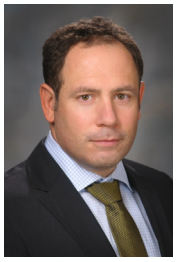
Today's Speakers and Panelists



Dr. Adi Diab

Assistant Professor of Melanoma Medical Oncology MD Anderson

Dr. Michael Hurwitz

Assistant Professor of Medicine, Medical Oncology Yale Cancer Center

Dr. Nizar M. Tannir

Professor of Genitourinary Medical Oncology & Deputy Department Chair of the Department of Genitourinary Medical Oncology MD Anderson

Dr. Mary Tagliaferri

Senior Vice President, Clinical Development Nektar Therapeutics

Dr. Jonathan Zalevsky

Senior Vice President, Biology & Preclinical Development Nektar Therapeutics

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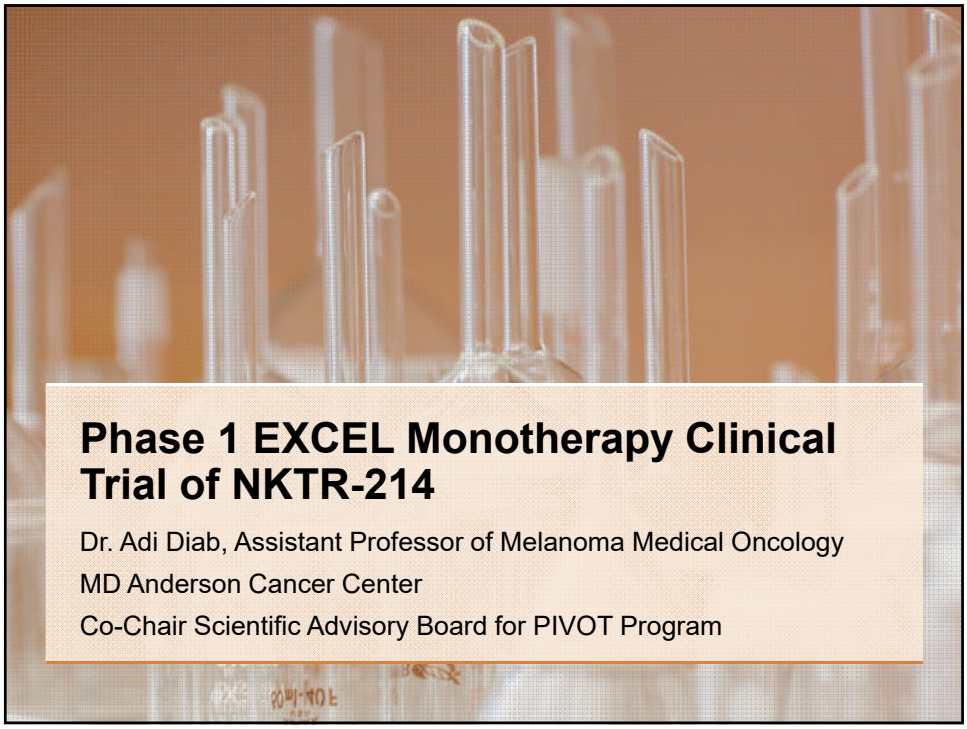


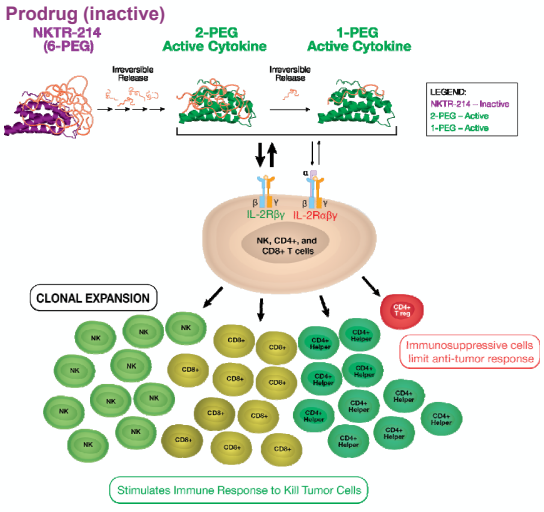
Phase 1 EXCEL Monotherapy Clinical Trial of NKTR-214

Dr. Adi Diab, Assistant Professor of Melanoma Medical Oncology

MD Anderson Cancer Center

Co-Chair Scientific Advisory Board for PIVOT Program

Harnessing the IL-2 Pathway the Right Way to Increase TILs



- Prodrug design to enable safe, outpatient dosing Q2W or Q3W
- Active cytokine species bias signaling through the heterodimeric IL-2 receptor pathway (IL-2Rβγ)
- Biased and sustained signaling to preferentially activate and expand effector CD8+ T and NK cells over Tregs in the tumor microenvironment

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EXCEL Phase 1 Dose Escalation, Stage IV Patients (N=28)

Phase 1

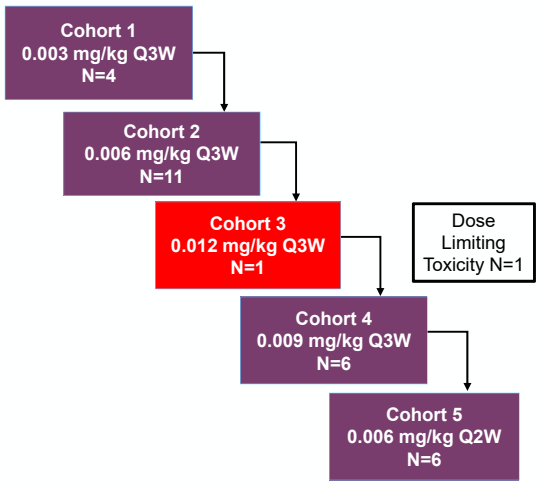
- Monotherapy Dose Escalation

Primary Objectives

- Define the MTD
- ORR

Eligibility

- Confirmed locally advanced or metastatic solid tumors
- Measurable disease
- ECOG 0 or 1



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Serial collection of blood samples and tumor biopsies for biomarker analysis

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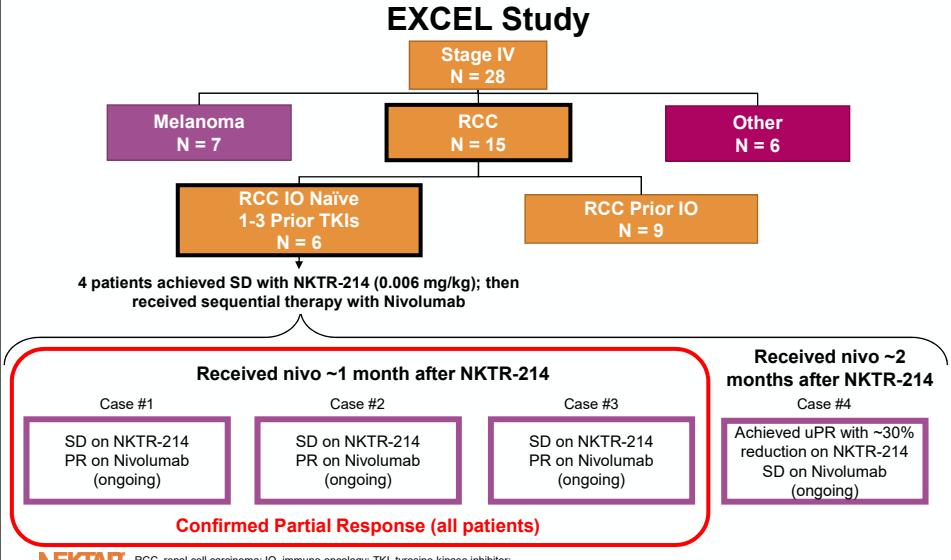
NKTR-214 Monotherapy Followed by Dosing With Nivolumab in RCC IO Naïve Patients



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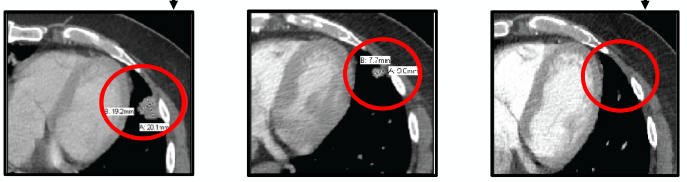
RCC, renal cell carcinoma; IO, immuno-oncology; TKI, tyrosine-kinase inhibitor; PR, confirmed partial response; uPR, unconfirmed partial response; SD, stable disease.

ASCO 2017 6

Case #1: Patient with RCC Stage IV, Age 59, Male, Progressed on Prior TKI

	Treatment	Duration of Treatment	Time Interval to Next Treatment
Prior Therapies	Sunitinib	~67 mos (PD)	~2 mos
Therapies Administered	NKTR-214	~5 mos (SD)	~1 mo
	Nivolumab	>9 mos	Ongoing

NKTR-214 (8 cycles) ⟷ ~1mo → Nivolumab →



Baseline | EOT NKTR-214 | Post-Nivolumab

Confirmed PR

(RECIST 1.1: Maximum tumor response -10% on NKTR-214)

(1st scan PR)

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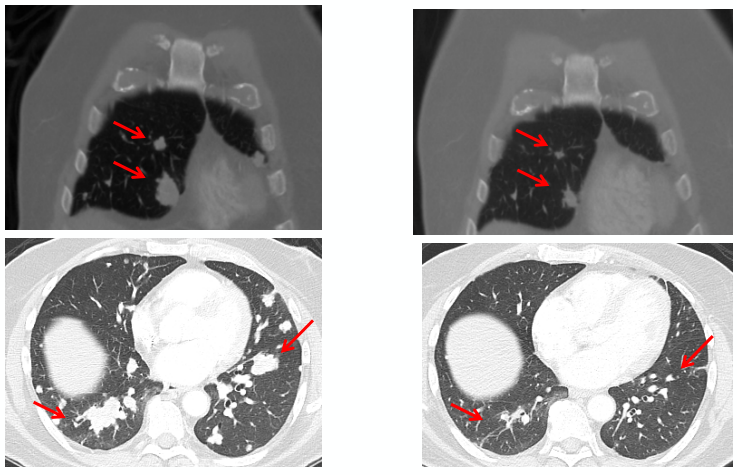
Case #1: Patient with RCC Stage IV, Age 59, Male, Progressed on Prior TKI



Scan post NKTR-214; Pre-Nivolumab

First 8-week scan; Post-Nivolumab

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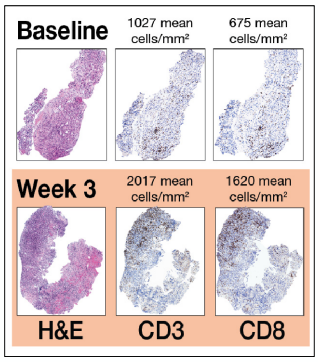
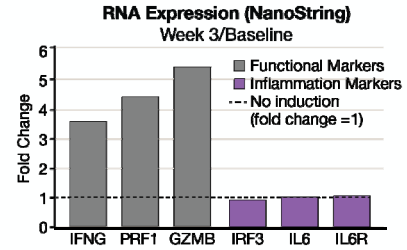
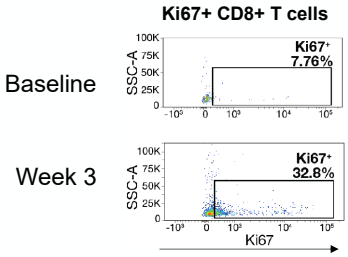
Case #1: Patient with RCC Stage IV, Age 59, Male, Progressed on Prior TKI

Tumor Biopsy: Observed Immunological Changes on NKTR-214 (IHC, Gene Expression, Flow Cytometry)



IHC, Immuno histochemistry; IFNG, interferon gamma; PRF1, perforin; GZMB, granzymeB, IRF3, interferon response factor 3.





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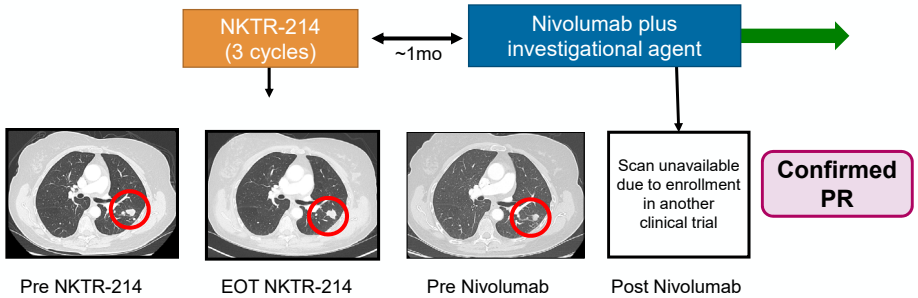
Case #2: Patient with RCC Stage IV, Age 66, Female, Prior TKI

	Treatment	Duration of Treatment	Time Interval to Next Treatment
Prior Therapies	Sunitinib	~8 mos (AE disc.)	~1.5 mos
Therapies Administered	NKTR-214	~1.5 mos (SD)	~1 mo
	Nivolumab	>9 mos	Ongoing



(RECIST 1.1: Maximum tumor response -20% on NKTR-214)

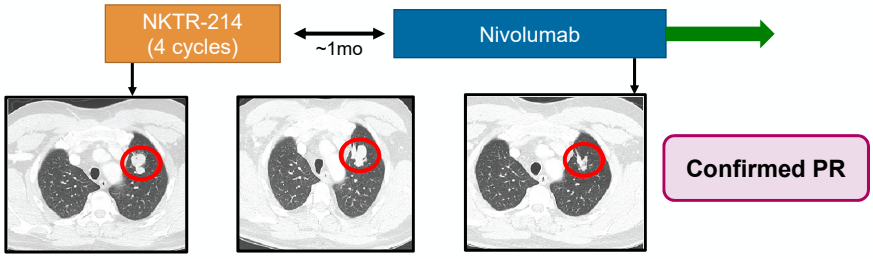
Pseudo progression observed

(1st scan PR)

ASCO 2017 10

Case #3: Patient with RCC Stage IV, Age 61, Male, Progressed on Prior TKI

	Treatment	Duration of Treatment	Time Interval to Next Treatment
Prior Therapies	Sunitinib	~2.5 mos (PD)	0
	Axitinib	~1.5 mos (PD)	~2 mos
	Bevacizumab + CRLX101	~3.5 mos (unknown)	~4.5 mos
Therapies Administered	NKTR-214	~1.5 mos (SD)	~1 mo
	Nivolumab	>7 mos	Ongoing



Baseline | EOT NKTR-214 | Post-Nivolumab

(RECIST 1.1: Maximum tumor response -1% on NKTR-214)

(1st scan PR)

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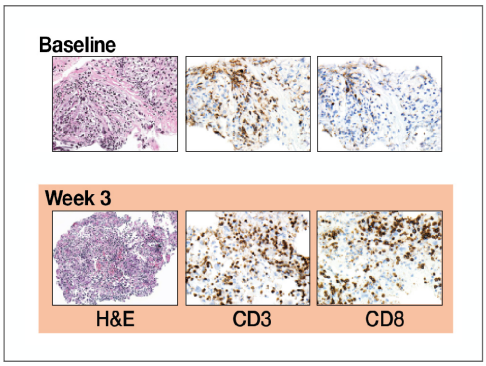
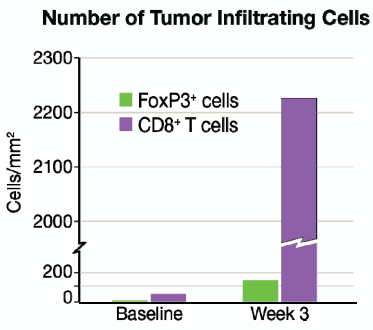
Case #3: Patient with RCC Stage IV, Age 61, Male, Progressed on Prior TKI

Tumor Biopsy: Observed Immunological Changes on NKTR-214 (IHC)





NEKTAR IHC, Immuno histochemistry.

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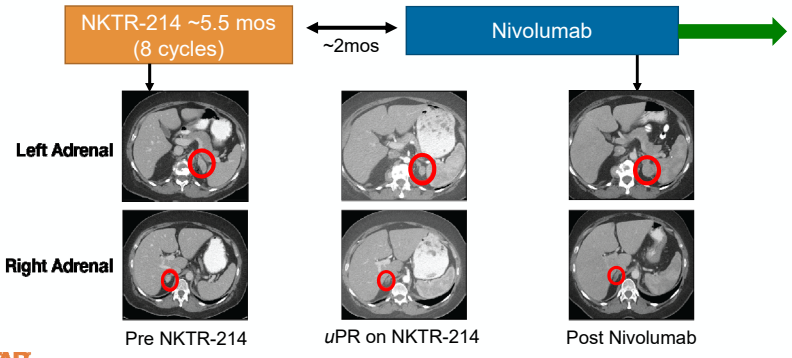
Case #4: Patient with RCC Stage IV, 60 Year Old Female, Progressed on Prior TKI

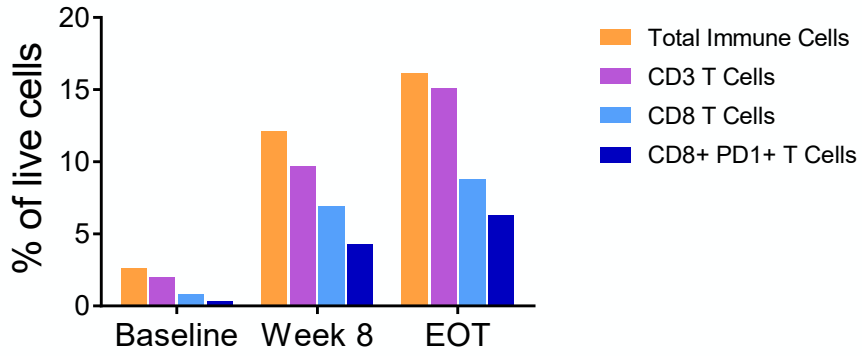
	Treatment	Duration of Treatment	Time Interval to Next Treatment
Prior Therapies	Pazopanib	~10.5 mos	~1 mo
	Axitinib	~5 mos (PD)	~2.5 mos
Therapies Administered	NKTR-214	~5.5 mos (SD)	~2 mos
	Nivolumab	>4 mos	Ongoing



(RECIST 1.1: Maximum tumor reduction -30% uPR on NKTR-214) *(1st scan SD)*

Case #4: Patient with RCC Stage IV, Age 60, Female, Progressed on Prior TKI

Tumor Biopsy: Observed Immunological Changes on NKTR-214 (Flow Cytometry)



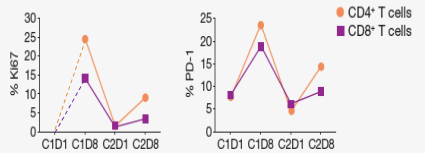
Two Patients in EXCEL with Durable Disease Control on NKTR-214 (Ongoing)

Robust Immune Activation in Patients Who Have Failed Prior Immunotherapy

Case #5	Treatment	Duration of Treatment	Time Interval to Next Treatment
Prior Therapies	Ipilimumab (ipi)	~1 mo	~45 mos
	Vemurafenib	~7 mos	~33 mos
Therapy Administered	NKTR-214	>15 mos	Ongoing

Ipi → Vemurafenib → NKTR-214 (23 cycles)

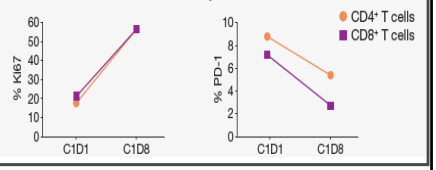
Increased Proliferation and PD-1 Expression on T Cells in Blood



Case #6	Treatment	Duration of Treatment	Time Interval to Next Treatment
Prior Therapies	HD IL-2	~3 mos	~22.5 mos
	Anti-OX-40 (OX40)	~2 mos	~1.5 mos
	Nivolumab	~2.5 mos	~1 mo
Therapy Administered	NKTR-214	>10 mos	Ongoing

HD IL-2 → OX40 (PD) → Nivo (PD) → NKTR-214 (15 cycles)

Increased Proliferation and PD-1 Expression on T Cells in Blood



NEKTAR Dash line represents missing C1D1 sample.

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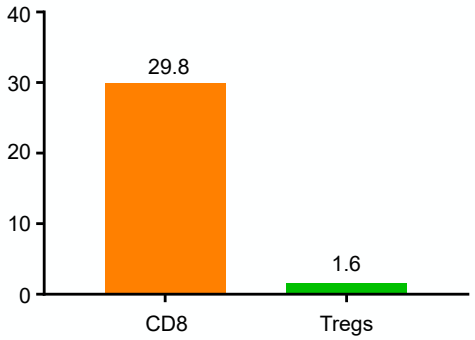
NKTR-214 Selectively Grows T Cells, NK Cells in Tumor Microenvironment in Cancer Patients

Analysis of T cell Populations in Tumor



Fold change expressed as Week 3 / pre-dose
Shown are results from N=10 patients
Q3W dose schedules

- NKTR-214 drives immune activation in the tumor
  - Increase in total T cells, NK and CD8 T cells
  - No increase in Tregs
  - Increase in PD-1 positive CD8 T cells
  - Increase in newly proliferating CD8 T cells
  - Activation and expression of anti-tumor genes
  - Change in T cell clonality in the tumor

Combination of increased TILs and increased expression of PD-1 provides strong mechanistic rationale with anti-PD-1

NEKTAR Source: SITC Nov, 2016; JPM Jan, 2017

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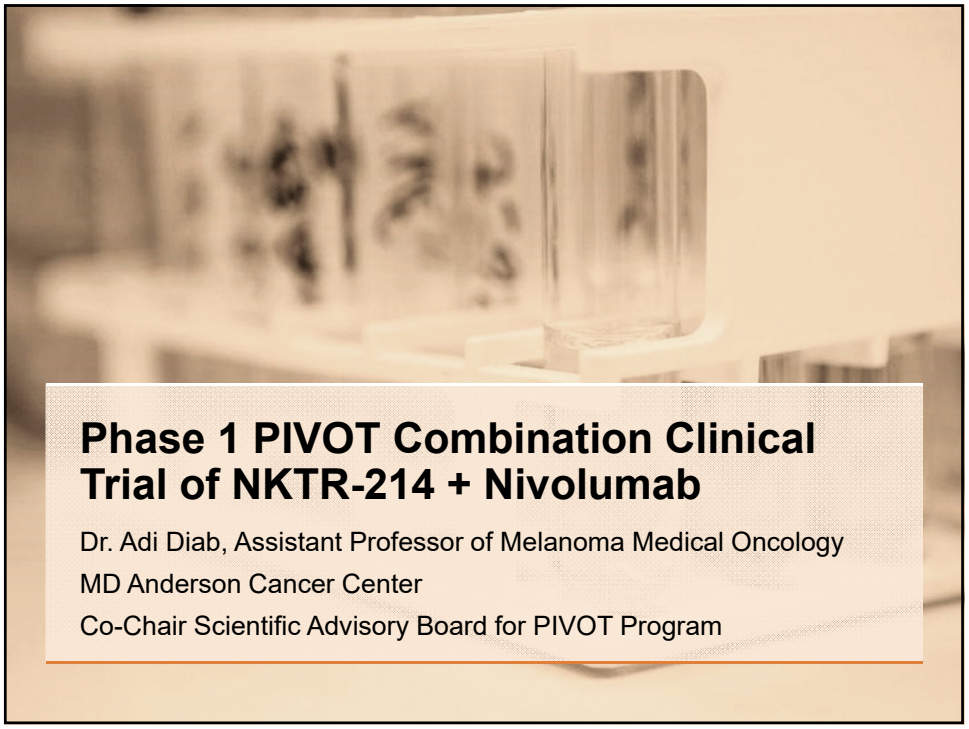

PIVOT Program: NKTR-214 plus Opdivo® with Eight Expansion Cohorts Planned

PIVOT

Phase 1 Dose Escalation (on label indications) N= 20-30

- **Melanoma** 1st line
- **Renal Cell Carcinoma** 1st, 2nd line I-O naïve
- **NSCLC** 1st, 2nd line I-O naïve

Initial Dose Combination Arm:
Group 1: 0.006 mg/kg q3w NKTR-214 + 240 mg q2w nivo
q2w and q3w Parallel Dose Combination Arms:
Group 2: 0.003 mg/kg q2w NKTR-214 + 240 mg q2w nivo
Group 3: 0.006 mg/kg q2w NKTR-214 + 240 mg q2w nivo
Group 4: 0.006 mg/kg q3w NKTR-214 + 360 mg q3w nivo
Group 5: 0.009 mg/kg q3w NKTR-214 + 360 mg q3w nivo

PIVOT Expansion

Phase 2 Expansion Cohorts 3Q 2017

- **Melanoma** 1st line, N=28
- **Melanoma** 2nd line I-O relapsed, N=26
- **Renal Cell Carcinoma** 1st line, 2nd line I-O naïve, N=26
- **Renal Cell Carcinoma** 2nd line I-O relapsed, N=26
- **NSCLC** 1st, 2nd line I-O naïve, N=36
- **NSCLC** 2nd line I-O relapsed, N=26
- **Urothelial Carcinoma (Bladder)** 1st line, cisplatin ineligible, N=40
- **Triple Negative BC** 2nd line I-O naïve, N=36

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Opdivo is a registered trademark of Bristol-Myers Squibb

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PIVOT Dose Escalation Patient Demographics (as of June 1, 2017)

Patient Characteristics Safety Population: Dose Escalation	N=20	
Sex		
Male	15	
Female	5	
Age (years)		
Median		58
Range		22-70
Tumor Type		
Melanoma (0-1 prior therapies)	8	
Renal Cell Carcinoma (0-1 prior therapies)	9	
Non-Small Cell Lung Cancer (0-1 prior therapies)	3	
Stage		
Unresectable Stage III	1	
IV	19	
ECOG Performance Status (0-1)	20	
Prior Therapies		
Chemotherapy	2	
Cancer Vaccine	2	
Targeted Therapy (TKI or anti-VEGF)	3	

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PIVOT Dose Escalation: Treatment-Related Adverse Events

- No DLTs or grade 3/4 treatment-related adverse events (TRAEs)
- No grade 3 or above immune-related AEs observed to date
- No patients discontinued treatment due to AE and no deaths

AE, N (%)	Total (N=20)	NKTR-214 0.006 mg/kg q3w + Nivo 240 mg q2w (N=4)	NKTR-214 0.006 mg/kg q3w + Nivo 360 mg q3w (N=10)	NKTR-214 0.006 mg/kg q2w + Nivo 240 mg q2w (N=3)	NKTR-214 0.003 mg/kg q2w + Nivo 240mg q2w (N=3)
≥ G3 AE Reported	0	0	0	0	0
Grade 1&2 (>25%)					
Fatigue	15 (75)	4 (100)	6 (60)	2 (67)	3 (100)
Flu-Like Symptoms*	15 (75)	3 (75)	7 (70)	3 (100)	2 (67)
Rash**	12 (60)	4 (100)	5 (50)	1 (33)	2 (67)
Pruritus	11 (55)	2 (50)	5 (50)	2 (67)	2 (67)
Headache	9 (45)	3 (75)	4 (40)	1 (33)	1 (33)
Flushing	8 (40)	3 (75)	2 (20)	2 (67)	1 (33)
Decreased Appetite	6 (30)	3 (75)	1 (10)	2 (67)	0

* Flu-like symptoms includes the following MedDRA preferred terms: influenza-like illness, pyrexia, and chills.
**Rash includes the following MedDRA preferred terms: Rash, rash erythematous, rash macular and rash maculo-popular.

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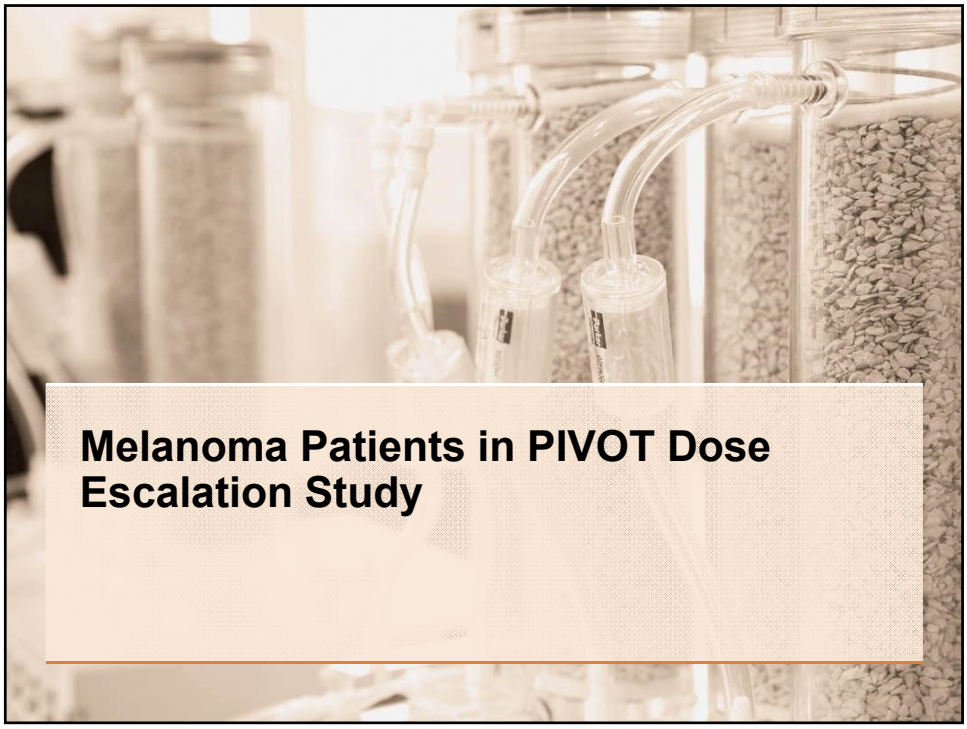
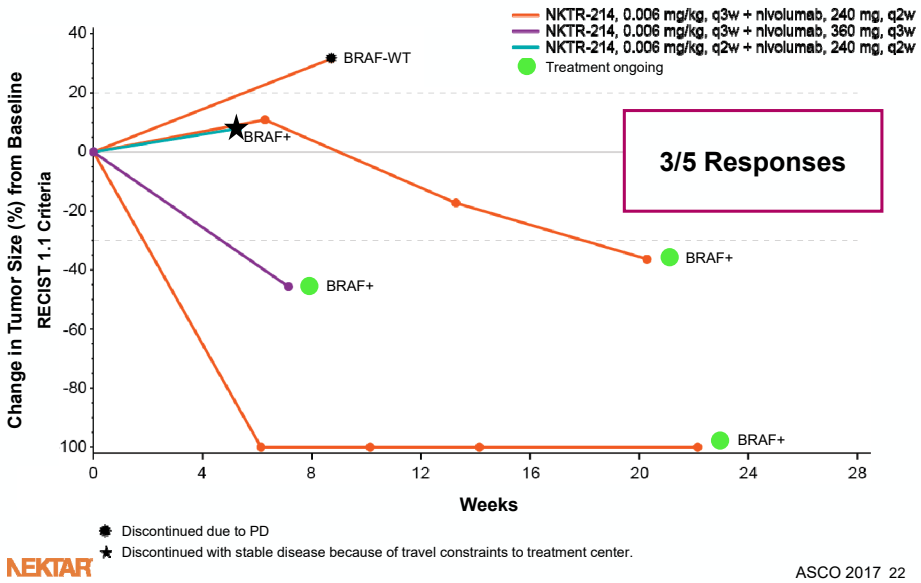


Melanoma Stage IV Patients 1st Line



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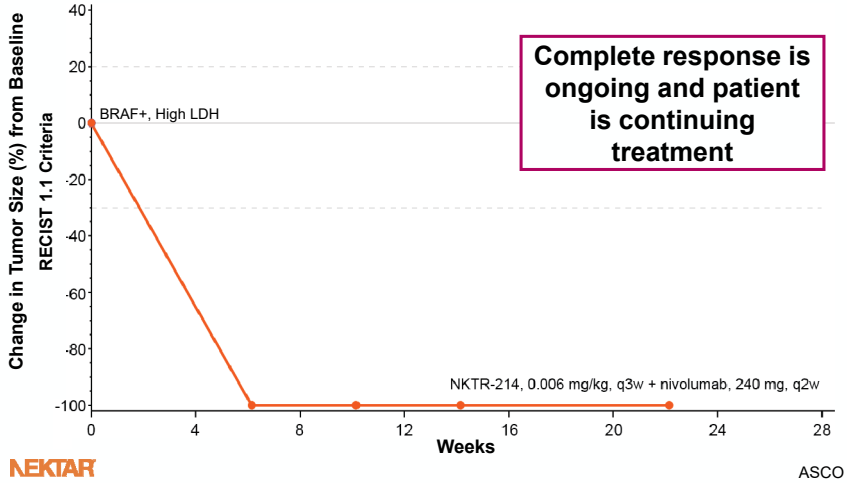
Patient with Stage IV Melanoma, Age 69, BRAF+, Prior Adjuvant Interferon

- Complete Response After 6 Weeks of Treatment
- Confirmed at 10 Weeks



Complete response is ongoing and patient is continuing treatment

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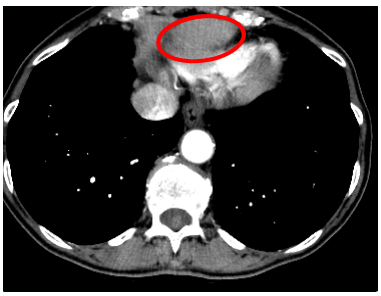
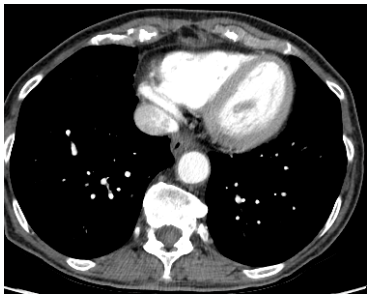
Patient with Stage IV Melanoma, Age 69, BRAF+, Prior Adjuvant Interferon

Pericardial Lesion, 45 mm



Baseline

Pericardial Lesion, Undetectable



6 Weeks

Lesion	Baseline Scan (mm)	1st Scan on Treatment (mm) 6-weeks
Pericardial	45	0
Peritoneal	21	0
Peritoneal	20	0
Peritoneal	17	0
Peritoneal	16	0
Peritoneal	10	0

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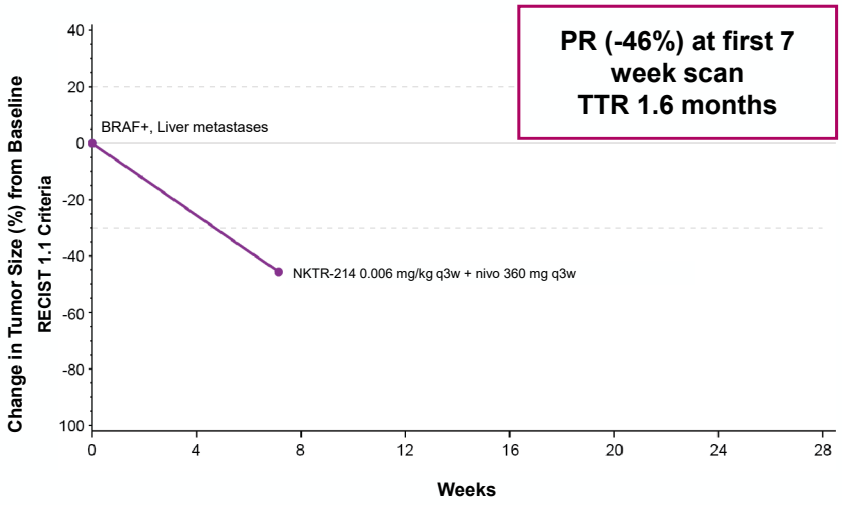
Patient with Stage IV Melanoma, Age 54, BRAF+, No Prior Therapy



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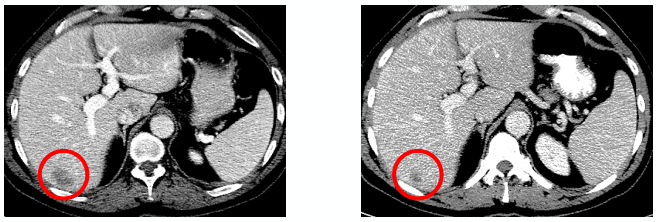
Patient with Stage IV Melanoma, Age 54, BRAF+, No Prior Therapy

Liver Lesion, 30 mm **Liver Lesion, 14 mm**



Baseline **7 Weeks**

Lesion	Baseline Scan (mm)	1st Scan on Treatment (mm) 7 Weeks
Liver	30	14
Skin (trunk)	16	11
Sum/% Change	46	**25 (-46%)**

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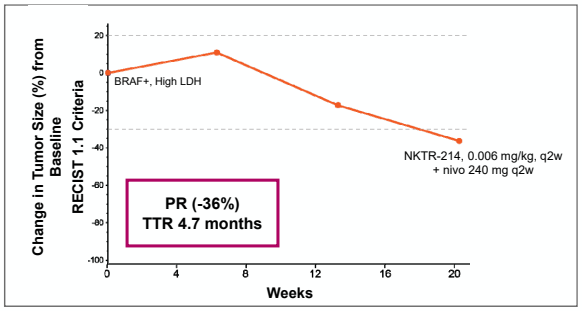
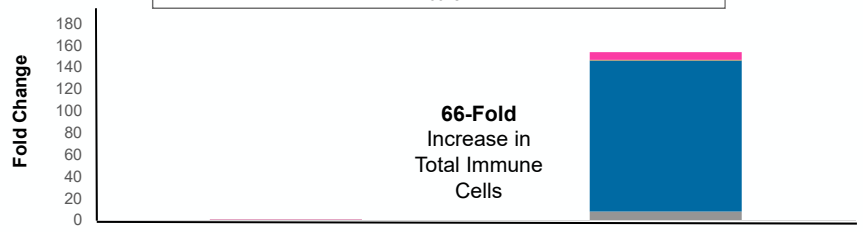
Correlation of Response with Tumor Infiltrating Immune Cells

Patient with Stage IV Melanoma, Age 43, No Prior Therapies





NEKTAR Lymph Node Biopsy

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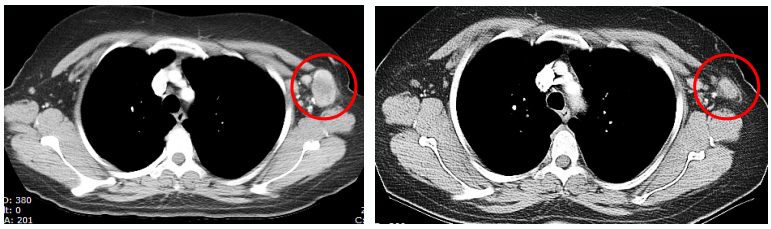
Patient with Stage IV Melanoma, Age 43, No Prior Therapies

Lymph Node, 30 mm | **Lymph Node, 11 mm**



Baseline | **21 Weeks**

Lesion	Baseline Scan (mm)	3rd Scan on Treatment 21 Weeks
Lymph Node	30	11
Chest Wall	30	31
Kidney	11	9
Lymph Node	25	11
Spleen	14	8
Sum/% Change	110	**70 (-36%)**

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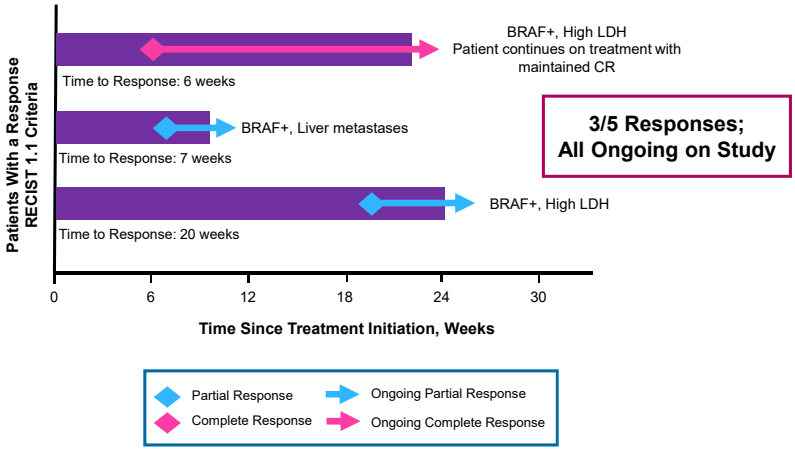
NKTR-214 and Nivolumab Responses in BRAF+ Melanoma



3/5 Responses; All Ongoing on Study

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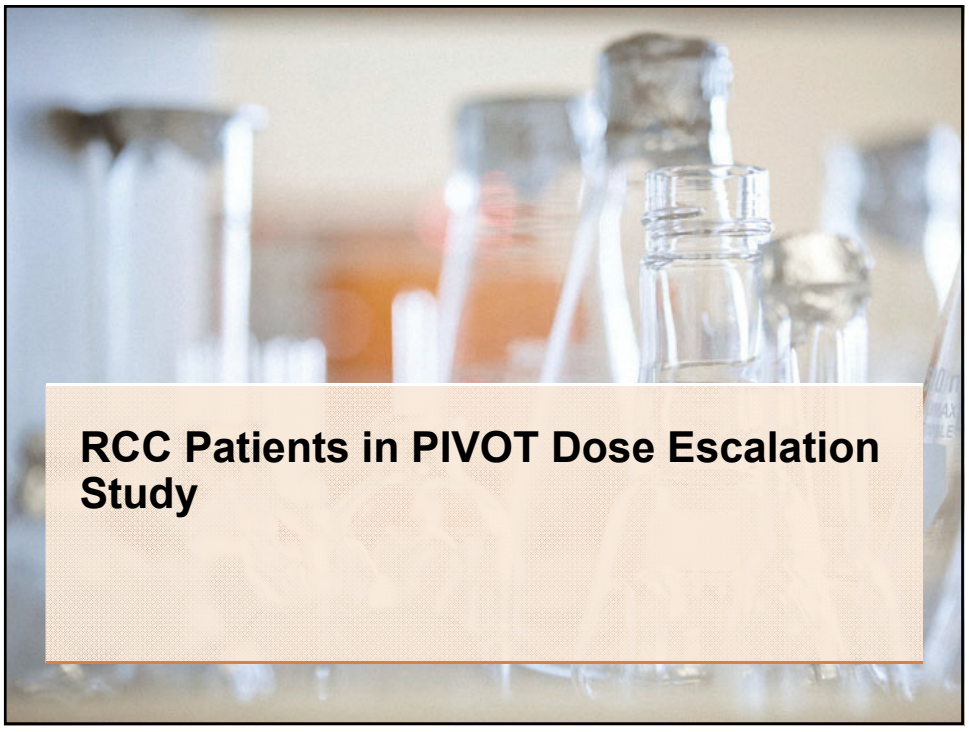

RCC Patients in PIVOT Dose Escalation Study

RCC Stage IV Patients, 0-1 Prior Therapies (Ongoing)

Only First Scan Available

Patient	Prior Therapy	Dose	Ongoing Response
#1	Pazopanib (PD)	NKTR-214 0.006 mg/kg Q3W + Nivolumab 240 mg Q2W	PR (-39%), Week 15
#2	Bevacizumab (PD)	NKTR-214 0.006 mg/kg Q2W + Nivolumab 240 mg Q2W (first scan only)	SD (-9%), Week 8
#3	None	NKTR-214 0.006 mg/kg Q2W + Nivolumab 240 mg Q2W	SD (0%), Week 7
#4	Sunitinib (PD)	NKTR-214 0.003 mg.kg Q2W + Nivolumab 240 mg Q2W	SD (-4%), Week 7
#5	Adjuvant oncophage vaccine (relapsed)	NKTR-214 0.003 mg.kg Q2W + Nivolumab 240 mg Q2W	SD (-9%), Week 7
#6	None	NKTR-214 0.006 mg.kg Q3W + Nivolumab 360 mg Q3W	SD of target lesions, PD of non-target lesion, Week 7

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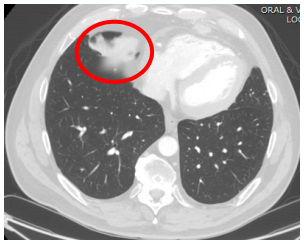
ASCO 2017 31

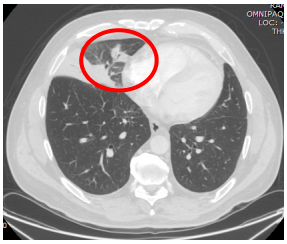
Patient with Stage IV RCC, Age 56, Progressed on a TKI

Pulmonary Lesion, 61 mm



Baseline

Pulmonary Lesion, 29 mm



Week 15

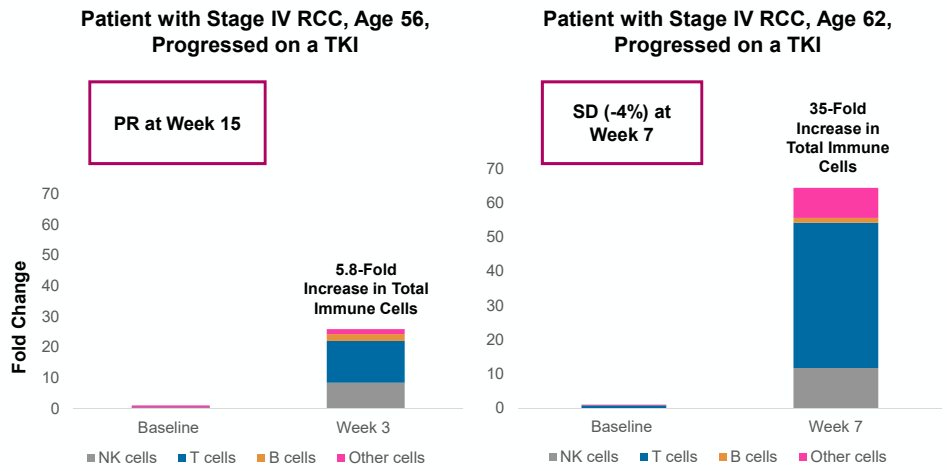
Confirmed PR

Lesion	Baseline Scan (mm)	2nd Scan on Treatment (mm) Week 15
Bronchopulmonary lymph Node	28	20
Lymph nodes: subcarinal	37	27
Lung: left upper pulmonary	61	29
Lung: left basal pulmonary nodule	13	9
Liver: hepatic dome	27	16
Sum/% Change	166	**101 (-39%)**

NEKTAR **Complete resolution of hemoptysis with the decrease in pulmonary lesions**

ASCO 2017 32

Robust Increase in Tumor Infiltrating Immune Cells in RCC Patients



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ASCO 2017 33

NKTR-214 + Nivolumab Combination: Conclusions to Date

- Enrolling patients to dose escalation of PIVOT 02 to identify the RP2D
  - Last dosing cohort NKTR-214 0.009 mg/kg q3w + nivo 360 mg q3w
- Favorable safety profile and well tolerated combination
  - Low-grade AEs are predictable, manageable and of short duration
  - No DLTs and grade 3 or above TRAEs
  - No immune-related AEs were observed to date (e.g. colitis, dermatitis, hepatitis, pneumonitis, adrenal insufficiency)
- Clinical benefit observed early with NKTR-214 and Nivolumab
  - Responses in 3/5 patients with Stage IV Melanoma (1 CR, 2 PR)
    - Time to responses: 6 weeks, 7 weeks, 20 weeks
  - PR in RCC patient who progressed on prior TKI (PD-L1 negative)
  - Responses in 3/4 RCC IO naïve patients with SD on NKTR-214 who received sequential therapy with Nivolumab
  - Total time on treatment to reach response is much shorter with concurrent dosing
- On treatment biopsies show robust elevation in immune cell frequency and activation
- Anticipate enrollment to expansion cohorts in 3Q 2017

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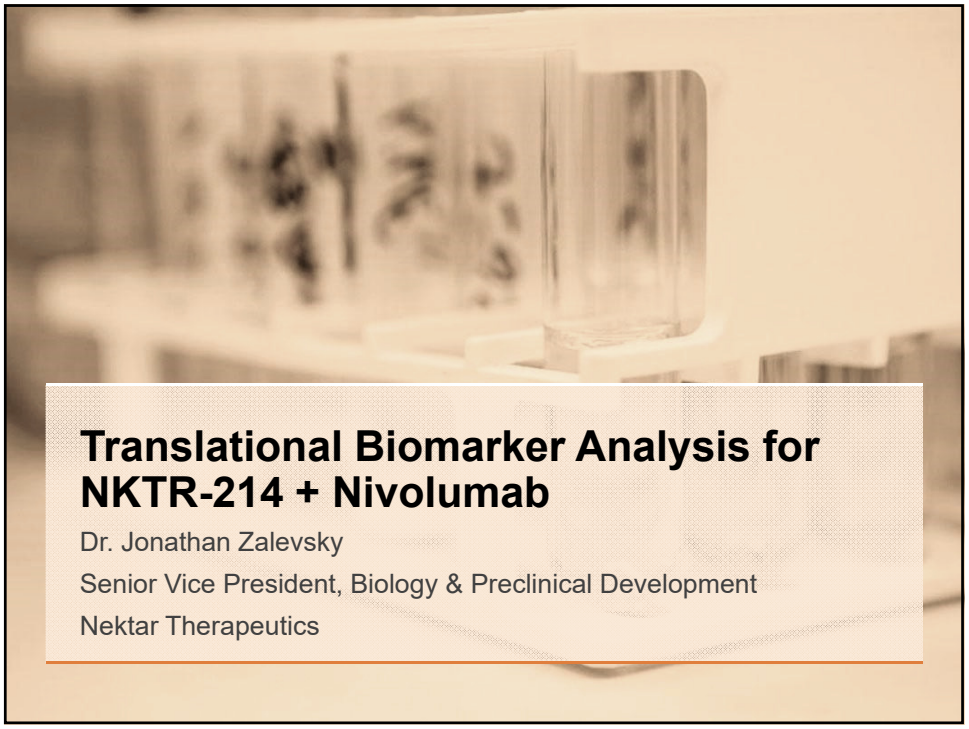

Biomarker Program Overview

- Understanding the human immunology obtained from NKTR-214 monotherapy and NKTR-214 + Nivolumab studies
  - Does Nivolumab impact the primary PK/PD relationship of NKTR-214?
  - Is there a measurable immunological difference between NKTR-214 and NKTR-214 + Nivolumab?
  - Which biomarkers are specific to NKTR-214 or NKTR-214 + Nivolumab?
- Early evaluation (03Jun2017) includes assessment of:
  - Primary PK/PD
  - Flow cytometry analysis of peripheral blood cells
  - Flow cytometry of serial tumor biopsy samples

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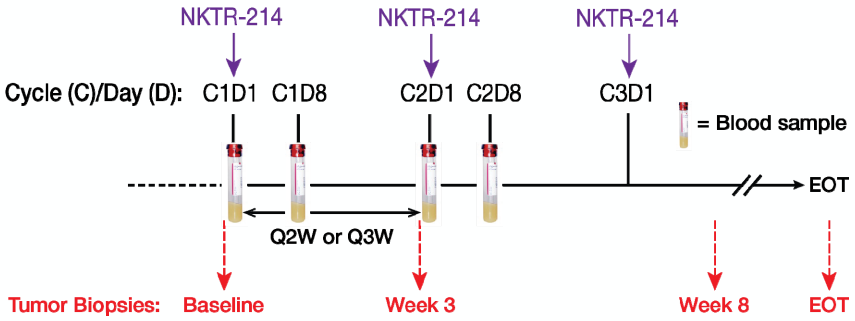
Blood and Tumor Biopsy Analysis



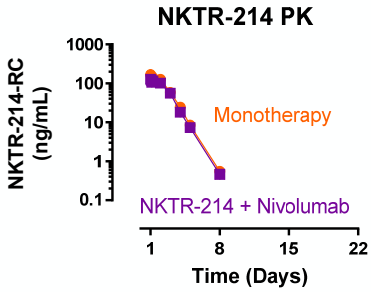
Tumor Analysis:
- Fresh TIL analysis by flow cytometry
- IHC
- T cell receptor gene sequencing
- Gene expression analysis

Blood Analysis:
- Flow cytometry
- Cytokines
- PK
- PD (sCD25, lymphocytes)

NEKTAR EOT, end of treatment.

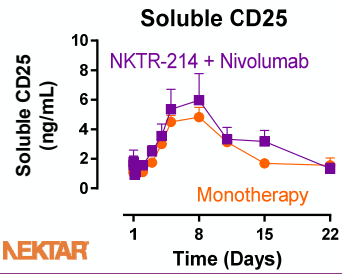
ASCO 2017 37

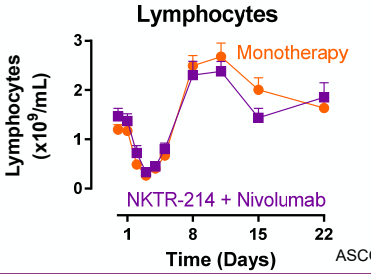
Nivolumab Does Not Change the PK/PD Relationship for NKTR-214



0.006 mg/kg NKTR-214
Mean ± Standard Error

Monotherapy (N=15)
NKTR-214 + Nivolumab (N=10)





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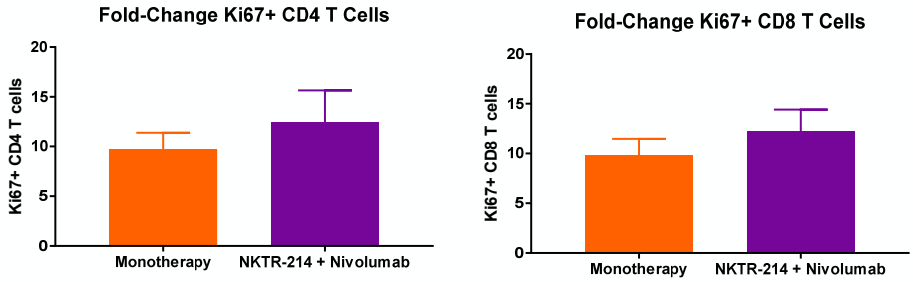
T Cell Proliferation is Primarily Driven by NKTR-214 in Blood



NKTR-214 Monotherapy (N=19)
NKTR-214 + Nivolumab (N=4)

Data is expressed as fold-change %Ki67+ T cells on C1D8 ÷ %Ki67+ T cells on C1D1. In some cases where a C1D1 specimen was not available (N=3 in monotherapy and N=1 in NKTR-214 + Nivolumab), average baseline values were calculated and used for C1D1 values. Data is plotted as Mean ± Standard Error.

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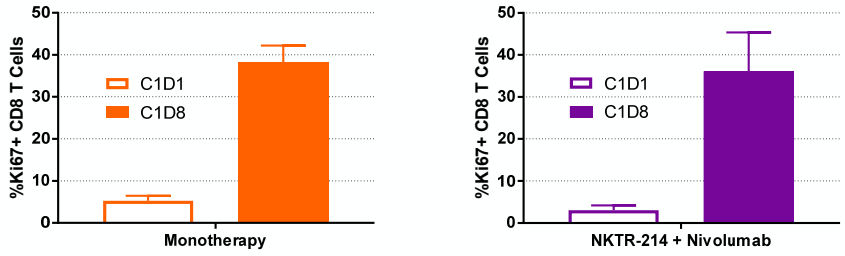
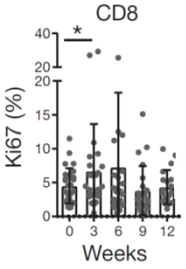
NKTR-214 Promotes T Cell Invigoration in Blood





T-cell invigoration to tumour burden ratio associated with anti-PD-1 response

Alexander C. Huang[1,2,3,4], Michael A. Postow[5,6,*], Robert J. Orlowski[1,2,3,4,*], Rosemarie Mick[3,4,7], Bertram Bengsch[1,2,4,8], Sasikanth Manne[1,2,8], Wei Xu[1,3], Shannon Harmon[1,3], Josephine R. Giles[2,4,8], Brandon Wenz[1,3], Matthew Adamow[9], Deborah Kuk[10], Katherine S. Panageas[10], Cristina Carrera[11], Phillip Wong[4,12], Felix Quagliarello[1,8], Bradley Wubbenhorst[1,3], Kurt D'Andrea[1,3], Kristen E. Pauken[1,8], Ramin S. Herati[1,2,3], Ryan P. Staupe[1,8], Jason M. Schenkel[13], Suzanne McGettigan[1,3], Shawn Kothari[1], Sangeeth M. George[2,4,8], Robert H. Vonderheide[1,2,3,4], Ravi K. Amaravadi[1,2], Giorgos C. Karakousis[3,4], Lynn M. Schuchter[1,2], Xiaowei Xu[3,10], Katherine L. Nathanson[1,3,4], Jedd D. Wolchok[3,12], Tara C. Gangadhar[1,2]§ & E. John Wherry[2,3,4,8]§

doi:10.1038/nature22079

Data is expressed as %Ki67+ T cells on C1D1 and C1D8 plotted as Mean ± Standard Error.

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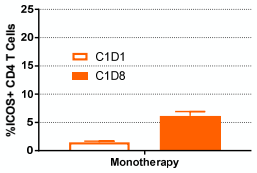
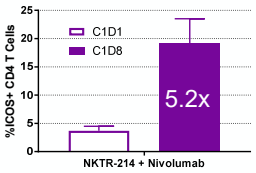
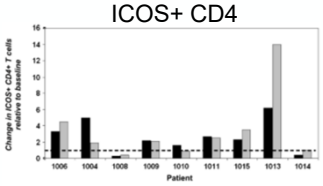
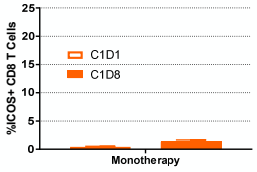
NKTR-214 + Nivolumab Promotes Expansion of ICOS+ T Cells in Blood

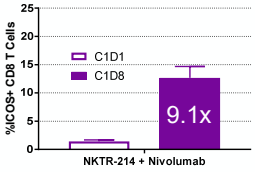




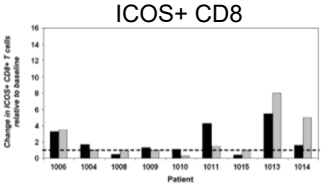
ICOS+ CD4







ICOS+ CD8




Cancer Therapy: Clinical

Tremelimumab in Combination with Exemestane in Patients with Advanced Breast Cancer and Treatment-Associated Modulation of Inducible Costimulator Expression on Patient T Cells

Data is expressed as %ICOS+ T cells on C1D1 and C1D8. N=17 C1D1 & N=21 C1D8 for monotherapy, N=3 C1D1 & N=4 C1D8. Results are plotted as Mean ± Standard Error. Numbers in the columns in white text represent fold-change increase over baseline.

Similar results observed with ipilimumab

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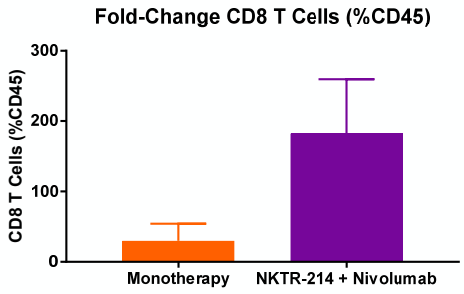
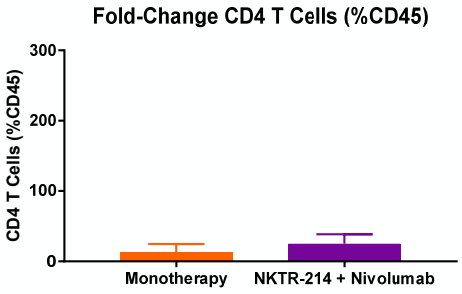
NKTR-214 + Nivolumab Drives Large Increase in Tumor Infiltrating Immune Cells





NKTR-214 Monotherapy (N=14)
NKTR-214 + Nivolumab (N=5)

Data is expressed as fold-change CD45+ cells, or CD4 T cells (of CD45), or CD8 T cells (of CD45) treatment ÷ baseline. Data is plotted as Mean ± Standard Error. For monotherapy, CD8 T Cells shown for monotherapy are for the q3w dose cohorts (n=10) and the CD4 T Cells shown for monotherapy includes q3w and q2w dose cohorts.

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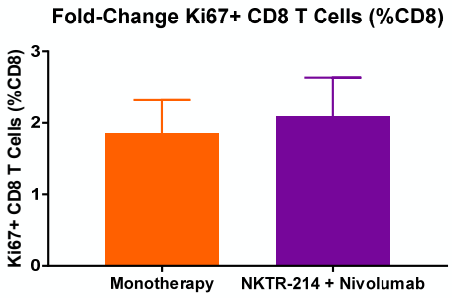
NKTR-214 Promotes CD8 T Cell Proliferation in Tumor



NKTR-214 Monotherapy (N=11)
NKTR-214 + Nivolumab (N=4)

Data is expressed as fold-change Ki67+ CD8 T cells treatment ÷ baseline. Data is plotted as Mean ± Standard Error.

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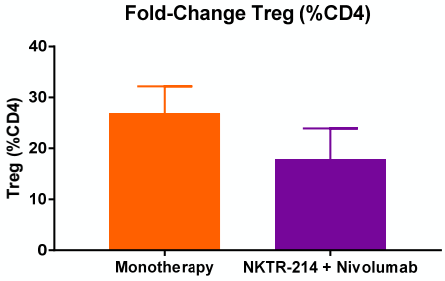
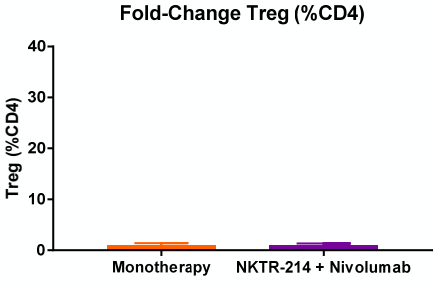
Monotherapy v. Combination: Comparison of CD4 Tregs in Blood and Tumor

Blood



NKTR-214 Monotherapy (N=21)
NKTR-214 + Nivolumab (N=4)

Tumor



NKTR-214 Monotherapy (N=9)
NKTR-214 + Nivolumab (N=4)

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Data is expressed as fold-change Tregs (CD3+CD4+CD25+FoxP3+) treatment ÷ baseline. Data is plotted as Mean ± Standard Error. For monotherapy the data includes both q3w and q2w regimens.

Biomarker Conclusions

- Does Nivolumab impact the primary PK/PD relationship of NKTR-214?
  - No
    - No effect on PK, sCD25, or lymphocyte levels
- Is there a measurable immunological difference between NKTR-214 and NKTR-214 + Nivolumab?
  - Yes
    - ICOS+ cells in blood and massive immune cell infiltrates, especially CD8 T cells in tumors
- Which biomarkers are specific to NKTR-214 or NKTR-214 + Nivolumab?
  - Proliferation (Ki67) appears to be driven by NKTR-214 in blood and tumor
  - ICOS+ CD4 and CD8 T cells are greatly expended by NKTR-214 + Nivolumab
  - Treg levels, elevation in blood and no change in tumor, appear to be driven by NKTR-214

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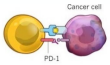
NKTR-214: Additional Clinical Development Programs in 2H 2017/1H 2018

Checkpoint Inhibitors

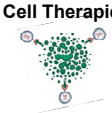


- **Start triplet combination of NKTR-214 with anti-PD-1 and anti-CTLA-4 agents**
- **Start Phase 1 trial of NKTR-214 and TECENTRIQ**
- **Start IST in Sarcoma with NKTR-214 and Opdivo® at Memorial Sloan Kettering and MD Anderson**

TLR Agonist

- **Start Phase 1 trial of NKTR-214 and NKTR-262 (TLR Agonist 7/8)**

Cell Therapies



- **Start Phase 1/2 trial of NKTR-214 in combination with Endogenous T Cell regimen in NSCLC patients (with MDA)**

Vaccines

- **Preclinical studies underway with NKTR-214 and vaccines with potential for clinical advancement in 2018**

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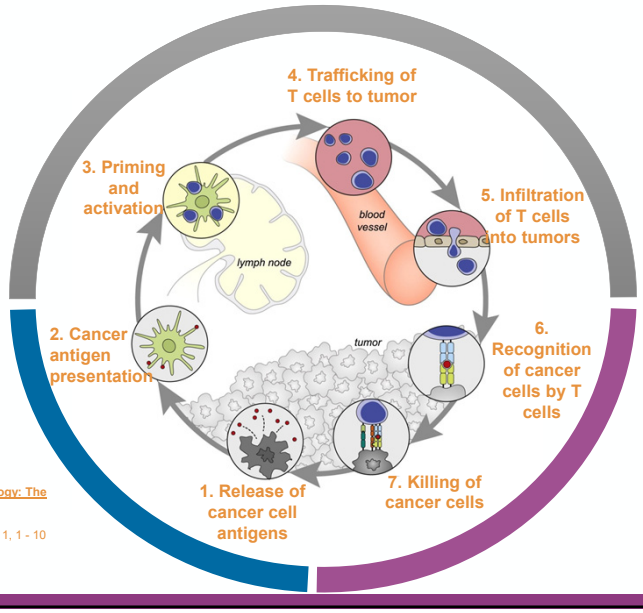
ASCO 2017 46

The Immunity Cycle and Multiple Points of Intervention for I-O Therapies



Source:
Oncology Meets Immunology: The Cancer-Immunity Cycle
Chen and Mellman
Immunity, Volume 39, Issue 1, 1 - 10

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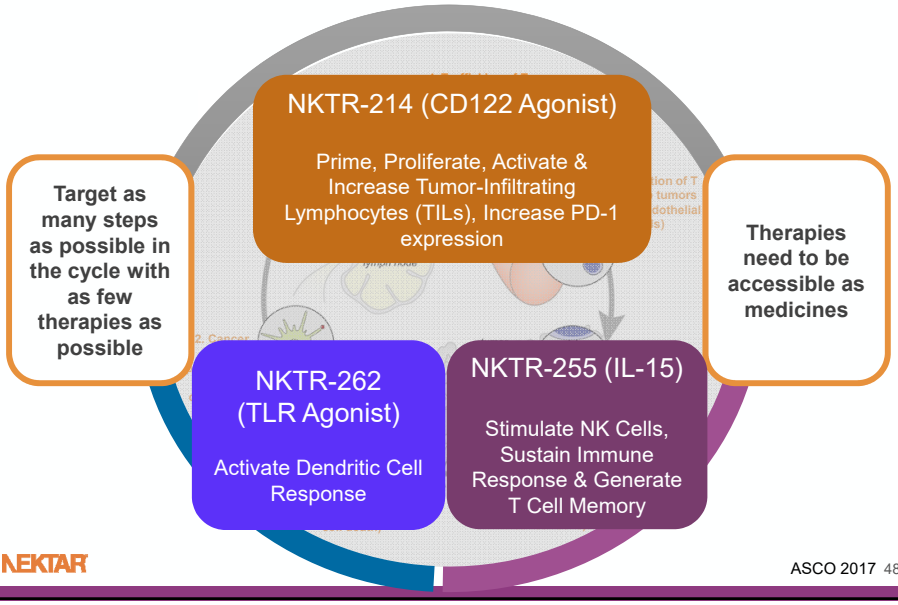
Nektar's Immuno-Oncology Strategy to Create Therapies that Cover the Immunity Cycle



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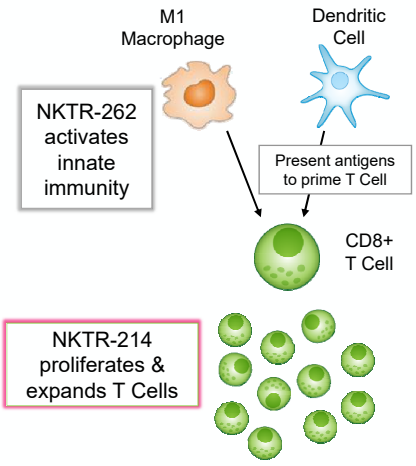
NKTR-262: Adding a Unique Intratumoral TLR Agonist to Nektar's Immuno-Oncology Portfolio

- **TLR agonists activate innate immunity, myeloid cell response and increase tumor antigen presentation**
  - **Creates tumor-suppressing micro-environment by mimicking local infection**
- **Nektar technology optimizes specific abscopal effect in tumors without systemic exposure of TLR agonist**
- **NKTR-262 designed to be highly synergistic with NKTR-214**
- **NKTR-262 with NKTR-214 represent a novel, wholly-owned combination regimen in immuno-oncology**



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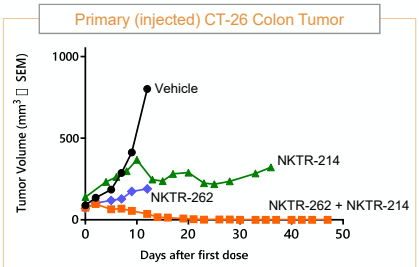
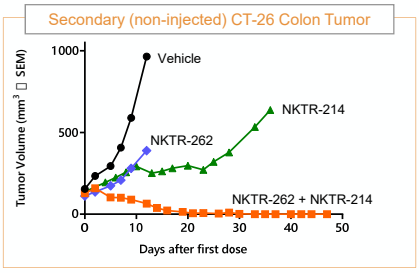
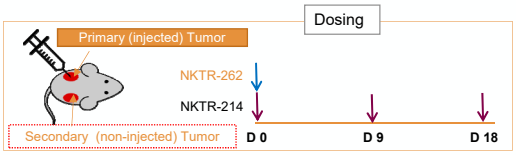
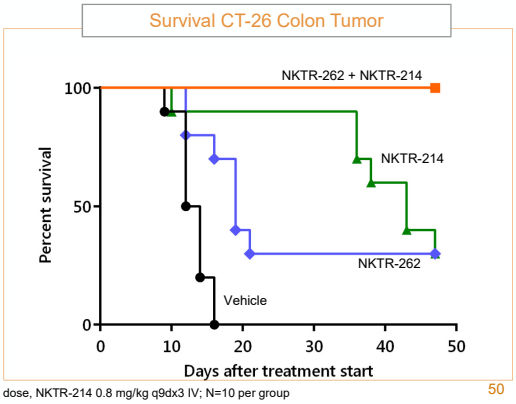
Complete Regression and Abscopal Effect with Combination of NKTR-262 and NKTR-214

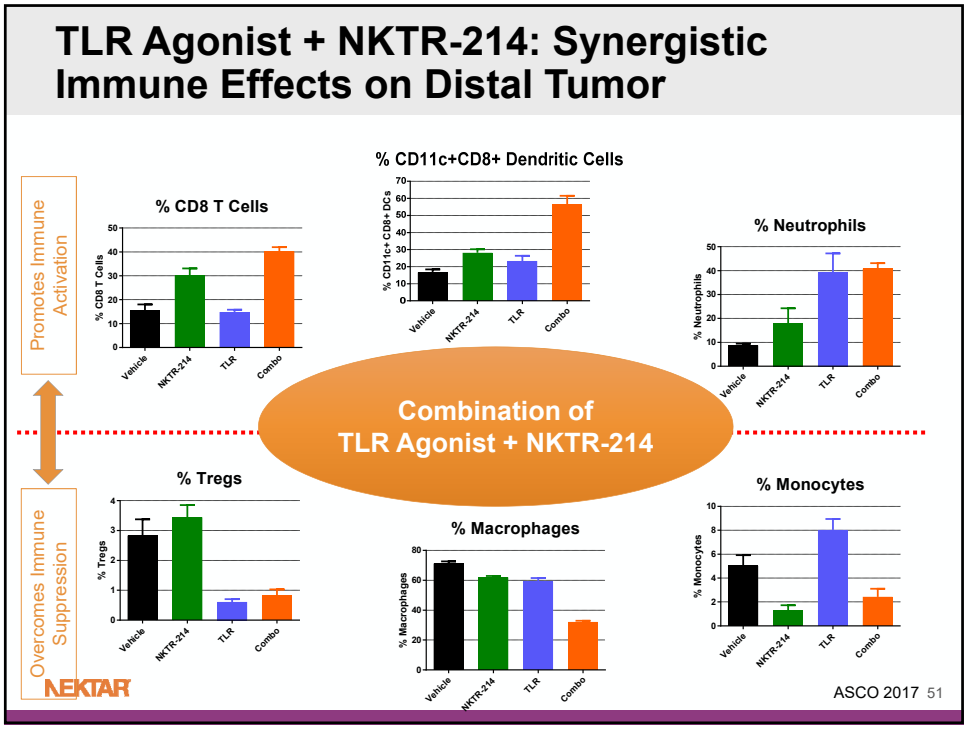








NEKTAR NKTR-262 0.8 mg in 40 µL volume given in a single IT dose, NKTR-214 0.8 mg/kg q9dx3 IV; N=10 per group 50


TLR Agonist + NKTR-214: Synergistic Immune Effects on Distal Tumor
Promotes Immune Activation
Overcomes Immune Suppression
% CD8 T Cells
% CD11c+CD8+ Dendritic Cells
% Neutrophils
% Tregs
% Macrophages
% Monocytes
Vehicle
NKTR-214
TLR
Combo
Combination of TLR Agonist + NKTR-214
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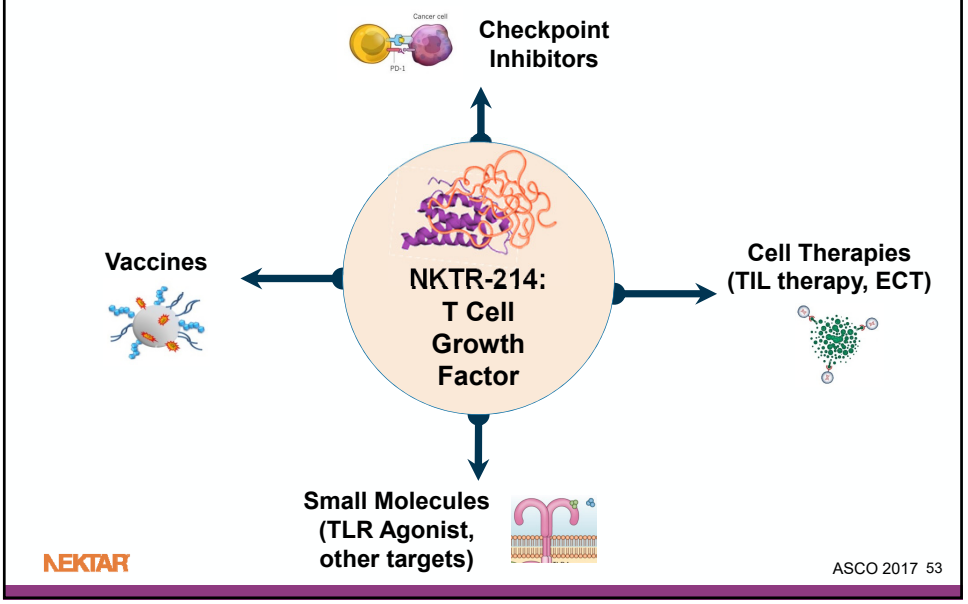
NKTR-214 Development Program
Dr. Mary Tagliaferri
Senior Vice President, Clinical Development
Nektar Therapeutics

NKTR-214 Provides A Central Mechanism to Combine with Multiple Modalities in Immuno-Oncology



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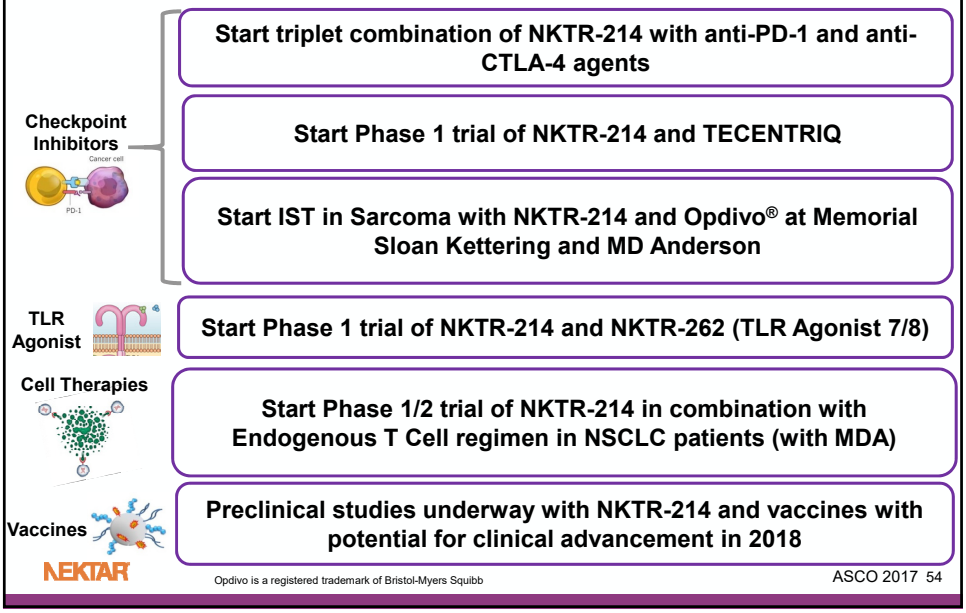
NKTR-214: Additional Clinical Development Programs in 2H 2017/1H 2018



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PROPEL Program: NKTR-214 plus TECENTRIQ® (atezolizumab)

PROPEL

Phase 1 Dose Escalation
(on label indications)
N= 20-30

NSCLC
2nd line – metastatic disease with progression following platinum regimen or targeted therapy

Urothelial Carcinoma
2nd line locally advanced or metastatic disease with progression following platinum regimen

- NKTR-214 in combination with Roche's anti-PD-L1 agent, atezolizumab
- Nektar sponsored program supporting checkpoint inhibitor combination strategy
- Study is expected to initiate mid-2017

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ASCO 2017 55

Investigator Initiated Study: Sarcoma

Phase 2 Study Proposed by Dr. Sandra D'Angelo (MSKCC) and Tony Conley (MD Anderson)
- Both investigators with proven track record of high enrollment to IO studies in sarcoma
- Initiate study with RP2D of NKTR-214 plus Opdivo
- Can amend proposal to evaluate triplet regimen

Eligibility: At least one prior line of systemic therapy

Basket Study: 2 Bone Sarcomas and 4 Soft Tissue Sarcomas

Endpoints
- Safety and tolerability
- PFS at 24 weeks, median PFS, OS at 12 months and median OS
- RECIST 1.1
- Radiographic scans every 8 weeks
- Measure biomarkers in blood and tumor

Osteosarcoma N=10

Chondrosarcoma N=10

Undifferentiated pleomorphic sarcoma/malignant fibrous histiosarcoma N=10

Angiosarcoma N=10

Dedifferentiated/ pleomorphic liposarcoma N=10

Leiomyosarcoma N=10

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ASCO 2017 56

Takeda and Nektar Research Collaboration

- Takeda and Nektar collaborating on combining NKTR-214 with five Takeda oncology compounds
- Collaboration will explore five targeted mechanisms in Takeda's oncology portfolio including:
  - SYK-inhibitor
  - Proteasome inhibitor
- Combinations will be tested in preclinical models of lymphoma, melanoma and colorectal cancer
- Takeda and Nektar will share costs and each will maintain global commercial rights to respective drugs/candidates

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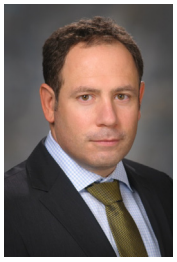
ASCO 2017 57

Q&A Panel



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Assistant Professor of Melanoma Medical Oncology MD Anderson

Dr. Michael Hurwitz

Assistant Professor of Medicine, Medical Oncology Yale Cancer Center

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Professor of Genitourinary Medical Oncology & Deputy Department Chair of the Department of Genitourinary Medical Oncology MD Anderson

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ASCO 2017 58

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- Brendan Curti, MD

New York University
- Daniel Cho, MD

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Seattle Cancer Center
- Scott Tycodi, MD

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