
Forty Seven
Helping Patients Defeat Their Cancer

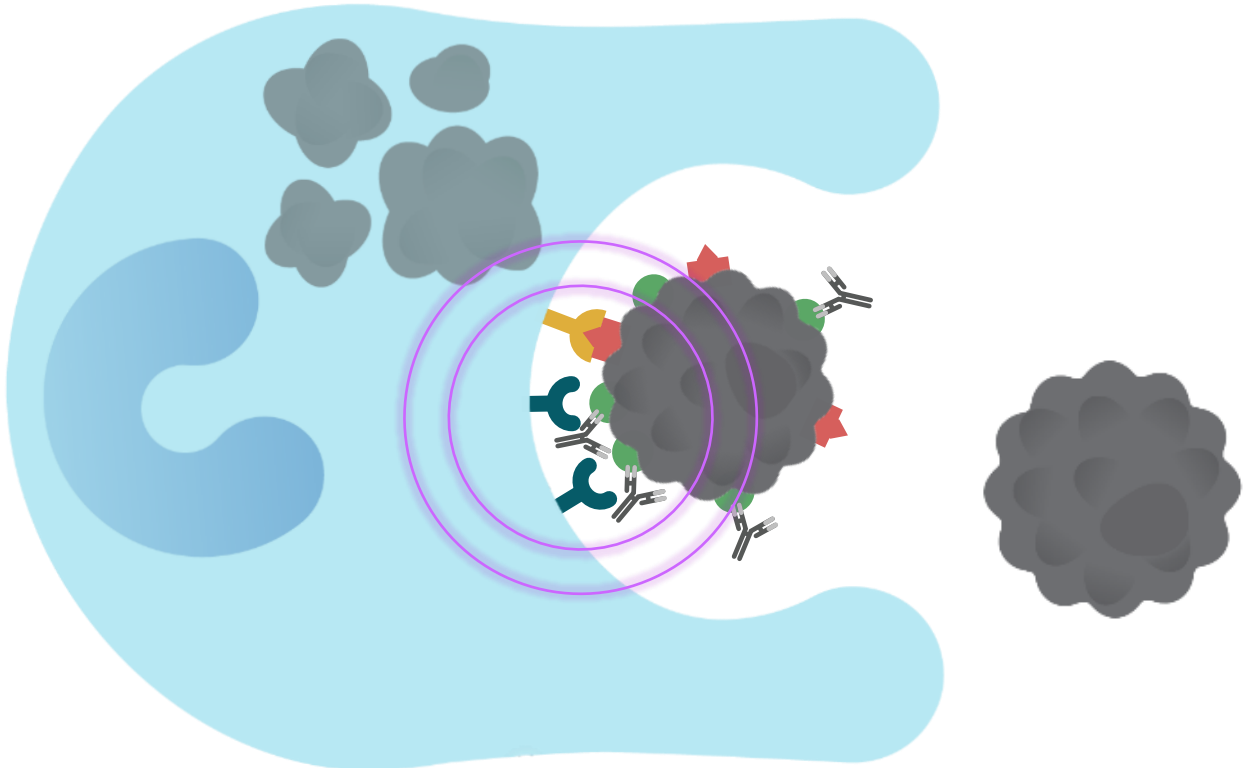
Forward Looking Statements

This presentation contains forward-looking statements that involve substantial risks and uncertainties. All statements other than statements of historical facts contained in this presentation, including statements regarding our future financial condition, results of operations, business strategy and plans, and objectives of management for future operations, as well as statements regarding industry trends, are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as “anticipate,” “believe,” “continue,” “could,” “estimate,” “expect,” “intend,” “may,” “plan,” “potentially” “predict,” “should,” “will” or the negative of these terms or other similar expressions.

We have based these forward-looking statements largely on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. These forward-looking statements are subject to a number of risks, uncertainties and assumptions, including, among other things: the success, cost and timing of our product development activities and clinical trials; our expectations about the timing of achieving regulatory approval and the cost of our development programs; our ability to obtain funding for our operations, including funding necessary to complete further development and commercialization of our product candidates; the commercialization of our product candidates, if approved; our plans to research, develop and commercialize our product candidates; our ability to attract collaborators with development, regulatory and commercialization expertise; our expectations regarding our ability to obtain and maintain intellectual property protection for our product candidates; future agreements with third parties in connection with the commercialization of our product candidates; our ability to maintain, expand, protect and enforce our intellectual property portfolio; our ability to operate our business without infringing, misappropriating or otherwise violating the intellectual property rights of third parties; the size and growth potential of the markets for our product candidates, and our ability to serve those markets; the rate and degree of market acceptance of our product candidates; regulatory developments in the United States and foreign countries; our ability to contract with third-party suppliers and manufacturers and their ability to perform adequately; the success of competing therapies that are or may become available; and our ability to attract and retain key scientific or management personnel. These risks are not exhaustive. New risk factors emerge from time to time and it is not possible for our management to predict all risk factors, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in, or implied by, any forward-looking statements. You should not rely upon forward-looking statements as predictions of future events. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance or achievements. Except as required by law, we undertake no obligation to update publicly any forward-looking statements for any reason after the date of this presentation.

In addition, statements that “we believe” and similar statements reflect our beliefs and opinions on the relevant subject. These statements are based upon information available to us as of the date of this presentation, and while we believe such information forms a reasonable basis for such statements, such information may be limited or incomplete, and our statements should not be read to indicate that we have conducted an exhaustive inquiry into, or review of, all potentially available relevant information. These statements are inherently uncertain and investors are cautioned not to unduly rely upon these statements.

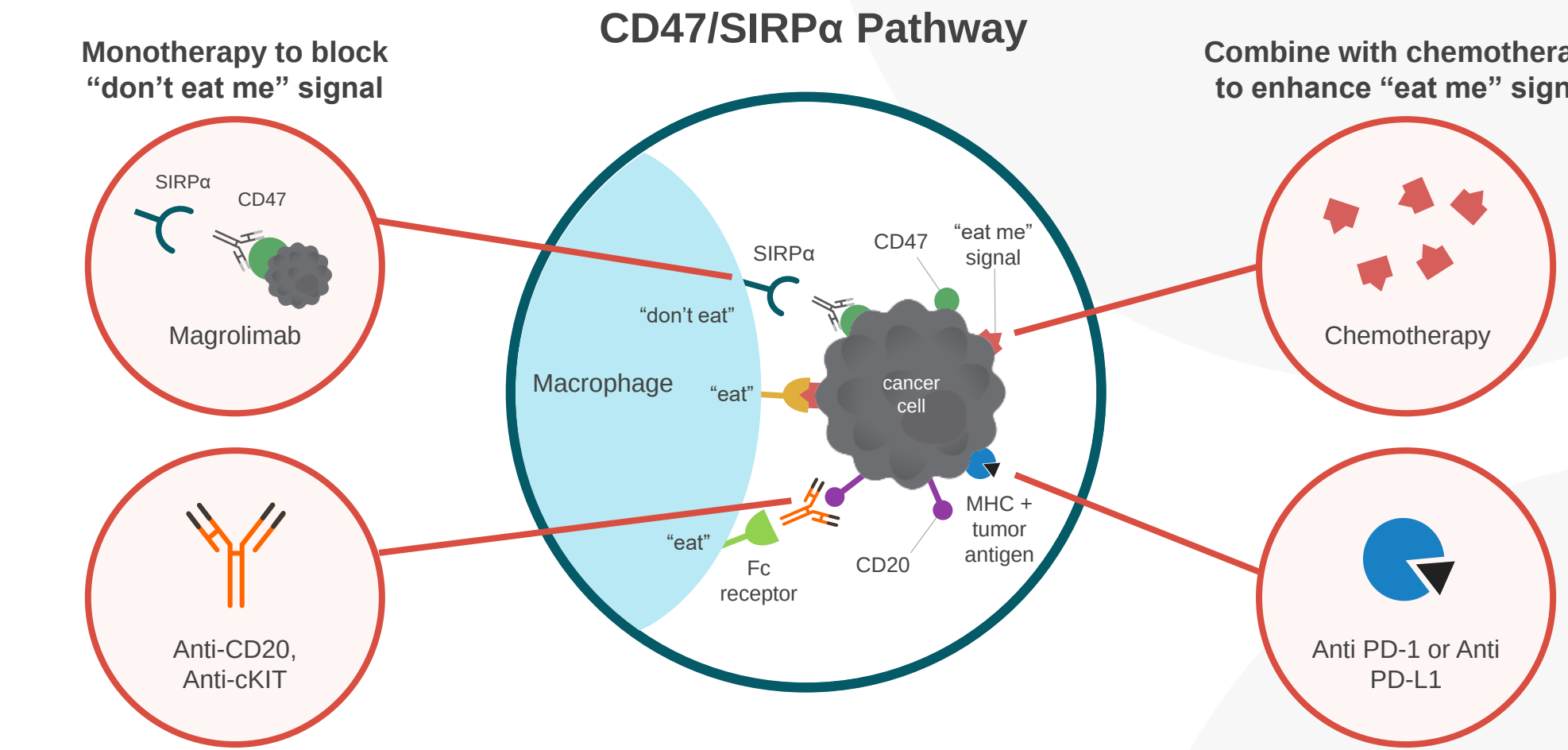
More information about the risks and uncertainties faced by Forty Seven is contained under the caption “Risk Factors” included in the company’s periodic filings with the Securities and Exchange Commission at www.sec.gov. Forty Seven disclaims any intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise.



Forty Seven is activating macrophages, the immune system's first responders to help patients defeat cancer with the engagement of previously unexploited phagocytic pathways.

CD47/SIRPα Pathway Offers Multiple Opportunities to Engage Macrophages

Target cells overexpress CD47 to evade destruction by macrophages



Broad Pipeline Targeting CD47/SIRPα Pathway

MAGROLIMAB*

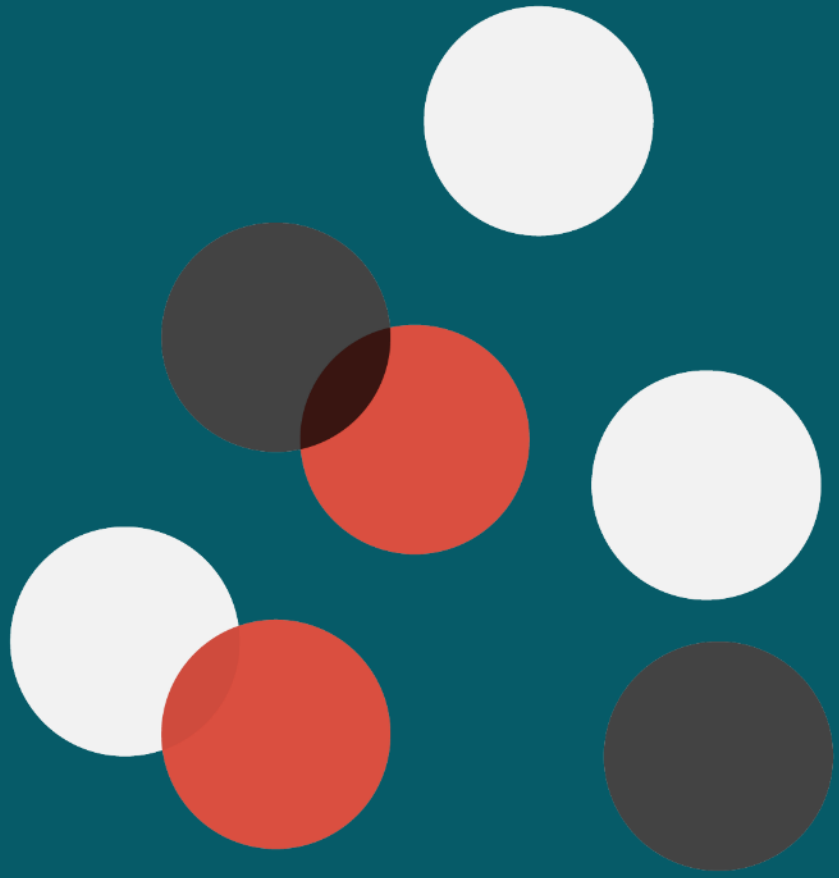
Discovery	Preclinical	Phase 1	Phase 2	Registrational Trial	Clinical Collaborators
Myelodysplastic Syndrome (MDS): *Magrolimab + Azacitidine*					CIRM; Leukemia & Lymphoma Society
Diffuse Large B-Cell Lymphoma (DLBCL): *Magrolimab + Rituximab*					Leukemia & Lymphoma Society
Acute Myeloid Leukemia (AML): *Magrolimab + Azacitidine*					CIRM
AML: *Magrolimab + Atezolizumab*					Roche Genentech
DLBCL: *Magrolimab + Rituximab + Atezolizumab*					Roche Genentech
DLBCL: *Magrolimab + Rituximab + Acalabrutinib*					Acerta Pharma; AstraZeneca
DLBCL: *Magrolimab + Rituximab + Gem/Ox***					
Bladder: *Magrolimab + Atezolizumab*					Roche Genentech
Colorectal: *Magrolimab + Cetuximab*					CIRM; Lilly
Ovarian: *Magrolimab + Avelumab*					Merck

ADDITIONAL PIPELINE PROGRAMS

Discovery	Preclinical	Phase 1	Phase 2	Registrational Trial	Clinical Collaborators
FSI-174: *Anti-cKIT Antibody for HSC Transplantation*					bluebirdbio
FSI-189: *Anti-SIRPα Antibody for Oncology/Non-Oncology*					

** Ono Pharmaceutical has rights to all magrolimab programs in Japan, Taiwan, South Korea and other ASEAN countries | **Expansion arm of ongoing NHL: magrolimab + rituximab trial*

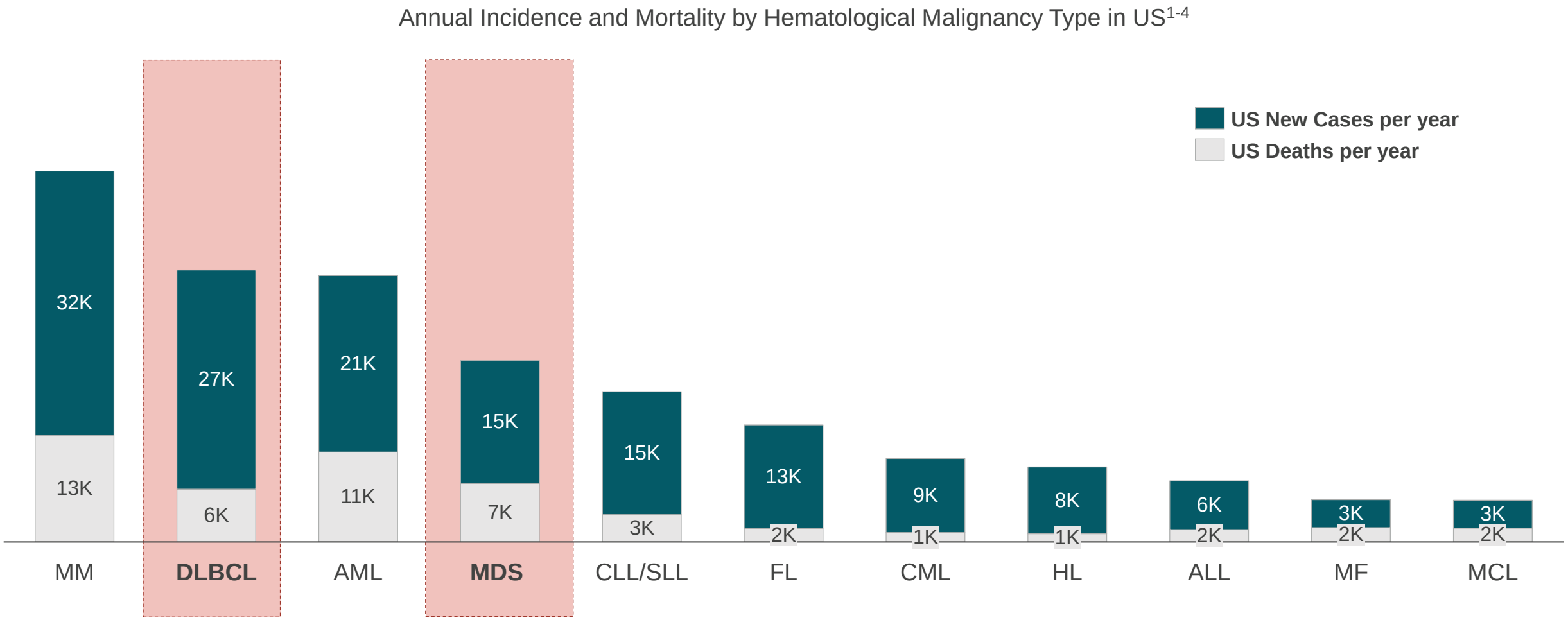
Magrolimab:
Anti-CD47 Antibody



The Value of Magrolimab

- Unique MOA is Synergistic with Other Immunotherapies and Oncolytics, Enhancing Anti-Tumor Response
- Favorable Safety & Tolerability Profile Supports Broad Use in Lower Risk, First Line Patients, as Well as Advanced, Elderly, Fragile Patients
- Fast Track Designation in Four Hematologic Malignancies:
  MDS, AML, DLBCL and FL
- Novel Mechanism and Tolerability Profile Enables Use in Combination with Other Agents

High Burden of Disease For MDS and DLBCL



Note: MDS incidence is underreported to registries (SEER) 14.7K and broader analyses of medical claims reveals >2x higher incidence

[1] National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Cancer Stat Facts,

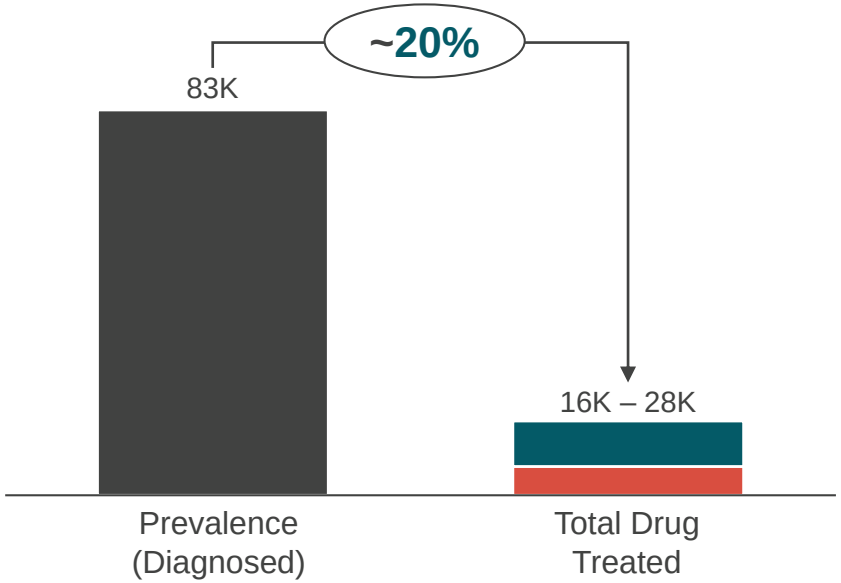
[2] CancerMPact® Patient Metrics (Kantar Health). Available from www.cancermpact.com. Accessed July 2019

[3] CDC Wonder https://wonder.cdc.gov, [4] Cancer statistics www.cancer.net

There is a High Unmet Need in MDS

Low Treatment Rates

US MDS Epidemiology 2018[1-3]



Limited Treatment Options

< 5%	~20%	~75%
Allogeneic Stem Cell Transplant	**Active Therapies** *Vidaza, Dacogen, Revlimid (Low Risk del5q)*	**Supportive Care** or **Watchful Waiting**

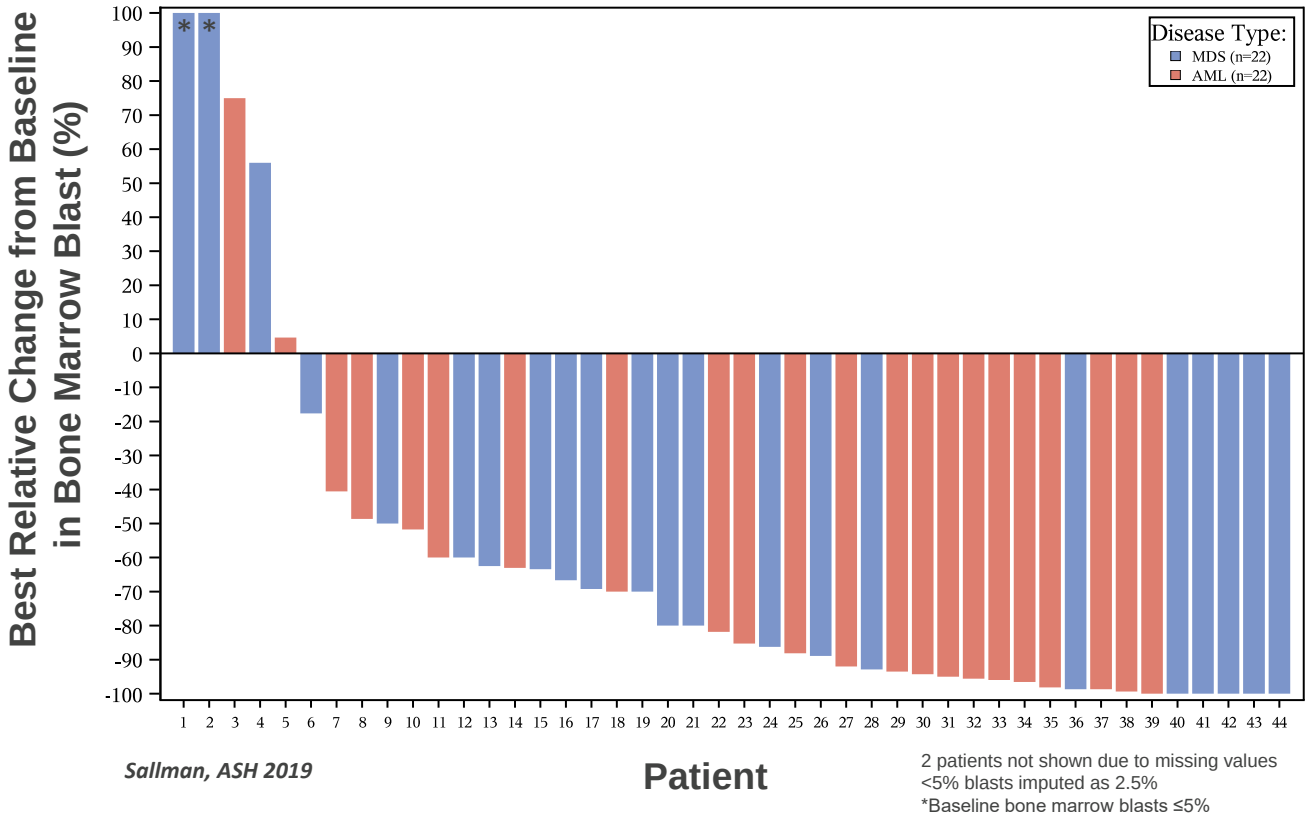
or or

No new therapies approved in over 13 years[5]

1L Higher Risk MDS US Estimated Market Size = $1B - $2B[4]

Source: [1.] CancerMPact® Patient Metrics (Kantar Health). Available from www.cancermpact.com. Accessed July 2019, [2] US MDS prevalence = 50 – 170K based on National Cancer Institute Surveillance, Epidemiology, and End Results – SEER (www.seer.cancer.gov) and Zeidan et al Blood Reviews 2019, [3] Decision Resource Group MDS Report 2019, [4] Estimated Market Size = Total Drug Treated MDS Patients (16K - 28K) x % of Higher Risk MDS (40%) x Average Branded Immuno-Oncology Drug Price ($158K); Average List Price of 7 approved I/O Agents (AnalySource June 2019), [5]Dacogen was last approved therapy for MDS; Package insert (https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/021790s021lbl.pdf) provides original approval date of 2006.

Anti-Leukemic Activity Observed in Patients Treated with Magrolimab and Azacitidine

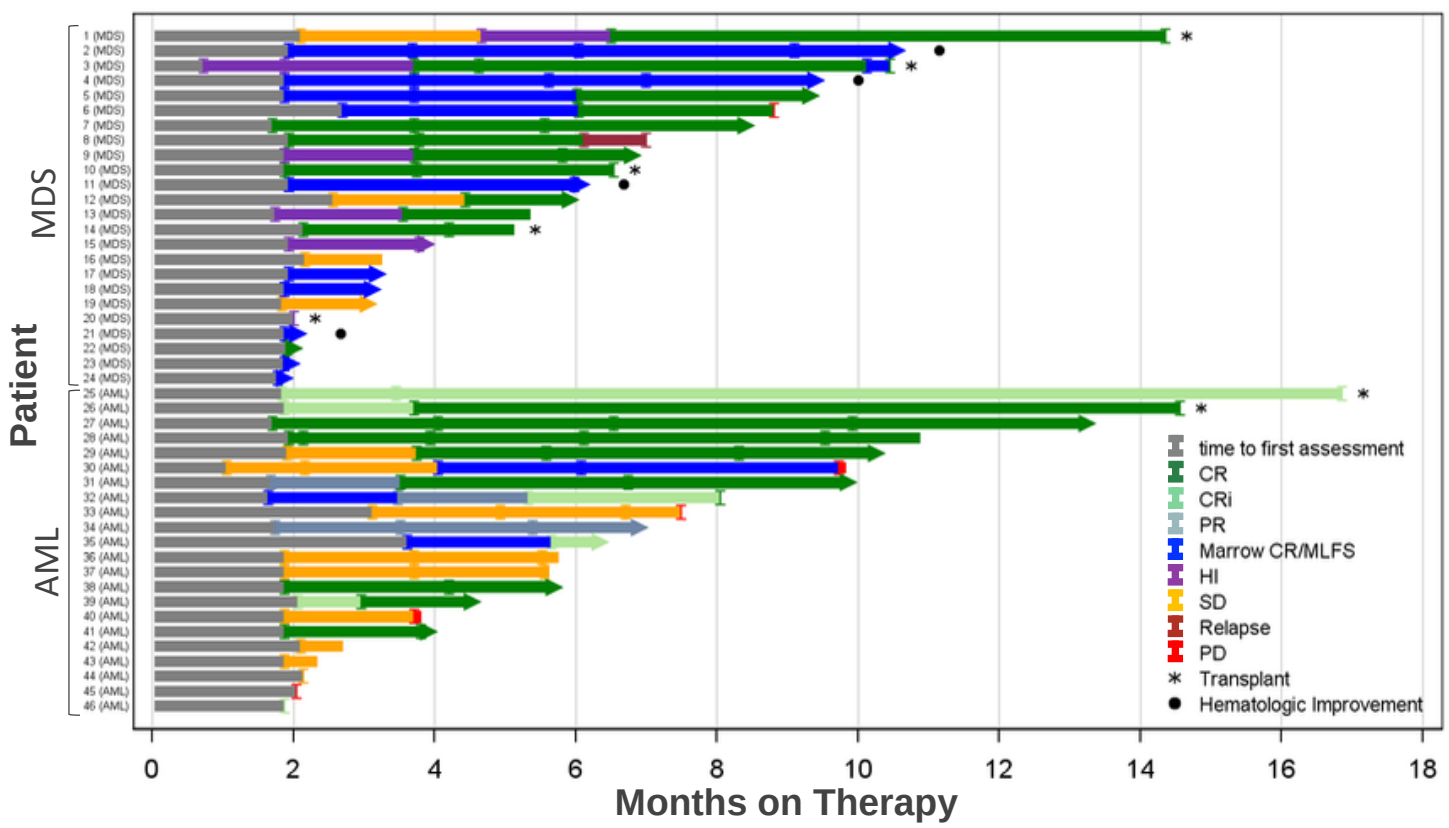


Best Overall Response	1L MDS N=24	1L AML N=22
ORR	22 (92%)	14 (64%)
CR	12 (50%)	9 (41%)
CRi	-	3 (14%)
PR	0	1 (5%)
MLFS/ marrow CR	8 (33%) 4 with marrow CR + HI	1 (5%)
Hematologic improvement	2 (8%)	-
SD	2 (8%)	7 (32%)
PD	0	1 (5%)

Median Time to Response: 1.9 months
which is more rapid than azacitidine alone

Response assessments per 2006 IWG MDS criteria and 2017 AML ELN criteria; Patients with at least one post-treatment response assessment are shown, all other patients are on therapy, too early for first response assessment except for 2 MDS patients not evaluable (withdrawal of consent) and 3 AML (1 AE, 2 PD)
"-" not applicable

Deep and Durable Responses Observed in MDS/AML Patients Treated with Magrolimab and Azaciditine



Parameter	1L MDS N=24	1L AML N=22
RBC transfusion independence[1]	4/9 (44%)	8/11 (73%)
Complete cytogenetic response in responders[2]	5/19 (26%)	6/10 (60%)
MRD negativity in responders	5/22 (23%)	8/14 (57%)
Median duration of response (months)	Not reached (0.03+ − 9.76+)	Not reached (0.03+ − 15.1+)
Median follow-up [range] (months)	6.4 [2.0 − 14.4]	8.8 [1.9 − 16.9]

- 15% of patients (7/46) received an allogeneic stem cell transplant and continue in response
- Median overall survival has not been reached in either MDS or AML patients

Sallman, ASH 2019

Ongoing response post-transplant is shown

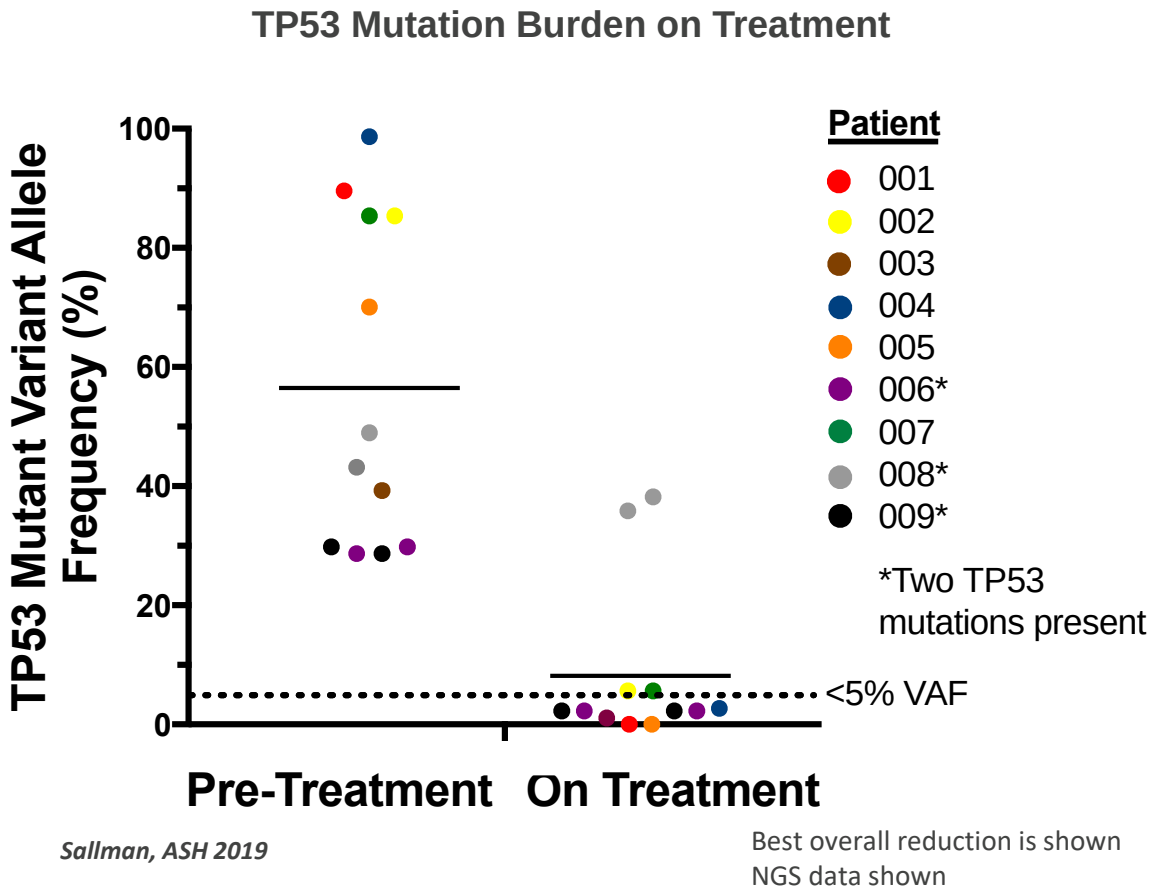
Minimal residual disease (MRD) was evaluated by multiparameter flow cytometry

Cytogenetic response defined per 2003 and 2006 IWG criteria;

[1]Patients shown for those who were RBC transfusion dependent at baseline and achieved RBC transfusion independence at any time on study

[2]Responses shown for all responding patients with abnormal cytogenetics at baseline

Magrolimab and Azacitidine Eliminates Disease in AML Patients with TP53 Mutation



Sallman, ASH 2019

Best overall reduction is shown
NGS data shown

Best Overall Response	AML TP53 Mutant (N=9)
ORR	7 (78%)
CR	4 (44%)
CRi	3 (33%)
Complete cytogenetic response in responders*	4/6 (67%)
MRD negative of responders	4/7 (57%)
Median duration of response (months)	Not reached (0.03+ − 15.1+)
Median overall survival (months)	Not reached (3.8+ − 16.9+)
Median follow-up [range] (months)	6.9 [1.9 − 16.9]

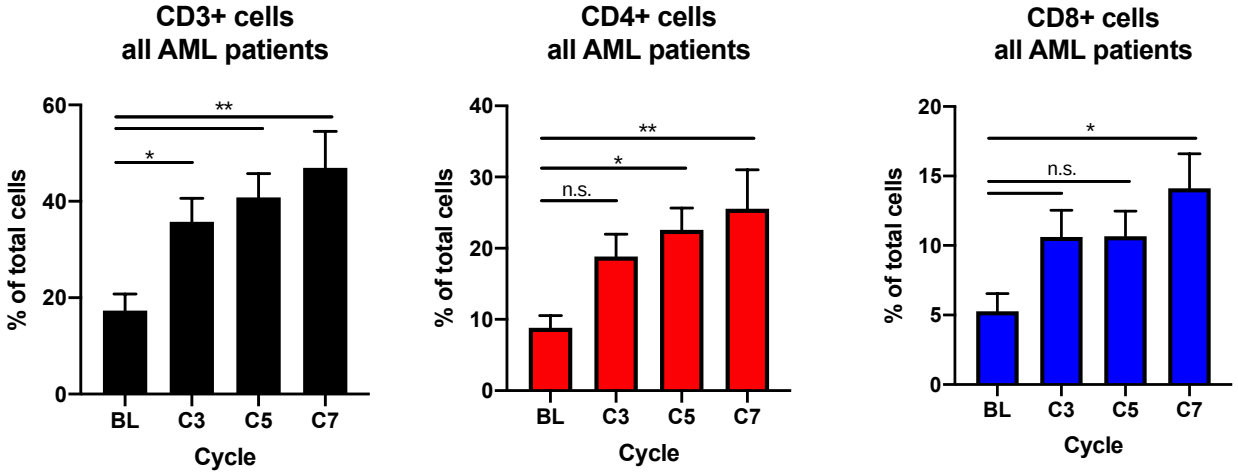
TP53 mutational burden is reduced in AML patients on therapy

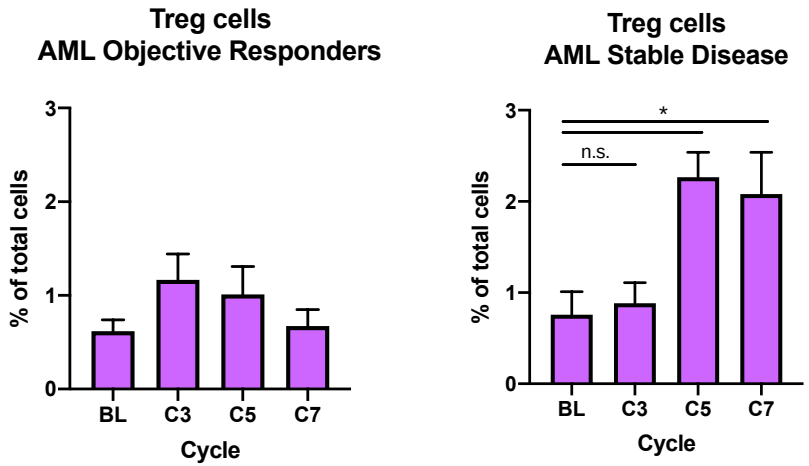
*For patients with abnormal cytogenetics at baseline

Increased T Cell Infiltration Suggests Magrolimab Drives an Adaptive Immune Response

Data produced in collaboration with the Immunotherapy Platform at MD Anderson Cancer Center

THE UNIVERSITY OF TEXAS MD Anderson Cancer Center





Sallman, ASH 2019

Data suggest the opportunity for combinations with checkpoint inhibitors

- In AML patients, an increase in total T cells, CD4+ cells and CD8+ cells is observed in the bone marrow
- Patients with stable disease show significantly elevated Treg levels
- Additional analyses ongoing

Registration Strategy for Magrolimab and Azacitidine in Higher Risk MDS

Two Distinct Opportunities for Accelerated Approval

- Enrolling approximately 90 patients in ongoing Phase 1b trial evaluating every two week dosing

  Completion of enrollment expected 3Q 2020

- Plan to initiate ENHANCE, a randomized, Phase 3 trial in 180 patients to support potential full and ex-U.S. approval

  Trial initiation expected 1H 2020

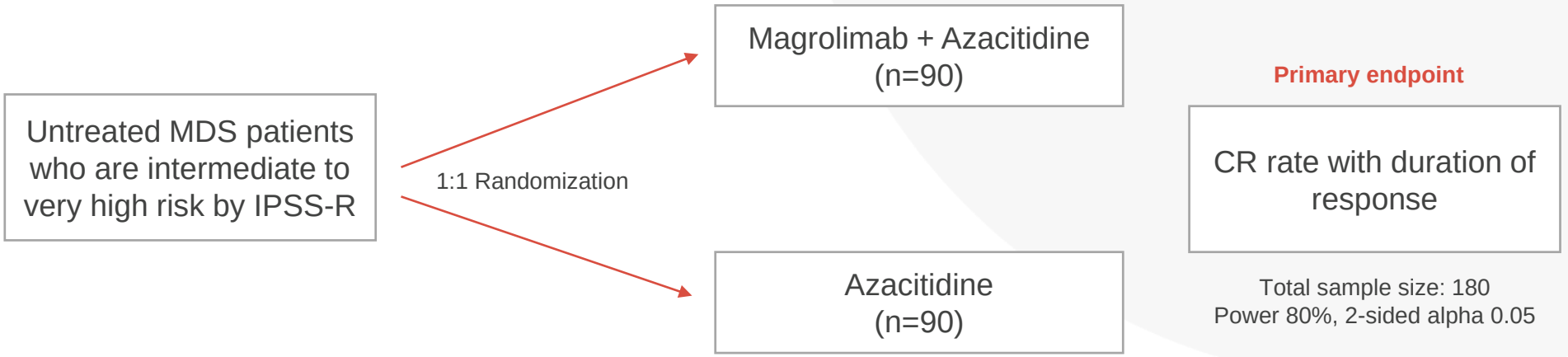
- Phase 1b trial and ENHANCE will share same primary endpoint: CR with duration of response

- Clinical and CMC-enabling activities ongoing

  Allow for BLA submission as early as 4Q 2021
  relying on single arm trial

- Continuing to enroll AML patients with TP53 mutant disease in ongoing Phase 1b trial

ENHANCE: A Randomized, Phase 3 Trial in 1L Higher Risk MDS

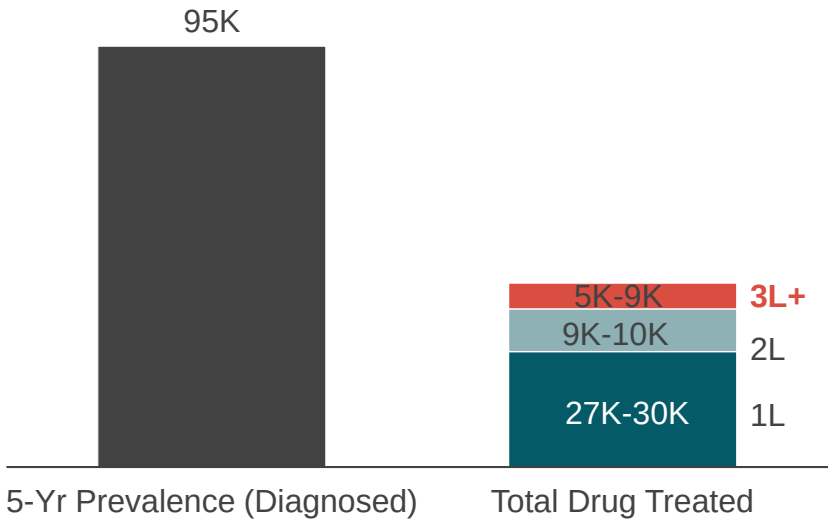


Primary Endpoint: CR rate with duration of response	**Primary Analysis**: CR / duration of response at 180 patients
Key Secondary Endpoint: Overall survival	**Pre-specified modification of sample size:** Based on the ongoing Phase 1b study and emerging data, the trial sample size can be modified to evaluate an overall survival endpoint for full approval and ex-U.S. approval

Addressing High Unmet Needs in R/R DLBCL

Substantial Relapsed / Refractory Population

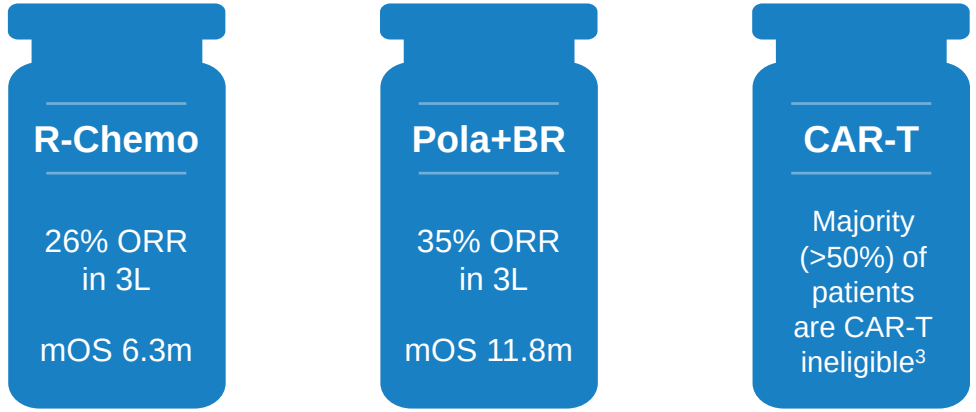
US DLBCL Epidemiology 2018[1,2]



35-40% of total treated patients are either Relapsed or Refractory to a prior treatment

High Unmet Needs in 3L+

DLBCL 3L+ Treatment Options[3-5]

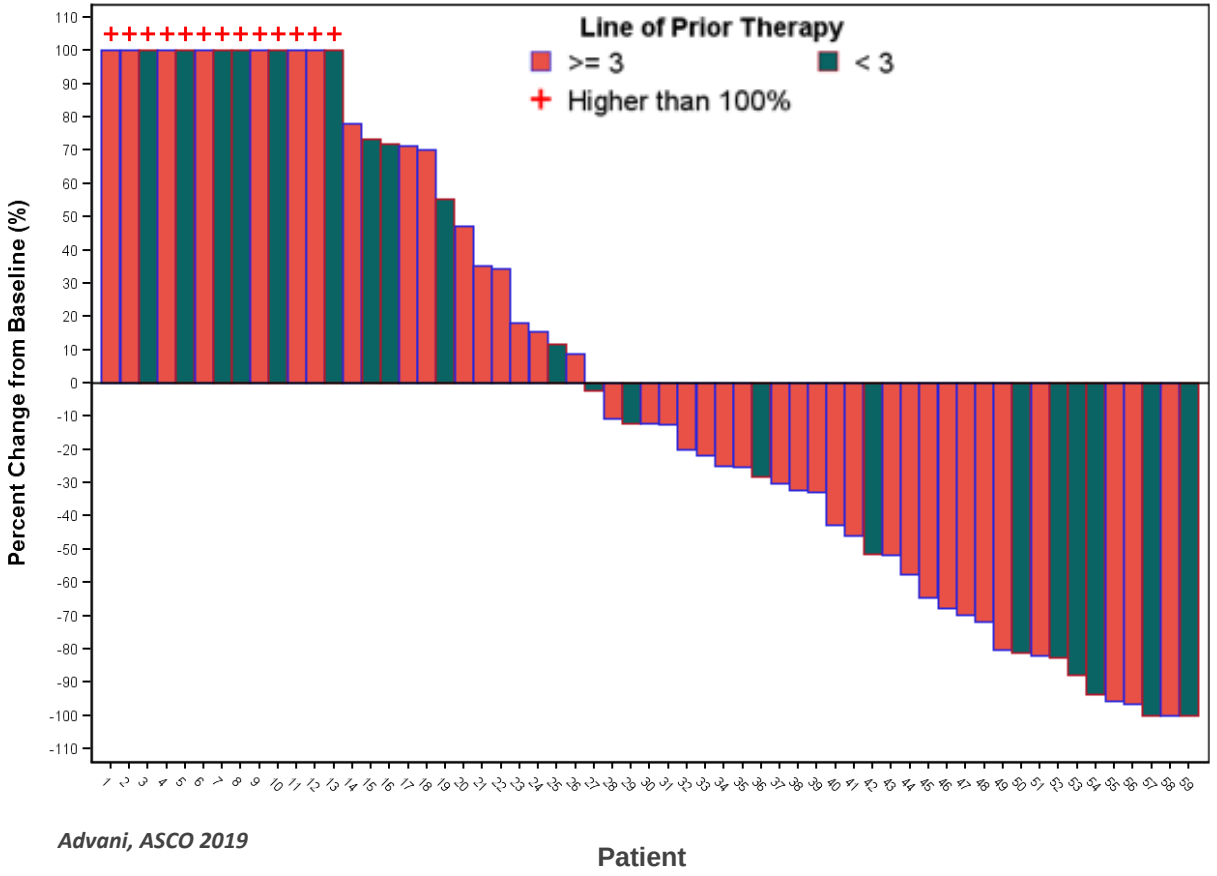


- **Substantial drop off in efficacy in later lines of therapy**
- **Chemo and CAR-T based regimens have high toxicity**

3L+ DLBCL US Estimated Market Size = $1B - $1.5B[6]

Source: [1.] CancerMPact® Patient Metrics (Kantar Health). Available from www.cancermpact.com. Accessed May 2018, [2] DRG 2019 DLBCL report, [3] Company market research 2019, [4] Crump et al. Blood 2017, [5] Polivy Package Insert & ASCO 2018, [6] Estimated Market Size = Total Drug Treated DLBCL 3L+ Patients (5K - 9K) x Average Branded Immuno-Oncology Drug Price ($158K); Average List Price of 7 approved I/O Agents (AnalySource June 2019)

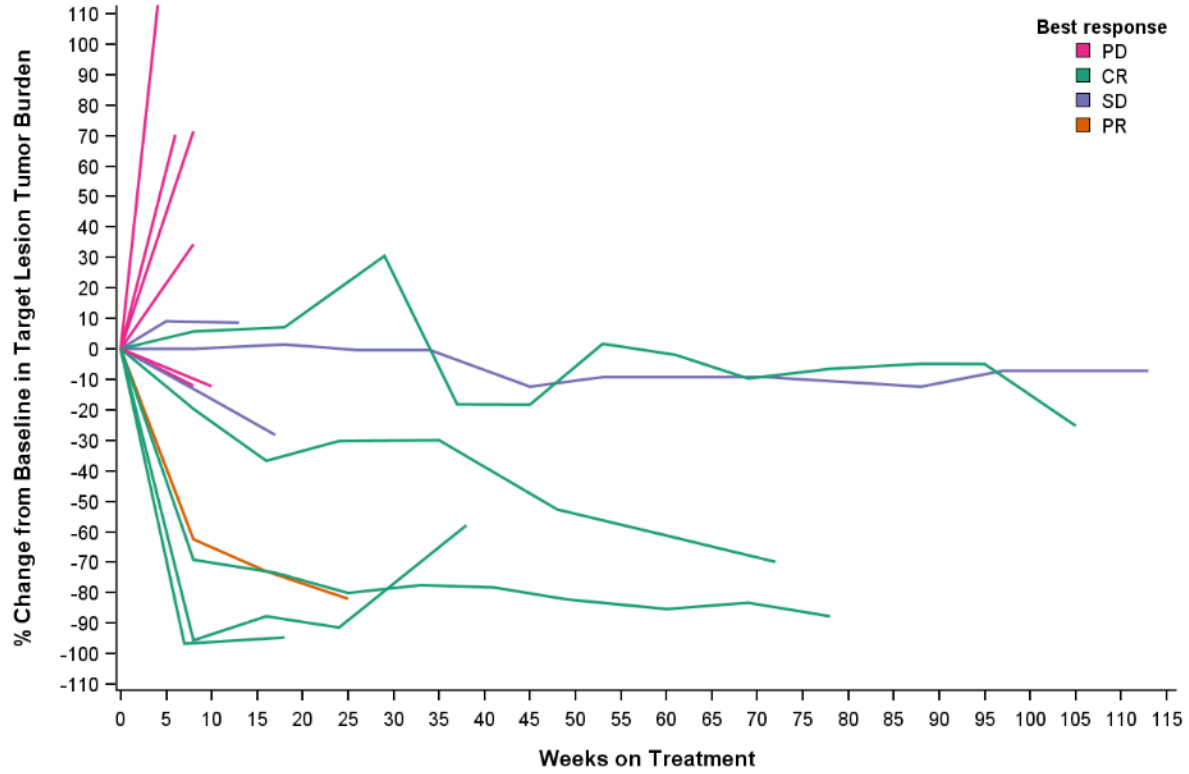
Magrolimab + Rituximab Combination Shows Clinical Activity in Heavily Pre-Treated DLBCL Patients



Advani, ASCO 2019

Best Overall Response	Total DLBCL N=59 (%)	≥3 lines of therapy N=39 (%)
ORR	21 (36)	15 (38)
CR	9 (15)	7 (18)
PR	12 (20)	8 (20)
SD	7 (12)	4 (10)
PD	31 (53)	20 (51)

Durable Responses Observed in Phase 1b DLBCL Patients Treated with Magrolimab and Rituximab



[1]*These plots show data from 15 Phase 1b patients as of May 2019, includes patients treated at 5F9 ≤ 30 mg/kg*
6 patients treated at 45 mg/kg in Ph1b not shown given early follow-up.

Phase 1b: Median Duration of Response Not Reached

- Median follow-up over 13.8 months
- 2 patients converted from PR to CR
- 3 patients with ongoing CRs (16+, 17+ and 24+ months)
- 1 patient with ongoing SD (24+ months)

Advani, ASCO 2019

Registration Strategy for Magrolimab and Rituximab in DLBCL

Potential Single Arm Path to Accelerated Approval Discussed in FDA Type C Meeting, May 2019

- FDA feedback indicates potential pathway for single arm registrational trial of magrolimab and rituximab in heavily pre-treated r/r DLBCL patients, based on ORR and durability of response
- Anticipated sample size of 100 patients with six months efficacy follow-up

Registration Plan

Defined enrollment criteria for registration enabling trial:

- Patients who have failed ≥2 prior lines of therapy

Continuing to evaluate biomarkers for options to advance into earlier lines of treatment

Trial initiation expected 1Q 2020

Initial efficacy data expected 4Q 2020

Magrolimab is Well-Tolerated Alone or In Combination

Over 400 patients treated across clinical programs

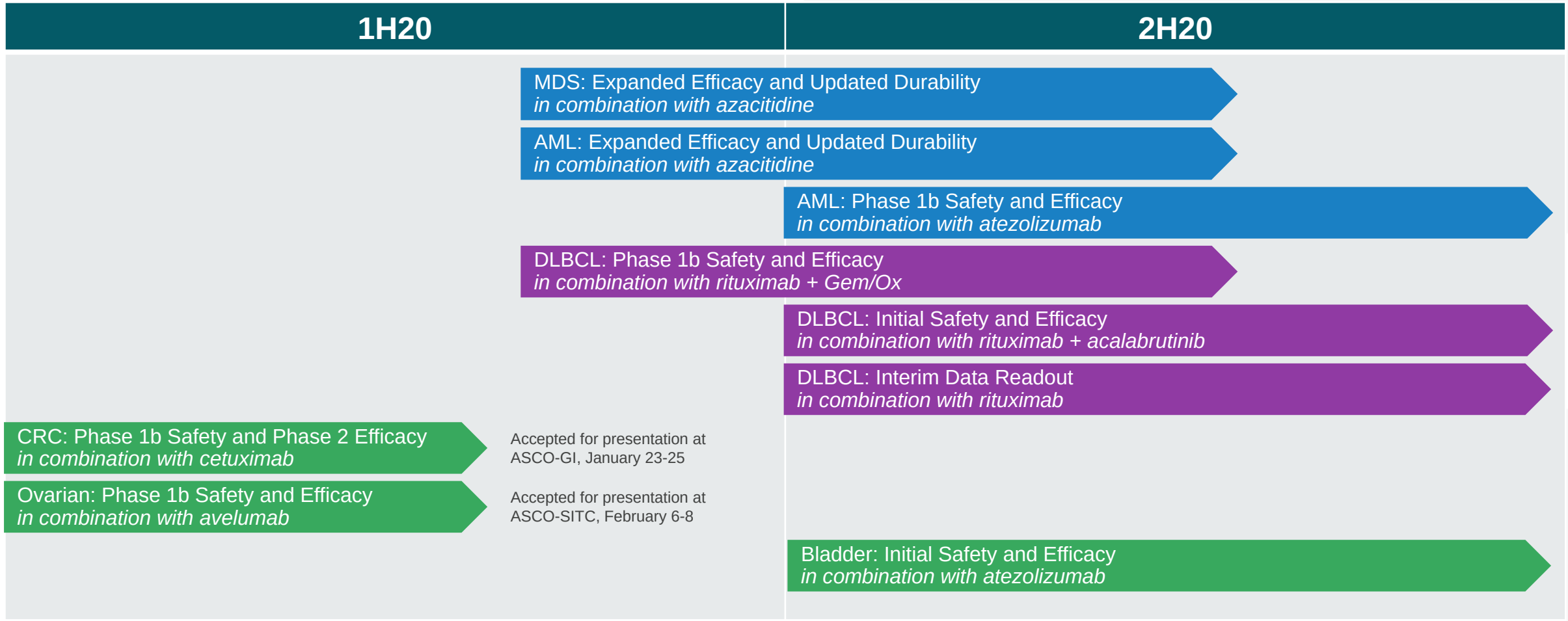
Safety Profile Supports Use in:

- Advanced, elderly, fragile patients
- Early-line and low-risk patients
- Combination with other therapies

No Maximum Tolerated Dose Reached with up to 45 mg/kg Dosing

- Most observed adverse events are Grade 1 or 2
- Most common adverse events are on-target anemia, infusion reactions and related symptoms (fever, chills, headache)
- No significant cytopenias, infections, or autoimmune adverse events observed
- Treatment discontinuation due to adverse event:
  - 7% (8/115) NHL patients
  - 1.6% (1/62) MDS or AML patients

Magrolimab Expected Data Readouts Through 2020



Magrolimab: Development Strategy

Demonstrate clinical value for high unmet needs, and expand into broader patient populations

NEAR-TERM FOCUS

HIGH UNMET NEED FAST TO MARKET

MDS 1L, Higher Risk

DLBCL 3L+

EXPAND TO BROADER PATIENT POPULATIONS

MDS

- Lower Risk
- Relapsed/Refractory

DLBCL 2L+

AML

- 1L Unfit,
- 1L Unfit TP53 Mutant
- Relapsed/Refractory

ONCOLOGY & BEYOND

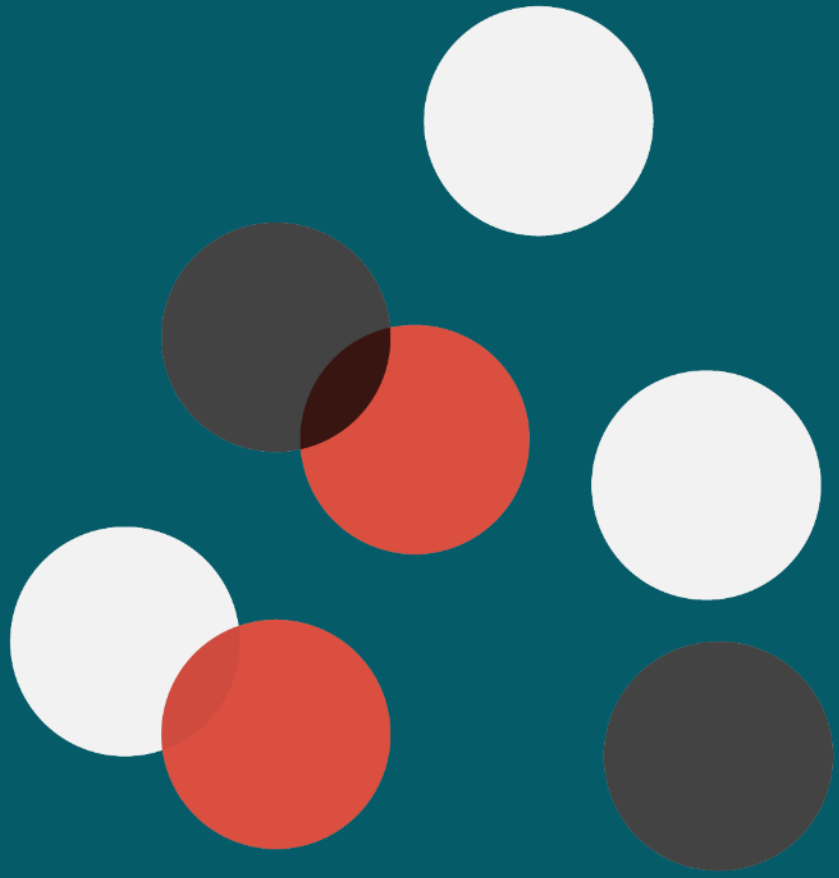
Follicular Lymphoma

Solid Tumors

Conditioning for HSCTs and GT

Near-term → **Mid-term** → **Long-term**

Emerging Pipeline Programs



FSI-174: A Humanized Anti-cKIT Antibody

cKIT is expressed on hematopoietic stem cells (HSCs); combination with magrolimab enhances phagocytosis of targeted HSCs

- Binds Both Human and Monkey cKIT with High Affinities
- Blocks Stem Cell Factor Signaling and Induces Antibody-Dependent Cell Phagocytosis, Cytotoxicity and Complement-Dependent Cytotoxicity with Active IgG1
- Combination of FSI-174 and Magrolimab Depleted HSCs from Bone Marrow with No Dose-Limiting Toxicities in Preclinical NHP Studies
- Has a Favorable Pharmacodynamic Profile in Preclinical NHP Studies

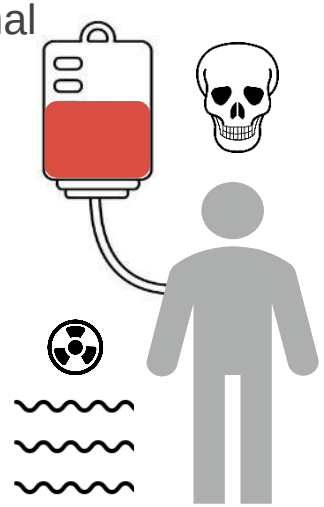
Hazards of Conditioning Limit Benefits of Hematopoietic Stem Cell Transplantation

Conditioning

Goal: Kill endogenous hematopoietic stem cells (HSC) with chemotherapy and/or radiation to make space for transplanted cells

Challenge: Highly toxic procedure that:

- Requires prolonged hospitalization
- Causes collateral damage to normal tissues, resulting in:
  - Impaired brain development
  - Infertility / endocrine dysfunction
  - Secondary malignancies
  - Organ damage
  - Cognitive decline
- Requires immune suppression
- Can cause graft vs. host disease or severe threatening infections

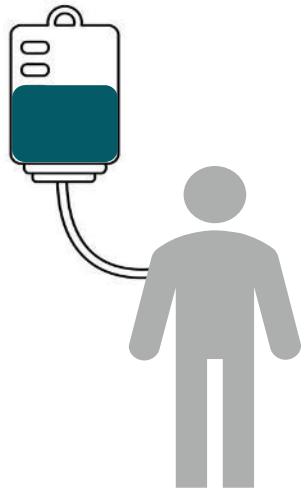


Transplantation

Goal: Replace patient's HSCs with **allogeneic** stem cells (from a healthy donor) or **autologous** stem cells (patients' own cells with or without gene therapy correction).

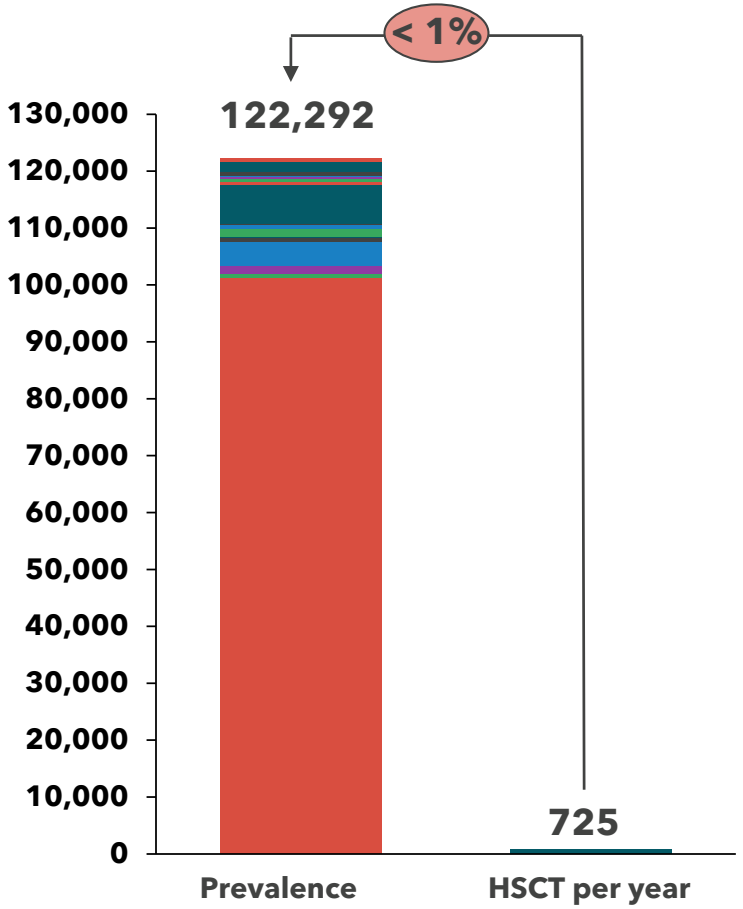
Successful transplantation may:

- Cure genetic blood diseases (in combination with gene therapy)
- Cure autoimmune diseases by generating a new, healthy immune cell pool
- Enable organ transplantation without need for chronic immune suppression



Given Risks of Current Conditioning Regimens, Fewer than 1% of Patients Receive Hematopoietic Stem Cell Transplants

Non-Malignant Diseases That Could be Treated with Hematopoietic Stem Cell Transplantation



- Chronic granulomatous disease
- Leukocyte adhesion deficiency
- Hemophagocytic lymphohistiocytosis
- X-linked hyper igM syndrome
- X-linked lymphoproliferative dis.
- X-linked agammaglobulinemia
- Common variable deficiency
- SCID
- B-Thalassemia
- Sickle cell disease
- Kostmann's syndrome
- Shwachman-Diamond syndrome
- Fanconi Anemia
- Osteopetrosis
- Metachromatic leukodystrophy
- X-linked adrenoleukodystrophy
- Mucopolysaccharidoses
- Gaucher disease
- Wiskott-Aldrich syndrome

Our Solution: All-Antibody Based Regimen Combining FSI-174 and Magrolimab

Science-driven Approach to Overcome Risks and Limitations of Existing Regimen

- Selective antibody-mediated depletion of Hematopoietic Stem Cells (HSCs) without affecting other normal cells
- Selective and short-term antibody-mediated immune suppression to prevent rejection of donor HSCs without causing broad and long-term immune cell depletion leading to life-threatening infections

Pursuing Broad Development Program

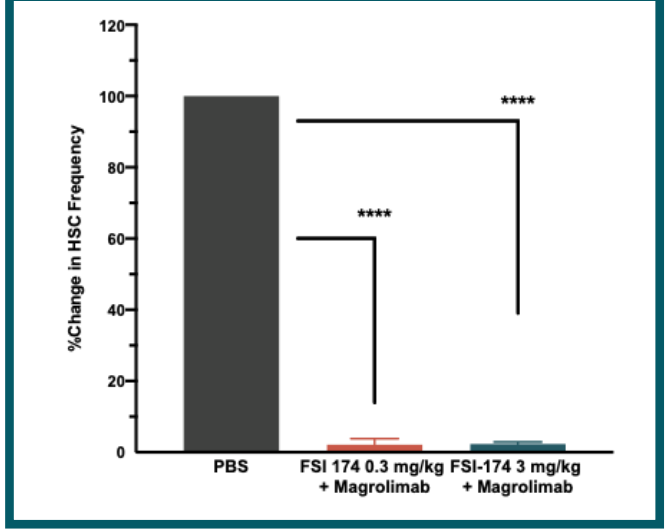
- Plan to initiate Phase 1 clinical trial in 1Q 2020 evaluating safety and tolerability of FSI-174 in healthy volunteers
- Partnership with bluebird bio to evaluate FSI-174 + magrolimab in combination with autologous lentiviral vector hematopoietic stem cell gene therapy – announced November 2019

bluebirdbio
recode for life™

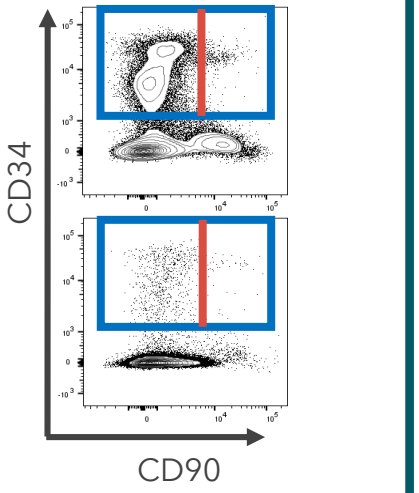
Preclinical Data Support Development of FSI-174 and Magrolimab as Novel, All Antibody Conditioning Regimen

Combination of FSI-174 and Magrolimab depleted HSCs from bone marrow in preclinical NHP studies

HSC Depletion



Bone Marrow Cytograms



Marjon, ASH 2019

FSI-174 has a favorable pharmacodynamic profile in preclinical NHP studies

- 100% cKIT receptor occupancy on HSCs was achieved with all dose levels (0.3, 1, 3 mg/kg)
- FSI-174 (0.3mg/kg) was washed out within 1 week while depletion of endogenous HSCs was sustained
- Opportunity for transplantation of HSCs within 1-2 weeks after antibody conditioning

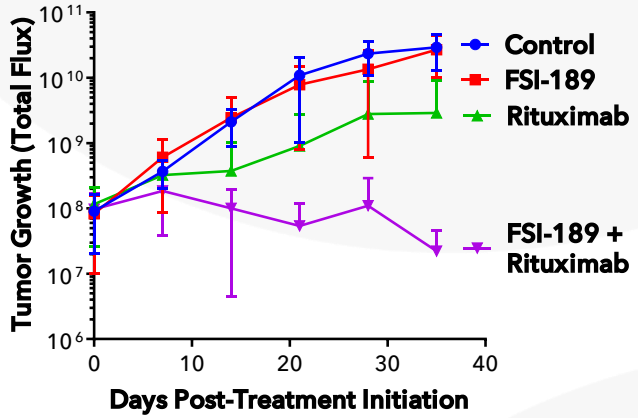
FSI-174 is well-tolerated in preclinical NHP studies

- Well tolerated with no evidence of mast cell degranulation or lymphopenia
- No observed adverse effect level at the highest dose (50 mg/kg)

FSI-189: anti-SIRPα Antibody

IND filing expected 1Q 2020 and Phase 1 trial expected to initiate 2Q 2020

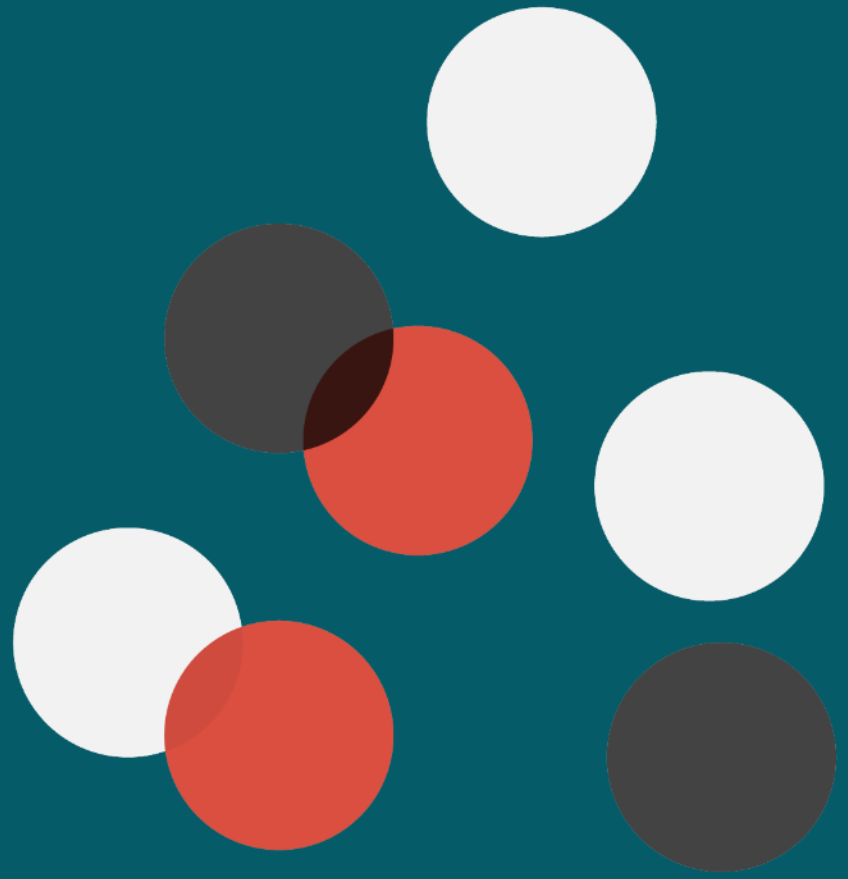
- Opportunity for a CD47- SIRPα therapy with
  - Lower antigen sink
  - Lower dose level
  - Improved dosing convenience
  - Lower cost of goods
- Plan to develop FSI-189 for oncology and non-oncology, including stem cell transplantation in combination with a cKIT antibody
- FSI-189 in combination with Rituximab enhances clearance of Non-Hodgkin's lymphoma and prolongs survival in mouse model



Benefits of FSI-189

- Binds both major SIRPα allelic variants
- Selectively binds SIRPα over SIRPγ
- Designed with inactivated Fc to prevent Fc receptor binding on macrophages that can inhibit phagocytic potency

Corporate



Highly Experienced Management Team and Advisors

Management Team

Mark McCamish, M.D., Ph.D. *President & Chief Executive Officer*	Sandoz a Novartis company; PDL BioPharma; Amgen; Abbott
Chris Takimoto M.D., Ph.D. *Chief Medical Officer*	Janssen Pharmaceutical Companies of Johnson & Johnson; START Center for Cancer Care; NIH National Cancer Institute
Ann Rhoads, M.B.A. *Chief Financial Officer*	Zogenix; Premier
Craig Gibbs, Ph.D., M.B.A. *Chief Business Officer*	Tobira Therapeutics; Gilead; Genentech
Norm Kruse, J.D., Ph.D. *Chief Patent Counsel*	verinata Health; maxygen; Chiron; Kilpatrick Townsend
Kyle Elrod *SVP of Corporate Planning & Operations*	virobay; life technologies; Celera; Axys
Mark Chao, M.D., Ph.D. *VP of Clinical Development*	Stanford School of Medicine
Jens-Peter Volkmer, M.D. *VP of Research & Early Development*	Stanford School of Medicine; Heinrich Heine Universität Düsseldorf
Mukul Agarwal, M.S., M.B.A. *VP of Corporate Development*	revance; Anacor Pharmaceuticals; Allergan; MedImmune; gsk GlaxoSmithKline
Aimee Murphy *VP of Clinical Operations*	Aduro Biotech; Cerus
Qinghai Zhao, Ph.D. *VP of Technical Development & Manufacturing*	AnaptysBio; NGMBio; Teva Pharmaceutical Industries Ltd.; Human Genome Sciences

Scientific Advisory Board

 **James Allison, Ph.D.**	Chair, Department of Immunology, Director, Parker Institute for Cancer Research, and Executive Director, Immunotherapy Platform at the University of Texas MD Anderson Cancer Center; Winner, 2018 Nobel Prize in Physiology or Medicine
 **Ronald Levy, M.D.**	Professor of Medicine at Stanford University School of Medicine
 **Padmanee Sharma, M.D., Ph.D.**	Professor, Department of Genitourinary Medical Oncology and Department of Immunology, Division of Cancer Medicine at the University of Texas MD Anderson Cancer Center, Scientific Director, Immunotherapy Platform and Co-Director of the Parker Institute for Cancer Immunotherapy at MD Anderson Cancer Center
 **Louis Weiner, M.D.**	Director, Georgetown Lombardi Comprehensive Cancer Center and Professor and Chair, Department of Oncology, at Georgetown University Medical Center

Board of Directors

Mark McCamish, M.D., Ph.D.	**Forty Seven, Inc.**	**Dennis Henner, Ph.D.**	**Blackstone Life Sciences (formerly Clarus)**
Kristine Ball, C.P.A.	**Menlo Therapeutics**	**Ravi Majeti, M.D., Ph.D.**	**Stanford School of Medicine**
Jeff Bird, M.D., Ph.D.	**Sutter Hill Ventures**	**Irving Weissman, M.D.**	**Stanford School of Medicine**
Ian Clark	**Former Genentech CEO**		

Robust Intellectual Property Rights Covering CD47, SIRPα, cKIT and Other Immunomodulatory Compounds

- Have license to approximately **187** issued patents worldwide, including 35 issued U.S. patents, and approximately 152 pending patent applications
- Magrolimab and FSI-189 are protected by multiple patent positions
  - Antibody and drug product composition
  - Methods of use – monotherapy and combination
  - Methods of use – proprietary prime and maintenance dose strategy
    - Patents granted in the U.S., Europe, Japan; expiration date 2034, excluding patient term extensions
  - Proprietary structure of anti-SIRPα antibodies to prevent inhibition of phagocytosis (Scorpion effect) – patent application filed
- FSI-174 patent applications filed
  - Antibody and drug product composition
  - Methods of use – for autologous and allogeneic HSC transplantation, including gene therapy indications

Cash Expected to be Sufficient to Fund Current Operations into Q1 2022

Cash, Cash Equivalents and Short Term Investments *as of 12/31/2019*	**$329.1 million**[1]
Common Stock Outstanding *as of 12/31/2019*	**47,983,366**

Raised **$195.6 million in gross proceeds** in December 2019 underwritten public offering to:

- Further clinical development of magrolimab towards a BLA submission, including funding of registrational studies in MDS and DLBCL as well as BLA-enabling CMC activities
- Further development of FSI-174, our anti-cKIT antibody, and FSI-189, our anti-SIRPα antibody

1. Based on preliminary estimates

Significant Development Progress Expected in 2020

Magrolimab
MDS

- Initiate Phase 3 ENHANCE trial evaluating magrolimab + azacitidine vs. azacitidine in untreated, higher-risk MDS in 2Q 2020
- Present updated data from ongoing Phase 1b trial of magrolimab + azacitidine in MDS in mid-2020
- Complete enrollment in ongoing Phase 1b trial in 3Q 2020

Magrolimab
DLBCL

- Initiate Phase 3 trial evaluating magrolimab + rituximab in heavily pre-treated, r/r DLBCL in 1Q 2020
- Present initial data from Phase 3 trial in 4Q 2020

Magrolimab
AML

- Present updated data from ongoing Phase 1b trial of magrolimab + azacitidine in AML in mid-2020
- Expand enrollment in ongoing Phase 1b trial of magrolimab and azacitidine in TP53 mutant AML patients

Magrolimab
Solid Tumors

- Present data from Phase 1b/2 trials in CRC and ovarian cancer in 1Q 2020
- While these data do not support a registration pathway, data will be used to identify next steps in solid tumors

FSI-174
anti-cKIT

- Initiate Phase 1 trial in healthy volunteers in 1Q 2020

FSI-189
anti-SIRPα

- File IND with FDA in 1Q 2020
- Initiate Phase 1 trial in oncology indications in 2Q 2020

Our Foundation

Forty Seven is built on a culture of scientific rigor and passion for helping people to live fuller, healthier lives. This is seen in our actions and every decision we make.