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LAG-3 IMMUNOTHERAPY

Global Webcast Slides for TACTI-002 data presented at ASCO 2022

Webcast Details

Date & Time: 5.00 pm CDT (Chicago) Monday 6 June 2022/
8.00 am AEST (Sydney) Tuesday 7 June 2022

Speakers: Immutep CEO Marc Voigt, CMO/CSO Dr Frederic Triebel and Christian Mueller, Vice President Strategic Development

Register: https://us02web.zoom.us/webinar/register/3616539572927/WN_fAVtcc30SXuBz-kBxfF86g

Questions: Investors are invited to submit questions in advance via immutep@citadelmagnus.com.

(ASX: IMM, NASDAQ: IMMP)

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This presentation was authorised for release by the CEO, Marc Voigt.

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LAG-3 Overview

A validated immune checkpoint

LAG-3 Therapeutic Landscape Overview

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		Company	Program	Preclinical	Phase I	Phase II	Phase III	Total Trials	Patients
Oncology	Agonist	immutep	Eftilagimod Alpha[5]		10	4		14	967
	Antagonist	BMS	Relatlimab		7	35	4	46	11,295
		Merck & Co. Inc.	Favezelimab		1	6	1	8	1,572
		Regeneron[1]	Fianlimab		1	1	1	3	1936
		NOVARTIS	Ieramilimab		1	4		5	952
		Macrogenics	Tebotelimab		3	3		6	1,397
		H-L Roche	RO7247669		1	3		4	692
		Incyte	INCAGN02385		1	2		3	198
		B.I.	Miptenalimab		4	1		5	650
		Innovent	IBI110		2	1		3	368
		Tesaro[3]	TSR-033		1	1		2	139
		BeiGene	LBL-007		3			3	324
		Symphogen[2]	SYM022		3			3	106
		F-star	FS-118		2			2	102
		EpimAb	EMB-02		1			1	43
Autoimmune	Agonist	immutep	IMP761					--	--
	Depleting Ab	gsk[4]	GSK2831781 (IMP731)		2	1		3	207

Notes:

Sources: GlobalData, Company websites, clinicaltrials.gov, and sec.gov, as of May **2022.** The green bars above represent programs conducted by Immutep &/or its partners. Total trials includes all active, completed &/or inactive trials. Patient totals are based on estimated total enrolled &/or to be enrolled. Not a complete list of currently existing LAG-3 products.

1) As of January 7, 2019 Regeneron is in full control of program and continuing development (https://www.sec.gov/Archives/edgar/data/872589/000110465919000977/a19-1325_18k.htm)
2) On 3 Apr. 2020 Les Laboratoires Servier acquired Symphogen
3) Tesaro was acquired by and is now part of GSK (www.gsk.com/en-gb/media/press-releases/gsk-completes-acquisition-of-tesaro-an-oncology-focused-biopharmaceutical-company/)
4) Includes two completed Phase I studies and one discontinued Phase 2 study
5) Including IITs, one planned trials (MBC trial by EOC)

Targeting LAG-3 / MHC II:

Immutep has multiple therapeutics in numerous diseases

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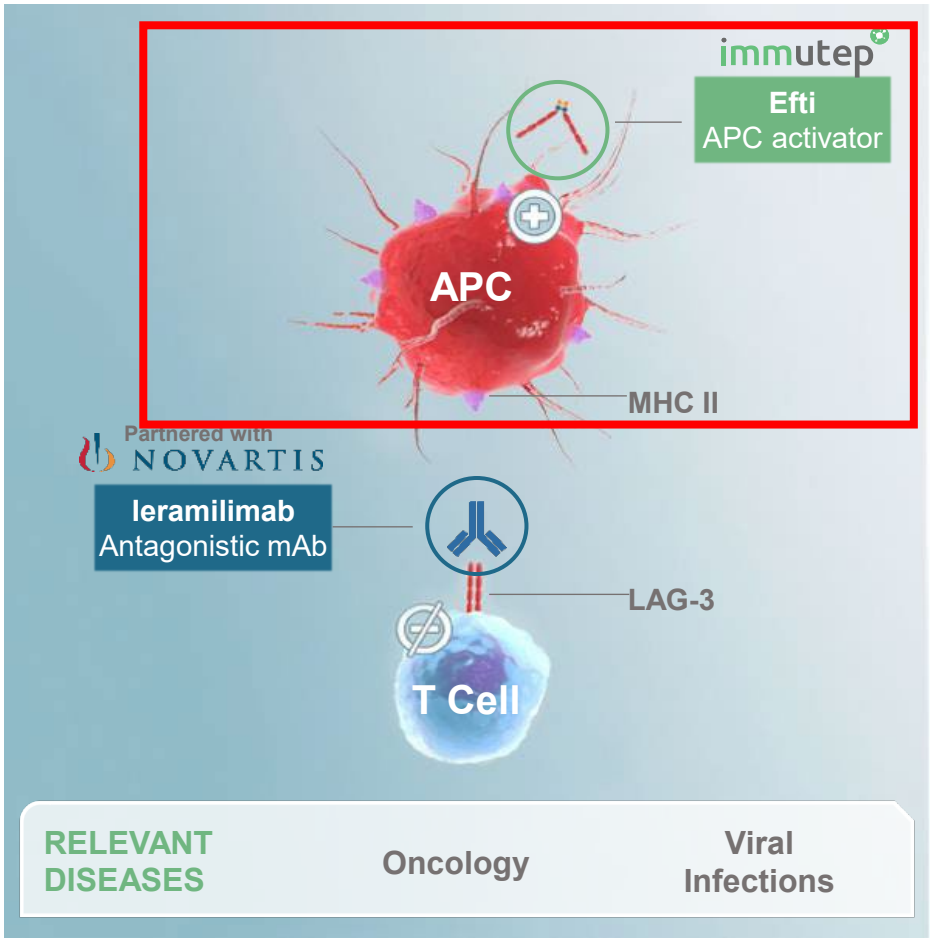
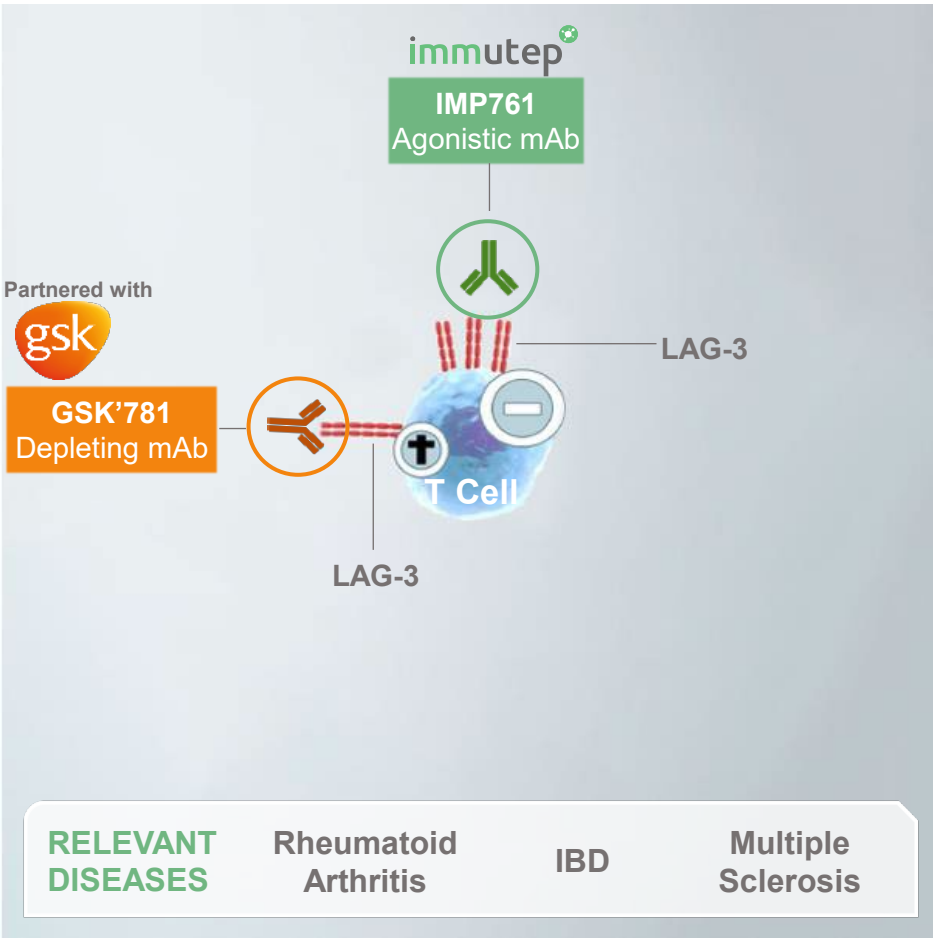
IMMUNOSTIMULATION



RELEVANT DISEASES	Oncology	Viral Infections

IMMUNOSUPPRESSION



RELEVANT DISEASES	Rheumatoid Arthritis	IBD	Multiple Sclerosis

- ✓ Immutep is the only company with four LAG-3 related candidates, each with a different mechanism of action for treatment of numerous diseases
- ✓ Two major partnerships with pharma and two candidates under own development

Notes:
* APC: antigen presenting cell

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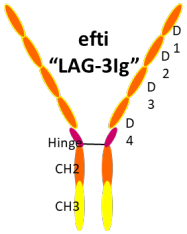
Eftilagimod Alpha

Bringing APC Activation into Oncology

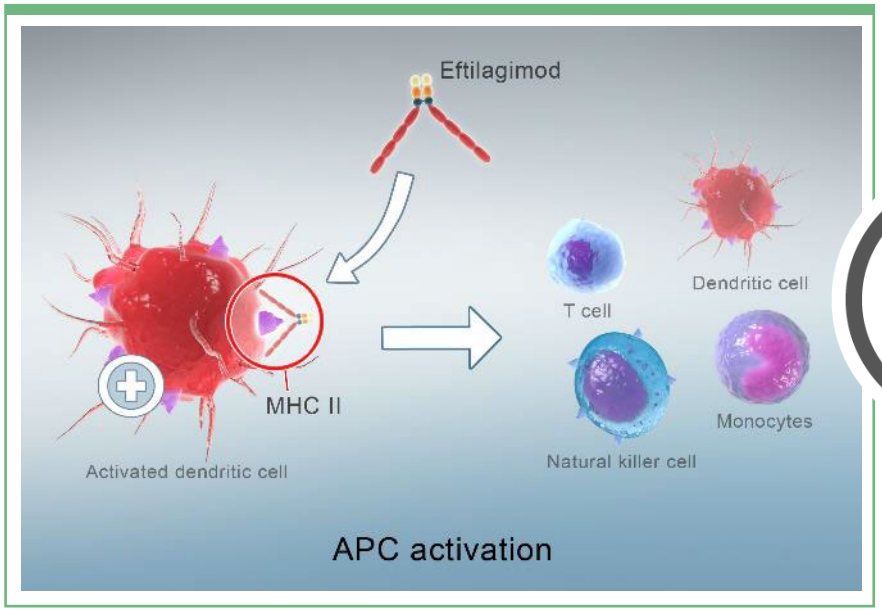
eftilagimod alpha ~ efti ~ IMP321

Efti: an Innovative I-O Product Candidate



- Efti is a soluble LAG-3 protein targeting a subset of MHC class II molecules on APCs
- Potentially synergistic with other therapeutic agents, e.g. Immuno-Oncology (I-O) agents or chemotherapies

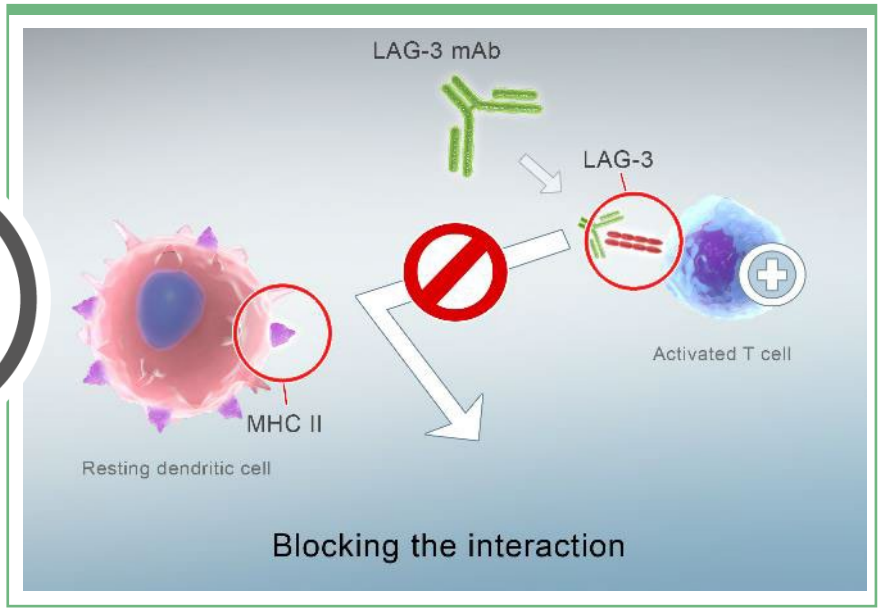
"PUSHING THE ACCELERATOR ON IMMUNE RESPONSES"



Efti is an **unique MHC II agonist:**
APC activator

- boost and sustain e.g. the $CD8^+$ T cell responses
- activate multiple immune cell subsets

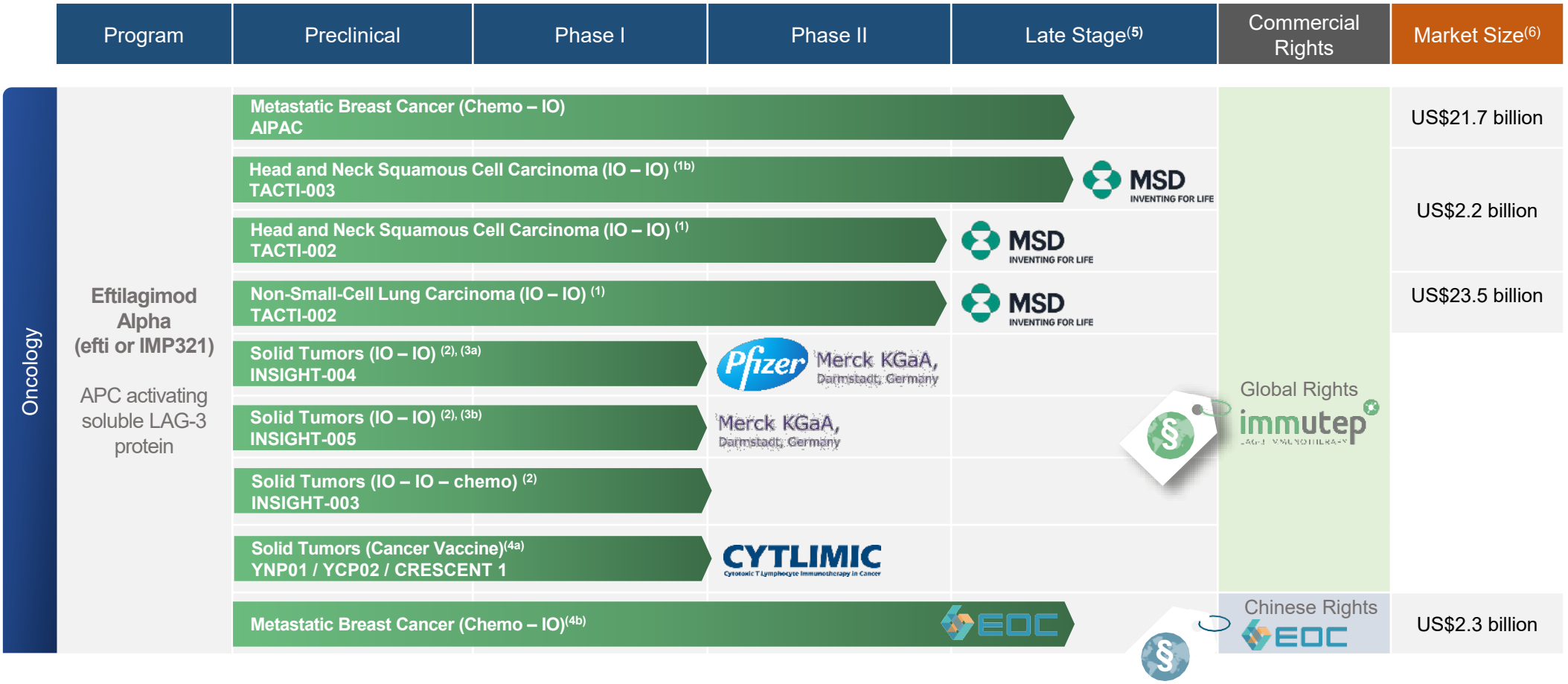
"RELEASING THE BRAKE ON THE T CELL"



LAG-3 antagonist, or blocking, antibodies:
Immune checkpoint inhibitor

- increase cytotoxicity of the pre-existing CD8 T cell response

Immutep's Efti Trial Pipeline*



Notes

* Information in pipeline chart current as of May 2022

(1) In combination with KEYTRUDA® (pembrolizumab) (1b) Planned new trial for 1st line HNSCC patients

(2) INSIGHT Investigator Initiated Trial ("IIT") is controlled by lead investigator and therefore Immutep has no control over this clinical trial

(3) a) In combination with BAVENCIO® (avelumab); b) in combination with Bintrafusp alfa

(4) a) Conducted by CYTLIMIC in Japan; b) Conducted by EOC in China. Immutep has no control over either of these trials.

(5) Late stage refers to Phase IIb clinical trials or more clinically advanced clinical trials

(6) GlobalData Market Size forecast for US, JP, EU5, Urban China and Australia; KBV Research: https://www.kbvresearch.com/autoimmune-disease-therapeutics-market/)

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Efti + anti-PD-1 Combination in 1st Line NSCLC

Extending the use of Pembro alone and Chemo + Pembro

Especially beneficial for PD-L1 low expressors

TACTI-002

Interim update from ASCO 2022

TACTI-002 (Phase II)

Design & Status

TACTI-002: Two ACTive Immunotherapeutics in NSCLC and HNSCC

SCREENING

UNSELECTED FOR PD-L1

PART A
1ST LINE MET. NSCLC

PART B
2ND LINE MET. NSCLC, REFRACTORY TO PD-1/PD-L1 TARGETING THERAPY

PART C
2ND LINE MET. HNSCC AFTER PLATINUM THERAPY

COMBINED IMMUNOTHERAPY
PEMBROLIZUMAB + EFTI FOR 12 MONTHS + 12 MONTHS PEMBROLIZUMAB MONO

ORR, PFS, OS, PK, biomarker, safety and tolerability

In collaboration with

MERCK
INVENTING FOR LIFE

Treatment	30 mg efti s.c. 200 mg pembrolizumab (Keytruda®) i.v.

Recruitment Status Report

- ✓ Fully approved in all countries
- ✓ 189 patients recruited (finished) in three indications
  - ✓ Part A (N=114)
  - ✓ Part B (N=36)
  - ✓ Part C (N=39)

Sites in Europe / US / Australia

Notes:
ORR – overall response rate, DCR – disease control rate, PFS – progression free survival, OS – overall survival, QoL – Quality of life

TACTI-002

1st line NSCLC (Part A) - Epidemiology, Landscape & Unmet need

Epidemiology[1],[2]:

- 1,870,000 NSCLC diagnoses per annum worldwide growing by 1.5% p.a.
- Most frequent cause of cancer death (18%)
- Approximately 1,300,000 develop metastatic disease and are eligible to receive anti-PD-(L)1

Unmet need:

- Median OS still < 24 months for most patients
- Low efficacy of anti-PD-(L)1 monotherapy for patients with TPS < 50% **(~70% of total population)**
- Double chemo + anti-PD-(L)1 → increased ORR & OS, but:
  - Substantially **shorter DoR due to chemo**
  - Toxicity for patients

	TPS	Treatment	Efficacy[4]
1st LINE	0 – 100%	Doublet Chemo	RR 19-30% PFS 5-9 mts OS 10.7 mts
		Doublet Chemo + Pembro	RR 48%-63% PFS 6-9 mts OS 17-22 mts
		Doublet Chemo + Atezo + Beva	RR 56% PFS 8.4 mts OS 19.2 mts
		Doublet Chemo + Ipi + Nivo	RR 38% PFS 6.7 mts OS 15.6 mts
	≥ 1%	Pembro mono[3]	RR 27.5% PFS 5.4 mts OS 16.7 mts
		Ipi + Nivo[3]	RR 36% PFS 5.1 mts OS 17.1 mts
	≥ 50%	Pembro/Atezo/Libtayo	RR 35-45% PFS 7-10 mts OS 20-30 mts

- **Doublet chemo + Pembro predominantly used in PD-L1 < 50% and PD-1 alone in PD-L1 high (e.g. >= 50%)**
- **Ipi + nivo, atezo combination, and pembro mono for 1-49% are approved in the US but not really used**

Notes:

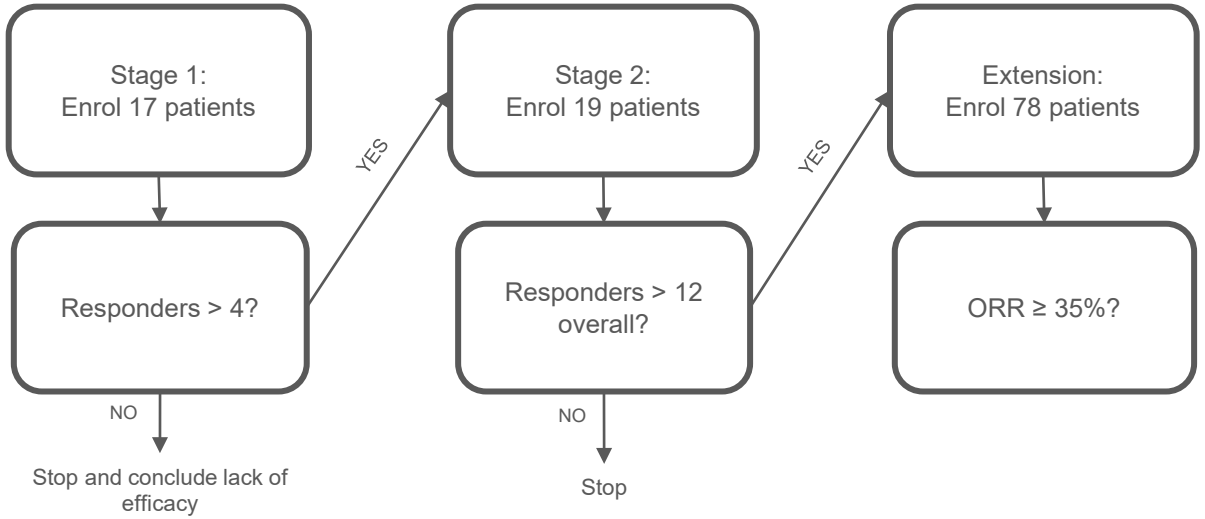
(1) Calculated from Global Cancer Observatory (WHO), 2020 data
(2) Informa Pharma Intelligence Report 2018 for US, Japan and EU5
(3) Only in US, not in EU.
(4) Arrow lengths are not proportional representations of efficacy data. Data taken from respective registrational trials

TACTI-002

1st line NSCLC (Part A) - Statistical Considerations

KEY ASSUMPTIONS	STATISTICAL CONSIDERATIONS	FINAL SAMPLE SIZE
• "True" ORR[1] pembro monotherapy = 23% • ORR test group = 35%	• Design: Simon's 2-stage design + extension. • For overall group: using the assumption of an ORR of 35% with a power of 80% and a one-sided level of significance of 2.5%, a sample size of 105 patients would be required.	• With an expected drop-out rate of 5%, a total of 110 patients to be enrolled.

Extended Simon's Two Stage Design:



[1] True response rates sources/assumptions: KEYNOTE-001 &-042 (KEYNOTE-001: NB Leighl et al, The Lancet 2019, http://dx.doi.org/10.1016/S2213-2600(18)30500-9; KEYNOTE-042: TSK Mok et al, The Lancet 2019, http://dx.doi.org/10.1016/S0140-6736(18)32409-7) & expecting that ~70% of patients will have PD-L1 TPS <50%.

TACTI-002 Results(*)

1st line NSCLC (Part A) - Baseline Characteristics

- **PD-L1 distribution as expected (~70% with PD-L1 TPS < 50% expression) → PD-L1 all comer trial**
- **114 1st line NSCLC patients enrolled with expected disease characteristics**

Baseline parameters		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	106 (93.0) / 8 (7.1)
PD-L1 expression TPS[1], n (%)	< 1% 1-49% ≥ 50% Not evaluable	37 (32.5) 40 (35.1) 31 (27.2) 6 (5.3)
Previous therapy, n (%)	Radiotherapy Surgery Systemic therapy for non-metastatic disease	38 (33.3) 23 (20.2) 25 (21.9)

[1] Central assessment of PD-L1 TPS using Dako PD-L1 IHC 22C3 pharmDx for 87 pts. For 21 pts, local assessment was used due to non evaluable central assessment results
TPS: tumor proportion score.

Notes:
(*) Preliminary data, cut-off Apr 15, 2022
ECOG… Eastern Cooperative Oncology Group
iRECIST… Immune Response Evaluation Criteria In Solid Tumors
BICR… Blinded Independent Central Review

TACTI-002 Results(*)

1st line NSCLC (Part A) - Safety and Exposure

Safety parameter[1]	n (%)
Any TEAE	113 (99.1)
Any Serious TEAE	45 (39.5)
Serious TEAE *related to study treatment*[2]	10 (8.8)
Any Grade ≥ 3 TEAE	59 (51.8)
Grade ≥ 3 TEAE related to study treatment[2]	12 (10.5)
Any Grade 4 TEAE	5 (4.4)
Any Grade 5 TEAE	12 (10.5)
Grade 5 TEAE related to study treatment[2]	3 (2.6)
Any TEAEs leading to discontinuation of study treatment[2]	23 (20.2)
TEAEs leading to discontinuation related to study treatment[2]	11 (**9.6**)

AE: adverse event
ALT: alanine aminotransferase
AST: aspartate aminotransferase
G: grade
SAE: serious adverse event
TEAE: treatment emergent adverse event, AEs with onset date on or after the first dose of study drug regardless of causality.
[1] AEs rated according to the current National Cancer Institute Common Terminology Criteria for Adverse Events (v5.0).
[2] Study treatment= efti and/or pembrolizumab.

- Median exposure of efti was 23.1 weeks (range 1-52.4) and 21.8 weeks for pembro (range 0.1-103.3)
- 5 patients completed 2 years of treatment until data cut-off
- 11 patients (9.6%) permanently discontinued treatment due to AEs related to study treatment[2]:
  - peripheral sensory neuropathy (G2), n=2
  - gait disturbance (G2), n=1
  - ALT (G3) and AST elevation (G3), n=1
  - acute kidney injury (G3), n=1
  - drug hypersensitivity (G3), n=1
  - bronchospasm (G3), n=1
  - immune-related hepatitis (G4), n=1
  - pneumonitis (G5), n=1
  - sudden death - unknown cause (G5), n=1
  - pulmonary embolism (G5), n=1

➢ Rate of discontinuation due to drug related adverse events comparable to pembrolizumab monotherapy**

Notes:
(*) Preliminary data, cut-off Apr 15, 2022
(**) (Source: KN042; KN001; KN024, TACTI-002)

TACTI-002 Results(1)

1st line NSCLC (Part A) - Safety - Frequent TEAEs

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Frequent TEAEs (incidence ≥ 15%) by PT regardless of relationship to any study drug

Adverse event by PT	Any grade n (%)	Grade 3 n (%)	Grade 4 n (%)	Grade 5 n (%)
Dyspnea	39 (34.2)	13 (11.4)	1 (0.9)	1 (0.9)
Asthenia	35 (30.7)	2 (1.8)	-	-
Decreased appetite	27 (23.7)	1 (0.9)	-	-
Cough	27 (23.7)	2 (1.8)	-	-
Anemia	24 (21.1)	3 (2.6)	-	-
Fatigue	23 (20.2)	1 (0.9)	-	-
Pruritus	22 (19.3)	-	-	-
Constipation	20 (17.5)	1 (0.9)	-	-
Diarrhea	18 (15.8)	1 (0.9)	-	-
Nausea	18 (15.8)	2 (1.8)	-	-

Frequency of TEAEs (by PT) with possible immune etiology regardless of relationship to any study drug

Adverse event by PT	Any grade n (%)	Grade 3 n (%)	Grade 4 n (%)	Grade 5 n (%)
Diarrhea	18 (15.8)	1 (0.9)	-	-
Hypothyroidism	10 (8.8)	-	-	-
Hyperthyroidism	6 (5.3)	-	-	-
Pneumonitis	4 (3.5)	-	1 (0.9)	1 (0.9)
Hepatitis	3 (2.6)	-	1 (0.9)	-
Nephritis + acute kidney injury	1 (0.9)	1 (0.9)	-	-
Thyroiditis	1 (0.9)	-	-	-
Adrenal insufficiency	1 (0.9)	-	-	-
Infusion related reaction*	1 (0.9)	1 (0.9)	-	-

* (i.e. drug hypersensitivity, serum sickness, infusion related hypersensitivity reaction, infusion related reaction, CRS, anaphylactic reaction, anaphylactic shock, anaphylactoid reaction, anaphylactoid shock)

- 20.3% of patients had any type of local injection site reactions (any PT contained injection site) any grade and thereof 1.8% with severity of G2. No ≥ G3 were reported

➢ Safety profile (incl. immune mediated adverse events) comparable to pembrolizumab monotherapy except for the addition of any type of local injection site reactions**

Notes:
(1) Preliminary data, cut-off Apr 15, 2022; (**) - Source: KN042; KN001; KN024, TACTI-002)
PT ~ Preferred Term; TEAE – treatment emergent adverse event

TACTI-002 Results(1)

1st line NSCLC (Part A) - ORR

ORR – PD-L1 all comer

Response(5)	iRECIST n (%), N=114	RECIST 1.1 n (%), N=114
Complete Response	**2 (1.8)**	**2 (1.8)**
Partial Response	42 (36.8)	41 (36.0)
Stable Disease	40 (35.1)	39 (34.2)
Progression	19 (16.7)	21 (18.4)
Not Evaluable[2]	11 (9.6)	11 (9.6)
ORR, (ITT=114); [95% CI][3]	**44 (38.6); [29.6-48.2]**	**43 (37.7); [28.8-48.3]**
DCR (ITT=114); [95% CI][3]	84 (73.7); [64.6-81.5]	82 (71.9); [62.7-80.0]
ORR (EVAL[4]=103); [95% CI][3]	**44 (42.7) [33.0-52.9]**	**43 (41.8); [32.1-51.9]**
DCR (EVAL[4]=103); [95% CI][3]	84 (81.5); [72.7-88.5]	82 (79.6); [70.5-86.9]

- ORR (iRECIST - primary endpoint) of 38.6% in the ITT
- RECIST 1.1 comparable with 37.7%
- ORR of 42.7% (iRECIST) and 41.8% (RECIST 1.1) in the EVAL[4] population
- ORR (iRECIST) of 35.0% in squamous and 38.9% in non-squamous tumors

➢ **Primary Objective (ORR > 35%) achieved**

[2] patients with no on-study post baseline tumor staging for any reason; [3] 95% CIs calculated using Clopper-Pearson method; [4] all patients with ≥ 1 on-study post baseline tumor staging 5- local investigator read, unconfirmed; ITT: intention-to-treat population; EVAL: evaluable population

Notes:
(1) Data cut-off Apr 15, 2022
iRECIST… Immune Response Evaluation Criteria In Solid Tumors
ORR by PD-L1 status for N=108 has also been published at ASCO22 according to local + central reed: TPS <1%: 24.3%; TPS 1-49%: 40%; TPS ≥50%: 51.6%; TPS ≥1%: 45.1%; TPS <50%: 32.5%

TACTI-002 Results(*)

1st line NSCLC (Part A) - ORR

- ORR (iRECIST) by PD-L1 (central only):
  - 28.1% in PD-L1 negative
  - 41.7% in PD-L1 1-49%
  - 52.6% in PD-L1 ≥ 50%
  - 45.5% in PD-L1 ≥ 1%
- DCR (iRECIST) with a range of 68.8-78.9% across all PD-L1 subgroups

➢ **Favourable ORR in PD-L1 low and PD-L1 negative tumors**

ORR – by PD-L1 status

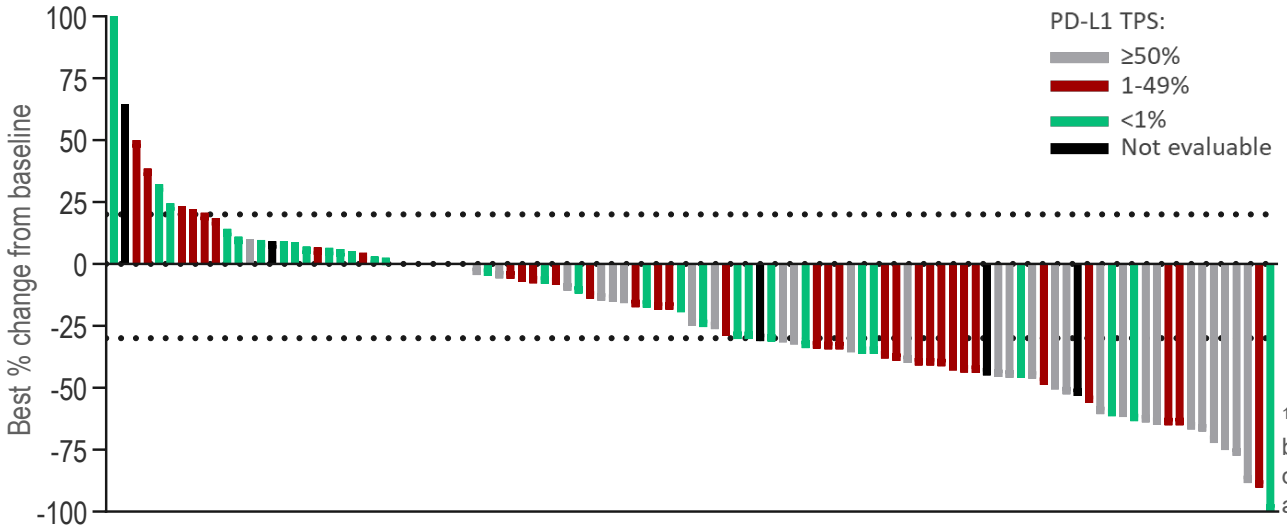
Tumor Response by central PD-L1 status (iRECIST, unconfirmed)[5], N=87	PD-L1 <1% n (%), N=32	PD-L1 1-49% n (%), N=36	PD-L1 ≥50% n (%), N=19	PD-L1 ≥1% n (%), N=55	PD-L1 <50% n (%), N=68
ORR [95% CI][6]	**9 (28.1)** [13.8-46.8]	**15 (41.7)** [25.5-59.2]	**10 (52.6)** [28.9-75.6]	**25 (45.5)** [32.0-59.5]	**24 (35.3)** [24.1-47.8]
DCR [95% CI][6]	**22 (68.8)** [50.0-83.9]	**28 (77.8)** [60.9-89.9]	**15 (79.0)** [54.4-94.0]	**43 (78.2)** [65.0-88.2]	**50 (73.5)** [61.4-83.5]

[5] Central assessment of PD-L1 TPS using Dako PD-L1 IHC 22C3 pharmDx for 87 patients.
[6] 95% CIs calculated using Clopper-Pearson method.

Notes:
* Data cut-off Apr 15, 2022
iRECIST… Immune Response Evaluation Criteria In Solid Tumors

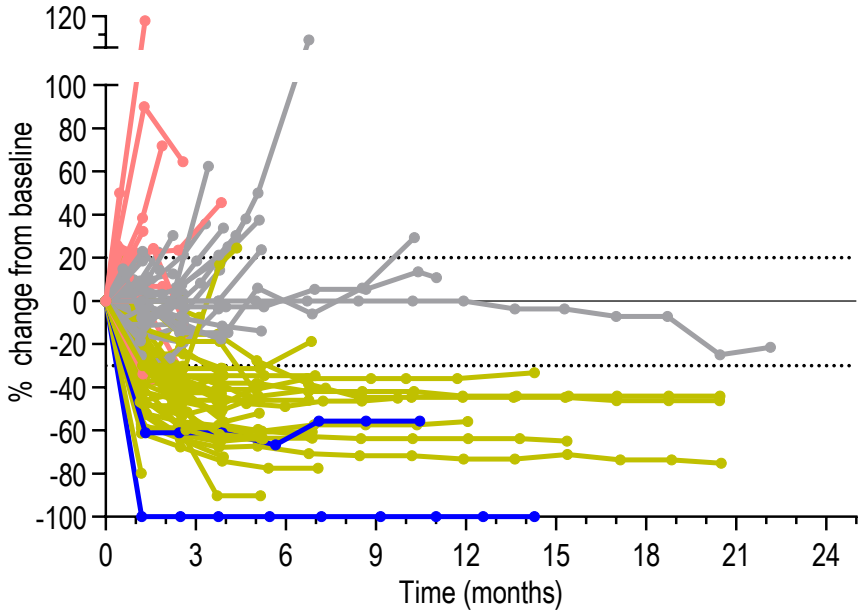
TACTI-002 Results(*)

1st line NSCLC (Part A) - Waterfall & Spider Plot



- 2 complete responses and 19.4% of patients with a target lesion decrease ≥ 50%
- 68/103 (66.0%) of patients with a post-baseline assessment had a decrease in target lesions

[1]All patients with ≥1 post-baseline CT scan n=103; [2] PD-L1 assessed by central assessment (Dako kit); n=79; [3] local assessment included due to non evaluable central assessment results, n=19; [4] no results available for neither central nor local testing, n=5.



- 80% (35/44) of responses[1] already confirmed & 5 (11.4%) pending confirmation
- 95% of patients having a response < 4 months after study start
- Responses are deep and long-lasting
- Only 8.6% of patients with confirmed response[2] progressed ≤ 6 months until data cut-off
- Median DoR not yet reached

All patients with ≥1 post-baseline CT scan; n=103; iUPD: unconfirmed progressive disease; iCPD: confirmed progressive disease; iPR: partial response; iCR: complete response.
[1] by iRECIST
[2] all patients with confirmed response by iRECIST

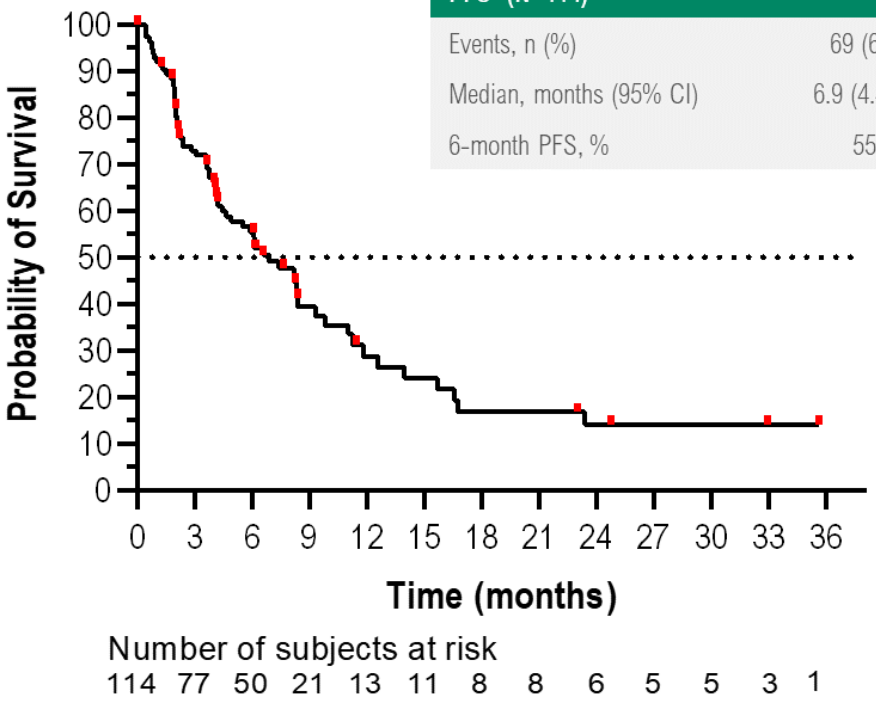
Notes:
* Data cut-off Apr 15, 2022
iRECIST… Immune Response Evaluation Criteria In Solid Tumors

TACTI-002 Results(*)

1st line NSCLC (Part A) - PFS

PFS ITT population (N=114)(*)

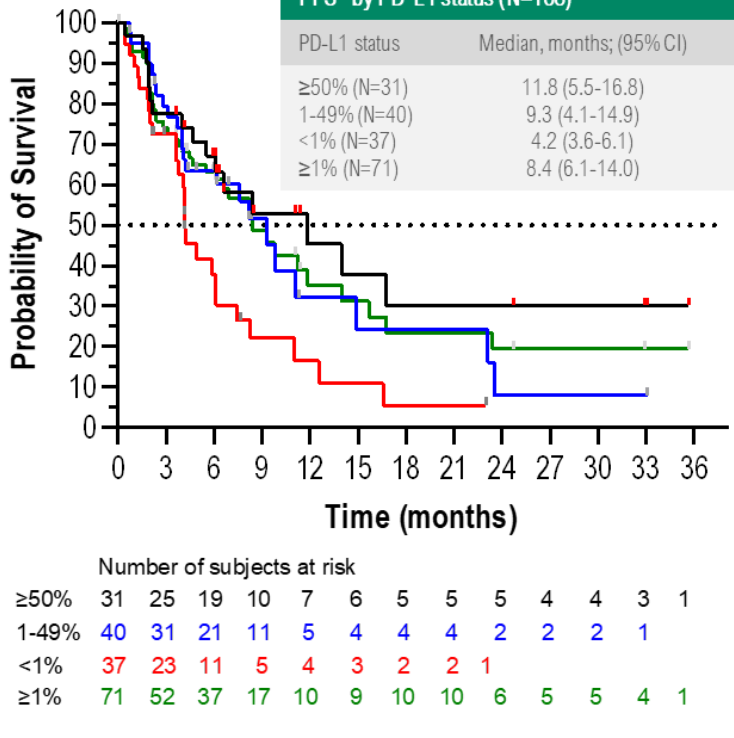
PFS[1] (N=114)	
Events, n (%)	69 (60.5)
Median, months (95% CI)	6.9 (4.4-8.4)
6-month PFS, %	55.4



- Interim median PFS(*) in the ITT (unselected for PD-L1) was 6.9 (95% CI: 4.4-8.4) months

PFS by PD-L1 status (N=108)(*, 1)

PFS[1] by PD-L1 status (N=108)		
PD-L1 status	Median, months; (95% CI)	Events, n (%)
≥50% (N=31)	11.8 (5.5-16.8)	16 (51.6)
1-49% (N=40)	9.3 (4.1-14.9)	23 (57.5)
<1% (N=37)	4.2 (3.6-6.1)	27 (73.0)
≥1% (N=71)	8.4 (6.1-14.0)	39 (54.9)



- Interim median PFS(1) in PD-L1 ≥ 1% was 8.4 (95% CI: 6.1-14.0) months and 11.8 (5.5-16.8) months in PD-L1 ≥ 50%

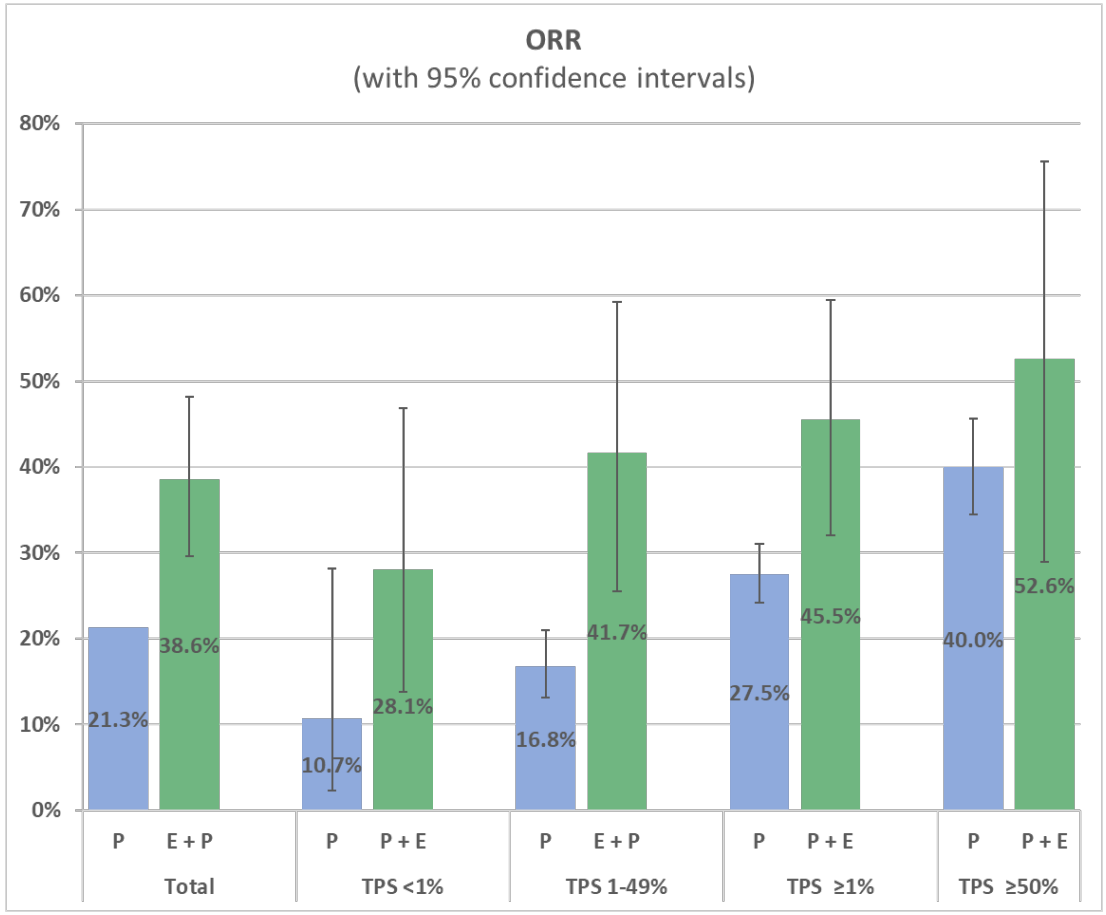
Notes:

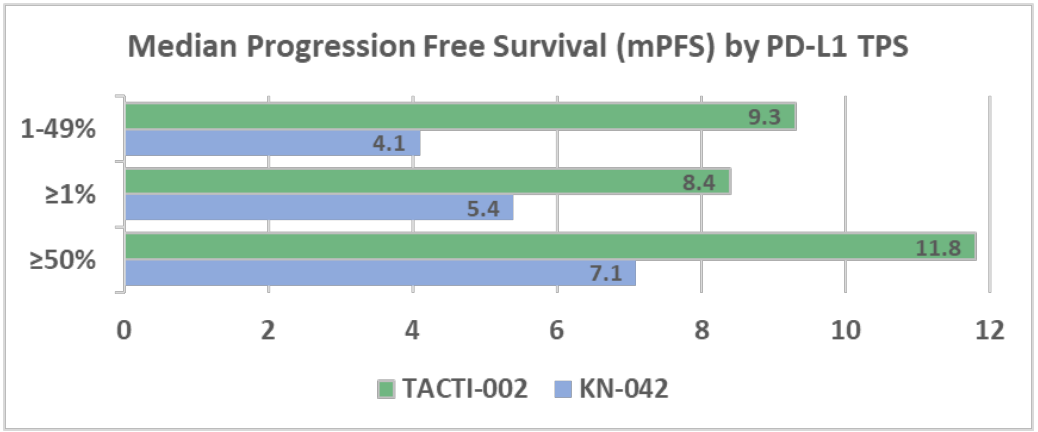
* Data cut-off Apr 15, 2022; *By iRECIST… Immune Response Evaluation Criteria In Solid Tumors*

(1) Central assessment as per footnote 1 for 87 patients. For 21 patients, local assessment was used due to non evaluable central assessment results.

TACTI-002 Results(*) - 1st line NSCLC

Benchmarking against pembro monotherapy





Pembro mono efficacy used for benchmarking:
Total: calculation based on KN-001; KN-042 and on adjustment for the same PD-L1 subgroup distribution as in TACTI-002.
< 1 % TPS: calculation based on a very limited data set from KN-001. 1st and 2nd line altogether.
1-49 % TPS: calculation based on KN-001, KN-042.
≥ 50 % TPS: calculation based on KN-001, KN-042.
≥ 1 % TPS: calculation based on KN-001, KN-042.

Efti + Pembro ORR by iRECIST, unconfirmed, Total (N=114) and PD-L1 TPS subgroups (N=87). Data cut-off date: April 15, 2022

95 % CIs are internal calculations using Clopper-Pearson: https://epitools.ausvet.com.au/ciproportion

PRIMARY OBJECTIVE REACHED

- ✓ Efti increases ORR in a PD-L1 unselected patient population compared to pembro
- ✓ Most prominent effects in pts with PD-L1^{low} or PD-L1^{-} patients
- ✓ Findings confirmed by PFS for all PD-L1 subgroups

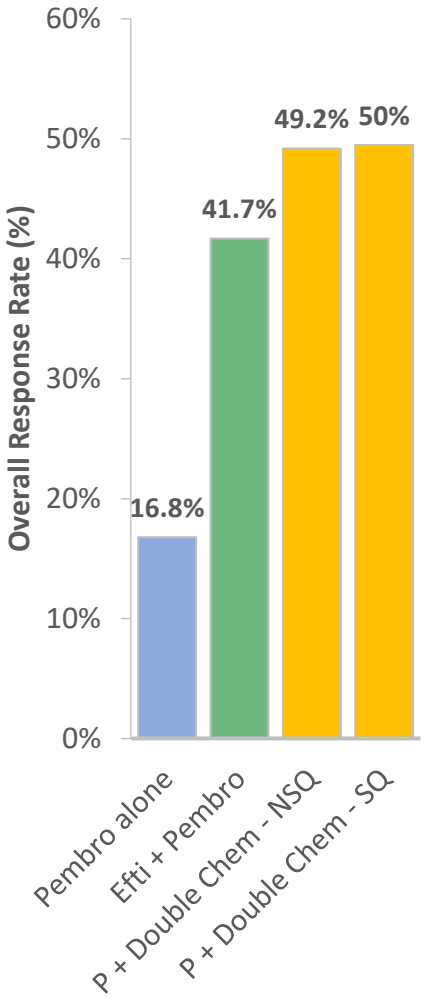
→ Only IO combination with good ORR in low and negative PD-L1 NSCLC tumors as efti works complementary to pembrolizumab‘s MoA

Notes:
* Data cut-off Apr 15, 2022; *By iRECIST… Immune Response Evaluation Criteria In Solid Tumors*

TACTI-002 Results(*) - 1st line NSCLC

Benchmarking for 1-49% against IO and IO-chemo

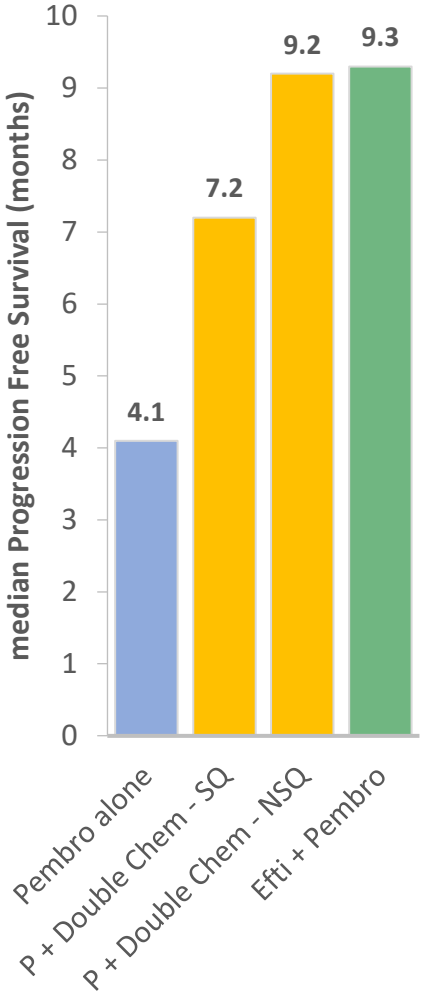
ORR
(TPS 1-49%)



EFTI OFFERS THE CHANCE FOR A CHEMO-FREE REGIMEN IN 1ST LINE NSCLC WITH TPS OF 1-49%

- ✓ ORR in the same range with 42% vs. 49-50% for chemo-IO
- ✓ mPFS highest with 9.3 vs. 7.2-9.2 for chemo-IO

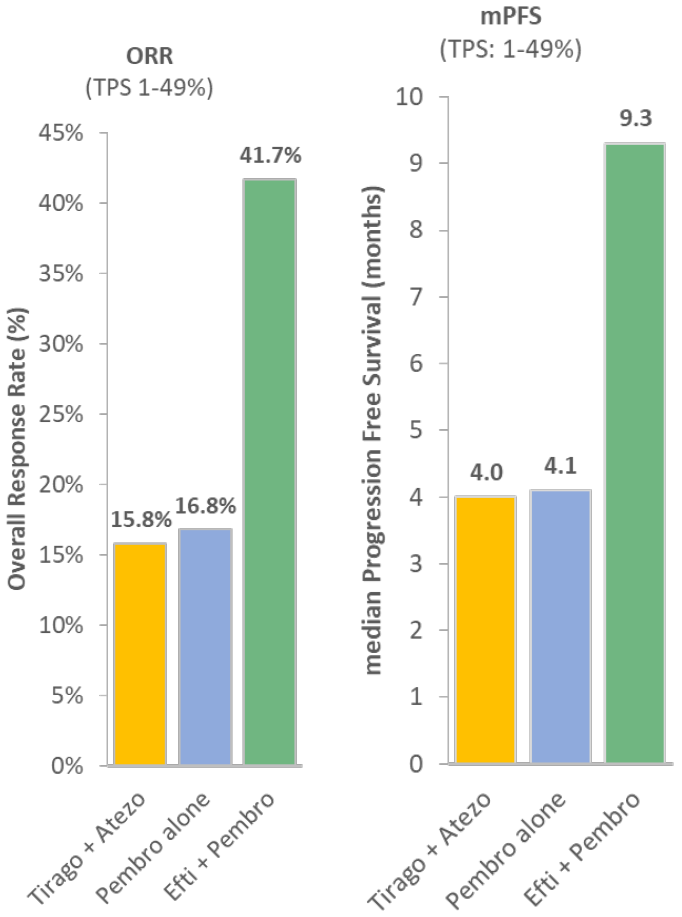
mPFS
(TPS: 1-49%)



Notes:
*Data for Efti + Pembro derived from ASCO22 oral presentation. Data cut-off: April 15, 2022
Data for pembro derived from KN-001, KN-042, KN-189, KN-407 publications

TACTI-002 Results (*) - 1st line NSCLC

Benchmarking against other IO-IO combinations



Tiragolumab (anti-TIGIT)

Tiragolumab plus atezolizumab (135 pts), 1st line NSCLC with ≥ 1% PD-L1(1)

Results:

CITYSCAPE	Results
1-49% TPS	ORR: 15.8% vs. 17.9% mPFS: 4.0 mts vs. 3.6 mts (HR 1.07)
≥ 50% TPS	ORR: 69.0% vs. 24.1% mPFS: 16.6 mts vs. 4.1 mts (HR 0.29)

Conclusion:

TIGIT probably has only effect in TPS ≥ 50% group & combo results are similar to pembro alone (atezolizumab weak comparator)

(note: Ph3 failed to demonstrate mPFS benefit for ≥ 50% TPS population)

Others

Vibo (a-TIGIT) + Pembro based on Ph1(2):

- all comer (n=39): ORR 26% (28% unconfirmed), mPFS: 5.0 mts
- TPS ≥ 1% (n = 12): 33% (42% unconfirmed), mPFS 9.0 mts
- TPS < 1% (n=11): ORR 27%, mPFS 3.0 mts.

Fave (a-LAG3) + Pembro based on Ph2(3):

- All comer (n=64): ORR ~25%

Lenvatinib + Pembro(4)

- Terminated due to failure to show OS benefit compared to Pembro mono in TPS ≥ 1%
- mOS: Lenva+Pembro: 14.1 mts vs. Pembro+Placebo: 16.4 mts, HR 1.1).

Source: CITYSCAPE trial: https://www.roche.com/media/releases/med-cor-2021-12-10
Pembro data based on KN-001 and/or KN-042
*TACTI-002: ASCO 2022 presentation, Data cut-off date: April 15, 2022

CONCLUSION

ORR and PFS trend favorably and data is more compelling than for anti-TIGIT and anti-LAG-3 → Efti combination benefits a much larger patient population due to its orthogonal therapeutic effect (APC activation) that complements the ICI effect of Pembro.

Notes:

(1) https://www.roche.com/media/releases/med-cor-2021-12-10
(2) J Niu et al. 2021. https://doi.org/10.1016/j.annonc.2021.11.002
(3) https://jitc.bmj.com/content/9/Suppl_2/A485
(4) https://cslide.ctimeetingtech.com/immuno2021v/attendee/confcal/show/session/12 *data cut off 15 Apr 2022

1st line NSCLC(*)

Efti Positioning in the Treatment Landscape

High unmet need:

- Median OS still < 24 months for most patients
- Low efficacy of anti-PD-(L)1 monotherapy for patients with TPS < 50% **(~70% of total population)**
- Double chemo + anti-PD-(L)1 → increased ORR & OS, but **shorter DoR due to chemo and more toxic** for combos with ipi & beva → high number of pts discontinuing and burden in terms of toxicity

→ Efti addresses both unmet needs with TACTI-002 results and **exploring chemo+pembro+efti combo in INSIGHT-003**

1st LINE NSCLC

TPS	Treatment	Efficacy(1)	Toxicity AEs leading to disc.
0 – 100%	Efti + Pembro	ORR 38.6% PFS 6.9 mts	< 10%
	Doublet Chemo	ORR 19-30% PFS 5-9 mts	8-22%
	Doublet Chemo + Pembro	ORR 48% (NSQ) & 63% (SQ) PFS 6 (SQ) & 9 (NSQ)	14%
	Doublet Chemo + Atezo + Beva	ORR 56% PFS 8.4 mts	33%
	Doublet Chemo + Ipi + Nivo	ORR 38% PFS 6.7 mts	19%
≥ 1%	Efti + Pembro	ORR 45.5% PFS 8.4 mts	< 10%
	Pembro mono	ORR 27.5% PFS 5.4 mts	1-14%
	Ipi + Nivo(2)	ORR 36% PFS 5.1 mts	18%
≥ 50%	Efti + Pembro	ORR 52.6% PFS 11.8 mts	< 10%
	Pembro/Atezo/Libtayo mono	ORR 35-45% PFS 7-10 mts	1-14%

Notes:

*Data cut-off date: April 15, 2022

Arrow lengths are not proportional representations of efficacy data.

(1) ORR and PFS results taken from respective publications of registrational trials.

(2) Only approved by FDA not by EMA for TPS ≥ 1%.

Summary & Conclusion

- ORR (iRECIST) of 38.6% (95% CI: 29.6-48.2) in 1st line NSCLC patients (ITT) unselected for PD-L1.
- Comparable results acc. to RECIST 1.1 for ORR with 37.7% (95% CI: 28.8-48.3) in the ITT.
- Promising ORR compared to historical control (KN-042[1]).
- Responses are deep and durable (< 10% of confirmed PRs progressed ≤ 6 months).
- In a PD-L1 unselected (incl. PD-L1 neg. + PD-L1 low tumors) population median PFS of 6.9 months [95% CI 4.4-8.4] is promising.
- Treatment with efti plus pembrolizumab is safe and well-tolerated (< 10% discontinuing due to study treatment-related TEAEs).

Conclusion: efti + pembrolizumab shows encouraging efficacy in 1st line PD-L1 unselected NSCLC patients and warrants late stage clinical investigation

Notes:

(1) Mok et al, The Lancet 2019, http://dx.doi.org/10.1016/S0140-6736(18)32409-7

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Outlook

2022 News Flow*

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2022

- ✓ New clinical data from TACTI-002 in 2nd line NSCLC presented at **ESMO Lung 2022** (30 March - 2 April)
- ✓ New biomarker & multivariate analysis from AIPAC presented at **ESMO Breast 2022** (3-5 May)
- ✓ New data from TACTI-002 in 1st line NSCLC presented in an Oral Presentation at **ASCO 2022** (3-7 June)
- Additional **study data** in H2 2022 (TACTI-002)
- Ongoing **recruitment & updates** from randomised trial in 1st line HNSCC (**TACTI-003**)
- **INSIGHT-003** recruitment & first results
- **Regulatory** updates
- Manufacturing **scale up** to 2,000 L
- **Expansion** of existing programs (incl. planned Phase III)
- Updates from **IMP761**
- Further updates from partnered programs (e.g. GSK, Novartis, EOC Pharma)

- ✓ Validation of LAG-3/MHC-II interaction through FDA's approval of Opdualag (BMS)
- ✓ 2022 is a breakthrough year for LAG-3 as it has become an approved commercial target

Notes:
*The actual timing of future data readouts may differ from expected timing shown above. These dates are provided on a calendar year basis.
A tick symbol indicates a completed item.

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LAG-3 IMMUNOTHERAPY

Thank You