IMMUNOCORE

Corporate Presentation

August 2022

Forward-Looking Statements

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Words such as “may,” “will,” “believe,” “expect,” “plan,” “anticipate” 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, statements regarding the marketing and therapeutic potential of KIMMTRAK for metastatic uveal melanoma (mUM); the expected clinical benefits of KIMMTRAK including extended overall survival benefit; expectations regarding the timing of the commercial launch of KIMMTRAK, the timing of commercial availability and ability to reach patients; the value proposition of KIMMTRAK in mUM and benefit as an orphan indication including expectations regarding the potential market size opportunity; Immunocore’s sales and marketing plans in the United States, including the size, timing and nature of such sales and marketing plans; the validation of the global supply chain; the magnitude of any potential revenues generated by KIMMTRAK; future development plans of tebentafusp, including the timing or likelihood of expansion into additional markets or geographies; the success of Immunocore's partnership with MEDISON; Immunocore's ability to support mUM patients on Early Access Program; the design, progress, timing, scope and results of the Company's other clinical trials including PRAME and MAGE A4; and the Company’s anticipated cash runway. These forward-looking statements are based on management's current expectations and beliefs and are subject to a number of risks, uncertainties and important factors that may cause actual events or results to differ materially from those expressed or implied by any forward-looking statements, including, without limitation, risks and uncertainties related to the impact of the ongoing COVID-19 pandemic and the Omicron variant on Immunocore’s business, strategy and anticipated milestones, including Immunocore’s ability to conduct ongoing and planned clinical trials; clinical supply of current or future product candidates; commercial supply of KIMMTRAK or any future approved products, and launching, marketing and selling of KIMMTRAK or any future approved products; Immunocore’s ability and plans in continuing to establish and expand a commercial infrastructure and to successfully launch, market and sell KIMMTRAK; 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 the COVID pandemic or patient enrollment delays; 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; actions of regulatory agencies, which may affect the initiation, timing and progress of clinical trials or future regulatory approval; Immunocore’s ability to obtain, maintain and enforce intellectual property protection for KIMMTRAK or any product candidates it is developing; and the success of Immunocore’s current and future collaborations, partnerships or licensing arrangements. 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 20-F, as supplemented by its most recent filings that Immunocore has made or may make with the SEC in the future. Any forward-looking statements represent Immunocore’s views only as of the date of this presentation and should not be relied upon as representing its views as of any subsequent date. Immunocore does not assume any obligation to update any forward-looking statements, except as may be required by law.

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KIMMTRAK™ is a trademark owned or licensed to Immunocore.

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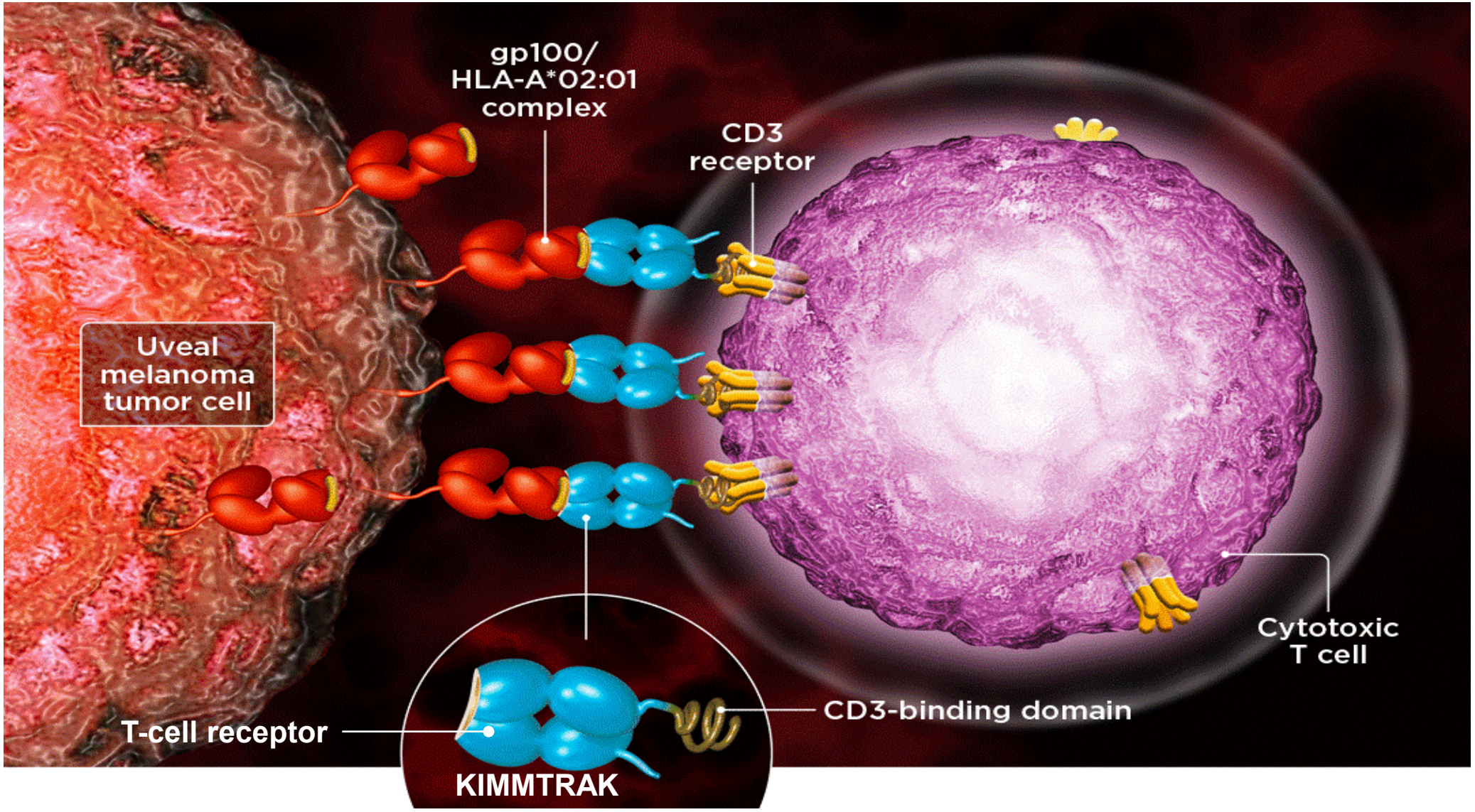
Harnessing the immune system to fight disease with targeted, off-the-shelf, bispecific, soluble T cell receptors (TCRs)



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Immunocore: Leading the way in TCR therapeutics

Pipeline with potential in multiple indications / therapeutic areas

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Our team

Proven track record with over 25 new medicines for patients & now KIMMTRAK®

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CEO

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IMFINZI, FASENRA, LUMOXITI, SELIQ, QAIV, SAPHNELO

Brian Di Donato
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Bristol Myers Squibb · MedImmune · AstraZeneca

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SYNAGIS, FLUMIST, VLP technology for HPV vaccines

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YERVOY, OPDIVO, TAXOTERE, ZOLADEX, PLAVIX, JEVTANA, ELOXATIN

Ralph Torbay
Head of Commercial

AstraZeneca · NOVARTIS

IMFINZI, TAGRISSO, CALQUENCE, GLEEVEC, TASIGNA, ARZERRA, FARYDAK

FDA & EMA approval of KIMMTRAK® in unresectable or metastatic uveal melanoma (mUM)

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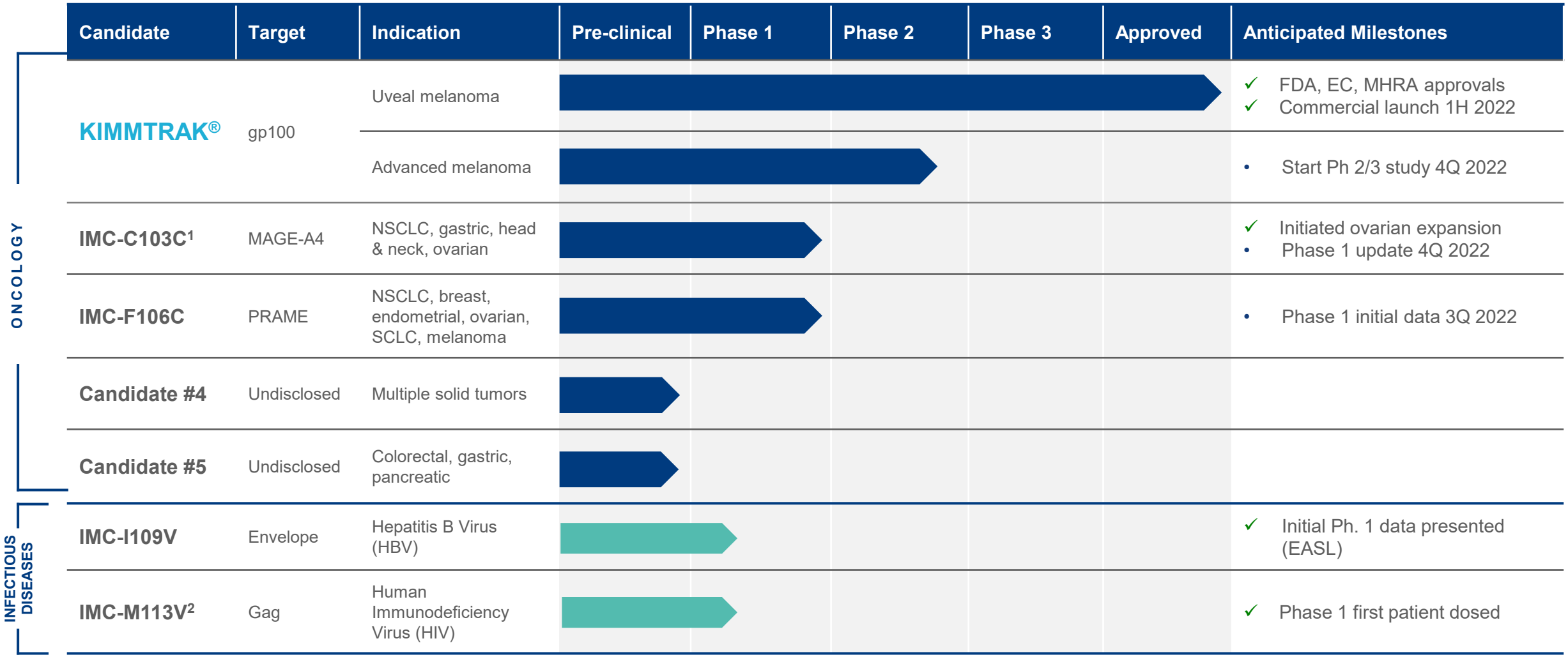
Our pipeline

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-C103C[1]	MAGE-A4	NSCLC, gastric, head & neck, ovarian						✓ Initiated ovarian expansion • Phase 1 update 4Q 2022
	IMC-F106C	PRAME	NSCLC, breast, endometrial, ovarian, SCLC, melanoma						• Phase 1 initial data 3Q 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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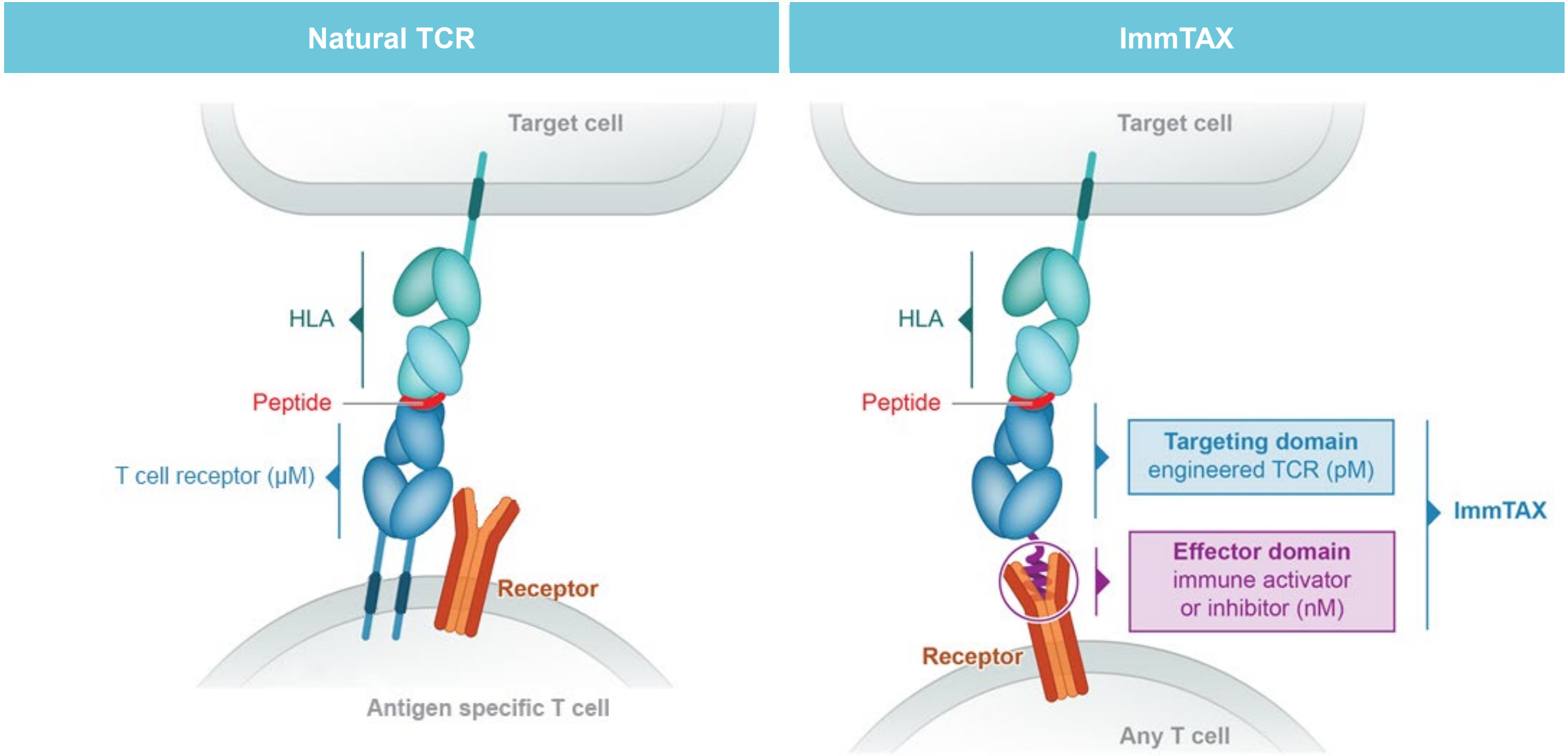
Technology Platform

We pioneered converting membrane-bound T cell receptors

Into soluble, off-the-shelf, bispecific therapeutics (ImmTAX)



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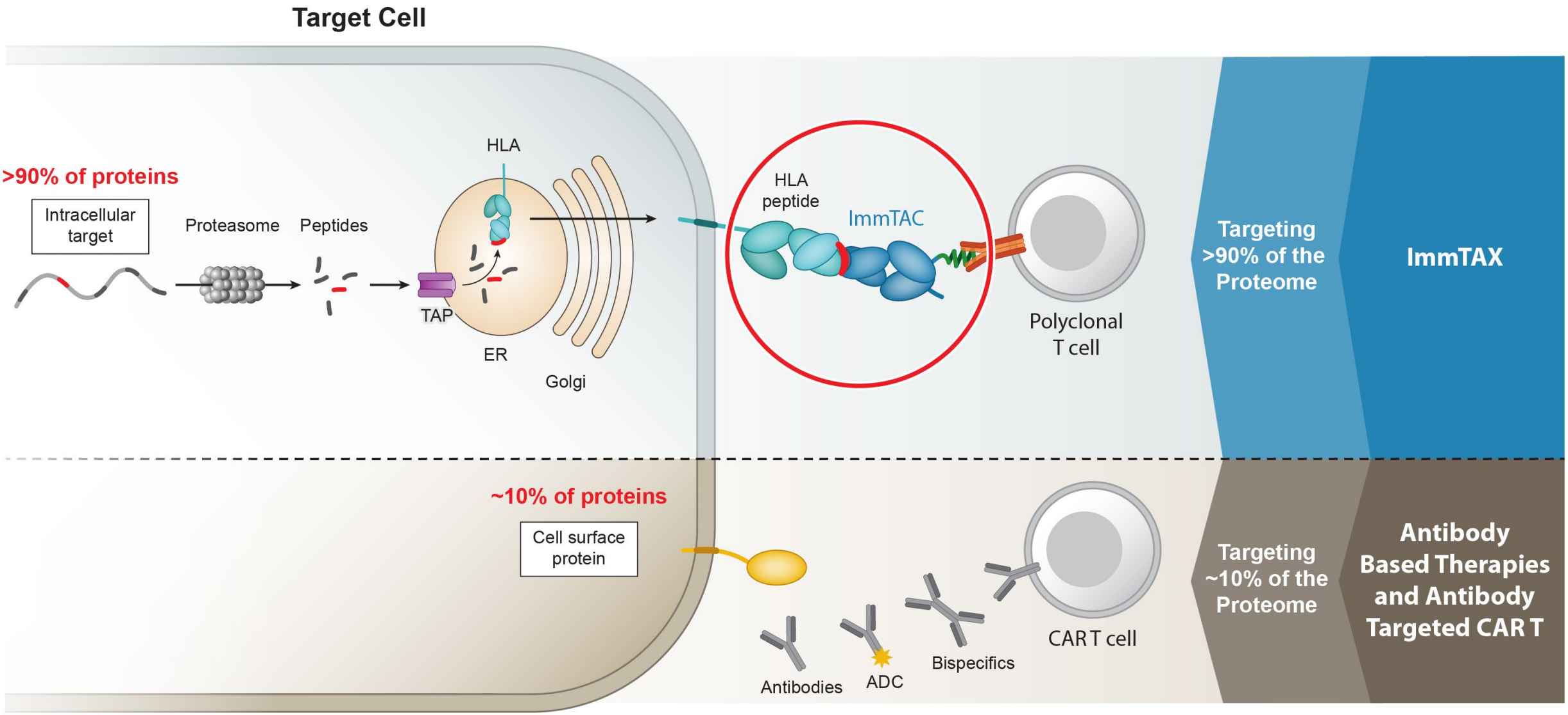
TCR therapeutics can target nearly the entire human proteome

Application to oncology, infectious disease and autoimmune



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KIMMTRAK® in Metastatic Melanoma

KIMMTRAK®: First-in-class, off-the-shelf, bispecific TCR

Targeting gp100 protein in melanoma

Uveal melanoma (UM) is an ultra-rare and aggressive tumor

Originates from melanocytes within the uveal tract of the eye

Median age at diagnosis is 62 years[1]

Up to 50% may develop metastatic disease; liver primary site of metastasis[2]

~1,000 HLA-02 mUM pts per year in the US/EU[2]

Until now, no approved treatment[3]

Historic median survival with metastatic disease[3]

~12 months

1. Yang J et al. Ther Adv Med Oncol. 2018 ; 2. Carvajal RD et al. Br J Ophthalmol. 2017; 3.Rantala ES et al. Melanoma Res. Published online. 2019

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Primary Endpoint: Overall Survival (OS) statistically significant

IMCgp100-202 study

KIMMTRAK was proven to extend median OS by 6 months

The NEW ENGLAND JOURNAL of MEDICINE

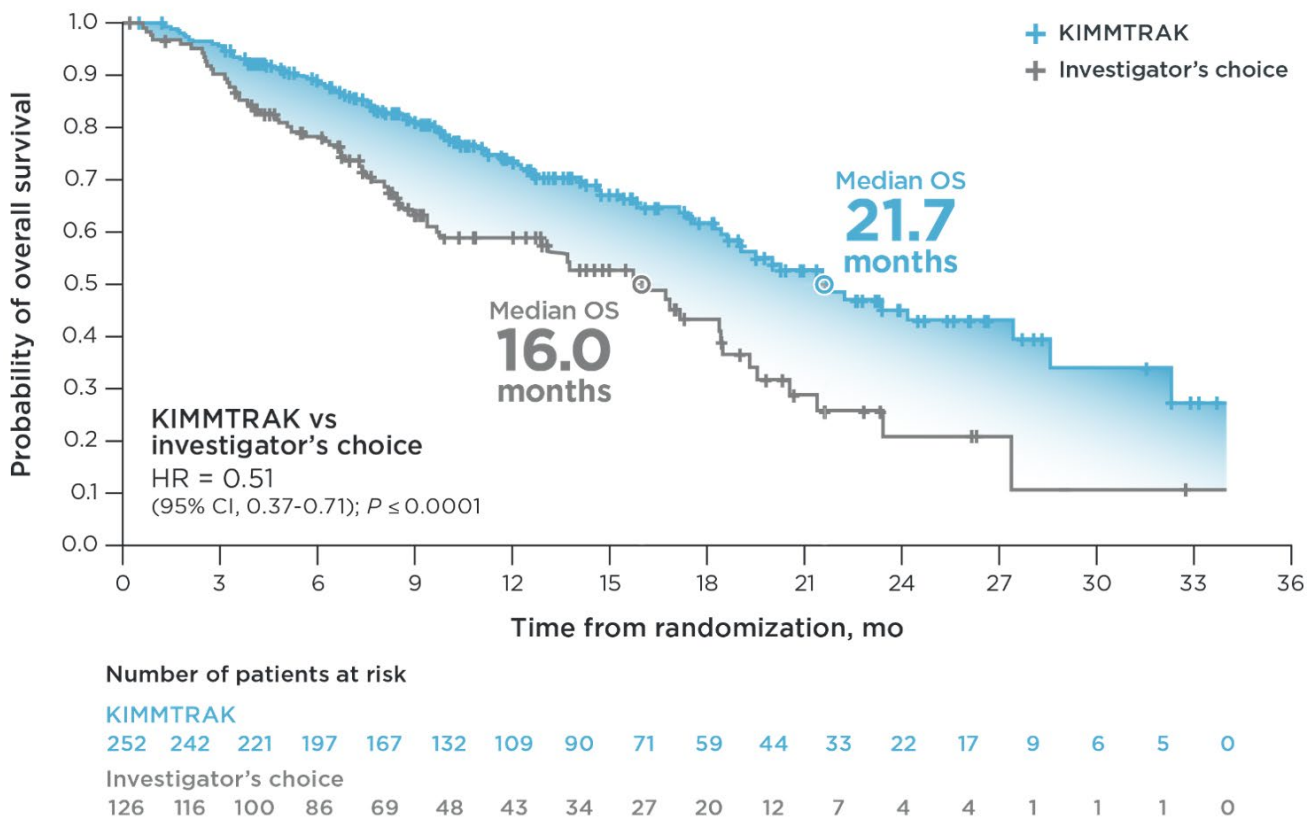
MEDIAN OS:

21.7 months

HAZARD RATIO:

0.51

Overall Survival benefit in patients treated with KIMMTRAK or investigator's choice in first-line



Nathan, P. et. al. *New England Journal of Medicine* 2021; 385:1196-1206

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Safety profile of KIMMTRAK was predictable and manageable

IMCgp100-202 study

KIMMTRAK (n = 245)*

Adverse Reactions (ARs)	Any grade, %	Grade 3 or 4, %
Any	**244 (99.6)**	**110 (45)**
Cytokine release syndrome[a]	89	0.8
Rash[b]	83	18.4
Pyrexia	76	3.7
Pruritus	69	4.5
Fatigue[b]	64	5.7
Nausea	49	2
Chills	48	0.4
Hypo-/hyperpigmentation[b]	47	0.4
Abdominal pain[b]	45	2.9
Edema[b]	45	0

Key KIMMTRAK findings

- Adverse Reactions (ARs) consistent with Mechanism of Action
- Majority of ARs in first 3 weeks
- Low discontinuation rate: KIMMTRAK 2% vs. Investigator's Choice of 4.5%
- No treatment related deaths

378 previously untreated mUM patients randomized 2:1 KIMMTRAK vs. Investigator's Choice

(Pembrolizumab 82%, Ipilimumab 13%, Dacarbazine 6%)

*KIMMTRAK. US Package insert. Immunocore Ltd.; 2021. Adverse reactions listed are those with any grade >45%; a) Represents algorithmic identification of CRS cases based on ASTCT grading criteria (Lee et al. 2019). b) Represents a composite of multiple related terms.

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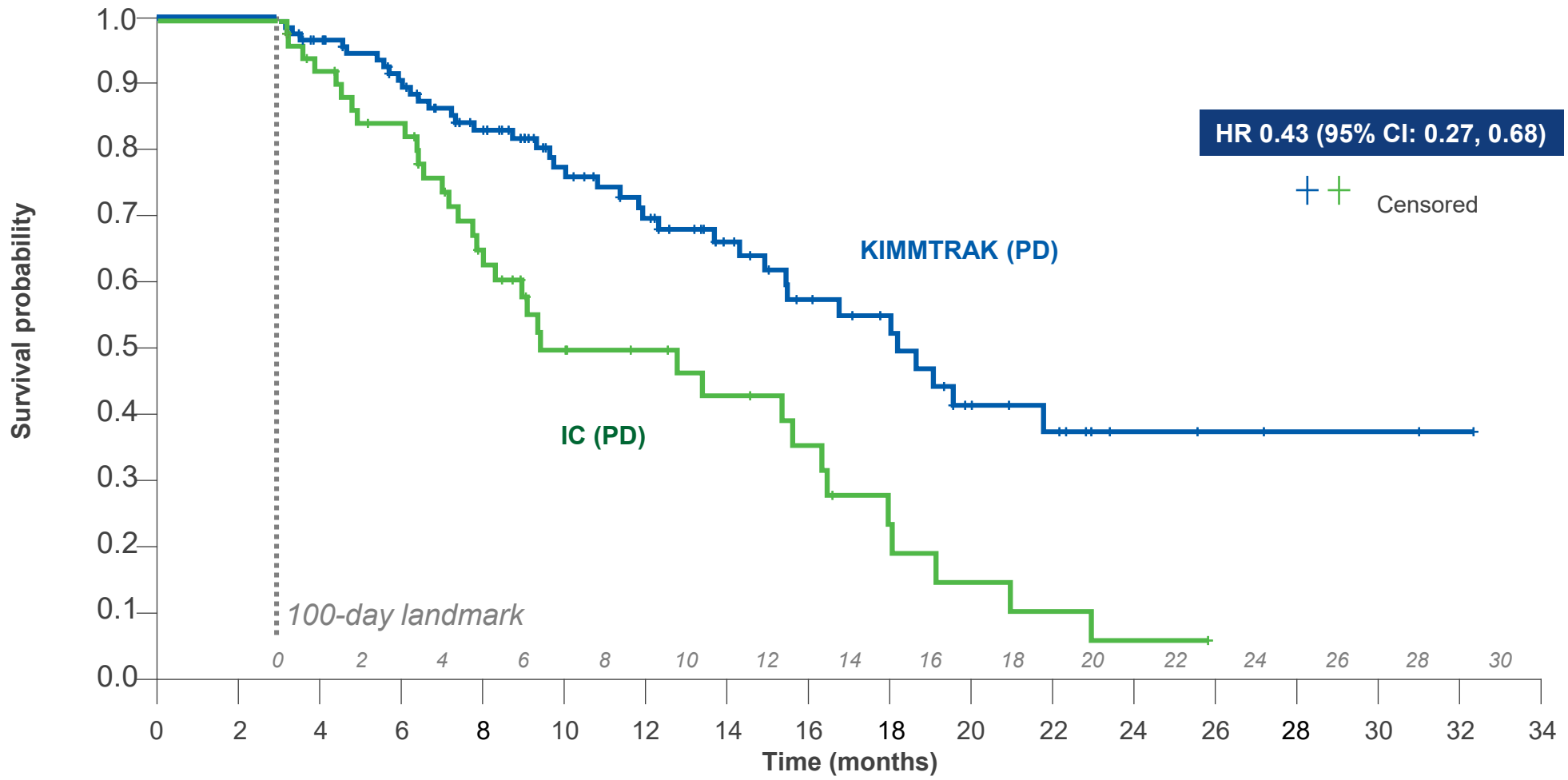
OS benefit in patients with best response of Progressive Disease

Landmark OS analysis beginning at Day 100

IMCgp100-202 study



KIMMTRAK (PD)	105	92	78	62	47	38	29	22	17	11	6	4	3	2	2	0
IC (PD)	53	42	35	23	16	13	11	6	4	3	2	1	0			

Joshua et. al. *ASCO Annual Meeting 2021*

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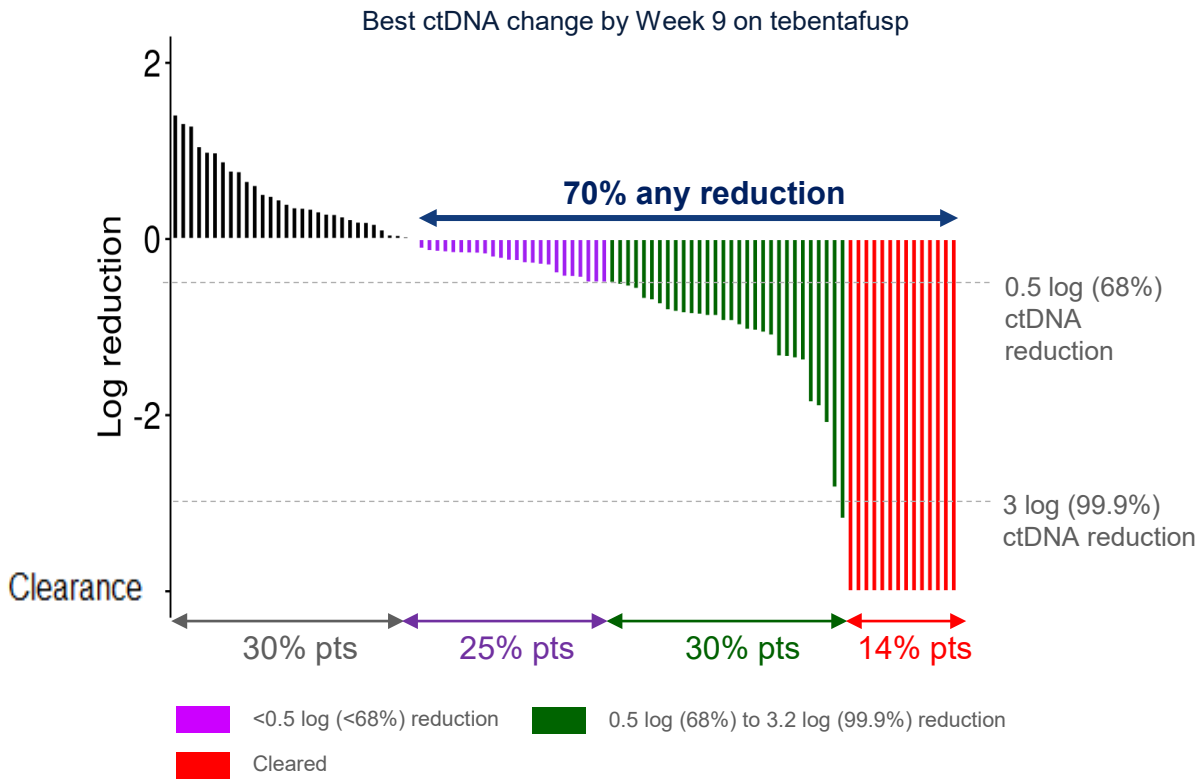
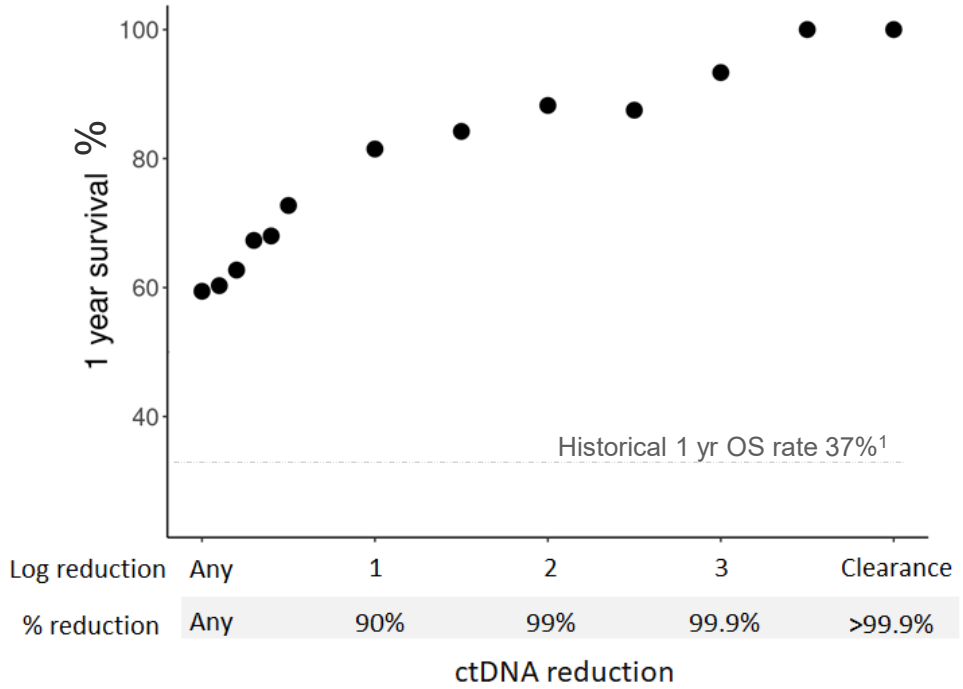
Circulating tumor (ctDNA) better surrogate of OS than RECIST

IMCgp100-102 study

70% evaluable patients had any ctDNA reduction[1]



ctDNA reduction correlates with 1 year OS



ctDNA = circulating tumor DNA

1. Shoushtari et al ESMO 2021

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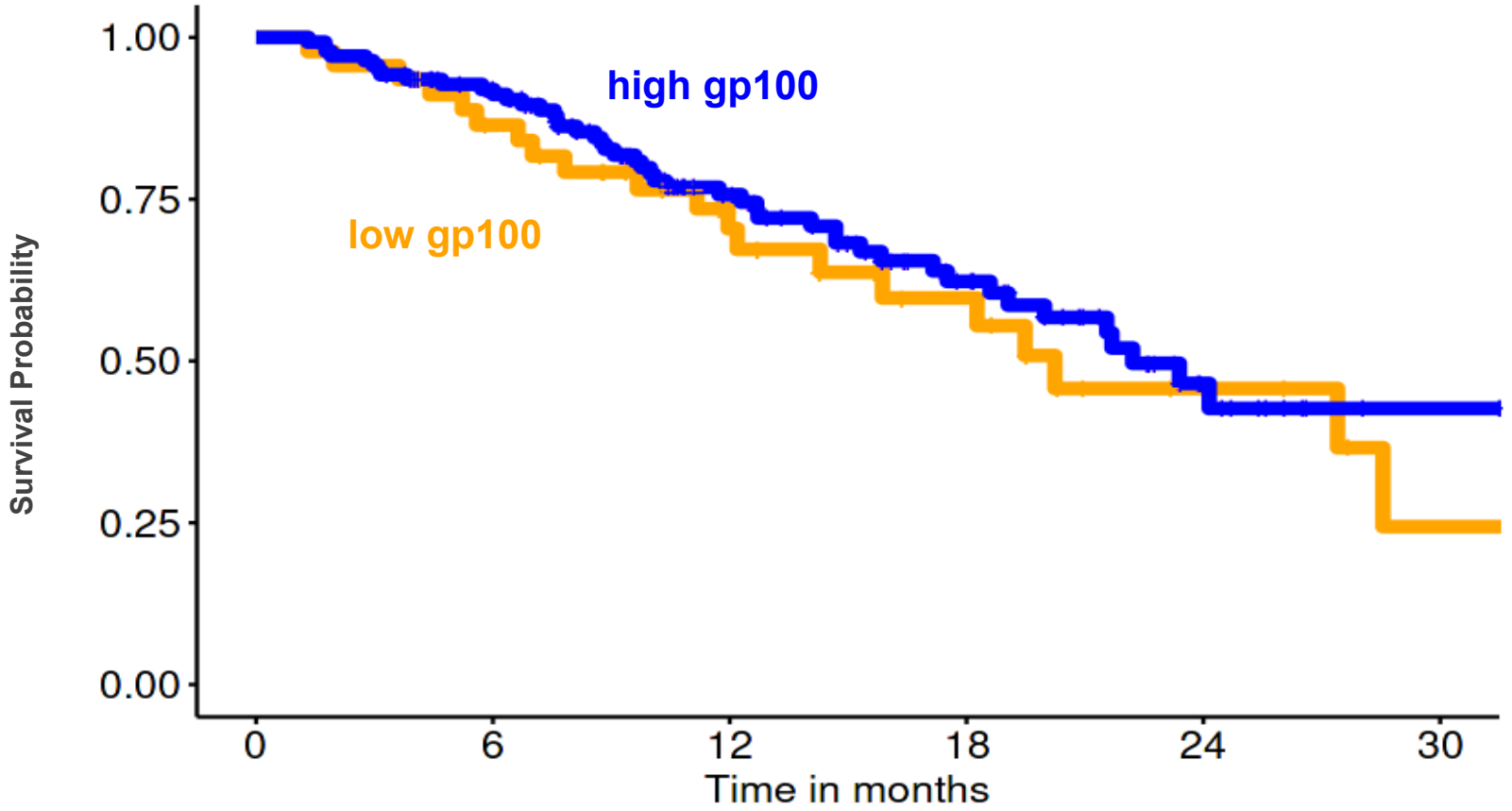
KIMMTRAK OS benefit in high and low gp100 expression

IMCgp100-202 study



Low gp100 H score < lowest quartile
High gp100 H score ≥ lowest quartile

Leach et. al., SITC 2021

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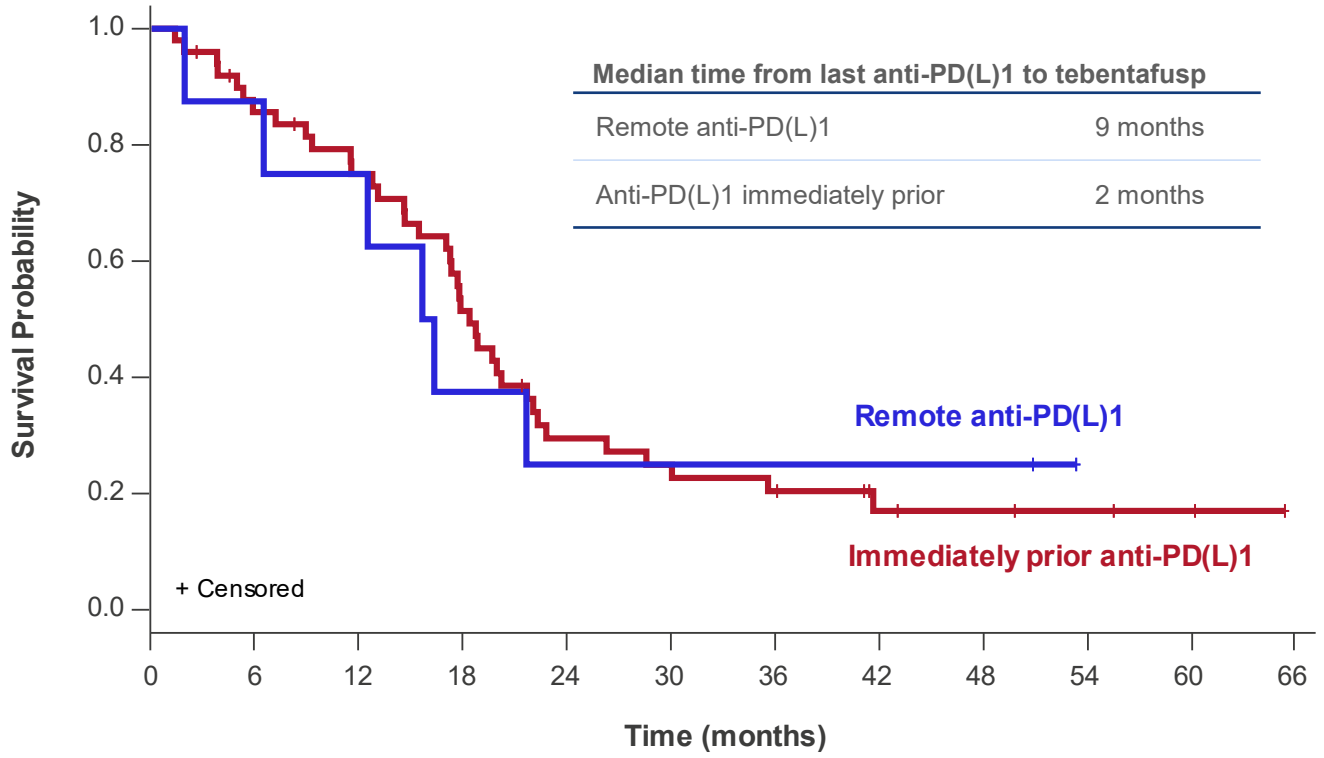
KIMMTRAK active in cutaneous melanoma

IMCgp100-201 study

OS by whether prior anti-PD(L)1 therapy was remote or most recent therapy



Median time from last anti-PD(L)1 to tebentafusp	
Remote anti-PD(L)1	9 months
Anti-PD(L)1 immediately prior	2 months

No. at risk												
Remote anti-PD(L)1	8	7	6	3	2	2	2	2	2	0		
Imm. prior anti-PD(L)1	50	41	35	24	13	11	9	5	4	3	2	0

Time from prior anti-PD(L)1	1-yr OS	2-yr OS
Remote	**75%**	**22%**
Immediately prior	**75%**	**23%**
Benchmark[1]	55%	N/A

Time since last dose of prior anti-PD(L)1 does not impact OS

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

Middleton et. al., ASCO 2022

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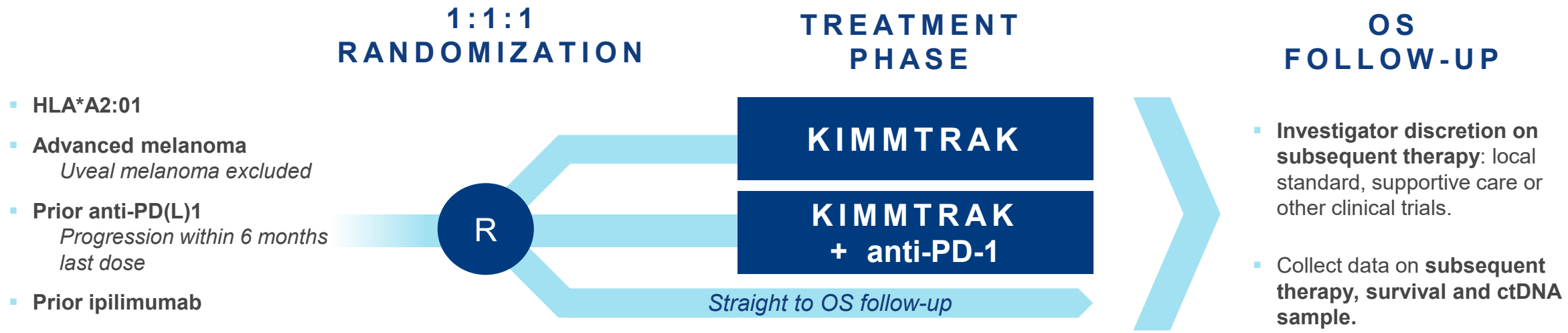
Phase 2/3 in previously treated, advanced melanoma

IMCgp100-203 study

Randomization to ‘real world’ treatment as a control arm | Initiation of trial expected Q4 2022



Phase	Primary Endpoint	Per Arm Size
2	ctDNA and OS	40
3	OS	170

Optionality to review Phase 2 data to inform changes to Phase 3, including line of prior therapy, dropping an Arm and optimize powering of study

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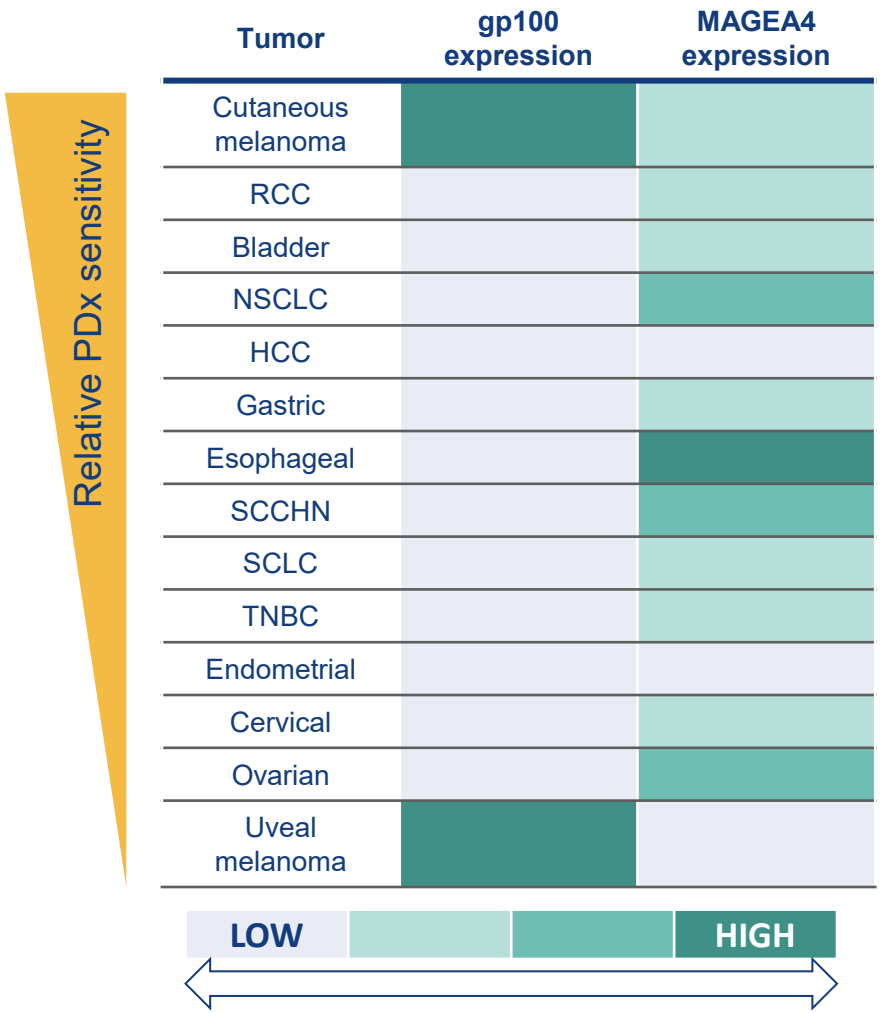
MAGE-A4 & PRAME

IMC-C103C targeting MAGE-A4, a cancer testis antigen expressed in multiple solid tumors

MAGE-A4 in PDx sensitive and insensitive tumors



Potential for > 75K patients/ yr (G7)

		Annual Metastatic Patients *MAGE-A4+ & HLA-A*02:01* US	Annual Metastatic Patients *MAGE-A4+ & HLA-A*02:01* G7
NSCLC	Squamous	8.5k	21k
	Adeno	6.5k	15k
Ovarian		3.5k	8k
SCCHN		3k	8k
Gastric + Esoph Adeno		2k	7.5k
Bladder		2k	5.5k
Esophageal Squamous		1k	5.5k
Select Others		5k	13k

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Dose escalation schema from minimum anticipated biological effect level (MABEL)

	# patients enrolled	Day 1 Dose	Day 8 Dose	Weekly Dose, Starting Day 15
Fixed Dose	2	0.5 mcg	0.5 mcg	0.5 mcg
	2	1.5 mcg	1.5 mcg	1.5 mcg
	3	4.5 mcg	4.5 mcg	4.5 mcg
	3	15 mcg	15 mcg	15 mcg
Step-Dose	9	15 mcg	45 mcg	45 mcg
	4	15 mcg	45 mcg	64 mcg
	7*	15 mcg	45 mcg	90 mcg
	7	15 mcg	45 mcg	140 mcg
	2	15 mcg	45 mcg	180 mcg
	5	15 mcg	45 mcg	240 mcg

Initial dose defined by MABEL

No to minimal pharmacodynamic activity

Initial pharmacodynamic activity identified

Strong and consistent pharmacodynamic activity

*7 patients assigned to the 90 mcg cohort; however 1/7 discontinued after 15 mcg and never received 45 mcg.

Steroid premedication has been recommended at biologically active doses and, more recently, has been required when the highest dose is given for the first time;

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Safety profile manageable and consistent with mechanism of T cell activation

Preferred Term*	0.5-4.5 mcg (n=7)	15-64 mcg (n=16)	90-240 mcg[§] (n=21)	TOTAL (N=44[†])
All Grades (treatment-related events in ≥ 20% of total patients)				
Chills	-	8 (50%)	13 (62%)	21 (48%)
Pyrexia*	2 (29%)	7 (44%)	12 (57%)	21 (48%)
Cytokine release syndrome[‡]	1 (14%)	4 (25%)	11 (52%)	16 (36%)
Headache	1 (14%)	6 (38%)	7 (33%)	14 (32%)
Nausea	1 (14%)	6 (38%)	6 (29%)	13 (30%)
Hypotension*	-	6 (38%)	5 (24%)	11 (25%)
Fatigue	1 (14%)	4 (25%)	5 (24%)	10 (23%)
Grade 3-4 (treatment-related events in ≥ 5% of total patients)				
Neutropenia	-	1 (6%)	7 (33%)	8 (18%)
Lymphocyte count decreased	1 (14%)	1 (6%)	2 (10%)	4 (9%)
ALT increased	-	1 (6%)	1 (5%)	2 (5%)
AST increased	-	1 (6%)	1 (5%)	2 (5%)
Headache	-	1 (6%)	1 (5%)	2 (5%)

- **No related AE led to treatment discontinuation**
- **No related AE led to death**

*Includes events reported as a sign/symptom of CRS
[†]One patient enrolled at 90 mcg and 9 months after discontinuing study treatment was re-enrolled at 180 mcg
[‡] Cytokine release syndrome (CRS) was graded by the Investigators using ASTCT criteria (Lee et al. 2019) [3]; all other events were graded using NCI CTCAE v5.0.
[§]Two DLTs at 240 mcg: Grade 3 AST increased (rapidly resolved; patient continued at 240 mcg until disease progression) and Grade 3 CRS (resolved; patient currently on 140 mcg)

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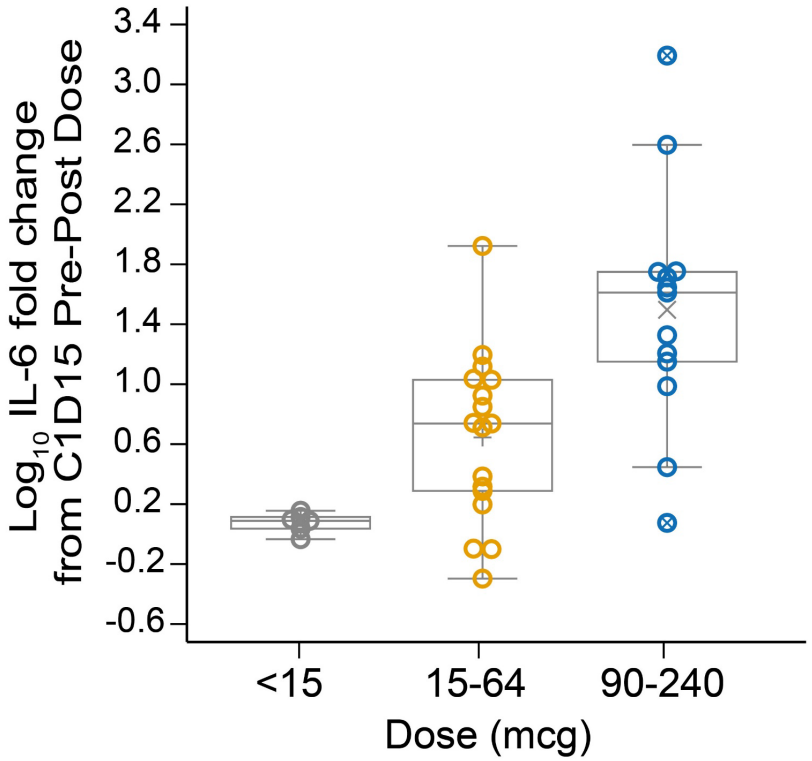
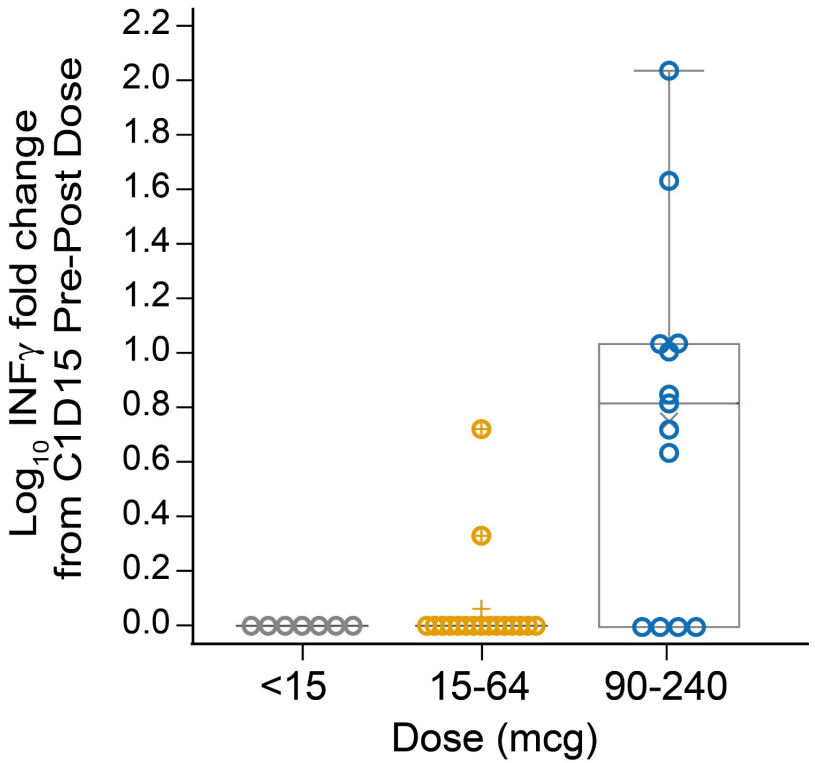
Consistent and robust evidence of T cell activity at ≥ 90 mcg IMC-C103C

Assessment after maximal dose (Day 15)

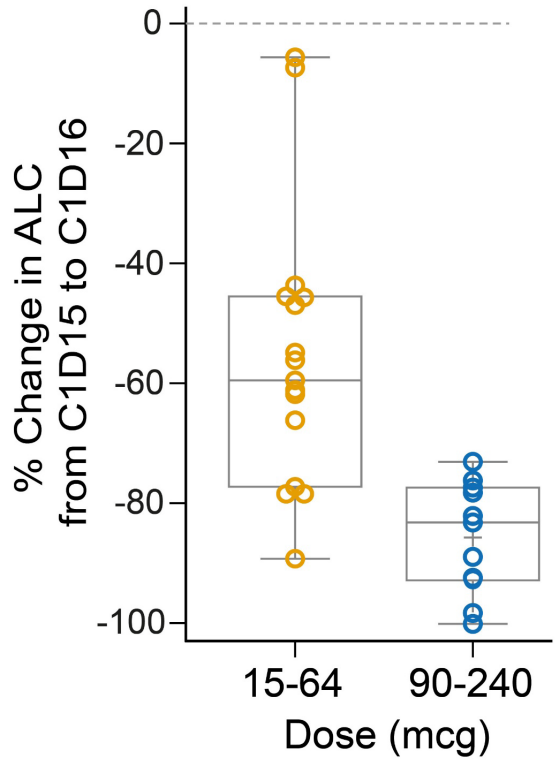
Interleukin-6 (IL-6)



Interferon-gamma (IFNγ)



Absolute Lymphocyte Count (ALC)*



Concentrations < LLOD were set to half LLOD for purposes of deriving fold change
Fold increase compares pre-dose to maximum post-dose (4hr, 8hr, and 24hr timepoints)
24 patients evaluable (pre and post-dose cytokine results available for the Day 15 dose)

* Day 16 ALC was only analyzed following introduction of intra-patient dose escalation; therefore, not collected in first cohorts.

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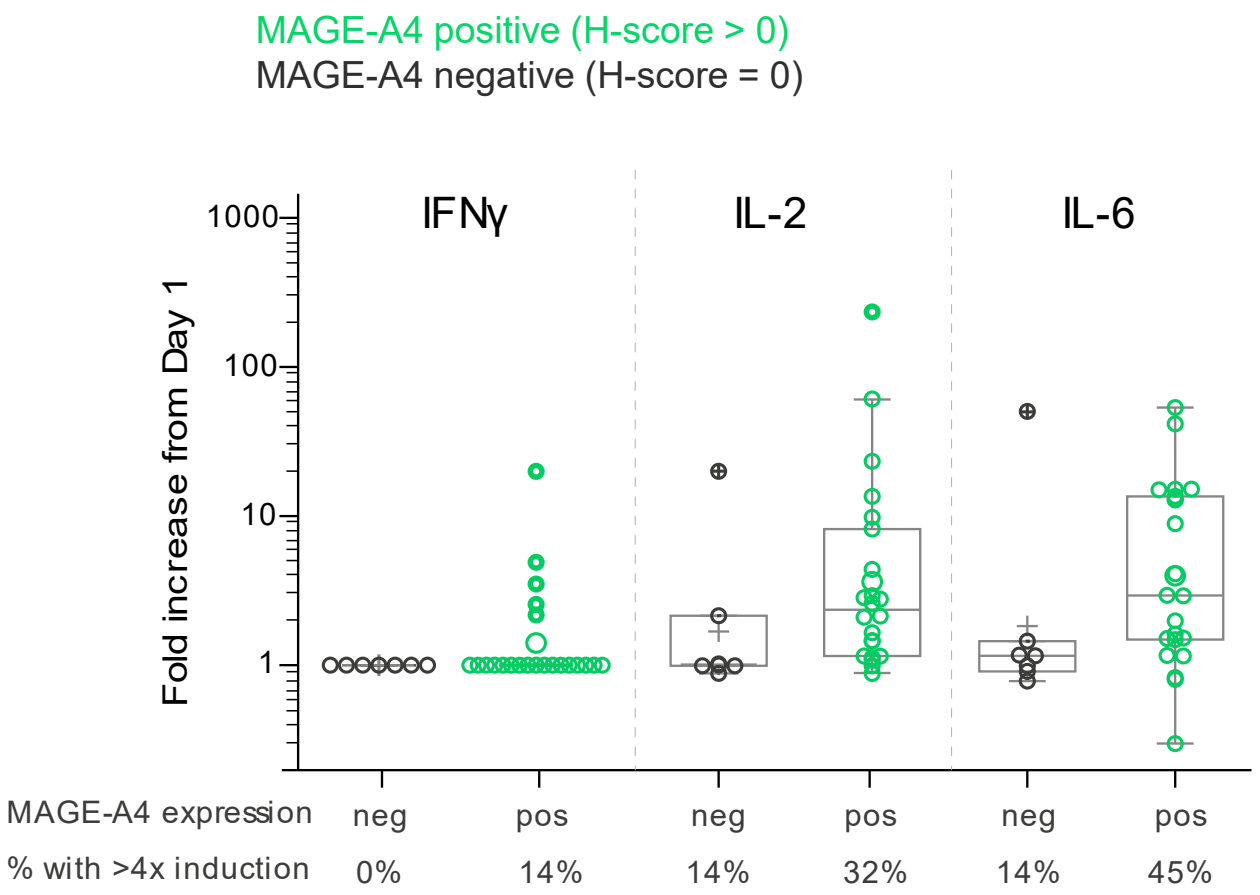
Cytokine induction primarily in patients with MAGE-A4 positive tumors

Assessment after initial dose, 15 mcg (Day 1)



- **IFNγ induction** only observed in patients with **MAGE-A4 positive tumors**
- **Median IL-2 and IL-6 induction higher** in patients with **MAGE-A4 positive tumors**

Concentrations < LLOD were set to half LLOD for purposes of deriving fold change
Fold increase compares pre-dose to maximum post-dose (4hr, 8hr, and 24hr timepoints)
29 patients evaluable (15 mcg on Day 1, pre and post-dose cytokine results and MAGE-A4 results available)

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Clinical activity in MAGE-A4 positive ovarian and HNSCC

Majority of evaluable patients had low MAGE-A4 expression

Efficacy evaluable by MAGE-A4 IHC status
all indications at 90-240 mcg

	Negative or NE MAGE-A4	Positive MAGE-A4	H-Score
HNSCC	-	**1**	285
Esophageal	-	**1**	175
Urothelial	-	**1**	3
Ovarian*	7	**8**	median 35 (range 7-128)
Total	7	**11**	

* 17 ovarian patients treated at 90-240 mcg; 15/17 efficacy evaluable and 2/17 (both MAGE-A4 negative) not yet efficacy evaluable. The 15 efficacy evaluable include: MAGE-A4 negative (n=5), not evaluable (NE) by IHC (n=2), and MAGE-A4 positive (n=8)

Clinical activity in ovarian and HNSCC

Indication	H-Score	Dose	Response	DOR
HNSCC	285	240 mcg	**Confirmed PR^ (ongoing)**	2+ mo
Ovarian	19	140 mcg	Overall TL reduction (-44%) but new lesions	
Ovarian	7	140 mcg	Overall TL reduction (-81%) but new lesions	
Ovarian	18	90 mcg	**Confirmed PR (ongoing)**	4.4+ mo
Ovarian	16	15 mcg	**Confirmed PR**	8.3 mo

TL, target lesions
HNSCC, Head and neck squamous cell carcinoma
^ confirmed after the presentation data cut-off date

- **4 had significant tumor shrinkage including 2 confirmed PR** of 11 MAGE-A4 positive (all indications),
- **1 confirmed PR (HNSCC)** of 2 high MAGE-A4 positive
- Durable partial responses, **includes low and high MAGE-A4 expression**

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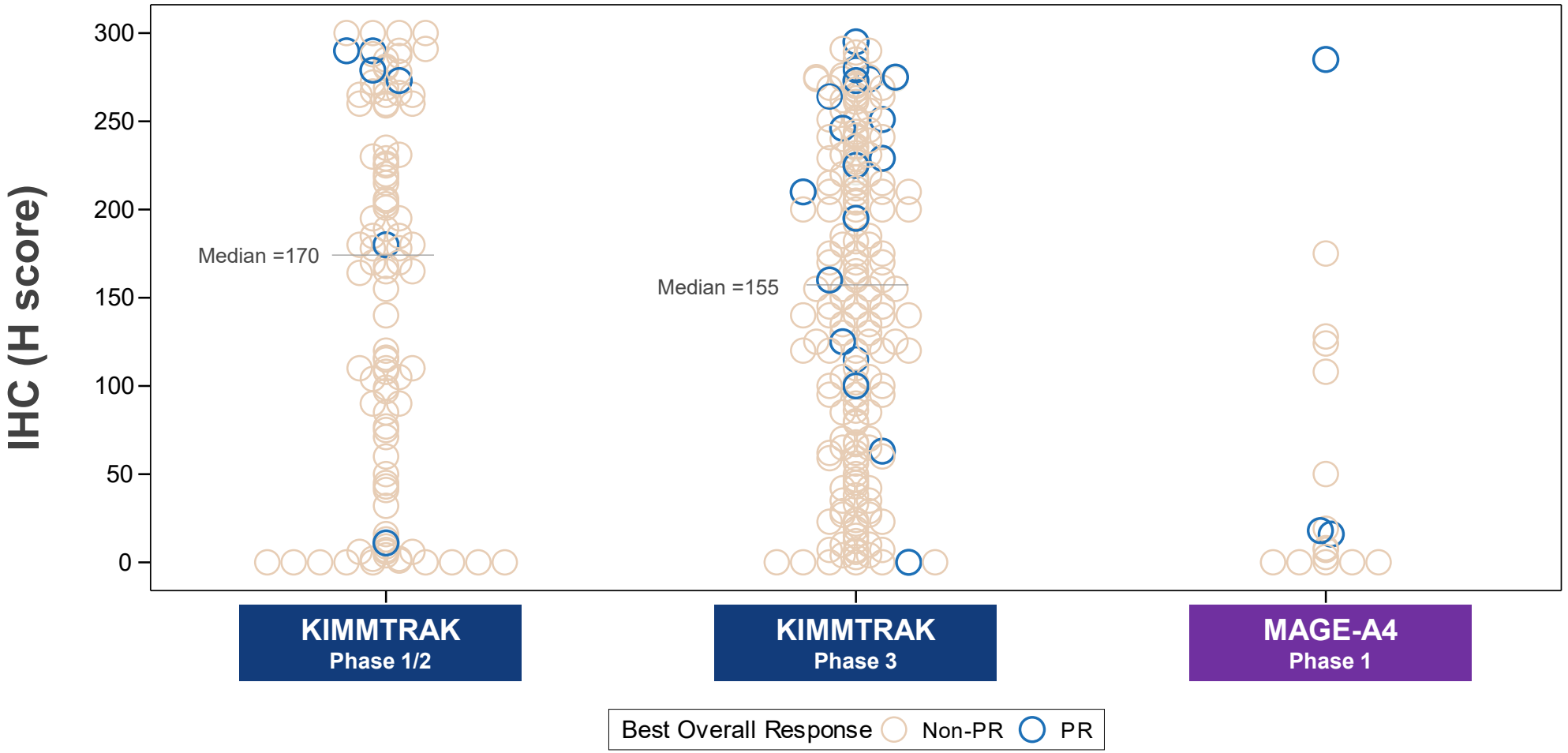
Enrichment of tebentafusp RECIST PRs at higher gp100 expression

In Phase 1, most MAGE-A4 patients to date have low or no MAGE-A4 expression



H score: % of tumor cells with 1+, 2+ or 3+ intensity
MAGE-A4 Phase 1 includes 16 efficacy evaluable patients who were evaluable by IHC (90-240 mcg) and single ovarian patient with PR (15 mcg)

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IMC-C103C, only clinical off-the-shelf candidate against MAGE-A4

IMC-C103C now demonstrated safety, MoA and clinical activity

- Manageable safety profile (primarily cytokine-mediated)
- Durable PRs in ovarian carcinoma, even with low MAGE-A4 expression, and a confirmed partial response in head and neck
- Phase 1 dose escalation trial ongoing in multiple solid tumors
- **Initiated first expansion arm in high grade serous ovarian at 140 micrograms**
- **Updated Phase 1 data expected 4Q 2022**

Potential for > 60K patients/ yr (G7)

		Annual Metastatic Patients *MAGE-A4+ & HLA-A*02:01*	
		US	G7
NSCLC	Squamous	8.5k	21k
	Adeno	6.5k	15k
Ovarian		3.5k	8k
SCCHN		3k	8k
Gastric + Esoph Adeno		2k	7.5k
Bladder		2k	5.5k
Esophageal Squamous		1k	5.5k
Select Others		5k	13k

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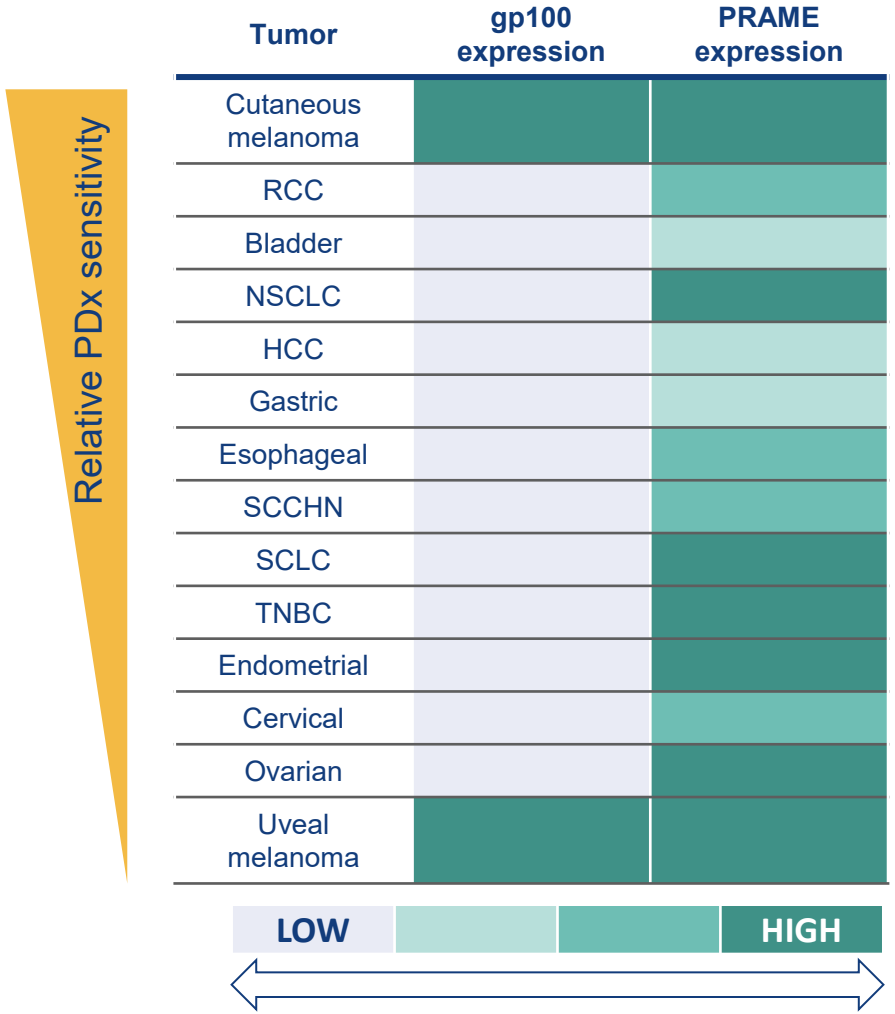
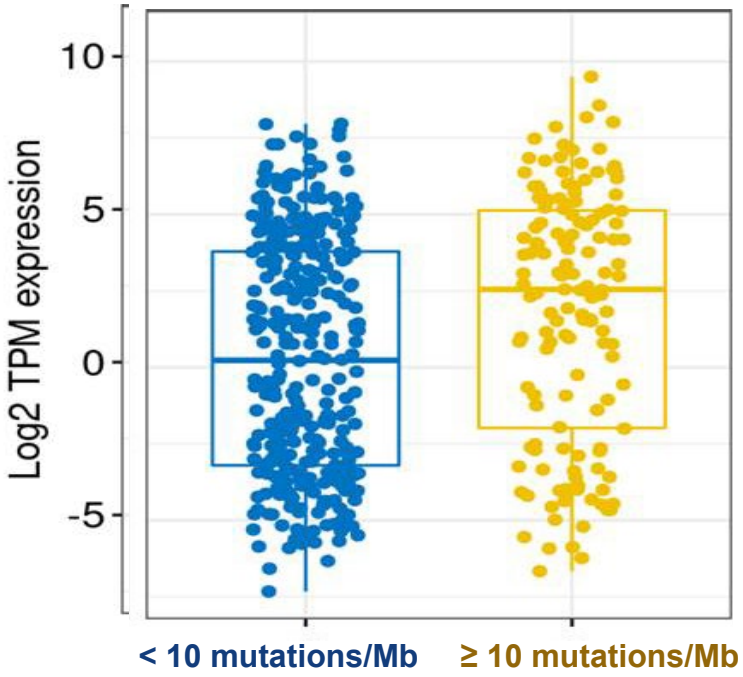
IMC-F106C targets PRAME, a negative prognostic marker in solid tumors

Expressed in PDx sensitive and insensitive tumors



Expressed in low and high TMB tumors (NSCLC)



TMB: tumor mutational burden

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PRAME is largest cancer-testes antigen opportunity

Ongoing Phase 1 study

- First, and only, off-the-shelf therapeutic against PRAME intracellular protein
- 39 patients enrolled in Phase 1 dose-escalation study*
- Biomarkers indicate having achieved biologically active doses
- **Initial Phase 1 data expected 3Q 2022**

Potential for >150,000 patients/ yr (G7)

		Annual Metastatic Patients *PRAME+ & HLA-A*02:01*	
		US	G7
NSCLC	Adeno	18.5k	42k
	Squamous	13.5k	32.5k
Ovarian		7.5k	17k
Small Cell Lung Cancer		7.5k	16.5k
Breast	Total	5.5k	14k
	TNBC	2.5k	5.5k
Endometrial		5.5k	11k
Cutaneous Melanoma		5k	10.5k
Select Others		10.5k	33.5k

*As of December 16, 2021

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Validation of ImmTAC platform beyond gp100

	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 WASHINGTON, D.C.	✓ 2021 ESMO congress	✓ The NEW ENGLAND JOURNAL of MEDICINE
IMC-C103C MAGE-A4	✓ ESMO IMMUNO-ONCOLOGY Onsite and Online Congress	✓ ESMO IMMUNO-ONCOLOGY Onsite and Online Congress	✓ ESMO IMMUNO-ONCOLOGY Onsite and Online Congress	✓ *To be presented*	
IMC-F106C PRAME	✓ *To be presented*				

On track to present additional clinical data across all three ImmTAC programs in 2022

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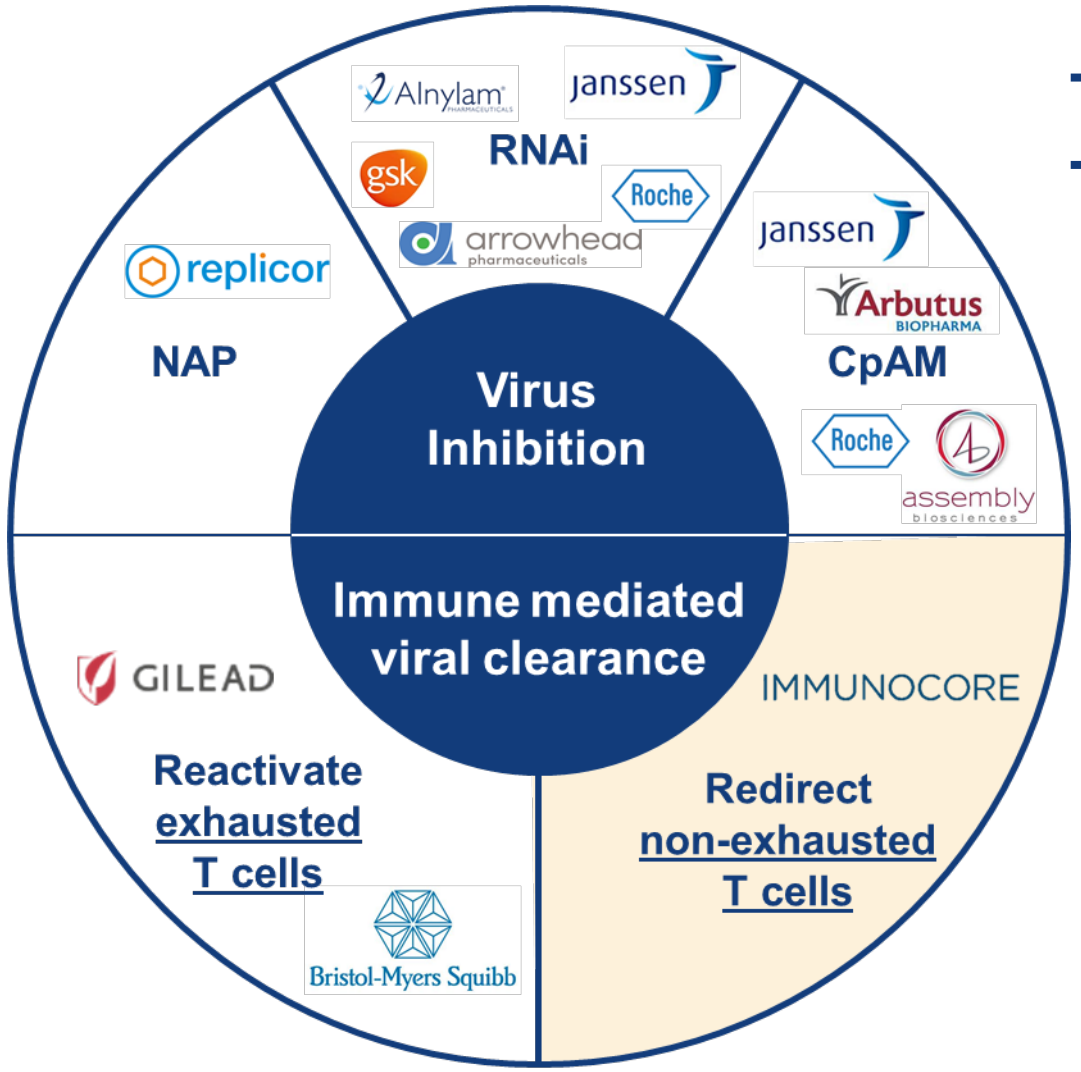
Potential for functional cure in chronic viral diseases

Our unique approach for functional cure of chronic HBV



Key advantages of redirecting non-exhausted T cells

- Same CD3 MoA validated in oncology
- Independent of natural T cell reactivity to Hep B
- Goal is functional cure with finite treatment

Mass-spectrometry antigen discovery engine for HBV

- Pipeline funnel (e.g., conserved sequences, pHLA presentation/stability, mimetic risk)
- Seven optimal targets identified from envelope, core capsid, and polymerase

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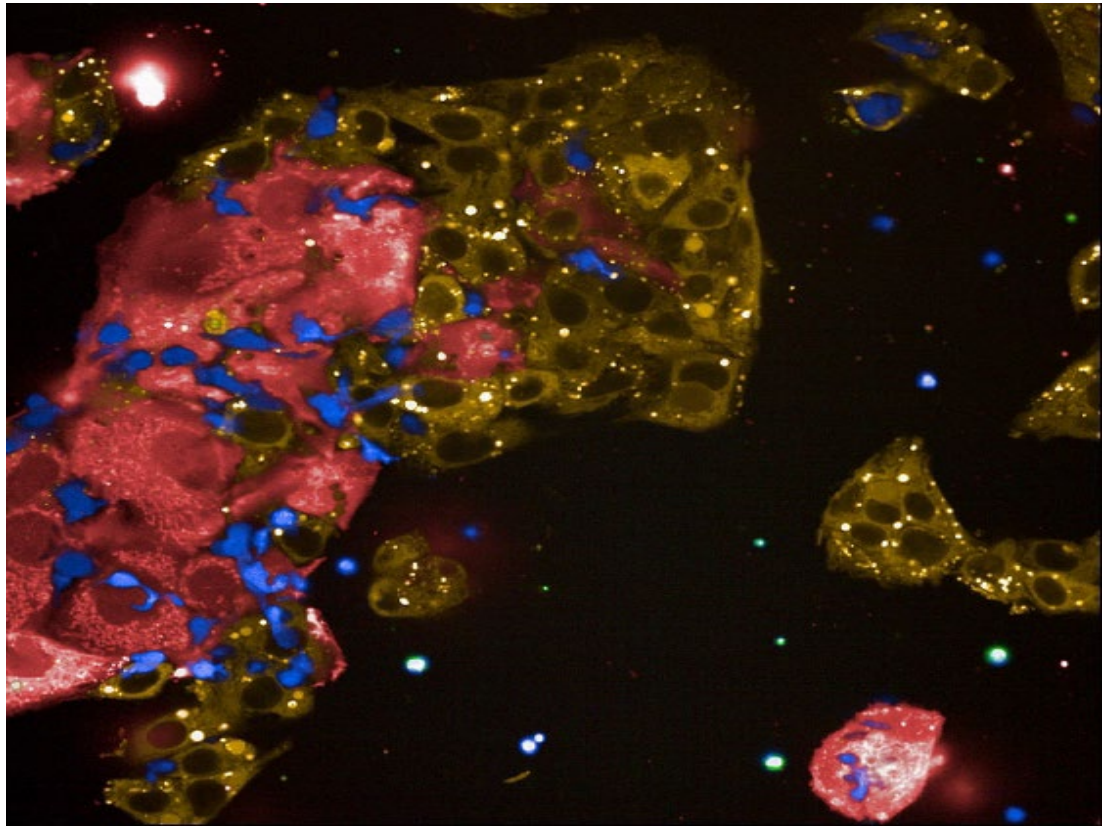
Highly specific killing of cells with integrated HBV DNA

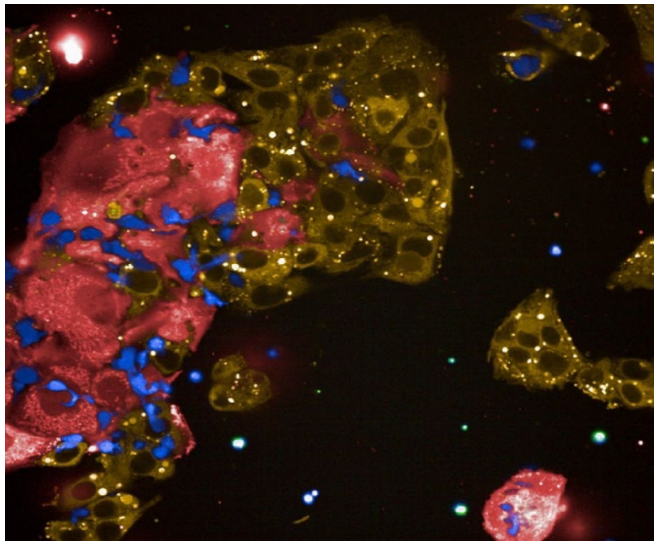


HBV+ cells

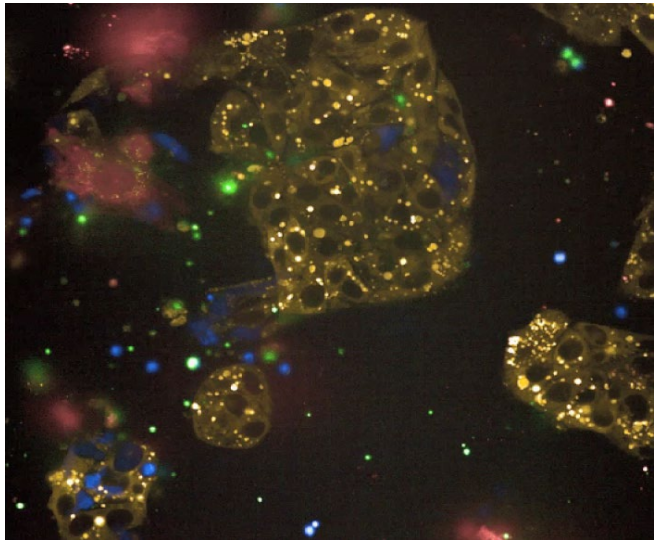
HBV- cells

T cells

Cell death



Co-incubation (start)



HBV+ cell death (end)

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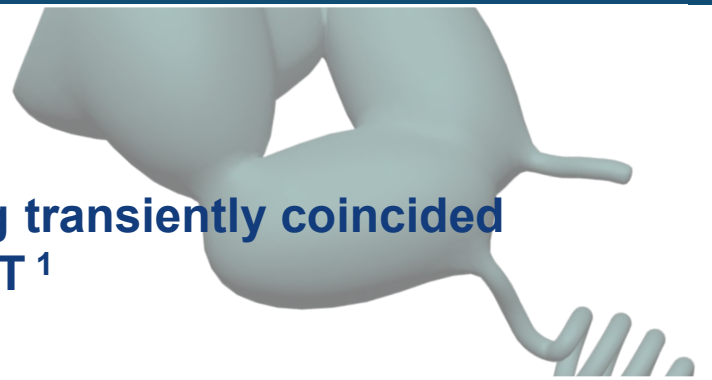
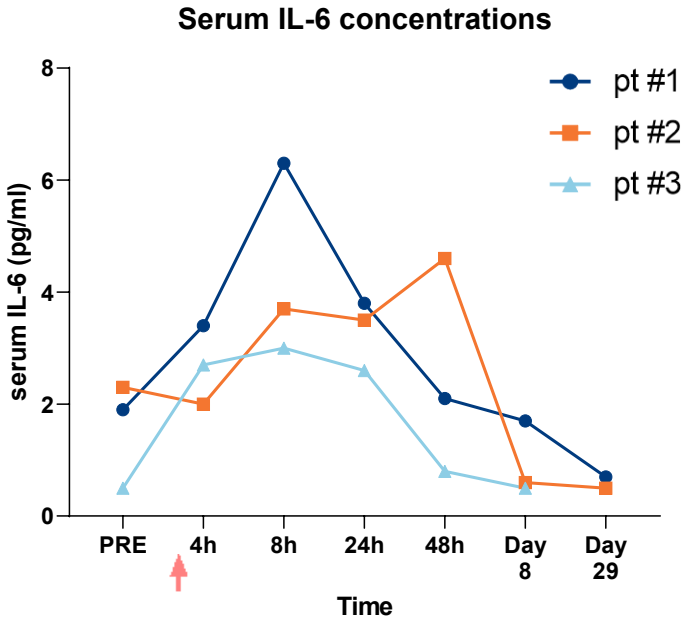
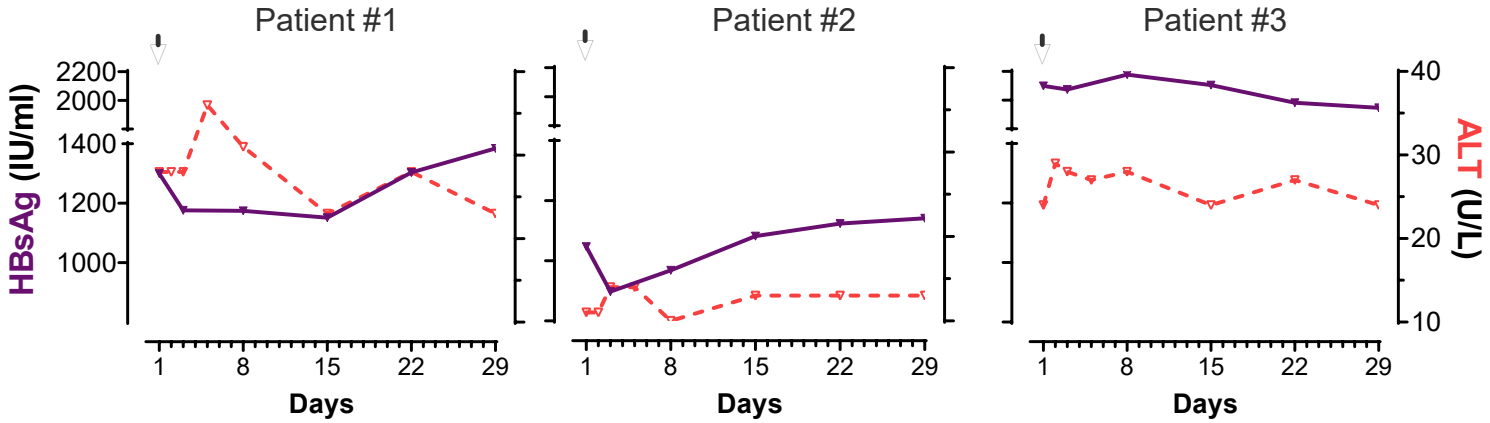
IMC-I109V: single 0.8 mcg dose results presented at EASL 2022



Induction of IL-6 in all 3 patients[1]



Transient decrease in HBsAg transiently coincided with transient increase in ALT [1]



EASL™ The Home of Hepatology

1. Bourgeois, et. al. EASL 2022

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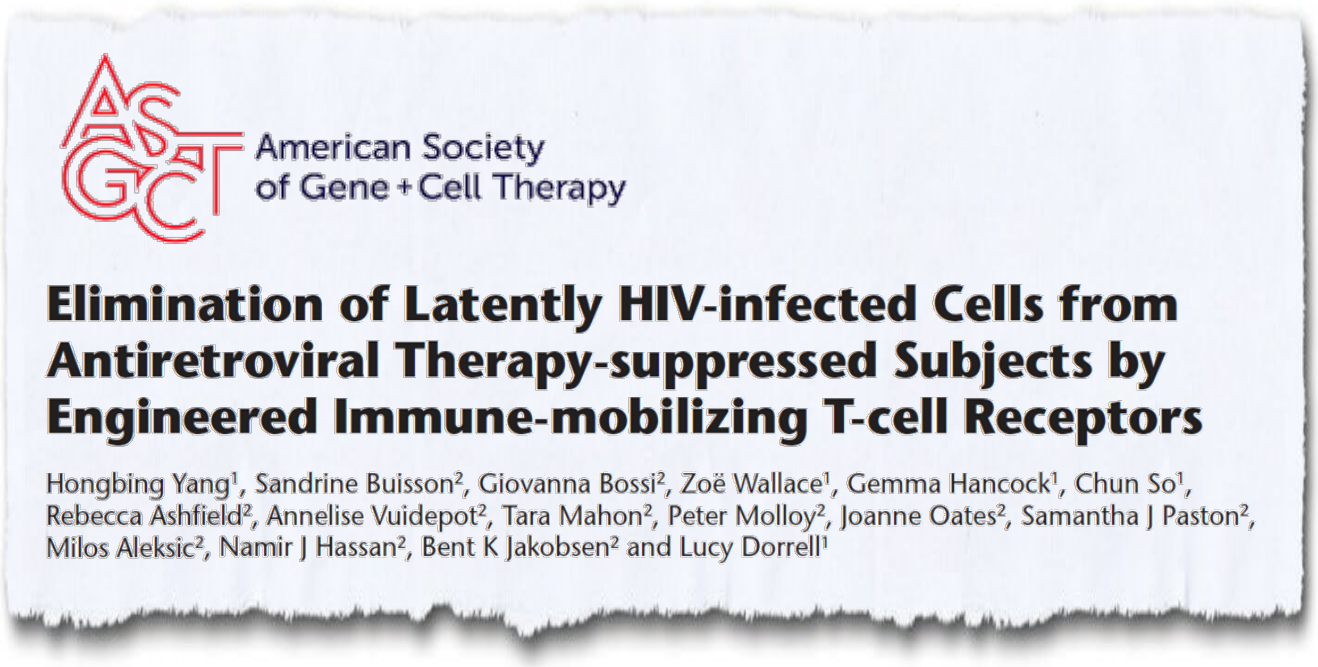
Functional cure program for HIV with goal of eliminating HIV reservoirs



American Society of Gene + Cell Therapy

Elimination of Latently HIV-infected Cells from Antiretroviral Therapy-suppressed Subjects by Engineered Immune-mobilizing T-cell Receptors

Hongbing Yang[1], Sandrine Buisson[2], Giovanna Bossi[2], Zoë Wallace[1], Gemma Hancock[1], Chun So[1], Rebecca Ashfield[2], Annelise Vuidepot[2], Tara Mahon[2], Peter Molloy[2], Joanne Oates[2], Samantha J Paston[2], Milos Aleksic[2], Namir J Hassan[2], Bent K Jakobsen[2] and Lucy Dorrell[1]

- Same MoA as tebentafusp, but optimized for low target viral peptide presentation
- Bypasses exhausted T cells
- Targets highly conserved & functionally constrained viral epitopes
- Active in ex vivo assays of infected CD4+ T cells from ART-treated HIV patients
- Soluble format access to tissue reservoirs

Initiated IMC-M113V Phase 1 2022

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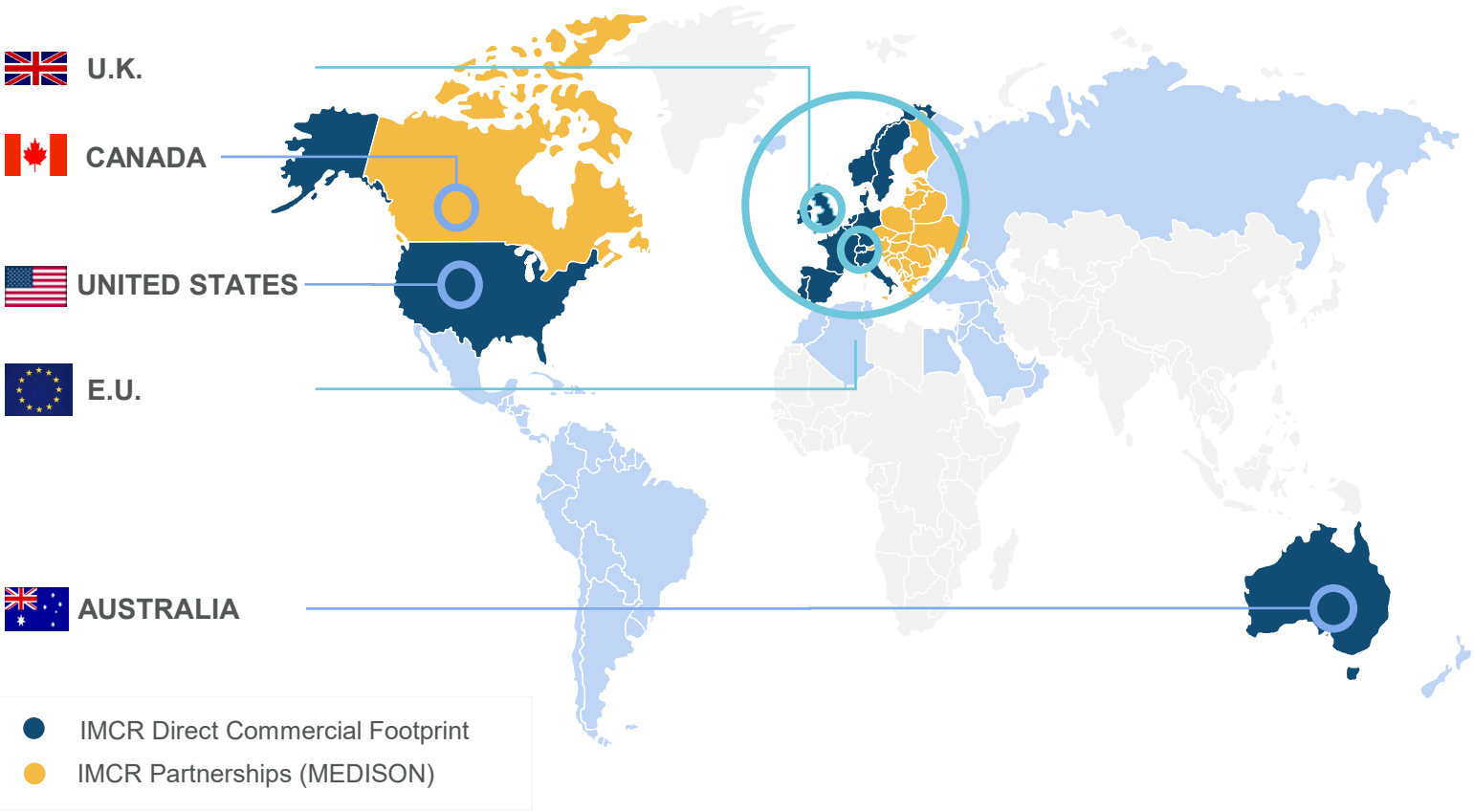
KIMMTRAK Launch Readiness & Upcoming Portfolio Milestones

Our ambition: transform the lives mUM patients around the world

5 Global marketing authorization acceptances

Regulatory approvals in 30 countries



US launched
All EAP patients transitioned in Q1

EU & UK approval

+22 countries
in partnership with MEDISON in Canada, Central & Eastern Europe, and Israel

~1,000 patients / year in US and initial priority European markets[1]

1. HLA-A*02:01-positive adult patients with unresectable or mUM

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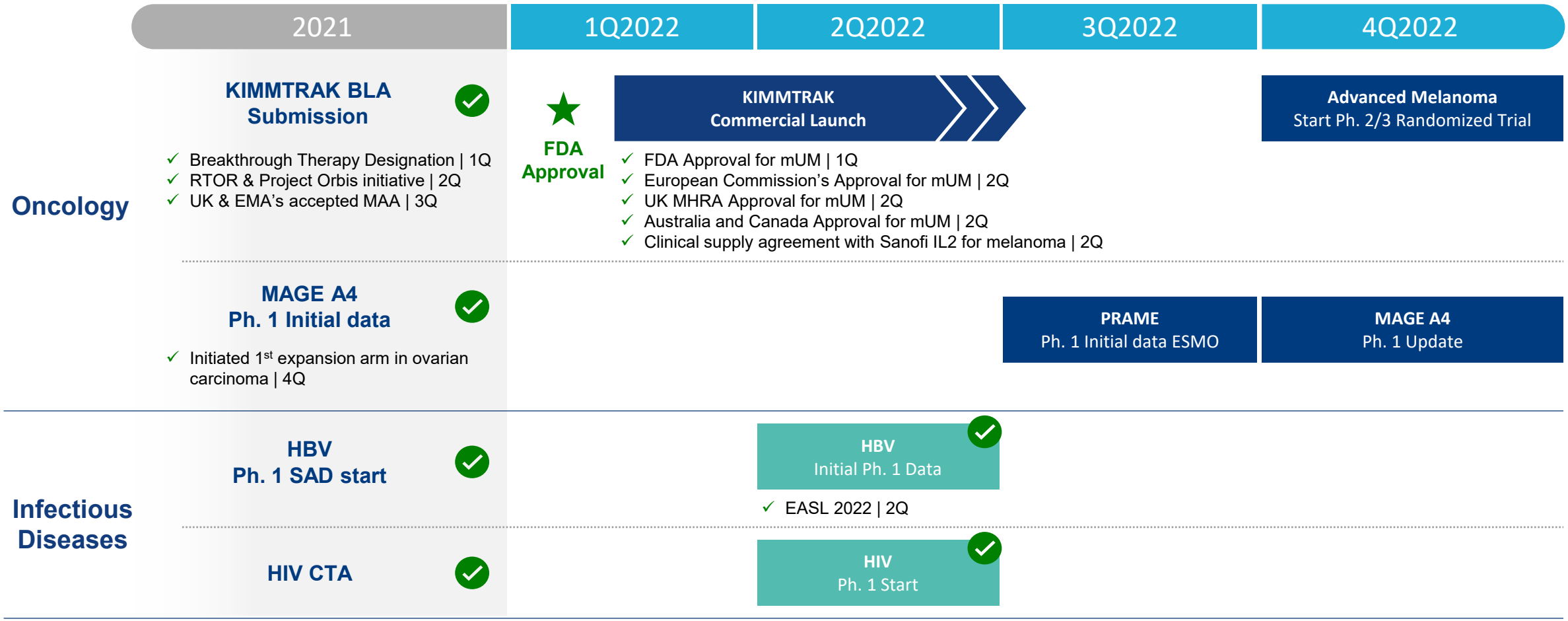
Portfolio milestones



~$393M Adjusted cash and cash equivalents[1]

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

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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

IMMUNOCORE

Immunocore is the most advanced TCR company

- First **clinically validated** TCR platform with survival benefit
- **5** clinical-stage programs across 2 therapeutic areas
- KIMMTRAK now approved in **30+ countries** (incl. US, UK, EU, & Australia)
- Multiple **value inflection points** over the next 6 months

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