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PS: Paul Stoffels, CEO Galapagos
TT: Tol Trimborn, CEO CellPoint
JM: John Mellors, CEO AboundBio
BF: Bart Filius, President, COO, Galapagos

SvG: [00:00] Welcome all to the Galapagos webcast on the acquisition of CellPoint and the AboundBio that we announced that we announced last night. Thank you all for joining. This recorded webcast is accessible via the Galapagos website home page, and will be available for downloads and replay later on today.

SvG: [00:16] We would like to remind everyone that we will be making forward-looking statements during today's webcast. These forward-looking statement include remarks concerning future developments of the pipeline in our company, and possible changes in the industry and comparative environments.

SvG: [00:30] Because these forward-looking statements involve risks and uncertainties, Galapagos's actual results may differ materially from the results expressed or implied in these statements.

SvG: [00:41] Today's speakers will be Dr Paul Stoffels, CEO, joined by Tol Trimborn, CEO of CellPoint, and Dr John Mellors, CEO of AboundBio, as well as by Bart Filius, COO and President of Galapagos.

SvG: [00:54] Paul will reflect on the strategic rationale, and highlights of the transaction. Then Tol and John will briefly introduce CellPoint and AboundBio respectively, and Bart will go over transaction details and financials.

SvG: [01:06] We estimate that the preparatory remarks will take about 20 to 25 minutes. Then we'll open up the call for Q&A. And with that, I will now turn it over to Paul.

PS: [01:16] Thank you, Sofie. Well, happy to be here today to announce the acquisition of Abound and CellPoint, and give you some background on why and what we are doing here.

PS: [01:32] As I go back to the discussion we had with the first quarter results in May or April, we hinted at that moment that we would go and create value by bringing in new assets, in the late preclinical, early clinical stage, and create value ourselves with partners, and that

was the mission, and that was what we started working on. And today, we show you the first results of that work, and go through the acquisition of AboundBio and CellPoint.

PS: [02:06] So our strategic priorities of capital allocation have been on how can we go for rethinking the R&D model with a disease-focused approach, in areas of high unmet medical need, so that you can accelerate the clinical pipeline to the market, by going after higher medical needs in areas where there is good science. And that accelerates the clinical pipeline through disciplined investments into good areas where you can create value.

PS: [02:41] The next step is how do you bring in external innovation? And we are accessing innovative programmes in late preclinical and early development, because that is the right sweet spot for us to step in, where you have a good value for money, in order to still be able to significantly create value yourself.

PS: [03:00] Second, we are going beyond our current drug modalities and disease areas, as we were singly focused on small molecules, inflammation and fibrosis areas, which is a long and tedious timeline, very attractive fields, but we need to accelerate the pipeline, and therefore, focusing on high medical need in late preclinical, early clinical development.

PS: [03:24] Accelerate time to market, and improve patient access globally, as with new products in important areas in high medical needs, you can get to access, and that creates value faster and bigger.

PS: [03:39] And then combining technology with cutting-edge science, while we were focused on small molecules, we absolutely first of all needed to go into biological modalities, but also, new technologies for manufacturing, as we only were in the small molecule space.

PS: [03:56] And then for commercial, we leverage commercial organisation beyond Jyseleca. By the way, Jyseleca, the first part is going very well. We launched in Europe and it's taken off very good, and with our special collaboration, a very attractive collaboration with our partner Gilead here, with opt-in rights for ex-Europe, we can really create value in the world, leveraging external resources as we grow through next product.

PS: [04:26] Why CellPoint and AboundBio? It brings together a disruptive CAR-T manufacturing, with a clinical stage pipeline and Tol will talk to you later, that was a big discovery for me that CellPoint was at the point that they had a clinical trial going, in CAR-T, where the CAR-T is manufactured at the point of care, and it's very scaleable with the partner Lonza. More to follow on that.

PS: [04:54] Combine that with AboundBio, which has a cutting-edge technology in science for the next-generation CAR-Ts, they bring a biological platform to us, focused on discovering new targets, but also, especially binders for targets, for example, in oncology, which then leads to [Edig] by specific, CAR-T opportunities ADCs.

PS: [05:17] And so the combination of that, the technology and the science, brings us the capability in oncology, to move fast into a new area. And this then has for us now, very particularly, the potential to accelerate access to CAR-T therapy, while already in clinical trials, and accelerate that to next-stage clinical development in the market.

PS: [05:43] The unmet need in haematological cancers with CAR-Ts remains high. The manufacturing constraints and logistics are there, limiting access, people wait, and it is a very significant challenge. Sometimes, people die before they get their therapy.

PS: [06:02] The centralised production is resulting in valuable time lost, high drop-out, as I said, and a higher death rate. The durability, at the moment, very spectacular results in patients, but there is a high relapse rate, and is the immunogenicity preventing re-dosing? And for toxicity, depending on the type of CAR-T today, there is still an occurrence of a lot of toxicity, which can lead to intensive care hospitalisation.

PS: [06:29] And therefore the opportunity to break through, to generate a break-through science and technology, and improvement in CAR-T, is now.

PS: [06:42] What is CellPoint bringing? CellPoint developed a, together with Lonza, in a collaborative and strong partnership way, a point of care technology, which is automated, rapid, efficient, and scaleable. And 7 days vein-to-vein, including release to the patient. The quality release is done within that 7 days.

PS: [07:06] This comes from a process which is now harvesting blood cells from the patient, freezing them, sending them to a central laboratory somewhere in the world, doing the CAR-T production there, freezing them again, sending them to the hospital, and that often results in best possible time, 17-20 days, worst, weeks to months.

PS: [07:30] And that with Lonza CellPoint, that technology, the cocoon developed by CellPoint, now gives the opportunity to just 7 days at the point of care. Today, in three centres in Europe, in three countries in Europe, validated by the authorities for clinical trials, in a clinical trial, which is running at the moment. So ToI will come back on that.

PS: [07:56] What brings Abound to us? Next-generation CAR-Ts. Highly experienced research team, proven track record, multiple

industry partnerships. Abound was a contract research organisation emerged from an academic centre at the NIH, and developed that capability into a partnership capability. The team, the founders, wanted to join a company where they could develop their products, and they are a very strong research capability for us in oncology, bringing that end-to-end, combined with CellPoint.

PS: [08:33] It's at the forefront of innovation, improving efficacy and prevent cancer relapse, differentiated fully human, multi-specific and multi-functional CAR-Ts, and the novel modalities also include bispecific antibodies and antibody drug conjugates, which can give us a next-generation modality in the company.

PS: [08:52] So bring CAR-T antibodies and oncology research capabilities in-house, to two in parallel acquired companies, was our goal.

PS: [09:03] And so, together with the fully integrated biopharma capabilities from Galapagos, our team has developed products end-to-end. We have a broad capability in different disease areas. Combine that with AboundBio and CellPoint, we aim to bring now three CAR-T drugs to the clinic in three years, and this will result in a CAR-T portfolio, an oncology portfolio for Galapagos.

PS: [09:32] I would now like to present the two leaders of the two companies we are acquiring – Tol Trimborn, the CEO of CellPoint, entrepreneur since a long time, John Mellors, top key opinion leader in the world, CEO of Abound. Both will shortly talk to you, and give some introduction about their capabilities and companies, and teams. Tol, why don't you take over from me?

TT: [10:01] Good afternoon, everybody. CellPoint is a company in Leiden, the Netherlands, employing 35 people currently, and we have developed a point of care, manufacturing paradigm, as Paul already alluded to, to manufacture CAR-T therapies, but also later on, other cell therapies, at the point of care. So our patients get into the hospital, and their cells are being manufactured locally, at those clinical centres.

TT: [10:32] This is based on three important pillars. So the first pillar is the relationship with Lonza, because Lonza has developed a bioreactor called Cocoon that can actually do the manufacturing of these CAR-T cells in six days. That's the protocol that we have developed internally.

TT: [10:50] The other important component is the clinical centres that we work with. So we have chosen centres that are familiar with treating patients at on-the-go CAR-T therapies, but also centres that have [GP] manufacturing facilities. So they know how to work with cells that have come from patients, and how to manufacture these.

TT: [11:08] And a third, very important component, is xCellit. xCellit is an internally developed software platform, together with a company in Germany, that allows the end-to-end orchestration of this process, and to ensure high quality, so we can develop a very strong clinical dossier. And this is very important to allow the 7 day vein to vein time, and very rapid treatment of patients.

TT: [11:40] So we have a unique collaboration with Lonza, the manufacturer of the Cocoon. It's a worldwide exclusive partnership, and in that partnership, Lonza is responsible for the deployment of the Cocoons and the maintenance of the machines, and CellPoint, now a Galapagos company, will be responsible for the training of the hospitals and the operators of these machines, but take full control of all the data, and of the clinical dossier.

TT: [12:13] The machine is regulatory-compliant, so in the EU, it has a CE mark; in the US, it has a drug master file, and in our view, it's the best machine at this moment, out there.

TT: [12:29] So the third component is xCellit. It's an internal IT platform, as I said. It end-to-end orchestrates what we have to do during the manufacturing of these cells, and one of the first steps, is that the patients will get a unique identifier, so allowing traceability of the product, but also ensuring chain of identity, chain of control.

TT: [12:50] It captures all the data, and it's also sort of the cookbook, so people really cannot make mistakes in the manufacturing process. So really key and very important, allowing this very short vein-to-vein time of only 7 days, at a very high level of quality.

TT: [13:11] So we have decided, as a company, to focus first on a CD19 CAR. As you know, CD19 is well known, and it is important to establish proof of concept, based on a known product, and we've chosen a CD19 CAR that has already treated over 60 patients in various indications.

TT: [13:31] The data of those studies are very encouraging, and you have to realise that this was done on the basis of a different manufacturing protocol. We believe we can actually increase the quality of the dataset by applying our commercial level manufacturing protocol that we have now introduced.

TT: [13:53] We have started two clinical phase 1 studies. The first one in the Netherlands and in Belgium in NHL, the second one in CLL in Spain, and those are both dose-escalating phase 1, 2 studies, primary objective of course, safety of the patients, but the goal is also to look at efficacy, and to establish the recommended dose for the pivotal trial.

TT: [14:21] First patients have been dosed in both cohorts, in both trials. We had extensive discussions with the authorities in the various countries, the three countries I mentioned, but in a relatively short period of time, we were able to get the approval to perform these studies, so a real proof of concept that the regulators understand what we're doing, and allow us to test this in patients.

TT: [14:52] So of course, we are extremely happy, and actually proud that we can join Galapagos now. It is a very complementary resources; we can tap into clinical, regulatory, and other resources at Galapagos, extremely proud of the leadership at Galapagos at this time, that can take us to the next level. And of course, it brings us financial stability.

TT: [15:18] Of course, we are extremely excited also to work and collaborate, start to collaborate with AboundBio, because we wanted to extend our pipeline with novel and very innovative CARs and that, of course, will be propelled by the collaboration with Abound. So extremely exciting to continue the journey that we started, to bring cell therapies, but CAR-Ts at first, to the point of care. And with that, I would like to hand over to John Mellors, the founder and CEO of AboundBio.

JM: [15:55] Thanks very much, Tol. It's a pleasure to speak to you today.

JM: [16:05] On behalf of Mitko Dimitrov, my co-founder at AboundBio, I'd like to express our highest level of enthusiasm for the acquisitions. We can't imagine a stronger partnership. Let me dig a little bit deeper into what AboundBio is about. It's a discovery engine that has a 30-year track record of success in discovery science, translational science, and clinical science, and this will allow us to develop cutting-edge cell therapy, and the goal here is to achieve deeper and more durable clinical responses.

JM: [16:49] So let's look under the hood. We are a discovery engine. Let's take a look at what's there. We have very, very large, probably some of the largest in the world, phage display, fully-human libraries. These are called super- or terra- libraries, and this allows multi-epitopic and multi-specific targeting of oncology targets, and allows us to create the next generation of CAR-Ts.

JM: [17:20] Mitko Dimitrov is one of the world's experts on VH domains that represent the next frontier. VH domains are the smallest functional component of antibodies. They are a tenth the size of normal antibodies that allows greater penetration, and better access to hidden epitopes that are difficult to reach. They are conformationally very stable; they have a small genetic footprint, which makes it easy to put in vectors, and easy to construct multi-peritopic binders, and multi-targeting of cancer cells. And because all our antibodies are fully human, they have low or absent immunogenicity.

JM: [18:07] So let me just review the process from target discovery to delivery. We can rapidly isolate binders in days to a few weeks, and we can isolate binders to more than one epitope for target, so-called biperitopic binders, and more than one target per cell, leading to multi-targeting of cancer.

JM: [18:34] We have a high throughput system to assess CAR-T cell constructs for killing and cytokine release, and to nominate IND candidates for further in vivo testing, in established animal models. We are very careful in assessing specificity of binders, including flow cytometric analyses, and looking at binding to the normal cell surface proteome and tissue cross-reactivity, and we work very closely with CellPoint, for vector production and optimisation.

JM: [19:08] And this process, we fully expect to allow INDs and entry into phase 1 within 12 to 18 months of target identification. So with that, I'm going to turn it back over to Paul, to give a summary of our innovation timeline. Thank you.

PS: [19:28] Thank you, John and I hope you can see that with bringing Tol and his team and the capabilities on board as well as John, we have a roadmap towards transformational cancer therapy. First, working on validated innovative technology, validated innovative CAR delivery technology, with an existing CAR, where two clinical trials are running today already.

PS: [19:53] And then the next step, bringing next-gen haematological oncology CAR-Ts into the CellPoint model, and there we aim to bring three additional programmes to the clinic in the next three years. And then the capability gives us also the possibility for broader applications for multi-targeting CAR-Ts, solid tumours, and allogeneic, as well as then going on to expand to new antibody-based mode of actions, modalities, such as ADC, and that created synergies also with our inflammatory franchise.

PS: [20:28] This is really the path forward for us. First step into oncology, but a solid step with two clinical trials, existing technology, and existing CAR-T, but also existing technology and new CAR-Ts coming. I will now give it over to Bart, for some transaction details. Thank you, Bart.

BF: [20:48] Thank you, Paul, and good morning everyone in the US, good afternoon here in Europe. Thanks for joining, Really excited to be here today to announce these transactions that we actually closed yesterday, so as you can see here on the slide, a transaction closing this quarter, it actually was done yesterday, before market closed.

BF: [21:09] We are acquiring 100% of the shares of both companies, CellPoint here in the Netherlands, and AboundBio in the US. The

transaction is all-cash, as you can have read in the press release, up-front payment of 125 million euros for CellPoint, with milestone payments that could be due up to 100 million, and then for AboundBio payment for the shares of 14 million dollars.

BF: [21:33] And important part of this transaction really is also the partnership with Lonza, it's been spoken about a lot already by Paul and by Tol. The Lonza partnership is a licence in blood cancers, and they actually deliver this in the full service model, which is crucial, I think, for the let's say, business model that we're proposing here, where Lonza is supplying the Cocoons and the cassettes, and they do this at their cost.

BF: [21:59] At the same time they are eligible for a royalty from the proceeds, once we are in commercial stage, and once we are actually treating patients. So this is a way to make sure that we can roll out in CAR-T therapy, in a not so capital intensive manner, as compared to other companies that are working in this field.

BF: [22:23] So why do we think this is really the right deal for Galapagos? So first of all, it's really our approach to accelerate our R&D. It's important that we fill the gap in our pipeline that we talked about a lot with you over the last couple of months, and this is one where you immediately get a product, which is in clinical stage.

BF: [22:41] But we do not only get the product which is in clinical stage, but we also get the capabilities that come. By going into this new therapeutic area, it's crucially important to make sure get the capabilities and the AboundBio team and the CellPoint team, are perfectly equipped to bring that to Galapagos.

BF: [23:00] We also believe it's a cost-efficient acquisition. At the end of the day, yes, it's a lot of money, but compared to the overall balance sheet of Galapagos, we believe it's a moderate investment that we make now in this space, and this really gives us the opportunity going forward, to make sure that our shareholders can benefit from the value creation, as we progress from early-stage clinic, to later stage clinical programmes.

BF: [23:24] Maybe also a quick word on our partnership with Gilead, which I think is very important here. That's really a strength, I think, of this collaboration. As you know, Gilead, through Kite, is one of the leaders, if not the leader in cell therapy, so there's a lot to learn, a lot to benefit from all the experience that they have built up over the last, what is it, four or five years, in cell therapy.

BF: [23:47] And obviously, for Gilead, this is an option ultimately, to participate in further down the line, if that comes to that stage. So for us, it's a real great alignment with the Gilead team, also supported by

all of our board members unanimously, including obviously the Gilead directors.

BF: [24:08] So we see here three companies, one mission really to accelerate time to market, and to access to medicines for patients globally. This is, we believe, a way to really expand the market place for cell therapy, in addition to the centralised models that are already out there.

BF: [24:26] Then with my final slides, I'll come back on how this overall fits into the Galapagos overall strategy. And you've seen this before, our approach is really to accelerate our pipeline rebuild, including expansion beyond our core business of inflammation and fibrosis.

BF: [24:44] And clearly, this does not mean that we are going to be fully all-in only on oncology, we still have our strongholds in our other areas, and most notably, in commercial, we have Jyseleca, which is now in the market in Europe in rheumatoid arthritis, and ulcerative colitis doing well, and we are still so keen to make sure that we get further leverage that infrastructure.

BF: [25:03] And this transaction here can be helpful there, but we're definitely also interested to look at other transactions. This is a first-step in BD, but we remain with enough firepower to make further steps in BD, and we will hopefully be announcing more of that later this year or in the next year. We're definitely not done yet with our rebuild of our pipeline.

BF: [25:27] And that's all against a good set of financials, balance sheet is strong, 4.6 billion at the quarter. We will give a slide update of our guidance at the H1 results that will be in the first week of August.

BF: [25:39] But to give you a bit of an indication here, we think that the second half operating expenses of the two companies that we are acquiring, i.e. that we are going to be absorbing, will be in the range of 25 to 50, obviously that's excluding the transaction itself, but the operating expenses between 25 and 50 that we're going to be absorbing in the second half of the year, and I'll get back to you with more details on the numbers in the update on H1.

BF: [26:02] Also finally, a strategic update foreseen later this year. We think somewhere around September or October time-frame, we're still evaluating our opportunities and our options in our own portfolio, and we'll give more details on that later this year. So with that, I conclude, and give the floor back to Sofie, for the Q&A. Thank you very much.

SvG: [26:25] Thank you, Bart. So that concludes the presentation portion for today. We would now like to open the floor for analyst Q&A.

Please use the Raised Hands function to ask a question, so not the Chat function, and we kindly ask you to restrict yourself to one question at a time. So I see we have a first question from Charlie [Mavot] of Bernstein, so Charlie, you should see a prompt on screen, and be able to unmute yourself now. Thank you.

CM: [26:54] Thanks for taking my question, Charlie [Mavot], so just one question from me, please. So this is clearly a foray into a completely different therapeutic area for Galapagos. So I'm interested to hear your reflections after several months on the existing internal pipeline and platform of the company. Do you still see this as differentiated? Thanks very much.

PS: [27:16] Yes, thank you for the question. We are still, as Bart was saying, doing further evaluation on our current capabilities, but what I can say, we have a strong capability in small molecule, which will continue to be the basis, a very strong pillar in our organisation for next-generation compounds.

PS: [27:36] We have Jyseleca with the next indication coming out early next year, Crohn's, and we have several assets in inflammation, which are moving forward in early clinical. We'll give you an update at a strategic session, which we'll give second half of the year, but definitely the current capabilities will be maintained going forward, but we'll make a selection on assets, which we'll progress in the second half of the year.

SvG: [28:08] Thanks very much. We have a second question from Brian Abrahams, of RBC. Brian, the floor is yours. Brian?

PS: [28:35] We don't hear anything. Maybe move on and come back to Brian.

SvG: [28:41] Yeah, let's go to the next question then, of Peter [Reselz] of Citi.

PR: [28:51] Yeah, hi there. I have a few, but I will stick to the rules and get back in the queue. Just one Paul, on the two ongoing studies to get validation in Europe. What about getting validation in the US with the next-gen CAR-T system? What are the plans and timelines you're working to there? Thank you.

PS: [29:07] Yeah, Tol and the team had the first interactions with the FDA on the current product, and that's in development. We have definitely as a target by the end of the year, or around that time, to get into the US clinical, but we want to prepare, together with Tol, a good package for the FDA, and launch in the US, also based on the data we have generated in Europe, which we are generating in Europe at the moment.

PS: [29:35] So that's in the making, but that is still for the first CD19. The first, as John was telling, we expect the next-gen CAR-T, the first one, to come within 12 to 18 months, onto the platform. John and team are working on that, and interacting with Tol, but so expect that in 12 to 18 months that we can enter a clinical trial with the next-gen CAR-T.

PV: [30:02] Thank you.

SvG: [30:05] We can take the next question from Phil [Nado of Cowan] please. Phil?

Phil: [30:11] Good morning, thanks for taking our question. It seems like the differentiation of CellPoint is on the manufacturing, so we're curious to understand how you expect the failure rate of manufacturing using the CellPoint system to compare to current autologous CAR-Ts, and then maybe a very similar question, how do you expect CellPoint to compare to the allogeneic CAR-Ts that are coming down the line? Thank you.

TT: [30:37] Yeah, thank you very much; both good questions, Phil. On the failure rate of manufacturing, it's relatively early to say, of course. We have set up the system, we have done now probably close to 100 runs over the past years, we started only a year and a half ago, and set up the process, together with Lonza, have done enough runs.

TT: [31:05] Based on healthy volunteer cells, we have now done the first manufacturing runs on patient material so far. So we had no failure in all those runs, yeah, so we have a very robust process, we have seen that now also on the patient data, because that's an obvious question, is healthy volunteer T-cells, are those really different compared to patient? Yes, they are, but if your process is robust enough, it can actually absorb these differences.

TT: [31:41] So up till now, no failures, and we believe that that has to do with our very robust and strong process. Only 6 days, and then 7 days vein to vein.

TT: [31:56] The second question was on allogeneic versus autologous. So we believe that the big driver for allogeneic are the costs and are there, off the shelf, so the short vein to vein times. You have to realise, for those of you that are not experts in CAR-T treatments, that patients, before they get the therapy, have at least a regimen of 4 to 5 days of pretreatment before they can get the CAR-T.

TT: [32:29] So we believe that a 5, 6-day manufacturing timeline is optimal, and that takes out basically most of the arguments to go after allogeneic. By definition, allogeneic cells are way more complicated to manufacture, and you always also in time, you will have to deal with the allogeneic effects.

TT: [32:59] So in that sense, the key drivers, I think, we can solve by this very short process, by the low cost of goods that we have, but I think these two can exist together for maybe allogeneic, for maybe a specific set or subset of patients. But for now, I think we believe with our new and novel way of bringing CARs to patients, we take out a lot of the key parameters that are the drivers behind allogeneic products.

SvG: [33:32] Thank you very much. Brian, can you try to unmute yourself again?

BA: [33:40] Yeah, can you hear me now?

SvG: [33:41] Yeah, this works, thanks.

BA: [33:43] Great, okay, thanks, and congratulations on the transaction. I was wondering if you could talk a little bit about how you envision the personnel at Galapagos and the talent evolving now as you expand into oncology, how much expansion would you expect in terms of headcount, and where you plan to focus, and then I guess along those lines, I'm curious how you can potentially leverage the core capabilities in cell therapy, of your partner Gilead, for the development of these assets, even prior to a potential opt-out, thanks.

PS: [34:19] Yeah, first on talent. Our team has a strong end-to-end capability for doing clinical trials, and regulatory, and many come from different industries where they have done biological capabilities, so the people are broadly trained, and came to us. So we have that end-to-end capability, which will support the cell therapy, as well as the regulatory knowledge and capacity we have to support Tol's team in moving forward.

PS: [34:51] We of course, need to add additional clinical oncology capabilities of people. We will select talent in different areas, where the real knowledge is needed. We have a lot of biology, cell biology capabilities in Galapagos from our phenotypic screening, we run several dozens of cell lines here. So there is a lot of scientific capability, which we can bring into this new area, but we will complement that with hiring expert talent.

PS: [35:21] Gilead actually is a very good partner for us with Kite here, and they have the experience, and they are bringing that experience, and they are bringing that experience to us, when we ask. We are open to consult with their expertise in the cell therapy, regulatory path, clinical, and Daniel O'Day and the team have a very strong commitment to this, and also their teams will bring capabilities.

PS: [35:46] So that, combined with the Lonza technical capability, we have a strong scientific, technical capability in Kite, I trust that we can bring together the team who can do this.

BA: [36:00] Thanks so much.

SvG: [36:02] Thank you. Our next question comes from Jeroen van den Bossche of KBC.

JB: [36:09] Yes, hello. I'm not sure you guys can hear me right now?

PS: [36:12] We can.

JB: [36:13] Fantastic. Thank you for this introduction and congratulations also from the side of KBC Securities. Maybe real brief, when we are looking at CellPoint technology, and also at the Abound, one of the things that is being mentioned, is a clear focus on the cost of bringing CAR-T to the patient, which to a certain extent, you may say, is somewhat prohibitive. What is the vision of Galapagos to reduce this, and where are we; I mean obviously you can't say it's going to be a certain price, but can you say look, we aim to reduce this by 10-fold, 20-fold, or do you have some let's say, guidance on that, or where you stand?

BF: [37:02] Yeah, let me take that question, Jeroen, and thanks for asking. So indeed, we think that costs can be one of the differentiators, but indeed, I should emphasise that I think also in this field, as in many fields in our industry, is ultimately about product quality and making sure that you can get better patient outcomes, which drives, let's say, the commercial success.

BF: [37:22] But indeed, costs are in this area, an important factor to consider, and I think you can all understand that if you have a decentralised model where you don't need to set up the GMP infrastructure, like the big players have been doing, or are doing as we speak, that you save on the capital costs quite meaningfully.

BF: [37:44] And in addition, the transportation costs are also a topic to consider here, which obviously is completely taken out of the equation. And then thirdly, through our model with Lonza, where it's really about a share of profits, rather than that we need to pay for the machines, and the cassettes.

BF: [38:04] We think that's also a very efficient way to deal with it, so we can be, we think, ultimately significantly cheaper than the centralised model, but I'm not going to be able to tell you exactly which factor, et cetera. But we think we have definitely an advantage there, but again, it's more about patient outcomes at the end of the day, and giving access to patients, which is really what counts in this market space.

SvG: [38:33] Thank you. So we can take the next question by Charlie Yang of the Morgan Stanley team. Charlie?

CY: [38:43] Thanks, can you hear me?

PS: [38:45] Yes.

CY: [38:47] Yes, so this is Charlie Yang [for Matthew], and I just have a question regarding the potential competition with YESCARTA, I guess once the new CAR-T [count] comes in, how do you and how does Gilead think about that? Thank you.

BF: [39:06] Yeah, if I could take that question. It's a bit referring back to what I just said. I think these can coexist very well in the market place. We should not forget that at the moment, I believe it's no more than 10 or 15% of patients that are treated in the lymphoma space, or in the multiple myeloma, it's even less, with CAR-T therapies. So there's an enormous ground to be won by not only the centralised model, but also by the decentralised model.

BF: [39:34] So this is really about expanding the market, making sure there's better access for patients, and I think the two models can and will coexist, so I don't see that issue. Neither does Gilead. I think Gilead thinks this is a very innovative approach, and thinks it's definitely an alternative model next to their own model, which they fully subscribe to, with Kite.

SvG: [39:39] Thanks, Bart. So the following question comes from [Dane Leon] at [Ring Cheeves]. Dane?

DL: [40:07] Hi, thank you. Hopefully you can hear me. So when you think about the clinical development for CellPoint and CD19 CAR-T, do you anticipate having to run comparative studies against the current autologous CD19 CAR-T products with YESCARTA obviously being one of those, or would you look to develop for patients that are currently ineligible for auto CD19 CAR-T? Thank you.

TT: [40:43] Yeah, thank you, a very good question. We believe that there are still a number of indications where we would not have to do comparative studies. And that's of course, the first studies will tell us, and it depends on the data that will come out of these first two studies, that will drive that strategy. So obviously, we'll try to do the first trial in an indication, and based on the data, to not have to do a comparative study.

SvG: [41:18] Thanks. The following question comes from Sebastian [Van Den Schoorts] of [Campen].

SV: [41:29] Hi, good afternoon everyone, and congratulations on the acquisitions. I was wondering, regarding the Cocoon system, can you elaborate on what the deal structure is with Lonza, and on what type of priorities we should think of? And should we think of this system more

as a plug and play platform in which other cellular therapies that are already on the market, can also be plugged into?

BF: [41:53] Yeah, maybe let me take that question first, and maybe you can take the second part, it's all on the plug and play. So the deal structure, there's not much more, Sebastian, that I can disclose at this stage, other than that we believe that including the payments to Lonza for royalties, this is still, we think, a differentiated cost of goods, compared to centralised manufacturing. Today I am not in a position to give you exact percentages, but it's not to a level where it suddenly takes over the entire benefit from a cost of goods point of view.

TT: [42:29] Yeah, and maybe I can… I really like you to bring up the plug and play model, because there was originally always in our slide deck, where we tried to explain it to venture capital investors, but yes, you are completely right. These machines will be in the manufacturing sites, in hospitals, in these hospitals there are multiple indications, multiple opportunities for cell therapies in general.

TT: [42:51] As we say, we focus on CAR-T first, but working already on other possible cell therapies that we could plug and play into the system. So yeah, you are absolutely right, this is the first step, getting proof of concept in CAR-T, with CD19, but then open to first of all, expand the CAR-T space, but also, potentially expand the cell therapy space. And that's part of the licence with Lonza, so it's cell therapy in general.

PS: [43:24] Well let me add to that. The whole GMP environment where this needs to be done. So we will become responsible for the release of the product in the end at the hospital, because it's a company product, developed under a licence. So then the discussions shall be one with the regulators, whether the same machines can be used for plug and play for other therapies, yes or no, and there the GMP discussion with the authorities has to happen on whether these machines can be multi-functional for multi-therapies, versus just dedicated to our CAR-T and only that. That's something to follow, following regulatory discussions.

SF: [44:05] Thank you very much.

?: [44:14] Yes, hello, can you hear me?

PS: [44:16] Yes.

?: [44:17] Thank you. So congratulations, and my question is, of the data that you have currently in hand, what can you tell us about what gives you the confidence that you will be able to address durability, and even toxicity limitations of the current platforms? Thank you.

TT: [44:38] Yeah, again a very good question. Shall I take it, Paul? A very good question. So the durability, we know from, as I said, the CD19 CAR comes from an academic group that has tested multiple patients, and there we see that the durability is very competitive. The tox, and the safety profile is also really encouraging in comparison to existing CARs that are commercial at this moment.

TT: [45:13] So the data package looks strong, and in that sense, we made the decision to go specifically with this CAR, because of that existing data set.

SvG: [45:29] Thank you. We can take the next question from Pete [Reselz] of Citi now. Pete?

PR: [45:39] Thank you, just a second question. I think one of you, Tol, I think, said that you have… or Bart, that you have an exclusive contract with Cocoon. Is that really the case across all [here] and potential solid targets? Can you just define exclusive, I just want to make sure I understood that correctly.

BF: [45:58] Yeah, let me… so it's exclusive for blood cancers; it's global with the exception of China and Israel, to be very precise, where for China there is also a right of first refusal, if we intend to go there. Solid tumours will be on the agenda, which we think long-term, definitely could be something that we will be interested in to pursue. We definitely have an option to discuss that with Lonza as well.

PR: [46:26] Thank you.

SvG: [46:29] Thanks. So we can take another question of Phil [Nado of Cowan].

PN: [46:37] Hi, good morning, thanks for taking my follow-up question. Just to follow up on that Gilead situation, can you talk a bit more about how Gilead will be involved in the early development, and longer-term, how you would expect Kite to be involved, both in the commercialisation as well as the later-stage clinical trials? Thank you.

BF: [46:59] Yeah, look, it actually follows the same logic that we have in our existing contract with Gilead. So I would say in the early stages, it's really up to us to make sure we get this to the next level. But in the meantime, we are interacting, and we have interacted quite intensely over the last couple of weeks as well, with the team at Gilead, because there is a tremendous amount of knowledge there about the diseases, about the CD19 approaches.

BF: [47:27] So we think we can learn a lot from what they do, but we will take, and keep control over developments, until the moment where they would opt in. If they opt in obviously, then there is a joint

development path from there on, and they would have the rights for geographies outside Europe for the existing contracts.

SvG: [47:51] Thank you. So we can take the next question from Charlie [Mavot] of Bernstein.

CM: [48:01] Hiya, thanks for taking my second question. So it seems that one of the unique attributes of the AboundBio platform is the breadth of binder formats. So you've mentioned the VH domain, but could you please discuss the others in a bit more detail, and how they can play their own role? Thanks very much.

JM: [48:20] Thanks very much for that question. So VH domains are, many believe, the next frontier in antibody-based therapeutics. VH stands for variable heavy-chain. This is the smallest binding component of an antibody, about a tenth the size.

JM: [48:40] It can have the affinity that's as high or higher than the full sized antibody. It can reach into places and penetrate tissues much better than a full size antibody. And by reaching into places, I mean epitopes on a target molecule expressed on the surface of the cell.

JM: [49:04] Its tissue penetration is less relevant for CAR-Ts, and more relevant for antibody drug conjugates. The beauty of the VH is that you can engineer multi-specificity relatively easily, and put it in one vector, and transduce cells with that, so that the CAR-T cell expresses multiple epitope specificity.

JM: [49:32] And in the case of haematologic malignancy, we fully believe that targeting multi epitopes, will induce deeper and more durable responses and prevent relapse. Because the likelihood that a given malignant cell has down-regulated more than one target, is lower than one target. If it were involved in targeting three targets, then that would be less than one or two target down regulations. So we think this is key to the next generation of deep and durable responses to therapy.

CM: [50:14] Thanks very much.

SvG: [50:17] Thank you. So now we can take the next question from Brian Abrahams of RBC. Brian, if you can unmute yourself?

BA: [50:31] Yeah, hi, are you able to hear me?

SvG: [50:33] Yes.

BA: [50:36] Okay, thanks. Actually, just a quick question, actually two quick questions on the CAR-T. I was wondering if you could maybe talk a little bit more about the intellectual property around it, I guess what's the core of that, is it a novel construct, is it a process, or is it just the capabilities to pull this point of care approach together? And then is

there any potential visibility towards improving vein to vein time even going less than the 7 days? Thanks.

TT: [51:08] Yeah, so first on the IP point of view. It's actually a combination, it's the typical Dutch way of locking your bike. So it has various components. Most important, is the Lonza exclusivity that we have for the point of care. The CD19 is a coco-cola trade secret, not protected by a patent, but the combination of things, we believe, is strong enough to give us security there.

TT: [51:43] The vein to vein time currently is, as we say, we have a 6-day manufacturing; the patients are being pretreated, so we also have shorter processes that we could transfer also to CD19, but currently we don't see the need. So we need to wait for the phase 1 and 2 data that we're generating, and then see what the doses would be that we need in the clinic.

TT: [52:12] Our dose currently is quite a bit lower, the starting dose, quite a bit lower than the current commercial product. So if that is the case, then we could easily go one or two days shorter. But at present, it's the 6 days, we can easily bring it back to 4 or 5 days, not needed now, but if needed in the future, then we can easily do it.

SvG: [52:35] Yeah, so it's Jeroen Van den Bossche of KBC.

JB: [52:38] So yeah, sorry for that, and thank you for the follow-up question. So maybe a quick question to follow up actually perfectly. We were wondering who then owns the IP, even though that's a trade secret. Is it [Saponbio]; will you guys need to pay any royalties to the university? This is one of the things we're wondering about, and then how long do you forecast, let's say in a best-case scenario, to come to market?

TT: [53:16] Yeah, so on the IP, sorry, I should have mentioned that. We do have the exclusive licence to that CAR, and the royalties on that one is low single digit. Come to market, as we look at it now, we hope to start a pivotal late last year or early 2024, it should be able to reach the market then. If we can identify… so, in 2026, that's the short answer.

SvG: [53:54] Thanks, and then I think we can take a last question of Sebastian van der Schoorts of the Camden.

SS: [54:01] Hi guys, thank you for taking my follow-up question. Regarding the phage display system, or the phage library, I'm just wondering, in the press release you also mentioned that it can be used for bispecifics and ADCs. Do you anticipate that you will only leverage this platform for CAR-Ts, or is it possible that in the future, we will also see bispecifics, or ADCs from this platform, coming into the pipeline?

JM: [54:33] I would say definitely, the CAR-T focus is the initial leveraging of our abilities. We very much anticipate antibody drug conjugates with a very strong chemistry group at Galapagos, and that would be a nice synergy between Abound and Galapagos, and as you well know, the bispecific field is very hot, including VH domain-based bispecifics, and with the right targets, we're optimistic that we can make a big impact there. But CAR-T first probably, and [bidrug] conjugates second, and bispecifics also. So thank you for that.

SvG: [55:21] Thank you very much.

PS: [55:22] Yeah, I think that's the right order, John, and why CAR-T is first, is because it's a very short-term to patient, very significant patient benefit, and it's ready now. And that's why we want to focus first on the CAR-T, and in the meantime, in parallel with our scientific teams, we do the next step, as John just expressed.

SvG: [55:48] Thanks, both. So that's all we have time for on today's call. Please feel free to reach out to the IR team if you still have questions. Scheduled next is our H1 financial results call on August 5th. Thank you all for participating, and have a great rest of your day.

PS: [56:03] Thank you.