Adaptimmune Therapeutics
Q3 Financial and Business Update
Transcript

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Presenters:

Juli Miller
Vice President, Investor Relations

Adrian Rawcliffe
Chief Executive Officer

Dr. Elliot Norry
Chief Medical Officer

Gavin Wood
Chief Financial Officer

Dr. Dennis Williams
Senior Vice President, Late Stage Development

Dr. Jo Brewer
Chief Scientific Officer

Dr. Helen Tayton-Martin
Chief Business and Strategy Officer

OPERATOR:

Hello and welcome to Adaptimmune's Third Quarter Call and Business Update.
I will now turn the call over to Juli Miller. Juli, please go ahead.

JULI MILLER:

Good morning and welcome to Adaptimmune's conference call to discuss our Third Quarter 2022 Financial Results and Business Update.

I would ask you to review the full text of our forward-looking statements from this morning's press releases. We anticipate making projections during this call, and actual results could differ materially due to several factors, including those outlined in our latest filings with the SEC.

Adrian Rawcliffe, our Chief Executive Officer, is here with me for the prepared portion of the call. Other members of our Management Team will be available for Q&A.

With that, I'll turn the call over to Adrian Rawcliffe. Adrian?

ADRIAN RAWCLIFFE:

Thank you, Juli, and thank you for joining us today.

As evident in a separate data press release we issued this morning, the SURPASS trial with our next generation SPEAR T-cell targeting MAGE-A4 continues to produce compelling response data across ovarian, bladder, and head and neck cancers with increasing durability and a new complete response in bladder cancer.

In addition, the recent pre-BLA meeting and the updated data from the SPEARHEAD-1 trial that we will be presented at CTOS, continue to demonstrate the value of afami-cel, our first-generation MAGE-A4 cell therapy as a product for people with synovial sarcoma.

Earlier this month, we announced we'll have full control of our PRAME programme going forward. And with ownership of affinity-enhanced SPEAR T-cells against MAGE-A4 and PRAME, we are well placed to deliver high value products with two of the most broadly expressed, well characterized, and validated TCR T-cell targets in the solid tumour field.

These developments whilst positive come during challenging economic times and it's evident that we need to focus on three key priorities: on advancing the MAGE A4 franchise, on the PRAME programme and on progressing the allogeneic platform, since these represent the highest value creation

opportunities. We've taken decisive action to pause, stop, de-prioritize, and limit resources for non-core programmes to concentrate our resources on these key priorities, and we've also made the difficult and painful decision to restructure the Company.

I will undergo a reduction in headcount of between 25% and 30% between now and Q1 2023. These actions, taken together, will extend our cash runway into early 2025. Although these were difficult choices, our shared sense of purpose and our confidence in the potential for afami-cel and our CD8 programme, to transform the lives of people with cancer, make it imperative that we take these steps to sustain the Company and position ourselves to successfully deliver these cell therapies.

Now, I want to give a little more detail about the focus of the Company going forward. For MAGE-A4, we will focus on the afami-cel BLA for synovial sarcoma and the SURPASS trials of our second generation CD8 product in ovarian, bladder, and head and neck cancers. For afami-cel, we are committed to submitting the BLA and will commence a rolling submission later this year. We plan to complete the submission in mid-year 2023.

We've had positive interactions with regulators, caregivers, and others in the sarcoma space throughout our clinical development of afami-cel and the need for and potential of this therapy is undeniable. For the next gen CD8 product targeting MAGE A4 being developed in the SURPASS trials, the latest data from the SURPASS trial across a basket of late-stage solid tumour indications continues to demonstrate the value of this product with very positive trends since the ESMO data.

The overall response rate across the entire trial is now 37% and importantly, duration of response has improved. It's now at five months in this ongoing trial and will further evolve with patients in continuing and ongoing response. Within the SURPASS family of trials, we will focus on those indications where we have seen outstanding response data, namely ovarian, urothelial, and head and neck cancers.

The ORR across these three tumour types is now 52%. In urothelial cancer, we are announcing a 57% ORR with one new complete responder, and we are pursuing a new cohort in the Phase 1 trial in combination with a checkpoint inhibitor in the second-line setting for these patients. Based on compelling efficacy reported at ESMO, with three out of four responders, we will also proceed with the new cohort in head and neck cancer in combination with a checkpoint inhibitor in the first line setting.

For ovarian cancer, the ORR is now 43% and the Phase 2 trial SURPASS-3 is initiating in monotherapy and in combination with a checkpoint inhibitor. Last Friday, we received FDA Regenerative Medicine Advanced Therapy, or RMAT, designation for ADP-A2M4CD8 for the treatment of patients with platinum-resistant ovarian cancer.

By granting RMAT, the FDA agrees that the preliminary clinical evidence indicates that CD8 has the potential to address unmet medical needs in platinum-resistant ovarian cancer. RMAT gives us the advantage of increased opportunities to meet with the FDA, as well as early meetings to discuss potential surrogate or intermediate endpoints.

It also allows for expedited pathways such as rolling review and priority review. And although RMAT is for platinum-resistant ovarian cancer, this designation will benefit the entire CD8 programme. And we now have PRAME as a wholly-owned asset with great potential as shown by data from our peers, as well as our own research. We aim to have the PRAME programme IND ready by the end of 2023.

Finally, we'll continue to advance the allogeneic platform, both wholly-owned and in partnerships with Genentech and Astellas. You can refer to this morning's press release for more details with respect to our decision to delay our first allogeneic IND until 2025 as we change cell lines for our MAGE A4 allogeneic programme, a decision that will not impact the work that we're doing with our collaboration partners.

Simplistically, anything that I've not just outlined as a priority will be paused or stopped. We will stop the SURPASS-2 trial in GE cancers and stop work on the TIL IL-7 programme. We will cease further investment in additional non-core activities, including work on preclinical pipeline projects, such as the HiT programme, additional targets, and broader HLA coverage. We will also delay investment in the commercialization of afami-cel based on the BLA timelines and will provide further guidance on a likely commercial launch date after the BLA has been submitted. And until we understand the terms of the transfer from GSK and the data package, we will not invest in lete-cel, targeting NY-ESO.

With resources focused on these key priorities and the corresponding restructuring, we anticipate that our cash runway will extend to early 2025. This will enable us to deliver the following: one, a filing of the BLA and subject to regulatory discussions approval for afami-cel in synovial sarcoma, the first engineered cell therapy for a solid tumour; two, a complete data set for the monotherapy arm of our ongoing Phase 1 SURPASS trial; three, an initial data set from the SURPASS Phase 1 combination arm across late stage tumours; four, an initial data set for the new cohort in second line urothelial cancer patients in combination with a checkpoint inhibitor; five, initial data set for the new cohorts in first line head and neck cancer patients in combination with a checkpoint inhibitor; six, complete recruitment of the Phase 2 SURPASS trial for people with ovarian cancer as monotherapy and in combination with checkpoint inhibitor; seven, initiating clinical development for our PRAME programme; and lastly, continued progress on our allogeneic platform for our wholly-owned and our partnered programmes.

The business of developing engineered cell-therapies for solid tumours is challenging and complex, but the strengthening data from afami-cel and our CD8 programme demonstrate we are succeeding in

something that has not been done before. We've made the difficult decisions to focus the Company, prioritizing our pipeline and reducing our headcount to extend our cash runway into 2025. And we will continue to make the choices necessary for Adaptimmune to successfully develop cell-therapies to transform the oncology landscape, starting with afami-cel for people with synovial sarcoma and CD8 for people with ovarian, urothelial, and head and neck cancers.

With that, I'll turn over to the Operator for questions. Operator?

OPERATOR:
Thank you. The first question comes from Marc Frahm with Cowen & Company. Please go ahead.

MARC FRAHM:
Thanks for taking my questions. Maybe just to start, the response rates are broadly similar across the three focused tumour types going forward in the refractory setting, but some of those tumour types are being advanced as monotherapy and others only in combination right now. Can you just walk-through kind of strategic rationale for why some of those are moving only as combinations and others as monotherapy as well?

ADRIAN RAWCLIFFE:
Thanks, Marc. I'll ask Elliot to take a stab at that.

DR. ELLIOT NORRY:
Yes. So, I mean, we could probably have a lengthy discussion going through tumour type by tumour type and maybe we should find the time to do that, but in general, the monotherapy arm of the SURPASS trial is relatively mature, and we're really focusing on getting additional data in combination in the Phase 1 trial. With respect to—and I would say that in the target indication, we have not eliminated the possibility of continuing with monotherapy in late line indications.

We think that the greatest benefit to patients with this type of therapy is likely in earlier lines, and likely in combination with checkpoint inhibitors. And that's why we're pursuing the two indications in particular, head and neck cancer and bladder cancer in earlier lines in combination with checkpoint inhibitor, and we outlined some of that back at the call in September. But there are several reasons for considering that.

MARC FRAHM:
Okay. That's helpful. Then maybe just a modeling question, just with the kind of organizational changes you announced, but also, yes, some of these cohorts are moving forward. Can you just walk through some of the pushes and pulls over the next few quarters in terms of expenses? Should we expect them to

go down short-term and then rise again or are the investments in some of the trials going to happen quickly enough that they kind of overwhelm some of the organizational changes?

ADRIAN RAWCLIFFE:

So, I'm going to ask Gavin, CFO, to talk about the puts and pulls as we go forward with the restructuring. Gavin?

GAVIN WOOD:

Yes. Thanks, Marc. I mean as we move into the restructuring that we arranged, organized, or announced today, we're going to have to think fairly carefully about the puts and pulls that you talked about. I think as we think about the shapes of spend over the next two years, is likely that we can try and make those broadly similar between years one and year two, not least because we believe in the intervening time, then the data we're delivering will continue to drive value.

I think there are some spikiness probably in Q1 as we get over some of the CapEx investments that we've been making here in the U.K. in our allogeneic facility that's nearly complete, but also in finishing off the Navy Yard expansion. And so, as we think through the shapes, we'll be able to update you in more detail early in the New Year.

MARC FRAHM:

Okay. Thank you. That's helpful.

ADRIAN RAWCLIFFE:

Thanks, Marc.

OPERATOR:

The next question comes from Tony Butler with Roth Capital Partners. Please go ahead.

TONY BUTLER:

Thanks very much. Adrian or Elliott, as you alluded to a few minutes ago, if you were able—if you move into lesser lines of therapy, less refractory patients in SURPASS, especially in urothelial and head and neck, can you provide some information as to what becomes the hurdle rate that suggests, hey, this is where we need to be, and we're going to continue to advance those patients in those particular cancers? Thanks very much.

ADRIAN RAWCLIFFE:

So, I think the strategy in both of those indications is that there are patients in both first-line head and neck and second-line bladder cancer for whom checkpoint inhibitors, whilst indicated for those patients, have a relatively low response rate as monotherapy. They're in the 20% range depending on patients. And the intent is that we would be able to dramatically transform that rate based on the response rates that we're seeing.

Then in combination with checkpoint inhibitors as standard of care, but also mechanistically as a way of continuing the efficacy of the T-cells and both that our T-cells and the T-cells recruited to the tumour by our T-cells can then extend those responses to be durable with ultimately a desire to impact not just on a sort of response rate base, but on a time to event endpoints, progression (inaudible 16:40) survival and overall survival.

So, the strategy is to drive very high response rates in those settings where the current response rates are low and for those responses to be durable.

TONY BUTLER:

Thanks, Adrian. May I ask one more follow-up and this is based with respect to headcount reduction. To the degree that you've made this public internally, could you provide some information as to what areas, be it R&D or other where the reduction may be most felt. In other words, provide some colour on the balance of the Company post the reductions, if you can?

ADRIAN RAWCLIFFE:

Yes. So, I think what we can say is obviously we're embarking on this process internally and this process is obviously subject to an appropriate process both in the U.S. and in the United Kingdom and will complete at the beginning of next year. I think it would be—I think inappropriate for me to go into more detail externally as we work through the details in the structure internally.

What I can say is that we anticipate that most areas of the Company will be impacted by this and also—and at the end of it, we will be not the 550-person company that we currently are, but more like 400 people company. Still split between the U.K. and the U.S., we will still be a transatlantic company in that regard but a smaller one and focused on the priorities that I outlined in my comments earlier in the call.

TONY BUTLER:

I appreciate the comments. Thank you.

ADRIAN RAWCLIFFE:

Thanks, Tony.

OPERATOR:

The next question comes from Mara Goldstein with Mizuho. Please go ahead.

MARA GOLDSTEIN:

Great. Thanks so much for taking the question. On the rolling submission for afami-cel, can you speak to the totality of the data that you'll be able to have in the submission as it goes into the agency in terms of the duration and what you'll be able to submit? And then I'm just curious on the allogeneic cell line, how did you discover the chromosomal abnormality?

ADRIAN RAWCLIFFE:

Certainly. So, I will ask Dennis who leads our late-stage development to—and has been responsible for delivery of afami-cel to talk about the first of those questions. And then I will ask Jo Brewer, the CSO, to cover the question on allogeneic after that. Dennis?

DR. DENNIS WILLIAMS:

Yes, sure. So, the clinical package that we proposed to include in the BLA, which we discussed with the FDA at the pre-BLA meeting and their in agreement that it supports a BLA submission for that indication. We'll include a longer duration of follow-up of all the patients, right. And that reflects the data that we're going to present at CTOS where the median duration of response by independent review is around a year and patients are still with ongoing responses.

So, that data cut is about 10 months more mature than what we originally prepared that we took last year. and we're sort of writing up that application—that aspect of the application now. So, hopefully that answers your question about the BLA. A lot of that data here again will be presented at CTOS later this month. So, you'll all have an opportunity to see what the efficacy and safety data looks like, as well as some translational data that we're putting into that presentation.

I will hand it over to my colleague, Jo Brewer, to talk about your question about the allo.

DR. JO BREWER:

Yes. Thanks. So, as we go through the allo programme, we're constantly looking at the genetics of the line, it's something that we're doing because (audio interference 21:12) stem cell programme. We're looking at what changes within the field and what is currently best practice. And so, we've been aware of this. It's in an area of chromosome 20, which is very common. It's a hotspot in IPSC lines and so we've

been looking at this region very carefully, and it's something we've been aware of for a while, but what has changed is our view on the balance of risk and that's from more recent analysis.

So, it hasn't happened because of the editing methods that we're using. It hasn't happen because of the expansion protocols we use in the banking technology either. It's been a very stable change. It's been there for a long time. It's just a change in how we view the risk of that particular level of mutation, why we've decided to switch to a different cell line.

MARA GOLDSTEIN:

Okay. Thank you very much. Also, if I could just ask on the additional data on SURPASS-1. Is there any—at this point, are you able to glean out any commonalities between ovarian cancer patients that are responding? Or have had responses?

DR. DENNIS WILLIAMS:

So this is Dennis Williams again. I would say, we see responses in a wide array of ovarian cancer patients. In SURPASS, there is some heterogeneity on the duration of their platinum pre-interval. There is heterogeneity in their MAGE A4 expression. There's heterogeneity in their tumour burden, but we do see responses in across a large number of these attributes. But certainly for the Phase 2 trial that's in SURPASS-3, which is in platinum-resistant ovarian cancer. We're looking to have a more homogeneous patient population. So, we're really defining the platinum-free interval periods.

I'm sorry, did you have a follow-up?

MARA GOLDSTEIN:

No, I'm sorry.

DR. DENNIS WILLIAMS:

Okay. Yes, I mean, so hopefully that addresses your question.

MARA GOLDSTEIN:

Okay. Thank you very much.

ADRIAN RAWCLIFFE:

Thanks Mara.

OPERATOR:

The next question comes from Jonathan Chang with SVP Securities. Please go ahead.

JONATHAN CHANG:

Good morning. Thanks for taking my questions. First question, maybe just to clarify, are the new responses disclosed today? Are these confirmed or unconfirmed?

ADRIAN RAWCLIFFE:

They're all confirmed. We tend not to report unconfirmed responses in our response rates.

JONATHAN CHANG:

Got it. And if I recall correctly at ESMO, you guys mentioned there were two unconfirmed responses in urothelial and melanoma. Have those been confirmed?

ADRIAN RAWCLIFFE:

The melanoma response did not confirm, the urothelial responses did. That's why we don't report on unconfirmed response. (Multiple speakers 24:23).

JONATHAN CHANG:

Got it. Is that the same urothelial…

ADRIAN RAWCLIFFE:

That same urothelial patients—yes, that is one of those urothelial patients is the complete responder, correct. Yes.

JONATHAN CHANG:

Understood. And then just one more question from me. Earlier you guys announced the transfer of the PRAME and (inaudible 24:45) programmes in GSK. Can you provide any colour on the reasons behind this and what the status and next steps for these programmes are?

ADRIAN RAWCLIFFE:

On the reasons behind that, I think you'll have to refer to GSK's statements on their portfolio prioritization. All I can say is that we are delighted that their strategic decision has resulted in such credible programmes returning to their mothership. And then in terms of development, I think I mentioned it earlier, we are looking forward to putting the PRAME programme into the clinic and it should be IND ready next year. And we think that is a very significant target and I think that is a view generally held by others in the field as well. So, we're very excited about that. With respect to lete-cel, we need to understand both the terms of the transition back from GSK and ultimately the data arising from the trials that they've conducted in order to be able to determine next steps for lete-cel.

JONATHAN CHANG:

Got it. Thanks for taking the questions.

ADRIAN RAWCLIFFE:

Thanks, Jonathan.

OPERATOR:

The next question comes from Michael Schmidt with Guggenheim. Please go ahead.

PAUL JENG:

Hey, this is Paul on for Michael. Thanks for taking our questions. Just a couple from us. So first on the afami-cel submission, could you provide some updates on the non-clinical data BLA components that were in progress as of last quarter, including the vector and T-cell PBQ (phonetic 26:32)? And just to clarify, does starting that rolling BLA process mean some of your remaining sort of components will be ongoing in the next quarters or do those have to be sort of completed to begin the process?

DR. DENNIS WILLIAMS:

Yes, sure. Thanks for the questions. So, vector PBQ, those lots have been filled and they're in analysis and reporting presently. T-cell PBQ, those batches have been harvested and they're also in testing and analysis presently. So, to answer your question, yes, some activities will be ongoing during the process of which the first part of the application would have gone out the door. So, there are a number of additional validation studies some of which influenced the last piece of the submission when it will go in that will be ongoing during that time.

Some authoring of module three, the CMC module, the quality module will be ongoing at the time that we are—the first part of the rolling review starts and that's part of the advantage of rolling your review, right? I mean, so you could—parts of the application that are complete can go in and start the process, the FDA review process, while the additional pieces are being finalized. But I'll just pause there for any follow-up questions.

PAUL JENG:

Got it. That's helpful. Thanks. And then just a second question on the PRAME programme that you recently gained full rights to from GSK. Just wondering how that recent transition impacts your near or mid-term development plans versus what was planned, I guess, previously? Maybe, talk about sort of where you see the opportunity across PRAME expressing indications, particularly with a couple of other competing programmes in the clinic right now? Thanks.

ADRIAN RAWCLIFFE:

So, maybe I'll start on that and then on the transition (phonetic 28:37) and then I'll hand over to Jo to talk about how we see PRAME going forward. I'll just touch on—the PRAME programme was being developed by us. We have yet to hand it over to GSK, although that decision was imminent in our consideration. So, there is no transfer back to us because we currently have that programme in-house. All of the transfers back is a future right. So, we're very pleased about that, so we can get going on that, move that into the clinic as they are IND ready going into next year.

Then I'll ask Jo to comment about where we see the opportunity for a PRAME therapy going forward.

DR. JO BREWER:

Thanks, Ed. Yes. So, as I've said, we have the data in hand and the team is very excited actually at being able to accelerate the programme forward. So, we were getting it to the stage where we were ready to pass that across the GSK. So, there may be a few changes, the differences between our manufacturing process and theirs that we will need to tweak up. But we are ready and we're having full control of the platform means that we can go through CMC in the way that we used to that we've put all our previous TCRs through that same process.

So, we know what we have to do for PRAME. We've done it before with other TCRs. So, that's quite relatively easy for us. We don't have to deal with a different manufacturing process, which is what we would have had to do if it had stayed with GSK and that would have been their choice. So, from that point of view, it's kind of come back into the fold and under our control.

And PRAME in itself is a really complementary target to MAGE-A4. It's obviously present in multiple places where MAGE-A4 is as well. And I think we will use our existing clinical experience to really try and maximize the leverage that we have there. So, PRAME's expressed in a wide range of indications and in the indications that we're familiar with and already have those clinical links that's where we will probably start, but that will be part of the process as we go through getting IND ready fully understanding the clinical path forward.

PAUL JENG:

Great. Thanks for taking the question.

OPERATOR:

The next question comes from Peter Lawson with Barclays. Please go ahead.

PETER LAWSON:

Great. Thanks for taking the questions. A couple of questions, clarifying questions. I think mostly for Gavin; A, just on, how should we think about the scale of the sales force in light of the restructuring, and should we think in the majority of these cost savings are happening in R&D?

GAVIN WOOD:

Hi, Peter. In terms of sales force, we were beginning to think about how we were going to stand that sales force up towards the backend of the year. And since you've been thinking quite hard about that. As a result of timing of the BLAs, as touched on earlier, we're going to be pausing that investment. So, at the moment, we won't be making the hiring in the same profile as we had been anticipating before this announcement.

In terms of the restructuring, that will be across the organization. We're just at the beginning of the consultation with people. I don't want to get too far ahead of our skis just at the moment. But one would imagine with the reduction of approximately 25% to 30% that most areas of the organization will be impacted.

PETER LAWSON:

Thank you. And then how are you thinking about the use of partnerships to help finance the Company? Just your thoughts about what could be partnered and areas you would kind of seek out partnerships for whether it's geographically or indication?

GAVIN WOOD:

Yes, I'll start and perhaps Helen will take over. I mean, we clearly as a company of our size and scale and then geographic partnerships, perhaps outside the U.S. and Europe will always be attractive. And we've got a broad range of assets and certain ones, which are very close to our hearts, but others that we're more—we'd be more interested in partnering and having those partnering conversations.

But I'll hand over to Helen to discuss a little further.

DR. HELEN TAYTON-MARTIN:

Yes. Thanks, Gavin. Hi, Peter. This is Helen Tayton-Martin. And just, I think one dimension I would emphasize is the co-development, co-commercialization strategy that we've applied in our most more recent partnerships with Astellas and with Genentech in relation to assets that we develop. Given the stage and potential value creation that we can achieve with a broad indication asset like MAGE-A4, we clearly have a lot on our hands in terms of development, demand, and commercial opportunity, but we'll

be thinking quite carefully about working with partners where there is a potential win-win on how we think about co-development and co-commercialization.

So, that would clearly be part of the thinking as we continue to build the capabilities to accelerate these assets. Clearly, we're always talking to potential partners, but there's got to be an alignment on how we continue to build value in the Company in those discussions.

PETER LAWSON:
Great. Thanks so much. Thanks for taking my questions.

OPERATOR:
The next question comes from Soumit Roy with Jones Trading. Please go ahead.

SOUMIT ROY:
Hi, everyone. Congratulations on all the progress and thank you for taking the question. Two quick ones on ovarian cancer. If you can provide any colour on these. Do we know the baseline CA125 levels of these patients as they were coming into your trial?

DR. DENNIS WILLIAMS:
Yes, thanks for the question. Actually, given the fact that SURPASS-1, its original design was a basket study. We did not necessarily have detailed information that you might collect if the trial would have been ovarian specific. So, CA125 originally was not a pre-specified item that we collected. And the response criteria that we use, it did not incorporate CA125 response. I think since that time as we started seeing signals, we started to collect CA125 data right to the standard of care in this disease, but we don't have that across all the patients. So, I don't think we're in a position a comment, but certainly for the Phase 2 trial that will be pre-specified. That is something we'll be collecting.

SOUMIT ROY:
I see. Can you characterize like where these patients, the ovarian cancer patients had a higher tumour burden, or they were like soon after they relapsed from the previous prior line of therapy? The ones who were responders at least.

DR. DENNIS WILLIAMS:
Yes, it's pretty heterogeneous. We see responses in folks that have tumour burden of, let's say, 34 millimetres up to over a hundred centimetres, right. So, I don't know that I could definitively say that responses are more likely in one group versus the other, other than in general, I would say those with lower tumour volume tend to do—have better responses than those that have higher tumour volume. And

that's true for afami-cel and that's somewhat certainly true for CD8, almost certainly true for most cancer therapies. But we do see responses across here again a wide range of tumour burdens, and this is not unique to ovarian cancer.

SOUMIT ROY:

Great. Then one last question. Do you see the level of MAGE-A4 expression? Is it homogenous in the—the levels are similar across the patients in ovarian cancer or head and neck or is it widely varying?

DR. DENNIS WILLIAMS:

There's certainly heterogeneity in MAGE-A4 expression. I think the interesting thing that I would say is, generally speaking in some of these indications, if you have MAGE-A4 expression, you have a lot of MAGE-A4 expression, right. So, when we present data by H-score or P-score, in some cases, the value that we have for this trial is actually higher than like we have for SPEARHEAD-1 where MAGE A4 expression is very commonplace in synovial sarcoma. It just happens to be that in a lot of these tumour types, if you have it, you have a lot of it.

SOUMIT ROY:

I see, and that you see in a third of the patients or less?

DR. DENNIS WILLIAMS:

Based on the trial entry for these tumour types—so, for ovarian cancer it's about 25%, for head and neck it's around the same number, and for bladder it's a little bit higher than that.

SOUMIT ROY:

Thank you. Really helpful. Congrats on the progress again.

DR. DENNIS WILLIAMS:

Thank you.

OPERATOR:

This concludes the question-and-answer session. I would like to turn the conference back over to Adrian Rawcliffe for any closing remarks.

ADRIAN RAWCLIFFE:

Thank you for your time. Thank you for your questions today. I look forward to further conversations, and please do reach out if you would like to discuss further. Have a great day.

OPERATOR:

This concludes today's conference call. You may disconnect your lines. Thank you for participating and have a pleasant day.