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EDITED TRANSCRIPT

ADAP - Q3 2017 Adaptimmune Therapeutics PLC Earnings Call

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PRESENTATION

Operator

Good day and welcome to the Q3 2017 Adaptimmune Earnings Conference Call. Today's conference is being recorded. At this time, I would like to turn the conference over to Juli Miller. Please go ahead, ma'am.

Juli Miller

Good morning, and welcome to Adaptimmune's conference call to discuss our third quarter 2017 financial results and other business updates. This call is being accompanied by a press release that was issued earlier this morning, and I would ask you to please review the full text of our forward-looking statements there.

As a brief reminder, we anticipate making projections during this call and actual results could differ materially due to a number of factors including those outlined in our latest filings with the SEC. James Noble, our Chief Executive Officer is with me for the prepared portion of this call. Adrian Rawcliffe, our Chief Financial Officer; Helen Tayton-Martin, our Chief Business Officer; and Bill Bertrand, our Chief Operating Officer will be available for Q&A after the prepared portion.

With that, I'd like to turn the call over to James Noble. James?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Thanks, Juli. Good morning, everyone, and thank you for joining us. This is a period of extensive endorsement to cell therapy with recent quality approvals by the FDA, a major acquisition, as well as GSK exercising its option over our own NY-ESO program, and we see this as a key inflection point for Adaptimmune.

We announced in September that GSK had exercised its option over our NY-ESO program and the transition to GSK is well underway. We believe that this option exercise represents a compelling validation of our data in synovial sarcoma, giving further support to our conviction that we have a pipeline capable of treating solid tumors. We expect the transition of the NY-ESO program to be completed during 2018, and we have now completed enrollment of patients in the ongoing non-small cell lung cancer study. We continued to enroll patients in the ongoing multiple myeloma in combination with KEYTRUDA study, the MRCLS study, and cohort 2 of the synovial sarcoma pilot study.

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An update on the pilot synovial sarcoma study will be presented next week at [CTOSS], and we are also presenting updated follow up survival data from our original multiple myeloma study in the context of autologous stem cell transplant next month at ASH. Ultimately GSK will take on responsibility for all of the ongoing studies, as well as the planned registration study in synovial sarcoma. We should emphasize that GSK's commitment to SPEAR T-cell therapy goes beyond the NY-ESO. You may recall that GSK has the ability to select up to 5 Adaptimmune programs. The first was NY-ESO and the second was [PREM] nominated by TSK in January.

After the NY-ESO transition is complete, GSK can nominate 2 more targets, but just to be clear, they cannot nominate anything in our wholly-owned pipeline including MAGE-A10, MAGE-A4, and AFP. If successful, GSK would pay development milestones of up to $500 million for NY-ESO, up to $300 million for PREM, and up to $325 million for each additional program, plus sales milestones and royalties. As we transition away from working on NY-ESO, we will have a greater ability to develop -- to deliver shareholder value by focusing the entire team of our clinical efforts on our wholly-owned pipeline.

Currently we have 3 open R&Ds in 4 ongoing studies. These include 2 studies with MAGE-A10, one in non-small cell lung cancer; and a triple tumor study in bladder, melanoma, and head and neck cancers; a basket study with MAGE-A4 across 7 solid tumor indications, including bladder; melanoma; head and neck; ovarian; non-small cell lung; esophageal and gastro cancers; and a study with AFP in (inaudible) cellular cancer. We can confirm that we have those patients with SPEAR T-cells from our wholly-owned pipeline, and we are on track to release initial safety data from MAGE-A10 in early 2018.

In terms of current financials, our total liquidity at the end of the third quarter was $232 million. This includes $28.5 million received from GSK of the up to $61 million receivable during the transition period of NY-ESO to GSK. This means that we are well-funded with a clear runway through to early 2020 enabling us to deliver data from our wholly-owned pipeline.

To deliver successful clinical trials, especially in the cell therapy area, manufacturing is essential to the success of companies. Currently we rely on all of our manufacturing to be carried out at PCT where we have had approximately 50 manufacturing runs this year. Looking forward, I'm delighted to say that we are nearing completion of our Navy Yard facility in Philadelphia. You will recall that we initiated this build-out of our pilot plant last year and the first module should double our current manufacturing capacity at PCT. In due course, once all of the 3 of the planned modules are constructed, we will have capacity to supply up to 1,000 patients per year.

In other news, as you may have seen, we recently announced that SÃ©bastien Desprez has joined the company as Vice President of Communications and Investor Relations, and he will undoubtedly become familiar to you over the coming months.

These are exciting times for Adaptimmune and cell therapy as a whole. We have demonstrated compelling results in the solid tumor which are further validated by GSK's option exercise over NY-ESO.

We remain committed to our patients and we'll work diligently with GSK to ensure that NY-ESO is transitioned smoothly. This is a critical inflection point for Adaptimmune enabling us to fully focus on our wholly-owned clinical stage assets, and we are funded and on-track to deliver data from these programs in up to 8 different tumor types by the end of 2018.

We are the leaders in the TCR T-cell space and our goal remains to be the first to market with an engineered TCR T-cell therapy in solid tumors.

With that, I'd like to open the call up for questions. Operator?

QUESTIONS AND ANSWERS

Operator

(Operator Instructions) We will now take our first question from Tony Butler from Guggenheim Securities.

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Charles Anthony Butler - *Guggenheim Securities, LLC, Research Division - MD & Senior Equity Analyst*

Question not on the current programs, but I know you have some research ongoing with universal cells, and I'm curious if you would not mind just elaborating a little bit on the progress that you may be making on effectively an off-the-shelf program for TCRs, that'd be very helpful?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Actually that program is going very well indeed, and we are rapidly expanding the team in-house next year to around 20 people because we believe that really has a future ahead of it, the -- we've hit quite a few milestones, I'm not at liberty to disclose what they are, but that program is definitely making progress towards developing an off-the-shelf product. I'm -- I feel more confident than ever that we're going to get there.

Charles Anthony Butler - *Guggenheim Securities, LLC, Research Division - MD & Senior Equity Analyst*

And James, could I ask, do you foresee in the very near term or could you maybe circle what date or range of dates where you may be able to enter the clinic?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

I don't think we -- I don't think we do have a date in mind, I don't know we published a date yet for the clinic. I mean, it's years, not months away. So it's not going to be the -- it's not going to be next year or the year after. I'm guessing it's 4 or 5 years away.

Operator

We will now take our next question from Peter Lawson from SunTrust Robinson Humphrey.

Peter Richard Lawson - *SunTrust Robinson Humphrey, Inc., Research Division - Director*

Just I guess it's interesting to see what you're going to have a CTOSS, what should we expect in terms of I guess follow-up et cetera size of cohorts?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Yes, so we presented the cohorts at ASCO, so it's just really an update from there, so it's a bit longer, I think a few more patients. Sandra D'Angelo is doing it, so she will cover all 4 cohorts. And it will be an update. Obviously it's only 4 months on from ASCO, so there won't be anything dramatic in that.

Peter Richard Lawson - *SunTrust Robinson Humphrey, Inc., Research Division - Director*

And then just back to the universal cell collaboration, would we see kind of preclinical work in the near term?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

I'll ask Helen to comment on that.

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Helen Katrina Tayton-Martin - *Adaptimmune Therapeutics plc - Co-Founder and Chief Business Officer*

Yes, no, it's a good question, and actually we do want to -- given the progress we've been making with this collaboration, we do want to be able to talk about this in the reason being near-term future, there are some -- because of that progress there was some proprietary positions that we are protecting in terms of how we make the cells both in terms of the stem cell differentiation and the T-Cell editing, with stem cell editing, so I would hope that perhaps sometime next year we will be able to talk about that more publicly.

Peter Richard Lawson - *SunTrust Robinson Humphrey, Inc., Research Division - Director*

And then just quickly on enrollment rates, how is it going for like A10 and I guess A4, has the steps picked up and kind of expectations around data for both of those?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

So we've recruited several patients into the MAGE-A10 study and that's why we're confident that we will be able to -â€“ we would actually be announcing the safety data on the first cohorts at JP Morgan. So when I say early 2018, I mean very early there, so because we've -- we always said that we're not going to comment patient by patient, but we've dosed enough people for sufficient time by JP Morgan that we can have a sensible debate about the safety profile of MAGE-A10. MAGE-A4 will then follow I'm guessing a quarter or so later, and then AFP would always be the slowest of the 3, which we told people at the time. So the sort of order of events if everything goes well would be MAGE-A10 right at the beginning of the year safety data followed by some efficacy data when obviously we've gone up the dosing schedule during 2018, and MAGE-A4 I guess running a quarter or 2 behind MAGE-A10. MAGE-A10, the program started much earlier than MAGE-A4. We are screening -- just to be clear, we are screening and have found quite a lot of patients who are MAGE-A4-positive, so we're very confident as we always said that the presentation of MAGE-A4 is actually at a very reasonable level in a number of serious diseases. And I have to say you only actually find that out when you go into the clinic whether or not the databases and other sources are correct. So we're very confident that we'll be present -- well, we will be presenting the MAGE-A10 safety data on a number of patients at JP Morgan and then I think then probably a sort of quarter or so later for MAGE-A4 and then efficacy after that.

Operator

We'll now take our next question from Reni Benjamin from Raymond James.

Reni John Benjamin - *Raymond James & Associates, Inc., Research Division - Senior Biotechnology Analyst*

Maybe just as a follow-up to Peter's enrollment question, can you talk a little bit more about the screens that you're running, how many sites will be fully enrolling when kind of all the studies are running at peak? And I guess related to that, if I'm reading you right, James, the safety data with the lower dose cohorts come out call it in the first half or so and more of the efficacy data with the higher doses coming out in the second half, what constitutes a go, no-go decision for you guys? What do you guys look for?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Yes, to take the first question on the number of sites, in total in the United States, we have around 20 sites open including all of the NY-ESO sites. We will take a one site open in Canada and actually we have the CK approved in the U.K. and Spain. So actually we could open sites in those 2 countries. So we don't break that down by studies, but I can tell you that the strategic alliance with the MD Anderson is easily the most significant site in terms of screening and patients because they have a very centralized system for screening. So that's been a fantastic strategic collaboration, and I expect them actually to dominate the -- at least the early phases of the cohorts. So in terms of the safety data, the way it's going to work is the studies are essentially 3 patients that you get a DLT, and then it becomes 6 patients of each dose, and so the first dose just to remind you with 100 million transfused cells. Now, with NY-ESO we saw no -- we didn't see any efficacy at 100 million transfused cells. We really set the lowest

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threshold for -- at 1 billion transfused cells is obviously very round numbers. That's the second dose level for each of the MAGE-A4, MAGE-A10 and AFP studies. So the order of events should be I think right at the beginning of the year MAGE-A10 safety somewhere for second quarter would be the MAGE-A4 safety data. But it simply depends on the recruitment of MAGE-A10 as to when we get people recruited for sufficient time and sufficient numbers who have a sensible efficacy debate. As I said, we're not going to publish data on single patients, we don't think that's very helpful.

Reni John Benjamin - *Raymond James & Associates, Inc., Research Division - Senior Biotechnology Analyst*

And then just I guess for looking at the totality of the efficacy data, how -- can you help maybe frame what it is that you would ideally be looking for at this stage?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Sorry. Yes, sorry, I missed the question, I didn't mean to ignore it. Yes, so we have -- we are obviously looking for response data, that's what we -- we're talking about response data, so that's a 30% reduction in the size of relevant tumors for a 4-week period minimum. And it's our rule of thumb as a company, if you don't see at least 3 good responses in a cohort of 10 let's say, unless there's some special reason, then we don't really think that's going to excite the world in cell therapy. Now we obviously hope to do better than that and did do better than that in the sarcoma study with basically a 50% response rate. So we would be looking for a good response rate in a significant number of patients. Our internal rule of thumb is 3 out of 10 is the minimum which constitutes a really good difference. It varies by disease of course, I mean the threshold would be higher in some diseases than others and obviously the bar is always moving, I mean in some very difficult diseases, 30% would be a fantastic result. In other diseases it wouldn't be so, but that's our rule of thumb as to whether we think that we can really see activity is looking at whether you get that sort of 3 and 10-plus response rate.

Reni John Benjamin - *Raymond James & Associates, Inc., Research Division - Senior Biotechnology Analyst*

And then just maybe one final question from me, in regards to safety, I feel and I'd love to get again your color, it seems to me that safety is extremely important in these cases, probably more for certain targets versus others. As you look at these 3 targets, how should we be thinking about that first safety readout and relative importance for that target?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Well, the main conclusion of the safety testing would be whether or not the cohorts is sufficiently safe at 100 million cells to allow us to proceed to the second dose which is a billion, I mean that's really the criteria. Now, there are 2 -- I agree with you by the way that I think safety is very important. I think there are 2 types of safety with cell therapy. One is if there's some very unexpected cross reactivity, and that would stop a program if you saw that obviously, and that's what we saw with MAGE-A3 back in 2011. So that's actually what you're looking for in my opinion at the 100 million cell dose. You're really looking to see if for some unexpected reason, your T-cell receptor is targeting some tissue that you weren't expecting, that's the most important safety signal for us. Other safety signals, I mean in terms of adverse events, in fact if you look at the CTOSS data, 100% of cancer patients in these studies have adverse events of one sort or another, first of all from the preconditioning, so you always get adverse events from the cyclophosphamide plus fludarabine, so that -- and then of course the 2 things that we look out for especially because of the [CAR] T-cells, one is the CRS where as you know so far we've seen lower CRS with NY-ESO than the CAR T-cells, and the other is the neurotox where we haven't seen any of the neurotoxin in the CAR T-cells. But the -- because of cell therapy, the field looks out for those things, those are the things we're looking out for, so it's 3 different things, the worst of all would be a gross cross reactivity which obviously would stop the program. And the second 2 most important [toxs] that we're looking for is CRS and neurotoxicity because of the CAR T-cells. So as I say we have never seen neurotox, but of course these patients are followed for every type of toxicity and we'll report on what we see in January.

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Operator

We will now take our next question from Michael Schmidt from Leerink Partners.

Michael Werner Schmidt - *Leerink Partners LLC, Research Division - MD, Biotechnology and Research Analyst*

I just had a housekeeping question. Through the transitioning of the NY-ESO program to Glaxo, does that have any meaningful impact to your P&L on the expense side for example?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

I'll ask Ad to answer that.

Adrian Rawcliffe - *Adaptimmune Therapeutics plc - CFO*

Yes, so we've talked about the milestones and option piece that we get from GSK over the transition period and you can see the treatment in the current quarter that we've released an amount of recognized some of the revenue from that, and from the historic milestones too. Looking forward, the deal you recall was set up to be effectively neutral to us from a cash perspective going forward including GSK paying for essentially the clinical trials through a series of milestones. And so yes, we will have a reduction in the expenses associated with NY-ESO and that will be offset by a reduction in the milestones that we would anticipate from GSK, and so we don't expect that much of a net benefit or deficit to us going forward although on individual courses it might have varied slightly from what we are anticipating.

Michael Werner Schmidt - *Leerink Partners LLC, Research Division - MD, Biotechnology and Research Analyst*

And remind me of the manufacturing responsibility going forward for NY-ESO, is that transitioning out as well and how do you think about potential manufacturing cost synergies longer term?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Yes, so the -- it's quite clear. There are 2 places to manufacture. One is our own Navy Yard where we will not produce any cell for GSK. That is entirely devoted to ourselves. With PCT the arrangement there is that we actually contractually have -- we sort of rent a room if you like, and it -- and GSK will rent a different room, so essentially that they will end up with PCT as their sole supplier until they do something else. So we will not make cells for GSK, they will make them at PCT, we will obviously get them made at PCT for the ongoing cohort so they are being made right as we speak at the -- for the ongoing cohorts, and then GSK will set up a contract with PCT as own contract. So it will be same manufacturer, but we would transition all responsibility along with the programs.

Operator

We will now take our next questions from Eric Schmidt from Cowen and Company.

Eric Thomas Schmidt - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

First question is you know that you've been in the field of screening for AFP for a number of months. If you can give an update on kind of where you're seeing the frequency relative to the -- roughly 1/3 that was predicted based on literature searches?

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James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Rafael, are you on the -- are you on the call? Sorry, Rafael is not on the call, he is traveling right now. We weren't sure if he was going to be able to join us. So the answer is that the -- we have found a number of -- the HLA is standing up as you'd expect, the HLA is generally between -- around a sort of 40%s-plus of patients. And the screening is showing a number -- we have actually found a number of patients -- people, this is a trial -- the reason it's going to be slow is this is a trial with extremely tight inclusion-exclusion criteria and not related to the (inaudible) presentation. This is to do with the fact that AFP is presented on certain normal progenitor cells in the liver and therefore we are only taking people into the trial who have a very good liver function apart from obviously having [APACHE] cellular cancer. So it's the inclusion and exclusion criteria that are making this a slow trial, not the percentages. I actually don't know the percentage off the top of my head, but we have found people who are AFP-positive.

Eric Thomas Schmidt - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

Have you dosed anyone in that trial already?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

We haven't. We're not disclosing anything apart from MAGE-A10 where we're saying we have those people.

Eric Thomas Schmidt - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

And then when we ultimately see MAGE-A10 efficacy data maybe in the second half next year, do you think that's going to be both trials, just the one cancer trial since that one started earlier or how do you feel that's going to play out?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

I think it's both. I think the (inaudible) so far, so unless -- so I would hope that we'd see data from both trials. So one is a lung cohort and one is a triple T, and I envisage that we see data from both.

Eric Thomas Schmidt - *Cowen and Company, LLC, Research Division - MD and Senior Research Analyst*

And then last question is kind of bigger picture for you, James. As NY-ESO transitioned to GSK, you mentioned you have -- that allows you some more space to kind of invest in your wholly-owned pipeline, I mean is that in your mind more of expanding and maybe picking up the pace on these 3 programs that you have in the clinic, or is that adding additional ones in the near term -- additional targets on the near term?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Actually it's on those 3 in particular, but just to give you a scale of it, roughly 2/3 of our clinical regulatory team in the USA has been devoted to NY-ESO, so we will able to switch the whole of that on a sort of gradual basis over the next several months to our own programs. I don't think that's really important. These trials are incredibly time-consuming to set up and deliver patients. They -- lot of education for the centers, there's a lot of screening work et cetera, et cetera, lot of -- it's a tremendously complex thing. So actually it just -- it's a beautiful transition period for us just at the very time we're going to need people to expand the trials from next summer onwards is exactly the time they'll be coming free from the GSK deal.

Operator

We will now take our next question from Jim Birchenough from Wells Fargo.

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Unidentified Analyst

It's Nick on for Jim this morning. And thank you for a very clear update. James, just a couple of things. One is can you comment on any progress you've made with the Belgacom collaboration. And then I have a follow on.

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

I'll let Helen deal with that because she is in charge of the collaborations.

Helen Katrina Tayton-Martin - *Adaptimmune Therapeutics plc - Co-Founder and Chief Business Officer*

So yes, I think it's fair to say we've been working through the proof of concept stage with the Belgacom collaboration and had some initial data on that which we will be talking to Belgacom about in the near future. So there's still work to be done in the proof of concept stage. But so far we've made some progress with some aspects, and others we need more work. So, yes, making progress, but nothing to report yet.

Unidentified Analyst

And do you know when you will make a go, no-go decision on that?

Helen Katrina Tayton-Martin - *Adaptimmune Therapeutics plc - Co-Founder and Chief Business Officer*

Anticipated during the course of 2018.

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Yes, next year sometime. Yes, we have made a lot of progress internally, just not announcable, and we also have to discuss with Belgacom and so -- because it's a joint decision as to whether we go forward or not.

Helen Katrina Tayton-Martin - *Adaptimmune Therapeutics plc - Co-Founder and Chief Business Officer*

Yes.

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

It's not one side or the other. We are obviously doing a lot of pre-clinical experiments, and if that works -- if we want to go ahead, and if it works out, then both companies have to say yes as it were, otherwise either company can just pull out without any further liability.

Unidentified Analyst

And then second question relates to the next generation of NY-ESO SPEAR T-cells. The -- you've talked in the past about having different functionality of those T-cells. So can you update us on where you are with those, and also how this relates to the GSK collaboration? Do they get access to these second gen T-cells or is that part of a different negotiation?

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James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

No. So that's a really interesting question. So the whole thing transfers to GSK. Under the collaboration we were obliged to come up with several different NY-ESO constructs with second generation versions, and then they can select which ones to take into the clinic if any, obviously it's up to them now. The answer is that we have been very successful and given them the construct, so if they want to put them into the clinic, they could do so. I should also say that we have several -- we have 1 for MAGE-A10 and several for MAGE-A4 also some of which are either at finished preclinical development or are going through preclinical development. So our own in-house programs are very advanced on that score. So if we need second generation constructs, they will follow pretty quickly on from generation 1 if we need them. So we will have that choice very -- not too -- in the not too distant future. Helen?

Helen Katrina Tayton-Martin - *Adaptimmune Therapeutics plc - Co-Founder and Chief Business Officer*

Yes, no, that's a perfect summary. I think just to say just for clarity, so there were a number of second gen programs we agreed with GSK and we took 3 of those forward, so there are 3 in particular which GSK will have preclinical data packages on and can decide what it wants to do. We have done considerably more work in just 3 programs in terms of second gen approaches. So we have -â€" obviously have all of the rights to those with any of our own programs, they will have the (inaudible) NY-ESO, any other targets they nominate. So we have both, but we have a lot of others besides, so we have more than those 3 ready with our own program.

Unidentified Analyst

And then just final one from me and that relates to the current clinical trial protocols. And specifically I'm thinking of what the sort of flexibility is for adding in additional therapies once you've dosed a patient and particularly the PD-1 inhibitors for example, so obviously we've seen some titles now, and we've heard before that for the CAR Ts that patients can be rescued, either they don't have a very good initial response or they lose response and they can be rescued with the addition of a PD-1 inhibitor. So in terms of your clinical protocols, obviously the very first patients are -- only just get the SPEAR T-cells, but are you considering allowing for the addition of a PD-1 inhibitor for example in those conditions?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

So the way the protocols are set up is as monotherapies right now. We want to work out very clearly what the signal is in different diseases before we sort of add bells and whistles, and those bells and whistles could either be combination studies with the PD-1 inhibitors or could be second generation versions of the -â€" of our own -- of our own T-cell receptors. But you may be aware that the multiple myeloma study that we are actually enrolling right now, that is a combination study with KEYTRUDA. So that's randomized. You -- either it's half-and-half, that either you get the NY-ESO T-cells on their own or you get the NY-ESO T-cells plus KEYTRUDA, and that's I think 14 patients in each arm and we've started enrolling in that study. So we're very much on the case, but I'm -- I do want to see what the responses is with the -- with the sort of generation 1 monotherapy to start with and then we'll look forward to, but definitely we're very, very aware of that and very keen to talk to other companies about it.

Operator

(Operator Instructions) We will now take our next question from Robyn Karnauskas from Citi.

Unidentified Analyst

Hi guys, this is (inaudible) for Robyn. She apologizes that she couldn't be on the call, she was booked. I just had a quick question about the rate of enrollment. Can you talk a little bit about how the KEYTRUDA combo study is enrolling? You just mentioned that you expect to enroll 14 patients on each arm. And also I apologize if you've already mentioned this before, but have you talked about when we might be able to see data from this trial? And also a similar question for ovarian cancer, I know that enrollment rates were relatively slow compared to the lung cancer enrollment rates and ovarian cancer study. Has there been any change in the rate of enrollment?

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James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

The ovarian one I'll take first. That was actually closed as part of the transition which we announced in early September. We are not enrolling in that study. We are enrolling in the ovarian patients in the MAGE-A4, but not with NY-ESO anymore. So that's continuing, and that does reflect the fact that we couldn't find the literature data on how many people, how many â€"- sorry, women with ovarian cancer presented NY-ESO clearly much higher than the reality. It was actually a very, very low percentage I comment, but so we stopped that. We are continuing that with the MAGE-A4. We don't -- so the KEYTRUDA study is enrolling, we haven't published figures on either the -- how many people we've enrolled and where it's going to finish because this is one of those studies that all publication rates, but it's one of the studies that's going to transfer to GSK in flight as it were. So there'll be one -- so we will sort of start it and they will finish it. So â€"- and they obviously when they take a study over, they also become responsible for all the publication rights on that particular study. So that's really a sort of GSK question I'm afraid.

Unidentified Analyst

And I have a quick question about the financials, I know you said the $61 million will be distributed over the transition period. Have you guided about how it's going to be split?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

So, no, we haven't guided, but it is actually reasonably obvious. We've said that we've received in Q3 $28.5 million worth of that $61 million, and that the transition period ends next year, and I think we've also guided that at mid next year and so the remainder is likely to be in that area.

Operator

We'll now take your next question from Ying Huang from Bank of America Merrill Lynch.

Unidentified Analyst

Hi, guys, this is Jenny on for Ying, sorry, he couldn't make the call. We just wanted to ask a little bit about your ASH abstract, so as you mentioned this is going to be a GSK program, but just kind of thinking about the overall strategy in multiple myeloma where you see and where you're still kind of fitting into that changing paradigm? And then also I wanted to flag the GVHD cases which I don't think we saw in any of the other studies. So was that specific to this study and kind of going forward, how do you guys plan to manage any GVHD cases?

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

There's a good question. So the way this works is if you like the ASH abstract is the tail-end of our responsibilities for the multiple myeloma studies apart from the initiation of the KEYTRUDA study. So first of all, the -- so it would be our last update, in fact to be able -- simply update people on the study that finished a good couple of years ago. We presented I think in 2012 and 2015 the sort of early data, so it 's really a -- it's updating the responses and the survival rates of those patients. GVHD we have mentioned before. Actually GVHD is actually relatively common in the context of autologous stem cell transplant in multiple myeloma, so we're not sure whether there's any added effect -- any added GVHD from the T-cell receptors. So we doubt it because we've never seen GVHD in any of the other studies that we've done. So we think that's really a function of the -- this was actually a sort of combination study if you like, not with another drug, but with autologous stem cell therapy. We have actually disclosed before, and they are -- you do get GVHD in autologous stem cell therapy without our TCRs. So I don't think it really has a read through. So I don't think there is a need to be concerned about that. We've never seen that anywhere else as I said. I think you ask a very good question as to how the -- how multiple myeloma fits in the combination -- sorry, in the context of all of the other really excellent data from the BCMA CARs. I think this study that's -- this study which we're currently running will answer that question. If you get very good data with the T-cell receptor plus KEYTRUDA for example, I think that would be a very interesting alternative. So that's what the point of that study is. You're right, the sector multiple myeloma

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has moved very significantly from when we started this study to now, and you need to have extremely efficacious molecules to treat multiple myeloma in the context of the CAR T-cells. So I think this study will recruit centers thinking to put the patients on to the study and we'll see what the data are at the end of the -- whether the T-cells on their own without autologous stem cell transplant, a), we'll see whether it's GVHD. We obviously hope there isn't, so therefore it would only have been because of the stem cell transplant. And secondly we'll see what the effect of that is, a PD-1 inhibitor KEYTRUDA alongside, and that for all we know may provide very good efficacy. We'll wait and see. Does that give you an answer?

Unidentified Analyst

Yes, that's great.

Operator

There appears to be no further questions in the queue at this time.

James Julian Noble - *Adaptimmune Therapeutics plc - CEO and Director*

Great. Well, we'd like to thank everybody. We feel that we are at a very exciting crossroads. We're transitioning out of NY-ESO towards our own programs. We dose people and we have cash on hand and the programs on hand we think to deliver very significant data during the next year or so. So thank you very much for your attention.

Operator

This concludes today's call. Thank you for your participation. You may now disconnect.

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