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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

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Omid Hamid, MD

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

The Angeles Clinic
AND RESEARCH INSTITUTE
A CEDARS-SINAI AFFILIATE

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

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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

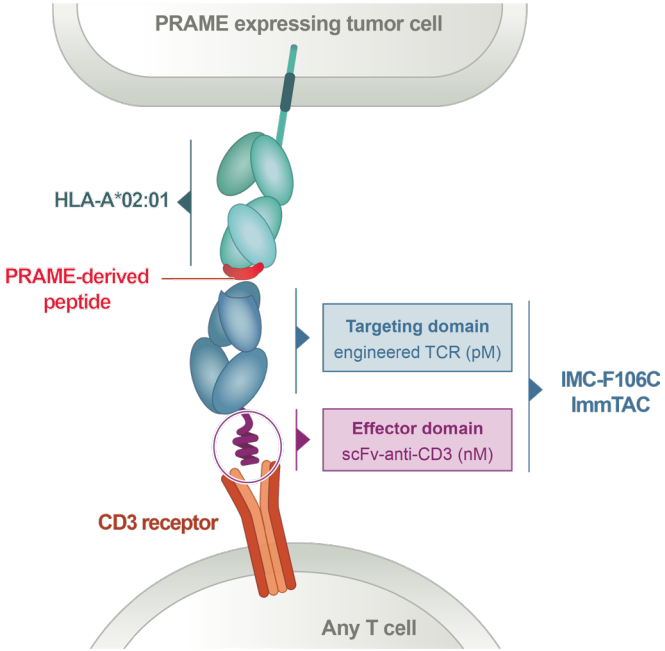
Honoraria: BMS, Novartis, Pfizer, Sanofi/Regeneron

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

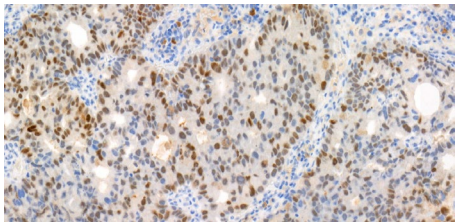
All statements contained in this presentation are based on preclinical and clinical trial data related to an investigational molecule, IMC-F106C. Development of this molecule is ongoing and, therefore, statements relating to study data to date should not be regarded as definitive reflections of safety, efficacy or the risk-benefit profile of the molecule.

IMC-F106C: ImmTAC targeting HLA-A2-presented peptide from PRAME (PRAME × CD3)

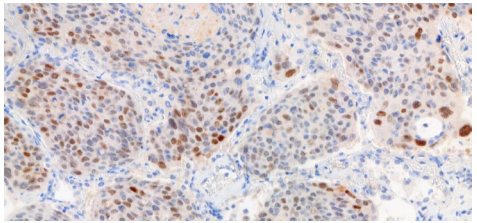


PRAME: most broadly expressed cancer-testis antigen in several tumor types but with minimal normal tissue expression

Adeno NSCLC



Squamous NSCLC



Tumor	Prevalence of PRAME expression
Melanoma, endometrial, NSCLC, TNBC, SCLC, ovarian	
RCC, esophageal, SCCHN, cervical	
Bladder, HCC, gastric	

LOW — HIGH

ImmTAC, Immune mobilizing T cell receptor Against Cancer; TCR, T cell receptor

Phase 1 Study Design

Tumor assessment every 9 weeks

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

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

Key objectives

Primary endpoint

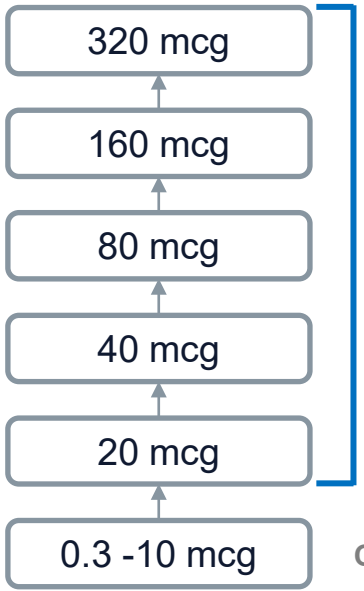
- Determine MTD/expansion dose

Secondary endpoints

- Preliminary antitumor activity
- Pharmacokinetics
- Pharmacodynamic markers

Dose escalation

Target Dose, Starting Day 15



Cohorts 6 and above

Efficacy population n=31*

Strong and consistent pharmacodynamic activity

Cohorts 1-5

Total safety population N=55

* 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)

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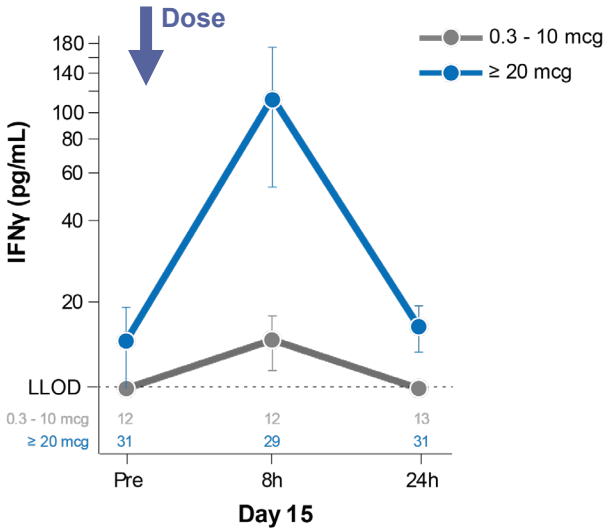
EudraCT No. 2019-004046-16; NCT04262466
Data cut-off date: 18 Jul 2022
IV, intravenous; MTD, maximum tolerated dose

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

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

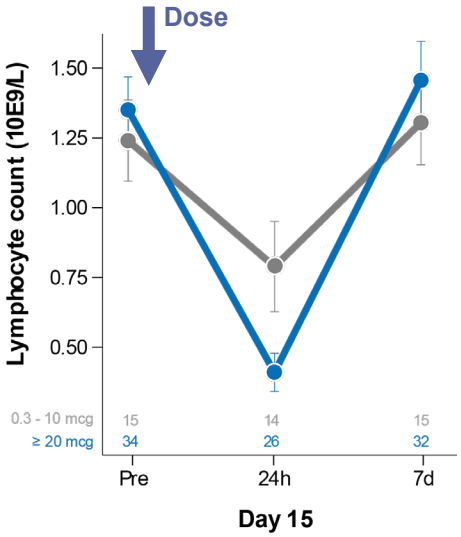
Interferon γ induction

Peripheral blood

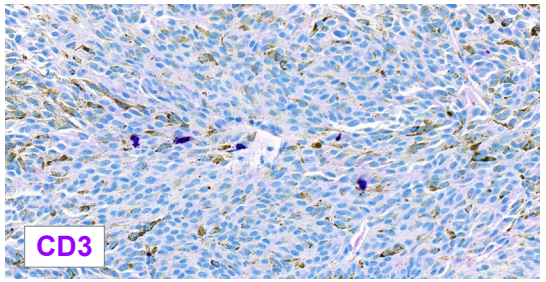


T cell trafficking

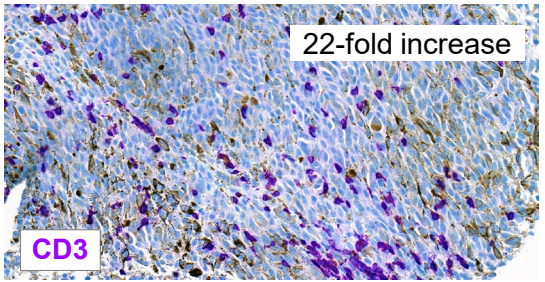
Peripheral blood ----------▸ **Tumor**



Pre-treatment



Day 28



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Results plotted as mean ± SEM

Baseline patient characteristics

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

- 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

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* 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

Preferred Term (MedDRA v23.1)	0.3 – 10 mcg† (N=18)	20 – 320 mcg† (N=37)	Total (N=55)
All Grades (events in ≥ 25% of patients), n (%)			
AT LEAST ONE EVENT	18 (100)	34 (92)	52 (95)
Pyrexia*	10 (56)	21 (57)	31 (56)
Cytokine release syndrome	5 (28)	22 (59)	27 (49)
Fatigue	6 (33)	13 (35)	19 (35)
Hypotension*	3 (17)	15 (41)	18 (33)
Chills	9 (50)	8 (22)	17 (31)
Nausea	7 (39)	10 (27)	17 (31)
Rash	3 (17)	12 (32)	15 (27)
Grade ≥ 3 (Events in > 1 patient), n (%)			
AT LEAST ONE EVENT	6 (33)	13 (35)	19 (35)
Lymphopenia	1 (6)	7 (19)	8 (15)
Aspartate aminotransferase increased	3 (17)	1 (3)	4 (7)
Anemia	1 (6)	2 (5)	3 (5)
Alanine aminotransferase increased	2 (11)	0	2 (4)
Arthralgia	1 (6)	1 (3)	2 (4)
Pyrexia*	0	2 (5)	2 (4)

- 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

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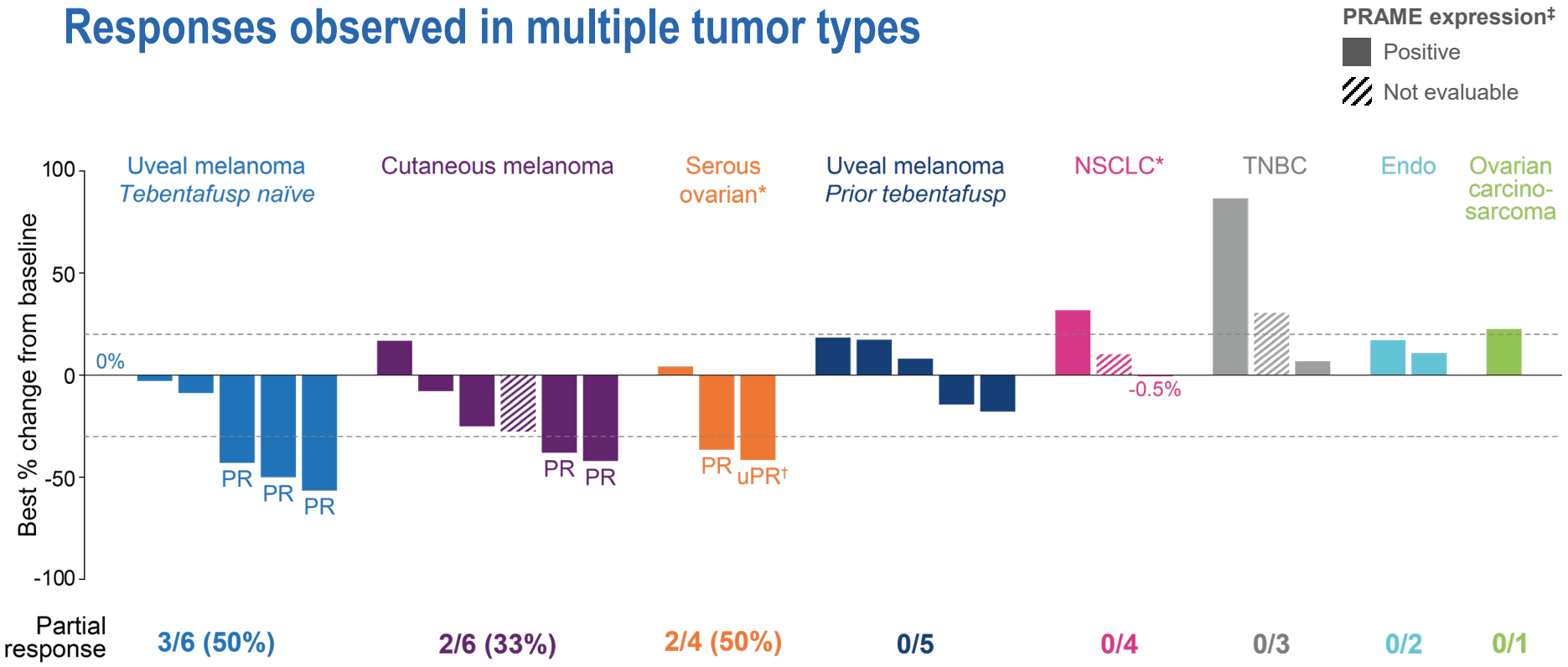
* Includes events reported as a sign/symptom of CRS

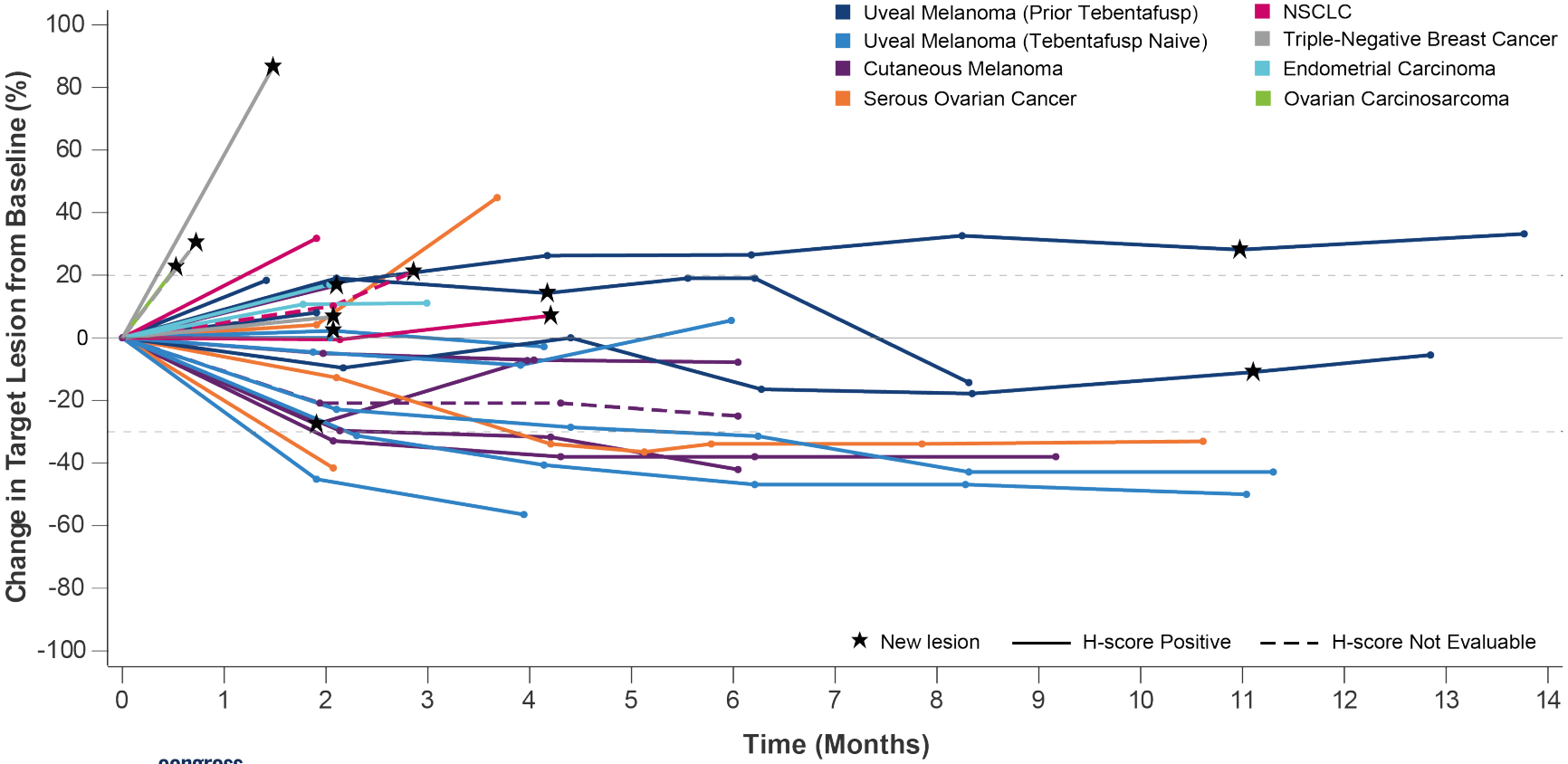
† Safety presented by intended target escalation dose on Day 15. 1/37 patients received only a single dose of 2 mcg and did not reach target dose of ≥ 20 mcg

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)
Endo, endometrial carcinoma; NSCLC, non small cell lung carcinoma; TNBC, triple-negative breast cancer;

Majority of patients have durable tumor response or disease stabilization



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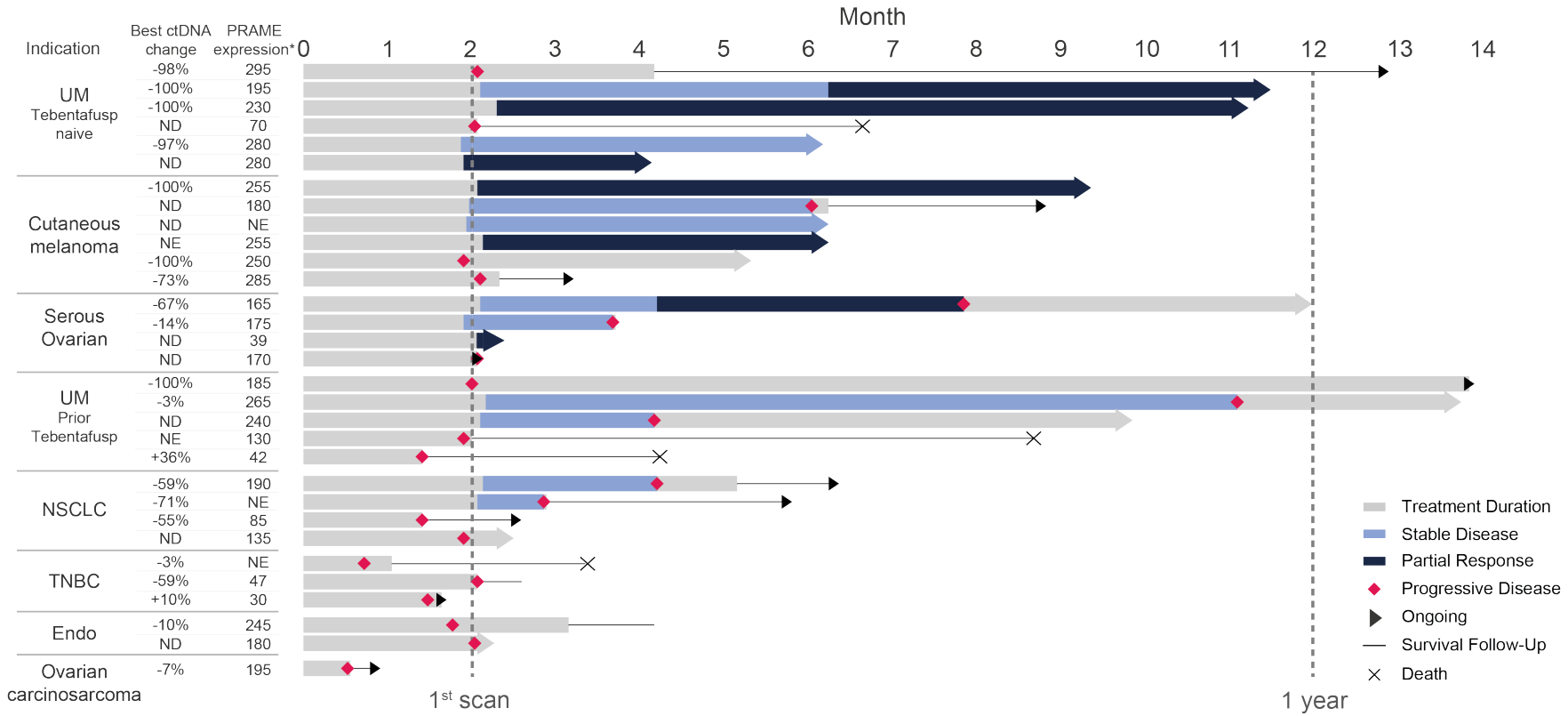
NSCLC, non small cell lung carcinoma

Responses are durable, 6 of 7 PRs still ongoing

Two PRs ongoing for 7+ months



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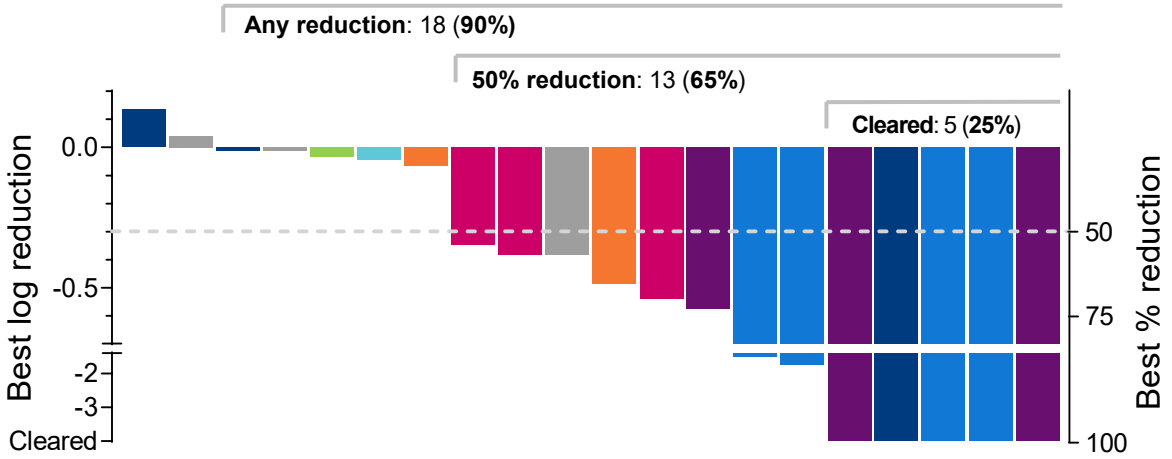
* PRAME expression assessed by IHC H-score

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

Reduction in circulating tumor DNA observed across tumor types (n=20)†



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

- 4 PR patients evaluated for ctDNA had > 50% reduction, including 3 with clearance
- Two patients had ctDNA clearance despite best response of PD

† 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

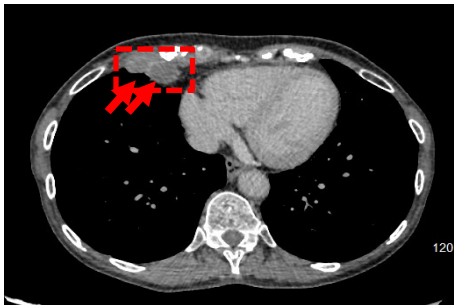
Baseline

On treatment

Patient #1

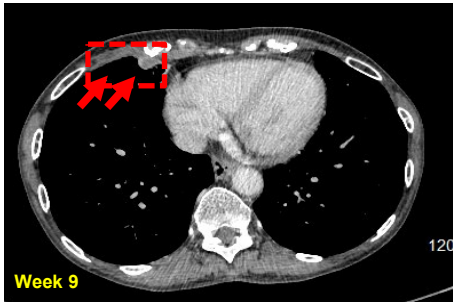
Ovarian cancer

5 prior lines, platinum resistant



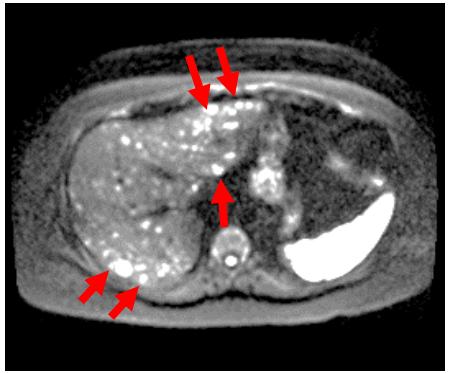
Unconfirmed PR

Ongoing treatment; ctDNA pending



Patient #2

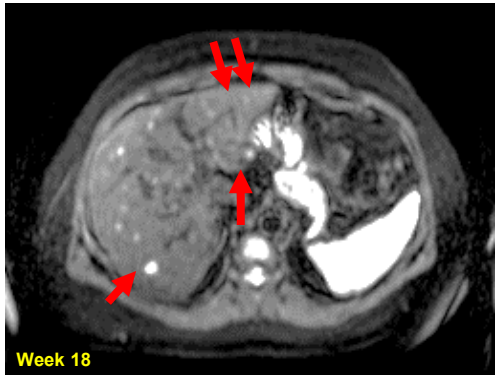
Uveal Melanoma



Confirmed PR

ctDNA cleared

Ongoing treatment 1+ year



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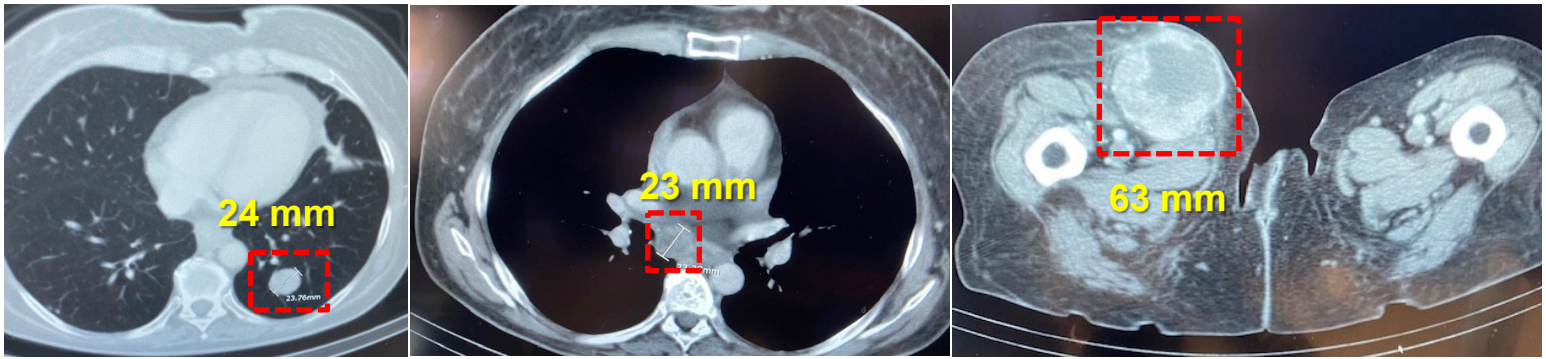
Images courtesy of Dr. Marlana Orloff (TJU) and Dr. Anja Williams (SCRI-UK)

Example responder: cutaneous melanoma

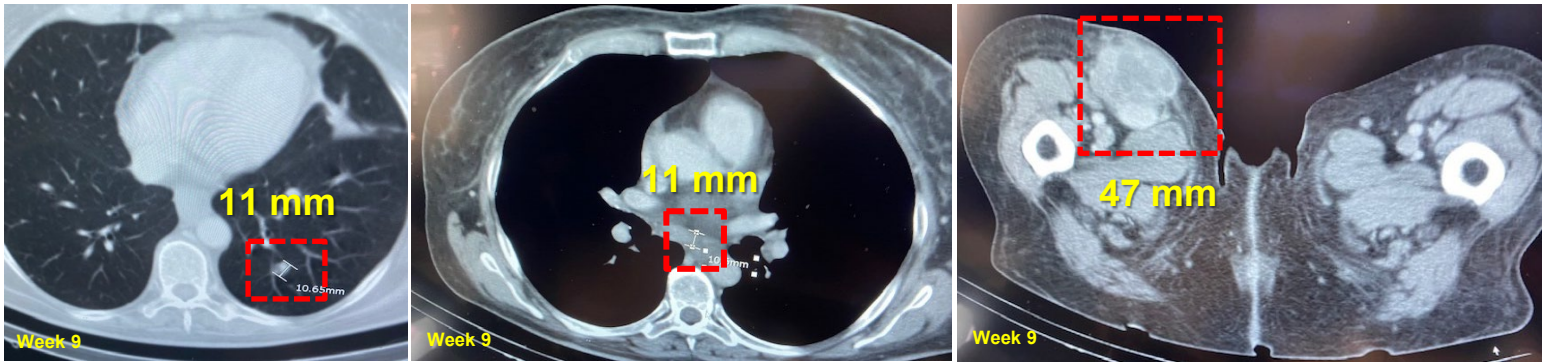
Prior anti-CTLA4, multiple anti-PD1s and oncolytic virus

Patient #3

Baseline



Confirmed PR
ongoing treatment 5+ months



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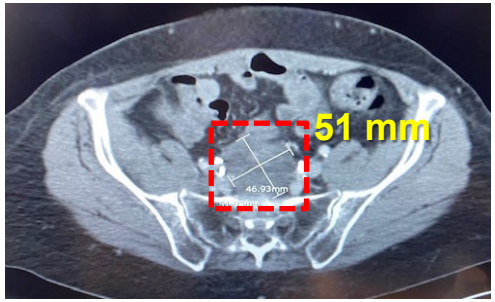
Images courtesy of Dr. Omid Hamid (Angeles Clinic)

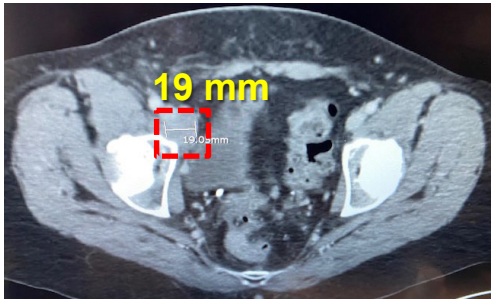
Example responder: serous ovarian carcinoma

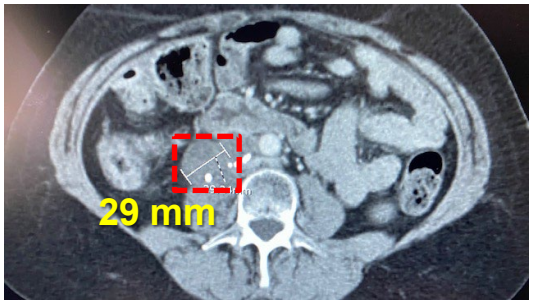
5 prior regimens including platinum, bevacizumab, anti-PD-1, investigational agents

Patient #4

Baseline



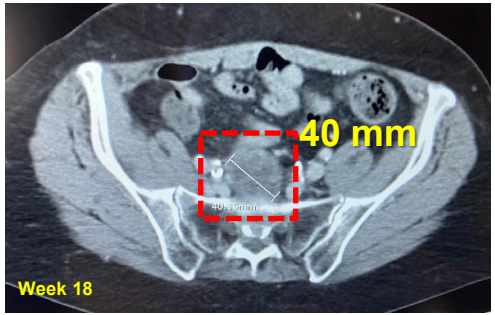


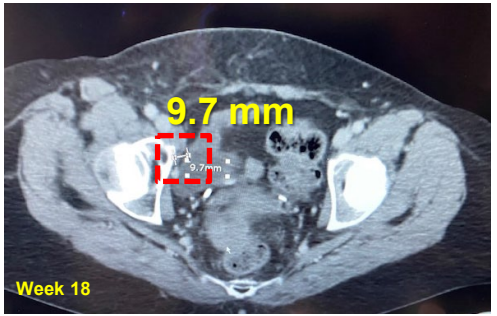


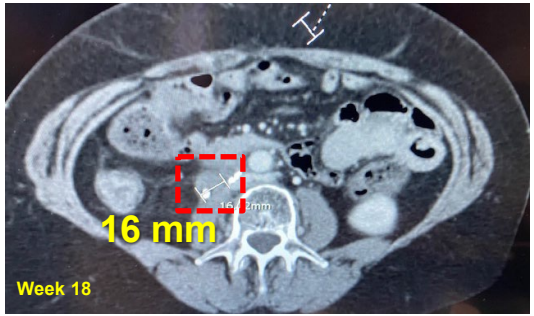
Confirmed PR

ctDNA 67% decrease

nontarget PD at Month 8 but ongoing treatment 1+ yr







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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	The Angeles Clinic and Research Institute, A Cedars-Sinai Affiliate
Takami Sato and Marlana Orloff	Thomas Jefferson University Hospitals
Diwakar Davar	University of Pittsburgh Medical Center
Margaret Callahan	Memorial Sloan Kettering Cancer Center
Raid Aljumaily	University of Oklahoma Peggy and Charles Stephenson Cancer Center
Melissa Johnson	Sarah Cannon Research Institute, Nashville
Ecaterina Dumbrava	MD Anderson Cancer Center
Benjamin Izar	Columbia University Medical Center
Hui Amy Chen	University of California Davis Comprehensive Cancer Center

Juanita Lopez	Royal Marsden NHS Foundation Trust and Institute of Cancer Research
Anja Williams and Hendrik-Tobias Arkenau	Sarah Cannon Research Institute, London
Fiona Thistlethwaite	The Christie NHS Foundation Trust
Heather Shaw	University College London

IMC-F106C Clinical Development Plan

DAVID BERMAN
Head of Research and Development

Insights from KIMMTRAK clinical development in mUM

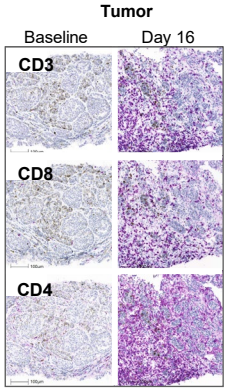
Overall Survival (OS) benefit

MEDIAN OS: **21.7** months

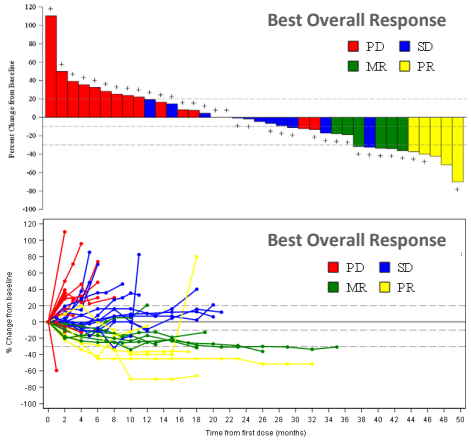
HAZARD RATIO: **0.51**

The NEW ENGLAND JOURNAL of MEDICINE

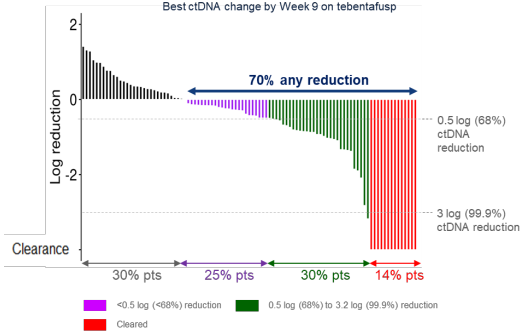
Redirects T cells into tumor[1]



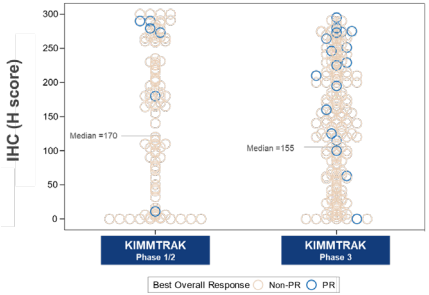
Durable clinical activity[2]



ctDNA **reduction**[3]



Activity at high and low H score[4]



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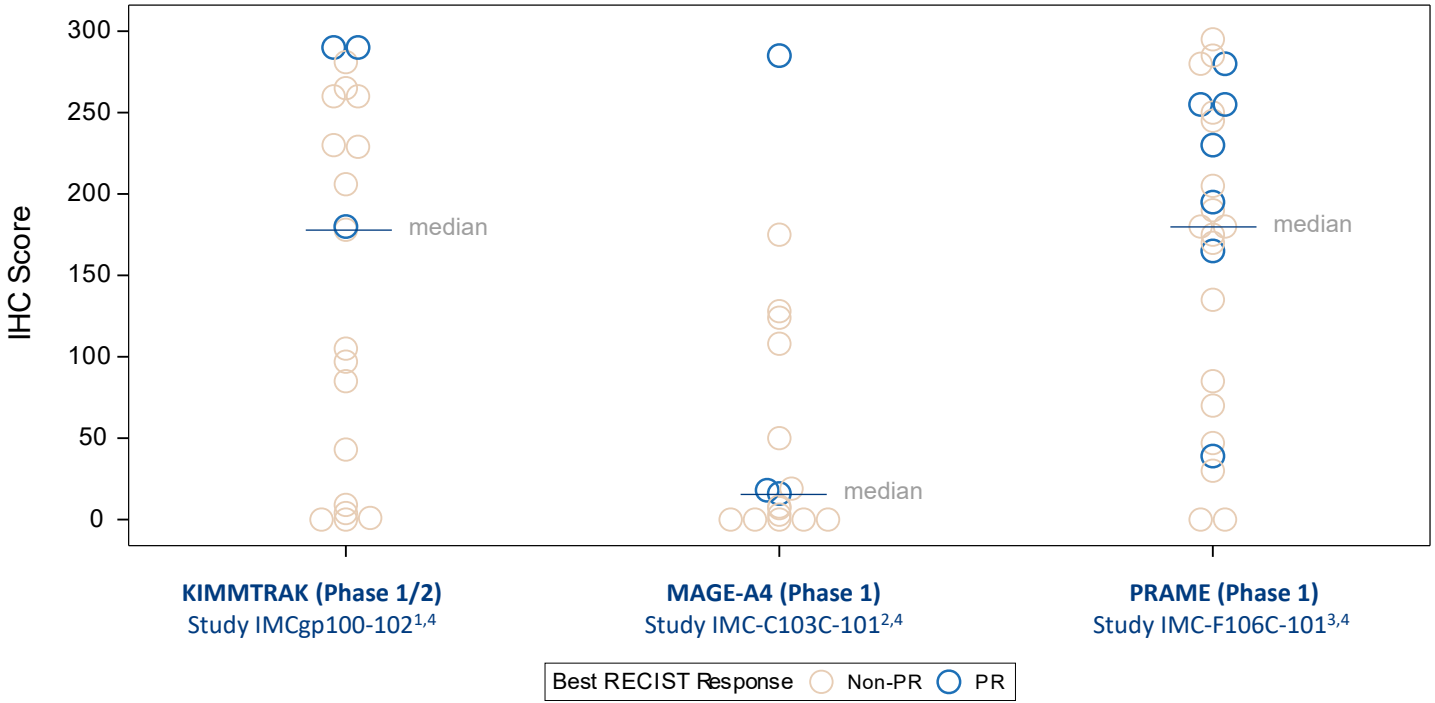
1. Butler, et. al. AACR Annual Meeting 2021; 2. Carvajal, et. al. J. Clin Oncol. 2022 Jun 10;40(17):1939-1948. doi: 10.1200/JCO.21.01805. Epub 2022 Mar 7;
3. Rantala ES et al. Melanoma Res. Published online. 2019; 4. D. Davar Annals of Oncology (2021) 32 (suppl_7): S1398-S1427. 10.1016/annonc/annonc786

RECIST responses enriched at higher H score for PRAME



1. Carvajal RD, et al. *J Clinical Oncology* 2022; 40:1939; 2. Davar D, et al. *Ann Oncol* 2021 32:S1411-S1413; 3. Hamid O et al. #728O ESMO 2022
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

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IMC-F106C-101 designed as an adaptive Phase 1/2 study

Monotherapy

All ongoing

Monotherapy IV dose escalation

Focus of today's presentation

Cutaneous melanoma
Monotherapy expansion

Ovarian
Monotherapy expansion

NSCLC
Monotherapy expansion

Endometrial
Monotherapy expansion

Adaptive design enables flexible expansion size

Combinations

Checkpoint inhibitor combinations

Chemotherapy combinations

ImmTAC combinations

Enables future randomized trials into earlier lines of therapy

Initial data provides optionality to develop in single arm or randomized trials

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PRAME, validated as TCR target, expressed in many solid tumors

Prevalence of PRAME expression[1]	Tumor type	HLA*02:01+, PRAME+ metastatic patients (G7)[2]
70-100%	Endometrial	>10K
	Melanoma	>10K
	Ovarian	>15K
	NSCLC-squamous	>30K
50-70%	NSCLC-adeno	>40K
	SCLC	>15K
	TNBC	>5K
20-50%	SCCHN	>30K
	Gastric	
	RCC	
	Esophageal	
	Cholangiocarcinoma	
	Cervical	

Total >150,000

PRAME+, HLA-A2 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

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Concluding Remarks

BAHIJA JALLAL
Chief Executive Officer

Validation of ImmTAC platform in multiple solid tumors

	T cell activation	Durable tumor shrinkage	Activity even in low target expression	ctDNA reduction	Overall survival benefit
KIMMTRAK® gp100	✓ CLINICAL CANCER RESEARCH	✓ ESMO IMMUNO-ONCOLOGY VIRTUAL CONGRESS	✓ SITC 2021	✓ 2021 ESMO congress	✓ The NEW ENGLAND JOURNAL of MEDICINE
IMC-C103C MAGE-A4	✓ ESMO IMMUNO-ONCOLOGY	✓ ESMO IMMUNO-ONCOLOGY	✓ ESMO IMMUNO-ONCOLOGY	✓ *To be presented*	
IMC-F106C PRAME	✓ PARIS 2022 ESMO congress	✓ PARIS 2022 ESMO congress	✓ PARIS 2022 ESMO congress	✓ PARIS 2022 ESMO congress	

Promising rate of RECIST PRs enables broad development options

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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®

	Candidate	Target	Indication	Pre-clinical	Phase 1	Phase 2	Phase 3	Approved	Anticipated Milestones
ONCOLOGY	KIMMTRAK®	gp100	Uveal melanoma						✓ FDA, EC, MHRA approvals ✓ Commercial launch 1H 2022
			Advanced melanoma						• 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-C103C[1]	MAGE-A4	Multiple solid tumors						✓ Initiated ovarian expansion arm • Phase 1 update 4Q 2022
	Candidate #4	Undisclosed	Multiple solid tumors						
	Candidate #5	Undisclosed	Colorectal, gastric, pancreatic						
INFECTIOUS DISEASES	IMC-I109V	Envelope	Hepatitis B Virus (HBV)						✓ Initial Ph. 1 data presented (EASL)
	IMC-M113V[2]	Gag	Human Immunodeficiency Virus (HIV)						✓ Phase 1 first patient dosed

[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.

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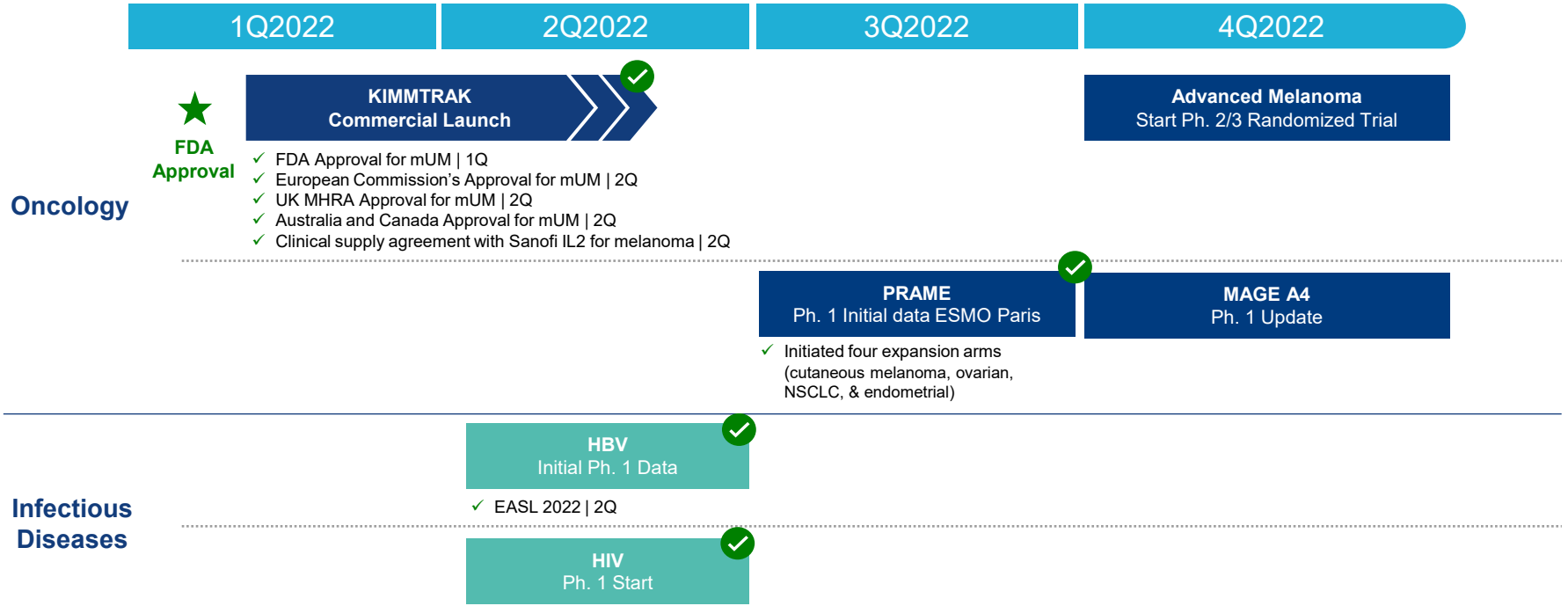
Key portfolio milestones anticipated in 2022



~$393M Adjusted cash and cash equivalents as of June 30, 2022[1]

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