

ZIOPHARM ONCOLOGY INC
Form 10-Q
May 10, 2016
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

(Mark One)

QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended March 31, 2016

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

Commission File Number 001-33038

ZIOPHARM Oncology, Inc.

(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of
incorporation or organization)
One First Avenue, Parris Building 34, Navy Yard Plaza
Boston, Massachusetts 02129
(617) 259-1970
(Address, including zip code, and telephone number, including
area code, of registrant's principal executive offices)

84-1475642
(I.R.S. Employer
Identification No.)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes: No:

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes: No:

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or smaller reporting company. See the definitions of large accelerated filer, accelerated filer, and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

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Large accelerated filer Accelerated filer
Non-accelerated filer (Do not check if a smaller reporting company) Smaller reporting company
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes: No:

The number of shares of the registrant's common stock, \$0.001 par value, outstanding as of April 26, 2016, was 131,840,428 shares.

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ZIOPHARM Oncology, Inc.

NOTE REGARDING FORWARD-LOOKING STATEMENTS

This report contains forward-looking statements that are based on our current beliefs and expectations. These forward-looking statements may be accompanied by such words as anticipate, believe, estimate, expect, forecast, intend, may, plan, project, target, will and other words and terms of similar meaning. Reference is made in part to forward-looking statements regarding:

our ability to finance our operations and business initiatives;

the sufficiency of our cash, investments and our expected uses of cash;

the costs and timing of the development and commercialization of our products;

additional planned regulatory filings for the approval and commercialization of our immuno-oncology y product candidates;

whether any of our other therapeutic discovery and development efforts will advance further in pre-clinical research or in the clinical trial process and whether and when, if at all, our product candidates will receive final approval from the U.S. Food and Drug Administration or equivalent foreign regulatory agencies and for which indications;

whether any other therapeutic products we develop will be successfully marketed if approved;

our ability to achieve the results contemplated by our collaboration agreements;

competition from other pharmaceutical and biotechnology companies;

the development of, and our ability to take advantage of, the market for our therapeutic products;

the anticipated amount, timing and accounting of deferred revenues, milestone and other payments under licensing, collaboration or acquisition agreements, research and development costs and other expenses;

the strength and enforceability of our intellectual property rights;

our assessment of the potential impact on our future revenues of healthcare reform legislation in the United States;

the timing and impact of measures worldwide designed to reduce healthcare costs;

the uncertainty of economic conditions in certain countries in Europe and Asia; and

general economic conditions.

These forward-looking statements involve risks and uncertainties, including those that are described in the *Risk Factors* section of this report and elsewhere within this report that could cause actual results to differ materially from those reflected in such statements. You should not place undue reliance on these statements. Forward-looking statements speak only as of the date of this report. We do not undertake any obligation to publicly update any forward-looking statements.

NOTE REGARDING COMPANY REFERENCES

Throughout this report, ZIOPHARM, the Company, we, us and our refer to ZIOPHARM Oncology, Inc.

NOTE REGARDING TRADEMARKS

All trademarks, trade names and service marks appearing in this Quarterly Report on Form 10-Q are the property of their respective owners.

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Table of Contents**Part I - Financial Information****Item 1. Financial Statements****ZIOPHARM Oncology, Inc.****BALANCE SHEETS****(unaudited)****(in thousands, except share and per share data)**

	March 31, 2016	December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 124,846	\$ 140,717
Receivables, net of reserves of \$322 and \$0 at March 31, 2016 and December 31, 2015, respectively	1,060	446
Prepaid expenses and other current assets	14,483	11,358
Total current assets	140,389	152,521
Property and equipment, net	667	581
Deposits	128	128
Other non-current assets	498	494
Total assets	\$ 141,682	\$ 153,724
LIABILITIES AND STOCKHOLDERS EQUITY		
Current liabilities:		
Accounts payable	\$ 1,908	\$ 2,008
Accrued expenses	8,582	8,906
Deferred rent - current portion	295	348
Deferred revenue - current portion	6,489	6,861
Total current liabilities	17,274	18,123
Deferred rent, net of current portion	276	313
Deferred revenue, net of current portion	46,319	47,917
Total liabilities	63,869	66,353
Commitments and contingencies (Note 5)		
Stockholders' equity:		

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Preferred stock, \$0.001 par value; 30,000,000 shares authorized and no shares issued and outstanding		
Common stock, \$0.001 par value; 250,000,000 shares authorized; 131,802,873 and 131,718,579 shares issued and outstanding at March 31, 2016 and December 31, 2015, respectively	132	132
Additional paid-in capital - common stock	582,400	579,939
Accumulated deficit	(504,719)	(492,700)
Total stockholders equity	77,813	87,371
Total liabilities and stockholders equity	\$ 141,682	\$ 153,724

The accompanying notes are an integral part of the unaudited interim financial statements.

Table of Contents**ZIOPHARM Oncology, Inc.****STATEMENTS OF OPERATIONS****(unaudited)****(in thousands, except share and per share data)**

	2016	March 31,	2015
Research contract revenue	\$ 1,969	\$	272
Operating expenses:			
Research and development, including costs of research contracts	10,199		74,249
General and administrative	3,810		4,250
Total operating expenses	14,009		78,499
Loss from operations	(12,040)		(78,227)
Other income (expense), net	21		(4)
Net loss	\$ (12,019)	\$	(78,231)
Net loss per share - basic and diluted	\$ (0.09)	\$	(0.69)
Weighted average common shares outstanding used to compute net loss per share - basic and diluted	130,157,927		113,410,250

The accompanying notes are an integral part of the unaudited interim financial statements.

Table of Contents**ZIOPHARM Oncology, Inc.****STATEMENT OF STOCKHOLDERS EQUITY****For the Three Months Ended March 31, 2016****(unaudited)****(in thousands, except share and per share data)**

	Common Stock		Additional Paid-in		Total Stockholders Equity
	Shares	Amount	Common Stock	Accumulated Deficit	
Balance at December 31, 2015	131,718,579	\$ 132	\$ 579,939	\$ (492,700)	\$ 87,371
Stock-based compensation			2,009		2,009
Exercise of employee stock options	84,462		367		367
Repurchase of common stock	(168)		(2)		(2)
Issuance of common stock in a license agreement			87		87
Net loss				(12,019)	(12,019)
Balance at March 31, 2016	131,802,873	\$ 132	\$ 582,400	\$ (504,719)	\$ 77,813

The accompanying notes are an integral part of the unaudited interim financial statements.

Table of Contents**ZIOPHARM Oncology, Inc.****STATEMENTS OF CASH FLOWS****(unaudited)****(in thousands)**

	For the Three Months Ended March 31,	
	2016	2015
Cash flows from operating activities:		
Net loss	\$ (12,019)	\$ (78,231)
Adjustments to reconcile net loss to net cash used in operating activities:		
Depreciation and amortization	72	122
Stock-based compensation	2,009	1,093
Common stock issued in exchange for license agreement		67,285
Issuance of common stock in a license agreement	87	
Change in operating assets and liabilities:		
(Increase) decrease in:		
Receivables	(614)	83
Prepaid expenses and other current assets	(3,125)	282
Other noncurrent assets	(5)	
Increase (decrease) in:		
Accounts payable	(100)	(1,224)
Accrued expenses	(324)	1,037
Deferred revenue	(1,969)	(272)
Deferred rent	(91)	108
Net cash provided by (used in) operating activities	(16,079)	(9,717)
Cash flows from investing activities:		
Purchases of property and equipment	(157)	(17)
Net cash used in investing activities	(157)	(17)
Cash flows from financing activities:		
Proceeds from exercise of stock options	367	2,541
Repurchase of restricted common stock	(2)	(246)
Proceeds from the issuance of common stock, net		94,320
Net cash provided by financing activities	365	96,615
Net increase (decrease) in cash and cash equivalents	(15,871)	86,881
Cash and cash equivalents, beginning of period	140,717	42,803

Cash and cash equivalents, end of period	\$ 124,846	\$ 129,684
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Supplementary disclosure of cash flow information:

Cash paid for interest	\$	\$
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Cash paid for income taxes	\$	\$
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Supplementary disclosure of noncash investing and financing activities:

Issuance of common stock in license agreement	\$	\$ 67,285
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The accompanying notes are an integral part of the unaudited interim financial statements.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS

(unaudited)

1. Business

Overview

ZIOPHARM Oncology, Inc., which is referred to herein as **ZIOPHARM** or the **Company**, is a biopharmaceutical company seeking to acquire, develop and commercialize, on its own or with commercial partners, a diverse portfolio of cancer therapies that address unmet medical needs.

The **Company**'s operations to date have consisted primarily of raising capital and conducting research and development. The **Company**'s fiscal year ends on December 31.

The **Company** has operated at a loss since its inception in 2003 and has minimal revenues. The **Company** anticipates that its losses will continue for the foreseeable future. At March 31, 2016, the **Company**'s accumulated deficit was approximately \$504.7 million. Given its current development plans, the **Company** anticipates cash resources will be sufficient to fund operations into the fourth quarter of 2017. The **Company**'s ability to continue operations after its current cash resources are exhausted depends on its ability to obtain additional financing or to achieve profitable operations, as to which no assurances can be given. Cash requirements may vary materially from those now planned because of changes in the **Company**'s focus and direction of its research and development programs, competitive and technical advances, patent developments, regulatory changes or other developments. Additional financing will be required to continue operations after the **Company** exhausts its current cash resources and to continue its long-term plans for clinical trials and new product development. There can be no assurance that any such financing can be obtained by the **Company**, or if obtained, what the terms thereof may be, or that any amount that the **Company** is able to raise will be adequate to support the **Company**'s working capital requirements until it achieves profitable operations.

Basis of Presentation

The accompanying unaudited interim financial statements have been prepared in accordance with the instructions to Form 10-Q pursuant to the rules and regulations of the Securities and Exchange Commission, or the SEC. Certain information and note disclosures required by generally accepted accounting principles in the United States have been condensed or omitted pursuant to such rules and regulations.

It is management's opinion that the accompanying unaudited interim financial statements reflect all adjustments (which are normal and recurring) that are necessary for a fair statement of the results for the interim periods. The unaudited interim financial statements should be read in conjunction with the audited financial statements and the notes thereto for the year ended December 31, 2015, included in the **Company**'s Annual Report on Form 10-K filed with the SEC on February 24, 2016, or the Form 10-K.

The year-end balance sheet data was derived from the audited financial statements but does not include all disclosures required by generally accepted accounting principles in the United States.

The results disclosed in the statements of operations for the three months ended March 31, 2016 are not necessarily indicative of the results to be expected for the full fiscal year.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Although the Company regularly assesses these estimates, actual results could differ from those estimates. Changes in estimates are recorded in the period in which they become known.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

1. Business (continued)

The Company's most significant estimates and judgments used in the preparation of its financial statements are:

Clinical trial expenses;

Collaboration agreements;

Fair value measurements for stock-based compensation; and

Income taxes.

Subsequent Events

The Company evaluated all events and transactions that occurred after the balance sheet date through the date of this filing. During this period, the Company did not have any material subsequent events that impacted its financial statements or disclosures.

2. Summary of Significant Accounting Policies

The Company's significant accounting policies were identified in the Company's Form 10-K for the fiscal year ended December 31, 2015. There have been no material changes in those policies since the filing of its Form 10-K.

Table of Contents**ZIOPHARM Oncology, Inc.****NOTES TO FINANCIAL STATEMENTS (unaudited)****3. Fair Value Measurements**

The Company accounts for its financial assets and liabilities using fair value measurements. The authoritative accounting guidance defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and enhances disclosures about fair value measurements. Fair value is defined as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The fair value hierarchy is based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value as follows:

Level 1 - Quoted prices in active markets for identical assets or liabilities.

Level 2 - Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 - Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

Assets and liabilities measured at fair value on a recurring basis as of March 31, 2016 and December 31, 2015 were as follows:

Description	Balance as of March 31, 2016	Fair Value Measurements at Reporting Date Using Quoted Prices in Active Markets for		
		Identical Assets/Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash equivalents	\$ 106,033	\$ 106,033	\$	\$

Table of Contents**ZIOPHARM Oncology, Inc.****NOTES TO FINANCIAL STATEMENTS (unaudited)****3. Fair Value Measurements (continued)**

(\$ in thousands)

Description	Balance as of December 31, 2015	Fair Value Measurements at Reporting Date Using Quoted Prices in Active Markets for		
		Identical Assets/Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash equivalents	\$ 137,405	\$ 137,405	\$	\$

The cash equivalents represent deposits in a short term United States treasury money market mutual fund quoted in an active market and classified as a Level 1 asset.

4. Net Loss per Share

Basic net loss per share is computed by dividing net loss by the weighted average number of shares of common stock outstanding for the period. The Company's potential dilutive shares, which include outstanding common stock options, unvested restricted stock and warrants, have not been included in the computation of diluted net loss per share for any of the periods presented as the result would be anti-dilutive. Such potential shares of common stock at March 31, 2016 and 2015 consisted of the following:

	March 31,	
	2016	2015
Stock options	3,404,463	5,924,297
Unvested restricted common stock	1,586,388	96,073
	4,990,851	6,020,370

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies

Operating Leases

Prior to December 31, 2012, the Company entered into an operating lease in New York, NY for office space. In accordance with this agreement, the Company entered into a letter of credit in the amount of \$388 thousand, naming the Company's landlord as beneficiary. In January 2012, the Company amended the lease agreement, adding additional office space. The collateral for the letter of credit is restricted cash and recorded in other non-current assets on the balance sheet as of March 31, 2016 and December 31, 2015. The lease for office space in New York, NY expires in October 2018.

On October 17, 2013, the Company entered into a sublease agreement to lease all of its New York office space to a subtenant. The Company remains primarily liable to pay rent on the original lease. The Company recorded a loss on the sublease in the amount of \$729 thousand for the year ended December 31, 2013, representing the remaining contractual obligation of \$2.3 million, less \$1.6 million in payments from its subtenant. The Company retired assets as a result of this sublease with a net book value of \$392 thousand, and recorded a loss on disposal of fixed assets for the same amount for the year ended December 31, 2013. The Company continues to maintain the \$388 thousand letter of credit in respect of the New York office space included in other non-current assets.

Prior to December 31, 2012, the Company entered into separate operating lease agreements for various spaces in a building in Boston, MA. In June 2012, the Company re-negotiated a master lease for the entire Boston office space that incorporated all three lease agreements under the same master agreement expiring in August 2016. On December 21, 2015 and April 15, 2016, the Company renewed the sublease for the Company's corporate headquarters in Boston, MA through August 31, 2021. As of March 31, 2016 and December 31, 2015, a total security deposit of \$128 thousand is included in deposits on the balance sheet.

On August 30, 2013, the Company entered into a sublease agreement to lease a portion of its Boston office to a subtenant. The Company remains liable to pay rent on the original lease. The Company recorded a loss on the sublease in the amount of \$42 thousand for the year ended December 31, 2013, representing the remaining contractual obligation of \$367 thousand, less \$325 thousand in payments from its subtenant. This sublease tenant vacated the leased premises in October 2014. At December 31, 2014, the Company applied the \$20 thousand deposit received from the sublease tenant against its outstanding rent obligation. On March 31, 2015, the Company recorded a loss of \$167 thousand on the first floor sublease. On May 22, 2015, the Company subleased the vacant office space for approximately \$105 thousand for the period of June 2015 through August 2016, and the tenant provided a security deposit of \$17 thousand. Since the prior lease obligation has been fully expensed, rent received from the tenant will reduce current rent expense.

Total rent expense was approximately \$104 thousand and \$177 thousand for the three months ended March 31, 2016 and 2015, respectively.

The Company records rent expense on a straight-line basis over the term of the lease. Accordingly, the Company has recorded a liability for deferred rent at March 31, 2016 and December 31, 2015 of \$571 thousand (\$295 thousand

current and \$276 thousand long-term) and \$661 thousand (\$348 thousand current and \$313 thousand long-term), respectively, which is recorded in deferred rent on the balance sheets.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies (continued)

License Agreements

Exclusive Channel Partner Agreement with Intrexon Corporation for the Cancer Programs

On January 6, 2011, the Company entered into an Exclusive Channel Partner Agreement, or the Channel Agreement, with Intrexon that governs a channel partnering arrangement in which the Company uses Intrexon's technology to research, develop and commercialize products in which DNA is administered to humans for expression of anti-cancer effectors for the purpose of treatment or prophylaxis of cancer, which the Company collectively refers to as the Cancer Program. This Channel Agreement establishes committees comprised of representatives of the Company and Intrexon that govern activities related to the Cancer Program in the areas of project establishment, chemistry, manufacturing and controls, clinical and regulatory matters, commercialization efforts and intellectual property.

The Channel Agreement grants the Company a worldwide license to use patents and other intellectual property of Intrexon in connection with the research, development, use, importing, manufacture, sale, and offer for sale of products involving DNA administered to humans for expression of anti-cancer effectors for the purpose of treatment or prophylaxis of cancer, which is collectively referred to as the ZIOPHARM Products. Such license is exclusive with respect to any clinical development, selling, offering for sale or other commercialization of ZIOPHARM Products, and otherwise is non-exclusive. Subject to limited exceptions, the Company may not sublicense these rights without Intrexon's written consent.

Under the Channel Agreement, and subject to certain exceptions, the Company is responsible for, among other things, the performance of the Cancer Program, including the development, commercialization and certain aspects of manufacturing of ZIOPHARM Products. Intrexon is responsible for establishing manufacturing capabilities and facilities for the bulk manufacture of products developed under the Cancer Program, certain other aspects of manufacturing and costs of discovery-stage research with respect to platform improvements and costs of filing, prosecution and maintenance of Intrexon's patents.

Subject to certain expense allocations and other offsets provided in the Channel Agreement, the Company will pay Intrexon on a quarterly basis 50% of net profits derived in that quarter from the sale of ZIOPHARM Products, calculated on a ZIOPHARM Product-by-ZIOPHARM Product basis. The Company has likewise agreed to pay Intrexon on a quarterly basis 50% of revenue obtained in that quarter from a sublicensor in the event of a sublicensing arrangement. In addition, in partial consideration for each party's execution and delivery of the Channel Agreement, the Company entered into a stock purchase agreement with Intrexon.

Upon termination of the Channel Agreement, the Company may continue to develop and commercialize any ZIOPHARM Product that, at the time of termination:

Is being commercialized by the Company;

Has received regulatory approval;

Is a subject of an application for regulatory approval that is pending before the applicable regulatory authority; or

Is the subject of at least an ongoing Phase 2 clinical trial (in the case of a termination by Intrexon due to an uncured breach or a voluntary termination by the Company), or an ongoing Phase 1 clinical trial in the field (in the case of a termination by the Company due to an uncured breach or a termination by Intrexon following an unconsented assignment by the Company or its election not to pursue development of a Superior Therapy (as defined in the Channel Agreement)).

The Company's obligation to pay 50% of net profits or revenue described above with respect to these retained products will survive termination of the Channel Agreement.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies (continued)

On March 27, 2015, the Company and Intrexon entered into an Exclusive Channel Partner Amendment, or ECP Amendment, amending the Channel Agreement. The ECP Amendment modifies the scope of the parties' collaboration under the Channel Agreement in connection with the Ares Trading Agreement discussed below. Pursuant to the ECP Amendment, the chimeric antigen receptor T cell products to be developed and commercialized pursuant to the Ares Trading Agreement shall be included within the Intrexon/ZIOPHARM collaboration under the Channel Agreement. The ECP Amendment provides that Intrexon will pay to the Company fifty percent of all payments Intrexon receives for upfronts, milestones and royalties under the Ares Trading Agreement.

Exclusive Channel Collaboration Agreement with Intrexon Corporation for Graft-Versus-Host Disease (GvHD)

GVHD may occur after a bone marrow or stem cell transplant in which someone receives bone marrow tissue or cells from a donor. The new, transplanted cells regard the recipient's body as foreign. When this happens, the newly transplanted cells attack the recipient's body. On September 28, 2015, the Company, entered into a new Exclusive Channel Collaboration Agreement, or the GvHD Agreement, with Intrexon, whereby the Company will use Intrexon's technology directed towards *in vivo* expression of effectors to research, develop and commercialize products for use in the treatment or prevention of graft-versus-host disease, or GvHD. The exclusive collaboration, or the GvHD Program, will focus on the pursuit of the following engineered cell therapy strategies, used either separately or in combination, for the targeted treatment of GvHD: (i) the infusion of regulatory T cells expressing membrane-bound and/or soluble interleukin-2 and (ii) the deployment of orally delivered, genetically modified *L. lactis* that express interleukin-2 to modulate immune function. The GvHD Agreement establishes committees comprised of Company and Intrexon representatives that will govern activities related to the GvHD Program in the areas of project establishment, chemistry, manufacturing and controls, clinical and regulatory matters, commercialization activities and intellectual property.

The GvHD Agreement grants the Company a worldwide license to use specified patents and other intellectual property of Intrexon in connection with the research, development, use, importing, manufacture, sale, and offer for sale of products developed under the GvHD Program, or the Products. Such license is exclusive with respect to any clinical development, selling, offering for sale or other commercialization of the Products, and otherwise is non-exclusive. Subject to limited exceptions, the Company may not sublicense the rights described without Intrexon's written consent.

Under the GvHD Agreement, and subject to certain exceptions, the Company is responsible for, among other things, the performance of the GvHD Program including development, commercialization and certain aspects of manufacturing of the Products. Among other things, Intrexon is responsible for the costs of establishing manufacturing capabilities and facilities for the bulk manufacture of the Products, certain other aspects of manufacturing, costs of discovery-stage research with respect to platform improvements and costs of filing, prosecution and maintenance of Intrexon's patents.

The Company paid Intrexon a technology access fee of \$10.0 million in cash in October 2015 and will reimburse Intrexon for all research and development costs. Subject to certain expense allocations and other offsets provided in the GvHD Agreement, the GvHD Agreement also provides for equal sharing of the profits derived from the sale of the Products.

The Company has determined that the rights acquired in the GvHD Agreement represent in-process research and development with no alternative future use. Accordingly, the Company recorded a charge of \$10.0 million to research and development expense in 2015.

During the first 24 months after September 28, 2015, the GvHD Agreement may be terminated by (i) either party in the event of a material breach by the other, except for the failure of the other party to use diligent efforts or to comply with any diligence obligations set forth in the GvHD Agreement and (ii) Intrexon under certain circumstances if the Company assigns its rights under the GvHD Agreement without Intrexon's consent. Following such twenty-four month period, Intrexon may also terminate the GvHD Agreement if the Company elects not to pursue the development of the GvHD Program identified by Intrexon that is a Superior Therapy, as such term is defined in the GvHD Agreement. Also following such period, the Company may voluntarily terminate the GvHD Agreement upon 90 days written notice to Intrexon.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies (continued)

Upon termination of the GvHD Agreement, the Company may continue to develop and commercialize any Product that, at the time of termination:

is being commercialized by the Company,

has received regulatory approval,

is a subject of an application for regulatory approval that is pending before the applicable regulatory authority, or

is the subject of at least an ongoing Phase 2 clinical trial (in the case of a termination by Intrexon due to a Company uncured breach or a voluntary termination by the Company), or an ongoing Phase 1 clinical trial (in the case of a termination by the Company due to an Intrexon uncured breach or a termination by Intrexon following an unconsented assignment by the Company or the Company's election not to pursue development of a Superior Therapy).

The Company's obligation to pay 50% of net profits or revenue with respect to these retained products will survive termination of the GvHD Agreement.

License Agreement The University of Texas MD Anderson Cancer Center

On January 13, 2015, the Company, together with Intrexon, entered into a License Agreement, or the MD Anderson License, with The University of Texas MD Anderson Cancer Center, or MD Anderson. Pursuant to the MD Anderson License, the Company and Intrexon hold an exclusive, worldwide license to certain technologies owned and licensed by MD Anderson including technologies relating to novel chimeric antigen receptor (CAR) T cell therapies, non-viral gene transfer systems, genetic modification and/or propagation of immune cells and other cellular therapy approaches, Natural Killer, or NK Cells and T cell receptors, or TCRs arising from the laboratory of Laurence Cooper, M.D., Ph.D., who became the Chief Executive Officer of the Company on May 7, 2015 and was formerly a tenured professor of pediatrics at MD Anderson and now currently a visiting scientist under that institution's policies, as well as either co-exclusive or non-exclusive licenses under certain related technologies.

Pursuant to the terms of the MD Anderson License, MD Anderson received consideration consisting of \$50.0 million in shares of the Company's common stock (or 10,124,561 shares), and \$50.0 million in shares of Intrexon's common stock, in each case based on a trailing 20 day volume weighted average of the closing price of the Company's and

Intrexon's common stock ending on the date prior to the announcement of the entry into the MD Anderson License, collectively referred to as the License Shares, pursuant to the terms of the License Shares Securities Issuance Agreement described below. The License Shares were issued to MD Anderson on March 11, 2015 pursuant to the terms of the MD Anderson License.

On January 9, 2015, in order to induce MD Anderson to enter into the MD Anderson License on an accelerated schedule, the Company and Intrexon entered into a letter agreement, or the Letter Agreement, pursuant to which MD Anderson received consideration of \$7.5 million in shares of the Company's common stock (or 1,597,602 shares), and \$7.5 million in shares of Intrexon's common stock, in each case based on a trailing 20 day volume weighted average of the closing price of the Company's and Intrexon's common stock ending on the date prior to the execution of the Letter Agreement, collectively referred to as the Incentive Shares, in the event that the MD Anderson License was entered into on or prior to 8:00 am Pacific Time on January 14, 2015. The Incentive Shares were issued to MD Anderson on March 11, 2015 pursuant to the terms of the Incentive Shares Securities Issuance Agreement described below.

On August 17, 2015, the Company, Intrexon and MD Anderson entered into a research and development agreement, or the Research and Development Agreement, to formalize the scope and process for the transfer by MD Anderson, pursuant to the terms of the MD Anderson License, of certain existing research programs and related technology rights, as well as the terms and conditions for future collaborative research and development of new and ongoing research programs.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies (continued)

Pursuant to the Research and Development Agreement, the Company, Intrexon and MD Anderson have agreed to form a joint steering committee that will oversee and manage the new and ongoing research programs. As provided under the MD Anderson License, the Company will provide funding for research and development activities in support of the research programs under the Research and Development Agreement for a period of three years and in an amount of no less than \$15.0 million and no greater than \$20.0 million per year. During the quarter ended March 31, 2016, the Company made one quarterly payment of \$3.75 million under this arrangement. As of March 31, 2016, MD Anderson has used \$1.4 million to offset costs incurred pursuant to the MD Anderson License and the Research and Development Agreement. The net balance of \$13.6 million is included in other current assets at March 31, 2016.

The term of the MD Anderson License expires on the last to occur of (a) the expiration of all patents licensed thereunder, or (b) the twentieth anniversary of the date of the License; provided, however, that following the expiration of the term of the MD Anderson License, the Company and Intrexon shall then have a fully-paid up, royalty free, perpetual, irrevocable and sublicensable license to use the licensed intellectual property thereunder. After ten years from the date of the MD Anderson License and subject to a 90-day cure period, MD Anderson will have the right to convert the MD Anderson License into a non-exclusive license if the Company and Intrexon are not using commercially reasonable efforts to commercialize the licensed intellectual property on a case-by-case basis. After five years from the date of the MD Anderson License and subject to a 180-day cure period, MD Anderson will have the right to terminate the MD Anderson License with respect to specific technology(ies) funded by the government or subject to a third party contract if the Company and Intrexon are not meeting the diligence requirements in such funding agreement or contract, as applicable. MD Anderson may also terminate the agreement with written notice upon material breach by the Company and Intrexon, if such breach has not been cured within 60 days of receiving such notice. In addition, the MD Anderson License will terminate upon the occurrence of certain insolvency events for both the Company and Intrexon and may be terminated by the mutual written agreement of the Company, Intrexon and MD Anderson.

In connection with the License and the issuance of the License Shares and the Incentive Shares, on January 13, 2015, the Company and MD Anderson entered into a Registration Rights Agreement, or the Registration Rights Agreement, pursuant to which the Company agreed to file a resale registration statement, or the Registration Statement, registering the resale of the License Shares, the Incentive Shares and any other shares of the Company's common stock held by MD Anderson on the date that the Registration Statement is filed. Under the Registration Rights Agreement, the Company is obligated to maintain the effectiveness of the Registration Statement until all securities therein are sold or are otherwise can be sold pursuant to Rule 144, without any restrictions. A prospectus supplement under the Company's already effective registration statement on Form S-3 (File No. 333-201826) was filed on April 1, 2015 in satisfaction of the Company's obligations under the Registration Rights Agreement.

The Company has determined that the rights acquired in the MD Anderson License represent in process research and development with no alternative future use. Accordingly, the Company recorded a charge of \$67.3 million to research

and development expense in 2015, representing the fair value of the 11,722,163 shares of its common stock on the date the MD Anderson License was executed.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies (continued)

Ares Trading License and Collaboration Agreement

On March 27, 2015, the Company and Intrexon signed a worldwide License and Collaboration Agreement, or the Ares Trading Agreement, with Ares Trading S.A. or Ares Trading, a subsidiary of the biopharmaceutical business of Merck KGaA, Darmstadt, Germany, through which the parties established a collaboration for the research and development and commercialization of certain products for the prophylactic, therapeutic, palliative or diagnostic use for cancer in humans.

Under the collaboration, Ares Trading has elected two CAR⁺ T targets and is providing certain research funding for the development of these targets. The Company is responsible for certain research and development expenditures. Once these candidates reach investigational new drug (IND) stage, the programs will be transferred to Ares Trading for clinical development and commercialization. The Company expects to perform multiple preclinical development programs, each consisting of the development of one product candidate, pursuant to the agreement. The Company and Intrexon will also independently conduct research and development on other CAR⁺ T candidates, with Ares Trading having the opportunity during clinical development to opt-in.

Intrexon is entitled to receive \$5.0 million payable in equal quarterly installments over two years for each identified product candidate, which will be used to fund discovery work. The Company will be responsible for costs exceeding the quarterly installments and all other costs of the preclinical research and development.

Ares Trading paid a non-refundable upfront fee of \$115.0 million to Intrexon as consideration for entry into the Ares Trading Agreement. Pursuant to the ECP Amendment, the Company was entitled to receive 50% of the upfront fee, or \$57.5 million, which the Company received from Intrexon in July 2015.

The Ares Trading Agreement provides for up to \$413.0 million of potential payments for certain development and commercial milestones for each product candidate, and royalties ranging from the lower-single digits to the low-teens of net sales derived from the sale of products developed under agreement. The Ares Trading Agreement also provides for up to \$50.0 million of payments upon the achievement of certain technical milestones. Intrexon will pay 50% of all milestone and royalty payments that it receives under the Ares Trading Agreement to the Company pursuant to the ECP Amendment.

The term of the Ares Trading Agreement commenced in May 2015 and may be terminated by either party in the event of a material breach as defined in the agreement and may be terminated voluntarily by Ares Trading upon 90 days written notice to the Company.

The Company considered FASB Accounting Standards Codification 605-25, *Multiple-Element Arrangements*, in evaluating the appropriate accounting for the Ares Trading Agreement. In accordance with this guidance, the Company identified the license and research and development services as the Company's deliverables in the

arrangement. The Company concluded that the license does not have standalone value independent from the research and development services. Accordingly, the Ares Trading Agreement is accounted for by the Company as a single unit of accounting. The \$57.5 million upfront payment received by the Company was recorded as deferred revenue and is being recognized over the estimated period of performance of the research and development services which are currently estimated to be 9 years, beginning with the commencement of the research and development services. During the three months ended March 31, 2016, the Company recognized \$1.6 million of revenue related to the Ares Trading Agreement. The remaining balance of deferred revenue associated with the upfront payment was \$52.7 million, of which \$6.4 million is current and \$46.3 million is classified as long term at March 31, 2016.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies (continued)

License Agreements with DEKK-Tec, Inc. and Southern Research Institute

On October 15, 2004, the Company entered into a license agreement with DEKK-Tec, Inc., or DEKK-Tec, pursuant to which it was granted an exclusive, worldwide license for palifosfamide. All of the Company's rights and obligations under the DEKK-Tec license agreement were assigned to Predictive Therapeutics, Ltd., in the first quarter of 2016, with the exception of the Company's obligation under a stock option to acquire 13,808 shares of the Company's common stock at an exercise price of \$0.02 per share, which remains outstanding in accordance with the terms.

On February 5, 2007, the Company exercised an option to enter into an exclusive license agreement with Southern Research Institute, or SRI, for certain isophosphoramidate mustard analogs. Under the license agreement, the Company was required to remit minimum annual royalty payments of \$25 thousand until the first commercial sale of a licensed product. These payments were made for the years ended December 31, 2015, 2014, and 2013. All of the Company's remaining obligations under the SRI license agreement were assigned to Predictive Therapeutics, Ltd., in the first quarter of 2016.

License Agreement with Predictive Therapeutics, Ltd.

On November 12, 2015, the Company entered into a License Agreement with Predictive Therapeutics, Ltd., or Predictive, which granted Predictive an exclusive license to develop and commercialize palifosfamide.

In exchange, the Company received an upfront payment of \$250 thousand and is entitled to receive additional payments of up to \$12.8 million in development-and sales-based milestones, single digit royalty payments on net sales of palifosfamide, once commercialized, and a percentage of any sublicense revenues generated by Predictive. Predictive will be responsible for all costs related to the development, manufacturing and commercialization of palifosfamide.

The \$250 thousand upfront payment received in November 2015 is being amortized over the period of the Company's research and development effort related to transitional services. There are certain deliverables that are included in the License Agreement including transfer of intellectual property and prior research and development results, which are estimated by management to be completed by June 30, 2016. Accordingly, the Company has recorded \$100 thousand in revenue during the three months ended March 31, 2016. The remaining deferred revenue balance of \$100 thousand at March 31, 2016 has been classified as current. In accordance with the License Agreement with Predictive, the Company is no longer obligated to continue their research and development efforts beyond the transitional services. In the first quarter of 2016, all of the Company's rights and obligations under the DEKK-Tec and SRI license agreements were assigned to Predictive Therapeutics, Ltd., with the exception of the Company's obligation to DEKK-Tec under a stock option to acquire 13,808 shares of the Company's common stock at an exercise price of \$0.02 per share, which remains outstanding in accordance with the terms. As of March 31, 2016, Predictive was in default of certain payments amounting to \$311 thousand related to transitional services provided by the Company and the

reimbursement of certain expenses incurred by the Company in connection with the transaction.

Patent and Technology License Agreement The University of Texas MD Anderson Cancer Center and the Texas A&M University System.

On August 24, 2004, the Company entered into a patent and technology license agreement with MD Anderson, which the Company refers to, collectively, as the Licensors. Under this agreement, the Company was granted an exclusive, worldwide license to rights (including rights to U.S. and foreign patent and patent applications and related improvements and know-how) for the manufacture and commercialization of two classes of organic arsenicals (water- and lipid-based) for human and animal use. The class of water-based organic arsenicals includes darinaparsin.

Table of Contents**ZIOPHARM Oncology, Inc.****NOTES TO FINANCIAL STATEMENTS (unaudited)****5. Commitments and Contingencies (continued)**

The Company issued options to purchase 50,222 shares outside of the Company's stock option plans following the successful completion of certain clinical milestones, of which 37,666 have vested. The remaining 12,556 shares vested upon enrollment of the first patient in a multi-center pivotal clinical trial i.e. a human clinical trial intended to provide the substantial evidence of efficacy necessary to support the filing of an approvable New Drug Application, or NDA. An expense of \$87 thousand was charged to research and development expense for the vesting event. This trial was initiated by Solasia Pharma K.K. on March 28, 2016. The start of this trial also triggered a \$1.0 million milestone payment to the Company from Solasia Pharma K.K. which is included in accounts receivable at March 31, 2016, and an equivalent milestone payment to M.D. Anderson which is included in accrued expenses at March 31, 2016. This transaction is reported on a net basis in the March 31, 2016 Statement of Operations. In addition, the Licensors are entitled to receive certain milestone payments. The Company may be required to make additional payments upon achievement of certain other milestones in varying amounts which on a cumulative basis could total up to an additional \$4.5 million. In addition, the Licensors are entitled to receive single digit percentage royalty payments on sales from a licensed product and will also be entitled to receive a portion of any fees that the Company may receive from a possible sublicense under certain circumstances.

Collaboration Agreement with Solasia Pharma K.K.

On March 7, 2011, the Company entered into a License and Collaboration Agreement with Solasia Pharma K.K., or Solasia. Pursuant to the License and Collaboration Agreement, the Company granted Solasia an exclusive license to develop and commercialize darinaparsin in both IV and oral forms and related organic arsenic molecules, in all indications for human use in a pan-Asian/Pacific territory comprised of Japan, China, Hong Kong, Macau, Republic of Korea, Taiwan, Singapore, Australia, New Zealand, Malaysia, Indonesia, Philippines and Thailand.

As consideration for the license, the Company received an upfront payment of \$5.0 million to be used exclusively for further clinical development of darinaparsin outside of the pan-Asian/Pacific territory, and will be entitled to receive additional payments of up to \$32.5 million in development-based milestones and up to \$53.5 million in sales-based milestones. The Company will also be entitled to receive double digit royalty payments from Solasia based upon net sales of licensed products in the applicable territories, once commercialized, and a percentage of sublicense revenues generated by Solasia. Under the License and Collaboration Agreement, the Company provided Solasia with drug product to conduct clinical trials. These transfers were accounted for as a reduction of research and development costs and an increase in collaboration receivables. The agreement provides that Solasia will be responsible for the development and commercialization of darinaparsin in the pan-Asian/Pacific territory.

On July 31, 2014, the Company entered into an amendment and restatement of the License and Collaboration Agreement granting Solasia an exclusive worldwide license to develop and commercialize darinaparsin, and related organoarsenic molecules, in both intravenous and oral forms in all indications for human use. In exchange, the Company will be eligible to receive from Solasia development- and sales-based milestones, a royalty on net sales of darinaparsin, once commercialized, and a percentage of any sublicense revenues generated by Solasia.

Solasia will be responsible for all costs related to the development, manufacturing and commercialization of darinaparsin. The Company's Licensors, as defined in the agreement, will receive a portion of all milestone and royalty payments made by Solasia to the Company in accordance with the terms of the Company's license agreement with the Licensors.

The \$5.0 million upfront payment received in March 2011 was amortized over the period of the Company's research and development effort. The Company originally estimated this period to be 75 months. In accordance with the amended and restated License and Collaboration Agreement with Solasia, the Company is no longer obligated to continue its research and development efforts in connection with the terms of the receipt of up-front payment. However, there were certain deliverables required pursuant to the amended and restated License and Collaboration Agreement including transfer of intellectual property and prior research and development results, which were originally estimated by management to be completed and delivered by March 31, 2015 at the time the amended and restated License and Collaboration Agreement was signed in July 2014 and are still current obligations. Management subsequently reassessed the period of performance related to the remaining transitional services to be completed under the amended and restated License and Collaboration Agreement and determined that the final deliverables would be completed by March 31, 2016. Accordingly, the Company has recorded \$272 thousand in revenue during the three months ended March 31, 2016. There is no deferred revenue related to the amended and restated License and Collaboration Agreement at March 31, 2016, as the research and development efforts set forth therein have been completed.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

5. Commitments and Contingencies (continued)

On March 28, 2016, Solasia initiated a multi-center pivotal clinical trial intended to provide substantial evidence of efficacy necessary to support the filing of an application for a new drug approval in certain of the territories assigned to Solasia. The start of this trial triggered a \$1.0 million milestone payment to the Company which is included in accounts receivable at March 31, 2016, and an equivalent milestone payment to M.D. Anderson which is included in accrued expenses at March 31, 2016. This transaction is reported on a net basis in the March 31, 2016 Statement of Operations.

License Agreement with Baxter Healthcare Corporation

On November 3, 2006, the Company entered into a definitive Asset Purchase Agreement for indibulin and a License Agreement to proprietary nanosuspension technology with affiliates of Baxter Healthcare S.A. The purchase included the entire indibulin intellectual property portfolio as well as existing drug substance and capsule inventories. The terms of the Asset Purchase Agreement included an upfront cash payment and an additional payment for existing inventory. No payments were made during the quarters ended March 31, 2016 and 2015. The Company is not actively pursuing the development of indibulin.

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

6. Related Party Transactions

On January 6, 2011, the Company entered into an Exclusive Channel Partner Agreement, which is referred to as the Channel Agreement, with Intrexon Corporation, or Intrexon (see Note 5). A director of the Company, Randall J. Kirk, is the CEO, a director, and the largest stockholder of Intrexon.

On February 3, 2015, Intrexon purchased 1,440,000 shares of common stock in the Company's public offering upon the same terms as others that participated in the offering.

On June 29, 2015, the Company re-purchased 3,711 shares of common stock from Intrexon, at a discount of 5% to the closing price of the Company's common stock on the date of purchase, which represented fractional shares that resulted from Intrexon's special stock dividend of the Company's shares to Intrexon's shareholders, for \$34 thousand. On January 8, 2016, the Company re-purchased an additional 168 shares of common stock from Intrexon for \$2 thousand at the same terms as the previous shares.

During the three months ended March 31, 2016 and 2015 the Company expensed \$5.9 million and \$1.7 million, respectively, for services performed by Intrexon. As of March 31, 2016 and December 31, 2015 the Company has recorded \$4.4 million and \$4.6 million in current liabilities, respectively, for amounts due to Intrexon.

On September 28, 2015, the Company, entered into a new Exclusive Channel Collaboration Agreement, or the GvHD Agreement, with Intrexon, whereby the Company will use Intrexon's technology directed towards *in vivo* expression of biologics to research, develop and commercialize products for use in the treatment or prevention of graft-versus-host disease, or GvHD (see Note 5, Commitments and Contingencies). The Company paid Intrexon a technology access fee of \$10.0 million in cash in October 2015 and will reimburse Intrexon for all research and development costs. Subject to certain expense allocations and other offsets provided in the ECC Agreement, the ECC Agreement also provides for equal sharing of the profits derived from the sale of the Products

On March 27, 2015, the Company and Intrexon entered into a Second Amendment to Exclusive Channel Partner Agreement amending the Channel Agreement, which is referred to as the ECP Amendment. The ECP Amendment modified the scope of the parties' collaboration under the Channel Agreement in connection with the worldwide License and Collaboration Agreement, or the Ares Trading Agreement, which the Company and Intrexon entered into with Ares Trading S.A., or Ares Trading, on March 27, 2015. The ECP Amendment provided that Intrexon will pay to the Company fifty percent of all payments that Intrexon receives for upfronts, milestones and royalties under the Ares Trading Agreement (see Note 5). The Amendment also reduces Intrexon's aggregate commitment under a Stock Purchase Agreement that the parties executed in connection with the initial Channel Agreement to purchase the Company's common stock from \$50.0 million to \$43.5 million, which has been satisfied.

On January 13, 2015, the Company, together with Intrexon, entered into a license agreement with MD Anderson, which is referred to as the MD Anderson License. Pursuant to the MD Anderson License, the Company and Intrexon hold an exclusive, worldwide license to certain technologies owned and licensed by MD Anderson including technologies relating to novel CAR⁺ T cell therapies arising from the laboratory of Laurence Cooper, M.D., Ph.D., the Chief Executive Officer of the Company, formerly a professor of pediatrics at MD Anderson and now currently a

visiting scientist under that institution's policies, as well as either co-exclusive or non-exclusive licenses under certain related technologies. In partial consideration for entering into the MD Anderson License, the Company issued MD Anderson an aggregate of 11,722,163 shares of common stock for which the Company incurred a \$67.3 million charge. The Company has determined that the rights acquired in the MD Anderson License represent in-process research and development with no alternative future use. As a result of the common stock issued to MD Anderson in connection with this transaction, MD Anderson became a beneficial holder of more than five percent of the Company's common stock. (see Note 5). During the three months ending March 31, 2016, the Company made one quarterly payment of \$3.75 million bringing the total aggregate payments to \$15.0 million under this arrangement.

Table of Contents**ZIOPHARM Oncology, Inc.****NOTES TO FINANCIAL STATEMENTS (unaudited)****7. Stock-Based Compensation**

The Company recognized stock-based compensation expense on all employee and non-employee awards as follows:

<i>(in thousands)</i>	For the three months ended March 31,	
	2016	2015
Research and development	\$ 417	\$ 295
General and administrative	1,592	798
Stock-based compensation expense	\$ 2,009	\$ 1,093

The Company granted 20,000 stock options during the three months ended March 31, 2016 with a weighted-average grant date fair value of \$3.88 per share. The Company granted 50,000 stock options during the three months ended March 31, 2015 with a weighted-average grant date fair value of \$6.58 per share.

Table of Contents**ZIOPHARM Oncology, Inc.****NOTES TO FINANCIAL STATEMENTS (unaudited)****7. Stock-Based Compensation (continued)**

For the three months ended March 31, 2016 and 2015, the fair value of stock options was estimated on the date of grant using a Black-Scholes option valuation model with the following assumptions:

	For the three months ended March 31,	
	2016	2015
Risk-free interest rate	1.58 - 1.90%	1.63 - 1.64%
Expected life in years	6	6
Expected volatility	79.15 - 79.69%	85.48 - 86.81%
Expected dividend yield	0	0

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ZIOPHARM Oncology, Inc.

NOTES TO FINANCIAL STATEMENTS (unaudited)

7. Stock-Based Compensation (continued)

Stock option activity under the Company's stock option plan for the three months ended March 31, 2016 is as follows:

<i>(in thousands, except share and per share data)</i>	Number of Shares	Weighted-Average Exercise Price	Weighted-Average Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding, December 31, 2015	3,481,469	\$ 4.96		
Granted	20,000	5.66		
Exercised	(93,672)	4.72		
Cancelled	(3,333)	3.28		
Outstanding, March 31, 2016	3,404,464	\$ 4.97	6.77	\$ 9,874
Vested and unvested expected to vest at March 31, 2016	3,337,935	\$ 4.29	5.72	\$ 9,681
Options exercisable, March 31, 2016	2,122,328	\$ 4.29	5.72	\$ 6,666
Options exercisable, December 31, 2015	2,120,834	\$ 4.24	5.84	\$ 8,622
Options available for future grant	2,751,563			

At March 31, 2016, total unrecognized compensation costs related to unvested stock options outstanding amounted to \$4.4 million. The cost is expected to be recognized over a weighted-average period of 1.53 years.

A summary of the status of unvested restricted stock for the three months ended March 31, 2016 is as follows:

	Number of Shares	Weighted-Average Grant Date Fair Value
Non-vested, December 31, 2015	1,586,388	\$ 9.00

Granted

Vested

Cancelled

Non-vested, March 31, 2016	1,586,388	\$	9.00
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At March 31, 2016, total unrecognized compensation costs related to unvested restricted stock outstanding amounted to \$10.8 million. The cost is expected to be recognized over a weighted-average period of 1.62 years.

Table of Contents**Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations****Forward Looking Statements**

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. In particular, statements contained in this Form 10-Q, including but not limited to, statements regarding the costs and timing of our clinical trials and of the development and commercialization of our pipeline products and services; the sufficiency of our cash, investments and cash flows from operations and our expected uses of cash; our ability to finance our operations and business initiatives and obtain funding for such activities; our future results of operations and financial position, business strategy and plan prospects, projected revenue or costs and objectives of management for future research, development or operations, are forward-looking statements. These statements relate to our future plans, objectives, expectations and intentions and may be identified by words such as may, will, should, expects, plans, anticipates, intends, targets, projects, contemplates, believes, seeks, goals, estimates, predict, continue or similar words. Readers are cautioned that these forward-looking statements are only predictions and are subject to risks, uncertainties, and assumptions that are difficult to predict, including those identified below, under Part II, Item 1A. Risk Factors and elsewhere herein. Therefore, actual results may differ materially and adversely from those expressed in any forward-looking statements. We undertake no obligation to revise or update any forward-looking statements for any reason.

Company Overview

ZIOPHARM Oncology, Inc. is a biopharmaceutical company seeking to acquire, develop and commercialize, on its own or with partners, a diverse portfolio of cancer therapies that address unmet medical needs. Pursuant to an exclusive channel partner agreement (or Channel Agreement) with Intrexon Corporation, or Intrexon, we obtained certain exclusive rights to Intrexon's technologies for use in the field of oncology, which included a clinical stage product candidate, Ad-RTS-IL-12 used with the oral activator veledimex. The technologies represent an industrialized engineering approach for molecular and cell biology and gene control. They employ an inducible gene-delivery system that enables controlled *in vivo* expression of genes that produce therapeutic proteins to treat cancer. Ad-RTS-IL-12 + veledimex uses this gene delivery system to produce interleukin-12, or IL-12, a potent, naturally occurring anti-cancer protein.

We have completed two Phase 2 studies evaluating Ad-RTS-IL-12 + veledimex, the first for the treatment of metastatic melanoma, and the second for the treatment of metastatic breast cancer. We have announced the initiation of a single-center Phase 1b/2 study following standard chemotherapy for the treatment of patients with locally advanced or metastatic breast cancer and the initiation of a multi-center Phase 1 study in patients with recurrent or progressive glioblastoma (GBM) or Grade III malignant glioma, a form of brain cancer. Both studies are actively enrolling patients. Early clinical data from the GBM trial was presented at the Society for Neuro-Oncology meeting in November 2015, and on February 24, 2016, we announced the successful completion of the initial dosing phase of the study and that the first patient has been dosed in the next succeeding cohort of the GBM study. We also presented information about the ongoing breast cancer study at the San Antonio Breast Cancer Symposium in December 2015. There will be an update of the GBM and breast cancer studies at the 2016 American Society of Clinical Oncology (ASCO) meeting in June. In addition to Ad-RTS-IL-12 + veledimex as monotherapy, we have undertaken pre-clinical studies which show that this viral-based immunotherapy may be able to be combined with an immune checkpoint inhibitor (iCPI) to improve the anti-tumor effect for GBM. This pre-clinical data has also been submitted for dissemination at the American Society of Cell and Gene Therapy (ASGCT) on May 6, 2016, and we believe will support the first-in-human application of combining Ad-RTS-IL-12 + veledimex with an iCPI for investigational treatment of GBM.

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In addition to our immuno-oncology programs, pursuant to our Channel Agreement, we, together with Intrexon, obtained an exclusive, worldwide license to certain immuno-oncology technologies owned and licensed by The University of Texas MD Anderson Cancer Center, or MD Anderson, including technologies relating to novel chimeric antigen receptors, or CARs, natural killer, or NK cells and T cell receptors, or TCRs. We plan to develop genetically modified T cells and other immune cells that will target and kill cancer cells. Control systems are also being developed such as the Intrexon RheoSwitch Therapeutic System® (RTS®) for receptor and/or cytokine expression as well as for the conditional ablation of genetically modified cells using a kill switch. We plan to leverage the synergy between the platforms to accelerate an immuno-oncology pipeline and programs for the development of allogeneic CAR⁺ T and/or natural killer (NK) cells that can be used as off-the-shelf (OTS) therapies. During 2015, the Company was in the clinic in collaboration with MD Anderson with CAR⁺ T therapies targeting CD19. A T-cell trial, using second generation technology, will continue in 2016. The Company expects to enter the clinic with an additional CAR⁺ T therapy for myeloid malignancies in 2016. Together with Intrexon, we have research programs evaluating additional CAR targets and CARs co-expressed with cytokines. In addition to developing T cells, the Company expects to enter the clinic in 2016 infusing OTS primary NK cells for investigational therapy of acute myelogenous leukemia (AML). The Company has additional interest in OTS products and is conducting a research program for the development of an allogeneic CAR⁺ T therapy in 2016. T-cell specificity can be redirected not only through CARs, but also T cell receptors (TCRs) and plans to initiate programs investigating T cells genetically modified to express TCR with preclinical studies planned for 2016. We plan to continue to combine Intrexon's technology suite with our capabilities to translate science to the patient, and to identify and develop additional products to stimulate or inhibit key pathways, including those used by the body's immune system, to treat cancer.

On March 27, 2015, we entered into a global collaboration with Intrexon focused exclusively on chimeric antigen receptor T cell, or CAR⁺ T, products with Ares Trading, or Ares, a biopharmaceutical division of Merck KGaA. Intrexon will share the economic provisions of this collaboration equally with us, including an upfront payment of \$115.0 million received in July 2015, milestones and royalties. Under the collaboration Ares already selected two CAR⁺ T targets for which we will perform certain research activities that will, in part, be funded by Ares. Pursuant to the terms of the Exclusive Channel Partner Amendment, or ECP Amendment, we will be responsible for any additional research and development expenditures. Once these candidates reach investigational new drug stage, the programs will be transferred to Ares for clinical development and commercialization. We, together with Intrexon will also independently conduct research and development on other CAR⁺ T candidates, with Ares Trading having the opportunity during clinical development to opt-in to these candidates for additional payments.

On September 28, 2015, the Company entered into a new Exclusive Channel Collaboration with Intrexon to develop treatments for graft-versus-host disease (GvHD), a major complication of allogeneic hematopoietic stem-cell transplantation, or HSCT, which significantly impairs the quality of life and survival of many recipients. The collaboration will initially focus on addressing the underlying pathologies of GvHD through engineered cell platforms to express and deliver interleukin-2, or IL-2, a cytokine critical for modulation of the immune system. The Company believes that the combined expertise and knowledge gained from our research programs with Intrexon in adoptive T-cell therapies and cytokine modulation for the treatment of cancer positions us well to develop and implement therapeutic approaches addressing an area of high unmet medical need for patients with GvHD. Through the GvHD Agreement, we, together with Intrexon, plan to pursue engineered cell therapy strategies, used either separately or in combination, for targeted prevention and/or treatment of GvHD. The first approach is expected to utilize the infusion of regulatory T cells, or Tregs, conditionally expressing IL-2 utilizing the RheoSwitch platform. The second approach is expected to utilize the deployment of orally-delivered microbe-based ActoBiotics® therapeutics expressing IL-2 to modulate immune function. Allogeneic HSCT is used for the treatment of various diseases including hematological malignancies, immunological deficiencies as well as non-malignant conditions. Approximately 40 to 60% of HSCT recipients develop GvHD, either acute or chronic, when immune (graft) cells in a transplant patient recognize their engrafted host as foreign and attack the patient's (host) cells. Immunosuppressive agents and systemic steroids

routinely used to treat GvHD have limited efficacy and toxicity, defining the need for safer, more effective therapies. Human studies have shown that administration of low-dose subcutaneous IL-2 in patients with steroid-refractory GvHD acts via Tregs to ameliorate its manifestations

Enabling Technology

The Company's approach to immuno-oncology entails the application of engineering principles to biological systems for the purpose of designing and constructing new biological systems or redesigning/modifying existing biological systems. Biological systems are governed by DNA, the building block of gene programs, which control cellular processes by coding for the production of proteins and other molecules that have a functional purpose and by regulating the activities of these molecules. This regulation occurs via complex biochemical and cellular reactions working through intricate cell signaling pathways, and control over these molecules modifies the output of biological systems. The Company's approach to immuno-oncology has been enabled by the application of information technology and advanced statistical analysis, also known as bioinformatics, to genetic engineering, as well as by improvements in DNA synthesis. This approach aims to engineer gene-based programs or codes to modify cellular function to achieve a desired biological outcome. Its application is intended to allow more precise control of drug concentration and dose, thereby improving the therapeutic index associated with the resulting drug. A further embodiment of this technology is the ability to eliminate genetically modified immune cells after infusion.

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On January 6, 2011, we entered into the Channel Agreement, to develop and commercialize novel DNA-based therapeutics in the field of cancer treatment by combining Intrexon's technological platform with our capabilities to translate science to the patient. As a result, our bioengineered DNA platform employs an inducible gene-delivery system that enables regulated and controlled delivery of genes that produce therapeutic proteins to treat cancer. The first example of this regulated controlled delivery is achieved by producing IL-12, a potent, naturally occurring anti-cancer protein, under the control of Intrexon's proprietary biological switch to turn on and off the therapeutic protein expression at the tumor site. We and Intrexon refer to this switch as the RheoSwitch Therapeutic System[®] or RTS[®], platform. Our initial drug candidate being developed using the immuno-oncology platform is Ad-RTS-IL-12 + veledimex.

More detailed descriptions of our clinical development plans for each of these programs are set forth below under the caption *Product Candidates*.

Immuno-oncology

Immuno-oncology, which typically utilizes a patient's own immune system to treat cancer, is one of the most actively pursued areas of research by biotechnology and pharmaceutical companies today. Cancer cells contain mutated proteins and may overexpress other proteins usually found in the body at low levels. The immune system typically recognizes unusual or aberrant cell protein expression and eliminates these cells in a highly efficient process known as immune surveillance. Central players in immune surveillance are types of white blood cell known as the T cells and NK cells. In healthy individuals, T cells and NK cells can identify and kill infected or abnormal cells, including cancer cells. Cancer cells develop the ability to evade immune surveillance, which is a key factor in their growth, spread, and persistence. In the recent past, there has been substantial scientific progress in countering these evasion mechanisms using immunotherapies, or therapies that activate the immune system.

On January 13, 2015, we, together with Intrexon, entered into a license agreement with MD Anderson, which we refer to as the MD Anderson License. Pursuant to the MD Anderson License, we and Intrexon hold an exclusive, worldwide license to certain technologies owned and licensed by MD Anderson including technologies relating to novel CAR⁺ T cell therapies arising from the laboratory of Laurence Cooper, M.D., Ph.D., who was then a tenured professor at MD Anderson, as well as either co-exclusive or non-exclusive licenses under certain related technologies.

Combining the non-viral genetic engineering technologies we licensed from MD Anderson together with Intrexon's industrialized approach to gene engineering and cell control, we believe we can reprogram T cells to express a particular CAR or TCR construct that will enable the T cell and/or NK cell to recognize and target cancer cells. CAR⁺ T cells target cell surface tumor antigens, such as CD19, that exist on cancer cells and that are independent of human

leukocyte antigens, or HLAs, and which we refer to as public antigens. TCR-expressing T cells target tumor antigens that are dependent on HLAs and which we refer to as private antigens and include neo-antigens. NK cells target tumors with loss or differences of HLAs, or tumors with no defined antigens. Most CAR⁺ T cell and TCR products currently being developed by competitors are autologous, or derived from the patient's own mononuclear white blood cells, and gene engineered with viral technology. As a result, the patient's blood must be harvested, shipped to a manufacturing facility where the isolated mononuclear white blood cells are modified using a retrovirus to express the CAR or TCR, and then shipped back to the hospital and infused into the patient. The process can take weeks and is labor intensive and costly. Currently, this complex technique can only be done in sophisticated laboratories. We believe we will be able to manufacture our CAR⁺ T cells and TCRs using viral and non-viral methods. The latter may result in a reduced cost of manufacturing. We intend to use our gene transfer methods to develop allogeneic treatments that can be used as an OTS treatment. An allogeneic OTS (also referred to as universal donor) treatment would enable a patient to be treated with a CAR⁺ T and/or NK cell product that is created in advance of need from one or more separate healthy donor(s), possibly genetically modified for a tumor type, and then distributed to multiple points of care. Our non-viral methods, which we believe are customizable, fast and less costly than other gene transfer approaches, together with our industrialized, scalable engineering approach are expected to enable highly efficient and less costly manufacturing approaches to gene engineered cell-based therapy. In addition, our proprietary RheoSwitch Therapeutic System[®] and/or kill switches may give us the ability to control *in vivo* gene expression of CAR or TCR or cytokine on T cells and/or NK cells, which we believe could result in significantly lower toxicity compared to other products currently in development.

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Cancer Overview

Cancer is a group of diseases characterized by either the runaway growth of cells or the failure of cells to die normally. Often, cancer cells spread to distant parts of the body, where they can form new tumors. Cancer can arise in any organ of the body and, according to the American Cancer Society, strikes slightly less than one of every two American men and a little more than one of every three American women at some point in their lives.

It is reported that there are more than 100 different varieties of cancer. Carcinomas, the most common type of cancer, originate in tissues that cover a surface or line a cavity of the body. Lymphomas are cancers of the lymph system, which is a circulatory system that bathes and cleanses the body's cells. Leukemias involve blood-forming tissues and blood cells. As their name indicates, brain tumors are cancers that begin in the brain, skin cancers, including melanomas, originate in the skin, while soft tissue sarcoma arises in soft tissue. Cancers are considered metastatic if they spread through the blood or lymphatic system to other parts of the body to form secondary tumors.

Cancer is caused by a series of mutations (alterations) in genes that control cells' ability to grow and divide. Some mutations are inherited; others arise from environmental factors such as smoking or exposure to chemicals, radiation, or viruses that damage cells' DNA. The mutations cause cells to divide relentlessly or lose their normal ability to die.

According to the American Cancer Society, it is estimated that about 1,685,210 new cases of cancer are expected to be diagnosed in 2016 and about 595,690 Americans are expected to die from cancer in 2016. The cost of treating cancer is significant. The Agency for Healthcare Research and Quality estimates that the direct medical cost of cancer in 2013 was \$74.8 billion.

Cancer Treatments

Major treatments for cancer include surgery, radiotherapy, chemotherapy and immunotherapy. Newer approaches such as anti-angiogenic and targeted therapies are rapidly evolving. While there are many experimental treatments under investigation, including DNA and other immunological-based therapies, we believe the prevalence of cancer will remain a significant unmet medical need. Many therapies, including combination approaches, with different mechanisms of action may be needed to overcome tumor escape. In addition to monotherapy treatment in GBM, the Company's approach to cancer treatment includes applying multiple modality and multi-delivery approaches that encompasses viral and non-viral mechanisms, differentiating us from many other companies in the field of adoptive cellular therapy today.

Product candidates

The following chart identifies our immuno-oncology product candidates and their current stage of development, each of which are described in more detail below.

Table of Contents**Immuno-oncology programs:*****Ad-RTS-IL-12 + veledimex***

Ad-RTS-IL-12 + veledimex has been evaluated in two Phase 2 studies, the first for the treatment of metastatic melanoma, and the second for the treatment of unresectable recurrent or metastatic breast cancer. We are continuing to evaluate Ad-RTS-IL-12 + veledimex, in brain cancer and breast cancer. Ad-RTS-IL-12 + veledimex, our most advanced product candidate, uses our gene delivery system to produce IL-12, a potent, naturally occurring anti-cancer protein.

More specifically, IL-12 is a potent immunostimulatory cytokine which activates and recruits dendritic cells that facilitate the cross-priming of tumor antigen-specific T cells. We have developed an adenoviral vector, Ad-RTS-IL-12, administered intra-tumorally under the control of the RheoSwitch Therapeutic System® (RTS) expression platform. Gene expression and subsequent IL-12 protein production is tightly controlled by the activator ligand veledimex.

Glioblastoma (GBM) and Grade III malignant glioma are recognized as the most frequent malignant brain tumor in adults and are associated with a particularly dismal prognosis, resulting in a very high unmet medical need. In the USA, as of 2016 it is estimated that there are approximately 18,000 new cases of glioblastomas and malignant gliomas per year given the annual incidence of 5.26 per 100,000 of population. Relative survival estimates for glioblastoma are quite low, with only 5.1% of patients surviving five years post diagnosis. Newly diagnosed glioblastoma subjects have a median overall survival (OS) of 11 to 17 months and 2-year OS rate between 15% and 27%. The current standard of care is based on surgical resection to the maximum feasible extent, followed by radiotherapy and concomitant adjuvant temozolomide. However, such aggressive treatment is associated with only modest improvements in survival with a median survival of 15 months versus 12 months with radiotherapy alone. After first line treatment, virtually all Glioblastoma patients experience disease progression after a median of 7-10 months. To date, no salvage treatment has been validated by Phase III data for recurrent or progressive glioblastoma. For such subjects, the median OS is 6 to 7 months, and median progression-free survival (PFS) is 2 to 3 months. The lack of standard and validated salvage therapies has prompted the use of nitrosureas, temozolomide rechallenge, bevacizumab, and other targeted agents that are unsatisfactory treatment options. This likely reflects the complexities of disease heterogeneity, and the treatment limitations of brain tumors given the low activity of antineoplastic agents, de novo or acquired drug resistance, the sensitivity of the brain to irreversible damage in response to treatment and the presence of the blood brain barrier (BBB), which maintains the brain as a privileged compartment. Surgical resection may be offered for subjects with recurrent disease, with the goal of alleviating mass effect, improving symptoms, and achieving cytoreduction. Surgical resection, however, is limited by the infiltrative nature of the disease and the lack of clear margins delimitating the tumor. After temozolomide and bevacizumab fail, the prognosis is extremely limited and the median survival is 3 or 4 months. Given the poor overall prognosis and lack of effective treatments, new therapeutic approaches for malignant gliomas are needed.

It is estimated that there are nearly 3 million women living in the United States with a history of invasive breast cancer, and an additional 226,870 women were diagnosed in 2012. Approximately 50% of women diagnosed with primary breast cancer will eventually relapse and develop metastatic or advanced disease. In addition, around 10% of patients present with metastatic disease at first diagnosis. The 5-year relative survival rate for women diagnosed with localized breast cancer is 98.6%; survival declines to 83.8% for regional stage and to 23.3% for distant stage. In addition to stage, factors that influence survival include tumor grade, hormone receptor status, and human epidermal growth factor receptor 2 (HER2) status.

Ad-RTS-IL-12 + veledimex for malignant glioma

We initiated the Phase 1 study during the second quarter of 2015. On July 23, 2015, the FDA granted orphan drug designation of Ad-RTS-IL-12 + veledimex for the treatment of malignant glioma. Orphan drug designation provides eligibility for a seven-year period of market exclusivity in the United States after product approval, an accelerated review process, accelerated approval where appropriate, grant funding, tax benefits and an exemption from user fees.

In June 2015 we began enrolling a multi-center gene therapy Phase I trial recruiting patients with recurrent or progressive glioblastoma (GBM) or Grade III malignant glioma. We reported biologic data from this study in our presentation titled Intra-tumoral regulated expression of IL-12 as a gene therapy approach to treatment of glioma at the Society for Neuro-Oncology (SNO) 20th Annual Scientific Meeting, November 19-22, 2015 in San Antonio, TX, and on February 24, 2016, we announced the successful completion of the initial dosing cohort and that the first patient has been dosed in the next succeeding cohort of the GBM study. We will be reporting pre-clinical data on combining Ad-RTS-IL-12 + veledimex with iCPI at ASGCT May, 6 2016. The combination of controlled expression of IL-12 with multiple immune checkpoint inhibitors in a GBM mice model showed superior results than either treatment alone, with a combination with anti-PD1 demonstrating 100% survival. These data provide a strong scientific rationale for evaluating this combination in human GBM; ZIOPHARM plans to initiate a combination study in 2016 at MD Anderson Cancer Center in recurrent GBM. At ASCO on June 4, 2016 we will update the results of the on-going Phase I open-label study of Ad-RTS-hIL-12 + veledimex gene therapy including data on additional patients, immune biomarkers, overall survival and safety profile.

Ad-RTS-IL-12 + veledimex for metastatic breast cancer and melanoma

We have completed Phase 2 monotherapy studies in melanoma and breast cancer using Ad-RTS-IL-12 + veledimex. We presented two poster presentations entitled Demonstration of systemic antitumor immunity via intra-tumoral regulated expression of IL-12 in advanced breast cancer and melanoma patients and Demonstration of systemic antitumor immunity via intra-tumoral regulated expression of IL-12 as a gene therapy approach to treatment of cancer at the CRI-CIMT-EATI-AACR Inaugural International Cancer Immunotherapy Conference, Translating Science into Survival on September 16-19, 2015 in New York, New York.

On April 27, 2015, we announced the initiation of a Phase 1b/2 study of Ad-RTS-hIL-12 + veledimex following standard chemotherapy for the treatment of patients with locally advanced or metastatic breast cancer. The study is being conducted at the Memorial Sloan Kettering Cancer Center in New York and will evaluate improving the patient's response at 12-weeks. A poster presentation of this study titled Phase 1b/2 study of intra-tumoral Ad-RTS-hIL-12 + veledimex in patients with chemotherapy-responsive locally advanced or metastatic breast cancer was presented at the San Antonio Breast Cancer Symposium, in San Antonio, Texas in December 2015. There will be an update of the breast cancer trial at the 2016 ASCO meeting on June 5, 2016.

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CAR⁺ T, NK and TCR cells

We are actively pursuing viral and non-viral genetic engineering technologies and approaches to propagation to develop novel CAR⁺ T, NK and TCR cells. Combining this technology with Intrexon's industrialized synthetic biologic engineering and clinically tested and validated RTS modules and/or kill switches, represents a differentiated approach to genetically modified T cells and other immune cells, such as NK cells. Employing novel cell engineering techniques and multigenic gene programs, we expect to implement next-generation non-viral and viral adoptive cellular therapies based on designer cytokines, CARs and TCRs targeting both hematologic malignancies and solid tumors.

The platform we, together with Intrexon, exclusively licensed from MD Anderson uses the *Sleeping Beauty*, or SB, non-viral genetic modification system to generate and characterize new CAR⁺ T and TCR designs, which enables a high throughput approach to evaluate the genetically modified immune cells in oncology. In addition, we can rapidly assemble CARs and TCRs to fashion immuno-receptors that differ in specificity and ability to activate T cells. These CAR⁺ T and TCR molecules are evaluated based on measurements of T cell function, phenotype, and genotype. We believe this non-viral gene transfer using the SB system is unique in the field of oncology and may avoid the expense and manufacturing difficulty associated with creating T cells engineered to express CAR and TCR using viral vectors. After electroporation, the transposon/transposase improves the efficiency of integration of donor plasmids used to express CAR and other transgenes in T cells. Propagation of genetically modified T cells on bio-engineered activating and propagating cells (AaPC) may provide a competitive advantage over other methods of modification. The SB system combined with AaPC can selectively propagate and thus retrieve CAR-expressing T cells suitable for human applications. The time in culture with AaPC may be shortened to manufacture minimally-manipulated T cells within days of gene transfer by electroporation. Associated pre-clinical data will be presented at ASGCT on May 5, 2016. Furthermore, we are exploring technologies that eliminate the need for *in vitro* propagation. We are also exploring the use of lentivirus to genetically reprogram T cells with CAR and TCR to redirect T-cell specificity.

The ability to genetically modify immune cells using non-viral and viral-based technologies enables us to express other genes in addition to immunoreceptors (CARs and TCRs) to redirect specificity. For example, we have developed a tethered or membrane-bound form of IL-15 (mbIL-15) which in pre-clinical modeling endows CAR-expressing T cells with an ability to be long-lived. The Company expects to build upon these data to co-express immunoreceptors with cytokines and to leverage its ability to control expression with RTS and/or kill switches. Using this unique set of genetic engineering tools, the company can employ a broad immunotherapy approach against cancer.

CAR⁺ T

Through the MD Anderson License, the Company was able to enter the clinic with three CAR⁺ T therapies in 2015 utilizing the non-viral genetic modification capabilities of the SB system. Two of these trials are with first generation technologies and one with second generation methodology. The latter will continue enrolling in 2016. The Company expects to enter the clinic with an additional CAR⁺ T therapy for myeloid malignancies in 2016. This will be based on co-expressing a CAR (outside of CD19) with a kill switch to eliminate T cells after administration and using lentivirus to genetically modify the T cells. Pre-clinical data including CAR expression, cytotoxicity and IFN γ production are encouraging and the Company is preparing for the clinical study. Development of CAR⁺ T therapies for other hematologic and solid tumor malignancies is also underway with preclinical studies planned throughout 2016.

The Company expects to conduct a research program for the development of an allogeneic CAR⁺ T therapy and plans to initiate programs investigating T cells genetically modified to express TCR with preclinical studies planned for 2016. The primary factor limiting the current deployment of a universal donor product is the potential for GvHD. GvHD occurs if infused allogeneic T cells regard the recipient's body as foreign. Previous research from Dr. Cooper

and colleagues at MD Anderson suggested that universal or OTS allogeneic T cells generated from one donor could be administered to multiple recipients. This is achieved by genetically editing CAR-expressing T cells to eliminate expression of the endogenous $\alpha\beta$ TCR, the receptor most responsible for triggering GvHD, without compromising CAR-dependent effector functions. Dr. Cooper and colleagues at MD Anderson also published research which demonstrated that T cells can be permanently modified to eliminate TCR expression, demonstrating how to *a priori* generate cells from one allogeneic donor for infusion into multiple recipients. These studies represent steps towards our goal of on-demand therapy that can be pre-deployed at multiple sites and infused when needed. The translation of the SB system and AaPC for use in clinical trials has the potential to show how a nimble and cost-effective approach to developing genetically modified T cells can be used to implement clinical trials infusing next-generation T cells with improved therapeutic potential.

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NK Cell

In addition to T cells, the Company is pursuing NK cell therapies for the treatment of cancer. NK cells may have advantages over T-cell therapies in that killing is independent of a target antigen. Initially, this OTS NK cell treatment will be tested in patients with AML; plans are to enter the clinic in 2016. Additional clinical trials which may employ combinations with other therapies will be considered in the future, e.g. for treatment of brain cancer.

Discovery programs are also underway to explore genetic modification of NK cells for increased tumor killing specificity. We expect to advance these and other exploratory NK-cell programs in preclinical studies in 2016.

TCR

Many of these aforementioned genetic engineering technologies can also be applied towards targeting intracellular antigens with one or more TCRs. This approach is particularly important for addressing the complexity of solid tumors. SB is ideally suited for targeting intracellular antigens by TCR as it may be more cost effective, should allow for rapid manufacturing and is customizable for individual patient therapies with the ability to include multiple TCRs in a single therapy. The company is pursuing discovery programs in TCR therapies for known as well as unknown (or neoantigen) targets. The development of an approach to truly create a personalized therapy for each cancer patient based on his/her neoantigens is a long term goal of the company.

GvHD Program

GVHD may occur after a bone marrow or stem cell transplant in which someone receives bone marrow tissue or cells from a donor. The new, transplanted cells regard the recipient's body as foreign. When this happens, the newly transplanted cells attack the recipient's body. We, together with Intrexon, are initiating a research program focused on addressing the underlying pathologies of GvHD through its engineered cell platforms. The exclusive collaboration, or the GvHD Program, will focus on the pursuit of the following engineered cell therapy strategies, used either separately or in combination, for the targeted treatment of GvHD: (i) the infusion of regulatory T cell expressing membrane-bound and/or soluble interleukin-2 and (ii) the deployment of orally delivered, genetically modified *L. lactis* such as that express interleukin-2 to modulate immune function. We believe these strategies have the potential to broaden the number of patients eligible to receive allogeneic HCST and also increase the number of effective donor/recipient combinations.

Milestones

We expect the following milestones to occur in 2016:

Intra-tumoral IL-12 RheoSwitch® programs:

Clinical update at ASCO 2016 for Phase 1 study of GBM

Update at ASCO 2016 for Phase 1/2 study in Breast Cancer with standard of care

Pre-clinical data presented at ASGCT 2016 for combining with iCPI

CAR⁺ T programs:

Continuation of CD19 CAR⁺ T clinical study in 2016

Initiate a CAR⁺ T clinical study for myeloid malignancies in the second half of 2016

Preclinical data presented at ASGCT 2016 for shortening the time of *ex vivo* manufacture of SB-modified T cells

Initiate CAR⁺ T-cell preclinical studies for other hematological malignancies and solid tumors in 2016

Initiate preclinical studies of allogeneic, OTS T-cell studies in 2016

TCR-T programs

Initiate TCR-modified T-cell preclinical studies in 2016

NK cell programs

Initiate a Phase 1 study of OTS NK cells for AML in 2016

GvHD programs

Initiate preclinical studies in 2016

We are also evaluating additional potential preclinical candidates and continuing discovery efforts aimed at identifying other potential product candidates under our Channel Agreement with Intrexon. In addition, we may seek to enhance our pipeline in immuno-oncology through focused strategic transactions, which may include acquisitions, partnerships and in-licensing activities.

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Small molecule programs

In addition to our immuno-oncology programs, we maintain certain rights to three small molecule programs, palifosfamide, darinaparsin and indibulin, all of which we are no longer directly developing. With respect to palifosfamide, in March 2013, we announced that the pivotal Phase 3 study, PICASSO 3, did not meet its primary endpoint of progression-free survival, and that we would terminate our development program in metastatic soft tissue sarcoma. The overall survival endpoint data from MATISSE, the study of palifosfamide in combination with carboplatin and etoposide chemotherapy versus carboplatin and etoposide alone in chemotherapy naïve patients with metastatic small cell lung cancer, was presented at the annual meeting of the American Society of Clinical Oncology in June 2015. We out-licensed palifosfamide to Predictive Therapeutics, Ltd, a privately-held company, on November 17, 2015. Pursuant to our agreement with Predictive Therapeutics we received an upfront payment of \$250 thousand, and we are entitled to receive additional clinical and commercial milestone payments, as well as royalties based on net sales. As of March 31, 2016, Predictive was in default of certain payments amounting to \$311 thousand related to transitional services provided us and the reimbursement of certain expenses incurred by the Company in connection with the transaction.

With respect to darinaparsin, we have entered into an amended and restated global licensing agreement with Solasia Pharma K.K., or Solasia, on July 31, 2014 granting Solasia an exclusive worldwide license to develop and commercialize darinaparsin, and related organoarsenic molecules, in both intravenous and oral forms in all indications for human use. In exchange, we will be eligible to receive from Solasia development-and sales-based milestones, a royalty on net sales of darinaparsin, once commercialized, and a percentage of any sublicense revenues generated by Solasia. On March 28, 2016, Solasia initiated a multi-center pivotal clinical trial intended to provide substantial evidence of efficacy necessary to support the filing of an application for a new drug approval in certain of the territories assigned to Solasia. The start of this trial triggered a \$1.0 million milestone payment to us which is included in accounts receivable at March 31, 2016, and an equivalent milestone payment to M.D. Anderson which is included in accrued expenses at March 31, 2016.

During 2014, we determined to no longer pursue clinical development of indibulin.

Table of Contents**Financial Overview****Overview of Results of Operations****Three Months ended March 31, 2016 Compared to Three Months ended March 31, 2015**

Revenue. Revenue during the three months ended March 31, 2016 and 2014 was as follows:

(\$ in thousands)	Three months ended March 31,		Change
	2016	2015	
Collaboration revenue	\$ 1,969	\$ 272	\$ 1,697 624%

Revenue for the three months ended March 31, 2016 has increased in comparison to revenue for the three months ended March 31, 2015. The increase resulted from revenue recognized related to the Ares Trading Agreement (Note 5, Commitments and Contingencies) in the amount of \$1.6 million for the three months ended March 31, 2016.

Deferred revenue of \$52.8 million is comprised of \$52.7 million from the Ares Trading Agreement which will be earned over the period of effort estimated to be 9 years and \$100 thousand from the license and collaboration agreement we entered into with Predictive which will be earned over the period of effort estimated to be eight months.

Research and development expenses. Research and development expenses during the three months ended March 31, 2016 and 2015 were as follows:

(\$ in thousands)	Three months ended March 31,		Change
	2016	2015	
Research and development	\$ 10,199	\$ 74,249	\$ (64,050) -86%

Research and development expenses for the three months ended March 31, 2016 decreased by \$64.1 million when compared to the three months ended March 31, 2015. The change in research and development is due to a one-time charge of \$67.3 million for the fair value of the common shares issued to MD Anderson in consideration for the MD Anderson License agreement in 2015, a \$400 thousand decrease in small molecule program expenses, an approximately \$150 thousand decrease in spending related to contracted outside services, and a \$200 thousand decrease in other R&D expenses. These decreases were offset by a \$4.0 million increase related to discovery and nonclinical activities.

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Our research and development expense consists primarily of licensing costs, collaboration costs, salaries and related expenses for personnel, costs of contract manufacturing services, costs of facilities and equipment, fees paid to professional service providers in conjunction with our clinical trials, fees paid to research organizations in conjunction with preclinical animal studies, costs of materials used in research and development, consulting, license and milestone payments and sponsored research fees paid to third parties.

We have not accumulated and tracked our internal historical research and development costs or our personnel and personnel-related costs on a program-by-program basis. Our employee and infrastructure resources are allocated across several projects, and many of our costs are directed to broadly applicable research endeavors. As a result, we cannot state the costs incurred for each of our oncology programs on a program-by-program basis.

Our future research and development expenses in support of our current and future programs will be subject to numerous uncertainties in timing and cost to completion. We test potential products in numerous preclinical studies for safety, toxicology and efficacy. We may conduct multiple clinical trials for each product. As we obtain results from trials, we may elect to discontinue or delay clinical trials for certain products in order to focus our resources on more promising products or indications. Completion of clinical trials may take several years or more, and the length of time generally varies substantially according to the type, complexity, novelty and intended use of a product. It is not unusual for preclinical and clinical development of each of these types of products to require the expenditure of substantial resources.

We estimate that clinical trials of the type generally needed to secure new drug approval are typically completed over the following timelines:

Clinical Phase	Estimated Completion Period
Phase 1	1 - 2 years
Phase 2	2 - 3 years
Phase 3	2 - 4 years

The duration and the cost of clinical trials may vary significantly over the life of a project as a result of differences arising during clinical development, including, among others, the following:

The number of clinical sites included in the trials;

The length of time required to enroll suitable patients;

The number of patients that ultimately participate in the trials;

The duration of patient follow-up to ensure the absence of long-term product-related adverse events; and

The efficacy and safety profile of the product.

As a result of the uncertainties discussed above, we are unable to determine the duration and completion costs of our programs or when and to what extent we will receive cash inflows from the commercialization and sale of a product. Our inability to complete our programs in a timely manner or our failure to enter into appropriate collaborative agreements could significantly increase our capital requirements and could adversely impact our liquidity. These uncertainties could force us to seek additional, external sources of financing from time-to-time in order to continue with our product development strategy. Our inability to raise additional capital, or to do so on terms reasonably acceptable to us, would jeopardize the future success of our business.

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General and administrative expenses. General and administrative expenses during the three months ended March 31, 2016 and 2015 were as follows:

(\$ in thousands)	Three months ended March 31,		Change	
	2016	2015		
General and administrative	\$ 3,810	\$ 4,250	\$ (440)	-10%

General and administrative expenses for the three months ended March 31, 2016 decreased by \$440 thousand when compared to the three months ended March 31, 2015. The decrease was primarily due to contracted outside service costs in 2015, for approximately \$1.2 million, used to finalize the MD Anderson License agreement. This decrease was offset by increased stock.

Other income (expense). Other income (expense) for three months ended March 31, 2016 and 2015 were as follows:

(\$ in thousands)	Three months ended March 31,		Change	
	2016	2015		
Other income (expense), net	\$ 21	\$ (4)	\$ 25	(625%)

The increase in other income (expense) from the three months ended March 31, 2016 as compared to the three months ended March 31, 2015 was due primarily to interest received on our cash balance.

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Liquidity and Capital Resources

As of March 31, 2016, we had approximately \$124.8 million in cash and cash equivalents, compared to \$140.7 million in cash and cash equivalents as of December 31, 2015. Given our current development plans, we anticipate that our current cash resources will be sufficient to fund our operations into the fourth quarter of 2017. However, changes may occur that would consume our existing capital prior to that time, including the scope and progress of our research and development efforts and changes in governmental regulation. Actual costs may ultimately vary from our current expectations, which could materially impact our use of capital and our forecast of the period of time through which our financial resources will be adequate to support our operations. We have estimated the sufficiency of our cash resources based in part on the anticipated advancement of our immuno-oncology product candidates in the clinic under our exclusive partnership and collaboration with Intrexon and the MD Anderson License, and we expect that the costs associated with these product candidates, as well as additional product candidates in our pipeline, will increase the level of our overall research and development expenses significantly going forward.

Although all human clinical trials are expensive and difficult to design and implement, we believe that due to complexity, costs associated with clinical trials for immuno-oncology products are greater than the corresponding costs associated with clinical trials for small molecule candidates.

In addition to these factors, our actual cash requirements may vary materially from our current expectations for a number of other factors that may include, but are not limited to, changes in the focus and direction of our development programs, competitive and technical advances, costs associated with the development of our product candidates, our ability to secure partnering arrangements, and costs of filing, prosecuting, defending and enforcing our intellectual property rights. If we exhaust our capital reserves more quickly than anticipated, regardless of the reason, and we are unable to obtain additional financing on terms acceptable to us or at all, we will be unable to proceed with development of some or all of our product candidates on expected timelines and will be forced to prioritize among them.

We expect that we will need additional financing to support our long-term plans for clinical trials and new product development. We expect to finance our cash needs through the sale of equity securities, strategic collaborations and/or debt financings, or through other sources that may be dilutive to existing stockholders. There can be no assurance that we will be able to obtain funding from any of these sources or, if obtained, what the terms of such funding(s) may be, or that any amount that we are able to obtain will be adequate to support our working capital requirements until we achieve profitable operations. We have no current committed sources of additional capital. Recently, capital markets have experienced a period of instability that may severely hinder our ability to raise capital within the time periods needed or on terms we consider acceptable, if at all. If we are unable to raise additional funds when needed, we may not be able to continue development and regulatory approval of our products, or we could be required to delay, scale back or eliminate some or all our research and development programs.

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The following table summarizes our net increase (decrease) in cash and cash equivalents for the three months ended March 31, 2016 and 2015:

	Three months ended March 31,	
	2016	2015
(\$ in thousands)		
Net cash provided by (used in):		
Operating activities	\$ (16,079)	\$ (9,717)
Investing activities	(157)	(17)
Financing activities	365	96,615
Net increase (decrease) in cash and cash equivalents	\$ (15,871)	\$ 86,881

Net cash used in operating activities was \$16.1 million for the three months ended March 31, 2016, as compared to \$9.7 million used in operating activities for the three months ended March 31, 2015. The \$6.4 million increase in cash used is due to an increase of \$3.5 million in prepaid expenses and other current assets related to prepayments to MD Anderson, a \$1.7 million increase in draw downs on deferred revenue as a result of the Ares Trading Agreement (Note 5, Commitments and Contingencies), a \$1.0 million increase in stock-based compensation as well as a \$0.2 million related to changes in operating assets and liabilities.

Net cash used in investing activities was \$157 thousand for the three months ended March 31, 2016 compared to \$17 thousand for the three months ended March 31, 2015. The change was due to increased spending on leasehold improvements during the quarter ended March 31, 2016.

Net cash provided by financing activities was \$365 thousand for the three months ended March 31, 2016 compared to \$96.6 million for the three months ended March 31, 2015. The \$96.2 million change in cash provided by financing activities is primarily attributable to proceeds of approximately \$94.3 million associated with our February 2015 public offering and \$2.5 million from stock option exercises in the prior year, compared to \$366 thousand in stock option exercises in the current year.

Table of Contents**Operating capital and capital expenditure requirements**

We anticipate that losses will continue for the foreseeable future. At March 31, 2016, our accumulated deficit was approximately \$504.7 million. Our actual cash requirements may vary materially from those planned because of a number of factors including:

Changes in the focus, direction and pace of our development programs;

Competitive and technical advances;

Costs associated with the development of our product candidates;

Our ability to secure partnering arrangements;

Costs of filing, prosecuting, defending and enforcing any patent claims and any other intellectual property rights, or other developments, and

Other matters identified under Part II Item 1A. Risk Factors.

Working capital as of March 31, 2016 was \$123.1 million, consisting of \$140.4 million in current assets and \$17.3 million in current liabilities. Working capital as of December 31, 2015 was \$134.4 million, consisting of \$152.5 million in current assets and \$18.1 million in current liabilities.

Contractual obligations

The following table summarizes our outstanding obligations as of March 31, 2016 and the effect those obligations are expected to have on our liquidity and cash flows in future periods:

(\$ in thousands)	Total	Less than 1 year	2 - 3 years	4 - 5 years	More than 5 years
Operating leases	\$ 5,116	\$ 1,203	\$ 2,179	\$ 1,432	\$ 302
Royalty and license fees	30,500	15,250	15,250		
Total	\$ 36,616	\$ 16,453	\$ 17,429	\$ 1,432	\$ 302

Our commitments for operating leases relate to the lease for our corporate headquarters in Boston, MA, and office space in New York, NY. On December 21, 2015 and April 15, 2016, we renewed the sublease for our corporate headquarters in Boston, Ma through August 31, 2021. Our commitments for royalty and license fees relate to license with MD Anderson, requiring payment upon the first patient treated in a pivotal trial in darinaparsin, currently being developed under the amended and restated License and Collaboration Agreement with Solasia. On March 28, 2016,

Solasia initiated a multi-center pivotal clinical trial which triggered a \$1.0 million milestone payment to us which is included in accounts receivable at March 31, 2016, and an equivalent milestone payment to M.D. Anderson which is included in accrued expenses at March 31, 2016. As part of the amended and restated License and Collaboration agreement with Solasia (see Note 5, Commitments and Contingencies), we will receive full reimbursement of this license payment. The contract milestone and contract installment payments relate to our agreement with Baxter Healthcare Corporation for the purchase of the assets relating to indibulin, and to our CRO agreements with Novella Clinical, Inc. The remaining contract installment payments to Baxter are comprised of two separate \$250 thousand payments on November 3rd of 2016, and 2017. However, for the purpose of the above table, we have assumed that the payment of the milestones will occur within five years of March 31, 2016. Included in the above table are obligations for the subleased portion of our New York and Boston offices (see Note 5, Commitments and Contingencies). We expect to receive a total of \$306 thousand in the next year, \$529 thousand in the next 2-3 years, and \$17 thousand in the next 4-5 years from our subtenants in the Boston and New York offices.

On January 13, 2015, we entered into the MD Anderson License as detailed in see Note 5, Commitments and Contingencies. The agreement includes minimum quarterly payments of \$3.75 million included in the above table within Royalty and License Fees . Our obligations related to this agreement are payments of \$15.0 million in the column Less than 1 Year and \$15.0 million in the column 2 - 3 Years.

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Off-balance sheet arrangements

During the three months ended March 31, 2016 and 2015, we did not engage in any off-balance sheet arrangements.

Critical Accounting Policies and Estimates

In our Annual Report on Form 10-K, for the fiscal year ended December 31, 2015, our most critical accounting policies and estimates upon which our financial status depends were identified as those relating to clinical trial expenses; collaboration agreements; fair value measurements for stock-based compensation; and net operating losses and tax credit carryforwards. We reviewed our policies and determined that those policies remain our most critical accounting policies for the three months ended March 31, 2016.

Item 3. Quantitative and Qualitative Disclosures about Market Risk

Our exposure to market risk is limited to our cash. The goals of our investment policy are preservation of capital, fulfillment of liquidity needs and fiduciary control of cash. We also seek to maximize income from our investments without assuming significant risk. To achieve our goals, we maintain our cash in interest-bearing bank accounts in global banks, United States treasuries and other government-backed investments, which are subject to minimal interest rate risk.

Effect of Currency Exchange Rates and Exchange Rate Risk Management

We conduct clinical studies outside of the United States primarily in Western Europe. These business operations are not material at this time, therefore any currency fluctuations will not have a material impact on our financial position, results of operations or cash flows.

Item 4. Controls and Procedures

Our management, with the participation of our principal executive officer and principal financial officer, has evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) or 15d-15(e) under the Securities Exchange Act of 1934, as amended, or the Exchange Act) as of the end of the period covered by this report. Based on such evaluation, our principal executive officer and principal financial officer have concluded that, as of the end of such period, our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported, on a timely basis, and is accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate, to allow timely decisions regarding required disclosure.

No change in our internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) occurred during the period covered by this quarterly report that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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Part II - Other Information

Item 1. Legal Proceedings

In the ordinary course of business, we may periodically become subject to legal proceedings and claims arising in connection with ongoing business activities. The results of litigation and claims cannot be predicted with certainty, and unfavorable resolutions are possible and could materially affect our results of operations, cash flows or financial position. In addition, regardless of the outcome, litigation could have an adverse impact on us because of defense costs, diversion of management resources and other factors.

As of March 31, 2016, there are no matters that, in the opinion of management, might have a material adverse effect on our financial position, results of operations or cash flows.

Item 1A. Risk Factors

The following important factors could cause our actual business and financial results to differ materially from those contained in forward-looking statements made in this Quarterly Report on Form 10-Q or elsewhere by management from time to time. The risk factors in this report have been revised to incorporate changes to our risk factors from those included in our Annual Report on Form 10-K for the fiscal year ended December 31, 2015. The risk factors set forth below with an asterisk (*) next to the title are new risk factors or risk factors containing changes, which may be material, from the risk factors previously disclosed in Item 1A of our Annual Report on Form 10-K for the fiscal year ended December 31, 2015, as filed with the Securities and Exchange Commission.

RISKS RELATED TO OUR BUSINESS

Our plans to develop and commercialize non-viral and viral adoptive cellular therapies based on engineered cytokines and novel chimeric antigen receptor (CAR) T cell and NK cell therapies as well as T cell Receptor (TCR) therapies can be considered as new approaches to cancer treatment that present significant challenges in a competitive landscape and the success of our efforts depends in large part on our owned and licensed intellectual property, and our efforts may be affected by litigation and developments in intellectual property law outside of our control.

We intend to employ technologies such as licensed from MD Anderson pursuant to the MD Anderson License described above, and from Intrexon, pursuant to our existing Channel Agreement and ECP Amendment with Intrexon, to pursue the development and commercialization of non-viral and viral adoptive cellular therapies based on cytokines, T cells, NK cells, CARs and TCRs possibly under control of the RT[®] and other switch technologies targeting both hematologic and solid tumor malignancies. Because this is a new approach to cancer immunotherapy and cancer treatment generally, developing and commercializing product candidates subjects us to a number of challenges, including:

obtaining regulatory approval from the FDA and other regulatory authorities that have very limited experience with the commercial development of genetically modified and/or unmodified T-cell and NK-cell therapies for cancer;

developing and deploying consistent and reliable processes for engineering a patient's and/or donor's T cells or NK cells *ex vivo* and infusing the T cells or NK cells back into the patient;

possibly conditioning patients with chemotherapy in conjunction with delivering each of the potential products, which may increase the risk of adverse side effects of the potential products;

educating medical personnel regarding the potential side effect profile of each of the potential products, such as the potential adverse side effects related to cytokine release;

developing processes for the safe administration of these potential products, including long-term follow-up for all patients who receive the potential products;

sourcing additional clinical and, if approved, commercial supplies for the materials used to manufacture and process the potential products;

developing a manufacturing process and distribution network with a cost of goods that allows for an attractive return on investment;

establishing sales and marketing capabilities after obtaining any regulatory approval to gain market acceptance;

developing therapies for types of cancers beyond those addressed by the current potential products; and

not infringing the intellectual property rights, in particular, the patent rights, of third parties, including competitors such as developing T-cell and/or NK-cell therapies.

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We cannot be sure that immunotherapy technologies that we intend to develop in partnership with MD Anderson and Intrexon will yield satisfactory products that are safe and effective, scalable, or profitable. Moreover, public perception of therapy safety issues, including adoption of new therapeutics or novel approaches to treatment, may adversely influence the willingness of subjects to participate in clinical trials, or if approved, of physicians to subscribe to the novel treatment mechanics. Physicians, hospitals and third-party payors often are slow to adopt new products, technologies and treatment practices that require additional upfront costs and training. Physicians may not be willing to undergo training to adopt this novel and personalized therapy, may decide the therapy is too complex to adopt without appropriate training and may choose not to administer the therapy. Based on these and other factors, hospitals and payors may decide that the benefits of this new therapy do not or will not outweigh its costs.

Our genetically modified and non-modified T Cell and NK cell CAR⁺ T product candidates are supported by limited clinical data, all of which has been generated through trials conducted by MD Anderson, not by us. We plan to assume control of the overall clinical and regulatory development of our T cell and NK cell product candidates, and any failure to obtain, or delays in obtaining, sponsorship of investigational new drug applications, or INDs, or in filing new INDs sponsored by us for these or any other product candidates we determine to advance could negatively affect the timing of our potential future clinical trials. Such an impact on timing could increase research and development costs and could delay or prevent obtaining regulatory approval for our product candidates, either of which could have a material adverse effect on our business. Further, we did not control the design or conduct of the previous trials. It is possible that the FDA will not accept these previous trials as providing adequate support for future clinical trials, whether controlled by us or third parties, for any of one or more reasons, including the safety, purity, and potency of the product candidate, the degree of product characterization, elements of the design or execution of the previous trials or safety concerns, or other trial results. We may also be subject to liabilities arising from any treatment-related injuries or adverse effects in patients enrolled in these previous trials. As a result, we may be subject to unforeseen third-party claims and delays in our potential future clinical trials. We may also be required to repeat in whole or in part clinical trials previously conducted by MD Anderson or other entities, which will be expensive and delay the submission and licensure or other regulatory approvals with respect to any of our product candidates.

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In addition, the results of the limited clinical trials conducted by MD Anderson to date may not be replicated in future clinical trials. Our genetically modified and non-modified T cell and NK cell product candidates, as well as other product candidates may fail to show the desired safety and efficacy in clinical development and we cannot assure you that the results of any future trials will demonstrate the value and efficacy of our product candidates. Moreover, there are a number of regulatory requirements that we must satisfy before we can continue clinical trials of CAR⁺ T or other cellular therapy product candidates in the United States. Satisfaction of these requirements will entail substantial time, effort and financial resources. Any time, effort and financial resources we expend on our genetically modified and non-modified T cell and NK cell product candidates and other early-stage product candidate development programs may adversely affect our ability to continue development and commercialization of our immuno-oncology product candidates.

The biopharmaceutical industry, and the rapidly evolving market for developing genetically engineered T cells in particular, is characterized by intense competition and rapid innovation. Genetically engineering T cells faces significant competition in the CAR and TCR technology space from multiple companies and their collaborators, such as Novartis/University of Pennsylvania, Bluebird bio/Celgene/Baylor College of Medicine, Kite Pharma/National Cancer Institute, Juno Therapeutics/Fred Hutchinson Cancer Research Center/Memorial Sloan-Kettering Cancer Center/Seattle Children's Research Institute, Cellectis/Pfizer, Adaptimmune/GSK, Celgene, and NantKwest. We face competition from non-cell based treatments offered by other companies such as Amgen, AstraZeneca, Bristol-Myers, Incyte, Merck, and Roche. Even if we obtain regulatory approval of potential products, we may not be the first to market and that may affect the price or demand for our potential products. Additionally, the availability and price of our competitors' products could limit the demand and the price we are able to charge for our potential products. We may not be able to implement our business plan if the acceptance of our potential products is inhibited by price competition or the reluctance of physicians to switch from existing methods of treatment to our potential products, or if physicians switch to other new drug or biologic products or choose to reserve our potential products. Additionally, a competitor could obtain orphan product exclusivity from the FDA with respect to such competitor's product. If such competitor product is determined to be the same product as one of our potential products, that may prevent us from obtaining approval from the FDA for such potential products for the same indication for seven years, except in limited circumstances.

We are dependent on patents, know-how, and proprietary technology that are licensed from others, particularly MD Anderson and Intrexon. Any termination of these licenses could result in the loss of significant rights and could harm our ability to commercialize our product candidates. Disputes may also arise between us and these licensors regarding intellectual property subject to a license agreement, including those relating to:

the scope of rights granted under the applicable license agreement and other interpretation-related issues;

whether and the extent to which our technology and processes, and the technology and processes of Intrexon, MD Anderson and our other licensors, infringe on intellectual property of the licensor that is not subject to the applicable license agreement;

our right to sublicense patent and other rights to third parties pursuant to our relationships with our licensors and partners;

whether we and/or Intrexon are complying with our diligence obligations with respect to the use of the licensed technology in relation to our development and commercialization of our potential products under the MD Anderson License with MD Anderson; and

the allocation of ownership of inventions and know-how resulting from the joint creation or use of intellectual property by our licensors and by us.

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If disputes over intellectual property that we have licensed prevent or impair our ability to maintain our current licensing arrangements, particularly with MD Anderson, on acceptable terms, we may be unable to successfully develop and commercialize the affected potential products. We are generally also subject to all of the same risks with respect to protection of intellectual property that we license as we are for intellectual property that we own. If we or our licensors fail to adequately protect this intellectual property, our ability to commercialize potential products under our applicable licenses could suffer.

There is a substantial amount of litigation involving patents and other intellectual property rights in the biotechnology and pharmaceutical industries, as well as administrative proceedings for challenging patents, including interference, derivation, and reexamination proceedings before the United States Patent and Trademark Office, or U.S. PTO, or oppositions and other comparable proceedings in foreign jurisdictions. Recently, due to changes in U.S. law referred to as patent reform, new procedures including inter partes review and post-grant review have been implemented, which adds uncertainty to the possibility of challenge to our or our licensors' patents in the future.

**** We will require additional financial resources in order to continue ongoing development of our product candidates; if we are unable to obtain these additional resources, we may be forced to delay or discontinue clinical testing of our product candidates.***

We have not generated significant revenue and have incurred significant net losses in each year since our inception. For the three months ended March 31, 2016, we had a net loss of \$12.0 million, and, as of March 31, 2016, we have incurred approximately \$504.7 million of cumulative net losses since our inception in 2003. We expect to continue to incur significant operating expenditures and net losses. Further development of our product candidates, including product candidates that we may develop under our Channel Agreement with Intrexon, pursuant to the MD Anderson License or pursuant to the Ares Trading Agreement, will likely require substantial increases in our expenses as we:

Continue to undertake clinical trials for product candidates;

Scale-up the formulation and manufacturing of our product candidates;

Seek regulatory approvals for product candidates;

work with regulatory authorities to identify and address program related inquiries;

Implement additional internal systems and infrastructure;

Hire additional personnel;

Begin to advance candidates pursuant to the MD Anderson License; and

Commence providing funding for certain research and development activities of MD Anderson pursuant to the terms of the License.

We continue to seek additional financial resources to fund the further development of our product candidates. If we are unable to obtain sufficient additional capital, one or more of these programs could be placed on hold. Because we are currently devoting a significant portion of our resources to the development of immuno-oncology, further progress with the development of our other candidates may be significantly delayed and may depend on the licensing of those compounds to third parties.

As of March 31, 2016, we have approximately \$124.8 million of cash and cash equivalents. Given our current development plans, we anticipate current cash resources will be sufficient to fund our operations into the fourth quarter of 2017 and we have no current committed sources of additional capital. We do not know whether additional financing will be available on terms favorable or acceptable to us when needed, if at all. Our business is highly cash-intensive and our ability to continue operations after our current cash resources are exhausted depends on our ability to obtain additional financing and/or achieve profitable operations, as to which no assurances can be given. If adequate additional funds are not available when required, or if we are unsuccessful in entering into partnership agreements for the further development of our products, we will be required to delay, reduce or eliminate planned preclinical and clinical trials and may be forced to terminate the approval process for our product candidates from the FDA or other regulatory authorities. In addition, we could be forced to discontinue product development, forego attractive business opportunities or pursue merger or divestiture strategies. In the event we are unable to obtain additional financing, we may be forced to cease operations altogether.

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**** We need to raise additional capital to fund our operations. The manner in which we raise any additional funds may affect the value of your investment in our common stock.***

As of March 31, 2016, we have incurred approximately \$504.7 million of cumulative net losses and had approximately \$124.8 million of cash and cash equivalents. Given our current development plans, we anticipate that our current cash resources will be sufficient to fund our operations into the fourth quarter of 2017. However, changes may occur that would consume our existing capital prior to then, including expansion of the scope of, and/or slower than expected progress of, our research and development efforts and changes in governmental regulation. Actual costs may ultimately vary from our current expectations, which could materially impact our use of capital and our forecast of the period of time through which our financial resources will be adequate to support our operations. Also our estimates include the advancement of our immuno-oncology product candidates in the clinic under our Channel Agreement with Intrexon and our increased expenses as we begin to advance candidates pursuant to the MD Anderson License with MD Anderson and commence providing funding for certain research and development activities of MD Anderson pursuant to the terms of the MD Anderson License, and we expect that the costs associated with these and additional product candidates will increase the level of our overall research and development expenses significantly going forward.

In addition to above factors, our actual cash requirements may vary materially from our current expectations for a number of other factors that may include, but are not limited to, changes in the focus and direction of our development programs, competitive and technical advances, costs associated with the development of our product candidates, our ability to secure partnering arrangements, and costs of filing, prosecuting, defending and enforcing our intellectual property rights. If we exhaust our capital reserves more quickly than anticipated, regardless of the reason, and we are unable to obtain additional financing on terms acceptable to us or at all, we will be unable to proceed with development of some or all of our product candidates on expected timelines and will be forced to prioritize among them.

The unpredictability of the capital markets may severely hinder our ability to raise capital within the time periods needed or on terms we consider acceptable, if at all. Moreover, if we fail to advance one or more of our current product candidates to later-stage clinical trials, successfully commercialize one or more of our product candidates, or acquire new product candidates for development, we may have difficulty attracting investors that might otherwise be a source of additional financing.

Our need for additional capital and limited capital resources may force us to accept financing terms that could be significantly dilutive to existing stockholders. To the extent that we raise additional capital by issuing equity securities, our stockholders may experience dilution. In addition, we may grant future investors rights superior to those of our existing stockholders. If we raise additional funds through collaborations and licensing arrangements, it may be necessary to relinquish some rights to our technologies, product candidates or products, or grant licenses on terms that are not favorable to us. If we raise additional funds by incurring debt, we could incur significant interest expense and become subject to covenants in the related transaction documentation that could affect the manner in which we conduct our business.

Clinical trials are very expensive, time-consuming, and difficult to design, initiate and implement.

Human clinical trials are very expensive and difficult to design, initiate and implement, in part because they are subject to rigorous regulatory requirements. The clinical trial start up and process itself is also time-consuming and results are inherently uncertain. We estimate that clinical trials of our product candidates will take at least several years to complete. Furthermore, failure can occur at any stage of the trials, and we could encounter problems that cause us to delay the start of, abandon or repeat clinical trials. The commencement and completion of clinical trials

may be delayed by several factors, including:

Additional nonclinical data requests by regulatory agencies;

Unforeseen safety issues;

Determination of dosing issues;

Lack of effectiveness during clinical trials;

Slower than expected rates of patient recruitment and enrollment;

Inability to monitor patients adequately during or after treatment;

Inability or unwillingness of medical investigators to follow our clinical protocols; and

Regulatory determinations to temporarily or permanently cease enrollment for other reasons not related to patient safety.

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Success in preclinical testing and early clinical trials does not ensure that later clinical trials will be successful. In addition, we or the FDA may suspend our clinical trials at any time if it appears that we are exposing participants to unacceptable health risks or if the FDA finds deficiencies in our Investigational New Drug, or IND, submission or in the conduct of these trials.

See also Risks Relating to the Clinical Testing, Regulatory Approval and Manufacturing of our Product Candidates *Our product candidates are in various stages of clinical trials, which are very expensive and time-consuming. We cannot be certain when we will be able to submit an NDA or BLA, to the FDA and any failure or delay in completing clinical trials for our product candidates could harm our business*

**** We may not be able to obtain or maintain orphan drug exclusivity for our product candidates.***

We have received Orphan Drug designations for Ad-RTS-IL-12 + veledimex for the treatment of malignant glioma in both the United States, and we may be able to receive additional Orphan Drug designation from the FDA and the European Medicines Agency, or EMA, for other product candidates. In the United States, orphan designation is available to drugs intended to treat, diagnose or prevent a rare disease or condition that affects fewer than 200,000 people in the United States at the time of application for orphan designation. Orphan designation qualifies the sponsor of the product for a tax credit and marketing incentives. The first sponsor to receive FDA marketing approval for a drug with an orphan designation is entitled to a seven-year exclusive marketing period in the United States for that product for that indication and, typically, a waiver of the prescription drug user fee for its marketing application. However, a drug that the FDA considers to be clinically superior to, or different from, the approved orphan drug, even though for the same indication, may also obtain approval in the United States during the seven-year exclusive marketing period. Orphan drug exclusive marketing rights may also be lost if the FDA later determines that the request for designation was materially defective or if the manufacturer is unable to assure sufficient quantity of the drug. There is no guarantee that any of our other product candidates will receive Orphan Drug designation or that, even if such product candidate is granted such status, the product candidate's clinical development and regulatory approval process will not be delayed or will be successful.

We may not be able to commercialize any products, generate significant revenues, or attain profitability.

To date, none of our product candidates have been approved for commercial sale in any country. The process to develop, obtain regulatory approval for, and commercialize potential drug candidates is long, complex, and costly. Unless and until we receive approval from the FDA and/or other regulatory authorities for our product candidates, we cannot sell our drugs and will not have product revenues. Even if we obtain regulatory approval for one or more of our product candidates, if we are unable to successfully commercialize our products, we may not be able to generate sufficient revenues to achieve or maintain profitability, or to continue our business without raising significant additional capital, which may not be available. Our failure to achieve or maintain profitability could negatively impact the trading price of our common stock.

**** Ethical, legal and social concerns about biologically engineered products could limit or prevent the use of our product candidates.***

Our products candidates use an immuno-oncology platform. Public perception about the safety and environmental hazards of, and ethical concerns over, genetically engineered products could influence public acceptance of our product candidates. If we and our collaborators are not able to overcome the ethical, legal and social concerns relating to biological engineering, our product candidates may not be accepted. These concerns could result in increased expenses, regulatory scrutiny, delays or other impediments to the public acceptance and commercialization of our product candidates. Our ability to develop and commercialize products could be limited by public attitudes and

governmental regulation.

The subject of genetically modified organisms has received negative publicity, which has aroused public debate. This adverse publicity could lead to greater regulation and trade restrictions on the development and commercialization of genetically altered products. Further, there is a risk that our product candidates could cause adverse health effects or other adverse events, which could also lead to negative publicity.

The biological platform that we use may have significantly enhanced characteristics compared to those found in naturally occurring organisms, enzymes or microbes. While we believe we produce biological technologies only for use in a controlled laboratory and industrial environment, the release of such biological technologies into uncontrolled environments could have unintended consequences. Any adverse effect resulting from such a release could have a material adverse effect on our business and financial condition, and we may have exposure to liability for any resulting harm.

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**** Our use of immuno-oncology to develop product candidates may become subject to increasing regulation in the future.***

Most of the laws and regulations concerning immuno-oncology relate to the end products produced using synthetic biology, but that may change. For example, the Presidential Commission for the Study of Bioethical Issues recommended in December 2010 that the federal government oversee, but not regulate, synthetic biology research. The Presidential Commission also recommended that the government lead an ongoing review of developments in the synthetic biology field and that the government conduct a reasonable risk assessment before the field release of synthetic organisms. Other findings and recommendations have been published by the Presidential Commission through 2014. Immuno-oncology may become subject to additional government regulations as a result of the recommendations, which could require us to incur significant additional capital and operating expenditures and other costs in complying with these laws and regulations.

The technology on which our Channel Agreements with Intrexon Corporation are based in part on early stage technology in the field of human oncologic and autoimmune therapeutics.

Our Channel Agreements with Intrexon contemplate our use of Intrexon's advanced transgene engineering platform for the controlled and precise cellular production of anti-cancer effectors and for the development of therapeutic approaches for GvHD. The immuno-oncology effector platform in which we have acquired rights represents early-stage technology in the field of human oncology biotherapeutic, with DC-RTS-IL-12 + veledimex having completed a Phase 1 study in melanoma and Ad-RTS-IL-12 + veledimex having completed two Phase 2 studies, in melanoma and breast cancer. We are continuing to pursue intra-tumoral injection of Ad-RTS-IL-12 + veledimex in brain cancer and breast cancer. Although we plan to leverage Intrexon's immuno-oncology platform for additional products targeting key pathways used by cancers to grow and metastasize, we may not be successful in developing and commercializing these products for a variety of reasons. The risk factors set forth herein that apply to our small molecule drug candidates, which are in various stages of development, also apply to product candidates that we seek to develop under our Channel Agreement with Intrexon.

We will incur additional expenses in connection with our Channel Agreements with Intrexon Corporation.

The immuno-oncology platform, in which we have acquired rights for cancer indications and for the development of therapeutic approaches for GvHD from Intrexon, includes two existing product candidates, Ad-RTS-IL-12+ veledimex and DC-RTS-IL-12 + veledimex. Upon entry into the Channel Agreements with Intrexon, we assumed responsibility for the clinical development of these product candidates, which we expect will increase the level of our overall research and development expenses significantly going forward. Although all human clinical trials are expensive and difficult to design and implement, we believe that due to complexity, costs associated with clinical trials for immuno-oncology products are greater than the corresponding costs associated with clinical trials for small molecule candidates. In addition to increased research and development costs, prior to the adoption of our April 2013 workforce reduction plan, we added headcount in part to support our Channel Agreement endeavors, and we may need to do so again in the future which would add to our general and administrative expenses going forward.

Although our forecasts for expenses and the sufficiency of our capital resources takes into account our plans to develop the Intrexon products, the actual costs associated therewith may be significantly in excess of forecasted amounts. In addition to the amount and timing of expenses related to the clinical trials, our actual cash requirements may vary materially from our current expectations for a number of other factors that may include, but are not limited to, changes in the focus and direction of our development programs, competitive and technical advances, costs associated with the development of our product candidates and costs of filing, prosecuting, defending and enforcing our intellectual property rights. If we exhaust our capital reserves more quickly than anticipated, regardless of the

reason, and we are unable to obtain additional financing on terms acceptable to us or at all, we will be unable to proceed with development of some or all of our product candidates on expected timelines and will be forced to prioritize among them.

**** We may not be able to retain the exclusive rights licensed to us by Intrexon Corporation to develop and commercialize products involving DNA administered to humans for expression of anti-cancer effectors for the purpose of treatment or prophylaxis of cancer.***

Under the Channel Agreement, we use Intrexon's technology directed towards in vivo expression of effectors in connection with the development of Ad-RTS-IL-12 + veledimex and generally to research, develop and commercialize products, in each case in which DNA is administered to humans for expression of anti-cancer effectors for the purpose of treatment or prophylaxis of cancer, which we collectively refer to as the Cancer Program. The Channel Agreement grants us a worldwide license to use patents and other intellectual property of Intrexon in connection with the research, development, use, importing, manufacture, sale, and offer for sale of products involving DNA administered to humans for expression of anti-cancer effectors for the purpose of treatment or prophylaxis of cancer, which we refer to collectively as the ZIOPHARM Products. Such license is exclusive with respect to any clinical development, selling, offering for sale or other commercialization of ZIOPHARM Products, and otherwise is non-exclusive. Subject to limited exceptions, we may not sublicense the rights described without Intrexon's written consent. Under the Channel Agreement, and subject to certain exceptions, we are responsible for, among other things, the performance of the Cancer Program, including development, commercialization and certain aspects of manufacturing of ZIOPHARM Products.

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Intrexon may terminate the Channel Agreement if we fail to use diligent efforts to develop and commercialize ZIOPHARM Products or if we elect not to pursue the development of a Cancer Program identified by Intrexon that is a Superior Therapy as defined in the Channel Agreement. We may voluntarily terminate the Channel Agreement upon 90 days written notice to Intrexon.

Our obligation to pay 50% of net profits or revenue as described further in our Annual Report on Form 10-K under the heading *Business License Agreements, Intellectual Property and Other Agreements Exclusive Channel Partner Agreement with Intrexon Corporation* with respect to these retained products will survive termination of the Channel Agreement.

There can be no assurance that we will be able to successfully perform under the Channel Agreement and if the Channel Agreement is terminated it may prevent us from achieving our business objectives.

**** We will incur additional expenses in connection with our License Agreement with The University of Texas M.D. Anderson Cancer Center***

Pursuant to the MD Anderson License with MD Anderson, we, together with Intrexon, obtained an exclusive, worldwide license to certain technologies owned and licensed by MD Anderson including technologies relating to novel CAR⁺ T cell, NK cell and TCR cell therapies arising from the laboratory of Laurence Cooper, M.D., Ph.D., who was then at MD Anderson, as well as either co-exclusive or non-exclusive licenses under certain related technologies. Pursuant to the MD Anderson License, MD Anderson agreed to transfer to us certain existing research programs described in the MD Anderson License and we, together with Intrexon, entered into a research and development agreement with MD Anderson pursuant to which we agreed to provide funding for certain research and development activities of MD Anderson for a period of three years from the date of the MD Anderson License, in an amount between \$15.0 and \$20.0 million per year. In addition, we also expect to enter into additional collaboration and technology transfer agreements with MD Anderson and Intrexon to accelerate technology and clinical development of these product candidates. We expect to increase the level of our overall research and development expenses significantly going forward as a result of each of these items.

Although our forecasts for expenses and the sufficiency of our capital resources takes into account our plans to develop the technology licensed from MD Anderson and our obligations under the MD Anderson License, the MD Anderson License is still only beginning to be implemented, therefore the actual costs associated therewith may be significantly in excess of forecasted amounts. In addition to the amount and timing of expenses related to our relationship with MD Anderson, our actual cash requirements may vary materially from our current expectations for a number of other factors that may include, but are not limited to, changes in the focus and direction of our development programs, competitive and technical advances, costs associated with the development of our product candidates and costs of filing, prosecuting, defending and enforcing our intellectual property rights. If we exhaust our capital reserves more quickly than anticipated, regardless of the reason, and we are unable to obtain additional financing on terms acceptable to us or at all, we will be unable to proceed with development of some or all of our product candidates on expected timelines and will be forced to prioritize among them.

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**** We may not be able to retain the rights licensed to us and Intrexon by The University of Texas M.D. Anderson Cancer Center to technologies relating to novel chimeric antigen receptor (CAR) T cell therapies and other related technologies.***

Under the MD Anderson License, we, together with Intrexon, received an exclusive, worldwide license to certain technologies owned and licensed by MD Anderson including technologies relating to novel CAR⁺ T cell, NK cell and TCR cell therapies arising from the laboratory of Laurence Cooper, M.D., Ph.D., who was then at MD Anderson, as well as either co-exclusive or non-exclusive licenses under certain related technologies. When combined with Intrexon's technology suite and ZIOPHARM's clinically tested RheoSwitch Therapeutic System[®] interleukin-12 modules, the resulting proprietary methods and technologies may help realize the promise of genetically modified CAR⁺ T cell and other immune cells by controlling cell expansion and activation in the body, minimizing off-target and unwanted on-target effects and toxicity while maximizing therapeutic efficacy. The term of the MD Anderson License expires on the last to occur of (a) the expiration of all patents licensed thereunder, or (b) the twentieth anniversary of the date of the MD Anderson License; provided, however, that following the expiration of the term, the Company and Intrexon shall then have a fully-paid up, royalty free, perpetual, irrevocable and sublicensable license to use the licensed intellectual property thereunder.

After 10 years from the date of the MD Anderson License and subject to a 90-day cure period, MD Anderson will have the right to convert the MD Anderson License into a non-exclusive license if we and Intrexon are not using commercially reasonable efforts to commercialize the licensed intellectual property on a case-by-case basis. After five years from the date of the MD Anderson License and subject to a 180-day cure period, MD Anderson will have the right to terminate the MD Anderson License with respect to specific technology(ies) funded by the government or subject to a third party contract if we and Intrexon are not meeting the diligence requirements in such funding agreement or contract, as applicable. Subject to a 30-day cure period, MD Anderson has the right to terminate the MD Anderson License if we and Intrexon fail to timely deliver the shares due in consideration for the MD Anderson License. MD Anderson may also terminate the agreement with written notice upon material breach by us or Intrexon, if such breach has not been cured within 60 days of receiving such notice. In addition, the MD Anderson License will terminate upon the occurrence of certain insolvency events for both us or Intrexon and may be terminated by the mutual written agreement of us, Intrexon and MD Anderson.

There can be no assurance that we will be able to successfully perform under the MD Anderson License and if the MD Anderson License is terminated it may prevent us from achieving our business objectives.

We have a limited operating history upon which to base an investment decision.

We have not demonstrated an ability to perform the functions necessary for the successful commercialization of any product candidates. The successful commercialization of any product candidates will require us to perform a variety of functions, including:

Continuing to undertake preclinical development and clinical trials;

Participating in regulatory approval processes;

Formulating and manufacturing products; and

Conducting sales and marketing activities.

Our operations have been limited to organizing and staffing our company, acquiring, developing and securing our proprietary product candidates, and undertaking preclinical and clinical trials of our product candidates. These operations provide a limited basis for you to assess our ability to commercialize our product candidates and the advisability of investing in our securities.

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Because we currently neither have nor intend to establish internal research capabilities, we are dependent upon pharmaceutical and biotechnology companies and academic and other researchers to sell or license us their product candidates and technology.

Proposing, negotiating, and implementing an economically viable product acquisition or license is a lengthy and complex process. We compete for partnering arrangements and license agreements with pharmaceutical, biopharmaceutical, and biotechnology companies, many of which have significantly more experience than we do, and have significantly more financial resources. Our competitors may have stronger relationships with certain third parties including academic research institutions, with whom we are interested in collaborating and may have, therefore, a competitive advantage in entering into partnering arrangements with those third parties. We may not be able to acquire rights to additional product candidates on terms that we find acceptable, or at all.

We expect that any product candidate to which we acquire rights will require significant additional development and other efforts prior to commercial sale, including extensive clinical testing and approval by the FDA and applicable foreign regulatory authorities. All drug product candidates are subject to the risks of failure inherent in pharmaceutical product development, including the possibility that the product candidate will not be shown to be sufficiently safe or effective for approval by regulatory authorities. Even if our product candidates are approved, they may not be economically manufactured or produced, or be successfully commercialized.

We actively evaluate additional product candidates to acquire for development. Such additional product candidates, if any, could significantly increase our capital requirements and place further strain on the time of our existing personnel, which may delay or otherwise adversely affect the development of our existing product candidates. We must manage our development efforts and clinical trials effectively, and hire, train and integrate additional management, administrative, and sales and marketing personnel. We may not be able to accomplish these tasks, and our failure to accomplish any of them could prevent us from successfully growing.

We may not be able to successfully manage our growth.

In the future, if we are able to advance our product candidates to the point of, and thereafter through, clinical trials, we will need to expand our development, regulatory, manufacturing, marketing and sales capabilities or contract with third parties to provide for these capabilities. Any future growth will place a significant strain on our management and on our administrative, operational, and financial resources. Therefore, our future financial performance and our ability to commercialize our product candidates and to compete effectively will depend, in part, on our ability to manage any future growth effectively. To manage this growth, we must expand our facilities, augment our operational, financial and management systems, and hire and train additional qualified personnel. If we are unable to manage our growth effectively, our business may be harmed.

Our business will subject us to the risk of liability claims associated with the use of hazardous materials and chemicals.

Our contract research and development activities may involve the controlled use of hazardous materials and chemicals. Although we believe that our safety procedures for using, storing, handling and disposing of these materials comply with federal, state and local laws and regulations, we cannot completely eliminate the risk of accidental injury or contamination from these materials. In the event of such an accident, we could be held liable for any resulting damages and any liability could have a materially adverse effect on our business, financial condition, and results of operations. In addition, the federal, state and local laws and regulations governing the use, manufacture, storage, handling and disposal of hazardous or radioactive materials and waste products may require our contractors to incur substantial compliance costs that could materially adversely affect our business, financial condition, and results

of operations.

We rely on key executive officers and scientific and medical advisors, and their knowledge of our business and technical expertise would be difficult to replace.

We are highly dependent on Dr. Laurence J.N. Cooper, our Chief Executive Officer, Caesar J. Belbel, our Chief Operating Officer, Executive Vice President and Chief Legal Officer and our principal scientific, regulatory, and medical advisors. Dr. Cooper's and Mr. Belbel's employment are governed by written employment agreements. Dr. Cooper and Mr. Belbel may terminate their employment with us at any time, subject, however, to certain non-compete and non-solicitation covenants. The loss of the technical knowledge and management and industry expertise of Dr. Cooper and Mr. Belbel, or any of our other key personnel, could result in delays in product development, loss of customers and sales, and diversion of management resources, which could adversely affect our operating results. We do not carry key person life insurance policies on any of our officers or key employees.

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If we are unable to hire additional qualified personnel, our ability to grow our business may be harmed.

We will need to hire additional qualified personnel with expertise in preclinical and clinical research and testing, government regulation, formulation and manufacturing, and eventually, sales and marketing. We compete for qualified individuals with numerous biopharmaceutical companies, universities, and other research institutions. Competition for such individuals is intense and we cannot be certain that our search for such personnel will be successful. Attracting and retaining qualified personnel will be critical to our success. If we are unable to hire additional qualified personnel, our ability to grow our business may be harmed.

We may incur substantial liabilities and may be required to limit commercialization of our products in response to product liability lawsuits.

The testing and marketing of medical products entail an inherent risk of product liability. If we cannot successfully defend ourselves against product liability claims, we may incur substantial liabilities or be required to limit commercialization of our products, if approved. Even a successful defense would require significant financial and management resources. Regardless of the merit or eventual outcome, liability claims may result in:

Decreased demand for our product candidates;

Injury to our reputation;

Withdrawal of clinical trial participants;

Withdrawal of prior governmental approvals;

Costs of related litigation;

Substantial monetary awards to patients;

Product recalls;

Loss of revenue; and

The inability to commercialize our product candidates.

We currently carry clinical trial insurance and product liability insurance. However, an inability to renew our policies or to obtain sufficient insurance at an acceptable cost could prevent or inhibit the commercialization of pharmaceutical products that we develop, alone or with collaborators.

Our business and operations would suffer in the event of system failures.

Despite the implementation of security measures, our internal computer systems and those of our current and future contractors and consultants are vulnerable to damage from computer viruses, unauthorized access, natural disasters, terrorism, war and telecommunication and electrical failures. While we are not aware of any such material system failure, accident or security breach to date, if such an event were to occur and cause interruptions in our operations, it could result in a material disruption of our development programs and our business operations. For example, the loss of clinical trial data from completed or future clinical trials could result in delays in our regulatory approval efforts and significantly increase our costs to recover or reproduce the data. Likewise, we rely on third parties to manufacture our drug candidates and conduct clinical trials, and similar events relating to their computer systems could also have a material adverse effect on our business. To the extent that any disruption or security breach were to result in a loss of, or damage to, our data or applications, or inappropriate disclosure of confidential or proprietary information, we could incur liability and the further development and commercialization of our drug candidates could be delayed.

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RISKS RELATED TO THE CLINICAL TESTING, REGULATORY APPROVAL AND MANUFACTURING OF OUR PRODUCT CANDIDATES

If we are unable to obtain the necessary U.S. or worldwide regulatory approvals to commercialize any product candidate, our business will suffer.

We may not be able to obtain the approvals necessary to commercialize our product candidates, or any product candidate that we may acquire or develop in the future for commercial sale. We will need FDA approval to commercialize our product candidates in the United States and approvals from regulatory authorities in foreign jurisdictions equivalent to the FDA to commercialize our product candidates in those jurisdictions. In order to obtain FDA approval of any product candidate, we must submit to the FDA a Biologics License Application, or BLA, demonstrating that the product candidate is safe for humans and effective for its intended use. This demonstration requires significant research and animal tests, which are referred to as preclinical studies, as well as human tests, which are referred to as clinical trials. Satisfaction of the FDA's regulatory requirements typically takes many years, depending upon the type, complexity, and novelty of the product candidate, and will require substantial resources for research, development, and testing. We cannot predict whether our research, development, and clinical approaches will result in drugs that the FDA will consider safe for humans and effective for their intended uses. The FDA has substantial discretion in the drug approval process and may require us to conduct additional preclinical and clinical testing or to perform post-marketing studies. The approval process may also be delayed by changes in government regulation, future legislation, or administrative action or changes in FDA policy that occur prior to or during our regulatory review. Delays in obtaining regulatory approvals may:

Delay commercialization of, and our ability to derive product revenues from, our product candidates;

Impose costly procedures on us; and

Diminish any competitive advantages that we may otherwise enjoy.

Even if we comply with all FDA requests, the FDA may ultimately reject one or more of our NDAs or BLAs. We cannot be sure that we will ever obtain regulatory approval for any of our product candidates. Failure to obtain FDA approval for our product candidates will severely undermine our business by leaving us without a saleable product, and therefore without any potential revenue source, until another product candidate can be developed. There is no guarantee that we will ever be able to develop or acquire another product candidate or that we will obtain FDA approval if we are able to do so.

In foreign jurisdictions, we similarly must receive approval from applicable regulatory authorities before we can commercialize any drugs. Foreign regulatory approval processes generally include all of the risks associated with the FDA approval procedures described above.

Our product candidates are in various stages of clinical trials, which are very expensive and time-consuming. We cannot be certain when we will be able to submit a BLA to the FDA and any failure or delay in completing clinical trials for our product candidates could harm our business.

Our product candidates are in various stages of development and require extensive clinical testing. Notwithstanding our current clinical trial plans for each of our existing product candidates, we may not be able to commence additional

trials or see results from these trials within our anticipated timelines. As such, we cannot predict with any certainty if or when we might submit a BLA for regulatory approval of our product candidates or whether such a BLA will be accepted. Because we do not anticipate generating revenues unless and until we submit one or more BLAs and thereafter obtain requisite FDA approvals, the timing of our BLA submissions and FDA determinations regarding approval thereof, will directly affect if and when we are able to generate revenues.

Our product candidates may cause undesirable side effects or have other properties that could delay or prevent their regulatory approval, limit the commercial profile of an approved label, or result in significant negative consequences following any potential marketing approval.

As with many pharmaceutical and biological products, treatment with our product candidates may produce undesirable side effects or adverse reactions or events. If our product candidates or similar products or product candidates under development by third parties demonstrate unacceptable adverse events, we may be required to halt or delay further clinical development of our product candidates. The FDA, the EMA or other foreign regulatory authorities could order us to cease further development of or deny approval of our product candidates for any or all targeted indications. The product-related side effects could affect patient recruitment or the ability of enrolled patients to complete the trial or result in potential product liability claims. Any of these occurrences may harm our business, financial condition and prospects significantly.

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Even if our clinical trials are completed as planned, we cannot be certain that their results will support approval of our product candidates. The FDA normally expects two randomized, well-controlled Phase 3 pivotal studies in support of approval of an NDA or BLA. Success in preclinical testing and early clinical trials does not ensure that later clinical trials will be successful, and we cannot be certain that the results of later clinical trials will replicate the results of prior clinical trials and preclinical testing. The clinical trial process may fail to demonstrate that our product candidates are safe for humans and effective for the indicated uses. This failure would cause us to abandon a product candidate and may delay development of other product candidates. Any delay in, or termination of, our clinical trials will delay the submission of our BLAs with the FDA and, ultimately, our ability to commercialize our product candidates and generate product revenues. In addition, our clinical trials involve small patient populations. Because of the small sample size, the results of these clinical trials may not be indicative of future results.

**** Our immuno-oncology product candidates are based on a novel technology, which makes it difficult to predict the time and cost of product candidate development and subsequently obtaining regulatory approval. Currently, no gene therapy products have been approved in the United States and only one product has been approved in Europe.***

We have recently focused our product research and development efforts on our immuno-oncology product candidates under our Channel Agreement with Intrexon. These products, including Ad-RTS-IL-12+ veledimex, are based on gene therapy technology. Due to the novelty of this medical technology, there can be no assurance that any development problems we experience in the future related to our immuno-oncology platform will not cause significant delays or unanticipated costs, or that such development problems can be solved. We may also experience unanticipated problems or delays in expanding our manufacturing capacity or transferring our manufacturing process to commercial partners, which may prevent us from completing our clinical studies or commercializing our immuno-oncology product candidates on a timely or profitable basis, if at all.

In addition, the clinical study requirements of the FDA, the EMA and other regulatory agencies and the criteria these regulators use to determine the safety and efficacy of a product candidate vary substantially according to the type, complexity, novelty and intended use and market of the potential products. The regulatory approval process for novel product candidates such as ours can be more expensive and take longer than for other, better known or extensively studied pharmaceutical or other product candidates. Currently, only one gene therapy product, UniQure's Glybera, which received marketing authorization from the EMA in 2012, has been approved in Europe but has not yet been launched for commercial sale, which makes it difficult to determine how long it will take or how much it will cost to obtain regulatory approvals for our product candidates in either the United States or Europe. Approvals by the EMA may not be indicative of what the FDA may require for approval.

Regulatory requirements governing gene and cell therapy products have changed frequently and may continue to change in the future. For example, the FDA has established the Office of Cellular, Tissue and Gene Therapies within its Center for Biologics Evaluation and Research, or CBER, to consolidate the review of gene therapy and related products, and the Cellular, Tissue and Gene Therapies Advisory Committee to advise CBER on its review. Gene therapy clinical studies conducted at institutions that receive funding for recombinant DNA research from the U.S. National Institutes of Health, or the NIH, are also subject to review by the NIH Office of Biotechnology Activities Recombinant DNA Advisory Committee, or the RAC. Although the FDA decides whether individual gene therapy protocols may proceed, the RAC review process can impede the initiation of a clinical trial, even if the FDA has reviewed the trial and approved its initiation. Conversely, the FDA can put an IND on clinical hold even if the RAC has provided a favorable review. Also, before a clinical trial can begin at an NIH-funded institution, that institution's institutional review board, or IRB, and its Institutional Biosafety Committee will have to review the proposed clinical trial to assess the safety of the trial. In addition, adverse developments in clinical trials of gene therapy products

conducted by others may cause the FDA or other regulatory bodies to change the requirements for approval of any of our product candidates.

These regulatory review committees and advisory groups and the new guidelines they promulgate may lengthen the regulatory review process, require us to perform additional studies, increase our development costs, lead to changes in regulatory positions and interpretations, delay or prevent approval and commercialization of these treatment candidates or lead to significant post-approval limitations or restrictions. As we advance our immuno-oncology product candidates, we will be required to consult with these regulatory and advisory groups, and comply with applicable guidelines. If we fail to do so, we may be required to delay or discontinue development of our product candidates. These additional processes may result in a review and approval process that is longer than we otherwise would have expected for oncology product candidates. Delay or failure to obtain, or unexpected costs in obtaining, the regulatory approval necessary to bring a potential product to market could decrease our ability to generate sufficient product revenue to maintain our business.

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Because we are dependent upon clinical research institutions and other contractors for clinical testing and for research and development activities, the results of our clinical trials and such research activities are, to a certain extent, beyond our control.

We materially rely upon independent investigators and collaborators, such as universities and medical institutions, to conduct our preclinical and clinical trials under agreements with us. These collaborators are not our employees and we cannot control the amount or timing of resources that they devote to our programs. These investigators may not assign as great a priority to our programs or pursue them as diligently as we would if we were undertaking such programs ourselves. If outside collaborators fail to devote sufficient time and resources to our drug development programs, or if their performance is substandard, the approval of our FDA applications, if any, and our introduction of new products, if any, will be delayed. These collaborators may also have relationships with other commercial entities, some of whom may compete with us. If our collaborators assist our competitors to our detriment, our competitive position would be harmed.

Our reliance on third parties to formulate and manufacture our product candidates exposes us to a number of risks that may delay the development, regulatory approval and commercialization of our products or result in higher product costs.

We do not have experience in drug formulation or manufacturing of drugs or biologics and do not intend to establish our own manufacturing facilities. Although we will work closely with and rely upon Intrexon on the manufacturing and scale-up of Intrexon product candidates, we lack the resources and expertise to formulate or manufacture our own product candidates. We currently are contracting for the manufacture of our product candidates. We intend to contract with one or more manufacturers to manufacture, supply, store, and distribute drug supplies for our clinical trials. If a product candidate we develop or acquire in the future receives FDA approval, we will rely on one or more third-party contractors or Intrexon to manufacture our products. Our anticipated future reliance on a limited number of third-party manufacturers exposes us to the following risks:

We may be unable to identify manufacturers on acceptable terms or at all because the number of potential manufacturers is limited and the FDA must approve any replacement contractor. This approval would require new testing and compliance inspections. In addition, a new manufacturer would have to be educated in, or develop substantially equivalent processes for, production of our products after receipt of FDA approval, if any.

Our third-party manufacturers might be unable to formulate and manufacture our products in the volume and of the quality required to meet our clinical needs and commercial needs, if any.

Our future contract manufacturers may not perform as agreed or may not remain in the contract manufacturing business for the time required to supply our clinical trials or to successfully produce, store, and distribute our products.

Drug manufacturers are subject to ongoing periodic unannounced inspection by the FDA, the Drug Enforcement Administration and corresponding state and foreign agencies to ensure strict compliance with current good manufacturing practices, or cGMP, and other government regulations and corresponding

foreign standards. We do not have control over third-party manufacturers' compliance with these regulations and standards.

If any third-party manufacturer makes improvements in the manufacturing process for our products, we may not own, or may have to share, the intellectual property rights to the innovation.

Our third-party manufacturers may not be able to comply with cGMP regulations or similar regulatory requirements outside the United States. Our failure, or the failure of our third-party manufacturers, to comply with applicable regulations could result in sanctions being imposed on us, including clinical holds, fines, injunctions, civil penalties, delays, suspension or withdrawal of approvals, license revocation, seizures or recalls of drug candidates or products, operating restrictions and criminal prosecutions, any of which could significantly and adversely affect supplies of our products.

Each of these risks could delay our clinical trials, the approval, if any, of our product candidates by the FDA or the commercialization of our product candidates or result in higher costs or deprive us of potential product revenues

Any product candidate for which we obtain marketing approval could be subject to post-marketing restrictions or withdrawal from the market and we may be subject to penalties if we fail to comply with regulatory requirements or if we experience unanticipated problems with our products, when and if any of them are approved.

Any product candidate for which we obtain marketing approval, along with the manufacturing processes, post-approval clinical data, labeling, advertising and promotional activities for such product, will be subject to continual requirements of and review by the FDA and other regulatory authorities. These requirements include, among other things, submissions of safety and other post-marketing information and reports, registration and listing requirements, cGMP requirements relating to manufacturing, quality control, quality assurance and corresponding maintenance of records and documents, requirements regarding the distribution of samples to physicians and recordkeeping. Even if marketing approval of a drug candidate is granted, the approval may be subject to limitations on the indicated uses for which the product may be marketed or to the conditions of approval, including the requirement to implement a risk evaluation and mitigation strategy, or REMS, which could include requirements for a restricted distribution system. If any of our product candidates receives marketing approval, the accompanying label may limit the approved uses, which could limit sales of the product.

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The FDA may also impose requirements for costly post-marketing studies or clinical trials and surveillance to monitor the safety or efficacy of our approved products. The FDA closely regulates the post-approval marketing and promotion of products to ensure that they are marketed only for the approved indications and in accordance with the provisions of the approved labeling. The FDA imposes stringent restrictions on manufacturers' communications regarding off-label use and if we market our products outside of their approved indications, we may be subject to enforcement action for off-label marketing. Violations of the FDCA relating to the promotion of prescription drugs may lead to investigations alleging violations of federal and state health care fraud and abuse laws, as well as state consumer protection laws.

In addition, later discovery of previously unknown adverse events or other problems with our products, manufacturers or manufacturing processes, or failure to comply with regulatory requirements, may yield various results, including:

Litigation involving patients taking our product;

Restrictions on such products, manufacturers or manufacturing processes;

Restrictions on the labeling or marketing of a product;

Restrictions on product distribution or use;

Requirements to conduct post-marketing studies or clinical trials;

Warning letters;

Withdrawal of the products from the market;

Refusal to approve pending applications or supplements to approved applications that we submit;

Recall of products;

Fines, restitution or disgorgement of profits or revenues;

Suspension or withdrawal of marketing approvals;

Damage to relationships with existing and potential collaborators;

Unfavorable press coverage and damage to our reputation;

Refusal to permit the import or export of our products;

Product seizure; or

Injunctions or the imposition of civil or criminal penalties.

Noncompliance with similar European Union requirements regarding safety monitoring or pharmacovigilance can also result in significant financial penalties. Similarly, failure to comply with U.S. and foreign regulatory requirements regarding the development of products for pediatric populations and the protection of personal health information can also lead to significant penalties and sanctions.

RISKS RELATED TO OUR ABILITY TO COMMERCIALIZE OUR PRODUCT CANDIDATES

If we are unable either to create sales, marketing and distribution capabilities or enter into agreements with third parties to perform these functions, we will be unable to commercialize our product candidates successfully.

We currently have no marketing, sales, or distribution capabilities. If and when we become reasonably certain that we will be able to commercialize our current or future product candidates, we anticipate allocating resources to the marketing, sales and distribution of our proposed products in North America and in certain other countries; however, we cannot assure that we will be able to market, sell, and distribute our products successfully. Our future success also may depend, in part, on our ability to enter into and maintain collaborative relationships for such capabilities and to encourage the collaborator's strategic interest in the products under development, and such collaborator's ability to successfully market and sell any such products. Although we intend to pursue certain collaborative arrangements regarding the sale and marketing of certain of our product candidates, there are no assurances that we will be able to establish or maintain collaborative arrangements or, if we are able to do so, whether we would be able to conduct our own sales efforts. There can also be no assurance that we will be able to establish or maintain relationships with third-party collaborators or develop in-house sales and distribution capabilities. To the extent that we depend on third parties for marketing and distribution, any revenues we receive will depend upon the efforts of such third parties, and there can be no assurance that such efforts will be successful. In addition, there can also be no assurance that we will be able to market and sell our product candidates in the United States or overseas.

If we are not able to partner with a third party and are not successful in recruiting sales and marketing personnel or in building a sales and marketing infrastructure, we will have difficulty commercializing our product candidates, which would harm our business. If we rely on pharmaceutical or biotechnology companies with established distribution systems to market our products, we will need to establish and maintain partnership arrangements, and we may not be able to enter into these arrangements on acceptable terms or at all. To the extent that we enter into co-promotion or other arrangements, any revenues we receive will depend upon the efforts of third parties that may not be successful and that will be only partially in our control.

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If we cannot compete successfully for market share against other biopharmaceutical companies, we may not achieve sufficient product revenues and our business will suffer.

The market for our product candidates is characterized by intense competition and rapid technological advances. If a product candidate receives FDA approval, it will compete with a number of existing and future products and therapies developed, manufactured and marketed by others. Existing or future competing products may provide greater therapeutic convenience or clinical or other benefits for a specific indication than our products, or may offer comparable performance at a lower cost. If our products fail to capture and maintain market share, we may not achieve sufficient product revenues and our business will suffer.

We will compete against fully integrated pharmaceutical companies and smaller companies that are collaborating with larger pharmaceutical companies, academic institutions, government agencies and other public and private research organizations. Many of these competitors have products already approved or in development. In addition, many of these competitors, either alone or together with their collaborative partners, operate larger research and development programs or have substantially greater financial resources than we do, as well as significantly greater experience in:

Developing drugs and biopharmaceuticals;

Undertaking preclinical testing and human clinical trials;

Obtaining FDA and other regulatory approvals of drugs and biopharmaceuticals;

Formulating and manufacturing drugs and biopharmaceuticals; and

Launching, marketing, and selling drugs and biopharmaceuticals.

Our commercial opportunity could be reduced or eliminated if our competitors develop and commercialize products that are more effective, have fewer or less severe side effects, are more convenient or are less expensive than any products that we may develop. Our competitors also may obtain FDA or other regulatory approval for their products more rapidly than we may obtain approval for ours, which could result in our competitors establishing a strong market position before we are able to enter the market. In addition, our ability to compete may be affected in many cases by insurers or other third-party payors seeking to encourage the use of generic products.

If physicians and patients do not accept and use our product candidates, our ability to generate revenue from sales of our products will be materially impaired.

Even if the FDA and/or foreign equivalents thereof approve our product candidates, physicians and patients may not accept and use them. Acceptance and use of our products will depend upon a number of factors including:

Perceptions by members of the healthcare community, including physicians, about the safety and effectiveness of our drugs;

Pharmacological benefit and cost-effectiveness of our products relative to competing products;

Availability of coverage and adequate reimbursement for our products from government or other healthcare payors;

Effectiveness of marketing and distribution efforts by us and our licensees and distributors, if any; and

The price at which we sell our products.

Because we expect sales of our current product candidates, if approved, to generate substantially all of our product revenues for the foreseeable future, the failure of a drug to find market acceptance would harm our business and could require us to seek additional financing in order to fund the development of future product candidates.

Our ability to generate product revenues will be diminished if our products do not obtain coverage or adequate reimbursement from payors.

Our ability to commercialize our product candidates, if approved, alone or with collaborators, will depend in part on the extent to which coverage and reimbursement will be available from government and health administration authorities, private health maintenance organizations and health insurers and other third-party payors.

Patients who are prescribed medicine for the treatment of their conditions generally rely on third-party payors to reimburse all or part of the costs associated with their prescription drugs. Adequate coverage and reimbursement from governmental healthcare programs, such as Medicare and Medicaid, and commercial payors is critical to new product acceptance. Coverage decisions may depend upon clinical and economic standards that disfavor new drug products when more established or lower cost therapeutic alternatives are already available or subsequently become available. Even if we obtain coverage for our product candidates, the resulting reimbursement payment rates might not be adequate or may require co-payments that patients find unacceptably high. Patients are unlikely to use our product candidates unless coverage is provided and reimbursement is adequate to cover a significant portion of the cost of our product candidates.

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In addition, the market for our product candidates for which we may receive regulatory approval will depend significantly on access to third-party payors' drug formularies, or lists of medications for which third-party payors provide coverage and reimbursement, which might not include all of the FDA-approved drugs for a particular indication. The industry competition to be included in such formularies often leads to downward pricing pressures on pharmaceutical companies. Also, third-party payors may refuse to include a particular branded drug in their formularies or otherwise restrict patient access to a branded drug when a less costly generic equivalent or other alternative is available.

Third-party payors, whether foreign or domestic, or governmental or commercial, are developing increasingly sophisticated methods of controlling healthcare costs. In addition, in the United States, no uniform policy of coverage and reimbursement for drug products exists among third-party payors. Therefore, coverage and reimbursement for drug products can differ significantly from payor to payor. As a result, the coverage determination process is often a time-consuming and costly process that requires us to provide scientific and clinical support for the use of our products to each payor separately, with no assurance that approval will be obtained. If we are unable to obtain coverage of and adequate payment levels for our product candidates from third-party payors, physicians may limit how much or under what circumstances they will prescribe or administer them and patients may decline to purchase them. This in turn could affect our ability to successfully commercialize our products and impact our profitability, results of operations, financial condition, and future success.

In addition, in many foreign countries, particularly the countries of the European Union, the pricing of prescription drugs is subject to government control. In some non-U.S. jurisdictions, the proposed pricing for a drug must be approved before it may be lawfully marketed. The requirements governing drug pricing vary widely from country to country. For example, the EU provides options for its member states to restrict the range of medicinal products for which their national health insurance systems provide reimbursement and to control the prices of medicinal products for human use. A member state may approve a specific price for the medicinal product or it may instead adopt a system of direct or indirect controls on the profitability of the company placing the medicinal product on the market. We may face competition for our product candidates from lower-priced products in foreign countries that have placed price controls on pharmaceutical products. In addition, there may be importation of foreign products that compete with our own products, which could negatively impact our profitability.

Healthcare legislative reform measures may have a material adverse effect on our business and results of operations.

In both the United States and certain foreign jurisdictions, there have been a number of legislative and regulatory enactments in recent years that change the healthcare system in ways that could impact our future ability to sell our product candidates profitably.

Furthermore, there have been and continue to be a number of initiatives at the federal and state level that seek to reduce healthcare costs. Most significantly, in March 2010, President Obama signed into law the Patient Protection and Affordable Health Care Act, as amended by the Health Care and Education Reconciliation Act, or collectively the ACA, which includes measures that significantly change the way healthcare is financed by both governmental and private insurers. Among the provisions of the ACA of importance to the pharmaceutical industry are the following:

An annual, nondeductible fee on any entity that manufactures or imports certain branded prescription drugs and biologic agents, apportioned among these entities according to their market share in certain government healthcare programs;

An increase in the statutory minimum rebates a manufacturer must pay under the Medicaid Drug Rebate Program to 23.1% and 13% of the average manufacturer price for most branded and generic drugs, respectively;

A new Medicare Part D coverage gap discount program, in which manufacturers must agree to offer 50% point-of-sale discounts off negotiated prices of applicable brand drugs to eligible beneficiaries during their coverage gap period, as a condition for the manufacturer's outpatient drugs to be covered under Medicare Part D;

An extension of manufacturers' Medicaid rebate liability to covered drugs dispensed to individuals who are enrolled in Medicaid managed care organizations;

New methodologies by which rebates owed by manufacturers under the Medicaid Drug Rebate Program are calculated for drugs that are inhaled, infused, instilled, implanted or injected, and for drugs that are line extensions;

Expansion of eligibility criteria for Medicaid programs by, among other things, allowing states to offer Medicaid coverage to additional individuals with income at or below 133% of the Federal Poverty Level, thereby potentially increasing both the volume of sales and manufacturers' Medicaid rebate liability;

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Expansion of the entities eligible for discounts under the Public Health Service pharmaceutical pricing program;

A new requirement to annually report drug samples that certain manufacturers and authorized distributors provide to physicians;

Expansion of healthcare fraud and abuse laws, including the False Claims Act and the Anti-Kickback Statute, new government investigative powers, and enhanced penalties for noncompliance;

A licensure framework for follow-on biologic products;

A new Patient-Centered Outcomes Research Institute to oversee, identify priorities in, and conduct comparative clinical effectiveness research, along with funding for such research;

Creation of the Independent Payment Advisory Board which has authority to recommend certain changes to the Medicare program that could result in reduced payments for prescription drugs and those recommendations could have the effect of law even if Congress does not act on the recommendations; and

Establishment of a Center for Medicare & Medicaid Innovation at the Centers for Medicare & Medicaid Services, or CMS to test innovative payment and service delivery models to lower Medicare and Medicaid spending, potentially including prescription drug spending.

In addition, other legislative changes have been proposed and adopted since the ACA was enacted. For example, in August 2011, President Obama signed into law the Budget Control Act of 2011, which, among other things, created the Joint Select Committee on Deficit Reduction to recommend proposals in spending reductions to Congress. The Joint Select Committee on Deficit Reduction did not achieve its targeted deficit reduction of at least \$1.2 trillion for the years 2013 through 2021, triggering the legislation's automatic reductions to several government programs. These reductions include aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect on April 1, 2013, and, due to subsequent legislative amendments, will stay in effect through 2024 unless additional Congressional action is taken. In January 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, which, among other things, further reduced Medicare payments to several providers and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. The full impact of these new laws, as well as laws and other reform and cost containment measures that may be proposed and adopted in the future, remains uncertain, but may result in additional reductions in Medicare and other healthcare funding, which could have a material adverse effect on our future customers and accordingly, our ability to generate revenue, attain profitability, or commercialize our products.

If we fail to comply with federal and state healthcare laws, including fraud and abuse and health information privacy and security laws, we could face substantial penalties and our business, results of operations, financial condition and prospects could be adversely affected.

As a pharmaceutical company, even though we do not and will not control referrals of healthcare services or bill directly to Medicare, Medicaid or other third-party payors, certain federal and state healthcare laws and regulations

pertaining to fraud and abuse and patients' rights are and will be applicable to our business. For example, we could be subject to healthcare fraud and abuse and patient privacy regulation by both the federal government and the states in which we conduct our business. The laws that may affect our ability to operate include, among others:

The federal Anti-Kickback Statute, which constrains our business activities, including our marketing practices, educational programs, pricing policies, and relationships with healthcare providers or other entities, by prohibiting, among other things, soliciting, receiving, offering or paying remuneration, directly or indirectly, to induce, or in return for, either the referral of an individual or the purchase or recommendation of an item or service reimbursable under a federal healthcare program, such as the Medicare and Medicaid programs;

Federal civil and criminal false claims laws and civil monetary penalty laws, which prohibit, among other things, individuals or entities from knowingly presenting, or causing to be presented, claims for payment from Medicare, Medicaid, or other third-party payors that are false or fraudulent;

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, which created new federal criminal statutes that prohibit, among other things, executing a scheme to defraud any healthcare benefit program or making false statements relating to healthcare matters;

HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, or HITECH, and its implementing regulations, which imposes certain requirements relating to the privacy, security and transmission of individually identifiable health information;

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Requirements to report annually to CMS certain financial arrangements with physicians and teaching hospitals, as defined in the ACA and its implementing regulations, including reporting any transfer of value made or distributed to teaching hospitals, prescribers, and other healthcare providers and reporting any ownership and investment interests held by physicians and their immediate family members and applicable group purchasing organizations during the preceding calendar year; and

State and foreign law equivalents of each of the above federal laws, such as anti-kickback and false claims laws which may apply to items or services reimbursed by any third-party payor, including commercial insurers; state laws that require pharmaceutical companies to comply with the industry's voluntary compliance guidelines and the applicable compliance guidance promulgated by the federal government that otherwise restricts certain payments that may be made to healthcare providers and entities; state laws that require drug manufacturers to report information related to payments and other transfer of value to physicians and other healthcare providers and entities; and state and foreign laws governing the privacy and security of health information in certain circumstances, many of which differ from each other in significant ways and often are not preempted by HIPAA, thus complicating compliance efforts

Because of the breadth of these laws and the narrowness of the statutory exceptions and safe harbors available, it is possible that some of our business activities could be subject to challenge under one or more of such laws. In addition, recent health care reform legislation has further strengthened these laws. For example, the ACA, among other things, amends the intent requirement of the federal anti-kickback and certain criminal healthcare fraud statutes. A person or entity no longer needs to have actual knowledge of this statute or specific intent to violate it. Moreover, the ACA provides that the government may assert that a claim including items or services resulting from a violation of the federal anti-kickback statute constitutes a false or fraudulent claim for purposes of the False Claims Act.

To the extent that any of our product candidates is ultimately sold in a foreign country, we may be subject to similar foreign laws and regulations.

If we or our operations are found to be in violation of any of the laws described above or any other governmental regulations that apply to us, we may be subject to penalties, including administrative, civil and criminal penalties, damages, fines, exclusion from participation in United States federal or state health care programs, such as Medicare and Medicaid, and the curtailment or restructuring of our operations any of which could materially adversely affect our ability to operate our business and our financial results. Although compliance programs can mitigate the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated. Any action against us for violation of these laws, even if we successfully defend against it, could cause us to incur significant legal expenses and divert our management's attention from the operation of our business. Moreover, achieving and sustaining compliance with applicable federal and state privacy, security and fraud laws may prove costly.

Our ability to use net operating loss carryforwards and research tax credits to reduce future tax payments may be limited or restricted.

We have generated significant net operating loss carryforwards, or NOLs, and research and development tax credits, or R&D credits, as a result of our incurrence of losses and our conduct of research activities since inception. We generally are able to carry NOLs and R&D credits forward to reduce our tax liability in future years. However, our ability to utilize the NOLs and R&D credits is subject to the rules of Sections 382 and 383 of the Internal Revenue Code of 1986, as amended, or the Code, respectively. Those sections generally restrict the use of NOLs and R&D credits after an ownership change. An ownership change occurs if, among other things, the stockholders (or specified groups of stockholders) who own or have owned, directly or indirectly, 5% or more of a corporation's common stock or are otherwise treated as 5% stockholders under Section 382 of the code and the United States Treasury Department

regulations promulgated thereunder increase their aggregate percentage ownership of that corporation's stock by more than 50 percentage points over the lowest percentage of the stock owned by these stockholders over the applicable testing period. In the event of an ownership change, Section 382 imposes an annual limitation on the amount of taxable income a corporation may offset with NOL carry forwards and Section 383 imposes an annual limitation on the amount of tax a corporation may offset with business credit (including the R&D credit) carry forwards. Any unused annual limitation may be carried over to later years until the applicable expiration date for the respective NOL or R&D credit carry forwards. We may have experienced an ownership change within the meaning of Section 382 in the past and there can be no assurance that we will not experience additional ownership changes in the future. As a result, our NOLs and business (including the R&D credit) may be subject to limitations and we may be required to pay taxes earlier and in larger amounts than would be the case if our NOLs or R&D credits were freely usable.

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****Our immuno-oncology product candidates may face competition in the future from biosimilars.***

With the enactment of the Biologics Price Competition and Innovation Act of 2009, or BPCIA, as part of the Patient Protection and ACA, an abbreviated pathway for the approval of follow-on biological products was created. The new abbreviated regulatory pathway establishes legal authority for the FDA to review and approve biosimilar biologics, including the possible designation of a biosimilar as interchangeable with an existing brand product. Under the BPCIA, an application for a biosimilar product cannot be approved by the FDA until 12 years after the original branded product was approved under a BLA. This data exclusivity does not prevent another company from developing a product that is highly similar to the original branded product, generating its own data and seeking approval. Data exclusivity only assures that another company cannot rely upon the data within the innovator's application to support the biosimilar product's approval.

In his proposed budget for fiscal year 2014, President Obama proposed to cut this 12-year period of exclusivity down to seven years. He also proposed to prohibit additional periods of exclusivity due to minor changes in product formulations, a practice often referred to as evergreening. It is possible that Congress may take these or other measures to reduce or eliminate periods of exclusivity.

Although final implementation of the BPCIA is not yet complete, such FDA implementation could have a material adverse effect on the future commercial prospects for our product candidates.

RISKS RELATED TO OUR INTELLECTUAL PROPERTY

If we or our licensors fail to adequately protect or enforce our intellectual property rights or secure rights to patents of others, the value of our intellectual property rights would diminish and our ability to successfully commercialize our products may be impaired.

Our success, competitive position, and future revenues will depend in part on our ability and the abilities of our licensors to obtain and maintain patent protection for our products, methods, processes and other technologies, to preserve our trade secrets, to prevent third parties from infringing on our proprietary rights, and to operate without infringing the proprietary rights of third parties.

To date, we have exclusive rights to certain United States and foreign intellectual property with respect to the Intrexon technology, including the existing Intrexon product candidates and the GvHD program, and with respect to CAR⁺ T, NK and TCR cell therapies arising from the laboratory of Laurence Cooper, M.D., Ph.D., who was then at MD Anderson. Under our Channel Agreement with Intrexon, Intrexon has the sole right to conduct and control the filings, prosecution and maintenance of the patents and patent applications licensed to us. Although under the agreement Intrexon has agreed to consider in good faith and consult with us regarding any comments we may have regarding these patents and patent applications, we cannot guarantee that our comments will be solicited or followed. Under the MD Anderson License, future filings and applications require the agreement of each of MD Anderson, Intrexon and us, and MD Anderson has the right to control the preparation and filing of additional patent applications unless the parties agree that we or Intrexon may prosecute the application directly. Although under the agreement MD Anderson has agreed to review and incorporate any reasonable comments that we or Intrexon may have regarding these patents and patent applications, we cannot guarantee that our comments will be solicited or followed. Without direct control of the channel program patents and patent applications, we are dependent on Intrexon or MD Anderson, as applicable, to keep us advised of prosecution, particularly in foreign jurisdictions where prosecution information may not be publicly available. We anticipate that we, Intrexon and MD Anderson will file additional patent applications both in the United States and in other countries. However, we cannot predict or guarantee:

The degree and range of protection any patents will afford us against competitors, including whether third parties will find ways to invalidate or otherwise circumvent our patents;

If and when patents will be issued;

Whether or not others will obtain patents claiming subject matter related to or relevant to our product candidates; or

Whether we will need to initiate litigation or administrative proceedings that may be costly whether we win or lose.

The patent prosecution process is expensive and time-consuming, and we may not be able to file and prosecute all necessary or desirable patent applications at a reasonable cost, in a timely manner, or in all jurisdictions. It is also possible that we will fail to identify patentable aspects of our research and development output before it is too late to obtain patent protection. Moreover, in some circumstances, we do not have the right to control the preparation, filing and prosecution of patent applications, or to maintain the patents, covering technology that we license from third parties. We may also require the cooperation of our licensors in order to enforce the licensed patent rights, and such cooperation may not be provided. Therefore, these patents and applications may not be prosecuted and enforced in a manner consistent with the best interests of our business.

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The patent position of biotechnology and pharmaceutical companies generally is highly uncertain, involves complex legal and factual questions and has in recent years been the subject of much litigation. In addition, the laws of foreign countries may not protect our rights to the same extent as the laws of the United States and we may fail to seek or obtain patent protection in all major markets. For example, European patent law restricts the patentability of methods of treatment of the human body more than United States law does. Publications of discoveries in the scientific literature often lag behind the actual discoveries, and patent applications in the United States and other jurisdictions are typically not published until 18 months after filing, or in some cases not at all.

Changes in patent laws or in interpretations of patent laws in the United States and other countries may diminish the value of our intellectual property or narrow the scope of our patent protection. In September 2011, the Leahy-Smith America Invents Act, or the Leahy-Smith Act, was signed into law, resulting in a number of significant changes to United States patent law. These changes include provisions that affect the way patent applications will be prosecuted and may also affect patent litigation. In addition, the United States Supreme Court has ruled on several patent cases in recent years, either narrowing the scope of patent protection available in certain circumstances or weakening the rights of patent owners in certain situations. This combination of events has created uncertainty with respect to the value of patents, once obtained, and with regard to our ability to obtain patents in the future. As the U.S. PTO continues to implement the Leahy-Smith Act, and as the federal courts have the opportunity to interpret the Leahy-Smith Act, the laws and regulations governing patents, and the rules regarding patent procurement could change in unpredictable ways that would weaken our ability to obtain new patents or to enforce our existing patents and patents that we might obtain in the future.

Certain technologies utilized in our research and development programs are already in the public domain. Moreover, a number of our competitors have developed technologies, filed patent applications or obtained patents on technologies, compositions and methods of use that are related to our business and may cover or conflict with our owned or licensed patent applications, technologies or product candidates. Such conflicts could limit the scope of the patents that we may be able to obtain or may result in the rejection of claims in our patent applications. Because patent applications in the United States and many foreign jurisdictions are typically not published until eighteen months after filing, or in some cases not at all, and because publications of discoveries in the scientific literature often lag behind actual discoveries, neither we nor our licensors can be certain that others have not filed or maintained patent applications for technology used by us or covered by our pending patent applications without our being aware of these applications. Therefore, we cannot know with certainty whether we were the first to make the inventions claimed in our owned patents or pending patent applications, or that we were the first to file for patent protection of such inventions, nor can we know whether those from whom we license patents were the first to make the inventions claimed or were the first to file. As a result, the issuance, scope, validity, enforceability and commercial value of our patent rights are highly uncertain. Our pending and future patent applications may not result in patents being issued which protect our technology or products, in whole or in part, or which effectively prevent others from commercializing competitive technologies and products. Changes in either the patent laws or interpretation of the patent laws in the United States and other countries may diminish the value of our patents or narrow the scope of our patent protection. In addition, our own earlier filed patents and applications or those of Intrexon may limit the scope of later patents we obtain or may result in the rejection of claims in our later filed patent applications. If third parties filed patent applications or obtained patents on technologies, compositions and methods of use that are related to our business and that cover or conflict with our owned or licensed patent applications, technologies or product candidates, we may be required to challenge such protection, terminate or modify our programs impacted by such protection or obtain licenses from such third parties, which might not be available on acceptable terms, or at all.

Even if our owned and licensed patent applications issue as patents, they may not issue in a form that will provide us with any meaningful protection, prevent competitors from competing with us or otherwise provide us with any competitive advantage. Our competitors may be able to circumvent our owned or licensed patents by developing

similar or alternative technologies or products in a non-infringing manner.

The issuance of a patent is not conclusive as to its inventorship, scope, validity or enforceability, and our owned and licensed patents may be challenged in the courts or patent offices in the United States and abroad. Such challenges may result in loss of exclusivity or freedom to operate or in patent claims being narrowed, invalidated or held unenforceable, in whole or in part, which could limit our ability to stop others from using or commercializing similar or identical technology and products, or limit the duration of the patent protection of our technology and products. Given the amount of time required for the development, testing and regulatory review of new drug candidates, patents protecting such candidates might expire before or shortly after such candidates are commercialized. As a result, our owned and licensed patent portfolio may not provide us with sufficient rights to exclude others from commercializing products similar or identical to ours.

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If we are unable to protect the confidentiality of our trade secrets, our business and competitive position would be harmed.

Our success also depends upon the skills, knowledge, and experience of our scientific and technical personnel, our consultants and advisors, as well as our licensors and contractors. To help protect our proprietary know-how and our inventions for which patents may be unobtainable or difficult to obtain, and to maintain our competitive position, we rely on trade secret protection and confidentiality agreements. To this end, it is our general policy to require our employees, consultants, advisors, and contractors to enter into agreements that prohibit the disclosure of confidential information and, where applicable, require disclosure and assignment to us of the ideas, developments, discoveries, and inventions important to our business. These agreements may not provide adequate protection for our trade secrets, know-how or other proprietary information in the event of any unauthorized use or disclosure or the lawful development by others of such information. Moreover, we may not be able to obtain adequate remedies for any breaches of these agreements. Our trade secrets may also be obtained by third parties by other means, such as breaches of our physical or computer security systems. Enforcing a claim that a party illegally disclosed or misappropriated a trade secret is difficult, expensive and time-consuming, and the outcome is unpredictable. In addition, some courts inside and outside the United States are less willing or unwilling to protect trade secrets. If any of our trade secrets were to be lawfully obtained or independently developed by a competitor, we would have no right to prevent them, or those to whom they communicate it, from using that technology or information to compete with us. If any of our trade secrets, know-how or other proprietary information is disclosed, the value of our trade secrets, know-how and other proprietary rights would be significantly impaired and our business and competitive position would suffer.

Third-party claims of intellectual property infringement would require us to spend significant time and money and could prevent us from developing or commercializing our products.

In order to protect or enforce patent rights, we, or Intrexon, may initiate patent infringement litigation against third parties. Similarly, we may be sued by others for patent infringement. We also may become subject to proceedings conducted in the United States Patent and Trademark Office, including interference proceedings to determine the priority or derivation of inventions, or post-grant review, inter partes review, or reexamination proceedings reviewing the patentability of our patented claims. In addition, any foreign patents that are granted may become subject to opposition, nullity, or revocation proceedings in foreign jurisdictions having such proceedings. The defense and prosecution, if necessary, of intellectual property actions are costly and divert technical and management personnel away from their normal responsibilities.

Our research, development and commercialization activities, as well as any product candidates or products resulting from these activities, may infringe or be claimed to infringe patents or patent applications under which we do not hold licenses or other rights. Patents do not protect its owner from a claim of infringement of another owner's patent. Therefore, our patent position cannot and does not provide any assurance that we are not infringing the patent rights of another.

The patent landscape in the field of immuno-oncology, which we are pursuing under our Channel Agreement with Intrexon, is particularly complex. We are aware of numerous United States and foreign patents and pending patent applications of third parties that cover compositions, methods of use and methods of manufacture of immuno-oncology, including biotherapeutics involving the in vivo expression of human IL-12. In addition, there may be patents and patent applications in the field of which we are not aware. The technology we license from Intrexon is early-stage technology and we are just beginning the process of designing and developing products using this technology. Although we will seek to avoid pursuing the development of products that may infringe any patent claims that we believe to be valid and enforceable, we may fail to do so. Moreover, given the breadth and number of claims in patents and pending patent applications in the field of immuno-oncology and the complexities and uncertainties

associated with them, third parties may allege that we are infringing upon patent claims even if we do not believe such claims to be valid and enforceable.

If a claim for patent infringement is asserted, there can be no assurance that the resolution of the claim would permit us to continue marketing the relevant product on commercially reasonable terms, if at all. We may not have sufficient resources to bring these actions to a successful conclusion. If we do not successfully defend any infringement actions to which we become a party or are unable to have infringed patents declared invalid or unenforceable, we may have to pay substantial monetary damages, which can be tripled if the infringement is deemed willful, or be required to discontinue or significantly delay commercialization and development of the affected products.

Any legal action against us or our collaborators claiming damages and seeking to enjoin developmental or marketing activities relating to affected products could, in addition to subjecting us to potential liability for damages, require us or our collaborators to obtain licenses to continue to develop, manufacture, or market the aff