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Transformative immunomodulating medicines for patients



November 2026

Forward Looking Statements

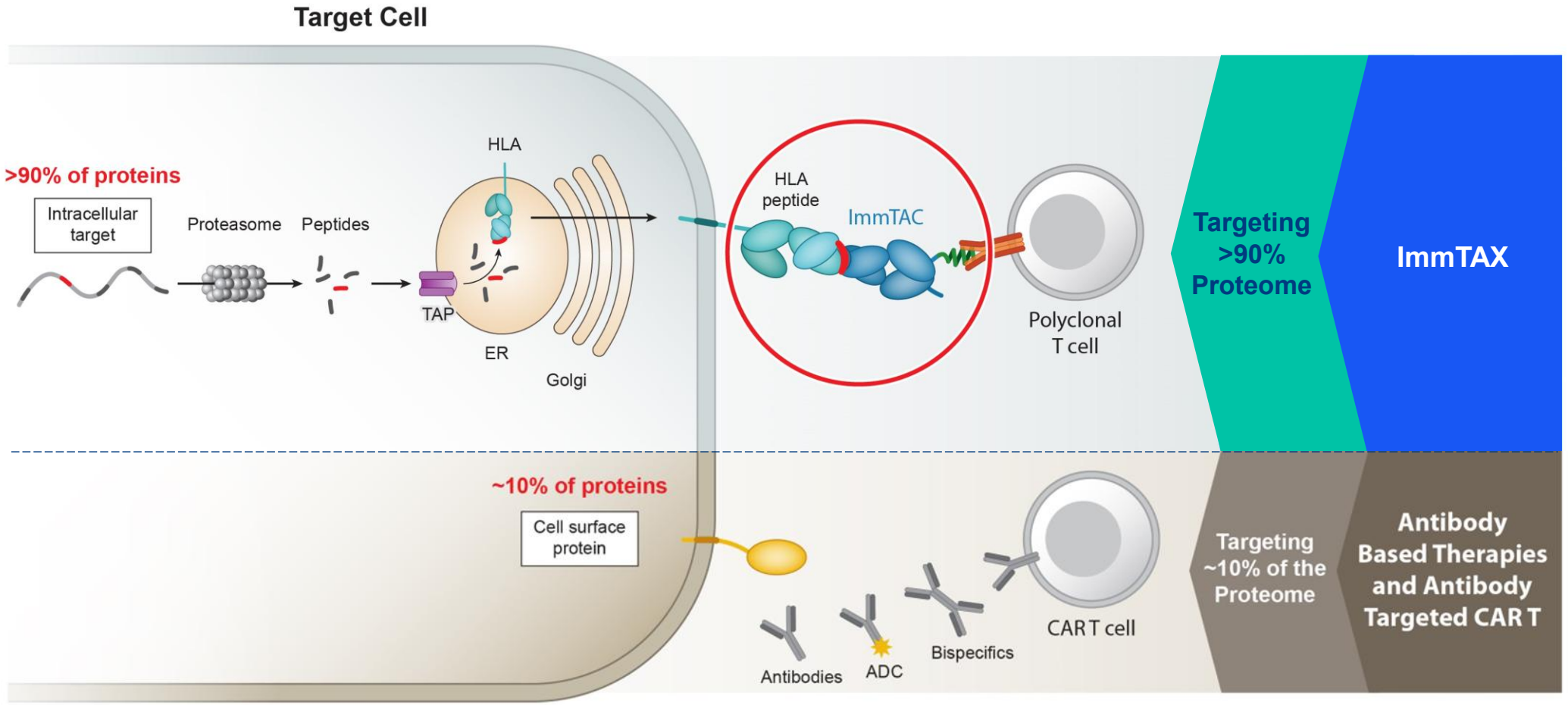
This presentation contains “forward-looking statements” within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Words such as “may”, “will”, “believe”, “expect”, “plan”, “anticipate”, “aim”, “continue”, “target” and similar expressions (as well as other 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 press release are forward-looking statements. These statements include, but are not limited to, statements regarding the Company’s ability to reach more patients for KIMMTRAK, including continued U.S. community and global market penetration in mUM, the potential expansion into 2L+ advanced cutaneous melanoma, and the potential expansion into adjuvant uveal melanoma; the Company’s ability to grow and advance its clinical pipeline; the estimated size of the patient populations for the Company’s product candidates; expectations regarding the design, progress, timing, enrollment, randomization, scope, expansion, and results of the Company’s and its collaborators’ existing and planned clinical trials; the timing and sufficiency of clinical trial outcomes to support potential approval of any of the Company’s product candidates or those of, or combined with, its collaboration partners; the expected submission of clinical trial applications or investigational new drug applications; the potential regulatory approval, and expected clinical benefits and availability of the Company’s product candidates, including brenetafusp alone and in combination with KIMMTRAK; the Company’s ability to engage with healthcare professionals regarding clinical data following inclusion of such data in product labeling; and expectations regarding the timing and amount of sales-related rebate, chargeback and return payments. Any forward-looking statements are based on management’s current expectations and beliefs of future events and are subject to a number of risks and uncertainties that could cause actual events or results to differ materially and adversely from those set forth in or implied by such forward-looking statements, many of which are beyond the Company’s control. These risks and uncertainties include, but are not limited to, preliminary, interim and top-line clinical trial results may not be indicative of, and may differ from, final clinical data; clinical trial data are subject to differing interpretations and assessments, including by regulatory authorities; the impact of worsening macroeconomic conditions, including as a result of health epidemics or pandemics, war in Ukraine, the conflict in the Middle East, or global geopolitical tension, on the Company’s business, financial position, strategy and anticipated milestones, including the Company’s ability to conduct ongoing and planned clinical trials; the Company’s ability to obtain a clinical supply of current or future product candidates or commercial supply of KIMMTRAK or any future approved products; the Company’s ability to obtain and maintain regulatory approval of KIMMTRAK and its other product candidates; the Company’s ability and plans in continuing to establish and expand a commercial infrastructure and to successfully launch, market and sell KIMMTRAK and any future approved products; the Company’s ability to successfully expand the approved indications for KIMMTRAK or obtain marketing approval for KIMMTRAK in additional geographies in the future; the delay of any current or planned clinical trials, whether due to patient enrollment delays or otherwise; the Company’s ability to successfully demonstrate the safety and efficacy of its product candidates and gain approval of its product candidates on a timely basis, if at all; competition with respect to market opportunities; unexpected safety or efficacy data observed during preclinical studies or clinical trials; actions of regulatory agencies, which may affect the initiation, timing and progress of clinical trials or future regulatory approval; the Company’s need for and ability to obtain additional funding, on favorable terms or at all, including as a result of changes in inflation and interest rates and unfavorable general market conditions; the Company’s ability to obtain, maintain and enforce intellectual property protection for KIMMTRAK or any of its product candidates it or its collaborators are developing; and the success of the Company’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 the Company’s filings with the Securities and Exchange Commission, including the Company’s most recent Annual Report on Form 10-K for the year ended December 31, 2025 filed with the Securities and Exchange Commission on February 25, 2026, as well as discussions of potential risks, uncertainties, and other important factors in the Company’s subsequent filings with the SEC. All information in this press release is as of the date of the release, and the Company undertakes no duty to update this information, except as required by law.

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



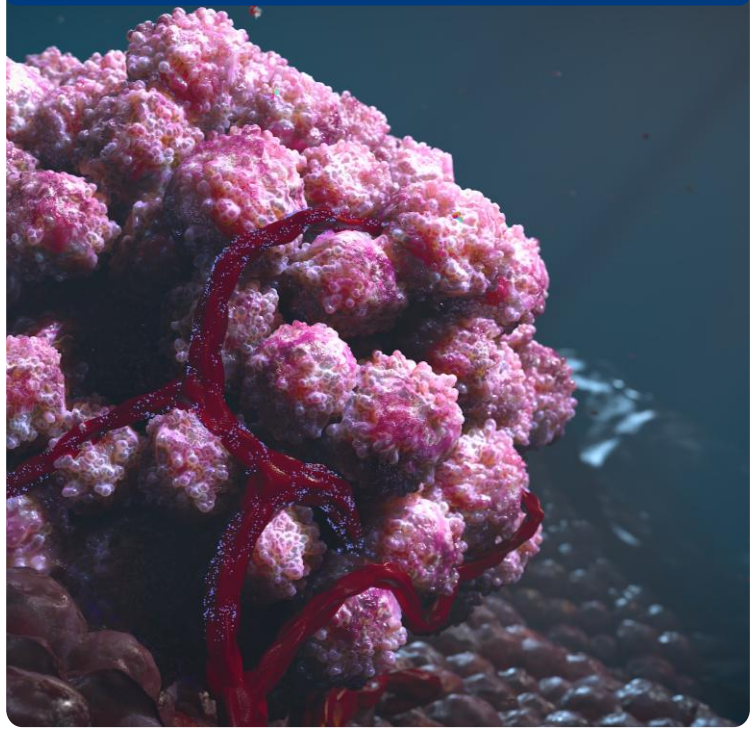
TCR therapeutics can target >90% of the human proteome

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Platform candidates and capabilities across 3 therapeutic areas

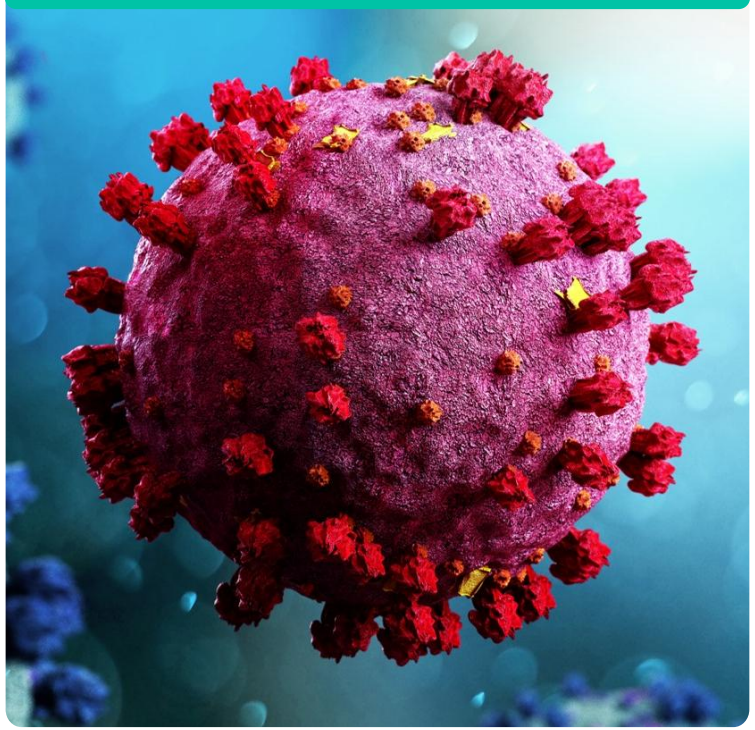
Oncology

ImmTAC therapies



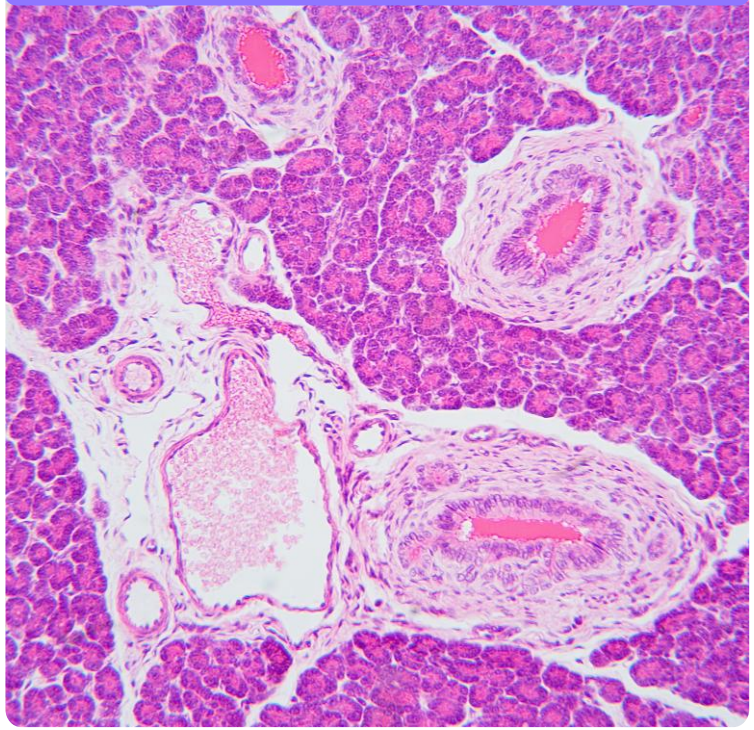
Infectious diseases

ImmTAV therapies



Autoimmune diseases

ImmTAAI therapies



Activation
of the immune system

Downmodulation
of the immune system

Leading bispecific TCR pipeline

Oncology

ID*

Autoimmune

Candidate	Target (HLA type)	Indication	Pre IND	Phase 1	Phase 2	Phase 3	Approved
KIMMTRAK (tebentafusp-tebn)	gp100-A02	Metastatic uveal melanoma					
		Adjuvant uveal (ocular) melanoma	ATOM sponsored by EORTC				
		2L+ advanced cutaneous melanoma	TEBE-AM				
KIMMTRAK + brenetafusp	gp100-A02 + PRAME-A02	Metastatic uveal melanoma	DUET-UVEAL Phase 2/3				
Brenetafusp	PRAME-A02	1L advanced cutaneous melanoma	PRISM-MEL-301				
		Ovarian, NSCLC[1]					
		Additional solid tumors					
IMC-P115C	PRAME-A02-HLE	Multiple solid tumors					
IMC-R117C	PIWIL1-A02	Colorectal and GI cancers					
IMC-M113V	Gag-A02	Human Immunodeficiency Virus (HIV)					
IMC-S118AI	PPI-A02 x PD-1	Type 1 Diabetes					
IMC-U120AI	CD1a x PD1 (non-HLA restricted)[2]	Atopic Dermatitis					

[1] NSCLC = Non-small cell lung cancer [2] Program is not HLA restricted (i.e. universal for all populations). *ID = Infectious diseases



Maximizing potential of KIMMTRAK® in HLA-A02+ melanoma

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KIMMTRAK is the global standard of care in 1L mUM[1]

10% year-over-year growth year to date

$325M

1Q-3Q 2026 net sales

$102M

Q3 2026 net sales



>30

launched markets

≥70%

penetration in all major launched markets[2]

~14 mo.

Duration of treatment [3]

Continuing to demonstrate long term OS benefit

Median OS of 28 months

Most recent real-world data (150 patients)[4]

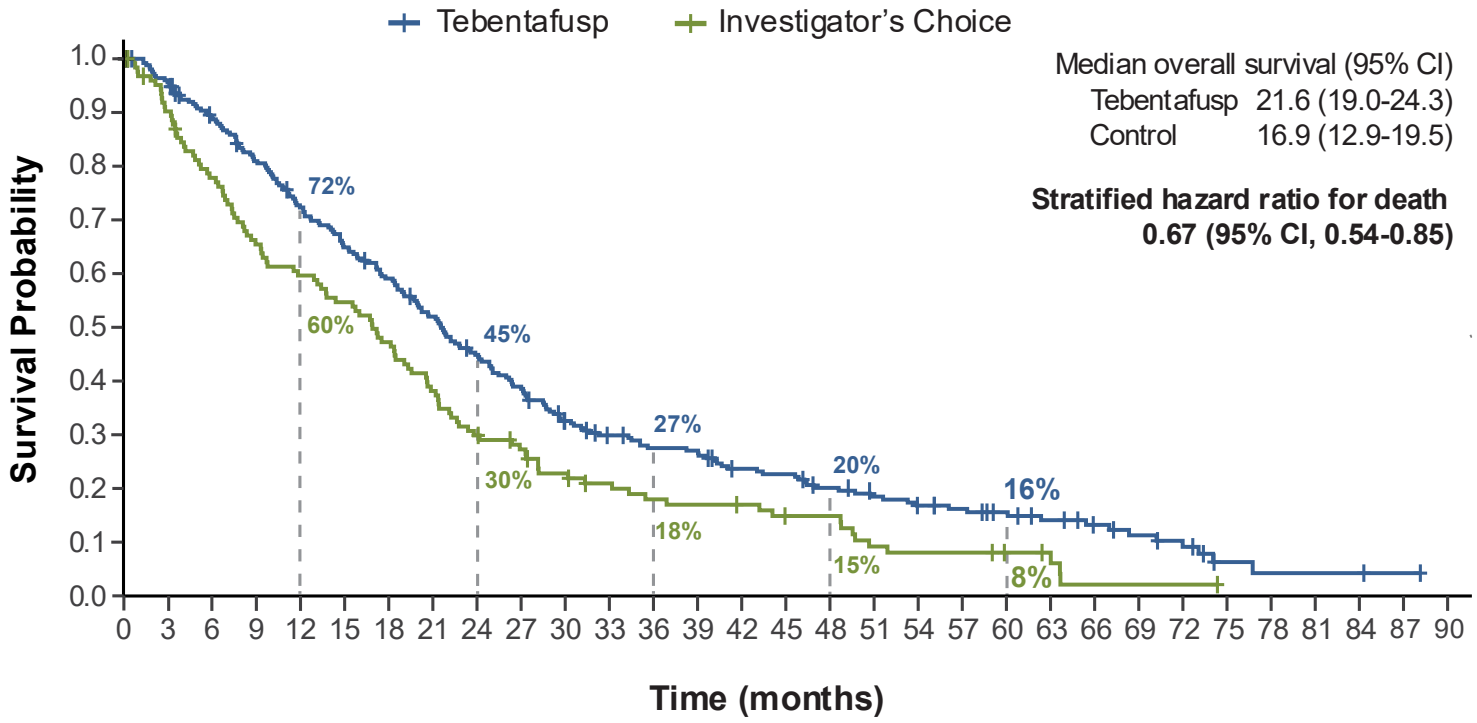
5-yr OS data presented at AACR

Longest OS follow-up in a randomized mUM trial and for any T cell engager in a solid tumor

1. For HLA-A*02:01-positive patients with 1L mUM treated with systemic therapies across majority of launched markets, including US and EUR5 2. Company estimate of market penetration (HLA testing x market share) 3. Company estimates 4. Rodrigues, et. al, ESMO IO 2025 (164P)

KIMMTRAK doubled likelihood of patients being alive at 5 years

Longest OS follow-up ever reported in a randomized metastatic uveal melanoma trial



→**16% OS rate on tebentafusp compared with 8% for investigator's choice (IC)**

- 44% only received tebentafusp
- 87% of IC patients received subsequent tebentafusp
- Of patients who did not receive subsequent tebentafusp, 1 was alive at 5-years

→**OS favored tebentafusp across most patient subgroups**

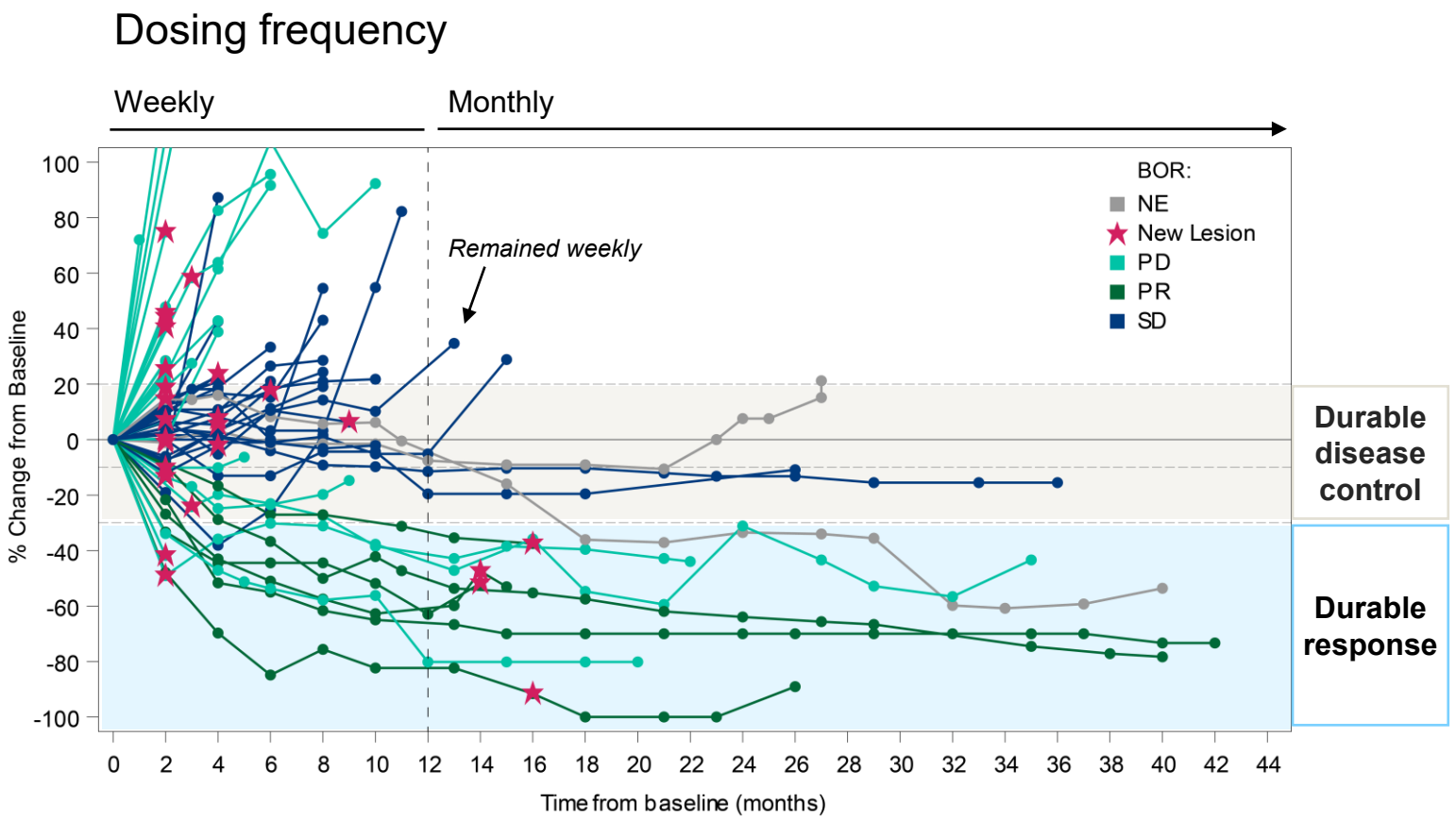
- OS benefit maintained after subsequent therapy was removed (HR 0.52, 95% CI: 0.31–0.83)*

Nathan P, et al. Presented at: AACR Annual Meeting 2026
Median duration of follow-up was 62.4 months (95% CI, 58.7-70.3); * Patients who received a subsequent line of anti-cancer therapy were censored and reweighted at the start of subsequent therapy using inverse probability of censoring weighting (IPCW) methodology
HR: hazard ratio; IC: investigator's choice; OS: overall survival

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KIMMTRAK active in cutaneous melanoma (CM)

Phase 1/2 study of KIMMTRAK + checkpoints in CM patients who progressed on prior anti-PD1



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

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

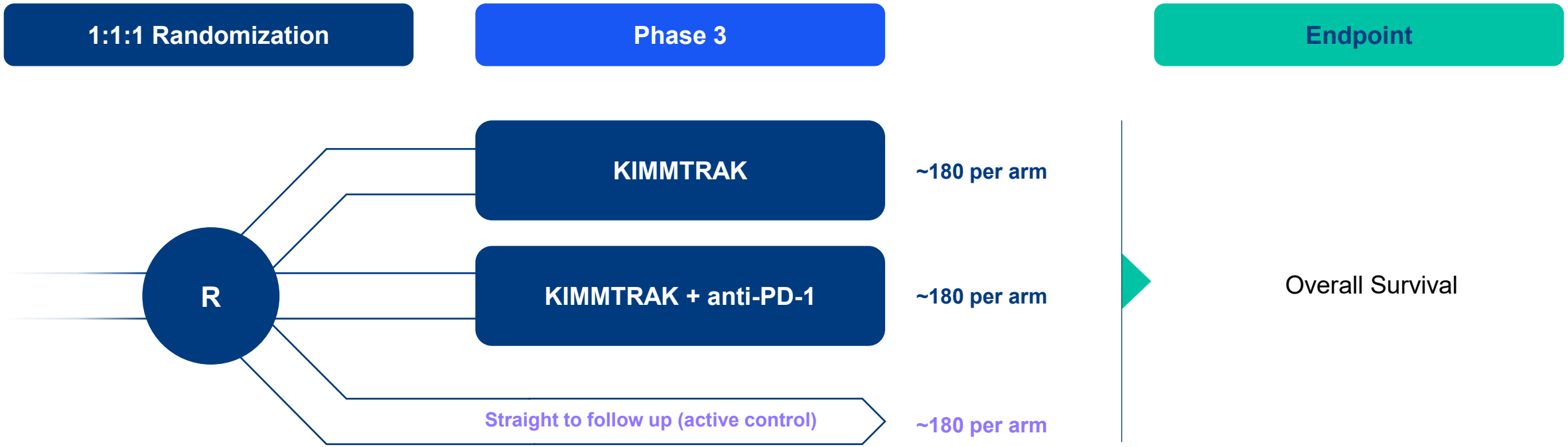
→ **Time since last dose of prior anti-PD1 does not impact outcome**

Hamid O, *et al.* JITC (2023). Middleton *et al.*, ASCO 2022. Remote = Patients received prior anti-PD1 but it was not most recent therapy prior to enrolment. Immediately prior = anti-PD1 was most recent therapy prior to enrolment. * Patients who received prior anti-PD(L)1 therapy and then received tebentafusp+ durvalumab +/- tremelimumab on Study IMCgp100-201. Included patients relapsed from or refractory to prior anti-PD(L)1.

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TEBE-AM: Phase 3 trial in 2L+ cutaneous melanoma

Completed target enrollment (540 patients) – Topline data expected 2Q 2027



2L+ cutaneous melanoma market opportunity **up to 4,000 patients***

* Estimated total number of drug treated HLA*02:01 positive patients per year in the US and 5EU (2024).

Opportunity in 2L+ CM for off-the-shelf therapy with OS benefit

	tebentafusp+/- pembrolizumab[1]	**Lifileucel**[2]	**Vusolimogene oderparepvec** (RP1)	**Other**
Status	Ph 3	FDA Accelerated approval	FDA Accelerated approval	Commonly used
Supporting data	Randomized Ph 3	Single arm Ph 2	Single arm Ph 2	—
Therapy	Biologic, off-the-shelf	Autologous cell therapy	Oncolytic virus	SoC re-treatment Chemotherapy Clinical trials
Route of administration	IV	*Resection → Manuf → Lymph → Admin → IL-2*	Intratumoral injection	IV/oral
Primary endpoint	**OS**	**ORR**	**ORR**	—

[1] KIMMTRAK +/- pembrolizumab: TEBE- AM (IMCgp100-203) trial. [2] J Immunother Cancer 2022
Manuf = manufacturing / Lymph = lymphodepletion / Admin = administration / OS = Overall survival / ORR = Overall response rate

Rationale for KIMMTRAK in adjuvant uveal melanoma

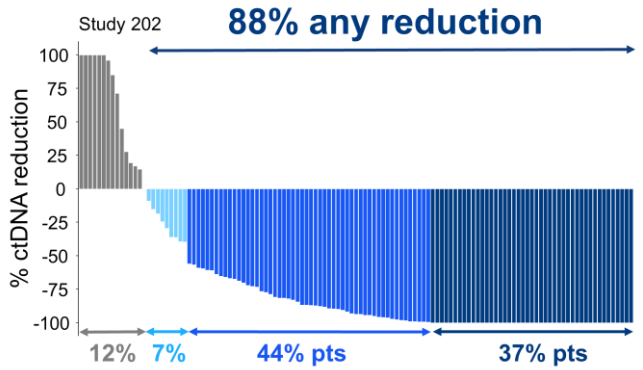
Clinical activity expected to be highest in adjuvant setting with minimal disease burden

In Phase 3 trial, highest clinical activity in tumors with minimal disease burden[1]

Largest metastatic lesion	PFS Hazard ratio	OS Hazard ratio
M1a (<3.0 cm)	0.68	0.36
M1b (3.1-8.0 cm)	0.74	0.71
M1c (≥8.1 cm)	0.95	0.76

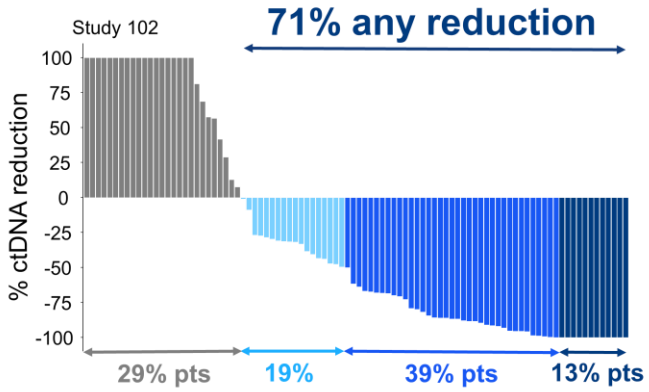
ctDNA reduction in 1st line > 2nd+ line mUM

1st line
(N=123)



37% ctDNA clearance[2]

2nd + line
(N=94)



13% ctDNA clearance[3]

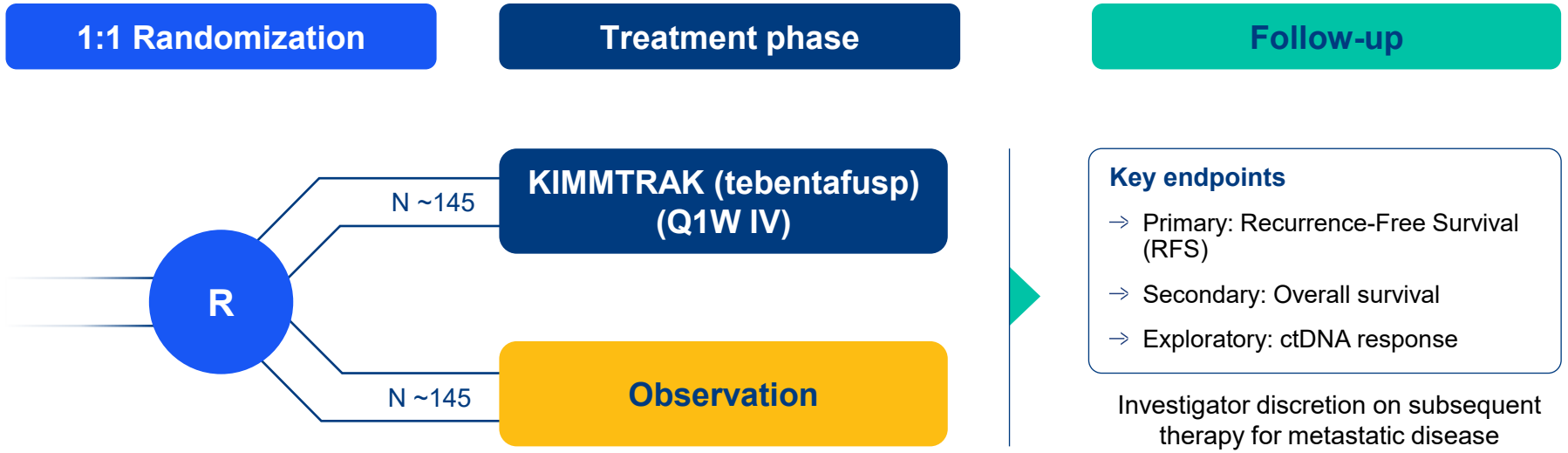
[1] Piperno-Neumann, *et al.* AACR Annual Meeting 2021. [2] Sullivan R, *et al.* Cancer Res (2023) 83 (7_Supplement): 1035. [3] Carvajal, R.D., *et al.* Nat Med 28, 2364–2373 (2022).

ATOM – Phase 3 KIMMTRAK adjuvant UM trial design

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

→ **~290 HLA-A*02:01 patients**

- Within 3 months of definitive treatment of high risk primary uveal (or ocular) melanoma
- No evidence of metastatic disease on imaging



Adjuvant uveal melanoma market opportunity **~1,200 patients***

* Estimated total number of drug treated HLA-A*02:01 positive adjuvant uveal (ocular) melanoma patients per year in the US and Europe (2024).

KIMMTRAK has the potential to benefit up to 6K patients per year

Significant lifecycle management opportunities ahead

Rare gp100+ tumors	**<100***	Investigator led
Adjuvant uveal melanoma	**~1.2K***	**ATOM Phase 3** **2028+[1]**
2L+ advanced cutaneous melanoma	**Up to 4K***	**TEBE-AM Phase 3** Target enrollment completed Topline OS data expected 2Q 2027
Metastatic UM	**~1K*** patients	**APPROVED in 2022** 1Q-3Q 2026 net sales **$325M**

Up to 6,000* patients



* Estimated number of HLA-A*02:01 positive patients per year in the US and Europe.



KIMMTRAK + Brenetafusp in metastatic uveal melanoma

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KIMMTRAK + brenetafusp: dual targeting with ImmTAC bispecific T cell engagers

Tebentafusp (gp100 × CD3)

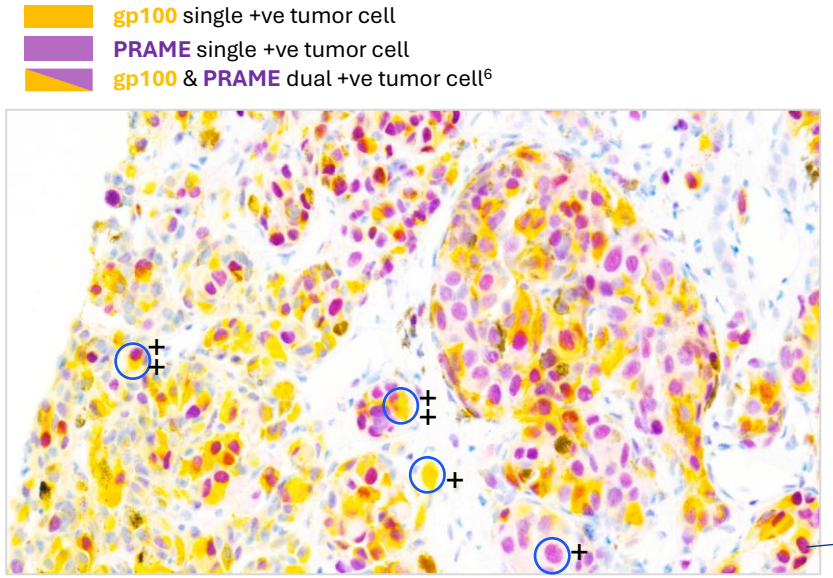
- First bispecific therapy to demonstrate survival benefit in a solid tumor[1]
- Only approved therapy for HLA-A*02:01+ patients with metastatic uveal melanoma
- Global first-line standard of care for HLA-A*02:01 positive patients
- Significant, durable OS benefit[2]

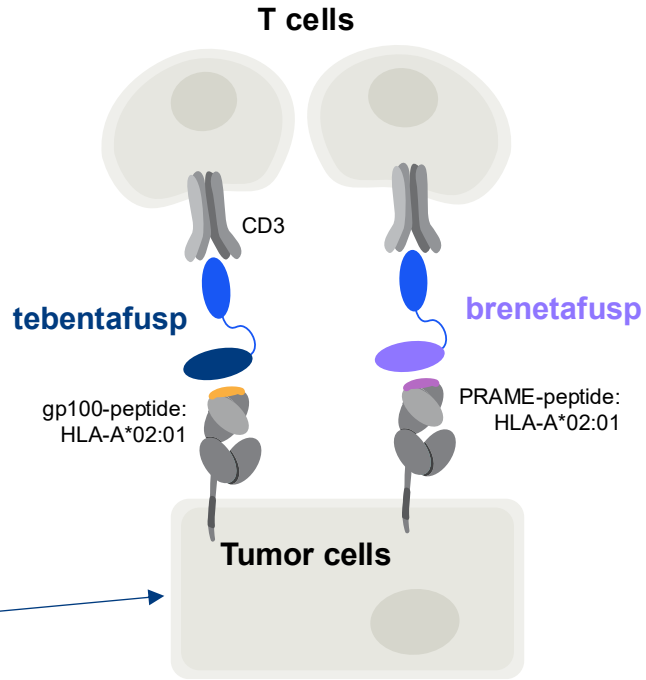
Brenetafusp (PRAME × CD3)

- Clinical activity in melanoma and other cancers[3,4]
- Ongoing Phase 3 trial in 1L advanced cutaneous melanoma
- High PRAME expression associated with worse survival in uveal melanoma[5,6]

Dual antigen targeting may improve anti-tumor activity by:

- Increasing target engagement
- Greater T cell mediated killing





ImmTAC, Immune mobilizing Therapeutic Against Cancer; PRAME, OS, overall survival; Preferentially Expressed Antigen in Melanoma; TCR, T cell receptor

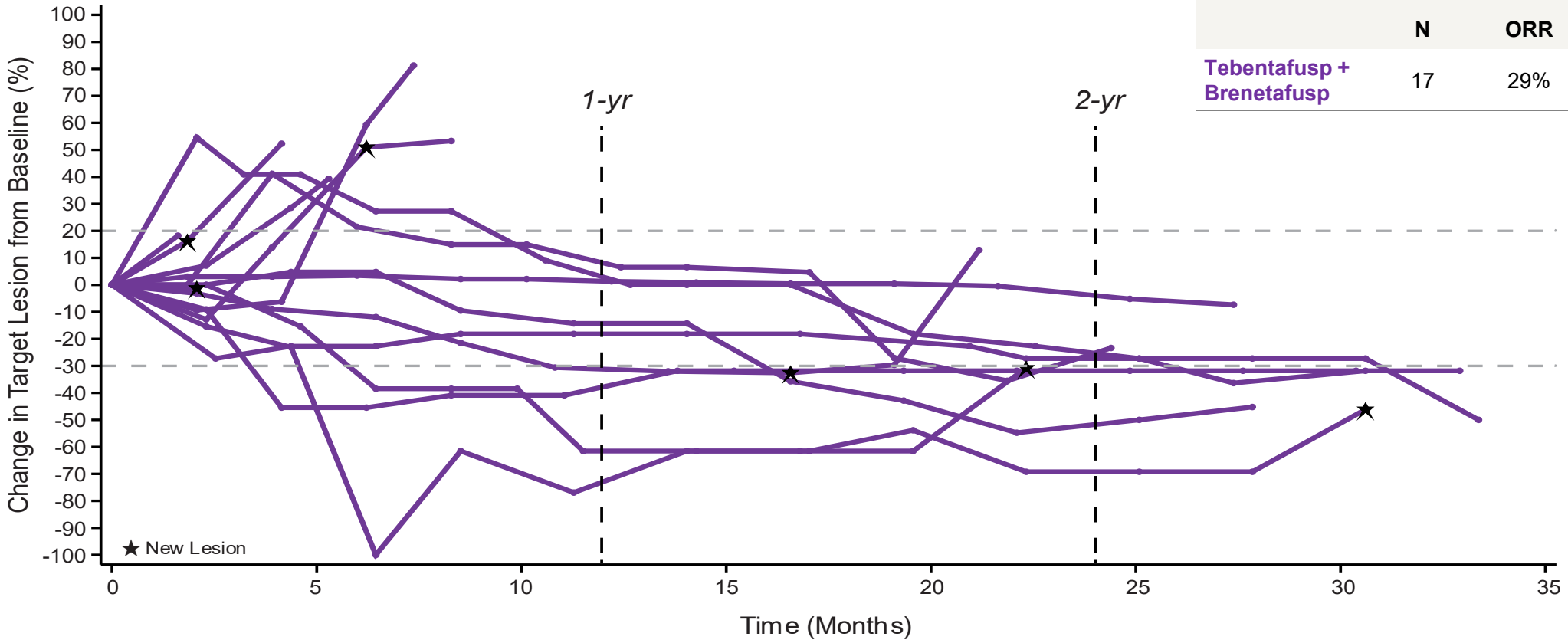
1. Nathan P, et al. N Engl J Med 2021;385:1196-1206; 2. Piperno-Neumann S & Rutkowski P, et al. Ann Oncol 2026; 37:1266-1277; 3. Hamid O., et al. Ann Oncol 2022; 33:S875;
4. Hamid O., et al. J Clin Oncol 2024; 42: suppl 9507; 5. Perez-Perez M., et al. J Clin Pathol 2025; 78:519-526; 6. Biopsy from 1L mUM patient enrolled in tebentafusp Study IMCgp100-202

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Promising response rate and durable disease control for KIMMTRAK + brenetafusp combination

1L tebentafusp + brenetafusp combination (n=17)*

	N	ORR	Median DOR	DCR (PR+SD)
Tebentafusp + Brenetafusp	17	29%	24.1 mo	71%



Randomized Phase 2/3 DUET-UVEAL trial planned

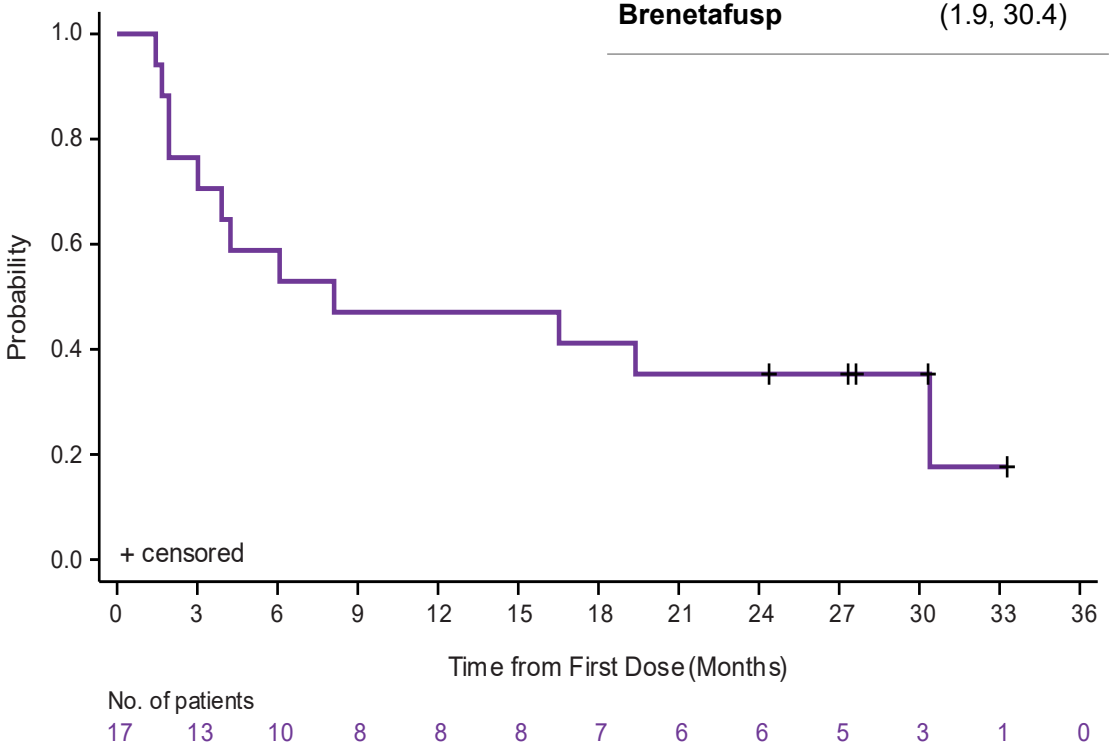
* Only patients with at least one evaluable post-baseline target lesion scan are included. There are 15 evaluable patients; 2 patients are not included due to non-measurable disease at baseline or no evaluable post-baseline target lesion scans.

KIMMTRAK + brenetafusp shows promising PFS & OS in mUM

1L tebentafusp + brenetafusp combination (n=17)

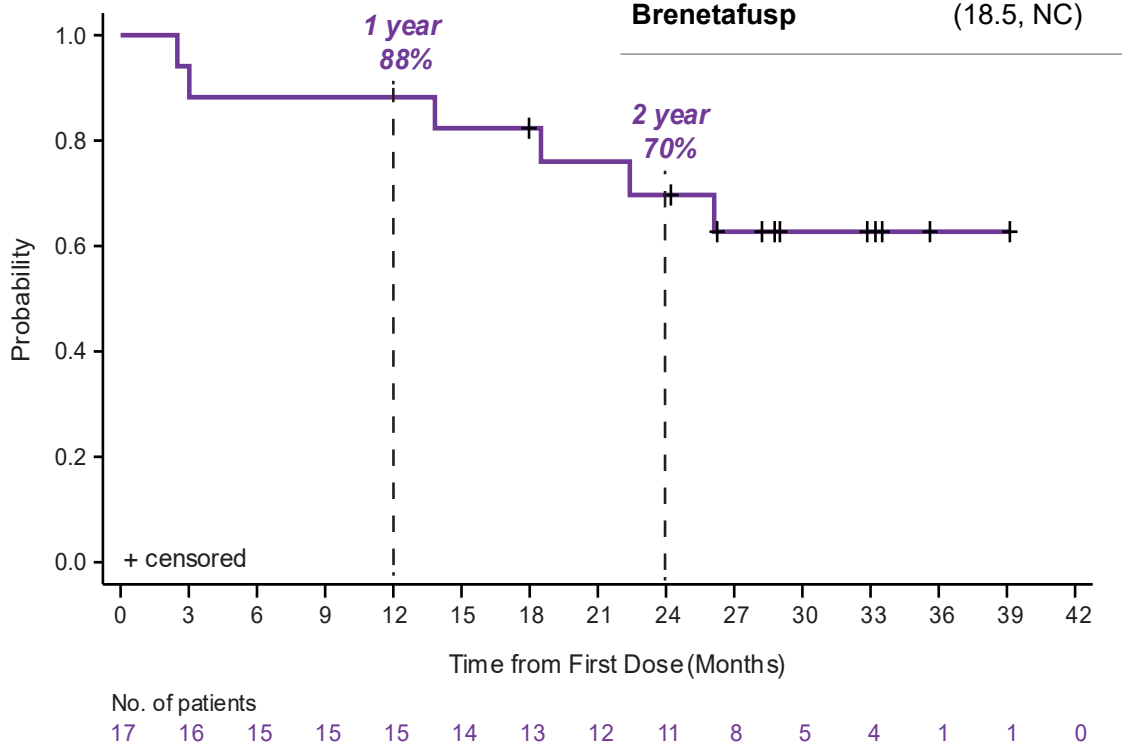
Progression free survival

	mPFS (95% CI)
Tebentafusp + Brenetafusp	8.1 mo (1.9, 30.4)



Overall survival

	mOS (95% CI)
Tebentafusp + Brenetafusp	Not reached (18.5, NC)

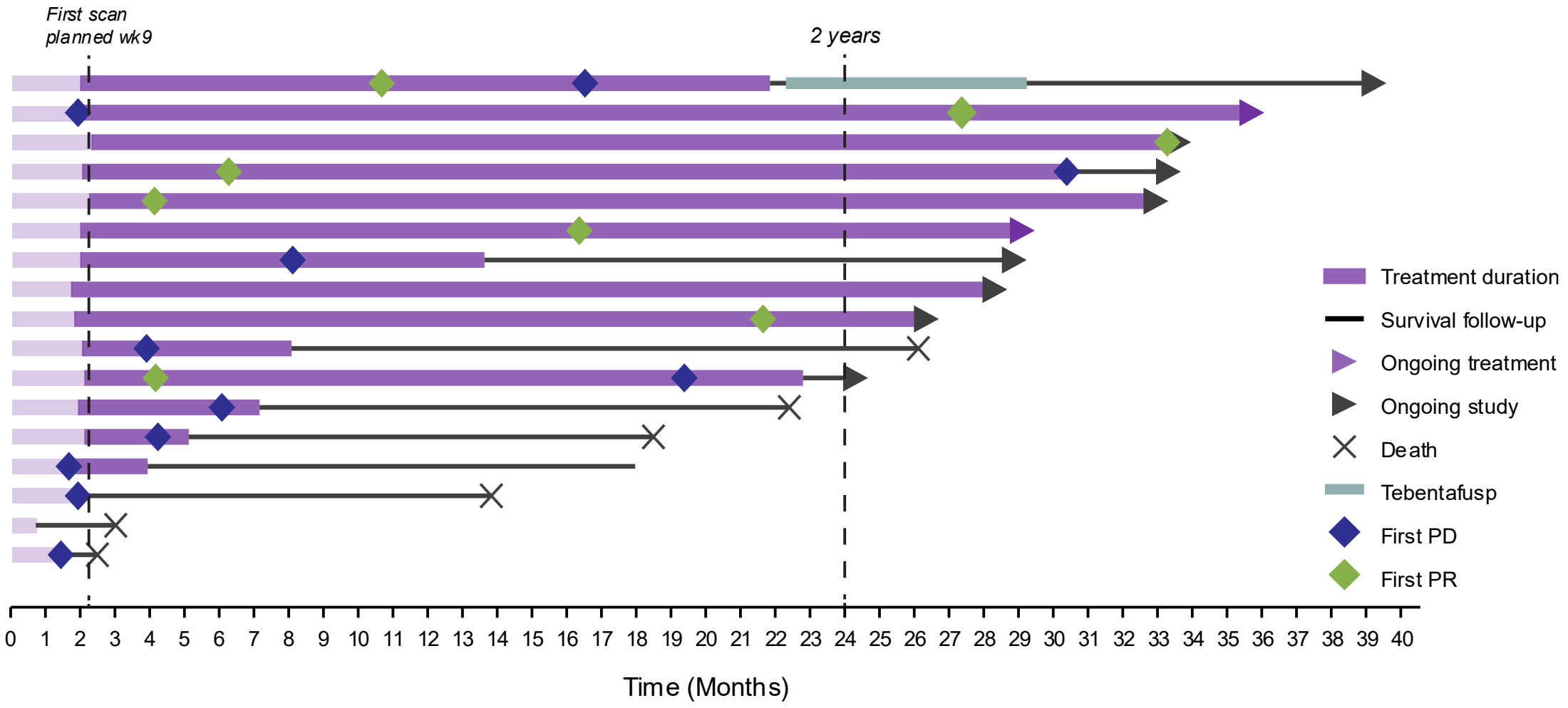


*as of data cut-off date: June 2026

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Majority of patients with OS >2 yrs (64%) only received KIMMTRAK and brenetafusp

1L tebentafusp + brenetafusp combination (n=17)



Patients may have received other therapies during survival follow up

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Phase 1 data compares favorably to other similar datasets with KIMMTRAK monotherapy

	N	ORR	Median PFS, months	Median OS, months	1-yr OS	2-yr OS
Tebentafusp + brenetafusp	**17**	**29%**	**8.1**	**Not reached*** (18.5-NC)	**88%**	**70%**
Tebentafusp mono Ph3[1,2] IMCgp100-202	252	11%	3.4	21.7 (18.6-28.6)	72%	45%
Brenetafusp monotherapy	**16**	**19%**	**4.2**	**20.3** (8.7-27.1)	**63%**	**31%**
Tebentafusp mono Ph2[3,4] IMCgp100-102	127	5%	2.8	16.8 (12.9-21.3)	61%	36%

*Median 1L OS follow up 29 months

1. Nathan P, et al. N Engl J Med 2021;385:1196-1206; 2. Hassel JC & Piperno-Neumann S, et al. N Engl J Med 2023;389:2256-2266; 3. Carvajal RD, et al. Nat Med 2022;**28:**2364–2373; 4. Sacco JJ & Carvajal RD, et al. J Immunother Cancer 2024; 12(6):e009028



PRAME portfolio



Brenetafusp in cutaneous melanoma

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Brenetafusp well tolerated as monotherapy and in combination with pembrolizumab

Brenetafusp treatment-related adverse events (TRAE) in ≥20%

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	Brenetafusp Monotherapy						Brenetafusp + Pembrolizumab	
	40 mcg N=16		160 mcg N=24		All mono 20-320mcg* N=66		N=10	
Preferred Term	**Any grade**	**Grade 3-4**	**Any grade**	**Grade 3-4**	**Any grade**	**Grade 3-4†**	**Any grade**	**Grade 3-4**
Any TRAE, n (%)	14 (88)	4 (25)	23 (96)	13 (54)	63 (95)	24 (36)	10 (100)	5 (50)
CRS‡	9 (56)		10 (42)		36 (55)		5 (50)	
Rash§	7 (44)		10 (42)		33 (50)	1 (2)	6 (60)	
Pyrexia	7 (44)		10 (42)	3 (13)	27 (41)	4 (6)	0	
Chills	6 (38)		9 (38)		19 (29)		1 (10)	
Fatigue	5 (31)		6 (25)		18 (27)		4 (40)	
Lymphocyte count decreased¶	6 (38)	4 (25)	8 (33)	7 (29)	18 (27)	15 (23)	3 (30)	2 (20)
Nausea	4 (25)		7 (29)		15 (23)		5 (50)	
Pruritus	7 (44)		5 (21)		15 (23)		3 (30)	

- Safety profile similar at TD 40 and 160 mcg
- Most frequent TRAEs were CRS and rash; mostly grade 1, with intensity decreasing over time
- Most frequent grade 3-4 TRAE was transient lymphocyte count decrease
- TRAE led to treatment discontinuation in 2 mono + 1 pembro combo patient**

CRS, cytokine release syndrome; pt(s), patient(s); TD, target dose; * Includes 1 pt at TD 10mcg who later escalated to 20mcg; † Other mono G3 TRAE: anemia in 2 pts, all others occurred in 1 pt each; ‡ CRS graded per ASTCT 2019 criteria; all other AE per CTCAE v5.0;§ Rash is a composite term for a list of skin toxicities of any grade [4]; ¶ Lymphocyte count decreased is a composite term including lymphocyte count decreased and lymphopenia; ** TRAE leading to discontinuation: mono 80 mcg papilledema; mono 160 mcg chronic inflammatory demyelinating polyneuropathy; pembro combo AST increased

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Higher efficacy observed at 160mcg dose

Clinical activity maintained in subgroups typically less responsive to anti-PD1

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	N	DCR % (PR+SD)	ORR %	6-mo OS %*	% Confirmed tumor reduction
Monotherapy IV	66	52	12	87	27
Dose assessment					
40 mcg	16	56	6	81	25
160 mcg	24	67	17	87	38
Clinical subgroups					
PD1 primary resistance	20	55	10	74	25
Acral / Mucosal	7	57	14	86	29
Cutaneous, Stage IV M1c/d	42	45	10	85	21
Baseline Sum of Target Lesions > 10 cm	25	44	12	83	24
Brenetafusp + Pembrolizumab	10	70	20	80	20
PD1 primary resistance	6	67	33	67	33

Monotherapy:

- Clinical benefit numerically higher for 160 mcg vs. 40 mcg despite worse baseline prognostic factors
- Objective responses and disease control seen across difficult-to-treat subgroups

Combination:

- Multiple measures of clinical benefit numerically higher in PD1 primary resistance subgroup compared to monotherapy

DCR, disease control rate; ORR, overall response rate; OS, overall survival; PD1, programmed cell death protein 1; PR, partial response; SD, stable disease

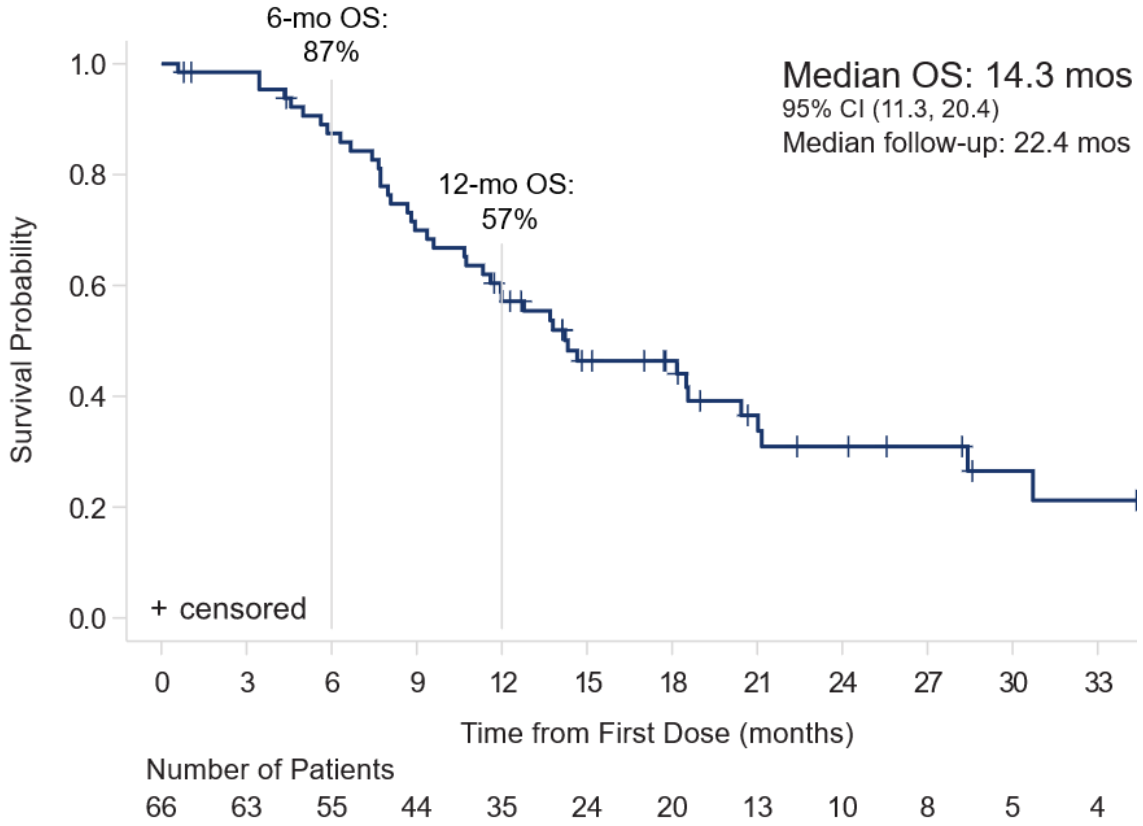
* Includes 1 pt at TD 10mcg who later escalated to 20mcg; † OS estimated based on Kaplan-Meier method; ‡ PD1 primary resistance defined as progressive disease within 6 months of 1st anti-PD(L)1 exposure; § Large tumor burden defined as baseline sum of target lesions >10cm

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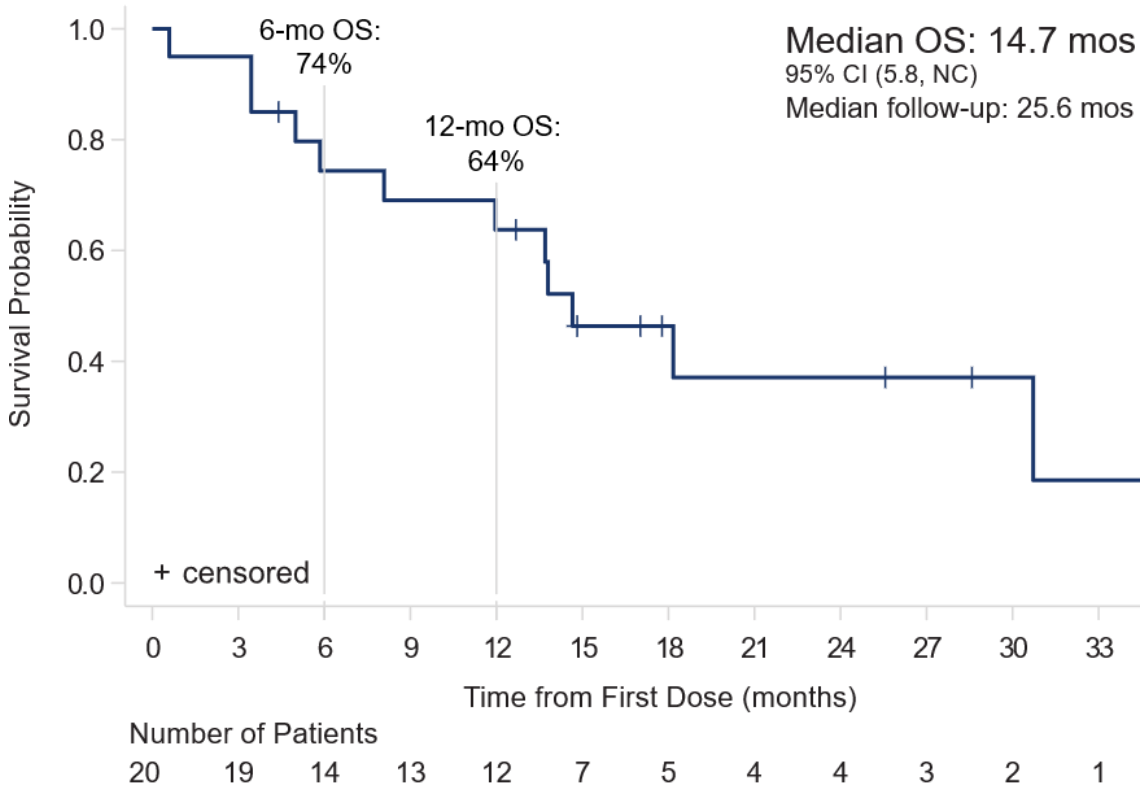
Promising overall survival seen in both monotherapy and PD1 primary resistant subgroup

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All Mono IV patients



PD1 primary resistant subset

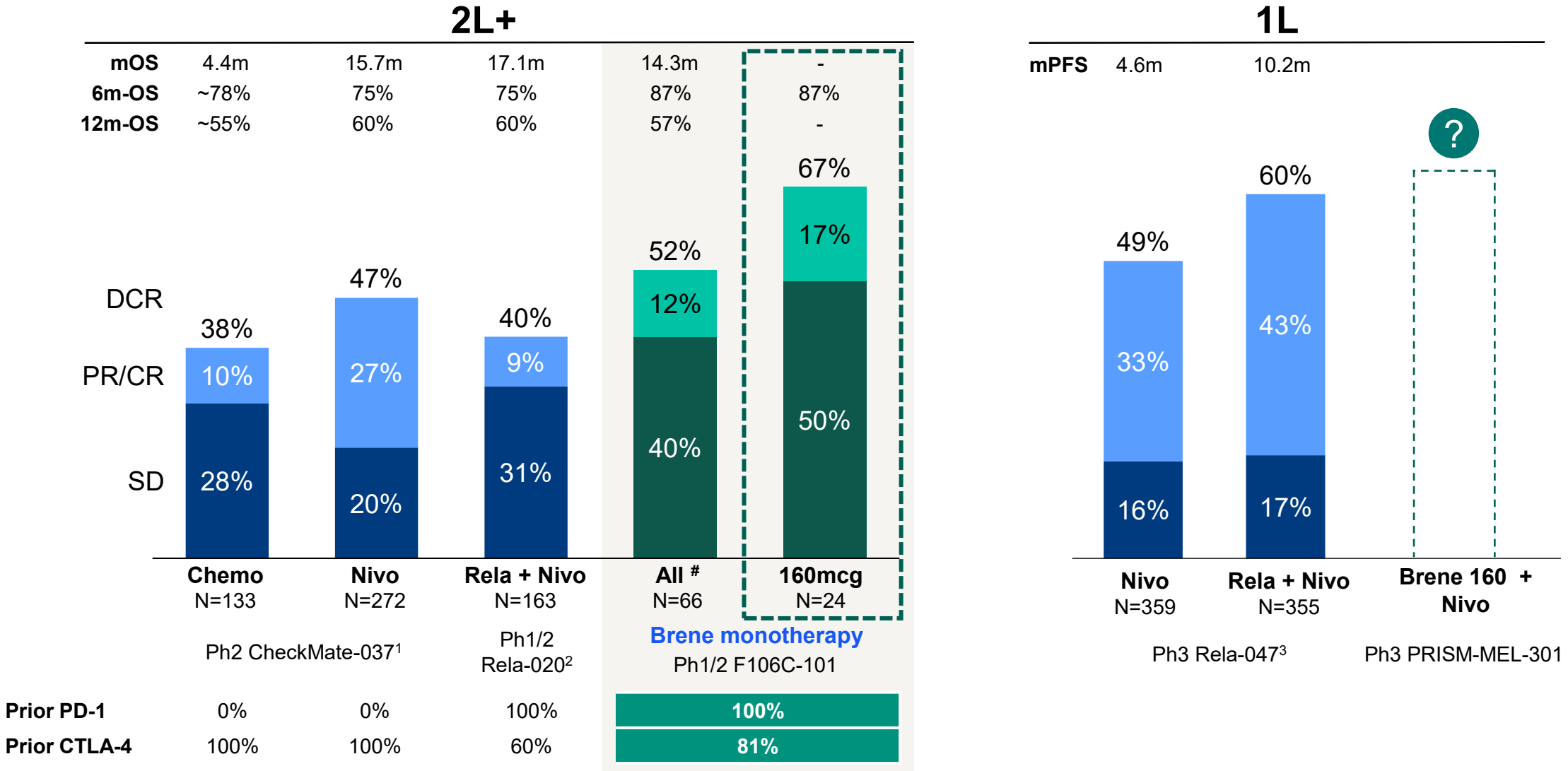


‡ PD1 Primary resistance defined as progressive disease within 6 months of 1st anti-PD1 exposure

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Multiple lines of evidence supports 1L Phase 3 trial of brene + nivo

Comparison to nivolumab and relatlimab + nivolumab



Note: data for informational purposes, no comparative claims are implied or intended. Nivo: nivolumab; Rela: relatlimab; 1. CM037: NCT01721746, Larkin J, et al. J Clin Onc 2018; 2. RELA020, NCT01968109: D2 Cohort (≥1 anti-PD-(L)1 containing regimen), Ascierto PA, et al. J Clin Onc 2023. 3. RELA047: NCT03470922, Long GV, et al. NEJM 2023. # Patients treated with brene monotherapy at 20 – 320mcg.

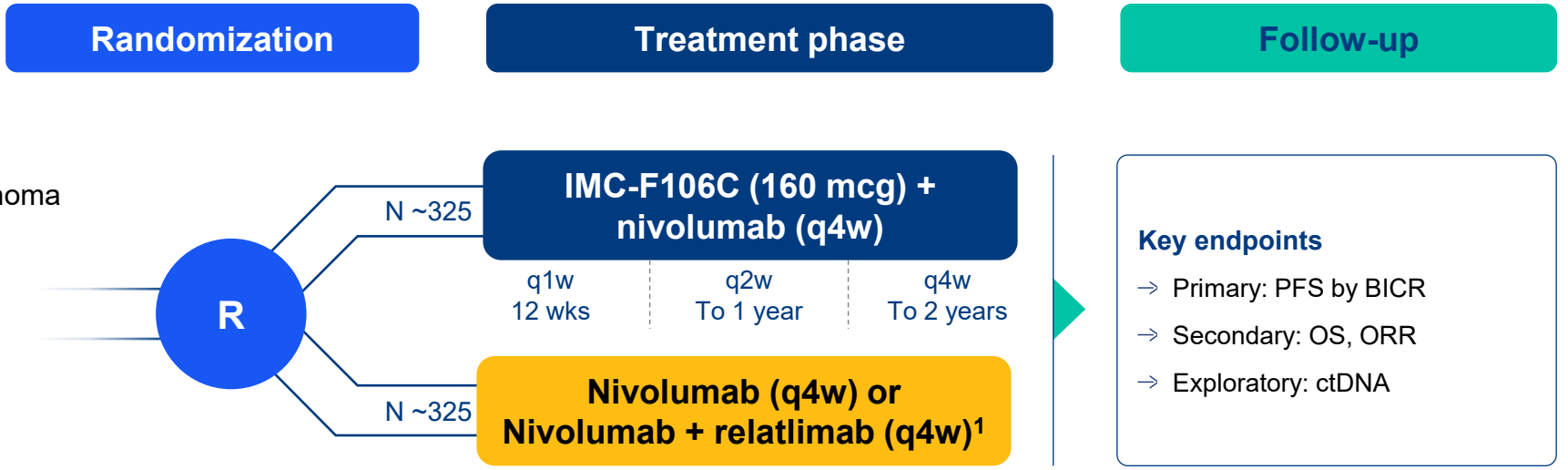
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PRISM-MEL-301: Phase 3 trial in 1L cutaneous melanoma

Global randomization ongoing

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

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



1L market opportunity

~10K HLA-A02+[3]

[1] Use of nivolumab or nivolumab + relatlimab as control will be country specific. [2] Represents target dose after intra-patient escalation. [3] Estimated total number of drug treated HLA-A*02:01 positive 1L cutaneous melanoma patients per year in the US and Europe (2024).
q1w = every week, q2w = biweekly, q4w = every 4 weeks. / IDMC = Independent Data Monitoring Committee

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Brenetafusp in ovarian

Brenetafusp, Phase 1 monotherapy and chemo combo, well tolerated

Treatment related adverse events (TRAE) frequency and severity attenuated over time

	Mono* N = 37		Chemo combo* N = 16	
Preferred Term	**TRAE**	**G3/4 TRAE§**	**TRAE**	**G3/4 TRAE§**
ANY	36 (97%)	7 (19%)	16 (100%)	8 (50%)
CRS‡	21 (57%)	---	12 (75%)	---
Rash§	19 (51%)	1 (3%)	13 (81%)	---
Nausea	14 (38%)	---	4 (25%)	---
Fatigue	13 (35%)	---	6 (38%)	1 (6%)
Vomiting	12 (32%)	---	2 (13%)	---
Pyrexia	11 (30%)	---	9 (56%)	---
ALT increased	4 (11%)	1 (3%)	8 (50%)	3 (19%)
AST increased	2 (5%)	1 (3%)	8 (50%)	2 (13%)
Flushing	1 (3%)	---	4 (25%)	---

Other mono G3 TRAE, each n=1: anemia, diarrhea, neutropenia, pericardial effusion, rash maculo-papular

Other combo G3 TRAE, each n=1: dyspnea, fatigue, neutropenia, presyncope

→ **No TRAE leading to treatment discontinuation or death**

→ **Monotherapy:**

- Most frequent TRAE was G1/G2 CRS
- Of patients who had CRS, vast majority had G1

→ **Combinations:**

- Additional chemo-related AEs were observed and consistent with each agent

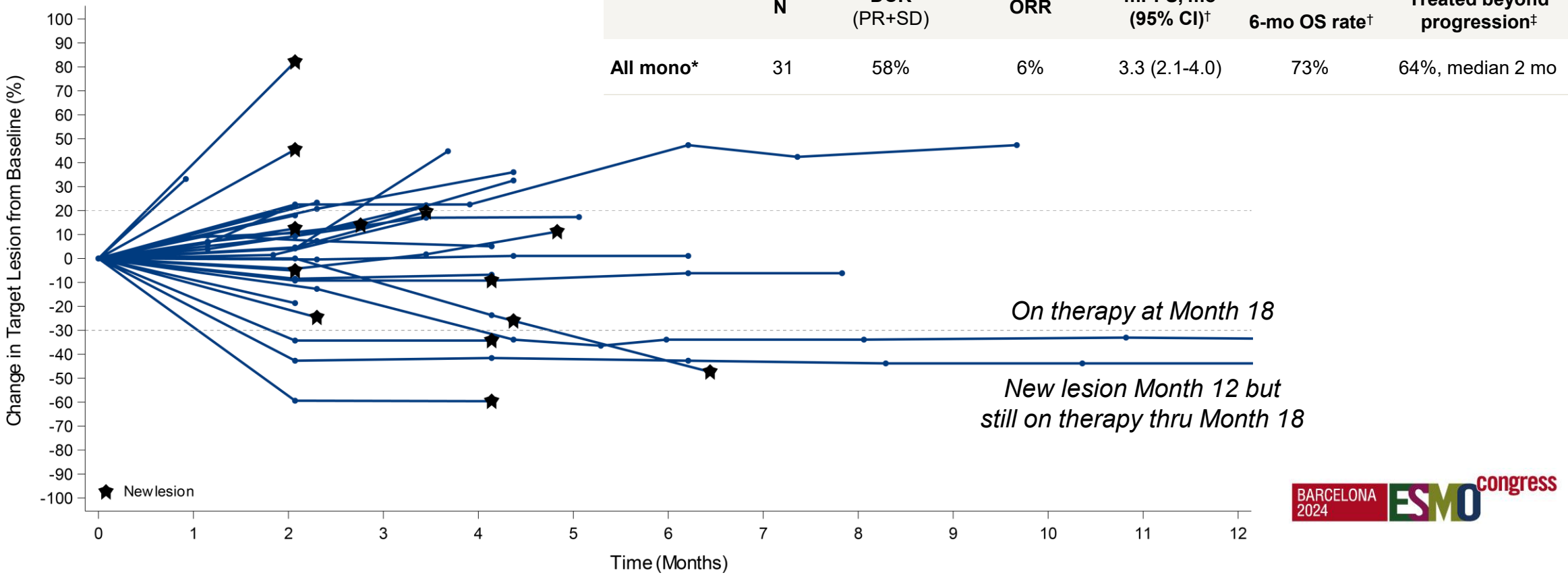
BARCELONA 2024 ESMO congress

CRS, cytokine release syndrome; ALT, alanine transaminase; AST, aspartate transaminase. * Includes patients receiving target doses ≥20mcg. § Other mono G3 TRAE, each N=1: anemia, diarrhea, neutropenia, pericardial effusion, rash maculo-popular; other combo G3 TRAE, each N=1: dyspnea, fatigue, neutropenia, presyncope. ‡ CRS graded per ASTCT 2019 criteria; all other AE per CTCAE v5.0. § Rash is a composite term for a list of skin toxicities of any grade (Nathan et al. 2021)

Monotherapy benefit characterized by durable disease control

Monotherapy (N = 31 evaluable*)

	N	DCR (PR+SD)	ORR	mPFS, mo (95% CI)†	6-mo OS rate†	Treated beyond progression‡
All mono*	31	58%	6%	3.3 (2.1-4.0)	73%	64%, median 2 mo



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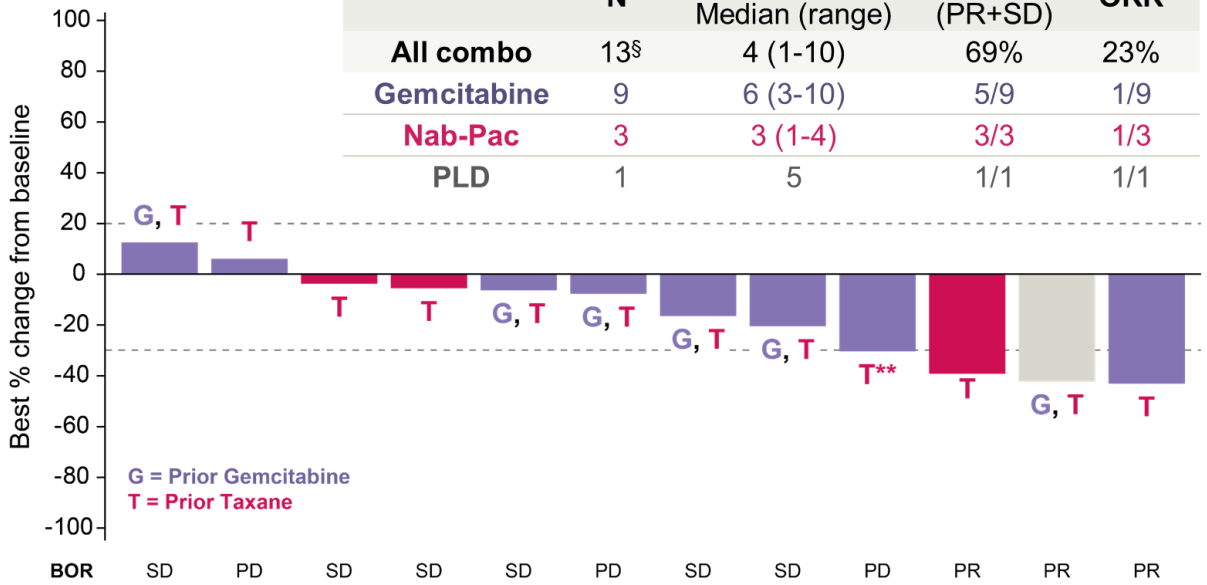
DCR, disease control rate; mPFS, median progression free survival; ORR, overall response rate; OS, overall survival; PR, partial response; SD, stable disease. * 31 of 37 patients had baseline and at least one tumor assessment on treatment; 6 patients not included due to no evaluable post-baseline tumor scans or non-measurable disease at baseline. † Median PFS and 6-month OS rate are based on all 37 monotherapy patients. ‡ 22 of 31 efficacy evaluable patients had progression events; 14 of 22 (64%) were treated beyond initial progression.

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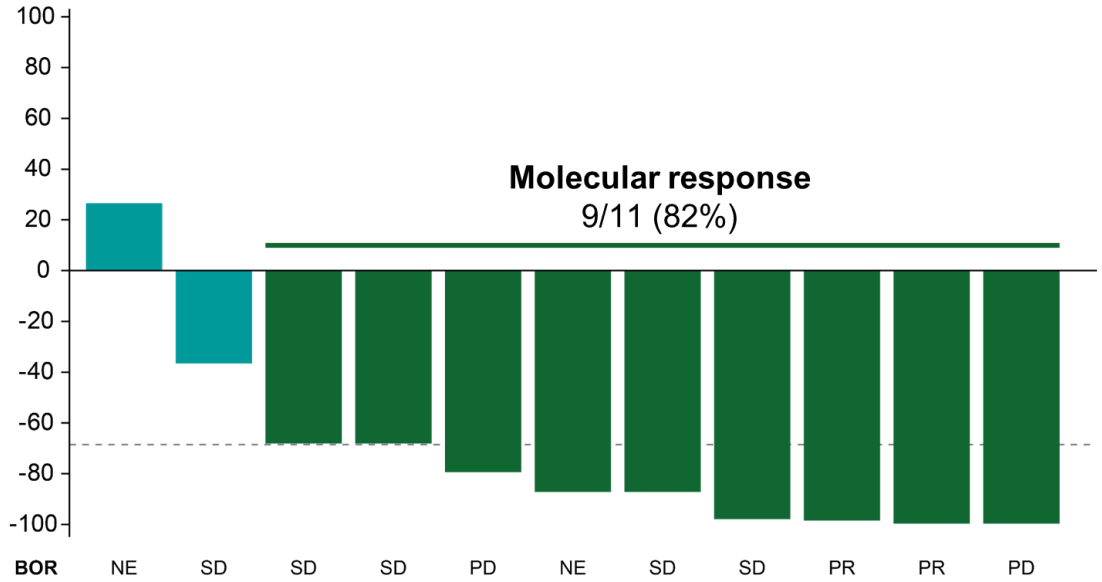
Clinical benefit with brenetafusp may be enhanced with chemotherapy

Best tumor reduction (N=13 evaluable§)

	N	Prior lines¶, Median (range)	DCR (PR+SD)	ORR
All combo	13§	4 (1-10)	69%	23%
Gemcitabine	9	6 (3-10)	5/9	1/9
Nab-Pac	3	3 (1-4)	3/3	1/3
PLD	1	5	1/1	1/1



Best ctDNA reduction† (N=11 evaluable‡)



- 18/40 pts (45%; 9 mono, 9 combo) had a molecular response (≥0.5 log reduction in ctDNA) by week 9
- Pts with a molecular response had longer median PFS (6mo vs 3mo) and higher 6-month OS rates (93% vs 58%) vs pts who did not, respectively#
- ctDNA clearance in 6/40 pts (15%), including pts with BOR of PD

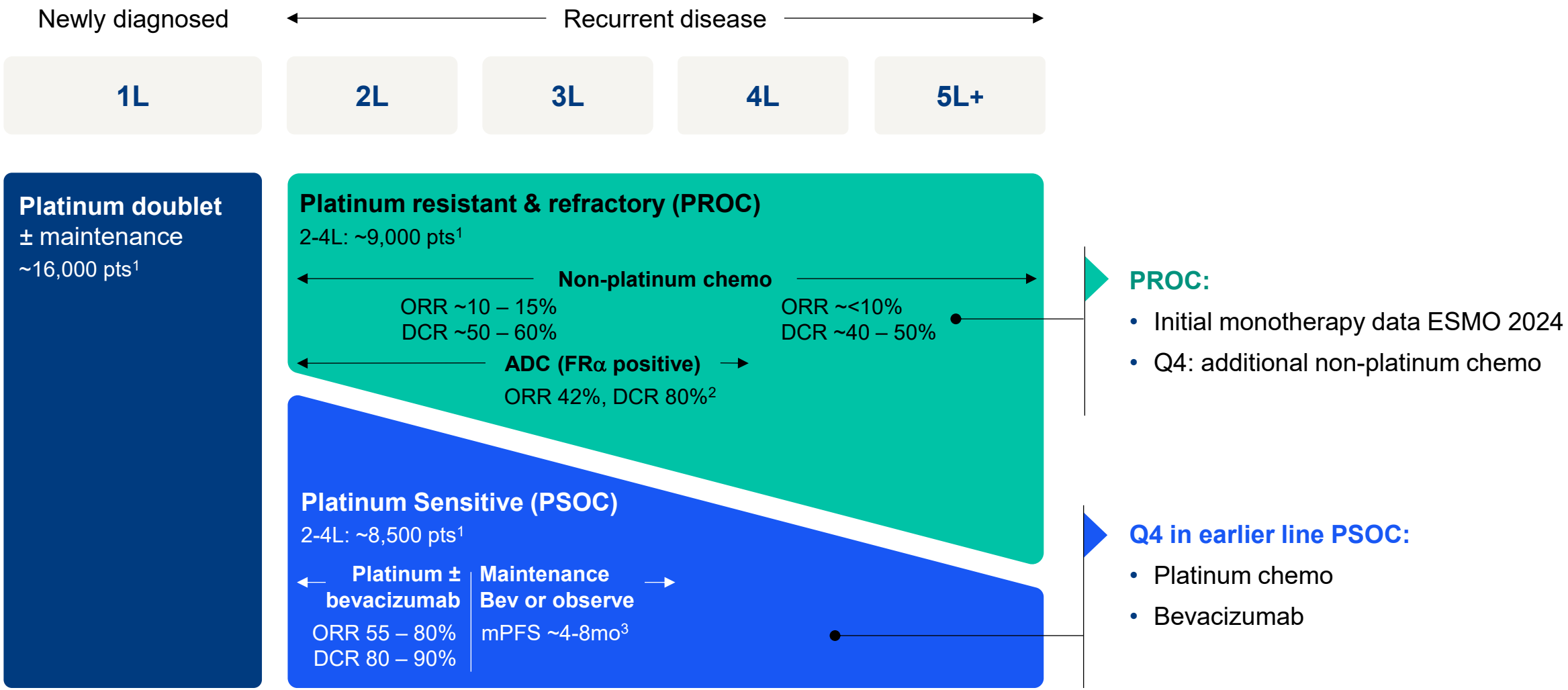
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BOR, best overall response by RECISTv1.1; DCR, disease control rate; ORR, overall response rate; PD, progressive disease; PR, partial response; SD, stable disease. * 31 of 37 mono patients had baseline and at least one tumor assessment on treatment; 6 patients not included due to no evaluable post-baseline tumor scans or non measurable disease at baseline. § 13 of 16 combo patients had baseline and at least one tumor assessment on treatment; 3 patients not included due to no post-baseline tumor scans and one patient not included in waterfall due to missing target lesion size data. ¶ Prior anthracycline was not permitted. ** prior taxane therapy per communication from investigator post data cutoff.

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Evaluating brenetafusp in ovarian cancer

Expect to present Phase 1 data in multiple cohorts in 2H 2026



[1] Estimated total number of treated HLA*02:01 positive patients per year in the US and 5EU across lines. [2] MIRASOL Ph3 (mirvetuximab) investigator assessed objective response. [3] Estimated mPFS for maintenance portion of treatment only

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Building our second product franchise

Translating data between brenetafusp and PRAME-HLE provides path for next steps

Brenetafusp Ph1/2 data presentations

2024 ASCO ANNUAL MEETING

Melanoma
Monotherapy & PD-1 combo

2026 ASCO ANNUAL MEETING

Melanoma
Monotherapy & PD-1 combo
updated data

BARCELONA 2024 ESMO congress

Ovarian – PROC
Mono & chemo combination

SITC 2026 Society for Immunotherapy of Cancer NOV. 4–8 | PHOENIX

Metastatic uveal melanoma
KIMMTRAK + Brenetafusp

Guiding next steps

PRISM MEL301
Metastatic cutaneous melanoma
Ph3 trial ongoing

2026
Ovarian – PROC/PSOC
Chemo & bevacizumab
combinations

2026
NSCLC
Mono, standard of care therapy
combinations

2027
PRAME HLE
(IMC-P115C)
Initial dose escalation

NEW
DUET-UVEAL
Metastatic uveal melanoma
Ph 2/3 trial planned

PROC = Platinum Resistant and Refractory Ovarian Cancer. PSOC = Platinum Sensitive Ovarian Cancer.



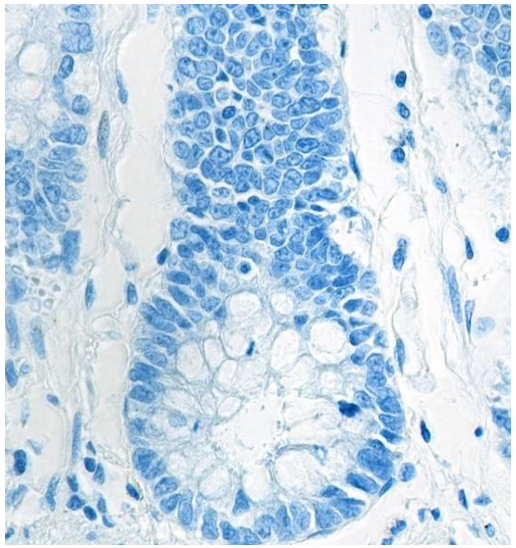
Novel ImmTAC candidate for GI cancers from our discovery engine

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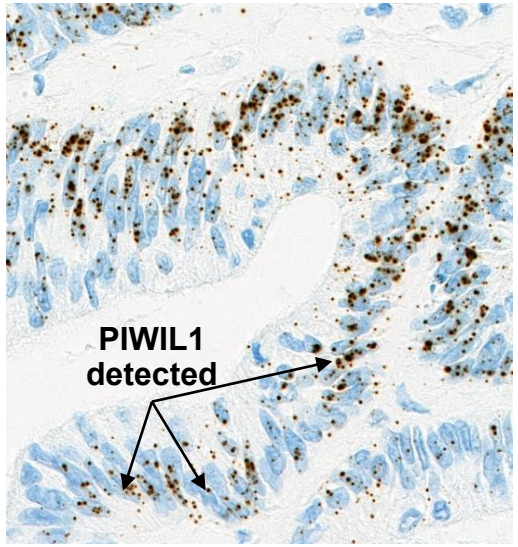
IMC-R117C: First-in-class target PIWIL1 for colorectal & GI cancers

PIWIL1 RNA *in situ* hybridization

Normal colon



Colon adenocarcinoma



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

→PIWIL1 is a negative prognostic marker in multiple cancers, including in CRC[1]

~20K colorectal + ~15K other tumors[2] patients positive for PIWIL1 and HLA-A02[3]

PIWIL1, piwi-like protein1.
1 CRC: colorectal cancer. 2 Estimated across esophageal, gastric, pancreatic, ovarian, endometroid cancers. 3 Estimated number of metastatic PIWIL and HLA-A*02:01 positive patients per year in G7 (2024).

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Pursuing a functional cure in infectious diseases

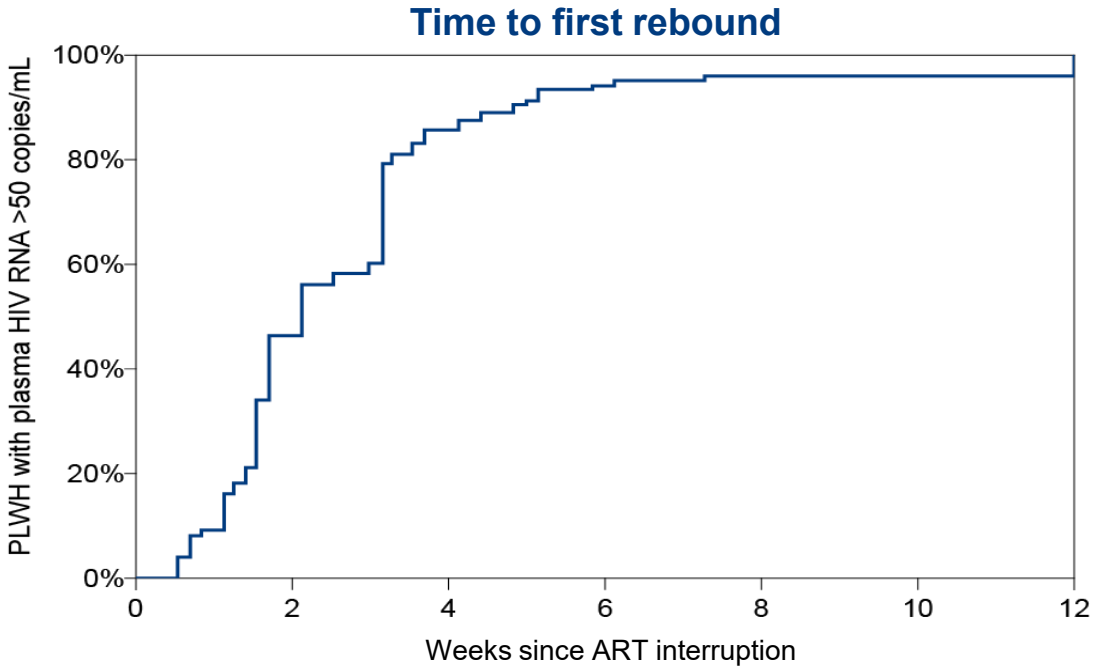
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A functional cure is key to ending the HIV pandemic

→ Lifelong antiretroviral therapy (ART), including long-acting, **not sustainable solution to global pandemic**

→ **Over 500K** HLA-A02+ people living with HIV (PLWH) in a range of countries are **currently on ART***

Rapid viral rebound (median ~2 weeks) after ART interruption



Detection level 50 copies/mL *Transmission level 200 copies/mL*

* Estimated number of HLA-A02+ PLWH on anti-retroviral therapy in US, 5EU, Japan, AUS / NZ

STRIVE Phase 1 HIV multiple ascending dose enrolling

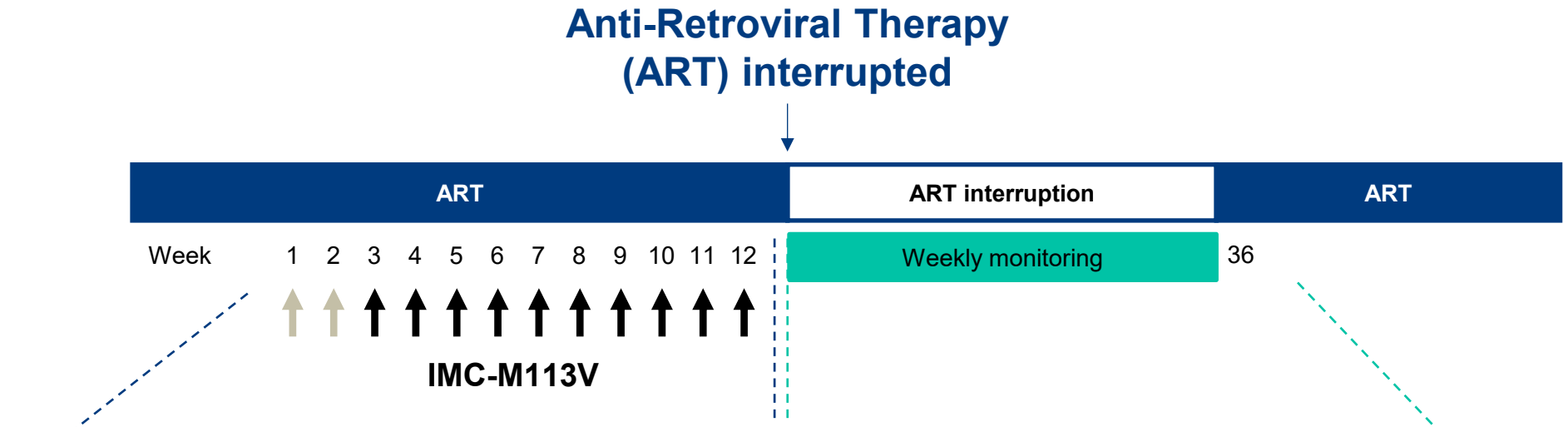
Ongoing Phase 1 trial at higher doses to determine safety and anti-viral activity of IMC-M113V[1]

→ **Key eligibility**

- PLWH on ART
- Initiated ART >3 mo after HIV acquisition

→ **IMC-M113V regimen:**

- Weekly for 12 weeks



Reservoir quantification (blood):

Endpoint	Interpretation
Cell-associated HIV Gag RNA	Active viral transcription

Viral rebound (magnitude and kinetics)

Endpoint	Interpretation
Plasma HIV RNA	Infectious virus

Step dose (initially 15 mcg) Target dose (60 - 300 mcg)

[1] Program is wholly owned. Immunocore retains all development and commercialization rights in the developed world
PLWH: People living with HIV. ART: Anti-retroviral therapy. ATI: analytical treatment interruption.

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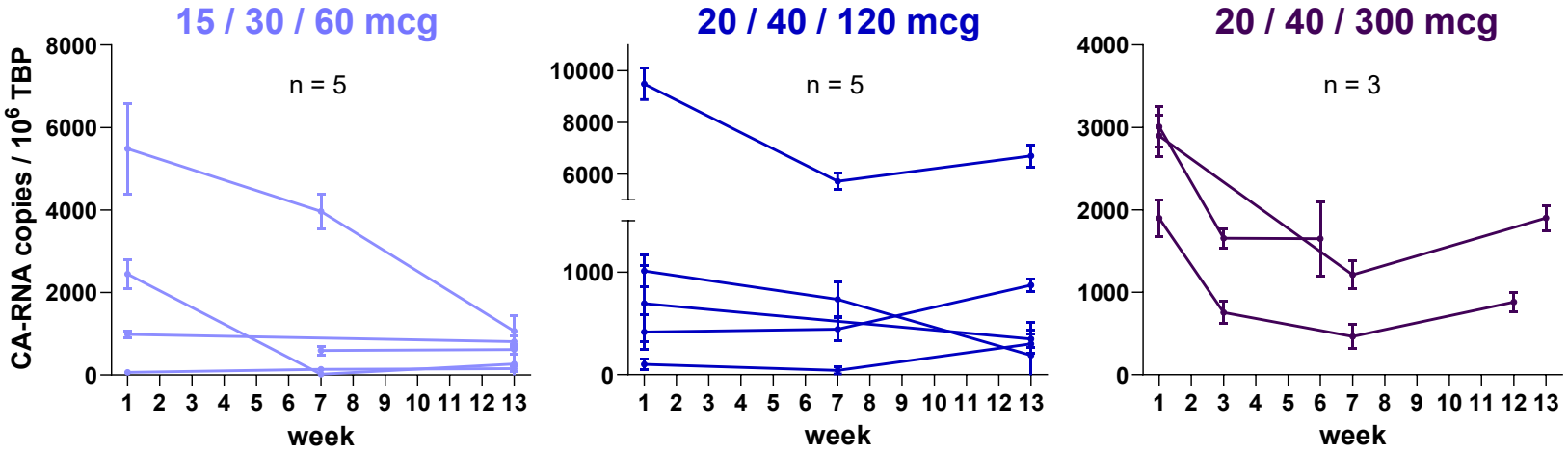
IMC-M113V is well tolerated, with only low-grade cytokine release syndrome

Target dose (mcg)	15 / 30 / 60	20 / 40 / 120	20 / 40 / 300
Participants (n)	*5*	*5*	*6*
Cytokine release syndrome*:			
Grade 1 (Fever ≥ 38 °C)	0	0	**5**
Grade ≥ 2 (Fever + hypoxia or hypotension)	0	0	0
Other treatment related AEs:			
Headache	0	3	5
Fatigue	1	2	3
Nausea / vomiting	1	0	1
SAE	0	0	0
AE leading to discontinuation	0	0	0

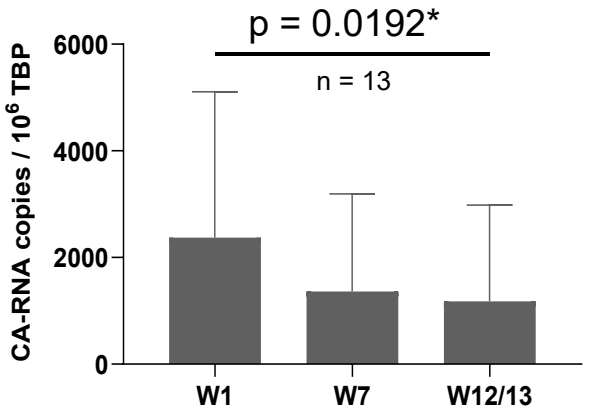
* ASCTC grading applied; Gr 1 CRS occurred at W3 only in 4/5 participants and W3 & W4 in 1/5 participants; all resolved in < 4 hrs. Treatment-related adverse events (AE) all mild-moderate except 1 x fatigue (severe). 1 participant withdrew after W6 due to relocation away from site

Significant reduction in cell-associated HIV Gag RNA and trend of reduction in intact HIV DNA after completion of multiple dose schedule

→ Cell-associated HIV Gag RNA



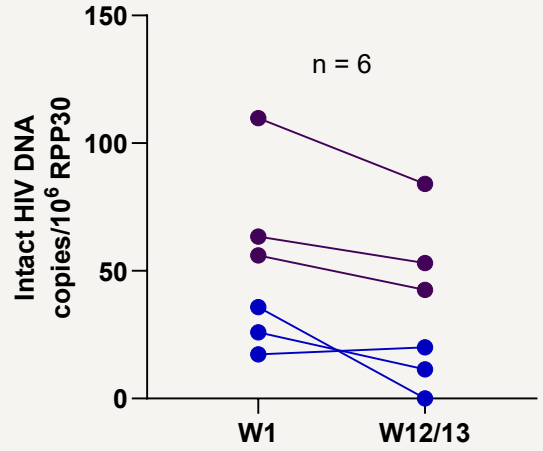
1 no signal detected; 2 in progress



Grouped analysis of 3 dose cohorts; bars show mean + SD.

*Mixed effects analysis

→ Intact HIV DNA



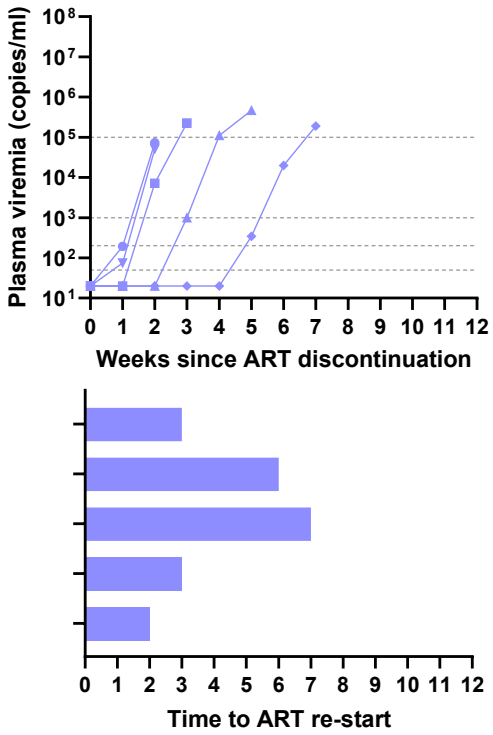
Evaluation of further participants ongoing

HIV Gag CA-RNA and intact HIV DNA quantified from CD4+ cells by DD-PCR using “cross-subtype” primer probe sets (Cassidy et al. iScience. 2021; 11;25:103615)

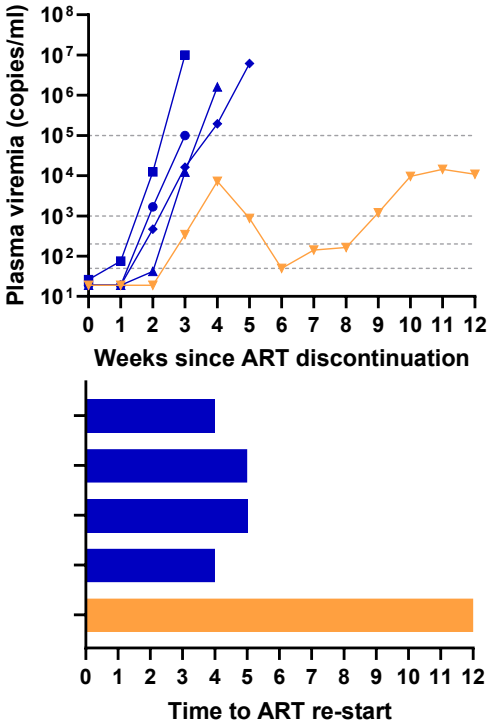
HIV initial Phase 1 data demonstrated delayed viral rebound

Very well tolerated with dose dependent antiviral effect

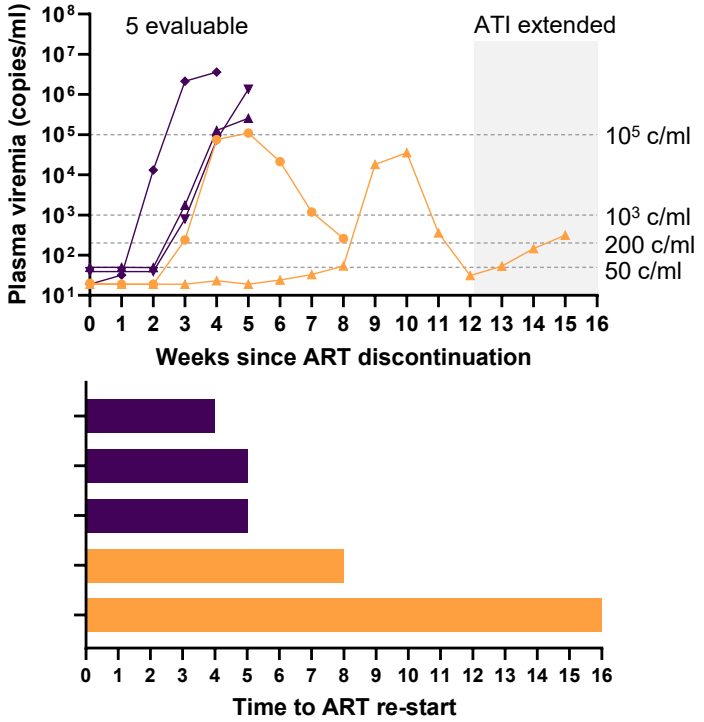
15 / 30 / 60 mcg



20 / 40 / 120 mcg



20 / 40 / 300 mcg



Completed enrollment of additional patients at up to 1,200 mcg dose – Data expected 1H 2027

ART re-start criteria: Confirmed CD4 <350 cells/µl | pVL ≥ 103 copies/mL for > 4 weeks (± 7 days) | pVL > 105 copies/mL x 2 visits 7 days apart (± 7 days) | Symptoms deemed attributable to ATI | participant choice / physician recommendation | pregnancy; PLWH: People living with HIV

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Pioneering tissue-specific immune downmodulation for treatment of autoimmune diseases

Our vision for autoimmunity and inflammation landscape: tissue-specific down modulation of the immune system

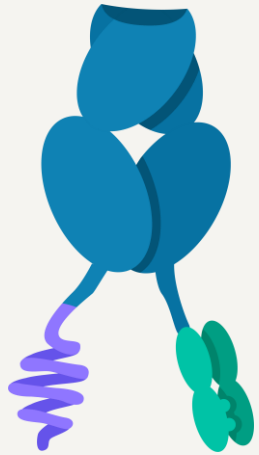
Vision for autoimmunity and inflammation landscape

Current
Systemic immune suppression, even if inflammation in single tissue

Future
Down modulation of immune system localized to inflamed tissue

ImmTAAI

Tissue-tethered targeting of HLA-family of molecules



PD1 agonist
suppresses T cells

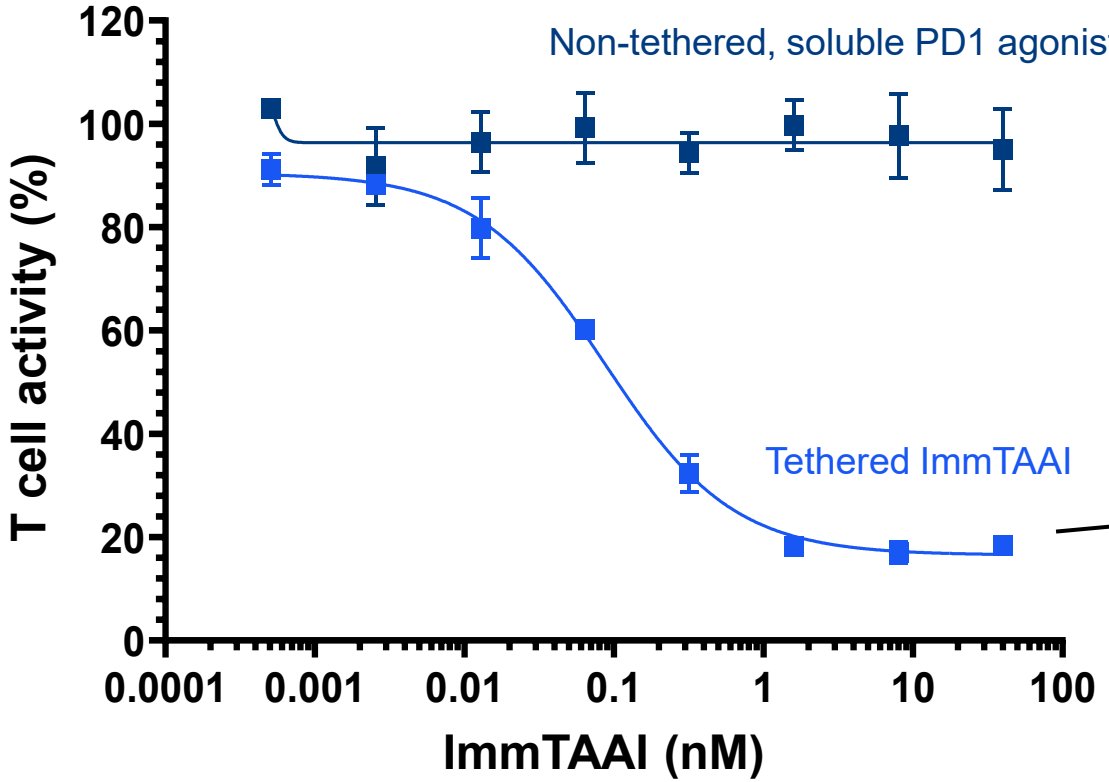
Fc fusion
infrequent dosing

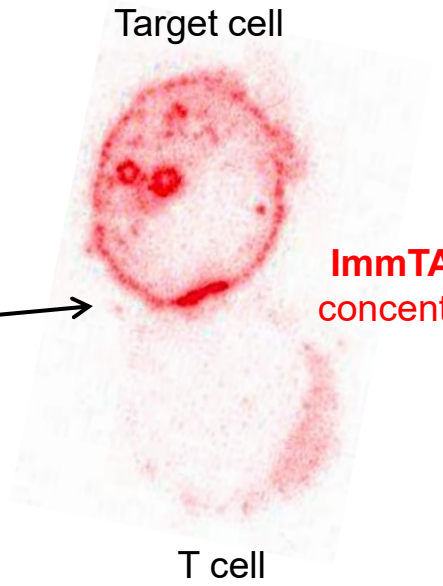
ImmTAAI candidates & area of focus

IMC-S118AI
(PPI x PD1-A-02)
intended for type 1 diabetes

IMC-U120AI
(CD1a x PD1)
non-HLA restricted candidate for atopic dermatitis

Inhibition of T cell activity only when tethered to target cell





ImmTAAI (red fluorescent) concentrates within synapse

Tethered PD1 agonist brought into T cell synapse – key to inhibiting T cell receptor signaling

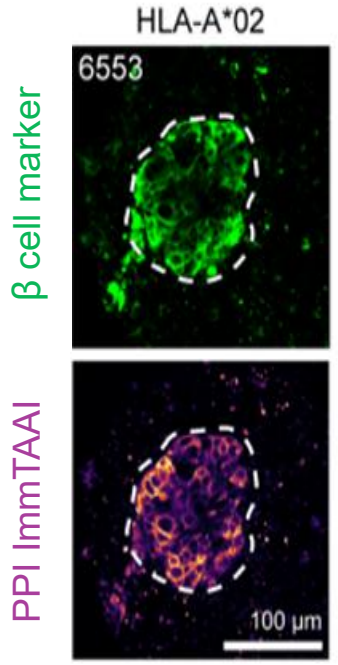
Phase 1 trial with IMC-S118AI in type 1 diabetes (T1D)

First person with type 1 diabetes dosed | First tissue-specific autoimmune candidate to enter the clinic

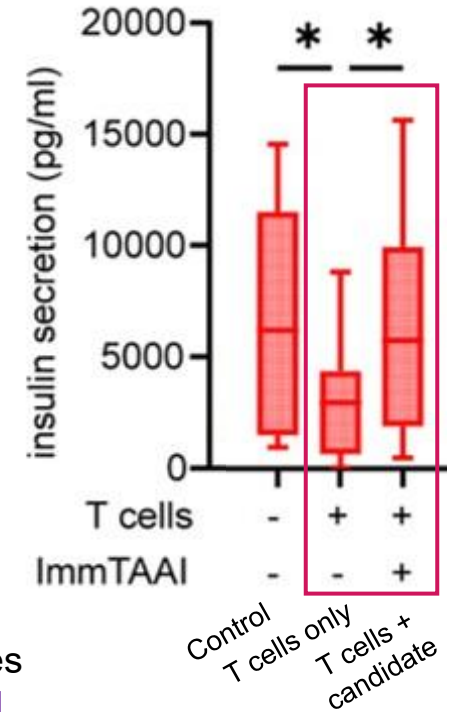


Data in live human pancreas tissue slices from a T1D donor show that IMC-S118AI protects β–cells from T cell destruction **and** preserves glucose stimulated insulin secretion

Data in human pancreas tissue slices



Confocal microscopy of pancreas slices incubated with labeled PPI* ImmTAAI confirm specific binding in the pancreas (indicated by β-cell marker)



PPI ImmTAAI preserves insulin secretion

~50K HLA-A02+ newly diagnosed T1D patients/yr (US + EU5)[2]

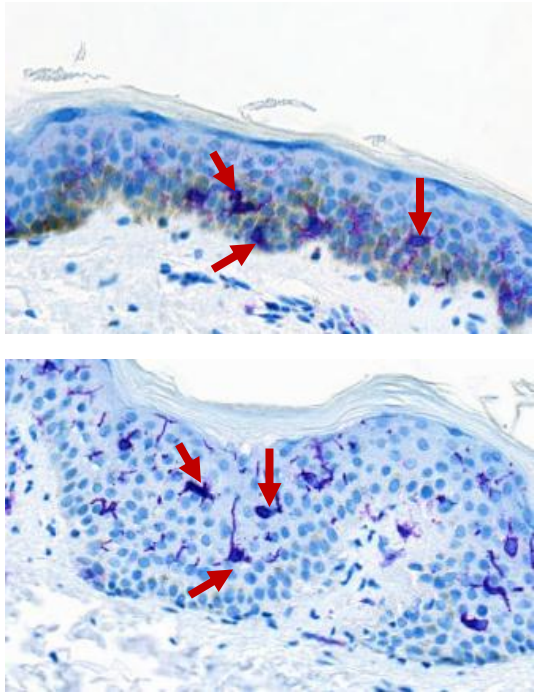
[1] Becker MW, B et al. Inhibition of cell-mediated immunity in type 1 diabetes by beta cell-targeted PD-1 agonists in pancreas tissue slices. bioRxiv [Preprint]. 2025 Oct 22:2025
[2] Estimated annual incidence of HLA-A02 positive newly diagnosed type 1 diabetes in US + EU5.
* PPI = preproinsulin

CD1a and Langerhans cell play key roles in allergic inflammation[1-4]

CD1a expressed on Langerhans cell

Healthy skin

Atopic dermatitis



CD1a stain in skin biopsy

Langerhans cells

→ **Antigen presenting cell in skin and mucosa**

→ **Monitor skin & trigger inflammation**

→ **Present lipid and peptide antigens to activate T cells**

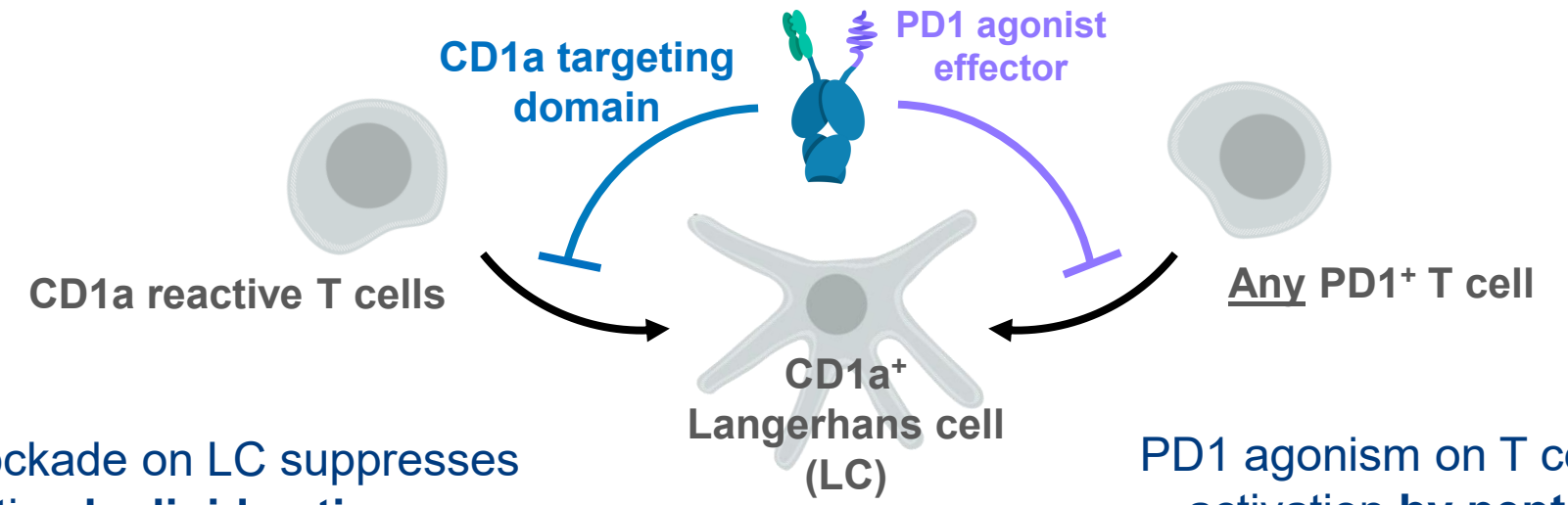
Antigens	Presentation	Polymorphism in humans
Lipids	CD1a	Non-polymorphic (universal)
Peptides	HLA class I/II	Polymorphic (non-universal)

Blocking both lipid presentation (via CD1a) **and peptide presentation** (via HLA I/II) may have therapeutic benefit in atopic dermatitis and potentially other immune pathologies such as psoriasis and allergic asthma

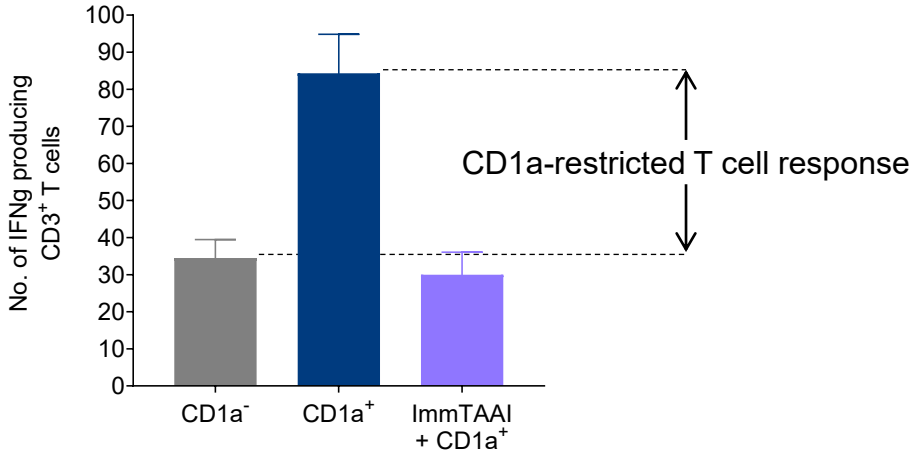
[1] Igyarto B *et al*. Immunity 2011. [2] Kim J *et al*. Nat Immunol. 2016. [3] Pan Y *et al*. JEADV 2024. [4] Hardman C.S. *et al*. Nat. Comm. 2022

IMC-U120AI : Universal (non-HLA restricted) candidate for dermatology

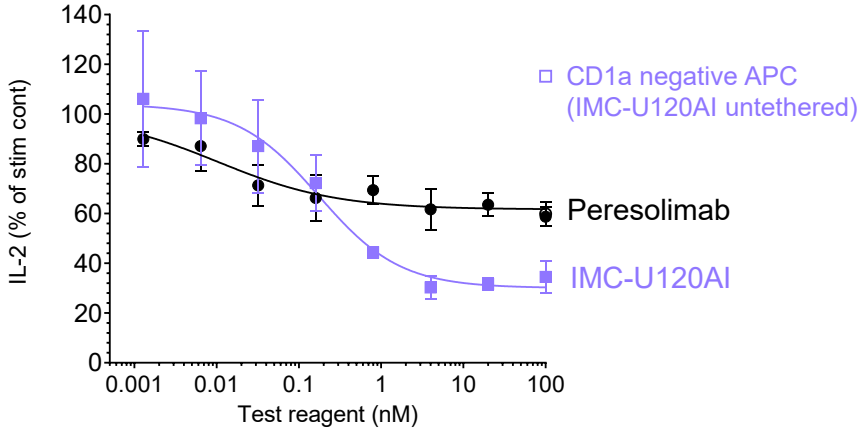
CD1a-tethered PD1 agonist ImmTAAI designed to block T cell activation by lipid and peptides



CD1a blockade on LC suppresses activation **by lipid antigens**



PD1 agonism on T cells suppresses activation **by peptide antigens**



CD1a mediates the presentation of lipid antigens to T cells while HLA mediates the presentation of peptide antigens to T cells.



Leading TCR pipeline

IMMUNOCORE

Upcoming milestones

Data readouts throughout 2026 and beyond

Q4 2026

Brenetafusp: Data from Phase 1/2 combinations in ovarian; including platinum-sensitive ovarian cancer

Brenetafusp: Data from Phase 1/2 monotherapy and combinations in NSCLC

Autoimmune Diseases: IND/CTA for CD1a x PD1 (non-HLA restricted) trial in atopic dermatitis

2027+ Milestones

Tebentafusp: Topline data readout for Phase 3 TEBE-AM trial expected 2Q 2027– event driven

PRAME-A02-HLE: Initial data from Phase 1 trial in multiple solid tumors

Infectious Diseases: Completed enrollment of 1,200 mcg cohort – Data expected 1H 2027

Complete registrational trials:

- PRISM-MEL-301
- ATOM

Additional programs – PIWIL1, T1D, atopic dermatitis

$901M 3Q 2026 cash position[1]

[1]Consists of cash, cash equivalents and marketable securities as of September 30, 2026.

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Thank you