IMUGENE

Developing Cancer Immunotherapies

ASX:IMU

Innovation in Cancer Treatment

March 2026

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Developing Cancer Immunotherapies

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Executive Summary

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Azer-cel is an off-the-shelf CAR-T therapy with compelling efficacy, regulatory clarity, and multiple capital-efficient paths to market

Compelling efficacy in advanced disease (Cohort 1)	• 82% ORR (14/17) in 3L+ DLBCL, including heavily pre-treated patients • ~50% failed bispecific therapies and prior autologous CAR-T • Compares favorably to approved autologous CAR-T therapies in earlier lines
Clear, derisked regulatory pathway	• Positive Type C meeting confirms regulatory and manufacturing pathway
Capital-efficient path to market (Cohort 2)	• CAR T Naïve patient population with rare / niche indications enable smaller, single-arm registrational studies (previously reported 83% ORR in basket study) • Strong overall response rate of 100% in CLL and 80% in MZL • Faster timelines and significantly lower development cost
Multiple upside options (Cohort 3)	• Planned Bruton Tyrosine Kinase inhibitor (BTKi) combination cohort leveraging a >$10bn therapeutic class • Provides optionality across registrational and commercial strategies
Disciplined capital management	• Active prioritisation of value-driving programs • Reduction in headcount and operating costs • Wind-down of non-core programs to extend cash runway and focus resources on azer-cel

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Azer-cel Overview

How is Imugene different? Allogeneic vs Autologous CAR-T

Allo CAR T Cell Therapy
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Allogeneic CAR-T Cell Therapy is significantly differentiated from approved Autologous CAR-T therapies on cost and wait times

	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

Autologous

1. Collection from cancer patient

- T-Cells extracted from **patient's blood**

2. Genetic Modification

- T-cells reprogrammed into CD19 CAR-T cells (19-42 days wait)

3. Infusion back into patient

- Modified T cells are multiplied in large numbers and infused **back into the patient**

- Reprogrammed T-cells targets and destroys cancer cells

Allogeneic

1. Collection from <u>healthy</u> donor

- T-Cells extracted from the **blood of a <u>HEALTHY UNIVERSAL donor</u>**

2. Genetic Modification

- T cells reprogrammed into CD19 CAR-T cells

3. Infusion into multiple patients

- Modified T cells are multiplied in large numbers and available for **<u>MANY</u>** patients

- Reprogrammed T-cells targets and destroys cancer cells

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

Introducing azer-cel

Allo CAR T Cell Therapy
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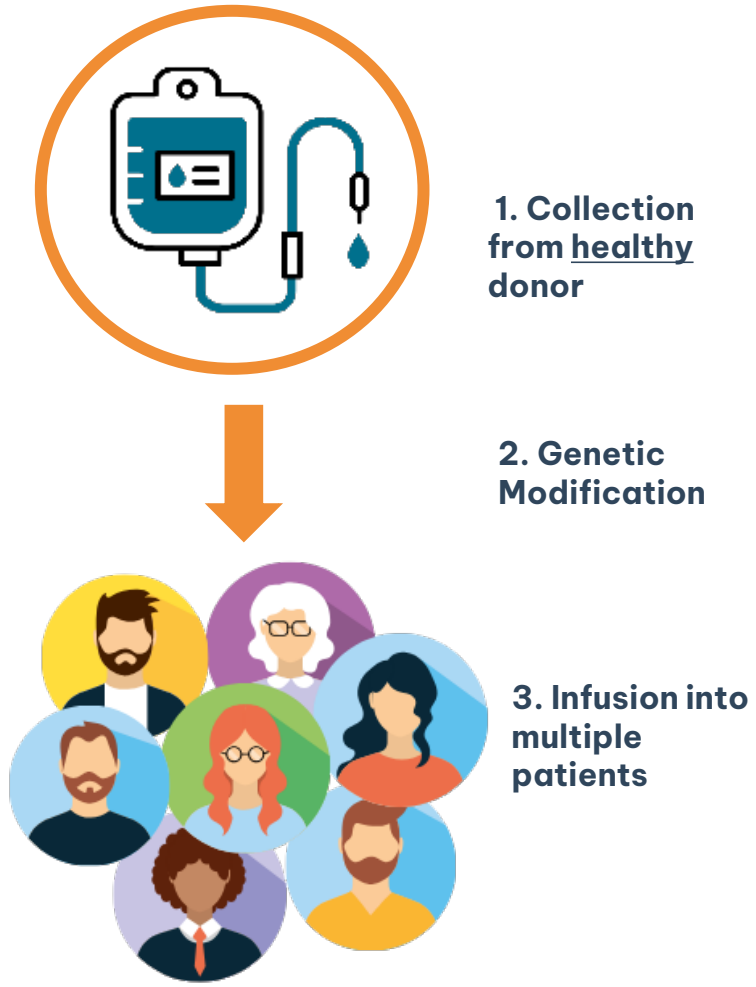
Imugene's potential first-in-class, off-the-shelf Allogeneic CAR-T Cell Therapy, with initial indications in Autologous CAR-T failed DLBCL and several CAR-T naïve lymphomas

1. **"Off-the-shelf" CD19 Allogeneic CAR-T**
2. Addresses high and growing unmet need post-autologous CAR-T treatment in DLBCL, other CAR-T naïve and BTKi combination in blood cancers
3. Current Phase 1b study enrolling at leading US and Australian centres
4. Fast Track Designation received, allows for greater FDA engagement and priority review. **FDA support for registrational pathway received Nov 2025**



[1]https://ascopost.com/news/november-2023/novel-strategy-may-improve-outcomes-in-patients-with-treatment-resistant-dlbcl/
DLBCL: Diffuse Large B-cell Lymphoma

Azer-cel Commercialization Opportunity

Allo CAR T Cell Therapy
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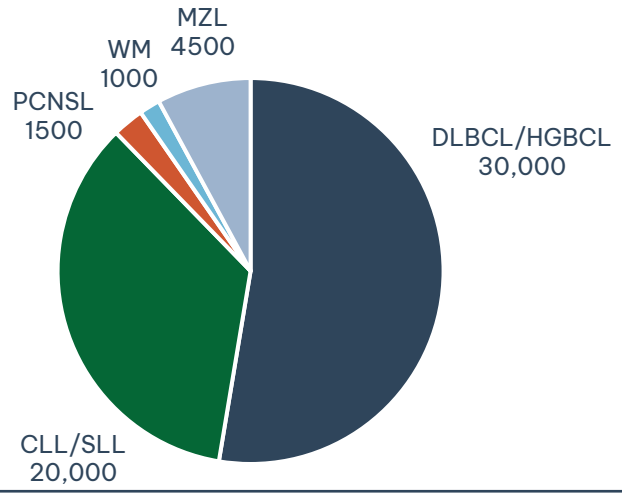
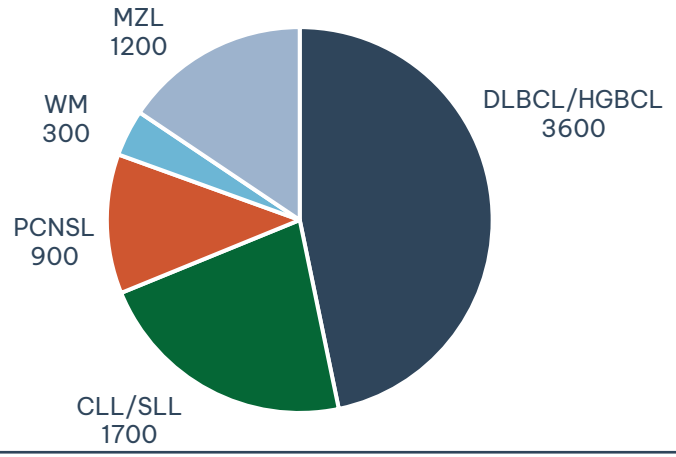
$3bn+ p.a. US potential market opportunity in rare & niche indications and 3L+ DLBCL

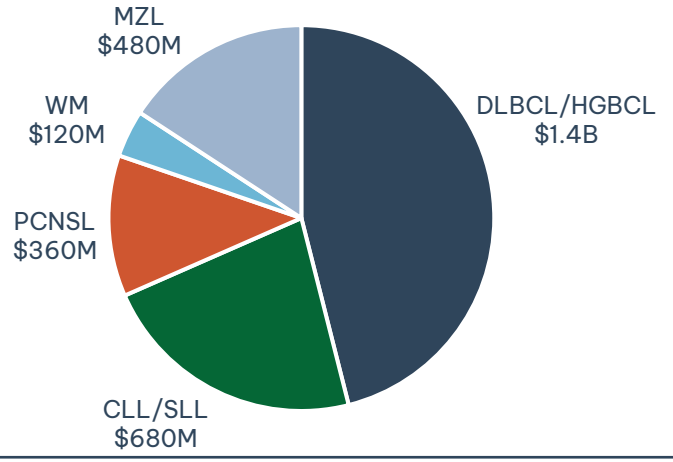
US INCIDENCE [1]



ELIGIBLE FOR CAR-T [2]



AZER CEL MARKET OPPORTUNITY [3]



Azer-cel: Commercial Opportunity may leverage a De-risked Regulatory Roadmap

- Azer-cel Targets High-Need Indications for Single-Arm Registrational/Pivotal Trial: Ideal for pursuing accelerated approval without comparators.
- Prioritizing Fast-to-Market Opportunities: azer-cel is positioned to leverage other high-need, less comparator-intensive indications for faster-to-market entry, using DLBCL to support broader development.
- Promising Niche Indications with Strong Commercial and Regulatory Potential
- A $2B+ Market Built on Strategically Chosen, Comparator-Free Indications: azer-cel's commercial roadmap is to prioritize rapid regulatory path with capital-efficient development for fast to market entry.

1. SEER 2020 Estimate; numbers of potential patients
2. NCCN guidelines, ASH, Peer-reviewed literature & CAR-T clinical trials; Assumes 3L+ for DLBCL and 2L+3L for all other cancers
3. TAM: total addressable market is total number of treatable patients x price (assumes $400,000/dose) at 100% market share. TAM is a potential market only and depends upon regulatory approval, successful commercialization, market share and timing

PCNSL = Primary Central Nervous System Lymphoma (≥1 prior line of therapy containing high-dose MTX)
CLL/SLL = Chronic or Small Lymphocytic Leukemia (Prior BTKi and BCL2i or only prior BTKi and high-risk features)
DLBCL = Diffuse Large B-cell Lymphoma (≥1 prior line of therapy, including anti-CD20 + anthracycline)
MZL = Marginal Zone Lymphoma (≥2L of prior therapy, including anti-CD20 chemoimmunotherapy)
WM = Waldenstrom's Macroglobulinemia (≥2L of prior therapy, including anti-CD20 chemoimmunotherapy)

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Azer-cel in DLBCL

Azer-cel has shown 82% Overall Response Rate in DLBCL patients

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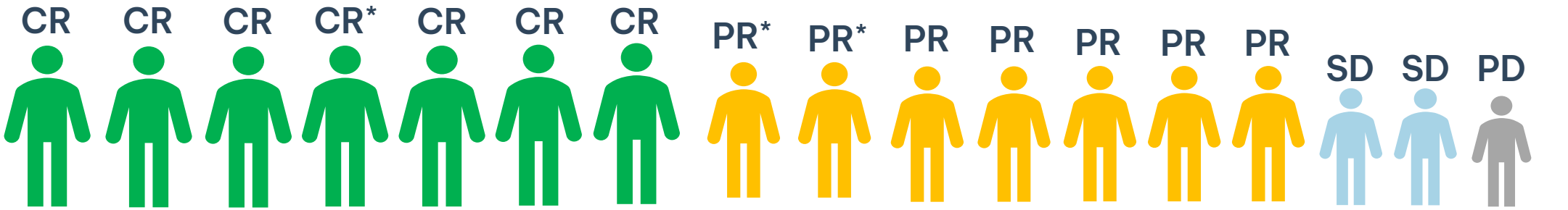
Azer-cel has delivered promising results in 3L+ DLBCL CAR-T relapsed patients

FINDINGS

- 82% Overall Response Rate (14/17 evaluable patients) observed in relapsed/refractory DLBCL patients who had failed prior autologous CAR-T therapy
- Among 17 evaluable patients, 7 achieved a Complete Response (CR) and 7 achieved a Partial Response (PR)

R/R DLBCL Best Response



- Overall Response Rate (ORR): the proportion of patients whose cancer shrinks or disappears after treatment - a measure of how well a treatment is working, specifically in clinical trials
- Complete Response (CR): all measurable or visible signs of cancer are no longer detectable after treatment
- Partial Response (PR): Significant reduction in tumor size (typically at least 50%) or disease burden, but not complete disappearance of the disease
- Durability of Response (DoR): a measure of how long a treatment effect lasts, meaning the cancer remains controlled for a significant period

*Allo transplant patients
Lymphoma response evaluation in hematologic (blood) cancers uses disease-specific criteria: Lugano Classification (2014, updated guidance)

Compelling Cohort 1 Phase 1b data in DLBCL to date

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82% Overall Response Rate in Relapsed/Refractory (R/R) DLBCL

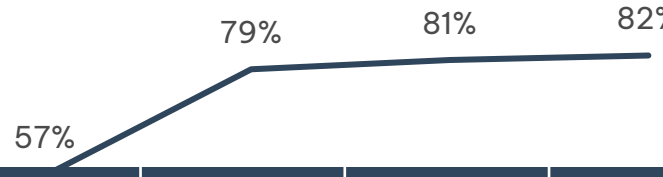
Cohort 1 of the Phase 1b study evaluates azer-cel in heavily pre-treated 3L+ patients with R/R DLBCL, including patients who have failed prior autologous CAR-T therapy

KEY TAKEAWAYS

2025 American Society Hematology (ASH) oral presentation

- Phase 1b trial continues to enrol patients across leading cancer centers in the US and Australia
- Responses were seen in patients who failed multiple prior treatments, including autologous CAR-T therapy with approximately 50% additionally failing bispecific therapies
- Highly encouraging data in patient population with significant unmet need
  - 14 out of 17 patients have achieved ORR of 82%, defined as either CR or PR
  - Excellent CAR-T expansion and evidence of persistence > 90 days;
  - Best durability of response as of February 2026, 22+ months and ongoing
- Good Safety profile / consistent with autologous CAR-T therapies
  - Well-tolerated with low rates of Grade 3 or higher CRS[1] or ICANS[2]
- Received Fast Track Designation for DLBCL

Overall Response rate



	February	August	September	December
Number of Patients	4/7	11/14	13/16	14/17
Best Durability (time of response)	>10 months on going	>15 months on going	>17 months on going	>19 months on going

Evaluable Patients	Treatment
DLBCL	Lymphodepletion (LD)[3] +azer-cel +Interleukin-2 (IL-2)

CR rate assessment requires longer patient follow-up: for approved, autologous CD19 CART products, the average time to best response is 2-3 months with some patients taking up to 6 months to achieve their best response

[1]CRS: Cytokine release syndrome
[2]ICANS: Immune Effector Cell-Associated Neurotoxicity Syndrome
[3]Lymphodepletion(LD)/chemotherapy: Aug Cy: Flu 30mg/m2 x 3d, Cy 750mg/m2 x 3d

Azer-cel compared to existing Approved Auto CAR-T Therapies

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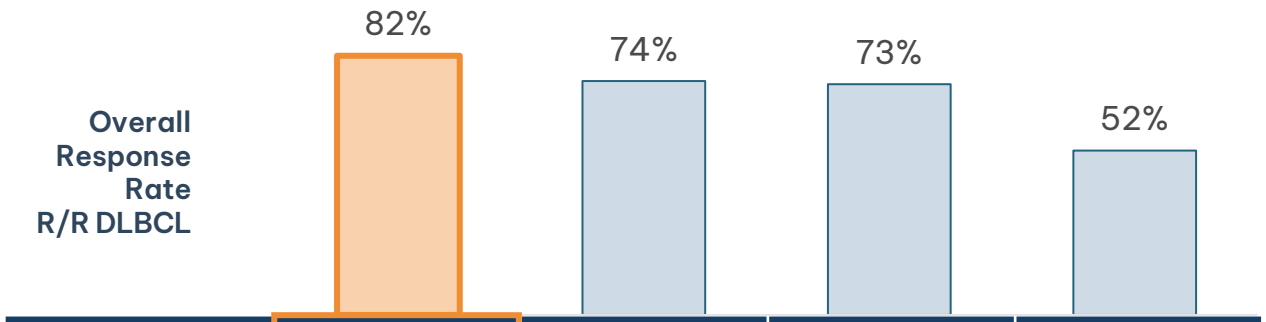
Initial azer-cel Ph 1b R/R DLBCL data is compelling when compared to approved Auto CAR-T treatments

Azer-cel is comparable to approved Auto CAR-Ts for treatment of DLBCL 2L+ of therapy[1]



Product	azer-cel allo CAR-T	Yescarta (Axi-cel)	Kymriah (Liso-cel)	Breyanzi (Tisa-cel)
Indication	**Adult r/r DLBCL 3L+ therapy**	Adult r/r DLBCL ≥2 prior lines	Adult r/r DLBCL ≥2 prior lines	Adult r/r DLBCL ≥2 prior lines
Complete response (CR) rate at day 60[2]	**45%-60%***	54%	40%	53%
Median Durability of Response[3] (DoR)	**22+ months and ongoing**	~11 months	~10.3 months	~16.7 months

Best DoR – median not yet available

*CR % may vary with ongoing enrolment and time to best response

Despite all patients failing prior Autologous CD19 CART products and approximately 50% failing bispecific therapies, azer-cel demonstrates Response Rates similar to CD19 CART-naïve patients.

[1]Company announcements and FDA.gov
[2]Initial response at D28 of PR, which improved to CR at later date. For approved, autologous CD19 CART products, the average time to best response is 2-3 months. Outcomes of CD19-Directed Chimeric Antigen Receptor T Cell Therapy for Transformed Nonfollicular Lymphoma.Dong, Ning et al.Transplantation and Cellular Therapy, Official Publication of the American Society for Transplantation and Cellular Therapy, Volume 29, Issue 6, 349.e1 - 349.e8
[3]Azer-cel Complete Response rate and median DoR can not yet be accurately determined as trial and patients are ongoing

Patient Case Study: Cancer Free for 22+ months

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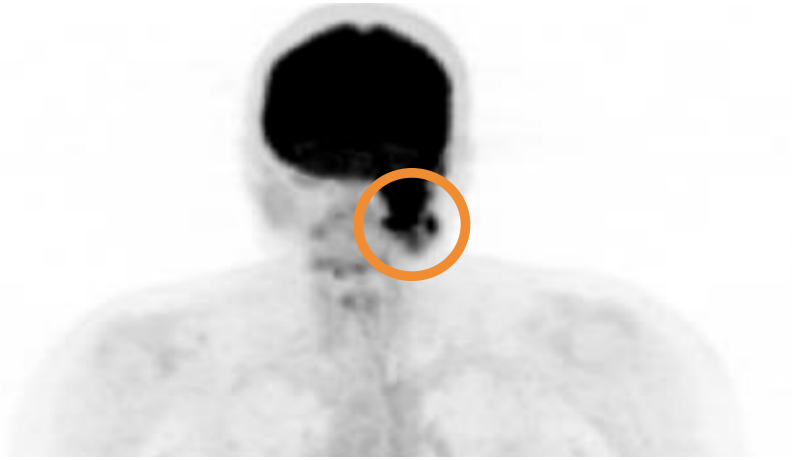
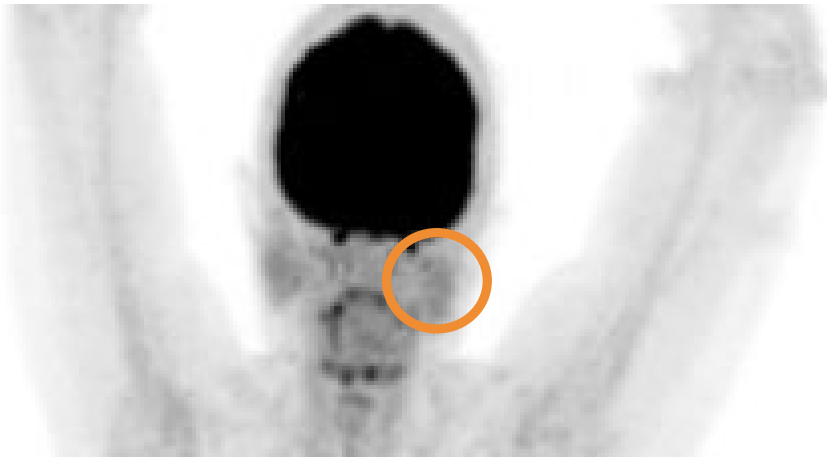
Complete Response for an azer-cel patient that failed 4 prior lines of therapy including autologous CAR-T. Durability of Response now out to 22+ months and patient currently remains cancer free

Tumor



Baseline

Tumor-free



Day 365

PATIENT TREATMENT SUMMARY

- 47 yo female, first diagnosed with high-grade B-cell lymphoma (HGBCL), stage IV in July 2022.
- Prior to azer-cel, **patient failed 4 prior lines of therapy**: R-CHOP (chemo combo); R-DHAP (chemo combo), Yescarta (Auto CAR-T), and prednisone
- Good initial response to Yescarta (CR) but short duration of response (relapsed ~7 months later)
- **Response:** CR @ D28. Remains in CR at greater than 22+ months and ongoing

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Azer-cel Registrational Opportunity

Cohort 2: CAR-T naïve patients show strong overall response rate of 100% in CLL and 80% in MZL

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Cohort 2: Evaluates azer-cel in CAR-T naïve patients across rare and niche lymphomas

Evaluable patients	N	Overall Response Rate (ORR)
Chronic/Small Lymphocytic Leukemia (CLL/SLL) and Marginal Zone Lymphoma (MZL)	9	CLL: **4/4 (100%)** MZL: **4/5 (80%)**

CR rate assessment requires longer patient follow-up: for approved, autologous CD19 CAR-T products, the average time to best response is 2-3 months with some patients taking up to 6 months to achieve their best response

KEY TAKEAWAYS

- Limited treatment options and no approved CAR-T therapies in several of these indications
- Clear opportunity to expand into high-value niche populations
- Expands the potential registrational pathway
- **Potential for single arm pivotal study with low number of patients for Fast to Market**

RESULTS

- Basket cohort enrolling across multiple CD19+ B-cell malignancies including DLBCL, FL, CLL/SLL, MZL, WM and PCNSL (previously reported 83% ORR 5/6 patients)
- **100% Overall Response Rate** (ORR) was observed in Chronic Lymphocytic Leukemia / Small Lymphocytic Lymphoma (CLL/SLL) (4/4 PR) in patients who had received a median of ≥3 prior lines of therapy. In CLL/SLL, CRs are uncommon and ORR has supported regulatory approvals (U.S. FDA guidance).
- **80% ORR** was observed in Marginal Zone Lymphoma (MZL) (3/5 CR, 1/5 PR) in patients who had received a median of ≥2 prior lines of therapy.

*Note: To be eligible for study, all CLL pts must have received a prior BTKi and BCL2i

Cohort 2: CAR T Naïve Subset Indication

Imugene's Cohort 2 has delivered impressive early results with a 100% ORR in CLL (4/4) and 80% ORR in MZL (4/5)

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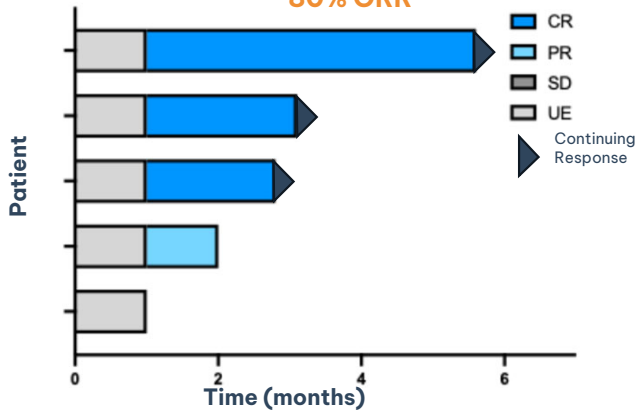
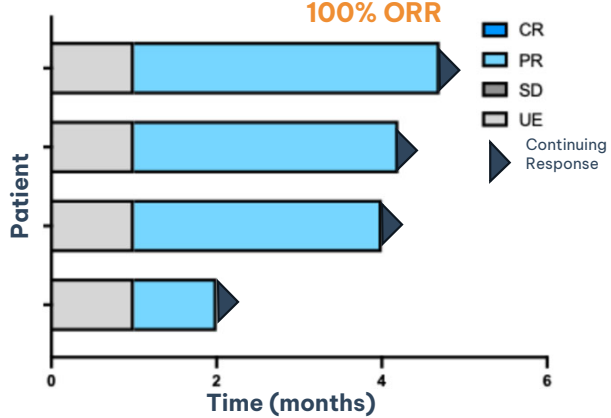
Marginal Zone Lymphoma (MZL)
80% ORR



Chronic/Small Lymphocytic Leukemia (CLL/SLL)
100% ORR



- In CLL/SLL, CRs are uncommon and ORR (including PRs) has supported regulatory approvals (U.S. FDA guidance).
- To be eligible for study, all CLL pts must have received a prior BTKi and BCL2i

EARLY DATA TRENDING FAVOURABLY IN COMPARISON TO OTHER POTENTIAL TREATMENT OPTIONS

Drug	Data	Comments
Azer-cel	ORR: 80%, CR: 60%	mPFS and mDoR ongoing
Zanubrutinib (BTKi)	ORR: 68%, CR: 26%,mPFS: 70% @ 24mo (median not reached)	Data in 3L+ (same line of therapy as azer-cel)
Liso-cel (Auto-CART)	ORR: 84%, CR: 56% mDoR Not reached	Commercial uptake TBD (66 patient cohort)

Drug	Data	Comments
Azer-cel	ORR: 100%	mPFS and mDoR ongoing
Pirtobrutinib (BTKi)	ORR: 69%, mPFS 14.1mo	sBLA for 1L submitted
Liso-cel (Auto-CART)	ORR: 48%, mPFS: 11.9mo	mDOR for PR: 23.8mo

Overall Response Rate (ORR): the percentage of patients whose cancer shrinks or disappears after treatment.

Complete Response (CR): disappearance of all detectable signs of cancer after treatment

Partial Response (PR): Significant reduction in tumour size (typically at least 50%) or disease burden, but not complete disappeared

Median Progression Free Survival (mPFS): the median time patients live without their disease worsening

Median Durability of Response (mDoR): the median time a treatment response lasts before the disease progresses.

Cohort 3: BTKi + azer-cel combination

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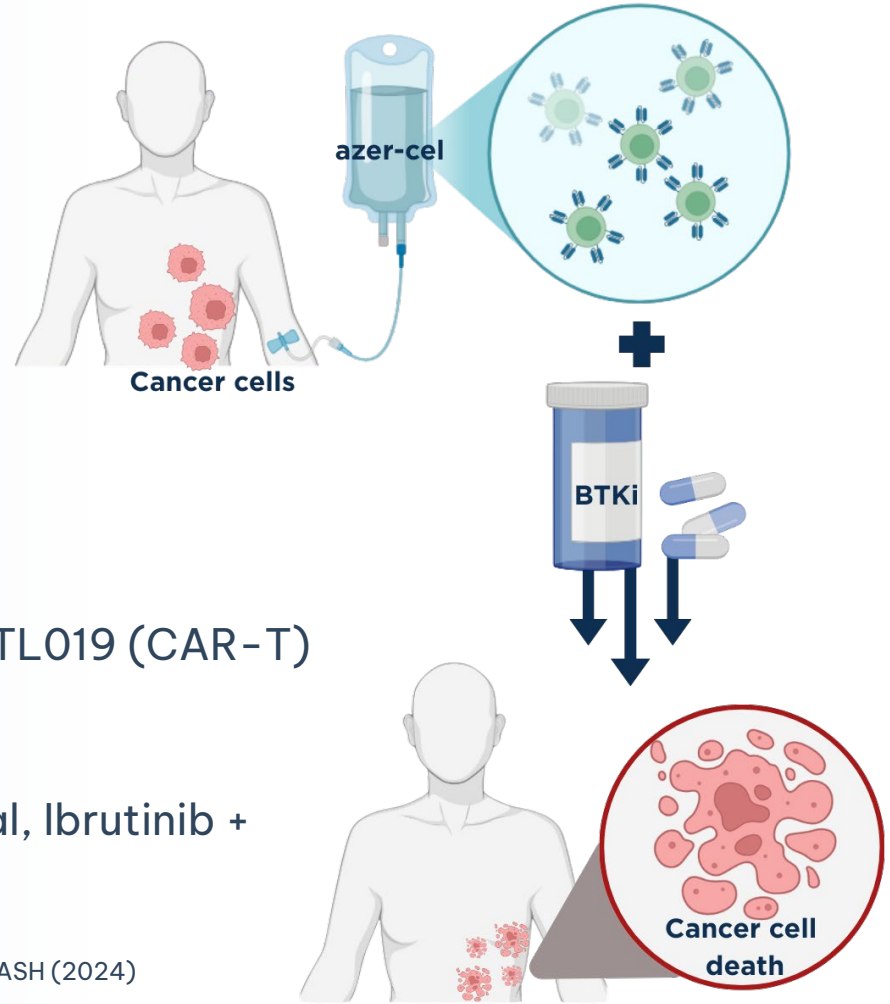
Combination Supports Expanded Registrational and Commercial Opportunity

BTK inhibitors are an established standard of care across multiple B-cell malignancies and when combined with azer-cel, BTKis:

- **Enhance CAR-T cell fitness and durability**, keeping T-cells younger, more energetic, and resistant to exhaustion over time[1,2]
- **Improves the tumor microenvironment**, making it less hostile and more supportive of sustained immune activity[2,3]



Clinical evidence of synergy

- **85% ORR / 80% CR** – TARMAC Phase 2 Trial of Ibrutinib (BTKi) + CTL019 (CAR-T) in R/R MCL[4]
- **86% ORR / 45% CR (N=51)** – TRANSCEND-CLL 004 Phase 1/2 Trial, Ibrutinib + Liso-cel (CAR-T) cohort[5]

[1]Yao et al., ASH 2025, [2]Luo et al., Cytotherapy (2023), [3]Frost et al., ASH 2024, [4]Minson et al., Blood (2024), [5]Wierda et al., ASH (2024)

CLL = Chronic Lymphocytic Leukemia, **MCL** = Mantle Cell Lymphoma

BTKi Market is Large and Growing

Combination with existing BTKi's to increase registrational and commercial opportunity

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- BTK inhibitors are an established standard of care across multiple B-cell malignancies with >US$10bn in annual global sales
- Combining azer-cel with an approved BTKi has the potential to expand addressable patient populations beyond current CAR-T settings
- Leverages an existing commercial drug class with significant physician adoption
- BTKi are currently approved in Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL), Waldenström macroglobulinemia (WM) and other B-cell malignancies and auto immune diseases

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

Proposed Clinical Pathway: Azer-cel Allogeneic CD19 CAR-T

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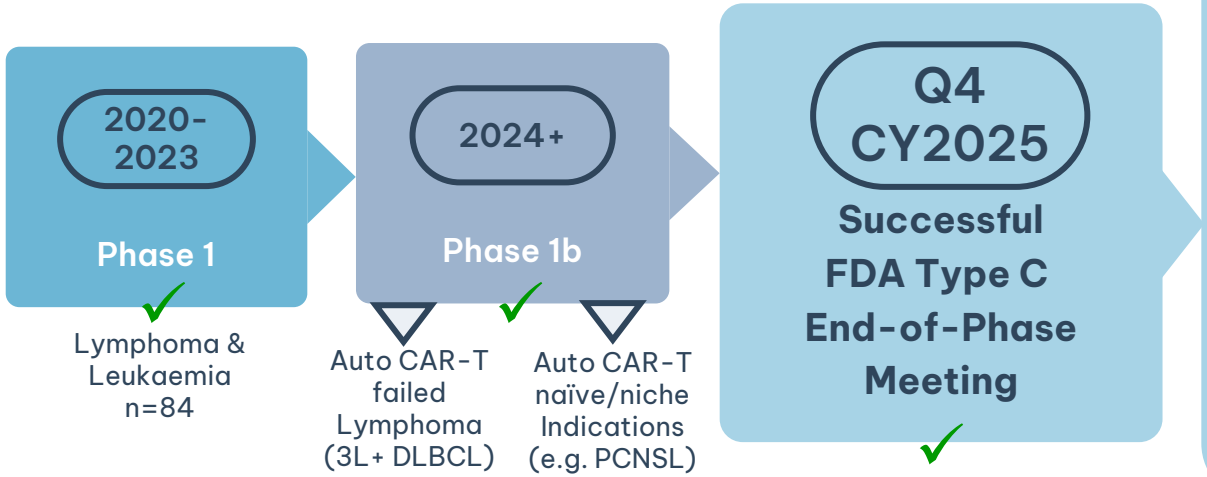
2026 Provides Opportunity to Progress Toward Registrational Strategy

- Continue advancement of azer-cel across Cohorts 1, 2 and planned Cohort 3, incorporating expansion into CAR-T naïve rare and niche indications
- Advance BTKi + azer-cel combination and CAR-T naïve lymphoma cohorts to support expanded Registrational Path
- Leverage FDA-aligned single randomized study design



2026 Execution

Clinical

- Continued enrollment and data maturation for:
  - **CAR-T naïve/ niche cohorts**
  - **BTKi + azer-cel combination cohorts**
- Additional data presentation at ASCO, EHA, ASH 2026

Manufacturing & Supply

- Scale-up and validation of registrational manufacturing
- Readiness for one-to-many allogeneic supply model
- **Continue to align our CMC activity with FDA**

Regulatory

- Continued FDA engagement to support:
  - **Accelerated approval pathway**
  - Label expansion into additional niche indications
- Potential regulatory designations to de-risk development timeline

Business Development

- Partnering / out-licensing discussion for:
  - Azer-cel (regional or indication-specific)
  - **BTKi combination strategy (major pharmaceutical blockbuster drug)**
- onCARlytics collaboration execution (JW Therapeutics)

Key Achievements & Expected Upcoming Milestones

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Recent Key Achievements

January 2025: First Aus site opened for R/R DLBCL clinical trial and first DLBCL patient dosed in AUS

February 2025: Phase 1b data update, 57% Overall Response/ Complete Response Rate Achieved in R/R DLBCL

March 2025: Fast Track Designation granted for treatment of DLBCL

July and August 2025: Release of additional Phase 1b R/R DLBCL azer-cel data

September 2025: R/R DLBCL Overall Response rate increases to 81%

October 2025: 83% Overall Response rate in CAR-T Naïve cohort

November 2025: ASH Oral Presentation

December 2025: R/R DLBCL Overall Response rate increases to 82% with best durability exceeding 19 months

December 2025: JW Therapeutics and IMU onCARlytics Collaboration

December 2025: Positive FDA Meeting feedback received supporting pathway for azer-cel registrational strategy/pivotal study, discussion for CAR-T naïve cohort

Expected Upcoming Milestones

Calendar Year 2026-2027

- **Regular and ongoing Phase 1b data on CAR-T naïve lymphoma patients and BTKi and azer-cel combination**
- Potential for FDA Fast Track, **Breakthrough and/or RMAT Designation** for additional niche blood cancer
- Initiation of manufacturing and supply for registration/pivotal study
- Initiate Activity for Registrational/Pivotal study
- FDA re-engagement
- On-going Partnering/Out-licensing Opportunities
- Potential Conference Presentations: e.g. ASCO, EHA, ASH

Key
BTKi: Bruton Tyrosine Kinase inhibitor
DLBCL: Diffuse Large B-Cell Lymphoma (Blood Cancer)
FPI: First Patient In
RMAT: Regenerative Medicine Advanced Therapy
R/R: Relapsed/Refractory

Projected timelines for trial initiation, site activation, and clinical milestones are subject to external factors beyond the Company's control, including regulatory approvals, site requirements, patient recruitment, dose escalation constraints, and expected and unexpected dose-limiting toxicities

Experienced Leadership Team and BoD has brought FDA-Approved Drugs to Market

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Executive Management Team

Leslie Chong
Chief Executive Officer & Managing Director

John Byon, MD, PhD
Chief Medical Officer

Ursula McCurry
Chief Clinical Operations Officer

Darren Keamy
Chief Financial Officer & Company Secretary

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Paul Hopper
Executive Chairman and Founder

Leslie Chong
CEO & Managing Director

Dr. Jakob Dupont, MD
Non-Executive Director

Kim Drapkin
Non-Executive Director

Dr. Lesley Russell
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