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Our Mission

Translate the genetic language of the adaptive immune system into clinical products to diagnose and treat disease

- Founded in 2009
- NASDAQ listed 2019 (ADPT)
- 700+ employees
- 700+ publications to date
The immune system detects and treats most diseases in the same way.

Adaptive Immune System Cells
- T Cell
- B Cell

Disease Signals (Antigens)

Receptors bind to specific signals of disease.

Disease Cell
Antigen
T Cell Receptor
Revealing its massively diverse genetic code may transform medicine

INDIVIDUAL

>100M GENES
ADAPTIVE IMMUNE REPERTOIRE

HUMAN GENOME

30K GENES

POPULATION

TRILLIONS
OF TCRs

MILLIONS
OF ANTIGENS

GGAGTGTAACTCGATGAGTT
ACCCGCTAATCGAACTGGGC
AGAGATCCCAGCGCTGATG
CACTCGATCCCCAGAGCTG
CCCGACAACACACTGAG
AGAGCGGGGCTGTTGACGT
TTGGGGTTGAAAAAATCTAT
TGTA
GC
GCCTCCACGCGCTGGGCG
AGGAGGGGCCACACCGAG
GACTGTTGCACGTT
GGCGATGGCGGTAGCTAAG

Sensitive
Specific
Amplified
Systemic
Persistant
Using the immune system as the source-code for immune medicine

Immune System

B Cells
T Cells

Genetics

Data

Immune Medicine

Autoimmune disorders
Cancer
Infectious diseases
Neurodegenerative disorders
Adaptive Innovation Timeline

Adaptive Biotechnologies
Founded by Harlan and Chad Robins

ImmunoSEQ
1st research product launch

Adaptive partners with Microsoft
To map the human immune system

Genentech
A Member of the Roche Group

Adaptive acquires Sequenta
NDS technology for MRD in blood cancers

clonoSEQ
Cleared by FDA for MRD in ALL and MM

clonoSEQ
Receives Medicare coverage ALL, MM, CLL

clonoSEQ
Expanded SSF Labs

clonoSEQ
Receives Medicare coverage in CLL

clonoSEQ
DLBCL receives Medicare coverage and launch

HQ Opening
In Seattle, WA

IPO
(Nasdaq: ADPT)

TCR Discovery
Antigen Specificity

TCR A/B PARRING
HIV, Hepatitis, T cell acute lymphoblastic leukemia

SAFETY
TCR, TCR, TCR, TCR, TCR

Genentech Partnership

Private Product Lab / Prototype

Ab Discovery Implemented

Capabilities build Target discovery, TCR and Antibody therapeutics

GNE T-Cell Therapy IND Accepted by FDA

Business areas of focus: MRD and Immune Medicine

**Minimal Residual Disease (MRD)**
Highly sensitive NGS-based assessment of MRD in heme for use in clinical practice and drug trials.

**Immune Medicine (IM)**
Rich immune receptor data informs clinical trials and development of transformative medicines.

**Clinical Testing**

**MRD Pharma**
NGS MRD

**Pharma Services**
Adaptive Immunosequencing

**Drug Discovery**
Target Discovery
T-cell Therapeutics
Antibody Therapeutics

TAM ~$5B*

TAM ~$44B*

* Global TAMs.
clonoSEQ is the gold standard for MRD in heme

- Highest sensitivity – detects one in 1M cancer cells
- Strong IP protection: 140+ MRD-specific patents
- Only FDA approved MRD assay for ALL, MM and CLL*
- 150+ publications, 100+ ongoing studies
- 300M covered lives (MM, ALL), ~200M in CLL
- NCCN guidelines ALL, MM, CLL
- 41 pharma partners, 160 active clinical trials

*All indications are CLIA validated including DLBCL
clonoSEQ assesses MRD by looking for specific DNA sequences associated with malignant B or T cells*

By sequencing the DNA associated with B- and T-cell receptors, clonoSEQ identifies and quantifies specific cancer-associated sequences, generating MRD results that are a direct measure of the tumor, not a surrogate of disease.

*T-cell testing is available as a CLIA-validated LDT and has not been cleared or approved by the FDA.

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Our MRD business provides value to all stakeholders

MRD is highly prognostic of outcomes...

Transforming care for lymphoid cancer
Disease burden assessment is integral to clinical decision-making throughout the treatment continuum

<table>
<thead>
<tr>
<th>Phase</th>
<th>Diagnosis</th>
<th>Active Treatment</th>
<th>Remission</th>
<th>Disease Recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>• Stage disease</td>
<td>• Inform treatment selection</td>
<td>• Monitor disease burden during remission</td>
<td>• Predict potential relapse</td>
</tr>
<tr>
<td></td>
<td>• Evaluate patient prognosis</td>
<td>• Assess treatment response</td>
<td>• Inform frequency of monitoring</td>
<td>• Decide to re-initiate treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intensify / de-intensify treatment</td>
<td>• Decide to discontinue treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Determine need for additional treatment (e.g., consolidation or maintenance)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Milestone</strong></th>
<th>Diagnosis</th>
<th>Induction</th>
<th>Consolidation</th>
<th>Stop Treatment</th>
<th>Relapse</th>
</tr>
</thead>
</table>

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Other methods for clinical MRD evaluation in lymphoid cancers are limited

Other approaches to monitoring lymphoid cancers

<table>
<thead>
<tr>
<th>ALL &amp; CLL</th>
<th>MM</th>
<th>DLBCL¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flow cytometry</td>
<td>Flow cytometry</td>
<td>PET / CT scans</td>
</tr>
<tr>
<td></td>
<td>M-protein tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serum FLC</td>
<td></td>
</tr>
</tbody>
</table>

LIMITATIONS

Variable Sensitivity • Low Specificity • Lack of Standardization
Imprecise quantitation • Radiation exposure • Cost

¹ clonoSEQ is available for MRD assessment in DLBCL as a CLIA-validated laboratory developed test. clonoSEQ is FDA-cleared for MRD assessment in ALL, CLL and MM.
How does clonoSEQ compare to MFC?

Percentage of patients who were MRD-negative by MFC but had residual disease by clonoSEQ

<table>
<thead>
<tr>
<th>Disease</th>
<th>MRD-negative by MFC</th>
<th>Residual disease by clonoSEQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM</td>
<td>40-50%</td>
<td>79%</td>
</tr>
<tr>
<td>CLL</td>
<td>46%</td>
<td>39%</td>
</tr>
</tbody>
</table>

clonoSEQ detects disease that MFC cannot

What it means

Many [patients] with apparent ‘MRD-negativity’ by MFC still relapse. These relapses are likely due to residual leukemia that is present below the level of detection of MFC.

-Short et al.

We are in early innings of penetration with significant opportunity to grow...

MRD Business Revenue ($M)\(^1\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue ($M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019</td>
<td>26</td>
</tr>
<tr>
<td>FY 2020</td>
<td>30</td>
</tr>
<tr>
<td>FY 2021</td>
<td>56</td>
</tr>
<tr>
<td>FY 2022</td>
<td>81</td>
</tr>
</tbody>
</table>

Used in ~7% of lymphoid cancer patients in US\(^2\)

Overall Pharma penetration of ~21%\(^3\)

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\(^1\) Excludes regulatory milestones from pharma partners

\(^2\) Incidence and prevalence from SEER database; 10 yr prevalence used for CLL and MM, 5 yr. prevalence used for ALL

\(^3\) Penetration rate estimated based number of trials using clonoSEQ divided by the total number of all active trials in ALL, NHL, CLL and MM
clonoSEQ is supported by a robust evidence base with significant commitment to additional data generation

- >160 peer-reviewed publications supporting the expanding clinical utility of clonoSEQ and NGS MRD in Heme cancers
- >100 ongoing prospective studies in partnership with clinician investigators for data/evidence generation

**Peripheral blood ctDNA assessments can predict for progression events with added value to standard PET-CT scans**
Frank et al. JCO, 2021

**Durable MRD negativity lasting ≥6 or ≥12 months may represent yet a deeper level of response with a higher prognostic value**
San-Miguel et al. Blood, 2022

**Minimal residual disease undetectable (uMRD) by next-generation sequencing predicts improved outcome in CLL after chemoimmunotherapy**
Thompson et al. Blood, 2019

**NGS MRD may provide more valuable prognostic information than RT-PCR for BCR::ABL1 and therapeutic decisions in Ph+ ALL may be better informed by also considering NGS MRD status**
Short et al. Am J Hematol, 2023

**MRD negativity is the most relevant predictor of clinical outcome compared with other prognostic factors for MM**
Cavo et al. Blood, 2021

**The best biomarker described to date for determining risk of relapse at any given time throughout the first year after CAR-T cell therapy ... is NGS-MRD assessment of the marrow.”**
Pulsipher et al. Blood Cancer Discovery, 2022
DETERMINATION and MASTER: Two recent trials that support personalizing treatment decisions based on MRD-negative status

**DETERMINATION trial: Similar 5-year PFS for MRD-negative patients regardless of transplant decision**

<table>
<thead>
<tr>
<th>53.5%</th>
<th>for those who received ASCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>59.2%</td>
<td>for those patients who did not</td>
</tr>
</tbody>
</table>

**MASTER trial: 2-year progression for patients who stopped treatment based on 2 MRD-negative tests**

<table>
<thead>
<tr>
<th>9%</th>
<th>in standard risk patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>9%</td>
<td>in high-risk patients</td>
</tr>
<tr>
<td>47%</td>
<td>in ultra-high risk patients</td>
</tr>
</tbody>
</table>

**What it means**

Emerging data show why you might consider personalizing treatment decisions based on MRD-negative status.

ASCT, autologous stem cell transplant; Dara-KRd, daratumumab + carfilzomib + lenalidomide + dexamethasone; NDMM, newly diagnosed multiple myeloma; RVD, lenalidomide + bortezomib + dexamethasone.

**About the studies**

DETERMINATION was a phase 3 trial evaluating RVD alone or RVD + ASCT in patients with NDMM (n = 357). MRD was assessed by clonoSEQ (10^-5) from the start of lenalidomide maintenance therapy in 108 patients in the RVD-alone group and 90 patients in the RVD + ASCT group.


MASTER was a multicenter, single-arm, phase 2 trial of patients with NDMM, conducted by Costa et al. Patients received Dara-KRd induction, ASCT, and Dara-KRd consolidation, according to MRD status. MRD was evaluated by NGS at the end of induction, post-ASCT, and every 4 cycles (maximum of 8 cycles) of consolidation. Primary endpoint was achievement of MRD negativity (10^-5). Subjects with 2 consecutive MRD-negative assessments entered treatment-free MRD surveillance.

clonoSEQ clinical testing is covered by Medicare and private payers for >300 million people in the U.S.

- Medicare coverage is available nationally for myeloma, ALL, CLL, and DLBCL and includes assessment of MRD at multiple timepoints.

- Positive coverage policies in place from the largest national private insurers*.

- Coverage for clinically relevant use in myeloma, ALL, and CLL, per commonly-used clinical practice guidelines.

Based on policies published as of July 2022. Coverage may vary by specific provider or plan.

*Based on insurance coverage and prior to applying any Adaptive-provided financial assistance.
Expanding clonoSEQ utilization in lymphoid cancer patients

Three-pronged strategy to increase penetration in heme MRD …

- Increase testing in blood
- Expand into NHL
- Increase usage per patient

… enhancing customer experience (EPIC integration), expanding coverage and increasing ASP
clonoSEQ is the test of choice for drug developers in heme cancers

*Only FDA approved MRD test in heme cancers*

**Portfolio overview**
- **41** Companies
- **160** Ongoing Clinical Trials
- **>$400M** Future Milestones

**Top ten accounts**

**Portfolio mix**
- **By indication ($ bookings)**
  - ALL: 18%
  - CLL: 20%
  - MM: 60%
  - NHL: 2%
- **By trial phase (number of studies)**
  - Phase 1: 26%
  - Phase 2: 37%
  - Phase 3: 37%
Several recent FDA drug approvals contain data supporting clinical utility of MRD

~$400M in eligible regulatory milestones from active & future trials
MRD business is well positioned to deliver strong revenue growth over time

Competitive Advantages
- Sensitivity ($10^{-6}$)
- Breadth of published evidence
- FDA approved
- Broad payer coverage (US)
- Product of choice for pharma R&D
- Sample type flexibility

External Catalysts
- Rich pipeline of new agents (bi-specifics, CAR-T, etc.) driving deeper responses
- Patients living longer as treatment choices advance
- NGS-MRD evolving as SOC in treatment algorithms across cancers
- FDA support for using NGS-MRD as an endpoint in trials

Internal Catalysts
- Sales force expansion
- Continued investments in evidence generation studies
- Expansion of reimbursement coverage & RWE studies
- EMR (EPIC) integration
- Product enhancements
Immune Medicine
Drug Discovery combines novel target discovery and therapeutic assets

- **Unique ability to discover and validate novel disease specific drug targets**

- **Target Discovery**

- **TCR Therapeutics**

- **Antibody Therapeutics**

- **Develop differentiated TCR and antibody therapeutic products against validated, novel targets**
Pharma Services growing portfolio across multiple indications

- **4+** Major therapeutic areas
- **500+** Total studies to date
- **140** Total active studies
- **85+** Companies

### Rich immune receptor biomarker data accelerates clinical trials

1. **Participant**
2. **Sequence**
3. **Repertoire Analyses**
4. **Monitor / track changes**

### Growth drivers

- Scale companies / # of studies using sequencing
- Increase penetration in later stage trials and across indications
Immune receptor data fuels our pipeline in cancer and autoimmune disease

High unmet clinical need...

- Cell therapy in heme with early success
- Cell therapy in solid tumors is the next frontier

Drug Discovery efforts to meet the need

- Efforts underway to discover disease-specific targets
- Opportunity to bring precision medicine to patients with autoimmune diseases

Cancer

- TCR Cell Therapy
  - Shared
  - Private

Autoimmune disorders

- Novel Targets
  - IBD, MS

- TCR Tx
  - Against novel targets

- Antibody Tx

Partner/(co)Develop
Partner/(co)Develop

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Cell Therapy in Oncology; Partnership with Genentech

- Cell therapies showing great efficacy
  - Limited to surface markers only
- T-cell receptors are cancer specific
- Our platform generates highly potent TCRs against cancer antigens

- Characterize TCRs against cancer antigens for cellular therapy
  - Shared Products
  - Private Products
- Ability to pursue partnerships outside of oncology

$300M
Upfront payment

$1.8B
In milestone payments

Royalties in mid-single digit to upper-teen range
Developing novel neoantigen directed T-cell therapies

**Shared Product**

1. Profile DNA in patient tumor to determine immunogenic antigens and neoantigens

2. Select TCRs against shared antigens from TruTCR Library

3. Deliver TCRs to patient whose tumor expresses shared antigen(s)

**Personalized Product**

1. Profile DNA in patient tumor to determine immunogenic antigens and neoantigens, and sequence blood for TCRs

2. **Screen in real-time** for TCRs against patient-specific neoantigens using Adaptive’s TCR discovery platform

3. Engineer cell therapy with patient-specific TCRs, **manufacture in real-time** for each patient

4. Deliver fully personalized therapeutic TCRs to patient

**DUAL TCR CELLULAR THERAPY APPROACHES**
Financials
Financial Highlights

Revenue (in millions)

- **MRD Revenue**
- **Immune Medicine Revenue**

<table>
<thead>
<tr>
<th>FY 2020</th>
<th>FY 2021</th>
<th>FY 2022</th>
<th>FY 2023 E</th>
</tr>
</thead>
<tbody>
<tr>
<td>$98.4</td>
<td>$154.3</td>
<td>$185.3</td>
<td>$210(^1)</td>
</tr>
<tr>
<td>67%</td>
<td>57%</td>
<td>53%</td>
<td>~55%</td>
</tr>
<tr>
<td>33%</td>
<td>43%</td>
<td>47%</td>
<td>~45%</td>
</tr>
</tbody>
</table>

- ~$417 million in cash, cash equivalents and marketable securities as of 06/30/2023
- No debt

Note: bar charts not at scale
\(^1\) Mid-point of guidance range $205M-$215M as of 06-30-23
Long-term expectations

Path to Profitability / Cash Flow breakeven

1. **Revenue CAGR from 2022-2027 to be 20-30%**
   - 2019-2021 CAGR of 35%

2. **Adj EBITDA\(^1\) positive 2025**
   - Prudent spend management: maintain operating expenses levels at low growth

3. **Cash Flow Breakeven 2026**
   - $417M cash, cash equivalents and marketable securities as of 6/30/23
   - Cash on hand >3 years

Estimated 5 yrs P&L progression

* Opex in this chart excludes stock comp, depreciation and amortization

\(^1\) Adjusted EBITDA excludes stock comp