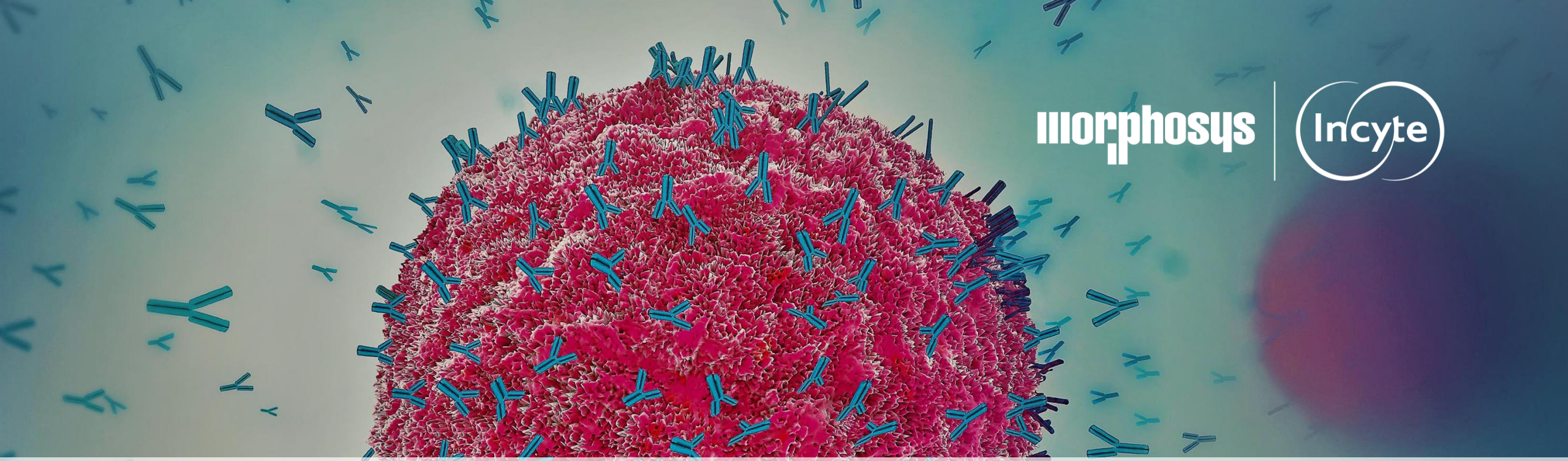


Tafasitamab Expert Event

Incyte and MorphoSys Joint Conference Call

September 29, 2020

MorphoSys/Incyte Joint Conference Call Agenda

Dr. Malte Peters, Chief R&D Officer (MOR)	Welcome and introduction
Dr. Gilles Salles	r/r DLBCL and front-line DLBCL landscape
Q&A Session	
Dr. Roland Wandeler, Chief Operating Officer (MOR)	Monjuvi launch update
Dr. Barry Flannelly, GM North America (INCY)	Monjuvi market access and U.S. opportunity in r/r DLBCL
Dr. Malte Peters, Chief R&D Officer (MOR)	Tafasitamab backbone strategy and DLBCL program updates
Dr. Steven Stein, Chief Medical Officer (INCY)	Global development in DLBCL and beyond
Dr. Jean-Paul Kress, Chief Executive Officer (MOR)	Summary
Q&A Session	

Forward-Looking Statements

Except for the historical information set forth herein, the matters set forth in this presentation contain predictions, estimates and other forward-looking statements, including without limitation statements regarding: expectations with respect to the commercialization of Monjuvi, including market uptake, distribution, reimbursement, the potential patient pools, and guidance with respect to peak potential revenue and market penetration; expectations with respect to the potential for Monjuvi to transform the treatment of patients with r/r DLBCL; expectations with respect to the potential for tafasitamab to treat indications beyond the currently approved indication; plans and expectations regarding the global development plan for tafasitamab, including with respect to clinical trials in additional indications and in combination with other therapies and potential therapies, such as parsaclisib, and commencement and receipt of results from clinical trials; and expectations regarding the timing and nature of determinations by regulatory authorities, including the MAA.

These forward-looking statements are based on current expectations by Incyte and MorphoSys and are subject to risks and uncertainties that may cause actual results to differ materially, including unanticipated developments in and risks related to: unanticipated delays; the effects of the COVID-19 pandemic and measures to address the pandemic on commercialization efforts and clinical trials, supply chain and other third-party providers, sales and marketing efforts, and business, development and discovery operations; further research and development and the results of clinical trials possibly being unsuccessful or insufficient to meet applicable regulatory standards or warrant continued development due to safety, efficacy or other reasons; the ability to enroll sufficient numbers of subjects in clinical trials and the ability to enroll subjects in accordance with planned schedules; determinations made by the FDA, MAA and other regulatory agencies outside of the United States; the acceptance of Monjuvi in the marketplace; market competition; the effects of announced or unexpected price regulation or limitations on reimbursement or coverage for Monjuvi; the continued ability to successfully commercialize and build commercial infrastructure for Monjuvi; and other risks detailed from time to time in the reports filed by Incyte and MorphoSys with the U.S. Securities and Exchange Commission, including Incyte's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020 and MorphoSys' Annual Report on Form 20-F for the year ended December 31, 2019. Given these uncertainties, the reader is advised not to place any undue reliance on such forward-looking statements These forward-looking statements speak only as of the date of publication of this document and Incyte and MorphoSys expressly disclaim any obligation to update any such forward- looking statements in this document to reflect any change in its expectations with regard thereto or any change in events, conditions or circumstances on which any such statement is based or that may affect the likelihood that actual results will differ from those set forth in the forward-looking statements, unless specifically required by law or regulation.

Dr. Gilles Salles, M.D.

Diffuse large B-cell lymphoma (DLBCL) current landscape and challenges

Professor Gilles Salles*

Memorial Sloan Kettering Cancer Center

New York

**Dr. Gilles Salles is acting in his personal capacity*

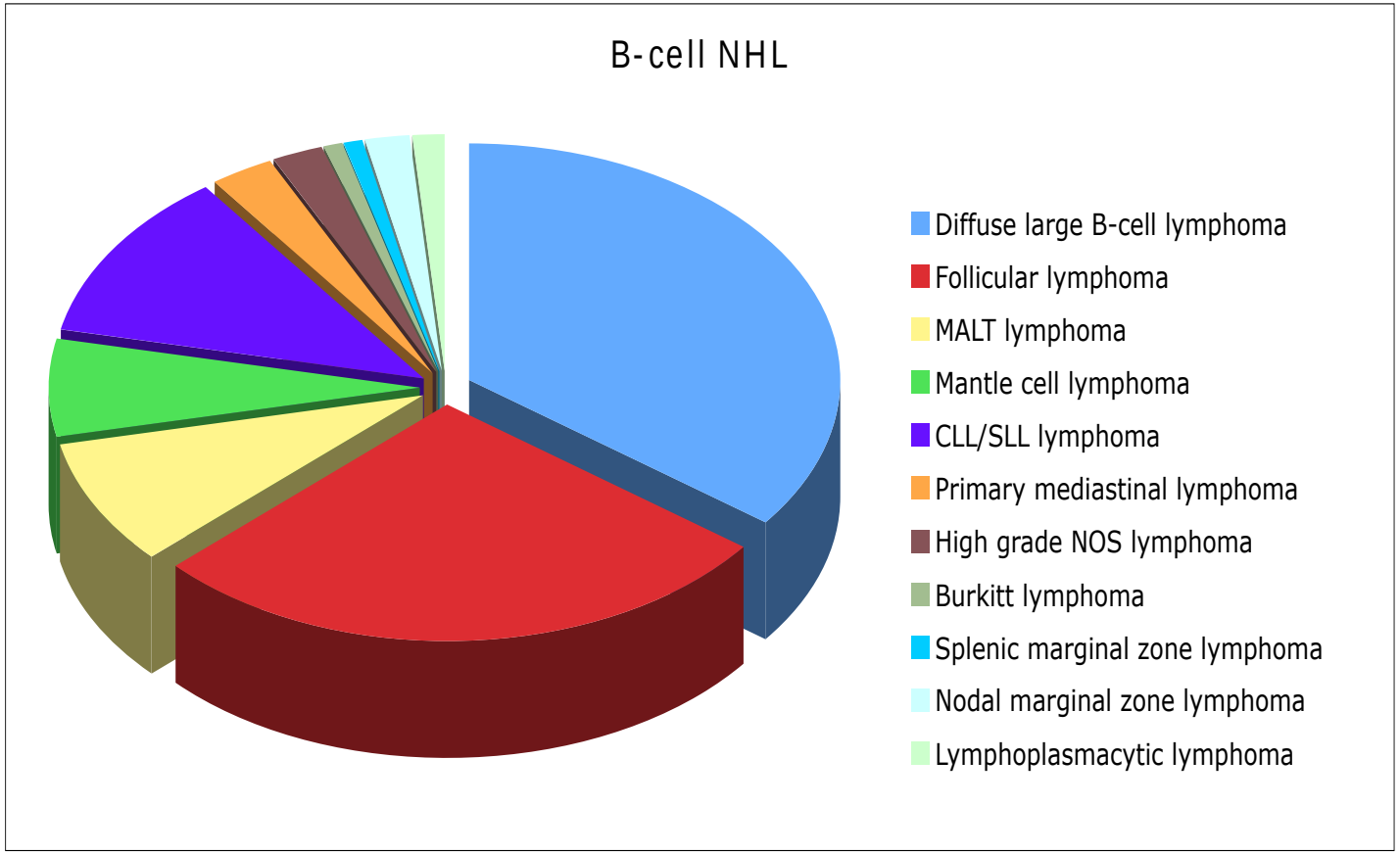
Disclosures

Gilles Salles has received financial compensations for participating to advisory boards, consulting or educational events from:

Abbvie, Allogene, Beigene, Autolus, BMS/Celgene, Debiopharm, Genmab, Kite/Gilead, Epizyme, Janssen, Karyopharm, Morphosys, Novartis, Roche, Velosbio

Epidemiology of non-Hodgkin lymphoma (NHL)

Incidence of B-cell lymphoma in the US # 70 000 new patients each year



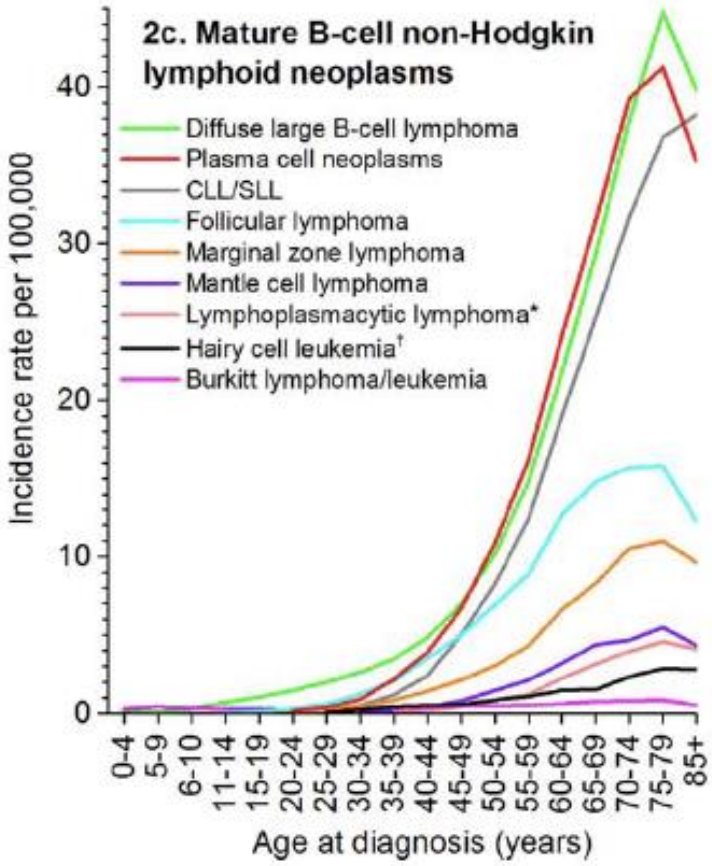
Teras LR, CA CANCER J CLIN 2016

Epidemiology of diffuse large B-Cell lymphoma (DLBCL)

- Most frequent Non Hodgkin Lymphoma (~30-35% of cases)
- Spontaneous aggressive evolution
- Various histological forms, and frequent coexistence or evolution from an indolent component
- Sex ratio male/female is 2

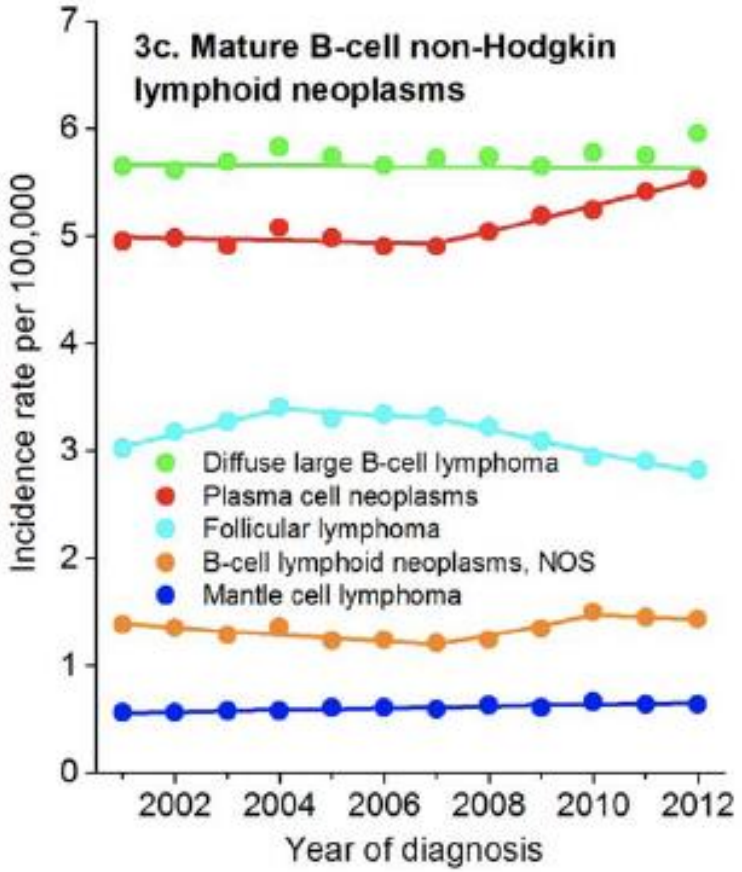
An increased frequency at older age

Median age at diagnosis # 65 - 70 years



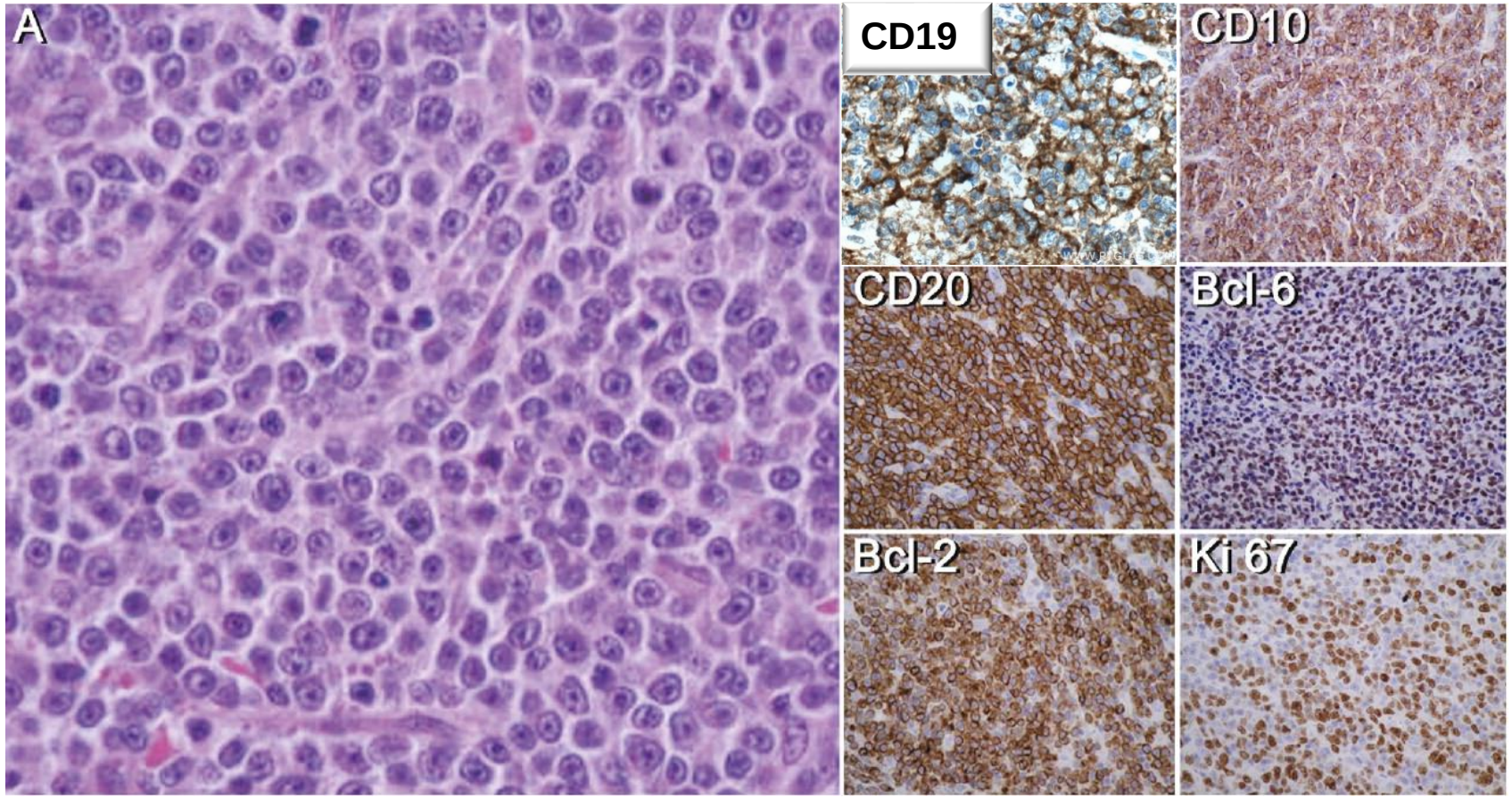
Teras LR, CA CANCER J CLIN 2016

Incidence stable over the last 2 decades



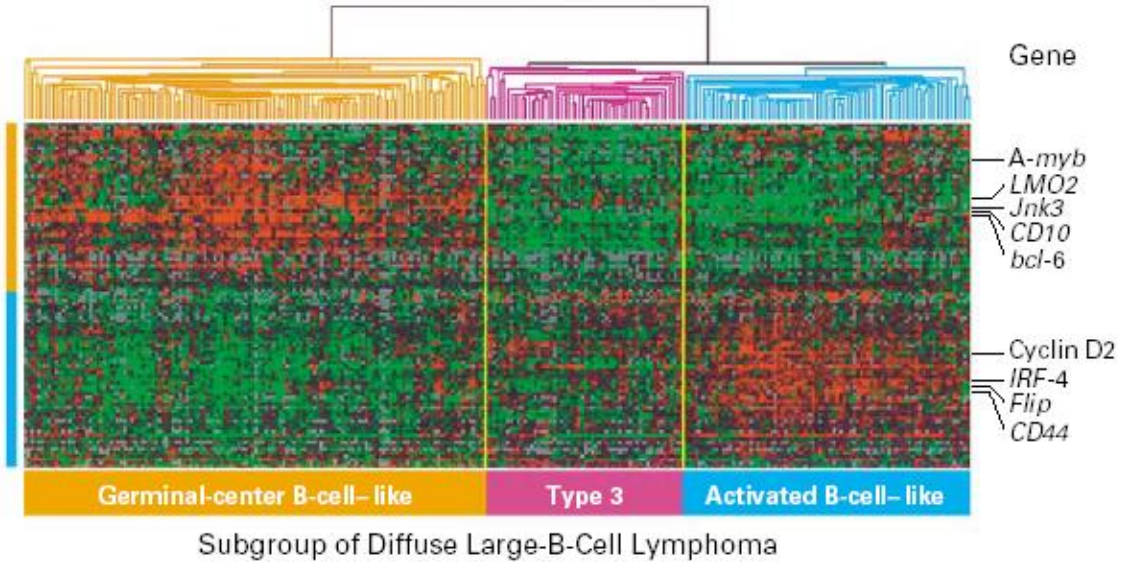
Teras LR, CA CANCER J CLIN 2016

DLBCL morphology



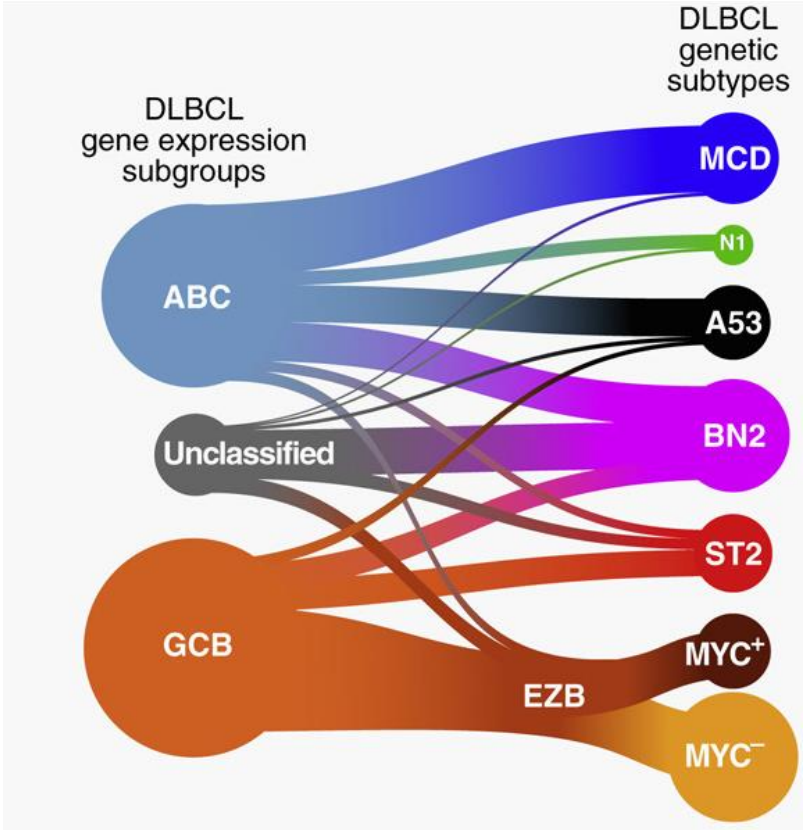
Modiefied from Le Gouill et al., Haematologica 2007

DLBCL molecular biology



Subgroup of Diffuse Large-B-Cell Lymphoma

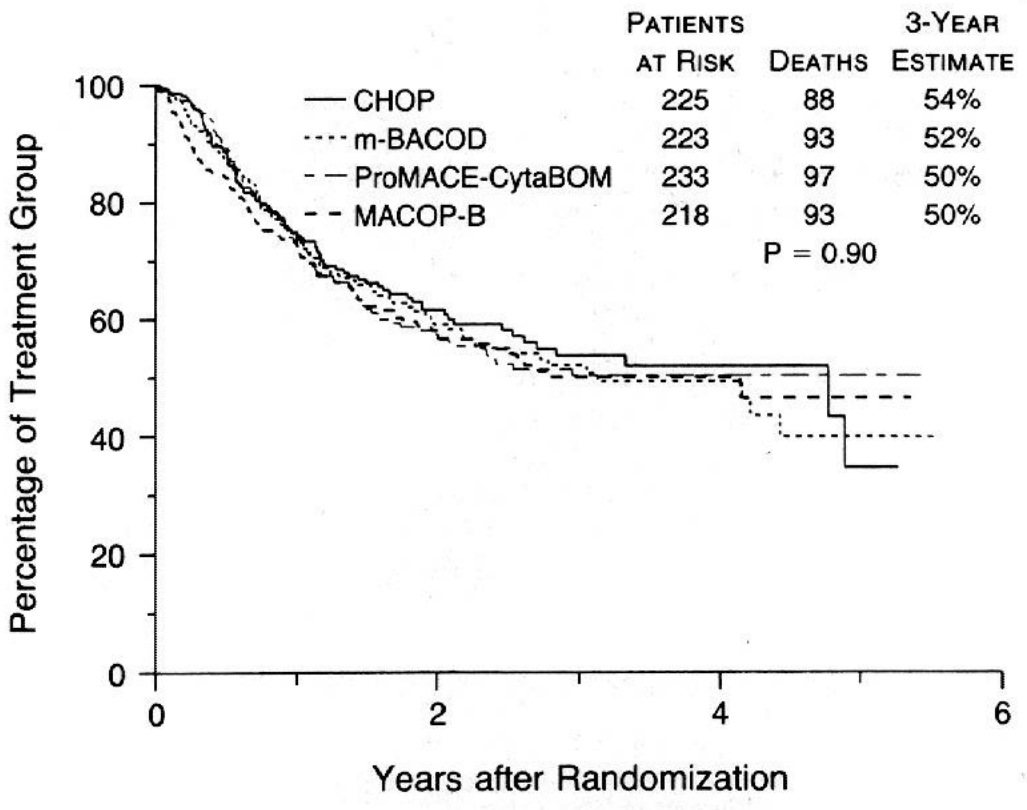
The Molecular Diagnosis of Large B Cell Lymphoma v2.0



Rosenwald et al., N Engl J Med. 2002; Wright GW, et al. Cancer Cell. 2020

Before the monoclonal antibodies…

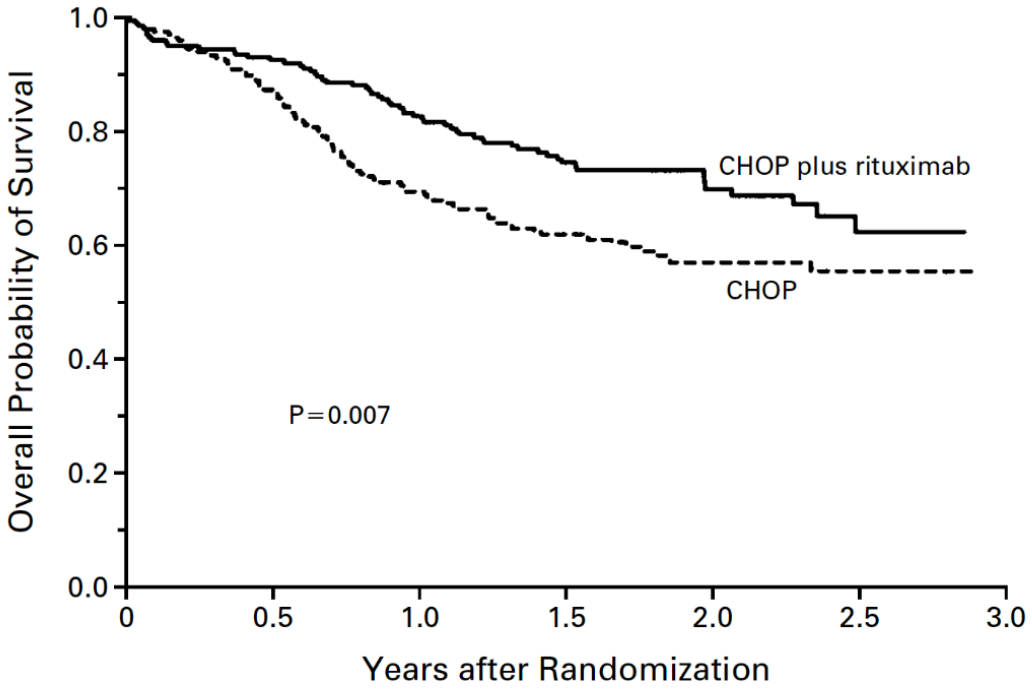
Overall Survival



Fisher et al, N Engl J Med 1993; 328:1002-1006

Adding a monoclonal anti-CD20 antibody to CHOP

Patients 60-80 yrs: LNH 98.5 GELA study

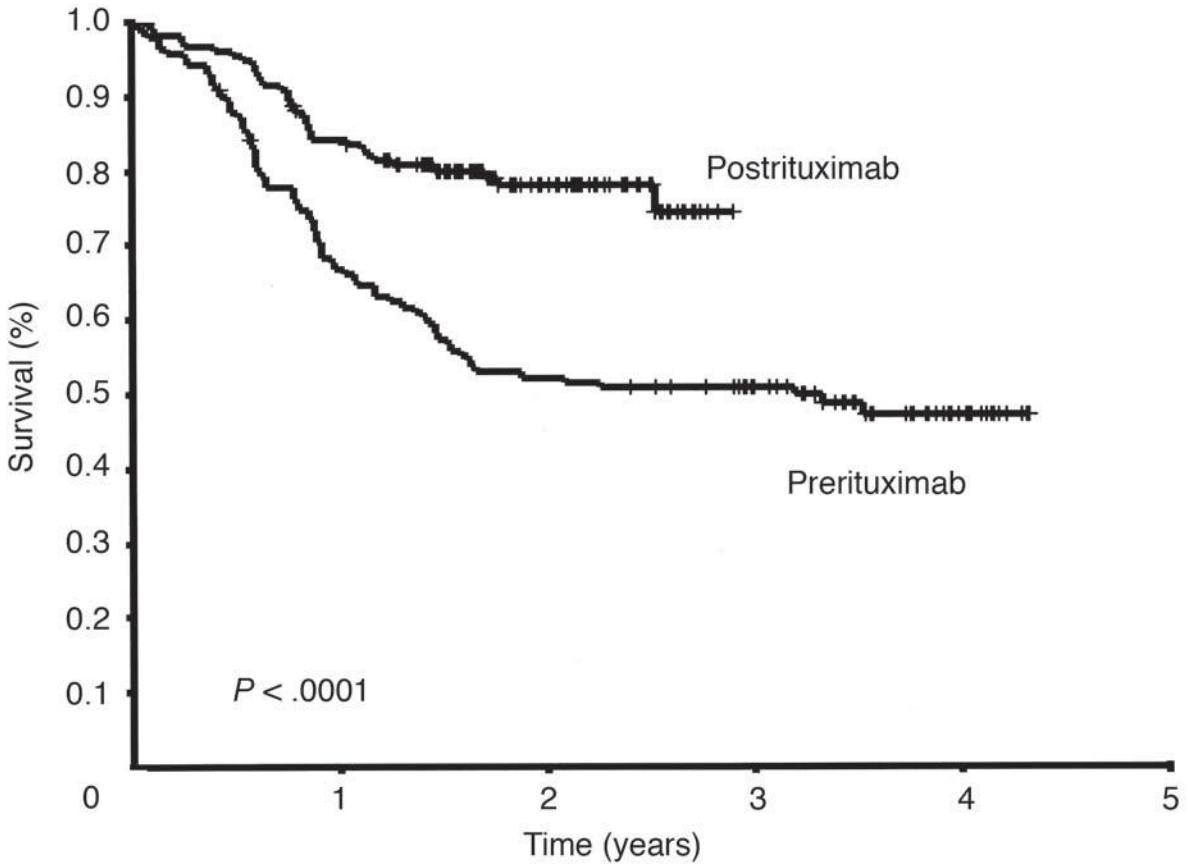


No. at Risk						
CHOP plus rituximab	202	187	167	118	64	21
CHOP	197	171	136	96	58	16

Coiffier et al. NEJM 2002

R-CHOP versus CHOP

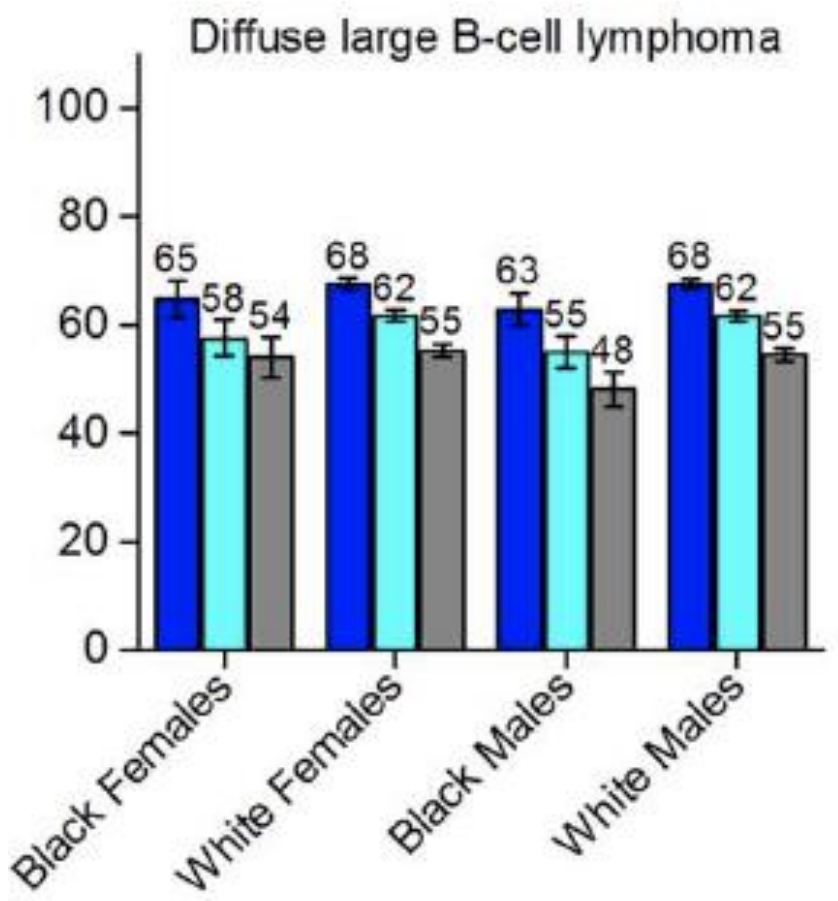
BCCA real life cohort



Sehn LH et al., J Clin Oncol. 2005

DLBCL survival at 3, 5 and 10 years in the United States

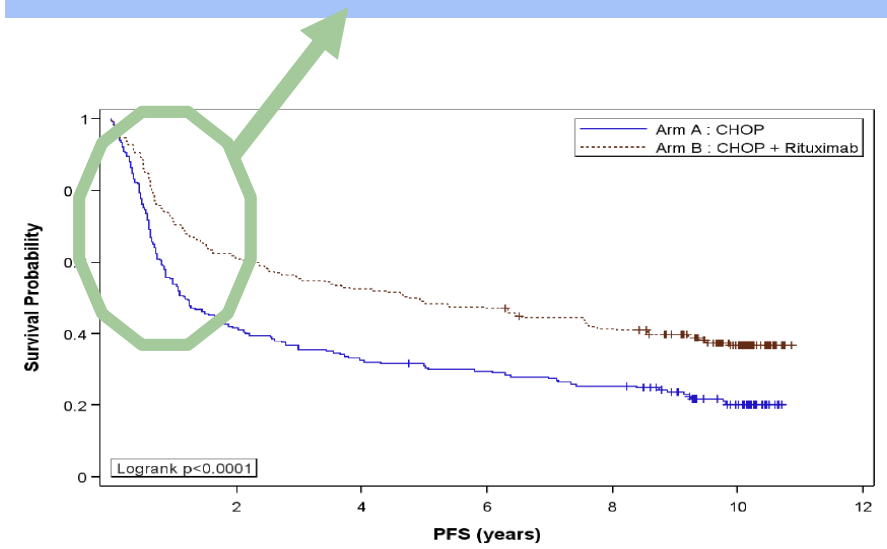
recent SEER data # 64% OS at 5 years



Teras LR, CA CANCER J CLIN 2016

DLBCL: recent attempts to improve R-CHOP

R-CHOP-21



Add a new targeted agent:
bortezomib[1], ibrutinib[2] and lenalidomide[3]

Consolidate with maintenance
rituximab[4], lenalidomide[5], enzastaurin[6], everolimus[7]

Replace one component
bortezomib[8], obinutuzumab[9]

1: Leonard, 2019 ; Davies, 2019 ; 2: Younes, 2019 ; 3: Vittolo, 2019 ; 4: Habberman, 2006; Jaeger, 2015 ; 5 :Thieblemont 2017 ; 6: Crump 2018 ; 7: Witzig 208 ; 8: Offner 205 ; 9 : Vittolo, 2017

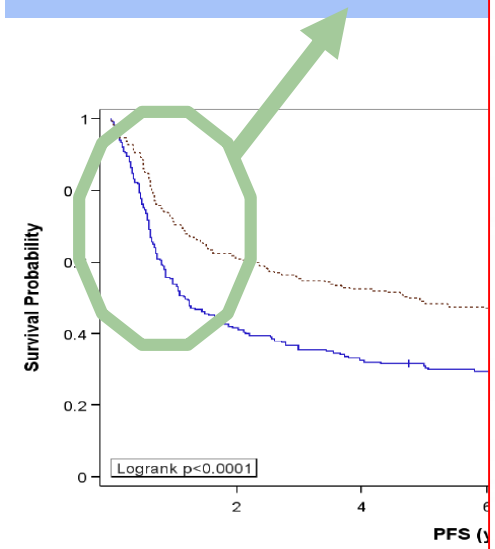
DLBCL: recent attempts to improve R-CHOP

R-CH

eted agent:
brutinib[2]
omide[3]

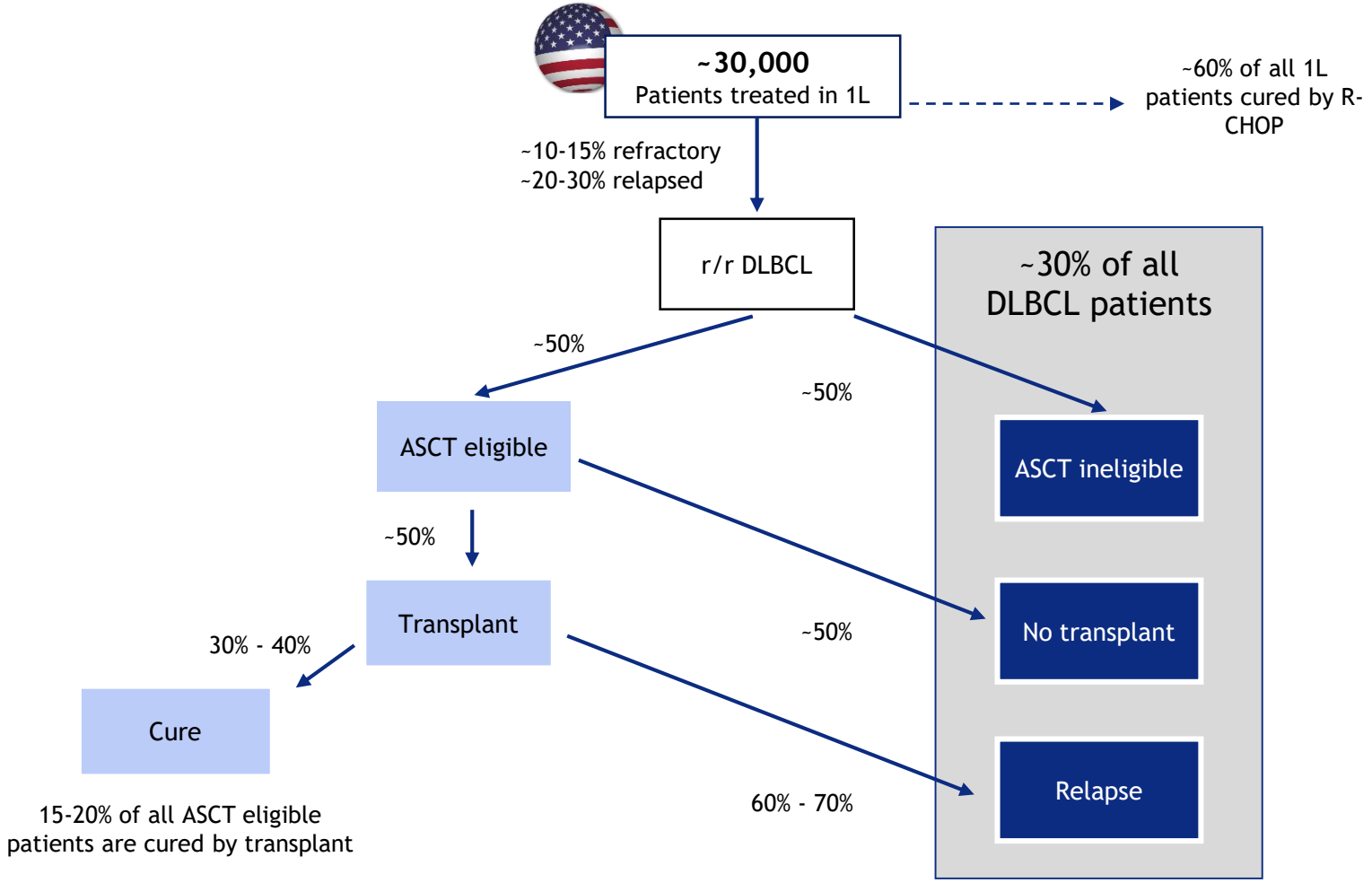
maintenance
alidomide[5],
verolimus[7]

omponent
nutuzumab[9]



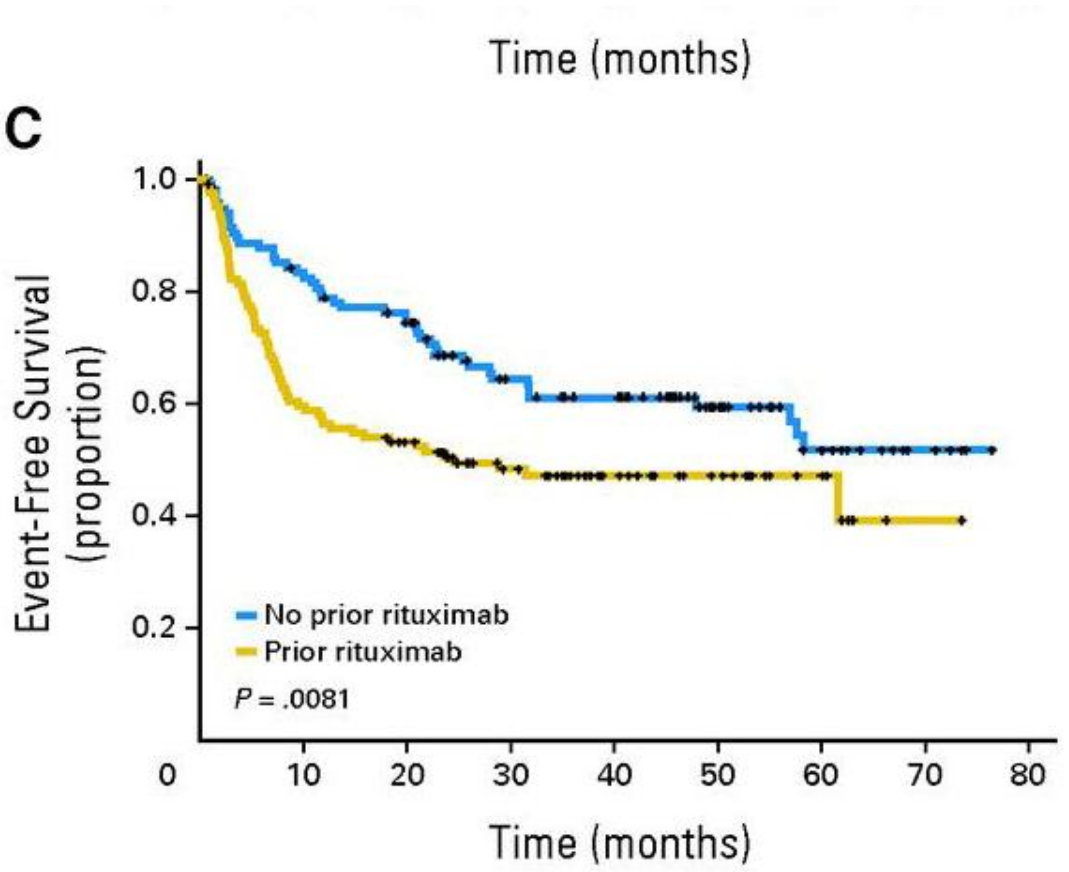
1: Leonard, 2019 ; Davies, 2019 ; 2: Younes, 2019 ; 3: Vittolo, 2019 ; 4: Habberman, 2006; Jaeger, 2015 ; 5 :Thieblemont 2017 ; 6: Crump 2018 ; 7: Witzig 208 ; 8: Offner 205 ; 9 : Vittolo, 2017

High incidence of r/r DLBCL within the U.S.



DRG Epidemiology data for DLBCL (de novo + transformed from FL or CLL); Kantar Market Research (TPP testing 2018), Friedberg et al., 2011

Event-Free Survival after ASCT



Gisselbrecht C, Schmitz N, Mounier N, Singh Gill D, Linch DC, Trneny M et al. Rituximab maintenance therapy after autologous stem-cell transplantation in patients with relapsed CD20(+) diffuse large B-cell lymphoma: final analysis of the collaborative trial in relapsed aggressive lymphoma. J Clin Oncol 2012; 30: 4462–4469.

R/R DLBCL: Standard of Care before approval of tafasitamab

Transplant eligible	Transplant ineligible		
≥ 2 line	**2nd line**	**≥ 3 line**	
DHAP +/- R		Pola-BR	approved
DHAX +/- R		CAR-T	approved
GDP… +/- R		Selinexor	approved
ICE… +/- R	GemOx +/- R		recommended
…	Bendamustine +/- R		recommended

NCCN Guidelines, Version 4.2020

Results of R-GemOx in r/r DLBCL

Rituximab plus gemcitabine and oxaliplatin in refractory/relapsed patients with diffuse large B-cell lymphoma who are not candidates for high-dose therapy. A phase II Lymphoma Study Association trial

by Nicolas Mounier, Taoufik El-gnaoui, Herve' Tilly, Danielle Canioni, Catherine Sebban, Rene'-Olivier Casasnovas, Richard Delarue, Anne Sonet, Pauline Beaussart, Tony Petrella, Sylvie Castaigne, Serge Bologna, Gilles Salles, Alain Rahmouni, Philippe Gaulard, and Corinne Haioun

Haematologica 2012 [Epub ahead of print]

According to time from last treatment

	n	Median PFS months
Time of last treatment / C1<1 year	**22**	**3**
Time of last treatment / C1≥1 year	**26**	**10**

According to prior Rituximab

	Prior rituximab:	No prior rituximab:	*P*
ORR	**32%**	71%	0.01
PFS	**4 months**	11 months	0.02
OS	**8 months**	27 months	0.02

Mounier et al, 2012

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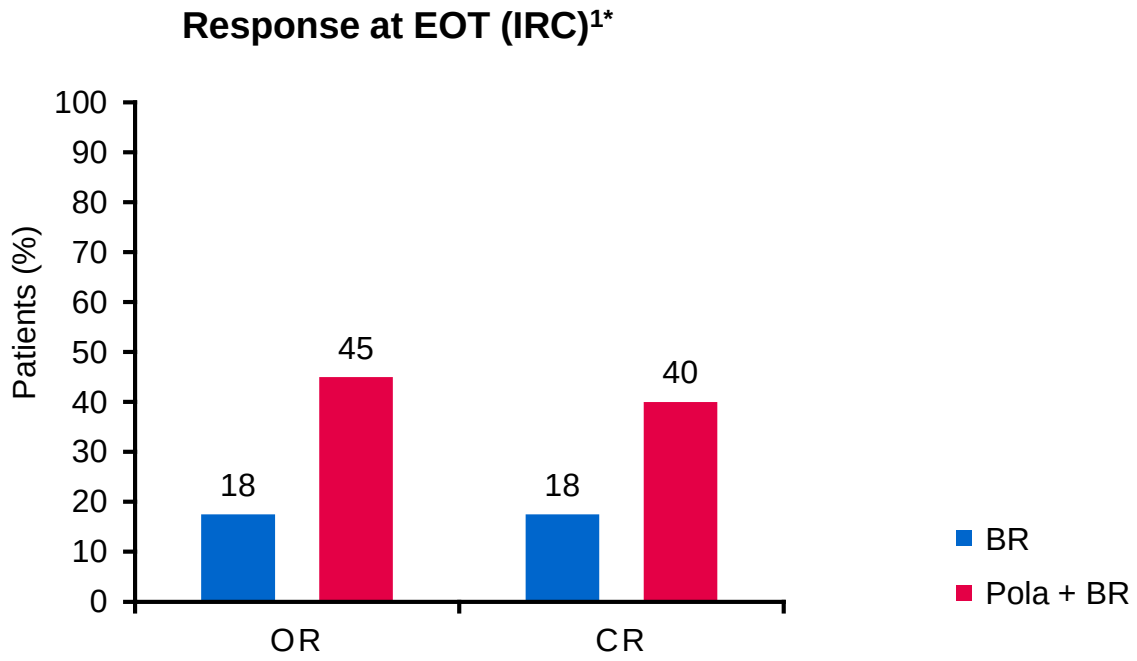
Mounier et al, 2012

Polatuzumab vedotin added to bendamustine / rituximab

Response rates



Seven patients have ongoing response durations of ≥20 months at data cut-off

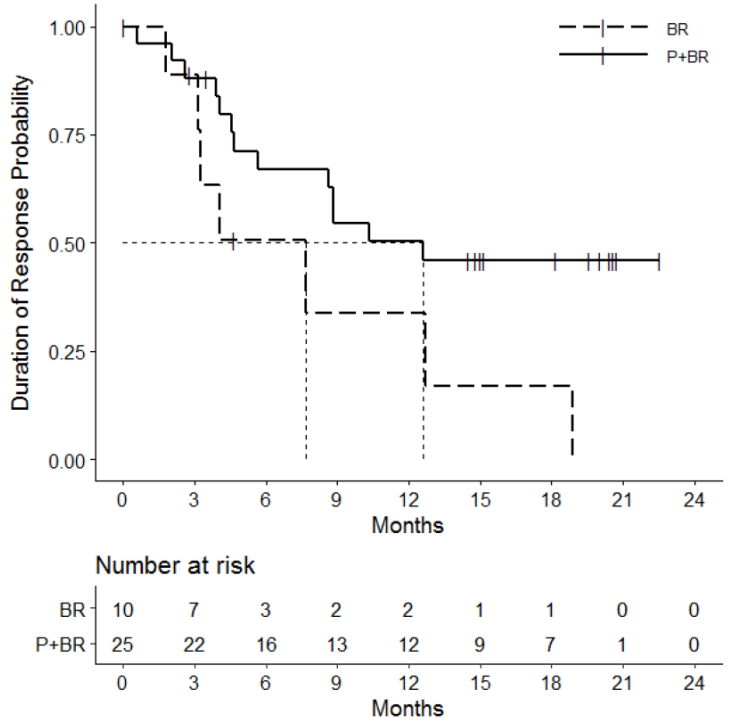
1. Sehn L, et al. Abstract #1683, ASH 2018 | 2. Sehn L, et al. Abstract #7507. ASCO 2018

Data cut-off: 1. 30 April 2018, 2. May 2017
*Primary endpoint; PET-CR is assessed by modified Lugano criteria
BOR, best overall response; BR, bendamustine and rituximab; CR, complete response; EOT, end of treatment; INV, investigator; IRC, independent review committee; OR, objective response; pola, polatuzumab vedotin

Polatuzumab vedotin added to bendamustine / rituximab

Duration of response

Figure 4: FDA-Adjudicated DOR per IRC (Randomized Phase 2)

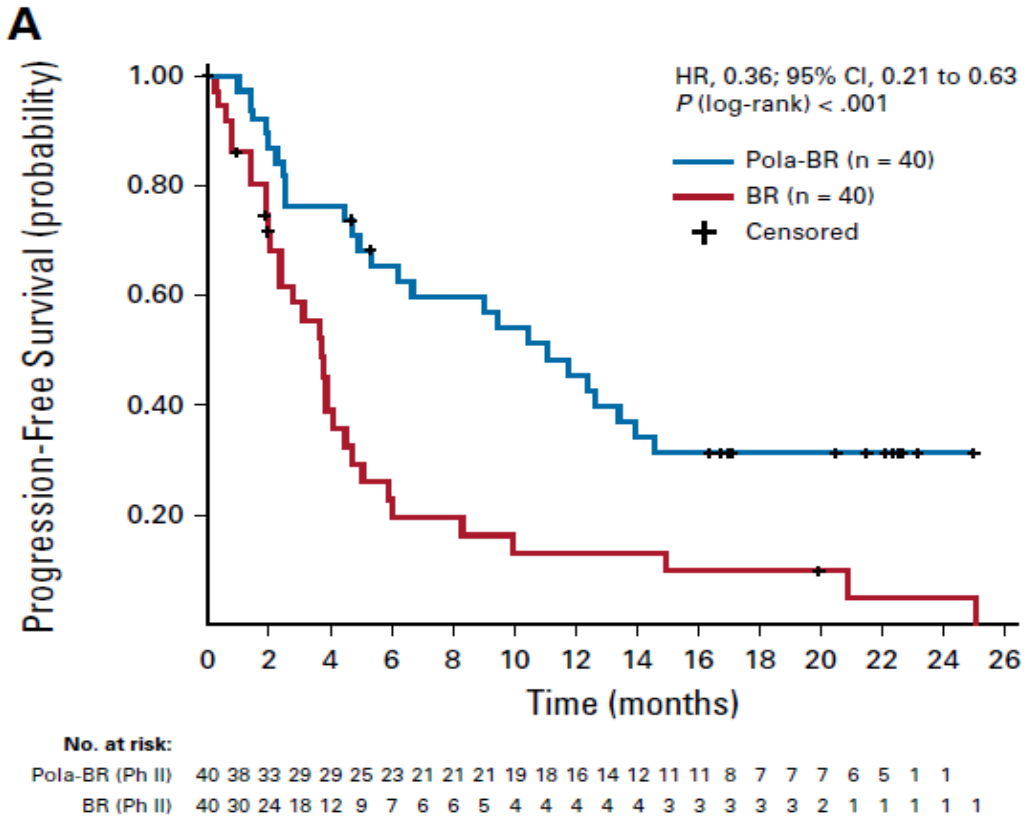


Source: FDA statistical reviewer.
Note: DOR is censored for NALT in remission.

https://www.accessdata.fda.gov/drugsatfda_docs/nda/2019/761121Orig1s000TOC.cfm

Polatuzumab vedotin added to bendamustine / rituximab

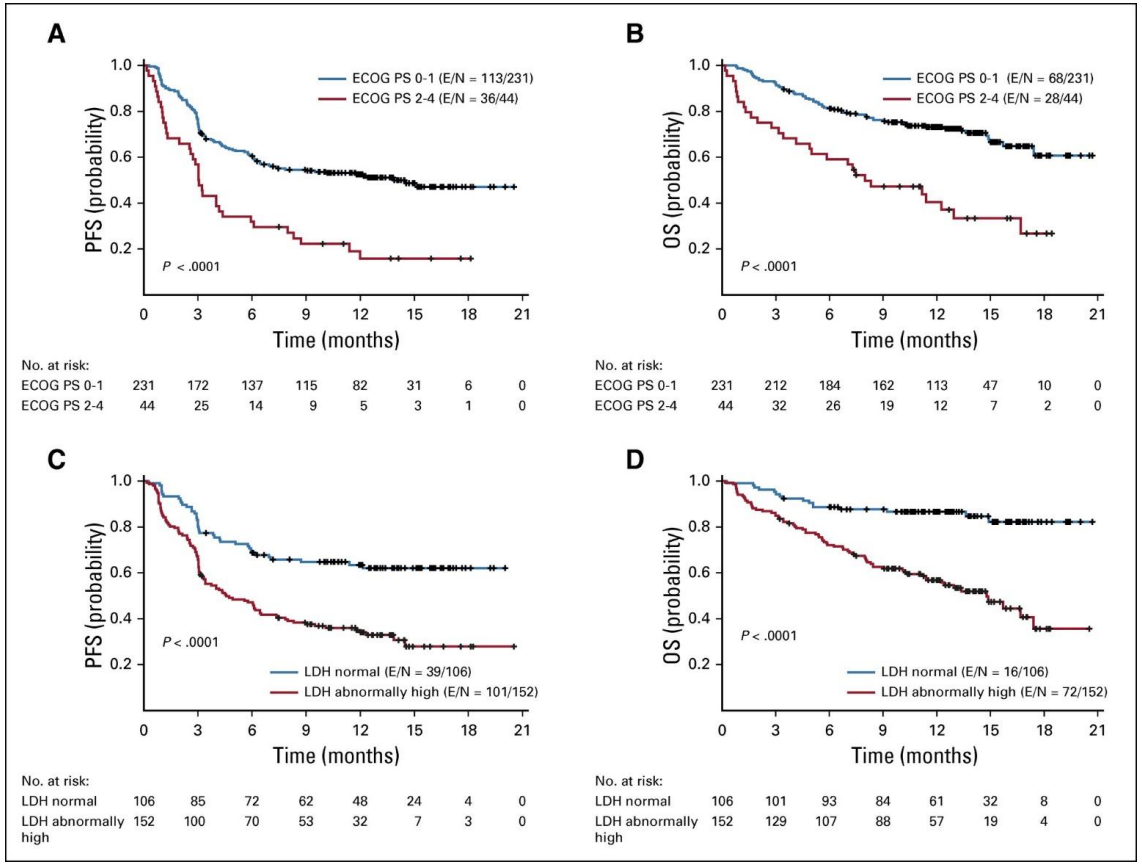
Progression Free Survival (IRC)



- Few patients with durable responses
- Toxicity: hematological, infectious, neurological

Sehn, JCO 2019

Axicabtagene Ciloleucel
PFS and OS by Baseline ECOG and LDH



Loretta J. Nastoupil et al, JCO 2020

CAR-T cells

FAVOR

- Attractive innovation
- High response rates
  - ORR 50 – 80%
- High CR rates
  - 40 – 55%
- Durable responses
  - 70 – 80% of CR patients at 2 y

ISSUES

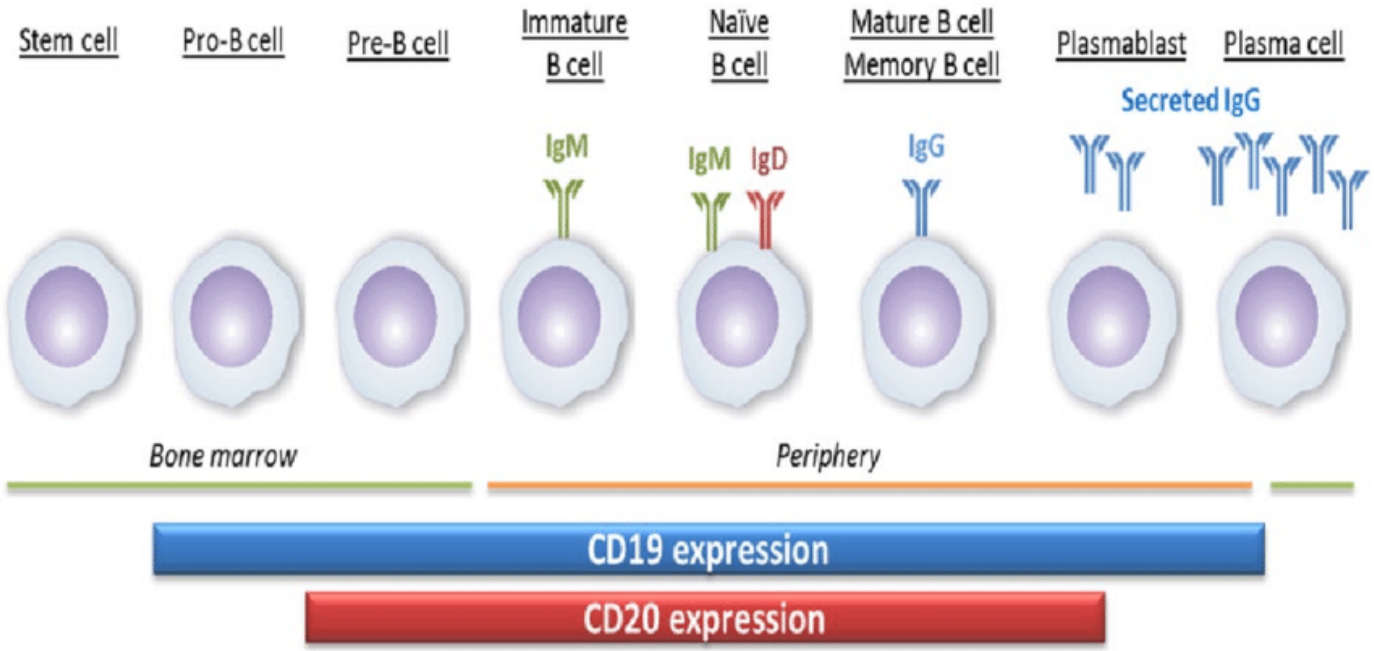
- Logistic complexity
- Not readily available
  - Patients selection
- Specific Gr 3-4 adverse events
- Costs, availability

R/R DLBCL: Standard of Care after approval of tafasitamab

Transplant eligible	Transplant ineligible		
≥ 2 line	**2nd line**	**≥ 3 line**	
DHAP +/- R	Tafasitamab + LEN	Pola-BR	approved
DHAX +/- R		CAR-T	approved
GDP… +/- R		Selinexor	approved
ICE… +/- R	GemOx +/- R		recommended
…	Bendamustine +/- R		recommended

NCCN Guidelines, Version 4.2020

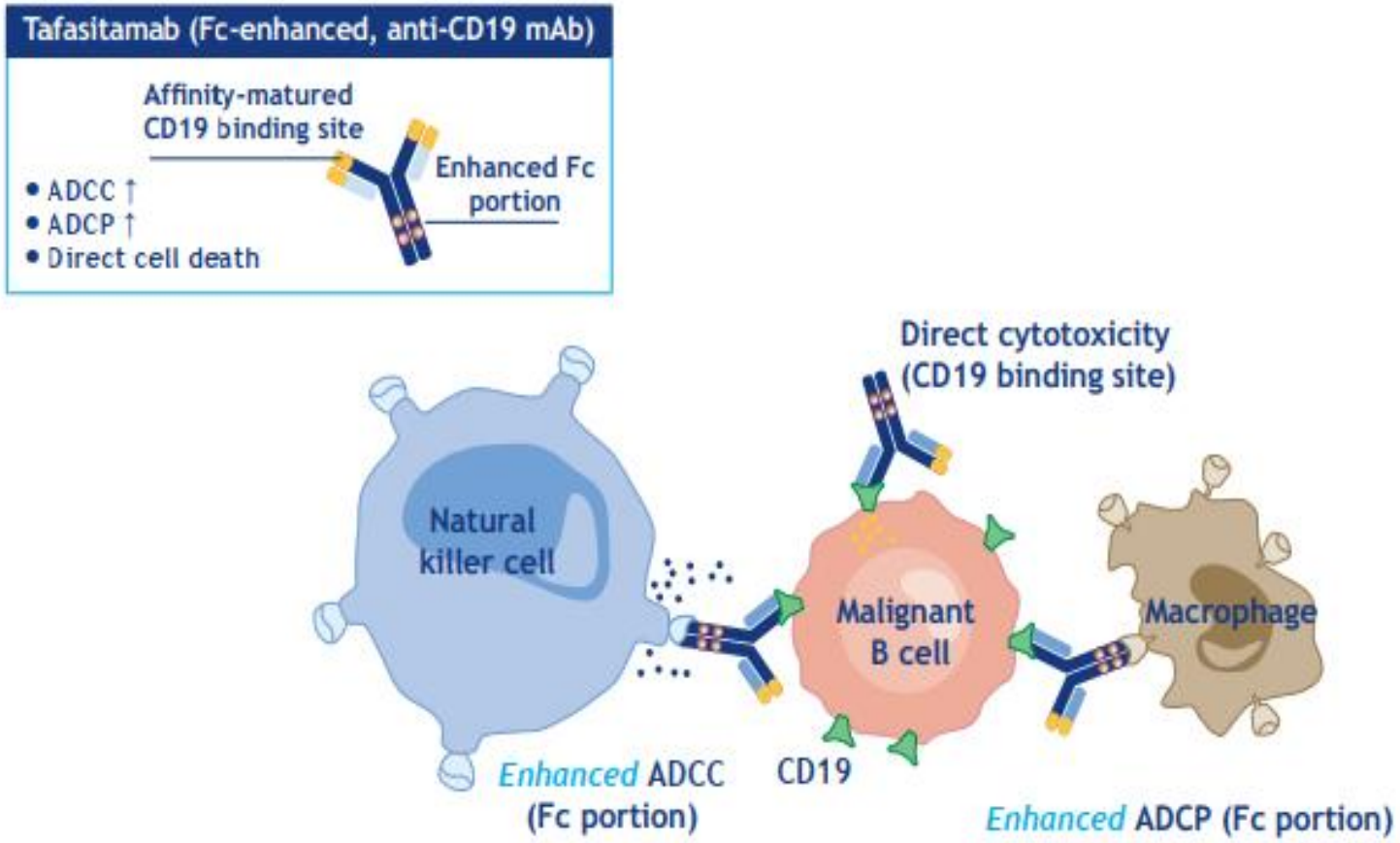
CD19 and CD20 expression during B-cell development



https://www.researchgate.net/figure/Summary-of-CD19-and-CD20-expression-during-B-cell-development-CD19-expression-is_fig1_323911459

Tafasitamab a humanized and engineered anti-CD19 Ab

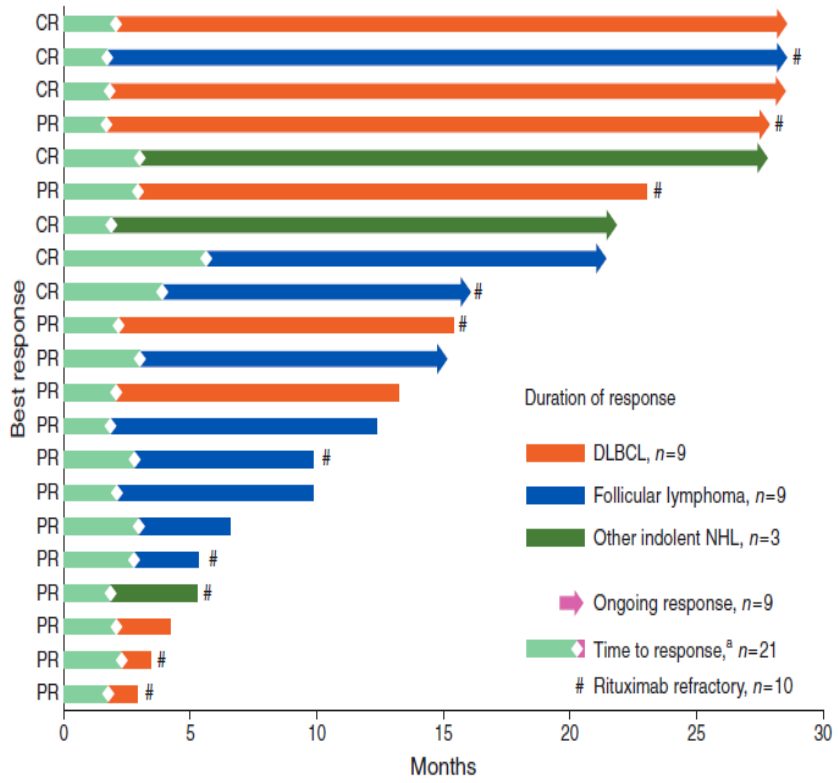
Previously known as XmAb5574, then MOR208



Long duration of response with tafasitamab as monotherapy

	ORR
DLBCL :	26% (6% CR)
FL:	29% (9% CR)

Phase II
Single agent study



Jurczak et al, Ann Oncol 2018

Mode of actions provide the rationale for tafasitamab + lenalidomide combination

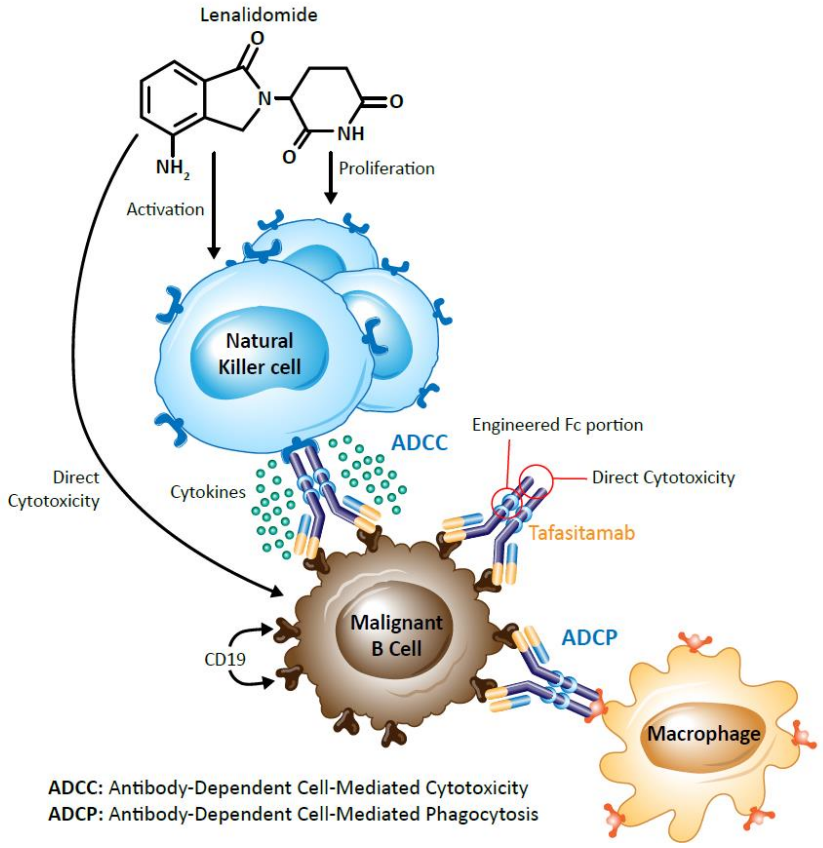
Tafasitamab MoA

- Antibody Dependent Cellular Cytotoxicity via NK cells (ADCC)
- Antibody Dependent Cellular Phagocytosis (ADCP)
- Direct cytotoxicity

Lenalidomide MoA

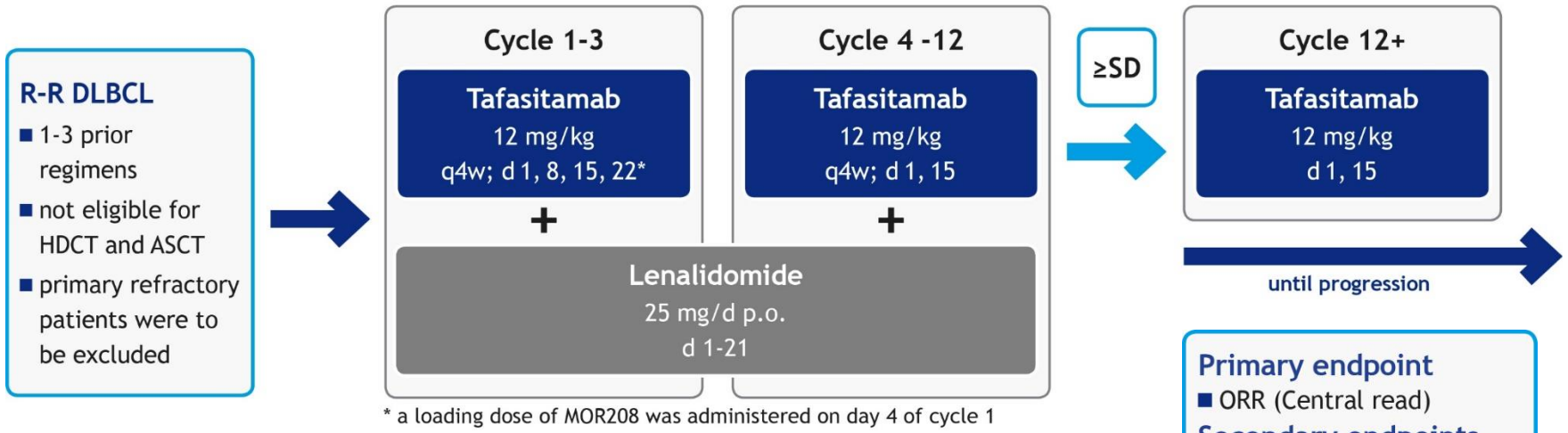
- Direct cytotoxicity
- Increase NK cell numbers (ADCC)
- Activate NK cells

Increased anti-tumor effects



L-MIND: Study design

Phase 2, single-arm, open-label, multicenter study (NCT02399085)



- Sample size suitable to detect ≥15% absolute increase in ORR for Tafasitamab/LEN combination vs. LEN monotherapy at 85% power, 2-sided alpha of 5%
- Mature Data: Primary Endpoint Analysis with data cut-off 30 Nov 2018; minimum Follow-Up 12 months, median Follow-Up 17.3 months

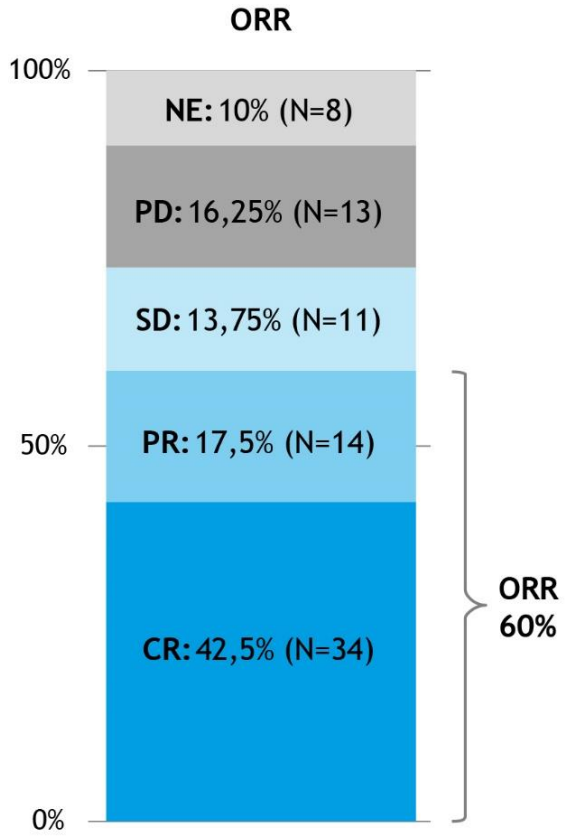
Patient characteristics

Characteristic	Specification	n=81 (%)
Age [years]*	median (range)	72 (41-86)
Risk (IPI)*	0-2 3-5	40 (49) 41 (51)
Ann Arbor Stage*	I-II III-IV	20 (25) 61 (75)
Elevated LDH*	Yes No	45 (56) 36 (44)
Prior Lines (median=2) *	1 2 3-4	40 (49) 35 (43) 6 (7)
Refractory to last prior therapy*	Yes No	36 (44) 45 (56)
Primary Refractory	Yes	15 (18)
Prior SCT	Yes	9 (11)
Cell of Origin (Centrally assessed - Hans algorithm)	GCB Non-GCB Unknown	37 (46) 20 (25) 24 (30)

*at study entry | IPI, international prognostic index; LDH, lactate dehydrogenase; SCT, stem cell transplant

Salles et al, Lancet Oncol. 2020

Primary endpoint: Overall Response Rate (ORR) by IRC



- ORR 60.0% (95% CI: 48.4%–70.8%)
- CR-rate 42.5%
  - 82% of CRs PET-confirmed
  - 18% of CRs based on CT only

N=80: full analysis set → patients receiving at least one dose of tafasitamab and LEN

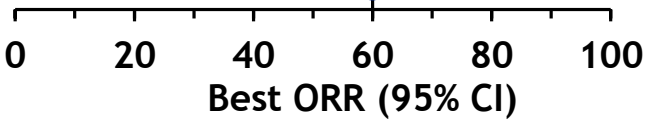
NE due to missing post-baseline tumor assessment

CI, confidence interval; CR, complete response; CT, computed tomography; IRC, independent review committee; LEN, Lenalidomide; NE, not evaluable; ORR, overall response rate; PET, positron emission tomography; PR, partial response; PD, progressive disease; SD, stable disease.

Salles et al, Lancet Oncol. 2020

Consistent ORR in subgroups, including refractory patients

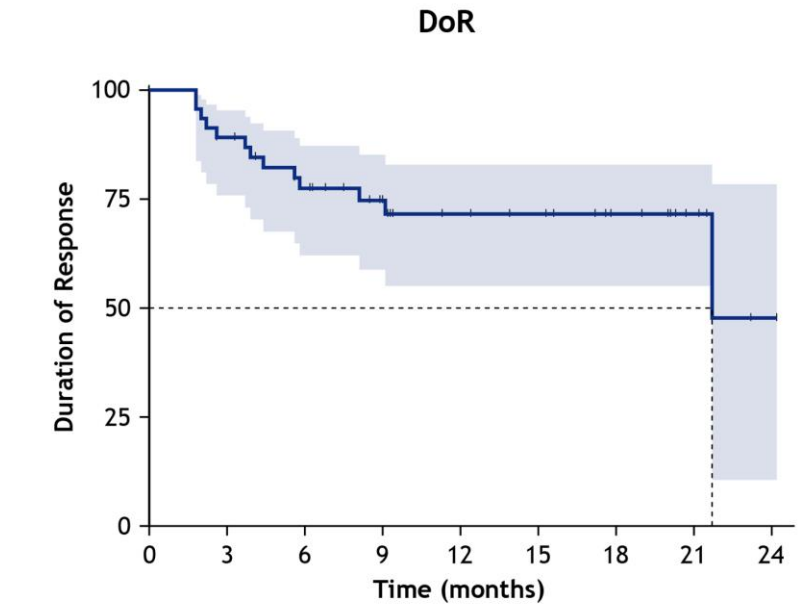
Characteristic		N	Best ORR, % (95% CI)	Best ORR, %
Age group	≤70 yr	35		62.9
	>70 yr	45		57.8
Gender	Female	37		54.1
	Male	43		65.1
IPI score	Intermediate-High and High risk	40		50.0
	Low and Low-Intermediate risk	40		70.0
Rituximab refractoriness	Yes	33		57.6
	No	46		60.9
Prior treatment lines	1	40		70.0
	≥2	40		50.0
Primary refractoriness	Yes	15		60.0
	No	65		60.0
Prior ASCT	Yes	9		77.8
	No	71		57.7
Refractoriness to last prior therapy	Yes	35		60.0
	No	45		60.0



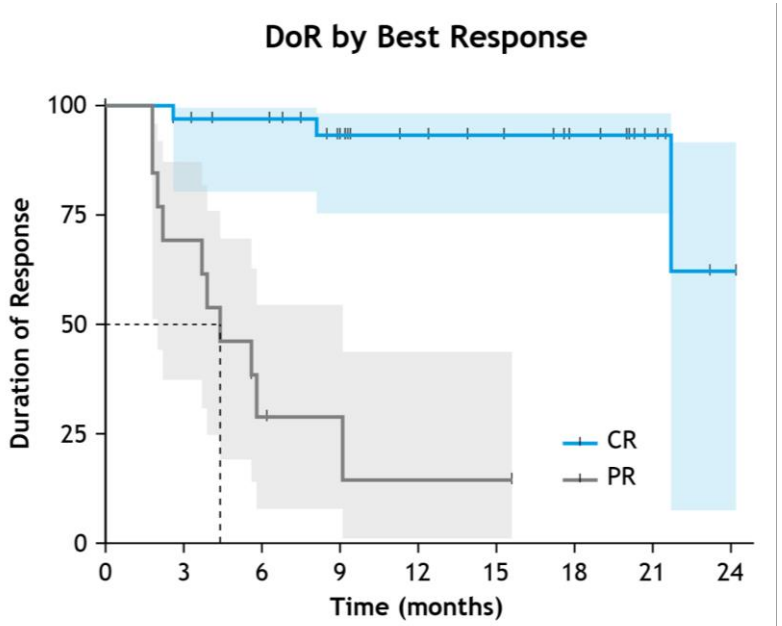
ORR=overall response rate; ASCT=autologous stem cell transplantation; IPI=international prognostic index

Salles et al, Lancet Oncol. 2020

Duration of Response (IRC)



Number of patients at risk									
Overall	48	40	32	25	18	16	11	5	1



Number of patients at risk									
CR	34	31	29	23	17	15	11	5	1
PR	14	9	3	2	1	1	0	0	0

- **Median DoR 21.7 mo (95% CI: 21.7-NR)**

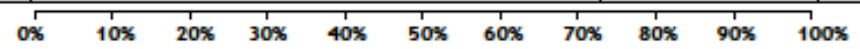
- **Median DoR for CR patients: NR (95% CI: 21.7-NR)**
- **Median DoR for PR patients: 4.4 mo (95% CI: 2.0-9.1)**

CI, confidence interval; CR, complete response; DoR, duration of response; IRC, independent review committee; NR, not reached; PR, partial response.

Salles et al, Lancet Oncol. 2020

12-months DOR by baseline characteristics

Subgroup		N	12-month duration of response (%) (95% CI)	12-month rate (%)	95% CI
Responders in the FAS		48		72	55–83
IPI score	Low risk and low–intermediate risk	28		87	63–96
	Intermediate–high risk and high risk	20		50	26–71
Cell of origin, phenotype*	Non-GCB	15		83	47–96
	GCB	18		53	28–74
Refractoriness to last prior therapy	Yes	21		71	46–86
	No	27		72	47–86
Primary refractory	Yes	9		44	14–72
	No	39		78	59–89
No. of prior lines	1	28		70	47–85
	≥2	20		73	46–88
BOR (CR or PR only)	PR	14		14	1–44
	CR	34		93	75–98



Two patients had DHL/THL after central FISH review: one with DHL achieved PR only; another patient with THL (was also primary refractory subgroup) achieved CR and remains in remission after >30 months.

Salles et al, Lancet Oncol. 2020 (supplemental data)

L-MIND – Outcome in 2nd line subpopulation

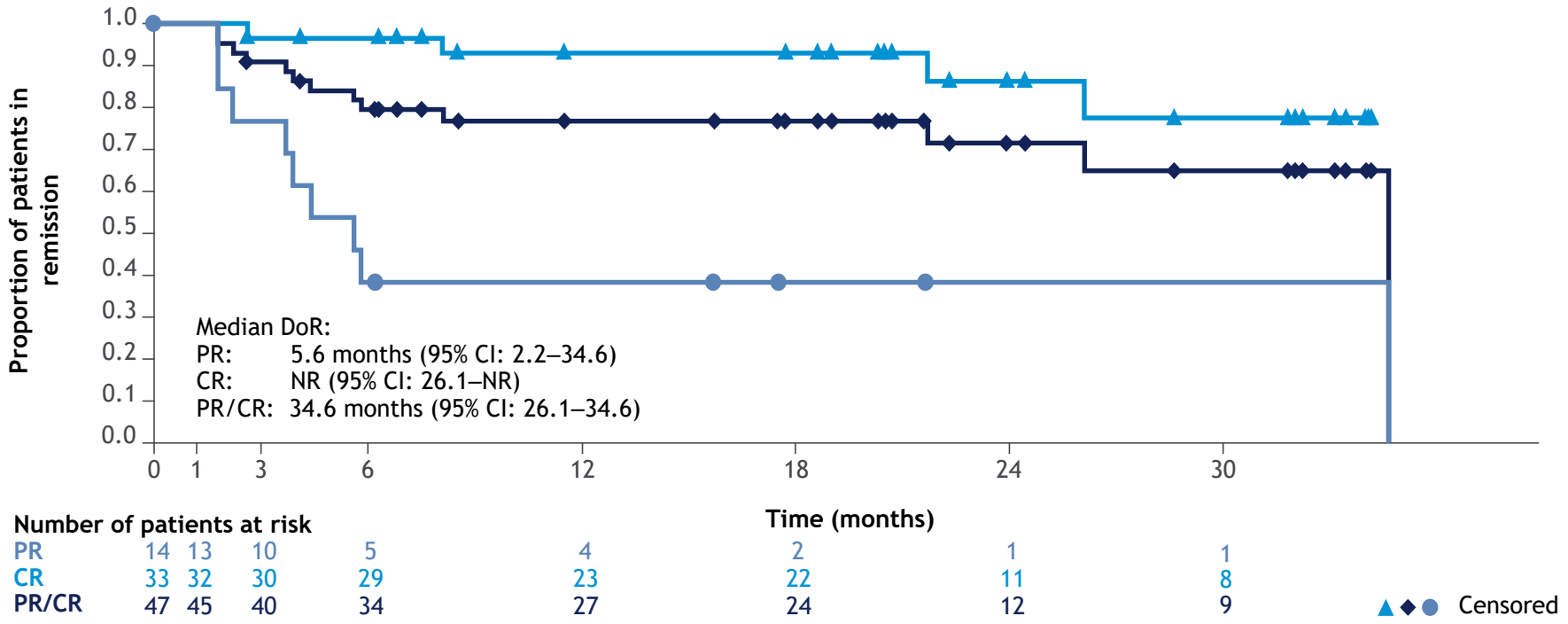
	N=40
ORR	70.0 %
CR rate	52.5%
Median PFS	23.5 mo
12 months OS rate*	86.9 %

*Kaplan Meier Analysis

Duell et al, ASH 2019

L-MIND – Long-term follow-up (≥24 months)

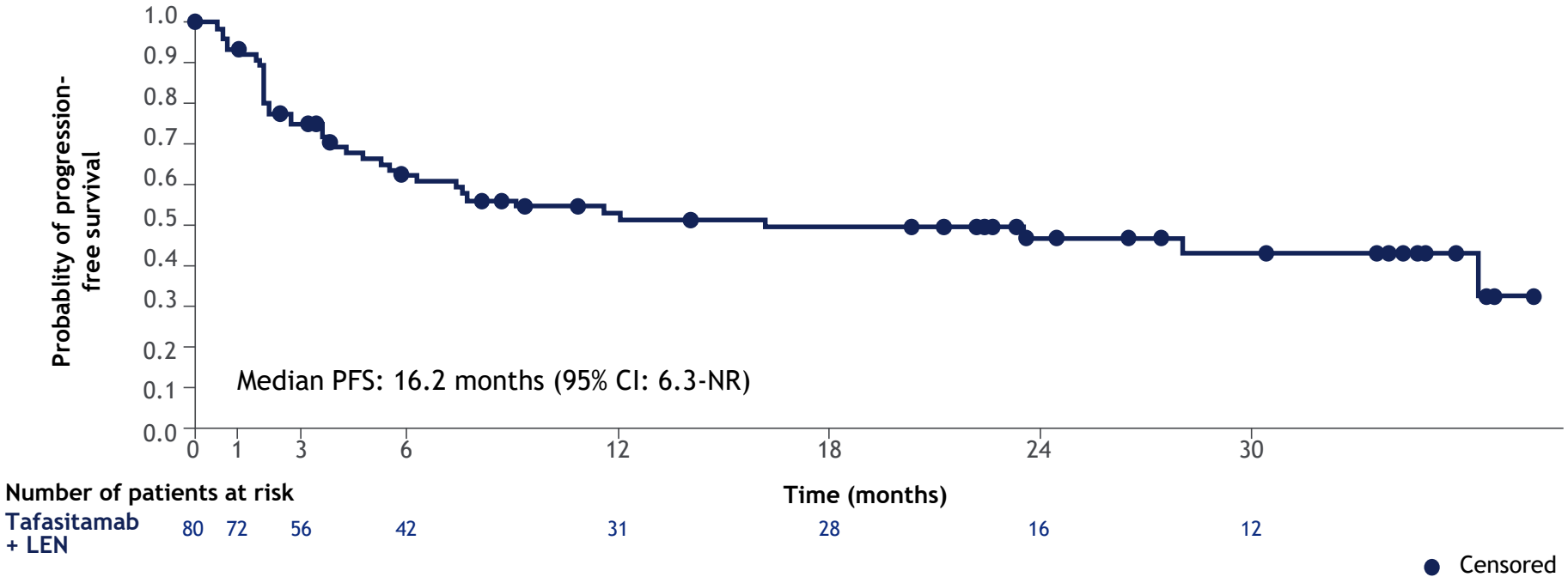
DOR (IRC)



Salles et al, EHA 2020

L-MIND – Long-term follow-up (≥24 months)

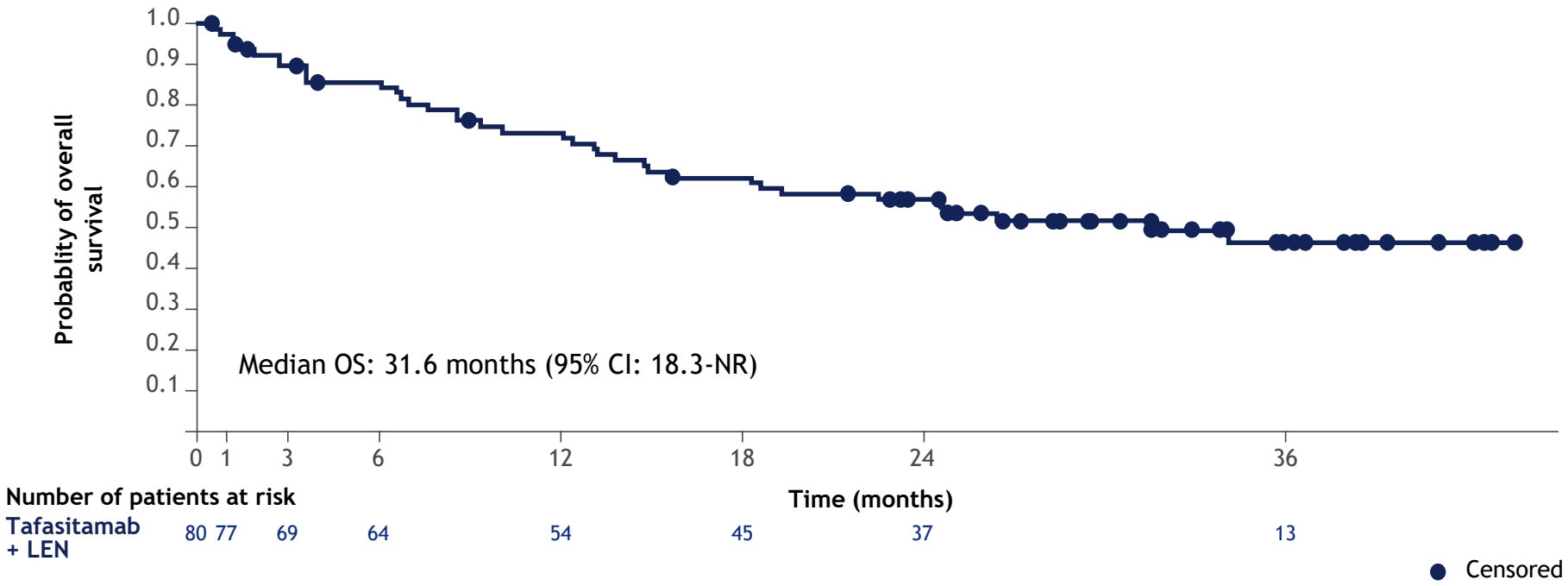
PFS (IRC)



Salles et al, EHA 2020

L-MIND – Long-term follow-up (≥24 months)

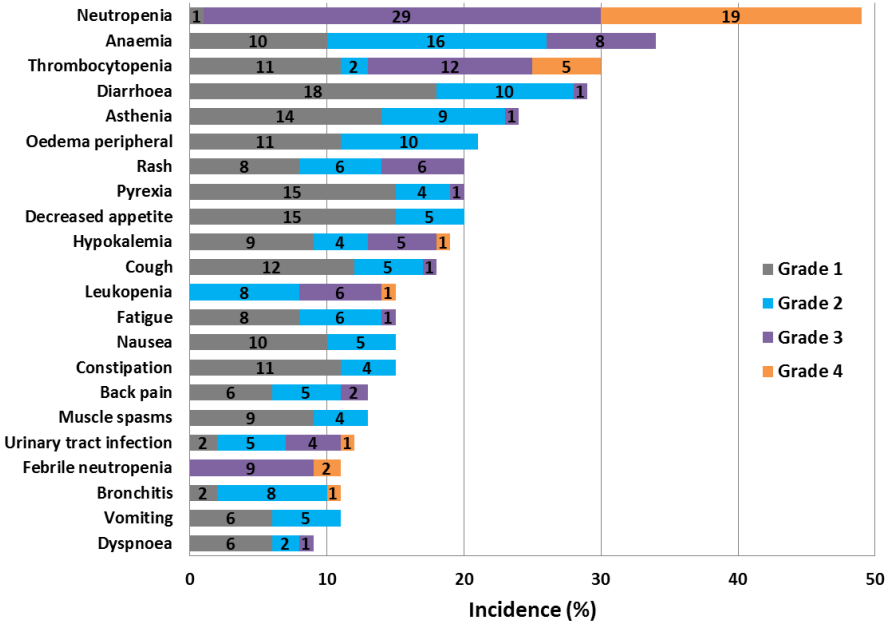
OS



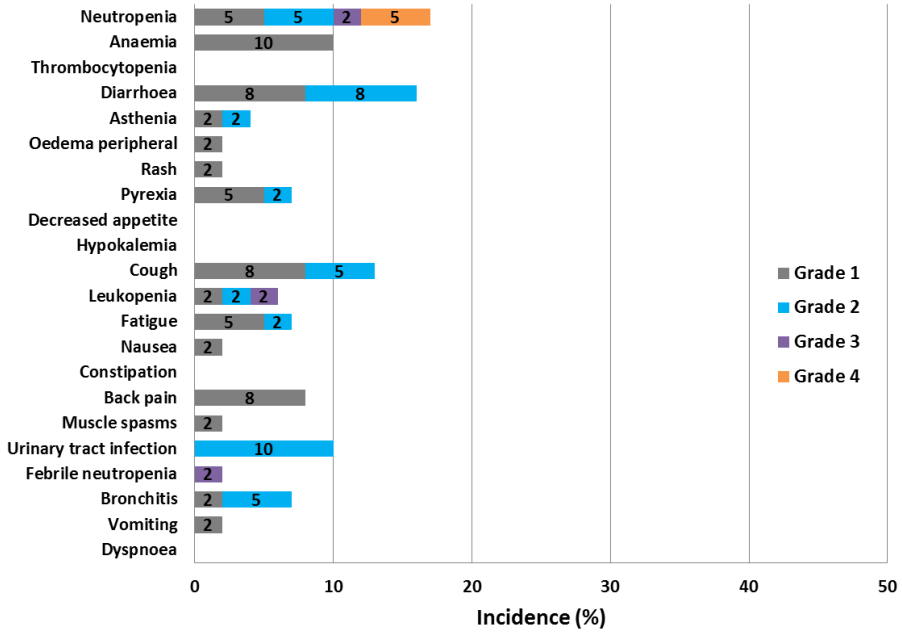
Salles et al, EHA 2020

Safety by treatment phase

Tafasitamab + LEN combination (up to 12 cycles) n=80, median exposure 6.5 months



Tafasitamab monotherapy (cycle 13 onwards or after LEN discontinuation) n=37, median exposure 8.7 months



- Incidence and severity of TEAEs is lower during the tafasitamab monotherapy phase
- 10 patients (12%) discontinued tafasitamab + LEN due to AE

AE collection period included 30 days after end of treatment. | LEN, Lenalidomide.

Salles et al, Lancet Oncol 2020

L-MIND: Conclusions

- Tafasitamab + LEN showed high ORR and CR rate with durable responses
- High activity consistently observed in patient subgroups with limited treatment options and poor prognosis
- Overall survival data are favourable
- The combination therapy was well tolerated
  - Safety profile largely driven by lenalidomide
  - Safety profile of tafasitamab is as expected for a B-cell depleting mAb

New agents in development in B-cell NHL

- Naked anti-CD20, anti-CD19 mAbs
- Antibody drug conjugates
- Bispecific antibodies

- Immune checkpoint blockers (new one's ?)
- IMIDs (new ones or in combination)
  - R2
  - L-MIND regimen

- Cell signaling (BCR & others)
- Intracellular trafficking (selinexor, …)
- Apoptosis (venetoclax, anti-MCL1)
- Epigenetic (tazemetostat)

Novel agents in development for DLBCL

Class	Target	Agent	Phase	Overall response rate (%)	Complete response rate (%)	Reference
Monoclonal antibody	CD19	tafasitamab + lenalidomide	2	60	43	Salles et al
Antibody drug conjugates	CD19	loncastuximab tesirine	1	59	41	Kahl et al
	CD79b	polatuzumab vedotin	1	52	13	Palanca-Wessels et al
		polatuzumab vedotin + BR versus BR	2 randomized	45 17.5	40 17.5	Sehn et al
Bispecific antibodies	CD19/CD3	blinatumomab	2	43	19	Viardot et al
	CD20/CD3	mosunetuzumab	1/1b	35	19	Schuster et al
		glofitamab	1/1b	38	31	Dickinson et al
Other target inhibitors	BCL2	venetoclax	1	18	12	Davids et al
	XPO1	selinexor	2b	28	12	Kalakonda et al
Checkpoint inhibitors	PD-1	nivolumab	2	≤ 10	≤ 3	Ansell et al
	CD47	magrolimab	1b	40	33	Advani et al

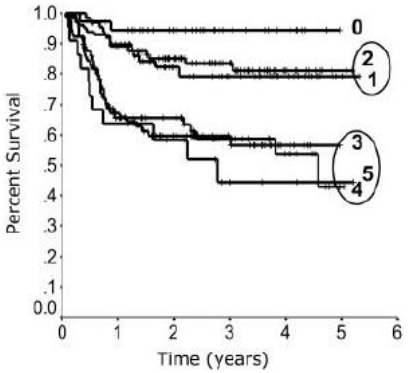
Salles et al., Lancet Oncol. 2020; Kahl et al., Clin Cancer Res. 2019; Palanca-Wessels et al., Lancet Oncol. 2015; Sehn et al., JCO 2020; Viardot et al., Blood 2016; Schuster el al., ASH 2019; Dickinson et al., EHA 2020; Davids et al., JCO 2017; Kalakonda et al., Lancet Haematol. 2020; Ansell et al., JCO 2019; Advani et al., N Engl J Med., 2018

Unmet need in frontline DLBCL

Prognosis significantly declines with IPI score of 3-5

	3-yr Progression-free survival (PFS)[1]	3-yr Overall survival (OS)[1]	Incidence[2]
Low risk – IPI score of 0 or 1	87%	91%	28%
Low-intermediate risk – IPI score of 2	75%	81%	27%
High-intermediate risk – IPI score of 3	59%	65%	21%
High risk – IPI score of 4 or 5	56%	59%	24%

Progression-free survival by IPI[2]

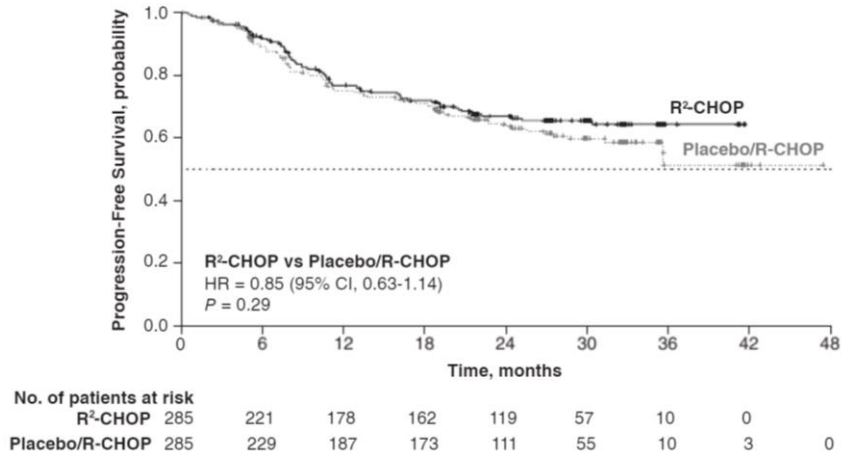


1: Ziepert M, et al.; J Clin Oncol. 2010; 2: Sehn eta al., Blood, 2007.

Clinical trials in 1L DLBCL - Points to consider

ROBUST Trial – Positive trend in high risk subgroup

PhIII R2-CHOP vs R-CHOP in previously untreated ABC-type DLBCL



	PFS Hazard Ratio
Overall Population	0.85 (95% CI, 0.63-1.14)
Disease stage III/IV	**0.81 (95% CI, 0.60-1.10)**
IPI score ≥ 3	**0.74 (95% CI, 0.53-1.05)**

Vitolo et al 2019

Rationale for combining tafasitamab and lenalidomide and R-CHOP in 1L DLBCL

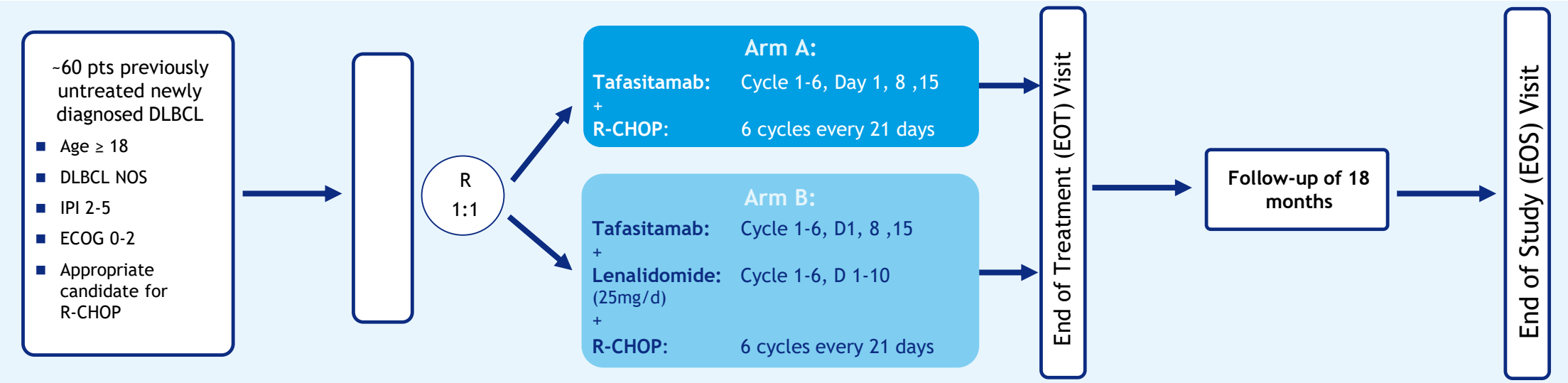
- Synergistic MoA of tafastimab + LEN
- Strong data of tafastimab + LEN in R/R DLBCL
- Expression pattern on biopsies of newly diagnosed B-cell lymphomas supports targeting CD20 and CD19*
  - CD19 expression more homogenous compared to CD20
  - CD19 expression preserved in small CD20-negative tumor subsets
- High risk patients (IPI 3-5) with unmet medical need and positive trend in previous 1L DLBCL PhIII trial

*Horna et al EHA, 2020

First-MIND: Purpose, objectives and endpoints

International, open-label, prospective, randomized phase 1b study in 1L DLBCL

First MIND to confirm the safety and preliminary efficacy of **tafasitamab in addition to R-CHOP (Arm A)** *or* **tafasitamab plus lenalidomide in addition to R-CHOP (Arm B)** in patients with newly diagnosed DLBCL (NCT04134936)



Primary endpoint

- **Safety (TEAEs)**

Secondary endpoints

- Long-term safety
- Efficacy: PET-CR, ORR, EFS, TTNT, PFS, and OS
- Pharmacokinetics and immunogenicity of Tafasitamab

Exploratory endpoints

- ctDNA analysis
- ORR/PFS by: COO; NK cell count in peripheral blood / tumor tissue; Quantitative CD19 and CD20 expression on tumor tissue
- Other biomarkers

Q&A Session

Dr. Roland Wandeler, Ph.D.

Chief Operating Officer, MorphoSys

First FDA approved 2nd line therapy in r/r DLBCL

Opportunity to transform standard of care in r/r DLBCL

Accelerated FDA approval	▪ FDA-accelerated approval of MONJUVI® (tafasitamab-cxix)* in combination with lenalidomide on 31 July 2020
First 2nd line	▪ First FDA-approved 2nd line therapy in r/r DLBCL, for patients not eligible for autologous stem cell transplant (ASCT)
Potential to transform standard of care	▪ Addressing significant unmet medical need ▪ Potential to transform the treatment of patients with r/r DLBCL
Building momentum	▪ Delivered on speed to market ▪ Able to engage customers in COVID context ▪ Encouraged by early adoption and uptake

*MONJUVI, in combination with lenalidomide, is indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma, and who are not eligible for autologous stem cell transplant (ASCT).

Addressing unmet medical need

Key messages

Indication

MONJUVI®, in combination with lenalidomide, is indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma, and who are not eligible for autologous stem cell transplant (ASCT).

Key efficacy data[1]

- Best overall response rate 55%
- Complete response rate 37%
- Median duration of response 21.7 months

For r/r DLBCL patients in 2L+, not eligible for autologous stem cell transplant,

MONJUVI® + lenalidomide …

Efficacy

… is the **first and only 2L+** therapy resulting in **complete and durable responses**

Safety & Tolerability

… has a **combined safety & tolerability profile** that supports treatment to progression, allowing for **long-term disease control**

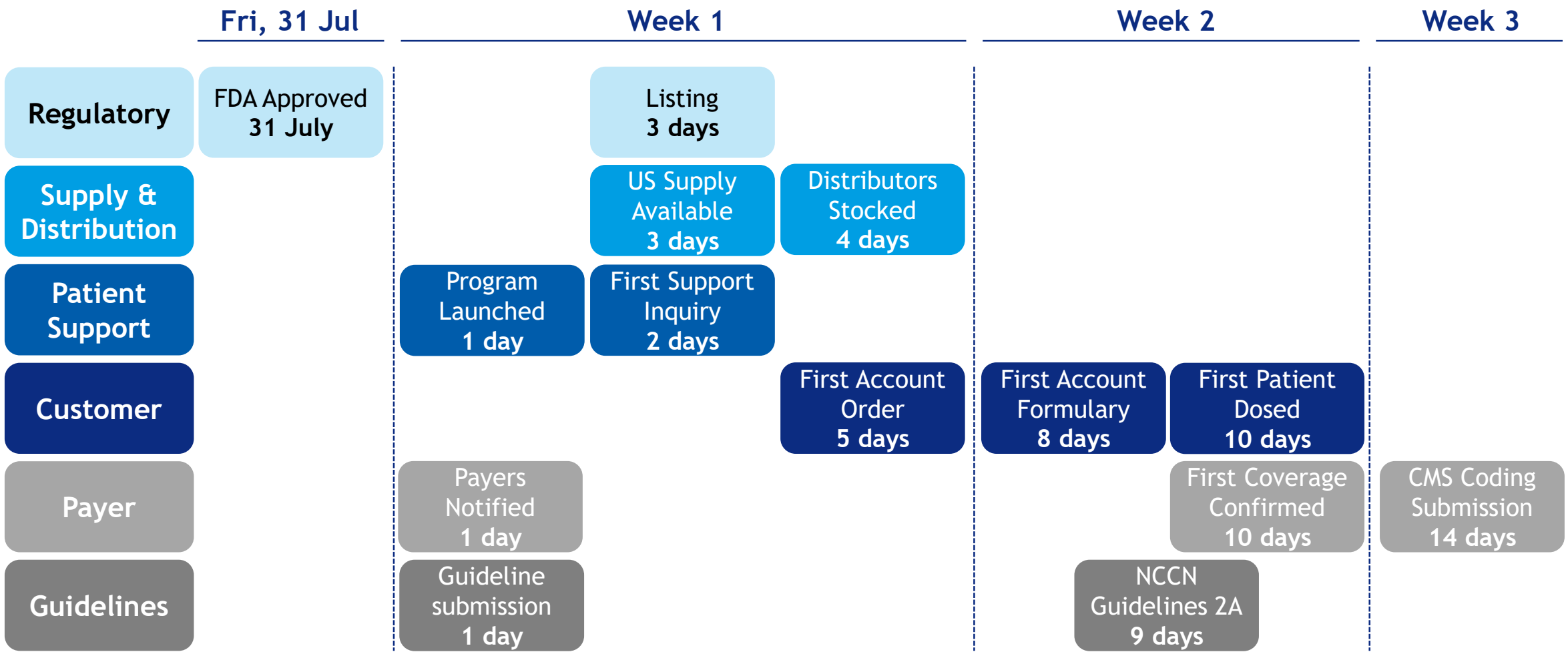
Accessibility

… is an efficient **anti-CD19 therapy**, both **community & academic-accessible**, easy to administer, and not requiring hospitalization or continuous monitoring

1. USPI https://www.monjuvi.com/pi/monjuvi-pi.pdf

Speed to market: First patient dosed 10 days after approval

Key milestones, business days after FDA approval



Reaching customers in COVID context

Driving engagement with physicians ahead of expectations

Individual engagement

>30,000
Emails to key customers

>4,400
Calls

>1,800
Medical engagements

Peer-to-peer engagement

>120
Speaker programs completed or planned over next 3 months

Virtual education platform

Closed loop digital engagement

HCP and patient websites

Social connections

BulletinHealthcare
OncLive
Cancer Therapy Advisor
Medscape
BioPharm Communications
Targeted Oncology

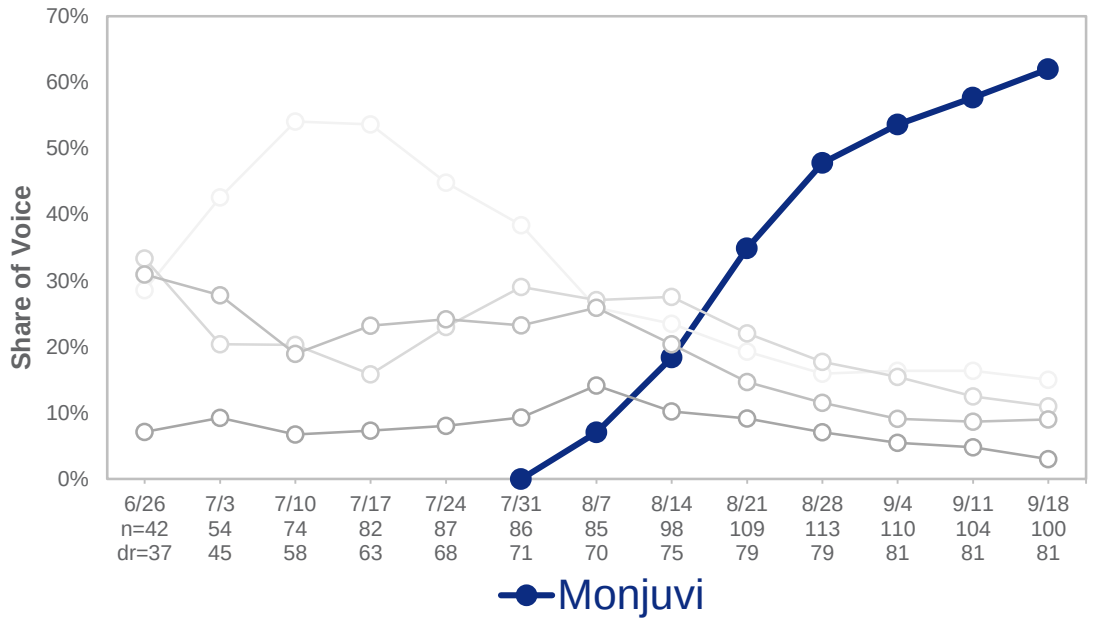
Digital advertising

Email campaigns

Attained clear leadership in share of voice

Translating share of voice into engagement

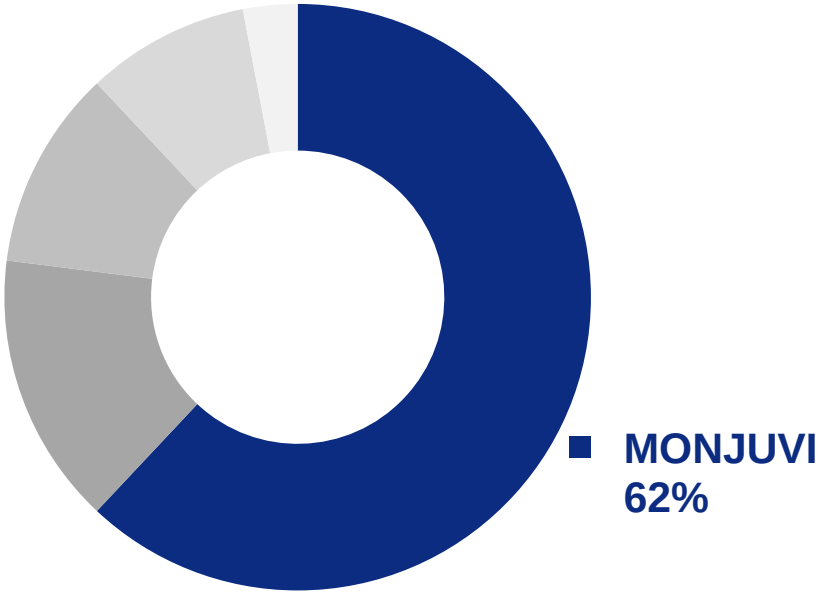
Evolution of share of voice



Share of voice *(As of 9/18/20)*

MONJUVI® compared to:

Kymriah
Polivy
Xpovio
Yescarta



MONJUVI® compared to: Kymriah, Polivy, Xpovio, Yescarta

Source: IQVIA BrandImpact Weekly Tracking; week ending September 18, 2020

Encouraged by early adoption and uptake by key centers

Select metrics as of late September

>6,200 Personal meetings with HCPs

as customers want to engage with us despite COVID

>100 Key accounts already ordered

many top accounts using exception processes for speed

>57% Formulary approvals in top 30 accounts

on track to gain positive formulary decisions in the remaining Key Accounts

>43% EMR / order sets added in top 30 accounts

supporting pull-through to enable broader uptake across networks

Thereof

- ~50% academic
  ~50% community
- ~50% of NCCN institutions

~50% of overall demand from top 100 key accounts

Early physician feedback suggests good adoption

Select quotes from advisory boards and personal engagements

Main HCP feedback

- **Impressive efficacy**, especially duration of response
- **Well tolerated**
- **Easy to use** in both community and academic settings

"What was most impressive was the durability of those responses. Well over 50% of patients were still in remission at 18 months."

"The duration of response is particularly impressive."

"If the goal is to keep the patient alive with minimum toxicity, I think that's a good drug to use

"A natural fit [for community-based physicians]."

"Accessibility is a huge benefit to patients, especially now during a healthcare crisis."

"Definitely fit immediately into my relapse/refractory paradigm especially for those that will not be a candidate for CAR-T"

Dr. Barry Flannelly, Pharm.D.

General Manager, North America, Incyte

Ensuring strong payer access and providing patient support for MONJUVI®

No notable access restrictions

- No distribution delays for MONJUVI
- Product availability within days of approval

Reimbursement progress

- Broad reimbursement achieved; where prior authorization req'd, policies in line with expectations
  - Reimbursed under Medicare Part B
  - Covered under multiple commercial plans
- Expect vast majority of lives covered within first year of launch

Rapid inclusion of MONJUVI in NCCN guidelines[1]

- Increases awareness of MONJUVI with HCPs
- Drives formulary discussions

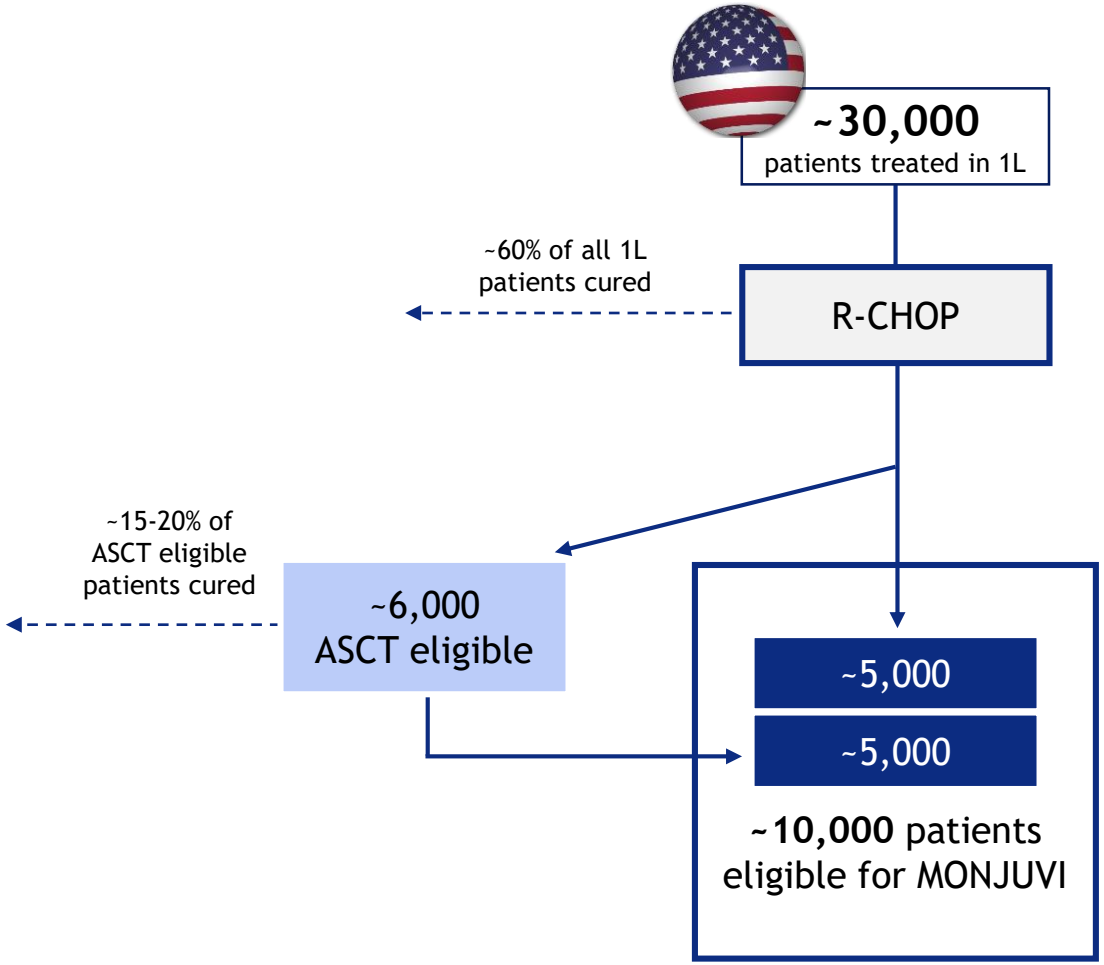
My MISSION Support; services include:

- Education and support with coverage, coding and reimbursement and financial assistance for eligible patients

1. Category 2A of NCCN guidelines: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
NCCN: National Comprehensive Cancer Network (NCCN) guidelines

High incidence of r/r DLBCL within the U.S.

Potential for MONJUVI® to transform the standard of care in 2L+ DLBCL



FDA approved therapies in DLBCL

1st Line	*R-CHOP*
2nd Line	MONJUVI® tafasitamab-cxix | 200mg for injection, for intravenous use
3rd Line+	MONJUVI® tafasitamab-cxix | 200mg for injection, for intravenous use *axicabtagene ciloleucel* *tisagenlecleucel* *polatuzumab* *selinexor*

Source: DRG Epidemiology data for DLBCL (de novo + transformed from FL or CLL); Incyte and MorphoSys analyses

r/r DLBCL represents a substantial opportunity in the U.S.

Potential for extended duration of therapy in complete responders

# of eligible patients

~10,000 new eligible patients each year; ~5,000 2L and ~5,000 3L+

New patients

Share of NEW patients:
One of the standards of care in r/r DLBCL

Ongoing patients

Growing proportion of ONGOING patients:
Treatment to progression and long duration of response

Price

US$ 6,000 (WAC) per dose, on average

Year 1: 33 doses; Year 2+: 26 doses

Peak sales potential for MONJUVI® in r/r DLBCL in the U.S.

US$ 500 - 750 million

Dr. Malte Peters, M.D.

Chief R&D Officer, MorphoSys

Ambition to improve cure rates in DLBCL

tafasitamab to become the backbone treatment to improve cure rates in hematological cancers

1

Establish MONJUVI® (tafasitamab)-LEN as Standard of Care in r/r DLBCL

- Preferred option for appropriate 2L patients, based on ORR and duration of response

2

Further develop tafasitamab as backbone in DLBCL

- The combination partner of choice along the entire patient journey – 1st line → 2nd line → 3rd line
- Supported by favorable benefit-risk profile, excellent combinability and ease of use

3

Expand development into other heme malignancies

- Development in other B-cell malignancies based on broadly expressed CD19 antigen: FL, CLL, MZL, ALL, MCL

4

Increase value through lifecycle management

- Increasing the value via purposeful developments in:
  - Additional regions, e.g. China, Japan
  - More convenient formulations & dosing / regimen, e.g. SC

Len: lenalidomide, FL: follicular lymphoma, MZL: marginal zone lymphoma, CLL: chronic lymphocytic leukemia, ALL: acute lymphocytic leukemia, MCL: mantle cell lymphoma

DLBCL: Tafasitamab backbone strategy

DLBCL: 1st Line

tafasitamab + len + R-CHOP

ongoing

- Phase 1b safety study ongoing
- Advanced protocol discussed with FDA for pivotal study
- Tafa/len in combination with novel agents

r/r DLBCL: 2nd Line

L-MIND: tafasitamab + len

FDA approved

B-MIND: tafasitamab + ben

ongoing

r/r DLBCL: 3rd+ Line

tafasitamab (+len) + combination partner

Discussions with companies developing innovative therapies, e.g.,

- Bi-specifics
- mAbs
- Small molecules
- Other established therapies

len: lenalidomide, ben: bendamustine

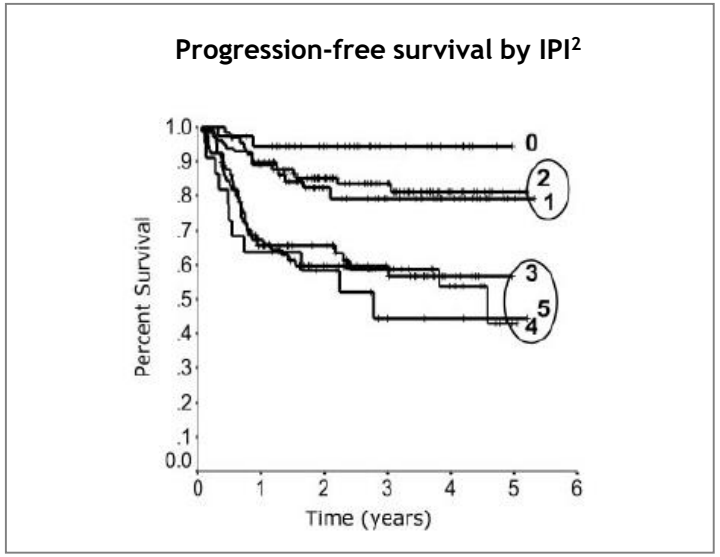
Epidemiology of diffuse large B-cell lymphoma

Rationale for combining tafasitamab + LEN with R-CHOP in front-line DLBCL

Most common type of NHL in adults worldwide

30,000 patients newly diagnosed in the U.S. per year

~40% of patients do not respond to R-CHOP or relapse



- Need to improve the efficacy of R-CHOP
- High risk patients (IPI 3-5) with unmet medical need

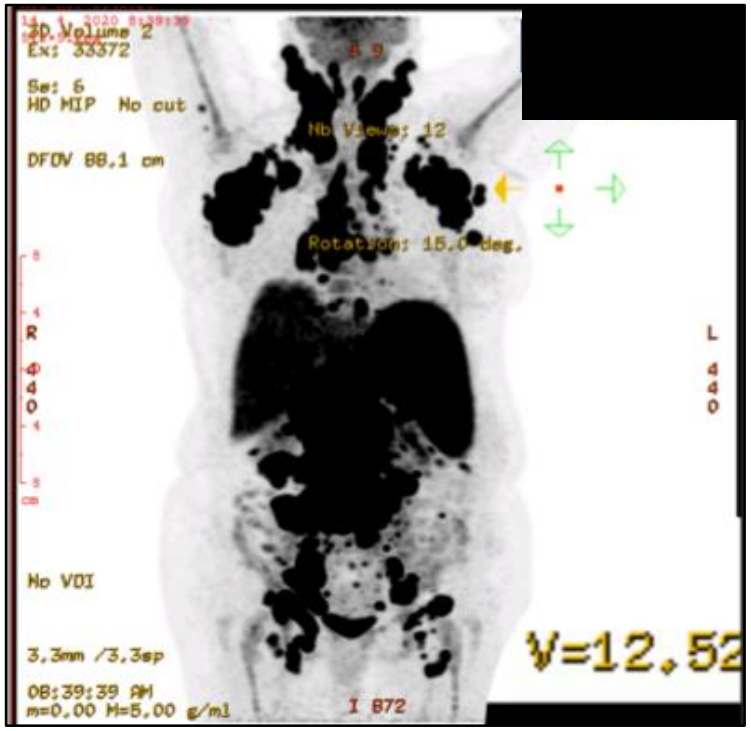
- Strong data of tafasitamab + LEN in r/r DLBCL
- Expression pattern on biopsies of newly diagnosed B-cell lymphomas supports targeting CD20 and CD19
  - CD19 expression more homogenous compared to CD20
  - CD19 expression preserved in small CD20-negative tumor subsets

Sehn et al., Blood, 2007

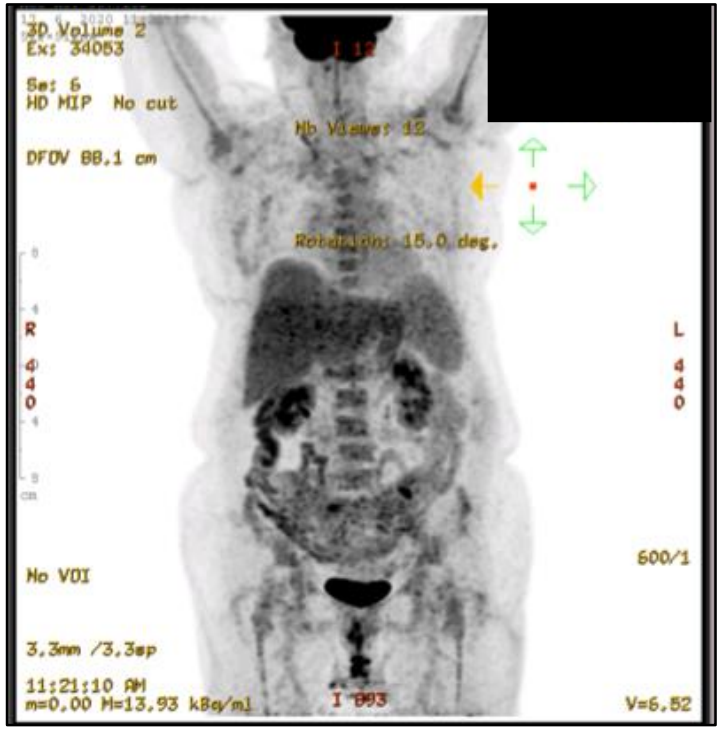
Ambition to improve cure rates in DLBCL

First-MIND Ph1b study – PET-CT at interim staging showing CR

Screening



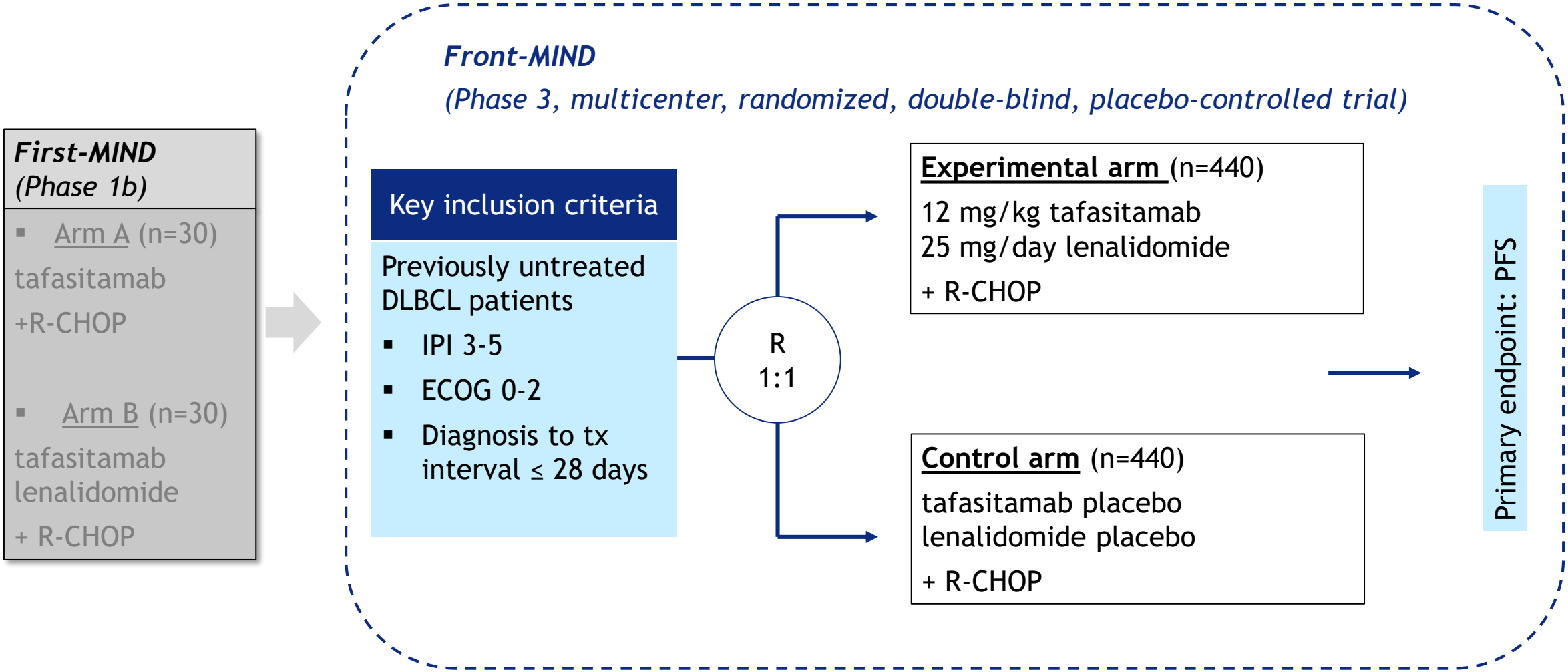
After 3 cycles (CR)



R-CHOP + tafasitamab + lenalidomide (75 years, stage IV, IPI 4)

Front-MIND: A pivotal phase 3 study in front-line DLBCL

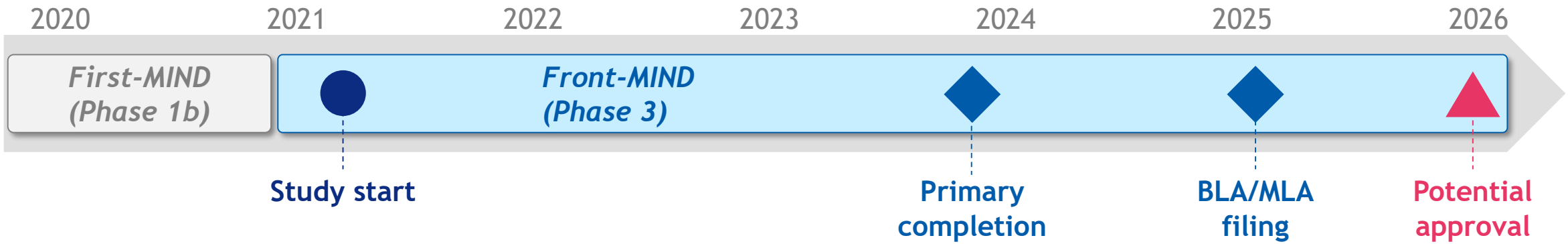
Study design discussed with FDA



Frontline DLBCL – Pivotal phase 3

Post marketing requirement: As agreed upon with FDA

Expected timelines



Tafasitamab development supported by IIT program

Combinations

- Chemotherapy
- Chemo-free regimen

Patients

- Pre / post CAR-T
- Transplant eligble patients
- Elderly patients: 80 y/o +

Indications

- Diffuse large B-cell lymphoma
- Marginal zone lymphoma
- Acute lymphocytic leukemia

Broad tafasitamab development supported by comprehensive IIT program

- >30 proposals from academic centers
- ~10 IITs jointly approved by MorphoSys and Incyte
- First IIT to start in Q4 2020

IIT: investigator initiated trial

Dr. Steven Stein, M.D.

Chief Medical Officer, Incyte

r/r DLBCL represents a significant unmet need worldwide

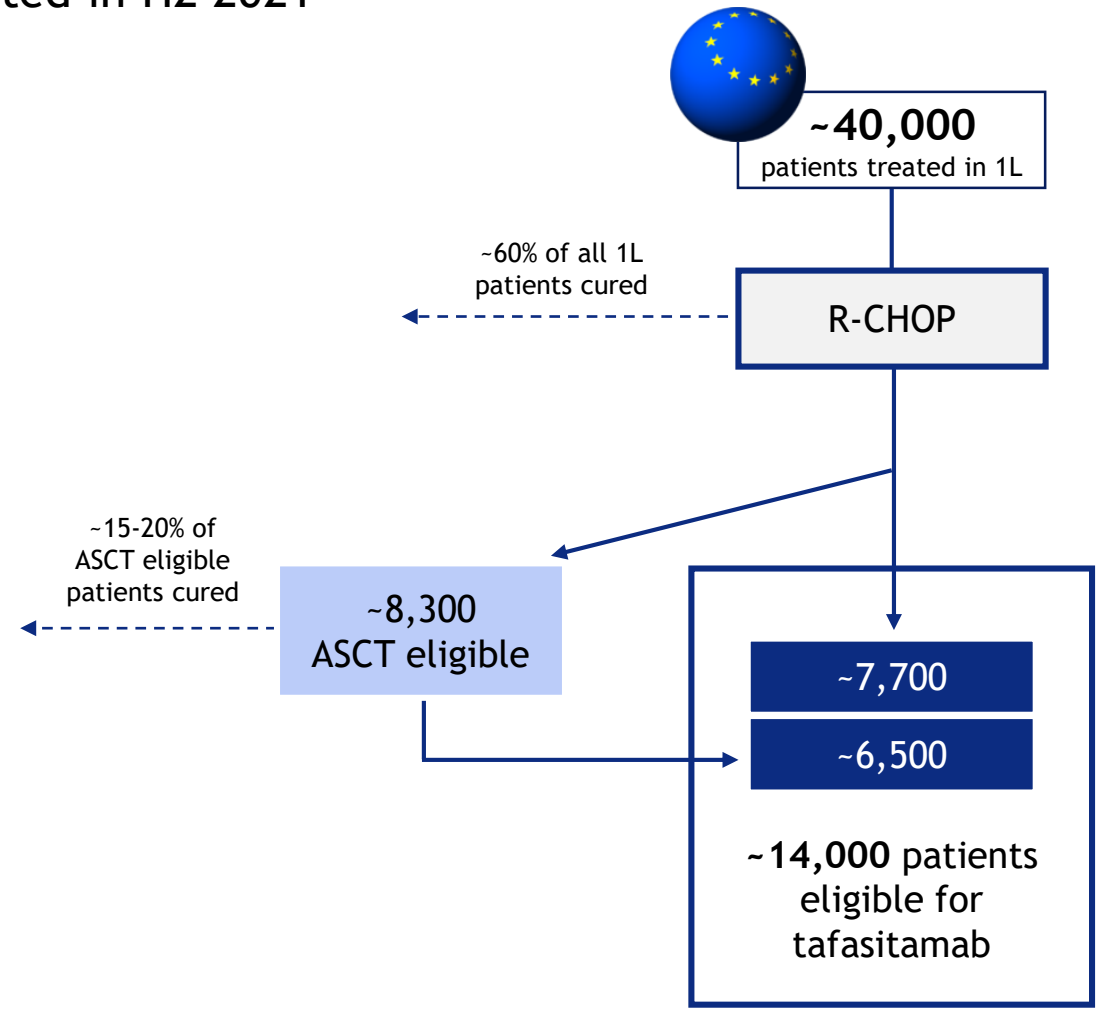
Development in Europe on track; MAA decision expected in H2 2021

r/r DLBCL epidemiology in Europe

- ~14,000 new patients with r/r DLBCL each year, not eligible for ASCT
- EMA approved therapies for DLBCL
  - 1L: R-CHOP
  - 2L: polatuzumab/RB
  - 3L: axicabtagene ciloleucel, tisagenlecleucel, selinexor

Key ex-US updates

- MAA decision expected in H2 2021
- Ongoing development plans for:
  - Canada
  - Japan
  - China

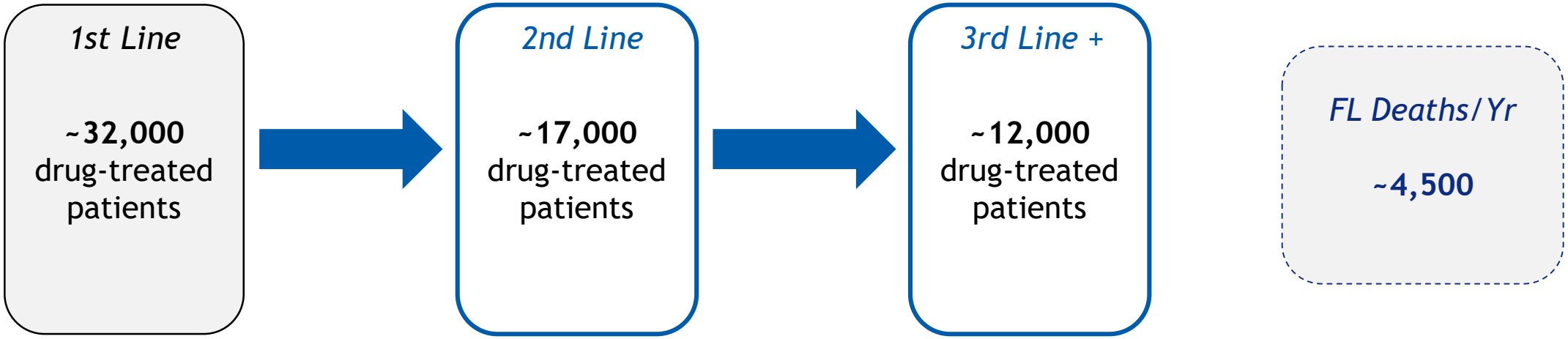


DRG Epidemiology data; Kantar Market Research (TPP testing 2018), Friedberg et al., 2011

Follicular lymphoma is the second most common subtype of NHL

More than 17,000 new treated cases of r/r follicular lymphoma in US, EU, Japan each year

- CD20/chemotherapy and R^2 are the preferred therapies in 2L
- PI3Kδ inhibitors are now part of 3L+ regimens



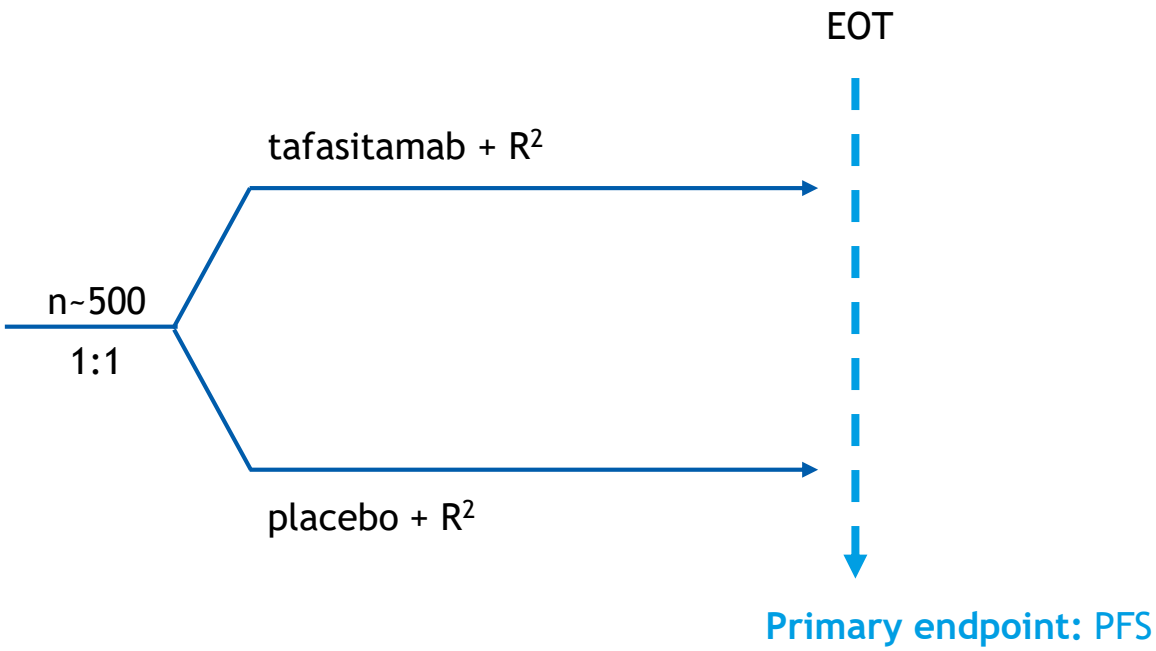
Epidemiology estimates based on DRG NHL report, Globocon/WHO NHL incidence estimates, SEER FL incidence and mortality estimates and American Cancer Society US incidence estimates.

Pivotal trial planned in r/r follicular lymphoma

Global safety and efficacy trial expected to start in early 2021

Summary study design (r/r FL)

- Phase 3, global safety/efficacy trial
- Randomized, placebo-controlled
- Key inclusion criteria
  - r/r FL patients aged ≥18 years
  - ≥1 prior anti-CD20 therapy
  - No prior R^2



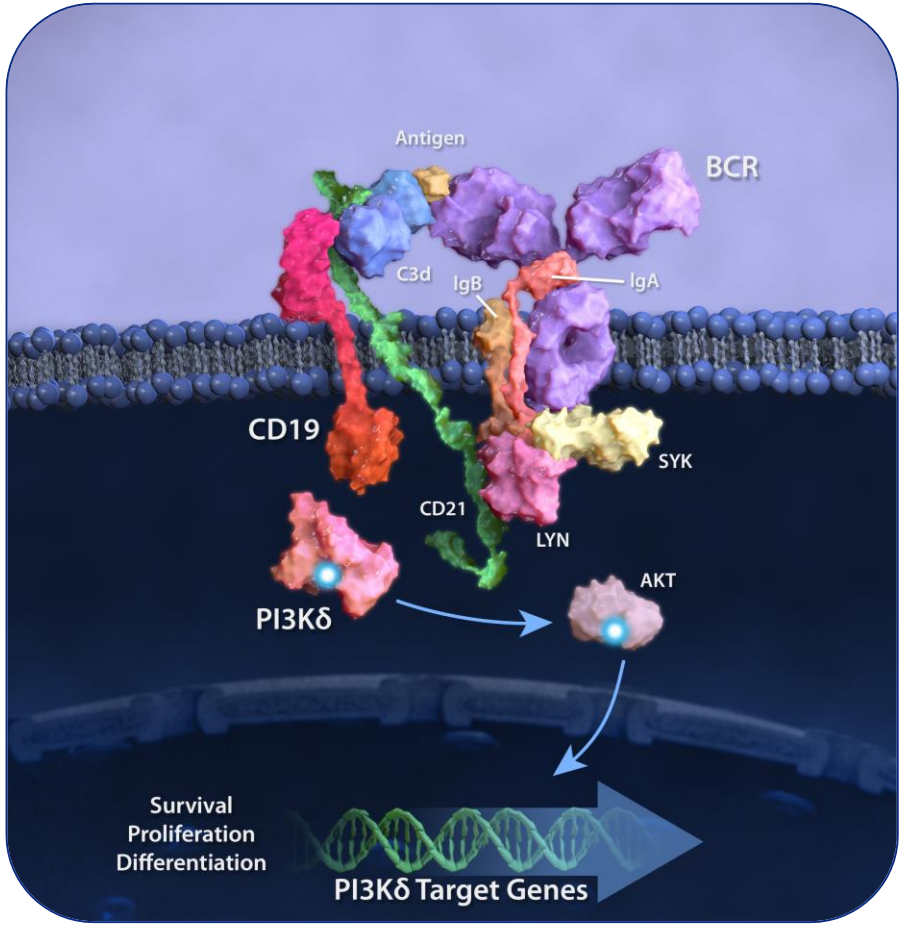
R^2 = lenalidomide (LEN) + rituximab; EOT = end of therapy

Opportunity for CD19 and PI3K delta combination

Potential for increased antitumor activity with tafasitamab + parsaclisib

Rationale for anti-CD19 + PI3Kδi combination

- PI3Kδ in cancer:
  - Dysregulated PI3K activity may promote tumor cell survival in cancer[1-4]
  - PI3Kδ plays a key role in survival and development of B lymphocytes[5]
  - PI3Kδ is upregulated and a critical driver of growth and survival in B-cell malignancies[5-8]
- CD19 plays a key role in:[9]
  - B-cell development and differentiation
  - B-cell proliferation
  - B-cell signaling



1. Chalhoub N, Baker SJ. Annu Rev Pathol. 2009;4:127-150. 2. Fruman DA, et al. Nat Rev Drug Discov. 2014;13:140-156. 3. Brana I, Siu LL. BMC Med. 2012;10:161. 4. Martini M, et al. Front Oncol. 2013;3:108. 5. Puri K, Gold MR. Front Immunol. 2012;3:256. 6. Ortiz-Maldonado V, et al. Ther Adv Hematol. 2015;6:25-36. 7. Akinleye A, et al. J Hematol Oncol. 2013;6:88. 8. Castillo J, et al. Onco Ther Targets. 2014;7:333-342. 9. Del Nagro CJ, et al. Immunol Res. 2005;31:119-131.

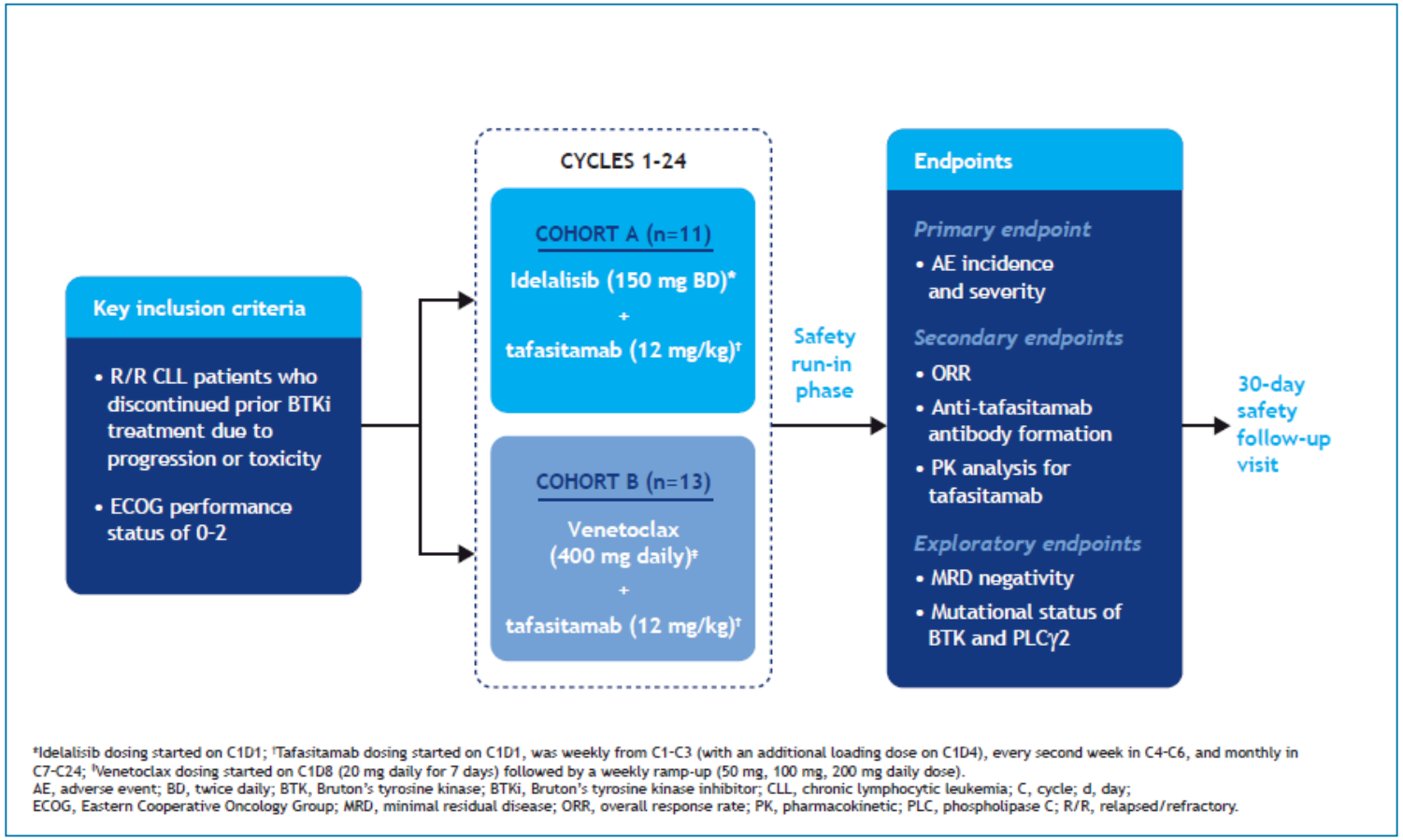
Combination of tafasitamab + PI3Kδi demonstrated activity in CLL

COSMOS PoC data warrant further study of anti-CD19 + PI3Kδi combination

COSMOS Recap

Cohort A (n=11)
tafasitamab + idelalisib
r/r CLL patients post BTKi

- **Efficacy**
  - ORR of 91% (10/11)
- **Safety**
  - Grade ≥3 TEAE (n):
    - neutropenia (5)
    - anemia (3)
    - thrombocytopenia (3)



*Idelalisib dosing started on C1D1; †Tafasitamab dosing started on C1D1, was weekly from C1-C3 (with an additional loading dose on C1D4), every second week in C4-C6, and monthly in C7-C24; ‡Venetoclax dosing started on C1D8 (20 mg daily for 7 days) followed by a weekly ramp-up (50 mg, 100 mg, 200 mg daily dose).
AE, adverse event; BD, twice daily; BTK, Bruton's tyrosine kinase; BTKi, Bruton's tyrosine kinase inhibitor; CLL, chronic lymphocytic leukemia; C, cycle; d, day;
ECOG, Eastern Cooperative Oncology Group; MRD, minimal residual disease; ORR, overall response rate; PK, pharmacokinetic; PLC, phospholipase C; R/R, relapsed/refractory.

ClinicalTrials.gov Identifier: NCT04134936. Primary analysis for both cohorts had cut-off date of Nov 2018 (start Nov 2016). Study completion August 2022. Preliminary results reported at ASH 2018 for Cohort B and EHA 2018 for Cohort A. Primary analysis for both cohorts at ASH 2019, with data cut-off October 2019. CLL = chronic lymphocytic leukemia; SLL = small lymphocytic leukemia.

Tafasitamab + parsaclisib development plan in NHL

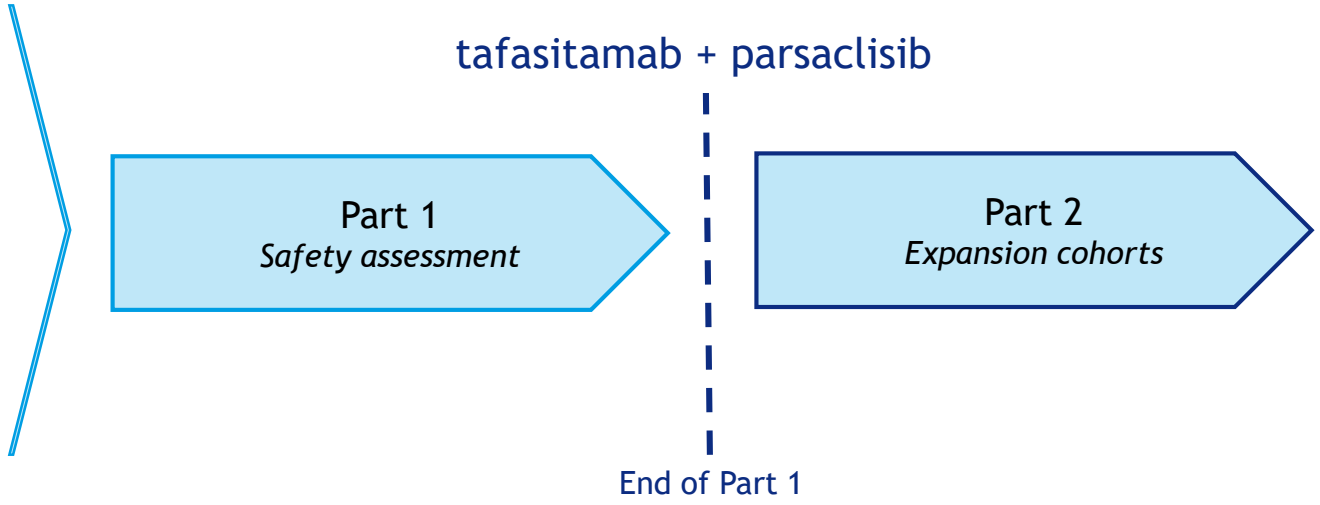
Parsaclisib is a potent and highly selective next-generation PI3Kδ inhibitor

Planned combination trial with tafasitamab + parsaclisib

Final protocol in preparation

Proposed study design

- PoC study
- Key inclusion criteria
  - r/r B-cell malignancies
  - ≥1 prior anti-CD20 therapy



Comprehensive global clinical program

Multiple opportunities to address significant unmet needs in non-Hodgkin lymphomas

	Study	Arms	Status	PoC → Pivotal
r/r DLBCL	L-MIND (~80 pts)	+ lenalidomide	FDA approved in 2L+ DLBCL	Primary endpoint: ORR (2-year analysis presented at EHA 2020)
r/r DLBCL	B-MIND (~450 pts)	+ bendamustine vs bendamustine + rituximab	Ongoing, data expected 2022	Primary endpoint: PFS (IDMC futility passed November 2019)
1L DLBCL	First-MIND (~60 pts)	+ R-CHOP or + lenalidomide + R-CHOP	Primary completion expected 2020	Safety
1L DLBCL	Front-MIND (~900 pts)	+ lenalidomide + R-CHOP vs R-CHOP	Trial initiation expected 2021	Primary endpoint: PFS
Other r/r NHL	PoC; r/r B-cell malignancies	+ parsaclisib	Final protocol in preparation	
Other r/r NHL	Follicular lymphoma (~500 pts)	+ lenalidomide + rituximab (R^2) vs R^2	Trial initiation expected 2021	Primary endpoint: PFS

Dr. Jean-Paul Kress, M.D.

Chief Executive Officer, MorphoSys

Potential to transform the treatment of patients with r/r DLBCL

U.S. peak sales potential for r/r DLBCL: **US$ 500 - 750 million**

EU decision expected in H2 2021; additional global territories planned

Opportunity to improve cure rates in first-line DLBCL

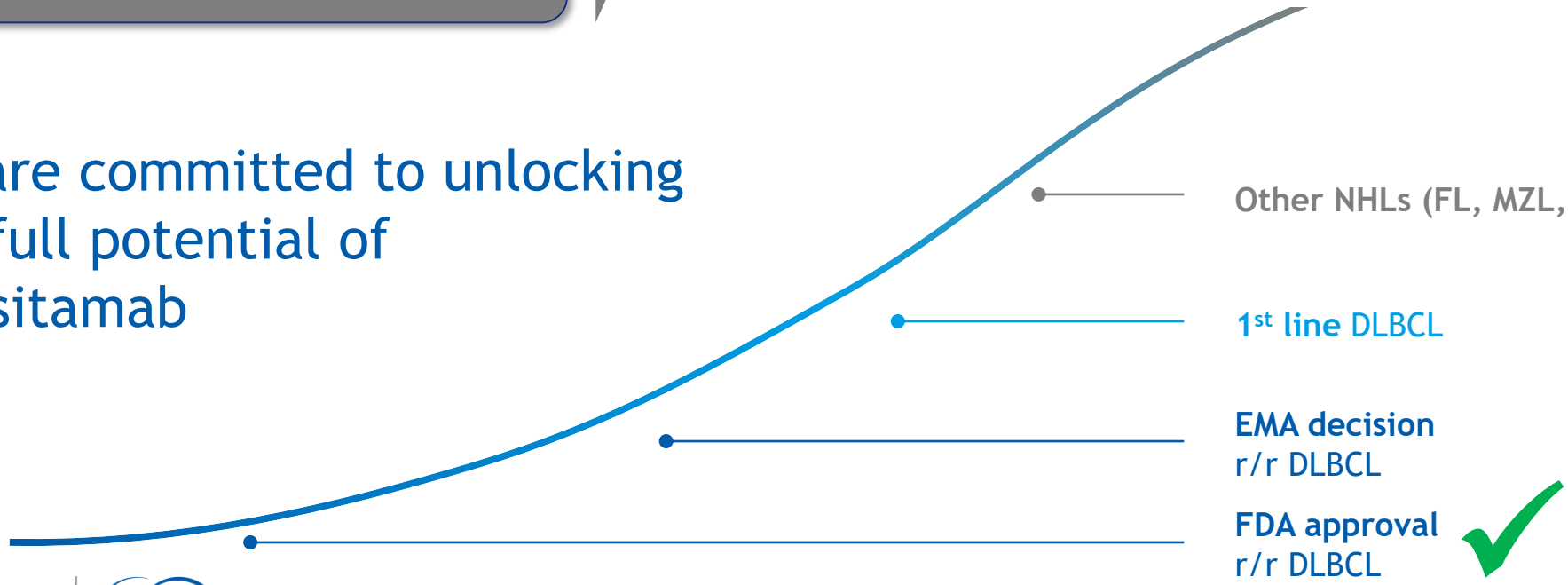
Global pivotal trial ready to start in early 2021

Expanding global development into other B-cell malignancies

Global pivotal trial in r/r follicular lymphoma in preparation

Multiple additional opportunities

We are committed to unlocking the full potential of tafasitamab



morphosys | Incyte

Q&A Session

MorphoSys

Jean-Paul Kress, CEO

Malte Peters, Chief R&D Officer

Roland Wandeler, COO

Jens Holstein, CFO

Incyte

Hervé Hoppenot, Chairman & CEO

Steven Stein, Chief Medical Officer

Barry Flannelly, GM North America

Christiana Stamoulis, CFO

Thank You