Adaptimmune Therapeutics plc (Q2 2020 Earnings)

August 06, 2020

Corporate Speakers:

- Juli Miller; Adaptimmune Therapeutics plc; Senior Director of IR
- Adrian Rawcliffe; Adaptimmune Therapeutics plc; CEO, Principal Accounting Officer & Director
- Elliot Norry; Adaptimmune Therapeutics plc; Senior VP & Chief Medical Officer
- Helen Tayton-Martin; Adaptimmune Therapeutics plc; Co-Founder & Chief Business Officer
- John Lunger; Adaptimmune Therapeutics plc; Chief Patient Supply Officer

Participants:

- Marc Frahm; Cowen and Company, LLC; Research Division, Director
- Charles Butler; ROTH Capital Partners, LLC; Research Division, MD, Senior Equity Analyst & Head of Biotechnology Research
- Mohit Bansal; Citigroup Inc.; Research Division, Director and Analyst
- Mohit Bansal; Citigroup Inc.; Research Division, Director and Analyst
- Nicholas Abbott; Wells Fargo Securities, LLC; Research Division, Director & Associate Analyst
- Wei Ji Chang; SVB Leerink LLC; Research Division, MD of Emerging Oncology & Senior Research Analyst
- Gabriel Fung; Mizuho Securities; Analyst

PRESENTATION

Operator^ Hello, and welcome to Adaptimmune Q2 Financial and Business Update. With me on today's call is Juli Miller. Juli, you may begin.

Juli Miller^ Good morning, and welcome to Adaptimmune's conference call to discuss our second quarter 2020 financial results.

I would ask you to please review the full text of our forward-looking statements from this morning's press release. 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.

Adrian Rawcliffe, our Chief Executive Officer, is with me for the prepared portion of this call, and other members of our management team will be available for Q&A. With that, I'll turn the call over to Adrian Rawcliffe. Ad?

Adrian Rawcliffe^ Thank you, Juli, and thank you, everyone, for joining us. After a strong start to the year, the second quarter of 2020 has continued to be very productive as we make progress to bring the promise of SPEAR T-cell therapy to people with cancer.

At ASCO, we reported new responses in gastroesophageal, lung and head and neck cancers.

We've now seen responses in a total of 6 different solid tumor types, including a complete response in a patient with liver cancer. We initiated a Phase II trial, combining ADP-A2M4 with pembrolizumab in head and neck cancer and announced that we would shortly initiate a new Phase II trial in gastroesophageal cancers.

We demonstrated continued efficacy and promising durability with ADP-A2M4 in patients with synovial sarcoma and announced that we have screened more than half the patients likely to be required to complete our SPEARHEAD-1 pivotal trial, working with 20 centers in Canada, France, Spain, the U.S. and now also in the U.K., and we remain on track for the U.S. launch of ADP-A2M4 in 2022.

In addition, further validating the potential of this product to meet the significant unmet medical need for patients with synovial sarcoma, the European Medicines Agency recently granted us access to PRIME regulatory support.

Finally, we raised approximately $244 million and finished the quarter with a total liquidity of $419 million, funding us into 2022 and so enabling us to focus on developing the signals we've seen in our trials and bringing ADP-A2M4 to market for patients with sarcoma.

For the remainder of 2020, we plan to provide clinical updates at major medical conferences, including an oral presentation by Dr. Bruno Sangro from Navarra University Clinic in Spain, who will present data from the third dose cohort of our ADP-A2AFP trial at the International Liver Congress later this month.

We also plan to present updates from our SURPASS trial and additional durability and translational data from patients with synovial sarcoma, our Phase I ADP-A2M4 trial in Q4. We will update data from the radiation sub-study of this trial in 2021 as we have not yet recruited sufficient patients to be meaningful, partially due to the impact of COVID-19, the next topic I want to cover.

Like most pharma and biotech companies, and as discussed last quarter, we have experienced recruitment delays in our clinical trials, but we and the centers we work with have done everything possible to carry on and be ready to hit the ground running as the situation allows.

We already have active sites across our trials in Europe, the U.K., the U.S. and Canada. And in each of those locations, the impact of COVID-19 is still evolving. And so we've seen variations between regions and between clinical sites as they react to the challenges of a pandemic.

We believe that we have seen more of an impact in our early phase trials, for instance with the radiation sub-study conducted MD Anderson Cancer Center in Houston, as

Texas is a region particularly affected. However, enrollment in our SPEARHEAD-1 pivotal trial has continued to progress well, in part due to the clear opportunity for benefit for patients based on the results seen in synovial sarcoma to date.

Our SPEAR T-cell manufacturing facility at the Navy Yard has been very busy throughout this period. We have been able to treat some patients, and we believe that others for whom we've manufactured cells will be able to continue on our trials when it's safe to do so.

But clearly, this has had an impact on patients in our trials. And whilst that impact was clearest across the board in April and May, it continues to impact on a site-by-site or country-by-country basis as the pandemic evolves, particularly in the United States.

Later this year, we plan to share patient data updates from our SURPASS trial and ADP-A2AFP trial, for whom we reported top line data earlier this year as well as for any new patients whom we have treated in the intervening period.

Looking beyond 2020, we will continue to progress indications with promise into later phase trials, starting with a new Phase II trial in gastroesophageal cancer and test combination therapies and next-generation enhancements as the data guides us.

We will also continue to pursue partnership opportunities, such as the deal we completed earlier this year with Astellas, and we will continue to develop our off-the-shelf allogeneic program as part of our future vision for cell therapies for people with cancer.

We are also preparing for the future by increasing our manufacturing capacity to meet the needs of the ongoing and planned clinical trials. In addition, our commercial preparation is ramping up, including development of our manufacturing capabilities towards commercial scale.

While external partners are important, we remain convinced that for Adaptimmune to be a leader in cell therapy, we need to own the manufacturing process, which enables us to innovate and be more efficient. This includes vector production, where we intend to start using our GMP vector manufactured in our dedicated facility in our SURPASS trial later this year.

Throughout this period, I have continued to be humbled by the dedication of my colleagues who have worked tirelessly in the midst of a global pandemic with its associated personal challenges to maintain the ability of patients to receive our therapies and to carry on crucial research on our pipeline.

I am pleased that we were recently named one of the best places to work in Philadelphia by the Philadelphia Business Journal. Our shared mission, transforming the lives of people with cancer by designing and delivering cell therapies, makes Adaptimmune a place where passionate people who want to cure cancer like to work.

However, the ongoing discussion about race and equity, particularly as it relates to black lives, should make everyone challenge themselves about whether we are equally welcoming and nurturing to all.

As CEO, I'm committed to do everything we can in due course, and I know my colleagues share this commitment to ensure that Adaptimmune is a great place to be, a place where all colleagues feel supported and can see a bright future. And now I'll open the call up to questions. Operator?

QUESTIONS AND ANSWERS

Operator^ (Operator Instructions) Our first question comes from the line of Marc Frahm with Cowen & Company.

Marc Frahm^ Adrian, in your prepared remarks, you mentioned presenting top line data in new patients, I believe, for both the SURPASS and AFP programs. Is that AFP presentation going to happen alongside the EASL presentation of new patients? Or is that going to be later in the year that we'll see additional AFP patients?

Adrian Rawcliffe^ So I'm going to ask Elliot Norry to outline what's coming up at the ILC at the end of August and further on in the year with AFP. Elliot?

Elliot Norry^ Thanks, Ad. So just to be clear about expectations for what will be presented at EASL. First of all, we will not be presenting the non-HCC, non-hepatocellular cancer cohort, at EASL.

And what you can mostly expect is an update on safety for the entire trial as well as a presentation of the patients in Group 3, which will include at least an update on the patients that we gave top line results for at the end of May, around ASCO.

And beyond that, there hasn't been much time, and I would not expect considerably more clinical information beyond those patients. And we don't have any specific plans to update AFP further beyond the EASL Conference for the rest of the year.

Marc Frahm^ Okay. Great. And then maybe, Elliot, if you can also just kind of speak generally, Adrian, kind of highlighted the pushes and pulls on enrollment and patient access to your trials from both the added enthusiasm of seeing responses, but then obviously, the impact of COVID.

Can you kind of just speak to where you are today? You know that maybe in some areas the impact has lessened or just people have adapted to it. Today, are you more or less active screening than, say, you were a year ago? How much more?

Elliot Norry^ So compared to a year ago, that's a -- I'm not -- I'd have to go back and look at our screening data to really answer that from a year ago. I can tell you what's really been the trajectory since March, April, when this really started, if that's helpful.

We really saw a marked cutback in screening across programs in March and April. And I think that centers were largely concerned that they just didn't have the capacity to manage the patients, concern about ICU beds and just minimizing traffic in their centers and exposure to staff and whatnot.

So I do think that things have improved since then, and it really does depend region by region. Some regions have recently gotten worse again, so I don't think that the story is over until we really have a handle on where the virus is heading, and regions could change day-to-day, really.

I will say that we are seeing screening across our programs. I think it would have been better, if not for COVID-19, perhaps with the exception of SPEARHEAD-1, where the screening really has met our projections by and large.

And we have worked with centers to the best of our ability to both respect their needs to protect their employees and manage their patient flow and also to treat patients when we can and advance patients in our trials from screening to manufacturing to treatment when safe and possible. It's hard to be more specific than that without walking around the globe, and what was true a month ago will be different a month from now.

Operator^ And our next question comes from the line of Tony Butler with ROTH Capital.

Charles Butler^ Two questions, if I may. One is on the trial in head and neck cancer where you're sequencing pembrolizumab. And I'd like to understand how you think about dosing pembro relative to a cell therapy.

It would be before you actually add the cell therapy or after? Importantly, given that pembro does have an indication in head and neck cancer is, if possible, that the patient population, this is the second question, for which you actually end up screening will be those that may be, in fact, refractory to pembro when you see them, which will be a very interesting experiment in and of itself.

I'm trying to understand what would be the patients that you see when you're able to screen them. And then, again, how do you think about sequencing pembro relative to cell therapy?

Adrian Rawcliffe^ Thanks, Tony. I think I'll ask Elliot to walk through the approach of that trial because I think the protocol for that chart because I think that will answer several of those questions, and then maybe we'll loop back if there's something else we can help with. Elliot?

Elliot Norry^ Yes, hi. Thanks again. So that trial, as you may know, we have a trial in progress poster to be presented at ESMO, and that will -- there won't be data presented, it will just be trial design, and there will be details provided in greater length at that time.

In general, though, to answer your question about the sequence, we're generally screening patients who are pembrolizumab naive or have recently started on pembrolizumab, with the idea that when patients either don't respond or progress on pembrolizumab that their cells would be ready for treatment at that time in combination with pembrolizumab.

And so -- and patients who respond to pembrolizumab initially would stay on pembrolizumab as it is indicated for first line of treatment. So we really see this as a first-line -- as a sequence following first-line pembrolizumab to continue pembrolizumab and receive cells as soon as possible after documenting that patients have not had clinical benefit from pembro alone.

Charles Butler^ That's perfect. But -- so basically, we get cells in virtually all cases after they've had pembro, and -- but they will continue on pembro as they get cells. That's fair to say?

Elliot Norry^ Yes.

Operator^ And our next question comes from the line of Mohit Bansal with Citigroup.

Mohit Bansal^ Great. So from the -- so just wanted to follow-up on Tony's question. Can you please help us understand at what -- what is the time difference between when the patient is either progressing and non-responding to not responding to pembro versus initiation of cell therapy?

I'm asking in the context of understanding whether you are administering cell therapy, why patients are progressing versus they have progressed? I mean as in like is there a time point where it is just too late to administer cell therapy after that?

Adrian Rawcliffe^ Elliot?

Elliot Norry^ I'm going to defer sort of greater detail explanation of the study until the ESMO poster. But to generally answer your question, if a patient has progressed beyond to the point of having potential benefit from continued therapy, then it would be the discretion of an investigator to not proceed.

But patients who have had pembrolizumab and do not respond have a significant unmet medical need, and it's really that position where we're trying to sequence as rapidly as possible so as to not have that patient wait for cell therapy at that point and be ready to go in combination with continued pembrolizumab.

Mohit Bansal^ Got it. And then another question on liver cancer. So far, we have seen 1 complete response, and I think 2 other patients did not respond, if I understand it correctly.

Did you see any other biomarkers in these 2 patients which would be worth noting? And then the follow-up is, do you have some internal bar that these many responses, if you see, you would actually move ahead with the Phase II kind of trial just like you have done with the SPEARHEAD-1 trials?

Elliot Norry^ Yes. So with respect to additional biomarkers and further details on those patients, I'm going to defer to the presentation that's only a couple of weeks away at the International Liver Congress.

There's -- there are embargoes and whatnot, and we should really just allow Dr. Sangro to make his presentation. With respect to the bar for proceeding to a Phase II study, I think it's more complex than any just single parameter, but we would look for some combination of response rate and duration of response.

Mohit Bansal^ Got it.

Adrian Rawcliffe^ Previously, Mohit, we've sort of used the rule of thumb of whether we're seeing a signal in 3 out of 10 patients being a good starting benchmark. Now obviously, the 2 out of 2 responses that we saw at the lowest dose in SURPASS were sufficient to persuade us that there is a tractable late-stage development program in gastroesophageal cancers.

But more generally speaking, a signal in cell therapy, we think 3 out of 10 seems reasonable and hence, the ongoing recruitment of patients in the AFP study to understand and further characterize the response rate and nature of the responses.

Operator^ And our next question comes from the line of Michael Schmidt with Guggenheim Securities.

Kelsey Goodwin^ This is Kelsey on for Michael. I guess now that we're seeing responses to TCR therapy across numerous solid tumors, I guess are you noticing any patterns in who or what types of tumors are more likely to respond.

And then specifically for the AFP cohort and the non-HCC tumors, I guess what kind of tumors are you seeing in that consort or which tumors do you expect to see?

Elliot Norry^ So I think that -- I'll separate it into two answers, first of all, with respect to the MAGE-A4 program. I think that the tumors that we might expect to see responses in going forward are the ones where we've seen a degree of antitumor activity to date, and we previously stated that we'll be focusing the SURPASS study going forward on those tumor types.

So that specifically, head and neck, bladder and lung and gastroesophageal. That's not to say that we've exhausted the ability to look at any other tumors, and we may continue to explore that, but that study will focus on those 4 tumors from the standpoint of how we approach study centers and investigators.

I think some of that has to do with the frequency of expression of MAGE-A4 in different tumor types and in those tumors, the degree of expression, but it's also guided by our clinical experience to date.

And then with respect to the non-HCC cohort in the AFP study, it's really a variety of tumors that we may see. They are rare tumors. If you look at the frequency of AFP expression and other tumor types, there are some rare gastric cancers that express AFP, cholangiocarcinoma, germ cell tumors, a rare hepatoblastoma.

So I think that there are some rare tumor types that we would never really find the numbers to study in individual cohorts on their own, and we had received requests from investigators to try and include these patients with limited treatment options in the study, so we opened a cohort that essentially is a basket of them that are non-HCC tumors.

Operator^ And our next question comes from the line of Jim Birchenough with Wells Fargo Securities.

Nicholas Abbott^ It's Nick for Jim this morning. First question is on the SURPASS trial. I believe in May, you announced that dose levels 2 and 3 would be launched, and the 3 patients will be treated at 5 million cells prior to 1 expansion cohort. Can you provide an update on those 3 patients and the timing of opening that expansion cohort and from what expectations investors should have from a data presentation? And then I have a follow-up.

Elliot Norry^ So we're not providing updates on the SURPASS patients at this time. We do plan to provide an update later in the year about specific patients, cohorts, et cetera.

Nicholas Abbott^ Okay. And then obviously, that product is designed such that CD4 T-cells become competent for the T-cell receptor. So have you had the opportunity from patient samples to look at the CD4 T-cells and ensure that they remain competent after you've given them for the patient?

Elliot Norry^ So it's -- I hate to be disappointing, but it's sort of the same answer, that we're going to provide information about that at an update later in the year.

Nicholas Abbott^ Okay. I'll try one more, which I suspect is the same answer as well, and that is very earlier in the year yet. Announcing with Astellas, where there was a formal collaboration on induced T-cell programs, and I believe you said that our candidate has been selected. Can you provide any updates on the program?

Helen Tayton-Martin^ Yes. This is Helen Tayton-Martin. Happy to take that. I think we also mentioned in our update at the end of May. The first program is moving forward successfully to date.

And we joined with Astellas have dominated our first target, which will be an HLA-independent TCR hit program. So a TCR that can see a cell surface protein, a bit like an antibody, but we're not disclosing the target of that joint program, but it is continuing to move forward on time and on track at this point. So we're really pleased with how the collaboration is moving forward.

Nicholas Abbott^ And what is roughly the timeline of moving that into the plan?

Helen Tayton-Martin^ So that's something that we are not disclosing at this point in time, and -- but I would also say that the first program for the clinic will be our MAGE-A4 program using the same technology, but that happens to be further advanced.

To some extent it depends on regulatory feedback on some of the CMC processes, et cetera, but we're not disclosing the timeline, because it's not imminent.

Operator^ And our next question comes from the line of Jonathan Chang with SVB Leerink.

Jonathan Chang^ First question, have the unconfirmed responses with the second-gen MAGE-A4 program reported at the time of ASCO being confirmed at this point?

Adrian Rawcliffe^ So we haven't issued any new information on that, and we will do later on this year.

Jonathan Chang^ Got it. And second question, I guess, related to that, for both the MAGE-A4 first-gen and second-gen programs, beyond sarcoma, how should we be thinking about durability of responses? What are the reasons for confidence in the durability of responses? And how are you thinking about benchmarks for durability?

Adrian Rawcliffe^ Good question. I think the reasons for confidence are looking difficult because, to me, confidence requires data at daytime and patients, and we're in the process of gathering those.

So we all understand a lot more about the longevity of the responses and the nature and rate of them as we go through these stats, which are -- I want to be clear, the SURPASS study, for example, is in dose escalation. The fact that we saw responses at the first doses is fantastic, but it's an early stage study, and we need to get more patients on the study. So I think we'll understand that.

And in terms of -- as we recruit those patients, in terms of the question of what I think benchmarks are, I think that largely depends on the indication and the setting that we're going after.

I think we'll have a bit more data, a bit more information to share when we talk about the nature of the gastroesophageal trial that we're setting up later on this year and as we go into next year where I think we've got an understanding of where the benchmarks are in

the second and third-line settings. But elsewhere, it's going to depend on what those settings are and what else is out there at the time that we see that signal.

Jonathan Chang^ Got it. And just last question, zooming with the promising early data from the next-gen MAGE-A4 program, how are you thinking about potential pipeline prioritization with regards to the first generation program?

Adrian Rawcliffe^ That's a really good question. I mean I think -- strategically for us, the commitment that we've made is that where we will see a signal such as we have done with a very robust signal in sarcoma, and there's a clear unmet medical need, and that signal is definitely there with the first generation program.

We are moving forward with that first generation program as fast as we can to market. And I think there's a -- it's important to do that because the evolution of these products, one, can be quite rapid because we're getting real-time translational data that we can feed back into research and back into the manufacturing, and so there will always be the potential for something better coming down the pipe.

And I don't think as a benefit -- I don't think that benefits anybody to constantly be waiting for the perfect cell therapy product or rather, our objective is where we see significant benefit to patients to move those things quickly as possible.

Having said that, the ADP-A2M4 trial has -- pilot trial has now finished enrolling- with the exception of the radiation sub-study. And so our focus for MAGE-A4, for example, is very much on the SURPASS study, the second-generation program on the combination of the Gen 1 with in head and neck cancer with pembrolizumab and on the radiation sub-study, so augmented approaches beyond the Gen 1 outside of sarcoma, where obviously, we have the product progressing towards registration.

So that's sort of how we think about it conceptually, but we are also -- I want to raise the point here for generally that I think cell therapy companies have got to get comfortable with the fact that if we are successful, then our emerging research will cannibalize our existing products in -- as they are on the market.

And that's just a feature of this space, of the early stage of the space. And our integrated capabilities enable us to understand that and to prioritize and execute quickly across our pipeline.

Operator^ (Operator Instructions) Our next question comes from the line of Gabriel Fung with Mizuho Securities.

Gabriel Fung^ This is Gabe on behalf of Mara Goldstein. Just have a question here on the data for SURPASS. Could we expect that to be at which target congresses? And also on the manufacturing, are there any expected differences in yield and cost using the Navy Yard facility to manufacture sales for SPEARHEAD?

Adrian Rawcliffe^ Sure. So I'll take the first 1 on SURPASS. And if you look very carefully in the headlines of our press release, you'll see that we're guiding to Q4 for that and ESMO is in September.

So the answer to that is no, it's not going to be at ESMO. And then secondly, the -- I'll hand over to John to talk about the Navy Yard manufacturing and costs of that.

John Lunger^ Yes. So in terms of -- this is John. In terms of the manufacturing cost, one of the things that we mentioned earlier is that we have our own in-house vector, which we plan to use later on in the year.

So certainly, in-sourcing vector will have a positive impact on COGS. One other thing we're also continuing to do is just optimize how we actually run the Navy Yard facility. So we're investing a fair bit of time and resources in electronic systems, for example, which allow us to optimize the process and reduce the overhead that goes into each 1 of those.

So I'd say that it's a continuous process of improving our cost, and we're making some fairly big step changes in terms of efficiency and optimization as we go along.

Gabriel Fung^ Great. And actually, just one really quick follow-up here. I was just wondering, has the company ever -- or actually, how does company think about exploring your assets -- your candidates in the outpatient setting, whether or not this could be a potential use in the future?

Adrian Rawcliffe^ Helen, do you want to talk to that?

Helen Tayton-Martin^ Yes. Yes, this is Helen. That's a great question. I think the answer is, yes, we are exploring that. We're thinking about that, but it's too early to say exactly what that will look at as we roll forward.

Clearly, the ability to treat patients depends quite a bit on safety as much as anything. So I think -- and we're quite pleased with how that has been tracking with our therapy. So yes, we are exploring it. But at this point, don't have a definitive answer as to how that will look.

Operator^ And we do have another question from the line of Tony Butler with ROTH Capital.

Charles Butler^ Yes. I'll be brief. Elliot, you made an enlightening comment about research cannibalizing existing products and then with respect to Helen's last comment on the community setting in effect as you think about outpatient.

The question really, outpatient therapy, the question really is around multiple dosing options. Right now, clearly, most therapy companies have a single dose. Redosing is just -- is -- it's interesting, and there's a lot of exploration.

But I'm just curious in the grand scheme of things when we want to fast forward. Do you all share or does Adaptimmune share the view that really truly cures are going to come when you have multi-dose optionality such that a single dose is most unlikely to generate cures, at least as we think across a variety of solid tumors?

Adrian Rawcliffe^ Yes. So maybe I'll take it. I think the short answer is we don't know, Tony, what the dynamic is between dosing and/or single versus multi antigen approaches, in order to get to curative therapies or any other facet that we and others are looking at in order to get to broadly curative therapies.

We do have experience of redosing patients in our trials. And we have, I would suggest that is somewhat mixed. There are definitely some patients who have responded to the second infusion of cells, and there are some patients where there isn't a response. And bearing in mind, we're only redosing in patients where there is continued expression of the target antigen.

So I think the jury is out on whether second or multiple dosing will be required. I think in the context of the current paradigm of lymphodepletion, that obviously puts an extra hurdle on second or third dosing. So to the extent that there's evolution around the lymphodepletion regimen, that would be interesting to help get to a place where more routine dosing is possible.

And then lastly, it's obvious that different product formats, and in particular, we think about our allogeneic platform, make multiple dosing potentially easier as well as potentially being able to address some of the other drivers that might lead to more prolonged durable responses and potentially, even a curative therapy in due course as well. So -- and we will continue to explore all of those elements as we think about how best to treat the patients with our cell therapies.

Operator^ And I'm showing no further questions at this time. And I would like to turn the conference back over to Adrian Rawcliffe for any further remarks.

Adrian Rawcliffe^ Thank you very much. And thanks, everybody, for your time and your questions today. We've made great progress in the first half of 2020. We've pushed forward with the products in sarcoma aggressively, and we are generating responses across a broad range of solid tumors.

And I look forward to updating you all as we continue to make progress to bring our SPEAR T-cells to people with cancer. And with that, we'll close the call. Thank you.

Operator^ Ladies and gentlemen, thank you for participating in today's conference. This does conclude the program, and you may all disconnect. Everyone, have a great day.