BerGenBio

Q4 and Full Year 2019

HIGHLIGHTS REPORT AND FINANCIALS

11th February 2020

Richard Godfrey, CEO
Rune Skeie, CFO

BerGenBio ASA
Jonas Lies vie 91, Bergen, 5009, Norway
www.bergenbio.com
IR contact: IR @bergenbio.com

Forward Looking statements

Certain statements contained in this presentation constitute forward-looking statements. Forward-looking statements are statements that are not historical facts and they can be identified by the use of forward-looking terminology, including the words "anticipate", "believe", "intend", "estimate", "expect", "will", "may", "should" and words of similar meaning. By their nature, forward-looking statements involve a number of risks, uncertainties and assumptions that could cause actual results or events to differ materially from those expressed or implied by the forward-looking statements. Accordingly, no assurance is given that such forward-looking statements will prove to have been correct. They speak only as at the date of the presentation and no representation or warranty, expressed or implied, is made by BerGenBio ASA or its affiliates ("BerGenBio"), or by any of their respective members, directors, officers or employees that any of these forward-looking statements or forecasts will come to pass or that any forecast result will be achieved and you are cautioned not to place any undue influence on any forward-looking statement. BerGenBio is making no representation or warranty, expressed or implied, as to the accuracy, reliability or completeness of this presentation, and neither BerGenBio nor any of its directors, officers or employees will have any liability to you or any other person resulting from the use of this presentation.

Copyright of all published material, including photographs, drawings and images in this presentation remain with BerGenBio and relevant third parties, as appropriate. Consequently, no reproduction in any form of the presentation, or parts thereof, is permitted without the prior written permission, and only with appropriate acknowledgements.

BerGenBio corporate over view

World leaders in understanding AXL biology

AXL tyrosine kinase is a novel drug target that mediates immune evasion, therapy resistance & metastasis

AXL mediates EMT, stabilises M2 macrophages, immune suppressive dendritic cells and blocks T-cell & NK cell activity

AXL inhibitors – potential cornerstone of cancer therapy

Pipeline opportunities in multiple cancers and fibrosis

3 selective AXL inhibitors in clinical development

Bemcentinib (oral once a day pill)
Tilvestamab (mAb), ADCT601* (ADC)

Phase II: Monotherapy and combos with, CPI, targeted & chemo

Biomarker correlation, parallel CDx development

Bemcentinib clinical development focus
AML (monotherapy), **AML** (chemo-combo)
NSCLC (KEYTRUDA combo)

Resourced to deliver milestones

Listed on Oslo Børs: BGBIO

Clinical trial collaborations with Merck and leading academic centres EU & USA

38 staff at two locations:
HQ & R&D in Bergen, Norway;
Clinical Development in Oxford, UK

Cash: Q4'19 + Jan'20 PIPE NOK470m ($53m)

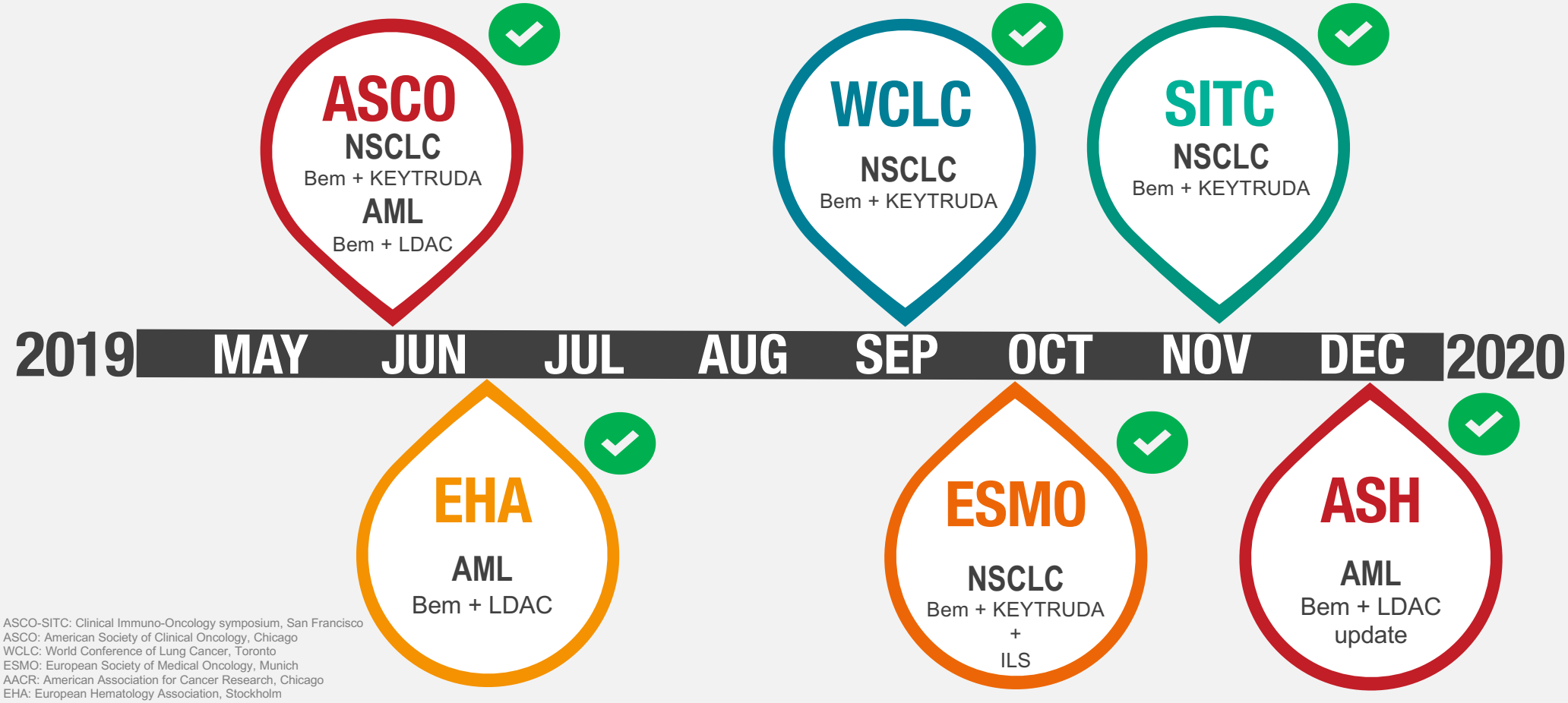
*AXL antibody out licensed to ADC Therapeutics SA

Q4 2019 and post-period highlights

Oct 2019	FDA Fast Track designation received for bemcentinib in relapse **AML**
Nov 2019	Primary & Secondary endpoint of ORR met in Phase II 2L **NSCLC** (cohort A) in combination with KEYTRUDA® Three-fold improvement over Keytruda monotherapy**
Nov 2019	CDX: Proprietary composite AXL tumor-immune (cAXL) score developed to diagnose patients with clinical benefit Five-fold improvement in ORR and four-fold mPFS improvement for cAXL +ve patients
Dec 2020	Presented preliminary clinical data from Ph II combination trial of bemcentinib and LDAC in **AML** patients at ASH conference Durable responses reported with long duration
Jan 2020	Met Primary end point of ORR in phase II clinical trial in **NSCLC** (cohort B) in 2L IO refractory patients Bemcentinib in combination with KEYTRUDA® meets primary end point and progress to stage 2 of the study cohort
Feb 2020	Cash and Cash Equivalents at end of Q4'19 + PIPE funding Jan '20 NOK 470m Operating loss of NOK 59.1m in Q4'19 and NOK 204.4m full year 2019

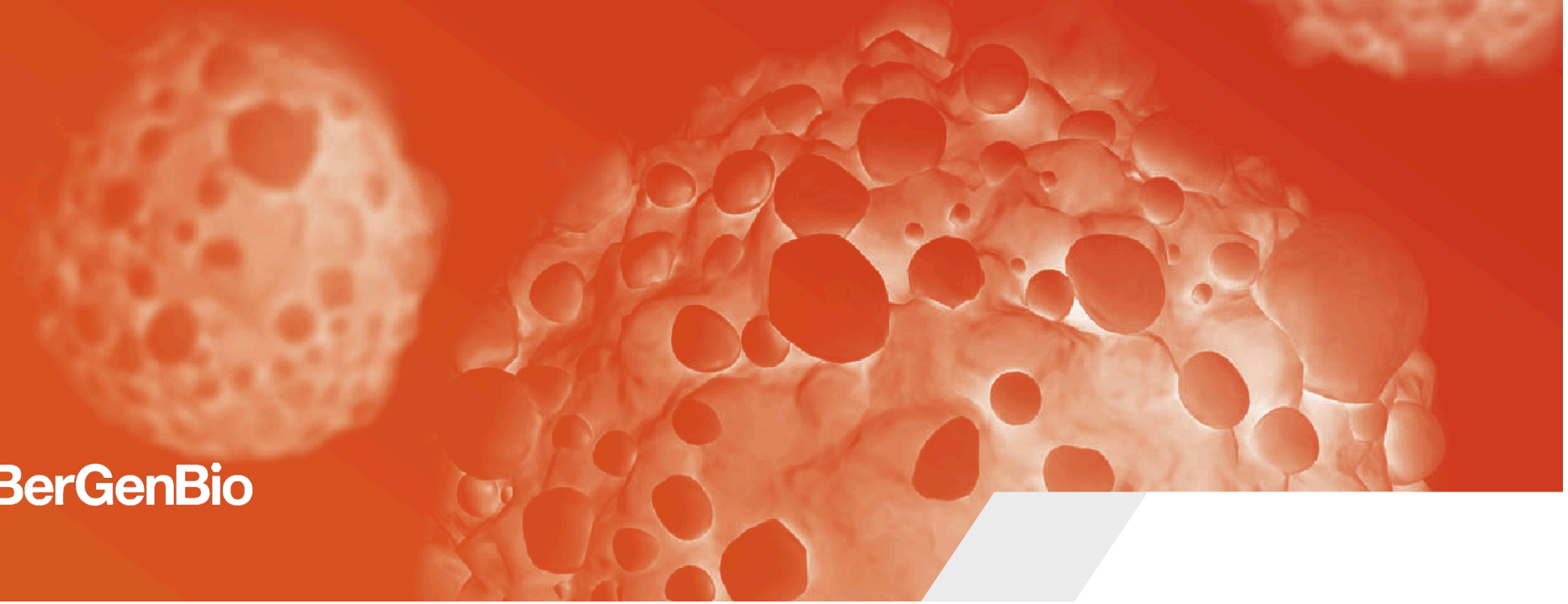
ORR – Overall Response rate OS – Overall Survival. mPFS – median Progression Free Surviva *cf. KN001; Garon *et al* NEJM 2015 ** cf. KN-010 Herbst *et al*, Lancet 2016

Newsflow 2019



ASCO-SITC: Clinical Immuno-Oncology symposium, San Francisco
ASCO: American Society of Clinical Oncology, Chicago
WCLC: World Conference of Lung Cancer, Toronto
ESMO: European Society of Medical Oncology, Munich
AACR: American Association for Cancer Research, Chicago
EHA: European Hematology Association, Stockholm
SITC: Society for Immunotherapy of Cancer, DC
ASH: American Society for Hematology, San Diego

AXL drives aggressive cancer

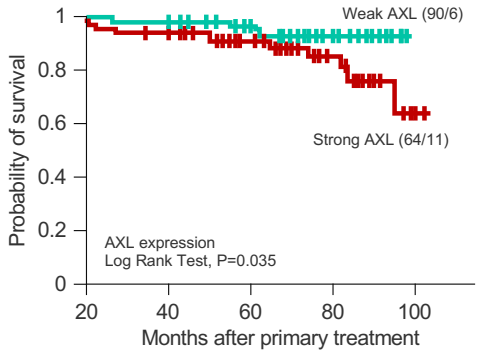


BerGenBio

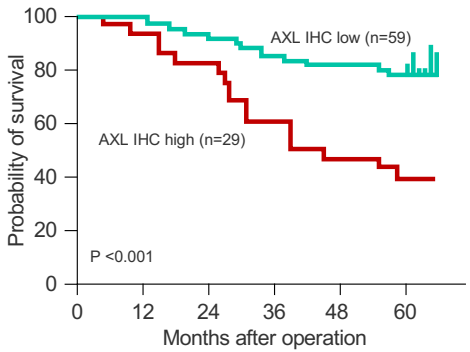
AXL +ve patients have a poor prognosis in most cancers

Strong AXL expression correlates with poor survival rate

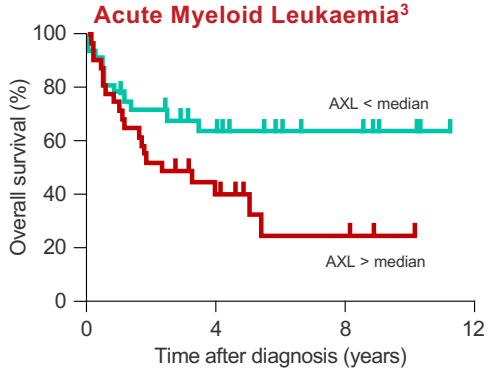
Breast carcinoma[1]



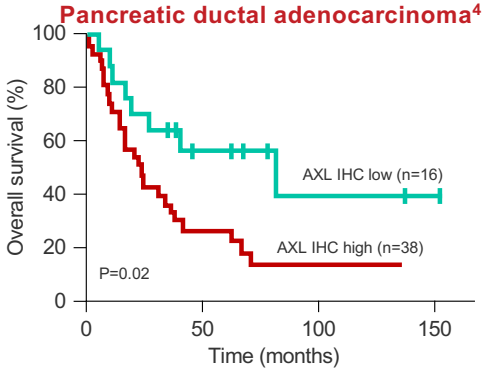
Lung adenocarcinoma (NSCLC)[2]



Acute Myeloid Leukaemia[3]



Pancreatic ductal adenocarcinoma[4]



Broad evidence of AXL linked with poor prognosis[5]

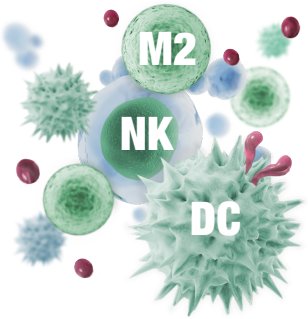
Astrocytic brain tumours	Melanoma
Breast cancer	Mesothelioma
Gallbladder cancer	NSCLC
GI	Pancreatic cancer
• Colon cancer	Sarcomas
• Oesophageal cancer	• Ewing Sarcoma
• Gastric cancer	• Kaposis sarcoma
Gynaecological	• Liposarcoma
• Ovarian cancer	• Osteosarcoma
• Uterine cancer	Skin SCC
HCC	Thyroid cancer
HNC	Urological
Haematological	• Bladder cancer
• AML	• Prostate cancer
• CLL	• RCC
• CML	

1 Gjerdrum, 2010; 2 Ishikawa, 2012; 3 Ben-Battala, 2013; 4 Song, 2010, 5 supported by > 100 publications

BerGenBio

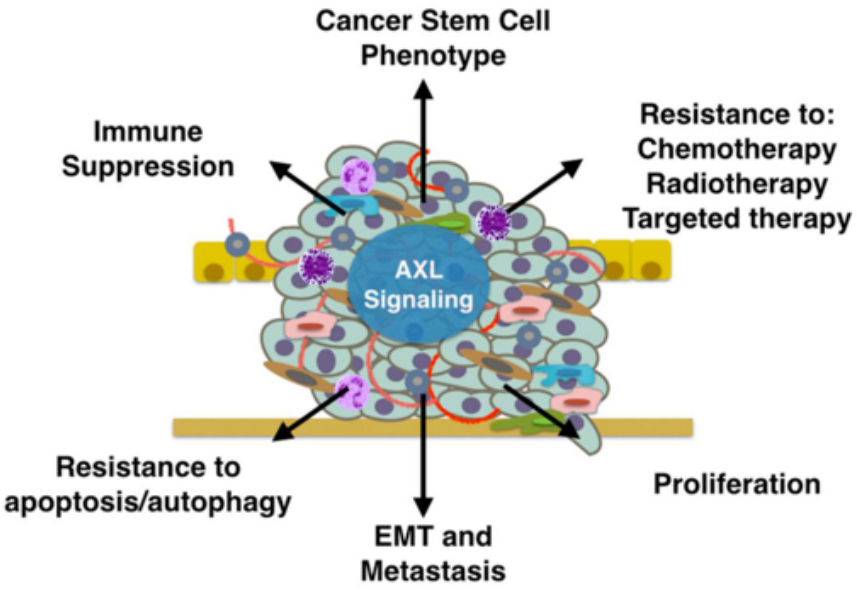
AXL is a key survival mechanism 'hijacked' by aggressive cancers and drives drug resistance, immune-suppression & metastasis

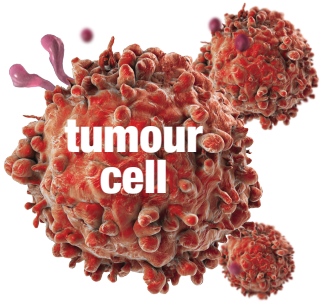
very low expression under healthy physiological conditions → overexpressed in response to hypoxia, inflammation, cellular stress & drug treatment → overexpression correlates with worse prognosis in most cancers



AXL increases on immune cells and suppresses the innate immune response

- M1 to M2 macrophage polarisation
- Decreased antigen presentation by DCs
- Prevent CD8+ T cell mediated cell death
- Activates Treg cells



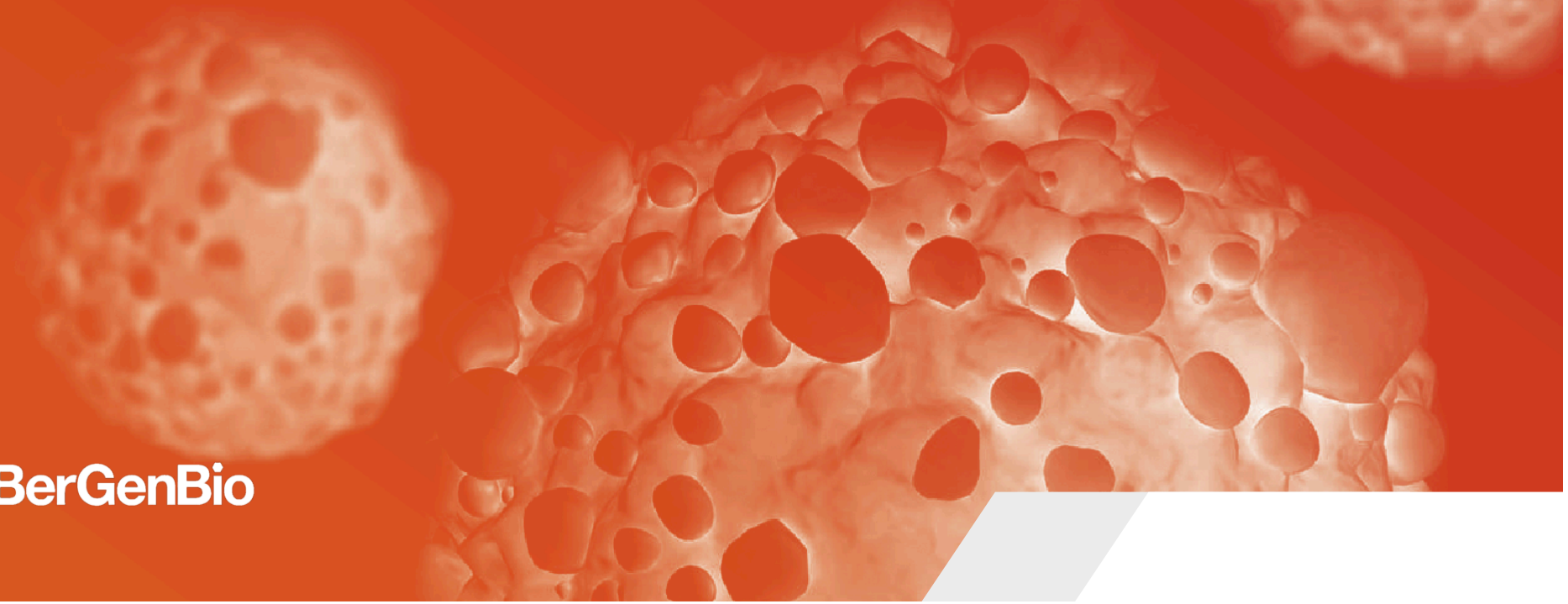


AXL increases on the tumor cell and causes cancer escape and survival

- AXL is a unique type I interferon (IFN) response checkpoint
- Acquired drug resistance
- Immune cell death resistant
- Metastasis

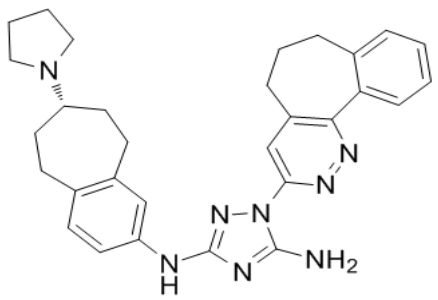
DC- dendritic cells Treg – Regulatory T Cell

Bemcentinib



BerGenBio

Bemcentinib, a first-in-class, potent, oral, highly selective AXL inhibitor



- ✓ Potent (IC_{50} = 14 nM)
- ✓ Selective (50-100 fold selective *cf.* TAM kinases)

- ✓ CMC scaled for regulatory filing
- ✓ Size 0 100mg HPMC capsules
- ✓ 3 years stability confirmed

- ✓ Uniquely selective for AXL
- ✓ MOA is synergistic with other cancer drugs enhancing response
- ✓ Favourable safety and tolerability profile supports broad use in lower risk first line, as well as advance elderly fragile patients
- ✓ Once daily oral dosing
- ✓ Fast Track Designation by FDA for AML
- ✓ Safety and tolerability profile supports use in combination with chemo, targeted and IO drugs

BerGenBio pipeline - 3 selective AXL inhibitors in clinical development

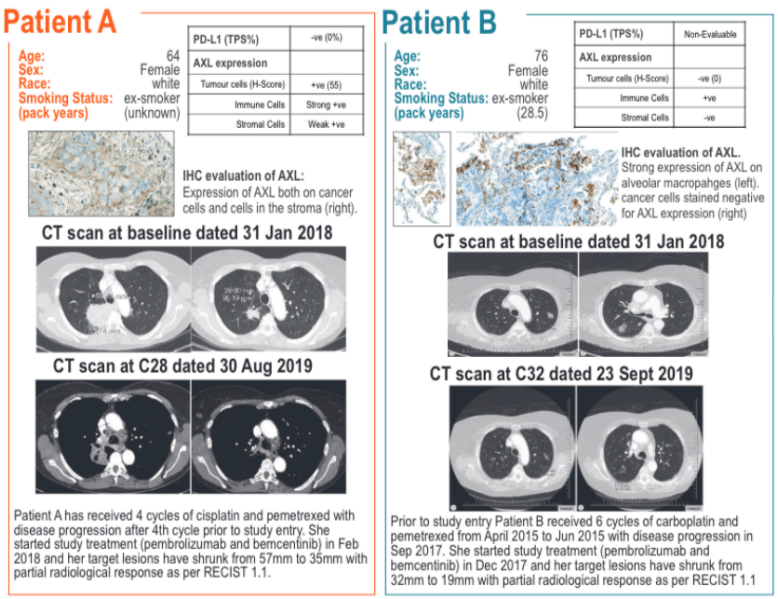
Multiple attractive opportunities in AML and NSCLC

Candidate	Targeted Indication	Discovery	Preclinical	Phase I	Phase II	Phase III.
Bemcentinib	>2L AML	Ph II safety and POC efficacy demonstrated in 39 patient trial				
Bemcentinib (combination with LDAC)	2L AML	Ph Ib Safety demonstrated, efficacy POC expansion study- 28 pts.				
Bemcentinib (combination with Keytruda) MERCK	2L NSCLC. (chemo refractory)	Ph II safety and POC efficacy demonstrated in 50 patient trial, end points met				
	2L NSCLC (CPI refractory)	Ph II POC study on going 29 pts – stage 1 met end point				
	2L NSCLC (CPI+chemo refractory)	Ph II POC study on going 29 pts				
Tilvestamab (BGB149)	TBA	Ph I Healthy volunteer study ongoing				
BGB601 ADC THERAPEUTICS	Various solid tumors	Ph I safety study ongoing				

CPI – checkpoint inhibitor

Companion Diagnostic (CDx)

- Developed a proprietary duplex IHC method with composite AXL tumor-immune Score (cAXL)
- A proprietary diagnostic algorithm using IHC scoring of AXL on tumor cells and on immune cells to identify solid tumour (NSCLC) patients that will respond / benefit from bemcentinib + CPI



Patient A: RESPONDER
- AXL stained +ve on tumor cells
- 61% tumor shrinkage

Patient B: RESPONDER
- AXL stained -ve on tumor cells
- AXL stained +ve on alveola macrophages
- 59% tumor shrinkage

AXL mediates aggressive cancer traits through EMT and Immune suppression in the tumour microenvironment:

Patient A: AXL +ve staining on lung tumour cells

- AXL mediated EMT in tumour cells
- AXL+ve Mesenchymal tumour cells are drug resistant & immune evasive

Patient B: AXL +ve staining on lung macrophages

- AXL is required to stabilize M2 macrophages
- M2 microphases are immune suppressive
- Bemcentinib inhibits AXL and macrophages switch to M1
- M1 macrophages are immune promoting

AXL inhibitors – emerging competitive landscape

Ref. BGBC003 / NCT02488408

Bemcentinib clinical development
Acute Myeloid Leukaemia (AML)

Objective: to develop a well tolerated, effective and convenient drug for this difficult to treat, elderly & frail patient population.

- Monotherapy ≥2L patients >75yrs
  43% ORR in AXL +ve R/R AML
- LDAC chemo combination 2L R/R patients >60 yrs

Acute Myeloid Leukaemia (AML)

Most common type of acute leukaemia in adults[1]

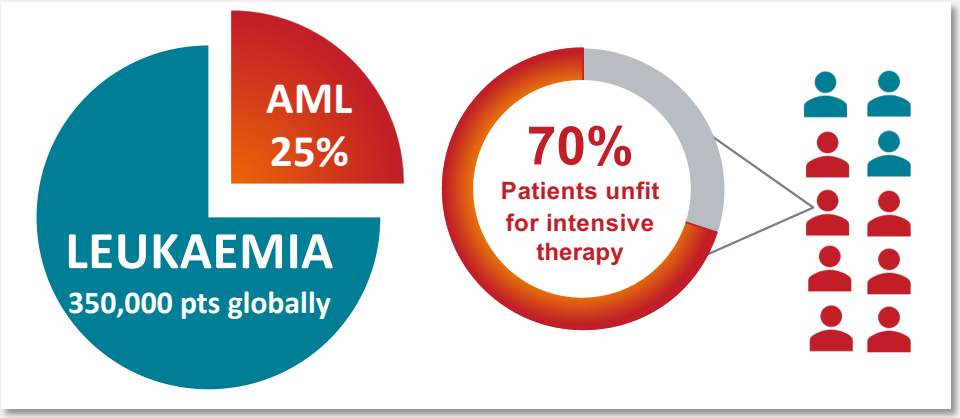
AML is a rare aggressive cancer of the blood and bone marrow characterised by difficult to treat malignancies

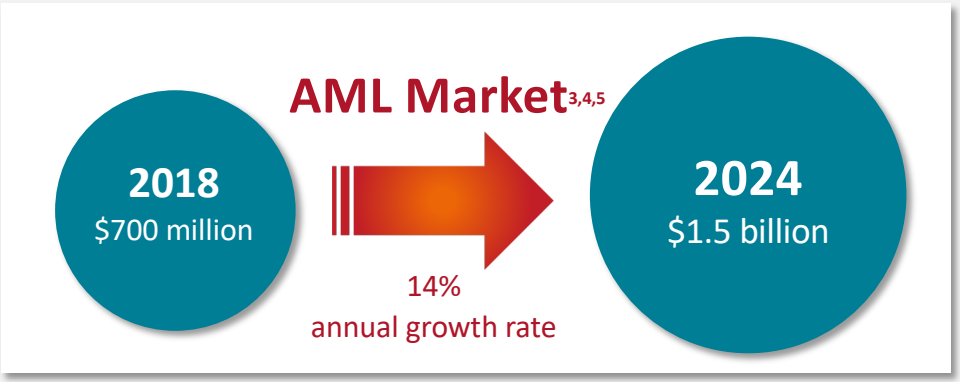
~ 20,000 new cases diagnosed and >10,000 deaths in the US in 2018[2]

AML makes up 32% of all adult leukaemia cases

Occurs in a predominantly elderly, frail patient population; 68% of patients diagnosed with AML were aged >60 years [6]

5 year survival rates of 3-8% in patients over 60 years old [7]





(1) Cancer.gov; (2) SEER; (3) https://www.who.int/selection_medicines/committees/expert/20/applications/AML_APL.pdf?ua=1ble
(4) https://www.cancer.net/cancer-types/leukemia-acute-myeloid-aml/statistics (5) https://www.businesswire.com/news/home/20190319005442/en/ (6) http://asheducationbook.hematologylibrary.org/content/2010/1/62.long, (7) https://www.ncbi.nlm.nih.gov/books/NBK65996/

Current Approach to AML in Elderly Patients Unfit for Intensive Chemotherapy

Newly Diagnosed AML: Choice of Low Intensity Induction Therapy:

- Hypomethylating agent (HMA) +/- venetoclax (approved in US only)
- LDAC alone or in combination with venetoclax or glasdegib (approved in US only)
- Targeted agent for AML with mutation of FLT3, IDH1/2

Opportunity for Bemcentinib + LDAC

1st Relapse

- Clinical trial
- No approved therapy, but options may include HMA, LDAC or single agent venetoclax
- Best supportive care (BSC) or palliative care

2nd Relapse

- Clinical trial
- BSC or palliative care

Opportunity for Single Agent Bemcentinib

Bemcentinib clinical trial in Acute Myeloid Leukemia, (BGBC003)

Phase 1 n=36

Single agent bemcentinib dose-finding in r/r AML/MDS*

Established safety and recommended Phase 2 dose in this population

Recommended Phase 2 dose of bemcentinib in AML or MDS is 400/200 mg as single agent OR in combination. No dose adjustment required.

Phase 2 Expansion Cohorts

Cohort B1 n=14
Monotherapy AML

Cohort B2 n=16
Combination with LDAC** in newly diagnosed or relapsed AML

Cohort B5 expansion
Combination with LDAC
relapsed AML (ongoing)

Cohort B3 n=14
Combination with decitabine in ND or relapsed AML

Cohort B4 n=14
Monotherapy MDS

* Myeloid Dysplastic Syndrome **LDAC = Low Dose Cytarabine

Bemcentinib + LDAC combination is active and effective in 1L newly diagnoses unfit/elderly AML patients

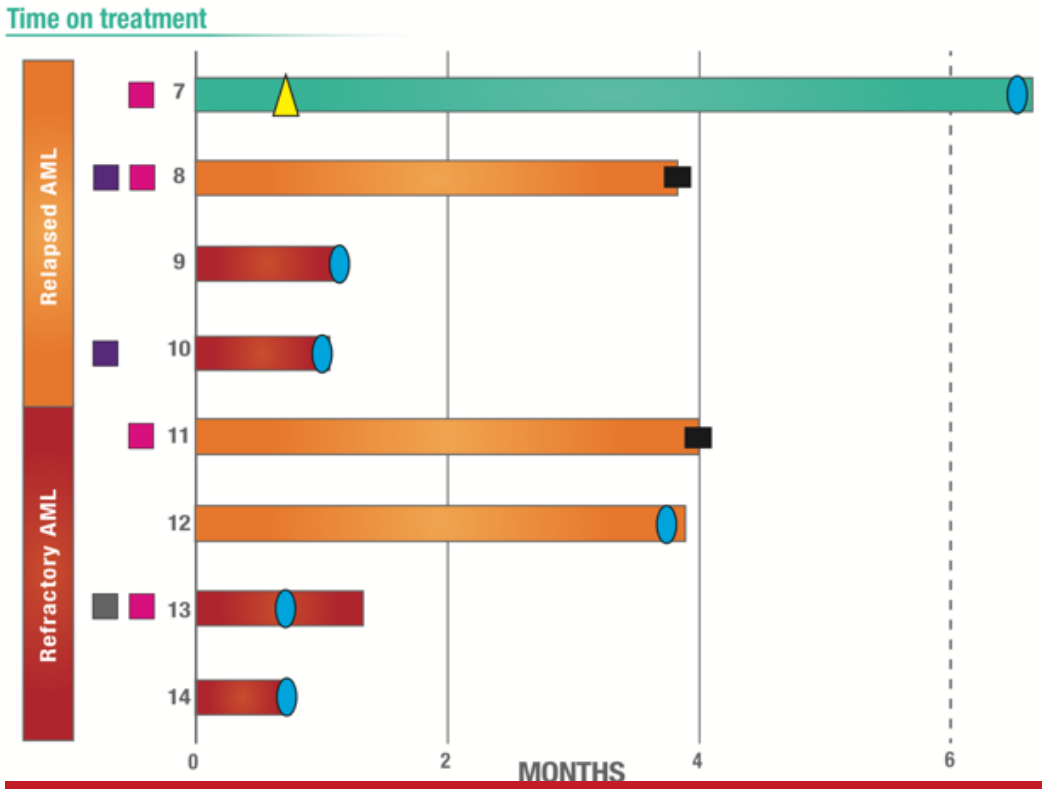
- 4/6 patients with ORR
- mDoR immature >12months and all 4 responding patients ongoing
- Responding patients have poor risk factors

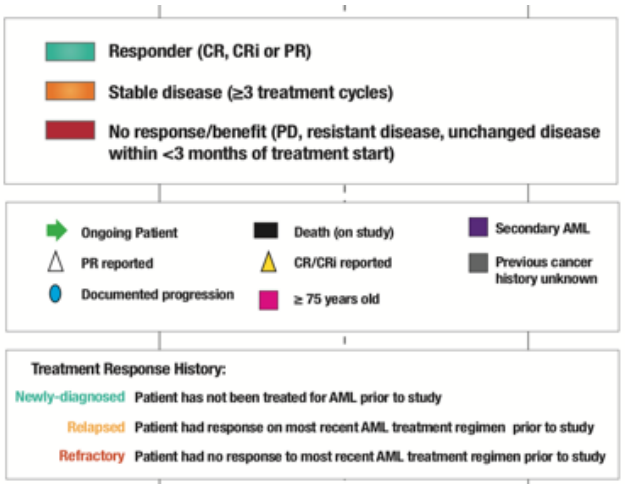
Clinical Activity in Newly-Diagnosed Patients

BerGenBio

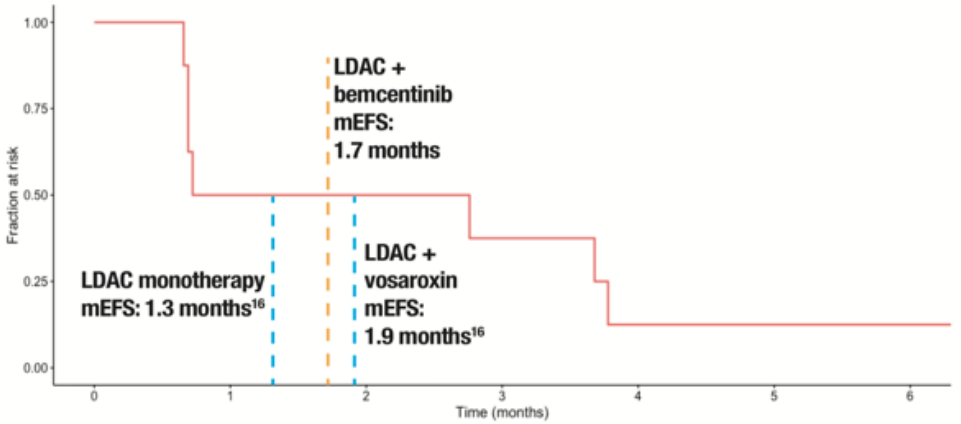
Bemcentinib + LDAC in r/r AML patients

Clinical Activity in Relapsed/Refractory Patients





Event-free Survival (Relapsed/Refractory Patients)



2L r/r AML LDAC combo expansion cohort 28pts ongoing

BerGenBio

Registration strategies for bemcentinib in AML under consideration

Bemcentinib has FAST TRACK DESIGNATION by FDA in AML.

3 possible registration paths are apparent, in slightly different patient populations

Scientific advice will be sort early 2020, route to registration to be discussed

1. 2L Bemcentinib + LDAC combination

- relapse patients >60 years, patients having failed HMA or HMA+Venetoclax
- rPh II / III, to receive bem+LDAC or LDAC alone
- End points: ORR and DoR
- Anticipated sample size 200 with 6 month f/u

2. ≥2L bemcentinib mono therapy

- Heavily pre-treated, ≥2L relapse patients >75yrs, with low sAXL
- sAXL assay is a validate Clinical Trial Assay method performed at a CLIA lab.
- Possible single arm or comparator being best supportive care (BSC) or palliative care
- End points: ORR and DoR
- Anticipated sample size 100 with 6 month f/u

3. 1L Bemcentinib + LDAC combination

- 1L patients >60 yrs, unsuitable for HMA+Venetoclax
- rPh II / III
- End points: ORR and DoR/OS
- Anticipated sample size 200 with 12 month f/u

Ref. BGBC008 / NCT03184571

Bemcentinib clinical development in Non Small Cell Lung Cancer (NSCLC)

Objective: to improve the effectiveness of immune check point inhibitor (CPI) (pembrolizumab/Keytruda) refractory NSCLC patients, with a well tolerated, effective, and convenient drug

Chemotherapy refractory patients

CPI +/- chemotherapy refractory patients

CPI+Chemotherapy refractory patients

NSCLC causes more cancer related deaths than breast, colon, pancreas and prostate combined

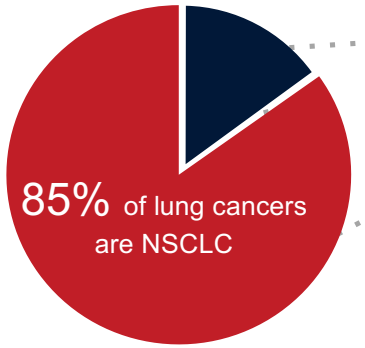
The largest cancer killer, most patients depend on drug therapy

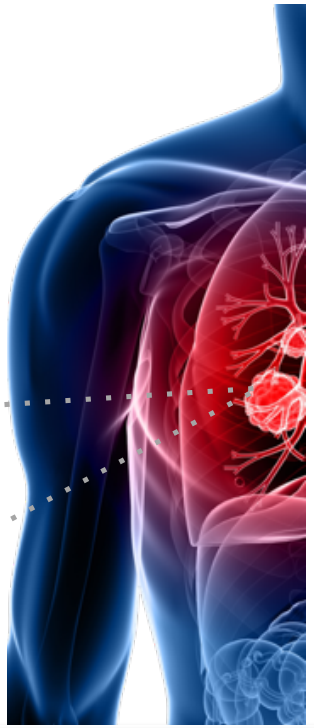
The most common type of cancer

2.09 million new cases of lung cancer diagnosed/yr worldwide, making up 11.6% of all cancer cases[1]

1.76 million lung cancer deaths/yr worldwide[1]

5-year survival rate is 3.5% in patients with PD-L1 <1%, and **12.6%** in patients PD-L1 1-49%

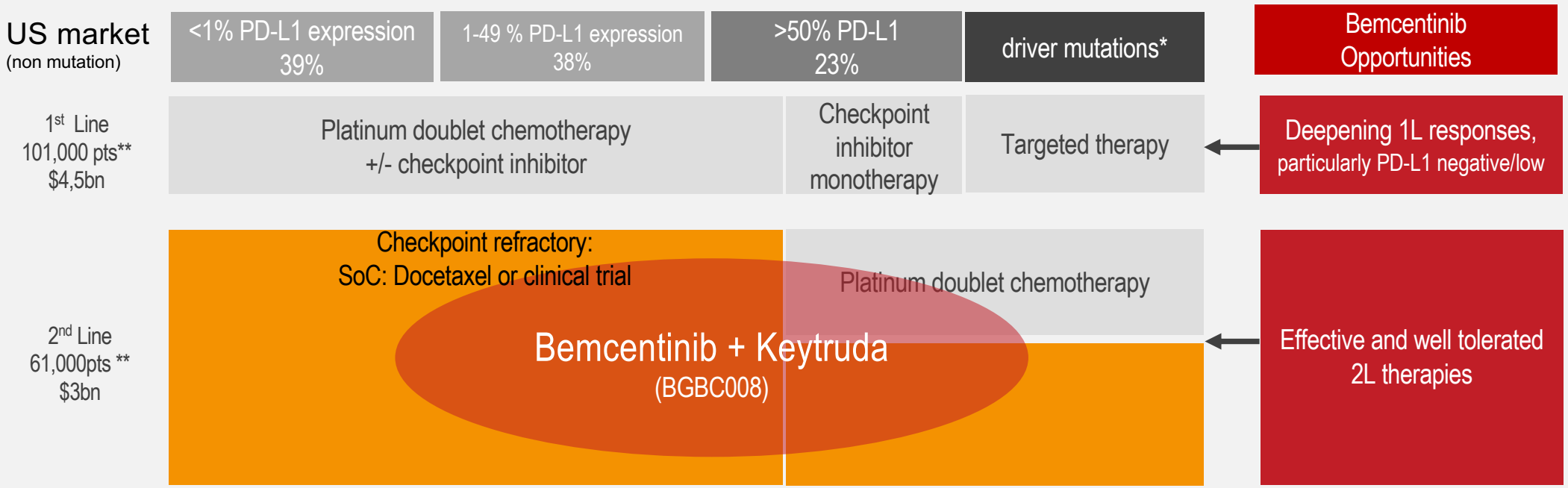




(1) fortunebusinessinsights.com/industry-reports/non-small-cell-lung-cancer-therapeutics-market-100484

Non- Small Cell Lung Cancer (NSCLC)

Rapidly evolving SoC creates opportunities for novel effective, chemo free well tolerated regimens



* Mutations / rearrangements with available targeted therapies such as EGFR and ALK
** Evaluate Pharma.USA only

Bemcentinib + KEYTRUDA in refractory/relapsed NSCLC

Phase II Study Design

BGBC008
Phase II 2-stage study of bemcentinib (BGB324) in combination with pembrolizumab

Inclusion criteria
- Adenocarcinoma histology
- Measurable disease
- Fresh tumor tissue
- AXL and PD-L1 All comers

Assessments
Efficacy
- **Primary endpoint**
  - Objective Response Rate
- **Secondary endpoints**
  - Duration of Response
  - Disease Control Rate
  - Time to Progression
  - Survival at 12 months
  - Response by Biomarker expression

Safety
PK

Regimen
- Pembrolizumab 200mg fixed
- Bemcentinib 400mg loading dose, then 200mg OD

Cohort A

- **Previously treated with a platinum containing chemotherapy**
- 2nd line advanced adeno NSCLC

Cohort B

- **Previously treated with a checkpoint inhibitor (PD-L1 or PD-1 inhibitor)**
- No more than 2 previous lines of treatment
- Must have had disease control for ≥12 weeks followed by progression
- 2nd or 3rd line advanced adeno NSCLC

Cohort C

- **Previously treated 1st line with a checkpoint inhibitor- containing regimen in combination with a platinum-containing chemotherapy**
- Disease control on 1st line therapy for ≥12 weeks followed by progression
- 2nd line advanced adeno NSCLC

COMPLETE
WILL INFORM 1L PIVOTAL STUDY

Interim Analysis

Stage 1
N=24 patients
(each patient has the potential for at least 24 weeks follow-up)

Stop at this stage for:
Futility (H0:15% if ≤3 responses)
Or unfavorable risk/benefit

Final Analysis

Stage 2
N=50 patients total
(each patient has the potential for at least 24 weeks follow-up)

Interim Analysis Cohorts B & C

Stage 1

N=13 patients/cohort

(each patient has the potential for at least 24 weeks follow-up)

Stop at this stage for
Futility (H0:15% if 0 responses)
Or unfavorable risk/benefit

Final Analysis Cohorts B & C

Stage 2

N=29 patients/cohort

(each patient has the potential for at least 24 weeks follow-up)

Ref. BGBC008 / NCT03184571 – clinical trial collaboration with Merck & Co., Inc.

MERCK

Cohort A Patient Disposition and Demographics*

Patient disposition	N
Screened	74
Enrolled	50
Evaluable	44
Ongoing	9

Patient demographics		N (%)
Age	Median	65
	Range	39-82
ECOG at screen	0	22 (44%)
	1	28 (56%)
Sex	Female	20 (40%)
Smoking Status	Smoker	10 (20%)
	Ex-smoker	29 (58%)
	Never smoked	10 (20%)
	Unknown	1 (2%)

Disease mutations	N (=50)
None	36 (72)
KRAS	7 (14)
TP53	2 (4)
EGFR	3 (6)
Other	4 (8)

Safety Summary

The safety profile of combination treatment is consistent with that of each individual drug

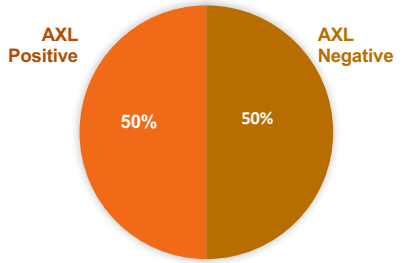
Treatment related adverse events were generally mild and reversible

Treatment related adverse events were considered to be less severe and better tolerated than for other TKIs or CPI combinations used in NSCLC

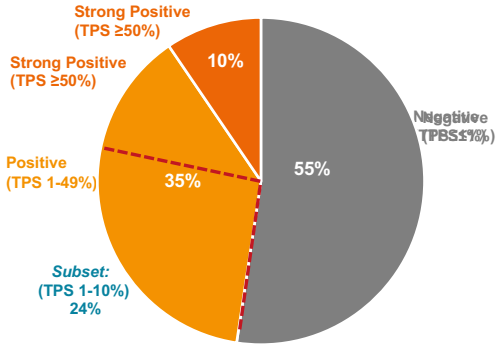
Most frequent TRAEs (≥10% dosed pts)	All Grades		Grade≥3	
Event Terms	n	%	n	%
Transaminase increased*	19	38 %	7	14%
Asthenia / Fatigue	15	30 %	4	8%
Diarrhoea	12	24 %	0	0%
Nausea	7	14 %	0	0%
Anaemia	6	12 %	1	2%
Blood creatinine increased	6	12 %	0	0%
Decreased appetite	6	12 %	0	0%
Pruritus	5	10 %	0	0%

Biomarker

cAXL status
n = 30



PD-L1 status
n = 37



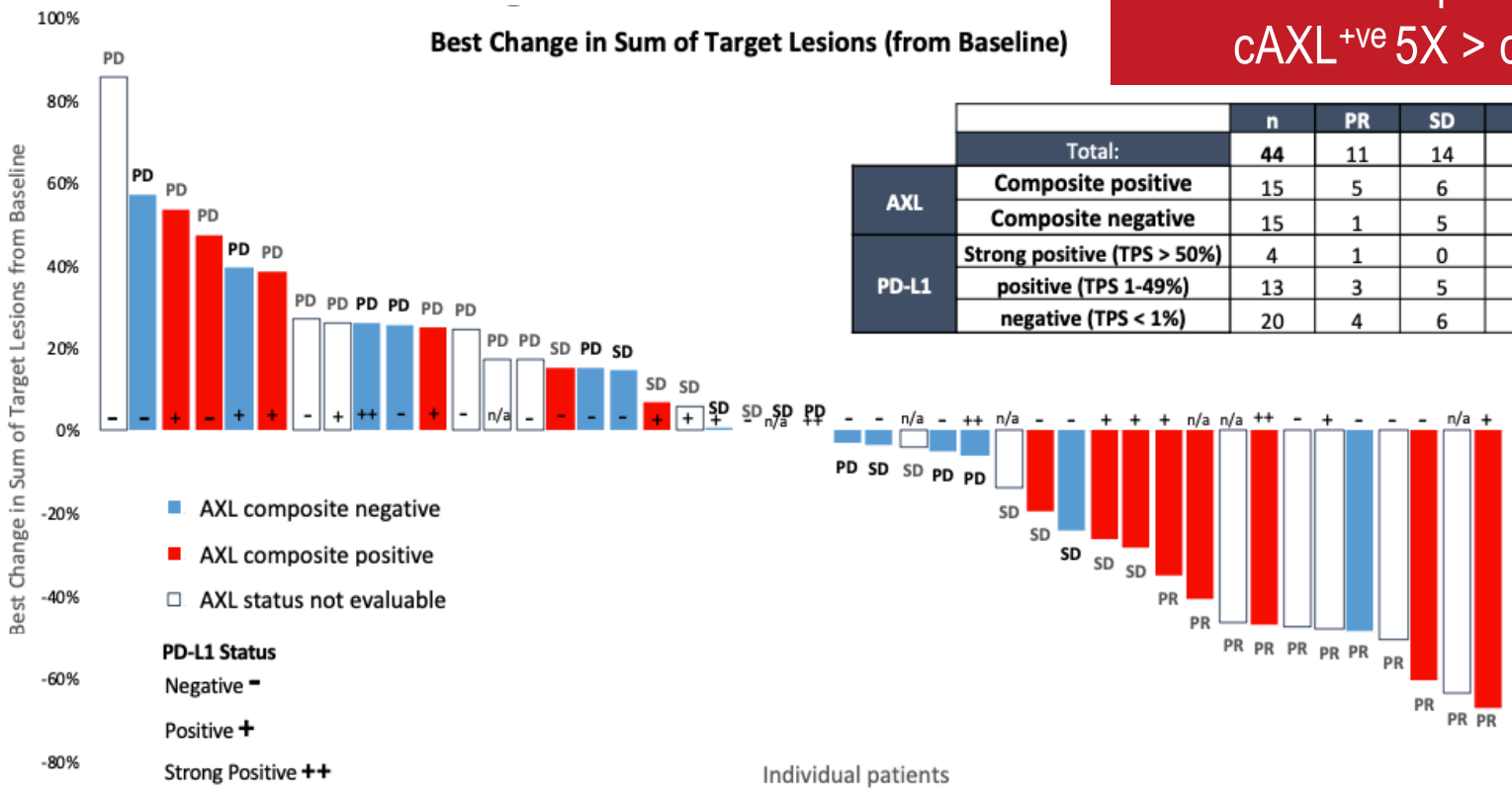
*Data cutoff (30 Sep 2019)

Cohort A: Anti-tumor activity of bemcentinib in combination with pembrolizumab

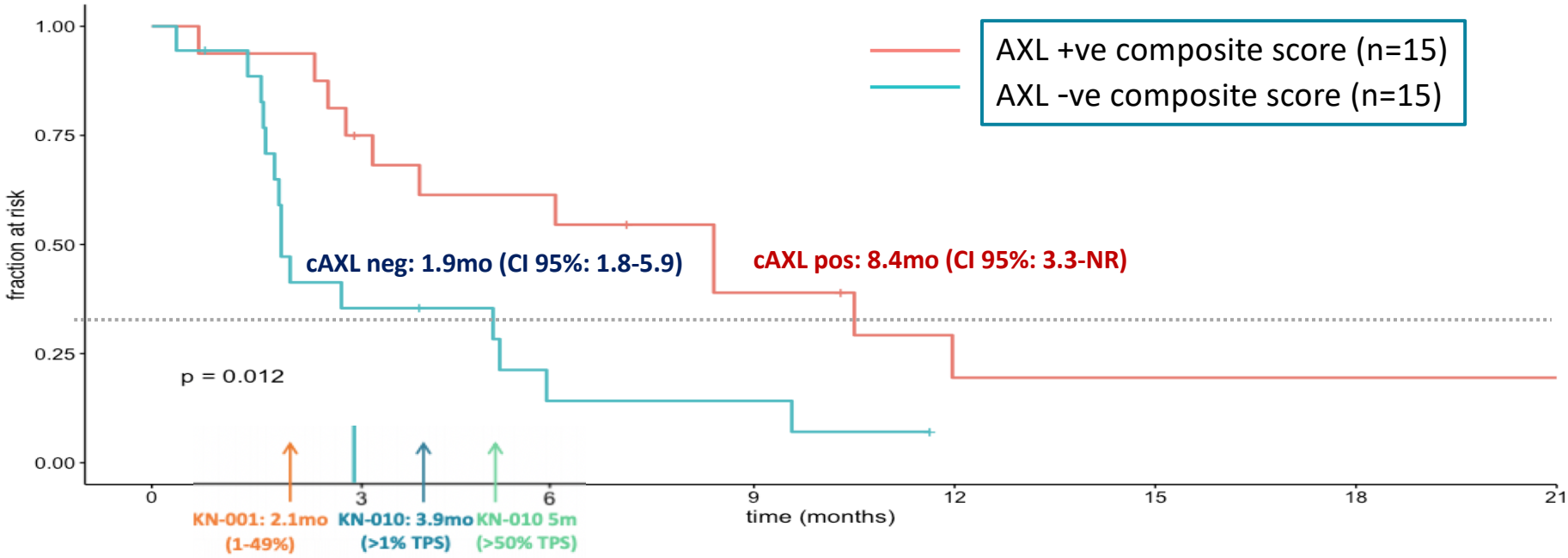
Change in tumour size from baseline by RECIST 1.1

Primary endpoint met:
Overal Response Rate
cAXL^{+ve} 5X > cAXL^{-ve}

		n	PR	SD	PD	ORR%	DCR%
	Total:	44	11	14	19	25	57
AXL	Composite positive	15	5	6	4	33	73
	Composite negative	15	1	5	9	7	40
PD-L1	Strong positive (TPS > 50%)	4	1	0	3	25	25
	positive (TPS 1-49%)	13	3	5	5	23	62
	negative (TPS < 1%)	20	4	6	10	20	50



Cohort A: >4 X improvement in mPFS* incomposite AXL positive patients



- ✓ 4-fold improvement in cAXL +ve vs. cAXL –ve patients.
- ✓ 4-fold improvement in what might be expected in the same patient population with Keytruda monotherapy

Cohort A results update : January 20, 2020

Source: KN001; Garon *et al* NEJM 2015; KN-010 Herbst *et al*, Lancet 2016 *Progression-free survival

Bemcentinib + KEYTRUDA in refractory/relapsed NSCLC

Phase II Study Design

BGBC008
Phase II 2-stage study of bemcentinib (BGB324) in combination with pembrolizumab

Inclusion criteria
- Adenocarcinoma histology
- Measurable disease
- Fresh tumor tissue
- AXL and PD-L1 All comers

Assessments
Efficacy
- **Primary endpoint**
  - Objective Response Rate
- **Secondary endpoints**
  - Duration of Response
  - Disease Control Rate
  - Time to Progression
  - Survival at 12 months
  - Response by Biomarker expression

Safety
PK

Regimen
- Pembrolizumab 200mg fixed
- Bemcentinib 400mg loading dose, then 200mg OD

Cohort A

- Previously treated with a platinum containing chemotherapy
- 2nd line advanced adeno NSCLC

Interim Analysis ✓

Stage 1
N=24 patients
(each patient has the potential for at least 24 weeks follow-up)

Stop at this stage for:
Futility (H0:15% if ≤3 responses)
Or unfavourable risk/benefit

Final Analysis ✓

Stage 2
N=50 patients total
(each patient has the potential for at least 24 weeks follow-up)

Cohort B

- Previously treated with a checkpoint inhibitor (PD L1 or PD-1 inhibitor)
- No more than 2 previous lines of treatment
- Must have had disease control for ≥12 weeks followed by progression
- 2nd or 3rd line advanced adeno NSCLC

Cohort C

- Previously treated 1st line with a checkpoint inhibitor- containing regimen in combination with a platinum-containing chemotherapy
- Disease control on 1st line therapy for ≥12 weeks followed by progression
- 2nd line advanced adeno NSCLC

Interim Analysis Cohorts B & C ✓

Stage 1

N=13 patients/cohort

(each patient has the potential for at least 24 weeks follow-up)

Stop at this stage for
Futility (H0:15% if 0 responses)
Or unfavourable risk/benefit

Final Analysis Cohorts B & C

Stage 2

N=29 patients/cohort

(each patient has the potential for at least 24 weeks follow-up)

ONGOING
WILL INFORM 2L PIVOTAL STUDY

Ref. BGBC008 / NCT03184571 – clinical trial collaboration with Merck & Co., Inc.

MERCK

Bemcentinib + KEYTRUDA in refractory/relapsed NSCLC – cohort B & C

CHECK POINT INHIBITOR REFRACTORY PATIENTS: precise and specific definition

Patients must have reported an initial clinical benefit (CR, PR or SD) for at least 12 weeks and subsequently progressed on treatment with an anti-PD1/L1 monoclonal antibody (mAb) administered either as monotherapy, or in combination with other checkpoint inhibitors or other therapies. PD-1 treatment progression is defined by meeting all of the following criteria:

a) Has received at least 2 doses of an approved anti-PD-1/L1 mAb.

b) Has demonstrated disease progression after PD-1/L1 as defined by RECIST v1.1. The initial evidence of disease progression (PD) is to be confirmed by a second assessment no less than four weeks from the date of the first documented PD, in the absence of rapid clinical progression.

c) Progressive disease has been documented within 12 weeks from the last dose of anti-PD-1/L1 mAb. Seymour et al; iRECIST: Guidelines for response criteria for use in trials testing immunotherapeutics. Lancet Oncol 18: e143-52

This determination is made by the investigator. Once PD is confirmed, the initial date of PD documentation will be considered the date of disease progression.

a) Other therapies not to be administered between last dose of anti PD-1/L1 mAb and commence of clinical trial agent

Interim Analysis Cohort B
Stage 1
N=13 patients/cohort

(each patient has the potential for at least 24 weeks follow-up)

- Stop at this stage for Futility (H0:15% if 0 responses)
- Or unfavourable risk/benefit

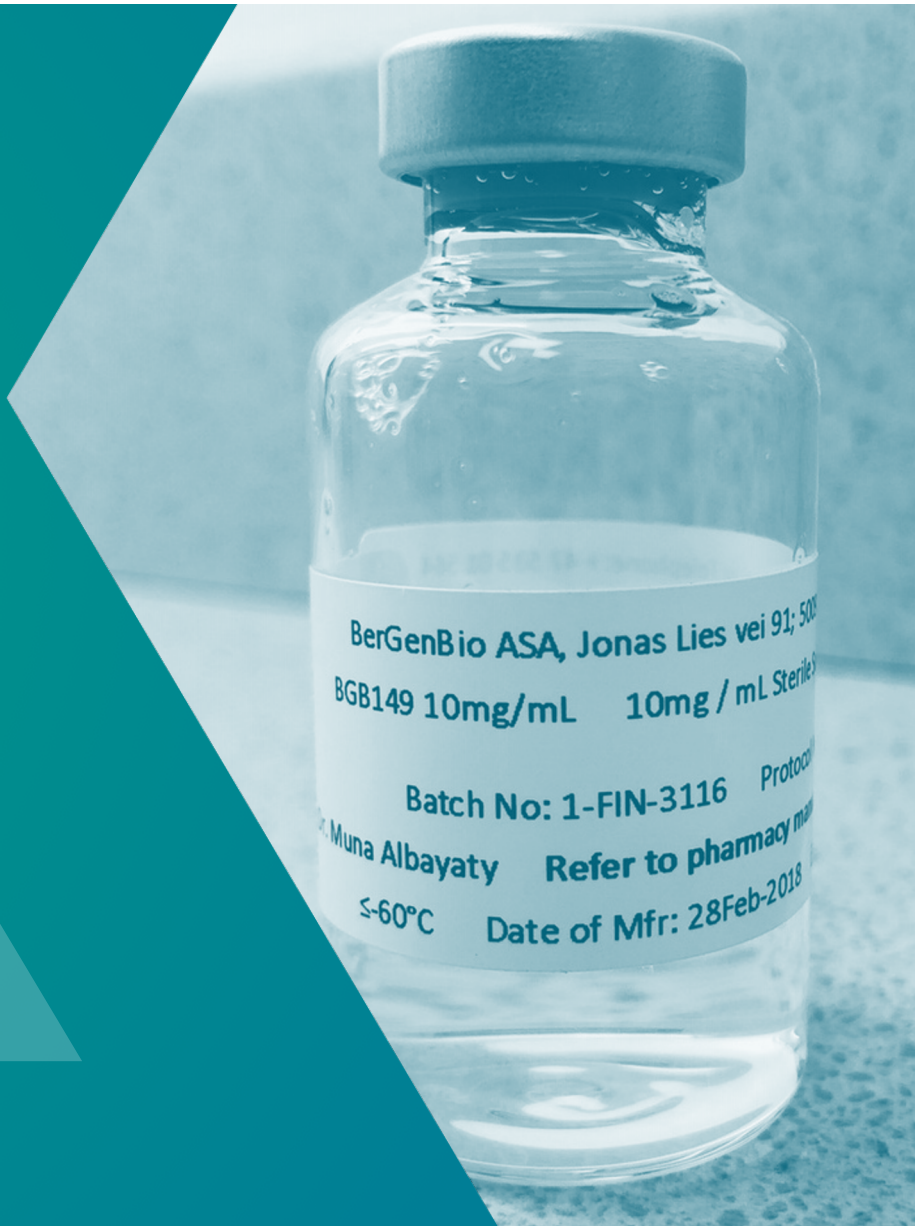
Development strategy for Bemcentinib in NSCLC (ad. & Sc.)

Clinical Position	Patient Population	Concept	Development Plan – Aim for conditional approval / BT
2L IO(+chemo) refractory	Stage III/IV Ad. PD-L1 all comer cAXL +ve.	Randomised Phase IIb / III Bemcentinib + CPI vs. docetaxol 1º endpoints: Interim mPFS, (for C/A A) 6 & 12mn OS, OS (for full approval) 2º endpoints: ORR, DoR, Safety, tolerability.	1. Pending data from BGBC008 cohort B + C 2. SA advice from FDA & EMA 3. cAXL assay validation in BGBC008 B&C
1L	TBA		

BerGenBio

BGB149

anti-AXL monoclonal antibody



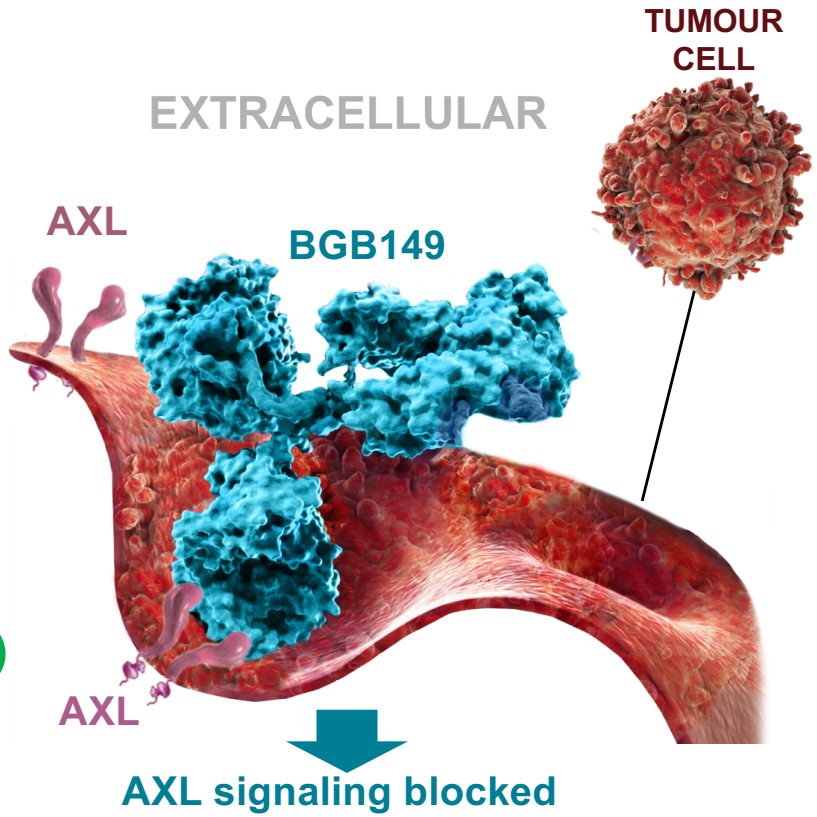
Ref. BGB149-101 / NCT03795142

BGB149: Anti-AXL monoclonal antibody

Phase I clinical trial ongoing

- Functional blocking fully-humanised IgG1 monoclonal antibody
- Binds human AXL, blocks AXL signalling
- High affinity (KD: 500pM), Anti-tumour efficacy demonstrated *in vivo*
- Robust manufacturing process established, 18 months stability
- Phase Ia healthy volunteer SAD study complete

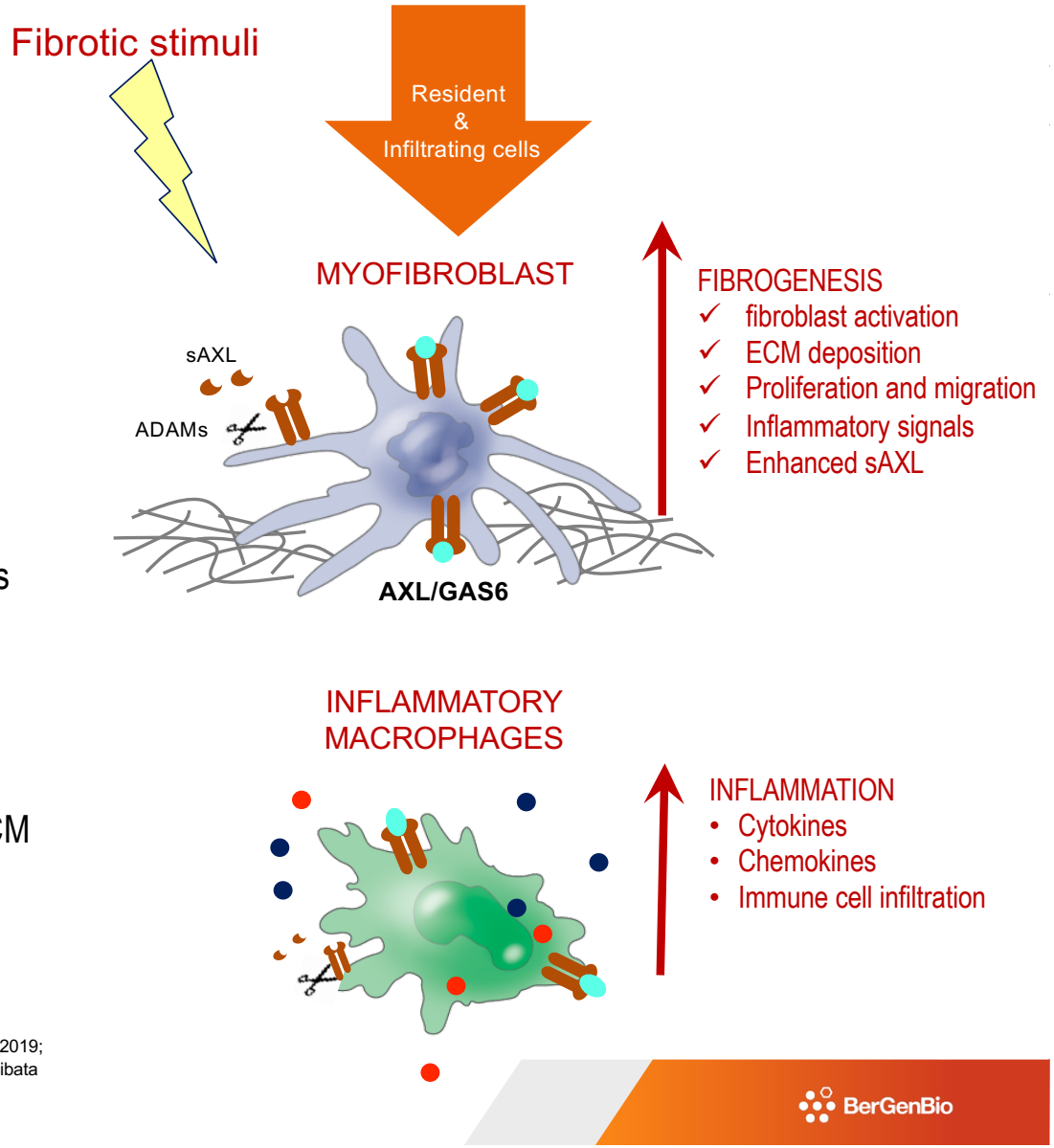
  Safety – no dose limiting toxicity seen up to 3mg/kg dose
  Pharmacokinetics - exposure predictable with dose proportional Cmax increase
  Confirmatory evidence of *in* vivo target engagement with sAXL -- stabilisation in circulation
- First-in-patient trial expected in H2 2019



BerGenBio

The role of AXL in fibrosis

- AXL Regulates and modulates key fibrogenic pathways
  - TGFb signaling[1,2]
  - Mechanosensing Hippo pathway[3]
  - Peroxisome proliferator-activated receptor[4]
- Axl regulates cellular plasticity implicated in fibrotic pathologies e.g. EMT, EndMT, Macrophage polarity
- AXL is a negative regulator of epithelial cell barrier integrity[5]
- Axl is required for hepatic stellate cell (HSC) activation and ECM deposition[6]



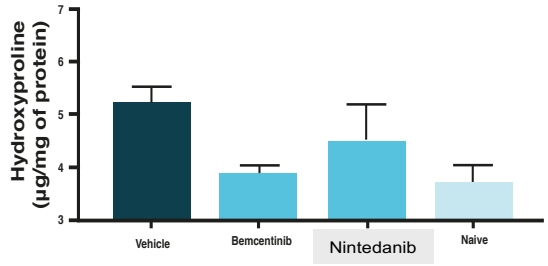
1 Gilbane ART 2015; 2 Reichl Hep. 2015; 3 Gibault ChemMed 2017; 4 Zhu AJTR 2016; Fuijno Lab invest 2017, J Exp Med 2019; 6 Barcena J. Hep 2015; 7 Tutusaus A. Cell Mol Gastroenterol 2019 Hepatol. 2019; 8 Landolt L. Physiol Reports 2019; 9 Shibata J Immunology 2014; 10 BerGenBio ASA, unpublilshed; 11 Espindola MS. Am J Respir Crit Care Med 2018)

AXL inhibition prevents fibrosis in a panel of preclinical models

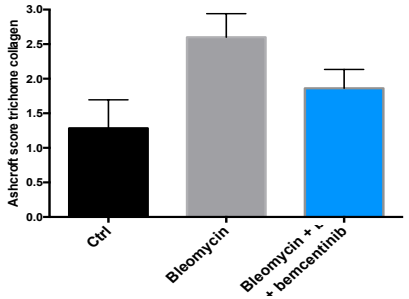
Pharmacological modulation of Axl with bemcentinib inhibits pre-clinical development of Liver ($CCl4_6$/$HighFatDiet_7$), Renal (UUO_8) and Pulmonary (Asthma[9], Bleo[10], IPF[10]) fibrosis

Lung

Bemcentinib reduces fibrosis in a human xenograft model of IPF [1]

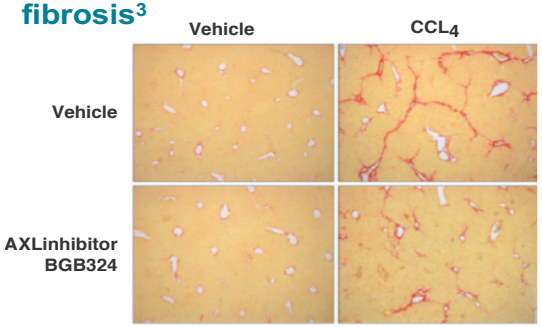


Bemcentinib reduces bleomycin induced fibrosis[2]

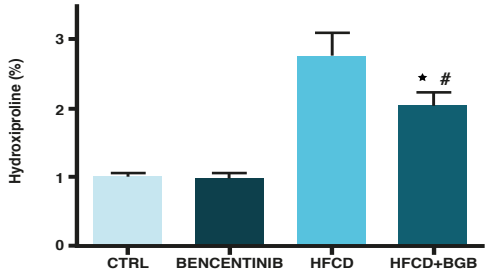


Liver

Bemcentinib reduces fibrosis in the CCL_4-induced model of liver fibrosis[3]



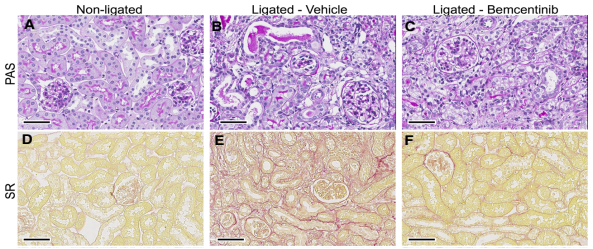
Bemcentinib reduces fibrosis in a diet induced model of NASH[4]



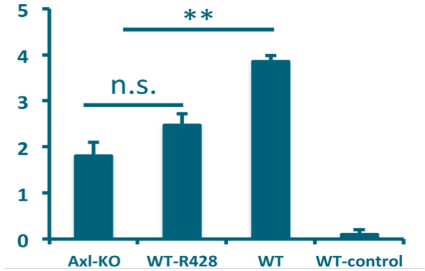
HFCD = high-fat, choline deficient diet
Leads to NASH in animal models

Kidney

Bemcentinib reduces kidney fibrosis following Unilateral Ureteral Obstruction (UUO) [5]



Bemcentinib ameliorates anti-GBM induced lupus like nephritis and improved kidney function [6]



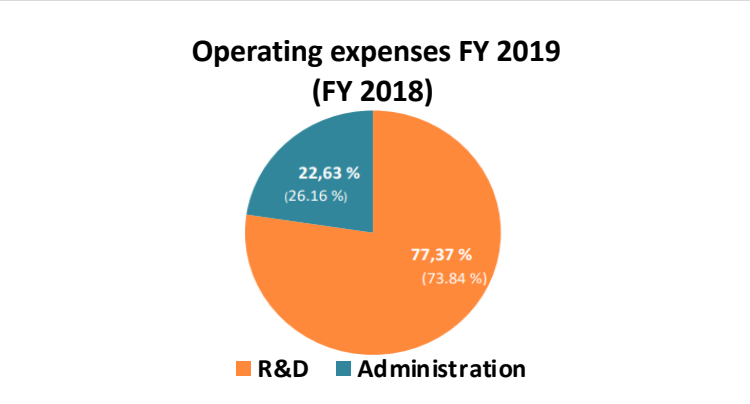
1 Espindola et al., 2018; 2 BerGenBio ASA; 3 Barcena et al., 2015; 4 Tutsaus et al., unpublished; 5 Landolt et al., 2019 6 Zhen et al., 2018

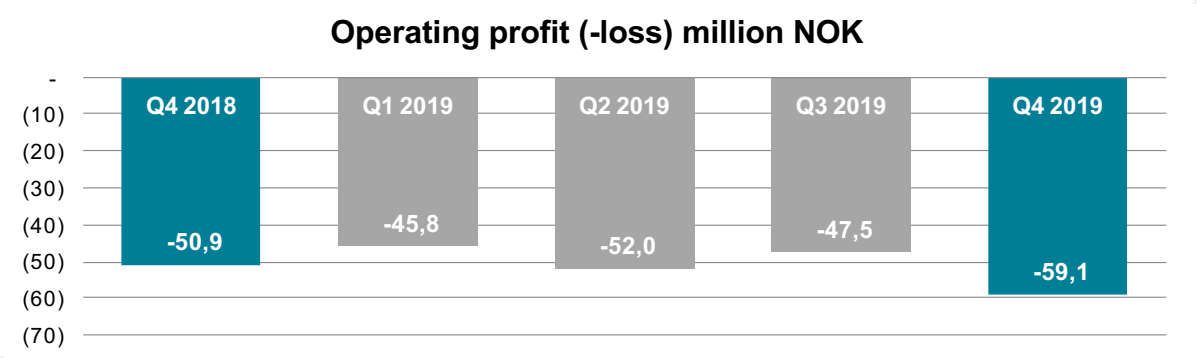
Finance Report

Rune Skeie - CFO

Key financial figures Q4 and full year 2019

(NOK million)	Q4 2019	Q4 2018	FY 2019	FY 2018
Operating revenues	0,2	2,3	8,9	2,3
Operating expenses	59,3	53,2	213,3	196,9
Operating profit (-loss)	-59,1	-50,9	-204,4	194,5
Profit (-loss) after tax	-57,6	-51,1	-199,3	-191,7
Basic and diluted earnings (loss) per share (NOK)	-0,94	-0,93	-3,43	-3,60
Net cash flow in the period	-35,9	-37,8	-106,8	-9,9
Cash position end of period	253,6	360,4	253,6	360,4



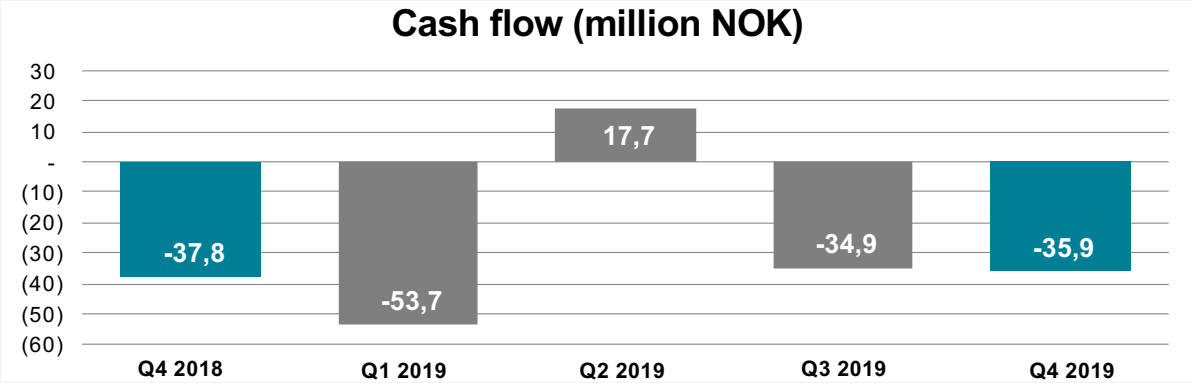


- Well managed overhead costs
- 77,37 % of operating expenses FY 2019 (FY 2018: 73.84 %) attributable to Research & Development activities.

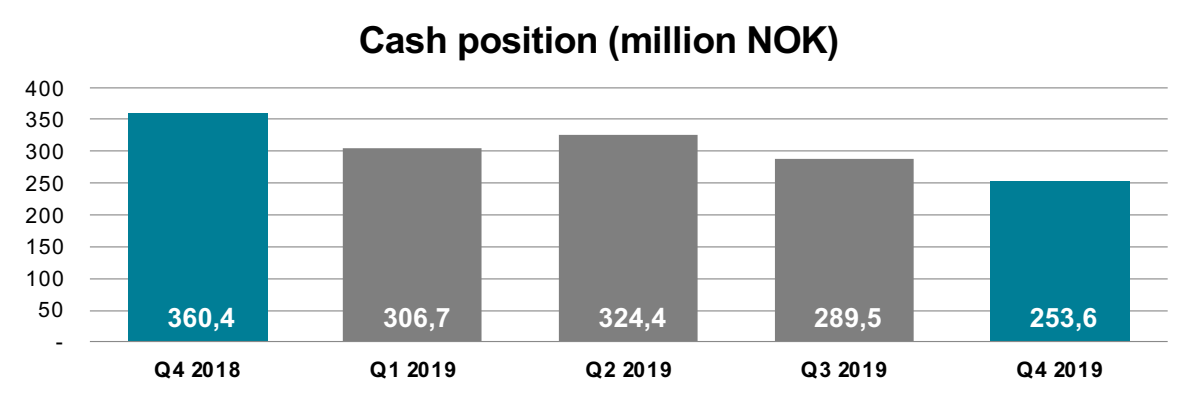
Increase in operation expenses due to expansion in clinical trials activity and as YE provisions

http://www.bergenbio.com/investors/reports/quarterly-reports/

Cash flow and cash position



- Q4'19: variance between cash flow and operation loss:
  - NOK10.4m received from grants
  - NOK2.5m share option expenses
  - NOK10.3m provision for YE expenses
- Quarterly average cash burn (Q418 – Q419) NOK 45.1m (USD 5.2m)



- Cash position YE 2019 NOK 253.6 m (USD 28.9m)
- Private Placement January 2020
  - Additional cash NOK 219.9m (USD 24.0m).
  - NOK 98.5m received by 10 February
  - NOK 121.3m subject to EGM approval (expected 25 February)

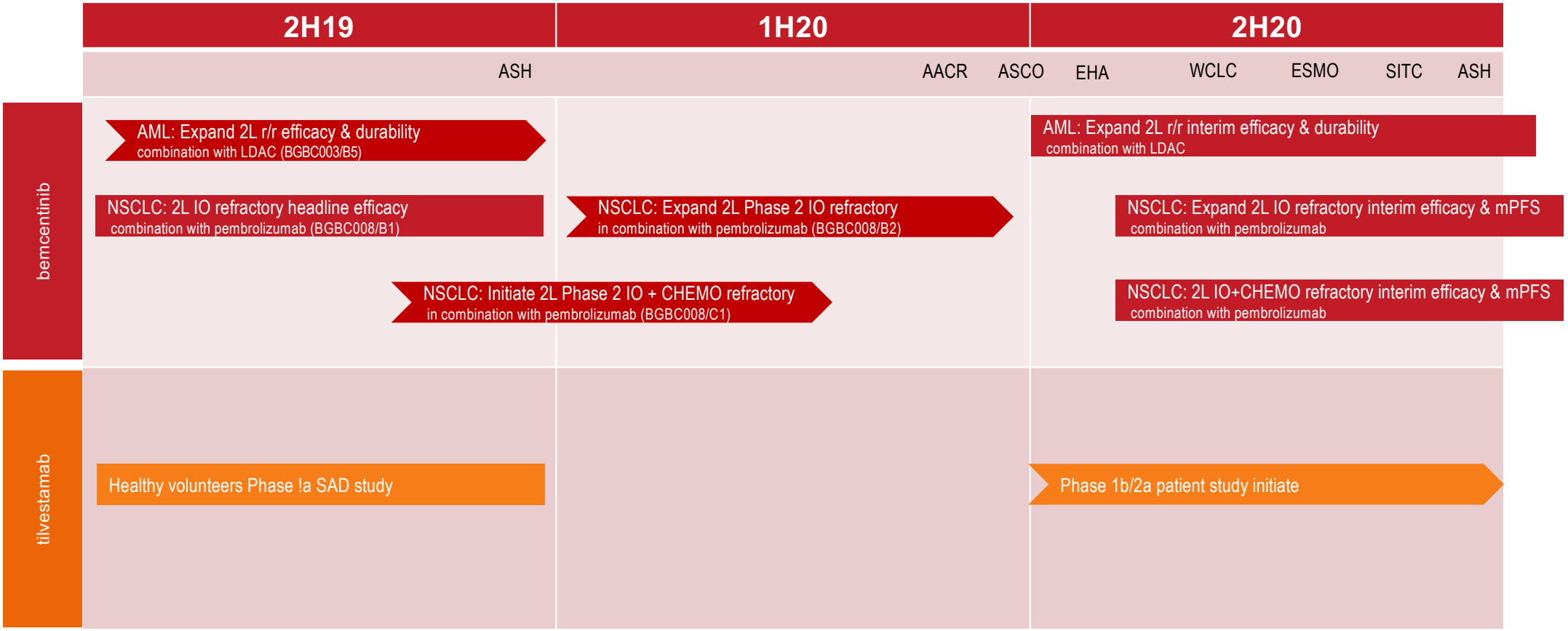
Cash Position strengthen following successful private placement

- NOK 220 million (USD 24 million) raised in gross proceeds through a private placement in January 2020 of 12,215,318 new shares at NOK 18 per share
  - The private placement was oversubscribed and attracted strong interest from existing shareholders and new institutional investors in Norway and internationally
  - Repair Offering of up to 1,500,000 new shares proposed to raise additional gross proceeds of approx. NOK 27 million (USD 3 million)
- Use of proceeds:
  - Execution of ongoing clinical trials of bemcentinib (2L AML and 2L NSCLC) and tilvestamab (phase Ib)
  - Manufacturing development activities for bemcentinib
  - General corporate purposes
- Current cash resources are expected to be sufficient to reach data read-out from ongoing trials in during 2020.

Private Placement and subsequent repair offering

- Subscription of 12,215,318 shares (20%) received and shares allocated.
- **Tranche 1 (completed):**
  - 5,475,136 shares issued and gross proceeds NOK 98.5 million received.
  - Total number of shares after Tranche 1: 66,551,726
- **Tranche 2 (expected to complete 25 February):**
  - Issue of 6,240,182 shares, subject to EGM approval (20 February 2020).
  - Gross proceeds NOK 121.3 million.
- **Extraordinary General Meeting** 20 February 17:00 CET
  - Place: Møllendalsbakken 9, Bergen.
  - Registration and Proxy form at: www.bergenbio.com/investors/general-meetings/
  - Agenda:
    - Approval of Tranche 2
    - Approval of subsequent repair offering
- **Subsequent Repair offering**
  - Issue up to 1,500,000 shares
  - Directed to shareholders at 29 January who did not participate in the Private Placement 29 January.
  - Shareholders at 29 January (reg. 31 January) will receive 0.045 subscription rights per share as of 29 Jan.
  - Completion of subsequent repair offering is subject to EGM approval, approved Prospectus and share price development.

Expected news flow through 2020



BerGenBio – Investment Highlights

- Pipeline of first-in-class anti AXL therapeutics: AXL is an increasingly validated novel target for aggressive cancers
- Bemcentinib, first in class, selective, oral AXL inhibitor: once-a-day pill
- Bemcentinib: attractive clinical profile targeting two large unmet medical needs: 2L AML and 2L NSCLC
- Strategic options include go to market in select indications and significant attractive high value partnering opportunities
- Proprietary CDx methods in parallel development for patient selection and personalised medicine approach for reimbursement
- Experienced management team
- Cash and Cash Equivalents at end of Q4'19 + PIPE funding Jan '20 NOK 470m.

Analyst coverage

H.C. Wainwright & Co

Joseph Pantginis
Telephone: +1 646 975 6968
E-mail: jpantginis@hcwresearch.com

ABG Sundal Collier

Viktor Sundberg
Telephone: +46 8 566 286 41
E-mail: viktor.sundberg@abgsc.se

Arctic Securities

Pål Falck
Telephone:+47 229 37 229
E-mail: pal.falck@arctic.com

Jones Trading

Soumit Roy
Telephone: +1 646 454 2714
E-mail: sroy@jonestrading.com

Sponsored research:

Trinity Delta

Mick Cooper, PhD
Telephone: +44 20 3637 5042
mcooper@trinitydelta.org

Link to reports from Trinity Delta:
https://www.bergenbio.com/investors/analyst-coverage/

Thank you

BerGenBio