IMMUNOCORE

Corporate Presentation

40th Annual J.P. Morgan Healthcare Conference
January 2022

Forward-Looking Statements

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Words such as “may,” “will,” “believe,” “expect,” “plan,” “anticipate” and similar expressions (as well as other words or expressions referencing future events or circumstances) are intended to identify forward-looking statements. Forward-looking statements contained in this presentation include but are not limited to, statements about the Company’s proposed regulatory plans for tebentafusp, the efficacy, safety and therapeutic potential of tebentafusp, the expected timing of a BLA review and action date for tebentafusp for the treatment of mUM, the potential approval and commercial launch of tebentafusp for mUM, the design, progress, timing, scope and results of the Company’s clinical trials including IMC-C103C, IMC-F106C, IMC-I109V and IMC-M113V, the anticipated achievement of upcoming clinical milestones, the potential benefit of Breakthrough Therapy Designation or Orphan Drug Designation for tebentafusp the design, progress, timing, scope and results of the Company’s clinical trials including IMC-C103C and tebentafusp; the potential clinical benefit of the Company’s product candidates; the timing and outcome of discussions with regulatory authorities; and the success of any licensing or partnering opportunities. Each of these forward-looking statements involves risks and uncertainties. These statements are based on the Company’s current expectations and projections made by management and are not guarantees of future performance. Therefore, actual events, outcomes and results may differ materially from what is expressed or forecast in such forward-looking statements. Factors that may cause actual results to differ materially from these forward-looking statements include the fact that initial data from clinical trials may not be indicative, and are not guarantees, of the final results of the clinical trials and are subject to the risk that one or more clinical outcomes may materially change as patient enrollment continues and or more patient data becomes available. Additional risks that could cause actual results to differ materially from those in the forward-looking statements are discussed in Immunocore’s filings with the U.S. Securities and Exchange Commission, including the "Risk Factors" sections contained therein. Such risks may be amplified by the COVID-19 pandemic and its potential impact on Immunocore’s business and the overall global economy. All forward-looking statements contained in this presentation speak only as of the date on which they were made. Except to the extent required by law, Immunocore undertakes no obligation to update such statements to reflect events that occur or circumstances that exist after the date on which they were made.

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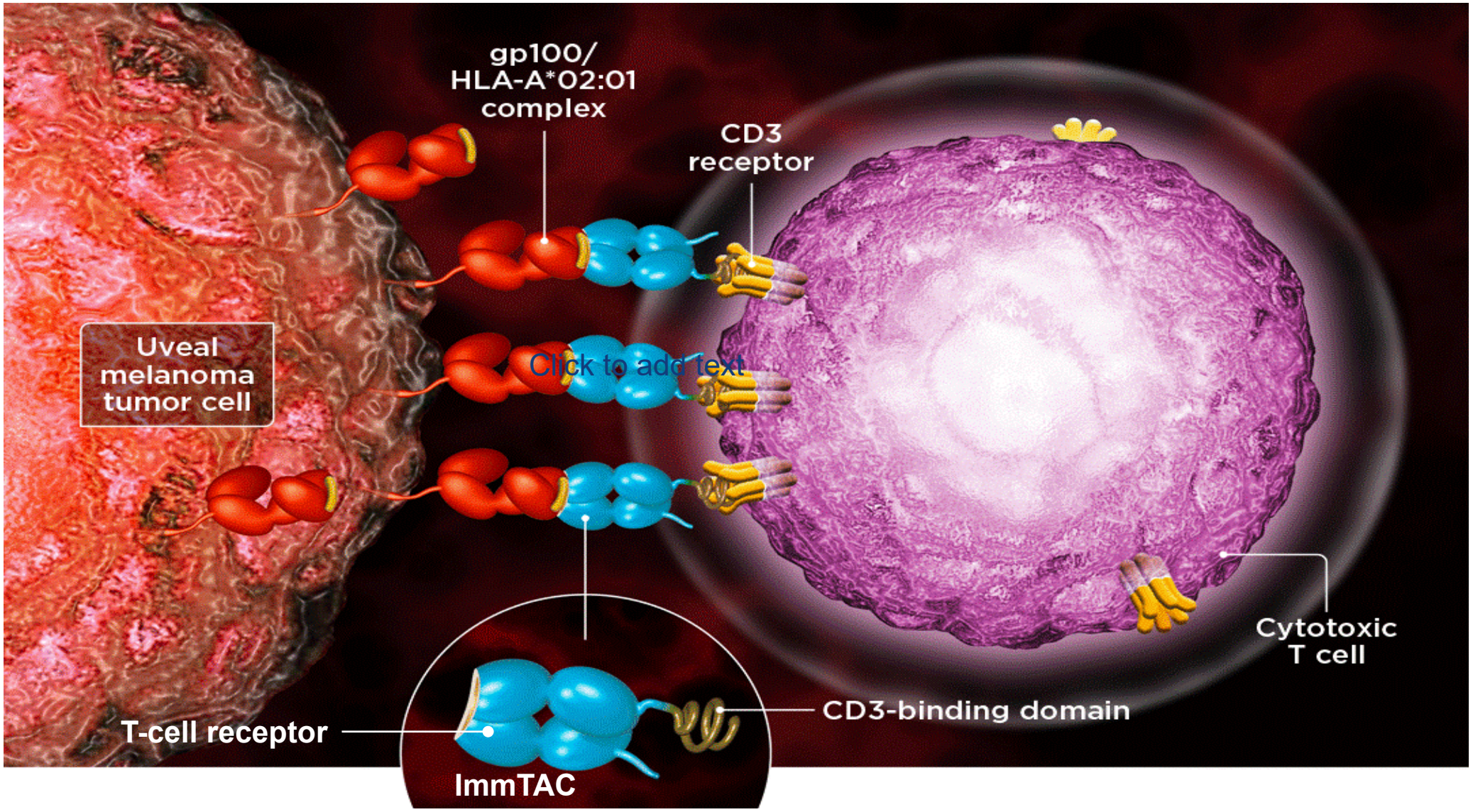
Harnessing the immune system to fight disease with targeted, off-the-shelf, bispecific, soluble T cell receptors (TCRs)



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Immunocore: Pioneering TCR therapeutics

Leader in off-the-shelf bispecific T-cell engagers

First TCR to demonstrate monotherapy overall survival (OS) benefit in solid tumor

Clinically-validated platform moving to commercialization in mUM[1]

Potential first FDA approval for a TCR therapeutic

Pipeline with potential in multiple indications / therapeutic areas

Oncology (tebentafusp, PRAME, MAGE-A4), infectious and autoimmune diseases

5 clinical stage programs

1. Metastatic uveal melanoma

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Our team

Proven track record with over 25 new medicines for patients

Bahija Jallal
CEO

MedImmune · SUGEN · CHIRON

IMFINZI, FASENRA, LUMOXITI, SELIQ, QAIV, SAPHNELO

Brian Di Donato
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Bristol Myers Squibb · MedImmune · AstraZeneca

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Ralph Torbay
Head of Commercial

AstraZeneca · NOVARTIS

IMFINZI, TAGRISSO, CALQUENCE, GLEEVEC, TASIGNA, ARZERRA, FARYDAK

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Our pipeline

Leading bispecific TCR pipeline with tebentafusp BLA & MAA submissions accepted

Candidate	Target	Indication	Pre-clinical	Phase 1 / 2	Phase 3	Approved	Anticipated Milestones
Oncology							
Tebentafusp	gp100	Uveal melanoma					❖ PDUFA Feb. 2022 ❖ Commercial launch 1H 2022
		Cutaneous melanoma					❖ Randomized study 4Q 2022
IMC-F106C	PRAME	NSCLC, breast, endometrial, ovarian, SCLC, melanoma					❖ Ph. 1 initial data mid 2022
IMC-C103C [1]	MAGE-A4	NSCLC, gastric, head & neck, ovarian, synovial sarcoma					✓ Initiated ovarian expansion ❖ Ph. 1 update 2H 2022
Candidate #4	Undisclosed	Multiple solid tumors					
Candidate #5	Undisclosed	Colorectal, gastric, pancreatic					
Infectious Diseases							
IMC-I109V	Envelope	Hepatitis B Virus (HBV)					❖ Enrolling Ph. 1
IMC-M113V [2]	Gag	Human Immunodeficiency Virus (HIV)					❖ First patient dosing 2Q 2022

[1] Developed under a co-development/co-promotion collaboration with Genentech. [2] Program is wholly owned, development costs being provided by the Bill & Melinda Gates Foundation (BMGF), Immunocore retain all development and commercialization rights in the developed world.

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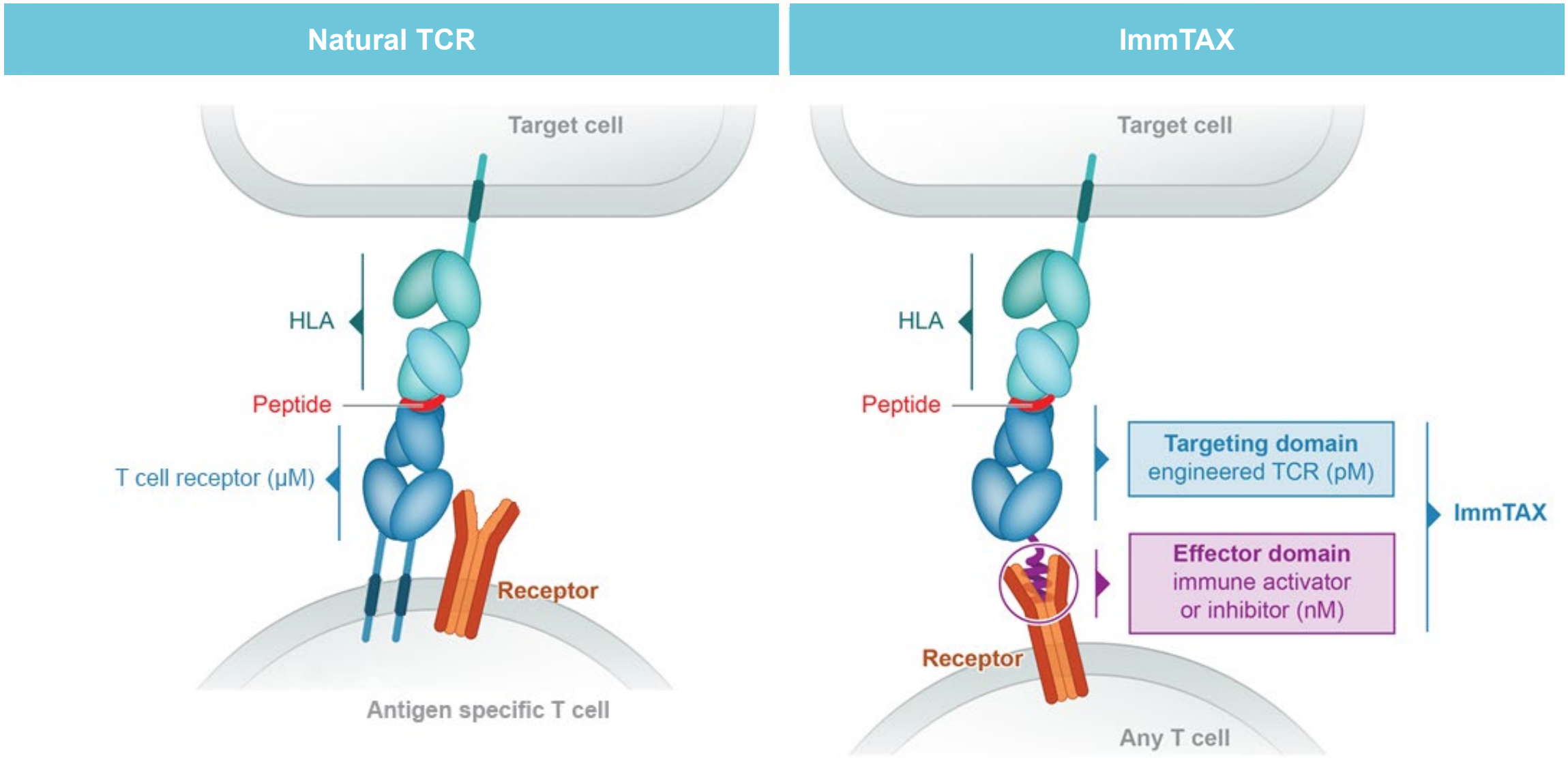
Technology Platform

We pioneered converting membrane-bound T cell receptors

Into soluble, off-the-shelf, bispecific therapeutics (ImmTAX)



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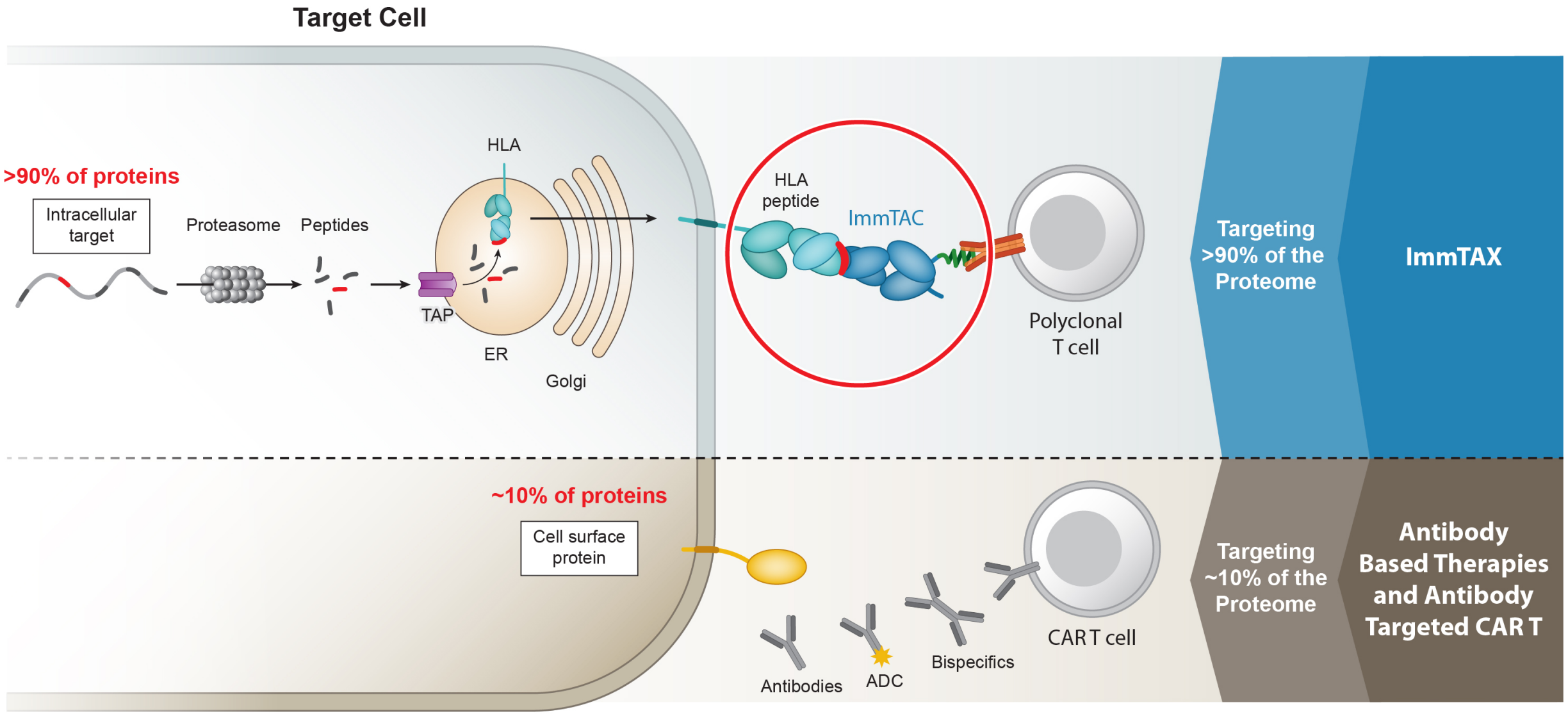
TCR therapeutics can target nearly the entire human proteome

Application to oncology, infectious disease and autoimmune



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Seamless suite of proprietary technologies spanning target discovery to clinic

1 ImmSPECT
Target identification platform

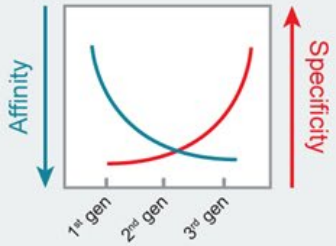
2 Dual TCR discovery platform
'Blind date' and T cell cloning

3 Unique TCR quality evaluation platform

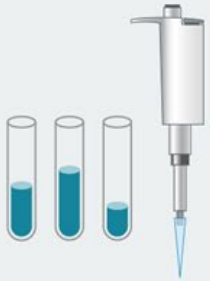
Large TCR crystallography database (>300 structures)

4 Proprietary TCR engineering

Million-fold stronger affinity while increasing specificity



5 Industry-leading tox platform
Proven for 5 clinical stage programs



- Fully *in vitro* systems
- De-risks TCR cross reactivity
- Evaluates potency, specificity and safety

6 Fully scaled manufacture

- *E. coli* based
- Successfully scaled
- Tebentafusp launch stocks manufactured
- >40 successful GMP batches across 5 clinical programs

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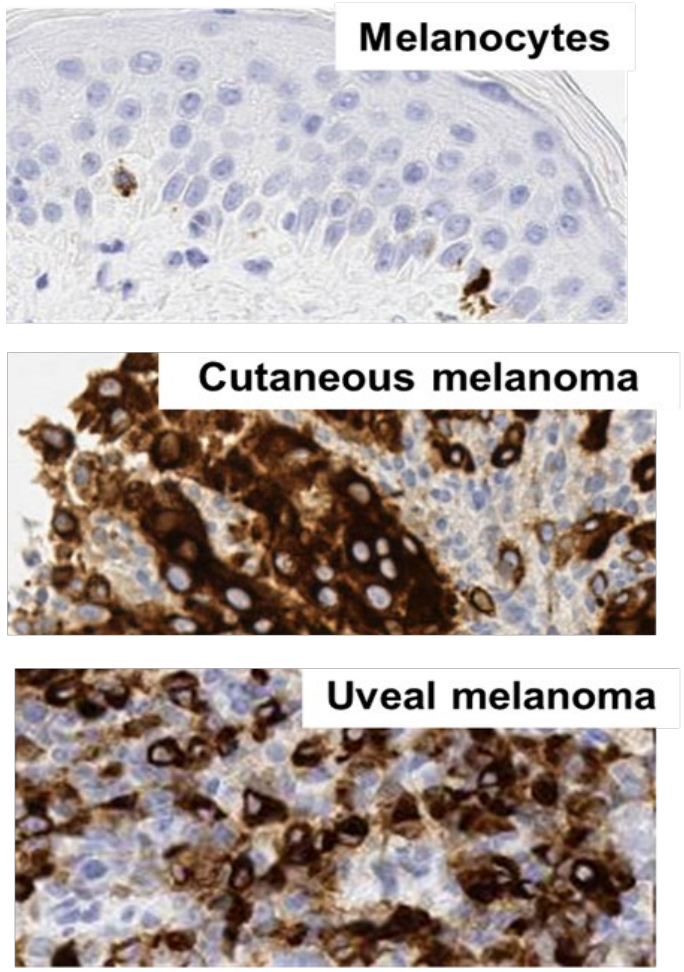
Tebentafusp in Metastatic Melanoma

Tebentafusp (Tebe): First-in-class, off-the-shelf, bispecific TCR

Targeting gp100 protein in melanoma

gp100 protein



Three melanoma clinical trials

IMCgp100-01:

Ph 1 in uveal & cutaneous melanoma[1]

Endpoints: safety and activity

IMCgp100-102:

Ph 2 in uveal melanoma[2]

Second or third line in metastatic disease

Primary endpoint: RECIST ORR

IMCgp100-202:

Ph 3 pivotal in uveal melanoma[3]

First line metastatic

Primary endpoint: Overall Survival

The NEW ENGLAND JOURNAL of MEDICINE

1 Middleton, et. al. *Journal of Clinical Oncology* 2016 34:15_suppl, 3016-3016; 2 Sacco, et. al., *ESMO Immuno-Oncology Virtual Congress 2020.* ;
3 Nathan, P. et. al. *New England Journal of Medicine* 2021; 385:1196-1206

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Randomized Ph 3 trial in previously untreated metastatic UM

IMCgp100-202 study

Metastatic UM:

- HLA-A*0201+
- No prior systemic therapy in the advanced setting
- No prior liver-directed therapy, except surgery
- Any LDH

378 patients Randomized 2:1

Tebentafusp

Investigator's Choice (IC):

- Dacarbazine **6%**
- Ipilimumab **12%**
- Pembrolizumab **82%**

Primary endpoint
Overall Survival (OS)

Data cut-off date: October 13, 2020; data snapshot date: January 22, 2021.

Nathan, P. et. al. *New England Journal of Medicine* 2021; 385:1196-1206

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Most frequent related AEs consistent with proposed MoA

IMCgp100-202 study

Tebentafusp (n=245)		
Adverse Event (AE), related*	Any grade n (%)	Grade 3/4 n (%)†
Any	244 (99.6)¶	110 (45)**
Cytokine-mediated		
Cytokine release syndrome‡	217 (89)	2 (1)
Pyrexia	185 (76)	9 (4)
Chills	114 (47)	1 (0.4)
Nausea	105 (43)	2 (1)
Fatigue	101 (41)	7 (3)
Hypotension	93 (38)	8 (3)
Vomiting	64 (26)	1 (0.4)
Headache	53 (22)	1 (0.4)
Skin-related		
Rash§	203 (83)	45 (18)
Pruritus	169 (69)	11 (5)
Dry skin	72 (29)	0
Erythema	56 (23)	0

IC (n=111)		
AE, related	Any grade n (%)	Grade 3/4 n (%)
Any	91 (82)	19 (17)
Fatigue	29 (26)	1 (1)
Rash	27 (24)	0
Pruritus	23 (21)	0

- Majority AEs in first few weeks
- AEs generally manageable; low related discontinuation rate for tebentafusp (2%) vs. IC (4.5%)
- No tebentafusp-related deaths as assessed by the investigators

*Table summarizes treatment related AEs that are present at least 20% any grade; †Other (2-4%) severe AEs in tebentafusp arm include AST, ALT, lipase, lymphopenia, hyperbilirubinemia, hypophosphatemia, hypertension;
¶Includes 1 patient with no related AEs (per Investigator) but with sponsor-adjudicated CRS; **Includes 1 patient with related AEs Grade <3 (per Investigator) but with sponsor-adjudicated Grade 3 CRS;
‡Cytokine release syndrome was adjudicated by sponsor according to ASTCT Consensus Grading for CRS (Lee et al. 2019); §Rash is a composite term for a list of skin toxicities of any grade. AE, adverse event

Nathan, P. et. al. *New England Journal of Medicine* 2021; 385:1196-1206

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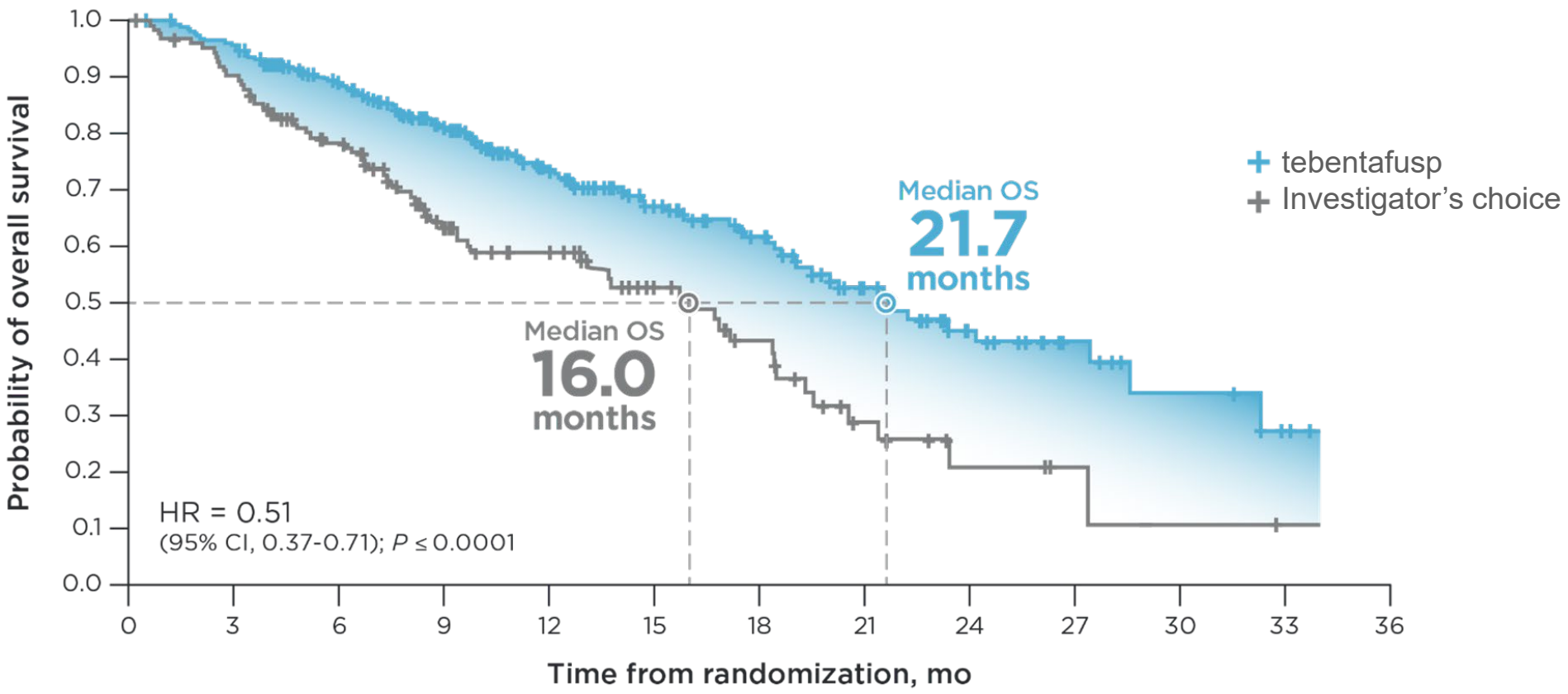
Primary Endpoint: Overall Survival (OS) statistically significant

Tebentafusp granted Breakthrough Therapy Designation by FDA

IMCgp100-202 study



Number of patients at risk

tebentafusp	252	242	221	197	167	132	109	90	71	59	44	33	22	17	9	6	5	0
Investigator's choice	126	116	100	86	69	48	43	34	27	20	12	7	4	4	1	1	1	0

Nathan, P. et. al. *New England Journal of Medicine* 2021; 385:1196-1206

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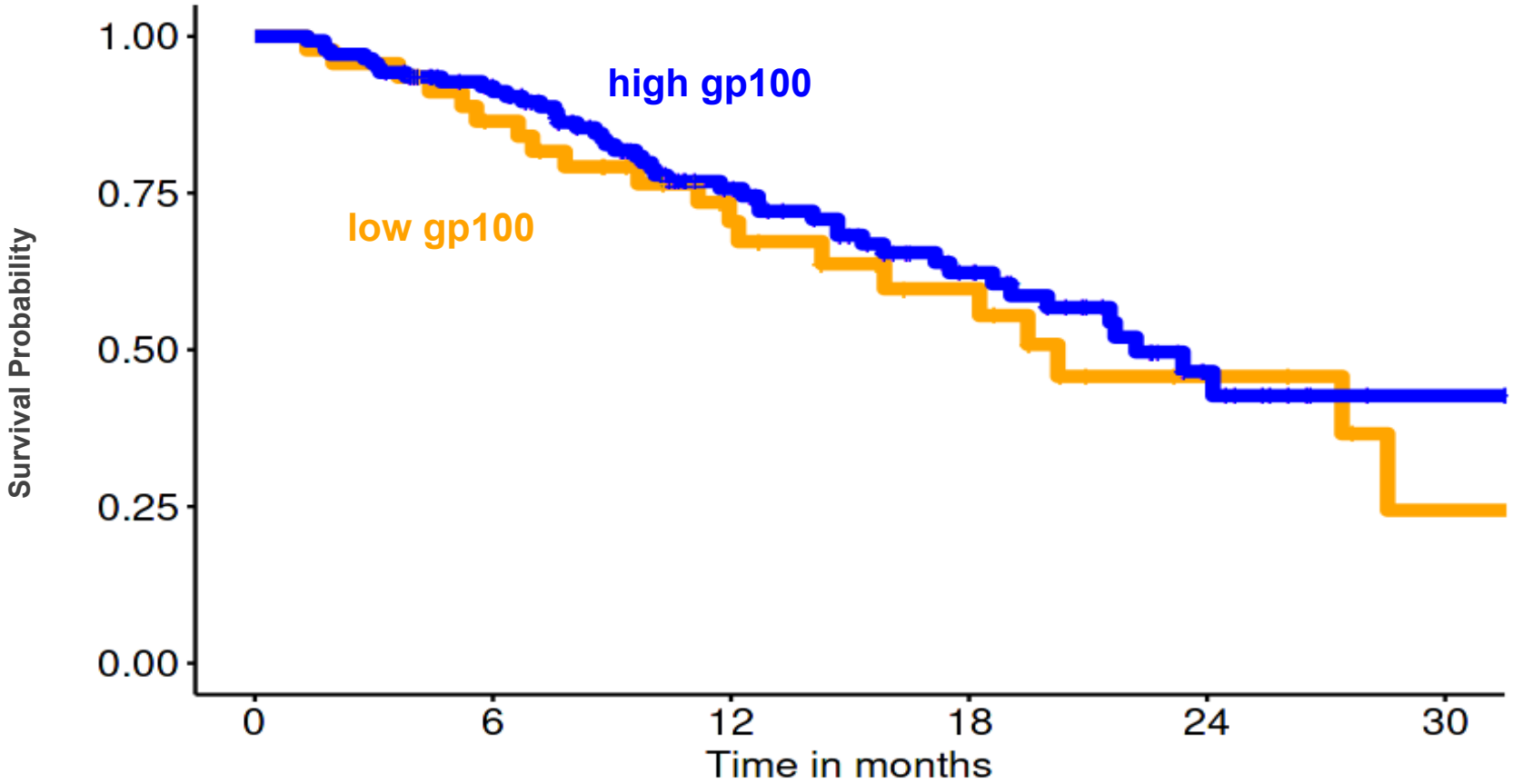
Tebentafusp OS benefit in high and low gp100 expression

IMCgp100-202 study



Low gp100 H score < lowest quartile
High gp100 H score ≥ lowest quartile

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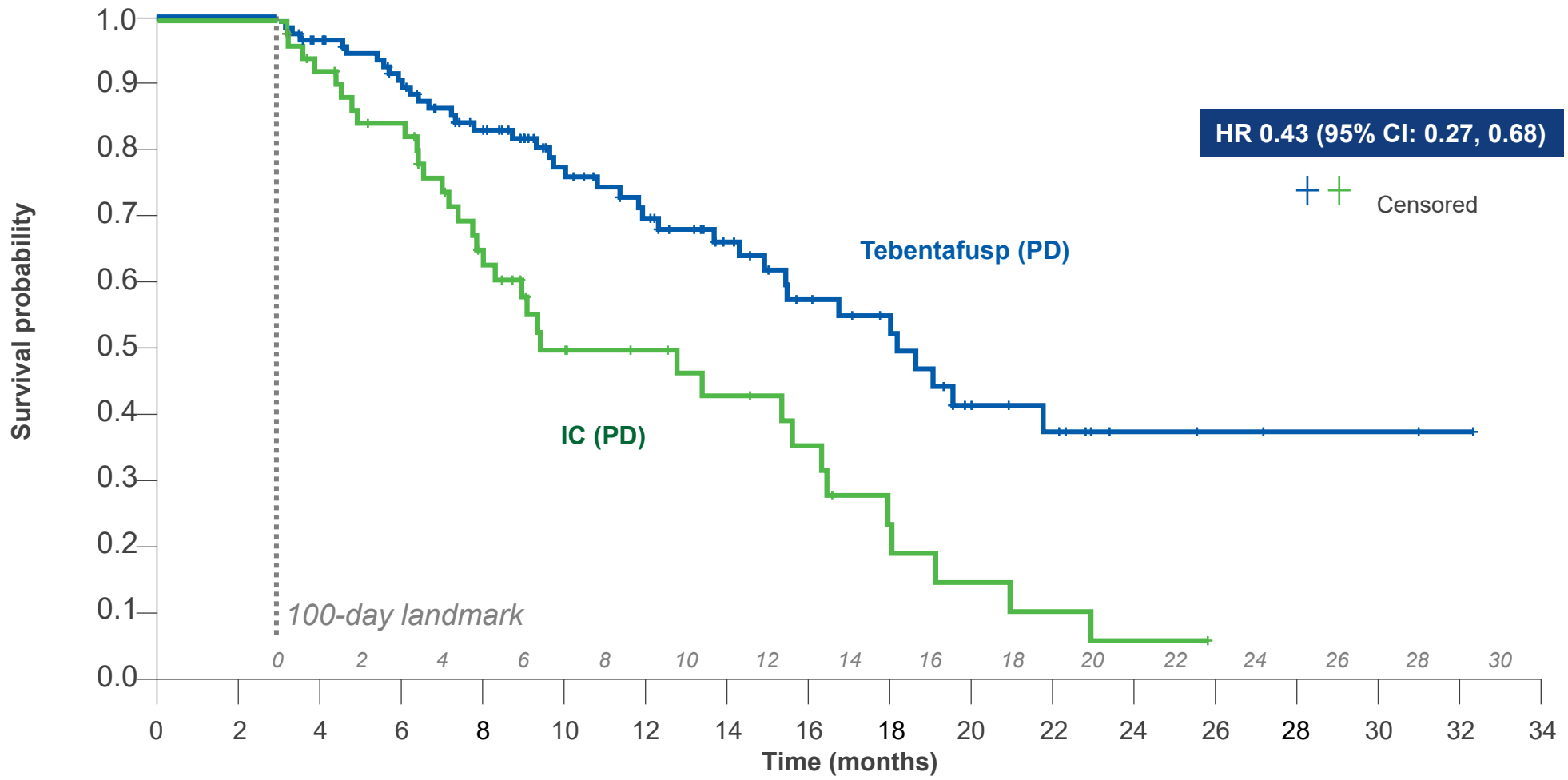
OS benefit in patients with best response of Progressive Disease

Landmark OS analysis beginning at Day 100

IMCgp100-202 study



Tebentafusp (PD)	105	92	78	62	47	38	29	22	17	11	6	4	3	2	2	0
IC (PD)	53	42	35	23	16	13	11	6	4	3	2	1	0			

Joshua et. al. *ASCO Annual Meeting 2021*

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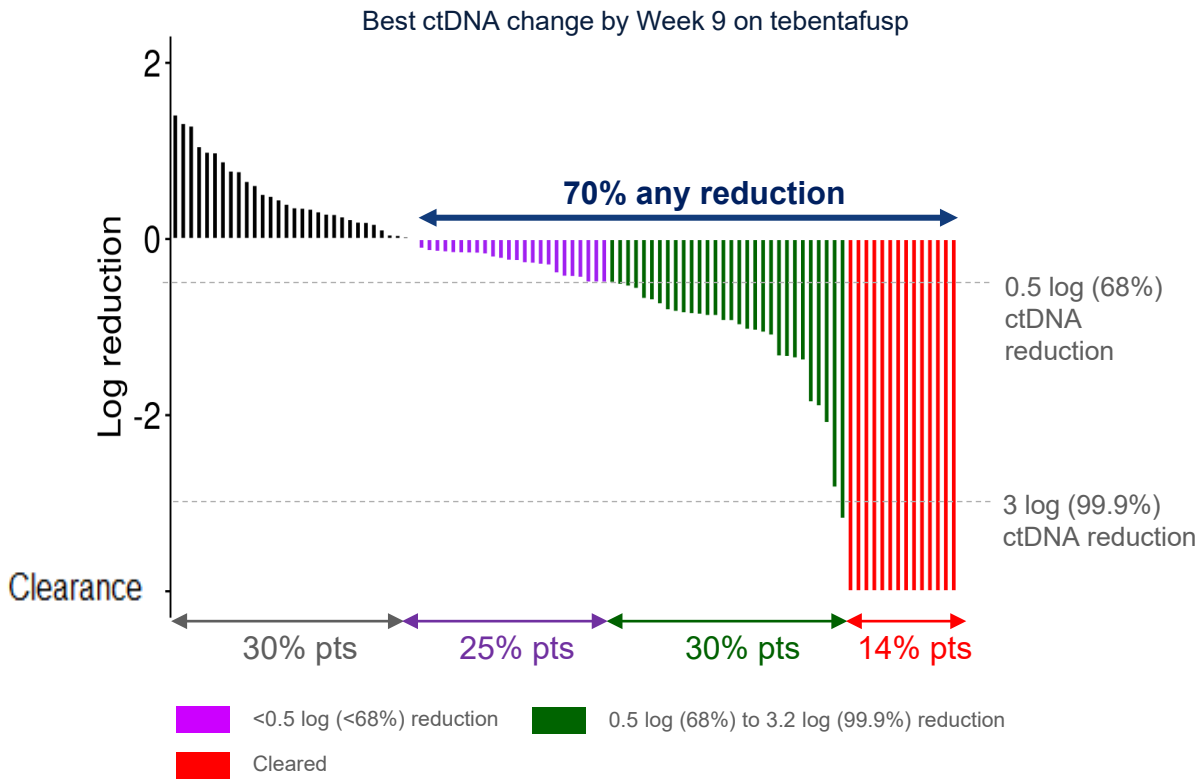
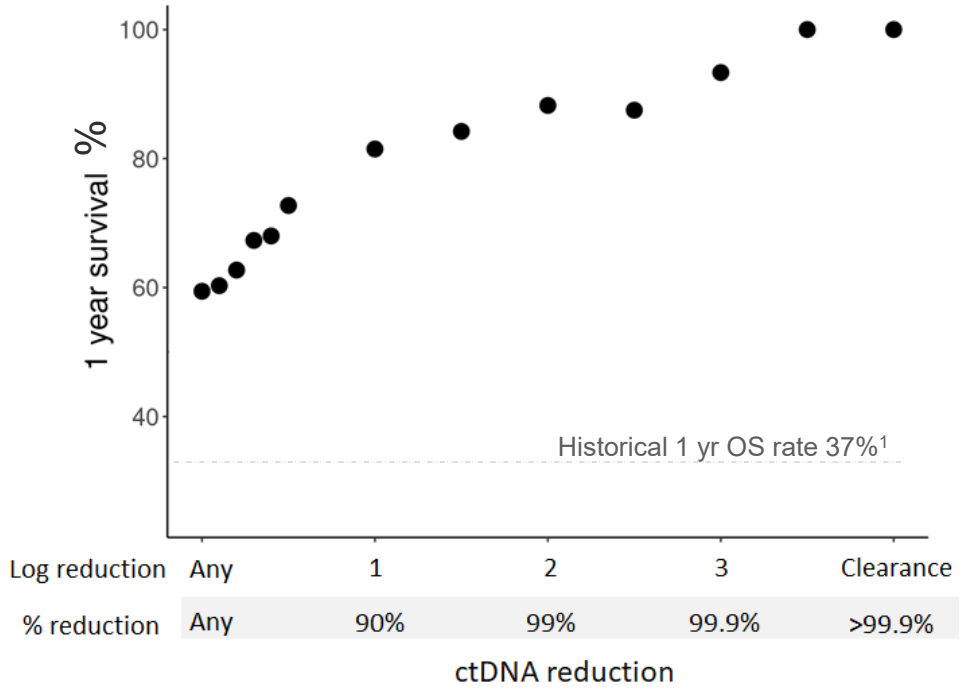
Circulating tumor (ctDNA) better surrogate of OS than RECIST

IMCgp100-102 study

70% evaluable patients had any ctDNA reduction



ctDNA reduction correlates with 1 year OS



ctDNA = circulating tumor DNA

1. Rantala ES et al. Melanoma Res. Published online. 2019

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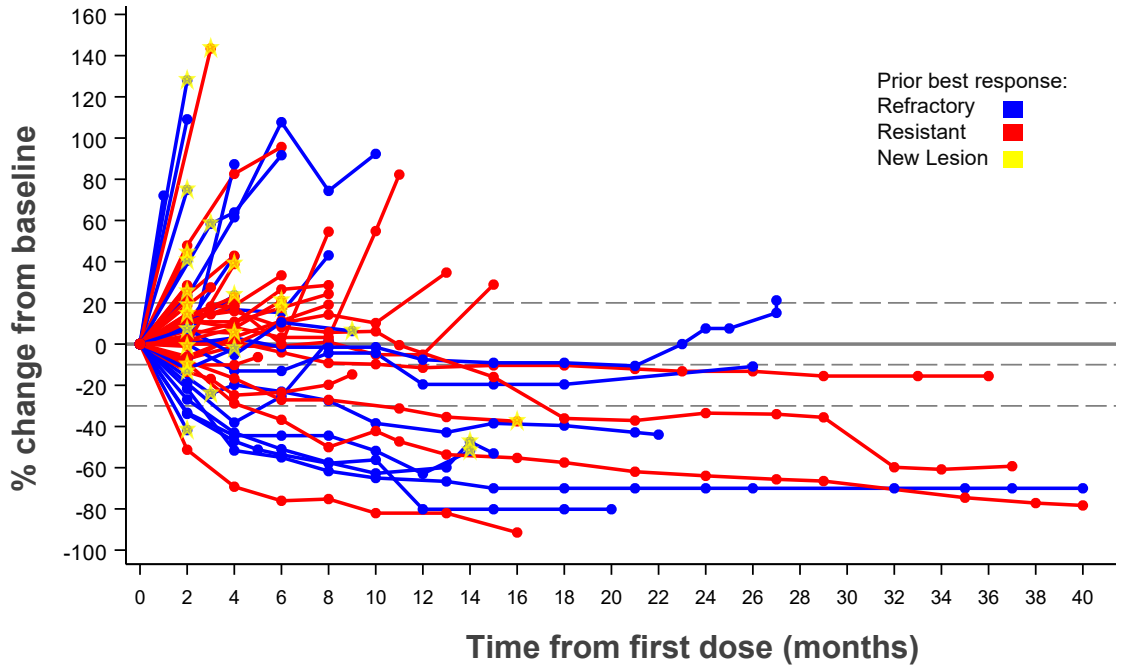
Tebentafusp active in cutaneous melanoma

IMCgp100-01 and -201 study

Durable tumor shrinkage in patients who progressed on prior anti-PD(L)1

tebentafusp + durvalumab*



*Study IMCgp100-201: 57 patients in this study received any dose of durvalumab and had a documented best overall response to prior anti-PD(L)1 therapy. Of these 57 patients, 31 received tebentafusp + durvalumab and 26 received tebentafusp + durvalumab + tremelimumab.

Best response to prior anti-PD(L)1: Resistant = best response CR/PR/SD to prior PD(L)1; Refractory = best response of PD to prior anti-PD(L)1

1-yr OS

74%, anti-PD(L)1 naïve

tebentafusp monotherapy^

76%, prior anti-PD(L)1

tebentafusp + durvalumab†

^ Study IMCgp100-01, n= 49

† Study IMCgp100-201, 61 patients received prior anti-PD(L)1 and who received tebentafusp with any dose of durvalumab on this study. Of these 61, 57% patients received tebentafusp + durvalumab and 43% received tebentafusp + durvalumab + tremelimumab.

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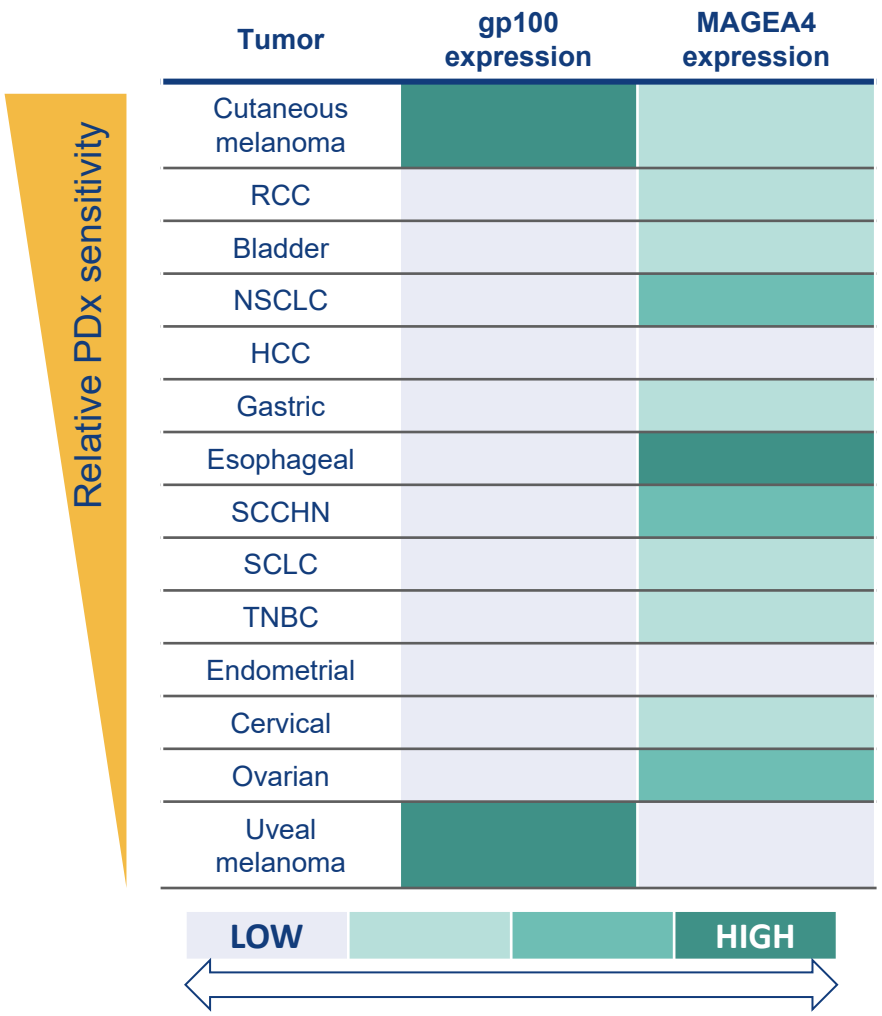
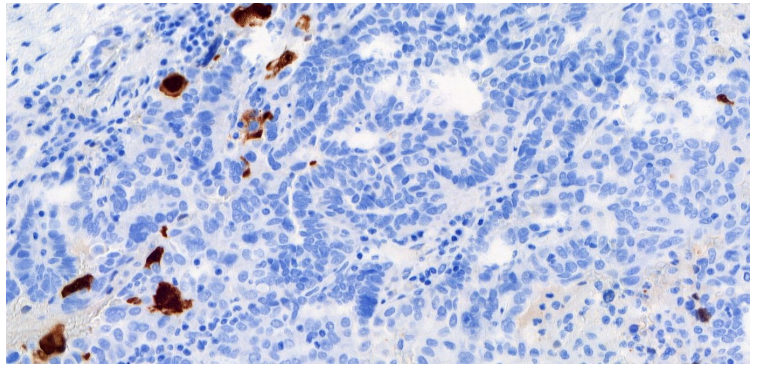
MAGE-A4 & PRAME

IMC-C103C targeting MAGE-A4, a cancer testis antigen expressed in multiple solid tumors

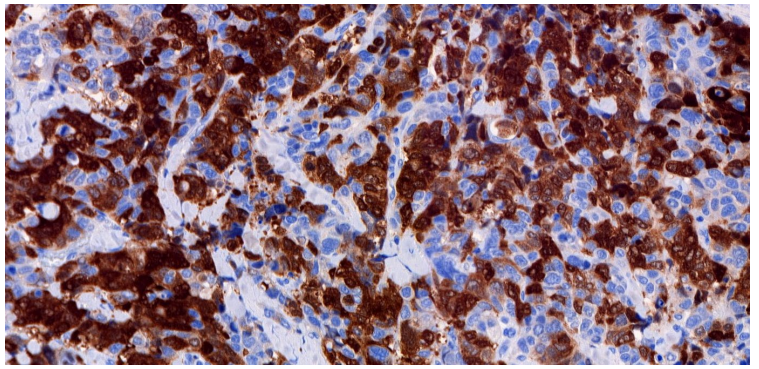
MAGE-A4 in PDx sensitive and insensitive tumors



MAGE- A4 low



MAGE- A4 high



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Phase 1: First-in-Human study of IMC-C103C targeting MAGE-A4

Design

- Weekly IV infusion
- 21-day DLT evaluation period
- Dose escalation decisions based on cohorts of 3-6 patients using mTPI-2 [2]*
- Once a dose has cleared safety review, patients treated for ≥10 weeks at a lower dose can escalate

Eligibility

- Selected advanced solid tumors
- HLA-A*02:01+ (central testing)
- Relapsed / refractory / intolerant of standard therapies
- ECOG 0-1
- Tumor MAGE-A4 by immunohistochemistry (IHC)

Indications	IHC testing
High prevalence of MAGE-A4†	Enroll all comers, retrospective testing
All other indications	Prospective MAGE-A4 confirmation

Objectives

- **Primary**: Determine MTD / expansion dose
- **Secondary**:
  - Preliminary antitumor activity
  - Pharmacokinetics
  - Pharmacodynamic markers, including lymphocyte counts and serum cytokines

*mTPI-2, modified toxicity probability interval-2 method

† e.g., ovarian and synovial

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Dose escalation schema from minimum anticipated biological effect level (MABEL)

	# patients enrolled	Day 1 Dose	Day 8 Dose	Weekly Dose, Starting Day 15
Fixed Dose	2	0.5 mcg	0.5 mcg	0.5 mcg
	2	1.5 mcg	1.5 mcg	1.5 mcg
	3	4.5 mcg	4.5 mcg	4.5 mcg
	3	15 mcg	15 mcg	15 mcg
Step-Dose	9	15 mcg	45 mcg	45 mcg
	4	15 mcg	45 mcg	64 mcg
	7*	15 mcg	45 mcg	90 mcg
	7	15 mcg	45 mcg	140 mcg
	2	15 mcg	45 mcg	180 mcg
	5	15 mcg	45 mcg	240 mcg

Initial dose defined by MABEL

No to minimal pharmacodynamic activity

Initial pharmacodynamic activity identified

Strong and consistent pharmacodynamic activity

*7 patients assigned to the 90 mcg cohort; however 1/7 discontinued after 15 mcg and never received 45 mcg.

Steroid premedication has been recommended at biologically active doses and, more recently, has been required when the highest dose is given for the first time;

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Safety profile manageable and consistent with mechanism of T cell activation

Preferred Term*	0.5-4.5 mcg (n=7)	15-64 mcg (n=16)	90-240 mcg[§] (n=21)	TOTAL (N=44[†])
All Grades (treatment-related events in ≥ 20% of total patients)				
Chills	-	8 (50%)	13 (62%)	21 (48%)
Pyrexia*	2 (29%)	7 (44%)	12 (57%)	21 (48%)
Cytokine release syndrome[‡]	1 (14%)	4 (25%)	11 (52%)	16 (36%)
Headache	1 (14%)	6 (38%)	7 (33%)	14 (32%)
Nausea	1 (14%)	6 (38%)	6 (29%)	13 (30%)
Hypotension*	-	6 (38%)	5 (24%)	11 (25%)
Fatigue	1 (14%)	4 (25%)	5 (24%)	10 (23%)
Grade 3-4 (treatment-related events in ≥ 5% of total patients)				
Neutropenia	-	1 (6%)	7 (33%)	8 (18%)
Lymphocyte count decreased	1 (14%)	1 (6%)	2 (10%)	4 (9%)
ALT increased	-	1 (6%)	1 (5%)	2 (5%)
AST increased	-	1 (6%)	1 (5%)	2 (5%)
Headache	-	1 (6%)	1 (5%)	2 (5%)

- **No related AE led to treatment discontinuation**
- **No related AE led to death**

*Includes events reported as a sign/symptom of CRS
[†]One patient enrolled at 90 mcg and 9 months after discontinuing study treatment was re-enrolled at 180 mcg
[‡] Cytokine release syndrome (CRS) was graded by the Investigators using ASTCT criteria (Lee et al. 2019) [3]; all other events were graded using NCI CTCAE v5.0.
[§]Two DLTs at 240 mcg: Grade 3 AST increased (rapidly resolved; patient continued at 240 mcg until disease progression) and Grade 3 CRS (resolved; patient currently on 140 mcg)

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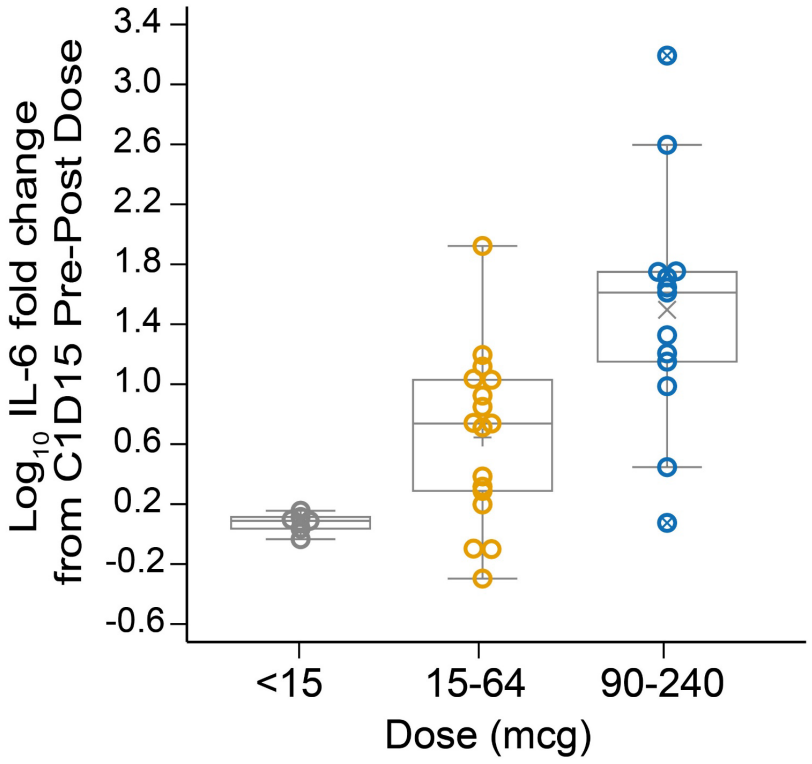
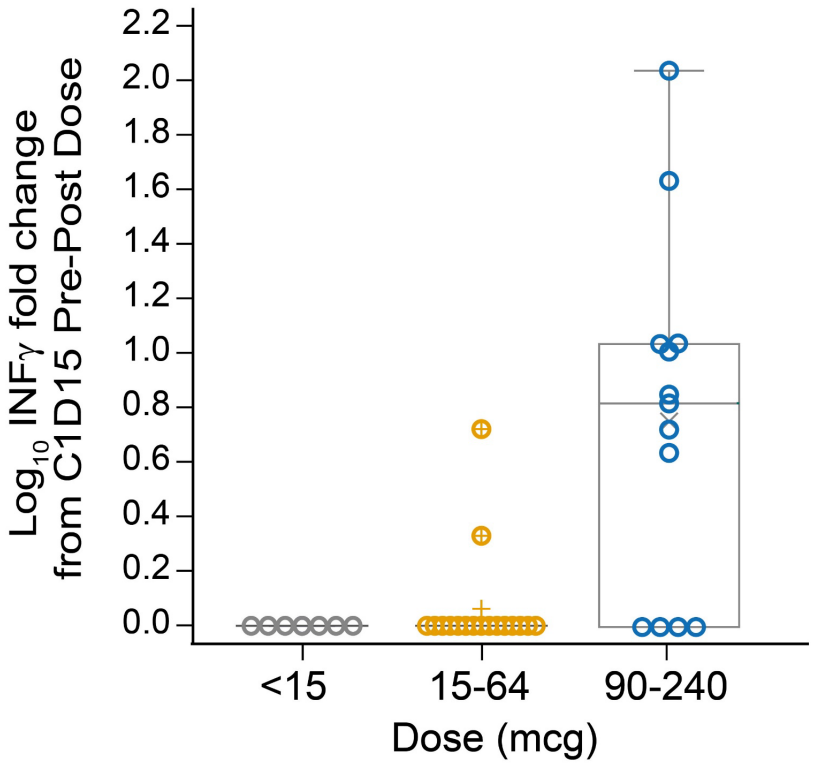
Consistent and robust evidence of T cell activity at ≥ 90 mcg IMC-C103C

Assessment after maximal dose (Day 15)

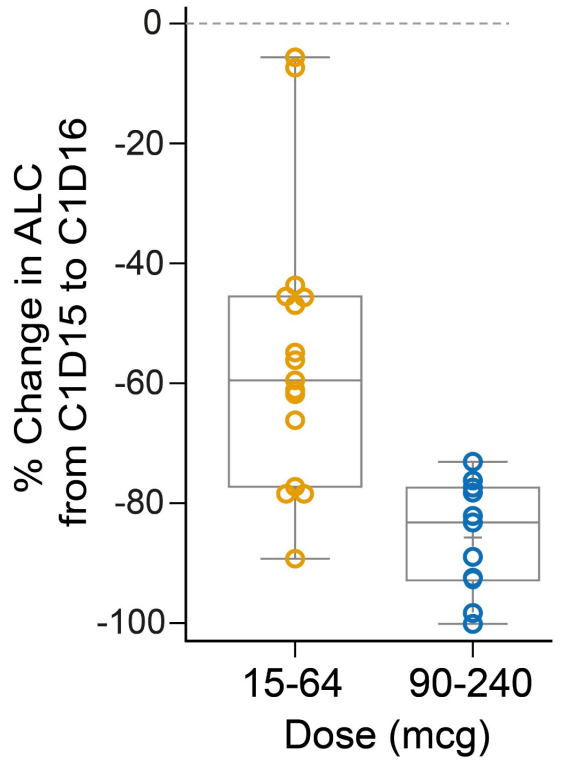
Interleukin-6 (IL-6)



Interferon-gamma (IFNγ)



Absolute Lymphocyte Count (ALC)*



Concentrations < LLOD were set to half LLOD for purposes of deriving fold change
Fold increase compares pre-dose to maximum post-dose (4hr, 8hr, and 24hr timepoints)
24 patients evaluable (pre and post-dose cytokine results available for the Day 15 dose)

* Day 16 ALC was only analyzed following introduction of intra-patient dose escalation; therefore, not collected in first cohorts.

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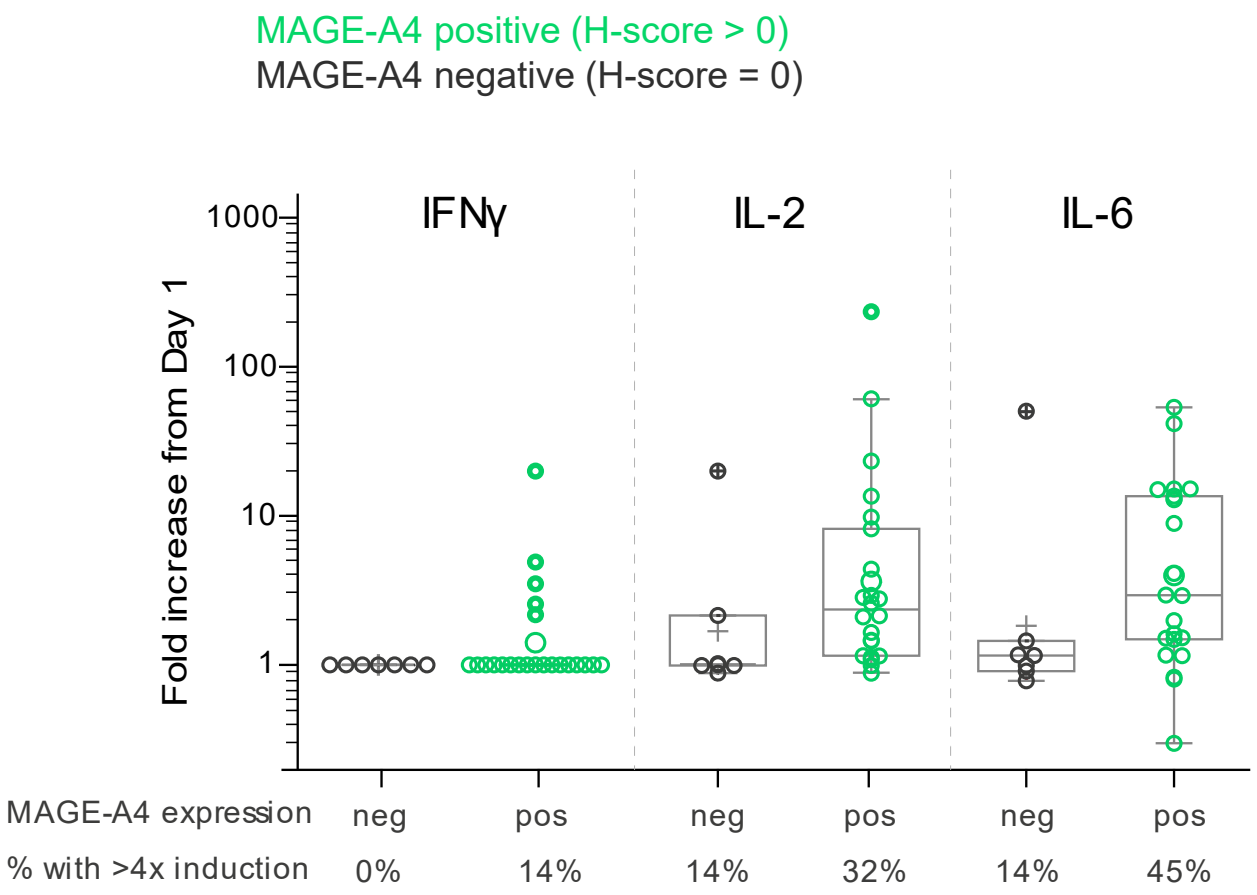
Cytokine induction primarily in patients with MAGE-A4 positive tumors

Assessment after initial dose, 15 mcg (Day 1)



- **IFNγ induction** only observed in patients with **MAGE-A4 positive tumors**
- **Median IL-2 and IL-6 induction higher** in patients with **MAGE-A4 positive tumors**

Concentrations < LLOD were set to half LLOD for purposes of deriving fold change
Fold increase compares pre-dose to maximum post-dose (4hr, 8hr, and 24hr timepoints)
29 patients evaluable (15 mcg on Day 1, pre and post-dose cytokine results and MAGE-A4 results available)

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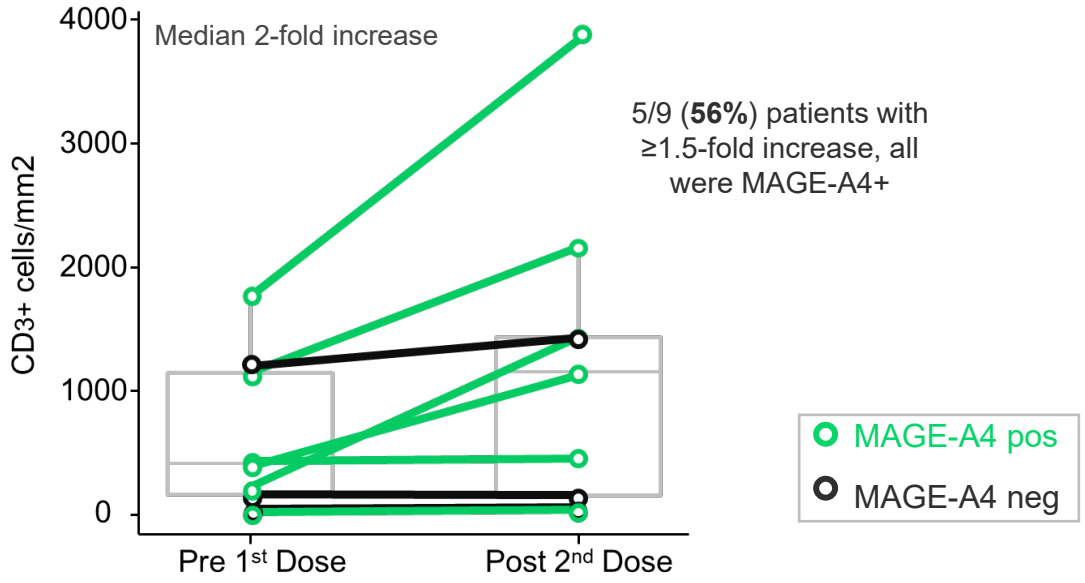
Increased T cell infiltration into MAGE-A4 positive tumors

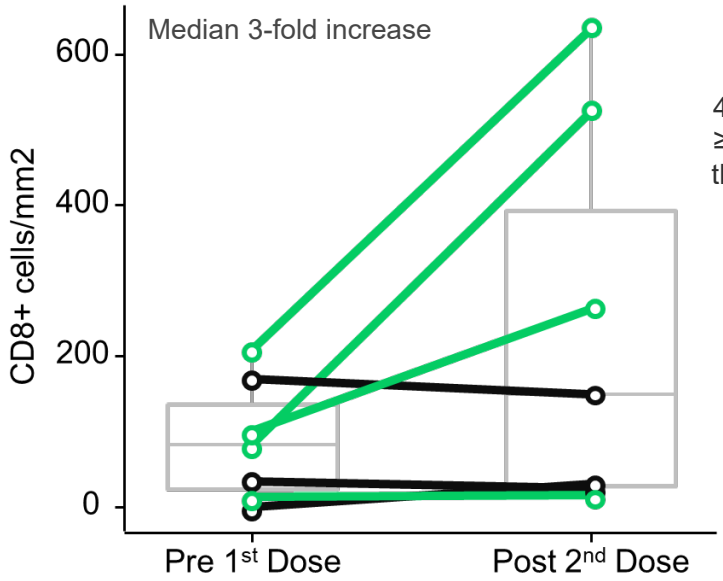
CD3+ T cells



5/9 (**56%**) patients with ≥1.5-fold increase, all were MAGE-A4+

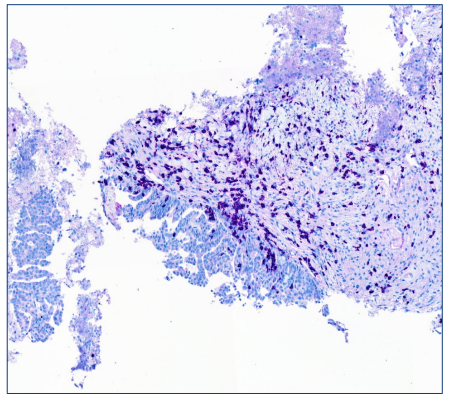
MAGE-A4 pos
MAGE-A4 neg

CD8+ T cells



4/7 (**57%**) patients with ≥1.5-fold increase, 3 of the 4 were MAGE-A4+

Pre



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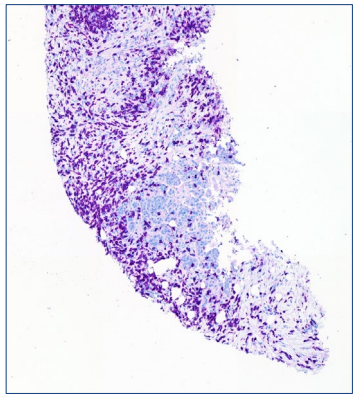
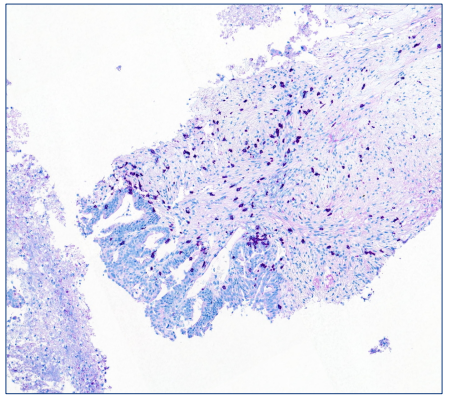


Pre



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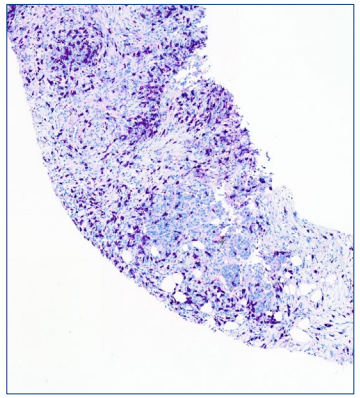

Biopsy after two doses (15 mcg on Day 1 and 45 mcg on Day 8)

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Clinical activity in MAGE-A4 positive ovarian and HNSCC

Majority of evaluable patients had low MAGE-A4 expression

Efficacy evaluable by MAGE-A4 IHC status

all indications at 90-240 mcg

	Negative or NE MAGE-A4	Positive MAGE-A4	H-Score
HNSCC	-	**1**	285
Esophageal	-	**1**	175
Urothelial	-	**1**	3
Ovarian*	7	**8**	median 35 (range 7-128)
Total	7	**11**	

* 17 ovarian patients treated at 90-240 mcg; 15/17 efficacy evaluable and 2/17 (both MAGE-A4 negative) not yet efficacy evaluable. The 15 efficacy evaluable include: MAGE-A4 negative (n=5), not evaluable (NE) by IHC (n=2), and MAGE-A4 positive (n=8)

Clinical activity in ovarian and HNSCC

Indication	H-Score	Dose	Response	DOR
HNSCC	285	240 mcg	**Confirmed PR^ (ongoing)**	2+ mo
Ovarian	19	140 mcg	Overall TL reduction (-44%) but new lesions	
Ovarian	7	140 mcg	Overall TL reduction (-81%) but new lesions	
Ovarian	18	90 mcg	**Confirmed PR (ongoing)**	4.4+ mo
Ovarian	16	15 mcg	**Confirmed PR**	8.3 mo

TL, target lesions
HNSCC, Head and neck squamous cell carcinoma
^ confirmed after the presentation data cut-off date

- Of 11 MAGE-A4 positive (all indications), **4 had significant tumor shrinkage including 2 confirmed PR**
- Of 2 high MAGE-A4 positive, **1 confirmed PR (HNSCC)**
- Durable partial responses, **includes low and high MAGE-A4 expression**

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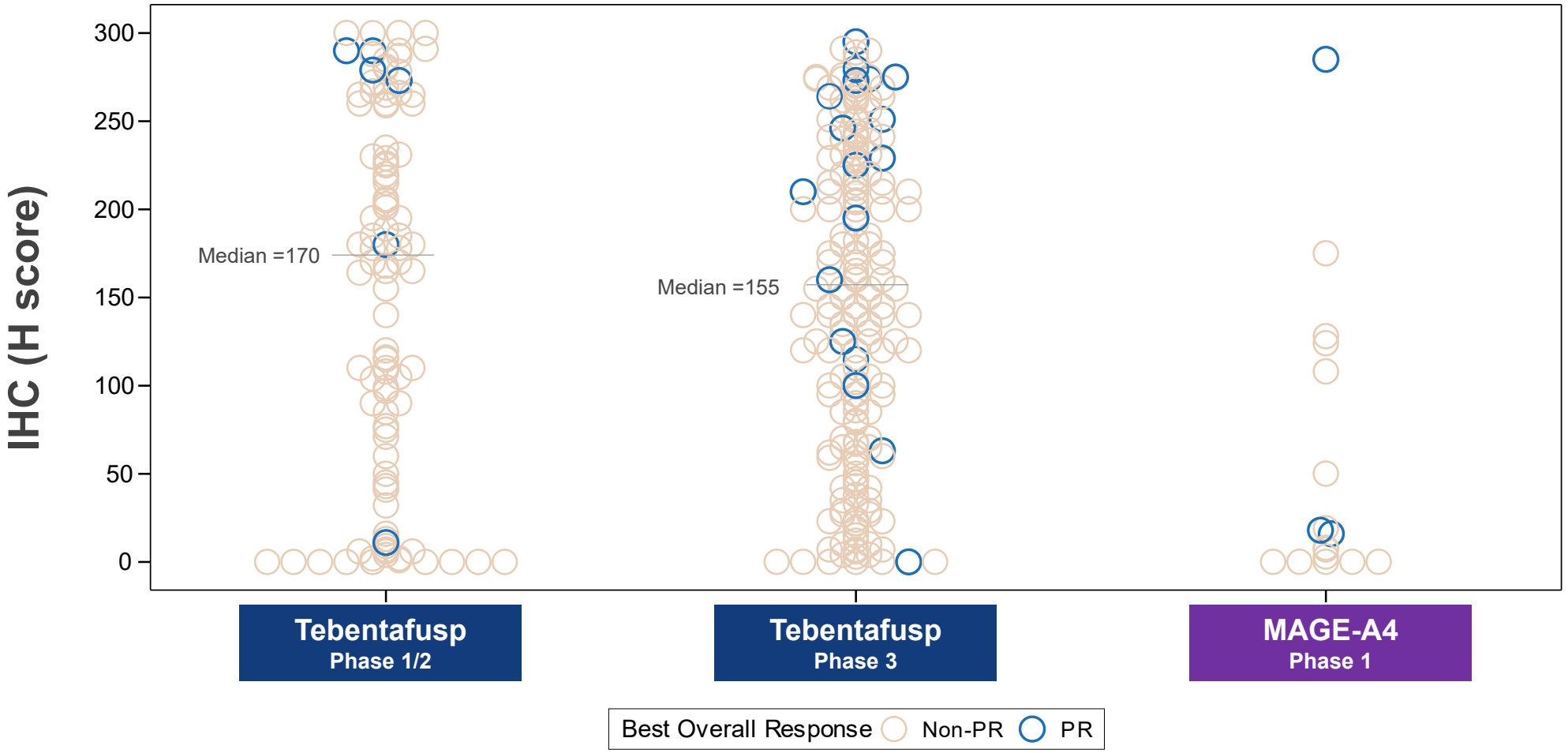
Enrichment of tebentafusp RECIST PRs at higher gp100 expression

In Phase 1, most MAGE-A4 patients to date have low or no MAGE-A4 expression



H score: % of tumor cells with 1+, 2+ or 3+ intensity
MAGE-A4 Phase 1 includes 16 efficacy evaluable patients who were evaluable by IHC (90-240 mcg) and single ovarian patient with PR (15 mcg)

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IMC-C103C now demonstrated safety, MoA and clinical activity

Only clinical off-the-shelf candidate against MAGE-A4

- Manageable safety profile (primarily cytokine-mediated)
- Consistent and robust biomarkers of T cell activation
- **Durable PRs in ovarian carcinoma, even with low MAGE-A4 expression, and a confirmed partial response in SCHNN**
- Phase 1 study ongoing in multiple solid tumors
- **Initiated first expansion arm in high grade serous ovarian at 140 micrograms**

Potential for > 75K patients/ yr (G7)

		Annual Metastatic Patients *MAGE-A4+ & HLA-A*02:01*	
		US	G7
NSCLC	Squamous	8.5k	21k
	Adeno	6.5k	15k
Ovarian		3.5k	8k
SCCHN		3k	8k
Gastric + Esoph Adeno		2k	7.5k
Bladder		2k	5.5k
Esophageal Squamous		1k	5.5k
Select Others		5k	13k

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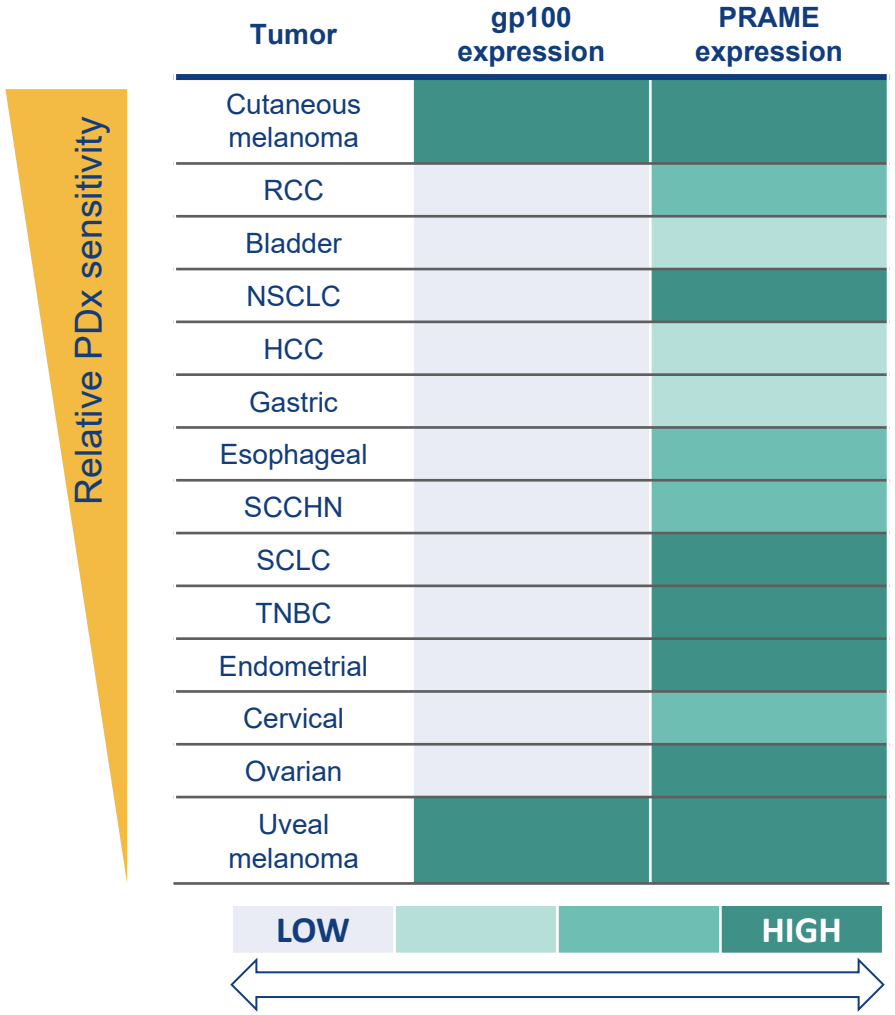
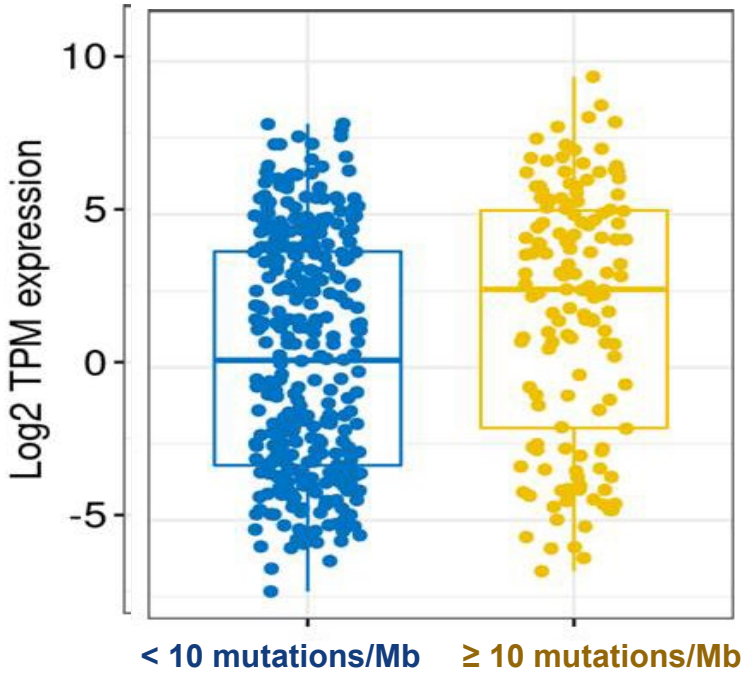
IMC-F106C targets PRAME, a negative prognostic marker in solid tumors

Expressed in PDx sensitive and insensitive tumors



Expressed in low and high TMB tumors (NSCLC)



TMB: tumor mutational burden

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PRAME is largest cancer-testes antigen opportunity

Ongoing Phase 1 study

- First, and only, off-the-shelf therapeutic against PRAME intracellular protein
- 39 patients enrolled in Phase 1 dose-escalation study*
- Biomarkers indicate having achieved biologically active doses
- **Initial Phase 1 data expected mid-2022**

Potential for >150,000 patients/ yr (G7)

		Annual Metastatic Patients *PRAME+ & HLA-A*02:01*	
		US	G7
NSCLC	Adeno	18.5k	42k
	Squamous	13.5k	32.5k
Ovarian		7.5k	17k
Small Cell Lung Cancer		7.5k	16.5k
Breast	Total	5.5k	14k
	TNBC	2.5k	5.5k
Endometrial		5.5k	11k
Cutaneous Melanoma		5k	10.5k
Select Others		10.5k	33.5k

*As of December 16, 2021

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Validation of ImmTAC platform beyond gp100

	T cell activation	Durable tumor shrinkage	Activity even in low target expression	ctDNA reduction	Overall survival benefit
Tebentafusp gp100	☑ CLINICAL CANCER RESEARCH	☑ ESMO IMMUNO-ONCOLOGY VIRTUAL CONGRESS	☑ SITC 2021 WASHINGTON, D.C.	☑ 2021 ESMO congress	☑ The NEW ENGLAND JOURNAL of MEDICINE
IMC-C103C MAGE-A4	☑ ESMO IMMUNO-ONCOLOGY Onsite and Online Congress	☑ ESMO IMMUNO-ONCOLOGY Onsite and Online Congress	☑ ESMO IMMUNO-ONCOLOGY Onsite and Online Congress	☑ *To be presented*	
IMC-F106C PRAME	☑ *To be presented*				

Immunocore intends to present additional clinical data across all three ImmTAC programs in 2022

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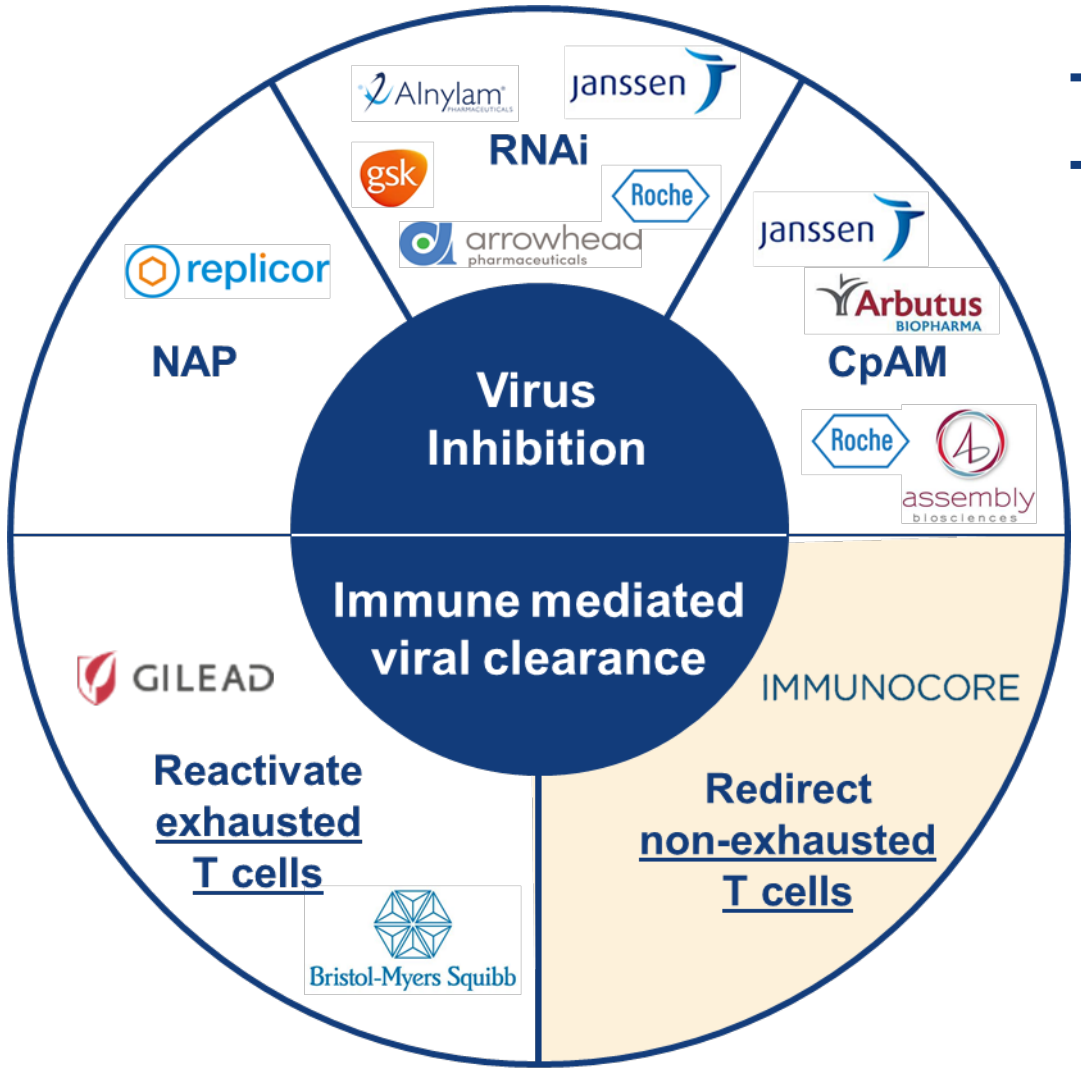
Potential for functional cure in chronic viral diseases

Our unique approach for functional cure of chronic HBV



Key advantages of redirecting non-exhausted T cells

- Same CD3 MoA validated in oncology
- Independent of natural T cell reactivity to Hep B
- Goal is functional cure with finite treatment

Mass-spectrometry antigen discovery engine for HBV

- Pipeline funnel (e.g., conserved sequences, pHLA presentation/stability, mimetic risk)
- Seven optimal targets identified from envelope, core capsid, and polymerase

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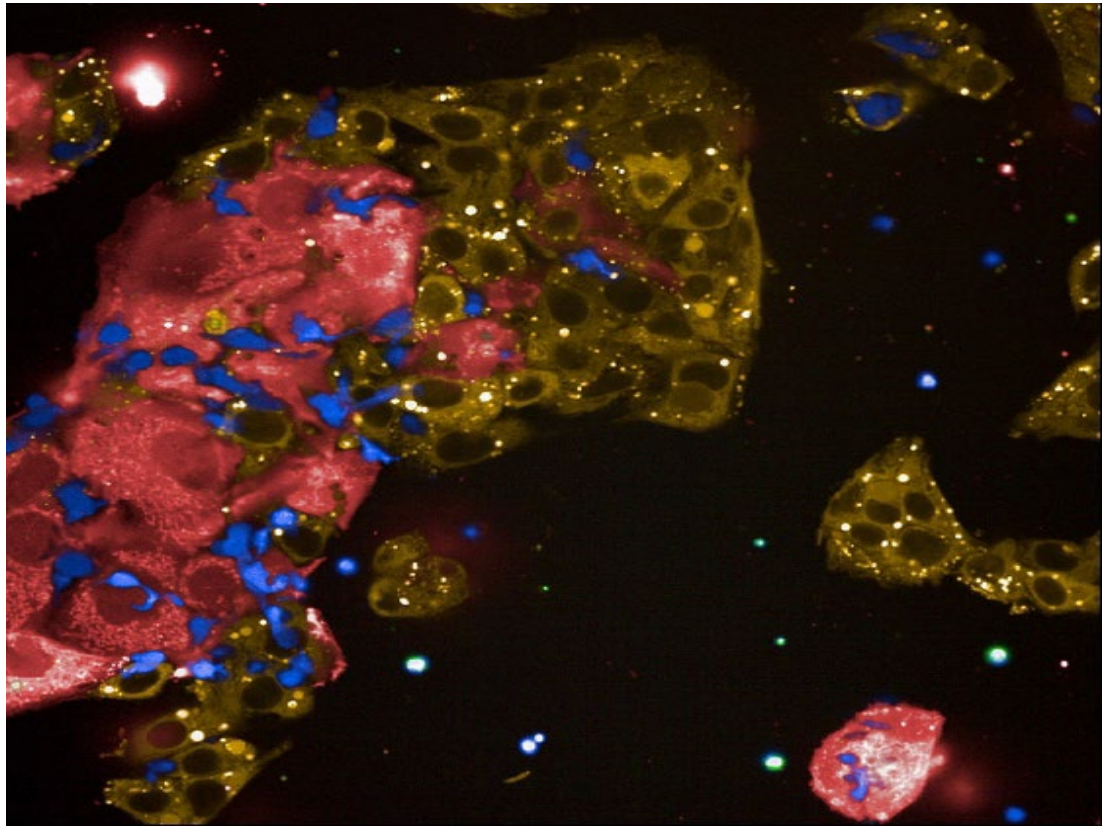
Highly specific killing of cells with integrated HBV DNA

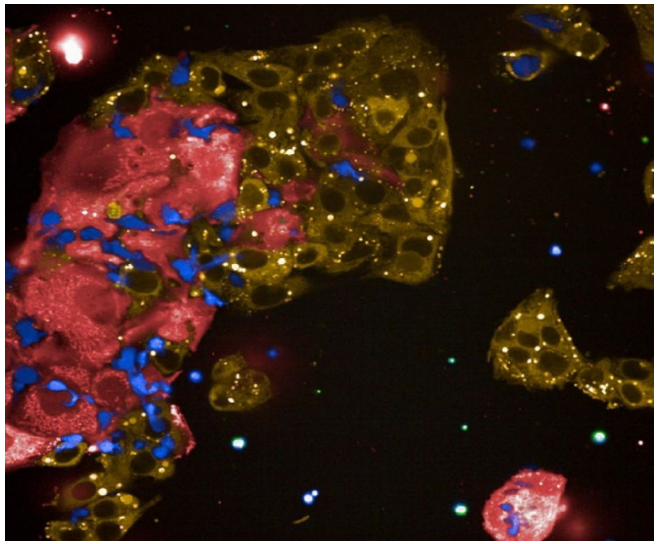


HBV+ cells

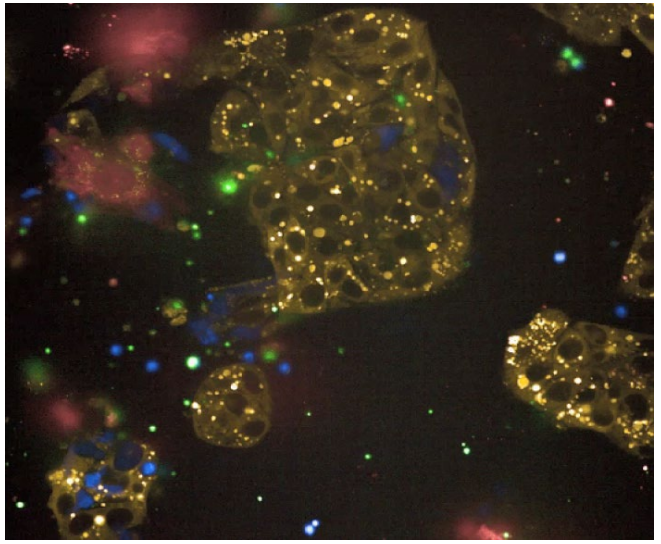
HBV- cells

T cells

Cell death



Co-incubation (start)



HBV+ cell death (end)

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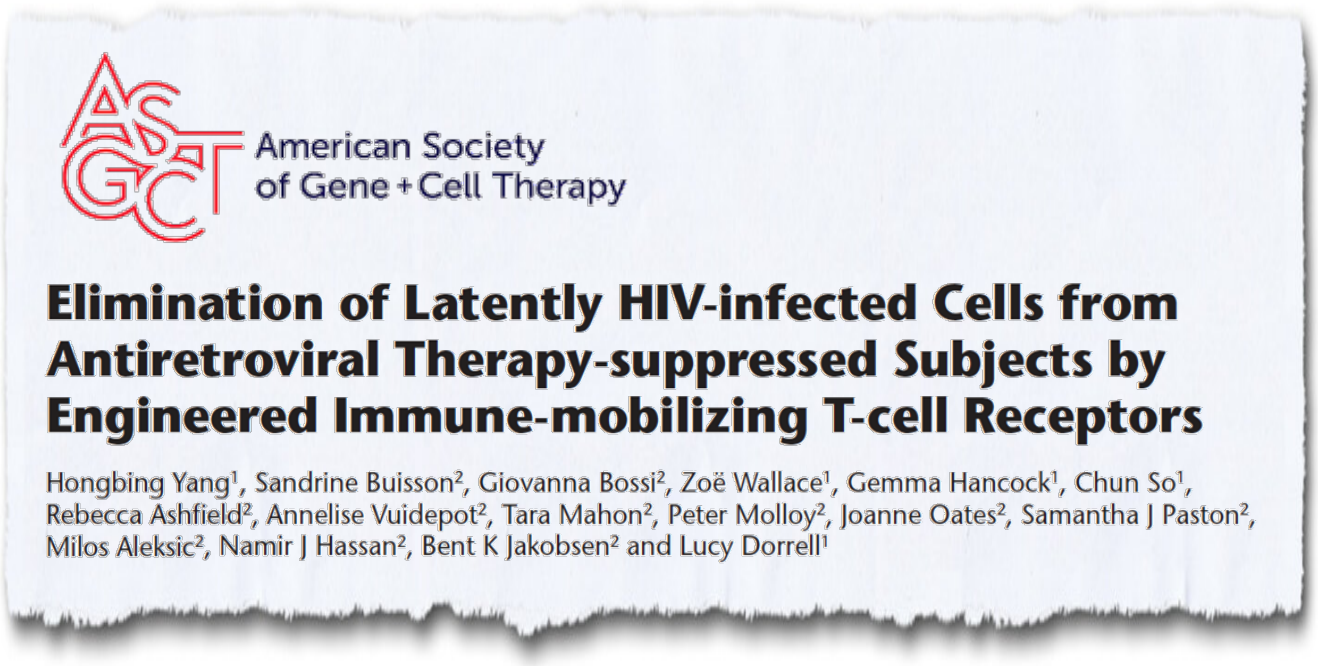
Functional cure program for HIV with goal of eliminating HIV reservoirs



American Society of Gene + Cell Therapy

Elimination of Latently HIV-infected Cells from Antiretroviral Therapy-suppressed Subjects by Engineered Immune-mobilizing T-cell Receptors

Hongbing Yang[1], Sandrine Buisson[2], Giovanna Bossi[2], Zoë Wallace[1], Gemma Hancock[1], Chun So[1], Rebecca Ashfield[2], Annelise Vuidepot[2], Tara Mahon[2], Peter Molloy[2], Joanne Oates[2], Samantha J Paston[2], Milos Aleksic[2], Namir J Hassan[2], Bent K Jakobsen[2] and Lucy Dorrell[1]

- Same MoA as tebentafusp, but optimized for low target viral peptide presentation
- Bypasses exhausted T cells
- Targets highly conserved & functionally constrained viral epitopes
- Active in ex vivo assays of infected CD4+ T cells from ART-treated HIV patients
- Soluble format access to tissue reservoirs

IMC-M113V CTA accepted in 2021

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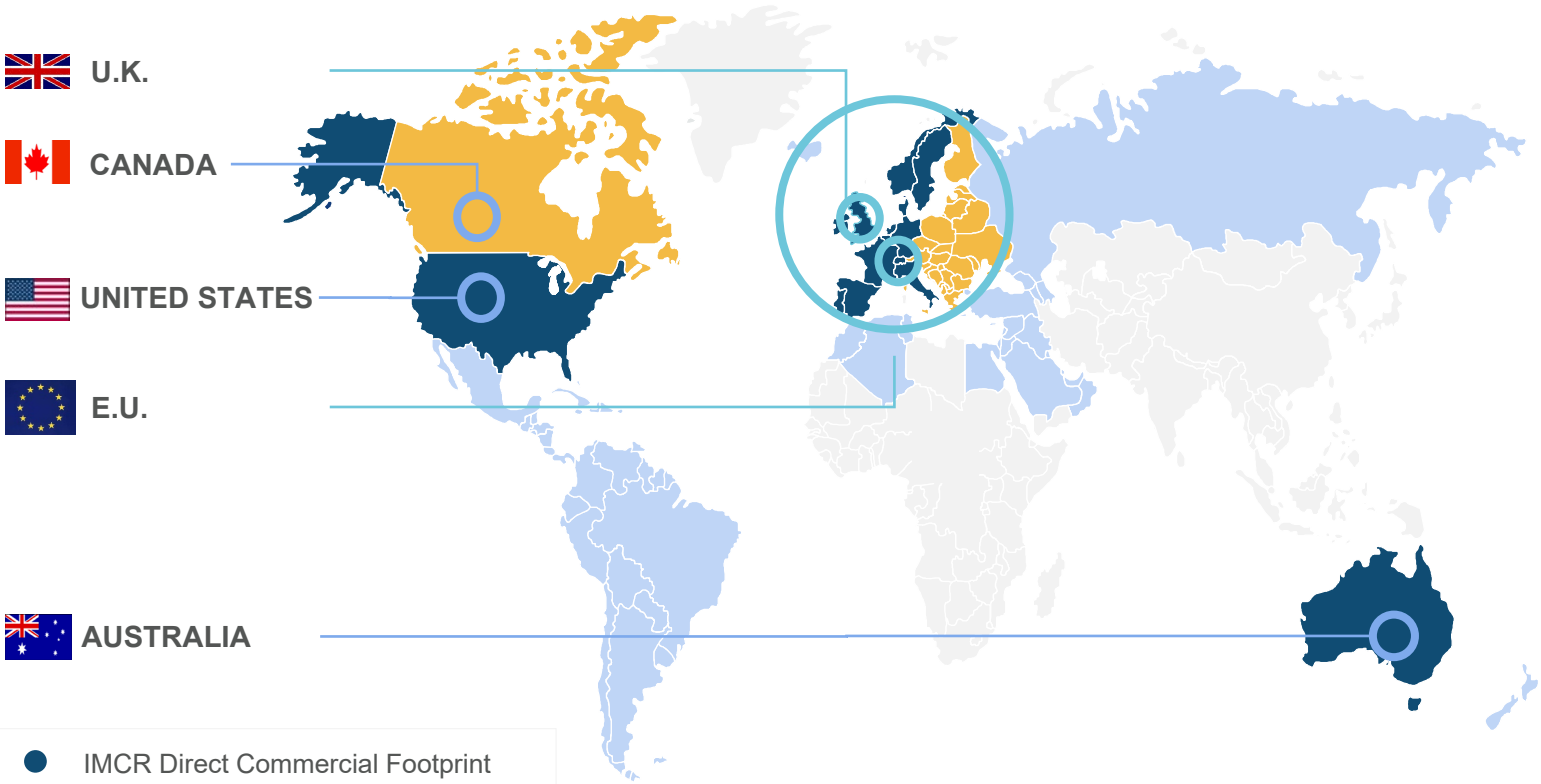
Tebentafusp Launch Readiness & Upcoming Portfolio Milestones

Our ambition: transform the lives mUM patients around the world

Global regulatory acceptances

5 accepted regulatory fillings



- **200+ patients on early access program**
- **US launch-ready**
- **Accelerated review in EU**
- **+22 countries**
  in partnership with MEDISON in Canada, Central Eastern Europe, and Israel

~1,000 patients / year in US and initial priority European markets[1]

1. HLA-A*02:01-positive adult patients with unresectable or mUM

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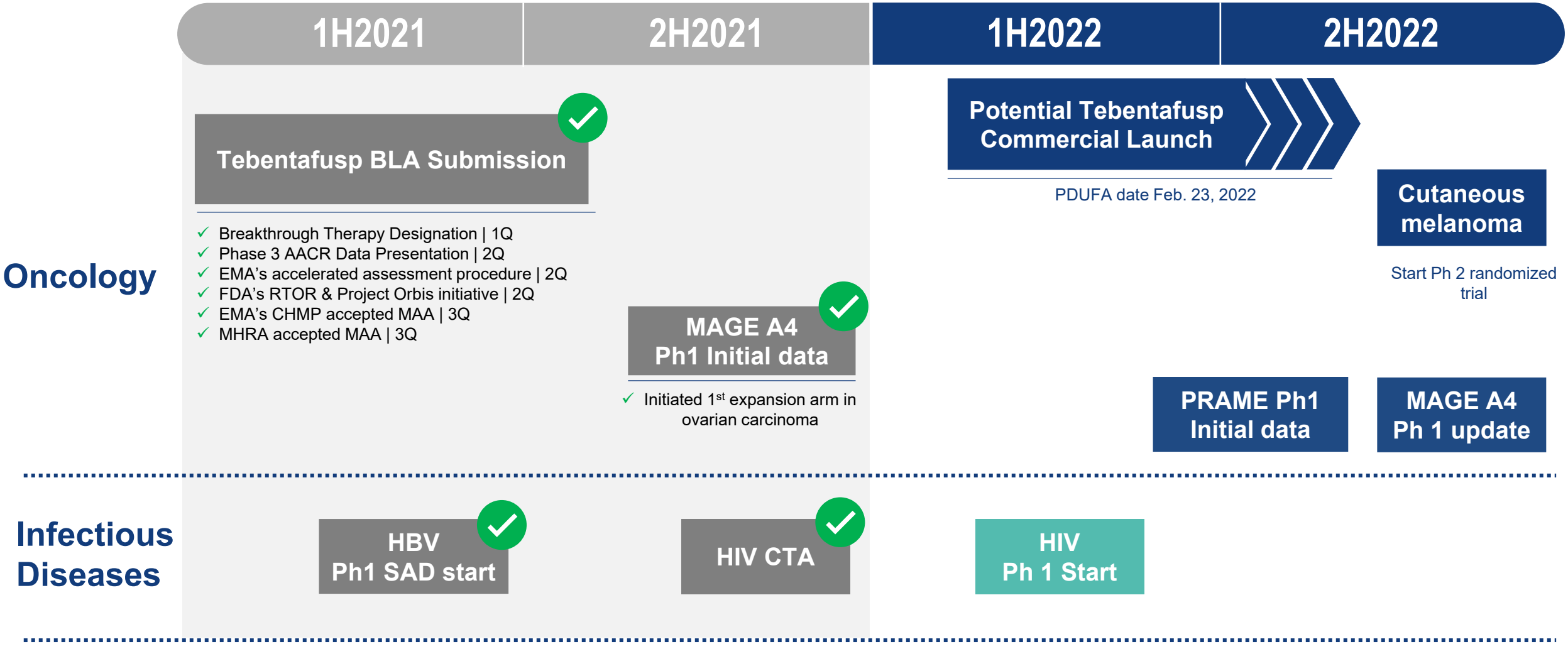
Portfolio milestones



$320M cash as of YE 2021

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Immunocore is the most advanced TCR company

- First **clinically validated** TCR platform with survival benefit
- **5** clinical-stage programs
- Tebentafusp **PDUFA** 2/2022, **EU** & **UK** MAA submissions accepted
- Multiple **value inflection points** over the next 12 months

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