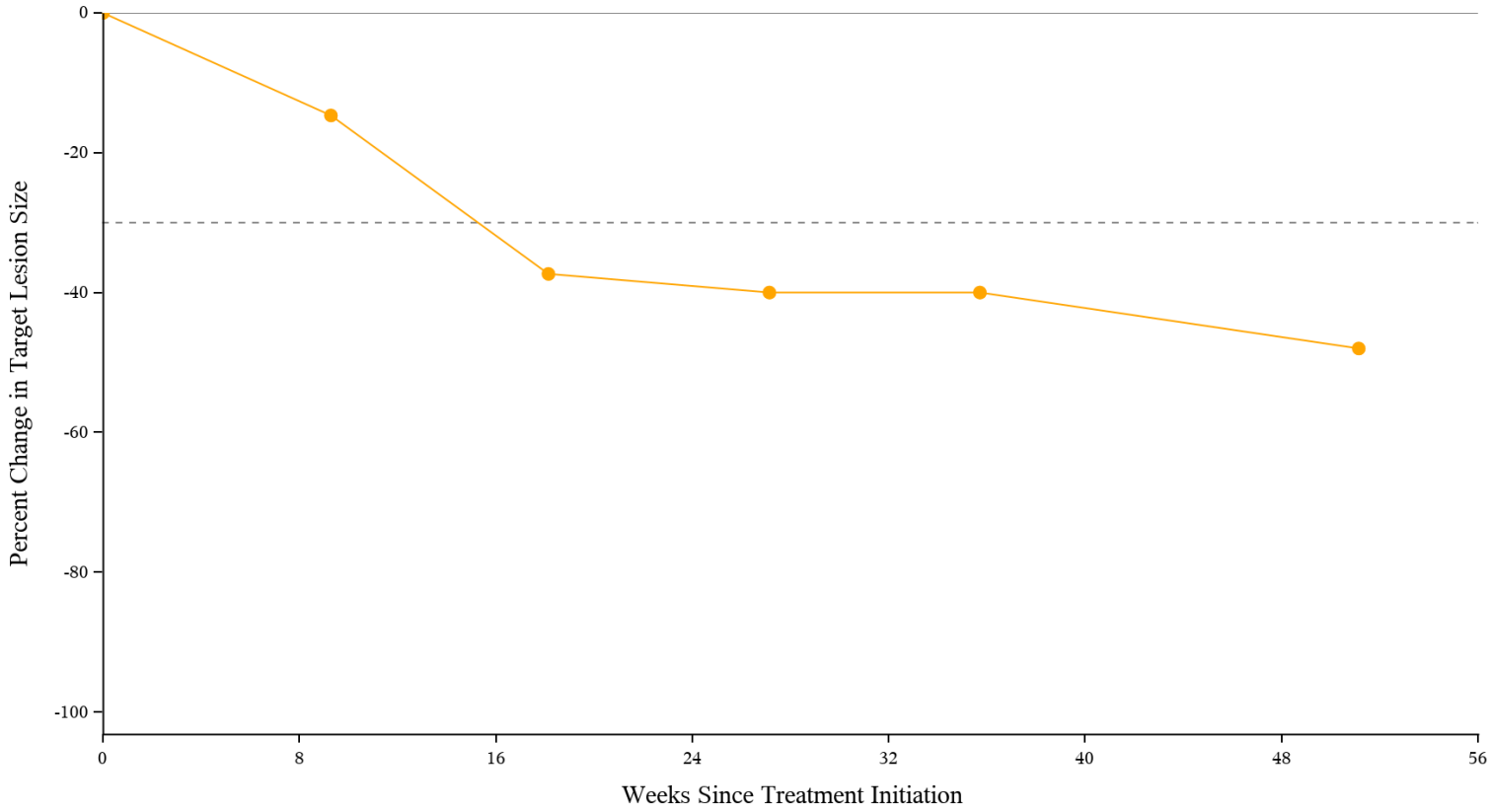
Medical History:

- 64-year-old, Male
- Squamous NSCLC
- ECOG Performance Status: 0
- Current Smoker
- Baseline Tumor Burden: 75 mm

Treating PI:

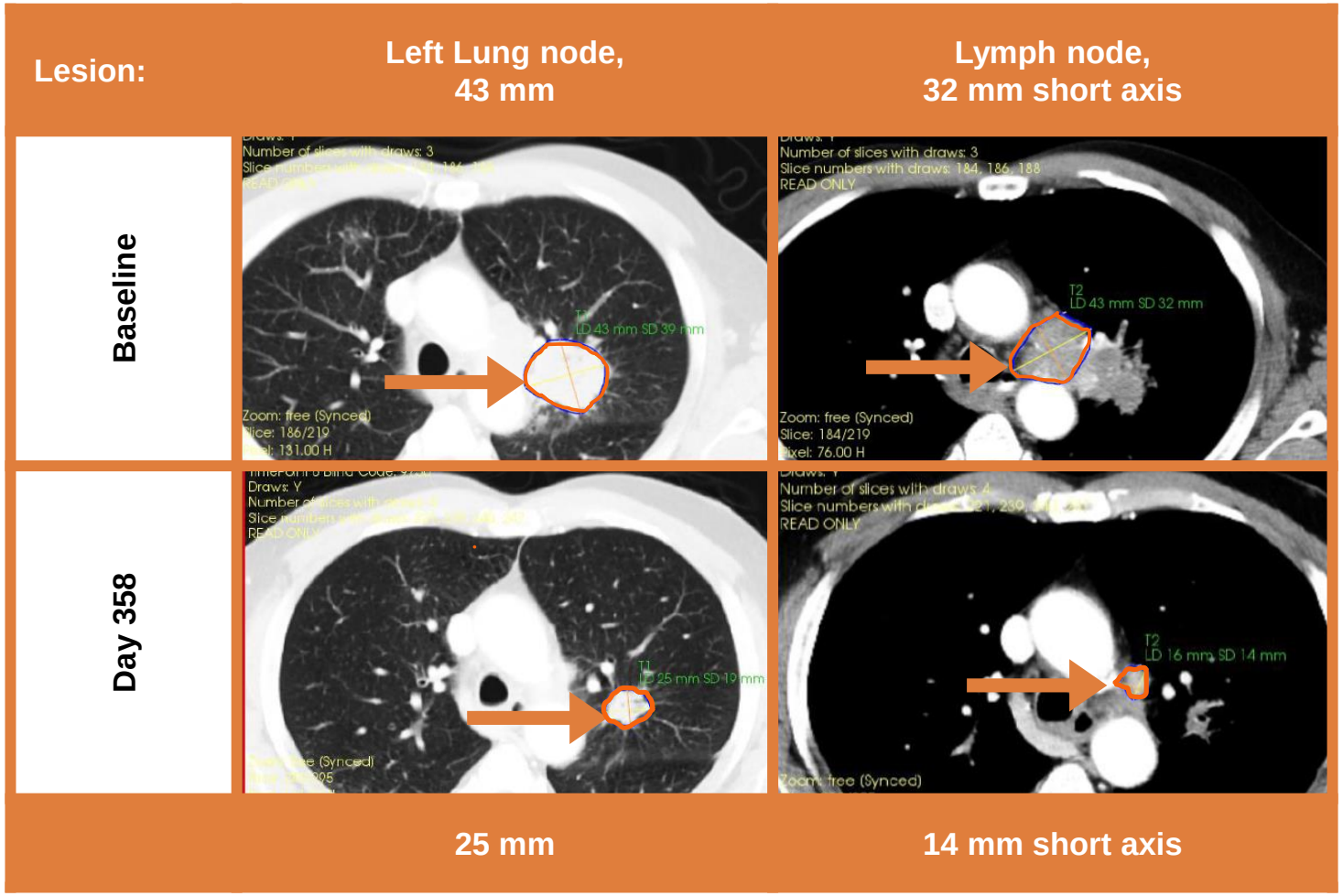
Dr. Daniel Johnson
Ochsner Medical Center

Percent Change in Target Lesion by BICR:



NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; PR, partial response; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment; Patient had 12 cycles of BEMPEG + pembrolizumab and, at cycle 13, discontinued both BEMPEG and pembrolizumab due to an AE of G3 ALT elevation; Patient was subsequently treated with single-agent pembrolizumab post-study and developed a new liver lesion in follow-up

Case Study #4 – 1L Stage IV NSCLC patient achieved a confirmed PR (-48%) by RECIST 1.1 (BICR)



CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; PR, partial response; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment

Case Study #5 – 1L Stage IV NSCLC patient achieved a confirmed PR (-73%) by RECIST 1.1 (BICR)

PD-L1 <1%

Case Study #5:

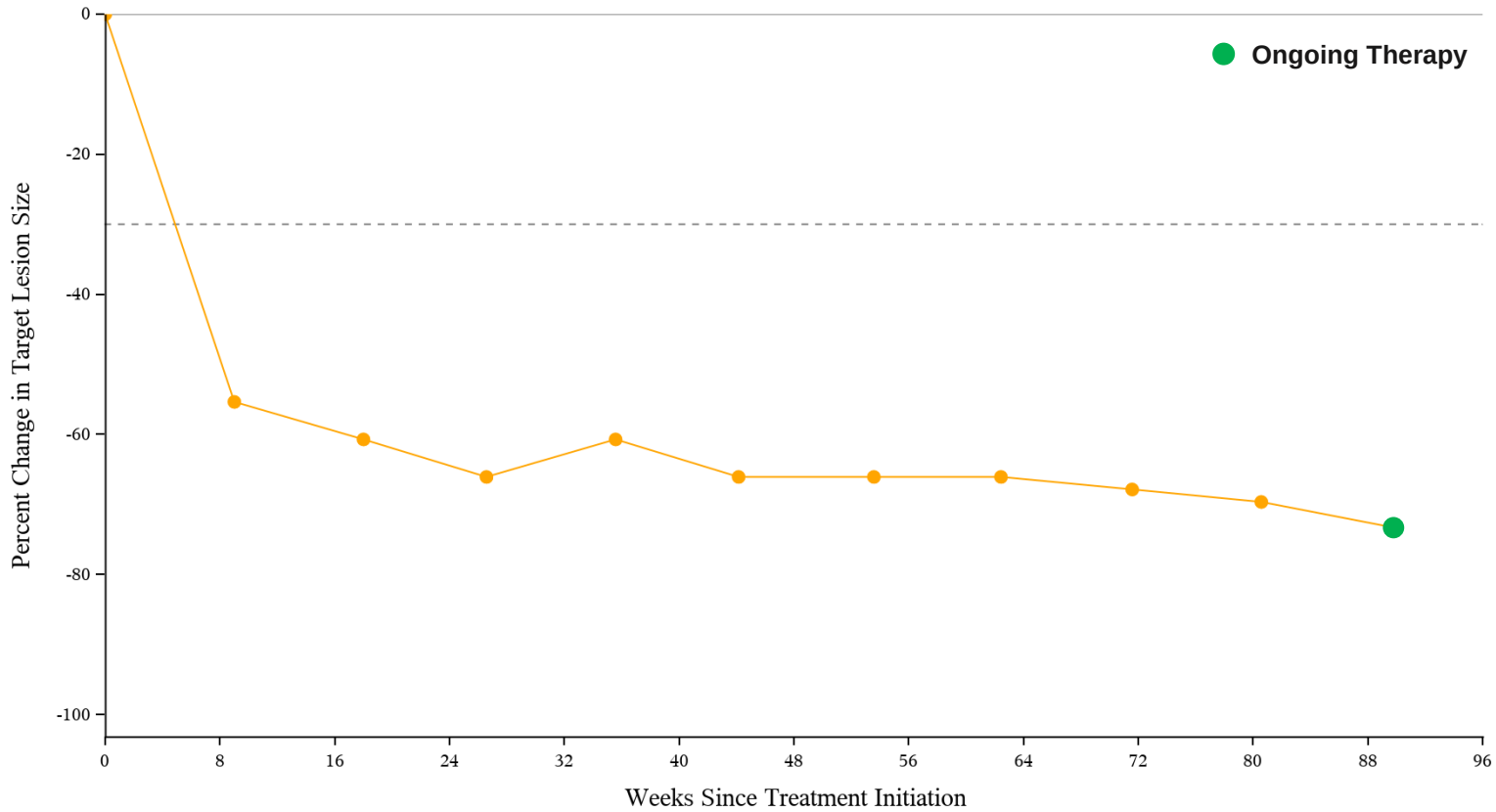
Medical History:

- 59-year-old, Female
- Non-squamous NSCLC
- Widespread metastases, including brain
- ECOG Performance Status: 0
- Non-smoker
- Baseline Tumor Burden: 56 mm

Treating PI:

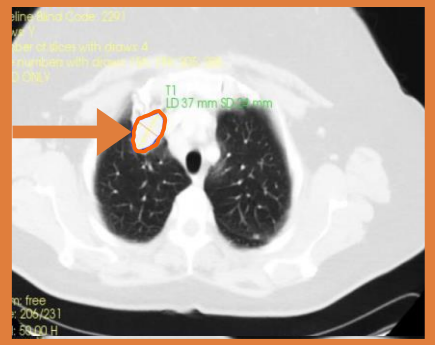
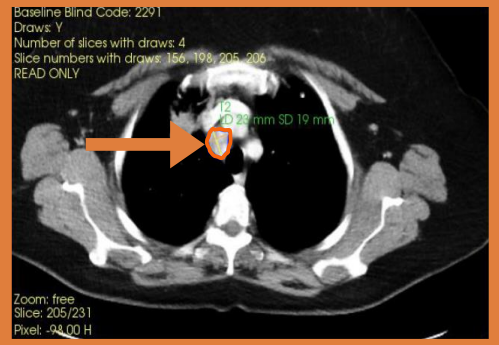
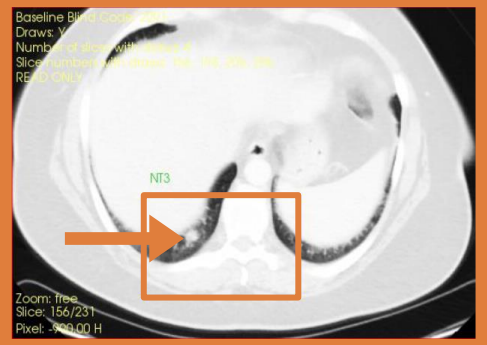
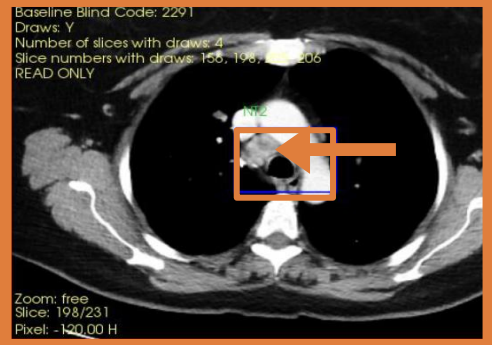
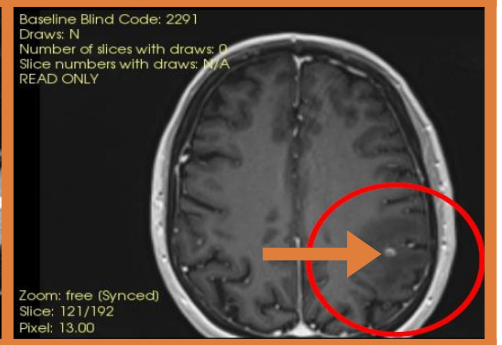
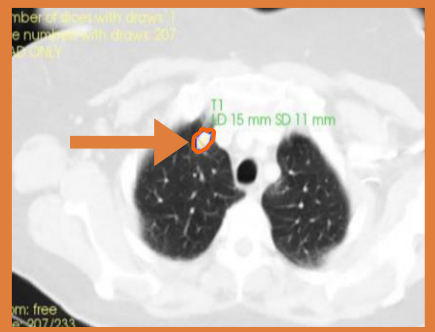
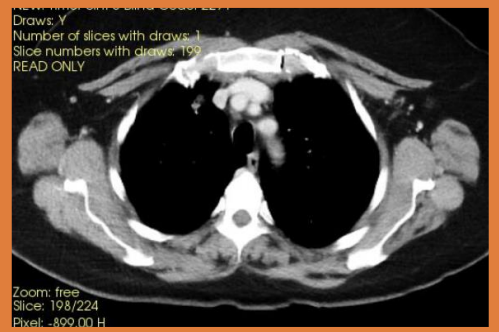
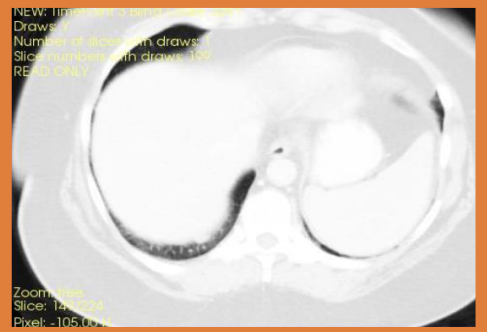
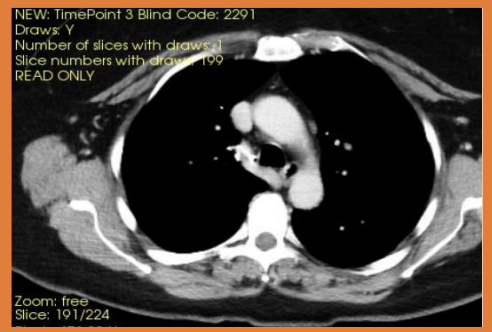
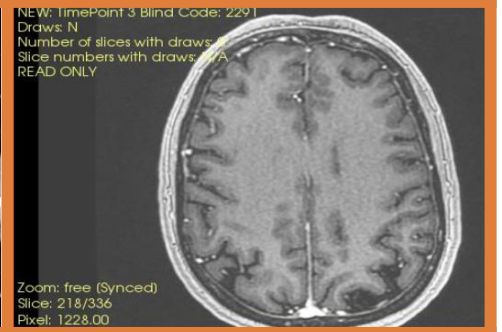
Dr. Daniel Johnson
Ochsner Medical Center

Percent Change in Target Lesion by BICR:



NEKTAR NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; PR, partial response; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment

Case Study #5 – 1L Stage IV NSCLC patient achieved a confirmed PR (-73%) by RECIST 1.1 (BICR)

Lesion:	R Lung, 37 mm	Lymph node, 19 mm (short axis)	Right lung, non-target	Lymph node, non-target	Brain metastasis, Non-target
Baseline					
Day 126*					
	15 mm	CR of lesion	CR of lesion	CR of lesion	CR of lesion

*Scan of right lung lesion is from Day 627; All other scans are Day 126

CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment

Case Study #6 – 1L Stage IV HNSCC patient achieved a confirmed CR by RECIST 1.1

PD-L1 <1%

Case Study #6:

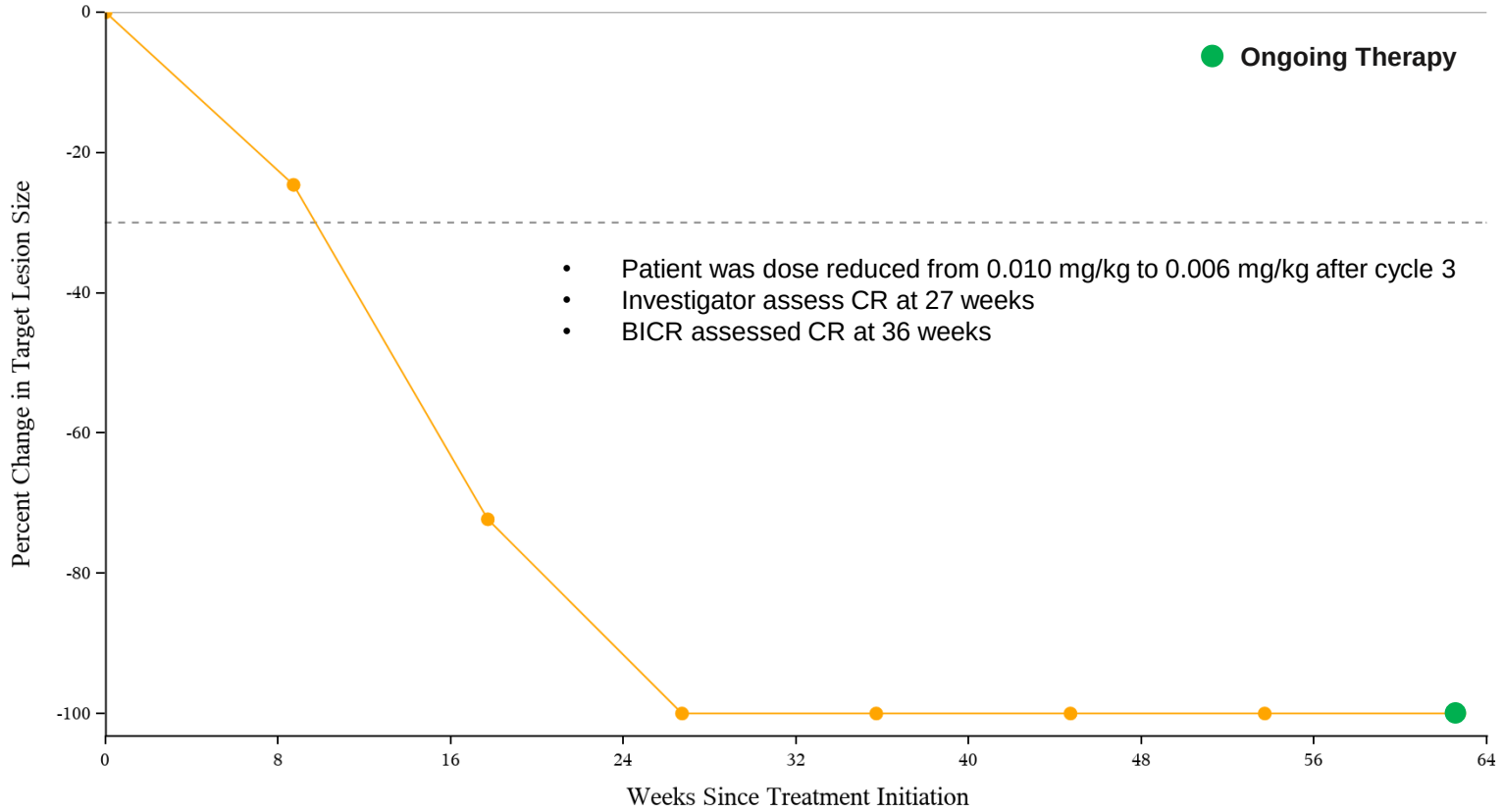
Medical History:

- 76-year-old, Female
- HNSCC with locoregional recurrence and new distant metastases (lung)
- ECOG Performance Status: 0
- Former Smoker
- Baseline Tumor Burden: 65 mm

Treating PI:

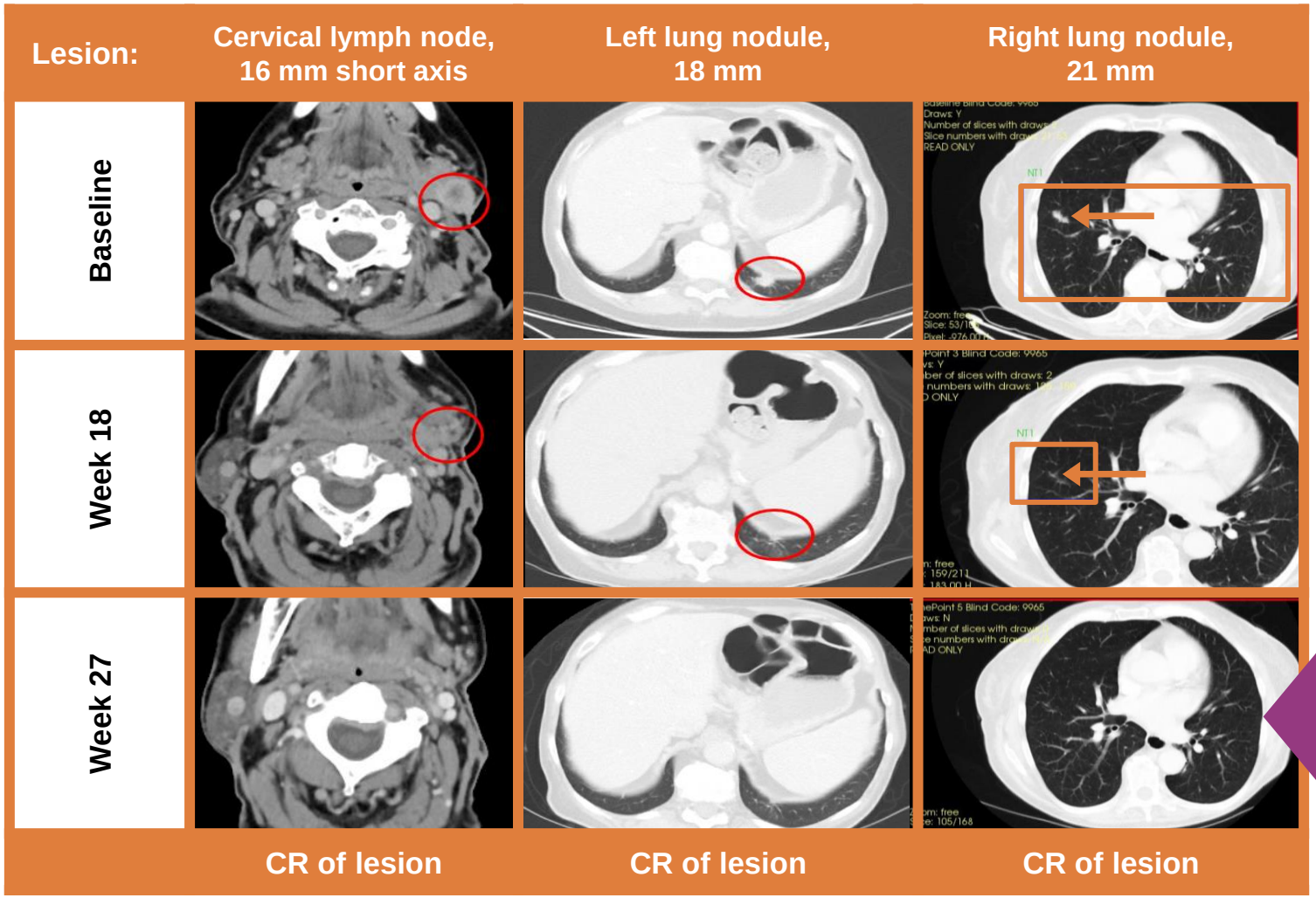
Dr. Daniel Johnson
Ochsner Medical Center

Percent Change in Target Lesion by Investigator:



CR, complete response; PD-L1, programmed death ligand-1; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment; Patient had 7 cycles of BEMPEG + pembrolizumab and, at cycle 8, continued on pembrolizumab alone due to a BEMPEG related AE (G3 Fatigue)

Case Study #6– 1L Stage IV HNSCC patient achieved a confirmed CR by RECIST 1.1



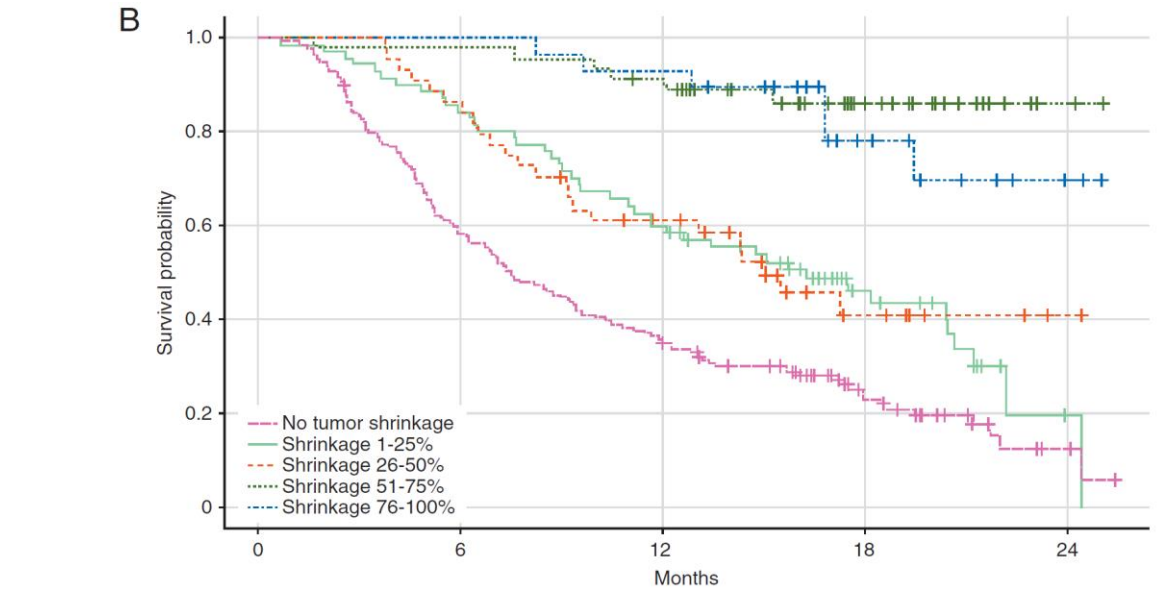
Investigator assessed CR at Week 27; CR confirmed by BICR at Week 36

*An additional 10 mm baseline parotidectomy bed lesion (not shown here) also noted to have a CR.

CR, complete response; NSCLC, non-small cell lung cancer; PD-L1, programmed death ligand-1; Baseline tumor burden is defined as the sum of the longest diameters of RECIST 1.1 target lesions prior to initiating treatment

OS by Depth of Response – PD-1 Inhibitors in NSCLC

PD-1 inhibitor depth of response in 2L NSCLC post-chemotherapy subgroups (n=355)



No tumor shrinkage	168	97	58	22	3
Shrinkage 1-25%	70	59	42	17	1
Shrinkage 26-50%	44	38	24	8	1
Shrinkage 51-75%	45	44	39	18	2
Shrinkage 76-100%	28	28	26	11	2

Depth of response has been shown to correlate with a longer OS with PD-1 inhibitors in NSCLC

NEKTAR McCoach CE, *et al*. *Ann Oncol* 2017; **28**: 2707–14

Agenda

Bempegaldesleukin (BEMPEG; NKTR-214): an IL-2 pathway agonist

- ***IL-2: The Central Immuno-Stimulatory Cytokine***
  - *Jonathan Zalevsky, Ph.D., Nektar Therapeutics*
- ***ESMO-IO 2021: "Preliminary results from PROPEL: A phase 1/2 study of bempegaldesleukin (BEMPEG: NKTR-214) plus pembrolizumab (PEMBRO) with or without chemotherapy in patients with metastatic NSCLC"***
  - *Dimitry Nuyten, M.D., Ph.D., Nektar Therapeutics*
- ***Depth of Response and Correlation to PFS and OS in NSCLC with Patient Case Studies from PROPEL***
  - *Daniel Johnson, M.D., Ochsner Medical Center*
- ***Remarks and Q&A Session***
  - *Mehmet Altan, M.D., MD Anderson Cancer Center, Daniel Johnson, M.D., Ochsner Medical Center*

Q&A session

Jonathan Zalevsky, PhD

Chief Research & Development Officer at Nektar Therapeutics

Dimitry Nuyten, MD, PhD

Chief Medical Officer at Nektar Therapeutics

Daniel Johnson, MD

Medical Oncologist, Gayle and Tom Benson Cancer Center; Deputy Director, Precision Cancer Therapies (Phase I) Research Program Ochsner Medical Center

Mehmet Altan, MD

Assistant Professor in the Department of Thoracic-Head and Neck Medical Oncology, Division of Cancer Medicine at The University of Texas MD Anderson Cancer Center

Poster presented at the ESMO Immuno-Oncology Congress 2021 | Dec 8–11, 2021. *Corresponding author Enriqueta Felip: efelip@vhebron.net*

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