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LAG-3 IMMUNOTHERAPY

Unlocking the power of the immune system to fight cancer and autoimmune disease

Forward-Looking Statements

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Immutep Highlights

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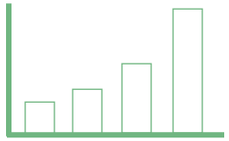
Leader in LAG-3 immunotherapy

LAG-3 pure play with four clinical-stage assets and one preclinical program designed to fight cancer & autoimmune diseases.

First-in-class lead candidate

Eftilagimod alfa (efti) is a unique immune system activator that has shown strong efficacy with a favourable safety profile in multiple cancer indications.



Multiple catalysts ahead; Phase III in 1L NSCLC

Phase III program with MSD in first line non-small cell lung cancer (1L NSCLC) with efti & KEYTRUDA, the top selling drug globally. Later-stage clinical programs in additional large markets* with data readouts in 2024 and beyond.

Validation through partnerships

Multiple partnerships and collaborations with large pharma and institutions.

Global presence; strong IP and balance sheet

Global presence and strong IP across LAG-3 portfolio. Well-funded with cash, cash equivalent, & term deposit of ~$182 million (US$ ~119 million)# providing runway to end of CY2026.

*Global market est. for NSCLC, HNSCC, and MBC are $24BB (current), $3.5BB (by 2025) and $12.7BB (by 2024), respectively, based on intelligence data from GlobalData and Nature Reviews Drug Discovery 22, 264-265 (23 Jan 2023). # As at 30 June 2024

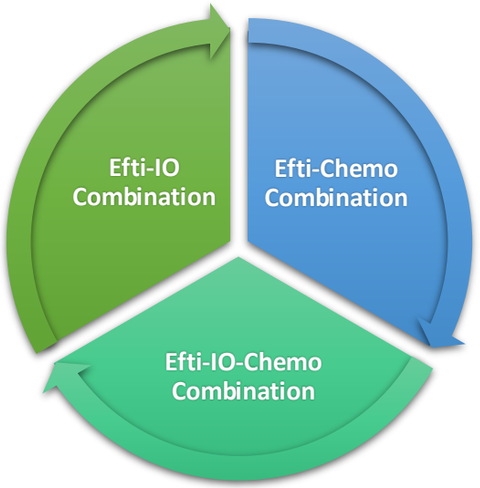
Company Overview

Pure-play LAG-3 company with deep pipeline in oncology & autoimmune diseases:

- **Multiple LAG-3 Programs** – Four clinical-stage assets and one preclinical program
- **Upcoming Milestones** – Multiple data updates from clinical programs

Lead candidate Efti addressing therapeutic gaps across the solid tumor treatment landscape:

- **First-in-class MOA** – As unique MHC Class II agonist, efti activates innate and adaptive anti-tumor immunity
- **Activity across PD-L1 spectrum** – Activity in hot/tepid/cold tumors addressing high unmet needs
- **Consistent Outcomes** – Improved survival across multiple indications with mature data
- **Favourable Safety** – Well-tolerated profile with standard-of-care IO and/or chemotherapy
- **Manufacturing** – Achieved 2000L commercial scale production; authorization for clinical trial use granted in Sept ‘23



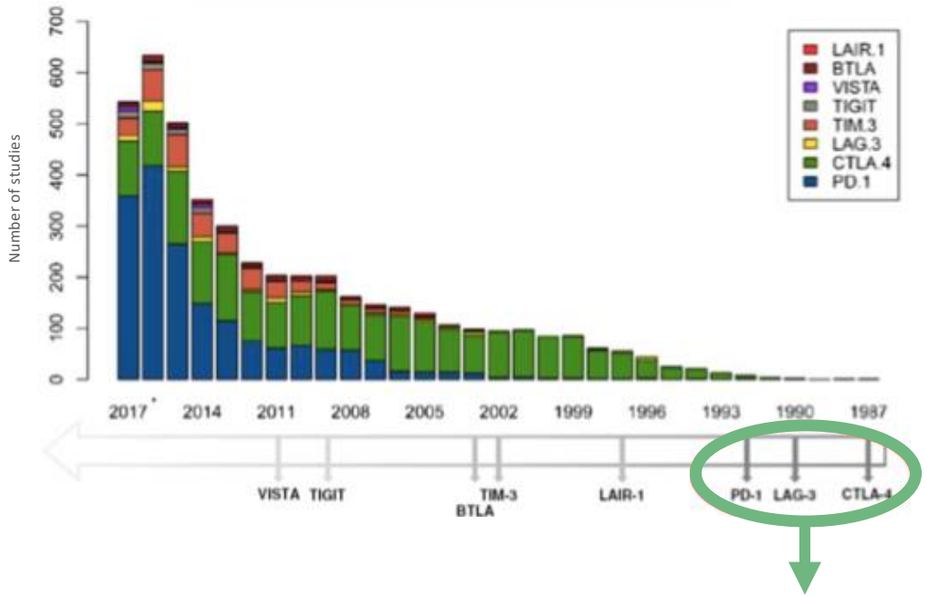
Strong IP/Balance Sheet:

- **Intellectual Property** – Comprehensive IP portfolio; innovative biologics also potentially entitled to test data exclusivity (e.g., up to 12 years in US)
- **Well-Financed** – Cash, cash equivalent and term deposit position totalling ~A$181.8 million (~US$118.7 million)[1] providing runway to end of 2026

1. As at 30 June 2024

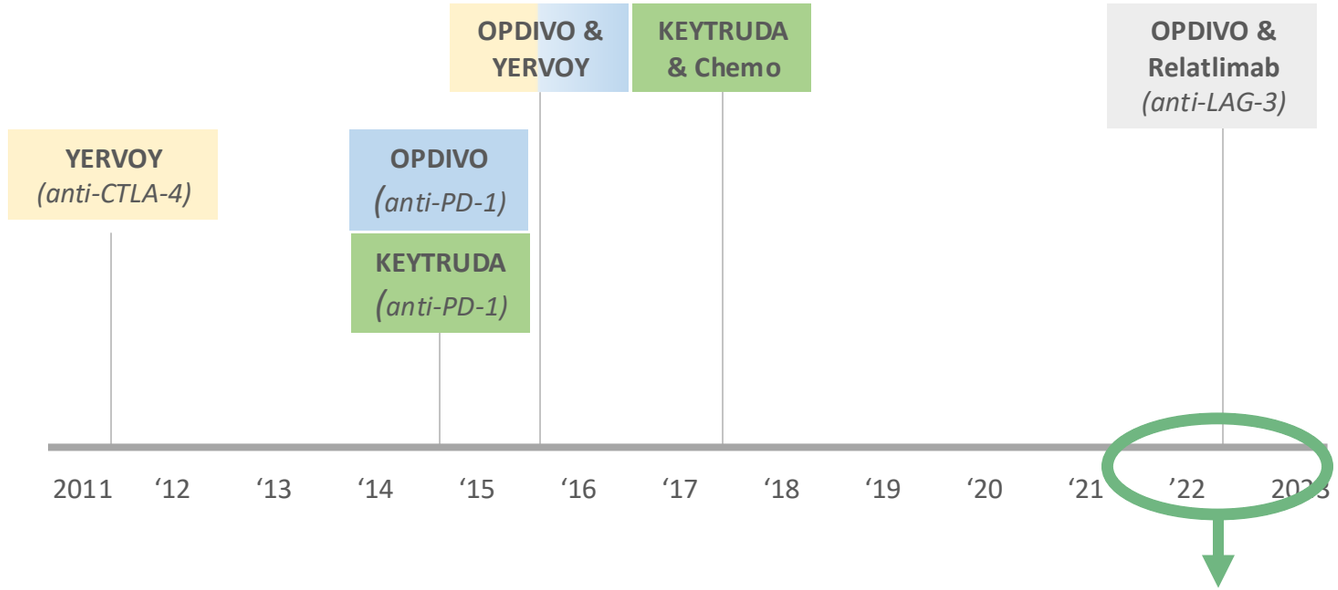
LAG-3 Newest Entrant to Immuno-Oncology (IO) Landscape

Immune Checkpoint Discovery and Clinical Studies*



LAG-3 discovered in 1990 by Immutep's Chief Scientific Officer, Dr. Frédéric Triebel

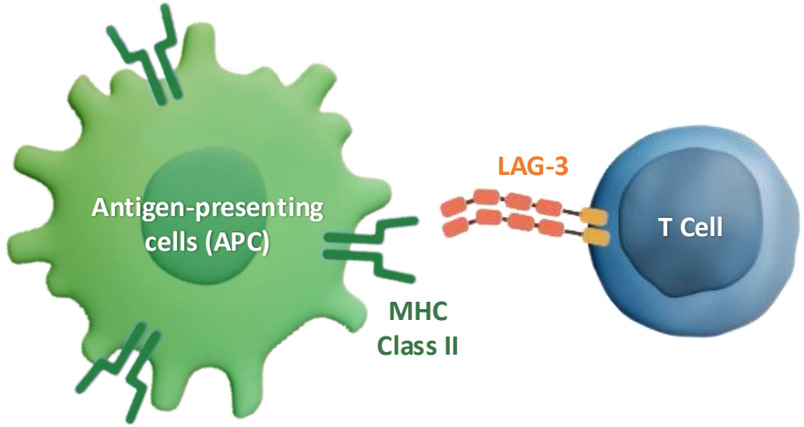
Regulatory Approval Timeline of Immuno-Oncology (IO) Therapies**



The immune system's ability to fight cancer has led to regulatory approval of IO therapies targeting the immune checkpoints **CTLA-4**, **PD-1**, and most recently **LAG-3**

*Checkpoint Inhibitors: Applications for Autoimmunity, Springer, September 2017 Current Allergy and Asthma Reports 17(10) DOI10.1007/s11882-017-0740-z. ** YERVOY (ipilimumab), OPDIVO (nivolumab), KEYTRUDA (pembrolizumab), OPDUALAG (nivolumab + relatlimab)

Pioneering LAG-3 Immunotherapy Portfolio



Immutep has designed multiple first-in-class therapeutics targeting either **MHC Class II molecules** on antigen-presenting cells (APC) or **LAG-3** on T-cells to fight cancer & autoimmune disease

Targeting MHC Class II on APCs#

Efti
Soluble LAG-3 fusion protein

Oncology
Immune Stimulation

Targeting LAG-3 on T cells

LAG525*
Blocking LAG-3 antibody

Anti-LAG-3 small molecule

Oncology
Immune Stimulation

IMP731*
Depleting LAG-3 antibody

IMP761
Agonist LAG-3 antibody

Autoimmune Disease
Immune Suppression

MHC Class II = Major Histocompatibility Complex Class II. * LAG525 (leramilimab) is out-licensed to Novartis. The clinical-stage asset GSK'781 (IMP731) is being transitioned back to Immutep as the licensing agreement has been terminated with an effective date of 30 May 2024.

Deep LAG-3 Pipeline in Oncology & Autoimmune Diseases

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	Program	Indication	Preclinical	Phase I	Phase II	Late Stage#	Collaborations	Commercial Rights
ONCOLOGY	**Eftilagimod Alfa** Soluble LAG-3 Protein & MHC Class II agonist	1L Non-Small Cell Lung Cancer (NSCLC)	TACTI-004 | Efti + Pembrolizumab + Chemo [a]				MERCK	immutep Global Rights ex-China
		1L Head & Neck Squamous Cell Carcinoma (HNSCC)	TACTI-003 | Efti + Pembrolizumab [a]				MERCK	
		1L NSCLC, 2L HNSCC, PD-X Refractory 2L NSCLC	TACTI-002 | Efti + Pembrolizumab [a]				MERCK	
		1L Non-Squamous NSCLC	INSIGHT-003 | Efti + Pembrolizumab + Chemo [§]				IKF	
		Urothelial Cancer	INSIGHT-005 | Efti + Avelumab [§, b]				Merck KGaA Darmstadt, Germany, IKF	
		Soft Tissue Sarcoma	EFTISARC-NEO | Efti + Pembro + Radiotherapy [§]				Narodowy Instytut Onkologii	
		HR+/HER2- Metastatic Breast Cancer & TNBC	AIPAC-003 | Efti + Paclitaxel					
		Metastatic Breast Cancer & Solid Tumors	Efti + Paclitaxel and Efti + Pembrolizumab [##]				EOC	EOC Efti China Rights
	Anti-LAG-3 Small Molecule	Undisclosed					CARDIFF UNIVERSITY	immutep Global Rights
	LAG525 Anti-LAG-3 Antibody	Solid Tumors & Blood Cancer					NOVARTIS	NOVARTIS Global Rights
		Triple Negative Breast Cancer						
		Melanoma						
		Solid Tumors						
		Triple Negative Breast Cancer						
AUTOIMMUNE DISEASE	**IMP731*** Depleting LAG-3 Antibody	Ulcerative Colitis						immutep Global Rights
		Psoriasis						
		Healthy Subjects						
	IMP761** Agonist LAG-3 Antibody	Undisclosed						

Information current as of August 2024. For EOC's China rights, Immutep may receive undisclosed milestones plus royalties; LAG525 (ieramilimab)- ClinicalTrials.gov (for Novartis' global rights, Immutep may receive milestones plus royalties); Immutep has no control over the trials. § Investigator Initiated Trials controlled by lead investigator & therefore Immutep has no control over these clinical trials. [a] In combination with KEYTRUDA®. [b] In combination with BAVENCIO®. # Late stage refers to active Phase IIb clinical trials or more clinically advanced clinical trials. ## Conducted by EOC in China. * IMP731 - The clinical-stage asset GSK'781 is being transitioned back to Immutep as the licensing agreement has been terminated with an effective date of 30 May 2024. ** IMP761 – Phase I study to launch mid-CY2024.

Efti

A proprietary soluble LAG-3 protein and
first-in-class MHC Class II agonist

Efti: A Soluble LAG-3 ‘Key’ to Stimulate Immune System via MHC II

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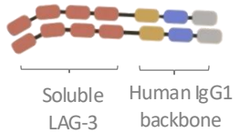
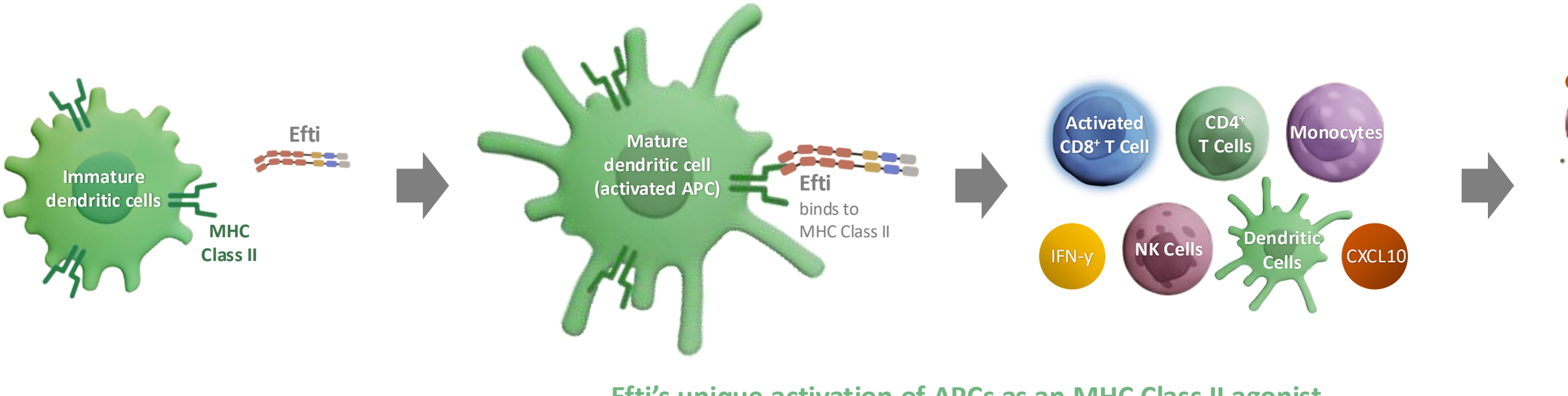
Eftilagimod alfa (efti)

A first-in-class soluble LAG-3 fusion protein with high affinity for a subset of MHC Class II molecules on antigen-presenting cells (APCs)





Efti’s unique activation of APCs as an MHC Class II agonist drives a broad, sustained adaptive/innate immune response to fight cancer*

* In clinical trials, including monotherapy and in combination with anti-PD-(L)1 therapies and with chemotherapy, efti has led to significant and sustained increases in anti-tumor cells and chemokines / cytokines including those listed in the graphic.
MHC Class II = Major Histocompatibility Complex Class II. APC = Antigen-Presenting Cell.

Systemic Immune Effect Leading to Positive Clinical Outcomes

Encouraging data from efti in combination with IO, chemotherapy, radiotherapy across multiple indications

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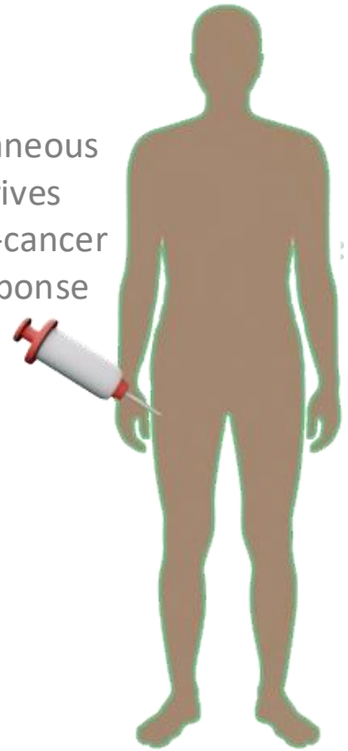
Efti's subcutaneous delivery drives systemic anti-cancer immune response



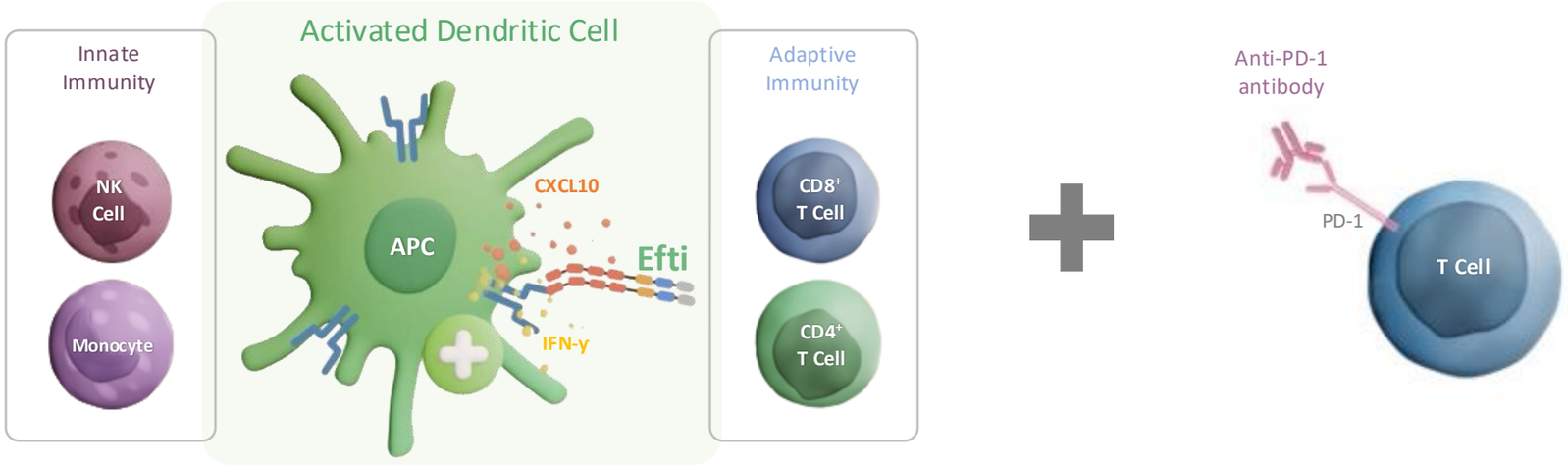
- **Non-Small Cell Lung Cancer**
- **Head & Neck Squamous Cell Carcinoma**
- **Melanoma**
- **Advanced Solid Tumors** (e.g., gastric, cervical)
- **Breast Cancer**
- **Soft Tissue Sarcoma** (first trial in neoadjuvant setting)

Efti + Anti-PD-1 Therapy | Efti + Anti-PD-L1 Therapy | Efti + Chemotherapy | Efti + Anti-PD-1 + Radiotherapy

* Based upon clinical data from TACTI-002, INSIGHT-004, TACTI-mel and AIPAC trials and historical results from pembrolizumab trials as well as paclitaxel chemotherapy in metastatic breast cancer. # In second line HNSCC

Differentiated Approach in Oncology

Efti has complementary action with immune checkpoint inhibitors (ICIs) like anti-PD-(L)1 therapy



Efti's unique activation of antigen-presenting cells (e.g. dendritic cells, monocytes) engages the adaptive and innate immune system, which complements anti-PD-(L)1 therapy to fight cancer

- Efficacy across "hot", "tepid", "cold" tumours in patients with high, low, and negative PD-L1 expression
- Additionally, efti in combination with anti-PD-(L)1 has a favourable safety profile

Substantial Commercial Opportunity in Combination with ICIs

Encouraging Clinical Data from Efti in Combination with Anti-PD-(L)1 Therapy including KEYTRUDA® & BAVENCIO®

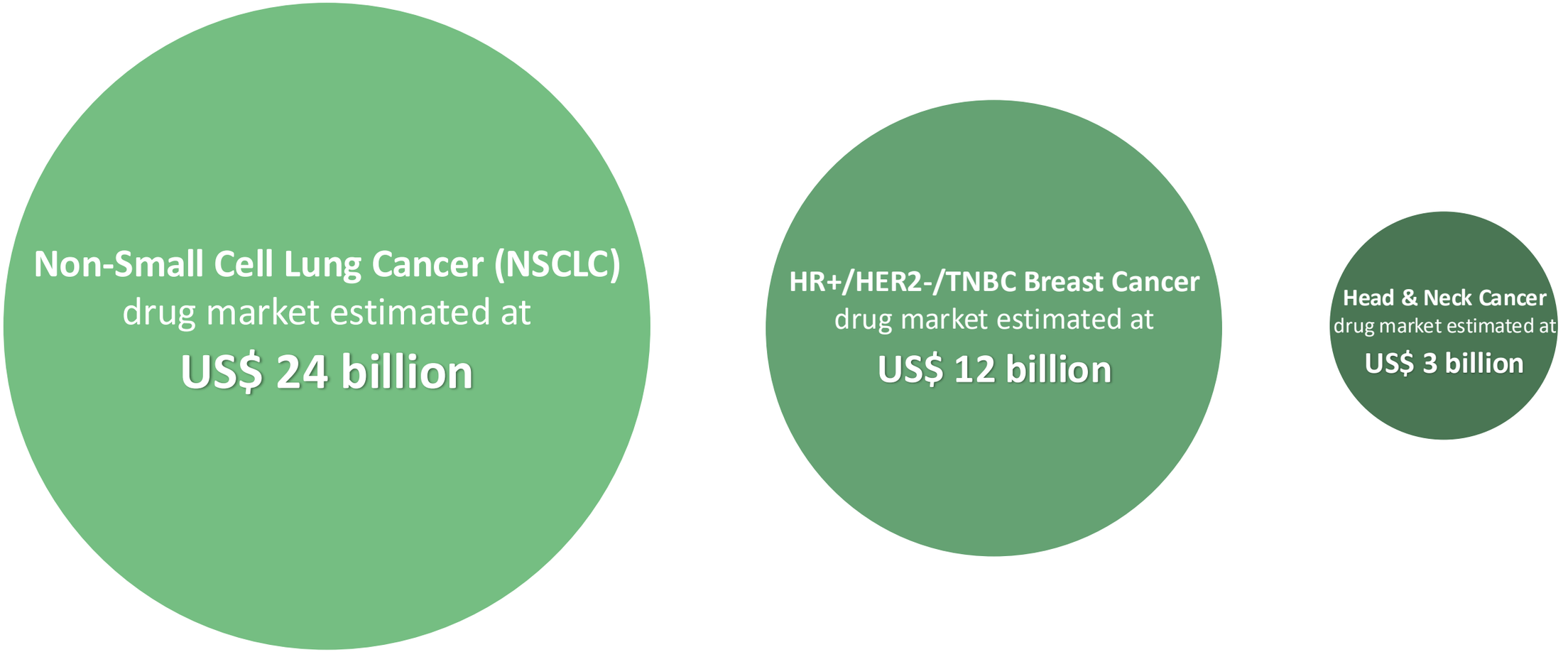
- **More than double Overall Survival** of KEYTRUDA® (anti-PD-1) monotherapy and well above other standard-of-care IO-IO and/or IO-chemotherapy combinations in first line non-small cell lung cancer (1L NSCLC) with any PD-L1 expression
- **More than double Progression Free Survival** of KEYTRUDA® monotherapy in 1L NSCLC patients across varying levels of PD-L1 expression
- **Double the Overall Response Rate** of KEYTRUDA® monotherapy in 1L NSCLC and higher response rates in 1L & 2L head & neck cancer (HNSCC)
- **Deep, durable responses in negative & low PD-L1 expressing patients** with both KEYTRUDA® and with BAVENCIO® (anti-PD-L1) across multiple indications

KEYTRUDA® became the world's top selling drug in 2023 with sales exceeding $25 billion

Anti-PD-1**	Anti-PD-L1**
KEYTRUDA® (pembrolizumab) Injection 100 mg OPDIVO® (nivolumab) LIBTAYO® (cemiplimab-rwlc) Injection 350 mg Jemperli® (dostarlimab-gxly) Injection 500 mg	TECENTRIQ® atezolizumab IMFINZI® durvalumab BAVENCIO® avelumab Injection 20 mg/mL
$35+ Billion in 2023 sales	**$9+ Billion** in 2023 sales

* Based upon clinical data from TACTI-002, INSIGHT-004, and TACTI-mel trials. Source of sales figures: 1. Bloomberg and company reports; Currency: USD. 2023 sales of approved anti-PD-1 therapies include pembrolizumab (KEYTRUDA®) ~$25 b, nivolumab (OPDIVO®) ~$9 b, cemiplimab (LIBTAYO®) ~$918 m, dostarlimab (JEMPERLI®) ~$175 m. Sales of approved anti-PD-L1 therapies include atezolizumab (TECENTRIQ®) ~$4.2 b, avelumab (BAVENCIO®) ~$961 m, durvalumab (IMFINZI®). ~$4.2 b

Clinical Trials Target Large Addressable Markets



*Efti has FDA Fast Track designation in 1L NSCLC and 1L HNSCC

Market size estimates are based on intelligence data extracted from GlobalData in June 2024 (estimations 2024 for 8MM: FR, DE, IT, JP, ES, UK, US, China), and Nature Reviews Drug Discovery 22, 264-265 (23 Jan 2023) doi: https://doi.org/10.1038/d41573-023-00017-9

Lead Indication

First Line Non-Small Cell Lung Cancer (NSCLC)

ASCO 2022 - Dr. Enriqueta Felip presenting 1L NSCLC data from TACTI-002/KN-798 in Oral Presentation

SITC 2022 - Dr. Wade Iams presenting 1L NSCLC data from TACTI-002/KN-798 in Late Breaking Abstract Oral Presentation

ESMO 2023 - Dr. Enric Carcereny presenting Overall Survival data in 1L NSCLC from TACTI-002/KN-798

NSCLC Overview

- Lung cancer is a leading cause of cancer death[1,2]
- 80 - 85% of lung cancers are non-small cell lung cancer (NSCLC)
- There are ~2.0 million NSCLC diagnoses worldwide annually
- Only ~20% of patients respond to immune checkpoint inhibitor (ICI) monotherapy
- Despite treatment advances, Overall Survival is still under 2 years for most NSCLC patients

Total addressable NSCLC drug market expected to nearly double to US$48 billion in 2031 and ICIs (including anti-PD-1 therapy) are expected to generate $26 billion in sales[3]

1. Calculated from Global Cancer Observatory (WHO), 2022 data & American Cancer Society, About Lung Cancer; 2.Tang S et al. Immune Checkpoint Inhibitors in Non-Small Cell Lung Cancer: Progress, Challenges, and Prospects. Cells. 2022 Jan 19;11(3):320. doi: 10.3390/cells11030320; 3. Nature Reviews Drug Discovery 22, 264-265 (23 Jan 2023) doi: https://doi.org/10.1038/d41573-023-00017-9.

PD-L1 Expression Levels and Why They Matter in 1L NSCLC

- PD-L1 expression as measured by Tumor Proportion Score (TPS) is an FDA approved predictive biomarker in 1L NSCLC for ICIs including anti-PD-(L)1 therapy
- Patients are grouped by high (TPS ≥50%), low (TPS 1-49%), and negative (TPS <1%) PD-L1 expression
- Generally, high expressors (who have a strong preexisting local anti-tumor T cell response) respond best, low expressors respond sub-optimally, and negative expressors have negligible responses to ICI therapies
- Mixed clinical responses to anti-PD-(L)1 therapy across these three PD-L1 levels are reflected in the regulatory landscape of approved chemo-free ICI therapies (as shown in the graphic to the right)

Approvals of Chemotherapy-free ICI Therapies in 1L NSCLC by PD-L1 Levels

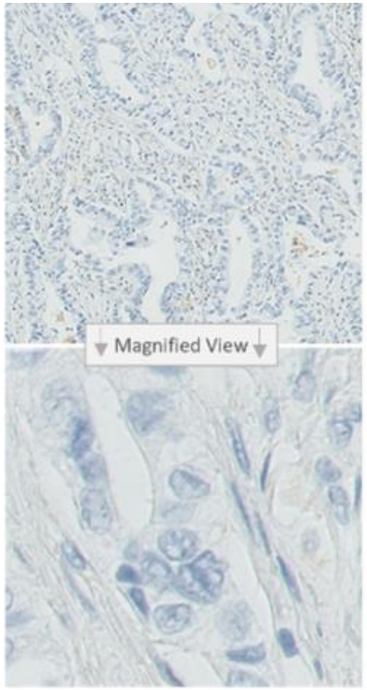
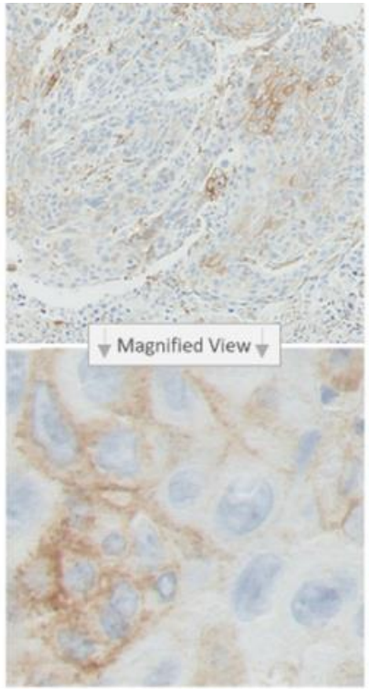
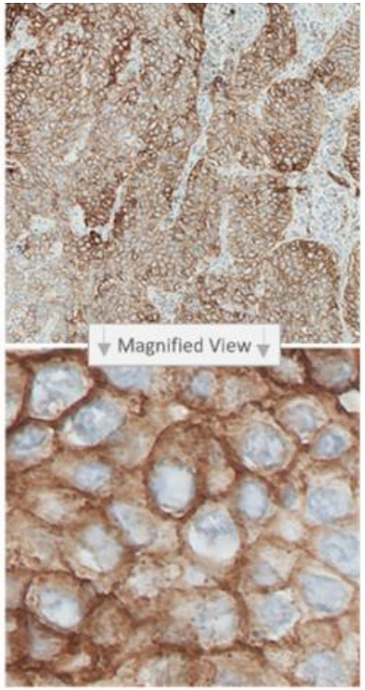
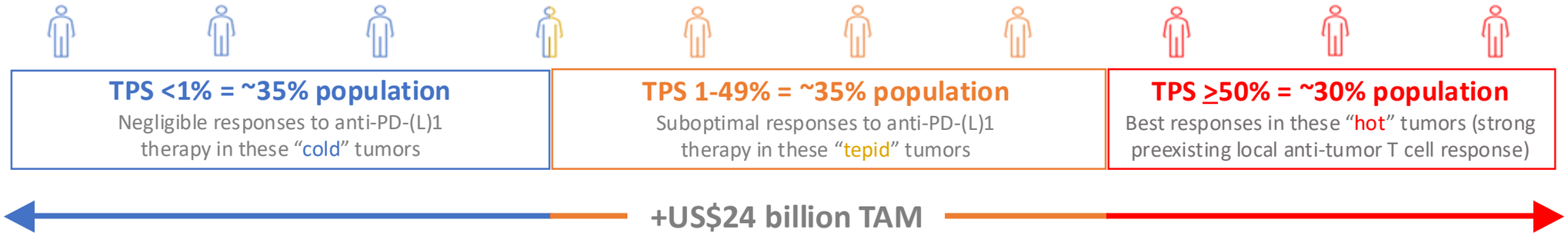
Negative PD-L1 (TPS <1%)	**Low PD-L1** (TPS 1-49%)	**High PD-L1** (TPS ≥50%)
		
None approved in Europe or the US for patients with negative PD-L1 expression	**None approved** in Europe and **two approved** in US for patients with low PD-L1 expression*	**Three approved** in both Europe and US for patients with high PD-L1 expression**

Image from Garon et al. Pembrolizumab for the treatment of non-small-cell lung cancer. N Engl J Med. 2015;372:2018–28. PD-L1 staining is shown by the presence of the brown chromogen. Expression of PD-L1 by tumor cells at baseline is known to be correlated with the level of IFN-gamma producing activated T cells at the tumor site and is reflective of a strong pre-existing tumor-specific T cell response. *For patients with low PD-L1 expression, KEYTRUDA monotherapy & OPDIVO combined with YERVOY are approved in the US. Of the two only OPDIVO/YERVOY is a NCCN Category 1 treatment option. **For patients with high PD-L1 expression, KEYTRUDA (anti-PD-1), TECENTRIQ (anti-PD-L1), and OPDIVO combined with YERVOY (anti-PD-1 + anti-CTLA4) are approved in US and Europe.

Targeting Entire 1L NSCLC Population Regardless of PD-L1 Status

Strength of clinical data from ***Efti in combination with KEYTRUDA*** in high, and particularly negative & low PD-L1 expressing patients, positions this novel combination to potentially establish a new standard of care in 1L NSCLC, one of the largest indications in oncology and the main revenue driver for KEYTRUDA today

1L NSCLC Patient Population by PD-L1 Tumor Proportion Score (TPS)[1]



(1) Patient population estimates by PD-L1 expression: based on publications of registrational trials KN-001, KN-189, KN-407, EMPOWER-Lung 3 and TACTI-002 all comer Phase II trial. (2) Aguilar et al. Ann. Onc. 2019, 1;30(10):1653-1659. DOI: 10.1093/annonc/mdz288. (3) Market size estimates are based on intelligence data from GlobalData and Nature Reviews Drug Discovery 22, 264-265 (23 Jan 2023) doi: https://doi.org/10.1038/d41573-023-00017-9. Note Efti + pembrolizumab has Fast Track Designation in ≥1% TPS in 1L NSCLC.

TACTI-002 / KN-798 Trial Overview and Baseline Characteristics

Part A: Large Phase II trial (N=114) in metastatic 1st Line non-small cell lung cancer (1L NSCLC)

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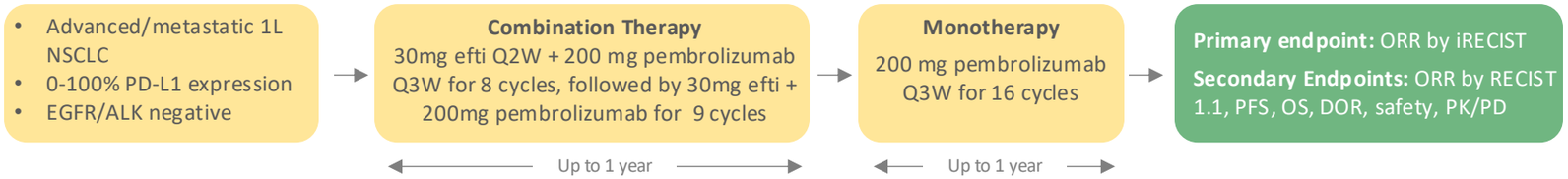
TACTI-002 (Part A) in 1L NSCLC

- Phase II, open label, Simon's two stage design
- Six countries (US, UK, ES, PL, UA, AU)
- 114 patients enrolled across 18 sites

PD-L1 Expression in TACTI-002

- TACTI-002 enrolled 1L NSCLC patients regardless of PD-L1 expression
- ~75% patients have PD-L1 TPS <50%, with ~35% having negative expression (TPS <1%)
- ~25% patients have high PD-L1 (TPS ≥50%); this is lower proportion than would typically be expected

TACTI-002 (Part A) Trial Design



Baseline characteristics for TACTI-002 Part A		N=114	
Age, median (range), years		67 (44-85)	
Sex, n (%)	Female / Male	30 (26.3) / 84 (73.7)	
ECOG PS score, n (%)	0 / 1	43 (37.7) / 71 (62.3)	
Smoking status, n (%)	Current or Ex-smoker / Non-smoker	108 (94.7) / 6 (5.3)	
Histology, n (%)	Squamous / Non-squamous / Unknown	40 (35.1) / 72 (63.2) / 2 (1.8)	
Metastatic disease, n (%)	Yes / No	113 (99.1) / 1 (0.9)	
PD-L1 expression TPS, n (%)		*Central only* [1]	*Central + local* [2]
	< 1%	32 (35.6)	37 (34.3)
	1-49%	38 (42.2)	42 (38.9)
	≥ 50%	20 (22.2)	29 (26.9)
Previous therapy, n (%)	Radiotherapy	38 (33.3)	
	Surgery	23 (20.2)	
	Systemic therapy for non-metastatic disease	26 (22.8)	

In collaboration with

MERCK

Patients were recruited according to Simon's optimal two-stage design: during the first stage, 17 pts were recruited; second stage recruitment (n=19) was opened only after the number of responses was above 4. An extension stage (n=78) could be added if there were above 12 responses. In total, 114 pts were enrolled.

[1] N=90; Central assessment of PD-L1 TPS using Dako IHC 22C3 pharmDx. [2] N=108; Central + local assessment. For 18 patients, local assessment used predominantly Dako IHC 22C3 pharmDx due to non-evaluable central assessment results.

Strong Efficacy Data across All PD-L1 Expression Levels in 1L NSCLC

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Tumor Response by PD-L1 Expression Level[1]

	All-Comer	Negative PD-L1	Low PD-L1	High PD-L1	Any PD-L1
	TPS 0-100% N=114	TPS <1% N=32	TPS 1-49% N=38	TPS ≥50% N=20	TPS ≥1% N=58
ORR[2,3,4]	40.4%	31.3%	44.7%	55.0%	48.3%
mPFS[2], months	6.6	4.2	9.3	16.5	11.2
mDoR[2], months	21.6	20.7	NR	18.7	24.2
mOS, months	**20.2**	**15.5**	**23.4**	**Not Reached**	**35.5**

ORR – Overall Response Rate
mPFS – median Progression Free Survival
mDOR – median Duration of Response
mOS – median Overall Survival

- Strong efficacy across all patients, including negative & low expressors (~75% of patients in TACTI-002), differentiates efti with anti-PD-1 from other chemotherapy-free IO combinations in 1L NSCLC
- Excellent Overall Survival, the gold standard benchmark in oncology
- Exceptional durability and quality of responses with favorable safety profile
- Results offer compelling evidence of efti's unique stimulation of patients' immune systems and the positive impact that has in fighting cancer

Data cut-off date: August 15, 2023. Median follow-up 25.1 months. [1] N=90; Central assessment of PD-L1 TPS using Dako IHC 22C3 pharmDx; [2] iRECIST; [3] unconfirmed; [4] calculated using Clopper Pearson method; NR: not reached. Results for PD-L1 central + local (N=108) were as follows (<1% / 1-49% / ≥50% / ≥1%): mOS, mo: 14.4 / 23.4 / 38.8 / 35.5; mPFS[2]: 4.2 / 8.3 / 16.3 / 9.8; mDoR[2]: 20.7 / 21.6 / 18.7 / 21.6.

Benchmarking to Pembrolizumab (KEYTRUDA®) Monotherapy

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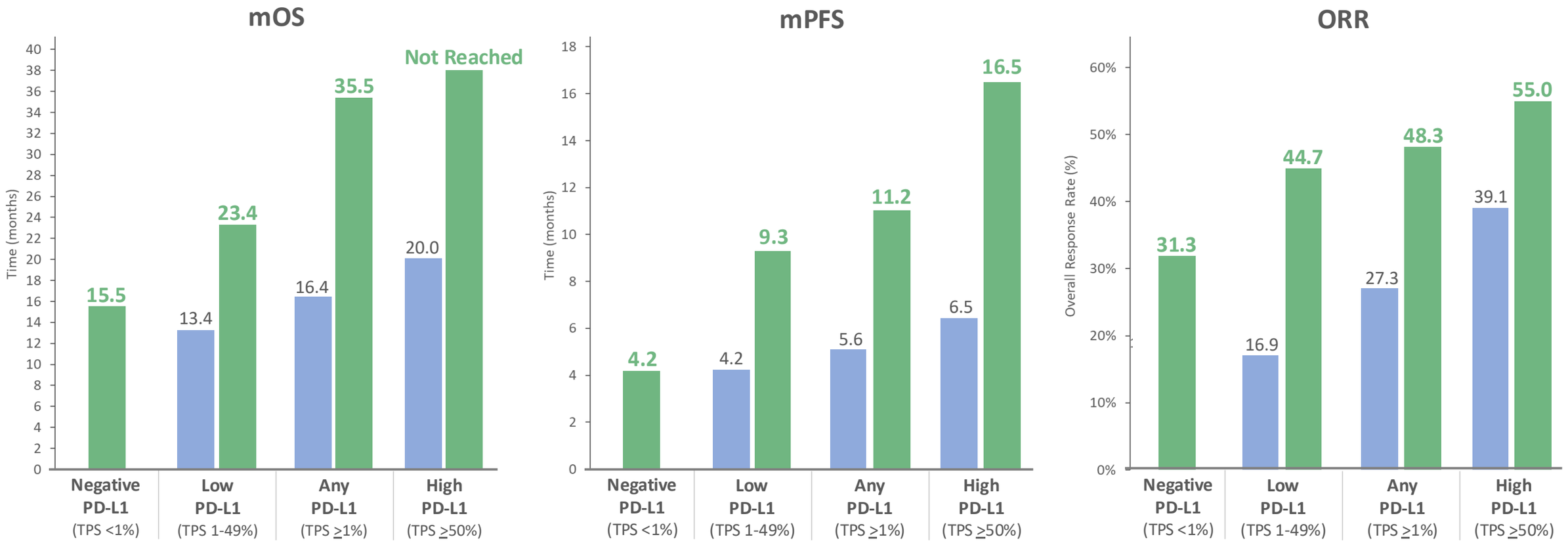
LAG-3 IMMUNOTHERAPY



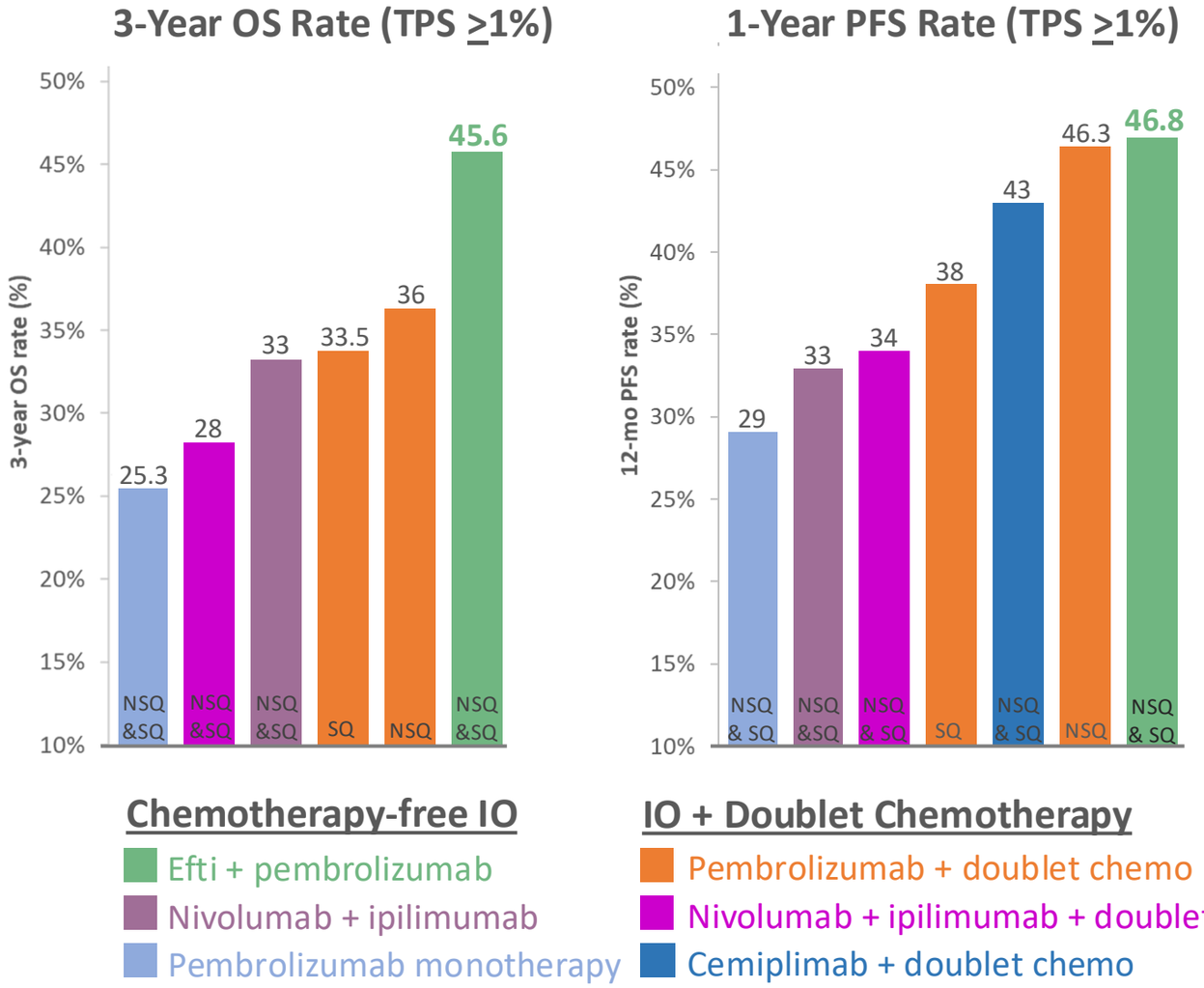
Robust median overall survival (mOS), median progression free survival (mPFS), and response rates (ORR) from efti plus pembrolizumab

Strength of efti plus pembrolizumab in TPS 1-49% contributes significantly to TPS ≥1% results, unlike other IO + anti-PD-1 combinations

OS/PFS/ORR in negative PD-L1 (TPS <1%) patients compares well to pembrolizumab monotherapy in low PD-L1 (TPS 1-49%) patients

Comparison of data is from different clinical trials. Pembrolizumab monotherapy data from publications/EPAR asessment report of KN-042 registrational trial. Given the lack of historical results in negative PD-L1 expressing 1L NSCLC patients who received pembrolizumab monotherapy in KN-042 and other trials, the chart only has data from patients in TACTI-002 with negative PD-L1 expression (TPS <1%). In 1L NSCLC patients with TPS ≥1%, TACTI-002 has 66% patients with TPS 1-49% and 34% with TPS ≥50%, which compares to KN-042 with ~53% patients with PD-L1 and ~47% patients with PD-L1 TPS ≥50%.

Exceptional Durability and Quality of Responses

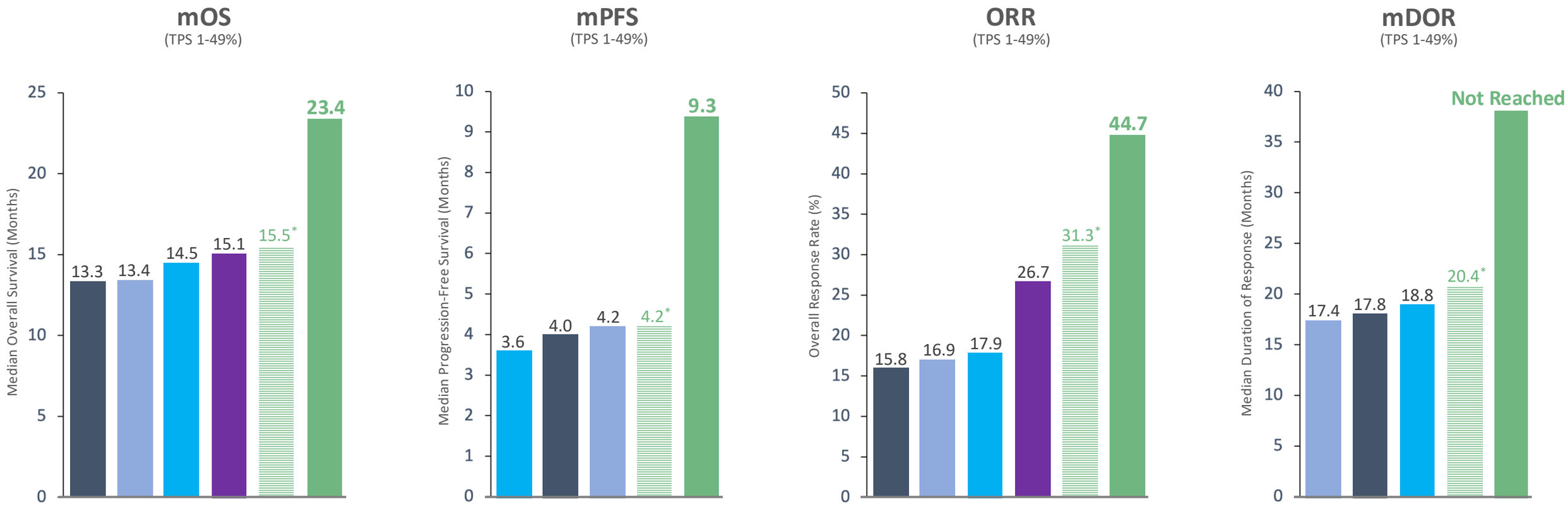


- Exceptional 3-year Overall Survival rate of 45.6% in 1L NSCLC, superior to pembrolizumab monotherapy and standard-of-care chemo-free & chemo-containing regimens
- Positive 12-month PFS rate of 46.8%, superior to pembro monotherapy and inline/above chemo-containing regimens
- Efti + pembro may be in a unique position to lift the tail of the survival curve in patients that express PD-L1

NSQ = Non-squamous NSCLC and SQ = Squamous NSCLC. Comparison of data is from different clinical trials. Data for standard-of-care therapies taken from publications of respective registrational trials (e.g., KN-042, KN-189, KN-407, CM-9LA, EMPOWER-Lung 3).

Differentiated Efficacy in Low & Negative PD-L1 Patients

Efti + pembro results in low & negative PD-L1 patients compare favorably to other therapies in low PD-L1



Chemotherapy-Free IO Therapies

- Pembrolizumab monotherapy
- Atezolizumab monotherapy
- Atezolizumab + Tiragolumab (anti-PD-L1) (anti-TIGIT)

- **Efti + Pembrolizumab**
- Efti + Pembrolizumab in negative PD-L1 (TPS <1%)*
- Nivolumab + Ipilimumab (anti-PD-1) (anti-CTLA-4)

Note: patients with negative PD-L1 (TPS <1%) typically have negligible responses to ICI therapies and are not expected to perform as well as patients with low PD- L1 (TPS 1-49%)

Comparison of data is from different clinical trials. Pembrolizumab monotherapy data from publications/EPAR asessment report of KN-042 registrational trial, Atezolizumab and Tiragolumab + Atezolizumab data from CITYSCAPE Phase II trial. Ipilimumab + Nivolumab from CM-227 registrational trial (did not include mPFS or mDOR data).

Th1 Biomarker Data Linked to Improved Clinical Outcomes

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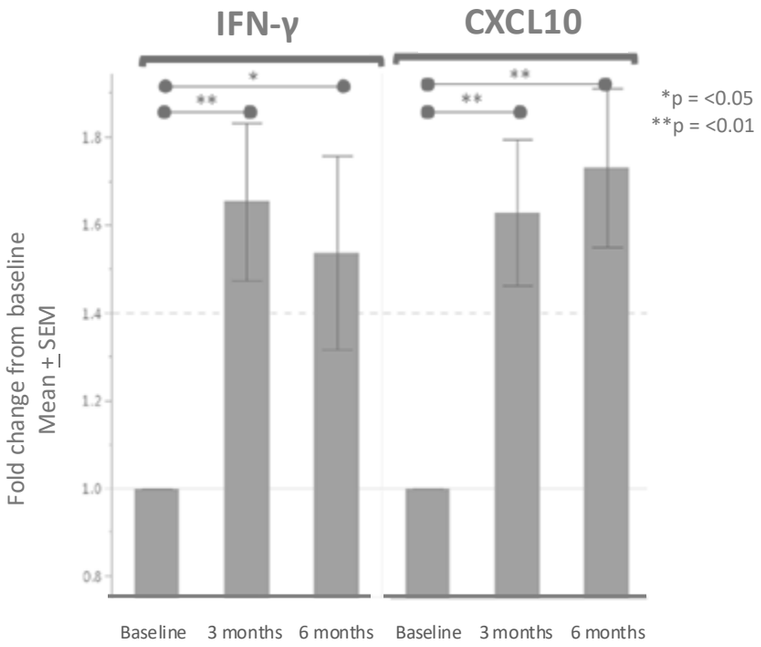
LAG-3 IMMUNOTHERAPY

Significant, sustained increases in CXCL10 & IFN-γ in TACTI-002 Phase II trial in 1L NSCLC tied to efti's unique stimulation of immune system



* Similar increase in Th1 biomarkers also seen in randomized AIPAC Phase IIb trial in metastatic breast cancer, which combined efti solely with chemotherapy

- **IFN-γ** – After first efti dosing, 86% (6/7) of responders* showed a ≥1.4-fold change and 86% (6/7) of non-responders# had less than a 1.4-fold change.
- **CXCL10** – After first efti dosing, 100% (7/7) of responders* showed a ≥1.4-fold change and 100% (5/5) of non-responders# had less than a 1.4-fold change.

CXCL10 may be an important biomarker with anti-PD-1 therapies**

"Strategies that support effector T cell recruitment via induction of CXCL10 should be considered as a mechanism-based intervention to expand immunotherapy efficacy."[1]

Journal for ImmunoTherapy of Cancer

"…Chemokines CXCL9/10 are indispensable for robust responses to immune checkpoint inhibitors (anti-PD-1 and anti-CTLA-4)…"[2]

CLINICAL CANCER RESEARCH

"CXCL9 and CXCL10 bring the heat to tumors"[3]

Science Immunology

"Circulating CXCL10 at baseline appeared to be a robust predictor of response."[4]

Journal for ImmunoTherapy of Cancer

Data from Immutep's SITC 2023 presentation. *Responders: CR=Complete Response, PR=Partial Response. #Non-responders: SD=Stable Disease, PD=Progressive Disease, NE=Non-Evaluable, NA=Not Available **1. Immune cell and tumor cell-derived CXCL10 is indicative of immunotherapy response in metastatic melanoma. Reschke R, Yu J, Flood BA, et al., *J Immunother Cancer 2021*; 9:e003521. doi:10.1136/ jitc-2021-003521; 2. Macrophage-Derived CXCL9 and CXCL10 Are Required for Antitumor Immune Responses Following Immune Checkpoint Blockade, House et al., *Clin Cancer Res (2020)* 26 (2): 487–504. https://doi.org/10.1158/1078-0432.CCR-19-1868; 3. CXCL9 & CXCL10 bring the heat to tumors, Reschke et al., *Sci Immunol. 2022* Jul 22;7(73):eabq6509. 4. Phase II study of pembrolizumab in refractory esophageal cancer with correlates of response and survival, de Klerk et al., *J Immunother Cancer. 2021;* 9(9)

Favorable Safety

Differentiated OS from **Efti + Pembrolizumab** achieved with a **favorable safety profile**

Therapy in 1L NSCLC TPS ≥1%	Drug-related Adverse Events Leading to Discontinuation[2]	Median Overall Survival[3]
Efti + Pembrolizumab	**9.6%**	**35.5 months**
Pembro + Doublet Chemo (NSQ)	20.5%	23.3 months
Pembro + Doublet Chemo (SQ)	16.8%	18.9 months
Ipilimumab + Nivolumab[1]	18.1%	17.1 months
Pembrolizumab monotherapy[1]	**9.9%**	16.4 months
Ipi + Nivo + 2 cycles of Doublet Chemo	22.1%	15.8 months

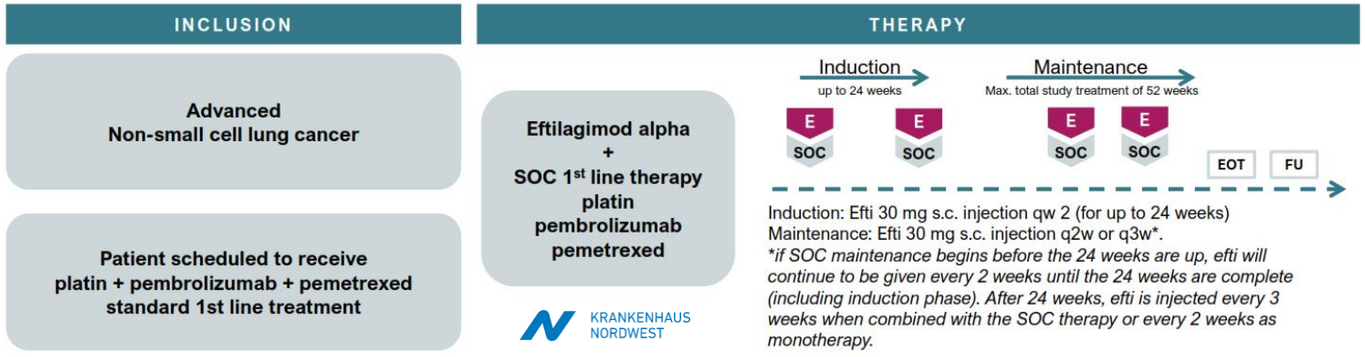
NSQ = Non-squamous; SQ = Squamous

Comparison of data is from different clinical trials. 1. Ipilimumab + Nivolumab approved in US for 1L NSCLC PD-L1 TPS >1% but not in EU; Pembro mono not approved in Europe for TPS 1-49%. 2. Treatment related adverse events leading to discontinuation taken from publications/EPAR assessments of respective trials (KN-042, KN-024, KN-189, KN-021, KN-407, CM-227, CM-9LA). 3. Arrow lengths are proportional representations of Overall Survival data. Data for standard-of-care therapies taken from publications of respective registrational trials (e.g., KN-042, KN-189, KN-407, CM-227, CM-9LA).

INSIGHT-003: IO-IO-Chemo Combination Trial in 1L NSCLC

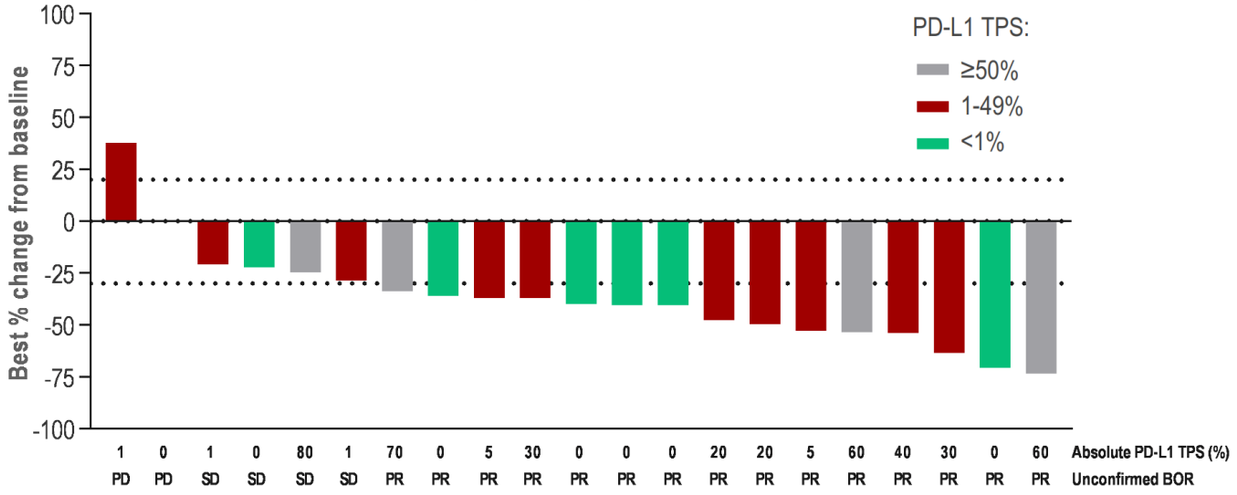
Promising initial efficacy & safety from first-in-human study evaluating Efti + KEYTRUDA + doublet chemo

INSIGHT-003 - Investigator-initiated study in first line non-squamous NSCLC

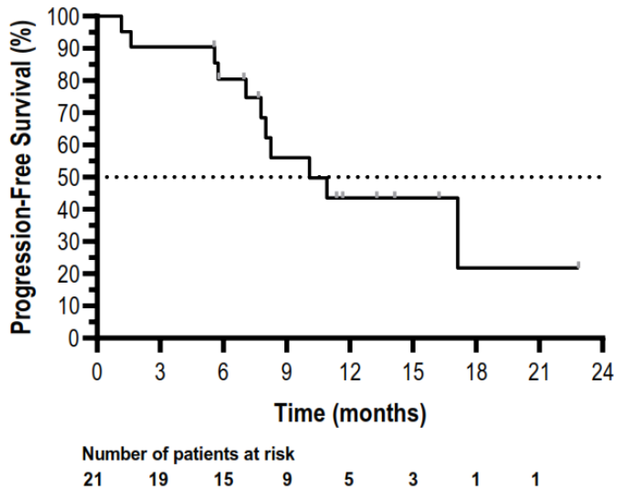


- Triple combination well tolerated and appears safe
- ~81% of patients have negative or low PD-L1
- At data cut-off, unconfirmed ORR of 71.4% (confirmed ORR of 66.7%)
- mPFS of 10.1 months and mOS not reached in ITT population (median follow up 12.4 months)

Best Overall Response by PD-L1 Status (N=21)



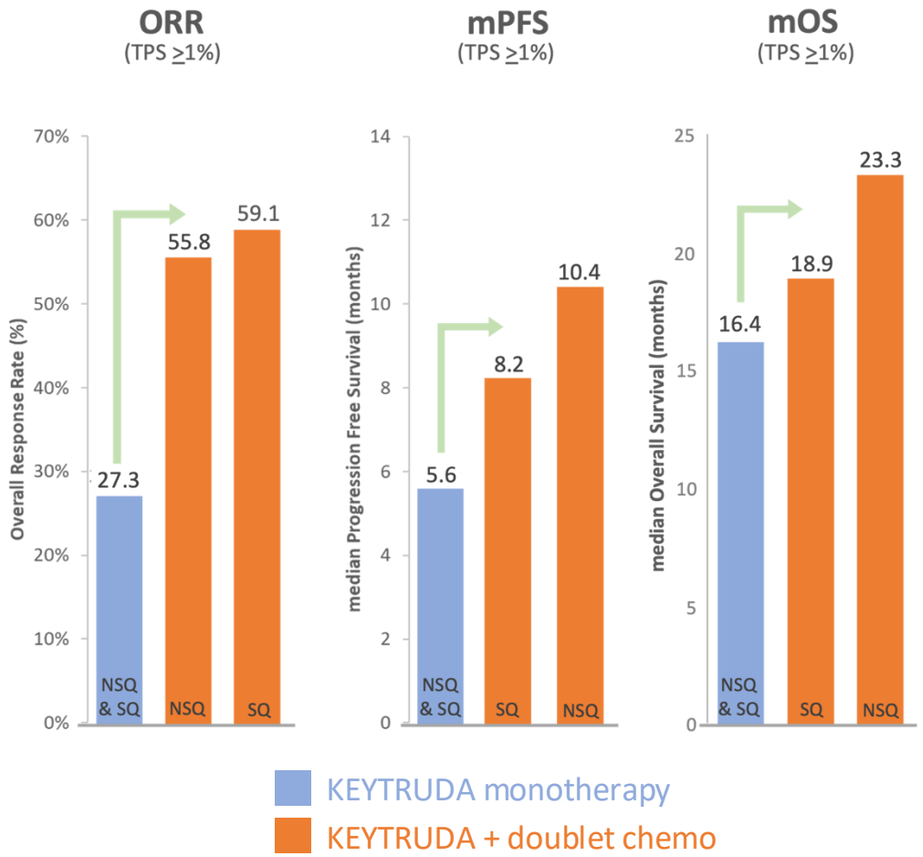
Progression-Free Survival



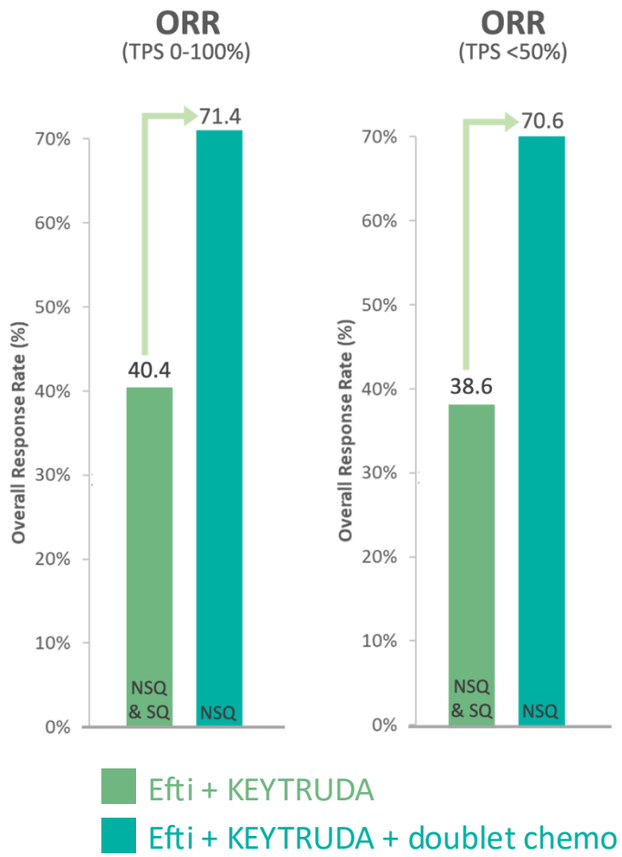
Source: ESMO 2023 Poster (#1042P) – A Atmaca et al., INSIGHT 003 evaluating feasibility of eftilagimod alpha (soluble LAG-3) combined with 1st line chemo-immunotherapy in metastatic non-small cell lung cancer (NSCLC) adenocarcinomas – a multicenter early phase trial.

Chemotherapy is Additive to KEYTRUDA's Efficacy in 1L NSCLC

KEYTRUDA with Chemotherapy has Superior Efficacy versus KEYTRUDA Monotherapy in 1L NSCLC



Same Additive Benefit from Chemotherapy to Efti + KEYTRUDA Observed in INSIGHT-003 trial in 1L NSCLC



- ***Without chemo…*** Efti + KEYTRUDA has higher ORR, PFS, OS vs KEYTRUDA monotherapy in 1L NSCLC across all PD-L1 levels
- ***With chemo added…*** Efti + KEYTRUDA sees large ORR boost and OS/PFS trending favorably in INSIGHT-003

Comparison of data is from different clinical trials. Data for KEYTRUDA monotherapy and chemotherapy combination taken from publications of registrational trials KN-042, KN-189, KN-407. Data for Efti + KEYTRUDA and Efti + KEYTRUDA + chemotherapy were taken from conference presentation/posters, see TACTI-002 presentation at ESMO´23 by Carcereny et al., SITC´23 by Forster et al., INSIGHT-003 poster at ESMO´23 by Atmaca et al., also available at Immutep website.

Registration Strategy in First line Non-Small Cell Lung Cancer (1L NSCLC)

Evolution of Efti + KEYTRUDA® in Clinical Trials

Growing collaborative effort with MSD over time with positive clinical outcomes across multiple cancers

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LAG-3 IMMUNOTHERAPY

TACTI-mel
Phase I

- First in human study of efti in combination with KEYTRUDA
- No collaboration or supply agreement with MSD for KEYTRUDA
- All patients enrolled had suboptimal responses or progressive disease after KEYTRUDA monotherapy
- Efti with KEYTRUDA led to encouraging responses, including disappearance of all target tumor lesions in patients

TACTI-002
Phase II

- 1st clinical trial collaboration & supply agreement with MSD (March ’18)
- 109 patients treated in two indications NSCLC (1L and 2L) and HNSCC (2L)
- Excellent initial efficacy and favorable safety in 1L NSCLC, and strong results in 2L HNSCC & 2L NSCLC
- Fast Track designation for 1L HNSCC based on trial data

TACTI-002 Expansion
Phase II

- Expansion of 1L NSCLC cohort to 114 patients from 36 patients in 2020 post initial results and to test robustness.
- Excellent overall survival along with very high response rates, progression free survival, and duration of response achieved in 1L NSCLC
- Fast Track designation for 1L NSCLC based on trial data

TACTI-003
Phase IIb

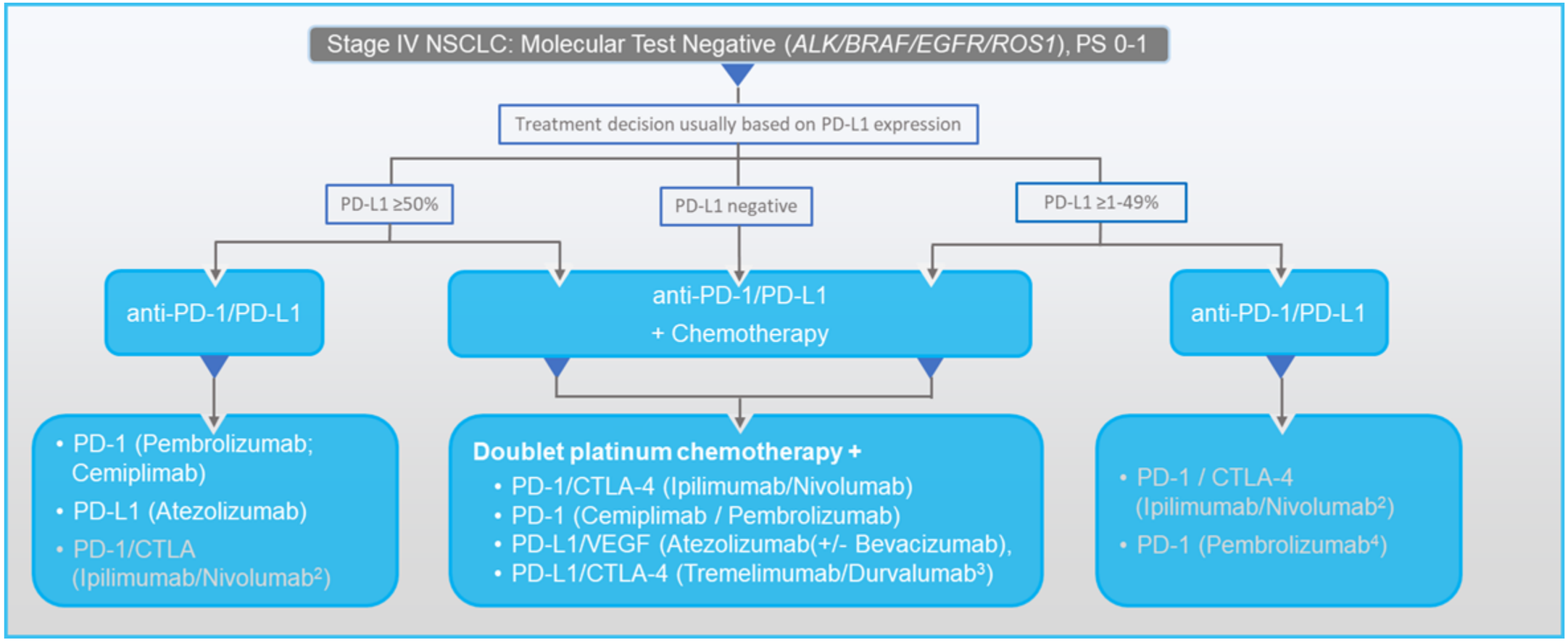
- 2nd clinical trial collaboration & supply agreement with MSD (March ’21)
- Prompted by strong results in 2L HNSCC patients in TACTI-002
- 171 patients treated in total with sole focus on 1L HNSCC
- Efti with KEYTRUDA led to response rates exceeding KEYTRUDA alone across all levels of PD-L1 expression with largest differential in CPS ≥20 and CPS <1

TACTI-004
Phase III

- **Third and most important collaboration & supply agreement with MSD (June ’24)**
- **Registrational Phase III trial in 1L NSCLC with ~750 patients**
- **Immutep to conduct trial & retains commercial rights to efti**
- **Potential to establish new standard of care in NSCLC, one of largest oncology indications and revenue drivers for KEYTRUDA**
- **Planned KEYTRUDA supply has significant value (typical ICI drug supply for such a PIII trial is approx. US$100m)**

TACTI-mel: publication by Atkinson et al. 2020, doi: 10.1136/jitc-2020-001681. TACTI-002: TACTI-002 presentation at ESMO´23 by Carcereny et al., SITC´23 by Forster et al. also available at Immutep website. TACTI-003: June 27 and July 12, 2024, press releases available at Immutep website.

Treatment Landscape in 1L NSCLC (US/EU)



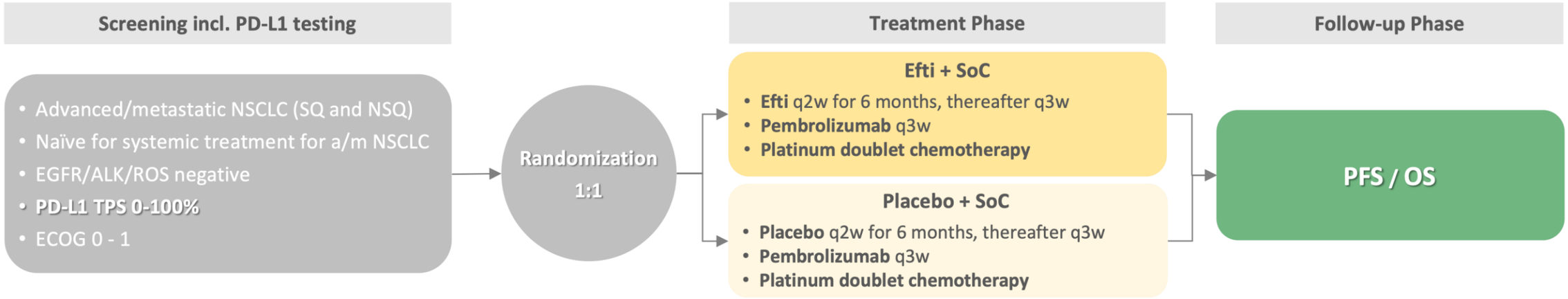
KEYTRUDA (pembrolizumab) and chemotherapy utilized across entire 1L NSCLC landscape, regardless of PD-L1 expression, which is the same patient population the efti + pembrolizumab + chemotherapy combination will be evaluated in

(1) Simplified based on ESMO and NCCN Guidelines: DOI:https://doi.org/10.1016/j.annonc.2022.12.013 and https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1450
(2) Ipilimumab/Nivolumab without chemotherapy is not approved in the EU, although recommended in the ESMO guidelines; approved in the US, only indicated in special circumstances in the NCCN guidelines for PD-L1 ≥ 50 %
(3) Not all options available for all histologies and all regions and PD-L1 negative patients, number of cycles and components of chemotherapy varies. Please see the guidelines for more detail.
(4) Pembrolizumab monotherapy not approved or recommended in EU for PD-L1 1-49%; it is approved in US, however only recommended in specific cases with lower level of evidence

Immutep & Merck (MSD) to Undertake Phase III Trial in NSCLC

Opportunity to set a new standard of care across entire NSCLC population regardless of PD-L1 expression

TACTI-004 / KEYNOTE-PNC-91 Trial Design



Trial Overview:

- TACTI-004 will be a 1:1 randomized, double-blind, multinational, controlled clinical study with ~750 patients
- Trial will enroll first line squamous and non-squamous NSCLC patients who are unselected for PD-L1 expression
- Dual primary endpoints will be Progression-Free and Overall Survival with both being adequately powered

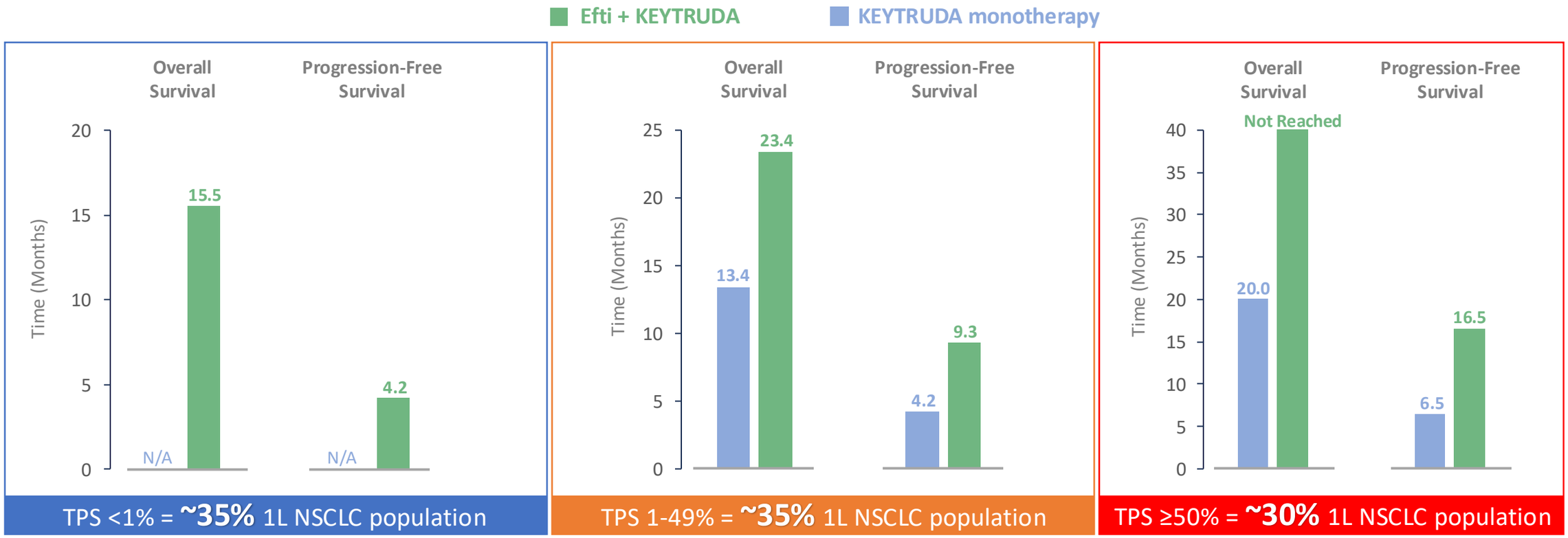
Key Milestones:

- First patient expected to be enrolled in Q4 2024 / Q1 2025
- Futility analysis expected in late 2025 / early 2026 and interim analysis in late 2026 till mid-2027 (event driven)

* Timelines are indicative and subject to change

Strong Results in Dual Primary Endpoints (OS/PFS) Across All PD-L1 Expression Levels Drives Confidence in TACTI-004

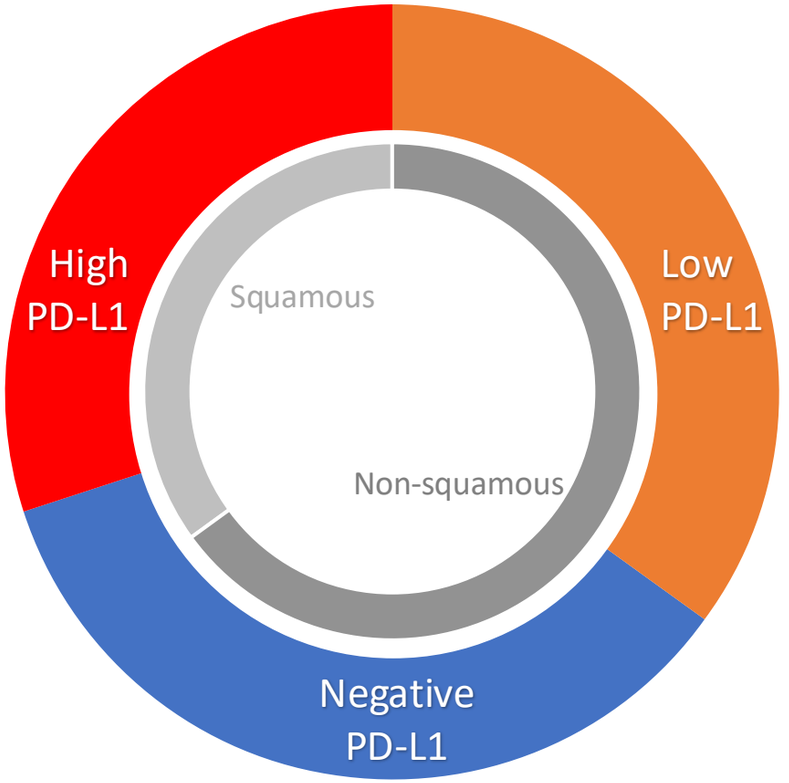
TACTI-004's large trial design will effectively capture 1L NSCLC patient populations with negative (TPS <1%), low (TPS 1-49%), and high (TPS ≥50%) PD-L1 expression. The strength of efti + KEYTRUDA results in TACTI-002 & INSIGHT-003 trials across all three levels, including negative & low PD-L1, drives confidence in a potential positive outcome.



Comparison of data is from different clinical trials. KEYTRUDA (pembrolizumab) monotherapy data from publications/EPAR assessment report of KN-042 registrational trial. Efti + KEYTRUDA data from TACTI-002 Phase II trial. Given the lack of historical results in 1L NSCLC patients with negative PD-L1 expression (TPS <1%) who received pembrolizumab monotherapy in KN-042 and other trials, the chart only has Efti + KEYTRUDA data from TACTI-002 in patients with negative PD-L1 expression (TPS <1%).

Uniquely Positioned Phase III in 1L NSCLC Landscape

- KEYTRUDA has revolutionized the treatment landscape in lung cancer, and as a result MSD (Merck) captures between 7 to 8 of every 10 metastatic lung cancer patients today*
- Of KEYTRUDA's ~US$25 billion in sales in 2023, it is estimated that ~US$9 billion or +35% are from lung cancer**
- Efti in combination with KEYTRUDA and chemotherapy is uniquely positioned to potentially drive a new standard of care for 1L NSCLC patients eligible for anti-PD-(L)1 therapy

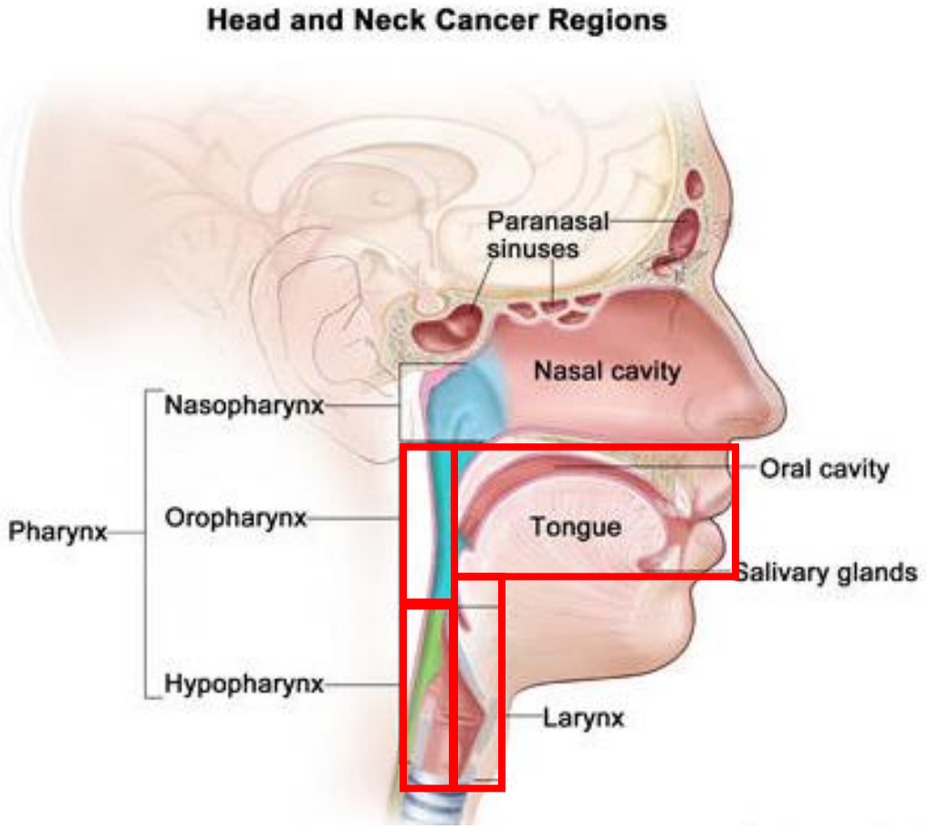


TACTI-004 among the few global Phase III trials evaluating combination therapies with KEYTRUDA that ***addresses almost the entire 1L NSCLC patient population*** eligible for anti-PD-(L)1 therapy

* MSD Investor Event at ASCO 2024. ** Source of sales figures: Bloomberg, Wall Street research reports and Company reports.. Patient population estimates by PD-L1 expression (~35% negative, ~35% low, and ~30% population high) based on publications of registrational trials KN-001, KN-189, KN-407, EMPOWER-Lung 3 and TACTI-002 all comer Phase II trial. Non-squamous and squamous represent ~70% and ~30%, respectively, of the 1L NSCLC patient population (Comparative outcomes of squamous and non-squamous non-small cell lung cancer (NSCLC) patients in phase II studies of ASA404 (DMXAA) – retrospective analysis of pooled data; Thorac Dis. 2010 Dec; 2(4): 199–204 doi: 10.3978/j.issn.2072-1439.2010.02.04.1

Efti + Anti-PD-1 in Head & Neck Cancer

Head and Neck Squamous Cell Carcinoma



TACTI-003 included cancers that originate from the areas delineated by red boxes

Overview:

- Head and neck squamous cell carcinoma (HNSCC) encompasses a spectrum of heterogeneous diseases originating in the oral cavity, pharynx, and larynx
- HNSCC is a complex disease involving distinct anatomical sites and with varying etiological factors including smoking, alcohol consumption and infection with Human Papilloma Virus (HPV)

Epidemiology:

- More than 890,000 HNSCC diagnoses and 450,000 deaths per annum worldwide[1]
- Up to ~100,000 estimated to develop metastatic disease in 8MM countries[2]
- 5-year survival for metastatic HNSCC is 39.3%[3] and varies depending on the anatomical site of cancer origin

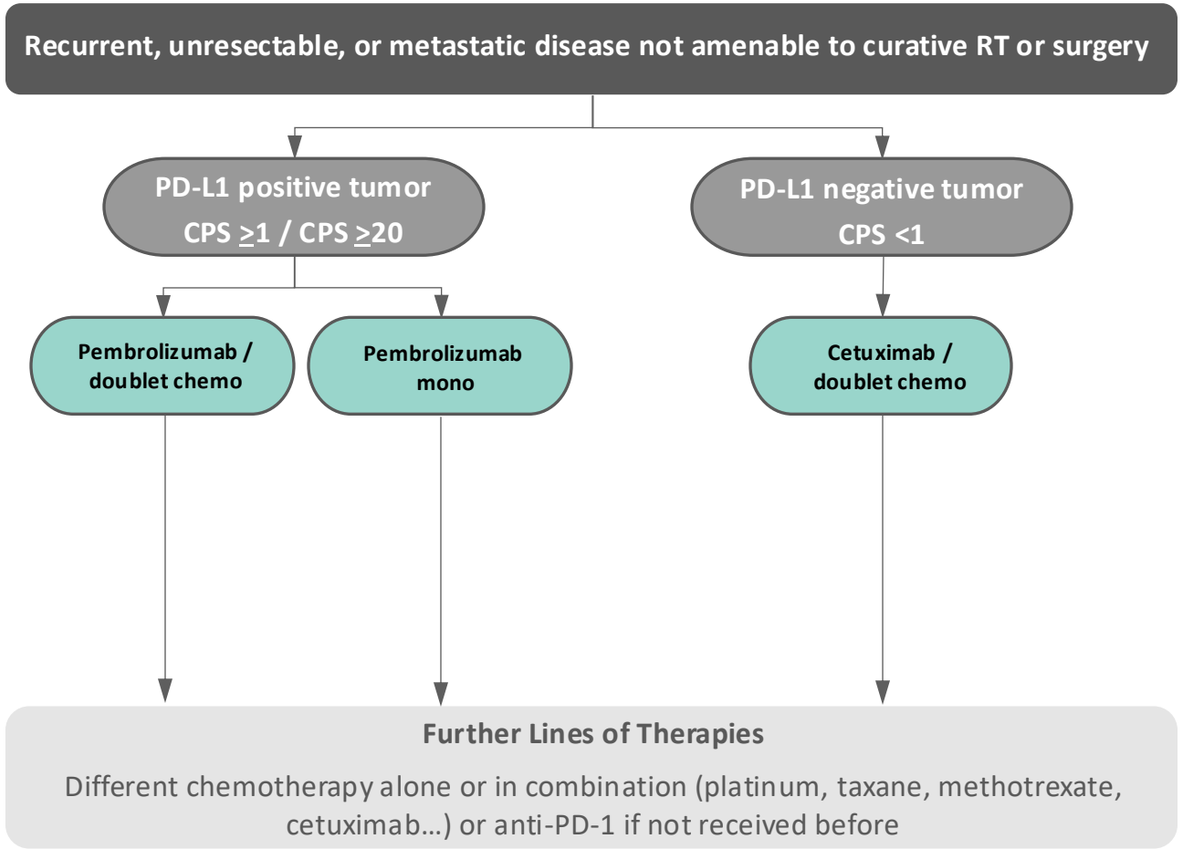
Treatment Landscape in 1L HNSCC

High unmet need:

- Overall Survival in first line HNSCC is ~12 months

PD-L1 expression:

- PD-L1 expression as measured by Combined Proportion Score (CPS) is an FDA approved predictive biomarker in 1L HNSCC for anti-PD-1 therapy
- Patients are grouped by high (CPS ≥20), low (CPS 1-19), and negative (CPS <1) PD-L1 expression[1]. Generally, high PD-L1 expressors respond best, low respond sub-optimally, and negative have negligible responses to anti-PD-1 therapies.
- Currently, there are no effective chemotherapy-free treatments for patients with no PD-L1 expression (CPS <1)



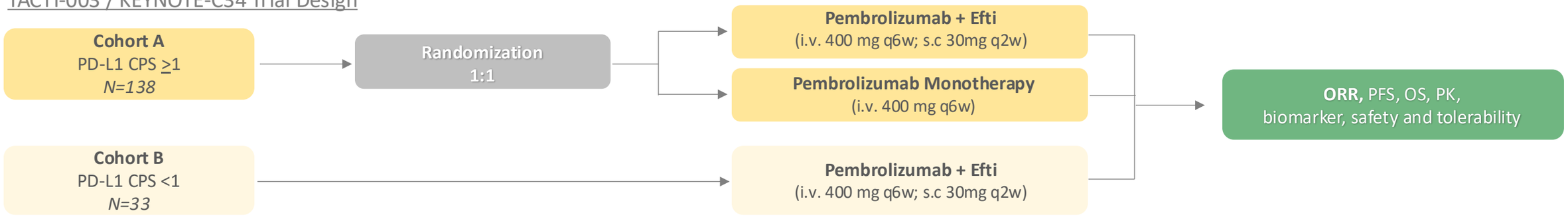
Simplified based on NCCN Guidelines Head and Neck Cancers and EHNS-ESMO-ESTRO Clinical Practice Guidelines

The Food and Drug Administration (FDA) approved pembrolizumab in combination with ChT as first-line treatment regardless of PD-L1 expression and pembrolizumab alone for patients with PD-L1-expressing tumours (CPS ≥1). In contrast, the European Medicines Agency (EMA) has approved pembrolizumab with or without ChT only for patients with a CPS ≥1. Source: DOI:https://doi.org/10.1016/j.annonc.2020.07.011

TACTI-003 Trial Overview

Efti + anti-PD-1 therapy has FDA Fast Track designation in recurrent or metastatic 1L HNSCC

TACTI-003 / KEYNOTE-C34 Trial Design



- Randomized, multicenter Phase IIb trial evaluating efti in combination with pembrolizumab (KEYTRUDA®) in first line recurrent or metastatic head and neck squamous cell carcinoma (1L R/M HNSCC). A total of 171 patients enrolled in 29 clinical sites across nine countries (US, UK, ES, UA, AU, RO, UA, DK, DE):
  - *Cohort A (N=138) - Patients with any PD-L1 expression (CPS ≥1) randomized 1:1 evaluating efti + KEYTRUDA® versus KEYTRUDA monotherapy*
  - *Cohort B (N=33) - Patients with negative PD-L1 expression (CPS <1), which could not be randomized as KEYTRUDA monotherapy is not approved in CPS <1*
- Primary endpoint is Objective Response Rate (ORR) among evaluable patients (>= 1 post baseline CT), according to RECIST1.1
- Secondary endpoints include Overall Survival and Progression-Free Survival, ORR (iRECIST), and Disease Control Rate

The Food and Drug Administration (FDA) approved pembrolizumab in combination with ChT as first-line treatment regardless of PD-L1 expression and pembrolizumab alone for patients with PD-L1-expressing tumours (CPS ≥1). In contrast, the European Medicines Agency (EMA) has approved pembrolizumab with or without ChT only for patients with a CPS ≥1. Source: DOI:https://doi.org/10.1016/j.annonc.2020.07.011. Approval based on KN-048. Immutep conducts this clinical trial and has a clinical trial collaboration and supply agreement with Merck & Co., Inc., Kenilworth, NJ, USA (known as MSD outside the US and Canada).

Favourable Safety Profile

Safety Parameter	Efti + KEYTRUDA (Cohorts A+B) n (%)	KEYTRUDA alone (Cohort A) n (%)
Any TEAE Leading to Discontinuation of Study Treatment	8 (7.8%)	4 (5.9%)
Related to Efti and/or Pembrolizumab	6 (5.9%)	3 (4.4%)

- **No new safety signals**
- **Rate of treatment related discontinuation was low and comparable between treatment regimens**
- **Safety profile comparable to KEYTRUDA monotherapy**

Data cut-off date: March 11, 2024

Overall Response Rate in Evaluable Patients

TACTI-003 primary endpoint is objective response rate (ORR) in evaluable patients, according to RECIST1.1

Efti plus KEYTRUDA achieved a ~34% ORR (N=89) regardless of HPV status and PD-L1 levels, including 31 patients with negative PD-L1 expression

"The strong, consistent response rates, irrespective of whether patients have high, low, or negative PD-L1 expression, is intriguing and offers a glimpse into this novel combination's ability to improve patients' clinical responses and expand patient populations that benefit from anti-PD-1 therapy."

- Dr. Martin Forster, UCL Cancer Institute, London, UK

Efti plus KEYTRUDA led to higher ORR across all levels of PD-L1 expression versus KEYTRUDA monotherapy and durability is tracking well

"We are pleased with the quality of responses. Once again, durability is tracking well driven by the complementary nature of these two unique immunotherapies in fighting cancer."

- Dr. Frédéric Triebel, CSO of Immutep

Data cut-off date: March 11, 2024
Evaluable patient with ≥1 evaluable post-baseline scan

Randomised Cohort A: Patients with Any PD-L1 Expression

	TACTI-003	
	Efti + KEYTRUDA	KEYTRUDA alone
High PD-L1 Expression (CPS ≥20)	**31.0% ORR (N=29)**	**18.5% ORR (N=27)**
In CPS ≥20, efti + KEYTRUDA shows strongest outperformance with 68% relative increase and 12.5% absolute increase. Patients with CPS ≥20 represent ~50% of the 1L HNSCC patient population.*		
Low PD-L1 Expression (CPS 1-19)	**34.5% ORR (N=29)**	**33.3% ORR (N=33)**
In CPS 1-19, efti + KEYTRUDA has relatively high 34.5% ORR in CPS 1-19. KEYTRUDA monotherapy's 33.3% ORR is higher than historical published data, including a 14.5% ORR in KN-048*, that may be explained by imbalances including gender, smoking status, HPV+/- status, and location of primary tumour.		
Any PD-L1 Expression (CPS ≥1)	**32.8% ORR (N=58)**	**26.7% ORR (N=60)**
In CPS ≥1, efti + KEYTRUDA has 23% relative Increase and 6.1% absolute increase against KEYTRUDA monotherapy results that were driven higher by results in CPS 1-19 group. efti + KEYTRUDA 90% CI: 22.6%-44.3%; KEYTRUDA 90% CI: 17.5%-37.6%		

- Multiple prognostic markers favor the KEYTRUDA mono arm in Cohort A
  - ✓ 30.0% female vs 20.7% in combination arm
  - ✓ 16.7% current smokers vs 22.4% in combination arm
  - ✓ 13.3% hypopharynx vs 19.0% in combination arm
  - ✓ 65.0% HPV+ vs 29.2% in combination arm
- No prognostic markers favor the Efti + KEYTRUDA combination arm

Data cut-off date: March 11, 2024. * Source: Burtness, B. et al. Pembrolizumab Alone or With Chemotherapy for Recurrent/Metastatic Head and Neck Squamous Cell Carcinoma in KEYNOTE-048: Subgroup Analysis by Programmed Death Ligand-1 Combined Positive Score. Journal of Clinical Oncology 2022 40:21, 2321-2332 . CI = Confidence Interval

Cohort B: Response Rate Among Highest Recorded in CPS <1

ESMO VIRTUAL PLENARY

Best objective response[1], n (%)	RECIST 1.1 N=31	iRECIST N=31
Complete response	3 (9.7)	3 (9.7)
Partial response	8 (25.8)	9 (29.0)
Stable disease	7 (22.6)	8 (25.8)
Progressive disease	13 (41.9)	11 (35.5)
ORR, [95% CI][2]	**11 (35.5)** [19.2-54.6]	**12 (38.7)** [21.8-57.8]
DCR, [95% CI][2]	**18 (58.1)** [39.1-75.5]	**20 (64.5)** [45.4-80.8]

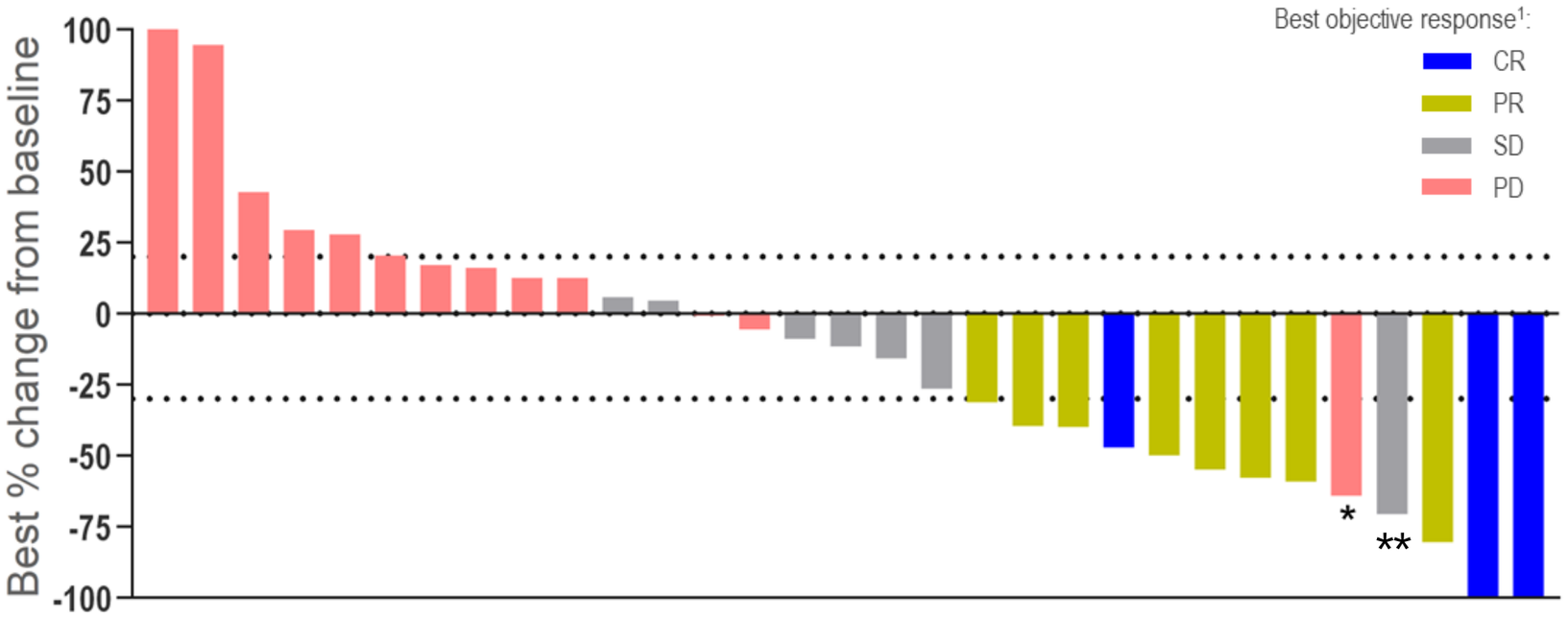
Key Takeaways:

- ORR of 35.5% and DCR of 58.1%, according to RECIST 1.1
- The 35.5% ORR is among the highest recorded for a chemo-free approach in 1L HNSCC patients with no PD-L1 (CPS <1) expression
- ~10% complete responses
- Responses are observed regardless of HPV status*

Data cut-off date: March 11, 2024; [1]Per Investigator read. [2] Calculated using Clopper-Pearson method.
* In patients with primary oropharyngeal tumours only (1/4 HPV-positive and 2/7 HPV-negative patients were responders)

Cohort B: Tumour Shrinkage in 60% of CPS <1 Patients

Change in Tumour Burden

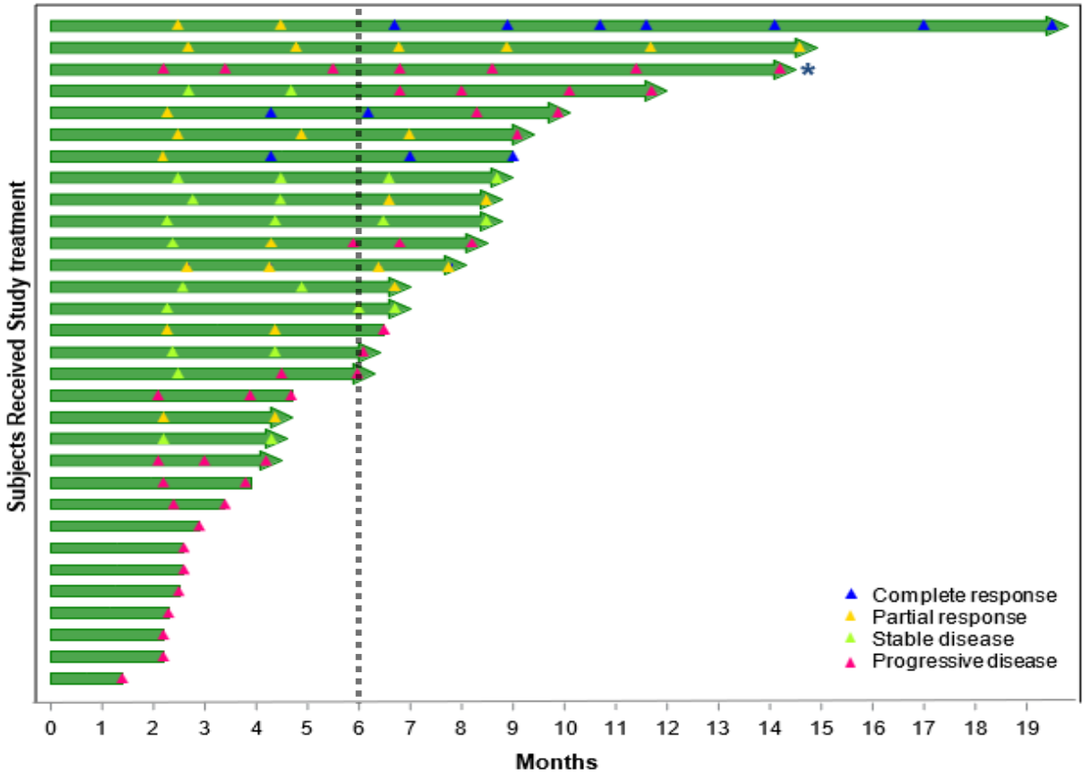


- ~60% of patients experienced tumour shrinkage
- Despite deep responses in target lesions, two patients not counted as responders:
  - One patient (*) with pseudoprogression later had a confirmed partial response (PR) according to iRECIST yet not RECIST 1.1
  - Another patient (**) with -71% shrinkage in target lesion diameters at week 27 had progression in a non-target lesion

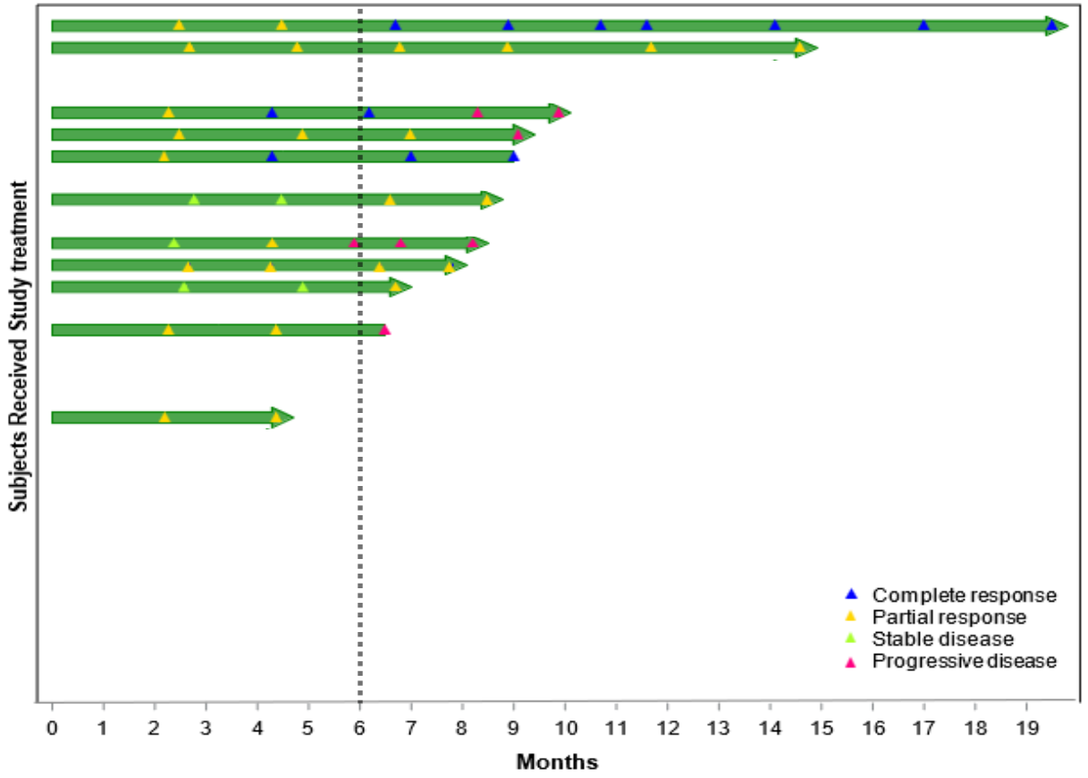
Data cut-off date: March 11, 2024; [1] Responses per RECIST 1.1, Investigator-assessed. Includes one complete response with a best % change of -47%. This patient had one target lesion of the lymph node, which shrunk to <10 mm.

Cohort B: Excellent Duration of Treatment

Tumour response dynamics over time*



Tumour response dynamics (RESPONDERS only)



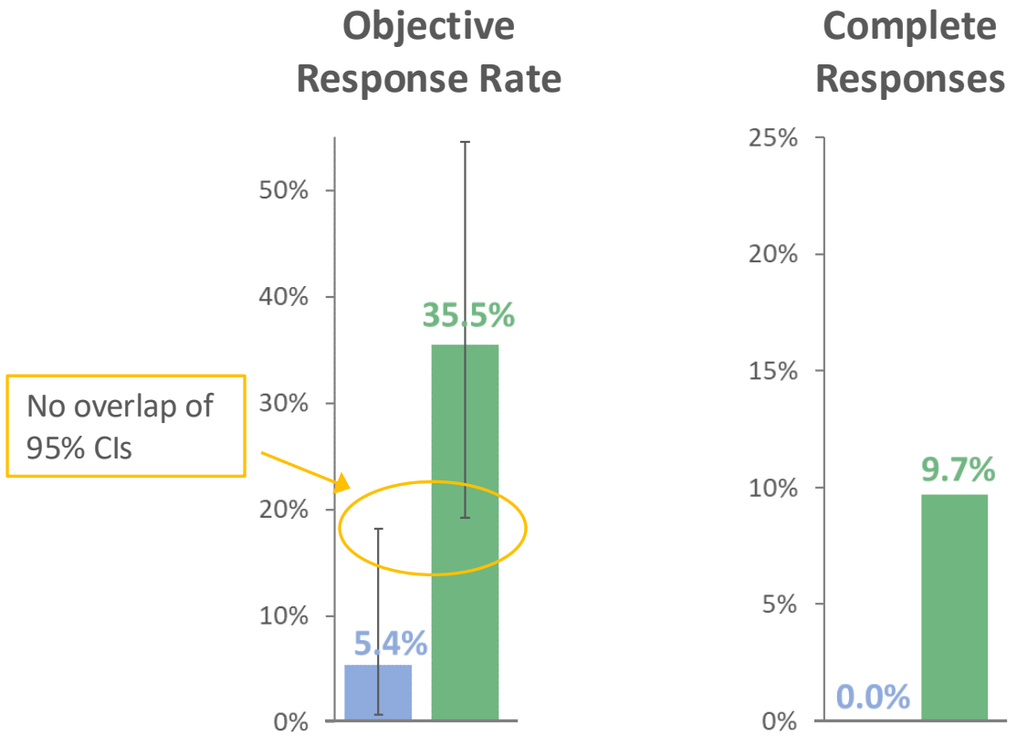
- Durability of treatment / responses tracks very well
- >50% patients remain on treatment 6+ months
- >90% of responders remain on treatment 6+ months

Data cut-off date: March 11, 2024. Patient treatment is decided based on iRECIST allowing for treatment beyond RECIST 1.1 progression. Each bar represents one patient in the study. The right arrow cap indicates patients who are ongoing on the study. Responses are per RECIST 1.1. One patient with clear early pseudoprogression (acc. to RECIST 1.1) and durable response later (acc. iRECIST; still on treatment at 14+ months → see previous slide).

Benchmarking: Exceptional Results for a Chemo-Free Regimen

Key takeaways, Cohort B (CPS <1)

- ✓ ORR of 35.5% and DCR of 58.1% are exceptional for a chemo-free regimen in this patient population
- ✓ Compares favorably to historical results from KEYTRUDA monotherapy (see figures to right)
- ✓ ORR similar to KEYTRUDA + chemo (~31%) and in range of EXTREME regimen (~40%)#, without toxicity of chemo
- ✓ Early trends in durability look favourable (90% responders ongoing treatment at 6 months)
  - → Typically, duration of response (DOR) is much longer with IO-only therapies (e.g., DOR for KEYTRUDA alone is ~23 months vs. ~7 months when it is combined with chemo**)



PD-L1 CPS <1	KEYTRUDA mono (N=37) (KN-048)#	Efti + KEYTRUDA (N=31) (TACTI-003)
ORR, [95% CI]*	**2 (5.4%)** [0.7-18.2]	**11 (35.5%)** [19.2-54.6]
Complete Responses	0 (0.0%)	3 (9.7%)
Partial Responses	2 (5.4%)	8 (25.8%)

Comparison of data is from different clinical trials. Data for pembrolizumab monotherapy in 37 evaluable patients with CPS <1 from KN-048 trial (https://ascopubs.org/doi/10.1200/JCO.21.02198). # ~31% & ~40% ORR in CPS <1 for KEYTRUDA + chemo and for EXTREME regimen (cetuximab + chemo), respectively, from KN-048 trial (https://ascopubs.org/doi/10.1200/JCO.21.02198). FDA approved pembrolizumab in combination with ChT as first-line treatment regardless of PD-L1 expression and pembrolizumab alone for CPS≥1. In contrast, the European Medicines Agency (EMA) has approved pembrolizumab with or without ChT only for patients with a CPS ≥1. Source: DOI:https://doi.org/10.1016/j.annonc.2020.07.011. * Calculated using Clopper-Pearson method. ** DOR data from KN-048 trial, Burtness et al., *The Lancet* 2019, https://doi.org/10.1016/S0140-6736(19)32591-7

Efti + Pembro in 2L Head & Neck Squamous Cell Carcinoma

Strong, durable efficacy in second line HNSCC (2L HNSCC)

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TACTI-002/KEYNOTE-798 (Part C): Second Line Head & Neck Squamous Cell Carcinoma (2L HNSCC)

TACTI-002 (Part C) Trial Design

- Advanced/metastatic recurrent HNSCC
- Failed 1L platinum therapy

→ **Combination Therapy**: 30mg efti Q2W + 200 mg pembrolizumab Q3W for 8 cycles, followed by 30mg efti + 200mg pembrolizumab for 9 cycles

← Up to 1 year →

→ **Monotherapy**: 200 mg pembrolizumab Q3W for 16 cycles

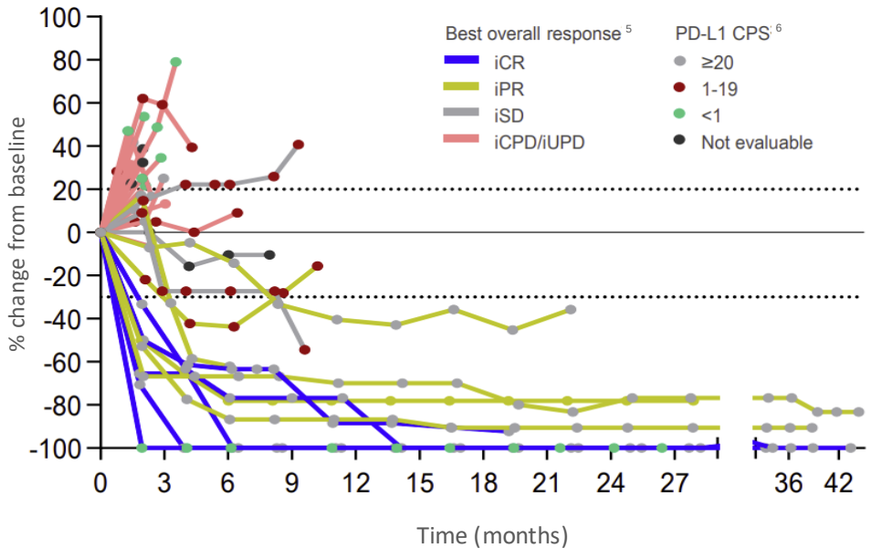
← Up to 1 year →

Primary endpoint: ORR by iRECIST

Secondary Endpoints: ORR by RECIST 1.1, PFS, OS, DOR, safety, PK/PD

- Encouraging ORR of 29.7% in ITT population (all-comer PD-L1) and treatment well-tolerated
- Early onset of responses (median ~2 months) that were deep (13.5% CRs) and durable (median DoR not reached despite a median follow up of ~39 months)
- Promising ORR of 60%, median PFS of 13.6 months and median OS of 15.5 months in patients with CPS ≥20

	ITT N=37	CPS ≥1* N=25	CPS ≥20* N=15
ORR[2,3]	29.7%	38.5%	60.0%
mPFS[2,4], months	2.1	2.3	13.6
6-mo PFS rate	32.4%	40.0%	53.3%
mDoR[2], months	NR	NR	NR
mOS[4], months	8.7	12.6	15.5
12-mo OS rate	46.0%	52.0%	66.7%



Data from Final results from TACTI-002 Part C: A Phase II study of eftilagimod alpha (soluble LAG-3 protein) and pembrolizumab in patients with metastatic 2nd line head and neck squamous cell carcinoma unselected for PD-L1 – ASCO 2023. * Central assessment of PD-L1 CPS using Dako IHC 22C3 pharmDx for 32 pts. 2. By iRECIST (local assessment). 3. 95% confidence intervals calculated using Clopper-Pearson method. 4. 95% confidence intervals calculated using Kaplan Meier survival analysis method. 5. Best overall response by iRECIST (local assessment). 6. Central PD-L1 assessment with Dako kit.

Efti + Chemotherapy in Metastatic Breast Cancer (MBC)

AIPAC-001: Efti + Chemo in Randomized Phase IIb in MBC

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AIPAC-001 Study Design

AIPAC was conducted in 34 sites across: Belgium, France, Hungary, Poland, Netherlands, UK, and Germany

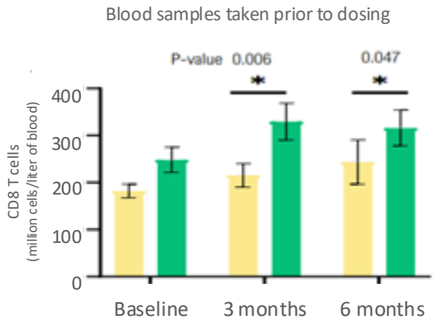
SABCS 2020 SPOTLIGHT SESSIONS

2SITC21 WASHINGTON, D.C. NOV. 10–14 Join us in person or virtually

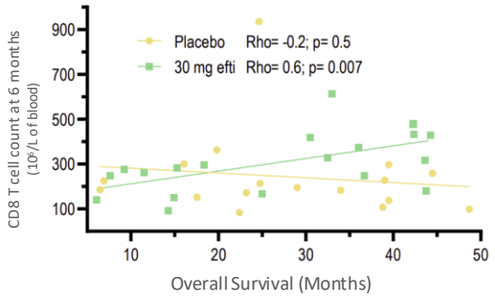
ESMO BREAST CANCER Onsite and Online Congress BERLIN GERMANY 3-5 MAY 2022

	Paclitaxel N=112	Efti + paclitaxel N=114
Overall Response Rate	38.4%	**48.3%**
Disease Control Rate	75.9%	**85.1%**
Median Overall Survival (mOS)	17.5 months	**20.4 months**
mOS in Pre-Specified Subgroups		
Low Monocytes, <0.25/nl	12.9 months	**32.5 months**
Under 65 Years	14.8 months	**22.3 months**
Luminal B	12.6 months	**16.8 months**

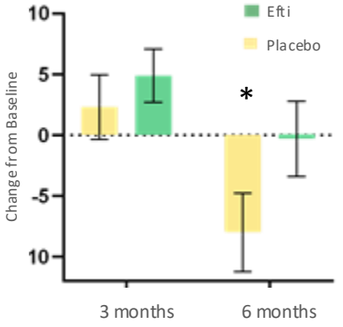
CD8⁺ T cell count increased significantly



Significant correlation between OS & Cytotoxic CD8⁺ T cell count



Sustained Quality of Life (QoL)
vs significant decline in placebo grp*



* Biomarker and multivariate analyses results from AIPAC: A phase IIb study comparing eftilagimod alpha (a soluble LAG-3 protein) to placebo in combination with weekly paclitaxel in HR + HER2 - metastatic breast carcinoma – ESMO Breast 2022; Combination of paclitaxel and a LAG-3 fusion protein (efti), as a first-line chemoimmunotherapy in patients with metastatic breast carcinoma (MBC): Final results from the run-in phase of a placebo-controlled randomized phase II – ASCO 2018

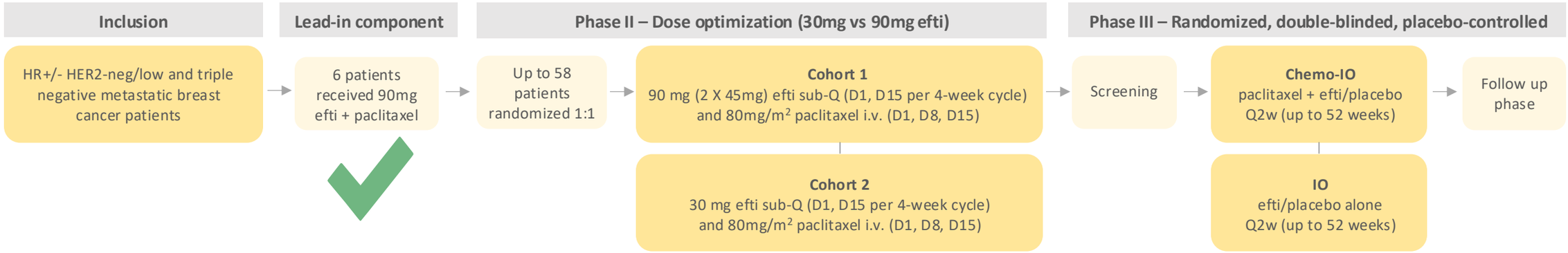
AIPAC-003 Phase II/III Trial Underway in MBC

AIPAC-003: **A**ctive **I**mmunotherapy (Eftilagimod Alfa) and **PAC**litaxel

AIPAC-003: Integrated Phase II/III trial in Metastatic Breast Cancer (MBC)

- Trial design incorporates feedback from FDA & EMA and provides risk-balanced approach
- Patient population: HR+/- HER2-negative/low and triple negative MBC (~78% breast cancer cases[1])
- Patients will receive efti + paclitaxel on same day and IO-chemo treatment can continue until disease progression (previous trial administered on different days & ceased paclitaxel at 6 months)
- Randomised Phase II dose optimization underway

AIPAC-003 Study Design



1. Cancer Stat Facts: Female Breast Cancer Subtypes - NCI SEER, World Health Organization; Breast Cancer Fact Sheet.

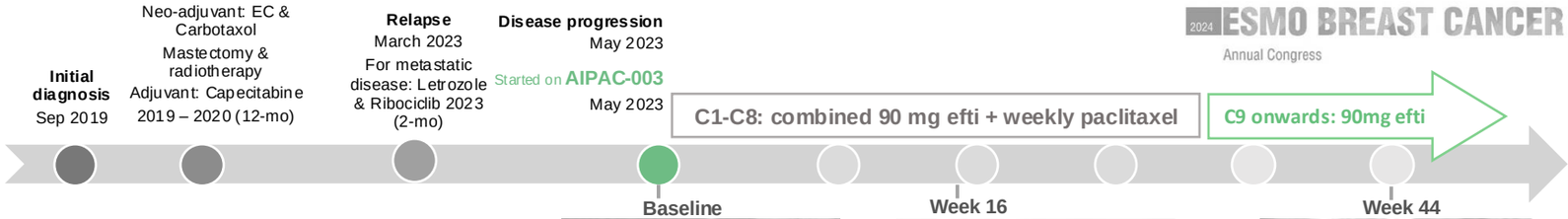
Encouraging Safety and Early Efficacy in AIPAC-003

50% Response Rate, 100% DCR, and a Confirmed Complete Response at Higher 90 mg Efti Dosing

AIPAC-003: **A**ctive **I**mmunotherapy (Eftilagimod Alfa) and **PAC**litaxel

- Efti + paclitaxel combination continues to be well tolerated with a favorable safety profile
- Encouraging initial efficacy in six MBC patients, who exhausted all endocrine therapy including CDK4/6 inhibitors, demonstrated by a confirmed 50% ORR and a 100% DCR
- Confirmed complete response (CR) in a patient with metastatic breast cancer refractory to several lines of therapy
  - CR achieved during combination treatment with 90mg efti & paclitaxel has been maintained with efti monotherapy for over 4 months**
- Data from randomized Phase II portion of study expected in CY2024

Case Study: 35-year-old Woman with Confirmed CR that Continues on Efti Monotherapy*



- 35-year-old woman, pre-menopausal. Diagnosed initially with a stage IIa TNBC.
- Baseline ECOG 0.
- HER2- low, ER+/PR+, EGFR pos, PD-L1 neg, BRCA neg, PIK3CA neg.
- Partial response turned into complete response (CR) during chemo-IO. Ongoing CR has been maintained for 2 months since patient has been treated with efti monotherapy.

TL SOD	36 mm	16 mm		3.6 mm
NTL (Right hilar LN)	-	Non-CR/non-PD		CR
Overall response (Change from baseline %)	-	PR (-55.6%)		CR (-91.7%)*

* ESMO Breast´24 Poster by Morales Murillo et al., Annals of Oncology (2024) 9 (suppl_4): 1-47. 10.1016/esmoop/esmoop103200. ** Update in Immutep Quarterly Activities Report (Q4 FY24) on 31 July 2024

Additional Oncology Indications and Studies

Efti + Anti-PD-L1 (Avelumab) in Metastatic Urothelial Cancer

INSIGHT-004 – Completed Phase I dose escalation study in advanced solid tumors*

- Efti in combination with avelumab (BAVENCIO®) safe with promising signals of efficacy in 12 patients
- 5/12 partial responses (42%) in different solid tumors**
- Encouragingly, durable responses achieved in patients with low & negative PD-L1 expression and in non-immunogenic tumors

INSIGHT-005 – Ongoing Phase I study in metastatic urothelial cancer

- Investigator-initiated study evaluating safety & efficacy of efti and avelumab (BAVENCIO®) in up to 30 patients
- Jointly funded by Immutep & Merck KGaA, Darmstadt, Germany
- Targeting area of high unmet need: patients not eligible for platinum-based chemotherapy or who are progressing during/after platinum-based chemotherapy
- Announced first patient enrolled and safely dosed in Jan 2024

Merck KGaA
Darmstadt, Germany

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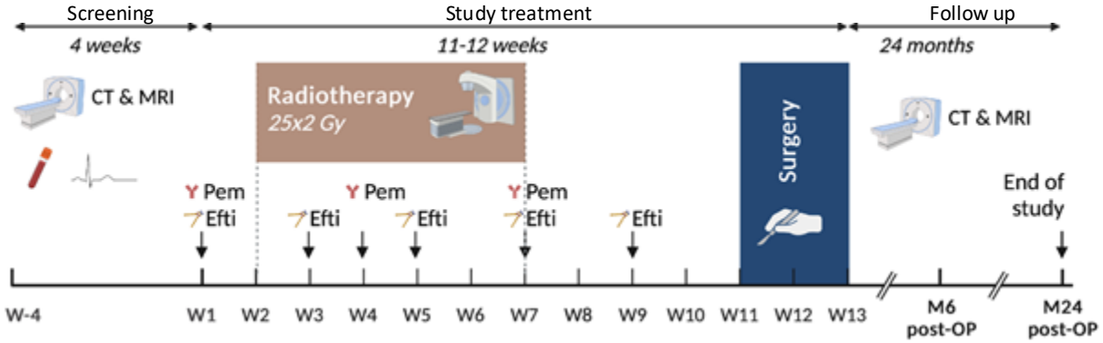
KRANKENHAUS NORDWEST

*ASCO 2021: J Clin Oncol 39, 2021 (suppl 15; abstract 2518); DOI 10.1200/JCO.2021.39.15_suppl.2518. **Two PRs in Cohort 1 (6mg efti + 800mg aveumab) in patients with MSI high colorectal cancer and pleural mesothelioma, and three PRs in Cohort 2 (30mg efti + 800mg avelumab) in patients with squamous cell anal carcinoma, squamous cervical cancer carcinoma (negative PD-L1 TPS <1%) , and adenocarcinoma gastroesophageal junction (GEJ Type III).

Soft Tissue Sarcoma: Orphan Disease with High Unmet Need

Investigator-initiated trial studying novel triple combination of Efti + Radiotherapy + KEYTRUDA

EFTISARC-NEO Phase II Trial Design*



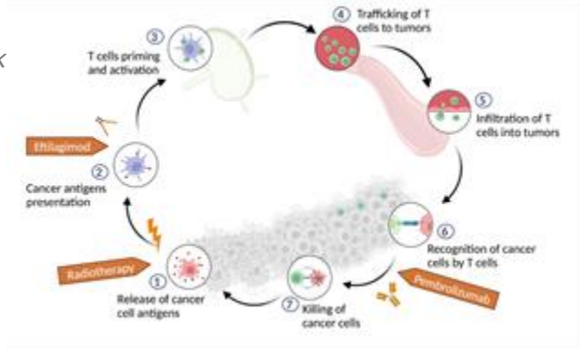
- First trial studying efti in neoadjuvant, non-metastatic cancer setting and also first to study efti with radiotherapy
- Importantly, study will provide access to tumor tissue prior to and after treatment, so tumor microenvironment can be assessed**
- Cost-efficient Phase II study funded by grant from Polish government
- Up to 40 patients will be enrolled

Rationale for triple combination based on cancer-immune cycle*

"…Given efti's synergistic effects with immune checkpoint inhibitors and its ability to arm, activate, and proliferate cytotoxic T cells with radiotherapy-induced cancer antigens, this combination has a strong foundation to drive effective immunity against soft tissue sarcoma, a rare and aggressive disease in immense need of new therapeutic approaches…"

- Dr. Paweł Sobczuk

Narodowy Instytut Onkologii
im. Marii Skłodowskiej-Curie
Państwowy Instytut Badawczy



Positive initial data from EFTISARC-NEO reported in May 2024:

- ✓ *Four of six patients treated have very good, near-complete pathologic responses (primary endpoint of study), which are rarely observed with standard therapies*
- ✓ *Triple combination therapy well tolerated*
- ✓ *Additional data planned for a medical conference in H2 CY2024*

*Pembrolizumab in combination with eftilagimod alpha and radiotherapy in neoadjuvant treatment of patients with soft tissue sarcomas - EFTISARC-NEO trial – Trial in Progress Poster at ESMO 2023. ** Blood samples and tumor biopsies will be taken for translational studies.

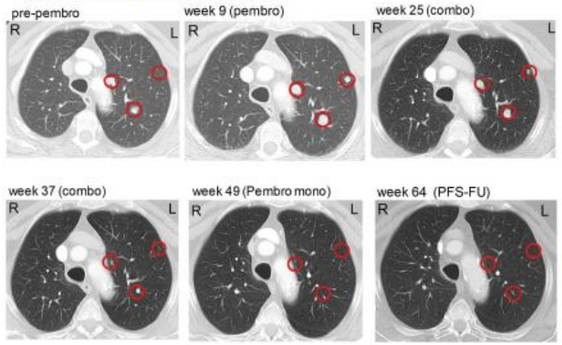
TACTI-mel: Efti plus KEYTRUDA in Metastatic Melanoma

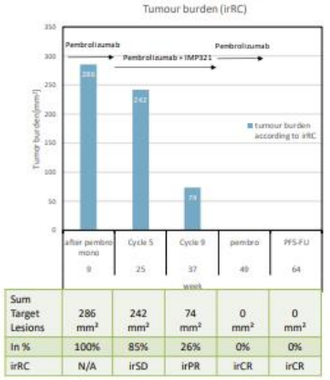
First-in-man study evaluating efti with KEYTRUDA® (pembrolizumab) in metastatic melanoma patients who had suboptimal responses to or progression after KEYTRUDA monotherapy:

- Patients had very late stage of disease: (a) 75% classified as M1c (associated with lowest probability of survival), (b) 67% lung metastasis, (c) 50% liver metastasis, (d) 50% elevated LDH
- Deep, durable responses observed with tumor shrinkage of 56% and 66% in Part A (efti 1, 6, 30mg; N=18) and Part B (efti 30mg given same day as KEYTRUDA; N=6)
- Part B had 50% ORR, 66% DCR, and two-thirds of patients were progression free at six months

Patient Case #1 - Pembrolizumab + 1mg Efti (IMP321)

- Male, Caucasian, 84 years
- stage IV visceral disease (lung and thorax metastases), best response pembrolizumab monotherapy irPD
- Patient completed study, PFS-FU (incl. Pembrolizumab monotherapy) was stopped due to patient wish after week 64 → PFS censored week 64
- **Best Response: confirmed irCR**

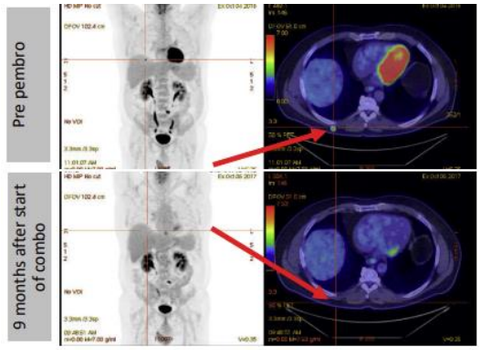




Sum Target Lesions	286 mm²	242 mm²	74 mm²	0 mm²	0 mm²
In %	100%	85%	26%	0%	0%
irRC	N/A	irSD	irPR	irCR	irCR

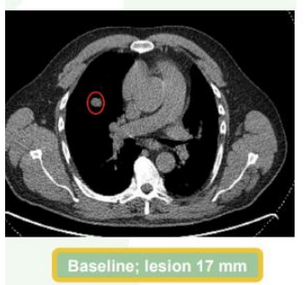
Patient Case #2 - Pembrolizumab + 6mg Efti (IMP321)

- Male, Caucasian, 54 years
- Stage IV skin/superficial disease → best response pembrolizumab monotherapy was irSD
- Target lesion: chest wall; Non-target lesion: Left common iliac LN
- Patient has completed the study treatment, PFS-FU (incl. Pembrolizumab monotherapy) ongoing → PFS 22+ months
- Complete disappearance of target lesions, lymph node normalized
- **Best Response: confirmed irPR**



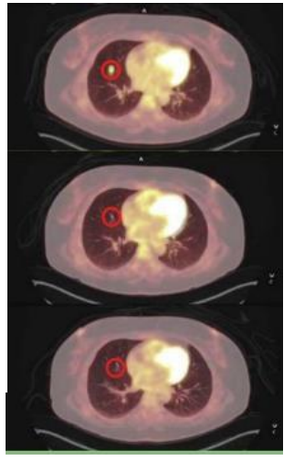
Patient Case #3 - Pembrolizumab + 30mg Efti (IMP321)

- 61-year-old male patient
- TxNxM1b at study entry in March 2018
- irPR reached by week 12 and maintained until end of study



Patient Case #4 - Pembrolizumab + 30mg Efti (IMP321)

- 46-year-old female patient
- TxNxM1c at study entry in August 2018
- Deep irPR reached by week 12 and maintained until end of study
- Residual tumor mass not metabolically active (complete metabolic response, CMR)
- PET-scans negative on two occasions, at the time of and after end of study



PET-Scans

← June 2018

← May 2019

← Aug 2019

Atkinson V, Khattak A, Haydon A, et al. Eftilagimod alpha, a soluble lymphocyte activation gene-3 (LAG-3) protein plus pembrolizumab in patients with metastatic melanoma. Journal for ImmunoTherapy of Cancer 2020;8:e001681. doi:10.1136/jitc-2020-001681

Novel Small Molecule Anti-LAG-3 Preclinical Program

Immutep aims to develop and commercialize an orally-available small molecule anti-LAG-3 treatment for cancer patients at a lower cost compared with anti-LAG-3 antibodies commercially available or under clinical development today.

"Our collaboration with Immutep has been exciting and fruitful, resulting in a number of small molecules with the potential to fight cancer by blocking the interaction between LAG-3 on T cells and MHC Class II on antigen-presenting cells. Small molecules represent the next generation of anti-LAG-3 therapies and hold tremendous promise, as they can be given to cancer patients as a convenient oral pill."

Professor Andrew Godkin, Theme Lead in Immunology in the College of Biomedical Life Sciences, Cardiff University*

* 25 June 2024, Immutep Signs Exclusive License Agreement with Cardiff University for Next Generation Anti-LAG-3 Molecules for Cancer

IMP761 & Summary

Targeting Autoimmune Disease with Immune Checkpoint Agonists

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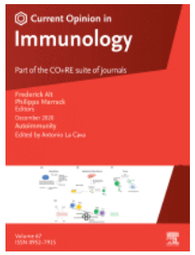


Inhibitory receptor agonists: the future of autoimmune disease therapeutics?

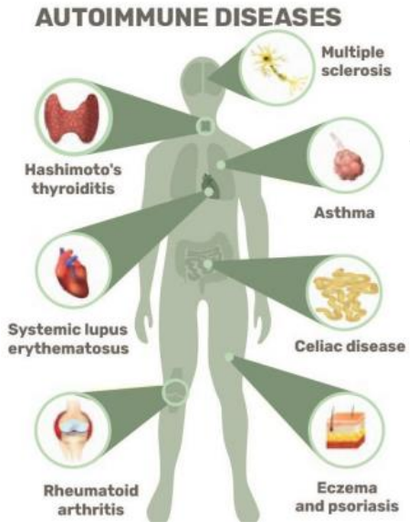
"Although critical questions remain, inhibitory receptor agonists represent an underappreciated and untapped opportunity for the treatment of autoimmune and inflammatory diseases"

From bench to bedside: targeting lymphocyte activation gene 3 as a therapeutic strategy for autoimmune diseases

"The manipulation of the LAG3 pathway can serve as a promising therapeutic strategy"

Fewer LAG-3^{+} T Cells in Relapsing-Remitting Multiple Sclerosis and Type 1 Diabetes

"These findings further support the potential clinical benefits of a LAG-3 agonist in the treatment of human autoimmunity"



Present Approaches Target the Symptoms of Autoimmune Diseases

Corticosteroids, methotrexate, TNF & interleukin inhibitors (anti-TNF-α,-IL-6, -IL-17, -IL-23 mAbs)

Future Approaches Target the Causes of Autoimmune Diseases

Targeting autoimmune effector T cells with immune checkpoint (e.g. LAG-3 and PD-1) agonists

1. Grebinoski S, Vignali DA. Inhibitory receptor agonists: the future of autoimmune disease therapeutics? Curr Opin Immunol. 2020 Dec;67:1-9. doi: 10.1016/j.coi.2020.06.001. Epub 2020 Jun 30. PMID: 32619929; PMCID: PMC7744338
2. Zhou, X., Gu, Y., Wang, H. et al. From bench to bedside: targeting lymphocyte activation gene 3 as a therapeutic strategy for autoimmune diseases. Inflamm. Res. 72, 1215–1235 (2023). https://doi.org/10.1007/s00011-023-01742-y
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Competitive Landscape for Checkpoint Agonists

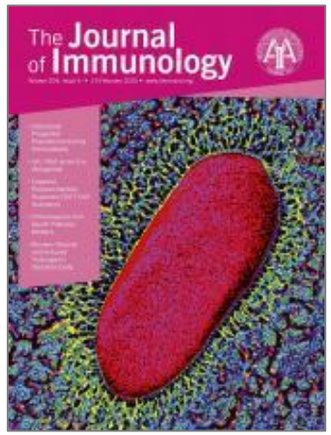
Immune Checkpoint / Checkpoint Receptor Agonists Targeting Autoimmune Diseases

Company	Program	Checkpoint / Checkpoint Receptor	Preclinical	Phase I	Phase II	Phase III
Lilly	Peresolimab	Programmed Cell Death Protein 1 (PD-1)				
AnaptysBio	Rosnilimab	Programmed Cell Death Protein 1 (PD-1)				
Johnson&Johnson	JNJ-4703	Programmed Cell Death Protein 1 (PD-1)				
GILEAD	GS-0272	Programmed Cell Death Protein 1 (PD-1)				
SANTA ANA BIO	SAB03	Programmed Cell Death Protein 1 (PD-1)				
Otsuka Pharmaceutical Co., Ltd.	N/A	Programmed Cell Death Protein 1 (PD-1)				
AnaptysBio	ANB032	B and T Lymphocyte Attenuator (BTLA)				
GILEAD	GS-0151	B and T Lymphocyte Attenuator (BTLA)				
avalo THERAPEUTICS	AVTX-008	B and T Lymphocyte Attenuator (BTLA)				
immutep LAG-3 IMMUNOTHERAPY	IMP761	Lymphocyte Activation Gene-3 (LAG-3)				

Immutep is uniquely positioned with IMP761, a first-in-class, clinical-stage LAG-3 agonist antibody

Sources: clinicaltrials.gov and respective company pipelines, websites, and presentations

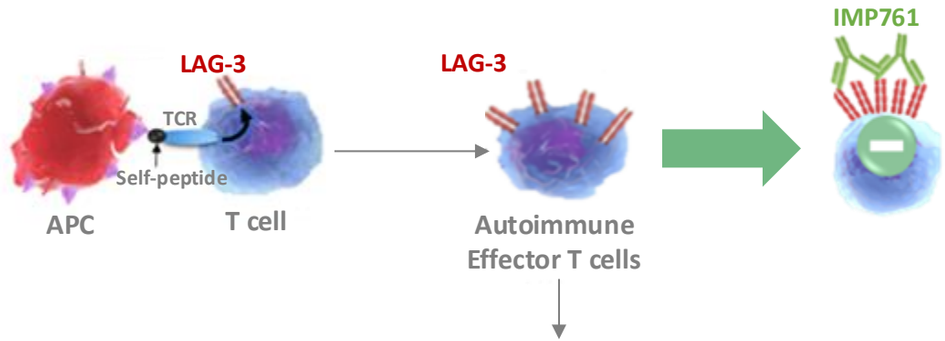
IMP761: First-in-Class LAG-3 Agonist is a Potential Game-Changer



IMP761 *- A LAG-3-Specific Agonist Antibody for the Treatment of T Cell-Induced Autoimmune Diseases*

IMP761 *- Juvenile idiopathic arthritis: LAG-3 is a central immune receptor in children with oligoarticular subtypes*

IMP761 is the world's first immunosuppressive LAG-3 agonist antibody that is designed to address the underlying cause of many autoimmune diseases. This potential game-changer in the treatment landscape received regulatory clearance in July 2024 and enrolled its first participant in August 2024.



IMP761 increases natural LAG-3-mediated down-regulation of auto-reactive memory T cells (root cause of many diseases)

Epigenetic reprogramming leads to T cell helper (Th) induced Autoimmune Diseases such as Rheumatoid Arthritis (Th1), Allergic Asthma (Th2), IBS (Th17), etc.

* 17 July 2024, Immutep Receives Regulatory Clearance for Phase I Study of First-in-Class LAG-3 Agonist Antibody Designed to Treat Autoimmune Diseases

Clinical Development of IMP761

Leading World-Call Research Institute Appointed to Conduct First-in-Human Study

Key aspects:

- Placebo-controlled, double-blind Phase I (N = 49)
- Centre for Human Drug Research (CHDR) has been selected for conduct
- First participant enrolled in August 2024
- First data expected in CY2024; study completion 2025
- Read-out: Safety, PK, Dose response through PD model
- GMP manufacturing process at 200L scale

Single Ascending Dose (SAD): Healthy volunteers

Part A: Healthy N=5 Cohort 1-SAD-A : 3 Subjects 0.0075 mg/kg + 2 placebo	FIH Microdosing	Single IV	
Part B: Healthy N=30 Cohort 2-SAD-B : 4 Subjects 0.03 mg/kg + 1 placebo Cohort 3-SAD-B : 4 Subjects 0.1 mg/kg + 1 placebo Cohort 4-SAD-B : 8 Subjects 0.3 mg/kg + 2 placebo Cohort 5-SAD-B : 8 Subjects 0.9 mg/kg + 2 placebo	3x KLH immunization, DTH	PK/PD	Single IV

Multiple Ascending Dose (MAD): Healthy volunteers

Part C: Healthy N=14. 3 dosing (3 months) Cohort 6-MAD-C : 5 Subjects 0.3 mg/kg + 2 placebo Cohort 7-MAD-C : 5 Subjects 0.9 mg/kg + 2 placebo	PK	Multiple (Q4W) IV

CHDR Centre for Human Drug Research

- World-class institute in Leiden, the Netherlands specializing in cutting-edge early-stage clinical drug research.
- CHDR offers a unique keyhole limpet haemocyanin (KLH) challenge model that allows for the evaluation of IMP761's pharmacological activity at the earliest stages of clinical development.

Board and Management

Dr Russel Howard

Non-Executive Chairman

Dr Howard has over 45 years' experience in Australian & US biotech sectors, including the Walter & Eliza Hall Institute, Schering-Plough, GSK and as Maxygen CEO. He currently is Chairman of NeuClone Pty Ltd and a former Director of Circadian Technologies Ltd.

Pete Meyers

Deputy Chairman

Mr Meyers spent 18 years in health care investment banking before taking on CFO roles in biotechnology including Eagle Pharmaceuticals, Motif BioSciences and TetraLogic Pharmaceuticals. Most recently he was CFO of Slayback Pharma, a KKR portfolio company acquired in Sept 2023.

Lis Boyce

Non-Executive Director

Ms Boyce has over 30 years' experience as a corporate lawyer and is a partner at Piper Alderman. She has a strong focus on Life Sciences and Healthcare, and is deputy chair of AusBiotech's AusMedtech Advisory Group, as well as a member of AusBiotech's State Committee for NSW.

Anne Anderson

Non-Executive Director

Ms Anderson's executive career of over 35 years spanned the global financial services and energy sectors, holding several Managing Director roles with UBS Asset Mgt, including leading its Asia Pacific Fixed Income business. She is a non-executive director of a leading Australian wealth manager, BTFM.

Marc Voigt

Executive Director & CEO

Mr Voigt has over 25 years of experience in the corporate and biotechnology sectors, including Deutsche Life Science, Revotar Biopharmaceuticals AG, Medical Enzymes AG and Allianz. He was appointed as CEO and Executive Director in July 2014. Mr Voigt is based in Berlin.

Prof. Frédéric Triebel, MD, PhD

Executive Director, CSO

Prof Triebel discovered the LAG-3 gene while working at the Gustave Roussy Institute and is a pioneer in the LAG-3 field of immuno-oncology. He was the founder of Immutep S.A., which was acquired by the Company in 2014. Based in Paris, he holds a Ph.D. in immunology (Paris University).

Deanne Miller

COO, General Counsel

Ms Miller has broad commercial experience having held legal, investment banking, regulatory compliance and tax advisory positions at RBC Investor Services, Westpac Group, Macquarie Group, the Australian Securities and Investment Commission, and KPMG.

Florian Vogl, MD, PhD

Chief Medical Officer

Dr Vogl is a board-certified MD and has over 13 years in the biopharmaceutical industry with extensive clinical development expertise in the field of oncology in the Europe and the US through roles at Cellestia Biotech, Rainier Therapeutics, Novartis and Amgen.

Christian Mueller

SVP, Strategic Development

Mr Mueller has +10 years of clinical development experience in oncology, including at Medical Enzymes AG focusing on therapeutic enzymes for cancer treatment and at Ganymed Pharmaceuticals AG developing ideal mAbs in immune oncology.

Claudia Jacoby, PhD

Director of Manufacturing

Dr Jacoby has +15 years of biotech industry experience with extensive skills in protein expression and purification as well as in analytical and preclinical development from her various positions at preclinical and clinical-stage pharmaceutical companies.

James Flinn, PhD

IP & Innovation Director

Dr Flinn is an Australian Patent Attorney with +25 years of professional experience in building and managing IP portfolios, including GSK, two US-based pharmaceutical companies, a major Australian retailer, and a Melbourne Patent Attorney firm.

David Fang

Finance Director

Joining Immutep in 2018, Mr Fang has over 12 years of accounting and auditing experience across various industries including biotechnology, manufacturing and healthcare including Group Finance Manager of Kazia Therapeutics Limited and auditor at PWC.

Outlook

Milestones & Catalysts Ahead

- **Non-Small Cell Lung Cancer –** TACTI-004 preparations for study start with FPI in late 2024 / early 2025
- **Non-Small Cell Lung Cancer –** Update from triple combo INSIGHT-003 trial
- **Head and Neck Squamous Cell Carcinoma –** Additional data will be presented in H2 CY2024
- **Soft Tissue Sarcoma –** Update from investigator-initiated EFTISARC-NEO study
- **Metastatic Breast Cancer –** Update from AIPAC-003 study evaluating 90mg vs 30mg efti dosing
- **Metastatic Urothelial Carcinoma –** Update from investigator-initiated INSIGHT-005 study
- **Autoimmune Diseases –** First participant enrolled in Phase I of IMP761; safety data anticipated by year-end & PK/PD data in H1 CY2025
- **Other indications –** Updates from partnered programs and potential expansion of clinical trial pipeline
- **Cash Balance –** Cash, cash equivalent and term deposit position totalling ~A$181.8 million (~US$118.7 million)[1] providing runway to end of calendar year 2026

1. As at 30 June 2024

immutep

LAG-3 IMMUNOTHERAPY

Thank You