Adaptimmune

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Moderator: Good afternoon, everyone. Welcome to the 43rd Annual JP Morgan Healthcare Conference here at San Francisco. It is my pleasure to introduce our presenting company today, Adaptimmune. Joining us today is Adrian Rawcliffe, the CEO. With that, Adrian, the floor is yours.

Adrian Rawcliffe: Thank you. Welcome. Thanks for sticking out all through the day to on the last sessions and thank you for coming to learn about Adaptimmune. Thank you to JP Morgan for hosting us.

I intend on making forward-looking statements, and these are covered by the disclaimer, which is also available on our website. Adaptimmune's proprietary TCR engineering platform has delivered the first engineered T-cell therapy for a solid tumor in history with the approval of Tecelra for the treatment of advanced synovial sarcoma last year by the FDA.

Today, I'm going to share with you how that's just the start of what we plan on building at Adaptimmune and, in particular, how 2025 will become the year of commercial execution for Tecelra and the start of our sarcoma franchise.

I'm going to be talking quite a lot about our sarcoma franchise because right behind Tecelra approved is lete-cel, where we presented successful pivotal trial data in November last year at the CTOS conference.

When you put those two products together, we see combined peak sales in the United States in the launch indications of approximately $400 million for both Tecelra and lete-cel, and we have established as a company the aspirational target of being cash flow breakeven in 2027.

Behind Tecelra and lete-cel is a focused pipeline with a partnership with Galapagos in uza-cel in head and neck cancer and two very exciting earlier programs in targeting PRAME and CD70, perhaps the largest targets in the cell therapy space for solid tumors.

The core competency of Adaptimmune rests in discovering, developing, and delivering cell

therapies based on our T-cell receptor platform and in the solid tumor space. We engineer T-cells that we integrate into patients' own immune systems. We grow those cells in our manufacturing facilities.

We infuse them in a one-time infusion, and those cells then go to work to kill the tumor and deliver the clinical data that we've demonstrated over the past few years in many tumors. In particular, the pivotal data in Tecelra and lete-cel that will form the basis of our sarcoma franchise, provide a meaningful advance over existing treatments, and ultimately, will become the standard of care for eligible patients with these sarcoma types.

We use this platform because it is uniquely suited to addressing the challenges of cell therapies in solid tumors. You're probably aware of the CAR-T therapies and the success that products like Yescarta, Kymriah, Abecma, Carvykti have had.

You're probably also aware that it's been very challenging getting those products out of the hematological space, where they sold probably four billion over the last year, and into the solid tumor space. There is a really good technical reasons why CAR-Ts face substantial challenges in the solid tumor space.

However, the engineered T-cell therapies are specifically going after targets that are on solid tumors, and our capabilities built over the last decade are specifically enabling us to develop and deliver those therapies in the solid tumor settings.

This is why we have the first approval of an engineered cell therapy for a solid tumor and the dawn of what we believe will be an entirely new way of treating a broad range of cancers over time. Our products in the pipeline start with Tecelra, which was approved in August last year for patients with synovial sarcoma who express MAGE-A4 as a target.

Next up is Lete-cel for both synovial sarcoma and myxoid/round cell liposarcoma, another soft tissue sarcoma. I'll abbreviate that to MRCLS going forward. Lete-cel targets the NY-ESO antigen, so a different target to Tecelra.

We presented substantial pivotal data in November at the CTOS meeting that will form the basis of a rolling BLA that will initiate this year. Behind that, we have the partnership with Galapagos in user cell in head and neck and two preclinical programs, PRAME, targeting PRAME and targeting CD70.

I'll go into each of those in a few minutes. The approval of Tecelra in advanced synovial sarcoma is just the first step in building our sarcoma franchise. As I said, this will be followed by Lete-cel, a complementary product, and there are tremendous commercial synergies because these effectively go through exactly the same commercial footprint and channel. Lete-cel is on track to start a rolling BLA submission in 2025.

This would expand the patient population by approximately two-and-a-half times from 400 patients with the right targets for Tecelra in the United States to over 1,000 patients. That produces peak year sales, when we think about how many of those patients we can get to, of approximately $400 million.

I would point out that $400 million we think of as a good start, and I'll talk in a little while about the expansion opportunities, both geographically and otherwise, that we see for our sarcoma franchise.

With an expected gross margin of about 70 percent and a relatively nimble infrastructure, this gives us clear line of sight to our target to achieve cash flow breakeven by the end of 2027. Let's talk a little bit about synovial sarcoma. It's an aggressive soft tissue cancer, and there has been, prior to the approval of Tecelra, no new approvals in this space in well over a decade.

These patients are typically young when they're diagnosed. The average age of diagnosis is in the 30s. Five-year mortality in the metastatic setting is 20 percent. A very young, very significant burden on a group of patients who have super high agency and deserve the best treatments. Tecelra is offering that.

There are alternatives at the moment, frontline anthracycline based chemotherapy which produces responses in the majority of the patients. Those responses are typically transient. Most patients progress within 12 months. Following that, there is nothing effective.

Pazopanib, or Votrient, is used in the second line setting. It has a response rate that's estimated somewhere between 4 percent and 14 percent. The data from the pivotal spearhead one trial of Tecelra and the approval of Tecelra, the first approval in this space in over a decade, gives doctors a truly transformative alternative for eligible patients.

These data showed a 43 percent response rate, six months median duration of response but in fact, there's a very long tail on this product. Up to 40 percent of the patients had a 12 months or greater duration of response, and many have responses measured in years at this point.

Again, this is a huge advance over decades old therapy, and it's a message that we're now carrying to the patients, to the physicians, to the payers as we continue to make excellent progress on our launch of Tecelra which has been going on since August. Let's provide a little update on that launch.

The product was approved in August together with two companion diagnostics. We believe, actually, this is the first time a product has ever been approved with simultaneous approval of the two companion diagnostics.

Our manufacturing capacity was stood up at the time and can develop all the way through to peak year sales. We have no issues with being able to manufacture this at any volumes that would be reasonable. We have been engaged with HCPs at 60 centers, over 500 HCPs at 60 sarcoma centers of excellence.

Our Adaptimmune Assist program was stood up on day one, ready to support patients from a logistics and financial perspective. We were exceptionally pleased that the NCCN guidelines were updated tail end of last year to include synovial sarcoma and the treat use of Tecelra in advanced synovial sarcoma as a recommendation.

As you know, the NCCN guidelines form a backbone of treatment guidance for oncology physicians. In addition, we have established coverage for Tecelra with over 70 percent of commercial lives and a little more in the Medicare space, and I'll talk a little bit about that in due course.

All of that is background. All of that is necessary, and the key thing we've been doing in the last six months is standing up the treatment sites and getting the patients through the process of screening, eligibility for the treatment, insurance eligibility, manufacturing, and then dosing.

When we launched the product, we anticipated we would dose our first patient in Q4 of 2024, and indeed, we did so. That patient was dosed on Thanksgiving Day at the Moffitt. We said that we wanted to stand up between 6 and 10 authorized treatment centers on our route to getting to 30 by the end of next year.

We stood up 11 authorized treatment centers. By the end of the year, we'd have apheresed further two patients for a total of three patients apheresed in the fourth quarter of last year. Everything that we are seeing, both those metrics and the patients coming through the funnel and

the number of biomarker eligible patients available to us who are looking for Tecelra as their next treatment option.

Everything is telling us that we are well on track to be able to deliver our 2025 objectives, to grow sales in a measured, consistent fashion, delivering increasing quarter-on-quarter sales throughout 2025.

This map shows the treatment centers that we are working with, and they are the ones that will be familiar to you. MD Anderson, Memorial Sloan Kettering, Moffitt Cancer Center, Stanford. These are the sites that we've worked out for the clinical trials, and these are the sites that we are standing up at the front end of our program of ATC openings.

It's important to note that these sites that we plan on opening, there's 30 of them across the country, cover 80 percent of the patients that are seen in the sarcoma centers of excellence. They provide a robust footprint and, obviously, patients will need to travel.

For a one-off treatment with the logistical support that we can provide, we believe this network will enable us to get to the vast majority of patients nationwide. In terms of reimbursement and payer coverage, as you know, rare oncology indications are not the most actively managed category.

As I discussed in this particular setting, there are no other effective alternatives, unfortunately, for the patients in this advanced synovial sarcoma space. There have been no roadblocks so far for patients to have access to the access that they need to the treatment.

In fact, we have established policies with insurers that cover over 70 percent of commercial lives and 70 percent of Medicare lives. This is a young patient population. The payer mix is quite favorable with the majority of patients having commercial insurance and about 20 percent having Medicare.

Shifting gears a little to talk about lete-cel. Tecelra is for synovial sarcoma. Lete-cel is for synovial sarcoma and for myxoid/round cell liposarcoma. Myxoid/round cell liposarcoma or MRCLS is another soft tissue sarcoma subset.

The treatment is very similar to synovial sarcoma. There is lots of grounds for improvement of that treatment and the prognosis for those patients is even worse than synovial sarcoma with about an eight percent, five-year survival rate.

The tremendous room for improvement that I referred to from a clinical perspective, I think we have delivered with the pivotal results for lete-cel that we presented at CTOS last November. What do those look like?

The vast majority of patients treated in this trial that enrolled 64 patients with MRCLS and synovial sarcoma, the vast majority saw a reduction in their tumor, a response rate of 42 percent, and unusually and very encouraging, six complete responses split evenly between the two indications.

That's about a 10 percent complete response rate in an advanced solid tumor setting with a single dose of T-cells which I think is a quite remarkable efficacy endpoint.

The other thing that was very encouraging about this is that there is a 12 months median duration of response across this patient population and the response rates and the duration of response between the two patient populations was similarly impressive.

These are the dates that we will use to seek approval beginning with our completing the initiation of a rolling BLA in Q4 2025. We just received breakthrough designation for lete-cel in MRCLS, and we already have breakthrough designation for lete-cel in synovial sarcoma.

That will give us not only the ability to talk to the FDA regularly throughout this process, but also the expedited eight-month review cycle. The goal is to complete the BLA submission by the second quarter of 2026, enabling approval in 2026, and we will be ready to launch lete-cel on approval.

One of the principal reasons we'll be able to launch lete-cel on approval and do so aggressively is because we will have stood up all of the infrastructure that we need to do so through the launch of Tecelra. This goes through exactly the same commercial channels, the same footprint, the same ATCs, many cases, the same doctors, the same patient support mechanisms, etc.

Everything that we're doing for Tecelra, we can flip into the approval and launch of lete-cel. I referred earlier to the expectation of a 400 million peak year sales for the initial launch indications for Tecelra and for lete-cel.

I think that's a good start, but there are multiple opportunities to go beyond that and to get the benefits of this cell therapy to more patients. We have the opportunity to launch both products outside of the US. These are wholly owned by Adaptimmune.

Over time, we anticipate that both products might be used earlier in the treatment paradigm and also potential for sequential use of each of the products in the event that patients are dual positive. Beyond lete-cel and Tecelra, these are targets that are expressed, but there are other HLAs that we can go after as well.

These are restricted by HLA. The other HLAs could almost double the size of that population and lastly, we have a program in development targeting PRAME, which has applicability across a broad range of sarcomas.

When you put all that together, this slide shows the patient numbers associated with those expansion opportunities that I just outlined. You see the left-hand side, I have a thousand patients that we saw beforehand and the 400 million peak year sales in the initial launch indications.

This patient pool doubles when we consider the opportunity for sequential use and for territories outside the US, and it almost doubles again when you consider products that against other HLA types. And then lastly, bringing PRAME more than doubles this to up to 9,000 patients who would be biomarker-eligible for treatment across the full range of our sarcoma potential pipeline in the long term.

In total, therefore, the opportunity to bring the benefits of cell therapy to this vastly underserved sarcoma patient population could enable a global business targeting thousands of patients with life-saving therapies in the long term.

Turn to the rest of our pipeline quickly. Below our sarcoma franchise opportunities, we have two wholly owned preclinical programs and the partnership with Galapagos. The partnership with Galapagos is studying user cell in head and neck cancer.

It's doing so on the basis of data that we gathered with user cell on our manufacturing platform that showed that of the five head and neck cancer patients we treated, every single patient saw a profound reduction in the size of their tumor with four bona fide confirmed responses.

The only reason the last patient was not a responder was they were very, very advanced patient. These patients generally were very advanced head and neck cancer patients, and the ability for them to wait four to six weeks for the manufacture of the cells was challenging.

That's why we thought this was the best possible place to use the distributed manufacturing that

Galapagos have, which offers a potential of a seven-day vein-to-vein period. That trial, proof of concept on Galapagos' platform will initiate this year with a CTA intended to be filed this year. Beyond that, we have our program targeting PRAME. ADP-600 is a highly sensitive TCR. We have used all of the engineering from the company over the last decade.

All of the experience with the TCRs that we've put into the clinic so far to engineer a highly sensitive and highly selective TCR that we estimate is approximately 10 times more sensitive than the competitor programs for this one of the largest cancer testes antigen programs with a potentially addressable patient population of up to 29,000 patients as well as the sarcoma opportunity that I talked about.

This is highly expressed in endometrial cancer, squamous lung cancer, breast cancer, uterine cancer, and others. IND for PRAME is also planned for 2025. Behind PRAME, TRuC technology, slightly different technology platform targeting CD70. CD 70 is also a clinically validated target. There are other programs.

We have the opportunity here, like with the PRAME program, to go for a best-in-class against a validated target based on our engineering and experience. Approximately 72,000 patients have tumors that express CD70 at high levels, and this includes not only hematological malignancies like AML but also large solid tumor settings like renal cell carcinoma.

We anticipate an IND for ADP-520 in 2026. Before wrapping up, here's a high-level look at the achievements of the last year and, importantly, the upcoming milestones for 2025. We will initiate the BLA for lete-cel this year, and we'll file the IND for PRAME program and the CTA for the head and neck study for user cell with Galapagos.

I suspect the majority of the interest will continue to be in the evolution of our launch of Tecelra, where we anticipate opening the full network of ATCs across the country and reporting increasing sales in each quarter of 2025, as we continue to bring the benefits of Tecelra, this first engineered T cell therapy for a solid tumor, to the people with synovial sarcoma who desperately need it.

I'll just leave you for the Q&A with this last slide, highlights Adaptimmune, a commercial-stage cell therapy company creating cell therapies for solid tumors with a very high value, real-term sarcoma franchise, prioritized pipeline, and we're targeting breakeven in 2027. Thank you.

[applause]

Moderator: Thank you, Adrian, for this insightful presentation. We are now ready to move into the second part of our session, the Q&A. As a reminder, you can address any questions to Adrian by raising your hand at the recent webcast session, so you can address your questions online as well, or you can email me directly. Any questions from the audience?

We can take the one from my email just now. Overall, when thinking about cell therapy space, Adrian, it seems like the space is quite unloved at the very moment by the market. What do you think they are missing?

Adrian: Yeah. I would agree. It's unloved by the markets, although it can be difficult to distinguish that from general biotech at the moment. I'm the CEO of a cell therapy company, I think they're missing absolutely everything. When we look back on this in 20 years' time, we would look at cell therapies in the same way as we currently look at antibodies.

This is a new modality of space with almost unlimited potential because cells can do things that no other modality of therapy can do. It's a one-off treatment, and it's the only treatment that will give you permanent gain of function, essentially. That's what our T cells do.

Cell and gene therapy, that's the only modality that would do that. One way of thinking about cell therapy is it's simply a way of doing gene therapy in a slightly more sophisticated way, and safer way perhaps. That's the first point.

What you're seeing at the moment is you're seeing the heme malignancies have become crowded with cell therapies, but the solid tumor space is just wide open still. You've had two products approved in 2024 with a TIL product from Iovance and an engineered T cell therapy from Adaptimmune.

Coincidentally, those companies sit opposite each other in Philadelphia's Navy Yard. They're right next to each other. So the first two engineered cell therapies came both out of Philadelphia. That is obviously just the start. You look at our pipeline, you look at the pipeline of the rest.

I genuinely believe that you will see, when you look at the top-selling pharmaceutical products in 20-plus years' time, a decent percentage of those will be cell therapy.

Moderator: This is really helpful. Thank you, Adrian. We have another question here. When we think about the Tecelra, what have you learned for the first six months since launching?

Adrian: It's reasonable that we would have learned a lot. The reason I say that is because it's a engineered cell therapy that requires testing in an environment that people are not accustomed to testing for antigen. However, you count it, we're the eighth cell therapy to be approved. There's not that many. It's not many trodden. We're the first in sarcoma and we're the first in solid tumors.

We've learned an immense amount. One of the things that, I don't know whether I learned it or it just reinforced this for me, is there is nothing in this space, in the cell therapy space, that tells me that the answer to the challenges of cell therapy is scale. This is why I think large companies are not actually going to be the most successful at doing this.

The answers to the problems of cell therapy are specialization and specificity. You've got to be dedicated and committed, and you've got to design everything that you do to deliver cell therapies. Those are very, very, very different to small molecules or biopharmas or others.

That's been true all the way through the development of these products, but it's really true in the commercial setting. There's a real advantage of our ability. We've got a small footprint, a relatively small opportunity.

$ 400 million is not huge by pharma scale, but we have the ability to go and touch every single center and interact with every single center that we want to on a one-to-one basis. We don't need to standardize, and we can be very specific as to delivery of this. I don't need to compromise with other products either or other types of products, so everything that I do can be focused on delivering these cell therapies to patients.

Moderator: This is understood. Thank you, Adrian. As a follow-up to the previous one, when we think about patient pools between the Tecelra and lete-cel, what do you think is the degree of overlap there?

Adrian: That's a really good question. When lete-cel gets approved, it will be, we believe, approved in synovial sarcoma and in Myxoid/round-cell liposarcoma. Myxoid, it will be the only product that we have that's approved and the only cell therapy...really the only effective treatment for advanced myxoid/round cell liposarcoma there. That one, there isn't really any overlap.

In synovial sarcoma, both of the targets are expressed in about 70 percent of the patients. When I say expressed, I mean expressed at a level that would qualify them for treatment. There's probably some low levels of expression in almost every patient, but in terms of treatment, 70 percent.

We believe that they are independent variables, and so, therefore, there is substantial overlap. There are patients who express only MAGE-A4 and only NY-ESO, but probably the majority of the patients, probably about half -- 40 to 50 percent -- express both of them at fairly high levels.

There's a slightly glib answer to the question, which is I don't really mind as long as they get one of these, which one they get, and that will be true. Maybe the more interesting thing will be what some of our physicians are saying how they would look at this, which is they'd really like to think about them in sequence.

It'd be lovely to have an option for those patients when you give them the first therapy and they get a great response, but it maybe isn't curative, and when they relapse, they have the opportunity to go on a second therapy against the other targets. I think that's a potential future upside.

From the terms of the sales, I just want to be very clear, though. We have only included those patients getting one of these therapies, and therefore, we've only included the incremental patients for Lete-cel that only express NY-ESO in our sales calculations. The reality will be more complicated, but we are well suited to be able to deliver whichever product the patients want.

Moderator: This is really helpful, Adrian. Thank you. Any questions from the audience on this point? Yeah.

Audience Member: Thank you. Great presentation. Thanks a lot and congrats to the first approval in a solid tumor indication of a TCR, T-cell. Both targets MAGE-A4 and NY-ESO-1 are expressed also in other tumor types. Are you looking beyond the sarcomas and the collaboration with Galapagos on head and neck cancer?

Adrian: Yes, yes. You're right. I think the order is that NY-ESO is expressed less well. MAGE-A4 is better than that. PRAME is probably better than that, but these are broadly expressed cancer test, these antigens.

Where they are expressed in other tumor types, they tend to be at lower percentages than they are in sarcoma. Sarcoma is in the 70-plus-percent range perhaps for each of those. Other tumor types may be in the 30, 40, 20 percent range.

Audience Member: But there may be larger indications.

Adrian: But very much larger indications, absolutely. For NY-ESO, when we partnered that with GSK for Lete-cel, when that was partnered with GSK, GSK explored development in other areas, and great difficulty recruiting the trials for NY-ESO.

For MAGE-A4, we had great success recruiting the SURPASS-1 trial in a basket of tumor types that express MAGE-A4. We saw responses at reasonable levels in gastroesophageal cancers, in bladder cancer, in ovarian cancer, in head and neck cancer, so yes, there is definitely the opportunity to go beyond that. Those programs could be partnered with Galapagos. That's for MAGE-A4.

For PRAME, it's wide open. The current programs against PRAME are largely being developed in the melanoma space. Largely, not exclusively.

I just want to point out that because of the sensitivity of our TCR, the whole purpose of having a very highly sensitive TCR is to be able to hunt down targets to lower levels, low expression levels that are expressed in other tumor types other than melanoma that expresses PRAME very highly. We absolutely believe that that's the direction to go.

The way that I would think about it, sarcoma was the first because of very high expression and because of sensitivity of that to particularly first-generation programs, but the future in other solid tumor types is wide open, and we will be prosecuting against them.

Audience Member: Thanks.

Moderator: It seems like we have another question from the audience.

Audience Member: You just said the T-cell platform will be one of the promising future, have a good...Could you point another two more platforms that they will have a very promising future also in the...

Adrian: Generally open question.

Audience Member: Yeah.

Adrian: I think there's a couple of spaces. I'll take one that I think is obvious because there's large companies already that are prosecuting it. I tend to think about this as modalities of therapy

discussion, and every generation or so, there's a new modality of therapy that then gets explored and exploited. Biopharmaceuticals, obviously, blah, blah, blah.

I still think the oligonucleotide space is wide open for further exploitation. Then something within our framework, within cell and gene therapy, obviously, everything that we do is autologous. It's your cells engineered by us and put back into you, and I can't give them to anybody else.

Over the long term, there are two approaches to dealing with that, and both of them have...there are companies out there who are trying to develop this. One is allogeneic platform so I can give them to anybody, off-the-shelf T-cells, so cell therapy, but rather than your cells with the logistics of that, allogeneic.

Then the second approach, which may leapfrog allogeneic, is what's called in vivo cell therapy. It's really in-vivo editing of the cells. Rather than me take your cells, edit them with a viral vector in an incubator, grow them and give them back to you, I would just give you the vector to edit the cells and then grow the T-cells inside you.

The reason that I hesitate a little bit, if you want to talk long-term, both of those are quite long term. I would argue that the next decade of cell therapy at least in the solid tumor space is autologous. Those will come and they may be very promising, but they are quite a long way away.

Moderator: Thank you for your questions. Any more questions from the audience?

Audience Member: If it's still possible to ask another question. One obvious tumor escape mechanism is downregulation of MHC Class II where the antigens are expressed. Do you see that in the clinical trials, or do you have any indication of tumor escape mechanisms of that type or beyond MHC II downregulation?

Adrian: Really good question. For broadening that out, the tumor can downregulate HLA. Our target is presented on HLA, but the tumor, if the tumor down regulates HLA, it can stop our target being presented.

The answer to that question is, one, in our clinical data, we have no evidence of the removal of antigen presenting machinery like that. We do have evidence of antigen loss, that's largely correlated with response not with relapse. We don't have any evidence of down regulation of HLA.

However, it is worth pointing out that the whole purpose of affinity maturation of the T cells, though of making high affinity T cells, which is what we do. The whole purpose of that is to be able to hunt down the target to the type of copy numbers that cancer typically presents.

Cancer will down regulate HLA because it doesn't want to display what's inside to the immune system normally. It does that anyway, but it can only go so far.

Because if it goes too far, if it completely down regulates HLA, all HLA, then it will become subject to...it won't look like self to the body and NK cells will kill it. There's this window that cancer can down regulate, and our t cells hunt down into that window and can kill in that window.

Therefore, I think that's probably what's behind the lack of that as an escape mechanism, effective escape mechanism for our therapy.

Moderator: Thank you, Adrian. I think we have one last question. If we can address it quickly, but essentially, it touches upon treatment centers. What are the challenges or key hurdles to setting up ATCs and getting patients through the testing, manufacturing, and treatment process?

Adrian: I think the process...to just outline the process very quickly. Patients need to be tested, they need to be tested for HLA, and they need to be tested for MAGE-A4. They need to be cleared for insurance. They then need to be apheresed, manufactured for, lymphodepleted and dosed.

That's the patient journey. In order for any of that to happen, the center has to be stood up. That's a process of qualification by us of that center, and we sign a contractual agreement. That can take some time.

We've been exceptionally pleased about the speed with which our centers move. We heard horror stories from previous launches of CAR-T therapies that this could take 9, 12, 18 months to get some of these centers up and running.

We've got some of our centers up and running in two or three months. I do think some of that is because we have been very specific about our ask, and we are very focused on this. Then in terms of getting the patients through, I think there's two challenges.

One is, we need more patients tested, and we need that testing to be earlier. That testing

shouldn't really be when they need Tecelra. It should be when they're diagnosed with synovial sarcoma.

Then the second piece is getting the therapies, the use of the therapy cleared by the insurance company. I think most of the companies have launched this way, that starts off being quite a long process. Iovance said maybe it takes six to eight weeks to get the first few patients.

Once you've done it once with an insurer, they've got a playbook, and then you go back and it takes two weeks, not six to eight weeks. Those are the challenges that we are overcoming in real time as we launch this.

Moderator: Thank you, Adrian. This wraps up our presentation. Thank you, everyone, for attending.
