Immutep TACTI-002 and INSIGHT Clinical Results & Update
Global Webcast Slides

Immutep will present these slides as part of its global webcast, as follows:

Date & Time
7.30 am Australian Eastern Daylight Time / 5.30 pm US Eastern Daylight Time

A replay of the webcast will also be available at www.immutep.com

(ASX: IMM, NASDAQ: IMMP)
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LAG-3 Overview & Product Candidates
Targeting LAG-3 / MHC II may lead to multiple therapeutics in numerous indications

**IMMUNOSTIMULATION**

- **APC activator**
- **Efti**
- **APC**
- **MHC II**
- **LAG-3**
- **T Cell**
- **Novartis**

**Partnered with**

**LAG525**
- **Antagonistic mAb**

**Immuno-oncology Combination Therapies**
- **Viral Infections**

**IMMUNOSUPPRESSION**

- **IMP761**
- **GSK'781**
- **Depleting mAb**
- **Agonistic mAb**
- **Partnered with GSK**
- **LAG-3**

**T Cell**

- **Rheumatoid Arthritis**
- **IBD**
- **Multiple Sclerosis**
Eftilagimod Alpha
(efti or IMP321)
## Immutep Controlled Immuno-Oncology Pipeline*

<table>
<thead>
<tr>
<th>Program</th>
<th>Preclinical</th>
<th>Phase I</th>
<th>Phase II</th>
<th>Late Stage(4)</th>
<th>Commercial Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eftilagimod Alpha (IMP321)</strong></td>
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<td>APC activating soluble LAG-3 Protein</td>
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<tr>
<td><strong>Oncology</strong></td>
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<td>Metastatic Breast Cancer (Chemo – IO)</td>
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<td>AIPAC</td>
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<td>Non-Small-Cell Lung Carcinoma (IO – IO)</td>
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<td>(1) TACTI-002</td>
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<td>Head and Neck Squamous Cell Carcinoma (IO – IO)</td>
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<td>(1) TACTI-002</td>
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<td>Solid Tumors (IO – IO)</td>
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<td>(2), (3) INSIGHT-004</td>
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<tr>
<td>Melanoma (IO – IO)</td>
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<tr>
<td>TACTI-mel</td>
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<tr>
<td>Solid Tumors (In situ Immunization)</td>
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<tr>
<td>(2) INSIGHT</td>
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<tr>
<td>Metastatic Breast Cancer (Chemo – IO)</td>
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<tr>
<td>EOC</td>
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</tbody>
</table>

**Notes:**

1. Information in pipeline chart current as at May 2020.
2. In combination with KEYTRUDA® (pembrolizumab) in non-small cell lung carcinoma ("NSCLC") or head and neck carcinoma ("HNSCC").
3. INSIGHT Investigator Initiated Trial ("IIT") is controlled by lead investigator and therefore Immutep has no control over this clinical trial.
4. Late stage refers to Phase IIb clinical trials or more clinically advanced clinical trials.
5. EOC Pharma is the sponsor of the EOC 202 clinical trial which is being conducted in the People’s Republic of China.
Efti: an innovative LAG-3 I-O product candidate

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

Efti is an MHC II agonist:
- APC activator
  - boost and sustain the CD8+ T cell responses
  - activate multiple immune cell subsets

LAG-3 antagonist, or blocking, antibodies:
- Immune checkpoint inhibitor
  - increase cytotoxicity of the pre-existing CD8 T cell response
Combining efti and anti-PD-L1 avelumab

INSIGHT-004
**Efti Clinical Development**

**INSIGHT-004 (Phase I)**

**INSIGHT-004: dose escalation of efti in combination with avelumab**

**Dose escalation, solid tumors, 2 cohorts of 6 patients each**

**efti + avelumab (Bavenico®) for 6 months + 6 months avelumab monotherapy**

**Phase I, monocenter DE, open label, IIT**

**RP2D, Safety, ORR, PFS, PK, PD**

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**Patient Population**

| Solid tumors after failure of standard therapy |

**Treatment**

| 6 / 30 mg efti s.c. 800 mg avelumab i.v. Both every 2 weeks |

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**Status Report**

- 1 site in Germany
- Protocol approved by CA / EC
- Recruitment completed in April 2020
- No dose limiting toxicity

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**In collaboration with:**

**Merck KGaA, I.K.F.**

Darmstadt, Germany

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**Key features: safety with a PD-L1 antagonist avelumab**

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**Notes:**

R2PD – recommended phase 2 dose, ORR – overall response rate, PFS – progression free survival, OS – overall survival, PK – pharmacokinetics
Efti Clinical Development
INSIGHT-004 – initial results

- Patients were/are treated for different tumor indications, but majority for cancers of the gastrointestinal tract.
- In colorectal (CRC)- gastric (GC) and gastroesophageal junction (GEJ) adenocarcinoma usually only a small proportion of patients – around 5% (3) – benefit from immunotherapy. Patients with proficient MMR (pMMR) or with microsatellite stable (MSS) typically do not benefit (1; 2).

Key findings

- No DLTs and no new safety signals with standard dose of avelumab
- 4/12 (33 %) patients with partial responses (3/12 pts not yet staged) in:
  - 1st line MSI high colorectal cancer
  - 1st line pleural mesothelioma
  - After radiochemo in squamous anal cell carcinoma
  - 3rd line gastroesophageal junction

- Efti plus avelumab is safe and well tolerated
- Encouraging single cases in non ICI sensitive cancers

Immunotherapy in gastrointestinal malignancies (1; 2; 3)

<table>
<thead>
<tr>
<th>Historical comparisons in metastatic colorectal cancer</th>
<th>ORR in MSS mCRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>anti-PD-1 monotherapy (pembr or nivo or atezo)</td>
<td>~0% - 2%</td>
</tr>
<tr>
<td>anti-PD-1 + anti-CTLA-4</td>
<td>~7% – 11%</td>
</tr>
<tr>
<td>Radiotherapy + ipi + nivo</td>
<td>~15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Historical comparisons in gastric and gastroesophageal junction adenocarcinoma</th>
<th>ORR in unselected GC/GEJ</th>
</tr>
</thead>
<tbody>
<tr>
<td>anti-PD-1/PD-L1 monotherapy (Pembro or Nivo or Avelumab) in 2nd/3rd line</td>
<td>~5% - 15%</td>
</tr>
</tbody>
</table>

Notes:
(2) A Zayac, K Almhanna: Esophageal, gastric cancer and immunotherapy: small steps in the right direction? Transl Gastroenterol Hepatol 2020;5:9
Combining efti and anti-PD-1 pembrolizumab

TACTI-002
Efti: Clinical Development TACTI-002 (Phase II)

**Trial Design + Introduction**

- Phase II, multi-national, open label, Simon’s 2 stage design; PD-L1 all comers
- In collaboration with Merck Sharp & Dohme (MSD)

### Eligibility

**Part A:**
1st line met. NSCLC

- Available tumor tissue
- ECOG 0-1
- Adequate organ functions
- PD-L1 all comers

**Part B:**
2nd line met. NSCLC, refractory for PD-1/PD-L1

**Part C:**
2nd line met. HNSCC after platinum

### Treatment

- **Part A:**
  - 30 mg efti SC
  - 200 mg pembrolizumab IV
  - Up to 12 months then pembrolizumab alone for another 12 months

- **Primary:** ORR (iRECIST)
- **Secondary:** PFS, OS, PK, biomarker, PD, safety and tolerability

### Study – Part

<table>
<thead>
<tr>
<th>Study – Part</th>
<th>Stage 1 (N) Actual/target</th>
<th>Stage 2 (N) target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>17/17</td>
<td>17/19</td>
</tr>
<tr>
<td>Part B</td>
<td>19/23</td>
<td>13 (not yet opened)</td>
</tr>
<tr>
<td>Part C</td>
<td>18/18</td>
<td>6/19</td>
</tr>
</tbody>
</table>

**Notes:**
Efti has a favourable safety profile in combination with pembrolizumab

**Summary TACTI-002 (N=76 in total)**

- No (0%) treatment related death
- 3 (3.9 %) treatment related adverse events leading to permanent discontinuation
- 31 pts (40.8%) had ≥ 1 adverse events ≥ grade 3
- No new safety signals of this combination identified until cut-off

<table>
<thead>
<tr>
<th>Regimen(2)</th>
<th>Treatment related adverse events leading to discontinuation</th>
<th>Treatment related adverse events leading to death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double Chemo</td>
<td>8-22%</td>
<td>1-6%</td>
</tr>
<tr>
<td>Ipi + Nivo</td>
<td>20%</td>
<td>&lt; 2%</td>
</tr>
<tr>
<td>Chemo + Pembro</td>
<td>23-33%</td>
<td>3-8%</td>
</tr>
<tr>
<td>Pembro alone</td>
<td>10-15%</td>
<td>&lt; 2%</td>
</tr>
<tr>
<td>Efti plus pembro</td>
<td>4%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Notes:
(1) Preliminary data, cut-off 30-Apr 2020
(2) Source: Calculated from corresponding publications e.g.: Checkmate-227; Keynote-40/189/407/48;
**High unmet medical need for well tolerated and efficacious treatment options**

**Epidemiology**<sup>(1)</sup>:
- 1,800,000 NSCLC diagnoses per annum worldwide growing by 1.5 % p.a.
- Approximately 1,300,000 develop metastatic disease and are eligible to receive anti-PD-1/PD-L1

**Unmet need:**
- Modest efficacy of anti PD-1/PD-L1 for pts with <50% PD-L1 (~70% of total population)
- Toxicity for patients / costs for health care systems of doublet chemo + PD-1/PD-L1 tremendous

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**Stage IV NSCLC: Molecular Test Negative (ALK/BRAF/EGFR/ROS1)**<sup>(3)</sup>

- PD-L1 expression
  - PD-L1 ≥ 50 %
  - Any PD-L1

**1st line:**
- Pembro
- PD-1/PD-L1 + Doublet Chemo
- Doublet Chemo

**2nd line:**
- Chemo
- PD-1 / PD-L1 / Chemo

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US$33.9 billion estimated market size by 2026<sup>(2)</sup>

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**Notes**

(1) Calculated from Global Cancer Observatory (WHO), 2018 data
(2) Informa Pharma Intelligence Report 2018 for US, Japan and EU5
(3) Based on ESMO Guidelines
Baseline Characteristics

- PD-L1 distribution as expected (~70% with < 50% PD-L1 expression) → PD-L1 all comer trial
- Patients are typical NSCLC 1st line pts

### Baseline Parameters (n=17)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age, yrs (range)</td>
<td>65 (53 – 76)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>6 (35.3)</td>
</tr>
<tr>
<td>Male</td>
<td>11 (64.7)</td>
</tr>
<tr>
<td>ECOG</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>12 (70.6)</td>
</tr>
<tr>
<td>1</td>
<td>5 (29.4)</td>
</tr>
<tr>
<td>Smoking status</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>1 (5.9)</td>
</tr>
<tr>
<td>Current / former</td>
<td>16 (94.1)</td>
</tr>
<tr>
<td>Histology</td>
<td></td>
</tr>
<tr>
<td>Squamous</td>
<td>10 (58.8)</td>
</tr>
<tr>
<td>Non-squamous</td>
<td>7 (41.2)</td>
</tr>
<tr>
<td>Location of disease at study entry</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>8 (47.1)</td>
</tr>
<tr>
<td>Bone</td>
<td>5 (29.4)</td>
</tr>
</tbody>
</table>

### Central assessment of tumor cell PD-L1 expression (done post enrollment)

<table>
<thead>
<tr>
<th>PD-L1 (n=13)</th>
<th>N (%)</th>
<th>Historical Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1%</td>
<td>3 (23%)</td>
<td>35%</td>
</tr>
<tr>
<td>1-49%</td>
<td>6 (46%)</td>
<td>35%</td>
</tr>
<tr>
<td>≥ 50%</td>
<td>4 (31%)</td>
<td>30%</td>
</tr>
</tbody>
</table>

Notes:
(1) Preliminary data, cut-off May 04, 2020
(2) % in reference to evaluable samples; 4 specimens not evaluable by central lab using standard IHC kit
### Responses and Waterfall plot

- **52.9 % iORR acc. to iRECIST in this PD-L1 all comers trial**
- **Responses in all PD-L1 subgroups**

#### Tumor response - iBOR as per iRECIST

<table>
<thead>
<tr>
<th>Response</th>
<th>N (%)</th>
<th>Total (N=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Response (iCR)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Partial Response (iPR)</td>
<td>9 (52.9)</td>
<td></td>
</tr>
<tr>
<td>Stable Disease (iSD)</td>
<td>5 (29.4)</td>
<td></td>
</tr>
<tr>
<td>Progressive Disease (iPD)</td>
<td>3 (17.7)</td>
<td></td>
</tr>
<tr>
<td>Objective Response Rate (iORR)</td>
<td>9 (52.9)</td>
<td></td>
</tr>
<tr>
<td>Disease Control Rate (iDCR)</td>
<td>14 (82.4)</td>
<td></td>
</tr>
</tbody>
</table>

- Responses in all PD-L1 subgroups
- 6/9 iPR confirmed
- 12/17 (71 %) patients with target lesion decrease
- 5 / 7 iPR with NSQ; 4 / 10 with SQ

#### Patients by PD-L1 category

<table>
<thead>
<tr>
<th>PD-L1 category</th>
<th>No. of Responses</th>
<th>No of pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (&lt; 1%)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Medium (1 - 49%)</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>High (≥ 50%)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Not evaluable</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Overall</td>
<td>9</td>
<td>17</td>
</tr>
</tbody>
</table>
At data cut-off\(^{(1)}\) 7 pts (41%) still under treatment  $\rightarrow$ estimated median PFS of 9+ months

- 2 late responders at 8 / 11 months!
- 7 pts still under therapy  $\rightarrow$ estimated median PFS of 9+ months
Positioning of efti in 1st line NSCLC

Selected SoCs 1st line NSCLC

<table>
<thead>
<tr>
<th>Regimen</th>
<th>ORR(^1,2)</th>
<th>Median DoR (months)</th>
<th>Median PFS (months)(^1,2)</th>
<th>Median OS (months) (^1,2)</th>
<th>Main downside/limitations(^1,2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double Chemo</td>
<td>20-30%</td>
<td>4.9 - 7.7</td>
<td>5 - 6.5</td>
<td>10.7 - 13.9</td>
<td>Toxicity + low efficacy</td>
</tr>
<tr>
<td>Ipi + Nivo</td>
<td>33%</td>
<td>23.2 (&gt;1%)</td>
<td>TBD</td>
<td>17.1</td>
<td>Toxicity, costs, low efficacy</td>
</tr>
<tr>
<td>Chemo + Pembro</td>
<td>48%</td>
<td>8 - 11.2</td>
<td>8.8</td>
<td>22.0</td>
<td>Costs, shorter DOR compared to IO alone, toxicity, nothing for 2nd line</td>
</tr>
<tr>
<td>Pembro alone(^3)</td>
<td>~20% (~17% in 1-49%)</td>
<td>20.2 (&gt;1%)</td>
<td>~5-6</td>
<td>~16</td>
<td>low efficacy for &lt; 50% PD-L1 expression</td>
</tr>
</tbody>
</table>

→ High unmet medical need in 1st line

Efti + pembro (stage 1, Part A): 53% iORR PD-L1 all-comer + median PFS expected 9+ mts

✓ Higher ORR/PFS compared to Pembro alone without additional toxicity

Efti could address unmet needs in 1st line NSCLC and be a key differentiator for any anti-PD-1/PD-L1 therapy

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\(^1\) Internal evaluation;
HNSCC Introduction

High unmet medical need for well tolerated and efficacious treatment options

Epidemiology:
- More than 585,000 HNSCC diagnoses per annum worldwide\(^{(1)}\)
- Approximately 350,000 develop metastatic disease and are eligible to receive anti-PD-1 monotherapy or in combination with chemotherapy

Unmet need:
- ORR of 10-18% and median PFS in 2\(^{nd}\) line regardless of therapy ~ 2 months

US$ 2.8 billion
Estimated market size by 2026\(^{(3)}\)


\((4)\) FDA and EMA approval differences. Pembrolizumab approval by the European Medicines Agency is for patients whose tumours express PD-L1 with a ≥ 50% TPS, which differs from FDA approval.

\((5)\) Kaplan-Meier curve was sourced from EEW Cohen et al. KEYNOTE-040, The Lancet 2018, http://dx.doi.org/10.1016/S0140-6736(18)31999-8

- approval for Pembro plus chemo in 1st line regardless of PD-L1 expression by FDA
Efti: Clinical Development
TACTI-002 – 2nd line HNSCC (part C, stage 1)

**Responses and Waterfall plot**

- **Initial iORR of 38.9 % in this PD-L1 all comer HNSCC 2nd line patients**

  - Median Age of 66, mostly male (94 %)
  - ECOG 1 in 47 %
  - All pre-treated with platinum-based therapy
  - Different subtypes

<table>
<thead>
<tr>
<th>Tumor response - iBOR as per iRECIST</th>
<th>N (%) Total (N=18)</th>
</tr>
</thead>
<tbody>
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<td>Complete Response (iCR)</td>
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<td>2 (11.1)</td>
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<tr>
<td>Progressive Disease (iPD)</td>
<td>7 (38.9)</td>
</tr>
<tr>
<td>Not evaluable*</td>
<td>2 (11.1)</td>
</tr>
<tr>
<td><strong>Objective Response Rate (iORR)</strong></td>
<td>7 (38.9)</td>
</tr>
<tr>
<td><strong>Disease Control Rate (iDCR)</strong></td>
<td>9 (50.0)</td>
</tr>
</tbody>
</table>

- **Part C* - 2nd line HNSCC**

  - Best response:
    - iUPD/iCPD
    - iSD
    - iPR
    - iCR

  - **n = 16**

  - 5/7 responses confirmed already
  - 1 iCR

* - dropped out prior to first restaging

Note:
(1) Preliminary data, cut-off 04 May 2020
Efti: Clinical Development
TACTI-002 – 2nd line HNSCC (part C, stage 1)

Spider plot

- At cut-off 8 pts (44%) still under therapy - HNSCC 2nd line patients

Part C* - 2nd line HNSCC

Best response:
- iPR
- iUPD/iCPD
- iSD
- iCR

Note:
(1) Preliminary data, cut-off 04-May 2020

Patients continuing treatment

- 1 iPR after pseudoprogression
- 1 iCR
- Responses getting deeper over time

n = 16 * cut-off 04-May 2020
Positioning of efti on 2nd line HNSCC

Current SoC 2nd line HNSCC

<table>
<thead>
<tr>
<th>Regimen</th>
<th>ORR&lt;sup&gt;(1,3)&lt;/sup&gt;</th>
<th>Median DoR (months)</th>
<th>Median PFS (months)&lt;sup&gt;(1, 3)&lt;/sup&gt;</th>
<th>PFS rate at 3 / 6 months&lt;sup&gt;(2)&lt;/sup&gt;</th>
<th>Median OS (months)&lt;sup&gt;(1)&lt;/sup&gt;</th>
<th>Main downside/limitations&lt;sup&gt;(1,2,3)&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemo</td>
<td>10.1%</td>
<td>5.0</td>
<td>2.3</td>
<td>45% / 20%</td>
<td>6.9</td>
<td>Not effective in &gt;&gt; 50% of patients</td>
</tr>
<tr>
<td>Pembro</td>
<td>14.6%</td>
<td>18.4</td>
<td>2.1</td>
<td>40% / 25%</td>
<td>8.4</td>
<td>Not effective in &gt;&gt; 50% of patients</td>
</tr>
<tr>
<td>Pembro ≥ 1% CPS</td>
<td>17.3%</td>
<td>18.4 (vs 9.6)</td>
<td>2.3</td>
<td>45% / 30%</td>
<td>8.7</td>
<td>Not effective in &gt;&gt; 50% of patients</td>
</tr>
<tr>
<td>Nivo</td>
<td>13.3%</td>
<td>9.7</td>
<td>2.0</td>
<td>37% / 21%</td>
<td>7.7</td>
<td>Not effective in &gt;&gt; 50% of patients</td>
</tr>
</tbody>
</table>

→ High unmet medical need in 2nd line HNSCC

Efti + pembro (stage 1, Part C): 39% iORR in PD-L1 all-comer incl. 1 iCR (6 %); 50 % DCR

✓ Higher ORR compared to Pembro alone without additional toxicity

Efti could adress unmet medical needs in 2nd line HNSCC offering a potential pathway to early regulatory interactions (registration)

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<sup>(2)</sup> Internal calculations based on the published results of the Keynote-040 clinical trial (internal calculation done in 2019)
Accelerated approval based on non-randomized phase II trials with ORR as primary endpoint

Based on: KEYNOTE-012:

- non-randomized, open-label, multi-cohort phase 1b study
- Primary EP:
  - ORR: 16% (95% CI: 11, 22), according to RECIST 1.1 assessed by BICR. (N=174)
  - Median PFS: 2.1 months
  - DoR*: median DoR not reached (range from 2.4+ to 27.7+ months), with 23 patients > 6 months

Supported by KEYNOTE-055 (N=171) interim data:

- open-label, non-randomized, Phase 2 (50 patients with >6 months of follow-up)
  - ORR: 18% acc. to RECIST 1.1
  - DoR*: estimated median of 6.9 months (range 3.0–8.31 months)

FDA condition: KEYNOTE-040 required → failed to show significant improvement in median OS but label was not changed

* - The difference in the estimated median DoR between KEYNOTE-055 and KEYNOTE-012 may be attributable to the difference in duration of follow-up between the trials, with a maximum follow-up duration of 8.3 months for KEYNOTE-055 versus 30 months in KEYNOTE-012
Summary and Outlook
In total experience with 2 drugs (pembrolizumab, avelumab) in 4 different trials (6+ different indications) in up to $\Sigma 145$ pts

<table>
<thead>
<tr>
<th>Trial / Indication</th>
<th>TACTI-002</th>
<th>TACTI-mel metastatic melanoma</th>
<th>INSIGHT-004 Advanced solid tumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A 1st line NSCLC</td>
<td>PD-L1 all comers; PD-X naive; SQ+NSQ</td>
<td>PD-L1 all comers; PD-X refractory</td>
<td>PD-L1 all comers; partly with suboptimal response to pembrolizumab alone</td>
</tr>
<tr>
<td>Part B 2nd line NSCLC</td>
<td>PD-L1 all comers; PD-X refractory</td>
<td>PD-L1 all comers; PD-X naive</td>
<td>PD-L1 all comers</td>
</tr>
<tr>
<td>Part C 2nd line HNSCC</td>
<td>Not yet</td>
<td>PD-L1 all comers; 39% iORR incl. 5% iCR</td>
<td>1 CR after PD on pembrolizumab 58% ORR*; 58% progression free at 6 months</td>
</tr>
<tr>
<td>No of pts</td>
<td>N=36 (Stage 1: 17/17; Stage 2: 17/19)</td>
<td>N=37 (Stage 1: 18/18; Stage 2: 6/19)</td>
<td>N=24 (Part A: 18; Part B: 6)</td>
</tr>
<tr>
<td>Highlights(1)</td>
<td>PD-L1 all comers; 53% iORR; median PFS 9+ months; responses, excellent safety</td>
<td>PD-L1 all comers; 39% iORR incl. 5% iCR</td>
<td>4 PRs in partly ICI insensitive indications</td>
</tr>
<tr>
<td>Historical comparison(2)</td>
<td>Pembro mono: ~20% ORR; 5-6 months median PFS</td>
<td>Pembro mono: 15-18% ORR in &gt; 1 % PD-L1</td>
<td>21-33% ORR; 34-46% progression free at 6 months</td>
</tr>
</tbody>
</table>

Notes:
(1) Preliminary data, cut-off May 2020 (TACTI-002); October 2019 (TACTI-mel); Presented at ASCO 2020 Virtual in May 2020 (INSIGHT);
*CD1 exploratory analysis
## What could be next?

### Landscape

<table>
<thead>
<tr>
<th>eftilagimod alpha</th>
<th>Other agonists</th>
<th>Other antagonists</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MHC class II agonist)</td>
<td><strong>TLR agonists:</strong> Limited mostly to i.t. administration, some encouraging results in combination with anti-PD-1</td>
<td><strong>LAG-3 antagonists:</strong> BMS, Novartis and others have different large programs</td>
</tr>
<tr>
<td>✓ Results from TACTI-002 (in 2 indications) are very encouraging compared to what has been published so far</td>
<td><strong>CD40 agonists:</strong> Early results in combination with anti-PD-1 look encouraging → PII ongoing (Apexigen Inc)</td>
<td><strong>TIGIT antagonists:</strong> Interesting data of tigarolumab (plus Atezolizumab) in 1st line NSCLC in phase II → ORR of 31% in PD-L1 all comer → ongoing phase III by Roche</td>
</tr>
<tr>
<td>✓ Immutep with its two different IO product candidates (one outlicensed to Novartis) is well positioned to potentially become “the next big thing” in oncology</td>
<td><strong>ICOS agonists:</strong> 26% ORR in ≥2nd line HNSCC with pembro in phase I → ongoing phase II/III by GSK</td>
<td></td>
</tr>
</tbody>
</table>

### Notes:
- Current as of May 2020 based on clinicaltrials.gov
2020 & 2021 Outlook* and News Flow

Upcoming in 2020:

- **NSCLC 1st line** - more data from Stages 1 and 2 from TACTI-002 throughout 2020
- **HNSCC 2nd line** - initial data from Stages 1 and 2 from TACTI-002 throughout 2020
- **NSCLC 2nd line** - initial data from Stage 1 from TACTI-002 throughout 2020
- **MBC** - Overall Survival data from AIPAC: End of 2020
- **Combination with avelumab** - initial data from Phase I trial throughout 2020
- Regulatory progress
- Progress from partnered programs

Expected in 2021:

- Final data from **TACTI-002** part A and C
- Final data from **INSIGHT-004**
- Ongoing regulatory engagement
- Updates from IMP761
- Progress from partnered programs

*The actual timing of future data readouts may differ from expected timing shown above. These dates are provided on a calendar year basis.

Notes:

*The actual timing of future data readouts may differ from expected timing shown above. These dates are provided on a calendar year basis.
Thank you!