IPHA Earnings Call Transcript

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Quarter: 3

Operator: Ladies and gentlemen, thank you for joining us, and welcome to the Innate Pharma Third Quarter 2025 Business Update and Financial Results. [Operator Instructions] I will now hand the conference over to Stephanie Cornen, Vice President, Investor Relations, Communication, and Commercial Strategy at Innate Pharma. Please go ahead.
Stephanie Cornen: Good morning, and good afternoon, everyone. Thank you for joining us for Innate Pharma Q3 2025 Business Update and Financial Results Conference Call. The press release and today's presentation are both available on the IR section of our website. Before we begin, I'd like to remind everyone that today's presentation includes forward-looking statements based on current expectations. These statements involve risks and uncertainties that could cause actual results to differ materially. To begin, I briefly cover today's agenda. Our CEO, Jonathan Dickinson, will discuss our strategic priorities and path forward. Then our CMO, Sonia Quaratino, will present clinical pipeline updates on IPH4502, monalizumab, and lacutamab. Afterwards, I will present the commercial opportunity for lacutamab before turning back to Jonathan with closing remarks, and we'll open the call for Q&A.; With that, I'll now hand it over to Jonathan.
Jonathan Dickinson: Thank you, Stephanie. Good morning to those joining from the U.S., and good afternoon to our European audience. Turning to Slide 5. I would like to start with the strong momentum around lacutamab, supported by meaningful regulatory progress and new commercial opportunity insights. A few days ago, we received FDA clearance to initiate the TELLOMAK-3 Phase III trial in cutaneous T-cell lymphoma. This is a major milestone for the program, positioning lacutamab to advance towards potential accelerated approval in Sezary syndrome, supported by robust Phase II data. We expect the study to initiate in the first half of 2026, with filing anticipated following achievement of key enrollment milestones. Our CMO, Sonia Quaratino, will provide additional color on the Phase III trial and the regulatory path. In parallel, we hosted a well-attended lacutamab KOL event in October, featuring leading experts in CTCL. The discussions highlighted the continued unmet medical need for new, effective, and well-tolerated therapies in this space and reinforced lacutamab's unique positioning. During the event, we also presented new real-world claims data underscoring the commercial opportunity in both CTCL, which we believe further strengthens the value proposition for this program. Stephanie Cornen, our Vice President of Investor Relations and Commercial Strategy, will review the real-world evidence-based commercial opportunities for lacutamab towards the end of our call today. Moving to Slide 6. As you know, Innate Pharma's core strength lies in applying our deep scientific expertise to advance life-enhancing cancer therapies. Through our years of pioneering work in antibody engineering, we have built a differentiated high-value clinical pipeline supported by compelling data, positioning us to deliver treatments with truly transformative potential for patients and for all our stakeholders. Moving to Slide 7. As we look ahead, our path forward is clear and focused. As you remember, at our half-year results, we announced the strategic decision to focus our investment on what we believe are our highest value clinical assets, including IPH4502, lacutamab, and monalizumab, to maximize impact and value creation. In parallel, we are advancing our next generation of ADC programs through research, building the foundation for future innovation. Finally, we are streamlining the organization to ensure we remain fit for purpose and aligned with our strategic objectives. I'll now hand over to Sonia, who will take us through the clinical pipeline progress. Sonia?

Sonia Quaratino: Thank you, Jonathan. In this update, I would like to highlight the 3 clinical programs we believe hold the strongest potential to create significant value for Innate, IPH4502, monalizumab, and lacutamab. Starting with IPH4502, our differentiated ADC directed against Nectin-4. As a reminder, I would like to pinpoint the preclinical model where IPH4502 has demonstrated the 2 major feature of differentiation to an approved drug such as enfortumab vedotin. The first one is related to the payload of IPH4502, which is exatecan, a potent topoisomerase 1 inhibitor. Exatecan can induce a bystander effect, a phenomenon where it kills neighboring cancer cells in addition to the targeted cells. The exatecan is released from the antibody drug conjugate in the tumor and diffuses into nearby cells. This is beneficial for treating heterogeneous tumors where cancer cells may not all express the target antigens. The second point of differentiation is that in preclinical models, we have demonstrated that IPH4502 can induce potent tumor regression in PADCEV MMAE-resistant models, allowing us to target tumors that are or have become resistant to PADCEV. We have, therefore, built the study design of the first-in-human trial on the basis of these preclinical findings. First, we look for signals in tumor types where Nectin-4 expression may be low or heterogeneous, opening to a very broad opportunity. Second, we enriched the study of urothelial cancer patients in the post-EV setting, where IPH4502 may overcome resistance to EV. This represents an area of high unmet need with no approved drugs and the potential to move rapidly into later-stage development. With this hypothesis, the emerging clinical data will indicate the indication where IPH4502 can make the greatest impact. The first-in-human trial is guided by an adaptive design, and the main objective of this study are to assess the safety, tolerability, and preliminary efficacy of IPH4502 in patients with advanced solid tumors known to express Nectin-4. Enrollment in the dose escalation part of the study is progressing very well. We started the trial in January, and we have now reached already a pharmacologically active dose, and we have started to see early signs of clinical activity. We remain on track to complete the dose escalation by the first quarter of 2026. And after that, the dose optimization part of the study should commence. Now let's turn to Slide 10 to provide an update on monalizumab, which continue to advance in collaboration with AstraZeneca. The double-blind PACIFIC-9 Phase III trial aims to demonstrate improved progression-free survival of durvalumab in combination with either oleclumab or monalizumab as compared to durvalumab with placebo in patients with unresectable Stage III non-small cell lung cancer who have not progressed after platinum-based chemo radiotherapy. The PACIFIC-9 study builds on very strong scientific rationale, supported by earlier studies such as COAST, NeoCOST and NeoCOST-2 trials. This is a large global study that has fully completed enrollment with 999 patients randomized 1:1:1 across the 3 treatment arms. The primary endpoint is progression-free survival with efficacy comparisons for both combination arms versus durvalumab monotherapy. The study is fully recruited, and the independent data monitoring committee recently recommended continuation of the trial following a preplanned analysis, an important validation of the program progress. And we look forward to the data expected in the second half of 2026. Now moving to Slide 11 and to lacutamab. As we highlighted during our KOL event last month, our development strategy is designed to enable a stepwise approach, beginning with Sézary syndrome, an indication with the highest unmet medical need, especially in patients who have progressed after mogamulizumab, then progressing with a larger opportunity in mycosis fungoides, and finally, expanding to peripheral T-cell lymphoma. We are preparing a confirmatory Phase III study in an FNSS, which, once underway, opens the door for our filing of the biologics license application for Sézary syndrome post mogamolizumab based on the existing Phase II TELLOMAK data. This represents a potential path to accelerated approval with a key milestone expected in 2027. The confirmatory Phase III will also include patients with mucosis fungoidis, the largest CTCL subtype, where there remains a clear need for disease-modifying therapies. These results of the confirmatory Phase III trial will support a full approval in 2029 in NF and then full approval for Sézary and help establish lacutamab as a game changer in the therapeutic landscape across CTCL. Our goal is to position lacutamab within the NCCN guidelines as a preferred systemic therapy, not only for late-stage Sézary and mucosis fungoides, but ultimately for earlier-stage CTCL patients who continue to face limited treatment options. Now beyond CTCL, we are also advancing development of lacutamab in peripheral T-cell lymphoma, a particularly aggressive lymphoma subtype with few effective treatment options, and an ongoing Phase II study will help

defining lacutamab role in this patient population. Turning to Slide 12. I would like to remind the data that will form the basis for the accelerated approval in Sézary post mogamulizumab. They are the long-term follow-up data from the TELLOMAK Phase II trial that was presented at ASCO 2025. Sézary is an aggressive subtype of CTCL. And post-mogamulizumab, there are no approved drugs that have demonstrated clinical efficacy. In heavily pretreated patients, all pretreated with mogamolizumab, lacutamab demonstrated an impressive global overall response rate of 42.9% with a median duration of response of 25.6 months. The median progression-free survival for the whole population was 8.3 months. Of note, lacutamab was very well tolerated with very favorable safety profile, underscoring lacutamab potential to deliver a meaningful clinical benefit in this aggressive and difficult-to-treat population. Turning now to mycosis fungoides. Long-term follow-up data from the TELLOMAK Phase II trial showed that lacutamab achieved a global overall response rate of 19.6% with consistent activity observed regardless of KIR3DL2 expression level. The median duration of response was 13.8 months, and median progression-free survival was 10.2 months, again, with no difference between the 2 subgroups. Also in MF, lacutamab was very well tolerated with an excellent safety profile that supports its potential use for long-term systemic therapy at an early-stage disease. Turning to the clinical development plan for the confirmatory trial. This is an open-label multicenter randomized comparative Phase III trial evaluating lacutamab in patients with cutaneous T-cell lymphoma who have failed at least one prior line of systemic therapy. In alignment with the FDA, the study includes 2 independent cohorts with distinct statistical analysis plans, one for Sézary syndrome and the other for mycosis fungoides. In the Sézary syndrome cohort, patients who have failed at least one prior systemic treatment, including mogamulizumab, will be randomized 1:1 to receive either lacutamab or Romidepsin, which is currently the only FDA-approved option for patients who progress after mogamulizumab. The primary endpoint is progression-free survival assessed by blinded independent central review, and the key secondary endpoint is overall survival. In the mycosis fungoides cohort, patients with Stage Ib to Stage IV disease will also be randomized 1:1 between lacutamab and mogamulizumab, which represent the current standard of care for this population. Here again, the primary endpoint is PFS, weak pruritus, and quality of life as a secondary endpoint. As the Sézary syndrome and MF study subpopulations are considered as independent cohorts, answering to distinct objective sample sizes are estimated to meet the primary endpoint in both SS and MF cohorts independently. From a regulatory standpoint, we have received clearance from the FDA about this clinical trial protocol. And therefore, we are well placed to initiate the Phase III trial in the first half of 2026. And with that, I will now hand over to Stephanie Cornen, who will walk us through the commercial opportunity for lacutamab and how we plan to unlock its full value across CTCL and beyond.

Stephanie Cornen: Thank you, Sonia. Now looking at commercial opportunity an important parameter is about eligible population. CTCL is aware of this diseases and assessment incidence and prevalence remain a challenge, potentially underestimating its true burden. During the occurring event, associates presented the most up-to-date source based on U.S. TELLOMAK data Versus CTCL Patient population, which highlights the higher incidents and prevalence than previously described. So if we look into each of these opportunities, starting with Sézary syndrome, as discussed it should release near-term in U.S. based on the Phase II TELLOMAK data. Sézary syndrome may affect around 3x more patients than previously believed, with an annual incidence was around 300 patients, prevalence around 1000 overall Sézary patients. And according to U.S. TELLOMAK data, approximately 300 patients treated with mogamulizumab annually. Importantly, these opportunities clearly define and actual of approximately concentrating in special and referral centers which accessible with a focused commercial footprint. Our launch strategy will therefore target specialized centers already managing these patients, allowing for a near-term and derisk opportunity in the U.S. Now moving to mycosis fungoides, which represents a larger opportunity. Here again, the TELLOMAK data shows a higher incidence than previous reported with approximately 3,000 U&M; patients diagnosed each year in the U.S., and about one in four of these patients received systematic therapy. The goal of our Phase III, TELLOMAK-3, is to establish lacutamab as the new second standard of care, and our primary market research supports the view that physicians would adopt lacutamab as a second line of treatment base. And again, importantly, Sézary syndrome enable a seamless expansion into mycosis fungoides since both indications are managed by sustainable network of prescribers. So in summary, we see Sézary

syndrome as our first focused entry point into the CTCL market in the U.S., a manageable and concentrated launch opportunity that will also serve as the foundation for a broader commercial in MA. Turning to Slide 17. This slide illustrates the market potential for lacutamab in CTCL and how we plan to expand over time through a stepwise strategy that Sonia previously described. We expect an initial opportunity of up to $150 million in the U.S. with accelerated approval in Sézary syndrome, where the patient population is small but highly concentrated and addressable through a focused commercial footprint. As lacutamab moves into mycosis fungoides and secures full approval the opportunity could expand to around $500 million across the U.S. and Europe. And beyond that, we see additional upside as part of our life cycle management strategy. Lacutamab offers important standard care for early-stage patients, a segment where systemic treatments are less used today. And the unique profile of lacutamab that combines tumor targeting activity, improved quality of life, and a favorable safety profile makes it a compelling candidate to unlock earlier use of systemic therapy. While the Phase III trial is designed to support registration across all stages of Innate in the second-line setting, we see a broader opportunity in addressing the Innate medical need of patients who are currently managed only with skin therapy and may benefit from lacutamab. In short, lacutamab offers a clear derisk path to commercialization starting with Sézary syndrome, expanded into larger CTCL segment over time, and then an even larger opportunity in PTCL. And now I'll hand the mic to Jonathan for closing remarks.

Jonathan Dickinson: Thank you, Stephanie. As part of our focused strategy, we are advancing 3 high-value clinical assets that form the core of Innate's portfolio. Starting with IPH4502, our novel and differentiated Nectin-4 ADC, we see a significant opportunity in bladder cancer, particularly in the post-PADCEV setting, as well as across other solid tumors with low to medium Nectin-4 expression. Enrollment in the ongoing Phase I trial is progressing well, with completion expected by late 2025 or early 2026. We've now reached a pharmacologically active dose level where we're beginning to see encouraging early signs of clinical activity. Monalizumab, partnered with AstraZeneca, continues to advance in Phase III for unresectable non-small cell lung cancer, where enrollment in the PACIFIC-9 trial is now complete. Top-line data are expected in the second half of 2026, and this collaboration remains a key value driver with up to $825 million in total milestones and $450 million already received to date. And with lacutamab, our anti-KIR3DL2 antibody for cutaneous T-cell lymphoma, long-term follow-up from the TELLOMAK Phase II study has demonstrated meaningful and durable clinical benefit in both mycosis fungoides and Sézary syndrome, leading to breakthrough therapy designation in Sézary syndrome. As you know, we've now received FDA clearance to proceed with the confirmatory Phase III TELLOMAK-3 trial, and we're on track to initiate in the first half of 2026, supporting the potential for accelerated approval in Sézary syndrome. To wrap up today's call, I'll remind you that we have several value-driving catalysts ahead across Innate's portfolio. In the first half of 2026, we expect Phase I data from IPH4502, our Nectin-4 ADC program. This will be followed in the second half of 2026 by data from the PACIFIC-9 Phase III trial of monalizumab in collaboration with AstraZeneca. Looking beyond to 2027 and onward, we anticipate multiple milestones, including a potential accelerated approval for lacutamab in Sézary syndrome, the monalizumab BLA filing, and IPH4502 expansion phase data. Finally, we ended the third quarter of 2025 with a cash position of EUR 56.4 million, providing runway through the end of Q3 2026 to deliver on these key milestones. Operator, we can now open the Q&A; session. Thank you.

Operator: [Operator Instructions] Your first question comes from the line of Christopher Liu with Lucid Capital Markets.

Christopher Liu: So I have 2. For the first one, what would you need to get done in the near term for the potential lacutamab commercial launch in Sézary syndrome? And for the second question, for IPH4502 and the upcoming data set, could you give us a little bit more color on what we can see at that readout?

Jonathan Dickinson: Okay. Christopher, I can take that. So from a commercial perspective, I think one of the key things that we would need to get done prior to Sézary launch is the work to ensure that lacutamab will be included in the NCCN guidelines. So what we're aiming to be able to do, and we've already started the discussions on this with KOLs, is to ensure that when the BLA is approved for Sézary, that we basically already have lacutamab included in those NCCN guidelines for Sézary syndrome, but also for mycosis fungoides. So that will be one of the key pieces of work that we believe we will need to have in place prior to the BLA. And then IPH4502, in terms of what we hope to have

next year, I think we've communicated this on a number of occasions, but what we're aiming to have is a cohort of patients in the PADCEV resistant setting, probably 10-plus patients where we will hopefully see an interesting response rate and be able to show clinical activity as well as safety data. We also hope to have data in 1 or 2 other tumor types in a similar perspective. So 10-plus patients in 1 or 2 tumor types. What we're doing with the study, and I think Sonia mentioned this earlier, is we've set up the study in a way where we can basically chase signals. We can backfill cohorts. So when we see a signal in a particular tumor type, our objective is to backfill and to substantiate that signal. So hopefully, then in 1 or 2 other tumor types, you would have 10-plus patients. And again, hopefully, an interesting response rate that allows us to then move forward into the next stages for the development of the product. Thank you for the question, Christopher.

Operator: Your next question comes from the line of Justin Zelin with BTIG.

Justin Zelin: You've indicated that FDA views an accelerated approval pathway here for lacutamab as viable once the Phase III study is underway. Could you just expand whether FDA is looking for any additional supplementary analyses beyond the existing Phase II data set as part of that accelerated approval package? And then just second, based off of the feedback from the October KOL event. Do you have a sense of growing momentum from the KOLs for lacutamab to become the preferred second-line option here? And should we expect mogalizumab to naturally move later in the treatment paradigm?

Jonathan Dickinson: Okay. So addressing the first part of your question, Justin. So from an FDA perspective, they have not given us an indication that we would require any further substantial analysis. So basically, the BLA approval will be based off the data we have in hand today from the TELLOMAK study and the results that we've already presented that led to the breakthrough therapy designation. So we see that as reasonably straightforward. The key thing to unlocking the BLA submission here is having the confirmatory study up and running and to have established an enrollment trajectory into that study that would satisfy FDA that this study will complete and will deliver the confirmation of the accelerated approval. So that's something that we're obviously working very hard to be ready to do that ASOP because that counts down the -- it's the countdown to the submission of the BLA. We hope to be able to initiate the confirmatory Phase III study sometime around the middle of 2026. We would anticipate potentially a 6-month enrollment period to get the right trajectory to satisfy FDA requirements. And then that would allow us to submit the BLA sometime in early 2027, leading to FDA approval of the BLA, hopefully, sometime in the second half of 2027. So yes, so that hopefully answers the first part of your question. Then in terms of KOL feedback, we do see very good KOL feedback on lacutamab, and we do sense a building momentum around that. I think if you were attending the KOL event, and I think the KOL used the word game changer, which was, I think, something that summarizes what lacutamab can potentially bring not only to Sezary syndrome, but also to mycosis fungoides. I think there's particular excitement around basically what can happen in MF. If we look at the 5-year survival, of patients with MF, we do see a dramatic decrease in 5-year survival when patients progress from Stage 2a to Stage IIb, it drops from 78% to 47%. And we know that physicians want to be able to prevent that progression. And lacutamab, based on its tolerability profile and the excellent quality of life data for patients, is incredibly well placed to be able to slot into that area and be able to treat those patients at Stage b, Stage 2a, and hopefully prevent that progression of the patients to Stage Ib when you see the reduction in 5-year survival. So that's clearly, I think, factoring into the thinking of KOLs and how they will use this drug. So I think particularly in MF, we anticipate that lacutamab will be used ahead of Moga. In Sezary, we're studying post-Moga. So our expectation is that the product will be used post-Moga. Based on the excellent safety profile, I think some physicians may choose to use it in the first-line setting off-label as well. But our main assessment and where we're targeting for positioning the product is post Moga and initially in the Sezary syndrome indication. Hopefully, I've answered your question.

Justin Zelin: If I could just fit in a quick question with a potential near-term approval here, could you just comment on your CMC readiness as far as commercial scale manufacturing, PPQ run stability work for lacutamab?

Jonathan Dickinson: Yes, I can comment on that. I think the answer is we're in a good place. We're basically ready to go. That won't be on the critical path to submission of the BLA. So we've ticked that

box, and we're ready to go from that perspective.
Operator: Your next question comes from the line of Swayampakula Ramakanth with H.C. Wainwright.
Swayampakula Ramakanth: So I appreciate your comments on how you plan to file the accelerated approval application by the end of 2026. So what -- does this mean you're still hoping to get a partner on board? And in your previous conversations with potential partners, how much stress was there in terms of getting a clear signal from the FDA and a protocol blessed by the FDA?
Jonathan Dickinson: Thank you for the question, RK. So in terms of partner discussions, having FDA acceptance of the protocol was an important consideration. It was potentially one of those boxes that we needed to tick for a number of them for us to be able to progress with those discussions. So yes, it was an important clearing event to be able to move forward with some of those partnering discussions. In terms of partnering, commenting on partnering, I think what the company is looking to do is basically to keep our options open. We basically were continuously evaluating a variety of financial options to ensure we're appropriately positioned to support our growth initiatives and create long-term shareholder value. And we remain disciplined and opportunistic in our approach to capital management, and we'll pursue the opportunities that basically support where we're going here. So I think it's important that we keep the options open at this particular stage, particularly with the exciting news that we've seen more recently with lacutamab and the great path that we have forward.
Swayampakula Ramakanth: Can I ask 2 quick follow-ups, one on 4502? What specific safety signals would you be looking out for, especially when you would like to see this differentiated against other TOPO1 inhibitor ADCs? And the second question is, so what's the thought process now for the ANKET platform, especially them taking a little bit of a backseat? What's the long-term plan for that platform?
Jonathan Dickinson: So maybe I can take the first question, and then I will ask Sonia to take the question on the safety signals that we're looking out for. So -- on the ANKET platform, we are basically waiting -- we're actually finalizing the study for IPH6501. I think we mentioned previously that we've completed the dose escalation phase of the study, and we were basically exploring the MTD at this stage. We're still in the process of doing that. And we'll basically make any future decisions based on -- for IPH6501 based off clinical data. And that clinical data should come sometime in the first half of next year, and then we will be able to make the evaluations and the next steps. In relation to IPH6101, we have now basically have most of the clinical data for the Phase I and Phase II returned to us from Sanofi. So we're now in the process of evaluating that data and trying to understand what next steps could be for the ANKET platform. What I would really like to clearly emphasize, though, is from a prioritization perspective, we're putting most of our time and effort behind IPH4502, behind lacutamab and behind monalizumab, and making sure that we advance those 3 assets as quickly as possible because we believe we have the highest chance to win for those 3 assets. Sonia, if you can take the question on the safety signals we're potentially looking out for?
Sonia Quaratino: Well, in terms of signal for IPH45, we try to establish a very well-tolerated and relatively safe drug. And in particular, we try to, of course, avoid all the MMA-specific adverse events like peripheral neuropathy, that is very often not reversible, and ocular toxicity. And so far, we did not see many adverse events or a specific trend in that respect. So the plan is to provide clinical efficacy in, let's say, unusual indication or indications where the Nectin-4 expression is not as high as urothelial cancer, with a very good benefit-to-risk ratio matched by a favorable safety profile. It's difficult to say a prior what you want to see, yes.
Operator: Your next question comes from the line of Diana Graybosch with Leerink Partners.
Daina Graybosch: Yes, Bill on for Dana. I change it up a little bit, just asking about monalizumab. So I guess I'm just curious, can you just give us some, I guess, expectations for the readout in the second half of '26? Sort of what gives you the confidence that monalizumab, I guess, and durva can actually win out against durva?
Jonathan Dickinson: Yes. So maybe I can take that question. So basically, we have good expectations for the PACIFIC-9 study. And what that is based on really is the COAST study, which was the Phase II study, a randomized Phase II study that was replicating the PACIFIC-9 setting. If you look at the results and the Kaplan-Meier curves from that study, they are very interesting. When you added monalizumab to durva, you basically added 12 months median PFS on top of durva. So if we retain a proportion of that effect size going into the PACIFIC-9 study, there's a very high chance that we will have a positive

study. So that gives us a, I would say, a relative sense of confidence that this will be a positive study. Hopefully, that addresses your question.

Operator: There are no further questions at this time. I will now turn the call back to Jonathan Dickinson, CEO, for closing remarks.

Jonathan Dickinson: Okay. I'd like to thank everybody for attending our quarterly earnings call. Thank you for your time and attention, and I wish you a great rest of the day. Thank you very much.

Operator: This concludes today's call. Thank you for attending. You may now disconnect.