ACTengine® IMA203 TCR-T Targeting PRAME

– Monotherapy Interim Data Update

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Delivering the Power of T cells to Cancer Patients

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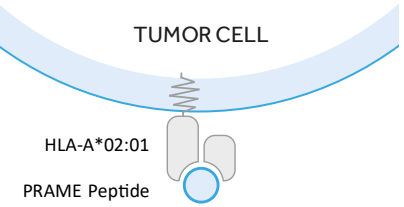
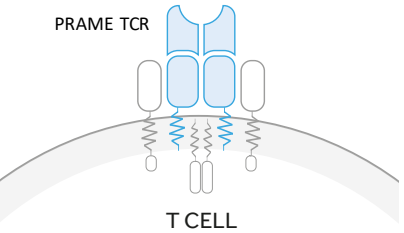
Multi-Tumor Target PRAME

Promising Opportunity for TCR-based Therapies



PRAME Peptide Target

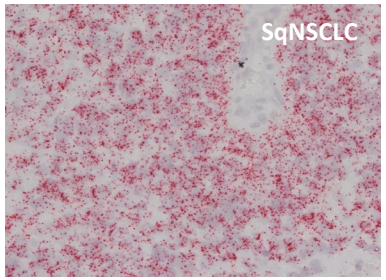
- HLA-A*02:01-presented peptide identified by XPRESIDENT® quant. mass spectrometry
- Presented at high target density in tumor tissue (100-1000 copies/cell)
- Homogenously expressed
- Highly cancer-specific, not expressed in normal tissue at relevant levels
- Highly prevalent across many solid cancers
- Potential to reach a large cancer patient population

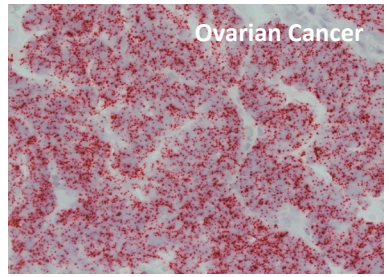


IMA203 T cell Receptor (TCR):

- Affinity-improved TCR by enhanced TCR chain pairing
- High functional avidity: EC50 ~5 ng/ml
- Off-target toxicity screening against normal tissue peptides selected from our immunopeptidome database to retain specificity

PRAME RNA detection in tumor samples (ISH)





Patient screening data from Immatics' clinical trials support high prevalence of PRAME:

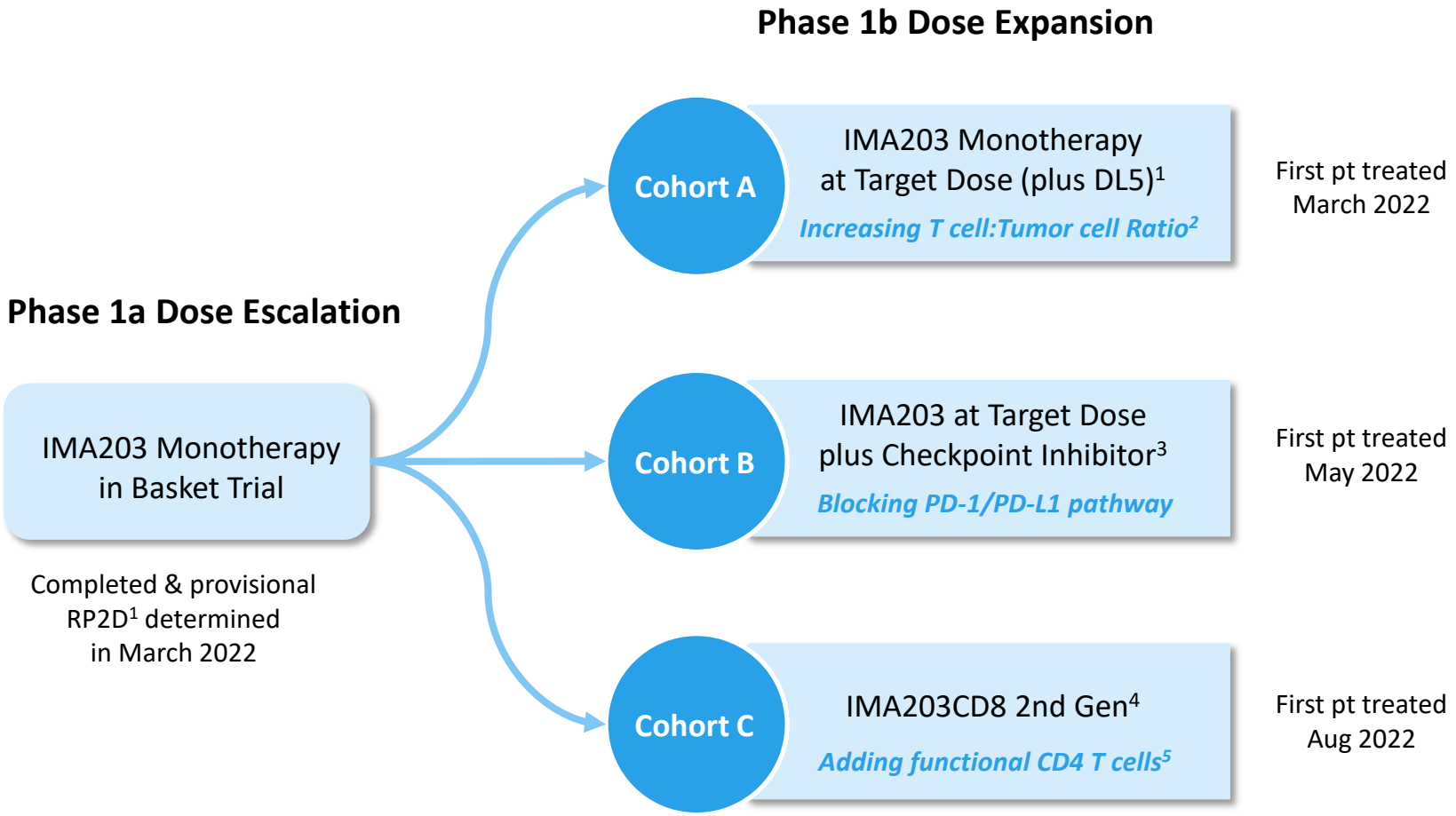
Uterine Carcinoma	90%
Cut. Melanoma	95%
Uveal Melanoma[2]	90%
Ovarian Carcinoma	70%

Indication	% PRAME positive patients[1]
Uterine Carcinoma	100%
Uterine Carcinosarcoma	100%
Sarcoma Subtypes	up to 100%
Cut. Melanoma	95%
Uveal Melanoma[2]	50%
Ovarian Carcinoma	80%
Squamous NSCLC	65%
TNBC	60%
Small Cell Lung Cancer	55%
Kidney Carcinoma	up to 45%
Cholangiocarcinoma	35%
Adeno NSCLC	25%
Breast Carcinoma	25%
HNSCC	25%
Esophageal Carcinoma	20%
HCC	20%
Bladder Carcinoma	20%

[1] PRAME target prevalence is based on TCGA (for SCLC: in-house) RNAseq data combined with a proprietary mass spec-guided RNA expression threshold; [2] 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; NSCLC: Non-small cell lung cancer, TNBC: Triple-negative breast cancer, HNSCC: Head and neck squamous cell carcinoma; HCC: Hepatocellular carcinoma

IMA203 TCR-T Phase 1 Design

Three Phase 1b Expansion Cohorts to Establish Durable Objective Responses

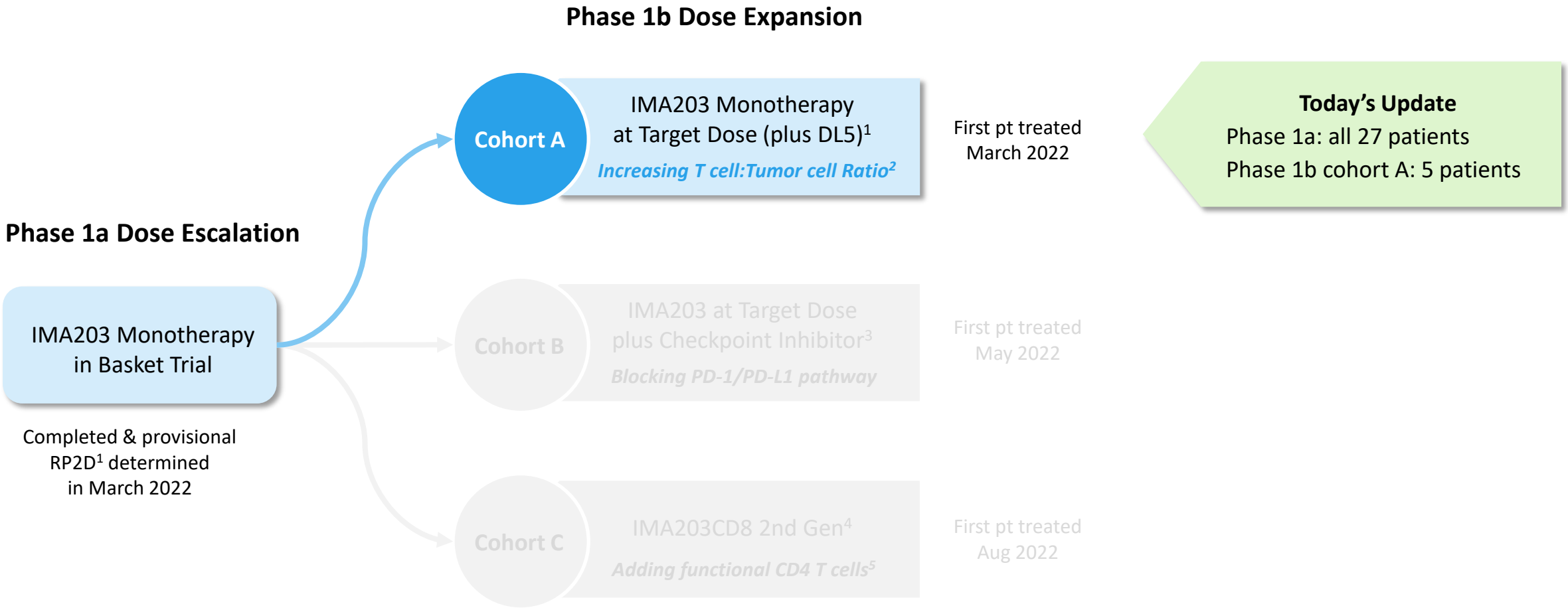


Each expansion cohort is designed to establish safety, evaluate the observed objective response rate, demonstrate durability & provide the trigger for registration trials

[1] RP2D (target dose) determined at DL4, exploration of higher dose (DL5) ongoing; [2] Demonstrated to be associated with durable response: Locke *et al.* 2020 Blood Advances; [3] Opdivo® (nivolumab): programmed death-1 (PD-1) immune checkpoint inhibitor; [4] Treatment of n=3 patients in DL3 prior to patient treatment at provisional RP2D (DL4); [5] Demonstrated to be important for long-term remission: Melenhorst *et al.* 2022 Nature, Bai *et al.* 2022 Science Advances

IMA203 TCR-T Phase 1 Design

Interim Clinical Data Update Focused on Phase 1a and Expansion Cohort A



Data cut-off – 06-Sept-2022

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Moving from Phase 1a to Phase 1b

Continuous Improvement of Key Aspects that May Influence Clinical Outcome

Our Focus in Phase 1a

- Safety
- Biological activity
- Initial signs of clinical activity

Our Focus in Phase 1b

- Safety
- Durability of response at 6 months and beyond to pave the way for registration trials

We continue to improve key determinants as we move from Phase 1a into Phase 1b

1. **Higher T cell dose:** Only RP2D or exploratory DL5
2. **Enhanced cell product:** Implementation of manufacturing enhancements (e.g. monocyte depletion, see appendix) focusing on robustness, quality, and speed of product release
3. **"Real life" patients:** Working with more disease area experts to reduce the fraction of very heavily pre-treated patients with extreme disease burden who have exhausted standard of care and have undergone multiple clinical trials

ACTengine® IMA203 – Interim Monotherapy Update

Phase 1a

Dose Escalation Data from 27 Patients

- Acceptable & manageable treatment-emergent adverse events (TEAEs)
- DL4 defined as provisional RP2D
- 48% (13/27) initial ORR[1] across all doses and multiple solid cancers
- Limited number of confirmed responses

Phase 1b Cohort A

Initial Data from 5 Patients

- Acceptable & manageable TEAEs
- Patients treated at RP2D (DL4) and exploratory DL5
- 80% (4/5) initial ORR[1] in patients with 4 different solid tumors
- 80% (4/5) confirmed ORR[2]: Confirmation of all objective responses after ~3 months; all responses ongoing

Key Take Aways

IMA203 Monotherapy

- Favorable tolerability profile
- Confirmed responses in multiple heavily pre-treated solid tumor types *(cut. melanoma, uveal melanoma, head and neck cancer, ovarian cancer, synovial sarcoma)*
- Positively evolving durability profile for IMA203
  - above 1 bn TCR-T cells (DL4/5)* in phase 1a and phase 1b: **50% (6/12) confirmed ORR[2]**
  - in phase 1b patients only: **80% (4/5) confirmed ORR[2]**

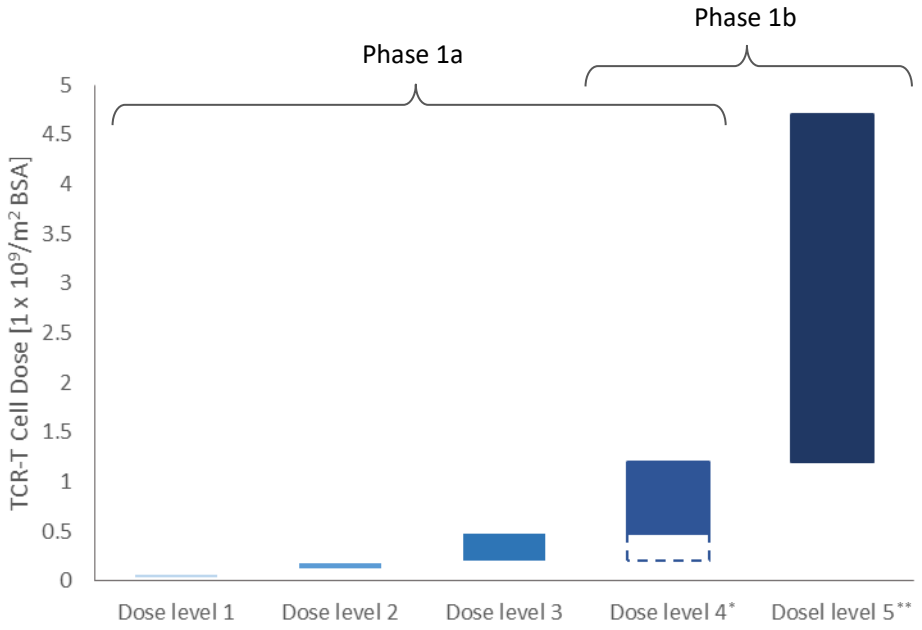
Data cut-off – 06-Sept-2022

[1] ORR: Objective response rate (partial responses) according to RECIST 1.1 at first scan post infusion (~6 weeks); [2] confirmed ORR: Confirmed objective response rate (confirmed partial responses) according to RECIST 1.1 at second scan post infusion (~12 weeks), 1 patient with SD at ~ 6-week scan with pending ~12-week scan considered as non-responder for confirmed ORR; * Total transduced viable CD8 T cells, all patients in Phase 1a DL4 and Phase 1b DL4/DL5; RPD2: Recommended Phase 2 dose; DL: Dose level

ACTengine® IMA203 Monotherapy – Patient and Product Characteristics

	Phase 1a Dose Escalation		Phase 1b (Cohort A) Dose Expansion
	All pts (DL1-4)	DL4 pts only	All pts (DL4/DL5)
Patients treated	27	7	5
Prior lines of treatment Mean (min, max)	4.2 (1, 8)	4.6 (1, 7)	4.0 (1, 10)
LDH at baseline >1 x ULN [% of patients]	66.7	85.7	40.0
Baseline tumor burden Mean target lesion sum of diameter [mm] (min, max)	130.3 (29.0, 219.7)	115.8 (37.0, 197.6)	55.2 (21.0, 102.9)
Dose Mean transduced viable CD8 T cells infused [x10^9] (min, max)	0.65 (0.08, 2.09)	1.48 (1.07, 2.09)	2.22 (1.30, 4.16)
Manufacturing Process	Prior versions[1]		Current version

IMA203 Dose Levels



32 heavily pre-treated patients, thereof **12 patients at target dose or above**, were infused with IMA203 TCR-T cells targeting PRAME

DL4 was defined as provisional RP2D for Phase 1b, exploration of higher DL5 ongoing

Data cut-off – 06-Sept-2022

[1] Except for 1 product for patient at DL3 generated with current manufacturing process; * DL4: 200m to 1.2bn transduced viable CD8 T cells per m^2 BSA, all patients in DL4 received cell doses in the upper tier of DL4, above DL3; ** DL5: up to 4.7bn transduced viable CD8 T cells per m^2 BSA; ULN: Upper limit of normal; BSA: Body surface area; RP2D: Recommended Phase 2 dose; LHD: Lactate dehydrogenase

IMA203 Tolerability Profile – Most Frequent Adverse Events

Acceptable and Manageable Treatment-emergent Adverse Events (TEAEs)

- **Expected cytopenia (Grade 1-4)** associated with lymphodepletion in all patients
- **Cytokine release syndrome (CRS)**: 31 of 32 (97%) patients infused with IMA203 experienced CRS of any Grade
  - 29 patients had Grade 1 or 2 CRS
  - 2 patients had Grade 3 CRS (both in phase 1a); recovered to Grade ≤2 after 3 and 4 days, respectively
- **Low-moderate ICANS[1]:** 5 of 32 (16%) patients infused with IMA203 experienced Grade 1 or 2 ICANS (all in phase 1a)
- **No dose-dependent increase of CRS and ICANS**
- **No additional DLT[2]**

Data cut-off – 06-Sept-2022

One patient that started lymphodepletion in Phase 1a died from sepsis of unknown origin and did not receive IMA203 T cells, patient reported earlier and not shown; CRS and ICANS graded by CARTOX criteria (Neelapu *et al.*, 2018);
[1] ICANS: Immune effector cell-associated neurotoxicity syndrome; [2] DLT: dose-limiting toxicity, one DLT in phase 1a at DL2 reported on March 17, 2021

Frequency of Observed Objective Responses

Improved ORR and Confirmed ORR at Higher Dose and in Phase 1b Cohort A

	Phase 1a		Phase 1a + Phase 1b	Phase 1b only
	All pts (DL1-4)	DL4 pts only[1]	DL4/DL5 pts only[1]	All pts (DL4/DL5)[1]
Patients Treated	27	7	12	5
ORR (~6 weeks)[2]	48% (13/27)	57% (4/7)	67% (8/12)	80% (4/5)
cORR (~12 weeks)[3]	19% (5/27)	29% (2/7)	50% (6/12)*	80% (4/5)*

- Higher ORR and confirmed ORR observed at doses above 1 billion TCR-T cells (DL4, DL5)
- Early trends towards higher ORR and confirmed ORR observed in Phase 1b vs. Phase 1a patients

Data cut-off – 06-Sept-2022

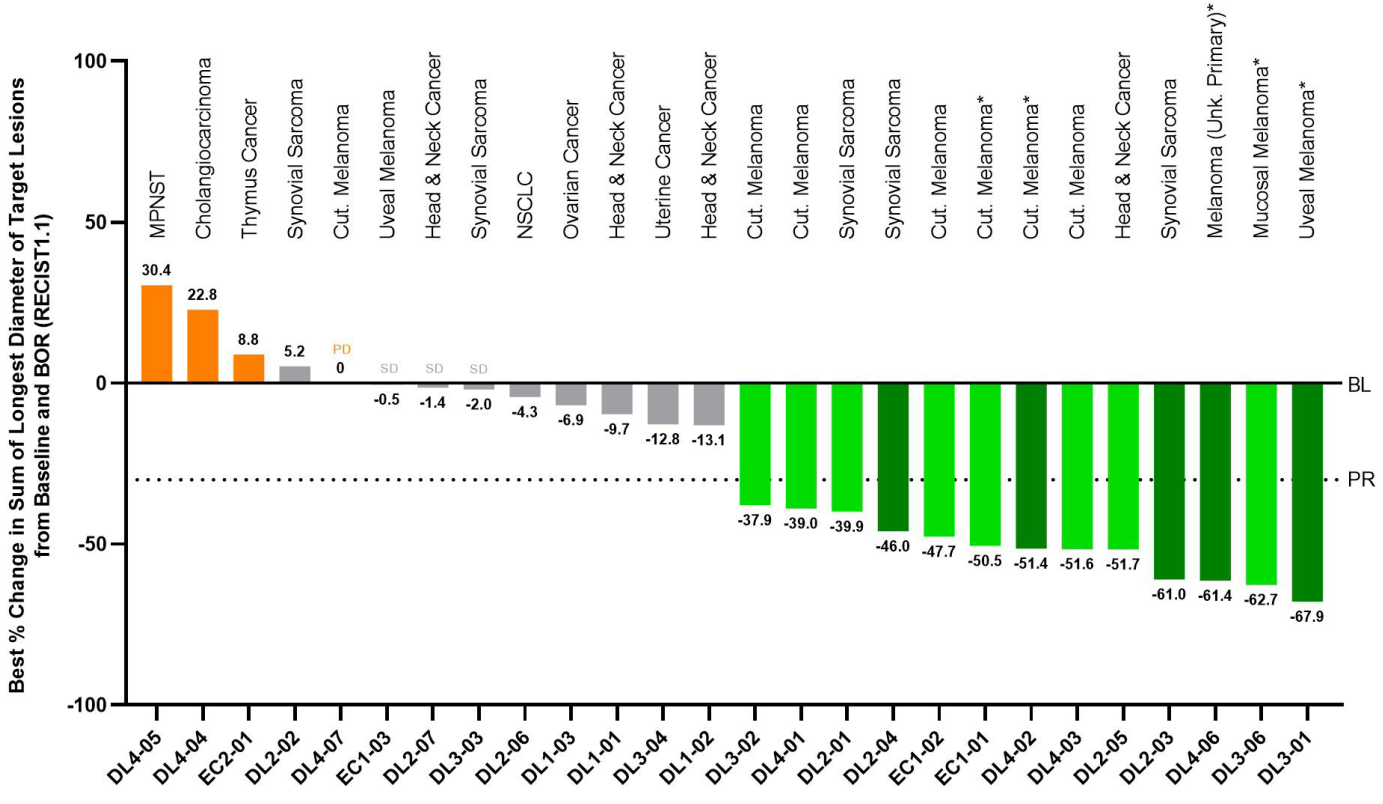
[1] All patients received >1 x 10^9 total transduced viable CD8 T cells; [2] ORR: Objective response rate (partial responses) according to RECIST 1.1 at first scan post infusion (~6 weeks); [3] Confirmed ORR (cORR): Confirmed objective response rate (confirmed partial responses) according to RECIST 1.1 at second scan post infusion (~12 weeks); * 1 patient with SD at ~ 6-week scan with pending ~12-week scan considered as non-responder for cORR.

Best Overall Response

IMA203 Continues to Deliver Objective Responses in Major Solid Tumor Types

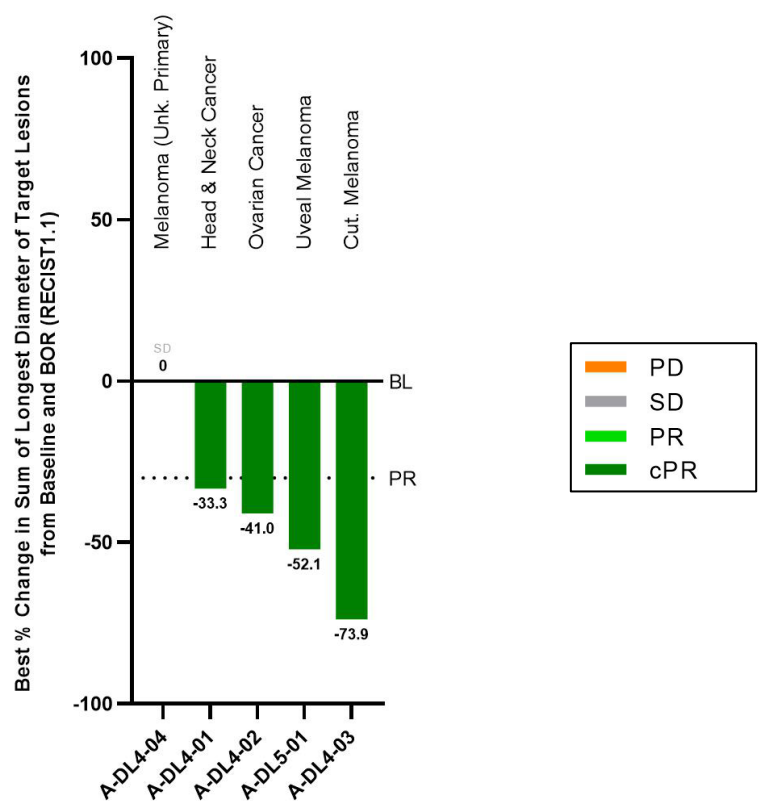
Phase 1a (Dose Escalation)

N=27#



Phase 1b (Cohort A)

N=5



Confirmed objective responses across a broad spectrum of different tumor types such as cutaneous melanoma, uveal melanoma, head and neck cancer, ovarian cancer, synovial sarcoma

Data cut-off – 06-Sept-2022

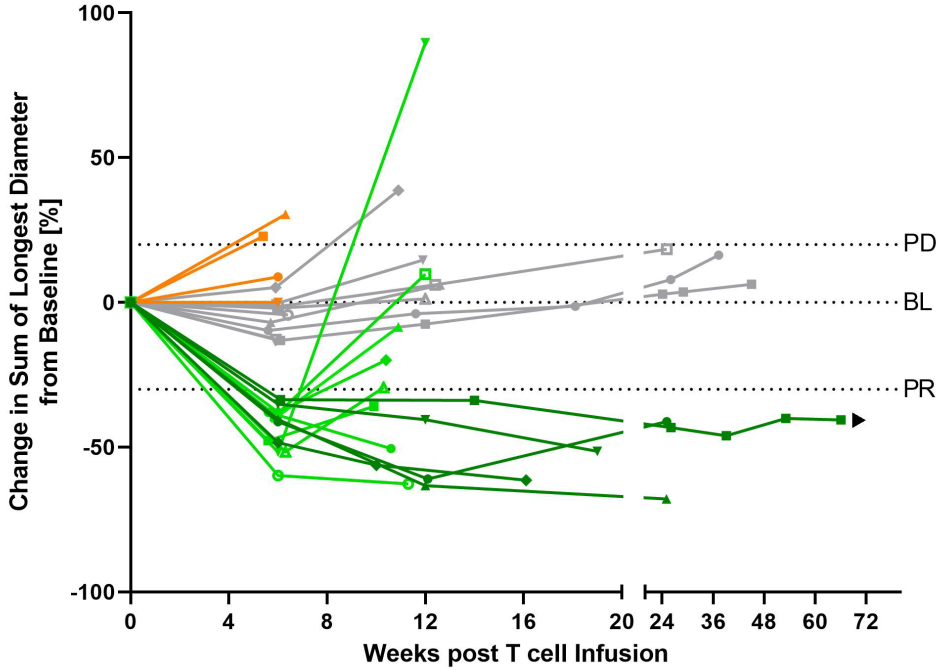
* Maximum change of target lesions and RECIST 1.1 BOR at different timepoints; # Synovial sarcoma patient (DL3) PD at week 6 not shown as target lesions were not evaluable;
PD: Progressive disease; SD: Stable disease; PR: Partial response; cPR: Confirmed partial response; BL: Baseline

Responses over Time

Encouraging Early Signs for Improved Durability at Higher Dose and in Phase 1b Patients

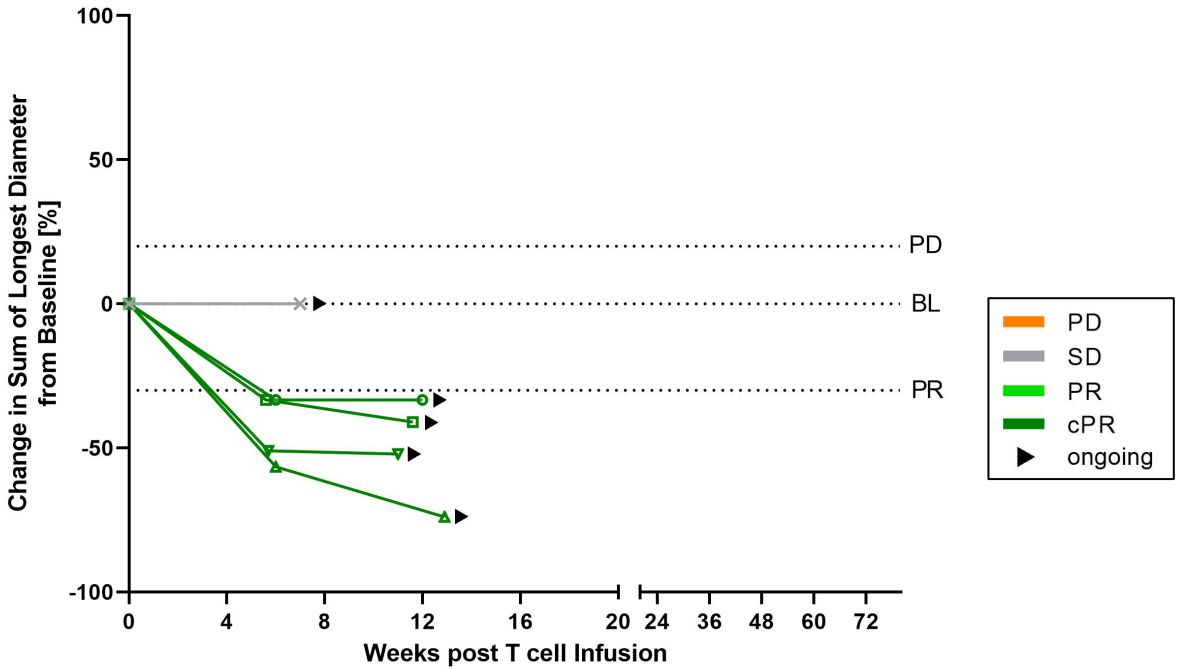
Phase 1a (Dose Escalation)

N=27#



Phase 1b (Cohort A)

N=5



Best overall response (RECIST1.1)

cPR	PR	SD	PD
DL2-03	EC1-01	DL1-01	DL2-06	EC2-01
DL2-04	EC1-02	DL4-01	DL1-02	DL2-07	DL4-04
DL3-01	DL2-01	DL4-03	DL1-03	DL3-03	DL4-05
DL4-02	DL2-05		EC1-03	DL3-04	DL4-07
DL4-06	DL3-02		DL2-02		

cPR	SD
A-DL4-01	A-DL4-04
A-DL4-02	
A-DL4-03	
A-DL5-01	

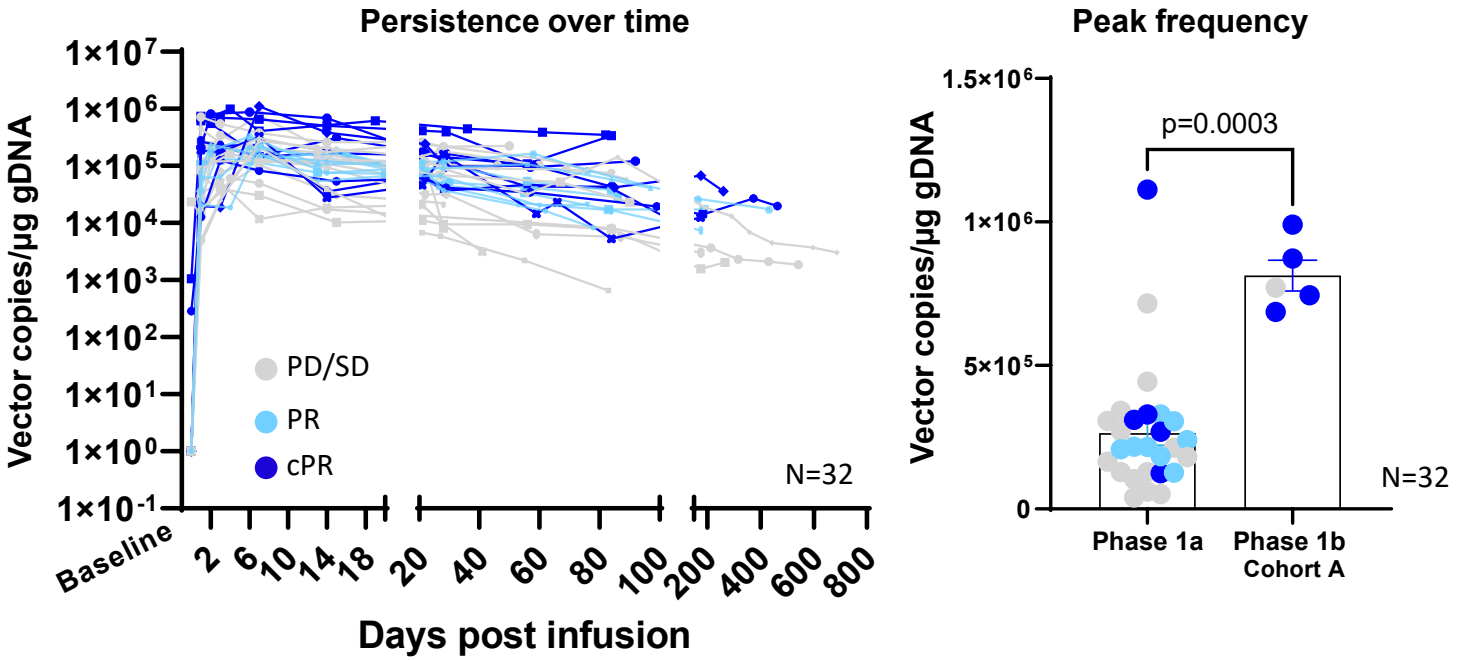
Data cut-off – 06-Sept-2022

Synovial sarcoma patient (DL3) PD at week 6 not shown as target lesions were not evaluable; PD: Progressive disease; SD: Stable disease; PR: Partial response; cPR: Confirmed partial response; BL: Baseline

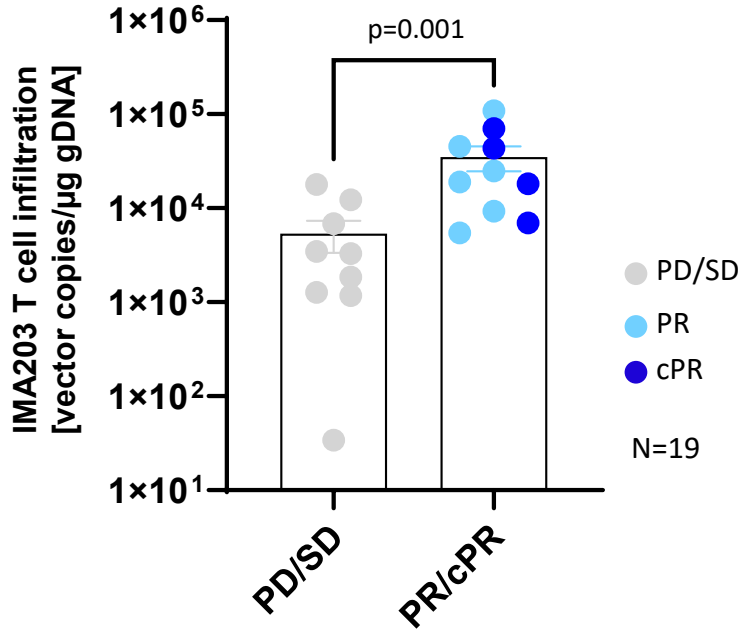
Translational Data Consistent with Clinical Outcomes

Supporting Proposed Mechanism of Action for IMA203

High IMA203 T cell engraftment and persistence in peripheral blood



IMA203 T cell infiltration into tumor correlates with objective responses[1]

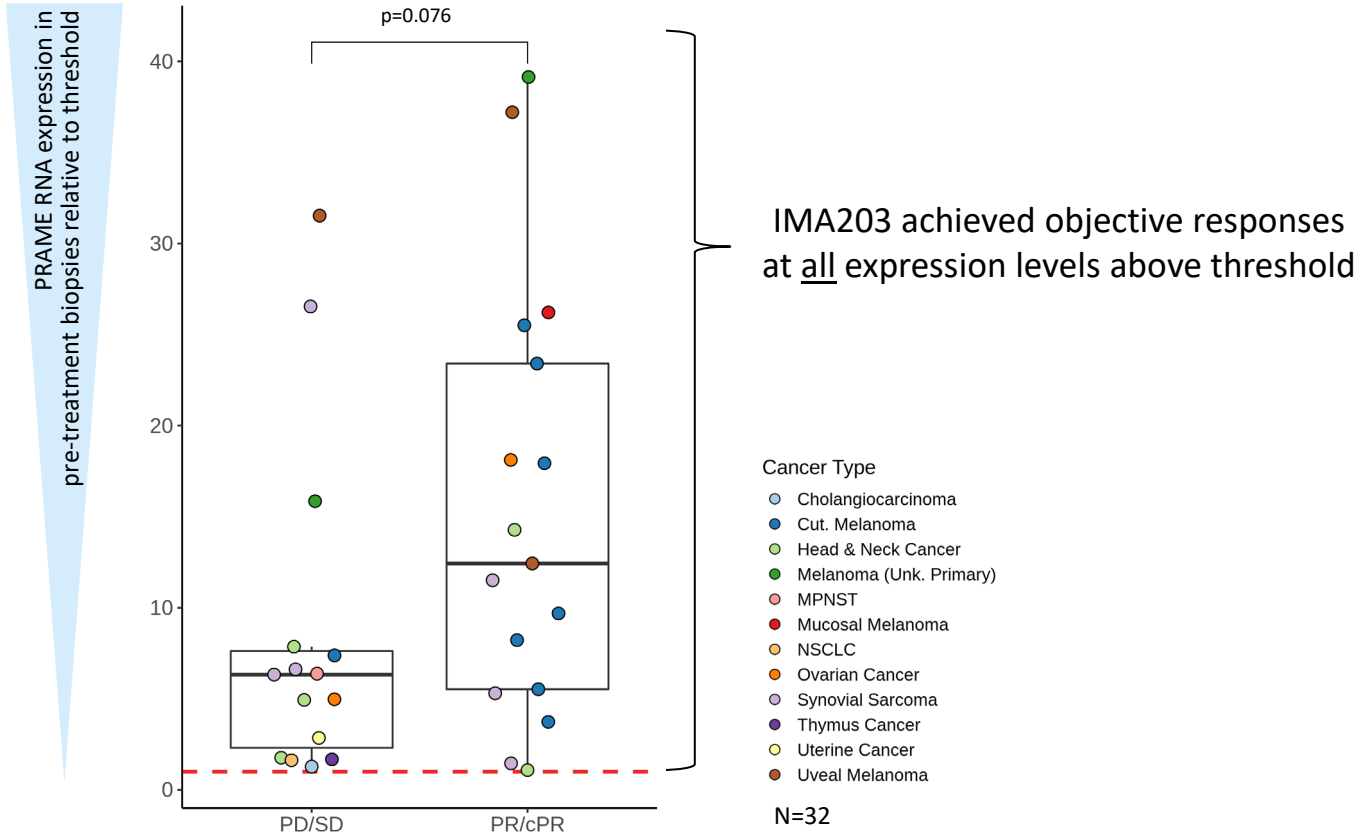


Data cut-off – 06-Sept-2022

Mann-Whitney U test; [1] T cell infiltration for 19 patients (9 non-responder, 10 responder) with 6-week post infusion biopsy available (1 patient with ~5-week post infusion biopsy)

PRAME Expression in Tumors from Screened Patients

Clinical Validation of Immatics' Mass Spectrometry-guided RNA Threshold for PRAME



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

Data cut-off – 06-Sept-2022

Mann-Whitney U test, p=0.076

Moving from Phase 1a to Phase 1b

Our Focus in Phase 1a

- Safety
- Biological activity
- Initial signs of clinical activity

Our Focus in Phase 1b

- Safety
- Durability of response at 6 months and beyond to pave the way for registration trials

We continue to improve key determinants as we move from Phase 1a into Phase 1b

1. **Higher T cell dose:** Only RP2D or exploratory DL5
2. **Enhanced cell product:** Implementation of manufacturing enhancements (e.g. monocyte depletion, see appendix) focusing on robustness, quality, and speed of product release
3. **"Real life" patients:** Working with more disease area experts to reduce the fraction of very heavily pre-treated patients with extreme disease burden who have exhausted standard of care and have undergone multiple clinical trials
4. **Transition to indication-specific development strategy:** Based on PRAME prevalence, patient population size and observed responses

IMA203 TCR-T Has the Potential to Reach a Large Patient Population

~39,000 Patients per Year in the US only

Initial indications of interest based on PRAME prevalence, patient population size and observed clinical responses

Selected Indications	Incidence	R/R Incidence	PRAME Positive	Patient Population (Based on R/R Incidence; PRAME and HLA-A*02:01+)
Cut. Melanoma	99,800	7,700	95%	2,999
Uveal Melanoma	1,500	800	90%	295
Ovarian Carcinoma	19,900	12,800	80%	4,198
Uterine Carcinoma	62,700	10,700	100%	4,387
Uterine Carcinosarcoma	3,300	1,900	100%	779
Synovial Sarcoma	1,000	400	100%	164
Squamous NSCLC	57,000	34,600	65%	9,221
Small Cell Lung Cancer	31,900	19,400	55%	4,375
Cholangiocarcinoma	8,000	7,000	35%	1,005
Adeno NSCLC	91,200	55,300	25%	5,668
Breast Carcinoma	290,600	43,800	25% TNBC: 60%	4,490
HNSCC	66,500	15,100	25%	1,548

TOTAL ~39,000 annually in the US

Multiple opportunities to broaden patient reach and patient benefit:

- Expand beyond US population
- Expand into other indications such as kidney, esophageal, bladder, liver cancer, other sarcoma subtypes through indication-specific or indication-agonistic label expansion
- Move into earlier lines of therapy (R/R Incidence → Incidence)
- Inclusion of patients with lower PRAME-threshold

Incidences based on public estimates and Immatics internal model; Relapsed/refractory (R/R) or last-line patient population approximated by annual mortality; Estimated 41% HLA-A*02:01 positive population in the US; PRAME target prevalence is based on TCGA (for SCLC: in-house) RNAseq data combined with a proprietary mass spectrometry-guided RNA expression threshold; Uveal melanoma target prevalence is based on IMADetect® qPCR testing of screening biopsies from clinical trial patients (n=21)

IMA203 Monotherapy – Conclusions

ACTengine® IMA203 Targeting PRAME Offers a Unique Opportunity for Solid Cancer Patients

IMA203 monotherapy Phase 1a and Phase 1b cohort A summary:

- IMA203 continues to be well tolerated with manageable safety profile
- Confirmed responses across a broad spectrum of different solid tumor types in heavily pre-treated patients
- Positively evolving durability profile for patients treated with higher doses and in phase 1b
- Clinical validation of PRAME biomarker threshold and associated prevalences

➢ **We have clinically validated PRAME as one of the largest known T cell targets for solid cancers to date**

IMA203 development strategy:

- Transition to indication-specific development strategy
- Three Phase 1b expansion cohorts ongoing each designed to establish safety, evaluate the observed objective response rate, demonstrate durability & provide the trigger for registration trials

Data highlight the clinical potential of IMA203 TCR-T to achieve meaningful benefit for a large patient population

Comprehensive PRAME Strategy

To Deliver Meaningful Clinical Benefit to Patients with PRAME-positive Cancers

Phase 1a Dose Escalation

IMA203 Monotherapy in Basket Trial

Completed & provisional RP2D[1] determined in March 2022

Phase 1b Dose Expansion

Cohort A
IMA203 Monotherapy at Target Dose (plus DL5)[1]
Increasing T cell:Tumor cell Ratio[2]
First pt treated March 2022

Cohort B
IMA203 at Target Dose plus Checkpoint Inhibitor[3]
Blocking PD-1/PD-L1 pathway
First pt treated May 2022

Cohort C
IMA203CD8 2nd Gen[4]
Adding functional CD4 T cells[5]
First pt treated Aug 2022

Upcoming Value Inflection Points for Our PRAME Programs

ACTengine® IMA203: Next data read-outs with meaningful data across all cohorts in 2023

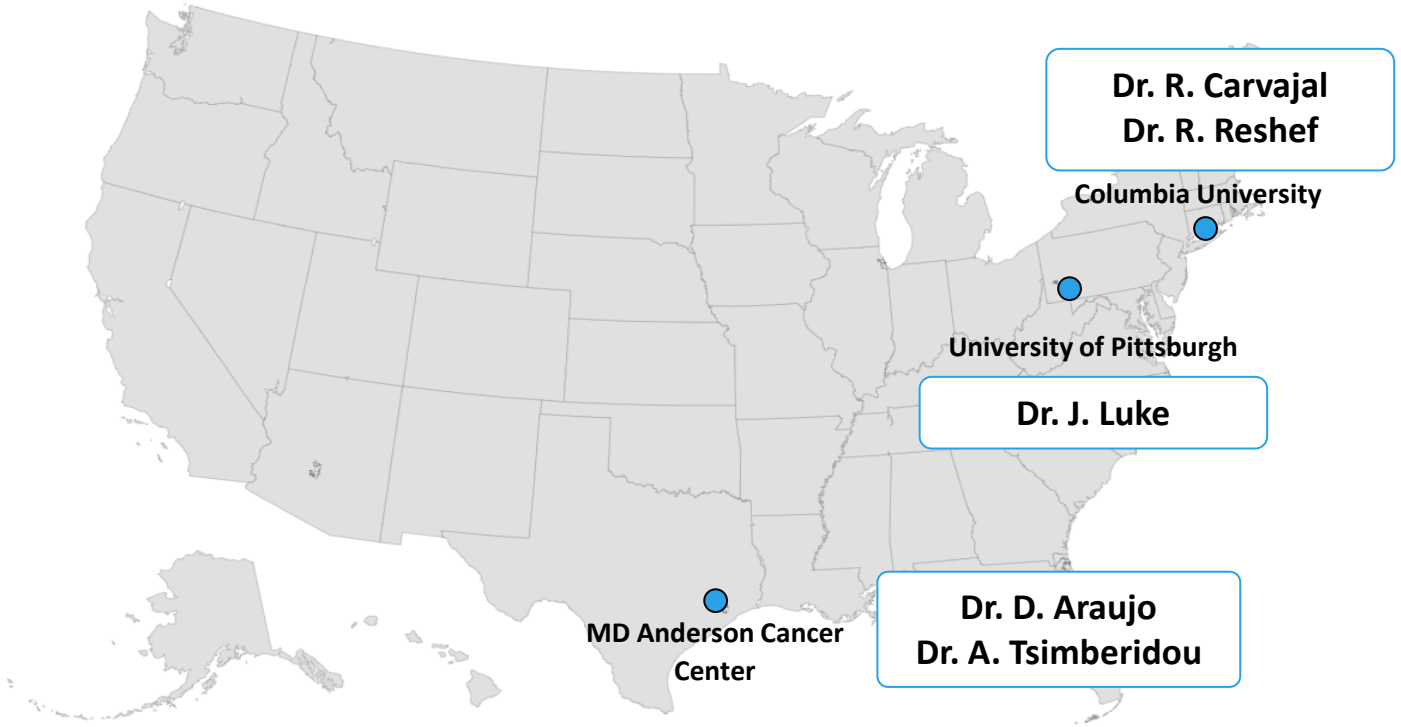
⊕

TCER® IMA402: Entering clinical development in 2023

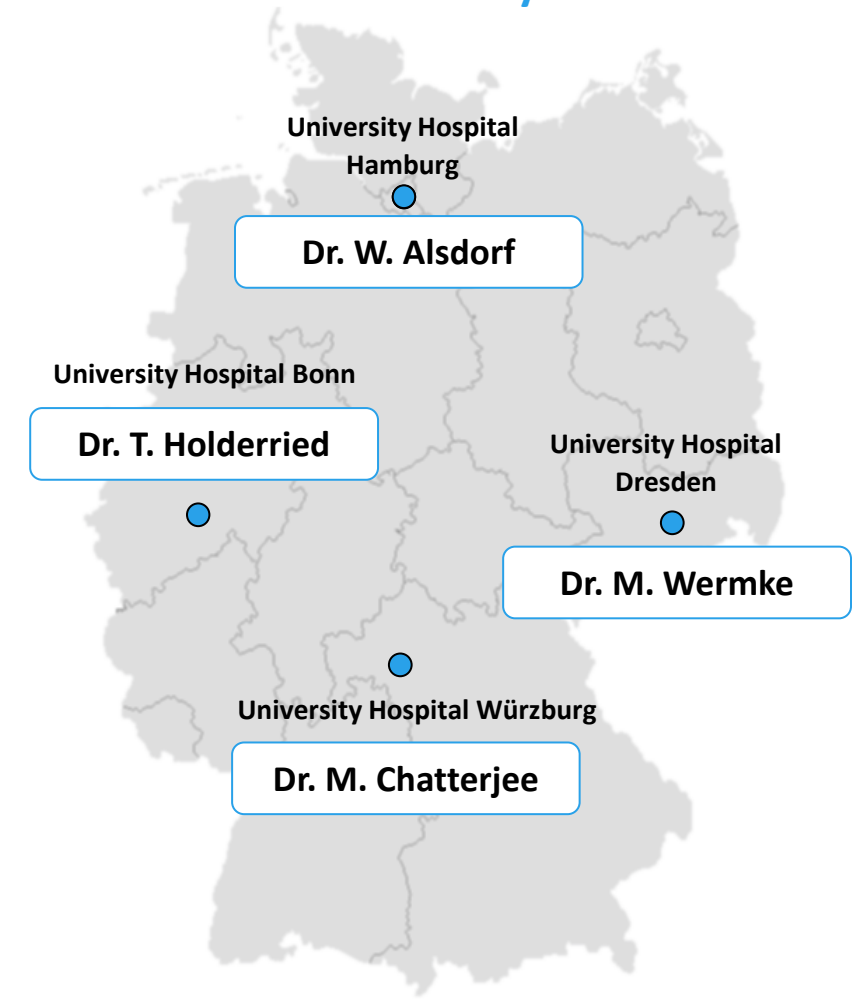
[1] RP2D (target dose) determined at DL4, exploration of higher dose (DL5) ongoing; [2] Demonstrated to be associated with durable response: Locke *et al.* 2020 Blood Advances; [3] Opdivo® (nivolumab): programmed death-1 (PD-1) immune checkpoint inhibitor; [4] Treatment of n=3 patients in DL3 prior to patient treatment at provisional RP2D (DL4); [5] Demonstrated to be important for long-term remission: Melenhorst *et al.* 2022 Nature, Bai *et al.* 2022 Science Advances

We are Immensely Grateful to the Patients, Their Families …

United States



Germany



… and the Investigators at the Clinical Sites

Delivering

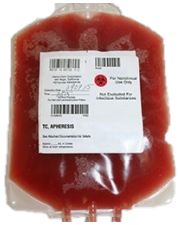
the Power of T cells to Cancer Patients

www.immatics.com

ACTengine® IMA203 Product Manufacturing

Targeting Higher Robustness, Favorable Product Attributes, Faster Turn Around Time

Accelerated Product Release



Leukapheresis

ACTengine® clinical programs: ~3 weeks

Manufacturing time (~1 week)	QC testing (Full sterility, 2 weeks)

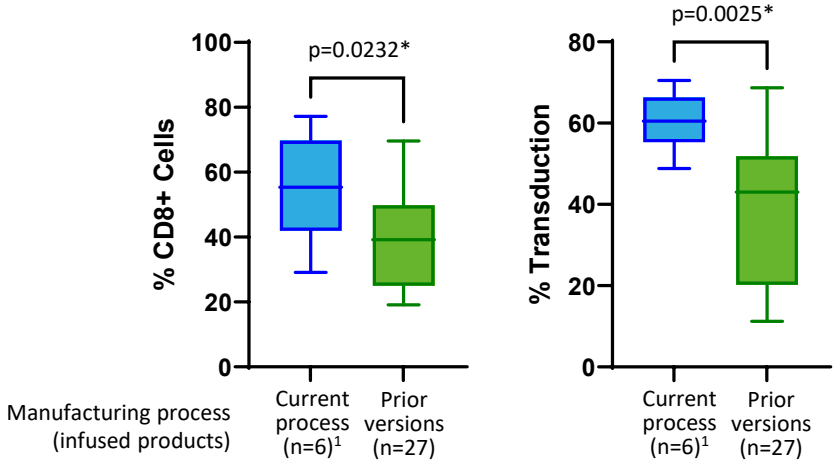
Faster ACTengine®: expected ~2 weeks

Manufacturing time (~1 week)	Expedited QC testing (~1 week)

Implementation planned

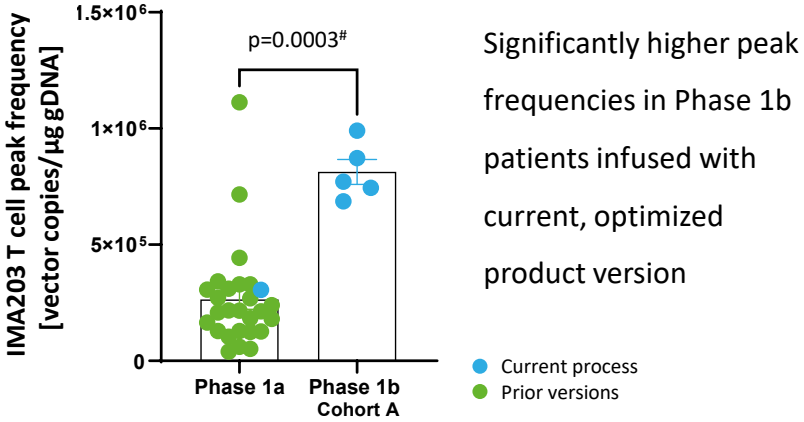
Infusion-Ready

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



All Phase 1b cell products were manufactured with the current, optimized process including manufacturing improvements such as

- ✓ Monocyte depletion
- ✓ Serum-free transduction



Significantly higher peak frequencies in Phase 1b patients infused with current, optimized product version

[1] Includes 5 IMA203 products infused into Phase 1b cohort A patients, and 1 product infused into Phase 1a patient at DL3; * Unpaired t test;
[#] Mann-Whitney U test, 1 patient in Phase 1a at DL3 received ~0.5 x 10^9 total transduced viable CD8 T cells manufactured with current process

IMA203 Tolerability Profile – All ≥Grade 3 Adverse Events

TEAEs by maximum severity (N=33)[1*]

Adverse event	≥ Grade 3 No.	≥ Grade 3 %
Patients with any adverse event	33	100.0
Adverse Events of Special Interest		
Cytokine release syndrome	2	6.1
ICANS[2]	0	0.0
Blood and lymphatic system disorders		
Neutropenia	27	81.8
Lymphopenia	22	66.7
Leukopenia	20	60.6
Anaemia	17	51.5
Thrombocytopenia	13	39.4
Cytopenia	1	3.0
Leukocytosis	1	3.0
Lymphocytosis	1	3.0
Infections and infestations		
Appendicitis	1	3.0
COVID-19	1	3.0
Enterococcal infection	1	3.0
Orchitis	1	3.0
Sepsis[4,5]	1	3.0
Septic shock[4]	1	3.0
Respiratory, thoracic and mediastinal disorders		
Hypoxia	2	6.1
Bronchial obstruction	1	3.0
Laryngeal inflammation	1	3.0
Pleural effusion	1	3.0
Respiratory failure	1	3.0
General disorders and administration site conditions		
Condition aggravated[4]	1	3.0
Fatigue	1	3.0
Pyrexia	1	3.0
Swelling face	1	3.0
Gastrointestinal disorders		
Abdominal pain	1	3.0
Diarrhoea	1	3.0
Vomiting	1	3.0

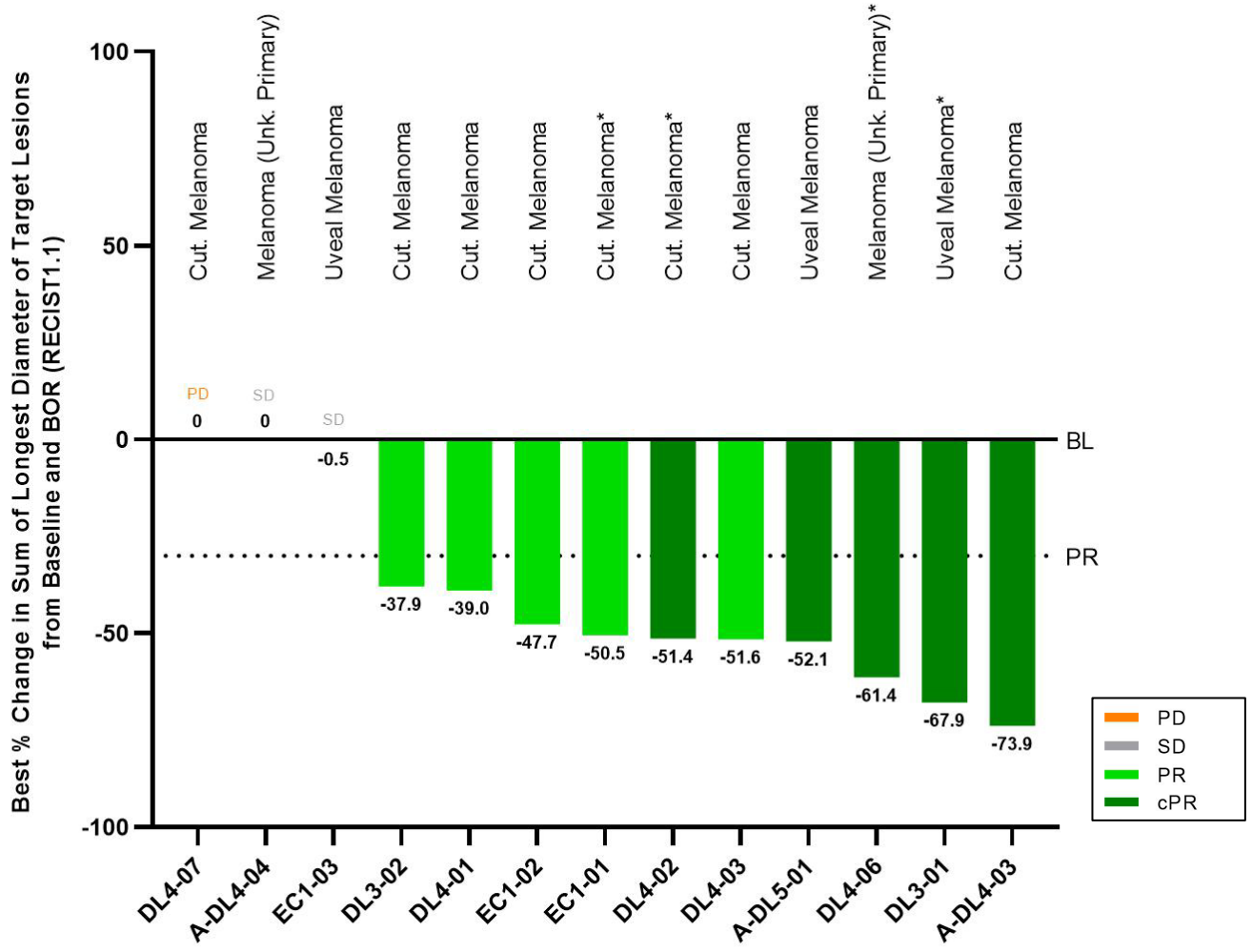
Adverse event	≥ Grade 3 No.	≥ Grade 3 %
table continued…		
Investigations		
Blood alkaline phosphatase increased	1	3.0
Blood creatinine increased	1	3.0
Blood fibrinogen decreased	1	3.0
Metabolism and nutrition disorders		
Hypokalaemia	2	6.1
Failure to thrive	1	3.0
Vascular disorders		
Hypertension	2	6.1
Hypotension	1	3.0
Injury, poisoning and procedural complications		
Fracture	1	3.0
Infusion related reaction	1	3.0
Renal and urinary disorders		
Acute kidney injury	1	3.0
Proteinuria	1	3.0
Cardiac disorders		
Atrial fibrillation[3]	1	3.0
Endocrine disorders		
Inappropriate antidiuretic hormone secretion	1	3.0
Eye disorders		
Ulcerative keratitis	1	3.0
Hepatobiliary disorders		
Cholangitis	1	3.0
Immune system disorders		
Contrast media allergy	1	3.0
Musculoskeletal and connective tissue disorders		
Muscle spasms	1	3.0
Reproductive system and breast disorders		
Vaginal haemorrhage	1	3.0
Skin and subcutaneous tissue disorders		
Rash maculo-papular	1	3.0

- IMA203 was well tolerated
- No ≥Grade 3 Adverse Events in ≥ 10% of patients except for expected events associated with lymphodepletion
- No IMA203-related Grade 5 Adverse Events

[1] All treatment-emergent adverse events (TEAEs) with ≥ Grade 3 regardless of relatedness to study treatment that occurred in at least 1 patient (except for ICANS, where only Grade 1-2 occurred; listed for completeness due to being an adverse event of special interest) are presented. Adverse events were coded using the Medical Dictionary for Regulatory Activities. Grades were determined according to National Cancer Institute Common Terminology Criteria of Adverse Events, version 5.0. Grades for CRS and ICANS were determined according to CARTOX criteria (Neelapu *et al.*, 2018). Patients are counted only once per adverse event and severity classification. Based on interim data extracted from open clinical database (06-Sep-2022); [2] ICANS: Immune effector cell-associated neurotoxicity syndrome; [3] DLT: Dose limiting toxicity in phase 1a at DL2 reported on March 17, 2021; [4] Fatal Adverse events in N=3 patients were not considered related to any study drug; [5] Patient did not receive IMA203 TCR-T cells; * Two patients with disease progression after first IMA203 infusion received exploratory second IMA203 infusion. They had these ≥ Grade 3 TEAEs only after second infusion, which are included in the table: First patient: Abdominal pain, Diarrhoea, Cytokine release syndrome, Hypokalaemia, Proteinuria; Second patient: Fracture, Muscle spasms, Neutropenia, Thrombocytopenia.

Focus on Melanoma Patients

High ORR and cORR in Heavily Pre-Treated Patients with High Tumor Burden



Patient Characteristics (n=13)	
Prior lines of treatment Mean (min, max)	4.5 (1, 7)
Previous lines of CPI Mean (Min, Max)	2.5 (1, 4)
LDH at baseline >1 x ULN [% of patients]	69%

Particular hard-to-treat patient population enrolled so far

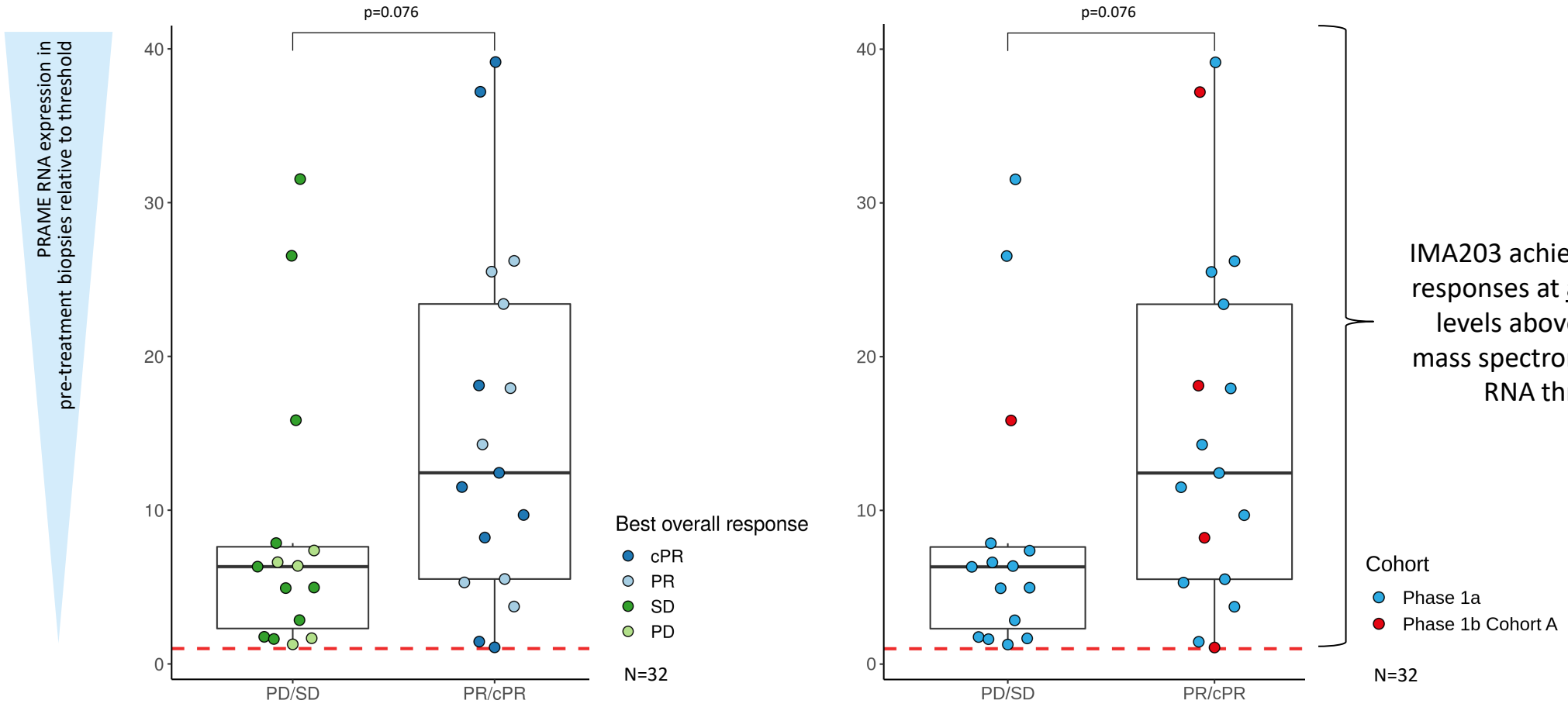
Melanoma Subtype	ORR (~6 weeks)[1]	cORR (~12 weeks)[2]
Melanoma (DL4/DL5)[3]	**6/8 (75%)**	**4/8 (50%)#**
Melanoma (all DL)	**10/13 (77%)**	**5/13 (38%)#**
Cutaneous Melanoma	7/8 (88%)	2/8 (25%)
Uveal Melanoma	2/3 (67%)	2/3 (67%)
Unknown Primary	1/2 (50%)	1/2 (50%)#

Data cut-off – 06-Sept-2022

* Maximum change of target lesions and RECIST1.1 response at different timepoints; [1] ORR: Objective response rate (partial responses) according to RECIST 1.1 at first scan post infusion (~6 weeks); [2] Confirmed ORR (cORR): Confirmed objective response rate (confirmed partial responses) according to RECIST 1.1 at second scan post infusion (~12 weeks); [3] All patients received >1x10^9 total transduced viable CD8 T cells; # 1 patient with SD at ~ 6-week scan with pending ~12-week scan considered as non-responder for cORR; CPI: checkpoint inhibitor

PRAME Expression in Tumors from Screened Patients

Highlighting Type of Best Overall Response (left) and Study Cohort (right)



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

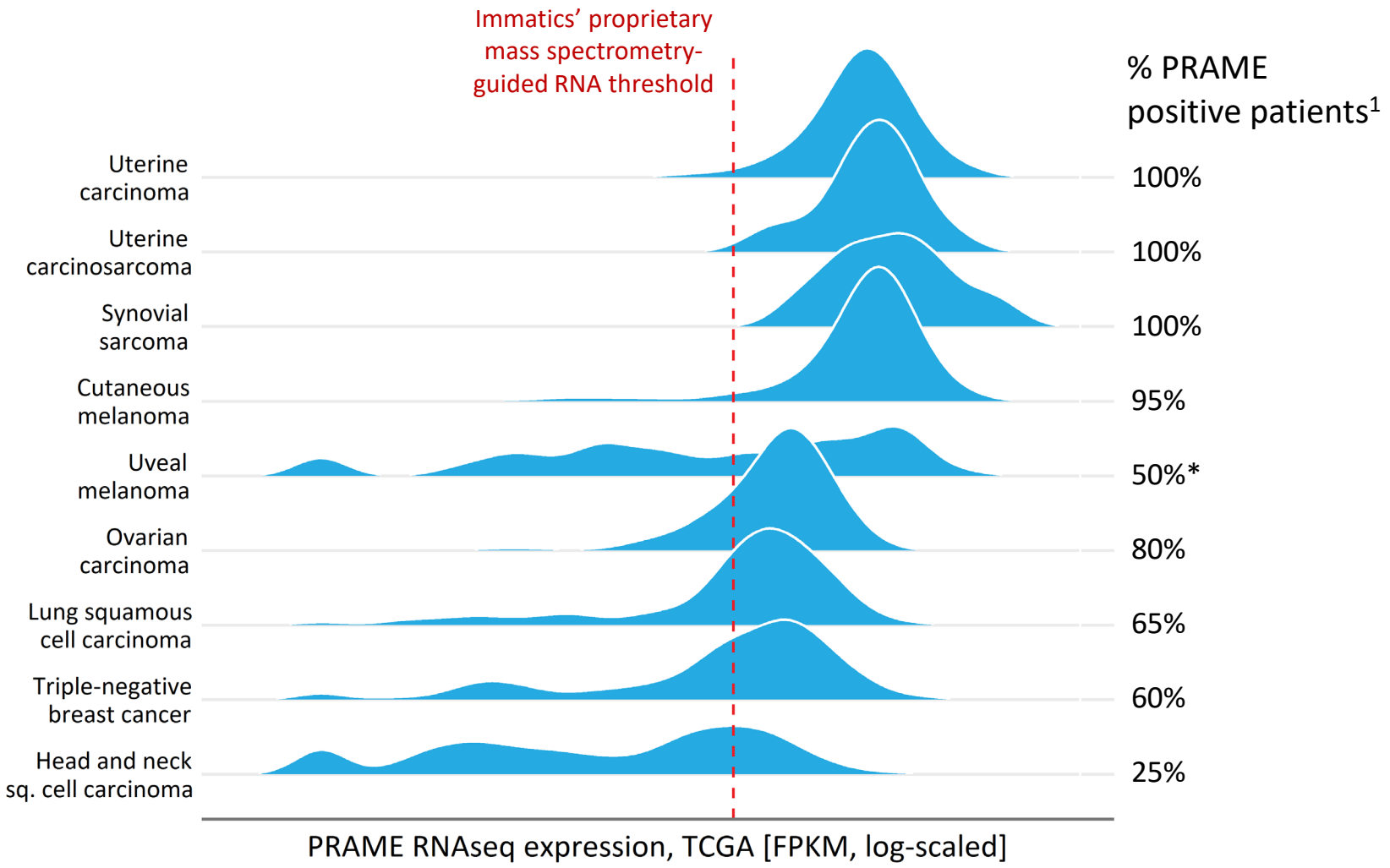
IMA203 has the potential to provide clinical benefit for all PRAME biomarker-positive cancer patients

Data cut-off – 06-Sept-2022

Mann-Whitney U test, p=0.076

PRAME Expression – RNAseq Data

Combined with Immatics' Mass Spectrometry-guided RNA Threshold for Prevalence Prediction



[1] PRAME target prevalence is based on TCGA RNAseq data combined with a proprietary mass spectrometry-guided RNA expression threshold; * PRAME target prevalence in uveal melanoma based on IMADetect® qPCR testing of screening biopsies from clinical trial patients (n=21) demonstrates substantial higher prevalence of 90%, 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