Imugene Ltd

Initiation Report

Off-the-shelf CAR-T

Biotech

11 May 2026

Imugene Ltd (ASX:IMU) is a clinical-stage immuno-oncology company that has transitioned from a wide-ranging (expensive) pipeline into a highly-focused, late-stage execution vehicle focused on CAR-T. It is currently developing its platform azer-cel, an allogeneic 'off-the-shelf' CD19 CAR-T cell therapy for blood cancers. It cannot be stressed enough how different IMU is now compared with even last year – the company has made a strategic pivot towards disciplined capital management with a singular focus on its highly-prospective allogeneic CAR-T therapy. Gone are the numerous projects of previous years which consumed substantial capital. Azer-cel is targeting large and specific unmet markets within the blood cancer space. The data to date has been compelling – Phase 1b trials have demonstrated an 82% Overall Response Rate (ORR) in heavily pre-treated DLBCL patients and strong ORR in CAR-T naïve niche lymphoma patients (100% in CLL and 80% in MZL). IMU's immediate priority is to complete Phase 1b with a focus on two cohorts (rare and niche blood cancers as well as a combination therapy), with the potential for a single-arm pivotal study to follow for FDA Accelerated Approval. The market cap of <$50m is very low vs. listed allogeneic CAR-T peers that trade much higher, particularly given IMU's positive trial data to date and the progress expected over the next 12-18 months.

Business model

IMU operates a typical biotech development model – it licenses or develops novel platform technologies, funds them through capital raises and other investor financing, progresses them through clinical trials to generate proof-of-concept data, and then aims to either out-license those assets to large pharma companies for milestone payments and royalties, or position the company as an acquisition target. IMU's focus more recently has been to take and develop later-stage products such that they could potentially get to market earlier. The primary focus is on azer-cel which was acquired in August 2023.

The allogeneic advantage in CAR-T cell therapy

CAR-T therapy for blood cancers entered the mainstream in 2017 when the FDA approved the first two CAR-T products; several other products have been approved since. Importantly, all approved CAR-T therapies to date are 'autologous' – they all require the patient's own cells to be used, an expensive process which takes several weeks to complete. IMU is developing azer-cel, which may potentially be the first approved 'allogeneic' CAR-T therapy, an innovative 'off-the-shelf' product that utilises healthy universal donor cells. This approach reduces costs and eliminates patient wait times (a critical factor for patients with spreading cancers). To date, azer-cel clinical data has demonstrated strong efficacy and safety.

Valuation of $0.24/share or $199.8m market cap

We value IMU through a probability-weighted NPV (rNPV), given IMU's expected cash flows are long-dated and predicated on FDA clearance and commercial success. Our unrisked NPV is $0.97/share and our rNPV is $0.24/share, which applies a Probability-of-Success (PoS) weighting of 25%. We assume FDA Accelerated Approval for azer-cel in two cohorts only, forecast sales explicitly to FY35, and a WACC of 14.9% incorporating a beta of 1.6x. N.B. while 403.3m shares are currently outstanding, we heavily dilute the share count to 824.3m shares on issue in deriving our valuation on a per share basis.

Historical earnings and RaaS' estimates (in A$m unless otherwise stated)

Year end	Revenue	Gross profit	EBITDA	NPAT	EPS (cps)	EV/EBITDA (x)	EV/Sales (x)
06/24a	0	0	(127.9)	(128.9)	(1.82)	n.m.	n.m.
06/25a	0	0	(69.7)	(67.2)	(0.90)	n.m.	n.m.
06/26f	0	0	(49.3)	(49.4)	(4.76)	n.m.	n.m.
06/27f	0	0	(27.7)	(39.2)	(5.94)	n.m.	n.m.

Source: Company data, RaaS estimates FY26f to FY27f

Share Details

ASX code	IMU
Share price (8-May)	$0.105
Market capitalisation	$42.3M
Shares on issue	403.3M
Options on issue (various)	89.9M
Warrants (various)	89.9M
Convertible SAR notes	$15.3M
Cash (post capital raise)	~$15M
Free float	~95%
Avg. daily volume (12-mths)	1.73M

Share Performance (12 Months)

Upside Case

- Phase 1b data on Cohort 2 and Cohort 3 confirming strong efficacy
- Initiation of pivotal trial
- Licensing agreement with Big Pharma

Downside Case

- Poor efficacy data
- Failure to raise funds to progress trials
- Failure to secure FDA approvals

Catalysts

- Initiation of Cohort 3 (imminent)
- ASCO oral presentation, May/Jun 2026
- Phase 1b completion in FY27

Board and Management

Paul Hopper	Executive Chairman
Leslie Chong	MD & CEO
Jakob Dupont	Non-Executive Director
Kim Drapkin	Non-Executive Director
Lesley Russell	Non-Executive Director

Company Contacts

Leslie Chong info@imugene.com

RaaS Contact

Naheed Rahman +61 422 314 710
naheed.rahman@raasgroup.com

Research as a Service

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Research as a Service

Imugene Ltd

Imugene Ltd (ASX:IMU) in its current form dates back to December 2012 when Biolife Science was taken public through a reverse takeover of an existing ASX-listed shell company called Imugene (name retained). Executive Chairman Paul Hopper, an Australian bioentrepreneur, was instrumental in identifying the HER-Vaxx project that Biolife Science was incorporated to develop, while CEO Leslie Chong joined in 2015. Over the years, IMU built a broad pipeline of drugs and platform technologies. A strategic pivot occurred in 2023, when the high rate of cash burn became increasingly apparent. The company decided to focus away from early-stage assets and shelve these vaccine and virus programmes as they would take substantial funds to develop. Instead, the company would focus on acquiring a product that was already well advanced clinically and had clear regulatory feedback – something that could potentially reach a commercial milestone on a shorter timeframe. This mandate was satisfied in August 2023, when IMU made a pivotal acquisition, licensing the global rights to azer-cel from Precision BioSciences. The strategic pivot became even more pronounced in late-2025 when azer-cel effectively became the sole focus of the company, with other remaining portfolio assets divested or paused/halted in their progress. Azer-cel's clinical data has been striking – the Phase 1b trial has shown an 82% response rate in relapse/refractory DLBCL patients who had failed prior autologous CAR-T therapy (Cohort 1) and strong ORR in CAR-T naïve niche lymphoma patients (Cohort 2; 100% in CLL and 80% in MZL). The regulatory trajectory has been very positive to date; the company has secured alignment with the FDA to advance azer-cel into a pivotal clinical trial. In addition, IMU is also now pursuing a BTKi combination therapy (Cohort 3). Investors should understand that IMU is particularly focused on Cohort 2 and Cohort 3; Cohort 2 has the potential for a single-arm pivotal study for FDA Accelerated Approval while Cohort 3 could also receive Accelerated Approval or a label expansion. The expected news flow ahead includes clinical trial progress and data from all three cohorts to complete Phase 1b, and the initiation of a pivotal trial. If azer-cel can demonstrate positive efficacy data, it has the potential to become the first approved allogeneic CAR-T therapy, a genuinely first-in-class product in a market where existing autologous therapies cost US$400,000-$500,000 per patient yet face significant manufacturing and scalability constraints.

Investment Case

We detail our investment case for IMU below:

- **Focused strategy.** IMU has transitioned to a focused company with its lead asset azer-cel expected to complete Phase 1b in FY27, with an immediate follow-on into a pivotal trial in FY28 (with Cohort 2 targeting CAR-T naïve niche lymphoma indications that have no approved CAR-T therapies). This focused strategy should also be reflected in an improved cash burn profile over the coming quarters, highlighting disciplined capital management.
- **Very strong efficacy data to date.** Azer-cel's Phase 1b trial to date has showed an 82% response rate in relapsed/refractory DLBCL patients who had failed prior autologous CAR-T therapy, and strong ORR in CAR-T naïve niche lymphoma patients (100% in CLL and 80% in MZL). These results are significant because they address a growing and urgent unmet need where a rising number of patients have very few options remaining.
- **Large addressable markets.** IMU is looking to apply azer-cel across two distinct paths initially, each of which has a TAM in the billions of dollars (further detail on size of market later in this report).
- **Capital-efficient regulatory pathways.** As Cohort 2 represents CAR-T naïve niche indications with no approved CAR-T therapies, this pathway has the potential to be a single-arm pivotal study as it addresses a growing and urgent unmet need. A single-arm pivotal study in CAR-T therapy would likely be 30-80 patients in size for a cost of $30-50m, which would be significantly cheaper than a standard randomised study requiring 200-500 patients across two arms costing $200-450m. If approved, the approval type would likely be Accelerated Approval, with the overall process of a single-arm pivotal trial being two-three years shorter than a standard randomised pivotal trial. Cohort 3 (BTKi combination) may also qualify for

Accelerated Approval (given significant unmet need in later lines), but the more likely pathway is through a label expansion into BTKi combination indications. Ultimately however, the registrational design for Cohort 2 will be dependent on the competitive landscape of pending and approved products, and FDA guidance and acceptance.

- **Acquisition potential.** There is a significant business development opportunity through the BTKi combination strategy being pursued. BTKi drugs are an established standard of care across multiple blood cancers with >US$10b in annual sales for Big Pharma – any of these companies would have strong strategic motivation to co-develop or license a combination that extends BTKi utility, something that IMU is seeking to prove with Cohort 3 studies.

- **Material progress and share price catalysts expected over the next 12 months.** Regular and ongoing Phase 1b data on CAR-T naïve niche lymphoma patients and BTKi combination is expected (although Cohort 3 is new, initial clinical data may be seen as soon as June 2026). There is potential for FDA Fast Track, Breakthrough and/or RMAT (Regenerative Medicine Advanced Therapy) Designation for additional niche lymphomas [IMU already has Fast Track Designation for DLBCL (Cohort 1)].

- **Valuation**. Our rNPV for IMU is $0.24/share, offering 129% upside potential from the current share price.

Company History

Imugene began as a research project in 2004 at the Medical University of Vienna, where Professor Ursula Wiedermann over nine years developed HER-Vaxx, a B-cell peptide cancer immunotherapy targeting HER-2 overexpressing tumours, such as gastric and breast cancers. In 2012, a start-up called Biolife Science was incorporated to develop HER-Vaxx, and it was taken public in December 2013 through a reverse takeover of an existing ASX-listed shell company called Imugene, whose name was retained. Executive Chairman Paul Hopper, an Australian bioentrepreneur, was instrumental in identifying the HER-Vaxx project, while CEO Leslie Chong joined in 2015 after working at Genentech in California. Recognising the limitations of relying solely on peptide vaccines, management embarked on an aggressive plan over the following years to build out a broad pipeline. PD1-Vaxx was licensed from Ohio State University and the Mayo Clinic in 2018, the CF33 oncolytic virus platform (invented by Professor Yuman Fong of City of Hope Cancer Center) was licensed in 2019, onCARlytics (CF33-CD19) was licensed in 2021, and VAXINIA and CHECKvacc subsequently entered the portfolio. At its broadest, Imugene was running four distinct platform technologies across B-cell vaccines, oncolytic viruses and cell therapy.

As is common with most biotechs, IMU has had a history of raising funds to fund its clinical trials:

- October 2016 – $3.2m placement, to support IMU's Phase 1b gastric cancer trial.
- November 2017 – $6.7m placement and $2.0m entitlement offer, to help complete the Phase 1b/2 HER-Vaxx clinical trial along with further trial expansion and development of the clinical pipeline.
- June 2018 – $12m placement and $8.1m entitlement offer, to fund expanded clinical programmes. It coincided with the licensing of PD1-Vaxx from Ohio State University and the Mayo Clinic.
- December 2019 – $24.6m placement, to fund IMU's clinical programmes including two oncolytic virotherapy candidates through completion of Phase 2 study (particularly oncolytic virus CF33), as well as B-cell immunotherapy candidates.
- August 2021 – $90m placement and $5m SPP. A large and transformational raise, aimed at funding all three technology platforms that IMU had at the time and bolster the clinical pipeline.
- September 2022 – $80m placement, aimed at extending the runway for IMU's pipeline of clinical programmes and provide flexibility for complementary acquisitions.
- August 2023 – $35m placement and $18m SPP, for the acquisition of exclusive licensing rights to azer-cel and associated trial costs.

- December 2024 – $20m zero coupon convertible notes and $26m unlisted warrants, both to CVI Investments (an affiliate of Heights Capital Management / Susquehanna International Group). The funds were to support ongoing trials for azer-cel, onCARlytics and VAXINIA.
- July 2025 – $22.5m placement and $15m SPP, to fund azer-cel.
- March 2026 – $12m placement and $4m SPP, to fund azer-cel, specifically expanding Cohort 2 and launching the new BTKi combination Cohort 3.

Further, over this period, various options have been exercised and R&D tax refunds received to also fund the company. IMU received an R&D tax refund of $5.9m in July 2025 for the FY24 year. In July 2025, IMU undertook a 34-for-1 share consolidation, reducing its shares on issue from ~7.5b to ~219m.

It is important to stress the strategic pivot that occurred in 2023. IMU is no longer working on multiple longer-dated projects as it has historically. Instead, the primary focus is on azer-cel and with it, more disciplined capital management. Following the most recent equity raise in March 2026, IMU has ~$15m in cash, which will largely be used to fund ongoing azer-cel clinical trials. The company says it is focused on commercialising azer-cel as quickly and efficiently as possible.

Company Overview

This section has an overview of cancer immunotherapy and blood cancers which is the market that IMU is focused on, and then explains CAR-T therapy as it applies to this market. Finally, IMU's aspiring CAR-T therapy azer-cel is discussed.

Cancer immunotherapy

Cancer immunotherapy is a class of treatment that enhances the body's own immune system to identify and destroy cancer cells, as opposed to relying on conventional approaches such as chemotherapy or radiation that indiscriminately target all rapidly dividing cells. Immunotherapy is appealing due to specificity – the immune system, once correctly programmed, can distinguish between malignant and healthy tissue, attack cancer with precision, and importantly maintain immunological memory that provides ongoing protection against relapse (where the cancer comes back).

Since the landmark FDA approval of ipilimumab (an immune checkpoint inhibitor) in 2011, immunotherapy has become one of the most dynamic and commercially significant areas of modern medicine, with global revenues across all immunotherapy classes now exceeding US$285b in 2025 and expected to grow at a CAGR of 11.4% to 2033[1]. The field has since evolved to encompass a broad range of modalities including cancer vaccines, bispecific antibodies, antibody-drug conjugates, oncolytic viruses and cellular therapies, each attempting to engage the immune system in a distinct way and across an increasing range of indications.

CAR-T (Chimeric Antigen Receptor T-cell) therapy (what IMU is involved in) is a type of cellular therapy, and is unique as rather than administering a drug that changes immune function, it involves the physical collection and genetic reprogramming of T-cells so that they express a Chimeric Antigen Receptor (CAR) engineered to recognise a specific protein antigen, CD19, on the surface of cancerous B-cells. These re-engineered T-cells are infused back into the patient, proliferate, seek out and destroy cells bearing the target antigen CD19. Functionally, this acts as a living drug that can persist in the body for months or years.

The success of CAR-T therapies over the years has generated intense interest from Big Pharma, driving billions of dollars in M&A. Most recently in April 2026, Eli Lilly agreed to acquire Kelonia Therapeutics (developing in-vivo CAR-T cell therapies) in a deal worth up to US$7b[2] (US$3.25b upfront). This follows Gilead's ~US$7.8b

[1] https://www.grandviewresearch.com/industry-analysis/immunotherapy-drugs-market-report
[2] https://www.biospace.com/business/lilly-adds-gene-delivery-technology-to-car-t-in-up-to-7b-kelonia-deal

acquisition of Arcellx (targeting BCMA antigen in multiple myeloma) in February 2026[3]. These recent large deals validate the broader cellular therapy space and Big Pharma appetite for next-generation CAR-T.

Blood cancers and the CAR-T opportunity

Blood cancers span three major categories – lymphoma, leukaemia and myeloma. There are approximately 1.3m new diagnoses annually worldwide[4]. Blood cancers account for 6.6% of all new cancer diagnoses globally and 7.2% of all cancer-related deaths[5].

Unlike solid tumours, blood cancers arise in and circulate through the blood and lymphatic system, making them challenging to treat with surgery or localised radiation. They are well-suited to CAR-T therapy however, for two reasons. First, blood cancer cells consistently express well-characterised surface antigens, most notably CD19 on B-cell malignancies and BCMA on myeloma cells. These serve as reliable and relatively tumour-specific targets for engineered T-cell receptors. Second, the systemic circulation of both the cancer cells and the infused CAR-T cells means that the therapy can achieve body-wide coverage without the trafficking and tumour penetration challenges that have frustrated CAR-T development in solid tumours.

Of the new cases globally across the three main categories of blood cancers, leukaemia accounts for 37%, lymphoma for 49% and myeloma for 14% (Exhibit 1).

Exhibit 1: Categories of blood cancers in the US and globally

Category	US new cases (2025 ACS)	US deaths (2025)	Global new cases (GLOBOCAN 2022)	US prevalence
Non-Hodgkin Lymphoma	80,350	19,390	~553,000	~879,000
Leukemia (all types)	66,890	23,540	~487,000	~536,000
Multiple Myeloma	36,110	12,030	~188,000	~192,000
Hodgkin Lymphoma	8,720	1,150	~82,400	~172,000
Total	**192,070**	**56,110**	**~1,310,000**	**~1,779,000**

Sources: ACS Cancer Facts & Figures 2025; SEER 21; GLOBOCAN 2022; Blood Cancer United 2025; US prevalence figures reflect persons living with or in remission from disease

Going forward, we'll focus on the US market as IMU is aiming for FDA regulatory approval in the US given it is one of the single largest markets in the world.

A B-cell malignancy is a cancer that originates in B-cells (a type of white blood cell that is a core component of the immune system). B-cell malignancies constitute the vast majority of commercially relevant blood cancers; all seven FDA-approved CAR-T products target either CD19 (B-cell marker) or BCMA (plasma cell marker). Recall, malignant B-cells retain the CD19 expression.

Non-Hodgkin Lymphoma (NHL) is the single largest blood cancer category (with over 60 subtypes) and the core CAR-T addressable market with 80,350 projected new cases in the US in 2025 (Exhibit 1). About 85-90% of NHL are B-cell malignancies and these are diseases that CAR-T can address (10-15% of NHL are T-cell malignancies and these diseases are outside the CAR-T addressable market). The major NHL subtypes are:

[3] https://www.pharmexec.com/view/gilead-sciences-billion-definitive-agreement-acquire-arcellx
[4] https://www.nature.com/articles/s41408-023-00853-3
[5] https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(25)00125-7/fulltext

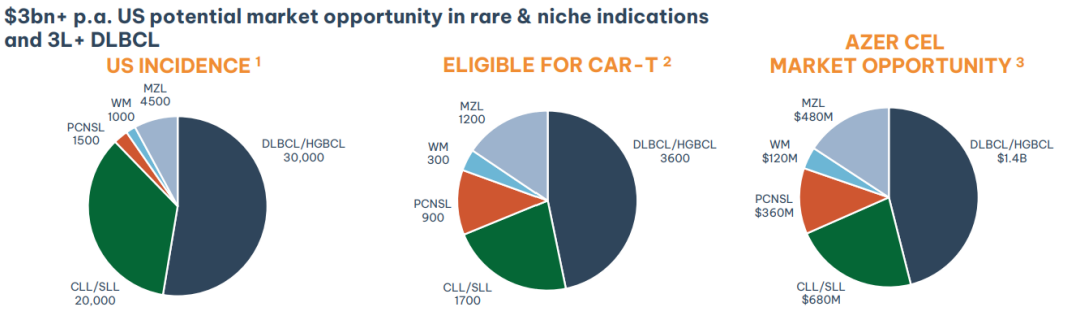
- Diffuse Large B-Cell Lymphoma (DLBCL) – the most common aggressive Lymphoma with 28-30k new US cases annually. First line treatment is chemotherapy, with CAR-T being second and third line. DLBCL is the most commercially developed CAR-T indication, and this is an azer-cel target indication.
- Follicular Lymphoma (FL) – 15-18k new US cases annually. Similarly, chemotherapy is first line with CAR-T following, yet this is not a primary focus indication for azer-cel.
- Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL) – classified as both a leukemia and an NHL. It's the most common adult leukemia in Western countries with ~21k new US cases annually. The standard of care is BTK inhibitors (BTKi), not chemotherapy. There is just one CAR-T approved therapy, and this is an azer-cel target indication.
- Marginal Zone Lymphoma (MZL) – ~6k new US cases annually. First-line treatment includes various drugs such as chemotherapy. There is just one CAR-T approved therapy, and this is an azer-cel target indication.
- Mantle Cell Lymphoma (MCL) – 4-5k new US cases annually. Chemotherapy and BTKi are first-line treatments, while two CAR-T therapies are approved. This is an azer-cel target indication in combination with a BTKi.
- Primary CNS Lymphoma (PCNSL) – 1,500-1,700 new US cases annually. Chemotherapy is the first-line treatment with no CAR-T therapies approved. This is an azer-cel target indication in the CAR-T naïve niche population.
- Waldenström's Macroglobulinemia (WM) – 1,000-1,500 new US cases annually. BTKi are the first line of treatment with no CAR-T therapies approved. This is an azer-cel target indication.

Leukaemias are a significant type of blood cancer, but the cell lineages are mixed, with most outside the B-cell/CD19 space. Only the B-cell leukaemias – B-cell Acute Lymphoblastic Leukaemia (B-ALL) and Chronic Lymphocytic Leukaemia (CLL/SLL) are addressable by CAR-T therapies.

Myelomas are also a significant type of blood cancer and occur due to clonal malignant plasma cells (different to B-cells). There are approved CAR-T therapies, which target BCMA antigen (a plasma cell marker), not CD19 antigen (a B-cell marker). Consequently, myeloma is outside the azer-cel (CD19) addressable market.

Exhibit 2 presents the various blood cancer NHL subtypes that IMU is pursuing with azer-cel.

Exhibit 2: Non-Hodgkin Lymphoma subtypes and azer-cel market opportunity



Source: Company data

CAR-T therapy

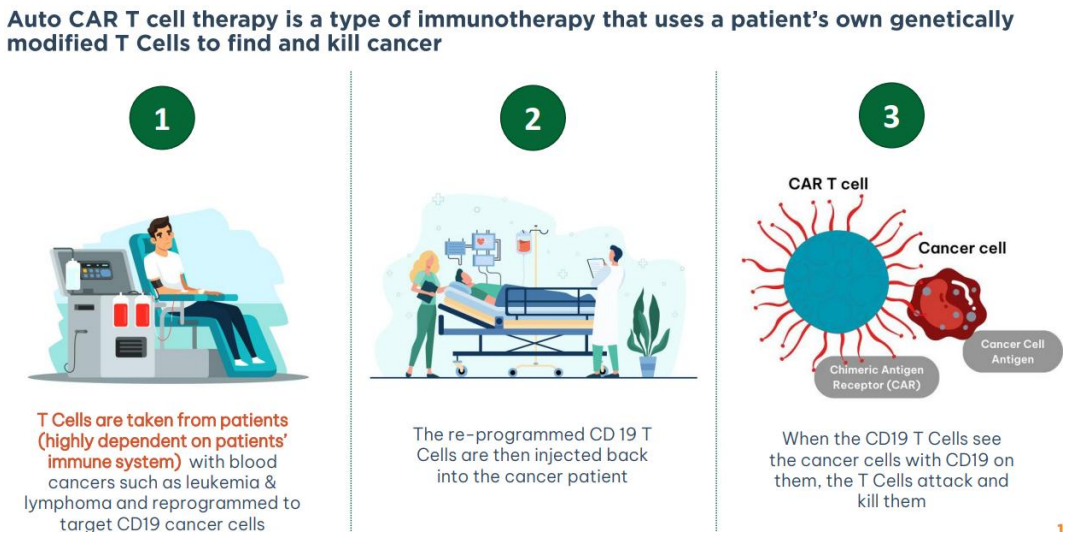
As mentioned earlier, CAR-T cell therapy is a form of cancer immunotherapy in which a patient's own T-cells are extracted via a blood draw, sent to a laboratory and genetically engineered to express a CAR that targets the CD19 protein antigen on the surface of cancerous B-cells. The modified cells are multiplied into the millions in the lab over a period of four-six weeks, before being infused back into the patient, whose immune system has usually been depleted with conditioning chemotherapy beforehand to give the new cells room to establish themselves. Once reinfused, the CAR-T cells seek out and kill cancer cells bearing the target CD19 antigen.

The concept traces back to the late 1980s, when Israeli scientist Zelig Eshhar first described the idea of engineering T-cells with chimeric receptors, but it took decades of refinement before the approach proved viable in humans. The breakthrough moment came in the early 2010s, when teams led by Carl June at the University of Pennsylvania and researchers at Memorial Sloan Kettering began treating patients with CD19-targeting CAR-T cells in clinical trials and saw extraordinary remissions in leukaemia and lymphoma patients who had exhausted all other options. These results led to the FDA approving the first two commercial CAR-T products in 2017 – Novartis' Kymriah for paediatric B-ALL, followed by Gilead/Kite's Yescarta for certain large B-cell lymphomas. Five more products have since been approved, expanding into additional blood cancers: Tecartus (Gilead/Kite), Breyanzi (Bristol-Myers Squibb), Abecma (Bristol-Myers Squibb), Carvykti (J&J/Legend) and Aucatzyl (Autolus Therapeutics).

Autologous vs. allogeneic

All seven CAR-T therapies currently approved by the FDA are *autologous*, meaning they use the patient's own cells. This highly personalised, 'one-to-one' manufacturing process is what makes them effective but also expensive (typically US$400,000–$500,000 per treatment) and slow to produce. Often, the T-cells harvested from heavily pre-treated cancer patients are intrinsically damaged, leading to high manufacturing failure rates. Sadly, for patients suffering from aggressive, rapidly progressing forms of blood cancer like DLBCL, this wait time is often fatal. Furthermore, the autologous process is inherently unscalable and carries a high Cost of Goods Sold (COGS) from a commercial perspective. The autologous CAR-T therapy process is described in Exhibit 3.

Exhibit 3: The autologous CAR-T therapy process



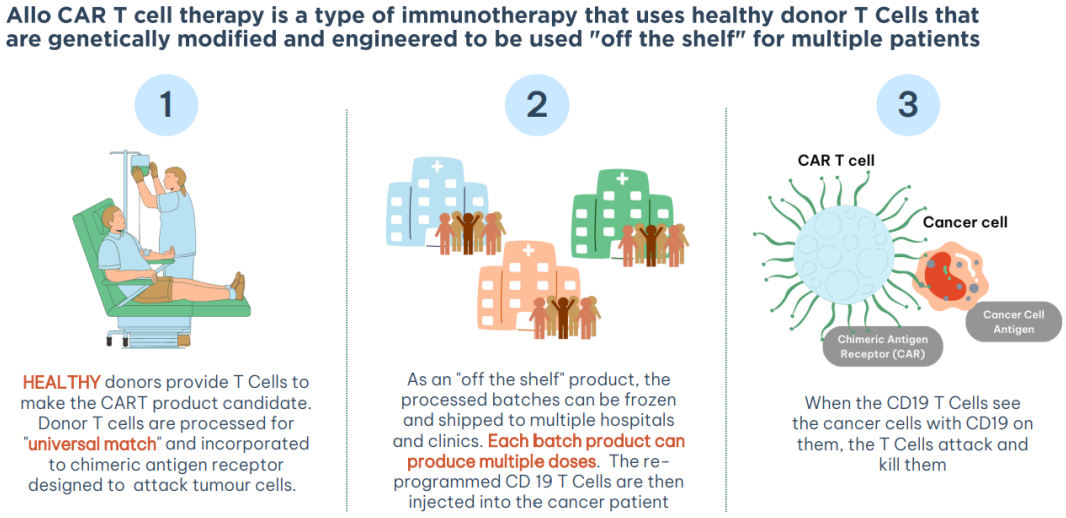
Source: Company data

IMU's azer-cel is an *allogeneic* CAR-T therapy – it is an 'off-the-shelf', 'one-to-many' product which should demonstrate many advantages with regards to costs and wait times. With allogeneic, CAR-T cells are made from the T-cells extracted from the blood of a healthy universal donor. These T-cells also undergo genetic modification and are reprogrammed into CD19 CAR-T cells, which are multiplied in large numbers, cryopreserved, and then available to many patients. Crucially, when a patient experiences a relapse (where the cancer comes back after a period where treatment appeared to have worked; up to 60% of patients relapse depending on the cancer type[6]), the allogeneic therapy is simply pulled from the hospital freezer and infused

[6] https://pubmed.ncbi.nlm.nih.gov/36963592/

immediately, eliminating the wait time entirely and ensuring that fit, energetic T-cells are administered. The allogeneic CAR-T therapy process is described in Exhibit 4.

Exhibit 4: The allogeneic CAR-T therapy process



Source: Company data

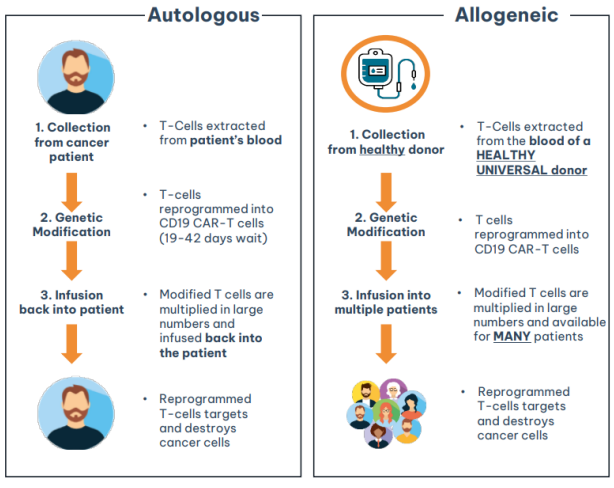
There are currently no FDA approved allogeneic CAR-T products; this is still an emerging modality. However, there is great potential to transition from autologous to allogeneic cellular therapies and represents the next great frontier in cancer immunotherapy. Several companies, including IMU, are aiming for this.

Exhibit 5 summarises the differences between the autologous and allogeneic CAR-T process.

Exhibit 5: Autologous vs allogeneic

	Autologous	Allogeneic
Overview	• Autologous CAR-T cells are made from the patient's own T-cells • Highly personalised (one to one therapy) • ~60% relapse off of CD19 auto CAR-T[1]	• Dose for multiple patients from a single healthy donor (one batch to many)
Cost	• High manufacturing costs • Greater risk of manufacturing issues due to single production runs	• **Highly scalable manufacturing** with potential attractive gross margins (lower COGS given 'one batch-to-many' approach)
Wait time	• Long process and wait time of around 4-6 weeks	• **No wait time**
Single vs multi dose	• Single does, can not be re-dosed with autologous CAR-T	• **Potential for multi dose**
Safety	• Acceptable safety profile	• Good safety profile
Access	• Limited access – major centres only given 1-1 nature	• Opens up new centres / regional markets for patients

[1]Science Direct publication 17 April 2025; Sequential CD19-20 CAR-T cell therapy for refractory/relapsed diffuse large B-cell lymphoma



Source: Company data

While the potential benefits of allogeneic CAR-T are clear, there are also some challenges and drawbacks of allogeneic that are well-documented, namely:

- Graft-versus-Host Disease (GvHD) – donor T-cells can mount an attack on the recipient's tissue as it's detected as 'foreign'.

- Host-versus-Graft (HvG) rejection – the patient's immune system can swiftly reject transferred allogeneic cells, limiting their persistence.

To overcome these issues, azer-cel has a novel formulation, as described in the next section.

Azer-cel

Azer-cel is IMU's potential first-in-class, allogeneic CAR-T cell therapy. It has initially been focused on indications where autologous CAR-T failed DLBCL (Cohort 1), as well as several CAR-T naïve niche lymphomas (Cohort 2). It is about to imminently start testing a BTKi + azer-cel combination therapy as well (Cohort 3).

The azer-cel regimen

It's important to appreciate IMU's FDA-endorsed proposed azer-cel regimen, as it's different to other approved CAR-T regimens and is arguably the reason for some better efficacy results (and why azer-cel might work as an allogeneic CAR-T therapy).

The FDA-endorsed regimen has three parts:

1. A *stronger*-than-usual (vs. other CAR-T) lymphodepletion. IMU's 'augmented lymphodepletion' is fludarabine 30mg/m2/day plus cyclophosphamide 750mg/m2/day for three days before CAR-T infusion. The purpose of lymphodepletion is to clear out the patient's existing immune cells so the donor-derived CAR-T cells have more 'space' to improve CAR-T expansion. IMU's augmented regimen is stronger as it has the additional job of reducing host immune rejection of the donor cells (given azer-cel is made from healthy *foreign* donor T-cells).
2. Infuse a *fixed* dose of azer-cel. A flat 500m cell dose is administered (it is not a body weight adjusted dose). The reason for a fixed dose is partly practical given the need for a standardised manufactured dose for an off-the-shelf product.
3. 14 days of low-dose subcutaneous IL-2. IL-2 is being used here as a post-infusion cytokine support step. Cytokines are small secreted proteins that act as chemical messengers to mediate and regulate immunity, inflammation and new blood cell generation; this step helps the infused azer-cel cells expand and persist. IMU's research determined that low-dose IL-2 improved pharmacokinetics and persistence, and longer detectability of azer-cel vs prior cohorts without IL-2[7].

To summarise the differences, the azer-cel regimen has more intensive lymphodepletion, as well as 14 days of low-dose subcutaneous IL-2 post CAR-T infusion.

Historical development of azer-cel

The biological and technological antecedents of azer-cel were established at Duke University, dating back to 2004, and then converted into a commercial enterprise with the formation of Precision BioSciences by the founding researchers. Azer-cel was created and initially developed as the company's allogeneic CAR-T programme, internally designated PBCAR0191 and later named azercabtagene zapreleucel (azer-cel). While the development of azer-cel spans over two decades, the commercial rights have moved over the years; moving to a collaboration with Baxalta in February 2016, a transfer to Servier in August 2018, before Precision reacquired azer-cel in April 2021. In August 2023, oncology rights and related CAR-T infrastructure were transferred to IMU (while all non-oncology rights e.g. for the treatment of severe autoimmune diseases such as multiple sclerosis were licensed to TG Therapeutics in 2024).

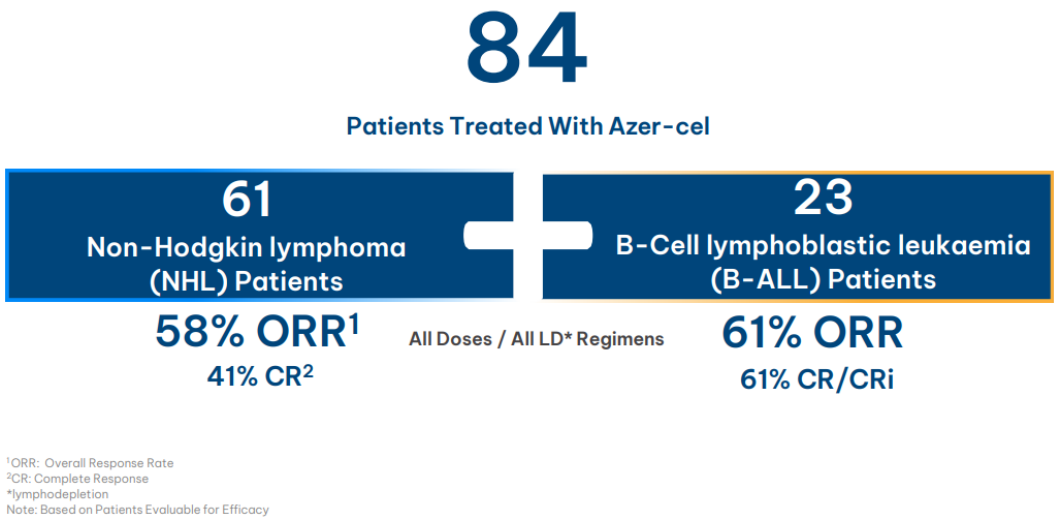
A significant amount of R&D investment has been made to azer-cel under Precision's prior ownership. While the programme-specific cumulative spend for azer-cel is not fully disclosed, we do know from various Precision SEC 10-K and 10-Q filings that prior to IMU acquisition, there was direct azer-cel development expense of

[7] https://cdn-api.markitdigital.com/apiman-gateway/ASX/asx-research/1.0/file/2924-02847297-3A649646&v

US$4.7m in 2019, US$8.6m in 2020, US$8.5m in 2021, US$3.8m in the first nine months of 2022, and US$5.3m in the first six months of 2023[8]. This total of $30.9m is from what we can find *directly* attributed to azer-cel, but is not total programme spend and excludes internal personnel, shared platform and manufacturing costs and earlier periods (prior to Precision's IPO in 2019). The underlying proprietary genome editing technology that made azer-cel possible is known as ARCUS and it's notable that Precision has reported cumulative R&D expenditure of US$400m+ between 2019-2023 (as per its SEC 10-K filings[9]) to sustain the ARCUS platform (appreciating that azer-cel was but one programme of many).

When IMU acquired azer-cel in 2023, it was in a multi-centre Phase 1b study (ClinicalTrials.gov ID NCT03666000[10]). Precision had an extensive data package for azer-cel which included 84 patients with NHL and B-ALL, demonstrating clinically meaningful activity (Exhibit 6).

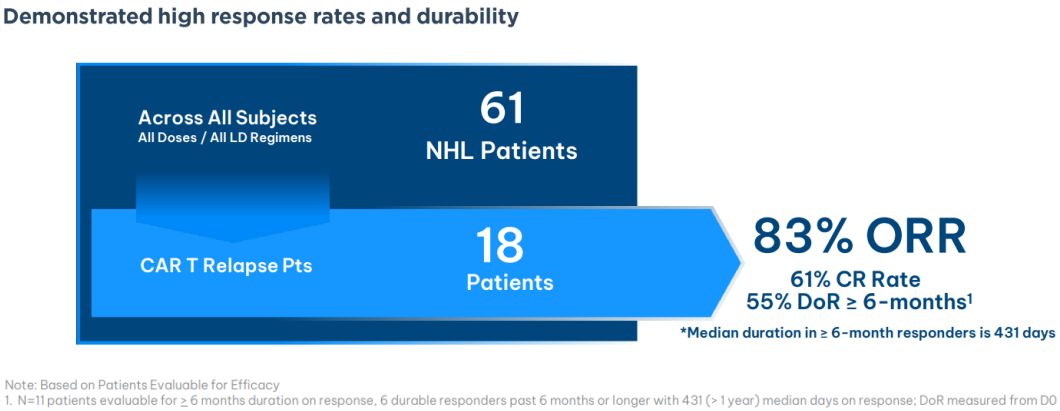
Exhibit 6: Azer-cel's clinical data summary prior to IMU ownership



Source: Company data

In particular, the azer-cel data was especially strong in patients with DLBCL who had relapsed following autologous CAR-T therapy (this was in 18 patients, a subset of the 61 NHL patients, Exhibit 7).

Exhibit 7: Azer-cel particularly strong in CAR-T relapsed patients



Source: Company data

[8] https://investor.precisionbiosciences.com/sec-filings/

[9] https://www.sec.gov/cgi-bin/browse-edgar?action=getcompany&CIK=0001357874&type=10-K&dateb=&owner=include&count=40

[10] https://clinicaltrials.gov/study/NCT03666000

Azer-cel's clinical trial progress under IMU ownership

Since IMU acquired azer-cel in 2023, it has continued to progress the Phase 1b trial. Below is a short summary of progress to date, with the following section going into detail on each of the trial cohorts.

In September 2024, IMU provided its initial data update reporting results where the addition of low-dose subcutaneous IL-2 to the regimen provided strong benefits that enhanced CAR-T cell persistence in the body (one of the central challenges in allogeneic cell therapy) – the addition demonstrated a 67% Overall Response Rate (ORR) and 67% Complete Response Rate (CRR) in Cohort B (with IL-2) vs. a 33% ORR and 17% CRR in Cohort A (without IL-2) (ORR is the proportion of patients who achieve either a partial or complete reduction in their disease after treatment, while CRR is the proportion of patients who achieve a complete disappearance of all detectable signs of disease after treatment; both are used in clinical trials and oncology to measure how well a treatment is working). IL-2 was added to the regimen going forward.

In March 2025, the FDA granted Fast Track Designation to azer-cel for the treatment of relapsed/refractory DLBCL (Cohort 1). This regulatory tool is designed to expedite the development and review of therapies addressing serious unmet medical needs.

In July 2025, IMU announced that additional patients into the trial over preceding months were delivering favourable responses, bringing the ORR to 75% and the complete response rate CRR to 55% across 12 patients The durability of response (DoR) continued to mature, with some responses ongoing for over 450 days (DoR refers to how long a patient's response to treatment lasts – essentially, the staying power of a positive outcome). On the strength of this data, IMU expanded the trial to include CAR-T naïve niche indications (Cohort 2).

In November 2025, Cohort 2 was also showing strong responses with an 83% ORR and a 50% CR on six patients.

In December 2025, IMU received written minutes from its 21 November FDA meeting resulting in clear alignment across key elements of the late-stage strategy (Cohort 1). The FDA confirmed support of a single, randomised study using ORR with durability for accelerated approval and Progression Free Survival (PFS) for full approval (PFS is the length of time during and after treatment that a patient lives without their disease getting worse or dying). The FDA also endorsed IMU's planned regimen combining augmented lymphodepletion, a fixed dose of 500 million azer-cel cells, and 14 days of low-dose subcutaneous IL-2.

In summary, to date, Phase 1b has achieved:

- Cohort 1 – 82% ORR in relapsed/refractory DLBCL (out of 17 patients) while the best durable response is at 24+ months (N.B. the mean DoR has not yet been determined).
- Cohort 2 – 100% ORR in CLL (out of four patients) and 80% in MZL (out of five patients).
- While patient cohort sizes are admittedly small, the data has actually steadily improved as the cohort sizes have increased through Phase 1b.

Azer-cel's current progress

There are three cohorts in Phase 1b that are being recruited across 10 sites in the US and five sites in Australia. Cohort 2 and 3, while less mature cohorts, may represent a faster path to market and would potentially add the most value to IMU investors with continued positive data. These two cohorts are the near-term priority of the company, and recently raised funds are currently being directed at progressing these two.

To be clear, the FDA regulatory progress on Cohort 1 described in the previous section is good validation and support of azer-cel's potential and IMU's position to capitalise on the opportunity, yet a pivotal trial in a crowded indication like DLBCL would likely require a large randomised pivotal trial requiring substantial capital. Cohorts 2 and 3 are the sensible immediate pathways to pursue for IMU as it potentially gets azer-cel commercialised in a significantly cheaper and quicker fashion.

Given the priorities, we first cover Cohort 2 and Cohort 3 below, before covering Cohort 1.

Azer-cel in CAR-T naïve niche lymphomas (Cohort 2)

The scope of the Phase 1b trial was expanded in July 2025 to include other forms of rare and niche lymphomas for which there were limited treatment options and where no CAR-T therapies were available (off-label for all autologous CAR-T therapies). This significantly expands the therapeutic application of azer-cel, and given the rare and niche application with limited options, any efficacy signal in these indications could potentially mean a faster path to market through FDA Accelerated Approval.

This cohort covers multiple CD19 B-cell malignancies including DLBCL, FL, CLL/SLL, MZL, WM and PCNSL. While a small patient population to date, ORR were observed as follows:

- 100% ORR observed for CLL/SLL; a 4/4 Partial Response (PR) in patients (PR is a significant reduction in tumour size, typically at least 50%, but not complete disappearance). In CLL/SLL, CRs are uncommon and ORR has supported regulatory approvals (FDA guidance).
- 80% ORR observed in MZL; a 3/5 complete response and 1/5 partial response in patients in patients who had received a median of ≥2 prior lines of therapy.

While a small sample size to date (nine; IMU aims to have ~20 patients total eventually enrolled in Cohort 2), there is clear benefit here from a clinical and commercial perspective. As these indications lack any approved CAR-T treatment options and represent areas of extremely high unmet medical need, the FDA frequently permits accelerated approval pathways based on smaller, single-arm registrational pivotal studies (with no control arm as there is no approved CAR-T comparator). This regulatory flexibility significantly compresses both the timeline and the capital expenditure required to reach commercialisation, providing IMU with a capital-efficient path to market that bypasses the autologous incumbents entirely. We stress that a small single-arm pivotal study has not been endorsed by the FDA yet, however, it is a possibility.

For niche CAR-T indications in rare blood cancers, 30-80 patients have historically been sufficient for accelerated approval in rare blood cancers. We estimate the cost of a pivotal study around this size to be $30-50m; we explicitly model 50 patients costing $50m in our forecasting (further details in the Financials section below).

Finally, there is potential for FDA Fast Track, Breakthrough and/or RMAT (Regenerative Medicine Advanced Therapy) Designation for additional niche lymphomas [IMU already has Fast Track Designation for DLBCL (Cohort 1)]. Fast Track enables more frequent FDA interaction and rolling BLA (Biologics License Application) review, which compresses the timeline to submission. Breakthrough and/or RMAT Designations are even more valuable, as they are granted when preliminary clinical evidence shows the therapy offers substantial improvement – what IMU will be aiming for in this cohort.

Azer-cel and BTKi combination (Cohort 3)

More recently, IMU filed a protocol amendment to evaluate azer-cel combined with Bruton Tyrosine Kinase inhibitors (BTKi). This is an interesting development as it potentially expands IMU's commercial opportunity into a very large market.

BTKi are a class of targeted drugs used mainly in particular types of blood cancers, especially B-cell malignancies (including CLL/SLL and WM) and autoimmune diseases. They are the established standard of care for certain subtypes with >US$10b in annual global sales (Exhibit 8).

Exhibit 8: BTKi drugs are a large and fast-growing segment

BTKi Drug	Annual Revenue Contribution
Ibrutinib (Johnson & Johnson, abbvie)	~$4-6B
Acalabrutinib (AstraZeneca)	~$1-2B
Zanubrutinib (BeOne)	~$1-2B
Pirtobrutinib & others (Lilly, sanofi, NOVARTIS)	Several hundred million, expanding

Total annual BTKi market[1]: USD ~$10-11.5B (2024-2025) and growing; Forecast to grow to USD 13.1B in 2026

[1]Global market for BTKi: GlobalData 18 Jan 2024, the Business Research Company, February 2026

Source: Company data

Bruton Tyrosine Kinase (BTK) is a key enzyme in the B-cell receptor (BCR) signalling pathway, that tells B-cells to survive, proliferate and migrate. In cancers, this pathway is often overactive, keeping cancer cells alive. BTK inhibitors work by blocking this signalling pathway which stops cancer cells from receiving 'survival signals', makes them more likely to die, and disrupts their ability to hide in protective niches (e.g. lymph nodes).

In addition to killing cancer cells, BTKi also:

1. Improve T-cell quality – reduce T-cell exhaustion; this can improve expansion of CAR-T cells.
2. Improve the tumour environment – make it less immunosuppressive; this can improve CAR-T persistence.

There have been previous studies and clinical evidence of synergy when BTKi is combined with CAR-T therapies, specifically:

- TARMAC Phase 2 trial [ibrutinib (BTKi) + Kymriah (Novartis CAR-T)]
- TRANSCEND-CLL-004 [ibrutinib (BTKi) + Breyanzi (Bristol-Myers Squibb CAR-T)]

This is why combining BTKi with CAR-T seems like a sensible strategy. From IMU's perspective, it is looking to turn this proof-of-concept into an actual asset.

As a final point on the BTKi strategy, it's important to understand the 'lines of therapy' concept. In cancer treatment, patients are treated in sequential 'lines':

- First-line (1L) is the initial treatment given after diagnosis; it is usually the standard of care with the highest chance of success.
- Second-line (2L) is given if the cancer comes back (relapse) or the patient doesn't respond (refractory) to 1L.
- Third-line (3L) is used after failure of 1L and 2L; and so on with 4L, 5L etc.

Moving up the lines (towards 1L) substantially increases patient numbers (the TAM expands), making it a better commercial outcome. The patient quality is better (healthier patients and better immune systems as earlier in the disease) meaning better treatment outcomes.

CAR-T was originally used in 3L and late-stage patients, but some approvals have moved into 2L. No approved 1L CAR-T therapy exists yet. The 1L for some blood cancers including CLL/SLL and WM is BTKi. The hypothesis behind Cohort 3 is that combining azer-cel with a BTKi could improve CAR-T persistence and reshape the tumour microenvironment. It potentially opens up an earlier-line commercial opportunity – rather than

waiting for BTKi failure before trying a CAR-T, a combination therapy could be found to be more efficacious. IMU's allogeneic CAR-T is well suited to this, as it would be available immediately (no wait time) to be used in combination with a BTKi. This potentially opens up a much larger patient population, and it's a large market, as the current BTKi sales in Exhibit 8 indicate.

Patient enrolment in Cohort 3 is about to commence imminently and IMU is aiming to have ~20 patients total enrolled. As a final point, if the BTKi combination therapy data looks promising, it would certainly enhance the IP of acquisitive Big Pharma companies already in the BTKi space. The company may release initial clinical data for Cohort 3 as soon as June 2026.

Azer-cel in DLBCL (Cohort 1)

Shortly after IMU acquired azer-cel, it was initially targeting the treatment of patients with relapsed/refractory DLBCL who had already received ≥3 prior lines of therapy (including autologous CAR-T) and failed (relapse has been defined previously; refractory means the cancer never responded to the treatment in the first place, or stopped responding while treatment was still ongoing). The data package from Precision BioSciences supported this initial focus.

As a group, relapsed/refractory patients describe a patient population that has already been treated and either didn't respond or responded initially but then the cancer came back. These are typically the hardest patients to treat because 'better' options have already been tried. Azer-cel's data is noteworthy for this very reason. It is dealing with harder-to-treat patients, yet data from Phase 1b is still compelling; achieving an 82% ORR in that population is remarkable because these patients have already failed three or more prior lines of therapy and their immune systems are profoundly exhausted. It underscores the potential of the healthy donor azer-cel construct. This is presumably why the FDA has been so receptive – there is currently no approved therapy for patients who relapse after autologous CAR-T. That's the unmet need azer-cel is targeting.

The mean DoR hasn't been determined yet, however it is maturing favourably, with the first patient dosed in 2024 remaining cancer-free for 24+ months. It's also important to note that the safety profile of azer-cel is in line with other CAR-T therapies in the market.

The latest update shows that 17 patients have come into Cohort 1, but we don't expect this cohort to grow much further as IMU focuses on progressing Cohort 2 and 3 (as discussed above).

Asco oral presentation

IMU announced early in April 2026 that it has been accepted for an oral presentation at ASCO 2026 (29 May–2 June). ASCO is considered one of the world's premier oncology conferences with over 8,500 abstracts reviewed this year by its Scientific Programme Committee, with only a small fraction chosen for oral presentations[11]. This development validates scientific/clinical credibility and raises the company's profile among oncologists and potential partners.

Competitors

The CAR-T landscape is very competitive, heavily capitalised and rapidly evolving. That being said, we like IMU's two focus areas of CAR-T naïve patients with rare and niche lymphomas, and the BTKi combination therapy with CAR-T, as these are two areas not being addressed by others in the space and are potentially faster routes to market.

We've broken down the competitive landscape into two areas – the allogeneic CAR-T competitors and the autologous CAR-T competitors.

[11] https://www.proactiveinvestors.com/companies/news/1089877/imugene-lands-asco-oral-slot-in-high-profile-azer-cel-milestone-1089877.html?region=ca&region=ca

Allogeneic CAR-T competitors

As discussed, there are no FDA approved allogeneic CAR-T therapies, yet there are numerous companies pursuing an allogeneic solution. The well-cited challenges in allogeneic are around GvHD, HvG rejection, persistence challenges, and the need for multi-edit engineering and manufacturing consistency.

IMU's differentiation vs allogeneic peers are around:

- Demonstrating durable responses with a regimen designed around conditioning plus IL-2 support.
- Offering capital-efficient niche registrational options via basket cohorts.
- Targeting the post-autologous CAR-T relapse/refractory segment with high unmet needs.

The companies listed in Exhibit 9 are all trying to develop an allogeneic CAR-T therapy and are at various stages.

Exhibit 9: Allogeneic CAR-T competitors, all pre-approval and at a clinical stage

CAR-T Therapy	Company	Marketcap (USD)	Phase/Stage	Key Indications	Notes
Zugo-cel / CTX112 (allogeneic CD19 CAR-T, gene-edited)	CRISPR Therapeutics (NASDAQ:CRSP)	$4.2b	Phase 1/2	r/r FL, MZL, LBCL; SLE, systemic sclerosis, myositis	CTX112 holds FDA RMAT in r/r FL and MZL and is being pursued in both B-cell malignancies and autoimmune disease. Focus on persistence and immune evasion.
SC291 (hypoimmune allogeneic CD19 CAR-T)	Sana Biotechnology (NASDAQ:SANA)	$550m	Phase 1	r/r B-cell malignancies; SLE, vasculitis, type 1 diabetes	Differentiates on proprietary hypoimmune platform designed to evade host immune rejection without lymphodepletion. SC291 dosing in B-cell malignancies and autoimmune (SLE, vasculitis).
Lasme-cel / UCART22 (allogeneic CD22 CAR-T)	Cellectis (NASDAQ:CLLS)	$280m	Phase 1/2	r/r B-ALL (adult); r/r B-NHL (UCART20x22)	AstraZeneca holds ~44% equity plus a collaboration covering up to 10 gene/cell therapy products. Lasme-cel showed 100% ORR in target Phase 2 population in r/r B-ALL. Pivotal BALLI-01 interim readout expected Q4 2026.
FT819 (iPSC-derived allogeneic CD19 CAR-T)	Fate Therapeutics (NASDAQ:FATE)	$210m	Phase 1	r/r B-cell malignancies; SLE	FT819 is in Phase 1 across oncology and autoimmune indications. Oncology efficacy still unproven.
Cema-cel (allogeneic CD19 CAR-T)	Allogene Therapeutics (NASDAQ:ALLO)	$260m	Phase 2 (Pivotal)	1L LBCL (consolidation post-CR); r/r LBCL; autoimmune (SLE, lupus nephritis)	Preeminent pure-play competitor in the allo space. Enrolling the pivotal Phase 2 ALPHA3 trial in 1L LBCL consolidation with initial readout targeted for 2026. Stock has been pressured by persistence questions.
Vispa-cel / CB-010 (allogeneic CD19 CAR-T)	Caribou Biosciences (NASDAQ:CRBU)	$220m	Phase 1	2L r/r LBCL; r/r multiple myeloma (CB-011)	Best early efficacy among allogeneic programs. Designed for better persistence via immune evasion. ASH 2025 ANTLER data in 2L LBCL showed durability "on par with autologous CAR-T". Phase 3 contingent on FDA alignment.

Source: RaaS research

One notable observation is that Cellectis (US$280m marketcap), Allogene Therapeutics (US$260m marketcap) and Caribou Biosciences (US$220m marketcap) are all pure-play allogeneic CAR-T therapy companies, and thus directly comparable to IMU (A$42m marketcap). IMU is obviously at a substantially lower marketcap vs. these peers, albeit we acknowledge that the cash positions of these peers are better than IMU's.

Autologous CAR-T competitors

All existing FDA approved CAR-T therapies are autologous solutions.

Unsurprisingly, the approved and commercial CAR-T therapies are all owned by large global pharma companies. Interestingly, some of these same companies are also trying to develop 'next-gen' autologous CAR-T therapies.

Exhibit 10: Autologous CAR-T competitors; several approved and several developing

CAR-T Therapy	Company	Marketcap	FY25 Sales	Phase/Stage	Key Indications	Notes
Kymriah (tisa-cel)	Novartis (NYSE:NVS)	$205b	$0.397b	Approved / Commercial	R/R B-ALL (pediatric), R/R DLBCL, R/R FL	First-ever approved CAR-T (2017) but has lost share to Yescarta/Breyanzi in DLBCL. Novartis continues to invest in next-gen YTB323 (rapcabtagene autoleucel) in autoimmune and oncology.
Yescarta (axi-cel)	Gilead / Kite (NASDAQ:GILD)	$141b	$1.528b	Approved / Commercial	R/R LBCL (2L+), R/R FL (3L+)	Largest CAR-T franchise by cumulative revenue but in sustained decline as Breyanzi takes share in 2L LBCL. Gilead's cell therapy strategy now centered on the $7.8B Arcellx acquisition (Feb 2026) for anito-cel.
Tecartus (brexu-cel)	Gilead / Kite (NASDAQ:GILD)	$141b	$0.372b	Approved / Commercial	R/R MCL, R/R B-ALL (adult)	Smaller niche product targeting MCL and adult B-ALL. Longer-term outlook depends on earlier-line MCL positioning.
Breyanzi (liso-cel)	Bristol Myers Squibb (NYSE:BMY)	$115b	$1.358b	Approved / Commercial	R/R LBCL, FL, CLL/SLL, MCL, MZL	Fastest-growing approved CAR-T; five-indication label (including CLL/SLL and MZL) is the broadest in the class.
Abecma (ide-cel)	Bristol Myers Squibb / 2seventy bio (NYSE:BMY)	$115b	$0.406b	Approved / Commercial	R/R multiple myeloma (3L+)	BCMA CAR-T approved in 2021; significantly lagging Carvykti on efficacy and duration, with delayed neurotoxicity signals.
Carvykti (cilta-cel)	J&J / Legend Biotech (NASDAQ:LEGN)	$9.5b	$1.95b	Approved / Commercial	R/R multiple myeloma (2L+)	Class-leading BCMA CAR-T on efficacy; 2L expansion (CARTITUDE-4) drove ~88% FY25 growth.
Aucatzyl (obe-cel)	Autolus Therapeutics (NASDAQ:AUTL)	$400m	$0.088b	Approved / Commercial	R/R adult B-ALL	First FDA-approved CAR-T for adult B-ALL with a differentiated fast-off CD19 binder yielding a best-in-class safety profile (minimal CRS/ICANS).
Zevor-cel (zevorcabtagene autoleucel)	CARsgen Therapeutics (HK:2171)	HK$4b	~$60m (est., China)	Approved (China); Phase 2 (US/global)	R/R multiple myeloma	BCMA CAR-T approved in China Feb 2024 (as Zevorcel); CARsgen also developing claudin 18.2-directed CT041 (satri-cel) in gastric/pancreatic solid tumors with pivotal Phase 2 data in r/r gastric cancer.
Fucaso (eque-cel / Equecabtagene autoleucel)	IASO Bio (private) / Innovent (HK:1801)	Private	~$50m (est.)	Approved (China)	R/R multiple myeloma	BCMA CAR-T approved in China June 2023.
Carteyva (relma-cel)	JW Therapeutics (HK:2126)	HK$1.5b	~$40m (est.)	Approved (China)	R/R LBCL; label expanded to FL and MCL.	First China-approved CD19 CAR-T (Sept 2021).
Anito-cel (anitocabtagene autoleucel)	Arcellx / Gilead (NASDAQ:ACLX)	$7.8b (acquisition)	N/A	BLA filed	R/R multiple myeloma (4L+), 2L+ in Phase 3	Gilead's $7.8B Feb 2026 acquisition priced against a potentially best-in-class BCMA CAR-T profile. iMMagine-1 showed 96% ORR, 74% CR/sCR, and no delayed neurotoxicities at 12+ months.
Satri-cel / CT041 (claudin 18.2 autologous CAR-T)	CARsgen Therapeutics (HK:2171)	HK$4b	N/A	Phase 2 (pivotal)	R/R gastric/GEJ adenocarcinoma, pancreatic cancer	Most advanced solid-tumor CAR-T globally; CLDN18.2-directed asset with confirmed ORR signals in heavily pretreated gastric cancer. Potential China BLA filing 2026 represents the first credible solid-tumor CAR-T approval opportunity.
Obe-cel pipeline (AUTO1/22, AUTO8 etc.)	Autolus Therapeutics (NASDAQ:AUTL)	$400m	N/A	Phase 1/2	Pediatric B-ALL (AUTO1/22); multiple myeloma (AUTO8)	Pipeline extensions beyond approved Aucatzyl leverage the same fast-off CD19 binder technology. AUTO1/22 dual CD19/CD22 targeting aims to address antigen escape in pediatric B-ALL; AUTO8 is a BCMA/CD19 asset for multiple myeloma.
GC012F (dual BCMA/ CD19 FasTCAR)	AstraZeneca (via Gracell acquisition)	$235b	N/A	Phase 1/2 (global)	R/R multiple myeloma (MM), 1L high-risk MM, SLE	Acquired via Gracell for up to $1.2B (Feb 2024); uses FasTCAR 24-hour manufacturing platform.
BMS-986393 / arlo-cel (GPRC5D autologous CAR-T)	Bristol Myers Squibb / 2seventy bio (NYSE:BMY)	$115b	N/A	Phase 3 (QUINTESSENTIAL)	R/R multiple myeloma	Next-gen MM CAR-T targeting GPRC5D to address post-BCMA relapse; Phase 3 underway.
Allo-in-a-bottle pipeline (CC-95266/alnuctabtagene autoleucel)	Bristol Myers Squibb (NYSE:BMY)	$115b	N/A	Phase 2	R/R multiple myeloma, r/r NHL	GPRC5D and next-gen CD19 autologous assets building out BMS's post-Breyanzi/Abecma CAR-T pipeline. Phase 2 development; BMS retains the broadest approved CAR-T footprint and is investing to extend it.

Source: RaaS Research Group

Key IMU Financials

We detail our key revenue assumptions below. Our modelling explicitly assumes that only the azer-cel registrational opportunities, CAR-T naïve niche indications (Cohort 2) and BTKi combination (Cohort 3) therapies are pursued in the near term and successfully commercialised. These are the capital-efficient paths to market that would likely require far less capital, and in-line with IMU management's current thinking. It is worth noting however, that the registrational design for Cohort 2 will be dependent on the competitive landscape of pending and approved products, and FDA guidance and acceptance.

We assume that the current Phase 1b continues with Cohort 2 expanding to 20 patients (nine currently enrolled), while Cohort 3 also commences (also targeting 20 patients). With regards to timing, we assume that Phase 1b completes in H2 FY27, with the pivotal trial initiation in H1 FY28. Finally, we assume FDA Accelerated Approval in FY30 with commercial sales in the US beginning in FY31 for both opportunities.

Revenue

For the revenue model, we assume that IMU employs a licensing model, as is common for many biotech developers, looking to leverage the marketing and sales capability of Big Pharma. We assume that a licensing deal is signed with big pharma in FY29, after the pivotal trial is well underway and data output provides the basis of a commercial deal. We model minimal sales in FY31, ramping up over five years to peak penetration and sales in FY35, as described below for each therapy:

- **CAR-T naïve niche indications**. These niche indications include CLL/SLL, PCNSL, MZL and WM. Out of 27,000 US incidences currently outstanding[12], 4,100 are expected to be eligible for CAR-T[13]. We assume that this patient population grows at 3% p.a., treatment cost is US$700k (higher than current market rates of ~US$500k as these are rare indications which command a premium in drug pricing), a 20% peak penetration rate in 2035, and a 15% royalty rate to IMU.
    - A 1.5% penetration in the first year 2031 yields a A$10.7m royalty to IMU.
    - A peak 20% penetration in 2035 yields a A$160.5m royalty to IMU.
- **BTKi combination.** This therapy is targeting CLL/SLL, MCL and other B-cell malignancies where BTKi is the standard of care. To stress, azer-cel is not replacing BTKi, but rather seeking to be dispensed as a combination therapy as treatment success is higher (N.B. azer-cel would be administered once only, while BTKi as therapy continues on a regular monthly basis, with higher efficacy due to CAR-T involvement). The total annual BTKi market is estimated at US$10-11.5b in size (in 2024-2025) and forecast to grow to US$13.1b in 2026 (a 14-15% growth rate)[14]. It's estimated that there are ~15k new US patients starting BTKi treatment per year[15]. We assume that this patient population grows at 7% p.a. (half the BTKi market growth rate of 14-15%), that 30% are clinically suitable for the combination therapy, treatment cost is US$500k (current market rates for autologous CAR-T therapy), a 20% peak penetration rate in 2035 and a 15% royalty rate to IMU. We also make an assumption on the prevalent population; existing BTKi patients (not new) who may be eligible for treatment – we estimate of the ~56k existing BTKi patients in the US (given the market size mentioned above, an estimated 75% of global sales are in the US[16], and BTKi drugs ranging in cost from US$125k/year to US$184k/year[17]), 30% are eligible but only 5% are treated over the first three years, resulting in a royalty stream of $30m in each of 2031, 2032 and 2033. Of the ongoing new patients:
    - A 1.5% penetration in the first year 2031 yields a A$10.1m royalty to IMU.
    - A peak 20% penetration in 2035 yields a A$178.1m royalty to IMU.

Gross margin

With the licensing model assumption, gross margins are not relevant as this is a matter for the Big Pharma licensee. However, it's worth highlighting that gross margins for current *autologous* CAR-T therapies range from 50-70%, given the personalised nature of autologous therapy. With scale, some manufacturers are targeting an 80-85% gross margin by 2030[18]. The economics of *allogeneic* CAR-T are structurally superior to autologous (given no personalised one-to-one aspect), meaning an 85-95% gross margin should be possible.

Operating costs

Key operating costs for IMU and our key assumptions for each line item are summarised below. We note that the company's recent focus on capital management has substantially reduced the operating loss of the business, from $154m in FY24 to $71m in FY25. This is set to decrease further as the company has narrowed its focus to azer-cel only.

- **Employee** costs are significantly lower with the company's divestment of its manufacturing facility in North Carolina, reducing headcount by over 80 heads to only ~15 employees, with a small number

[12] SEER 2020 estimate; numbers of potential patients

[13] NCCN guidelines. ASH, peer-reviewed literate and CAR-T clinical trials; assumes 3L+ for DLBCL and 2L+3L for all other cancers.

[14] Global market for BTKi: GlobalData 18 Jan 2024, the Business Research Company, February 2026.

[15] https://pmc.ncbi.nlm.nih.gov/articles/PMC10443285/; https://www.cancer.gov/types/lymphoma/hp/mantle-cell-lymphoma-treatment

[16] https://www.precisionbusinessinsights.com/market-reports/btk-inhibitors-market

[17] https://www.cancernursingtoday.com/post/researchers-evaluate-cost-effectiveness-of-btk-inhibitors-for-cll

[18] https://www.mmm-online.com/home/channel/7-day-supply/car-t-makers-quest-to-scale-drugs-production/

of consultants used. We use the most recent employee benefits expense of $5.6m from the company's H126 result as a base, and expect an increase to ~25 employees as clinical trials progress and hires are made in operations, regulatory/medical affairs, business development etc.

- **Operating** expenses are modelled around the $4.1m from the H126 result, growing at 4% p.a.
- **R&D** costs have been exceptionally high for the business historically with the various programmes in place. Exhibit 12 demonstrates the decrease in R&D expenses from 2024 to 2025; this is set to decrease further substantially with azer-cel being the sole focus going forward. For simplicity, we assume all clinical trial costs are captured in R&D costs only. Azer-cel R&D expense in H126 was only $6.6m, but this will increase going forward as:
    - IMU continues Cohort 2 Phase 1b (11 more patients to recruit), which we assume to cost ~$5m more to complete.
    - Cohort 3 is initiated (targeting 20 patients), which we assume to cost ~$10m.
    - The pivotal trial for accelerated approval is conducted. We assume 50 patients are recruited (single arm studies for accelerated approval in rare haematology are typically 30-80 patients in size). Together with the licensing work and FDA submission, we assume this to cost $50m, in the lead up to commercialisation commencing in FY31.

Exhibit 11: IMU's R&D expenses have decreased substantially and should continue to do so

	2025 $	2024 $
Research and development expenses		
HER-Vaxx	1,404,794	5,982,032
PD1-Vaxx (KEY-Vaxx)	4,024,904	2,011,819
CF33	18,808,334	24,306,034
CD19	6,838,680	13,870,505
Azer-Cel	22,474,256	16,331,622
Movement within milestone expenses	(6,444,560)	17,204,650
Consulting	3,323,646	2,448,477
Impairment expenses/(reversal) of R&D Tax Incentive accrual	(3,976,630)	4,542,287
Other research and development expenses	237,943	188,058
Total Research and development expenses	**46,691,367**	**86,885,484**

Source: Company data

- **Costs to Precision BioSciences** under the terms of the licence agreement – some costs to Precision have already been paid since IMU licensed azer-cel from the company in 2023, yet other costs remain, namely:
    - US$8m on satisfactory completion of the Phase 1b clinical trial. IMU may elect to pay by the issue of IMU shares. We assume US$8m is paid at the end of FY27 when Phase 1b is assumed to complete.
    - Up to US$198m performance-based payments over the development life of azer-cel linked to the achievement of certain value-inflection development milestones, including approval in multiple indications and sales in US and EU. We assume only US$40m is paid to Precision given (US$20m each in FY29 and FY30) the current objective is narrower than what was envisaged in 2023 i.e. US only focus, in a smaller number of indications.
    - 'Industry standard royalties on net sales' – which we assume to be 12% in our modelling.

Other Financial Commentary

Cash flow

First positive cash flows are only expected in FY31 with commercialisation of both CAR-T naïve niche indications and BTKi combination therapies. Operating cash flow progressively ramps up over the following years to $290m+ in FY35f, as sales of azer-cel increase. In the near term, operating cash outflow is expected to be in the $25-35m p.a. range, as the company progresses its clinical trial programme.

Equity raises are explicitly forecast to fund IMU's clinical trial programme. With ~$15m of cash on the balance sheet, we currently assume that IMU raises $30m of equity each time in late 2026 and late 2027. For each of these raises, we assume progressively higher equity raising share prices of $0.20/share and $0.30/share, as positive clinical trial data results translates to higher share prices over time. This results in 150m and 100m of new shares issued at each equity raising.

Minimal capex spend is forecast as IMU would not manufacture directly from its own facilities given the licensing model assumed.

Balance sheet

Cash at bank is estimated at ~$15.0m post the recent equity raise.

Options out of the money. IMU has 89.9m options outstanding, but all out of the money. 66.7m of these options were issued in the March 2026 equity raise and have an exercise price of $0.18 each. The balance has significantly higher exercise prices and are unlikely to be exercised, in our view. Consequently, we assume only the 66.7m options are exercised in April 2027, raising $12m and adding to dilution.

Restricted stock (2.5m units) and performance rights (2.0 units) are assumed to convert to stock.

Warrants (89.9m units, various). These warrants have various reference prices ($0.25-0.276/share range) and can be exercised at any time leading up to their maturity date. They are not overly dilutive, in our opinion.

SAR zero-coupon convertible notes at $15.3m face value. These are a more complicated structured finance product with rolling dilution built in through a quarterly amortisation mechanism, making them complex to model. They mature on 24 January 2030, and the initial conversion price is $0.18/share. For simplicity in the modelling, we assume they convert to ~85m shares in January 2030. N.B. there is a $0.09/share floor scenario, which may result in ~170m shares issued.

Tax losses. Significant unused tax losses of $152.9m exist. If IMU becomes profitable, these accumulated tax losses could shelter $152.9m of future taxable income. This amount is expected to increase given IMU will remain unprofitable over the next several years, in our view.

Valuation

IMU is trading at a relatively low level vs. other global allogeneic CAR-T peers, especially given the strong efficacy data with the potential to commence its pivotal trial in 2027. Our thinking is that the market may be unaware of IMU's recent sole focus on azer-cel and capital management. We do acknowledge the requirement for further funding (equity or otherwise) to fund its clinical programme to commercialisation.

DCF valuation

We use a DCF methodology, specifically a probability-weighted NPV (rNPV), as our primary valuation approach, as is typical with biotechs given timelines and catalysts are binary and tied to regulatory milestones rather than steady cash flows.

Earnings are estimated out to FY35, with a terminal value to reflect ongoing sales of azer-cel. Our unrisked valuation (NPV) is $0.97/share. To this, we assign a Probability-of-Success (PoS) weighting of 25% given many milestones are yet to be achieved over the next few years. This yields a rNPV of $0.24/share. We anticipate increasing the PoS applied to the NPV provided milestones are met, to potentially achieve our unrisked NPV over time.

We would highlight the following as being key drivers/assumptions of this valuation:

- 14.9% discount rate incorporating a beta of 1.6x, RFR 4.5% and equity risk premium of 6.5%;
- Perpetuity growth rate of 2.2%;
- Only sales of azer-cel for CAR-T naïve niche indications and BTKi combination therapies are assumed. If successful and profitable, in time, azer-cel sales may expand to other indications. Sales are described in the Revenue section of this report above;
- We assume a 12% royalty cost paid to Precision BioSciences (IMU has specified low double digits); and
- Shares on issue are diluted to 824.3m shares, from 403.3m shares currently. This is significant.

Exhibit 12: IMU base-case rNPV (in A$m unless otherwise stated)

Parameters	Outcome
Discount rate/WACC (%)	14.9
Beta (x)	1.6
Terminal growth rate assumption (%)	2.2
Sum of PV ($m)	172.6
PV of terminal value ($m)	601.7
PV of enterprise ($m)	774.3
Debt (cash) @ December 2024 ($m)	(15.0)
Net value – shareholder ($m)	799.3
No. of diluted shares on issue (m)	824.3
NPV ($/share)	**0.97**
rNPV ($/share) – 25% Probability of Success (PoS) applied	**0.24**

Source: RaaS estimates

SWOT Analysis

Our Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis is summarised below.

Exhibit 13: Strengths, Weaknesses, Opportunities, Threats

Strengths	Opportunities
Azer-cel clinical data genuinely compelling with strong results to date. Further positive data should create value.	Azer-cel's allogeneic design could be a genuine commercial breakthrough. 'Off-the-shelf' model solves many problems.
Newfound focus on azer-cel only, both from a capital perspective as well as from management's time and focus.	Partnership or licensing deal could transform the investment case overnight – this is a stated IMU strategy.
Experienced executive team and board for clinical development.	FDA regulatory pathway is becoming clearer.
Australian R&D tax incentive of up to a 48.5% cash refund on eligible R&D expenditure.	Growing global CAR-T market – Big Pharma has interest and an allogeneic product that works should attract commercial interest.
Capital markets access to keep funding clinical trials. Positive azer-cel data should support investor interest.	
Weaknesses	**Threats**
Funding gap to complete a pivotal trial is very large; further capital raises almost assured.	Cash runway is a serious risk. On current burn rates and without a partnership deal, IMU will need to return to the market again.
Severe share dilution over several years, with numerous options, warrants and convertible debt still outstanding.	The CAR-T market is competitive and dominated by large, well-capitalised Big Pharma.
Weak share price performance reflecting years of capital investment in several projects without a return.	Pivotal trial failure may be terminal for the company, given azer-cel is IMU's primary asset.
Even with success in azer-cel, commercial revenue is likely years away.	Dilution from options, warrants and convertible debt – reducing per-share value in the future.
Low market visibility – lack of commercial success historically has taken the stock off the radar of institutional investors.	Regulatory risk is binary and unpredictable. The FDA can impose clinical holds, request additional safety data etc.

Source: RaaS analysis

Key Sensitivities and Risks

Following are the RaaS assessed key sensitivities and risks around earnings forecast and resulting valuation:

Clinical risk

The entire investment thesis rests on azer-cel. Phase 1b data has been encouraging, but the trial has involved small patient numbers so response rates need to hold up as cohort sizes expands and patient selection broadens. Allogeneic CAR-T products carry specific immunological risks not present in autologous approaches, e.g. GvHD and HvD rejection. Any safety signal of this nature in Cohort 2 or 3 data could trigger an FDA clinical hold, materially delaying the programme or requiring a trial redesign. Given the broader field's relapse data, durability of response will be a key scrutiny point at any regulatory interaction.

Funding and dilution risk

IMU will likely be required to raise further equity or debt capital in the future, to fund its ongoing azer-cel programme. There is a large funding gap to complete the pivotal trial; we assumed two equity raises of $30m each in FY27 and FY28. There is no guarantee that it will be able to raise funds when required, or at satisfactory terms.

Regulatory risk

IMU has not yet had its pivotal trial design agreed with the FDA. The FDA could request a larger trial than the company currently expects. The allogeneic CAR-T space is relatively novel at the regulatory level, meaning there is less established precedent for what constitutes an acceptable approval package. Ultimately, there is no certainty of regulatory approval.

Competitive risk

The CAR-T market is dominated by Big Pharma: Novartis, Gilead/Kite, BMS, and Johnson & Johnson/Legend etc., all with approved products, established manufacturing, commercial infrastructure, and large R&D budgets. In the specific allogeneic segment that azer-cel targets, IMU faces direct competition from Allogene Therapeutics, Caribou Biosciences and others.

Sales and market share assumptions

Our modelling assumes that IMU is successful in commercialising azer-cel. Assumptions made are long-dated, with sales commencing in FY31 and penetration of the market increasing to FY35. These assumptions underpin the NPV of the company and may prove to be optimistic.

Discount rates applied to NPV

We currently apply a WACC of 14.9% incorporating a beta of 1.6x to arrive at our NPV valuation. At this stage, a Probability of Success (PoS) of 25% is also applied given the numerous binary events expected over the next 12-24 months. We expect the PoS applied to increase over time provided milestones are met favourably.

Board of Directors

The Board is an internationally-oriented group with genuine depth in oncology drug development and biotech capital markets. The skill mix is well suited to a clinical-stage oncology company, in our view. While the Chairman is not independent, it's not unusual given that he is the founder of the company; the five-person board is majority independent, however, with three non-executive directors.

Paul Hopper, Executive Chairman. Mr Hopper is an Australian biotech entrepreneur and founded IMU in 2012 and was appointed to the board on 31 October 2012. His signature achievement is Viralytics, an immuno-oncology company he chaired that was acquired by Merck for A$502m in 2018.

Mr Hopper brings over 20 years' experience in the management and funding of biotechnology public companies, where he has served as chairman, CEO and director in over 15 companies in the US, Australia and Asia. His sector experience has covered several therapeutic areas with a particular emphasis on immunotherapy.

Mr Hopper also founded Chimeric Therapeutics (ASX:CHM) and Radiopharm Theranostics (ASX:RAD) and is also a chairman of the latter.

Leslie Chong, Managing Director and Chief Executive Officer. Ms Chong brings genuine, pedigreed clinical development expertise to the company. She spent five years as Senior Clinical Program Leader at Genentech in San Francisco before joining IMU in September 2015. She has over 25 years of oncology development experience, was promoted to CEO in November 2016, and joined the board as MD in March 2018.

Ms Chong has no other directorships currently.

Lesley Russell, Non-Executive Director. Dr Russell is a haematologist/oncologist with over 25 years of experience in the international pharmaceutical industry as a Chief Medical Officer. She has overseen multiple new drug approvals with both the FDA and the European Medicines Agency — experience that is directly relevant to IMU's regulatory pathway.

Dr Russell is a member of the Royal College of Physicians UK and brings NASDAQ-listed company board experience through her ongoing directorship at Enanta Pharmaceuticals (NASDAQ:ENTA). She also sits on the board of Chimeric Therapeutics.

Jakob Dupont, Non-Executive Director. Dr Dupont brings more than 20 years of oncology drug development expertise, including his time at Atara Biotherapeutics (NASDAQ:ATRA) where he oversaw all R&D across multiple clinical-stage programmes from Phase 1 through Phase 3.

Dr Dupont currently serves as Executive Venture Partner at Sofinnova Investments, one of the leading global life sciences venture capital firms, which brings valuable deal-flow perspective and industry networks to the board. He also sits on the boards of Pyxis Oncology (NASDAQ:PYXS) and Bolt Therapeutics (NASDAQ:BOLT), giving him active, current exposure to the US biotech landscape.

Dr Dupont also chairs the Remuneration & Nomination Committee.

Kim Drapkin, Non-Executive Director. Ms Drapkin has over 25 years of experience in biotech and pharma finance, including CFO roles at Jounce Therapeutics and EPIX Pharmaceuticals, a decade in progressive finance roles at Millennium Pharmaceuticals, and early career experience at PwC in its technology and life sciences practice.

Most recently Ms Drapkin was CEO and board member at Graphite Bio, where she led a strategic alternatives process culminating in a reverse merger with LENZ Therapeutics (NASDAQ:LENZ) – a company she now also sits on as a non-executive director, alongside her board seat at Acumen Pharmaceuticals (NASDAQ:ABOS). She is a US-based director, which brings important cross-jurisdictional perspective for a company with clinical operations and regulatory ambitions in the US.

Ms Drapkin also chairs the Audit & Risk Committee.

Shareholders

The shareholder base is broad and largely retail (~80%). Board and management own ~5%, with foreign and Australian institutions owning the balance.

Exhibit 14: IMU substantial shareholders 27 April 2026

Holder	% total
Citicorp Nominees	5.8
Precision Biosciences Inc	5.2
HSBC Custody Nominees (Australia)	3.5
JP Morgan Nominees Australia	3.1
BNP Paribas Noms	2.5

Source: ASX disclosures

Exhibit 15: IMU Financial Summary

Imugene (ASX:IMU)					
Profit and Loss (A$m)					
Y/E 30 June	**FY24A**	**FY25A**	**FY26F**	**FY27F**	**FY28F**
Sales Revenue	0.0	0.0	0.0	0.0	0.0
Gross Profit	0.0	0.0	0.0	0.0	0.0
EBITDA underlying	(127.9)	(69.7)	(49.3)	(27.7)	(35.8)
Depn	(3.3)	(1.1)	(0.5)	(0.1)	(0.0)
Amort	0.0	0.0	0.0	0.0	0.0
EBIT underlying	(131.2)	(70.9)	(49.8)	(39.3)	(35.8)
Interest	4.0	1.9	0.4	0.0	0.0
Tax	0.0	0.0	0.0	0.0	0.0
Minorities	0.0	0.0	0.0	0.0	0.0
Equity accounted assoc	0.0	0.0	0.0	0.0	0.0
NPAT pre significant items*	(128.9)	(67.2)	(49.4)	(39.2)	(35.8)
Significant items	(19.4)	(6.2)	(1.4)	0.0	0.0
NPAT (reported)	**(148.2)**	**(73.4)**	**(50.8)**	**(39.2)**	**(35.8)**
Cash flow (A$m)					
Y/E 30 June	**FY24A**	**FY25A**	**FY26F**	**FY27F**	**FY28F**
EBITDA underlying (Stat)	(127.9)	(69.7)	(49.3)	(27.7)	(35.8)
Interest	0.0	2.4	0.4	0.0	0.0
Tax	0.0	0.0	0.0	0.0	0.0
Working capital changes	26.2	(8.2)	13.9	0.0	0.0
Operating cash flow	(101.7)	(75.6)	(35.0)	(27.7)	(35.7)
Mtce capex	(7.1)	(7.5)	(0.0)	(0.0)	(0.0)
Free cash flow	(108.8)	(83.1)	(35.0)	(27.7)	(35.7)
Growth capex	0.0	0.0	0.0	0.0	0.0
Acquisitions/Disposals	(4.6)	(5.1)	(4.6)	0.0	0.0
Other	4.4	0.0	0.0	0.0	0.0
Cash flow pre financing	(109.0)	(88.3)	(39.6)	(27.7)	(35.7)
Equity	51.0	18.7	23.3	30.0	42.0
Debt	0.0	0.0	0.0	0.0	0.0
Dividends paid	0.0	0.0	0.0	0.0	0.0
Net cash flow for year	(58.0)	(69.6)	(16.3)	2.3	6.3
Balance sheet (A$m)					
Y/E 30 June	**FY24A**	**FY25A**	**FY26F**	**FY27F**	**FY28F**
Cash	93.1	21.9	5.1	5.8	10.0
Accounts receivable	12.6	10.0	0.0	0.0	0.0
Inventory	0.0	0.0	0.0	0.0	0.0
Other current assets	7.3	9.8	13.8	13.8	13.8
Total current assets	*113.0*	*41.7*	*18.9*	*19.7*	*23.8*
PPE	1.7	1.7	0.1	0.0	0.0
Intangibles and Goodwill	34.1	31.7	26.8	26.8	26.8
Investments	0.0	0.0	0.0	0.0	0.0
Deferred tax asset	0.0	0.0	0.0	0.0	0.0
Other non current assets	2.5	8.4	8.3	8.3	8.3
Total non current assets	*38.4*	*41.8*	*35.2*	*35.1*	*35.1*
Total Assets	151.4	83.6	54.1	54.8	58.9
Accounts payable	7.8	11.7	10.0	10.0	10.0
Short term debt	0.0	6.7	4.8	4.8	4.8
Tax payable	0.0	0.0	0.0	0.0	0.0
Other current liabilities	21.5	3.8	3.3	3.3	3.3
Total current liabilities	*29.3*	*22.2*	*18.1*	*18.1*	*18.1*
Long term debt	0.6	2.8	0.0	0.0	0.0
Other non current liabs	3.2	13.6	7.6	7.6	7.6
Total long term liabilities	*3.8*	*16.4*	*7.6*	*7.6*	*7.6*
Total Liabilities	33.1	38.6	25.7	25.7	25.7
Net Assets	**118.3**	**45.0**	**28.4**	**29.1**	**33.2**
Share capital	370.3	380.7	418.8	446.8	486.8
Accumulated profits/losses	(289.8)	(352.7)	(400.0)	(427.8)	(463.6)
Reserves	37.8	17.1	9.5	9.5	9.5
Minorities	0.0	0.0	0.0	0.0	0.0
Total Shareholder funds	**118.3**	**45.0**	**28.4**	**28.6**	**32.8**

Share price						**A$**	**0.105**
Interim (A$m)	**H125A**	**H225A**	**H126F**	**H226F**	**H127F**	**H227F**
Revenue	0.1	4.3	0.0	0.0	0.0	0.0
EBITDA	(43.1)	(20.0)	(40.4)	(13.4)	(13.7)	(14.0)
EBIT	(47.0)	(23.9)	(39.6)	(13.5)	(13.8)	(14.1)
NPAT (normalised)	(45.5)	(22.1)	(39.2)	(13.5)	(13.8)	(14.1)
Minorities	-	-	-	-	-	-
NPAT (reported)	(48.9)	(25.0)	(40.7)	(13.5)	(13.8)	(14.1)
EPS (normalised)	(0.61)	(0.29)	(0.51)	(4.25)	(2.94)	(3.00)
EPS (reported)	(0.66)	(0.33)	(12.82)	(4.23)	(2.94)	(3.00)
Dividend (cps)	-	-	-	-	-	-
Imputation	-	-	-	-	-	30.0
Operating cash flow	(38.6)	(36.9)	(25.9)	(9.1)	(13.7)	(14.0)
Free Cash flow	(27.9)	(40.2)	(25.9)	(9.0)	(13.7)	(14.0)
Divisions	**H125A**	**H225A**	**H126F**	**H226F**	**H127F**	**H227F**
Azer-cel - CAR-T naïve/niche	0.0	0.0	0.0	0.0	0.0	0.0
Azer-cel - BTKi Combo (Cohort 3)	0.0	0.0	0.0	0.0	0.0	0.0
Sales revenue	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
COGS	0.0	0.0	0.0	0.0	0.0	0.0
Employment costs	(10.0)	(9.1)	(5.8)	(5.0)	(5.2)	(5.3)
Operating costs	(2.0)	0.1	(4.1)	(3.5)	(3.6)	(3.6)
R&D costs	(31.3)	(15.4)	(30.5)	(4.9)	(5.0)	(5.1)
EBITDA (adjusted)	(43.1)	48.3	(40.4)	(13.4)	(13.7)	(14.0)

Margins, Leverage, Returns		**FY24A**	**FY25A**	**FY26F**	**FY27F**	**FY28F**
EBITDA		n/a	n/a	n/a	n/a	n/a
EBIT		n/a	n/a	n/a	n/a	n/a
NPAT pre significant items		n/a	n/a	n/a	n/a	n/a
Net Debt (Cash)		92.5	12.4	0.3	1.0	5.2
Net Debt/EBITDA (x)	(x)	n/a	n/a	n/a	n/a	n/a
ND/ND+Equity (%)	(%)	(358.7%)	(38.1%)	(0.9%)	(3.7%)	(18.8%)
EBIT interest cover (x)	(x)	n/a	n/a	n/a	n/a	n/a
ROA		(173.3%)	(60.3%)	(72.3%)	(72.1%)	(63.0%)
ROE		(250.7%)	(89.9%)	(138.5%)	(137.8%)	(116.6%)
ROIC		(999.6%)	(230.3%)	(162.7%)	(141.0%)	(129.7%)
Working capital		4.8	(1.7)	(10.0)	(10.0)	(10.0)
WC/Sales (%)		n/a	n/a	n/a	n/a	n/a
Revenue growth		n/a	n/a	n/a	n/a	n/a
EBIT growth pa		n/a	n/a	n/a	n/a	n/a
Pricing		**FY24A**	**FY25A**	**FY26F**	**FY27F**	**FY28F**
No of shares (y/e)	(m)	7,481	7,658	318	468	468
Weighted Av Dil Shares	(m)	7,089	7,436	7,658	468	635
EPS Reported	cps	(2.09)	(0.99)	(2.33)	(3.13)	(3.39)
EPS Normalised/Diluted	cps	(1.82)	(0.90)	(4.76)	(5.94)	(5.63)
EPS growth (norm/dil)		n/a	n/a	n/a	n/a	n/a
DPS	cps	-	-	-	-	-
DPS Growth		n/a	n/a	n/a	n/a	n/a
Dividend yield		0.0%	0.0%	0.0%	0.0%	0.0%
Dividend imputation		0	0	0	0	30
PE (x)		-	-	-	-	-
PE market		21.0	21.0	21.0	21.0	21.0
Premium/(discount)		n/a	n/a	n/a	(100.0%)	n/a
EV/EBITDA		n/a	n/a	n/a	-1.6	n/a
FCF/Share	cps	-1.3	-0.9	-11.0	-5.9	-7.6
Price/FCF share		- 8.3	- 11.8	- 1.0	- 1.8	- 1.4
Free Cash flow Yield		(12.0%)	(8.5%)	(104.6%)	(56.3%)	(72.6%)
* excludes non-cash share-based payments						

Source: Company data for actuals, RaaS estimates (FY26F-FY28F)

FINANCIAL SERVICES GUIDE

RaaS Research Group Pty Ltd

ABN 99 614 783 363

Corporate Authorised Representative, number 1248415, of

BR SECURITIES AUSTRALIA PTY LTD; ABN 92 168 734 530; AFSL 456663

Effective Date: 26th March 2024

About Us

BR Securities Australia Pty Ltd (BR) is the holder of Australian Financial Services License ("AFSL") number 456663. RaaS Research Group Pty Ltd (RaaS) is an Authorised Representative (number 1248415) of BR.

This Financial Service Guide (FSG) is designed to assist you in deciding whether to use RaaS's services and includes such things as who we are, our services, how we transact with you, how we are paid, and complaint processes

Contact Details, BR and RaaS

BR Head Office: Level 1, 160 Edward Street, Brisbane, QLD, 4000 www.brsecuritiesaustralia.com.au

RaaS:. c/- Rhodes Docherty & Co Pty Ltd, Suite 1, Level 1, 828 Pacific Highway, Gordon, NSW, 2072.

P: +61 414 354712

E: finola.burke@raasgroup.com

RaaS is the entity providing the authorised AFSL services to you as a retail or wholesale client.

What Financial Services are we authorised to provide? RaaS is authorised to

- provide general advice to retail and wholesale clients in relation to
  - Securities

The distribution of this FSG by RaaS is authorized by BR.

Our general advice service

Please note that any advice given by RaaS is general advice, as the information or advice given will not take into account your particular objectives, financial situation or needs. You should, before acting on the advice, consider the appropriateness of the advice, having regard to your objectives, financial situation and needs. If our advice relates to the acquisition, or possible acquisition, of a particular financial product you should read any relevant Prospectus, Product Disclosure Statement or like instrument. As we only provide general advice we will not be providing a Statement of Advice. We will provide you with recommendations on securities.

How are we paid?

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Complaints

If you have a complaint about our service, you should contact your representative and tell them about your complaint. The representative will follow BR's internal dispute resolution policy, which includes sending you a copy of the policy when required to. If you aren't satisfied with an outcome, you may contact AFCA, see below.

BR is a member of the Australian Financial Complaints Authority (AFCA). AFCA provide fair and independent financial services complaint resolution that is free to consumers.

Website: www.afca.org.au; Email: info@afca.org.au; Telephone: 1800931678 (free call)

In writing to: Australian Financial Complaints Authority, GPO Box 3, Melbourne, VIC, 3001.

Professional Indemnity Insurance

BR has in place Professional Indemnity Insurance which satisfies the requirements for compensation under s912B of the Corporations Act and that covers our authorized representatives.

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The science of climate change is common knowledge and its impacts may damage the global economy. Mitigating climate change may also disrupt the global economy. Investors need to make their own assessments and we disclaim any liability for the impact of either climate change or mitigating strategies on any investment we recommend.

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