Transformative immunomodulating medicines for patients

February 2024
Forward Looking Statements

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These statements include, but are not limited to, Immunocore’s capabilities across oncology, autoimmune and infectious disease therapeutic areas and its ability to grow and further development the PFRAME franchise; the estimated market size and patient population for KIMMTRAK and Immunocore’s other product candidates; the three growth areas of KIMMTRAK including HLA-A02+ melanoma, metastatic cutaneous melanoma and adjuvant uveal melanoma; expected submission of investigational new drug applications or clinical trial applications; the potential regulatory approval, expected clinical benefits and availability of Immunocore’s product candidates; the commercial performance of KIMMTRAK including planned launches in additional countries, expanded access to KIMMTRAK in the United States and globally, and indication expansion; the ability to enter into pricing agreements and to translate such pricing agreement into a successful launch; the potential benefits and advantages KIMMTRAK and Immunocore’s other product candidates will provide for patients; the benefits of Immunocore’s collaboration with the European Organisation for Research and Treatment of Cancer (EORTC); expectations regarding the design, progress, timing, enrollment, scope, expansion, and results of Immunocore’s existing and planned clinical trials, those of Immunocore’s collaboration partners or the combined clinical trials with Immunocore’s collaboration partners; the timing and sufficiency of clinical trial outcomes to support potential approval of any of Immunocore’s product candidates or those of, or combined with, its collaboration partners; Immunocore’s goals to develop and commercialize product candidates based on its KIMMTRAK platform alone or with collaboration partners; Immunocore’s ability to develop new product candidates using its discovery engine; Immunocore’s ability to initiate CMC manufacturing for autoimmune candidates on the expected timeline, or at all; potential growth opportunities and trends, including in connection with product launches; and Immunocore’s preliminary unaudited cash and cash equivalents. 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KIMMTRAK™ is a trademark owned or licensed to Immunocore.
Harnessing the immune system to fight disease with targeted, off-the-shelf, bispecific, soluble T cell receptors (TCRs)

TCR therapeutics can target >90% of the human proteome
Platform candidates and capabilities across 3 therapeutic areas

- **Oncology**
  - ImmTACs

- **Infectious diseases**
  - ImmTAVs

- **Autoimmune diseases**
  - ImmTAAs

- **Activation of the immune system**
- **Downmodulation of the immune system**
Leading bispecific TCR pipeline

<table>
<thead>
<tr>
<th>Candidate</th>
<th>Target (HLA type)</th>
<th>Indication</th>
<th>IND-enabling</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
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<th>Catalyst</th>
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<td>gp100 (A02)</td>
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<td>TEBE-AM</td>
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<td>PRAME (A02)</td>
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<td>PRISM-MEL-301</td>
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<td>Multiple solid tumors</td>
<td>Mono. &amp; combination arms</td>
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<td>IMC-P115C</td>
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<td>IND/CTA</td>
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<td>IMC-T119C</td>
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<td>IND/CTA</td>
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<td>PIWIL1 (A02)</td>
<td>Colorectal and GI cancers</td>
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<td>IMC-M113V²</td>
<td>Gag (A02)</td>
<td>Human Immunodeficiency Virus (HIV)</td>
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<td>Hepatitis B Virus (HBV)</td>
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<td>IMC-S118AI</td>
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<td>Dermatology</td>
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</table>

New candidate added to pipeline January 2024. ¹ Platinum refractory or resistant serous ovarian carcinoma. 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. ³ Program is not HLA restricted (i.e. universal for all populations).
Maximizing potential of KIMMTRAK® in HLA-A02+ melanoma
KIMMTRAK’s 3 growth areas

- **Continued growth in US and global launches (incl. EU)**
  (FY23 sales ~$239M)

- **Phase 2/3 trial in 2L+ advanced cutaneous melanoma (TEBE-AM)**
  (Phase 2 data expected 4Q 2024)

- **Phase 3 trial in adjuvant uveal melanoma (ATOM)**
  (Phase 3 expected to start 2H 2024)

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KIMMTRAK Estimated Market Opportunity

- **Today**
  - 2L+ Advanced Cutaneous Melanoma
    - ~2,000 - 4,000 pts†
  - Adjuvant Uveal Melanoma
    - ~1,200 pts†
  - Metastatic Uveal Melanoma
    - ~1,000 pts†

† Estimated number of HLA-A*02:01 positive patients per year in the US and EU.
We continue to reach more patients with KIMMTRAK

$238.7M
FY 2023 net sales

Approved in 38 countries
Launched in 12 countries²
Published 3 yr OS in NEJM

1 Early Access Program (EAP). ² US, Germany, France, Israel, Italy, Austria, Finland, Belgium, Switzerland, Slovenia, Australia and Canada
Overall survival benefit of KIMMTRAK vs investigator’s choice in 1L mUM

3-year OS follow-up

27% KIMMTRAK arm

17% Investigator’s choice arm

KIMMTRAK TRAEs mostly in first month and decrease thereafter
Adverse events manageable, very low rate of discontinuation (2%) & no treatment-related deaths

The KIMMTRAK U.S. Prescribing Information has a BOXED WARNING for the risk of Cytokine Release Syndrome. CRS, which may be serious or life-threatening, occurred in patients receiving KIMMTRAK. Monitor for at least 16 hours following first three infusions and then as clinically indicated.

* Rash, hypotension, and liver function tests are composite terms for a list of related adverse events of any grade AE: adverse event; TRAE: treatment-related adverse event.
Rationale for KIMMTRAK in adjuvant uveal melanoma
Clinical activity expected to be highest in adjuvant setting with minimal disease burden

0.36 OS HR for small tumor (M1a, <3 cm largest lesion)

<table>
<thead>
<tr>
<th>Largest metastatic lesion</th>
<th>OS Hazard ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1a (≤3.0 cm)</td>
<td>0.36</td>
</tr>
<tr>
<td>M1b (3.1-8.0 cm)</td>
<td>0.71</td>
</tr>
<tr>
<td>M1c (≥8.1 cm)</td>
<td>0.76</td>
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</tbody>
</table>

cDNA reduction in 1st line > 2nd+ line mUM

Treatment phase
Follow-up

1:1 Randomization

Global trial led by European Organisation for Research and Treatment of Cancer (EORTC)

ATOM – Phase 3 KIMMTRAK adjuvant UM trial design

(~300 HLA-A*02:01 patients)
- Within 3 months of definitive treatment of high risk primary uveal (or ocular) melanoma
- No evidence of metastatic disease on imaging

KIMMTRAK (tebentafusp) (Q1W IV)

Observation

Key endpoints
- Primary: Relapse-Free Survival (RFS)
- Secondary: Overall survival
- Exploratory: ctDNA response

Investigator discretion on subsequent therapy for metastatic disease

Anticipate EORTC to start randomization in 2H 2024
KIMMTRAK active in cutaneous melanoma (CM)
Phase 1/2 study of KIMMTRAK + checkpoints in CM patients who progressed on prior anti-PD1

60 cutaneous melanoma (all progressed on prior anti-PD1) received KIMMTRAK (tebentafusp) + durvalumab*

Middleton et al., ASCO 2022. Remote = Patients received prior anti-PD1 but it was not most recent therapy prior to enrolment. Immediately prior = anti-PD1 was most recent therapy prior to enrolment.

TEBE-AM – Phase 2/3 trial for previously treated, advanced melanoma patients
Randomization to ‘real world’ treatment as a control arm

→ HLA-A*02:01 advanced melanoma
  • Uveal melanoma excluded

→ Prior anti-PD(L)1
  • Progression within 6 months last dose

→ Prior ipilimumab

→ Prior targeted therapy (BRAFm)

→ Anticipate Phase 2 topline data by 4Q 2024

1:1:1 Randomization

Treatment phase

OS follow-up

KIMMTRAK (tebentafusp)

KIMMTRAK + anti-PD-1

Investigator discretion on subsequent therapy: local standard, supportive care or other clinical trials.
Collect data on subsequent therapy, survival and ctDNA sample.

Anticipate Phase 2 topline data by 4Q 2024

<table>
<thead>
<tr>
<th>Phase</th>
<th>Primary Endpoint</th>
<th>Per Arm Size</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>ctDNA and OS</td>
<td>40</td>
</tr>
<tr>
<td>3</td>
<td>OS</td>
<td>170</td>
</tr>
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</table>

Optionality to review Phase 2 data to inform changes to Phase 3, including dropping an Arm and optimize powering of study
PRAME Franchise: A02, A24, A02-HLE
PRAME franchise opportunity spans multiple solid tumors

→ PRAME is negative prognostic marker in multiple tumors

→ PRAME broadly expressed in multiple tumors including:

<table>
<thead>
<tr>
<th>Candidate</th>
<th>Opportunity</th>
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<tbody>
<tr>
<td><strong>IMC-F106C</strong></td>
<td>• Up to 150,000 patients/year</td>
</tr>
<tr>
<td><strong>IMC-P115C</strong> Half Life Extension</td>
<td>• Half-life Extended (HLE); less frequent dosing</td>
</tr>
<tr>
<td><strong>IMC-T119C</strong></td>
<td>• Up to 50,000 additional patients per year beyond HLA-A02</td>
</tr>
</tbody>
</table>

![Imagery of PRAME expression in various tumors](attachment:prame_expression_images.png)

**Cutaneous Melanoma**

**Ovarian**

**NSCLC**

**Endometrial**
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>All grades (events in ≥ 25% of patients), n (%)</td>
<td></td>
<td></td>
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<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>
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<tr>
<td>Hypotension*</td>
<td>3 (17)</td>
<td>15 (41)</td>
<td>18 (33)</td>
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<td>Chills</td>
<td>9 (50)</td>
<td>8 (22)</td>
<td>17 (31)</td>
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<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>
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<tr>
<td>Grade ≥ 3 (Events in &gt; 1 patient), n (%)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>At least one event</td>
<td>6 (33)</td>
<td>13 (35)</td>
<td>19 (35)</td>
</tr>
<tr>
<td>Lymphopenia</td>
<td>1 (6)</td>
<td>7 (19)</td>
<td>8 (15)</td>
</tr>
<tr>
<td>Aspartate aminotransferase increased</td>
<td>3 (17)</td>
<td>1 (3)</td>
<td>4 (7)</td>
</tr>
<tr>
<td>Anemia</td>
<td>1 (6)</td>
<td>2 (5)</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Alanine aminotransferase increased</td>
<td>2 (11)</td>
<td>0</td>
<td>2 (4)</td>
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<tr>
<td>Arthralgia</td>
<td>1 (6)</td>
<td>1 (3)</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Pyrexia*</td>
<td>0</td>
<td>2 (5)</td>
<td>2 (4)</td>
</tr>
</tbody>
</table>

† 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.

* Includes events reported as a sign/symptom of CRS.

→ MTD not reached
→ No treatment-related discontinuation or Grade 5 related AEs
→ 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

Majority of patients have durable tumor response or stabilization

IMC-F106C (ESMO 2022)
IMC-F106C monotherapy melanoma activity shows durability
Update to ESMO 2022 melanoma patients (n=18)

Data cut-off May 2023 from live database.
DoR= duration of response. ^ Patient had disease progression after Month 12.

**Melanoma type**  | **PRAME status**  | **Prior therapy**
-------------------|------------------|------------------
Cutaneous (n=7)    | 5+; 1 unknown; 1 negative | All prior anti-PD1 & ipilimumab
Uveal (n=5)        | All +             | Prior tebentafusp
Uveal (n=6)        | All +             | Tebentafusp naïve

**Radiation to index lesion after this date**

**DoR =**
- 6 mo
- 10 mo^
- 12 mo
- 17 mo
- 16+ mo
- 12 mo

**Durable disease control**

**Durable response**
## IMC-F106C (PRAME HLA-A02) Next Steps

<table>
<thead>
<tr>
<th>Phase 1 Data</th>
<th>Phase 1 2024 Data Plan</th>
<th>Next Steps</th>
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<tbody>
<tr>
<td>Cutaneous melanoma</td>
<td><strong>Q2</strong> – Monotherapy and anti-PD1 combination</td>
<td>Q1 - Start PRISM-MEL301 1L Melanoma</td>
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<tr>
<td>Ovarian</td>
<td><strong>Q3</strong> – Monotherapy and chemotherapy combination</td>
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<tr>
<td>NSCLC</td>
<td><strong>Q4</strong> – Monotherapy and combination data</td>
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<tr>
<td>Endometrial</td>
<td>Enrolling</td>
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<tr>
<td>KIMMTRAK combination</td>
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<tr>
<td>40 mcg dose optimization (Project Optimus)</td>
<td>Enrolling</td>
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</table>
PRISM-MEL301: First-line advanced cutaneous melanoma Phase 3
Design based on Type B FDA meeting

Key inclusion criteria
- Previously untreated, advanced melanoma
- HLA-A*02:01
- No prospective PRAME testing

Stratification factors
- AJCC M stage
- Prior anti-PD1 adjuvant therapy
- BRAF V600 status

Key endpoints
- Primary: PFS by BICR
- Secondary: OS, ORR
- Exploratory: ctDNA

Randomization expected to start Q1 2024

Initial randomization includes comparison of two IMC-F106C regimens (~90 patients or 30/arm)

Control arm
- 40 mcg IMC-F106C + nivolumab
- 160 mcg IMC-F106C + nivolumab

Interim analysis of two experimental arms
- No pause in randomization during review
- Drop one experimental arm
- All patients in the ‘go-forward’ arm included in ITT analysis

Use of nivolumab or nivolumab + relatlimab as control will be country specific.
Represents target dose after intra-patient escalation.
ITT: intent to treat.
PRAME-A02 has the potential to benefit a large number of patients

<table>
<thead>
<tr>
<th>Prevalence of PRAME expression¹</th>
<th>Tumor type</th>
<th>HLA-A*02:01+, PRAME+ metastatic patients (G7)²</th>
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<tr>
<td>70-100%</td>
<td>Endometrial</td>
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<td></td>
<td>Melanoma</td>
<td>&gt;10K</td>
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<td></td>
<td>Ovarian</td>
<td>&gt;15K</td>
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<td>NSCLC-squamous</td>
<td>&gt;30K</td>
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<td>50-70%</td>
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<td></td>
<td>SCLC</td>
<td>&gt;15K</td>
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<td></td>
<td>TNBC</td>
<td>&gt;5K</td>
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<td>20-50%</td>
<td>SCCHN</td>
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<td>Gastric</td>
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<td>RCC</td>
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<td>Cholangiocarcinoma</td>
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<td>Cervical</td>
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</table>

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.

Total ~150,000 PRAME+, HLA-A02 patients/year
Novel ImmTAC candidate for GI cancers from our discovery engine
Negative prognostic marker in multiple cancers, role in tumor progression

Expressed in CRC\(^1\), historically insensitive to IO, and across major subgroups\(^2\)

25% CRC have broad PIWIL1 expression (with > 75% of tumor cells positive)

\(~20K\) colorectal + \(~15K\) other tumors patients positive for PIWIL1 and HLA-A02

Phase 1 start expected in 2H 2024
Pursuing a functional cure in infectious diseases
Aiming for functional cure in HIV by reducing/eliminating the reservoir

Anti-retroviral therapy (ART) suppresses reservoir but cannot eliminate

Rare (i.e. 1 in a million) HIV-infected T cells (reservoir) persist despite ART\textsuperscript{1,2}

Historically, rapid viral rebound occurs after ART interruption at median ~2 weeks\textsuperscript{3}

Flow cytometry of CD4+ T cells from peripheral blood

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1. Fun, Axel et al. Scientific reports vol. 7 43321, 2017. 2. Pardons M et al. PLoS Pathog 15(2), 2019, e1007619. 3 Feher C et al. Open Forum Infect Dis, 2019; 6: ofz485; N = 249 (from non-interventional studies), detectable viral load (VL) defined as > 50 copies/mL, time to detectable VL \( \cdot \text{IQR} = 2-4 \) weeks.
Single dose of IMC-M113V well tolerated and biologically active
Phase 1 Soluble T cell Receptors In Viral Eradication (‘STRIVE’) HIV trial

**Single Ascending Dose**

- **Key inclusion criteria**
  - Participants living with HIV (PLWH) on anti-retroviral therapy (ART)

- **Regimen**
  - Single dose

- **Key endpoint**
  - Primary: Safety

- **Key biomarker**
  - T cell activation

- **15 mcg, n = 10**  
  - 15 mcg was well tolerated and met pre-defined biomarker threshold for expansion

- **5 mcg, n = 1**

- **1.6 mcg, n = 1**

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**IL-6 increase (marker of T cell engagement)**

- **Cohort 1** (1.6 mcg)

- **Cohort 2** (5 mcg)

- **Cohort 3** (15 mcg; n = 10)

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Active dose definition: ≥ 4-fold increase in plasma IL-6 at 8-24 hours post-dose.
HIV STRIVE multiple ascending dose portion now enrolling

Goal is to determine safety and anti-viral activity of IMC-M113V

Key inclusion criteria
• PLWH on ART

Regimen:
• Weekly for 12 weeks

Reservoir quantification (blood):
- Endpoint: Cell-associated HIV Gag RNA
  - Interpretation: Active viral transcription

Viral rebound (magnitude and kinetics):
- Endpoint: Plasma HIV RNA
  - Interpretation: Infectious virus

Step dose (initially 15 mcg)
Target dose (> 30 mcg)

PLWH: People living with HIV; ART: Anti-retroviral therapy; ATI: ART treatment interruption.
**IMC-I109V: Encouraging signs of activity observed in HBV**

Initial results from single 0.8 mcg dose presented at EASL 2022

**Induction of IL-6 in all 3 patients**

<table>
<thead>
<tr>
<th>Time</th>
<th>Serum IL-6 concentrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE</td>
<td>0.0 pg/ml</td>
</tr>
<tr>
<td>4h</td>
<td>2.0 pg/ml</td>
</tr>
<tr>
<td>8h</td>
<td>4.0 pg/ml</td>
</tr>
<tr>
<td>24h</td>
<td>6.0 pg/ml</td>
</tr>
<tr>
<td>48h</td>
<td>8.0 pg/ml</td>
</tr>
<tr>
<td>Day 8</td>
<td>6.0 pg/ml</td>
</tr>
<tr>
<td>Day 29</td>
<td>4.0 pg/ml</td>
</tr>
</tbody>
</table>

**Transient decrease in HBsAg coincided with transient increase in ALT**

<table>
<thead>
<tr>
<th>Days</th>
<th>ALT (U/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>29</td>
<td>50</td>
</tr>
</tbody>
</table>

**HBsAg (IU/ml)**

<table>
<thead>
<tr>
<th>Days</th>
<th>HBsAg (IU/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1000</td>
</tr>
<tr>
<td>8</td>
<td>1200</td>
</tr>
<tr>
<td>15</td>
<td>1400</td>
</tr>
<tr>
<td>22</td>
<td>1600</td>
</tr>
<tr>
<td>29</td>
<td>1800</td>
</tr>
</tbody>
</table>

1 Bourgeois, et al. EASL 2022. Arrow indicates timing of administration of IMC-I109V.
Pioneering tissue-specific immune down modulation for treatment of autoimmune diseases
ImmTAAI: tissue-specific down modulation of the immune system

**Vision**

**Current**
Systemic immune suppression, even if inflammation in single tissue

**Future**
Down modulation of immune system localized to tissue under attack

---

**ImmSPECT: target peptide discovery engine**

>250K
Unique peptides that are tissue-specific

Initial candidates

- Brain
- Breast
- Heart
- Stomach
- Kidney
- Pancreas
- Ovary
- Bladder
- Esophagus
- Lung
- Liver
- Uterus
- Colon
- Blood
- Brain
- Breast
- Heart
- Stomach
- Kidney
- Pancreas
- Ovary
- Bladder
- Esophagus
- Lung
- Liver
- Uterus
- Colon
- Blood
ImmTAAI: off-the-shelf down modulation of immune system

Only suppress T-cells only when ImmTAAI is tethered to target tissue

1. Tissue-tethered targeting of HLA-antigen
   - Only active when tethered to target tissue

2. PD1 agonist suppresses T cells
   - Suppresses T cell and NK cell activation
   - Promotes T cell exhaustion
   - Non-competitive with natural PDL-1
   - Does not interfere with Treg

3. Fc fusion
   - Infrequent dosing
   - Designed for long half-life, infrequent dosing
ImmTAAI: tissue-specific and lasting immune suppression

Potential to treat autoimmune disease and modify disease course

→ Inhibits T cell activity only when tissue-tethered
→ Clustering at immune synapse drives potency

→ Suppress IL2 release (T cell activation marker)
→ T cells remain suppressed after ImmTAAI removed

T cells activated with target cells +/- ImmTAAI for 8 days then washed and re-stimulated on Day 10 with target cells in absence of ImmTAAI (yellow or red)
**IMC-S118AI (PPIxPD1) for type 1 diabetes**

Pancreas-tethered ImmTAAI (HLA-A02) protects against killing by autoreactive T cells

ImmTAAI binds specifically to pre-pro-insulin (PPI) peptide on pancreatic β-cells

Potent protection of β-cells from killing by autoreactive T cells

β-cell marker

PPI ImmTAAI

Non-targeted ImmTAAI

~1.4M

HLA-A2+ type 1 diabetes patients (US + EU5)¹

Immune system attacks and kills the beta cells responsible for controlling glucose levels through the release of insulin

* Quantity measured as area under the curve. ¹Current Diabetes Reports (2023) 23:277–291 (~700K in US & ~700K in EU5)
Universal (non-HLA restricted) candidate for dermatology

Antigen presenting cell (APC) tethered ImmTAAI inhibits T cell activation

ImmTAAI binds specifically to APC in skin

Potent inhibition of cytokine release

Potential dermatological diseases: atopic dermatitis, psoriasis, and lichenoid skin diseases
Upcoming milestones
Looking ahead
Pro-forma cash position of ~$785 million

→ Commercial milestones

| KIMMTRAK                  | Continued global growth including commercial launches in Australia and Canada | 2024 |

→ Clinical milestones

| KIMMTRAK Expansion       | Topline data from Ph 2 2L+ advanced cutaneous melanoma (TEBE-AM) | 4Q 2024 |
| First patient randomized in Ph 3 registrational adjuvant uveal melanoma trial (ATOM); led by EORTC | 2H 2024 |
| PRAME Franchise          | First patient randomized in Ph 3 registrational 1L cutaneous melanoma (PRISM-MEL301) | 1Q 2024 |
| Cutaneous melanoma data from Phase 1 PRAME trial | 2Q 2024 |
| Serous ovarian data from Phase 1 PRAME trial | 3Q 2024 |
| NSCLC data from Phase 1 PRAME trial | 4Q 2024 |
| IND/CTA for PRAME-HLE trial | Mid-2024 |
| IND/CTA for PRAME-A24 trial | 4Q 2024 |
| PIWIL1                   | First patient dosed in PIWIL1 Phase 1 trial | 2H 2024 |
| Infectious Diseases      | Data from Ph 1 HIV MAD/POC trial | 2H 2024 |
| Autoimmune Diseases      | Initiating CMC manufacturing for autoimmune candidates | 2024 |
|                         | Enroll Ph 1 HBV MAD (now including HCC) trial | 2024 |
Thank you