Focused on Therapy:

_Cancer, Autoimmune & Other Serious Diseases_

World ADC San Francisco 2013
Cynthia L. Sullivan, President & CEO

Good morning. Thank you for attending this session.
Forward-Looking Statements

This presentation, in addition to historical information, contains certain forward-looking statements made pursuant to the Private Securities Litigation Reform Act of 1995. Such statements may involve significant risks and uncertainties, and actual results could differ materially from those expressed or implied herein. Factors that could cause such differences include, but are not limited to, new product development (including clinical trials outcome and regulatory requirements/actions); competitive risks to marketed products; forecasts of future operating results; availability of required financing and other sources of funds on acceptable terms, if at all; as well as those discussed in the Company's filings with the Securities and Exchange Commission.

I’ll begin by reminding you that I will be making forward-looking statements during this presentation, and that you should be aware of the risks associated with such statements. Please refer to our regulatory filings, most recently our annual report for the year ended June 30, 2013.
Overview (Ticker: IMMU)

**Multiple opportunities in large underserved markets**

**Epratuzumab in late-stage trials for lupus (SLE)**
- Phase III trials funded by partner UCB
- Statistically significant efficacy results from Phase IIb study
- Strong long-term safety and efficacy data from open-label extension studies. Reductions in corticosteroid doses

**Clivatuzumab advancing for pancreatic cancer**
- High unmet medical need
- Encouraging survival benefit data from early phase studies
- Phase III PANCRIT* study planned for late 2013 or early 2014

* PANcreatic Cancer Radioimmunotherapy Trial

We are a biopharmaceutical company focused on developing highly targeted therapeutic agents for the treatment of diseases with large market opportunities.

Our lead product candidate is epratuzumab, which is in two ongoing Phase III trials for lupus therapy conducted by our partner UCB. This humanized anti-CD22 antibody has previously demonstrated clinically meaningful and statistically significant efficacy results in patients with lupus, a potential billion dollar market. More recently, continued administration of epratuzumab was reported to have maintained improvements or further improved lupus disease activity and reductions in corticosteroid dosing over approximately 4 years.

We are developing clivatuzumab as a therapeutic for pancreatic cancer, a disease with high unmet medical need. The yttrium-90-labeled antibody, in combination with low-dose gemcitabine, has produced encouraging results in two early phase studies. Based on those results, we have decided to proceed with a Phase III registration trial with the acronym PANCRIT, which stands for PANcreatic Cancer Radioimmunotherapy Trial. We plan to launch this trial in patients who have received at least 2 prior therapies before the end of this year or the beginning of next year.
Another market that we are focusing our efforts on is in the antibody-drug conjugate, or ADC, space. The targeted delivery of drug by an antibody is an exciting new approach in cancer treatment that has gained significant interest. So far, 3 ADCs have been approved by FDA.

Mylotarg was approved in May 2000 under the FDA’s accelerated approval program for patients with acute myeloid leukemia. However, in June 2010, Pfizer voluntarily withdrew the drug from the U.S. market after results from a clinical trial raised new concerns about the product’s safety combined with the drug’s failure to demonstrate clinical benefit to patients.

Adcetris was approved in August 2011 for relapsed Hodgkin lymphoma and relapsed anaplastic large cell lymphoma. The drug, developed and marketed by Seattle Genetics, generated $138 million in sales revenue in the U.S. in 2012.

More recently in February 2013, the FDA approved Genentech’s Kadcyla for patients with HER2-positive, metastatic breast cancer.

This sector is going to become very competitive as there are approximately 30 ADCs in various stages of clinical development targeting more than 24 antigens. Most of these agents are supported by large multinational companies concentrating on cancer therapy.

The global anticancer drug market was valued at $46 billion in 2010, with antibody-based targeted therapies capturing more than 35% of the market share. The ADC market is still in its infancy, with many molecules not yet in pivotal trials, but we believe this sector will capture a significant portion of the global cancer market as the pipeline continues to mature. ADC markets in the US are estimated to be worth about $9 billion in 2023.
ADCs in Clinical Development

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<th>ADC</th>
<th>Lead</th>
<th>Lead indications</th>
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<th>Payload</th>
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<tr>
<td>ImmunoCD® conjugates (ADC-544)</td>
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<td>RG-7918</td>
<td>Genentech</td>
<td>DLBCL, follicular non-Hodgkin lymphomas</td>
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<td>Gardatuzumab vedotin</td>
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<td>Mavacamte-maytansinoid (IMUG-899)</td>
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<td>Small cell lung cancer</td>
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<td>Biogenex</td>
<td>Multiple myelomas</td>
<td>CD38</td>
<td>DM1</td>
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<td>PSMA ADC</td>
<td>Progenics</td>
<td>Prostate cancer</td>
<td>PSMA</td>
<td>MMAE</td>
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<td>Doxorubicin</td>
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<td>IMMU-333</td>
<td>Immunomedics</td>
<td>Solid tumour</td>
<td>TACSTD2</td>
<td>TROF or DTP</td>
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<tr>
<td>Labatuzumab-SN-38</td>
<td>Immunomedics</td>
<td>Carcinoma, colorectal cancer</td>
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<td>Inhibitor</td>
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ADC, antibody-drug conjugate; CAE, carboxyamidopyrimidine; DBC, double-bond cytotoxin; EGF, epidermal growth factor receptor; GFHR, glycophorin FHR; MMAE, monomethyl auristatin E; MMAF, monomethyl auristatin F; PSMA, prostate specific membrane antigen; SN-38, a topoisomerase inhibitor; TACSTD2, tumor-associated calcium signal transducer 2.


This is 1 of 2 slides summarizing the current ADC pipeline. Most of these ADCs are conjugated with auristatins, MMAE or MMAF. Adcetris is a MMAE-carrying ADC. The other popular drug for conjugation is a maytansinoid, DM1 or DM4, for which Kadcyla is an example. The three ADC programs under development by Immunomedics, milatuzumab-doxorubicin (IMMU-110), TROP2-SN-38 (IMMU-132) and labatuzumab-SN-38 (IMMU-130) will be discussed in the upcoming slides. The development of ADCs requires the consideration of three parts; the antibody, the linker and the cytotoxic.
### ADCs in Clinical Development (cont’d)

<table>
<thead>
<tr>
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As mentioned earlier, the majority of the pipeline ADCs are in Phase I clinical trials. Furthermore, as can be seen on these two slides, most of these ADC candidates use linker technologies from Seattle Genetics or ImmunoGen.
Because the linker is a critical feature in a ADC, I would like to spend a few moments on this subject. This slide describes the linker technologies that are used in the ADCs listed in the two pipeline slides.

Pfizer used a hydrazone linker in Mylotarg and CMC-544. Upon internalization into the acidic conditions of the tumors, the acid-labile hydrazone group is cleaved, releasing the payload inside the tumors.

In contrast, Seattle Genetics opts for a stable dipeptide linker in their ADCs including Adcetris, which depends on the enzyme protease to liberate its drug. ImmunoGen employs a non-cleavable linker with a stable thioether bond in Kadcyla.

However, we have created our own linker called CL2 that uses a carbonate linkage that is sensitive to pH. CL2 was further optimized to CL2A, which is the linker of choice in our 2 ADCs: IMMU-130 and IMMU-132.
This is the chemical structure of our patented CL2A linker. On one end of the molecule we have positioned an antibody coupling group while on the other end we have an alcohol chemical group for binding with a drug. We have also added a short polyethylene glycol to improve the solubility of CL2A.

CL2A was designed with targeted delivery of SN-38 in mind. SN-38 is about 3 orders of magnitude more potent than irinotecan, its parent drug, but it cannot be administered systemically to patients because of its poor solubility and toxicity. The linker, CL2A, allows us to produce SN-38 conjugates that are soluble in water with excellent yields, as well as preservation of antibody binding and drug activity.
**Immunomedics’ ADC Platform**

**Structure of SN-38**

- **Active lactone form**
- **Inactive carboxylate form**

**CL2A linker chosen to maximize efficacy *in vivo***

- Protects SN-38 lactone ring from forming inactive carboxylate form
- pH-sensitive carbonate ester linkage for rapid detachment of SN-38
- Half-life in serum ~ 1 day

Furthermore, because SN-38 can be converted from its active lactone form to the inactive carboxylate form, by attaching CL2A close to the lactone ring at position number 20 of SN-38, the linker protects the lactone ring from opening up thereby maintaining the activity of SN-38. Another key feature of our ADC platform is that the linkage between CL2A and SN-38 is sensitive to both acidic and alkaline conditions and will allow the detachment of SN-38 at a rate of about 50% per day *in vivo*. 
The final structure of our ADC is depicted in this slide, with the pH-sensitive cleavable linkage highlighted. What differentiates our ADC platform from other companies is the high drug to antibody ratio of about 6 molecules of drug per IgG. That is to say, when our ADCs bind to their targets on cancer cells, they are delivering up to 6 molecules of SN-38 per antibody molecule into the blood or at the vicinity of the tumor. We believe this is more than 80-times the amount of SN-38 made available compared to when irinotecan, the parent compound, is given. We can deliver this drug concentration because our drug is not as supertoxic as the ones being pursued by others, thus permitting us to give higher antibody doses, in repeated therapy cycles, that we believe provide a better therapeutic index.
Immunomedics’ ADC Programs

**IMMU-132 (hRS7-SN-38)**
- Internalizing antibody targeting TROP-2 or EGP-1
- TROP-2 expressed on wide variety of human carcinomas
- Multicenter Phase I/II trial in diverse solid cancers

**IMMU-130 (labetuzumab-SN-38)**
- Less-internalizing antibody targeting CEACAM5
- CEACAM5 expressed on all colorectal cancers
- Multicenter Phase I/II trial in metastatic colorectal cancer

**IMMU-110 (milatuzumab-dox)**
- Internalizing antibody targeting CD74
- CD74 expressed on many hematological cancers including lymphomas and leukemias
- In Phase I dose-finding trials

To fully utilize the potential of our humanized antibodies, we have conjugated SN-38, for solid tumor therapy, and doxorubicin for lymphoma and leukemia therapy to 3 different antibodies that cover more than 80 percent of human cancers by incidence.

For solid cancers, we are pursuing the development of IMMU-132, which is our humanized antibody, hRS7, conjugated with SN-38. IMMU-132 targets the human trophoblast cell-surface antigen, or TROP-2, and is an internalizing antibody. TROP-2 is a cell-surface receptor expressed by many human tumors, such as cancers of the breast, cervix, colon, rectum, liver, lung, pancreas, ovary, kidney, and prostate, but with only limited expression in normal human tissues. IMMU-132 is in a multicenter Phase I/II trial in 13 different types of solid cancers.

In addition to IMMU-132, we are also developing IMMU-130 focusing on colorectal cancer. IMMU-130 involves our proprietary humanized antibody, labetuzumab, that targets the carcinoembryonic antigen, called CEACAM5. This antigen is abundant at the site of virtually all cancers of the colon and rectum, and is associated with other solid tumors, such as breast and lung cancers. This ADC is also in a multicenter Phase I/II study for the treatment of patients with metastatic colorectal cancer. Clinical updates on the IMMU-132 and IMMU-130 programs are part of a separate presentation at this meeting on Wednesday.

Our third ADC agent is for blood cancers where we are developing IMMU-110, a ADC containing milatuzumab, our anti-CD74 antibody. The scientific rationale for developing this agent is based on our understanding of the function and properties of CD74, which is expressed not only on many hematologic tumors, such as non-Hodgkin lymphoma and chronic lymphocytic leukemia, but also on certain solid cancers. When milatuzumab binds to CD74, it rapidly internalizes, making it an ideal antibody for selectively delivering a high concentration of doxorubicin inside the cancer cells. CD74 is involved in a cell-to-cell communication pathway that is critical for survival. When CD74 is blocked by milatuzumab, it can lead to cell death, or apoptosis. Thus, the therapeutic efficacy of IMMU-110 may be the combined cytotoxic effects of both the antibody and the drug. This ADC is currently in dose-finding clinical trials in patients with NHL or CLL. It is too early to report results, so the remainder of the presentation will focus on IMMU-132 and IMMU-130.
### IMMU-132 (hRS7-SN-38) in Solid Cancers

#### Phase I/II trial in patients with advanced solid cancer
- Targets TROP-2 or epithelial glycoprotein-1
- Multicenter study in ovarian, prostate, lung, breast, gastric, colorectal, esophageal, pancreatic, kidney, head and neck, bladder, and hepatocellular cancers

#### Dosing schedule
- Doses on days 1 and 8 of a 21-day cycle
- Up to 8 cycles may be administered
- Treatment continues until DLT/POD
- PR/SD - treatment continues past 24 weeks

#### Encouraging results from Phase I dose-escalation study
- Safe & well tolerated up to dose level of 10 mg/kg
- Multiple objective responses observed

IMMU-132 is currently in a Phase I/II trial examining its safety and tolerability for the treatment of diverse epithelial cancers. Patients with advanced solid cancers receive IMMU-132 weekly for 2 consecutive weeks, followed by one week off, in 3-week cycles, for up to 8 cycles until unacceptable toxicity or progression of disease. Encouraging results have been reported with this ADC from the dose-escalation phase of the study.
Continuing on the IMMU-132 program, the best responses in target lesion from the 20 CT-evaluable patients are shown on this slide. A total of seventeen of the twenty patients (85%) had partial response or stable disease as their best response. Fourteen patients fit the definition of stable disease with +/- 20% by RECIST criteria, while three patients demonstrated a partial response by the same criteria. We have seen that in 2 patients to date with partial responses of 51% and 52%, their disease showed reduction with time, from the first CT to the second CT measurement, thus suggesting that maintaining therapy with IMMU-132 can increase the response. Treatment is continuing in half of these patients as indicated by the red asterisk.
Examples of CTs from the partial responders in the IMMU-132 trial occur on these next few slides. These are CT images from the colonic cancer patient. As you can clearly see, this patient had multiple liver metastases (arrows). After 16 doses of IMMU-132, the target lesion, shown by the white arrow, decreased by more than 50%. Non-target lesions are also liver metastases of the same colonic cancer but they are not used for efficacy assessment under RECIST criteria.
This slide shows the before and after CT images from the patient with triple-negative breast cancer who is continuing to report a partial response. The lesion was reduced from 44 mm to 18 mm after 11 doses of IMMU-132 in less than 5 months.
These are before and after CT images from the small-cell-lung cancer patient who has a partial response. After 5 doses of IMMU-132, one lesion reduced from 5.8 cm to 2.7 cm while another lesion decreased from 3.2 cm to 1.1 cm.
**IMMU-130 (hMN14-SN-38) in mCRC**

### Phase I/II trial for patients with mCRC

- Advanced colorectal cancer patients relapsed to at least 1 prior irinotecan-containing regimen

### Two dosing schedules

- Once every 2 weeks
- Twice weekly for 2 weeks followed by one week of rest
- No DLT/POD - treatment continues for 8 cycles
- PR/SD - treatment continues past 24 weeks

### Encouraging results from Phase I dose-escalation study

- Safe & well tolerated up to dose level of 16 mg/kg
- 1 partial response, lasting almost 5 months
- Second dose-escalation study also showed tumor shrinkage

IMMU-130 is currently in a Phase I/II trial in metastatic colorectal cancer. Patients who had previously been treated with at least one prior irinotecan-containing regimen are enrolled to receive IMMU-130 either once every 2 weeks or twice weekly for 2 weeks, followed by a week off therapy in a 21-day cycle. In the absence of progression of disease or unacceptable toxicity, treatment will continue for 4 cycles.

Encouraging results were obtained from the Phase I dose-escalation study, with a patient showing reduction in tumor burden by CT constituting a partial response by RECIST after receiving treatments at the dose level of 16 mg/kg, once every 2 weeks. This response lasted for almost 5 months. It is important to note that responses in our trials with IMMU-130 have occurred in patients who have relapsed or are refractory to irinotecan.
This is a CT scan from a metastatic colon cancer patient with a partial response from the IMMU-130 trial. The liver metastases, indicated by the blue arrows, reduced from 71 mm at baseline to 41 mm after 17 weeks of treatments with IMMU-130 at the 16 mg/kg level.
## Summary

**Novel ADC platform**
- Proprietary CL2A linker
- Designed to be used with SN-38

**3 ADCs address > 80% human cancers**
- hRS7-SN-38 for diverse solid cancers
- Labetuzumab-SN-38 for colorectal cancer
- Milatuzumab-doxorubicin for blood cancers

**Encouraging Early Efficacies**
- Multiple objective responses observed
- Responses observed in heavily pre-treated, relapsed/refractory patients
- Responses durable

In summary, we have developed a novel ADC platform using our proprietary linker, CL2A, for use with SN-38. We have created 3 ADCs using our humanized antibody platform to address more than 80% of human cancers. Encouraging early responses were observed with these ADCs in difficult to treat patient populations with multiple solid tumor types.
Thank you!