Immatics
Corporate Presentation

August 18, 2026

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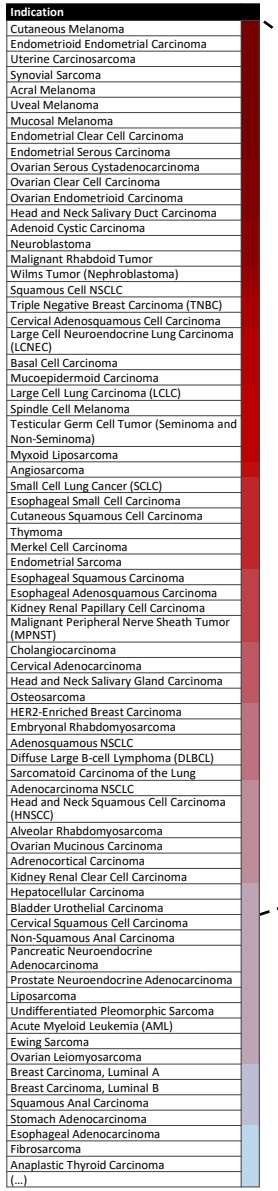
PRAME Is Expressed in More Than 50 Cancers

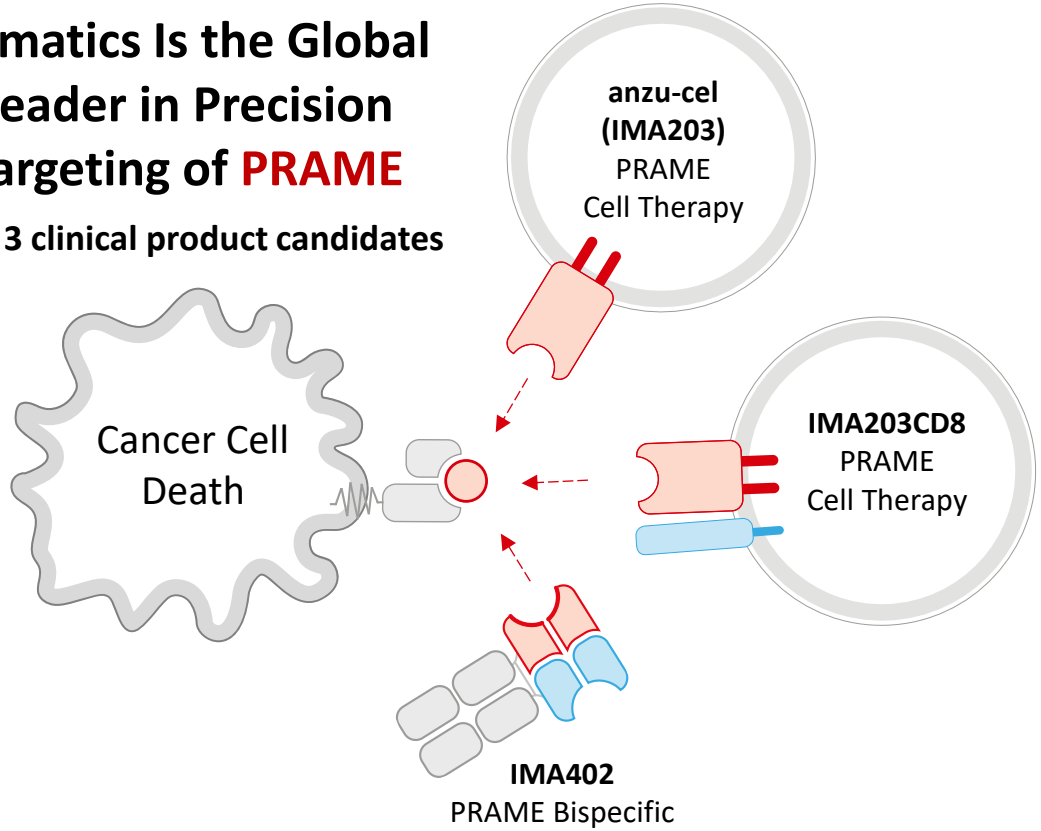


PRAME prevalence in selected indications

Indication	% PRAME+ patients[1]
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

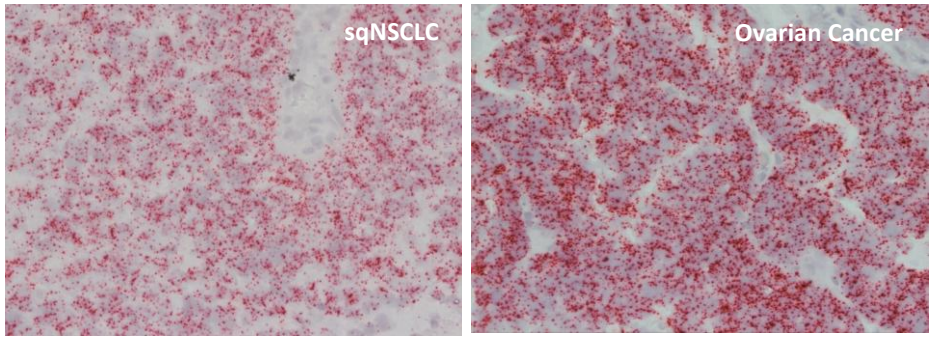
with 3 clinical product candidates



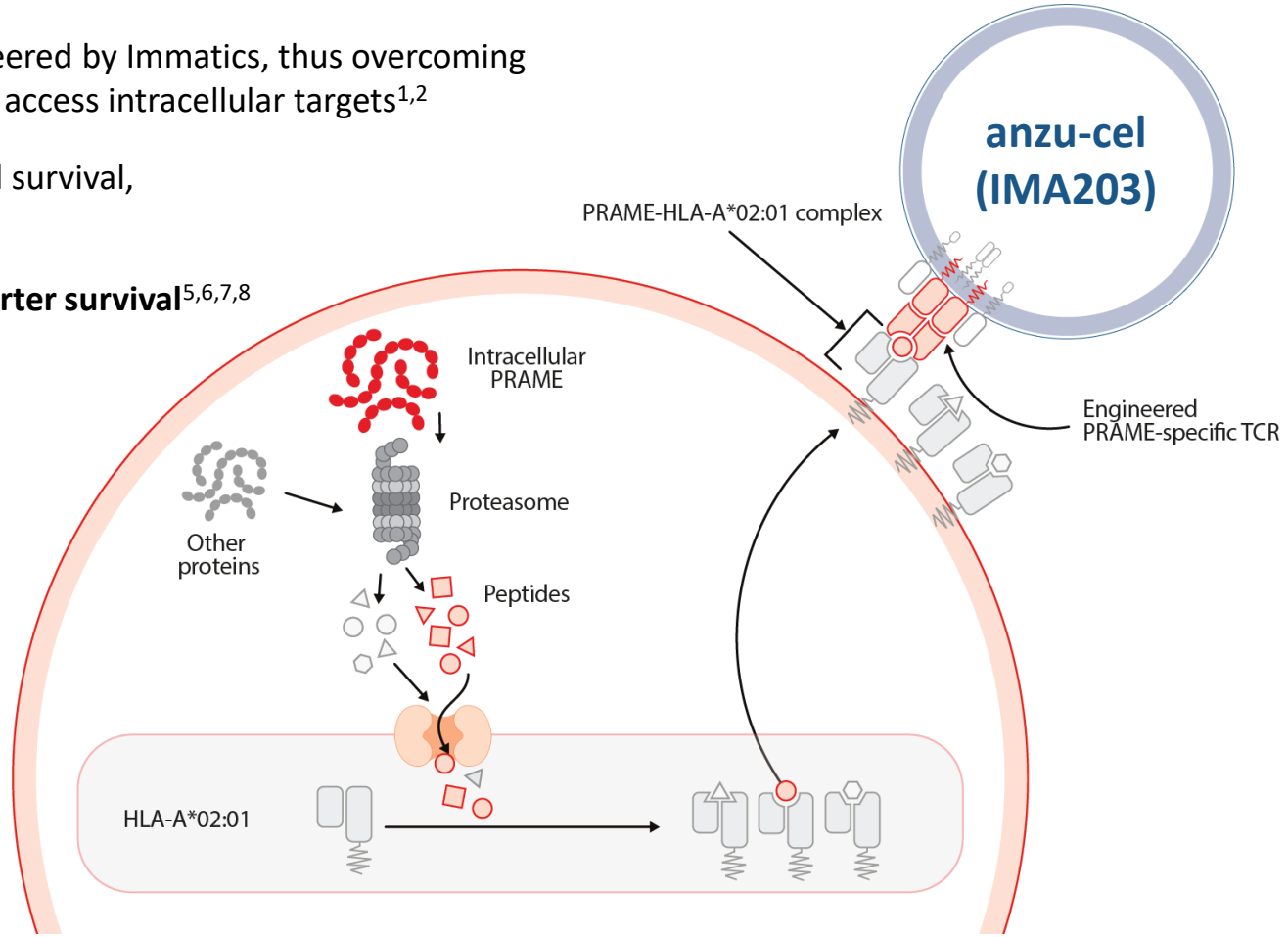
Anzutresgene autoleucel (anzu-cel, formerly IMA203), [1] Data on file: PRAME target prevalence is based on a proprietary initial mass spec-guided expression threshold applied to RNAseq and/or IHC data (approximate values, values between 95-100% shown as 95%); anzu-cel (IMA203), IM203CD8, IMA402 are being 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[#,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), #Activation of proliferative and survival pathways, including PI3K/AKT/mTOR[3], 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: Preclinical / 1a[1] / 1b[1] / 2 / 3
Anzu-cel (IMA203)	Cell therapy	2L melanoma[2]	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[3]	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[4]	Bispecific	Undisclosed	moderna	other	

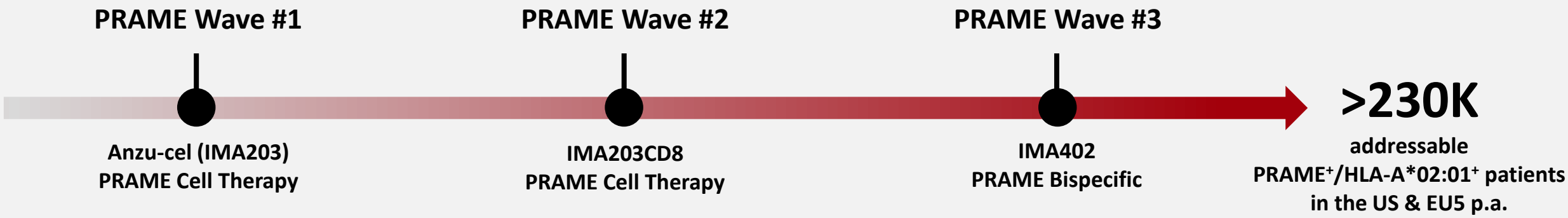
PRAME Franchise

- 3 Product Candidates
- 2 Therapeutic Modalities
- 3 Combinations

PRAME

Anzutresgene autoleucel (anzu-cel, formerly IMA203), [1] Phase 1a: Dose escalation, Phase 1b: Dose expansion; [2] 2L melanoma: patients with unresectable or metastatic melanoma who have received at least 1 prior PD-1 inhibitor; [3] In combination with immune checkpoint inhibitor (pembrolizumab or nivolumab/relatlimab; [4] mRNA-enabled *in vivo* expressed TCER® molecules; 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



Market entry in advanced melanoma

~9K addressable patients p.a.

Expansion to all advanced PRAME cancers

>75K addressable patients p.a.

Expansion to earlier-line PRAME cancers

>145K addressable patients p.a.

Anzu-cel (IMA203)

- Anzu-cel will be Immatics' **first PRAME therapy** to enter the market
- First target indications: **2L unresectable or metastatic melanoma[a]; metastatic uveal melanoma**

IMA203CD8

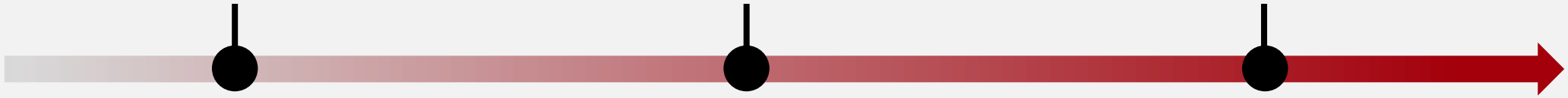
- Enhanced pharmacology provides potential to expand to **tumor-agnostic label in 2L PRAME solid cancers** beyond melanoma
- First target indications: **ovarian cancer, endometrial cancer**

IMA402

- Next-gen half-life extended bispecific as monotherapy or ICI/SOC combo in **earlier and later treatment lines**
- First target indications: **melanoma, gynecologic cancers, sqNSCLC (IMA402/IMA401 combination)**

Anzutresgene autoleucel (anzu-cel, formerly IMA203), All patient numbers refer to PRAME+/HLA-A*02:01+ patients in the US and EU5 in 2025; Source: Clarivate Disease Landscape and Forecast; EU5: France, Germany, Italy, Spain, United Kingdom;
[a] 2L: patients with unresectable or metastatic melanoma who have received at least 1 prior PD-1 inhibitor; 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



PRAME Wave #1

Anzu-cel (IMA203)
PRAME Cell Therapy

STATUS

- Orphan Drug and RMAT designation[1] by FDA
- **Phase 3 SUPRAME** trial in patients with advanced melanoma post PD-1 inhibitor ongoing; Primary endpoint: PFS
- **Phase 2 cohort** in patients with metastatic uveal melanoma ongoing

EXPECTED MILESTONES

- ☑ Data update from Ph1/2 trial in unresectable or metastatic melanoma and metastatic uveal melanoma: **ASCO 2026**
- ❑ Ph3 SUPRAME disclosure of topline data for final analysis[2]: **1H 2027**
- ❑ BLA submission: **2027**

PRAME Wave #2

IMA203CD8
PRAME Cell Therapy

STATUS

- GEN2 PRAME cell therapy leveraging CD8 and CD4 T cells
- Enhanced pharmacology
- Phase 1 study ongoing

EXPECTED MILESTONES

- ☑ Ph1a data update with focus on ovarian cancer at relevant doses at a major medical conference: **ASCO 2026**
- ☑ Ph1a dose escalation completed: **2026**
- ❑ Updated data across multiple PRAME-positive tumors: **ESMO 2026**

PRAME Wave #3

IMA402
PRAME Bispecific

STATUS

- Off-the-shelf Bispecific
- Next-gen, half-life extended format
- Phase 1b dose expansion ongoing

EXPECTED MILESTONES

- ☑ Initiation of addtl. Ph1b/Ph2 expansion cohorts in melanoma and gyn-onc: **2026**
- ☑ Initiation of IMA402/IMA401 combo in sqNSCLC: **2026**
- ❑ Ph1b data update at RP2D range: **ESMO 2026**
- ❑ Completion of Ph1b dose expansion with focus on melanoma and gyn-onc to determine the final RP2D: **2026**

>230K
addressable PRAME$^+$/HLA-A*02:01$^+$ patients in the US & EU5 p.a.

Anzutresgene autoleucel (anzu-cel, formerly IMA203), [1] Includes all benefits of Breakthrough Therapy Designation; [2] Pre-specified final analysis expected to be triggered upon the occurrence of a defined number of events for PFS (progressive disease or death); ICI: immune checkpoint inhibitor; sqNSCLC: squamous non-small-cell lung cancer

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

PRAME Cell Therapy

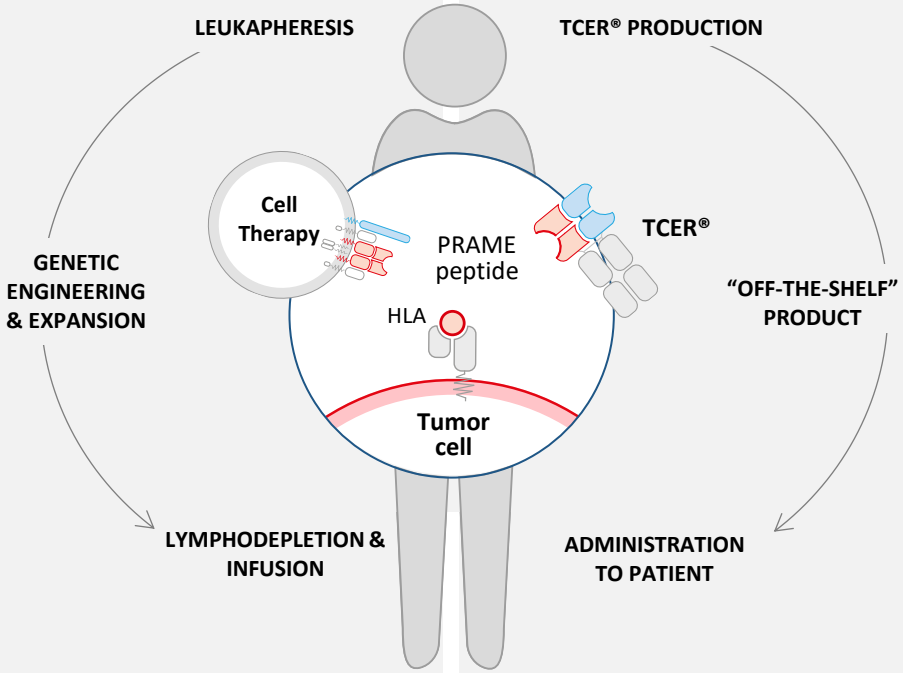
Modality: Autologous TCR T-cell Therapy

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[1]: ≥40% cORR, ≥6 months mDOR (monotherapy, 2L or later)



PRAME Bispecific

Modality: Half-life extended (HLE) bispecific T cell engager (TCER®)

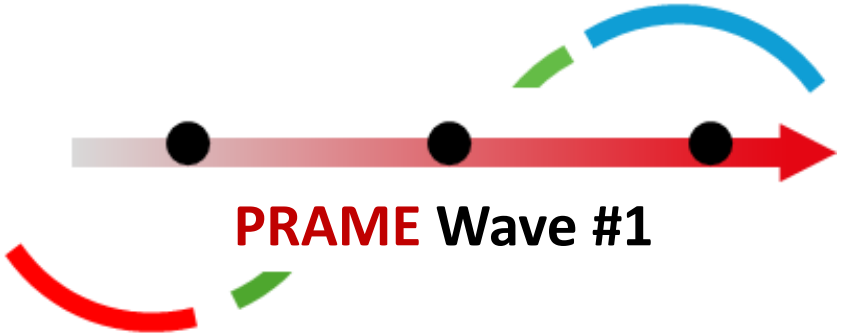
Application: Repeat dose

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[1]: ≥20% cORR, ≥6 months mDOR (monotherapy, 2L or later)

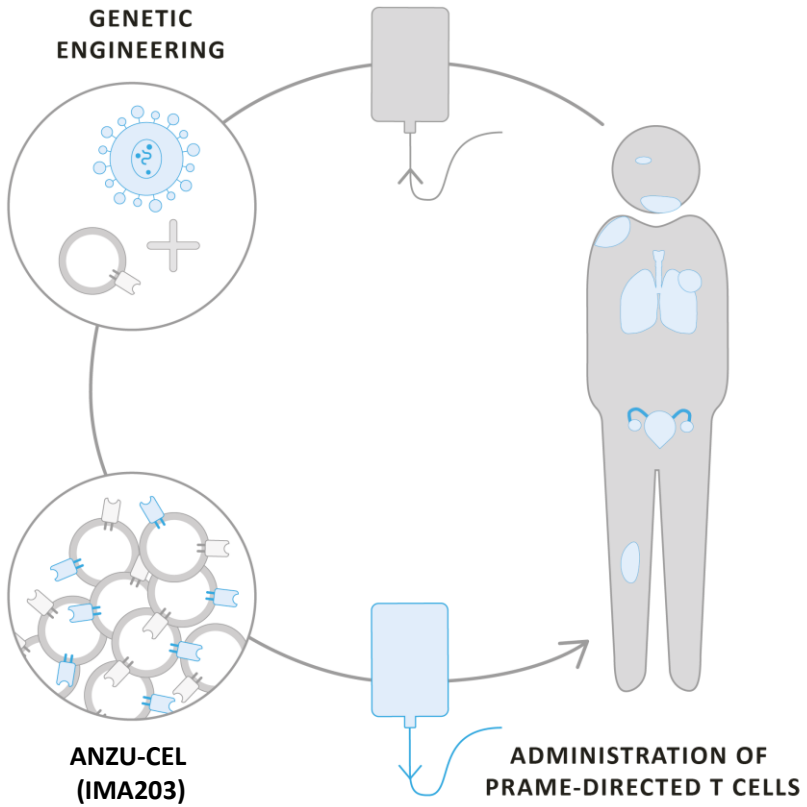
[1] Target product profile (TPP) in monotherapy in 2L or later settings post SOC at recommended phase 2 dose ("RP2D") for development beyond Ph1b. Other factors such as mPFS (median progression free survival) and mOS (median overall survival) may also be considered. SOC: standard of care



Anzu-cel (IMA203) PRAME Cell Therapy

Market Entry in Advanced Melanoma

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



~7.3K

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

~1.3K

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

Anzu-cel (IMA203) Opportunity

2L Unresectable or Metastatic Cutaneous Melanoma*

US	EU5
~3.7K	~3.6K

Metastatic Uveal Melanoma

US	EU5
~0.6K	~0.7K

Anzutresgene autoleucel (anzu-cel, formerly IMA203), all patient numbers refer to PRAME+/HLA-A*02:01+ patients in the US and EU5 in 2025; Source: Clarivate Disease Landscape and Forecast;
*2L: patients with unresectable or metastatic melanoma who have received at least 1 prior immune checkpoint inhibitor; EU5: France, Germany, Italy, Spain, United Kingdom

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

Positive Data and High Unmet Need

Predictable and Manageable Tolerability

Anticipated & manageable cytopenias associated with lymphodepletion

Mostly mild to moderate CRS

Infrequent ICANS

Potential for outpatient administration

Compelling Response Rate

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%)

Durable Responses

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

Rapid & Robust Manufacturing

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

Commercial Opportunity

~9K[b] addressable patients in US/EU5 in cutaneous and uveal melanoma,
~4.3K in the US alone

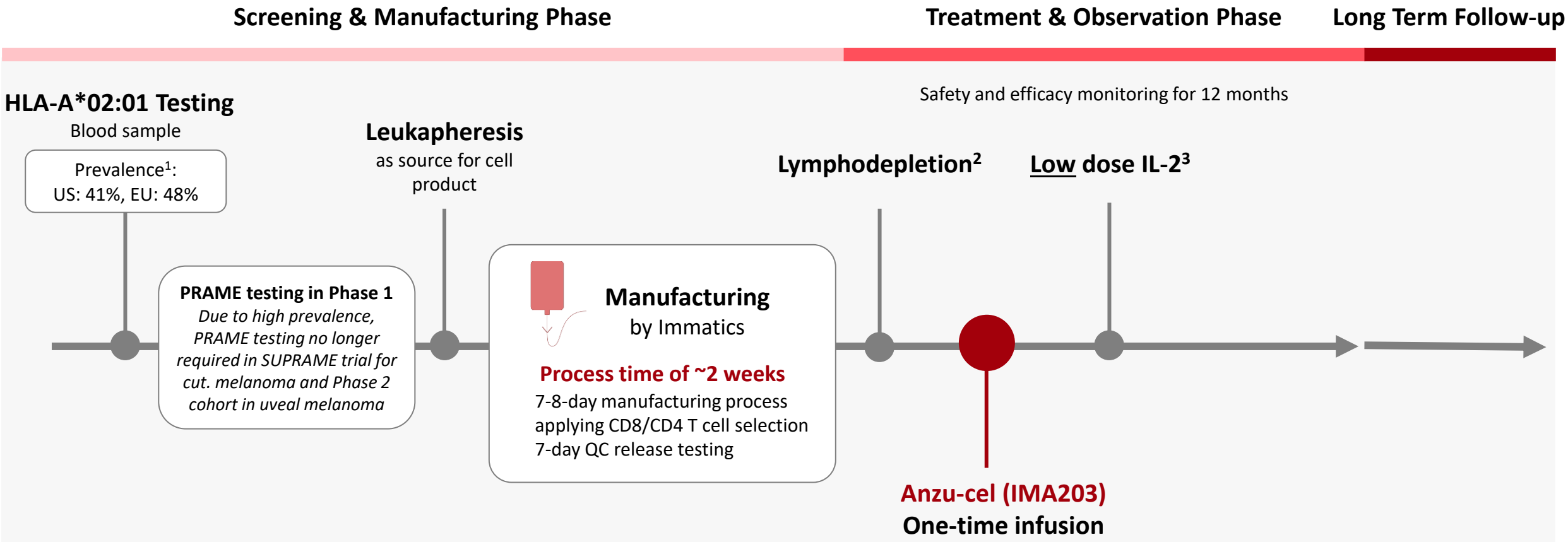
Orphan Drug Designation and RMAT designation[c] received for the treatment of both, cutaneous and uveal melanoma

SUPRAME: Phase 3 randomized trial of anzu-cel vs. investigator choice in 2L cutaneous 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: Clarivate Disease Landscape and Forecast 2025; [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%[4]**	**Predictable and manageable tolerability profile with potential outpatient administration – no high-dose IL-2**

Anzutresgene autoleucel (anzu-cel, formerly IMA203), [1] Gragert *et al.* 2013 and census numbers; HLA-A*02:01 prevalence in Immatics' clinical trials: US 65% and Germany 55% as of March 2025; [2] 30 mg/m² Fludarabine and 500 mg/m² Cyclophosphamide for 4 days; [3] 1m IU SC daily days 1-5 and twice daily SC days 6-10, total dose is approx. only 5% of the overall dose for high-dose IL-2 given typically with TIL therapy (Sarnaik et al. 2021 Journal of Clinical Oncology); [4] 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)	10.4 (1.5, 31)	12.1 (1.5, 31)	10.3 (3.1, 21)	8.7 (2.1, 17)
Target + non-target lesions, n, median (range)	6 (1, 20)	6 (1, 10)	7 (3, 13)	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 (%)			13 (81)	
Liver only / extrahepatic only, n (%)			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 a Predictable 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

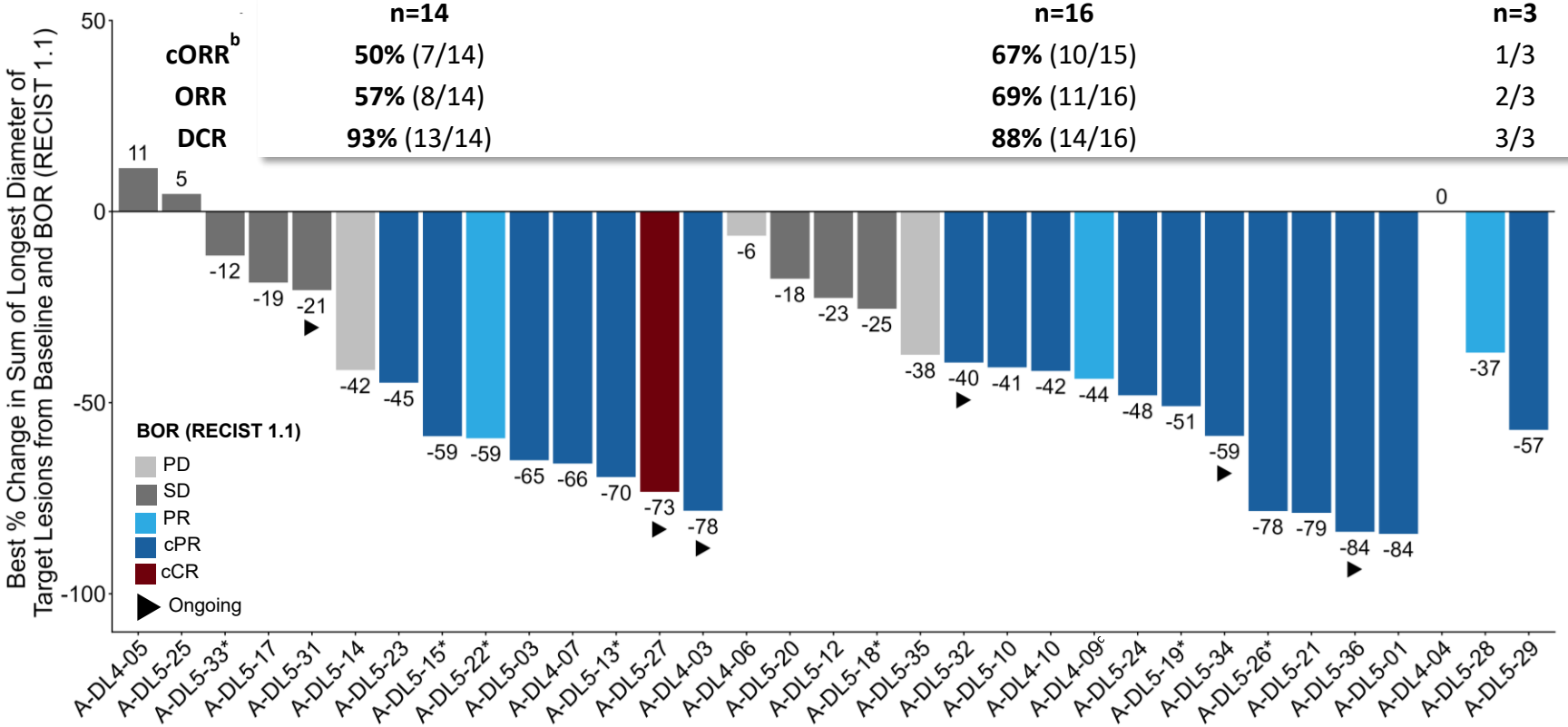
Immune-mediated AESIs occurred by Day 30 of TCR T-cell infusion

- 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 time 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

	Cutaneous Melanoma	Uveal Melanoma	Melanoma (other)[a]	All Melanoma
	n=14	n=16	n=3	n=33
cORR[b]	**50%** (7/14)	**67%** (10/15)	1/3	**56%** (18/32)
ORR	**57%** (8/14)	**69%** (11/16)	2/3	**64%** (21/33)
DCR	**93%** (13/14)	**88%** (14/16)	3/3	**91%** (30/33)

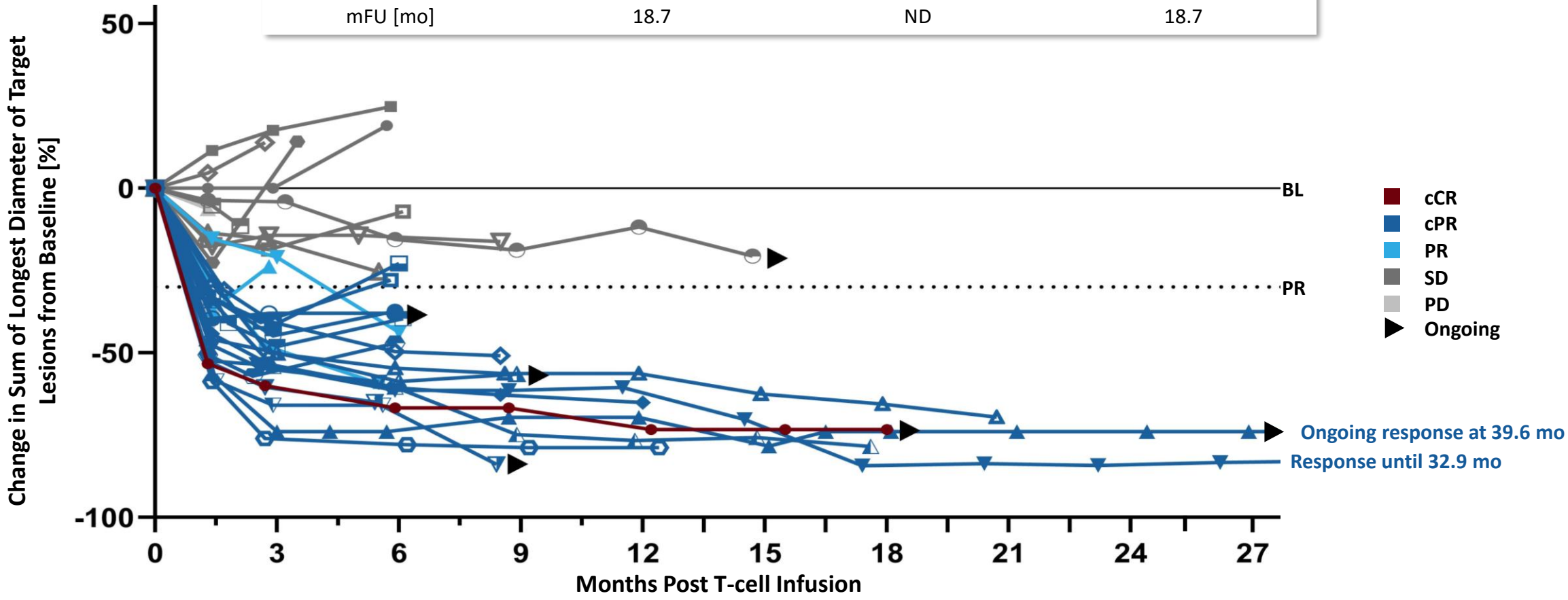


- Median time to BOR was 1.4 months (1.2-2.8)
- Most responders exhibit shrinkage of ≥1 lesion by first scan
- Responses observed in target and non-target lesions

[a] Includes melanoma (other) n=3: MM n=2, MUP n=1; [b] Exploratory analysis of 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. [c] Patient left study (withdrew consent) with ongoing unconfirmed PR.* Maximum change of target lesions and RECIST1.1 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

	Cutaneous Melanoma n=14	Uveal Melanoma n=16	All Melanoma[a] n=33
mDOR [mo] (range)	17.9 (4.2, 38.2+)	11 (4.4, 31.6)	**14.6** (4.2, 38.2+)
mFU [mo]	18.7	ND	18.7



[a] 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.

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

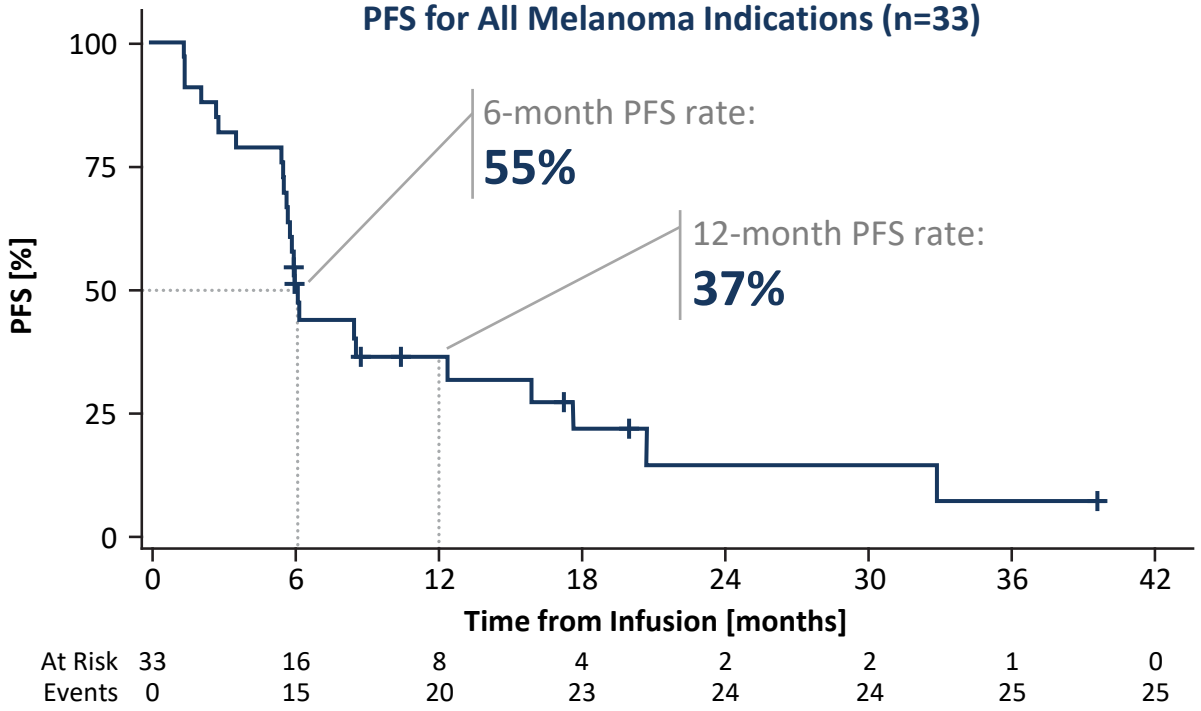
Median Progression Free Survival

	Cutaneous Melanoma n=14	Uveal Melanoma n=16	All Melanoma[a] 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

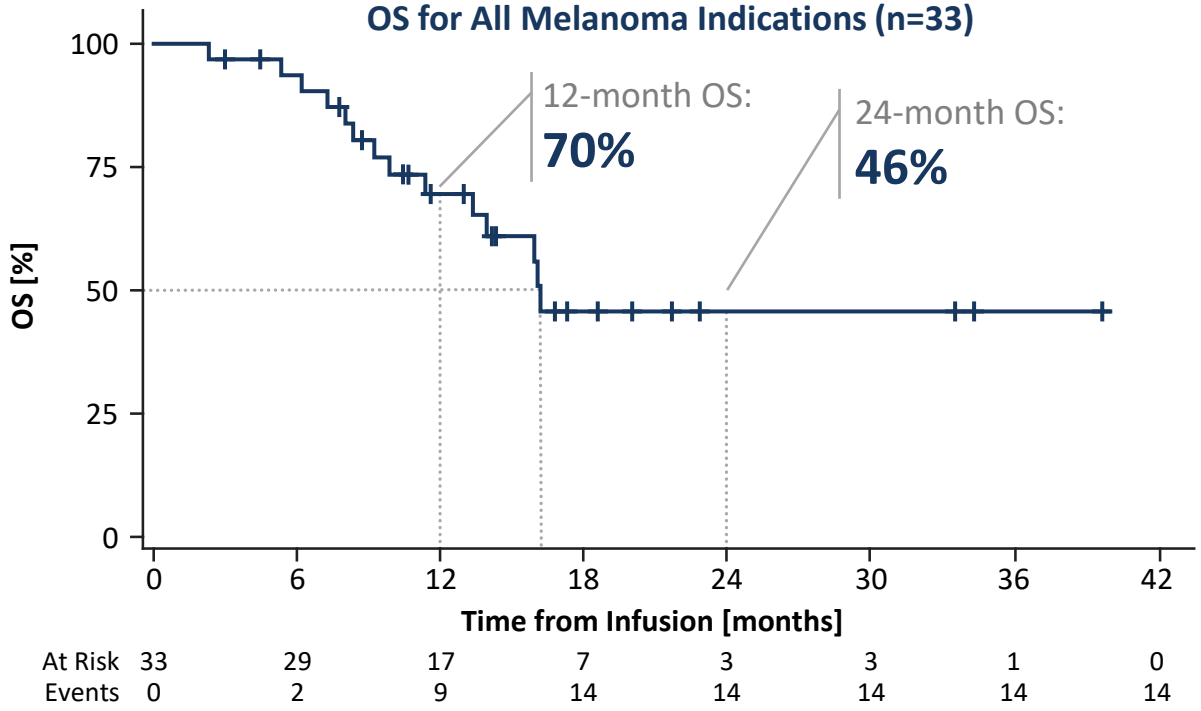
Median Overall Survival

	Cutaneous Melanoma n=14	Uveal Melanoma n=16	All Melanoma[a] 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

PFS for All Melanoma Indications (n=33)



OS for All Melanoma Indications (n=33)



[a] 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 Studies

PFS and OS Data in Melanoma Cohorts

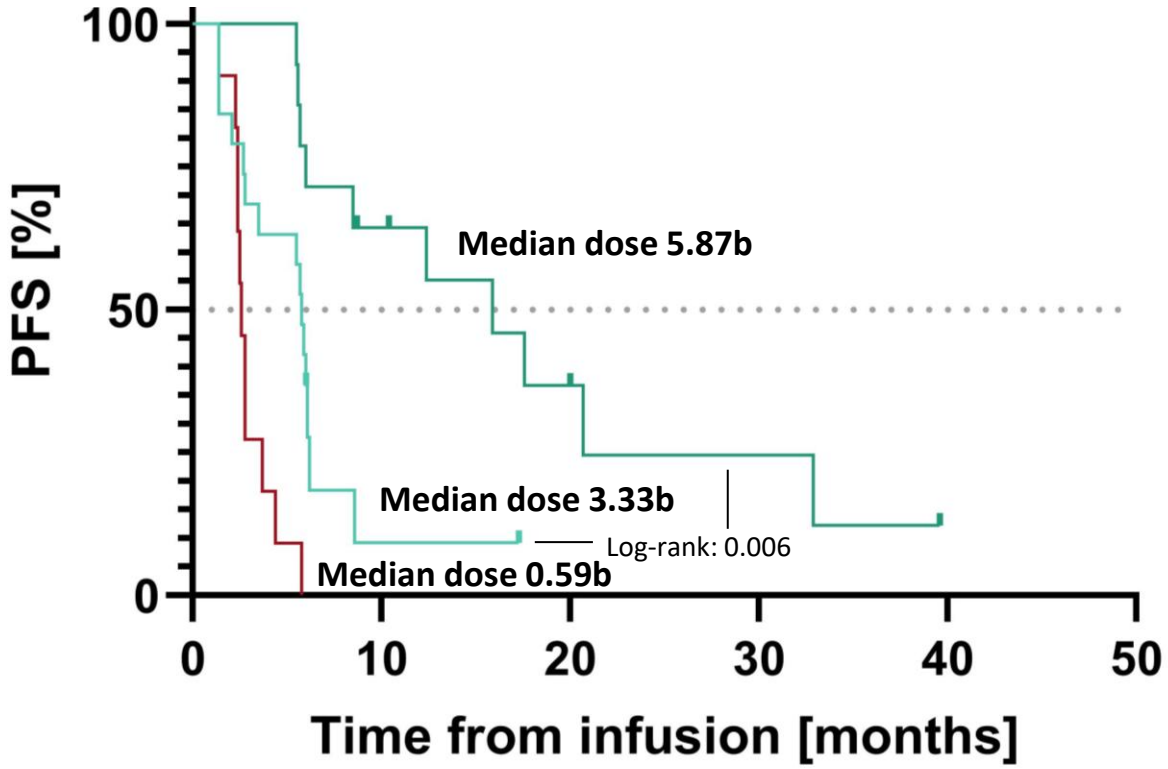
Drug Product	Phase	N	Melanoma patient population	Prior lines of therapies	mPFS (months)	mOS (months)
Anzu-cel in Melanoma	1b (Dose Expansion)	33	42% cutaneous 48% uveal 9% other	3% n=0, 24% n=1, 30% n=2, 24% n=3:, 6% n=4, 6% n=5, 6% n=6 82% received prior ICI (median of 1 prior line of ICI in overall 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

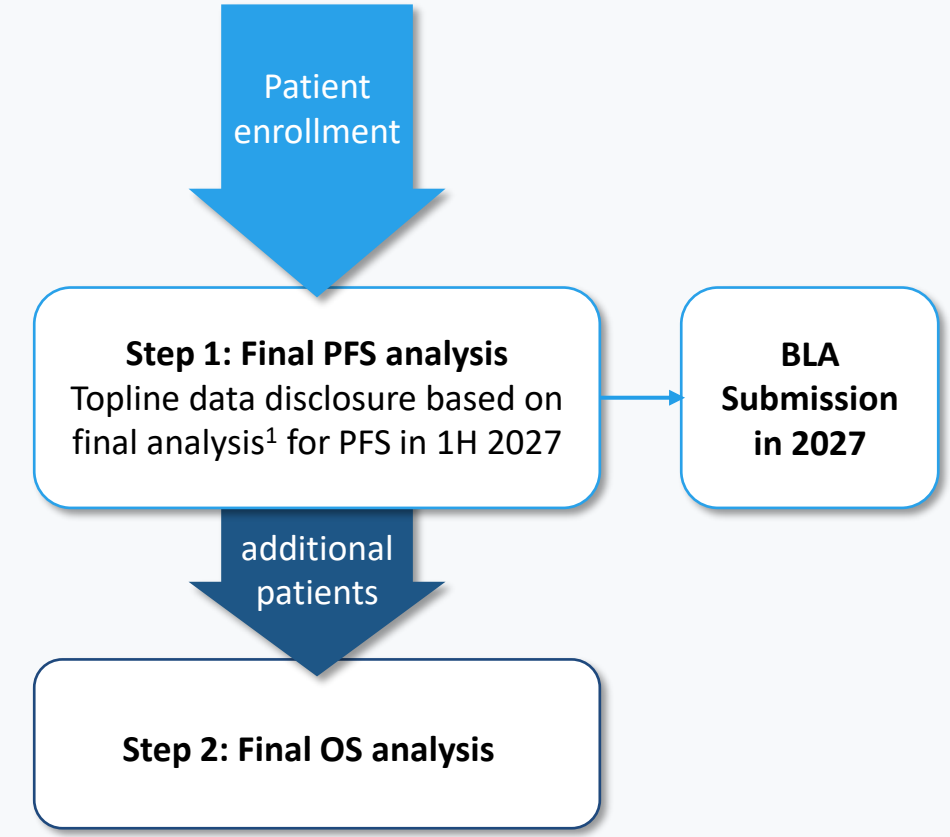
Patient Population:
Unresectable or metastatic melanoma post ICI
N=360
plus N=90 patients for increased OS power

Randomization 1:1

- **Anzu-cel (IMA203)**
- **Investigator's choice**
  nivolumab/relatlimab, nivolumab, ipilimumab, pembrolizumab, lifileucel, chemotherapy

Primary Endpoint	Key Secondary Endpoint	Secondary Endpoints
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



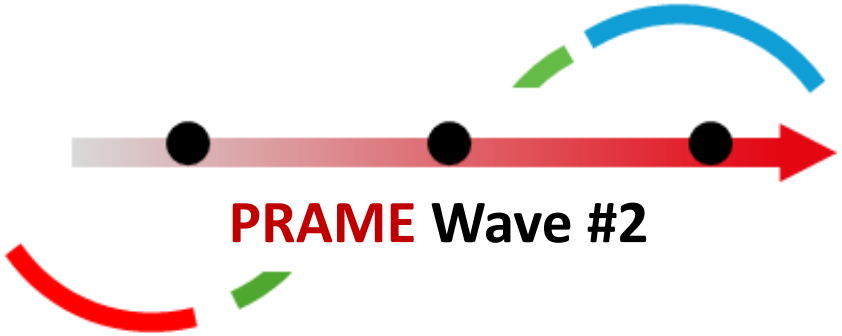
Anzutresgene autoleucel (anzu-cel, formerly IMA203 [1] Pre-specified final analysis will be triggered upon the occurrence of a defined number of events for primary endpoint PFS (progressive disease or death) statistically powered at 90%; ICI: immune checkpoint inhibitor; PFS: progression-free survival; 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

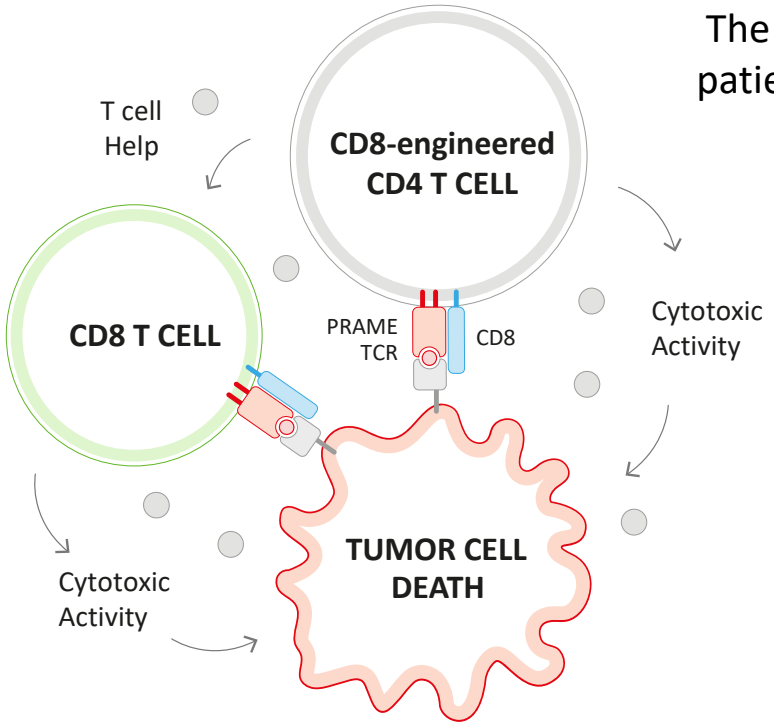
Anzutresgene autoleucel (anzu-cel, formerly IMA203); BLA: Biologics License Application



IMA203CD8 PRAME Cell Therapy

Expansion to all Advanced PRAME Cancers

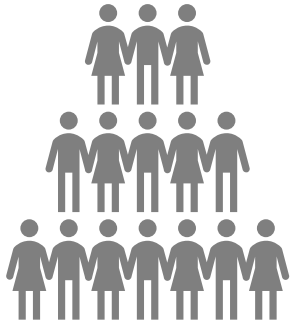
IMA203CD8 PRAME Cell Therapy:
Expansion of Commercial Opportunity to all Advanced PRAME Cancers



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

>75K

per year



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**

- 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

All patient numbers refer to PRAME⁺/HLA-A*02:01⁺ patients in the US and EU5 in 2025; Source: Clarivate Disease Landscape and Forecast; 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

Anticipated 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 PRAME-positive tumor indications with distinct biology and differing levels of PRAME expression

Deep & Durable Responses

- **Platinum-resistant ovarian cancer and in uterine cancer** at clinically relevant doses (DL4c+): 63% ORR, 50% cORR, incl. 4 complete responses, and longest ongoing response at 12 months
- **Synovial sarcoma** at low doses: 67% ORR and 64% cORR, including one complete response, and ongoing responses up to ~3 years across all doses at low median dose
- Responses were observed ± low-dose IL-2

Development Opportunity

IMA203CD8 to be positioned in tumor-agnostic setting of advanced PRAME+ cancers beyond melanoma, starting with gynecologic cancers

The Phase 1 trial could also support the positioning of IMA203CD8 without the requirement of post-infusion low-dose IL-2 in the future

Updated data across multiple PRAME-positive solid tumors are planned for presentation at the ESMO Congress 2026

AE: adverse event; cPR: confirmed partial response; RP2D: recommended phase 2 dose.

Phase 1 Multicenter Trial of IMA203CD8 in PRAME+ Solid Tumors

Key Objectives

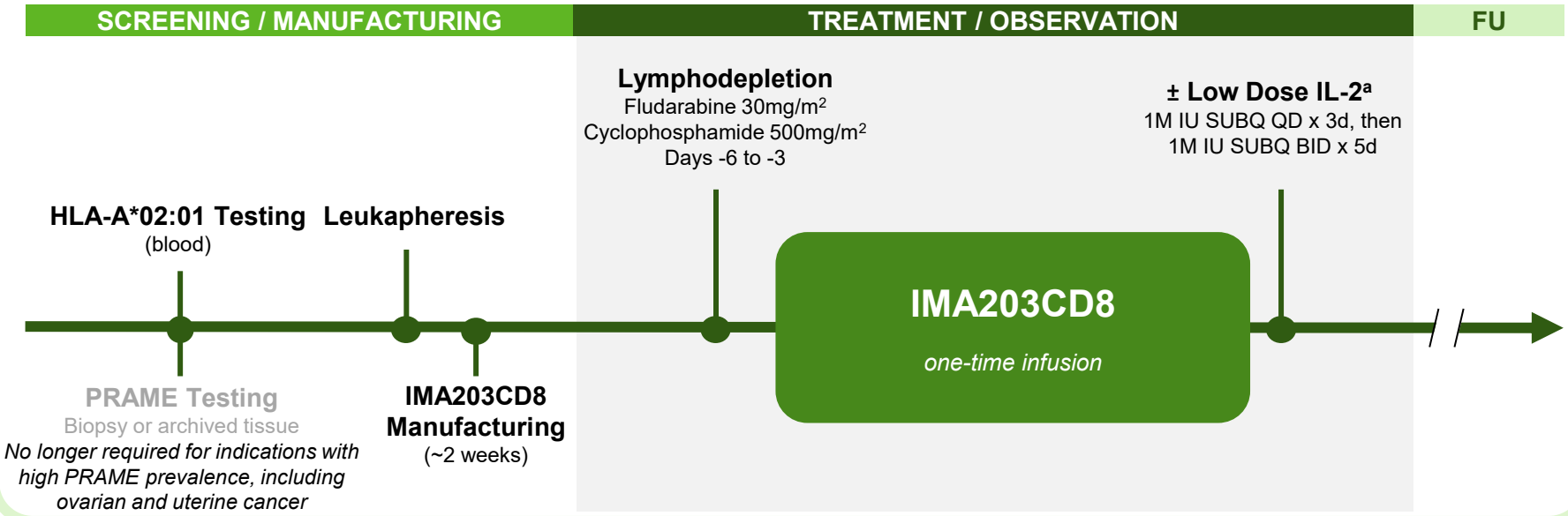
Primary:
- Tolerability
- Determination of RP2D

Secondary:
- Efficacy
- Pharmacokinetics

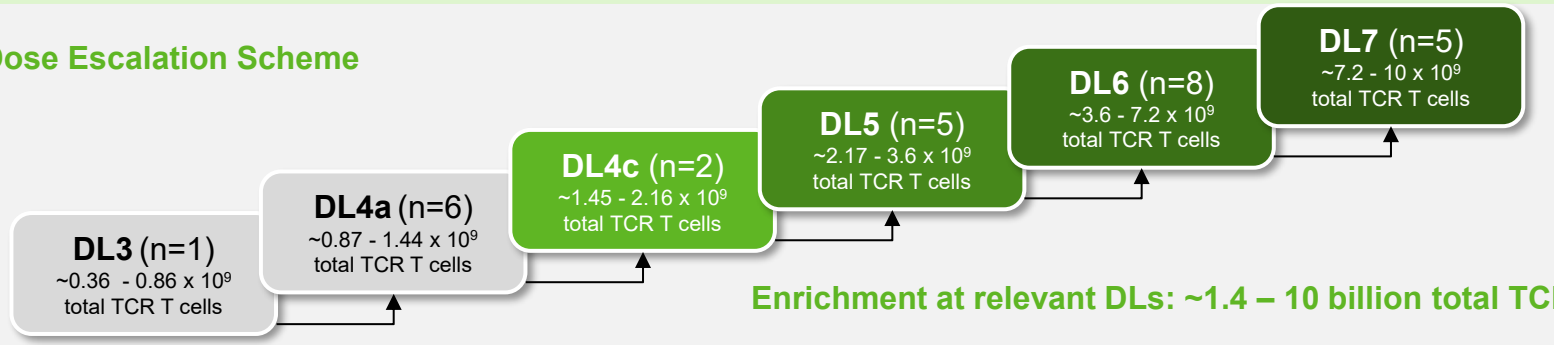
Key Eligibility Criteria

- 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

Patient Journey



Dose Escalation Scheme



Enrichment at relevant DLs: ~1.4 – 10 billion total TCR T cells

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 x 1.8 m² BSA; [a] Dose 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; outpt IL-2 admin. at investigator's discretion. BID, twice daily; BSA, body surface area; DL, dose level; ECOG PS, Eastern Cooperative Oncology Group Performance Status; FU, follow-up; IL, interleukin; IU, international unit; PRAME, preferentially expressed antigen in melanoma; QD, daily; SOC, standard of care; SUBQ, subcutaneous; TCR, T-cell receptor.

Patients Were Heavily Pretreated with Limited Treatment Options

Baseline Characteristics

	Ovarian Carcinoma	Uterine Cancer[a]
	n=24	n=3
Age, median (range)	60 (35, 75)	52 (49, 55)
ECOG PS 1, n (%)	10 (42)	0
LDH ≥1 x ULN, n (%)	8 (33)	2 (67)
Tumor burden Target lesion SLD [cm], median (range)	6.2 (1.5, 21.6)	8.1 (1.1, 12.4)
Number of target tumor lesions, median (range)	2 (1, 5)	4 (1, 4)
Cancer subtype, high-grade serous, n (%)	21 (88)	1 (33)
Liver metastasis, n (%)	10 (42)	2 (67)
Peritoneal disease, n (%)	17 (71)	3 (100)
Platinum-resistant, n (%)	19 (79)	na

Treatment Experience

	Ovarian Carcinoma	Uterine Cancer[a]
	n=24	n=3
Prior treatment, n (%)		
Radiation	4 (17)	1 (33)
Systemic treatment	24 (100)	3 (100)
Prior lines of systemic treatment		
Median, (range)	4 (1, 7)	2 (1, 3)
≥3, n (%)	22 (92)	1 (33)
Lines post-platinum resistance, med (range)	1 (0, 2)	na
Chemotherapy, n (%)	24 (100)	3 (100)
Lines of chemotherapy, median (range)	3 (1, 5)	1 (1, 1)
Platinum-based regimen, n (%)	24 (100)	3 (100)
Lines of platinum-based regimen, median (range)	3 (1, 4)	1 (1, 1)
Targeted therapies, n (%)		
Bevacizumab	18 (75)	-
PARPi	17 (71)	-
Checkpoint inhibitors	2 (8)	3 (100)

Dose	n=24	n=3
Total infused dose **TCR T cells [x10^9],** median (range)	3.3 (0.5, 12.5)	3.2 (1.3, 10.1)

n=27, includes all patients who started lymphodepletion; [a] Includes 1 patient with endometrial carcinoma; ADC, antibody-drug-conjugate; ECOG PS, Eastern Cooperative Oncology Group Performance Status; LDH, lactate dehydrogenase; na, not applicable; PARPi, PARP inhibitor; SLD, sum of longest diameter(s); TCR, T-cell receptor; ULN, upper limit of normal.

IMA203CD8: Safety in Patients with Gynecologic Indications (n=27[a])

TEAEs in ≥25% of patients

	Any Time	
Preferred term, n (%)	**Any grade**	**Grade ≥3**
Nausea	22 (81)	0
Neutropenia	20 (74)	20 (74)
Anaemia	18 (67)	17 (63)
Rash	16 (59)	3 (11)
Thrombocytopenia	16 (59)	11 (41)
Abdominal pain	13 (48)	2 (7)
Vomiting	12 (44)	0
Fatigue	11 (41)	0
Hypokalaemia	10 (37)	1 (4)
Constipation	9 (33)	0
Lymphopenia	9 (33)	9 (33)
Hypophosphataemia	8 (30)	2 (7)
Pyrexia	8 (30)	0
Hypomagnesaemia	7 (26)	1 (4)
Hyponatraemia	7 (26)	0

Adverse events of special interest

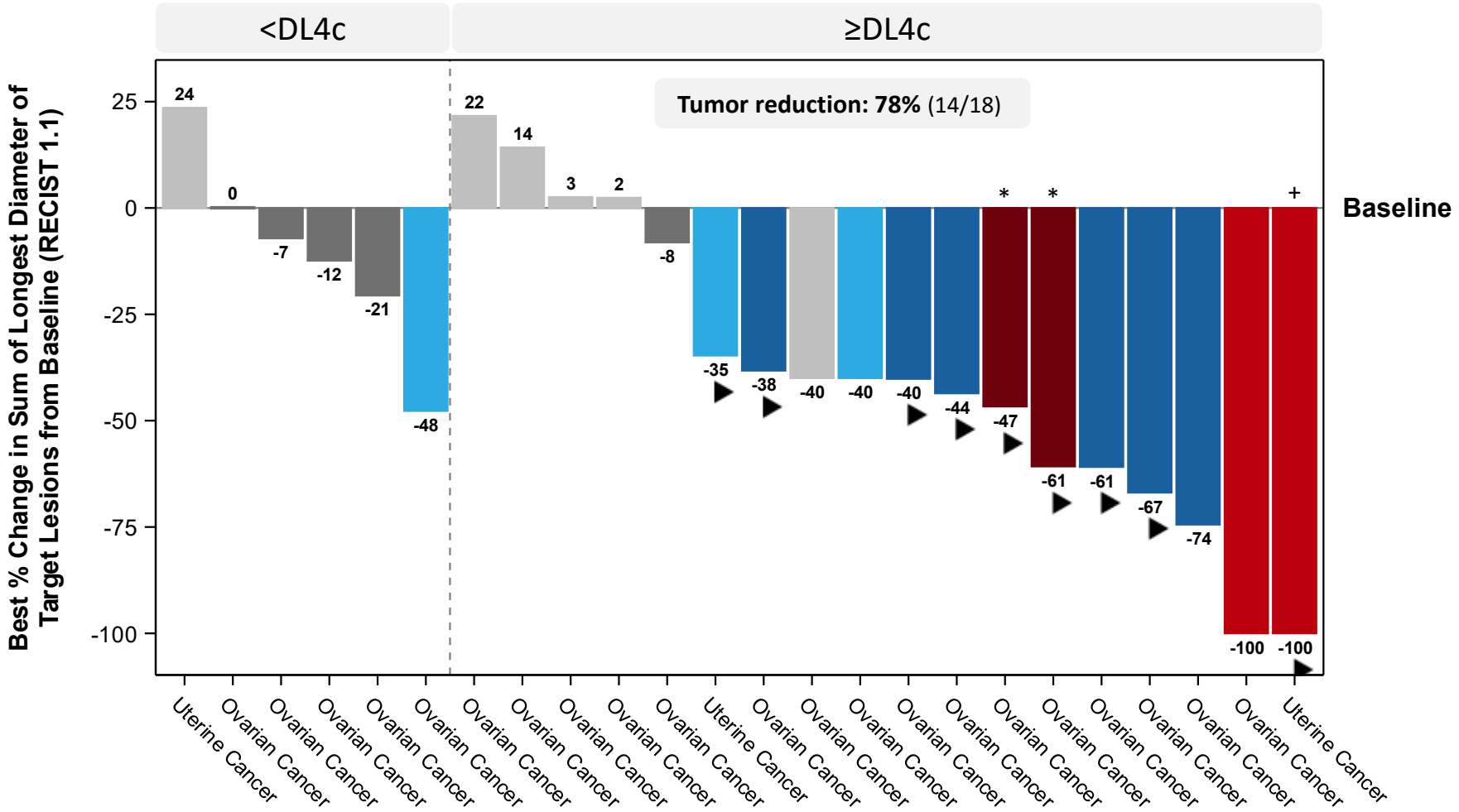
	Any Time
CRS, any grade, n (%)	**26 (96)**
Grade 1	12 (44)
Grade 2	12 (44)
Grade 3	2 (7)
HLH, any grade, n (%)	**2 (7)**
Grade 1	0
Grade 2	1 (4)
Grade 3	0
Grade 4	1 (4)
ICANS, any grade, n (%)	**2 (7)**
Grade 1	1 (4)
Grade 2	0
Grade 3	1 (4)

Overall manageable tolerability profile

- Most frequent TEAEs were anticipated cytopenias associated with lymphodepletion
- Expected and manageable CRS, mostly grade 1-2, consistent with mechanism of action
- 2 DLTs:
  - DL5: Grade 3 ICANS
  - DL7: Grade 4 skin infection
- MTD not reached
- No IMA203CD8-related grade 5 events[b]

Tolerability across all indications: Busse et al ESMO-IO, 2025.
[a] Includes all patients who started lymphodepletion; [b] One grade 5 event at DL4a (~1.4 billion total TCR T cells) was deemed to be unlikely related to IMA203CD8 by investigator. Patient died from sepsis in the setting of IEC-HS. This event led to further modifications of eligibility criteria to exclude patients at higher risk for infectious complications or severe immune-related toxicities, together with IL-2 de-intensification; no further treatment-emergent fatal events were observed with escalating doses up to ~10 billion total TCR T cells. AE, adverse event; CRS, cytokine release syndrome; d, day; DL, dose level; DLT, dose-limiting toxicity; HLH, hemophagocytic lymphohistiocytosis; ICANS, immune effector cell-associated neurotoxicity syndrome; TCR, T-cell receptor; TEAE, treatment-emergent adverse event.

IMA203CD8: BOR in Patients with Gynecologic Indications at All DL (n=26[a])



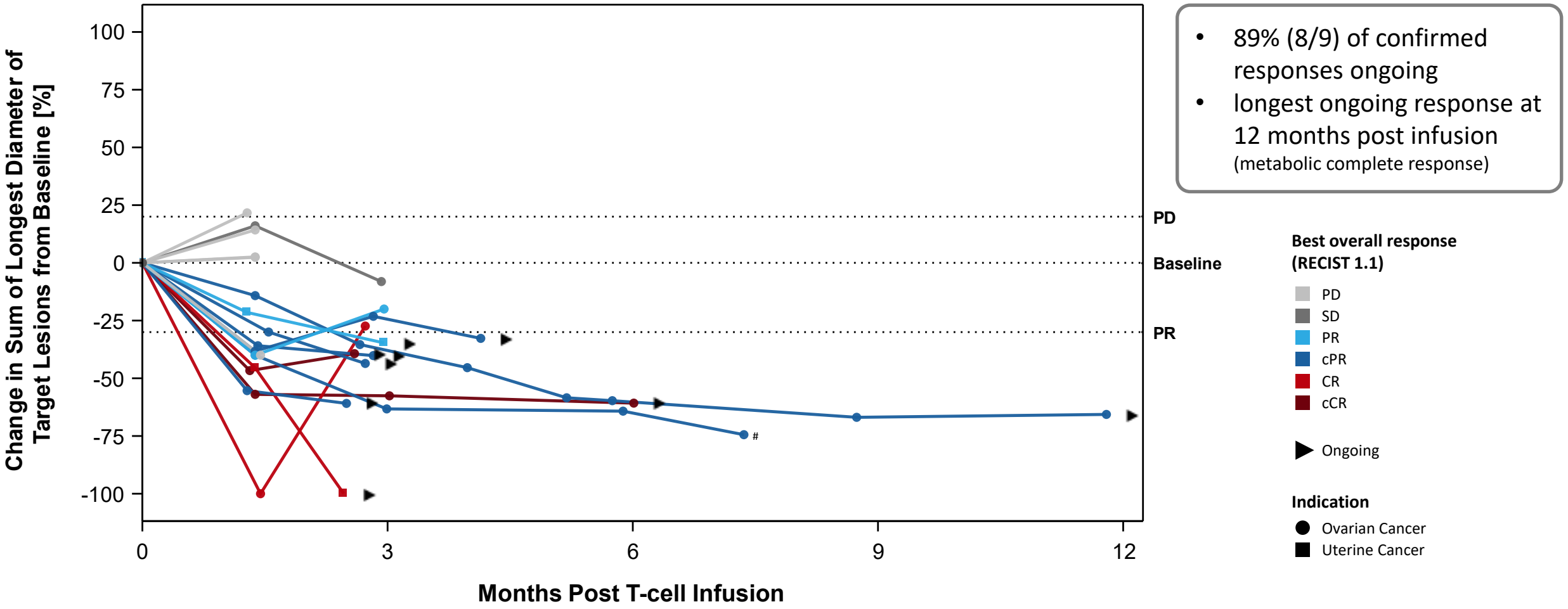
Evaluable patients ≥DL4c	
ORR[b]	**63%** (12/19)
cORR[c]	**50%** (9/18)
DCR (at week 6)	**68%** (13/19)

Best overall response (RECIST 1.1)

- PD
- SD
- PR
- cPR
- CR
- cCR
- ▶ Ongoing

[a] Two patients with ovarian cancer at DL4a and DL5 deceased prior to first post-BL scan non-evaluable for assessment of tumor reduction, not depicted in plot but assessed for ORR calculation; [b] ORR: according to RECIST 1.1 at any post-BL scan, PD or death at any prior timepoint; [c] 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. * For those patients who achieved a (c)CR with <100% changes from baseline, target lesions were lymph nodes that resolved to <10 mm per RECIST 1.1; * Patient had a PR prior to CR. BL, baseline; BOR, best overall response; (c)CR, (confirmed) complete response; DCR, disease control rate; DL, dose level; (c)ORR, (confirmed) objective response rate; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

IMA203CD8: Changes in Tumor Size Over Time in Patients with Gynecologic Indications ≥DL4c (n=19[a])



- 89% (8/9) of confirmed responses ongoing
- longest ongoing response at 12 months post infusion (metabolic complete response)

[a] One patient with ovarian cancer at DL5 deceased prior to first post-BL scan non-evaluable for assessment of tumor reduction, not depicted in plot but assessed for ORR calculation. For those patients who achieved 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. BOR, best overall response; (c)CR, (confirmed) complete response; DCR, disease control rate; (c)ORR, (confirmed) objective response rate; PD, progressive disease; (c)PR, (confirmed) partial response; SD, stable disease.

IMA203CD8: Safety in Synovial Sarcoma

TEAEs in ≥25% of patients (N=12)

	Any Grade	Grade ≥3
Neutropenia	12 (100)	12 (100)
Anemia	11 (92)	6 (50)
Thrombocytopenia	11 (92)	4 (33)
Transaminase elevation	11 (92)	1 (8)
Lymphopenia	9 (75)	9 (75)
Nausea	8 (67)	0
Fatigue	6 (50)	0
Rash	5 (42)	0
Creatinine elevation	4 (33)	1 (8)
Constipation	4 (33)	0
Headache	4 (33)	0
Hyponatremia	4 (33)	0
Hypophosphatemia	4 (33)	1 (8)
Pyrexia	4 (33)	0
Testicular/scrotal disorders[a]	4 (33)	0
Back pain	3 (25)	0
Dyspnoea	3 (25)	0
Hypertension	3 (25)	2 (17)
Insomnia	3 (25)	0
Edema peripheral	3 (25)	0

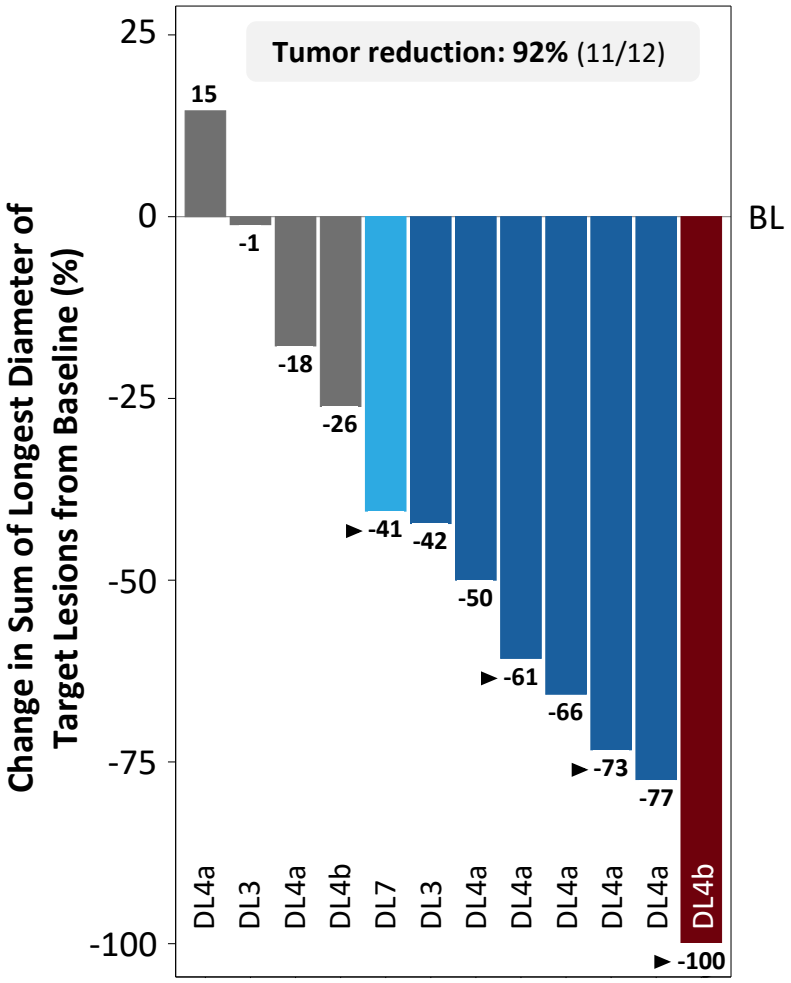
Adverse events of special interest (AESI)

	N=12
CRS, any grade, n (%)	**12 (100)**
Grade 1	5 (42)
Grade 2	5 (42)
Grade 3	2 (17)
HLH, any grade, n (%)	**0**
ICANS, any grade, n (%)	**0**

- Most frequent TEAEs were anticipated cytopenias associated with lymphodepletion
- Infrequent long-term (Day ≥ 90) grade ≥3 TEAEs included cytopenias (n=6) and/or hypertension (n=2)
- AESIs were low-grade (1-2), occurred early, and were transient
  - CRS was mostly low-grade (1-2), expected and manageable
  - No HLH or ICANS
- 1 DLT[b] at DL4b (MTD not reached[c])

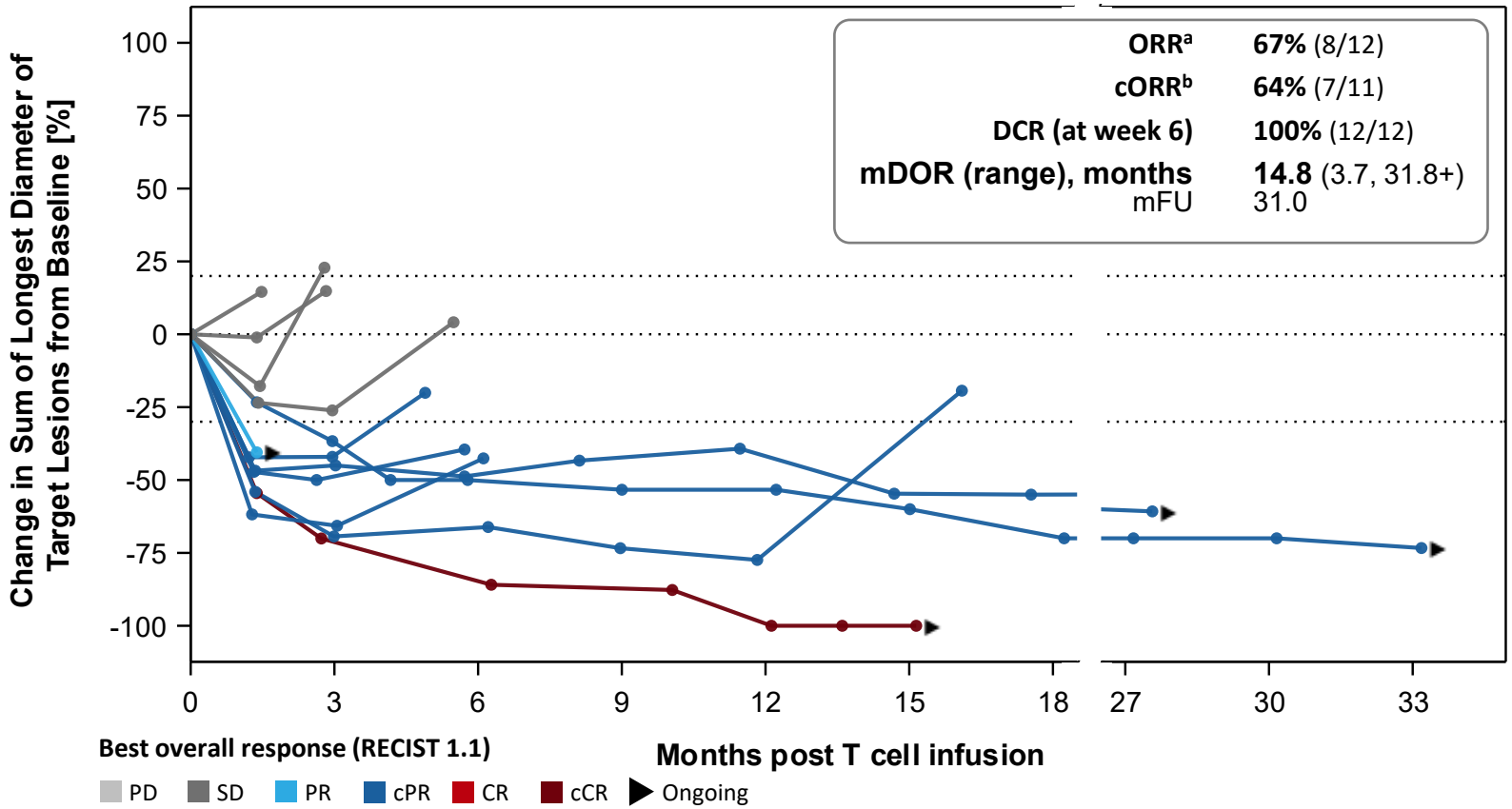
[a] Testicular/scrotal disorders includes grouped terms; [b] Grade 3 CRS with transient Grade 3 hepatotoxicity improved to Grade 2 within 10 days; CRS resolved completely without need for vasopressors/ventilator support; [c] Further modification of the inclusion/exclusion criteria and IL-2 scheme allowed continuation of dose escalation from DL4c up to present DL7; CRS, cytokine release syndrome; HLH, hemophagocytic lymphohistiocytosis; ICANS, immune effector cell-associated neurotoxicity syndrome; LD, lymphodepletion; MTD, maximum tolerated dose; TEAE, treatment-emergent adverse event.

IMA203CD8: BOR in Patients with Synovial Sarcoma (n=12)

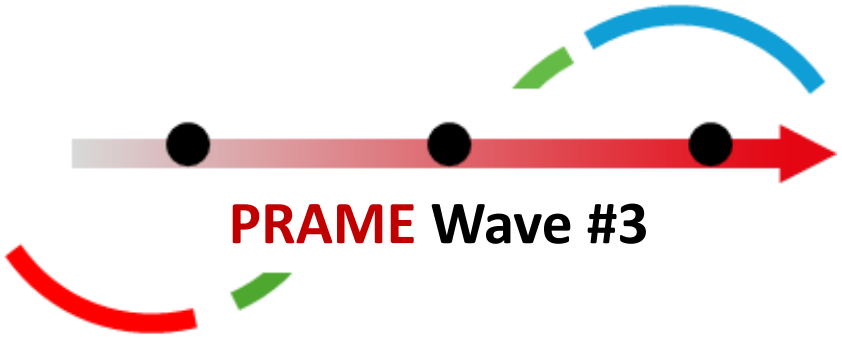


Clinical activity including durable responses observed at all dose levels

Median dose: 1.59 x10^9 total TCR T cells



[a] ORR: according to RECIST 1.1 at any post-BL scan, PD or death at any prior timepoint; cORR: according to RECIST 1.1 for patients with ≥2 post-BL scans, PD or death at any prior timepoint; [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. BL, baseline; BOR, best overall response; (c)CR, (confirmed) complete response; (c)ORR, (confirmed) objective response rate; (c)PR, (confirmed) partial response; DCR, disease control rate; mDOR, median duration of response; mFU, median follow-up; NR, not reached; PD, progressive disease; SD, stable disease; TCR, T-cell receptor.



IMA402 PRAME Bispecific

Expansion to Earlier-Line PRAME Cancers

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

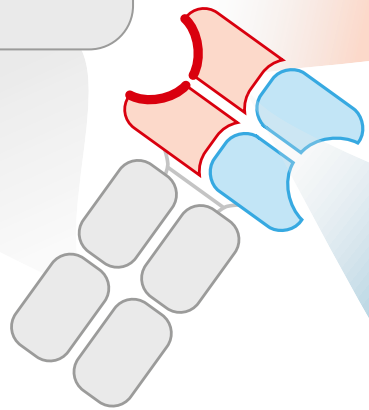
TCR Bispecifics (TCER®)

✓ **Antibody-like format with half-life extension (HLE)**

Long half life of 1-2 weeks[1] allows for q2w or longer dosing intervals

✓ **Anti-tumor Activity**

High-affinity and specificity TCR domain targeting tumor pHLA molecules

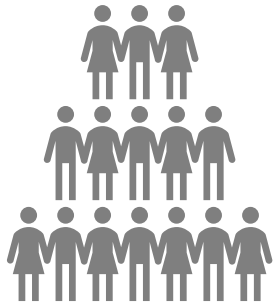


✓ **Optimized tolerability**

Low-affinity T cell recruiter against CD3/TCR allows higher dosing

>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**

[1] median half-life IMA402: ~7 days; 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: Clarivate Disease Landscape and Forecast; 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

Favorable tolerability profile

Most common treatment-related AEs are low-grade CRS and expected & transient lymphopenia

Activity & Duration of Response[1]

Promising clinical activity and deep and durable responses observed at RP2D range during dose escalation

30% (6/20) cORR across all indications, incl. **melanoma** & **ovarian carcinoma**

Promising early PFS/iPFS, OS

Pharmacokinetics

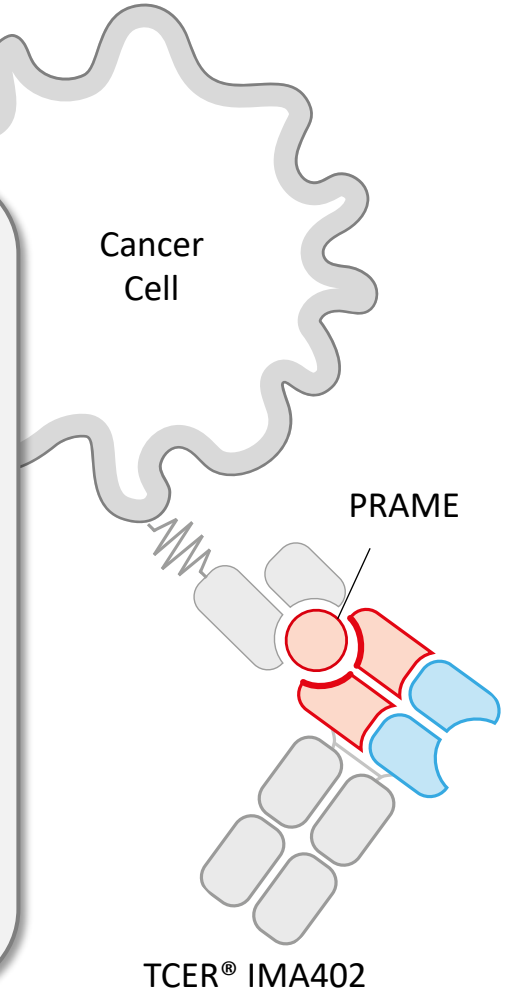
Median half-life of ~7 days

Potential for bi-weekly dosing or longer dosing intervals offering a **more convenient dosing schedule**, including combination treatment approaches

Development Potential

Possible future use in later-lines as monotherapy or combination setting with the potential to expand to earlier lines incl. frontline or (neo)adjuvant setting (in combination with ICI/SOC)

Initial focus on cut. melanoma, gyn-onc as well as sqNSCLC (IMA402/IMA401 combo)



- **Phase 1b data at RP2D range across multiple cancers planned for presentation at the ESMO Congress 2026**
- **IMA402/IMA401 combination cohort in sqNSCLC enrolling at multiple clinical trial sites, with first data expected in 2027**

[1] at doses 10-30 mg; AE: adverse event; CRS: Cytokine release syndrome; ICI: immune checkpoint inhibitor; RP2D: recommended phase 2 dose; SOC: standard of care

Phase 1/2 Clinical Trial to Evaluate IMA402 PRAME Bispecific

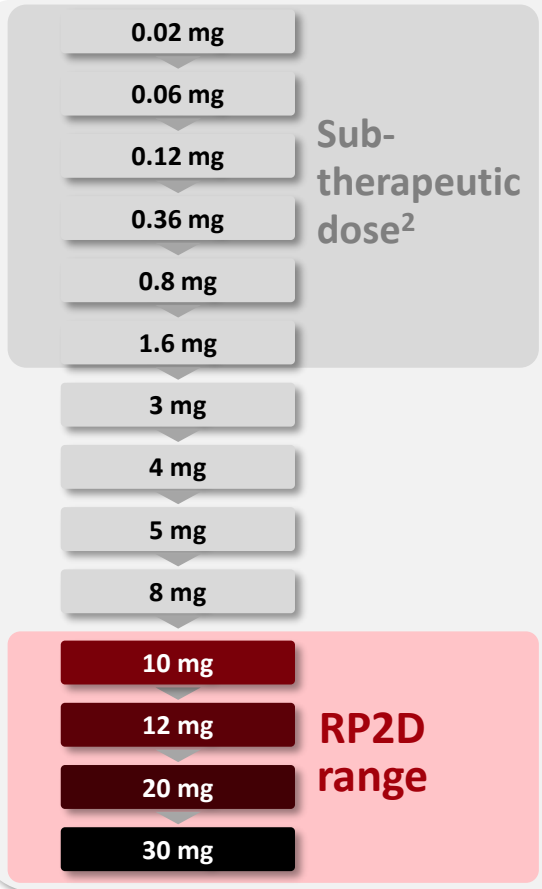
Objectives

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

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

Key Eligibility Criteria

- Recurrent and/or refractory **solid tumors expressing PRAME**[1]
- 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



Total safety population (N=80)

- MABEL-based starting dose
- Dose escalation based on cohorts of 1-6 patients using adaptive design (BLRM model)
- q1w step dosing (3 doses) up to target dose[3]
- q2w dosing planned based on favorable PK and already applied for individual patients

- **Ph1a dose escalation completed, MTD not reached at 30 mg**
- **Provisional RP2D range identified at 10 to 30 mg**
- **Ph1b dose expansion ongoing at two distinct doses within RP2D range**
- **Combination with immune checkpoint inhibitor started**

EudraCT No. 2022-503133-54-00; NCT05958121; [1] Cutaneous melanoma, melanoma of unknown primary, uveal melanoma, synovial sarcoma, endometrial carcinoma, ovarian carcinoma, squamous non-small cell lung cancer; [2] Based on preclinical *in vitro* and *in vivo* data; [3] Step dosing introduced at 0.36 mg, optimized step dosing currently being applied: 0.03 mg/0.3 mg/6 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; BLRM: bayesian logistic regression model; MABEL: minimum anticipated biological effect level ; MTD: maximum tolerated dose; q1w: every week; q2w: every 2 weeks; RP2D: recommended phase 2 dose.

Demographics and Baseline Characteristics IMA402 PRAME Bispecific

	Safety population (N=80)	Efficacy population (N=57)[1]		
	0.02-30 mg	≤1.6 mg (n=15)	3 – 8 mg (n=22)	**RP2D range, ≥10 mg (n=20)**
Age				
Median (min, max)	**59 (21, 82)**	61 (28, 82)	55 (34, 74)	**56 (37, 74)**
ECOG performance status				
0, n (%)	**47 (59)**	6 (40)	11 (50)	**11 (55)**
1, n (%)	**33 (41)**	9 (60)	11 (50)	**9 (45)**
Prior lines of systemic treatment				
Median (min, max)	**3 (1, 7)**	3 (2, 7)	3 (1, 5)	**3 (1, 6)**
LDH at baseline				
≤ 1xULN, n (%)	**39 (49)**	5 (33)	11 (50)	**14 (70)**
1-2xULN, n (%)	**40 (50)**	9 (60)	11 (50)	**6 (30)**
> 2xULN, n (%)	**1 (1)**	1 (7)	0 (0)	**0 (0)**
Baseline tumor burden				
Median target lesion sum of diameter (mm) (min, max)	**80 (16, 398)**	80 (46, 398)	68 (25, 258)	**76 (21, 255)**
Tumor lesions				
Number of lesions, median (min, max)	**4 (1, 15)**	4 (2, 10)	6 (1, 15)	**4 (2, 11)**
Liver metastases, n (%)	**33 (41)**	8 (53)	8 (36)	**6 (30)**
Brain metastases, n (%)	**6 (8)**	1 (7)	1 (5)	**3 (15)**

Heavily pre-treated patient population with comparable baseline characteristics across dose groups

[1] Efficacy-evaluable population: All patients treated as of Jun 26, 2025 (who had the opportunity for at least 3 months follow-up or who discontinued early due to disease progression or death), tested positive or not tested/not evaluable for PRAME and received ≥4 infusions as defined per protocol (thereof 3 step doses, currently at 0.03 mg/0.3 mg/6 mg, and 1 target dose); Baseline characteristics for melanoma and ovarian carcinoma are listed in the appendix; ECOG: eastern cooperative oncology group; LDH: Lactate dehydrogenase; RP2D: recommended phase 2 dose; ULN: upper limit of normal.

IMA402 PRAME Bispecific Shows a Favorable Tolerability Profile

Safety Population (N=80)

Treatment-related AEs[1], n (%)	All Grades	≥ Grade 3
Lymphopenia	40 (50)	30 (38)
Cytokine release syndrome	31 (39)	1 (1)
Arthralgia	21 (26)	1 (1)
Fatigue	19 (24)	
Alanine aminotransferase increased	16 (20)	7 (9)
Aspartate aminotransferase increased	14 (18)	5 (6)
Rash	13 (16)	
Pruritus	11 (14)	
Pyrexia	11 (14)	
Anaemia	10 (13)	2 (3)
Myalgia	10 (13)	1 (1)
Nausea	9 (11)	
Gamma-glutamyltransferase increased	8 (10)	3 (4)
Lipase increased	7 (9)	
Abdominal pain	7 (9)	
Hypertension	3 (4)	2 (3)
Neutropenia	2 (3)	2 (3)
Blood creatinine increased	2 (3)	1 (1)
Stomatitis	2 (3)	1 (1)
Tumour pain	2 (3)	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)

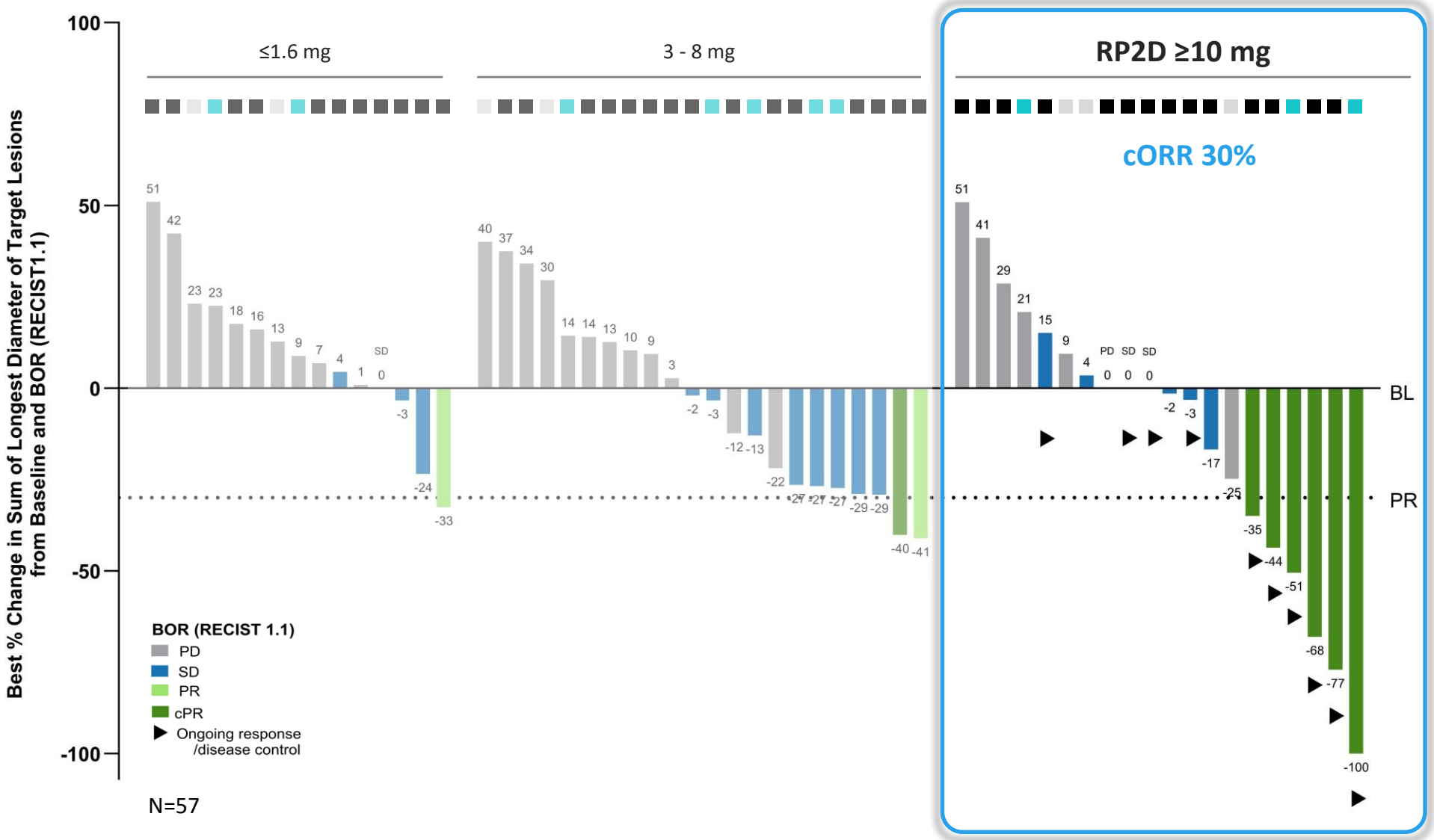
TEAEs, n (%)	All Grades	≥ Grade 3
Any	78 (98)	48 (60)
Treatment-related	76 (95)	42 (53)

- **Favorable tolerability** across wide dose range and consistent with tolerability at RP2D range (see appendix)
- **Most frequent/relevant related AEs** were
  - Expected and transient lymphopenia, consistent with the mechanism of action
  - Low-grade CRS (33% G1, 5% G2, 0% G3, 1% G4) mostly at first step dose
    - One CRS G4 event in patient at 0.08 mg starting dose only; no further CRS G4 events after step dose optimization
- No ICANS observed
- No IMA402-related Grade 5 events
- **MTD not reached[2] at 30 mg**

[1] All treatment-emergent adverse events (TEAEs) for IMA402 monotherapy at least possibly related to IMA402 infusion with Grade 1-2 occurring in at least 7% of patients and all events with ≥ Grade 3, one additional patient treated with IMA402 at first step dose + pembrolizumab is not included in the safety population/table and had the following AEs: lymphopenia G3, erythema G1 , TSH decrease G1; [2] Two dose-limiting toxicities (DLTs) at 0.08 mg and 0.3 mg; AE: adverse event; CRS: cytokine release syndrome; G: grade; ICANS: immune effector cell-associated neurotoxicity syndrome; MTD: maximum tolerated dose; RP2D: recommended phase 2 dose.

Clinical Proof-of-Concept of IMA402 PRAME Bispecific across Various Indications

Dose-Response Relationship in Monotherapy Setting



Indications

- Ovarian Carcinoma
- Melanoma[1]
- Other Indications[2]

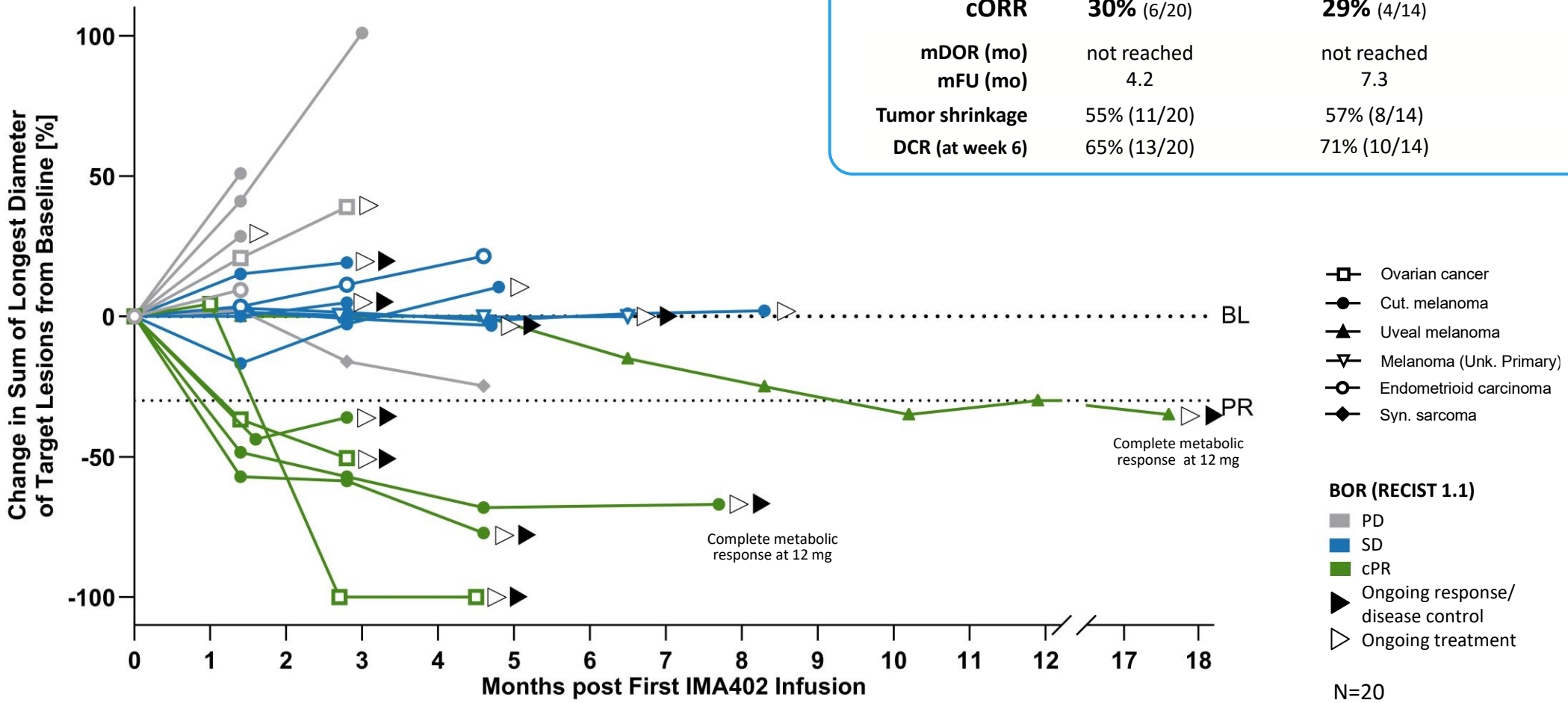
- **All responders with ovarian carcinoma were platinum resistant**
- **All responders with melanoma were ICI-resistant**

[1] Melanoma includes cutaneous melanoma, melanoma of unknown primary, uveal melanoma; [2] Other indications include endometrioid carcinoma, synovial sarcoma and one patient with sqNSCLC at 1.6 mg; BL: baseline; BOR: best overall response; cORR: confirmed objective response rate; cPR: confirmed partial response; ICI: immune checkpoint inhibitor; PD: progressive disease; SD: stable disease; PR: partial response; RECIST: response evaluation criteria in solid tumors; RP2D: recommended phase 2 dose.

Deep and Durable Responses at RP2D Range

6/6 Confirmed Objective Responses Ongoing, incl. Two Complete Metabolic Responses at 12 mg IMA402

RECIST 1.1	All indications	Melanoma	Ovarian carcinoma
cORR	**30%** (6/20)	**29%** (4/14)	**2/3**
mDOR (mo)	not reached	not reached	not reached
mFU (mo)	4.2	7.3	2.2
Tumor shrinkage	55% (11/20)	57% (8/14)	2/3
DCR (at week 6)	65% (13/20)	71% (10/14)	2/3



BL: baseline; BOR: best overall response; cPR: confirmed partial response; cORR: confirmed objective response rate; DCR: disease control rate; mDOR: median duration of response; mFU: median follow-up; PD: progressive disease; PR: partial response; RP2D: recommended phase 2 dose; SD: stable disease.

Early Promising PFS and OS Snapshot for IMA402 at RP2D Range

Survival Outcomes Across All Indications at All Dose Levels

Median PFS

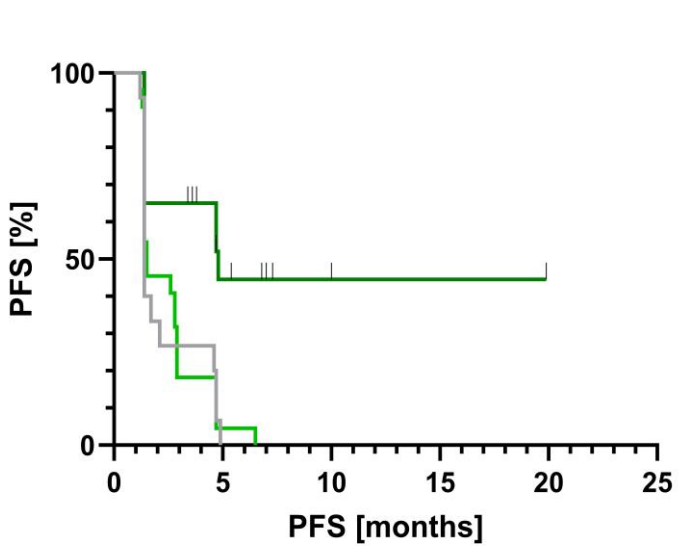
	≤ 1.6 mg	3 – 8 mg	≥10 mg
mPFS (mo)	**1.4**	**1.5**	**4.8**
mFU (mo)	NA	NA	6.8
6m PFS rate	0%	5%	45%

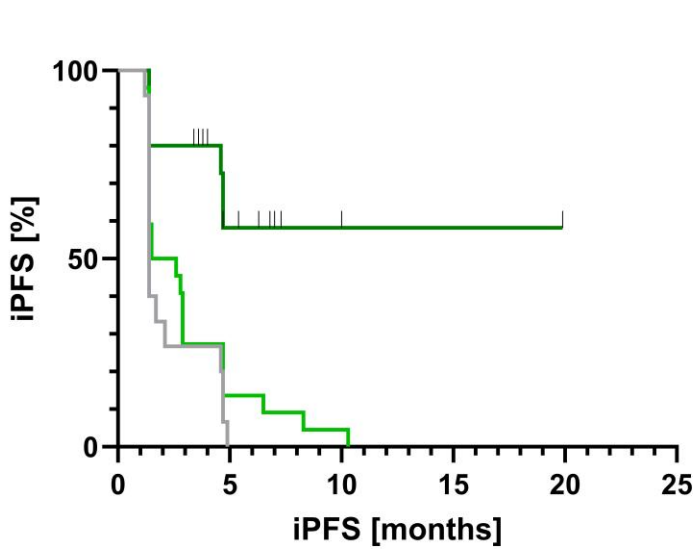
Median iPFS[1]

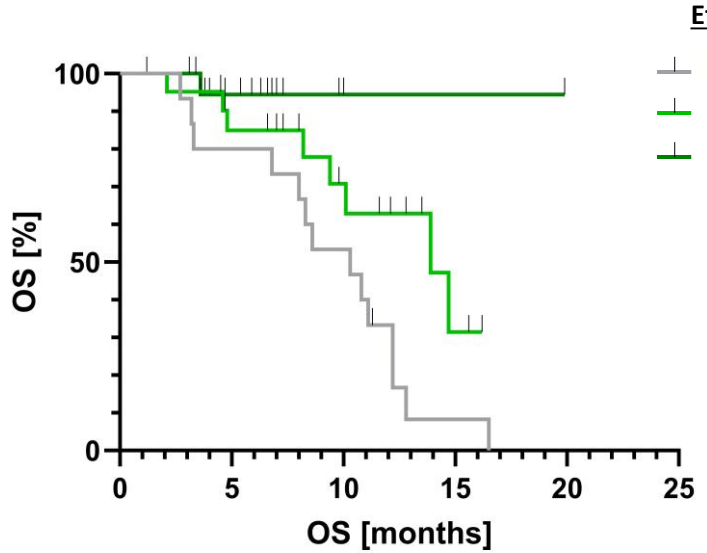
	≤ 1.6 mg	3 – 8 mg	≥10 mg
miPFS (mo)	**1.4**	**2.1**	**Not reached**
mFU (mo)	NA	NA	6.3
6m iPFS rate	0%	14%	58%

Median OS

	≤ 1.6 mg	3 – 8 mg	≥10 mg
mOS (mo)	**10.3**	**13.9**	**Not reached**
mFU (mo)	NA	12.1	5.4
1y-OS rate	33%	63%	94%







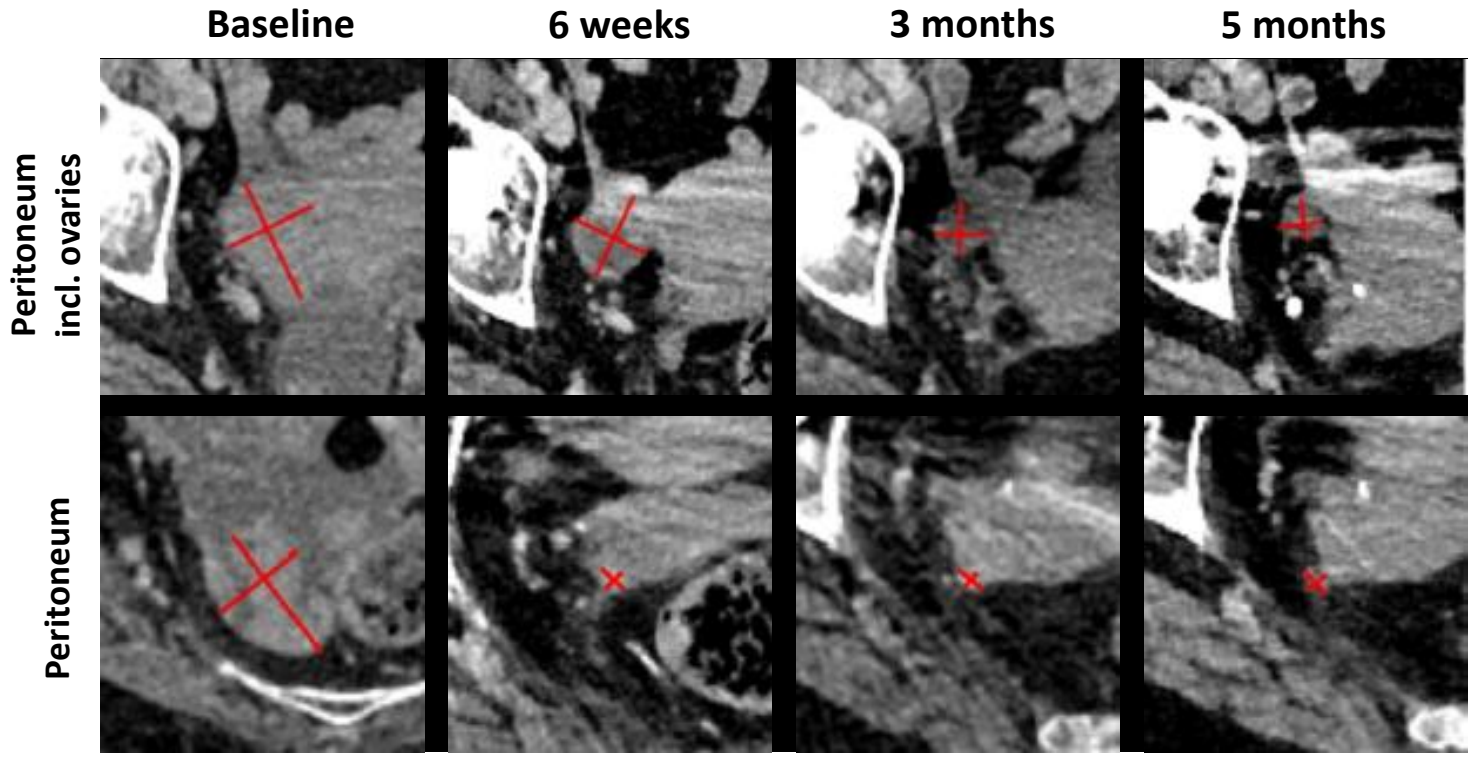
Efficacy population

- ≤1.6 mg n=15
- 3-8 mg n=22
- ≥10 mg n=20

[1] 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; mFU: median follow-up; (m)PFS: (median) progression-free survival; (m)OS: (median) overall survival; RP2D: recommended phase 2 dose; 6m: 6 months; 1y: 1 year.

Patient Case: Ongoing PET-based Complete Metabolic Response in Cutaneous Melanoma

Patient Characteristics & Outcomes	
Patient & Diagnosis	68-year-old female with ICI-resistant cutaneous melanoma; initial diagnosis in 2004
Disease at Baseline	• Target lesions: 2 peritoneal, 1 abdominal • Non-target lesions: brain and lung (left and right) • Intensive immune-related previous medical history
Prior systemic therapy	3 prior lines of therapy: • Adjuvant: nivolumab • Ipilimumab + nivolumab, discontinued due to toxicity • Lenvatinib + pembrolizumab, BOR: PD
Study Treatment	Initial dose: 5 mg, escalated to 20 mg Bi-weekly treatment 9 months post treatment start
Response Assessment	• First assessment (6 weeks): PR • Complete response in brain lesion • **Ongoing cPR with -68% tumor reduction and PET scan with complete metabolic response** at 8 months after switch to 12 mg

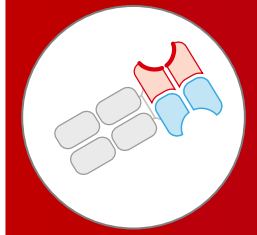


Scans courtesy of Dr. Dirk Schadendorf, University Hospital Essen

BOR: best overall response; (c)PR: (confirmed) partial response; ICI: immune checkpoint inhibitor; PD: progressive disease; PET: positron emission tomography.

IMA402 PRAME Bispecific Ph1a Dose Escalation Summary and Next Steps

Expansion to Earlier-Line PRAME Cancers



Promising Monotherapy & High Potential in Combination

- ✓ Favorable tolerability profile
- ✓ Deep & durable responses
- ✓ Promising early PFS/iPFS and OS

Development Opportunities in 2026

- ➢ **Ph1b dose expansion** completion (RP2D with & w/o ICI)
- ➢ **Initiation of additional Ph1b/Ph2 expansion cohorts** in focus indications

Initial Focus Indications	Development Opportunities
Cut. melanoma	IMA402 1L advanced: ICI combo IMA402 2L ICI-resistant[1]: monotherapy or ICI combo
Gyn-Onc	IMA402 PSOC: SOC combo IMA402 PROC[1]: monotherapy or non-platinum SOC combo IMA402 2L EC: ICI combo
sqNSCLC	IMA402 + IMA401 with or without ICI

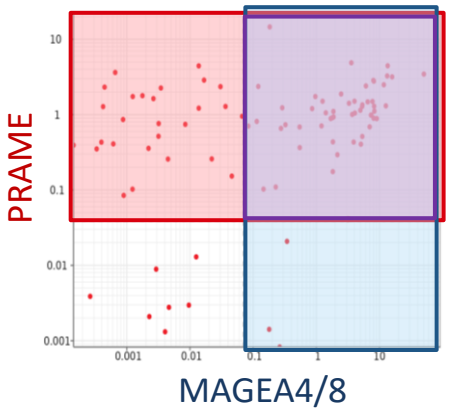
[1] Potential to become registration-directed subject to Ph1b data; 1L: first line or later, 2L: second line or later; cut. melanoma: cutaneous melanoma; EC: endometrial carcinoma; Gyn-Onc: gynecologic cancers; ICI: immune checkpoint inhibitor; OS: overall survival; PFS: progression-free survival; PROC: platinum-resistant ovarian cancer; PSOC: platinum-sensitive ovarian cancer; RP2D: recommended phase 2 dose; SOC: standard of care; sqNSCLC: squamous cell non-small cell lung cancer.

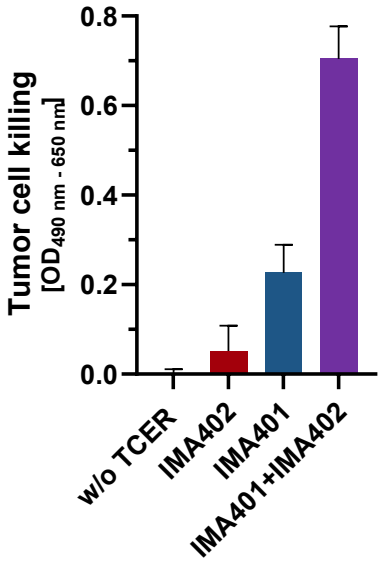
Potential to Unlock >90% of sqNSCLC Patients with IMA401 + IMA402 Dual Targeting

> 90%

PRAME+ or MAGEA4/8+

including 60% double positive





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

Expanded Patient Reach

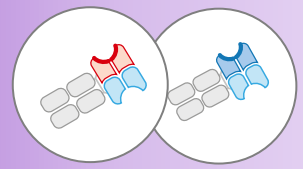
>90% of patients with sqNSCLC are targetable, potentially unlocking broad treatment coverage for

~40K patients with sqNSCLC in the US and EU per year[3]

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

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; [3] Refers to addressable 1L advanced HLA-A*02:01/target+ patients in the US & EU5 in 2025, Source: Clarivate Disease Landscape and Forecast; HNSCC: head and neck squamous cell carcinoma; sqNSCLC: squamous non-small cell lung cancer.

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

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.

Activity & Duration of Response[1]

- 29% cORR (4/14) in head and neck cancer
- 33% cORR (2/6) in melanoma
- Promising early clinical activity in sqNSCLC

Pharmacokinetics

Median terminal half-life of >2 weeks

Potential for:

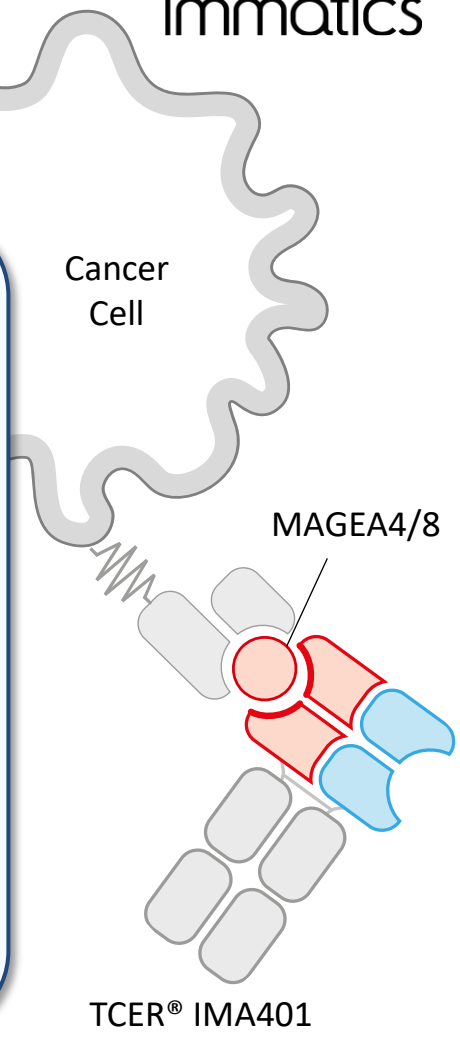
- Flexibility in dosing schedules
- Combination with IMA402 with or without ICI

Development Potential

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

Wermke et al., ASCO 2026
Data cutoff Mar 02, 2026

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

Phase 1a Dose Escalation
0.0066 mg - 2.5 mg IMA401
(n=61)

- **MABEL-based starting dose**
- Dose escalation based on cohorts of 1-6 patients using **adaptive design** (BLRM model)
- Initial q1w step dosing[a] (2-4 doses) up to target dose, q2w after reaching target dose[b]

0.0066 mg
0.02 mg
0.06 mg
0.18 mg
0.54 mg
1.0 mg
1.2 mg
1.5 mg
1.8 mg
2.0 mg
2.5 mg

Phase 1a dose escalation completed

RP2D Selection
1.0 - 2.0 mg IMA401
(n=32)

Dose selection:
MTD not reached per adaptive BLRM model[c], RP2D defined at 1-2 mg based on optimal risk-benefit-profile

1.0 mg
1.2 mg
1.5 mg
1.8 mg
2.0 mg

RP2D selection completed

ICI Combination at RP2D
1.0 or 1.5 mg IMA401 with Pembrolizumab
(n=12)

ICI combination:
Pembrolizumab started 1 week before IMA401 (400 mg IV q6w)

1.0 mg + Pembrolizumab
1.5 mg + Pembrolizumab

IMA401 + ICI completed

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 [cm], 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

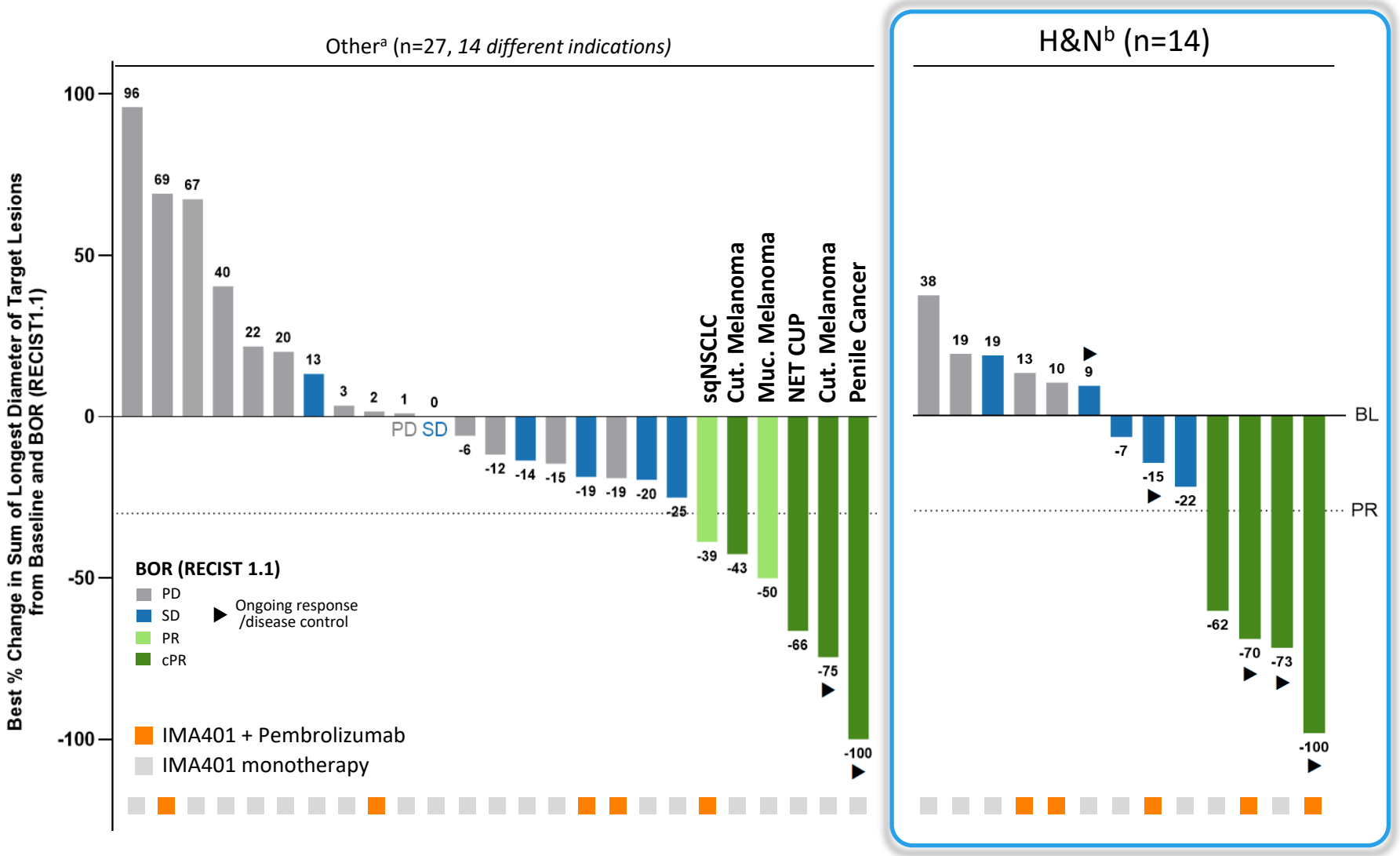
	IMA401 (Monotherapy)		IMA401 + Pembrolizumab	
Treatment-related Adverse Events (safety analysis set)	**1-2 mg (RP2D)** n=32		**1-2 mg (RP2D)[b]** n=12	
TRAEs[a], n (%)	All Grades	≥ Grade 3	All Grades	≥ Grade 3
Any TRAE	28 (88)	16 (50)	11 (92)	3 (25)
Cytokine release syndrome	12 (38)	0	5 (42)	0
Lymphopenia	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.

Tolerability of IMA401 at RP2D ± Pembrolizumab



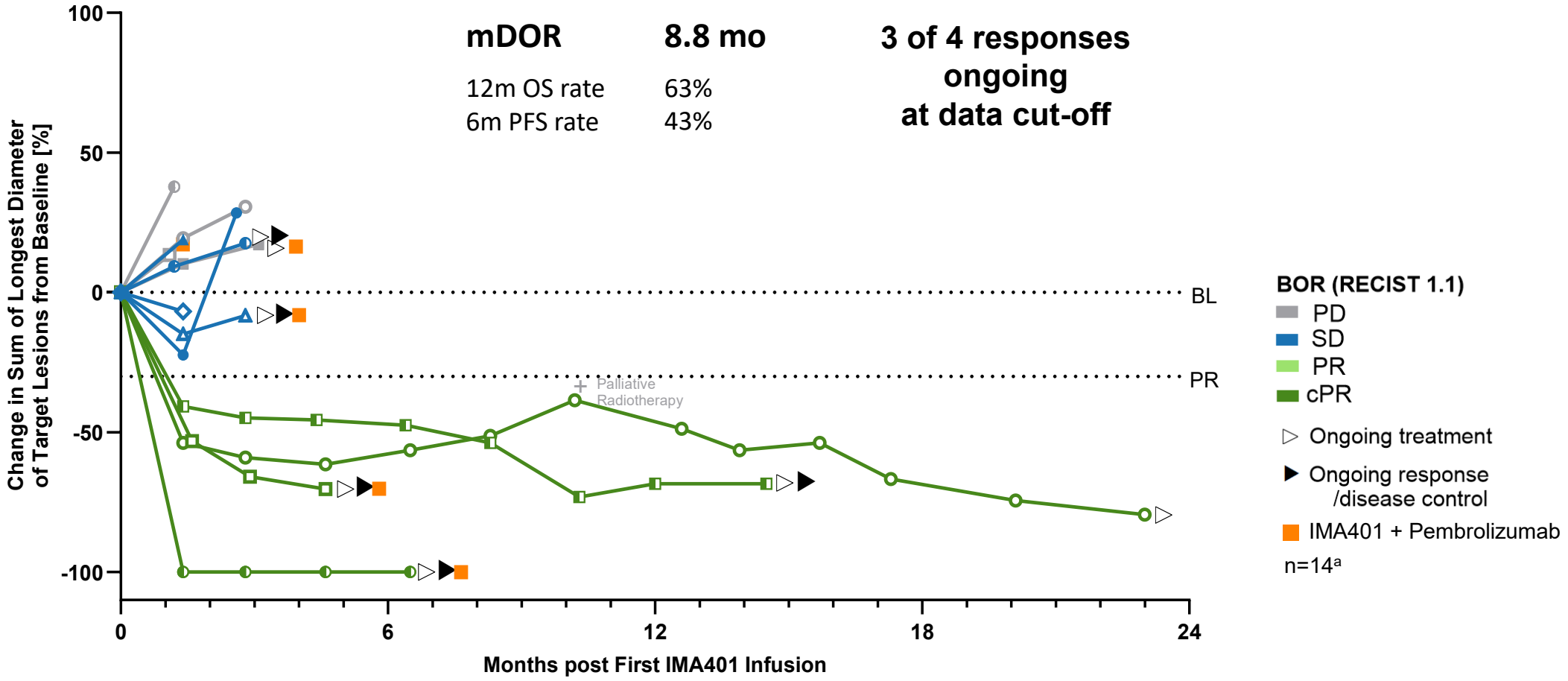
H&N (n=14)

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

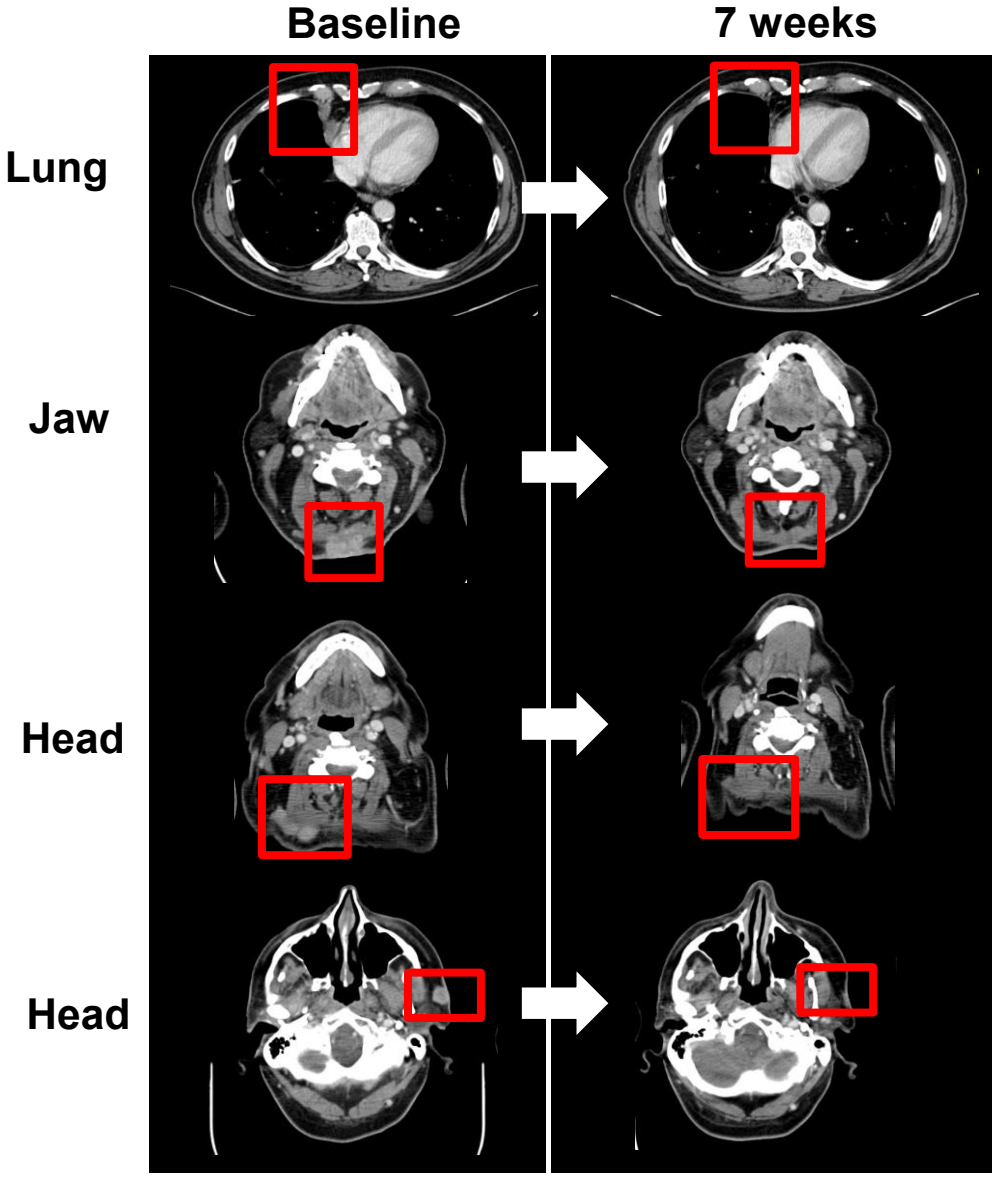


Efficacy population: all patients in the safety set who received 4 IMA401 infusions in monotherapy and in addition at least 1 pembrolizumab infusion in combination therapy and had a post-baseline efficacy assessment, including patients with clinical progression; [a] One patient not shown in plot due 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.

Wermke et al., ASCO 2026
Data cutoff Mar 02, 2026

Appendix

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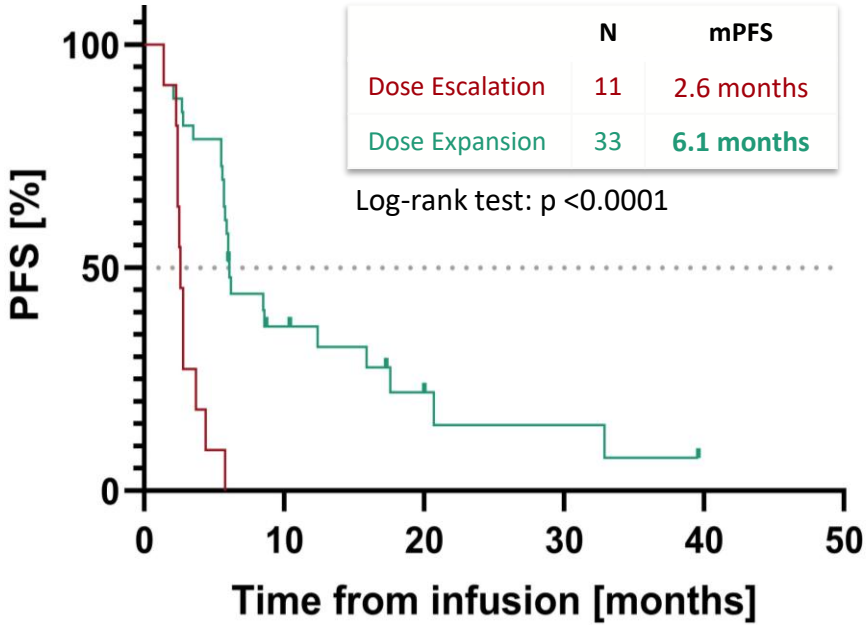
Anzu-cel (IMA203): Significant Shift in PFS and OS Between Dose Escalation & Dose Expansion

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

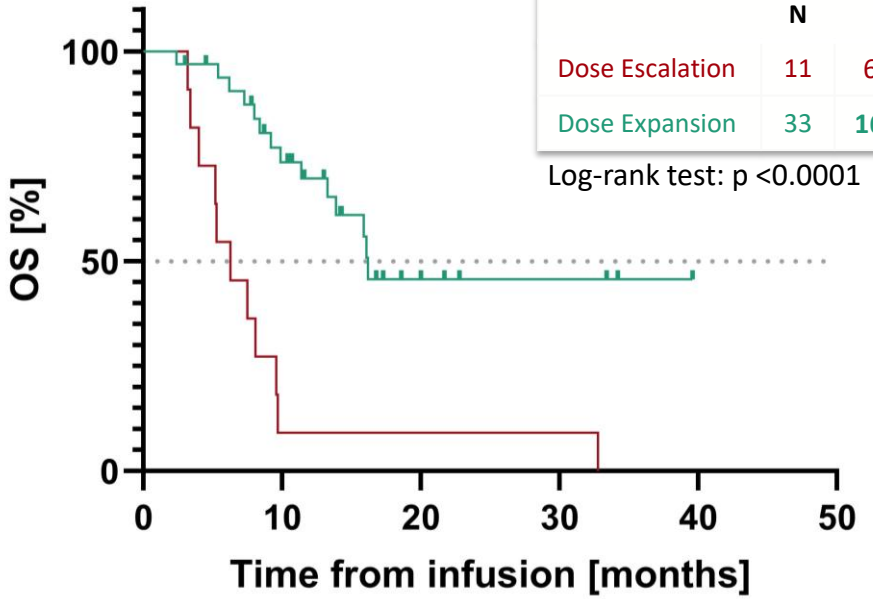
Progression Free Survival



	N	mPFS
Dose Escalation	11	2.6 months
Dose Expansion	33	**6.1 months**

Log-rank test: p <0.0001

Overall Survival



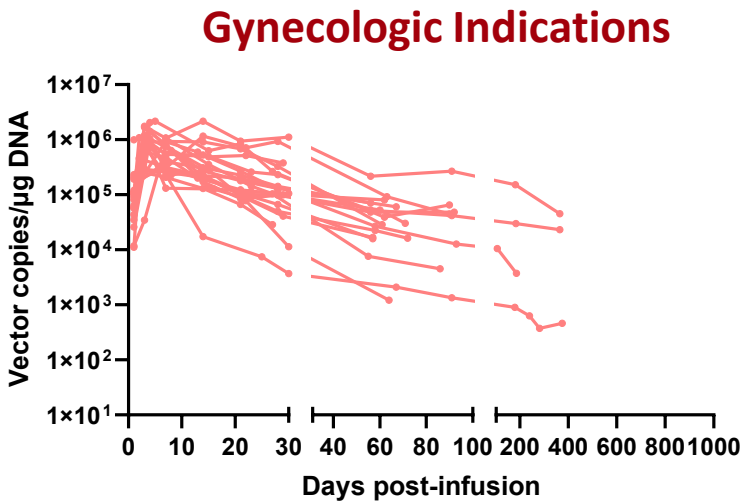
	N	mOS
Dose Escalation	11	6.3 months
Dose Expansion	33	**16.2 months**

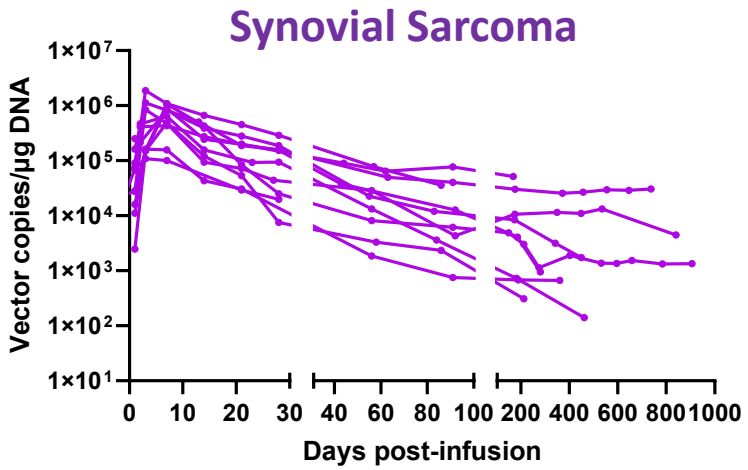
Log-rank test: p <0.0001

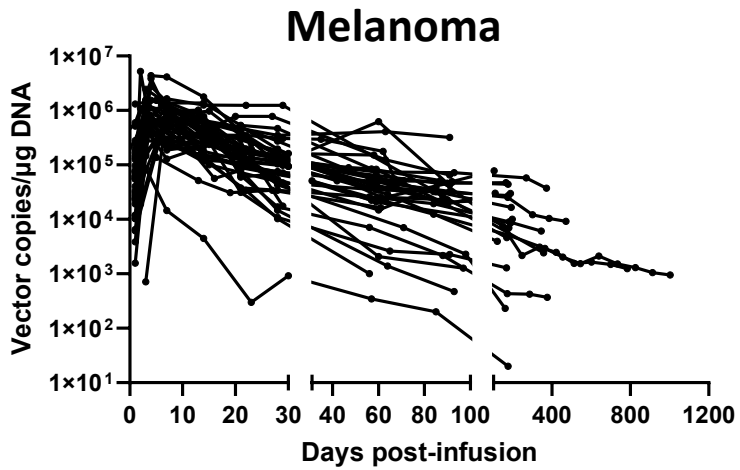
- Significant shift in mPFS and mOS between melanoma patients treated during the dose escalation and dose expansion
- mPFS in dose escalation is comparable to reported data in 2L+ cut. melanoma population*
- mOS in dose escalation is shorter than reported mOS for 2L+ cut. melanoma population*
- All patients 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)

IMA203CD8 T-cell Persistence in Peripheral Blood in Multiple Indications



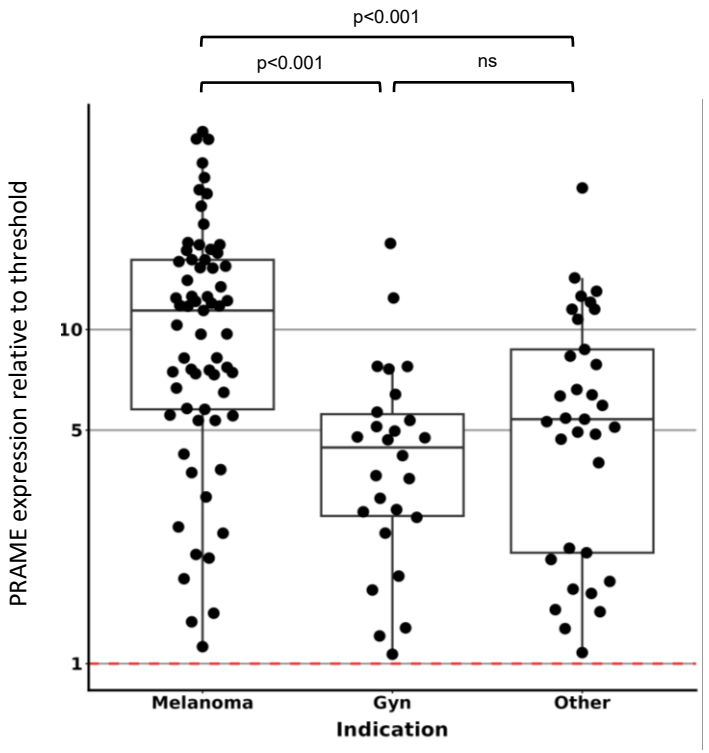




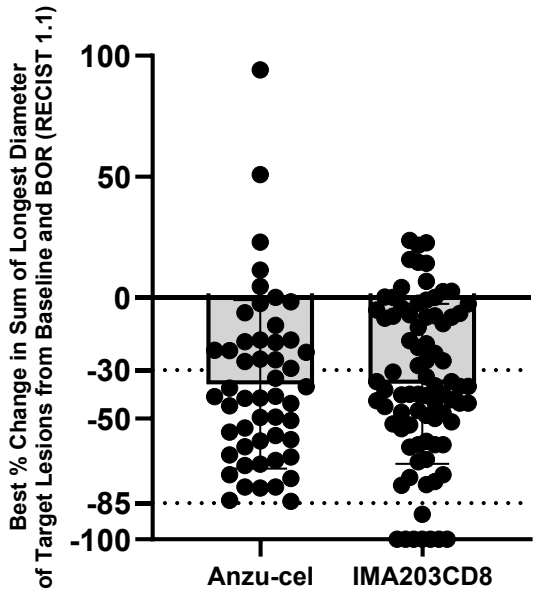
- Sustained persistence of IMA203CD8 T cells beyond 1-year post-infusion represents an important prerequisite for durable clinical benefit in all main indications evaluated
- Similar kinetics between indications with no significant differences seen in terms of peak expansion, timepoint of peak expansion and persistence at day 30, 60 and 90 post-infusion between indications (*data on file*)

Opportunity of IMA203CD8 across Broad Range of PRAME+ Indications

Potential of IMA203CD8 in PRAME-positive tumors with varying expression levels



Deep responses with IMA203CD8 at low doses



	Anzu-cel	IMA203CD8
Number of patients	51	90
Total infused dose TCR-T cells [x10^9]	4.50 (1.00-10.20)	1.71 (0.44-12.50)
Tumor burden at baseline (mm)	100.60 (11.00-309.80)	72.55 (11.00-434.40)

IMA203CD8 shows higher number of deep responses at -100% tumor reduction at lower infused dose compared to anzu-cel. IMA203CD8 may offer an **enhanced opportunity** to treat cancers across a broad spectrum of **PRAME expression** including ovarian carcinoma, uterine cancer, sqNSCLC, triple-negative breast cancer and others

Data on file; PRAME expression: evaluated biopsies (FFPE tissue) prior to treatment with anzutresgene autoleucel (anzu-cel, formerly IMA203) or IMA203CD8, melanoma: cutaneous melanoma, uveal melanoma, acral melanoma, melanoma of unknown primary, Gyn (gynecologic cancers): ovarian carcinoma and endometrial cancer; Other: head and neck cancer, lung cancer, synovial sarcoma, triple-negative breast cancer and others.

IMA203CD8 Shows Broad Clinical Activity across Diverse PRAME+ Solid Tumors

Clinical Activity in PRAME+ Tumors with Distinct Pathology / Biology

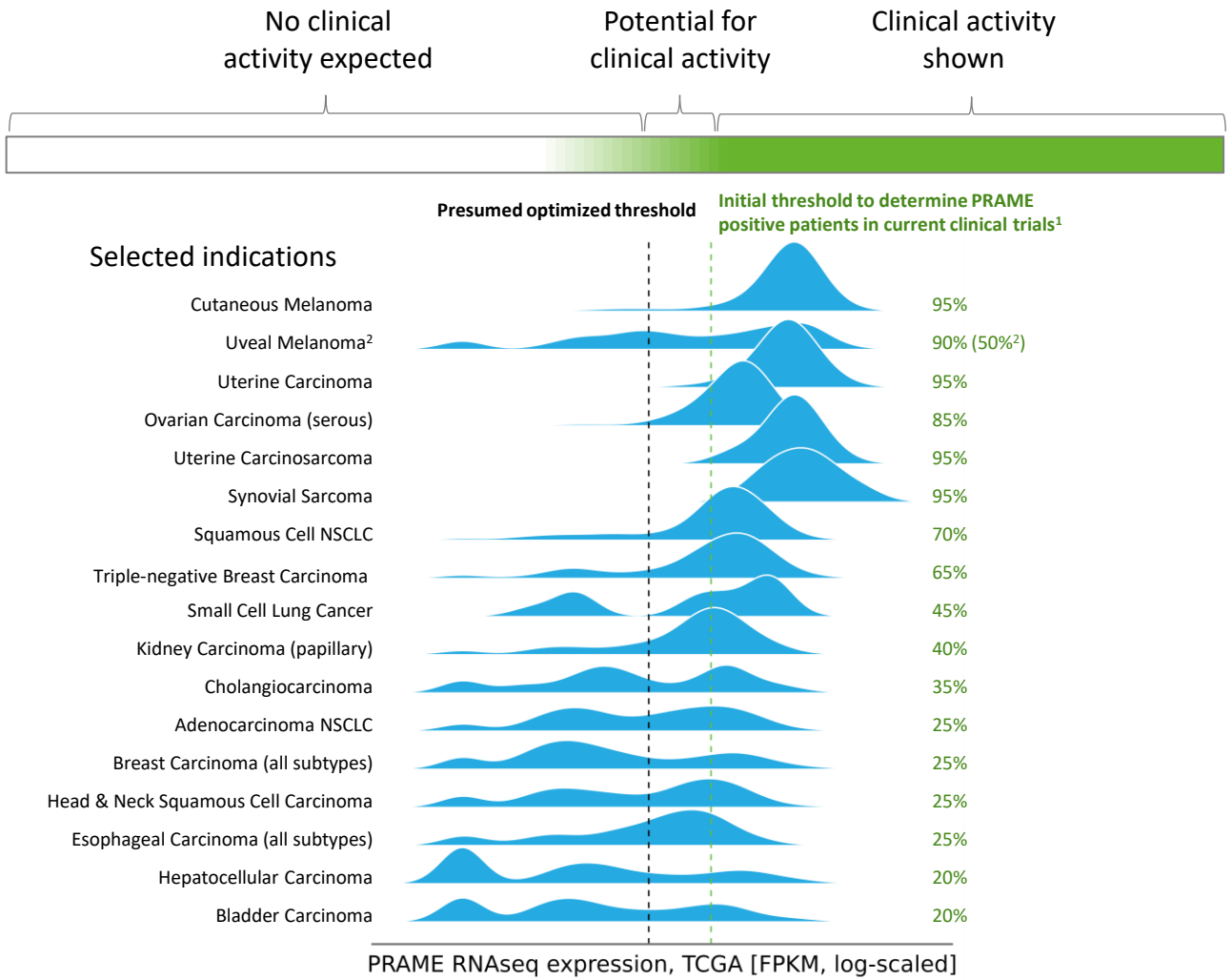
	Relative PRAME Expression	Immunological phenotype[a]	Clinical Activity
Melanoma	High	Hot	✓ *Busse et al, ESMO-IO 2025*
Uterine cancer	High	Mixed	✓ *Busse et al, ASCO 2026*
Synovial sarcoma / Uveal melanoma	High	Cold	✓ *Araujo et al, ASCO 2026* *Busse et al, ESMO-IO 2025*
Ovarian carcinoma	Low	Cold	✓ *Busse et al, ASCO 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

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; [1] 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%); [2] 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

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