Phase 1 dose escalation of IMC-F106C, the first PRAME × CD3 ImmTAC bispecific protein in solid tumors

September 9, 2022
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These statements include, but are not limited to, statements regarding the marketing and therapeutic potential and clinical benefits of IMC-F106C for a wide range of cancers, including its ability to influence a diverse range of tumors and ability to result in a durable response; the timing of patient enrollment for and expansion arms of the IMC-F106C-101 trial, including the option for Phase 2 expansion; and expectations regarding the development plan, design, progress, timing, scope and results of Immunocore’s existing and planned clinical trials, including the IMC-F106C-101 trial, including statements regarding upcoming cohorts, trial expansion and the timing of the availability of future clinical trial results, the KIMMTRAK clinical development and the marketing and therapeutic potential of KIMMTRAK for metastatic uveal melanoma (mUM), expectations regarding the potential market size and opportunity for Immunocore’s product candidates, and expectations regarding receipt of regulatory approvals of Immunocore’s product candidates. 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Overview & ImmtAC Platform
Bahija Jallal, PhD – Chief Executive Officer

Phase 1 study of IMC-F106C Targeting PRAME
Omid Hamid, MD – Cedars-Sinai Cancer, the Angeles Clinic & Research Institute

Next steps for IMC-F106C
David Berman, MD, PhD – Head of R&D

Concluding Remarks
Bahija Jallal, PhD – Chief Executive Officer

Q&A Session
We are defining a new frontier of cancer treatment

1949
Chemotherapy

1997
Targeted Therapy

2011
Immunotherapy

2013
Antibody-Drug Conjugate

2017
Cell Therapy

2022
T Cell Receptor (TCR) Therapy
Off-the-shelf bispecific T cell engagers
Omid Hamid, MD

Chief, Translational Research and Immunotherapy and Co-Director, Melanoma Therapeutics

Internationally recognized leader in immuno-oncology drug development and melanoma therapeutics

Investigator in the initial trials with ipilimumab, pembrolizumab, nivolumab, atezolizumab and vemurafenib

Current focus on next-generation checkpoint inhibitors, T cell adoptive therapies and bispecific antibodies
Phase 1 dose escalation of IMC-F106C, the first PRAME × CD3 ImmTAC bispecific protein in solid tumors

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DECLARATION OF INTERESTS

Dr Omid Hamid

Advisory/Consulting: Aduro Biotech, Akeso Biopharma, Alkermes, Amgen, BeiGene, BioAtla, BMS, Genentech, GlaxoSmithKline, Idera, Immunocore, Incyte, Iovance Biotherapeutics, Janssen, Merck, NextCure, Novartis, Pfizer, Regeneron, Roche, Sanofi, Seattle Genetics, Tempus, Zelluna; Speaker’s Bureau: BMS, Novartis, Pfizer, Sanofi/Regeneron

Honoraria: BMS, Novartis, Pfizer, Sanofi/Regeneron

Research Funding (Institute): Aduro Biotech, Akeso Biopharma, Amgen, Arcus Biosciences, Bioatla, BMS, CytomX Therapeutics, Exelixis, Genentech, GlaxoSmithKline, Idera, Immunocore, Incyte, Iovance Biotherapeutics, Merck, Merck Serono, Moderna Therapeutics, NextCure, Novartis, Pfizer, Regeneron, Roche, Rubius Therapeutics, Sanofi, Seattle Genetics, Torque, Zelluna

DISCLAIMER
All statements contained in this presentation are based on preclinical and clinical trial data related to an investigational molecule, IMC-F106C. Development of this molecule is ongoing and, therefore, statements relating to study data to date should not be regarded as definitive reflections of safety, efficacy or the risk-benefit profile of the molecule.
IMC-F106C: ImmTAC targeting HLA-A2-presented peptide from PRAME (PRAME × CD3)

**PRAME**: most broadly expressed cancer-testis antigen in several tumor types but with minimal normal tissue expression.

<table>
<thead>
<tr>
<th>Tumor</th>
<th>Prevalence of PRAME expression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma, endometrial, NSCLC, TNBC, SCLC, ovarian</td>
<td>HIGH</td>
</tr>
<tr>
<td>RCC, esophageal, SCCHN, cervical</td>
<td>LOW</td>
</tr>
<tr>
<td>Bladder, HCC, gastric</td>
<td>LOW</td>
</tr>
</tbody>
</table>

ImmTAC, Immune mobilizing T cell receptor Against Cancer; TCR, T cell receptor
## Phase 1 Study Design

**Key objectives**

**Primary endpoint**
- Determine MTD/expansion dose

**Secondary endpoints**
- Preliminary antitumor activity
- Pharmacokinetics
- Pharmacodynamic markers

**Key eligibility criteria**
- HLA-A*02:01 (central testing)
- Select advanced solid tumors
- Tumor PRAME by immunohistochemistry
  - High PRAME prevalence: enroll all comers; test retrospectively
  - All other indications: prospective confirmation of PRAME

### Tumor assessment every 9 weeks

Weekly IV infusion with intra-patient dose escalation (over 3 weeks)

#### Dose escalation

**Target Dose, Starting Day 15**

<table>
<thead>
<tr>
<th>Dose (mcg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>320</td>
</tr>
<tr>
<td>160</td>
</tr>
<tr>
<td>80</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>0.3 - 10</td>
</tr>
</tbody>
</table>

**Total safety population N=55**

Cohorts 1-5

Cohorts 6 and above

**Efficacy population n=31**

Strong and consistent pharmacodynamic activity

* Of 36 patients treated at target escalation dose of ≥20 mcg, 5 patients were excluded from efficacy analyses as they were PRAME-negative (n=2) or not yet had tumor assessment (n=3)

EudraCT No. 2019-004046-16; NCT04262466

Data cut-off date: 18 Jul 2022

IV, intravenous; MTD, maximum tolerated dose
Strong and Consistent Pharmacodynamic Activity at ≥20 mcg IMC-F106C

Interferon induction

Peripheral blood

Dose

IFN\(\gamma\) (pg/mL)

- 0.3 - 10 mcg
- ≥ 20 mcg

Day 15

Pre 12 12 13
8h 31 29 31
24h

Results plotted as mean ± SEM

T cell trafficking

Peripheral blood → Tumor

Pre-treatment

Day 28

22-fold increase

CD3

Strong and Consistent Pharmacodynamic Activity at ≥20 mcg IMC-F106C

- T cell activation and re-direction into tumor seen across ImmTAC platform

Results plotted as mean ± SEM
Baseline patient characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Safety Population N=55</th>
<th>Efficacy Population N=31†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age – median yr (range)</td>
<td>60 (26, 79)</td>
<td>61 (36, 79)</td>
</tr>
<tr>
<td>ECOG status 0 – n (%)</td>
<td>30 (55%)</td>
<td>19 (61%)</td>
</tr>
<tr>
<td>PRAME status (IHC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>49 (89%)</td>
<td>28 (90%)</td>
</tr>
<tr>
<td>Negative</td>
<td>2 (4%)</td>
<td>0</td>
</tr>
<tr>
<td>Not evaluable</td>
<td>4 (7%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Median H-score</td>
<td>195</td>
<td>188</td>
</tr>
<tr>
<td>Tumor type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanoma</td>
<td>34 (62%)</td>
<td>17 (55%)</td>
</tr>
<tr>
<td>Uveal (UM)</td>
<td>26 (47%)</td>
<td>11 (35%)</td>
</tr>
<tr>
<td>Cutaneous (CM)*</td>
<td>8 (15%)</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>Ovarian Carcinoma</td>
<td>10 (18%)</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Serous (SOC)*</td>
<td>7 (13%)</td>
<td>4 (13%)</td>
</tr>
<tr>
<td>Non-serous</td>
<td>3 (5%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>NSCLC</td>
<td>4 (7%)</td>
<td>4 (13%)</td>
</tr>
<tr>
<td>TNBC*</td>
<td>3 (5%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Endometrial*</td>
<td>4 (7%)</td>
<td>2 (6%)</td>
</tr>
</tbody>
</table>

- Median PRAME H-score in efficacy population was high, 188; most patients enrolled regardless of PRAME testing
- Patients in efficacy population were heavily pretreated
  - Ovarian: all platinum resistant
  - CM: all received prior anti-PD1 and anti-CTLA4
  - NSCLC: all received prior anti-PD1
  - TNBC and endometrial: 2-5 prior lines of therapy

* In efficacy population, these tumors enrolled regardless of PRAME immunohistochemistry (IHC) testing, which was evaluated retrospectively. NSCLC squamous also enrolled regardless of PRAME testing
† Of 36 patients treated at target escalation dose of ≥20 mcg, 5 patients were excluded from efficacy analyses as they were PRAME-negative (n=2) or not yet had tumor assessment (n=3)
**IMC-F106C was well tolerated**

Most frequent related AE was Grade 1/2 CRS, consistent with proposed mechanism

<table>
<thead>
<tr>
<th>Preferred Term (MedDRA v23.1)</th>
<th>0.3 – 10 mcg† (N=18)</th>
<th>20 – 320 mcg† (N=37)</th>
<th>Total (N=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT LEAST ONE EVENT</td>
<td>18 (100)</td>
<td>34 (92)</td>
<td>52 (95)</td>
</tr>
<tr>
<td>Pyrexia*</td>
<td>10 (56)</td>
<td>21 (57)</td>
<td>31 (56)</td>
</tr>
<tr>
<td>Cytokine release syndrome</td>
<td>5 (28)</td>
<td>22 (59)</td>
<td>27 (49)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>6 (33)</td>
<td>13 (35)</td>
<td>19 (35)</td>
</tr>
<tr>
<td>Hypotension*</td>
<td>3 (17)</td>
<td>15 (41)</td>
<td>18 (33)</td>
</tr>
<tr>
<td>Chills</td>
<td>9 (50)</td>
<td>8 (22)</td>
<td>17 (31)</td>
</tr>
<tr>
<td>Nausea</td>
<td>7 (39)</td>
<td>10 (27)</td>
<td>17 (31)</td>
</tr>
<tr>
<td>Rash</td>
<td>3 (17)</td>
<td>12 (32)</td>
<td>15 (27)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade ≥ 3 (Events in &gt; 1 patient), n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT LEAST ONE EVENT</td>
</tr>
<tr>
<td>Lymphopenia</td>
</tr>
<tr>
<td>Aspartate aminotransferase increased</td>
</tr>
<tr>
<td>Anemia</td>
</tr>
<tr>
<td>Alanine aminotransferase increased</td>
</tr>
<tr>
<td>Arthralgia</td>
</tr>
<tr>
<td>Pyrexia*</td>
</tr>
</tbody>
</table>

- MTD not reached
- No treatment-related discontinuation or Grade 5 adverse events
- CRS events were all manageable
  - Majority (77%) within first 3 doses
  - 71% Grade 1
  - 29% Grade 2
  - No Grade ≥ 3 CRS
- Adverse events attenuate over time

* Includes events reported as a sign/symptom of CRS
† Safety presented by intended target escalation dose on Day 15. 1/37 patients received only a single dose of 2 mcg and did not reach target dose of ≥ 20 mcg
Responses observed in multiple tumor types

- Two patients (1 with NSCLC, 1 serous ovarian) discontinued treatment due to PD with scan data not available at DCO
- Ovarian cancer patient with unconfirmed PR (uPR) remains on treatment and eligible for confirmation
- PRAME expression assessed by IHC H-score
- Two PRAME-negative patients both had PD (not shown)

* Two patients (1 with NSCLC, 1 serous ovarian) discontinued treatment due to PD with scan data not available at DCO
† Ovarian cancer patient with unconfirmed PR (uPR) remains on treatment and eligible for confirmation
‡ PRAME expression assessed by IHC H-score

Endo, endometrial carcinoma; NSCLC, non-small cell lung carcinoma; TNBC, triple-negative breast cancer;
Majority of patients have durable tumor response or disease stabilization

Change in Target Lesion from Baseline (%)

Time (Months)

-100 -80 -60 -40 -20 0 20 40 60 80 100

-1 2 3 4 5 6 7 8 9 10 11 12 13 14

New lesion H-score Positive H-score Not Evaluable

Uveal Melanoma (Prior Tebentafusp) Uveal Melanoma (Tebentafusp Naive) Cutaneous Melanoma Serous Ovarian Cancer NSCLC Triple-Negative Breast Cancer Endometrial Carcinoma Ovarian Carcinosarcoma

NSCLC, non small cell lung carcinoma
Responses are durable, 6 of 7 PRs still ongoing

Two PRs ongoing for 7+ months

<table>
<thead>
<tr>
<th>Indication</th>
<th>Best ctDNA change</th>
<th>PRAME expression</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>UM Tebentafusp naïve</td>
<td>-96%</td>
<td>295</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-100%</td>
<td>195</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-100%</td>
<td>230</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-97%</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>280</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>280</td>
<td></td>
</tr>
<tr>
<td>Cutaneous melanoma</td>
<td>-100%</td>
<td>255</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>180</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>NE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>255</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-100%</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-73%</td>
<td>285</td>
<td></td>
</tr>
<tr>
<td>Serous Ovarian</td>
<td>-67%</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-14%</td>
<td>175</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>170</td>
<td></td>
</tr>
<tr>
<td>UM Prior Tebentafusp</td>
<td>-100%</td>
<td>185</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-3%</td>
<td>265</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>240</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>130</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+36%</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>NSCLC</td>
<td>-59%</td>
<td>190</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-71%</td>
<td>ND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-55%</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>TNBC</td>
<td>-3%</td>
<td>NE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-59%</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+10%</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Endo</td>
<td>-10%</td>
<td>245</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ND</td>
<td>180</td>
<td></td>
</tr>
<tr>
<td>Ovarian carcinosarcoma</td>
<td>-7%</td>
<td>195</td>
<td></td>
</tr>
</tbody>
</table>

* PRAME expression assessed by IHC H-score
Endo, endometrial carcinoma; NSCLC, non small cell lung carcinoma; TNBC, triple-negative breast cancer; UM, uveal melanoma; ctDNA, circulating tumor DNA; ND, not yet determined (9 patients pending); NE, not evaluable; PR, partial response

1st scan

1 year

Treatment Duration
Stable Disease
Partial Response
Progressive Disease
Ongoing
Survival Follow-Up
Death
Reduction in circulating tumor DNA observed across tumor types (n=20)†

- 20 of 31 efficacy evaluable patients had paired ctDNA. Data not yet available for 9 patients, including 3 PRs. Two patients did not have baseline detectable ctDNA.
- 4 PR patients evaluated for ctDNA had > 50% reduction, including 3 with clearance
- Two patients had ctDNA clearance despite best response of PD

| Tumor | U | B | U | B | O | E | O | LS | LA | B | O | LS | C | U | U | C | U | U | U | U | C |
|-------|---|---|---|---|---|---|---|----|----|---|---|----|---|---|---|---|---|---|---|---|---|---|
| BOR   | PD| PD| SD| PD| PD| PD| SD| NE| SD| PD| SD| PD| SD| PD| PD| PR| PR| PR| PR| PR| PR| PR|
| Prior tebe | *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *|
| Prior CPI  | *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *| *|

† 20 of 31 efficacy evaluable patients had paired ctDNA. Data not yet available for 9 patients, including 3 PRs. Two patients did not have baseline detectable ctDNA.

B, triple-negative breast cancer; C, cutaneous melanoma; ctDNA, circulating tumor DNA; E, endometrial carcinoma; LA, non small cell lung adenocarcinoma; LS, non small cell lung squamous cell carcinoma; O, ovarian; U, uveal melanoma; CPI, checkpoint inhibitor; tebe, tebentafusp
Example responders: ovarian carcinoma and uveal melanoma

Patient #1
Ovarian cancer
5 prior lines, platinum resistant

Baseline

On treatment
Unconfirmed PR
Ongoing treatment; ctDNA pending

Patient #2
Uveal Melanoma

Baseline

On treatment
Confirmed PR
ctDNA cleared
Ongoing treatment 1+ year

Images courtesy of Dr. Marlana Orloff (TJU) and Dr. Anja Williams (SCRI-UK)
Example responder: cutaneous melanoma
Prior anti-CTLA4, multiple anti-PD1s and oncolytic virus

Patient #3
Baseline

Confirmed PR
ongoing treatment 5+ months
Example responder: serous ovarian carcinoma
5 prior regimens including platinum, bevacizumab, anti-PD-1, investigational agents

Patient #4
Baseline

Confirmed PR
ctDNA 67% decrease
nontarget PD at Month 8
but ongoing treatment 1+ yr

Images courtesy of Dr. Omid Hamid (Angeles Clinic)
Conclusions

- IMC-F106C, first PRAME×CD3 ImmTAC, activates T cells and is well-tolerated
  - CRS is mostly Grade 1, no Grade ≥3, and predominantly during initial 3 doses
  - Treatment-related AEs are manageable; none have led to discontinuation or death

- Durable (up to 9+ months) RECIST PRs across multiple tumor types, including
  - Cutaneous melanoma, progressed following prior anti-PD1 and anti-CTLA4
  - Heavily pre-treated, platinum-resistant ovarian carcinoma
  - Uveal melanoma

- Benefit also apparent in disease control, including conversion of SD to PR

- Almost all evaluable patients, across multiple tumor types, have ctDNA reduction
  - Early reduction appears associated with clinical benefit
  - Complete ctDNA clearance common in melanoma

- Expansions open in cutaneous melanoma, NSCLC, endometrial and ovarian carcinoma

- Dose escalation continues and combinations with chemotherapy and checkpoint inhibitors planned
Thank you to all patients, their families and their caregivers who were involved in this global clinical trial & all investigators and their teams

Omid Hamid
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Benjamin Izar
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Thomas Jefferson University Hospitals
University of Pittsburgh Medical Center
Memorial Sloan Kettering Cancer Center
University of Oklahoma Peggy and Charles Stephenson Cancer Center
Sarah Cannon Research Institute, Nashville
MD Anderson Cancer Center
Columbia University Medical Center
University of California Davis Comprehensive Cancer Center

Juanita Lopez
Anja Williams and Hendrik-Tobias Arkenau
Fiona Thistlethwaite
Heather Shaw

Royal Marsden NHS Foundation Trust and Institute of Cancer Research
Sarah Cannon Research Institute, London
The Christie NHS Foundation Trust
University College London
IMC-F106C Clinical Development Plan

DAVID BERMAN
Head of Research and Development
Insights from KIMMTRAK clinical development in mUM

Overall Survival (OS) benefit

**MEDIAN OS:** 21.7 months

**HAZARD RATIO:** 0.51

Redirects T cells into tumor\(^1\)

Durable clinical activity\(^2\)

ctDNA reduction\(^3\)

Activity at high and low H score\(^4\)

RECIST responses enriched at higher H score for PRAME

4. All KIMMTRAK -naïve patients in phase 1 trials, including those with H score =0. Excluded are patients with unevaluable H score and 5 mUM IMC-F106C patients who progressed on prior KIMMTRAK

4. All KIMMTRAK -naïve patients in phase 1 trials, including those with H score =0. Excluded are patients with unevaluable H score and 5 mUM IMC-F106C patients who progressed on prior KIMMTRAK
IMC-F106C-101 designed as an adaptive Phase 1/2 study

**Monotherapy**

- Monotherapy IV dose escalation
- Cutaneous melanoma
  - Monotherapy expansion
- Ovarian
  - Monotherapy expansion
- NSCLC
  - Monotherapy expansion
- Endometrial
  - Monotherapy expansion

**Combinations**

- Checkpoint inhibitor combinations
- Chemotherapy combinations
- ImmTAC combinations

- Enables future randomized trials into earlier lines of therapy

**Focus of today’s presentation**

- Adaptive design enables flexible expansion size

**All ongoing**

- Initial data provides optionality to develop in single arm or randomized trials
**PRAME, validated as TCR target, expressed in many solid tumors**

<table>
<thead>
<tr>
<th>Prevalence of PRAME expression(^1)</th>
<th>Tumor type</th>
<th>HLA*02:01+, PRAME+ metastatic patients (G7)(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70-100%</td>
<td>Endometrial</td>
<td>&gt;10K</td>
</tr>
<tr>
<td></td>
<td>Melanoma</td>
<td>&gt;10K</td>
</tr>
<tr>
<td></td>
<td>Ovarian</td>
<td>&gt;15K</td>
</tr>
<tr>
<td></td>
<td>NSCLC-squamous</td>
<td>&gt;30K</td>
</tr>
<tr>
<td>50-70%</td>
<td>NSCLC-adeno</td>
<td>&gt;40K</td>
</tr>
<tr>
<td></td>
<td>SCLC</td>
<td>&gt;15K</td>
</tr>
<tr>
<td></td>
<td>TNBC</td>
<td>&gt;5K</td>
</tr>
<tr>
<td>20-50%</td>
<td>SCCHN</td>
<td></td>
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<tr>
<td></td>
<td>Gastric</td>
<td></td>
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<tr>
<td></td>
<td>RCC</td>
<td></td>
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<tr>
<td></td>
<td>Esophageal</td>
<td></td>
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<tr>
<td></td>
<td>Cholangiocarcinoma</td>
<td></td>
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<tr>
<td></td>
<td>Cervical</td>
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</tr>
</tbody>
</table>

**Total >150,000**

PRAME+, HLA-A2 patients/year

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1. PRAME prevalence derived from immunohistochemistry and RTqPCR of patient samples and analysis of TCGA
2. Epidemiology data from cancer registries and Decision Resources, Annual incidence of metastatic patients
Concluding Remarks

BAHIJA JALLAL
Chief Executive Officer
## Validation of ImmTAC platform in multiple solid tumors

<table>
<thead>
<tr>
<th></th>
<th>T cell activation</th>
<th>Durable tumor shrinkage</th>
<th>Activity even in low target expression</th>
<th>ctDNA reduction</th>
<th>Overall survival benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KIMMTRAK®</strong></td>
<td><img src="image1" alt="Clinical Cancer Research" /></td>
<td><img src="image2" alt="ESMO Immuno-Oncology Virtual Congress" /></td>
<td><img src="image3" alt="2021 ESMO Congress" /></td>
<td><img src="image4" alt="2021 ESMO Congress" /></td>
<td><img src="image5" alt="The New England Journal of Medicine" /></td>
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<tr>
<td>gp100</td>
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<tr>
<td><strong>IMC-C103C</strong></td>
<td><img src="image6" alt="ESMO Immuno-Oncology" /></td>
<td><img src="image7" alt="ESMO Immuno-Oncology" /></td>
<td><img src="image8" alt="ESMO Immuno-Oncology" /></td>
<td><img src="image9" alt="To be presented" /></td>
<td></td>
</tr>
<tr>
<td>MAGE-A4</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>IMC-F106C</strong></td>
<td><img src="image10" alt="ESMO Congress" /></td>
<td><img src="image11" alt="ESMO Congress" /></td>
<td><img src="image12" alt="ESMO Congress" /></td>
<td><img src="image13" alt="ESMO Congress" /></td>
<td><img src="image14" alt="ESMO Congress" /></td>
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<tr>
<td>PRAME</td>
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</table>

Promising rate of RECIST PRs enables broad development options
Q&A Session

OMID HAMID, MD
The Angeles Clinic
Chief, Translational Research and Immunotherapy and Co-Director, Melanoma Therapeutics

BAHIJA JALLAL, PhD
Chief Executive Officer

BRIAN DI DONATO
Chief Financial Officer and Head of Strategy

DAVID BERMAN, MD, PhD
Head of Research and Development

MOHAMMED DAR, MD
Chief Medical Officer
### Our pipeline

**Leading bispecific TCR pipeline; FDA approval for KIMMTRAK®**

<table>
<thead>
<tr>
<th>Candidate</th>
<th>Target</th>
<th>Indication</th>
<th>Pre-clinical</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Approved</th>
<th>Anticipated Milestones</th>
</tr>
</thead>
</table>
| KIMMTRAK® | gp100  | Uveal melanoma |             |         |         |         | ✓        | FDA, EC, MHRA approvals  
|           |        | Advanced melanoma |     |         |         |         | ✓        | Commercial launch 1H 2022 |
|           |        |             | ✓            | ✓       | ✓       |         | ✓        | Start Ph 2/3 study 4Q 2022 |
| IMC-F106C | PRAME  | Multiple solid tumors |             |         |         |         | ✓        | Phase 1 data presented at ESMO  
|           |        |             | ✓            |         |         |         | ✓        | Initiated 4 expansion arms (cutaneous melanoma, ovarian, NSCLC, & endometrial)  
|           |        |             | ✓            |         |         |         | ✓        | Dose escalation continues |
| IMC-C103C¹ | MAGE-A4 | Multiple solid tumors |             |         |         |         | ✓        | Initiated ovarian expansion arm  
|           |        |             | ✓            |         |         |         | ✓        | Phase 1 update 4Q 2022 |
| Candidate #4 | Undisclosed | Multiple solid tumors |             |         |         |         |         | ✓        | Initial Ph. 1 data presented (EASL) |
| Candidate #5 | Undisclosed | Colorectal, gastric, pancreatic |             |         |         |         |         | ✓        | Phase 1 first patient dosed |
| IMC-I109V | Envelope | Hepatitis B Virus (HBV) |             |         |         |         | ✓        | ✓        |
| IMC-M113V² | Gag    | Human Immunodeficiency Virus (HIV) |             |         |         |         | ✓        | ✓        |

¹ Developed under a co-development/co-promotion collaboration with Genentech. ² Program is wholly owned, development costs being provided by the Bill & Melinda Gates Foundation (BMGF). Immunocore retains all development and commercialization rights in the developed world.
## Key portfolio milestones anticipated in 2022

<table>
<thead>
<tr>
<th>1Q2022</th>
<th>2Q2022</th>
<th>3Q2022</th>
<th>4Q2022</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KIMMTRAK Commercial Launch</strong></td>
<td></td>
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<td><strong>Advanced Melanoma Start Ph. 2/3 Randomized Trial</strong></td>
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<tr>
<td>✓ FDA Approval for mUM</td>
<td>✓ European Commission’s Approval for mUM</td>
<td>✓ UK MHRA Approval for mUM</td>
<td>✓ Australia and Canada Approval for mUM</td>
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<tr>
<td>2Q</td>
<td>2Q</td>
<td>2Q</td>
<td>2Q</td>
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<tr>
<td>Clinical supply agreement with Sanofi IL2 for melanoma</td>
<td>2Q</td>
<td></td>
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</tbody>
</table>

### Oncology

- **FDA Approval**
- **1Q2022**
- **2Q2022**
- **3Q2022**
- **4Q2022**

### Infectious Diseases

- **HBV Initial Ph. 1 Data**
  - Initiated four expansion arms (cutaneous melanoma, ovarian, NSCLC, & endometrial)
- **HIV Ph. 1 Start**
- **EASL 2022 | 2Q**

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~$393M Adjusted cash and cash equivalents as of June 30, 2022

1. Gives effect to receipt of $139.6M proceeds from July 2022 PIPE transaction, net of offering expenses payable by the Company.