HARNESSING THE POTENTIAL OF THE INNATE IMMUNE SYSTEM FOR ONCOLOGY

NASDAQ: AFMD

Webcast/Conference Call

11 December 2023

Forward-Looking Statements

This presentation and the accompanying oral commentary contain "forward-looking" statements that involve substantial risks and uncertainties. All statements other than statements of historical facts contained in this presentation and the accompanying oral commentary, including statements regarding our future financial condition, business strategy and plans and objectives of management for future operations, are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as "believe," "will," "may," "estimate," "continue," "anticipate," "intend," "should," "plan," "might," "approximately," "expect," "predict," "could," "potentially" or the negative of these terms or other similar expressions.

Forward-looking statements appear in a number of places throughout this presentation and the accompanying oral commentary and include statements regarding our intentions, beliefs, projections, outlook, analyses and current expectations concerning, the potential of acimtamig, AFM24, AFM28 and our other product candidates, the value of our ROCK® platform, the safety and efficacy of our product candidates, the potential of the LuminICE-203 study design to support accelerated approval by the FDA, our ongoing and planned preclinical development and clinical trials, our collaborations and development of our products in combination with other therapies, the timing of and our ability to make regulatory filings and obtain and maintain regulatory approvals for our product candidates, our intellectual property position, our collaboration activities, our ability to develop commercial functions, clinical trial data, our results of operations, cash needs, financial condition, liquidity, prospects, future transactions, growth and strategies, the industry in which we operate, the macroeconomic trends that may affect the industry or us, such as the instability in the banking sector experienced in the first quarter of 2023, impacts of the COVID-19 pandemic, the benefits to Affimed of orphan drug designation, the impact on our business by political events, war, terrorism, business interruptions and other geopolitical events and uncertainties, such as the Russia-Ukraine conflict and, the risks, fact that the current clinical data of acimtamig in combination with NK cell therapy is based on acimtamig precomplexed with fresh allogeneic cord blood-derived NK cells from The University of Texas MD Anderson Cancer Center, as opposed to Artiva's AlloNK and other uncertainties and other factors described under the heading "Risk Factors" in Affimed's filings with the Securities and Exchange Commission (the "SEC").

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Today's Speakers and Agenda

Agenda

- Acimtamig update: Evolving HL market, Latest AFM13-104 data, LuminICE-203 progress
- AFM24 program update: Latest data with a focus on NSCLC

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Acimtamig

ICE® for CD30+ Lymphomas

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LuminICE-203: The Path Forward for Acimtamig (AFM13)

Acimtamig: Unique Mechanism of Action Addressing Significant Unmet Need with Large Market Opportunity

- There is a void of viable agents for r/r HL patients due to the emergence of patients who are double refractory to BV and CPIs
- Acimtamig + AlloNK® has the potential to address a ~$3 billion market opportunity in r/r HL & PTCL where new treatment options are needed
- Acimtamig + NK cells have **shown 97% ORR, 78% CR**, with a well manageable safety profile

LuminICE-203 Builds on Strong Phase 1/2 Data with Accelerated Approval Potential Confirmed by FDA Interactions

- Study enrolling with **dosing of first two cohorts** underway
- Expect initial data update from run-in phase H1 2024
- Includes a PTCL cohort to establish POC
- FDA **Fast Track** Designation granted

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While Newer Agents have Improved Outcomes in HL, the Majority of R/R Patients Will Require Additional Interventions

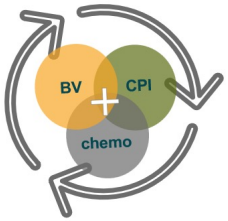
DOUBLE-REFRACTORY / RELAPSED HODGKIN LYMPHOMA: TACKLING RELAPSE AFTER BV AND CPI

*"The **approval of BV and CPIs has revolutionized the management of R/R HL.** In recent years, **these agents have rapidly moved to earlier lines of therapy**. This **shift in practice** means that **double-refractory** (i.e., refractory to both BV & CPI) **HL is becoming an increasingly common clinical problem**."*

2021 by The American Society of Hematology DOI 10.1182/hematology.2021000256

Regardless of treatment, a majority of R/R HL patients will need multiple therapies[1,2]

>50% of patients receiving SCT will progress[3,4]



Future therapies currently being studied for R/R HL are limited

- *Pembro+Lag3 - limited data to-date*
  - ORR 29% & CR 9%[5]
- *Current intelligence shows no other novel drugs under clinical investigation for double R/R HL*

1. Othman, et. al.; Emerging Therapies in Relapsed and Refractory Hodgkin Lymphoma: What Comes Next After Brentuximab Vedotin and PD-1 Inhibition? Curr Hematol Malig Rep. 2021 Feb;16(1):1-7. doi: 10.1007/s11899-020-00603-3. Epub 2021 Jan 6. PMID: 33409966. | 2. Kuruvilla et. al.; Pembrolizumab versus brentuximab vedotin in relapsed or refractory classical Hodgkin lymphoma (KEYNOTE-204): an interim analysis of a multicentre, randomised, open-label, phase 3 study. Lancet Oncol. 2021 Apr;22(4):512-524. doi: 10.1016/S1470-2045(21)00005-X. Epub 2021 Mar 12. Erratum in: Lancet Oncol. 2021 May;22(5):e184. PMID: 33721562. | 3. Narendranath et.al.; Double-refractory Hodgkin lymphoma: tackling relapse after brentuximab vedotin and checkpoint inhibitors. *Hematology Am Soc Hematol Educ | Program* 2021; 2021 (1): 247–253. | 4. Sureda et.al. Improving outcomes after autologous transplantation in relapsed/refractory Hodgkin lymphoma: a European expert perspective. *BMC Cancer* 20, 1088 (2020). 5. Poster 1068; Presented at the EHA2023 Hybrid Congress; Frankfurt, Germany; June 8-11, 2023

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For HL Patients that Have Advanced Past BV and CPI, There Are No Compelling Treatment Options Available

History of Prior Tx, Response, PFS, with select agents with 3+ prior lines of treatment in R/R HL

Regimen	N	Median prior lines (range)	Prior BV / CPI	ORR %	CR %	PFS, EFS Median # Months
Current NCCN Guidelines: Selected agents, 3+ prior lines of Tx in R/R HL (excluding BV and CPI tx)						
GVD[1]	40	3	R/R HL studies were conducted between 2000-2010 prior to either BV or CPI approval	75%	17%	8.5
Bendamustine[2]	34	4 (1-17)		56%	34%	5.2
Lenalidomide[3]	38	4 (2–9)		18.4%	2.6%	4.0
Everolimus[4]	19	6 (3-14)		47%	5%	6.2
Novel Investigational Therapies						
Pembro+LAG3[5]	34	5	Y / Y	29%	9%	9.7

Therapies show CRs ranging from 5% to 34 % and PFS ranging from 4.0 – 9.7 months

1. Bartlett N, Niedzwiecki D, Johnson J, et al. Gemcitabine, vinorelbine, and pegylated liposomal doxorubicin (GVD), a salvage regimen in relapsed Hodgkin's lymphoma: CALGB 59804. Ann Oncol 2007;18:1071-1079, (only patients with prior transplant included)
2. Moskowitz AJ, Hamlin PA, Perales M-A, et al. Phase II study of bendamustine in relapsed and refractory Hodgkin lymphoma. J Clin Oncol 2013;31:456-460.
3. Fehniger TA, Larson S, Trinkaus K, et al. A phase 2 multicenter study of lenalidomide in relapsed or refractory classical Hodgkin lymphoma. Blood 2011;118:5119-25
4. Johnston PB, Inwards DJ, Colgan JP, et al. A Phase II trial of the oral mTOR inhibitor everolimus in relapsed Hodgkin lymphoma. Am J Hematol 2010;85:320-324
5. Poster 1068; Presented at the EHA2023 Hybrid Congress; Frankfurt, Germany; June 8-11, 2023

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A Significant Opportunity Exists to Address R/R HL in the 7 Major Markets with Additional Potential in R/R PTCL

Cases and Percentage of R/R CD30+ HL in the 7 Major Markets (MM)*

Hodgkin lymphoma***

~21K
HL Patients in the 7MM**

~26% (5.4K)
Advance beyond front-line treatment

~13% (2.7K)
Require 3 or more treatments

= 200 individuals

$1.1B
Combined HL Market Potential

CD30+ R/R HL

Acimtamig + NK cell combo:

- Addresses the challenges of R/R HL
- Initial market value in HL is in the ≥3-line setting
- Additional HL value with earlier lines of treatment
- Market research indicating premium above CAR-T pricing

Cases and Percentage of R/R CD30+ PTCL in the 7 Major Markets (MM)*

PTCL CD30+**

~9.5K
CD30+ PTCL patients in the 7MM**

~56% (5.3K)
Advance beyond front-line treatment

= 200 individuals

$2.2B
Combined PTCL Market Potential

CD30+ R/R PTCL

Acimtamig + NK cell combo:

- Addresses R/R CD30+ PTCL
- Limited treatment options exist for R/R PTCL
- Market research indicating premium above CAR-T pricing

Data as of April 2023; *7MM include US, EU5 (France, Germany, Italy, Spain, United Kingdom), and Japan
****Source:** SEER, WHO Globocan, Global Data; Kantar; Affimed Internal Research
***** Source:** SEER, WHO Globocan, Global Data; Kantar; Leukemia & Lymphoma Society; Lymphoma Research Foundation; Laribi, Oncologist. 2018 Sep; 23(9): 1039–1053.; Brossard, Blood (2014) 124 (19): 2983–2986.; Sabattini, Haematologica. 2013 Aug; 98(8): e81–e82.; Savage, Blood. 2008 Jun 15;111(12):5496-504; Affimed Internal Research

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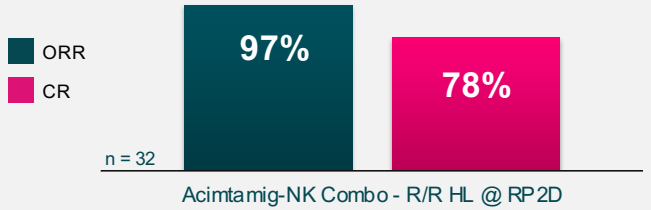
Acimtamig + NK Cells Shows Unprecedented ORR and CR Rates in Double Refractory HL Patients

- **All patients were heavily pre-treated** and double-refractory to BV and CPIs
- **All patients were refractory** to their most recent treatment



Acimtamig + NK cells is the most promising therapy being studied in HL patients who are relapsed or refractory to BV & CPIs

	AFM13-104 (NK cell combo) HL patients @ RP2D
Number Treated	32
No. Prior Lines Therapy (range)	7 (1-13)
Prior BV	100%
Prior CPI	100%
Prior SCT	63%
Response to Most Recent Treatment	**0%**

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AFM13-104: The First Clinical Study of an ICE® in Combination with NK Cells

Active, Recruiting

DESIGN

- A **Phase 1/2**, dose-escalation, proof of concept and safety study (NCT04074746; AFM13-104)

PATIENTS

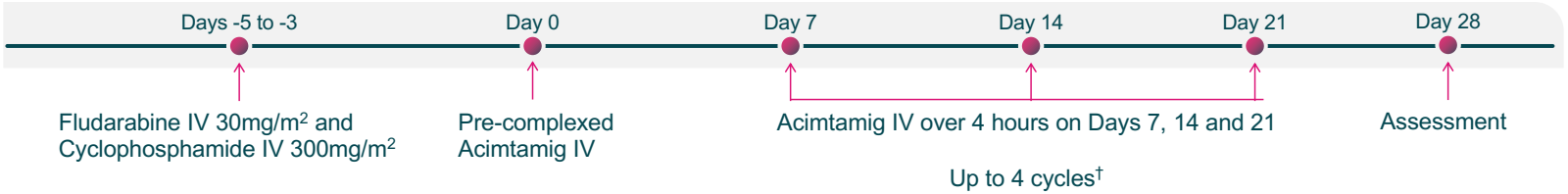
- **Key Inclusion Criteria:** Patients with r/r CD30+ Lymphoma aged 15 – 75 years, refractory / intolerant to BV

OBJECTIVES

- **Primary:** Safety and RP2D of NK cells pre-complexed with acimtamig, followed by IV acimtamig
- **Secondary:** ORR, and CR and PR rate; DOR, PFS and OS; Persistence of Acimtamig-NK cells; Immune reconstitution

Arms and Interven-tions

PROCEDURES



PHASE 2: EFFICACY

Cohort 3a: HL	1×10^8/kg acimtamig precomplexed allo cb-NK cells	Acimtamig dose 200 mg Q1W
Cohort 3b: CD30+ NHL	1×10^8/kg acimtamig precomplexed allo cb-NK cells	

†Additional cycles if clinically indicated; protocol changed from maximum of 2 to 4 cycles following patient 19.

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AFM13-104: Was Well Tolerated, with No Cases of Cytokine Release Syndrome, ICANS, or GVHD

Safety Profile (N=42)
There were no cases of cytokine release syndrome, immune cell associated neurotoxicity syndrome (ICANS) or GVHD
As expected with the lymphodepleting chemotherapy, all patients had transient and reversible myelotoxicity
There was only one case (0.9%) of grade 2 infusion-related reaction (IRR) to acimtamig-NK cells and 27 instances of IRR in 19 patients (1 grade 3, 21 grade 2 and five grade 1) to 349 infusions of acimtamig alone (7.7%)
There were no dose limiting toxicities and the RP2D of NK cells was established at dose level 3 (10^8/Kg)

Acimtamig + NK Cells was well tolerated with a manageable safety profile

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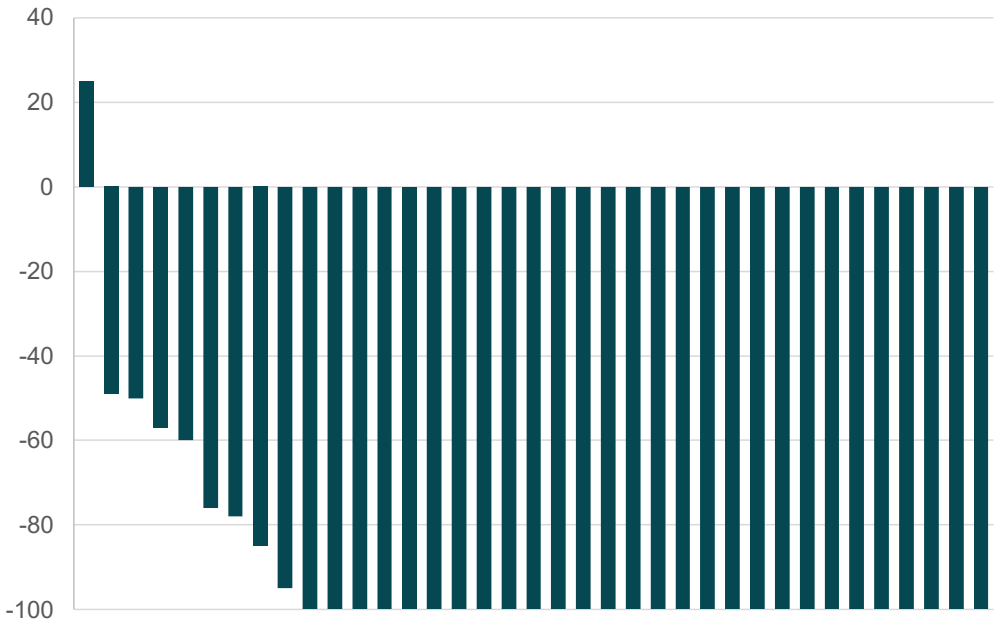
AFM13-104: Demonstrates Unprecedented Response Rates in Heavily Pretreated Patients

- **HL patients treated at the RP2D (n=32):**
  - **97%** ORR (n=31)
  - **78%** CR (n=25)
  - **72%** 6-month CR rate (n=23)
- **CD30+ NHL patients treated at RP2D (n=4):**
  - **75%** ORR (n=3)
  - **25%** CR (n=1)
- All 4 patients who had previously experienced PD with CAR-T had a CR

Percent change in target lesions; HL patients, all dose levels



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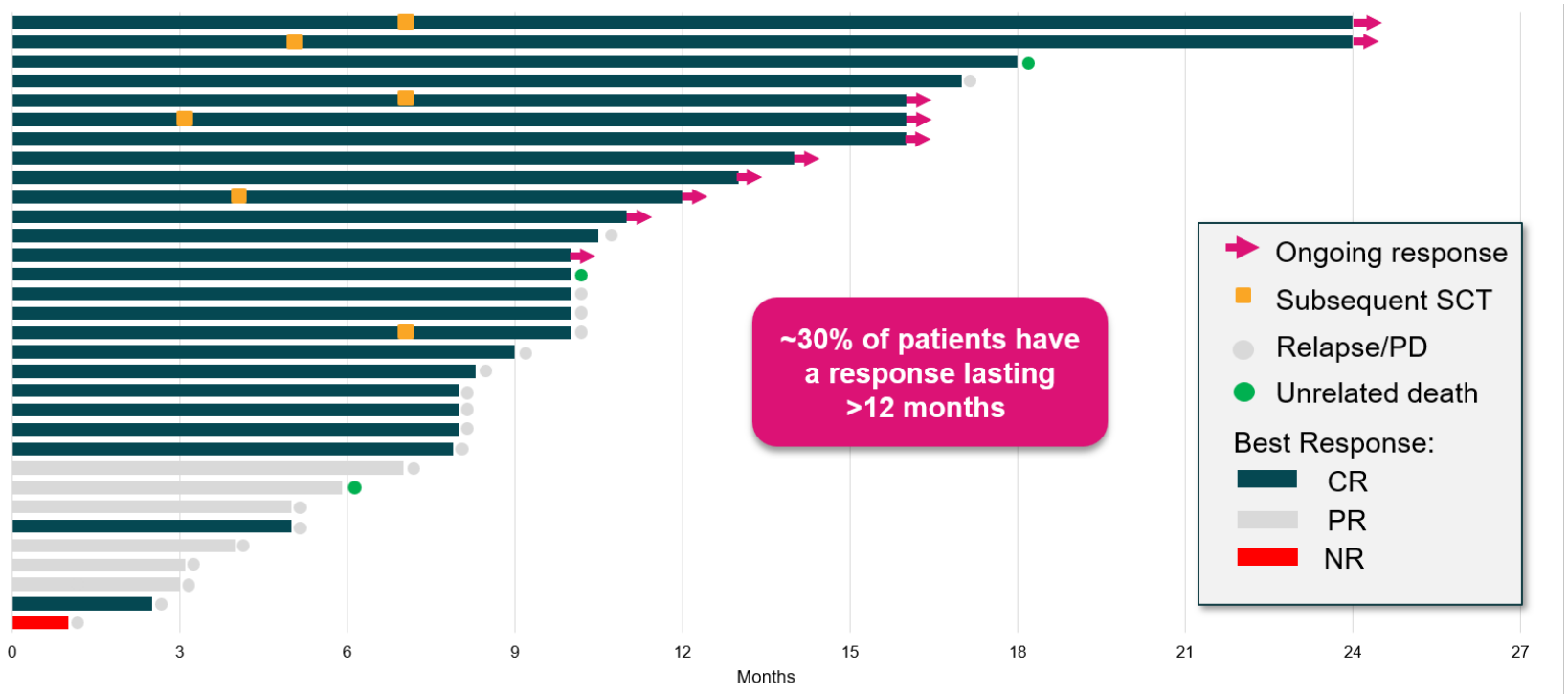
AFM13-104: Median EFS of 9.8 Months, Median DOR of 8.8 Months and 30% of Patients Remained in Remission for More than 12 Months



r/r HL Patients @ RP2D

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LuminICE-203 Background, Regulatory Update & Next Steps

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Recent Interactions with FDA Validated Overall Approach and Confirmed Study Could Support Registration Pending Data

Insights from **FDA Written Response** to the Type C request:

- LuminICE-203 study designed based on FDA's recommendations/ guidelines to support accelerated approval, the final alignment on the package to support regulatory approval will depend on the demonstrated magnitude of clinical benefit
- FDA is highly engaged to support the progress and design of the study combining acimtamig and AlloNK® as evidenced by the granted fast track designation and Type C feedback
- The FDA agrees with AFMD's approach to address the question of the contribution of single components activity by adding a cohort to the study evaluating the treatment with AlloNK/IL-2 only

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AlloNK® Cohort (n=12) to be Added to LuminICE-203 Study to Demonstrate Contribution of Components

PHASE 2 TRIAL, R/R HL (SIMON TWO-STAGE DESIGN)

- Cohort 1, DL1* NK cell dose, 200mg acimtamig (cHL) — Run-in N=6 pts
- Cohort 2, DL1 NK cell dose, 300mg acimtamig (cHL) — Run-in N=6 pts
- Cohort 3, DL2** NK cell dose, 200mg acimtamig (cHL) — Run-in N=6 pts
- Cohort 4, DL2 NK cell dose, 300mg acimtamig (cHL) — Run-in N=6 pts

*DL1: $2x10^9$ NK cells
**DL2: $4x10^9$ (dose 1), $2x10^9$ (dose 2 & 3) NK cells

Simon Two-Stage Design Study (68 to 110 patients)

Select cohorts for Stage Two

1:1 randomization

Dose Optimization
- 2 cohorts selected from safety run-in
- 13 patients / cohort

Dose Expansion
- 1 or 2 cohorts depending on interim data

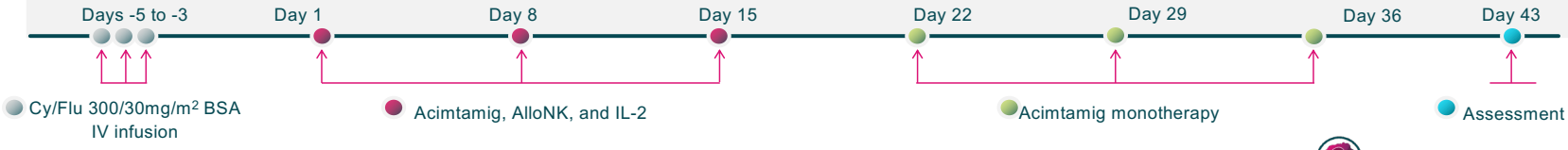
New - Based on FDA Feedback

AlloNK/IL-2
Cohort 6, one of the doses from dose optimization phase, N = 12

EXPLORATORY ARM IN CD30+ R/R PTCL

Cohort 5, one of the Stage 1 doses, N = 20

STUDY TREATMENT REGIMEN, UP TO 3 CYCLES



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LuminICE-203 Builds on Strong Phase 1/2 Data with Accelerated Approval Potential Confirmed by FDA Interactions

Evolving HL Landscape with Unmet Needs

- There is a void of viable agents for r/r patients due to the emergence of patients who are double refractory to BV and CPIs

Remarkable Efficacy

- Acimtamig + NK cells have shown 97% ORR, 78% CR, with a well manageable safety profile

LuminICE-203 Underway with FDA Fast Track Designation

- Study enrolling with dosing of first two cohorts underway
- Expect initial data update from run-in phase H1 2024
- Includes a PTCL cohort to establish POC
- Type C meeting achieved alignment on new cohort to assess contribution of components

Attractive Opportunity

- Acimtamig + AlloNK® has the potential to address a ~$3 billion market opportunity in r/r HL & PTCL where new treatment options are needed

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AFM24

ICE® in EGFR+ Solid Tumors

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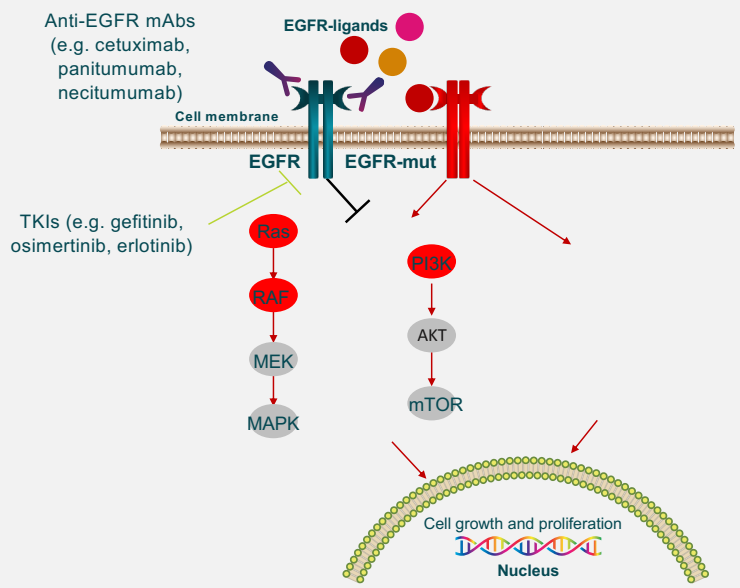
AFM24 is an EGFR/CD16A Tetravalent Bi-Specific Antibody with a Novel Approach to Treating EGFR-Expressing Solid Tumors

AFM24 with its differentiated mode of action unleashes the potential of Innate Immunity in treating EGFR-expressing solid tumor indications

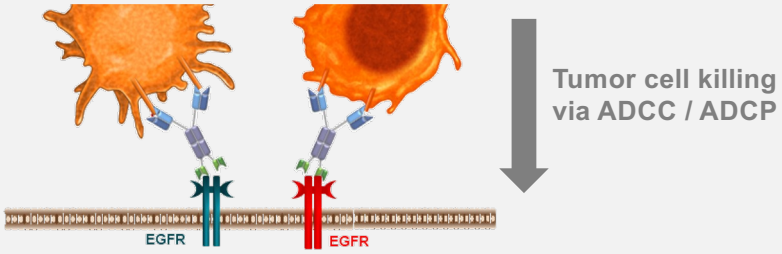


Current standard of care drugs:

- Disruption of the EGFR signaling cascade
- Resistance → activation of alternate pathways / downstream mutations
- Dose-limiting toxicities

The promise of AFM24's differentiated MoA*:

- Docking to EGFR only, no dependence on EGFR signaling
- Efficacy toward cells with mutated EGFR-signaling pathway
- Activation and recruitment of both the innate and adaptive immune cells
- Differentiated safety profile



Disclaimer: The image provides an overview of selected EGFR-targeting therapeutic agents and does not represent an exhaustive summary.

* … Based on in vitro and in vivo data in mouse, and cynomolgus monkeys and early clinical data (Wingert et al. mAbs 2021;13: 1950264).

TKI = tyrosine kinase inhibitor.

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AFM24 Path Forward: NSCLC in Combination with Atezolizumab

AFM24, a first in class ICE® for EGFR-positive solid tumors

- Early clinical program:
  - demonstrated **safety** as monotherapy and in combinations (NK, PD1)
  - showed **anti-tumor activity** as a monotherapy in combinations
  - provided clinical validation that **triggering innate immunity activates adaptive immunity**
- **Highest efficacy seen in NSCLC** across a range of indications evaluated:
  - Emerging data in NSCLC *EGFR*wt with AFM24 in combination atezolizumab (**73% DCR including 4 objective responses**) is highly encouraging
  - Monotherapy activity seen in *EGFR*mut NSCLC led to inclusion in AFM24-102 trial

AFM24 in combination with atezolizumab has potential to demonstrate a meaningful clinical benefit with a favorable safety profile in both EGFR*wt *and EGFR*mut *NSCLC patient populations

* 3 of 4 response awaiting confirmation per RECIST 1.1

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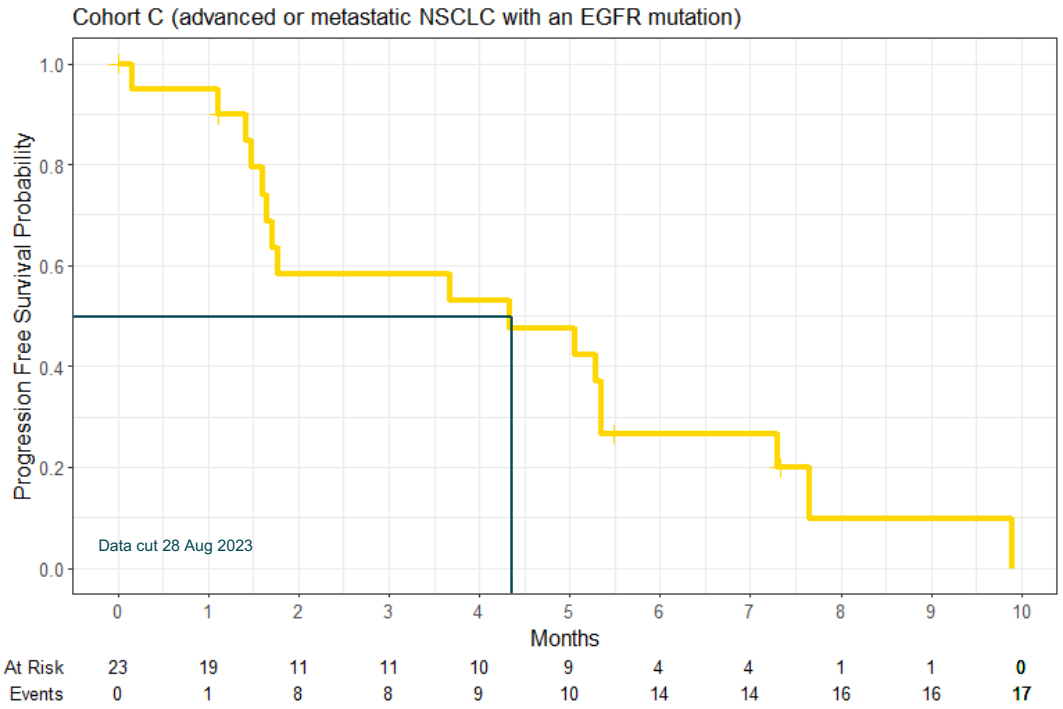
Monotherapy: NSCLC *EGFR*mut Cohort Data Confirms Signs of Efficacy in Line with SOC Combination Chemotherapy* (~4.5 months)

Analysis of Progression Free Survival



* mPFS: ~4.4 mths for pemetrexed+Pt CTx

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AFM24 + Atezolizumab to Focus on 2 NSCLC Cohorts

Building on the AFM24 monotherapy experience led to the focused development of AFM24 with atezolizumab

AFM24-102
I-O combination
Dose escalation & expansion study (AFMD, Roche)

Exploring potential synergistic effect of co-activation of innate and adaptive immune systems

Dose Expansion

- NSCLC *EGFR*mut
- NSCLC *EGFR*wt
- * Gastric
- * HCC, PanC*

* Enrollment in Gastric and HCC/PanC expansion cohorts concluded as they are unlikely to meet efficacy hurdle

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AFM24-102 NSCLC *EGFR*wt Cohort Patient Characteristics & AFM24 Related Treatment-Emergent Adverse Events

Patient Characteristics NSCLC *EGFR*wt cohort	**N=17***
Age (years) Median-Range	66 (45-75)
Sex n (%)	
• Male	14 (82.4)
• Female	3 (17.6)
Race n (%)	
• White	8 (47.1)
• Asian	9 (52.9)
ECOG PS (n, %)	
• 0	2 (11.8)
• 1	15 (88.2)
No. Prior Lines of treatment Median (range)	2 (1-5)
Prior CPI	**100%**
Response to CPI	4 PR / 7 SD
Refractory to CPI**	6

Most Relevant AFM24 Related Treatment Emergent Adverse Events NSCLC *EGFR*wt cohort	**N=17**
Asthenia G1	1 (1)
AST elevation	
G1	2 (2)
G2	1 (1)
ALT elevation	
G1	3 (2)
G2	2 (1)
Erythematous rash	
G1	3 (3)
G2	1 (1)
Infusion related reaction	
G1	3 (2)
G2	2 (2)
G3	1 (1)

- AFM24 has demonstrated to be safe and well-tolerated as both a monotherapy and in combination
- Combination with atezolizumab has not led to unexpected toxicity: Observed toxicity in line with toxicity profile of the individual agents

*Overall 17 pts were recruited into the cohort, 15 pts are included in the FAS (full analysis set) for efficacy as per protocol.
**All patients ultimately had progressed to previous CPI treatment

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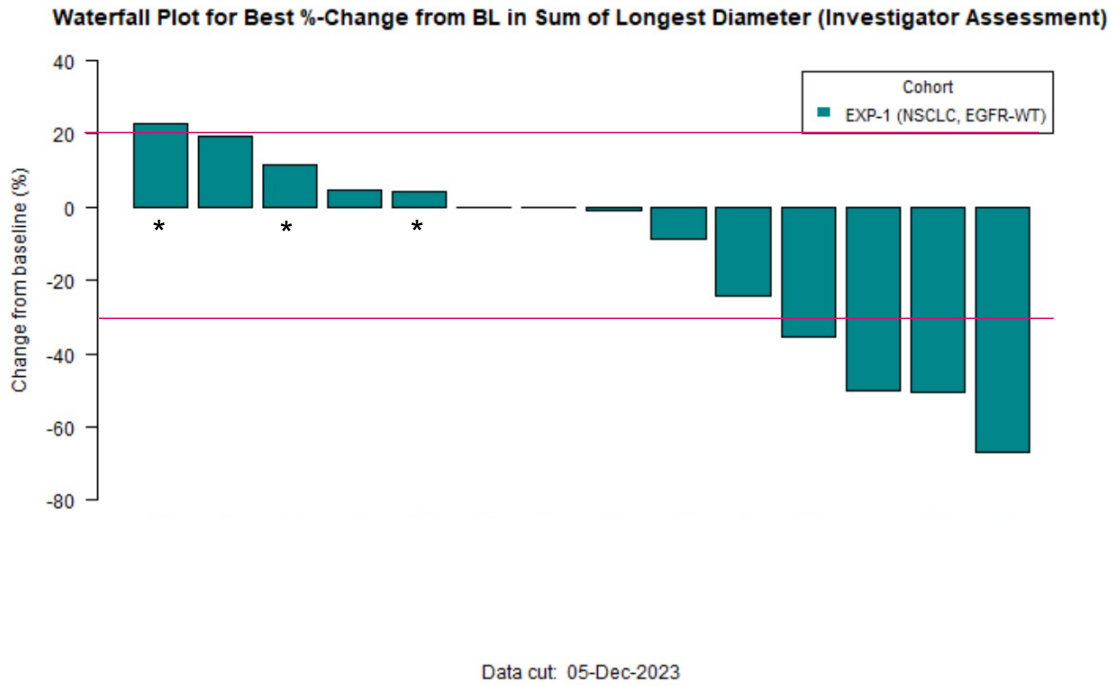
AFM24-102 NSCLC *EGFR*wt Expansion Cohort with Tumor Shrinkage in 7 Patients (47%)



Best Percent Change From Baseline

- **Overall, 14 of 15 patients with at least 1 efficacy scan# available**
- **1 CR (unconfirmed):**
  - -70% change from baseline
- **1 PR (confirmed):**
  - -32% change from baseline
- **2 PR (unconfirmed):**
  - -50% change from baseline
  - -50% change from baseline
- **7 SD**
- **3 PD***

According to RECIST 1.1, a subsequent second scan is required for confirmation
* One additional patient (ES-002-3014 - not displayed in the waterfall plot) discontinued early and was not evaluable according to RECIST 1.1
# valid post-baseline efficacy scan according to RECIST 1.1

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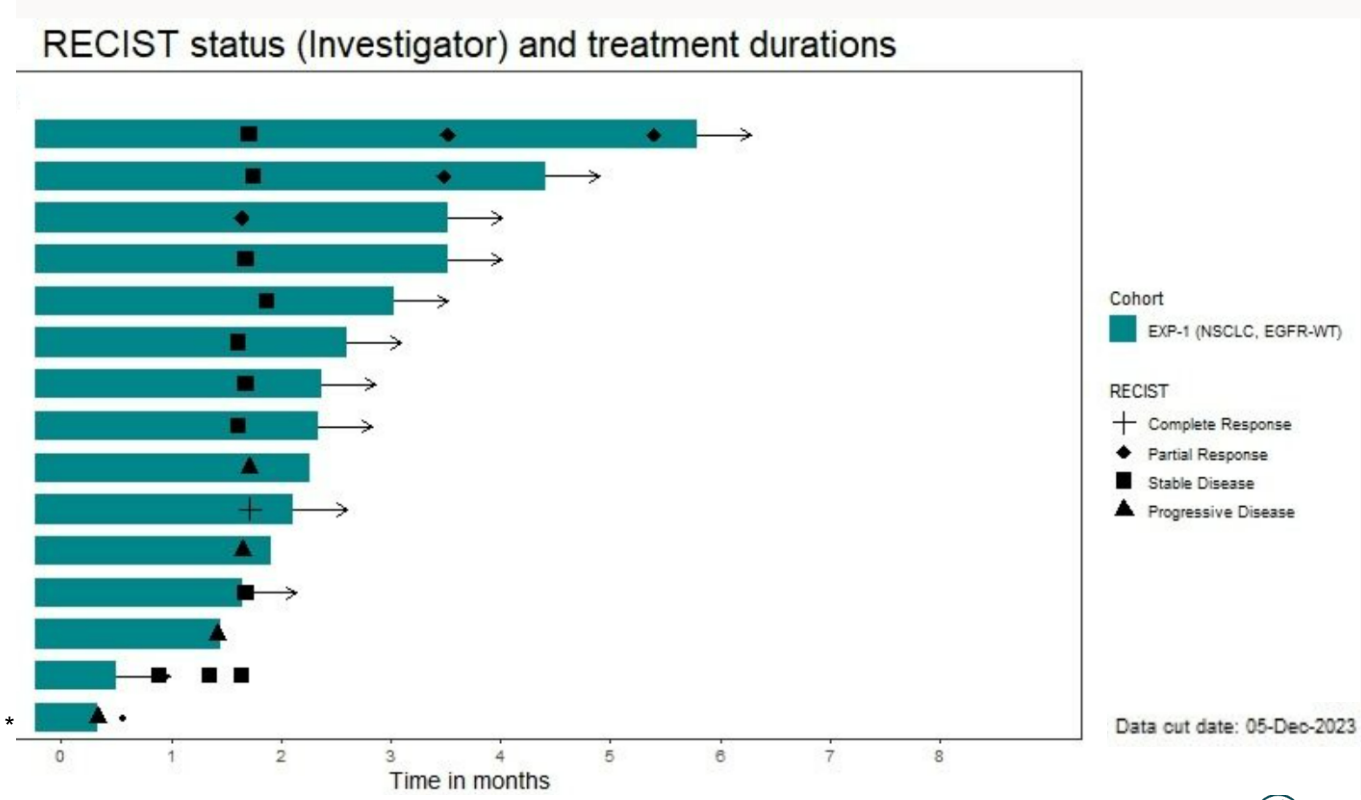
AFM24-102 NSCLC *EGFR*wt Expansion Cohort: Treatment Ongoing in 11 of 14 Evaluable Patients



According to RECIST 1.1, a subsequent second scan is required for confirmation
* Early discontinuation

Based on Rechallenge Data, Atezolizumab Monotherapy has Little to No Activity After Progression on CPI

Metric	Atezo Monotherapy[1]
ORR	0-7%
mPFS	2.9-3.9 months

It is unlikely the results in NSCLC EGFRwt are driven solely by atezolizumab

1. "Retreatment With Anti-PD-L1 Antibody in Advanced Non-small Cell Lung Cancer Previously Treated With Anti-PD-1 Antibodies", ANTICANCER RESEARCH 39: 3917-3921 (2019), "Switching administration of anti-PD-1 and anti-PD-L1antibodies as immune checkpoint inhibitor rechallenge in individuals with advanced non-small cell lung cancer: Case series and literature review," Thoracic Cancer 11 (2020) 1927–1933

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Treatment Landscape for 2L+ NSCLC *EGFR*wt Characterized by Low ORR and/or PFS

There is a significant unmet need in 2L+ NSCLC EGFRwt creating potential for AFM24+CPI in a large number of patients

	Non-Small Cell Lung Cancer (*EGFR*wt)
1st line treatment, for Stage IV/ metastatic patients	CPI Immunotherapy +/- chemotherapy
SOC, 2L patients	CYRAMZA (ramucirumab) + docetaxel • ORR: 23%, DCR: 64%, mPFS: 4.5 months • Grade 3+ TEAE: 79%, SAE: 45%
Emerging therapies	Datopotamab Deruxtecan (NSQ pts only) • ORR: 31%, mPFS: 5.6 months • Grade 3+ AE: 25%, Serious TRAE: 10%

Source: CYRAMZA Package Insert, Clinicaltrials.gov, ESMO 2023 LBA12, Mok, et. Al. N Engl J Med 2017; 376:629-640, ESMO 2023 LBA15, WCLC 2023 #954, Daichi Sankyo

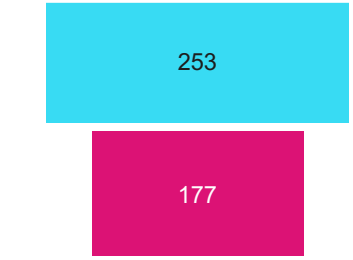
2L+ NSCLC *EGFR*wt and *EGFR*mut Patient Population Represents a Significant and Growing Opportunity

NSCLC Addressable Cases and Number of 2L NSCLC *EGFR*wt and *EGFR*mut in the 7 Major Markets (MM)**

331K

Stage IV metastatic NSCLC cases

NSCLC *EGFR*wt Cases in 7MM



~253K (76%)
Are *EGFR*wt

177K (70%)
*EGFR*wt are r/r to first-line treatment

NSCLC *EGFR*mut Cases in 7MM

~53K (16%)
Are *EGFR*mut

37K (70%)
*EGFR*mut are r/r to first-line treatment

Incidence = 613K NSCLC in 7MM; 331K stage IV metastatic are the addressable population; 214K 2L *EGFR*wt + *EGFR*mut

Data as of November 2023
*7MM include US, EU5 (France, Germany, Italy, Spain, United Kingdom), and Japan
****Source:** SEER, WHO Globocan, Global Data; Kantar; Affimed Internal Research

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AFM24 Path Forward: NSCLC in Combination with Atezolizumab

Activity in Combination Atezolizumab

- Encouraging signals in atezo combination study in NSCLC *EGFR*wt
  - 1 confirmed PR, 3 unconfirmed responses (1 CR, 2 PR) awaiting confirmation
  - 73% DCR and 47% tumor shrinkage rate

Data Updates H1 2024

- Further updates, including PFS, for NSCLC *EGFR*wt cohort
- Initial data update on NSCLC *EGFR*mut cohort

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Summary & Upcoming Milestones

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Multiple Potential Inflection Points in H1 2024 - Cash Runway into 2025

Program	Milestone	Timing
LuminICE-203	Data update from patients treated in cohorts 1-4	H1 2024
AFM24-102	PFS data update from NSCLC *EGFR*wt cohort	H1 2024
AFM24-102	Data update from NSCLC *EGFR*mut cohort	H1 2024
AFM28-101	Progress updates from dose escalation study (safety, dose levels)	H1 2024

AFM13 = acimtamig AFM24 AFM28

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Q & A

Appendix

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Survival Subgroup Analysis

Suppl. Table 3. Tumor response in patients receiving the RP2D by disease.

	Overall (N=36)	Patients with Hodgkin (N=32)
ORR (%) (95% CI)	94.4% (86.9-100%)	96.9% (90.9-100%)
Best Overall Response		
Complete Response	72.2%	78.1%
Partial Response	22.2%	18.7%
Stable Disease	0%	0%
Progressive Disease	5.5%	3.1%
Not Evaluable	0%	0%

Suppl. Table 4. Outcomes of patients receiving the RP2D by disease and planned number of cycles.

	Overall (N=36)		Patients with Hodgkin (N=32)	
	2 cycles (N=13)	4 cycles (N=23)	2 cycles (N=12)	4 cycles (N=20)
Median EFS, mo	8 months	10 months	8 months	10 months
At 6 months (%) (95% CI)	61.5% (35-87.9%)	69.6% (50.8-88.4%)	66.7% (40-93.3%)	67.6% (19.9-100%)
At 12 months (%) (95% CI)	30.8% (5.7-55.9%)	28.6% (9.3-47.9%)	33.3% (6.6-60%)	26.5% (11.7-41.3%)
Median OS, mo	NR	NR	NR	NR
At 6 months (%) (95% CI)	84.6% (65-100%)	86.9% (73.1-100%)	91.7% (76-100%)	85% (69.3-100%)
At 12 months (%) (95% CI)	84.6% (65-100%)	85% (69.3-100%)	91.7% (76-100%)	82.3% (64.2-100%)

NR: Not reached.

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