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Resumption of Coverage

IMUGENE LTD.

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Imugene Limited (ASX: IMU)

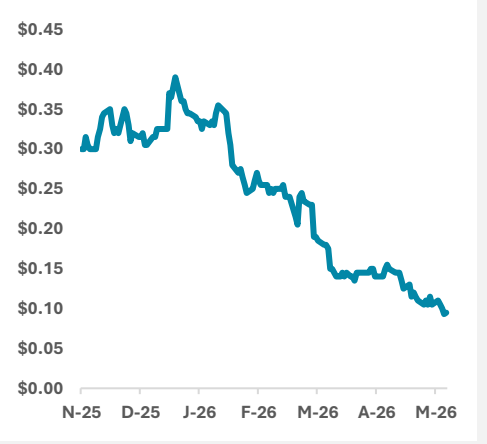
Key Statistics	
52 Week Range	A$0.09 - A$0.73
Avg. Volume (3 months)	1.65MM
Shares Outstanding	415.84MM
Market Capitalization	A$39.09M
EV/Revenue	N/A
Cash Balance*	A$5.96M
Analyst Coverage	2

***Cash Balance as of March 2026**

Revenue (in A$mm)			
June – FY	2025A	2026E	2027E
H1	0.00	0.00	0.00
H2	0.00	0.00	0.00
FY	0.00	0.00	0.00

EPS (in A$)			
June – FY	2025A	2026E	2027E
H1	(0.22)	(0.13)	(0.05)
H2	(0.10)	(0.03)	(0.04)
FY	(0.32)	(0.16)	(0.09)

Stock Price Chart (in A$)



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Imugene Limited: Azer-cel Anchors the Investment Case Through a Scalable Allogeneic CAR-T Platform Targeting B-Cell Malignancies

Share Price	A$0.094	Valuation	A$0.43

Investment Highlights

Azer-cel Drives the Central Investment Case through a Differentiated off-the-shelf CAR-T Approach - Imugene's investment case is increasingly anchored around azer-cel, an allogeneic CD19 CAR-T therapy that addresses several structural limitations of autologous CAR-T, including long manufacturing timelines, patient-specific production complexity, and constrained real-world access. By enabling pre-manufactured, donor-derived treatment with a materially shorter vein-to-vein time (3-5 days vs 2-4 weeks for autologous), azer-cel is positioned with certain catalysts to improve treatment accessibility in aggressive B-cell malignancies where speed of deployment is clinically important. Beyond speed, the allogeneic approach enables batch-based manufacturing, improving scalability and product consistency while leveraging healthy donor-derived cells. Additionally, inventory-based distribution allows immediate treatment availability, eliminating logistical bottlenecks associated with autologous therapies. Economically, autologous CAR-T therapies are priced at $400,000-$500,000 per patient, while allogeneic approaches are structurally more cost-efficient. Collectively, these factors position azer-cel as potentially a more accessible and scalable alternative within the CAR-T paradigm.

Clinical Data Provide Early Validation in High-Risk, Heavily Pre-Treated Populations - Azer-cel's current clinical evidence base is now best framed around Imugene's ongoing Phase1b expansion program. Following prior dose-escalation and regimen-optimization work, the Phase 1b study is evaluating the selected go-forward regimen of 500 million azer-cel cells, Aug/Cy lymphodepletion, and adjunctive low-dose IL-2 to support CAR-T expansion and persistence. In Cohort 1 of the ongoing Phase 1b expansion, azer-cel has shown encouraging early clinical activity in heavily pre-treated B-cell malignancies, particularly in post-autologous CAR-T relapsed DLBCL. Azer-cel achieved an 82% ORR in 17 evaluable patients, with 14 responses, including 7 complete responses and 7 partial responses. The durability profile also continues to mature, with the best observed response extending to approximately 24 months and ongoing. Importantly, azer-cel has demonstrated a favorable and manageable safety profile, broadly consistent with autologous CAR-T therapies, with no Grade 3 or higher CRS, supporting continued evaluation in a heavily pre-treated patient population. Beyond DLBCL, early Cohort 2 data in CAR-T-naïve niche indications showed 100% ORR in CLL/SLL and 80% ORR in MZL, supporting the potential for azer-cel to address multiple CD19-positive B-cell malignancies with high unmet need.

Company Description

Imugene Limited is a clinical-stage biotechnology company developing immuno-oncology therapies with its pipeline centered around azer-cel, an allogeneic CD19 CAR-T therapy. Azer-cel is designed to enable scalable, off-the-shelf treatment for B-cell malignancies with improved access, reduced vein-to-vein times, and simplified manufacturing complexity.

Market Opportunity Driven by Underpenetration Rather Than Competitive Displacement - The opportunity for azer-cel is supported by both disease prevalence and a structural treatment gap in CAR-T utilization. DLBCL accounts for approximately 30-40% of non-Hodgkin lymphoma, representing 150,000 global cases annually and 20,000-30,000 cases in the U.S. Despite curative intent in frontline therapy, 40-50% of patients relapse or become refractory, forming the primary target population for advanced therapies. While 60-65% of these patients are clinically eligible for CAR-T, only 25% currently receive treatment due to manufacturing delays, referral bottlenecks, and logistical constraints. This implies that of approximately 10,000-12,000 U.S. patients entering the relapsed/refractory setting, 6,000-7,000 are eligible but materially under-treated. At an estimated $400,000 per treatment, this equates to a $2.4-$2.8 billion addressable U.S. market. Azer-cel's off-the-shelf profile, if approved, is positioned to expand access and increase utilization, supporting our assumption of penetration increasing toward 50% of eligible patients over time.

Unique Relative to Autologous and Emerging in Vivo CAR-T Modalities - Strategically, azer-cel occupies an unique intermediate position within the evolution of cell therapy. First-generation autologous CAR-T therapies such as Yescarta® (2025 - $1.5 billion), Breyanzi® (2025 - $1.35 billion), and Carvykti® (2025 - $1.9 billion) have demonstrated strong efficacy and commercial success but remain constrained by scalability. At the other end of the spectrum, recent M&A activity has increasingly focused on in vivo CAR-T platforms (AbbVie-Capstan of up to $2.1 billion, AstraZeneca-EsoBiotech of $1.0 billion, Eli Lilly - Orna of up to $2.4 billion), which aim to eliminate manufacturing but remain early and clinically unproven. Azer-cel, by contrast, leverages validated CD19 biology and established CAR-T mechanisms, while addressing operational constraints through an allogenic model. While risks such as immune rejection and limited persistence remain, these are better characterized and increasingly mitigated through gene-editing strategies and regimen optimization, supporting a more favorable unique profile relative to next-generation modalities.

Financial Profile and Valuation Reflect a Concentrated, Asset-Driven Investment Case - Imugene is a pre-revenue, clinical-stage biotechnology company with sustained operating losses driven by ongoing R&D investment. In FY 2025, the company reported R&D expenses of A$46.7 million and G&A of A$27.8 million, resulting in a net loss of A$69.0 million and operating cash burn of A$75.6 million. The financial profile remains consistent with a pipeline-driven model, where near-term performance is not anchored to revenues but to the progression and value realization of its lead asset, azer-cel. Following recent capital raising initiatives and cost rationalization efforts, including pipeline prioritization and reduced operating intensity, the company is increasingly positioned to allocate resources toward its core value driver. For valuing Imugene, we adopt a probability-adjusted discounted cash flow (DCF) framework, with azer-cel as the primary contributor to future cash flows. Our model incorporates key assumptions around pricing of approximately $350,000 in the U.S. and $262,500 in ex-U.S. markets, peak market penetration of 25% in the U.S. and 20% internationally, and a probability of success of 30%, reflecting its Phase 1b stage and encouraging early clinical signals. We apply a discount rate of 12.0% and assume no terminal value, given the finite visibility of pipeline cash flows, while assigning a 90% weighting to DCF and 10% to comparable company analysis. Based on this blended methodology, we derive a valuation of A$0.43 per share, contingent upon successful execution by the company.

Company Overview

Imugene Limited (ASX: IMU) is an Australia-based clinical-stage biotechnology company that has increasingly centered itself around the development of azer-cel (azercabtagene zapreleucel), an allogeneic, CAR-T cell therapy targeting CD-19 expressing hematological malignancies. The company acquired global rights to azer-cel from Precision BioSciences, gaining access to an advanced clinical dataset, established manufacturing infrastructure, and prior regulatory engagement, which collectively accelerated development timelines. The transaction is structured with up to $227 million in milestone payments and double-digit royalties, creating a back-ended economic framework with commercialization success. Development is currently focused primarily on relapsed or refractory diffuse large B-cell lymphoma (DLBCL), with potential expansion into other CD19-expressing malignancies over time. Designed as an off-the-shelf therapy, azer-cel utilizes a scalable manufacturing approach, enabling rapid treatment initiation compared to autologous CAR T therapies. The product is manufactured using the proprietary ARCUS gene-editing platform, which inserts the CAR construct into the TRAC locus, eliminating the native T-cell receptor and supporting a more controlled and consistent product profile.

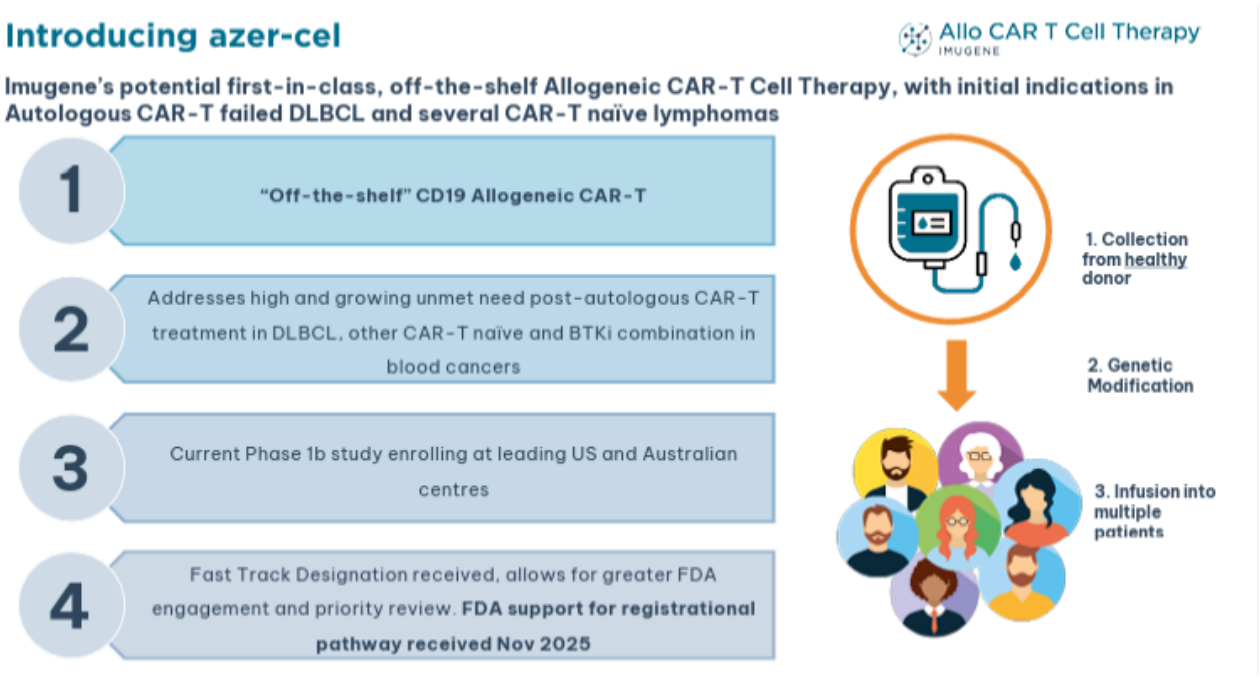

Exhibit 1: Imugene Clinical Pipeline. Source: Company Website

Azer-cel is currently being evaluated in a global Phase 1/1b study across both CAR T-relapsed and CAR T-naïve patient populations. Dose escalation has been completed, establishing a recommended Phase 2 dose of 500 million cells alongside an optimized lymphodepletion regimen, with the FDA subsequently endorsing this dosing regimen for registrational development. Early clinical data demonstrate encouraging response rates in heavily pre-treated populations, with durability signals and a manageable safety profile, including no evidence of graft-versus-host disease or high-grade cytokine release syndrome observed to date. The program has also progressed on the regulatory front, with a successful FDA Type C meeting completed in November 2025. This interaction resulted in alignment on a registrational pathway in third-line or later DLBCL, including support for a single randomized Phase 3 trial with dual endpoints designed to enable both accelerated and

full approval. In addition to monotherapy development, Imugene is exploring combination approaches, particularly with Bruton's tyrosine kinase inhibitors (BTKi), a well-established class of therapies with more than $10 billion in annual global sales.[1] These combinations are intended to enhance CAR T-cell expansion, persistence, and overall efficacy, while potentially broadening the addressable patient population across multiple B-cell malignancies.

Imugene is a clinical-stage immune-oncology company primarily focused on advancing azer-cel, which integrates clinical validation, scalable manufacturing, and regulatory alignment to target r/r DLBCL.

Imugene's current profile is defined by a concentrated strategic focus on azer-cel, reflecting a transition toward a more streamlined, asset-centric operating model. The company has combined an advanced clinical dataset with internalized manufacturing capabilities and ongoing regulatory engagement to establish a structured development pathway for the program. This approach positions Imugene within a select group of companies advancing allogeneic CD-19-directed CAR-T therapies, where progress is increasingly shaped by execution, trial design, and alignment with evolving treatment paradigms. At the same time, the company's concentrated reliance on a single core asset amplifies both upside potential and execution risk, making the timely delivery of clinical milestones, regulatory advancement, and eventual commercialization strategy central to long-term value creation.

Azer-cel - Scalable Off-the-Shelf Allogeneic CAR-T Targeting CD19

The company's acquisition of Precision BioSciences' allogeneic CAR-T cell therapy program in 2023 represents a strategically significant step toward expanding its capabilities in scalable, cell-based immunotherapy. The transaction provides access to azer-cel (azercabtagene zapreleucel), a clinically advancing CD19-targeted CAR-T candidate, along with associated manufacturing infrastructure and enabling technologies required to advance the program. Importantly, azer-cel's standardized manufacturing process is designed to support batch production, improve product consistency, and potentially lower the cost of goods, thereby addressing key structural constraints that have historically limited the scalability of CAR-T therapies. By integrating this platform, the company can utilize donor-derived, pre-manufactured T cells, enabling an off-the-shelf treatment approach that eliminates patient-specific manufacturing and materially reduces vein-to-vein time (approximately 3-5 days vs. 2–4 weeks for autologous CAR-T therapies)[2]. This reduction in turnaround time is particularly important in aggressive hematologic malignancies such as relapsed or refractory diffuse large B-cell lymphoma, where delays in treatment can directly impact eligibility and outcomes. This effect has been observed in autologous CAR-T therapies, where shorter vein-to-vein times are associated with higher complete response rates and improved survival outcomes. Consistent with this, real-world data indicate that patients receiving autologous CAR-T therapies such as Yescarta, where vein-to-vein times are typically ≤30 days, achieve higher complete response rates (50–55%) compared to therapies with longer timelines (>30–40 days), such as

Azer-cel represents Imugene's core value driver, offering a scalable, off-the-shelf CAR-T approach that addresses key limitations of autologous therapies, with early clinical validation and a clear path to commercialization

[1] Pharmasources.com
[2] ajmc.com

Kymriah, where CR rates decline to 30–35%.[3] Taken together, this highlights the clinical importance of rapid treatment deployment and strengthens the strategic rationale for advancing an off-the-shelf CAR-T approach.

The current commercial landscape for CAR-T therapies reflects a key disconnect between strong clinical efficacy and limited real-world scalability. While approved autologous therapies have established a multi-billion-dollar market, their penetration remains restricted to a subset of eligible patients. In this context, azer-cel is strongly positioned for the next phase of CAR-T evolution, shifting from individualized treatment models to much broader accessibility.

Company	Drug	Targeted Disease	Line of Treatment	Annual Revenue
Gilead Sciences/Kite Pharma	Yescarta® (axi-cel)	R/R DLBCL, FL	2L and 3L+	$1.5 billion
Novartis	Kymriah® (tisa-cel)	R/R DLBCL, ALL	3L+	$0.38 billion
Bristol Myers Squibb	Breyanzi® (liso-cel)	R.R DLBCL	2L and 3L+	$1.35 billion
Bristol Myers Squibb	Abecma® (ide-cel)	Multiple Myeloma	4L+	$0.43 billion
Johnson & Johnson / Legend Biotech	Carvykti® (cilta-cel)	Multiple Myeloma	2L-4L+	$1.9 billion

Exhibit 2: Key Autologous CAR-T Therapies by Indication and their 2025 Annual Revenue. Source: Company Website

Azer-cel's Mechanism of Action, Clinical Positioning, and Target Indications

Azer-cel is an allogeneic CAR-T cell therapy engineered to target CD-19, a surface antigen broadly expressed across B-cell malignancies. Following lymphodepletion, donor-derived T-cells expressing a chimeric antigen receptor are infused into the patient, enabling direct recognition of CD-19-positive malignant cells. Upon binding to the target antigen, CAR-T cells undergo activation and proliferation, releasing cytotoxic granules and pro-inflammatory cytokines that induce tumor cell apoptosis and amplify the immune response. While this mechanism is consistent with established CAR-T biology, the key differentiation lies in the allogeneic design, which allows pre-manufacturing from healthy donors and immediate availability at the point of care.

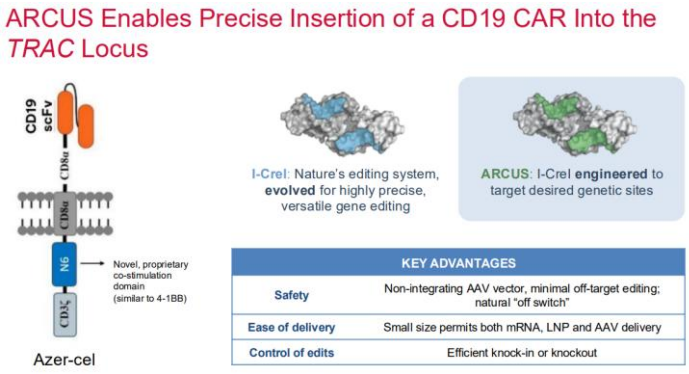

Exhibit 3: ARCUS Gene Editing Enables Precise CAR Insertion and TCR Disruption in azer-cel. Source: Company Presentation.

[3] Locke FL et al., Blood Adv, 2025

A critical challenge historically associated with allogeneic CAR-T therapies has been the risk of graft versus host disease (GvHD) and host immune rejection, which can limit both safety and persistence of the infused cells. In this context, Precision's ARCUS® gene-editing platform enables precise insertion of the CD19 CAR into the TRAC region of the T-cell, effectively switching off the cell's natural receptor that could perceive the patient's cells as foreign and attack them. This modification allows azer-cel to address the limitations through gene editing strategies that disrupt natural T-cell receptor (TCR) signaling, thereby reducing the ability of donor-derived T-cells to recognize and attack host tissues, which is the primary driver of GvHD.

Additionally, the use of adjunctive low-dose interleukin-2 (IL-2) is intended to enhance in vivo expansion and persistence of CAR-T cells. The ARCUS platform also enables improved compatibility and persistence in the host environment, including modifications aimed at reducing immune-mediated clearance of the infused cells. This approach is consistent with broader industry efforts to develop "universal" CAR-T products, where gene editing has been shown to significantly mitigate alloreactivity while preserving anti-tumor function.

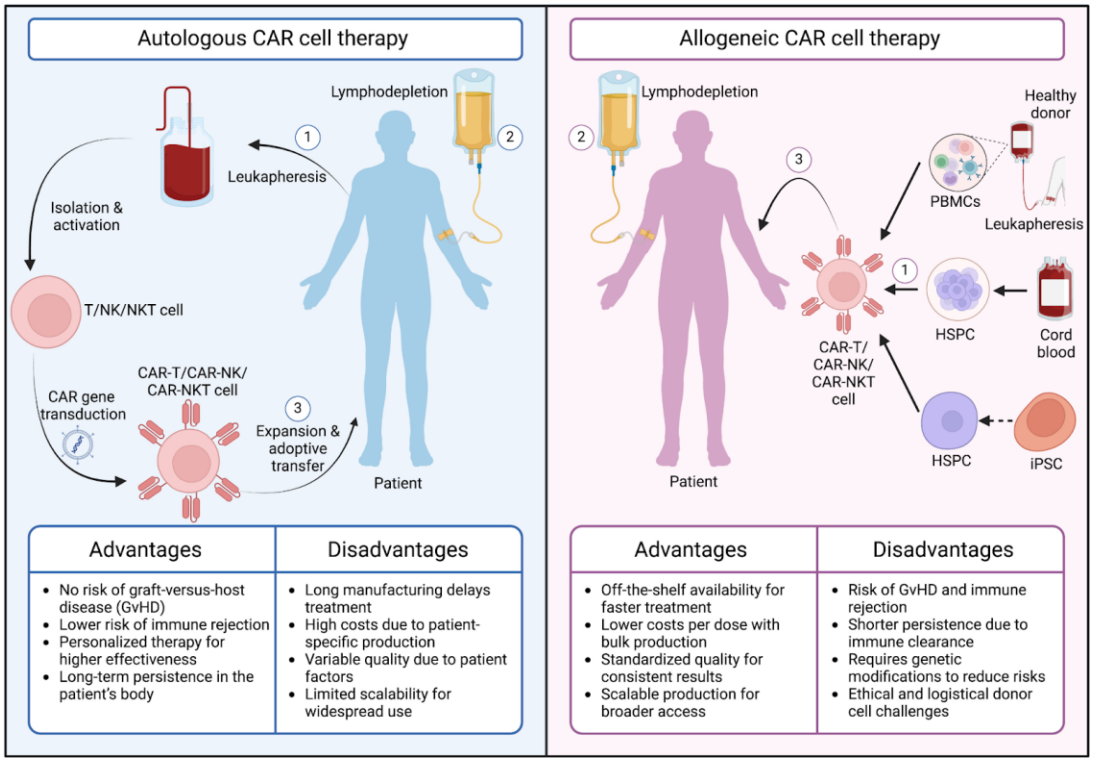

Exhibit 4: Autologous and Allogeneic CAR Therapy. Source: Yan-Ruide Li et el.

Clinically, azer-cel is being developed for relapsed or refractory B-cell malignancies, particularly diffuse large B-cell lymphoma, where CD-19-directed therapies have demonstrated strong efficacy and established CAR-T as a standard of care in later-line settings.[4] Azer-cel is being evaluated across both CAR-T naive and relapsed patient populations, with potential expansion into additional CD-19 positive indications such as follicular lymphoma, chronic lymphocytic leukemia, and mantle cell lymphoma. If supported by continued clinical validation, the therapy may be positioned not only as an alternative in later-line settings but also as a platform capable of enabling earlier intervention and broader adoption across the treatment paradigm.

[4] Ghilardi G., The Emerging Role of CAR-T Cell Immunotherapy in Early Treatment of Large B-Cell Lymphoma

Clinical Evidence Showcasing Early Efficacy Signals and Positive Safety Profile

Azer-cel is being evaluated under a Phase 1/1b clinical study structure, beginning with a dose-escalation phase and progressing into a focused cohort-expansion phase. The initial dose-escalation is shown having treated 84 patients, comprising 23 patients with B-ALL and 61 patients with NHL. This phase was primarily used to assess safety, dose levels, lymphodepletion strategies and early clinical activity. This process supported selection of the go-forward regimen, including a 500 million-cell dose of azer-cel and an optimized lymphodepletion regimen (Aug/Cy – Flu 30mg/m^2 x 3 days, Cy 750mg/m^2 x 3 days)

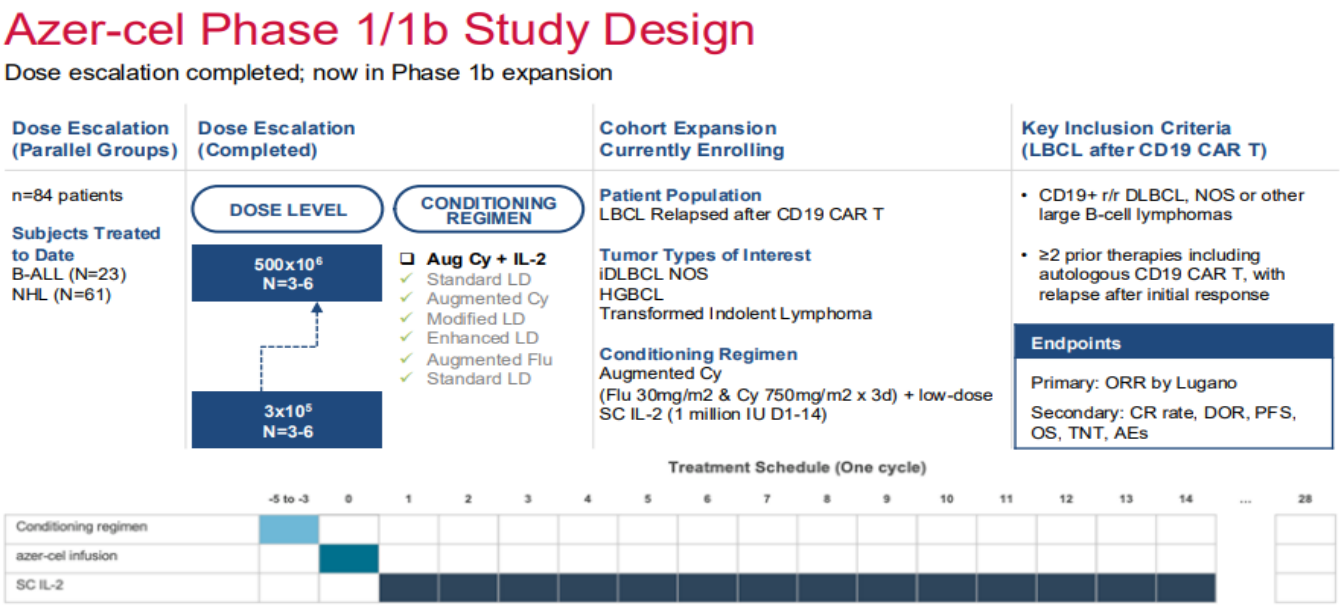

Exhibit 5: Azer-cel Phase 1/1b Study design. Source: ASH 2025 Conference Presentation

Following completion of dose escalation, the program moved into Phase 1b expansion, where the focus shifted from broad dose/regimen optimization to testing the selected regimen in more clinically defined patient cohorts. The most advanced expansion group is Cohort 1, which evalutes azer-cel in heavily pretreated 3L+ relapsed/refractory DLBCL patients who failed prior autologous CD19 CAR-T therapy. This is particularly difficult treatment setting because patients have already failed one of the most active approved treatment modalities, and many have also received multiple prior lines of therapy, including bispecific antibodies. The primary endpoint is overall response rate by Lugano criteria, while secondary endpoints include complete response rate, duration of response, progression-free survival, overall survival, time to next treatment, and adverse events.

Early Phase 1/1b data for azer-cel demonstrate compelling efficacy and manageable safety, particularly among high-risk post-CAR-T DLBCL patients, supporting its potential as a differentiated allogeneic CAR-T therapy .

Cohort 1 of the study enrolled patients (n=18) with relapsed or refractory DLBCL who had received multiple prior lines of therapy (median prior lines of therapy, n=4), including autologous CAR-T, and in many cases, bispecific antibodies.[5] This is a particularly challenging population, as outcomes following CAR-T failure are

[5] Company Conference Presentation

typically poor, with limited effective treatment options and short progression-free survival. The ongoing Cohort 2 expands this by enrolling a broader group of CAR-T-naive patients across various indications, including DLBCL, FL, CLL/SLL, MZL, WM, and PCNSL, with 9 patients enrolled, and recruitment remains ongoing, thereby enabling evaluation across a more heterogeneous patient population.[6] Across both cohorts, the study applies the optimized regimen of 500 million cells in combination with Aug Cy lymphodepletion, along with adjunctive low-dose interleukin-2 (IL-2) to support in vivo expansion and persistence of the infused CAR-T cells. This standardized approach enables more consistent assessment of efficacy and safety while supporting dose selection for potential registrational development.

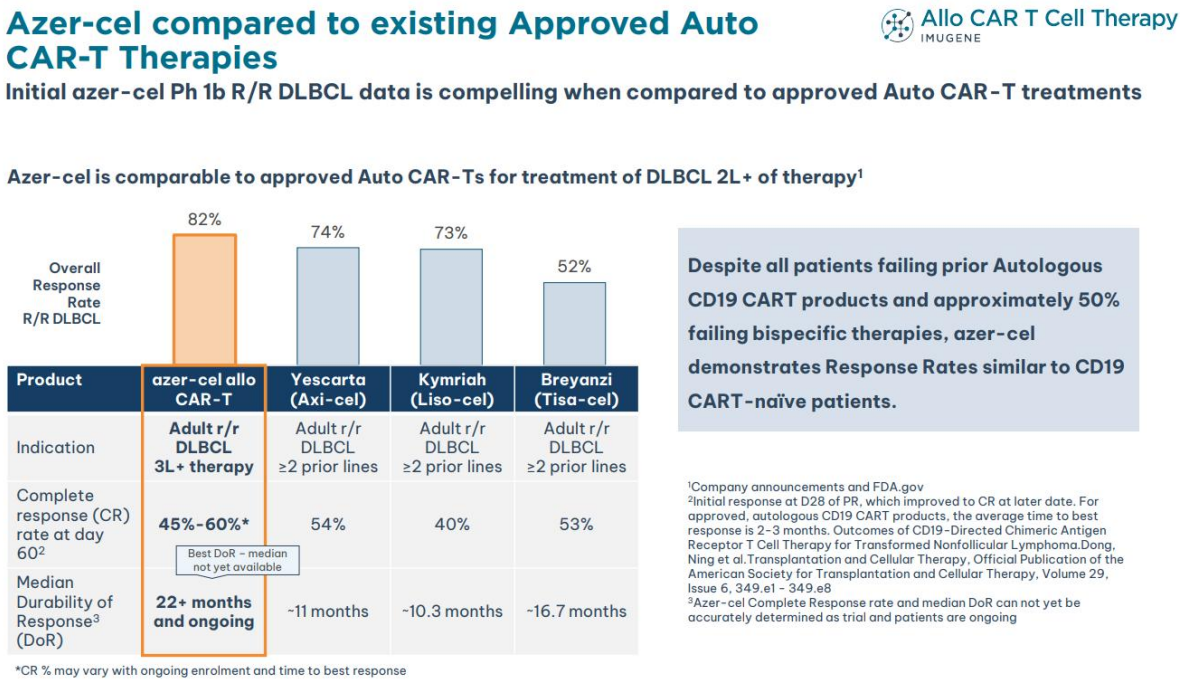

Exhibit 6: Azer-cel compared to existing approved auto CAR-T therapies. Source: Company Presentation

Interim results from the Phase 1b study demonstrate encouraging efficacy and a favorable safety profile, beginning with Cohort 1, which enrolled heavily pre-treated patients who had progressed following prior autologous CAR-T Therapy. Azer-cel achieved an overall response rate of 82% (14/17 evaluable patients), including 7 complete responses and 7 partial responses, demonstrating consistent anti-tumor activity.[7] Notably, durability signals are particularly strong with the best duration of response extending to approximately 24 months and ongoing, indicating the potential for sustained disease control.[8] Additionally, clinical responses are supported by strong in vivo CAR-T expansion and persistence. From a safety perspective, the regimen was well tolerated with no evidence of GvHD, no Grade ≥3 CRS, and infrequent ICANS, although Grade 3 ICANS events were reported and resolved. These data support continued evaluation in a heavily pre-treated post-autologous CAR-T relapsed populations.

Azer-cel's clinical activity is further demonstrated in Cohort 2, which evaluates CAR-T naive patients across rare and niche CD19-positive B-cell malignancies, expanding the scope of clinical validation beyond DLBCL.

[6] Company Press Release
[7] Company Press Release
[8] Company Presentation

In this context, the therapy achieved a 100% ORR (4/4) in CLL/SLL and 80% ORR (4/5) in MZL patients who had received multiple prior lines of therapy.[9] Early data also suggest favorable durability trends, with responses ongoing and comparing positively to existing treatment options, including BTK inhibitors and autologous CAR-T therapies. Collectively, Cohort 2 extends azer-cel's clinical relevance beyond the post-CAR-T DLBCL setting, highlighting its potential applicability across a broader range of CD19-positive malignancies and supporting a multi-indication development strategy.

Cohort 3 Demonstrates Potential Synergy with BTK Inhibitor Combination

Cohort 3 represents a strategically important extension of the azer-cel program, as it moves beyond demonstrating activity as a standalone allogeneic CAR-T and begins to explore whether combination therapy can improve the two areas critical for long-term success: depth of response and durability. While CAR-T therapies have demonstrated high initial response rates, long-term outcomes are often limited by T-cell exhaustion, suboptimal persistence, and an immunosuppressive tumor microenvironment. BTK Inhibitors offer a mechanistically compelling strategy to address these limitations by directly modulating both tumor biology and immune function.

BTK inhibitors target Bruton's Tyrosine Kinase, a critical signaling node within the B-cell receptor (BCR) pathway that regulates proliferation, survival, and trafficking of malignant B-cells. Inhibition of BTK disrupts downstream signaling cascades, including NF-κB, PI3K-AKT, and MAPK, thereby reducing tumor cell viability and mobilizing malignant cells from protective lymphoid niches. Beyond direct tumor suppression and modulation of the tumor microenvironment (TME), BTK inhibitors also exert immunomodulatory effects. They have been shown to attenuate T-cell exhaustion markers and alter cytokine profiles, thereby enhancing T-cell functionality and creating a more favorable immune milieu for antitumor activity. This mechanism has been clinically validated across multiple B-cell malignancies, with BTK inhibitors now established as standard-of-care therapies in indications such as CLL, MCL, WM, and MZL, supporting their broad utility and durable clinical benefit across diverse disease settings.

The integration of BTK inhibitors with CAR-T therapies represents a mechanistically synergistic approach to enhance T-cell expansion, persistence, and depth of response by modulating both tumor biology and the immune environment

The evolution of BTK inhibitors across multiple generations, with improvements in selectivity, safety, and activity in resistant disease, has expanded their role beyond monotherapy and positioned them as an attractive combination therapy in B-cell malignancies. In particular, their integration with CD19-directed CAR-T therapies has gained increasing clinical interest, given the complementary mechanisms of action.[10] While CAR-T therapies provide direct cytotoxic targeting of malignant B-cells, BTK inhibitors modulate both tumor biology and the immune microenvironment, creating conditions that may enhance CAR-T cell expansion, persistence, and overall therapeutic efficacy. This combination approach is therefore aimed not only at improving initial response rates but more importantly at deepening responses and extending durability, which remain key challenges in the CAR-T treatment paradigm.

[9] Company Press Release
[10] Luo et al., Blood 2024

Drug	Company	Key Indications	Generation	Annual Sales
Imbruvica® (Ibrutinib)	AbbVie/Johnson & Johnson	CLL, MCL, WM, MZL	1st Generation	$2.87 billion
Calquence® (Acalabrutinib)	AstraZeneca	CLL, MCL	2nd Generation	$3.51 billion
Brukinsa® (Zanubrutinib)	BeOne	CLL, MCL, WM	2ND Generation	$3.9 billion
Jaypirca® (Pirotbrutinib)	Eli Lilly	CLL, MCL	3rd Generation	$0.51 billion

Exhibit 7: Key BTK Inhibitors and Annual Revenue (2025). Source: Diamond Equity Research, Company Sources.

Clinical evidence supports a synergistic interaction between BTK inhibitors and CD-19-directed CAR-T therapies across multiple B-cell malignancies. Combination studies have demonstrated consistently high overall and complete response rates, alongside improved minimal residual disease (MRD) negativity and extended progression-free survival. Ibrutinib in combination with tisagenlecleucel in patients with R/R mantle cell lymphoma has shown an ORR of 85% and CR rates approaching 80%, with high MRD negativity rates, while combinations with lisocabtagene maraleucel in patients with R/R CLL/SLL have demonstrated an ORR of 86% with durable responses and median progression-free survival extending beyond 30 months.[11] In a pilot cohort from a Phase I/II open-label study of CD19 CAR-T therapy in relapsed/refractory CLL (n=19) patients treated with concurrent Ibrutinib, reported an ORR of 83% at 4 weeks compared to 56% in the non-ibrutinib cohort, alongside a more favorable safety profile.[11] Notably, any grade CRS was reduced (74% vs 95%), with no Grade ≥3 CRS observed in the ibrutinib cohort (vs 11%), and lower rates of neurotoxicity overall. Across these studies, enhanced CAR-T cell expansion and persistence have been observed, supporting the hypothesis that BTK inhibition improves the functional quality of infused T-cells.

Cohort 3 positions azer-cel for broader adoption, as a combination with BTK inhibitors could address key limitations of allogeneic CAR-T therapies while enabling expansion into earlier lines and BTKi-established indications

Additional datasets involving second-and third-generation BTK inhibitors further support the robustness of this combination strategy. Regimens incorporating acalabrutinib, zanubrutinib, and pitrobrutinib have demonstrated high response rates across r/r DLBCL, MCL, and other CD19-positive malignancies, with complete response rates frequently exceeding 70% and durable remissions observed beyond 18-24 months. Notably, these combinations have generally maintained a favorable safety profile, with a low incidence of high-grade CRS and ICANS. In the context of azer-cel, the incorporation of BTK inhibitors is particularly compelling given the allogeneic platform, where immune-mediated clearance and limited persistence remain key challenges. By modulating both intrinsic T-cell functionality and the tumor microenvironment, BTK inhibition may enhance CAR-T expansion, prolong persistence, and improve durability of response, thereby addressing one of the primary historical limitations of allogeneic CAR-T therapies. From a clinical development perspective, this strategy also enables expansion into indications where BTK inhibitors are

[11] BTK Inhibitors with CAR T-cell therapy, Pharmacy Times

already embedded within the treatment paradigm, including CLL/SLL, MCL, and MZL, potentially facilitating earlier-line use and broader adoption.

Overall, Cohort 3 reflects a mechanistically grounded approach to improving CAR-T performance through combination therapy. If validated in clinical studies, the integration of BTK inhibitors with azer-cel could enhance depth and durability of response while expanding the addressable market, positioning the therapy within a more durable and scalable treatment framework across CD-19 positive malignancies.

Broad Pipeline and Narrow Leadership, as CD19 Allogeneic CAR-T Field Consolidates Around a Few Viable Players

The CD19-directed allogeneic CAR-T landscape represents an emerging but still evolving segment within the broader cell therapy market, aimed at addressing key limitations of autologous CAR-T therapies, including manufacturing complexity, vein-to-vein time, and scalability constraints. Multiple companies are pursuing off-the-shelf CD19 CAR-T approaches, with leading clinical programs including cema-cel (Allogene Therapeutics), CTX110 (CRISPR Therapeutics), UCART19 (Cellectis), and FT819 (Fate Therapeutics), to name a select few. Despite this apparent breadth, the competitive field remains uneven, with only a couple of programs demonstrating sufficient clinical activity and development progression to support a credible path toward registrational studies.

Company	Program	Development Stage	Target Setting	Key Takeaway
Allogene Therapeutics	Cema-cel (ALLO-501A)	Pivotal Phase 2 (ALPHA3)	1L consolidation (MRD+) + prior r/r LBCL	Most advanced and de-risked program
Imugene	Azer-cel	Phase 1b	r/r LBCL	Higher upside, but early-stage risk
CRISPR Therapeutics	Zugo-Cel (CTX112™)	Phase 1/2	r/r B-cell malignancies and Autoimmune Diseases	Early but promising CD19 allogeneic program
Cellectis	UCART19	Early Phase 1	ALL/NHL	Limited recent progress
Fate Therapeutics	FT819	Phase 1	r/r B-cell malignancies	Conceptually strong, clinically early

Exhibit 8: CD19 CAR-T Cell Therapy Landscape. Source: Diamond Equity Research, Company Sources.

Among these cema-cel has emerged as the most clinically advanced program. In the pooled Phase 1 ALPHA trial and ALPHA2 trial dataset, which included 33 evaluable r/r LBCL patients, cema-cel delivered a 58% overall response rate and 42% complete response rate, with a median duration of response of 23.1 months among complete responders. In the preferred FCA90 regimen subgroup, efficacy improved further to 67% ORR and 58% CR, while safety remained notable for the absence of GvHD, ICANS, or grade ≥ 3 CRS.[12] More recently, cema-cel has progressed into a randomized pivotal Phase 2 ALPHA3 trial in a first-line MRD-positive consolidation LBCL, which is expected to enroll approximately 220 patients. An interim futility analysis conducted after the first 24 patients (12 per arm) reached assessment demonstrated MRD negativity in 58.3% of treated patients versus 16.7% in the control arm, although the primary endpoint of event-free survival

[12] Locke et al., J Clin Oncol, 2025

remains blinded.[13] Azer-cel, on the other hand, represents an earlier-stage but more broadly explored program. The Phase 1/1b dose escalation component included 84 treated patients across relapsed/refractory NHL and B-ALL, comprising 61 NHL and 23-B-ALL patients, and provided an optimized dose level, lymphodepletion strategy. The ongoing Phase1b study, structured as a multi-cohort expansion across both post CAR-T and CAR-T naive patients, has reported an 82% ORR (14/17 evaluable patients - cohort 1) in heavily pre-treated r/r DLBCL, and a favorable safety profile.

We believe both cema-cel and azer-cel stand out as the most clinically relevant and strategically positioned programs, albeit at different stages of development. Cema-cel currently represents the more de-risked and advanced asset, supported by a more homogeneous, indication-specific dataset and progression into a randomized pivotal study in an earlier-line setting, which enhances visibility on a registrational pathway. In contrast, azer-cel reflects a broader but more exploratory clinical approach, with encouraging efficacy signals across heterogeneous populations, particularly in the post-autologous CAR-T relapse setting. Recent interactions with the FDA suggest alignment on pursuing this later-line population as an initial regulatory entry point, while ongoing trial expansion preserves the option to move into earlier lines of therapy over time. This divergence is also reflected in the current market capitalization contrast, with Allogene at approximately $822 million versus Imugene at $38 million. While this gap partly reflects differences in clinical maturity and financing capacity, and breadth of Allogene's pipeline (most of them are in very early stages), we believe the current market valuation may not fully capture the strength of azer-cel's emerging clinical signal in a high unmet need setting. Accordingly, while cema-cel offers greater near-term certainty, azer-cel presents a significant asymmetric opportunity, with potential for meaningful re-rating as its clinical data mature and its development pathway becomes more clearly defined.

DLBCL Landscape: Disease Overview, Market Opportunity, Treatment Paradigm, and CAR-T M&A Trends

The selection of diffuse large B-cell lymphoma (DLBCL) as the lead indication for azer-cel reflects both its clinical urgency and commercial attractiveness, as evidenced by azer-cel's U.S. FDA Fast Track designation for relapsed/refractory (R/R) DLBCL. Strategically, Imugene's focus on DLBCL is well aligned with the evolving treatment landscape, where rapid disease progression, high relapse rates, and logistical constraints associated with autologous CAR-T therapies create a clear opportunity for off-the-shelf allogeneic approaches such as azer-cel. Epidemiologically, DLBCL represents the largest and most commercially relevant subtype of non-Hodgkin lymphoma (NHL), accounting for approximately 30-40% of all NHL cases globally.[14] This translates into an estimated 150,000 new cases worldwide each year, including approximately 20,000-30,000 in the United States.[15] Incidence rate is estimated at 5.6 per 100,000 population in the U.S., with global variation between 2.3 and 13.8 per 100,000, reflecting geographic and demographic differences. Despite curative intent in frontline therapy, outcomes remain suboptimal for a meaningful proportion of patients. Standard first-line chemoimmunotherapy achieves durable remission in approximately 60% of patients, leaving up to 50% of patients who either relapse or become refractory to treatment.[14] This relapsed/refractory population (second and further lines) represents the primary target for advanced therapies, including CAR-T and bispecific antibodies. Within this group, real-world analyses suggest that up

[13] Allogene Press Release
[14] Sineshaw HM et al., Cancer Med, 2024 – Real-world DLBCL treatment patterns by line of therapy
[15] Laurie H. Sehn & Gilles Salles, N Engl J Med, 2021 – DLBCL review

to 60-65% of patients may be clinically eligible for CAR-T therapy, based on disease status and fitness criteria; however, approximately 25% eligible patients ultimately receive CAR-T therapy.[16-17] This highlights a significant treatment gap, with the majority of eligible patients unable to access therapy due to factors such as rapid disease progression, manufacturing timelines, referral delays, and logistical constraints associated with autologous cell therapy. This implies that out of approximately 10,000 - 12,000 DLBCL patients entering the relapsed/refractory setting (second line and further), 6,000 - 7,000 patients may be eligible for CAR-T, implying an estimated total addressable market (TAM) of $2.4 - $2.8 billion based on an assumed per-patient treatment cost of $400,000.

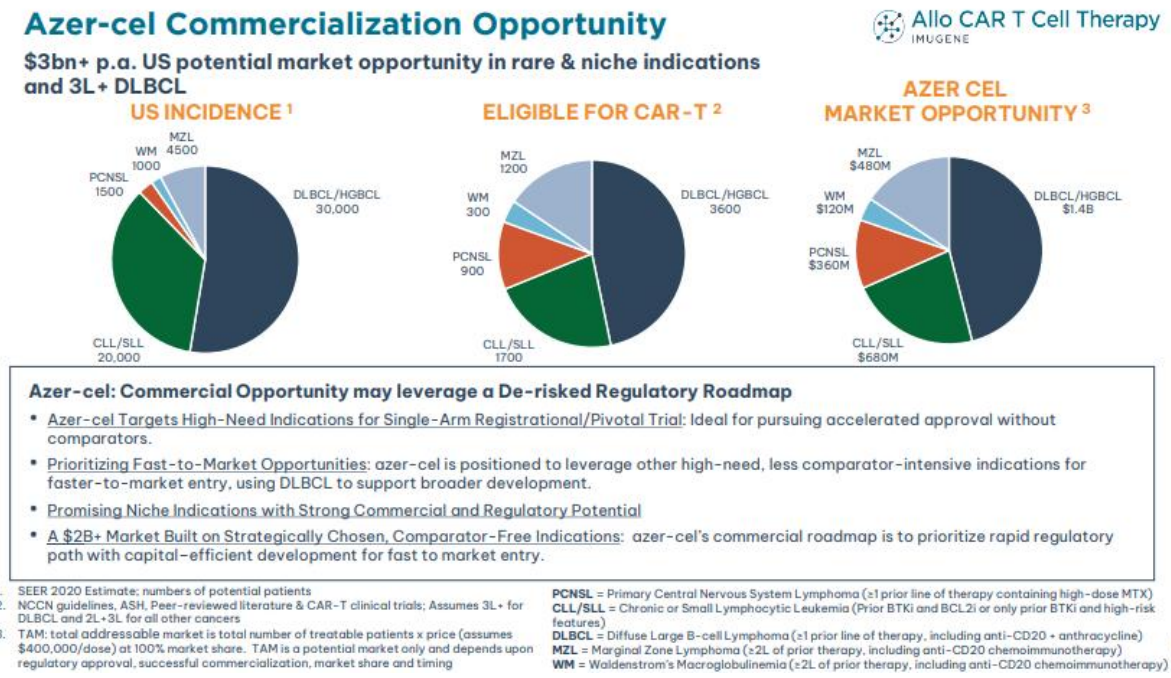

Exhibit 9: Imugene's Estimation of the U.S. Market Opportunity for Multiple Hematological Malignancies at 3L+.
Source: Company Presentation

The treatment gap in relapsed/refractory DLBCL, combined with the high economic value of advanced therapies, has driven increasing strategic interest across the CAR-T landscape. As competition intensifies and the limitations of first-generation autologous CAR-T therapies become more apparent, large pharmaceutical and biotechnology companies have actively pursued mergers, acquisitions, and partnerships to strengthen their presence in cell therapy. These transactions reflect a broader shift toward the acquisition of next-generation platforms, including allogeneic CAR-T, gene editing technologies, in vivo approaches, and scalable manufacturing capabilities, which are expected to define the next phase of growth in the CAR-T market.

The following table highlights selected recent strategic transactions across the CAR-T and broader cell therapy landscape, illustrating the accelerating consolidation and focus on next-generation platforms.

[16] Puckrin R et al., Transplant Cell Ther, 2022 – Real-world eligibility for 2L CAR-T in LBCL
[17] Cartvision.com

Year	Acquirer	Target	Deal Value	Strategic Focus
2026	Eli Lilly	Orna Therapeutics	Up to $2.4 billion	RNA-based in vivo CAR-T platform, scalable non-viral engineering.
2026	Gilead Sciences	Arcellx	$7.8 billion	Acquisition of anito-cel (BCMA CAR-T) to strengthen leadership in multiple myeloma with next-gen efficacy and safety profile.
2025	AbbVie	Capstan Therapeutics	Up to $2.1 billion	mRNA/LNP-based in vivo CAR-T platform targeting autoimmune disease, enabling repeat dosing and expansion beyond oncology
2025	AstraZeneca	EsoBiotech	Up to $1.0 billion	ENaBL viral delivery platform enabling rapid in vivo CAR-T generation, reducing manufacturing complexity and treatment time.
2025	Kite Pharma	Interius BioTherapeutics	$350 million	DNA-based in vivo CAR-T delivery approaches to eliminate ex vivo manufacturing and improve scalability.
2025	Bristol Myers Squibb	2Seenty BIO	$286 million	Full control of Abecma economics and pipeline; consolidates cell therapy franchise and improves margin capture
2025	Bristol Myers Squibb	Orbital	$1.5 billion	RNA-based delivery platform applicable to next-gen cell therapies, including in vivo CAR-T, expands modality toolkit beyond viral vectors.
2024	Roche	Poseida Therapeutics	Up to $1.5 billion	Allogenic CAR-T platform using piggyBac transposon system, enabling off-the-shelf therapies with lower cost and scalable manufacturing.
2024	AstraZeneca	Gracell Biotechnology	$1.2 billion	Next-gen CAR-T pipeline including dual-target constructs (BCMA/CD19) to address antigen escape and improve durability.

Exhibit 10: Recent M&A Activity in the CAR-T and Cell Therapy Landscape. Source: Diamond Equity Research.

Azer-cel, as an allogenic CAR-T therapy, occupies a strategically important middle ground between first-generation autologous CAR-T treatments and emerging in vivo approaches, and this positioning shapes both its opportunity and risk profile. Autologous CAR-T therapies, developed by companies such as Gilead/Kite and Bristol Myers Squibb, have demonstrated strong clinical efficacy but are inherently constrained by complex, patient-specific manufacturing, long vein-to-vein timelines, high cost of goods, and limited scalability. At the other end of the spectrum, the current wave of M&A is increasingly focused on in vivo CAR-T platforms, which aim to engineer immune cells directly within the patient, thereby eliminating manufacturing bottlenecks and potentially enabling significantly lower costs, faster treatment, and broader access, albeit with significantly higher clinical and regulatory uncertainty at this stage. Azer-cel sits between these two paradigms by addressing key limitations of autologous therapies while still relying on ex vivo processes. Importantly, this positioning supports a more attractive risk-adjusted value proposition, as azer-cel benefits from established biological validation of the CAR-T mechanism and manufacturing processes, in contrast to in vivo platforms where clinical outcomes remain largely unproven. While allogeneic approaches introduce their own challenges, such as GvHD and persistence, these risks are better characterized and are actively being

addressed through evolving engineering strategies. As a result, azer-cel offers a compelling balance between innovation and de-risking, providing meaningful operational and economic advantages over autologous CAR-T without assuming the same level of clinical uncertainty embedded in next-generation in vivo modalities. Recent M&A transactions indicate that large pharmaceutical companies are pursuing a dual-track strategy, consolidating best-in-class CAR-T assets while investing in disruptive delivery technologies. In this context, azer-cel could represent an attractive "bridge asset" with both near-term commercial relevance and strategic optionality, and given the ongoing release of strong trial data, it is likely to attract acquisition interest from players seeking to strengthen their cell therapy portfolios as they transition toward next-generation platforms.

Management Team

The company's leadership combines clinical development expertise with strong financial and strategic oversight across both large-cap biopharma and emerging biotechnology platforms. The executive team brings extensive experience in oncology and immuno-oncology across all stages of development, including involvement in multiple regulatory approvals and commercialized products.

Leslie Chong - CEO & Managing Director

Ms. Chong is the CEO & Managing Director at Imugene Ltd. and brings over 28 years of oncology clinical development experience across Phase I–III programs, including leadership involvement in two commercialized products. She previously served as Senior Clinical Program Lead at Genentech, Inc., a leading oncology-focused biotech known for therapies such as Herceptin. She holds a B.Sc. in Biology from the University of North Carolina at Greensboro and a Master of Fine Arts (MFA) from the University of North Carolina system.

Paul Hopper - Executive Chairman

Mr. Paul Hopper is the Executive Chairman at Imugene with over 25 years of experience across the biotech, healthcare, and life sciences sectors, with a focus on start-up and high-growth companies. He has served as Founder, Chairman, CEO, or non-executive director across more than fifteen companies globally, including Imugene, Radiopharm Theranostics, Chimeric Therapeutics, Viralytics, Prescient Therapeutics, and Polynoma. His experience spans capital raising across the U.S., Australia, Asia, and Europe, alongside deep expertise in corporate governance, strategy, and financial oversight. He holds a B.A. in Political Science from UNSW and has completed the YPO Advanced Management programs at Harvard Business School.

Ursula McCurry - Chief Clinical Operations Officer

Ms. Ursula McCurry is the Chief Clinical Operations Officer at Imugene. She brings over 20 years of global clinical development experience across biotech and pharmaceutical companies, including Genentech, Inc., Exelixis, Astex, QLT Inc, and Amunix Pharmaceuticals. She has led clinical operations across all phases of development, contributing to over 20 programs and multiple regulatory approvals, with additional expertise in partnership management and pharmacovigilance. Prior to joining Imugene, she served as Clinical Program Director at Genentech, leading programs including taselisib and GDC-9545 through late-stage development. She holds an M.A. from Simon Fraser University and a certificate in Biotechnology, Clinical Trial Design and Management from San Francisco State University.

Dr. John Byon – Chief Medical Officer

Dr. John Byon is the Chief Medical Officer at Imugene Limited. He brings deep oncology drug development expertise spanning immuno-oncology and next-generation cell therapies, with experience across both large-cap biopharma and emerging biotech platforms. He began at Genentech, Inc., contributing to Tecentriq in hematologic malignancies, followed by roles at Juno Therapeutics and Lyell Immunopharma in cell therapy development. Most recently, he served as VP, Clinical Development at Fate Therapeutics. He holds a B.S. from Massachusetts Institute of Technology, a Ph.D. in Physiology from Tulane University, and an M.D. from Tulane University School of Medicine.

Darren Keamy - Chief Financial Officer and Company Secretary

Mr. Darren Keamy is the CFO and Company Secretary at Imugene Limited. He brings over 25 years of experience in corporate finance, financial strategy, and investor relations within the biopharmaceutical sector. Prior to joining Imugene, he served as CFO and Company Secretary at Clinuvel Pharmaceuticals Ltd from 2005 to 2024, where he played a key role in scaling the business from a start-up to a profitable, multinational ASX-listed company. He holds a Bachelor of Commerce in Accounting from La Trobe University, is a Certified Practicing Accountant through CPA Australia, and has completed a Graduate Diploma in Applied Corporate Governance from the Governance Institute of Australia.

At the board and advisory level, the company benefits from experienced industry operators and globally recognized clinicians, providing expertise across capital formation, strategic partnerships, and advanced therapeutic modalities such as cell therapy and immunotherapy, supporting execution across clinical and strategic priorities.

Executive	Role	Overview
Dr. Jakob Dupont	Non-Executive Director	Was part of the breast cancer franchise at Genentech/Roche and serves as Global Head of R&D at Atara Biotherapeutics, with multiple CMO roles, deep expertise in oncology and cell therapy, and a strong track record across IPOs, capital raises, and strategic partnerships.
Kim Drapkin	Non-Executive Director	Finance executive with over 25 years in biotech, including CFO of Jounce Therapeutics and board member at Acumen Pharmaceuticals, with expertise in capital markets and financial strategy.
Dr. Lesley Russell	Non-Executive Director	Biopharma leader with over 25 years of global experience across oncology and hematology, including roles at Amgen, Eli Lilly, and Teva Pharmaceuticals.

Financials and Forecast Assumptions

Imugene's historical financials demonstrates its current positioning as a clinical-stage biotechnology company, characterized by zero revenue generation and sustained operating losses driven by high R&D investment. For the year ended June 2025, the company reported Research & Development (R&D) expenses of A$46.7 million and General & Administrative (G&A) expenses of A$27.8 million, resulting in an operating

loss of $70.9 million and a net loss of A$69.0 million.[18] More recent half-yearly results (December 2025) indicate continued pipeline investment, with R&D expenses of A$30.5 million, G&A of A$8.5 million, and a net loss of A$37.8 million.[19] Operating cash burn for the year ended June 2025 and the nine months ended March 2026 was reported at A$75.6 million and A$35.6 million, respectively. For the year ended June 2025, azer-cel accounted for approximately 47% of total R&D expenses, highlighting a clear focus on the company's key value-driving asset. The company reported cash balance of A$5.96 million as of March 2026. In addition, the company recently concluded a A$16 million capital raise via placement and SPP initiated in March 2026, aimed at strengthening its balance sheet and supporting ongoing clinical development, particularly across its azer-cel program and broader pipeline.[20] Overall, Imugene's financial profile should be viewed through the lens of a pipeline-driven investment model, where near-term valuation is not anchored to current earnings, but rather to the probability-weighted future cash flows of its core asset, azer-cel.

In this context, the company has increasingly prioritized capital allocation toward a narrower set of high-value programs, with a clear strategic focus emerging around azer-cel. During the period, Imugene entered into a collaboration with JW Therapeutics to evaluate a combination of its onCARlytics (CF33-CD19) platform with JW's CD19 CAR-T therapy, Carteyva®. As part of this strategic realignment, the company has elected to transition the onCARlytics program toward a partnership-led model, rather than continuing standalone internal development. This approach is expected to reduce capital intensity while allowing management to redirect resources toward advancing azer-cel. More broadly, the company has indicated its intention to pursue out-licensing or joint venture opportunities for CF33 and onCARlytics, further indicating a shift toward a capital-efficient model. This development is further reflected in broader cost optimization measures, including a reduction in employee headcount to approximately 15 in H1 FY 2026 (less than half the prior corresponding period), supported by a lean consultant base, alongside material rationalization of clinical trial and research expenditures with increased focus on advancing core, value-driving assets. Given the focus only on core assets and prioritization of resources, we model normalization of cash burn in the near term. Importantly, recent investor presentations and corporate communications have increasingly centered on azer-cel as the primary value driver, highlighting its clinical progress, regulatory positioning, and scalability advantages. Taken together, these developments suggest a deliberate strategic pivot to concentrate financial and operational resources on azer-cel while leveraging partnerships to advance non-core assets.

Management has signaled a deprioritization of non-core assets, shifting toward partnerships and out-licensing rather than internal clinical development

In line with these evolving dynamics, we have refined our forecasting framework to reflect a more focused approach centered exclusively on azer-cel, reflecting its position as the company's lead asset and primary driver of value. Azer-cel is the only program with meaningful clinical data, an emerging efficacy and safety profile, and a developing regulatory pathway that supports forward-looking financial modeling. Our revised model incorporates updated assumptions about the patient population, treatment penetration, pricing, and the probability of success.

[18] Company Filings
[19] Company Filings
[20] Company Press Release

Asset	KPIs	Rationale
Azer-cel	Indication	R/R DLBCL
	Development Stage	Phase 1b
	Markets	U.S., Europe. Australia, New Zealand, Japan, and South Korea
	Estimated Patent Expiry	2040
	Patient Population Estimation	Based on NHL incidence, we estimate that approximately 35% of cases are DLBCL. Of the patients treated in the first-line setting, we estimate that 40% progress to second-line and subsequent therapies (2L+), forming the core addressable population for advanced treatments. Within this cohort, we assume that 76% of patients receive treatment, of which an assumed 50% will be CAR-T therapies, while the remaining 50% are assumed to be treated with alternative modalities.
	Price Estimates	The current product cost of CAR-T therapy ranges from $400,000 - $500,000, primarily reflecting autologous products. To account for the expected cost advantages of allogeneic approaches, we apply an approximate discount of 20%, arriving at an estimated U.S. pricing of $350,000. For ex-U.S. markets, we apply an additional 25% discount to reflect differences in healthcare pricing dynamics, including lower reimbursement levels, government pricing controls, and reduced per-patient spending capacity, resulting in an estimated price of $262,500 across international markets.
	Penetration Rate	Of the clinically eligible CAR-T population, only 25% currently receive therapy. We expect this penetration to increase meaningfully following the introduction of allogeneic CAR-T therapies. Accordingly, we assume 50% eligible patients are treated with CAR-T, with a growing share attributable to allogeneic platforms. Within this framework, we model azer-cel achieving 25% peak penetration for U.S. markets and 20% for other markets, supported by its off-the-shelf profile and scalability advantages. This assumption also incorporates expansion into earlier lines of therapy, as the company broadens its clinical focus beyond the current 3L+ setting.
	Probability of Success	We have assumed a probability of success (PoS) of 30%, modestly above typical Phase 1 benchmarks, reflecting azer-cel's progression into Phase 1b and encouraging early clinical signals. This is supported by validated CD19 biology, prior proof-of-concept data, and established CAR-T mechanisms, alongside regulatory support such as Fast Track designation and a well-defined development pathway in R/R DLBCL

Exhibit 11: Core-Pipeline Asset Forecast Assumptions. Source: Diamond Equity Research

Valuation

Imugene's investment proposition is centered on the azer-cel as the primary value driver, supported by both asset-specific de-risking and favorable industry dynamics within the CAR-T landscape. azer-cel's allogeneic, off-the-shelf approach addresses key structural limitations of autologous CAR-T therapies, including manufacturing delays, limited accessibility, and suboptimal real-world penetration, positioning it to expand the treated patient pool rather than merely compete for market share. Early clinical data demonstrating robust response rates in heavily pre-treated populations, combined with a manageable safety profile and regulatory support (Fast Track designation), provide initial validation of the platform. Notably, azer-cel's efficacy has been observed to be comparable to, and in certain cohorts potentially competitive with, FDA-approved autologous CAR-T therapies, despite being evaluated in a more heavily pre-treated and clinically challenging patient population. At the same time, recent strategic actions, including pipeline prioritization, cost rationalization, and partnership-led development of non-core assets, indicate a clear shift toward a capital-efficient, azer-cel-led strategy, supporting its central role in the company's valuation.

Key Catalysts and Milestones

- Continued Phase 1b data readouts across CAR-T naive, relapsed/refractory, and BTKi combination cohorts.
- Expansion into earlier lines of therapy (2L+) increases the addressable patient population.
- Ongoing FDA engagement and potential for accelerated approval pathways and additional regulatory designations.
- Manufacturing scale-up and validation of the allogeneic supply chain

We value Imugene using a probability-adjusted discounted cash flow (DCF) framework, with azer-cel as the principal driver of valuation. A probability of success (PoS) has been incorporated at the revenue build level to derive a blended PoS, which is then applied to discounted cash flows. We use a discount rate of 12.0% and assume no terminal value, based on the finite visibility of pipeline cash flows. Our discount rate assumption is broadly in line with industry benchmarks for similarly staged biotechnology companies and captures a balance between the company's early-stage risk profile and the partial de-risking achieved through encouraging clinical data, validated CD19 biology, and regulatory support. In addition, we complement our DCF approach with a comparable company analysis, using P/B and P/R&D multiples as reference points to benchmark valuation against relevant peers. We assign a 90% weighting to DCF and the remaining 10% to comparable analysis, given the asset-driven nature of the business. Based on this blended framework, we derive an illustrative valuation of A$0.43 per share, contingent on successful execution by the company.

Overall, our valuation framework reflects a concentrated, azer-cel-led investment case, where the value is derived from the successful advancement of a single lead asset. In our view, Imugene offers a high-risk, high-reward opportunity, with meaningful upside if azer-cel continues to validate its clinical profile and progress toward the Phase 3 registrational pathway. Conversely, as is typical for development-stage biotechnology companies, valuation remains highly sensitive to clinical execution, regulatory progress, and funding discipline.

Approaches	Value (AUD)	Weight	Wtd. Value (AUD)
DCF	183,944,873	90%	166,550,386
GPCM	142,010,441	10%	14,201,044
Wtd. Avg. Equity Value			179,751,430
No of Shares			415,835,040
Intrinsic Value Per Share			0.43

Discount Rate	
	12.00%
Terminal Growth Rate	
	-

Enterprise Value	A$173,164,873
Financial Debt and Minority Interest	A$4,803,000
Cash and Cash Equivalents	A$15,583,000
Value of Equity	A$183,944,873
Number of Shares Outstanding	415,835,040
Equity Value Per Share	A$0.44

Company	Ticker	Currency	Country	Market Cap. (in mm)	P/B*	P/R&D#
Allogene Therapeutics, Inc.	ALLO	USD	United States	745.96	2.40	4.97
Cellectis S.A.	ALCLS	EUR	France	268.59	4.10	3.36
Caribou Biosciences, Inc.	CRBU	USD	United States	188.44	1.50	1.72
Fate Therapeutics, Inc.	FATE	USD	United States	152.31	0.70	1.41
Oncolytics Biotech Inc.	ONCY	USD	Canada	121.93	n.a.	9.16
Adicet Bio, Inc.	ACET	USD	United States	68.26	0.40	0.69
Atara Biotherapeutics, Inc.	ATRA	USD	United States	39.99	n.a.	1.07
Celularity Inc.	CELU	USD	United States	36.91	n.a.	2.38
Average					**1.82**	**3.10**
Median					**1.50**	**2.05**

Exhibit 12: Valuation Summary. Source: Diamond Equity Research

#The valuation multiples are based on the TTM basis.

Appendix

Year-end 30TH June (in A$)	2024A	2025A	2026E	2027E	2028E
INCOME STATEMENT					
Revenue	-	-	-	-	-
Cost of Sales (Depletion)	-	-	-	-	-
Gross Profit	**-**	**-**	**-**	**-**	**-**
Operating expenses					
General and administrative exp.	(59,906,919)	(27,769,555)	(18,050,211)	(14,440,169)	(15,162,177)
Research and Development	(86,885,484)	(46,691,367)	(45,757,540)	(32,030,278)	(33,631,792)
Total Operating Expenses	(146,792,403)	(74,460,922)	(63,807,751)	(46,470,446)	(48,793,969)
Income From Operations	(146,792,403)	(74,460,922)	(63,807,751)	(46,470,446)	(48,793,969)
Interest and Other Inc. / Exp.	(2,888,136)	5,439,310	3,583,441	2,310,479	669,686
Profit Before Tax (PBT)	(149,680,539)	(69,021,612)	(60,224,310)	(44,159,967)	(48,124,283)
Profit After Tax (PAT)	(149,680,539)	(69,021,612)	(60,224,310)	(44,159,967)	(48,124,283)
Basic Shares Outstanding	208,494,300	218,703,200	371,795,440	483,334,072	555,834,183
EPS - basic	(0.72)	(0.32)	(0.16)	(0.09)	(0.09)
BALANCE SHEET					
Cash and cash equivalents	93,107,5380	21,935,432	14,114,129	2,065,232	10,464,619
Other current assets	19,926,273	19,809,194	19,809,194	19,809,194	19,809,194
Total current assets	113,033,811	41,744,626	33,923,323	21,874,426	30,273,813
Non-current assets	38,364,006	41,843,051	39,082,698	36,247,344	33,336,991
Total Assets	**151,397,817**	**83,587,677**	**73,006,021**	**58,121,770**	**63,610,804**
Short-term borrowing	-	6,666,667	6,666,667	6,666,667	6,666,667
Other current liabilities	29,298,575	15,483,803	19,711,393	15,377,068	15,957,948
Total current liabilities	29,298,575	22,150,470	26,378,060	22,043,734	22,624,615
Long-term borrowing	-	2,582,333	2,582,333	2,582,333	2,582,333
Other non-current liabilities	3,844,835	13,822,541	16,404,874	16,404,874	16,404,874
Total liabilities	33,143,410	38,555.344	42,782,935	38,448,609	39,029,489
Total Equity	118,254,407	45,032,333	30,223,086	19,673,162	24,581,315
Total Liabilities & Equity	**151,397,817**	**83,587,677**	**73,006,021**	**58,121,770**	**63,610,804**
CASH FLOW STATEMENT					
Cash Flow from Operating	(101,726,143)	(75,568,516)	(48,616,866)	(42,257,863)	(40,761,345)
Cash Flow from Investing	(7,250,386)	(12,698,635)	1,145,157	558,559	(489,674)
Cash Flow from Financing	49,428,222	17,371,435	40,000,000	30,000,000	50,000,000
Increase (decrease) in cash	**(59,548,307)**	**(70,895,716)**	**(7,821,303)**	**(12,048,897)**	**8,399,387**
Cash at the end of period	**93,107,538**	**21,935,432**	**14,114,129**	**2,065,232**	**14,464,619**

Exhibit 13: Financial Statement Snapshot.
Source: Diamond Equity Research

Risk Profile

Clinical and Translational Risk: The investment case is heavily dependent on the successful clinical progression of azer-cel. While early-stage data are encouraging, they are derived from small, uncontrolled cohorts. There is a material risk that efficacy, durability, or safety outcomes may not be replicated in larger, randomized trials, particularly as the program advances toward registrational studies.

Regulatory Pathway Risk: Despite FDA alignment on a potential registrational pathway, including a single Phase 3 study design, regulatory outcomes remain uncertain. Failure to meet agreed endpoints, changes in regulatory expectations, or delays in trial execution could materially impact timelines and approval probability.

Execution and Trial Expansion Risk: The expansion of azer-cel across multiple cohorts (CAR T-relapsed, CAR T-naïve, and combination arms) increases operational complexity. Delays in patient recruitment, site activation, or protocol amendments could extend development timelines and increase capital requirements.

Manufacturing and Scalability Risk: Although the allogeneic model offers scalability advantages, commercial manufacturing of cell therapies remains technically complex. The company must demonstrate consistent, regulatory-compliant production at scale. Any issues related to process validation, comparability, or supply chain could delay commercialization.

Competitive and Modality Risk: The CD19 treatment landscape is highly competitive, with approved autologous CAR T therapies and emerging alternatives such as bispecific antibodies. Additionally, other allogeneic CAR T programs are in development. Superior efficacy, safety, or logistical advantages will be required to achieve meaningful market penetration.

Combination Strategy Risk: The BTKi combination strategy introduces incremental scientific and regulatory risk. While the mechanistic rationale is strong, clinical validation is limited, and failure to demonstrate an additive benefit could constrain expansion into broader indications.

Pipeline Concentration Risk: Near- to medium-term value is primarily driven by azer-cel. Any adverse clinical or regulatory developments related to this program would have a disproportionate impact on the company's valuation.

Financing and Dilution Risk: As a clinical-stage company, Imugene is expected to require additional capital to fund ongoing trials and manufacturing scale-up. Future equity raises may result in dilution, particularly if conducted prior to key value inflection points.

Early-Stage Pipeline Risk: Other programs, including CF33 oncolytic viruses and B-cell vaccines, remain in early stages of development and carry higher scientific and commercial uncertainty, though they are not currently primary valuation drivers.

This list of risk factors is not comprehensive. For a full list risk factors, please read Imugene's latest prospectus and/or annual filings

Disclosures

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