Forward-Looking Statements

This presentation contains forward-looking statements, including, but not limited to, statements regarding the ability and strategies of Advaxis, Inc. (the “Company”) to develop and commercialize cancer immunotherapies, timing of planned clinical trials and regulatory milestones, potential partnership opportunities and the safety and efficacy of the Company’s proprietary immunotherapies. These forward-looking statements are subject to a number of risks including the risk factors set forth from time to time in the Company’s SEC filings including, but not limited to, its report on Form 10-K for the fiscal year ended October 31, 2018 as well as its Forms 10-Q and 8-K, which are available at http://www.sec.gov.

Any forward-looking statements set forth in this presentation speak only as of the date of this presentation. The Company does not intend to update any of these forward-looking statements to reflect events or circumstances that occur after the date hereof other than as required by law. Our fiscal year ends October 31. Throughout this presentation, all references to quarters and years are to the calendar quarters and years unless otherwise noted.
Advaxis Overview
Creating a Broad Portfolio of Cancer Immunotherapies Using a Validated Platform

**Platform Yielding Broad Portfolio of I-O Drug Candidates:** Listeria monocytogenes (Lm) platform optimized so as to generate a broad portfolio of I-O drug candidates to treat various solid tumors

**Clinical Validation:** High immunogenicity with clinical activity and manageable safety profile demonstrated in clinical trials with over 470 patients treated to date

**Four clinical stage programs:** Two single antigen-target drug candidates and two multiple antigen-target drug programs in the promising neoantigen-directed treatment space

**Strong Intellectual Property Position:** Over 400 patents/patent applications

**Experienced Management Team:** Chief Executive Officer, Chief Financial Officer and Chief Medical Officer joined within past year

Multiple Catalysts (Read-outs)
Anticipated in 2019
Prolonged survival and complete responses in cervical and anal cancer patients and antigen spreading observed.

In combination with KEYTRUDA® prolonged survival in metastatic castration-resistant prostate cancer.

Personalized, patient-specific candidates based on sequencing of each patient’s tumor; early data suggest rapid and strong immunogenicity.

Cancer type-specific candidates based on commonly expressed public hotspot mutations and proprietary cancer antigens.

Lm Technology Evolution: Higher Payloads, New Targets

ADXS-HPV (AXAL)  ADXS-PSA  ADXS-NEO  ADXS-HOT

Single antigen delivery platform  Multiple antigen delivery platform
## Clinical Pipeline Overview

<table>
<thead>
<tr>
<th>CANCER INDICATION</th>
<th>IND</th>
<th>PHASE 1</th>
<th>PHASE 2</th>
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<tbody>
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<td><strong>ADXS-HPV (AXAL)</strong></td>
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<td>AIM2CERV, High-Risk, Locally Advanced Cervical&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>★ 1H 2019</td>
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<td>HPV+ Head and Neck (Partners to be announced)</td>
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<td><strong>ADXS-PSA</strong></td>
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<td>Metastatic Prostate in Combination with KEYTRUDA® (pembrolizumab)</td>
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<td><strong>ADXS-NEO</strong></td>
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<tr>
<td>Multiple Cancers by Targeting Personal Neoantigens (NSCLC, CRC, Head &amp; Neck, Melanoma, Bladder)</td>
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<tr>
<td><strong>ADXS-HOT</strong></td>
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<tr>
<td>Non-Small Cell Lung</td>
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<tr>
<td>Prostate</td>
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<td></td>
<td>★</td>
<td>★</td>
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<tr>
<td>Bladder</td>
<td></td>
<td></td>
<td>★</td>
<td>★</td>
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<sup>1</sup> FDA has placed a partial clinical hold on this study due to CMC requests which allows continued dosing of patients already enrolled but which prevents enrollment of new patients until resolution of this partial hold.
Our Differentiator:

*Lm* Technology™ Platform
How Our *Lm* Platform is Designed

*Lm* vectors: Mimic natural infection and redirect immune response against cancer through:

1. **INNATE IMMUNITY:** Enhanced antigen presentation activates multiple pathways and alerts and trains the immune system

2. **ADAPTIVE IMMUNITY:** Mobilizes and generates a cancer-specific *T cell* response to attack the tumor

3. **CHANGES TO TUMOR MICROENVIRONMENT (TME):** Reduces tumor-protective cells (*Tregs and MDSCs in the TME*) that shield the tumor from the immune system

The *Lm* platform has been *clinically evaluated* in over 470 patients across multiple clinical trials.
Anti-Tumor Immunity: Building Blocks for Clinical Success

**Induction of peripheral immune responses**
- CD8+, CD4+, increased Myeloid proliferation, Decreased Tregs & MDSCs
- HPV, PSA, HER2, ADXS-NEO, ADXS-HOT (In vitro)

**Priming of T cell response**
- Neoantigen Specific T cells after 1 week
- 90% of neoantigens generate CD8+ T cells in Lm vectors (In vitro, clinical data pending)
- Non-immunogenic neoantigens are immunogenic when presented by Lm vector

**Convert “cold” tumors into “hot” tumors**
- Preclinical Models: Upregulates PD-L1
- Reduces Tregs, MDSCs, M2 TAMs (M2-M1 shift)

**Vaccine-induced T cells infiltrate to the tumor**
- Chemokines traffic T cells into TME
- Clinical Evidence: HPV+ Head and Neck, ADXS-NEO (pending)
- In Vitro: All Constructs Including ADXS-NEO and ADXS-HOT (prototype)

**Promote antigen spreading**
- Demonstrated with 5 different constructs in clinical trials
- Multiple targets not included in the vaccine
- Magnitude of T cell response vs. target is associated with increased antigen spreading and clinical outcomes

Lm-based drug candidates have demonstrated broad anti-tumor immunity through achieving these

References on Slide 35
ADXS-HPV
(Axalimogene Filolisbac or AXAL)

AIM2CERV – Phase 3 clinical trial in high-risk, locally advanced cervical cancer
Cervical cancer: Statistics and Unmet Need

5-year survival rates are poor for high-risk locally advanced (HRLA) patients; High recurrence rate represents area of great unmet need

- An estimated 91% of all cervical cancers are caused by an HPV infection
- HRLA patients range from stage IB with clinical lesions in the cervix to stage IVA with cancer that has spread to adjacent organs
  - ~53% of overall cervical cancer incidence is HRLA while ~8% of incidence is metastatic
- The average recurrence rate for HRLA patients is ~40%; stage IB2-II has a recurrence of ~20%, while stage III-IV is ~53%. Physicians estimated that the average time to recurrence is ~13 months

Note: *Stage 0 is carcinoma in situ (CIN III) and is considered pre-invasive cancer
Source: American Cancer Society; National Cancer Institute
Annual, Worldwide Peak Revenue Opportunity of $500M for AXAL in High-Risk Locally Advanced Cervical Cancer

Market Opportunity in the U.S and Europe - Estimated Annual Revenues

Combined Worldwide Estimated Market Opportunity of ~$500M

* Source: December 2016, LEK AXAL Assessment Report
AXAL Phase 2 Study in India: Prolonged Survival and Tumor Response in Randomized, Multicenter Phase 2 Study in Recurrent/Refractory CC Illustrated the Promise of Lm Technology¹

- 34.9% 12-month survival rate (38/109), 24.8% (27/109) 18-month survival rate, 3 confirmed CRs observed (RECIST 1.1)
- Accepted for publication in the May edition of peer-reviewed International Journal of Gynecological Cancer

AXAL Phase 2 GOG-0265 Study: Improvement of survival rates in Recurrent / Metastatic Cervical Cancer Confirmed the Findings²

- 38.0% 12-month survival rate (19/50); highest achieved to-date in GOG PRmCC studies to date, 1 durable CR observed
- GOG Model-Predicted 12 month survival was 24.5%, based on the characteristics of patients in 0265
- Primary efficacy endpoint met

**12-month and median overall survival**

- 12-month OS rate: 38%
- Median OS: 6.2 months
- 95% CI: (4.4–12.3)

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PRmCC, Persistent Recurrent Metastatic Cervical Cancer; GOG, Gynecological Oncology Group; CR= complete response

¹Data Presented at ASCO 2014 ²Data presented at SGO 2017.
Promising efficacy results in challenging population:
8 of 9 patients recurrence free at median follow-up of 42 months

Relapse Free Survival Data

<table>
<thead>
<tr>
<th>TRAE</th>
<th>N (%)</th>
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<tbody>
<tr>
<td></td>
<td>Grade 2</td>
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<tr>
<td>Chills/Rigors</td>
<td>4 (40)</td>
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<tr>
<td>Fatigue</td>
<td>1 (10)</td>
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<tr>
<td>Pyrexia</td>
<td>3 (30)</td>
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<tr>
<td>Headache</td>
<td>1 (10)</td>
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<tr>
<td>Flu-like symptoms</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Pain (back/neck)</td>
<td>0</td>
</tr>
<tr>
<td>Hypotension</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0</td>
</tr>
</tbody>
</table>

Commentary

- 11 total patients enrolled; 10 treated
- All patients who completed RT and received treatment achieved a CR at six months (N = 9)
- 8/9 patients (89%) were recurrence free at a median follow up of 42 months
- Safety profile consistent with previous clinical experience
- No Grade 4 adverse events
- Encouraging data to support AXAL in adjuvant setting

Note: Patient #1 enrolled but was never treated on study
Safran et al., Poster Presentation at ASCO 2016
Manuscript accepted for publication in the International J of Radiation Oncology
*BrUOG, Brown University Oncology Group. CR, Complete response; TRAE, Treatment related adverse events
These data were sufficient for USDA to grant expedited approval for treat canine osteosarcoma in December 2017

- This Phase 1 trial compared SOC amputation and chemotherapy (in case matched controls) to SOC followed by 3 doses of ADXS31-164 (ADXS-HER2)
- These data show a **highly significant improvement in progression free survival and overall survival** with treatment that led to USDA expedited approval
- Without treatment 100% will recur and expire within 1-2 years; with treatment using ADXS-HER2, after SOC, the likelihood of recurrence is significantly reduced, delayed, or eliminated
- This study exemplifies the ability of ADXS Lm vectors to control the sub-clinical micro-metastases that would ultimately have progressed into a “recurrence”
- **Monetization of ADXS-HER2**: Licensing deals signed with a) Aratana in 2014 for canines and b) OS Therapies in 2018 for pediatric osteosarcoma

**Median Survival Times:**
- Control – 423 days
- ADXS-164 – 956 days *

\[ P = 0.014, \text{HR} 0.33; 95\% \text{ CI}, 0.136--.802 \]

\*P= 0.014, HR 0.33; 95% CI, 0.136--.802

**Figure 3B, Mason et. al.. Clin Cancer Res. 2016 Sep 1;22(17):4380-90.**
Axalimogene Filolisbac in High-Risk, Locally Advanced Cervical Cancer\(^1\)
AIM2CERV Phase 3 Study as Adjuvant Monotherapy to Prevent Recurrence in High-Risk Cervical Cancer

Eligibility
- HRLACC
- FIGO stage I–II with positive pelvic nodes
- FIGO stage III–IVA
- Any FIGO stage with paraaortic nodes

Treatment with Cisplatin
- Treatment with cisplatin (at least 4-weeks exposure) and radiation (minimum 40-Gy external beam radiation therapy)

Treatment with Axalimogene Filolisbac
- \(n=300\)
- \(1 \times 10^9\) CFU
- Up to 1 year

Placebo IV
- \(n=150\)
- Up to 1 year

Primary Endpoint:
- Disease-free survival

Secondary Outcome Measures:
- Safety & Tolerability
- Overall survival

AIM2CERV – Axalimogene Filolisbac Immunotherapy Following Chemo/Radiation in Patients who have High Risk Locally Advanced Cervical Cancer (HRLACC)

“Just as we need options to prevent HPV-related cancers, there is a significant need for more therapeutic options to treat those with cancer. No woman should die from cervical cancer.”

Deborah Arrindell
Vice President, Health Policy

Currently in discussions with FDA to modify trial design to include earlier Interim Analyses

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\(^1\) FDA has placed a partial clinical hold on this study due to CMC requests which allows continued dosing of already enrolled patients but which prevents enrollment of new patients until resolution of this partial hold.

SPA= Special Protocol Assessment; FIGO= International Federation of Gynecology and Obstetrics; HRLACC= high-risk locally advanced cervical cancer; IV= intravenous.

https://clinicaltrials.gov/ct2/show/NCT02853604
Combination Therapy of ADXS-PSA with Pembrolizumab in Late Stage Prostate Cancer
Keynote-046: Phase 1/2 trial of ADXS-PSA ± Pembrolizumab in Metastatic, Castration-Resistant Prostate Cancer (mCRPC)

**Rationale**

- **Systemic therapy for mCRPC includes next generation hormonal agents (NGHAs) such as abiraterone and enzalutamide), chemotherapy (i.e., docetaxel, mitoxantrone, cabazitaxel), pembrolizumab and/or radium-223**
  - Docetaxel improves survival in mCRPC and is recommended treatment after enzalutamide or abiraterone therapy
  - Patients with docetaxel-pretreated mCRPC have few therapeutic options and represent an unmet need
    - Median overall survival in recurrent disease treated with NGHAs after failing antiandrogen deprivation + docetaxel is ~14.8-18.4m

- **Pembrolizumab is a humanized, monoclonal anti-PD-1 antibody which has shown antitumor activity and manageable safety profile in patients with mCRPC**
  - Pembrolizumab is only approved for the treatment of adult patients with microsatellite instability-high (MSI-H) or mismatch repair deficient (MMRD) tumors, which represent ~8% of the mCRPC population with tumors enriched for higher T cell infiltration and PD-L1 protein expression

- **ADXS-PSA is a live attenuated *Listeria monocytogenes*, Lm-immunotherapy that secretes an antigen adjuvant fusion protein of listeriolysin (tLLO) fused to human prostate-specific antigen (PSA)**
  - Treatment of mCRPC patients with ADXS-PSA has been associated with anti-tumor effects, as evidenced by increased T cell reactivity to PSA and antigen spreading

- Based on preclinical and clinical data, the combination of ADXS-PSA with pembrolizumab could be synergistic, particularly in MSI-H/MMRD-negative cases

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Efficacy (Overall Survival)

ADXS-PSA in Combination with KEYTRUDA® Prolongs Survival in Metastatic Castration-Resistant Prostate Cancer

Update on Survival Data Provided at AACR in April 2019

Key baseline characteristics

<table>
<thead>
<tr>
<th></th>
<th>Part A (n=13)</th>
<th>Part B (n=37)</th>
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<tbody>
<tr>
<td>Median Gleason score (range)</td>
<td>8.0 (7.0, 10.0)</td>
<td>9.0 (6.0, 10.0)</td>
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<tr>
<td>Presence of visceral metastases, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4 (29)</td>
<td>11 (30)</td>
</tr>
<tr>
<td>No</td>
<td>10 (71)</td>
<td>26 (70)</td>
</tr>
<tr>
<td>MSI-H negative status, n (%)</td>
<td>Not reported</td>
<td>In process</td>
</tr>
<tr>
<td>Prior therapies, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>5 (36)</td>
<td>21 (57)</td>
</tr>
<tr>
<td>Hormonal therapy</td>
<td>12 (86)</td>
<td>33 (89)</td>
</tr>
<tr>
<td>Next-generation hormonal agents</td>
<td></td>
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</tr>
<tr>
<td>Abiraterone only</td>
<td>3 (21)</td>
<td>7 (19)</td>
</tr>
<tr>
<td>Enzalutamide only</td>
<td>1 (7)</td>
<td>12 (32)</td>
</tr>
<tr>
<td>Abiraterone + enzalutamide</td>
<td>4 (29)</td>
<td>11 (30)</td>
</tr>
<tr>
<td>Immunotherapy*</td>
<td>6 (43)</td>
<td>7 (19)</td>
</tr>
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</table>

* Immunotherapy included sipuleucel-T and PCaDCVAC, but no checkpoint inhibitors
Combination Therapy of ADXS-PSA with Pembrolizumab in Metastatic Castration-Resistant Prostate Cancer Study Results – Combination Arm

Safety Profile

- Combination of ADXS-PSA and pembrolizumab appeared safe and tolerable in this heavily pre-treated, unselected patient population with bone predominant mCRPC
- Mostly grade 1-2 treatment related adverse events
- There was no additive toxicity observed with the combination therapy

Immune Activity

- T-cell responses against PSA in 75% of subjects
- Antigen spreading in 85% of subjects to PSMA, PAP, PSCA, and/or Prostein
- 3x longer duration of T cell generation in combination (3 weeks vs. 9 weeks)
- Broader immune stimulation, including B-cell activation in combination

Efficacy

- Median overall survival was 21.1 months (95% CI, range 16.0 months to not-yet-reached) at data cutoff (February 1, 2019) in this dataset of 37 patients
- Prolonged survival was observed in some patients despite prior docetaxel + NGHAs, presence of visceral metastasis and MSI-H negative status
Neoantigen-Directed Programs:

ADXS-NEO: Patient Specific

ADXS-HOT: Off-the-Shelf
**Why Neoantigens?**

Mutations cause cancer and also create neoantigens

Neoantigens are only found in cancer cells which makes them good therapeutic targets

T cells that target neoantigens are the common link among successful immunotherapies developed to date (e.g., checkpoint inhibitors, Tumor Infiltrating Lymphocytes or TILs)

Our *Lm* platform is effective at generating broad and rapid T cell response against neoantigens

Preclinical data demonstrate that over 90% of neoantigens in an ADXS-NEO vector generated T cell responses that controlled tumor growth\(^1\) and preliminary clinical data demonstrate broad and rapid T cell response against personal neoantigens\(^2\)

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\(^1\)Presented at AACR 2018 by Coder et al.

\(^2\)Presented at AACR 2019 by Hecht, et al.
ADXS-NEO

Patient-specific, neoantigen-directed therapies
ADXS-NEO: The Personalized Approach

- Activates a patient's immune system, creating a targeted T cell response to personal neoantigens based on unique, patient-specific mutations
- The $Lm$ platform’s impact on the immune system (i.e., innate immunity, adaptive immunity and changes to TME) provides potential for strong anti-cancer effects
- Platform capacity allows for targeting a large number of personal neoantigens (currently using 40)
- Potential application in any solid tumor type

Massive Parallel Sequencing of Tumor Biopsies

Identify neoepitopes

Patient-Specific Immunotherapies

Advaxis designs vector based on neoepitopes and bioengineers $Lm$

Patient's Hospital or Treating Institution

Treat patient with personalized immunotherapy vector programed to patient-specific neoepitopes
ADXS-NEO: Personalized Neoantigen Vaccine
Phase 1 Clinical Study Design

**ADXS-NEO**

Personalized, patient-specific drug candidates based on sequencing of each subject's tumor

Endpoints:

- **Primary**
  - Tolerability/ Safety

- **Secondary**
  - Clinical activity
  - RP2D

- **Exploratory**
  - Immunological

CFU, Colony-Forming Unit; SCCHN, squamous cell carcinoma head and neck; NSCLC, non-small cell lung cancer; MSS CRC, microsatellite stable colon cancer; RP2D, recommended phase 2 dose

Clinical Data From Initial Cohort (safety, immune response) Presented at AACR 2019

ClinicalTrials.gov Id: NCT03265080
A Phase 1 Study of ADXS NEO Expressing Personalized Tumor Antigens ± Pembrolizumab in Subjects with Advanced or Metastatic Solid Tumors

Preliminary Findings

- Four patients have been treated so far with ADXS-NEO in dose escalation
  - Manufactured ADXS-NEO constructs had a large payload with capacity for 40 personal neoantigens or ≥150aa frameshift mutations
    - Needle-to-Needle manufacturing time was ~7-8 weeks
  - Dose level $1 \times 10^9$ CFU was beyond MTD as evaluated in 2 patients
    - Adverse events observed (i.e., hypoxia ± hypotension) seem to be related to increased IL-6 levels that can be managed with tocilizumab
  - Dose level $1 \times 10^8$ CFU has been safe and tolerable in 2 patients – completion of this cohort is ongoing
  - One evaluable patient with advanced NSCLC achieved stable disease after only two doses, consistent with the rapid immune activation observed

- Immunological effects were observed at the two dose-levels evaluated, including:
  - Efficient priming generated CD8+ T cells against most neoantigens (deconvolution work ongoing)
  - Rapid neoantigen-specific CD8+ T-cell generation – 1 week after first dose
  - Substantial T-cell responses: ~2000 neoantigen-specific T cells/400,000 cells (10,000 neoantigen-specific T cells/mL blood) in multiple pools
  - 100% antigen spreading – 6/6 antigen spreading/secondary epitope pools are positive
  - Increased secretion of chemokines consistent with T-cell trafficking into tumor microenvironment was observed
ADXS-HOT

Cancer-type specific, neoantigen-directed drug candidates
ADXS-HOT: Targeting Multiple Hotspots, OFAs and CTAs Increases Patient Applicability and Clinical Activity Potential

Hotspot mutations have demonstrated pre-clinical activity in Advaxis’ Lm Technology\(^1\)

ADXS-HOT constructs target both public, or shared, hotspot neoantigens and multiple proprietary tumor associated antigen targets, including oncofetal antigens (OFAs) and cancer testis antigens (CTAs)

Over 10 drug candidates designed using this approach

ADXS-HOT constructs can include over 30 antigen targets and are designed to allow for multiple shots on goal to control the tumor in nearly all patients

Antigen spreading could further increase the potential number of targets

Can be used as monotherapy and/or in combination with other cancer treatments like checkpoint inhibitors

coverage of nearly 100%

Off-the-shelf and available for patients to start treatment immediately

Manufactured in bulk with good stability keeping cost of goods low vs. “individualized” products

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**ADXS-HOT**

**Cancer type-specific drug candidates**
- based on commonly expressed public hotspot mutations and proprietary cancer antigens

**Endpoints:**
- **Primary**
  - Tolerability/Safety
- **Secondary**
  - Clinical activity
  - RP2D
- **Exploratory**
  - Immunological

**ADXS-503: NSCLC-Specific Vaccine (HOT Lung)**
Phase 1/2 Clinical Study Design: First patient enrolled February 2019

**Part A**
ADXS-503 Monotherapy Dose Escalation
3+3 Design

**Part B**
ADXS-503 + anti-PD-1 antibody
Dose Escalation
3+3 Design

- 5x10^8 CFU of **ADXS-503 (DL2)** + anti-PD-1 antibody

**Part C**
ADXS-503 + anti-PD-1 antibody

- 1x10^8 CFU of **ADXS-503 (DL1)** + anti-PD-1 antibody

**Safety Phase**
- Refractory setting
- Up to 3 lines of prior therapy permitted
- Enrollment irrespective of EGFR/ALK mutation status or PD-L1 expression
- Subjects receiving treatment with pembrolizumab monotherapy who have PD assessed on initial scan
- ADXS-503 administered as add-on therapy while awaiting confirmatory scan (4-8 weeks after initial PD)

**Efficacy Phase**
- 1st line setting
- Enroll subjects with PD-L1 expression ≥50%
- and without EGFR mutations or ALK translocations

Clinical Data From Initial Cohort (safety, immune response)
Anticipated 1H 2019
Neoantigen Competitive Landscape: How We Measure Up

Advaxis’ Lm platform + Antigen Targets: Directed against tumor-specific targets and engaging the patient’s immune system to destroy tumor cells

Select Companies in the Space:

OTHER NEOANTIGEN APPROACHES¹

- Limited clinical evidence and immune response
- No demonstrated effect on TME
- Typically have poor priming, may require addition of adjuvants/co-stims
- Practical limitations in number of peptides administered

Advaxis’ Lm Platform + Antigen Targets

- Proven activity in pre-clinical models
- Demonstrated effect on the TME (MDSCs, Tregs)
- Immunogenic proprietary targets
- Priming via innate immune stimulation; adjuvant/co-stims not required
- Ability to “convert” non-immunogenic peptides into immunogenic peptides and “turn cold tumors hot”

¹ Not all challenges apply to all companies/platforms
## Anticipated Catalysts Over the Next 12 Months

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>ANTICIPATED MILESTONES</th>
<th>TARGET</th>
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<tbody>
<tr>
<td>ADXS-PSA</td>
<td>• Metastatic Prostate Ph1/2 Combination with pembrolizumab--Part B Monotherapy Combination Therapy Data (updated survival and preliminary biomarker data)</td>
<td>Q1 2019</td>
</tr>
<tr>
<td>ADXS-NEO</td>
<td>• Data from initial clinical cohort (safety, immune response)</td>
<td>1H 2019</td>
</tr>
<tr>
<td>ADXS-HOT NSCLC (ADXS-503)</td>
<td>• Data from initial clinical cohort (safety, immune response)</td>
<td>1H 2019</td>
</tr>
<tr>
<td>ADXS-HPV (axalimogene filolisbac)</td>
<td>• Announce planned Investigator Sponsored Trial in Head and Neck Cancer</td>
<td>1H 2019</td>
</tr>
<tr>
<td>ADXS-HOT Prostate</td>
<td>• IND Submission</td>
<td>2H 2019</td>
</tr>
<tr>
<td>ADXS-HOT Bladder</td>
<td>• IND Submission</td>
<td>2H 2019</td>
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</tbody>
</table>

NSCLC = Non-small cell lung cancer; IND = Investigational New Drug
Financial Information

- Cash on hand - $32.7 million as of January 31, 2019
  - Net proceeds of $9.1 million from equity financing on April 5, 2019
  - Reduced annual net cash burn to ~$45 million, from ~$80 million

- Shares outstanding: 8.0 million as of April 5, 2019
  - Fully diluted shares outstanding: ~8.6 million

- No debt
Platform Yielding Broad Portfolio of I-O Drug Candidates: Listeria monocytogenes (Lm) platform optimized so as to generate a broad portfolio of I-O drug candidates to treat various solid tumors

Clinical Validation: High immunogenicity with clinical activity and manageable safety profile demonstrated in clinical trials with over 470 patients treated to date

Four clinical stage programs: Two single antigen-target drug candidates and two multiple antigen-target drug programs in the promising neoantigen-directed treatment space

Strong Intellectual Property Position: Over 400 patents/patent applications

Experienced Management Team: Chief Executive Officer, Chief Financial Officer and Chief Medical Officer joined within past year

Multiple Catalysts (Read-outs) Anticipated in 2019


