ACTengine® IMA203 TCR-T Monotherapy Targeting PRAME

– Phase 1b Cohort A Interim Data Update

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Delivering the Power of T cells to Cancer Patients

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Update on IMA203 TCR-T Monotherapy – Phase 1b Cohort A

Delivering a Meaningful Benefit to Patients with an Unmet Need

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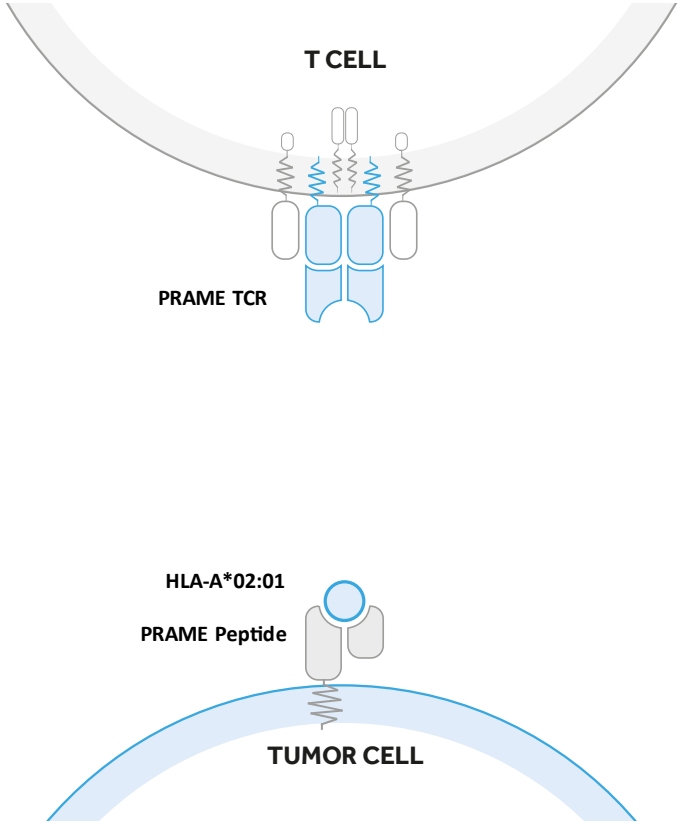
The Multi-Cancer Opportunity of PRAME

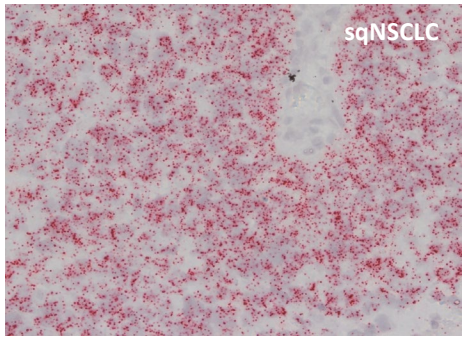
One of the Most Promising Solid Tumor Targets for TCR-based Therapies Known To Date

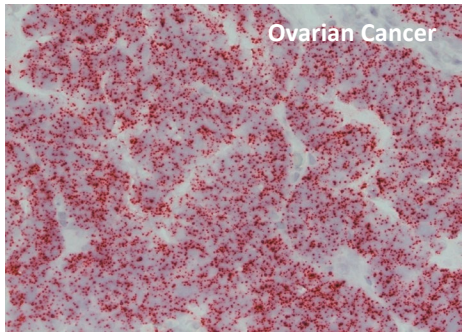


PRAME fulfills all properties of an ideal target for TCR-based therapies

- High prevalence
- High target density
- Homogeneous expression
- “Clean” expression profile
- Clinical proof-of-concept

PRAME RNA detection in tumor samples (ISH)





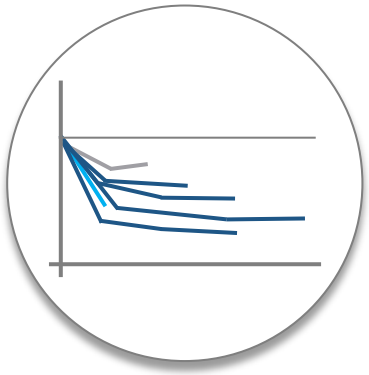
ISH: in situ hybridization, sqNSCLC: squamous non-small cell lung cancer

Unlocking Novel Treatments for Patients with Solid Cancers

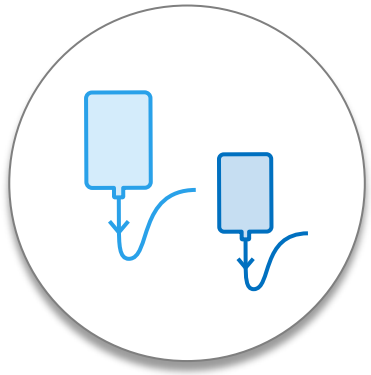
Key Pillars of Developing a Successful TCR-T Product Candidate

Safety

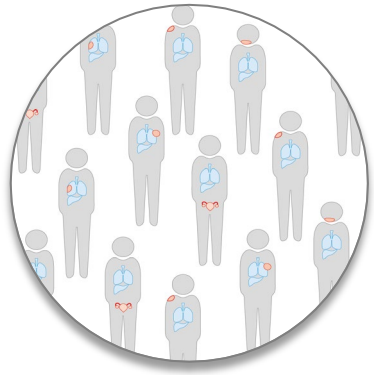
Anti-Tumor Activity



Durability



Product Quality



Broad Reach

Key Pillars of Developing a Successful TCR-T Product Candidate

Summary of Today's Update on IMA203 TCR-T Phase 1b Cohort A

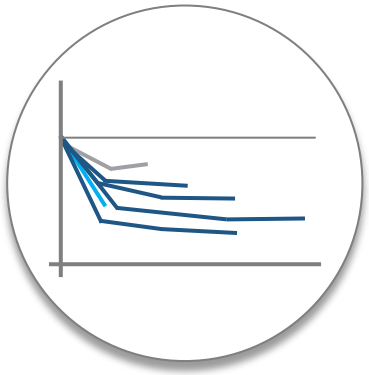
Safety

Manageable tolerability at doses as high as ~$9x10^9$ TCR-T cells

Anti-Tumor Activity

High rate of objective responses:

64% (7/11) ORR[1]
67% (6/9) cORR[2]

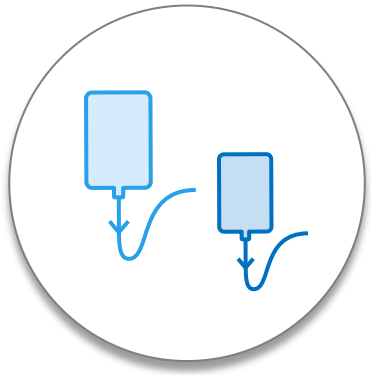


Durability

Ongoing durable responses at 9+ months

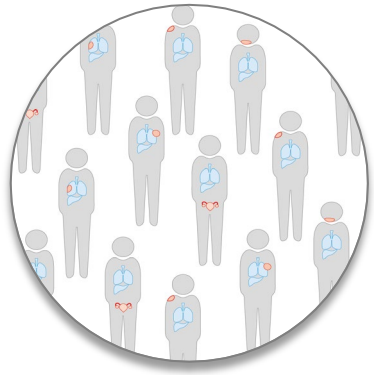
mDOR: Not reached
min 1.3+, max 8.8+

mFU: 8.5 months



Product Quality

Rapid manufacturing time of 7 days (+ 7-day release testing), manufacturing success rate of 94%



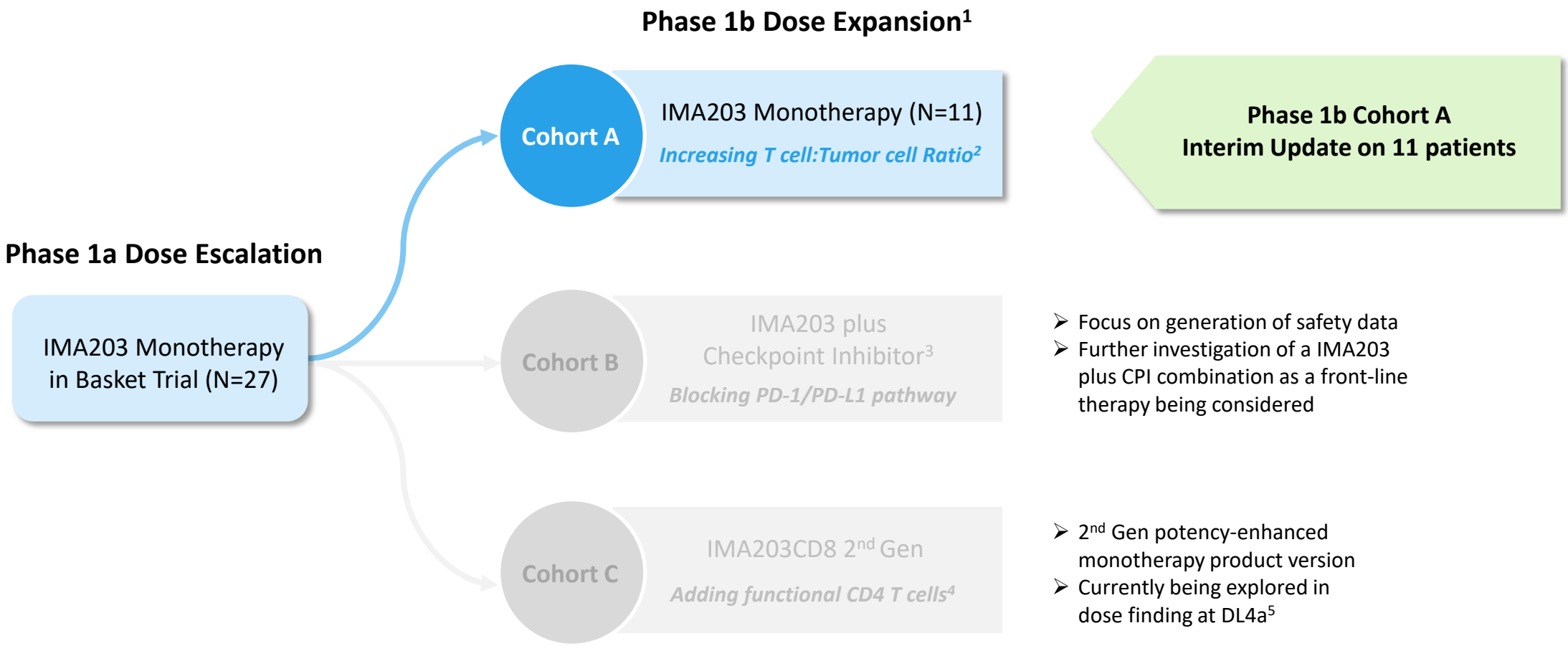
Broad Reach

Confirmed objective responses in broad range of solid cancer types at low, medium and high PRAME levels above threshold

[1] Initial ORR: Objective response rate according to RECIST 1.1 at first scan post infusion at ~week 6; [2] Confirmed ORR (cORR): Confirmed objective response rate according to RECIST 1.1 for patients with available second scan post infusion at ~month 3 or patients with progressive disease (PD) at any timepoint before this scan; mDOR: median duration of response; mFU: median follow-up

ACTengine® IMA203 TCR-T Phase 1 Design

Focus on IMA203 TCR-T Monotherapy Investigated in Cohort A



Data cut-off Apr 04, 2023

[1] Updated target dose (provisional recommended Phase 2 dose, RP2D) determined at DL4+DL5 for Cohort A and B, for Cohort C treatment of n=3 patients at DL3 completed, enrollment at DL4a ongoing before continuation at DL4b and potentially DL5; [2] Demonstrated to be associated with durable response: Locke *et al.* 2020 Blood Advances; [3] Opdivo® (nivolumab): programmed death-1 (PD-1) immune checkpoint inhibitor; [4] Demonstrated to be important for long-term remission: Melenhorst *et al.* 2022 Nature, Bai *et al.* 2022 Science Advances; [5] IMA203CD8 Dose Level 4a: 0.481-0.8x10^9 transduced viable CD8 T cells/m^2 BSA

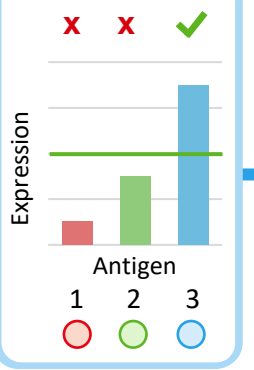
ACTengine® IMA203 TCR-T Monotherapy – Patient Flow

Screening & Manufacturing Phase | **Treatment & Observation Phase** | **Long Term Follow-up**

Safety and efficacy monitoring for 12 months

HLA-A*02 Testing
Blood sample;
Central lab

Target Profiling
Fresh Tumor Biopsy;
IMADetect®



Leukapheresis

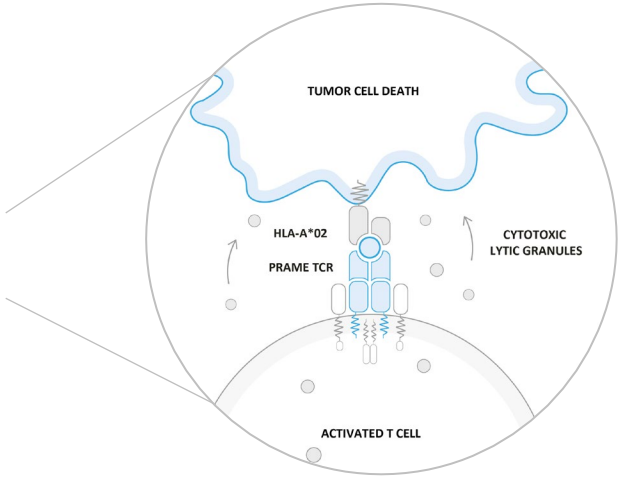
Manufacturing
by Immatics

Short process time of 14 days
7-day rapid manufacturing process
7-day expedited QC release testing
Monocyte depletion process
implemented in Phase 1b

Lymphodepletion*

Low dose IL-2**

**Infusion of ACTengine®
IMA203 TCR-T Product**



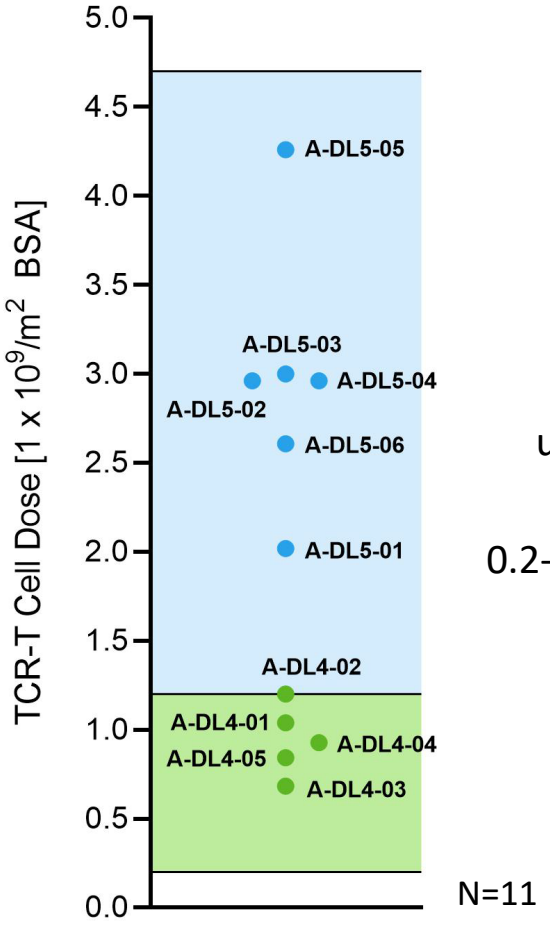
* 30 mg/m² Fludarabine and 500 mg/m² Cyclophosphamide for 4 days; ** 1m IU daily days 1-5 and twice daily days 6-10

ACTengine® IMA203 TCR-T Monotherapy – Phase 1b Cohort A

Patient and Product Characteristics

Patients in Phase 1b Cohort A (N=11)[1]	
Age Mean (min, max)	**55.4** **(31, 79)**
Gender Male / Female [% of patients]	**45.5 / 54.5**
Prior lines of treatment Mean (min, max)	**3.7** **(1, 10)**
LDH at baseline >1 x ULN [% of patients]	**54.5**
Baseline tumor burden Mean target lesion sum of diameter [mm] (min, max)	**73.8** **(21.0, 207.3)**
Total infused dose Mean TCR-T cells[2] infused [x10^9] (min, max)	**3.67** **(1.30, 8.84)**

Heavily pre-treated, metastatic last-line patients that have exhausted all available standard of care treatments



DL5 cleared for safety, updated provisional RP2D comprises DL4 + DL5: 0.2-4.7 x 10^9 TCR-T cells/m^2 BSA

[1] Including ovarian cancer patient A-DL5-04 who erroneously received one dose of nivolumab and is part of intent-to-treat (shown here) but not per-protocol population;
[2] Transduced viable CD8 T cells; ULN: Upper limit of normal; LDH: Lactate dehydrogenase; BSA: Body surface area; RP2D: Recommended Phase 2 Dose

Most Frequent Adverse Events – Phase 1b Cohort A (N=11)

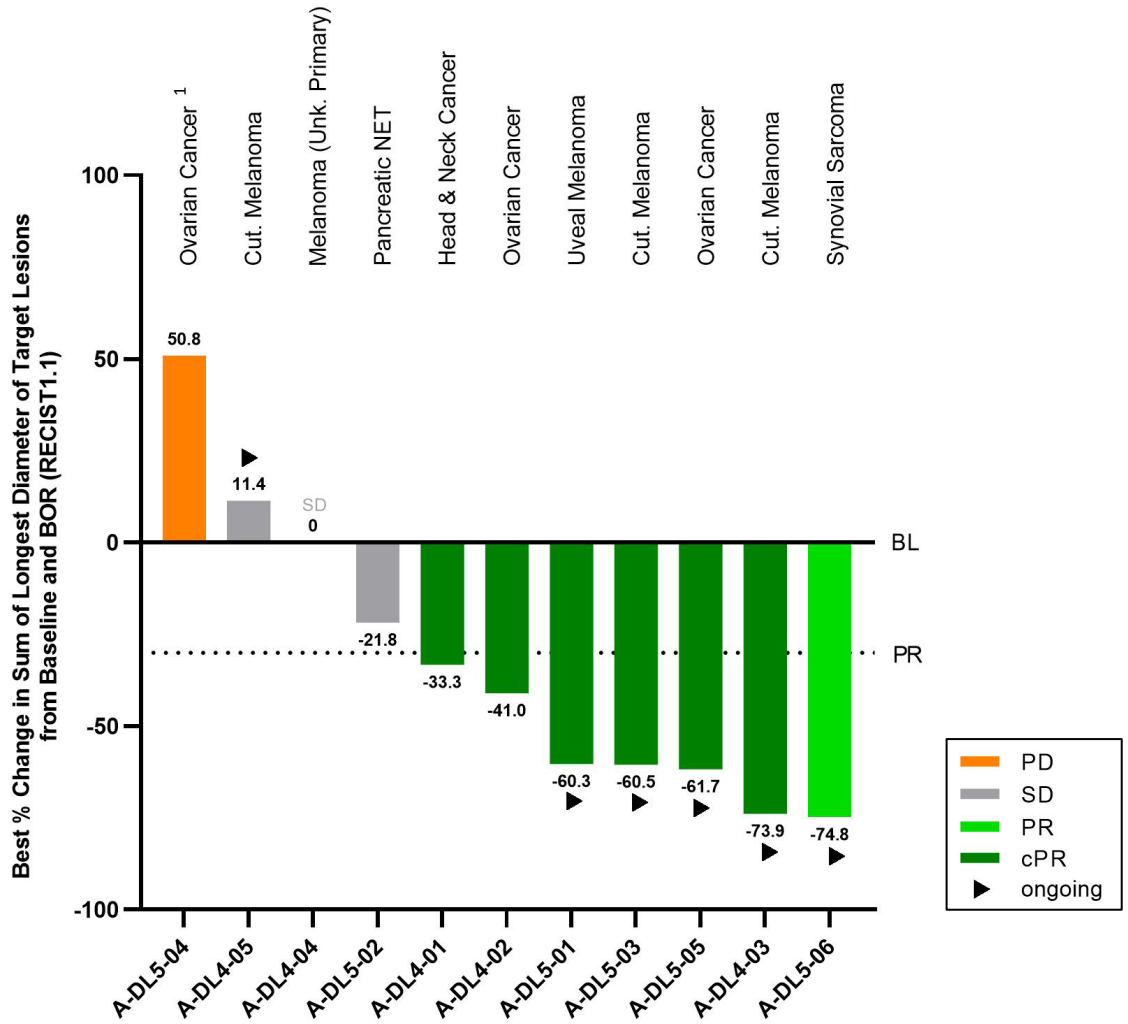
Manageable Treatment-emergent Adverse Events (TEAEs)

- **Expected cytopenia (Grade 1-4)** associated with lymphodepletion in all patients
- **Low-moderate cytokine release syndrome (CRS)** in 91% (10/11) of patients
  - 45% (5/11) of patients had Grade 1 CRS (3 in DL4, 2 in DL5)
  - 45% (5/11) of patients had Grade 2 CRS (2 in DL4, 3 in DL5)
  - No dose-dependent increase of CRS
- **No ICANS[1]**
- **No Dose-limiting toxicity**
- For IMA203 TCR-T monotherapy tolerability profile including Phase 1a dose escalation, see appendix

IMA203 TCR-T monotherapy shows managable tolerability at total doses as high as ~$9x10^9$ TCR-T cells

Best Overall Response – Phase 1b Cohort A

Deep Objective Responses Independent of Tumor Type



ORR (at ~week 6)[2] **64% (7/11)**

cORR (at ~month 3)[3] **67% (6/9)**

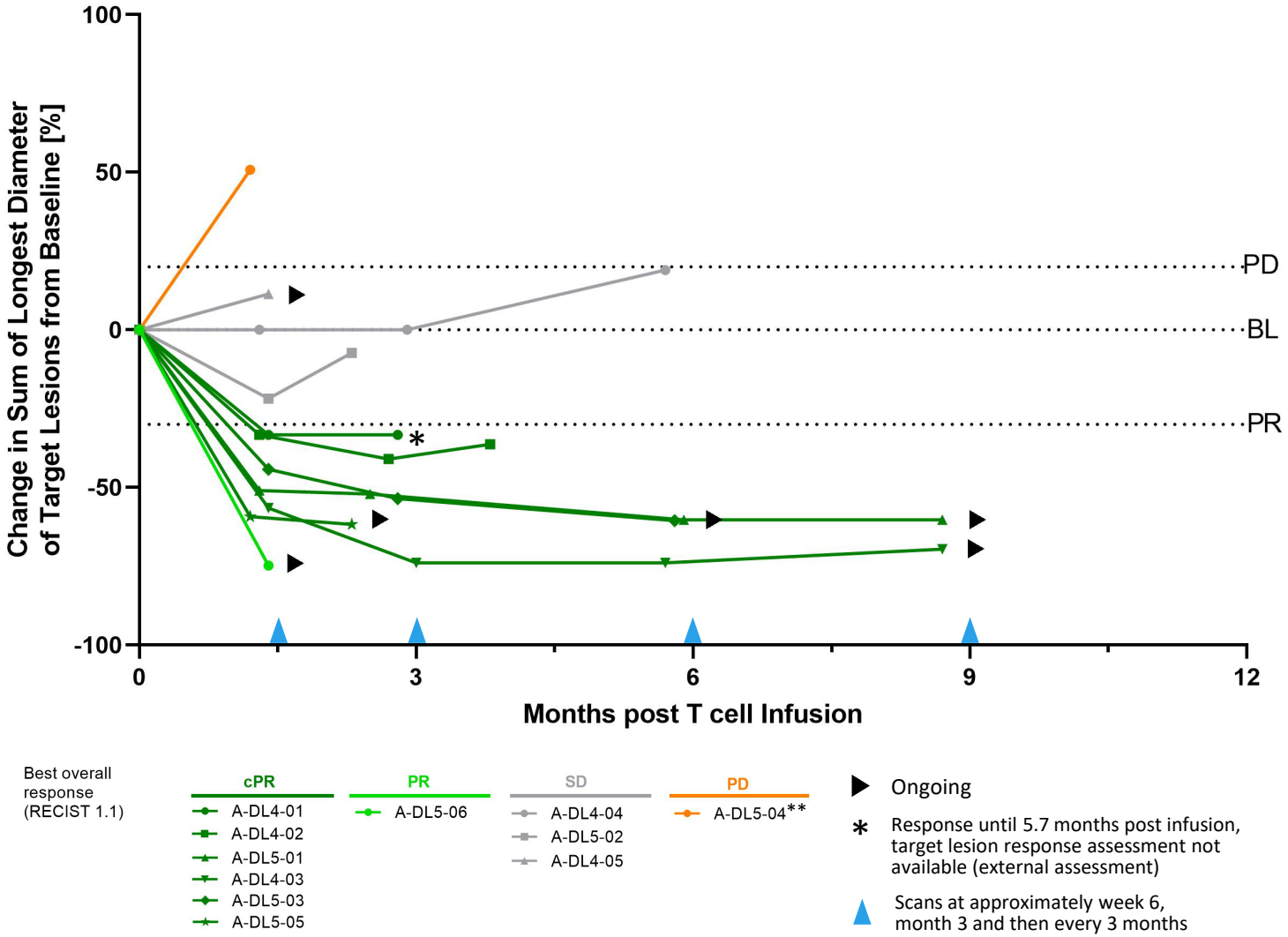
Deep objective responses observed across multiple, heavily pre-treated tumor types

- Responses observed in cutaneous and uveal melanoma, synovial sarcoma, head and neck cancer, and ovarian cancer
- Initial responses at week 6 were confirmed in all 6 responders with available subsequent 3-month scan
- All cut. melanoma patients were CPI-refractory
- All ovarian cancer patients were platinum-resistant

[1] Ovarian cancer patient A-DL5-04 erroneously received one dose of nivolumab and is part of intent-to-treat population (shown here) but not per-protocol population; [2] Initial ORR: Objective response rate according to RECIST 1.1 at first scan post infusion at ~week 6; [3] Confirmed ORR (cORR): Confirmed objective response rate according to RECIST 1.1 for patients with available second scan post infusion at ~month 3 or patients with progressive disease (PD) at any timepoint before this scan; PD: Progressive Disease; SD: Stable Disease; PR: Partial Response; cPR: Confirmed Partial Response; BL: Baseline; BOR: Best Overall Response; NET: Neuroendocrine Tumor; CPI: Checkpoint Inhibitor

Response over Time – Phase 1b Cohort A

Durable Partial Responses 9+ Months after IMA203 TCR-T Treatment



Median DOR[1], min, max DOR	**Not reached, 1.3+, 8.8+ months**
Median Follow-up[2]	**8.5 months**

Median time from IMA203 TCR-T infusion to onset of response was 1.4 months

Ongoing responses in 5 of 7 responders:

- 2 cPRs (cut. & uveal melanoma) ongoing at 9+ months
- 1 cPR (cut. melanoma) ongoing at 6+ months
- 1 cPR (ovarian cancer) ongoing at ~3 months
- 1 PR (synovial sarcoma) ongoing at 6+ weeks

**Ovarian cancer patient A-DL5-04 erroneously received one dose of nivolumab and is part of intent-to-treat population (shown here) but not per-protocol population; [1] Duration of response (DOR) in confirmed responders is defined as time from first documented response until disease progression/death. Patients with ongoing response will be censored at date of data cut-off. Median DOR is analyzed by using the Kaplan-Meier method; [2] Median Follow-up is analyzed by using the reverse Kaplan-Meier method; PD: Progressive Disease; SD: Stable Disease; PR: Partial Response; cPR: Confirmed Partial Response; BL: Baseline

Deep & Durable Responses in Heavily Pre-Treated Patients – Phase 1b Cohort A

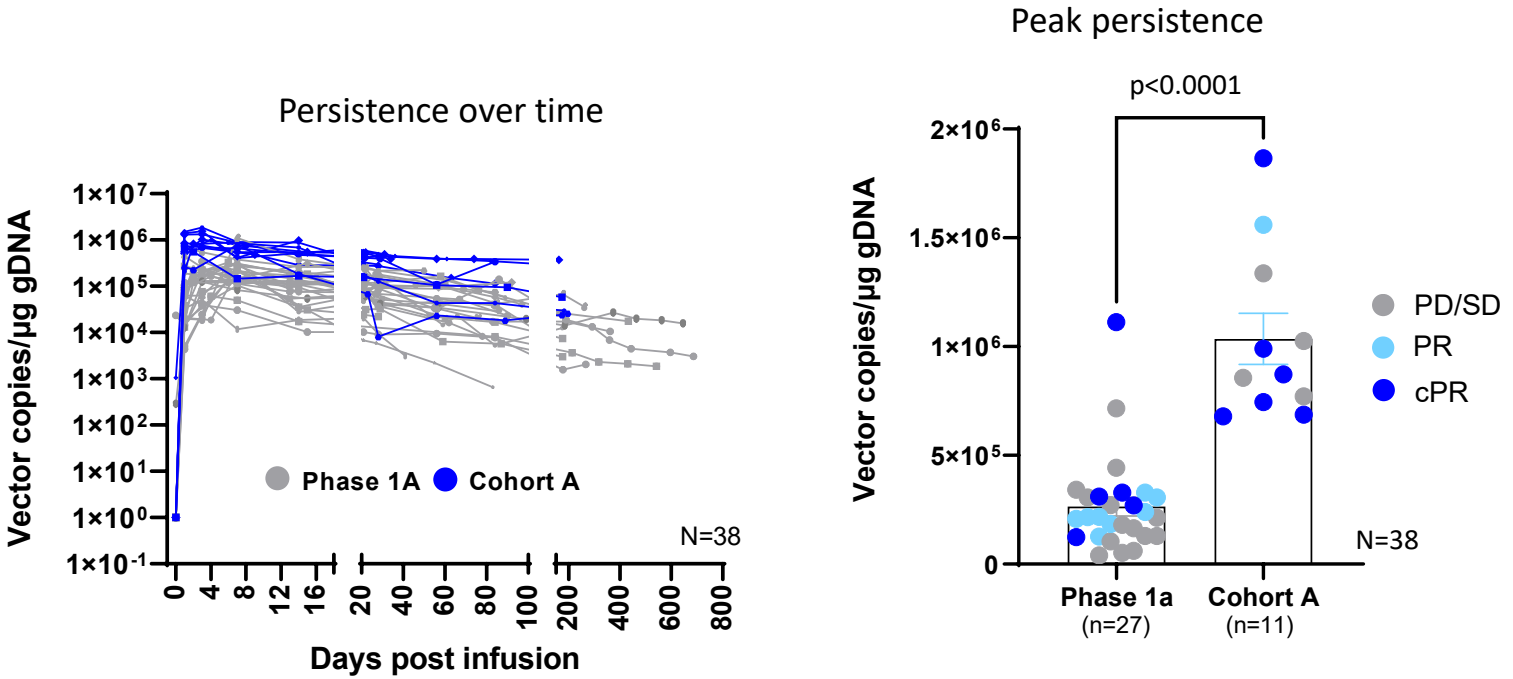
Patient ID	Indication	No of prior treatment lines	Prior treatments	Total infused dose TCR-T cells[1] [x10^9]	BOR	BOR (Max % change of target lesions)	Comment
A-DL5-01	Uveal Melanoma	1	ARRY614/Nivolumab	**4.16**	**cPR**	**-60.3**	Ongoing response 10.1 months post infusion
A-DL4-03	Cut. Melanoma	7	Dabrafenib/Trametinib, Pembrolizumab, Dabrafenib/Trametinib, Vemurafenib/Cobimetinib, Dabrafenib/Trametinib, IMCgp-100, Encorafenib/Binimetinib	**1.30**	**cPR**	**-73.9**	Ongoing response 9.9 months post infusion
A-DL5-03	Cut. Melanoma	3	Interferon, Pembrolizumab, Nivolumab/Ipilimumab	**5.12**	**cPR**	**-60.5**	Ongoing response 6.2 months post infusion
A-DL4-01	Head & Neck Cancer	1	Carboplatin/Paclitaxel	**1.92**	**cPR**	**-33.3**	Response until 5.7 months post infusion
A-DL4-02	Ovarian Cancer	10	Carboplatin/Taxol, Taxol, Gemcitabine/Carboplatin, Olaparib, Letrozole, Rucaparib, UPCC 03118 (CAR-T cell directed folate receptor), Bevacizumab/Cyclophosphamide, Carboplatin, Doxorubicin	**1.97**	**cPR**	**-41.0**	Response until 3.8 months post infusion
A-DL5-05	Ovarian Cancer	3	Adriamycin/Cytotaxan/Taxol, Carboplatin/Taxol, Carboplatin/Doxil	**8.84**	**cPR**	**-61.7**	Ongoing response 2.5 months post infusion
A-DL5-06	Synovial Sarcoma	1	Adriamycin/Ifosfamide/Mesna	**3.94**	**PR**	**-74.8**	Initial PR at week 6, 3-month scan pending
A-DL4-04	Melanoma (Unk. Primary)	2	Nivolumab/Ipilimumab, Nivolumab	**1.73**	**SD**	**0.0**	Disease stabilization until 5.7 months post infusion
A-DL4-05	Cut. Melanoma	5	Nivolumab, Nivolumab (re-exposure), Nivolumab/Ipilimumab, Dabrafenib/Trametinib, Nivolumab	**1.63**	**SD**	**11.4**	Ongoing disease stabilization 2.1 months post infusion
A-DL5-02	Pancreatic Neuroendocrine Tumor	3	Lanreotid, Streptozocin/5-Fluorouracil, Everolismus	**5.12**	**SD**	**-21.8**	Disease stabilization until 2.3 months post infusion
A-DL5-04*	Ovarian Cancer	5	Paclitaxel/Carboplatin, Niraparib, Doxorubicin/Liposomal/Carpoplatin, 2020-0808 ZN-C3/Gemcitabine, 2020-0755 COM 701/BMS-986207/Nivolumab	**4.68**	**PD**	**50.8**	Progressive disease at 1.2 months post infusion

[1] Transduced viable CD8 T cells; PD: Progressive Disease; SD: Stable Disease; PR: Partial Response; cPR: Confirmed Partial Response; BL: Baseline; BOR: Best Overall Response
*Ovarian cancer patient A-DL5-04 erroneously received one dose of nivolumab and is part of intent-to-treat population (shown here) but not per-protocol population.

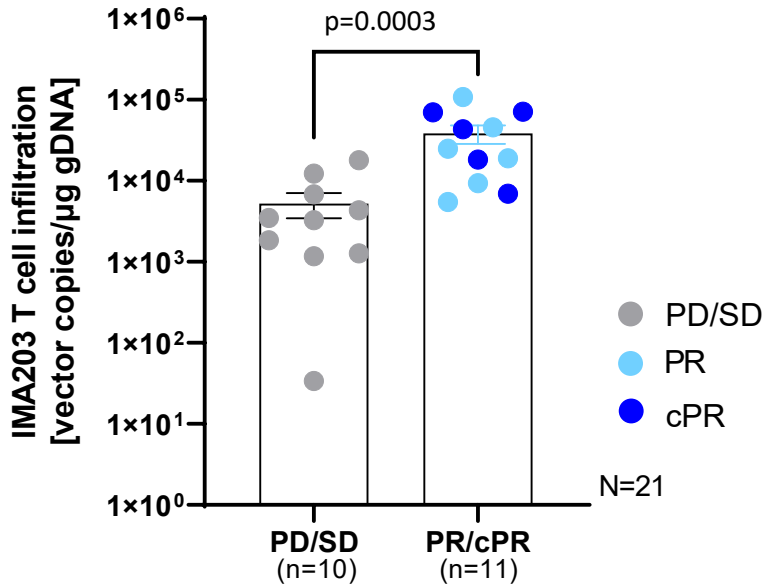
Biological Data Consistent with Clinical Data

IMA203 TCR-T Levels and Tumor Infiltration across Patients in Phase 1a and Phase 1b Cohort A

Increased levels of IMA203 T cells in the blood of patients in Cohort A following increase of cell dose and switch to monocyte depletion process



IMA203 T cells found in all evaluable tumor tissues, level of infiltration associated with objective responses[1]

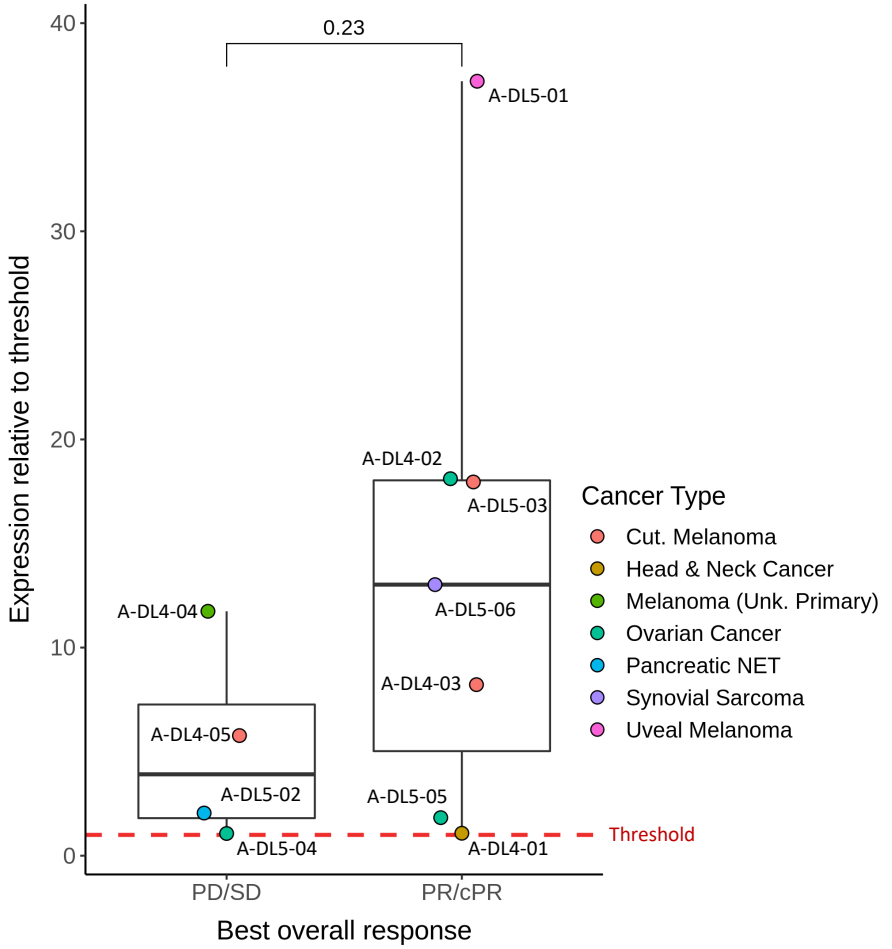


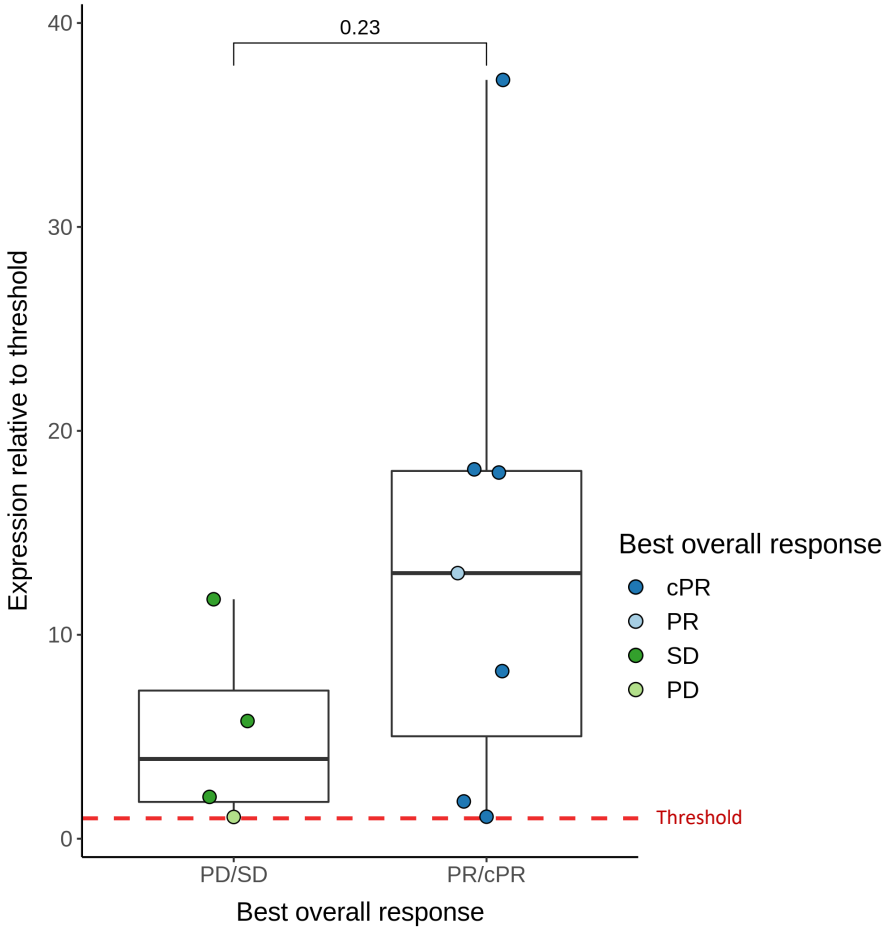
Mann-Whitney U test; [1] T cell infiltration for 21 patients (10 non-responder, 11 responder) with 6-week post infusion biopsy available (1 patient with ~4-week, 2 patients with ~13-week post infusion biopsy);
PD: Progressive Disease; SD: Stable Disease; PR: Partial Response; cPR: Confirmed Partial Response

Responses above Immatics' PRAME RNA Threshold Independent of Tumor Type

Highlighting Tumor Types (left) and Type of Best Overall Response (right) – Phase 1b Cohort A

PRAME RNA expression in pre-treatment biopsies relative to threshold





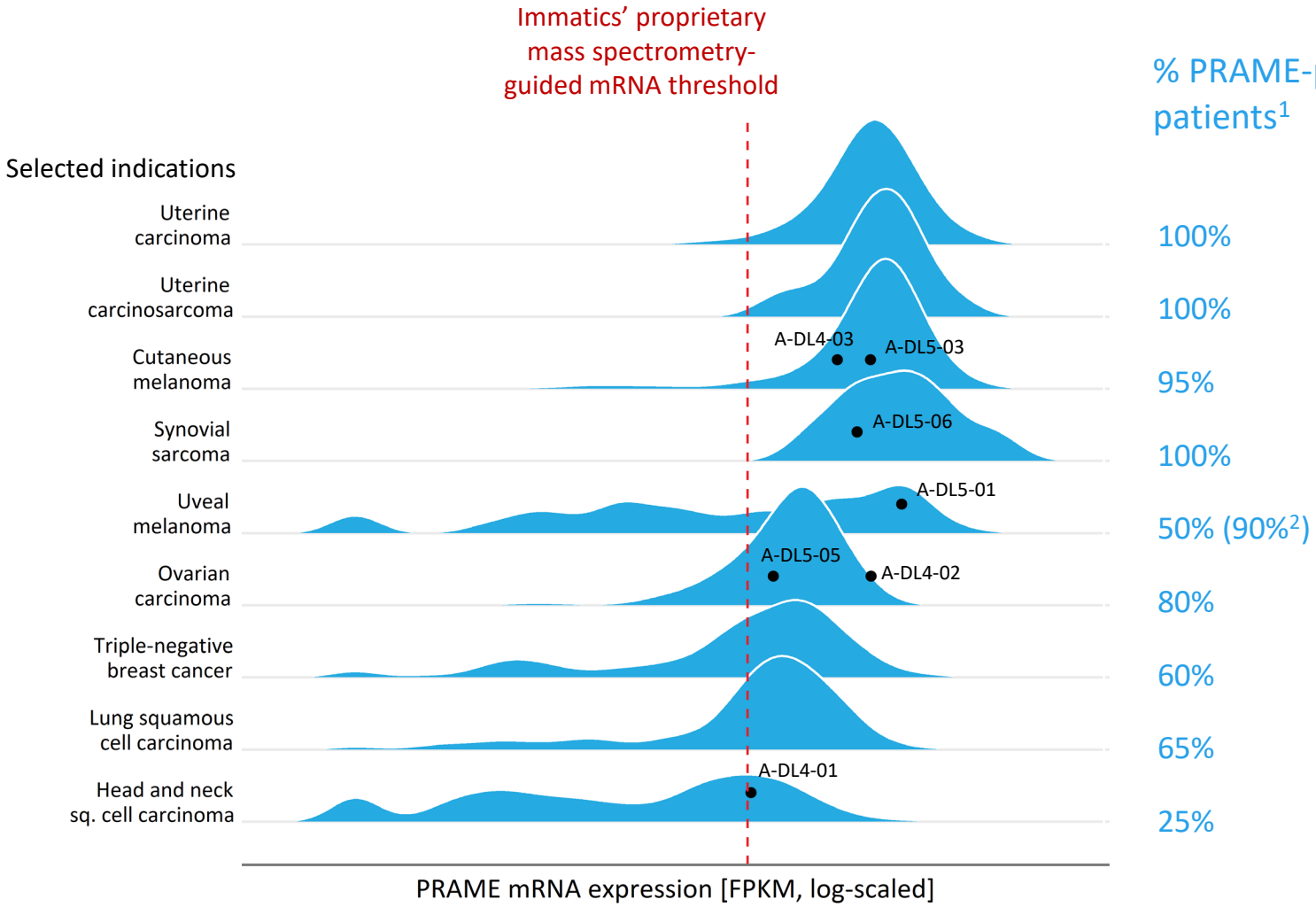
IMA203 achieved objective responses at all expression levels above Immatics' mass spectrometry-guided RNA threshold

IMA203 has the potential to provide clinical benefit for all PRAME biomarker-positive cancer patients

Mann-Whitney U test, p=0.23; PD: Progressive Disease; SD: Stable Disease; PR: Partial Response; cPR: Confirmed Partial Response; NET: Neuroendocrine Tumor

Potential of IMA203 in Additional Solid Cancer Indications

Based on PRAME Expression in IMA203 TCR-T Responders – Phase 1b Cohort A



● PRAME mRNA expression in Phase 1b Cohort A responders

PRAME target expression distribution (blue histogram) based on TCGA RNAseq data, patient data (black dots) based on IMADetect® qPCR testing of screening biopsies; [1] PRAME target prevalence is based on TCGA RNAseq data combined with a proprietary MS-guided RNA expression threshold; [2] PRAME target prevalence in uveal melanoma based on IMADetect® qPCR testing of screening biopsies from clinical trial patients (n=21) demonstrates substantial higher prevalence of 90% compared to prevalence based on TCGA data of 50%, TCGA: early & late-stage primary tumor samples, Immatics clinical trials: late-stage/metastatic tumor samples, Role of PRAME in metastasis of uveal melanoma: Field *et al.* 2016 Clinical Cancer Research; MS: mass spectrometry

ACTengine® IMA203 TCR-T Monotherapy Targeting PRAME

Summary of Phase 1b Cohort A Interim Data Update

- **Manageable tolerability** with no high-grade CRS, no ICANS in 11 patients in Cohort A[1]
- **Objective responses observed in heavily pre-treated last-line solid cancer patients** including checkpoint-refractory cutaneous melanoma, platinum-resistant ovarian cancer, uveal melanoma, head and neck cancer, synovial sarcoma
- **High objective response rate (ORR):**
  - 64% (7/11) ORR (at ~week 6)
  - 67% (6/9) cORR (at ~month 3)
- **Ongoing durable responses:**
  - Median duration of response not reached at a median follow-up time of 8.5 months
  - Ongoing PRs 9+ months after IMA203 TCR-T treatment
- **Objective responses independent of tumor type at low, medium and high PRAME levels above threshold**
- **Manufacturing success rate of 94%** to reach current RP2D, **rapid 7-day manufacturing process (+7-day release testing)**

Increased confidence in the success and broad potential of targeting PRAME and our product candidate IMA203 TCR-T

[1] For IMA203 TCR-T monotherapy tolerability profile including Phase 1a dose escalation, see appendix;
CRS: Cytokine Release Syndrome; ICANS: Immune effector cell-associated neurotoxicity syndrome; RP2D: provisional recommended Phase 2 dose

Immatics' ACTengine® IMA203 TCR-T Development Strategy

Two Pillared Strategy

FAST & FOCUSED

Objective: Deliver best-in-class therapy in 1-2 last-line solid cancer types as fast as possible

- Focus on indications with PRAME prevalence above 80% with available clinical PoC, such as cut. melanoma (potentially bundled with uveal melanoma) and ovarian cancer
- Highly modular and scalable manufacturing facility expected to be operational in 2024 to support efforts to maximize speed to market
- Planned start of a first Phase 2 trial in 1H 2024 – targeted to be already registration-directed

GO BROAD

Objective: Expand development to other cancer types

- Signal finding in other cancer types with a broad patient reach, such as uterine cancer, lung cancer, breast cancer, head and neck cancer

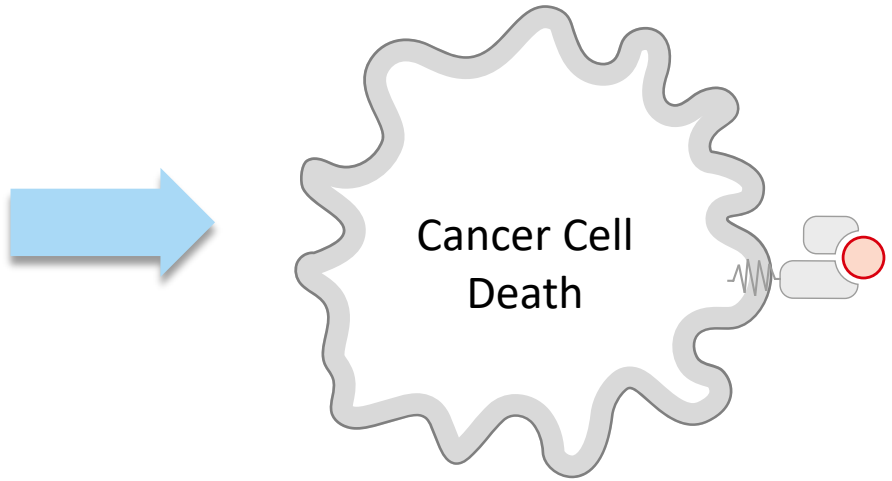
Update on all three IMA203 Phase 1b cohorts and clinical development path towards registration-directed trials and potential commercialization for PRAME TCR-T monotherapy is planned for 4Q 2023

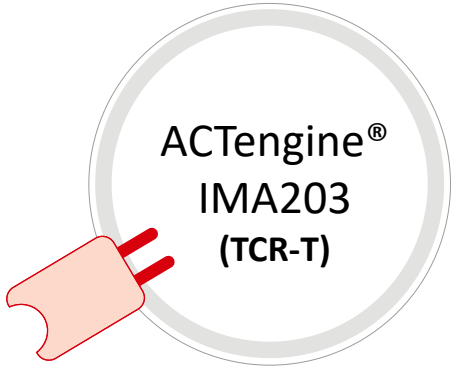
Realizing the Full Multi-Cancer Opportunity of PRAME

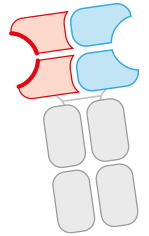
ACTengine® IMA203 (TCR-T) and TCER® IMA402 (TCR Bispecific)

Indication	% PRAME positive patients[1]
Uterine Carcinoma	100%
Uterine Carcinosarcoma	100%
Sarcoma Subtypes	up to 100%
Cut. Melanoma	95%
Uveal Melanoma[2]	90%
Ovarian Carcinoma	80%
Squamous NSCLC	65%
TNBC	60%
Small Cell Lung Cancer	55%
Kidney Carcinoma	up to 45%
Cholangiocarcinoma	35%
Adeno NSCLC	25%
Breast Carcinoma	25%
HNSCC	25%
Esophageal Carcinoma	20%
HCC	20%
Bladder Carcinoma	20%

PRAME is one of the most promising and most prevalent, clinically validated solid tumor targets known to date







TCER® IMA402
(TCR Bispecific)

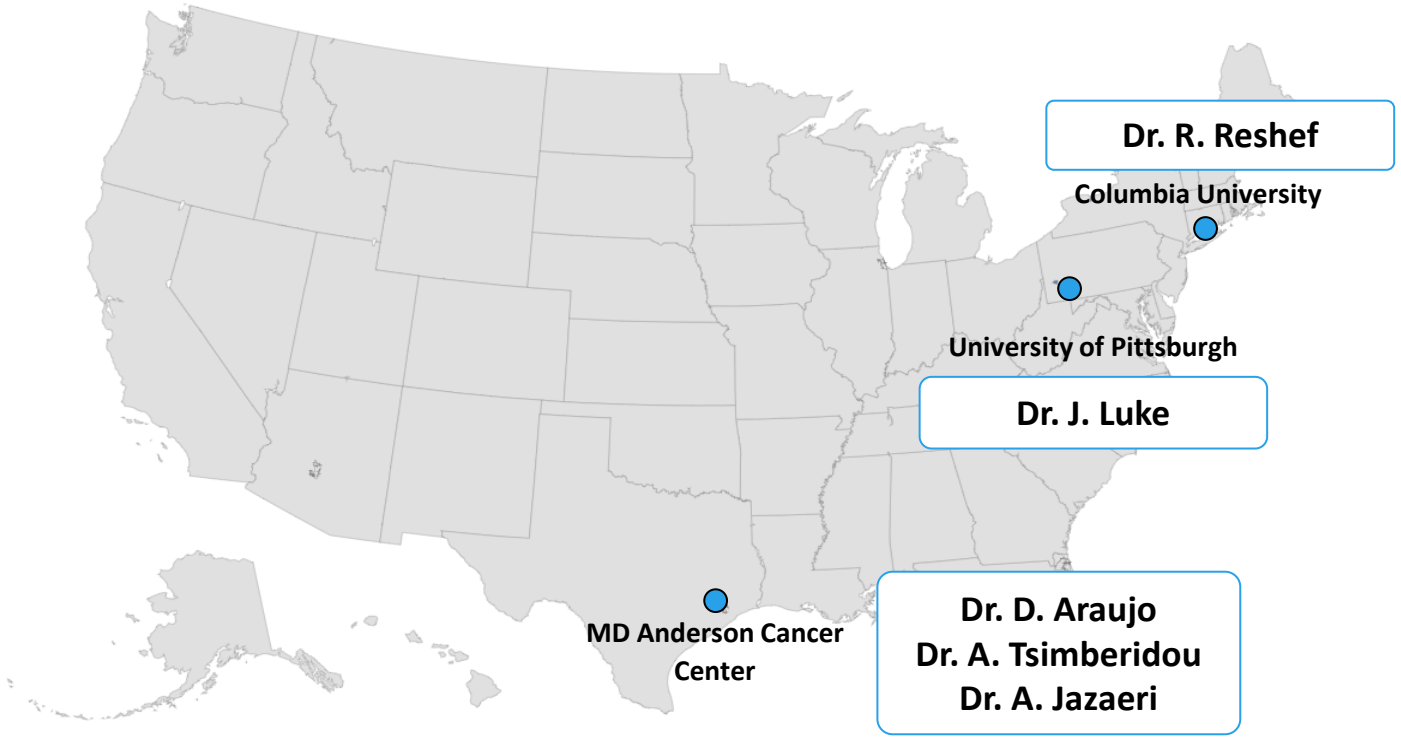
- ✓ CTA submitted
- ✓ Start of clinical trial planned in 2H 2023
- ✓ First clinical data 2024

Leverage the full potential of targeting PRAME by continued evaluation of the best suited therapeutic modality (ACTengine® vs. TCER® or both) for each cancer type

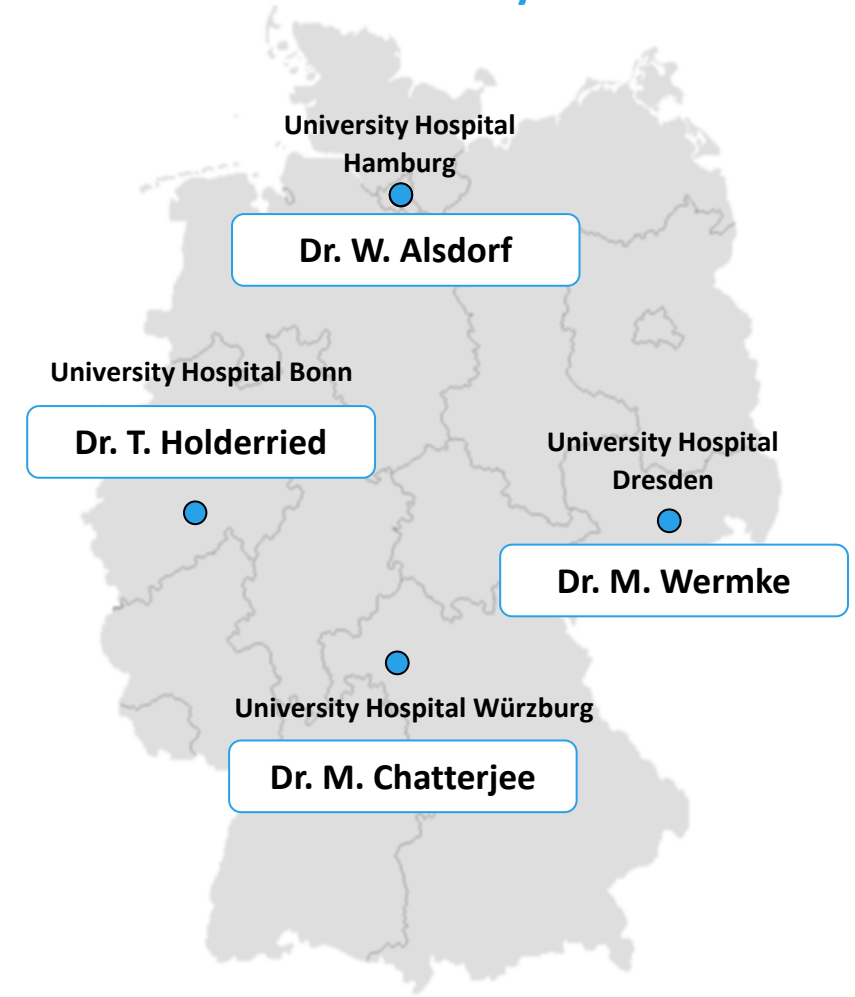
[1] PRAME target prevalence is based on TCGA (for SCLC: in-house) RNAseq data combined with a proprietary mass spec-guided RNA expression threshold; [2] Uveal melanoma target prevalence is based on IMADetect® qPCR testing of screening biopsies from clinical trial patients (n=21); NSCLC: Non-small cell lung cancer, TNBC: Triple-negative breast cancer, HNSCC: Head and neck squamous cell carcinoma; HCC: Hepatocellular carcinoma

We are Immensely Grateful to the Patients, Their Families …

United States



Germany



… and the Investigators at the Clinical Sites

Delivering

the Power of T cells to Cancer Patients

Appendix

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ACTengine® IMA203 TCR-T 1st Gen Monotherapy Tolerability Data

Phase 1a and Phase 1b Cohort A – All ≥Grade 3 Adverse Events (N=39)

TEAEs by maximum severity for all patients in Ph1a dose escalation and Ph1b Cohort A dose expansion (N=39)[1]

Adverse event (System organ class, Preferred term)	≥ Grade 3 No.	≥ Grade 3 %
Patients with any adverse event	39	100.0
Adverse Events of Special Interest		
Cytokine release syndrome	2	5.1
ICANS[2]	0	0.0
Blood and lymphatic system disorders		
Neutropenia	32	82.1
Lymphopenia	24	61.5
Leukopenia	22	56.4
Anaemia	20	51.3
Thrombocytopenia	15	38.5
Cytopenia	1	2.6
Leukocytosis	1	2.6
Lymphocytosis	1	2.6
Infections and infestations		
Appendicitis	1	2.6
COVID-19	1	2.6
Enterococcal infection	1	2.6
Infection	1	2.6
Orchitis	1	2.6
Sepsis[4,5]	1	2.6
Septic shock[4]	1	2.6
Respiratory, thoracic and mediastinal disorders		
Hypoxia	2	5.1
Bronchial obstruction	1	2.6
Laryngeal inflammation	1	2.6
Pleural effusion	1	2.6
Respiratory failure	1	2.6
Investigations		
Alanine aminotransferase increased	1	2.6
Aspartate aminotransferase increased	1	2.6
Blood alkaline phosphatase increased	1	2.6
Blood creatinine increased	1	2.6
Blood fibrinogen decreased	1	2.6
Gastrointestinal disorders		
Abdominal pain	1	2.6
Diarrhoea	1	2.6
Ileus	1	2.6
Vomiting	1	2.6

Adverse event (System organ class, Preferred term)	≥ Grade 3 No.	≥ Grade 3 %
table continued…		
General disorders and administration site conditions		
Condition aggravated[4]	1	2.6
Fatigue	1	2.6
Pyrexia	1	2.6
Swelling face	1	2.6
Vascular disorders		
Hypertension	3	7.7
Hypotension	1	2.6
Metabolism and nutrition disorders		
Hypokalaemia	2	5.1
Failure to thrive	1	2.6
Injury, poisoning and procedural complications		
Humerus fracture	1	2.6
Infusion related reaction	1	2.6
Renal and urinary disorders		
Acute kidney injury	1	2.6
Proteinuria	1	2.6
Cardiac disorders		
Atrial fibrillation[3]	1	2.6
Endocrine disorders		
Inappropriate antidiuretic hormone secretion	1	2.6
Eye disorders		
Ulcerative keratitis	1	2.6
Hepatobiliary disorders		
Cholangitis	1	2.6
Immune system disorders		
Contrast media allergy	1	2.6
Musculoskeletal and connective tissue disorders		
Muscle spasms	1	2.6
Nervous system disorders		
Headache	1	2.6
Reproductive system and breast disorders		
Vaginal haemorrhage	1	2.6
Skin and subcutaneous tissue disorders		
Rash maculo-papular	1	2.6

- IMA203 was well tolerated
- No Adverse Event ≥Grade 3 was observed with a frequency ≥10% when excluding expected cytopenias associated with lymphodepletion
- No IMA203-related Grade 5 Adverse Events

All treatment-emergent adverse events (TEAEs) with ≥ Grade 3 regardless of relatedness to study treatment that occurred in at least 1 patient (except for ICANS, where only Grade 1-2 occurred; listed for completeness due to being an adverse event of special interest) are presented. Adverse events were coded using the Medical Dictionary for Regulatory Activities. Grades were determined according to National Cancer Institute Common Terminology Criteria of Adverse Events, version 5.0. Grades for CRS and ICANS were determined according to CARTOX criteria (Neelapu et al., 2018). Patients are counted only once per adverse event and severity classification. Based on interim data extracted from open clinical database (04-Apr-2023); [1] Two patients with disease progression after first IMA203 infusion received exploratory second IMA203 infusion. They had these ≥ Grade 3 TEAEs only after second infusion, which are included in the table: First patient: Abdominal pain, Cytokine release syndrome, Diarrhoea, Hypokalaemia, Proteinuria; Second patient: Humerus fracture, Muscle spasms, Neutropenia, Thrombocytopenia; [2] ICANS: Immune effector cell-associated neurotoxicity syndrome; [3] DLT: Dose limiting toxicity in phase 1a at DL2 reported on March 17, 2021; [4] Fatal Adverse events were not considered related to any study drug; [5] Patient died from sepsis of unknown origin and did not receive IMA203 TCR-T cells.

ACTengine® IMA203 TCR-T 1st Gen Monotherapy Tolerability Data

Focus on IMA203 Phase 1b Cohort A – All ≥Grade 3 Adverse Events (N=11)

TEAEs by maximum severity for all patients in Ph1b Cohort A dose expansion (N=11)

Adverse event (System organ class, Preferred term)	≥ Grade 3 No.	≥ Grade 3 %
Patients with any adverse event	**11**	**100.0**
Adverse Events of Special Interest		
Cytokine release syndrome	0	0.0
ICANS[1]	0	0.0
Blood and lymphatic system disorders		
Neutropenia	10	90.9
Lymphopenia	6	54.5
Leukopenia	5	45.5
Anaemia	5	45.5
Thrombocytopenia	4	36.4
Leukocytosis	1	9.1
Lymphocytosis	1	9.1

Adverse event (System organ class, Preferred term)	≥ Grade 3 No.	≥ Grade 3 %
table continued…		
Investigations		
Alanine aminotransferase increased	1	9.1
Aspartate aminotransferase increased	1	9.1
Blood alkaline phosphatase increased	1	9.1
Eye disorders		
Ulcerative keratitis	1	9.1
Gastrointestinal disorders		
Ileus	1	9.1
Infections and infestations		
Infection	1	9.1
Nervous system disorders		
Headache	1	9.1
Respiratory, thoracic and mediastinal disorders		
Laryngeal inflammation	1	9.1

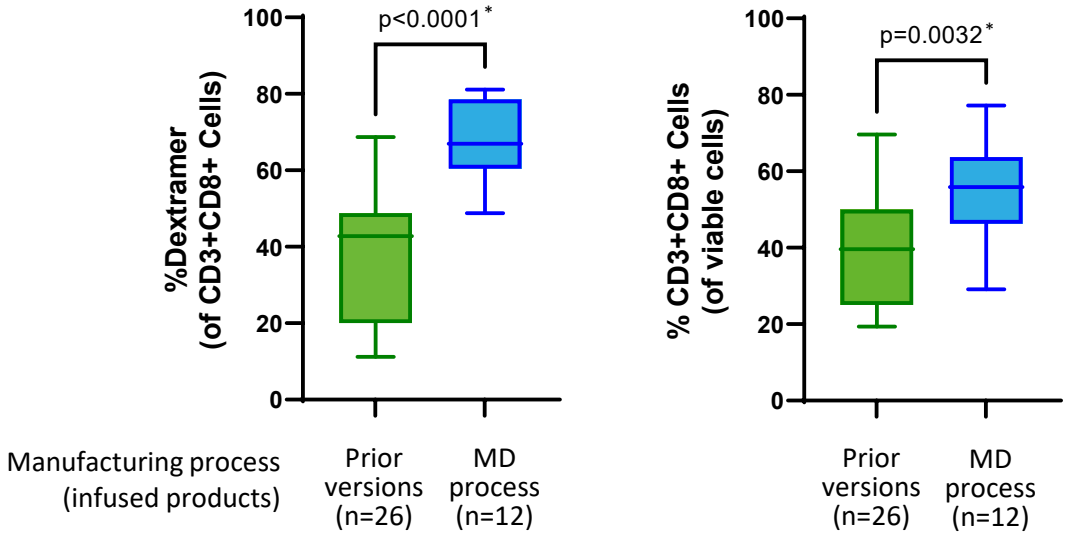
All treatment-emergent adverse events (TEAEs) with ≥ Grade 3 regardless of relatedness to study treatment that occurred in at least 1 patient (except for CRS and ICANS, where only Grade 1-2 occurred; listed for completeness due to being adverse events of special interest) are presented. Adverse events were coded using the Medical Dictionary for Regulatory Activities. Grades were determined according to National Cancer Institute Common Terminology Criteria of Adverse Events, version 5.0. Grades for CRS and ICANS were determined according to CARTOX criteria (Neelapu *et al.*, 2018). Patients are counted only once per adverse event and severity classification. Based on interim data extracted from open clinical database (04-Apr-2023). [1] ICANS: Immune effector cell-associated neurotoxicity syndrome.

- IMA203 was well tolerated
- No Adverse Event ≥Grade 3 was observed with a frequency ≥10% when excluding expected cytopenias associated with lymphodepletion
- No IMA203-related Grade 5 Adverse Events

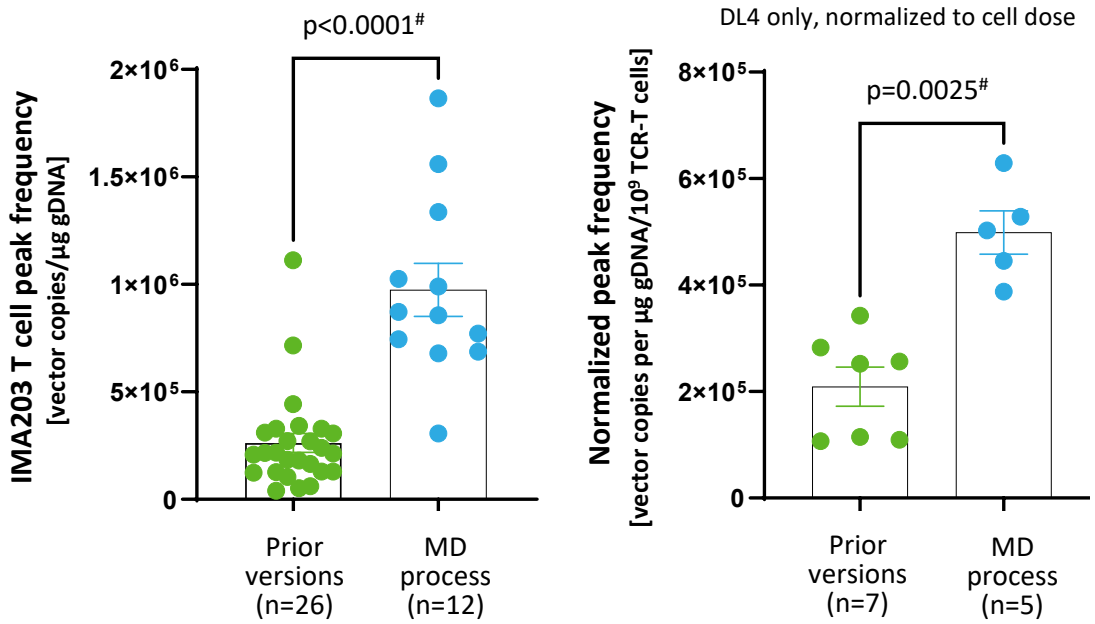
Favorable TCR-T Product Characteristics and High TCR-T Levels in Patients

Manufacturing Improvements Implemented in Phase 1b Enhance Key Features of the Cell Product

Improved TCR-T product features



Increased peak TCR-T levels in patients



Manufacturing success rate of 94% to reach provisional RP2D**

Mean cell dose infused in 11 patients in Phase 1b Cohort A was 3.67x10^9 TCR-T cells

MD process: Monocyte depletion process; * Unpaired t test; # Mann-Whitney U test;
** Updated provisional RP2D comprises DL4 + DL5: 0.2-4.7x10^9 transduced viable CD8 T cells/m^2 BSA;

Focus on Melanoma Patients Phase 1a (DL4 only) and Phase 1b Cohort A

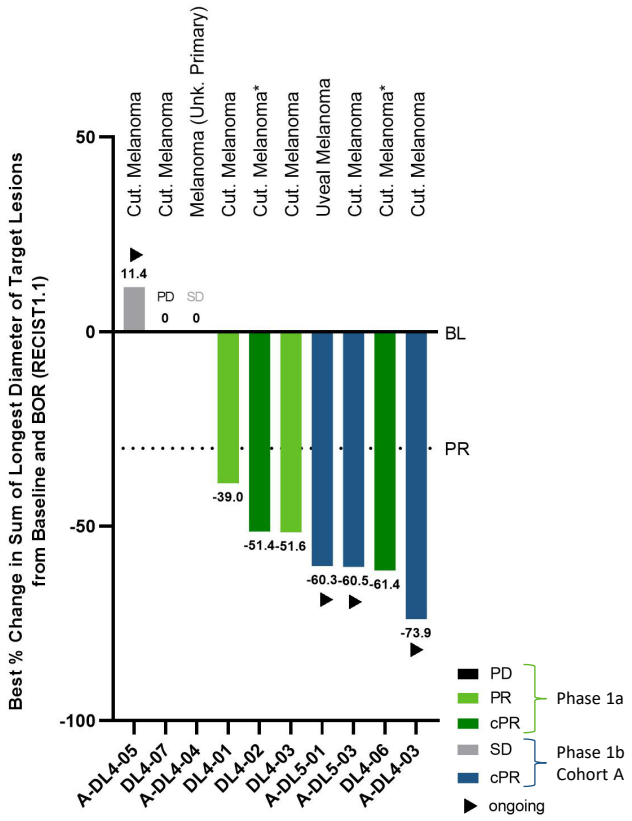
Continuous Improvement from Phase 1a to Phase 1b Cohort A

Patient Characteristics (n=10)	
Prior lines of treatment Mean (min, max)	4.5 (1, 7)
Previous lines of CPI Mean (Min, Max)	2.6 (1, 4)
LDH at baseline >1 x ULN [% of patients]	60.0
Baseline tumor burden Mean target lesion sum of diameter [mm] (min, max)	66.9 (21.0, 178.7)
Total infused dose Mean TCR-T cells[1] infused [x10^9] (min, max)	2.12 (1.07, 5.12)
No. of Target- & Non-Target Lesions	60.0% with >3 lesions 40.0% with liver/brain lesions

- Heavily pre-treated melanoma patients after 1-4 lines of CPI: Cutaneous (N=8), uveal (N=1) and melanoma of unk. primary (N=1)

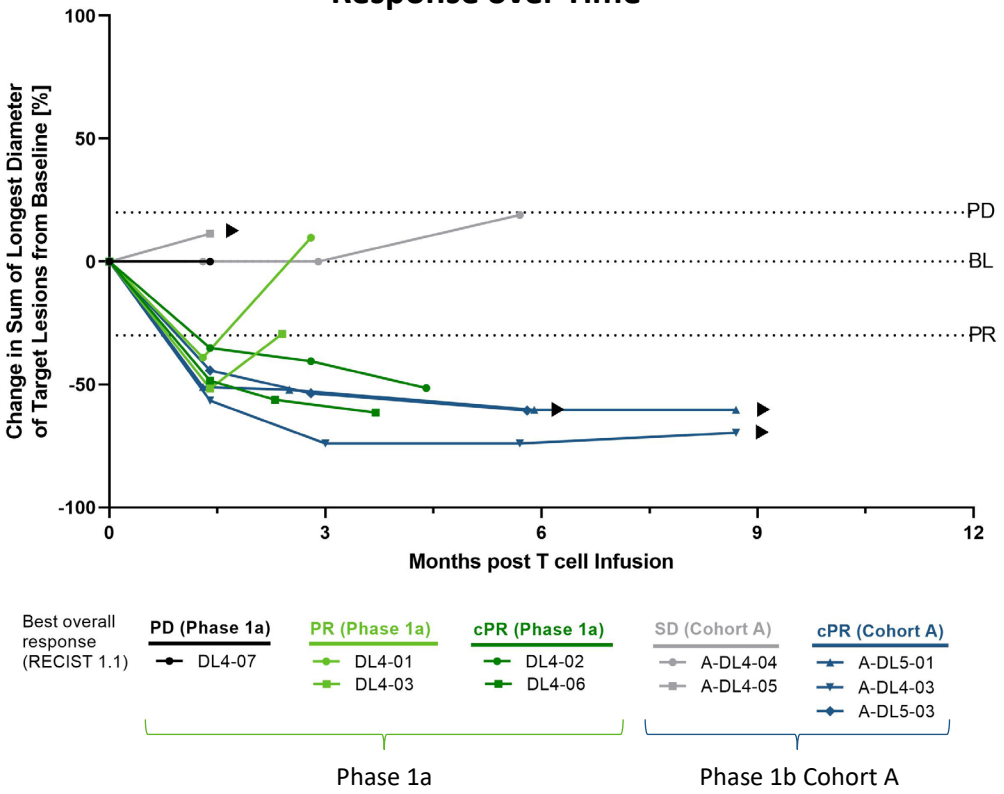
- Phase 1a (N=5): previous manufacturing process
- Phase 1b Cohort A (N=5): new monocyte depletion process, higher dose

Best Overall Response



ORR[2] = 70% (7/10)
cORR[3] = 56% (5/9)

Response over Time



Median DOR[4], min, max DOR	Not reached, 2.4, 8.8+ months
Median Follow-up[5]	8.5 months

* Maximum change of target lesions and RECIST 1.1 at different timepoints. [1] Transduced viable CD8 T cells; [2] Initial ORR: Objective response rate according to RECIST 1.1 at first scan post infusion at ~week 6; [3] Confirmed ORR (cORR): Confirmed objective response rate according to RECIST 1.1 for patients with available second scan post infusion at ~3 months or patients with progressive disease (PD) at any timepoint before this scan; [4] Duration of response (DOR) in confirmed responders is defined as time from first documented response until disease progression/death. Patients with ongoing response will be censored at date of data cut-off. Median DOR is analyzed by using the Kaplan-Meier method; [5] Median Follow-up is analyzed by using the reverse Kaplan-Meier method; PD: Progressive Disease; SD: Stable Disease; PR: Partial Response; cPR: Confirmed Partial Response; BOR: Best Overall Response; BL: Baseline; CPI: Checkpoint inhibitor; LDH: Lactate dehydrogenase

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the Power of T cells to Cancer Patients

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