Developing Highly Differentiated Antibody Therapeutics

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Company Highlights

Differentiated therapeutic antibodies pioneering in severe autoimmune diseases & cancer

Novel concept in autoimmunity

- **ARGX-113**: first-in-class FcRn antagonist targeting array of IgG mediated AI diseases
  - Phase 1: favorable safety profile; IgG reduction up to 85%
  - Phase 2: ongoing in myasthenia gravis, immune thrombocytopenia and pemphigus vulgaris

Deep pipeline with multiple shots on goal

- **ARGX-110:** first-in-class CD70 antagonist in Phase 1/2 in CTCL and AML
- 4 clinical stage programs; 3 preclinical programs; Innovative Access Program

Powerful technology suite

- **SIMPLE Antibody™:** Human V-regions sourced from llama unlock **novel & complex targets**
- **NHance®, ABDEG™, POTELLIGENT®:** Fc engineering to augment natural properties of antibodies

Validating selective partnerships

- abbvie: **ARGX-115** (Immuno-oncology-focused novel target GARP)
  - $40mm upfront and up to $625mm in potential milestone payments
- Additional partnerships designed to maximize value of platform in non-core areas

Well financed to execute plan

- **Strong cash position:** €162mm Sept 30, 2017
- Blue chip investor base: more than 60% U.S. Shareholders
- 26.9 mio shares outstanding

Recent Progress

Pipeline

- ARGX-113 Phase 2 study in MG patients: 100% recruited (Oct ‘17)
- ARGX-113 for MG: Orphan drug designation by FDA (Sept ‘17)
- ARGX-113 Phase 2 study in ITP patients: 50% recruited (Sept ‘17)
- ARGX-113 Phase 2 study initiation in PV patients (Sept ‘17)
- ARGX-113 Phase 1 study initiation in healthy volunteers with subcutaneous formulation (Oct ‘17)

Partnerships

- ARGX-115: 1st $10mm preclinical milestone payment received from AbbVie (May ‘17)
- ARGX-112: 2nd undisclosed preclinical milestone payment received from LEO Pharma (June ‘17)

Financing

- Upsized $115mm IPO on Nasdaq (ticker: ARGX)(May ‘17)
- U.S. shareholding expanded above 60%
- Expanded U.S. analyst coverage
- Use of proceeds
  - Clinical development of ARGX-113 for the treatment of autoimmune diseases
  - Expand applications of ARGX-113 to develop a subQ formulation & explore additional indications
  - Clinical development of ARGX-110 for the treatment of hematological malignancies

Disciplined Business Model

Maximizes value of our suite of technologies and capabilities

Generating differentiated antibody candidates...

Novel Targets + **argenx Technology Suite** =  **Differentiated mAbs**

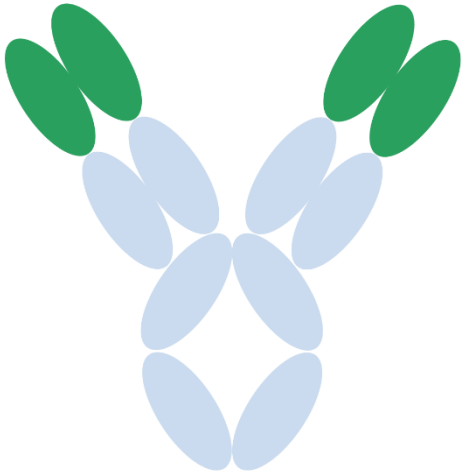
...capturing value at optimal stages

Discovery	Preclinical development		Early & late clinical development		
Platform deals	Product deals outside strategic focus		Product deals large indications		Product portfolio progress to clinical PoC
Shire ✓	ARGX-109	Bird Rock Bio ✓	ARGX-115	abbvie ✓	ARGX-113 ☐
BAYER ✓	ARGX-112	LEO ✓	ARGX-111	☐	ARGX-110 ☐
✓	ARGX-116	STATEN BIOTECHNOLOGY ✓			

Value inflection point

Augmenting Intrinsic Therapeutic Properties Of Antibodies

Antibody	Technology Role	Suite of technologies
V-region	Unlock novel and complex targets	**SIMPLE Antibody™ Platform** • Llama immune system delivers V-regions with high human homology • Highly diverse antibody output covers a multitude of target epitopes
Fc region	Modulate immune response	**NHance®** • Extends half-life • Enhances tissue penetration **ABDEG™** • Clears disease target • Clears autoantibodies **POTELLIGENT®** • Boosts cell killing



We apply our unique suite of technologies to create differentiated product candidates against novel targets

Klarenbeek et al. 2015, mAbs
Basilico et al. 2014, J Clin Inv.

Deep Pipeline In Severe Autoimmune Diseases and Cancer

Product Candidate	Target	Indication	Preclinical	Phase 1	Phase 2	Phase 3	Next Milestone / Commentary
Wholly-Owned Product Candidates							
ARGX-113 (efgartigimod)	FcRn	Myasthenia Gravis					1Q18: Phase 2 topline results
		Immune Thrombocytopenia					2H18: Phase 2 topline results
		Pemphigus Vulgaris					2H18: Phase 2 interim data
		Chronic Autoimmune Diseases			SubQ Formulation		2H18: Phase 1 interim data
ARGX-110 (cusatuzumab)	CD70	T-Cell Lymphoma		Phase 1/2			2H18: Phase 2 topline results CTCL
		Acute Myeloid Leukemia		Phase 1/2			YE17: Interim update Phase 2 CTCL and Phase 1 dose-escalation in AML/MDS
ARGX-111	c-MET	Solid Tumors / Blood Cancer					Intend to partner
Partnered Product Candidates							
ARGX-109 (gerilimzumab)	IL-6	Rheumatoid Arthritis					Eligible for up to €32.5mm in milestones, royalties & additional shares of Bird Rock stock
ARGX-112	IL-22R	Skin Inflammation					Eligible for up to ~€100mm in milestones and tiered royalties
ARGX-115	GARP	Cancer Immunotherapy					Received $50mm so far; eligible for up to $625mm milestones & tiered royalties
ARGX-116	ApoC3	Dyslipidemia					Eligible for double-digit royalties and exclusive option to license the program

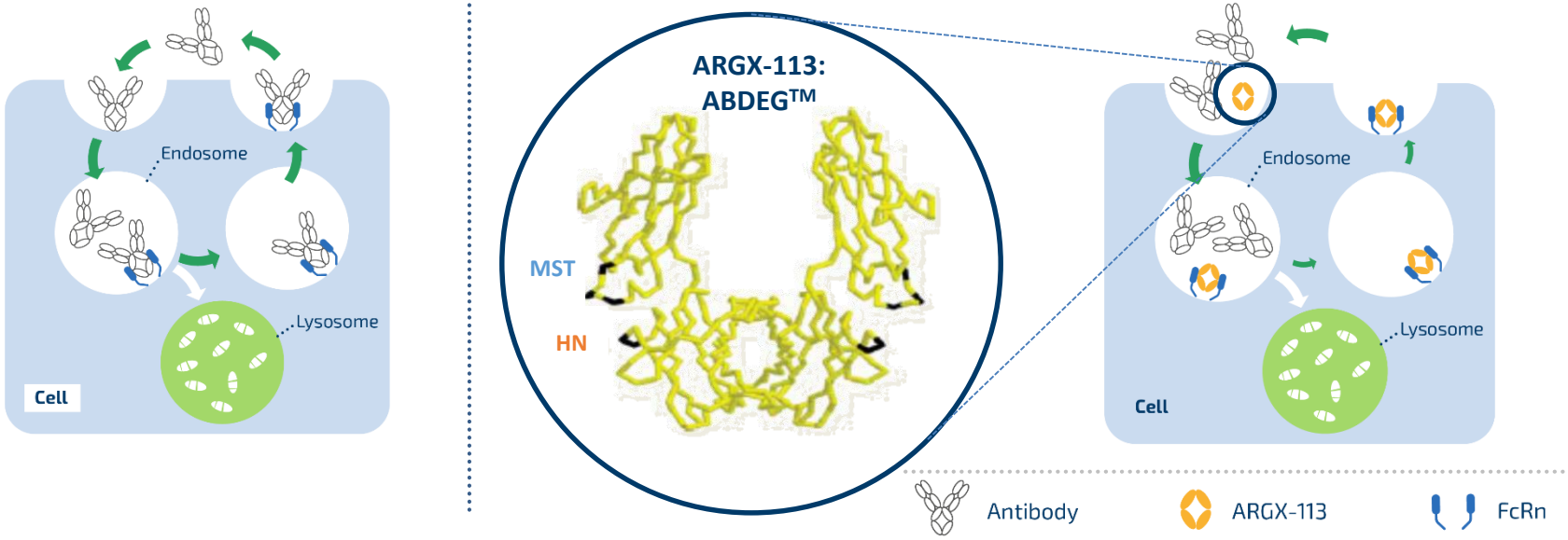
- We obtained the exclusive license option from **Broteio Pharma** for an antibody against a novel complement target
- We have an antibody discovery alliance with Shire focused on multiple rare disease targets

ARGX-113: A Pipeline-in-a-Product Opportunity

ARGX-113: Lead Program Based On Novel Target FcRn

An innovative approach to eliminate IgG autoantibodies

IgG antibodies recycle through FcRn(1)… **…ARGX-113 potently blocks FcRn…** **…leading to IgG elimination**



- ARGX-113 is a human IgG1 Fc-fragment that utilizes ABDEG™ Fc engineering technology(2)(3)
- ARGX-113 targets and binds to FcRn blocking the recycling of IgG leading to an elimination of IgG antibodies
  - Demonstrated 50% to 85% reduction of circulating IgG antibody levels in Phase 1 trial
- Pathogenic IgG antibodies mediate multiple autoimmune diseases
  - 30% pathogenic IgG reduction believed to be clinically meaningful in MG
- Phase 2 focus on myasthenia gravis (MG) and immune thrombocytopenia (ITP), data est. 1Q2018/2H2018

(1) Roopenian et al. 2007, Nat Rev Immunol.
(2) Vaccaro et al. 2005, Nat Biotech.
(3) argenx data

ARGX-113: Pipeline-In-Product Opportunity

Prioritizing IgG autoantibody mediated diseases

Landscape of IgG severe autoimmune diseases (selection)

Immune Thrombocytopenia
Scleroderma
Lupus
Epidermolysis Bullosa Acquisita
Multiple Sclerosis
Anca Vasculitis
Myasthenia Gravis
Rheumatoid Arthritis
Pemphigus
Bullous Pemphigoid

Solid Biological Rationale
Disease proven to be predominantly mediated by pathogenic IgGs

Feasible for Biotech
Orphan potential, economically viable, efficient clinical & regulatory pathway

Proof of Concept Value
Spill-over effect into adjacent indications

Myasthenia Gravis	Immune Thrombocytopenia	Pemphigus vulgaris
Beachhead neuromuscular diseases	Beachhead heme disorders	Beachhead blistering diseases

argenx data

Myasthenia Gravis (MG) Overview

What is Myasthenia Gravis?

- Rare autoimmune disorder; 64,000[(1)] patients in U.S., 55,000[(2)] with generalized MG, affecting all ages and both genders
- MG associated with muscle weakness; can be life threatening if respiratory muscles affected
- Symptoms include: Life-threatening choking; muscle dislocation; eyelid fatigue; pain; problems with vision, speech, mobility, fatigue

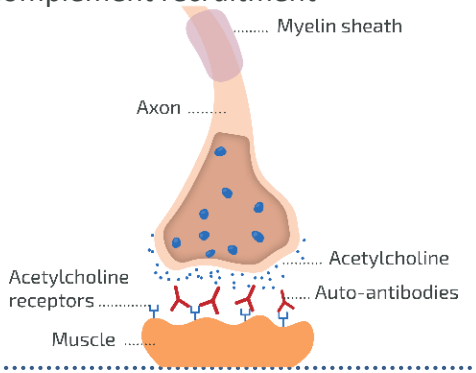
Limited current treatment options

- Limited treatment options
  - Cholinesterase inhibitors
  - Corticosteroids
  - Immunosuppressants
  - IVIg or Plasmapheresis (exacerbations or rescue)
  - Thymectomy (minority of patients)
- Severe side effects of current treatment options: Injury, liver malignancy, osteopenia, osteoporosis, cataracts, depression, hypertension, hematologic suppression, headache, disfigurement, infection, thrombosis
- IVIg and Plasmapheresis place a heavy cost burden on healthcare systems in the acute setting (~$79,000[(3)] and ~$101,000[(3)] respectively)

Myasthenia Gravis Cause

Autoantibodies (IgG type) destroy neuromuscular junctions:

- Blocking of Acetylcholine Receptors (AChRs)
- Cross-linking + internalization of AChRs
- Complement recruitment



(1) Philips et al. 2003, Ann N Y Acad Sci.
(2) Drachman et al. 1993, New Eng J Med.
(3) Heatwole et al. 2011, J Clin Neuromuscul Dis.

Autoantibody Levels (IgGs) Correlate With MG Disease Score

>30% autoantibody reduction clinically meaningful

Treatment*	Plasmapheresis	Immuno-adsorption	IVIg
Decrease in autoantibody levels (%) after treatment	62.6 ± 0.9	55.1 ± 3.2	28.9 ± 3.8
Decrease in disease score (%) after treatment	60.8 ± 3.5	42.4 ± 4.2	23.8 ± 3.7
Clinical efficacy rate after 14 days**	12/15	7/10	6/15
Duration of hospital stay (days)	12.80 ± 0.28	13.50 ± 0.50	16.00 ± 0.50

* Comparison between 3 cycles of Plasmapheresis/Immunoadsorption every 24h-48h and 5 cycles of IVIg every 24h
** Clinically effective if disease score has improved by >50% 14 days after treatment

Degree of autoantibody reduction correlates with clinical improvement and reduced hospital stay

Liu et al. 2010, Ther Apher Dial.

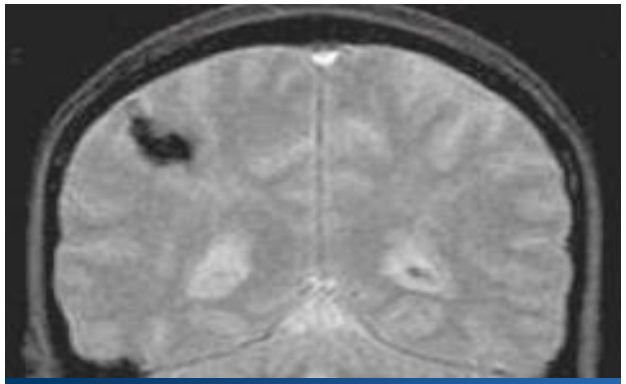
Immune Thrombocytopenia (ITP) Overview

What is Immune Thrombocytopenia?

- Rare bleeding disease; estimated 72,000[(1)] patients in US, more frequent in females and patients over 60
- Symptoms range from mild bruising to severe bleeding
- Symptoms include: Fatigue, emotional strain, impact on work, fear of bleeding, impact on social activities, bruising

Limited current treatment options

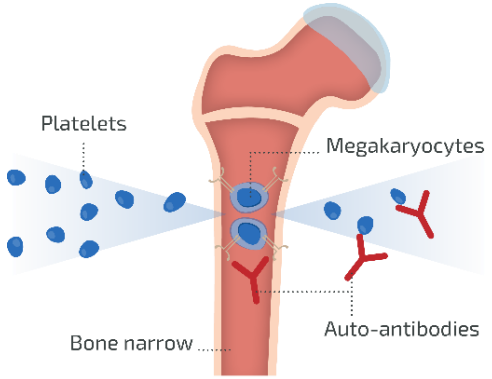
- Limited treatment options
  - Multiple iterations on corticosteroids & IVIg
  - Immunomodulatory agents
  - TPO mimetics & splenectomy
- Severe side effects from current treatments:
  Anaphylaxis, anorexia, backache, cancer, cataracts, depression, diabetes, fatal hemolysis, hepatitis, hypertension, infections, infusion-related reactions, leukoencephalopathy, nausea, osteoporosis, psychosis, sweating, neutropenia, thrombosis, vomiting, weakness
- Romiplostim and Eltrombopag, last-line therapies for ITP and have generated global revenues of $584 million[(2)] and $635 million[(3)] in 2016



Immune Thrombocytopenia Cause

Autoantibodies (IgG type) destroy blood platelets:

- Increased platelet removal
- Reduced platelet production



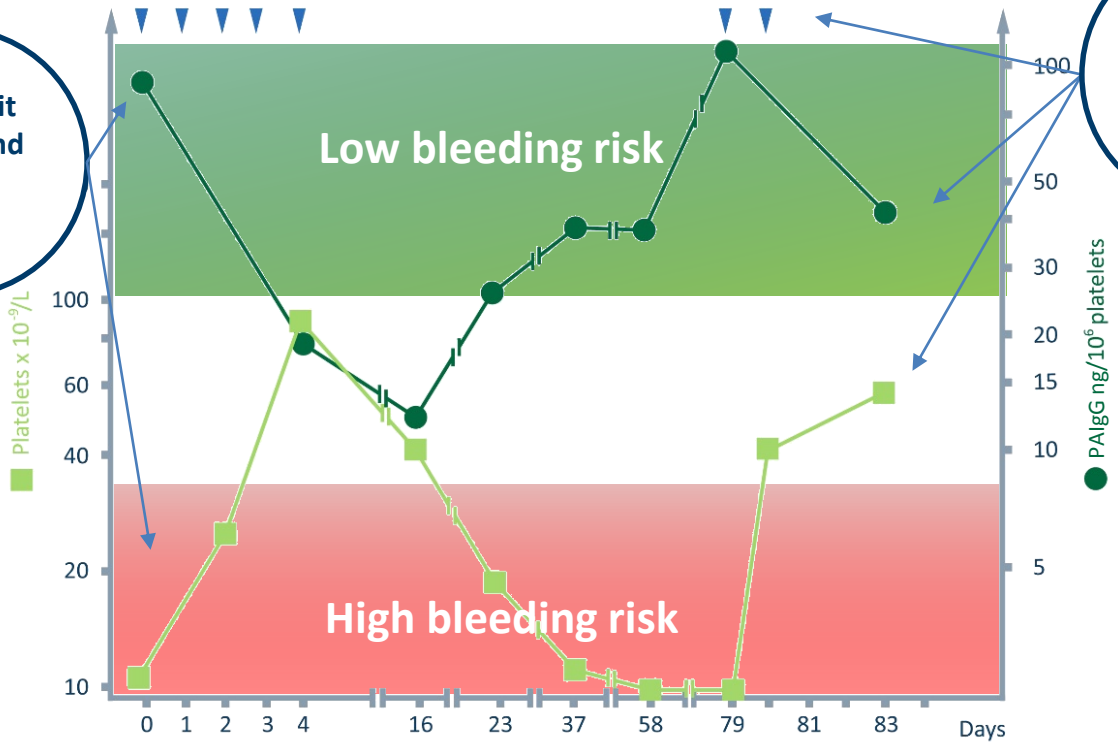
(1) Saleh et al. 2015, Curr Med Res Opin.; Terell et al. 2012, Am J Hematol.; Grace et al. 2012, Pediatr Blood Cancer.
(2) Amgen Inc. 2016, Form 10-K.
(3) Novartis Annual Report 2016

Autoantibody Levels (IgGs) Correlate With ITP Disease Score

Autoantibodies inhibit platelet production and accelerate platelet destruction

Therapy aimed at reducing autoantibodies like IVIg (shown), plasmapheresis and immunoadsorption results in platelet increase

Platelet levels during IVIg treatment in Adult Immune Thrombocytopenia



▼ = IVIg treatment ● = Autoantibody level ■ = Platelet counts

Winiarski et al. 1983, Scand J Haematol.

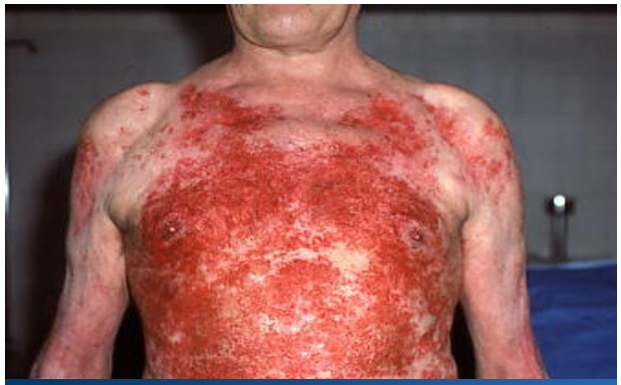
Pemphigus Vulgaris: Overview

What is Pemphigus Vulgaris?

- Chronic, severe – potentially life-threatening – auto-immune disease
- ~ 17,000 people treated (US)[1]
- Mucosal and skin blisters leading to pain, difficult swallowing, skin infection
- Disease severity directly correlates to pathogenic IgG levels against desmoglein-1 (skin involvement) and desmoglein-3 (mucosal involvement)[2]
- Patients cycle through periods of remission and relapse for extended periods

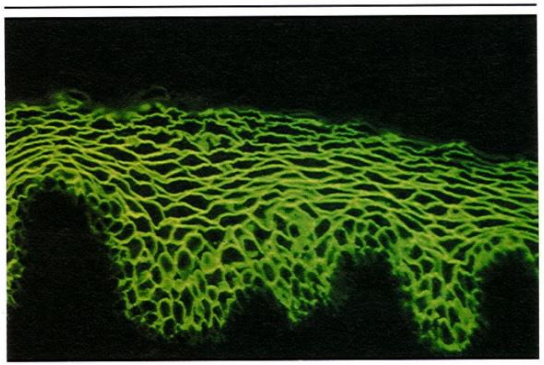
Limited current treatment options

- Current disease management comes with significant side effects and impacts QoL
  - High dose of corticosteroids and chronic immunosuppression (AZA, MFM)
  - Rituximab, IVIg, immunoadsorption and plasma exchange used for severe or refractory patients (10%), but not perceived as curative
- Treating physicians require new effective therapies with rapid onset of action that are safe
- Rituximab therapy shows slow onset of action, risk of developing serious adverse events and significant relapse rate [2] [3] [4]



Pemphigus Vulgaris Cause

Diagnosis based on presence of pathogenic autoantibodies targeting desmoglein-1 and -3 in the skin

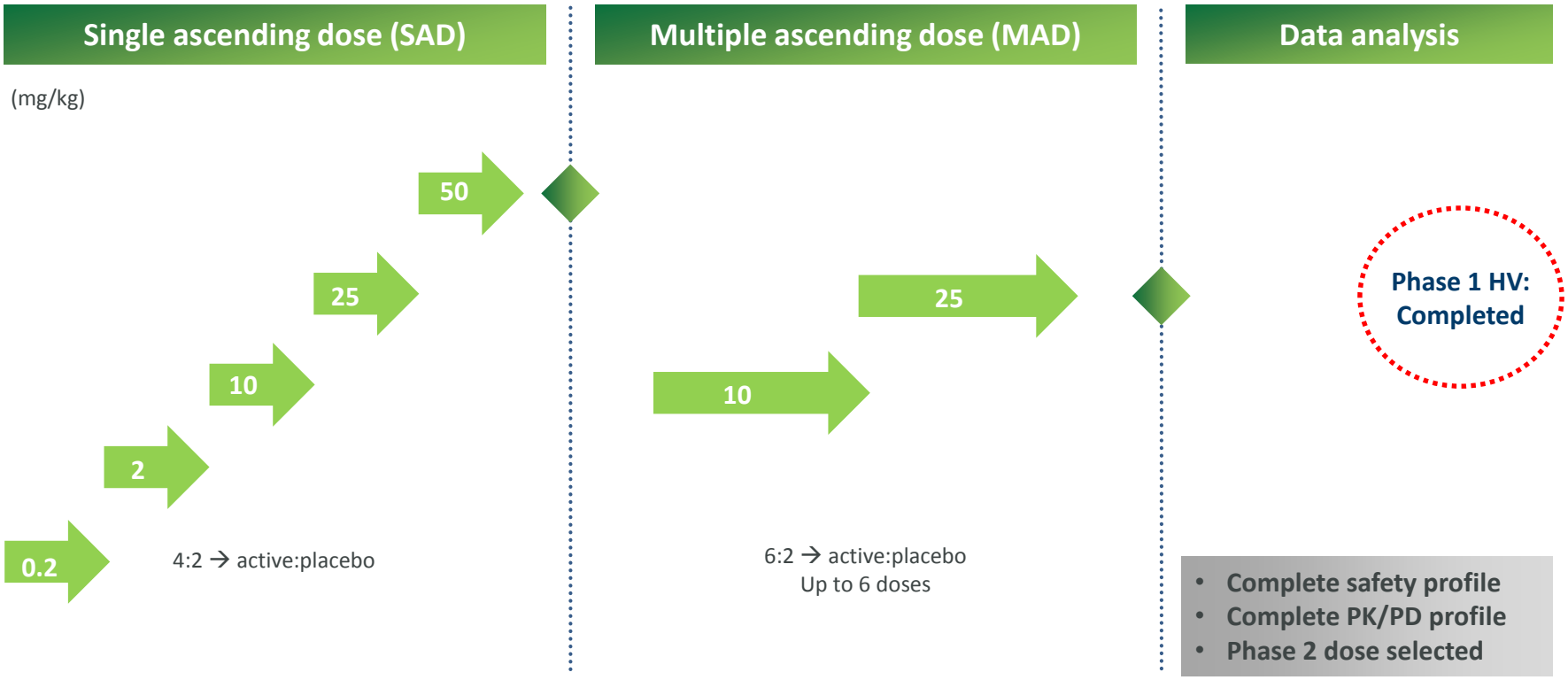


Auto-antibodies (predominantly IgG4 type) sterically hinder desmosomal adhesion and assembly – no complement involvement or immune effector activation[2]

(1) Collective Acumen study (2) Kasperkiewicz et al. 2017, Nature Reviews
(3) Colliou et al. 2013, Autoimmunity (4) Joly et al. 2017, Lancet

ARGX-113: Favorable Safety & Tolerability Profile

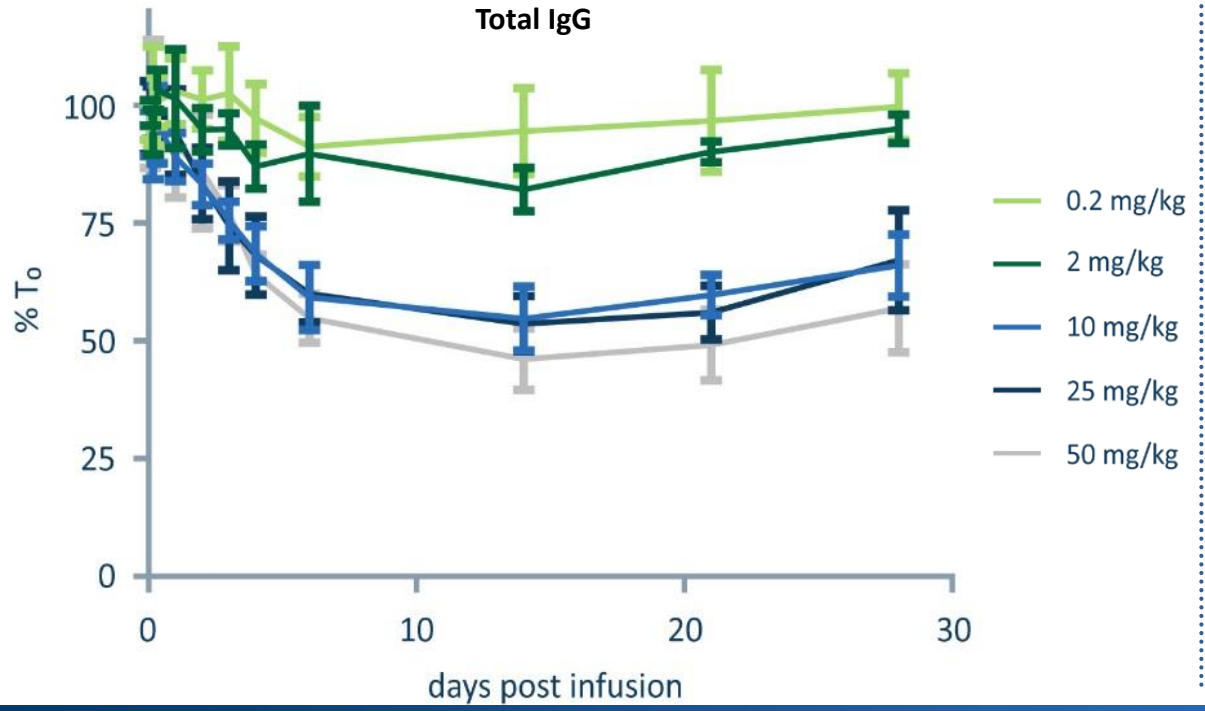
Phase 1 design: Double-blind, placebo-controlled trial in healthy volunteers

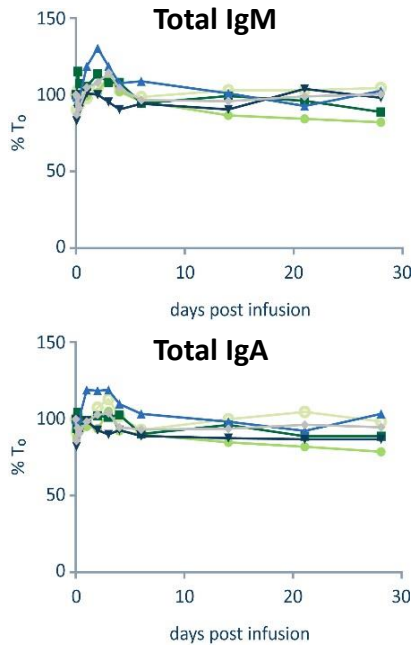


- SAD & MAD studies completed according to plan (62 healthy volunteers in total)
- Reported to be well tolerated in single and multiple doses of up to 25 mg/kg

ARGX-113: Selective IgG Reduction seen in Phase 1

Single ascending dose escalation study (SAD) in healthy volunteers (single 2hr infusion)





- ~50% IgG reduction (maximal PD effect) as of 6 days after infusion
- Selective IgG reduction, no significant reductions in IgM/IgA and albumin levels
- Low IgG levels maintained for more than four weeks after the last dose
- Saturation of PD effect observed at 10 mg/kg dose

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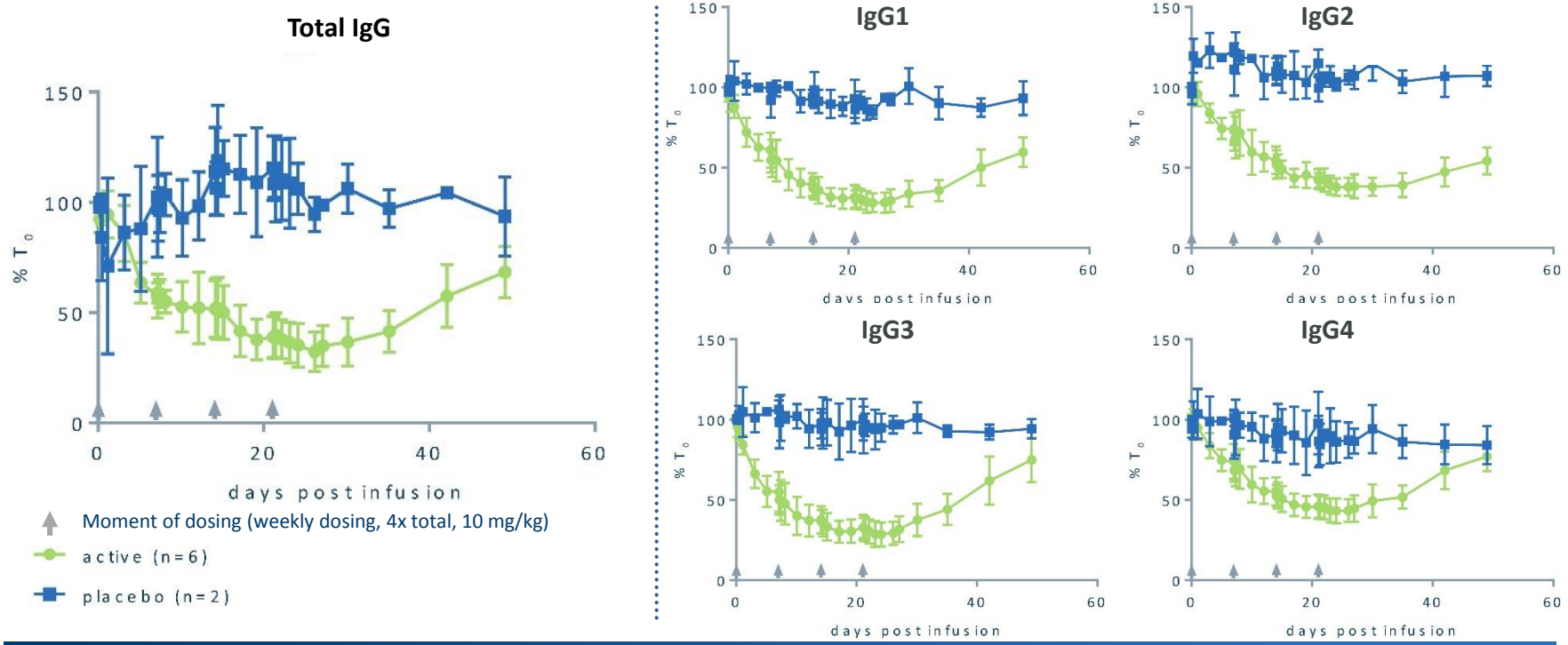
ARGX-113: Potent and Lasting IgG Reduction seen in Phase 1

PD data multiple ascending dose (MAD) study in healthy volunteers

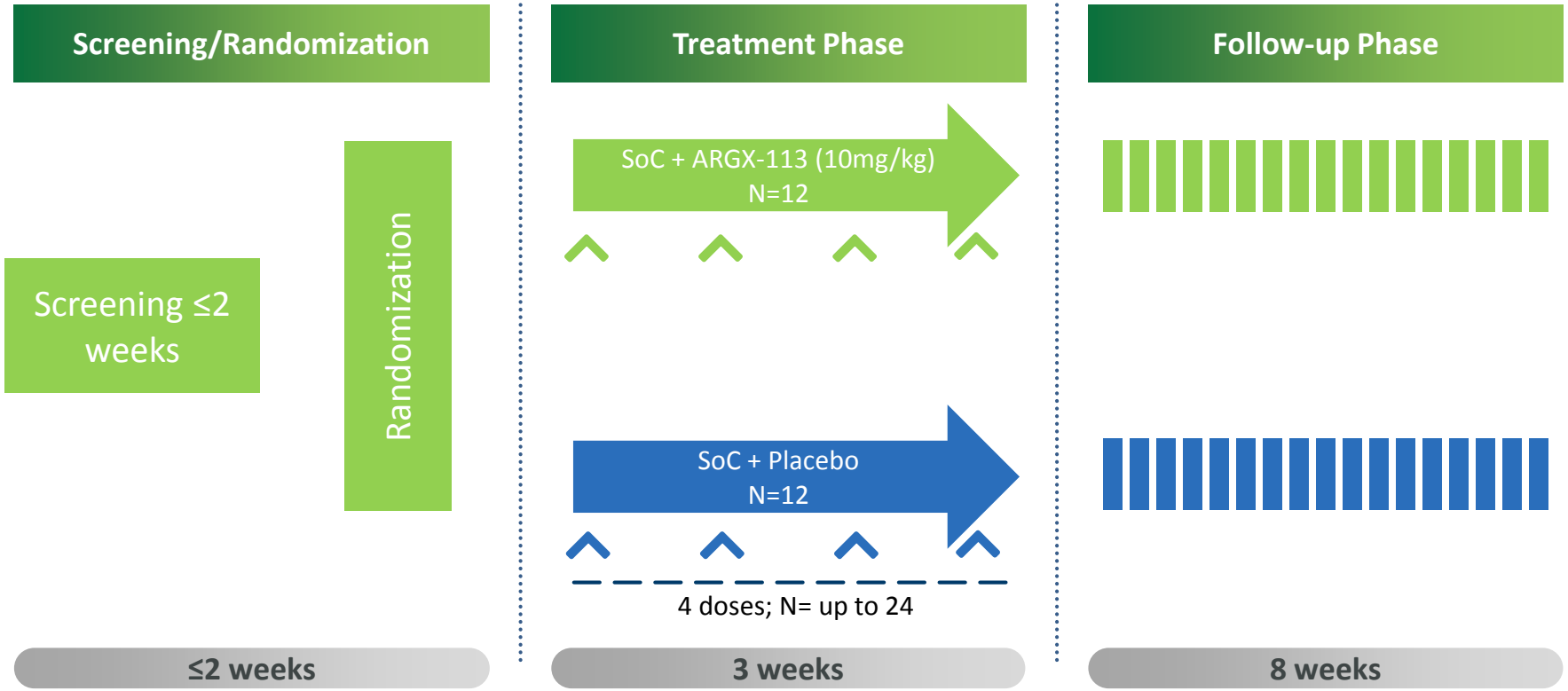
Dosing 10 mg/kg; every 7 days



- Potent IgG reduction accross isotypes (AChR autoantibodies are IgG1/3; MuSK autoantibodies are IgG4)
- IgG reduction: 50% achieved in 1 week; up to 85% maximum reduction
- After last dose, IgG levels remain reduced by 50% or more for ~3 weeks, return to baseline after > 1 month
- Comparable data for 25 mg/kg, every 7 days (data not shown)

ARGX-113 in MG: Phase 2 Trial Design

Study
100% recruited
Oct 2017

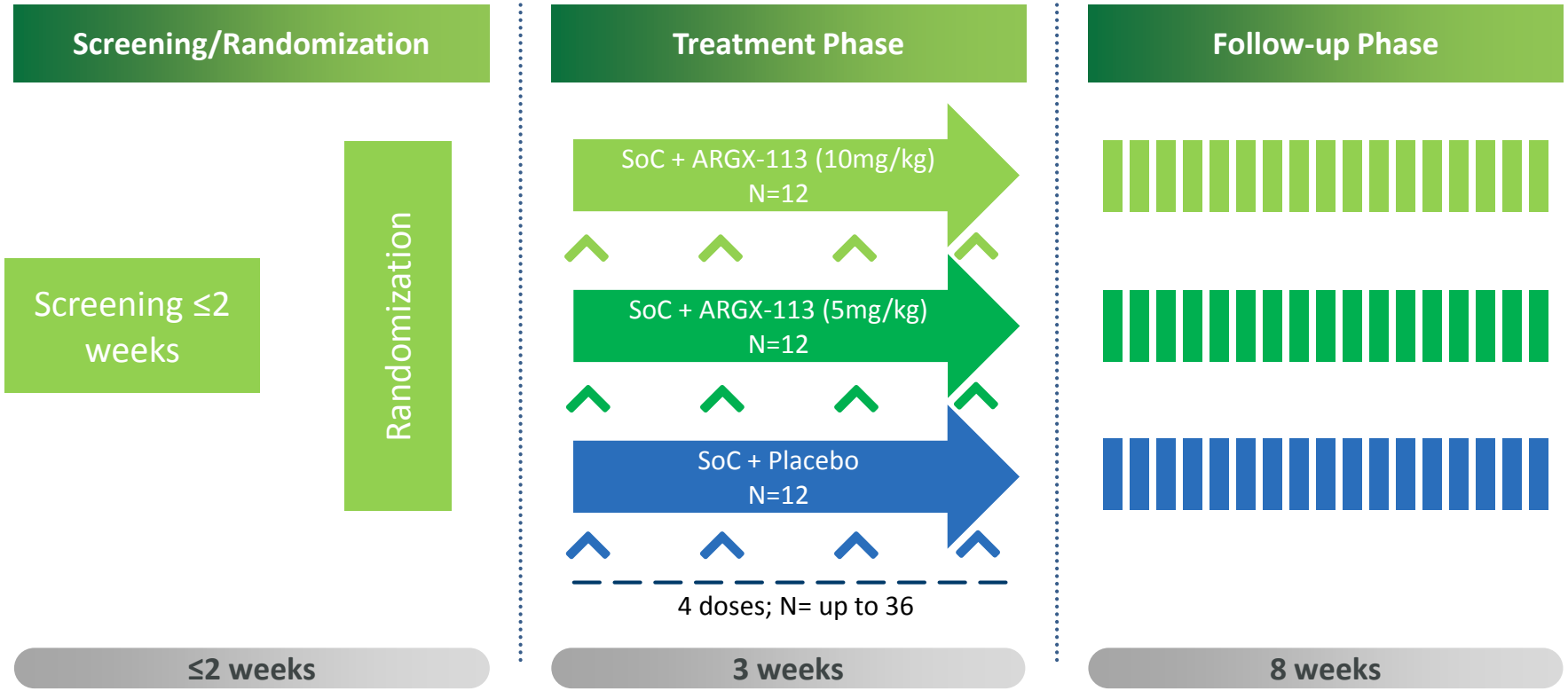


- Population: MG patients with generalized muscle weakness with total MG-ADL score ≥ 5*
- Primary Objectives: Evaluate safety and tolerability
- Secondary Objectives: (i) Evaluate efficacy, impact on quality of life and immunogenicity
  (ii) Assess pharmacokinetics (PK) and pharmacodynamics (PD) markers

argenx data, *> 50% of this score attributed to non-ocular items.

ARGX-113 in ITP: Phase 2 Trial Design

Study
50% recruited
Sept 2017



- Population: ITP patients with platelet levels < 30 X 10^9/L
- Primary Objectives: Evaluate safety and tolerability
- Secondary Objectives: (i) Evaluation of efficacy based on platelet counts, use of rescue treatment & bleeding events
  (ii) Assess pharmacokinetics (PK) and pharmacodynamics (PD) effect
  (iii) Evaluate immunogenicity

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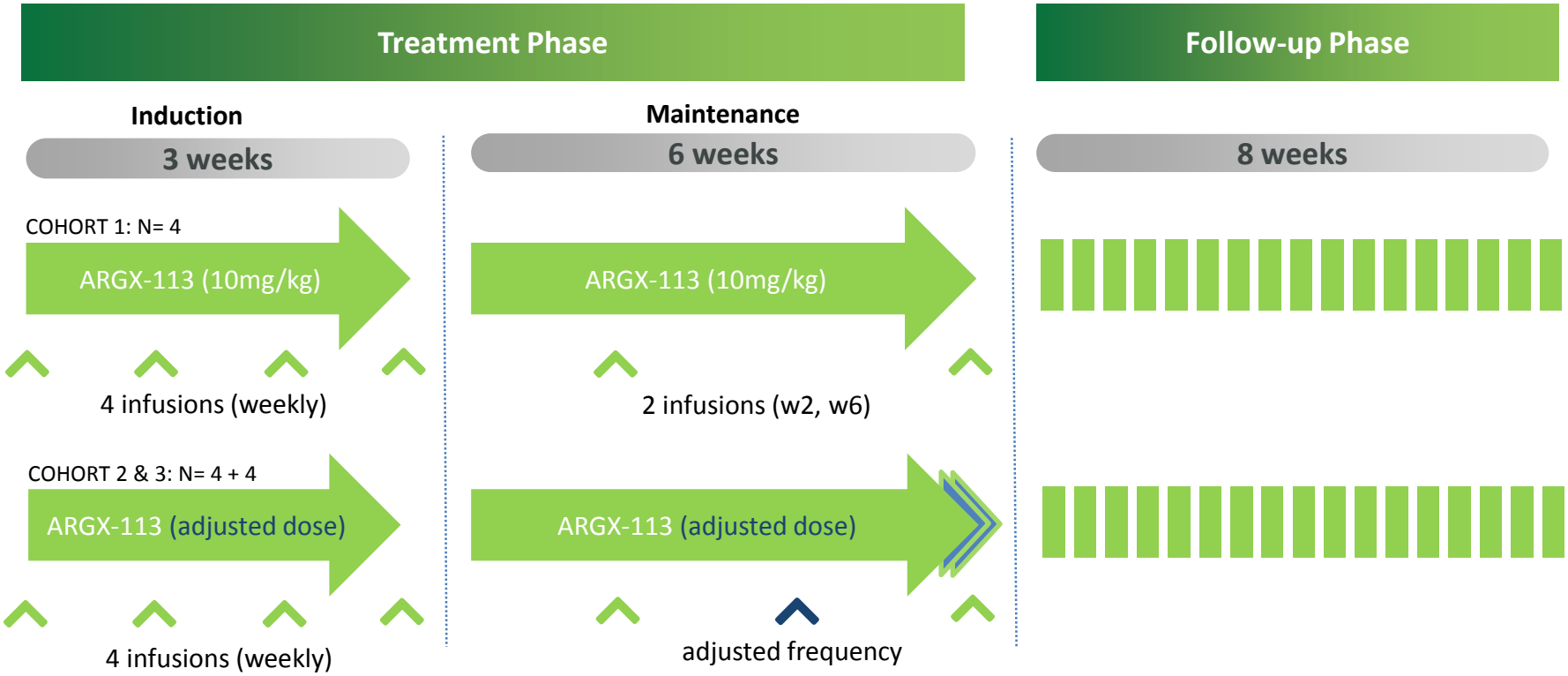
ARGX-113 Phase 2 study : IDMC-driven adaptive design

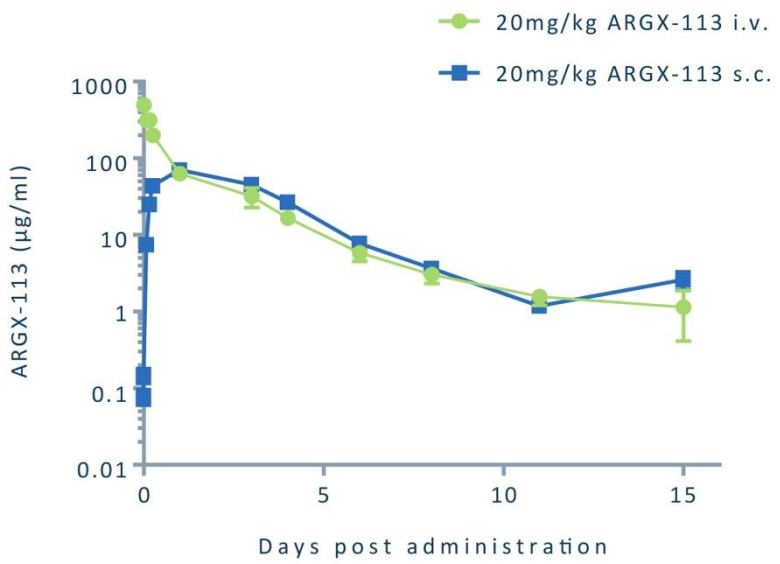


- Patients enrollment divided in 3 sequential cohorts
- IDMC recommendations for cohorts 2 & 3:
  - Change of dose (max dose of 25mg/kg)
  - Frequency of administration at maintenance (max 2 extra doses after each cohort)
  - Expansion of maintenance duration

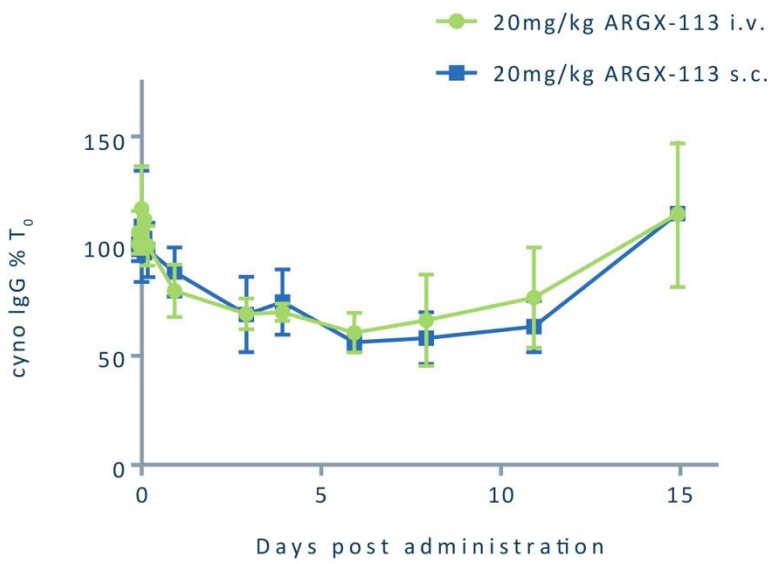
ARGX-113: Feasibility of SubQ Dosing

Exploring SubQ formulations for larger patient populations (chronic, ex-hospital)

PK single dose administration: IV vs SubQ (in cyno)



PD single dose administration: IV vs SubQ (in cyno)

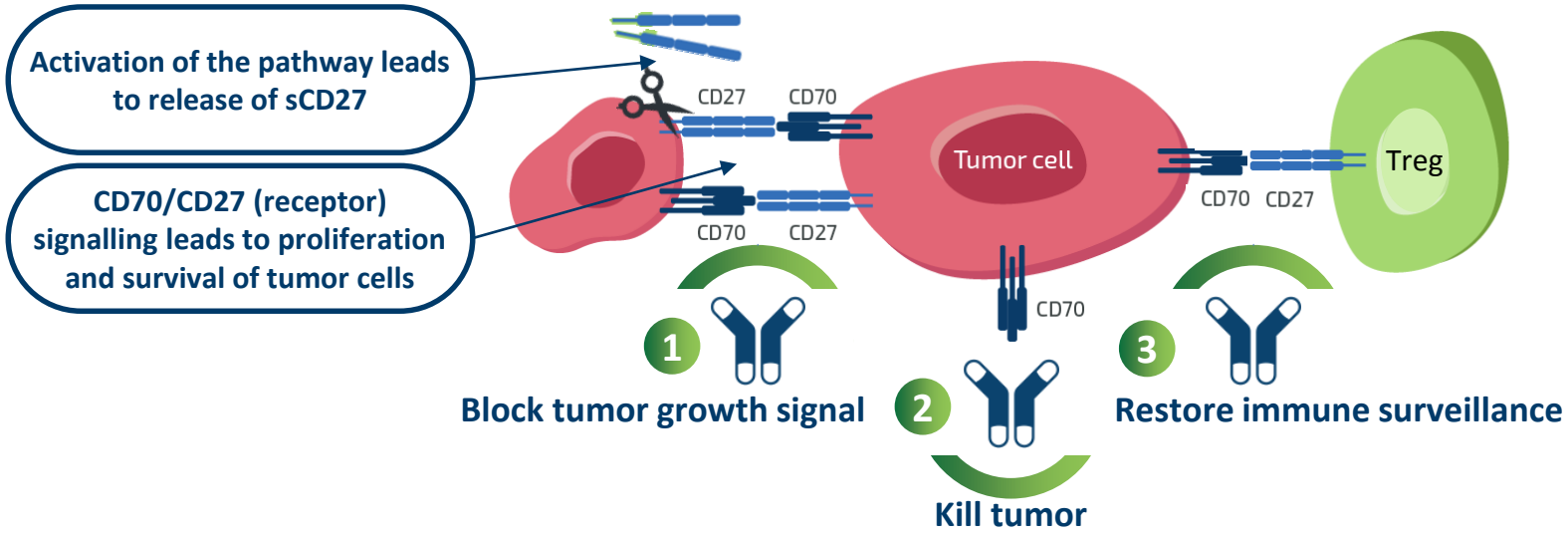


- Comparable PK and PD of IV versus SubQ dosing in preclinical studies demonstrated
  - Comparable half life
  - Favorable bio-availability of the compound in SubQ dosing (> 75%)
  - Comparable reduction of IgGs with single dose; up to 50%

ARGX-110: Phase 1 / 2 Mono & Combo Therapy

ARGX-110: Lead Cancer Program Based On Novel Target CD70

Three distinct modes of action to target CD70+ tumor cells



- ARGX-110 is a SIMPLE Antibody™, equipped with POTELLIGENT® Fc engineering technology
- ARGX-110 targets CD70 to block CD27 interaction, kill CD70 expressing cells and restore immune surveillance
- Soluble CD27 is a biomarker
- Phase 1: encouraging safety & tolerability profile and promising preliminary signs of efficacy in CTCL
- Focus on two rare & aggressive hematological tumors: CTCL and newly diagnosed AML / high-risk MDS
  - Interim results from dose escalation part of Phase 1/2 AML/MDS trial expected YE:2017
  - Interim POC data from Phase 2 CTCL trial expected YE:2017

Silence et al. 2014, mAbs.

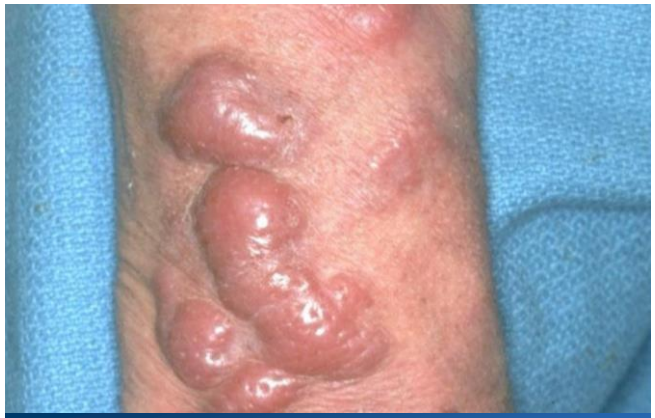
Cutaneous T-Cell Lymphoma: Fact sheet

What is Cutaneous T-Cell Lymphoma?

- Rare and incurable sub-type of T-cell lymphoma
- Prevalence (US & Canada): ~ 30,000 & Incidence (US): ~ 3,000[1]
- Patients typically diagnosed in their 60s
- Mycosis fungoides (50%), Sézary syndrome most common types [2]
- Symptoms include: severe rash, itching, tumor, skin Infections
- Skin infection often cause of death

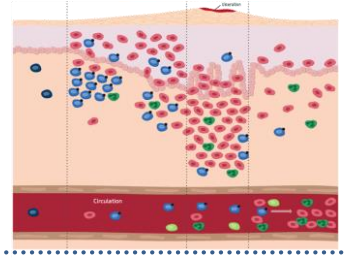
Limited current treatment options

- Initial treatment includes topical dermatology agents (corticosteroids, PUVA, e-beam therapy)
- Advanced stage patients treated with systemic oncology agents which are only moderately effective and not curative
  - Targretin bexarotene (oral) 1st line option – ease of administration
  - Istodax romidepsin (ORR: 34%, mDoR: 13-15 mos)[3] 2nd line – complicated dosing and myelosuppression
  - Antifolates (methotrexate, pralatrexate), Campath, chemo (Doxil, CHOP, etc)
- Heavily pre-treated, elderly patients are unfit for aggressive chemotherapy or stem cell transplantation
- Significant unmet need for effective, tolerable, long-lasting CTCL treatments



Cutaneous T-Cell Lymphoma Cause

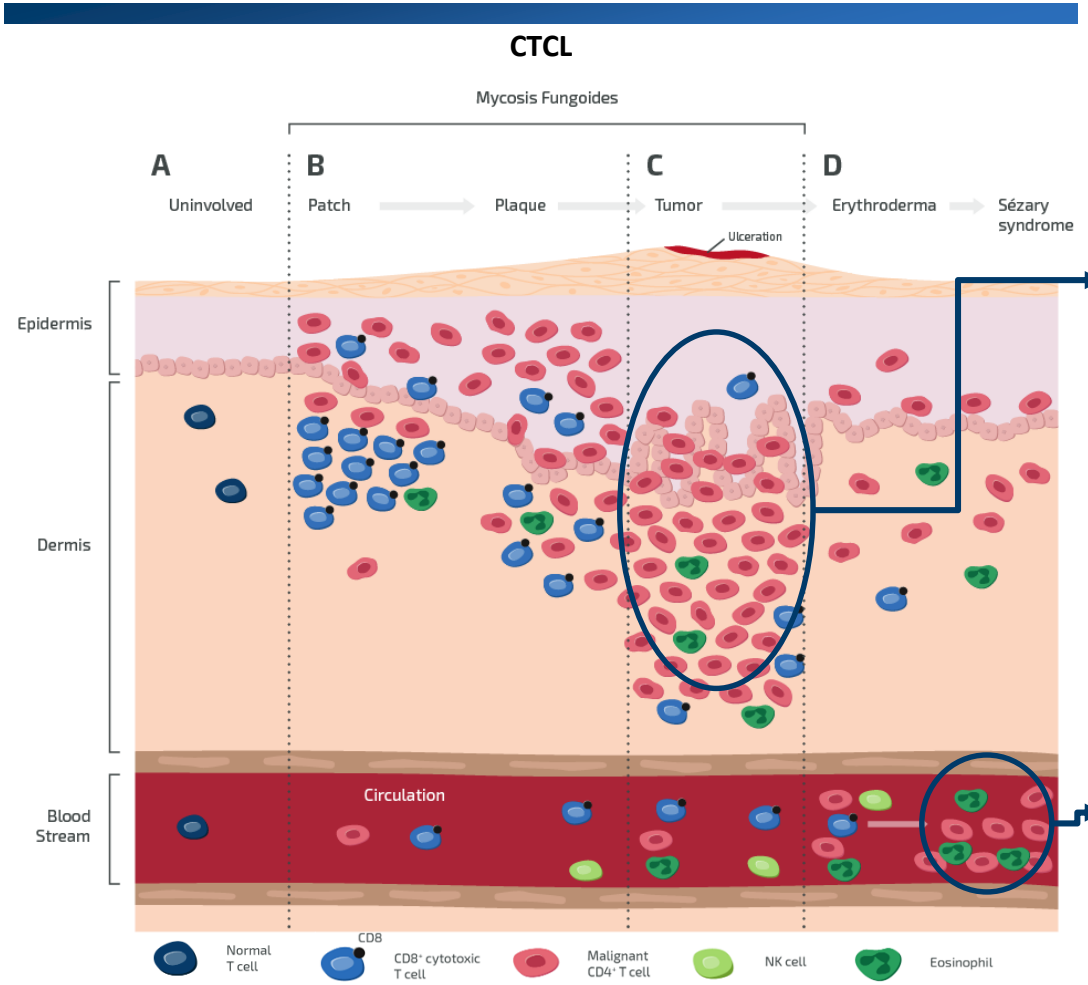
- Disease aetiology unknown
- Potentially caused by aberrant stimulation of CD4+ T-cells by Langerhans cells, specialized antigen presenting cells in skin
- Malignant T-cells become independent of stimulation by LCs and invade other tissues
- Sézary syndrome is a leukemic variant of CTCL



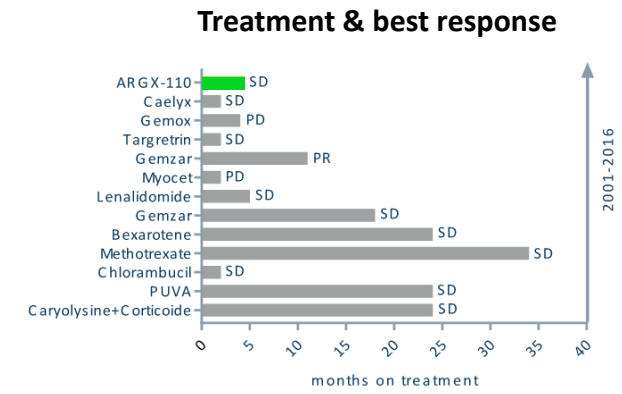
(1) Cutaneous Lymphoma Online Learning Center: http://www.clfoundation.org/online-learning-center/disease/faq/who-gets-cutaneous-lymphoma-how-many-people-have-it.
(2) Lymphoma Research Foundation: http://www.lymphoma.org/site/pp.asp?c=bkLTKaOQLmK8E&b=6300151
(3) http://www.istodax.com/hcp/ctcl/study-design/efficacy

ARGX-110 In Cutaneous TCL

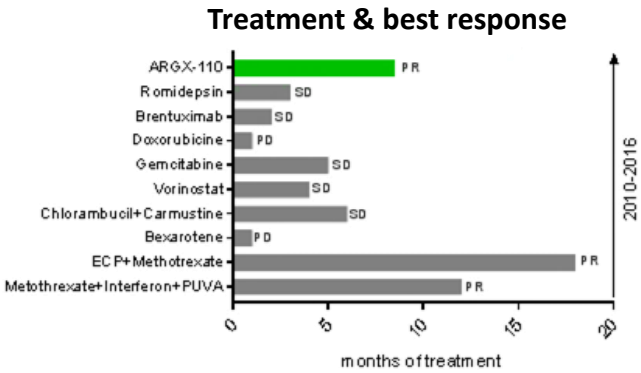
Phase 1-2: Typical patients are elderly and failing multiple lines of previous treatment



Example Mycosis fungoides (MF) patient



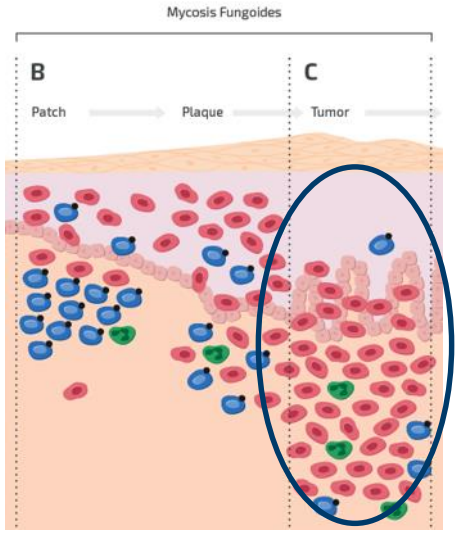
Example Sézary Syndrome (SS) patient



ARGX-110: Effect On Malignant Cells In Skin

Patient example 1: Cutaneous TCL – mycosis fungoides (MF)

Typical Mycosis fungoides (MF) patient

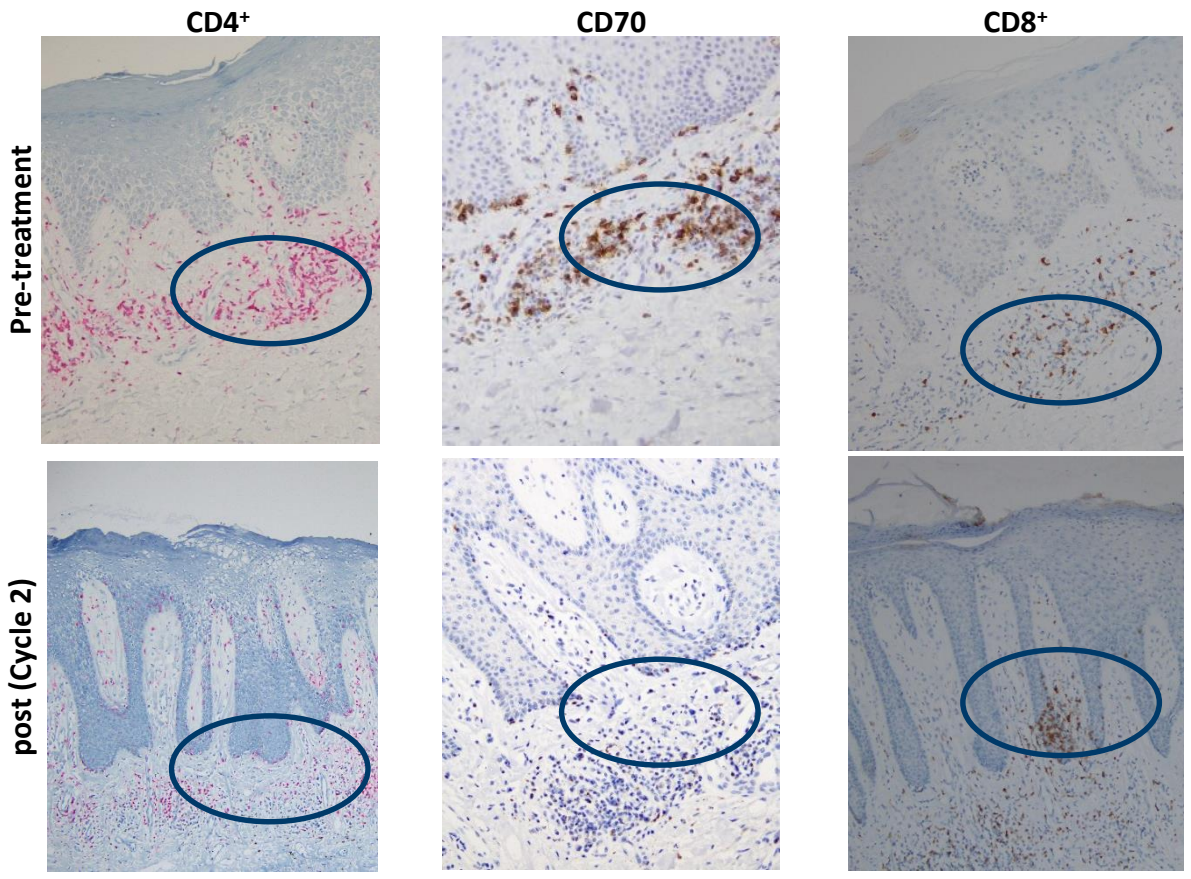


Patient	67 year old male CTCL-MF, diagnosed 2001
Tumor	Skin T4, Nx, M0, B0 (Stage IIIA)
Doses	6

Decrease of CD4+ malignant T-cells

Depletion of CD70+ malignant T-cells

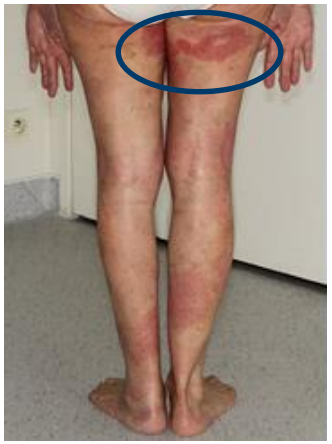
Infiltration of CD8+ T-cells

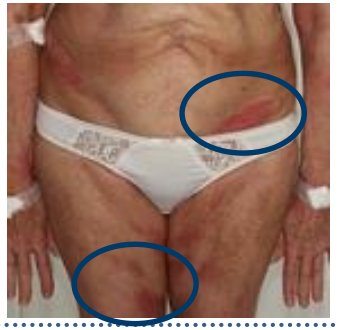


ARGX-110: Improved mSWAT & Skin Lesions

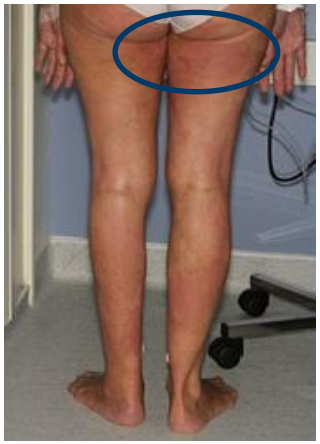
Patient example 2: Cutaneous TCL – mycosis fungoides (MF)

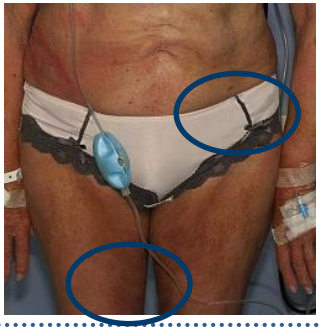
Pre treatment

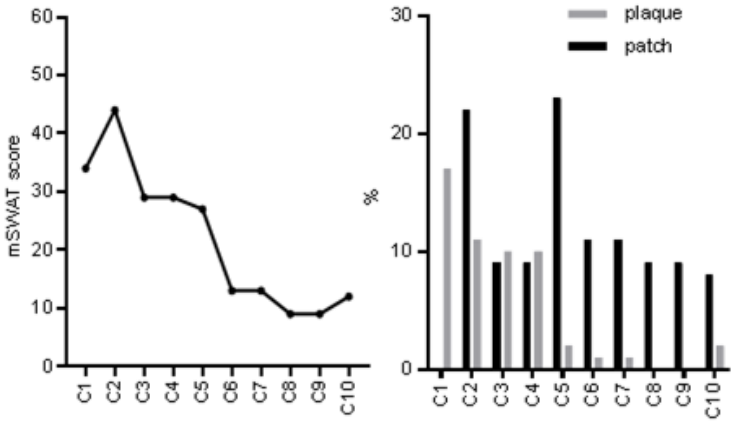




At cycle 6







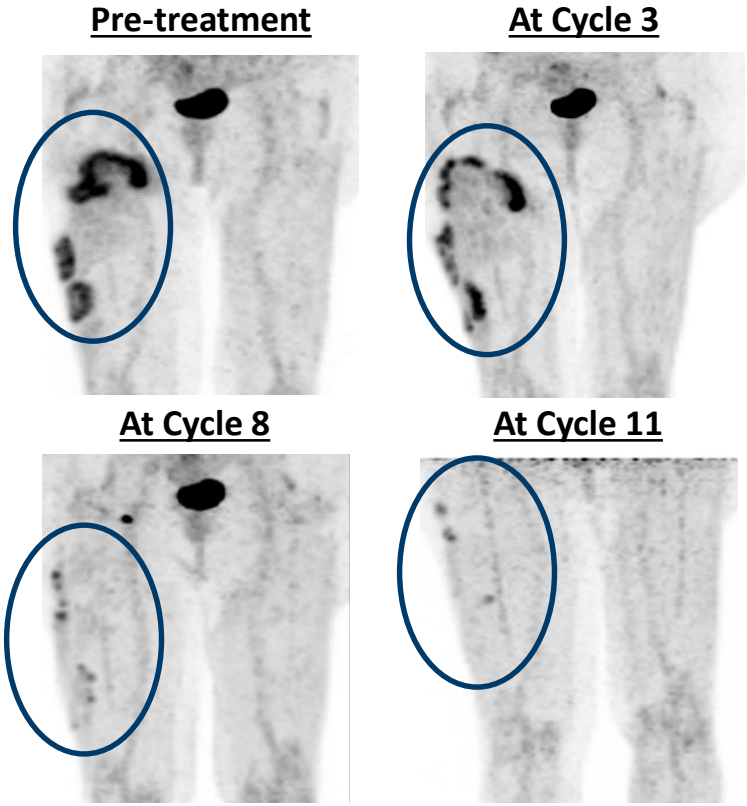
- 60% reduction of mSWAT score constitutes a partial response (PR)
- Decrease in surface area of cutaneous tumor lesions
- Lesions improve from plaques to patches
- Some lesions completely resolved

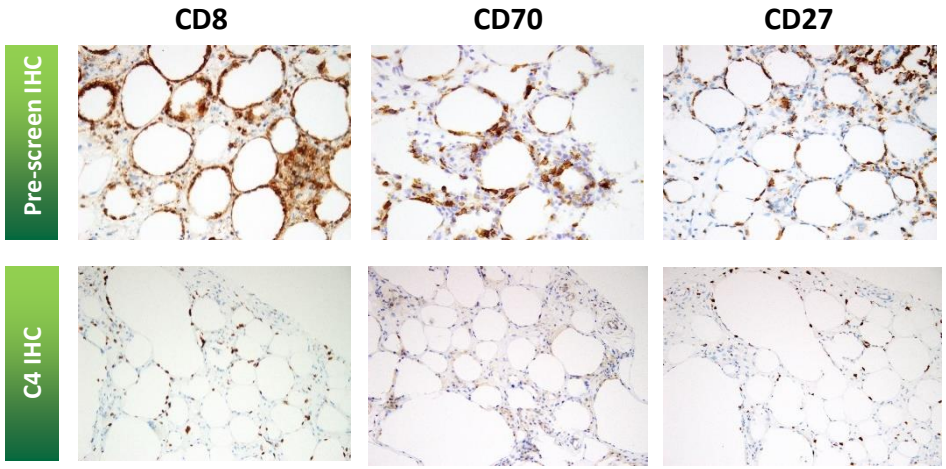
Patient	79 year old female with CTCL-MF, diagnosed 2007
Tumor	Skin T2, N0, M0, B0 (stage IB)
Doses	16, 1 mg/kg q3w

argenx data –patient anecdotes – uncleaned. Pictures kindly provided by investigator.

ARGX-110: Partial Response Confirmed by PET/CT

Patient example 3: CTCL (panniculitis like TCL type)





Patient	84-year old female, Diagnosed June 2015
Tumor	Skin T3, Nodal N0, Visceral M0, Blood B0
Doses	11, ongoing

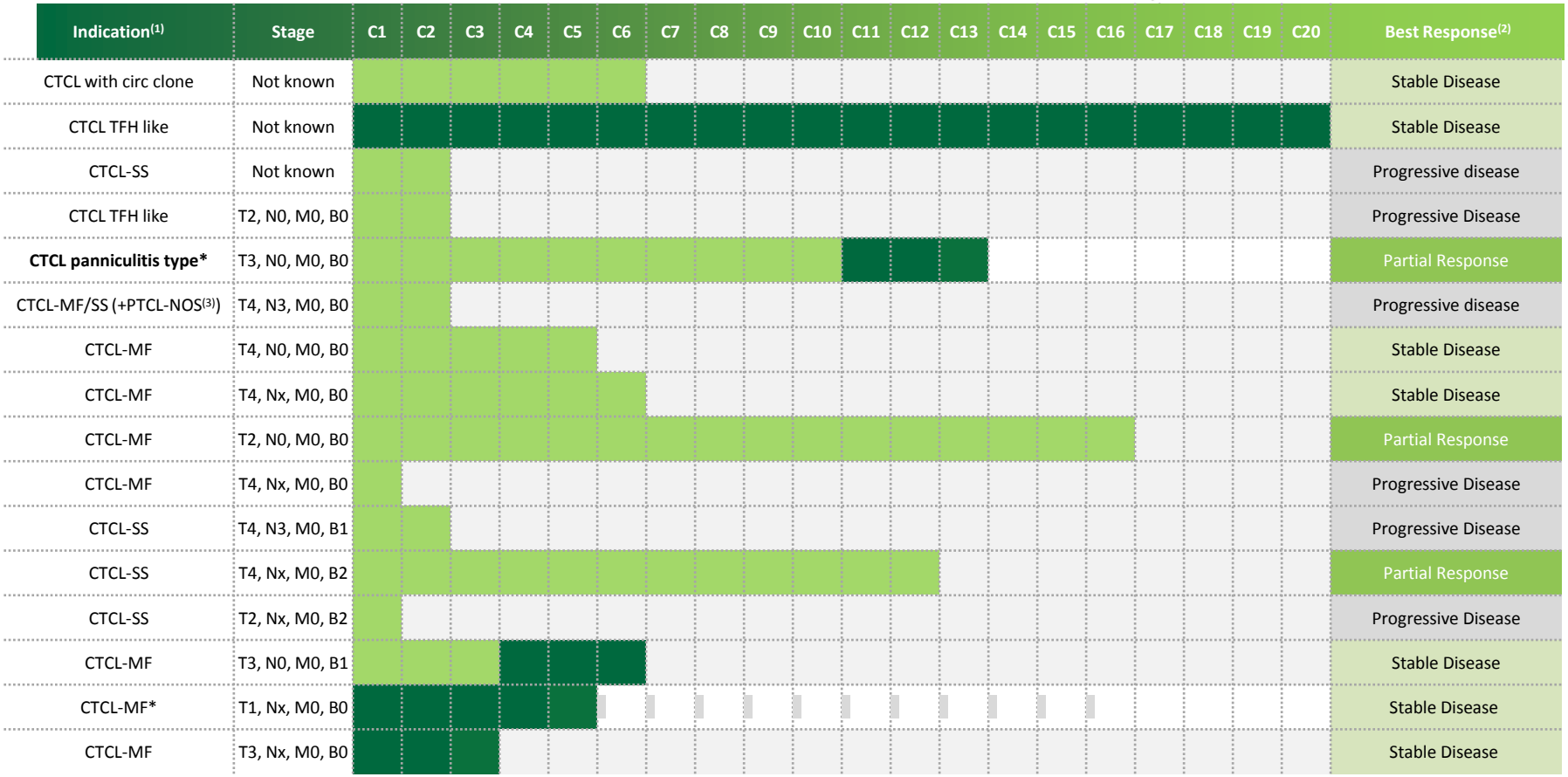
- Partial Response after 5 doses (dose 1 mg/kg)
- Further improvement through cycle 8 to 11 cycles (dose increased to 5 mg/kg)
- Patient now on maintenance dose of 5 mg/kg q6wk

argenx data –patient anecdotes – uncleaned. Pictures kindly provided by investigator.

ARGX-110 Shows Activity Across CTCL Types & Disease Stages

Interim Phase 1b data in CTCL

June 1, 2017



- Encouraging signs of clinical activity
- Heavily pre-treated patients on study dosed up to 16 cycles
- Itching often disappears after first cycle(s)

Number of cycles on study, one cycle = 3 weeks, 17 cycles = ~1 year

1 mg/kg 5 mg/kg

argenx data (uncleaned)

* Still on study as of June1, 2017

(1) CTCL = cutaneous T-cell lymphoma; MF = mycosis fungoides; SS = Sézary syndrome.

(2) Based on modified Severity Weighted Assessment Tool (mSWAT) scoring, a common method of scoring skin lesions in CTCL; assess number and severity of lesions as and total body surface area affected. Stable disease = mSWAT score does not increase by >25%; partial response = at least 50% reduction in mSWAT score; complete response = 100% reduction in mSWAT score.

(3) NOS: not other specified. PTCL-NOS is the most common TCL subtype.

Acute Myeloid Leukemia (AML) Overview

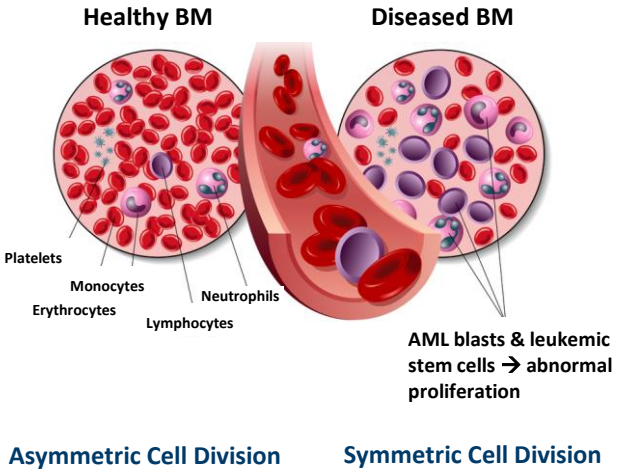
What is Acute Myeloid Leukemia?

- Rare hematologic cancer characterized by **excessive proliferation of myeloid stem cells** and their **failure to properly differentiate into mature white blood cells**
- Symptoms include: weight loss, fatigue, fever, night sweats, loss of appetite, shortness of breath, easy bruising, infections, bleeding
- Disease progresses very rapidly and is fatal if left untreated
- ~22,000(1) new cases per year in the U.S. — **2nd most common leukemia subtype** in adults
- Generally a **disease of the elderly** — 60% of diagnosed patients are older than 60

Limited current treatment options

- **Elderly, frail patients** are typically unfit for high dose chemotherapy — **receive palliative treatment with hypomethylating agents**
  - Median survival of 7 – 10 months
  - 5 year survival rate of ~6%(2) for patients over 65
- Younger patients (<45yr) typically get aggressive chemotherapy ("7+3" regimen) to induce remission followed by stem cell transplant
  - 5 year survival rate of ~57%(2) for patients under 45
- **Significant need for safer and more effective treatment options**

Effects of AML on Bone Marrow



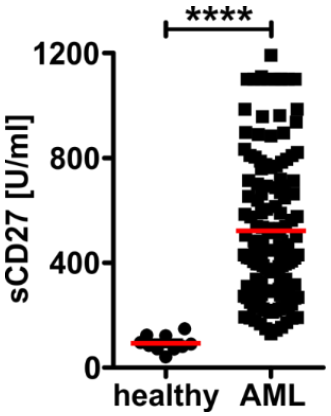
(1) American Cancer Society: http://www.cancer.org/cancer/leukemia-acutemyeloidaml/detailedguide/leukemia-acute-myeloid-myelogenous-key-statistics .
(2) National Cancer Institute: Howlader et al. (eds). SEER Cancer Statistics Review, 1975-2013, National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2013/, based on November 2015 SEER data submission, posted to the SEER web site, April 2016. Table 13.16

CD70 Unifying Rationale Across Risk & Age Classes in AML

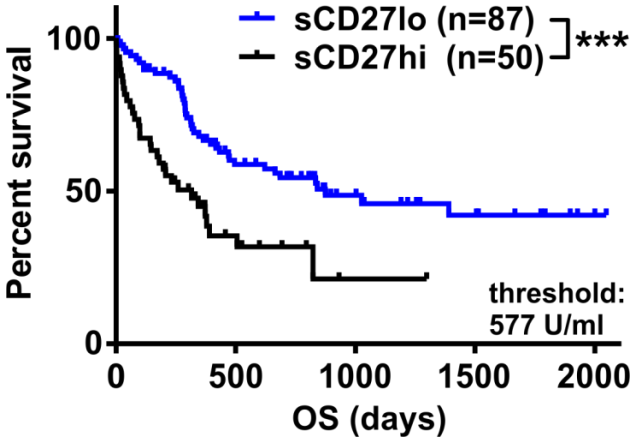
Potential to selectively target leukemic stem cells in AML patients

Elevated sCD27 serum levels correlate with poor prognosis

CD27 serum levels

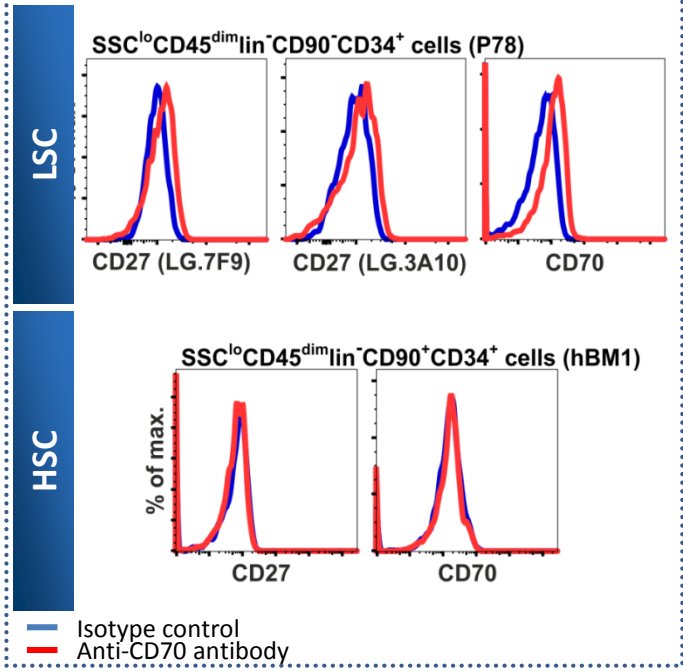


Prognosis AML patients



CD70 is selectively overexpressed on LSCs

CD70 expression

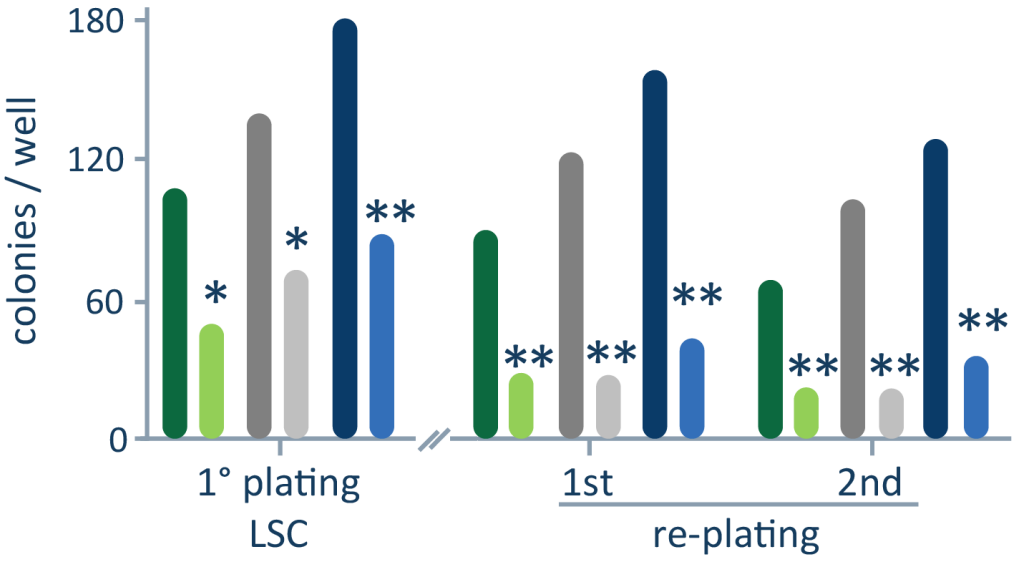


- Elevated sCD27 serum levels in all newly diagnosed AML patients, **regardless of risk or age categories**
- sCD27 levels are an independent **negative prognostic marker in all newly diagnosed AML patients**
- **CD70 expressed on ~100% of AML blasts**, majority of malignant cells are CD70/CD27 double-positive
- **CD70/CD27 selectively overexpressed on Leukemic Stem Cells (LSCs)**, not on Hematopoietic Stem Cells (HSCs)

Riether et al. 2017, J Exp Med.

ARGX-110: Inhibits LSC Proliferation In Lasting Fashion

Long-term effects *ex vivo*



After o/n incubation colony assays (14d)
+ARGX-110 variant

Bulk cells from 1st colony

Serial re-platings
-ARGX-110 variant

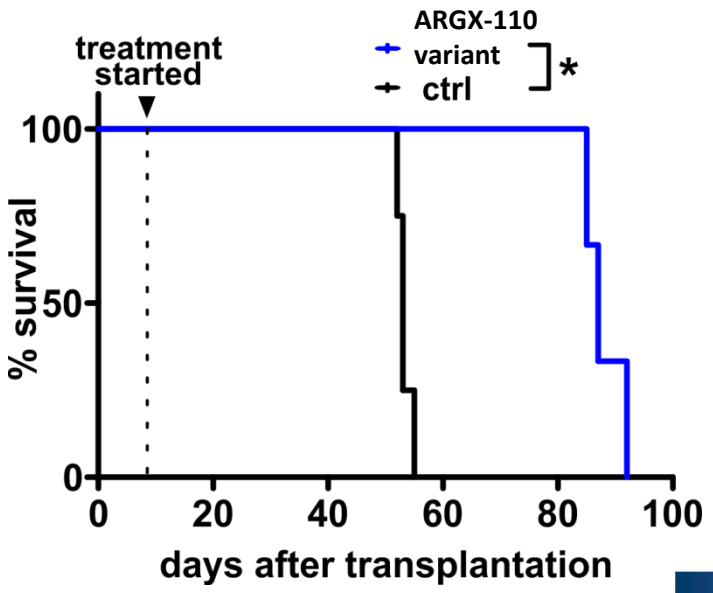
ARGX-110 variant = ARGX-110 without Fc effector functions

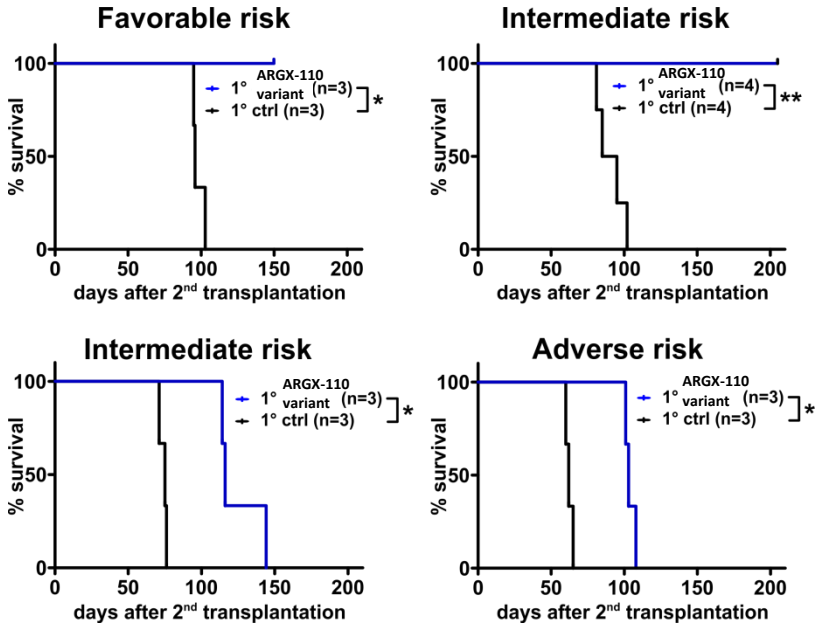
- Reduces LSC colony formation across patient risk categories (favorable/intermediate/adverse risk)
- Reduces LSC numbers as determined in serial re-plating experiments
- Blocking CD70 results in: (1) lasting down-regulation of stem cell genes (2) **increasing myeloid differentiation**

Riether et al. 2017, J Exp Med.

ARGX-110: Curative Potential Of Monotherapy In Mouse Model

Shown to reduce LSCs, increasing survival in AML model





Initial in vivo treatment
+ARGX-110 variant

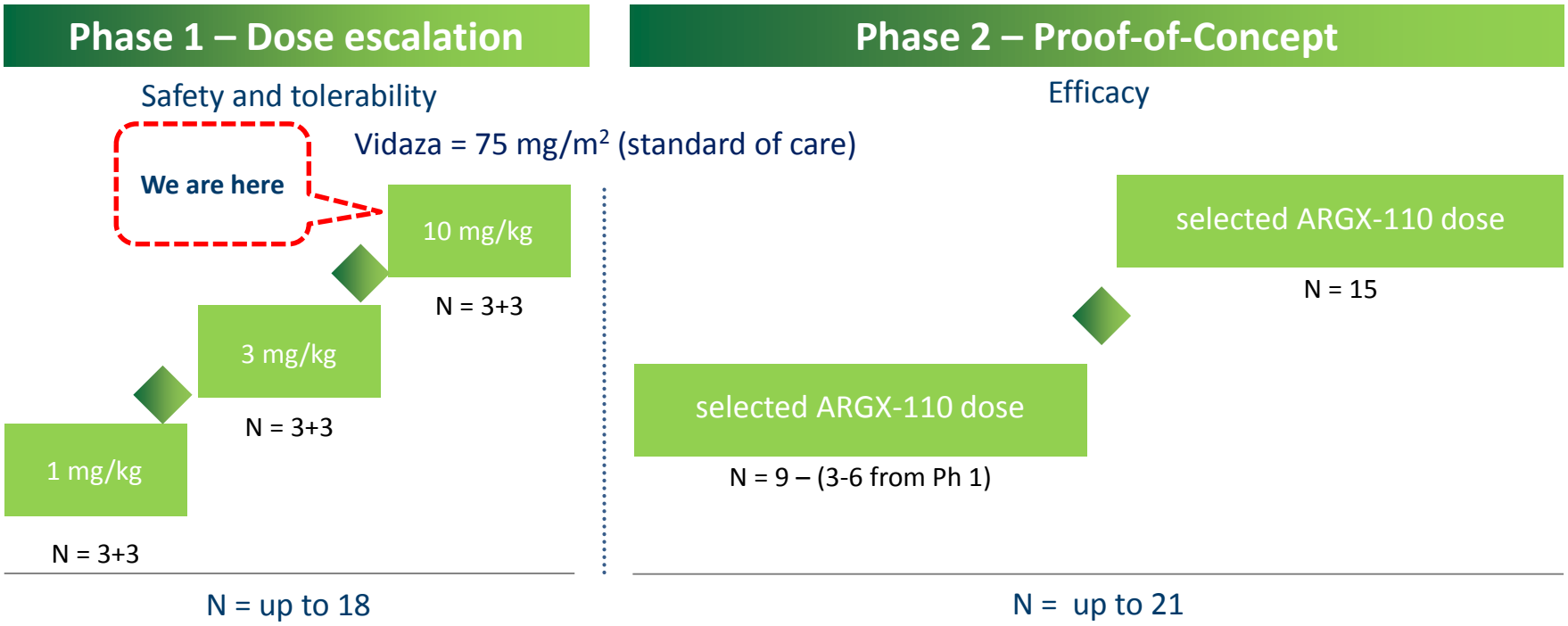
Grafting Whole Bone Marrow cells from treated into new mice (14d after start of treatment)

Transplant, evaluation
-ARGX-110 variant

- Increased survival after secondary transplantation of AML BM cells from primary recipients transiently treated with ARGX-110 variant
- Increased survival observed for AML blasts taken from all 3 AML risk categories (fav/int/adv)

Riether et al. 2017, J Exp Med.

ARGX-110 & Azacitidine For AML/MDS: Phase 1 / 2 Combo



- Hypomethylation agents such as Azacitidine increase CD70 expression[1]
- Population: untreated AML & high risk of myelodysplastic syndrome (MDS)*, eligible for AZA
- Design: open-label, non-controlled, non-randomized

*Some Myelodysplastic Syndrome (MDS) patients are at high risk of developing AML; MDS affects bone marrow cells, reducing their ability to produce red & white blood cells

(1) Zhou et al. 2011, Lupus.

Business development & financials

AbbVie Partnership for Novel Target GARP

Strategic Antibody Collaboration Details

- **GARP** is a protein specifically present on the surface of activated regulatory T-cells (Tregs)
- **AbbVie** has option to
  - obtain exclusive, worldwide license to develop and commercialize ARGX-115
  - fund further GARP-related research by argenx beyond ARGX-115
- **argenx** conducts and funds all R&D through completion of IND-enabling studies
- **argenx** retains rights to combine ARGX-115 with its pipeline programs

Financial Highlights

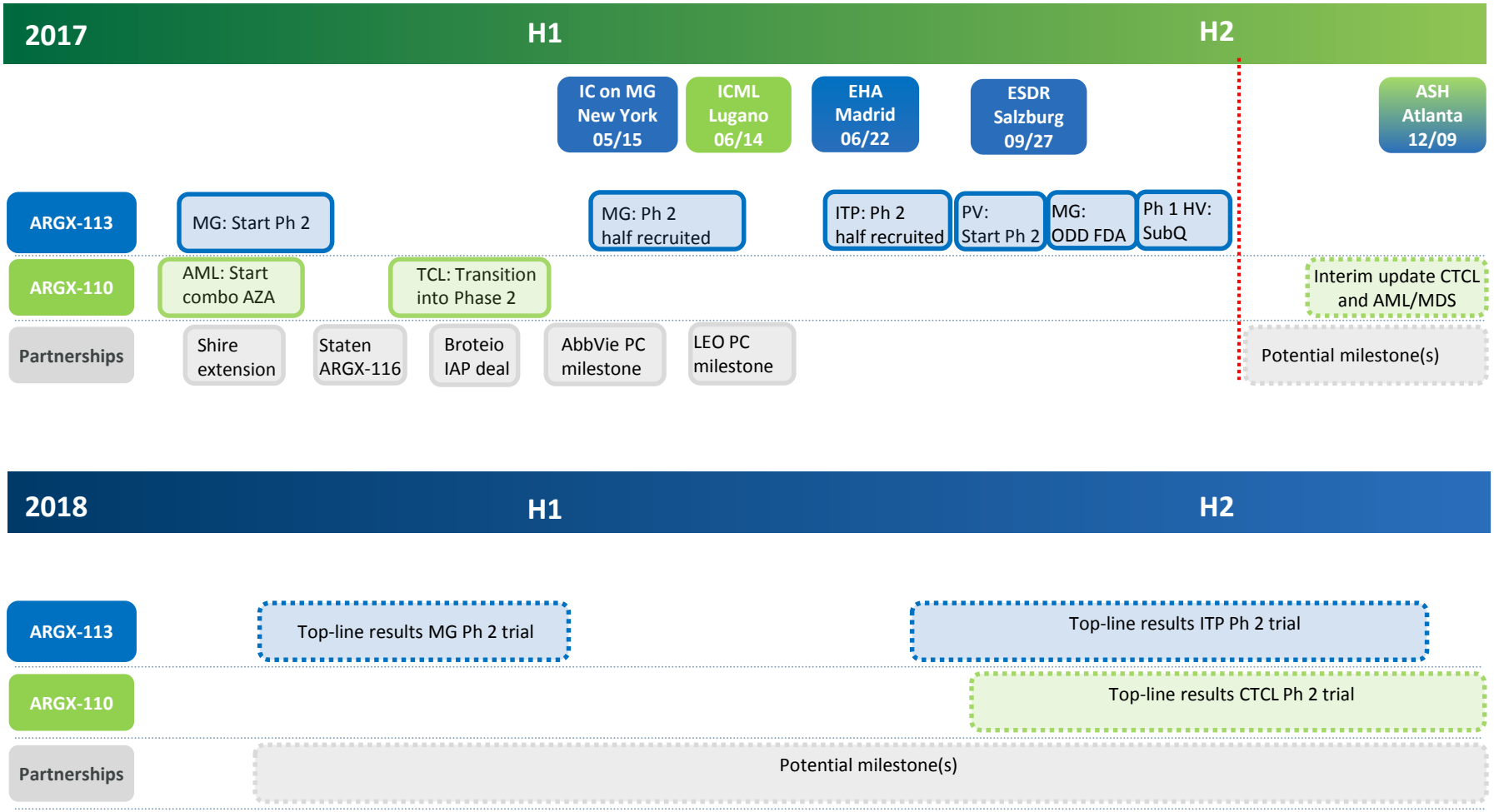
- **$40mm upfront payment**
- **Received** first of two **$10mm** preclinical milestones
- **$625mm in potential** development, regulatory and commercial **milestones**
- **Tiered royalties** on sales at percentages ranging from **mid-single digits to low teens**
- **Co-promotional** rights for ARGX-115-based products in the **European Economic Area and Switzerland**

Cuende et al., 2015, Science Trans Med.

Additional Strategic Collaborations

Partner	Asset	Key commentary
BIRD ROCK BIO	**ARGX-109** (Gerilimzumab)	• Focused on developing an anti-IL-6 antibody for **Rheumatoid Arthritis** • Bird Rock responsible for all costs incurred in R&D and commercialization
LEO	**ARGX-112**	• Focused on **inflammation-based dermatological indications** • LEO Pharma funds >50% of all development costs up to CTA approval and all development post-approval of first Phase 1 trial in Europe • argenx is eligible for ~€100mm in aggregate milestone payments + tiered royalties
STATEN BIOTECHNOLOGY	**ARGX-116**	• Focused on developing an anti-ApoC3 antibody for **dyslipidemia** • Jointly responsible for conducting dyslipidemia research — Staten responsible for additional clinical development • argenx eligible for royalties in the low twenties
Broteio Pharma	**Undisclosed**	• Focused on developing a differentiated antibody against a novel complement target • Potential to act synergistically with ARGX-113 • Jointly responsible for development expenses until preclinical POC — argenx granted exclusive option to license program after achieving preclinical POC
Shire	**Discovery Programs**	• Focused on **novel rare disease targets** • Provides Shire access to SIMPLE Antibody™ platform + Fc engineering technologies • argenx has received $12mm in aggregate upfront and milestone payments and R&D fees over the course of the collaboration • Shire purchased €12mm of argenx ordinary shares through participation in July 2014 IPO

Key Upcoming Milestones & Communications



Appendix

Company Leadership

Management

Tim Van Hauwermeiren
Chief Executive Officer

Eric Castaldi
Chief Financial Officer

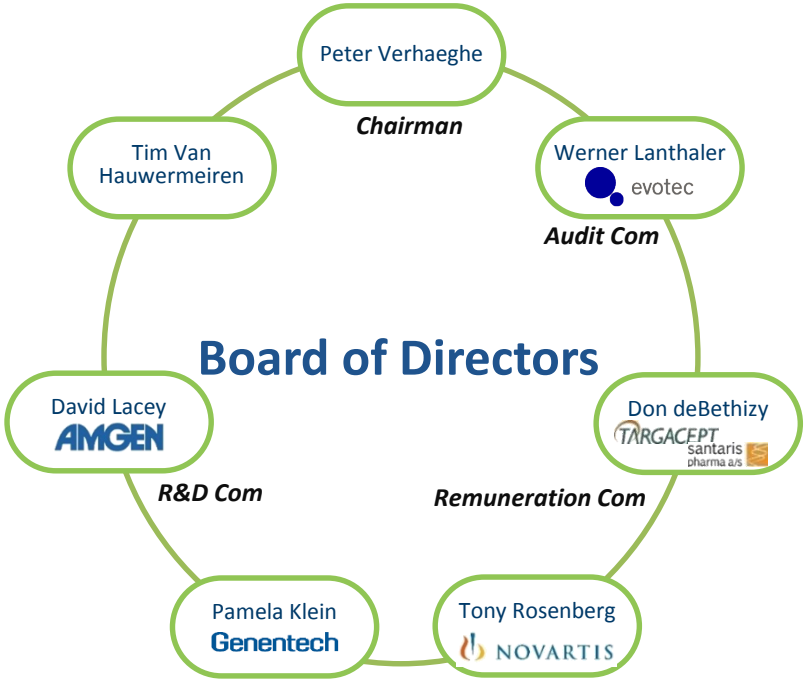
Hans de Haard, Ph.D.
Chief Scientific Officer

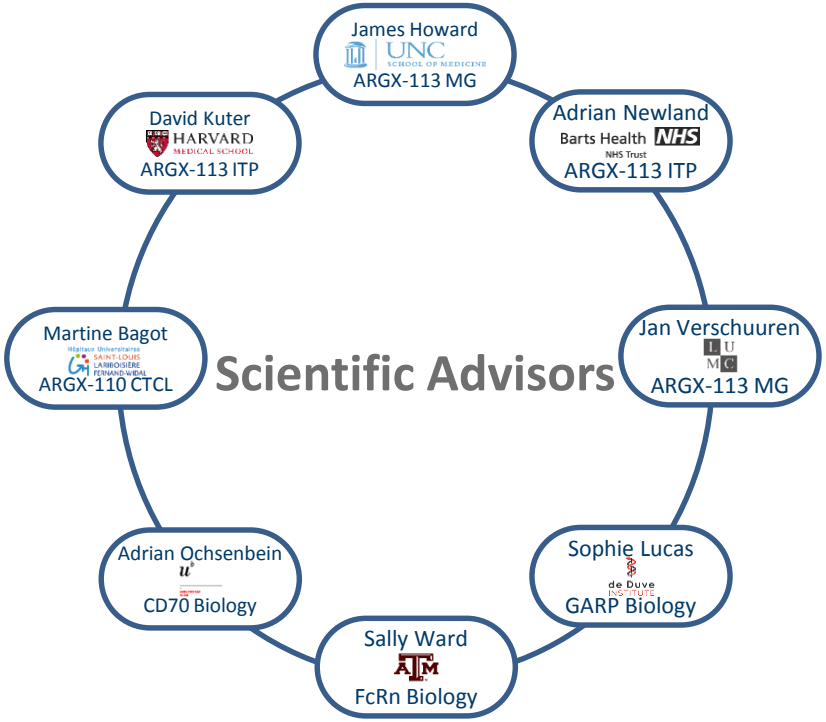
Torsten Dreier, Ph.D.
Chief Development Officer

Nicolas Leupin, M.D.
Chief Medical Officer

Debbie Allen, Ph.D.
SVP, Business Development

Dirk Beeusaert
General Counsel





argenx

Please Join argenx for a Lunch and Discussion during the ASH Annual Meeting

Advancing ARGX-110 to clinical proof-of-concept in acute myeloid leukemia (AML) & cutaneous t-cell lymphoma (CTCL)

Monday, December 11, 2017

12:00 PM – 1:30 PM

Omni Atlanta Hotel

South Tower Atrium Terrace
Birch Room
100 CNN Center NW
Atlanta, GA 30303
Next to Convention Center

Please RSVP by Monday, December 4

Rachel Frank
rachelf@sternir.com
212.362.1200

Agenda

Overview of AML
Gail Roboz, MD
Weil Cornell Medicine, New York

CD70: Novel AML Target
Hans de Haard, PhD, argenx

Phase 1/2 AML Trial: Proof-of-Biology Data
Nicolas Leupin, MD, argenx

Phase 1/2 CTCL Trial: Data Update
Nicolas Leupin, MD, argenx

Q&A

Guest Speaker

Gail Roboz, MD

Professor of Medicine and Director of Clinical and Translational Leukemia Program

Weill Medical College of Cornell University and New York Presbyterian Hospital

Following the presentation, please join us and our colleagues from the University of Bern for an informal mix and mingle.