



Arming the immune system to fight cancer

Capital Markets Update

June 26th 2017

Important notice and disclaimer

This report contains certain forward-looking statements based on uncertainty, since they relate to events and depend on circumstances that will occur in future and which, by their nature, will have an impact on the results of operations and the financial condition of Targovax. Such forward-looking statements reflect the current views of Targovax and are based on the information currently available to the company. Targovax cannot give any assurance as to the correctness of such statements.

There are a number of factors that could cause actual results and developments to differ materially from those expressed or implied in these forward-looking statements. These factors include, among other things, risks or uncertainties associated with the success of future clinical trials; risks relating to personal injury or death in connection with clinical trials or following commercialization of the company's products, and liability in connection therewith; risks relating to the company's freedom to operate (competitors patents) in respect of the products it develops; risks of non-approval of patents not yet granted and the company's ability to adequately protect its intellectual property and know-how; risks relating to obtaining regulatory approval and other regulatory risks relating to the development and future commercialization of the company's products; risks that research and development will not yield new products that achieve commercial success; risks relating to the company's ability to successfully commercialize and gain market acceptance for Targovax's products; risks relating to the future development of the pricing environment and/or regulations for pharmaceutical products; risks relating to the company's ability to secure additional financing in the future, which may not be available on favorable terms or at all; risks relating to currency fluctuations; risks associated with technological development, growth management, general economic and business conditions; risks relating to the company's ability to retain key personnel; and risks relating to the impact of competition.

Capital Markets Update - Agenda

- Introduction – *CEO, Øystein Soug*

- Targovax's technology and trials – *CMO, Dr Magnus Jäderberg*

- A physician's view on pancreatic cancer – *Prof Daniel Palmer*

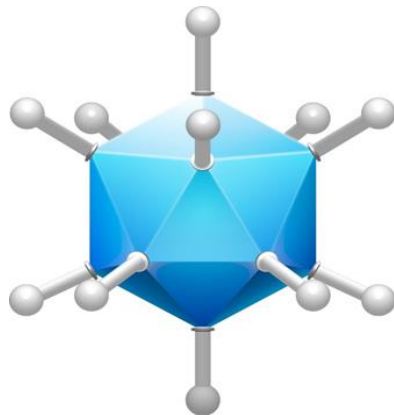
- Financial update – *CFO, Erik Wiklund*

- Q&A

Targovax develops two novel cancer immunotherapy drugs – both with promising phase I/II data

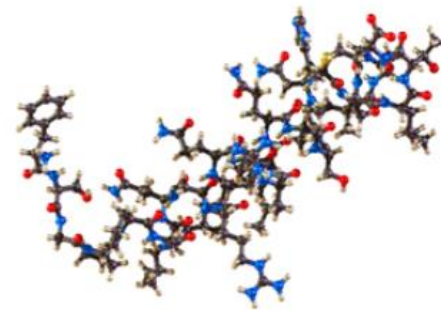
ONCOS-102 Oncolytic virus

- Injected into the tumor
- Releases antigens
- Stimulates “killer” white blood cells (T-cells)



TG01 Cancer vaccine

- Therapeutic vaccine
- Mimics antigens
- Stimulates “killer” white blood cells (T-cells)

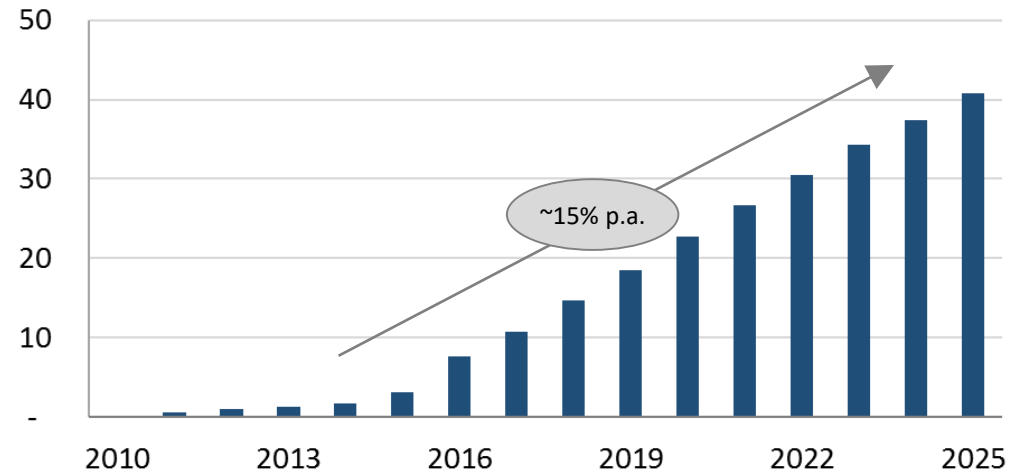


Immunotherapy is considered to have enormous potential, and the market is expected to reach 30-50b USD by 2025



Science, December 2013

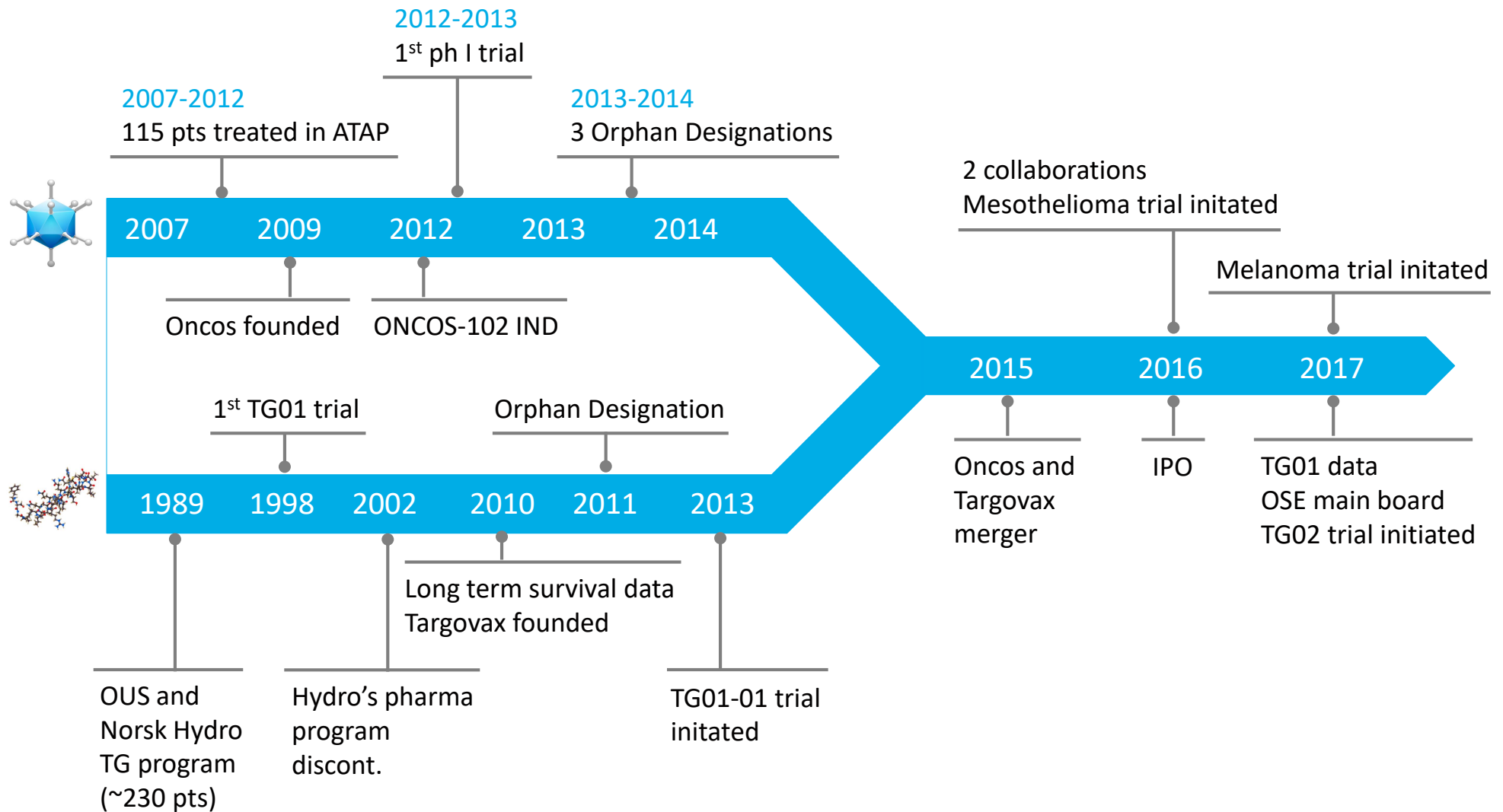
Estimated market size (\$Bn)*



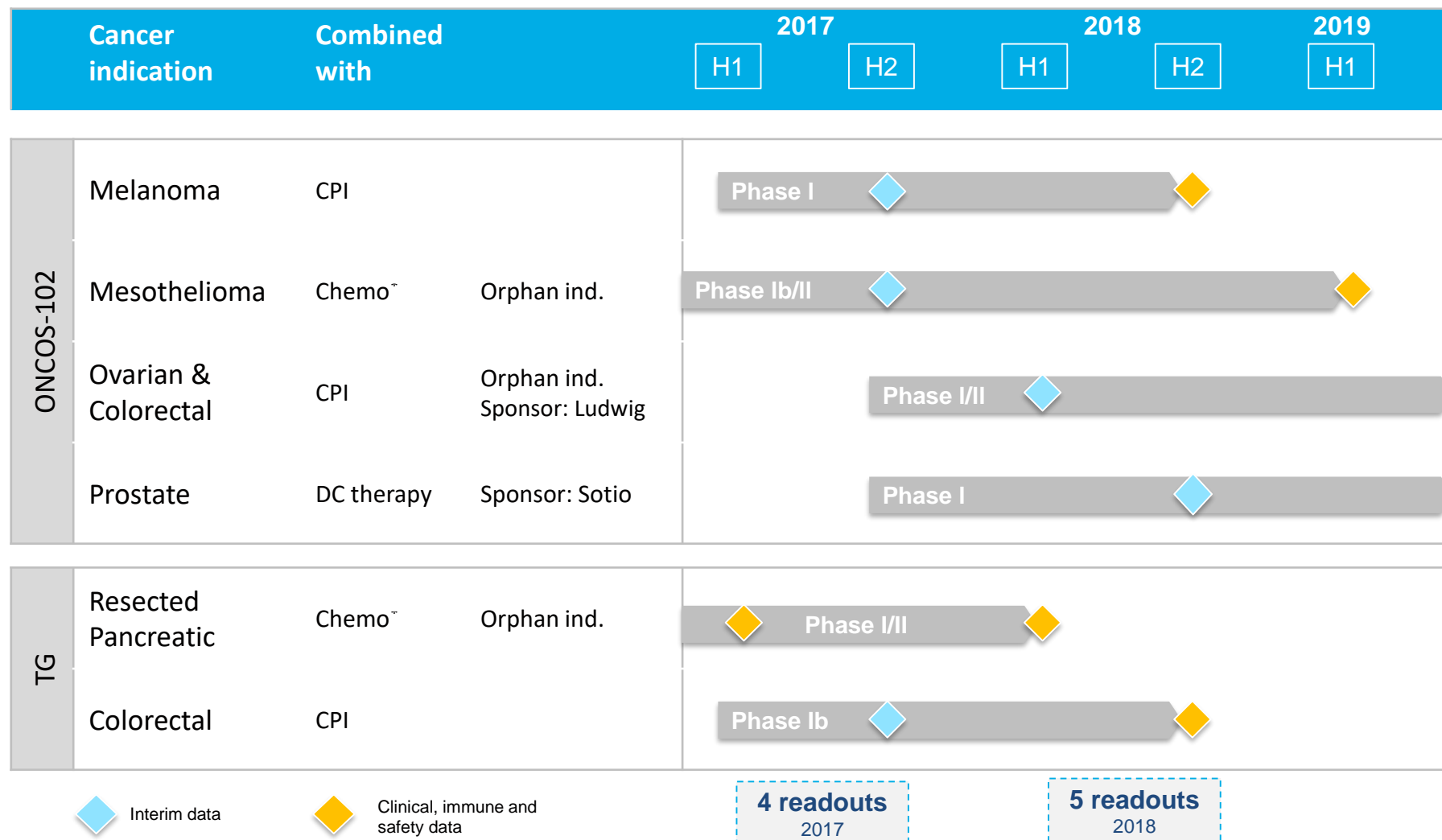
- 8 products currently on the market
- Market estimated to reach 40b USD in 2025
- Estimated that 2/3 of cancers will be treated with immunotherapy by 2025

* Citi Research, Barclays Capital, Leerink Swann, BMO Capital Markets

Targovax history



Two platforms and six clinical trials in total ensures a diversified program with frequent data readouts



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○ A physician's view on pancreatic cancer – *Prof Daniel Palmer*

○ Financial update – *CFO, Erik Wiklund*

○ Q&A

Agenda

- **Introduction to immunotherapy**

- ONCOS-102 oncolytic virus platform

- TG RAS-peptide vaccine platform

- Targovax clinical program overview

Immunotherapy is revolutionizing the way we treat cancer, in some cases curing previously thought incurable patients

Case example – Patient in a Yervoy checkpoint inhibitor trial



*Prior to Yervoy**



4 weeks



8 weeks



20 weeks

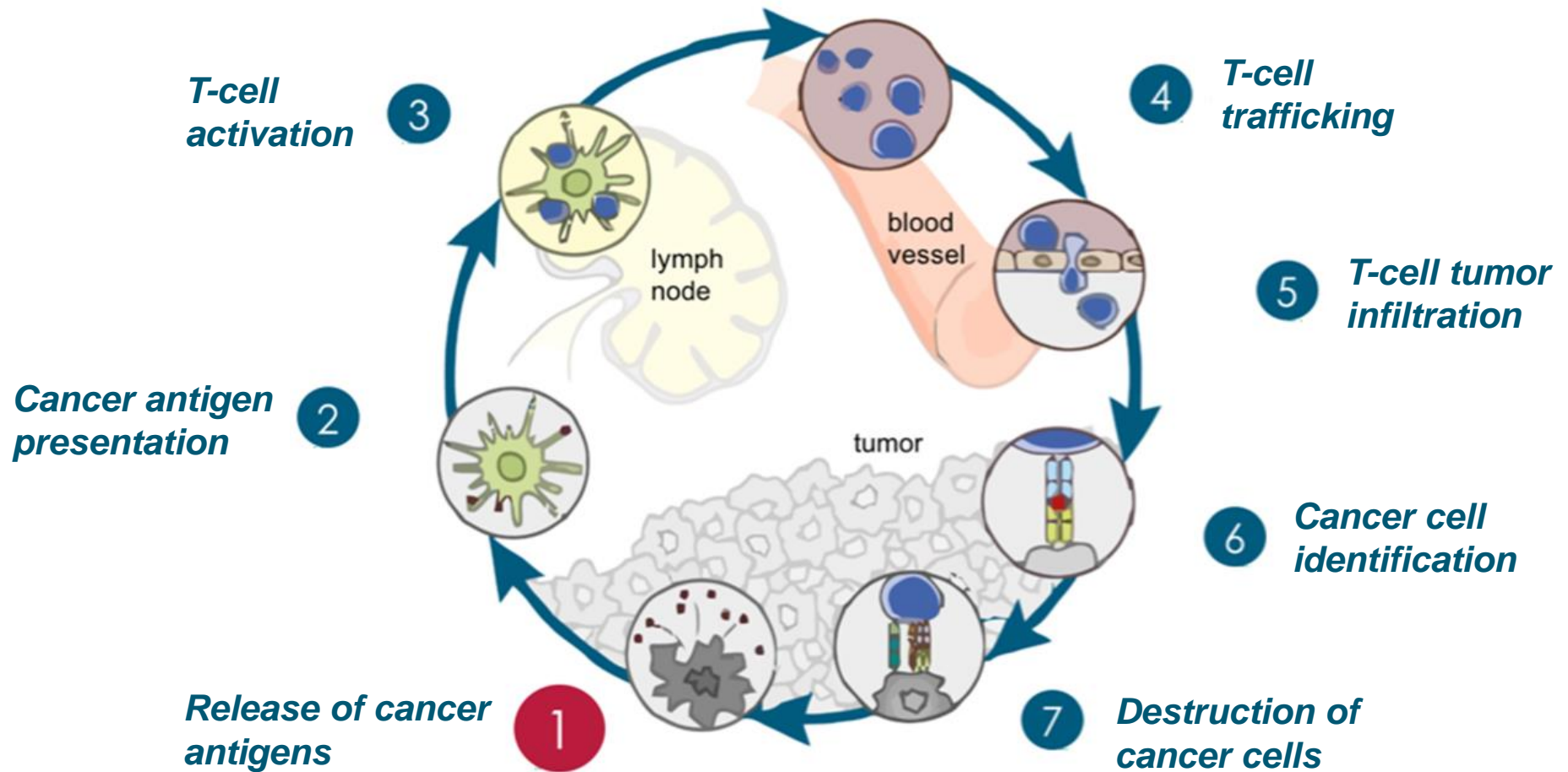


8 months

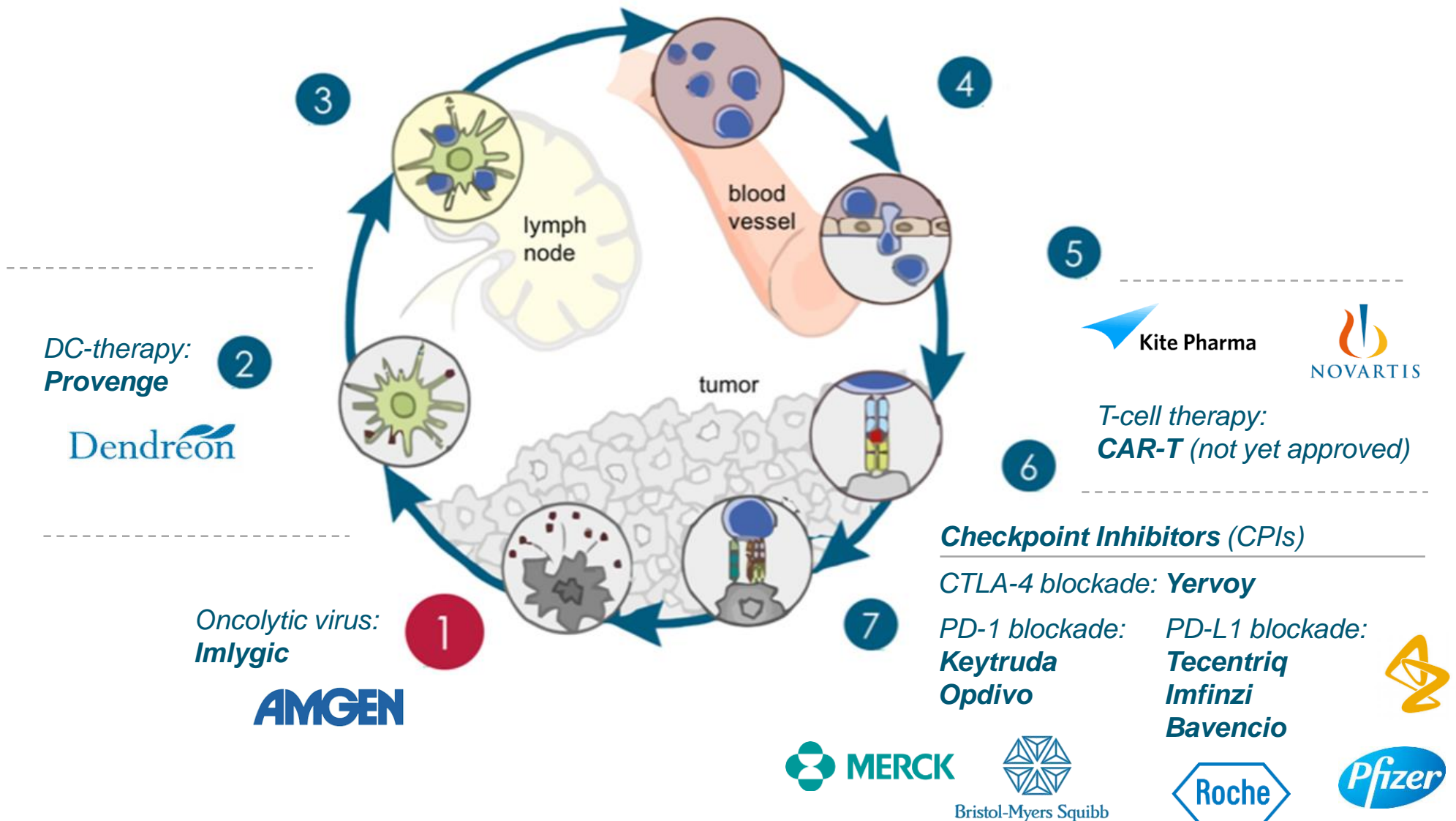


1 year

The aim of cancer immunotherapy is to boost the natural cancer immunity cycle



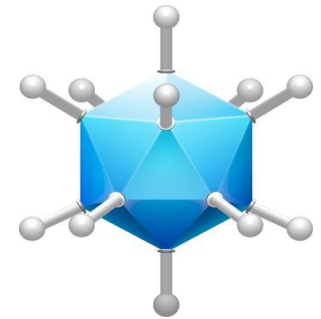
Immunotherapies target different aspects of the cancer immunity cycle



Targovax is developing two novel proprietary immunotherapy platforms, with promising phase I/II data

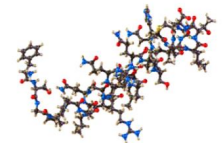
ONCOS-102 Oncolytic virus

- Genetically tailored Adenovirus
- Selectively infects and lyses cancer cells
- Releases cancer antigens
- Triggers immune response

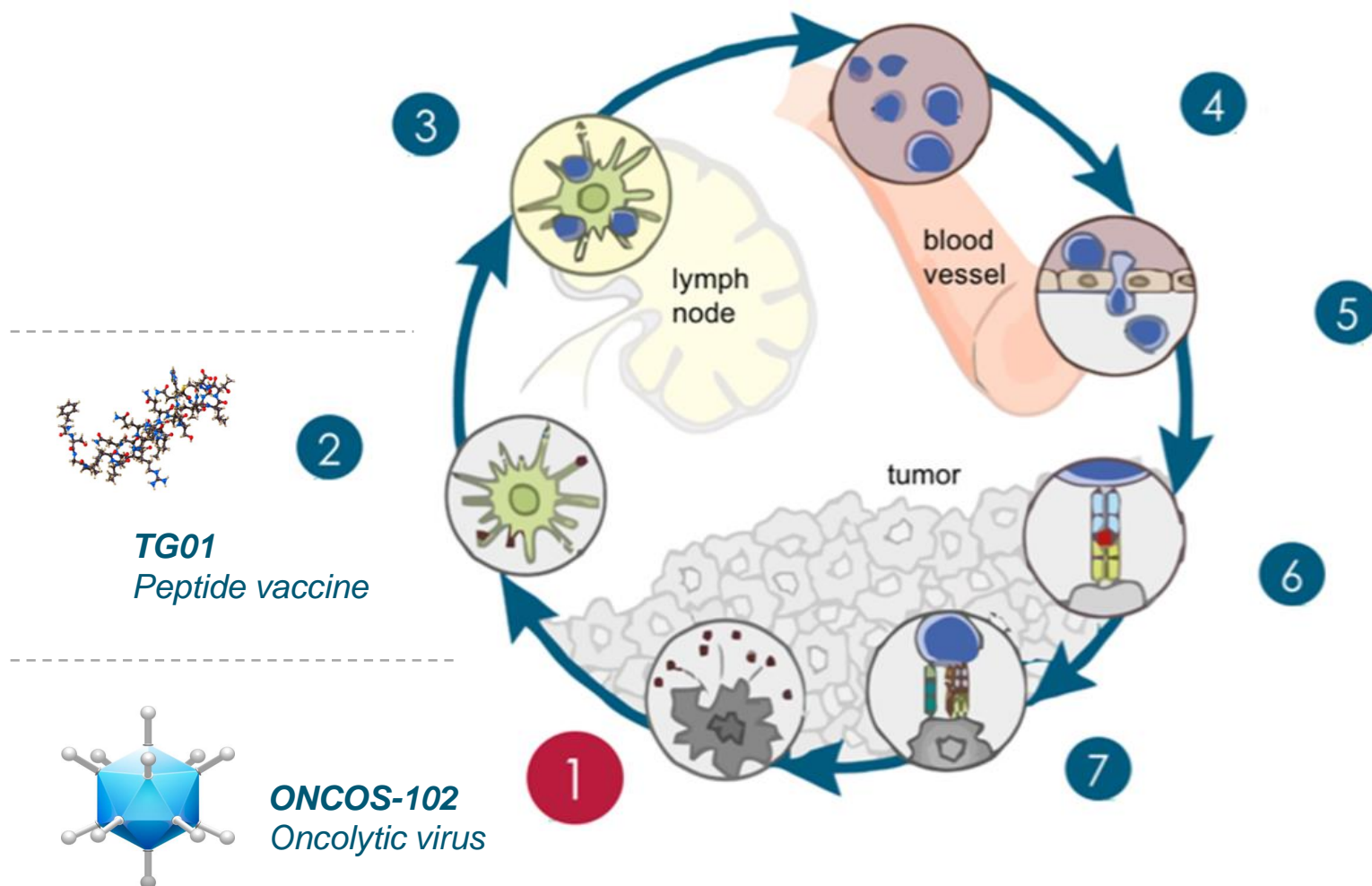


TG01 Peptide vaccine


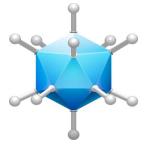
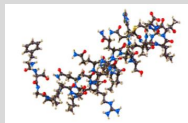


- Cocktail of 7 synthetic peptides mimicking clinically relevant RAS mutations
- Generates RAS-specific T-cells
- T-cells kill cancer cells displaying mutated RAS antigens on their surface



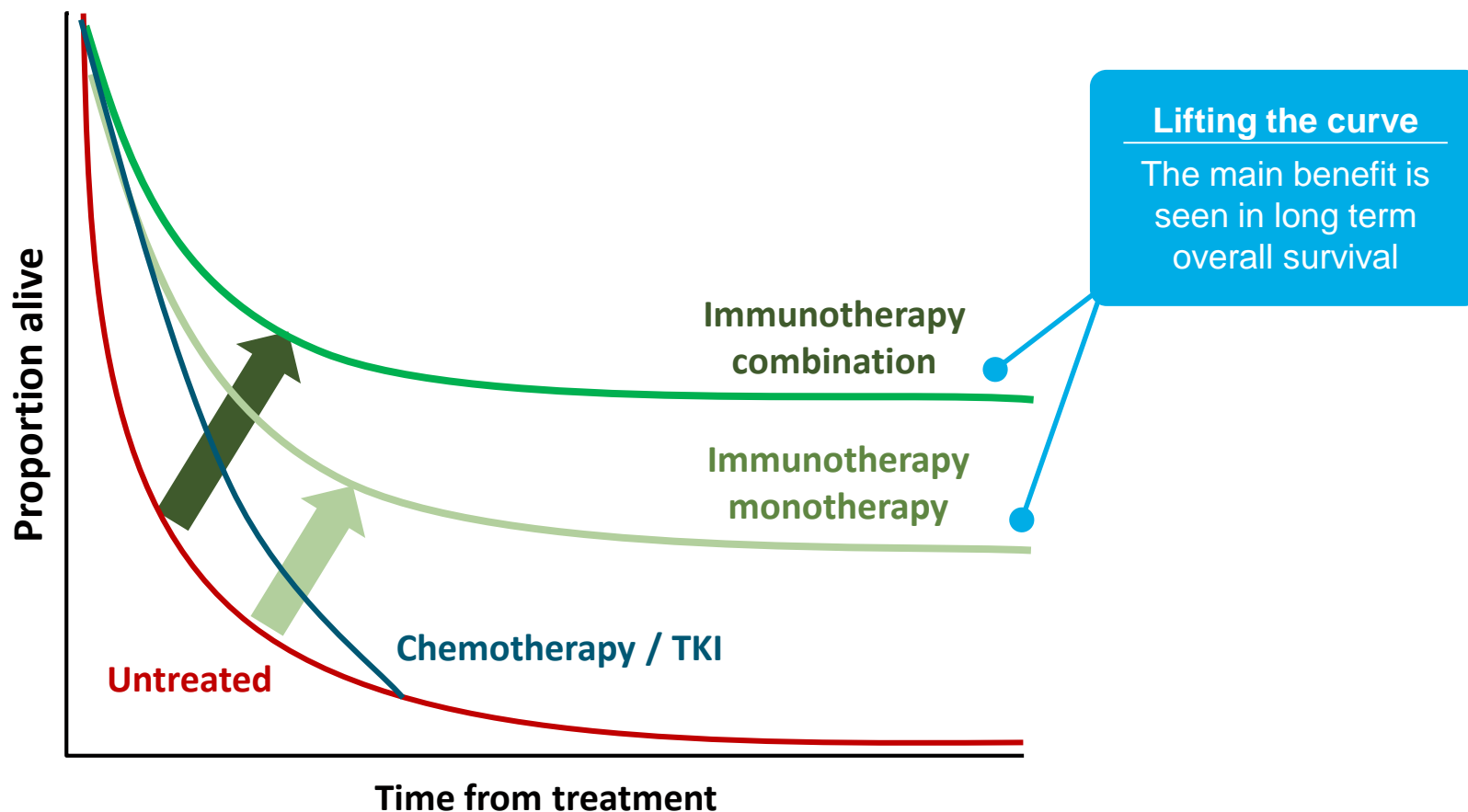
TG01 and ONCOS-102 have distinct targeting mechanisms in the cancer immunity cycle



By combining immunotherapies multiple aspects of the cancer immunity cycle can be modulated in parallel

Immuno-oncology mechanisms	Wake up the immune system	Train cancer specific T-cells	T-cells attack the cancer	Disarm cancer defence
 <i>Car analogy</i>	<i>Ignite engine</i>	<i>Switch on GPS-targeting</i>	<i>Press the gas pedal</i>	<i>Release brakes</i>
 ONCOS-102 – Oncolytic virus	✓	✓	✓	–
 TG 01 – Peptide vaccine	✓	✓	✓	–
 Kite Pharma Peptide viral vaccine T-Cell therapy (CAR)	✓	✓	✓	–
 Check point inhibitors (CPIs)	–	–	–	✓

The goal is to turn cancer into a manageable chronic disease by combining immuno-oncology therapies



Agenda

- Introduction to immunotherapy

- **ONCOS-102 oncolytic virus platform**

- TG RAS-peptide vaccine platform

- Targovax clinical program overview

ONCOS-102 works by making cancer antigens visible to the immune system, thus generating tumor specific T-cells

Activate immune system:

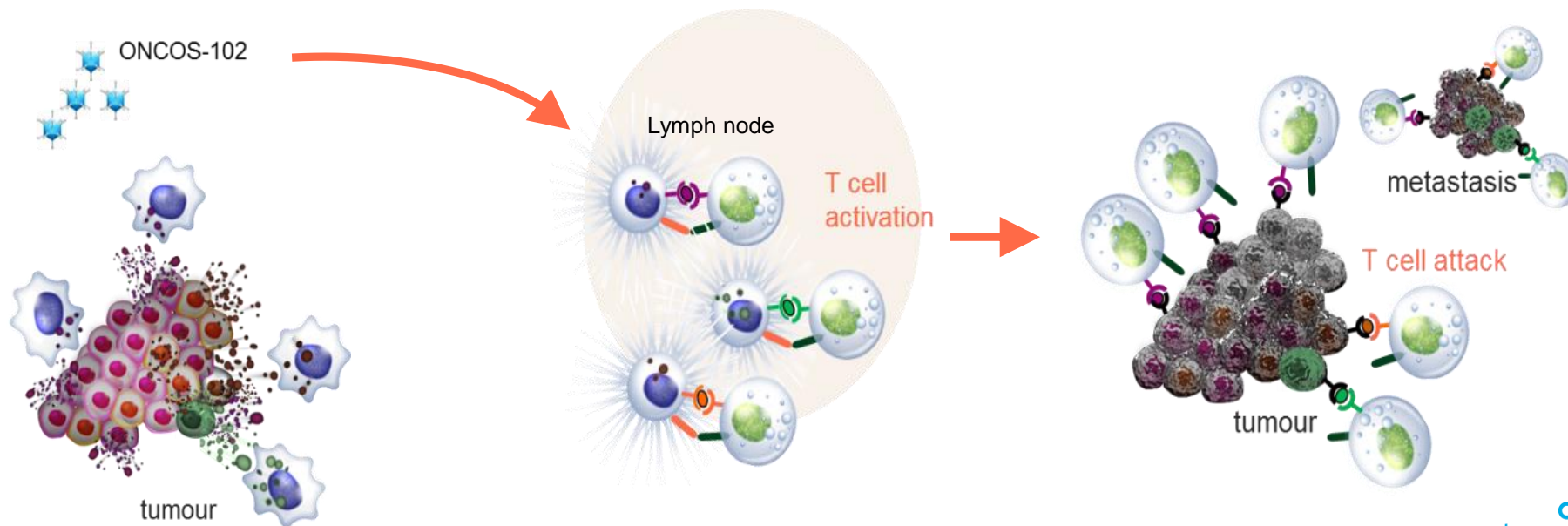
- Virus injected directly into the tumor / peritoneum
- Infected cells lyse and release cancer-specific antigens
- Immune system picks up antigens

Train T-cells:

- APCs present tumor specific antigens at lymph nodes
- Production of tumor specific T-cells

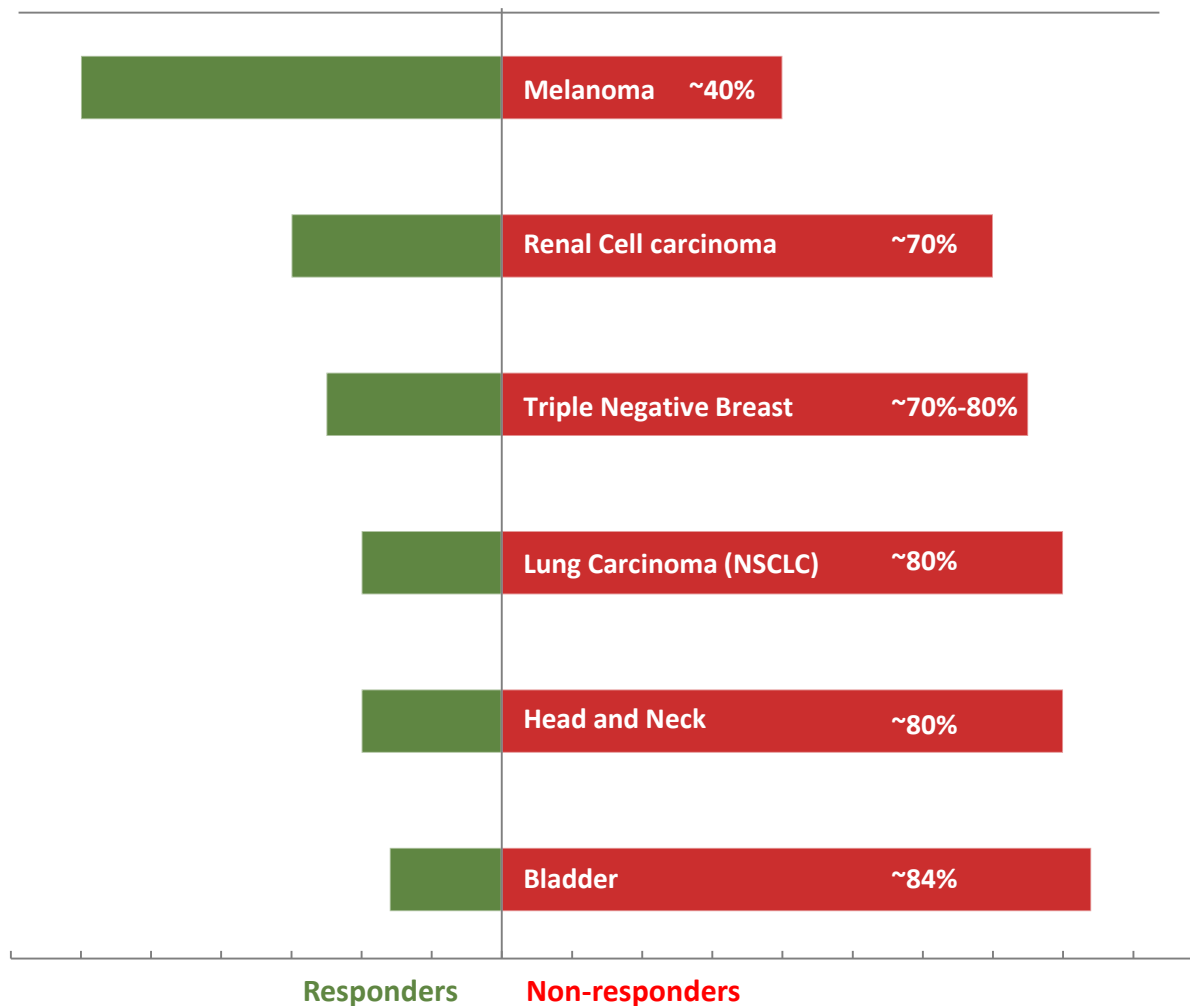
Attack the cancer:

- Tumor specific T-cells circulate in the body
- Identify lesions and kill the cancer cells



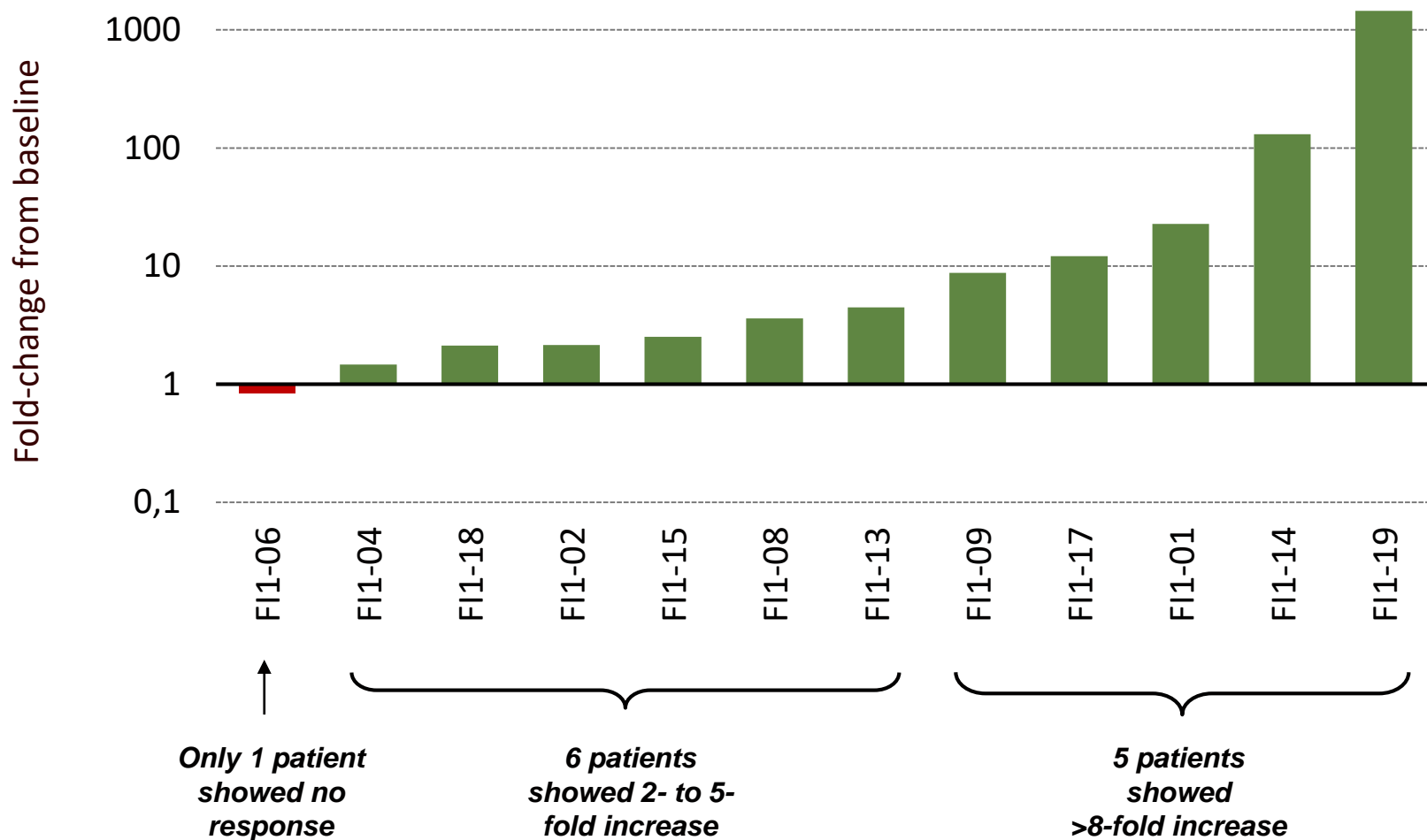
Most patients do not respond to check point inhibitors (CPIs), due to lack of T-cells in the tumor microenvironment

Response rate to checkpoint inhibitors (CPIs)



*Complimentary
immune priming
medicines may make
tumors **respond**
better to checkpoint
inhibitors*

ONCOS-102 phase I: Increased tumor infiltrating CD8+ T-cells in 11 of 12 cancer patients with a range of solid tumors



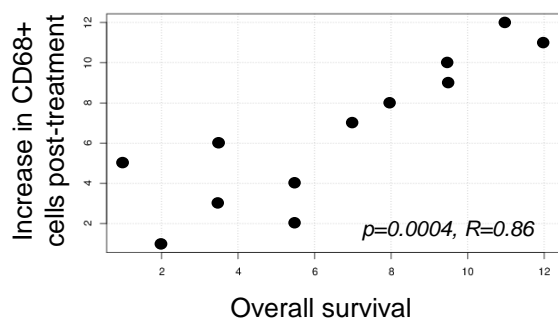
In the initial Phase I ONCOS-102 trial tumor specific and systemic immune response was observed

Evidence that immune system recognizes tumor threat

Innate Immune System (biopsy)

- Induction of proinflammatory cytokines + fever (all patients)
- Infiltration of innate immune cells into tumors in 11 out of 12 patients

Scatterplot of ranks



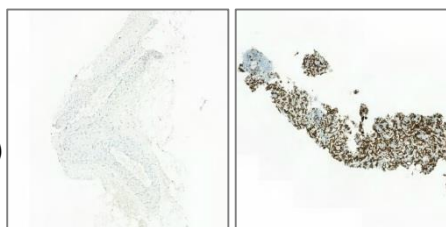
Correlation between post-treatment increase in innate immune cells and OS

Evidence that T-cells find the tumor and are cell killing

Adaptive immune system (biopsy)

- Increase in T-cell infiltration into tumors (including CD8+ killer T-cells) in 11 out of 12 patients
- Observation in one non-injected distant metastasis

OvCa. patient (F11-19)



Correlation between post-treatment increase in CD8+ T-cells and OS

Evidence of production of tumor antigen specific T-cells

Anti-tumor immune response (blood)

- Systemic induction of tumor-specific CD8+ T-cells

Ovarian patient:

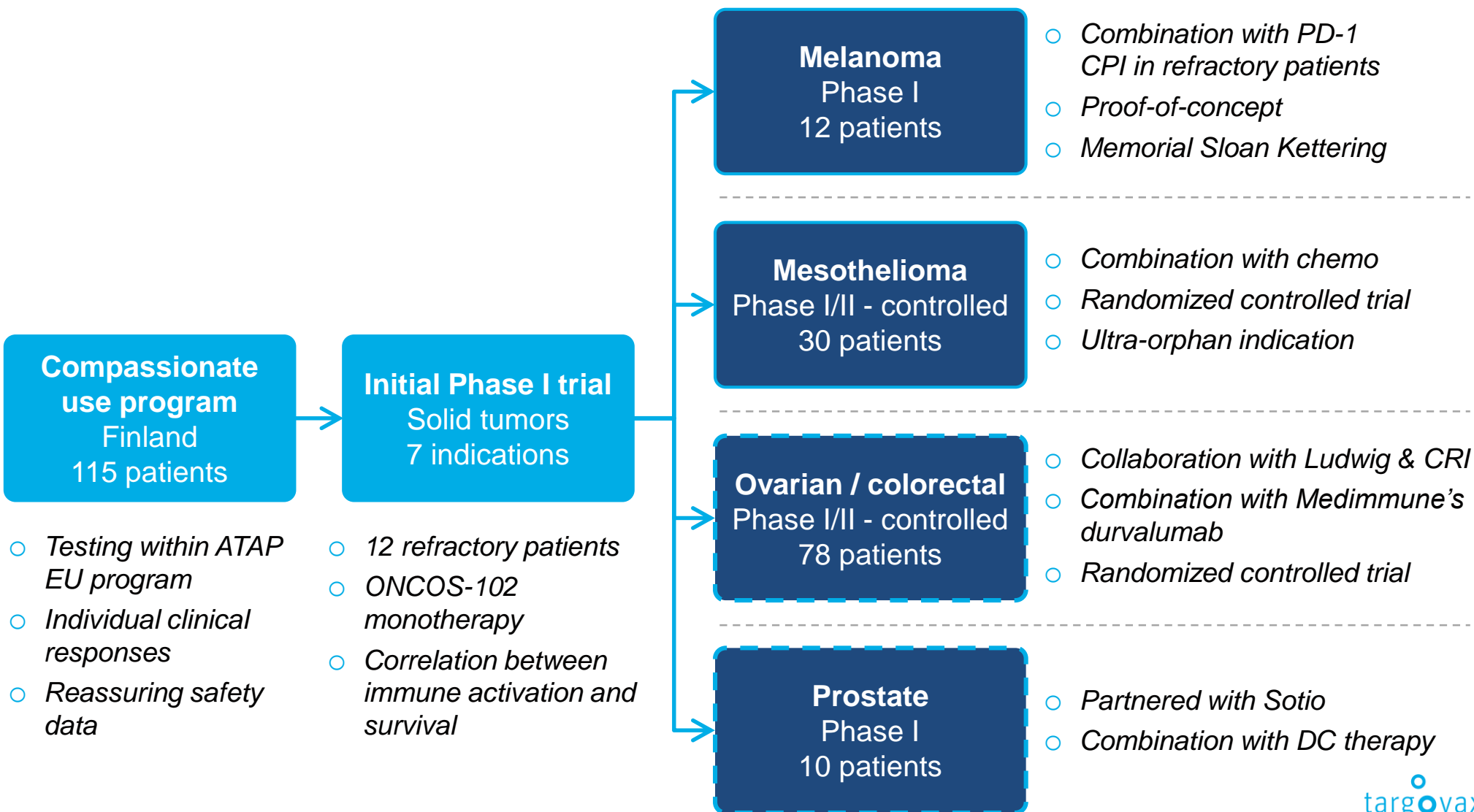
NY-ESO-1, MAGE-A1, MAGE-A3, and Mesothelin specific CD8+ cells

Mesothelioma patient:

MAGE-A3 specific CD8+ cells

Associated with clinical benefit

The encouraging Phase I results have triggered the initiation of a broad ONCOS-102 clinical program consisting of four new trials



Melanoma trial – will CPI refractory patients start responding after immune-priming with ONCOS-102?

Setting

- Advanced malignant melanoma patients not responding to CPIs
- Immune activate patients with ONCOS-102, then re-challenge with a CPI (Keytruda®)

Site

- 12 patients
- Memorial Sloan Kettering Cancer Centre

Key endpoints

- Safety
- Immune activation
- Clinical response data

Sequence

ONCOS-102 – 3 weeks

Keytruda – 5 months

Proof-of-concept

- *Will CPI refractory melanoma patients start responding to Keytruda after challenge by ONCOS-102?*

Agenda

- Introduction to immunotherapy
-

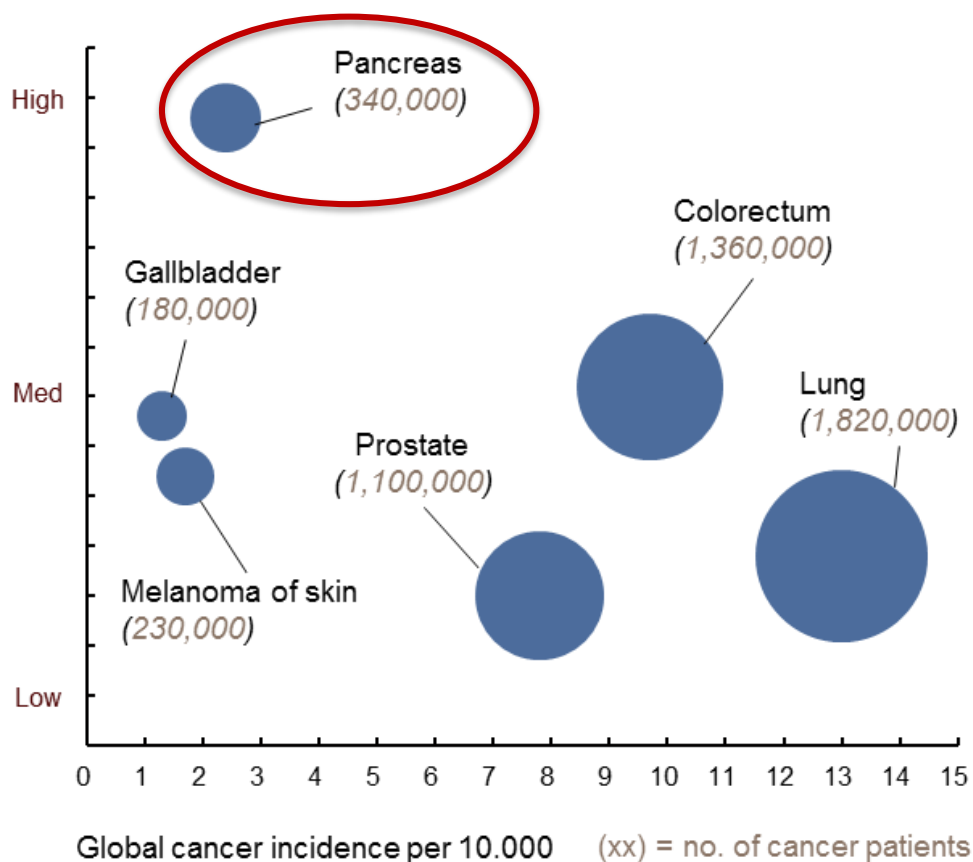
- ONCOS-102 oncolytic virus platform
-

- **TG RAS-peptide vaccine platform**
-

- Targovax clinical program overview

RAS is a key regulator of cell cycle that is mutated in 20-30% of all cancer patients, and >85% of pancreatic cancers

Incidence of RAS mutations

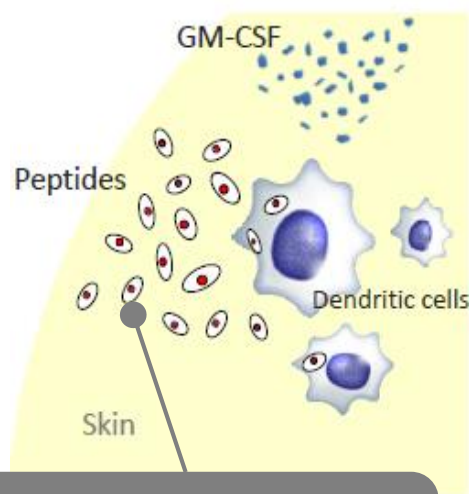


- One of the **most common mutations** in cancer
- RAS is one of the most **well-defined neoantigens**
- Results in **cell division permanently switched on**
- **No existing therapies** targeting RAS
- Occurs in **>85% of pancreatic cancer** patients

The TG peptides prime the immune system to recognize and destroy RAS mutated cancer cells

Activate immune system:

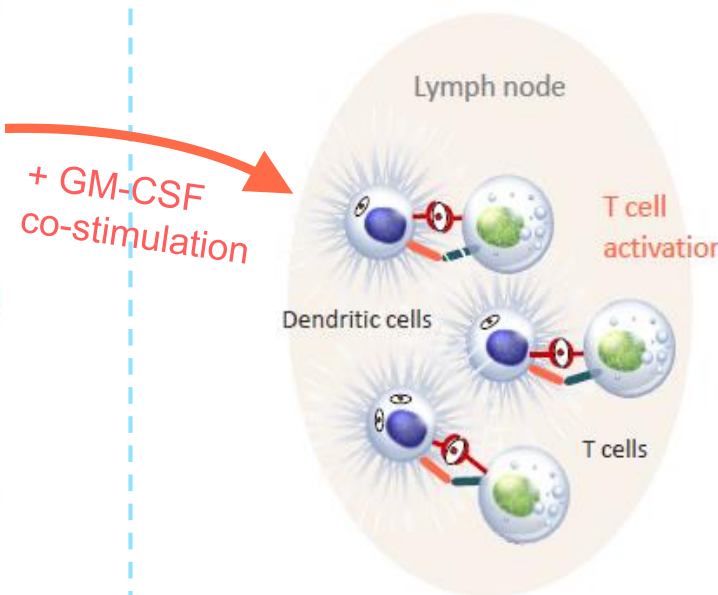
- TG peptides injected into the skin with GM-CSF adjuvant
- APCs pick up the TG RAS antigens



Cocktail of 7 peptides covering all relevant RAS mutations in pancreas

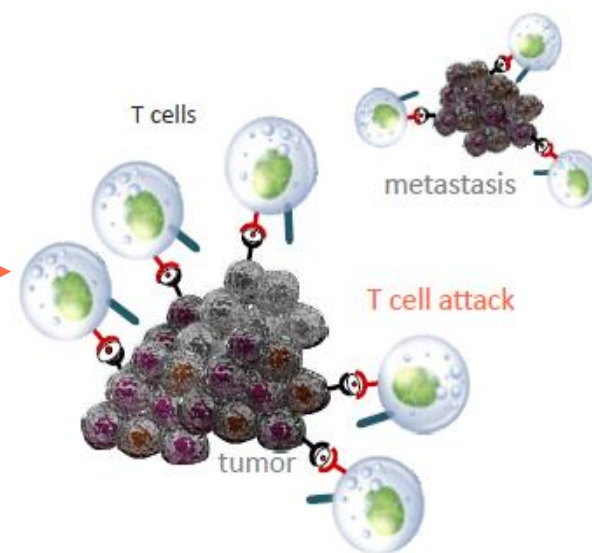
Train T-cells:

- APCs migrate to lymph nodes and present RAS specific antigens
- Production of RAS specific T-cells



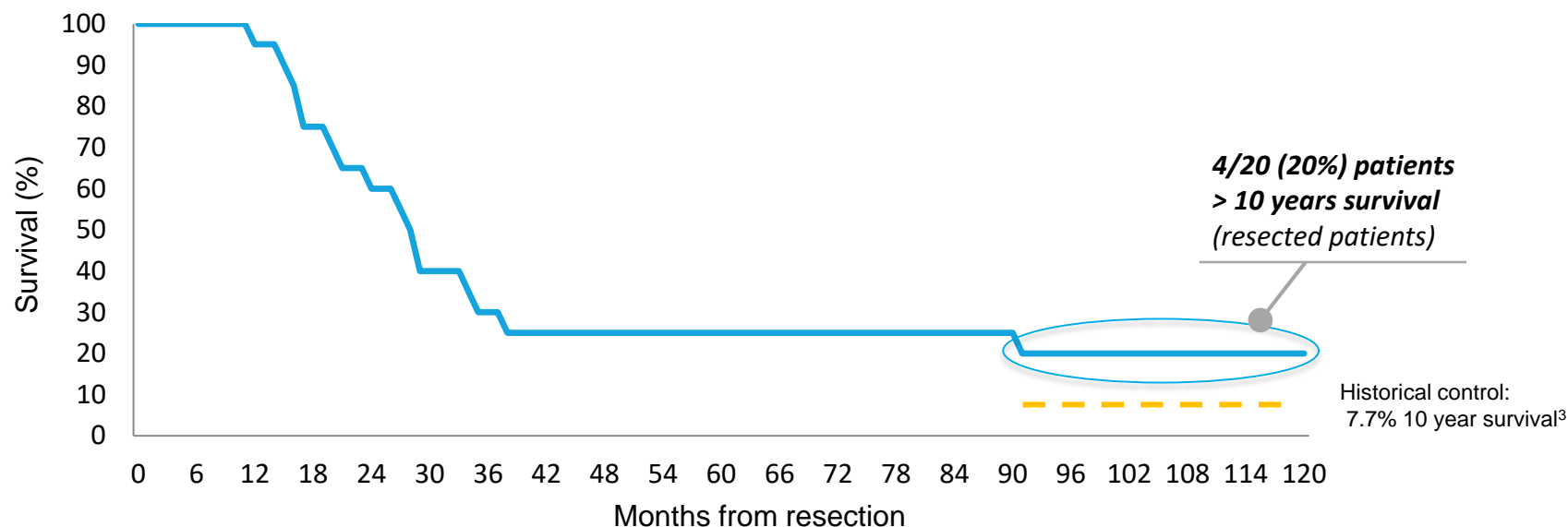
Attack the cancer:

- RAS specific T-cells identify mutated RAS antigens on cancer cell surface
- Killer T-cells destroy the cancer cells



These results are backed by encouraging 10 year survival data and immune response correlation from earlier trials

Long-term data from earlier TG mono-therapy trials – resected pancreatic cancer



Advanced pancreatic cancer TG01/GM-CSF (mono-therapy)	Evaluable patients	Median survival (from 1 st vaccination)	1 year survival (from 1 st vaccination)
Detected immune response	14 / 25 (56%)	156 days	3 (21%)
Not detected Immune response	11 / 25 (44%)	109 days	1 (9%)

**Significantly better
outcome for
patients with
immune response
(non-resected)**

(Clinical study report CTN RAS 98010 on file)

¹ Wedén et al., 2011

² Oettle H et al., JAMA 2007, vol 297, no 3

³ Oettle H et al., JAMA 2013, vol 310, no 14

We are currently working to replicate and expand on these encouraging clinical results

Historical trials



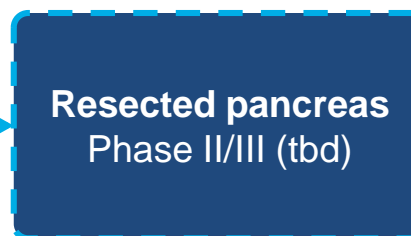
- 10 year survival data
- Correlation between immune response and survival
- Excellent safety

Completing trial

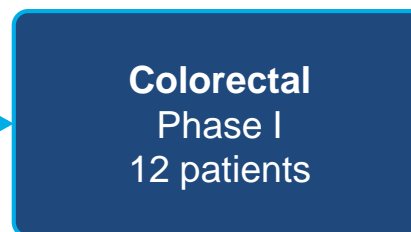


- Encouraging survival data
- Potent immune activation

Planned / recruiting trials



- Randomized controlled trial
- Aim to reach registration



- Combination with CPI
- >50% of patients RAS mutated
- Currently recruiting patients

A randomized Phase II/III registration trial being designed

Agenda

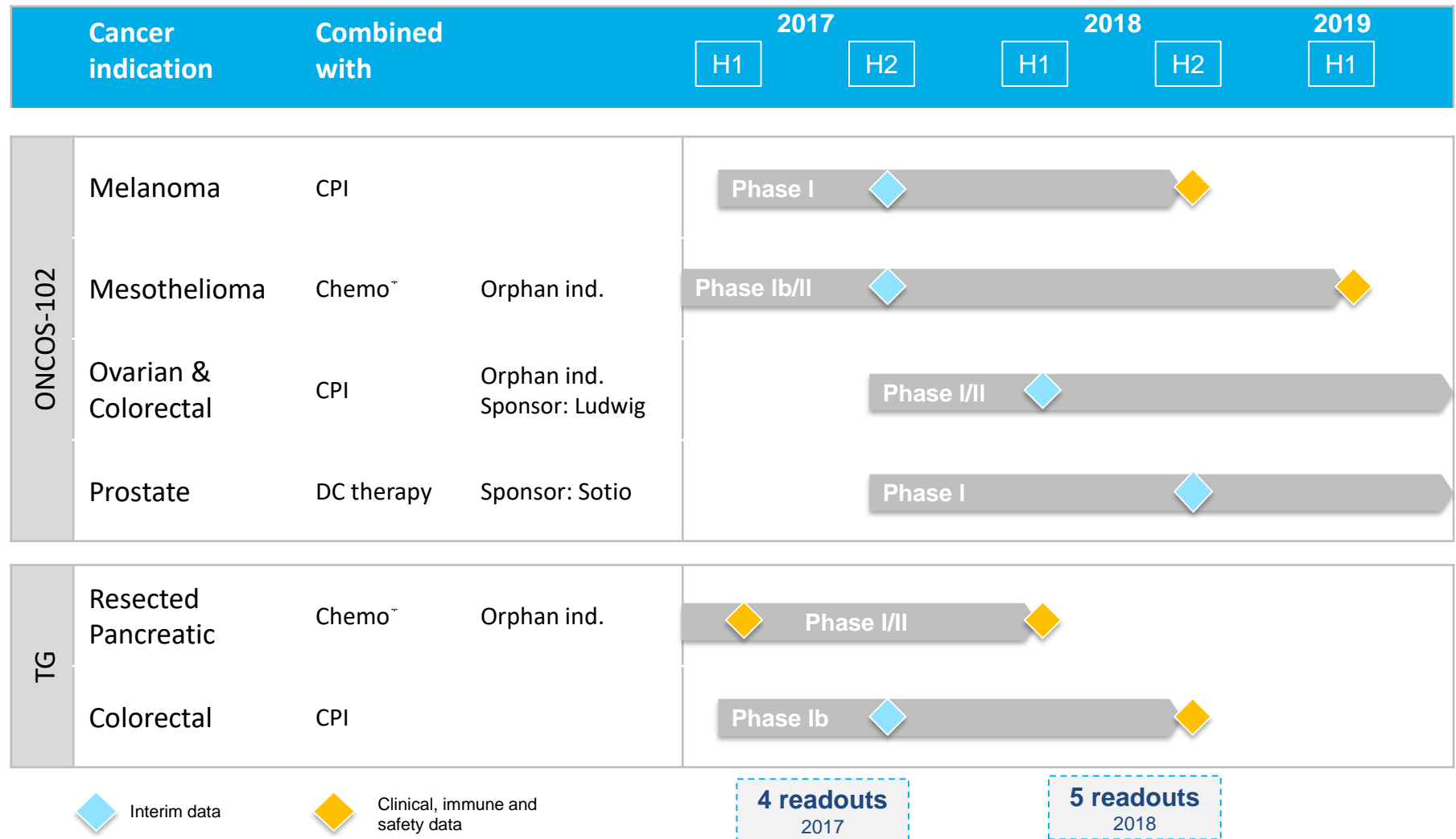
- Introduction to immunotherapy
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Two platforms and six clinical trials in total ensures a diversified program with frequent data readouts



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- **A physician's view on pancreatic cancer – *Prof Daniel Palmer***

- Financial update – *CFO, Erik Wiklund*

- Q&A

Adjuvant therapy for resectable pancreatic cancer

London, June 2017



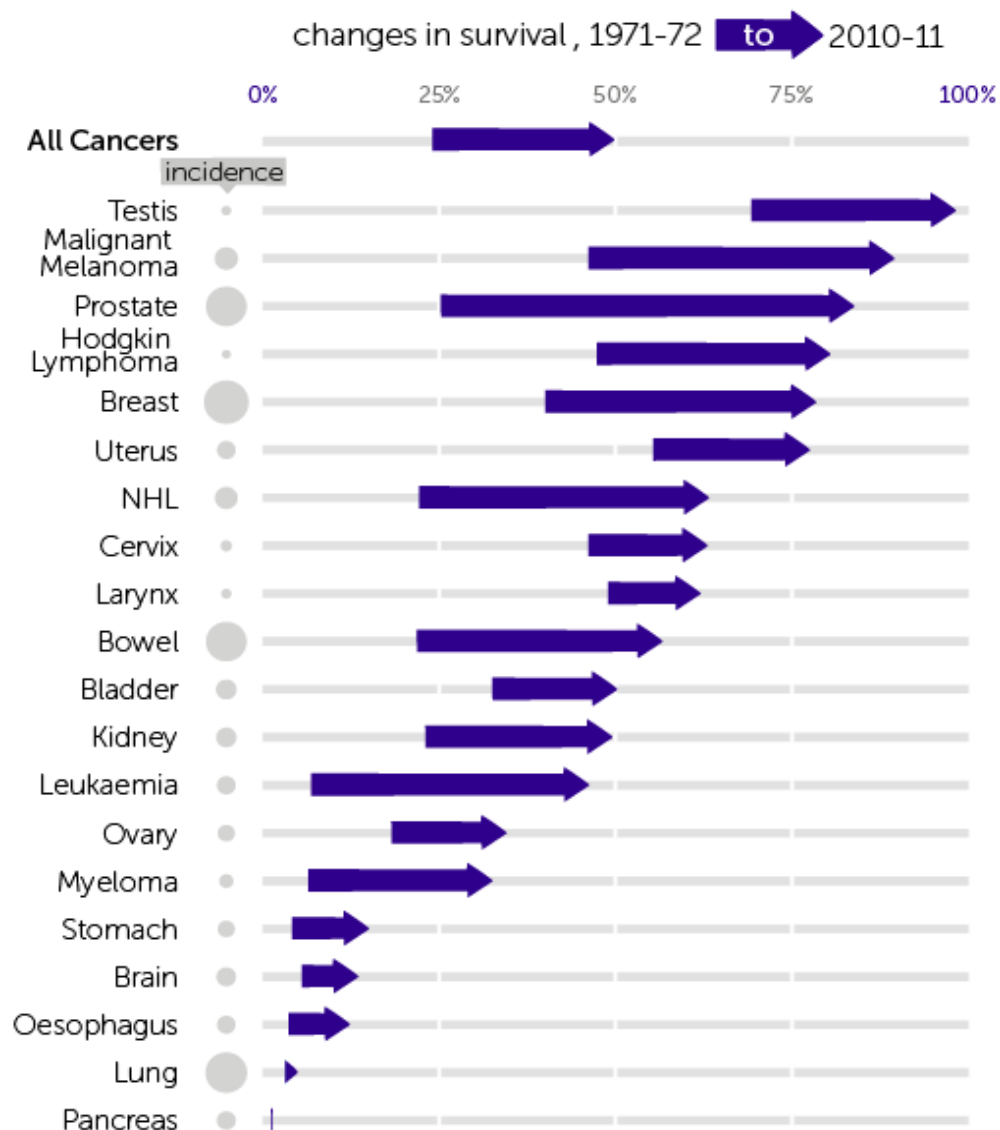
Daniel Palmer

Department of Molecular and Clinical Cancer Medicine
University of Liverpool and Clatterbridge Cancer
Centre

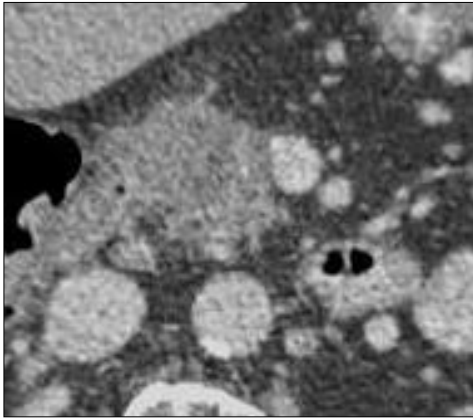
Plan of the Talk

- Epidemiology
- The challenges of pancreatic cancer
- Palliative chemotherapy: current status
 - Gemcitabine
 - Folfirinox
 - Nab-paclitaxel
- Adjuvant therapies for resected pancreatic cancer
 - Clinical trials
 - Current state-of-the-art
- Where next?
 - Rationale for immunotherapy
- Targovax trial

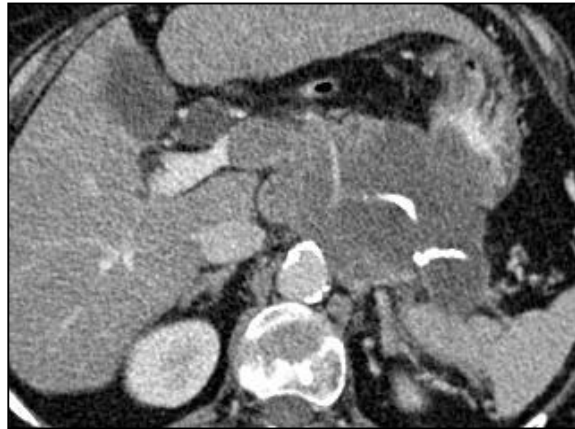
Age-Standardised Ten-Year Net Survival Trends, Adults England and Wales, 1971-2011



Why so challenging?



Resectable
10-20%



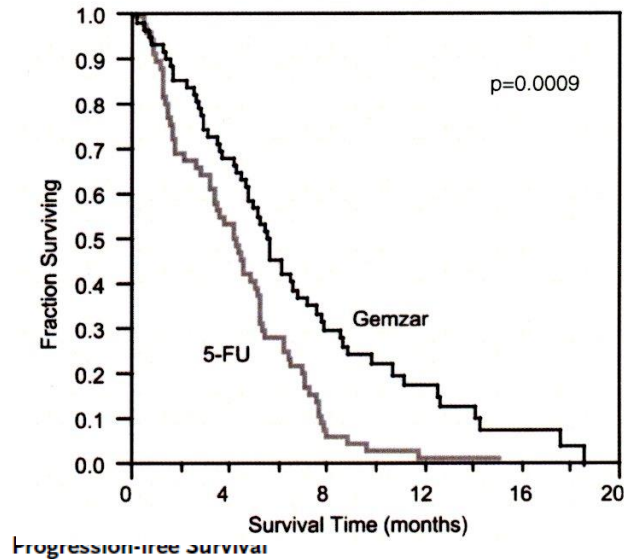
Locally advanced
30-40%



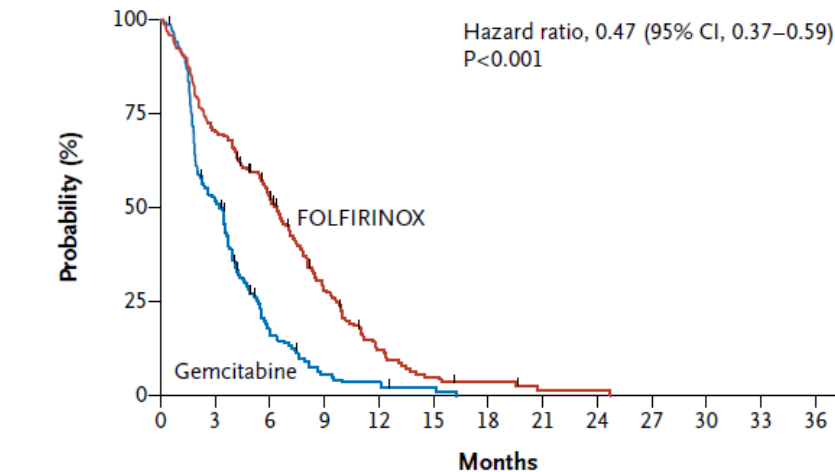
Metastatic
50-60%

- Advanced stage at time of diagnosis
- Even in operable cases
 - Challenging (and dangerous) surgery
 - High recurrence rates
- Relatively resistant to chemotherapy
 - Gemcitabine standard chemotherapy for 20 years
 - Gem vs weekly bolus 5-FU

Advanced pancreatic cancer is relatively resistant to chemotherapy

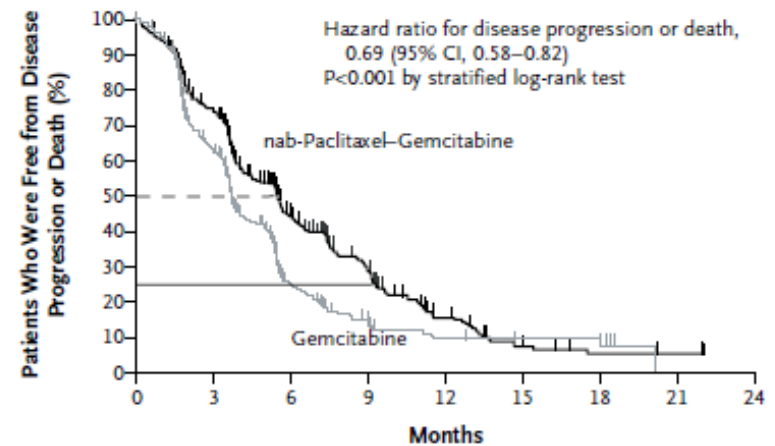


	5-FU	Gem	
Response	0%	5%	
Median OS	4.4m	5.7m	$P=0.025$
1yr survival	2%	18%	
CBR	4.8%	23.8%	$P=0.022$



No. at Risk												
Gemcitabine	171	88	26	8	5	2	0	0	0	0	0	0
FOLFIRINOX	171	121	85	42	17	7	4	1	1	0	0	0

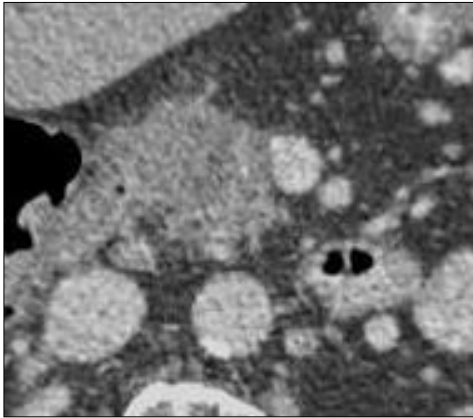
FOLFIRINOX



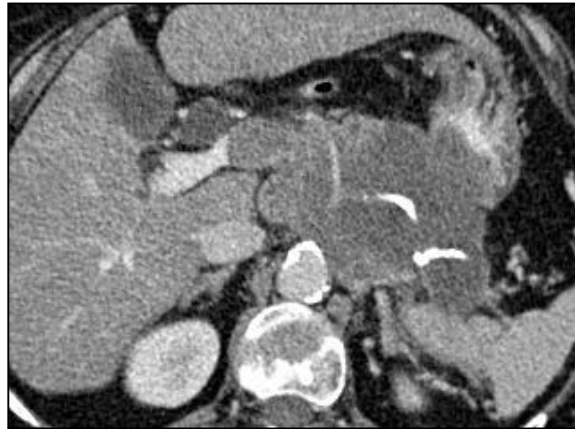
No. at Risk												
nab-Paclitaxel-Gemcitabine	431	281	122	62	24	8	4	2	0			
Gemcitabine	430	209	51	23	10	6	4	0	0			

GEM+ABRAXANE

Why so challenging?



Resectable
10-20%



Locally advanced
30-40%



Metastatic
50-60%

- Even in operable cases
 - Challenging (and dangerous) surgery
 - High recurrence rates
- Long-term survival <10%
- Is the problem due to:
 - Local recurrence?
 - Metastatic recurrence?
 - Both?

Adjuvant Therapy

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Randomized Trial of Chemoradiotherapy and Chemotherapy after Resection of Pancreatic Cancer

John P. Neoptolemos, M.D., Deborah D. Stocken, M.Sc., Helmut Friess, M.D.,
Claudio Bassi, M.D., Janet A. Dunn, M.Sc., Helen Hickey, B.Sc., Hans Beger, M.D.,
Laureano Fernandez-Cruz, M.D., Christos Dervenis, M.D., François Lacaine, M.D.,
Massimo Falconi, M.D., Paolo Pederzoli, M.D., Akos Pap, M.D.,
David Spooner, M.D., David J. Kerr, M.D., and Markus W. Büchler, M.D.,
for the European Study Group for Pancreatic Cancer

NEJM 2004; 350:1200-10



UNIVERSITY OF
LIVERPOOL



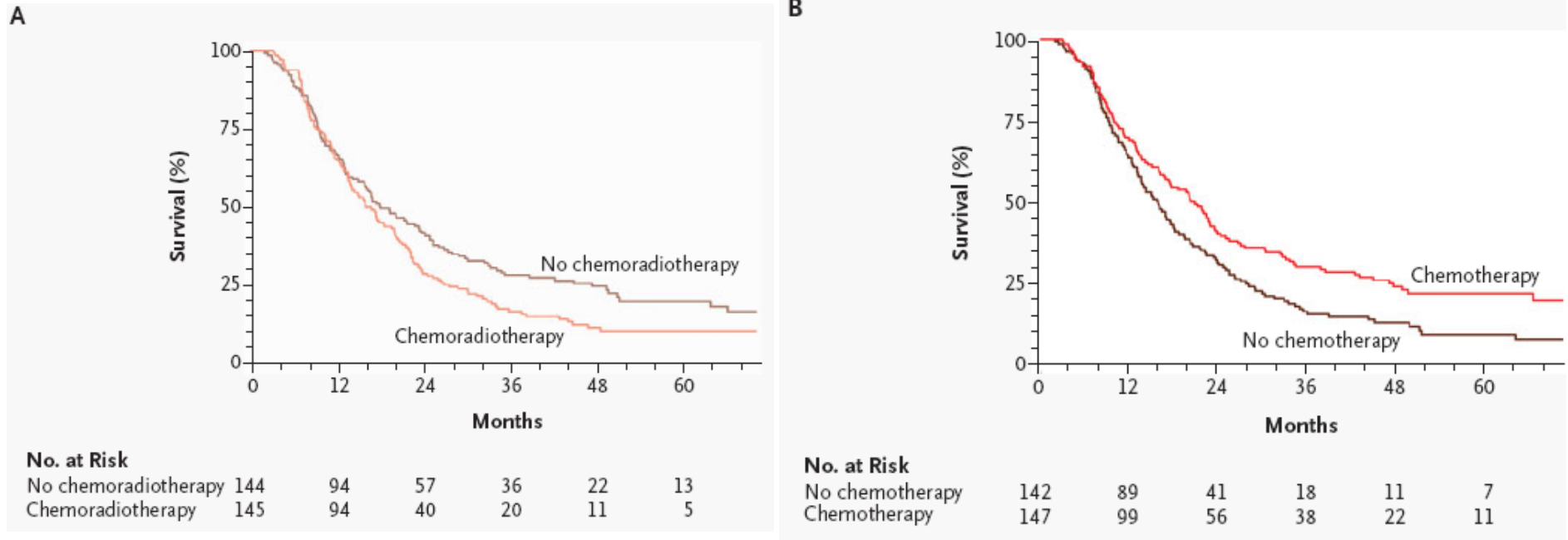
NHS
National Institute for
Health Research

Freedom of the
City of Liverpool



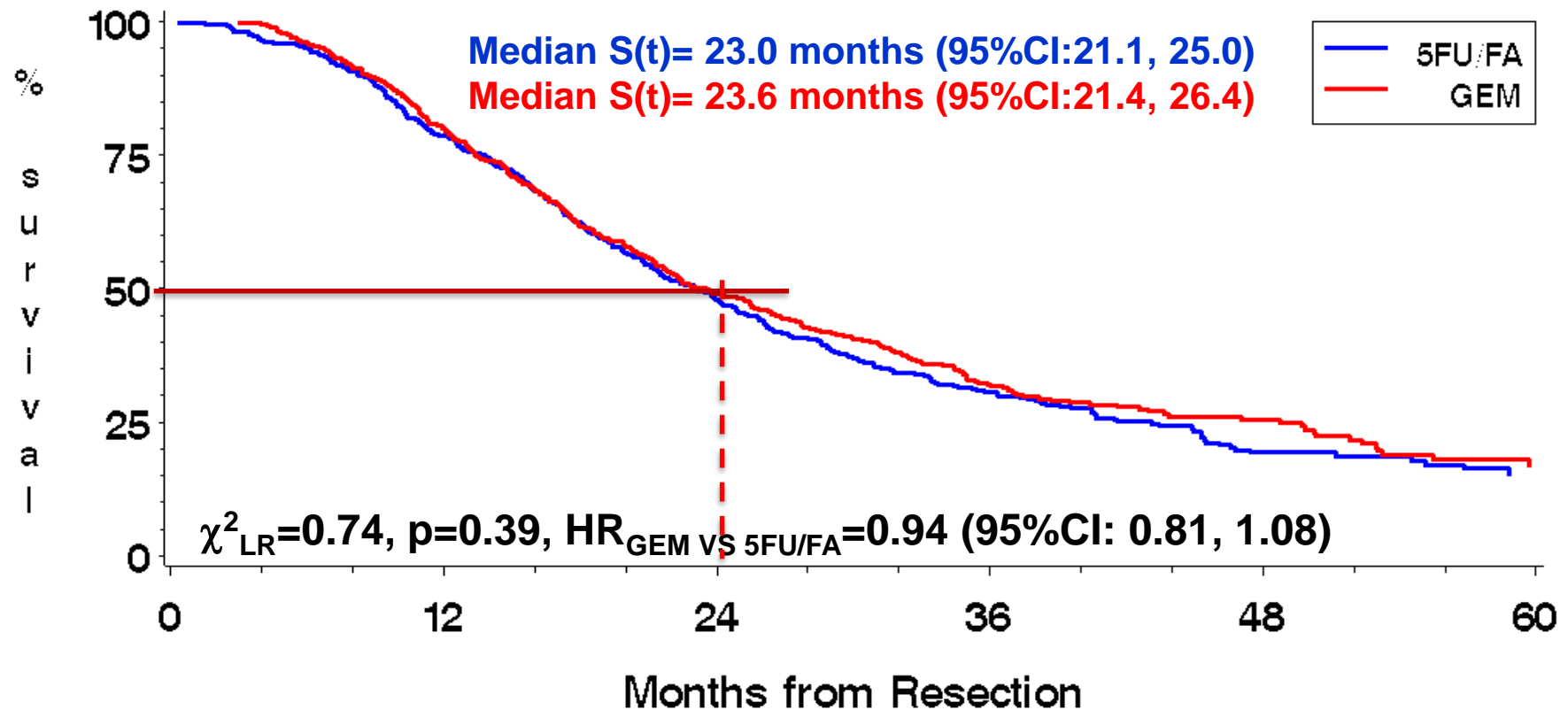
CANCER
RESEARCH
UK

A randomized trial of chemoradiotherapy and chemotherapy after resection of pancreatic cancer – ESPAC 1



NEJM 2004;
350:1200-10

ESPAC-3: Survival by treatment



No. at Risk					
5FU/FA551	413	249	109	36	15
GEM 537	415	251	103	42	13

Neoptolemos et al JAMA 2010; 304: 1073-81

ESPAC - 4

722 patients
pancreatic ductal adenocarcinoma
'curative' resection ≤ 12 wks



**RANDOMISATION at
Liverpool Cancer Trials Unit**

GEMCITABINE

1000mg/m² - Days 1,8 and
15 for 6 cycles

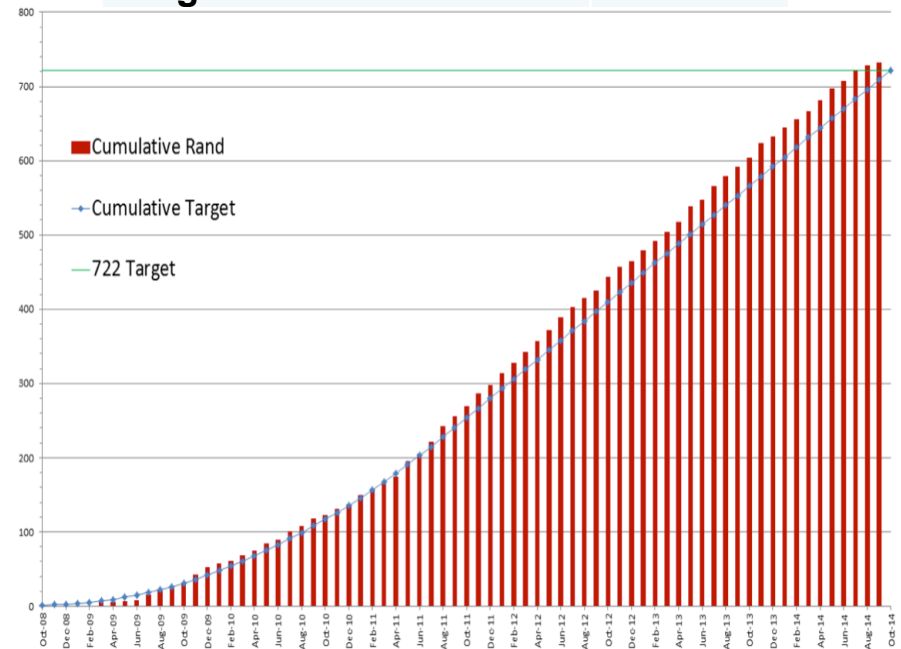
GEMCITABINE

1000mg/m² - Days 1,8 and
15 for 6 cycles
CAPECITABINE
1660mg/m²/day – 21/28d
i.e. 24 weeks

**3-MONTHLY FOLLOW UP
FROM RANDOMISATION TO
DEATH**

Stratified log-rank test with 5% 2-sided α , for a
10% difference in 2 year survival, 90% power
= 480 events = 722 patients, 361 in @ arm

Target number of patients	722
Start date	13/01/08
Number of sites opened	106
Planned close date	01/11/14
Target achieved	31/07/14

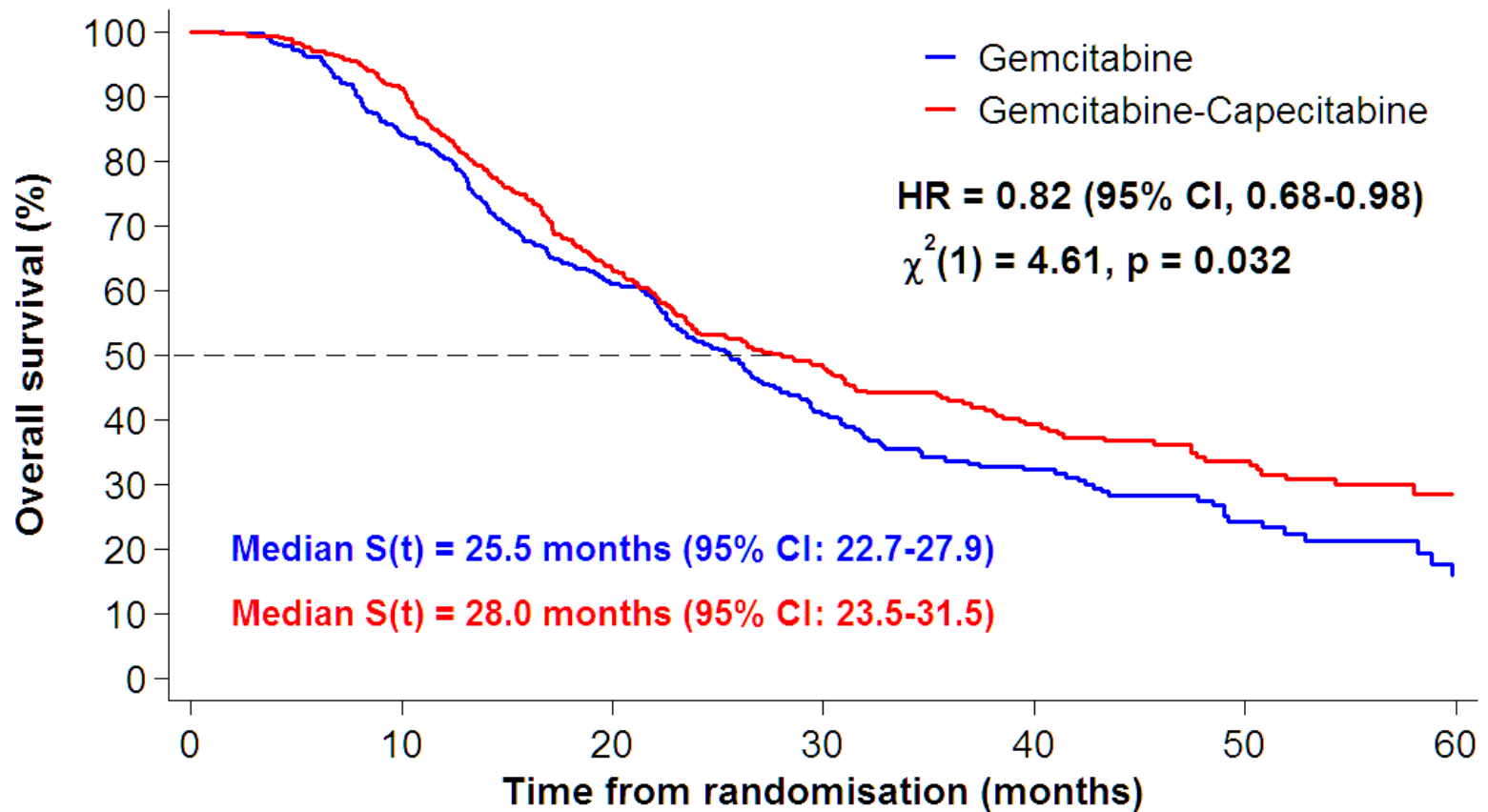


Patient Demographics

		GEM n=366	GEMCAP n=364	TOTAL n=730
*Age (years)		65 (37-80)	65 (39-81)	65 (37-81)
Sex	Male	212 (58%)	202 (55%)	414 (57%)
	Female	154 (42%)	162 (45%)	316 (43%)
Baseline PS	0	158 (43%)	150 (41%)	308 (42%)
	1	199 (54%)	202 (56%)	401 (55%)
	2	9 (3%)	12 (3%)	21 (3%)
Smoking	Never	151 (41%)	146 (40%)	297 (41%)
	Past	136 (37%)	148 (41%)	284 (39%)
	Present	62 (17%)	61 (17%)	123 (17%)
	Unknown	17 (5%)	9 (2%)	26 (3%)
*Surgery to Rand (days)		65 (23-111)	64 (21-111)	64 (21-111)

* Median (Range)

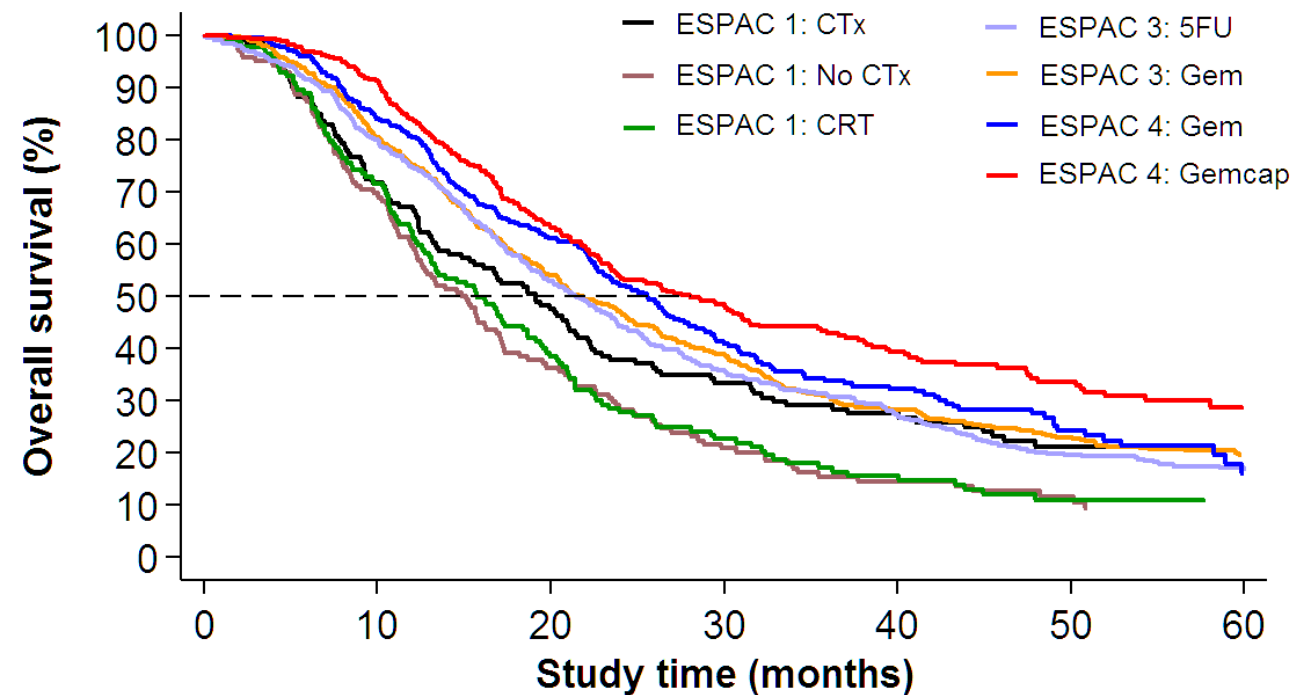
Survival by Treatment



No. at Risk

Gem	366	302	207	109	61	27	9
GemCap	364	328	219	139	83	50	19

ESPAC Trials Overall Survival



No. at Risk							
E1 - CTx	149	105	68	46	34	19	16
E1 - No CTx	143	99	50	28	17	10	8
E1 - CRT	145	103	54	30	19	10	8
E3 - Gem	539	422	283	187	126	93	64
E3 - 5FU	551	430	283	180	131	81	56
E4 - Gem	366	302	207	109	61	27	9
E4 - GemCap	364	328	219	139	83	50	19

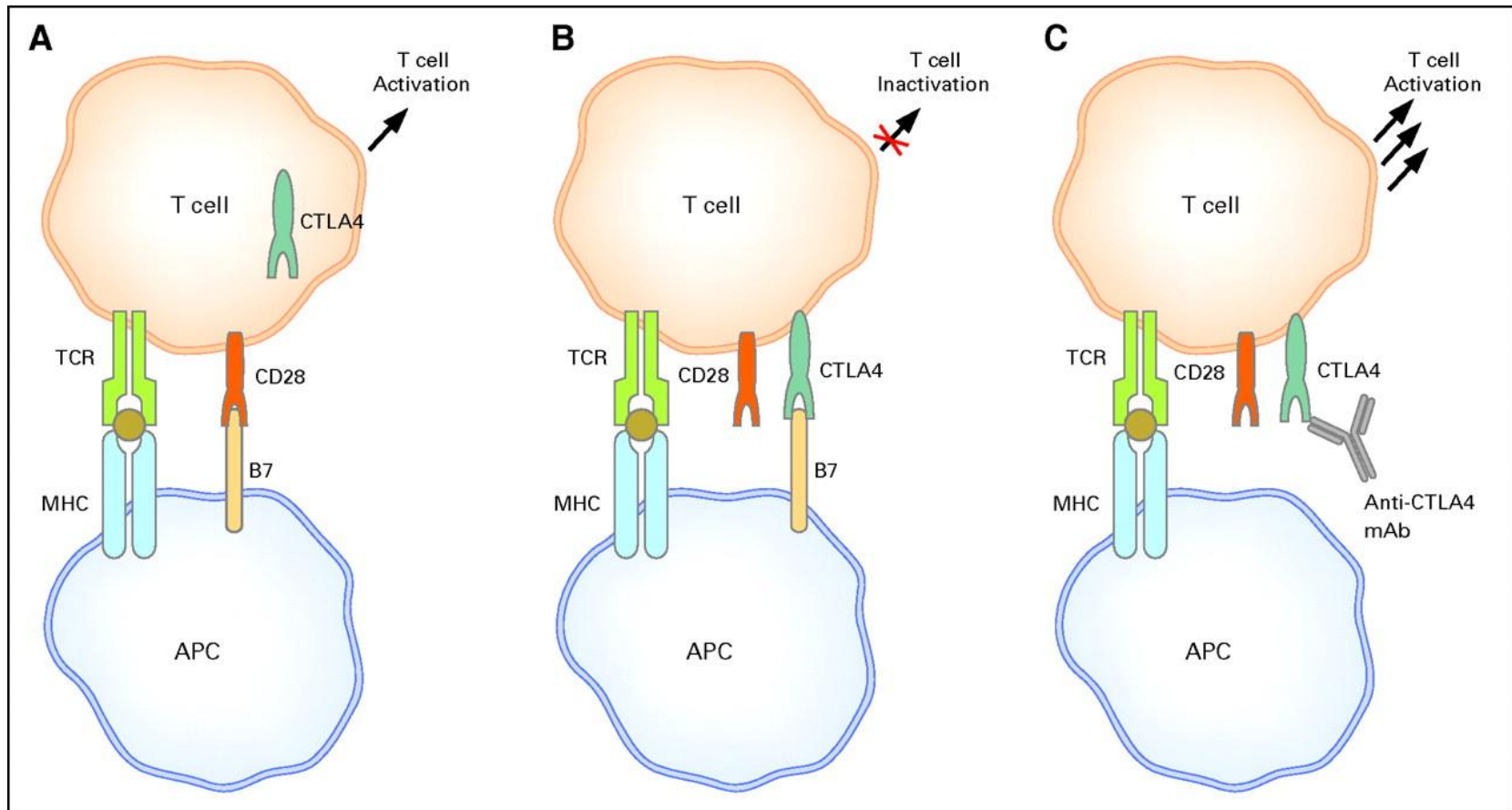
**Study time = time from surgery for ESPAC 1/3, study time = time from randomisation for ESPAC 4*

Where next?

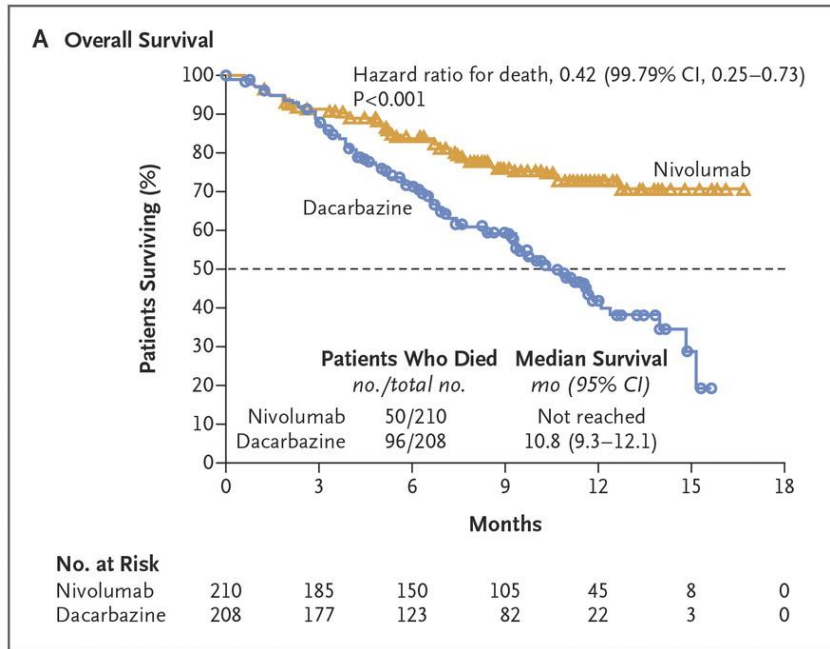
- Rationale for immunotherapy in cancer
- Targovax trial

Immunotherapy approaches

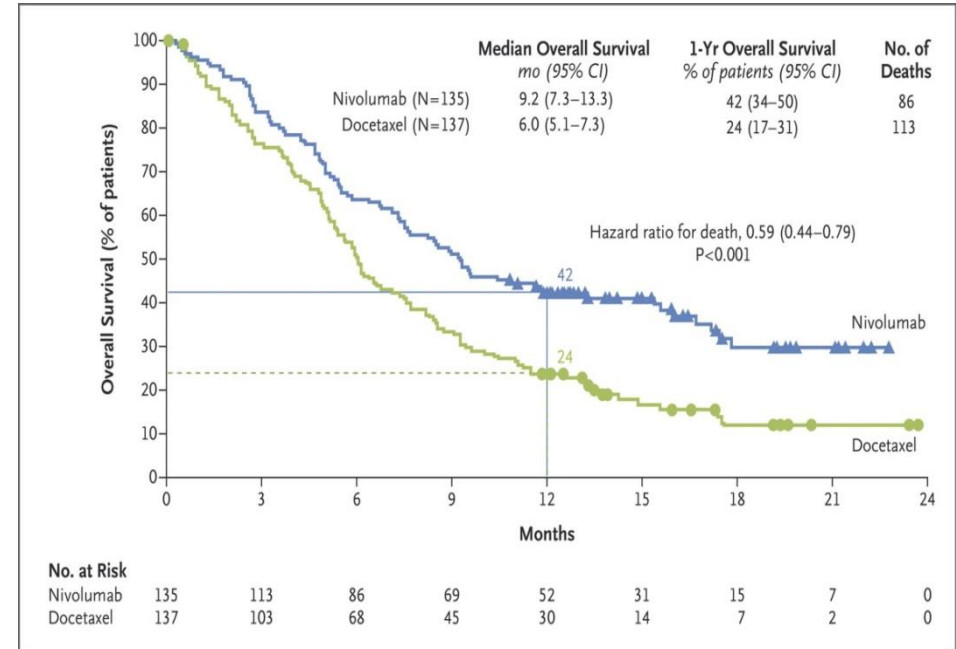
- T cell checkpoints



Checkpoint inhibition in advanced melanoma and lung cancer



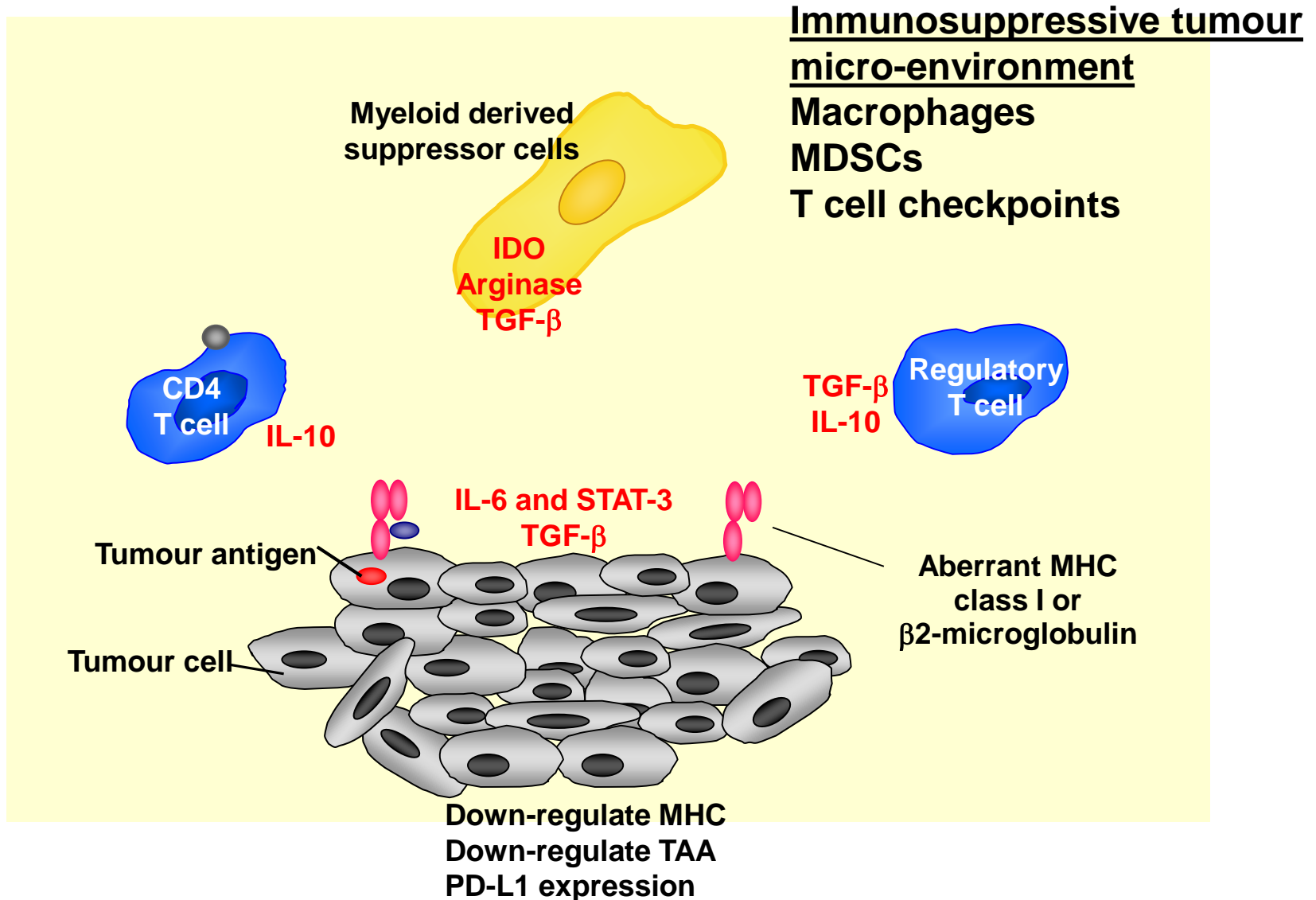
melanoma



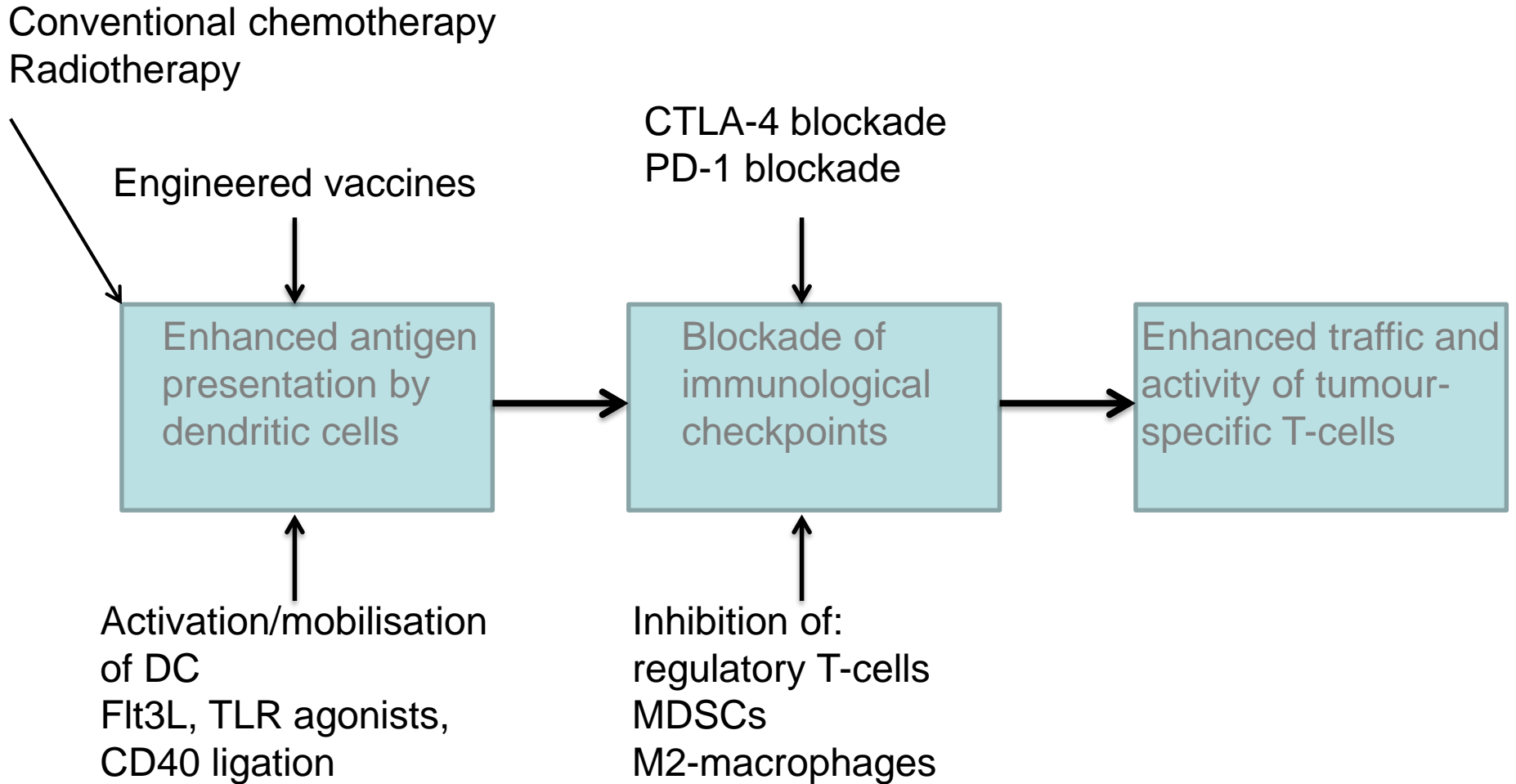
Non-small cell lung cancer

- Significant survival benefit
- Some long-term survivors
- Non-specific immune stimulation
 - Risk of auto-immune toxicities

Advanced pancreatic cancer is resistant to checkpoint inhibitors



Multiple points of intervention for immunotherapy





Arming the immune system to fight cancer

A Phase I/II trial of TG01/GM-CSF and gemcitabine as adjuvant therapy for treating patients with resected RAS-mutant adenocarcinoma of the pancreas

TG01-01 Background

TG01

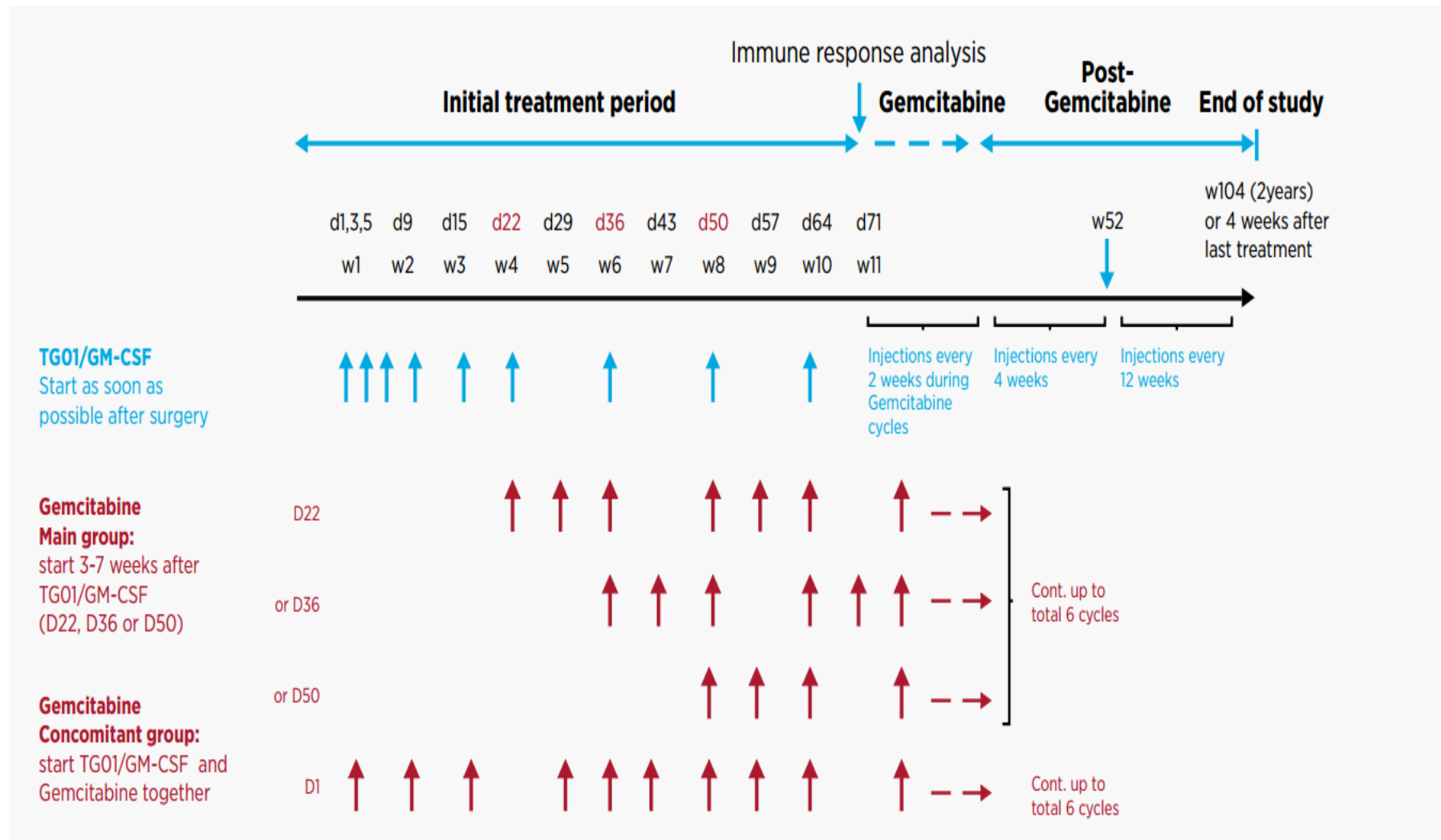
- injectable antigen-specific cancer immunotherapy
- targeted to treat patients with RAS mutation
 - found in more than 85% of pancreatic adenocarcinomas
- a mixture of 7 synthetic peptides
 - representing 7 of the most common 12 & 13 mutations in RAS assoc. with human cancer
- induces RAS mutant-specific T-cell responses which are enhanced by co-administration of GM-CSF

Earlier studies

- demonstrated that adjuvant vaccination with TG01/GM-CSF given as **monotherapy** to pancreatic cancer patients after tumor resection induce mutant RAS specific immune response in 100% of patients

This study evaluates safety, immunological response and Overall Survival of TG01-immunotherapy with adjuvant gemcitabine chemotherapy.

TG01-01 Study design



Modified cohort is ongoing (n=13). Last patient last visit May 2018

TG01-01 Study objectives

Primary

- To assess the safety of GM-CSF/TG01 vaccination and adjuvant chemotherapy
- To assess the immune response to GM-CSF/TG01 and the effect of adjuvant chemotherapy in patients receiving GM-CSF/TG01 after primary resection of pancreatic adenocarcinoma

Secondary

- To assess, at 2 years, the clinical efficacy of GM-CSF/TG01 in patients with resected pancreatic cancer

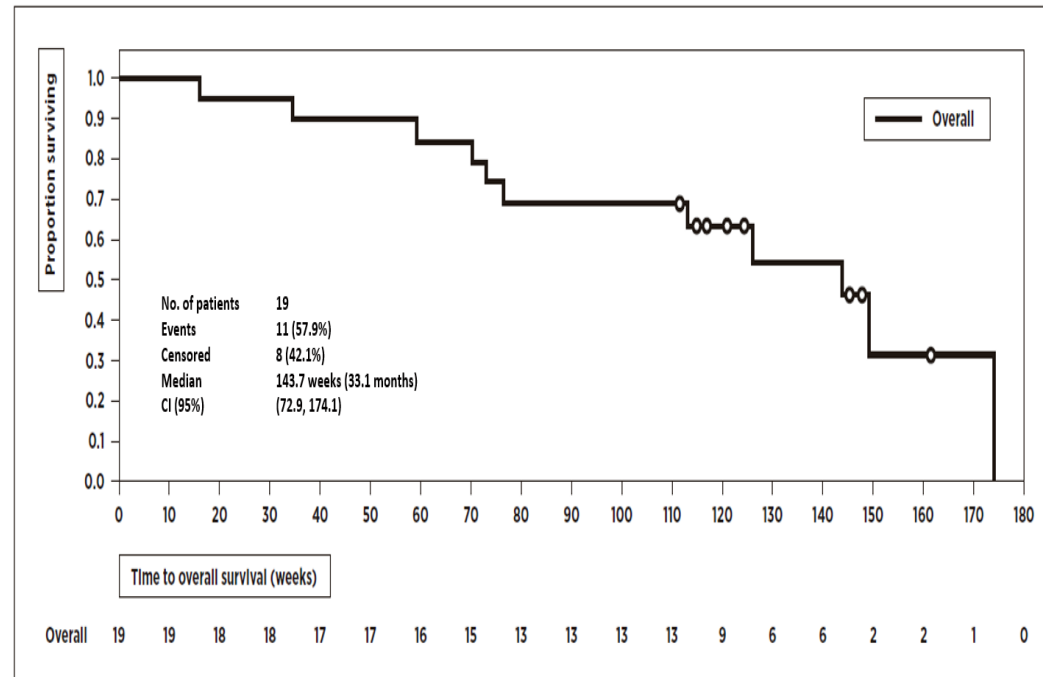
Exploratory

- To assess the relationship of KRAS status to recurrence
- To monitor CA19-9 levels

Demographics

Parameters	Number of patients (N=19)
Age (Y) median (min, max)	67 (49, 79)
Gender, n (%)	
Male	10 (53%)
Female	9 (47%)
ECOG, n (%)	
0	8 (42%)
1	11 (58%)
CA19-9 (n=15) U/ml median (min, max)	16 (8, 240)
Hemoglobin (g/L) median (min, max)	124.0 (104, 153)
Disease staging at diagnosis	
<i>T stage</i>	
T1	1 (5%)
T2	1 (5%)
T3	17 (90%)
<i>N stage</i>	
N0	7 (37%)
N1	12 (63%)
<i>M stage</i>	
M0	19 (100%)
Resection surgical outcome, n (%)*	
R0	6 (32%)
R1	13 (68%)
KRAS mutation detected, n (%)	
Yes	16 (84%)
No	3 (16%)
Time from surgery to first IMP adm (week) median (range)	8 (7-12)

TG01-01 Efficacy (survival rate from resection)



	1 year*	2 years*
Assessed from resection (8 weeks before first IMP)	17/19 (90%)	13/19 (68%)

Compares favorably with published historical two-year survival rates of resected cancer patients treated with gemcitabine alone of 30%-53%¹⁻⁵

TG01-01 Immune response

Immune response by week 11 and entire study period (N=19)

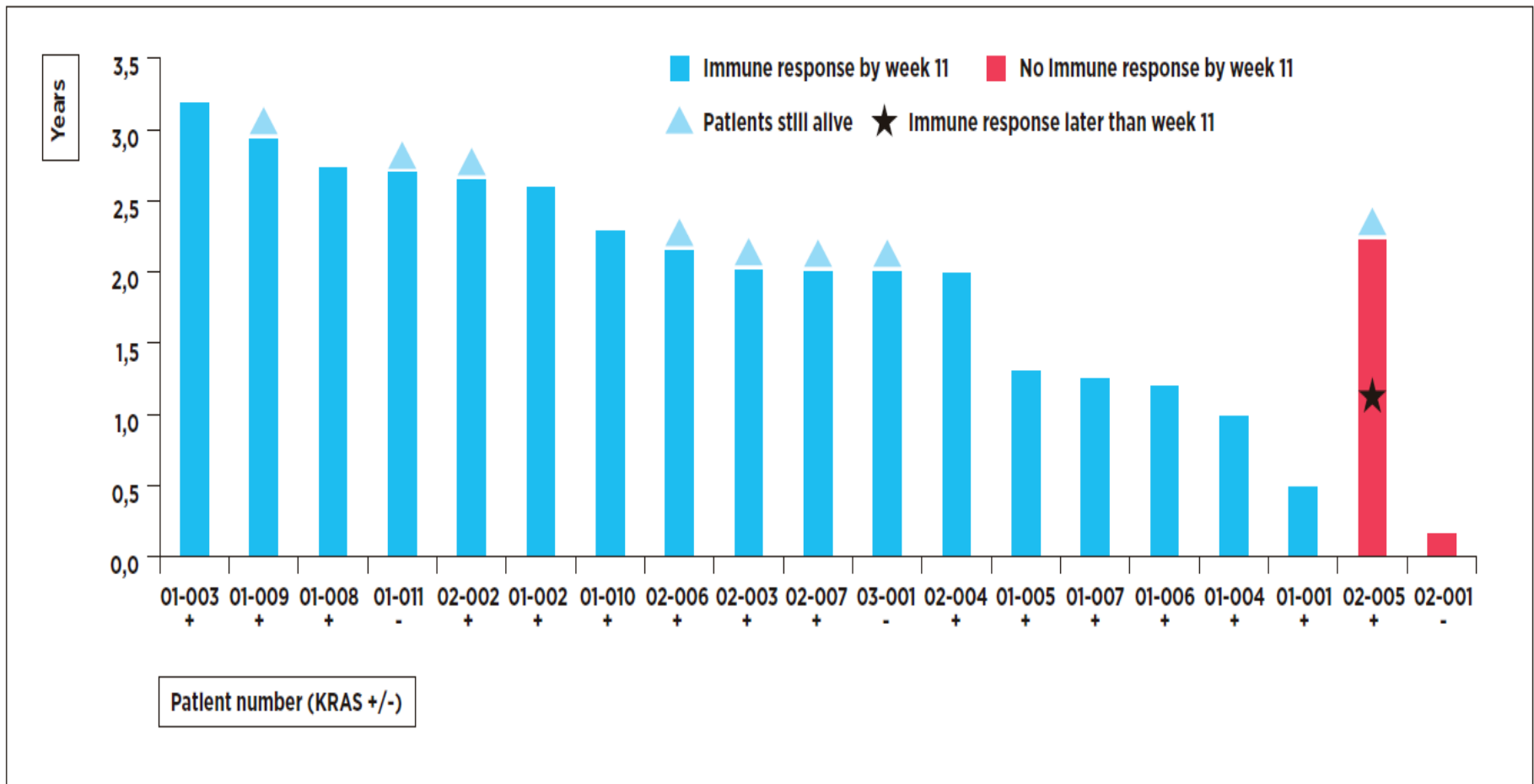
Study period	Immune responders	Immune responders DTH	Immune responders T-cells
By end of initial treatment (week 11)	17/19 (89%)	16/19 (84%)	10/19* (53%)
Entire study period	18/19 (95%)	18/19 (95%)	14/19* (74%)

*Three patients (week 11) and two patients (entire study period) without blood samples for analysis

Immune response after week 11 (n=11)

Study time point	No. of pts with immune monitoring after week 11	Patients with positive immune response after week 11
After week 11	11	9/11 (82%)

TG01-01 Overall survival and immune response



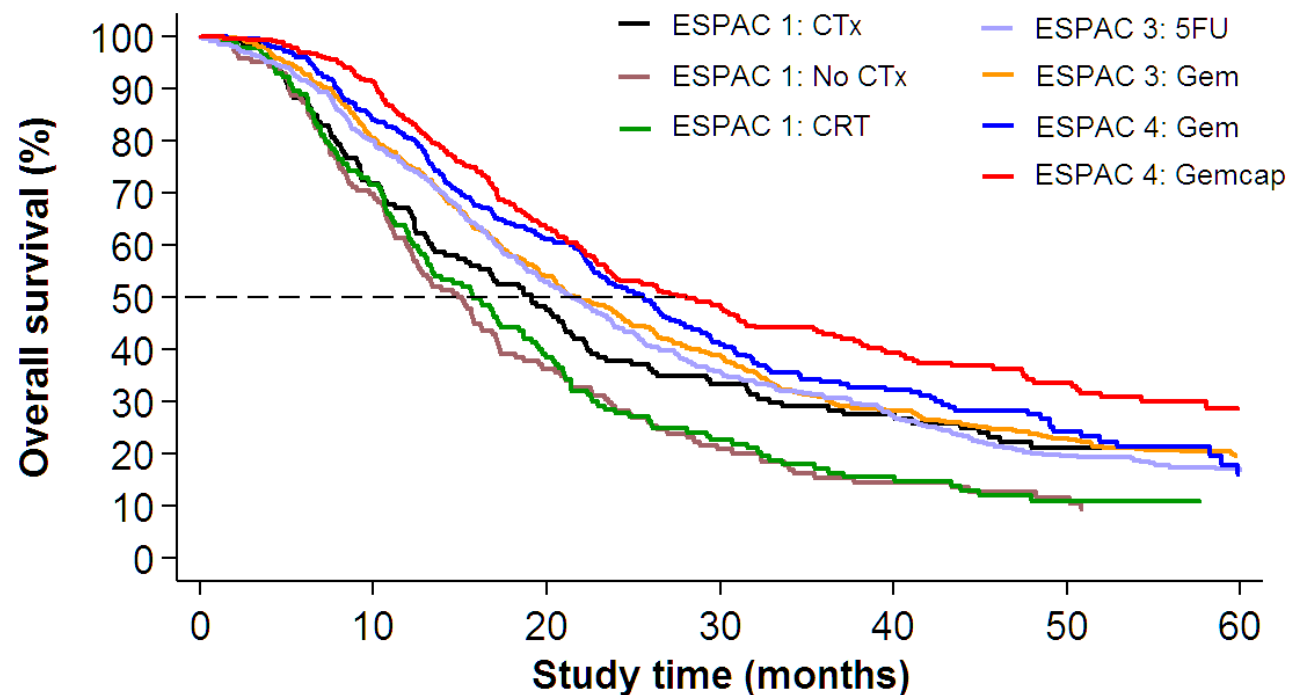
TG01-01 Safety profile (N=19)

Serious Adverse Events Preferred term	Number of Events	Relationship to study treatment
Anaphylactic reaction	2	Related to TG01 +/- GM-CSF
Hypersensitivity	1	
Dyspnea	1	Related to Gemcitabine and TG01/GM-CSF
Lung infection	1	Related to Gemcitabine
Pyrexia (fever)	2	
Anaemia	1	
Anaphylactic shock related to a concomitant medication (Emend)	1	Unrelated to study treatments
Hyperglycemia	1	
Urosepsis	1	
Pneumonia	1	
Viral upper respiratory tract infection	1	

TG01-01 Conclusions

- TG01/GM-CSF generated early immune responses in 89% of patients with R0/R1 resected pancreatic cancer. This demonstrate that TG01 vaccination activate mutant RAS specific T cells.
- The regimen was generally well tolerated although some late, manageable allergic reactions were seen.
- Median OS of 33.1 months is encouraging in context of published data
- Immune activation at both DTH and PBMC level is associated with the positive clinical findings.

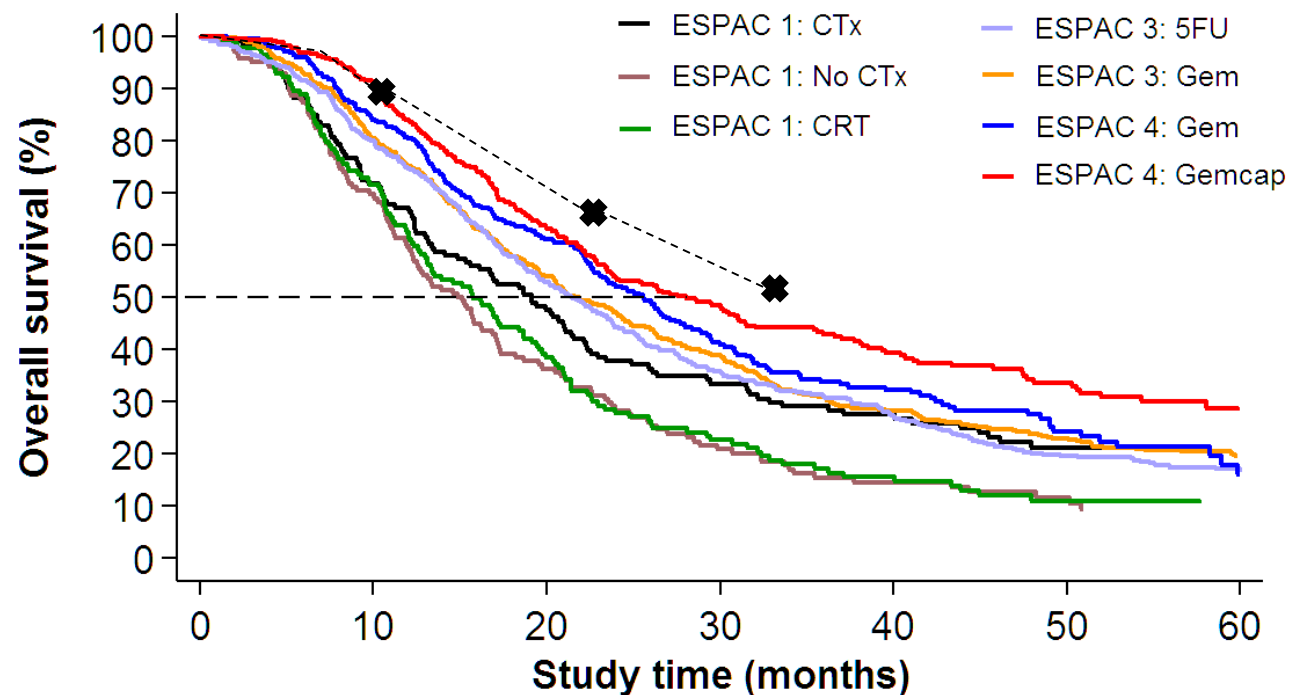
ESPAC Trials Overall Survival



No. at Risk							
E1 - CTx	149	105	68	46	34	19	16
E1 - No CTx	143	99	50	28	17	10	8
E1 - CRT	145	103	54	30	19	10	8
E3 - Gem	539	422	283	187	126	93	64
E3 - 5FU	551	430	283	180	131	81	56
E4 - Gem	366	302	207	109	61	27	9
E4 - GemCap	364	328	219	139	83	50	19

***Study time = time from surgery for ESPAC 1/3, study time = time from randomisation for ESPAC 4**

ESPAC Trials Overall Survival



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Capital Markets Update - Agenda

- Introduction – *CEO, Øystein Soug*

- Targovax's technology and trials – *CMO, Dr Magnus Jäderberg*

- A physician's view on pancreatic cancer – *Prof Daniel Palmer*

- **Financial update – *CFO, Erik Wiklund***

- Q&A

Financial summary – end of Q1 2017

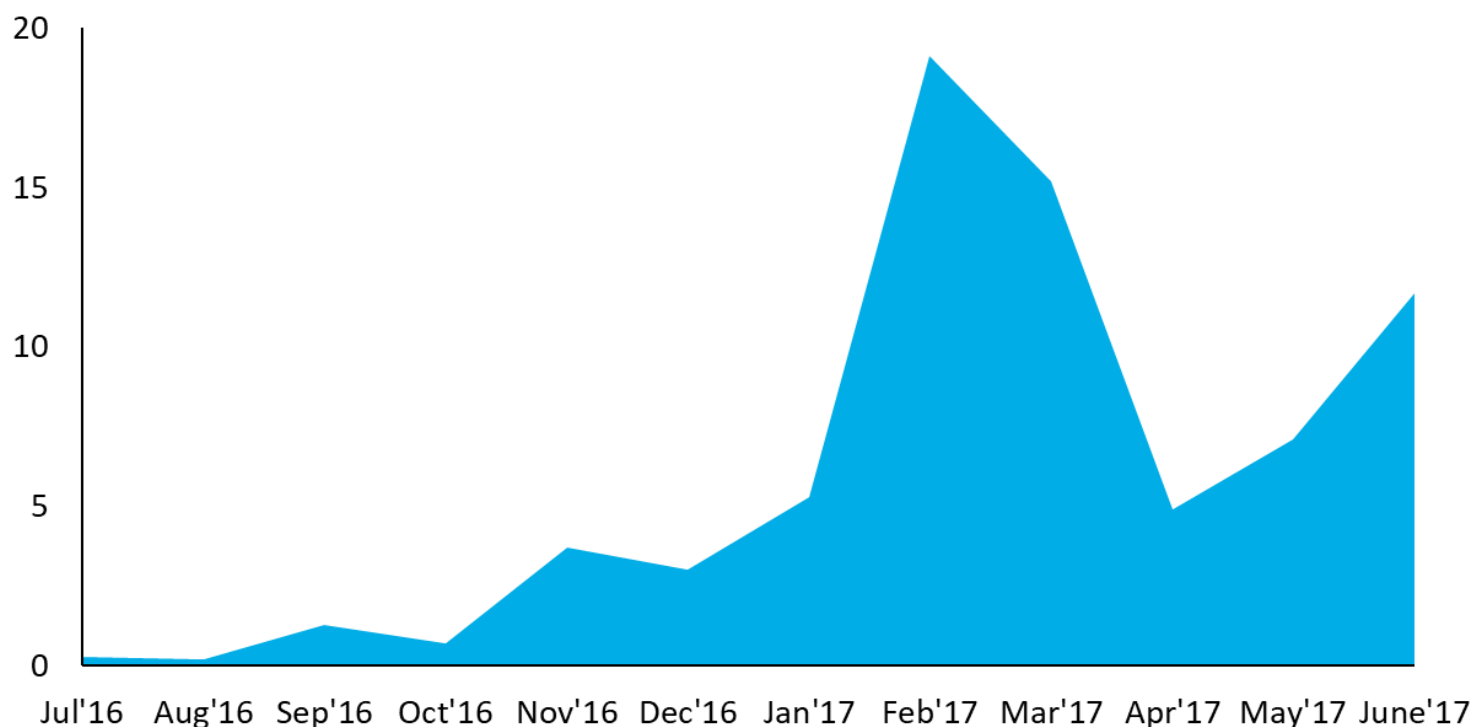
Raised NOK 200 million 8 June 2017
10,000,000 new shares @ NOK 20 per share

Operations			
Cash	NOK 147m	USD 17m	<i>End of Q1 2017</i>
Net cash flow	NOK -24m	USD -3m	<i>Total Q1</i>
Annual run rate	NOK 104m	USD 12m	<i>Last four quarters</i>
Annual opex	NOK 116m	USD 13m	<i>Last four quarters</i>

The share	OSE: TRVX		
Market Cap	NOK ~1bn	USD ~120m	<i>At share price NOK ~24</i>
Daily turnover	NOK 10m	USD 1m	<i>Typical daily volume</i>
Debt	NOK 43m	USD 5m	<i>EUR 6m conditional</i>
No. of shares	42.2m	<i>46.0m fully diluted per April 18</i>	
Analysts	DNB, ABG Sundal Collier, Arctic, Redeye, Norske Aksjeanalyser		

TRVX was upgraded to the main list on OSE in March, and has showed a positive trend in share turnover in 2017

*Development in daily average share turnover (NOK million / day)**



- **NOK ~1b** market cap
- **NOK 10m** avg. daily turnover in last 3 months
- **NOK 850m** total turnover in Q1
- **560k shares** avg. daily volume in Q1
- **>3,700 owners**
- **42.2m shares*** (46.0 fully diluted)

* Up until 8th June

* Before Private Placement 8th June

Strong shareholder base as per May 2017

Shareholder		Estimated ownership	
		Shares m	Relative
HealthCap	Sweden	11,2	26,4 %
RadForsk	Norway	4,1	9,7 %
Nordea	Norway	3,0	7,0 %
Nordnet Livsforsikring	Norway	1,5	3,5 %
KLP	Norway	1,3	3,1 %
Statoil	Norway	0,9	2,2 %
Danske Bank (nom.)	Norway	0,8	1,9 %
Timmuno AS	Norway	0,7	1,7 %
Prieta AS	Norway	0,7	1,7 %
Nordnet Bank AB (nom.)	Sweden	0,7	1,6 %
Thorendahl Invest AS	Norway	0,3	0,7 %
Sundt AS	Norway	0,3	0,7 %
Netfonds Livsforsikring AS	Norway	0,3	0,6 %
Avanza Bank AB (nom.)	Sweden	0,3	0,6 %
The Bank of NY Mellon (nom.)	Belgium	0,2	0,5 %
Tobech Invest AS	Norway	0,2	0,5 %
Istvan Molnar	Norway	0,2	0,4 %
Danske Bank (nom.)	Norway	0,2	0,4 %
NHO - P665AK	Norway	0,2	0,4 %
Kristian Falnes AS	Norway	0,2	0,4 %
Top 20		27,0	64,1 %
Other shareholders (3772)		15,2	35,9 %
Total		42,2	100,0 %

New shareholders in Private Placement:

- Nyenburgh
- Trium
- Millenium Capital Partners
- Interogo
- AP3
- Aramea AM

42.2m ordinary shares¹

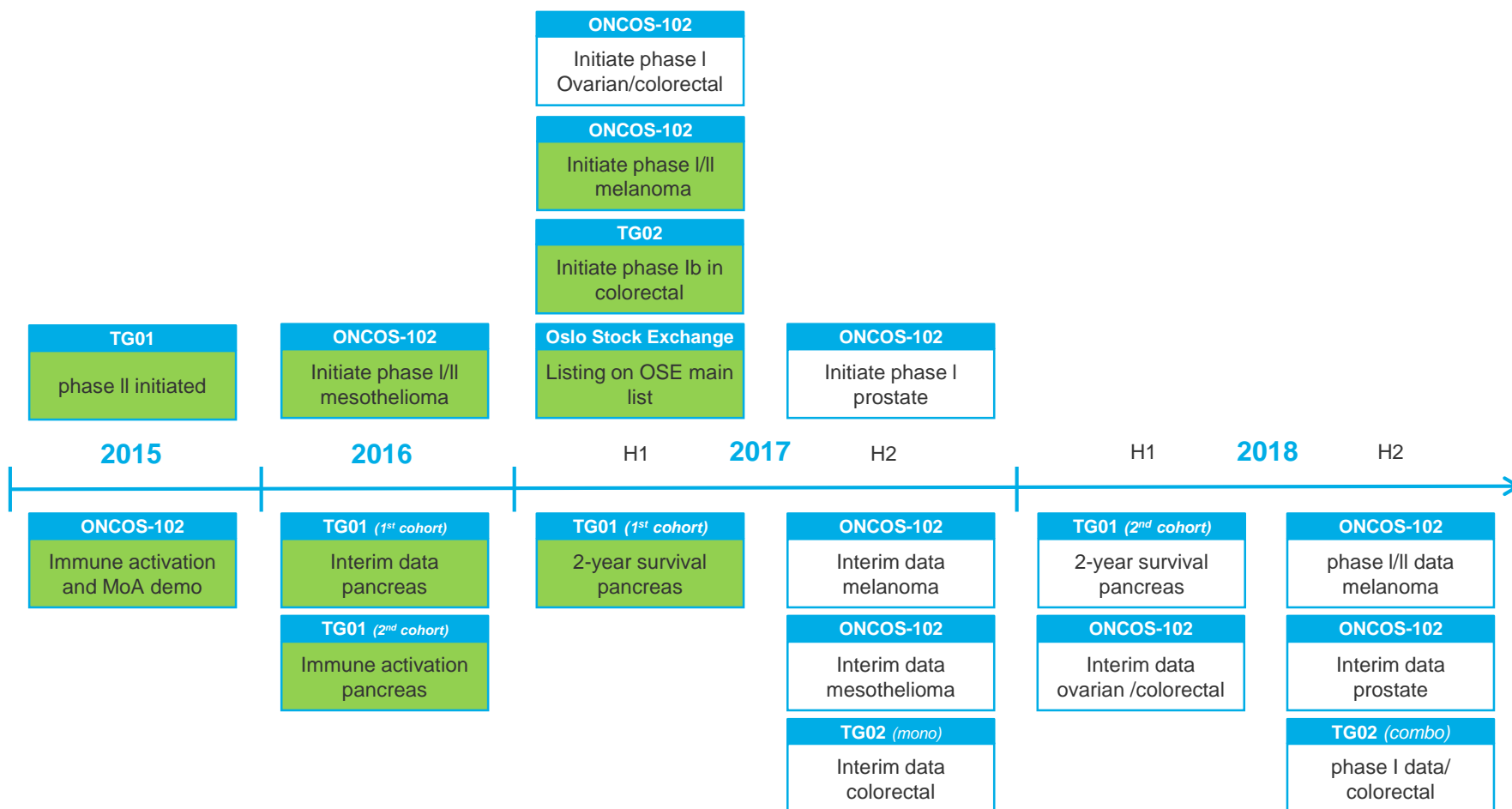
- Management ownership: 2.1%
- 3,792 shareholders

46.0m² shares fully diluted*

- Average strike price on options ~NOK 21
- Total dilutive effect of options is 7.9%

¹ Includes outstanding options (3,634,263) and Restricted Stock Units (169,128) to Board members

Multiple near term value inflection points



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