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## Seattle Genetics, Inc. Q3 2008 Earnings Call Transcript

### Question-and-Answer Session

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#### Operator

Thank you. (Operator instructions) Our first question comes from the line of Mark Monane with Needham & Company. Please go ahead.

#### Mark Monane – Needham & Company

Good afternoon. Greetings from New York City. And thanks for reviewing the very busy third quarter. A couple of questions. I'm going to start with some very concrete questions to begin. Let's start with 35. Is the experience – can you describe the experience so far, Clay, in terms of thinking about patients who have already been treated with frontline therapy? In the refractory setting, do these patients respond equally well depending on what therapy they get in the frontline? And then second question is, do you see any inherent effects of the anti-CD30 in these patients? Or do you believe the clinical effect is due to the payload and the ADC technology?

#### Clay Siegall

Thank you for the questions, Mark. First of all, I'll address the second question and then I'll turn it over to Tom to address the first question. The second question, I think that we had already done a pretty detailed clinical analysis through testing. SGN-30, the naked antibody, that's present – that's part of the major component of SGN-35, which is the antibody carrying the orastatin [ph] payload. And SGN-30 on its own with that agent, we saw no objective responses in Phase II Hodgkin lymphoma, and we saw a modest level of response in ALCL. I think it was about 17% or so response with ALCL. And so we know those data. Now we have the data that we've reported at ASCO. And we'll be updating at ASH with the newest data with duration, response rate, etc. But what we've reported at ASCO was 45% response rate, clearly way above where the naked antibody comes from. In our opinion based on our preclinical data and our clinical data, it clearly comes from binding to the target, but the major source of the efficacy is the delivery of the payload. So we believe that really is the key here, that delivery of the payload utilizing our ADC technology. Now I'll turn it over to Tom to talk about the patients.

#### Tom Reynolds

Right. So, Mark, I think you kind of have a two-parter for me. One is what's the kind of mix in terms of what patients get frontline and then how do they respond, and is there any difference. The majority of our patients are treated with ABVD upfront that's currently the standard of care in the US, which is where the trial is being run. So nearly all of our patients have had that with the exception of the few ALCL patients that we've had on the initial Phase I, which typically get a CHOP-type regimen.

So almost everybody has either had ABVD or CHOP, and there doesn't appear to be any difference depending on that. What happens next then is for patients that relapse is as a large fraction of those go on to autologous stem cell transplant. And we've done an analysis to look at patients that have received 35 prior to transplant or post-transplant. The majority of the patients have already received autologous transplant. And there just not appear to be a difference in terms of their ability to respond to 35 as to whether they have had – what they have had second line, either pre- or post-transplant, or how many prior therapies they have had of any sort.

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