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Investment Highlights

☆ LEADING PROPRIETARY ANTI-C5A TECHNOLOGY

• Complete and selective blockade of the biological activity of C5a in vitro and in vivo
• Strong patent coverage on anti-C5a technology until end of 2030 / 2035 with extension

☆ ESTABLISHED CLINICAL EFFICACY FOR LEAD DRUG IFX-1

• Proven anti-inflammatory effect in multiple Phase II studies
• Statistically significant reduction of inflammatory lesions in Phase IIb Hidradenitis Suppurativa study and impressive long-term efficacy
• Full data set analysis warrants continued development towards Phase III despite missing the primary endpoint (HiSCR) in Phase IIb study
• Favorable safety profile and excellent tolerability (n > 300 patients)

☆ MULTIPLE ONGOING STUDIES AND INDICATION + PIPELINE EXTENSION

• Ongoing Phase IIb studies in ANCA-associated vasculitis in the US and EU
• Ongoing Phase IIa open label study in Pyoderma Gangraenosum in US and Canada
• Follow-on anti-C5a mAb IFX-2 in pipeline (pre-clinical stage)
• Pipeline extension of IFX-1 in other inflammatory diseases & oncology
### Pipeline with Multiple Opportunities

We have multiple ongoing Phase II studies with potential to expand into further indications

<table>
<thead>
<tr>
<th>PROPOSED INDICATIONS</th>
<th>PREVALENCE</th>
<th>PRE-CLINICAL</th>
<th>PHASE I</th>
<th>PHASE II</th>
<th>PHASE III</th>
<th>UPDATE</th>
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</thead>
<tbody>
<tr>
<td>IFX-1&lt;br&gt;<strong>C5a Inhibitor</strong>&lt;br&gt;Hidradenitis Suppurativa (HS)</td>
<td>• Up to 200,000 patients in the US&lt;br&gt;• Over 200,000 patients in Europe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Phase IIb completed&lt;br&gt;• Planning for next steps</td>
</tr>
<tr>
<td>ANCA-Associated Vasculitis</td>
<td>• ~40,000 patients in the US&lt;br&gt;• ~75,000 patients in Europe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Phase IIb enrollment ongoing in both Europe and US</td>
</tr>
<tr>
<td>Pyoderma Gangraenosum</td>
<td>• ~50,000 patients in the US and Europe are affected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Phase IIa open label enrollment ongoing in US and Canada</td>
</tr>
<tr>
<td>Oncology</td>
<td>• Undisclosed Indication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Development of TPP ongoing</td>
</tr>
<tr>
<td>IFX-2&lt;br&gt;<strong>C5a Inhibitor</strong>&lt;br&gt;Undisclosed Chronic Inflammatory and Autoimmune Diseases</td>
<td>• Not applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Developing as injectable with optimized use for other chronic inflammatory indications</td>
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</tbody>
</table>

These compounds and/or uses of approved products are investigational and have not been approved by the FDA or any other regulatory agency for the uses under investigation. The safety and efficacy of these agents have not been established.
The Terminal Complement Pathway

C5 concentration in blood: ~75 µg/ml (~400 nM)

C5a concentration in blood: 10 ~ 30 ng/ml (~1-2.5 nM)

- Membrane Attack Complex (MAC) triggers lysis of pathogens
  - C5b-9 = MAC

- Other ligands: C3a, ASP, C4a etc.

- C5L2 has a different binding pocket for C5a compared to other ligands like C3a, ASP, etc. and this causes different cell signaling. *
  - The C5a signaling has been shown to be pro-inflammatory. **

- C5L2 has upregulated in many tissues during inflammation

- Other signaling involved e.g. in triglyceride synthesis, etc.

- C5aR
  - Cell activation
  - Cytokine generation

- C5L2
  - PKC-signaling
  - HMGB-1 induction* (Inflammasome)

C5a

Other ligands: C3a, ASP, C4a etc.

- Inflammation

- Upregulated in many tissues during inflammation

** Rittirsch et al. Nat Med. 2008 May ; 14(S): 551;
Colley et al. MABS. 2018,10 (1), 104
Songlin et. al. J. Biol. Chem. 2019; 294(21) 8384–839
IFX-1 is a First-in-Class Anti-C5a Monoclonal Antibody

KEY FEATURES

• Blocks C5a biological effects up to 100% in human blood
• Leaves MAC formation intact
• Binds with high affinity to the discovered epitope
The C5a Blocking Potential of IFX-1 in Plasma of Patients Suffering from Hidradenitis Suppurativa

5 nM IFX-1 highly effectively blocks HS-plasma / C5a-induced neutrophil activation in human blood

Data source: InflaRx GmbH in-house data
IFX-1 Specificity In Vitro and In Vivo

IFX-1 impact on hemolytic activity (CH50)*

IFX-1 impact on CH50 analysis in patients**

IFX-1 does not influence the hemolytic activity and leaves C5 cleavage and formation of C5b-9 (MAC) intact.


** Data: InflaRx in house – Sepsis Clinical Trial Phase IIa
IFX-1 FOR HIDRADENITIS SUPPURATIVA
A chronic severely debilitating C5a-driven inflammatory skin condition with high unmet need

**HURLEY STAGING FOR HS**

**Stage I**
Single / multiple abscesses but no sinus tracts or scarring

**Stage II**
Single or multiple separated, recurrent abscesses with tract formation and scarring

**Stage III**
Multiple interconnected tracts and abscesses involving an entire anatomic region

**CLINICAL FEATURES**
- Chronic, inflammatory, recurrent, debilitating skin disease of the hair follicles
- Most commonly in the armpit, groin and genital regions
- Extremely painful inflammatory nodules, boils or abscesses
- Draining fistulas leading to considerable scarring and functional disability
- Hurley staging system used to classify progression / chronicity (Stage I – III)

**PREVALENCE**
- Up to 200,000 moderate to severe (Hurley II+III) HS patients in US
- Higher prevalence in Europe with reports > 1% total HS prevalence

**CURRENT TREATMENT – MEDICAL NEED**
- Adalimumab (TNF-alpha inhibitor) from AbbVie is the only approved biological in US and Europe
- Accepted (but not approved) SOC includes topical, oral or i.v. antibiotics
- In some instances, surgery is required
- Approximately 50% of patients with moderate to severe HS do not respond and about 50% of responder patients lose response to Humira*

* Combined Phase III trial data for Humira: response measured by HiSCR 50 and KOL quotes in LifeSci Capital initiation report 12/2018
• **InflaRx established** that HS patients have **significant complement activation** with elevated C5a levels.

• **C5a is involved** in several **key pathophysiological mechanisms** in HS:
  – Neutrophil activation is driven by C5a
  – Various C5a dependent players potentially involved (TNFa, IL-17, etc.)

• **C5a is key neutrophil activator in HS patient plasma**
  – HS patient plasma strongly provoked neutrophil activation in healthy donor blood; this effect could be completely blocked by the addition of IFX-1
IFX-1 in Hidradenitis Suppurativa

HISCR – A VALIDATED ENDPOINT

• Humira was approved based on HiSCR response – providing a potential pathway to approval

• HiSCR defines 3 types of lesions:
  • Abscesses
  • Inflammatory nodules
  • Draining fistulas

• HiSCR response defined as:
  ✓ At least 50% reduction in total AN count
  ✓ No increase in the number of abscesses from baseline
  ✓ No increase in the number of draining fistulas from baseline
IFX-1 Phase IIa Promising Results in HS
Clinical efficacy

HISCR response rate in HS patients

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Day 22</th>
<th>Day 29</th>
<th>Day 36</th>
<th>Day 43</th>
<th>Day 50</th>
<th>Day 134</th>
</tr>
</thead>
<tbody>
<tr>
<td>HiSCR response</td>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>42%</td>
<td>67%</td>
<td>75%</td>
<td>83%</td>
</tr>
</tbody>
</table>

**DESIGN**
Open label / single center / 12 patients / 1 dose group with weekly i.v. 800 mg until week 8 (plus one additional loading dose on day 4)

**EFFICACY OUTCOME**
75% of patients HISCR responders at week 8 and 83% at end of trial (late-stage patients who previously failed to respond to SOC incl. TNF-alpha blockade)

**SAFETY / TOLERABILITY RESULTS**
Repeated high dose i.v. administration of IFX-1 observed to be well tolerated with no detected safety issues
PHASE IIB SHINE STUDY SNAPSHOT RESULTS
**IFX-1 in HS:**
**SHINE Study Details**

**Main Period – n = 177 treated**
- Placebo
- IFX-1 minimal dose (400 mg q4w)
- IFX-1 low dose (800 mg q4w)
- IFX-1 medium dose (800 mg q2w)
- IFX-1 high dose (1200 mg q2w)

**Open Label Extension Period (OLE) – n = 156**
- Week 16 HiSCR Responders:
  - IFX-1 low dose (800 mg q4w)
- Week 16 HiSCR Non-Responders:
  - IFX-1 medium dose (800 mg q2w)

**Screening**
16 weeks (double blind)

**TOTAL TREATMENT TIME:**
- 9 months (week 40) + 1 month observation (week 44)

**MAIN GOALS**
- Test a dose-dependent effect of IFX-1 on HiSCR response at week 16 (primary endpoint)
- Assess long-term safety of IFX-1
- Test durability of response with lower maintenance therapy in open label extension period

**Important Note:** Patients entering the OLE were not unblinded to their initial therapy
SHINE Study:
Primary Outcome HiSCR at Week 16 versus AN Count Reduction

Primary endpoint: HiSCR dose response signal not met but signal towards improved AN count

* Full analysis set
SHINE Study:
Outcome on Draining Fistula and IHS-4 Score Reduction – Week 16

**Statistically significant change in DF and in IHS-4 scores detected**

* Full analysis set for patients with at least 1 DF at baseline, baseline adjusted
** Full analysis set – baseline adjusted
IHS-4 Score: Includes and Weights All Inflammatory Lesions

**IHS-4 POINTS = SUM OF**

<table>
<thead>
<tr>
<th>Lesion Type</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>number of inflammatory nodules</td>
<td>× 1</td>
</tr>
<tr>
<td>number of abscesses</td>
<td>× 2</td>
</tr>
<tr>
<td>number of draining fistulas</td>
<td>× 4</td>
</tr>
</tbody>
</table>

**HS STAGE**

- **Mild:** ≤ 3 points
- **Moderate:** 4-10 points
- **Severe:** ≥ 11 points

Developed by KOLs / physicians to establish a new severity scoring system, suitable for tracking treatment response.

Captures reduction of draining fistulas (unlike HiSCR).

Weighs the most fluctuating lesions (infl. nodules) less than abscesses or fistula – lower variability.

Internal validation work shows correlation with DLQI, Pain Scores, Drainage etc. in SHINE data set.
Comparison of HiSCR for Week 16 Responder versus Non-responder Groups (OLE) Over Time

HiSCR response rate (%) per visit* (OLE) – with 95% CI

Responders: 71% maintain HiSCR response with low dose IFX-1
Non-responders: 42% become HiSCR responders with medium dose IFX-1

* Full analysis set
Inflammatory Lesion Reductions in All OLE Patients at End of Treatment (Week 40) Compared to Placebo Group Performance in Main Period (Week 16)

Relative reduction (% mean) of counts / scores compared to respective baseline (Day 1)*

-66.9  -46.0  -54.5  -60.9

-26.5  -17.7  -21.4  -26.3

Marked improvement of all inflammatory lesions over time – not explainable by placebo effect

* Full analysis set (unadjusted)
IHS-4 Scores Over Time in OLE:
Non-responders versus Responders

Change in **IHS-4 scores** between week 16 and week 40 in week 16 HiSCR responders versus non-responders*

- **Non-responders** improve under medium dose IFX-1 treatment during OLE
- **Responders** are relatively “stable” with their IHS-4 scores on low dose IFX-1

* Full analysis set
IHS-4 Scores in OLE Patients: Relative Change from Baseline (Day 1) HiSCR Non-responder Group (Week 16)

**IHS-4 scores**: Relative change from baseline (mean) in OLE patients week 16 + week 40 in HiSCR non-responder patients (week 16) – displayed per main period treatment group*

- **Main period placebo and minimal dose patients** show strongest improvement in IHS-4 scores when being treated with medium IFX-1 dose (for week 16 HiSCR non-responders)

* Last observation carried forward analysis set
HiSCR is burdened by high variability (driven by AN count variability) and by a lack of capturing reduction of draining fistula.

Evidence for a high C5a turnover rate in HS, leading to increased dose requirements of IFX-1.

IFX-1 leads to a marked reduction of all inflammatory lesions in HS with a durable long-term effect detected even at non-optimal doses.

IFX-1 long-term treatment was well tolerated, no drug related SAEs* in the open label extension phase.

* Serious adverse events
HS – Next Steps

NEXT STEPS

• Request End-of-Phase II FDA Meeting in Q1 2020

• Discuss with FDA the path forward for regulatory approval towards a Phase III pivotal program

• Depending on meeting timing and feedback: define path forward by 2H 2020
IFX-1 FOR ANCA-ASSOCIATED VASCULITIS
ANCA-Associated Vasculitis (AAV)

A life-threatening autoimmune condition

CLINICAL FEATURES

- Rare, life-threatening autoimmune disease, characterized by necrotizing vasculitis
- Life-threatening flare phases affect organs, leading to potentially fatal organ dysfunction and failure
- Predominantly affecting small vessels associated with anti-neutrophil cytoplasmic antibodies, or ANCA
- Disease activity is assessed using Birmingham Vasculitis Activity Score v3 (BVAS)

PREVALENCE

- Approx. 40,000 AAV patients in the US
- Approx. 75,000 AAV patients in Europe
- Orphan drug market

CURRENT TREATMENT – MEDICAL NEED

- Induction of remission critical during flare phases – induction treatment differs from maintenance therapy and consists of high dose corticosteroids plus either cyclophosphamide or rituximab
- Induction of remission therapy has significant side effects

Source: Chen, Jayne and Zhao. Complement in ANCA-associated vasculitis: mechanism and implication for management
IFX-1 in AAV
Clinical PoC established for Role of C5a / C5aR Pathway in AAV

**RATIONALE**

- C5a is essential for development of MPA-ANCA crescentic glomerulonephritis in a mouse model
- Complement activation in active AAV patients is significant
- Evidence for role of C5a / C5aR pathway through recent Phase III success of an oral C5aR inhibitor*

**POTENTIAL ADVANTAGES OF IFX-1 FOR AAV**

- **Rapid onset of action**: intravenous administration with fast onset of action, inhibiting C5a signaling completely protecting from C5a induced priming and activation of neutrophils → potentially quicker induction of remission compared to the SOC
- **Potential potency difference**: by blocking upstream ligand C5a, which inhibits signaling through both receptors, C5aR and C5L2; C5a pro-inflammatory MoA through both C5aR and C5L2 has been shown to be important for ANCA-primed and C5a-induced neutrophil degranulation as key disease-driving mechanism in AAV.**

* Chemocentryx. (25 November 2019). ChemoCentryx and VFMCRP Announce Positive Topline Data from Pivotal Phase III ADVOCATE Trial Demonstrating Avacopan’s Superiority Over Standard of Care in ANCA-Associated Vasculitis

** Hao & Wang et al 2013, PLoS ONE, 8(6)
IFX-1 – P2.6 Phase II study in AAV in the US (IXPLORE)

Study Design

**GROUPS:**

<table>
<thead>
<tr>
<th></th>
<th>TREATMENT: 16 WEEKS</th>
<th>FOLLOW UP: 8 WEEKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>IFX-1 low dose + SOC (n=12)</td>
<td>Remission Induction Phase</td>
</tr>
<tr>
<td>B</td>
<td>IFX-1 high dose + SOC (n=12)</td>
<td>Maintenance Phase</td>
</tr>
<tr>
<td>C</td>
<td>Placebo + SOC (n=12)</td>
<td></td>
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</tbody>
</table>

Randomization 1:1:1

SOC = Rituximab or Cyclophosphamide + glucocorticoids

**Study objective (target: n=36)**

- Assessing safety and efficacy of IFX-1 in AAV – **First Patient Dosed in October 2018**
- **Primary endpoint:** Safety
- **Secondary endpoint:** Response rate based on the Birmingham Vasculitis Score (BVAS), various other secondary endpoints

*Guideline maintenance allows for: azathioprin / methotrexate / mycophenolate mofetil / low dose corticosteroids
IFX-1 – P2.5 Phase II study in AAV in Europe (IXCHANGE) Study Design

<table>
<thead>
<tr>
<th>Part 1</th>
<th>A</th>
<th>IFX-1 + SOC with reduced GC (n=15)</th>
</tr>
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<tbody>
<tr>
<td>B</td>
<td>placebo + SOC incl. GC (n=15)</td>
<td></td>
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</table>

**Study objective (target: n=81)**
- First patient dosed: May 2019
- Primary objective: Efficacy of IFX-1 treatment as replacement for glucocorticoid (GC) therapy in GPA and MPA
- Secondary objectives: To assess safety and tolerability of IFX-1 & compare toxicity of standard-dose GC with IFX-1

* Guideline maintenance allows for: azathioprin / methotrexate / mycophenolate mofetil / low dose corticosteroids

<table>
<thead>
<tr>
<th>Part 2</th>
<th>A</th>
<th>IFX-1 + SOC w/o GC (n=33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>placebo + SOC incl. GC (n=18)</td>
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</table>

**TREATMENT: 16 WEEKS**
- Remission Induction Phase
- Maintenance Phase

**FOLLOW UP: 8 WEEKS**

**Dosing scheme:**

<table>
<thead>
<tr>
<th>Week:</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>12</th>
<th>14</th>
<th>16</th>
<th>20</th>
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</table>

**Safety analysis**

**Part 2**

**Maintenance Therapy:**
- remain on SOC or transition to guideline maintenance therapy*

**SOC** = rituximab or cyclophosphamide
**GC** = glucocorticoids
IFX-1 FOR PYODERMA GANGRAENOSUM
An autoimmune condition with high unmet need

**CLINICAL FEATURES**

- PG is a rare ulcerative skin disorder that can lead to chronic painful and difficult-to-treat wounds / ulcers occurring predominantly in people in their 40s and 50s.
- Many PG patients also suffer from other autoimmune disorders, including inflammatory bowel diseases like ulcerative colitis, rheumatoid arthritis, and hematological diseases.
- Patients suffer from severe pain, long healing times, and frequent relapses.
- Diagnosis is based on the exclusion of other conditions and typical ulcers.

**INCIDENCE**

- Rare - Estimated that up to 50,000 patients in the US and Europe are affected.
- Orphan drug market.

**CURRENT TREATMENT – MEDICAL NEED**

- No drugs currently approved.
- Current treatment options include the use of systemic immunosuppression in rapidly progressing cases or, for less severe cases, topical or intralesional treatments can be used, including topical steroids.
### Overview of IFX-1 Phase IIa Study in PG

#### Study Design

- **Assessing safety and efficacy of IFX-1 in PG**

#### Rationale:

PG is associated with a neutrophilic leukocytosis, which is likely to be triggered by C5a. Pyoderma Gangraenosum lesions have pronounced neutrophilic infiltration and the expression of interleukin (IL)-1β, IL-17, tumor necrosis factor (TNF)-alpha, and their receptors are significantly elevated, indicating auto-inflammatory conditions.

#### Primary endpoint:

Safety

#### Key secondary endpoints:

Responder rate defined as Physicians Global Assessment ≤3 of target ulcer at visits V4, V6, V10, and V16 (end of treatment); Time to complete closure of Pyoderma Gangraenosum target ulcer (investigator assessment)
STRATEGIC LONG-TERM GOALS
Our Strategy

GOALS AND STRATEGY

• Advance our lead program IFX-1 for HS towards Phase III / approval based on regulatory guidance

• Explore application of IFX-1 for AAV, PG and within the oncology field in Phase II clinical development

• Extend pipeline with initiation of clinical development of IFX-1 in other complement-mediated autoimmune / inflammatory diseases

• Pursue the development of IFX-2 and continue to expand the breadth of our anti-C5a technology

• Broaden R&D pipeline beyond anti-C5a technology as part of diversification strategy

As of Q3 2019, we have a strong cash balance of ~US$151 million to pursue these activities
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