FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): November 19, 2013

SORRENTO THERAPEUTICS, INC.
(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction
of incorporation or organization)
001-36150
(Commission
File Number)
33-0344842
(IRS Employer
Identification No.)

6042 Cornerstone Ct. West, Suite B
San Diego, CA 92121
(Address of principal executive offices)

Registrant’s telephone number, including area code: (858) 210-3700

(Former name or former address, if changed since last report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communication pursuant to Rule 425 under the Securities Act (17 CFR 230.425)
☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)
☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))
☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))
**Item 7.01 Regulation FD Disclosure.**

Sorrento Therapeutics, Inc. (the “Company”) intends to conduct meetings with third parties in which its corporate slide presentation will be presented. The Company’s presentation is furnished as Exhibit 99.1 to this Current Report on Form 8-K and is incorporated herein by reference.

The information contained in this Item 7.01, including Exhibit 99.1, shall not be deemed “filed” for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, nor shall it be incorporated by reference in any registration statement filed under the Securities Act of 1933, as amended, unless specifically identified therein as being incorporated by reference therein.

**Item 9.01 Financial Statements and Exhibits.**

(d) Exhibits.

<table>
<thead>
<tr>
<th>Exhibit No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99.1</td>
<td>SorrentoTherapeutics, Inc. Corporate Presentation.</td>
</tr>
</tbody>
</table>
Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

Dated: November 19, 2013

SORRENTO THERAPEUTICS, INC.

By: /s/ Richard Vincent

Name: Richard Vincent
Title: Chief Financial Officer, EVP and Secretary
This presentation contains "forward-looking statements" as that term is defined under the Private Securities Litigation Reform Act of 1995 (PSLRA), including statements regarding our business, technologies, product candidates, and other factors affecting such forward-looking statements. Actual results may differ from those projected due to a number of risks and uncertainties, including, but not limited to, the possibility that some or all of the matters and transactions being considered by the Company may not proceed as contemplated, and other factors specified in the Company’s filings with the Securities and Exchange Commission, as well as risks inherent in funding, developing, and obtaining regulatory approvals of new, commercially-viable and competitive products and product candidates. Sufficiency of the data for approval with respect to Cynviloq™ will be a review issue after NDA filing. These statements are made based upon current expectations that are subject to risk and uncertainty and information available to the Company as of the date of this presentation. The Company does not undertake to update forward-looking statements in this presentation to reflect actual results, changes in assumptions or changes in other factors affecting such forward-looking information. Assumptions and other information that could cause results to differ from those set forth in the forward-looking information can be found in the Company’s filings with the Securities and Exchange Commission, including its most recent periodic report. We intend that all forward-looking statements be subject to the safe-harbor provisions of the PSLRA.
<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>President &amp; CEO</td>
<td>Vuong Trieu, Ph.D.</td>
</tr>
<tr>
<td>CSO</td>
<td>George Uy</td>
</tr>
<tr>
<td>CTO</td>
<td>David (Zhenwei) Miao, Ph.D.</td>
</tr>
<tr>
<td>EVP, CFO, Director</td>
<td>Richard Vincent</td>
</tr>
<tr>
<td>Chief Commercial Officer</td>
<td>Henry Ji, Ph.D.</td>
</tr>
</tbody>
</table>

- Co-inventor of IP covering ADC technologies
- Built commercial infrastructures and organizations in startup companies
- Directed the launches of Abraxane®, Xeloda® & Fusilev®
- Meritage Pharma option agreement with ViroPharma ($900M upfront + milestones)
- Meritage Pharma acquisition of ViroPharma to Astazeneca
- $310M sale of Verus asthma program to Astazeneca
- $430M sale of Elevation to Sunovion/Dainippon
- $300M

- Meritage acquired Abraxis Biosciences for > $3 billion
- Instrumental in the approval of Abraxane®
- Co-inventor of IP covering Abraxane®
- Founder and CEO of IgDraSol
- VP of CombiMatrix and Stratagene
- President & CEO of Stratagene Genomics
- Inventor of G-MAB Technology
- Meritage acquired Abraxis Biosciences for > $3 billion
- Instrumental in the approval of Abraxane®
- Co-inventor of IP covering Abraxane®
- Founder and CEO of IgDraSol
- VP of CombiMatrix and Stratagene
- President & CEO of Stratagene Genomics
- Inventor of G-MAB Technology
Investment Highlights

Intractable Pain in Advanced Cancer

• Ongoing Phase 1/2 study
• Orphan drug status received
• Two potential drug products from same API (Resiniferatoxin)
• G-MAB® antibody as specific targeting warhead
• Proprietary toxins as potent tumor killing payload
• Cytoviglog™ RTX G-MAB® ADC

Targeted Drug Delivery (ADC)

• First antibody drug candidate in clinic 1H 2015
• Antibody market >$50B in 2012
• Antibody engineering
• Selective conjugation chemistry for homogenous ADC generation
• Proprietary toxins as potent tumor killing payload

Therapeutic Antibody Engine

• Two potential drug products from same API (Resiniferatoxin)
• Orphan drug status received
• Ongoing Phase 1/2 study
• Intractable Pain in Advanced Cancer

Product launch in 1H 2016

• Bioequivalence registration trial in 2014 (study direct costs ~ $5M)
• Abbreviated regulatory pathway ("bioequivalence") for approval
• Addresses multi-billion dollar palliative market
• Late stage oncology drug with exclusive US and EU Rights

Investment Highlights
Sorrento's Next-Generation Cancer Therapeutics

ADC: Antibody Drug Conjugate

- Effective against heterogeneous tumors
- G-MAB targets approved chemotherapy agents to the tumor
- G-MAB targets toxin to cancer cell
- Programs include VEGFR2, c-Met
- Programs include Pvt-c
- G-MAB targets toxin to cancer cell
- Programs include VEGFR2, c-Met
- Programs include Pvt-c
- G-MAB targets toxin to cancer cell
- Programs include VEGFR2, c-Met
- Programs include Pvt-c

PROGRAMS INCLUDE:
- G-MAB targets toxin to cancer cell
- Programs include VEGFR2, c-Met
- Programs include Pvt-c
- G-MAB targets toxin to cancer cell
- Programs include VEGFR2, c-Met
- Programs include Pvt-c

Lead mAb programs include:
- FTO and no stacking royalties
- PD-L1, PD-1, and CCRI
- High-diversity human Ab library
- G-MAB

G-MAB®

Efficacy demonstrated
- US and EU rights
- Pathway for approval
- Bioguivalence (BE)
- Abraxane®
- Next-generation

Cynvlago®
**PHASE 1 PHASE 2**

**INDICATION**
- Cynviloq™
  - Metastatic Breast Cancer
  - Non-Small Cell Lung Cancer
  - Bladder Cancer (sNDA)
  - Ovarian Cancer (sNDA)
  - Pancreatic Cancer (BE, or sNDA)

**G-MAB**
- Oncology/Inflammation > CC3, CXCR3

**Oncology**
- Oncology > PD-L1
- Oncology > VEGFR2, C-Met, EGFR, EGR2

**Strategic**
- RTX
  - Refractory Pain in Cancer Patients

**Multiple**
- Cynviloq™
  - 505(b)(2) Bioequivalence

**Opportunities**
- ADC
- 1H 2014 1H 2015 505(b)(2) Bioequivalence

---

**Pipeline**
- Abraxane® orphan drug status (FDA approval, September 2013)
Cynviloq is the 3rd Generation Paclitaxel Therapy

Abraxane®

Mean size 130 nm

Biological polymer: Donor-derived human serum albumin (HSA)

Taxol® paclitaxel

Cremophor EL excipient:
Polyoxylated castor oil

Conversion of Abraxane sales + new indications + Product Sales Peak

$430M in 2012

Est. >$1.7B (US)

$1.6B (WW in 2000)

Maximum Tolerated Dose

175 mg/m²

115 mg/m²

Mean size ~25 nm

Chemical polymer: Poly-lactide and polyethylene glycol poly-lactide and: Polyethyleneglycol diblock copolymer

Mean size 250 nm

Polymeric micelle

Cynviloq™ paclitaxel polymeric micelle

Cynviloq™

3rd

2nd

1st

Analyst projection; in MBC + NSCLC + PC

Conversion of Abraxane sales + new indications + Product Sales Peak

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Mean size 250 nm

Polymeric micelle

Cynviloq™ paclitaxel polymeric micelle

Cynviloq™

3rd

2nd

1st

Analyst projection; in MBC + NSCLC + PC
Cynviloq is a high value proposition

1. Exclusive US and EU Rights
2. Cynviloq efficacy demonstrated in Phase 2 and Phase 3 studies
3. FDA concurred
   a. Available data support pursuing 505(b)(2) regulatory pathway
   b. Bioequivalence (BE) study sufficient for approval of indications in Abraxane
4. Large market opportunity
   a. Abraxis (Abraxane) sold to Celgene for > $3B
   b. $1.7B in projected US peak revenues for Abraxane

Label (MBC and NSCLC)

2. Cynviloq efficacy demonstrated in Phase 2 and Phase 3 studies
   a. Approved and marketed under brand name Genexol-PM in S. Korea
   b. FDA concurred

Total number of patients across all trials: 1,260

**Phase 1:**
Trials established higher MTD in US - Dana Farber Cancer Inst, Russia, & S. Korea (total n=80)

> 300 mg/m² vs. Taxol 175 mg/m² + cis, 275 mg/m² (Abraxane; q3w)

> Taxol: weekl

**Data suggestive of efficacy comparable to historic data for Abraxane and superior to historic Taxol data o**

**Phase 2:**
Completed trials in MBC, NSCLC, PC, OC, BC; in US - Yale Cancer Center, Russia, S. Korea (total n=259)

**Efficacy and safety data supportive of 505(b)(2) BE submission**

**PM-Safety:**
Completed for MBC and NSCLC (total n=502)

**Chemo-naïve Stage IIIb/IV NSCLC vs Taxol in S. Korea (total n=276; Cynviloq n=140)**

**Interim analysis suggests ORR superior to Taxol and comparable to historic Abraxane efficacy**

**Efficacy and safety data supportive of 505(b)(2) BE submission**

**Phase 3:**
Ongoing trial for MBC in S. Korea (total n=209; Cynviloq n=105)

**GPMBC301. An Open-label, Randomized, Parallel, Phase 3 Trial to Evaluate the Efficacy and Safety of Cynviloq compared to Genexol® (Paclitaxel with Cremophor EL) in Subjects with Recurrent or Metastatic Breast Cancer**

**Possible Phase 3 sNDA programs in these tumor types**

**Data suggestive of efficacy comparable to historic data for Abraxane and superior to historic Taxol data or**

**Breast Cancer:**
Cynviloq compared to Genexol® (Paclitaxel with Cremophor EL) in Subjects with Recurrent or Metastatic Breast Cancer

**PM-Safety:**
Completed for MBC and NSCLC (total n=502)

**Chemo-naïve Stage IIIb/IV NSCLC vs Taxol in S. Korea (total n=276; Cynviloq n=140)**

230 mg/m² + cis (q3w) vs. Taxol 175 mg/m² + cis; non-inferiority established

**Phase 2b (IIS):**
Chemo-naïve Stage IIIb/IV NSCLC vs Taxol in S. Korea (total n=276; Cynviloq n=140)

**Efficacy and safety data supportive of 505(b)(2) BE subm**

**PM-Safety:**
Completed for MBC and NSCLC (total n=502)

**Efficacy and safety data supportive of 505(b)(2) BE submission**

**Phase 1:**
Completed trials in MBC, NSCLC, PC, OC, BC; in US - Yale Cancer Center, Russia, S. Korea (total n=80)

**Trials established higher MTD in US - Dana Farber Cancer Inst, Russia, & S. Korea (total n=80)**

**Total number of patients across all trials: 1,260**
### Equivalent Pharmacokinetics in Mice

<table>
<thead>
<tr>
<th>Drug</th>
<th>CYNVILIQ</th>
<th>ABRAXANE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL (mL/kg)</td>
<td>2.99</td>
<td>2.83</td>
</tr>
<tr>
<td>Vz (mL/kg)</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>AUC (hr*ng/mL)</td>
<td>615.61</td>
<td>511.33</td>
</tr>
<tr>
<td>T max (hr)</td>
<td>2.99</td>
<td>2.99</td>
</tr>
<tr>
<td>HL (hr)</td>
<td>2.83</td>
<td>2.99</td>
</tr>
</tbody>
</table>

Data on file

**IV bolus at 30 mg/kg; n = 3**
<table>
<thead>
<tr>
<th></th>
<th>Abraxane®</th>
<th>Cytoxan™</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27.4</td>
<td>25.5</td>
</tr>
<tr>
<td>1.2.9</td>
<td>1.2.7</td>
<td>1.35</td>
</tr>
<tr>
<td>5654</td>
<td>5473</td>
<td>1392</td>
</tr>
<tr>
<td>(L/hr/m²) CI</td>
<td>(hr) half-life</td>
<td>(ng/ml*h) AUC_{inf}</td>
</tr>
</tbody>
</table>

Data from 2 separate studies

(3 h infusion, 135 mg/m² dose, n=3)
Simulated PK Parameters Supportive of BE: Cynviloq vs. Abraxane

- PK BE was calculated as 95% confidence interval (CI)
- PK BE was established as 95% confidence interval (CI)
- PK BE was established as 95% confidence interval (CI)

### Comparison of mean non-compartmental pharmacokinetic parameters of Cynviloq (T) and Abraxane (260 mg/m²) at 30 min infusion time:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Cynviloq (Simulated PK)</th>
<th>Abraxane (Actual PK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cmax</td>
<td></td>
<td>19486 ng/mL</td>
</tr>
<tr>
<td>AUCinf</td>
<td></td>
<td>22198 ng·h/mL</td>
</tr>
<tr>
<td>Ratio</td>
<td>19.2%</td>
<td>99.6%</td>
</tr>
</tbody>
</table>

* Gardner et al. 2008

Cynviloq vs. Abraxane

Simulated PK Parameters Supportive of BE:
Bioequivalence = Efficient Pathway to Market

- Bioequivalence registration study in breast cancer patients (2014)

Cycle 1
- Cyvitol
  - 50 patients
- Abraxane
  - 50 patients

Cycle 2
- Cyvitol
  - 50 patients
- Abraxane
  - 50 patients

Key Parameters:
- Cmax (90% CI)
- Endpoints: AUC and
- Duration: 3 weeks +
  - Infusion time: 30 min
  - Dose: 260 mg/m²

- Direct trial cost ~$5M
- 12 months of duration (including patient recruitment)

Based on FDA “Draft Guidance on Paclitaxel” – September 2012
<table>
<thead>
<tr>
<th>Cynviloq Advanta</th>
<th>Taxol®</th>
<th>Abraxane®</th>
<th>Cynviloq™</th>
<th>Advanta</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dosage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploits PK advantage</td>
<td>q3w 8 weekly</td>
<td>q3w 8 weekly</td>
<td>q3w 8 weekly</td>
<td></td>
</tr>
<tr>
<td>Reduced side effects</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Chemical polymer</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Controlled temp storage</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>No requirement for serum albumin (HSA)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>No viral / prion concerns</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Conveniences and pharmacoeconomic</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Potential for higher efficacy</td>
<td>175</td>
<td>260</td>
<td>&gt;300</td>
<td></td>
</tr>
<tr>
<td>Maximum Tolerated Dose</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- ● = MBC; ● = NSCLC & PC
15,903 patients eligible for treatment with Abraxane® + Gemcitabine combination

15,903 PC patients eligible for treatment with Abraxane® + Gemcitabine combination

Note: In Pancreatic Cancer, the blue portion represents # patients treated with gem-based Rx in 2012

**Summary:**
- High unmet need - no FDA-approved 2nd line drug
- Demonstrated clinical Overall Response Rate (ORR)
- Phase 3-ready for development as 2nd line chemotherapy in patients refractory to platinum-based therapy
- Phase 2 Japan

<table>
<thead>
<tr>
<th>Phase 2 (Japan)</th>
<th>Phase 3 (EU)</th>
<th>Best Supportive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3 M*** / 4.3 M***</td>
<td>6.5 M</td>
<td>6.5 M ***</td>
</tr>
<tr>
<td>1.5 M***</td>
<td>2.7 M</td>
<td>6.5 M **</td>
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<tr>
<td>-</td>
<td>-</td>
<td>6.5 M **</td>
</tr>
<tr>
<td>0% ***</td>
<td>21%</td>
<td>4%***</td>
</tr>
<tr>
<td>n=23 *** / n=108 ***</td>
<td>n=34</td>
<td>n=260-300 mg/m2 Phase 2 (Korea)</td>
</tr>
</tbody>
</table>

# advanced urothelial carcinoma patients refractory to gemcitabine and cisplatin
* AUA- San Diego May 4th-8th 2009
** JCO (2009): 4454-61

Potential to Expand Label Indications – For Example: 2nd Line Bladder Cancer

<table>
<thead>
<tr>
<th>Overall Survival</th>
<th>Progression Free Rate (ORR)</th>
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<tbody>
<tr>
<td>6.5 M ***</td>
<td>21% ***</td>
</tr>
<tr>
<td>6.5 M *</td>
<td>4%***</td>
</tr>
<tr>
<td>6.5 M **</td>
<td>6.5 M **</td>
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<td>6.5 M **</td>
<td>6.5 M **</td>
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</table>
Next Steps for Cynviloq

1. Bioequivalence (BE) trial: 2014
2. NDA filing: 2015
3. Approval: 2016
   a. MBC and NSCLC
   b. Future Abraxane indications (Pancreatic cancer and Melanoma)
5. sNDA planning for label expansion into Bladder and Ovarian cancers
Expanded Clinical Pipeline with Multiple Opportunities
Resiniferatoxin (RTX): Non-opiate Drug Candidate for Treating Cancer Pain

"Prickly Painkiller: An experimental plant extract may end intractable pain with a single injection."

RTX Ultra Potent and Selective Toxin

Pharmacology:

- Ultra potent agonist of the TRPV1 receptor
- Binding in primate ex-vivo spinal cord
- Resiniferatoxin Ki = 349 pM dorsal horn
- Resiniferatoxin Ki = 309 pM dorsal root ganglion
- Resiniferatoxin Ki = 349 pM dorsal horn
- Resiniferatoxin Ki = 309 pM dorsal root ganglion

RTX induces apoptosis of TRPV1-expressing afferent nerves.

Treatment: Spinal cord after treatment

Cross section of spinal cord after treatment
Veterinary Market: Strategic Partnership Opportunity

- No opioid-associated side effects
- Visibly improved personality & mood of animals
- All subjects responded
- Attractive therapeutic effect
- Permanent ablation of nerves
- Single intrathecal injection

Weeks

n=4  n=5  n=8  n=18

µ = 18

VAS (0 to 100 mm)

Observational Pain Score

(p < 0.0001 for all time points)
Next Steps for Dual Pathway of RTX Development

2014

1. Intractable cancer pain clinical trial (intrathecal injection); n~40 patients
2. Phase 1/2 trial for intraganglionic injection (osteosarcoma); n~15 patients

~3 years for clinical development
Pre-IND Immunotherapy Programs

G-MAB® ADC

Antibodies + Proprietary Toxins
**G-MAB®: Library of Therapeutic Antibodies**

**Size of Target Antigen**

- **High Value Oncology Targets:** Immunomodulation: PD1 and PDL1
  - Antibody Drug Conjugates: VEGFR2 and c-Met
- **Most Difficult Targets:**
  - G Protein-Coupled Receptors (GPCRs)

**Difficult Targets:**

- Small Peptides

**Most Difficult Targets:**

- G Protein-Coupled Receptors (GPCRs)

**High Value Oncology Targets:**

- Immuno modulation: PD1 and PDL1
  - Antibody Drug Conjugates: VEGFR2 and c-Met

**High successful screening hit rate**

- Fully human antibodies
- Fully human antibodies
- 2.1 x 10^16 distinct antibodies
- Very high library diversity:

**No stacking royalties**

- Freedom-To-Operate
- Library generation
- RNA amplification used for
- Proprietary technology

**G-MAB®:** Library of Therapeutic Antibodies
**Anti-PD-L1 mAbs Exhibit Potent Activity**

**Immune Modulation**

**Tumor Mouse Model**

* p<0.05, mean tumor volumes are significantly reduced in STI-1410 group versus control groups as determined by Mann-Whitney u-test.

**Xenograft model using H1975 human NSCLC cells; % inhibition relative to control mAb treatment.

**mAbs @ 0.05 mg/ml.
**Potent Antibody against Difficult GPCR Target**

Sorrento mAb against C-C Chemokine Receptor 2 (CCR2)

---

**Days After Disease Induction**

<table>
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<tr>
<th>Days</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
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<tr>
<td>Competitor</td>
<td>Sorrento</td>
<td>0.17</td>
<td>Sorrento</td>
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<tr>
<td>Cell Binding (EC50 - nm)</td>
<td>mAb</td>
<td>21</td>
<td>sider</td>
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</table>
Drug Released in CANCER CELL

Key Components:
1. Target-specific internalizing antibody
2. Potent cytotoxic produgs
3. Linker and conjugation chemistries

Antibody Drug Conjugates (ADC)
Proprietary ADC Screening and Optimization Panels

- Expansion to new MOA payloads, if needed
- Optimization of linkers and conjugation methods
- Optimization of payloads
- Optimization of conjugation methods

- 50-panel for generation of ADC candidates
- 20 ADCs by rationale design with linker/conjugation technologies and payload pool
- 3 benchmark ADCs for Rapid POC studies
- 20-panel for discovery of lead ADCs

![Diagram of ADC screening and optimization process]
K-Lock Conjugation Enables Homogeneous ADCs

- Better control of DAR
- Fewer positional isomers
- Selective ADC chemistry
C-lock enhances ADC stability leading to:

- Prolonged PK profile
- Reduced off-target effects
Proprietary Toxin Potency 30-fold Higher than DM1.*
<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Oncology/Inflammation (GPCR)</th>
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<tr>
<td>CCR2 ADC</td>
<td>HER2 (STI-4160X)</td>
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<td>CCR3 ADC</td>
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**Strategic**

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**Partnerships**

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Positioned to Become Oncology Leader

G-MAB® ADC

Antibodies + Proprietary Toxins

Cynviloq™

RTX

Registration Trial

Intractable Pain in Advanced Cancer

Advanced Cancer
Intractable Pain in Advanced Cancer

• Clinical Phase 1/2 study at NIH
• Potential patients for treatment: ~150,000 in the U.S. annually

Two potential drug products from same API

• G-MAB® antibody as specific targeting warhead
• Proprietary toxins as potent tumor killing payload

Selective conjugation chemistry for homogeneous ADC generation

Targeted Drug Delivery (ADC)

• First antibody drug candidate in clinic in H2 2015
• Antibody market >$50B in 2012

Therapeutic antibody engine

• Two potential drug products from same API
• Potential patients for treatment: ~150,000 in the U.S. annually

Clinical Phase 1/2 study ongoing at NIH

• Intractable Pain in Advanced Cancer

Product launch in H1 2016

• Biorelevant regulatory pathway ("biorelevantence" for approval)
• Addresses multi-billion dollar palliative market

Investment Highlights

Late Stage Oncology Drug with Exclusive US and EU Rights
Sorrento Therapeutics
Next-Generation Cancer Therapeutics

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(858) 668-6923