IMMUNOCORE

Corporate Presentation

November 2021

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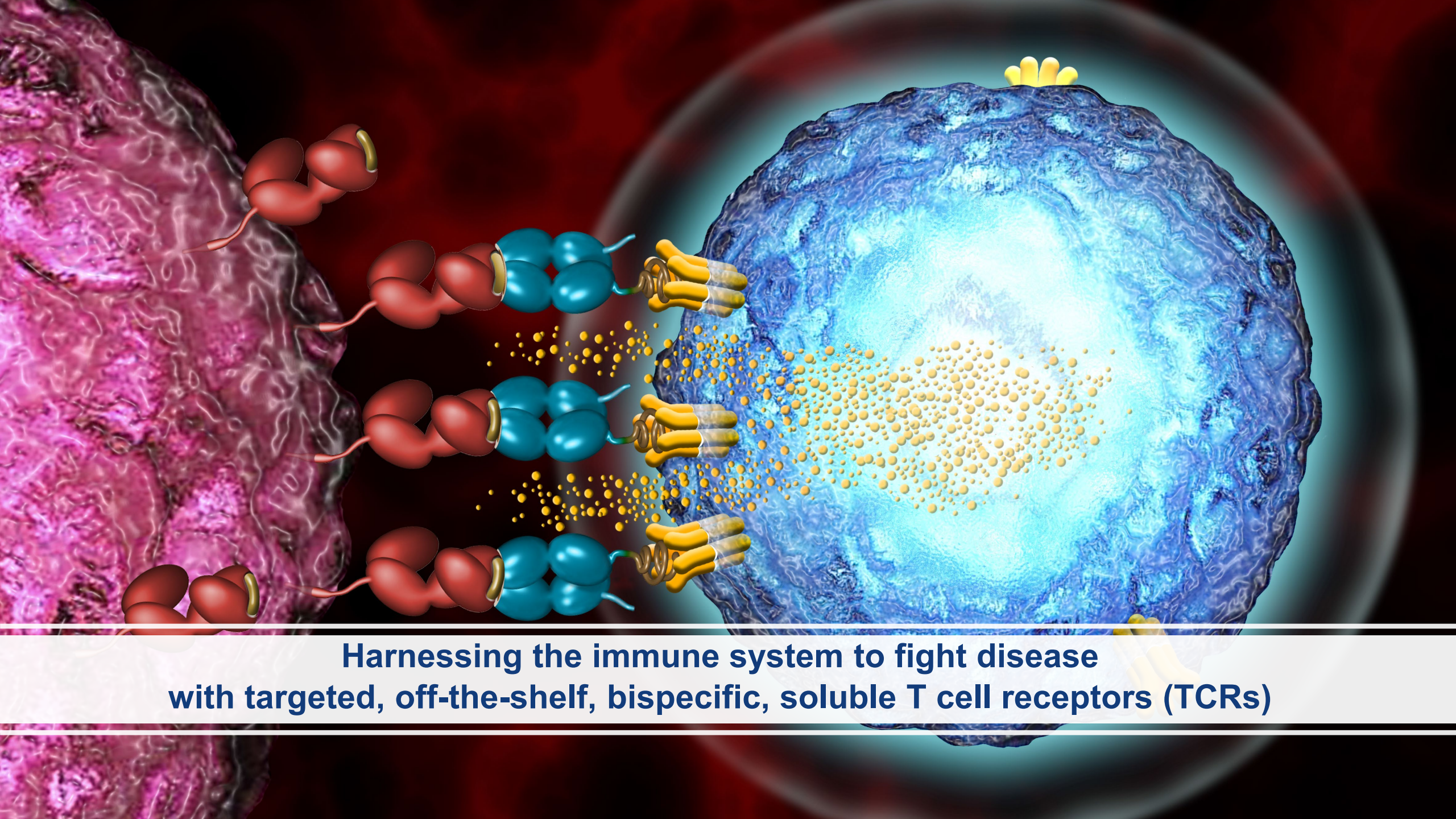

Harnessing the immune system to fight disease with targeted, off-the-shelf, bispecific, soluble T cell receptors (TCRs)

Immunocore: Pioneering TCR therapeutics

Leader in off-the-shelf bispecific T-cell engagers

First TCR to demonstrate monotherapy overall survival (OS) benefit in solid tumor

Clinically-validated platform moving to commercialization in mUM[1]

Potential first FDA approval for a TCR therapeutic

Pipeline with potential in multiple indications / therapeutic areas

Oncology (gp100, PRAME, MAGE-A4), infectious and autoimmune diseases; 5 clinical stage programs

1. Metastatic uveal melanoma

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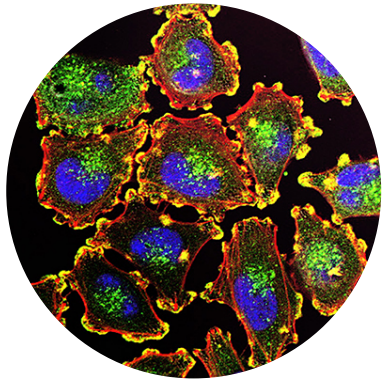
Our strategy

Flexibility of our platform is applicable across three therapeutic areas

ONCOLOGY

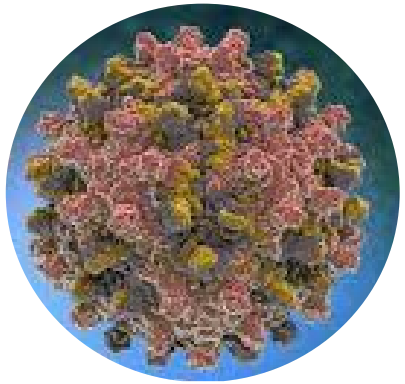


Tebentafusp BLA/MAA

MAGE A4 Phase 1

PRAME Phase 1

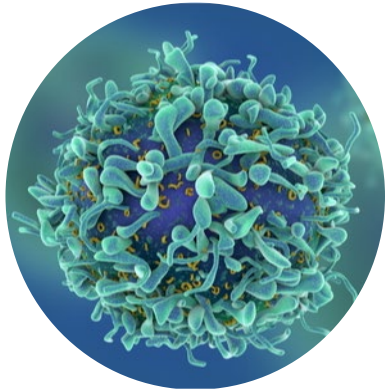
INFECTIOUS DISEASES



HBV Phase 1

HIV Pre-Clinical

AUTOIMMUNE/ INFLAMMATION



Pre-Clinical

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Our team

Proven track record with over 25 new medicines for patients

Bahija Jallal
CEO

- MedImmune, Chiron & Sugen
- IMFINZI, FASENRA, LUMOXITI, SELIQ, QAIV, SAPHNELO

Brian Di Donato
CFO & Head of Strategy

- Achillion CFO sold to Alexion in early 2020
- Morgan Stanley, UBS

David Berman
Head of R&D

- MedImmune/AZ & BMS
- YERVOY, EMPLICITI, LUMOXITI, IMFINZI

Mohammed Dar
CMO

- GSK, MedImmune
- VOTRIENT, IMFINZI, LUMOXITI

Andy Hooker
VP, CMC & Supply Chain

- Ipsen Bioinnovation, Syntaxin Ltd; UCB, Slough; & Pfizer
- CIMZIA

JoAnn Suzich
Head of Research

- MedImmune/AZ & Molecular Genetics
- SYNAGIS, FLUMIST, VLP technology for HPV vaccines

Mark Moyer
Head of Regulatory

- Sanofi, AZ & BMS
- YERVOY, OPDIVO, TAXOTERE, ZOLADEX, PLAVIX, JEVTANA, ELOXATIN

Ralph Torbay
Head of Commercial

- AZ, Novartis
- IMFINZI, TAGRISSO, CALQUENCE, GLEEVEC, TASIGNA, ARZERRA, FARYDAK

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Our pipeline

Leading bispecific TCR pipeline with tebentafusp BLA & MAA submissions accepted

	Candidate	Target	Indication	IND enabling	Phase 1	Phase 2	Phase 3	Upcoming Milestone	Rights
ImmTAC	**Oncology**								
	Tebentafusp	gp100	Uveal melanoma					✓ **Submit BLA & MAA in Q3 2021**	IMMUNOCORE
	IMC-C103C	MAGE-A4	Solid tumors: NSCLC, gastric, head & neck, ovarian, synovial sarcoma					❖ **Ph. 1 initial data Q4 2021**	Genentech[1] A Member of the Roche Group
	IMC-F106C	PRAME	Solid tumors: breast, endometrial, ovarian, SCLC					❖ **Ph. 1 initial data mid 2022**	IMMUNOCORE
ImmTAV	**Infectious Diseases**								
	IMC-I109V	Envelope	Hepatitis B Virus (HBV)					✓ **Started Ph. 1 SAD 2Q 2021**	IMMUNOCORE
	IMC-M113V	Gag	Human Immunodeficiency Virus (HIV)					❖ **Submit IND or CTA in 2H 2021**	IMMUNOCORE Bill & Melinda Gates foundation[2]

[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 retain all development and commercialization rights in the developed world.

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Technology Platform

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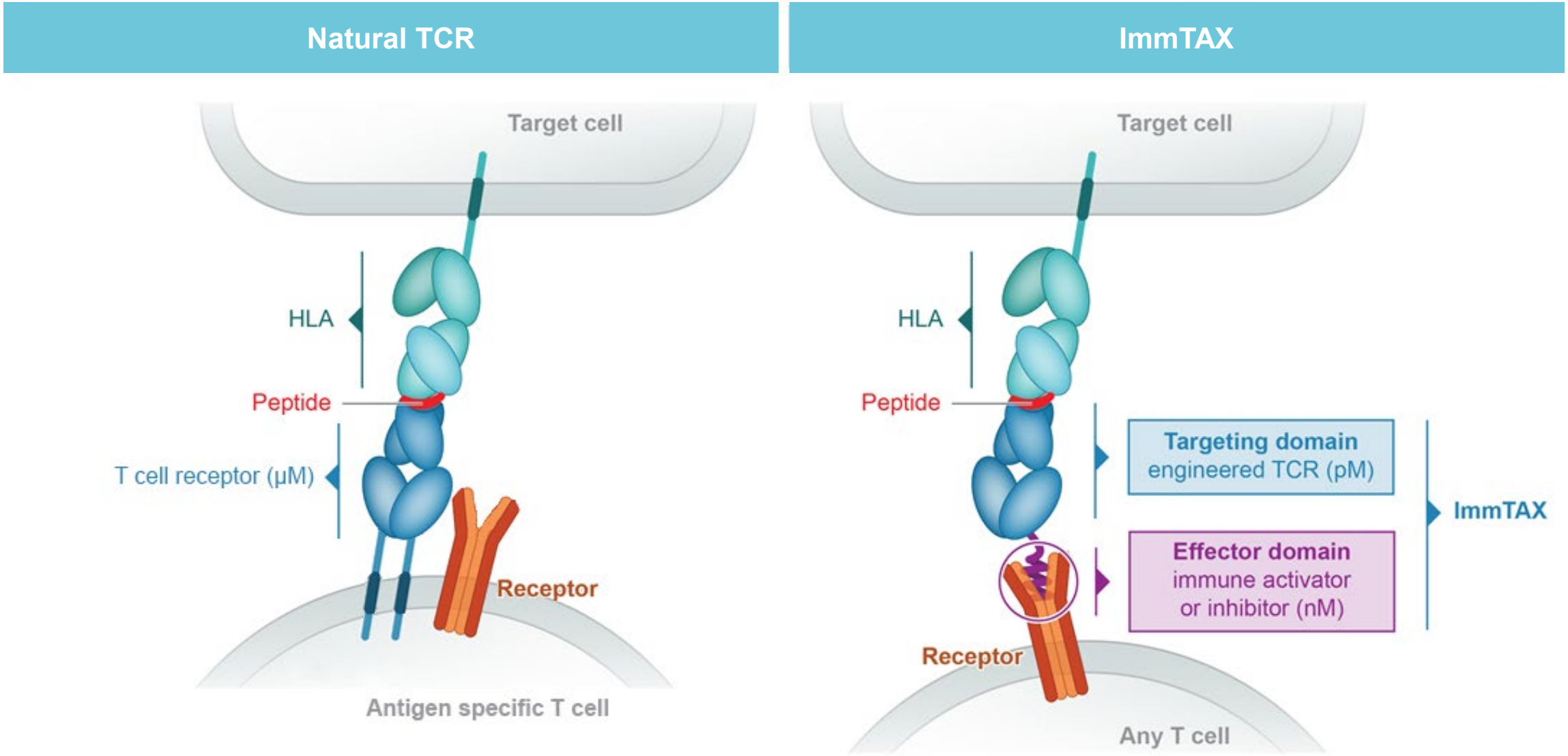
We pioneered converting membrane-bound T cell receptors

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



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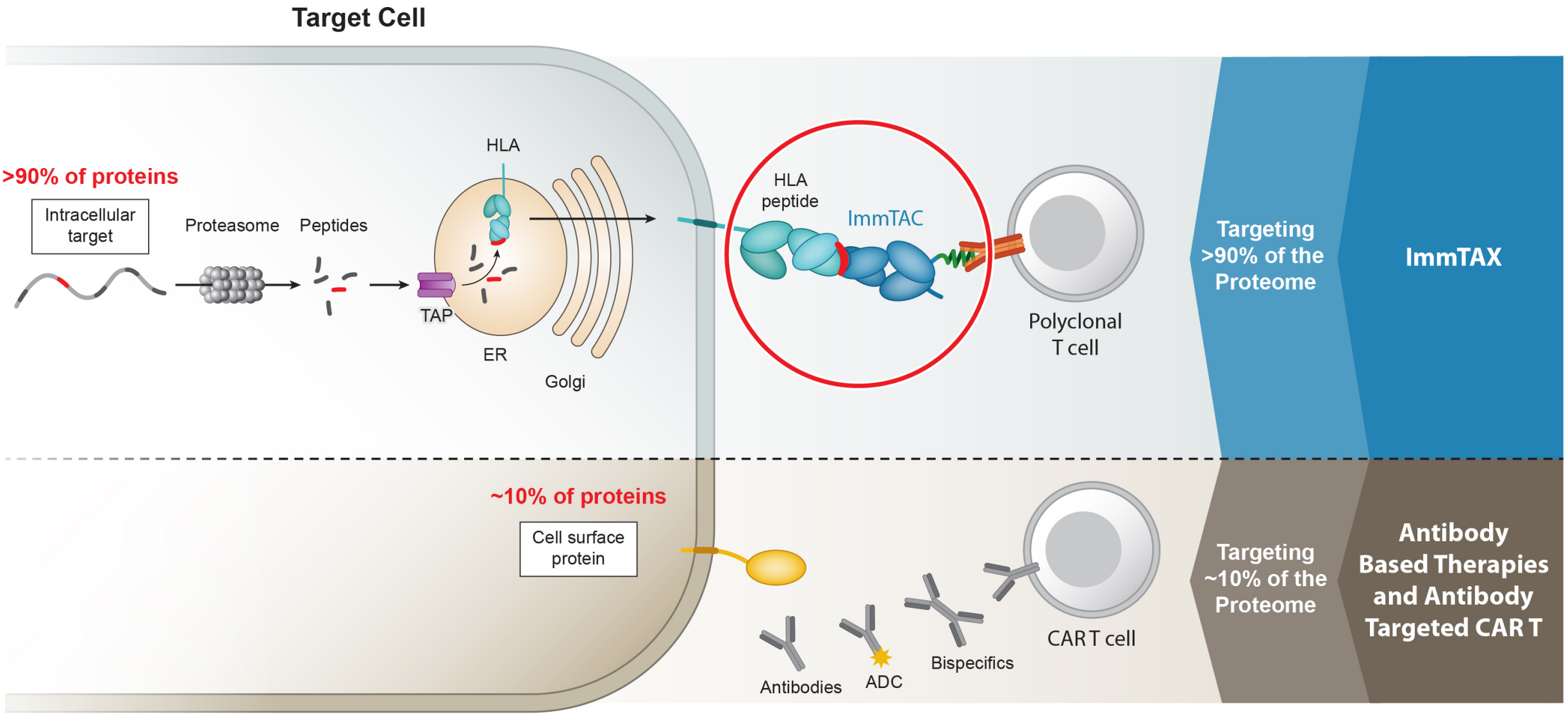
TCR therapeutics can target nearly the entire human proteome

Application to oncology, infectious disease and autoimmune



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Seamless suite of proprietary technologies spanning target discovery to clinic

1 ImmSPECT
Target identification platform

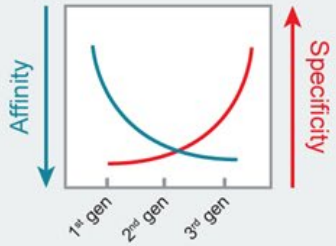
2 Dual TCR discovery platform
'Blind date' and T cell cloning

3 Unique TCR quality evaluation platform

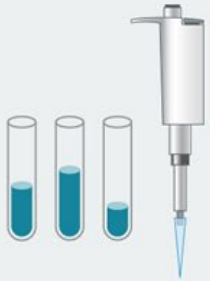
Large TCR crystallography database (>300 structures)

4 Proprietary TCR engineering

Million-fold stronger affinity while increasing specificity



5 Industry-leading tox platform
Proven for 5 clinical stage programs



- Fully *in vitro* systems
- De-risks TCR cross reactivity
- Evaluates potency, specificity and safety

6 Fully scaled manufacture

- *E. coli* based
- Successfully scaled
- Tebentafusp launch stocks manufactured
- >40 successful GMP batches across 5 clinical programs

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Tebentafusp in Metastatic Uveal Melanoma (UM)

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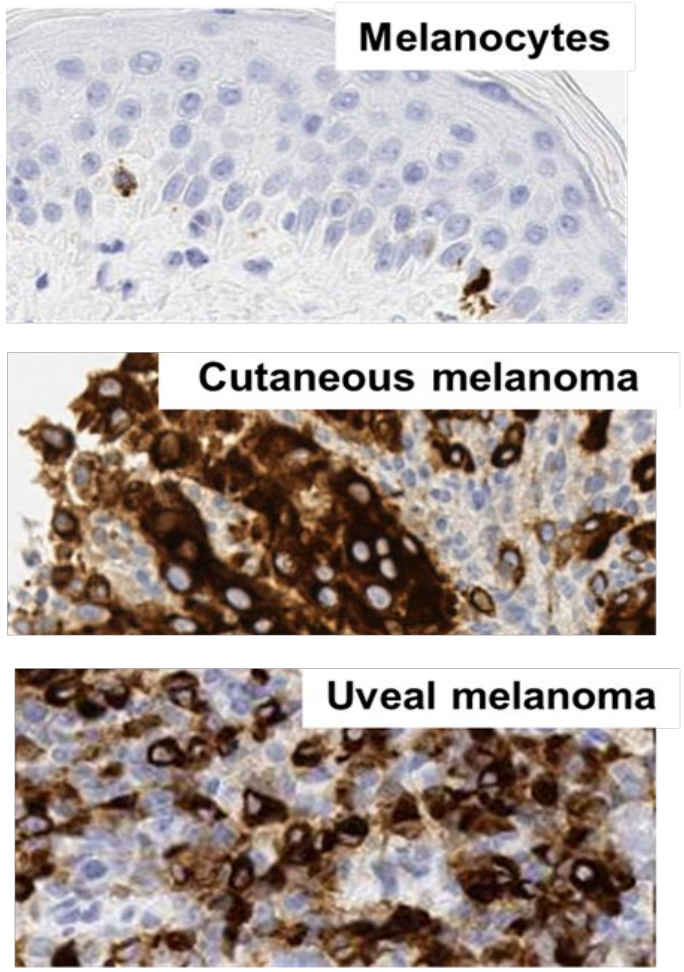
Tebentafusp (Tebe): First-in-class, off-the-shelf, bispecific TCR

Targeting gp100 protein in melanoma

gp100 protein



Three melanoma clinical trials

IMCgp100-01:

Ph 1 in uveal & cutaneous melanoma[1]

Endpoints: safety and activity

IMCgp100-102:

Ph 2 in uveal melanoma[2]

Second or third line in metastatic disease

Primary endpoint: RECIST ORR

IMCgp100-202:

Ph 3 pivotal in uveal melanoma[3]

First line metastatic

Primary endpoint: Overall Survival

The NEW ENGLAND JOURNAL of MEDICINE

1 Middleton, et. al. *Journal of Clinical Oncology* 2016 34:15_suppl, 3016-3016; 2 Sacco, et. al., *ESMO Immuno-Oncology Virtual Congress 2020.* ;
3 Piperno-Neumann, et. al. *AACR Annual Meeting 2021*

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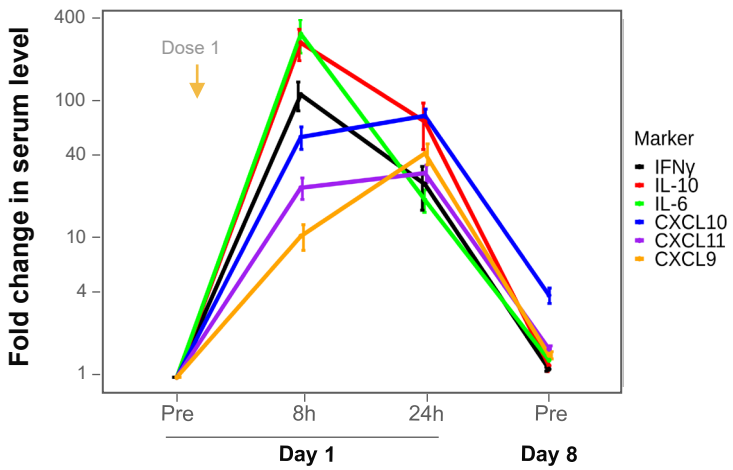
Tebe drives strong T cell infiltration into tumor

IMCgp100-102 study

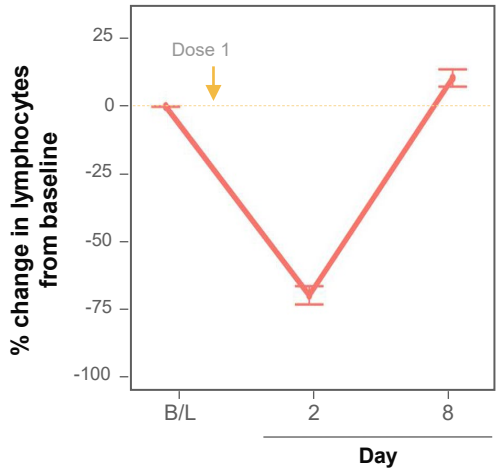
Cytokine induction

Peripheral blood

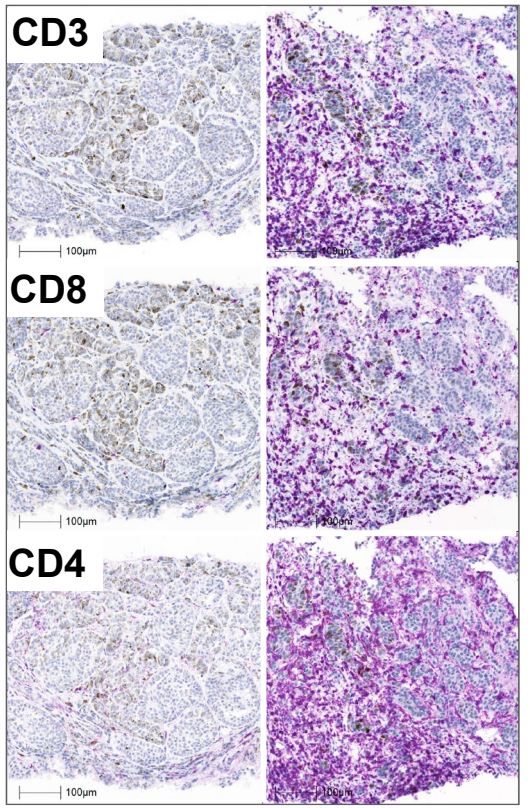


T cell trafficking

Peripheral blood



Tumor



68% any increase in CD3
avg 3.2-fold increase; p<0.001, N=57

Validates ImmTAC mechanism of action, including induction of cytokines and T-cell trafficking into the tumor

Uveal melanoma represents high hurdle for T cell engagers, liver metastases and immune-cold at baseline

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Randomized Ph 3 trial in previously untreated metastatic UM

IMCgp100-202 study

Metastatic UM:

- HLA-A*0201+
- No prior systemic therapy in the advanced setting
- No prior liver-directed therapy, except surgery
- Any LDH

378 patients Randomized 2:1

Stratification by LDH level
(>ULN vs ≤ULN)

Tebentafusp:

- 20 mcg Week 1
- 30 mcg Week 2
- 68 mcg Week 3+

Investigator's Choice (IC):

- Dacarbazine 1000 mg/m^2 Q3W — 6%
- Ipilimumab 3 mg/kg Q3W — 12%
- Pembrolizumab 2 mg/kg Q3W — 82%

Primary endpoint
Overall Survival (OS)

Data cut-off date: October 13, 2020; data snapshot date: January 22, 2021.
ITT, intent-to-treat; ORR, overall response rate; PFS, progression free survival.

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Most frequent related AEs consistent with proposed MoA

IMCgp100-202 study

Tebentafusp (n=245)		
Adverse Event (AE), related*	Any grade n (%)	Grade 3/4 n (%)†
Any	244 (99.6)¶	110 (45)**
Cytokine-mediated		
Cytokine release syndrome‡	217 (89)	2 (1)
Pyrexia	185 (76)	9 (4)
Chills	114 (47)	1 (0.4)
Nausea	105 (43)	2 (1)
Fatigue	101 (41)	7 (3)
Hypotension	93 (38)	8 (3)
Vomiting	64 (26)	1 (0.4)
Headache	53 (22)	1 (0.4)
Skin-related		
Rash§	203 (83)	45 (18)
Pruritus	169 (69)	11 (5)
Dry skin	72 (29)	0
Erythema	56 (23)	0

IC (n=111)		
AE, related	Any grade n (%)	Grade 3/4 n (%)
Any	91 (82)	19 (17)
Fatigue	29 (26)	1 (1)
Rash	27 (24)	0
Pruritus	23 (21)	0

- AEs consistent with tebentafusp's proposed mechanism of action
- Majority of AEs occur in first few weeks
- AEs generally manageable; low related discontinuation rate for tebentafusp (2%) vs. IC (4.5%)
- No tebentafusp-related deaths as assessed by the investigators

*Table summarizes treatment related AEs that are present at least 20% any grade; †Other (2-4%) severe AEs in tebentafusp arm include AST, ALT, lipase, lymphopenia, hyperbilirubinemia, hypophosphatemia, hypertension;
¶Includes 1 patient with no related AEs (per Investigator) but with sponsor-adjudicated CRS; **Includes 1 patient with related AEs Grade <3 (per Investigator) but with sponsor-adjudicated Grade 3 CRS;
‡Cytokine release syndrome was adjudicated by sponsor according to ASTCT Consensus Grading for CRS (Lee et al. 2019); §Rash is a composite term for a list of skin toxicities of any grade. AE, adverse event

Piperno-Neumann, et. al. *AACR Annual Meeting 2021*

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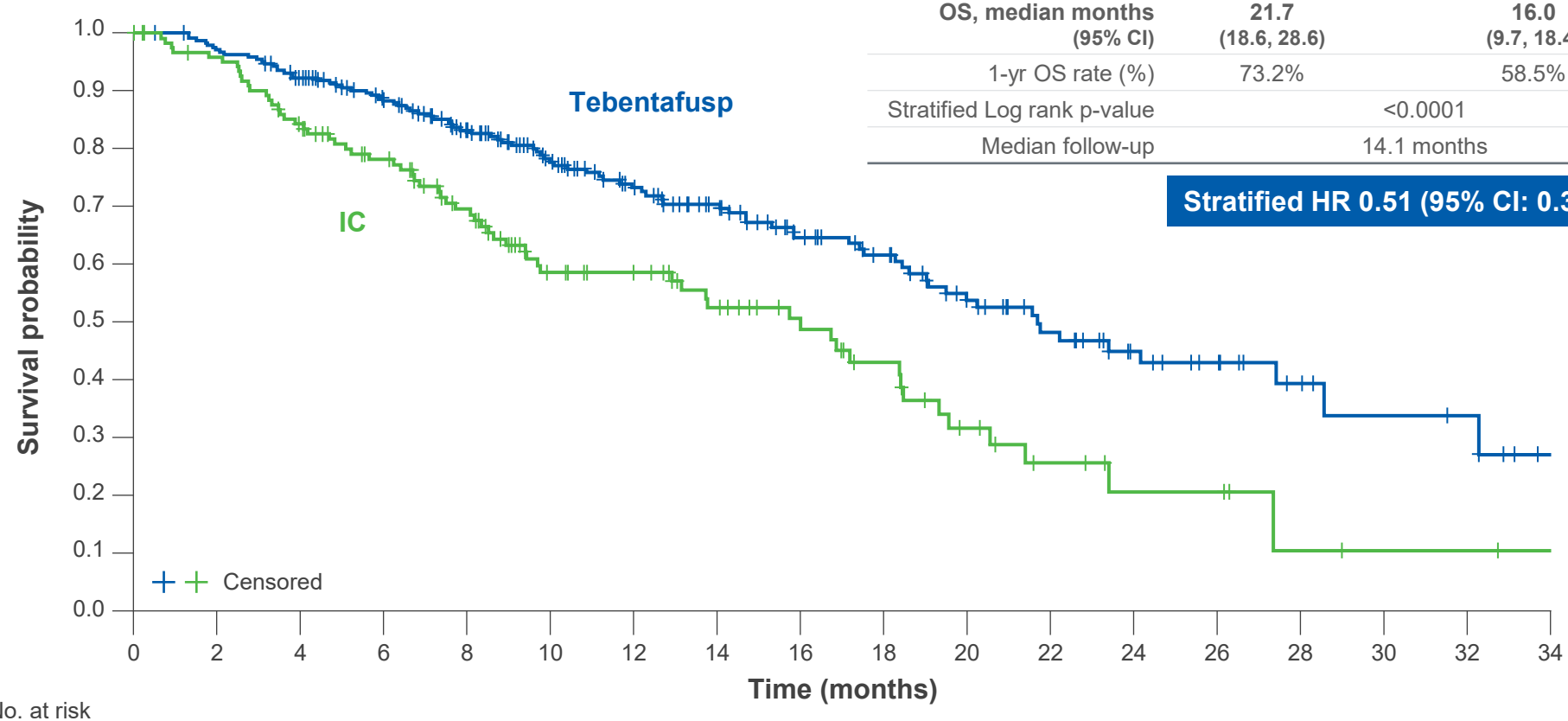
Primary Endpoint: Overall Survival (OS) statistically significant

Tebentafusp granted Breakthrough Therapy Designation by FDA

IMCgp100-202 study

	Tebentafusp	IC
OS, median months (95% CI)	21.7 (18.6, 28.6)	16.0 (9.7, 18.4)
1-yr OS rate (%)	73.2%	58.5%
Stratified Log rank p-value	<0.0001	
Median follow-up	14.1 months	

Stratified HR 0.51 (95% CI: 0.37, 0.71)



No. at risk

Tebentafusp	252	242	221	197	167	132	109	90	71	59	44	33	22	17	9	6	5	0
IC	126	116	100	86	69	48	43	34	27	20	12	7	4	4	1	1	1	0

HR, hazard ratio.

Piperno-Neumann, et. al. *AACR Annual Meeting 2021*

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Numerically higher ORR and Disease Control Rate (DCR)

IMCgp100-202 study

Best response to systemic therapy	**Tebentafusp** (n=252) n (%)	**IC** (n=126) n (%)
Overall Response Rate (ORR)*	**23 (9)**	**6 (5)**
Complete Response (CR)	1 (0.4)	0
Partial Response (PR)	22 (9)	6 (5)
Median duration of response (months)	9.9	9.7
Stable Disease (SD)	92 (37)	28 (22)
Progressive Disease (PD)	131 (52)	78 (62)
Non-evaluable/not applicable	6 (2)	10 (8)
Disease Control Rate ≥12 wks†	**115 (46)**	**34 (27)**

* Defined as CR or PR †Defined as CR, PR or SD for ≥12 weeks.

Piperno-Neumann, et. al. *AACR Annual Meeting 2021*

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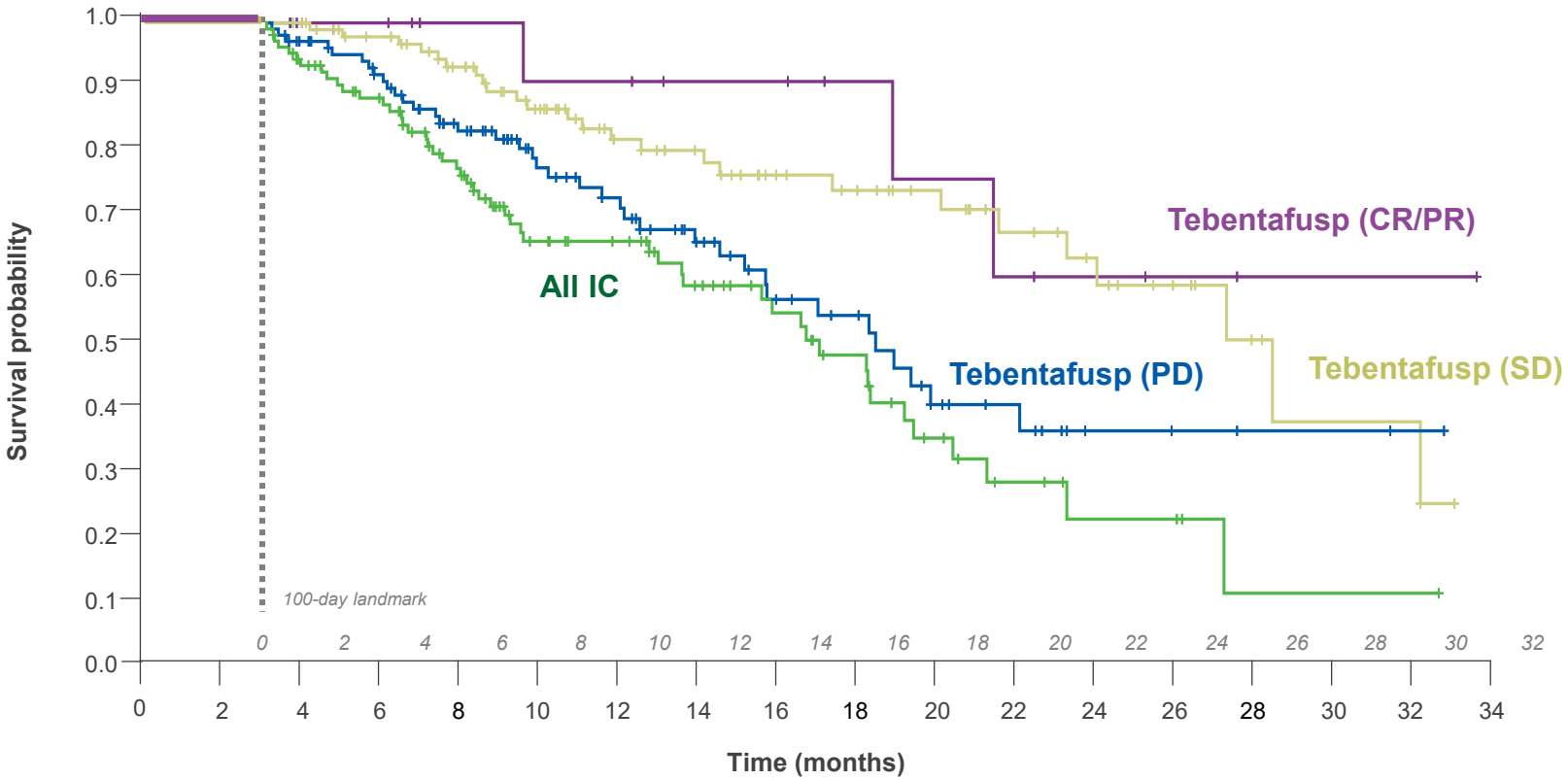
OS in tebentafusp arm by best response relative to IC arm

Landmark OS analysis beginning at Day 100

IMCgp100-202 study



Tebentafusp (CR/PR)	15	14	11	11	10	8	8	7	5	5	3	3	2	1	1	1	0
Tebentafusp (SD)	101	89	82	67	53	45	37	32	26	21	17	12	7	3	3	0	
Tebentafusp (PD)	105	92	78	62	47	38	29	22	17	11	6	4	3	2	2	0	
IC	107	89	76	54	44	36	29	20	15	9	6	4	2	1	1	0	

CR, Complete Response; PR, Partial Response; PD, Progressive Disease; SD, Stable Disease.

Tebentafusp patients with any RECIST response, including progressive disease, had survival curves trending above IC arm

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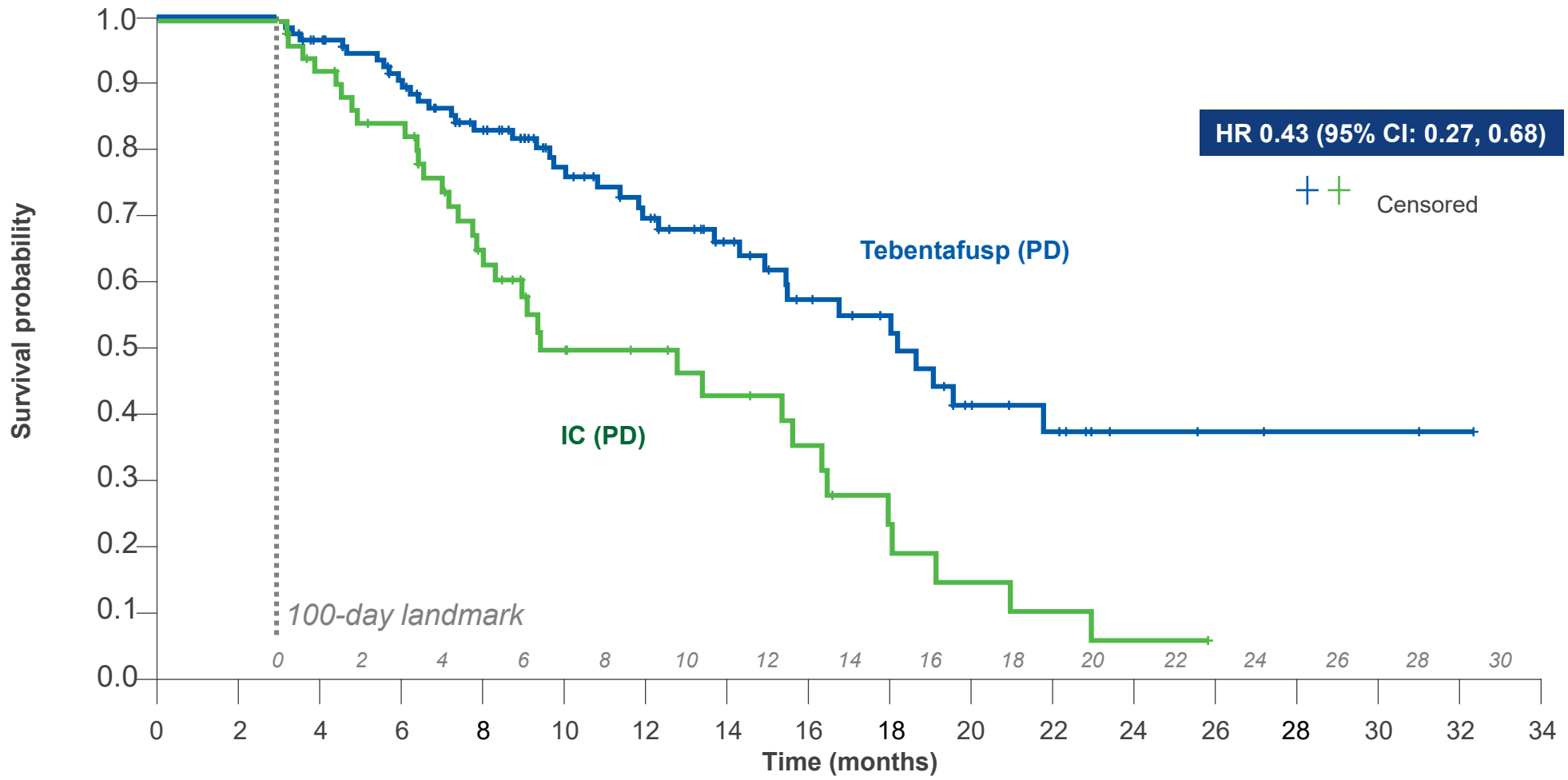
OS in patients with best response of Progressive Disease

Landmark OS analysis beginning at Day 100

IMCgp100-202 study



Tebentafusp (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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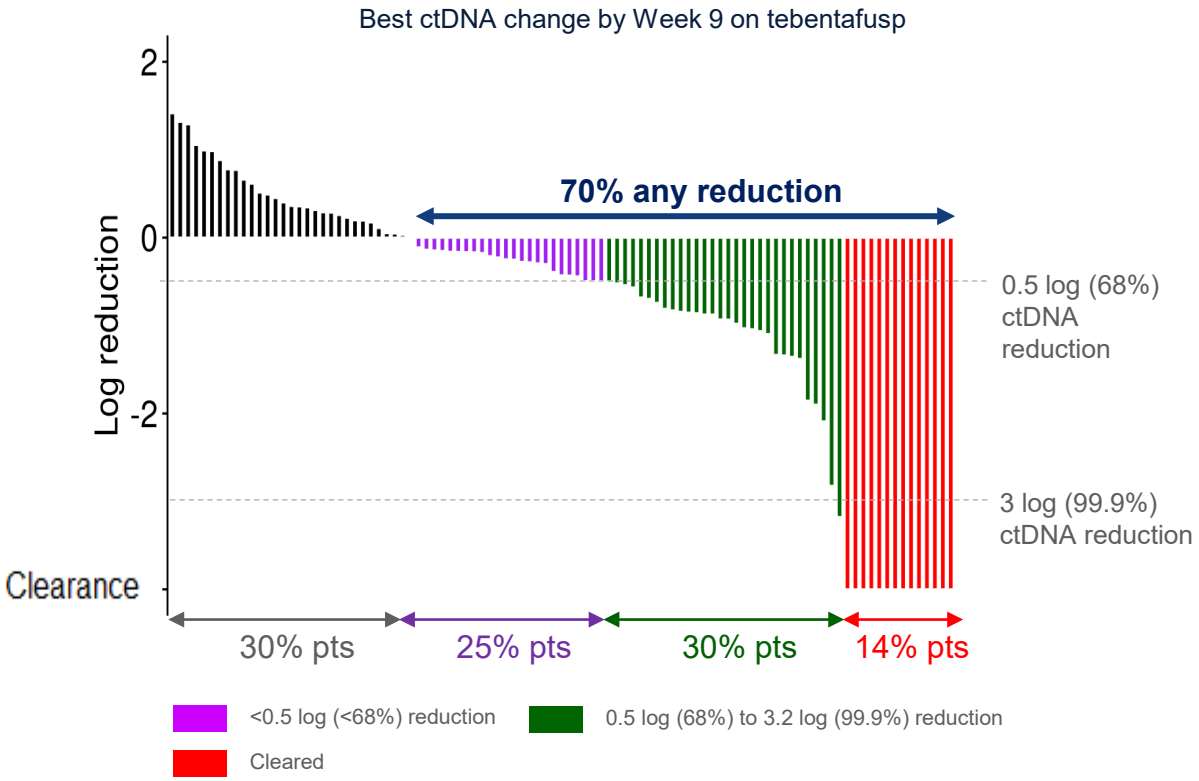
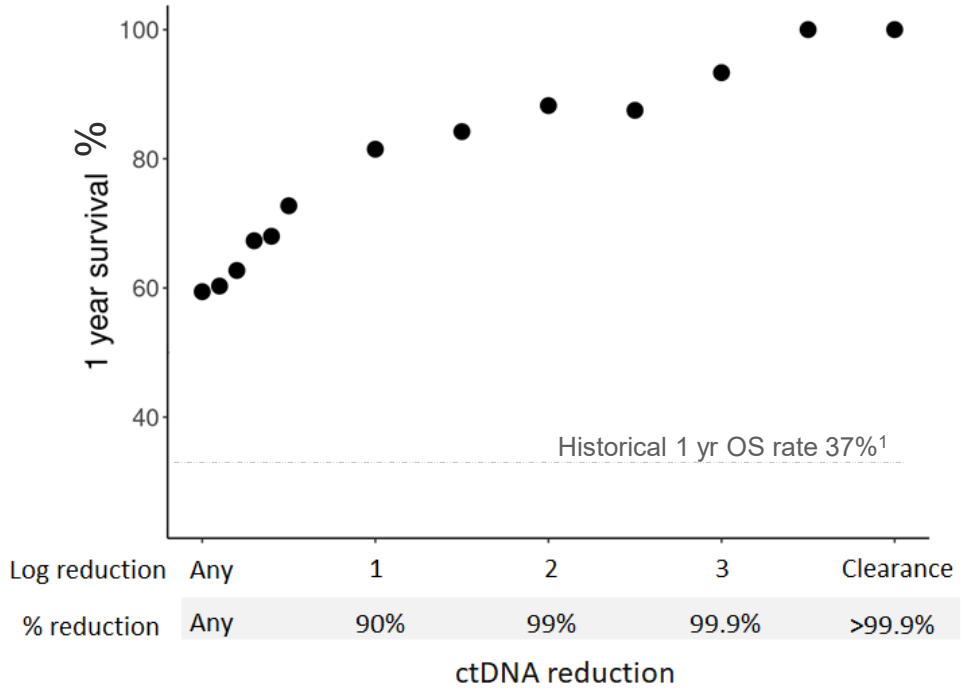
Circulating tumor (ctDNA) better surrogate of OS than RECIST

IMCgp100-102 study

70% evaluable patients had any ctDNA reduction



ctDNA reduction correlates with 1 year OS



ctDNA = circulating tumor DNA

[1] Rantala et al.

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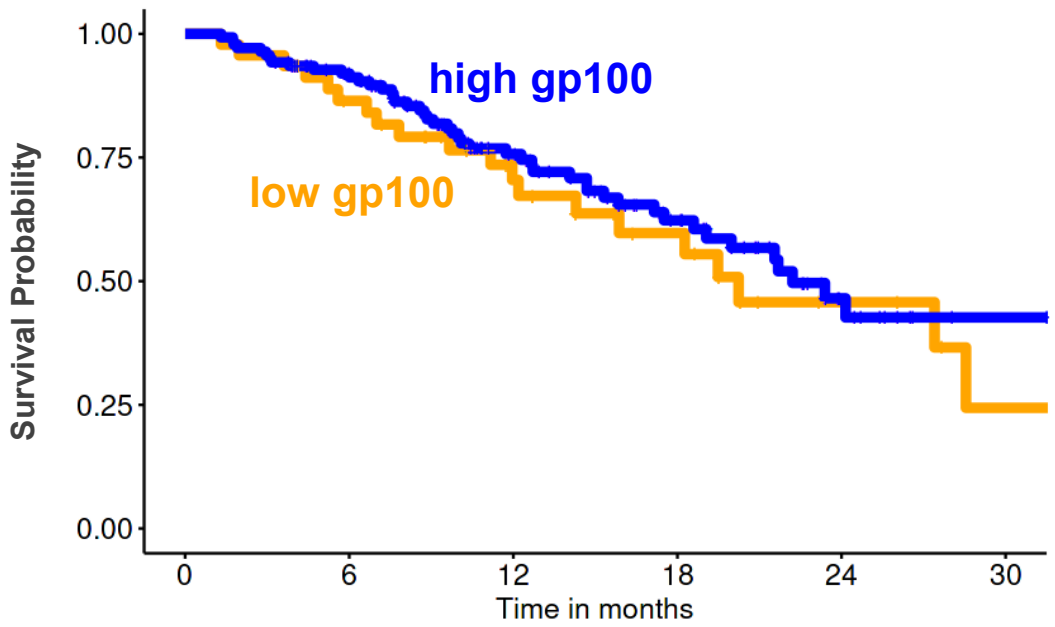
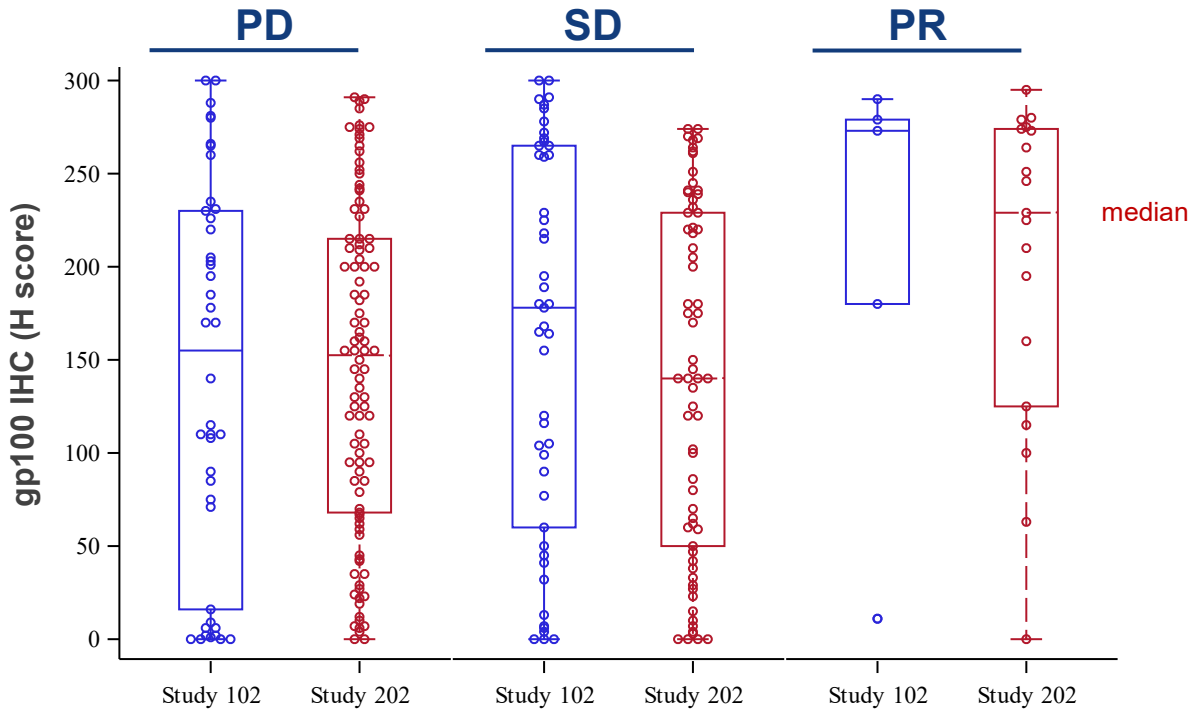
Tebentafusp OS benefit for high and low gp100 expression

Tebentafusp OS similar between high and low gp100 expression
(Study 202)



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

Most RECIST PRs at higher gp100



PD, Progressive Disease; SD, Stable Disease; PR, Partial Response.
H score: intensity X expression

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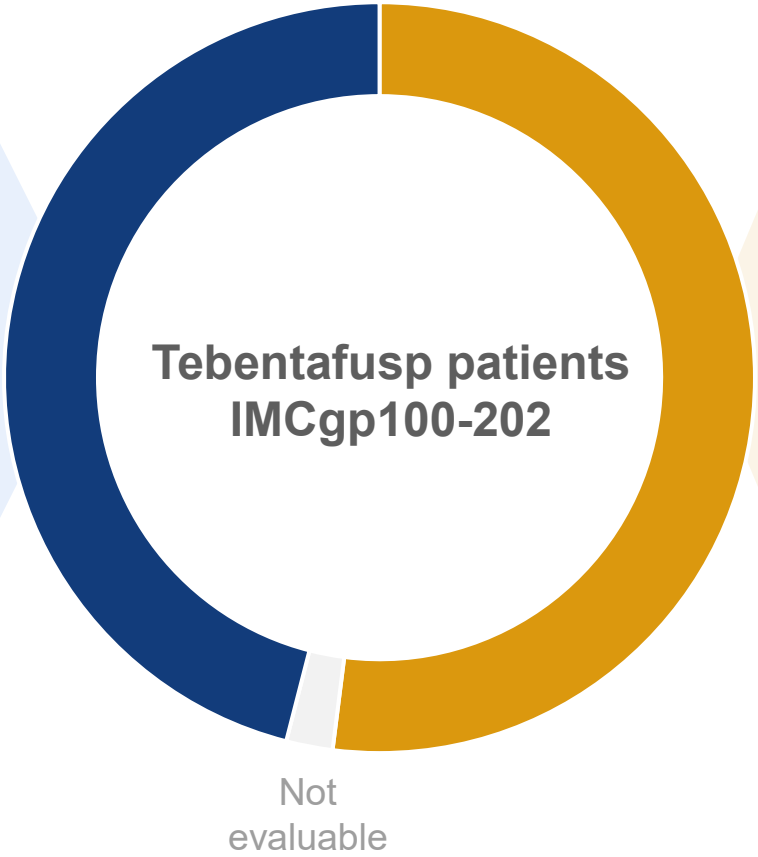
Tebe Monotherapy Overall Survival (OS) benefit with Hazard Ratio = 0.51

Best response PR + SD

46% vs 27%
Higher disease control rate vs. IC

0.73 HR
Progression Free Survival



Best response of PD

0.43 HR
Overall Survival

> 1/3*
ctDNA reduction and long OS

* IMCgp100-102

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Monotherapy overall survival (OS) in mUM benefit validates platform

First positive Phase 3 for a TCR

- Benefit across all RECIST categories of response
- ctDNA suggests majority patients responding
- OS benefit across all gp100 expression levels
- Durability of responses

Consistent signals across Phase 1, 2 and 3

- AE profile manageable and consistent with proposed mechanism of action
- Biomarkers consistent with T cell re-direction into tumor
- OS consistently best endpoint; early surrogates include tumor shrinkage, ctDNA, durable responses

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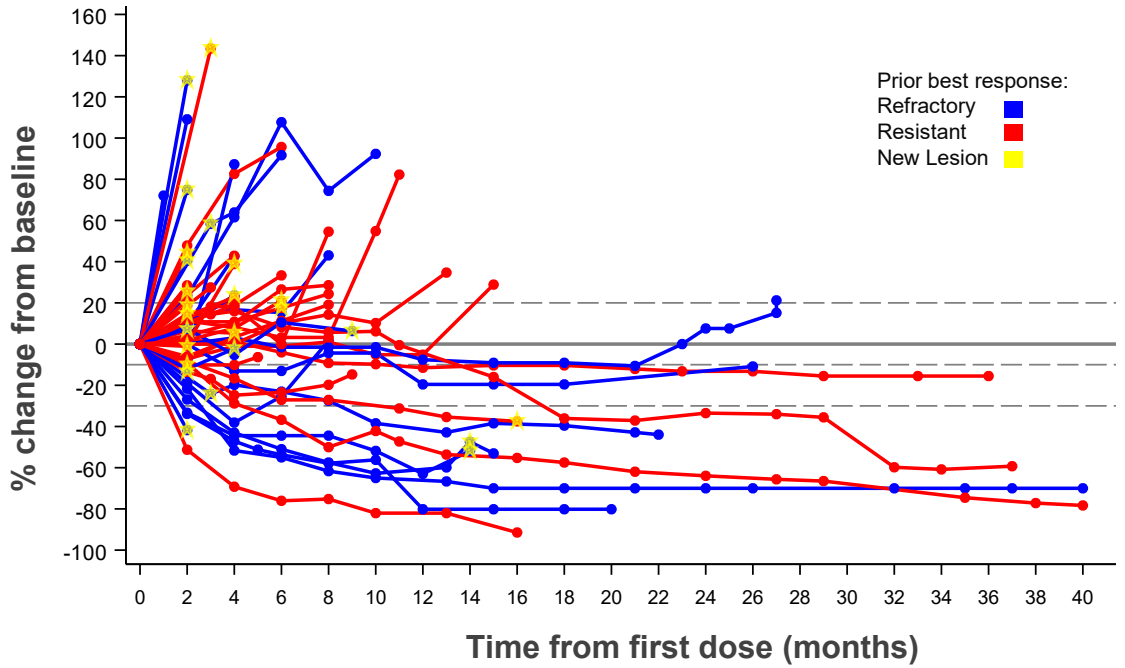
Tebentafusp active in cutaneous melanoma

IMCgp100-01 and -201 study

Durable tumor shrinkage in patients who progressed on prior anti-PD(L)1

tebentafusp + durvalumab*



*Study IMCgp100-201: 57 patients in this study received any dose of durvalumab and had a documented best overall response to prior anti-PD(L)1 therapy. Of these 57 patients, 31 received tebentafusp + durvalumab and 26 received tebentafusp + durvalumab + tremelimumab.

Best response to prior anti-PD(L)1: Resistant = best response CR/PR/SD to prior PD(L)1; Refractory = best response of PD to prior anti-PD(L)1

1-yr OS

74%, anti-PD(L)1 naïve

tebentafusp monotherapy^

76%, prior anti-PD(L)1

tebentafusp + durvalumab†

^ Study IMCgp100-01, n= 49

† Study IMCgp100-201, 61 patients received prior anti-PD(L)1 and who received tebentafusp with any dose of durvalumab on this study. Of these 61, 57% patients received tebentafusp + durvalumab and 43% received tebentafusp + durvalumab + tremelimumab.

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Next generation oncology targets

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Beyond UM: Harnessing the power of TCRs

Universe of TCR targets

Lineage antigens
gp100(tebe)

Cancer-testes antigens
MAGE-4, PRAME

Neoantigens
oncogenes

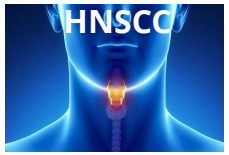
Viral antigens
HBV

Universal targets
HLA-E

Beyond metastatic UM

CPI-insensitive tumors

CPI-sensitive tumors



Adjuvant indication

CPI: checkpoint inhibitor

Rational combinations

Checkpoint inhibitors (CPI)

Multiple ImmTACs

Standard of care therapies, including chemotherapy, targeted therapy and other IO

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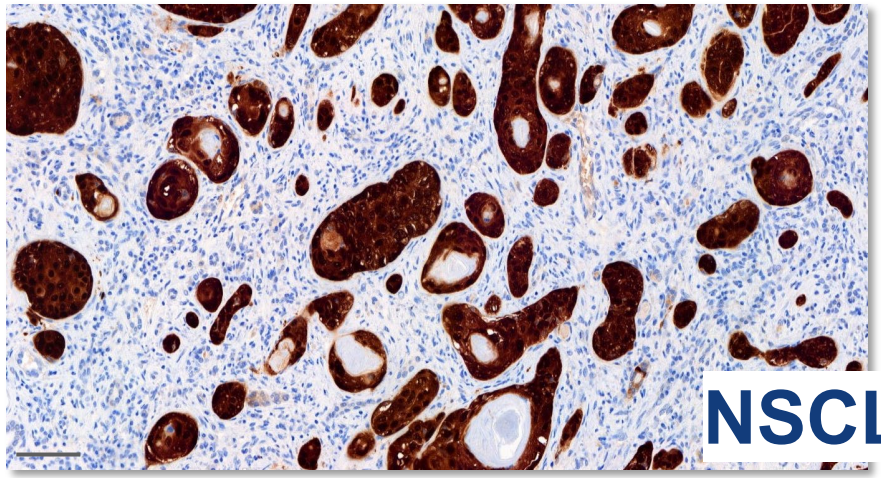
IMC-C103C: Targeting MAGE-A4 has potential in multiple tumor types

Only clinical off-the-shelf candidate against MAGE-A4

- IMC-C103C targets clinically-validated peptide
- 39 patients enrolled* in Phase 1
- PD data indicates at biologically active dose
- **Initial Phase 1 study data expected Q4 2021**



Est. annual net addressable population

		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

Potential for > 75,000 patients / annum in G7 countries

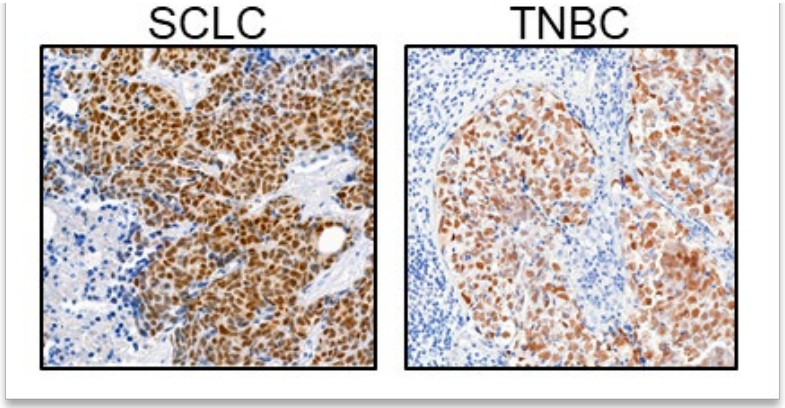
*As of June 30, 2021

IMMUNOCORE

IMC-F106C: PRAME is largest cancer-testes antigen opportunity

First off-the-shelf therapeutic against PRAME

- IMC-F106C targets PRAME, a negative prognostic marker in many tumors
- 23 patients enrolled* in Phase 1 study
- PD data indicates at biologically active dose
- **Initial Phase 1 study data expected mid-2022**



Est. annual net addressable population

		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

Potential for >150,000 patients/ annum in G7 countries

*As of June 30, 2021

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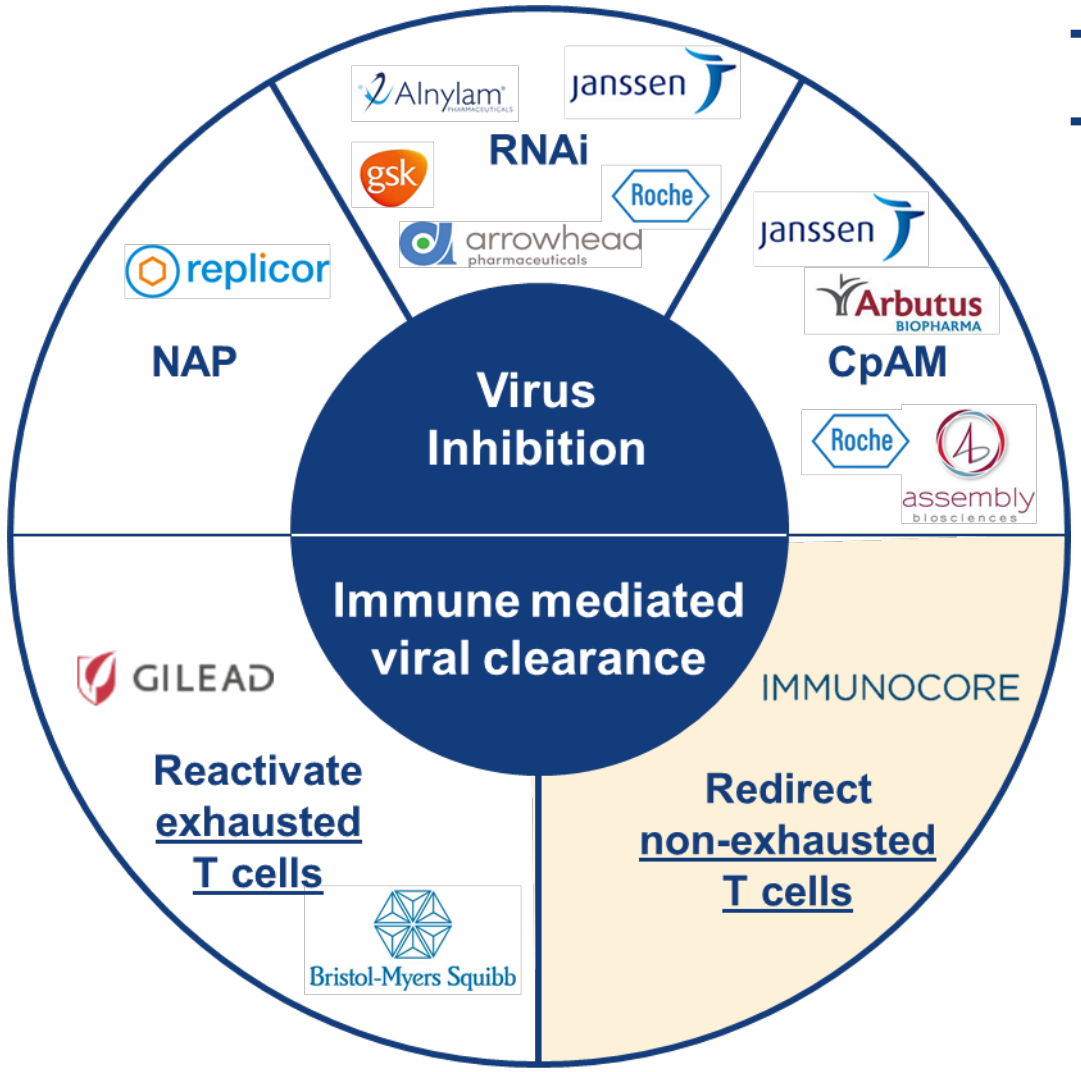
HBV

IMMUNOCORE

Our approach is unique in redirecting non-exhausted, non-HBV specific T cells



Key advantages of redirecting non-exhausted T cells

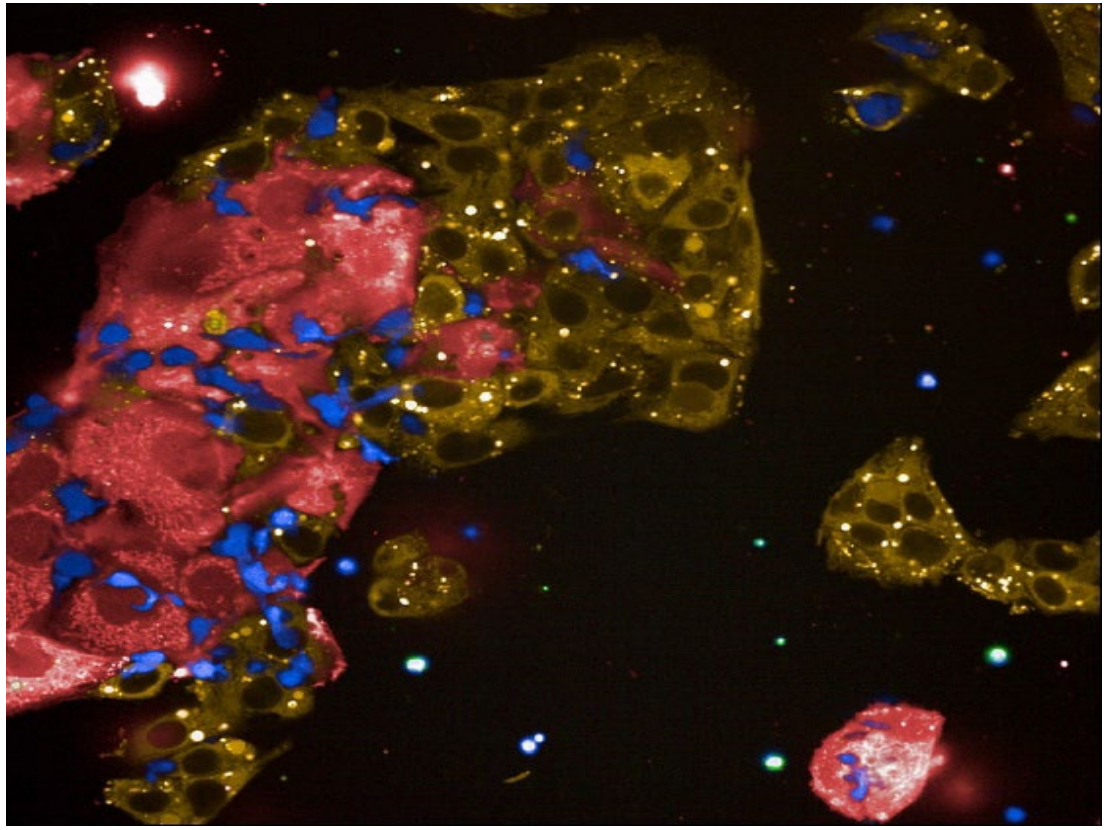
- Same CD3 MoA validated in oncology
- Independent of natural T cell reactivity to Hep B
- Goal is functional cure with finite treatment

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

IMMUNOCORE

Highly specific killing of cells with integrated HBV DNA

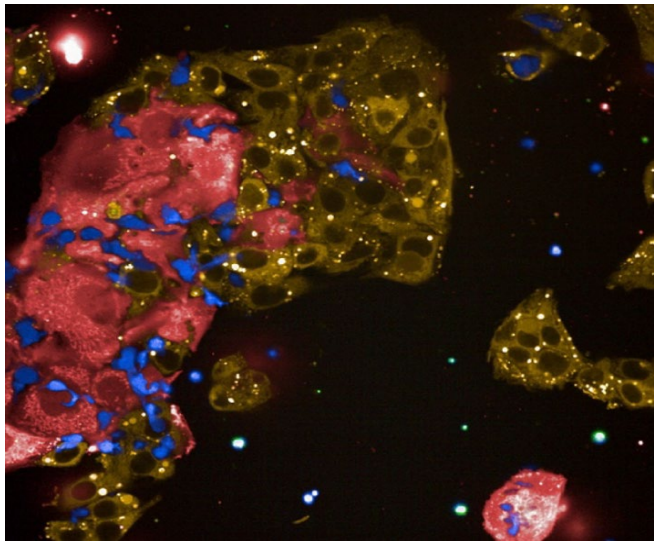


HBV+ cells

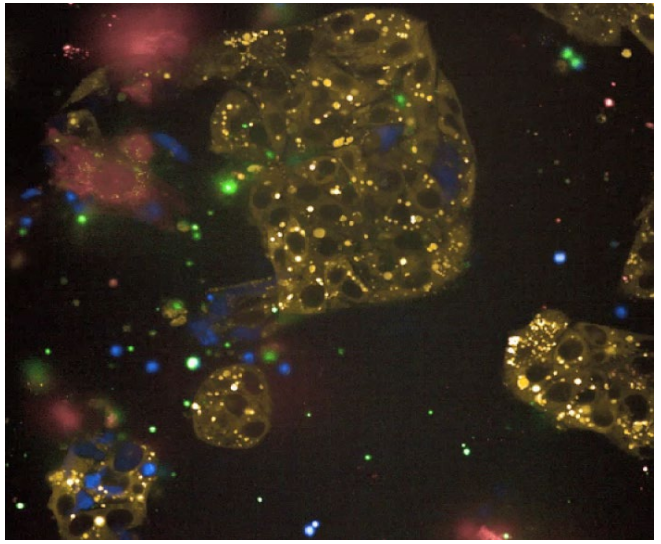
HBV- cells

T cells

Cell death



Co-incubation (start)



HBV+ cell death (end)

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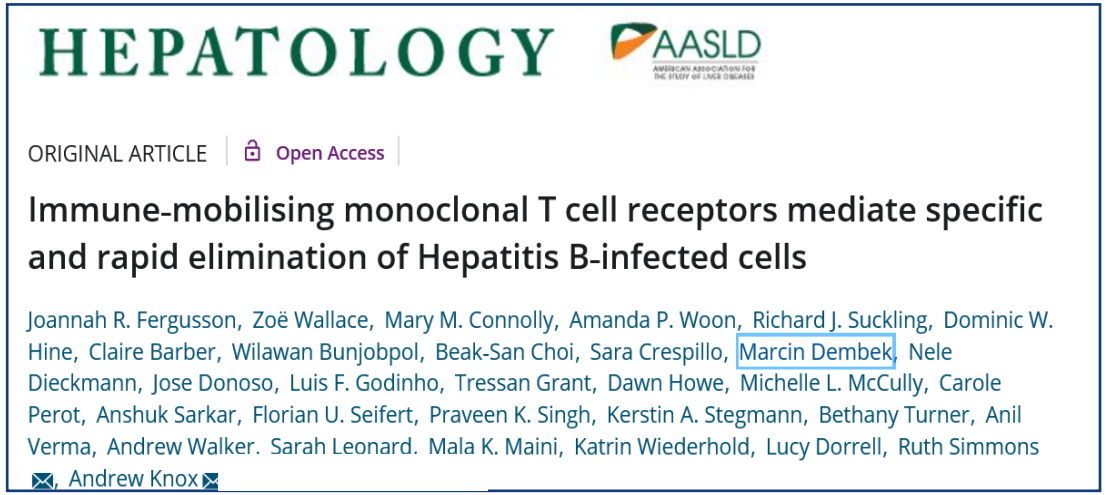
IMC-I109V (Envelope specific ImmTAV) – patient screening initiated

Recently published…



HEPATOLOGY AASLD

ORIGINAL ARTICLE | Open Access

Immune-mobilising monoclonal T cell receptors mediate specific and rapid elimination of Hepatitis B-infected cells

Joannah R. Fergusson, Zoë Wallace, Mary M. Connolly, Amanda P. Woon, Richard J. Suckling, Dominic W. Hine, Claire Barber, Wilawan Bunjobpol, Beak-San Choi, Sara Crespillo, Marcin Dembek, Nele Dieckmann, Jose Donoso, Luis F. Godinho, Tressan Grant, Dawn Howe, Michelle L. McCully, Carole Perot, Anshuk Sarkar, Florian U. Seifert, Praveen K. Singh, Kerstin A. Stegmann, Bethany Turner, Anil Verma, Andrew Walker. Sarah Leonard. Mala K. Maini, Katrin Wiederhold, Lucy Dorrell, Ruth Simmons ✉, Andrew Knox ✉

… with accompanying editorial

HEPATOLOGY AASLD

EDITORIAL

ImmTAV, a new Immunotherapy targeting the source of HBV infection

Antonio Bertoletti ✉

First published: 31 August 2020 | https://doi.org/10.1002/hep.31527

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi:10.1002/hep.31527

First-in-human trial

- Eligibility: HLA-A*02:0+ patients with Chronic HBV who are non-cirrhotic, hepatitis B antigen-negative, and virally suppressed
- **Part 1: Single ascending dose for safety**
  - ✓ First patient dosed 2Q 2021
- Part 2 – Multiple ascending dose to identify well tolerated but efficacious regimen

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Highlighted Discovery Programs

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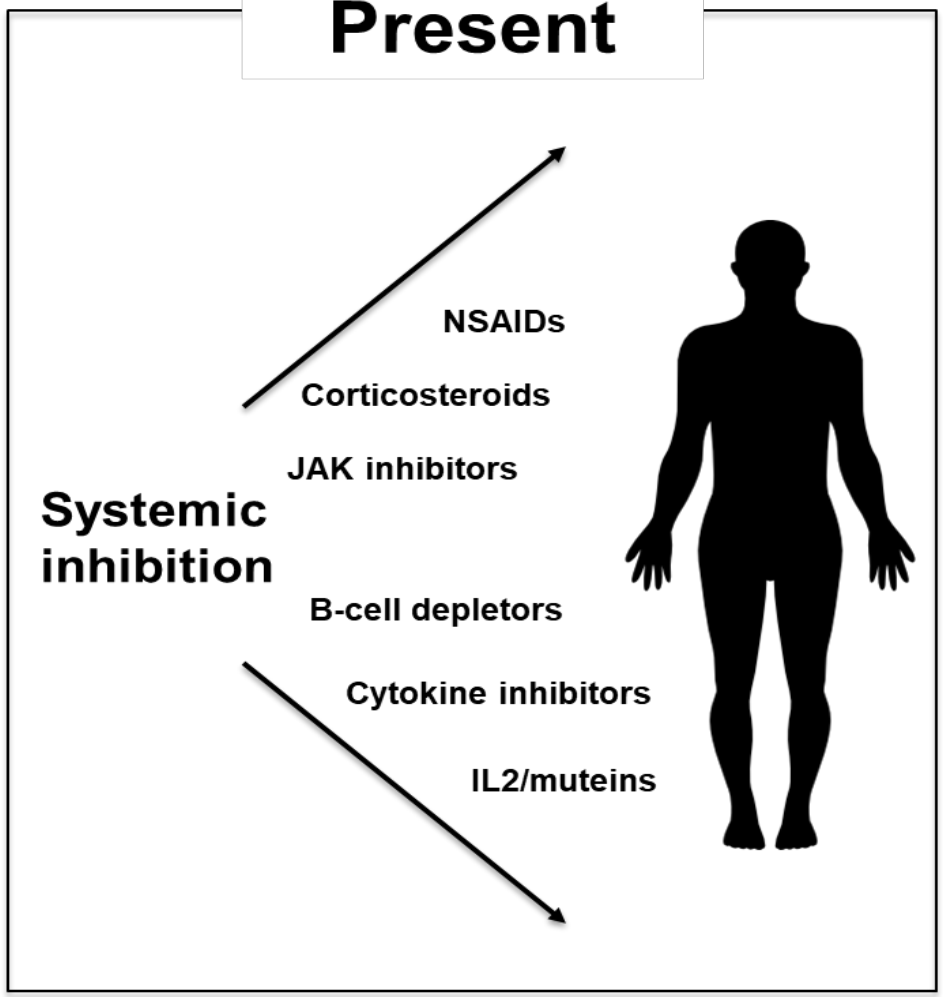
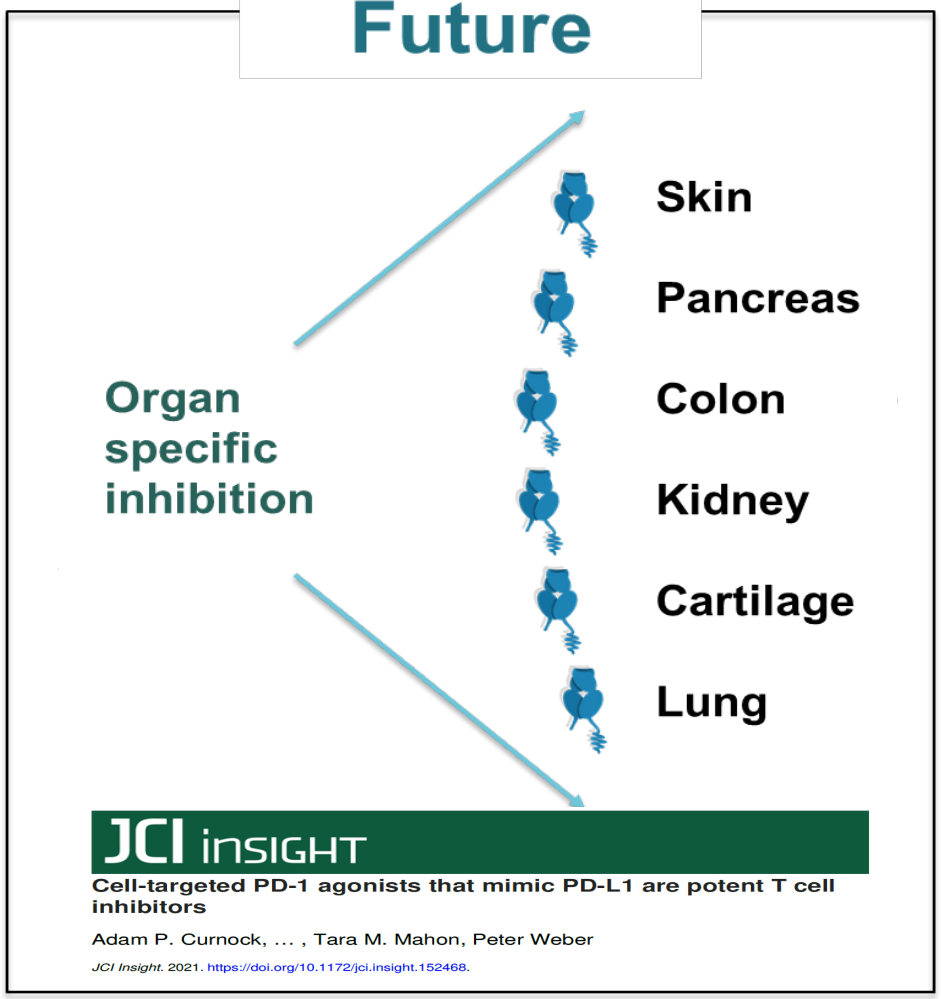
Autoimmune Program: organ-specific immune modulation to minimize toxicity

Unique approach of turning off T cells by activating PD1

Present



Future



1 Juvenile Diabetes Research Foundation which is conducting Type 1 diabetes research

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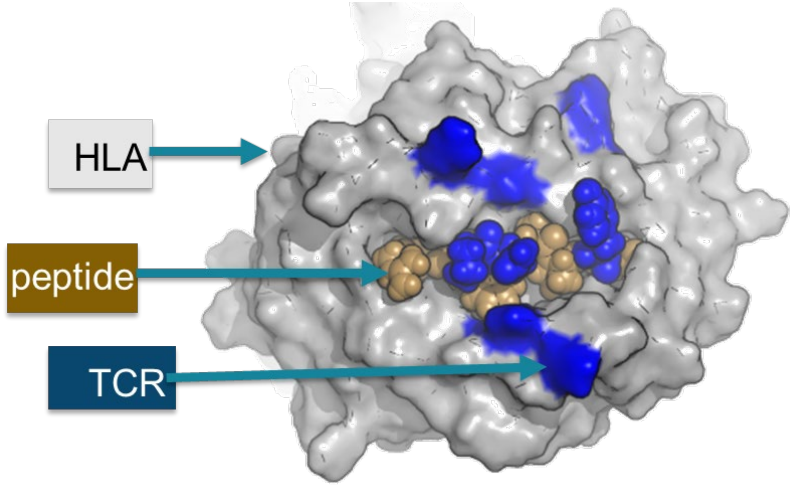
Universal TCRs: single off-the-shelf TCR therapeutic for all patients

Problem for TCR field



- Classical HLA are highly polymorphic
- Most common in West is HLA-A02
- **TCRs restricted to specific HLA types**

HLA-E is one potential solution

- Normally presents peptides derived from classical HLA – **under stress, present pathogen or alternative self peptides**
- **No polymorphism at TCR interface** – single TCR therapeutic feasible
- HLA-E broadly expressed in multiple tumors – role as **checkpoint for NK cells**

We created tool kit to develop universal TCR

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Upcoming Milestones & Financial Strategy

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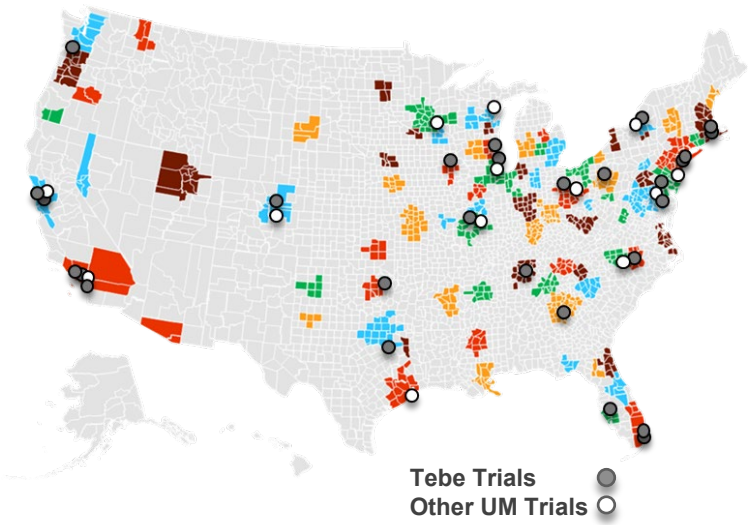
Market potential for tebentafusp in metastatic uveal melanoma

Majority of patients treated by low number of specialists



High awareness of tebentafusp among UM KOLs

Compelling value proposition

- No current standard of care
- High unmet medical need
- Unprecedented Phase 3 data

Investigational drug not yet approved in any jurisdiction

Initial addressable population >1,000 patients / annum

>5k patients / annum (US and EU28)

Up to 50% metastasize

47% HLA-A*02:01

>1,000 patients / annum US and initial priority European markets

IMMUNOCORE

Potential inflection points & milestones

1H2021	2H2021	1H2022	2H2022

Oncology

Tebentafusp BLA Submission ✓

- ✓ Breakthrough Therapy Designation | 1Q
- ✓ Phase 3 AACR Data Presentation | 2Q
- ✓ EMA's accelerated assessment procedure | 2Q
- ✓ FDA's RTOR & Project Orbis initiative | 2Q
- ✓ EMA's CHMP accepted MAA | 3Q
- ✓ MHRA accepted MAA | 3Q

Potential Tebentafusp Commercial Launch

- PDUFA targeted Feb. 23, 2022

MAGE A4 Ph1 Initial data

PRAME Ph1 Initial data

Infectious Diseases

HBV Ph1 SAD start ✓

HIV CTA or IND

Approximately $346M cash position as of Q3 2021

IMMUNOCORE

Immunocore is the most advanced TCR company

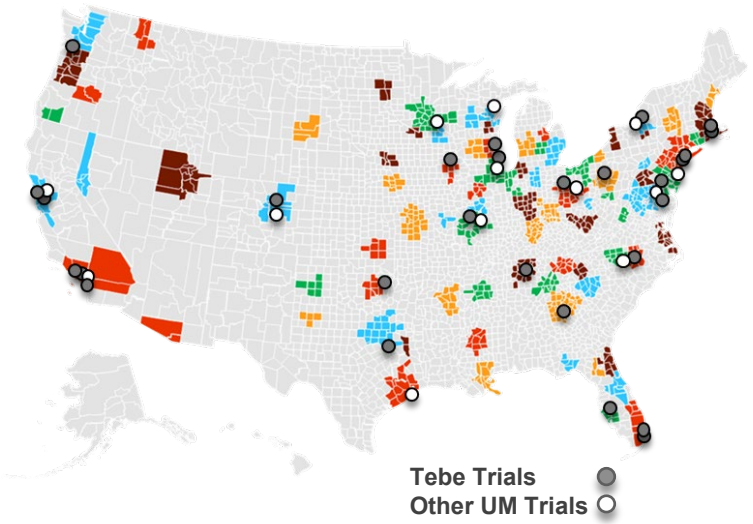
- First **clinically validated** TCR platform with survival benefit
- 5 clinical-stage programs with tebentafusp **BLA/MAA** submitted
- Pipeline with potential in **multiple indications / therapeutic areas**
- Multiple **value inflection points** over the next 12 months
- Solid fundamentals; **cash runway projected into mid-2023 (pre-revenue)**

IMMUNOCORE

IMMUNOCORE

Market potential for tebentafusp in metastatic uveal melanoma

Majority of patients treated by low number of specialists



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IMMUNOCORE

Baseline characteristics generally well balanced

IMCgp100-202 study

Characteristic	Tebentafusp n=252	IC n=126
Age — median yr (range)	64 (23–92)	66 (25–88)
Gender, male — n (%)	128 (51)	62 (49)
Time since primary diagnosis — median yr (range)	3.0 (0.1–25)	2.4 (0.1–36)
ECOG status* — n (%)		
0	192 (76)	85 (68)
1	49 (19)	31 (25)
Elevated LDH level (>ULN) — n (%)	90 (36)	46 (37)
Largest metastatic lesion — n (%)		
M1a (≤3.0 cm)	139 (55)	70 (56)
M1b (3.1–8.0 cm)	92 (37)	46 (37)
M1c (≥8.1 cm)	21 (8)	10 (8)
Metastasis location† — n (%)		
Hepatic only	131 (52)	59 (47)
Extrahepatic only	9 (4)	10 (8)
Hepatic & extrahepatic	111 (44)	55 (44)

*One patient had ECOG status of 2 (IC); 20 patients had missing ECOG status (11 tebentafusp; 9 IC); †Three patients had missing metastasis location (1 tebentafusp; 2 IC).

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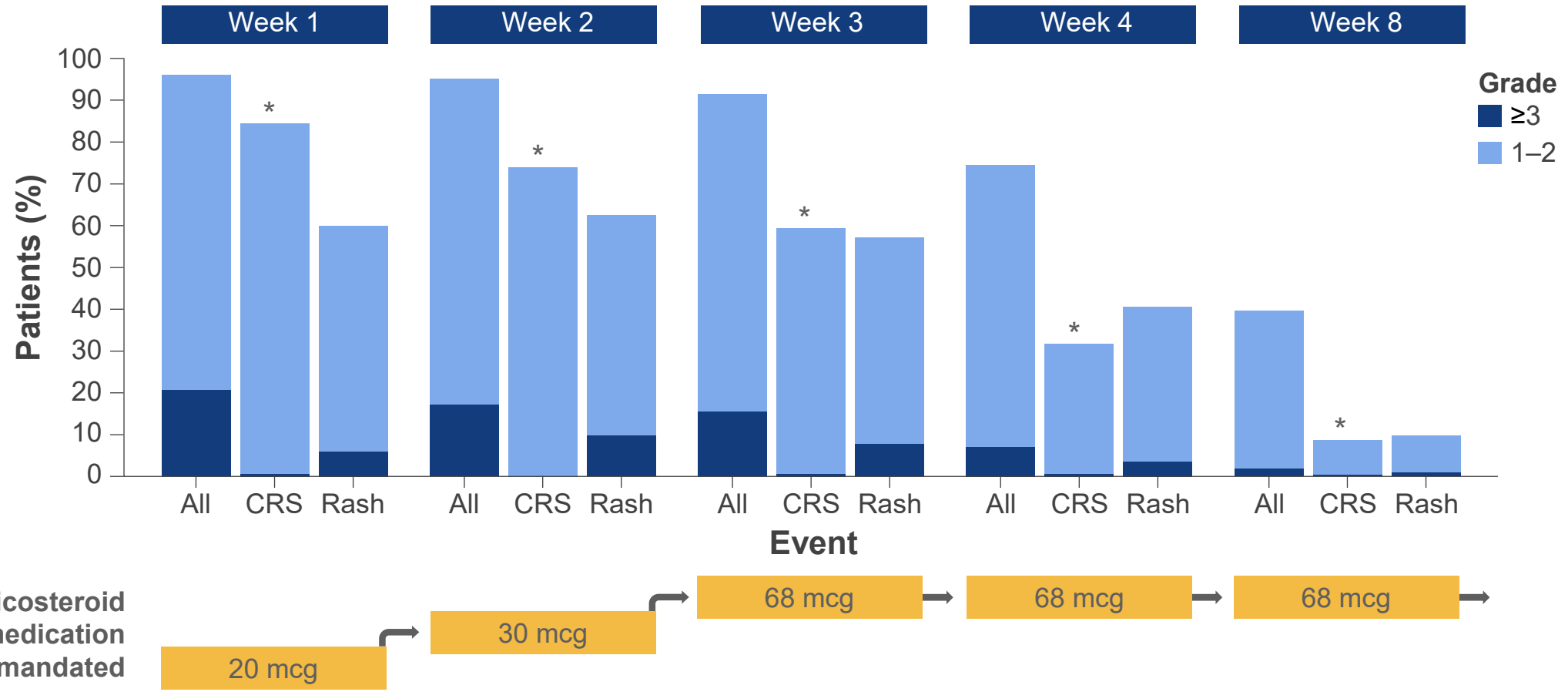
Attenuation of on-target treatment-related AEs

IMCgp100-202 study

Percentage of treated patients experiencing any grade or Grade ≥3 treatment-related AEs after each dose of tebentafusp



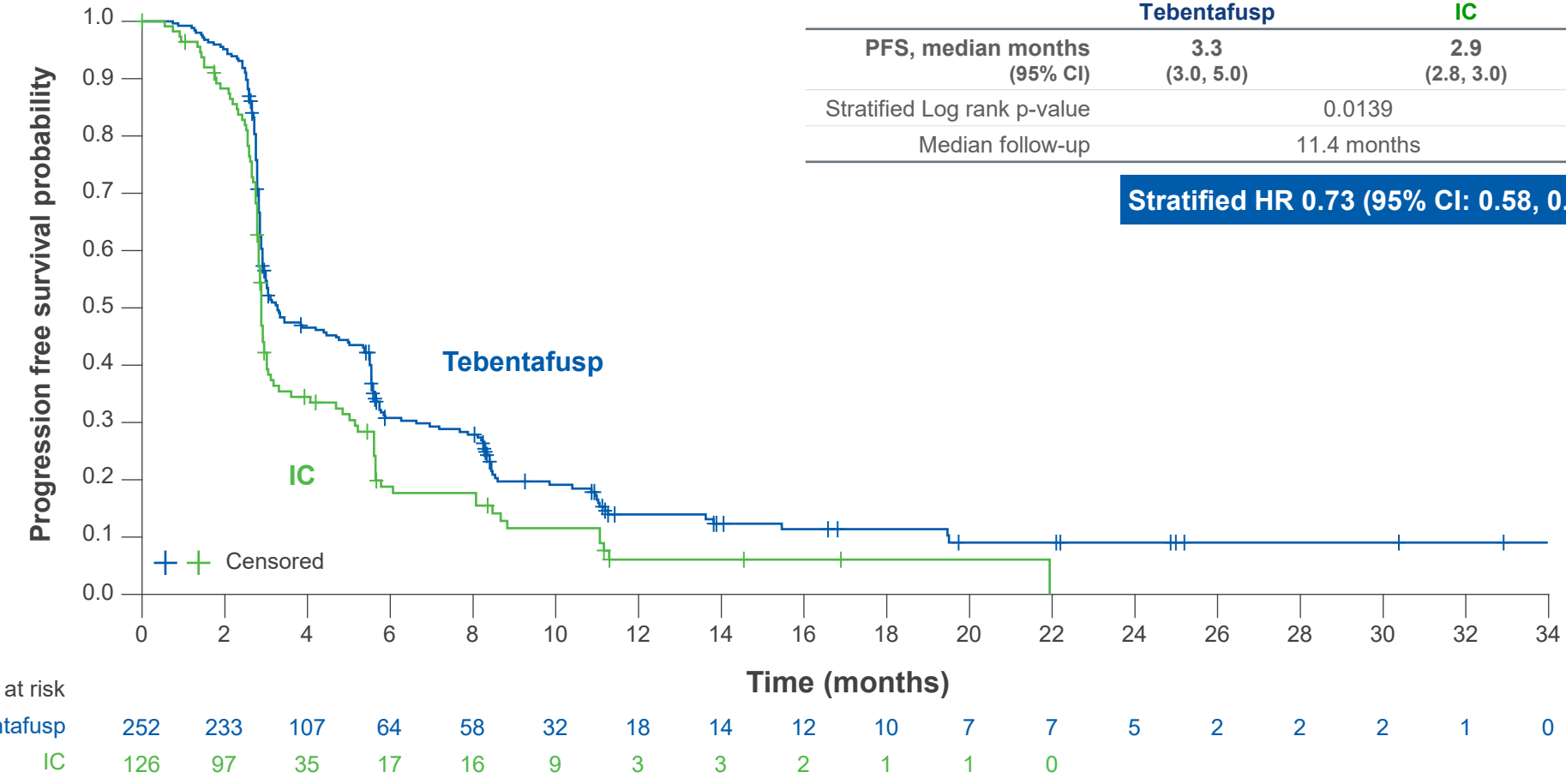
*Total # of patients experiencing Gr 3 CRS episodes (3 episodes in 2 patients):1/245 (wk 1); 0/233 (wk 2); 1/232 (wk 3); 1/226 (wk 4); 0/227 (wk 8)

Piperno-Neumann, et. al. *AACR Annual Meeting 2021*

IMMUNOCORE

Statistically significant Progression Free Survival

IMCgp100-202 study



	Tebentafusp	IC
PFS, median months (95% CI)	3.3 (3.0, 5.0)	2.9 (2.8, 3.0)
Stratified Log rank p-value	0.0139	
Median follow-up	11.4 months	

Stratified HR 0.73 (95% CI: 0.58, 0.94)

Piperno-Neumann, et. al. *AACR Annual Meeting 2021*

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Consistent benefit across OS subgroup analysis

IMCgp100-202 study

Subgroup	Tebentafusp No. of Patients	Tebentafusp No. (%) of Death	IC No. of Patients	IC No. (%) of Death	Hazard Ratio (95% CI)
Region					
North America	86	28 (33)	52	24 (46)	0.52 (0.30-0.91)
Non-North America	166	59 (36)	74	39 (53)	0.49 (0.33-0.74)
Investigator's Choice					
Pembrolizumab	199	65 (33)	103	49 (48)	0.51 (0.35-0.75)
Ipilimumab	40	16 (40)	16	7 (44)	0.89 (0.38-2.31)
Dacarbazine	13	6 (46)	7	7 (100)	0.29 (0.09-0.86)
Gender					
Male	128	48 (38)	62	35 (57)	0.48 (0.31-0.75)
Female	124	39 (32)	64	28 (44)	0.57 (0.35-0.94)
Age					
<65 yr	130	41 (32)	61	29 (48)	0.48 (0.30-0.79)
≥65 yr	122	46 (38)	65	34 (52)	0.58 (0.38-0.92)
ECOG status					
0	192	59 (31)	85	42 (49)	0.48 (0.33-0.72)
1	49	24 (49)	31	18 (58)	0.72 (0.39-1.36)
Baseline alkaline phosphatase					
≤ ULN	198	49 (25)	102	43 (42)	0.44 (0.29-0.66)
> ULN	53	37 (70)	24	20 (83)	0.60 (0.35-1.05)
Lactate dehydrogenase					
≤ ULN	162	28 (17)	80	29 (36)	0.35 (0.21-0.60)
> ULN	90	59 (66)	46	34 (74)	0.70 (0.46-1.09)
Largest metastatic lesion					
M1a (≤3.0 cm)	139	29 (21)	70	28 (40)	0.36 (0.21-0.61)
M1b (3.1-8.0 cm)	92	43 (47)	46	26 (57)	0.71 (0.44-1.17)
M1c (≥8.1 cm)	21	15 (71)	10	9 (90)	0.76 (0.34-1.82)
ITT population	**252**	**87 (35)**	**126**	**63 (50)**	**0.51 (0.37-0.71)**

Piperno-Neumann, et. al. *AACR Annual Meeting 2021*

IMMUNOCORE

Mass-spectrometry antigen discovery engine applied to HBV

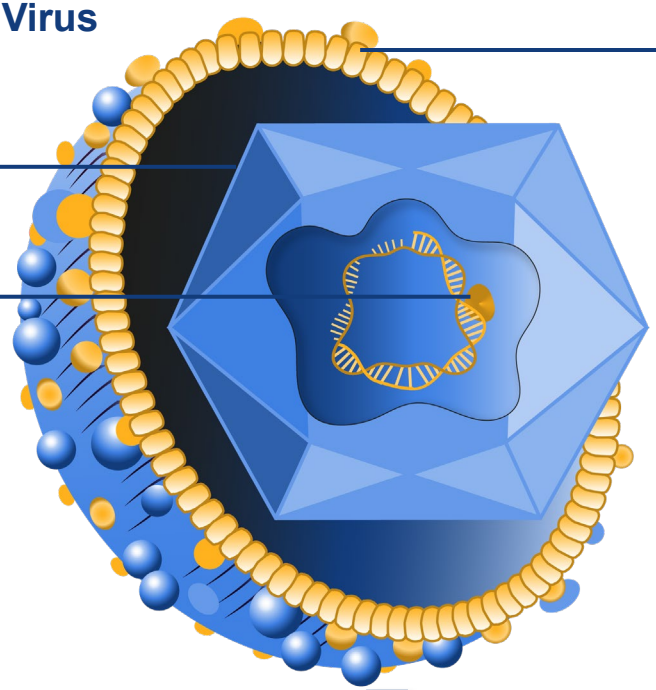
Core Capsid

- 3 HLA-A2 peptides identified
- 1 optimal target selected

Polymerase

- >20 HLA-A2 peptides identified
- 3 optimal targets selected

Hepatitis B Virus



Envelope

- >20 HLA-A2 peptides identified
- 3 optimal targets selected

Pipeline funnel (e.g. conserved sequences, pHLA presentation/stability, mimetic risk)

Seven optimal targets identified

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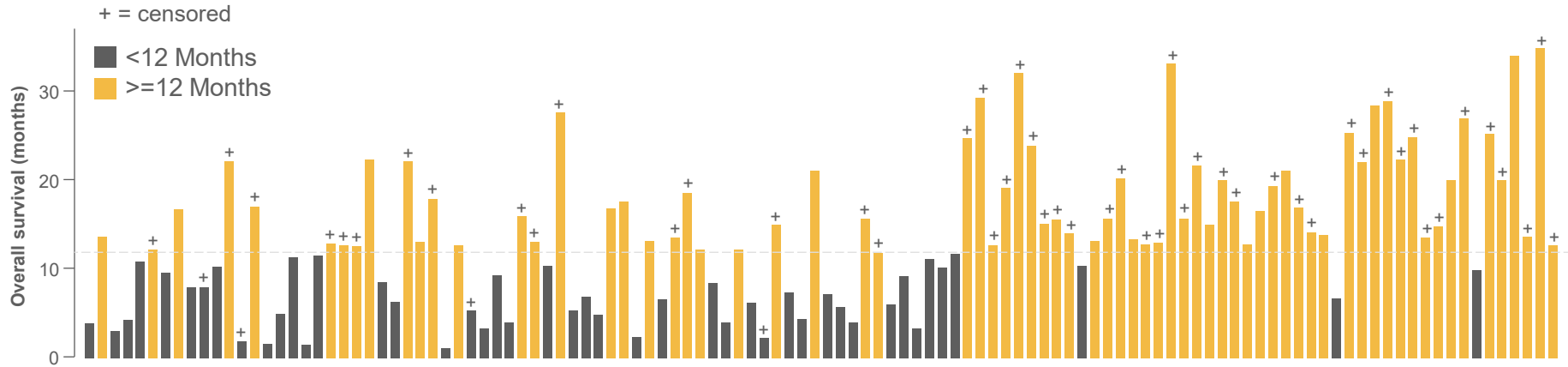
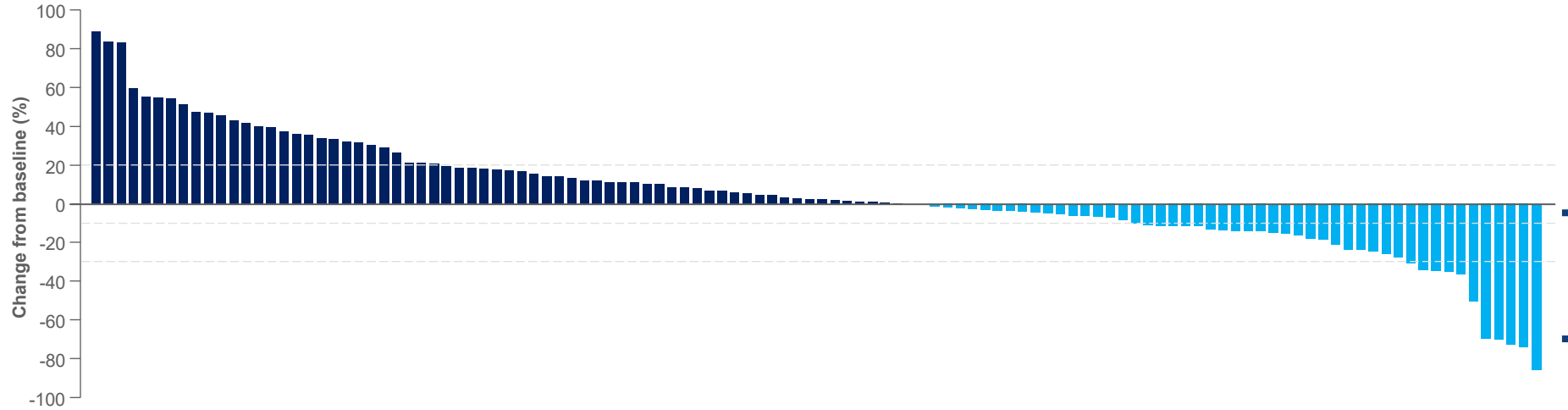
86% of patients with tumor reduction alive at least 12 months

IMCgp100-102 study

42% pts with tumor increase alive ≥ 12 months



86% pts with tumor shrinkage alive ≥ 12 months



44% pts with tumor shrinkage

Tumor size is measured as sum of longest diameters or short axis of target lesions according to RECIST 1.1 by central review
Best % change in target lesion size is maximum % reduction from baseline or minimum % increase from baseline (in absence of reduction
Only pts with at least one evaluable post-baseline scan are included (n=116)

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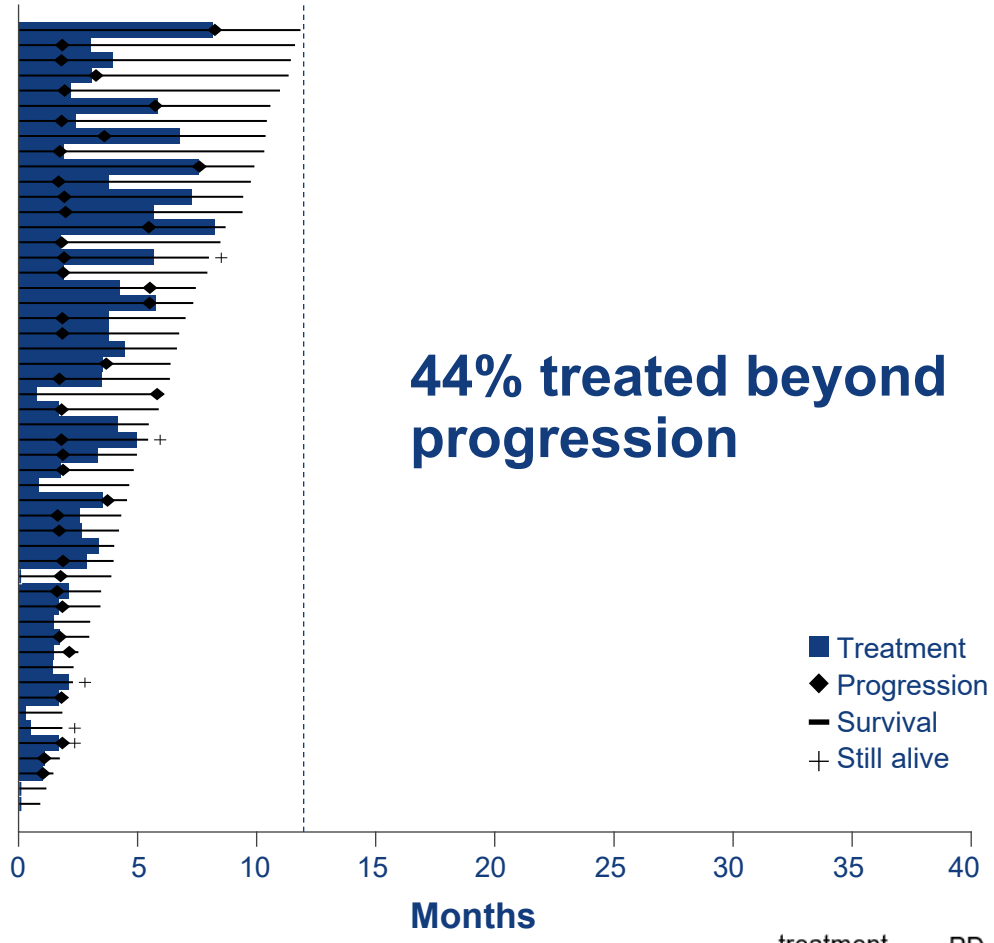
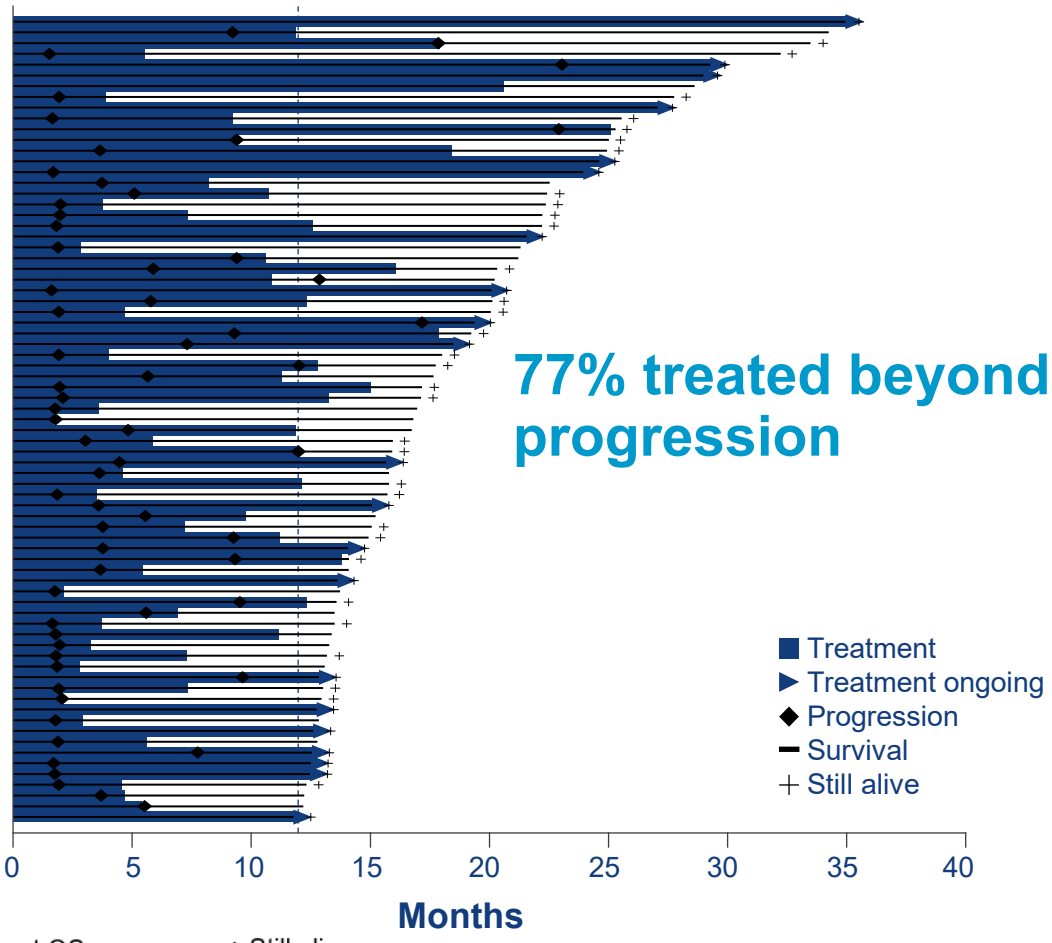
Most OS≥12 patients were treated with tebentafusp beyond disease progression

OS <12 months



44% treated beyond progression

OS ≥12 months



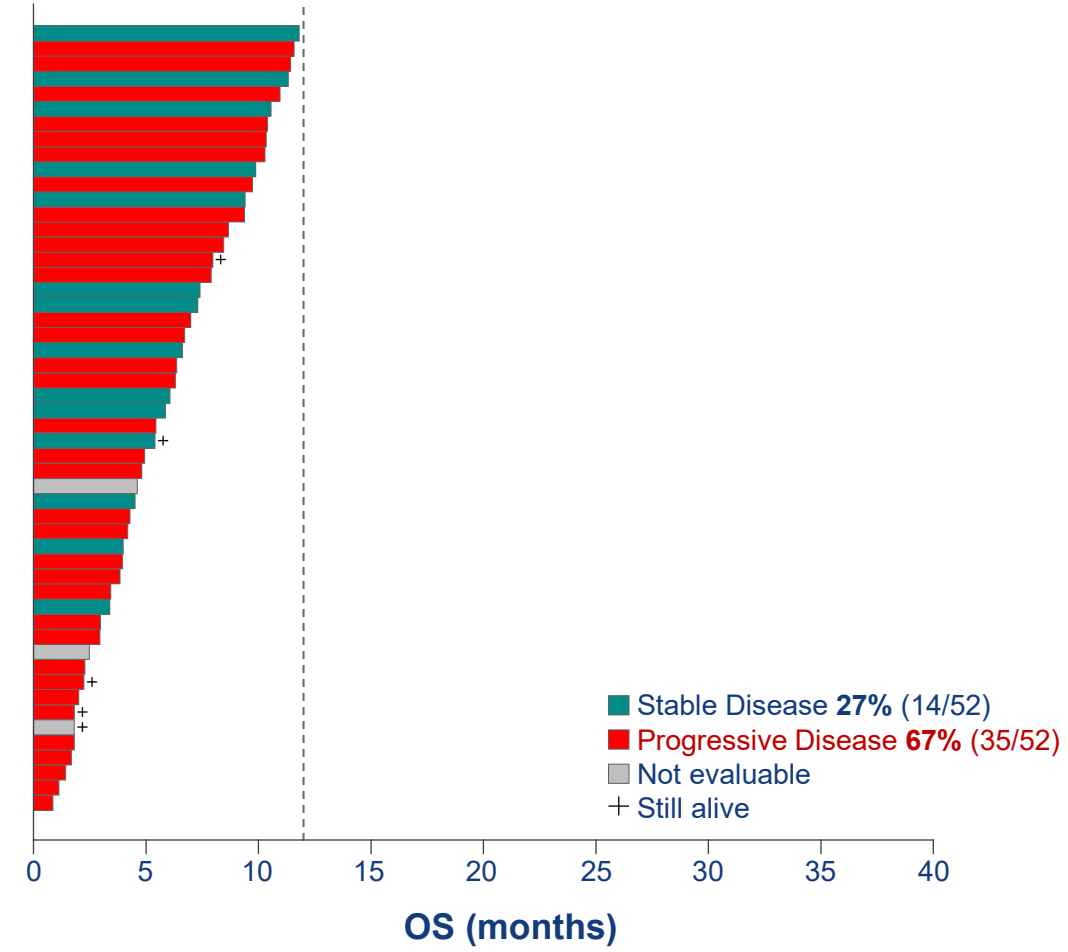
77% treated beyond progression

treatment | PD | Post-treatment OS | + Still alive

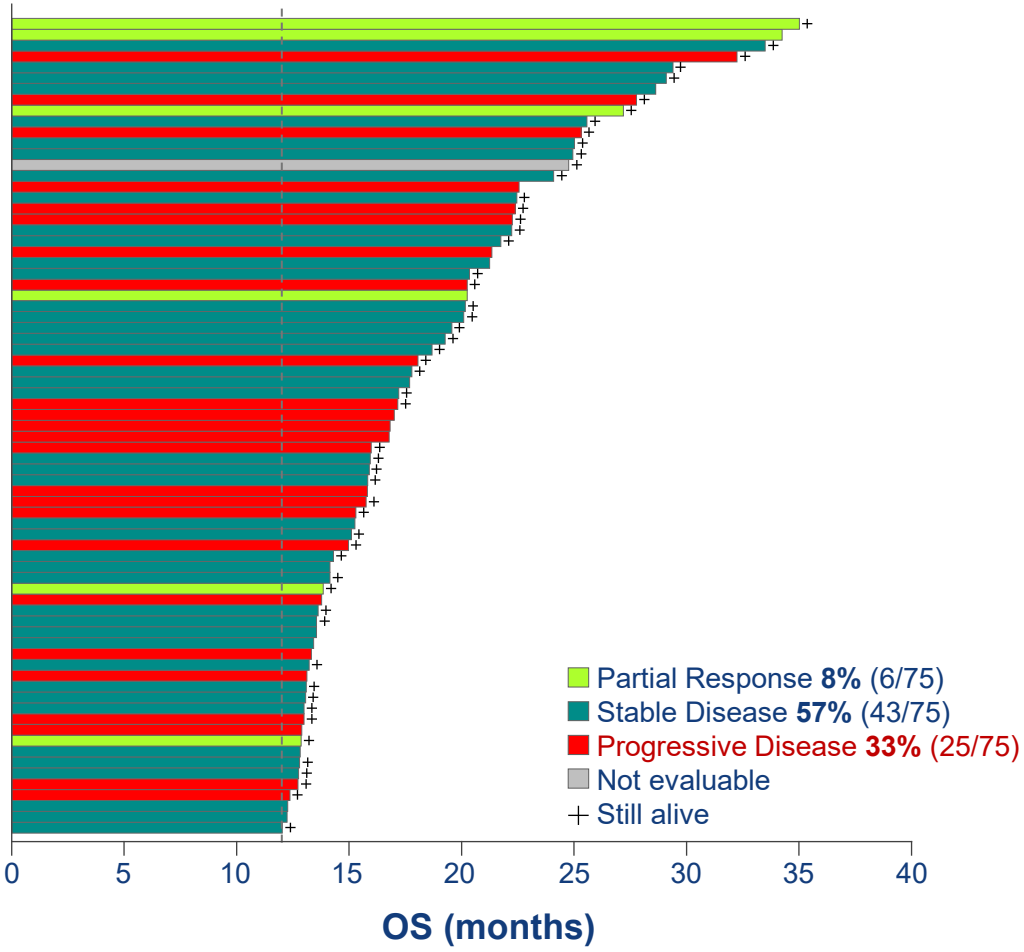
Disease progression is based on investigator's assessment.

OS ≥12 months includes all categories of RECIST response

OS <12 months



OS ≥12 months



[50] Disease assessment by Independent Central Review

Monotherapy Overall Survival (OS) benefit in randomized Phase 3

RECIST ORR underestimates OS

IMCgp100-102

Evidence of T cell redirection

>90%
Cytokine increase

>90%
T cell trafficking out blood

68%
T cell increase in tumor

IMCgp100-102 and -202

Tumor shrinkage surrogate

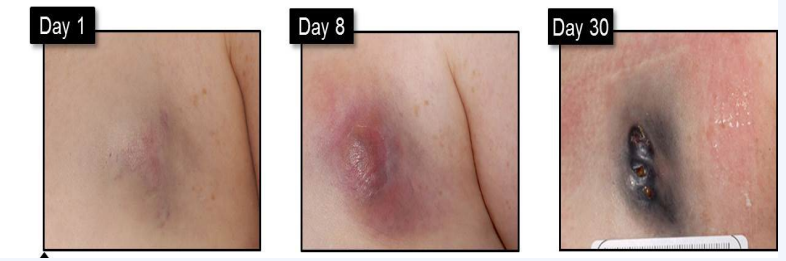
4.7%
RECIST response rate

44%
Tumor shrinkage

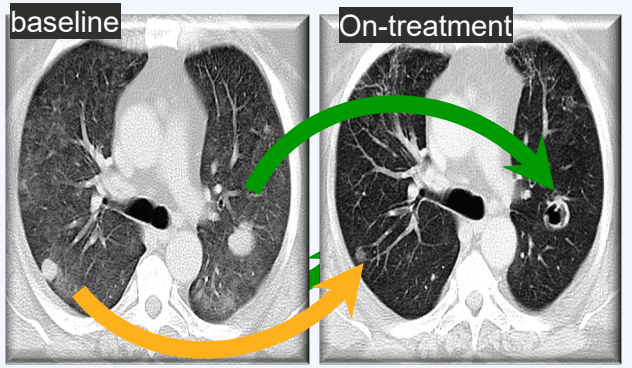
0.51
OS Hazard ratio

IMCgp100-01 and -102

Immune-related responses predominate



Initial increase in tumor size from inflammation



Tumor necrosis no size change

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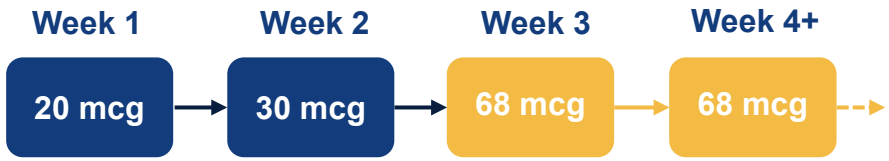
IMCgp100-102: tebentafusp monotherapy in 2L+ mUM

While ORR was only 5%, OS was promising relative to historical published data

Eligibility

- Metastatic UM
- HLA-A*02:01 positive
- ≥1 prior therapy in metastatic setting
- Measurable disease

Treatment Regimen



	N=127	Historical 2L+[1]
Response rate	5%	-
Duration of response	8.7 month	-
OS, median months	16.8 month	7.8 month
1-yr OS rate	62%	37%
2-yr OS rate	37%	15%

N=127

↓

ctDNA, any time point
N=118

↓

ctDNA, at baseline
N=116

↓

ctDNA, at baseline & by Week 9
N=99

1. Rantala ES, et al. *Melanoma Res.* 2019; 29:561-568

ctDNA, circulating tumor DNA; ICR, Independent Central Review; ORR, Overall Response Rate

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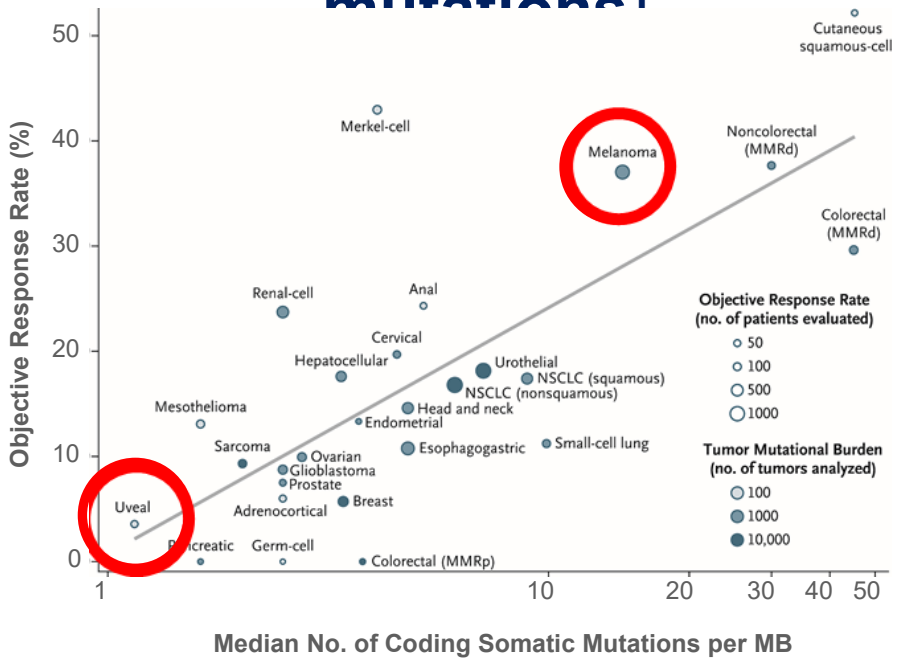
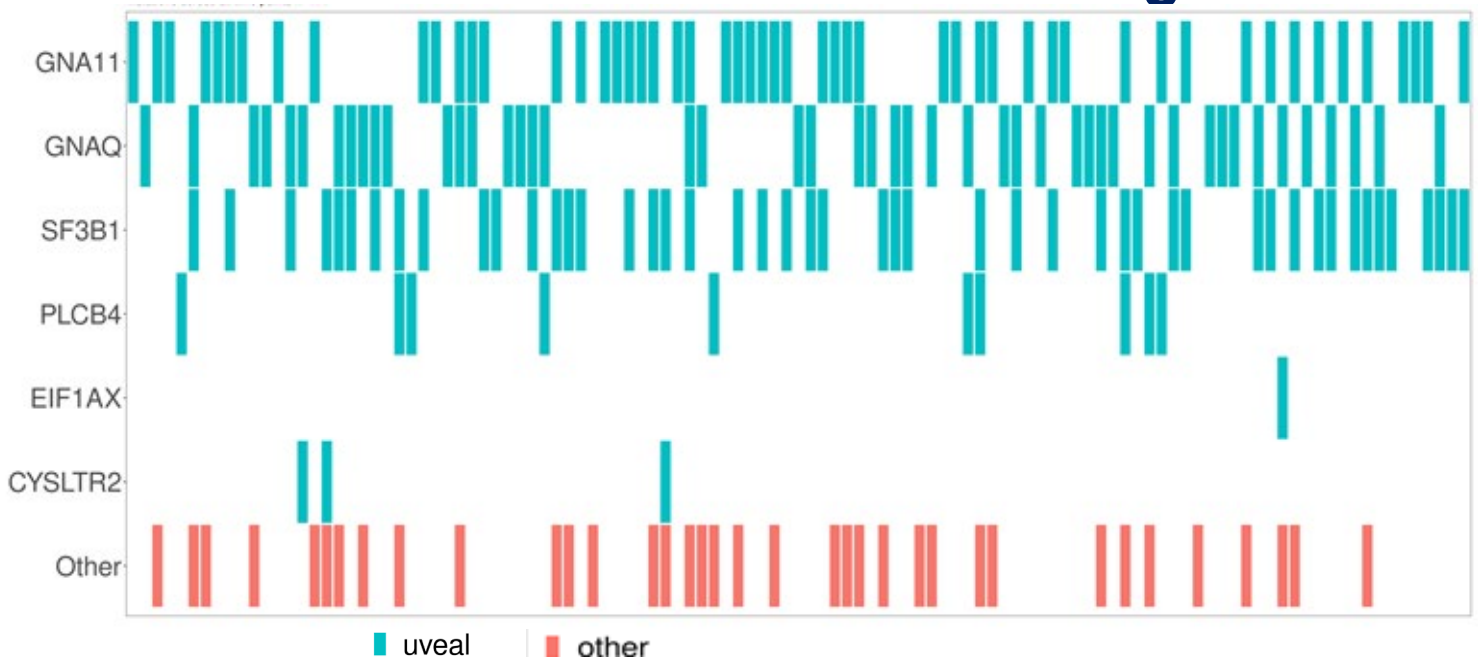
92% patients had detectable ctDNA with mutations in known UM oncogenes

UM has lowest number of somatic mutations[1]



Almost all evaluable patients had mutations in known UM oncogenes



New custom panel to detect melanoma ctDNA using multiplex PCR followed by next gen sequencing, including UM specific: GNAQ, GNA11, SF3B1, PLCB4, CYSLTR2, EIF1AX

1. Yarchoan M, et al. *NEJM* 2017; 377(25): 2500-2501.

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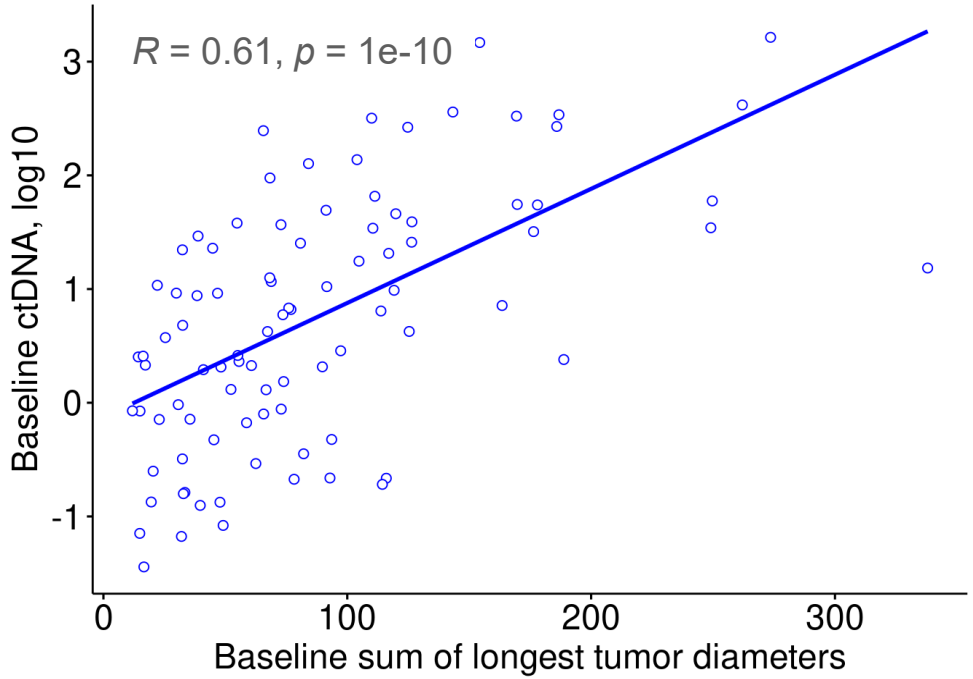
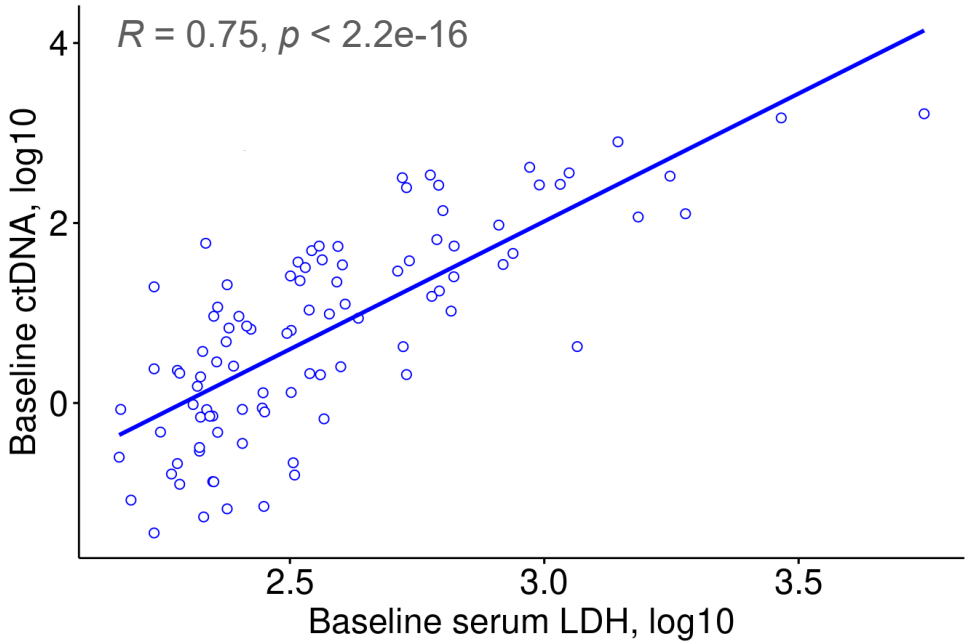
Baseline ctDNA levels significantly correlated with tumor burden

Baseline ctDNA vs. tumor size



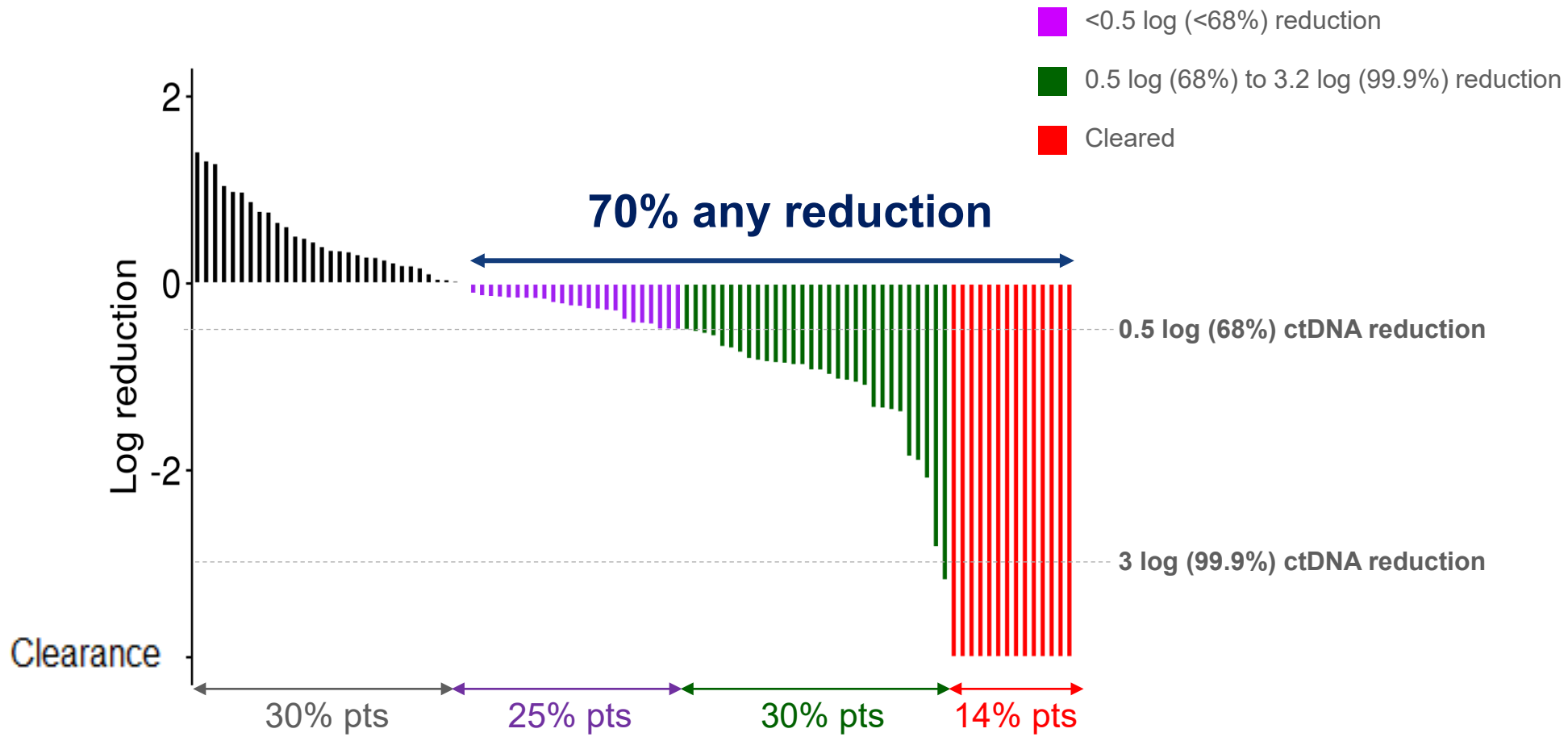
Baseline ctDNA vs. serum LDH



LDH, lactate dehydrogenase.

70% evaluable patients had any ctDNA reduction

Waterfall plot of best ctDNA change by Week 9 on tebentafusp



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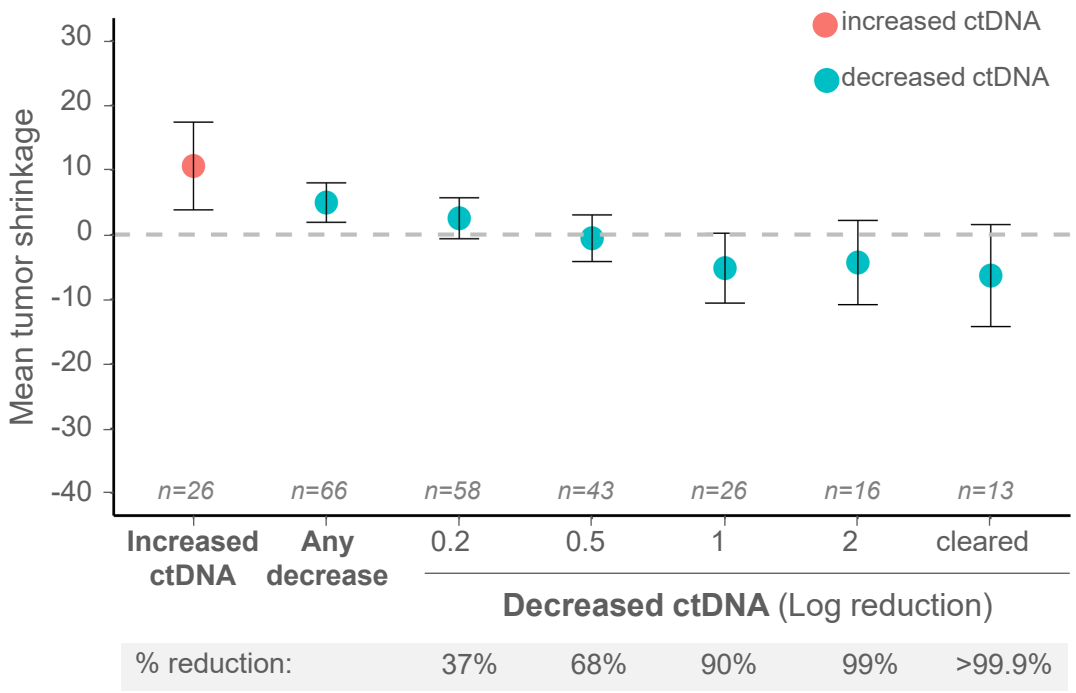
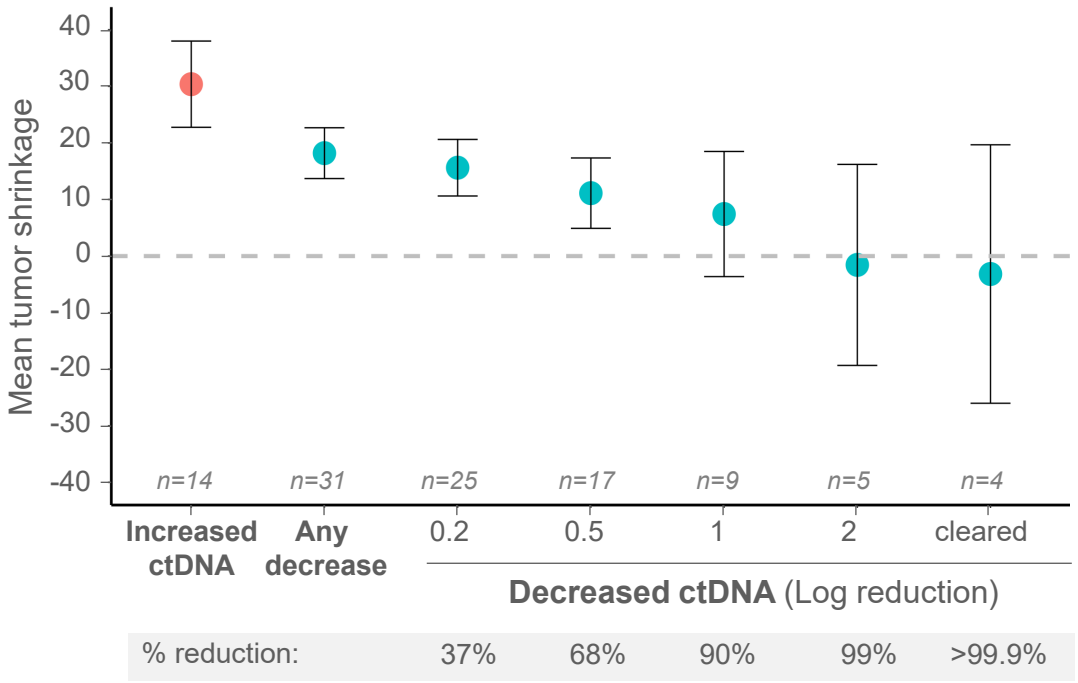
ctDNA reduction is more sensitive measure of tebentafusp effect than tumor size

All evaluable ctDNA patients



ctDNA reduction associated with greater mean tumor shrinkage

Patients with best response of progressive disease



ctDNA reduction associated with less tumor growth

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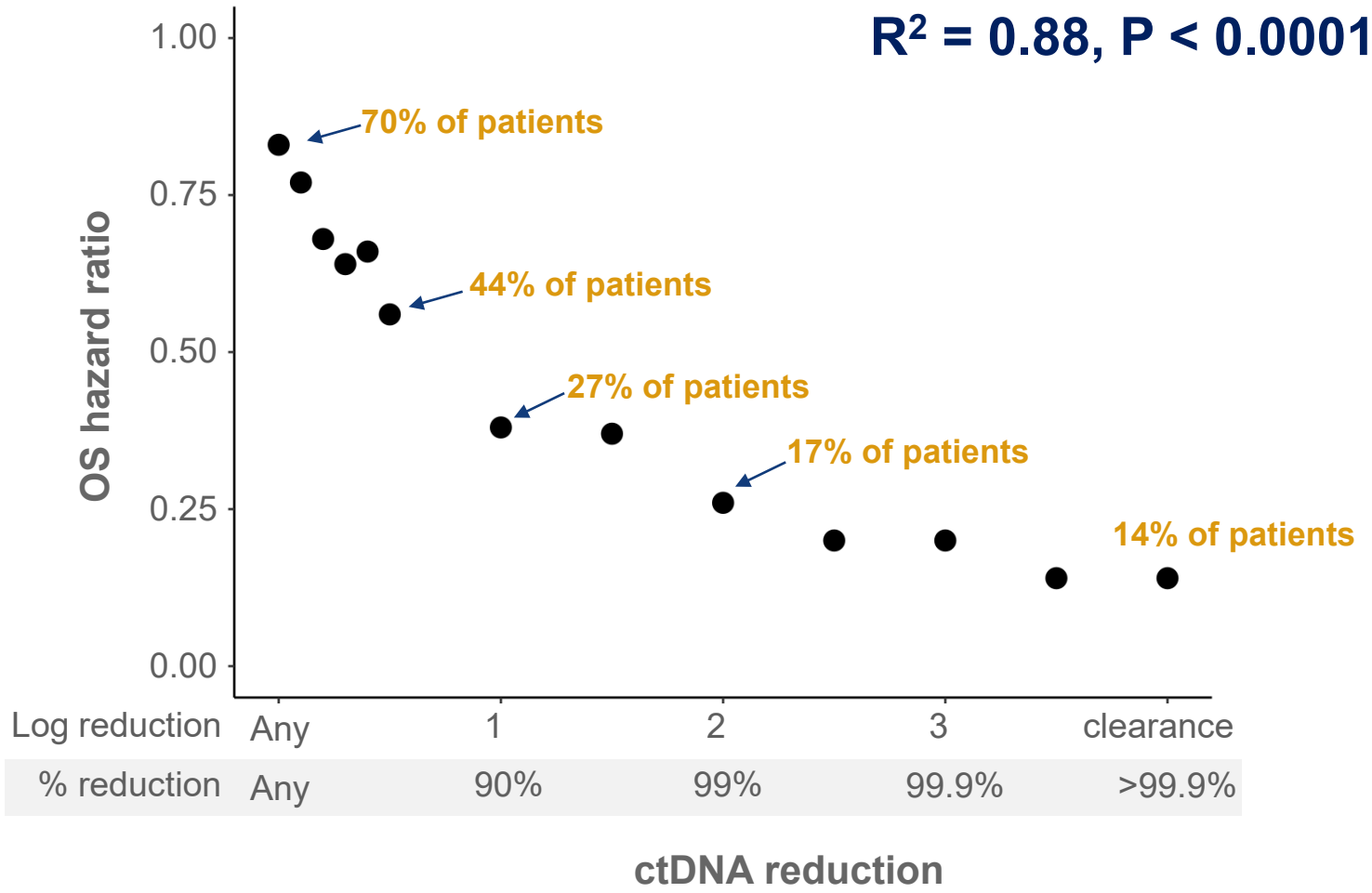
Linear correlation between ctDNA reduction and better OS



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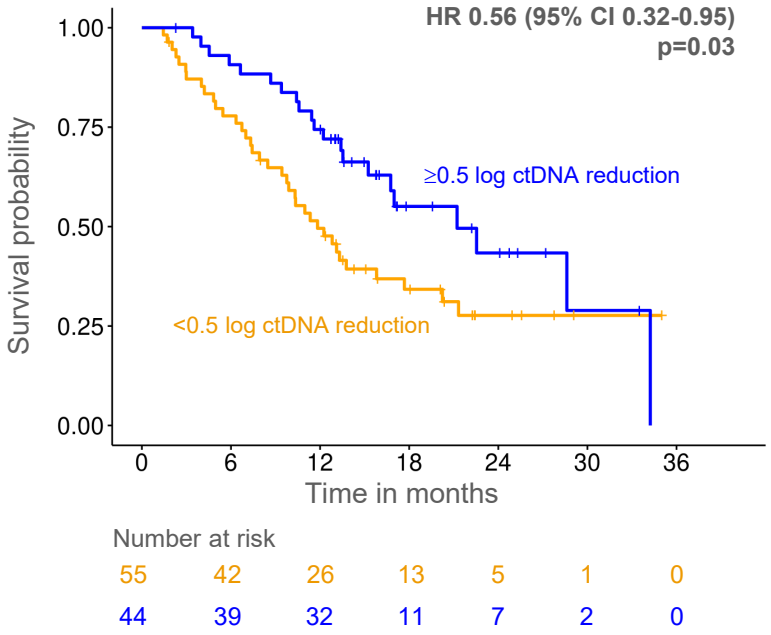
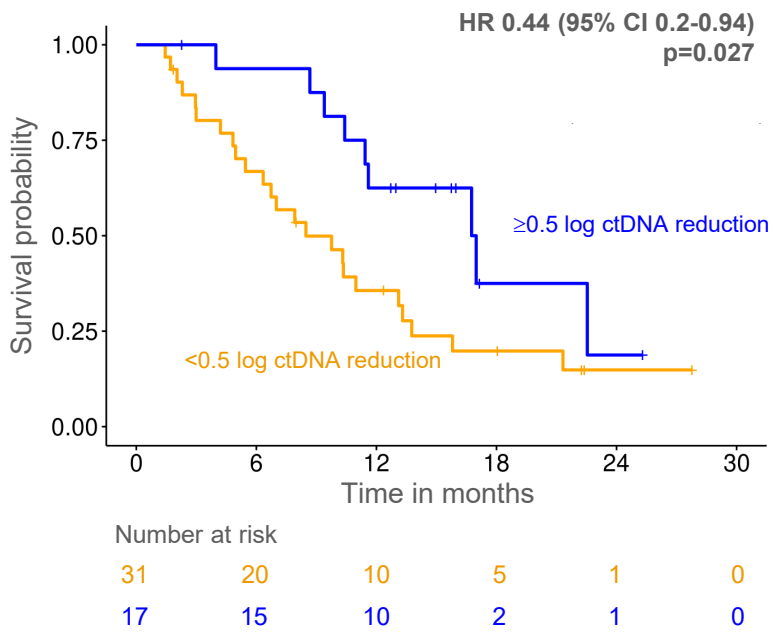
ctDNA reduction identifies patients with OS benefit, regardless best RECIST response

All evaluable patients



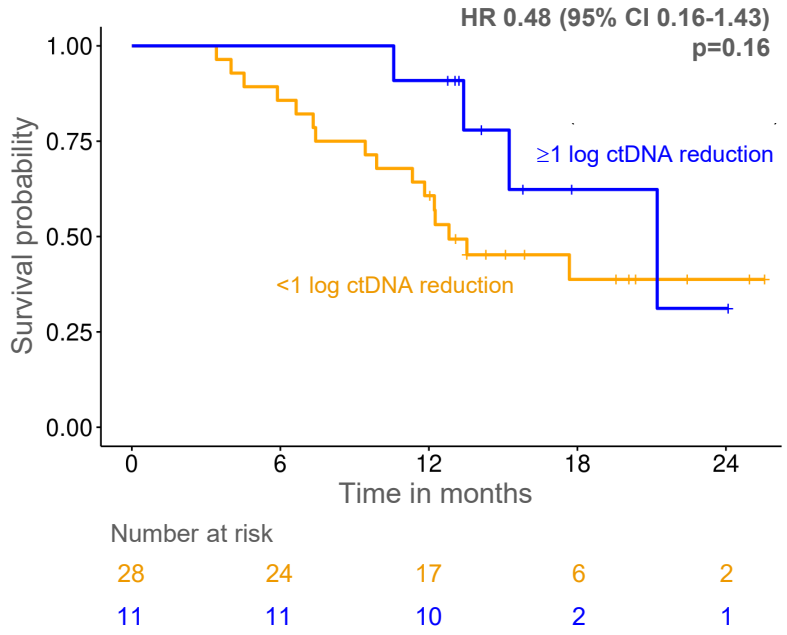
44% of these patients had ≥ 0.5 log reduction ctDNA

Patients with best response progressive disease



35% of these patients had ≥ 0.5 log reduction ctDNA

Patients with best response stable disease



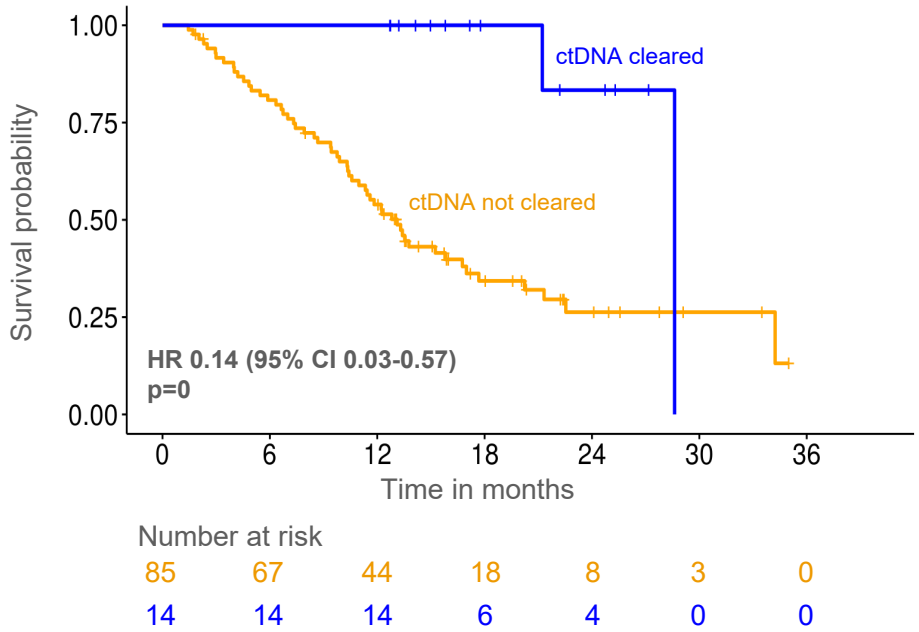
28% of these patients had ≥ 1 log reduction ctDNA

14% patients cleared ctDNA, including some with best RECIST response of SD or PD

Best RECIST response for patients who cleared ctDNA

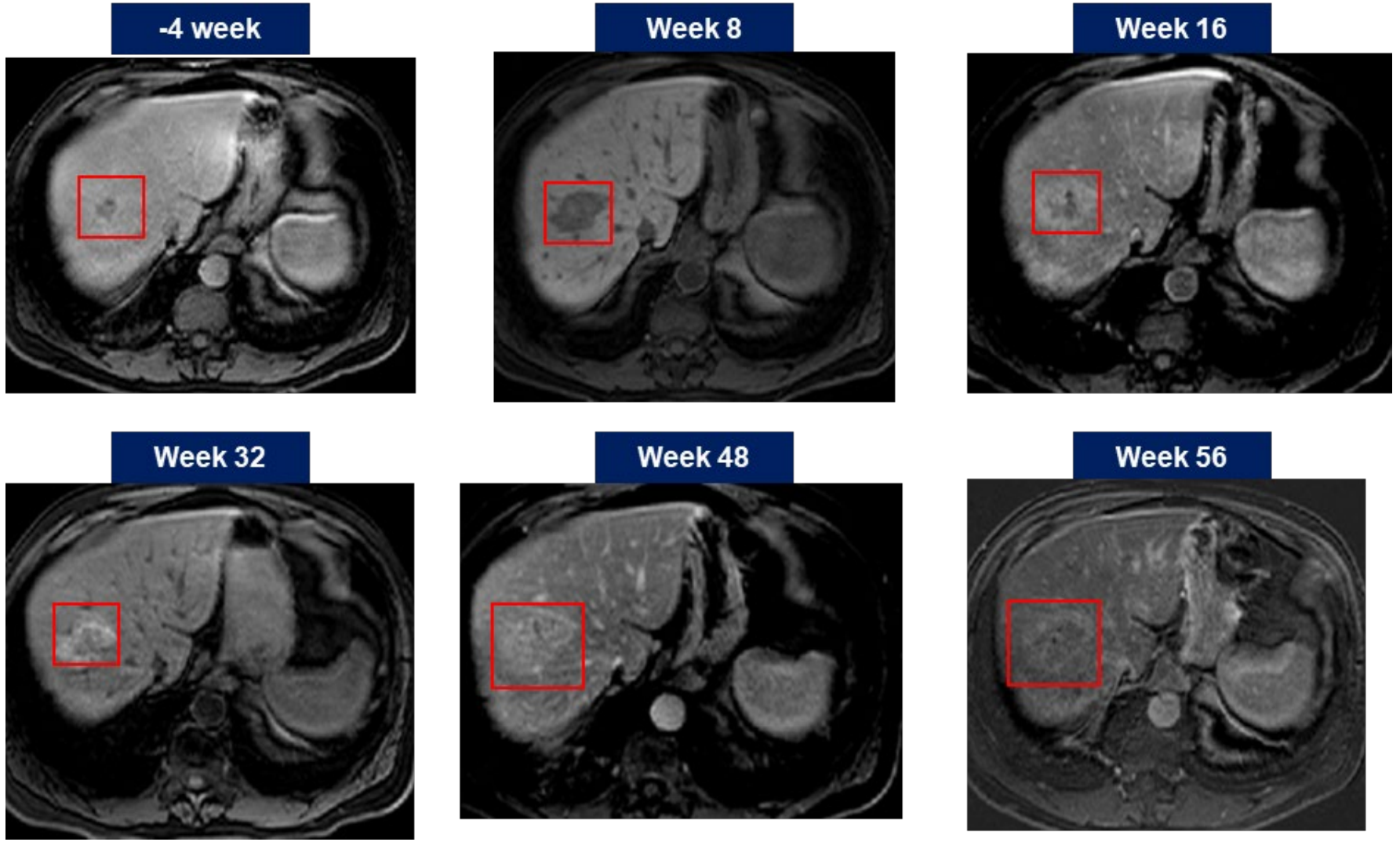
	Cleared ctDNA
Total	**14**
Partial response	1
Stable Disease	8
Progressive Disease	4
Not evaluable	1

All patients with ctDNA clearance alive > 1 year



SD, stable disease; PD, progressive disease

Patient with best response progressive disease (Wk 8) but ctDNA clearance (Wk 9) and long OS



Conclusions

ctDNA detectable >90% 2L+ metastatic UM patients; baseline levels correlated with tumor burden

Among tebentafusp-treated patients, 70% had ctDNA reduction vs 39% tumor shrinkage and 5% RECIST ORR

Linear correlation between magnitude of ctDNA reduction and improved OS on tebentafusp, uncoupled from best RECIST response

14% patients had complete ctDNA clearance and long OS, including some with RECIST response of stable or progressive disease

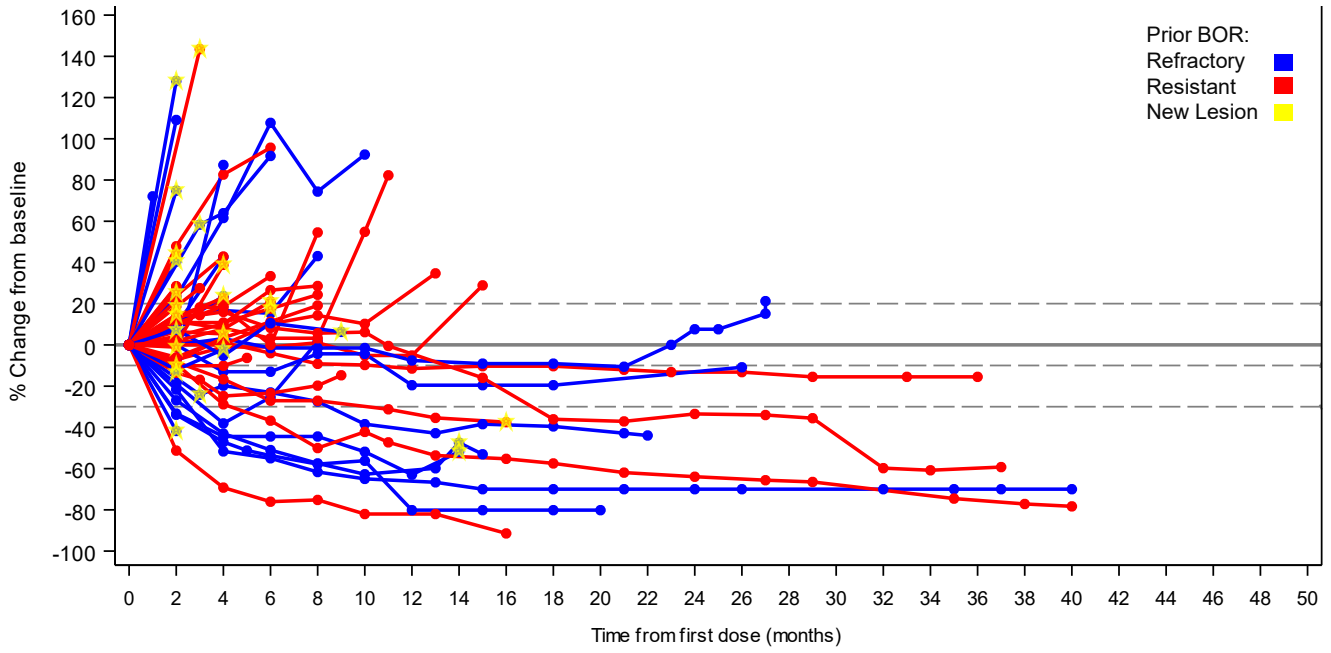
For tebentafusp, ctDNA reduction may be better surrogate of OS than RECIST response

Tebentafusp active in cutaneous melanoma

IMCgp100-01 and -201 study

Durable tumor shrinkage in patients who progressed on prior anti-PD(L)1

tebentafusp + durvalumab*



*Study IMCgp100-201 patients with known best overall response to prior anti-PD(L)1 therapy includes 31 patients who received tebentafusp+ durvalumab and 26 received tebentafusp + durvalumab + tremelimumab

Best response to prior anti-PD(L)1: Resistant = best response CR/PR/SD to prior PD(L)1; Refractory = best response of PD to prior anti-PD(L)1

1-yr OS

74%, anti-PD(L)1 naïve
tebentafusp monotherapy^

76%, prior anti-PD(L)1
tebentafusp + durvalumab†

81%, prior anti-PD(L)1
tebentafusp + ≥10 mg/kg durvalumab#

^ Study IMCgp100-01, n= 49
† Study IMCgp100-201, n=61, 57% patients received tebentafusp + durvalumab; 43% received tebentafusp + durvalumab + tremelimumab.
# Study IMCgp100-201, n= 38, 63% patients received tebentafusp + durvalumab; 37% received tebentafusp + durvalumab + tremelimumab.

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