

Moderna Oncology Event

October 24, 2026

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Forward-looking statements

This presentation contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, as amended, including statements regarding: intismeran's potential in cancer care and to set a new benchmark for adjuvant melanoma treatment; intismeran's clinical development program, including ongoing clinical trials and the timing of potential readouts; the potential of intismeran in other tumor types and across settings; Phase 1 pancreatic cancer data; efficacy and safety; the trend in overall survival data; the ability for intismeran to be supplied at scale; and the potential long-term benefit of intismeran. In some cases, forward-looking statements can be identified by terminology such as "will," "may," "should," "could," "expects," "intends," "plans," "aims," "anticipates," "believes," "estimates," "predicts," "potential," "continue," or the negative of these terms or other comparable terminology, although not all forward-looking statements contain these words. The forward-looking statements in this presentation are neither promises nor guarantees, and you should not place undue reliance on these forward-looking statements because they involve known and unknown risks, uncertainties, and other factors, many of which are beyond Moderna's control and which could cause actual results to differ materially from those expressed or implied by these forward-looking statements. These risks, uncertainties, and other factors include, among others, those risks and uncertainties described under the heading "Risk Factors" in Moderna's Annual Report on Form 10-K for the fiscal year ended December 31, 2025, filed with the U.S. Securities and Exchange Commission (SEC), and in subsequent filings made by Moderna with the SEC, which are available on the SEC's website at www.sec.gov. Except as required by law, Moderna disclaims any intention or responsibility for updating or revising any forward-looking statements contained in this presentation in the event of new information, future developments or otherwise. These forward-looking statements are based on Moderna's current expectations and speak only as of the date of this presentation.

Agenda

Intismeran: Advancing individualized cancer immunotherapy

David Berman, MD, PhD
Chief Development Officer, Moderna

INTerpath-001: Phase 3 Study of the mRNA-Based Individualized Neoantigen Therapy (INT) Intismeran Autogene plus Pembrolizumab vs Pembrolizumab Alone for Adjuvant Treatment of Resected Stage IIB-IV Melanoma

Georgina Long, AO BSc PhD MBBS FRACP FAHMS AAHMS FAA FASCO
Medical Director of Melanoma Institute Australia

Conclusion

David Berman, MD, PhD
Chief Development Officer, Moderna

Key opinion leader perspectives

Paolo Ascierto, MD
Department of Skin Cancers, Cancer Immunotherapy and Development Therapeutics, National Cancer Institute IRCCS, Fondazione G. Pascale Naples

Antoni Ribas, MD, PhD
Professor of Medicine, Surgery, and Molecular and Medical Pharmacology, UCLA

Q&A

Intismeran: Advancing individualized cancer immunotherapy

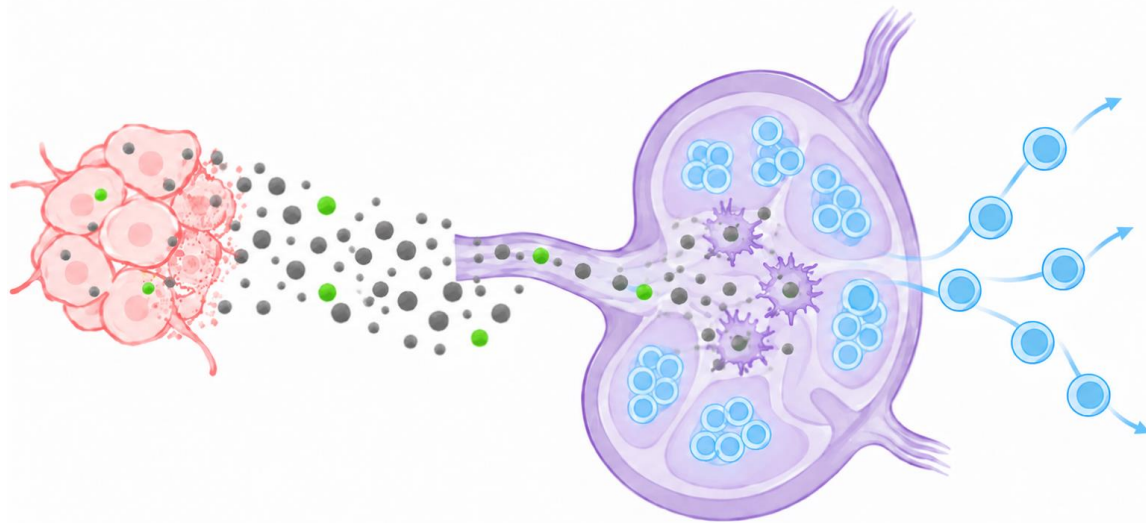
David Berman, MD, PhD

Chief Development Officer, Moderna

Immune surveillance controls emerging cancer cells

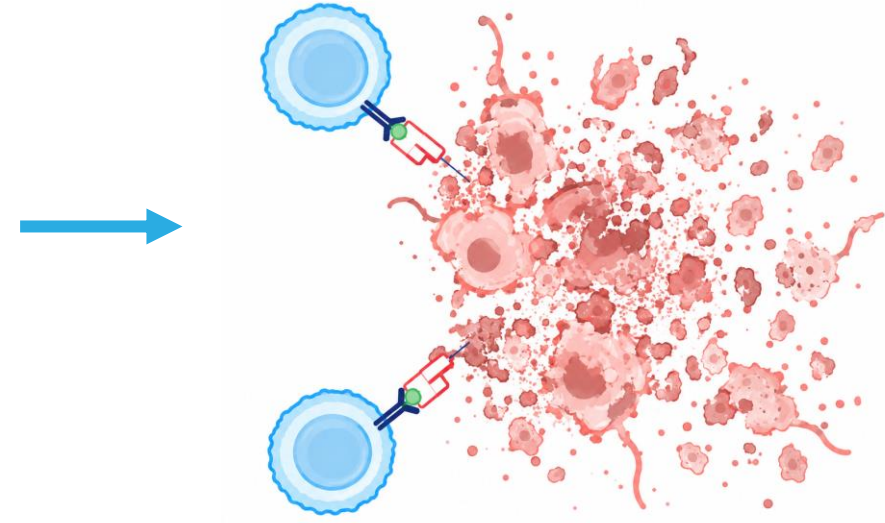
Immune system detects cancer antigens (neoantigens)

Neoantigens drain to lymph node and are presented by antigen presenting cells (APC) to T cells



Activated T cells eliminate cancer

Neoantigen-reactive T cells are activated and target the cancer

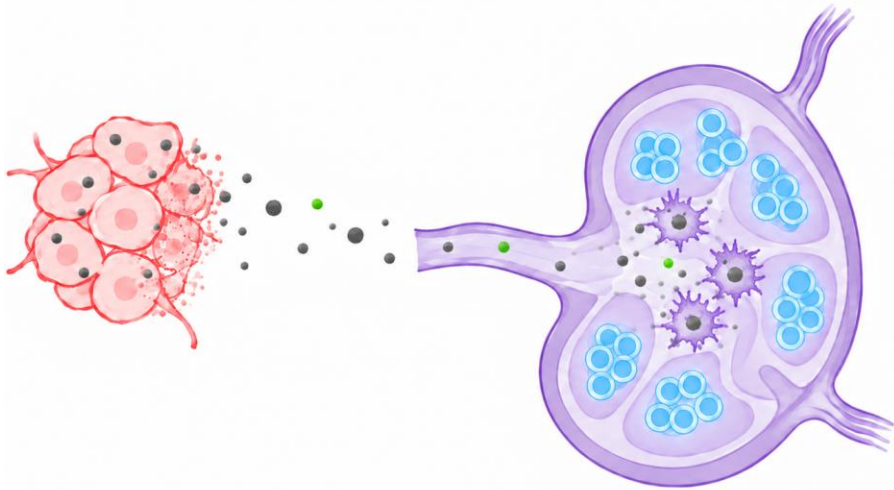


Gavin P., et al. 2004. The Three Es of Cancer Immunoediting. *Annual Review of Immunology* 22:329-360.

Cancers can escape immune surveillance when...

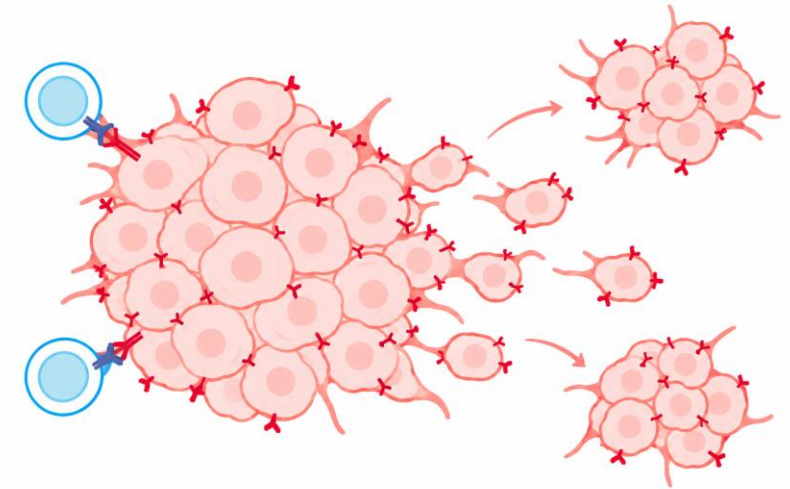
APCs do not activate T cells

Insufficient neoantigen processing, presentation, or T cell activation

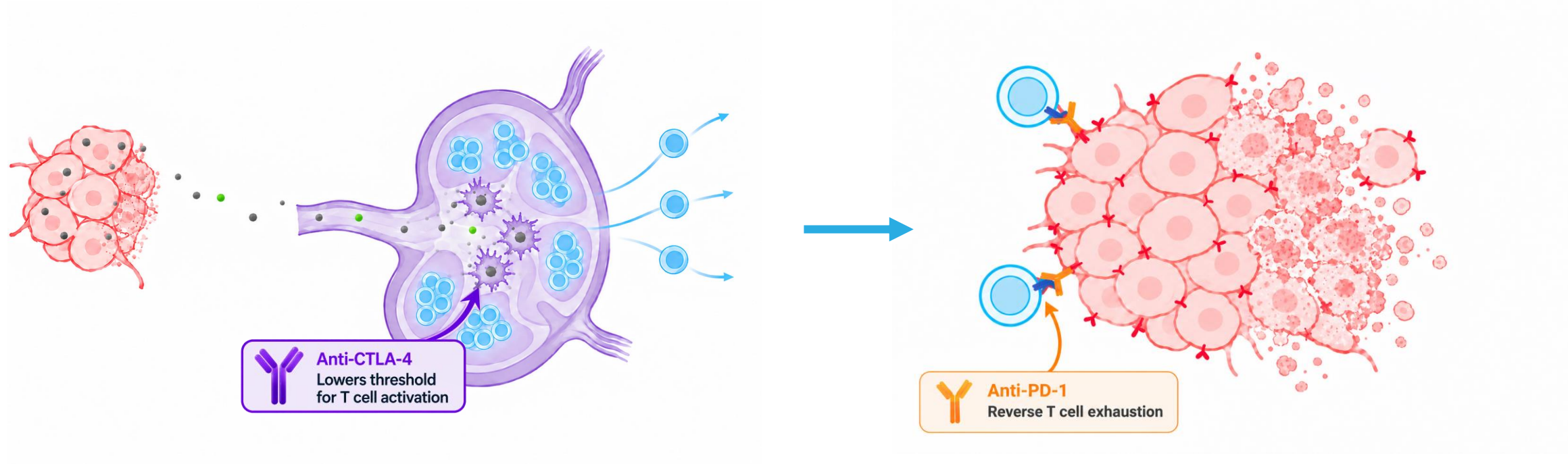


T cells become exhausted

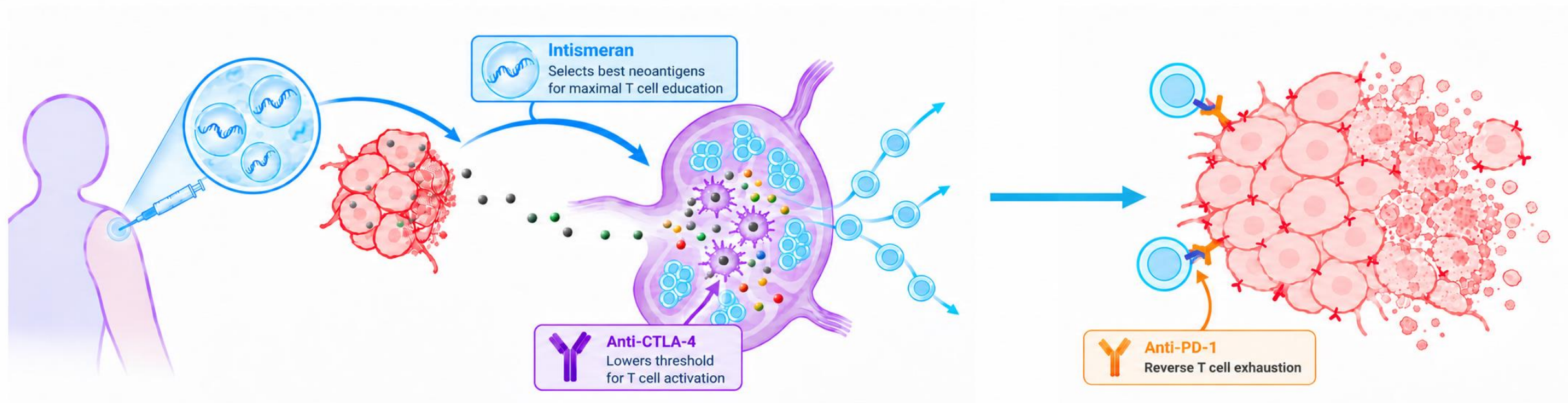
e.g. PD1/PDL1



Checkpoints act on T cells, but are limited by available neoantigens



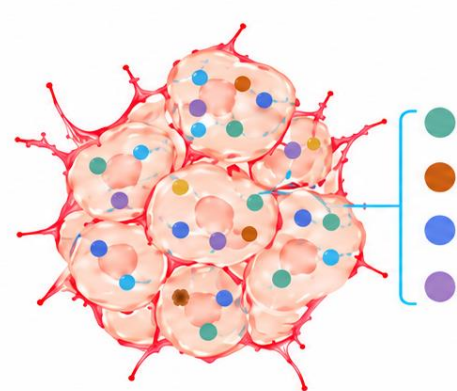
Intismeran optimizes neoantigen presentation



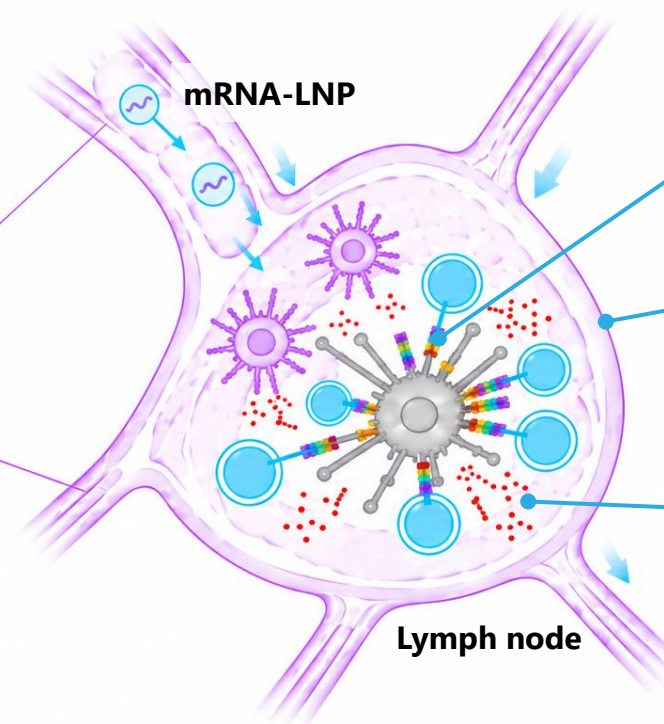
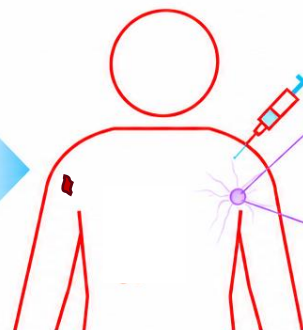
How intismeran activates tumor-specific T cells

1 Algorithm selects most promising neoantigens

2 mRNA-LNP delivers neoantigens to APCs in lymph node



Tumor



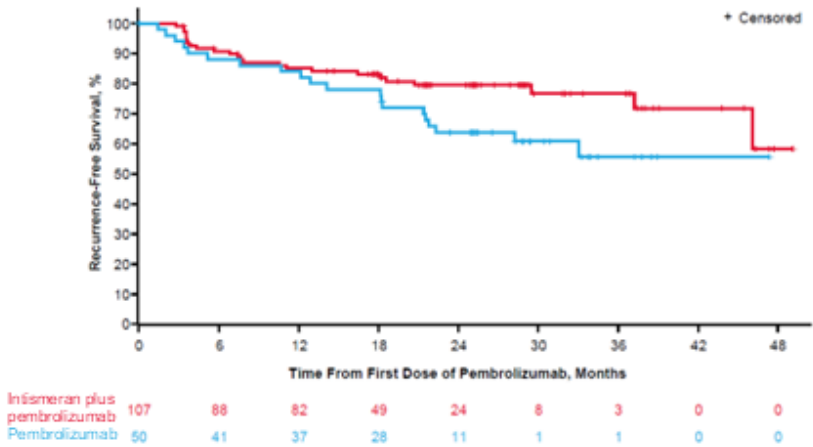
High neoantigen expression
Neoantigen-derived peptides *produced and presented* in antigen presenting cell

Optimal environment
Activation in lymph node *away from* immunosuppressive tumor microenvironment

Polyfunctional T cells
Cytokines support *CD4+ and CD8+ T-cell* proliferation, differentiation, and acquisition of effector functions

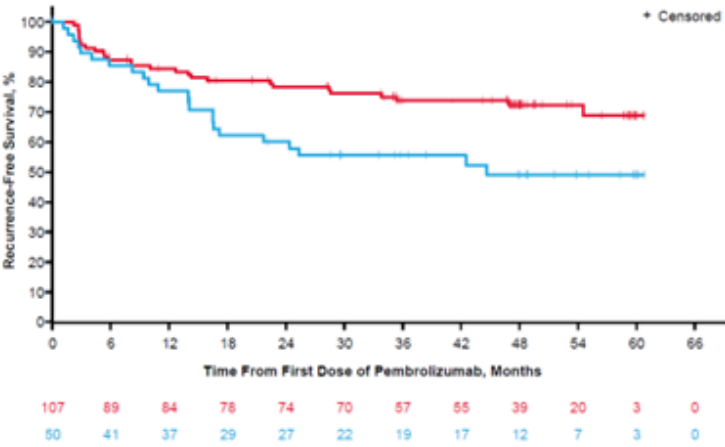
RFS benefit maintained through 5-year follow up

Primary Analysis: Nov 14, 2022¹



	Events, % (n/N)	Hazard Ratio (95% CI)
Intismeran plus pembrolizumab	22.4 (24/107)	0.561 (0.309–1.017) <i>P</i> = 0.0266 ^a
Pembrolizumab	40.0 (20/50)	

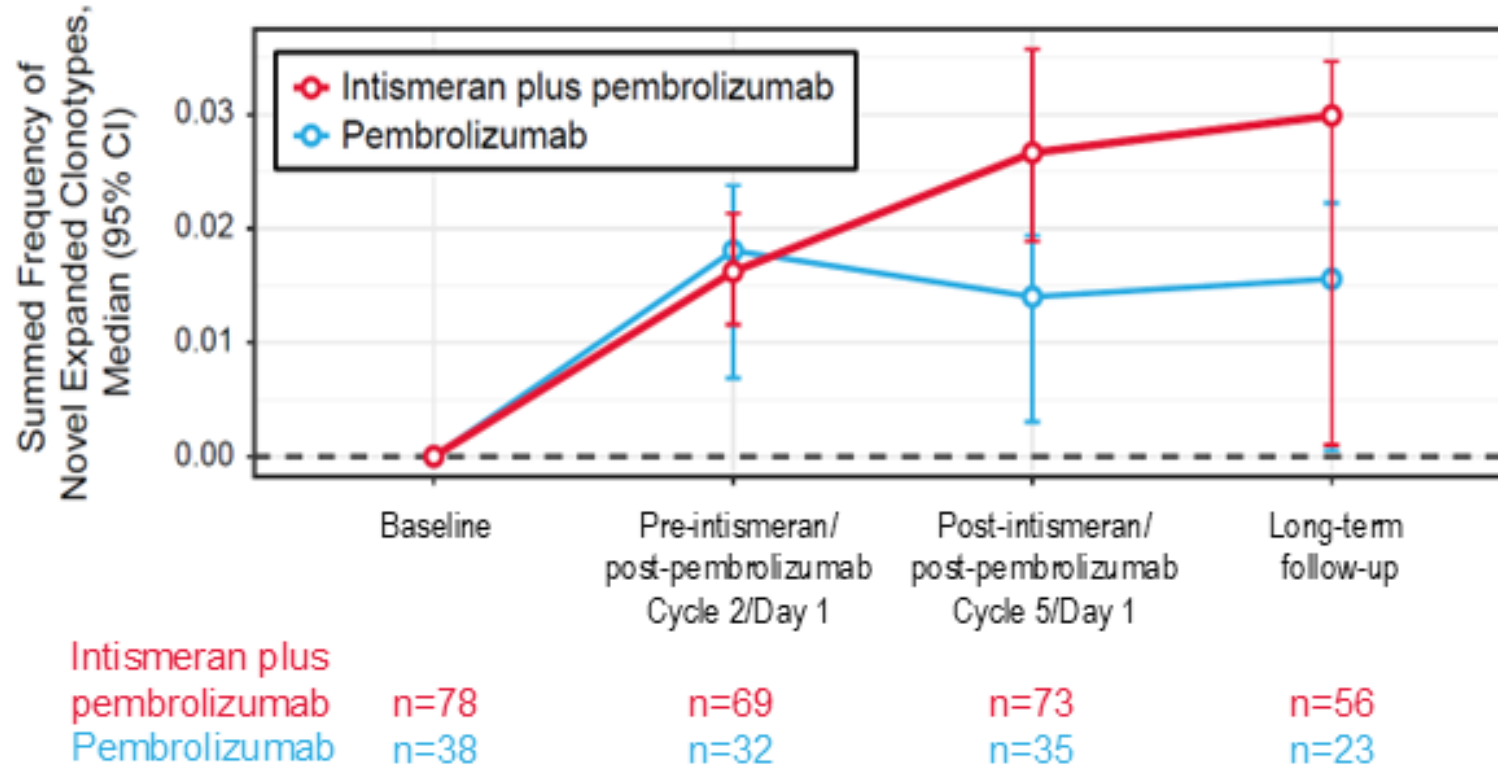
5-Year Analysis: Dec 15, 2025



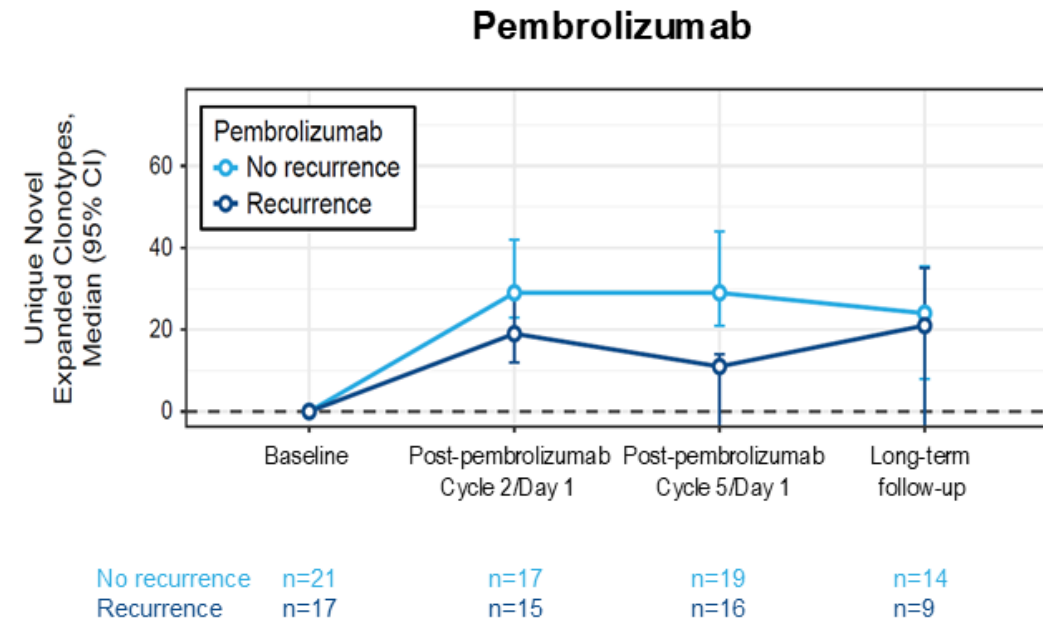
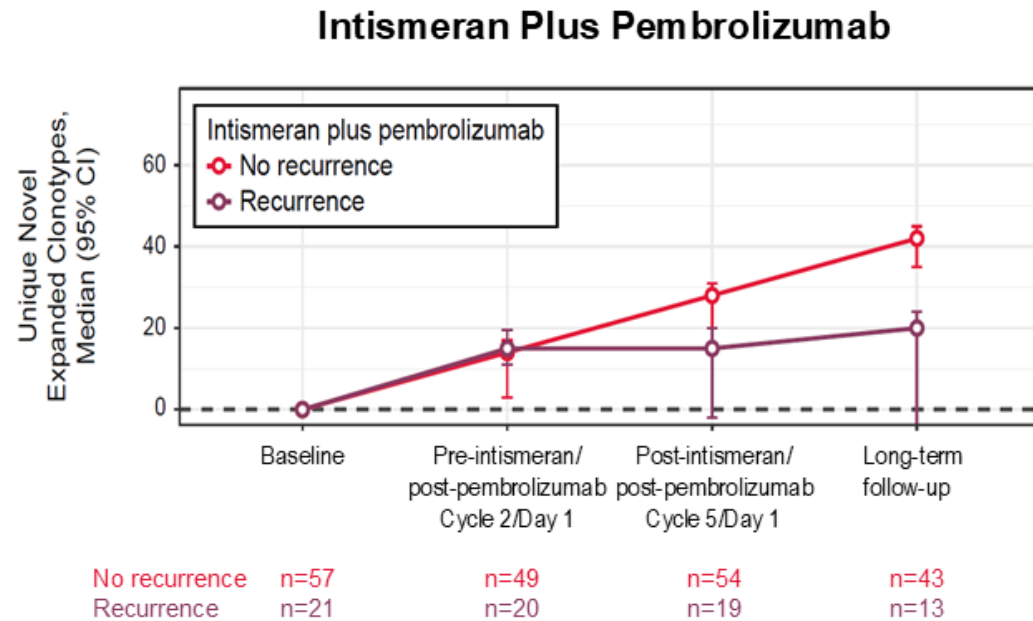
	Events, % (n/N)	Hazard Ratio (95% CI)
Intismeran plus pembrolizumab	26.2 (28/107)	0.510 (0.294–0.887)
Pembrolizumab	46.0 (23/50)	

^aFormal hypothesis testing of RFS (overall one-sided $\alpha=0.10$) was performed at primary analysis (Nov 2022 data cut).
1. Weber JS, et al. Lancet. 2024;403(10427):632–644.

Intismeran plus pembrolizumab induces more novel T cell clones



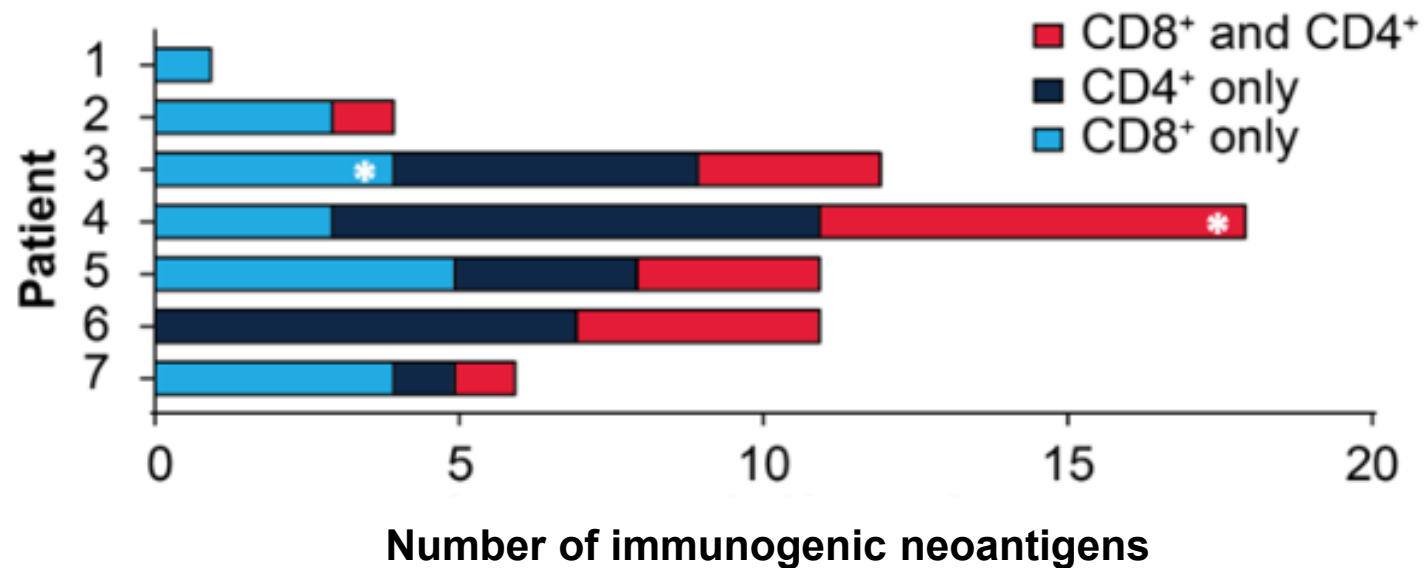
Patients without recurrence on intismeran plus pembrolizumab showed greater expansion of novel T cell clones



Data are shown as median and bootstrapped 95% CI. Whole blood TCR RNA sequencing at baseline, pre-intismeran/post-pembrolizumab (Cycle2/Day1), post-intismeran/post-pembrolizumab (Cycle5/Day1), and 30 days after the last pembrolizumab dose. Long-term follow-up data were collected at >170 days after last intismeran dose.

Intismeran induces neoantigen-specific T cells

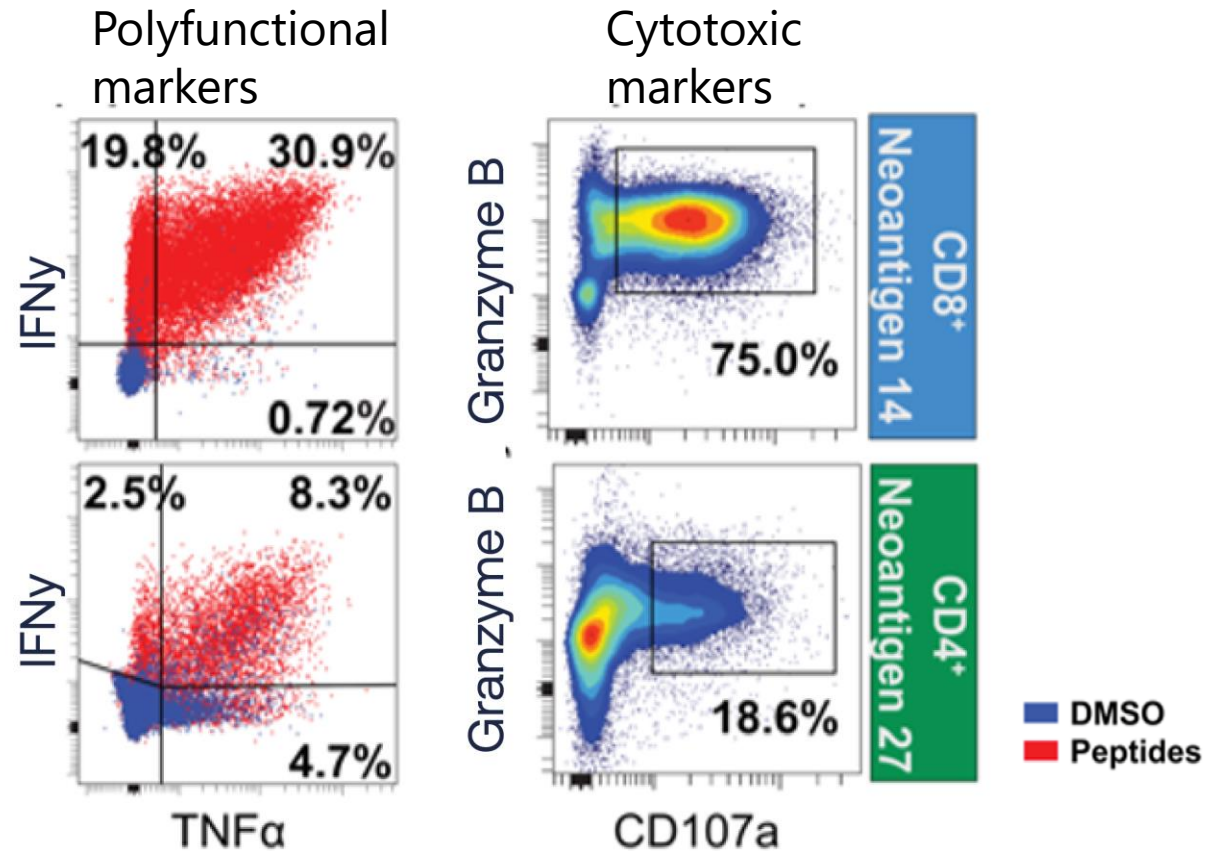
Neoantigens recognized by patient's T cells



* Hotspot mutation

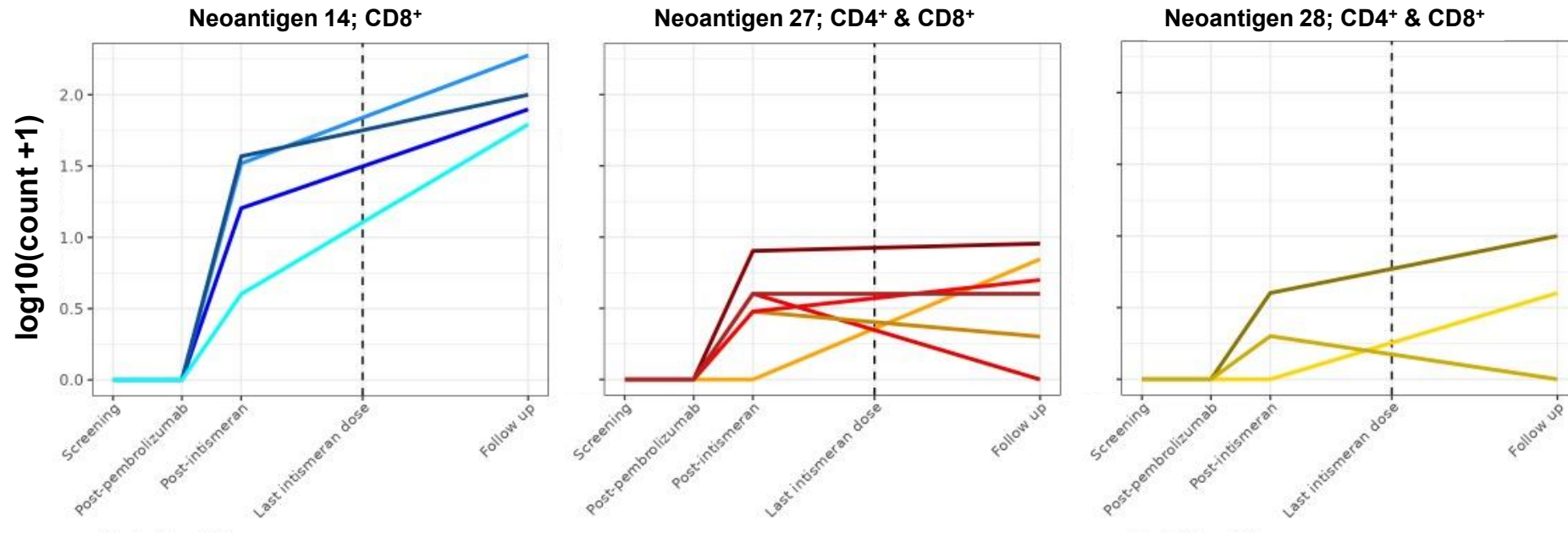
- On average 1 of 3 selected neoantigens induce T cell response
- Induces both CD4 and CD8 neoantigen reactive T cells

The CD8+ and CD4+ neoantigen T cells are polyfunctional and cytotoxic



Intracellular cytokine staining (ICS) of neoantigen reactive T cells from patient #3

The neoantigen-specific T cell clones detected after intismeran



Multiple T cell clones recognize same neoantigens

Method: AIM-based enrichment of CD4+ and CD8+ T cells *ex vivo* or after *in vitro* expansion; a ≥ 5 -cell threshold per clonotype (n=57 for neoantigen 14, n=38 for neoantigen 27, n=28 for neoantigen 28)

Phase 3 INTerpath-001 adjuvant melanoma results shared at ESMO 2026

October 22, 2026 2:59 PM

Merck and Moderna Will Present Results From Landmark Phase 3 INTerpath-001 Trial for Intismeran Autogene Plus KEYTRUDA® (pembrolizumab) at ESMO 2026 Presidential Symposium

Intismeran plus KEYTRUDA significantly reduced the risk of recurrence or death by 42% (HR=0.58 [95% CI, 0.45–0.75]; two-sided $p<0.001$) compared to KEYTRUDA alone for patients with completely resected stage IIB-IV melanoma

Benefit was greater after six months, following the intismeran immunization regimen, as intismeran plus KEYTRUDA reduced the risk of recurrence or death by 58% (piecewise HR=0.42 [95% CI, 0.30–0.58]) compared to KEYTRUDA alone in a pre-specified sensitivity analysis



Georgina Long
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REPRISE: ESMO 2026 PRESENTATION

INTerpath-001: Phase 3 Study of the mRNA-Based Individualized Neoantigen Therapy (INT) Intismeran Autogene plus Pembrolizumab vs Pembrolizumab Alone for Adjuvant Treatment of Resected Stage IIB-IV Melanoma

Georgina Long, AO BSc PhD MBBS FRACP FAHMS AAHMS FAA FASCO

Medical Director of Melanoma Institute Australia

Georgina V. Long; Muhammad A. Khattak; Helen J. Gogas; Dirk Schadendorf; Ana Arance; Matteo S. Carlino; Piotr Rutkowski; Gareth Rivalland; Antoni Ribas; Janice M. Mehnert; Patrick A. Ott; Reinhard Dummer; Paola Queirolo; Christoffer Gebhardt; Laureen S. Ojalvo; Jinchun Zhang; Dmitri O. Grebennik; Mizuho Fukunaga-Kalabis; Paolo A. Ascierto; Michele Del Vecchio on behalf of the INTerpath-001 Investigators

¹Westmead and Blacktown Hospitals, Melanoma Institute Australia, and The University of Sydney, Sydney, NSW, Australia; ²One Clinical Research, Hollywood Private Hospital and Edith Cowan University, Perth, WA, Australia; ³Saint John of God Subiaco Hospital, Subiaco, WA, Australia; ⁴Washington University School of Medicine, St. Louis, MO, USA; ⁵Earle A. Chiles Research Institute, Providence Cancer Institute, Portland, OR, USA; ⁶California Pacific Medical Center Research Institute, San Francisco, CA, USA; ⁷Sarah Cannon Research Institute, Nashville, TN, USA; ⁸Melanoma Institute Australia, The University of Sydney, and Royal North Shore and Mater Hospitals, Sydney, NSW, Australia; ⁹Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA; ¹⁰The Angeles Clinic and Research Institute, a Cedars-Sinai affiliate, Los Angeles, CA, USA; ¹¹Smilow Cancer Center at Yale New Haven Hospital, New Haven, CT, USA; ¹²Texas Oncology PA, Dallas, TX, USA; ¹³Hackensack University Medical Center, Hackensack, NJ, USA; ¹⁴University of Colorado Cancer Center, Aurora, CO, USA; ¹⁵Princess Alexandra Hospital, Brisbane, QLD, Australia; ¹⁶Merck & Co., Inc., Rahway, NJ, USA; ¹⁷Moderna, Inc., Cambridge, MA, USA; ¹⁸Laura and Isaac Perlmutter Cancer Center at NYU Langone Health, New York, NY, USA

INTerpath-001: Phase 3 Study of the mRNA-Based Individualized Neoantigen Therapy (INT) Intismeran Autogene plus Pembrolizumab vs Pembrolizumab Alone for Adjuvant Treatment of Resected Stage IIB-IV Melanoma

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Declaration of Interests

Georgina V. Long

- Consultant advisor: BioNTech, Boehringer Ingelheim, Bristol Myers Squibb, Byondis B.V., Evaxion, Fortiva Biologics, GI Innovation, Immunocore, Innovent Biologics USA, Iovance Biotherapeutics, Jazz Pharmaceuticals, MSD, Replimune, Regeneron, Scancell, Strand Therapeutics
- Principal investigator: more than 60 clinical trials

All Authors

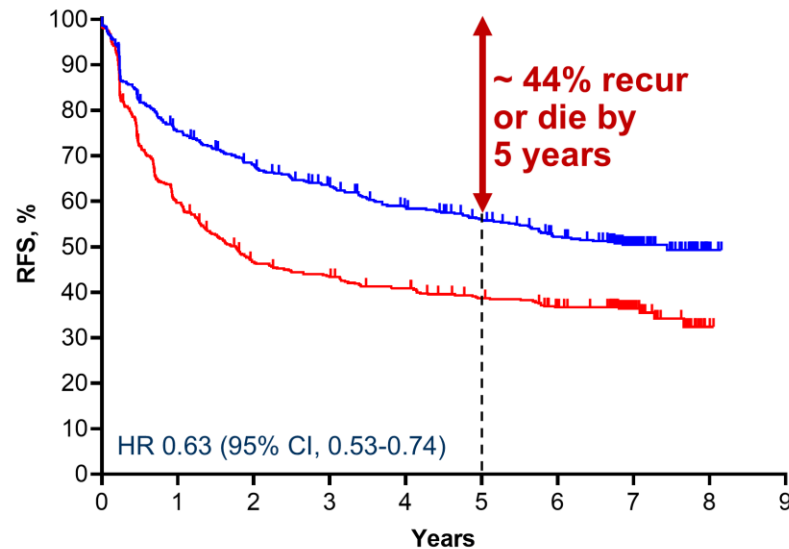
- Funding to institution to support conduct of INTeraph-001: Merck Sharp & Dohme, LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA (MSD) and Moderna, Inc., Cambridge, MA, USA
- Medical writing and editorial support for this presentation: Provided by Melanie Leiby of MSD

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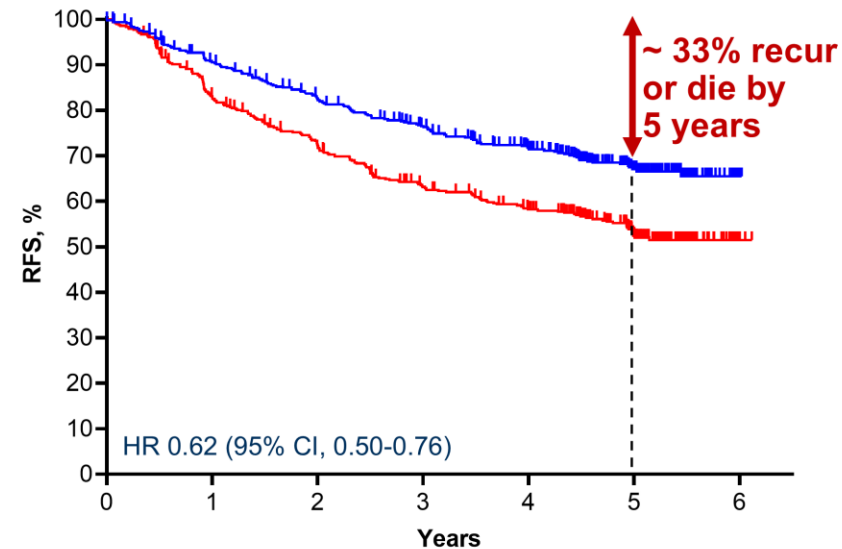


Despite RFS and DMFS benefit for adjuvant PD-1 inhibition in phase 3 melanoma trials, many patients have recurrence¹⁻¹⁰

EORTC-1325/KEYNOTE-054¹
Pembrolizumab vs placebo, stage III



KEYNOTE-716²
Pembrolizumab vs placebo, stage IIB/IIC



¹Eggermont AMM et al. *Eur J Cancer* 2024;211:114327. ²Luke JJ et al. *Ann Oncol* 2025;36:abstr 1611P. ³Eggermont AMM et al. *N Engl J Med* 2018;378:1789–1801. ⁴Eggermont AMM et al. *Lancet Oncol* 2021;22:643–54. ⁵Luke JJ et al. *Lancet* 2022;399:1718–29. ⁶Long GV et al. *Lancet Oncol* 2022;23:1378–88. ⁷Weber J et al. *N Engl J Med* 2027;377:1824–35. ⁸Ascierto PA et al. *Lancet Oncol* 2020;21:1465–77. ⁹Kirkwood JM et al. *Nat Med* 2023;29:2835–43. ¹⁰Ascierto PA et al. *N Engl J Med* 2026;394:333–42.

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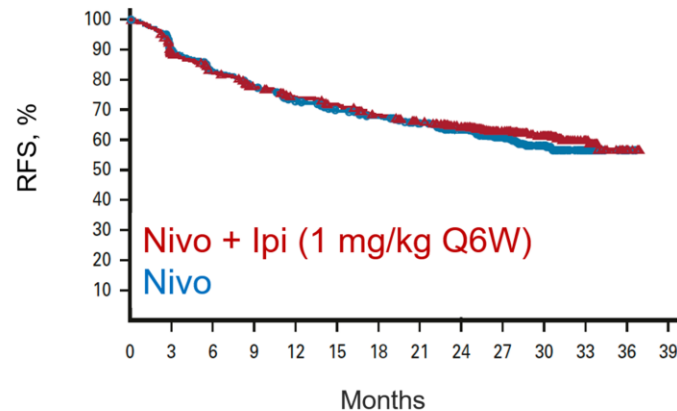
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Dual checkpoint blockade in the adjuvant setting has failed to improve efficacy while increasing toxicity in phase 3 trials

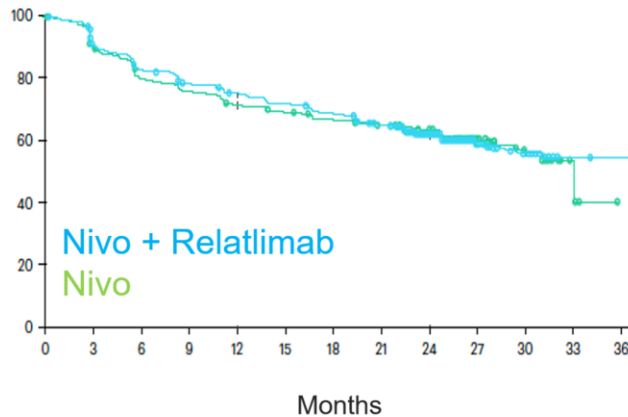
CheckMate 915¹

RFS: HR 0.92 P = 0.269
Grade 3-4 TRAEs: 32.6% vs 12.8%



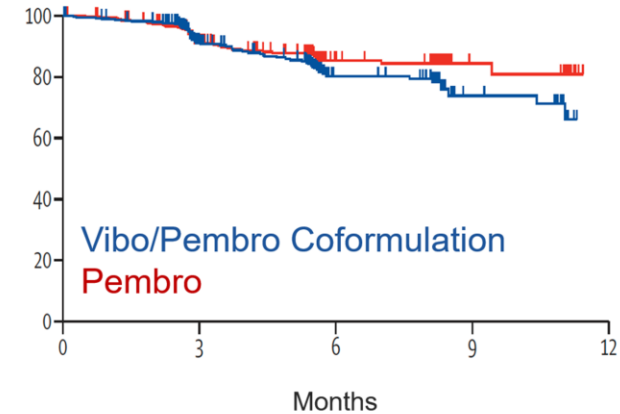
RELATIVITY-098²

RFS: HR 1.01 P = 0.928
Grade 3-4 TRAEs: 19.0% vs 8.4%



KEYVIBE-010³

RFS: HR 1.25 (95% CI 0.9-1.8)
Grade 3-5 TRAEs: 16% vs 7%



¹Weber JS et al. *J Clin Oncol* 2023;41:517-27. ²Long GV et al. *Nat Med* 2025;31:4301-9. ³Dummer R et al. *Lancet Oncol* 2026;27:327-39.

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Science enables individualized therapeutic cancer vaccines

Neoantigen discovery

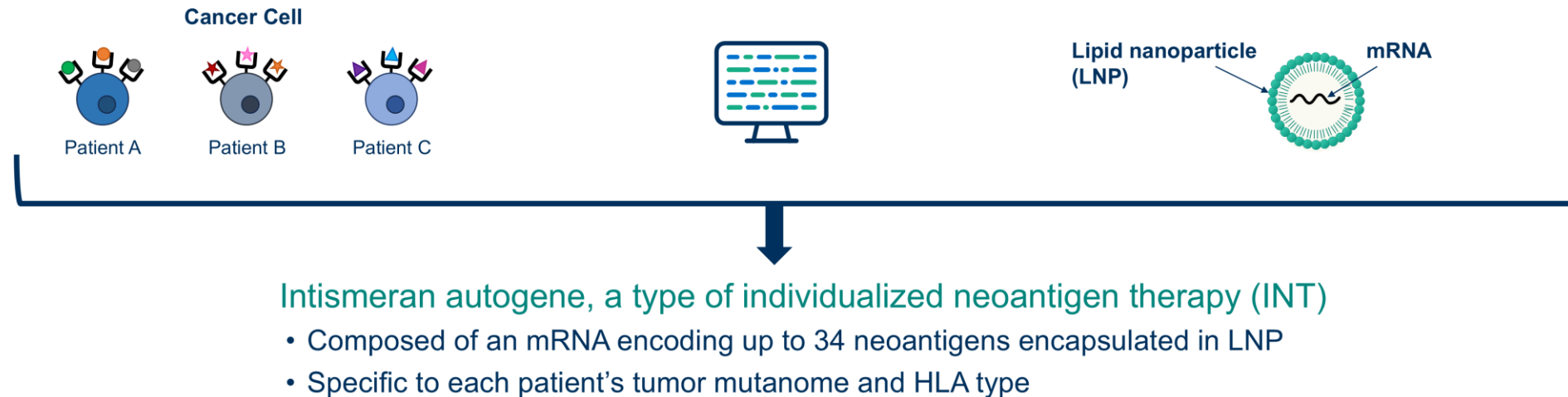
- Tumor-specific mutations
- Potential for enhanced immunogenicity

Neoantigen selection

- NGS identifies tumor mutations
- Computational prediction of HLA presentation and ranking

The mRNA platform

- Multiple antigens per mRNA
- Robust CD8+ and CD4+ T cell responses
- Rapid, individualized manufacturing



HLA, human leukocyte antigen; mRNA, messenger RNA; NGS, next-generation sequencing.

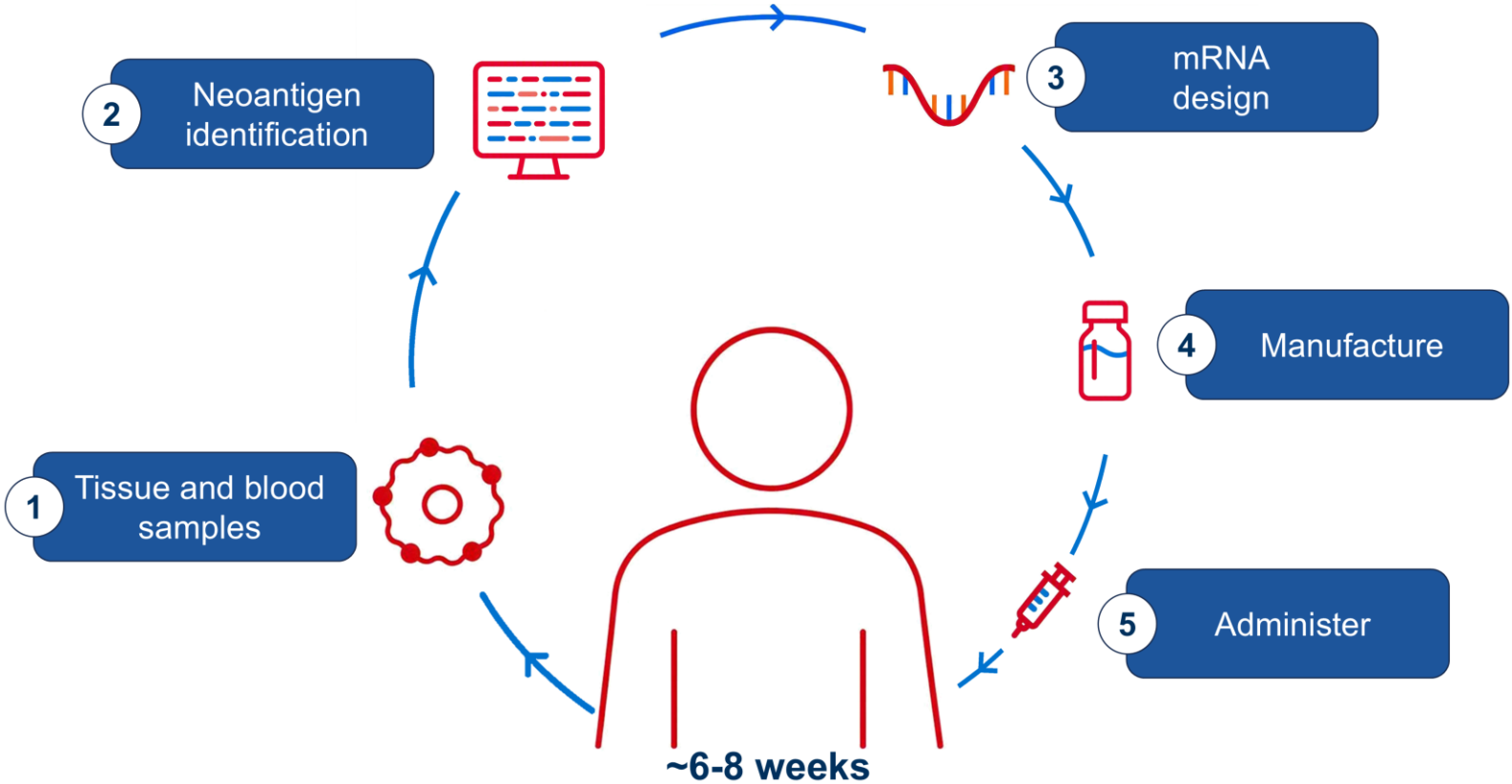
Ascierto PA, Melero I. *J Immunother Cancer* 2025;13:e013766. Zaidi N et al. *Nat Rev Cancer* 2025;25:517–33. Haanen JB et al. *Nat Med* 2026;32:828–40. Weber JS et al. *Lancet* 2024;403:632–44. Ojalvo LS et al. *JCO Oncol Adv* 2026;3:e2500206.

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Standardized intismeran workflow

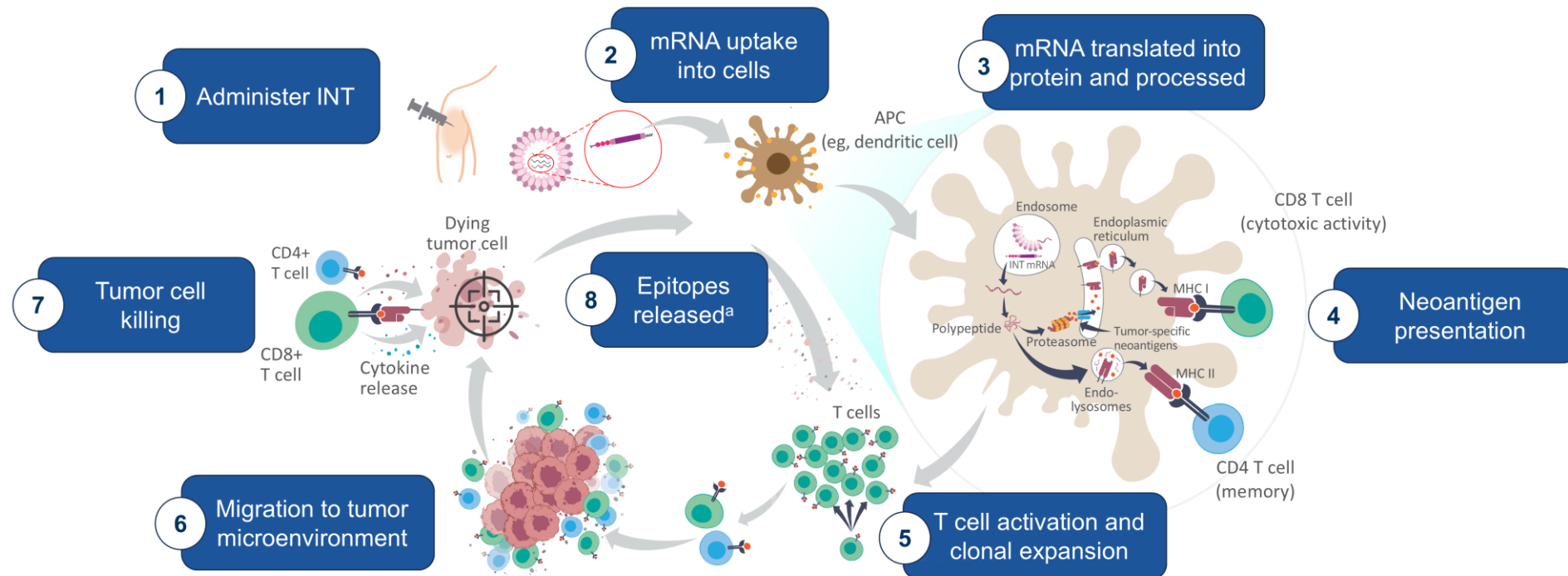


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Intismeran mechanism of action

- Intismeran is designed to **strengthen existing** and **create new** T cell responses¹⁻³
- Pembrolizumab **blocks PD-1** to enhance T-cell activity, complementing intismeran's MOA



^aHypothetical mechanism of action.

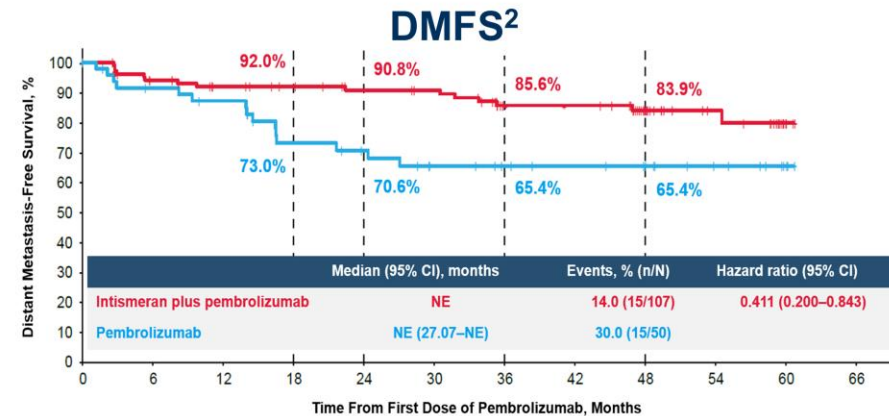
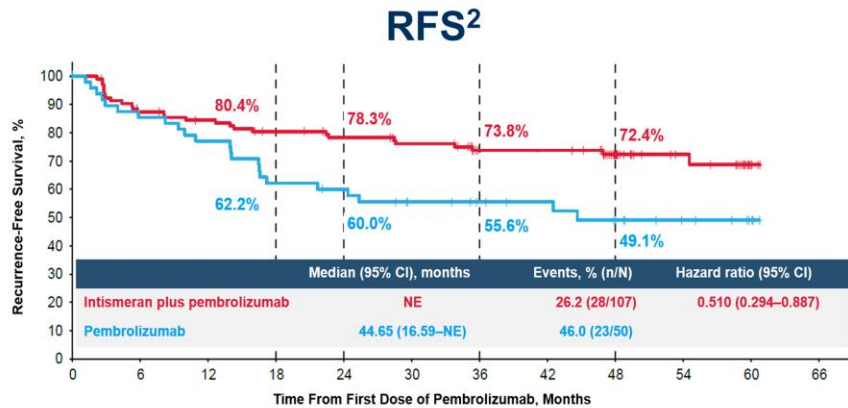
¹Weber JS et al. *Lancet* 2024;403:632–44. ²Ojalvo LS et al. *JCO Oncol Adv* 2026;3:e2500206. ³Gainor JF, et al. *Cancer Discov.* 2024;14(11):2209-2223

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KEYNOTE-942: Phase 2b trial of pembrolizumab ± intismeran: Proof of concept in stage IIIB–IV resected melanoma



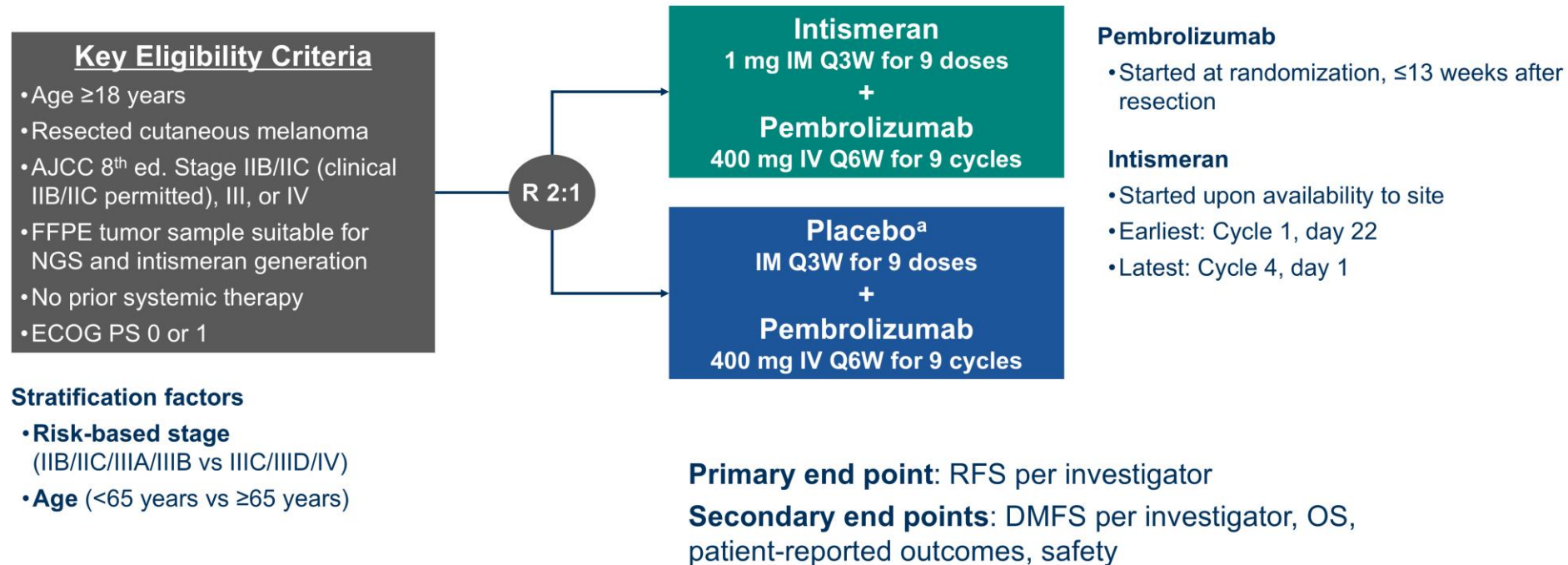
- Intismeran + pembrolizumab significantly improved RFS and DMFS and had a tolerable safety profile¹
 - Clinical benefit durable at 5 years²
- Intismeran-induced immune responses are associated with clinical outcomes²
 - Greater sustained expansion of novel T-cell clonotypes was associated with lack of recurrence^{2,3}
- Novel T-cell clonotypes were mapped to intismeran-encoded neoantigens and functionally validated³

¹Weber JS et al. *Lancet* 2024;403:632–44. ²Khattak A et al. *J Clin Oncol* 2026;44:2482–9. ³Sullivan RJ et al. *J Clin Oncol* 2026;44:abstr 9564.

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INTerpath-001: Randomized, Double-Blind, Phase 3 Trial



^aNormal saline or dextrose. Placebo was started at random to maintain the blind.
ClinicalTrials.gov identifier: NCT05933577.

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Key Statistical Considerations

Statistical methods

- Hierarchical testing^a: order of RFS → DMFS → OS
- Between-group treatment differences: stratified log-rank test^b
- Magnitude of treatment differences
 - Primary method: HR (95% CI) based on stratified Cox regression model^b in ITT population
 - Sensitivity analysis 1: unstratified piecewise HRs (95% CIs) in ITT population
 - Sensitivity analysis 2: HR (95% CI) based on stratified Cox regression model^b in mITT population^c

Interim analysis 1 (IA1)

- Timing: after ~240 RFS events and ≥18 months after last patient randomized
- Data cutoff date: June 30, 2026
 - Median follow-up^d: 24.6 months (range, 18.2–34.5)

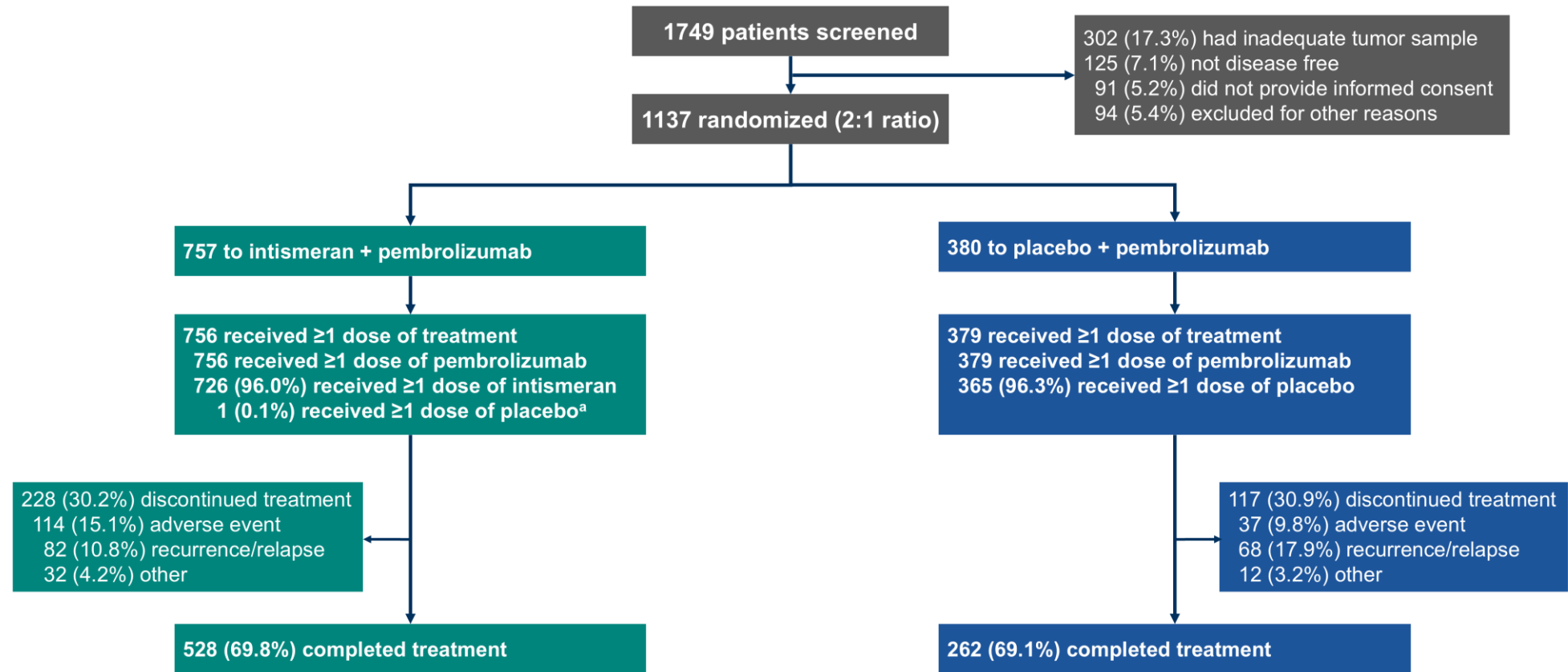
^aThe overall type I error was strongly controlled at one-sided 0.025 across RFS, DMFS, and OS. All alpha was initially allocated to RFS; alpha was transferred to DMFS and OS only if the preceding end point was significant. ^bRandomization stratification factors applied to all stratified analyses. ^cModified ITT (mITT) population included all randomized patients who received intismeran or placebo as planned. ^dDefined as time from randomization to the data cutoff date.

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Treatment Disposition and Exposure



^aThe patient for whom intismeran could not be manufactured received placebo to maintain the blind.

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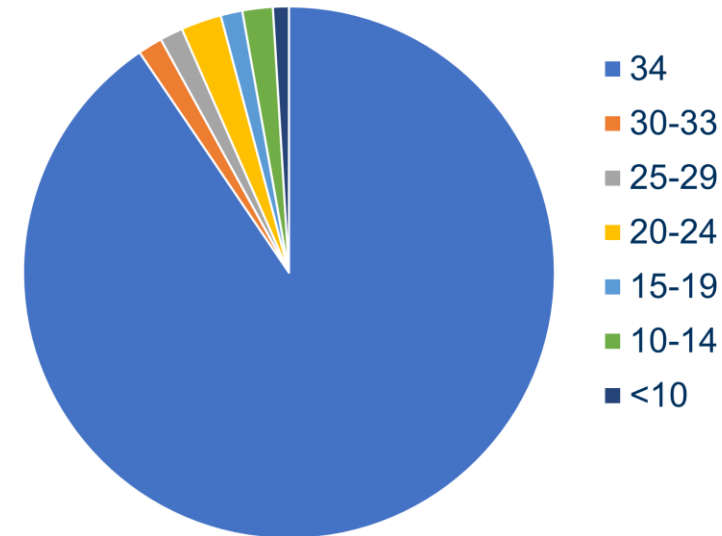
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Intismeran Design, Manufacture,^a and Exposure

- 91% of the 1137 randomized patients had the maximum 34 neoantigens identified for intismeran design
- >99% of the 757 patients in the intismeran + pembrolizumab arm had their intismeran successfully manufactured
- Median time to first intismeran dose was 64 days
- Median number of intismeran doses was 9^b

No. neoantigens in each intismeran
Median: 34 (range, 7–34)



^aIntismeran was designed for all randomized patients. The manufacturing workflow was initiated when it was known that a patient was randomized to the intismeran + pembrolizumab arm.

^bThe median number of placebo administrations and pembrolizumab cycles was also 9.

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Baseline Characteristics

	Intismeran + pembrolizumab (N = 757)	Placebo + pembrolizumab (N = 380)		Intismeran + pembrolizumab (N = 757)	Placebo + pembrolizumab (N = 380)
Age, median (range)	61.0 y (18–89)	61.5 y (18–88)	ECOG PS 0, n (%)	697 (92.1)	350 (92.1)
Male sex, n (%)	456 (60.2)	227 (59.7%)	Risk-based disease stage, n (%)		
Race, n (%)			IIB/IIC/IIIA/IIIB	441 (58.3)	230 (60.5)
Asian	15 (2.0)	13 (3.4)	IIIC/IIID/IV	316 (41.7)	150 (39.5)
Multiple	5 (0.7)	4 (1.1)	Overall disease stage, n (%)		
White	696 (91.9)	337 (88.7)	IIA	1 (0.1) ^c	0
Other	10 (1.3) ^a	4 (1.1) ^b	IIB	155 (20.5)	73 (19.2)
Missing	31 (4.1)	22 (5.8)	IIC	92 (12.2)	42 (11.1)
Geographic region, n (%)			IIIA	50 (6.6)	32 (8.4)
Australia	89 (11.8)	39 (10.3)	IIIB	143 (18.9)	83 (21.8)
Europe	415 (54.8)	209 (55.0)	IIIC	245 (32.4)	118 (31.1)
Latin America	45 (5.9)	22 (5.8)	IIID	10 (1.3)	4 (1.1)
United States	84 (11.1)	35 (9.2)	IV	61 (8.1)	28 (7.4)
Rest of world	124 (16.4)	75 (19.7)			

^aIncludes American Indian or Alaska Native (n = 5), Black or African American (n = 3), and Native Hawaiian or other Pacific Islander (n = 2). ^bIncludes American Indian or Alaska Native (n = 3) and Black or African American (n = 1). ^cProtocol deviation.

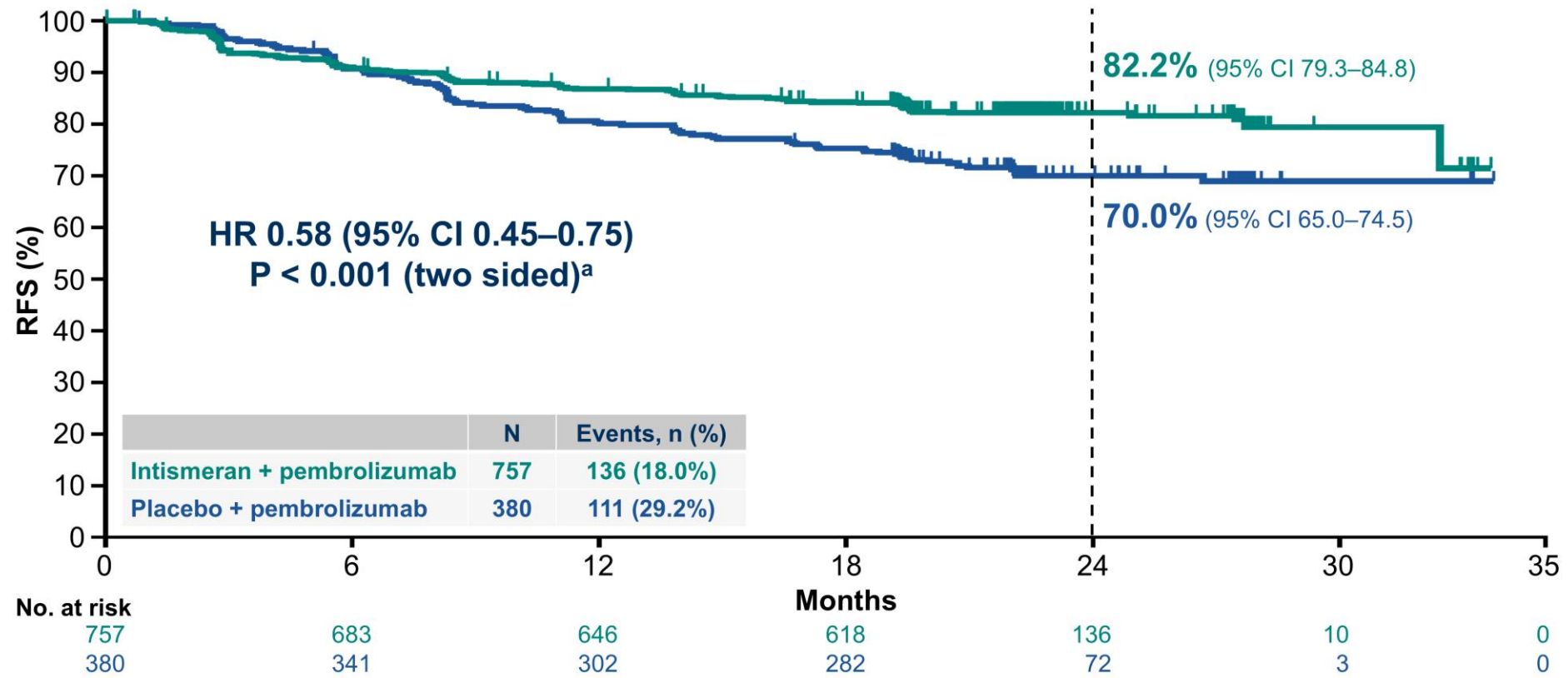
ITT population: all randomized patients according to the arm to which they were assigned. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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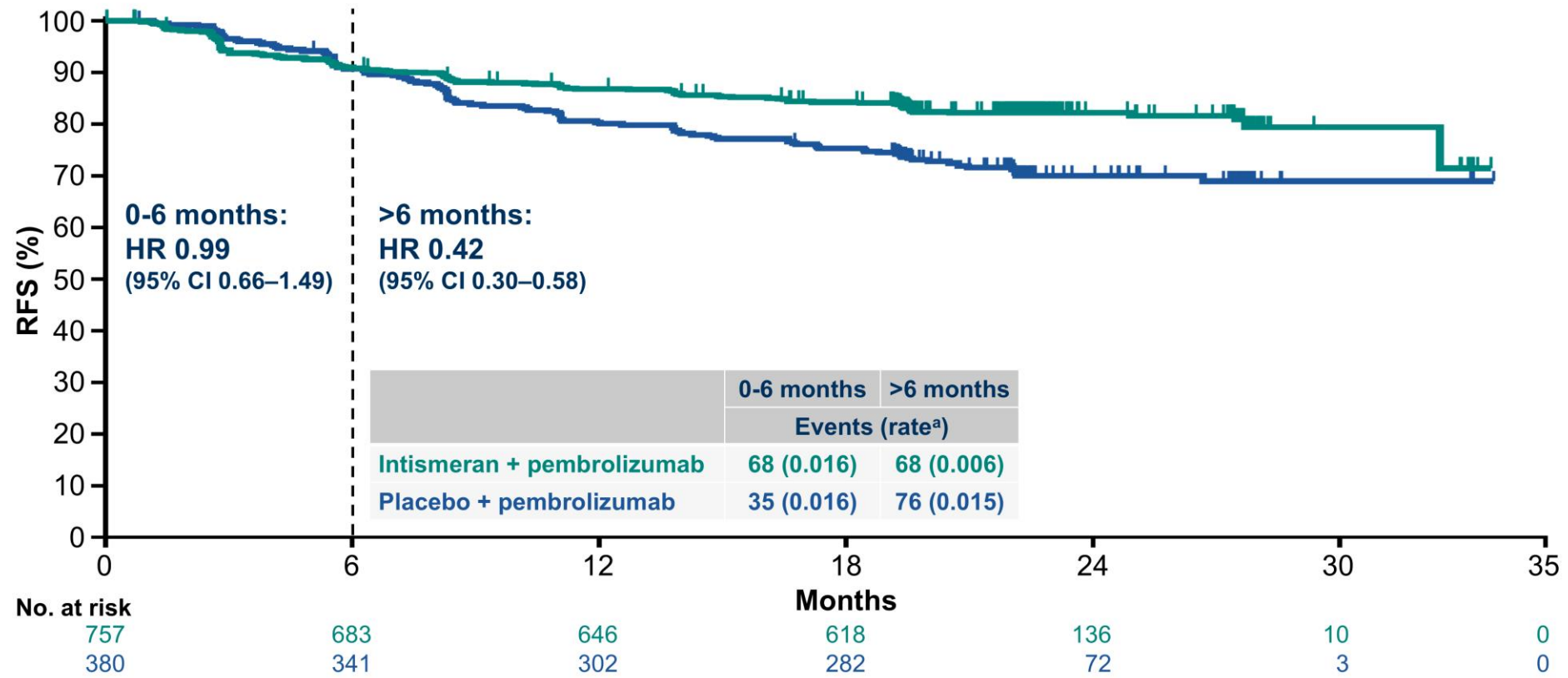
RFS Primary Analysis: ITT



^aMultiplicity-adjusted significance level: two-sided 0.024692.
 ITT: all randomized patients according to the arm to which they were assigned.
 RFS: time from randomization to the first occurrence of any recurrence or death from any cause. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).
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RFS Sensitivity Analysis: Piecewise Hazard Ratios, ITT

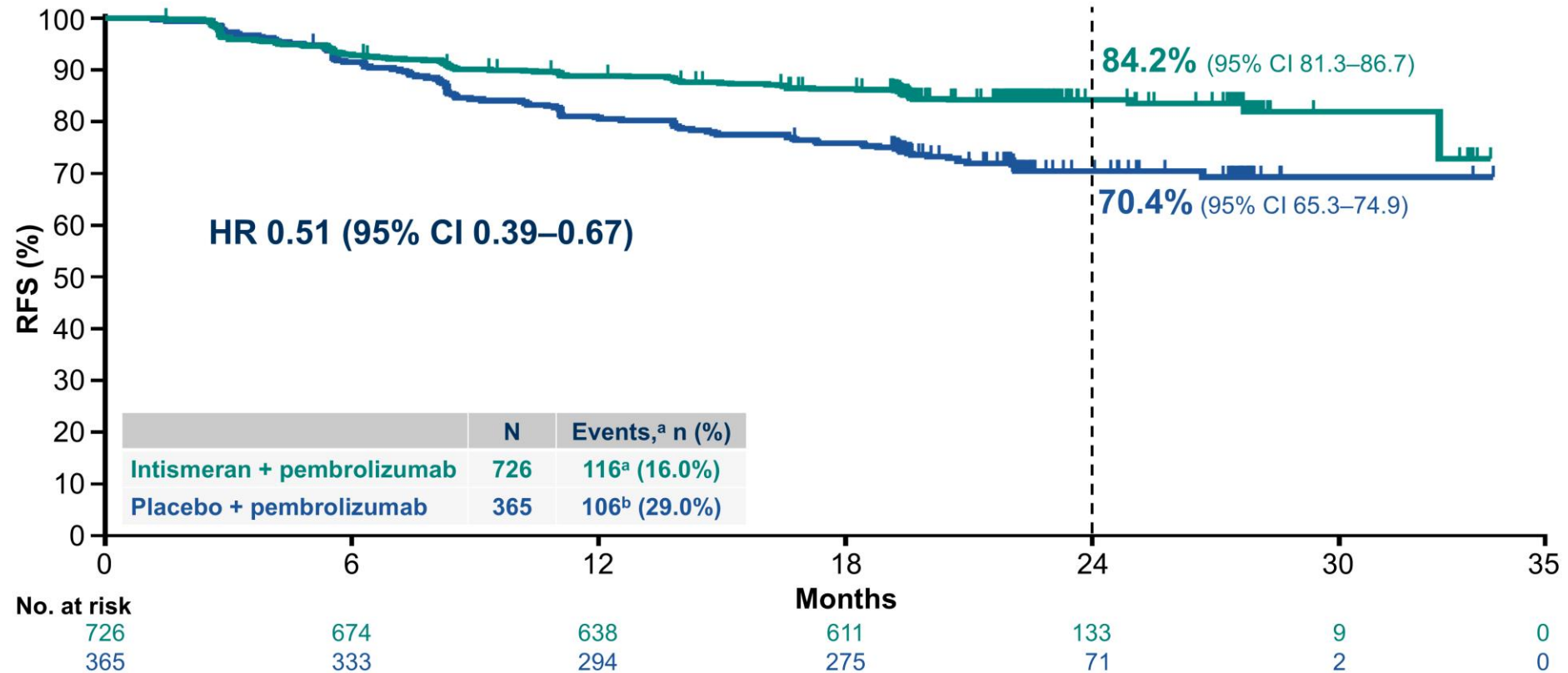


^aRate calculated as no. of events divided by person-time in each interval. ITT: all randomized patients according to the arm to which they were assigned.
RFS: time from randomization to the first occurrence of any recurrence or death from any cause. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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RFS Sensitivity Analysis: mITT



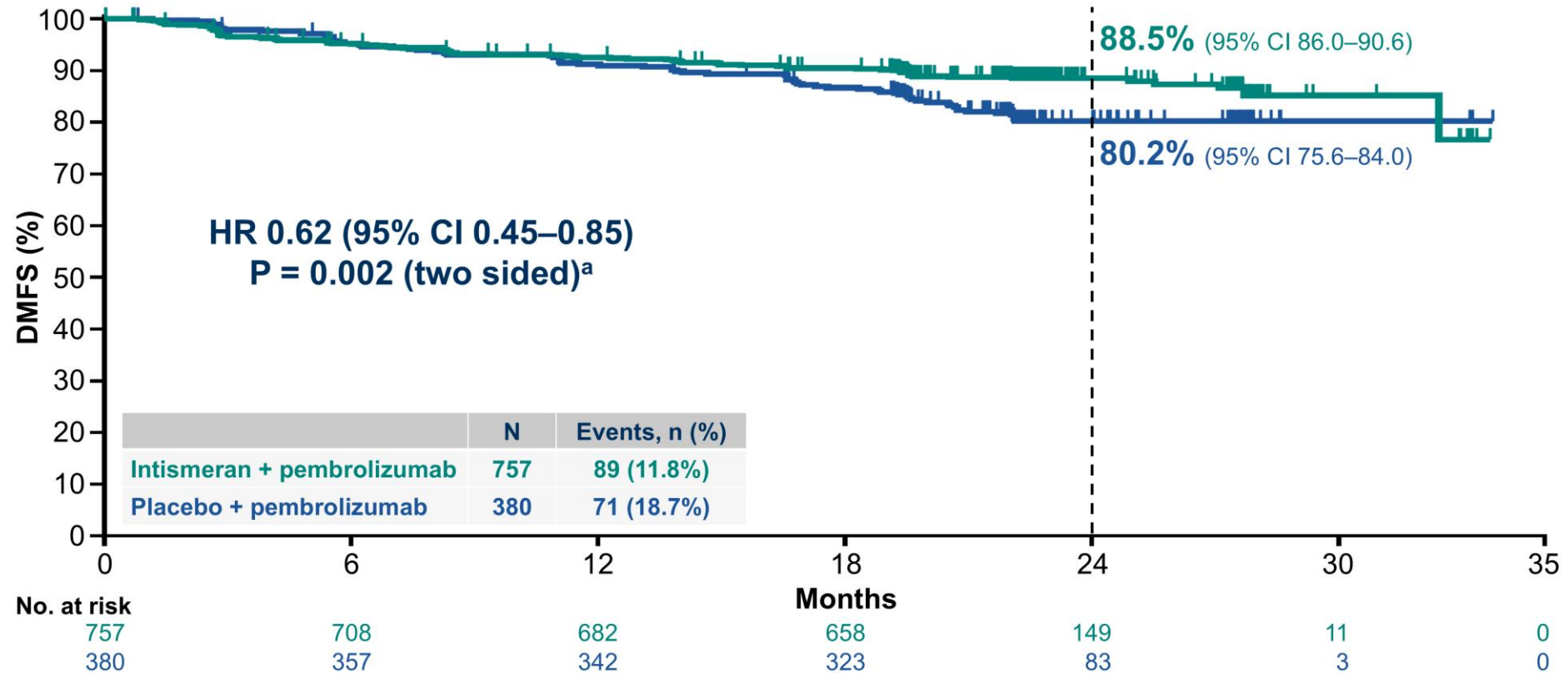
^a31 patients in the intismeran + pembrolizumab arm were excluded from the mITT population due to AEs (n=13), recurrence (n=10), or other reason (n=8). RFS events occurred in 20 (64.5%) of the 31 patients who did not receive intismeran as planned. ^b15 patients in the placebo + pembrolizumab arm were excluded from the mITT population due to AEs (n=5), recurrence (n=4), or other reason (n=6). RFS events occurred in 5 (33.3%) of 15 patients who did not receive placebo as planned. mITT: all randomized patients who received intismeran or placebo as assigned. RFS: time from randomization to the first occurrence of any recurrence or death from any cause. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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DMFS Primary Analysis: ITT



^aMultiplicity-adjusted significance level: two-sided 0.01608.

ITT: all randomized patients according to the arm to which they were assigned.

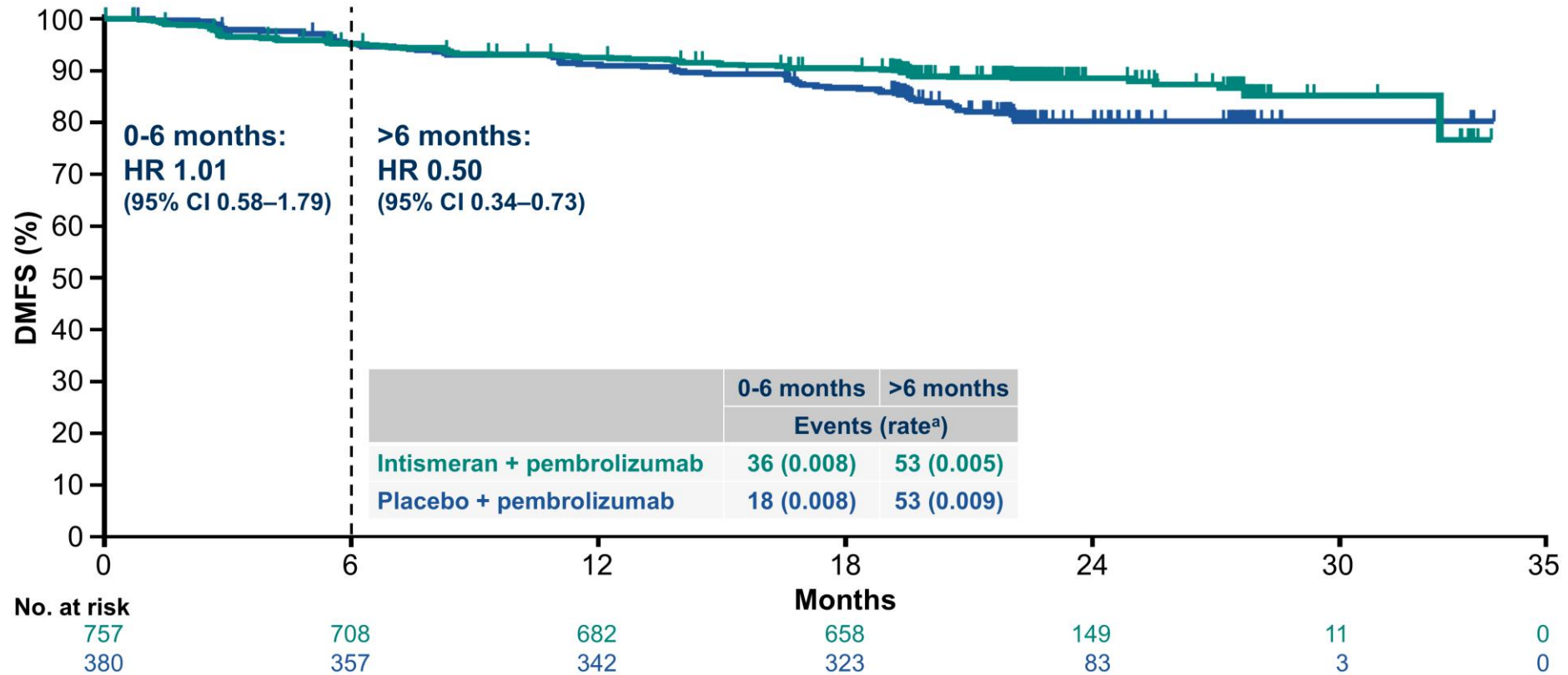
DMFS: time from randomization to first occurrence of distant metastasis or death from any cause. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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DMFS Sensitivity Analysis, Piecewise Hazard Ratios, ITT



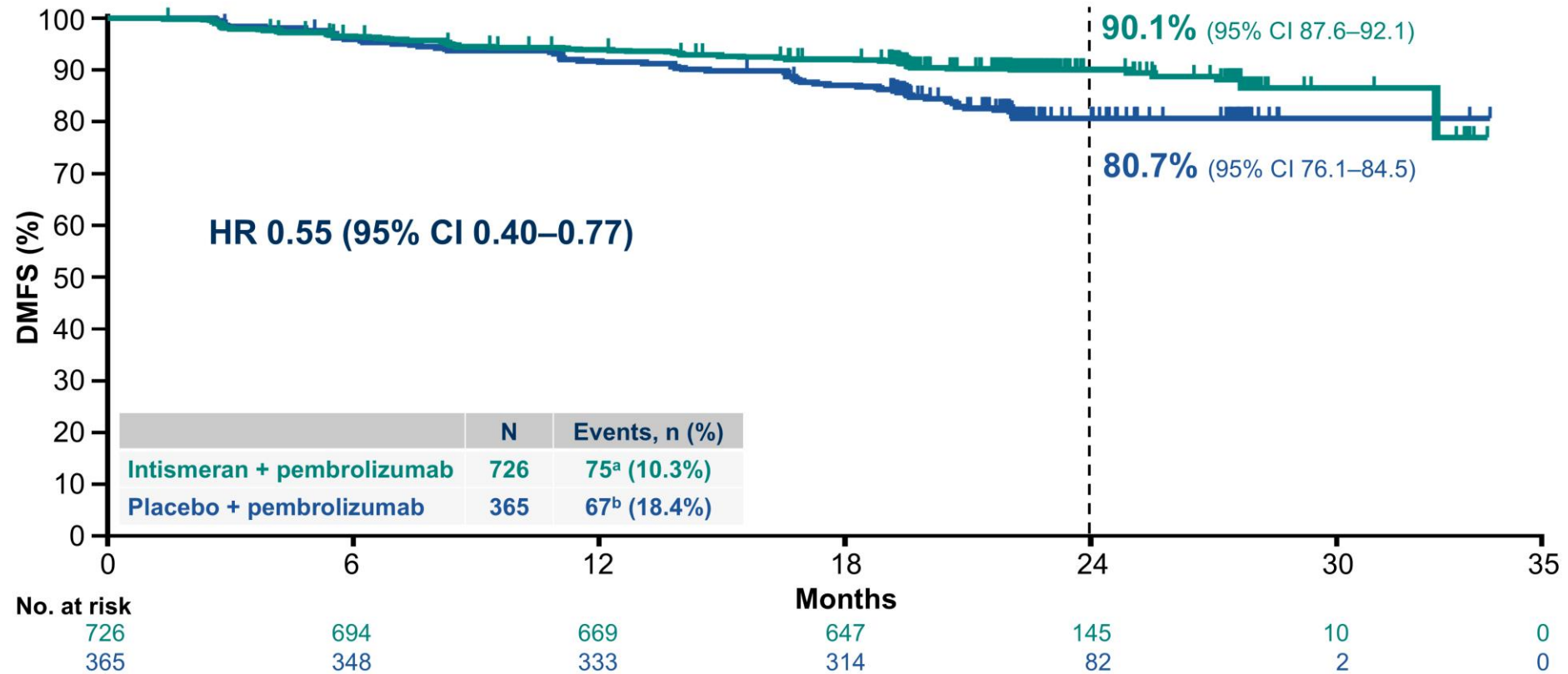
^aRate calculated as no. of events divided by person-time in each interval. ITT: all randomized patients according to the arm to which they were assigned.
DMFS: time from randomization to first occurrence of distant metastasis or death from any cause. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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DMFS Sensitivity Analysis: mITT



^aDMFS events occurred in 14 (45.2%) of 31 patients who did not receive intismeran. ^bDMFS events occurred in 4 (26.7%) of 15 patients who did not receive placebo as planned.

mITT: all randomized patients who received intismeran or placebo as assigned.

DMFS: time from randomization to first occurrence of distant metastasis or death from any cause. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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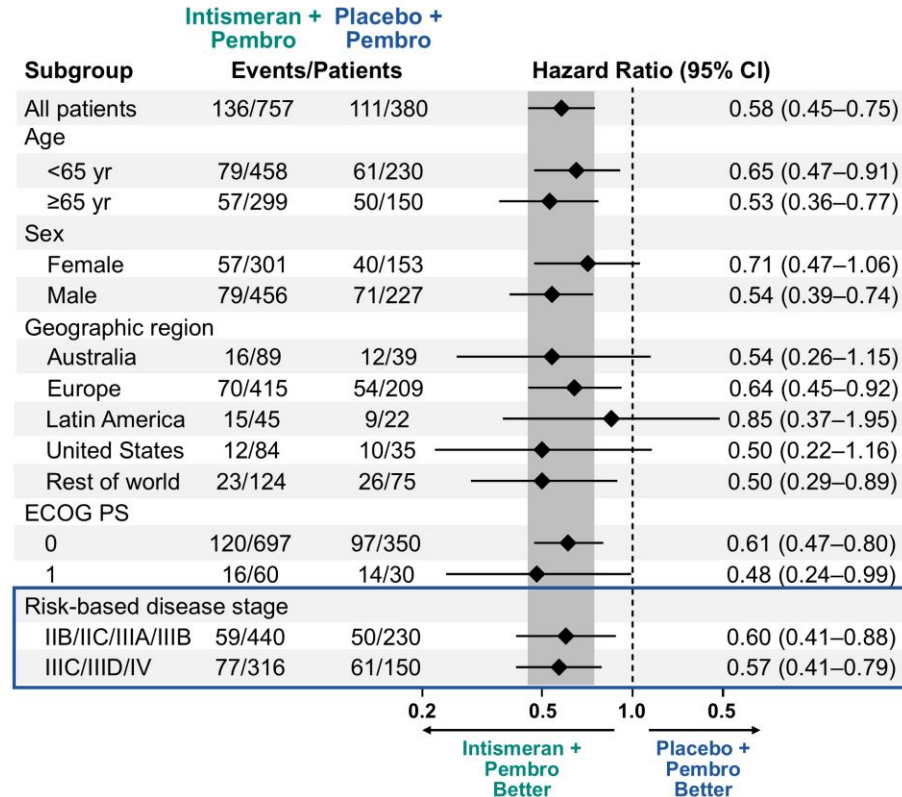
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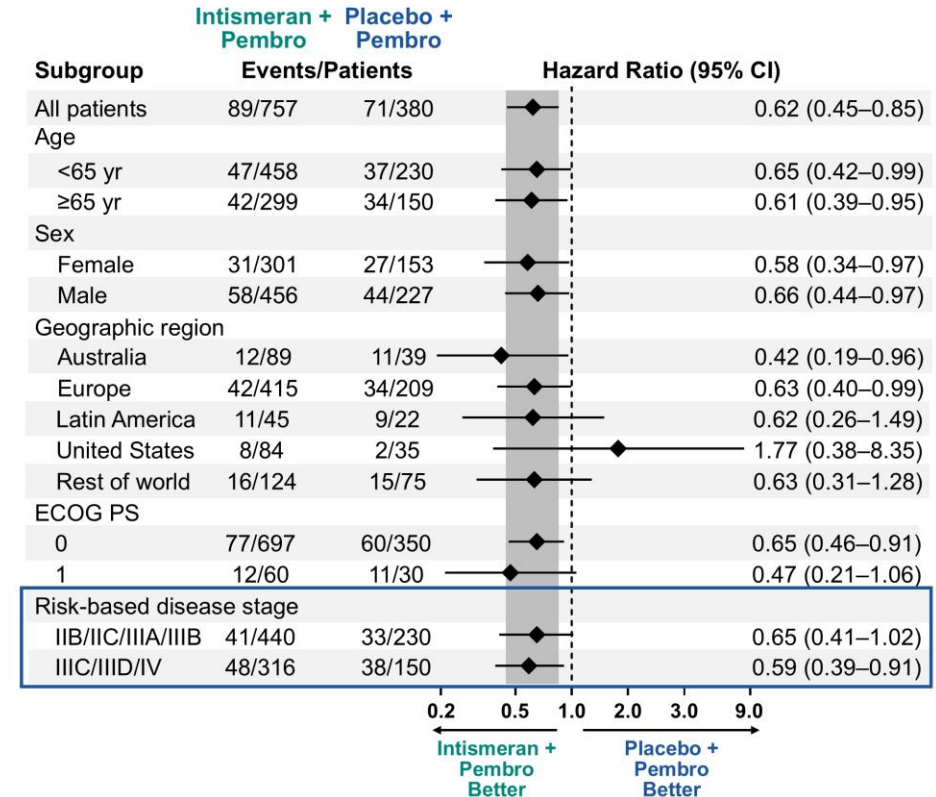
Efficacy in Prespecified Subgroups

RFS and DMFS benefits observed in most subgroups

Recurrence-Free Survival



Distant Metastasis-Free Survival



ITT: all randomized patients according to the arm to which they were assigned. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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Adverse Event Summary

	All-Cause AEs		Treatment-Related AEs	
	Intismeran + Pembrolizumab (N = 755)	Placebo + Pembrolizumab (N = 380)	Intismeran + Pembrolizumab (N = 755)	Placebo + Pembrolizumab (N = 380)
Any grade	742 (98.3)	366 (96.3)	723 (95.8)	342 (90.0)
Grade 3-5	178 (23.6)	77 (20.3)	107 (14.2)	51 (13.4)
Serious	133 (17.6)	60 (15.8)	74 (9.8)	42 (11.1)
Led to discontinuation of any drug	125 (16.6)	36 (9.5)	106 (14.0)	33 (8.7)
Discontinuation of pembrolizumab	115 (15.2)	36 (9.5)	97 (12.8)	33 (8.7)
Discontinuation of intismeran or placebo	66 (8.7)	21 (5.5)	54 (7.2)	19 (5.0)
Discontinuation of both drugs simultaneously	49 (6.5)	20 (5.3)	39 (5.2)	18 (4.7)
Led to death (none related to intismeran)	8 (1.1)	0	2 (0.3)	0

Grade 5 AEs

- 5 of the deaths occurred **before** the first dose of intismeran^a; 2 were attributed to pembrolizumab
- 3 of the deaths occurred **after** the first dose of intismeran^b; none attributed to treatment

^aOf the 5 events, 2 were attributed to pembrolizumab (muscular weakness, myocarditis, and myositis in 1 patient and myasthenia gravis in 1 patient); the remaining deaths were due to cardiac failure (n=1), road traffic accident (n=1), and sudden death (n=1).

^bOf the 3 events, none were attributed to study treatment (acute myocardial infarction (n=1), aspiration pneumonia (n=1), and sudden cardiac death (n=1)).

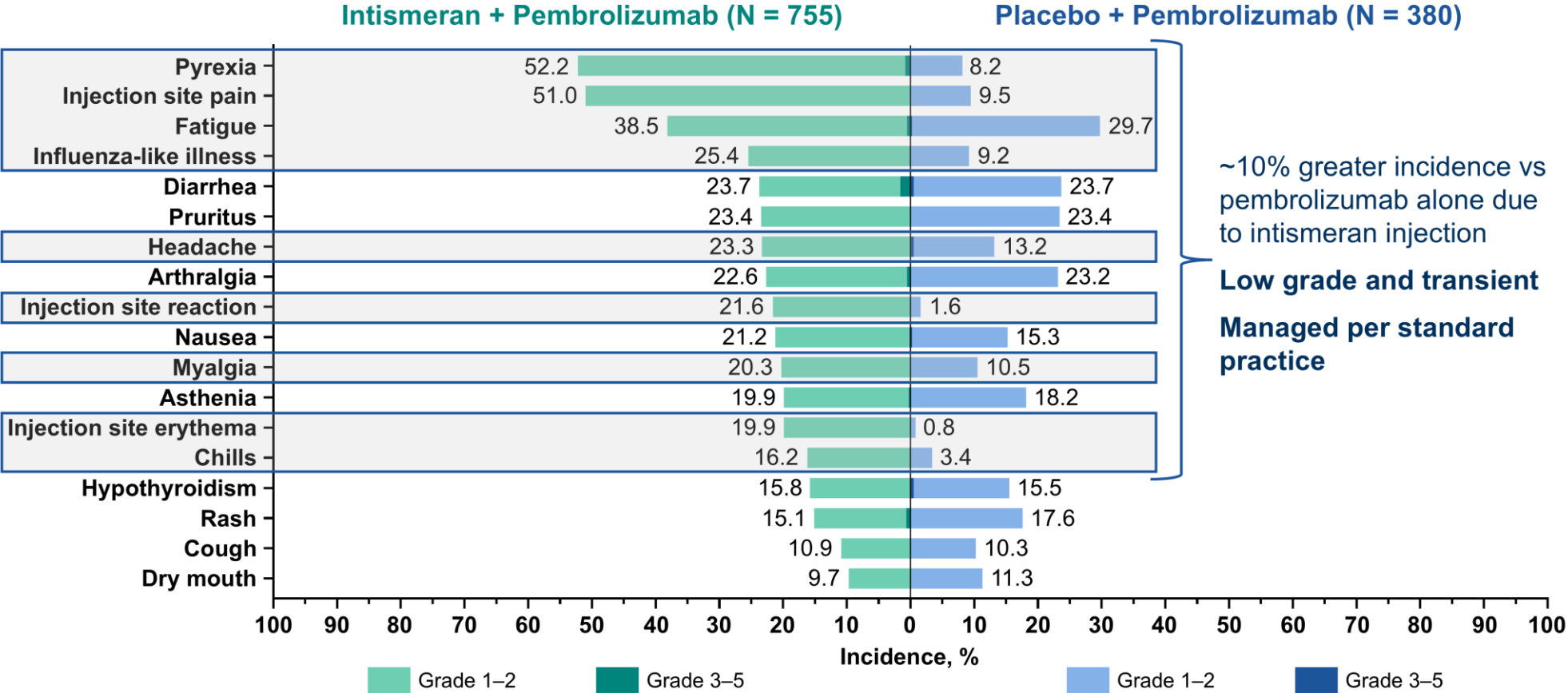
As-treated population: all randomized patients who received at ≥1 dose of study treatment. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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All-Cause AEs, Incidence $\geq 10\%$



As-treated population: all randomized patients who received at ≥ 1 dose of study treatment. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

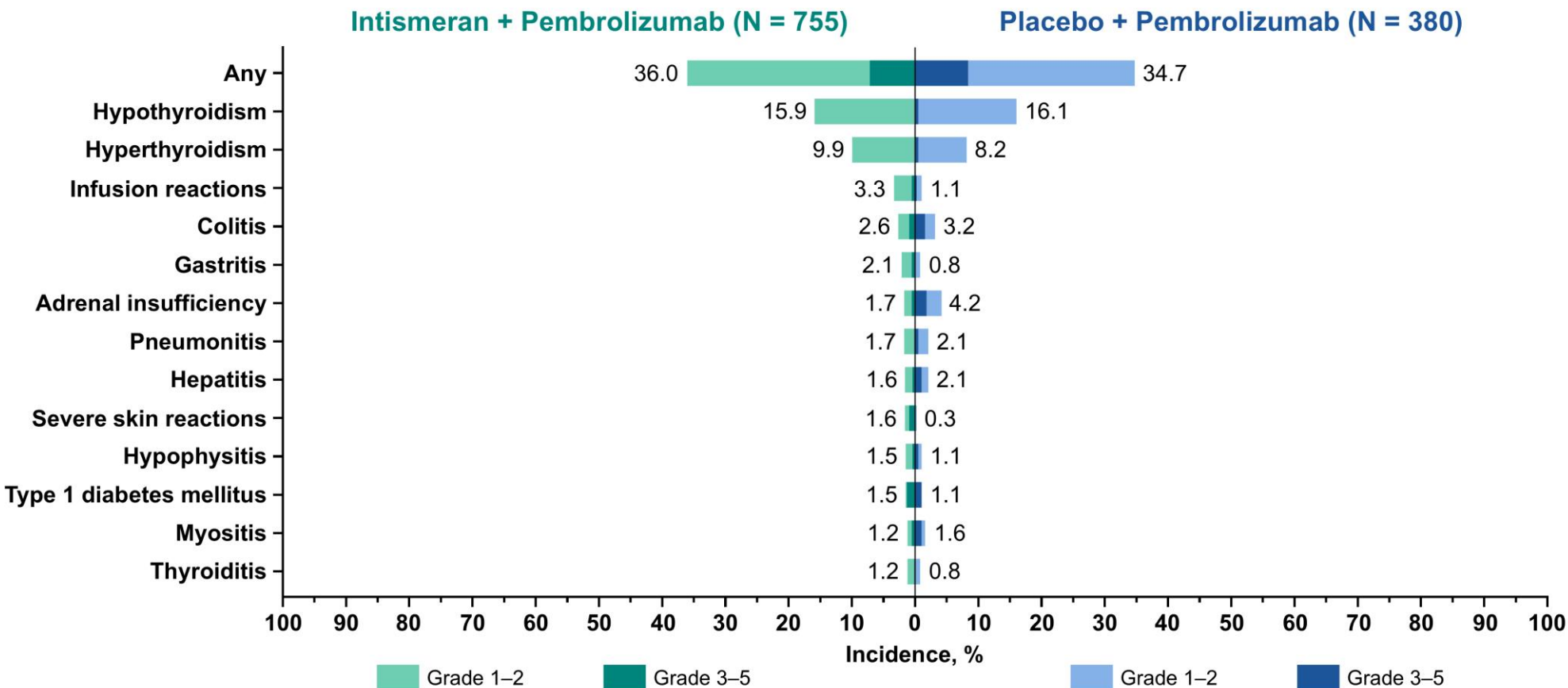
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AEs of Interest for Pembrolizumab, Incidence $\geq 1\%$

Intismeran did not potentiate pembrolizumab-associated AEs



As-treated population: all randomized patients who received at ≥ 1 dose of study treatment. Data cutoff date: June 30, 2026 (median study follow-up, 24.6 mo).

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Summary and Conclusions

- INTerpath-001 met both the primary RFS and key secondary DMFS endpoints
 - Intismeran + pembrolizumab reduced the risk of recurrence or death by 42% and the risk of distant metastasis or death by 38% compared with placebo + pembrolizumab
 - In a sensitivity analysis, intismeran + pembrolizumab reduced the risk of recurrence or death by 58% after month 6
 - Benefit was observed in most prespecified subgroups, including risk-based disease stages
 - OS was immature and did not meet prespecified significance boundary^a; follow-up is ongoing
- Safety was generally consistent with previous experience, with no potentiation of pembrolizumab-associated AEs with the combination
- Intismeran was reliably delivered at a global scale
- Ongoing phase 2 and 3 trials are evaluating intismeran for bladder cancer, melanoma, NSCLC, and RCC in the neoadjuvant, adjuvant, or metastatic settings
- INTerpath-001 sets a new benchmark for adjuvant therapy in melanoma and establishes intismeran as a landmark advance in personalized cancer medicine

^aThe hazard ratio for OS was 0.77 (95% CI, 0.45–1.31); two-sided P = 0.33.

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Acknowledgments

PATIENTS AND THEIR FAMILIES

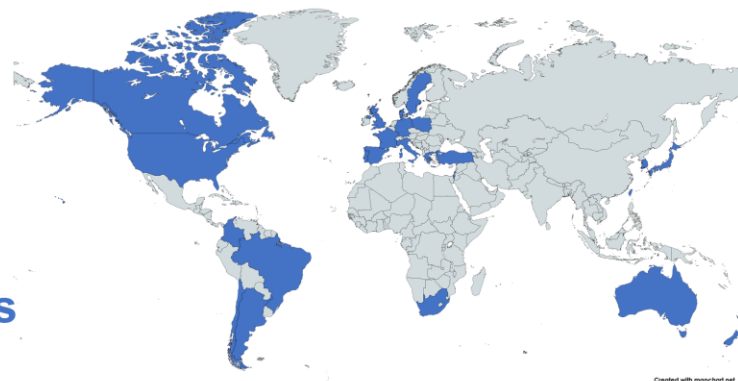
Investigators and site personnel from 157 global sites

The members of the Independent Data and Safety Monitoring Committee

Dr. Jeffrey S. Weber (1952–2024) for contributions to the INTerpath-001 design, and the enrolment and care of patients

All current and former personnel of MSD and Moderna who supported the study, particularly Stephan Anami, Claudia Del Vino, Li Fan, Jia Guo, Giulia Indellicati, Clemens Krepler, Tejaskumar Mehta, Kristen Pesci, Nivetha Ramachandran, Lili Zhu

Contact Dr. Georgina Long at georgina.long@sydney.edu.au for questions or comments



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The NEW ENGLAND
JOURNAL of MEDICINE

ORIGINAL ARTICLE

Intismeran Autogene plus Pembrolizumab
for Resected Stage IIB–IV Melanoma

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Michele Del Vecchio, M.D.,⁴⁴ for the INTerpath-001 Investigators*

In press. Currently planned for publication on November 11, 2026.

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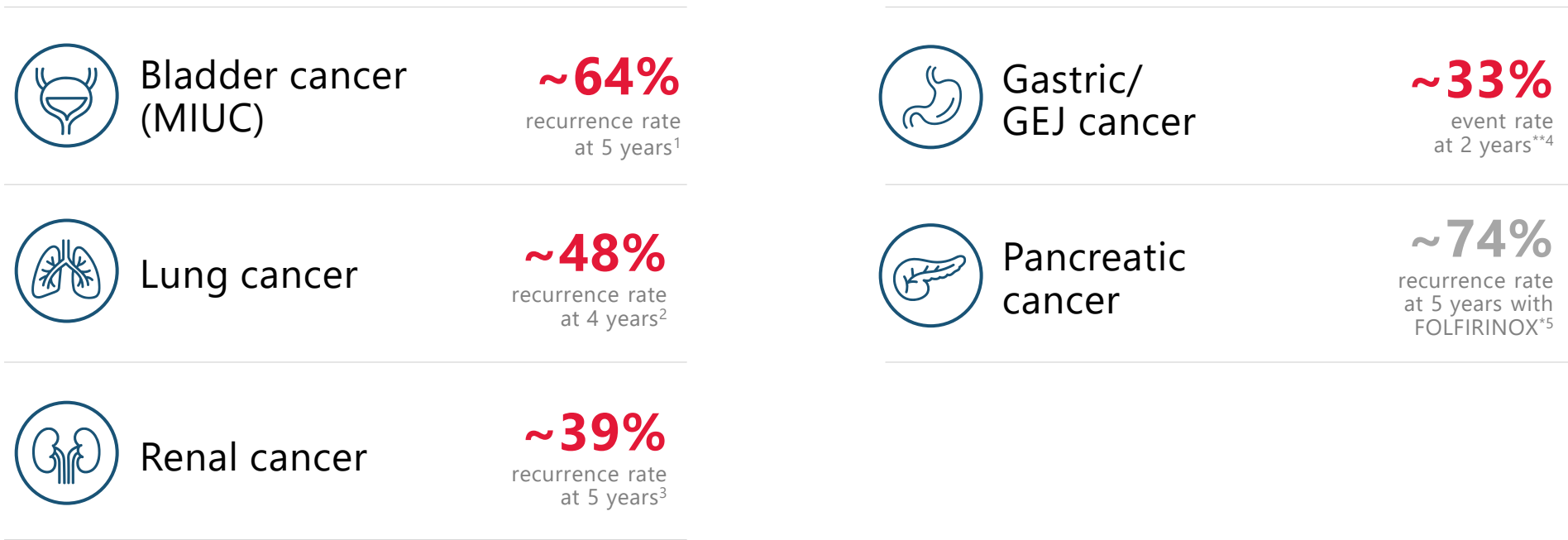
Conclusion

David Berman, M.D, PhD

Chief Development Officer, Moderna

Beyond melanoma, unmet need remains across adjuvant cancer settings

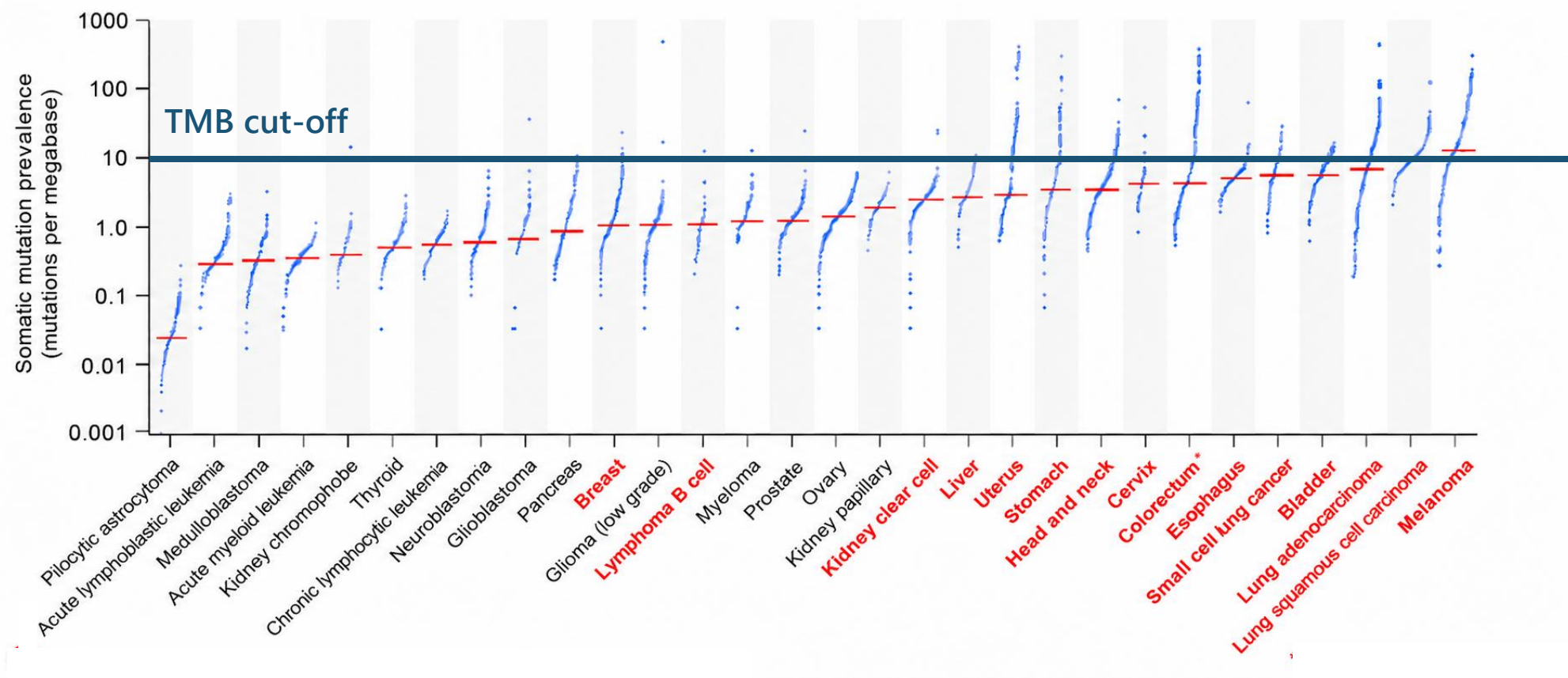
Estimated recurrence rate with adjuvant checkpoint inhibitors



*No Phase 3 data from checkpoint inhibitor; **Event rate as EFS is the endpoint in the peri-operative setting.

1. Galsky, Matthew D., et al. "Adjuvant Nivolumab versus Placebo for High-Risk Muscle-Invasive Urothelial Carcinoma: 5-Year Efficacy and ctDNA Results from CheckMate 274." *Annals of Oncology*, vol. 37, no. 1, 2026, pp. 69–78, 2. Merck & Co., Inc. KEYNOTE-091: Clinical Trial Results & Study Design. KEYTRUDA® (pembrolizumab) HCP website. Accessed May 27, 2026, 3. Klaassen Z. ASCO 2025: Five-year follow-up results from the phase 3 KEYNOTE-564 study of adjuvant pembrolizumab for the treatment of clear cell RCC. *UroToday*. Published during the American Society of Clinical Oncology 2025 Annual Meeting, May 30-June 3, 2025. Accessed May 27, 2026., 4. Janjigian, Yelena Y., et al. "Perioperative Durvalumab in Gastric and Gastroesophageal Junction Cancer." *New England Journal of Medicine*, vol. 393, no. 3, 16 July 2025, pp. 217–230, 5. Conroy, Thierry, et al. "Five-Year Outcomes of FOLFIRINOX vs Gemcitabine as Adjuvant Therapy for Pancreatic Cancer: A Randomized Clinical Trial." *JAMA Oncology*, vol. 8, no. 11, 2022, pp. 1571–1578

Phase 2 adjuvant melanoma data strengthen confidence in intismeran's potential across multiple cancer indications



Similar RFS benefit in Ph 2 between TMB High vs Non-High

Red text: Checkpoint inhibitors are approved for treatment of this cancer indication

* Primarily MSI-H/dMMR disease

Open-label, phase 1 study in adults with resected pancreatic ductal adenocarcinoma

Study overview

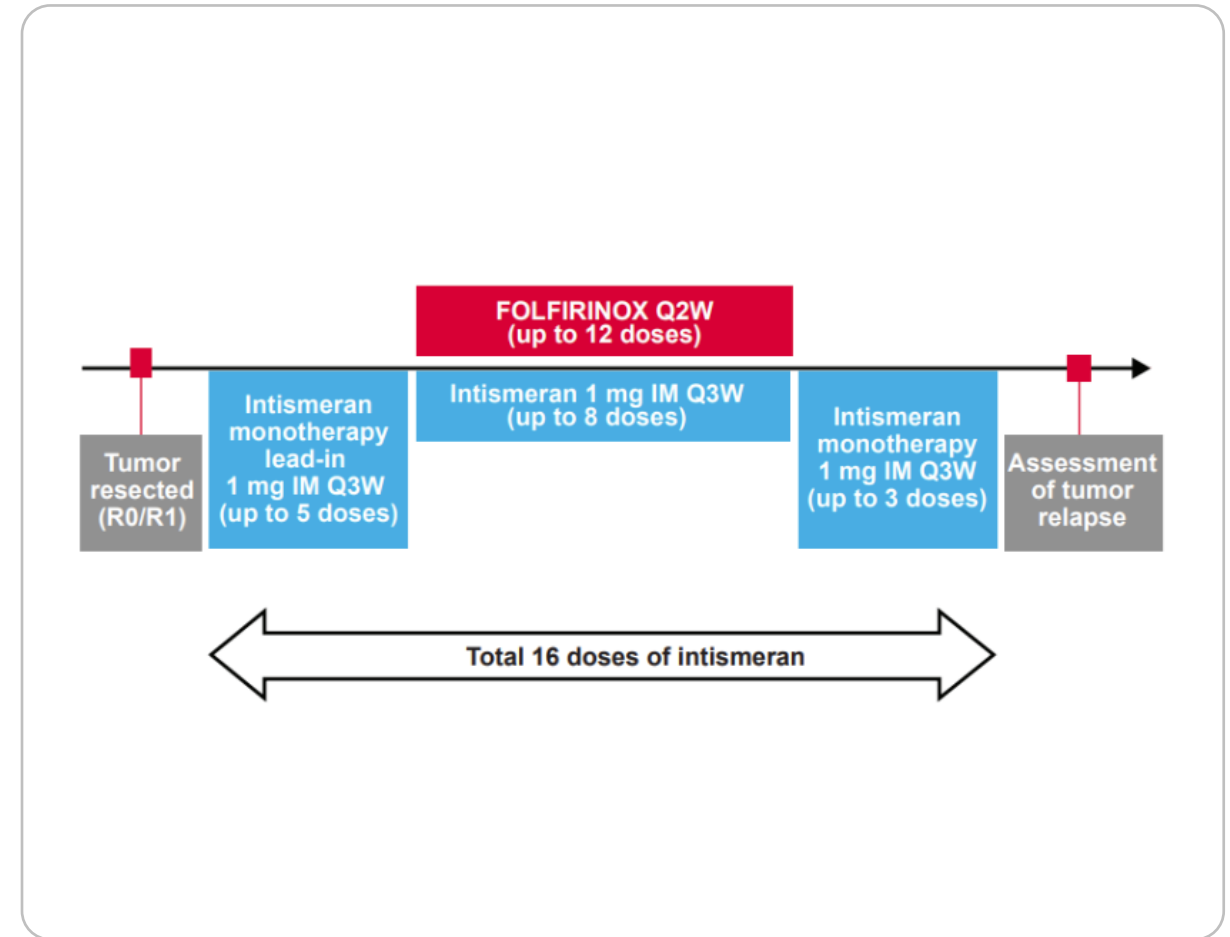
- Pancreatic adenocarcinoma following complete macroscopic resection

Study objectives

- Feasibility of intismeran from low TMB tumor
- Safety and tolerability with chemotherapy

Study endpoints

- **Primary:** safety and feasibility
- **Secondary:** Recurrence-free survival (RFS)
- **Exploratory:** Immunogenicity as exploratory endpoint by IFN- γ ELISpot and TCR sequencing.



Phase 1 pancreatic cancer data demonstrate neoantigen-specific T-cell responses following intismeran treatment

Patient population

- Twenty patients (pts) (stage IA–III) treated, including 7 who received prior neoadjuvant therapy.

Tumor characteristics

- **Low TMB** (range 0.26 to 2.75 mutations/Mb) and KRAS mutations in 65% (n = 13).

Biomarker results

- The median number of encoded neoantigens per intismeran was **34**.
- Among 19 immunogenicity-evaluable pts, **all 19 had neoantigen-specific T cell responses**
- In a subset of pts with apheresis, intismeran-specific neoantigens drove **polyfunctional T cell response**.
- T cell responses **increased over time** following intismeran; higher responses following intismeran dosing after FOLFIRINOX.

Conclusions

- Adjuvant intismeran with FOLFIRINOX induced **neoantigen-specific T cells in all evaluable PDAC, a low-TMB malignancy**

Full poster to be presented Sunday October 25 at 12:00 – 12:45 PM CET at ESMO 2026

Intismeran's clinical development program

Partnered with Merck

	Ph 1	Ph 2	Ph 3	Commercial	Treatment in investigational arm: intismeran +	Enrollment status	Clinical readouts
ADJUVANT							
Melanoma					pembrolizumab	Fully enrolled	Data presented today
NSCLC					pembrolizumab	Enrollment target met	Event-driven
NSCLC non-pCR post-neoadjuvant					pembrolizumab		
Stage 1 NSCLC					Arm 1: monotherapy Arm 2: pembrolizumab subcutaneous		
Renal cell carcinoma (RCC)					pembrolizumab	Fully enrolled	Event-driven
Bladder cancer (MIBC)					pembrolizumab	Fully enrolled	Event-driven
Bladder cancer (NMIBC)					Bacillus Calmette-Guérin		
METASTATIC							
First-line melanoma					pembrolizumab		
First-line squamous NSCLC					pembrolizumab + chemotherapy		
EARLY AND ADVANCED CANCERS							
Solid tumors					standard of care	Fully enrolled	Pancreatic translational data to be presented at ESMO 2026

Perspectives



Paolo Ascierto, MD

Department of Skin Cancers, Cancer Immunotherapy and Development Therapeutics, National Cancer Institute IRCCS, Fondazione G. Pascale Naples



Antoni Ribas, MD, PhD

Professor of Medicine, Surgery, and Molecular and Medical Pharmacology, UCLA; Director of the Tumor Immunology Program, Jonsson Comprehensive Cancer Center, director of the Parker Institute for Cancer Immunotherapy Center at UCLA

Q&A