UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

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): January 9, 2024

BIOATLA, INC.
(Exact name of Registrant as Specified in Its Charter)

Delaware	001-39787	85-1922320
(State or Other Jurisdiction of Incorporation)	(Commission File Number)	(IRS Employer Identification No.)

11085 Torreyana Road San Diego, California	92121
(Address of Principal Executive Offices)	(Zip Code)

Registrant's Telephone Number, Including Area Code: 858 558-0708

(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 communications 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))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.0001 par value per share	BCAB	Nasdaq Global Market

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§ 230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§ 240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 7.01 Regulation FD Disclosure.

On January 9, 2024, BioAtla, Inc. updated its corporate presentation (the "Corporate Presentation"), which it intends to use at various meetings with investors, investment banks and investment bank analysts, including at meetings at the 42nd Annual J.P. Morgan Healthcare Conference in San Francisco, California. The Corporate Presentation is attached hereto as Exhibit 99.1.

The information set forth in Item 7.01 of this Current Report on Form 8-K ("Current Report"), including Exhibit 99.1 attached hereto, is being furnished and shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or otherwise subject to the liabilities of such section. The information set forth in Item 7.01 of this Current Report, including Exhibit 99.1 attached hereto, shall not be incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Exchange Act, regardless of any incorporation by reference language in any such filing.

Item 9.01 Financials Statements and Exhibits

(d) Exhibits

Exhibit Number	Description
99.1	BioAtla, Inc. Corporate Presentation, dated January 2024.
104	Cover Page Interactive Data File-the cover page XBRL tags are embedded within the Inline XBRL document.

SIGNATURES

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.

BioAtla, Inc.

Date: January 9, 2024

By: /s/ Richard Waldron
Richard Waldron
Chief Financial Officer

Exhibit 99.1

Conditionally **A**ctive **B**iologics: Transforming Cancer Therapy

Corporate Presentation

January 2024

bioatla

Important Notices & Disclaimers

This presentation (the "Presentation") by BioAtla, Inc. ("we", "us", "our", "BioAtla", or the "Company") contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995 relating to our business, operations and financial conditions, including but not limited to statements regarding business plans and prospects and whether our clinical trials will support registration; achievement of milestones; results, conduct, progress and timing of our research and development programs and clinical trials; expectations with respect to enrollment and dosing in our clinical trials, plans and expectations regarding future data updates, clinical trials, regulatory meetings and regulatory submissions; plans to form collaborations or other strategic partnerships for selected assets; the potential regulatory approval path for our product candidates; expectations about the sufficiency of our cash and cash equivalents and plans to prioritize and focus development on selected assets and indications. Words such as, but not limited to, "anticipate", "believe", "could", "estimate", "expect", "intend", "may", "plan", "potential", "predict", "project", "should", "will", "would" or the negative of those terms, and similar expressions that convey uncertainty of future events or outcomes, identify forward-looking statements.

These forward-looking statements reflect management's beliefs and views with respect to future events and are based on estimates and assumptions as of the date of this Presentation and are subject to risks and uncertainties, including those described in the Company's filings with the SEC, including but not limited to the Company's latest Quarterly Report on Form 10-Q. Moreover, the Company operates in a very competitive and rapidly changing environment. New risks emerge from time to time. It is not possible for management to predict all risks, nor can the Company assess the impact of all factors on its business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements we may make. Given these uncertainties, you should not place undue reliance on these forward-looking statements. The Company qualifies all the forward-looking statements in this Presentation by these cautionary statements. Except as required by law, the Company undertakes no obligation to publicly update any forward-looking statements, whether as a result of new information, future events or otherwise.

Statements contained herein are made as of the date of this Presentation unless stated otherwise, and this Presentation shall not under any circumstances create an implication that the information contained herein is correct as of any time after such date or that the information will be updated or revisited to reflect information that subsequently becomes available or changes occurring after that date hereof.

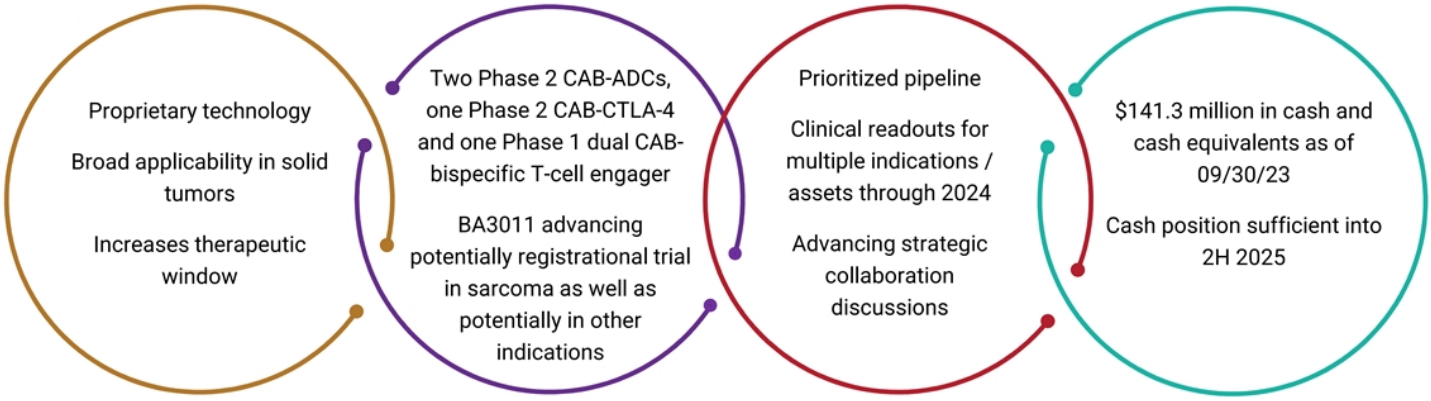
Certain information contained in this Presentation relates to or is based on statistical and other industry and market data obtained from independent industry publications and research, surveys and studies conducted by independent third parties as well as the Company's own estimates of the prevalence of certain diseases and conditions. The market data used in this Presentation involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such data. Industry publications and third-party research, surveys and studies generally indicate that their information has been obtained from sources believed to be reliable, although they do not guarantee the accuracy or completeness of such information. The Company's estimates of the patient population with the potential to benefit from treatment with any product candidates the Company may develop include several key assumptions based on its industry knowledge, industry publications and third-party research, which may be based on a small sample size and may fail to accurately reflect the addressable patient population. While the Company believes that its internal assumptions are reasonable, no independent source has verified such assumptions.

This Presentation may contain trademarks, trade names, or service marks belonging to other entities. The Company does not intend the use or display of other parties' trade names, trademarks or service marks to imply a relationship with, or endorsement or sponsorship of, or by these other parties.

None of the Company or any of its directors, officers, employees, contractors, agents, consultants, advisors or other representatives makes any representation or warranty, express or implied, as to the accuracy or completeness of the information contained in this Presentation.

BioAtla© is a clinical stage company focused on transforming cancer therapy

with **C**onditionally **A**ctive **B**iologics (CABs)



Leadership Team

Jay Short, Ph.D.

Chairman, CEO and Cofounder

Richard Waldron, M.B.A.

Chief Financial Officer

Eric Sievers, M.D.

Chief Medical Officer

Sheri Lydick

Chief Commercial Officer

Bin Zhang, M.D.

Sr. VP, Clinical Development.

William Boyle, Ph.D.

Sr. Research Fellow

Monica Sullivan

Sr. VP, Intellectual Property & Contracts

Susie Melody

Sr. VP, Human Resources

Board of Directors and Advisors

Jay Short, Ph.D.
Chairman, Chief Executive Officer & Cofounder
Director

Mary Ann Gray, Ph.D.
Director

Sylvia McBrinn
Director

Susan Moran, MD, MSCE
Director

Scott Smith
Director

Lawrence Steinman, MD
Director

Eddie Williams
Director

James Allison, Ph.D.
MD Anderson Cancer Center
Scientific Advisor

Lawrence Fong, MD
Cancer Immunotherapy Program, UCSF
Scientific Advisor

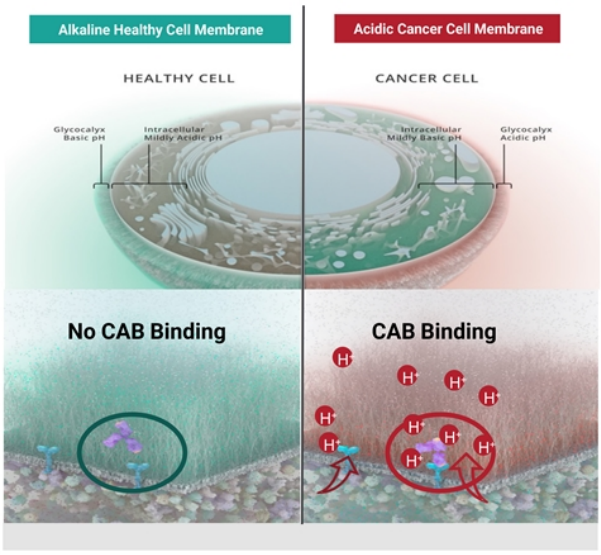
Padmanee Sharma, MD, Ph.D.
MD Anderson Cancer Center
Scientific Advisor

Michael Manyak, MD
GlaxoSmithKline
Scientific Advisor

Selective and targeted CAB technology widens therapeutic window,

thus has the potential to enhance clinical outcomes in multiple tumor types

- BioAtla discovered that acidic pH at the cancer cell surface unveils binding sites that are shielded at normal pH of healthy cells
- BioAtla invented CAB technology, creating antibodies that bind ***only*** to these unveiled sites on cancer cells
- CAB binding region is not masked or caged and thus different from prodrugs that require irreversible enzymatic cleavage to become activated
- CAB antibodies have the potential for increased efficacy with improved safety relative to traditional antibodies



Chang, H.W., Frey, G., Liu, H., Xing, C., Steinman, L, Boyle, B.J., & Short, J.M. (2021) PNAS 118(9): 1-10, Suppl. 1-19.

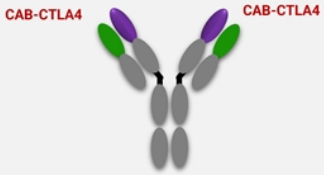
Broad applicability of BioAtla's CAB platform across several antibody types

has the potential to treat multiple solid tumors

I/O Antibodies

Target: CTLA-4

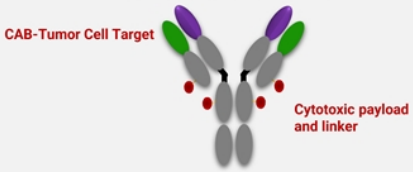
CTLA-4 blockade activates effector T cells, thereby enhancing anti-tumor immunity



ADCs

Targets: AXL, ROR2

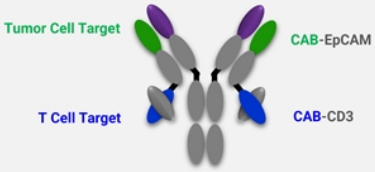
Widely expressed in a variety of tumor types, AXL and ROR2 overexpression correlates with poor prognosis, metastasis, and drug resistance to PD-1 and EGFR therapies



Bispecific TCE

Target: EpCAM & CD3

Bispecific antibodies bridge cancer cells and cytotoxic T lymphocytes, activating T cells and promoting cancer cell lysis



ADC – antibody drug conjugate; IO – immuno-oncology; TCE – T-cell engager

Focused Pipeline with Broad Applicability of Differentiated CAB Assets Designed to Deliver Near-term value

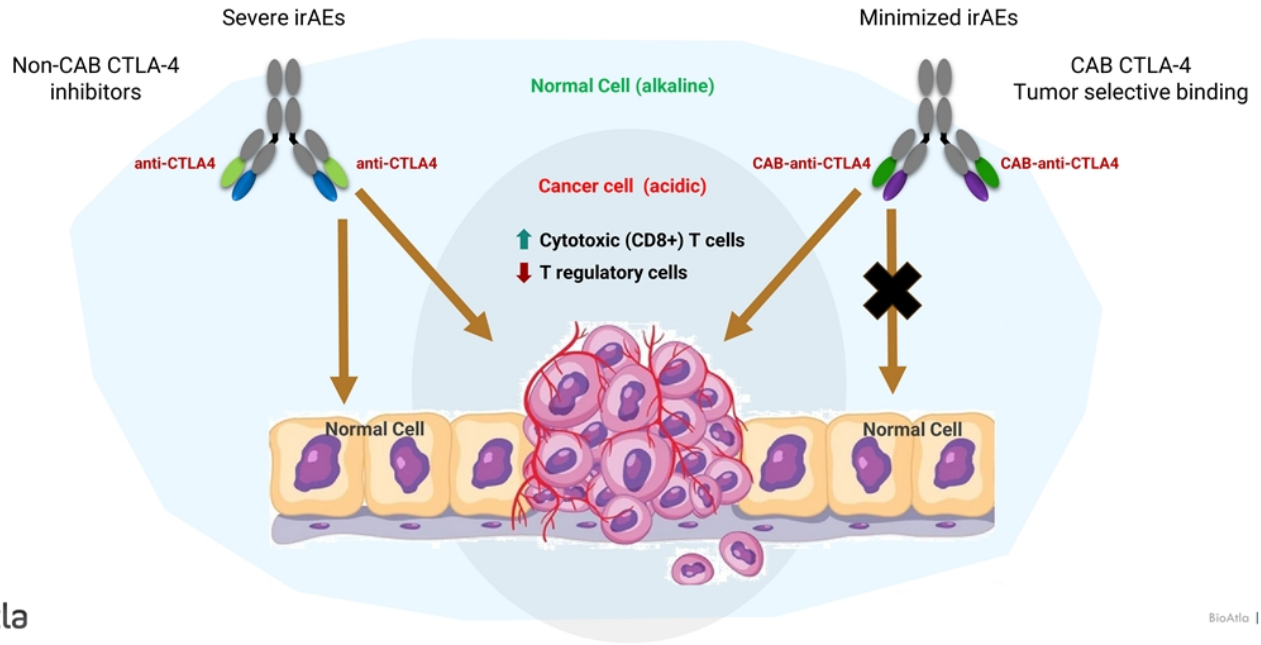
	CAB Program	Target	Indications	IND Enabling Pre-Clinical	Phase 1 Clinical	Phase 2 Clinical
CAB-ADCs	**BA3011** *Mecbotamab Vedotin*	AXL	UPS NSCLC			
	BA3021 *Ozuriftamab Vedotin*	ROR2	Melanoma SCCHN			
CAB-I/O	**BA3071** *Evalstotug*	CTLA-4	Melanoma NSCLC Carcinomas			
CAB-Bispecific TCE	**BA3182**	EpCAM x CD3	Multiple tumor types			
CAB	Additional programs	Various	Multiple tumor types			

IND, investigational new drug; UPS, Undifferentiated Pleomorphic Sarcoma; NSCLC, Non-small Cell Lung Cancer; SCCHN, Squamous Cell Carcinoma of the Head and Neck

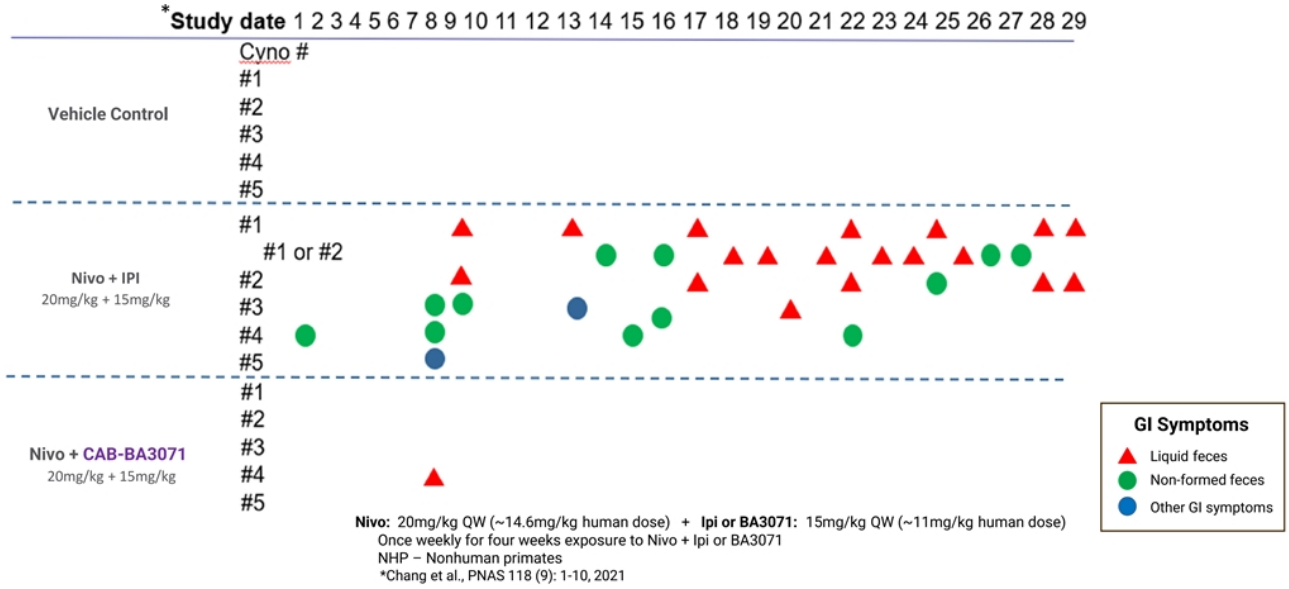
I/O Antibody Platform:

CTLA-4 (BA3071) – Basket Trial

CAB-CTLA4 Selectively Active in Tumor Microenvironment, thereby Reducing Immune Related Adverse Events (irAEs)



CAB BA3071 Effectively Reduces Clinically Relevant GI Toxicity in NHP



Nivo: 20mg/kg QW (~14.6mg/kg human dose) + **Ipi or BA3071:** 15mg/kg QW (~11mg/kg human dose)
Once weekly for four weeks exposure to Nivo + Ipi or BA3071
NHP – Nonhuman primates
*Chang et al., PNAS 118 (9): 1-10, 2021

BA3071 significantly reduces GI toxicity relative to ipilimumab analog in combination with nivo

Phase 1 BA3071 Dose Escalation ongoing

Key Objectives:

Define safety profile and determine Phase 2 dose and MTD

Evaluate antitumor activity and immunogenicity

Determine PK parameters

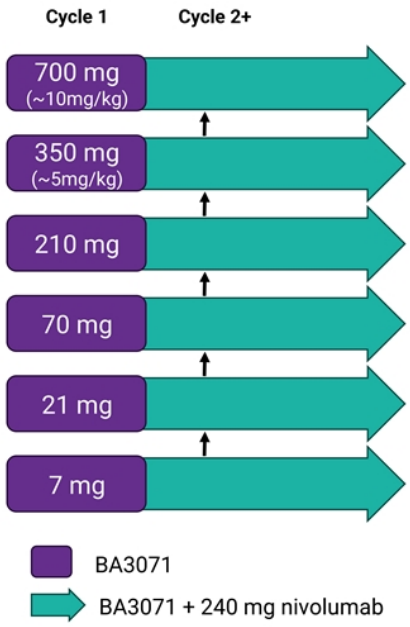
Key Eligibility Criteria:

CTLA-4 naïve

Treatment refractory:

- melanoma
- non-small cell lung cancer (NSCLC)
- renal cell carcinoma
- urothelial cancer
- gastric cancer
- hepatocellular carcinoma (HCC)
- cervical cancer
- small cell lung cancer (SCLC)

Combination Therapy (Q3W)



Further dose escalation planned to 1,000 mg

Phase 1 BA3071: Demographics - Baseline Patient Characteristics

Median of at least 3 prior lines of treatment

	Total (N=18)
Age, y, mean (range)	**65.5 (43 - 79)**
ECOG Status, n (%)	
0	**10 (55.6)**
1	**8 (44.4)**
# of prior systemic therapies, n (%)	
1	**5 (27.8)**
2	**2 (11.1)**
3	**4 (22.2)**
≥4	**7 (38.9)**

Data Cut Date: 15Nov23

Phase 1 BA3071: Demographics – Tumor Types

All patients experienced failure of prior PD1 treatment

Tumor Type	Total (N=18)	Prior Number of Tx	Prior Treatment
Cervical	**1 (5.6)**	3	pt, anti-VEGF, anti-PD1
Gastric	**4 (22.2)**	4 – 6	anti-PD1 and pt chemotherapies
Melanoma	**5 (27.8)**	1 – 2	anti-PD1
Uveal	3 (16.7)		
Cutaneous	2 (11.1)		
Renal cell	**4 (22.2)**	1 – 6	prior anti-PD1 and TKI
Urothelial	**1 (5.6)**	4	pt chemotherapies, anti-PD1 and ADC
NSCLC	**2 (11.1)**	3 – 7	pt chemotherapies, taxanes, anti-PD1, TKI, anti-VEGF
SCLC	**1 (5.6)**	3	pt chemotherapies, anti-PD1

Pt – Platinum;
Data Cut Date: 15Nov23

Grade 3+ Adverse Events of Special Interest

BA3071 Q3W + nivolumab 240 mg Q3W	7 mg (N=1)	21 mg (N=1)	70 mg (N=3)	210 mg (N=3)	350 mg (N=7)*	700 mg (N=3)	Total (N=18)
Number of subjects with at least one Grade 3+ AESI	0	0	2	0	1	2	**5 (27.8)**
GI Toxicity	0	0	1	0	1	0	**2 (11.1)**
Abdominal pain	0	0	1	0	0	0	**1 (5.6)**
Diarrhea	0	0	0	0	**1**	0	**1 (5.6)**
Liver Toxicity	0	0	2	0	0	0	**2 (11.1)**
AST increased	0	0	1	0	0	0	**1 (5.6)**
ALP increased	0	0	2	0	0	0	**2 (11.1)**
Pulmonary Toxicity	0	0	0	0	0	1	**1 (5.6)**
Pneumonia	0	0	0	0	0	1	**1 (5.6)**
Endocrine Toxicity	0	0	0	0	0	1	**1 (5.6)**
Diabetic ketoacidosis	0	0	0	0	0	**1**	**1 (5.6)**

^Patient with diarrhea also experienced Grade 3 gastritis
* 1 Pt at 350 mg dose for Phase 2 included
Red text denotes immune related AEs
Data Cut Date: 15Nov23
AST - Aspartate aminotransferase; ALP - Alkaline phosphatase

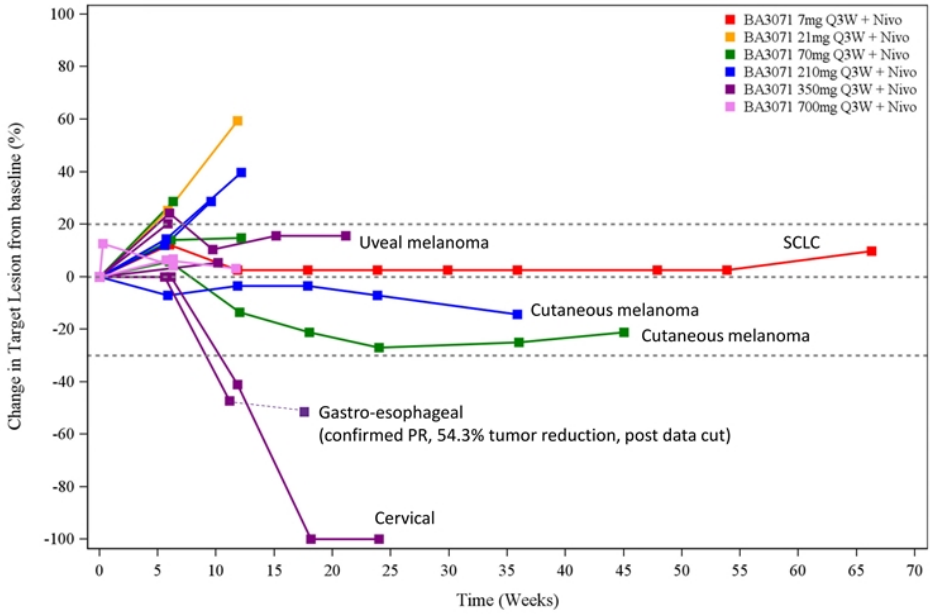
Grade 3+ Adverse Events of Special Interest

BA3071 Q3W + nivolumab 240 mg Q3W	7 mg (N=1)	21 mg (N=1)	70 mg (N=3)	210 mg (N=3)	350 mg (N=7)*	700 mg (N=3)	Total (N=18)
Number of subjects with at least one Grade 3+ AESI	0	0	2	0	1	2	**5 (27.8)**
GI Toxicity	0	0	1	0	1	0	**2 (11.1)**
Abdominal pain	0	0	1	0	0	0	**1 (5.6)**
Diarrhea	0	0	0	0	1	0	**1 (5.6)**
Liver Toxicity						0	**2 (11.1)**
AST increased						0	**1 (5.6)**
ALP increased	0	0	2	0	0	0	**2 (11.1)**
Pulmonary Toxicity	0	0	0	0	0	1	**1 (5.6)**
Pneumonia	0	0	0	0	0	1	**1 (5.6)**
Endocrine Toxicity	0	0	0	0	0	1	**1 (5.6)**
Diabetic ketoacidosis	0	0	0	0	0	1	**1 (5.6)**

Only 2 patients with immune related AEs observed among 18 treated patients

^Patient with diarrhea also experienced Grade 3 gastritis
* 1 Pt at 350 mg dose for Phase 2 included
Red text denotes immune related AEs
Data Cut Date: 15Nov23
AST - Aspartate aminotransferase; ALP - Alkaline phosphatase

Phase 1 BA3071: Confirmed Responses (n=2) and Stable Disease (n=9) Among 16 Evaluable Patients

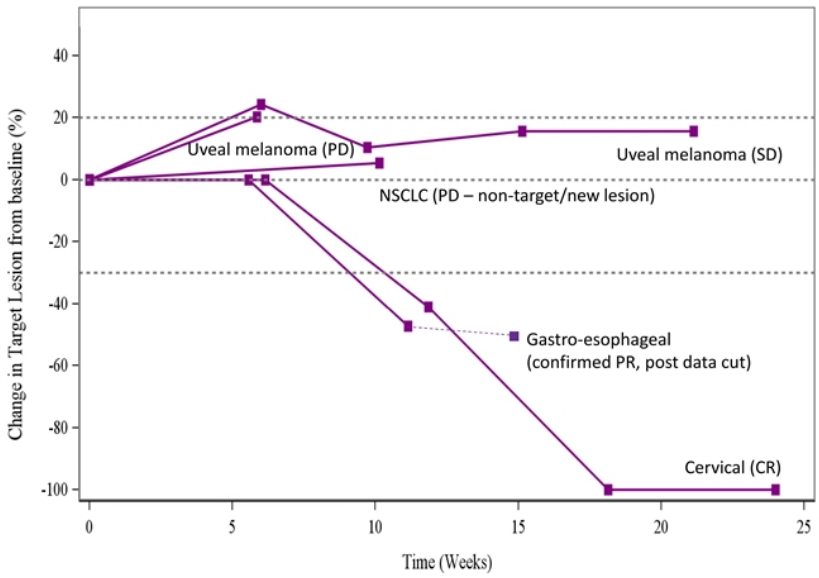


Data Cut Date: 15Nov23

Phase 1 BA3071: Meaningful Clinical Benefit at 350 mg in Combination with PD1

Confirmed Partial and Complete Responses

Overall Response to date	N=5
Complete Response	1
Partial Response	1
Stable Disease	1
Progressive Disease	2

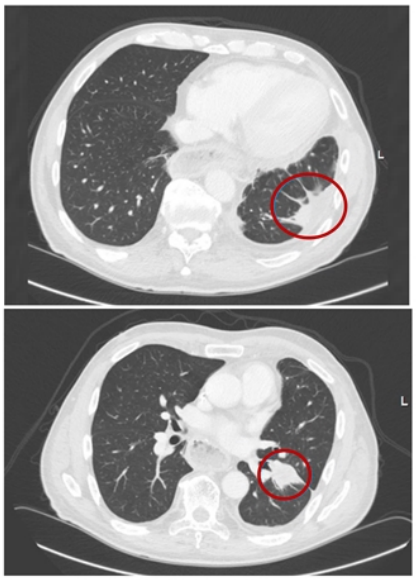


Data Cut Date: 15Nov23

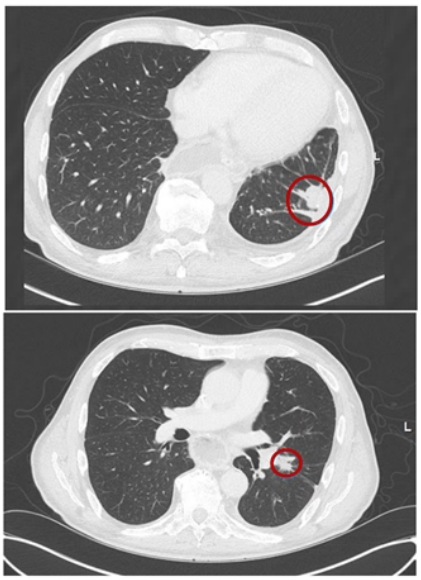
Confirmed PR - Gastro-esophageal Cancer

63-year-old male, stage IV gastro-esophageal cancer HER2 negative, post-FOLFOX, taxane, TKI, anti-PD1 and anti-VEGFI

Baseline - July 31,2023



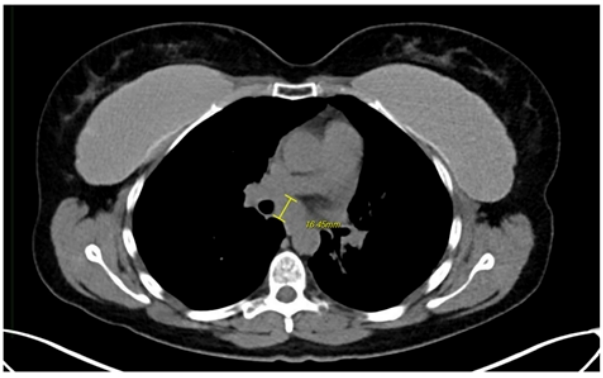
On Treatment - October 23, 2023



Confirmed CR - Cervical Cancer

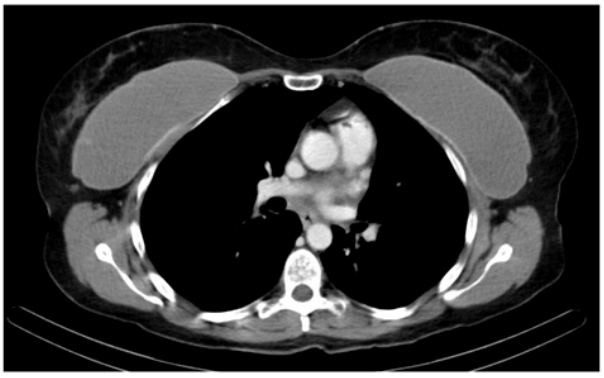
43-year-old female, stage IV cervical cancer HPV+16 positive, post-platinum, taxane, anti-PD1 and anti-VEGF

Baseline – March 23, 2023



"Multiple enlarged mediastinal, paraesophageal, and right hilar lymph nodes…"

On Treatment – August 9, 2023



"No enlarged mediastinal, hilar or axillary lymph nodes are present. There is persistent resolution of previously noted enlarged mediastinal and paraesophageal lymph nodes."

BA3071-001 Dose Titration Ongoing

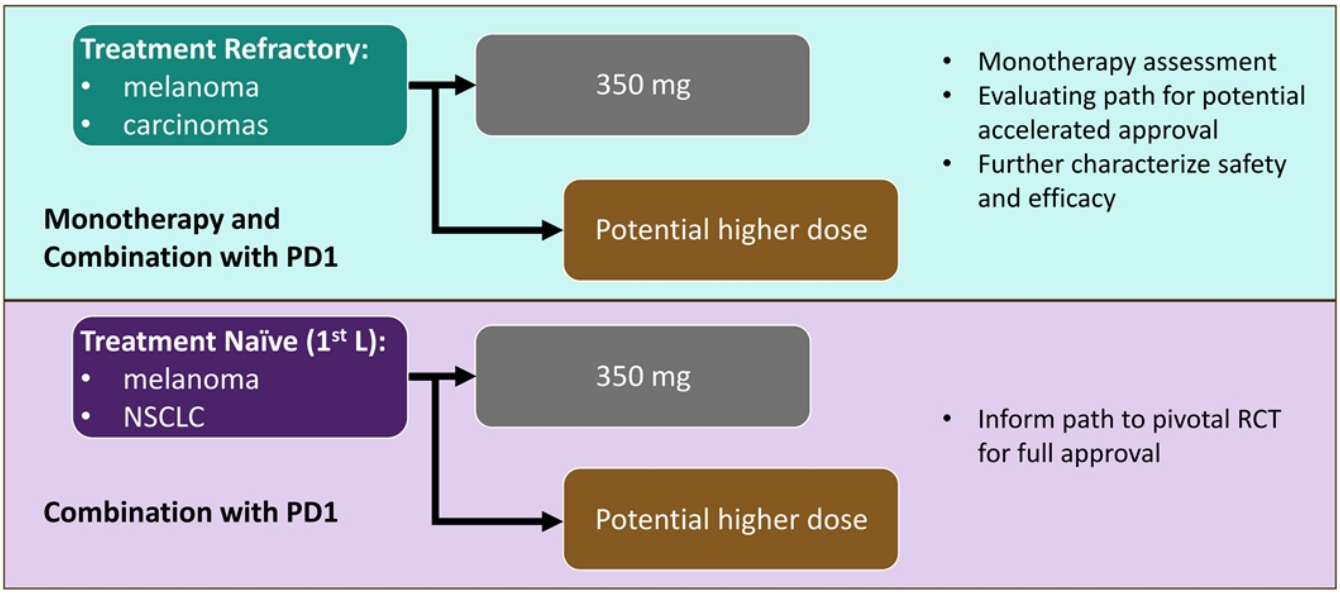
3 patients dosed at 700 mg Q3W in combination with nivolumab

Cancer Type	Age	Prior Tx	Adverse Events	DLT	Cycles Completed	Overall Response	Disposition
Renal cell	78	5	G1 fever and chills; G2 transient hypoxia	No	6	SD	Ongoing
Gastro-esophageal	66	4	G1 fever and chills	No	2	SD	DC - Subject Decision
NSCLC	76	7	G1 fever and chills; G2 transient hypoxia	Yes (atrial fibrillation)	2	SD	DC - AE

- Renal cell patient commenced prophylactic tocilizumab cycle 4 onward, now post 6 cycles and tolerating continued therapy
- Further evaluation of 700 mg and potentially 1000 mg both with prophylactic tocilizumab

BA3071 Phase 2 Mono and Combo Study Currently Underway

Study designed for multiple approval paths



CAB-AXL-ADC Platform

BA3011 Mecbotamab Vedotin: Sarcoma and NSCLC

Potential market opportunity in undifferentiated pleomorphic sarcoma (UPS)

~15%	2nd most common Soft Tissue Sarcoma (STS) subtype[1,2]
0	Targeted therapies specifically approved to treat UPS
~55%	patients developing recurrent or metastatic disease[3,4]
1 year	Median time to metastatic/local recurrence[4,5,6]

Available Treatment:

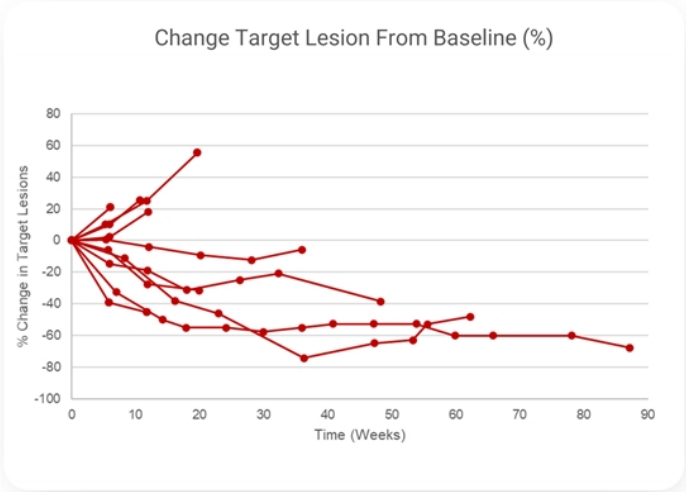
1L: Approved treatments for sarcoma ORR ~15%[7]

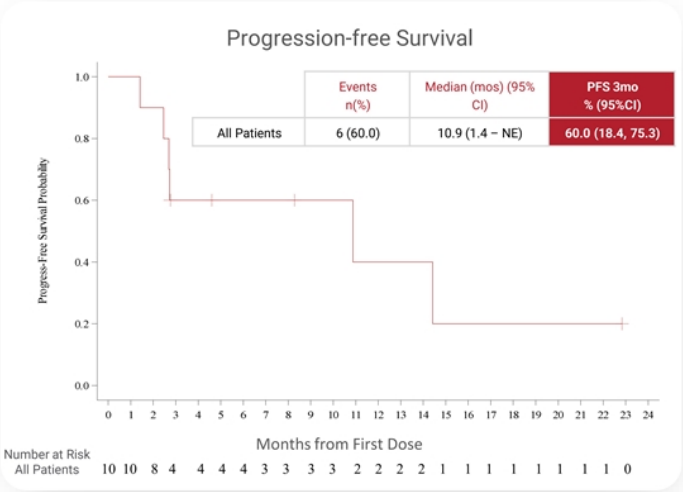
[1]Brennan MF, Antonescu CR, Moraco N, Singer S. Lessons learned from the study of 10,000 patients with soft tissue sarcoma. Ann Surg. 2014;260(3):416–21; [2] Penel N, Coindre J-M, Giraud A, Terrier P, Ranchere-Vince D, Collin F, et al. Presentation and outcome of frequent and rare sarcoma histologic subtypes: a study of 10,262 patients with localized visceral/soft tissue sarcoma managed in reference centers. Cancer. 2018;124(6):1179–87; [3]Vodanovich DA, Spelman T, May D, Slavin J, Choong PFM. Predicting the prognosis of undifferentiated pleomorphic soft tissue sarcoma: a 20-year experience of 266 cases. ANZ J Surg. 2019;89(9):1045-1050; [4]Roland CL, May CD, Watson KL, et al. Analysis of Clinical and Molecular Factors Impacting Oncologic Outcomes in Undifferentiated Pleomorphic Sarcoma. Ann Surg Oncol. 2016;23(7):2220-2228; [5]Delisca GO, Mesko NW, Alamanda VK, et al. MFH and high-grade undifferentiated pleomorphic sarcoma-what's in a name?. J Surg Oncol. 2015;111(2):173-177; [6]Winchester D, Lehman J, Tello T, et al. Undifferentiated pleomorphic sarcoma: Factors predictive of adverse outcomes. J Am Acad Dermatol. 2018;79(5):853-859; [7]Product USPIs

ORR, objective response rate (best objective response as confirmed complete response or partial response)

Undifferentiated Pleomorphic Sarcoma (UPS): ORR 50%, Median PFS 10.9 months

Phase 1 & Phase 2, part 1 change in target lesion and progression free survival (1.8mg/kg; n=10)





- Combined Phase 1 & 2: efficacy evaluable = 10 TmPS ≥ 50%
  - 5 / 10 patients achieved PRs, with an ORR of 50% and PFS rate at 3 months of 60%
  - Responses to BA3011 treatment are durable, with DOR currently exceeding 8 months
- Interim results satisfied the pre-defined Go criteria of UPS cohort into part 2 of the Phase 2 study
- Average prior lines of systemic therapy = 3

- Phase 3 randomized study of pazopanib versus placebo in metastatic soft-tissue sarcoma ("other" cohort that included UPS), progressing despite previous chemotherapy, reported a median PFS of 4.6 months for pazopanib and 1.0 months for placebo.*
- Single-arm SARC028 study of pembrolizumab in advanced UPS, reported median PFS of 3.0 months**
- Limitations of cross trial comparison should be taken into account when comparing studies

Interim data- Data cut-off of Jan 18, 2023
*Votrient package insert, accessed March 2023. **DOI: 10.1200/JCO.2019.37.15_suppl.11015 Journal of Clinical Oncology 37, no. 15_suppl (May 20, 2019) 11015-11015.
TmPS, tumor membrane percent score; ORR, objective response rate; PFS, progression free survival; DOR, duration of response.

Phase 2, part 1 Topline Interim Analysis Results Confirm Phase 1 Signal

Following BA3011 in remaining sarcoma subtypes

Sarcoma Subtype	# of Pt	PFS rate	PR/CR
Leiomyosarcoma	19 13	28.8% (Q2W) 10.3% (3Q4W)[1]	0
Synovial	7	35.7%	0
Liposarcoma	8	62.5%	0
Osteosarcoma	12	45.5%	2 PRs
Ewing sarcoma	8	18.8%	0
Bone Other: (Chondro/Chordo)	8/3	62.5%/66.7%	0
Combo CD20 Positive	14	32.1%	1 PR (UPS)
Combo CD20 Negative	12	41.7%	1 PR (LMS)

'Go' if ≥1 CR/PR or PFS rate at 3 months ≥40%;

'No Go' if 0 CR/PR and PFS rate at 3 months <40%;

[1]Low patient compliance

PFS, progression-free survival; PR, partial response; UPS, undifferentiated pleomorphic sarcoma; NE, not evaluable

Continued promising safety and tolerability profile in sarcoma

Phase 2 at the RP2D 1.8 mg/kg Q2W

Characteristic	BA3011 (N=73)	BA3011 + Opdivo (N=26)
Any Adverse Events (AEs)	69 (94%)	24 (92%)
Related AEs with CTCAE[1] Grade 3 or 4[2]	20 (27%)	10 (39%)
Any related serious AEs[2]	5 (7%)	5 (19%)
Related AEs leading to death[2]	0	0
Related AEs leading to treatment discontinuation[2]	4 (5%)[§]	1 (4%)[^]

Constipation	Grade 1-2 (21%)
	Grade 3 (1%)
Peripheral Neuropathy	All Grade 1-2 (16%)
	Grade 3-4 (0%)
Diarrhea	Grade 1-2 (16%)
	Grade 3-4 (0%)

Low-grade constipation observed is consistent with baseline levels seen in advanced cancer patients

- No treatment-related deaths
- Few treatment-related SAEs, consistent with MMAE-based toxicity, including reversible myelosuppression, transient liver enzyme elevation, metabolic disturbances
- Very few related AEs leading to treatment discontinuation
- No clinically meaningful on-target toxicity observed over background
- Differentiated profile due to avoiding on-target off-tumor toxicity

Interim data- Data cut-off of Jan 18, 2023

[1]CTCAE: Common Terminology Criteria for Adverse Events. The NCI Common Terminology Criteria for Adverse Events is a descriptive terminology which is utilized for Adverse Event (AE) reporting. A grading (severity) scale is provided for each AE term. [2]As assessed by the investigator. Missing responses are counted as related. [§]Grade 2 peripheral neuropathy; pancreatitis; ^grade 2 Ileus

Phase 2 Potentially Registrational UPS Study Design

- UPS Phase 2, part 2 potentially registrational study
  - Enrolling total of ~80 AXL-expressing UPS patients in Phase 2, part 2
    - FDA supportive of investigating a more frequent dosing regimen (3Q4W 44% and 2Q3W 38% increased exposure over Q2W)
    - First 40 patients with a TmPS >=50% will be randomized 1:1 to 3Q4W or 2Q3W dosing regimen
    - Additional 40 patients to be enrolled at the selected dose
  - Primary efficacy endpoint is objective response rate (ORR) per RECIST v1.1
    - Primary efficacy analysis will be based on ~60 patients treated at the selected dosing regimen
  - Prior systemic regimens limited to ≤3

Potential market opportunity in metastatic NSCLC

>540K	people in the U.S. living with lung cancer[1]
~200K	newly diagnosed patients / year (U.S.) – **majority** advanced / metastatic[2]
~75 - 80%	non-squamous represents **majority** of NSCLC patients[3]
2L+	despite advances in 1L care, **majority** of patients **progress**[4]

Available Treatment:

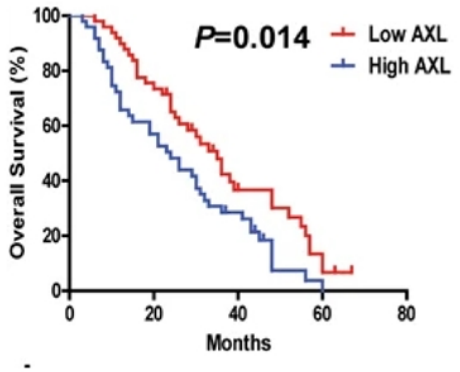
1L: Chemo + ICI 50% ORR[5]

2L+: SOC 14% - 23% ORR[6]; median PFS 4.5 months[6]

[1]https://www.lung.org/lung-health-diseases/lung-disease-lookup/lung-cancer/resource-library/lung-cancer-fact-sheet [2]https://www.cancer.net/cancer-types/lung-cancer-non-small-cell/statistics, [3]https://thoracickey.com/carcinomas-of-the-lung-classification-and-genetics/#F1-72, [4]Wang F, Wang S and Zhou Q (2020) The Resistance Mechanisms of Lung Cancer Immunotherapy. *Front. Oncol.* 10:568059. doi: 10.3389/fonc.2020.568059, [5]*Transl Lung Cancer Res* 2021;10(7):3093-3105. [6]Cyramza package insert (accessed March 2023)

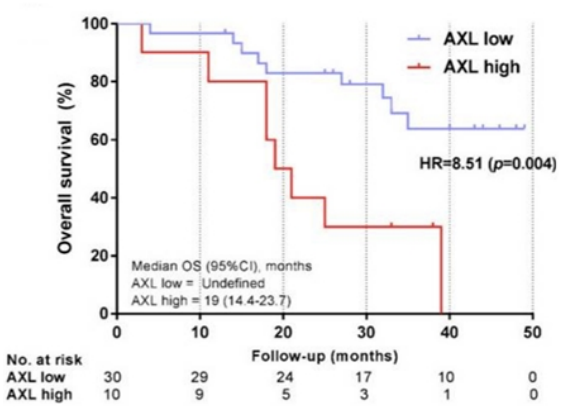
1L, first line; 2L+, second line or greater; NSCLC, non-small cell lung cancer; ORR, objective response rate (best objective response as confirmed complete response or partial response), SOC, standard of care (docetaxel alone, docetaxel + ramucirumab)

AXL expression is associated poor prognosis in metastatic NSCLC



In a cohort of 98 patients with metastatic NSCLC, OS was significantly worse for those patients with high AXL expression by IHC

Wu et al., J Cancer Res and Clin Oncol, 2017



Lower overall survival (OS) in patients with early stage, surgically resected lung adenocarcinoma with high levels of tissue AXL

Reproduced from de Miguel-Pérez D, et al. 2019

BA3011-002 Non-Small Cell Lung Cancer

Multicenter, Phase 2, open-label trial evaluating the efficacy and safety of BA3011 alone and in combination with nivolumab

Patient disposition:

- Confirmed locally advanced or metastatic NSCLC
- Age ≥ 18 years
- ECOG performance status of 0 or 1
- Treatment failure of a PD-1/L1 inhibitor or approved therapy for EGFR or ALK genomic tumor aberrations
- AXL+ tumor staining (TmPS ≥ 1%)

BA3011
1.8 mg/kg Q2W, 2Q3W, 3Q4W

BA3011 + nivolumab
1.8 mg/kg Q2W

Primary endpoint:

- ORR via RECIST v1.1
- Incidence and severity of AEs*

Secondary endpoints:

- DOR
- PFS
- BOR, DCR, TTR, OS

*Coded by MedDRA and graded according to NCI CTCAE v5

Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

Phase 2 BA3011-002 NSQ NSCLC: Baseline Demographics and Characteristics

BioAtla study enrolled a heavily pretreated 3L+ population

	BA3011 monotherapy (N=23)	BA3011 + nivolumab (N=17)	Total (N=40)
Age, y, mean (SD)	68.3 (8.0)	68.9 (8.2)	68.6 (8.0)
Number of prior systemic therapies, n (%)			
1	4 (17.4)	2 (11.8)	6 (15.0)
2	6 (26.1)	3 (17.6)	9 (22.5)
3	9 (39.1)	2 (11.8)	11 (27.5)
≥4	4 (17.4)	10 (58.8)	14 (35.0)
Received prior anti-PD-1/L1 treatment, n (%)			
Yes	21 (91.3)	15 (88.2)	36 (90.0)
No	2 (8.7)	2 (11.8)	4 (10.0)
EGFR mutation status, n (%)			
Wild-type	16 (69.6)	13 (76.5)	27 (67.5)
Mutant	4 (17.4)	2 (11.8)	6 (15.0)
Unknown or missing	3 (13.0)	2 (11.8)	7 (17.5)

Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

Data Cut Date: 30Jun23

Phase 2 BA3011 Non-Squamous NSCLC

Data Cut Date: 30Jun23	Prior PD-1/L1 treatment EGFR wild-type (N=15)	Prior PD-1/L1 treatment (N=18)
Best Overall Response, n (%)		
Confirmed PR	3 (20.0)	3 (16.7)
Unconfirmed PR	2 (13.3)	2 (11.1)
SD	7 (46.7)	10 (55.6)
PD	2 (13.3)	2 (11.1)
NA (early discontinuation due to AE)	1 (6.7)	1 (5.6)
Response Rate		
n (%)	5 (33.3)	5 (27.8)
Exact 95% CI	11.8, 61.6	9.7, 53.5
Disease Control Rate		
n (%)	8 (53.3)	10 (55.6)
Exact 95% CI	26.6, 78.7	30.8, 78.5

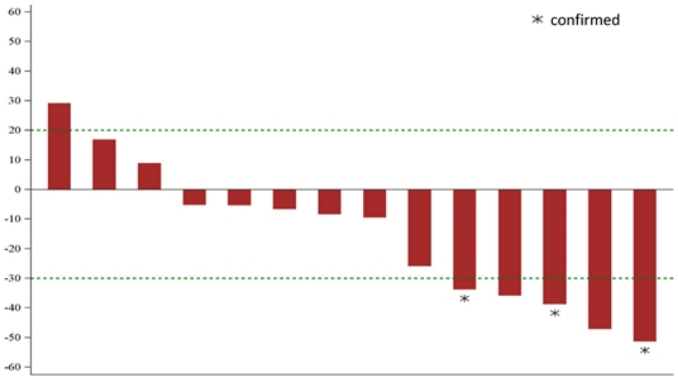
- Monotherapy median Duration of Response was estimated to be 4.8 months with a range of 2.3-12.1+ months*
- Combination therapy (n=17)*:
  - Evaluable patients (majority with 4+ prior lines of therapy) received BA3011 + nivolumab
  - One patient experienced an ongoing complete response (CR), 2 patients experienced PR, and 8 patients experienced stable disease (SD)

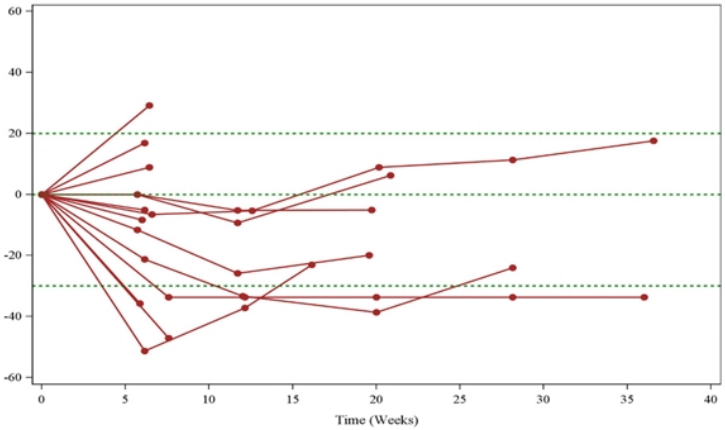
Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

*As of November 20, 2023

BA3011-002 NSCLC interim analysis

BA3011 Monotherapy 1.8 mg/kg Q2W





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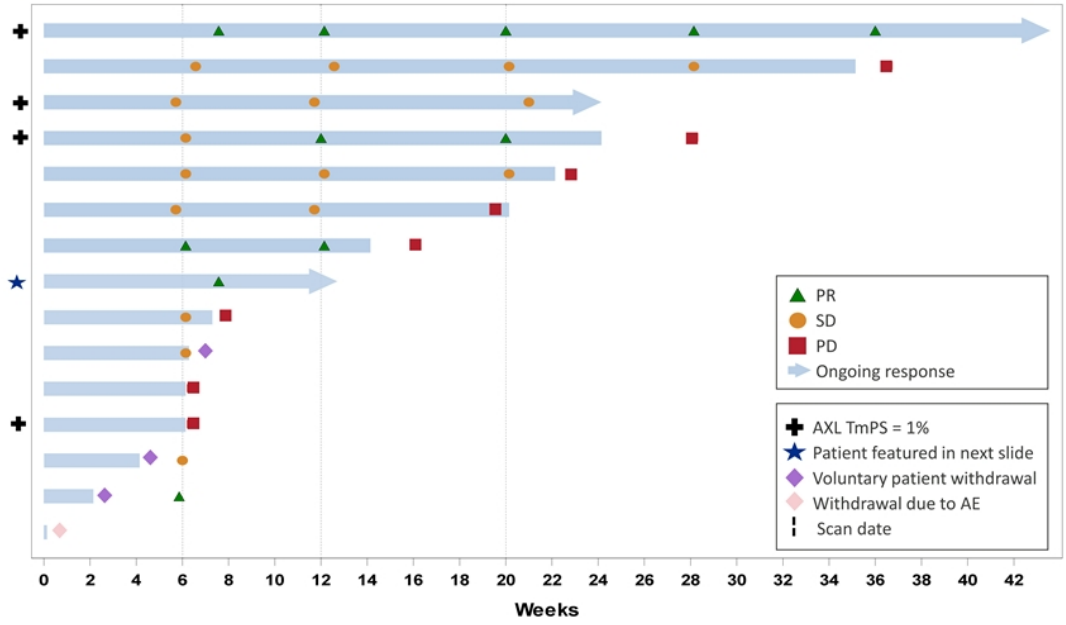
Data Cut Date: 30Jun23

BA3011-002 NSCLC interim analysis

BA3011 Monotherapy 1.8 mg/kg Q2W



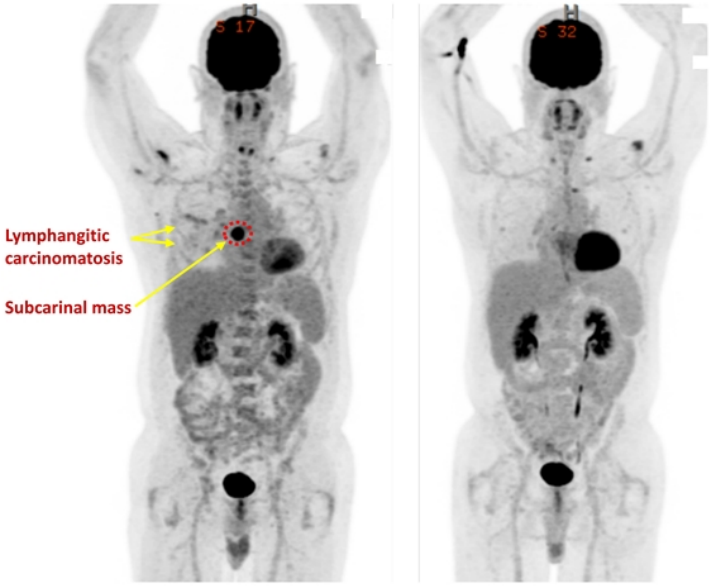
Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

Data Cut Date: 30Jun23

Radiographic response to BA3011 monotherapy

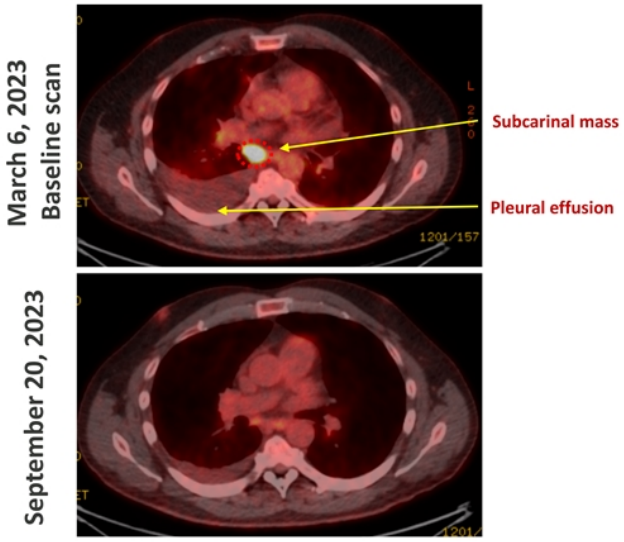
March 6, 2023 – Baseline scan

September 20, 2023



Red circle on left indicates subcarinal mass, resolved on right.

53 yo male with adenocarcinoma of the lung,
PDL1 <1%, *TP53* mutation, 3 prior lines of tx
(carbo/pem/pembro, docetaxel, durva/treme/selumetinib)



Red circle on top indicates subcarinal mass, resolved below.
Note also improvement in malignant pleural effusion.

Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

Summary of Treatment Emergent Adverse Events (non-squamous NSCLC)

	BA3011 monotherapy (n=23)	BA3011 + nivolumab (n=17)	Total (N=40)
TEAEs with CTCAE grade 3 or 4	15 (65.2)	8 (47.1)	23 (57.5)
Related grade 3 or 4 AEs	8 (34.8)	3 (17.6)	11 (27.5)
Any serious TEAEs	9 (39.1)	5 (29.4)	14 (35.0)
Related SAEs	3 (13.0)	1 (5.9)	4 (10.0)
TEAEs leading to treatment d/c	1 (4.3)	1 (5.9)	2 (5.0)
Related AEs leading to treatment d/c	1 (4.3)	1 (5.9)	2 (5.0)
TEAEs leading to death	0	1 (5.9)	1 (2.5)
Related AEs leading to death	0	0	0

Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

Data Cut Date: 30Jun23

Treatment Emergent Adverse Events (Non-Squamous NSCLC)

Any grade (≥15% of patients) OR grade ≥3* (≥3% of patients) in the study population

Preferred term	TEAEs of any grade, n (%)	TEAEs of grade 3, n (%)
Fatigue	14 (35.0)	1 (2.5)
Diarrhea	10 (25.0)	1 (2.5)
Constipation	9 (22.5)	0
Decreased appetite	9 (22.5)	1 (2.5)
Anemia	8 (20.0)	2 (5.0)
Nausea	8 (20.0)	0
Peripheral neuropathy	7 (17.5)	1 (2.5)
Increased AST	7 (17.5)	3 (7.5)
Dyspnea	6 (15.0)	2 (5.0)
Neutropenia	6 (15.0)	2 (5.0)
Increased ALT	5 (12.5)	3 (7.5)

*No grade 4+ TEAEs among most frequent

Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

Data Cut Date: 30Jun23

Phase 2 BA3011 NSCLC Dose Optimization

In-line with FDA Project Optimus

- 2Q3W dosing regimen
  - 11 patients treated
  - 4 patients have been evaluable (3 SD and 1 PD) as of 12/4; target agnostic data expected in 1H 2024

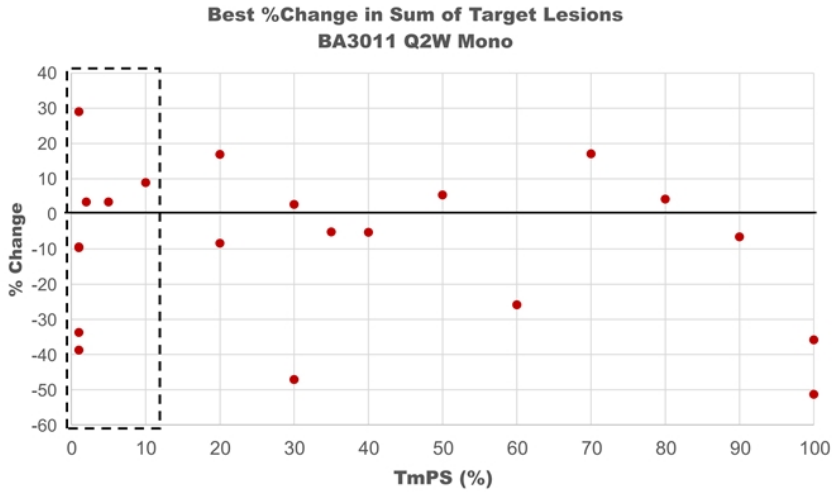
- 3Q4W dosing regimen
  - Suboptimal compliance observed and enrollment has been discontinued

Benefit-Risk profile observed to date with 1.8 mg/kg Q2W supports advancing this dose in registrational studies

Rotow J, Dy GK, Camidge DR. Poster presented at: International Association for the Study of Lung Cancer 2023 North America Conference on Lung Cancer; December 1-3, 2023; Chicago, IL.

BA3011 NSCLC AXL Expression in Relation to Anti-tumor Activity

Considerable anti-tumor activity among patients regardless of AXL expression level



Anti-tumor activity seen among patients with AXL low expression level supports target agnostic development

BA3011 NSCLC Randomized Registrational Study Design

Two Potentially Registrational Paths Enabled via the FDA Type C Meeting

2nd Line +

- **Open-label**; control: docetaxel
- Patients with NSCLC who have been previously treated with at least **one** prior line of therapy for metastatic disease
- Dual primary endpoints: Progression Free Survival and Overall Survival

3rd Line +

- **Blinded**; control: chemo monotherapy
- Patients with NSCLC who have been previously treated with at least **two** prior lines of therapy for metastatic disease
- Primary endpoint: Overall Survival

CAB-ROR2-ADC Platform

BA3021 Ozuriftamab Vedotin – NSCLC, Melanoma, SCCHN

Potential market opportunity in metastatic NSCLC

>540K	people in the U.S. living with lung cancer[1]
~200K	newly diagnosed patients / year (U.S.) – **majority** advanced / metastatic[2]
~75 - 80%	non-squamous represents **majority** of NSCLC patients[3]
2L+	despite advances in 1L care, **majority** of patients **progress**[4]

Available Treatment:

1L: Chemo + ICI 50% ORR[5]

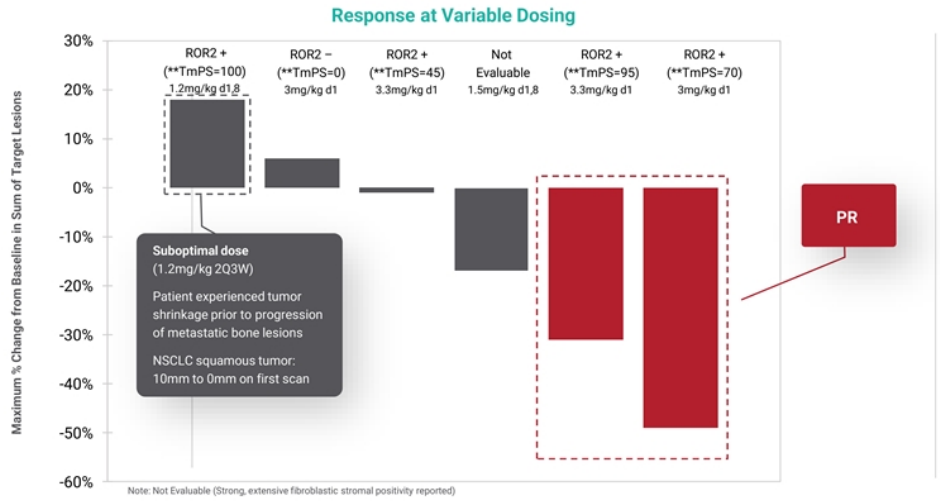
2L+: SOC 14% - 23% ORR[6]; median PFS 4.5 months[6]

[1]https://www.lung.org/lung-health-diseases/lung-disease-lookup/lung-cancer/resource-library/lung-cancer-fact-sheet [2]https://www.cancer.net/cancer-types/lung-cancer-non-small-cell/statistics, [3]https://thoracickey.com/carcinomas-of-the-lung-classification-and-genetics/#F1-72, [4]Wang F, Wang S and Zhou Q (2020) The Resistance Mechanisms of Lung Cancer Immunotherapy. *Front. Oncol.* 10:568059. doi: 10.3389/fonc.2020.568059, [5]*Transl Lung Cancer Res* 2021;10(7):3093-3105. [6]Cyramza package insert (accessed March 2023)

1L, first line; 2L+, second line or greater; NSCLC, non-small cell lung cancer; ORR, objective response rate (best objective response as confirmed complete response or partial response), SOC, standard of care (docetaxel alone, docetaxel + ramucirumab)

Encouraging Phase 1 results with BA3021 (Ozuriftamab Vedotin)

in refractory patients with NSCLC



- Two out of three ROR2+ patients had a partial response following ozuriftamab vedotin treatment

**Suboptimal dose 1.2 mg/kg 2Q3W. Tumor shrinkage occurred prior to progression of metastatic bone lesions. NSCLC squamous tumor 10mm to 0mm on first scan.

Potential market opportunity in metastatic melanoma

~1.3MM	people in the U.S. **living with** melanoma[1]
~100K	**newly diagnosed** invasive cases / year (U.S.)[1]
~50%	**do not respond** to PD-1 therapy in 1L setting[2]
30-40%	initial responders **progress**[2]

Available Treatment

1L: ICIs 33% - 50% ORR[3]; (BRAF / Mek inhibitors for BRAF+)

2L+: ICIs 9% - 28% ORR (mono – combo, respectively)[4]

[1]Clarivate, Disease Landscape and Forecast: Malignant Melanoma (2022). www.cancer.net; www.cancer.org; [2]Oncology (Williston Park). 33(4):141-8. [3]Keytruda USPI accessed June 2022; Opdivo USPI accessed June 2022. [4]VanderWalde A, Moon J, Bellasea S, et al. Ipilimumab plus nivolumab versus ipilimumab alone in patients with metastatic or unresectable melanoma that did not respond to anti-PD-1 therapy. Presented at: 2022 AACR Annual Meeting; April 8-13, 2022; New Orleans, LA. Abstract CT013.

1L, first line; 2L+, second line or greater; ICIs – Immune checkpoint inhibitors.

Phase 2 BA3021 in stage IV multi-refractory melanoma

Promising early signals of efficacy - continuing to collect data in ongoing study

- Completed enrollment Q2W targeted cohort who previously progressed on PD-1/L1 therapy
- As of Nov 3, eight melanoma monotherapy patients are evaluable* with reported first scan data across Phase 1 and Phase 2
  - We observed a total of four responses, two stable disease and two progressive disease
  - Two responses observed in ROR2 TmPS negative patients
- Phase 2 initial data readout (n = ~20) expected in 1H 2024

*7 patients in Phase 2 received 1.8 mg/kg Q2W and 1 patient in Phase 1 received 3.0 mg/kg Q3W

Potential market opportunity in SCCHN

>400K	people **living with** head and neck cancer (U.S.)[1]
~66K	**newly diagnosed** cases / year (U.S.)[1]
~50%	with locally advanced disease **develop recurrent or refractory** disease[2]
2L+	**limited** effective options post IL[3]

Available Treatment

1L: Pembro, cetuximab, platinum 36% ORR[4]

2L+: ICIs 13% - 16% ORR[4]

[1]Clarivate, Disease Landscape and Forecast: SCCHN (2022). www.cancer.net; [2]Argiris A, et al.(2017) Evidence-Based Treatment Options in Recurrent and/or Metastatic Squamous Cell Carcinoma of the Head and Neck. *Front. Oncol.* 7:72; [3]Future Oncology, Jan. 2019. Vol. 15, No. 8; [4]Ketruda USPI accessed June 2022; Opdivo USPI access June 2022.

SCCHN, squamous cell carcinoma of the head and neck; 1L, first line; 2L, second line; 2L+, second line or greater; ICIs – Immune checkpoint inhibitors.

Phase 1 results with BA3021 support advancing into Phase 2

in multiple indications

ROR2+ Tumor Types	Results
NSCLC	▪ PR in 2 / 3 patients who previously experienced failure on PD-1 and who received Phase 2 dose or higher
Melanoma	▪ CR in 1 / 1 patient who previously experienced failure on PD-1 ▪ Clearance of pulmonary metastases followed by normalization of adenopathy ▪ Continued CR off treatment for over 2 years
SCCHN	▪ PR in 1 / 1 ROR2+ refractory to four prior lines of therapy including cetuximab and PD-1 (pembrolizumab)
Promising safety and tolerability profile across multiple tumor types	

No ROR2 ADC or small molecules in the clinic to date, suggesting CAB-ROR2-ADC is a first-in-class therapy across multiple tumor types

Dosing regimens under evaluation for CAB-ROR2-ADC

BA3021 Ozuriftamab Vedotin

		Dose			
		Day1	Day 8	Day 15	Day 22
	Q2W				
All cycles (28 days)		1.8 mg/kg	no drug	1.8 mg/kg	no drug
	2Q3W				
All cycles (21 days)		1.8 mg/kg	1.8 mg/kg	no drug	–
	3Q4W				
Cycle 1 (21 days)		2.0 mg/kg	1.3 mg/kg	1.3 mg/kg	–
Cycle 2 (28 days) and subsequent cycles		1.3 mg/kg	1.3 mg/kg	1.3 mg/kg	no drug

Source: Form 10-K

Summary of Dosing Regimens for Phase 2 Clinical Studies with CAB-ROR2-ADC

BA3021 Ozuriftamab Vedotin

Indication	Dose	Maximum Patient #	Status
NSCLC*	Q2W monotherapy	N ~ 20	√
	Q2W in combo w/ nivolumab	N ~ 20	√
	3Q4W monotherapy	N ~ 20	Not advancing; suboptimal compliance
Melanoma	Q2W monotherapy	N ~ 25	Fully enrolled
Head and Neck	Q2W monotherapy	N ~ 20	Not advancing
	2Q3W monotherapy	N ~ 20	Fully enrolled

*Currently no plans to internally explore NSCLC further at this time
NSCLC = non small cell lung cancer

Bispecific Platform

CAB-EpCAM x CAB-CD3 (BA3182) – Adenocarcinoma

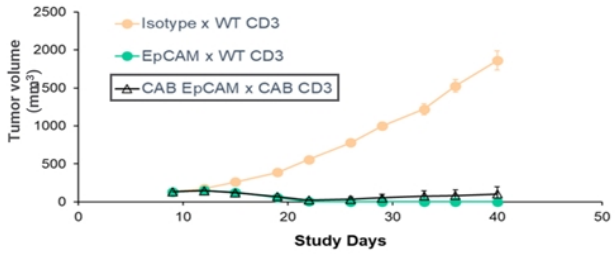
BA3182 – CAB-EpCAMxCAB-CD3 bispecific T-Cell Engager (TCE)

significant opportunity for safe and effective EpCAMxCD3 bispecific

- EpCAM expressed on normal epithelial cells and overexpressed in a wide range of tumors (adenocarcinoma)
- CD3-bispecifics have demonstrated beneficial effects but hampered by dose-limiting toxicity, namely, cytokine release syndrome (CRS)

- BA3182 exhibits efficient tumor shrinkage with superior safety profile
- In non-GLP and GLP tox studies in NHP, dual selection results in high selectivity
  - 160-fold TI increase
  - MTD not reached (5mg/kg highest dose studied=NOAEL)
  - No Cytokine release observed or other EpCAM or CD3 known related toxicities

Tumor shrinkage



MiXeno Model with HCT116 = Colorectal Cancer Cell Line
1mg/kg twice/week in mice (equivalent to 0.25mg/kg in non-human primates)

Safety Profile

WT-EpCAM x WT-CD3
***0.025mg/kg** = 2 ill
***0.05 mg/kg** = 2 expired

Single Dose – non-GLP Toxicity Study

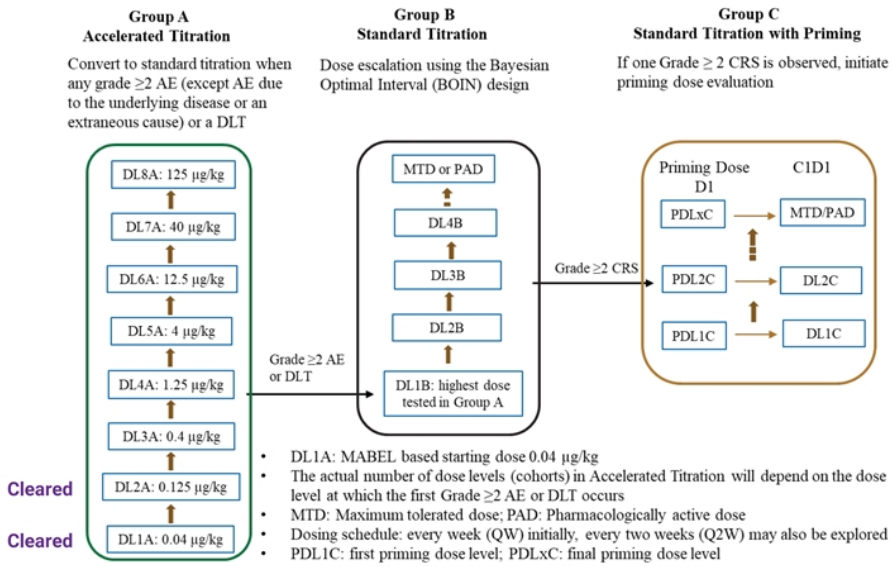
CAB-EpCAM x CAB-CD3 (BA3182)	
***0.25mg/kg**	= 2 normal
***1.0 mg/kg**	= 2 normal
***2.5 mg/kg**	= 2 normal
***2.5 mg/kg**	= 10 normal
***5.0 mg/kg**	= 10 normal

QW x 4 weeks – GLP Toxicity Study

WT = wild type; *from independent experiments
MTD = Maximum Tolerated Dose
TI = Therapeutic Index

FDA cleared IND for CAB-EpCAMxCAB-CD3 bispecific TCE (BA3182)

Phase 1/2 trial design in advanced adenocarcinoma



Part 1:

Up to 128 patients with advanced adenocarcinoma

- Up to 8 patients in the accelerated titration
- Up to 60 in each of the 2-treatment schedules for 10 planned standard titration dose levels

Part 2:

Open-label study to evaluate the efficacy and safety of BA3182 in patients with advanced adenocarcinoma who have a qualifying EpCAM-expressing tumor membrane percent score (TmPS) (to be determined based on Part 1 data).

Key milestones and catalysts throughout 2024

2024	
1H	2H
• BA3071: ○ Evaluate safety and efficacy of BA3071 at 10mg/kg and potentially, 14.2mg/kg dose levels ○ Initial readout Phase 2 in treatment-refractory solid tumors (~20 pts) ○ Demonstrate supportive data as mono- and combo- therapy • BA3011: ○ Confirm clinical benefit in target-agnostic NSCLC patients (~30 pts) ○ Update UPS status • BA3021: Readout final data sets in melanoma (n = ~25 pts) and SCCHN (~20 pts)	• BA3071: ○ Readout additional Phase 2 data in treatment-refractory solid tumors ○ Define pivotal path for BA3071 in treatment-refractory indications • Initiate potentially registrational study with either BA3071 in a solid tumor and/or BA3011 in NSCLC • Establish strategic collaboration for BA3071 and/or one CAB ADC • EpCAM Phase 1 data readout; initiate Phase 2 as data support

BioAtla© is a clinical stage company focused on transforming cancer therapy

with **C**onditionally **A**ctive **B**iologics (CABs)