Business Update Call

PRESENTATION DETAILS
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CORPORATE PARTICIPANTS
Dr. Thomas R. Cannell, Sesen Bio, Inc. – President, CEO & Director
Erin Clark, Sesen Bio, Inc. – VP of Corporate Strategy & IR

CONFERENCE CALL PARTICIPANTS
Christopher Lawrence Howerton, Jeffries LLC, Research Division – Equity Analyst
John Newman, Canaccord Genuity Corp., Research Division – Principal & Senior Healthcare Analyst
Swayampakula Ramakanth, H.C. Wainwright & Co, LLC, Research Division – MD of Equity Research & Senior Healthcare Analyst

TELECONFERENCE REPLAY
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BUSINESS UPDATE CALL

Operator: Good day and thank you for standing by. Welcome to the Sesen Bio Business Update. At this time, all participants are in listen-only mode. After the speakers' presentation, there will be a question and-answer session. Please be advised that today's conference is being recorded.

(Operator Instructions)

I would now like to hand the conference over to your speaker today, Erin Clark, VP of Corporate Strategy and Investor Relations. Please go ahead.

Erin Clark: Thank you, and good morning, everyone. Thanks for joining us on today's call. With me today is Dr. Thomas Cannell, President and Chief Executive Officer, to discuss the Complete Response Letter (CRL) we received last Friday, August 13, from the FDA.

I would like to remind you that today's discussion will include forward-looking statements related to the company's current plans and expectations, which are subject to risks and uncertainties. Actual results may differ materially due to various factors, including those described in Sesen Bio's most recent annual report on Form 10-K, quarterly report on form 10-Q and other SEC filings. These statements represent Sesen Bio's views as of this call and should not be relied upon as of any future date. Sesen Bio undertakes no obligation to publicly update these forward-looking statements.

With that, I will turn the call over to Tom. Tom?

Dr. Thomas Cannell: Thank you Erin, and good morning everyone.

As Erin mentioned, on Friday we received a Complete Response Letter from the FDA. In the letter, the FDA determined that it cannot approve the BLA (Biologics License Application) for Vicineum in its present form and the agency has provided recommendations specific to additional clinical and statistical data and analyses and CMC (Chemistry, Manufacturing and Controls) issues.

We are deeply disappointed by this unexpected result, and most importantly, we are disappointed for patients suffering from BCG-unresponsive non-muscle invasive bladder cancer (NMIBC).

We remain dedicated to our mission to save and improve the lives of patients by developing new treatment options, and we intend to work closely with the FDA to understand next steps.

We plan to send a request to the FDA this week for a Type A meeting to discuss next steps, and we expect this meeting to take place in the fourth quarter of this year.

There will be two primary topics for our Type A meeting.

First, we will discuss with the FDA its request for additional clinical and statistical data. It appears that we will need to do a clinical trial to provide the additional efficacy and safety data necessary for the FDA to assess the benefit-risk profile, which is the basis for approval.

Obviously, this is a very surprising turn of events, given that no deficiencies, including any substantive or major deficiencies, in our clinical data were raised by the FDA at the Late-Cycle Meeting on July 13th. In addition, at the Late-Cycle Meeting, the FDA indicated that an additional clinical trial was not identified as necessary at such time, an Advisory Committee meeting (Adcom) was not required, and there were no discipline review letters. And last Monday, we reached agreement with the FDA on the final wording of the USPI – or product label – for Vicineum.

In the February 2018 guidance, the FDA states that a single-arm clinical trial with complete response rate and duration of response as the primary endpoint can provide primary evidence of effectiveness to support a marketing application. However, in that guidance, the FDA makes it clear that an additional trial may be necessary.

So, in our Type A meeting, we need to confirm several things with the Agency. First, we need to confirm that the primary endpoints should be Complete Response and Duration of Response. We will confirm that to have sufficient sample size and statistical power, the trial will need to be 90-100 patients, as described in the FDA guidance. We will confirm that it needs be a 12-month trial, and we will confirm the study population. Once we get this feedback from the FDA, we will provide you with guidance on this topic as quickly and transparently as possible.

Next, I'd like to turn to the second topic for the Type A meeting with the FDA, which is CMC.

As previously disclosed, at the Late-Cycle Meeting, the Company and the FDA discussed questions related to manufacturing facility inspections, product quality information requests, and additional information related to CMC.

In the CRL, the FDA raised other questions about drug substance and drug product manufacturing, cell bank, characterization, resin reuse, reference standards, methods, specifications, stability, and microbiology.

So, we also have a lot to discuss at the Type A meeting about the Agency's CMC concerns.

I will add that we will need to better understand the Agency's concerns in the context that if we do another clinical trial, we will be able to use drug substance and drug product from full-scale GMP commercial runs, and that should obviate the need to demonstrate analytical comparability, which was a large part of this submission.

Separately, we are planning a meeting with the FDA to discuss the regulatory path forward for our head and neck program, and then we will need to consider the timing of the head and neck trial relative to the NMIBC trial.

Finally, I will remind you that as of June 30, 2021, the Company had $151.1 million in cash, cash equivalents and restricted cash. We believe we have the capital to do what is necessary to resubmit the BLA, and gain approval of a product that has the potential to save and improve the lives of patients.

With that, Shannon, we will turn it over for questions.

QUESTIONS AND ANSWERS

Operator: Thank you. (Operator Instructions). Our first question comes from John Newman with Canaccord.

Question – John Newman: Thanks for holding the call and giving us some more insight on the FDA decision. I am wondering if you can start by giving us your view on the situation at the FDA at the moment. It seems like, especially since the beginning of June, the agency has taken a more conservative approach across the board with many different types of applications. Obviously, that may have had an effect on Sesen. Just curious if you can give us your views on that, given that you spent a lot of time at Merck and saw lots of applications go to the FDA.

Answer – Dr. Thomas Cannell: Thanks John. First, I want to say I have tremendous respect for the FDA. As I've said many times, within the FDA I've never seen a stronger review team than the team we've worked with for this review from the Division of Oncology 1 (DO1). They are talented and dedicated public servants. I am proud to engage with them, and I am always amazed at how well-prepared they are and how smart they are. So that's been a real pleasure. If we do a head and neck study, we need to move to the Division of Oncology 2 (DO2) for that review, so we will have get to know a whole new team. But so far we have been very impressed by the review team.

Your question, though, is at the macro-level. And I would say at the macro-level, there is an unprecedented level of scrutiny at the FDA – maybe the most scrutiny we have seen since the early 1960s. First of all, there was the approval of the Alzheimer's drug in June despite a very negative Advisory Committee (Adcom) vote. And at least three of the Adcom members stepped down. That triggered an independent review by the Office of Inspector General of the FDA, which is very unusual. There has been tremendously heavy, toxic media coverage. And still there is no permanent FDA commissioner and several senior positions are not filled, so there is a kind of leadership vacuum. Here the Agency is with all that going on, plus the unbelievable pressure of trying to work in a pandemic with an extreme focus on COVID vaccines and treatment.

They are working in a white-hot light. And it is easy to see why they might be, as you say, more conservative or risk averse. We saw an analysis recently – maybe, John, your team can confirm it – but from January to early June, only about 15% percent of the FDA's decisions resulted in a Complete Response Letter. But from early June until now, roughly 50% of FDA decisions have been complete response letters. When you are under pressure, the risk-averse or the safer strategy, will always be to punt the ball down the field and to ask for more data.

So we are requesting a Type A meeting. We worked on it all weekend to get it out as soon as we can. That meeting will be in the fourth quarter, as I mentioned. And I am hopeful that things have calmed down by then. I still think there are a lot of potential solutions. That is our overall assessment. Is there a follow-up question to that, John?

Question – John Newman: I still have one follow-up question that is more specific to Sesen, but that does answer the first question, thank you. The follow-up question is – I am wondering if you could talk a bit more about the type of additional clinical study the Agency might ask you for. Have they asked for a randomized study or are they simply asking for a larger number of patients with a similar study design?

Answer – Dr. Thomas Cannell: Well, it is a really good question. The short answer is we don't know. That is why we have been developing all of our questions for the Type A meeting request.

If they just want a new registration trial, we go back to the February 2018 guidance. It is going to be 90-100 patients; it is going to be powered for Complete Response and Duration of Response; and it is going to need to be 12 months of data. But we have done that trial.

So, maybe they want us to do something like the confirmatory trial protocol synopsis we worked on when we thought we were going to get Accelerated Approval and go into the less-than-adequate BCG population, or maybe even primary or first-line treatment. And that could be with or without checkpoint inhibitors as an add-on therapy. So, we need to agree with the Agency on the size, scope, duration, and the patient type.

The interesting thing is, do we run the head and neck trial in parallel? Is there some way to collect the safety data to allow us to shorten the timeline?

The other thing is that there are other trials going on. There is a trial in China with our partner Qilu. There is a trial at the National Cancer Institute (NCI), a very well-run trial. Is there anything we can do there to collect those data? I think those are all possible sources of discussion.

For now, I am guiding clinical trial. I want to take the conservative approach, but I am hoping we can come up with other possible solutions when we meet with the FDA in the fourth quarter.

John Newman: Great, thanks for answering my questions, Tom.

Operator: Our next question comes from Chris Howerton with Jefferies. Your line is open.

Question – Chris Howerton: Great, thanks for taking the questions and appreciate you hosting the call just as John said. Tom, I just wanted to confirm or maybe just hear again what you were saying with respect to the trial design. Are you going to propose a trial similar to what you had previously proposed for the quote-unquote confirmatory trial, or is there a slightly different design in mind?

And the second one – if you could help us better understand what the different outcomes are for CMC. In one case you were mentioning that the bioequivalence would be obviated in the case where you have to do another clinical trial. But what are some of the other outcomes that you may have with respect to that side of the operations?

Answer – Dr. Thomas Cannell: Yeah, thanks Chris. First of all, on trial design, we are going to talk about the patient population, size, statistical power, duration and primary endpoints they want. We are assuming it is a single-arm trial because there is still no good comparator in the market, but do they want a controlled study or a single-arm trial? We really want to come to an agreement on the protocol synopsis at that Type A meeting in the fourth quarter.

Regarding CMC, as we have said all along and everybody knows, we manufactured our own drug substance and drug product at our Winnipeg site for Phase 1, Phase 2 and Phase 3. We realize that the Winnipeg site does not have capacity for global demand – it has just a single, little bioreactor – so we partnered with Fuji, Baxter, and later Qilu to provide drug substance and drug product.

But, when you do that, it creates a huge additional component to Module 3 of the BLA submission because you have to prove that the drug you used in clinical trials (with the safety and efficacy results you are presenting) is almost perfectly identical to the drug being manufactured by your new commercial partners. That is kind of tough because the science with

all those partners gets more sophisticated; they are so good at manufacturing, but they have to manufacture the identical drug substance and drug product as we did in Winnipeg.

Now, if we move forward, we have already have lots manufactured. They are sitting there in vials. They have gone through drug substance and drug product packaging, fill and finish, and we would use that product for our clinical trials. So, it seems to obviate the need for analytical comparability. That greatly simplifies Module 3. Now, it is just three PPQ runs. You just have to show that each run is consistent with the last one, and that it is the right kind of quality and that you meet all of the specs. So, it may really lighten the load on Fuji and Baxter for the resubmission, and that could help to accelerate timelines.

Did you have a follow up question to those, Chris, or anything else on those topics?

Chris Howerton: No, I think I am good on those topics. But I did have a follow-up. If you could remind us of the status of the head and neck trial and the goal of that? And then, as perhaps Vicineum has to take a pause in bladder cancer for a few months, what else is in the pipeline that might be coming up in the next year or so?

Answer – Dr. Thomas Cannell: Yeah, thanks. We have had such a laser focus on the bladder program and getting back to the FDA, but it is a really good question. Obviously, we want to get this product approved, first and foremost, for NMIBC. Once we do that, we want to move into the earlier treatment, the less-than-adequate BCG population. Then, as we have said, we eventually want to move into first line therapy with or without checkpoint inhibitors. So, there is that.

The next is head and neck. As you know, we have Phase 1 and Phase 2 data, and head and neck remains an area of huge unmet need. Our next step is probably a Type B meeting with the FDA to discuss the study protocol for a final registration trial. We will just need to see how that runs in parallel with the bladder program.

The next thing in our pipeline – we have these IV fusion proteins. As you know, Vicineum is only to be given intravesically or intratumorally, but we have other proteins in the pipeline, what we call our deBouganin program, that has promising pre-clinical data that we believe could be appropriate IV drugs, and that would allow us to target other tumor types. We are anxious to get that program into the clinic, but we have not guided on timing.

We also of course have the IL-6 program for ophthalmic conditions such as diabetic macular edema. Roche is running those clinical trials. Phase 1 is right on track. As you know, we could be eligible for up to $240 million in milestones as well as potential royalties, and there are buyout options as well. It is a very promising IL-6 monoclonal antibody, and as you probably noticed in our last 10-Q, when we enter Phase 2, potentially next year, there is a $20 million milestone payment due. That is a nice source of non-dilutive capital as you are doing other things like clinical trials.

Finally, there is the Imaging Agent, which allows surgeons to clearly visualize the edge of the tumor to help ensure clean and clear margins. That is with our partner LUMC (Leiden University Medical Center). We have promising Phase 1 and Phase 2 results, and we are anxious to get the next trial going as well.

So, there are many potential sources of value. We want to have a laser focus putting first things first, but we are really trying to be conscious of all the ways that we can create value for patients and shareholders.

Chris Howerton: Excellent, thank you very much Tom, and again, appreciate you taking the questions.

Thomas Cannell: Thanks Chris.

Operator: Our next question comes from RK with HC Wainwright. Your line is open.

Question – Swayampakula Ramakanth: Good morning, Tom. I appreciate you giving us all this additional time to discuss the CRL. I am sure after diligently going through everything with the FDA you are disappointed about this decision. Did the FDA in the CRL specify anything regarding the material that was used in your clinical trial? Did you get any indication that because it was from the Winnipeg facility that they need you to do another trial? Anything or any indication at all on that?

Answer – Dr. Thomas Cannell: No, not to that level of detail. As I mentioned, they raised topics such as drug substance and drug product manufacturing, cell banks, characterization, but we did not get any of the data on how it looks from analytical comparability and how they thought each of those parameters against specs compared from clinical source to commercial source. That is part of what we will put together and talk to them about.

The other question is – if we do another trial, do we just flip back to a normal BLA Module 3, which is just about showing the quality and hitting specs at your core manufacturing sites? So that is part of what we hope to learn in the fourth quarter.

Question – Swayampakula Ramakanth: Okay. If you can get a good decision on the Type A meeting, how quickly can you get back into the clinic, and how much lead time would you need?

Answer – Dr. Thomas Cannell: That is a really good question. It kind of speaks to guidance and people trying to update their models. Right now, and again, I want to guide conservatively, until we will learn more: if it is a 12 month trial, that will have an enrollment period, then you run a 12 month trial, then you get your BLA back in, and then that would probably be 2023. Then the FDA has a 180-day window to respond to BLAs that are submitted after a CRL. That is what we know right now. If we have to do a clinical trial, we would probably be projecting resubmitting the BLA in 2023.

Swayampakula Ramakanth: Okay. Thank you, Tom, and good luck.

Thomas Cannell: Thank you, RK.

Operator: This concludes the Question & Answer session. I would now like to turn the call back over to Dr. Thomas Cannell for closing remarks.

Thomas Cannell: In summary, we are disappointed by this unexpected outcome, and most importantly, we are disappointed for patients suffering from bladder cancer.

We remain dedicated to our mission to help save and improve the lives of patients, and we intend to work closely with the FDA to understand next steps. We will continue to update you regularly as we gain more information and work to better understand the FDA guidance.