Corporate Presentation

December 2016

Forward-looking Statements

Certain statements contained herein including, but not limited to, expected licensing transactions, statements related to anticipated timing of initiation and completion of clinical trials, anticipated size of clinical trials, therapeutic and market potential of XOMA's product candidates, the manufacture of our product candidates, the expansion of our endocrine program, regulatory approval of unapproved product candidates, sufficiency of our cash resources and anticipated levels of cash utilization, or that otherwise relate to future periods are forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934.

These statements are based on assumptions that may not prove accurate, and actual results could differ materially from those anticipated due to certain risks inherent in the biotechnology industry and for companies engaged in the development of new products in a regulated market. Potential risks to XOMA meeting these expectations are described in more detail in XOMA's most recent filing on Form 10-K and in other SEC filings. Consider such risks carefully when considering XOMA's prospects. Any forward-looking statement herein represents XOMA's views only as of the date of this presentation and should not be relied upon as representing its views as of any subsequent date. XOMA disclaims any obligation to update any forward-looking statement, except as required by applicable law.

All XOMA 358 Phase 2 data herein is only as of September 15, 2016 webcast presentation.

Investment Thesis – Driving Development in Endocrine Therapeutics

Advancing endocrine clinical portfolio

- XOMA 358: Phase 2 proof-of-concept (POC) studies ongoing
- XOMA 129: Confirm lead and initiate IND-enabling studies
- XOMA 213: Phase 2 POC study ongoing

Expanding endocrine rare disease portfolio with ongoing high-value research programs

- All portfolio assets have come from XOMA's labs

Leveraging strong partners to advance non-endocrine programs and to provide capital for endocrine efforts

XOMA's Endocrinology Advantage

XOMA antibody discovery capabilities provide unique advantages

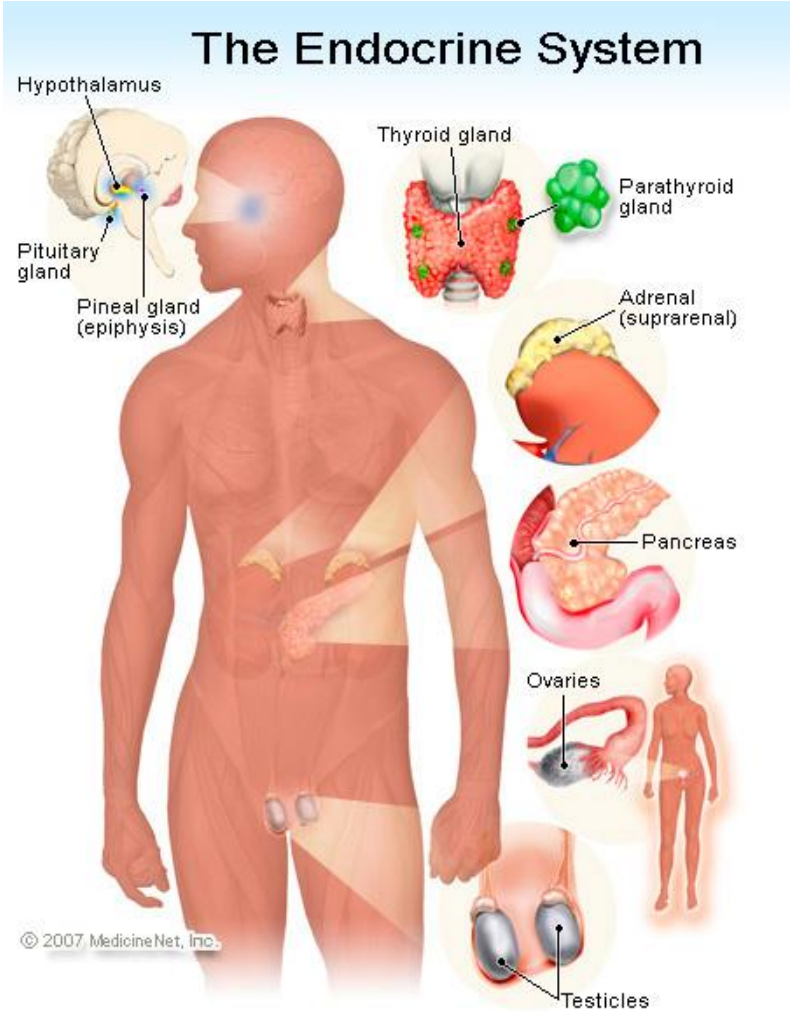
- Allosteric modulation provides opportunity to enhance or attenuate activity without complete blockade
- Successful interrogation of GPCR (G-protein-coupled receptors) targets

5 assets with multiple potential indications

- Two Phase 2 assets
- Additional asset could be at IND within a year

Potential for acute, single-administration indications

- May allow simpler and faster clinical development
- Early signals of effect



Hyperinsulinemic Hypoglycemia: Significant Medical Need

High levels of insulin due to abnormal pancreatic beta cell secretion or abnormal response to glucose

- Causes fainting, seizure, permanent brain damage, death

Congenital	Acquired
Congenital hyperinsulinism (CHI)	**Post-bariatric surgery** (PBS)
Transitional neonatal hyperinsulinism	**Insulinoma**

Patients require alternatives for hyperinsulinemic hypoglycemic states

- Efficacy where there are no good options (e.g. diazoxide-unresponsive CHI, much of PBS HH)
- Prevent / delay pancreatectomy
- Improved therapeutic index (i.e. undesirable side effects in current meds)
- Enhanced quality of life

XOMA 358: Phase 2 Lead Indications

Congenital Hyperinsulinism (CHI)

- Chronic condition due to unregulated secretion of insulin leading to severe episodic hypoglycemia (low blood sugar)
  - Most common cause of hyperinsulinemic hypoglycemia in neonatal, infant and childhood periods[1]
- Current therapies have side-effects or limited efficacy
  - Disease management options are continuous ingestion of glucose, surgical removal of part or all of the pancreas
- U.S. incidence = between 1:20,000 and 1:50,000 births
  - Claims data reveals a prevalence in U.S. of approximately 6,000
- XOMA 358 received Orphan Drug Designation from FDA and EMA
- Hypoglycemia can occur in CHI patients without provocation or when provoked by a fast or a meal (post-prandially)

1. Arnoux, Jean-Baptiste. Congenital Hyperinsulinism: Current Trends in Diagnosis and Therapy. Orphanet Journal of Rare Diseases (10/2011)

XOMA 358: CHI Disease Burden in Neonatal and Pediatric Population

Disease Burden

- Major emotional burden on families
- Parents in constant fear of hypoglycemic attacks
  - Constant monitoring of blood glucose
  - Irreversible brain damage and permanent developmental issues may result

Economic Burden

- Medical Treatment: **$150,000 / year**
- Cost of Nursing Care: **$200,000 / year**
- In event of pancreatectomy: **$1,000,000**
  - Type 1 diabetics post-pancreatectomy

Healthcare System Burden

- Patients may require medical treatment for many years
- Significant costs incurred over patient's lifetime
- Long-term care requirements: epilepsy, permanent brain damage
- CHI centers of excellence: 5 in U.S., 8 outside U.S.

Source: Arnoux, Jean-Baptiste. Congenital Hyperinsulinism: Current Trends in Diagnosis and Therapy. Orphanet Journal of Rare Diseases. 10/03/2011. http://www.ojrd.com/content/6/1/63 McLaughlin, Tracey.

XOMA 358: Phase 2 Lead Indications and Plans

Post-bariatric Surgery Hyperinsulinism (PBS)

- Some patients develop recurrent hypoglycemia following post-bariatric surgery
  - Can occur without provocation, but typically after meals
- Onset observed up to 3 yr post-surgery, especially after the most common bypass procedure
  - ~5% of Roux-en-Y patients develop hyperinsulinemic hypoglycemia
- ~30,000 currently addressable patients

Separate POC Phase 2 studies in patients who are hypoglycemic due either to CHI or PBS

Overarching goal of the Phase 2 studies: provide data enabling a robust design for Phase 3 study acceptable to Regulatory Agencies

1. Marsk, R, Jonas E, Nationwide cohort study of post gastric bypass hypoglycemia including 5,040 patients undergoing surgery for obesity. Diabetologia, 2010 Nov 53 (11) : 2307-11 2.Lee,C et al Prevalence of and Risk factors for Hypoglycemic Symptoms after Gastric Bypass and Sleeve Gastrectomy .Obesity, Vol: 23, No 5, May 2015

XOMA 358: Down-regulates Insulin Receptor Activity

First-in-class, fully human, monoclonal antibody

- Binds to insulin receptor (INSR) and reduces excessive insulin action, thus improving glucose levels
- Long half-life and duration of action

Positive Phase 1 data presented at ENDO 2015

- Post-meal glucose was higher and insulin signaling decreased
- Dose-dependent increase in insulin resistance
  - Magnitude peaks at ~3 mg/kg
- Effect was longer than expected
  - Reduced insulin sensitivity from Day 2 through at least Day 11
  - Long half-life (~15-26 days)
  - Potential for once or twice monthly dosing

XOMA 358: Phase 2 Study in CHI

Children's Hospital of Philadelphia (CHOP); London, UK; Magdeburg, Germany

- Single-dose in children ≥ 12 yrs
- May adapt to multi-dose in younger children (effort in progress)
- Baseline & treatment occur over 3 weeks at Clinical Research Units
- Patients act as their own control
  - Hypoglycemic events documented at baseline
  - Hypoglycemia without provocation or provoked by fast, protein challenge or meal test
  - Hypoglycemia documented by continuous glucose monitoring (CGM)

Multi-cohort study expected to include up to 15 CHI patients

- Cohort 1: 2 patients receiving 1 mg/kg; Cohort 2: 3 patients receiving 3 mg/kg; Cohort 3: enrolling patients at 6 mg/kg
- Additional cohorts expected at increasing dose levels

XOMA 358: Phase 2 Study in PBS

PBS patients experiencing symptomatic episodes of hypoglycemia

Study design similar to the CHI study

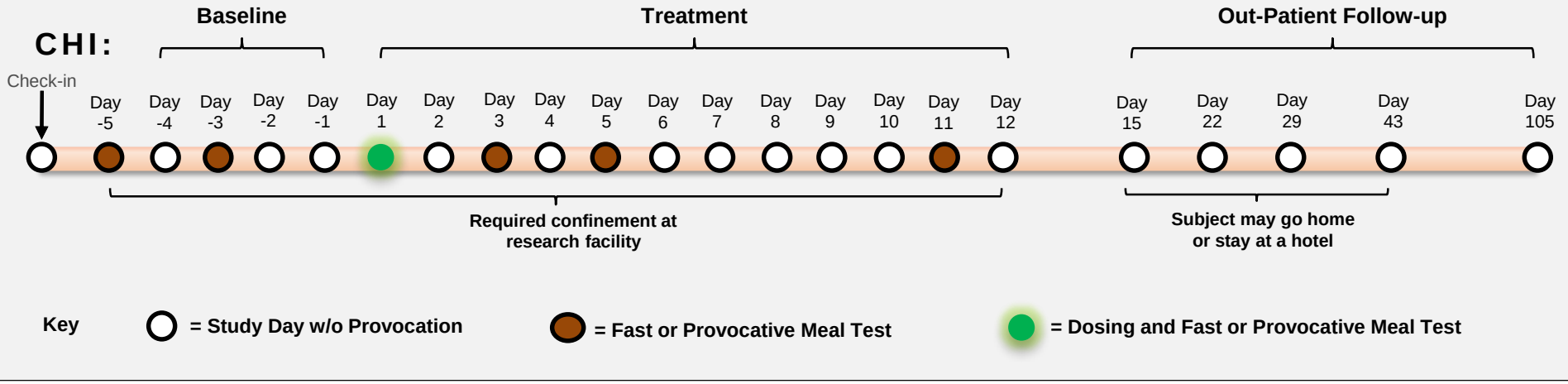
Several prestigious U.S. centers

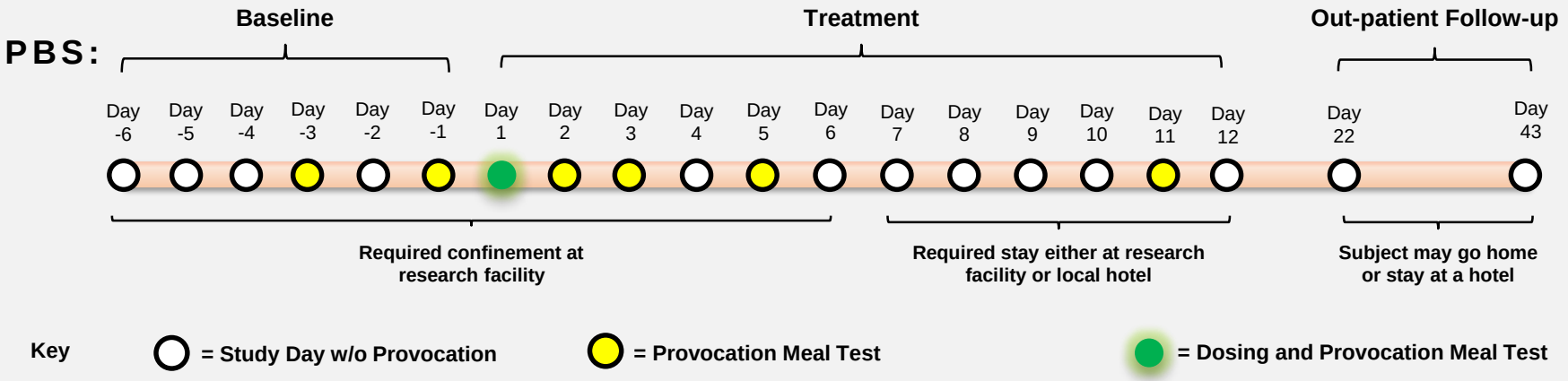
Patients act as their own control and treated in dose cohorts

- Enroll up to 20 patients
- Hypoglycemia documented at baseline via CGM
  - Can be unprovoked or provoked by a meal (post-prandial)
- Cohort 1 received single 3mg/kg dose with additional cohorts determined from previous cohorts

Design may allow evolution from a single-dose to a multi-dose study

XOMA 358: CHI and PBS Trial Designs





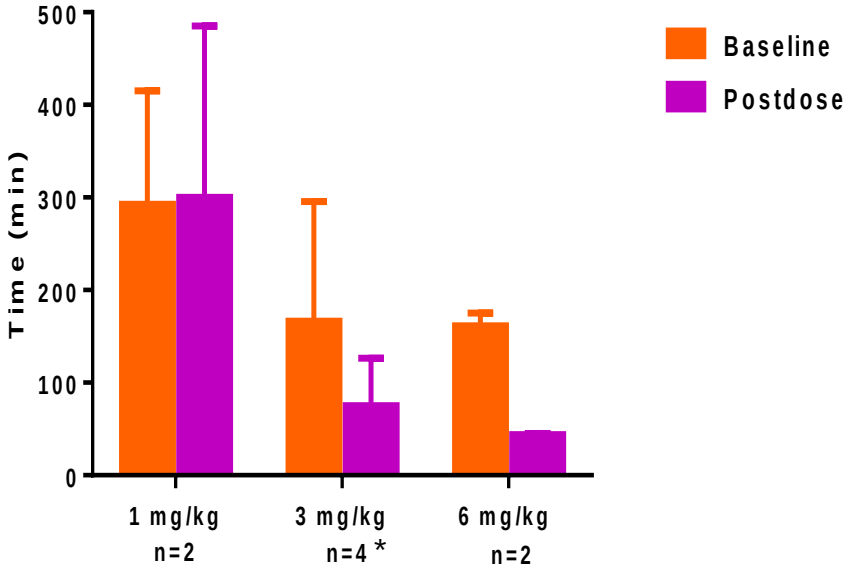
Phase 2: Dosing Progression and Findings

CHI Study		Learnings
1 mg/kg	N=2	Drug effect established but not clinically relevant; Dose too low to overcome the insulin excursions
3 mg/kg	N=3	Appears to achieve effective peak systemic concentrations
6 mg/kg	N=2	Magnitude and duration of action > 3mg/kg; Reduced duration and number of hypoglycemic episodes (<70 mg/dL) btw Days 2-6

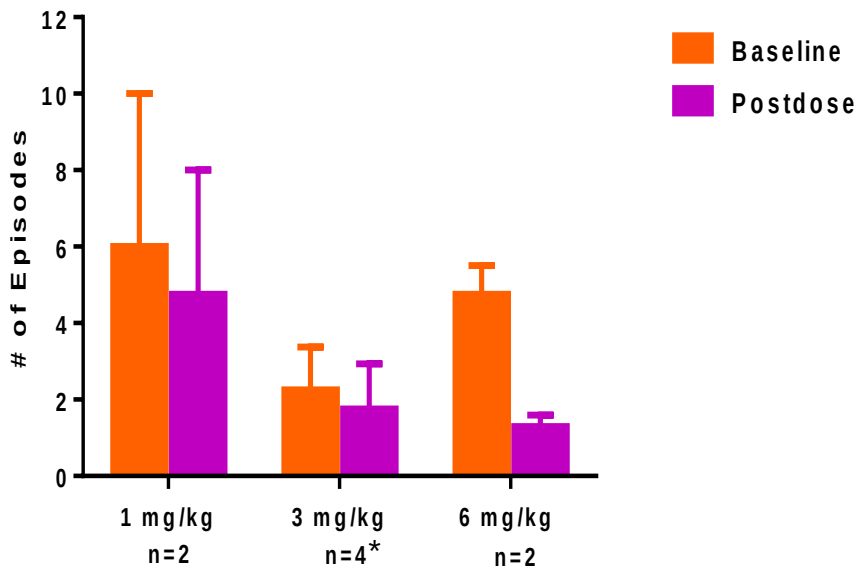
PBS Study		Learnings
3 mg/kg	N=2	Reduced duration and number of hypoglycemic episodes (<70 mg/dL) btw Days 2-6

XOMA 358: Administration at 3-6 mg/kg Reduces Hypoglycemia in Hyperinsulinemic Patients

Duration of Glucose <70 mg/dL



Episodes of Glucose <70 mg/dL



CGM data at Baseline = mean of Days -2, -1 and Post-dose = mean of Days 2, 4, 6

Days without prolonged fast and minimal provocation

*Excludes one patient with significant discrepancy between CGM and bedside glucose due to calibration error and/or sensor misplacement

XOMA 358: Key Findings in Clinical Development

- **XOMA 358 appears safe and well-tolerated**
  - 31 drug-treated subjects to date (22 healthy volunteers, 7 CHI, 2 PBS)
  - PK predictable and similar between genders, HV vs patients
- **Mechanism of insulin resistance established**
- **CHI patients:**
  - Dose-related response demonstrated
  - Clinically relevant improved glucose control in 3 & 6 mg/kg dose groups
    - Reduced number of hypoglycemic episodes, duration of hypoglycemia, or prevention of provoked hypoglycemia
- **PBS patients:**
  - CGM establishes hypoglycemia independent of meal provocation
  - Encouraging results at the starting dose level (3 mg/kg)
  - Additional analyses and patient enrollment at 3 & 6 mg/kg is proceeding
- **To date, patients with hypoglycemic CGM profiles show improved glucose control following 3 or 6 mg/kg XOMA 358 dosing**

XOMA 358: Further studies in CHI

- **Data generated to date leads us to believe "real-world" study in CHI patients may be appropriate**
- **Patients would be monitored by CGM, accompanied by electronic diaries in addition to regular blood glucose monitoring**
- **Enrollment criteria would include pre-set time in hypoglycemia requirements during screening period**
- **Potential endpoint: Measurements of pre- and post-dose time (and # episodes) in hypoglycemia**
  - Duration & episode frequency of hypoglycemic events are meaningful from both clinical and regulatory perspectives
- **Modified, but similar, design may be used in PBS**

XOMA 358: Next Steps in Development

- **Complete single-administration dosing in CHI & PBS patients at 9 mg/kg**
- **Initiate repeat-administration study for CHI**
  - Protocols have been designed and submitted
  - Targeting CHI patients 2 yrs & up
- **Submit PBS repeat-dosing protocols**
- **Expand global development**
- **Initiate natural history hypoglycemia profiling in CHI patients to best enable pivotal trial designs**
- **Complete long-term and juvenile animal toxicology studies**
  - Enables chronic dosing and administration to neonatal and older humans

XOMA 129: Potential Fast-Acting Treatment for Acute Severe Hypoglycemia

Highly potent XMetD Fab fragment which downregulates INSR activity

- Offers potential for rapid onset, improved efficacy, and tailored duration of therapy
- Treatment for acute severe hypoglycemia
  - Severe hypoglycemia is life-threatening and has cardiovascular impacts[1]
  - ~10% of all ER visits results from insulin-related severe hypoglycemia

Hypoglycemia caused by insulin or related therapies remains one of the greatest challenges to glucose management in diabetes[2]

Bolus Insulin-treated Rat models (ENDO 2016) demonstrated:

- Faster onset of action and improved efficacy over variant mAbs
- Encouraging potency and duration of efficacy

1. Frier, B. M., G. Schernthaner, and S. R. Heller. "Hypoglycemia and Cardiovascular Risks." *Diabetes Care* 34, no. Supplement 2 (2011).
2. P. Cryer M.D., Hypoglycemia During Therapy of Diabetes, in DeGroot et al, Endotext, 2015)

XOMA 213 for Prolactinoma: MOA Study Underway

Fully human, monoclonal antibody against the prolactin receptor

- Open IND transferred to XOMA from Novartis
- Significant number of patients treated for potential oncology indications for up to 48 weeks at doses up to 20x higher than predicted clinical dose for hyperprolactinemia

Prolactinoma – primary indication

- Benign tumors of the pituitary gland
- Results in sexual dysfunction, infertility and osteoporosis
- 10 – 20% of all prolactinomas are either resistant or don't tolerate dopamine agonists[1]

Phase 2 POC study initiated

- Ex-US study in women who wish to suppress lactation immediately postpartum
- Not a target indication

1. Dopamine agonist-resistant prolactinomas: J Neurosurg. 2011 May;114(5):1369-79

XOMA's Pipeline

Compound	Indication	Pre-clinical	Phase 1	Phase 2	Phase 3
Endocrine Assets					
XOMA 358 (INSR)	CHI & PBS	→	→	→	
XOMA 129 (INSR)	Short acting reversal of insulin	→			
XOMA 213 (Prolactin receptor)	Various hyperprolactinemias	→	→	→	
Assets Available for Licensure					
Anti-PTH1R	Primary hyperparathyroidism, Humoral hypercalcemia of malignancy	→			
Anti-IL-2	Oncology, anti-tumor immunity	→			

Financial Highlights

$20.6M cash at September 30, 2016

Cash runway through at least first quarter of 2017

~ 6M shares outstanding at October 18, 2016

Significant partnerships advancing non-endocrine assets

Value Created Through Partnerships

Novartis anti-CD40 Antibody (CFZ533) Program

- Five ongoing clinical studies
- Milestones received; tiered high-single to lower mid-teen digit royalties

Novartis TGFβ Antibody Program – October 2015

- $480M potential milestones; tiered mid-single to low-double digit royalties

Novo Nordisk XMetA Antibody Program – December 2015

- Selective insulin receptor up regulator for diabetes
- $290M potential milestones; tiered mid- to high-single digit royalties

Investment Thesis – Driving Development in Endocrine Therapeutics

XOMA 358 (XMetD)	XOMA 129 (XMetD Fab)	XOMA 213	EXPAND ENDOCRINE	NON-CORE ASSETS
Continue to enroll patients in Phase 2 POC studies in CHI & PBS	Conduct pre-clinical development	Enroll patients in Phase 2 MOA study	Rare disease portfolio with ongoing high-value research programs	Partner non-core assets for advancement and finance endocrine effort


XOMA