Nektar Therapeutics
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Jennifer Ruddock:

Thank you. Good afternoon and thank you for joining us. With us today are Howard Robin, our president and CEO; Gil Labrucherie, our Chief Financial Officer; Dr. Ivan Gergel, our Chief Medical Officer; Dr. Steve Doberstein, our Chief Scientific Officer; Dr. Jonathan Zalevsky, our Senior Vice President of Biology and Dr. Mary Tagliaferri, our Senior Vice President of Clinical Development.

On this call, we expect to make forward-looking statements regarding our business, including potential regulatory approval decisions and commercial launch timings, the timing of future clinical trials and clinical trial results, clinical development plans, the economic potential of our collaboration partnerships, the therapeutic and market potential of certain drugs and drug candidates, as well as those of our partners, our financial guidance for 2017, and certain other statements regarding the future of our business.

Because forward-looking statements relate to the future, they are subject to inherent uncertainties and risks that are difficult to predict and many of which are outside of our control. Important risks and uncertainties are set forth in our Form 10-K which is available at sec.gov. We undertake no obligation to update any forward-looking statements, whether as a result of new information, future developments, or otherwise. A webcast of this call will be available on the IR page at Nektar's website at nektar.com.

With that, I will now turn the call over to Howard. Howard?

Howard Robin:

Thank you, Jennifer, and thank you to everyone for joining us today for our first quarter conference call.

On today's call, we will discuss the many upcoming milestones for Nektar's pipeline over the next year and we will reiterate our financial guidance for the remainder of 2017.

We had a highly successful first quarter with a number of significant accomplishments. First, we announced overwhelmingly positive Phase 3 efficacy and safety data for NKTR-181. I'll talk more about this important data and next steps for NKTR-181 in a moment.

Second, in Q1, we initiated the first clinical trial of NKTR-358, our first-in-class Treg stimulator that we are developing for the treatment of immune and inflammatory disorders. We've already completed the first dose cohort of the Phase 1 trial and Jonathan will discuss more on the trial and the development strategy for NKTR-358 later on the call.

We continue to advance our PIVOT clinical program with our collaborator Bristol-Myers Squibb to evaluate the combination of our lead I-O program NKTR-214 and BMS' anti-PD-1 agent Opdivo. We are pleased with the way the trial is progressing and we are currently bringing on additional investigator sites for the expansion phase of the trial that will begin in the third quarter of 2017. We look forward to seeing many of you at our event

at ASCO this year…and we've invited investigators to share preliminary data on the first patients enrolled in the dose-exploration phase of the study. Mary will cover more details on that in a moment and she will also discuss the trial that we are initiating next month for NKTR-214 in combination with Roche's anti-PDL-1 agent, TECENTRIQ.

For NKTR-214, as we've stated in the past, the BMS collaboration is the first of a number of collaborations for NKTR-214 which are designed to position NKTR-214 as a keystone therapeutic in I-O that is able to be combined with many different mechanisms in different cancer settings to improve patient outcomes. You'll hear more about our strategy with NKTR-214 on this call, and also about our next I-O development candidates – NKTR-262, a new TLR agonist which complements NKTR-214, and NKTR-255, our novel IL-15 agonist.

Nektar's impressive wholly-owned R&D pipeline across immuno-oncology, immunology, AND pain position us well for the coming year. In addition, our partnered portfolio includes existing products such as MOVANTIK with AstraZeneca, which is at a $160 million annual run rate in US sales with over 10,000 prescriptions written each week, and ADYNOVATE with Shire, which just noted on their last conference call, an annual run rate of $200 million. It also includes late-stage partnered and filed products, such as ONZEALD with Daiichi Sankyo, and the Bayer anti-infective programs.

For ONZEALD, which is partnered with Daiichi Sankyo Europe, the conditional marketing authorization is currently under review in Europe and

we are hoping for an opinion on the conditional approval in May. During the continued review of the ONZEALD MAA, the latest round of feedback in the last month included some additional questions. We recently submitted written responses that we believe adequately address these questions. ONZEALD is scheduled for an oral explanation at the upcoming CHMP meeting in mid-May. We look forward to a CHMP opinion following this meeting.

With respect to Bayer, Amikacin Inhale is on track to complete Phase 3 around the middle of this year as well, and we will be working with Bayer to announce results from this program sometime in the third quarter of 2017.

So let's now move on to discuss Nektar's growing pipeline…..We have built an impressive portfolio with five highly-valuable wholly owned drug candidates in the therapeutic areas of immuno-oncology, immunology, and chronic pain….

In the area of chronic pain, NKTR-181 is emerging as an important new potential medicine to treat patients with moderate to severe chronic pain. Opioid abuse continues to be a major societal problem, one that has heavy focus from both the FDA and the White House. As the first new full mu-opioid agonist molecule to be developed in decades, NKTR-181's unique inherent properties as a new pain medicine position the drug to not only address the opioid abuse epidemic but also to reduce diversion of prescription pain medicines for abuse. Importantly, the analgesic doses that were established in the SUMMIT-07 study have already shown abuse

potential comparable to placebo in a separate human abuse potential study, also known as a human abuse liability study. In the second half of this year, we will wrap up much of the remaining ongoing development work for NKTR-181, including the second human abuse potential trial and the long-term safety trial.

At Pain Week in September, we plan to present additional positive data from the SUMMIT-07 efficacy trial which includes secondary endpoints using specific metrics of physical and psychological dependence and withdrawal. These important new data support that NKTR-181 is a truly unique new pain medicine that is not associated with the symptoms of dependence that are common to the opioid class. We are extremely pleased with the body of data that we have for this program and the clear benefit potential of this new molecule for patients. The NKTR-181 data establish the potency of its analgesia, its low abuse potential, its favorable safety and dependency profile and the strength of its molecular structure which can't be broken or converted and isn't metabolized into a rapid-acting, euphorigenic opioid form.

We intend to review our data for NKTR-181 with the agency in the second half of this year to see if we can find a rapid path to approval for NKTR-181. We also remain committed to establishing a partnership for NKTR-181 this year in order to allow us to bring this important new medicine to patients.

As you know, Nektar is developing a broad portfolio in immuno-oncology. Our goal is to develop medicines which can target multiple steps in the

immune cycle in order to stimulate a patient's immune system to fight cancer. Our two I-O candidates, NKTR-214 and NKTR-255, are biologics which capitalize on the important signaling pathways controlled by IL-2 and IL-15 to stimulate tumor-killing T cells, memory T cells, and natural killer cells. And we recently introduced NKTR-262, which is a novel small molecule TLR agonist designed to complement NKTR-214, which would give Nektar our first wholly-owned combination regimen in I-O.

NKTR-214, as a T cell growth factor, has the potential to fill a critical gap in immuno-oncology therapeutic regimens. NKTR-214 is a new medicine that can activate the immune system and increase the amount of TILs in the tumor micro-environment without the corresponding severe toxicities associated with other modalities. By supplying physicians and patients with an effective means to replenish and activate the effector T-cell population, NKTR-214 has the potential to dramatically change the way patients are treated with I-O therapies.

As I stated earlier, Mary will go into more detail on the NKTR-214 development program in a moment, but we are excited about the data that is emerging to-date from the combo trial and we expect to present initial results from patients who are continuing on treatment in the dose-escalation part of this study at our ASCO event.

Another important landmark for our I-O portfolio will be the entry into the clinic of our next I-O candidate, NKTR-262. We anticipate filing an IND for NKTR-262 by the end of 2017. Jonathan will discuss more on the strategy

for development of NKTR-262 in combination with NKTR-214 later on the call.

Now turning to our immunology program, and in particular NKTR-358. We are very excited about the important milestone achieved in March with the start of our first-in-human trial of NKTR-358. NKTR-358 is a unique and highly differentiated new therapeutic which stimulates growth of the body's own regulatory T cells to address the underlying cause of immune-mediated disorders. We announced last week that Dr. Brian Kotzin has joined Nektar as head of the development program for NKTR-358. Brian has over 30 years of expertise in inflammation and immunology in both research and industry, including most recently, 11 years leading immunology R&D at Amgen. Brian is in expert on auto-immune and inflammatory diseases and his leadership skills, development experience and strategic guidance will be highly valuable in the advancement of this very important program for Nektar.

Unlike current immuno-suppressant agents which globally weaken the immune system to only address disease symptoms, NKTR-358 is a first-in-class resolution therapeutic designed to specifically correct the underlying pathology of auto-immune disease. NKTR-358 is the only medicine of its kind in clinical trials. It has the potential to have a profound effect on a number of immune and inflammatory disorders including lupus, IBD, RA, psoriasis, MS, Type 1 diabetes and even allergy. With an asset that has this much broad potential in so many indications, we believe that the right strategy for NKTR-358 is to seek a co-development and co-promotion

partnership with a company that has a strong leadership position in immunology and importantly, shares our vision for the broad development of NKTR-358. Our goal is to enter into a partnership this year. With that, I will now hand the call over to Mary.

Mary Tagliaferri:

Thank you, Howard, and good afternoon.

Today, I'd like to review in more detail the clinical strategy and development program for NKTR-214. This includes the PIVOT program which is evaluating NKTR-214 plus OPDIVO and the PROPEL study, which will evaluate NKTR-214 plus TECENTRIQ.

The Phase 1 dose escalation portion of the PIVOT program, PIVOT-02, is well underway. BMS and Nektar believe that the combination of Opdivo with NKTR-214, the first medicine that grows tumor-killing TILs, has tremendous promise in advancing the field of immuno-oncology. This is why the PIVOT program is pursuing eight or more indications in at least five different tumor types.

As a reminder, in the dose escalation portion of the program, we are enrolling approximately 20 to 30 patients with first-line melanoma, second-line renal cell carcinoma and second-line non-small cell lung cancer. The dosing regimens we are exploring include a number of two-week and three-week infusion dosing regimens of NKTR-214 with OPDIVO. As we've

stated in the past, we have not observed any dose limiting toxicities in the trial to-date. This portion of the trial will help us to identify the optimal dosing regimen for NKTR-214 with OPDIVO.

Our current target is to select the combination regimen with the optimal safety and efficacy profile so that in the third quarter of this year, we can begin to enroll into the 8 expansion cohorts of PIVOT. The expansion part of the program will enroll up to 260 patients and will include first-line melanoma patients, first line or IO naïve populations with non-small cell lung cancer, renal cell carcinoma, triple negative breast cancer and bladder cancer, as well as IO relapsed or refractory patient populations with melanoma, renal cell carcinoma and non-small cell lung cancer. The three latter populations could provide us with a potential for an accelerated pathway to regulatory approval.

As Howard stated earlier, we are very excited about the efficacy and safety data that are emerging to-date from the ongoing dose-escalation stage of the combo trial. At our ASCO investor event, we expect to share a mix of initial safety, efficacy and biomarker data for 15 - 20 patients who are currently in the ongoing dose escalation part of the study, bearing in mind that depending upon when they entered the study, some of these patients will only have had first scans, some will have not yet been scanned and others will have been on treatment longer with more than one scan available.

At ASCO, we also plan to present updated positive efficacy and biomarker data from the NKTR-214 single-agent trial for 4 patients who have renal cell carcinoma and were IO naïve at study entry. These patients had stable disease with tumor shrinkage or unconfirmed partial response as best overall response with NKTR-214 monotherapy and they went on to receive anti-PD-1 based therapy, including nivolumab, shortly thereafter.

In June, we are initiating a trial of NKTR-214 with Roche's TECENTRIQ. As we've said in the past, our strategy is to position NKTR-214 as a keystone in I-O and also demonstrate that NKTR-214 is synergistic with both anti-PD-1 and anti-PD-L1 agents. The PROPEL trial will enroll approximately 20-30 patients with on label TECENTRIQ indications – which include non-small cell lung cancer patients with metastatic disease who have progressed on a platinum regimen or an EGFR or other targeted therapy and also patients with bladder cancer who have progressed on a platinum regimen. We expect to start this trial by the middle of the year as it is an important part of our strategy to position NKTR-214 to be able to be combined with the various checkpoint mechanisms.

Nektar and BMS are also co-funding an investigator-initiated trial in approximately 60 patients with sarcoma which will start around the middle of this year once we've established the recommended Phase 2 dose for NKTR-214 plus OPDIVO. This trial, which will be conducted at Memorial Sloan-Kettering and MD Anderson, will evaluate the combination regimen in 6 different sarcoma sub-types: osteosarcoma, chondrosarcoma,

undifferentiated pleomorphic sarcoma, angiosarcoma, liposarcoma, and leiomyosarcoma.

Finally, as NKTR-214 is a broad-based mechanism, we have ongoing preclinical work with several collaborators which is designed to evaluate the combination of NKTR-214 with additional mechanisms in I-O beyond anti-PD-1 and anti-PD-L1. This includes preclinical research with personalized vaccines to explore a cancer vaccine program and it also includes preclinical studies with an oral HDAC inhibitor and other small molecules. We are currently assessing other NKTR-214 collaborations and potential research work including targeted agents outside of I-O which could be highly promising in both liquid or solid tumors in the context of the strong T-cell activity provided by NKTR-214. In addition, as you've seen and as Howard mentioned, we have shared promising preclinical data for our own NKTR-214 combination regimen that includes a wholly-owned TLR 7/8 agonist. As we achieve positive preclinical results for these initiatives, we expect that we could advance some of these programs rapidly into the clinic.

With that, I'll turn the call over to Jonathan….

Jonathan Zalevsky

Thanks Mary.

I'd like to build on Mary's comments first with respect to our plans for NKTR-262, which is a novel TLR 7/8 agonist that we are preparing for its first clinical study to be evaluated in combination with NKTR-214. TLRs or toll-like receptors, stimulate an inflammatory response that activates the innate immune system, and additional myeloid cell functions such as dendritic cell maturation and antigen presentation. With respect to lymphoid cells, TLR 7/8 agonists are known to stimulate cytotoxic cell function and inhibit Treg suppressive cell function. These properties are highly desirable in the tumor microenvironment and as a result, TLR agonists have held great promise for anti-cancer therapy. However, the problem has been that TLR agonists, when given systemically generate a powerful uncontrolled immune response leading to major safety liabilities. Our vision was to use our technology to create our own TLR agonist molecule that could overcome these limitations and could be used with NKTR-214 in a combination regimen to target all of the patient's tumors with only minimal intratumoral injections of the TLR agonist.

This combination regimen is really a perfect one in immuno-oncology because NKTR-214 and NKTR-262 target key non-overlapping biological mechanisms. NKTR-262 targets the innate immune system and myeloid cell pathways, while NKTR-214 targets the adaptive immune system and lymphoid cell pathways. We have evaluated this combination in a number

of studies where two tumors are implanted into animals, one on each flank, and we treat one of these two tumors with a single intratumoral injection of NKTR-262 and then give systemic NKTR-214. We observe a complete abscopal response with complete regression in both tumors, even the tumor that was not injected with NKTR-262. This is because of the combined innate and adaptive immune mechanisms at play with the combination of NKTR-262 with NKTR-214.

The efficacy of this combination is tremendous and these complete tumor regressions are durable and we now have **complete survival** of **all** animals in multiple preclinical models. And because of this potential for a curative effect, we are very excited about this program. Importantly, NKTR-262 with NKTR-214 provides Nektar with a wholly-owned I-O combination opportunity in our portfolio. We have prioritized this program and are on track to have an IND submitted by the end of 2017 to begin testing the combination of NKTR-262 with NKTR-214 in cancer patients.

I'd like to now expand on Howard's discussion of NKTR-358 and highlight the scientific differentiation of NKTR-358 versus anything that has been done in the field of immunology previously.

NKTR-358 is a novel agent that allows for pharmacological control of immune regulatory pathways by increasing the number and suppressive function of regulatory T cells, the body's natural mechanism of immune regulation. Patients with autoimmune disease have either an insufficient number and/or insufficient function of these Tregs in their body. In the case

of normal health, the Tregs control the normal population of self-reactive T cells and also play a key role in peripheral tolerance mechanisms.
But when there are insufficient numbers or function of Tregs, it leads to a breakdown of these peripheral tolerance mechanisms and ultimately results in the patient developing an immune-mediated disorder. So we know that it would be ideal to have an easily accessible medicine that could potentiate or stimulate this population of Tregs.

With NKTR-358, we've created a molecule that not only selectively stimulates the proliferation and overall number of Tregs but also their functional activity. NKTR-358 does this at low dose levels and has an extended duration of action. For example, a single subcutaneous dose of 25 ug/kg of NKTR-358 in nonhuman primates generated functional Treg increases greater than seven-fold for a two-week long period. Based on this, NKTR-358 could be a self-administered once or twice a month subcutaneous medicine in humans.

A drug that mobilizes Treg mechanisms has long been sought after in the field of immunology. Although attempts have been made and are still being made to try to achieve a Treg induction profile with small molecules and other approaches, no one has yet been successful. We've learned that the IL-2 pathway is critical for controlling Treg biology and so it follows that to create an IL-2 based therapeutic could be a far better way to solve this problem. However, we knew that current R&D approaches, such as IL-2 mutein Fc fusions and ex-vivo Treg cell-therapies, are not an ideal way to approach this pathway. We've learned from our work with NKTR-214 in

cancer that there is a very narrow therapeutic window with the IL-2 pathway across the desired impact on target cell populations such as T effectors for cancer and Tregs for auto-immune disease. With NKTR-214, this enabled us to apply our technology to bias receptor binding and favor proliferation of tumor-killing T cells and minimize Treg production. With NKTR-358, we flipped this approach and applied our technology to attenuate IL-2 receptor binding with marked specificity on Tregs in order to widen the therapeutic window possible between T cell populations. Alternative approaches to this mechanism have used protein mutagenesis where significant portions of the protein are altered which could greatly increase the risk of immunogenicity.

In fact, NKTR-358 is the only molecule of its kind that is in the clinic that gives us the opportunity to truly mobilize Tregs and target the underlying cause of immune-mediated disorders.

The promise of a first-in-class resolution therapeutic that fixes the underlying immune system dysfunction is tremendously exciting, not only to us, but also to many others working in immunology. NKTR-358 has the potential to address a number of immune and inflammatory disorders including lupus, IBD, rheumatoid arthritis, psoriasis, Type 1 diabetes, MS, psoriasis, and allergy.

The first human trial for NKTR-358 is underway. The study is a single ascending dose trial in healthy volunteers and is measuring safety and tolerability, increase and duration of changes in Tregs and their function,

and PK. The study began this past March and so far, the first dose cohort has been completed. Our goal is to quickly complete this study in the third quarter of this year to enable us to go right into Phase 1b studies. As Howard stated, we look forward to presenting these Phase 1 data at a medical meeting in the second half of 2017.

With that, I'd like to hand the call to Gil.

Gil Labrucherie

Thank you, Jonathan and good afternoon everyone.

Our financial guidance for this year is unchanged from our last conference call.

As a reminder, revenue for 2017 is still expected to be between $145 and $155 million. Our 2017 revenue guidance includes approximately $25 to $28 million of Movantik royalty revenue, $9 to $11 million of Adynovate royalty revenue, and $30 million of non-cash royalty revenue from Cimzia and Mircera. As I mentioned on the last call, we are not expecting 2017 revenue to be ratable across quarters. We currently anticipate the remainder of our 2017 revenue to be recognized across the next three quarters as follows: approximately 25% in Q2 and a relatively even split between Q3 and Q4. We expect our second quarter revenue to include

approximately $10 million for final shipments to Ophthotech to close out binding 2017 purchase commitments. We expect to recognize both the milestone for EU approval of Adynovate and the French reimbursement milestone for Moventig in the third quarter. Right now, we are modeling the milestone for first commercial sale of Onzeald in the fourth quarter of 2017. As a reminder, this does not include any GAAP recognition of the proceeds from any potential clinical collaborations.

We anticipate 2017 GAAP R&D expense will range between $230 and $240 million, which includes approximately $29 million of non-cash depreciation and stock compensation expense.

2017 G&A expense is projected to be between $45 and $47 million which includes approximately $12 million of non-cash depreciation and stock compensation expense.

We ended Q1 with $362 million in cash and investments as compared to $389.1 million at the end of 2016. To reiterate our cash guidance for the year, we still plan to end 2017 with approximately $**225 million** dollars in cash and investments. It is important to continue to keep in mind that our

2017 projected ending cash position does NOT include proceeds from potential partnerships for NKTR-358, or NKTR-181, both of which we are targeting to complete by year-end.

With that, I will now open the call to questions. Operator?

Q&A SESSION TO BE TRANSCRIBED BY NASDAQ IF AVAILABLE

Howard Robin

Again, thank you all for joining us this afternoon. I'd like to thank our employees for their hard work and dedication to the company. We look forward to seeing many of you at ASCO, UBS or Jefferies in the next month.

Q&A reactive only --- what were the new questions raised in the last round with the CHMP?

The questions were not around manufacturing, safety or any baseline differences between groups, or any of the efficacy data. But as you know we are seeking conditional approval based upon a small subset of 70 patients with advanced breast cancer and brain metastases from the BEACON trial, the new questions were mostly on this subset of patients, the mechanism by which this patient population performed much better on ONZEALD, and the appropriate scope of a potential conditional approval. As I said, we believe we have adequately addressed these questions and in the oral explanation, we plan to present these answers along with our experts.