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

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): January 10, 2025

Immunocore Holdings plc

(Exact name of registrant as specified in its Charter)

England and Wales	**001-39992**	**Not Applicable**
(State or other jurisdiction of incorporation)	**(Commission File Number)**	**(IRS Employer Identification No.)**
92 Park Drive, Milton Park **Abingdon, Oxfordshire,** **United Kingdom**		**OX14 4RY**
(Address of principal executive offices)		**(Zip Code)**

+44 1235 438600
(Registrant's telephone number, including area code)

Not Applicable
(Former name or former address, if changed since last report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Trading Symbol(s)**	**Name of each exchange on which registered**
American Depositary Shares, each representing one ordinary share, nominal value £0.002 per share	**IMCR**	**The Nasdaq Stock Market LLC**
Ordinary share, nominal value £0.002 per share*	*****	**The Nasdaq Stock Market LLC**

* *Not for trading, but only in connection with the listing of the American Depositary Shares on The Nasdaq Stock Market LLC.*

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 2.02. Results of Operations and Financial Condition.

On January 10, 2025, Immunocore Holdings plc (the "Company") announced a preliminary estimate of the amount of its cash and cash equivalents at December 31, 2024. The Company preliminarily estimates that its cash and cash equivalents as of December 31, 2024 were approximately $820 million.

The information in this Item 2.02 is preliminary, has not been audited and is subject to change pending completion of the Company's audited financial statements for the year ended December 31, 2024. It is possible that the Company or its independent registered public accounting firm may identify items that require the Company to make adjustments to the amounts included in this Item 2.02, and such changes could be material. Additional information and disclosures would also be required for a more complete understanding of the Company's financial position and results of operations as of December 31, 2024.

Item 7.01. Regulation FD Disclosure.

On January 10, 2025, the Company issued a press release announcing its strategic priorities for 2025. A copy of the press release is attached as Exhibit 99.1 to this Current Report on Form 8-K and is incorporated by reference herein.

Also on January 10, 2025, the Company updated its corporate presentation to reflect certain business and strategic updates. The Company intends to use an abbreviated version of the presentation in meetings with analysts, investors and others from time to time, including its presentation by management at the 43rd Annual J.P. Morgan Healthcare Conference on January 15, 2025 at 8:15 a.m. PT. A copy of the presentation is attached as Exhibit 99.2 to this Current Report on Form 8-K and is incorporated by reference herein. The corporate presentation and a webcast of the Company's presentation at the 43rd Annual J.P. Morgan Healthcare Conference will also be available in the "Investors/Media" section of the Company's website at www.immunocore.com. The Company's website and any information contained on the Company's website are not incorporated by reference into this Current Report on Form 8-K.

The information contained in Item 7.01 of this Current Report on Form 8-K, including Exhibits 99.1 and 99.2 attached hereto, is being furnished and shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), or otherwise subject to the liabilities of that section, and shall not be deemed incorporated by reference into any of the Company's filings under the Securities Act of 1933, as amended, or the Exchange Act, whether made before or after the date hereof, regardless of any general incorporation language in such filing, except as shall be expressly set forth by specific reference in such filing.

Item 8.01 Other Events.

On January 10, 2025, the Company published an updated pipeline chart of KIMMRAK and its therapeutic candidates in development, which is filed as Exhibit 99.3 to this Current Report on Form 8-K and incorporated by reference herein.

Item 9.01. Financial Statements and Exhibits

Exhibit No.	Description
99.1	Press Release dated January 10, 2025.
99.2	Corporate Presentation, dated January 2025.
99.3	Pipeline Chart.
104	Cover Page Interactive Data File (embedded within the Inline XBRL document).

SIGNATURES

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

IMMUNOCORE HOLDINGS PLC

Dated: January 10, 2025

By: /s/ Bahija Jallal, Ph.D.
Name: Bahija Jallal, Ph.D.
Title: Chief Executive Officer

IMMUNOCORE

Immunocore announces strategic priorities at 43rd Annual J.P. Morgan Healthcare Conference

Reaching more mUM patients globally with KIMMTRAK (tebentafusp) in 2025 through additional launches and increased community penetration

Enrolling three Phase 3 trials across multiple melanoma indications – potential data readouts beginning with TEBE-AM in 2026

Enrolling Phase 1/2 trial with brenetafusp combinations in ovarian and lung cancer; ongoing dose escalation with IMC-R117C (PIWIL1) and IMC-P115C (PRAME-A02-HLE)

Presenting initial HIV Phase 1 MAD data in the first quarter 2025

Progressing first-in-class, tissue-tethered autoimmune platform – Type 1 diabetes candidate on track for CTA submission in 2025; first universal candidate targeting CD1a initially for atopic dermatitis announced today

Company to present at 43rd Annual J.P. Morgan Healthcare Conference on Wednesday, January 15, 2025, at 8:15 AM PST / 4:15 PM GMT

(OXFORDSHIRE, England & CONSHOHOCKEN, Penn. & GAITHERSBURG, Md., US, 10 January 2025) Immunocore Holdings plc (Nasdaq: IMCR) ("Immunocore" or the "Company"), a commercial-stage biotechnology company pioneering and delivering transformative immunomodulating medicines to radically improve outcomes for patients with cancer, infectious diseases and autoimmune diseases, today set out its strategic priorities for 2025 including its plans for reaching more patients with melanoma and other diseases with high unmet needs.

The Company also highlights the potential of its melanoma franchise building on KIMMTRAK's performance and reveals details of IMC-U120AI (CD1a x PD1), its first non-HLA restricted candidate. This second autoimmune therapy adds to the Company's pipeline of ImmTAX candidates across three therapeutic areas. The updates will be shared during a presentation at the 43rd Annual J.P. Morgan Healthcare Conference in San Francisco.

"Since launching the world's first bispecific TCR therapy, we have made KIMMTRAK available to patients in 23 countries. We are now building a melanoma franchise through life cycle management with two Phase 3 KIMMTRAK trials, and with the brenetafusp Phase 3 trial in first-line melanoma. We anticipate topline results for the first of these three pivotal trials in 2026," **said Bahija Jallal, Immunocore's Chief Executive Officer**. "In 2025, we plan to report initial multiple ascending dose data for our HIV TCR therapy, expand enrollment in multiple oncology Phase 1/2 trials, including our PRAME and PIWIL1 programs, and advance our autoimmune candidates toward the clinic."

Key Strategic Priorities 2025

Immunocore's mission is to bring transformative medicines to patients with cancer, infectious diseases, and autoimmune diseases. In 2025, the Company's priorities will be:

- Building a melanoma franchise – reaching more metastatic uveal melanoma (mUM) patients and delivering KIMMTRAK's lifecycle management program through two ongoing registrational Phase 3 trials (TEBE-AM and ATOM). The Company is also enrolling a third registrational trial, PRISM-MEL-301, evaluating brenetafusp in first-line melanoma.

- Advancing the clinical portfolio – enrolling patients in multiple Phase 1 oncology trials with brenetafusp (PRAME-A02), IMC-P115C (PRAME-A02-HLE), IMC-R117C (PIWIL1-A02), and IMC-M113V in HIV.

- Innovating for sustainable growth – planning to submit a clinical trial application (CTA) for the Company's two autoimmune disease candidates: IMC-S118AI (PPI x PD1) by year end 2025 and IMC-U120AI (CD1a x PD1) in 2026.

Building a melanoma franchise

In 2025, Immunocore will continue expanding access to KIMMTRAK to more patients with mUM globally, through additional launches and approvals, building on the 38 country approvals and 23 launches as of year-end 2024.

In countries where KIMMTRAK has been launched, the Company will continue to focus on reaching more patients in the community and highlighting the three-year overall survival data.

The Company is enrolling patients in three registrational Phase 3 trials, with the first topline results anticipated in 2026 and a potential to reach up to 15,000 additional patients across three new melanoma indications:

- TEBE-AM – trial evaluating KIMMTRAK for HLA-A*02:01 in second-line and later cutaneous melanoma – with a potential to address up to 4,000 previously treated advanced cutaneous melanoma patients. This is an area of great unmet need where no therapy has shown an Overall Survival (OS) improvement in a randomized clinical trial.

- PRISM-MEL-301 – trial evaluating brenetafusp + nivolumab versus a control arm of either nivolumab or nivolumab + relatlimab for HLA-A*02:01 patients with first-line, advanced or metastatic cutaneous melanoma. Despite approved therapies, there remains an unmet need, and there is the potential to address an estimated 10,000 patients.

- ATOM – led by the European Organisation for Research and Treatment of Cancer (EORTC) to evaluate KIMMTRAK as adjuvant therapy for uveal (or ocular) melanoma for HLA-A*02:01 patients. The Company estimates that the HLA-A*02:01 high risk adjuvant uveal melanoma patient population could be up to 1,200 patients.

Advancing the clinical portfolio

In 2025, beyond executing the three ongoing registrational trials in three additional melanoma indications, Immunocore will continue to enroll patients in the multiple ongoing Phase 1 trials in oncology and infectious diseases, to evaluate safety and efficacy across several cohorts. The Company will also use its translational medicine (i.e. ctDNA, T cell fitness) dataset from more than a thousand patients treated in the clinic with KIMMTRAK and its investigational therapies to inform clinical development.

PRAME portfolio

The Company is evaluating brenetafusp in a Phase 1/2 trial in combination with non-platinum chemotherapies in platinum resistant ovarian cancer (PROC) and with bevacizumab or with platinum chemotherapy in earlier lines of platinum sensitive ovarian cancer (PSOC). In the same trial, the Company continues signal detection in metastatic non-small cell lung cancer (NSCLC) cohorts, including brenetafusp in combination with docetaxel and with osimertinib in earlier-line NSCLC.

The Company has recently started enrolling patients in the Phase 1 dose escalation trial with IMC-P115C (PRAME-A02-HLE) in multiple solid tumors. IMC-P115C is the Company's half-life extended ImmTAC therapy – targeting the same PRAME peptide and with the same CD3 effector and TCR specificity as brenetafusp – and is designed to improve patient convenience by reducing the frequency of treatment administration.

PIWIL1-A02

The third ongoing Phase 1 clinical trial in oncology is evaluating the safety and clinical activity of IMC-R117C (targeting PIWIL1) in HLA-A*02:01-positive patients with advanced solid tumors, including colorectal cancer, as a single agent and in combination with standards of care.

Infectious diseases

The Company continues to enroll people living with HIV (PLWH) in the multiple ascending dose (MAD) part of the Phase 1 clinical trial with IMC-M113V and will present initial data during the first quarter of 2025. The trial aims to identify a safe and tolerable dosing schedule, test whether IMC-M113V could lead to reduction in the viral reservoir and, after stopping all therapies (antiretroviral therapies and IMC-M113V), delay or prevent HIV rebound (known as functional cure). A biologically active dose has been reached, and the Company is enrolling more PLWH to characterize anti-viral activity and to explore higher doses.

The Company plans to present data from the single ascending dose (SAD) portion of the Phase 1 trial with IMC-I109V for people living with hepatitis B virus (HBV) in 2025.

Innovating for sustainable growth

Immunocore will continue pioneering immunotherapy and unlocking the full potential of its platform to generate transformative treatments for patients, by using different targeting mechanisms and immune effectors for next-generation bispecific therapies.

This approach is most recently illustrated by the Company's second candidate in autoimmune diseases, IMC-U120AI, which is also its first non-HLA restricted (i.e. universal for all populations) program.

Autoimmune diseases

The key differentiator of the ImmTAAI platform is tissue-specific down modulation of the immune system as the candidates suppress pathogenic T cells via PD1 receptor agonism only when tethered to the target tissue.

In the second half of 2025, the Company plans to file a CTA for its first candidate – IMC-S118AI (PPI x PD1) – targeted specifically to the pancreatic beta-cell and intended as a disease-modifying treatment in type 1 diabetes. IMC-S118AI recognizes a peptide from pre-pro-insulin presented by HLA-A02 on beta cells, coupled with a PD1 agonist effector arm.

The Company announced today its second autoimmune candidate. IMC-U120AI (CD1a x PD1) is a CD1a-tethered PD1 agonist ImmTAAI therapy. CD1a is an HLA-like protein that is expressed on skin and mucosal antigen presenting cells, such as Langerhans cells. It plays an important role in triggering allergic inflammation in atopic dermatitis and potentially other immune diseases. The Company plans to file a CTA in 2026 for a Phase 1 trial in atopic dermatitis for this candidate.

Corporate updates

In January 2025, Travis Coy was appointed Executive Vice President, Chief Financial Officer and Head of Corporate Development. Travis brings with him over 20 years of experience working at Eli Lilly and Company, where his most recent role was Vice President, Head of Transactions and M&A, Corporate Business Development.

Preliminary Year-End 2024 cash position

Preliminary unaudited cash, cash equivalents and marketable securities were approximately $820 million as of December 31, 2024. In the fourth quarter of 2024, the Company prepaid in full the loan outstanding under the Pharmakon Loan Agreement and also paid sales-related rebate accruals. These preliminary unaudited results are subject to adjustment. Immunocore will report its final and complete fourth-quarter and full-year 2024 financial results in late February 2025, and the actual results could be different from these preliminary unaudited financial results.

43rd Annual J.P. Morgan Healthcare Conference

The Company has updated its corporate presentation to reflect its business and strategic updates. The Immunocore management team will discuss these updates during a live and webcast presentation at the 43rd Annual J.P. Morgan Healthcare Conference, on Wednesday, January 15, 2025, at 8:15 a.m. Pacific Standard Time (PST). The presentation and webcast will be available in the 'Investors/Media' section of Immunocore's website at www.immunocore.com. A replay of the presentation will be made available for a limited time.

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About ImmTAC® molecules for cancer

Immunocore's proprietary T cell receptor (TCR) technology generates a novel class of bispecific biologics called ImmTAC (Immune mobilizing monoclonal TCRs Against Cancer) molecules that are designed to redirect the immune system to recognize and kill cancerous cells. ImmTAC molecules are soluble TCRs engineered to recognize intracellular cancer antigens with ultra-high affinity and selectively kill these cancer cells via an anti-CD3 immune-activating effector function. Based on the demonstrated mechanism of T cell infiltration into human tumors, the ImmTAC mechanism of action holds the potential to treat hematologic and solid tumors, regardless of mutational burden or immune infiltration, including immune "cold" low mutation rate tumors.

About ImmTAV® molecules for infectious diseases

ImmTAV (Immune mobilizing monoclonal TCRs Against Virus) molecules are novel bispecifics that are designed to enable the immune system to recognize and eliminate virally infected cells.
Immunocore is advancing clinical candidates to achieve functional cure for patients with HIV and hepatitis B virus (HBV). The Company aims to achieve sustained control of HIV after patients stop anti-retroviral therapy (ART), without the risk of virological relapse or onward transmission. This is known as 'functional cure'. For the treatment of HBV, the Company aims to achieve sustained loss of circulating viral antigens and markers of viral replication after stopping medication for people living with chronic HBV.

About ImmTAAI™ molecules for autoimmune diseases

ImmTAAI (Immune mobilizing monoclonal TCRs Against AutoImmune disease) molecules are novel bispecifics that are designed for tissue-specific down modulation of the immune system. When tethered to the tissue of interest, ImmTAAI candidates suppress pathogenic T cells via PD1 receptor agonism. The Company is currently advancing two candidates for autoimmune diseases, including type 1 diabetes and inflammatory dermatological diseases.

About PRISM-MEL-301 (NCT06112314) – Phase 3 trial with brenetafusp (IMC-F106C, PRAME-A02) in 1L advanced cutaneous melanoma

The Phase 3 registrational trial is randomizing HLA-A*02:01-positive patients with previously untreated advanced melanoma, to brenetafusp + nivolumab versus nivolumab or nivolumab + relatlimab, depending on the country where the patient is enrolled. The trial will initially randomize to three arms: two brenetafusp dose regimens (40 mcg and 160 mcg) and a control arm. One of the two brenetafusp dose regimens will be discontinued after an initial review of the first 60 patients randomized to the two experimental arms (90 patients randomized total). The primary endpoint of the trial is progression free survival (PFS) by blinded independent central review (BICR), with secondary endpoints of overall survival (OS) and overall response rate (ORR).

About the IMC-F106C-101 Phase 1/2 trial

IMC-F106C-101 is a first-in-human, Phase 1/2 dose escalation trial in patients with multiple solid tumors, including non-small cell lung and ovarian cancers. The Phase 1 dose escalation trial was designed to determine the maximum tolerated dose (MTD), as well as to evaluate the safety, preliminary anti-tumor activity and pharmacokinetics of IMC-F106C (brenetafusp), a bispecific protein built on Immunocore's ImmTAC technology, and the Company's first molecule to target the PRAME antigen. The Company is currently focusing on enrolling patients in combination arms with standards-of-care across multiple tumor types..

About the TEBE-AM Phase 3 registrational trial with tebentafusp in previously treated advanced cutaneous melanoma

The trial is randomizing patients with second-line or later advanced cutaneous melanoma who have progressed on an anti-PD1, received prior ipilimumab and, if applicable, received a BRAF kinase inhibitor. Patients are randomized to one of three arms, including tebentafusp – as monotherapy or in combination with an anti-PD1 – or a control arm. The primary endpoint is overall survival.

About the ATOM Phase 3 trial

The EORTC-led Phase 3 clinical trial will include sites in 10 EU countries and the United States and will randomize HLA-A*02:01-positive patients with high-risk primary uveal melanoma after definitive treatment, by surgery or radiotherapy, and no evidence of metastatic disease on imaging. The trial will be randomized 1:1 to one of two arms: tebentafusp as monotherapy or observation. The primary endpoint of the trial is relapse-free survival (RFS), with secondary objectives of overall survival and safety and tolerability of tebentafusp. Exploratory objectives include comparison of health-related quality of life between the treatment arms and evaluation of the role of circulating tumor DNA (ctDNA) as a biomarker for the presence of residual disease.

About Uveal Melanoma

Uveal melanoma is a rare and aggressive form of melanoma affecting the eye. Although it is the most common primary intraocular malignancy in adults, the diagnosis is rare, and up to 50% of people with uveal melanoma will eventually develop metastatic disease. Unresectable or metastatic uveal melanoma typically has a poor prognosis and had no approved treatment until KIMMTRAK. There is a significant unmet need in the adjuvant setting due to the high risk of metastasis and no effective treatment options. Approximately 50% of patients develop metastatic disease, often leading to poor survival outcomes.

About Cutaneous Melanoma

Cutaneous melanoma (CM) is the most common form of melanoma. It is the most aggressive skin carcinoma and is associated with the vast majority of skin cancer-related mortality. The majority of patients with CM are diagnosed before metastasis but survival remains poor for the large proportion of patients with metastatic disease. Despite recent progress in advanced melanoma therapy, there is still an unmet need for new therapies that improve first-line response rates and duration of response as well as for patients who are refractory to first-line treatments.

About KIMMTRAK®

KIMMTRAK is a novel bispecific protein comprised of a soluble T cell receptor fused to an anti-CD3 immune-effector function. KIMMTRAK specifically targets gp100, a lineage antigen expressed in melanocytes and melanoma. This is the first molecule developed using Immunocore's ImmTAC technology platform, designed to redirect and activate T cells to recognize and kill tumor cells. KIMMTRAK has been approved for the treatment of HLA-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma in the United States, European Union, Canada, Australia, and the United Kingdom.

IMPORTANT SAFETY INFORMATION

Cytokine Release Syndrome (CRS), which may be serious or life-threatening, occurred in patients receiving KIMMTRAK. Monitor for at least 16 hours following first three infusions and then as clinically indicated. Manifestations of CRS may include fever, hypotension, hypoxia, chills, nausea, vomiting, rash, elevated transaminases, fatigue, and headache. CRS occurred in 89% of patients who received KIMMTRAK, with 0.8% being grade 3 or 4. Ensure immediate access to medications and resuscitative equipment to manage CRS. Ensure patients are euvolemic prior to initiating the infusions. Closely monitor patients for signs or symptoms of CRS following infusions of KIMMTRAK. Monitor fluid status, vital signs, and oxygenation level and provide appropriate therapy. Withhold or discontinue KIMMTRAK depending on persistence and severity of CRS.

Skin Reactions

Skin reactions, including rash, pruritus, and cutaneous edema occurred in 91% of patients treated with KIMMTRAK. Monitor patients for skin reactions. If skin reactions occur, treat with antihistamine and topical or systemic steroids based on persistence and severity of symptoms. Withhold or permanently discontinue KIMMTRAK depending on the severity of skin reactions.

Elevated Liver Enzymes

Elevations in liver enzymes occurred in 65% of patients treated with KIMMTRAK. Monitor alanine aminotransferase (ALT), aspartate aminotransferase (AST), and total blood bilirubin prior to the start of and during treatment with KIMMTRAK. Withhold KIMMTRAK according to severity.

Embryo-Fetal Toxicity

KIMMTRAK may cause fetal harm. Advise pregnant patients of potential risk to the fetus and patients of reproductive potential to use effective contraception during treatment with KIMMTRAK and 1 week after the last dose.

The most common adverse reactions (≥30%) in patients who received KIMMTRAK were cytokine release syndrome, rash, pyrexia, pruritus, fatigue, nausea, chills, abdominal pain, edema, hypotension, dry skin, headache, and vomiting. The most common (≥50%) laboratory abnormalities were decreased lymphocyte count, increased creatinine, increased glucose, increased AST, increased ALT, decreased hemoglobin, and decreased phosphate.

For more information, please see full Summary of Product Characteristics (SmPC) or full U.S. Prescribing Information (including BOXED WARNING for CRS).

About KIMMTRAKConnect

Immunocore is committed to helping patients who need KIMMTRAK obtain access via our KIMMTRAKConnect program. The program provides services with dedicated nurse case managers who provide personalized support, including educational resources, financial assistance, and site of care coordination. To learn more, visit KIMMTRAKConnect.com or call 844-775-2273.

About Immunocore

Immunocore is a commercial-stage biotechnology company pioneering the development of a novel class of TCR bispecific immunotherapies called ImmTAX – Immune mobilizing monoclonal TCRs Against X disease – designed to treat a broad range of diseases, including cancer, autoimmune diseases and infectious diseases. Leveraging its proprietary, flexible, off-the-shelf ImmTAX platform, Immunocore is developing a deep pipeline in multiple therapeutic areas, including clinical and pre-clinical programs in oncology, infectious diseases, and autoimmune diseases. The Company's most advanced oncology TCR therapeutic, KIMMTRAK, has been approved for the treatment of HLA-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma in the United States, European Union, Canada, Australia, and the United Kingdom.

Forward Looking Statements

This press release contains “forward-looking statements” within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Words such as “may”, “will”, “believe”, “expect”, “plan”, “anticipate”, “aim”, “continue”, “target” and similar expressions (as well as other words or expressions referencing future events or circumstances) are intended to identify forward-looking statements. All statements, other than statements of historical facts, included in this press release are forward-looking statements. These statements include, but are not limited to, statements regarding the Company’s strategic priorities for 2025, the potential of the Company’s melanoma franchise, the Company’s ability to advance its clinical pipeline and to innovate for sustainable growth; the Company’s ability to expand access to KIMMTRAK to more patients, including through additional launches and approvals and the potential for expansion into other indications such as cutaneous and adjuvant uveal melanoma; expectations regarding the estimated size of the patient populations for the Company’s product candidates; expectations regarding the design, progress, timing, enrollment, randomization, scope, expansion, and results of the Company’s and its collaborators’ existing and planned clinical trials; the timing and sufficiency of clinical trial outcomes to support potential approval of any of the Company’s product candidates or those of, or combined with, its collaboration partners; the Company’s ability to leverage its expertise and dataset to inform clinical development, and technology and learnings to generate transformative therapies for patients; the Company’s goals to develop and commercialize product candidates based on its KIMMTRAK platform alone or with collaboration partners; the expected submission of clinical trial applications; the potential regulatory approval, expected clinical benefits and availability of the Company’s product candidates; and the Company’s preliminary unaudited cash, cash equivalents and maketable securities as of December 31, 2025. Any forward-looking statements are based on management’s current expectations and beliefs of future events and are subject to a number of risks and uncertainties that could cause actual events or results to differ materially and adversely from those set forth in or implied by such forward-looking statements, many of which are beyond the Company’s control. These risks and uncertainties include, but are not limited to, the impact of worsening macroeconomic conditions on the Company’s business, financial position, strategy and anticipated milestones, including Immunocore’s ability to conduct ongoing and planned clinical trials; Immunocore’s ability to obtain a clinical supply of current or future product candidates or commercial supply of KIMMTRAK or any future approved products including as a result of health epidemics or pandemics, war in Ukraine, the conflict in the Middle East, or global geopolitical tension; Immunocore’s ability to obtain and maintain regulatory approval of its product candidates, including KIMMTRAK; Immunocore’s ability and plans in continuing to establish and expand a commercial infrastructure and to successfully launch, market and sell KIMMTRAK and any future approved products; Immunocore’s ability to successfully expand the approved indications for KIMMTRAK or obtain marketing approval for KIMMTRAK in additional geographies in the future; the delay of any current or planned clinical trials, whether due to patient enrollment delays or otherwise; Immunocore’s ability to successfully demonstrate the safety and efficacy of its product candidates and gain approval of its product candidates on a timely basis, if at all; competition with respect to market opportunities; unexpected safety or efficacy data observed during preclinical studies or clinical trials; actions of regulatory agencies, which may affect the initiation, timing and progress of clinical trials or future regulatory approval; Immunocore’s need for and ability to obtain additional funding, on favorable terms or at all, including as a result of worsening macroeconomic conditions, including changes in inflation and interest rates and unfavorable general market conditions, and the impacts thereon of the war in Ukraine, the conflict between Hamas and Israel, and global geopolitical tension; Immunocore’s ability to obtain, maintain and enforce intellectual property protection for KIMMTRAK or any of its product candidates it or its collaborators are developing; and the success of Immunocore’s current and future collaborations, partnerships or licensing arrangements. These and other risks and uncertainties are described in greater detail in the section titled "Risk Factors" in Immunocore’s filings with the Securities and Exchange Commission, including Immunocore’s most recent Annual Report on Form 10-K for the year ended December 31, 2023 filed with the Securities and Exchange Commission on February 28, 2024, as well as discussions of potential risks, uncertainties, and other important factors in the Company’s subsequent filings with the SEC. All information in this press release is as of the date of the release, and the Company undertakes no duty to update this information, except as required by law. In addition, as the reported cash and cash equivalents in this press release are preliminary, have not been audited and are subject to change pending completion of the Company’s audited financial statements for the year ended December 31, 2024, it is possible that the Company or its independent registered public accounting firm may identify items that require the Company to make adjustments to the amount included in this release, and such changes could be material. Additional information and disclosures would also be required for a more complete understanding of the Company’s financial position and results of operations as of December 31, 2024.

IMMUNOCORE

Contact Information

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Exhibit 99.2

IMMUNOCORE

Transformative immunomodulating medicines for patients

January 2025

Forward Looking Statements

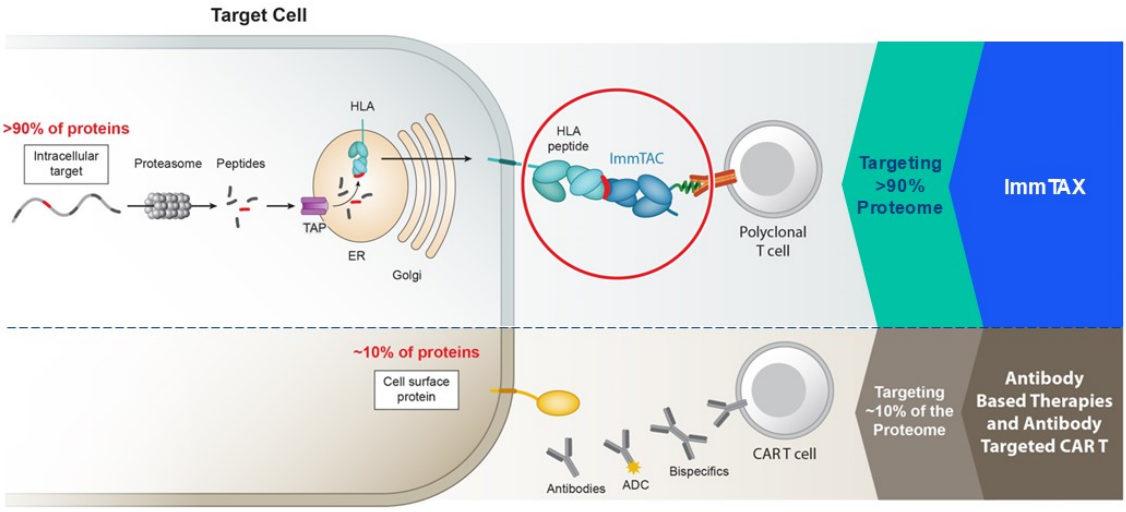
This presentation contains "forward-looking statements" within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. Words such as "may", "will", "believe", "expect", "plan", "anticipate", "estimate" and similar expressions (as well as other words or expressions referencing future events or circumstances) are intended to identify forward-looking statements. All statements, other than statements of historical facts, included in this presentation are forward-looking statements. These statements include, but are not limited to, Immunocore's capabilities across oncology, autoimmune and infectious disease therapeutic areas and its ability to grow, and further development the PRAME portfolio; the estimated market size and patient population for KIMMTRAK and Immunocore's other product candidates; the three growth areas of KIMMTRAK, including HLA-A02+ melanoma, cutaneous melanoma and adjuvant uveal melanoma; expected submission of investigational new drug applications or clinical trial applications; the potential regulatory approval, expected clinical benefits and availability of Immunocore's product candidates; the commercial performance of KIMMTRAK including indication expansion; the potential benefits and advantages KIMMTRAK, brenetafusp and Immunocore's other product candidates will provide for patients; the potential of the PRAME portfolio opportunity to expand into additional solid tumor indications; expectations regarding the design, progress, timing, enrollment, scope, expansion, funding, and results of Immunocore's existing and planned clinical trials, those of Immunocore's collaboration partners or the combined clinical trials with Immunocore's collaboration partners; the timing and sufficiency of clinical trial outcomes to support potential approval of any of Immunocore's product candidates or those of, or combined with, its collaboration partners; expected commercial and clinical milestones and Immunocore's ability to achieve those milestones on their expected timeline, or at all; the value of Immunocore's products and product candidates for patients and shareholders; and potential growth opportunities and trends, including in connection with product launches. Any forward-looking statements are based on management's current expectations and beliefs of future events and are subject to a number of risks and uncertainties that could cause actual events or results to differ materially and adversely from those set forth in or implied by such forward-looking statements, many of which are beyond Immunocore's control. These risks and uncertainties include, but are not limited to, the impact of worsening macroeconomic conditions on Immunocore's business, financial position, strategy and anticipated milestones, including Immunocore's ability to conduct ongoing and planned clinical trials; Immunocore's ability to obtain a clinical supply of current or future product candidates or commercial supply of KIMMTRAK or any future approved products, including as a result of health epidemics or pandemics, war in Ukraine, the conflict in the Middle East, the broader risk of a regional conflict in the Middle East, or global geopolitical tension; Immunocore's ability to obtain and maintain regulatory approval of its product candidates, including KIMMTRAK; Immunocore's ability and plans in continuing to establish and expand a commercial infrastructure and to successfully launch, market and sell KIMMTRAK and any future approved products; Immunocore's ability to successfully expand the approved indications for KIMMTRAK or obtain marketing approval for KIMMTRAK in additional geographies in the future; the delay of any current or planned clinical trials, whether due to patient enrollment delays or otherwise; Immunocore's ability to successfully demonstrate the safety and efficacy of its product candidates and gain approval of its product candidates on a timely basis, if at all; competition with respect to market opportunities; unexpected safety or efficacy data observed during preclinical studies or clinical trials; actions of regulatory agencies, which may affect the initiation, timing and progress of clinical trials or future regulatory approval; Immunocore's need for and ability to obtain additional funding, on favorable terms or at all, including as a result of worsening macroeconomic conditions, including changes inflation and interest rates and unfavorable general market conditions, and the impacts thereon of the war in Ukraine, the conflict in the Middle East, and global geopolitical tension; Immunocore's ability to obtain, maintain and enforce intellectual property protection for KIMMTRAK or any product candidates it or its collaborators are developing; and the success of Immunocore's current and future collaborations, partnerships or licensing arrangements, including the risk that Immunocore may not realize the anticipated benefits of its collaboration with Bristol Myers Squibb. These and other risks and uncertainties are described in greater detail in the section titled "Risk Factors" in Immunocore's filings with the Securities and Exchange Commission, including Immunocore's most recent Annual Report on Form 10-K for the year ended December 31, 2023 filed with the Securities and Exchange Commission on February 28, 2024, as well as discussions of potential risks, uncertainties, and other important factors in Immunocore's subsequent filings with the Securities and Exchange Commission.

All forward looking statements contained in this presentation speak only as of the date on which they were made and should not be relied upon as representing its views as of any subsequent date. 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.

Certain information contained in this presentation relates to or is based on studies, publications, surveys, and other data obtained from third party sources and Immunocore's own internal estimates and research. While Immunocore believes these third party sources to be reliable as of the date of this presentation, it has not independently verified, and makes no representation as to the adequacy, fairness, accuracy, or completeness of, any information obtained from third party sources.

KIMMTRAK is a trademark owned or licensed to Immunocore.

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

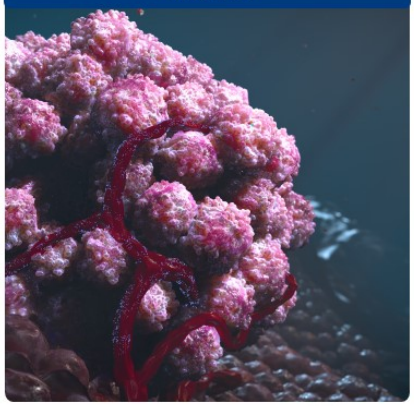


TCR therapeutics can target >90% of the human proteome

Platform candidates and capabilities across 3 therapeutic areas

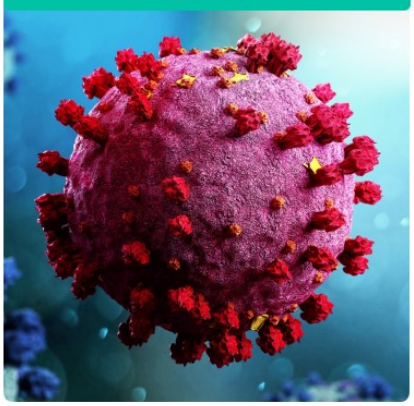
Oncology

ImmTACs



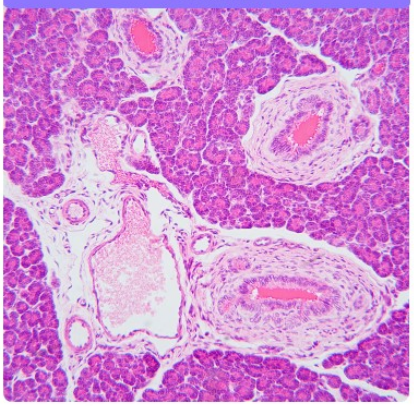
Infectious diseases

ImmTAVs



Autoimmune diseases

ImmTAAIs



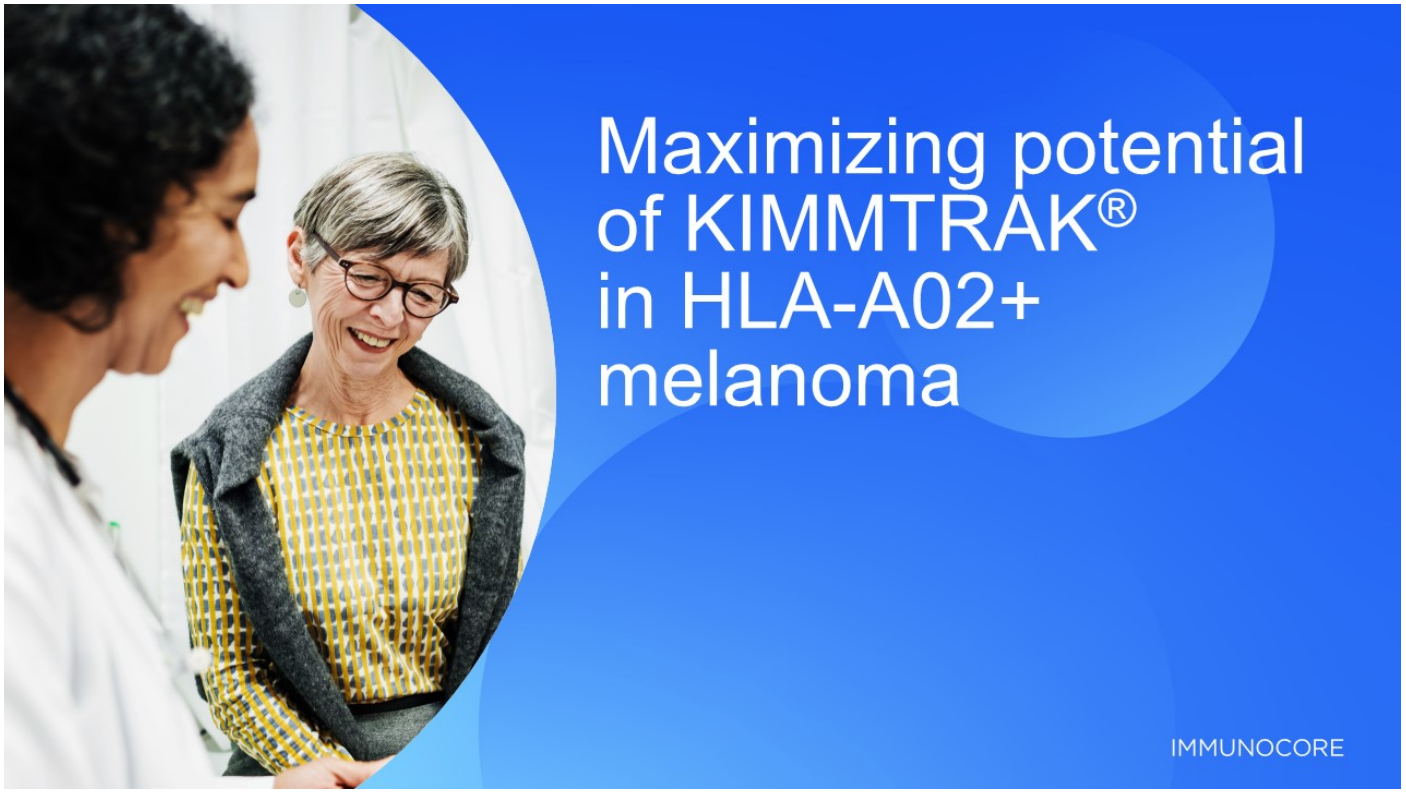
Activation
of the immune system

Downmodulation
of the immune system

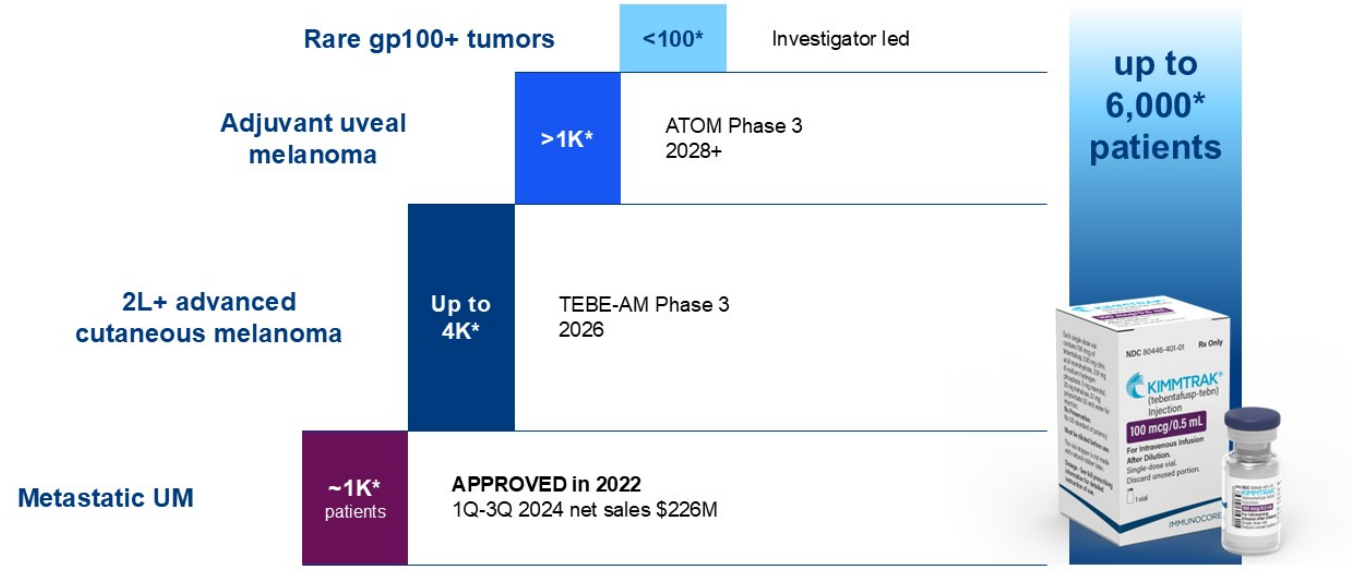
Leading bispecific TCR pipeline

	Candidate	Target (HLA type)	Indication	IND-enabling	Phase 1	Phase 2	Phase 3	Approved	
Oncology	KIMMTRAK	gp100-A02	Uveal (ocular) melanoma						On Market
			Adjuvant uveal (ocular) melanoma		ATOM sponsored by EORTC				Phase 3 ongoing
			2L+ advanced cutaneous melanoma		TEBE-AM				Enrolment completion | 1H26
	Brenetafusp	PRAME-A02	1L advanced cutaneous melanoma		PRISM-MEL-301				Phase 3 ongoing
			Combo arms: Ovarian[1]						Phase 1/2 ongoing
			Combo arms: NSCLC[2]						
			Combo arms: Additional solid tumors						
	IMC-P115C	PRAME HLE-A02	Multiple solid tumors						Phase 1/2 ongoing
	IMC-T119C	PRAME-A24	Multiple solid tumors						
	IMC-R117C	PIWIL1-A02	Colorectal and GI cancers						Phase 1/2 ongoing
Infectious	**IMC-M113V**[3]	Gag-A02	Human Immunodeficiency Virus (HIV)						MAD Data | 1Q 2025
	IMC-I109V	Envelope-A02	Hepatitis B Virus (HBV)						SAD Data | 2025
Autoimmune	**IMC-S118AI**	PPI x PD1-A02	Type 1 Diabetes						Submit CTA/IND[5] | 4Q 2025
	IMC-U120AI	CD1a x PD1 (non-HLA restricted)	Dermatology						Submit CTA/IND[5] | 2026

[1] Platinum refractory or resistant serous ovarian carcinoma. [2] NSCLC = Non-small cell lung cancer. [3] Program is wholly owned, development costs being provided by the Bill & Melinda Gates Foundation (BMGF). Immunocore retains all development and commercialization rights in the developed world. [4] Program is not HLA restricted (i.e. universal for all populations). 5. submission

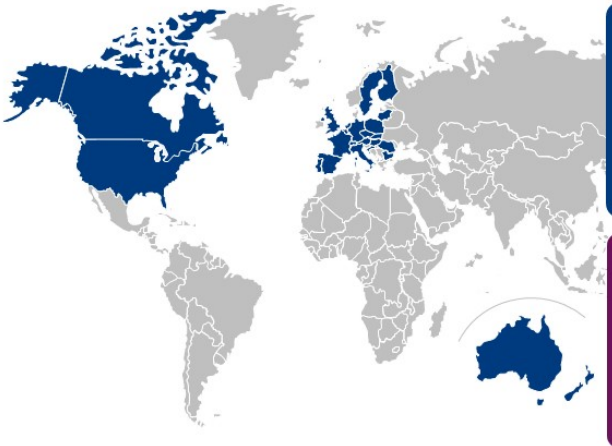

Maximizing potential of KIMMTRAK® in HLA-A02+ melanoma
IMMUNOCORE

KIMMTRAK has the potential to help up to 6K patients per year



* Estimated future number of HLA-A*02:01 positive patients per year in the US and Europe.

We continue to reach more patients globally with KIMMTRAK



+13
launches in 2024

$226m
Q1-Q3 2024 net revenues

23
launched countries[1,2]

Approved in
38+
countries[2]

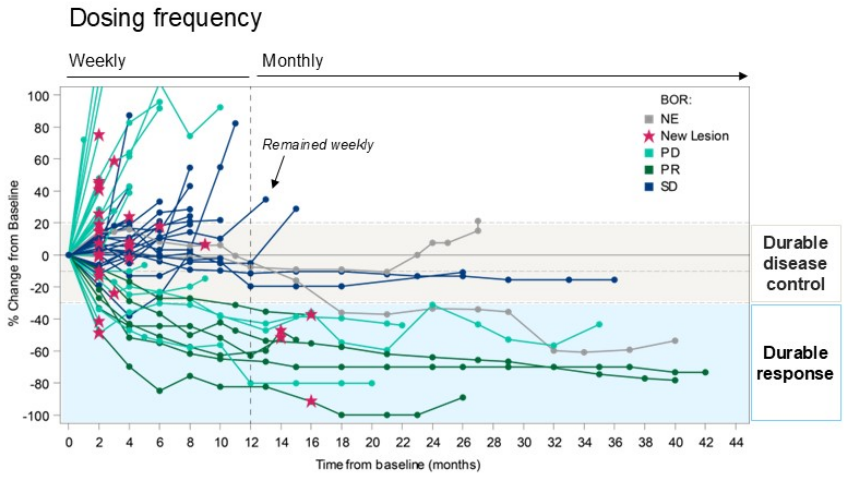
3 yr
OS data

The NEW ENGLAND JOURNAL of MEDICINE

[1] US, Germany, France, Israel, Italy, Austria, Finland, Belgium, Switzerland, Slovenia, Australia, Canada, Spain, Bulgaria, Luxemburg, Czech Republic, Lithuania, Cyprus, Portugal, Slovakia, Sweden, Poland, and United Kingdom. [2] As of December 31, 2024.

KIMMTRAK active in cutaneous melanoma (CM)

Phase 1/2 study of KIMMTRAK + checkpoints in CM patients who progressed on prior anti-PD1



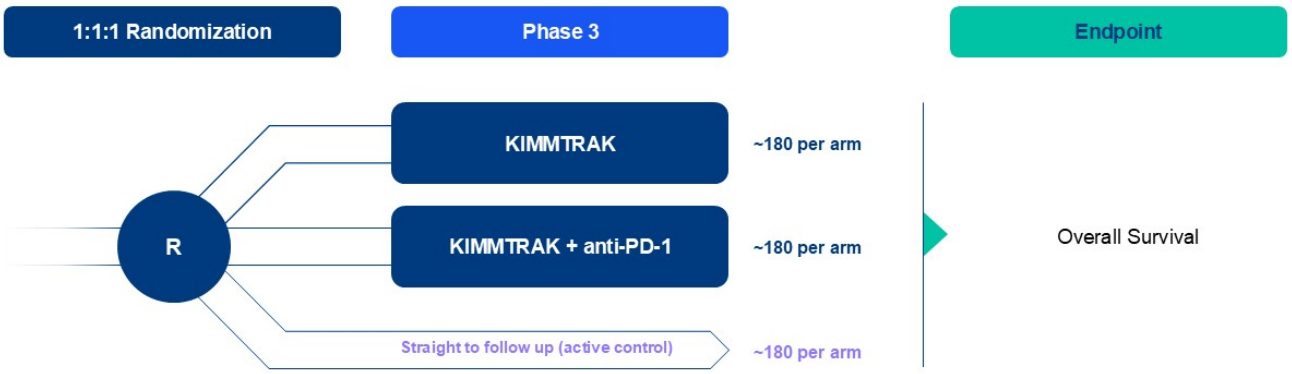
60 cutaneous melanoma (all progressed on prior anti-PD1) received KIMMTRAK (tebentafusp) + durvalumab*

Time from prior anti-PD(L)1	1-yr OS	2-yr OS
Remote	75%	22%
Immediately prior	75%	23%
Benchmark	55%	N/A

→ **Time since last dose of prior anti-PD1 does not impact outcome**

Hamid O, *et al*. JITC (2023). Middleton *et al*., ASCO 2022. Remote = Patients received prior anti-PD1 but it was not most recent therapy prior to enrolment. Immediately prior = anti-PD1 was most recent therapy prior to enrolment. * Patients who received prior anti-PD(L)1 therapy and then received tebentafusp+ durvalumab +/- tremelimumab on Study IMCgp100-201. Included patients relapsed from or refractory to prior anti-PD(L)1.

TEBE-AM: Phase 3 trial in 2L+ cutaneous melanoma



1H 2026: expected enrollment completion

2L+ cutaneous melanoma market opportunity **up to 4,000 patients***

* Estimated total number of drug treated HLA*02:01 positive patients per year in the US and 5EU (2024). CPI = checkpoint inhibitor

Rationale for KIMMTRAK in adjuvant uveal melanoma

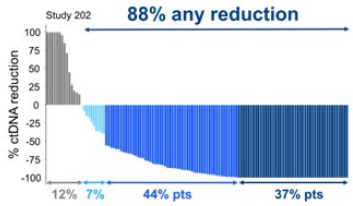
Clinical activity expected to be highest in adjuvant setting with minimal disease burden

In Phase 3 trial, highest clinical activity in tumors with minimal disease burden[1]

Largest metastatic lesion	PFS Hazard ratio	OS Hazard ratio
M1a (<3.0 cm)	0.68	0.36
M1b (3.1-8.0 cm)	0.74	0.71
M1c (≥8.1 cm)	0.95	0.76

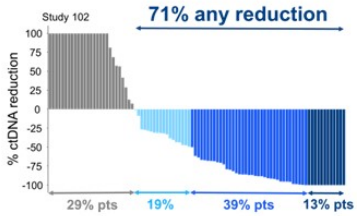
ctDNA reduction in 1st line > 2nd+ line mUM

1st line (N=123)



37% ctDNA clearance[2]

2nd + line (N=94)

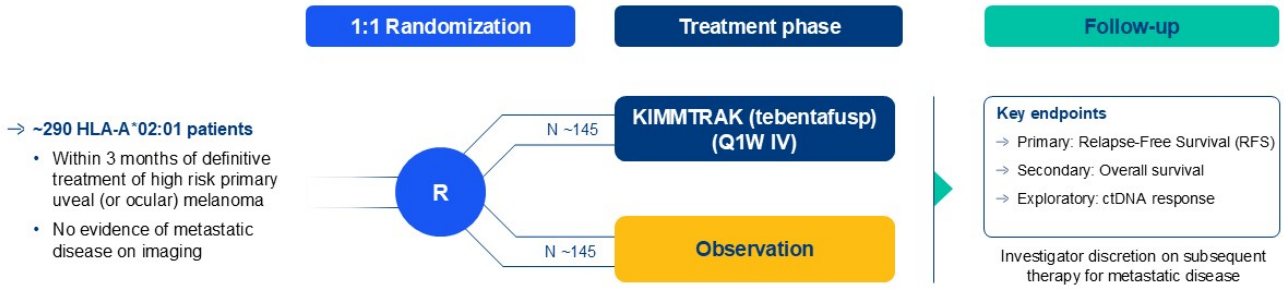


13% ctDNA clearance[3]

[1] Pipemo-Neumann, *et al.* AACR Annual Meeting 2021. [2] Sullivan R, *et al.* Cancer Res (2023) 83 (7_Supplement): 1035. [3] Carvajal, R.D., *et al.* Nat Med 28, 2364–2373 (2022).

ATOM – Phase 3 KIMMTRAK adjuvant UM trial design

Global trial led by European Organisation for Research and Treatment of Cancer (EORTC)



First patient randomized in Q4 2024

Adjuvant uveal melanoma market opportunity **~1,200 patients***

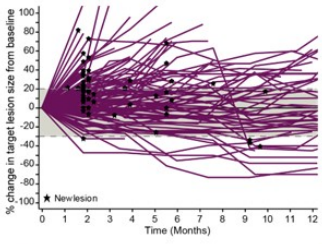
* Estimated total number of drug treated HLA-A*02:01 positive 1L cutaneous melanoma patients per year in the US and Europe (2024).

PRAME portfolio

Based on data to date, disease control is hallmark of ImmTAC

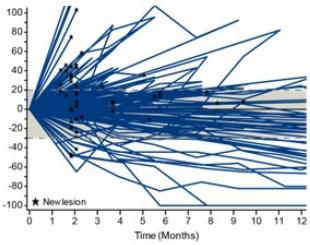
KIMMTRAK

late line mUM (IMCgp100-102)



OS benefit in
metastatic uveal melanoma

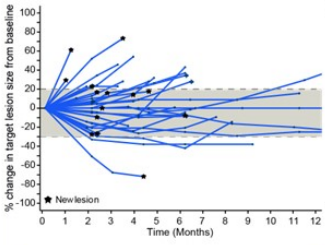
late line mCM[1] (IMCgp100-201)



Ongoing Ph3 study
TEBE AM

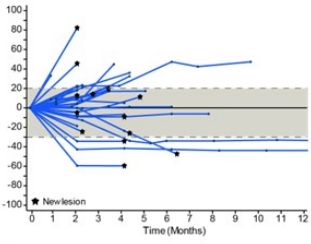
Brenetafusp

late line mCM (IMCF106C-101)



Ongoing Ph3 study
PRISM MEL301

late line PROC[2] (IMCF106C-101)



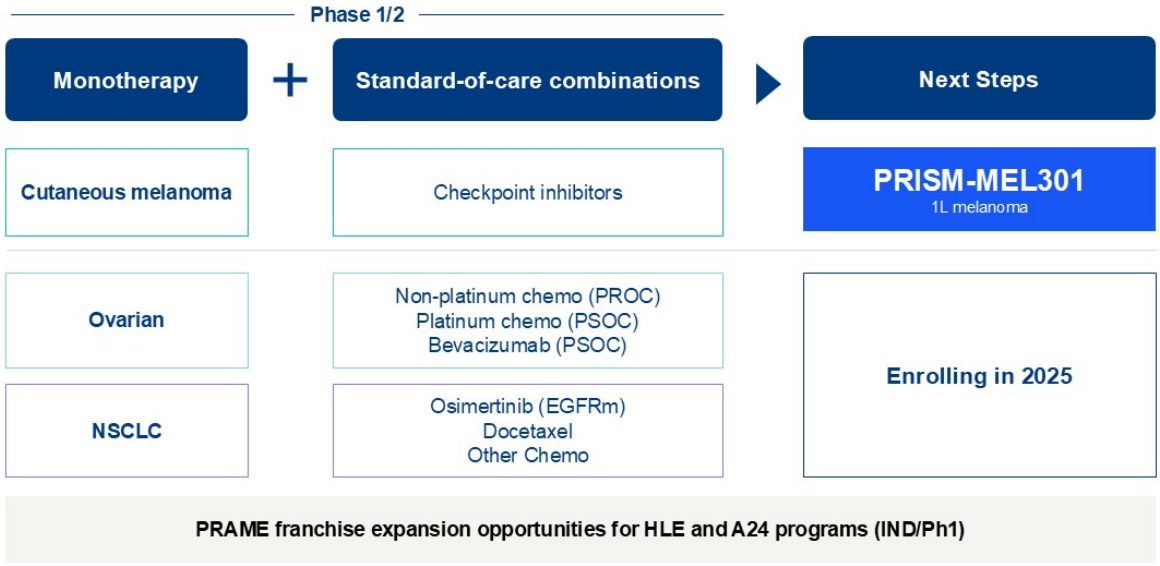
Evaluating combos in PROC
and PSOC

Greatest benefit may be in earlier lines of therapy and with combinations

[1] In combination with durvalumab +/- tremelimumab. [2] Platinum resistant ovarian carcinoma

Executing to maximize PRAME portfolio potential

Currently evaluating brenetafusp in combination with standards of care in ovarian and NSCLC



Brenetafusp in cutaneous melanoma

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CM Demographics and baseline characteristics

Brenetafusp monotherapy and in combination with pembrolizumab

Characteristic	Monotherapy N = 47	+ Pembro N = 9
Age, yr – median (range)	64 (31-79)	65 (24-78)
Female – n (%)	19 (40%)	4 (44%)
ECOG status 0 – n (%)	27 (57%)	8 (89%)
Baseline disease status		
Stage III/IV M1a	3 (6%)	3 (33%)
Stage IV M1b/c/d	44 (94%)	6 (67%)
Brain metastasis – n (%)	10 (21%)	2 (22%)
Liver metastasis – n (%)	21 (45%)	3 (33%)
Sum of target lesions[1], mm – median (range)	84 (14-309)	73 (24-117)
Prior therapy		
# lines – median (range)	2 (1-9)	4 (1-7)
Anti-PD1	47 (100%)	9 (100%)
Primary resistant[2] – n (%)	14 (30%)	6 (67%)
Anti-CTLA4	38 (81%)	8 (89%)
BRAF inhibitor	7 (15%)	4 (44%)
PRAME status (IHC)		
Positive[3]	42 (89%)	9 (100%)
H-score[4] – median	215	155

→ **Patients were heavily pre-treated**

- All received prior checkpoint inhibitors (CPI)
  - Median 2 prior anti-PD1 regimens
  - 81% prior ipilimumab – nearly all in combination with nivolumab
  - 38% had another IO, in addition to anti-PD1, anti-CTLA4
- Pembro combo pts. more heavily pre-treated
- Higher percentage with prior BRAFi and primary resistance to anti-PD1

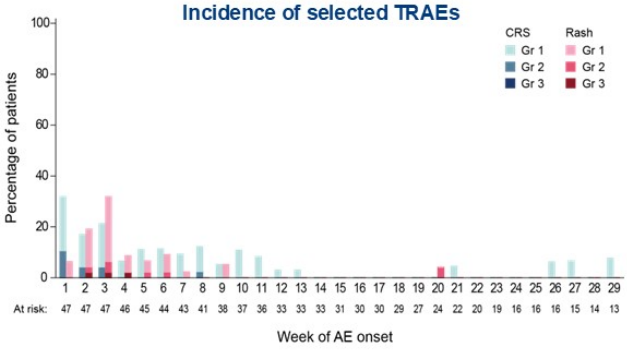
→ **PRAME expression was high (median H score 215 in monotherapy)[4]**

Includes patients receiving target doses ≥20mcg. [1] Sum of target lesions at baseline; one pembro combo pt had non-target lesions only. [2] Primary resistant to anti-PD1: progressed within 6 months of starting first anti-PD1-containing regimen. [3] PRAME positive group for efficacy analysis includes H-score ≥1 and pts with unknown PRAME IHC results; maximum H-score 300. [4] Amongst IHC evaluable pts (n=38 mono, n=5 combo).

Brenetafusp CM monotherapy was well-tolerated

Preferred Term (%)	TRAE in ≥ 15% of patients (N = 47) Any grade	Grade 3/4
Any	43 (92%)	19 (40%)
Cytokine release syndrome[1]	24 (51%)	-
Rash (composite)[2]	23 (49%)	1 (2%)
Pyrexia	17 (36%)	1 (2%)
Chills	13 (28%)	-
Lymphocyte decrease	12 (26%)	11 (23%)
Pruritus	11 (23%)	-
Nausea	9 (19%)	-
Fatigue	7 (15%)	-

Incidence of selected TRAEs



- → **Safety profile consistent with previous report; no new signal with continued dosing**
- → **Most frequent TRAE was G1/G2 CRS, consistent with mechanism**
- → **TRAE frequency and severity attenuated over time**

- → **The only G4 TRAEs were lymphocyte decrease (N = 11) / lymphopenia (N = 3), transient and related to mechanism**
- → **No severe neutropenia observed**
- → **1 TRAE resulted in treatment discontinuation**
- → **No treatment-related deaths**

Includes patients receiving target doses ≥20mcg. [1] CRS graded per ASTCT 2019 criteria; all other AE per CTCAE v5.0. [2] Rash is a composite term for a list of skin toxicities of any grade (Nathan *et al.* 2021). Other G3 treatment-related adverse events (TRAE, in 1 pt each): anemia, chronic inflammatory demyelinating polyneuropathy, fever, hypertension, hypotension, hypoxia, pain in extremity, tumor lysis syndrome, urticaria.

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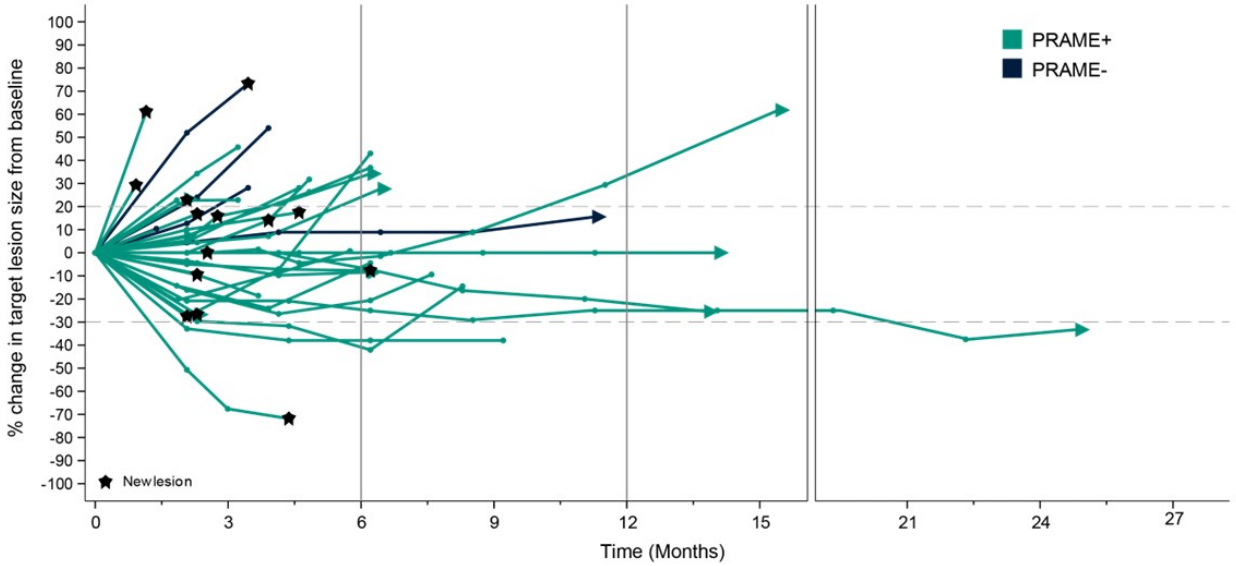
Clinical benefit characterized by durable disease control

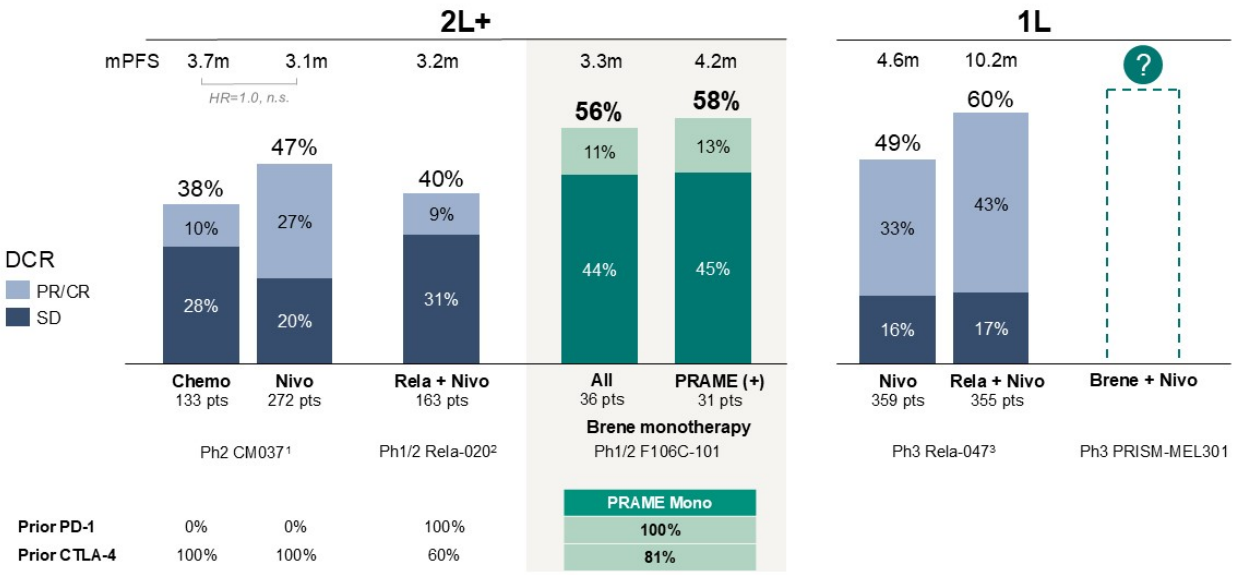
Brenetafusp CM monotherapy (N = 36 evaluable*)



PRAME positive group for efficacy analysis includes H-score ≥1 and pts with unknown PRAME IHC results. * 36/47 patients had baseline and at least one tumor assessment on treatment; 10 patients had no evaluable post-baseline tumor scans and 1 had non-target lesions only at baseline.

Promising DCR for brenetafusp rationale for 1L Ph3 (nivo + brene)

Comparison to nivolumab and relatlimab + nivolumab



Note: data for informational purposes, no comparative claims are implied or intended. Nivo: nivolumab. Rela: relatlimab. [1] CM037: NCT01721746, Larkin J, *et al.* J Clin Onc 2018. [2] RELA020, NCT01968109; D2 Cohort (≥1 anti-PD-(L)1 containing regimen), Ascierto PA, *et al.* J Clin Onc 2023. [3] RELA047: NCT03470922, Long GV, *et al.* NEJM 2023. Disease control rate (DCR)

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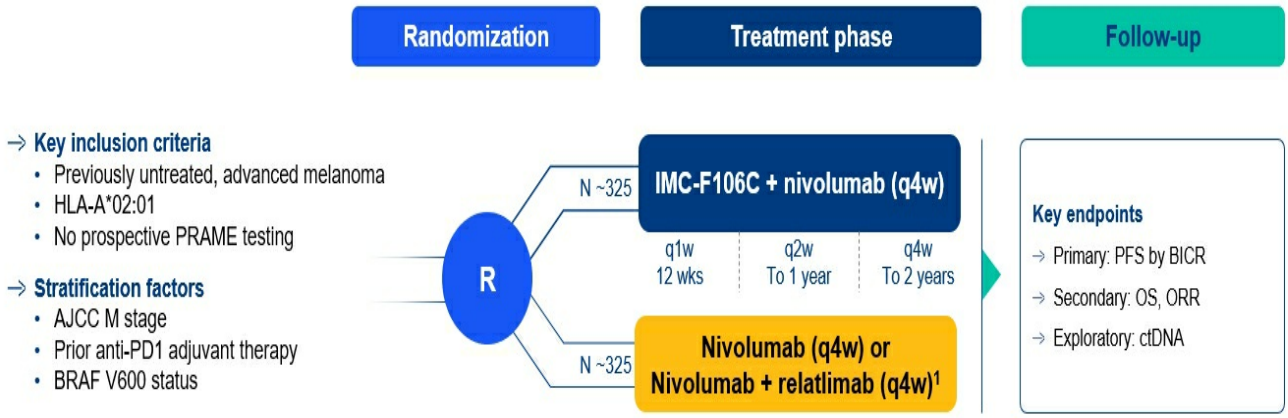
PRISM-MEL-301: Phase 3 trial in first-line advanced cutaneous melanoma

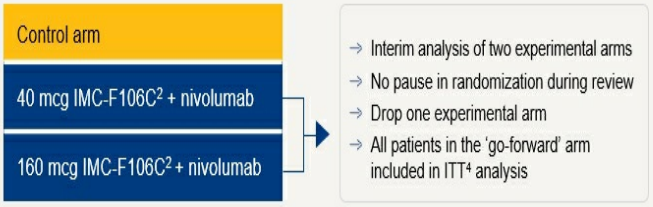
Registrational trial currently enrolling patients



1L market opportunity

~10K HLA-A02+[3]

Initial randomization includes comparison of two IMC-F106C regimens (~90 patients or 30/arm)



[1] Use of nivolumab or nivolumab + relatlimab as control will be country specific. [2] Represents target dose after intra-patient escalation. [3] Estimated total number of drug treated HLA-A*02:01 positive 1L cutaneous melanoma patients per year in the US and Europe (2024). [4] ITT: intent to treat. q1w = every week, q2w = biweekly, q4w = every 4 weeks.


Brenetafusp in ovarian
22
IMMUNOCORE

Phase 1 ovarian demographics and baseline characteristics[1]

	Mono N = 37	Chemo Combo N = 16
General		
Age, median yr (range)	63 (40-80)	65 (47-72)
ECOG PS 0, n (%)	19 (51%)	4 (25%)
BRCA mutant, n (%)	9 (24%)	1 (6%)
TL sum, median mm (range)	67 (12-217)	76 (16-194)
Prior treatment[2]		
# regimens, median (range)	5 (2-10)	4 (1-10)
Bevacizumab	30 (81%)	12 (75%)
PARPi	22 (59%)	12 (75%)
Anti-PD-[L]1	5 (14%)	4 (25%)
ADC	4 (11%)	4 (25%)
PRAME status (IHC)		
Evaluable	32	16
Positive	30 (94%)	13 (81%)
H-score, median	130	93

→ **Patients were heavily pre-treated**

- Median 4-5 prior lines
- All platinum resistant, majority prior bevacizumab (81%, 75%) and PARPi (59%, 75%)

→ **PRAME prevalence was high**

- 94% positive in monotherapy
- 81% positive in combination

ADC, antibody-drug conjugates; IHC, immunohistochemistry; PLD, pegylated liposomal doxorubicin; Plt, platinum; TL, target lesion. [1] Includes patients with high-grade serous ovarian carcinoma who received ≥ 20 mcg brenetafusp. [2] 2 mono & 1 combo pt had prior T cell engager.

Brenetafusp, Phase 1 monotherapy & chemo combo, well-tolerated

Treatment related adverse events (TRAE) frequency and severity attenuated over time

	Mono N = 37		Chemo combo N = 16	
Preferred Term	**TRAE**	**G3/4 TRAE†**	**TRAE**	**G3/4 TRAE†**
ANY	36 (97%)	7 (19%)	16 (100%)	8 (50%)
CRS‡	21 (57%)	---	12 (75%)	---
Rash§	19 (51%)	1 (3%)	13 (81%)	---
Nausea	14 (38%)	---	4 (25%)	---
Fatigue	13 (35%)	---	6 (38%)	1 (6%)
Vomiting	12 (32%)	---	2 (13%)	---
Pyrexia	11 (30%)	---	9 (56%)	---
ALT increased	4 (11%)	1 (3%)	8 (50%)	3 (19%)
AST increased	2 (5%)	1 (3%)	8 (50%)	2 (13%)
Flushing	1 (3%)	---	4 (25%)	---

Other mono G3 TRAE, each n=1: anemia, diarrhea, neutropenia, pericardial effusion, rash maculo-papular

Other combo G3 TRAE, each n=1: dyspnea, fatigue, neutropenia, presyncope

→ **No TRAE leading to treatment discontinuation or death**

→ **Monotherapy:**

- Most frequent TRAE was G1/G2 CRS
- Of patients who had CRS, vast majority had G1

→ **Combinations:**

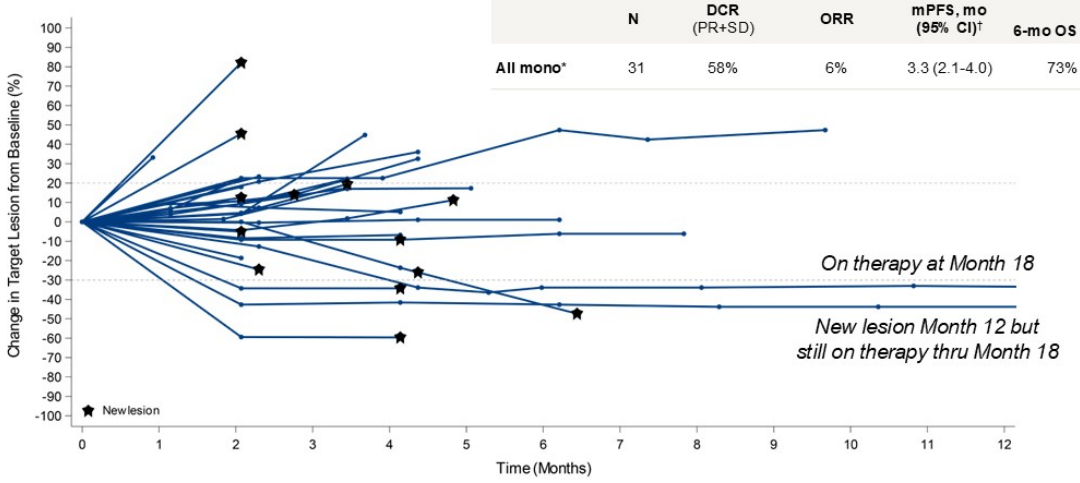
- Additional chemo-related AEs were observed and consistent with each agent

CRS, cytokine release syndrome; ALT, alanine transaminase; AST, aspartate transaminase. * Includes patients receiving target doses ≥20mcg. † Other mono G3 TRAE, each N=1: anemia, diarrhea, neutropenia, pericardial effusion, rash maculo-popular; other combo G3 TRAE, each N=1: dyspnea, fatigue, neutropenia, presyncope. ‡ CRS graded per ASTCT 2019 criteria; all other AE per CTCAE v5.0. § Rash is a composite term for a list of skin toxicities of anygrade (Nathan et al. 2021)

Monotherapy benefit characterized by durable disease control

Monotherapy (N = 31 evaluable*)

	N	DCR (PR+SD)	ORR	mPFS, mo (95% CI)†	6-mo OS rate†	Treated beyond progression‡
All mono*	31	58%	6%	3.3 (2.1-4.0)	73%	64%, median 2 mo



DCR, disease control rate; mPFS, median progression free survival; ORR, overall response rate; OS, overall survival; PR, partial response; SD, stable disease. * 31 of 37 patients had baseline and at least one tumor assessment on treatment; 6 patients not included due to no evaluable post-baseline tumor scans or non-measurable disease at baseline. † Median PFS and 6-month OS rate are based on all 37 monotherapy patients. ‡ 22 of 31 efficacy evaluable patients had progression events; 14 of 22 (64%) were treated beyond initial progression.

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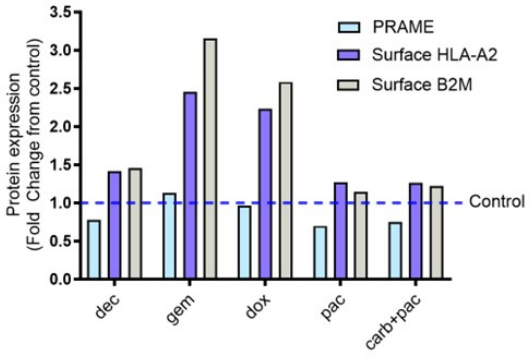
Chemotherapy combination may enhance clinical benefit

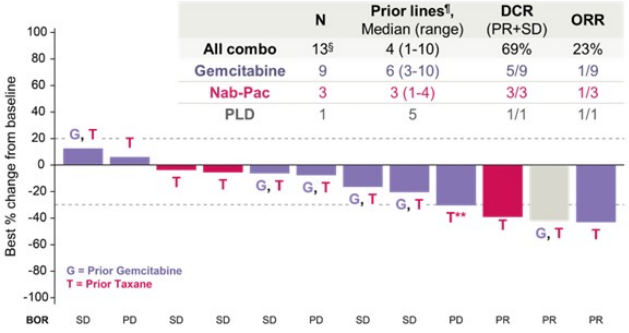
Chemo increases antigen presenting machinery



Chemo increases antigen presenting machinery

Best tumor reduction (N=13 evaluable§)

	N	Prior lines¶, Median (range)	DCR (PR+SD)	ORR
All combo	13§	4 (1-10)	69%	23%
Gemcitabine	9	6 (3-10)	5/9	1/9
Nab-Pac	3	3 (1-4)	3/3	1/3
PLD	1	5	1/1	1/1



BOR, best overall response by RECISTv1.1; DCR, disease control rate; NE, non-evaluable; ORR, overall response rate; PD, progressive disease; PR, partial response; SD, stable disease. * 31 of 37 mono patients had baseline and at least one tumor assessment on treatment, § patients not included due to no evaluable post-baseline tumor scans or non-measurable disease at baseline. ‡ Rapid cfDNA reduction by Week 9 = cfDNA evaluable ≥ at least one variant allele detected at >0.3% VAF at baseline, plus data available for at least one on-treatment timepoint from week 2 to week 9. ¶ 1 of 37 mono patients had baseline and at least one tumor assessment on treatment, 2 patients not included due to no post-baseline tumor scans and one patient not included in waterfall due to missing target lesion size data. ¶Prior antibody-drug was not permitted. ** prior taxane therapy per communication from investigator post data cutoff.

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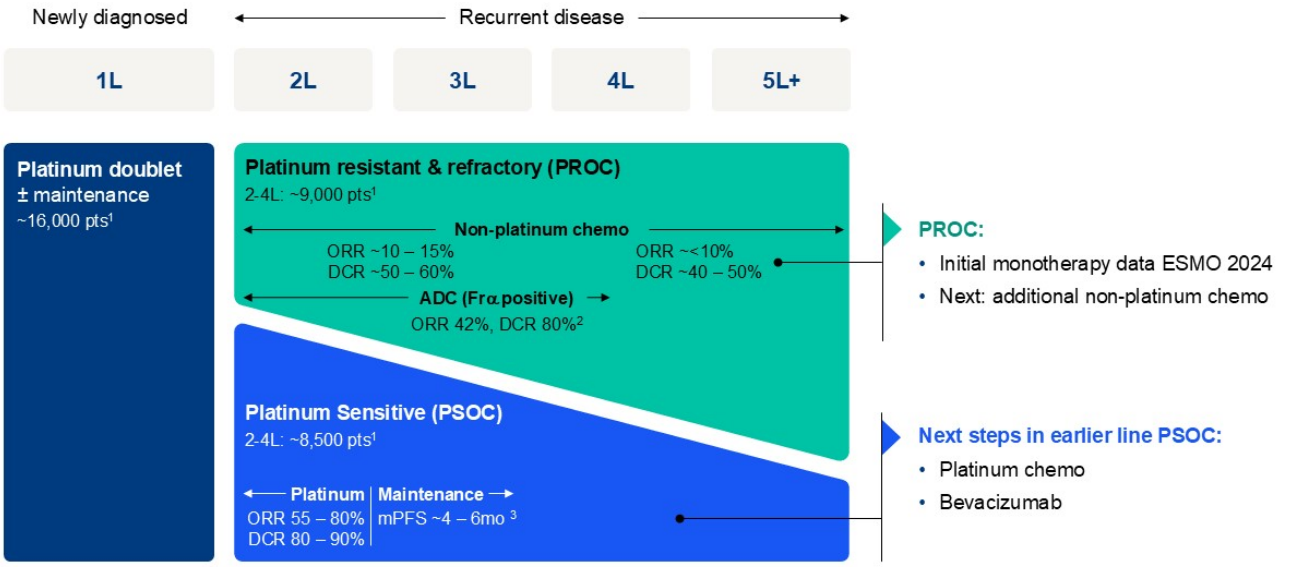
Evaluating brenetafusp in ovarian cancer

Multiple cohorts in ongoing Phase 1 trial



[1] Estimated total number of treated HLA*02:01 positive patients per year in the US and 5EU across lines. [2] MIRASOL Ph3 (mirvetuximab) investigator assessed objective response. [3] mPFS for maintenance portion of treatment only

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Advancing PRAME candidates through a proven framework

Development Steps	KIMMTRAK		Brenetafusp	
	Uveal melanoma	Cutaneous melanoma	Cutaneous melanoma	Serous ovarian
Robust monotherapy activity?	The NEW ENGLAND JOURNAL of MEDICINE	SITC 21 2022 ASCO ANNUAL MEETING	2024 ASCO ANNUAL MEETING	BARCELONA 2024 ESMO congress
ctDNA reduction	✓	✓	✓	✓
PR/CR/DCR	✓	✓	✓	✓
OS rate	✓	✓	✓	✓
Combinability with standard of care?	–	✓	✓	✓ *Ongoing*
Treatment effect supports endpoint of future registrational trial	✓	✓	✓	--
	Phase 3 KIMMTRAK *ATOM*	**Phase 3 Tebe +/- pembro** *TEBE-AM*	**Phase 3 Brene + nivo** *PRISM-MEL-301*	**Enrolling in multiple combination cohorts**
	Enrolling	**Enrolling**	**Enrolling**	*Additional enrollment in NSCLC & other tumors ongoing*

T Cell Fitness (TCF)

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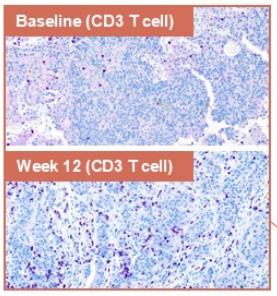
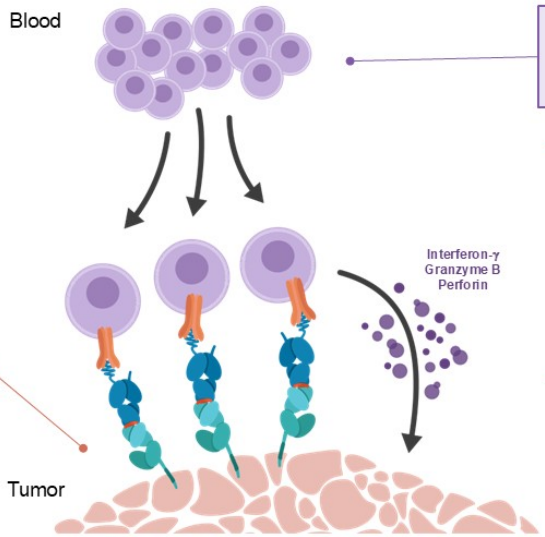
Phenotype of peripheral blood T cells, which are recruited by brenetafusp, may be important for clinical activity

Brenetafusp recruits peripheral blood T cells into the tumor



Metastatic cutaneous melanoma



Hypothesis:
Specific T cell subsets in the blood may be associated with brenetafusp benefit

→ **Method:**

- RNAseq whole blood at baseline
- Analyzed key T cell subsets:
  - Naïve /stem cell memory T cell (T_{scm})
  - Effector
  - Exhausted
  - Regulatory

→ **Naïve T/T_{scm} have been associated with anti-tumor activity of other T cell therapies[1].**

Tscm, stem cell memory T cell. [1] Gattinoni, *et al*. Nature Rev Cancer 2012; 12:671-684; Kishton, *et al*. Curr Opin Imm 2022; 74:39-45; Mehta, *et al*. Front Immunol 2021; 12:780442; Arcangeli, *et al*. J Clin Invest 2022; 123:e150807; Rosenberg, *et al*. Clin Cancer Res 2011; 17:4550-4557.

Novel T cell fitness (TCF) signature associated with ImmTAC benefit

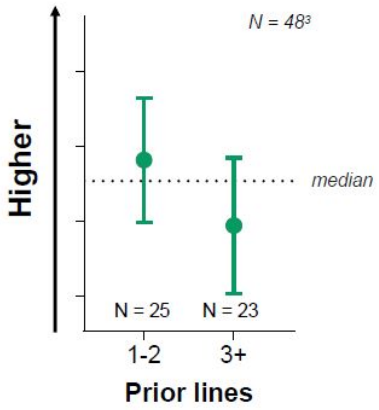
TCF higher in earlier lines of therapy and highly correlated with naïve/T_{scm} cells

Monotherapy benefit by TCF signature

	High[1]	Low
N = 41[2]	N = 21	N = 20
mPFS	6 mo	2 mo
ORR	19%	0%
DCR	69%	42%

→ **Other gene signatures, including T effector and exhausted T cell phenotype, not associated with clinical benefit (data not shown)**

TCF signature, by line of therapy



[1] For exploratory analysis, 'high' defined as ≥ median gene expression signature level. [2] 41 monotherapy CM patients had baseline TCF and were evaluable for tumor assessment on therapy. [3] 42 monotherapy CM and 6 pembrolizumab combination patients had baseline T cell fitness evaluated.

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Novel ImmTAC candidate for GI cancers from our discovery engine
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IMC-R117C: First-in-class target PIWIL1 for colorectal & GI cancers

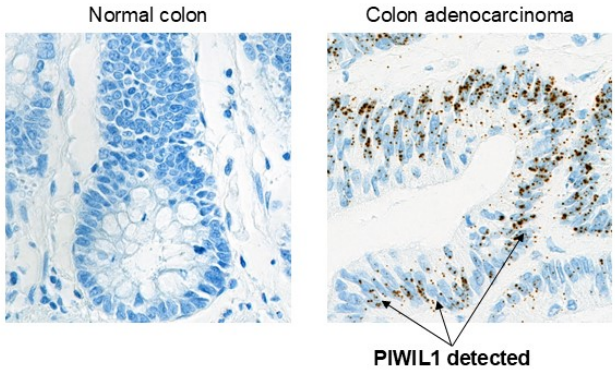
First patient randomized Q4 2024

→ **Negative prognostic marker in multiple cancers**, role in tumor progression

→ **Expressed in CRC[1], historically insensitive to IO,** and across major subgroups[2]

→ **25% CRC have broad PIWIL1 expression** (with >75% of tumor cells positive)

PIWIL1 RNA *in situ* hybridization



~20K colorectal + ~15K other tumors[2]

patients positive for PIWIL1 and HLA-A02

PIWIL1, piwi-like protein1. [1] CRC: colorectal cancer. [2] Estimated across colorectal, esophageal, gastric, pancreatic, ovarian, endometroid cancers.

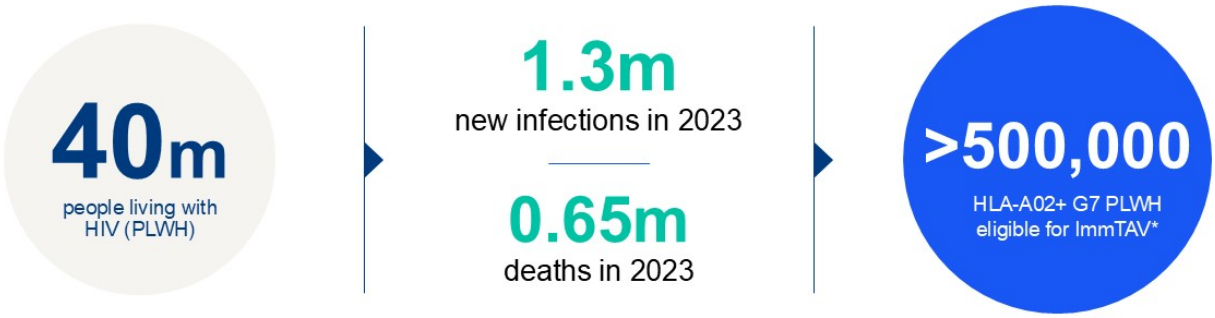

Pursuing a functional cure in infectious diseases
IMMUNOCORE

A cure is key to ending the HIV pandemic

→ **Providing lifelong antiretroviral therapy (ART) globally is not a sustainable solution to the pandemic**

→ **ART, including long-acting, alone is not enough**

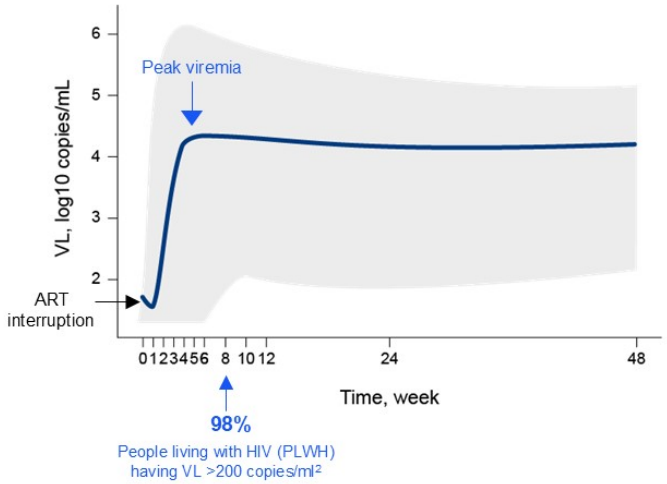
- Benefits depend on lifelong adherence
- Does not remove stigma
- Co-morbidities related to ongoing immune activation and long-term toxicities



*US, 5EU, Japan, AUS/NZ

HIV managed by anti-retroviral therapy (ART) but currently no cure

Historically, rapid viral rebound at median ~2 weeks[1] after ART interruption



→ **Current ART regimens:**

- 2 mechanisms
- Daily oral therapy for life

→ **Goal of functional cure:**

- Reduce or eliminate active reservoir
- Enable stopping ART for 2+ yrs[3]
- Not yet shown for any therapy

[1] Feher C *et al.* Open Forum Infect Dis. 2019; 6: ofz485. N = 249 (from non interventional studies), detectable viral load (VL) defined as > 50 copies/mL, time to detectable VL - IQR = 2-4 weeks. [2] Estimated number of US and SEU A*02:01 positive people living with HIV treated with anti-retroviral therapy, based on data from CDC, ECDC and UNAIDS. [3] Lewin S *et al.* Lancet HIV 2023; 6: e42-e50. Target product profile for HIV cure therapy minimum criteria: viral load <200 c/ml for 2 years, effective in ≥ 20%, relapse rate <10%/year

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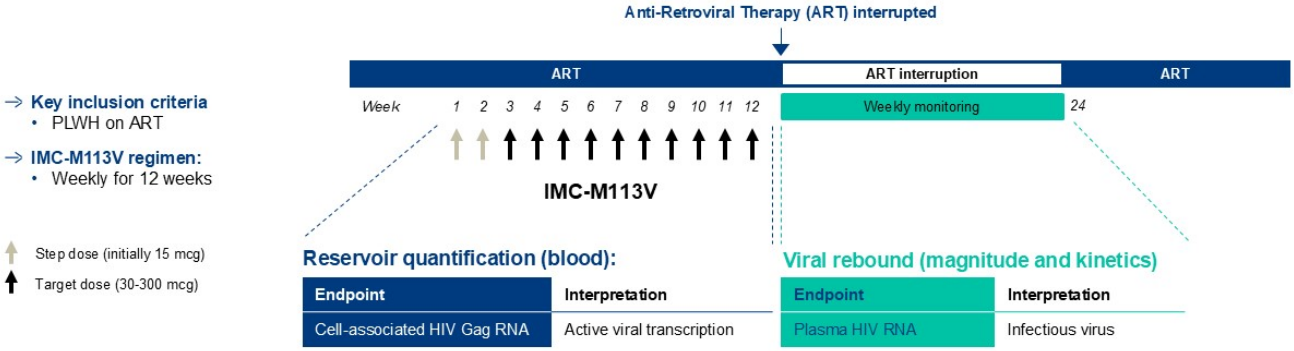
HIV STRIVE Phase 1 multiple ascending dose enrolling

Goal is to determine safety and anti-viral activity of IMC-M113V

→ **Key inclusion criteria**
- PLWH on ART

→ **IMC-M113V regimen:**
- Weekly for 12 weeks



→ **As of June 2024, enrolled 15 people living with HIV (PLWH) (5 PLWH / 3 cohorts)**

→ **Biologically active dose has been reached**

→ **Next step: enroll more PLWH to characterize activity and explore higher doses. Phase 1 MAD data planned for 1Q 2025**

PLWH: People living with HIV. ART: Anti-retroviral therapy. ATI: analytical treatment.

Pioneering tissue-specific immune downmodulation for treatment of autoimmune diseases

Our vision for autoimmunity and inflammation landscape: tissue-specific down modulation of the immune system

Vision for autoimmunity and inflammation landscape

Current
Systemic immune suppression, even if inflammation in single tissue

Future
Down modulation of immune system localized to inflamed tissue

ImmTAAI

Tissue-tethered targeting of HLA-family of molecules

PD1 agonist suppresses T cells

Fc fusion infrequent dosing

ImmTAAI Mechanism

- ✓ Suppresses activation only when ImmTAAI is tethered to target tissue
- ✓ Reduces T cell activation
- ✓ Non-competitive with natural PDL1
- ✓ Promotes T cell suppression
- ✓ Does not interfere with Treg
- ✓ Suppresses NK activation
- ✓ Potential for non-HLA restricted

IMC-S118AI (PPI x PD1) for type 1 diabetes (T1D)

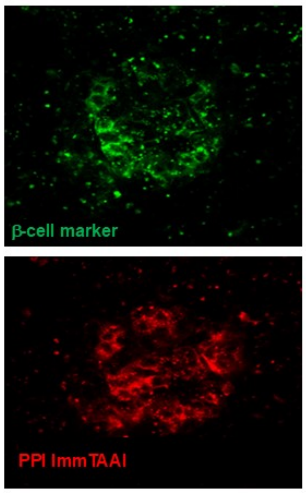
Pancreas-tethered ImmTAAI (HLA-A02) protects against killing by autoreactive T cells

~50K

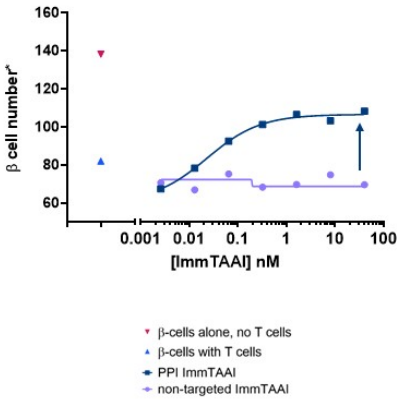
HLA-A02+
Newly diagnosed T1D patients/yr (US + EU5)*

→ **Expected to submit CTN for Phase 1 trial by end of 2025**

→ **ImmTAAI binds specifically to pre-pro-insulin (PPI) peptide on pancreatic β-cells**

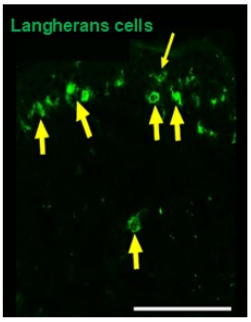


→ **ImmTAAI protects β-cells from killing by autoreactive T cells**



* Estimated annual incidence of HLA-A02 positive newly diagnosed type 1 diabetes in US + EU5. (~50% of T1D patients)

CD1a (hallmark of Langerhans cells) is an HLA-like protein with key role in allergic inflammation[1-4]



Skin biopsy

Langerhans cells (LC)

→ Antigen presenting cell in **skin and mucosa**

→ **Monitor local environment** and **triggers inflammation**

→ **LC present lipid and peptide antigens to T cells**

Presentation	Antigens	Polymorphism in humans
CD1a	Lipids	Non-polymorphic (universal)
HLA class I/II	Peptides	Polymorphic (non-universal)

→ **CD1a and LC role** in **atopic dermatitis** and potentially other immune pathologies such as **psoriasis and allergic asthma**

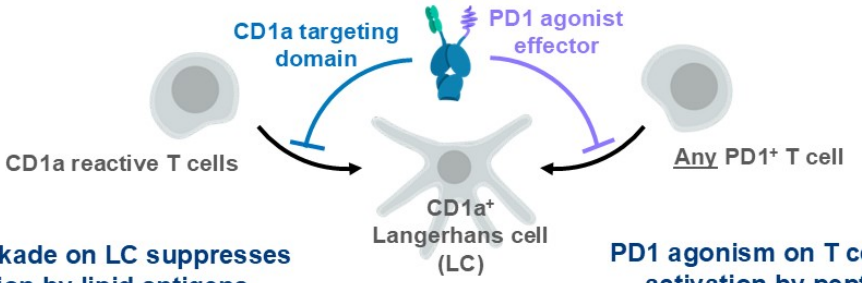
→ **Past** approach attempted to **block only CD1a** presenting lipid antigens from activating T cells

→ However, **better approach** would be to **prevent both lipid AND peptide** antigens on LC from activating T cells

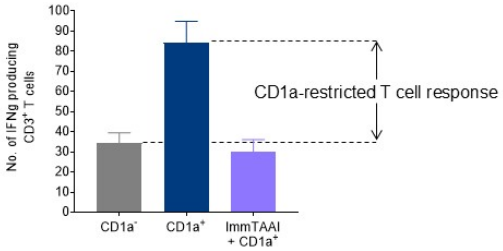
[1] Igyarto B *et al.* Immunity 2011. [2] Kim J *et al.* Nat Immunol. 2016. [3] Pan Y *et al.* JEADV 2024. [4] Hardman C.S. *et al.* Nat. Comm 2022

IMC-U120AI – Universal (non-HLA restricted) candidate for dermatology

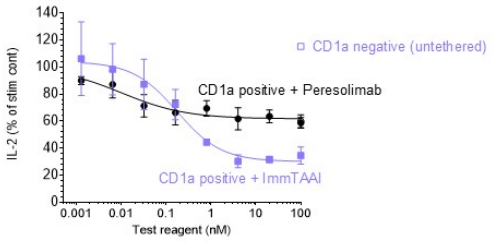
CD1a-tethered PD1 agonist ImmTAAI therapy with dual mechanism of action



CD1a blockade on LC suppresses activation by lipid antigens



PD1 agonism on T cells suppresses activation by peptide antigens



CD1a mediates the presentation of lipid antigens to T cells while HLA mediates the presentation of peptide antigens to T cells.


Leading TCR pipeline
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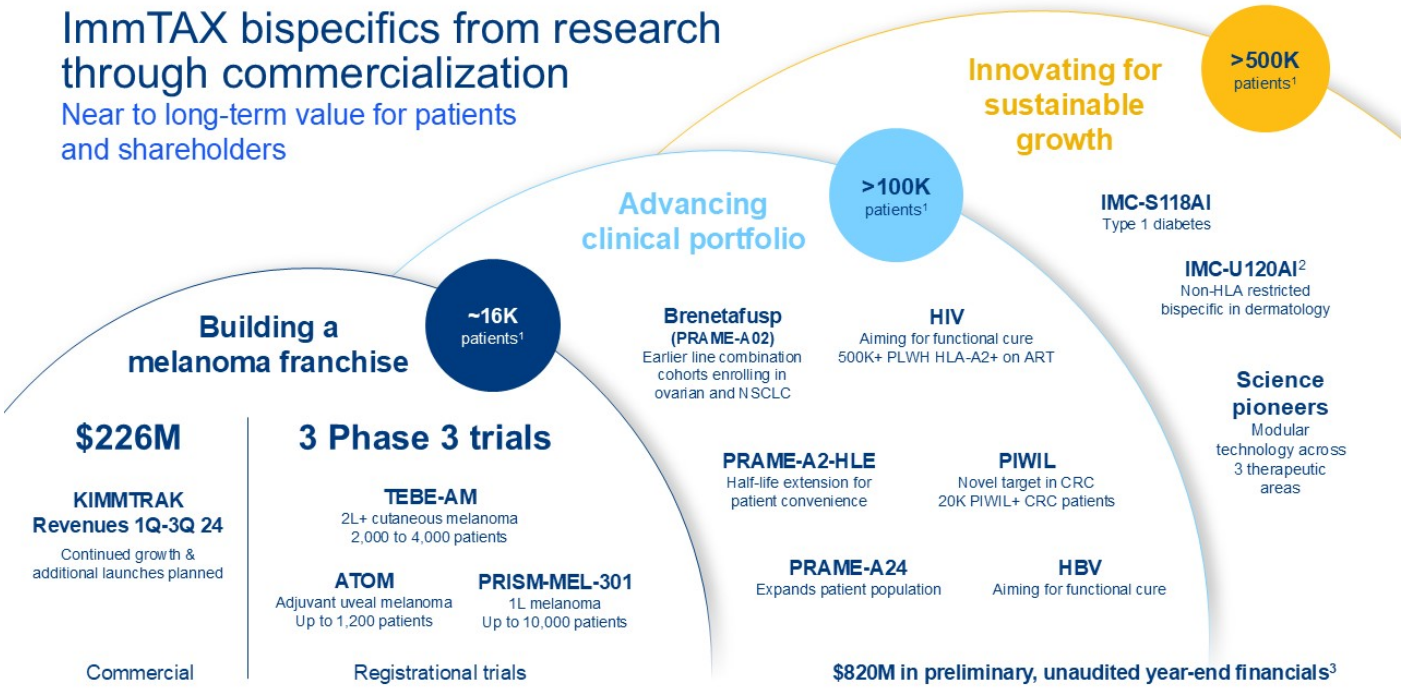
ImmTAX bispecifics from research through commercialization

Near to long-term value for patients and shareholders



[1] Estimated future number of HLA-A*02:01 positive patients per year in the US and Europe. [2] IMC-U120AI is non-HLA restricted, other addressable patient populations based on HLA-A02. [3] Year-end cash position is preliminary, has not been audited and is subject to change pending completion of the Company's audited financial statements for the year ended December 31, 2024.

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Thank you

Leading bispecific TCR pipeline

[1] Platinum refractory or resistant serous ovarian carcinoma. [2] NSCLC = Non-small cell lung cancer [3] Program is wholly owned, development costs being provided by the Bill & Melinda Gates Foundation (BMGF). Immunocore retains all development and commercialization rights in the developed world. [4] Program is not HLA restricted (i.e. universal for all populations). [5] Submission

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