

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

Forward-Looking Statements

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Deep LAG-3 Pipeline in Oncology & Autoimmune Diseases

	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 MERCK MERCK IKF Merck KGaA Darmstadt, Germany IKF Narodowy Instytut Onkologii EOC CARDIFF UNIVERSITY	 LAG-3 IMMUNOTHERAPY Global Rights ex-China
		1L Head & Neck Squamous Cell Carcinoma (HNSCC)	TACTI-003 Efti + Pembrolizumab ^a						
		1L NSCLC, 2L HNSCC, PD-X Refractory 2L NSCLC	TACTI-002 Efti + Pembrolizumab ^a						
		1L Non-Squamous NSCLC	INSIGHT-003 Efti + Pembrolizumab + Chemo [§]						
		Urothelial Cancer	INSIGHT-005 Efti + Avelumab ^{§, b}						
		Soft Tissue Sarcoma	EFTISARC-NEO Efti + Pembro + Radiotherapy [§]						
		HR+/HER2- Metastatic Breast Cancer & TNBC	AIPAC-003 Efti + Paclitaxel						
Metastatic Breast Cancer & Solid Tumors	Efti + Paclitaxel and Efti + Pembrolizumab ^{##}								
	Anti-LAG-3 Small Molecule	Undisclosed						EOC Efti China Rights Global Rights	
	LAG525 Anti-LAG-3 Antibody	Solid Tumors & Blood Cancer Triple Negative Breast Cancer Melanoma Solid Tumors Triple Negative Breast Cancer						NOVARTIS Global Rights	
AUTOIMMUNE DISEASE	IMP731* Depleting LAG-3 Antibody	Ulcerative Colitis Psoriasis Healthy Subjects						 LAG-3 IMMUNOTHERAPY Global Rights	
	IMP761** Agonist LAG-3 Antibody	Undisclosed							

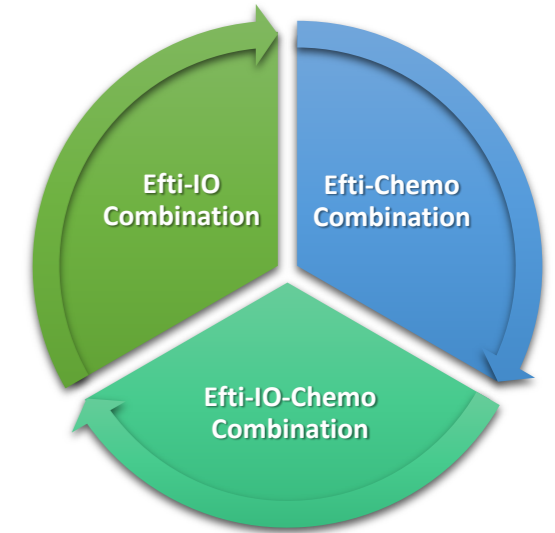
Information current as of September 2024. For EOC's China rights, Immutep may receive undisclosed milestones plus royalties; LAG525 (ieramilimab)- ClinicalTrials.gov (for Novartis' global rights, Immutep may receive milestones plus royalties); Immutep has no control over the trials. § Investigator Initiated 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.

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

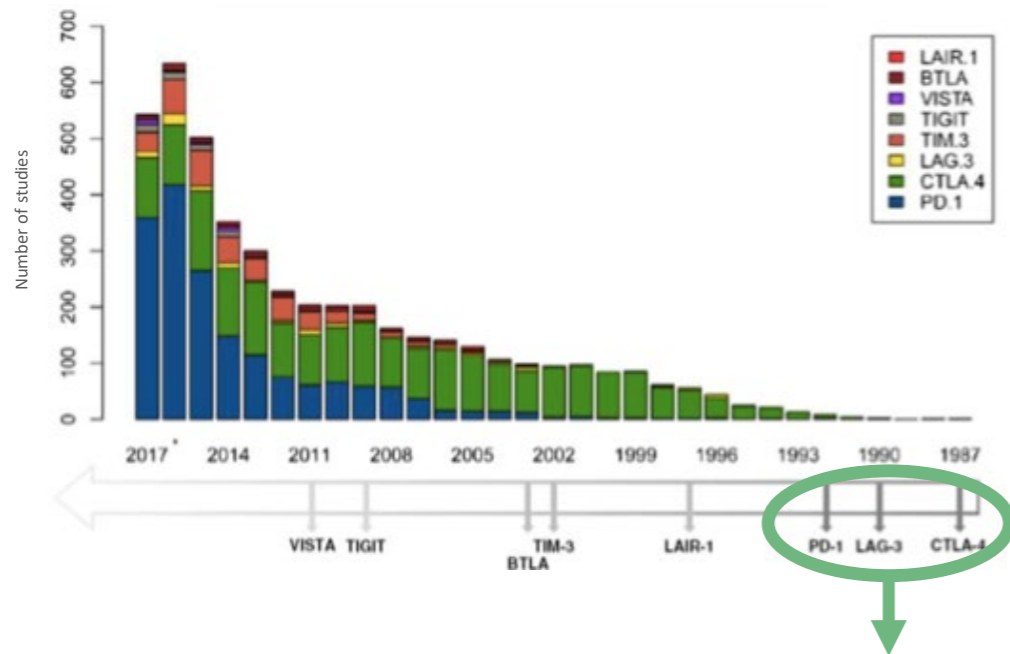


Strong IP/Balance Sheet:

- **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

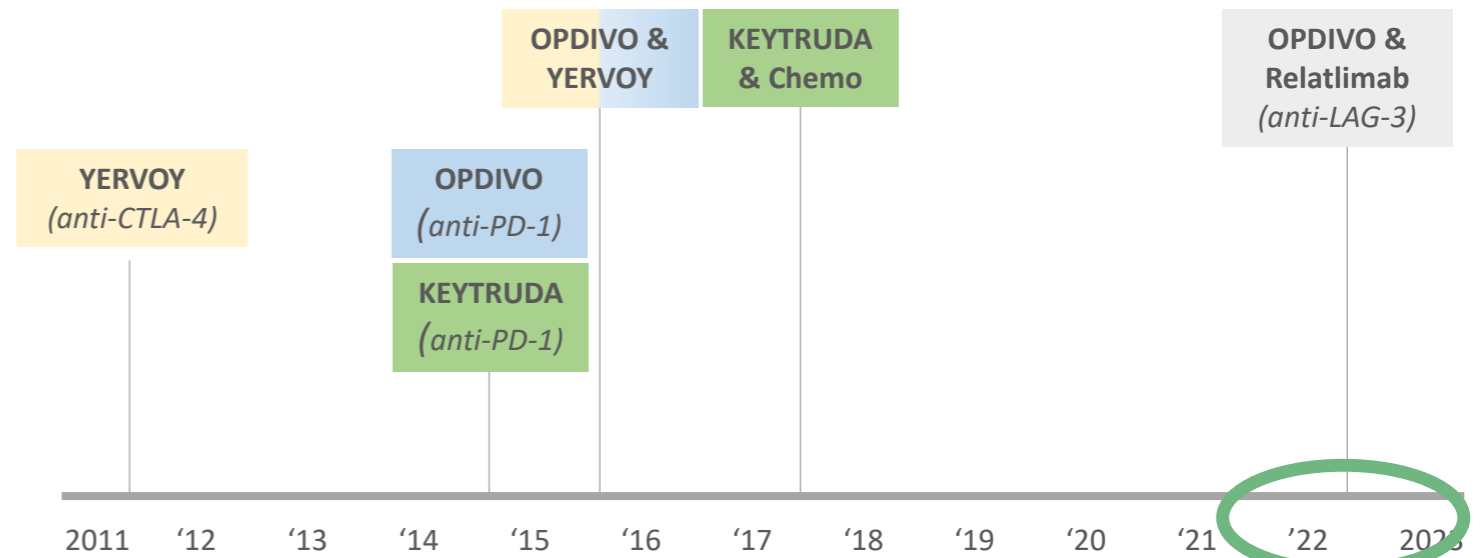
LAG-3 Newest Entrant to Immuno-Oncology (IO) Landscape

Immune Checkpoint Discovery and Clinical Studies*



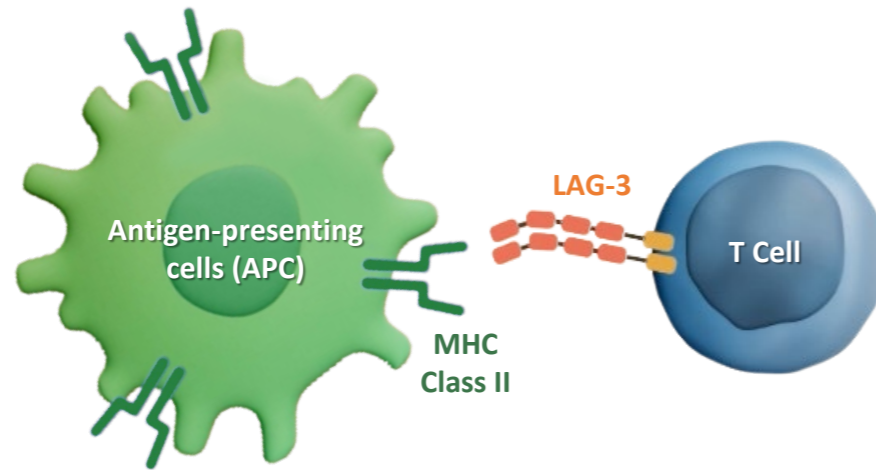
LAG-3 discovered in 1990 by ImmuteP's Chief Scientific Officer, Dr. Frédéric Triebel

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



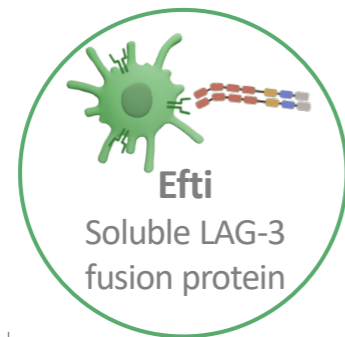
The immune system's ability to fight cancer has led to regulatory approval of IO therapies targeting the immune checkpoints **CTLA-4**, **PD-1**, and most recently **LAG-3**

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#



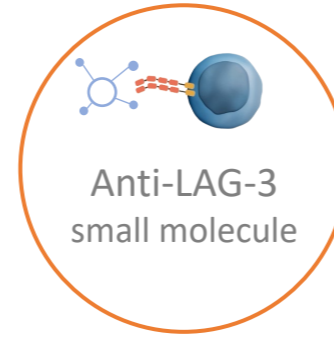
Oncology
Immune Stimulation

Targeting LAG-3 on T cells

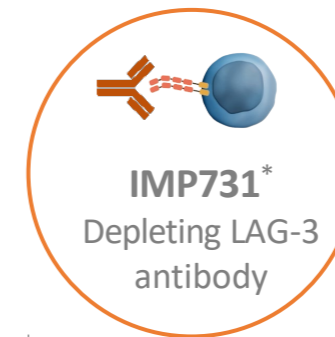


LAG525*
Blocking LAG-3
antibody

Oncology
Immune Stimulation

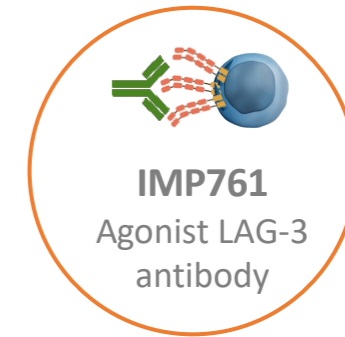


Anti-LAG-3
small molecule



IMP731*
Depleting LAG-3
antibody

Autoimmune Disease
Immune Suppression



IMP761
Agonist LAG-3
antibody

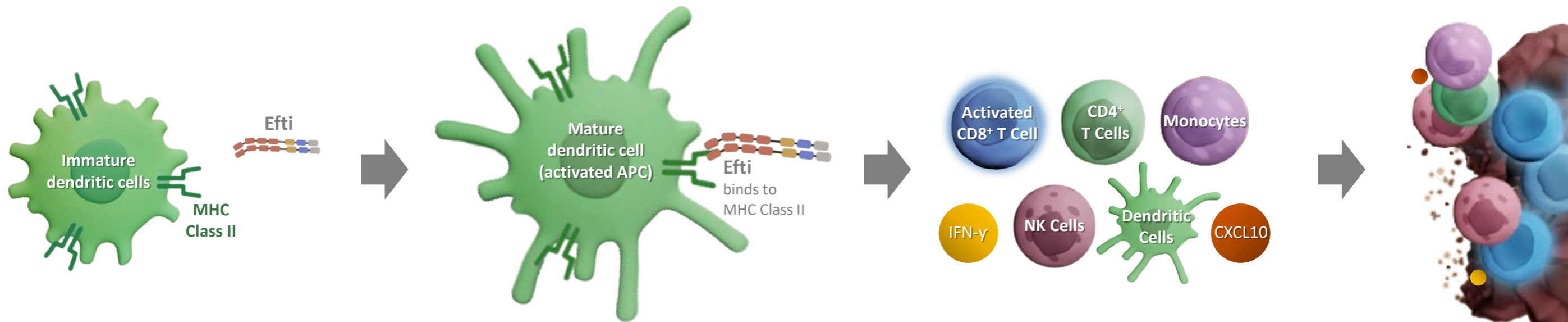
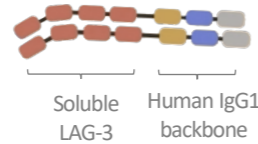
Efti

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

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)

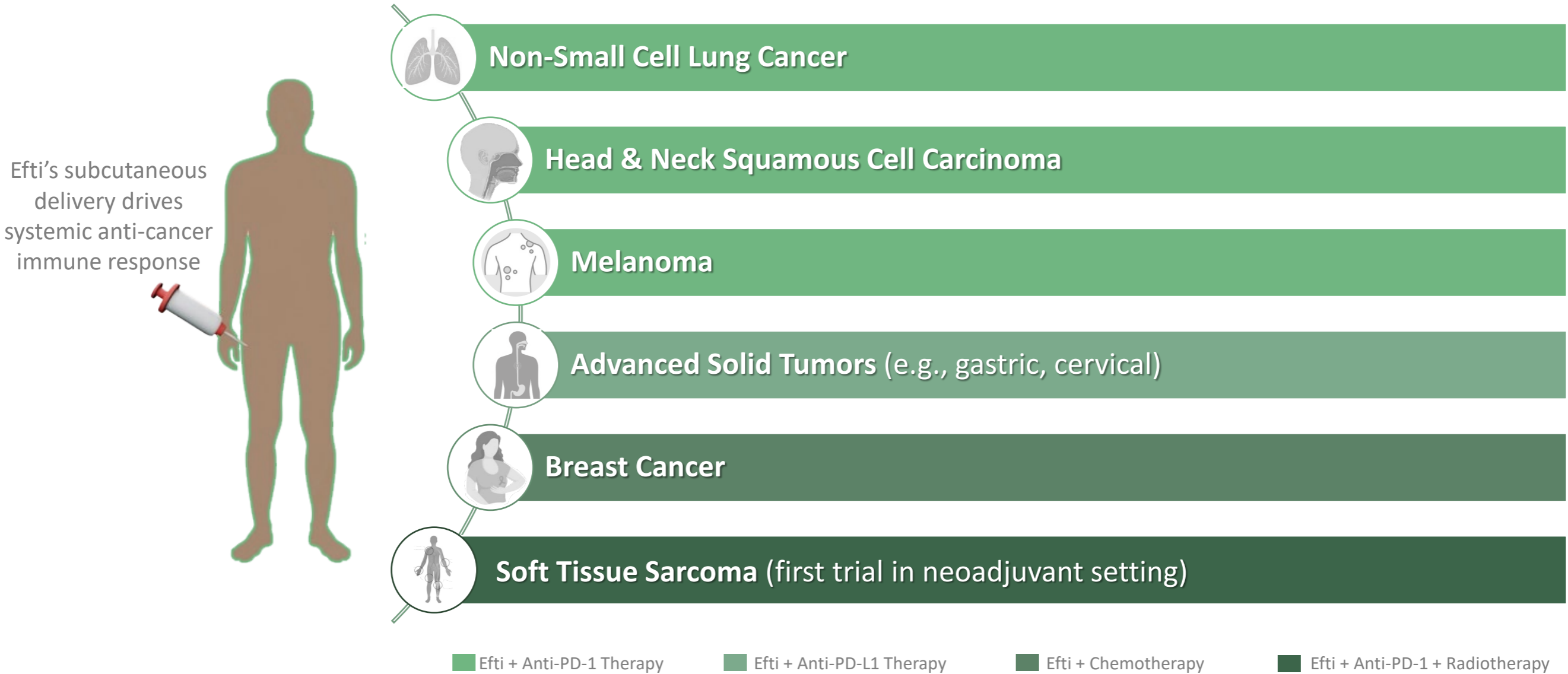


Efti's unique activation of APCs as an MHC Class II agonist drives a broad, sustained adaptive/innate immune response to fight cancer*

* 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.

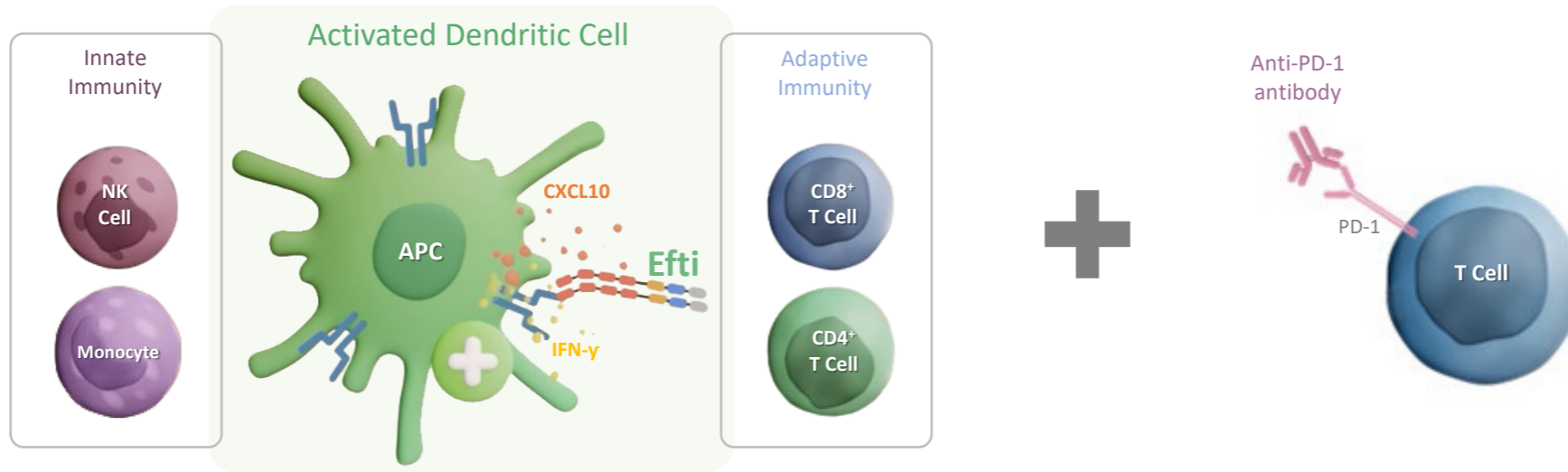
Systemic Immune Effect Leading to Positive Clinical Outcomes

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



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**



\$35+ Billion
in 2023 sales

Anti-PD-L1**



\$9+ Billion
in 2023 sales

Clinical Trials Target Large Addressable Markets

Non-Small Cell Lung Cancer (NSCLC)
drug market estimated at
US\$ 24 billion

HR+/HER2-/TNBC Breast Cancer
drug market estimated at
US\$ 12 billion

Head & Neck Cancer
drug market estimated at
US\$ 3 billion

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

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

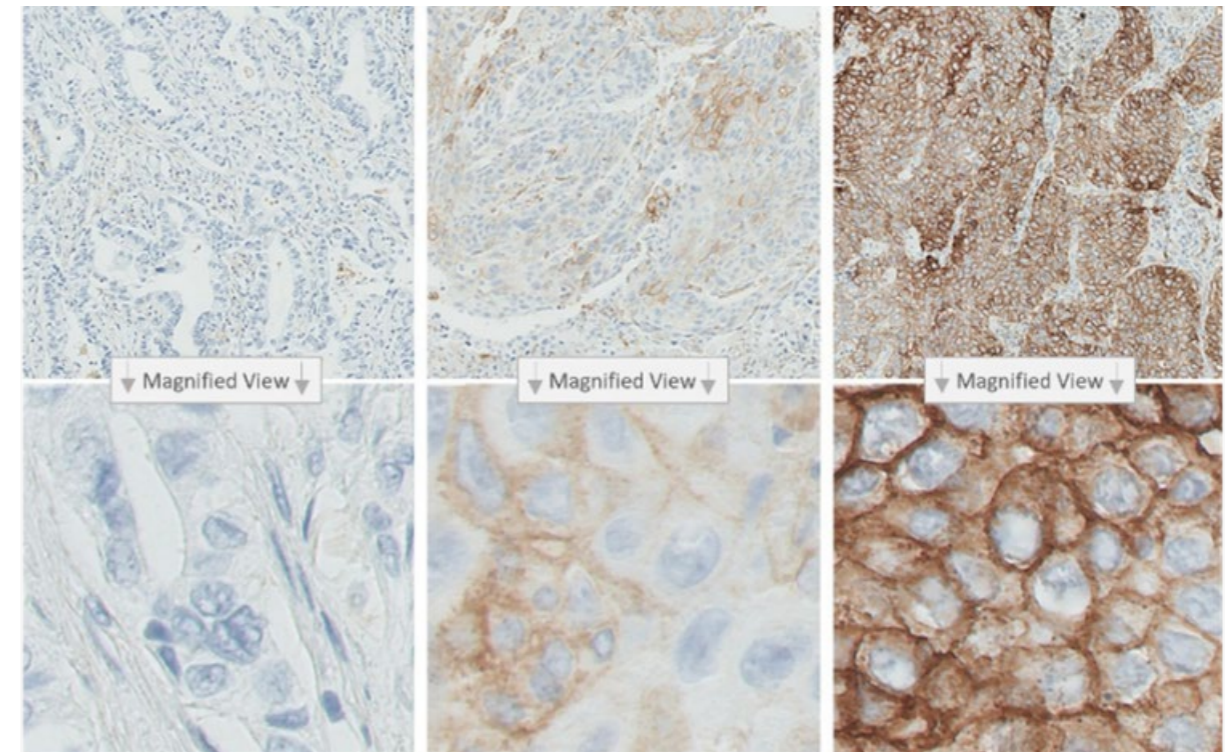
Total addressable NSCLC drug market expected to nearly double to US\$48 billion in 2031 and ICIs (including anti-PD-1 therapy) are expected to generate \$26 billion in sales³

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 $\geq 50\%$), 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 $\geq 50\%$)**



None approved in Europe or the US for patients with negative PD-L1 expression

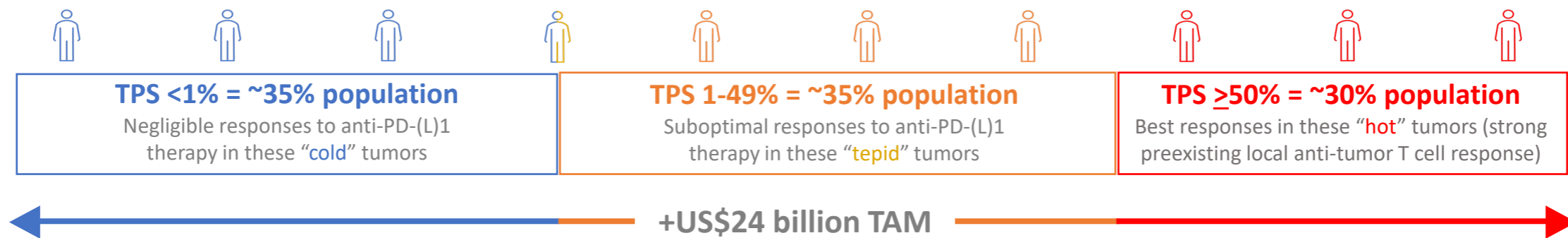
None approved in Europe and **two approved** in US for patients with low PD-L1 expression*

Three approved in both Europe and US for patients with high PD-L1 expression**

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



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)

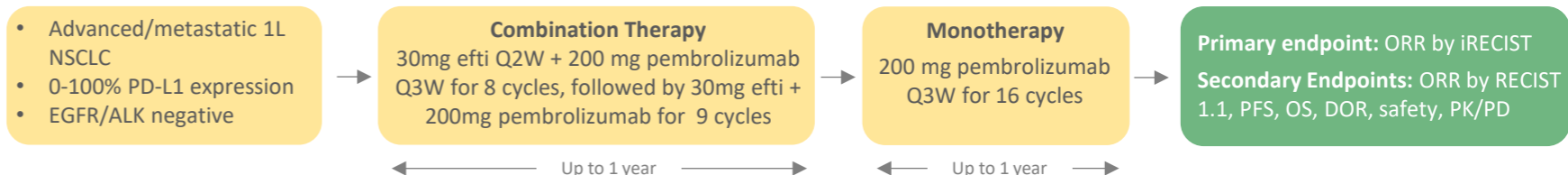
TACTI-002 (Part A) in 1L NSCLC

- 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 (%)	< 1%	Central only ¹ 32 (35.6)	Central + local ² 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



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.

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

LAG-3 IMMUNOTHERAPY

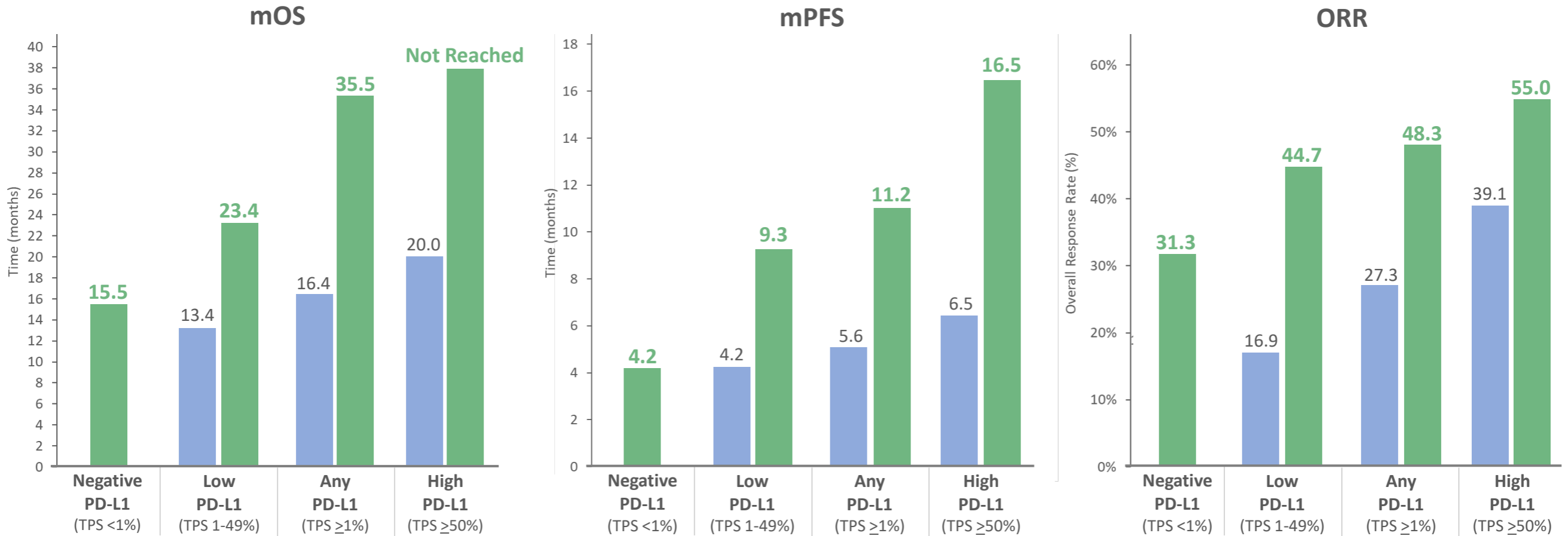
Tumor Response by PD-L1 Expression Level¹

	All-Comer	Negative PD-L1	Low PD-L1	Any PD-L1	High PD-L1
	TPS 0-100% N=114	TPS <1% N=32	TPS 1-49% N=38	TPS ≥1% N=58	TPS ≥50% N=20
ORR^{2,3,4}	40.4%	31.3%	44.7%	48.3%	55.0%
mPFS², months	6.6	4.2	9.3	11.2	16.5
mDoR², months	21.6	20.7	NR	24.2	18.7
mOS, months	20.2	15.5	23.4	35.5	Not Reached

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

Benchmarking to Pembrolizumab (KEYTRUDA®) Monotherapy



■ Efti + Pembrolizumab ■ Pembrolizumab monotherapy

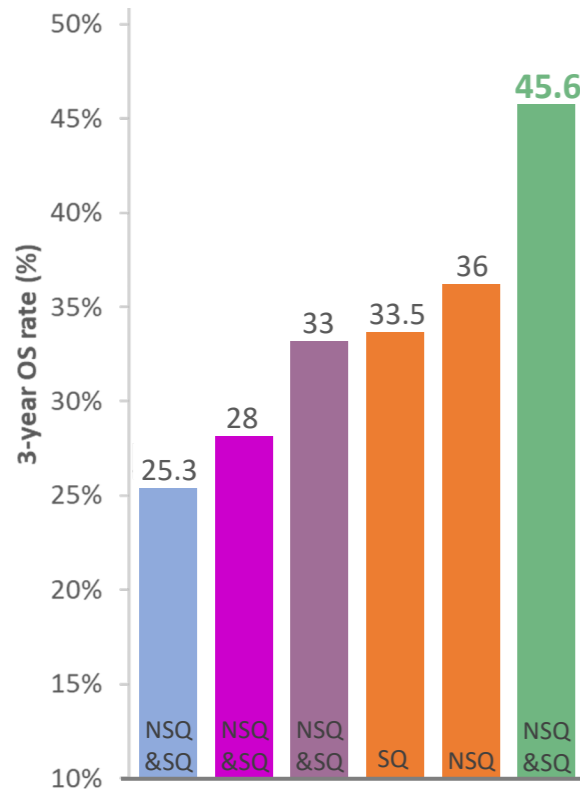
Robust median overall survival (mOS), median progression free survival (mPFS), and response rates (ORR) from efti plus pembrolizumab

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

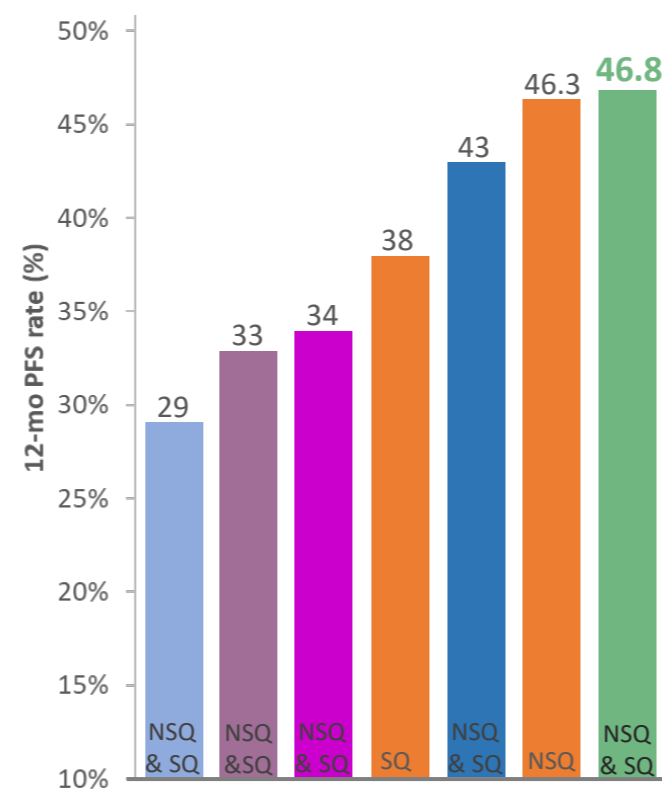
OS/PFS/ORR in negative PD-L1 (TPS <1%) patients compares well to pembrolizumab monotherapy in low PD-L1 (TPS 1-49%) patients

Exceptional Durability and Quality of Responses

3-Year OS Rate (TPS \geq 1%)



1-Year PFS Rate (TPS \geq 1%)



- 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

Chemotherapy-free IO

Efti + pembrolizumab

Nivolumab + ipilimumab

Pembrolizumab monotherapy

IO + Doublet Chemotherapy

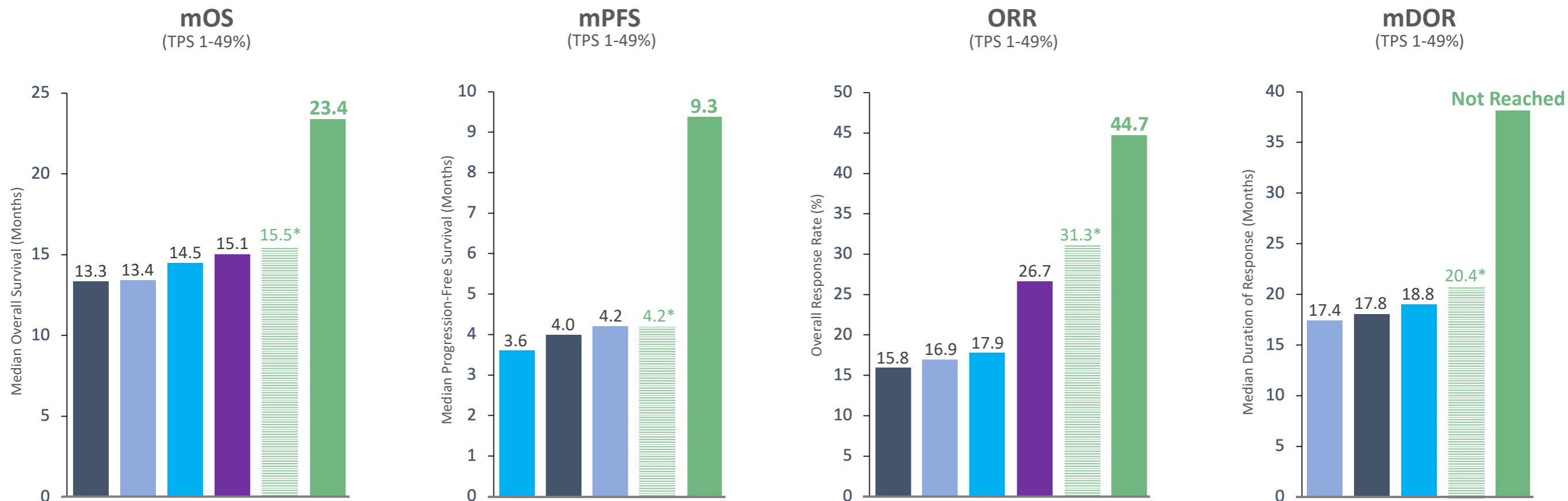
Pembrolizumab + doublet chemo

Nivolumab + ipilimumab + doublet chemo

Cemiplimab + doublet chemo

Differentiated Efficacy in Low & Negative PD-L1 Patients

Strong results in low & negative PD-L1 patients who collectively represent ~70% of the 1L NSCLC population



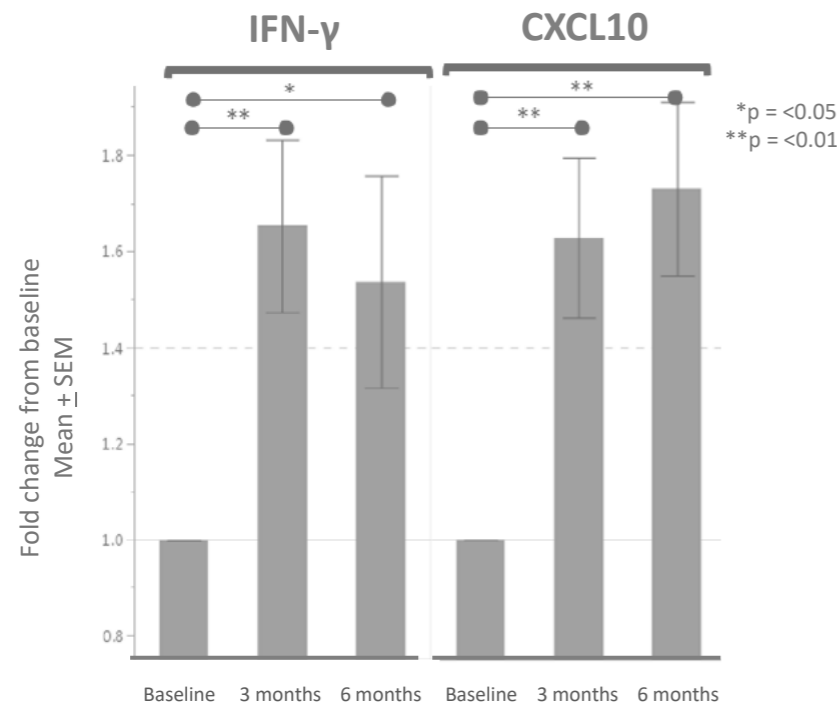
Chemotherapy-Free IO Therapies

- Pembrolizumab monotherapy
- Atezolizumab monotherapy
- Atezolizumab + Tiragolumab (anti-PD-L1)
- Efti + Pembrolizumab
- Efti + Pembrolizumab (TPS <1%)*
- Nivolumab + Ipilimumab (anti-PD-1) (anti-CTLA-4)

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%), yet addition of efti to ICI therapy leads to inline/superior results as shown above

Th1 Biomarker Data Linked to Improved Clinical Outcomes

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

“CXCL9 and CXCL10 bring the heat to tumors”³

Science Immunology

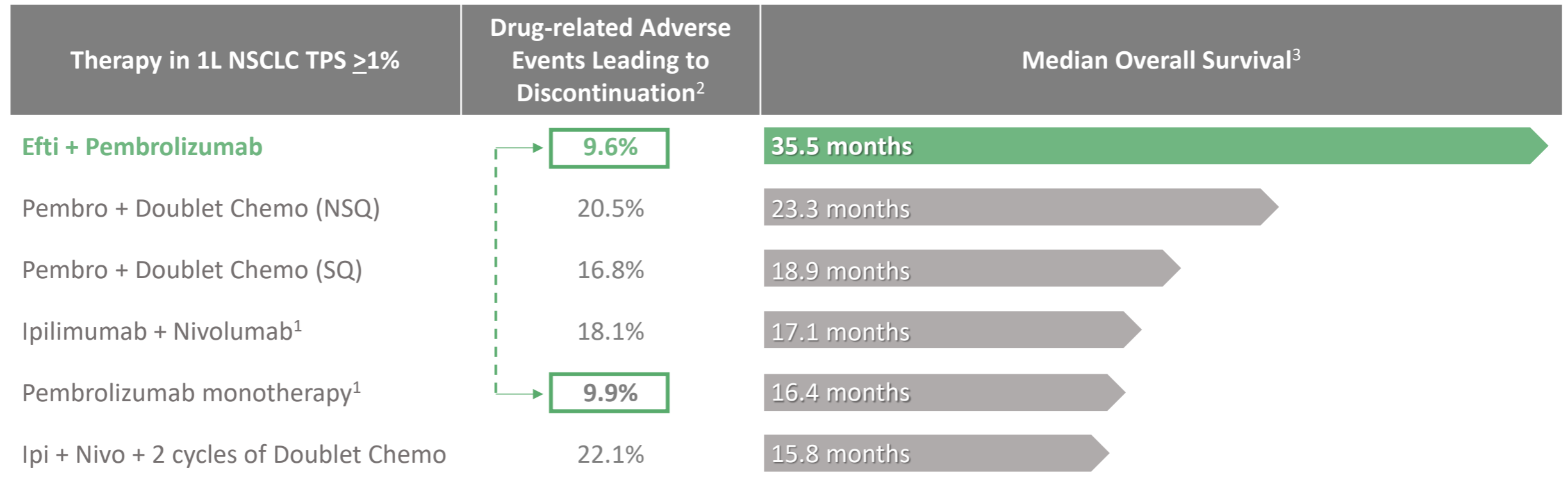
“...Chemokines CXCL9/10 are indispensable for robust responses to immune checkpoint inhibitors (anti-PD-1 and anti-CTLA-4)...”²

CLINICAL CANCER RESEARCH

“Circulating CXCL10 at baseline appeared to be a robust predictor of response.”⁴

Journal for Immunotherapy of Cancer

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



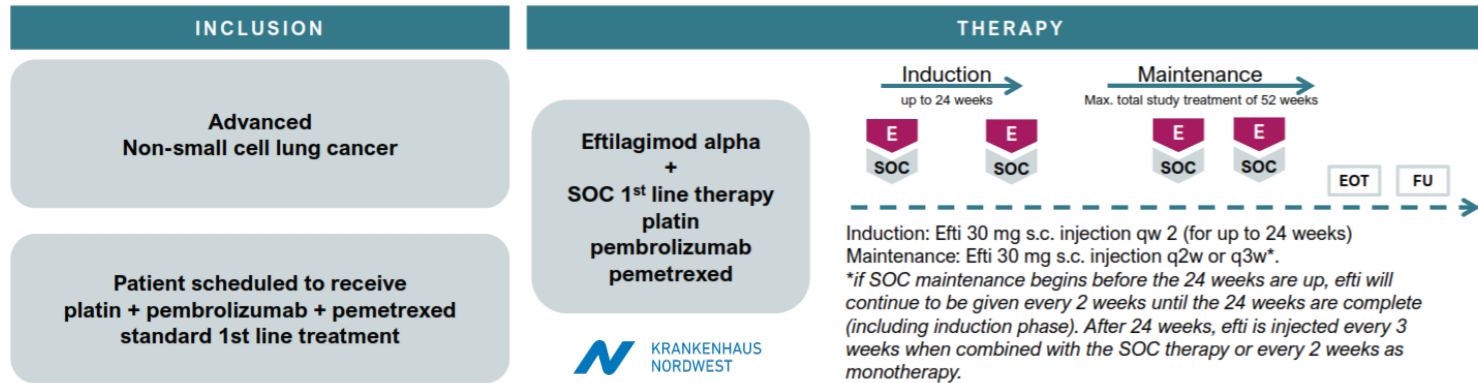
NSQ = Non-squamous; SQ = Squamous

23 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

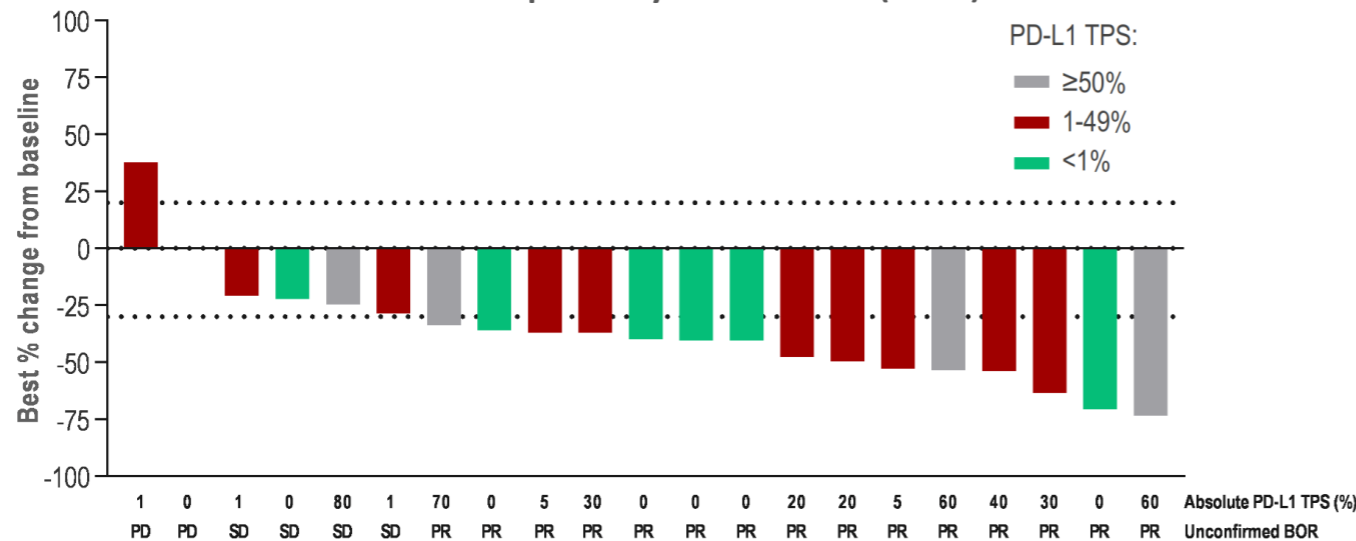
Promising initial efficacy & safety from first-in-human study evaluating Efti + KEYTRUDA + doublet chemo

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

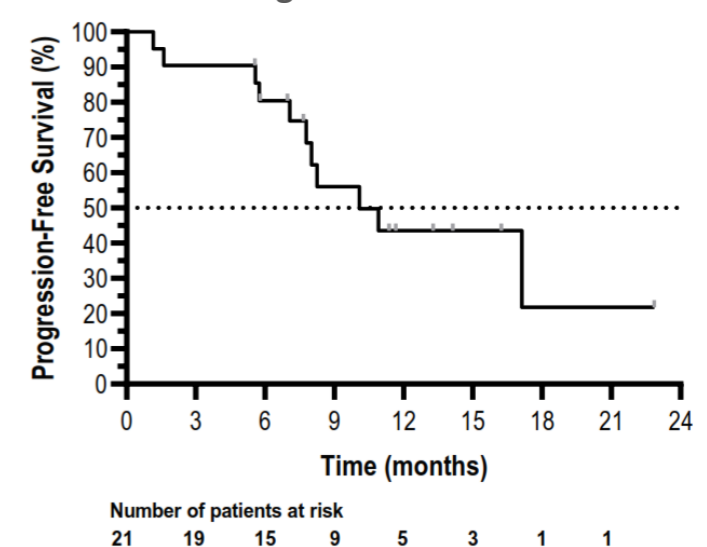


- Triple combination well tolerated and appears safe
- ~81% of patients have negative or low PD-L1
- At data cut-off, unconfirmed ORR of 71.4% (confirmed ORR of 66.7%)
- mPFS of 10.1 months and mOS not reached in ITT population (median follow up 12.4 months)

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



Progression-Free Survival

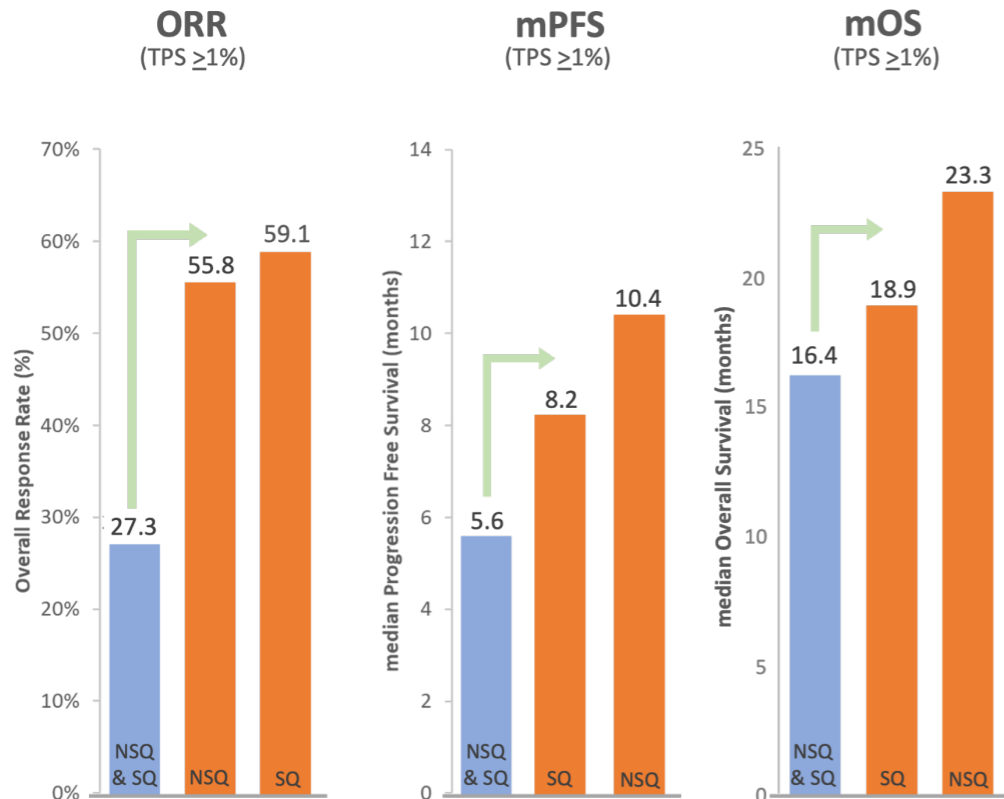


Chemotherapy is Additive to KEYTRUDA's Efficacy in 1L NSCLC

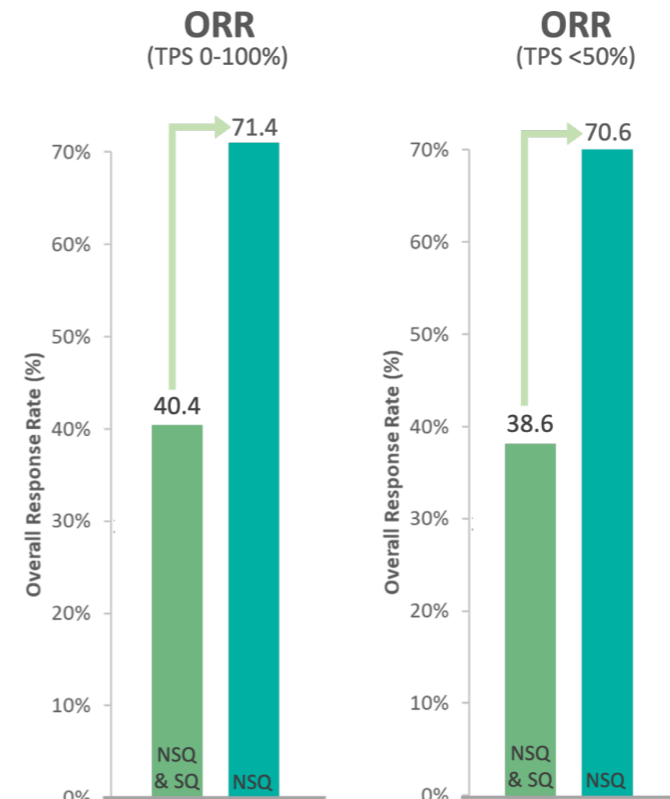
KEYTRUDA with Chemotherapy has Superior Efficacy versus KEYTRUDA Monotherapy in 1L NSCLC



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



■ KEYTRUDA monotherapy
■ KEYTRUDA + doublet chemo



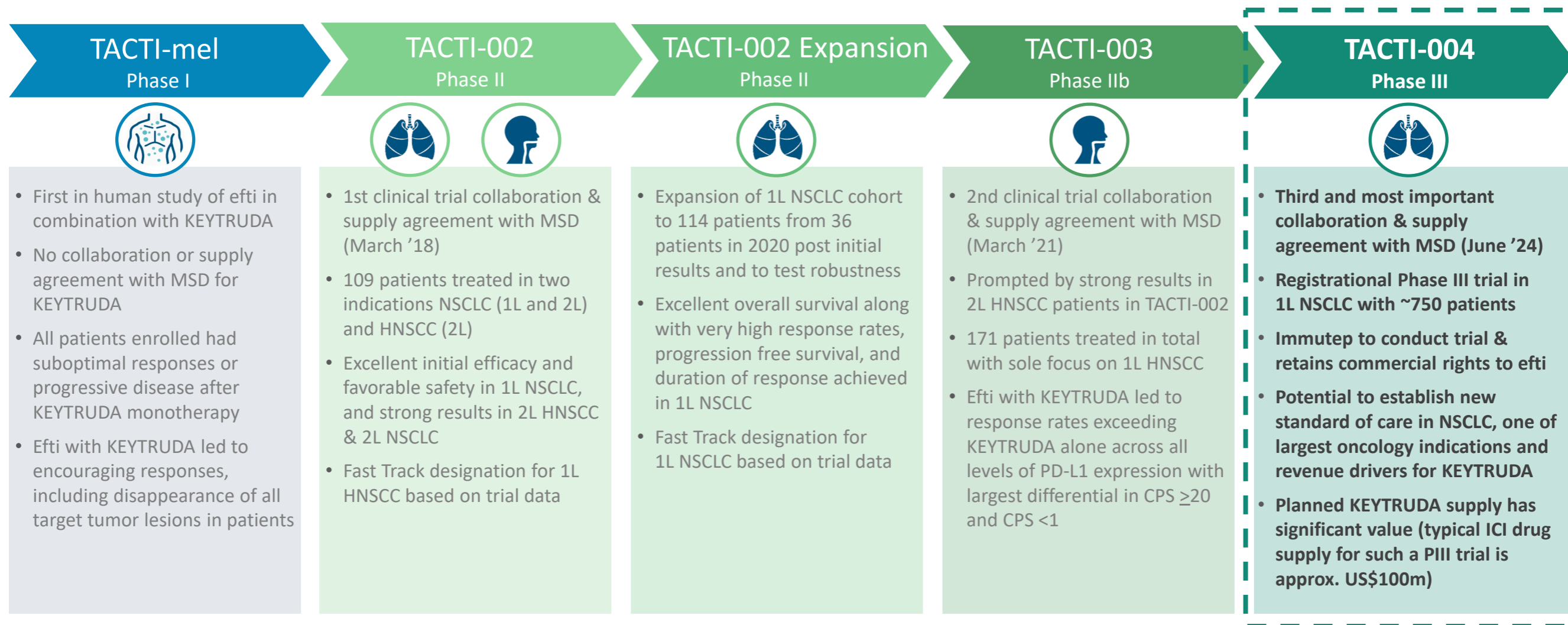
■ Efti + KEYTRUDA
■ Efti + KEYTRUDA + doublet chemo

- **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

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

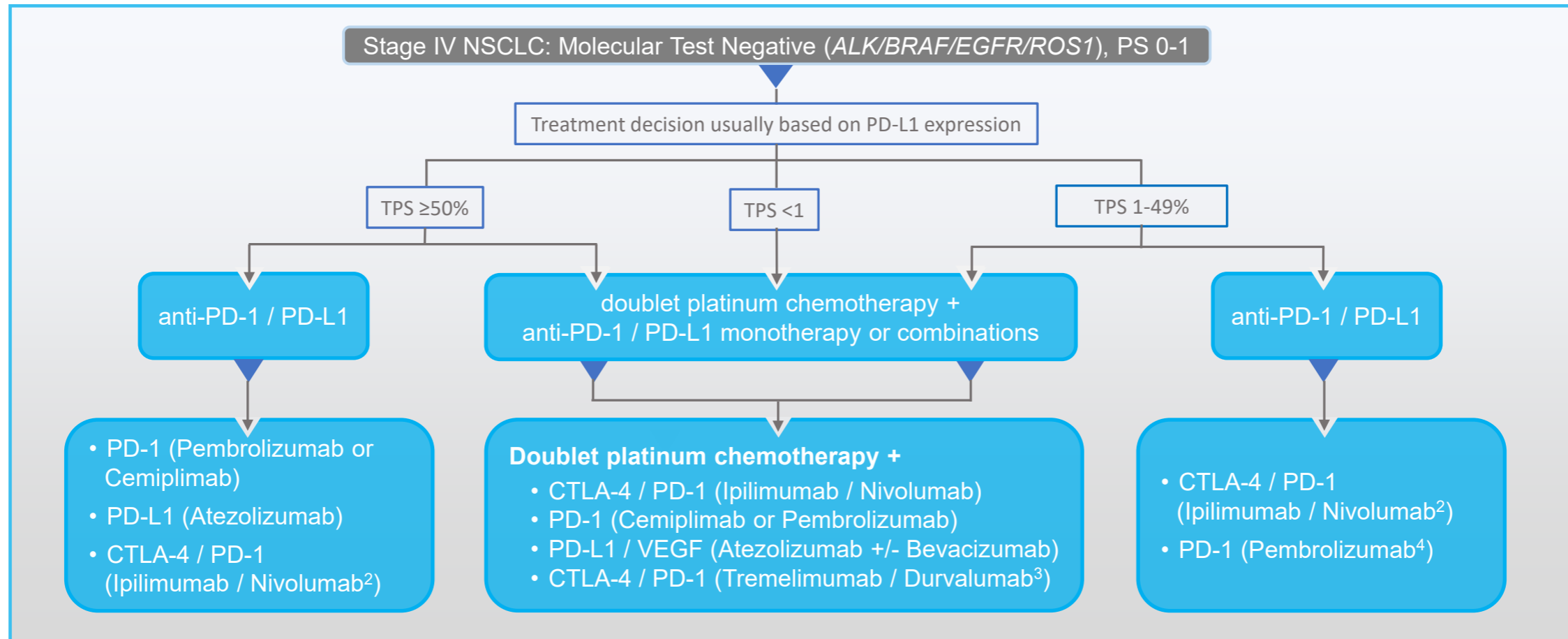
Evolution of Efti + KEYTRUDA® in Clinical Trials

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



Treatment Landscape 1st line NSCLC

IO-based approaches based on ESMO / NCCN (1)



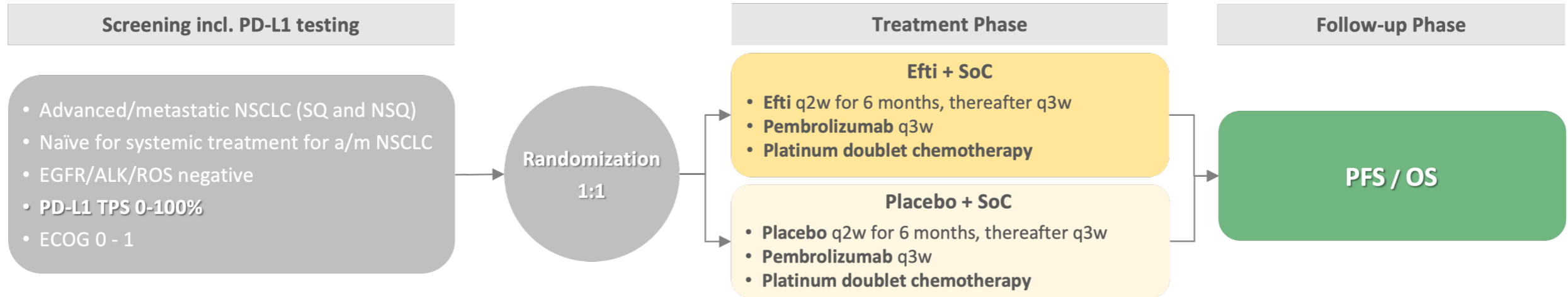
KEYTRUDA (pembrolizumab) and chemotherapy utilized across entire 1L NSCLC landscape, regardless of PD-L1 expression, which is the same patient population the efti + pembrolizumab + chemotherapy combination will be evaluated in.

(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:

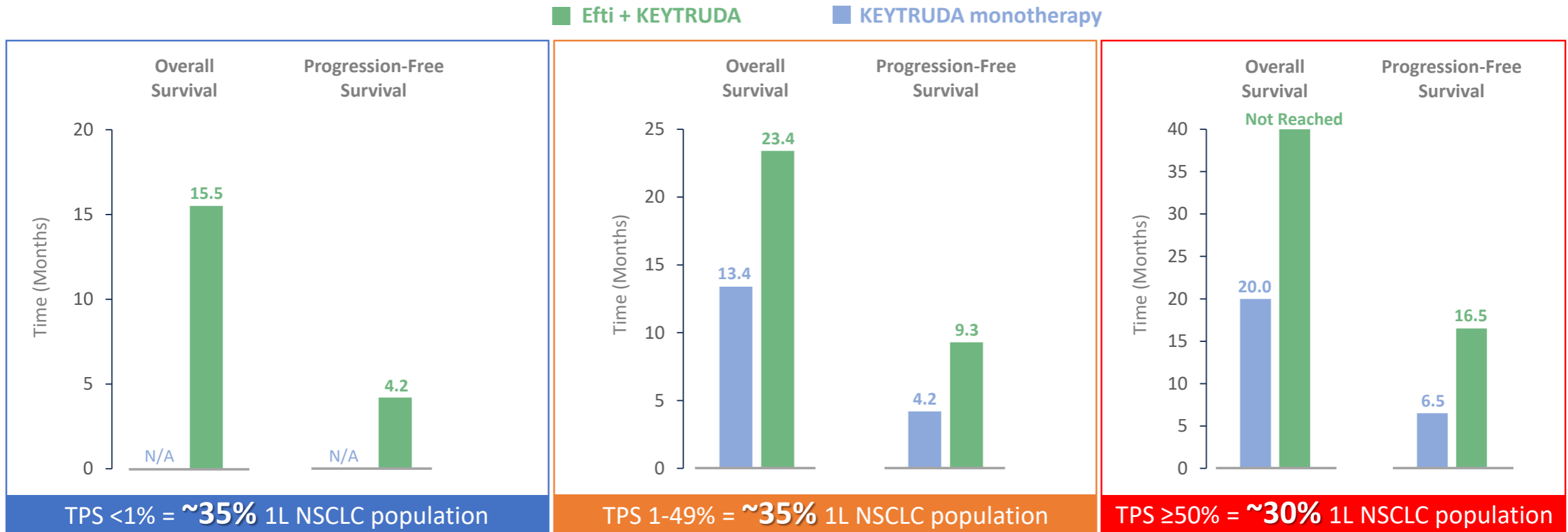
- TACTI-004 will be a 1:1 randomized, double-blind, multinational, controlled clinical study with ~750 patients
- Trial will enroll first line squamous and non-squamous NSCLC patients who are unselected for PD-L1 expression
- Dual primary endpoints will be Progression-Free and Overall Survival with both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

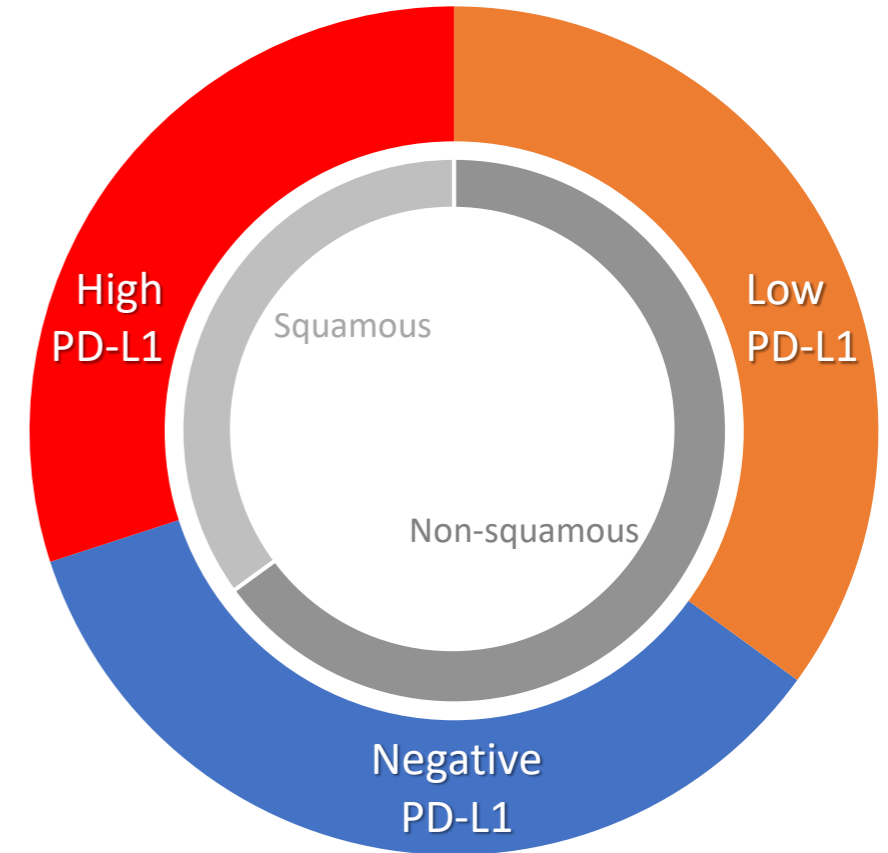
Strong Results in Dual Primary Endpoints (OS/PFS) Across All PD-L1 Expression Levels Drives Confidence in TACTI-004

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 efi + KEYTRUDA results in TACTI-002 & INSIGHT-003 trials across all three levels, including negative & low PD-L1, drives confidence in a potential positive outcome.



Uniquely Positioned Phase III in 1L NSCLC Landscape

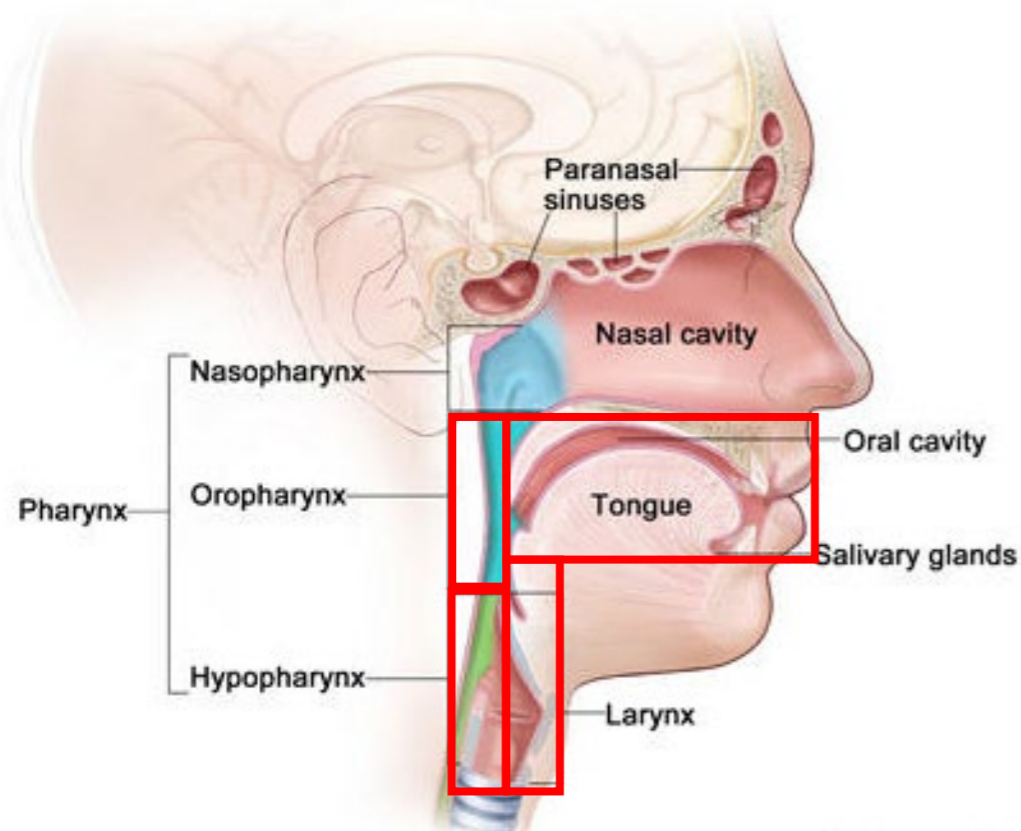
- KEYTRUDA has revolutionized the treatment landscape in lung cancer, and as a result MSD (Merck) captures between 7 to 8 of every 10 metastatic lung cancer patients today*
- Of KEYTRUDA's ~US\$25 billion in sales in 2023, it is estimated that ~US\$9 billion or +35% are from lung cancer**
- Efti in combination 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

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

Head and Neck Cancer Regions



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 worldwide¹
- Up to ~100,000 estimated to develop metastatic disease in 8MM countries²
- 5-year survival for metastatic HNSCC is 39.3%³ and varies depending on the anatomical site of cancer origin

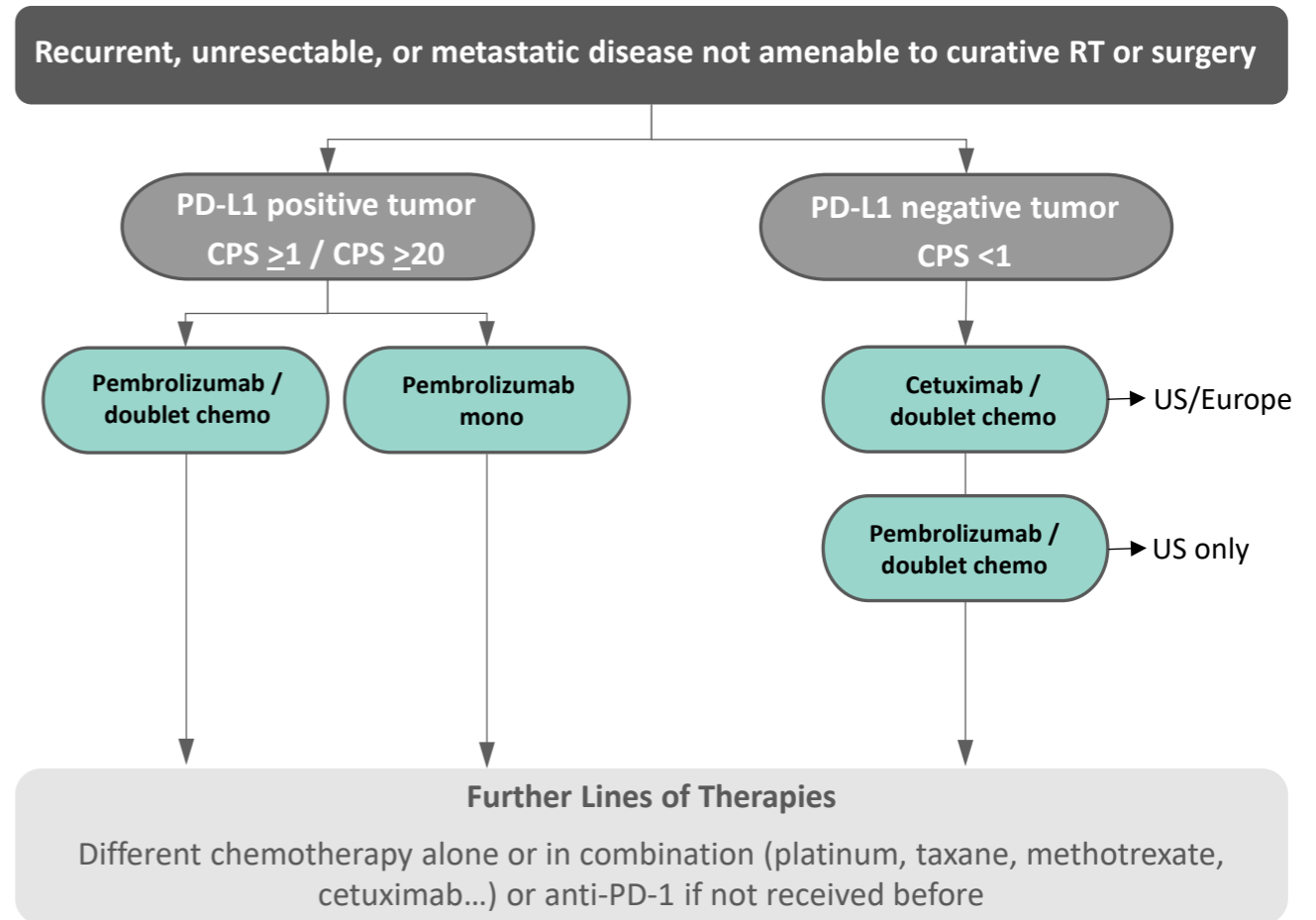
Treatment Landscape in 1L HNSCC

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 expression¹. 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)

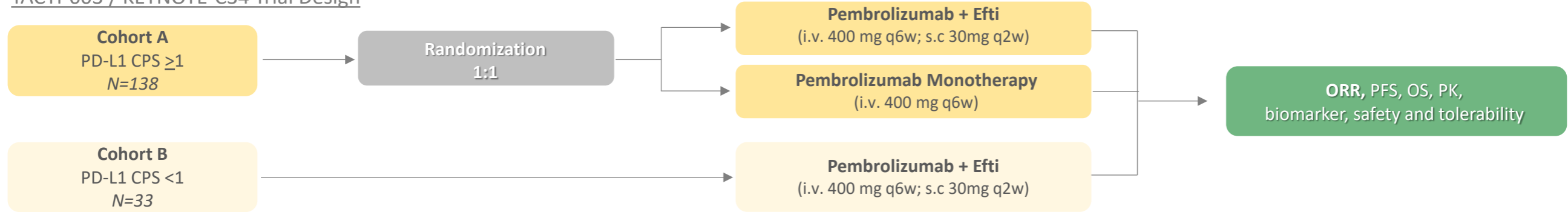


Simplified based on NCCN Guidelines Head and Neck Cancers and EHNS-ESMO-ESTRO Clinical Practice Guidelines

TACTI-003 Trial Overview

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

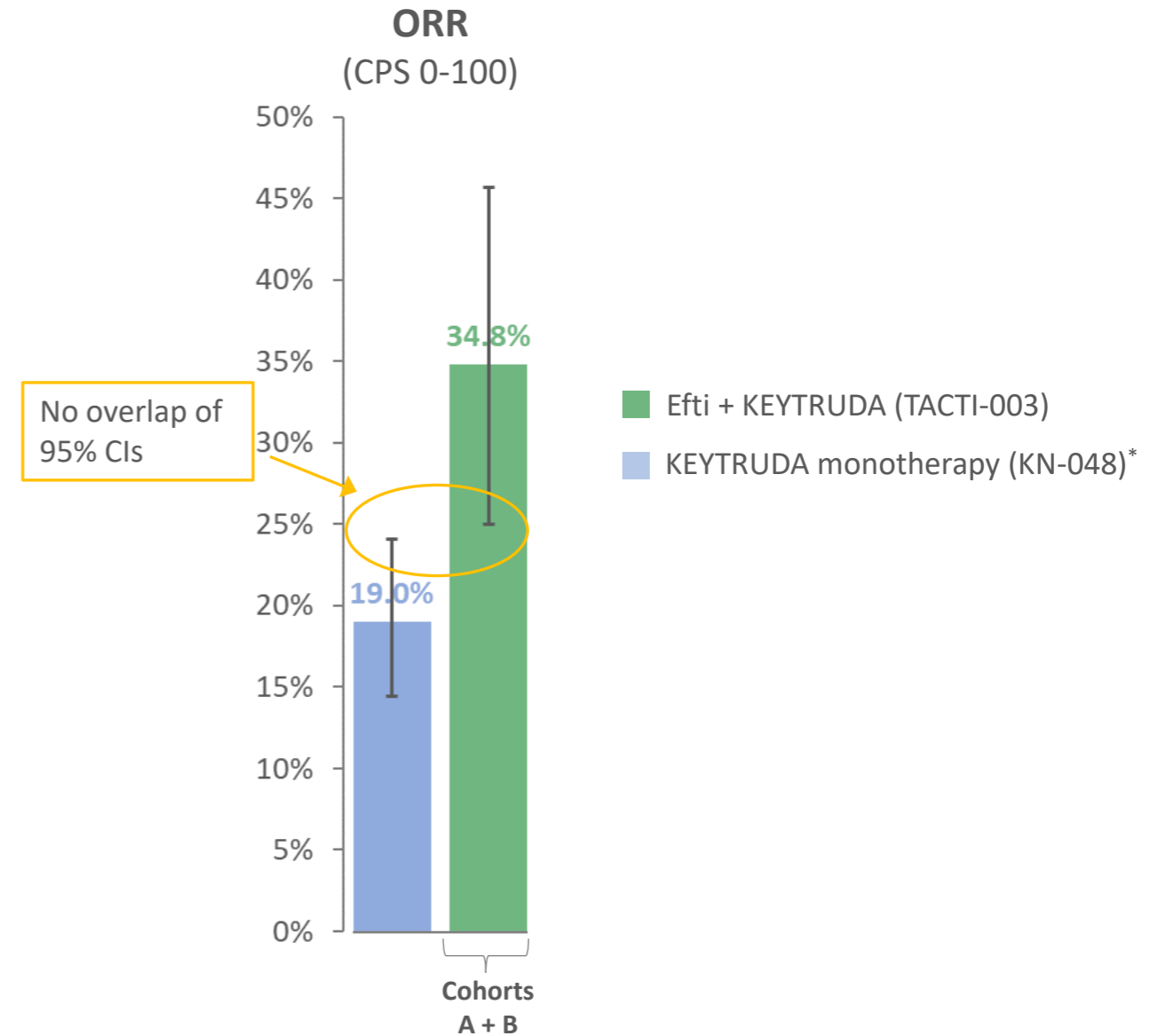
TACTI-003 / KEYNOTE-C34 Trial Design



- 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

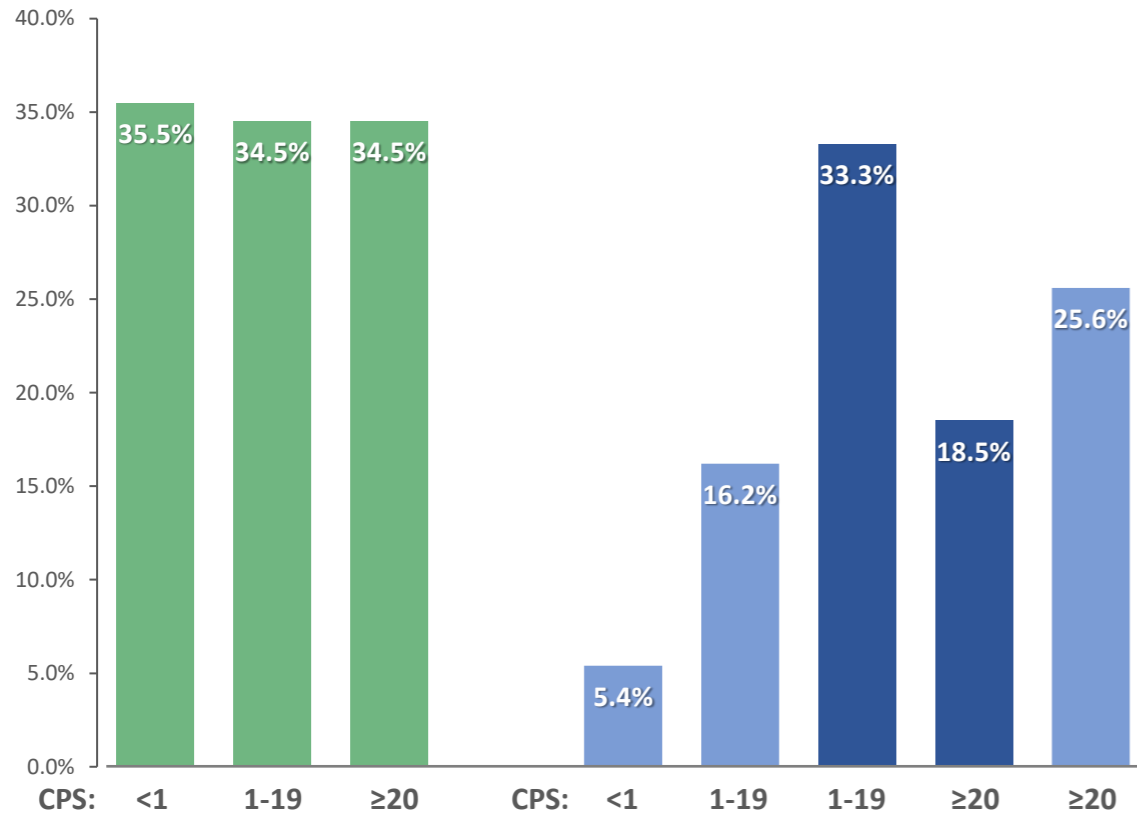
High Objective Response Rate (ORR) in TACTI-003 Trial

- In the total patient population (N=89) of TACTI-003 from Cohorts A (CPS ≥ 1) and B (CPS < 1), efti combined with KEYTRUDA delivered a substantially higher response rate of 34.8% compared to 19.0% for KEYTRUDA monotherapy from historical data in KN-048, which also included patients with CPS < 1

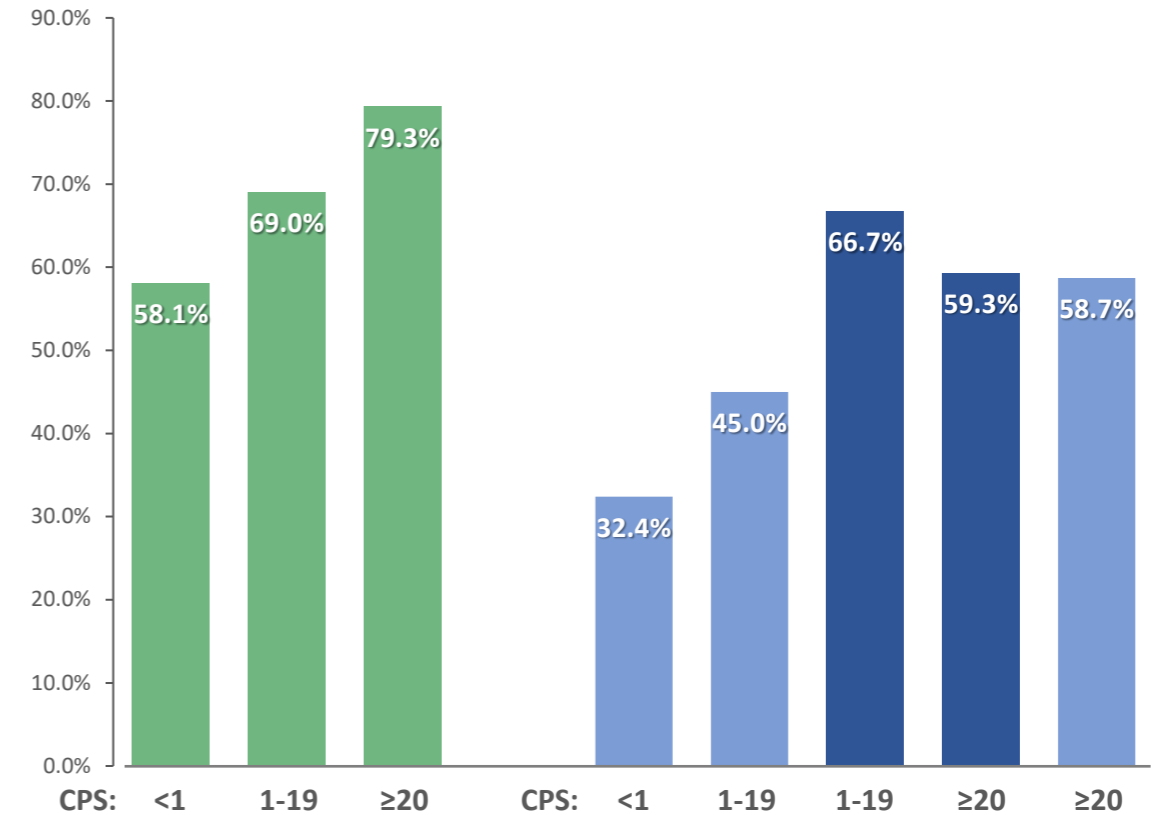


Cohorts A/B: ORR and DCR across PD-L1 Levels (CPS 0-100)

Objective Response Rate (ORR)



Disease Control Rate (DCR)



■ Efti + KEYTRUDA (TACTI-003)

■ KEYTRUDA monotherapy (TACTI-003)

■ KEYTRUDA monotherapy (KN-048)*

Data cut-off date: March 11, 2024. An additional partial response in Efti + KEYTRUDA arm was reported in CPS ≥20 after data cut-off leading to a 34.5% ORR in the CPS ≥20 group. ORR and DCR in evaluable patients (primary and secondary endpoints in TACTI-003 study).

* 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

Cohorts A/B: Favourable Safety Profile

Safety Parameter	KEYTRUDA alone (Cohort A, n=68) n (%)	Efti + KEYTRUDA (Cohort A, n=69) n (%)	Efti + KEYTRUDA (Cohort B, n=33) n (%)
Any TEAR Leading to Discontinuation of Study Treatment	3 (4.4%) ¹	3 (4.3%) ²	3 (9.1%) ³

TEAR: Treatment-emergent adverse reaction

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

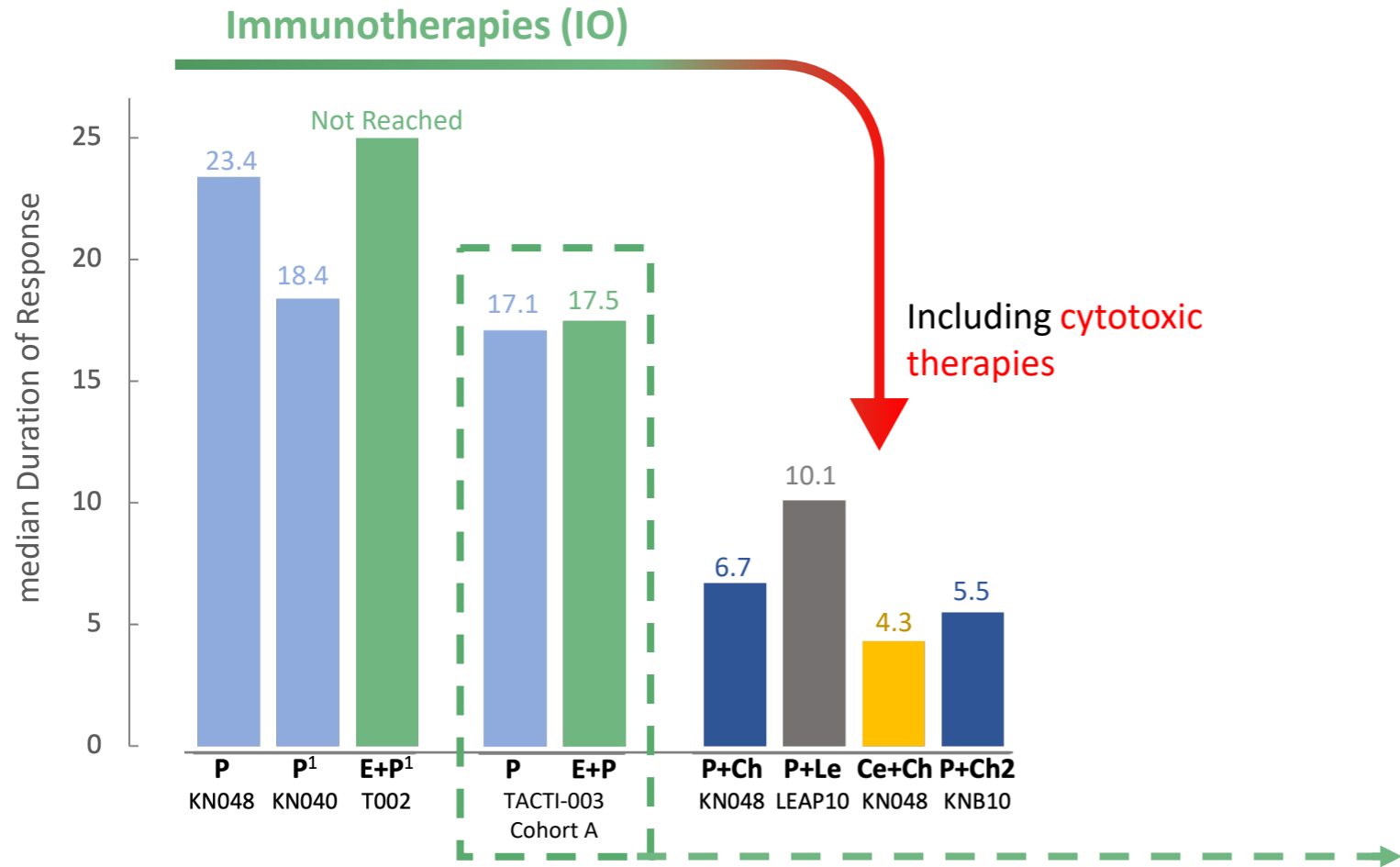
Cohort A: Patients with Any PD-L1 Expression

TACTI-003		
	Efti + KEYTRUDA	KEYTRUDA alone
High PD-L1 Expression (CPS \geq20)	34.5% ORR (N=29)	18.5% ORR (N=27)
In CPS \geq 20, efti + KEYTRUDA shows strongest outperformance with 87% relative increase. Patients with CPS \geq 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 in treatment arms (see right).		
Any PD-L1 Expression (CPS \geq1)	34.5% ORR (N=58)	26.7% ORR (N=60)
In CPS \geq 1, efti + KEYTRUDA has 29% relative increase against KEYTRUDA monotherapy results in patients with any PD-L1 expression, which 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

Cohort A: Superior DOR Compared to Cytotoxic Therapies



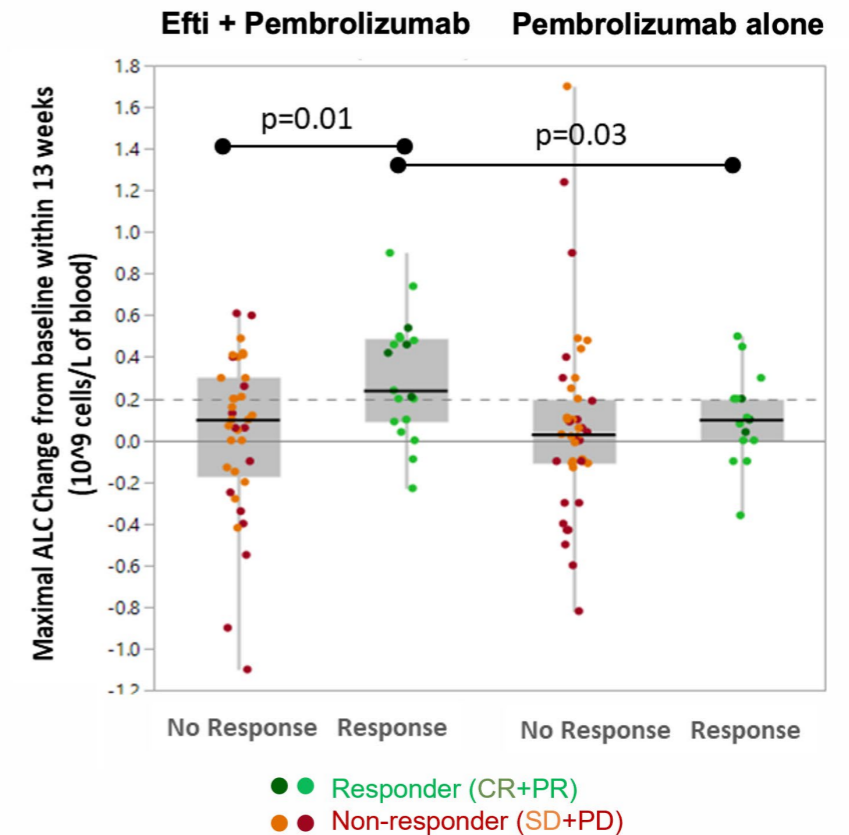
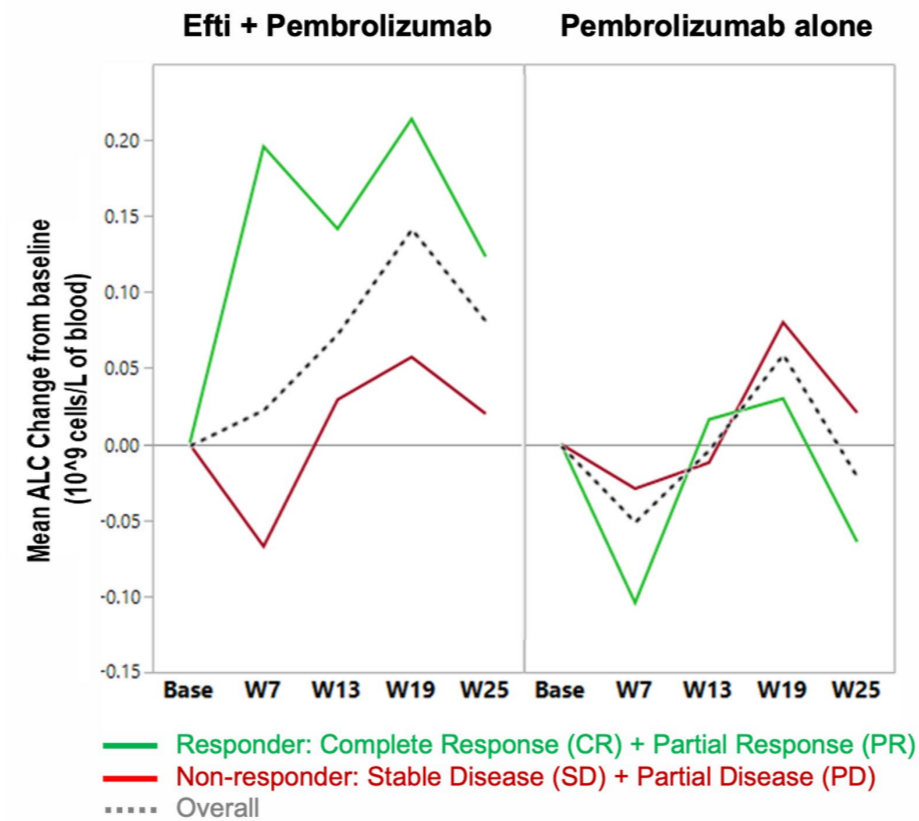
Duration of Response (DOR): “the time from onset of response to progression or death due to any reason”

- Immunotherapies engage/train immune system against the tumor enabling better quality responses.
- It is easier for tumor cells to develop evasion strategies against cytotoxic agents, which can harm the immune system as well.
- PFS and OS curve depends on the quality of responses.
- **Case study:** LEAP-010 trial, where high ORR / PFS did not translate into improved OS.

Addition of efti to pembrolizumab increases response rates & maintains high median Duration of Response, which may translate to improved Overall Survival

Cohort A: Exploratory Biomarker Analysis

- **Absolute lymphocyte count (ALC)** sees significant increase in E+P group on study (left figure).
- ALC increased significantly in responders compared to non-responders ($P=0.01$) in E+P group and compared to responders ($P=0.03$) in P alone (right figure).
- Increase of ALC shows the biological activity of efi in this randomized setting.



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

ESMO VIRTUAL PLENARY



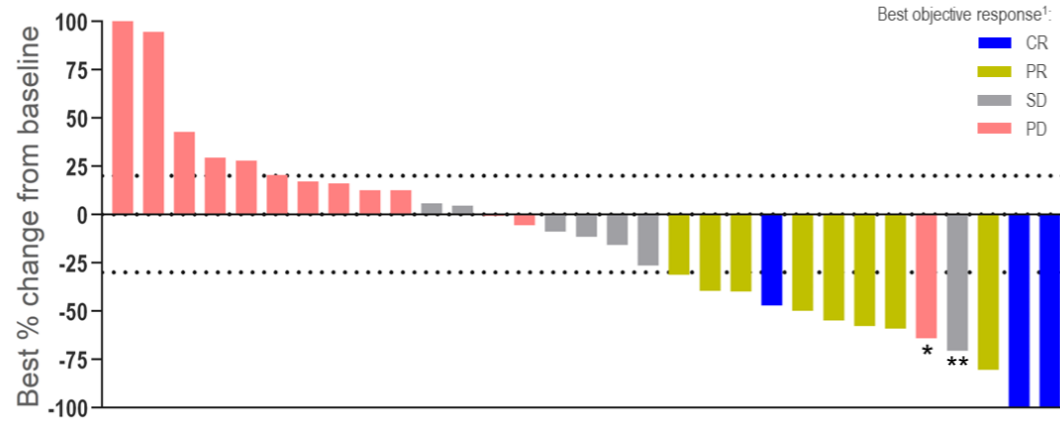
Best objective response ¹ , n (%)	RECIST 1.1 N=31	iRECIST N=31
Complete response	3 (9.7)	3 (9.7)
Partial response	8 (25.8)	9 (29.0)
Stable disease	7 (22.6)	8 (25.8)
Progressive disease	13 (41.9)	11 (35.5)
ORR, [95% CI]²	11 (35.5) [19.2-54.6]	12 (38.7) [21.8-57.8]
DCR, [95% CI]²	18 (58.1) [39.1-75.5]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

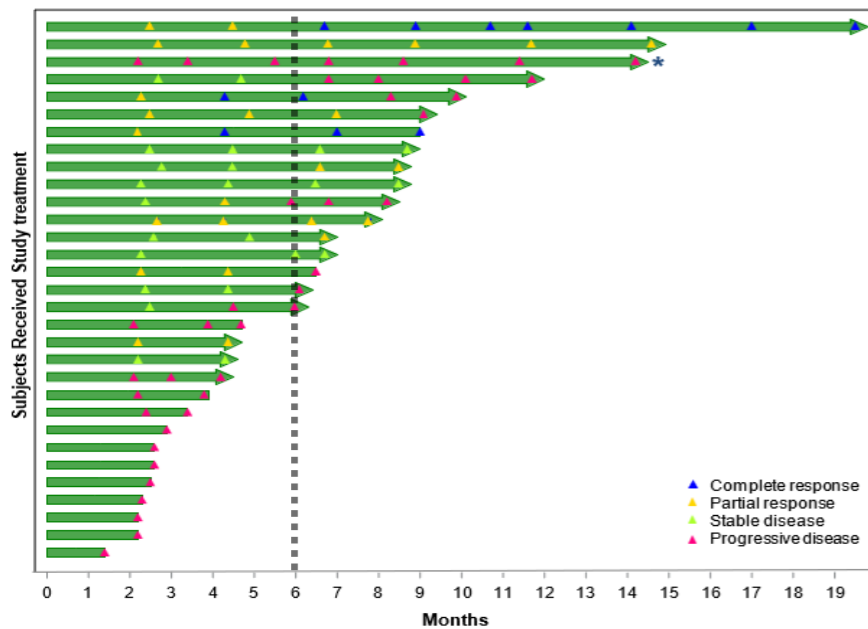
Cohort B: Tumour Shrinkage in 60% of Patients with CPS <1 and Excellent Duration of Treatment

Change in Tumour Burden

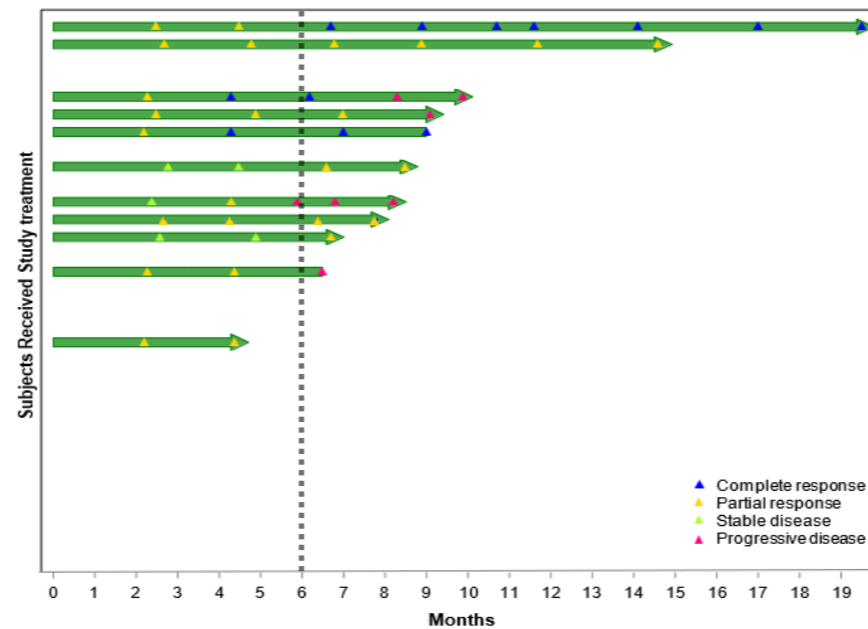


~60% of patients experienced tumour shrinkage and despite deep responses in target lesions, two patients not counted as responders according to RECIST 1.1 (see */** on waterfall plot)

Tumour response dynamics over time*



Tumour response dynamics in responders

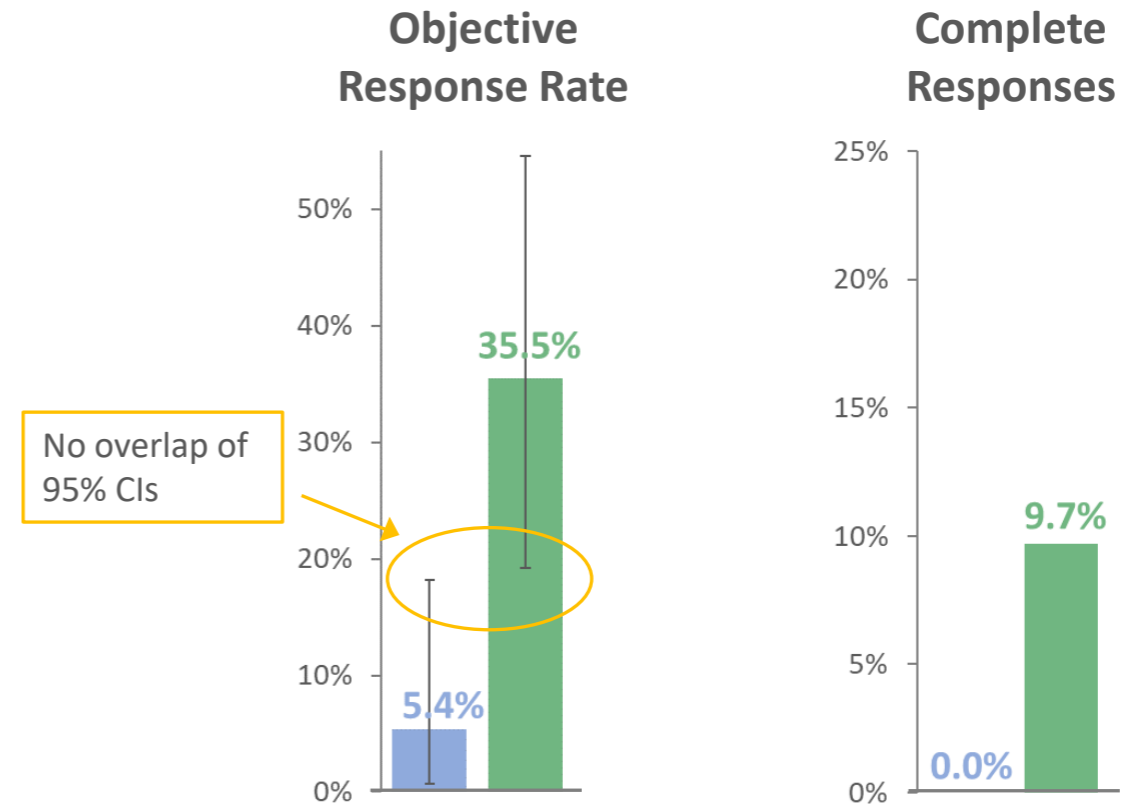


Durability of treatment / responses tracks very well with over 50% patients on treatment 6+ months & over 90% of responders on treatment 6+ months

Cohort B: Exceptional Results for a Chemo-Free Regimen

Key takeaways, Cohort B (CPS <1)

- ✓ ORR of 35.5%, DCR of 58.1%, and ~10% complete response rate are exceptional for a chemo-free regimen in this patient population. Data compares favorably to historical results from KEYTRUDA monotherapy (*see figures to right*).
- ✓ 35.5% ORR is similar to KEYTRUDA+chemo (~31%) and in range of EXTREME regimen (~40%)#, without the added toxicity of chemotherapy that both these approaches have
- ✓ Early trends in durability look favourable with 90% responders ongoing treatment at 6+ months. Notably, duration of response (DOR) for standard-of-care cetuximab+chemo (EXTREME) or KEYTRUDA+chemo treatments range from ~4 to ~7 months.



PD-L1 CPS <1	KEYTRUDA mono KN-048 (N=37)#	Efti + KEYTRUDA TACTI-003 (N=31)
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%)

Cohort B: Limited Competition in a Valuable Market

Limited competition in CPS <1

- Most IO combinations with anti-PD-1 therapy like KEYTRUDA exclude CPS <1 patients as anti-PD-1 alone is not very active
- No chemotherapy-free therapies available for 1L HNSCC patients with CPS <1
- 35.5% ORR among the highest reported for chemotherapy-free regimen in CPS <1
- Durability tracking well: >50% patients remain on treatment 6+ months and >90% of responders remain on treatment 6+ months

~\$2.8 billion market

Overall head and neck cancer market valued at ~\$2.8 billion¹ with HNSCC representing ~90% cases²

~100,000 metastatic HNSCC patients

>890,000 HNSCC diagnoses per annum worldwide³ with ~100,000 patients who develop metastatic disease in 8 major market countries¹

~Up to 20% of HNSCC population

CPS <1 patients represent up to ~20% of the HNSCC patient population⁴

Next Steps

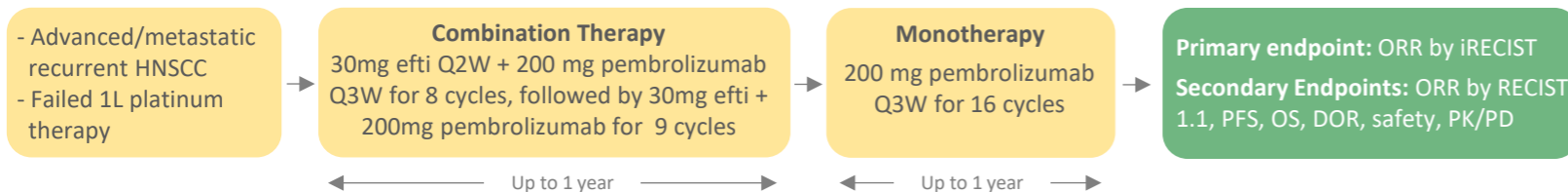
- Discuss the path forward in 1L HNSCC CPS <1, where we have FDA Fast Track designation, with regulatory agencies
- Discuss results with key stakeholders (investigators, payers, etc.)

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

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

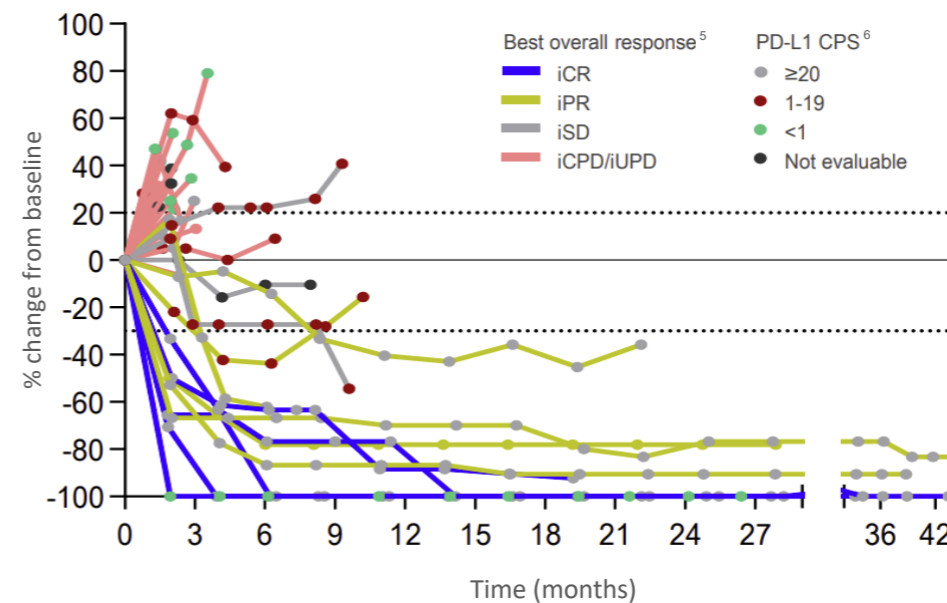
TACTI-002/KEYNOTE-798 (Part C): Second Line Head & Neck Squamous Cell Carcinoma (2L HNSCC)

TACTI-002 (Part C) Trial Design



- 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 $\geq 1^*$ N=25	CPS $\geq 20^*$ 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%
mDoR², months	NR	NR	NR
mOS⁴, months	8.7	12.6	15.5
12-mo OS rate	46.0%	52.0%	66.7%



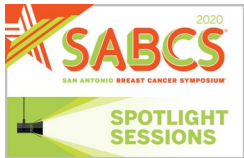
Efti + Chemotherapy in Metastatic Breast Cancer (MBC)

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

AIPAC-001 Study Design

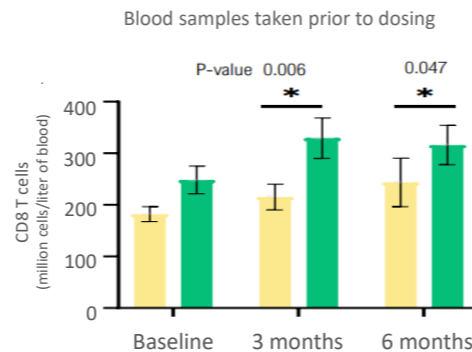


AIPAC was conducted in 34 sites across: Belgium, France, Hungary, Poland, Netherlands, UK, and Germany

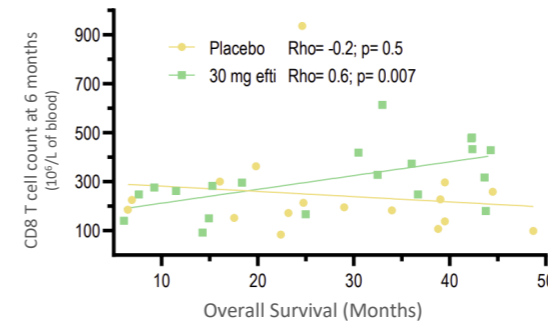


	Paclitaxel N=112	Efti + paclitaxel N=114
Overall Response Rate	38.4%	48.3%
Disease Control Rate	75.9%	85.1%
Median Overall Survival (mOS)	17.5 months	20.4 months
mOS in Pre-Specified Subgroups		
Low Monocytes, <0.25/nl	12.9 months	32.5 months
Under 65 Years	14.8 months	22.3 months
Luminal B	12.6 months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

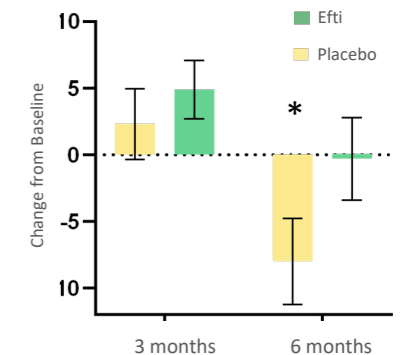
CD8⁺ T cell count increased significantly



Significant correlation between OS & Cytotoxic CD8⁺ T cell count



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



AIPAC-003 Phase II/III Trial Underway in MBC

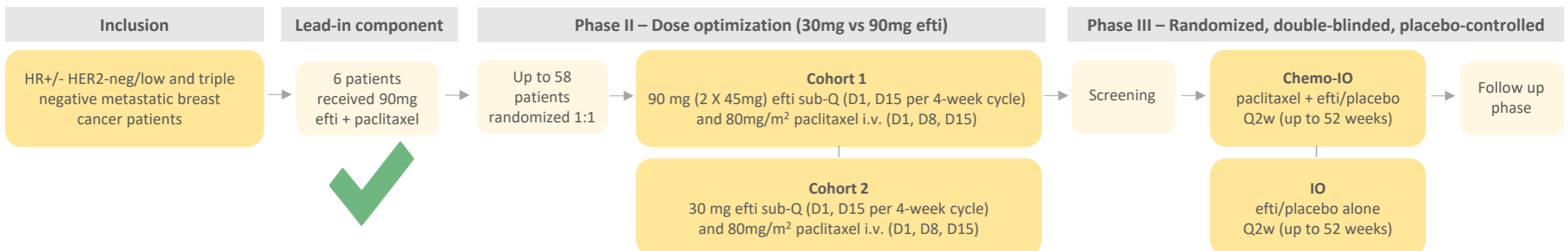
AIPAC-003: Active Immunotherapy (Eftilagimod Alfa) and **PA**clitaxel



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 cases¹)
- 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 to find optimal biological efti dosing (30mg or 90mg)

AIPAC-003 Study Design



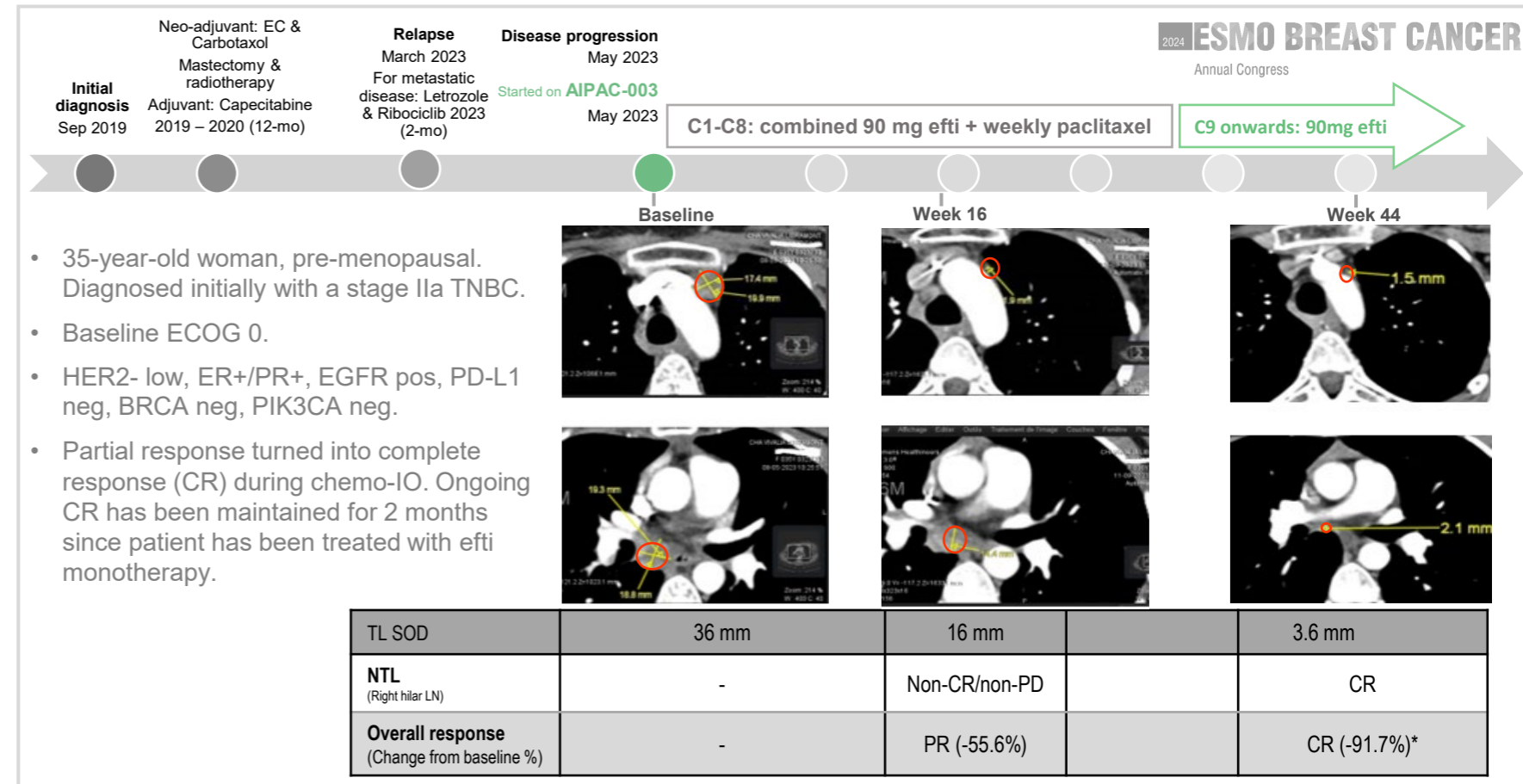
Encouraging Safety and Early Efficacy in AIPAC-003

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

AIPAC-003: Active Immunotherapy (Eftilagimod Alfa) and PAClitaxel

- 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) achieved during combination treatment in a patient with metastatic breast cancer refractory to several lines of therapy has been maintained with efti monotherapy for over 4 months**

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



Additional Oncology Indications and Studies

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 Immunetep & 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

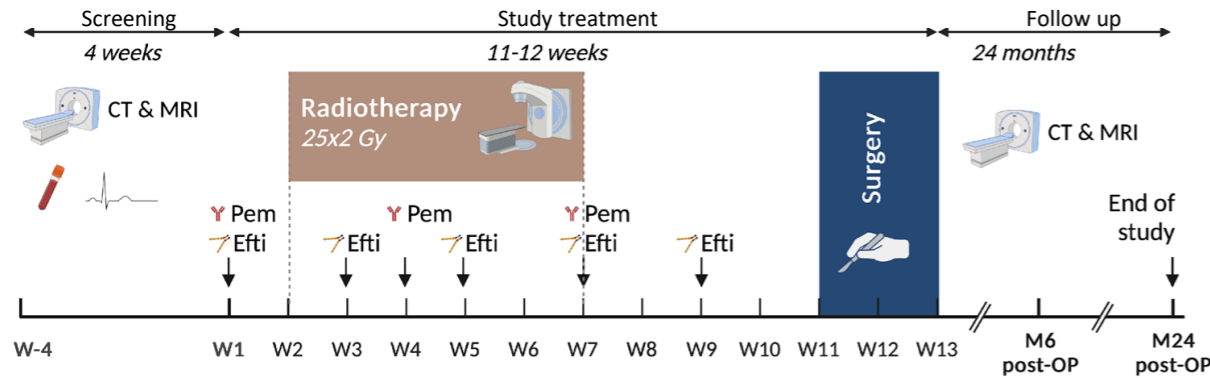
immunetep
LAG-3 IMMUNOTHERAPY

**KRANKENHAUS
NORDWEST**

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*

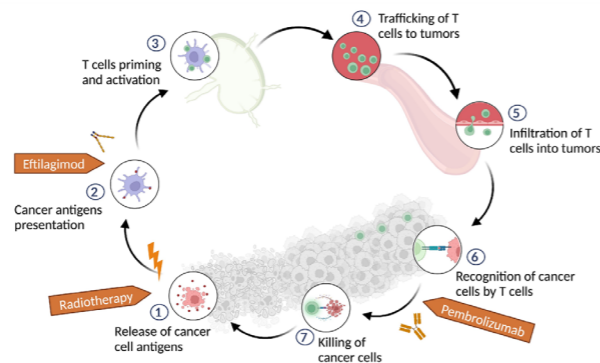


- First trial studying efti in neoadjuvant, non-metastatic cancer setting and also first to study efti with radiotherapy
- Importantly, study will provide access to tumor tissue prior to and after treatment, so tumor microenvironment can be assessed**
- Cost-efficient Phase II study funded by grant from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



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

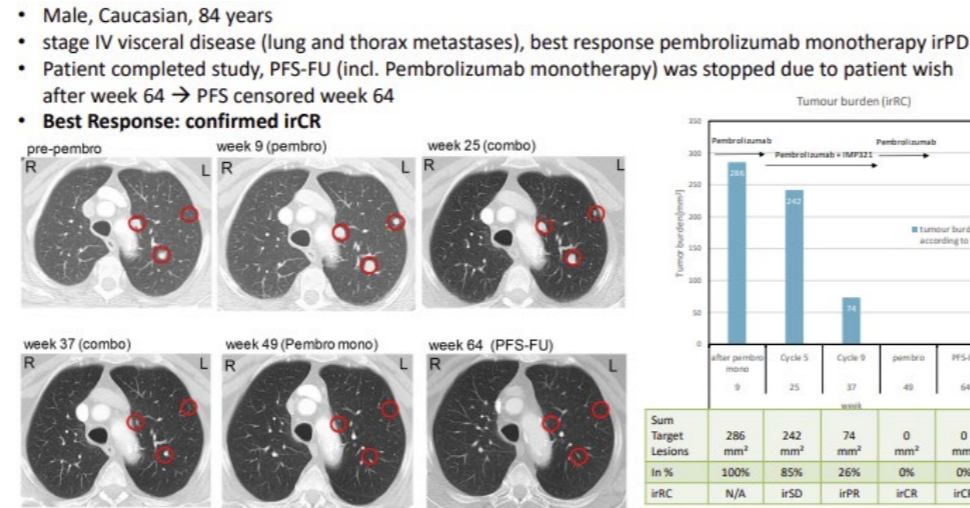
- ✓ Four of six patients treated have very good, near-complete pathologic responses (primary endpoint of study), which are rarely observed with standard therapies
- ✓ Triple combination therapy well tolerated
- ✓ Additional data will be presented at the 2024 Connective Tissue Oncology Society (CTOS) Annual Meeting in November

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:

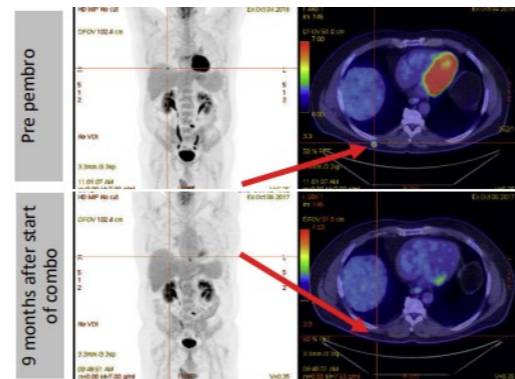
- Patients had very late stage of disease: (a) 75% classified as M1c (associated with lowest probability of survival), (b) 67% lung metastasis, (c) 50% liver metastasis, (d) 50% elevated LDH
- Deep, durable responses observed with tumor shrinkage of 56% and 66% in Part A (efti 1, 6, 30mg; N=18) and Part 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)



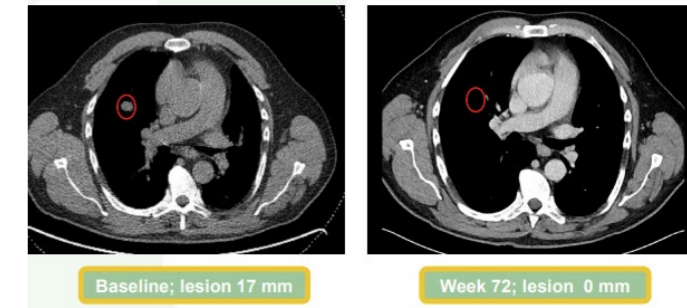
Patient Case #2 - Pembrolizumab + 6mg Efti (IMP321)

- 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**



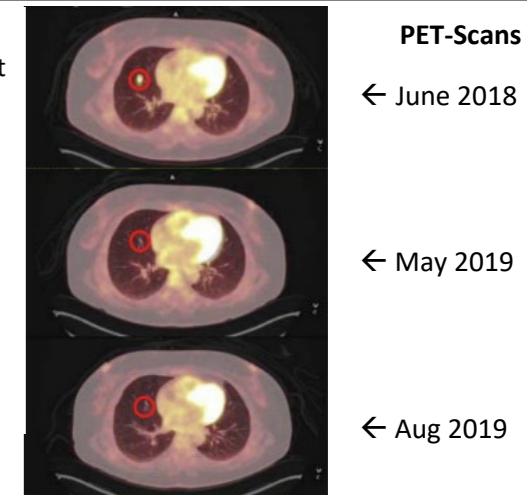
Patient Case #3 - Pembrolizumab + 30mg Efti (IMP321)

- 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



Novel Small Molecule Anti-LAG-3 Preclinical Program

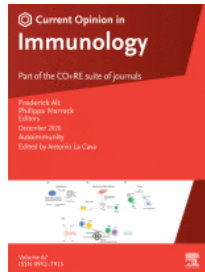


Immutep aims to develop and commercialize an orally-available small molecule anti-LAG-3 treatment for cancer patients at a lower cost compared with anti-LAG-3 antibodies commercially available or under clinical development today.

“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*

IMP761 & Summary



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”



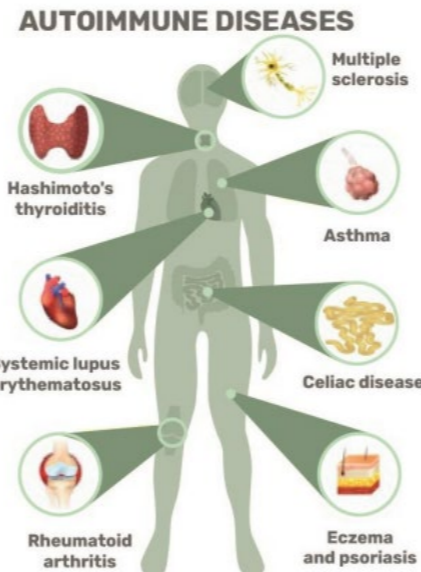
From bench to bedside: targeting lymphocyte activation gene 3 as a therapeutic strategy for autoimmune diseases

“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

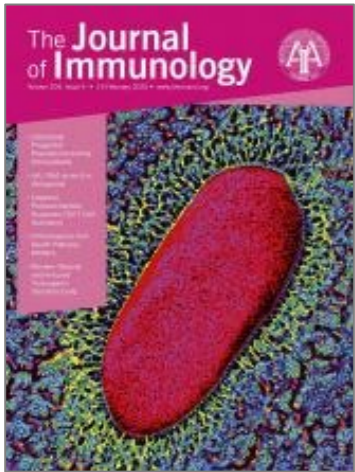
Competitive Landscape for Checkpoint Agonists

Immune Checkpoint / Checkpoint Receptor Agonists Targeting Autoimmune Diseases

Company	Program	Checkpoint / Checkpoint Receptor	Preclinical	Phase I	Phase II	Phase III
	Peresolimab	Programmed Cell Death Protein 1 (PD-1)	▶			
	Rosnilimab	Programmed Cell Death Protein 1 (PD-1)	▶			
	JNJ-4703	Programmed Cell Death Protein 1 (PD-1)	▶			
	CC-90006	Programmed Cell Death Protein 1 (PD-1)	▶			
	GS-0272	Programmed Cell Death Protein 1 (PD-1)	▶			
	SAB03	Programmed Cell Death Protein 1 (PD-1)	▶			
	N/A	Programmed Cell Death Protein 1 (PD-1)	▶			
	ANB032	B and T Lymphocyte Attenuator (BTLA)	▶			
	GS-0151	B and T Lymphocyte Attenuator (BTLA)	▶			
	AVTX-008	B and T Lymphocyte Attenuator (BTLA)	▶			
	IMP761	Lymphocyte Activation Gene-3 (LAG-3)	▶			

ImmuteP is uniquely positioned with IMP761

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

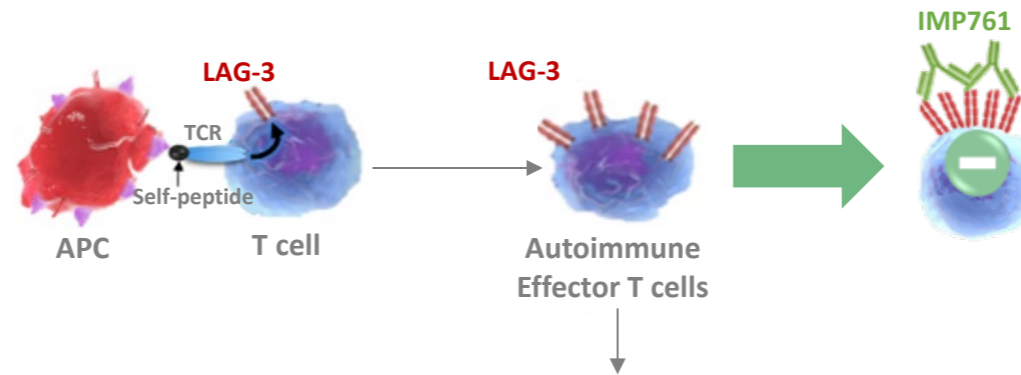


IMP761 - A LAG-3-Specific Agonist Antibody for the Treatment of T Cell-Induced Autoimmune Diseases



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.

Clinical Development of IMP761

Leading World-Class 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



- 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 immunology. He was the founder of Immunetep 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 Immunetep 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.

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



Thank You