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

FORM 8-K
Current Report

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

Date of Report (date of earliest event reported): January 10, 2023

IOVANCE BIOTHERAPEUTICS, INC.

(Exact Name of Registrant as Specified in Charter)

Delaware	
(State of Incorporation)	
001-36860	**75-3254381**
Commission File Number	**(I.R.S. Employer Identification No.)**
825 Industrial Road, Suite 400 **San Carlos, California**	**94070**
(Address of Principal Executive Offices)	**(Zip Code)**

(650) 260-7120
(Registrant's Telephone Number, Including Area Code)

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

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

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

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

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

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

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

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common stock, par value $0.000041666 per value	IOVA	The Nasdaq Stock Market, LLC

Item 8.01 Other Events.

On January 10, 2023, Iovance Biotherapeutics, Inc. (the "Company") updated its corporate presentation that it uses for presentations at healthcare conferences and to analysts, current stockholders, and others. A copy of the Company's presentation that it intends to use at such events is attached as Exhibit 99.1 and incorporated herein by reference.

Item 9.01 Financial Statements and Exhibits.

(d) Exhibits.

Exhibit No.	Description
99.1	Iovance Biotherapeutics, Inc., Corporate Presentation – January 2023
104	Cover Page Interactive Data File (embedded as Inline XBRL document)

SIGNATURES

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

Date: January 10, 2023

IOVANCE BIOTHERAPEUTICS, INC.

By: /s/ Frederick G. Vogt
Frederick G. Vogt, Interim CEO & General Counsel

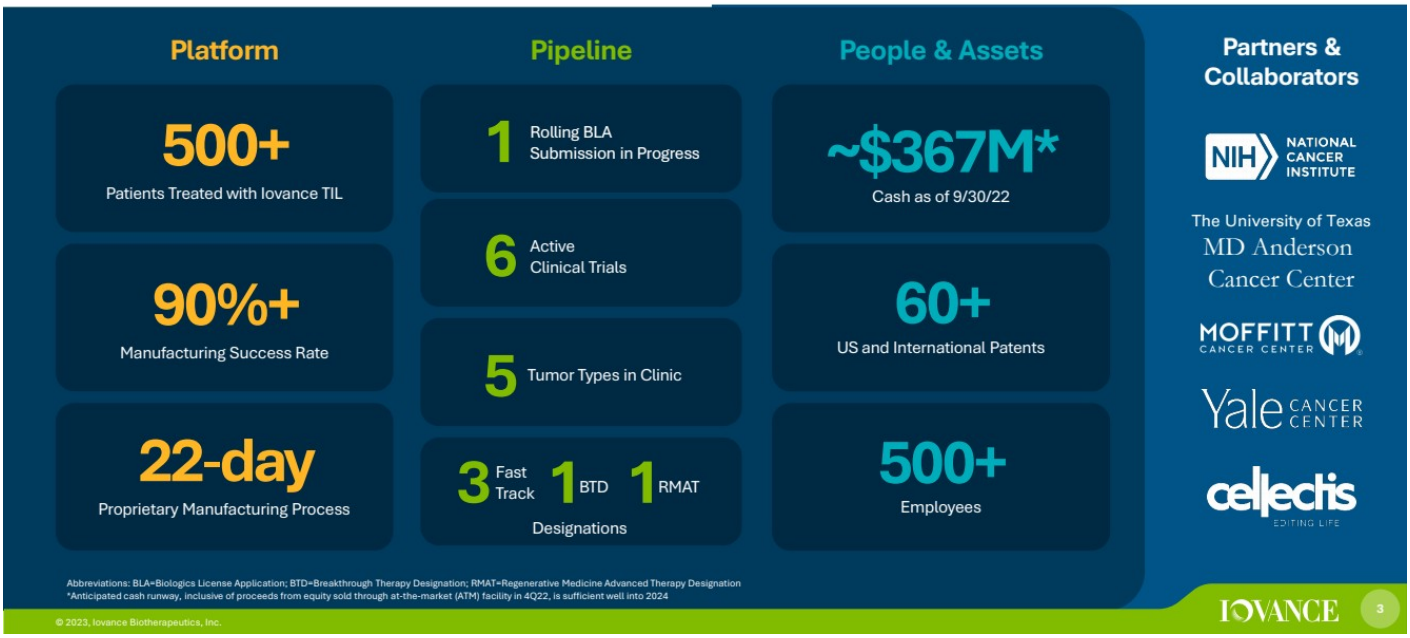
Exhibit 99.1


IOVANCE
BIOTHERAPEUTICS
Corporate Overview
January 2023
ADVANCING IMMUNO-ONCOLOGY
© 2023, Iovance Biotherapeutics, Inc.
1

Forward-Looking Statements

Certain matters discussed in this press release are "forward-looking statements" of Iovance Biotherapeutics, Inc. (hereinafter referred to as the "Company," "we," "us," or "our") within the meaning of the Private Securities Litigation Reform Act of 1995 (the "PSLRA"). All such written or oral statements made in this press release, other than statements of historical fact, are forward-looking statements and are intended to be covered by the safe harbor for forward-looking statements provided by the PSLRA. Without limiting the foregoing, we may, in some cases, use terms such as "predicts," "believes," "potential," "continue," "estimates," "anticipates," "expects," "plans," "intends," "forecast," "guidance," "outlook," "may," "could," "might," "will," "should" or other words that convey uncertainty of future events or outcomes and are intended to identify forward-looking statements. Forward-looking statements are based on assumptions and assessments made in light of management's experience and perception of historical trends, current conditions, expected future developments and other factors believed to be appropriate. Forward-looking statements in this press release are made as of the date of this press release, and we undertake no duty to update or revise any such statements, whether as a result of new information, future events or otherwise. Forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and other factors, many of which are outside of our control, that may cause actual results, levels of activity, performance, achievements and developments to be materially different from those expressed in or implied by these forward-looking statements. Important factors that could cause actual results, developments and business decisions to differ materially from forward-looking statements are described in the sections titled "Risk Factors" in our filings with the Securities and Exchange Commission, including our most recent Annual Report on Form 10-K and Quarterly Reports on Form 10-Q, and include, but are not limited to, the following substantial known and unknown risks and uncertainties inherent in our business: the effects of the COVID-19 pandemic; risks related to the timing of and our ability to successfully develop, submit, obtain and maintain U.S. Food and Drug Administration ("FDA") or other regulatory authority approval of, or other action with respect to, our product candidates, and our ability to successfully commercialize any product candidates for which we obtain FDA approval; whether clinical trial results from our pivotal studies and cohorts may support registration and approval by the FDA; preliminary and interim clinical results, which may include efficacy and safety results, from ongoing clinical trials or cohorts may not be reflected in the final analyses of our ongoing clinical trials or subgroups within these trials or in other prior trials or cohorts; the risk that enrollment may need to be adjusted for our trials and cohorts within those trials based on FDA and other regulatory agency input; the changing landscape of care for cervical cancer patients may impact our clinical trials in this indication; the risk that we may be required to conduct additional clinical trials or modify ongoing or future clinical trials based on feedback from the FDA or other regulatory authorities; the risk that our interpretation of the results of our clinical trials or communications with the FDA may differ from the interpretation of such results or communications by the FDA (including from the recent pre-BLA meeting with the FDA); the risk that the rolling BLA submission for lifileucel in metastatic melanoma may take longer than expected; the acceptance by the market of our product candidates and their potential reimbursement by payors, if approved; our ability or inability to manufacture our therapies using third party manufacturers or our own facility may adversely affect our potential commercial launch; the results of clinical trials with collaborators using different manufacturing processes may not be reflected in our sponsored trials; the risk that unanticipated expenses may decrease our estimated cash balances and forecasts and increase our estimated capital requirements; and other factors, including general economic conditions and regulatory developments, not within our control.

Global Leadership in Innovating, Developing and Delivering TIL Therapy for Patients with Cancer



2022 Accomplishments

REGULATORY	☑ BLA: Commenced rolling BLA submission in August 2022
PIPELINE	☑ Advanced melanoma (post-anti-PD-1): Cohort 4 data at SITC 2022 and in JITC
	☑ Frontline advanced melanoma: began Phase 3 trial
	☑ NSCLC: enrolled additional patients in IOV-LUN-202 and IOV-COM-202 trials
	☑ Cervical: expanded Cohort 2 to support regulatory submissions
	☑ TIL combinations: continued ongoing solid tumor cohorts of TIL + pembrolizumab
	☑ Genetically-modified TIL: initiated IOV-GM1-201 first-in-human trial of IOV-4001
	☑ Research: advanced new products toward clinic
MANUFACTURING	☑ Executed GMP commercial readiness activities, scaled up production at *i*CTC
COMMERCIAL	☑ Executed ATC onboarding activities and payer engagement

Iovance Solid Tumor Pipeline Highlights

	PRODUCT CANDIDATE	INDICATION(S)	PHASE 1	PHASE 2	PIVOTAL
Advanced Melanoma (Metastatic or Unresectable)	Lifileucel + pembro	Frontline	TILVANCE-301 Phase 3		Confirmatory, FTD
	TIL (Lifileucel/LN-144)	Post-anti-PD-1	C-144-01, Cohorts 2 & 4		Rolling BLA In Progress, RMAT
	Lifileucel + pembro	Anti-PD-1 naïve	IOV-COM-202, Cohort 1A		
Next Generation	PD-1 Inactivated TIL (IOV-4001)	Post-anti-PD-1	IOV-GM1-201, Cohort 1		
Metastatic NSCLC	LN-145	2L post-chemo & post-anti-PD-1	IOV-LUN-202, Cohorts 1 & 2		
	LN-145 + pembro	Anti-PD-1 naïve	IOV-COM-202, Cohort 3A		
	LN-145	2-4L incl. post-anti-PD-1	IOV-COM-202, Cohort 3B*		
	LN-145 + ipi/nivo	Post-anti-PD-1	IOV-COM-202, Cohort 3C		
Next Generation	LN-145 Gen 3 + core biopsy	2L post-chemo & post-anti-PD-1	IOV-LUN-202 Cohort 3		
	PD-1 Inactivated TIL (IOV-4001)	2-4L incl. post-anti-PD-1	IOV-GM1-201, Cohort 2		
Cervical	Lifileucel	Post-chemo & post-anti-PD-1	C-145-04, Cohort 2		BTD, ODD
	LN-145 + pembro	1L – chemo and anti-PD-1 naïve	C-145-04, Cohort 3*		

*Enrollment complete
Abbreviations: 1L=first line; 2L=second line; 4L=fourth line; BTD=breakthrough therapy designation; FTD=fast track designation; ipi/nivo=ipilimumab/nivolumab; NSCLC=non-small cell lung cancer; ODD=orphan drug designation; PD-1=programmed cell death protein-1; RMAT=Regenerative Medicines Advanced Therapy; TIL=tumor infiltrating lymphocytes

Significant Market Potential in Solid Tumors

90%

of all cancer cases are solid tumors[1]

1.7M

New cases of solid tumors in the U.S.[1]

Move into earlier line of therapy

Expand into other indications

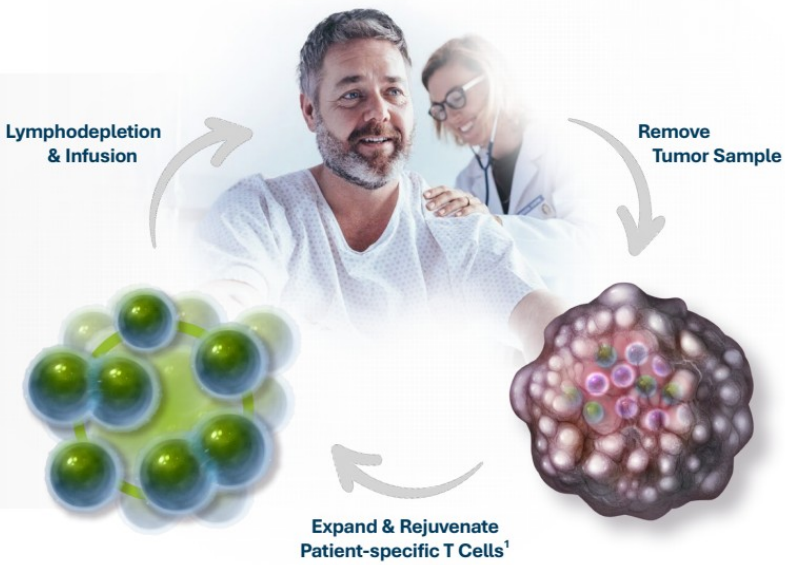
	Deaths[1]	New Cases[1]
Melanoma	7,650	99,780
Cervical	4,280	14,100
Lung & Bronchus	130,180	236,740
Oral Cavity, Pharynx & Larynx	15,050	66,470
Breast	43,780	290,560
Pancreatic	49,830	62,210
Brain & Other Nervous System	18,280	25,050
	Potential to address unmet need in late lines of treatment	**Potential market for early lines in combo with standard of care**

1. https://seer.cancer.gov accessed May 2022

Tumor Infiltrating Lymphocytes (TIL): Leading Platform for Treatment of Solid Tumors

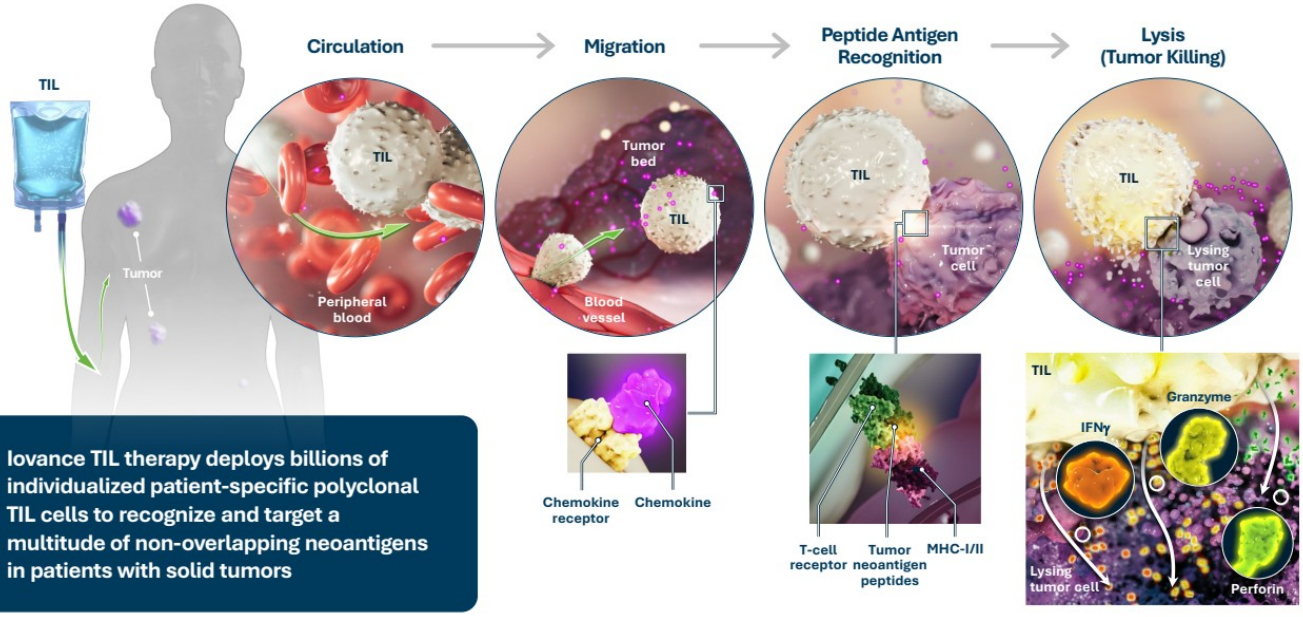
TIL – Unique Mechanism of Action

- Individualized
- Patient's own immune system amplified and rejuvenated
- One-time therapy



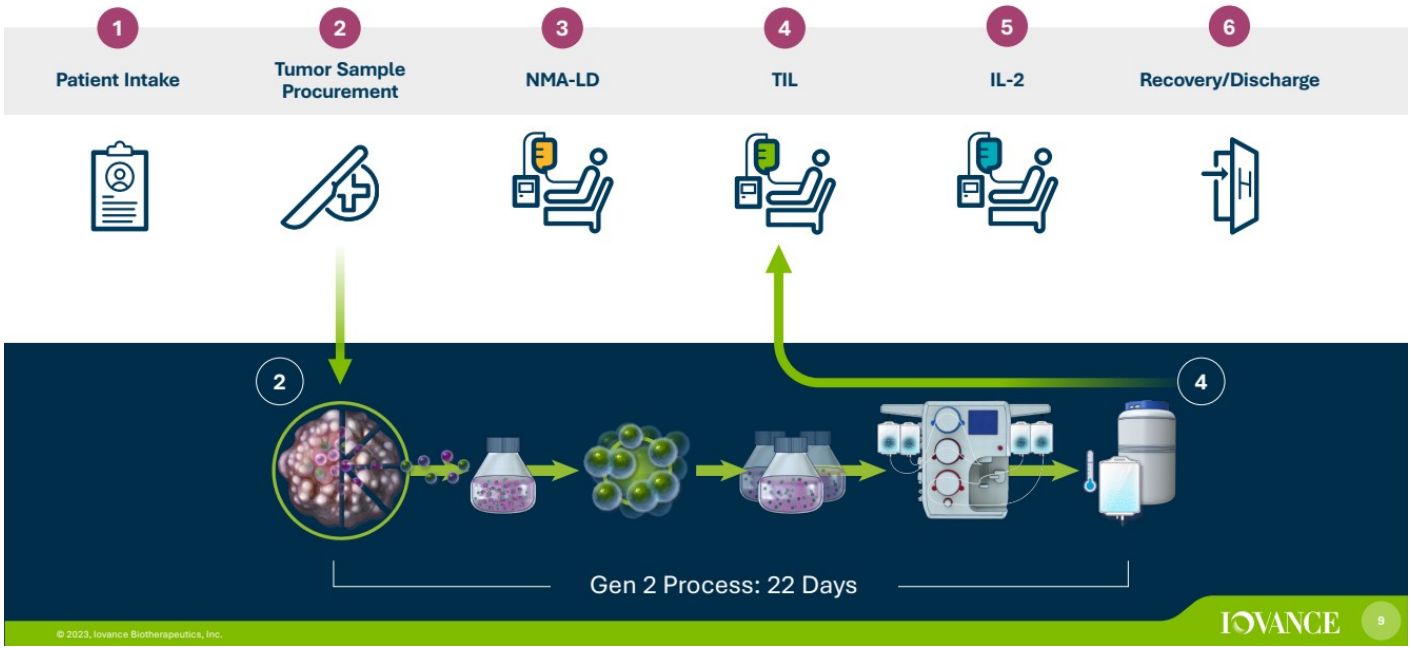
1. Simpson-Abelson et al., ESMO 2020

TIL Mechanism of Action



Iovance TIL therapy deploys billions of individualized patient-specific polyclonal TIL cells to recognize and target a multitude of non-overlapping neoantigens in patients with solid tumors

Iovance Streamlined 22-Day GMP Manufacturing Process



IOVANCE

Iovance Cell Therapy Center: *i*CTC

Built-to-suit custom facility in Navy Yard Philadelphia

136,000 ft², $85M investment

LEED gold certification for core and shell building

Honorable Mention Winner: 2022 ISPE Facility of the Year Awards

Clinical supply initiated 3Q21

Commercial manufacturing expected with BLA approval

Control to optimize capacity, quality & COGS

Leading Cell Therapy Manufacturing Facility

IOVANCE BIOTHERAPEUTICS
CELL THERAPY CENTER

FOYA 2022
ISPE Facility of the Year Awards
CATEGORY WINNER
Honorable Mention

Iovance Cell Therapy Center (*i*CTC): Building Annual Capacity for Thousands of Cancer Patients

Phase 1 *i*CTC Today

100s
of patients/year

BLA Prep
in core suites for commercial

4
separate flex suites for clinical

Phase 2 *i*CTC Ongoing Staffing

2,000+
patients/year

12
core suites for commercial

4
separate flex suites for clinical

Phase 3 *i*CTC Expansion[1]

5,000+
patients/year

24
core suites for commercial

4
separate flex suites for clinical

Phase 4 *i*CTC+ Additional Site(s)

10,000+
patients/year

***i*CTC**

Adjacent and new sites[2]

Automation

1. Expansion within existing shell
2. Option to build on adjacent parcel

Iovance TIL Therapy in Advanced Melanoma

IOVANCE BIOTHERAPEUTICS

Unmet Medical Need for Metastatic Melanoma Therapy

No FDA Approved Treatment Options After Progression on ICI (Anti-PD-1) Therapy and BRAF/MEK inhibitors

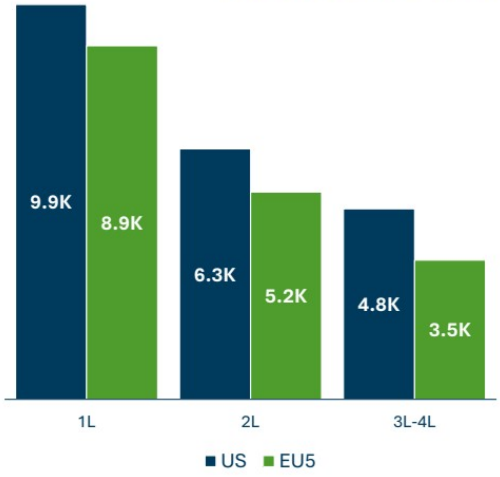
325k Annual new cases worldwide[1]

57k Annual deaths worldwide[1]

100k Annual new cases in U.S.[2]

7.7k Annual deaths in U.S.[2]

Melanoma Drug-Treated Population in 2021[3]
Unresectable / Metastatic (US and EU5)



Available Care:

1L Anti-PD-1 Immunotherapy **21%-33% ORR[4]**

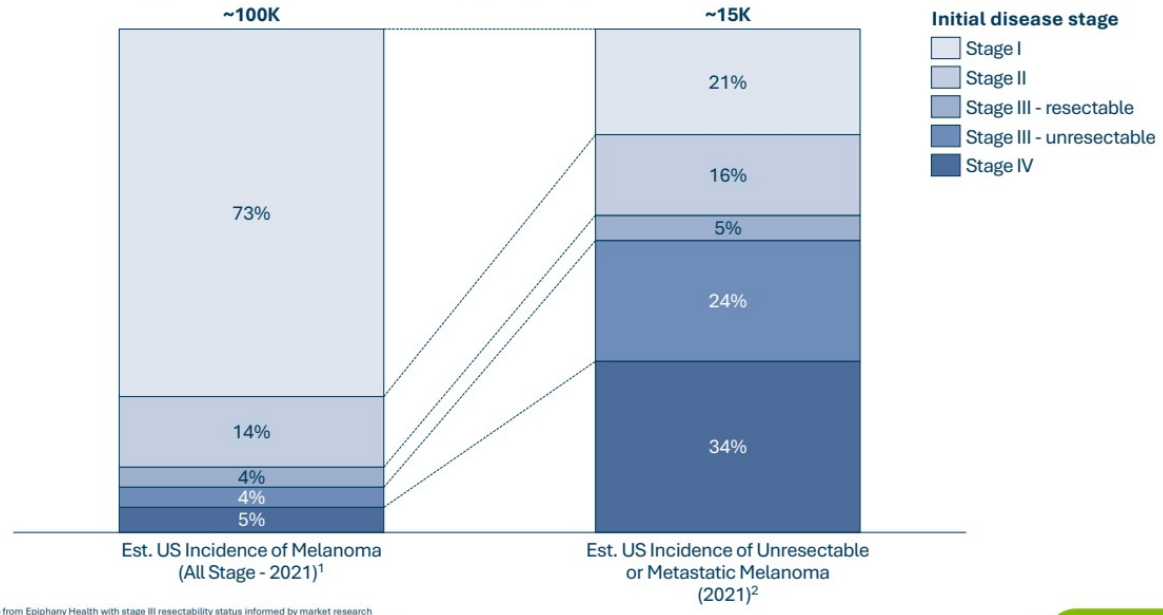
BRAF/MEK inhibitors if BRAF mutation +

2L+ Chemotherapy **ORR 4-10%[5]** **mOS ~7-8 months[6]**

1. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries, CA Cancer J Clin., May 2021
2. https://seer.cancer.gov accessed May 2022
3. Clarivate DRG Disease Landscape (2021)
4. Keytruda USPI accessed Mar 2022
5. Keytruda USPI accessed Mar 2022 (4%) and Weber et al., Lancet Oncol 2015 (ICC 10%)
6. Kirchburger et al., Eur J Cancer 2016 and Goldinger et al., J Clin Oncol 2018

Abbreviations: EU5=France, Germany, Italy, Spain and United Kingdom; 1L=first line therapy, 2L=second line therapy, 3L=third line therapy, 4L=fourth line therapy; ICI=immune checkpoint inhibitor; ORR=objective response rate; mOS=median overall survival; PD-1=programmed cell death protein-1

Estimated total incidence and incidence of unresectable or metastatic melanoma by initial disease stage (US)

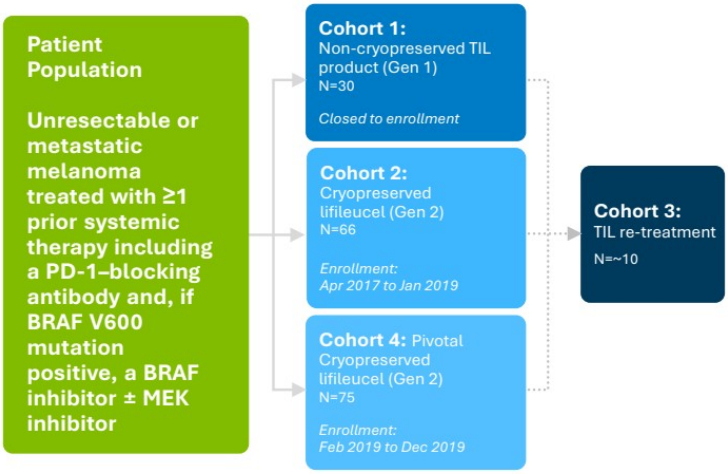


1. Estimate of US incidence from Epiphany Health with stage III resectability status informed by market research
2. Estimate of US incidence of unresectable or metastatic melanoma based on secondary and primary market research

C-144-01 Phase 2 Study Design

Identical Eligibility and Treatment for Cohorts 2 and 4

Phase 2, multicenter study to assess the efficacy and safety of autologous TIL (lifileucel) for treatment of patients with metastatic melanoma (NCT02360579)



Key Endpoints

- Primary: ORR (IRC-assessed using RECIST v1.1)
- Secondary: DOR, PFS, OS, TEAE incidence and severity

Key Eligibility Criteria

- Tumor lesion/s for TIL generation and response assessment
- No limit on number of prior therapies or markers of tumor burden (including size or LDH)

Treatment Regimen (Cohorts 2 and 4)

- 22-day Gen 2 manufacturing process
- All patients received NMA-LD, a single lifileucel infusion, and up to 6 doses of high-dose IL-2

Data cutoff date: July 15, 2022

Abbreviations: DOR=duration of response; ECOG=Eastern Cooperative Oncology Group; IL-2=interleukin 2; IRC=Independent Review Committee; NMA-LD=nonmyeloablative lymphodepletion; ORR=objective response rate; OS=overall survival; PD-1=programmed cell death protein 1; RECIST=Response evaluation Criteria in Solid Tumors; TEAE=treatment-emergent adverse events; TIL=tumor-infiltrating lymphocytes

Highlighted Prior Therapy and Baseline Disease Characteristics*

Cohorts 2 and 4 Heavily Pre-Treated and Mostly Similar; Cohort 4 had Higher Disease Burden and LDH Elevation

Prior Therapy Experience (Cohorts 2+4)

- Median of 3 lines of therapy (range, 1-9)[1]
- Median of 2 lines (range, 1-7) of ICI-containing therapy
- 113 (73.9%) retreated with ICI-containing therapy
- 125 (81.7%) received anti–CTLA-4
- 82 (53.6%) received anti–PD-1 + anti–CTLA-4 combination

Baseline Disease Characteristics

Disease burden (>3 lesions)

83.9%	65.2%
Cohort 4 (n=87)	Cohort 2 (n=66)

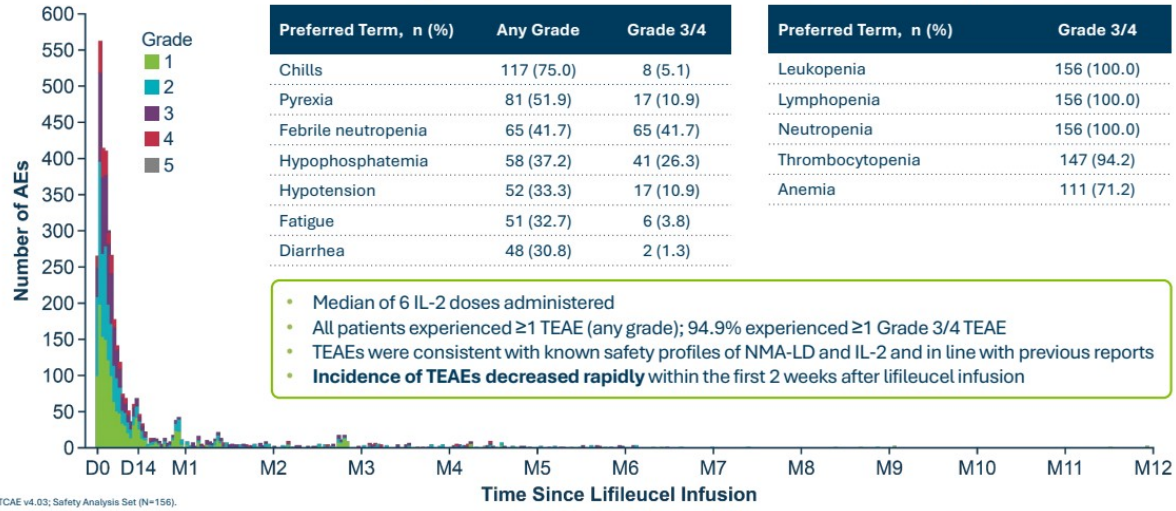
Elevated LDH (>ULN), a negative prognostic factor

64.4%	40.9%
Cohort 4 (n=87)	Cohort 2 (n=66)

*Refer to SITC 2022 presentation for full baseline characteristics
1. All patients received prior anti-PD1 therapy
Abbreviations: CTLA-4=cytotoxic T-lymphocyte antigen 4; ICI=immune checkpoint inhibitor; LDH=lactate dehydrogenase; PD-1=programmed cell death protein 1; ULN=upper limit of normal

Safety

Transient and Manageable Nature of AEs Support the Potential Benefit of One-Time Treatment with Lifileucel



Non-Hematologic TEAEs in ≥30% of Patients*†

Preferred Term, n (%)	Any Grade	Grade 3/4
Chills	117 (75.0)	8 (5.1)
Pyrexia	81 (51.9)	17 (10.9)
Febrile neutropenia	65 (41.7)	65 (41.7)
Hypophosphatemia	58 (37.2)	41 (26.3)
Hypotension	52 (33.3)	17 (10.9)
Fatigue	51 (32.7)	6 (3.8)
Diarrhea	48 (30.8)	2 (1.3)

Grade 3/4 Hematologic Lab Abnormalities*

Preferred Term, n (%)	Grade 3/4
Leukopenia	156 (100.0)
Lymphopenia	156 (100.0)
Neutropenia	156 (100.0)
Thrombocytopenia	147 (94.2)
Anemia	111 (71.2)

- Median of 6 IL-2 doses administered
- All patients experienced ≥1 TEAE (any grade); 94.9% experienced ≥1 Grade 3/4 TEAE
- TEAEs were consistent with known safety profiles of NMA-LD and IL-2 and in line with previous reports
- **Incidence of TEAEs decreased rapidly** within the first 2 weeks after lifileucel infusion

*Per CTCAE v4.03; Safety Analysis Set (N=156).
†Grade 5 TEAEs included pneumonia (n=1), acute respiratory failure (n=1), arrhythmia (n=1), and intra-abdominal hemorrhage (n=1).
All occurrences of AEs were counted if a patient experienced a new onset of the same AE at different timepoints. If multiple records were reported on the electronic case report form because of toxicity grade decrease of the same AE that had not resolved, then the event was counted once with the highest grade reported. 15 events were reported after Month 12 (Grade 1, n=7; Grade 2, n=6; Grade 3, n=1; Grade 5, n=1).
AE=adverse event; D=day; IL-2=interleukin 2; M, month; NMA-LD=nonmyeloablative lymphodepletion; TEAE=treatment-emergent adverse event

Objective Response Rate (ORR) of 31.4% by IRC

91% Concordance Rate between IRC- and Investigator-assessed ORR

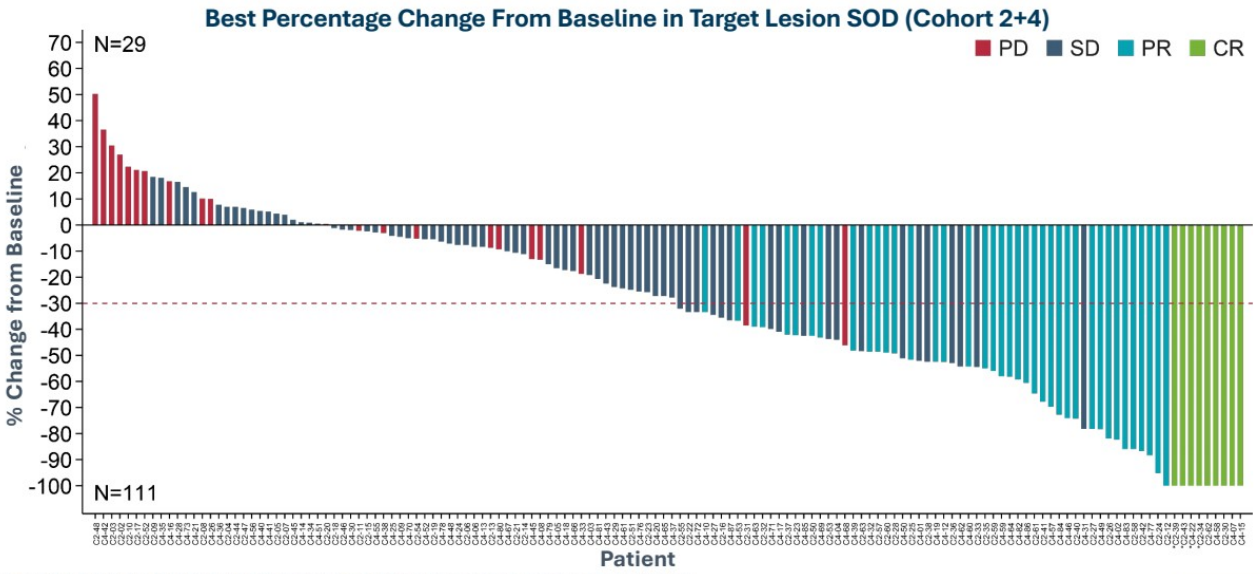
	Cohort 2 (n=66)	Cohort 4 (n=87)	Cohort 2+4 (N=153)
ORR, n (%)	**23 (34.8)**	**25 (28.7)**	**48 (31.4)**
(95% CI)	(23.5, 47.6)	(19.5, 39.4)	(24.1, 39.4)
Best overall response, n (%)			
CR	5 (7.6)	4 (4.6)	9 (5.9)
PR	18 (27.3)	21 (24.1)	39 (25.5)
SD	24 (36.4)	47 (54.0)	71 (46.4)
Non-CR/Non-PD*	1 (1.5)	0	1 (0.7)
PD	15 (22.7)	12 (13.8)	27 (17.6)
Nonevaluable†	3 (4.5)	3 (3.4)	6 (3.9)

- 33 days median time from resection to lifileucel infusion
- Lifileucel manufactured within specification in 94.7% of patients
- Median number of TIL cells infused was 21.1×10^9 (range, 1.2×10^9 to 99.5×10^9)

*Patient did not have acceptable target lesions and had best overall response of non-CR/non-PD per IRC assessment.
†Six patients were nonevaluable for response (5 due to early death; 1 due to new anticancer therapy).
CR,=complete response; IRC=independent review committee; ORR=objective response rate;
PD=progressive disease; PR=partial response; SD=stable disease

Tumor Burden Reduction and Best Response to Lifileucel

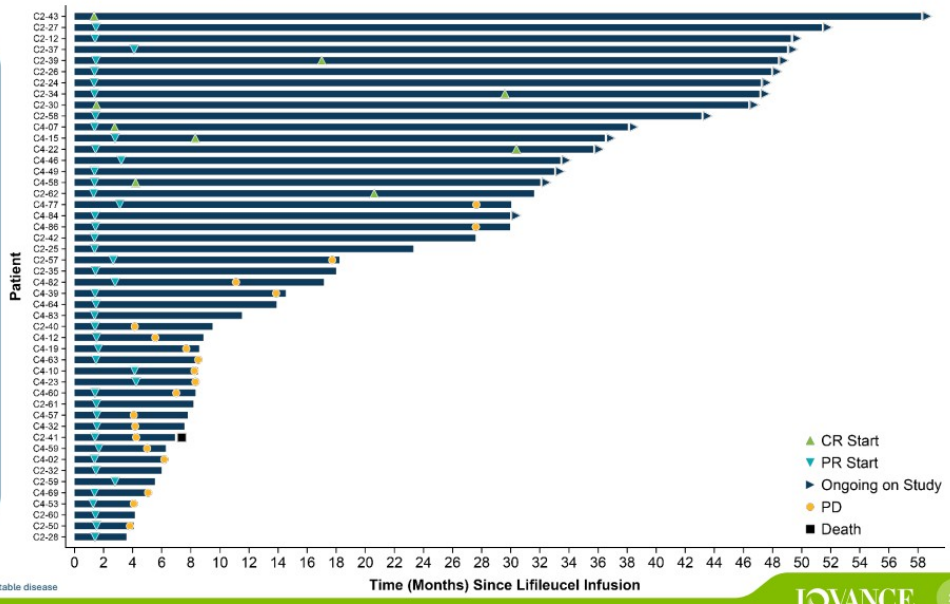
Reduction of Tumor Burden in 79.3% (111/140) of Patients



13 patients in the full analysis set are not included (9 had no post lifileucel target lesion SOD measurements, and 4 had no acceptable target lesions by IRC).
*-100% change from baseline is presented for CR assessment that includes lymph node lesions.
CR=complete response; PD=progressive disease; PR=partial response; SD=stable disease; SOD=sum of diameters

Time to Response, Duration of Response, and Time on Efficacy Assessment for Confirmed Responders (PR or Better)

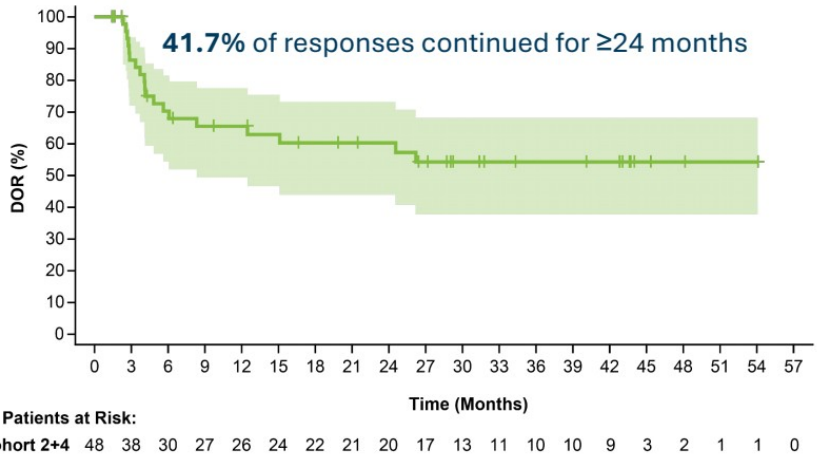
- **Median time from lifileucel infusion to best response was 1.5 months**
- **Responses deepened over time**
  - 7 patients (14.6%) initially assessed as PR were later confirmed CR
  - 4 patients (8.3%) converted to CR >1 year post-lifileucel infusion; 2 (4.2%) of 4 patients converted after 2 years
  - 10 patients (20.8%) improved from best response of SD to PR
- **35.4% of responses ongoing as of data cutoff**



Abbreviations: CR=complete response; PD=progressive disease; PR=partial response; SD=stable disease

Duration of Response*

Median DOR Not Reached at Median Study Follow Up of 36.5 Months



Patients at Risk:

Cohort 2+4	48	38	30	27	26	24	22	21	20	17	13	11	10	10	9	3	2	1	1	0

	Cohort 2 (n=23)	Cohort 4 (n=25)	Cohort 2+4 (N=48)
Median follow-up, months	45.1	33.0	36.5
95% CI	(44.2, 51.4)	(30.4, 35.2)	(34.7, 44.2)
Median DOR†, months	NR	10.4	NR
95% CI	(NR, NR)	(4.1, NR)	(8.3, NR)
Min, max (months)	1.4+, 54.1+	1.4+, 34.3+	1.4+, 54.1+
DOR ≥12 months, n (%)	**15 (65.2)**	**11 (44.0)**	**26 (54.2)**
DOR ≥24 months, n (%)	**11 (47.8)**	**9 (36.0)**	**20 (41.7)**

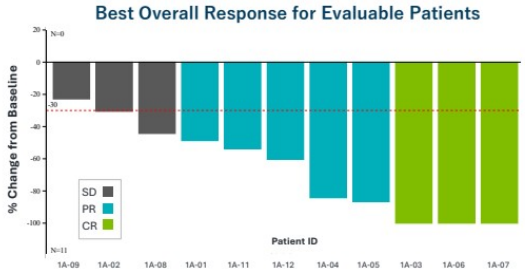
*Patients not experiencing PD or who did not die prior to the time of data cut had their event times censored at the last adequate tumor assessment. For patients who received new anticancer therapies, DOR was censored at the date of last tumor response assessment prior to the start of new anticancer therapies. For patients with PD or death immediately after ≥2 consecutive missing tumor assessment visits, DOR was censored at the last adequate tumor assessment prior to the missing tumor assessments.
†Based on Kaplan-Meier estimate.
Shaded area indicates 95% CI
DOR=duration of response; NR=not reached; PD=progressive disease

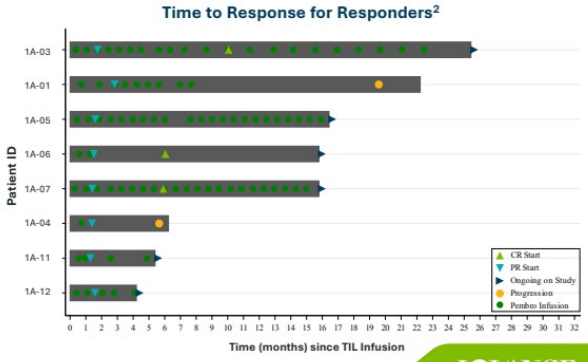
Iovance TIL Clinical Highlights in Combination with Pembrolizumab in Metastatic Melanoma

Lifileucel in combination with anti-PD-1/PD-L1 therapy in ICI-naïve patients
(IOV-COM-202 Cohort 1A, N=12)[1]

66.7% ORR

- 8 / 12 patients had a confirmed objective response per RECIST 1.1 (3 CRs & 5 PRs)
- 6 / 8 responders had ongoing response at the time of the last data cut
- 5 responders had a duration of response >1 year
- FDA Fast Track Designation





1. As assessed by investigator using RECIST 1.1 (January 20, 2022 data cutoff).
2. Each bar is presented for each patient starting from date of TIL infusion up to date of new anti-cancer therapy, end of assessment, death, or data cutoff date, whichever occurs earlier.

Abbreviations: CR=complete response; ICI=immune checkpoint inhibitor; ORR=objective response rate; PR=partial response; SD=stable disease; pembro=pembrolizumab; RECIST=Response Evaluation Criteria in Solid Tumors

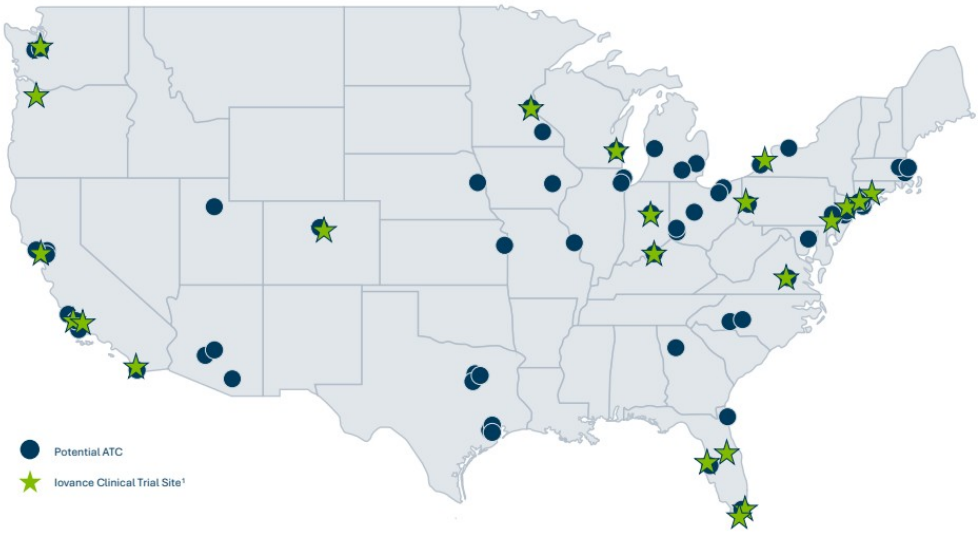
Launch Preparation

IOVANCE BIOTHERAPEUTICS

*i*CTC Designed for High-Volume TIL Manufacturing and Flexibility

- Core suites: TIL commercial manufacturing
- Flexible suites: clinical supply, pipeline expansion and advanced manufacturing, including IOV-4001 and Gen 3
- Integrated quality control, supply chain and IT systems
- 100+ employees with additional staffing into launch and beyond
- *i*CTC supplemented with external CDMO manufacturing capacity

Targeting Potential Authorized Treatment Centers (ATCs)



Targeting Considerations

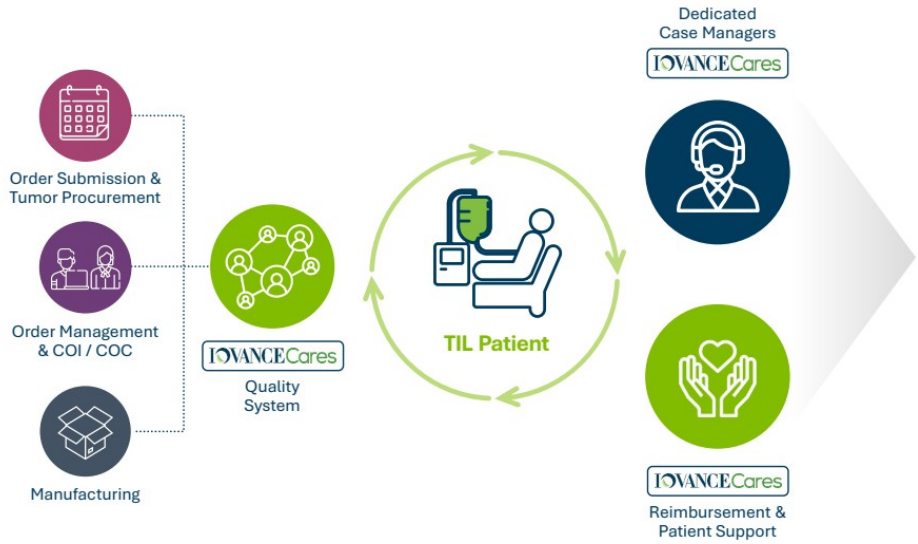
- Patient volume
- NCCN status, KOLs
- Existing cell therapy / BMT
- Inpatient capacity
- Iovance clinical trial(s)

Drive Demand

- Top account prioritization
- Community referrals

1. ClinicalTrials.gov
Abbreviations: NCCN=National Comprehensive Cancer Network; KOL=Key Opinion Leaders; BMT=Bone Marrow Transplant

Supporting Providers & Patients: IovanceCares™



Customer-Centric

- Patient management ecosystem
- Proprietary COI/COC
- Treatment center quality program

Patient-Centric

- Dedicated case managers
- Reimbursement support
- Patient support

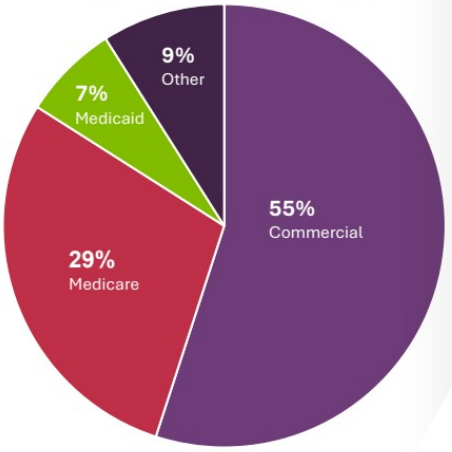
Abbreviations: COI=Chain of Identity; COC=Chain of Custody

Enabling Market Access

High Unmet Need in Metastatic Melanoma and Clinical Value of Lifileucel

Metastatic Melanoma Payer Mix

All Treatment Settings and Lines of Therapy[1]



Payer Engagement

- Unmet need
- Clinical data
- Educational presentations and tools
- Engagement with commercial and Medicare payers responsible for ~90% of covered lives

Coding, Coverage and Payment

- ICD-10 PCS codes issued
- Medicare expanded DRG-018 to other immunotherapies, including lifileucel, in IPPS FY 2022 final rule

1. Metastatic Melanoma Insurance Claims Analysis, TIL-eligible patients treated in the ATC setting (1/1/2018 – 6/30/2021)

Abbreviations: ICD-10 PCS=International Classification of Diseases, 10th Revision, Procedure Coding System; IPPS=In-patient Prospective Payment System

TIL Therapy Clinical Program Highlights

IOVANCE BIOTHERAPEUTICS

Potential Market for Non-Small Cell Lung Cancer (NSCLC)

Addressing a Defined Unmet Need in Second Line NSCLC

> The clinical data for LN-145 in heavily treated patients with metastatic non-small cell lung cancer is exciting. It represents the first experience for TIL monotherapy to show clinical benefit in metastatic non-small cell lung cancer."

Adam J. Schoenfeld, MD
Medical Oncologist
Memorial Sloan Kettering Cancer Center

2.2M New cases WW each year[1]

1.8M Deaths WW each year[1]

237k New cases in U.S. each year[2]

130k Deaths in U.S. each year[2]

Available Care:

Checkpoint Inhibitor + Chemo as 1st line option

9-13% ORR for docetaxel in 2nd line NSCLC following progression on chemo[3]

1. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries, CA Cancer J Clin., May 2021
2. https://seer.cancer.gov accessed May 2022
3. Brahmer et al., NEJM 2015; Borghaei et al., NEJM 2015; Herbst et al., Lancet 2016; Rittmeyer et al., Lancet 2017

Iovance IOV-COM-202 Efficacy: NSCLC Cohort 3B (post ICI)

Single-Agent LN-145 Following Progression on Anti-PD-1 Therapy
(IOV-COM-202 Cohort 3B, N=28)

21% ORR **37+** months ongoing CR

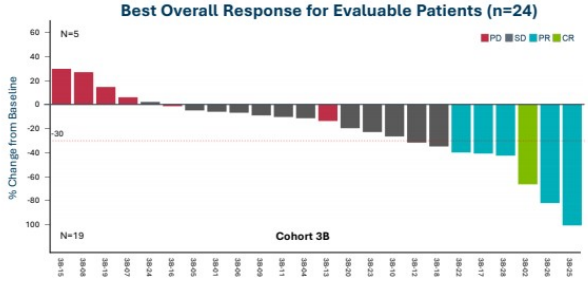
Heavily Pre-Treated Patient Population

- All received prior anti-PD-1 / anti-PD-L1 therapy
- 24/28 patients (85.7%), including all responders, received ≥2 prior lines of systemic therapy

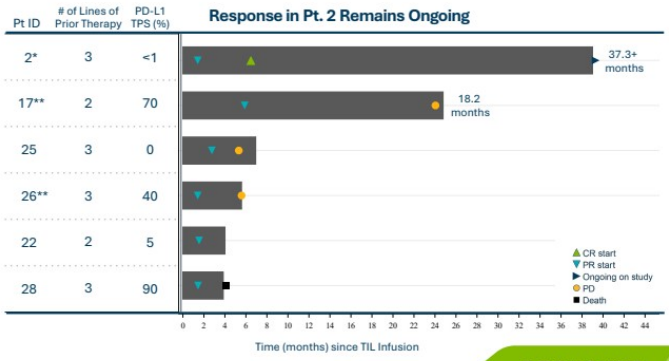
Long Lasting Responses with Durations of 18 and 37+ (ongoing) Months

*Patient 2 is reported as a CR based on negative FDG-PET scans by investigator
**Driver oncogene mutations: Patient 17 (KRAS G12C); Patient 26 (KRAS G12D)
Abbreviations: CR=complete response; PD=progressive disease; PR=partial response; SD=stable disease; TIL=tumor infiltrating lymphocytes; PD-1=programmed cell death protein-1; ICI=immune checkpoint inhibitor

Best Overall Response for Evaluable Patients (n=24)

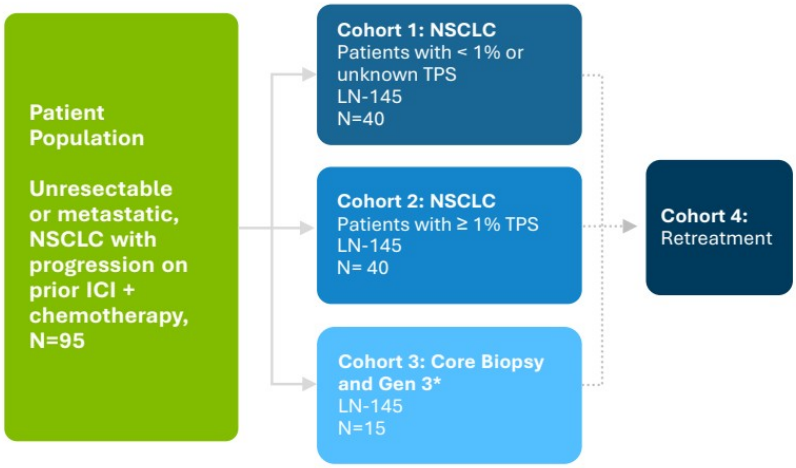


Time to Response for Confirmed Responders (PR or Better; n=6)



IOV-LUN-202

Phase 2, Multicenter Study of LN-145 in Patients with Metastatic NSCLC (NCT04614103)



Endpoints

- Primary: Efficacy defined as ORR by IRC
- Secondary: Safety and efficacy

Study Updates

- 2Q21: first patients treated
- 40+ sites are active in U.S., Canada, Europe

IOV-LUN-202 (NCT04614103) is designed to enroll patients with NSCLC with an unmet medical need but with fewer prior lines of therapy to maximize the potential for more sustained responses

*Cohort 3 patients unable to undergo surgical harvest, TIL grown from core biopsy

Abbreviations: ICI=immune checkpoint inhibitor; IRC=independent review committee; NSCLC=non-small-cell lung cancer; ORR=objective response rate; TPS=tumor proportion score

Phase 1/2 Open-Label First-in-Human Study: IOV-GM1-201

Genetically Modified, PD-1 Inactivated TIL Therapy IOV-4001 in Previously Treated Metastatic Melanoma and NSCLC (NCT05361174)

Patient Population

Adults with unresectable or metastatic melanoma or advanced NSCLC

N=53

Cohort 1: Unresectable or metastatic melanoma
Post-anti-PD-1/L1, post-BRAF/MEK inhibitor in patients with BRAF mutations

Cohort 2: Stage III or IV NSCLC
Post -anti-PD-1/L1 or post targeted therapy and either chemotherapy or anti-PD-1/L1

Endpoints

- Phase 1: Safety
- Phase 2: Objective Response Rate (ORR) per RECIST v1.1 as assessed by the investigator
- Secondary endpoints include complete response (CR) rate, duration of response (DOR), disease control rate (DCR), progression free survival (PFS), overall survival (OS), safety and tolerability, feasibility

Study Updates

- 1Q22: Investigational New Drug (IND) Allowance
- 3Q22: first patient treated

NSCLC=non-small-cell lung cancer

Moving TIL Therapy into Relevant Lines of Therapy in NSCLC

COM-202 Cohort 3A (TIL+pembrolizumab) | COM-202 Cohort 3C (TIL+nivolumab/ipilimumab) | GM1-201 Cohort 2 IOV-4001 (PD1-KO TIL) | LUN-202 Cohorts 1-3 (TIL mono) | Current Standard of Care

Patient Populations: Advanced or metastatic NSCLC, no prior systemic therapy

		1L Therapy		2L Therapy		3L Therapy		4L Therapy	
		SOC	IOVA Trial	SOC	IOVA Trial	SOC	IOVA Trial	SOC	IOVA Trial
Driver mutation (-)	PD-L1 ≥50%	Anti-PD-1 Mono *ORR 39-45%[1]*	COM-202 Cohort 3A	Chemo Doublet	COM-202 Cohort 3C	Docetaxel or Docetaxel + Ramucirumab *ORR 9-23%[2]*	LUN-202 Cohorts 1-3		GM1-201 Cohort 2*
Driver mutation (-)	PD-L1 0-49%	Anti-PD-1 + Chemo *ORR 48-58%[1]*	COM-202 Cohort 3A	Docetaxel or Docetaxel + Ramucirumab *ORR 9-23%[2]*	LUN-202 Cohorts 1-3; GM1-201 Cohort 2*		GM1-201 Cohort 2*		GM1-201 Cohort 2*
Driver mutation (+)	Other actionable mutations	TKI		Anti-PD-1 +Chemo *ORR 48-58%[1]*	COM-202 Cohort 3A	Docetaxel or Docetaxel + Ramucirumab *ORR 9-23%[2]*			
Driver mutation (+)	EGFR ALK ROS	1(-3) L TKI		Chemo *ORR 17-32%[3]*	COM-202 Cohort 3A		COM-202 Cohort 3A		

Abbreviations: L=line; NSCLC=non-small cell lung cancer PD-1=programmed cell death protein-1; TIL=tumor infiltrating lymphocytes; TKI=tyrosine kinase inhibitor

* GM1-201 Cohort 2 population is comparable to completed COM-202 Cohort 3B

1. KEYTRUDA USPI; 2. CYRAMZA USPI; Brahmer et al., NEJM 2015; Borghaei et al., NEJM 2015; Herbst et al., Lancet 2016;Rittmeyer et al., Lancet 2017 3. Park et al., Cancer Res Treat 2015; Yoshida et al., Lung Cancer 2017

IOVANCE

Potential Market for Cervical Cancer

Addressing a Defined Unmet Need in Cervical Cancer Following Chemo and Anti-PD-1

604k New cases WW each year[1]

342k Deaths WW each year[1]

14k Diagnoses in U.S. each year[2]

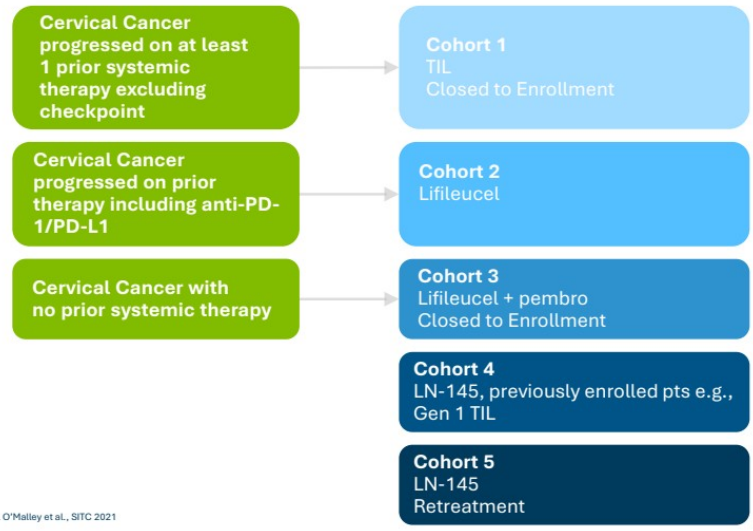
4k Deaths in U.S. each year[2]

Available Care	ORR	Median DOR
Frontline:		
Combination chemotherapy + bevacizumab[3]	48%	Not Reported
pembrolizumab + chemo + bevacizumab (PD-L1+ patients)[4]	68.1%	18 months
Second Line/Third Line:		
pembrolizumab post-chemo (PD-L1+ patients)[5]	14.3%	Not Reached
tisotumab vedotin-tftv post-chemo[6]	24%	8.3 months
Chemotherapy in second line/third line[7,8]	3.4%–15%	4.4 months[8]

1. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries, CA Cancer J Clin., May 2021; 2. https://seer.cancer.gov accessed May 2022; 3. Tewari, et al., NEJM 2014
4. Colombo et al., NEJM 2021; 5. Keytruda USPI; 6. Coleman et al., Lancet Oncol 2021; 7. McLachlan et al., Clin Oncol 2017; 8. Miller et al., Gynecol Oncol 2008

Pivotal Phase 2 Study of Lifileucel (Formerly LN-145) in Recurrent, Metastatic or Persistent Cervical Carcinoma (NCT03108495)

Regulatory Strategy Focused on Significant Unmet Need in Cervical Cancer Following Chemo and Anti-PD-1 Therapy



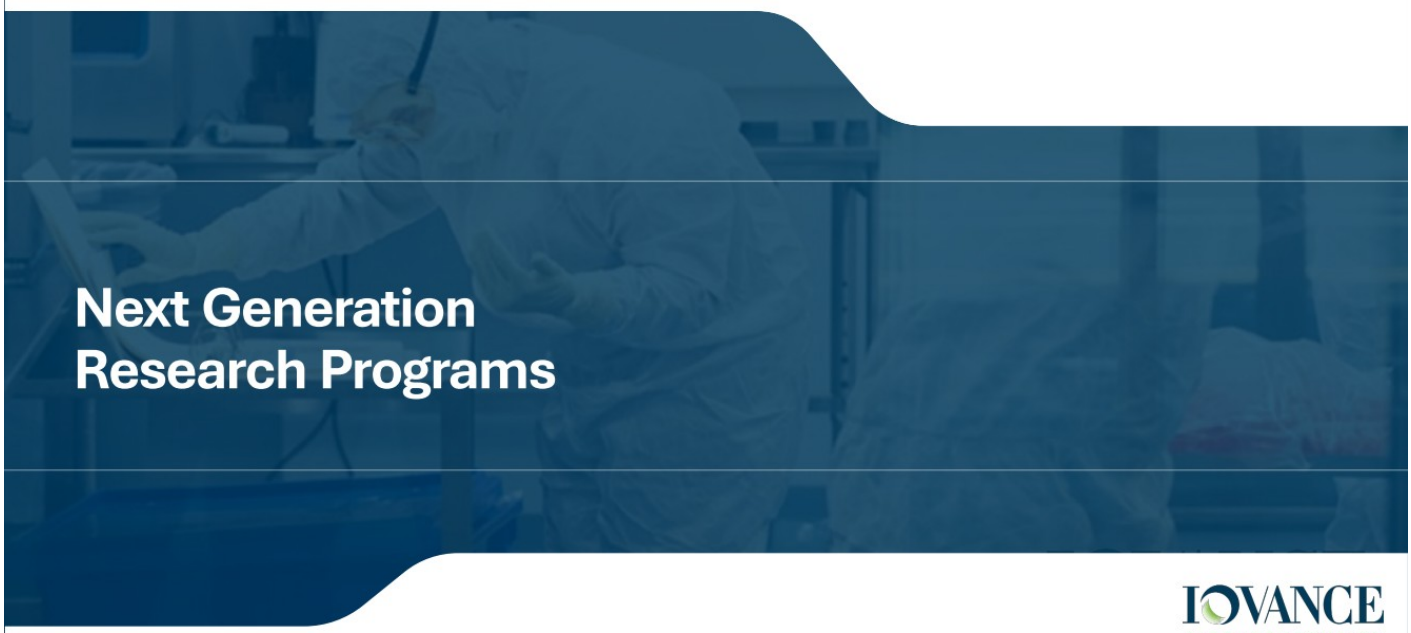
Endpoints (Pivotal Cohort 2)

- Primary: ORR as determined by IRC
- Secondary: safety and efficacy

Study Updates

- 4Q21: Initial Cohort 3 data at SITC[1]
- 3Q22: regulatory strategy updated with Cohort 2 to be pivotal
- Expanded Cohort 2 to support regulatory submissions

1. O'Malley et al., SITC 2021



Next Generation Research Programs

IOVANCE BIOTHERAPEUTICS

What's Next

Genetically modify TIL

Cellectis gene-editing TALEN® collaboration[1,2]

PD-1 and other immune checkpoint targets

Double knockouts

Cytokine tethered TILs

Develop more potent TIL

PD-1+ selected TIL

CD39/69 double negative TILs[3]

Optimize process

Gen 3 (16-day) process

Core biopsy

Expand TIL into new regimens

IOV-3001 IL-2 analog licensed from Novartis: IND enabling studies

1. Ritthipichai et al., ESMO 2020
2. Natarajan, et al., AACR 2022
3. Cubas et al., ESMO IO 2021

Corporate Summary & Milestones

IOVANCE BIOTHERAPEUTICS

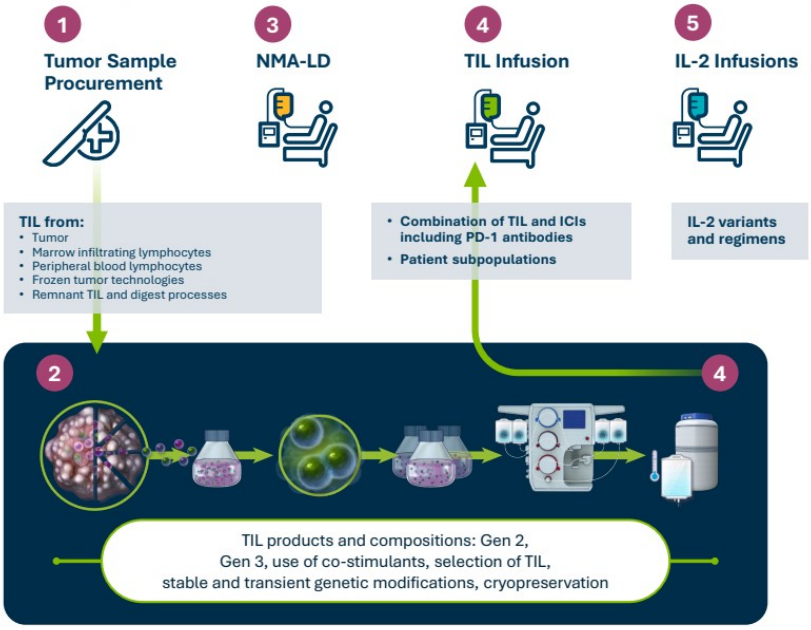
Well-Capitalized in Pursuit of TIL Commercialization

September 30, 2022	In millions (unaudited)
Common shares outstanding	157.8
Preferred shares outstanding	2.9[1]
Stock options and restricted stock units outstanding	17.3
Cash, cash equivalents, investments, restricted cash	$366.6[2]

Anticipated cash runway, inclusive of proceeds from equity sold through at-the-market (ATM) facility in 4Q22, is sufficient well into 2024

1. Preferred shares are shown on an as-converted basis
2. Includes Restricted Cash of $6.4 million as of September 30, 2022

Broad, Iovance-Owned IP Around TIL Therapy



- ✓ 60+ granted or allowed US and international patents
- ✓ Compositions of matter for TIL products
- ✓ Methods of treatment in a broad range of cancers
- ✓ Manufacturing processes

Investment Highlights

Pioneering a Transformational Approach to Cure Cancer

Large market opportunity & strong unmet need

- Initial focus in post-ICI solid tumors
- Expansion into combinations, earlier lines of therapy, and genetic modification(s)
- Key late-stage trials in melanoma, cervical, and NSCLC
- First-in-human trial of genetically modified TIL (PD-1 inactivated)

Potential to be first one-time cell therapy approved for solid tumors

- BLA submission on track to complete in 1Q23
- Phase 3 frontline advanced melanoma confirmatory trial (FTD)
- Accelerated path to approval in melanoma (RMAT) and cervical cancer (BTD)
- Defined registration strategy in cervical cancer

Efficient & scalable proprietary manufacturing

- Iovance Cell Therapy Center (*i*CTC) in-house manufacturing
- Additional capacity with contract manufacturers
- Rapid 22-day Gen 2 manufacturing with 90%+ success rate
- >500 patients treated with Iovance proprietary process

Infrastructure for commercial success

- Fully integrated
- Experienced cross-functional cell therapy team
- Partnering with leading U.S. Cancer Centers to develop TIL service-line capabilities
- IovanceCares™ proprietary platform

Abbreviations: BLA=Biologics License Application; BTD=breakthrough therapy designation; FTD=fast track designation; ; ICI=immune checkpoint inhibitor; NSCLC=non-small cell lung cancer; PD-1=programmed cell death protein-1; RMAT=Regenerative Medicines Advanced Therapy; TIL=tumor infiltrating lymphocytes

Anticipated 2023 Milestones

REGULATORY	☐ BLA: Complete rolling BLA submission in Q1 2023
	☐ BLA: FDA approval
PIPELINE	☐ Melanoma: enroll frontline advanced melanoma Phase 3 confirmatory trial
	☐ NSCLC: report data and continue to enroll IOV-LUN-202, IOV-COM-202, IOV-GM1-201 trials
	☐ Cervical: enroll additional patients in registrational Cohort 2
	☐ PD-1 inactivated TIL (IOV-4001): complete Phase 1 safety portion and proceed to Phase 2 portion of IOV-GM1-201 trial
	☐ Research: advance new products toward clinic, including additional genetically-modified TIL therapies
MANUFACTURING	☐ Execute GMP commercial readiness activities to support BLA approval and supply lifileucel at launch
COMMERCIAL	☐ Prepare for and execute commercial launch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ADVANCING IMMUNO-ONCOLOGY
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