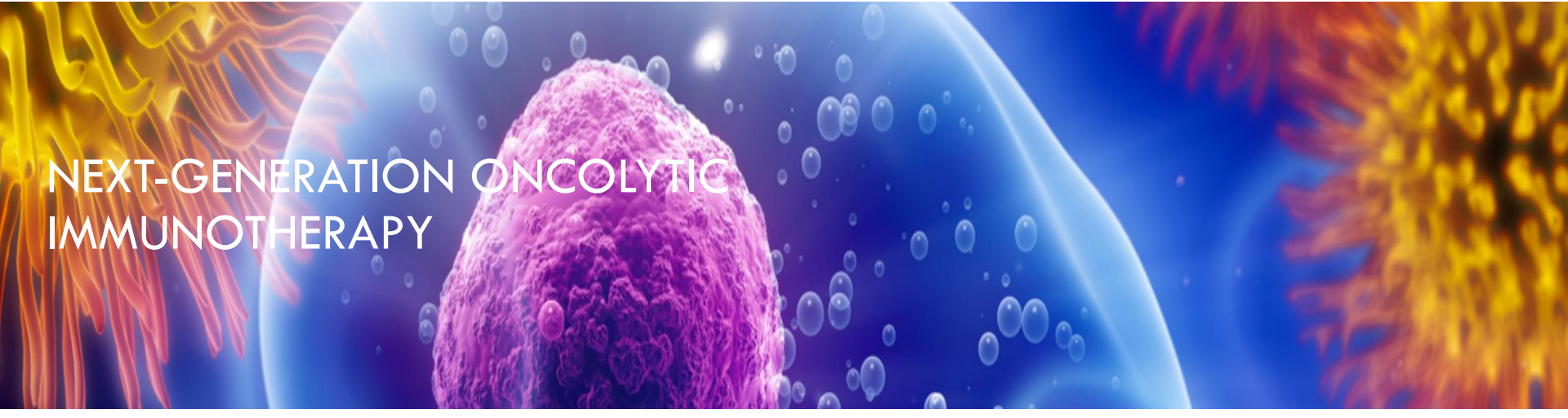
Replimune



BMO Capital Markets 2018 Prescriptions for Success Healthcare Conference

Safe harbor

Any statements contained herein that are not statements of historical facts may be deemed to be forward-looking statements which are subject to risks and uncertainties. Accordingly, actual outcomes or results may differ materially from those indicated in these statements for many reasons, including, without limitation, risks associated with our collaborations, our clinical development activities, regulatory oversight, as well as the risks, uncertainties and other factors described under the heading "Risk Factors" in our registration statement filed on Form S-1 (including a prospectus) with the SEC which was declared effective on July 19, 2018. Our forward-looking statements are based on beliefs, assumptions and information available to the Company only as of the date of this presentation and include, but are not limited to, statements regarding the development of our product candidates, the success of our collaborations, and/or the delay or lack of success of any of our ongoing or planned clinical trials. We undertake no obligation to publicaly update such forward-looking statements to reflect subsequent events or circumstances.

- Founded in 2015 by the ex-BioVex management team
- Proprietary genetically "armed" oncolytic immunotherapy platform intended to maximally activate the immune system against a patient's cancer
  - "Oncolytic immuno-gene therapy"
- Multiple next generation product candidates armed with 2-4 genes in or being prepared for clinical trials in combination with anti-PD1 therapy
  - Collaboration with BMS for supply of nivolumab (ongoing 150 patient phase 1/2 trial)
  - Collaboration with Regeneron (50:50 cost sharing + cemiplimab supply) across multiple tumor types & products (initially 240 patient randomized controlled phase 2 trial starting H1 2019)
- Commercial scale manufacturing capability being established
- IPO in July 2018 (Nasdaq: REPL); current cash balance ≈$150m
- Headquartered near Boston, MA, labs in the UK, ≈43 employees

The most experienced oncolytic immunotherapy team

ROB COFFIN
Chief Executive Officer
Founder & CTO at BioVex, VP at Amgen

PHILIP ASTLEY-SPARKE
Executive Chairman
CEO BioVex, Chairman at uniQure

COLIN LOVE
Chief Operating Officer
SVP BioVex; VP at Amgen through T-Vec BLA filing

PAMELA ESPOSITO
Chief Business Officer
VP BD at BioVex; CBO at Ra Pharmaceuticals

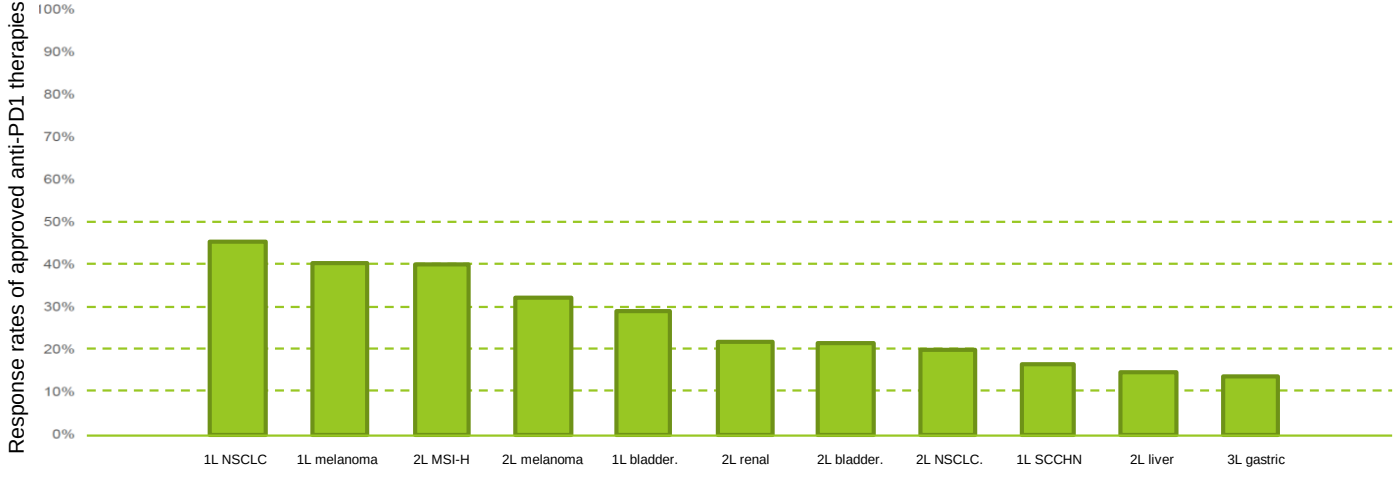
HOWARD KAUFMAN
Chief Medical Officer
World leading clinical immuno-oncologist; ex-SITC President

SUSAN DOLEMAN
VP Clinical Development
Director of Clinical Operations at BioVex/Amgen for T-Vec

ANNE WOODLAND
SVP Regulatory & Quality
VP Regulatory at BioVex; led T-Vec BLA filing for Amgen post acquisition

The problem

- Immune checkpoint blockade is only effective for patients with a pre-existing immune response to their cancer and whose tumors are inflamed
- The key problem to be addressed in immuno-oncology is how to most effectively vaccinate patients against their own tumor for the rest
  - 'The rest' represents the vast majority of cancer patients



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Objectives

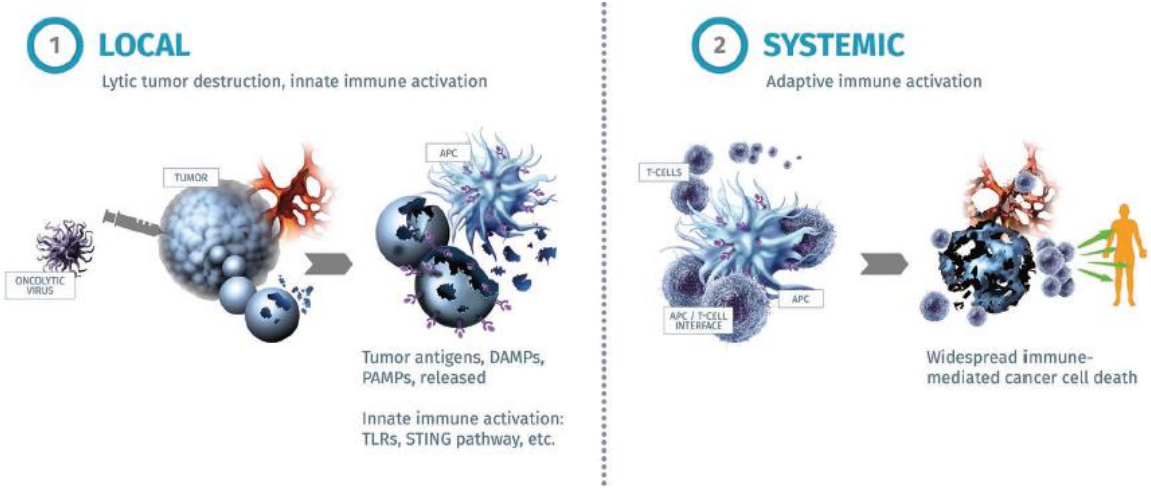
- Render all solid tumor patients responsive to immune checkpoint blockade
  - Immunologically cold tumor types & patients, as well as immunologically hot
- Maximally vaccinate patients against their own cancer
  - Includes neoantigens, as well as defined antigens
  - Off the shelf approach, no patient specific information or manufacturing
  - Potently activate both innate & adaptive immunity
  - Potentially applicable to all solid tumor patients in combination with anti-PD1/L1

How can we vaccinate?

- Options are limited & mainly not yet proven
  - Vaccines made from cancer cell lines or proteins commonly expressed in cancers
    - Tested in extensively in numerous formats – little evidence of activity
    - *The immunogens are generally recognized as 'self', & therefore not very potent immune activators*
  - Vaccines made from immunogens which are uniquely present in a patient's cancer but not normal tissue
    - Arise from the genetic mutations which accumulate in tumors
    - 'Non-self' – should be more immunogenic
    - *Considerable current interest, but not yet clinically proven*
    - *Complex manufacturing – a vaccine needs to be made for each patient following sequencing of their tumor*
  - Activators of the innate immune system
    - TLR9, STING agonists etc - early indications of clinical activity
- Oncolytic immunotherapy – off the shelf, activates innate and adaptive immunity, induces a broad immune response to all antigens present, clinically validated
- Replimune believes this to be the best, most practical & versatile approach

Oncolytic immunotherapy

- The use of viruses that selectively replicate in & kill tumors to treat cancer
  - ✓ Highly inflammatory
  - ✓ Activates both innate and adaptive immunity
  - ✓ Releases the full array of tumor antigens into an inflamed environment
  - ✓ Systemically activates the immune system against the tumor & neo-antigens released
  - ✓ Can be 'armed' with additional genes to increase efficacy
- Single agent T-Vec is FDA approved for the treatment of advanced melanoma



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Oncolytic immunotherapy + checkpoint blockade

Immune response to neo-antigens, inflamed tumor

- Oncolytic and immune-based efficacy in its own right
- Patient-specific neo-antigen vaccine generated in situ

'Brakes removed' from the immune response generated

- Without a pre-existing neo-antigen response, nothing to remove the brakes from
- Only some patients respond

Oncolytic immunotherapy is expected to be an ideal combination partner for checkpoint blockade therapies

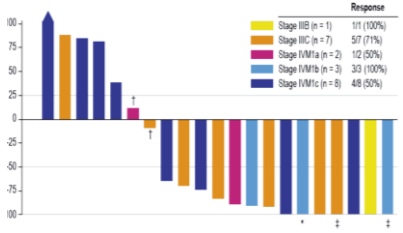
Replimune

Oncolytic immunotherapy is synergistic with immune checkpoint blockade

- Randomized controlled 198 patient phase 2 study of T-VEC + ipilimumab vs. ipilimumab alone in advanced melanoma
- Response rates more than doubled in combination (38% vs. 18%)
- No additional toxicity as compared to ipilumumab alone Chesney et al JCO, 2017

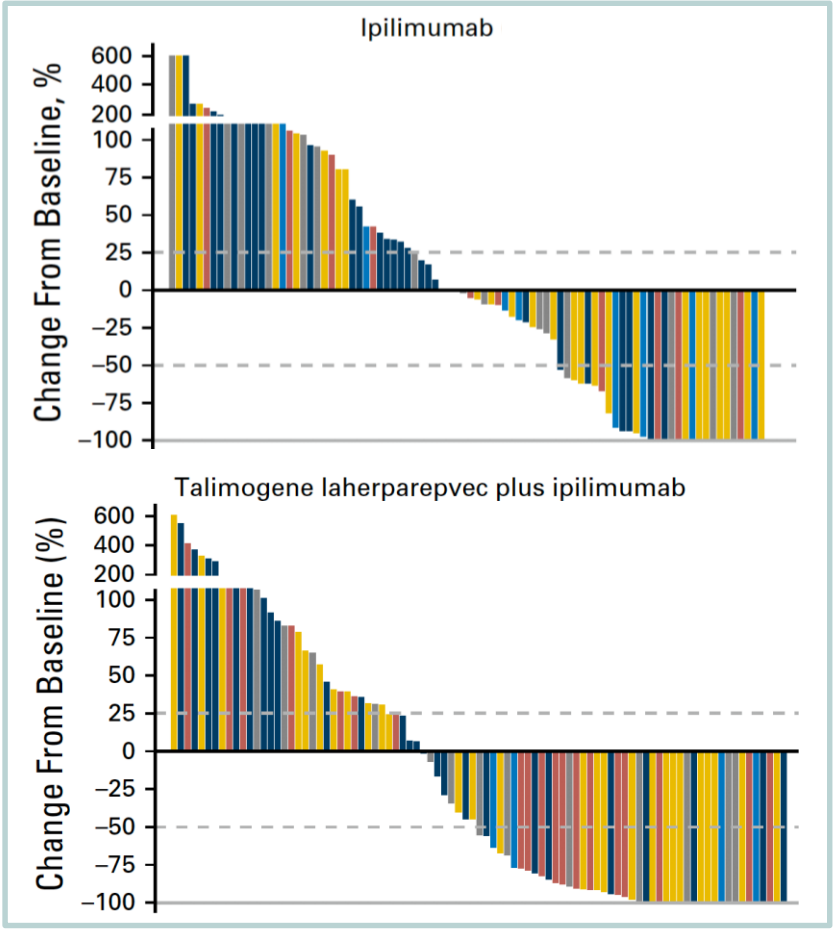
T-VEC+pembrolizumab ph1b study

Ribas *et al* Cell 2017 170: 1109-1119



62% response rate; 33% CR rate

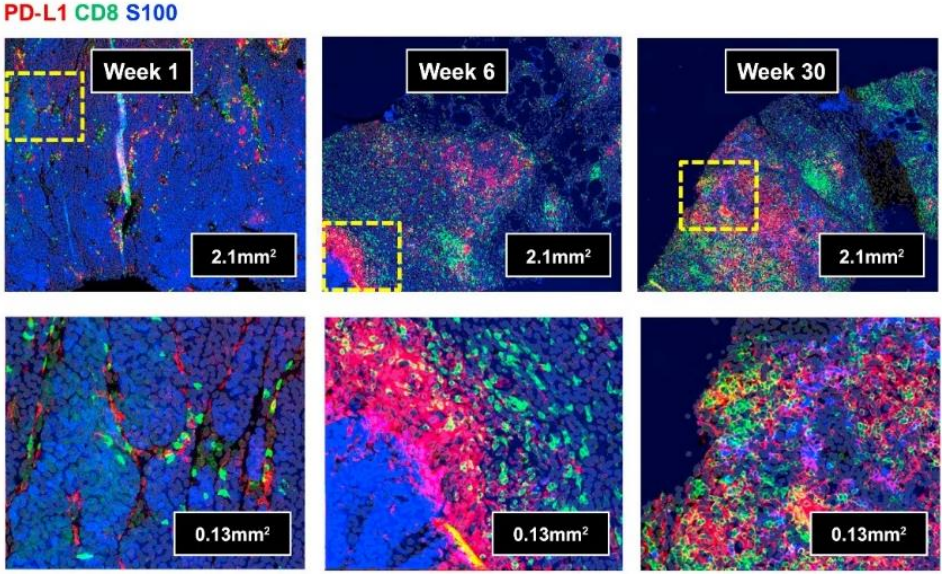
Pembrolizumab+T-VEC currently in a >700 patient phase 3 study



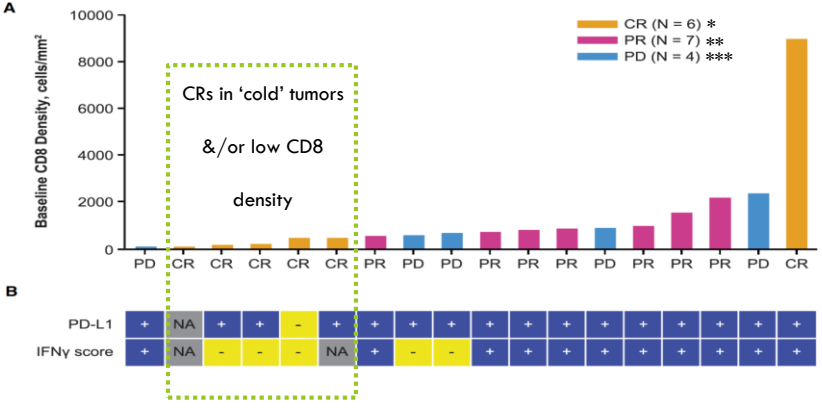
Oncolytic immunotherapy turns “cold” tumors “hot”

T-Vec+pembrolizumab

Ribas *et al* Cell 2017 170: 1109-1119



Baseline | After T-VEC alone | After T-VEC+ pembrolizumab



* CR = Complete response
** PR = Partial response
*** PD = Progressive disease

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Replimune objectives & vision

- Maximize the effectiveness of oncolytic immunotherapy through
  - Direct tumor killing and intra-tumoral spread
  - Immunogenicity of cell death
  - Anti-tumor immune response generation
  - Loading with multiple immune stimulating genes
    - "Oncolytic immuno-gene therapy"
- Extend the utility of oncolytic immunotherapy beyond melanoma to include most solid tumor types
  - RP1 – 'easier' indications – expected first FDA approval
  - RP2 – 'intermediate' indications
  - RP3 – more challenging indications
  - RP4-n - ?
- Provide the most practical & effective universal combination partners for anti-PD1/L1 drugs providing the *essential* tumour specific immune response without which they can't work

Replimune uses HSV

- HSV has ideal properties for oncolytic immuno-gene therapy:
  - Biology well understood
  - Proven safety & efficacy
    - Includes in combination with immune checkpoint blockade
  - Infects human tumor cells broadly, highly lytic & inflammatory, kills mainly by necrosis
  - Potent activator of innate immunity, including through STING/cGAS & TLRs
  - Large genome able to package multiple genes
    - These are then delivered and expressed in the tumor and draining lymph nodes – the optimal sites for anti-tumor immune response induction

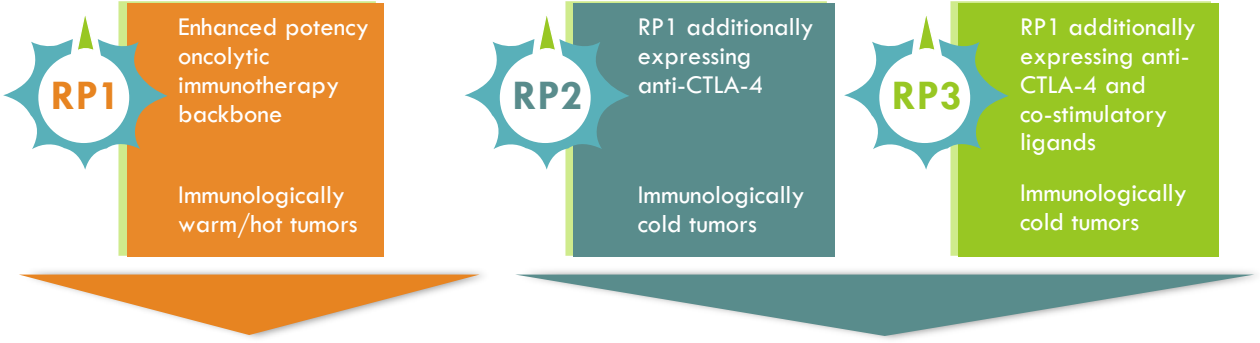
Our Immulytic platform

1. A potent underlying HSV-1 strain

There is great diversity among clinical HSV strains

We tested 29 new strains & selected the most effective

We have armed all of our product candidates with two to four genes encoding therapeutic proteins



2. Increased tumor killing & spread

In addition to the potent cytokine GM-CSF, a modified fusogenic protein (GALV) is expressed

Large bystander effect, highly immunogenic cell death

Provides a substantial increase in direct tumor killing potency

3. Delivery of potent immune stimulatory proteins

Focus on pathways where systemic engagement is sub-optimal

CTLA-4 blockade, immune-costimulatory pathway activation

Delivery directly to the tumor

Replimune

GALV-GP *R*-

- GALV-GP is the envelope glycoprotein of gibbon ape leukemia virus (GALV)
- Highly fusogenic
  - Truncated *R*- version provides constitutive fusion activity, without GALV itself
  - Binds to the PiT1 receptor (GALV and other retrovirus entry receptor)
  - PiT1 is widely expressed on mammalian, including human tumor, cells
  - PiT1 is a Na+-phosphate (Pi) cotransporter
    - PiT1 is critical for cell proliferation (Beck et al 2009 JBC **284**; 31363)
- Rapidly kills by cell to cell membrane fusion giving a large bystander effect
- Results results highly immunogenic cell death*

*Bateman et al 2000 Cancer Research **60**, 1492
Vile et al 2002 Cancer Research **62**, 6566
Errington et al 2006 Gene Therapy **13**, 138

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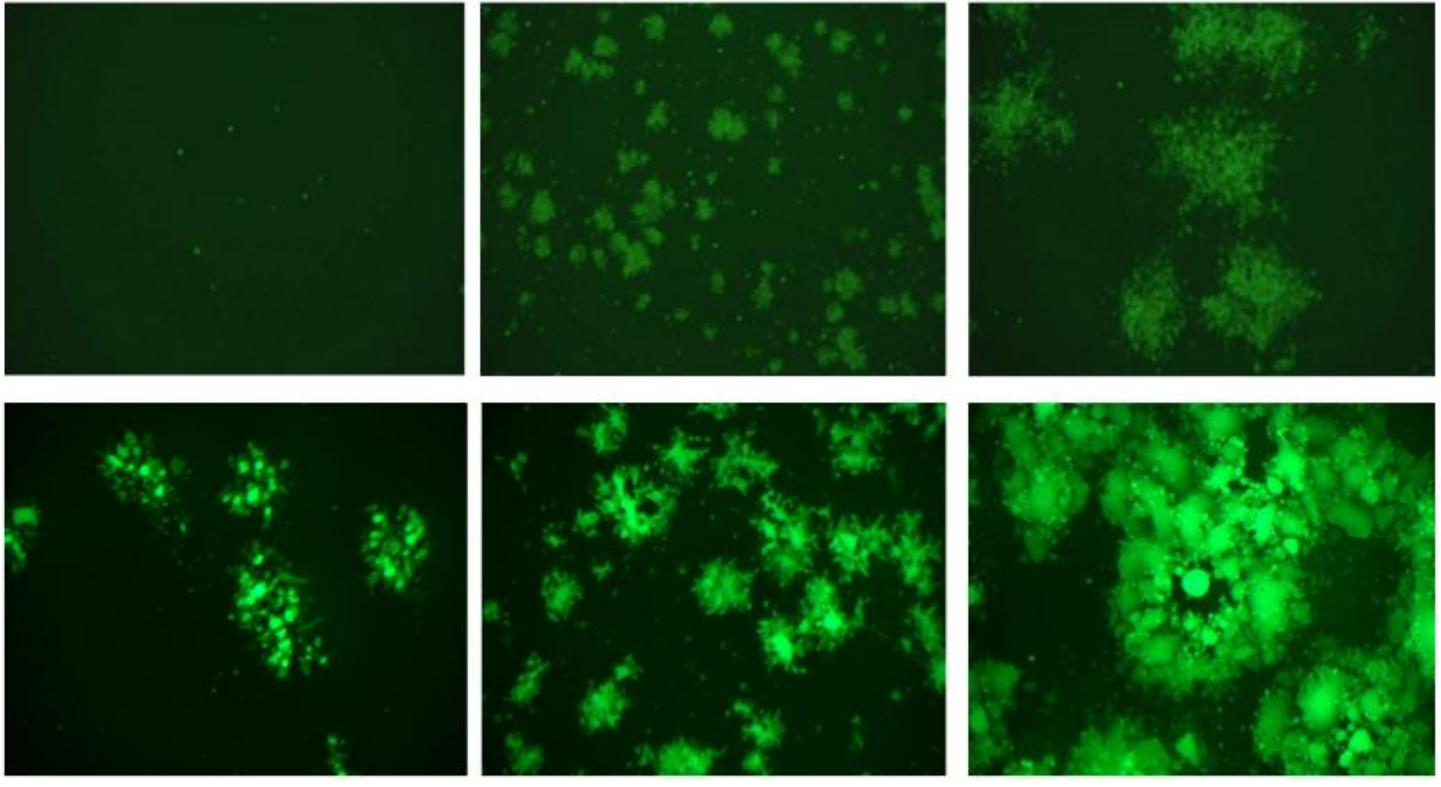
GALV expression enhance potency in vitro

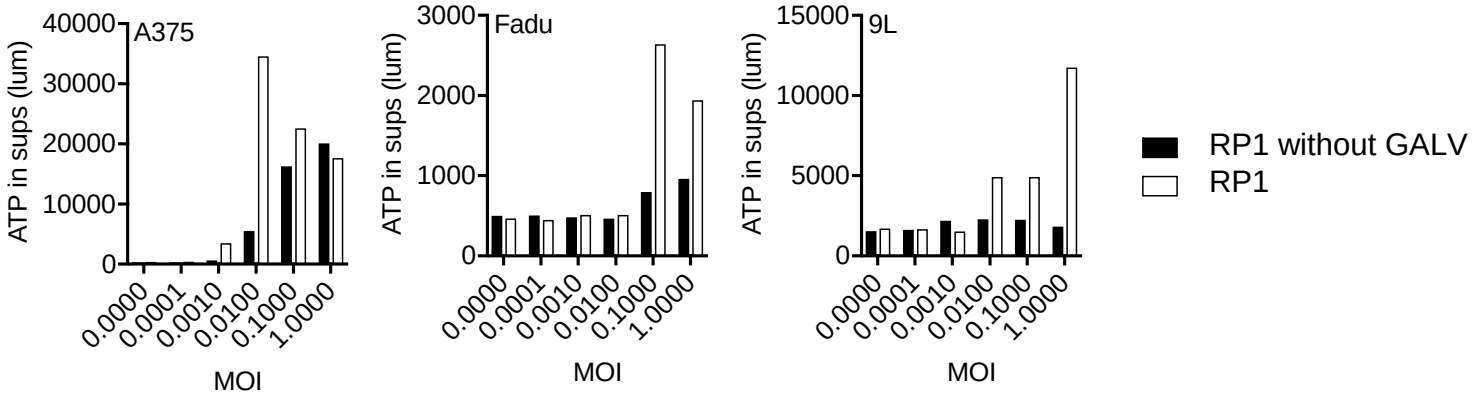


Immunogenic cell death (ICD)

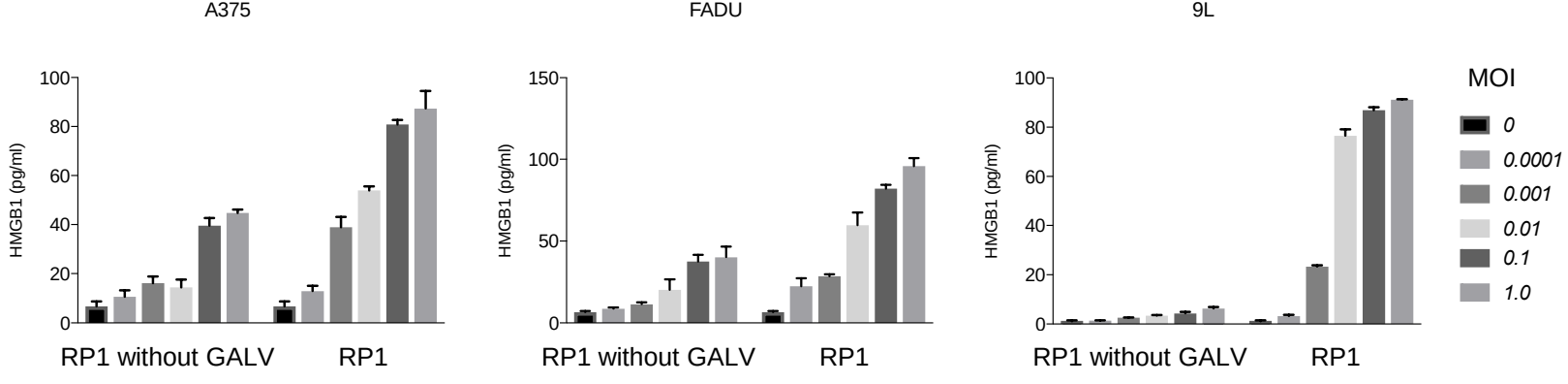
- ICD enables the induction of an effective antitumour immune response through the activation of DCs
- ICD is characterized by secretion of damage-associated molecular patterns (DAMPs)
- DAMPs classically used to assess the level of ICD are HMGB1 & ATP secretion & surface expression of calreticulin
  - Release of HMGB1 is required for the optimal release and presentation of tumour antigens to DCs
    - Binds to several pattern recognition receptors on APCs including TLR2 & 4
  - ATP functions as a "find-me" signal for monocytes

GALV increases ICD: ATP & HMGB1 release

ATP release

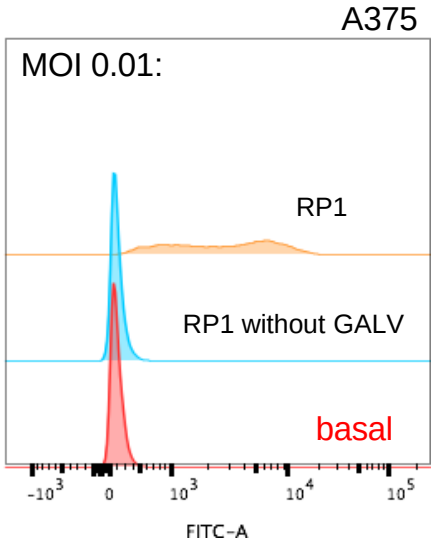


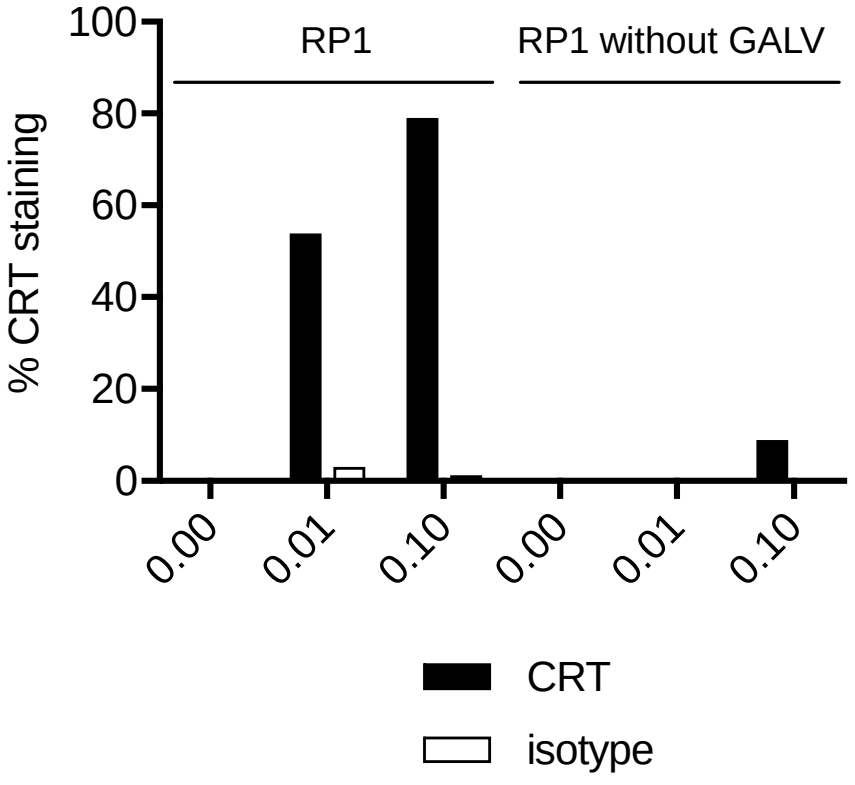
HMGB1 release



Collaboration with The Institute of Cancer Research, London

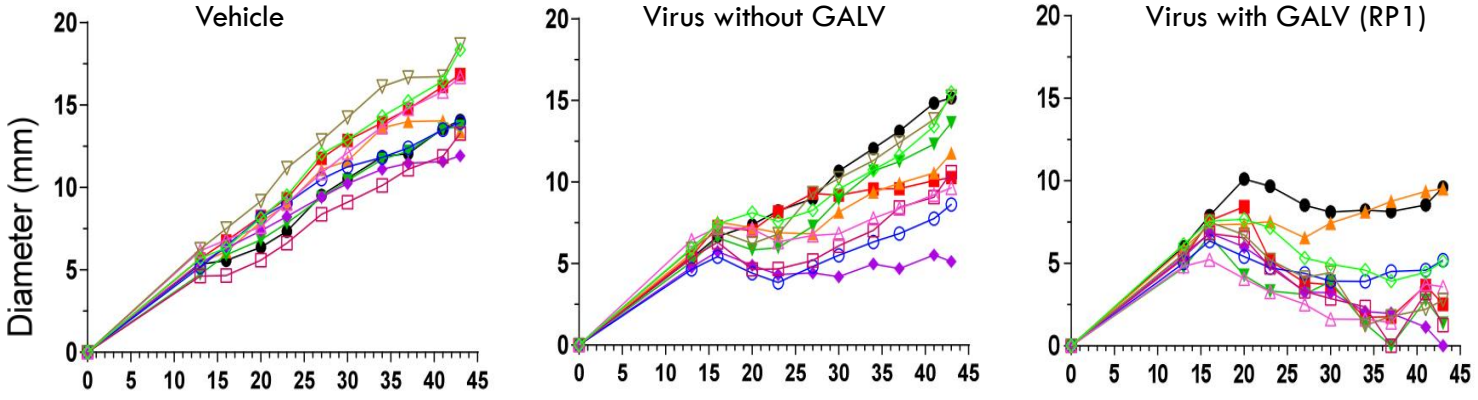
GALV increases ICD: Calreticulin cell surface expression



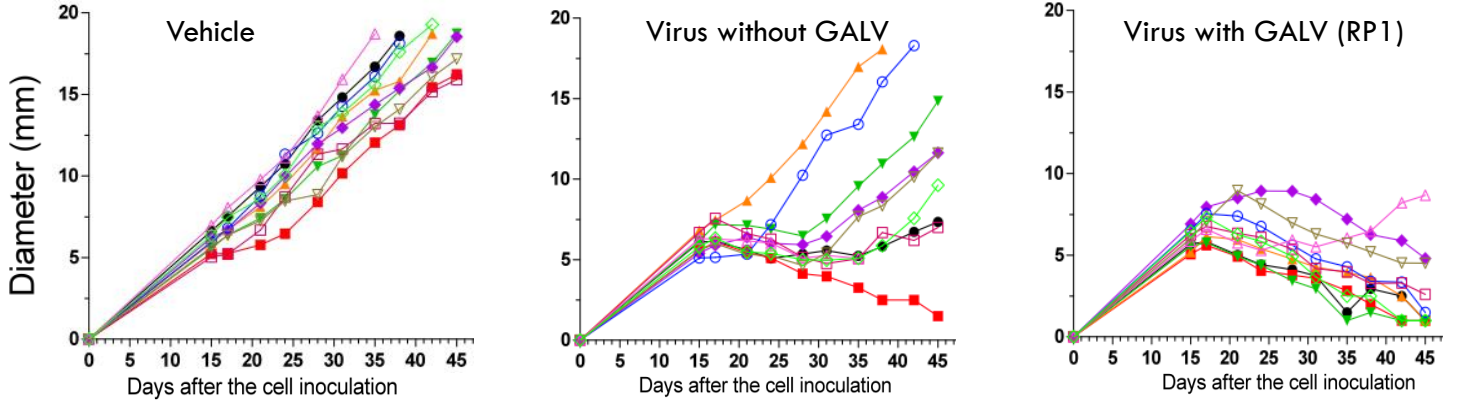


GALV enhances efficacy in vivo

A549
lung cancer



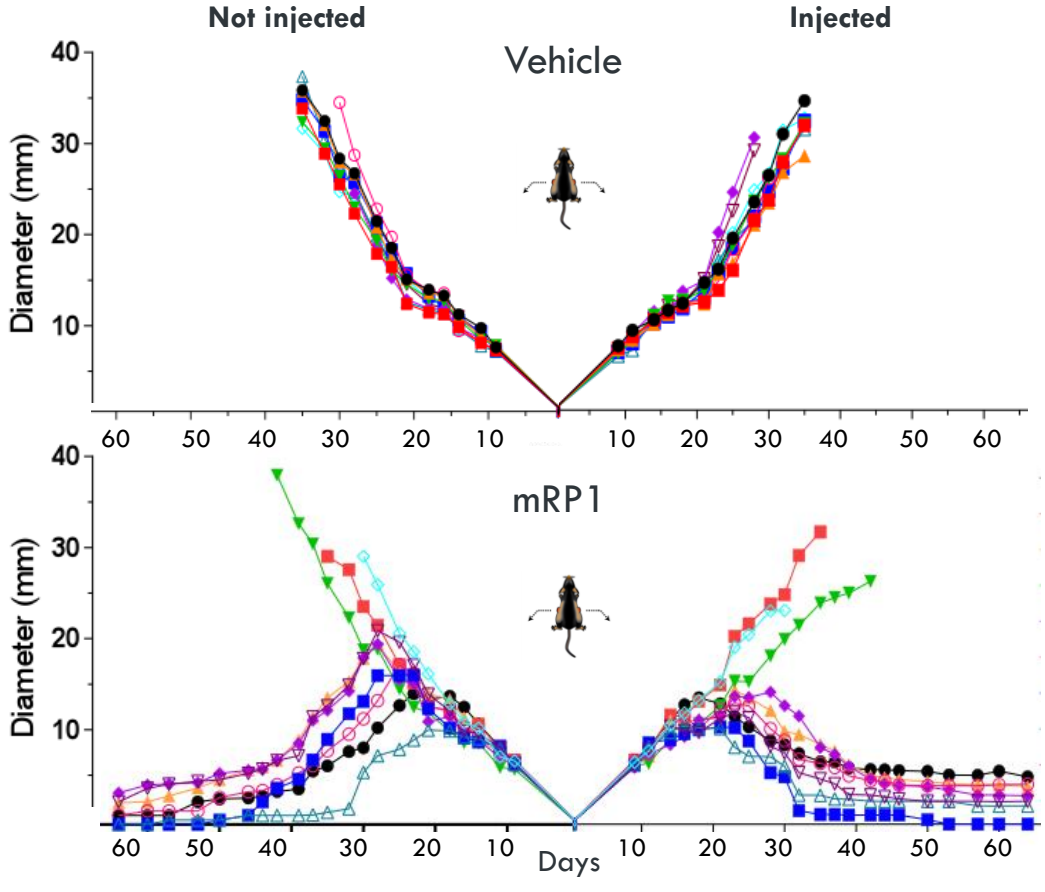
MDA-MB-231
breast cancer



3 injections over 1week; virus dose $5x10^3$ pfu

Replimune®

RP1 treats large injected & uninjected tumors



<u>Immune competent rat model (dual flank)</u>

While rat tumor cells are of limited susceptibility to HSV, GALV is active in rats. Right flank tumors injected 5x with $5x10^6$ pfu

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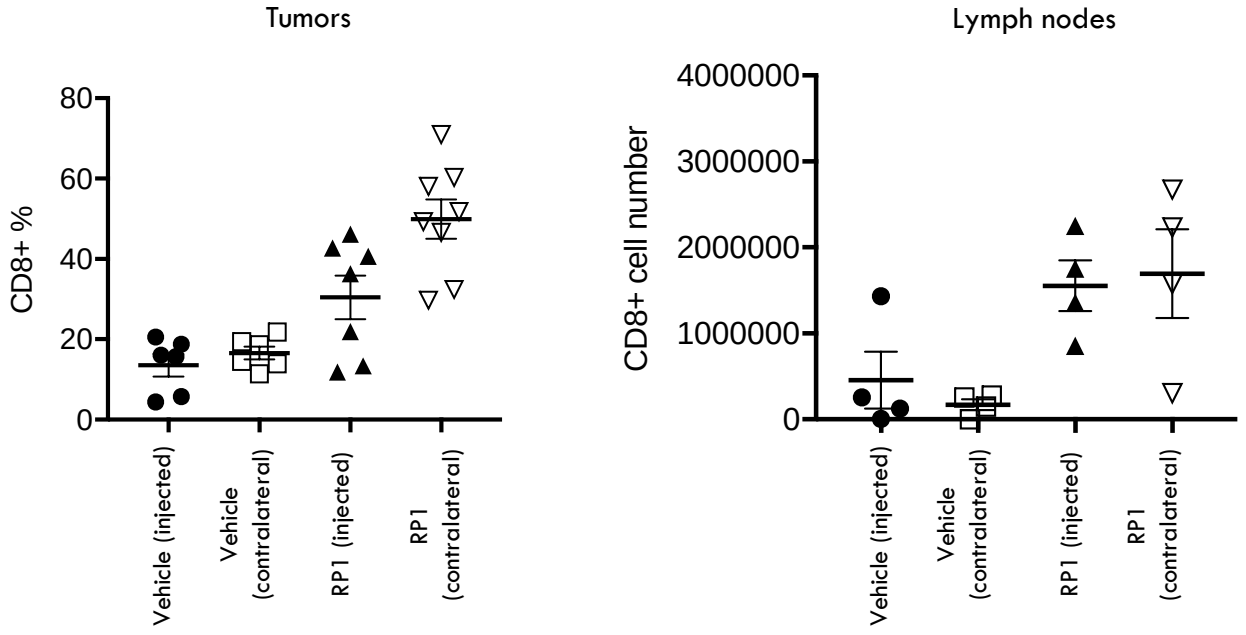
CD8+ T cells are increased in tumors and lymph nodes



Mouse 4434 melanoma tumors (dual flank)

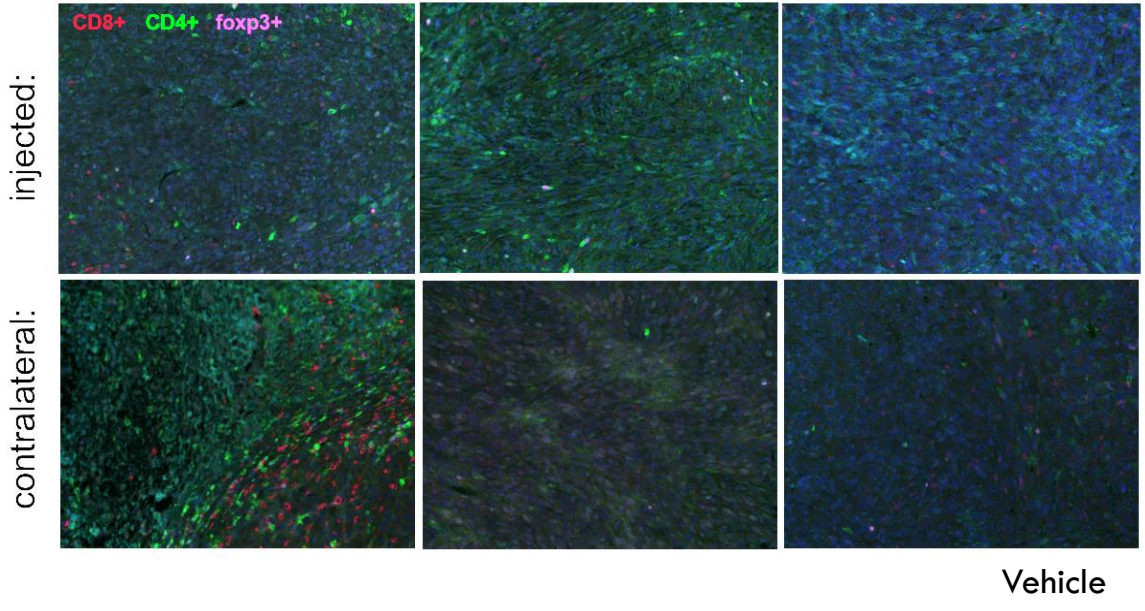
50ul ($1x10^8$ pfu/ml) of RP1 injected 3x into the right tumor only (Days 1, 3, 5)

Tumors & draining lymph nodes were harvested eight days after treatment initiation

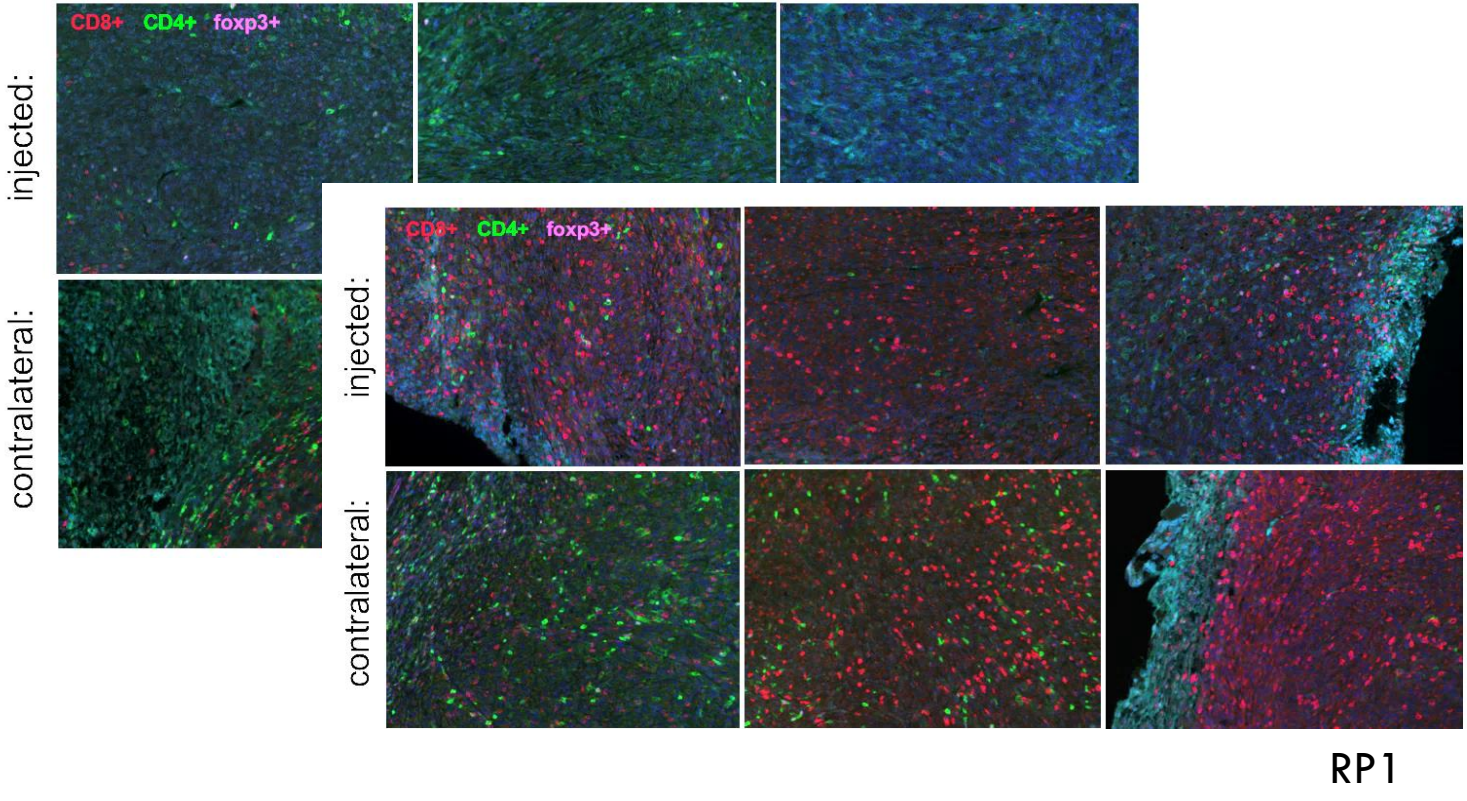
Replimune®

Collaboration with The Institute of Cancer Research, London

RP1 increases CD8 T cells in injected and uninjected tumors



RP1 increases CD8 T cells in injected and uninjected tumors



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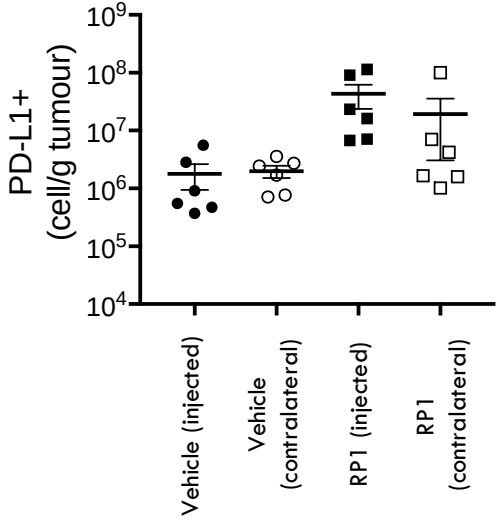
RP1 increases PDL1 expression in injected and uninjected tumors



Mouse 4434 melanoma tumors (dual flank)

50ul ($1x10^8$ pfu/ml) of RP1 injected 3x into the right tumor only (Days 1, 3, 5)

Tumors were harvested 1 week after treatment initiation

Replimune®

RP1: Developing for tumor types with underlying sensitivity to anti-PD1

Potential rapid path to initial approval

Replimune

RP1 clinical strategy

Phase 1 (underway)
Safety confirmation & determination of dose for phase 2, all comers
(N≈30)

Phase 2 (initiates H1 2019)
Defined indications
(N≈30 patients per group)

Phase 1/2 clinical trial in ≈150 patients

- Single agent RP1
- RP1 + nivolumab*[1]

- Melanoma + nivolumab*[2]
- NMSC[3] + nivolumab*[2]
- Bladder cancer + nivolumab*[2]
- MSI-H cancers + nivolumab*[2]

EXPAND PROMISING COHORTS (dependent on data & FDA input)

Initiates H1 2019

Randomized, controlled Phase 2 clinical trial in ≈240 patients with CSCC

- RP1+ cemiplimab vs. cemiplimab alone#

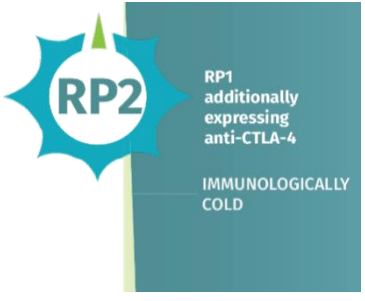
[1] Includes biomarker component to confirm MOA [2] Efficacy to be assessed by ORR, CR rate and biomarker analysis [3] Non-melanoma skin cancers

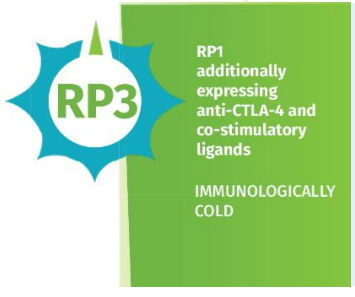
* Under clinical trial collaboration & supply agreement with BMS for the supply of nivolumab

Under clinical trial collaboration agreement with Regeneron; 50:50 sharing of clinical trial costs
(part of a broader collaboration under which clinical trials in additional tumor types may also be conducted)

CSCC – intended initial path to approval

- 4,000-9,000 US deaths annually
  - Expected to overtake melanoma as the most lethal skin cancer
- Anti-PD-1 therapy active
  - Cemiplimab (Regeneron) demonstrated 46% response rate, but low CR rate
  - Recently FDA approved (only approved therapy)
- Tumors are frequently accessible for direct injection
- Highly mutated – contain a lot of neoantigens
- We believe CSCC provides a rapid route to market for RP1
- Preparing for a registration-directed randomized controlled phase 2 trial in collaboration with Regeneron
  - 240 patients randomized 2:1 (RP1+ cemiplimab vs cemiplimab alone)
  - Primary endpoint ORR, secondary endpoints including CR rate, PFS, OS





RP2/3: Target anti-PD1/L1 non-responsive tumor types

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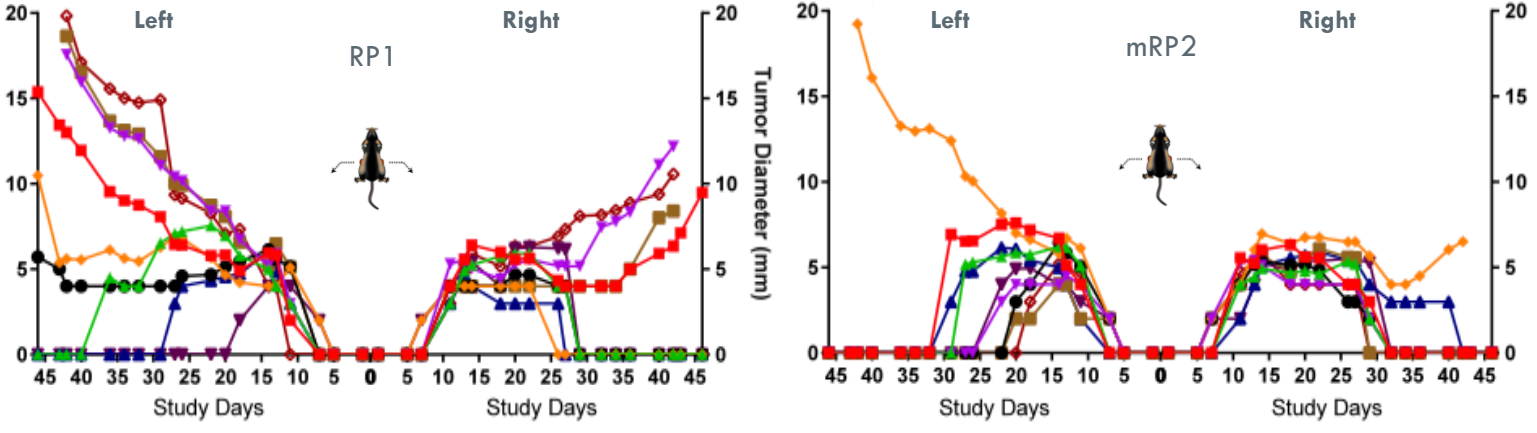
Intratumoral anti-CTLA-4 & co-stimulatory pathway agonists

- Focus on delivery of proteins which act as the immune response is being generated
  - Systemic antibody approaches probably don't act at the right place or the right time
  - Potential for toxicity
- RP2
  - Delivery of anti-CTLA-4 directly into the tumor
  - Blocks Treg activation/inhibition of T cell activation at the site of immune response initiation
  - Retain the efficacy of ipilimumab alone & in combination with anti-PD1 but reduce toxicity
    - Potential for improved activity as compared to combination anti-CTLA-4/anti-PD1
- RP3
  - Delivery of immune co-stimulatory pathway ligands
    - CD40L, 4-1BBL, GITRL, OX40L, ICOSL
  - Antibody approaches have given indications of activity, but toxic
    - Considerable pharma interest retained by pharma in these targets
  - RP3 payload to be finalized Q4 2018

Expression of anti-mCTLA4 from RP1 enhances efficacy



Immune competent A20 mouse tumor model
Subtherapeutic dose for RP1 ($5x10^4$ pfu) injected 3x into the right tumor only

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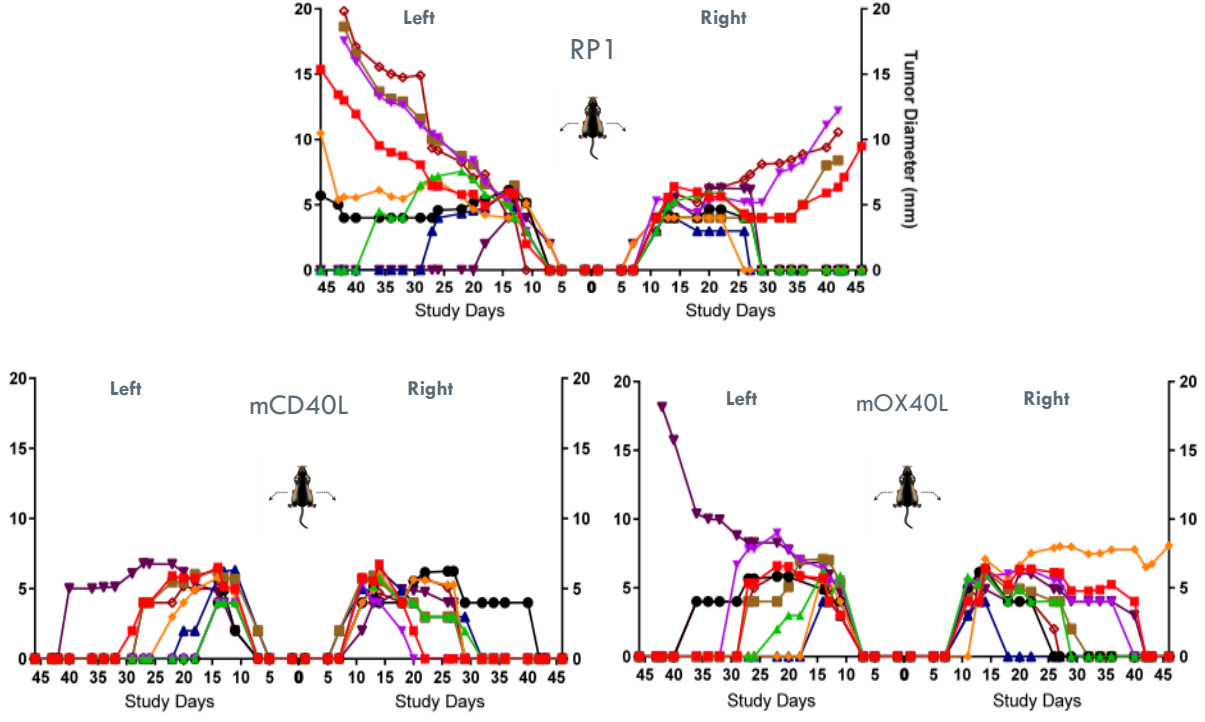
Similarly increased effects with co-stimulatory pathway ligands



Replimune

Intratumoral anti-CTLA-4 & co-stimulatory pathway agonists

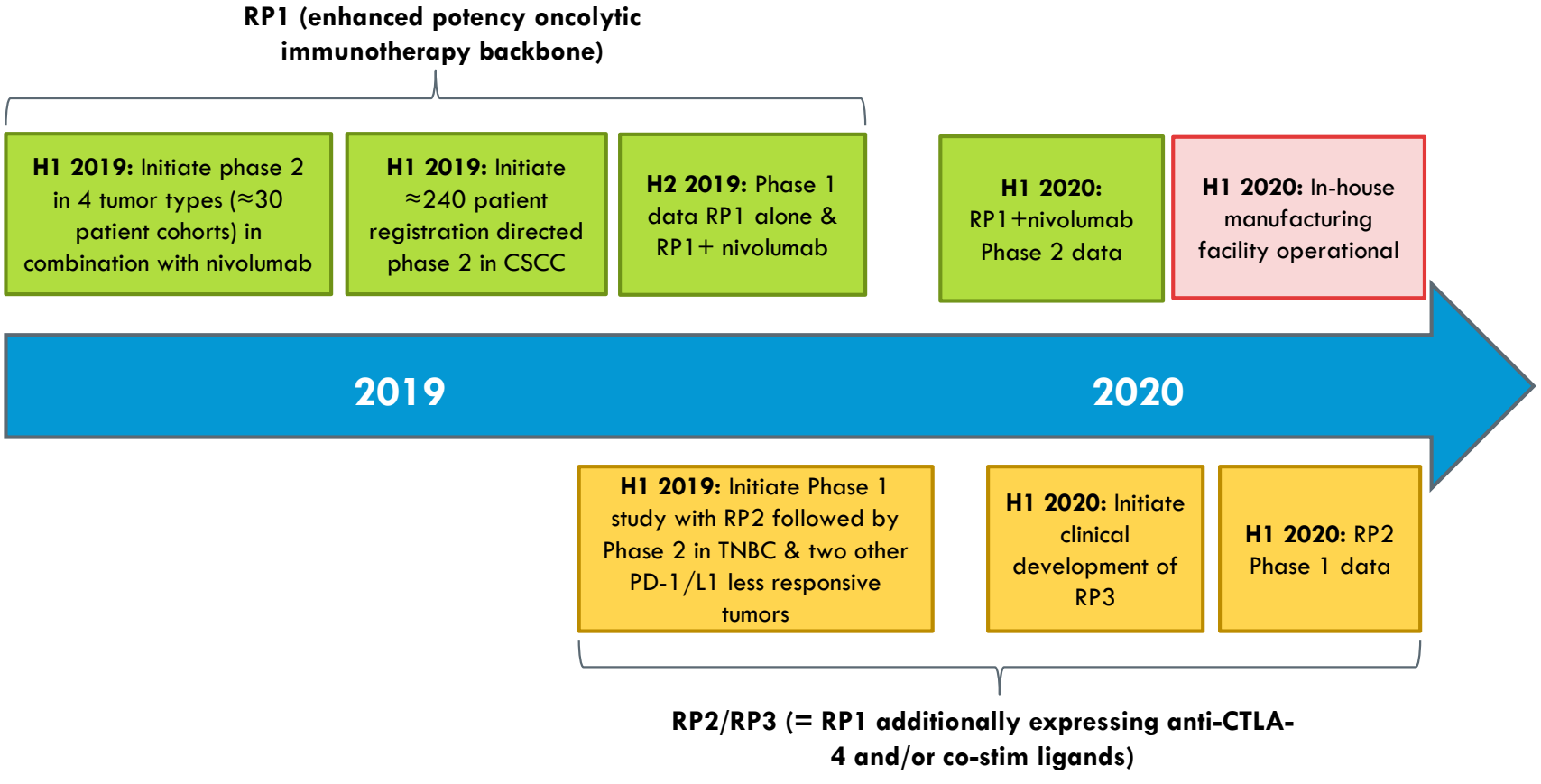
- Focus on delivery of proteins which act as the immune response is being generated
  - Systemic antibody approaches probably don't act at the right place or the right time
  - Potential for toxicity
- RP2 – Targeted to enter the clinic H1 2019
  - Delivery of anti-CTLA-4 directly into the tumor
  - Blocks Treg activation/inhibition of T cell activation at the site of immune response initiation
  - Retain the efficacy of ipilimumab alone & in combination with anti-PD1 but reduce toxicity
    - Potential for improved activity as compared to combination anti-CTLA-4/anti-PD1
- RP3 – Targeted to enter the clinic H1 2020
  - Delivery of immune co-stimulatory pathway ligands
    - CD40L, 4-1BBL, GITRL, OX40L, ICOSL
  - Antibody approaches have given indications of activity, but toxic
    - Considerable pharma interest retained by pharma in these targets
  - RP3 payload to be finalized Q4 2018

Critical focus on manufacturing

- Product candidates currently manufactured by a CMO for ongoing clinical development
- For later stage development & commercialization, in-house manufacturing is preferable
- The team has extensive manufacturing experience
- 63,000 ft^2 manufacturing facility leased in July 2018 in Framingham, MA, appropriate for multi-product production – intended to include translational biomarker lab
- Expected to be on-line to produce clinical product in H1 2020

* Rendered depiction of the intended final facility

Key target milestones



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Maximally activating the immune system against cancer

- Multi-product candidate oncolytic immunotherapy platform company
- Broad clinical development program initiated
- RP1 intended to enter a potentially registration-directed 240 patient phase 2 clinical trial in cutaneous squamous cell carcinoma (CSCC) in H1 2019 (collaboration with Regeneron)
- RP1 being studied in an additional four tumor types in an ongoing 150 patient phase 1/2 clinical trial combining with nivolumab (collaboration with BMS)
- RP2 & RP3 for PD-1/L1 less responsive tumors expected to enter the clinic in 2019/20
- Further product candidates intended
- Commercial scale manufacturing capability being established
- Aim to become a universal combination partner for PD-1/L1 therapies potentially applicable to all solid tumors