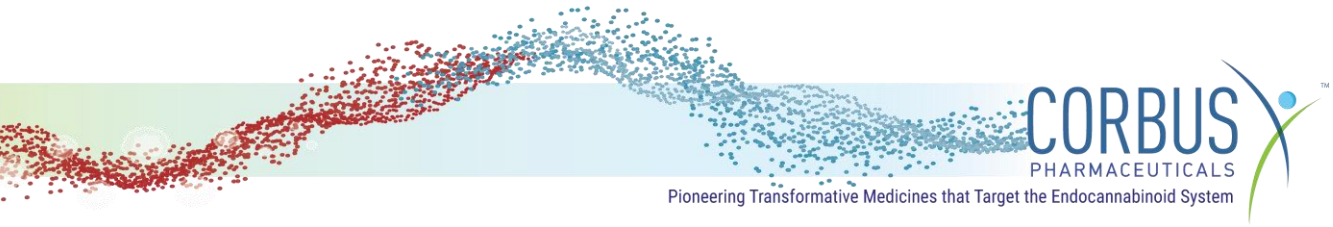

Corbus Pharmaceuticals
Fourth Quarter and Year-End 2020 Earnings Conference Call
March 15, 2021

***Operator**:* Hello, and welcome to the Corbus Pharmaceuticals Fourth Quarter and Year-End 2020 Earnings Conference Call. As a brief reminder, all participants are currently in a listen-only mode. If anyone requires operator assistance during the conference, please press star zero on your telephone keypad.

Following the presentation, there will be a question-and-answer session. Note that this conference call is being recorded at the Company's request and will be made available on the Company's website following the end of the call.

I would now like to turn the conference over to your host, Ted Jenkins, Senior Director, Investor Relations, and Corporate Communications. Please go ahead, sir.

***Ted Jenkins**:* Thank you, operator, and good morning, everyone. Thank you for joining us today. At this time, I'd like to remind our listeners that remarks made during this call state may management's intentions, hopes, beliefs, expectations, or future projections. These are forward-looking statements and involve risks and uncertainties. Forward-looking statements on this call are made pursuant to the Safe Harbor provisions of the federal securities laws. These forward-looking statements are based on Corbus' current expectations, and actual results could differ materially. As a result, you should not place undue reliance on any forward-looking statements. Some of the factors that could cause actual results to differ materially from these contemplated by such forward-looking statements are discussed in the periodic reports Corbus files with the Securities and Exchange Commission. These documents are available in the Investors section of the Company's website and on the Securities and Exchange Commission's website. We encourage you to review these documents carefully.

Joining me on the call today are Dr. Yuval Cohen, our Chief Executive Officer, Dr. Barbara White, our Chief Medical Officer and Head of Research, Sean Moran, our Chief Financial Officer, and Craig Millian, our Chief Commercial Officer. With that, it's now my pleasure to turn the call over to Yuval.

***Yuval Cohen**:* Thank you, Ted. Good morning and thank you to all of you joining us this morning. Since we reported clinical data last year, we have made progress on executing our strategic plan I laid out on the last quarter's call.

First, we continue to work to maximize the value of lenabasum. Second, we are working to move our internal pipeline into clinical testing in 2022. Third, we are actively engaging with potential partners to expand our pipeline.

Analyses of preclinical and clinical data show lenabasum is an active compound. As such, we believe our Phase 3 study in dermatomyositis represents a potentially significant inflection point in the coming months. We have executed our previously announced plan to move the primary endpoint from Week 52 to Week 28. All patients in the studies have now completed the Week

28 visit. Topline data remains on track for the second quarter of this year. The data from this study will shape our path forward on lenabasum.

We continue to advance and prioritize our in-house endocannabinoid system targeting assets, which Barbara will discuss today. We remain in a unique position, being on the forefront of research and development of molecules that target this biology that has applicability across many potential indications. This pipeline encompasses drug candidates for metabolic disorders, fibrotic diseases, and cancer. We anticipate that lead compounds from these internal programs will start clinical studies in 2022. The third element of our strategy is to expand our pipeline through acquisitions of external assets. We are focusing on biology beyond the endocannabinoid system and new indications that will leverage our expertise and capabilities within immunology.

Our ability to advance our internal programs, along with bringing in external assets, depends on Corbus having the necessary human and financial resources. As we reported this morning, the Company's cash position has been significantly strengthened and now stands at approximately $127 million, a record for Corbus. This capital provides a cash runway into early 2024 based on our current expectations and gives us an opportunity to expand and diversify our pipeline. We believe we are well positioned to execute on our plan and look forward to the next quarter. I will now turn the call over to Barbara.

***Barbara White**:* Thank you, Yuval. The Phase 3 DETERMINE study, which is testing safety and efficacy of lenabasum in adult patients with dermatomyositis, is progressing on schedule. As Yuval said, we amended the protocol to change the timing of the primary efficacy endpoint from Week 52 to Week 28. As a reminder, the primary efficacy endpoint is the composite ACR EULAR total improvement score, comparing lenabasum 20 milligrams twice daily and placebo groups. In this study, lenabasum and placebo are added on to stable doses of standard treatments for dermatomyositis, including immunosuppressive therapies. All subjects in the DETERMINE study have completed their Week 28 visits, and most have completed a 28-day safety follow-up visit off study drug. Topline results are expected in the second quarter of this year.

The outcome of the DETERMINE study will inform our decision about next steps in our systemic sclerosis program. Forced vital capacity is being measured in these dermatomyositis subjects over the course of the study. We note with interest that Roche's ACTEMRA® was approved by the FDA for the treatment of interstitial lung disease in systemic sclerosis recently, despite failing to meet the primary efficacy endpoint in both the Phase 2 and Phase 3 studies. The approval appeared to be based on findings of less decline in forced vital capacity and post-hoc analysis of sub-groups of the systemic sclerosis subjects. We are considering potential implications for the lenabasum program, in which less decline in forced vital capacity was also observed in a sub-group of subjects in that study.

Currently, we are not considering additional studies of lenabasum in cystic fibrosis. We are working with investigators on post-hoc analysis of the data to better understand pulmonary

exacerbations in people with cystic fibrosis who are at high risk for these medically significant events. We want to take this opportunity to reiterate our gratitude to the leadership of the Cystic Fibrosis Foundation, staff at the Cystic Fibrosis Foundation Therapeutics Inc., all our investigators, and especially all the patients who participated in these studies for their support throughout our two Phase 2 studies in cystic fibrosis. This is an incredible community.

The NIH sponsored and managed 100-patient Phase 2 study of lenabasum in systemic lupus erythematosus is nearing completion of enrollment. We anticipate the NIH may release topline data in the second half of the year.

Our internal pipeline is also progressing. Clinical data about our CB1 inverse agonist and our CB2 agonist programs were presented in January at the New York Academy of Sciences webinar titled "*Targeting the Endocannabinoid System to Treat Human Diseases*." The cannabinoid receptor type 1, or CB1, is a major regulator of energy in the body, as demonstrated in studies with Rimonabant, in which inhibition of CB1 led to weight loss, as well as improvement in fasting glucose influence sensitivity, dyslipidemia, and metabolic syndrome.

CB1 has been shown in animal studies to have reciprocal functional activities with the receptors for the incretin's glucose-dependent insulinotropic polypeptide, or GIP, and the glucagon-like peptide 1, or GLP-1. This is of importance because recent data showed that GIP GLP-1 receptor agonists, semaglutide and tirzepatide, reduce obesity and blood sugar in humans. In animal studies, GIP GLP-1 receptor agonists are reported to have greater metabolic effects when used in combination with CB1 inhibitors than when used with monotherapy. Beneficial effects of the combination of GIP GLP-1 receptor agonist and CB1 inhibitors have been observed on body weight, fat mass, insulin action, dyslipidemia, and hepatic steatosis in obese diabetic mice.

With this background, we have applied our proprietary learnings about structure activity relationships to develop next-generation CB1 inverse agonist that maintain functional metabolic activity while reducing brain levels of those compounds, as a potential means to avoid psychoactive adverse events. We believe levels of CB1 occupancy in the brain must be kept low to minimize safety concerns about potential adverse events of anxiety, depression, and suicidality that occurred with Rimonabant treatment, causing it to be withdrawn from the European market. Rimonabant freely cross the blood-brain barrier, whereas we have identified compounds with levels in the rodent brain with chronic dosing that are less than 10% of the levels in the plasma.

In testing to date, our compounds have shown promising efficacy as monotherapy in a mouse model of diet-induced obesity. We have also observed anti-inflammatory and anti-fibrotic activities of our CB1 inverse agonist that are greater than those seen with the Rimonabant comparator, as well as anti-fibrotic activities in a human liver steroid model of hepatic fibrosis. We believe the combination of potentially beneficial metabolic effects with inhibition of inflammation and fibrosis may make our CB1 inverse agonist useful in the treatment of disorders

such as diabetic nephropathy, diabetic retinopathy, or NASH. We plan further testing of these compounds in animal models of obesity, glucose intolerance, diabetic nephropathy, and fibrosis. We also plan to test metabolic effects of our CB1 inverse agonist in combination with GLP-1 receptor agonist in animal models.

As you know, we have been developing CB2 agonist for the treatment of inflammatory and fibrotic diseases. The literature reports that CB2 agonists have potential efficacy in cancer, in multiple animal models through multiple pathways, including effects on cell cycle and signal transduction. Indeed, we have found that some of our own CB2 agonists directly inhibit growth of some lymphoma, breast, colon, non-small cell lung, and glioblastoma tumor cells. These effects appear to be mediated through induction of apoptosis of the tumor cells. In testing to-date, some of our CB2 agonists have other effects that might contribute to antitumor activity, including inhibition of TGF-beta signaling pathways and tissue fibrosis. We plan to test these compounds in syngeneic animal models of cancer as monotherapy and in combination with checkpoint inhibitors. We look forward to bringing both CB1 inverse agonist and CB2 agonist compounds into Phase 1 human testing in 2022.

As Yuval mentioned, we plan to expand and diversify our pipeline through business development activities. To be clear, we are looking to diversify beyond the endocannabinoid system and beyond autoimmune and genetic diseases. We are looking for best-in-class compounds that target disease pathways that are strongly supported by existing scientific data or even fully validated pathways. We are looking to expand our pipeline with both preclinical and early clinical stage assets. We will prefer external assets whose development will be supported by our existing expertise in immunology. Stay tuned. We look forward to disclosing more details about these programs as they progress at a future R&D Day. With that, I'll turn the call back to Yuval.

***Yuval Cohen**:* Thank you, Barbara. I will now provide an update regarding our financial position. Corbus has significantly strengthened its balance sheet. We expect the cash on hand of approximately $127 million as of March 15, 2021, to fund operations into the first quarter of 2024 based on our current budget. This should allow us to complete our dermatomyositis study, move our two internal programs into the clinic next year, and pursue complementary external opportunities without a financing overhang.

In closing, we continue to believe that the endocannabinoid system is a key target for the development of therapeutics for the treatment of inflammatory, fibrotic, and metabolic diseases, as well as cancer. We are excited for the completion of our Phase 3 clinical trials in dermatomyositis this year. We also look forward to data from the study of lenabasum in Lupus. We are actively advancing our pipeline to focus on those programs that we can deliver at the earliest data inflection point. We have the resources and are committed to bringing in external assets that complement our existing pipeline and expertise. We look forward to updating you on those initiatives in the very near future. With that, I'd like to thank you all for your time and attention and turn it over to the operator for any questions from our listeners today.

***Operator**:* Thank you. We will now be conducting a question-and-answer session. If you would like to be placed in the question queue, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the question queue. You may press star two if you would like to remove your question from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing star one. One moment, please, while we poll for questions.

Our first question today is from Brian Abrahams of RBC Capital Markets. Please proceed with your question.

***David Szeto**:* Hi. This is David Szeto on for Brian. Thanks for taking my questions. I just have a couple and I'll be quick here. So, first one, I was just wondering if you could elaborate maybe a little more on how comfortable you're getting towards selecting candidates for both the CB1 and CB2 programs. I know that you mentioned you'll go into more details at a future R&D Day. But I guess, just given the Academy of Sciences data they presented, it does look like you're starting to clearly differentiate some of the profiles, and I guess I'm just curious if you can provide any more color on kind of how comfortable you are reaching a profile that's desirable.

And then my second question is just on cash runway. So, it looks like the $127 million that you mentioned just now should last potentially 12 or so quarters through 1Q 2024, which suggests maybe a flat run rate of just around $10 million for OpEx per quarter. I guess, could you remind us how that comes down from the $21 million last quarter? And if this takes into account anything for entering the clinic with additional molecules in 2022 and beyond? Thanks so much.

***Barbara White**:* Okay. I'll take the first question, which was I think about our level of comfort that we'll be able to reach candidate selection with the CB1 inverse agonist and the CB2 agonist. Let me start with the CB1 inverse agonist.

For us, I think there's just so much data that show the metabolic effects of these compounds in animals and in humans, and we've been able to confirm that with some of our candidates, as well. So, I suspect that the ability to show desired metabolic activity is not going to be an issue. The real question is—to do our very best to minimize the levels of CB1 receptor occupancy in the brain with the compounds. And we have spent a lot of time testing a lot of compounds and redesigning compounds in order to be able to do that. And at this point, based on data that we have with some chronic dosing—28-day dosing in mice—we really have several promising compounds. So, while those tests are ongoing, and we need to get into them in even more detail, at this point, I'm actually quite confident that we're going to get there, and we intend to get there by the end of the year, perhaps before the very end of the year. So, things are progressing nicely in terms of our ability to understand the pharmacokinetics of these compounds in the brain, as well as to move forward with the metabolic studies.

We're especially excited to look forward to determining the effects of these compounds in combination with some of the GLP-1 receptor antagonists that are currently being used to treat obesity and are useful in diabetes. So, we're quite excited about the CB1 inverse agonist programs.

The CB2 agonist program is slightly behind that. We have compounds that have some broad ability to inhibit tumor cell growth. We think perhaps the real activity will come when we see them in syngeneic mouse models where we can engage the immune system, because, as you know, these compounds have some pretty extensive activities in the immune system. So, that's where I think we'll see real efficacy, and we're looking forward, as well, to testing those in combination with checkpoint inhibitors where immunosuppression tends to inhibit the applicability of those compounds. So, we also anticipate selecting a candidate by the end of the year. I think it looks good for both of them. Sean?

***Sean Moran**:* So, regarding cash—Sean Moran, CFO. So, we just completed two pivotal studies, very expensive, in CF and SSc. So, those costs were reflected in last year's burn rates, and DM has just finished up. The other thing to keep in mind is, we went through a reduction in workforce that really cut our personnel costs. So, we do project about a $10 million burn on average going forward with our cash, and that will fund the development of our compounds in the Phase 1 studies, as well.

***David Szeto**:* Got it. Thanks.

***Operator**:* As a reminder, if you would like to ask a question, please press star one on your telephone. The next question is from Maury Raycroft of Jefferies. Please proceed with your question.

***Maury Raycroft**:* Hi. Good morning, everyone. Thanks for taking my questions. So, first question is on the dermatomyositis study. Just wondering if you could say how many patients have gone on to the open-label extension and are still on drug, and if you can talk about discontinuation rate in the study, too? And potentially, anything that you're seeing in the open-label extension study that you can comment on at this point.

***Barbara White**:* Sure, Maury. This is Barbara. Thanks for the question. Some numbers: we have had a discontinuation rate of around 8% from the study, which was a bit lower than we had anticipated. We have had, I think, 166 patients complete the Week 28 visit which is now the primary efficacy endpoint. We anticipate having perhaps about 100 patients, give or take a few, complete the Visit 10 by the time the study is actually shut down. And we have had, of those that are eligible, 90% of the subjects who have been eligible so far have enrolled in the open-label extension. Does that help? Any other numbers?

***Maury Raycroft**:* Yes, that's helpful. Thank you. And then the other question was just based on the ACTEMRA approval, and you commented a little bit about it on the call. But just wondering if you can provide more on what next specific steps are and potentially even a little bit more on timeline. I guess, what else do you need to do in order to see if your SSc data could be sufficient to approach FDA? And is it contingent on what you see in the dermatomyositis study?

***Barbara White**:* So, I think, Maury, as you know, that we found the approval of ACTEMRA for the treatment of interstitial lung disease in systemic sclerosis of great interest because that drug had failed—had two negative studies, Phase 2 and a Phase 3, with not meeting the primary endpoints. But they did have, I think, really encouraging data in forced vital capacity. It is our understanding that the FDA actually requested the data. We certainly don't know that. We're not privy to that. But think that that may be the case. And then looked at a subset wasn't even a secondary analysis in the first Phase 2 study. So, it was of great interest that a drug got approved under those circumstances, which I think points out the need for more treatments for this very severe autoimmune disease.

So, it makes us look at our data twice or 3 or 4 or 20 times, because we also saw an effect—a less decline in forced vital capacity in the patients who've been on stable immunosuppressants. The other thing about the ACTEMRA data was those patients were not receiving what one would consider now standard of care. In fact, they were on no background immunosuppressants or a low dose of corticosteroids, which is really not what the treatment is for interstitial lung disease, which our patients were on standard treatment, and we were able to also see an impact on forced vital capacity those people who are on stable doses or had been on it for an established period of time a couple of years. And so, we also see the same kind of improvement.

Our numbers are smaller, and we want to look for supportive data. And we think there can be supportive data that might come from open-label expansions, people who switched over to placebo. When we look and see how much improvement continues over time. Is it durable? And from the dermatomyositis study because we are measuring forced vital capacity there. A smaller percentage of the patients have interstitial lung disease. It's about 38%, I believe, in our DM study. We are going to be very eager to see what change in forced vital capacity looks like in those patients, lenabasum versus placebo, when they've been on stable immunosuppressant.

So, the timelines for doing that will be after we get the DM data, after we get the additional data analysis done. Then we will see if we think it's worthwhile. It's hard to know if this FDA decision was a one-off or if it signals some sort of change in willingness to consider subset analysis to prove drugs in this rare disease.

***Maury Raycroft**:* Got it. That's really helpful perspective. So, it sounds like, potentially, the next update on this potential path would be in the second half this year.

***Barbara White**:* I think that's fair, by the time we get the DM data and look through everything else, because getting the DM data is going to be our first priority right now.

***Maury Raycroft**:* Got it. Okay. Thank you very much for taking my questions.

***Operator**:* Thank you. We have reached the end of our question-and-answer session. Ladies and gentlemen, that concludes today's teleconference and webcast. We thank you for your participation. You may disconnect your lines at this time and have a wonderful day.