Transformative immunomodulating medicines for patients
Forward Looking Statements

This presentation contains “forward-looking statements” within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Words such as “may”, “will”, “believe”, “expect”, “plan”, “anticipate”, “estimate” and similar expressions (as well as other words or expressions referencing future events or circumstances) are intended to identify forward-looking statements. All statements, other than statements of historical facts, included in this presentation are forward-looking statements. 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 PRAIME franchise; the estimated market size and patient population for KIMMTRAK and Immunocore’s other product candidates, including the target potential of T cell receptor therapeutics; 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 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 (); the potential of the PRAIME franchise opportunity to expand into additional solid tumor indications; expectations regarding the design, progress, timing, enrollment, scope, expansion, funding, 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 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; expected commercial and clinical milestones and Immunocore’s ability to achieve those milestones on their expected timeline, or at all; and potential growth opportunities and trends, including in connection with product launches. Any forward-looking statements are based on management’s current expectations and beliefs of future events and are subject to a number of risks and uncertainties that could cause actual events or results to differ materially and adversely from those set forth in or implied by such forward-looking statements, many of which are beyond Immunocore’s control. These risks and uncertainties include, but are not limited to, the impact of worsening macroeconomic conditions on Immunocore’s business, financial position, strategy and anticipated milestones, including Immunocore’s ability to conduct ongoing and planned clinical trials; Immunocore’s ability to obtain a clinical supply of current or future product candidates or commercial supply of KIMMTRAK or any future approved products, including as a result of health epidemics or pandemics, war in Ukraine, the conflict between Hamas and Israel, the broader risk of a regional conflict in the Middle East, or global geopolitical tension; Immunocore’s ability to obtain and maintain regulatory approval of its product candidates, including KIMMTRAK; Immunocore’s ability and plans in continuing to establish and expand a commercial infrastructure and to successfully launch, market and sell KIMMTRAK and any future approved products; Immunocore’s ability to successfully expand the approved indications for KIMMTRAK or obtain marketing approval for KIMMTRAK in additional geographies in the future; the delay of any current or planned clinical trials, whether due to patient enrollment delays or otherwise; Immunocore’s ability to successfully demonstrate the safety and efficacy of its product candidates and gain approval of its product candidates on a timely basis, if at all; competition with respect to market opportunities; unexpected safety or efficacy data observed during preclinical studies or clinical trials; actions of regulatory agencies, which may affect the initiation, timing and progress of clinical trials or future regulatory approval; Immunocore’s need for and ability to obtain additional funding, on favorable terms or at all, including as a result of worsening macroeconomic conditions, including changes inflation and interest rates and unfavorable general market conditions, and the impacts thereon of the war in Ukraine, the conflict between Hamas and Israel, and global geopolitical tension; Immunocore’s ability to obtain, maintain and enforce intellectual property protection for KIMMTRAK or any product candidates it or its collaborators are developing; and the success of Immunocore’s current and future collaborations, partnerships or licensing arrangements, including the risk that Immunocore may not realize the anticipated benefits of its collaboration with Bristol Myers Squibb. These and other risks and uncertainties are described in greater detail in the section titled “Risk Factors” in Immunocore’s filings with the Securities and Exchange Commission, including Immunocore’s most recent Annual Report on Form 10-K for the year ended December 31, 2023 filed with the Securities and Exchange Commission on February 28, 2024, as well as discussions of potential risks, uncertainties, and other important factors in Immunocore’s subsequent filings with the Securities and Exchange Commission.

All forward looking statements contained in this presentation speak only as of the date on which they were made and should not be relied upon as representing its views as of any subsequent date. Except to the extent required by law, Immunocore undertakes no obligation to update such statements to reflect events that occur or circumstances that exist after the date on which they were made.

Certain information contained in this presentation relates to or is based on studies, publications, surveys, and other data obtained from third party sources and Immunocore’s own internal estimates and research. While Immunocore believes these third party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy, or completeness of, any information obtained from third party sources.

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**
  - ImmTAAIs

**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>
<th>Approved</th>
<th>Catalyst</th>
</tr>
</thead>
<tbody>
<tr>
<td>KIMMtrak gp100 (A02)</td>
<td>gp100 (A02)</td>
<td>Uveal (ocular) melanoma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adjuvant uveal (ocular) melanoma</td>
<td>ATOM sponsored by FORTC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phase 3 Start</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2L+ advanced cutaneous melanoma</td>
<td>TEBE-AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phase 2 Data</td>
</tr>
<tr>
<td>IMC-F106C PRAME (A02)</td>
<td>PRAME (A02)</td>
<td>1L advanced cutaneous melanoma</td>
<td>PRISM-MEL-301</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phase 3 Start</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2L+ cutaneous melanoma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PRR ovarian(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2L+ NSCLC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advanced endometrial</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple solid tumors</td>
<td>Mono- &amp; combination arms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMC-P115C PRAME-HLE (A02)</td>
<td>PRAME-HLE (A02)</td>
<td>Multiple solid tumors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IND/CTA</td>
<td>Mid-24</td>
</tr>
<tr>
<td>IMC-T119C PRAME (A24)</td>
<td>PRAME (A24)</td>
<td>Multiple solid tumors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IND/CTA</td>
<td>4Q24</td>
</tr>
<tr>
<td>IMC-R117C PIWIL1 (A02)</td>
<td>PIWIL1 (A02)</td>
<td>Colorectal and GI cancers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phase 1 Start</td>
</tr>
<tr>
<td>IMC-M113V(^2) Gag (A02)</td>
<td>Gag (A02)</td>
<td>Human Immunodeficiency Virus (HIV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MAD Data</td>
</tr>
<tr>
<td>IMC-I109V Envelope (A02)</td>
<td>Envelope (A02)</td>
<td>Hepatitis B Virus (HBV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMC-S118AI PPIxPD1 (A02)</td>
<td>PPIxPD1 (A02)</td>
<td>Type 1 Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undisclosed (universal)(^3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) 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. \(^2\) 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)

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†

L+ Advanced Cutaneous Melanoma
~1,200 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

$70M
1Q 2024 net sales

1L
standard of care in launched markets

Approved in 38 countries
Launched in 17 countries

Treated >1.5k patients in trials, EAP1 & commercial

Published 3 yr OS in NEJM

1 Early Access Program (EAP). 2 US, Germany, France, Israel, Italy, Austria, Finland, Belgium, Switzerland, Slovenia, Australia, Canada, Spain, Bulgaria, Luxemborg, Czech Republic, and Lithuania
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

The NEW ENGLAND JOURNAL of MEDICINE
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.
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)\(^1\)

<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>
</tr>
</tbody>
</table>

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

ATOM – Phase 3 KIMMTRAK adjuvant UM trial design
Global trial led by European Organisation for Research and Treatment of Cancer (EORTC)

1:1 Randomization

- ~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)

Treatment phase

Observation

Follow-up

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

Hamid O, et al. JITC (2023). 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.

Time since last dose of prior anti-PD1 does not impact outcome
TEBE-AM – Phase 2/3 trial for previously treated, advanced melanoma patients
Randomization to ‘real world’ treatment as a control arm

1:1:1 Randomization

Treatment phase

OS follow-up

→ 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)

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.

R

Straight to follow-up

→ Anticipate Phase 2 topline data by 4Q 2024

<table>
<thead>
<tr>
<th>Phase</th>
<th>Primary Endpoint</th>
<th>Per Arm Size</th>
</tr>
</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>
</tbody>
</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:

  - Cutaneous Melanoma
  - Ovarian
  - NSCLC
  - Endometrial

<table>
<thead>
<tr>
<th>Candidate</th>
<th>Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMC-F106C</td>
<td>• Up to 150,000 patients/year</td>
</tr>
<tr>
<td>IMC-P115C</td>
<td>• Half-life Extended (HLE); less frequent dosing</td>
</tr>
<tr>
<td>IMC-T119C</td>
<td>• Up to 50,000 additional patients per year beyond HLA-A02</td>
</tr>
</tbody>
</table>
IMC-F106C was well tolerated
Most frequent related AE was Grade 1/2 CRS, consistent with proposed mechanism

- 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

---

**IMC-F106C (n = 55)**

<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><strong>All grades (events in ≥ 25% of patients), n (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
<tr>
<td><strong>Grade ≥ 3 (Events in &gt; 1 patient), n (%)</strong></td>
<td></td>
<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>
</tr>
<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>

* 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. Hamid, O., et al., Annals of Oncology (ESMO 2022) 33 (suppl_7): S331-S355.
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
- Cutaneous (n=7)
  - PRAME status: 5+, 1 unknown; 1 negative
  - Prior therapy: All prior anti-PD1 & ipilimumab

- Uveal (n=5)
  - PRAME status: All +
  - Prior therapy: Prior tebentafusp

- Uveal (n=6)
  - PRAME status: All +
  - Prior therapy: Tebentafusp naïve

Change in Target Lesion from Baseline (%)

Time (Months)

- Radiation to index lesion after this date
- DoR = 6 mo
- DoR = 10 mo *
- DoR = 12 mo
- DoR = 17 mo
- DoR = 16+ mo
- Durable disease control
- Durable response

New Lesion or Non-Target PD
## 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>
</tr>
</thead>
<tbody>
<tr>
<td>Cutaneous melanoma</td>
<td>ASCO – Monotherapy and anti-PD1 combination</td>
<td>Q2 - Start PRISM-MEL301 1L Melanoma</td>
</tr>
<tr>
<td>Ovarian</td>
<td>Q3 – Monotherapy and chemotherapy combination</td>
<td></td>
</tr>
<tr>
<td>NSCLC</td>
<td>Q4 – Monotherapy and combination data</td>
<td></td>
</tr>
<tr>
<td>Endometrial</td>
<td>Enrolling</td>
<td></td>
</tr>
<tr>
<td>KIMMTRAK combination</td>
<td>Enrolling</td>
<td></td>
</tr>
<tr>
<td>40 mcg dose optimization (Project Optimus)</td>
<td>Enrolling</td>
<td></td>
</tr>
</tbody>
</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

随机化

治疗阶段

随访

关键入组标准
- 之前未经治疗的进展期黑色素瘤
- HLA-A*02:01
- 无前瞻性PRAME检测

关键分层因素
- AJCC M阶段
- 先前的PD1辅助治疗
- BRAF V600状态

随机化定于2024年第二季度开始

初始随机化包括比较两种IMC-F106C方案
（~90例患者或30例/组）

控制组

- 40 mcg IMC-F106C\(^b\) + nivolumab
- 160 mcg IMC-F106C\(^b\) + nivolumab

IMC-F106C + nivolumab (q4w)

q1w 12 wks
q2w To 1 year
q4w To 2 years

Nivolumab (q4w) or Nivolumab + relatlimab (q4w)\(^a\)

关键 endpoints
- 主要：PFS由BIRC
- 次要：OS，ORR
- 探索性：ctDNA

-  interim分析的两个实验性组
- 无在审查期间暂停随机化
- 退出一个实验组
- 所有在‘前进’组的患者包括在ITT\(^c\)分析
PRAME-A02 has the potential to benefit a large number of patients

<table>
<thead>
<tr>
<th>Prevalence of PRAME expression</th>
<th>Tumor type</th>
<th>HLA-A*02:01+, PRAME+ metastatic patients (G7)</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>
</tr>
<tr>
<td></td>
<td>Gastric</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RCC</td>
<td>&gt;30K</td>
</tr>
<tr>
<td></td>
<td>Esophageal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cholangiocarcinoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cervical</td>
<td></td>
</tr>
</tbody>
</table>

Total ~150,000 PRAME+, HLA-A02 patients/year

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.
Novel ImmTAC candidate for GI cancers from our discovery engine
IMC-R117C: First-in-class target PIWIL1 for colorectal & GI cancers

CTA for European Union submitted in December 2023

→ 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)

\(\sim 20K\) colorectal + \(\sim 15K\) other tumors

patients positive for PIWIL1 and HLA-A02

Phase 1 start expected in 2H 2024

PIWIL1, piwi-like protein1. \(^1\) CRC, colorectal cancer. \(^2\) Estimated across colorectal, esophageal, gastric, pancreatic, ovarian, endometroid cancers
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

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

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Dose (mcg)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.6</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td>10</td>
</tr>
</tbody>
</table>

15 mcg, n = 10
5 mcg, n = 1
1.6 mcg, n = 1

15 mcg was well tolerated and met pre-defined biomarker threshold for expansion

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

Cohort 1 (1.6 mcg)  
Cohort 2 (5 mcg)  
Cohort 3 (15 mcg; n = 10)

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

ART interrupted

Week 1 2 3 4 5 6 7 8 9 10 11 12
IMC-M113V

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

→ Reservoir quantification (blood):

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell-associated HIV Gag RNA</td>
<td>Active viral transcription</td>
</tr>
</tbody>
</table>

→ Viral rebound (magnitude and kinetics):

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plasma HIV RNA</td>
<td>Infectious virus</td>
</tr>
</tbody>
</table>

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

Transient decrease in HBsAg coincided with transient increase in ALT

**Serum IL-6 concentrations**

**HBsAg (IU/ml)**

**ALT (U/L)**
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

2
Initial candidates
ImmTAAI: off-the-shelf down modulation of immune system

Only suppress T-cells only when ImmTAAI is 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

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

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
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 number

[ImmTAAI] nM

~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

¹ Quantity measured as area under the curve. 1 Current 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
Cash position of ~$832 million as of 1Q2024

→ 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) | 2Q 2024 |
|                 | Cutaneous melanoma data from Phase 1 PRAME trial | ASCO - 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 |
|                     | Enroll Ph 1 HBV MAD (now including HCC) trial | 2024 |

| Autoimmune Diseases | Initiating CMC manufacturing for autoimmune candidates | 2024 |
Thank you