UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 6-K

REPORT OF FOREIGN PRIVATE ISSUER PURSUANT TO RULE 13a-16 OR 15d-16 UNDER THE SECURITIES EXCHANGE ACT OF 1934

October 24, 2026

Commission File Number: 001-39363

IMMATICS N.V.

Paul-Ehrlich-Straße 15
72076 Tübingen, Federal Republic of Germany
(Address of principal executive office)

Indicate by check mark whether the registrant files or will file annual reports under cover of Form 20-F or Form 40-F:

Form 20-F ☒ Form 40-F ☐

INFORMATION CONTAINED IN THIS REPORT ON FORM 6-K

IMA402 Data Release

On October 24, 2026, the Company announced updated clinical trial data from its ongoing phase 1b study with IMA402 PRAME TCR bispecific (TCER®) in a heavily pretreated patient population with a median of three prior lines of therapy.

Patient Population. As of the June 1, 2026 data cutoff, 126 heavily pretreated patients across multiple tumor types, primarily melanoma and ovarian cancer, received at least one infusion of IMA402 during the dose escalation or dose expansion part of the ongoing trial (NCT05958121). Patients had received a median of three prior lines of systemic treatment (range: 0 – 7), had a median target lesion sum of diameter of 7.4 cm (range: 1.2 – 39.8) and had a median of four tumor lesions (range: 1 – 15). The efficacy population included 40 patients treated within the recommended Phase 2 dose (RP2D) range of 10 to 45 mg across varying levels of PRAME expression. Within this population, 31 patients exhibited high PRAME expression levels (PRAME-high)[1] in their tumors. Of these, all patients with PRAME-high melanoma had received prior systemic treatment with immune checkpoint inhibitors ("ICI"), with a median of 2 prior ICI-regimens and all patients with PRAME-high ovarian cancer were previously treated with platinum-based chemotherapy. Of the 31 patients exhibiting high PRAME expression, 22 were melanoma patients, 20 of which received monotherapy and two received the combination of IMA402 and pembrolizumab.

Safety Data. IMA402 showed favorable tolerability across all doses. The most frequent treatment-related adverse events ("TRAEs") were expected, transient lymphopenia and low-grade cytokine release syndrome ("CRS"), consistent with the mechanism of action. No cases of Immune Effector Cell-Associated Neurotoxicity Syndrome ("ICANS") were reported. No IMA402-related Grade 5 events were reported. Tolerability was consistent across all evaluated doses, including the RP2D range, with no additive toxicity observed when combined with an ICI.

The following table shows TRAEs across all indications and dose levels:

Treatment-related AEs, n (%)[a]	All Grades	≥ Grade 3
Lymphopenia	56 (44)	44 (35)
Cytokine release syndrome	46 (37)	2 (2)
Arthralgia	42 (33)	2 (2)
Fatigue	32 (25)	1 (1)
ALT/AST increased	23 (18)	10 (8)
Pruritus	18 (14)	0
Pyrexia	18 (14)	0
Anaemia	17 (13)	4 (3)
Myalgia	17 (13)	1 (1)
Rash	16 (13)	0
Gamma-glutamyltransferase increased	12 (10)	4 (3)
Nausea	10 (8)	1 (1)
Erythema	10 (8)	0
Lipase increased	9 (7)	4 (3)
Diarrhoea	9 (7)	0
Abdominal pain	9 (7)	1 (1)
Hypertension	4 (3)	3 (2)
Leukopenia	4 (3)	1 (1)
Vomiting	4 (3)	1 (1)
Blood creatinine increased	3 (2)	1 (1)
Tumour pain	3 (2)	1 (1)
Neutropenia	2 (2)	2 (2)
Back pain	2 (2)	1 (1)
Pancreatitis	2 (2)	1 (1)
Stomatitis	2 (2)	1 (1)
Urinary tract disorder	2 (2)	1 (1)
Acute kidney injury	1 (1)	1 (1)
Electrocardiogram abnormal	1 (1)	1 (1)
Herpes zoster	1 (1)	1 (1)
Immune-mediated arthritis	1 (1)	1 (1)
Liver function test increased	1 (1)	1 (1)
Tumour lysis syndrome	1 (1)	1 (1)

Treatment-ermegent AEs, n (%)	All Grades	≥ Grade 3
Any	125 (99)	81 (64)
Treatment-related	120 (95)	65 (52)

[1] *Patients showed PRAME expression 3-fold higher than the PRAME qPCR threshold, based on an exploratory analysis in the efficacy population. More than 80% of patients with cut. melanoma are estimated to have PRAME-high expression based on Immatics and TCGA RNA seq data.*

[a] *TRAEs: All treatment-emergent adverse events at least possibly related to IMA402 with grade 1-2 occurring in at least 9 patients (incidence ≥7.1%), and all events with grade 3-5. One uncoded grade 1 AE ("spotting") is not included. Abdominal pain incudes "Abdominal Pain" and "Abdominal Pain Upper"; Patients are counted only once per adverse event.*

The following table shows TRAEs for IMA402 as monotherapy and IMA402 with pembrolizumab at all dose levels:

IMA402 Monotherapy (n=107)

Treatment-related AEs, n (%)[a]	All Grades	≥ Grade 3
Lymphopenia	46 (43)	36 (34)
Cytokine release syndrome	41 (38)	2 (2)
Arthralgia	35 (33)	2 (2)
Fatigue	29 (27)	0
ALT/AST increased	20 (19)	10 (9)
Pyrexia	17 (16)	0
Myalgia	16 (15)	1 (1)
Pruritus	16 (15)	0
Anemia	14 (13)	4 (4)
Rash	14 (13)	0
Gamma-glutamyltransferase increased	11 (10)	3 (3)
Nausea	10 (9)	1 (1)
Lipase increased	9 (8)	4 (4)
Abdominal pain	9 (8)	1 (1)
Diarrhea	8 (7)	0
Hypertension	4 (4)	3 (3)
Leukopenia	4 (4)	1 (1)
Vomiting	4 (4)	1 (1)
Neutropenia	2 (2)	2 (2)
Back pain	2 (2)	1 (1)
Blood creatinine increased	2 (2)	1 (1)
Pancreatitis	2 (2)	1 (1)
Stomatitis	2 (2)	1 (1)
Tumor pain	2 (2)	1 (1)
Urinary tract disorder	2 (2)	1 (1)
Acute kidney injury	1 (1)	1 (1)
Electrocardiogram abnormal	1 (1)	1 (1)
Herpes zoster	1 (1)	1 (1)
Immune-mediated arthritis	1 (1)	1 (1)
Liver function test increased	1 (1)	1 (1)
Tumour lysis syndrome	1 (1)	1 (1)

IMA402 + Pembrolizumab (n=19)[b]

Treatment-related AEs, n (%)[b]	All Grades	≥ Grade 3
Lymphopenia	10 (53)	8 (42)
Arthralgia	7 (37)	0
Cytokine release syndrome	5 (26)	0
Fatigue	3 (16)	1 (5)
ALT/AST increased	3 (16)	0
Anemia	3 (16)	0
Erythema	3 (16)	0
Arthropathy	2 (11)	0
Dry skin	2 (11)	0
Headache	2 (11)	0
Pruritus	2 (11)	0
Rash	2 (11)	0
Gamma-glutamyltransferase increased	1 (5)	1 (5)
Alopecia	1 (5)	0
Atrial fibrillation	1 (5)	0
Blood creatinine increased	1 (5)	0
Blood thyroid stimulating hormone decreased	1 (5)	0
Body temperature increased	1 (5)	0
Decreased appetite	1 (5)	0
Diarrhea	1 (5)	0
Dysgeusia	1 (5)	0
Herpes simplex reactivation	1 (5)	0
Hyponatraemia	1 (5)	0
Myalgia	1 (5)	0
Oedema	1 (5)	0
Oedema peripheral	1 (5)	0
Pyrexia	1 (5)	0
Thrombocytopenia	1 (5)	0
Tumour pain	1 (5)	0
Uveitis	1 (5)	0

[a] *TRAEs: All treatment-emergent adverse events at least possibly related to IMA402 with grade 1-2 occurring in at least 8 patients for monotherapy (incidence ≥7%), and all events with grade 3-5. One uncoded grade 1 AE ("spotting") is not included. Abdominal pain incudes "Abdominal Pain" and "Abdominal Pain Upper"; Patients are counted only once per adverse event.* [b] *Out of 19 patients treated with IMA402 + pembrolizumab, 3 have ongoing early step dosing and did not yet reach their target dose and 6 did not have the opportunity of at least 3 months of follow-up. Of the remaining 10 patients, 3 were treated with IMA402 below 10 mg, 2 were PRAME negative, and 1 had LDH >1.5x ULN. ALT, alanine aminotransferase; AST, aspartate aminotransferase.*

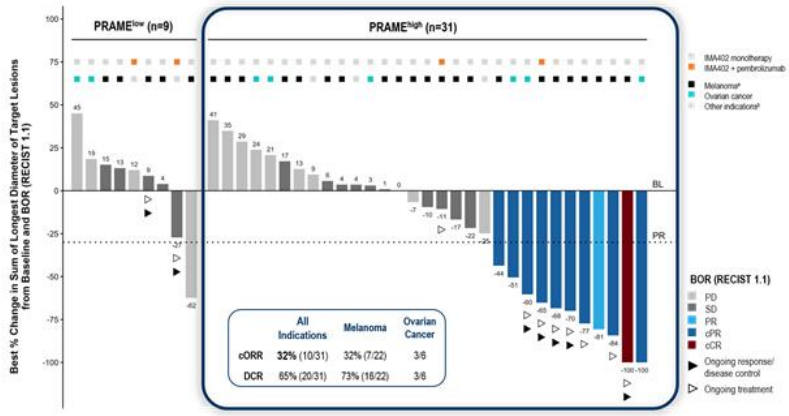
The following table shows TRAEs for IMA402 as monotherapy with and without pembrolizumab for the efficacy population:

IMA402 Efficacy Population ± Pembrolizumab (n=40)

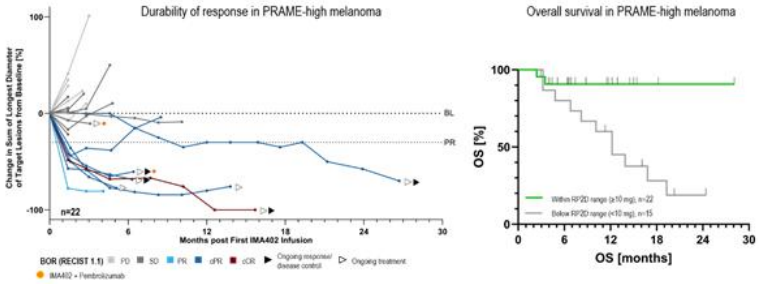
Treatment-related AEs, n (%)[a]	All Grades	≥ Grade 3
Lymphopenia	19 (48)	16 (40)
Arthralgia	17 (43)	1 (3)
Cytokine release syndrome	15 (38)	0
Fatigue	14 (35)	1 (3)
ALT/AST increased	11 (28)	4 (10)
Myalgia	9 (23)	0
Gamma-glutamyltransferase increased	8 (20)	2 (5)
Anemia	7 (18)	1 (3)
Lipase increased	6 (15)	3 (8)
Amylase increased	6 (15)	0
Pruritus	6 (15)	0
Blood alkaline phosphatase increased	5 (13)	0
Diarrhea	5 (13)	0
Erythema	5 (13)	0
Pyrexia	5 (13)	0
Leukopenia	2 (5)	1 (3)
Back pain	1 (3)	1 (3)
Herpes zoster	1 (3)	1 (3)
Hypertension	1 (3)	1 (3)
Liver function test increased	1 (3)	1 (3)
Pancreatitis	1 (3)	1 (3)

[a] *TRAEs: All treatment-emergent adverse events at least possibly related to IMA402 with grade 1-2 occurring in at least 4 patients (incidence ≥10%), and all events with grade 3-5. One uncoded grade 1 AE ("spotting") is not included. Patients are counted only once per adverse event.. ALT, alanine aminotransferase; AST, aspartate aminotransferase.*

Anti-Tumor Activity and Durability. IMA402 showed promising anti-tumor activity as monotherapy (n=36) or in combination with an immune checkpoint inhibitor (n=4) in the efficacy population at RP2D range. Treatment with IMA402 demonstrated 10 confirmed responses resulting in an overall confirmed objective response rate ("cORR") of 25% (10/40) and a disease control rate (DCR) of 63% (25/40). This includes one confirmed complete response in melanoma. The longest ongoing response exceeded 2 years. In the PRAME-high population, cORR was 32% (10/31) across all indications and 32% (7/22) in patients with melanoma. The PRAME-high melanoma population further showed a median duration of response ("mDOR") of 12.5 months, with a median follow-up time ("mFU") of 16.8 months. Median overall survival ("mOS") was not reached (mFU 8.8 months), with 91% of patients alive at 1 year (versus 60% of patients treated below RP2D range), indicating promising overall survival data irrespective of best response. Among 6 patients with PRAME-high ovarian cancer, 3 confirmed responses were reported.



[a] *Includes cutaneous melanoma and one patient with uveal melanoma.* [b] *Includes endometrial cancer (n=2), sqNSCLC (n=2), and synovial sarcoma (n=1); BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; DCR, disease control rate; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.*



BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

Next Development Steps

The promising clinical profile of IMA402 supports a development path across various solid tumors in earlier and later treatment lines. These include combination approaches with ICIs in melanoma and in gynecologic cancers as well as IMA402 in combination with the Company's MAGEA4/8-directed bispecific, IMA401, in lung cancer with first data expected in 2027. Furthermore, the use of Immatics' proprietary rapid, sensitive and reliable liquid biopsy-based PRAME testing enables precise patient selection and could support potential fast-to-market strategies, subject to regulatory approval, in PRAME-high melanoma and beyond.

Anzu-cel Poster Presentation

On October 23, 2026, additional exploratory analyses (data cutoff September 24, 2025) of anzu-cel (anzutresgene autoleucel, IMA203), presented in a poster (2128P) by Sapna Patel, M.D., demonstrated durable clinical benefit following a one-time treatment in a heavily pretreated population of patients with advanced melanoma. Durable clinical benefit was observed across patients with varied baseline clinical and treatment characteristics, with no single characteristic identified as a predictor of prolonged PFS. Exploratory analyses suggested that lower tumor burden, lower LDH, and a higher effector-to-target ratio may be associated with longer PFS. These findings further strengthen the clinical profile of anzu-cel, which is currently being evaluated in the Phase 3 SUPRAME trial in advanced melanoma.

* * *

Certain statements in this report may be considered forward-looking statements. Forward-looking statements generally relate to future events or the Company's future financial or operating performance. For example, statements concerning timing of data read-outs for product candidates, the timing, outcome and design of clinical trials, the nature of clinical trials (including whether such clinical trials will be registration-enabling), the timing and outcomes of IND, CTA, BLA and other regulatory filings, or the timing of commercial launches, estimated market opportunities of product candidates, manufacturing timetables, capacity and success rates, the potential benefits of product candidates, the Company's focus on partnerships to advance its intended strategy, and other metrics are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as "may", "should", "expect", "plan", "target", "intend", "will", "estimate", "anticipate", "believe", "predict", "potential" or "continue", or the negatives of these terms or variations of them or similar terminology. Such forward-looking statements are subject to risks, uncertainties, and other factors which could cause actual results to differ materially from those expressed or implied by such forward-looking statements. These forward-looking statements are based upon estimates and assumptions that, while considered reasonable by Immatics and its management, are inherently uncertain. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. Factors that may cause actual results to differ materially from current expectations include, but are not limited to, various factors beyond management's control including general economic conditions and other risks, uncertainties and factors set forth in the Company's Annual Report on Form 20-F and other filings with the Securities and Exchange Commission (SEC). Nothing in this report should be regarded as a representation by any person that the forward-looking statements set forth herein will be achieved or that any of the contemplated results of such forward-looking statements will be achieved. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. The Company undertakes no duty to update these forward-looking statements. All the scientific and clinical data presented within this report are – by definition prior to completion of the clinical trial and a clinical study report – preliminary in nature and subject to further quality checks including customary source data verification.

* * *

In connection with the foregoing, the Company issued a press release, copy of which is attached hereto as Exhibit 99.1, made available presentations, copies of which are attached hereto as Exhibits 99.2 and 99.3, and made available an updated corporate presentation, a copy of which is attached hereto as Exhibit 99.4.

INCORPORATION BY REFERENCE

This Report on Form 6-K (other than the exhibits hereto) shall be deemed to be incorporated by reference into the registration statements on Form F-3 (Registration Nos. 333-240260, 333-274218 and 333-286151) of Immatics N.V. and to be a part thereof from the date on which this report is filed, to the extent not superseded by documents or reports subsequently filed or furnished.

EXHIBIT INDEX

Exhibit No.	Description
99.1	Press release dated October 24, 2026
99.2	Initial Results With IMA402, a PRAME-Targeted T-cell Receptor (TCR)-based Bispecific T-cell Engager (TCER) in Advanced Solid Tumors
99.3	Response Durability with Anzutresgene Autoleucel (Anzu-cel), a PRAME-directed T-cell Receptor T-cell Therapy, in Advanced Melanoma
99.4	Corporate presentation dated October 24, 2026

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Date: October 26, 2026

IMMATICS N.V.

By: /s/ Harpreet Singh
Name: Harpreet Singh
Title: Chief Executive Officer

PRESS RELEASE

Immatics Presents Clinical Activity of IMA402 PRAME Bispecific and IMA203CD8 PRAME Cell Therapy across Advanced Solid Tumors in Two Oral Presentations at 2026 ESMO Annual Meeting

- IMA402 PRAME bispecific continues to demonstrate encouraging anti-tumor activity in multiple indications, alongside a favorable safety profile
- IMA402 achieved a cORR of 32%, 12.5 months median DOR and a 1-year OS rate of 91% in advanced melanoma patients with high PRAME expression
- Clinical profile of IMA402 reinforces development path across multiple solid tumor indications, including melanoma, gynecologic cancers and lung cancer, in earlier and later treatment lines, supported by Immatics' innovative, rapid liquid biopsy-based PRAME testing
- IMA203CD8 PRAME cell therapy demonstrated deep and durable anti-tumor activity across multiple tumor types with a manageable safety profile, supporting its tumor-agnostic potential. At clinically relevant dose levels in patients with advanced, heavily pretreated gynecologic cancers, cORR was 55% with a median DOR of 8.4 months

Houston, Texas and Tuebingen, Germany, October 24, 2026 – Immatics N.V. (NASDAQ: IMTX, "Immatics" or the "Company"), the global leader in precision targeting of PRAME with multiple clinical-stage programs spanning cell therapies and bispecifics, today announced updated clinical trial data from its ongoing Phase 1b study with IMA402 PRAME bispecific and its Phase 1 study with IMA203CD8 PRAME cell therapy.

The IMA402 data will be presented in a rapid oral presentation (1955RO) by Dirk Schadendorf, M.D., and the IMA203CD8 data were presented in an oral presentation (1946O) by Antonia Busse, M.D., at the 2026 Annual Meeting of the European Society for Medical Oncology (ESMO) in Madrid, Spain. In addition, exploratory analyses of the anzu-cel Phase 1b melanoma cohort will be presented in a poster (2128P) by Sapna Patel, M.D. The slides are available in the 'Events & Presentations' section of the Investor & Media page on the Company's website.

"The data presented at ESMO further underscore the potential of IMA402 as an off-the-shelf treatment option for patients with solid cancers. This promising clinical profile reinforces our strategy as we continue to advance IMA402 across multiple cancer types and treatment lines,

with combination approaches further expanding its reach," said Cedrik Britten, M.D., Ph.D., Chief Medical Officer at Immatics. "In addition, as the IMA203CD8 PRAME cell therapy data continue to mature, we are increasingly encouraged by its broad potential for patients with advanced PRAME-positive cancers. Together with anzu-cel, IMA402 and IMA203CD8 give us three distinct and complementary approaches to target PRAME, with the potential to reach more patients across a broad range of cancers."

Rapid Oral Presentation Summary - IMA402 PRAME TCR Bispecific Phase 1b Trial

Patient Population: *Heavily pretreated patient population with a median of 3 prior lines of therapy*

As of the data cutoff on June 1, 2026, 126 heavily pretreated patients across multiple tumor types, primarily melanoma and ovarian cancer, received at least one infusion of IMA402 during the dose escalation or dose expansion part of the ongoing trial (NCT05958121). Patients had received a median of 3 prior lines of systemic treatment, had a median target lesion sum of diameter of 7.4 cm and had a median of 4 tumor lesions. The efficacy population included 40 patients treated within the recommended Phase 2 dose (RP2D) range of 10 to 45 mg across varying levels of PRAME expression. Within this population, 31 patients exhibited high PRAME expression levels (PRAME-high)[1] in their tumors. Of these, all patients with PRAME-high melanoma had received prior systemic treatment with immune checkpoint inhibitors (ICI), with a median of 2 prior ICI regimens and all patients with PRAME-high ovarian cancer were previously treated with platinum-based chemotherapy.

Safety: *Favorable tolerability profile as monotherapy and as combination therapy*

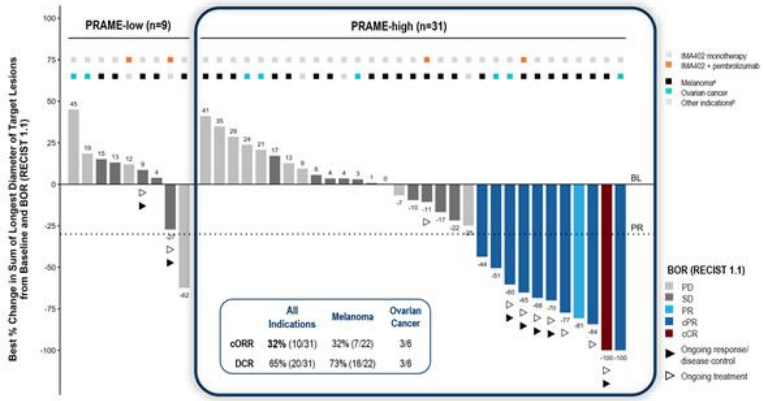
IMA402 showed favorable tolerability across all doses. The most frequent treatment-related adverse events (TRAEs) were expected, transient lymphopenia and low-grade cytokine release syndrome (CRS), consistent with the mechanism of action. No cases of ICANS were reported. No IMA402-related Grade 5 events were reported. Tolerability was consistent across all evaluated doses, including the RP2D range, with no additive toxicity observed when combined with an ICI.

Anti-tumor Activity and Durability: *32% cORR in PRAME-high melanoma with promising durability and survival*

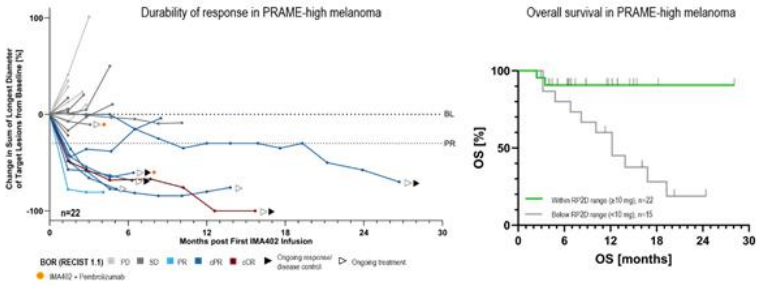
IMA402 showed promising anti-tumor activity as monotherapy (n=36) or in combination with an immune checkpoint inhibitor (n=4) in the efficacy population at RP2D range. Treatment with IMA402 demonstrated 10 confirmed responses resulting in an overall confirmed objective response rate (cORR) of 25% (10/40) and a disease control rate (DCR) of 63% (25/40). This includes one confirmed complete response in melanoma. The longest ongoing response exceeded 2 years. In the PRAME-high population, cORR was 32% (10/31) across all indications and 32% (7/22) in patients with melanoma. The PRAME-high melanoma population further showed a median duration of response (mDOR) of 12.5 months (median follow-up, mFU, 16.8 months). Median overall survival (mOS) was not reached (mFU 8.8 months), with 91% of patients alive at 1 year (versus 60% of patients treated below RP2D range), indicating

[1] Patients showed PRAME expression 3-fold higher than the PRAME qPCR threshold, based on an exploratory analysis in the efficacy population. More than 80% of patients with cut. melanoma are estimated to have PRAME-high expression based on Immatics and TCGA RNA seq data.

promising overall survival data irrespective of best response. Among 6 patients with PRAME-high ovarian cancer, 3 confirmed responses were reported.



[a] Includes cutaneous melanoma and one patient with uveal melanoma. [b] Includes endometrial cancer (n=2), sqNSCLC (n=2), and synovial sarcoma (n=1); BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; DCR, disease control rate; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.



BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

Next Development Steps for IMA402:

The promising clinical profile of IMA402 supports a development path across various solid tumors in earlier and later treatment lines. These include combination approaches with ICIs in melanoma and in gynecologic cancers as well as IMA402 in combination with the Company's MAGEA4/8-directed bispecific, IMA401, in lung cancer with first data expected in 2027. Furthermore, the use of Immatics' proprietary rapid, sensitive and reliable liquid biopsy-based PRAME testing enables precise patient selection and could support potential fast-to-market strategies, subject to regulatory approval, in PRAME-high melanoma and beyond.

Oral Presentation Summary - IMA203CD8 PRAME Cell Therapy Phase 1 Trial

Patient population: *Heavily pretreated patient population with limited treatment options*

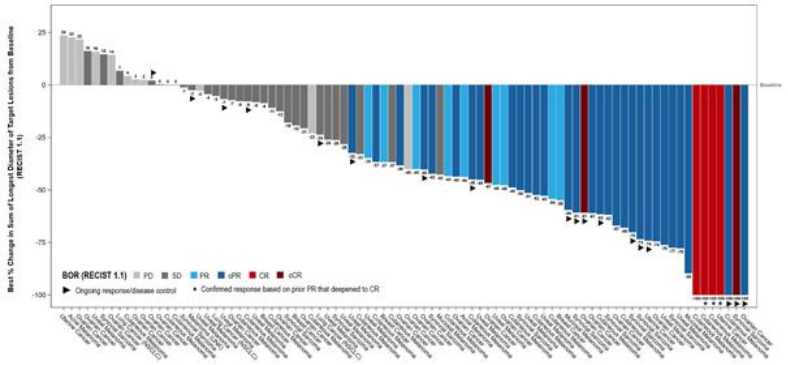
As of the data cutoff on August 7, 2026, 98 heavily pretreated patients across multiple advanced solid tumor types expressing PRAME that had undergone a median of 3 prior systemic treatments were enrolled in the ongoing Phase 1 dose escalation/dose expansion trial (NCT03686124). Of these, 90 patients were evaluable for efficacy, including 27 with gynecologic cancers (ovarian and uterine cancer), 44 with melanoma, 12 with synovial sarcoma and 7 with other solid tumor types. All patients with ovarian cancer had received prior platinum-based therapy.

Safety: *Treatment with IMA203CD8 was manageable*

IMA203CD8 demonstrated a consistent and manageable safety profile across different solid tumor types and a wide dose range (median dose $1.81x10^9$ TCR T cells, range $0.44\text{-}12.50x10^9$). The most frequent treatment-emergent adverse events (TEAEs) were expected and included transient cytopenias associated with the lymphodepletion regimen and low-grade cytokine release syndrome (CRS), consistent with the mechanism of action. ICANS was infrequently observed, and no IMA203CD8-related Grade 5 events occurred. Maximum tolerated dose (MTD) was not reached with doses up to 12.5 billion IMA203CD8 cells.

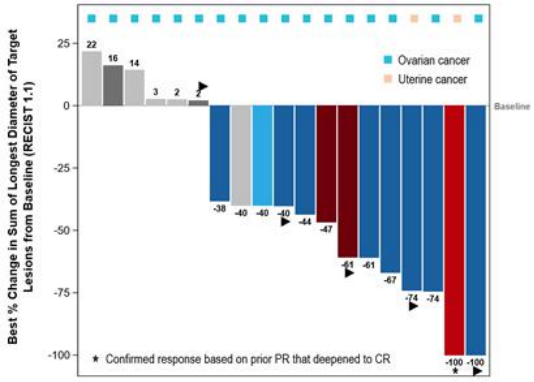
Anti-tumor Activity and Durability: *One-time infusion of IMA203CD8 PRAME cell therapy showed anti-tumor activity across multiple tumor types*

Across all evaluated dose levels and tumor types, including lower dose levels not selected for further clinical development, a one-time infusion of IMA203CD8 demonstrated an ORR of 51% (46/90) and a cORR of 41% (36/87). The DCR was 82% (74/90) and 83% (71/86) of patients with evaluable target lesions experienced tumor reduction. Responses were observed across multiple solid tumors expressing PRAME, including ovarian cancer, uterine cancer, melanoma, synovial sarcoma, and others. Durable long-term responses were observed with ongoing responses for more than 2.5 years.



3 patients without any post-baseline scan not evaluable for assessment of tumor reduction, not depicted in the plot, but included in efficacy calculations. For patients achieving a (c)CR with <100% change from baseline, target lesions were lymph nodes that resolved to <10 mm per RECIST 1.1; BOR, best overall response; (c)CR, (confirmed) complete response; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

In 20 patients with gynecologic cancers (ovarian and uterine cancer) treated at clinically relevant dose levels (≥DL4c), IMA203CD8 demonstrated consistent anti-tumor activity with an ORR of 60% (12/20) and a cORR of 55% (11/20), a DCR of 70% (14/20) and tumor reduction in 68% (13/19) of patients. Early durability data showed a mDOR of 8.4 months (mFU 6.0 months), a mPFS of 5.8 months (mFU 8.1 months) and mOS not reached at 7.8 months mFU.



1 patient without any post-baseline scan not evaluable for assessment of tumor reduction, not depicted in plot, but included in efficacy calculations; those patients achieving a (c)CR with <100% changes from baseline, target lesions were lymph nodes that resolved to <10 mm per RECIST 1.1; BOR, best overall response; (c)CR, (confirmed) complete response; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

Next Development Steps for IMA203CD8:

Phase 1a dose escalation is complete. Immatics is currently enrolling patients with uterine cancer at clinically relevant doses to further expand the clinical dataset in this indication. In addition, a Phase 1/2 investigator-initiated trial (IIT) in patients with PRAME-positive pediatric cancers is planned to start in 1H 2027. The clinical activity of IMA203CD8 observed across tumor types with distinct biology and differing levels of PRAME expression, including ovarian cancer, uterine cancer, melanoma and synovial sarcoma, supports the broad applicability of IMA203CD8 across PRAME-positive cancers. The development approach for IMA203CD8 will leverage targeted cohorts of selected tumor types, such as ovarian cancer, uterine cancer, rare cancers and pediatric cancers to build the clinical evidence base for broader, tumor-agnostic application.

Poster Presentation Summary – Anzu-cel Phase 1b Melanoma Cohort

Additional exploratory analyses (data cutoff Sept 24, 2025) of anzu-cel (anzutresgene autoleucel, IMA203), presented in a poster (2128P) by Sapna Patel, M.D., demonstrated durable clinical benefit following a one-time treatment in a heavily pretreated population of patients with advanced melanoma. Durable clinical benefit was observed across patients with varied baseline clinical and treatment characteristics, with no single characteristic identified as a predictor of prolonged PFS. Exploratory analyses suggested that lower tumor burden, lower LDH, and a higher effector-to-target ratio may be associated with longer PFS. These findings further strengthen the clinical profile of anzu-cel, which is currently being evaluated in the Phase 3 SUPRAME trial in advanced melanoma.

About IMA402 PRAME Bispecific

IMA402 is a molecule from Immatics' TCR bispecifics (TCER®) pipeline directed against an HLA-A*02:01-presented peptide derived from PRAME. IMA402 is currently being evaluated in a Phase 1b clinical trial in patients with solid tumors expressing PRAME. IMA402 is part of Immatics' strategy to leverage the full clinical potential of targeting PRAME, one of the most promising targets for TCR-based therapies.

About IMA203CD8 PRAME Cell Therapy

IMA203CD8 is Immatics' PRAME-directed TCR T-cell therapy engineered to recognize an intracellular PRAME-derived peptide presented by HLA-A*02:01 on the cell surface and initiate a potent and specific anti-tumor response. Co-transduction of CD8αβ with the PRAME TCR adds functional CD4+ T cells designed to boost anti-tumor activity. IMA203CD8 is currently being evaluated in a Phase 1b clinical trial in solid tumors expressing PRAME.

About Anzu-cel PRAME Cell Therapy

Anzu-cel (anzutresgene autoleucel; IMA203) is a PRAME-directed TCR T-cell therapy engineered to recognize an intracellular PRAME-derived peptide presented by HLA-A*02:01 on the cell surface and initiate a potent and specific anti-tumor response. Anzu-cel PRAME cell therapy is currently being evaluated in a registration-enabling randomized controlled Phase 3 trial, "SUPRAME," in patients with unresectable or metastatic melanoma who have disease progression on or after treatment with at least one checkpoint inhibitor. In parallel, the Phase 1/2 clinical trial is ongoing with a focus on uveal melanoma.

About PRAME

PRAME is a tumor-associated target expressed in more than 50 cancers. Immatics' PRAME franchise includes multiple product candidates, therapeutic modalities, indications and combination approaches: anzu-cel (anzutresgene autoleucel; IMA203) and IMA203CD8, both PRAME-directed cell therapies, and IMA402, a PRAME-directed bispecific. Combination approaches include IMA402 with immune checkpoint inhibitors, IMA402 with the MAGEA4/8-directed bispecific IMA401, and anzu-cel in combination with Moderna's PRAME mRNA therapy designed to enhance the cell therapy response.

About Immatics

Immatics is committed to making a meaningful impact on the lives of patients with cancer. We are the global leader in precision targeting of PRAME, a target expressed in more than 50 cancers. Our cutting-edge science and robust clinical pipeline form the broadest PRAME franchise with the most PRAME indications and modalities, spanning TCR T-cell therapies and TCR bispecifics.

Immatics intends to use its website www.immatics.com as a means of disclosing material non-public information. For regular updates, you can also follow us on LinkedIn and Instagram.

Forward-Looking Statements

Certain statements in this press release may be considered forward-looking statements. Forward-looking statements generally relate to future events or the Company's future financial or operating performance. For example, statements concerning timing of data read-outs, the timing, outcome and design of clinical trials, the nature of clinical trials (including whether such clinical trials will be registration-enabling), the timing and outcomes of IND, CTA, BLA and other regulatory filings, the timing of commercial launches, estimated market

opportunities, manufacturing timetables, capacity and success rates, the potential benefits of product candidates, the Company's intended strategy, and other metrics are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as "may", "should", "expect", "plan", "target", "intend", "will", "estimate", "anticipate", "believe", "predict", "potential" or "continue", or the negatives of these terms or variations of them or similar terminology. Such forward-looking statements are subject to risks, uncertainties, and other factors which could cause actual results to differ materially from those expressed or implied by such forward-looking statements. These forward-looking statements are based upon estimates and assumptions that, while considered reasonable by Immatics and its management, are inherently uncertain. New risks and uncertainties may emerge from time to time, and it is not possible to predict all risks and uncertainties. Factors that may cause actual results to differ materially from current expectations include, but are not limited to, various factors beyond management's control including general economic conditions and other risks, uncertainties and factors set forth in the Company's Annual Report on Form 20-F and other filings with the Securities and Exchange Commission (SEC). Nothing in this press release should be regarded as a representation by any person that the forward-looking statements set forth herein will be achieved or that any of the contemplated results of such forward-looking statements will be achieved. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. The Company undertakes no duty to update these forward-looking statements. All the scientific and clinical data presented within this press release are – by definition prior to completion of the clinical trial and a clinical study report – preliminary in nature and subject to further quality checks including customary source data verification.

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MADRID 2026 ESMO congress

Initial Results With IMA402, a PRAME-Targeted T-cell Receptor (TCR)-based Bispecific T-cell Engager (TCER) in Advanced Solid Tumors

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Prof. Dr. Dirk Schadendorf

Rapid Oral Presentation

Abstract #8465



Declaration of Interests

Advisory board, consulting, speaker's honoraria:

AstraZeneca, BioAlta, BioNTech, BMS, Boehringer Ingelheim, Daiichi Sankyo, EeBeTe, Formycon, ImCheck, Immatics, Immunocore, IOBioTech, Iovance, Ipsen, Merck-Serono, Moderna, MSD, Neracare, Novartis, Philogen, Pierre Fabre, Regeneron, Replimune, SkylineDx

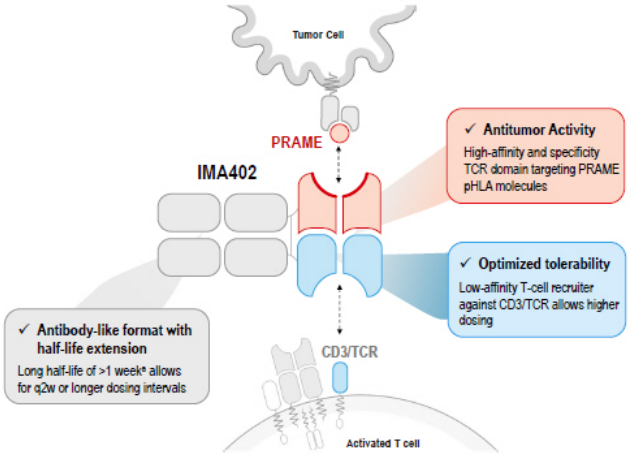
Research funding:

BMS, MSD

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IMA402 is an Optimized T-cell Engager (TCER) Designed to Target PRAME

Improved benefit-risk profile with half-life extension[1]



PRAME is expressed in more than 50 cancers



PRAME prevalence in selected indications

Indication	% PRAME+ patients[b]
Cutaneous Melanoma	95%
Uterine Carcinoma	95%
Uterine Carcinosarcoma	95%
Synovial Sarcoma	95%
Uveal Melanoma	90%
Mucosal Melanoma	90%
Ovarian Carcinoma Subtypes	85%
Squamous Cell NSCLC	70%
Triple-negative Breast Carcinoma	65%
Small Cell Lung Cancer	45%
Esophageal Carcinoma Subtype	45%
Kidney Carcinoma Subtype	40%
Cholangiocarcinoma	35%
HER2-Enriched Breast Carcinoma	30%
Adenocarcinoma NSCLC	25%
Head & Neck Squamous Cell Carcinoma	25%
Hepatocellular Carcinoma	20%
Bladder Carcinoma	20%

[a] Half-life calculated by non compartmental analysis (NCA). [b] Data on file. PRAME target prevalence is based on a proprietary mass spec-guided initial expression threshold applied to RNAseq and/or immunohistochemistry data (approximate values, values between 95%-100% shown as 95%).
NSCLC, non-small cell lung cancer; pHLA, peptide-human leukocyte antigen; PRAME, preferentially expressed antigen in melanoma; q2w, every 2 weeks; TCR, T-cell receptor.

1. Hofmann M, et al. mAbs. 2026;18(1):1-34.

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IMA402-101 Study Design

Key Objectives

Primary:
- Determine MTD and/or RP2D
- Assess safety and tolerability

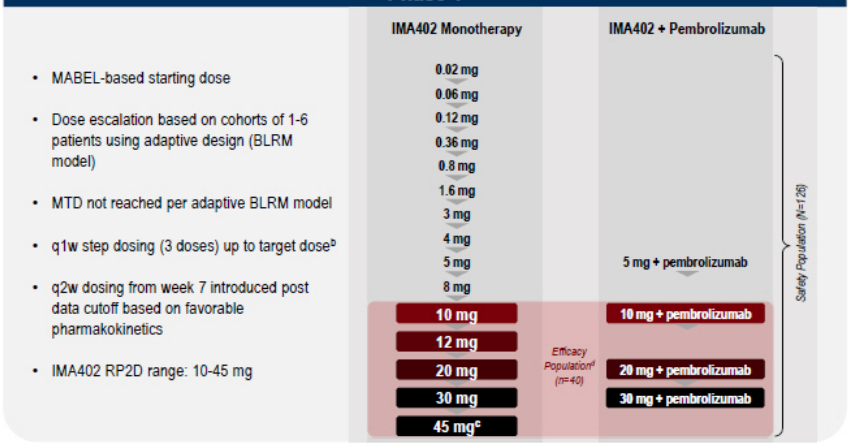
Secondary:
- Evaluate initial antitumor activity (RECIST 1.1 and iRECIST)
- Assess pharmacokinetics

Key Eligibility Criteria

- Recurrent and/or refractory **solid tumors expressing PRAME**[a]
- No prospective PRAME testing required
- HLA-A*02:01 positive
- ECOG performance status 0-1
- Received or not eligible for all available indicated standard of care treatments

Phase 1

- MABEL-based starting dose
- Dose escalation based on cohorts of 1-6 patients using adaptive design (BLRM model)
- MTD not reached per adaptive BLRM model
- q1w step dosing (3 doses) up to target dose[b]
- q2w dosing from week 7 introduced post data cutoff based on favorable pharmakokinetics
- IMA402 RP2D range: 10-45 mg



EudraCT No. 2022-503133-54-00; NCT05958121. [a] Cutaneous melanoma, melanoma of unknown primary, uveal melanoma, synovial sarcoma, endometrial carcinoma, ovarian carcinoma, squamous non-small cell lung cancer. [b] Step dosing introduced at 0.36 mg, optimized step dosing: 0.03 mg/0.3 mg/10 mg/target dose, low-dose dexamethasone used as preventive measure for initial doses as applied for other bispecific T-cell engagers; ability to increase dose to previously cleared dose levels. [c] Exploratory high dose in n=5. [d] Efficacy population: All patients treated within the RP2D range as of Mar 1, 2026 (who had the opportunity for at least 3 months follow-up or who discontinued early due to disease progression or death), tested positive for PRAME, received ≥4 infusions as defined per protocol (thereof 3 step doses, currently at 0.03 mg/0.3 mg/10 mg, and 1 target dose), and had LDH ≤1.5xULN.
BLRM, Bayesian logistic regression model; ECOG, Eastern Cooperative Oncology Group; MABEL, minimum anticipated biological effect level; MTD, maximum tolerated dose; q1w, every week; q2w, every 2 weeks; RP2D, recommended phase 2 dose.

Data cutoff Jun 1, 2026

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Demographics: Heavily Pretreated Patient Population

Baseline Characteristics	Safety Population N=126	Efficacy Population n=40
Indication, n		
Melanoma - cutaneous, uveal, unknown primary	78 - 62, 13, 3	27 - 26, 1, 0
Ovarian cancer	31	8
Other - endometrial cancer, sqNSCLC, synovial sarcoma	17 - 7, 6, 4	5 - 2, 2, 1
Age		
Median (range)	60 (21-82)	59 (29-77)
ECOG performance status		
0, n (%)	78 (62)	25 (63)
1, n (%)	48 (38)	15 (38)
LDH at baseline		
>1xULN, n (%)	57 (45)	10 (25)
Baseline tumor burden		
Median target lesion sum of diameter (cm) (range)	7.4 (1.2-39.8)	7.9 (1.5-19.4)
Tumor lesions		
Number of lesions, median (range)	4 (1-15)	4 (2-10)
Liver metastases, n (%)	44 (35)	11 (28)
Brain metastases, n (%)	7 (6)	3 (8)
Treatment Experience		
No. of prior lines of systemic treatment		
Median (range)	3 (0-7)	3 (0-6)
Prior systemic treatments, n (%)		
Chemotherapy	60 (48)	19 (48)
ICI	89 (71)	31 (78)
Targeted therapy	60 (48)	18 (45)

Data cutoff Jun 1, 2025

ECOG, Eastern Cooperative Oncology Group; ICI, immune checkpoint inhibitor; LDH, lactate dehydrogenase; sqNSCLC, squamous non-small cell lung cancer; ULN, upper limit of normal.

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Safety Profile Across All Indications and Dose Levels (N=126)

Treatment-related AEs, n (%)[a]	All Grades	≥ Grade 3
Lymphopenia	56 (44)	44 (35)
Cytokine release syndrome	46 (37)	2 (2)
Arthralgia	42 (33)	2 (2)
Fatigue	32 (25)	1 (1)
ALT/AST increased	23 (18)	10 (8)
Pruritus	18 (14)	0
Pyrexia	18 (14)	0
Anaemia	17 (13)	4 (3)
Myalgia	17 (13)	1 (1)
Rash	16 (13)	0
Gamma-glutamyltransferase increased	12 (10)	4 (3)
Nausea	10 (8)	1 (1)
Erythema	10 (8)	0
Lipase increased	9 (7)	4 (3)
Diarrhoea	9 (7)	0
Abdominal pain	9 (7)	1 (1)
Hypertension	4 (3)	3 (2)
Leukopenia	4 (3)	1 (1)
Vomiting	4 (3)	1 (1)
Blood creatinine increased	3 (2)	1 (1)
Tumour pain	3 (2)	1 (1)
Neutropenia	2 (2)	2 (2)
Back pain	2 (2)	1 (1)
Pancreatitis	2 (2)	1 (1)
Stomatitis	2 (2)	1 (1)
Urinary tract disorder	2 (2)	1 (1)
Acute kidney injury	1 (1)	1 (1)
Electrocardiogram abnormal	1 (1)	1 (1)
Herpes zoster	1 (1)	1 (1)
Immune-mediated arthritis	1 (1)	1 (1)
Liver function test increased	1 (1)	1 (1)
Tumour lysis syndrome	1 (1)	1 (1)

Treatment-emergent AEs, n (%)	All Grades	≥ Grade 3
Any	125 (99)	81 (64)
Treatment-related	120 (95)	65 (52)

- **Most frequent** related AEs were:
  - Transient lymphopenia (resolved within a median of 5d)
  - Low-grade CRS
    - One CRS G4 event at 0.08 mg starting dose only; no further CRS G4 events after step dose optimization
    - One CRS G3 event at 0.03 mg starting dose only, completely resolved within 7d
- **No ICANS** observed
- **No** IMA402-related G5 events

No additive toxicity was observed in patients treated with IMA402 + pembrolizumab (see appendix)

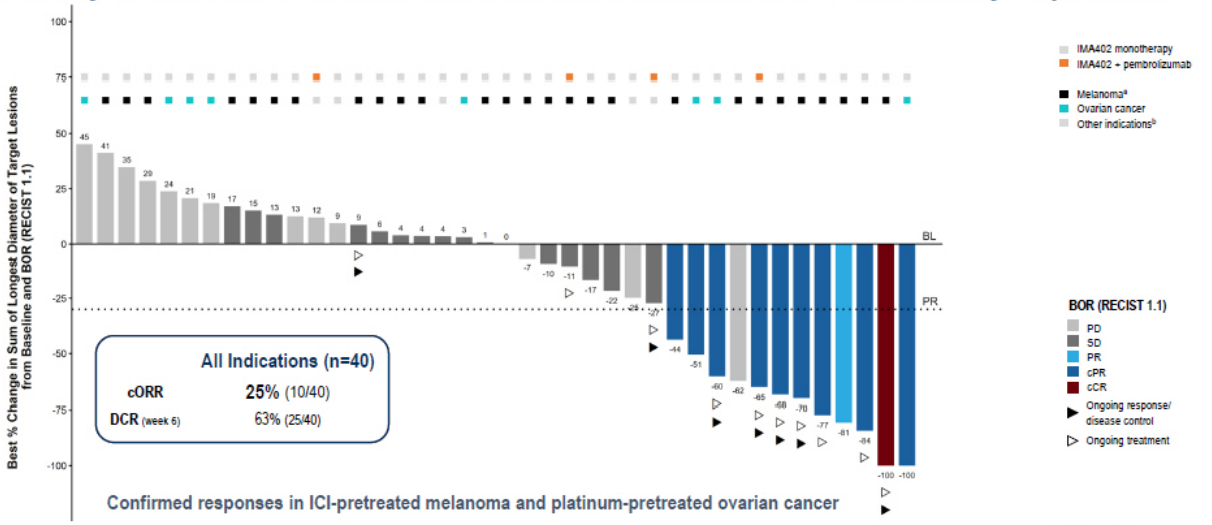
[a] TRAEs: All treatment-emergent adverse events at least possibly related to IMA402 with grade 1-2 occurring in at least 9 patients (incidence ≥7.1%), and all events with grade ≥3. One uncoded grade 1 AE ("spotting") is not included. Abdominal pain includes "Abdominal Pain" and "Abdominal Pain Upper". Adverse events are coded using the MedDRA Version 28.0. Grades are determined according to National Cancer Institute CTCAE, version 5.0, except grades for CRS and ICANS which are determined according to Lee et al., 2019; Neelapu et al., 2019 and tumor lysis syndrome which is determined according to Cairo and Bishop, 2004. Patients are counted only once per adverse event.

Data cutoff Jun 1, 2025

AE, adverse event; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CRS, cytokine release syndrome; ICANS, immune effector-cell associated neurotoxicity syndrome; TEAE, treatment-emergent AE; TRAE, treatment-related AE.

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Efficacy of IMA402 ± Pembrolizumab Across All Indications in the Efficacy Population



Confirmed responses in ICI-pretreated melanoma and platinum-pretreated ovarian cancer

[a] Includes cutaneous melanoma and 1 patient with uveal melanoma. [b] Includes endometrial cancer (n=2), sqNSCLC (n=2), and synovial sarcoma (n=1).
BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; DCR, disease control rate; ICI, immune checkpoint inhibitor; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

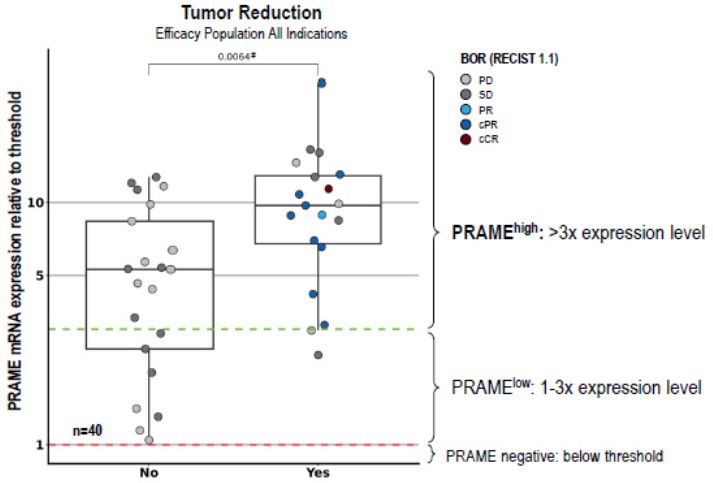
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Exploratory Analysis of PRAME Levels and Disease Outcome in Efficacy Population

- IMA402 shows association of higher PRAME levels with improved disease outcomes and tumor reduction
- All responders[a] with melanoma are PRAME^{high}
- >80%[b] of patients with melanoma are PRAME^{high}

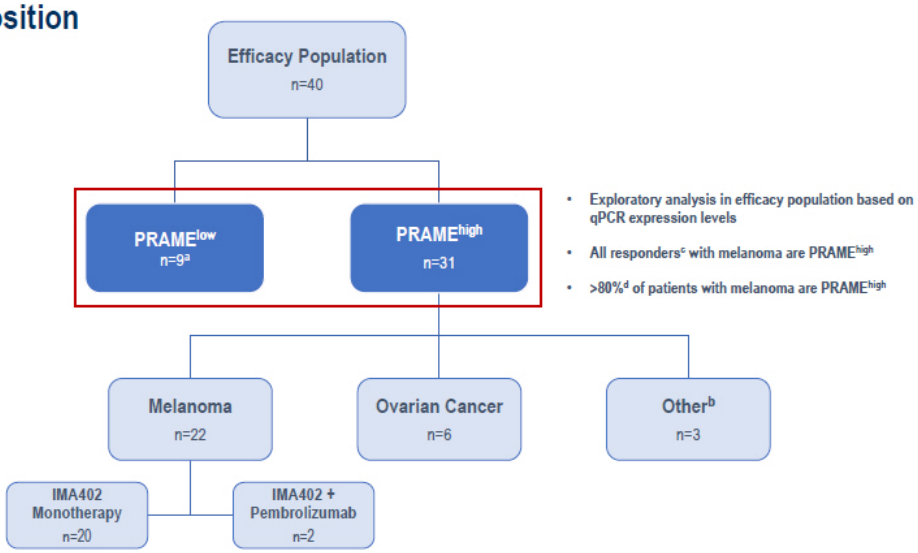


[a] PRAME^{low} does not preclude response to IMA402, 1 cPR observed in a patient with PRAME^{low} endometrial cancer below RP2D range; [b] Data on file. PRAME target prevalence is based on in-house (n=126) and TCGA RNAseq (n=473) analysis using proprietary mass spec-guided initial expression threshold.
Mann-Whitney U test. BOR, best overall response; cCR, confirmed complete response; PD, progressive disease; cPR, (confirmed) partial response; SD, stable disease; TCGA, The Cancer Genome Atlas.

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Patient Disposition



- Exploratory analysis in efficacy population based on qPCR expression levels
- All responders[c] with melanoma are PRAME^high
- >80%[d] of patients with melanoma are PRAME^high

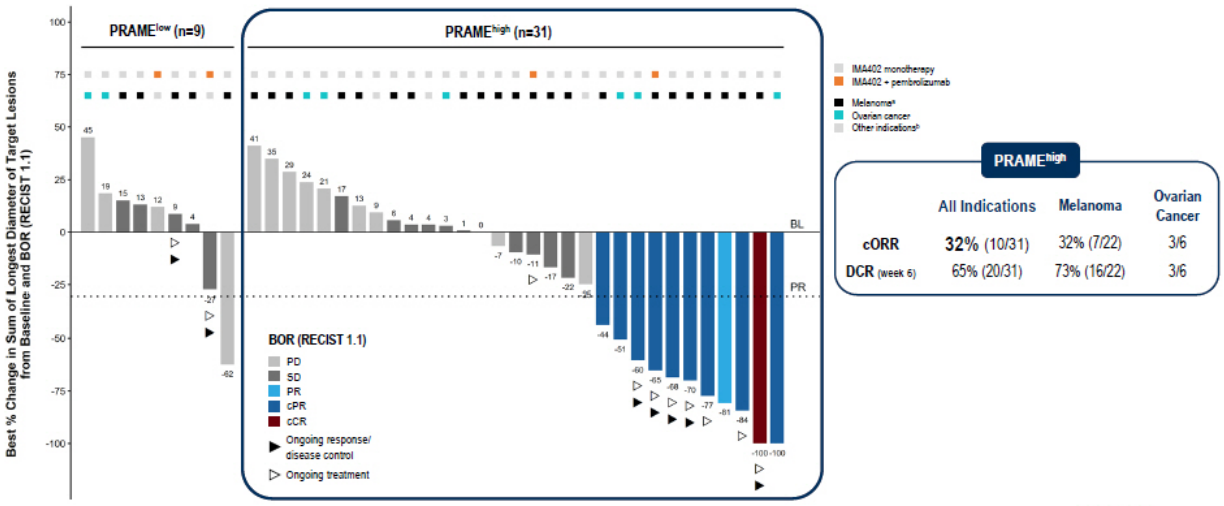
[a] Includes 2 patients treated with IMA402 + pembrolizumab. [b] Other includes endometrial cancer (n=2) and synovial sarcoma (n=1). [c] PRAME^low does not preclude response to IMA402, 1 cPR observed in a patient with PRAME^low endometrial cancer below RP2D range. [d] Data on file: PRAME target prevalence is based on in-house (n=138) and TCGA RNAseq (n=473) analysis using proprietary mass spec-guided initial expression threshold.
cPCR, quantitative polymerase chain reaction.

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Efficacy of IMA402 ± Pembrolizumab by PRAME Expression



PRAME^high

	All Indications	Melanoma	Ovarian Cancer
cORR	32% (10/31)	32% (7/22)	3/6
DCR (week 6)	65% (20/31)	73% (16/22)	3/6

[a] Includes cutaneous melanoma and one patient with uveal melanoma. [b] Includes endometrial cancer (n=2), sqNSCLC (n=2), and synovial sarcoma (n=1).
BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; DCR, disease control rate; PD, progressive disease; (c)PR, (confirmed) partial response; RP2D, recommended phase 2 dose; SD, stable disease.

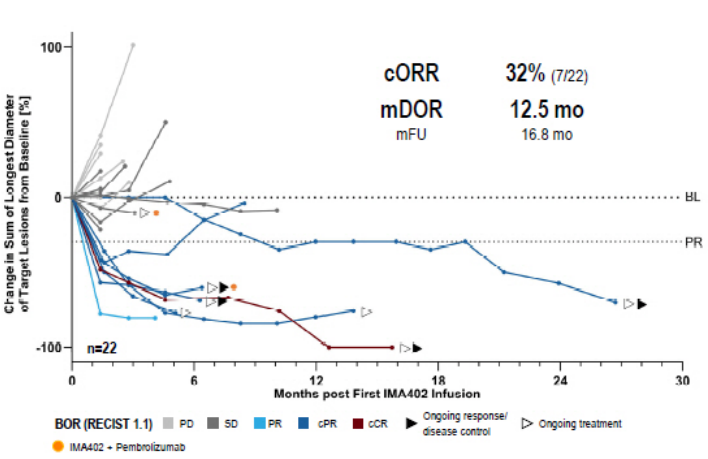
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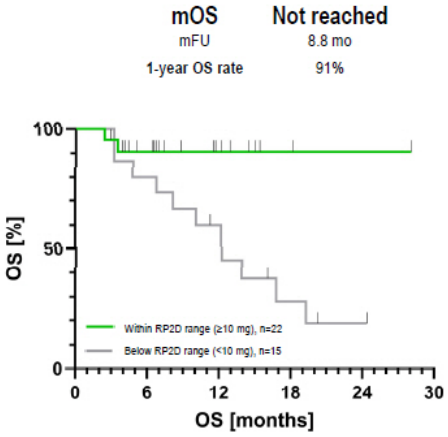
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Durability of Responses in PRAME^{high} Melanoma

All patients with melanoma in the efficacy population received prior ICI





Ongoing patients were censored at the data cutoff for OS; OS rates were calculated using the Kaplan–Meier method. BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; ICI, immune checkpoint inhibitor; mDOR, median duration of response; mFU, median follow up; mOS, median overall survival; PD, progressive disease; (c)PR, (confirmed) partial response; RP2D, recommended phase 2 dose; SD, stable disease.

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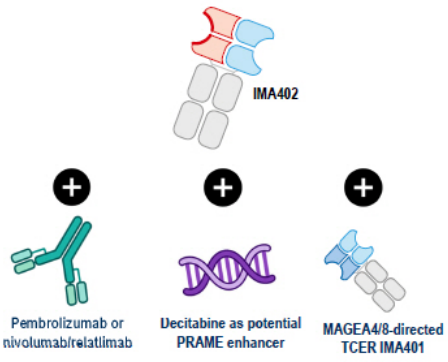
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Key Takeaways

- **TCR-based therapies** enable immune recognition of **intracellular** tumor antigens presented by cell-surface HLA, expanding the therapeutic landscape **beyond targets** accessible to conventional immunotherapies
- IMA402 is a **novel TCR-based bispecific T-cell engager** (TCER) targeting the cancer-associated antigen **PRAME**, a target expressed in more than **50 cancers**
- IMA402 demonstrates a **favorable tolerability** profile and **encouraging initial antitumor activity** across various indications, including melanoma

In addition to IMA402 monotherapy, three ongoing cohorts of IMA402 with:

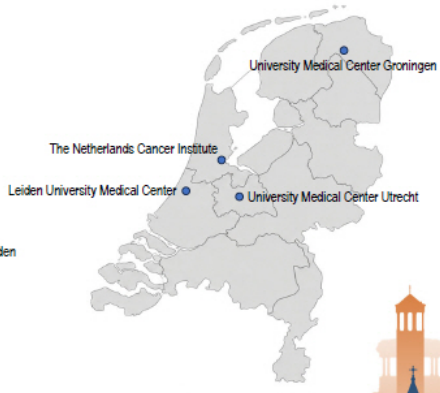


HLA, human leukocyte antigen; ICI, immune checkpoint inhibitor; TCR, T cell receptor.

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Thank You – Trial Participants & Caregivers





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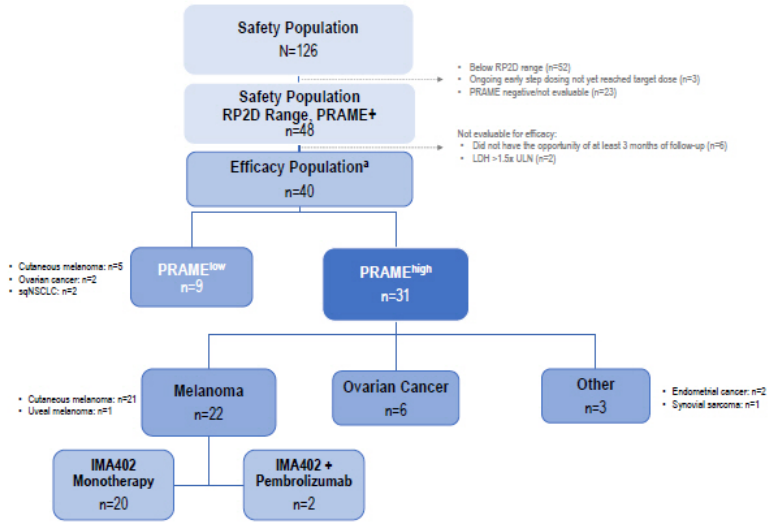
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APPENDIX



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Patient Disposition



[a]Efficacy population: All patients treated within the RP2D range as of Mar 1, 2026 (who had the opportunity for at least 3 months follow-up or who discontinued early due to disease progression or death), tested positive for PRAME, received ≥4 infusions as defined per protocol (thereof 3 step doses, currently at 0.03 mg/0.3 mg/10 mg, and 1 target dose), and had LDH ≤1.5x ULN.
LDH, lactate dehydrogenase; sqNSCLC, squamous non-small-cell lung cancer; RP2D, recommended phase 2 dose; ULN, upper limit of normal.

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Demographics in PRAME^{high} Melanoma

	Below RP2D Range (n=15)	At RP2D Range (n=22)
Indication, n (%)		
Cutaneous melanoma	11 (73)	21 (95)
Melanoma of unknown primary	1 (7)	0
Uveal melanoma	3 (20)	1 (5)
Age		
Median (range)	62 (38-82)	57.5 (29-76)
ECOG performance status		
0, n (%)	7 (47)	18 (82)
1, n (%)	8 (53)	4 (18)
LDH at baseline		
>1xULN, n (%)	6 (40)	5 (23)
Baseline tumor burden		
Median target lesion sum of diameter (cm) (range)	6.7 (2.5-18.3)	8.0 (1.5-19.4)
Tumor lesions		
Number of lesions, median (range)	6 (1-15)	3.5 (2-10)
Liver metastases, n (%)	6 (40)	7 (32)
Brain metastases, n (%)	1 (7)	3 (14)
Metastatic staging, n (%)[a]		
IIIb/IIIc/IVM1a	0	4 (19)
IVM1b/c/d	11 (92)	17 (81)
Treatment Experience		
Prior lines of systemic treatment, median (range)	4 (1-7)	3 (1-6)
Prior lines of ICI, median (range)	2 (0-6)	2 (1-4)
Prior systemic treatments, n (%)		
ICI	14 (93)	22 (100)
Ipilimumab + nivolumab	13 (87)	20 (91)
Relatlimab + nivolumab	1 (7)	1 (5)
TCR-based therapy	4 (27)	1 (5)
PRAME-directed therapy	2 (13)	0

Data cutoff Jun 1, 2025

[a] Excludes patients with uveal melanoma due to different staging guidelines. n=1 below RP2D range missing due to missing data entry. ECOG, Eastern Cooperative Oncology Group; ICI, immune checkpoint inhibitor; LDH, lactate dehydrogenase; ULN, upper limit of normal

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Safety Profile of IMA402 Monotherapy and IMA402 + Pembrolizumab

No additive toxicity was observed in patients treated with IMA402 + pembrolizumab

IMA402 Monotherapy (n=107)

Treatment-related AEs, n (%)[a]	All Grades	≥ Grade 3
Lymphopenia	46 (43)	36 (34)
Cytokine release syndrome	41 (38)	2 (2)
Arthralgia	35 (33)	2 (2)
Fatigue	29 (27)	0
ALT/AST increased	20 (19)	10 (9)
Pyrexia	17 (16)	0
Myalgia	16 (15)	1 (1)
Pruritus	16 (15)	0
Anemia	14 (13)	4 (4)
Rash	14 (13)	0
Gamma-glutamyltransferase increased	11 (10)	3 (3)
Nausea	10 (9)	1 (1)
Lipase increased	9 (8)	4 (4)
Abdominal pain	9 (8)	1 (1)
Diarrhea	8 (7)	0
Hypertension	4 (4)	3 (3)
Leukopenia	4 (4)	1 (1)
Vomiting	4 (4)	1 (1)
Neutropenia	2 (2)	2 (2)
Back pain	2 (2)	1 (1)
Blood creatinine increased	2 (2)	1 (1)
Pancreatitis	2 (2)	1 (1)
Stomatitis	2 (2)	1 (1)
Tumor pain	2 (2)	1 (1)
Urinary tract disorder	2 (2)	1 (1)
Acute kidney injury	1 (1)	1 (1)
Electrocardiogram abnormal	1 (1)	1 (1)
Herpes zoster	1 (1)	1 (1)
Immune-mediated arthritis	1 (1)	1 (1)
Liver function test increased	1 (1)	1 (1)
Tumour lysis syndrome	1 (1)	1 (1)

IMA402 + Pembrolizumab (n=19)[b]

Treatment-related AEs, n (%)[b]	All Grades	≥ Grade 3
Lymphopenia	10 (53)	8 (42)
Arthralgia	7 (37)	0
Cytokine release syndrome	5 (26)	0
Fatigue	3 (16)	1 (5)
ALT/AST increased	3 (16)	0
Anemia	3 (16)	0
Erythema	3 (16)	0
Arthropathy	2 (11)	0
Dry skin	2 (11)	0
Headache	2 (11)	0
Pruritus	2 (11)	0
Rash	2 (11)	0
Gamma-glutamyltransferase increased	1 (5)	1 (5)
Alopecia	1 (5)	0
Atrial fibrillation	1 (5)	0
Blood creatinine increased	1 (5)	0
Blood thyroid stimulating hormone decreased	1 (5)	0
Body temperature increased	1 (5)	0
Decreased appetite	1 (5)	0
Diarrhea	1 (5)	0
Dysgeusia	1 (5)	0
Herpes simplex reactivation	1 (5)	0
Hyponatraemia	1 (5)	0
Myalgia	1 (5)	0
Oedema	1 (5)	0
Oedema peripheral	1 (5)	0
Pyrexia	1 (5)	0
Thrombocytopenia	1 (5)	0
Tumour pain	1 (5)	0
Uveitis	1 (5)	0

[a] TRAEs: All treatment-emergent adverse events at least possibly related to IMA402 with grade 1-3 occurring in at least 8 patients for monotherapy (incidence ≥7%), and all events with grade ≥3. One uncoded grade 1 AE ("spotting") is not included. Abdominal pain includes [1]Abdominal Pain[2] and [2]Abdominal Pain Upper[2]; Adverse events are coded using the MedDRA Version 26.0. Grades are determined according to National Cancer Institute CTCAE, version 5.0, except grades for cytokine release syndrome and immune cell-associated neurotoxicity syndrome are determined according to Lee et al., 2019; Neelapu et al., 2019 and tumor lysis syndrome which is determined according to Cairo and Bishop, 2004. Patients are counted only once per adverse event. [b] Out of 19 patients treated with IMA402 + pembrolizumab, 3 have ongoing early step dosing and did not yet reach their target dose and 6 did not have the opportunity of at least 3 months of follow-up. Of the remaining 10 patients, 3 were treated with IMA402 below 10 mg, 2 were PRAME negative, and 1 had LDH >1.5x ULN. ALT, alanine aminotransferase; AST, aspartate aminotransferase.

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Safety Profile of the Efficacy Population

IMA402 Efficacy Population ± Pembrolizumab (n=40)

Treatment-related AEs, n (%)[a]	All Grades	≥ Grade 3
Lymphopenia	19 (48)	16 (40)
Arthralgia	17 (43)	1 (3)
Cytokine release syndrome	15 (38)	0
Fatigue	14 (35)	1 (3)
ALT/AST increased	11 (28)	4 (10)
Myalgia	9 (23)	0
Gamma-glutamyltransferase increased	8 (20)	2 (5)
Anemia	7 (18)	1 (3)
Lipase increased	6 (15)	3 (8)
Amylase increased	6 (15)	0
Pruritus	6 (15)	0
Blood alkaline phosphatase increased	5 (13)	0
Diarrhea	5 (13)	0
Erythema	5 (13)	0
Pyrexia	5 (13)	0
Leukopenia	2 (5)	1 (3)
Back pain	1 (3)	1 (3)
Herpes zoster	1 (3)	1 (3)
Hypertension	1 (3)	1 (3)
Liver function test increased	1 (3)	1 (3)
Pancreatitis	1 (3)	1 (3)

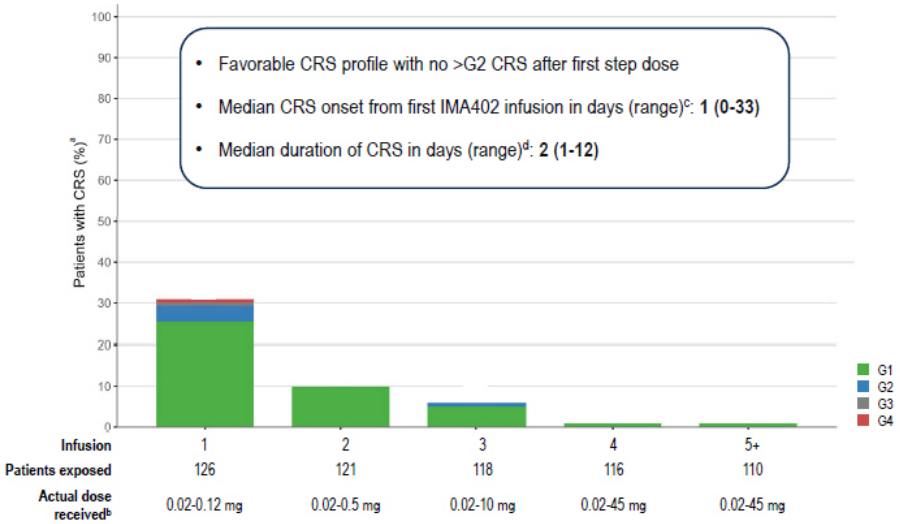
[a] TRAEs: All treatment-emergent adverse events at least possibly related to IMA402 with grade 1-2 occurring in at least 4 patients (incidence ≥10%), and all events with grade ≥3. One uncoded grade 1 AE ('spotting') is not included. Adverse events are coded using the MedDRA Version 28.0. Grades are determined according to National Cancer Institute CTCAE, version 5.0, except grades for cytokine release syndrome and immune cell-associated neurotoxicity syndrome are determined to Lee et al., 2019; Neelapu et al., 2019 and tumor lysis syndrome which is determined according to Cairo and Bishop, 2004. Patients are counted only once per adverse event. ALT, alanine aminotransferase; AST, aspartate aminotransferase.

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CRS Dynamics



Infusion	1	2	3	4	5+
Patients exposed	126	121	118	116	110
Actual dose received[b]	0.02-0.12 mg	0.02-0.5 mg	0.02-10 mg	0.02-45 mg	0.02-45 mg

Overall maximum CRS grade and interventions

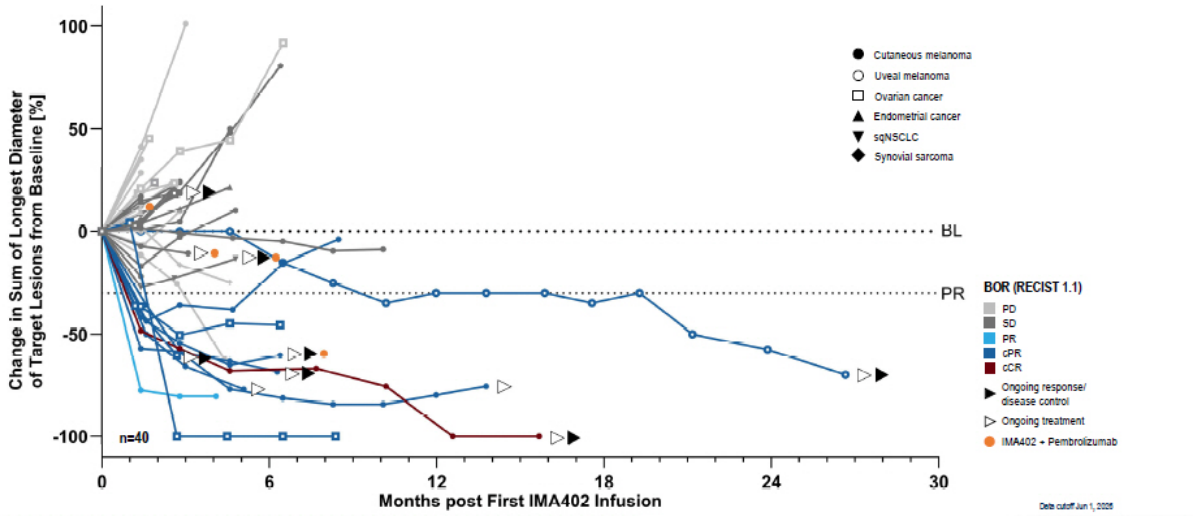
IMA402 safety population, n (%)	126
Any grade CRS	**46 (37)**
Grade 1	38 (30)
Grade 2	6 (5)
Grade 3[e]	1 (1)
Grade 4[e]	1 (1)
Received tocilizumab and/or steroids	**14 (11)**
Tocilizumab only	6 (5)
Steroids only	4 (3)
Tocilizumab and Steroids	4 (3)

[a] Plot shows adverse events with onset during the specified infusion. [b] Step dosing was introduced during dose escalation at a dose of 0.36 mg. Optimized step dosing is now at 0.03 mg/0.3 mg/ 10 mg target dose. [c] Onset per CRS event (n=54), recurrent events analyzed separately. [d] Duration per resolved CRS events at data cutoff (n=43), recurrent events analyzed separately. [e] 1 CRS G3 event at 0.03 mg starting dose only, completely resolved within 7 d; 1 CRS G4 event at 0.08 mg starting dose only, no further CRS G4 events after step dose optimization. CRS, cytokine release syndrome.

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Durability of IMA402 ± Pembrolizumab Across All Indications in Efficacy Population



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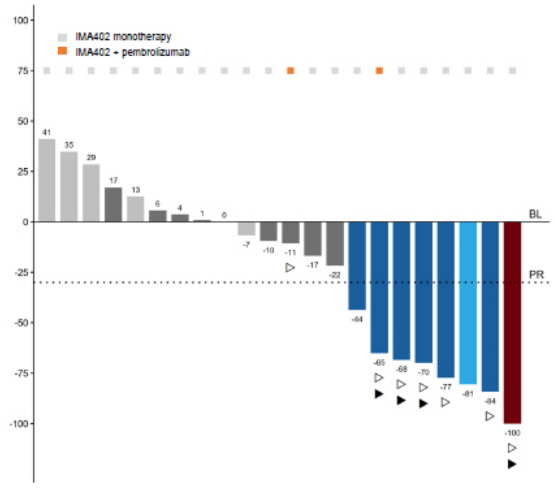
BOR, best overall response; BL, baseline; cCR, confirmed complete response; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease; sqNSCLC, squamous non-small cell lung cancer.

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Responses to IMA402 ± Pembrolizumab in PRAME^{high} Melanoma

All patients with melanoma in the efficacy population received prior ICI (n=22)



Melanoma	IMA402 ± Pembrolizumab (n=22)	IMA402 Monotherapy (n=20)	IMA402 + Pembrolizumab (n=2)
cORR	**32%** (7/22)	**30%** (6/20)	**1/2**

BOR (RECIST 1.1)

- PD
- SD
- PR
- cPR
- cCR
- ▶ Ongoing response/ disease control
- ▷ Ongoing treatment

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BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; ICI, immune checkpoint inhibitor; PD, progressive disease; (c)PR, (confirmed) partial response; RP2D, recommended phase 2 dose; SD, stable disease.

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Promising Initial PFS and OS in PRAME^{high} Melanoma (n=22)

Initial survival data indicate promising overall survival across all treatment outcomes

Median PFS

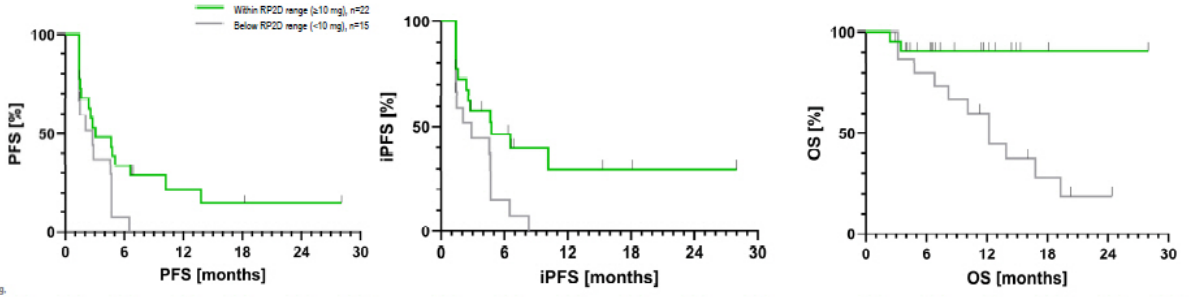
mPFS (mo)	**3.1**
mFU (mo)	18.2
6mo-PFS rate	34%

Median iPFS[a]

miPFS (mo)	**4.8**
mFU (mo)	6.9
6mo-iPFS rate	46%

Median OS

mOS (mo)	**Not reached**
mFU (mo)	8.8
1y-OS rate	91%



<10mg, at risk (event)	15 (0)	1 (13)	0 (14)	0 (14)	0 (14)	0 (14)
≥10mg, at risk (event)	22 (0)	7 (14)	3 (16)	2 (17)	1 (17)	0 (17)

<10mg, at risk (event)	15 (0)	2 (12)	0 (14)	0 (14)	0 (14)	0 (14)
≥10mg, at risk (event)	22(0)	8 (11)	3 (13)	2 (13)	1 (13)	0 (13)

<10mg, at risk (event)	15 (0)	12 (3)	8 (6)	3 (10)	1 (11)	0 (11)
≥10mg, at risk (event)	22 (0)	15 (2)	7 (2)	2 (2)	1 (2)	0 (2)

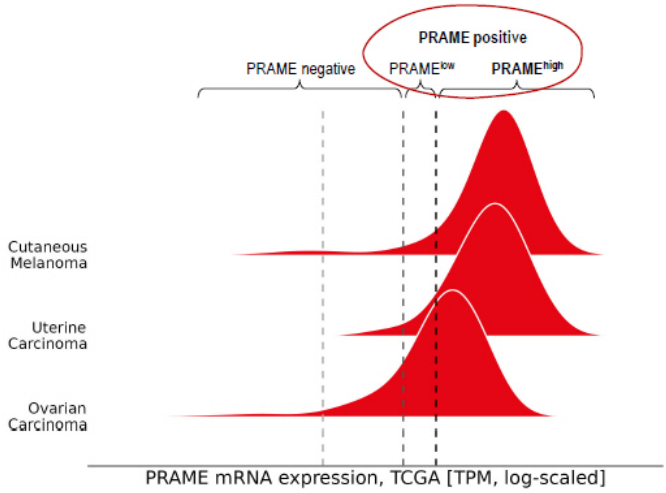
[a] iRECIST, developed by the RECIST Working Group, adapts RECIST 1.1 definition for progression for immunotherapies by introducing unconfirmed (iUPD) and confirmed (iCPD) progression to account for atypical response patterns. Patients with iUPD not confirmed at a subsequent scan but turning into SD or response are not considered progressive according to iRECIST. PFS (according to RECIST 1.1) and iPFS (according to iRECIST), are prospectively defined co-secondary endpoints in the IMA402 trial protocol to provide a balanced view of efficacy. Ongoing patients were censored at the data cutoff for PFS, iPFS and OS; PFS, iPFS and OS rates were calculated using the Kaplan–Meier method. mFU, median follow up; mOS, median overall survival; miPFS, median progression-free survival; RP2D, recommended phase 2 dose; SD, stable disease.

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PRAME Prevalences in Selected Indications



Indication	PRAME positive TCGA[a]	PRAME^{high} TCGA	PRAME^{high} based on actual in-house data
Cutaneous melanoma	95%	92%	>80% (n=136)
Uterine carcinoma	97%	95%	60%-95% (n=15)
Ovarian carcinoma	84%	64%	~60% (n=50)

[a] Data on file. PRAME target prevalence is based on TCGA RNAseq analysis using proprietary mass spec-guided initial expression threshold.
TCGA, The Cancer Genome Atlas.

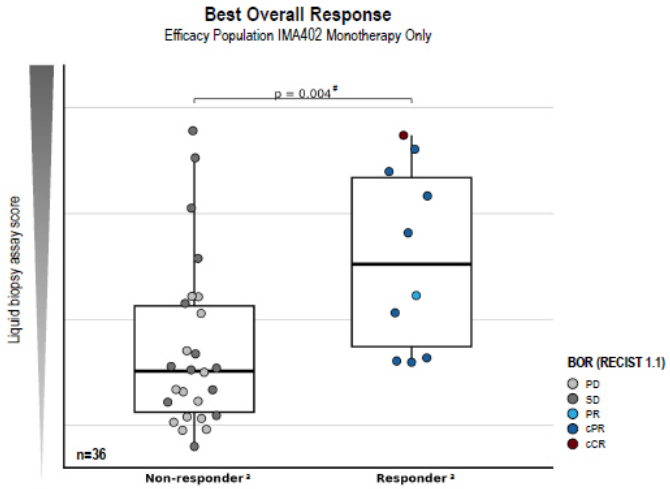
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Outlook: Liquid Biopsy for Patient Selection

- Proprietary liquid biopsy assay for patient selection
- Few millilitres of blood sufficient
- Fast, sensitive and reliable detection of PRAME in blood
- Representative PRAME levels across all tumor lesions prior to treatment start



‡ Non-responder: PD, SD. Responder: PR, cPR, cCR. ‡ Mann-Whitney U test
cCR, confirmed complete response; (c)PR, (confirmed) partial response; PD, progressive disease; SD, stable disease.

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Outlook: Decitabine as Potential PRAME Enhancer for Combination with IMA402

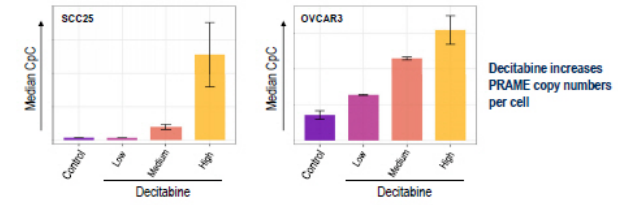
Pharmacologic upregulation of PRAME

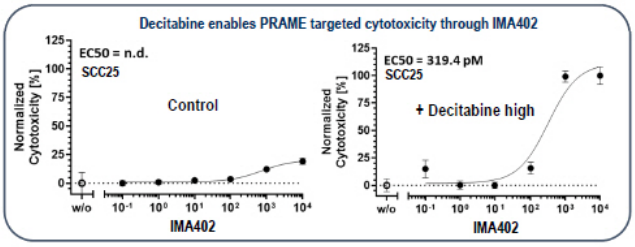
Rationale:

Based on literature

- Increased PRAME expression and pHLA presentation
- Induction of type I IFN
  - Leading to HLA upregulation and modulation of tumor microenvironment
- Effects described in different indications

Based on preclinical data[a]





Selected Publications

Gutierrez-Cosio S, et al. *Leuk Res*. 2012;36(7)895-899

Gang AO, et al. *Blood Cancer J*. 2014;4(3):e197

Zhang W, et al. *Oncotarget*. 2016;7(29):45352-45369

Yao Y, et al. *PLoS One*. 2013;8(8):e70522

Topper MJ, et al. *Cell*. 2017;171(6):1284-1300

Goyal A, et al. *Nat Commun*. 2023;14(1):6731

Ortmann CA, et al. *Ann Hematol*. 2008;87(19):809-818

Stone ML, et al. *Proc Natl Acad Sci U S A*. 2017;114(51)

Chiappinelli KB et al. *Cell*. 2015;162(5):974–986

[a]Data on file. SCC25: epithelial-like squamous cell carcinoma cell line. OVCAR3: Ovarian carcinoma cell line. CpC, copy number per tumor cell; EC50=n.d., half maximal effective concentration not determined; IFN, interferon

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Clinical Responses in PRAME^{high} Efficacy Population

Indication	No of prior treatment lines	List of prior treatment lines	Highest dose received [mg]	Baseline tumor burden [cm][a]	BOR (RECIST 1.1)	BOR [max % change of target lesions]	PFS [months]	Ongoing treatment
Cutaneous melanoma	3	Nivolumab Ipilimumab + nivolumab Lenvatinib + pembrolizumab	20	8.97	cCR	-100	18.2 (ongoing)	Yes
Ovarian carcinoma	3	Bevacizumab + chemotherapy (carboplatin, paclitaxel) Chemotherapy (carboplatin, pegylated liposomal doxorubicin, mitoxantron) Chemotherapy (carboplatin, cisplatin)	21.5	2.2	cPR	-100	8.4	No
Cutaneous melanoma	4	Pembrolizumab Ipilimumab + nivolumab Chemotherapy (dacarbazine) Ipilimumab + nivolumab	30	7.0	cPR	-84.3	13.8	Yes
Cutaneous melanoma	2	Ipilimumab + nivolumab Lenvatinib + pembrolizumab	30	4.4	cPR	-77.3	5.1	Yes
Uveal melanoma	3	Ipilimumab + nivolumab Nivolumab Tebentafusp	30	4.0	cPR	-70	28.1 (ongoing)	Yes
Cutaneous melanoma	3	Nivolumab Nivolumab Ipilimumab + nivolumab	12	9.6	cPR	-68.4	6.7 (ongoing)	Yes
Cutaneous melanoma	5	Nivolumab Ipilimumab + nivolumab Nivolumab[b] Chemotherapy (dacarbazine) Pembrolizumab	10 + pembrolizumab	10.0	cPR	-65.2	6.9 (ongoing)	Yes
Ovarian carcinoma	2	Bevacizumab + niraparib + chemotherapy (carboplatin, paclitaxel) Mirvetuximab soravtansine	45	13.5	cPR	-60.4	3.5 (ongoing)	Yes
Ovarian carcinoma	3	Bevacizumab + olaparib + chemotherapy (carboplatin, paclitaxel) Niraparib + chemotherapy (carboplatin, doxorubicin/caelyx) Chemotherapy (cisplatin, gemcitabine)	30	9.5	cPR	-50.5	4.6	No

[a] Median target lesion sum of diameter. [b] Bridging therapy.
BOR, best overall response; cCR, confirmed complete response; PFS, progression-free survival; cPR, confirmed partial response.

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Clinical Responses in PRAME^{high} Efficacy Population

Indication	No of prior treatment lines	List of prior treatment lines	Highest dose received [mg]	Baseline tumor burden [cm][a]	BOR (RECIST 1.1)	BOR [max % change of target lesions]	PFS [months]	Ongoing treatment
Cutaneous melanoma	3	IFNα Nivolumab Ipilimumab + nivolumab	30	5.4	cPR	-43.7	6.6	No
Cutaneous melanoma	3	Nivolumab Trametinib + dabrafenib Ipilimumab + nivolumab	30	3.1	PR	-80.6	2.8	No
Cutaneous melanoma	6	IFNα Ipilimumab + nivolumab Dabrafenib + trametinib Ipilimumab + nivolumab Chemotherapy (dacarbazin)[b] Encorafenib + Binimetinib	30	17.5	SD	-21.7	1.4 (censored)	No
Cutaneous melanoma	3	Nivolumab Ipilimumab + nivolumab Lenvatinib + pembrolizumab	30	7.5	SD	-16.8	4.8	No
Cutaneous melanoma	1	Pembrolizumab + T-VEC + IL2	20 + pembrolizumab	1.5	SD	-10.6	3.1	Yes
Cutaneous melanoma	3	Pembrolizumab Ipilimumab + nivolumab TIL + Cy/Flu lymphodepletion	30	12.6	SD	-9.5	10.2	No
Cutaneous melanoma	4	Relatlimab + nivolumab Binimetinib + encorafenib Ipilimumab + nivolumab Dabrafenib + trametinib	12	6.0	PD	-6.7	1.5	No
Cutaneous melanoma	3	Pembrolizumab Ipilimumab + nivolumab Chemotherapy (dacarbacin)	30	12.2	SD	0.8	4.6	No

[a] Median target lesion sum of diameter. [b] Bridging therapy.
BOR, best overall response; PFS, progression-free survival; (c)PR, (confirmed) partial response; SD, stable disease; T-VEC, talimogene laherparepvec; TIL, tumor-infiltrating lymphocyte.

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Clinical Responses in PRAME^{high} Efficacy Population

Indication	No of prior treatment lines	List of prior treatment lines	Highest dose received [mg]	Baseline tumor burden [cm][a]	BOR (RECIST 1.1)	BOR [max % change of target lesions]	PFS [months]	Ongoing treatment
Ovarian carcinoma	2	Olaparib + megace + chemotherapy (carboplatin, paclitaxel) Chemotherapy (doxorubicin, carboplatin, paclitaxel)	30	9.7	SD	3.1	2.6	No
Endometrioid carcinoma	5	Olaratumab + chemotherapy (doxorubicin) Chemotherapy (paclitaxel, carboplatin) Pembrolizumab Trastuzumab + deruxtecan Chemotherapy (paclitaxel)	20	6.8	SD	3.5	4.7	No
Cutaneous melanoma	4	Talimogen-laherparepvec + nivolumab Ipilimumab + nivolumab + chemotherapy (bleomycin) Ipilimumab + nivolumab + daroumun Ipilimumab + nivolumab	45	8.4	SD	3.6	2.6	No
Cutaneous melanoma	4	Pembrolizumab Ipilimumab + nivolumab IL2 Chemotherapy (dacarbazine)	30	8.7	SD	5.7	2.4	No
Cutaneous melanoma	2	Nivolumab Ipilimumab + nivolumab	30	19.4	SD	17.1	1.6	No
Synovial sarcoma	1	Chemotherapy (doxorubicin, isosfamide)	12	13.7	PD	-24.8	1.4	No
Cutaneous melanoma	3	Ipilimumab + nivoulamb Nivolumab IL2 + chemotherapy (cyclophosphamide, fludarebine)	20	2.1	PD	0	1.4	No
Endometrioid carcinoma	3	Chemotherapy (carboplatin, paclitaxel) Chemotherapy (carboplatin, paclitaxel) Lenvatinib + pembrolizumab	20	3.2	PD	9.4	1.4	No
Cutaneous melanoma	4	Nivolumab Trametinib + dabrafenib Nivolumab Ipilimumab + nivolumab	30	9.5	PD	12.6	1.4	No

[a] Median target lesion sum of diameter.
BOR, best overall response; PFS, progression-free survival; SD, stable disease; PD, progressive disease.

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Clinical Responses in PRAME^{high} Efficacy Population

Indication	No of prior treatment lines	List of prior treatment lines	Highest dose received [mg]	Baseline tumor burden [cm][a]	BOR (RECIST 1.1)	BOR [max % change of target lesions]	PFS [months]	Ongoing treatment
Ovarian carcinoma	4	Durvalumab + bevacizumab + olaparib + chemotherapy (carboplatin, paclitaxel) Chemotherapy (carboplatin, gemcitabine) Chemotherapy (carboplatin, pegylated liposomal doxorubicin) Raludotatug + chemotherapy (paclitaxel)	20	7.7	PD	20.8	1.4	No
Ovarian carcinoma	3	Bevacizumab + olaparib + chemotherapy (paclitaxel, carboplatin) Chemotherapy (carboplatin, pegylated liposomal doxorubicin) Mirvetuximab-soravtansine	30	10.5	PD	23.8	0.7	No
Cutaneous melanoma	1	Ipilimumab + nivolumab	30	11.2	PD	28.6	1.4	Yes
Cutaneous melanoma	4	Encorafenib + binimetinib Ipilimumab + nivolumab Ipilimumab + nivolumab Encorafenib + binimetinib	45	6.9	PD	34.8	1.4	No
Cutaneous melanoma	2	Pembrolizumab + IO102-103 Encorafenib + binimetinib	20	2.1	PD	41.1	1.4	No

[a] Median target lesion sum of diameter.
BOR, best overall response; PFS, progression-free survival; SD, stable disease; PD, progressive disease.

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Poster 9049

Response Durability With Anzutresgene Autoleucel (Anzu-cel), a PRAME-directed T-cell Receptor T-cell Therapy, in Advanced Melanoma

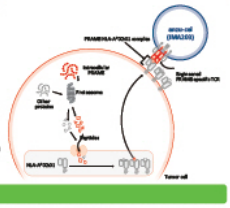
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BACKGROUND

- For patients with advanced melanoma, treatment options after first-line therapy provide limited responses and poor survival, highlighting the need for new systemic therapies with durable disease control[1,2]
  - 2-year survival is approximately 48% in cutaneous melanoma following first-line immune checkpoint inhibitors and approximately 40% in previously treated uveal melanoma
- TCR T-cell therapies enable increase recognition of intracellular tumor antigens presented by cell-surface HLA, expanding the therapeutic landscape beyond targets accessible to conventional immunotherapies[3]
- Anzutresgene autoleucel (anzu-cel, IMA203) is a one-time autologous TCR T-cell therapy targeting the cancer-associated antigen PRAME, which is expressed in >50 cancers and represents a novel immunotherapy target for melanoma (Figure 1)[4]
- Results from IMA203-101 (NCT03686124) demonstrate a predictable and manageable tolerability profile and rapid, deep, and durable systemic antitumor activity with anzu-cel[5]
- Here we characterize durable clinical benefit, including baseline characteristics associated with extended PFS (>12 months), and provide a longitudinal assessment of hematologic recovery
  - In addition to conventional cytopenia reporting, immune effector cell-associated hematotoxicity (ICAHT) criteria, developed to characterize the depth and duration of cytopenia following CAR T-cell therapy, were applied to evaluate early and late hematotoxicity, supportive care requirements, and associated infectious complications

Figure 1. Anzu-cel Mechanism of Action



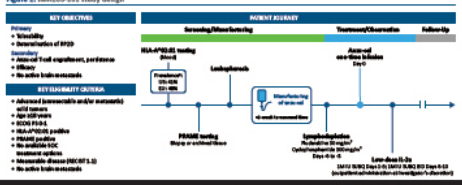
METHODS

- IMA203-101 (NCT03686124) is an ongoing phase 1 study evaluating anzu-cel in patients with PRAME-positive solid tumors (Figure 2)
- Data cutoff: Sept 24, 2025 (median follow-up for PFS: 28 months)
- Univariate Cox proportional hazards regression models were used to evaluate a subset of clinical factors associated with PFS
  - The current presentation is a part of a broader exploratory analysis to examine variables across the patient journey including baseline characteristics, starting apheresis material, manufacturing, treatment, and postinfusion treatment course
  - This analysis was conducted in a cohort of patients with advanced melanoma who were treated with anzu-cel at cell doses between 1-10 billion TCR T cells (N=51); clinical variables evaluated in patients with melanoma with complete data included age, sex, ECOG performance status, target lesions, largest target lesion, LDH, prior lines of ICI therapy, infused cell dose, and effector-to-tumor (E:T) ratio
  - Variables were evaluated individually, without adjustment for other clinical or treatment characteristics
  - 3 patients were censored due to ongoing PFS <12 months (n=1) or withdrawal of consent (n=2)
- Hematologic recovery was characterized using ANC measurements following anzu-cel one-time infusion
- Late neutropenia-associated ICAHT (N-ICAHT) was assessed using ERA/EBMT consensus ANC thresholds developed for CAR T-cell therapy (Table 1)[6,7]
- For this analysis, late N-ICAHT required ≥2 ANC measurements meeting the applicable threshold between days 28 (±3) to 180, including ≥1 qualifying ANC measurement between days 91-93

Table 1. Late N-ICAHT Grading

Parameter, n (%)	ANC (cells/μL)
Grade 1	≤1500
Grade 2	≤1000
Grade 3	≤500
Grade 4	≤100

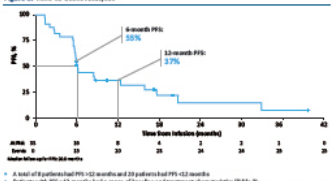
Figure 2. IMA203-101 study design



RESULTS

- For all patients with melanoma, the median PFS was 6.1 months (range, 1.4-19.6+; Figure 3); median PFS for cutaneous melanoma was 6.9 months (1.4-19.6+) and for uveal melanoma was 8.5 months (1.4-32.9)[8]
- The median OS was 26.2 months (range, 2.4-39.6+ months)[8]
  - 12-month OS for all melanoma: 70%; cutaneous: 72%; uveal: 71%
  - 24-month OS: 45%; cutaneous: 45%; uveal: 57%
- The confirmed ORR was 56% (n=18/32) for all patients with melanoma (cORR-1; cPR=17[9]
  - The median DoR was 14.6 months for all patients with melanoma (range, 4.2-38.2+ months); 6 of 18 (33%) responses were ongoing at data cutoff

Figure 3. Time-to-Event Analyses



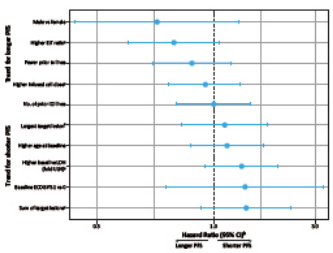
- A total of 8 patients had PFS >12 months and 29 patients had PFS <12 months
- Patients with PFS >12 months had a range of baseline and treatment characteristics (Table 2)
- In exploratory univariate Cox proportional hazards analyses, each clinical variable was evaluated separately. No variable showed a statistically significant association with PFS, as all 95% confidence intervals for the hazard ratios included 1 (Figure 4)
- Point estimates suggested longer PFS with lower LDH, a lower sum of target-lesion diameters, and a higher E:T ratio.
  - These findings are hypothesis-generating; the absence of statistical significance does not exclude clinically meaningful associations

Table 2. Clinical Characteristics by PFS Category (>12 or <12 months)

Baseline Characteristics	All (N=51)	Patients Evaluable for PFS category/status[a]	
		PFS >12 Months (n=8)	PFS <12 Months (n=29)
Median age, years (range)	57 (31-79)	47 (31-71)	61 (37-79)
Female, n (%)	16 (48)	2 (25)	11 (55)
ECOG PS 0, n (%)	29 (61)	6 (75)	13 (55)
ECOG PS 1, n (%)	13 (39)	2 (25)	9 (45)
Median prior lines of systemic treatment (range)	2 (0-6)	3 (1-5)	3 (0-6)
Median prior lines of ICI treatment (range)	1 (0-4)	1 (0-3)	1 (0-4)
≥1 line of ICI treatment, n (%)	27 (82)	6 (75)	18 (90)
Median largest lesion SLD, cm (range)	10.4 (1.5-31.0)	10.1 (1.5-12.8)	11.9 (2.1-31.0)
Largest target lesion, site (range)	4.1 (1.1-15.8)	4.0 (1.5-6.6)	4.1 (1.1-15.8)
Elevated LDH at baseline, n (%)	19 (58)	5 (63)	13 (68)
Median LDH x ULN (range)	1 (0.7-3.1)	1.02 (0.66-1.26)	1.13 (0.76-3.07)
Treatment Experience	**All**	**PFS >12 Months**	**PFS <12 Months**
Median infused TCR T cell dose, x10⁹ (range)	6.04 (1.30-33.10)	6.16 (1.3-10.26)	5.52 (1.55-9.76)
Median effector cell to tumor lesion ratio (range)[b]	0.0433 (0.0113-0.6800)	0.071 (0.017-0.600)	0.038 (0.011-0.697)
Median PFS, month (range)	6.1 (1.4-19.6+)	20.7 (12.4-39.6+)	5.6 (1.4-8.6)
Median OS, month (range)	26.2 (2.4-39.6+)	NE (15.9-39.6+)	11.4 (2.4-21.4+)
ORR, % (n/N)	64 (21/33)	88 (7/8)	45 (9/20)
cORR, % (n/N)	56 (18/32)	88 (7/8)	35 (7/20)

[a] 3 patients were censored due to ongoing PFS <12 months (n=1) or withdrawal of consent (n=2).
[b] Calculated by infused TCR T-cell dose divided by mean of target lesions.

Figure 4. Univariate Analysis of Clinical Characteristics and PFS



*Variables were log-transformed prior to modeling. Hazard ratios are reported per SD increase of the corresponding log-transformed variable. ECF ratio calculated by infused TCR T-cell dose divided by the sum of target lesions.
Where indicated, are reported per 1 SD (standard deviation) increase for all variables except ECOG PS (0 vs 1) and sex (male vs female).
Hazard ratios <1 indicate a trend toward longer PFS, and hazard ratios >1 indicate a trend toward shorter disease progression or death; HR =1 indicates a lower estimated hazard; 95% CI indicates no difference. Each model contains one variable without adjustment for other variables.

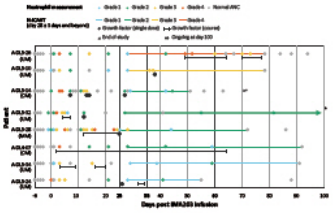
- The safety profile of anzu-cel was previously reported in clinical trials.[5] The most common AEs were lymphodepletion-related cytopenias. CRS was early-onset (grade 1: 96%, grade 2: 44%, grade 3: 10%); ICANS (grade 1: 6%, grade 3: 6%) and HLH (grade 3: 3%, grade 5: 3%) were infrequent.
- This exploratory analysis provides temporal and clinical context for previously reported cytopenias, extending incidence reporting to characterize neutrophil recovery, supportive-care use, and clinical events during the later postinfusion period
- Late N-ICAHT was observed in 8 of 33 patients (24%) including grade 3-4 N-ICAHT in 3 patients (9%; Table 3; Figure 5)
- Growth-factor support was used in 6 of 8 patients (75%) with N-ICAHT; 4/6 with grade 1-2 N-ICAHT and 2/2 with grade 3-4 N-ICAHT
- One patient experienced pancytopenia requiring hospitalization during the N-ICAHT period
- Both grade 3-4 N-ICAHT events had proved to grade ≤2 by day 78 postinfusion
- All N-ICAHT events resolved at a median of 78 days post infusion (range, 51-272)

Table 3. Incidence and Grade of Late N-ICAHT

Parameter	All Melanoma Patients (N=33), n (%)
Late N-ICAHT beyond day 28*	8 (24.2)
Grade 1	2 (6.1)
Grade 2	4 (12.1)
Grade 3	1 (3.0)
Grade 4	1 (3.0)

*Late N-ICAHT grade was based on the worst of lowest absolute neutrophil count between days 28 to 180 postinfusion and required ≥2 neutropenia measurements ≥7 days apart (i.e. including ≥2 between days 91-93). If the recovery is before the day 28 visit were not used for late N-ICAHT grading but were considered when determining supportive treatment and duration. Day 28 ±3 days could have a maximum gap in between or after day 28.

Figure 5. Late N-ICAHT Duration and Growth Factor Use



*Patient died from PD.
N-ICAHT marked with ▲ if not further assessing and resolved on day 272.
N-ICAHT grades defined as grade 1: ≥1000 -<1500 cells/μL; grade 2: ≥500 -<1000 cells/μL; grade 3: ≥100 -<500 cells/μL; grade 4: <100 cells/μL.
ANC values were used for this analysis; grading is based on the 2-3 closest ANC values.
Patients with at least 2 ANC values below threshold between days 28(±3) to 180, with 1 abnormal ANC value occurring between days 91-93.
ANC measurements before day 25 are displayed for context but are not used to define late N-ICAHT eligibility.
Growth factor use: shown as filled circle for a single day dose or a line for a multi-day course (or patient administration data).

CONCLUSIONS

- Durable clinical benefit following anzu-cel for treatment of advanced melanoma was observed in patients with varied baseline and treatment characteristics[4]
  - No variable evaluated individually showed a statistically significant association with PFS
  - Point estimates suggested longer PFS with lower LDH, a lower sum of target-lesion diameters, and a higher E:T ratio; these findings remain hypothesis-generating and warrant further evaluation
- Durable benefit was achieved with a one-time treatment and a time-limited treatment burden
- Late N-ICAHT occurred in a minority of patients and resolved by data cutoff
- These findings support continued postinfusion monitoring of complete blood counts in the subset of patients with incomplete hematologic recovery or recurrent cytopenias, with supportive care guided by clinical need and protocol recommendations

ABBREVIATIONS: ANC, absolute neutrophil count; BID, twice daily; CAR, chimeric antigen receptor; cCR, confirmed complete response; cORR, confirmed objective response rate; cPR, confirmed partial response; CRS, cytokine release syndrome; DoR, duration of response; ECOG, Eastern Cooperative Oncology Group; E:T, effector cell to tumor lesion ratio; FU, follow-up; HLA, human leukocyte antigen; HLH, hemophagocytic lymphohistiocytosis; ICANS, immune effector cell-associated hematotoxicity; ICANS, immune effector cell-associated neurotoxicity syndrome; ICI, immune checkpoint inhibitor; IL, interleukin; IU, international unit; LDH, lactate dehydrogenase; N-ICAHT, neutropenia-associated ICAHT; NE, not estimable; ORR, objective response rate; OS, overall survival; PFS, progression-free survival; PRAME, preferentially expressed antigen in melanoma; PS, performance status; RECIST, Response Evaluation Criteria in Solid Tumors; RP2D, recommended phase 2 dose; SD, standard deviation; SLD, sum of the longest diameters; SOC, standard of care; ULN(), subcutaneous; TCR, T cell receptor; ULN, upper limit of normal.

REFERENCES:
1. Ascierto PA, et al. J Clin Oncol. 2019;15(9):2724-2735.
2. Yousef-Wazie A, et al. Nat Med. 2021;27(9):2278-2285.
3. Sacco JJ, et al. J Immunother Cancer. 2020;8(2):e001089.
4. Kirkwood JM, et al. Nat Rev Drug Discov. 2018;17(11):896-1017.
5. Wermke M, et al. JAM Med. 2025;19(7):1065-2174.
6. Davar D, et al. ASCO 2026. Abstract #9508.
7. Rejeski K, et al. Blood. 2023;141:861-877.
8. Geigert L, et al. Ann Immunol. 2025;7:1010-1020.
9. Rejeski K, et al. Blood Adv. 2024;8:1857-1868.
10. Rejeski K, et al. Blood. 2023; 142(10):885-877.

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PRAME Is Expressed in More Than 50 Cancers

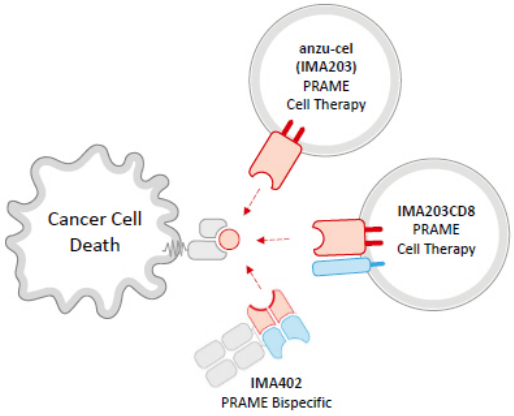


≥95 % ≥10 %

PRAME prevalence in selected indications

Indication	% PRAME+ patients[a]
Cutaneous Melanoma	95%
Uterine Carcinoma	95%
Uterine Carcinosarcoma	95%
Synovial Sarcoma	95%
Uveal Melanoma	90%
Mucosal Melanoma	90%
Ovarian Carcinoma Subtypes	85%
Squamous Cell NSCLC	70%
Triple-negative Breast Carcinoma	65%
Small Cell Lung Cancer	45%
Esophageal Carcinoma Subtype	45%
Kidney Carcinoma Subtype	40%
Cholangiocarcinoma	35%
HER2-Enriched Breast Carcinoma	30%
Adenocarcinoma NSCLC	25%
Head & Neck Squamous Cell Carcinoma	25%
Hepatocellular Carcinoma	20%
Bladder Carcinoma	20%

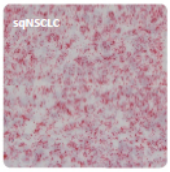
Immatics Is the Global Leader in Precision Targeting of PRAME with 3 clinical product candidates

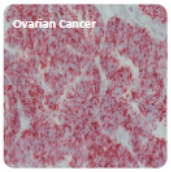


Anzutresgene autoleucel (anzu-cel, formerly IMA203), [a] Data on file: PRAME target prevalence is based on a proprietary initial mass spec-guided expression threshold applied to RNAseq and/or IHC data (approximate values, values between 95-100% shown as 95%); anzu-cel (IMA203), IMA203CD8, IMA402 are being evaluated in separate clinical trials; NSCLC: Non-small cell lung cancer

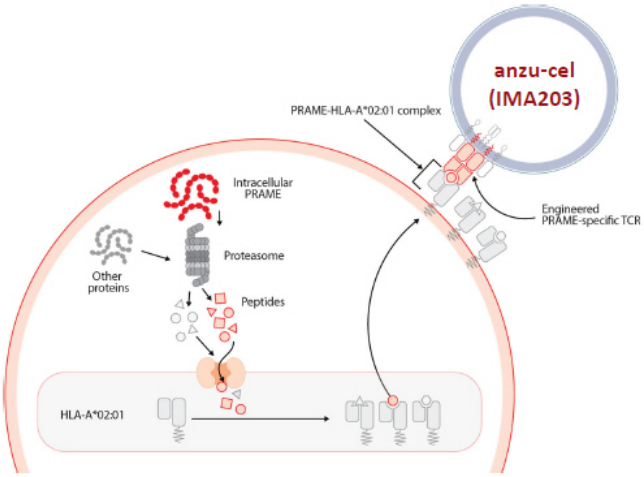
Immatics Is the Global Leader in Precision Targeting of PRAME

- PRAME is an **intracellular protein** presented as a peptide on the surface of tumor cells by HLA molecules[1]
- The **PRAME peptide** can be targeted by **T-cell receptors (TCRs)** engineered by Immatics, thus overcoming limitations of classical antibodies and CAR T-cell therapies not able to access intracellular targets[1,2]
- PRAME has **multiple functions in tumor biology** enhancing tumor cell survival, tumor proliferation and resistance to apoptosis[2,3,4]
- PRAME expression has been **associated with poor prognosis incl. shorter survival**[5,6,7,8]
- PRAME is **homogenously expressed** in tumor tissue[9]





PRAME RNA detection in tumor samples (ISH)



Anzutresgene autoleucel (anzu-cel, formerly IMA203), [A]Activation of proliferative and survival pathways, including PI3K/AKT/mTOR[B], and inhibition of retinoic acid signaling preventing retinoic acid-induced differentiation and apoptosis[4]

[1] Wermke et al., 2025; [2] Chandran et al., 2019, [3] Yu et al., 2023; [4] Epping et al., 2005; [5] Al-Khadairi & Decock. 2019; [6] Naik et al., 2021; [7] Gezgin et al., 2017; [8] Field et al., 2016; [9] Hukelmann et al., SITC 2022.

Immatics has the Broadest PRAME Franchise with the Most PRAME Indications and Modalities

Product candidate	Modality	Indication		Target	Phase[c]
Anzu-cel (IMA203)	Cell therapy	2L advanced melanoma	immatics	PRAME	SUPRAME
Anzu-cel (IMA203)	Cell therapy	Uveal melanoma	immatics	PRAME	
Anzu-cel (IMA203) + mRNA-4203	Cell therapy	Solid cancers	immatics moderna	PRAME	
IMA203CD8	Cell therapy	Gynecologic cancers	immatics	PRAME	
		Other solid cancers	immatics	PRAME	
IMA402	Bispecific	Melanoma, gynecologic cancers, others	immatics	PRAME	
IMA402 + ICI[a]	Bispecific	Melanoma, gynecologic cancers, others	immatics	PRAME	
IMA402 + IMA401	Bispecific	sqNSCLC	immatics	PRAME / MAGEA4/8	
IMA401 ± ICI	Bispecific	HNSCC, sqNSCLC, others	immatics	MAGEA4/8	
Undisclosed[b]	Bispecific	Undisclosed	moderna	other	

Phase[c]: Preclinical | 1a | 1b | 2 | 3

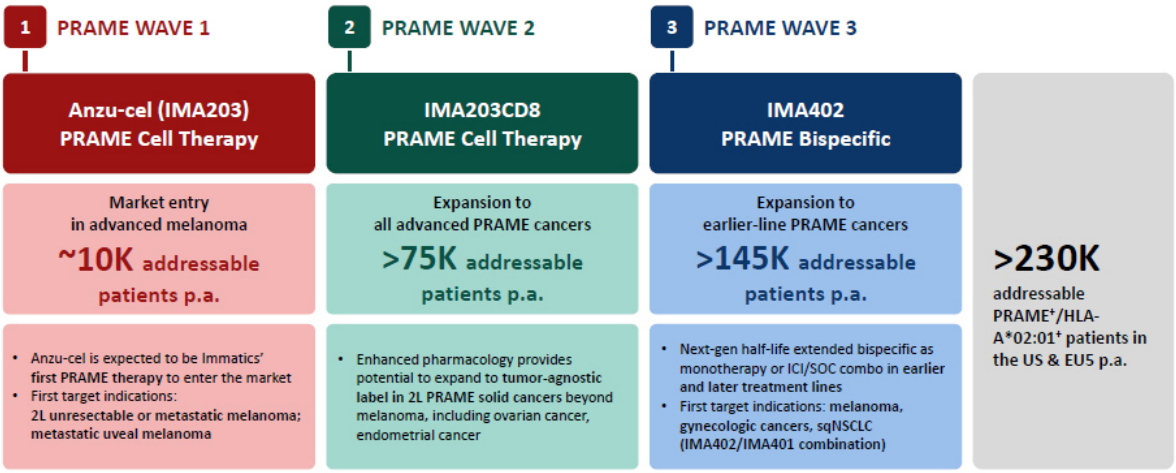
3 PRAME product candidates

2 Therapeutic modalities

3 PRAME combinations

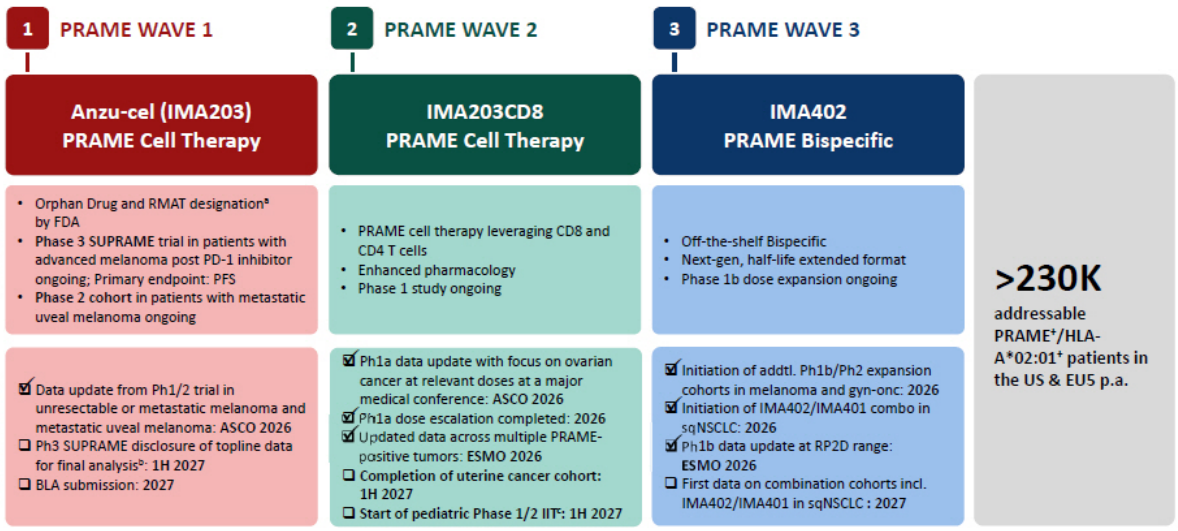
Anzutresgene autoleucel (anzu-cel, formerly IMA203). [a] In combination with immune checkpoint inhibitor (pembrolizumab or nivolumab/relatlimab); [b] mRNA-enabled *in vivo* expressed TCER® molecules; [c] Phase 1a: Dose escalation, Phase 1b: Dose expansion; HNSCC, head and neck squamous cell carcinoma; ICI, immune checkpoint inhibitor; sqNSCLC, squamous non-small-cell lung cancer

Immatics has the Broadest PRAME Franchise with the Most PRAME Indications and Modalities



Anzutresgene autoleucel (anzu-cel, formerly IMA203), All patient numbers refer to PRAME+/HLA-A*02:01+ patients in the US and EU5; Source: Internal Forecast 2026; EU5: France, Germany, Italy, Spain, United Kingdom; ICI, immune checkpoint inhibitor; SOC, standard of care; sqNSCLC, squamous non-small-cell lung cancer

Immatics has the Broadest PRAME Franchise with the Most PRAME Indications and Modalities

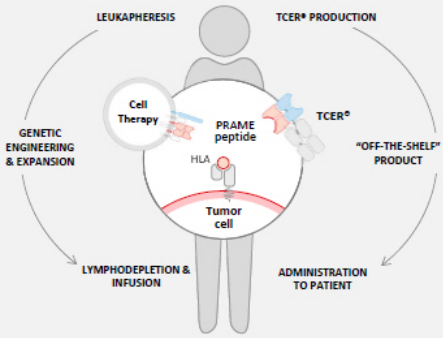


Anzutresgene autoleucel (anzu-cel, formerly IMA203), [a] Includes all benefits of Breakthrough Therapy Designation; [b] Pre-specified final analysis expected to be triggered upon the occurrence of a defined number of events for PFS (progressive disease or death); [c] Being conducted at Hopp Children's Cancer Center Heidelberg (KiTZ), Germany; ICI, immune checkpoint inhibitor; IIT, investigator-initiated trial; sqNSCLC, squamous non-small-cell lung cancer

Immatics has the Broadest PRAME Franchise with the Most PRAME Indications and Modalities

PRAME Cell Therapy

Modality:	Autologous TCR T-cell Therapy
Application:	Single dose ("one and done") (no tumor surgery, no high-dose IL-2)
Positioning:	Primarily second line and later monotherapy setting
Deployment:	Administered in specialized hospitals and medical centers; potential for outpatient administration
TPP at RP2D[a]:	≥40% cORR, ≥6 months mDOR (monotherapy, 2L or later)



PRAME Bispecific

Modality:	Half-life extended (HLE) bispecific T cell engager (TCER®)
Application:	Repeat dose
Positioning:	Primarily in earlier lines incl. frontline or (neo)adjuvant setting (in combination with SOC)
Deployment:	Outpatient administration, hospitals and community centers
TPP at RP2D[a]:	≥20% cORR, ≥6 months mDOR (monotherapy, 2L or later)

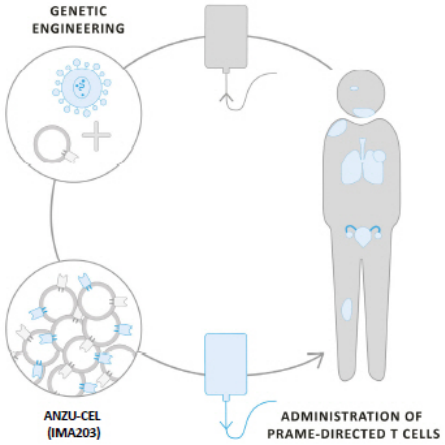
[a] Target product profile (TPP) in monotherapy in 2L or later settings post SOC at recommended phase 2 dose ("RP2D") for development beyond Ph1b. Other factors such as mPFS (median progression free survival) and mOS (median overall survival) may also be considered. SOC, standard of care

PRAME WAVE 1
Anzu-cel (IMA203) PRAME Cell Therapy

Market Entry in Advanced Melanoma



Anzu-cel (IMA203) PRAME Cell Therapy: Market Entry in Advanced Melanoma



Anzu-cel (IMA203) Opportunity

2L unresectable or metastatic melanoma

~10K

addressable PRAME$^+$/HLA-A*02:01$^+$ patients in the US & EU5

Anzutresgene autoleucel (anzu-cel, formerly IMA203). All patient numbers refer to PRAME+/HLA-A*02:01+ patients in the US (~4,500) and EU5 (~5,500) in 2028; Source: Internal Forecast 2026; EU5: France, Germany, Italy, Spain, United Kingdom

Summary: Anzu-cel (IMA203) PRAME Cell Therapy in Advanced Melanoma

Positive Data and High Unmet Need

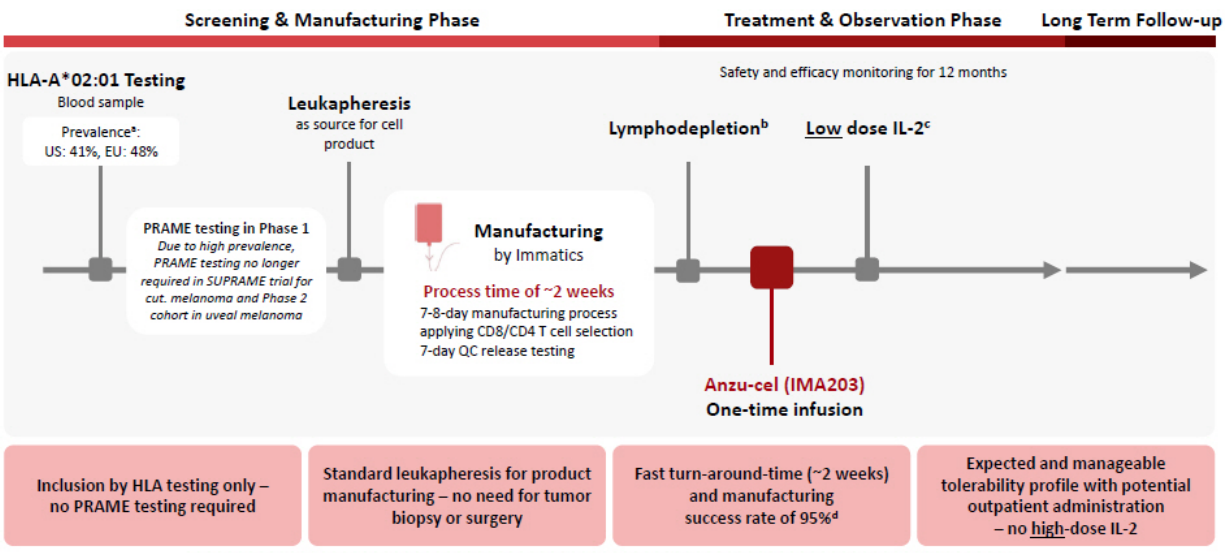
Expected and Manageable Tolerability	Compelling Response Rate	Durable Responses	Rapid & Robust Manufacturing	Commercial Opportunity
• Anticipated & manageable cytopenias associated with lymphodepletion • Mostly mild to moderate CRS • Infrequent ICANS • Potential for outpatient administration	• **cORR: 56% (18/32)** • **42% (14/33) of patients had deep responses** (≥50% tumor size reduction) • Encouraging activity in both cutaneous melanoma (cORR 50%) and uveal melanoma (cORR 67%)	• **14.6 months mDOR** and ongoing responses for up to >3 years • **mPFS of 6.1 months** • **mPFS 15.9 months in patients with deep responses** • **mOS: 16.2 months**	• Fast turnaround time: 7-8 days + 7 days QC release testing • 95% manufacturing success rate to reach target dose[a] • Optimized process to achieve desirable cellular functionality	• ~10K[b] addressable patients in US/EU5 in 2L advanced melanoma • Orphan Drug Designation and RMAT designation[c] received for the treatment of both, cutaneous and uveal melanoma

SUPRAME: Phase 3 randomized trial of anzu-cel vs. investigator choice in 2L advanced melanoma[d] ongoing (#NCT06743126)
Phase 2 single arm cohort of anzu-cel in metastatic uveal melanoma ongoing (#NCT03686124)

Anzutresgene autoleucel (anzu-cel, formerly IMA203). [a] Manufacturing success rate for Phase 1; [b] PRAME+/HLA-A*02:01+ addressable patient population, Source: Internal Forecast 2026; [c] Includes all benefits of Breakthrough Therapy Designation, RMAT designation received in multiple PRAME expressing cancers, including cutaneous and uveal melanoma; [d] 2L: patients with unresectable or metastatic melanoma who have received at least 1 prior PD-1 inhibitor; CRS: cytokine release syndrome; ICANS: immune effector cell associated neurotoxicity syndrome; cORR: confirmed objective response rate; mDOR: median duration of response; mPFS: median progression-free survival; OS: overall survival ; mFU: median follow-up; EU5: France, Germany, Italy, Spain, United Kingdom;

Ph 1b Study of Anzu-cel (IMA203) PRAME Cell Therapy in Advanced Melanoma

Patient Journey



Inclusion by HLA testing only – no PRAME testing required	Standard leukapheresis for product manufacturing – no need for tumor biopsy or surgery	Fast turn-around-time (~2 weeks) and manufacturing success rate of 95%[d]	Expected and manageable tolerability profile with potential outpatient administration – no high-dose IL-2

Anzutresgene autoleucel (anzu-cel, formerly IMA203); [a] Gragert *et al.* 2013 and census numbers; HLA-A*02:01 prevalence in Immatics' clinical trials: US 63% and Germany 55% as of March 2023; [b] 30 mg/m² Fludarabine and 500 mg/m² Cyclophosphamide for 4 days; [c] 1m IU SC daily days 1-5 and twice daily SC days 6-10, total dose is approx. only 3% of the overall dose for high-dose IL-2 given typically with TIL therapy (Sarnaik et al. 2021 Journal of Clinical Oncology); [d] Manufacturing success rate for Phase 1

Patients with Metastatic Melanoma in High Unmet Need Settings: PD-1-Relapsed Melanoma and Metastatic Uveal Melanoma

Baseline Characteristics	All Melanoma n=33	Cutaneous Melanoma n=14	Uveal Melanoma n=16	Other Melanoma[a] n=3
Age, median (range)	57 (31, 79)	55 (31, 79)	62 (32, 74)	51 (40, 58)
Female, %	48	21	63	100
Baseline ECOG status 1, %	39	36	44	33
Prior lines of systemic treatment, median (range)	2 (0, 6)	2.5 (1, 5)	2 (0, 6)	2 (1, 3)
Prior ICI treatment, median (range)	1 (0, 4)	2 (1, 3)	1 (0, 4)	2 (1, 2)
≥1 line of ICI treatment, % (n/N)	82 (27/33)	100 (14/14)	63 (10/16)	100 (3/3)
Prior tebentafusp, % (n/N)	—	—	63 (10/16)	—
Tumor burden Target lesion SLD, cm, median (range) Target + non-target lesions, n, median (range)	10.4 (1.5, 31) 6 (1, 20)	12.1 (1.5, 31) 6 (1, 10)	10.3 (3.1, 21) 7 (3, 13)	8.7 (2.1, 17) 17 (5, 20)
Liver metastasis, %	79	64	94	67
Brain metastasis, %	3	0	0	33
Lung metastasis, %	64	71	50	100
Uveal melanoma: Liver + extrahepatic, n (%) Liver only / extrahepatic only, n (%)			13 (81) 2 (13) / 1 (6)	
Elevated LDH at baseline, % LDH × ULN, median, (range)	58 1 (0.7, 9.1)	64 1.1 (0.7, 9)	56 1.1 (0.7, 9.1)	33 0.9 (0.8, 1.6)
Treatment Experience	**All Melanoma**	**Cutaneous Melanoma**	**Uveal Melanoma**	**Other Melanoma**
Infused TCR T cell dose ($\times 10^9$), median (range)	4.04 (1.30, 10.20)	4.58 (1.30, 10.20)	3.94 (1.62, 8.43)	3.33 (1.73, 7.94)

[a] Mucosal melanoma n=2; melanoma of unknown primary n=1. ECOG, Eastern Cooperative Oncology Group; ICI, immune checkpoint inhibitor; LDH, lactate dehydrogenase; TCR, T-cell receptor; ULN, upper limit of normal.

Anzu-cel (IMA203) PRAME Cell Therapy Demonstrated an Expected and Manageable Tolerability Profile

TEAEs in ≥30%	All Melanoma (n=33)	
Preferred term, n (%)	Any grade	Grade ≥3
Nausea	22 (67)	0
ALT/AST increased	17 (52)	6 (18)
Rash[a]	14 (42)	3 (9)
Fatigue	13 (39)	0
Constipation	12 (36)	0
Hyponatremia	10 (30)	3 (9)
Pyrexia	10 (30)	0

Key Lab Abnormalities	All Melanoma (n=33)	
Preferred term, n (%)	Any grade	Grade ≥3
Any cytopenia	33 (100)	33 (100)
Neutropenia	33 (100)	33 (100)
Anemia	33 (100)	17 (52)
Thrombocytopenia	31 (94)	13 (39)
Leukopenia	33 (100)	33 (100)
Lymphopenia	33 (100)	33 (100)

AESI	All Melanoma (n=33)	
Preferred term, n (%)	Any grade	Grade ≥3
CRS	33 (100)	6 (18)
ICANS	4 (12)	2 (6)
HLH	2 (6)	1 (3)

Most frequent TEAEs were anticipated cytopenias associated with lymphodepletion

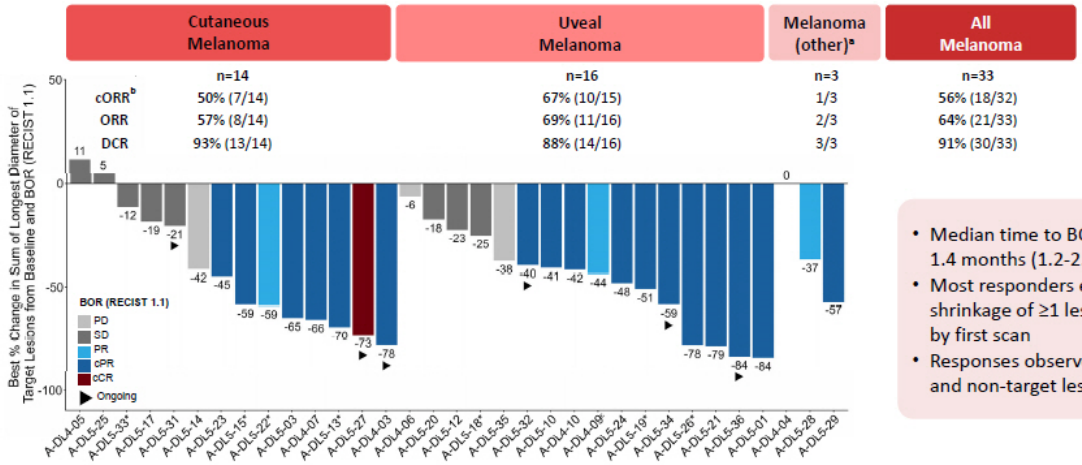
- Most grade ≥3 cytopenias (any lineage) resolved to grade 2 or better within 30 days of lymphodepletion

Immune-mediated AESIs occurred by Day 30 of TCR T-cell infusion

- Expected and manageable CRS, mostly grade 1/2, consistent with mechanism of action
- Infrequent, manageable, and mostly mild ICANS

[a]Includes rash and rash maculopapular. Grades were determined according to NCI-CTCAE v5.0. Grades for CRS and ICANS were determined according to CARTOX criteria (Neelapu et al, 2018, for patients enrolled under protocol v11.0 and higher according to Neelapu et al. 2019). All TEAEs regardless of relatedness to study treatment are presented. System Organ Class Blood and lymphatic system disorders excluded from analysis; Adverse events are coded to Preferred Term (PT) according to the MedDRA v24.0. Patients are only counted once per preferred term by the highest severity grade reported in the EDC. AESI, adverse event of special interest; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CRS, cytokine release syndrome; d, day; HLH, haemophagocytic lymphohistiocytosis; ICANS, immune effector cell-associated neurotoxicity syndrome; mo, month; TEAE, treatment-emergent adverse event.

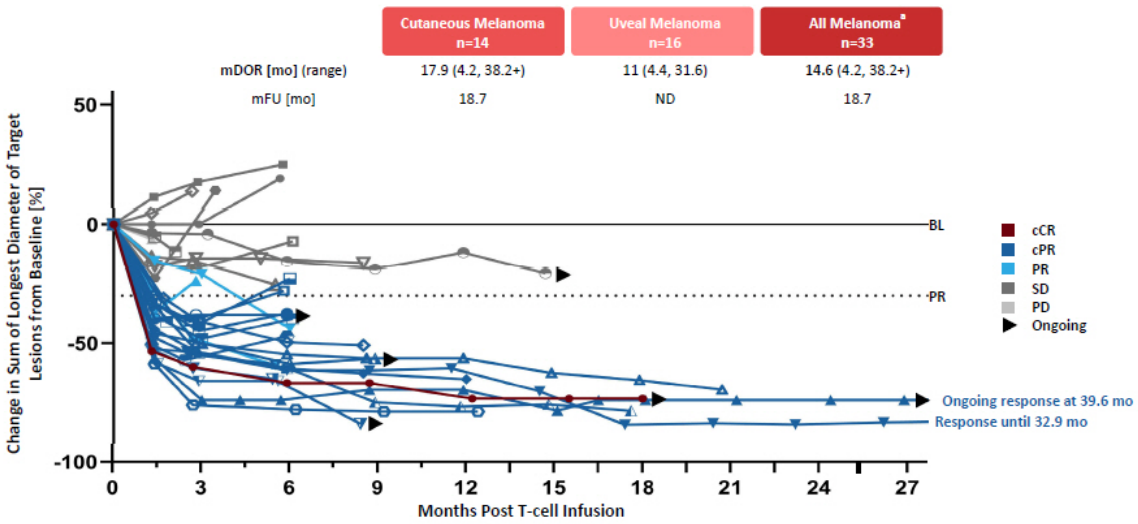
Anzu-cel (IMA203) PRAME Cell Therapy Induced Rapid and Deep Responses in Metastatic PD-1-Relapsed Melanoma and Metastatic Uveal Melanoma



- Median time to BOR was 1.4 months (1.2-2.8)
- Most responders exhibit shrinkage of ≥1 lesion by first scan
- Responses observed in target and non-target lesions

[a] Includes melanoma (other) n=3: MM n=2, MUP n=1; [b] Confirmed ORR for patients with ≥2 post-BL scans per RECIST 1.1, PD or death at any prior timepoint, those with ongoing unconfirmed PR/CR were excluded. * Patient left study (withdrew consent) with ongoing unconfirmed PR. * Maximum change of target lesions and RECIST 1.1 response at different timepoints. Anzu-cel, anzutresgene autoleucel; BOR, best overall response; cCR, confirmed complete response; cORR, confirmed objective response rate; cPR, confirmed partial response; DCR, disease control rate at week 6; PD, progressive disease; PR, partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease.

Anzu-cel (IMA203) PRAME Cell Therapy Induced Durable Responses in Metastatic PD-1-Relapsed Melanoma and Metastatic Uveal Melanoma



PRAME Wave 1: anzu-cel

* Includes melanoma (other) n=3: mucosal melanoma n=2, melanoma of unknown primary n=1.

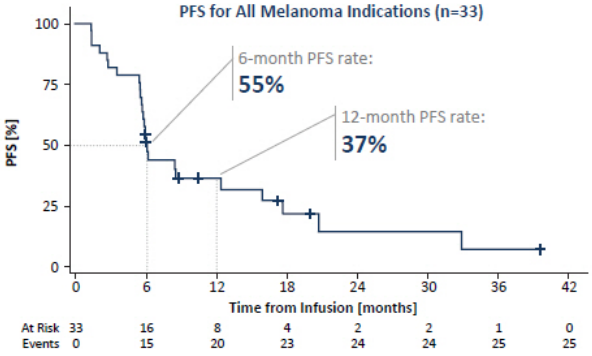
Anzu-cel, anzutresgene autoleucel; BL, baseline; cCR, confirmed complete response; cPR, confirmed partial response; mDOR, median duration of response; mFU, median follow-up; mo, month; ND, not defined; PD, progressive disease; PR partial response; RECIST, Response Evaluation Criteria in Solid Tumors; SD, stable disease.

Data cutoff Sep 24, 2025
Davar et al., ASCO 2026

Anzu-cel (IMA203) PRAME Cell Therapy Induced Durable Responses in Metastatic PD-1-Relapsed Melanoma and Metastatic Uveal Melanoma

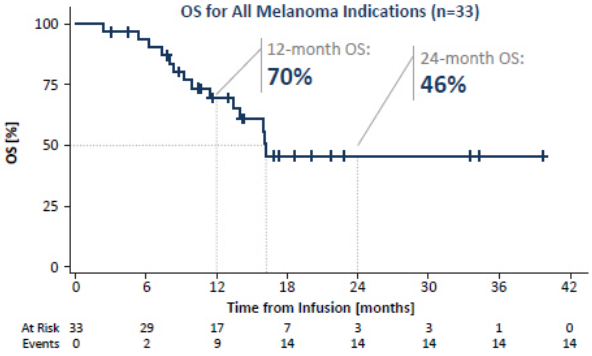
Median Progression Free Survival

	Cutaneous Melanoma n=14	Uveal Melanoma n=16	All Melanoma* n=33
mPFS [mo] (range)	6.0 (1.4 , 39.6+)	8.5 (1.4, 32.9)	**6.1** (1.4, 39.6+)
mFU [mo]	20.0	10.4	20.0



Median Overall Survival

	Cutaneous Melanoma n=14	Uveal Melanoma n=16	All Melanoma* n=33
mOS [mo] (range)	13.9 (2.4, 39.6+)	NR (4.5, 34.2)	**16.2** (2.4, 39.6+)
mFU [mo]	20.0	14.3	17.3



* Includes melanoma (other) n=3: mucosal melanoma n=2, melanoma of unknown primary n=1; PFS and OS of ongoing patients censored at data-cut; PFS and OS rates were calculated using Kaplan-Meier method.
Anzu-cel, anzutresgene autoleucel; mFU, median follow-up; mOS, median overall survival; mPFS, median progression-free survival; OS, overall survival; PFS, progression-free survival.

Anzu-cel (IMA203) PRAME Cell Therapy in Melanoma: Overview of Competitive Studies

PFS and OS Data in Melanoma Cohorts

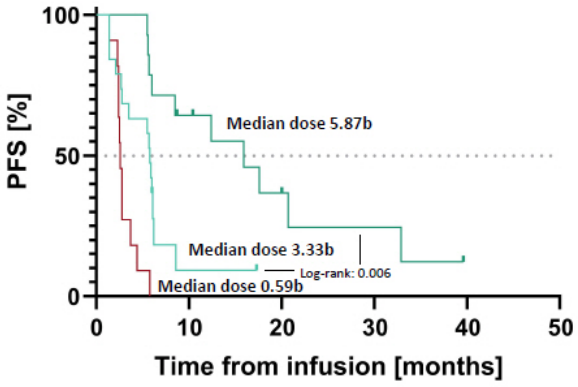
Drug Product	Phase	N	Melanoma patient population	Prior lines of therapies	mPFS (months)	mOS (months)
Anzu-cel in Melanoma	1b (Dose Expansion)	33	42% cutaneous 48% uveal 9% other	3% n=0, 24% n=1, 30% n=2, 24% n=3, 6% n=4, 6% n=5, 6% n=6 82% received prior ICI (median of 1 prior line of ICI in overall population, median of 2 prior lines of ICI in cut. melanoma) Median of 2 prior lines, median of 2.5 prior lines in cut. melanoma	6.1	16.2
Anzu-cel in Melanoma	1a (Dose Escalation)	11	73% cutaneous 18% uveal 9% other	0% n=1, 27% n=2, 73% n>2 prior lines 100% received prior ICI (median of 2 prior lines of ICI, median of 2.5 prior lines of ICI in cut. melanoma) Median of 4 prior lines, median of 4.5 prior lines in cut. melanoma	2.6	6.3
IMA201/202/anzu-cel combined in Melanoma	1a (Dose Escalation)	19	63% cutaneous 11% uveal 26% other	0% n=1, 16% n=2, 84% n>2 prior lines 100% received prior ICI (median 3 prior lines of ICI) Median of 4 prior lines, median of 4.5 prior lines in cut. melanoma	2.5	5.3
Lifileucel (C-144-01, Cohort 2+4)[1]	Registrational Ph2	153	54% cutaneous 0% uveal 45% other	median of 3 prior lines (min/max: 1/9) 100% received prior ICI	4.1	13.9
Tilsotolimod + Ipilimumab (ILLUMINATE-301)[2]	3	238	85% cutaneous 0% uveal 15% other	57% n=1, 27% n=2, 12% n>2 prior lines 99% received prior ICI	2.9	11.6
Nivolumab + Relatlimab (RELATIVITY-020, D1 Cohort)[3]	1/2	354	68% cutaneous 0% uveal 32% other	46% n=1, 35% n=2, 19% n≥3 prior lines 99% received prior ICI	2.1	14.7
Tudriqev (RP1) + Nivolumab (IGNYTE)[4]	Registrational Ph2	140	100% cutaneous	100% received prior ICI	3.6	32.2

These data are derived from different clinical trials at different points in time with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted.

Anzutresgene autoleucel (anzu-cel, formerly IMA203). [1] Chesney et al., 2022; [2] Diab et al., 2024; [3] Ascierto et al., 2023; [4] Wong et al. 2025, Wong et al. 2026; PFS: progression-free survival; OS: overall survival; ICI: immune checkpoint inhibitor

Anzu-cel (IMA203) PRAME Cell Therapy

Enhanced mPFS of >1 Year in Melanoma Patients with Deep Responses



	n	mPFS	mFU
Dose Escalation anzu-cel	11	2.6	ND
Dose Expansion anzu-cel <50% tumor size reduction (including tumor size increase)	19	5.8	17.3
Dose Expansion anzu-cel ≥50% tumor size reduction	14	15.9	39.6

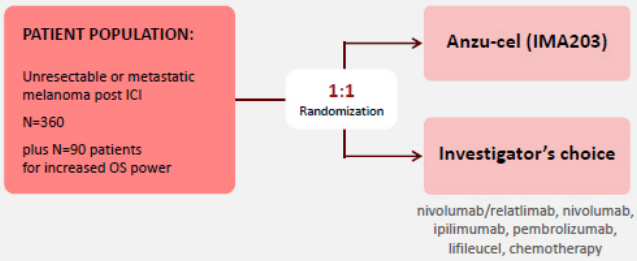
- 42% (14/33) patients in dose expansion have a deep response (≥50% tumor reduction)
- This subgroup of patients has highly medically meaningful mPFS of more than 1 year
- Patients with <50% tumor reduction (including tumor size increase) still observe a more than 2x longer mPFS as compared to patients treated in dose escalation with suboptimal doses

Anzutresgene autoleucel (anzu-cel, formerly IMA203); b, billion; ND, not defined; mFU, median follow-up; mPFS, median progression-free survival.

SUPRAME: A Randomized Ph3 Trial of Anzu-cel (IMA203) PRAME-directed TCR T-cell Therapy vs Investigator's Choice in Unresectable or Metastatic Melanoma post ICI

Actively Enrolling across North America and Europe

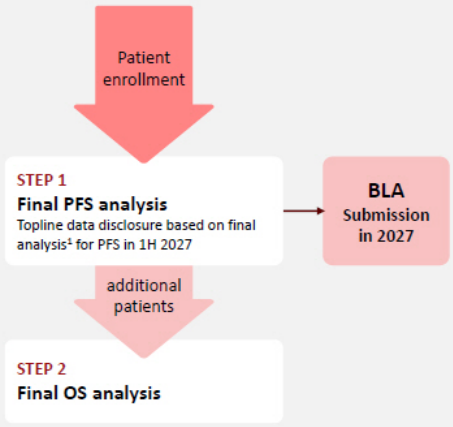
TRIAL DESIGN



ENDPOINTS

PRIMARY	KEY SECONDARY	SECONDARY
Progression-free survival	**Overall survival**	**Efficacy:** ORR **Safety:** TESAEs, AEs of special interest **Quality of life:** EORTC QLQ-C30 and EQ-5D-5L

Expected SUPRAME Trial Analyses



Anzutresgene autoleucel (anzu-cel, formerly IMA203) [1] Pre-specified final analysis will be triggered upon the occurrence of a defined number of events for primary endpoint PFS (progressive disease or death) statistically powered at 90%; ICI: immune checkpoint inhibitor; PFS: progression-free survival; ORR: objective response rate; TESAEs: treatment-emergent serious adverse events; AE: adverse event; EORTC: European Organization for Research and Treatment of Cancer; QLQ-C30: Core Quality of Life questionnaire; EQ-5D-5L: European Quality of Life 5 Dimensions 5 Level Version

Cell Therapy Manufacturing Facility

To Support Planned Anzu-cel BLA and Commercialization

- ~100,000 sq ft state-of-the-art research & GMP manufacturing facility
- Modular design for efficient and cost-effective scalability - total of 8 manufacturing suites, plus further expansion space
- Capacity sufficient to serve early-stage and registration-directed clinical trial as well as planned initial commercial supply
- In-house manufacturing and QC allows full control of process, product and costs
- Located in the Houston, Texas, Metropolitan Area offering economic labor and operating costs and talent pool highly qualified in cell therapy manufacturing & QC

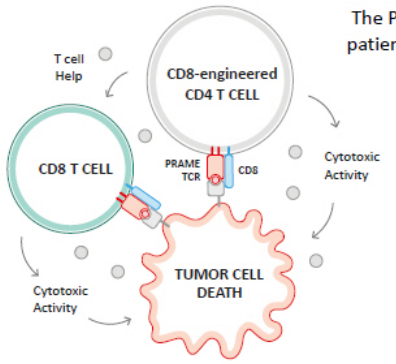


PRAME WAVE 2
IMA203CD8 PRAME Cell Therapy

Expansion to all Advanced PRAME Cancers



IMA203CD8 PRAME Cell Therapy:
Expansion of Commercial Opportunity to all Advanced PRAME+ Solid Tumors



The PRAME+/HLA-A*02:01+ addressable patient opportunity across a broad range of PRAME expression is

>75K

per year



- Co-transduction of CD8αβ alongside PRAME TCR adds **functional CD4+ T cells** designed to boost cytotoxicity
- Proof of concept from preclinical experiments[1] and CD19 CAR T cell studies in leukemia[2]
- Based on its **enhanced pharmacology**, IMA203CD8 provides the potential to expand to **tumor-agnostic** label in 2L PRAME cancers across broad spectrum of PRAME expression level (see appendix for PRAME expression levels)
- **Ovarian carcinoma** chosen as initial proof-of-concept

IMA203CD8 Opportunity

2L Solid Tumors

	US	EU5
Ovarian	2K	2K
Uterine	4K	4K
sqNSCLC	7K	10K
HNSCC	2K	2K
Breast	5K	8K
Others	16K	18K

All patient numbers refer to PRAME+/HLA-A*02:01+ patients in the US and EU5 in 2025; Source: Internal Forecast 2026; EU5: France, Germany, Italy, Spain, United Kingdom [1] Bajwa et al. 2021 Journal for Immunotherapy of Cancer; [2] Melenhorst et al. 2022 Nature, Bai et al. 2022 Science Advances; 2L: patients with unresectable or metastatic solid tumors who have received at least 1 prior therapy; sqNSCLC: squamous cell non-small-cell lung cancer, HNSCC: head and neck squamous cell carcinoma

Summary: IMA203CD8 Cell Therapy in PRAME+ Solid Tumors

Towards Proof-of-concept for Tumor-agnostic Targeting of PRAME Cancers with IMA203CD8

Manageable Tolerability

- Most frequent TEAEs were expected
- Transient cytopenias associated with lymphodepletion
- Mostly low-grade CRS
- Infrequent ICANS
- Potential for outpatient administration

Activity Across PRAME+ Tumors

- One-time infusion of IMA203CD8 showed clinical anti-tumor activity across multiple tumor types with distinct biology and differing levels of PRAME expression
- 51% ORR, 41% cORR, including multiple complete responses, and tumor reduction in 83% of patients across all dose levels and indications
- **Gynecologic cancers (platinum-pretreated ovarian cancer and uterine cancer)** at clinically relevant doses (≥DL4c):
  60% ORR, 55% cORR, incl. complete responses; mDOR 8.4 months, mPFS 5.8 months, and mOS not reached (mFU: 7.8 months)
- **Synovial sarcoma** at low doses: 67% ORR and 67% cORR, including one complete response, and ongoing responses up to ~3 years across all doses at low median dose

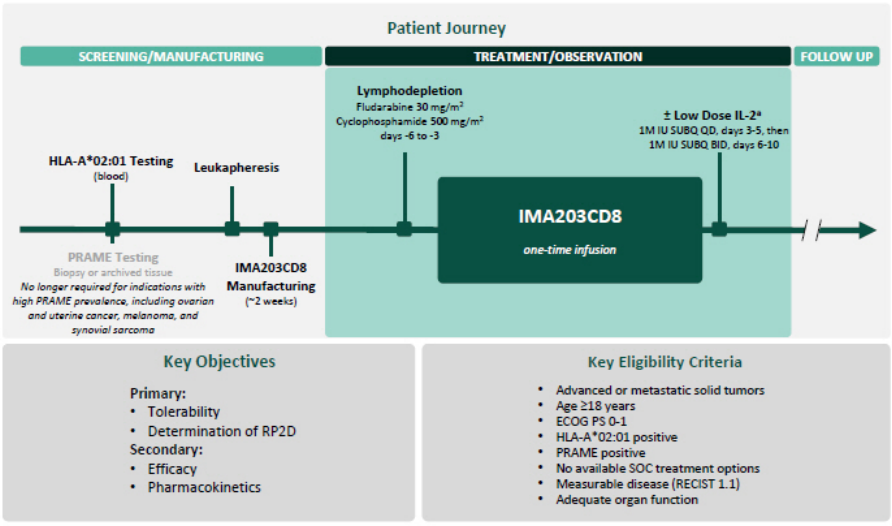
Development Opportunity

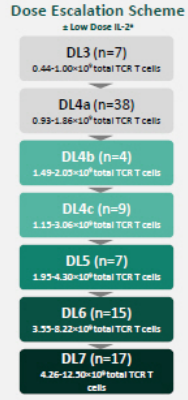
Clinical activity across tumor types with distinct biology and differing levels of PRAME expression supports the broad applicability of IMA203CD8 across PRAME-positive cancers and its tumor-agnostic development

- **Completion of Phase 1b uterine cancer cohort expected in 1H 2027**
- **Planned start of pediatric Phase 1/2 IIT[a] in PRAME-positive solid tumors in 1H 2027**

[a]Being conducted at Hopp Children's Cancer Center Heidelberg (KiTZ), Germany;
cPR, confirmed partial response; IIT, investigator-initiated trial; TEAE, treatment-emergent adverse events

Phase 1 Multicenter Trial of IMA203CD8 in PRAME+ Solid Tumors





Dose escalation completed

Enrichment at relevant DLs (≥DL4c):
~1.2–12.5 billion total TCR T cells

Key Objectives

Primary:
- Tolerability
- Determination of RP2D

Secondary:
- Efficacy
- Pharmacokinetics

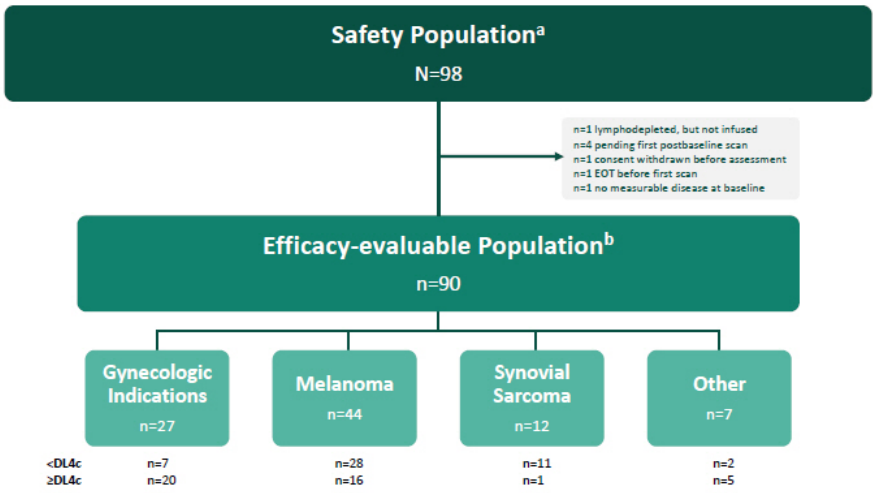
Key Eligibility Criteria

- Advanced or metastatic solid tumors
- Age ≥18 years
- ECOG PS 0-1
- HLA-A*02:01 positive
- PRAME positive
- No available SOC treatment options
- Measurable disease (RECIST 1.1)
- Adequate organ function

IMA203-101: NCT03686124; Based on initial safety data observed with anzu-cel (IMA203), IMA203CD8 dose escalation was initiated at DL3. Total TCR T cells calculated from defined number of TCR T cells/m² BSA per dose level *1.8 m² BSA.

ªDose level ≥DL4c is evaluated ±IL-2, starting without IL-2. If tolerable, add IL-2 at the same dose or escalate to next dose without IL-2; outpatient IL-2 administration at investigator's discretion. Anzu-cel, anzutresgene autoleucel; bid, twice daily; BSA, body surface area; DL, dose level; ECOG, Eastern Cooperative Oncology Group; HLA, human leukocyte antigen; IL, interleukin; IU, international unit; PRAME, preferentially expressed antigen in melanoma; PS, performance status; qd, once daily; RP2D, recommended phase 2 dose; SOC, standard of care; SUBQ, subcutaneous; TCR, T-cell receptor.

IMA203CD8 PRAME Cell Therapy: Patient Disposition



Gynecologic indications include ovarian cancer and uterine cancer; melanoma includes cutaneous, uveal, mucosal, acral melanoma, and melanoma of unknown primary; other indications include breast and non-small cell lung cancer. [a] All patients who started lymphodepletion. [b] All patients who received IMA203CD8 infusion and had ≥1 postbaseline scan, progressive disease or death. DL, dose level; EOT, end of treatment.

IMA203CD8: Baseline Characteristics

	Safety Population[a]	Efficacy-evaluable Population[b]			
	All N=98	Gynecologic Indications n=27	Melanoma n=44	Synovial Sarcoma n=12	Other n=7
Median age (range), years	58 (20-85)	58 (35-75)	62 (23-85)	46 (20-66)	56 (38-71)
Female, n (%)	63 (64)	27 (100)	22 (50)	4 (33)	4 (57)
ECOG PS 1, n (%)	40 (41)	10 (37)	21 (48)	2 (17)	4 (57)
LDH ≥1×ULN, n (%)	43 (44)	11 (41)	21 (48)	4 (33)	5 (71)
Median target lesion SLD (range), cm[c]	6.8 (1.1-43.4)	6.2 (1.1-21.6)	7.9 (1.3-43.4)	8.1 (1.2-41.1)	6.4 (3.9-14.7)
Median number of tumor lesions (range) [c]	5 (1-25)	5 (1-25)	4 (1-25)	8 (1-16)	6 (5-25)
Liver metastasis, n (%)	45 (46)	14 (52)	25 (57)	1 (8)	3 (43)
Brain metastasis, n (%)	9 (9)	0 (0)	7 (16)	0 (0)	1 (14)
Bone metastasis, n (%)	16 (16)	3 (11)	7 (16)	2 (17)	4 (57)
Peritoneal disease, n (%)	32 (33)	17 (63)	9 (20)	1 (8)	2 (29)

[a] All patients who started lymphodepletion. [b] All patients who received IMA203CD8 infusion and had ≥1 postbaseline scan, progressive disease or death. Gynecologic indications include ovarian cancer and uterine cancer; melanoma includes cutaneous, uveal, mucosal, acral melanoma, and melanoma of unknown primary; other indications include breast cancer and non-small cell lung cancer. [c] Two patients were excluded from the target lesion analysis due to unavailable target lesion measurements at the time of data cutoff.
ECOG, Eastern Cooperative Oncology Group; LDH, lactate dehydrogenase; PS, performance status; SLD, sum of longest diameter; ULN, upper limit of normal.

IMA203CD8: Treatment Experience

Prior Therapy	Safety Population[a]	Efficacy-evaluable Population[b]			
	All N=98	Gynecologic Indications n=27	Melanoma n=44	Synovial Sarcoma n=12	Other n=7
Treatment, n (%)					
Radiation	53 (54)	5 (19)	31 (70)	9 (75)	6 (86)
Systemic treatment	97 (99)	27 (100)	43 (98)	12 (100)	7 (100)
Lines of systemic treatment, median (range)	3 (0-9)	4 (1-7)	3 (0-9)	2 (1-5)	4 (2-7)
≥3, n (%)	77 (79)	22 (81)	37 (84)	5 (42)	6 (86)
Immune checkpoint inhibitors, n (%)					
Chemotherapy, n (%)	55 (56)	5 (19)	39 (89)	0	6 (86)
Ovarian cancer only (n=24):	68 (69)	27 (100)	14 (32)	12 (100)	7 (100)
Lines of prior platinum-based therapy, n (%)	-	24 (100)	-	-	-
Platinum-resistant, n (%)	-	19 (79)	-	-	-
Lines post-platinum resistance, median (range)	-	1 (0-4)	-	-	-
Targeted therapies (ie, ADCs, TKIs), n (%)	54 (55)	23 (85)	15 (34)	5 (42)	5 (71)
TCR-based therapies, n (%)	18 (18)	0	15 (34)	1 (8)	0

On Study	Safety Population[a]	Efficacy-evaluable Population[b]			
	All N=98	Gynecologic Indications n=27	Melanoma n=44	Synovial Sarcoma n=12	Other n=7
Total infused dose TCR T cells [$\times 10^9$], median (range)	**1.81** (0.44-12.50)	**3.55** (0.47-12.50)	**1.67** (0.44-11.80)	**1.59** (0.89-10.00)	**1.95** (1.47-10.00)

[a] All patients who started lymphodepletion. [b] All patients who received IMA203CD8 infusion and had ≥1 postbaseline scan, progressive disease or death. Gynecologic indications include ovarian cancer and uterine cancer; melanoma includes cutaneous, uveal, mucosal, acral melanoma, and melanoma of unknown primary; other indications include breast cancer and non-small cell lung cancer. ADC, antibody drug conjugate; TKI, tyrosine kinase inhibitor; TCR, T-cell receptor.

Tolerability of IMA203CD8 in Advanced Solid Tumors

TEAEs in ≥20% of Patients (N=98[a])		
Preferred term, n (%)	**Any grade**	**Grade ≥3**
Patients with any adverse event	98 (100)	97 (99)
Neutropenia	88 (90)	87 (89)
Anemia	78 (80)	54 (55)
Thrombocytopenia	71 (72)	36 (37)
Nausea	64 (65)	2 (2)
Lymphopenia	45 (46)	45 (46)
Rash	39 (40)	5 (5)
Fatigue	37 (38)	6 (6)
Transaminase elevation	37 (38)	12 (12)
Hypokalemia	34 (35)	2 (2)
Constipation	33 (34)	0
Vomiting	28 (29)	0
Abdominal pain	26 (27)	3 (3)
Leukopenia	25 (26)	23 (23)
Hyponatremia	23 (23)	2 (2)
Pyrexia	23 (23)	0
Hypophosphatemia	21 (21)	3 (3)
Diarrhea	20 (20)	3 (3)
Headache	20 (20)	1 (1)

All TEAEs occurring in at least 20 patients (≥20%) are presented. Grades were determined according to National Cancer Institute Common Terminology Criteria for Adverse Events, version 5.0. Grades for CRS and ICANS were determined according to CARTOX criteria (Neelapu et al, 2018 before protocol v11.0; Neelapu et al, from protocol v11.0 onward)

Adverse Events of Special Interest (N=98[a])	
CRS, any grade, n (%)	94 (96)
Grade 1	38 (39)
Grade 2	47 (48)
Grade 3	8 (8)
Grade 4	1 (1)
HLH, any grade, n (%)	7 (7)
Grade 1	0
Grade 2	4 (4)
Grade 3	2 (2)
Grade 4	1 (1)
ICANS, any grade, n (%)	8 (8)
Grade 1	5 (5)
Grade 2	1 (1)
Grade 3	2 (2)

Late N-ICAHT Beyond Day 28 (N=87)	
ICAHT, any grade, n (%)	20 (23)
Grade 1-2	15 (17)
Grade 3-4	5 (6)

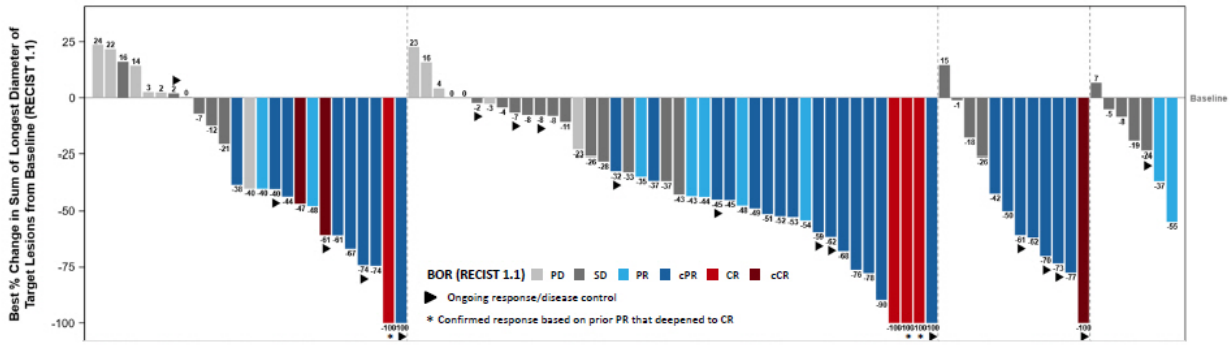
Late neutropenia-based Immune Effector Cell-Associated Hematotoxicity (N-ICAHT) grade was based on the second-lowest absolute neutrophil count between days 28-100 postinfusion and required ≥2 neutropenic measurements during this period, including ≥1 between days 35-60. Measurements before the day 28 visit were not used for late ICAHT grading but were considered when determining neutropenia onset and duration. Day 28 visits could have occurred ±3 days before or after day 28. Assessments were available for n=87 patients.

- Most frequent TEAEs were cytopenias associated with lymphodepletion
- CRS was mostly grade 1-2
- DLTs in 4 of 98 patients:
  1. DL4b: grade 4 neurotoxicity/CRS with grade 3 HLH
  2. DL4b: grade 3 CRS
  3. DL5: grade 3 ICANS[b]
  4. DL7: grade 4 skin infection[b]
- Late grade 3-4 N-ICAHT in 5 patients was manageable with supportive treatment; all improved to grade ≤2 at a median of 69 days postinfusion (range, 42–121)
- No IMA203CD8-related grade 5 event[c]
- **MTD not reached with doses up to 12.5 billion IMA203CD8 cells**

[a] All patients who started lymphodepletion, including 1 patient who did not receive IMA203CD8 cells. [b] 2 events met DLT criteria but did not limit dose escalation: 1 in an enrichment cohort at DL5 and 1 at highest dose, DL7 (1/8 patients), both within protocol-defined dose-finding rules. [c] Possibly related grade 5 event as previously reported was determined by the PI to be unlikely related to IMA203CD8 after complete assessment. Patient died from sepsis that was aggravated by immunosuppression from fludarabine/cyclophosphamide (possibly related), a grade 4 HLH event, the toxicity management, and rapidly progressing disease. CARTOX, CAR T-cell therapy-associated toxicity; CRS, cytokine release syndrome; DL, dose level; DLT, dose-limiting toxicity; HLH, hemophagocytic lymphohistiocytosis; ICANS, immune effector cell-associated neurotoxicity syndrome; PI, principal investigator; MTD, maximum tolerated dose; TEAE, treatment-emergent adverse event.

Tumor Reduction Achieved by IMA203CD8 Across Dose Levels During Dose Escalation by Indication

	ALL (n=90)	Gynecologic Indications (n=27)	Melanoma (n=44)	Synovial Sarcoma (n=12)	Other (n=7)
Median dose [x10⁹ total TCR T cells]	1.77	3.55	1.67	1.59	1.95
ORR	51% (46/90)	48% (13/27)	52% (23/44)	67% (8/12)	29% (2/7)
cORR	41% (36/87)	41% (11/27)	41% (17/42)	67% (8/12)	0% (0/6)
DCR	82% (74/90)	70% (19/27)	82% (36/44)	100% (12/12)	100% (7/7)
Tumor reduction	83% (71/86)	68% (17/25)	88% (37/42)	92% (11/12)	86% (6/7)

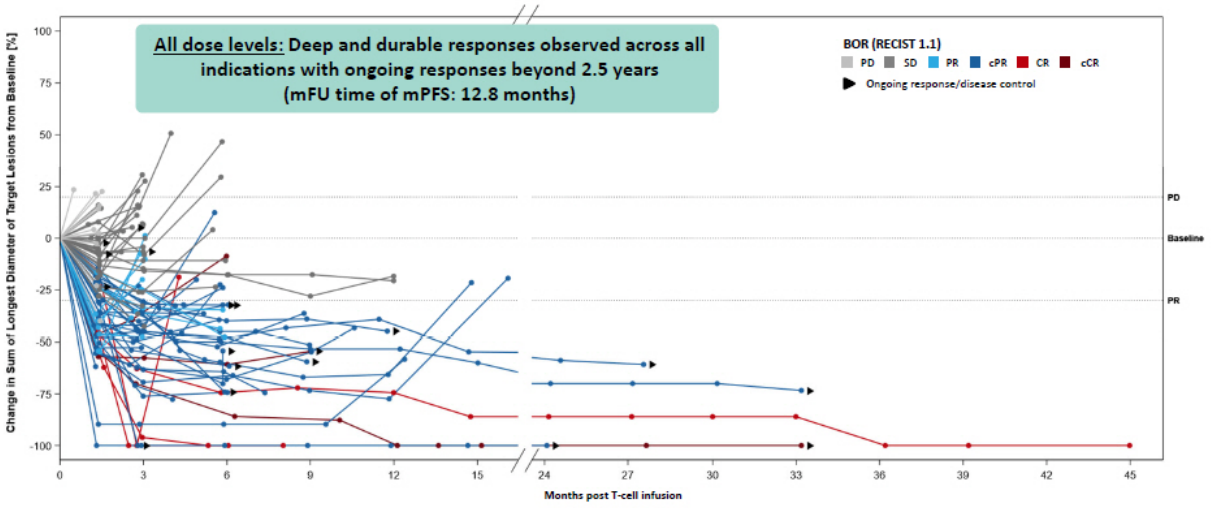


PRAME Wave 2: IMA203CD8

mCI patients with ovarian cancer and mCI patient with melanoma died before first postbaseline scan and mCI additional patient with melanoma had a non-evaluable target lesion; these patients are not depicted in the plot but were included in the ORR, cORR and DCR calculation. ORR: according to RECIST 1.1 at any postbaseline scan, PD or death at any prior timepoint; Confirmed ORR for patients with ≥2 postbaseline scans per RECIST 1.1, PD or death at any prior timepoint, those with ongoing unconfirmed PR/CR were excluded. For patients achieving a ≥30% with <100% change from baseline, target lesions were lymph nodes that resolved to <10 mm per RECIST 1.1. Gynecologic indications include ovarian cancer and uterine cancer; melanoma includes cutaneous, uveal, mucosal, acral melanoma, and melanoma of unknown primary; other indications include breast cancer and non-small cell lung cancer. BOR, best overall response; cDCR, (confirmed) complete response; DCR, disease control rate; cORR, (confirmed) objective response rate; PD, progressive disease; cPR (confirmed) partial response; SD, stable disease.

Data cutoff August 7, 2026
Busse et al., ESMO 2026

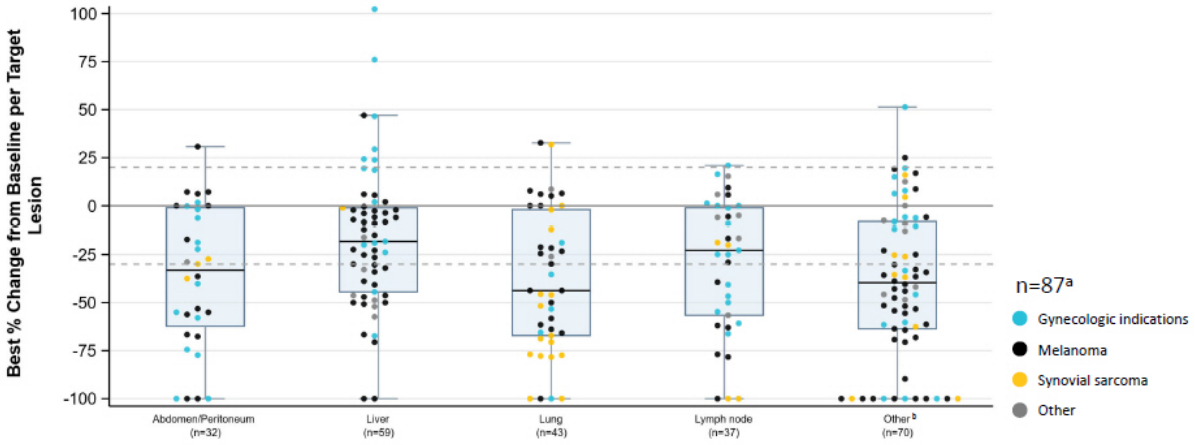
Changes in Tumor Size Over Time after Treatment with IMA203CD8



BOR, best overall response; (c)CR, (confirmed) complete response; mFU, median follow-up; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease

Data cutoff August 7, 2026
Busse et al., ESMO 2026

Responses of Metastatic Lesions after Treatment with IMA203CD8

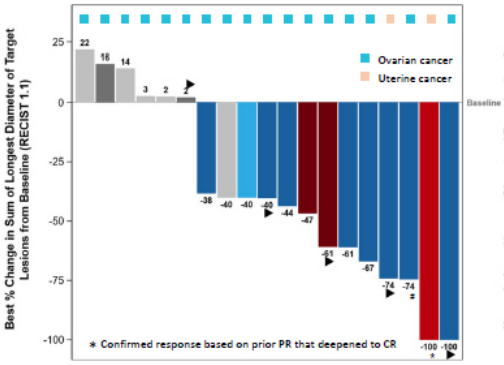


PRAME Wave 2: IMA203CD8

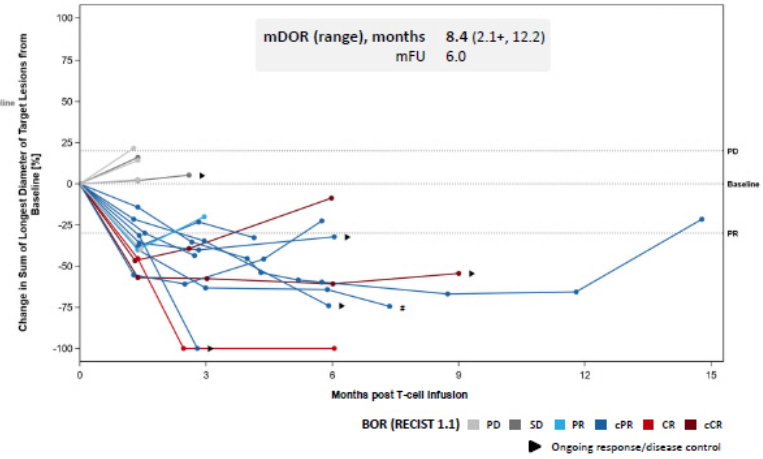
Each data point represents reduction of a target lesion. Total number of target lesions evaluated: 241. [a] Best overall response of target lesions not available for n=3 patients. Gynecologic indications include ovarian cancer and uterine cancer; melanoma includes cutaneous, uveal, mucosal, acral melanoma, and melanoma of unknown primary; other indications include breast cancer and non-small cell lung cancer. [b] Other: bone, breast, cervical neck, chest, colon, esophagus, gastric, kidney, pelvis, pleural effusion, skin, vagina, and other investigator specified locations.

Data cutoff August 7, 2026
Busse et al., ESMO 2026

Antitumor Activity of IMA203CD8 at Higher Doses ≥DL4c in Patients with Gynecologic Indications



N=20	Gynecologic Indications	Ovarian Cancer	Uterine Cancer
ORR	60% (12/20)	56% (10/18)	2/2
cORR	55% (11/20)	50% (9/18)	2/2
DCR (at week 6)	70% (14/20)	67% (12/18)	2/2
Tumor reduction	68% (13/19)	65% (11/17)	2/2



n=1 patient with ovarian cancer died prior to first post baseline scan not evaluable for assessment of tumor reduction, not depicted in plot but included in ORR, cORR and DCR calculation; ORR: according to RECIST 1.1 at any postbaseline scan, PD or death at any prior timepoint; Confirmed ORR for patients with ≥2 postbaseline scans per RECIST 1.1, PD or death at any prior timepoint, those with ongoing unconfirmed PR/CR were excluded. For those patients achieving a (c)CR with <100% changes from baseline, target lesions were lymph nodes that resolved to <10 mm per RECIST 1.1. # Ongoing confirmed PR (RECIST 1.1) as of last scan at month 7.5, suspected clinical progression by clinical site at month 6 in discrepancy to RECIST response due to tumor marker increase; patient off study at month 8 and receiving further anti-tumor treatment. Initially reported unconfirmed CR according to database entry by site referred to a lesion incorrectly classified as target lesion. Retrospective review determined that patient has no measurable target lesion at baseline and was therefore removed from efficacy population.

BOR, best overall response; (c)CR, (confirmed) complete response; DCR, disease control rate; DL, dose level; (c)ORR, (confirmed) objective response rate; mDOR, median duration of response; mFU, median follow-up; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

IMA203CD8 Ongoing Trials and Development Approach

1 CLINICAL PROOF-OF-CONCEPT

Anti-tumor activity observed across multiple PRAME-positive tumor types with diverse biology and PRAME expression level

- Ovarian Cancer
- Uterine Cancer
- Melanoma
- Synovial Sarcoma
- Brain metastases[a]

2 BUNDLE DEVELOPMENT

Advance selected tumor types with high PRAME expression in targeted cohorts to build the clinical evidence base for broader development

- Uterine Cancer
- Ovarian Cancer
- Rare Cancers
- Pediatric Cancers[b]

Potential addressable population for this bundle is >10,000 patients in US alone[c]

Pediatric voucher opportunity:
Potential eligibility for a Priority Review Voucher through development of a qualifying pediatric indication

3 TUMOR-AGNOSTIC DEVELOPMENT

Clinical activity across PRAME-positive tumors, independent of tumor type, biology, and PRAME expression level, supports broader development with the goal of **expanding into all advanced PRAME-positive cancers**

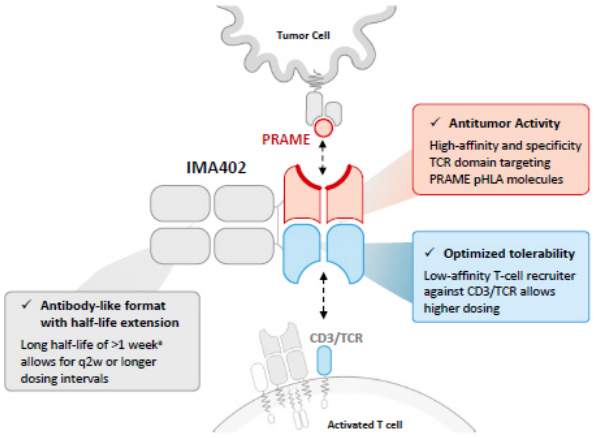


[a] Data on file. [b] Clinical data as part of an individual experimental treatment attempt with a TCR T-cell therapy in a pediatric patient using Immatics PRAME-directed TCR published in Meir K, Rossi C, Westhoff JH, et al. PRAME-Specific T-Cell Therapy in Advanced Pediatric Nephroblastoma. N Engl J Med. 2026;395(7):721-724; [c] Exemplary number assuming bundle of PRAME+/HLA-A*02:01+ patients in the US: 2L uterine cancer, 2L platinum-refractory ovarian cancer, adult and pediatric met. sarcoma; Source: Internal Forecast 2026


PRAME WAVE 3
IMA402 PRAME Bispecific
Expansion to Earlier-Line PRAME Cancers
immatics

IMA402 PRAME Bispecific: Expansion of the Commercial Opportunity to Earlier-Line PRAME+ Cancers

TCR Bispecifics (TCER®)



>145K

addressable PRAME+/HLA-A*02:01+ patients in the US & EU5



IMA402 Opportunity

1L Solid Tumors

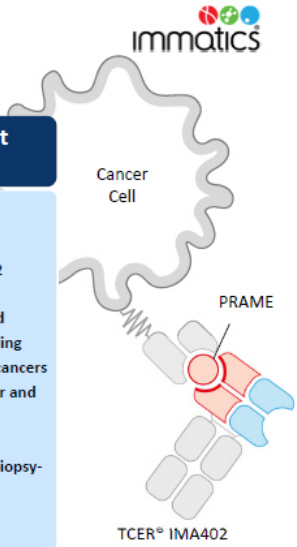
	US	EU5
Cut. Melanoma	6K	6K
Ovarian	7K	9K
Uterine	6K	6K
sqNSCLC	16K	23K
Breast	7K	10K
Others	25K	32K

[a] Half-life calculated by non compartmental analysis (NCA); All patient numbers refer to PRAME+/HLA-A*02:01+ patients in the US and EU5 in 2025 based on initial threshold for all indications except for sqNSCLC (optimized threshold considered for further development due to IMA401 combination potential); Source: Internal Forecast 2026; EU5: France, Germany, Italy, Spain, United Kingdom; q2w: once every two weeks; sqNSCLC: squamous cell non-small-cell lung cancer

IMA402 PRAME Bispecific

Summary: Phase 1 Dose Escalation Study

Tolerability	Activity & Duration of Response	Pharmacokinetics	Development Potential
Favorable tolerability profile Most frequent treatment-related AEs are low-grade CRS and expected & transient lymphopenia	• Promising anti-tumor activity with deep and durable responses • 25% cORR at RP2D range across all indications • 32% cORR across all PRAME^{high} indications • 32% cORR, 12.5 months mDOR and 91% 1-year OS rate in PRAME^{high} melanoma	Median half-life of >1 week Bi-weekly dosing introduced and potential for longer dosing intervals, offering a convenient dosing schedule, including for combination treatment approaches	Clinical profile of IMA402 reinforces development path across multiple solid tumor indications, including melanoma, gynecologic cancers and lung cancer, in earlier and later treatment lines, supported by Immatics' innovative, rapid liquid biopsy-based PRAME testing



- First data on IMA402 combination cohorts incl. IMA402/IMA401 in sqNSCLC: 2027

AE: adverse event; CRS: Cytokine release syndrome; ICI: immune checkpoint inhibitor; RP2D: recommended phase 2 dose; SOC: standard of care

Phase 1/2 Trial Design to Evaluate IMA402 PRAME Bispecific

Key Objectives

Primary:
- Determine MTD and/or RP2D
- Assess safety and tolerability

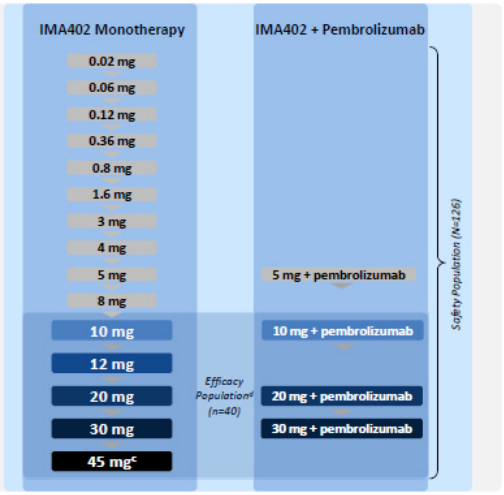
Secondary:
- Evaluate initial antitumor activity (RECIST 1.1 and iRECIST)
- Assess pharmacokinetics

Key Eligibility Criteria

- Recurrent and/or refractory **solid tumors expressing PRAME**[a]
- No prospective PRAME testing required
- HLA-A*02:01 positive
- ECOG performance status 0-1
- Received or not eligible for all available indicated standard of care treatments

Phase 1

- MABEL-based starting dose
- Dose escalation based on cohorts of 1-6 patients using adaptive design (BLRM model)
- MTD not reached per adaptive BLRM model
- q1w step dosing (3 doses) up to target dose[b]
- q2w dosing from week 7 introduced post data cutoff based on favorable pharmakokinetics
- IMA402 RP2D range: 10-45 mg



EudraCT No. 2022-002133-54-00; NCT05958121. [a]Cutaneous melanoma, melanoma of unknown primary, uveal melanoma, synovial sarcoma, endometrial carcinoma, ovarian carcinoma, squamous non-small cell lung cancer. [b]Step dosing introduced at 0.06 mg, optimized step dose (0.02, 0.06 mg/0.3 mg/1.0 mg target dose, low-dose exposure effect at initial dose as assessed for other bispecific T-cell engagers, ability to increase dose to previously cleared dose levels. [c]Exploratory high dose level. [d]Efficacy population: all patients treated within the RP2D range as of the data cutoff date who had the opportunity for at least 12W follow-up or who discontinued early due to disease progression or death), tested positive for PRAME, and received infusions as defined per protocol (received 3 step doses, currently at 0.02 mg/0.3 mg/1.0 mg, and 3 target dose), and had 12W. ≥1 Sum of Diameters. BLRM, Bayesian logistic regression model; ECOG, Eastern Cooperative Oncology Group; MABEL, minimum anticipated biological effect level; MTD, maximum tolerated dose; q1w, every week; q2w, every 2 weeks; RP2D, recommended phase 2 dose.

Data cutoff Jun 1, 2026
Schadendorf et al., ESMO 2026

Demographics: Heavily Pretreated Patient Population Enrolled in IMA402 Trial

Baseline Characteristics	Safety Population N=126	Efficacy Population n=40
Indication, n		
Melanoma - cutaneous, uveal, unknown primary	78 - 62, 13, 3	27 - 26, 1, 0
Ovarian cancer	31	8
Other - endometrial cancer, sqNSCLC, synovial sarcoma	17 - 7, 6, 4	5 - 2, 2, 1
Age		
Median (range)	60 (21-82)	59 (29-77)
ECOG performance status		
0, n (%)	78 (62)	25 (63)
1, n (%)	48 (38)	15 (38)
LDH at baseline		
>1xULN, n (%)	57 (45)	10 (25)
Baseline tumor burden		
Median target lesion sum of diameter (cm) (range)	7.4 (1.2-39.8)	7.9 (1.5-19.4)
Tumor lesions		
Number of lesions, median (range)	4 (1-15)	4 (2-10)
Liver metastases, n (%)	44 (35)	11 (28)
Brain metastases, n (%)	7 (6)	3 (8)
Treatment Experience		
No. of prior lines of systemic treatment		
Median (range)	3 (0-7)	3 (0-6)
Prior systemic treatments, n (%)		
Chemotherapy	60 (48)	19 (48)
ICI	89 (71)	31 (78)
Targeted therapy	60 (48)	18 (45)

ECOG, Eastern Cooperative Oncology Group; ICI, immune checkpoint inhibitor; LDH, lactate dehydrogenase; sqNSCLC, squamous non-small cell lung cancer; ULN, upper limit of normal.

Safety Profile of IMA402 Across All Indications and Dose Levels (N=126)

Treatment-related AEs, n (%)[a]	All Grades	≥ Grade 3
Lymphopenia	56 (44)	44 (35)
Cytokine release syndrome	46 (37)	2 (2)
Arthralgia	42 (33)	2 (2)
Fatigue	32 (25)	1 (1)
ALT/AST increased	23 (18)	10 (8)
Pruritus	18 (14)	0
Pyrexia	18 (14)	0
Anaemia	17 (13)	4 (3)
Myalgia	17 (13)	1 (1)
Rash	16 (13)	0
Gamma-glutamyltransferase increased	12 (10)	4 (3)
Nausea	10 (8)	1 (1)
Erythema	10 (8)	0
Lipase increased	9 (7)	4 (3)
Diarrhoea	9 (7)	0
Abdominal pain	9 (7)	1 (1)
Hypertension	4 (3)	3 (2)
Leukopenia	4 (3)	1 (1)
Vomiting	4 (3)	1 (1)
Blood creatinine increased	3 (2)	1 (1)
Tumour pain	3 (2)	1 (1)
Neutropenia	2 (2)	2 (2)
Back pain	2 (2)	1 (1)
Pancreatitis	2 (2)	1 (1)
Stomatitis	2 (2)	1 (1)
Urinary tract disorder	2 (2)	1 (1)
Acute kidney injury	1 (1)	1 (1)
Electrocardiogram abnormal	1 (1)	1 (1)
Herpes zoster	1 (1)	1 (1)
Immune-mediated arthritis	1 (1)	1 (1)
Liver function test increased	1 (1)	1 (1)
Tumour lysis syndrome	1 (1)	1 (1)

Treatment-emergent AEs, n (%)	All Grades	≥ Grade 3
Any	125 (99)	81 (64)
Treatment-related	120 (95)	65 (52)

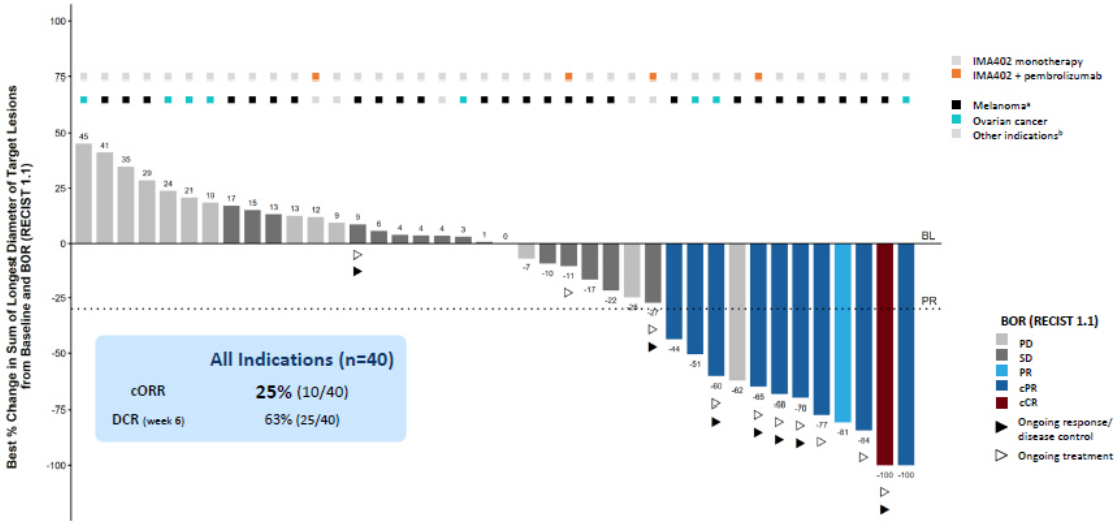
- **Most frequent** related AEs were:
  - Transient lymphopenia (resolved within a median of 5d)
  - Low-grade CRS
    - One CRS G4 event at 0.08 mg starting dose only; no further CRS G4 events after step dose optimization
    - One CRS G3 event at 0.03 mg starting dose only, completely resolved within 7d
- **No ICANS** observed
- **No** IMA402-related G5 events

No additive toxicity was observed in patients treated with IMA402 + pembrolizumab

[a] TRAEs: All treatment-emergent adverse events at least possibly related to IMA402 with grade 1-2 occurring in at least 9 patients (incidence ≥7.1%), and all events with grade ≥3. One uncoded grade 1 AE ("spotting") is not included. Abdominal pain includes "Abdominal Pain" and "Abdominal Pain Upper"; Adverse events are coded using the MedDRA Version 26.0. Grades are determined according to National Cancer Institute CTCAE, version 5.0, except grades for CRS and ICANS which are determined according to Lee et al., 2019; Neelapu et al., 2019 and tumor lysis syndrome which is determined according to Cairo and Bishop, 2004. Patients are counted only once per adverse event.

AE, adverse event; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CRS, cytokine release syndrome; ICANS, immune effector-cell associated neurotoxicity syndrome; TEAE, treatment-emergent AE; TRAE, treatment-related AE.

Efficacy of IMA402 ± Pembrolizumab Across All Indications in the Efficacy Population

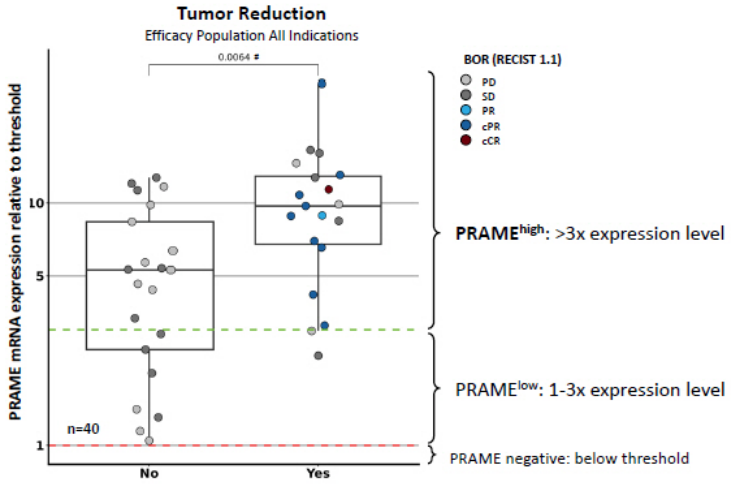


Confirmed responses in ICI-pretreated melanoma and platinum-pretreated ovarian cancer

[a] Includes cutaneous melanoma and 1 patient with uveal melanoma. [b] Includes endometrial cancer (n=2), sqNSCLC (n=2), and synovial sarcoma (n=1).
BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; DCR, disease control rate; ICI, immune checkpoint inhibitor; PD, progressive disease; [c]PR, [confirmed] partial response; SD, stable disease.

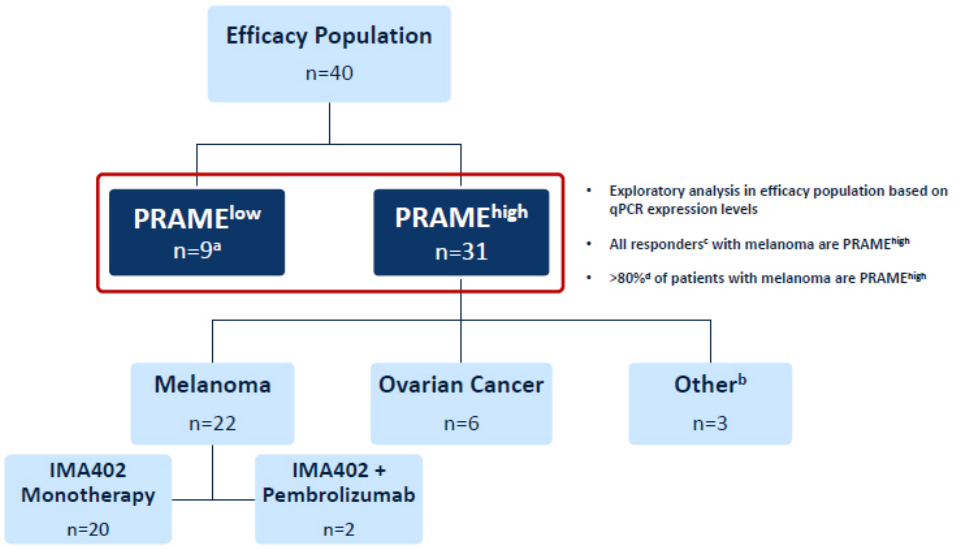
IMA402 PRAME Bispecific: Exploratory Analysis of PRAME Levels and Disease Outcome in Efficacy Population

- IMA402 shows association of higher PRAME levels with improved disease outcomes and tumor reduction
- All responders[a] with melanoma are PRAME^{high}
- >80%[b] of patients with melanoma are PRAME^{high}



[a] PRAME^{low} does not preclude response to IMA402, 1 cPR observed in a patient with PRAME^{low} endometrial cancer below RP2D range; [b] Data on file: PRAME target prevalence is based on in-house (n=136) and TCGA RNAseq (n=473) analysis using proprietary mass spec-guided initial expression threshold. # Mann-Whitney U test. BOR, best overall response; cCR, confirmed complete response; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease; TCGA, The Cancer Genome Atlas.

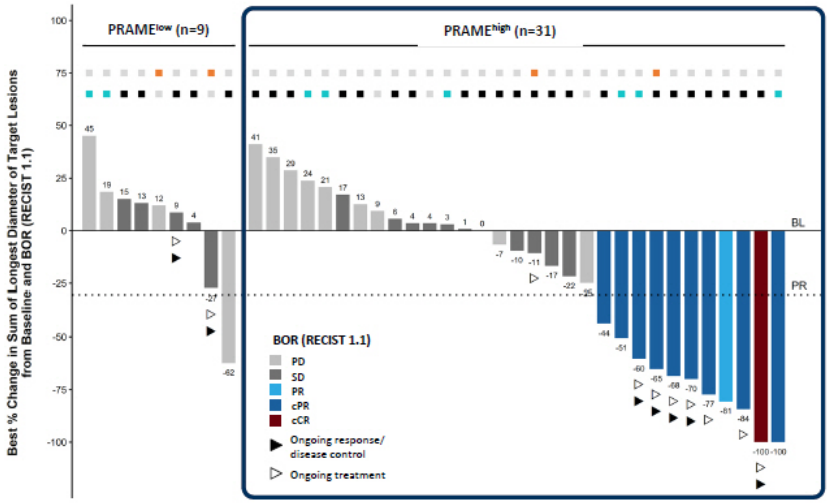
IMA402 PRAME Bispecific: Patient Disposition



- Exploratory analysis in efficacy population based on qPCR expression levels
- All responders[c] with melanoma are PRAME^high
- >80%[d] of patients with melanoma are PRAME^high

[a] Includes 2 patients treated with IMA402 + pembrolizumab. [b] Other includes endometrial cancer (n=2) and synovial sarcoma (n=1). [c] PRAME^low does not preclude response to IMA402. 1 cPR observed in a patient with PRAME^low endometrial cancer below RP2D range. [d] Data on file: PRAME target prevalence is based on in-house (n=136) and TCGA RNAseq (n=473) analysis using proprietary mass spec-guided initial expression threshold. qPCR, quantitative polymerase chain reaction.

Efficacy of IMA402 ± Pembrolizumab by PRAME Expression

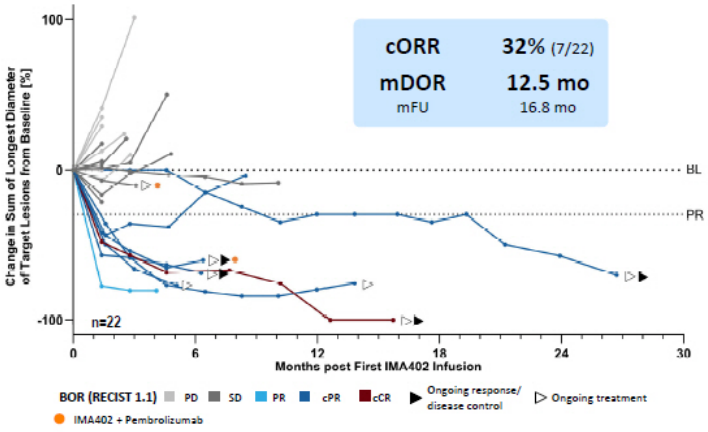


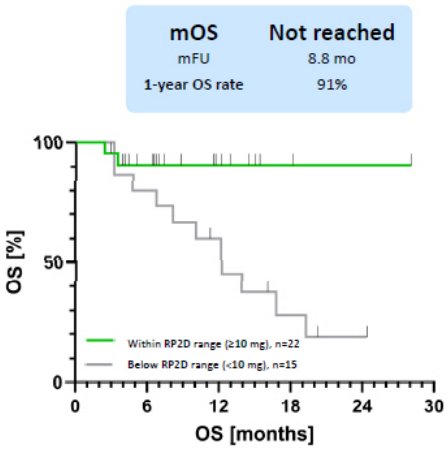
PRAME^high	All Indications	Melanoma	Ovarian Cancer
cORR	**32%** (10/31)	32% (7/22)	3/6
DCR (week 6)	65% (20/31)	73% (16/22)	3/6

[a] Includes cutaneous melanoma and one patient with uveal melanoma. [b] Includes endometrial cancer (n=2), sqNSCLC (n=2), and synovial sarcoma (n=1).
BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; DCR, disease control rate; PD, progressive disease; (c)PR, (confirmed) partial response; RP2D, recommended phase 2 dose; SD, stable disease.

Durability of Responses with IMA402 ± Pembrolizumab in PRAME^{high} Melanoma

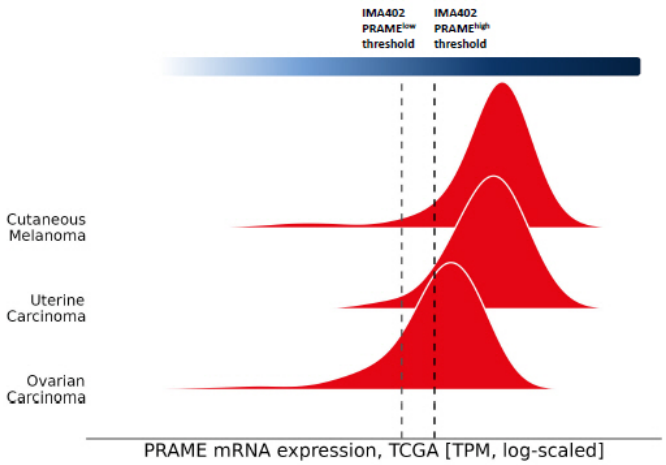
All Patients with Melanoma in the Efficacy Population Received prior ICI





Ongoing patients were censored at the data cutoff for OS; OS rates were calculated using the Kaplan–Meier method. BOR, best overall response; BL, baseline; cCR, confirmed complete response; cORR, confirmed objective response rate; ICI, immune checkpoint inhibitor; mDOR, median duration of response; mFU, median follow up; mOS, median overall survival; PD, progressive disease; (c)PR, (confirmed) partial response; RP2D, recommended phase 2 dose; SD, stable disease.

PRAME Prevalences for IMA402 Development in Selected Indications



IMA402 patient coverage based on applied thresholds:

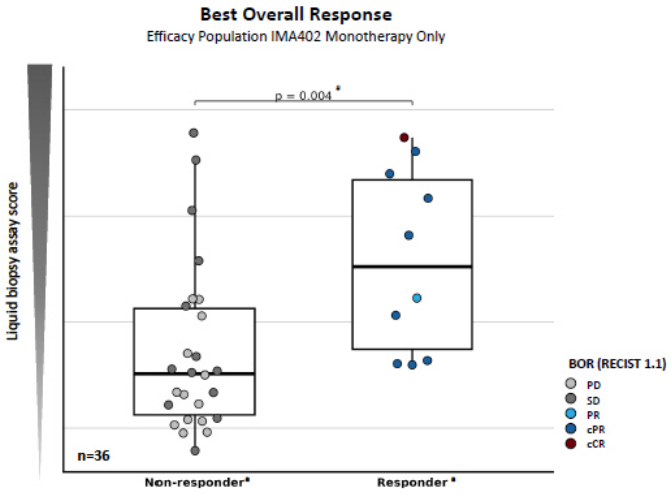
Indication	PRAME$^{low+high}$ TCGA[a]	PRAME^{high} TCGA	PRAME^{high} based on actual in-house data
Cutaneous melanoma	95%	92%	>80% (n=136)
Uterine carcinoma	97%	95%	60%-95% (n=15)
Ovarian carcinoma	84%	64%	~60% (n=50)

PRAME^{low} threshold: initial threshold in IMA402 trial
PRAME^{high} threshold: presumed threshold for IMA402 fast-track development

[a] PRAME target prevalence is based on TCGA RNAseq analysis using proprietary mass spec-guided initial expression threshold. Values not rounded. No screening and threshold requirement for anzu-cel and IMA203CD8.
TCGA, The Cancer Genome Atlas

Outlook: Liquid Biopsy for Patient Selection

- Proprietary liquid biopsy assay for patient selection
- Few millilitres of blood sufficient
- Fast, sensitive and reliable detection of PRAME in blood
- Representative PRAME levels across all tumor lesions prior to treatment start



* Non-responder: PD, SD. Responder: PR, cPR, cCR. * Mann-Whitney U test
cCR, confirmed complete response; (c)PR, (confirmed) partial response; PD, progressive disease; SD, stable disease.

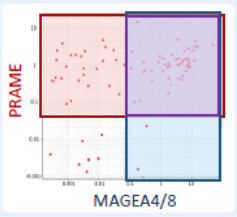
Potential to Unlock >90% of sqNSCLC Patients with IMA401 + IMA402 Dual Targeting

1 TARGET COVERAGE

> 90%

PRAME+ or MAGEA4/8+

including 60% double positive



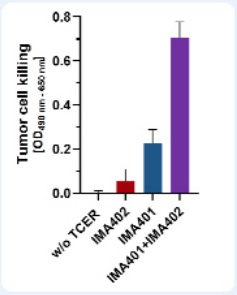
Expanded Patient Reach

>90% of patients with sqNSCLC are targetable, potentially unlocking broad treatment coverage for

~40K patients with sqNSCLC in the US and EU per year[a]

2 IN-VITRO TUMOR CELL KILLING

In vitro model of PRAME and MAGEA4/8 double positive tumor

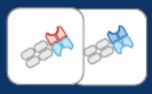


Synergistic Anti-Tumor Activity

Dual targeting has the potential to improve depth and durability of tumor response by counteracting tumor heterogeneity and escape

~60% of patients with sqNSCLC express both targets

Bispecifics Combination with Increased Commercial Potential



Expands addressable market as first step in sqNSCLC, potential for many other indications like HNSCC, esophageal squamous carcinoma, TNBC, endometrial carcinoma, ovarian carcinoma, melanoma, sarcoma and others as next steps

IMA401 data across cancer types incl. lung:
Wermke, et al. ASCO 2026.
Wermke, et al. *Nat Med.* 2026.

Data on file - dot plot: PRAME and MAGEA4/8 mRNA expression in stage III/IV sqNSCLC TCGA samples (TPM, log-scale), PRAME and MAGEA4/8 target prevalences are based on an optimized proprietary target expression threshold applied to TCGA data; Bar graph: *In vitro* LDH-killing assay, A375 tumor cell line with low target density of PRAME (~50 copies per cell) and medium target density of MAGEA4/8 (~250 copies per cell), TCER® concentration: 1nM IMA401 and 10 nM IMA402; [a]Refers to addressable 1L advanced HLA-A*02:01/target+ patients in the US & EU5 in 2025, Source: Internal Forecast 2026; HNSCC: head and neck squamous cell carcinoma; sqNSCLC: squamous non-small cell lung cancer.

IMA402 Development Path to Deliver an Off-the-Shelf PRAME Therapy

IMA402 Cohorts in Phase 1b Clinical Evaluation		
IMA402 monotherapy	2L melanoma	COMPLETED
IMA402 + ICI[a]	2L melanoma	ONGOING
IMA402 + ICI[a]	1L melanoma	ONGOING
IMA402 + IMA401	sqNSCLC	ONGOING
IMA402 + pembrolizumab	Gynecologic cancers	ONGOING
IMA402 + decitabine	Ovarian cancer, melanoma	ONGOING

Development Path

Monotherapy
in 2L PRAME-high melanoma

ICI combination in earlier-line melanoma
(post-adjuvant & ICI-naïve 1L melanoma)

Expansion to additional cancer types
Lung cancer (in combination with IMA401)
Gynecologic cancers (in combination with SOC)

Proprietary **liquid biopsy assay** for rapid PRAME testing to support efficient patient selection & accelerated development across indications

[a] pembrolizumab or nivolumab/relatlimab; ICI, immune checkpoint inhibitor;

Entering the PRAME Franchise
IMA401 MAGEA4/8 Bispecific

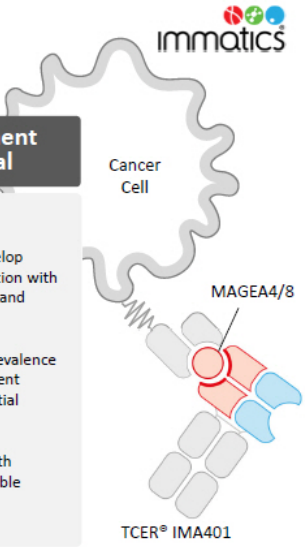
Maximizing the Potential
of Bispecifics Combination



IMA401 MAGEA4/8 Bispecific

Summary: Phase 1 Dose Escalation Study

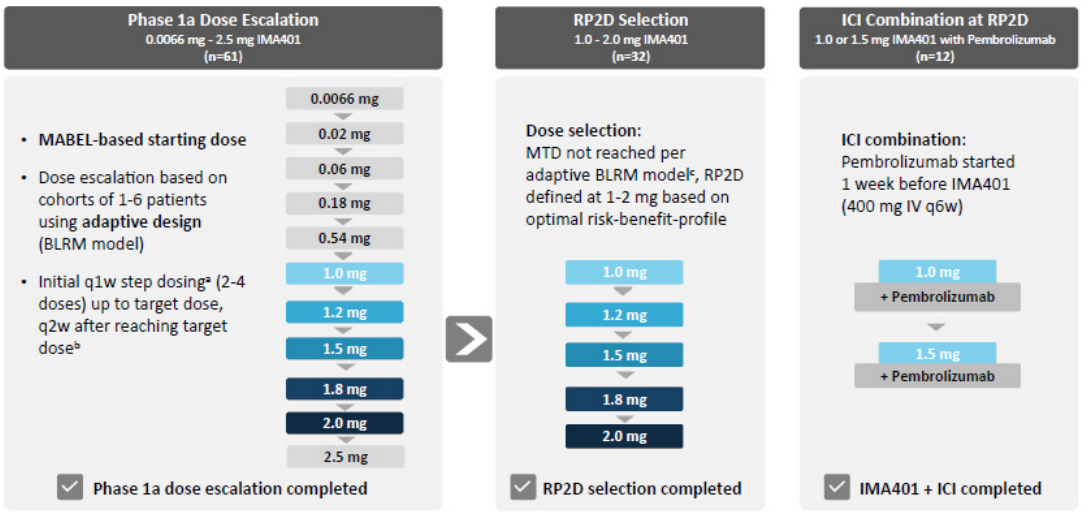
Tolerability	Activity & Duration of Response[1]	Pharmacokinetics	Development Potential
Favorable tolerability at RP2D ±pembrolizumab, suggesting the potential of IMA401 for broad combinability Most frequent clinically relevant TRAE were low-grade cytokine release syndrome (CRS), expected and transient lymphopenia, consistent with the mechanism of action, and manageable neutropenia.	• 29% cORR (4/14) in head and neck cancer • 33% cORR (2/6) in melanoma • Promising early clinical activity in sqNSCLC	**Median terminal half-life of >2 weeks** Potential for: • Flexibility in dosing schedules • Combination with IMA402 with or without ICI	Opportunity to develop IMA401 in combination with IMA402 in sqNSCLC and other indications Combined target prevalence supports broad patient coverage and potential synergistic activity >90% of patients with sqNSCLC are targetable



- **Phase 1a dose escalation completed**
- **IMA401/IMA402 combination cohort in sqNSCLC is now enrolling at multiple clinical trial sites, with first data expected in 2027**

[1] at RP2D of 1-2 mg; AE: Adverse Event; CRS: Cytokine Release Syndrome; (c)ORR: (confirmed) objective response rate; DCR: disease control rate; ICI: immune checkpoint inhibitor; HNSCC: Head and neck squamous cell carcinoma; sqNSCLC: squamous cell non-small-cell lung cancer

Phase 1 Basket Trial of IMA401 in MAGEA4/8 Solid Tumors



EudraCT No 2021-004326-30; NCT05359445; [a]Step dosing introduced at dose levels ≥1 mg, low-dose dexamethasone partially used as preventive measure for initial doses as applied for other bispecific T-cell engagers; ability to increase dose to previously cleared dose levels; [b]q2w: once every two weeks, weekly (q1w) IMA401 dosing was applied up to 0.54 mg; [c]MTD was not reached at 2.5 mg as defined by the adaptive BLRM model specifying probabilities of DLTs at tested doses. BLRM, Bayesian logistic regression model; ICI, immune checkpoint inhibitor; IV, intravenous; MABEL, minimum anticipated biological effect level; MTD, maximum tolerated dose, RP2D, recommended phase 2 dose; q6w, every 6 weeks.

Phase 1 Basket Trial of IMA401 in MAGEA4/8 Solid Tumors

Highly heterogenous patient population with >15 different indications

Different Indications (all dose levels)	# of Patients
H&N (squamous, adenocarcinoma, others)	16
Melanoma (Cutaneous & Mucosal)	8
Synovial Sarcoma	8
sqNSCLC	4
TNBC	4
adNSCLC	3
Ovarian Carcinoma	3
Gastric Cancer	2
SCLC	2
Urothelial Carcinoma	2
Bladder Carcinoma	1
Esophageal Carcinoma	1
Gallbladder Adenocarcinoma	1
LCNEC Esophageal	1
LCNEC Lung	1
NET CUP	1
Non-melanoma Skin Cancer (Squamous)	1
Penile Cancer	1
Testicular GCT	1

Baseline Characteristics	All Dose Levels	RP2D (1-2 mg)	
	IMA401 ± Pembrolizumab n=61	IMA401 (Monotherapy) n=32	IMA401 + Pembrolizumab[b] n=12
Age (years), median (min, max)	62 (19, 82)	62 (19, 82)	63 (33, 77)
Sex, male/female n (%)	39 (64)/ 22 (36)	19 (59)/ 13 (41)	12 (100)/ 0 (0)
ECOG performance status			
0, n (%)	21 (34)	11 (34)	6 (42)
1, n (%)	38 (62)	20 (63)	6 (50)
2, n (%)	2 (3)	1 (3)	0
LDH at baseline			
< 1xULN, n (%)	36 (59)	17 (53)	8 (67)
1-2xULN, n (%)	21 (34)	14 (44)	4 (33)
> 2xULN, n (%)	4 (7)	1 (3)	0
Baseline tumor burden			
Target lesion SLD [mm], median (range)	67 (11.3, 202.8)	60 (11.3, 202.8)	63.1 (15.5, 121.0)
Tumor lesions			
Number of lesions, median (min, max)	4 (1, 10)	4 (1, 10)	4.5 (2, 10)
Liver metastases, n (%)	18 (30)	10 (31)	4 (33)
Brain metastases, n (%)	4 (7)	2 (6)	0
Treatment Experience			
No. of prior lines of systemic treatment median (min, max)	3 (1, 8)	4 (1, 8)	3 (1, 4)
Prior treatments, n (%)			
Chemotherapy	52 (85)	25 (78)	11 (92)
ICI	40 (66)	18 (56)	11 (92)
Targeted Therapy[a]	41 (67)	22 (69)	9 (75)
Hormone Therapy	4 (7)	2 (6)	0
Others	7 (11)	4 (13)	0

[a] Includes small molecule drugs and antibodies. [b]IMA401 dose in pembrolizumab expansion cohorts were 1 mg (n=8) or 1.5 mg (n=4); adNSCLC, adenocarcinoma non-small cell lung cancer; ECOG, Eastern Cooperative Oncology Group; GCT, germ cell tumor; H&N, head and neck; HNSCC, head and neck squamous cell carcinoma; ICI, immune checkpoint inhibitor; LCNEC, large cell neuroendocrine carcinoma; LDH, lactate dehydrogenase; NET CUP, neuroendocrine tumor of cancer of unknown primary; RP2D, recommended phase 2 dose; SCLC, small cell lung cancer; SLD, sum of longest diameter(s); sqNSCLC, squamous cell non-small cell lung cancer; TNBC, triple-negative breast cancer; ULN, upper limit of normal.

Tolerability of IMA401 Monotherapy

	All treated patients		IMA401 (Monotherapy)			
Treatment-related Adverse Events (safety analysis set)	**All Dose Levels** N=61		**1-2 mg (RP2D)** n=32		**> 2 mg** n=7	
TRAEs[a], n (%)	All Grades	≥ Grade 3	All Grades	≥ Grade 3	All Grades	≥ Grade 3
Any TRAE	54 (89)	31 (51)	28 (88)	16 (50)	7 (100)	7 (100)
Cytokine release syndrome	23 (38)	0	12 (38)	0	3 (43)	0
Lymphopenia	20 (33)	16 (26)	9 (28)	7 (22)	5 (71)	5 (71)
Neutropenia	19 (31)	11 (18)	11 (34)	5 (16)	5 (71)	5 (71)
Thrombocytopenia	10 (16)	2 (3)	5 (16)	0	3 (43)	2 (29)
Leukopenia	9 (15)	5 (8)	7 (22)	4 (13)	1 (14)	1 (14)
Headache	9 (15)	2 (3)	7 (22)	1 (3)	2 (29)	1 (14)
Anaemia	8 (13)	7 (11)	2 (6)	2 (6)	4 (57)	3 (43)
Facial pain	7 (11)	2 (3)	0	0	4 (57)	1 (14)
ALT increased	7 (11)	1 (2)	3 (9)	1 (3)	1 (14)	0
Pyrexia	7 (11)	0	2 (6)	0	1 (14)	0
AST increased	5 (8)	3 (5)	3 (9)	2 (6)	0	0
Hypertension	4 (7)	2 (3)	3 (9)	2 (6)	0	0
GGT increased	2 (3)	1 (2)	0	0	0	0
Hypoxia	2 (3)	1 (2)	0	0	0	0
C-reactive protein increased	1 (2)	1 (2)	1 (3)	1 (3)	0	0
Chest pain	1 (2)	1 (2)	0	0	0	0
Febrile neutropenia	1 (2)	1 (2)	0	0	1 (14)	1 (14)
Pneumonia	1 (2)	1 (2)	0	0	1 (14)	1 (14)
Sinus tachycardia	1 (2)	1 (2)	1 (3)	1 (3)	0	0

Manageable tolerability profile with mostly transient AEs, consistent with MoA

- **Most common AEs:**
  - Low-grade CRS (38% G1-G2, no ≥G3), mainly at first step dose, resolving within 1-3 days
  - Transient, mechanism-related lymphopenia
  - Mostly transient neutropenia, manageable with dexamethasone and G-CSF; not recurring after resolution with continued IMA401 treatment
- **No ICANS observed**
- **MTD not reached**
- Neutropenia-related DLTs in 5 patients (incl. 3 at >RP2D[b])
- **No DLTs at RP2D with dexamethasone premedication**

[a] All TRAEs at least possibly related to IMA401 infusion and/or pembrolizumab infusion with grade 1-2 occurring in at least 10% of all patients, all events with ≥ grade 3; [b] in patients with and without dexamethasone pre-medication, one possibly related death (pneumonia in the context of lung tumor progression and concurrent neutropenia) as previously reported, patient did not receive dexamethasone pre-medication; ALT, alanine aminotransferase; AST, aspartate aminotransferase; CSF, colony-stimulating factor, CRS, cytokine release syndrome, DLT, dose-limiting toxicity; ICANS, immune effector cell-associated neurotoxicity syndrome; GGT, gamma-glutamyltransferase; MoA, mechanism of action; RP2D, recommended phase 2 dose; TRAE, treatment-related adverse event.

Tolerability of IMA401 at RP2D ± Pembrolizumab

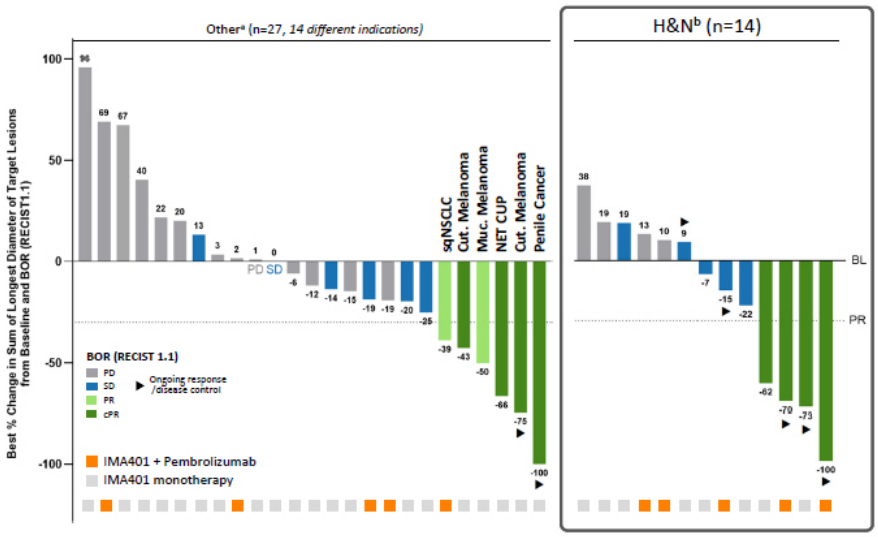
	IMA401 (Monotherapy)		IMA401 + Pembrolizumab	
Treatment-related Adverse Events (safety analysis set)	**1-2 mg (RP2D)** n=32		**1-2 mg (RP2D)[b]** n=12	
TRAEs[a], n (%)	All Grades	≥ Grade 3	All Grades	≥ Grade 3
Any TRAE	28 (88)	16 (50)	11 (92)	3 (25)
Cytokine release syndrome	12 (38)	0	5 (42)	0
Lymphopenia	9 (28)	7 (22)	4 (33)	2 (17)
Neutropenia	11 (34)	5 (16)	1 (8)	0
Thrombocytopenia	5 (16)	0	1 (8)	0
Leukopenia	7 (22)	4 (13)	1 (8)	0
Headache	7 (22)	1 (3)	0	0
Anaemia	2 (6)	2 (6)	0	0
Facial pain	0	0	0	0
Alanine aminotransferase increased	3 (9)	1 (3)	2 (17)	0
Pyrexia	2 (6)	0	3 (25)	0
Aspartate aminotransferase increased	3 (9)	2 (6)	1 (8)	0
Hypertension	3 (9)	2 (6)	0	0
Gamma-glutamyltransferase increased	0	0	1 (8)	1 (8)
Hypoxia	0	0	0	0
C-reactive protein increased	1 (3)	1 (3)	0	0
Chest pain	0	0	0	0
Febrile neutropenia	0	0	0	0
Pneumonia	0	0	0	0
Sinus tachycardia	1 (3)	1 (3)	0	0

ICI-associated toxicities	Any group analyzed
Immune-mediated colitis	0
Immune-mediated pneumonitis	0
Immune-mediated hepatitis	0
Nephritis	0
Adrenal insufficiency	0
Immune-mediated hypophysitis	0

No overlapping and/or additive toxicity observed in the combination cohort, supporting IMA401 combinability with ICIs.

[a] All TRAEs at least possibly related to IMA401 infusion and/or pembrolizumab infusion with grade 1-2 occurring in at least 10% of all patients, all events with ≥ grade 3 and typical ICI-associated toxicities; [b] IMA401 dose in pembrolizumab expansion cohorts were 1 mg (n=8) or 1.5 mg (n=4); ICI, immune checkpoint inhibitor; RP2D, recommended phase 2 dose; TRAE, treatment-related adverse event.

Anti-Tumor Activity of IMA401 at RP2D ± Pembrolizumab



H&N (n=14)

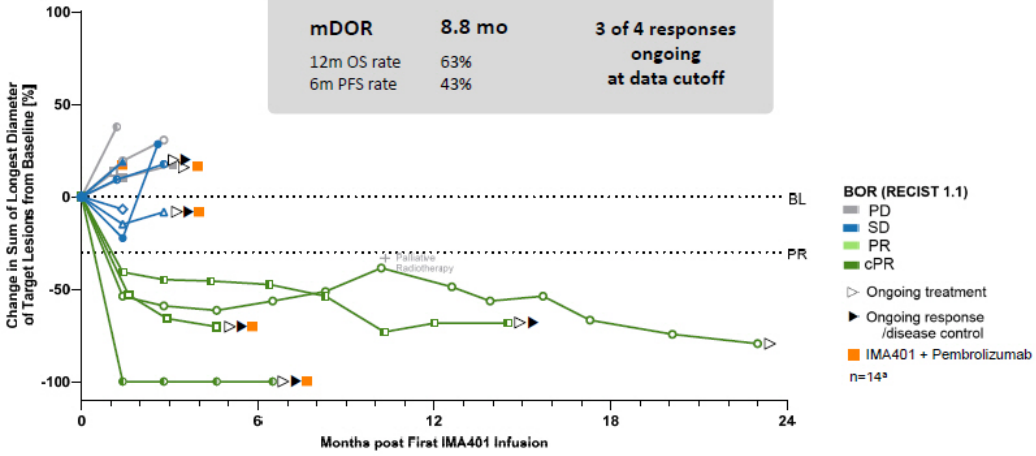
cORR	29% (4/14)
DCR	64% (9/14)

All H&N responders achieved deep responses with 60% - 100% tumor reduction

Efficacy population: all patients in the safety set who received 4 IMA401 infusions in monotherapy and in addition at least 1 pembrolizumab infusion in combination therapy and had a post-baseline efficacy assessment, including patients with clinical progression; [a]Two patients not shown in plot due to clinical progression before post-infusion scan. [b]One patient not shown in plot due to clinical progression before post-infusion scan. BOR, best overall response; (c)ORR, (confirmed) objective response rate; (c)PR, (confirmed) partial response; DCR, disease control rate; H&N, head and neck cancer; PD, progressive disease; PFS, progression-free survival; RECIST, response evaluation criteria in solid tumors; RP2D, recommended phase 2 dose; SD, stable disease; OS, overall survival; mDOR, median duration of response.

Durable Responses to IMA401 ± Pembrolizumab in Patients with H&N Cancer

mDOR	**8.8 mo**	**3 of 4 responses ongoing at data cutoff**
12m OS rate	63%	
6m PFS rate	43%	

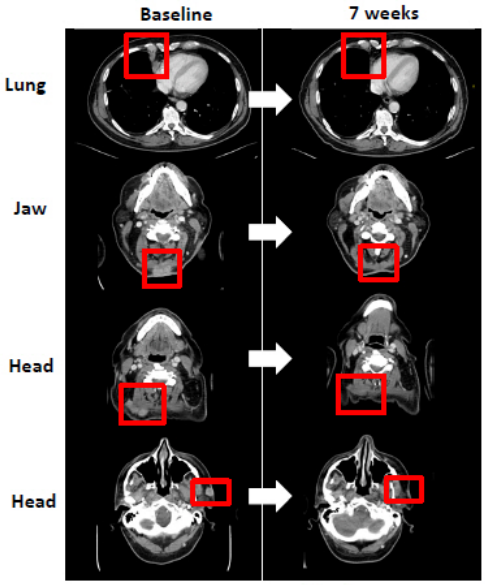


Efficacy population: all patients in the safety set who received 4 IMA401 infusions in monotherapy and in addition at least 1 pembrolizumab infusion in combination therapy and had a post-baseline efficacy assessment, including patients with clinical progression; [a]One patient not shown in plot due to clinical progression before post-infusion scan. BOR, best overall response; cPR, confirmed partial response; DOR, duration of response; H&N, head and neck cancer; PD, progressive disease; PR, partial response; RECIST, response evaluation criteria in solid tumors; RP2D, recommended phase 2 dose; SD, stable disease.

Patient Case: Partial Response after IMA401 + Pembrolizumab in sqNSCLC

Patient Characteristics & Outcome	
Patient & Diagnosis	63-year-old male with ICI-resistant sqNSCLC; initial diagnosis in July 2018
Disease at Baseline	Multiple metastases in lymph nodes, skin, lung and bone
Prior systemic therapy	4 prior lines of systemic therapy with BOR SD • Adjuvant: cisplatin, vinorelbine • Carboplatin, ipilimumab, nivolumab, paclitaxel, BOR: SD • Docetaxel, ramucirumab, BOR: SD • Progressed after all prior treatments • Carboplatin, gemcitabine, BOR: SD, discontinued early due to toxicity
Study Treatment[a]	1 mg IMA401 + 400 mg pembrolizumab Q6W; Pt died during a biopsy due to pulmonary haemorrhage
Response Assessment	PR at first scan post IMA401 treatment start with -39% tumor reduction

PR with IMA401 in 5th line ICI-resistant sqNSCLC patient with shrinkage of all target lesions



[a]Treatment start 5 weeks after last prior systemic therapy; scans courtesy of treating physician Prof. Dr. Martin Wermke, TU Dresden; BOR, best overall response; ICI, immune checkpoint inhibitor; PR, partial response; Pt, patient; Q6W, once every 6 weeks; SD, stable disease; sqNSCLC, squamous cell non-small cell lung cancer.

immatics

THE PRAME LEADER

Making a Meaningful Impact
on the Lives of Patients with Cancer

Appendix

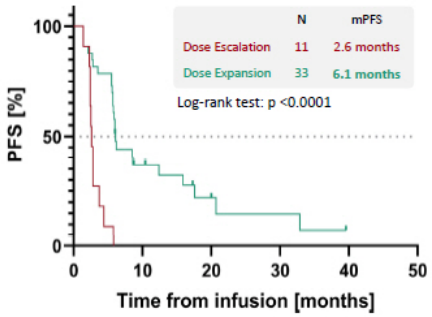


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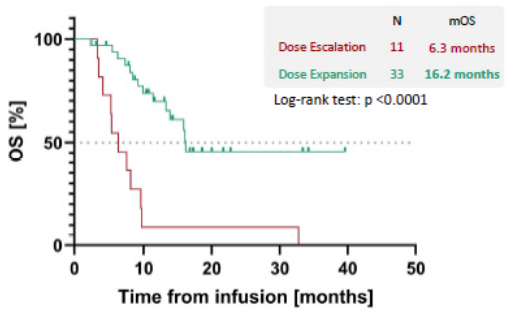
Anzu-cel Ph1 Trial: Significant Shift in PFS and OS Between Dose Escalation & Dose Expansion

PFS of 6 Months and OS of 16 Months in Melanoma Efficacy Population

Progression Free Survival



Overall Survival

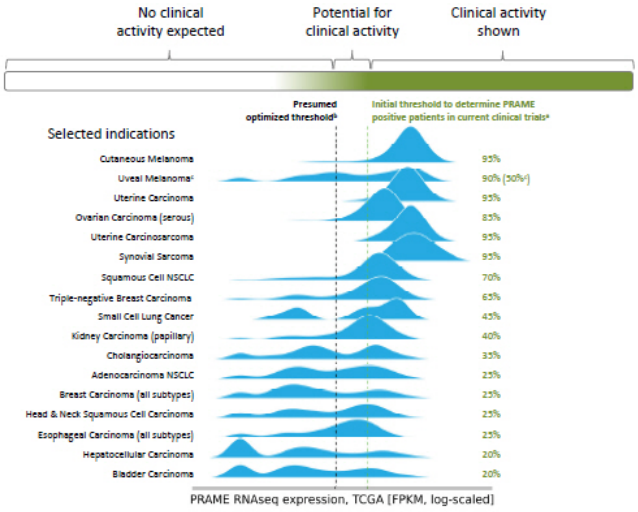


- Significant shift in mPFS and mOS between melanoma patients treated during the dose escalation and dose expansion
- mPFS in dose escalation is comparable to reported data in 2L+ cut. melanoma population*
- mOS in dose escalation is shorter than reported mOS for 2L+ cut. melanoma population*
- All patients in the dose escalation group deceased and 9/23 evaluable patients are alive in dose expansion#

Anzutresgene autoleucel (anzu-cel, formerly IMA203), Overall survival (OS) and progression-free survival (PFS) censored at data-cut; * These data are derived from different clinical trials at different points in time with differences in trial design and patient populations. As a result, cross-trial comparisons cannot be made, and no head-to-head clinical trials have been conducted
#10 patients out of study at data-cut (withdrew consent)

Potential of PRAME-Directed Therapies in Solid Cancers

PRAME Target Expression and Prevalences in Selected Solid Cancer Types



Hukelmann et al., SITC 2022, updated prevalences as of May 2025; [a] Data on file: PRAME target prevalence is based on a proprietary mass spec-guided initial expression threshold applied to TCGA or in-house (SCLC) RNAseq data (approximate values, values between 95-100% shown as 95%); [b] Presumed optimized threshold used for combination approaches (e.g. IMA402/IMA401) and cell therapies, including anzu-cel and IMA203CDR. [c] PRAME target prevalence in uveal melanoma based on IMADetect® qPCR testing of screening biopsies from clinical trial patients 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; NSCLC: non-small cell lung cancer

IMA203CD8 Shows Broad Clinical Activity across Diverse PRAME+ Solid Tumors

Clinical Activity in PRAME+ Tumors with Distinct Pathology / Biology

	Relative PRAME Expression	Immunological phenotype[a]	Clinical Activity
Melanoma	High	Hot	✓ *Busse et al, ESMO 2026*
Uterine cancer	High	Mixed	✓ *Busse et al, ESMO 2026*
Synovial sarcoma / Uveal melanoma	High	Cold	✓ *Busse et al, ESMO 2026*
Ovarian carcinoma	Low	Cold	✓ *Busse et al, ESMO 2026*

Clinical activity to date spans different PRAME levels, tumor biologies and tumor immune phenotypes, supporting broad applicability of IMA203CD8 for PRAME+ solid tumors, beyond the ones investigated

[a] Hot = T cell infiltrated/inflamed; Cold = non-T-cell infiltrated /non-inflamed according to Galon and Bruni, Nat Rev Drug Discov, 2019. Dominant phenotype for a tumor indication shown, intermediate "altered" immunological phenotypes not assessed for simplicity. Mixed: larger fractions of molecular subtypes exist with both, hot and cold immunological phenotype


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