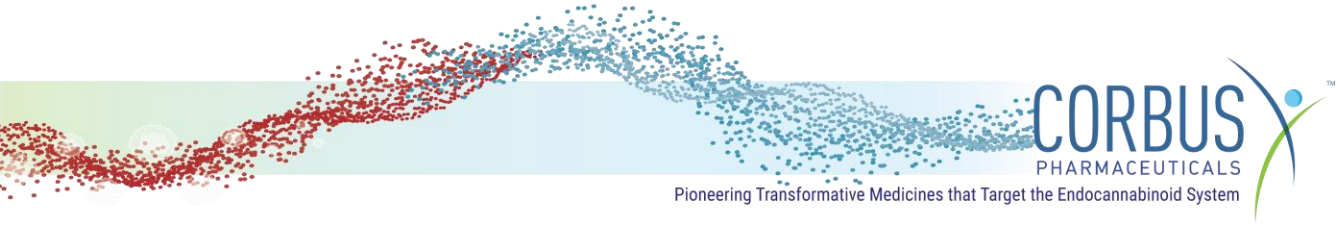

Corbus Pharmaceuticals Holdings
Lenabasum Phase 3 RESOLVE-1 Topline Results Conference Call
September 8, 2020

Operator: Hello and welcome to Corbus Pharmaceuticals September 8th Lenabasum Phase 3 RESOLVE-1 Topline Results Conference Call. As a reminder, all participants are in a listen-only mode. If anyone should require operator assistance during the conference, please press star-zero on your telephone keypad.

This conference is being recorded at the Company's request and will be available on the Company's website following the end of the call. I would now like to turn the call over to your host, Ted Jenkins, Senior Director, Investor Relations and Corporate Communications. Please go ahead.

Ted Jenkins: Thank you and good morning, everyone. At this time, I'd like to remind our listeners that remarks made during this call may state management's intentions, hopes, beliefs, expectations, or projections for the future. 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's 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 those 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 website. We encourage you to review these documents carefully.

Today we'll be discussing results from the analysis of our topline results from the RESOLVE-1 Phase 3 study of lenabasum for treatment of systemic sclerosis. After our remarks, we'll open the call for Q&A.

Joining me on the call 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, I will turn the call over to Yuval.

Yuval Cohen: Thank you, Ted. Good morning, everyone. As we announced in this morning's press release, the RESOLVE-1 Phase 3 study testing lenabasum in systemic sclerosis did not show statistically significant differences in the primary or secondary endpoints when comparing lenabasum to placebo. Both were added to background drug therapy.

As you can imagine, we are both surprised by and deeply disappointed with this topline data. Topline data from the RESOLVE-1 study continued to demonstrate lenabasum's positive safety

profile. Lenabasum treatment was safe and well-tolerated in the Phase 3 study with no new safety signals observed.

We have had topline data only for a few days, and we made the right decision to announce them quickly. We will be getting additional analyses to help us understand these results. In the meantime, I want to share some initial thoughts about our results with you.

We were all surprised by the very high ACR CRISS score we saw in the control arm, which was placebo added to background drug therapy. The median ACR CRISS score in this arm was 0.887, which is higher than any ACR CRISS score for a control arm in previous studies of systemic sclerosis that we are aware of. I will remind you that the maximum achievable ACR CRISS score is just 1. For the lenabasum 20 milligrams twice daily arm, the median ACR CRISS score was an equally high 0.888. You can begin to realize the challenge of trying to determine the effect of an experimental drug where the control arm of the study is scoring so near the top of the scale.

Our study was designed to include patients as currently treated in clinical practice. And to our knowledge, it is the first 52-week, randomized, placebo-controlled, Phase 3 study in diffuse cutaneous systemic sclerosis in which the majority of patients, 84% to be precise, were indeed receiving background immunosuppressive drugs.

In collaboration with our principal investigators and steering committee, we will interrogate our data to understand the higher than expected ACR CRISS score in the control arm, as well as to understand if there are groups where lenabasum offered potential clinical benefit. We plan to present this data at upcoming medical conferences.

Once we have a fuller understanding of the data, we would like to engage the FDA to determine potential next steps in the clinical development program of lenabasum in systemic sclerosis. We remain committed to lenabasum and to our additional pipeline programs. We look forward to upcoming topline results from our study of lenabasum in patients with cystic fibrosis, and we have fully enrolled our Phase 3 in dermatomyositis.

I will now turn to Dr. Barbara White, our Chief Medical Officer, Head of Research, to discuss these details further.

Dr. Barbara White: Thank you, Yuval. Good morning. To echo Yuval, we are all deeply disappointed and surprised by these results. I'd like to review the design of the RESOLVE-1 Phase 3 study with you. The trial was a multinational, randomized, placebo-controlled study evaluating the efficacy and safety of lenabasum in systemic sclerosis when tested as add-on to background treatment. This design took into consideration input from our principal investigators and other experts in the field.

The eligibility criteria were very similar to those used in the Phase 2 study. This study deliberately enrolled subjects on their current background therapy without significantly limiting background immunosuppressive use. This approach of allowing background immunosuppressive therapy was and still would be the right thing to do because it allowed us to enter patients whose treatments represent current practice.

The relevance of this design and decision was supported by the fact that 84% of patients were on background immunosuppressive therapy. The degree of improvement that was observed in the control arm in this study far exceeded what we expected based on our analyses of the literature, reports from other clinical studies, and input from our principal investigators and other experts.

It seems clear to us that this improvement in the control arm is because of the effect of background immunosuppressive therapy. This level of improvement was unexpected. Our principal investigators and our steering committee are all equally surprised.

Dr. Robert Spiera, one of our principal investigators on RESOLVE-1, shared that immunosuppressive drugs alone or in combination are increasingly becoming the mainstay of treatment for patients with early diffuse cutaneous systemic sclerosis. However, to our knowledge, the impact of these drugs on disease has not previously been studied systematically and was underappreciated. The degree of improvement in the control arm was great enough to make it difficult to see any improvement when lenabasum was added as background therapy in the study. However, even preliminary analysis suggests that we may be able to discern patient characteristics and treatment characteristics that allow us to identify groups of patients in which the potential therapeutic benefit of lenabasum can be shown.

We now have data that no one else has. Our RESOLVE-1 data set will provide us with unique understandings about relationships between patient characteristics, current treatment, and outcome. We look forward to working with our principal investigators and steering committee on the design of a potential future study of lenabasum in systemic sclerosis.

Although patients are improving more than previously recognized on background immunosuppressive therapy, it doesn't mean that these improvements are good enough. Chris Denton, our other principal investigator, shared that despite the unexpected magnitude of improvement provided by current immunosuppressive treatment, it is not enough. Patients are still suffering and need new drugs that can provide additional improvement.

Both Rob and Chris expressed excitement about the potential value of a non-immunosuppressive treatment for these patients such as lenabasum. They highlighted that the safety profile and tolerability of lenabasum make it very attractive for potential use in scleroderma patients.

In particular, no new safety signals were observed for lenabasum in the study. Similar proportions of placebo-treated and lenabasum-treated subjects had at least one treatment emergent adverse event. Serious adverse events occurred in 14.6% of subjects in the control arm and 9.2% of subjects in the lenabasum 20 milligram arm.

Severe adverse events, which are slightly different, occurred in 13% of subjects in the control arm and by 5.8% of subjects in the lenabasum 20 milligram arm. Lenabasum was well-tolerated and no subject who was receiving lenabasum withdrew from the study because of an AE related to study drug. No evidence of lenabasum related immunosuppression or new safety signals for lenabasum were observed.

In summary, this study had the unexpected finding of high improvement on background immunosuppressive therapy. Nonetheless, there remains need for additional treatments for this rare and serious disease. Our data set allows us to have unique insights about interactions between patient characteristics and usual treatments that are relevant to clinical trial design in SSc. We are optimistic that our interrogation of the data will provide clarity on patients who could potentially benefit from lenabasum.

On behalf of the entire staff at Corbus, we are deeply grateful to and thank all those who made the RESOLVE-1 study possible. We are especially grateful to the people with systemic sclerosis who participated in the study, and to our principal investigators, Dr. Robert Spiera and Dr. Christopher Denton, our other steering committee members, members of our data monitoring committee, the site investigators, and study staff at each site who among them provided advice and encouragement or performed the daily work of the study at the sites.

Yuval, back to you.

Yuval Cohen: Thank you. Thank you, Barbara. Before we wrap up and take questions and answers, I just wanted to add a couple of more comments. The one is, again, the study has generated an invaluable database for two reasons.

The first is we have a much better understanding of how these patients should be treated. And I don't think it's an exaggeration to say that this will have a very, very significant impact on how the tens of thousands of systemic sclerosis patients worldwide will now be treated and which standard of care they'll be put on. That in and of itself is a very, very worthy outcome for a clinical study, and we are immensely proud of that.

The second thing is, and again it is very early on, but I have a very high degree of confidence that, out of this data, we will emerge with a much better, clearer understanding of the contribution lenabasum could have to the standard of care and how it could fit in this new

paradigm that we will bring about. I remain very, very optimistic about lenabasum, about the potential of the CB2 agonism, and the potential for the endocannabinoid system across multiple indications, including systemic sclerosis.

And I just want to echo what Barbara said. This has been a journey of over three years in the making with hundreds and hundreds of people participating, both patients, physicians, our staff, who have worked incredibly hard. I am so grateful to them. And I am so pleased that, out of this study, something very positive will come out, and maybe more than just one thing.

So, with that, thank you, all of you, for your time this morning. I wish we had different news for you this morning, but nevertheless we are excited about the next steps. We are excited about lenabasum and we look forward to the future. I will now turn it back to the operator for any questions to our team.

Operator: Thank you. We'll now be conducting a question and answer session. If you'd 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'd 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 coming from Brian Abrahams from RBC Capital Markets. Your line is now live.

***Brian Abrahams*:** Hey, guys. Thanks for taking my question. Sorry for the outcome, but clearly a very robust set of data that can hopefully advance the field going forward. I guess first off, the CRISS primary endpoint I know was a median. Are there any other ways to analyze CRISS, either a threshold effect, a mean, or a spread, that might be able to better discern a treatment effect given the high placebo rates on median? Just wondering if you'd seen any signals on those types of analyses.

Dr. Barbara White: Brian, this is Barbara. Thank you for the question. We certainly have already looked at those things and looked at other aspects. And the answer is no, we don't see it there in the ACR CRISS, and the outcomes are really quite similar across the ACR CRISS and the secondaries.

I do think it is because we saw, without exaggeration, what I might consider just as unprecedented improvement in these people with background therapy. And when they are clustered together, different therapies, different baseline characteristics, different characteristics of the drugs and how long they've been on the drugs, those kinds of things, it's just not possible for us in aggregate to see the improvement. I do also remain quite optimistic

that we will be able with this data set to understand enough to allow us to place lenabasum in where it can provide benefit, because there still is great need for treatment of these patients.

We do have much to learn. We will do this with our principal investigators and our steering committee as we interrogate this database. But I do also remain optimistic that we will see clear signals of efficacy when the data are teased apart.

***Brian Abrahams*:** That's really helpful. And maybe just a follow-up to that, Barbara, just wondering if you could talk a little bit more about the types of subgroups that you may be looking at, what you would need to observe to warrant continued development in scleroderma, and any hints that you may have seen thus far. Obviously, I know the data is very fresh.

Dr. Barbara White: You know, I think--while I would love to share our hints with you and where we think we are, I think it's too premature. We really need to have further time to analyze these, discuss these, review them with our experts, our steering committee, our principal investigators and be very certain about them. I wouldn't want to be premature in that.

We will disclose the data in much more detail at upcoming medical meetings. And we will continue to--we will publish results and we will make these data available. Also again, trying not to overstate it, but I think the importance of these data will be very big when it comes to allowing physicians to make choices about what treatments they may or may not want to put particular patients on. And I think that it's a great opportunity for us to contribute to the field, and that's the one aspect of the study that makes us happy.

***Brian Abrahams*:** Got it. One more quick one, if I could, then I'll hop back in the queue. It did look like the severe adverse events were lower for the lenabasum arm versus placebo. And I guess I was wondering if that might suggest any underlying immunosuppressive sparing effect that you may be seeing, such that this could provide a safer alternative for systemic sclerosis patients. Thanks.

Dr. Barbara White: Well, I'm glad you speculated on that, not me. But I can say that--simply that we are pleased that we continued to see a very acceptable safety profile. This is echoed by sentiments from our principal investigators and the steering committee.

These are sick patients. They're on lots of the background treatments, including immunosuppressives. Anything that can be done not to greatly increase burden just of treatments themselves would be a--would be very helpful to them. And so, we're pleased that the safety profile continues to be quite favorable in this group of patients in this study.

***Brian Abrahams*:** Thanks again.

Operator: Thank you. Our next question today is coming from Maury Raycroft from Jefferies. Your line is now live.

Maury Raycroft: Hi. Good morning, everyone. Thanks for taking my questions, and I'm sorry to hear about the news today. First question is just on the use of background immunosuppressives in RESOLVE-1. I guess how does that compare to your dermatomyositis study? And can you talk about key evidence or new understanding from RESOLVE-1 that gives you insight into how the DM or other studies could play out?

Dr. Barbara White: Maury, thank you for the question. Patients with dermatomyositis, it is a related disease. It is a different disease. Those patients, because they are also ill, are treated with background immunosuppressants. In the past, corticosteroids were considered the mainstay, large dose, high doses of corticosteroids, and then if they didn't respond, switch over to additional immunosuppression.

We will see what we get when the study--we've published an abstract form at the American College of Rheumatology, the background characteristics of these patients. And indeed, they are also heavily treated with immunosuppressants. That in and of itself doesn't mean we will see exactly the same effect in the dermatomyositis study.

It's not clear to date, or at least we can't find in the literature or have that insight from our steering committees, that one immunosuppressive is better than the other or that there are certain characteristics that make a difference, or even that they're terribly effective. So, I think the results of the DM study will need to await topline data. But again, it's true the patients are heavily treated, as are most patients with systemic autoimmune diseases in nearly all cases.

What's different about this one was that I think it has been really underappreciated that the patients were receiving some significant benefit. It doesn't mean it was enough. But indeed, what the physicians were doing was helping and is helping the patients that they take care of. That's good news.

Maury Raycroft: Got it. That's helpful. And just wondering if you've done any preliminary check into blood biomarkers, and do you have a sense of whether the drug is having a biological effect that would benefit patients with SSc or even the other diseases too?

Dr. Barbara White: We don't have any of the biomarker data available to us yet. These are just topline. These just came in. In the next few weeks, we actually--as you may know, when you get study data results, they come in batches. First you get the topline and then you get the rest of the story, and you can also do further analysis to interrogate the data.

We have just gotten the topline data. We don't have the rest of the planned analyses, and it will inform us as a company about the full extent of what went on in the study, as will our other interrogations in collaboration with experts in the field.

Maury Raycroft: Got it. And last quick question, you mentioned potential for another future study in SSc. Do you have an idea of what that study would look like, and any views on timing for when that could be revealed and initiated?

Dr. Barbara White: No and no; too preliminary.

Maury Raycroft: Got it. Understood. Okay. Thank you for taking my questions.

Operator: Thank you. Our next question today is coming from Dae Gon Ha from BTIG. Your line is now live.

Dae Gon Ha: Hey, good morning, guys. Thank you very much for taking the question, and I'm sorry to hear about the outcome this morning as well. So, just a couple of questions, I guess. Realizing that this is topline, I was wondering if you had any insights that you could share potentially on, say, the overall trend in ACR CRISS. I know you mentioned no significant difference on CRISS, but also on the secondary. So, were there any kind of separation in the curves over the course of the 52 weeks that, I guess, placebo just happened to catch up towards the end part of that time duration?

And secondly, you know, you mentioned 84% of your patients were on background immunosuppressants. So, I was wondering if you had any, I guess, preliminary insights on whether certain immunosuppressants engendered a more meaningful benefit. And then I have a follow up. Thank you.

Dr. Barbara White: Dae Gon, thank you again for your question and comment. Probably we are--we're not going to disclose that level of detail at this point. Again, we will at upcoming medical conferences soon. However, I am confident to say--I feel confident in saying that it wasn't some fluke of the last visit in the study. I don't think that's what it was.

We have no evidence as we look at the data that this was a study which had any significant operational problems or flaws to it. Patients in certain subsets, well defined, behaved exactly as expected. It was just that overall, when you look at patients on background immunosuppressants, they're doing far better than the community had appreciated or had been reported in the literature. That's really the bottom line of the study.

We are also not disclosing the preliminary insights we may have about the who, what, where, why, and when at this time. These will come out when we've had time to do more complete

analysis, to do a number of analyses of impact of different variabilities. We're just not there yet. At the same time, I'm also confident in saying that we are optimistic from very preliminary looks that we will be able to discern the important interactions between patient characteristics and treatment and where there is a place for lenabasum.

Dae Gon Ha: Got it. And then just to follow up on an earlier question regarding your future plans in SSc, I was wondering if you had any kind of internal rubric or a threshold that would give you the go/no-go signal for a subsequent study. So, for example, if during your, I guess, subgroup analyses you find out that perhaps like 10% of the SSc patients would realistically benefit, would that still warrant a future study, or what else would there be for your consideration? Thanks.

Dr. Barbara White: Dae Gon, again, I simply think it's too premature for us to address questions in that level of detail. We've very recently gotten these data. We've, I think, done a good job of digesting them and understanding what is being observed in this study to date, and it is just much too premature for us to make such decisions at this time.

Dae Gon Ha: Great. Thank you very much for taking the questions.

Operator: Thank you. Our next question today is coming from Leland Gershell from Oppenheimer. Your line is now live.

Leland Gershell: Hey, good morning. Thanks for taking my question, and also so sorry to hear about the data. Wanted to ask--given that it is topline, but want to ask if you're able to share any geographic differences between, let's say, U.S. and Europe in terms of the responses, given the nature of the differences in various immunotherapies that are used. Thanks.

Dr. Barbara White: So, Leland, again, thank you for participating and your interest. What I can say is we did publish in abstract form at the American College of Rheumatology Annual Meeting, I think--Lindsey, you may help me--I think it was in 2019, the baseline characteristics of the patients in the RESOLVE-3 study. And if you look carefully at that poster that we put up, you will see that patients are grouped in an unusual way.

The geography is described in an unusual manner, and that is based on how different--physicians in different countries treat patients, where the standard of care is different by geographies. And there are some data in there in which you have sort of heavier treated patients, medium treated patients, and lesser treated patients, if I can very crudely describe the groups. And so, those data are available.

But as one would expect, patients in the United States are most aggressively treated with background immunosuppressants, as are similarly treated patients in some other countries

such as the United Kingdom, in Great Britain, in Australia, in Canada. Among countries in Europe, I would say it's a mixed bag, and in Asia, probably much lighter in the use of immunosuppressants. So, there are geographic differences.

Leland Gershell: Okay, great. Thanks for taking my question.

Operator: Thank you. We have time for one more question from the line of Elemer Piros from Roth Capital. Your line is now live.

Elemer Piros: Yes, good morning; a very unexpected outcome here. Barbara, how did those patients fare who weren't on immunosuppressants? I know it's a small group, but have you seen any directional effect at least favoring the drug there?

Dr. Barbara White: Elemer, thank you again for joining. And as always, thank you for your insightful questions. We are not going to disclose that information at this point. It will be forthcoming, and it points out the value of this rich dataset that we now have about patients, background characteristics, treatment duration, all those sort of things.

And it will allow us to identify potential subsets such as those who are not receiving immunosuppressives to look for the most clear signals of clinical benefit, and also to go beyond that and look in patients who are receiving a broader array of standard treatments to discern the clinical benefit. So, again, we remain optimistic, and those--that type of detailed data will be forthcoming once we have the opportunity to really analyze it with appropriate care and vigor.

Elemer Piros: We touched upon the dermatomyositis trial, but if I'm correct to assume, there is no such confounding factor in the CF study, which you're about to unveil in the next several weeks. Am I correct?

Dr. Barbara White: Right. Well, for sure, Elemer, the last thing you want to do is treat those patients with immunosuppressives.

Elemer Piros: Right.

Dr. Barbara White: And the ones we're studying are patients who have CF who are especially sick, those that are prone to recurrent pulmonary exacerbations, those that have really persistent and significant inflammation in their lungs and are often colonized and infected with bacteria even--especially bad bacteria.

The last thing you want to do is immunosuppress those people and when it's happened, they've gotten sicker. So, it's a very different subset. There's no background immunosuppression in

these patients. So, again, we anticipate those data near term, and we will let you know when we get them.

Elemer Piros: Okay. Thank you so much, Barbara.

Operator: Thank you. We have reached the end of our question and answer session. I'd like to turn the floor back over for any further or closing comments.

Yuval Cohen: It's Yuval again. Thank you so much, everyone. We have a lot of work to do ahead of us, both in the very near future as well as the very--several months ahead and looking into next year. We're hoping to come back to you with clearer and better news.

And again, thank you to the team, and thank you to our audience for taking so much interest in this program and in this indication. It is a really, really important disease. And with that, everyone, thank you. Stay safe and have a great day.

Operator: Thank you. That does conclude today's teleconference and webcast. You may disconnect your line at this time and have a wonderful day. We thank you for your participation today.