

## PERCHERON THERAPEUTICS CORPORATE PRESENTATION

**Melbourne, Australia – 18 February 2026:** Percheron Therapeutics Limited (ASX: PER) ('the Company'), an international biotechnology company focused on the development of novel therapies for oncology and rare diseases, is pleased to provide shareholders with a copy of an updated non-confidential corporate presentation. The presentation will be delivered by CEO Dr James Garner at Emergence 2026 Investment Conference to be held today at the Four Seasons Hotel Sydney.

The attached presentation supersedes the corporate presentation released to the market on 5 November 2025 and includes expanded information on the Company's lead program, HMBD-002, together with an updated overview of the Company's financial position following the release of its latest Quarterly Activities report and Appendix 4C.

~ ENDS ~

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### About Percheron Therapeutics Limited

Percheron Therapeutics Limited [ASX: PER | US OTC: PERCF] is a publicly listed biotechnology company focused on the development and commercialisation of novel therapies for oncology and rare diseases. The company's lead program is HMBD-002, a monoclonal antibody targeting the immune checkpoint regulator, VISTA. HMBD-002 has completed a phase I clinical trial in patients with advanced cancer, which has shown the drug to be generally safe and well-tolerated, and Percheron aims to commence further clinical trials in CY2026.

For more information, please contact [info@PercheronTx.com](mailto:info@PercheronTx.com).

*This announcement has been authorized for release to the Australian Securities Exchange  
by the Board of Directors.*

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# Developing a Next Generation Immune Checkpoint Inhibitor for the Treatment of Patients with Cancer

## Corporate Overview

February 2026

# Forward-Looking Statements

This presentation contains **forward-looking statements** within the meaning of the safe-harbor provisions such as the Private Securities Litigation Reform Act of 1995. These statements do not relate strictly to historical or current facts and may be accompanied by words such as ‘could,’ ‘would,’ ‘may,’ ‘potentially,’ ‘suggest,’ ‘believes,’ ‘expects,’ ‘should,’ ‘intends,’ ‘plans,’ ‘forecasts,’ and similar words or expressions.

Such statements involve substantial risks and uncertainties, not all of which may be known at the time. All statements contained in this presentation, other than statements of historical fact, including without limitation statements regarding our strategy, research and development plans, collaborations, future operations, future financial position, future revenues, projected costs, pricing, prospects, plans, and objectives of management, are forward-looking statements. Not all forward-looking statements in this presentation are explicitly identified as such.

The Company does not warrant any of the forward-looking statements in this presentation, and investors are advised to interpret such statements in the context of other available sources of information and with the assistance of expert advisors as appropriate.

Many factors could cause the actual results of the Company to differ materially from the results expressed or implied herein, and you should not place undue reliance on the forward-looking statements. Drug development is inherently risky, and only a small proportion of research and development programs lead to a marketed product. Factors which could change the Company’s expected outcomes include, without limitation, our ability to: advance the development of our programs, and to do so within any timelines that may be indicated herein; the safety and efficacy of our drug development candidates; our ability to replicate experimental data; the ongoing validity of patents covering our drug development candidates, and our freedom to operate under third party intellectual property; our ability to obtain necessary regulatory approvals; our ability to enter into and maintain partnerships, collaborations, and other business relationships necessary to the progression of our drug development candidates; changes in the competitive landscape pertaining to our drug development candidates; the timely availability of necessary capital to pursue our business objectives; changes in the public policy environment in one or more countries in which we operate or may seek to operate which disfavour our business; our ability to attract and retain qualified personnel; changes from anticipated levels of customer acceptance of existing and new products and services; and other factors.

Although the Company believes that the expectations reflected in such forward-looking statements are reasonable, and although they reflect our current views as at the date of this presentation, there can therefore be no assurance that such expectations will prove to be correct. The Company has no obligation as a result of this presentation to pursue any specific strategy or plan outlined herein, or to deliver any specific outcome that may be implied or inferred.

Any forward-looking statements contained in this presentation speak only as of the date this presentation is made, and we expressly disclaim any obligation to update any forward-looking statements, whether because of new information, future events or otherwise, except as may be required by law.



# Percheron is developing HMBD-002, a novel, mid-clinical-stage, immuno-oncology therapy with applicability to multiple forms of cancer and high combination potential

## THE SCIENCE



**Percheron is developing HMBD-002, a next generation immune checkpoint inhibitor, with the potential to treat many forms of cancer**

HMBD-002 targets VISTA, a novel immune checkpoint, similar in many respects to PD-1, the target of Keytruda® (pembrolizumab)

Previous attempts to drug VISTA have been limited by toxicity; HMBD-002 is built on a different antibody scaffold, substantially reducing potential toxicity

HMBD-002 has potential as a monotherapy, but also appears synergistic with other checkpoint inhibitors such as Keytruda®

## THE COMPANY



**Percheron is listed on the ASX (ASX: PER), with a market cap of ~\$9 million, and cash at 31DEC25 of ~\$4.5 million**

The company trades at a substantial discount to ASX-listed peers, following a corporate transformation during CY2025

Enterprise value largely reflects acquisition cost of HMBD-002 (~\$4.5 million), currently imputing no value to future positive data

Percheron's cash reserves and low burn imply 3.7 quarters of funding

## THE OPPORTUNITY



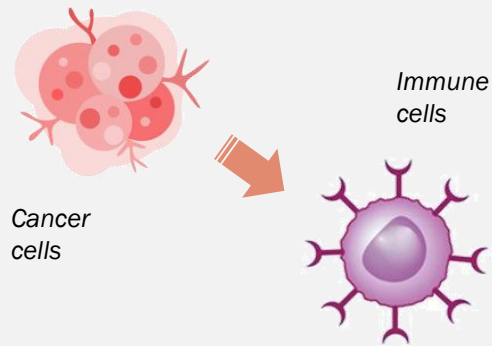
**With phase 1 successfully completed in CY2025, Percheron aims to take HMBD-002 into an international phase 2 human trial in CY2026**

US-based phase 1 study, conducted under IND with US FDA, showed very favourable safety profile, both as monotherapy and in combination with Keytruda® (pembrolizumab)

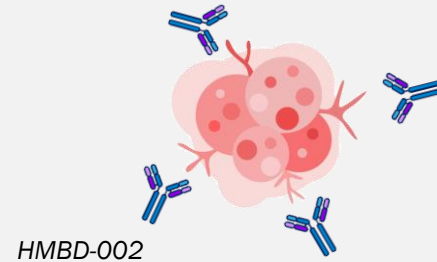
Adaptive, modular phase 2 study design can be launched with very modest cash resources and is designed to provide early validating read-outs

Keytruda® patent expiry in 2028 creates substantial opportunity for novel immune checkpoint inhibitors to expand and extend US\$ ~100 billion market

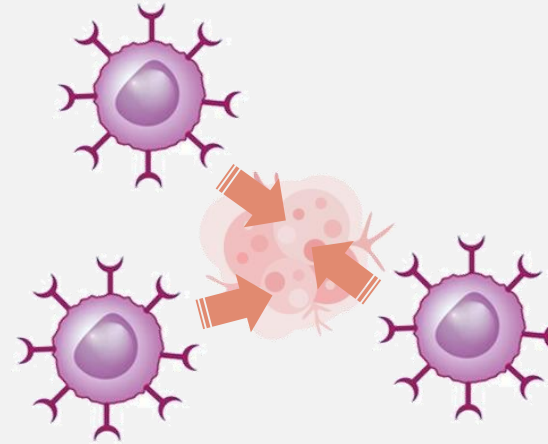
# Immune checkpoint inhibitors such as HMBD-002 work by reactivating the body's immune response so that it can attack the tumour



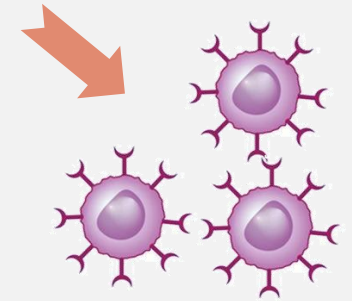
- Ordinarily, our immune system protects us against tumour cells in the same way that it protects against bacteria and viruses
- Growing tumours need to inhibit the patient's immune system to avoid being attacked by normal defences
- One of the ways tumours accomplish this is via 'immune checkpoints' such as PD-1 (the target of Keytruda®) and VISTA (the target of HMBD-002)



- Immune checkpoint inhibitors such as HMBD-002 block these inhibitory signals on the surface of the cancer cell
- A number of such immune checkpoint inhibitor drugs have been approved by FDA in recent years, including Keytruda®, Opdivo®, Tecentriq®, Yervoy® and others
- There are not yet any commercial VISTA inhibitors, partly because the target is relatively newly discovered



- Removal of the inhibitory signals allows the body's own immune system to attack the cancer cells
- The reinvigorated immune system can be potent in its own right, but can also work synergistically with other cancer treatments such as chemotherapy and radiotherapy
- In some cancers, inhibiting multiple immune checkpoints is more effective than just one (e.g. PD-1 and CTLA-4 in melanoma)



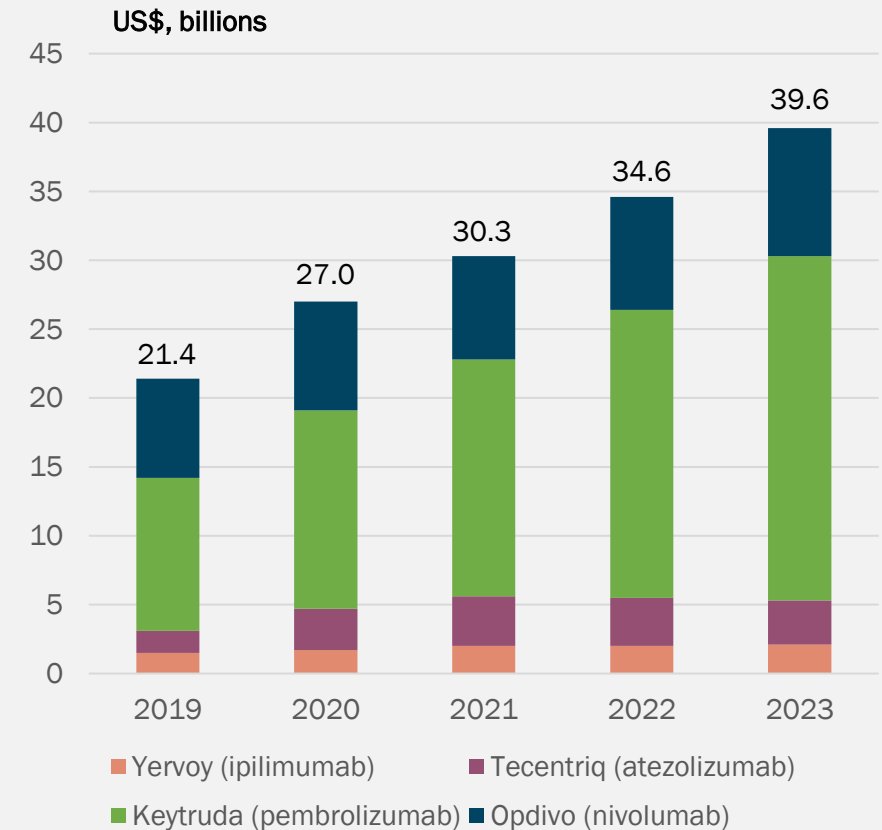
- In addition to making the cancer cells vulnerable to the immune system, VISTA inhibition helps to attract more immune cells into the 'tumour microenvironment,' potentially amplifying its effects by turning 'cold tumours' into 'hot tumours'
- In particular, VISTA inhibition appears to attract myeloid cells, which are less susceptible to other immune checkpoint inhibitors

# Immune checkpoint inhibitors have been one of the fastest growing classes of medicine in the immuno-oncology field, with more than US\$ 40 billion in annual sales

Immuno-oncology therapies target the interaction between tumours and the immune system to enhance the immunological response to cancer



Immuno-oncology has grown to a ~US\$ 40+ billion market

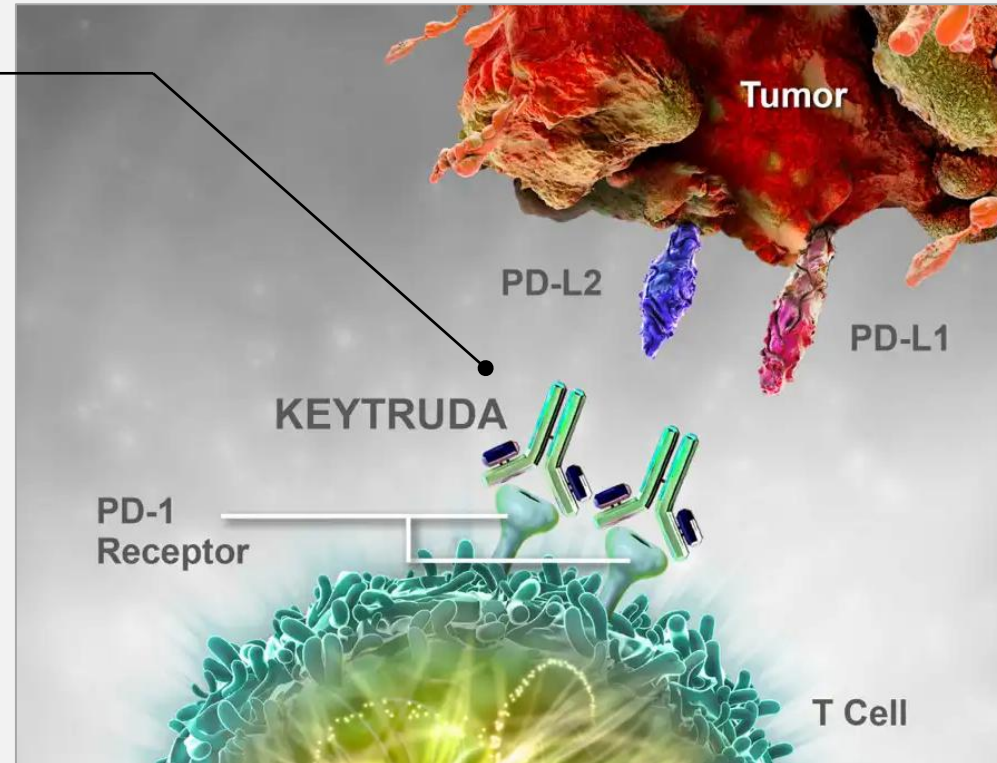


# Keytruda® (pembrolizumab), one of the first-generation immune checkpoint inhibitors, has grown to become the largest cancer product in history

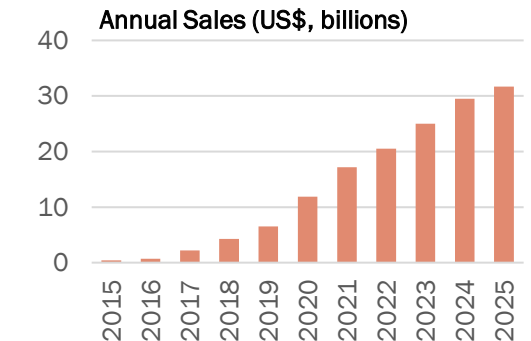
Like Percheron's HMBD-002, Keytruda works by blocking the immune checkpoint on immune cells, so that the tumour cannot 'deactivate' them

Since its first FDA approval in melanoma in 2014, Keytruda has gone on to secure approval in more than a dozen tumours

|                                   |                                                    |
|-----------------------------------|----------------------------------------------------|
| Melanoma                          | Renal Cell Carcinoma                               |
| Non-Small Cell Lung Cancer        | Endometrial Carcinoma                              |
| Bladder Cancer                    | Triple-Negative Breast Cancer                      |
| Gastric Cancer                    | Merkel Cell Carcinoma                              |
| Oesophageal Cancer                | High Tumour Mutational Burden Cancers (TMB-H)      |
| Cervical Cancer                   | High Microsatellite Instability Cancers (MSI-High) |
| Biliary Tract Cancer              |                                                    |
| Cutaneous Squamous Cell Carcinoma |                                                    |



Keytruda has become the best-selling cancer medicine in history



Although a game-changer, most patients ultimately become unresponsive to Keytruda

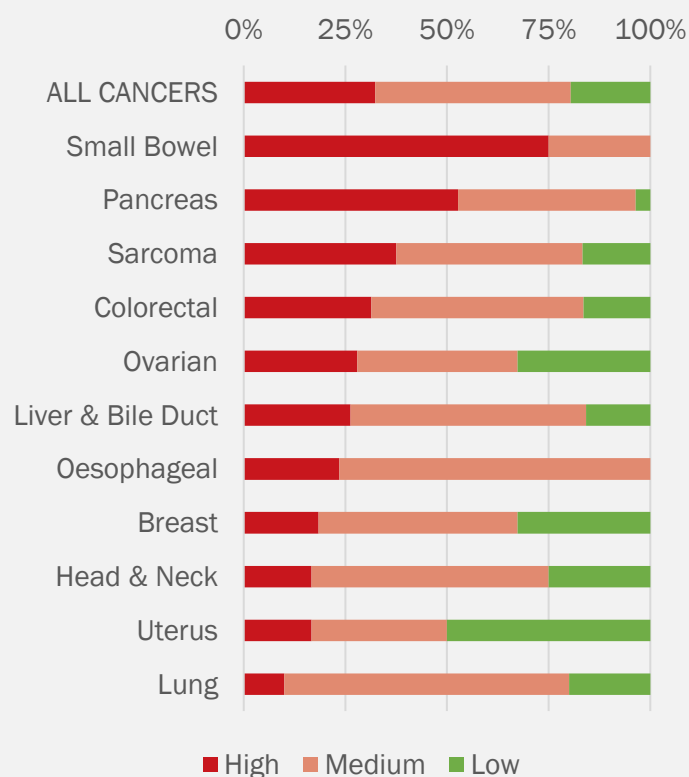
**~40%**  
of melanoma  
patients never  
respond

**~30%**  
of responders  
eventually show  
disease relapse



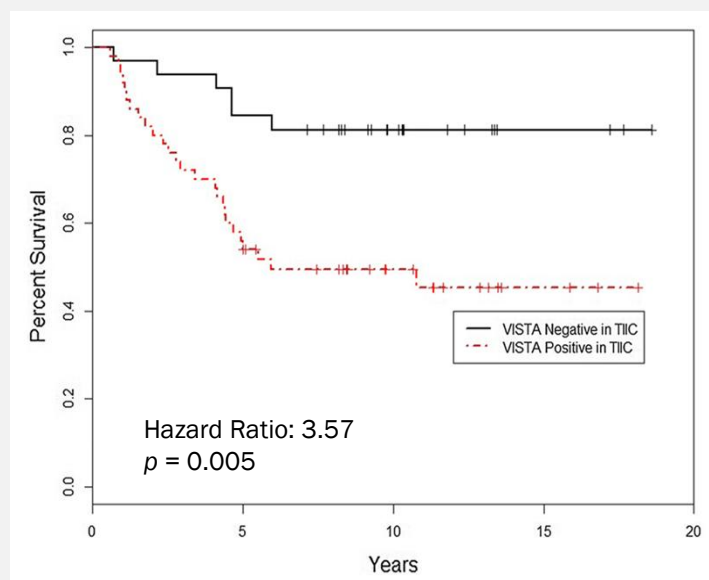
# VISTA is a highly attractive target for novel oncology therapies, showing high expression on many tumours and clear correlation with prognosis

## VISTA is expressed on a wide range of tumours



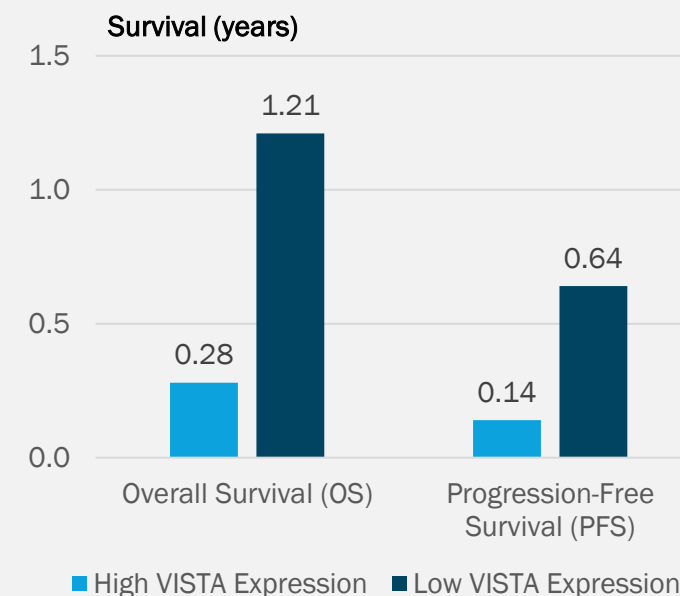
## High expression of VISTA is associated with worse prognosis

Survival of 85 melanoma patients comparing those with VISTA positive tumour-infiltrating inflammatory cells (TIICs) and those with VISTA negative TIICs



## High VISTA expression is associated with resistance to PD-1 inhibition

Survival of 16 pancreatic cancer patients, all treated with immunotherapy, comparing those with high and low VISTA expression



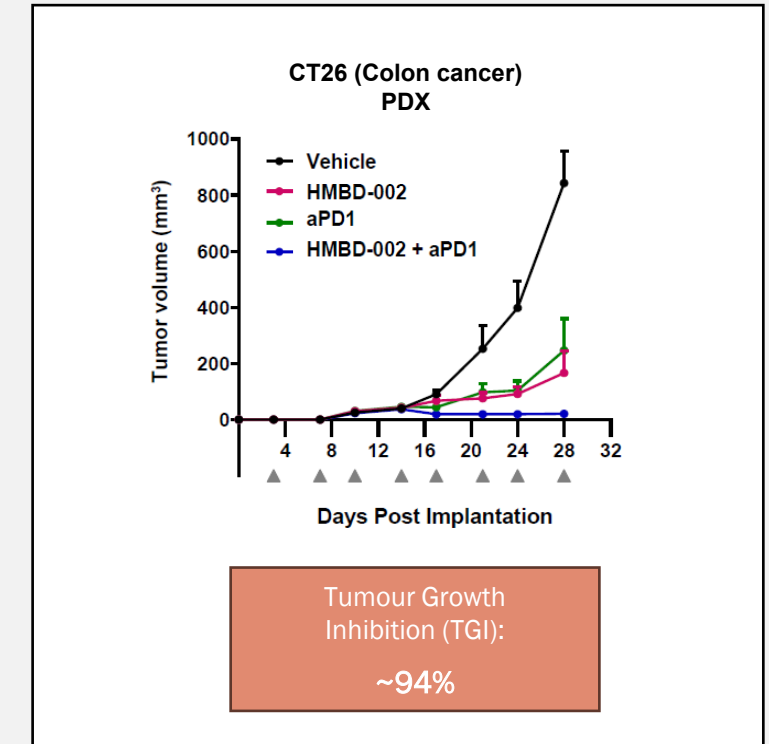
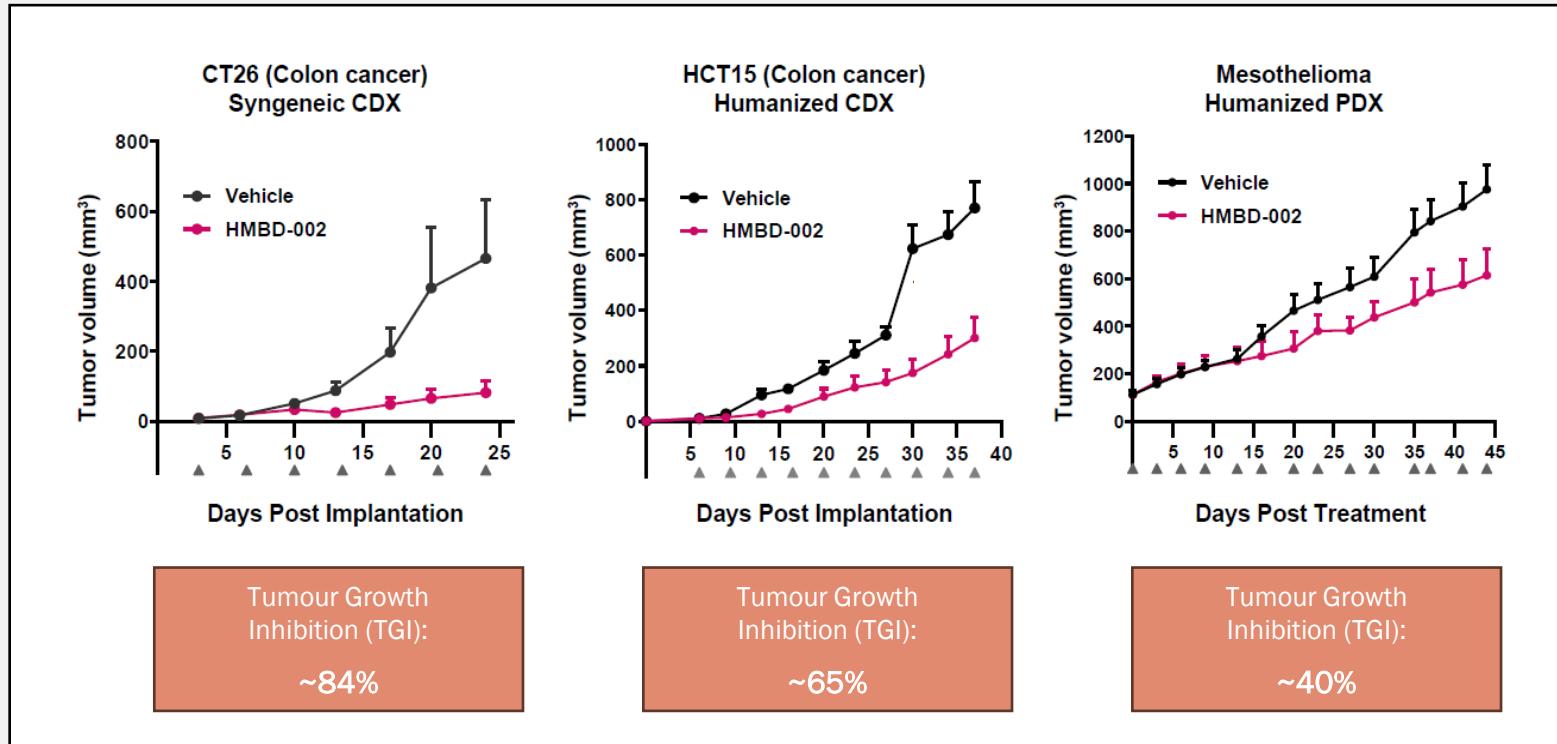
Sources: [D Nishizaki et al. \(2024\) ESMO Open 9\(4\):102942](#) (panels 1 & 3); [LF Kuklinski et al. \(2018\) Cancer Immunol. Immunother. 67:1113-1121](#) (panel 2)



# HMBD-002 has shown compelling evidence of activity in a range of preclinical tumour models, and is synergistic with PD-1 inhibition

Monotherapy administration yields up to 80% tumour growth inhibition, depending on tumour type

Combination with PD-1 inhibition provides substantial synergy



Source: [B Dharmadhikari et al. \(2022\) J Immunother. Cancer 10\(Suppl 2\):A558-A558](#) (poster presentation to SITC 37<sup>th</sup> Annual Meeting)

# HMBD-002 is arguably the most advanced VISTA antibody in clinical development, and likely the only active member of the IgG4 class

| Program                    | HMBD-002                                                                                                                                                               | CI-8993                                                                                                                                                                | JNJ-61610588                                                                        | SNS-101                                                                             | W0180                                                                               |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Company                    | <br> | <br> |  |  |  |
| Isotype                    | IgG4                                                                                                                                                                   | IgG1                                                                                                                                                                   | IgG1                                                                                | IgG1                                                                                | IgG1                                                                                |
| Stage                      | Phase I Complete                                                                                                                                                       | Phase I Complete                                                                                                                                                       | Phase I Terminated                                                                  | Phase I Terminated                                                                  | Phase I Terminated                                                                  |
| Exposure to Date           | 48 patients                                                                                                                                                            | 26 patients                                                                                                                                                            | 12 patients                                                                         | -                                                                                   | 33 patients                                                                         |
| Combination Data Available | Monotherapy & Combination with Pembrolizumab                                                                                                                           | Monotherapy                                                                                                                                                            | Monotherapy                                                                         | Monotherapy & Combination with Cemiplimab                                           | Monotherapy & Combination with Pembrolizumab                                        |
| Status                     | Ongoing                                                                                                                                                                | Inactive                                                                                                                                                               | Discontinued                                                                        | Discontinued                                                                        | Discontinued                                                                        |
| Notes                      |                                                                                                                                                                        |                                                                                                                                                                        |                                                                                     | pH-sensitive antibody                                                               |                                                                                     |

In general, IgG1 antibodies activate antibody-dependent cellular cytotoxicity (ADCC), recruiting immune cells such as natural killer (NK) cells to destroy the target.

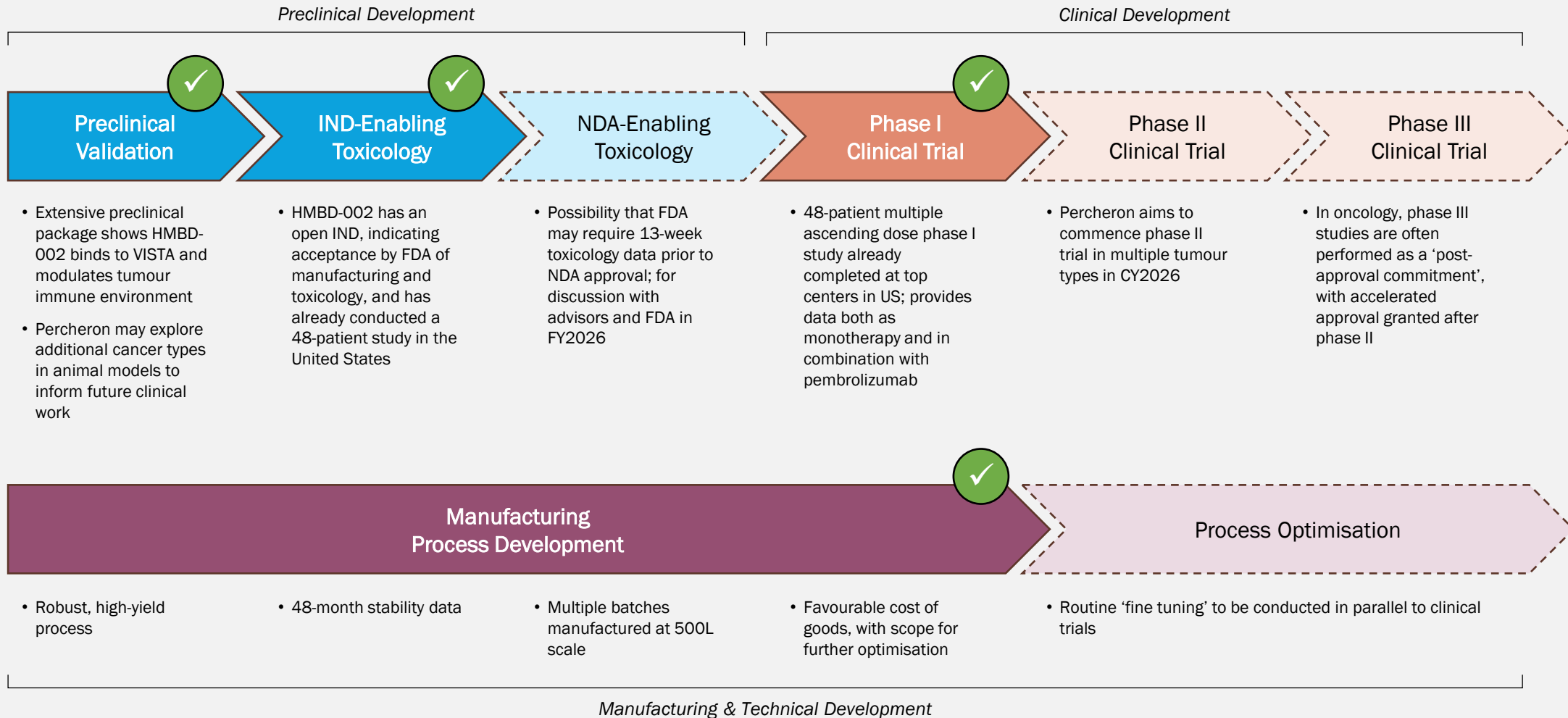
This can be a very effective approach in cancer, but can also lead to significant toxicity, including cytokine release syndrome (CRS).

Expert feedback indicates that the key challenge with other VISTA antibodies, which are almost exclusively IgG1, is that they have often proven toxic in clinical trials.

HMBD-002 is an IgG4 antibody, so it blocks VISTA signalling, but does not necessarily destroy VISTA-positive cells. This is likely to make it significantly less toxic in clinical use.

Sources: Company filings; Clinicaltrials.gov

# HMBD-002 is well-advanced in clinical development, with a clear path towards commercialisation



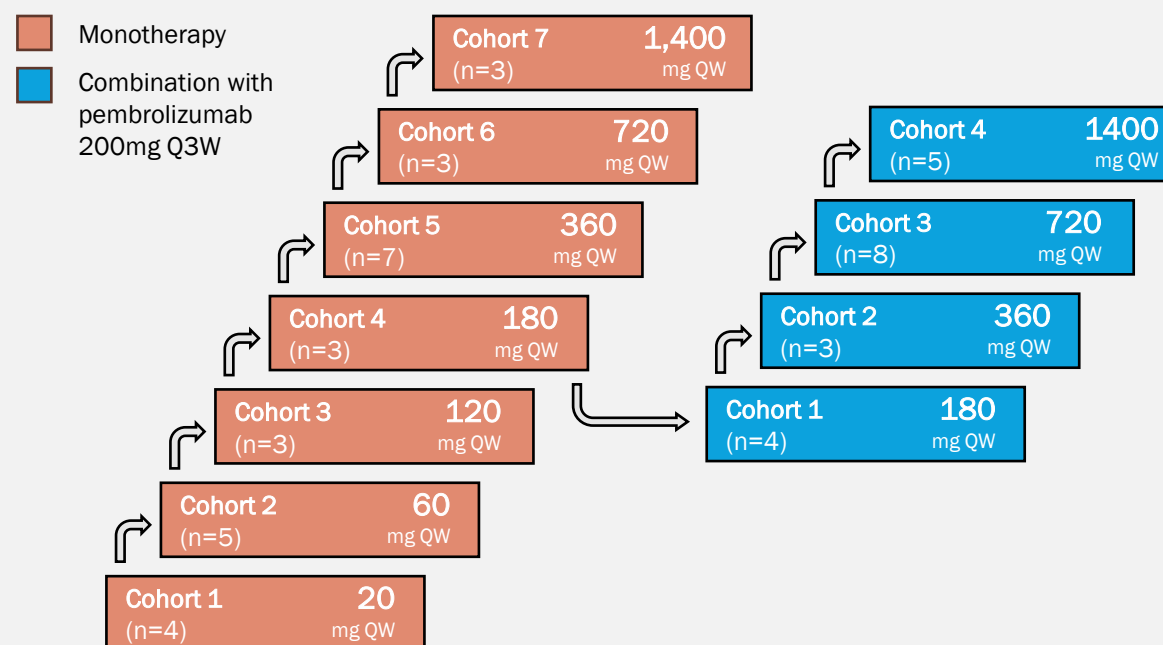
New Drug Application to FDA

# The HMBD-002 phase I study adopted a standard '3+3' design, with an initial monotherapy group ( $n=28$ ) followed by a pembrolizumab combination group ( $n=20$ )

## Patient Population & Study Design

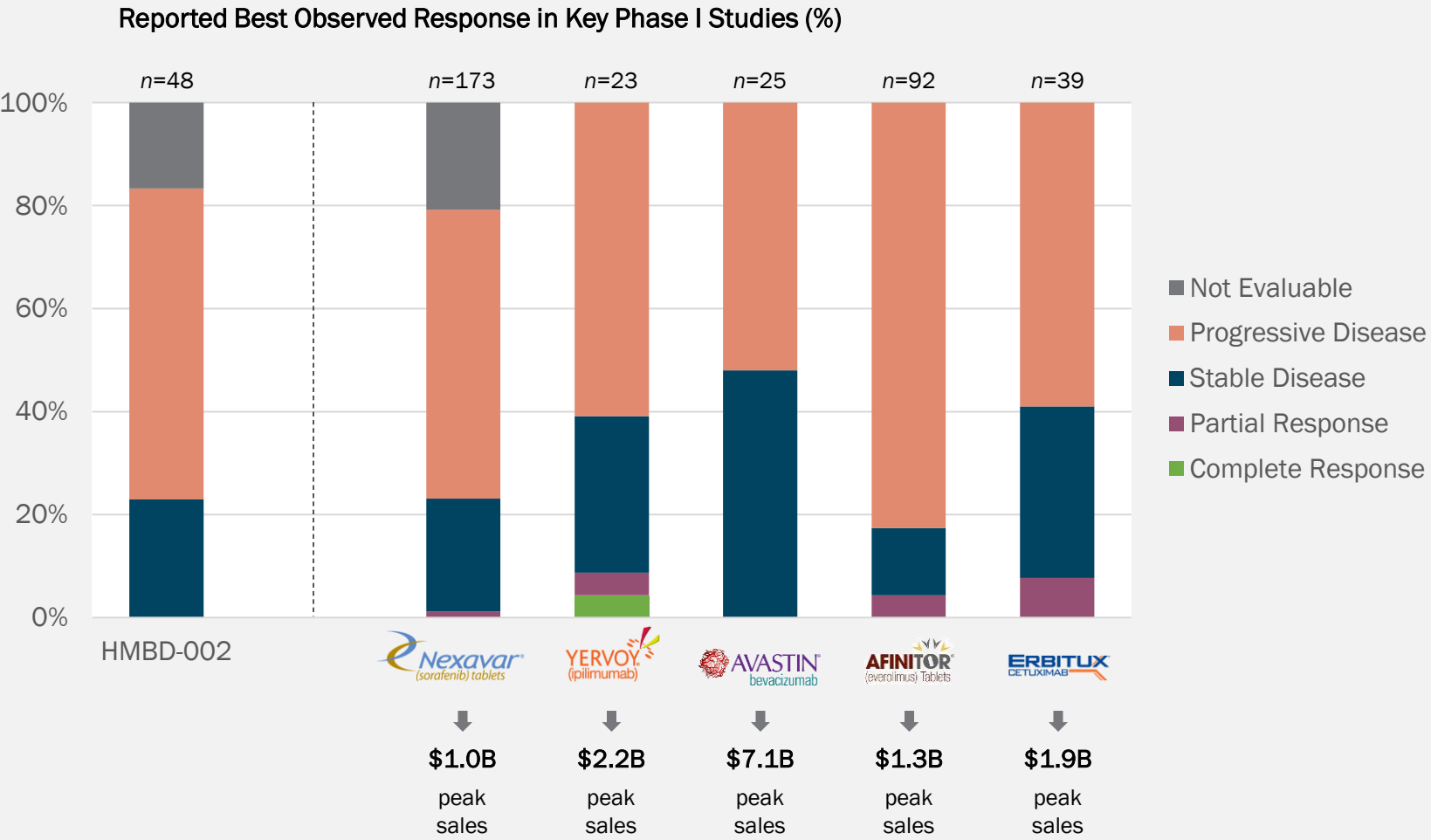
- Advanced cancer patients with no available treatment options known to confer clinical benefit
- ECOG performance status  $\leq 1$
- 3+3 dose escalation design, with a 21-day observation period for dose limiting toxicities
- HMBD-002 administered weekly via 60-minute iv infusion
- 28 patients on monotherapy and 20 patients in combination with pembrolizumab

## Dose Escalation





# Overall response rates such as were seen in this study are common for targeted and cytostatic therapies



### Commentary

- Many targeted therapies have shown similar response profiles in early-phase studies, and some have gone on to become blockbuster commercial products.
- There are several reasons why ORR in phase I sometimes primarily demonstrates a stabilisation effect:
  - Phase I studies are typically performed in very advanced patients, who may be resistant to almost any therapeutic intervention.
  - ORR can be a reasonable measure of cytotoxicity and is therefore more useful in the context of cytotoxic chemotherapy, but it often performs less well when measuring the primarily cytostatic effects of targeted therapies.
  - Immunotherapies in particular can take longer to show benefit, whereas ORR is typically a relatively early-focused measure.

Sources: D Strumberg et al. (2007) *Oncologist* 12(4):426-437; MS Gordon et al. (2001) *J Clin Oncol.* 19(3); A O'Donnell et al. (2008) *J Clin Oncol.* 26(10); JS Weber et al. (2008) *J Clin Oncol.* 26(36); PM Fracasso et al. (2007) *Clin Cancer Res* 13(3):986-993; company and analyst reports

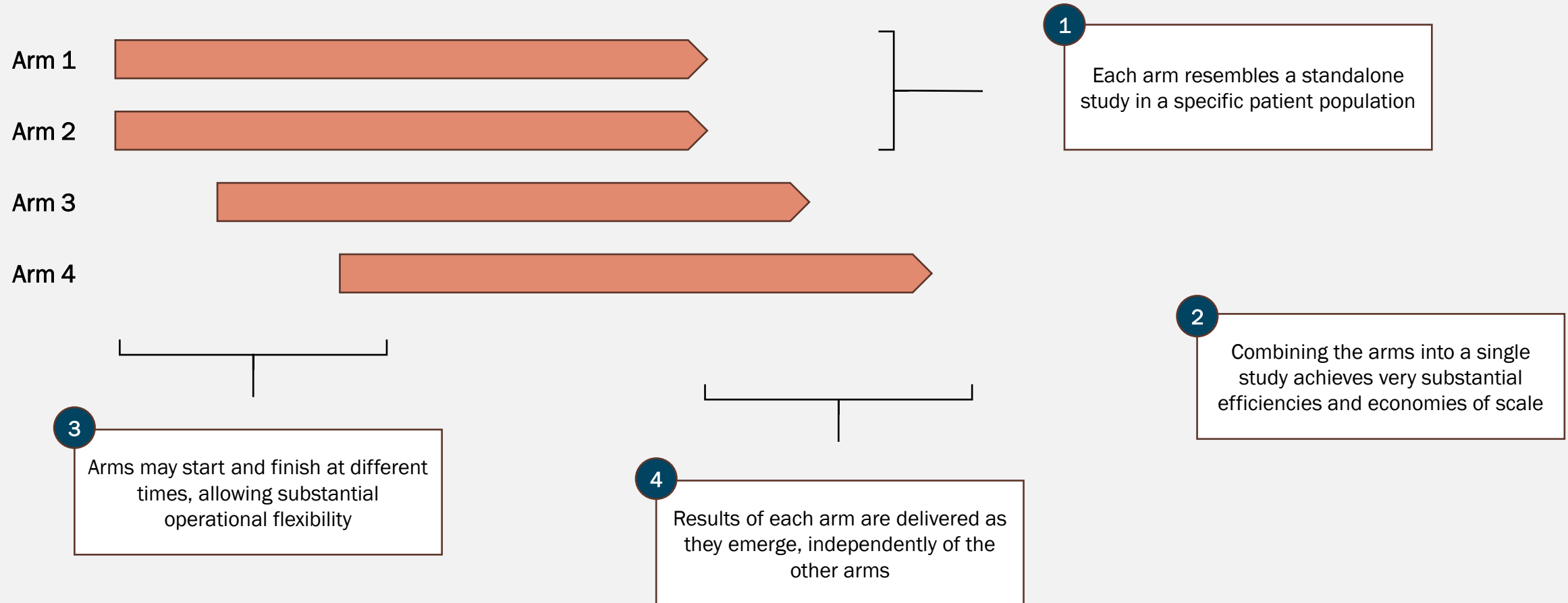
# A number of patients in the study showed evidence of clinical benefit, providing a positive signal of potential future efficacy

| Patient | Diagnosis                                             | Time Since Diagnosis | Prior Lines of Therapy | Treatment Group   | Maximum Tumour Reduction | Time on Therapy |
|---------|-------------------------------------------------------|----------------------|------------------------|-------------------|--------------------------|-----------------|
| 27M     | Metastatic dedifferentiated liposarcoma               | 5.1 years            | 3                      | 360mg Monotherapy | ↓ 17.2%                  | 53 weeks        |
| 67F     | Metastatic triple-negative breast cancer              | 2.8 years            | 3                      | 360mg Monotherapy | ↓ 6.2%                   | 26 weeks        |
| 49M     | Metastatic non-small-cell lung cancer                 | 2.5 years            | 5                      | 360mg Combination | ↓ 1.1%                   | 30 weeks        |
| 45F     | Metastatic triple-negative breast cancer              | 2.7 years            | 5                      | 720mg Combination | ↓ 26.9%                  | 5 weeks         |
| 59M     | Metastatic squamous cell carcinoma of the head & neck | 2.9 years            | 4                      | 720mg Combination | ↓ 13.2%                  | 15 weeks        |

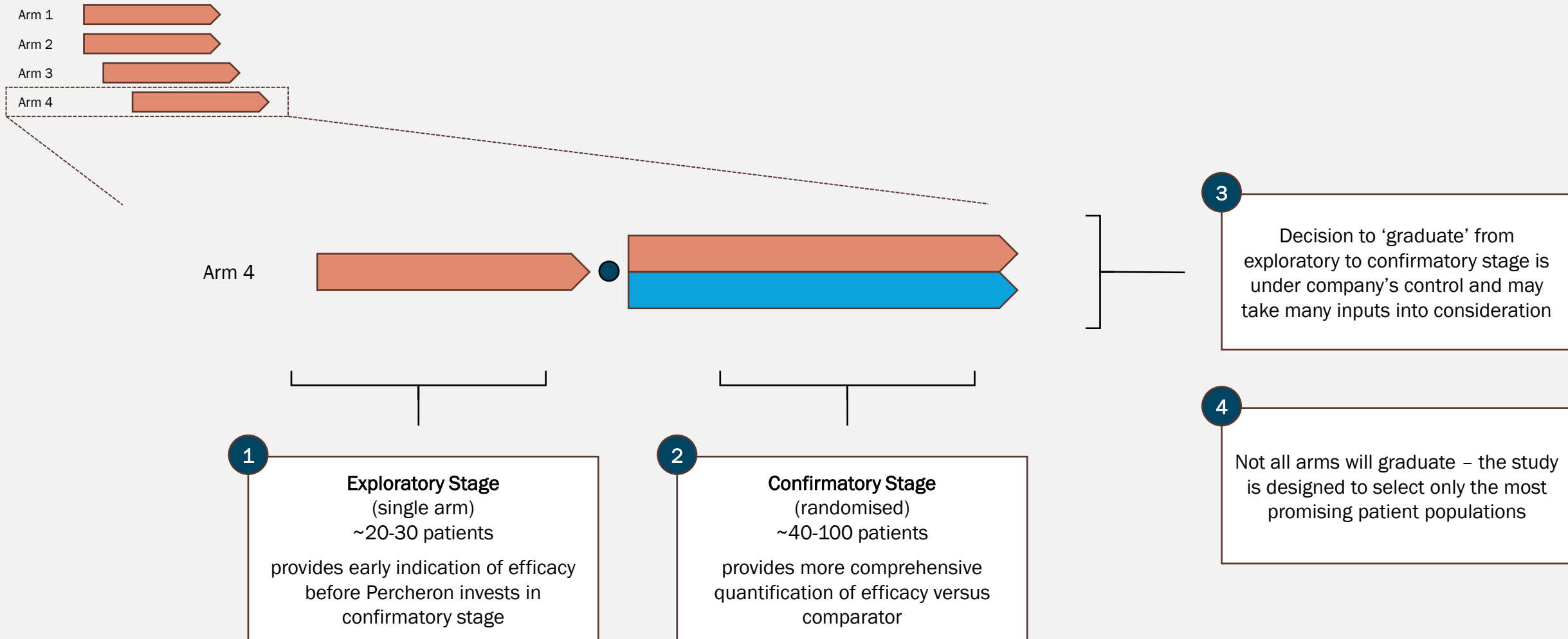
*Patients in the study were very late-stage and heavily pre-treated*

*Tumour shrinkage and prolonged periods of stable disease are positive markers of potential future efficacy*

The phase II study will commence in one tumour type, but will have the ability to expand to additional tumour types at the company's discretion



# Each arm will potentially have two stages, allowing for an early read-out of activity before investing in confirmatory data



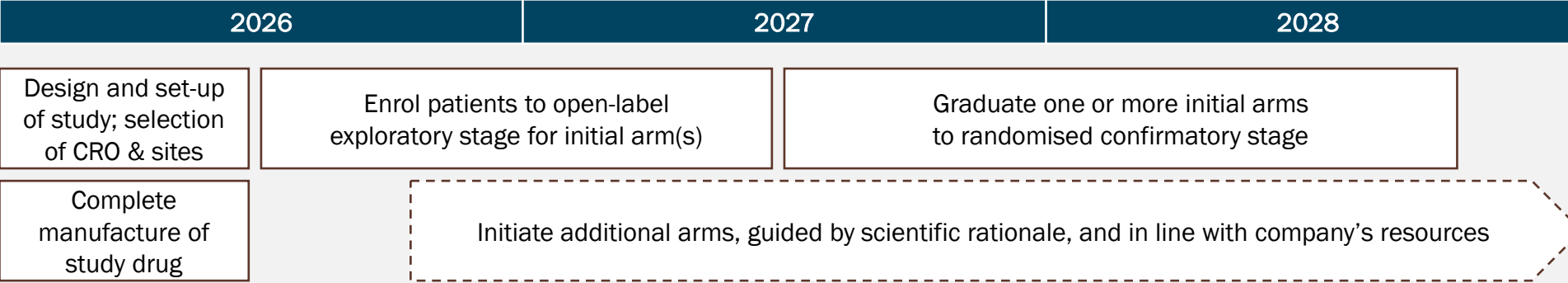
# Four patient groups have been identified as high priority targets, with selection of the first arm anticipated in Q2 CY2026

| Triple-Negative Breast Cancer (TNBC)                                                                                                                                                                                                                                                                                         | EGFR-Mutant Non-Small Cell Lung Cancer (NSCLC)                                                                                                                                                                                                                                                 | HER2-Negative Oesophageal Adenocarcinoma                                                                                                                                                                                                                  | Endometrial Cancer                                                                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ~36,000 patients per annum in United States                                                                                                                                                                                                                                                                                  | ~15,000 patients per annum in United States                                                                                                                                                                                                                                                    | ~10,000 patients per annum in United States                                                                                                                                                                                                               | up to ~65,000 patients per annum in United States*                                                                                                                                                                                    |
| <ul style="list-style-type: none"> <li>TNBC lacks surface receptors for estrogen, progesterone, or HER2, which are common targets for therapies, making it very resistant to drug treatment</li> <li>TNBC disproportionately affects younger women</li> <li>Pembrolizumab provides only marginal survival benefit</li> </ul> | <ul style="list-style-type: none"> <li>EGFR-mutant NSCLC is driven by a mutation in a growth signaling pathway</li> <li>It is more common in women, non-smokers, and Asian patients</li> <li>EGFR-mutant NSCLC is relatively less responsive to immunotherapy such as pembrolizumab</li> </ul> | <ul style="list-style-type: none"> <li>Adenocarcinoma is the most common form of oesophageal cancer in the Western world</li> <li>HER2-negative disease is generally unresponsive to trastuzumab, a common therapy used in HER2-positive cases</li> </ul> | <ul style="list-style-type: none"> <li>Endometrial cancer is the most common form of uterine cancer</li> <li>Pembrolizumab is approved but only partially effective, with typical progression-free survival of 6-11 months</li> </ul> |

Note: endometrial cancer population subject to further refinement in consultation with advisors



# The plan provides the potential for significant news flow from CY2026 onwards



**Indicative Cost Estimates**

*Approximate Cost per Patient*  
**~US\$ 150,000**  
(industry-wide benchmark)

*Estimated Number of Patients in Exploratory Stage*  
**20 - 25**

*Estimated Cost of Exploratory Stage for Each Arm*  
**~US\$ 3.0 - 3.5 million**  
(~AU\$ 5 million)  
(not including impact of R&D Tax Incentive Rebate)

|         |                                       |
|---------|---------------------------------------|
| 1H 26   | Selection of CRO                      |
| Mid 26  | Initiation of sites                   |
| Mid 26  | First patient in to Arm 1             |
| 2H 26   | First patient in to subsequent arms   |
| Mid 26  | Potential grant of orphan designation |
| 2H 26   | Award of international non-prop. name |
| Late 26 | Possible initial data                 |

|        |                                      |
|--------|--------------------------------------|
| 1H 27  | Efficacy data from Arm 1             |
| Mid 27 | Efficacy data from subsequent arms   |
| 2H 27  | Graduation of arm(s) to confirmatory |
| Mid 27 | Potential initiation of new arms     |
| 2H 27  | Potential grant of Fast Track        |

|        |                                   |
|--------|-----------------------------------|
| Mid 28 | Confirmatory data from Arm 1      |
| Mid 28 | Confirmatory data from other arms |
| Mid 28 | Efficacy data from other arms     |
| 2H 28  | Potential grant of Breakthrough   |
| 2H 28  | Possible New Drug Application     |

Potential timeframe for partnering discussions with 'big pharma'

Potential timeframe for accelerated approval discussions with FDA

Note: all timelines, costs, forecasts, and other estimates are preliminary, and subject to ongoing revision

# A high-level estimate of market opportunity suggests enormous commercial potential for HMBD-002; only one indication needs to be successful for a profitable product

|                                                  | Triple-Negative Breast Cancer | EGFR-Mutant Non-Small-Cell Lung Cancer | HER2-Negative Oesophageal Cancer | Endometrial Cancer |                                                                                               |
|--------------------------------------------------|-------------------------------|----------------------------------------|----------------------------------|--------------------|-----------------------------------------------------------------------------------------------|
| Estimated incident patients in United States, pa | 36,000                        | 15,000                                 | 10,000                           | 6,500*             |                                                                                               |
| Annualised treatment cost, US\$                  | \$250K                        | \$250K                                 | \$250K                           | \$250K             | Median treatment cost in 2020-24 was \$350K; reduced to \$250K for conservative estimate      |
| Estimated time on treatment, months              | 6 months                      | 4 months                               | 4 months                         | 6 months           | Earlier stage patients, and patients in combination, may result in longer treatment durations |
| US addressable market, US\$ pa                   | \$4.5 billion                 | \$1.2 billion                          | \$0.8 billion                    | \$0.8 billion      |                                                                                               |
| Global addressable market, US\$ pa               | \$9.0 billion                 | \$2.4 billion                          | \$1.6 billion                    | \$1.6 billion      | Assume that US represents 50% of global sales                                                 |

\* Endometrial cancer patients estimated at 10% of total pending further analysis of target sub-population

# Successful immuno-oncology assets are highly partnerable, with comparable deals suggesting attractive valuations

| Date               | Asset        | Licensors                                                                                                             | Licensee                                                                                                 | Target | Stage        | Deal Terms                                                                   |
|--------------------|--------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------|--------------|------------------------------------------------------------------------------|
| Early-Mid Clinical |              |                                                                                                                       |                                                                                                          |        |              |                                                                              |
| Oct 2018           | COM701       |  COMPUGEN<br>Dream. Design. Deliver. |  Bristol Myers Squibb™ | PVRIG  | Phase I / II | \$20M upfront; \$200M milestones; royalties                                  |
| Jun 2021           | EOS-448      |  ITEOS<br>THERAPEUTICS               |  GSK                  | TIGIT  | Phase I / II | \$625M upfront; \$1.45B milestones; royalties                                |
| Dec 2022           | XTX-101      |  xiliO<br>THERAPEUTICS*              |  GILEAD               | CTLA-4 | Phase I / II | \$30M upfront; \$604M milestones; royalties                                  |
| Jan 2023           | ICB-01       |  ImCheck<br>therapeutics             |  maruho<br>medical    | BTN3A  | Phase I / II | <i>Japan rights only</i><br>€15M upfront; milestones; royalties              |
| Late Clinical      |              |                                                                                                                       |                                                                                                          |        |              |                                                                              |
| Jan 2021           | Tislelizumab |  BeiGene                             |  NOVARTIS             | PD-1   | Phase III    | <i>Ex-China rights only</i><br>\$650M upfront; \$1.55B milestones; royalties |
| Dec 2021           | Ociperlimab  |  BeiGene                           |  NOVARTIS           | TIGIT  | Phase III    | \$300M upfront; \$700M milestones; royalties                                 |
| Jul 2022           | Cemiplimab   |  REGENERON                         |  sanofi             | PD-1   | Phase III    | \$900M upfront; \$1.5B milestones; profit split                              |

Source: Company filings

# The Percheron Board and Management Team bring extensive international experience in drug development, commercialisation, and partnering



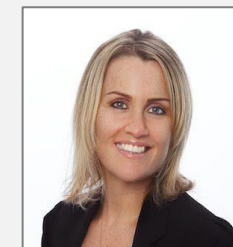
**Dr Charmaine Gittleson**  
Non-Executive Chair of the Board

25 years of drug development experience, including 15-year tenure with CSL in international roles



**Dr James Garner**  
Chief Executive Officer  
& Managing Director

20+ year track record of international drug development, including ten years as a public company life sciences CEO



**Deborah Ambrosini**  
Chief Financial Officer  
& Company Secretary

Over 20 years of strategic financial experience with a diverse range of ASX-listed companies



**Dr Gil Price**  
Non-Executive Director  
& Chair of Audit

Experienced biotech executive and entrepreneur with extensive experience in drug development



**Valentina Dubljevic**  
Chief Technical Officer

20-year track record of international drug development in multinational companies

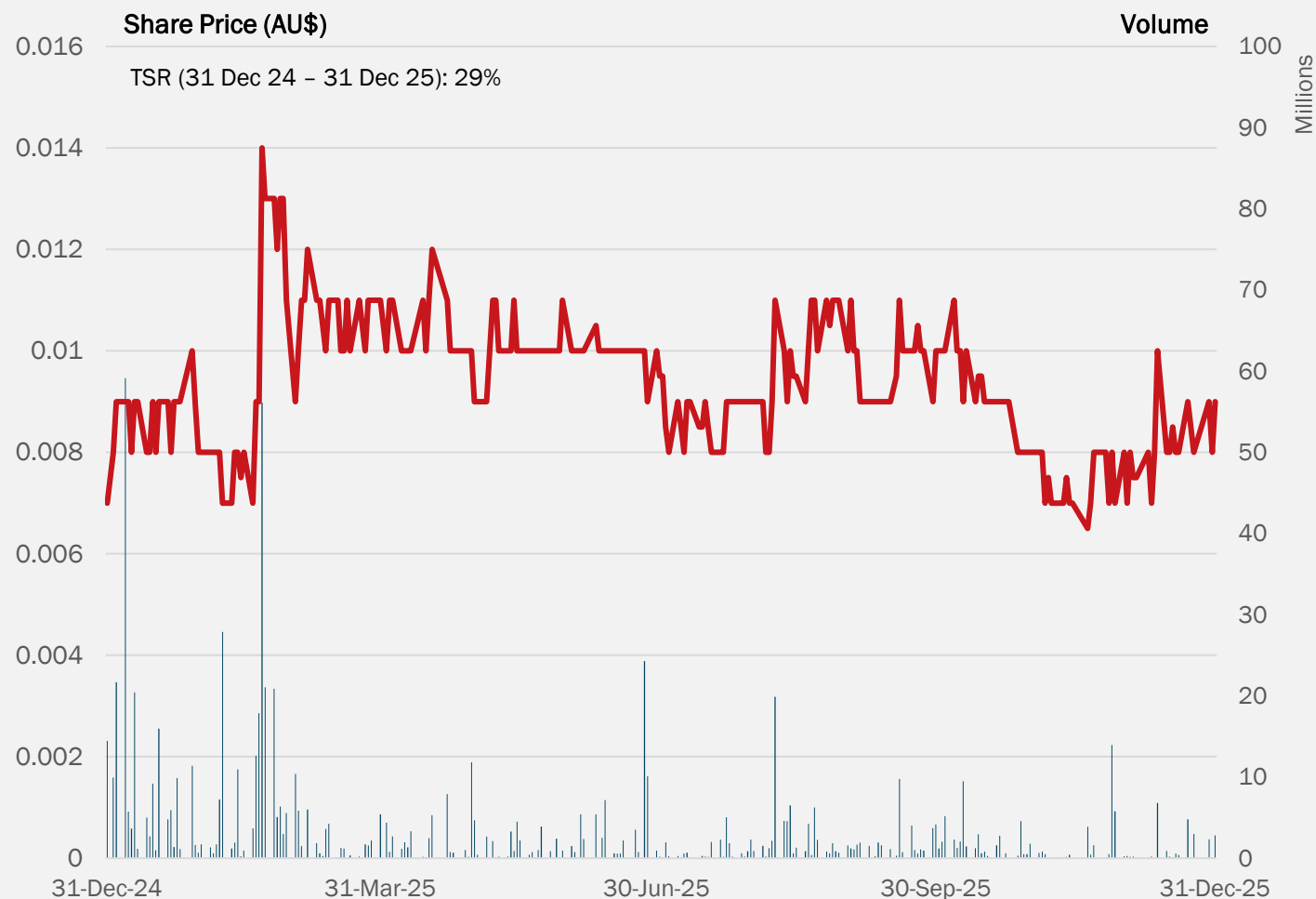


**Dr Eugene Kennedy**  
Chief Medical Officer

Johns Hopkins-trained cancer surgeon with over ten years of experience in immuno-oncology drug development



# Percheron benefits from an ultra-lean operating model, with the majority of cash outlays being applied directly to R&D



## Corporate Fundamentals (as at 31 December 2025)

|                        |               |
|------------------------|---------------|
| Market Capitalisation: | AU\$ 9M       |
| Primary Listing:       | ASX: PER      |
| Secondary Quotations:  | OTC: PERCF    |
| Shares on Issue:       | 1,087 Million |

## Financial Position (as at 31 December 2025)

|                           |                  |
|---------------------------|------------------|
| Cash Balance:             | AU\$ 4.5 million |
| Runway (per Appendix 4C): | 3.7 quarters     |

## Key Shareholders

|                                |      |
|--------------------------------|------|
| Mutual Investments Limited     | 5.4% |
| Non-Correlated Capital Limited | 4.6% |
| Directors and Management       | 5.6% |

## Asset Economics

|                                                                                         |                |
|-----------------------------------------------------------------------------------------|----------------|
| Acquisition Cost<br>(includes manufacture of one batch of drug substance)               | ~\$4.5 Million |
| Confidential, substantially back-ended participation for licensor in success of product |                |

# Percheron is competitively valued in comparison to peer ASX-listed companies

Indicative List of Comparator ASX-Listed Oncology Companies

| Company                                                                                                                               | Ticker | Number of Programs | Highest Stage of Development | Cash at 30 June 25 | Market Cap at 30 June 25 |
|---------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------|------------------------------|--------------------|--------------------------|
|  <b>immuteP</b><br>LAG-3 IMMUNOTHERAPY               | IMM    | 4                  | Phase III                    | \$67.4M            | \$350.5M                 |
|  <b>RACE ONCOLOGY</b>                                | RAC    | 1                  | Phase II                     | \$13.6M            | \$204.1M                 |
|  <b>arovella</b><br>THERAPEUTICS                     | ALA    | 2                  | Preclinical                  | \$20.9M            | \$118.9M                 |
|  <b>IMUGENE</b><br>Developing Cancer Immunotherapies | IMU    | 5                  | Phase II                     | \$21.9M            | \$97.1M                  |
|  <b>Amplia</b><br>THERAPEUTICS                       | ATX    | 1                  | Phase II                     | \$7.0M             | \$77.6M                  |
|  <b>RAD</b><br>RADIOPHARM THERANOSTICS               | RAD    | 6                  | Phase II                     | \$29.1M            | \$52.0M                  |
|  <b>Prescient</b><br>Therapeutics                   | PTX    | 3                  | Phase II                     | \$6.9M             | \$35.4M                  |
|  <b>percheron</b><br>THERAPEUTICS                  | PER    | 1                  | Phase II – CY2026            | \$10.2M            | \$10.9M                  |

Source: ASX; Company filings



# Percheron is focused on moving its pipeline forward expeditiously, with potential for rich, value-generating news flow over FY2026

| CY2025                                                                                         |           |   |
|------------------------------------------------------------------------------------------------|-----------|---|
| Release of full phase I data                                                                   | 2H CY2025 | ✓ |
| Initiate manufacture of new batch of drug substance for clinical trial use                     | 2H CY2025 | ✓ |
| Publication of new preclinical data in head & neck cancer and in triple-negative breast cancer | 2H CY2025 | ✓ |
| Clinician consultation to determine optimal path(s) forward for HMBD-002 in phase II           | 2H CY2025 | ✓ |
| Disclosure of phase II study design and target tumours                                         | 2H CY2025 | ✓ |
| CY2026                                                                                         |           |   |
| Appointment of CRO for phase II clinical trial of HMBD-002                                     | 1H CY2026 |   |
| Presentation of data at scientific conference(s)                                               | 1H CY2026 |   |
| Potential application for international non-proprietary name for HMBD-002                      | 1H CY2026 |   |
| Ethics Committee approval for phase II clinical trial of HMBD-002                              | CY2026    |   |
| First Patient In to phase II clinical trial of HMBD-002                                        | CY2026    |   |

Note: All timelines are indicative and subject to ongoing review



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# GLOSSARY

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cold Tumours</b>                         | Tumours with few immune cells in the tumour microenvironment. They are typically relatively resistant to immuno-oncology therapies. Some cancers, such as ovarian cancer and brain cancer, are usually considered to be generally 'cold' tumours. By implicit contrast, a 'hot tumour' or inflammatory tumour is one with a large and active population of immune cells in the tumour microenvironment.                                                                       | <b>Overall Survival (OS)</b>                | A measurement of the average time to death from any cause in a clinical trial. When treated patients are compared to a control group, an improvement in OS is considered the 'gold standard' for FDA approval.                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Expression</b> (of an immune checkpoint) | In the context of immuno-oncology, a tumour with, on average, a lot of a given immune checkpoint on the surface of its cells is said to highly express that immune checkpoint. For example, a tumour with high PD-1 expression has a lot of PD-1 on the surface of its constituent cancer cells.                                                                                                                                                                              | <b>Progression-Free Survival (PFS)</b>      | A measurement of the average time to disease progression (20% increase in size of tumour) or death in a clinical trial. When treated patients are compared to a control group, PFS is often a swifter and more sensitive measure of efficacy than OS, and can often provide a basis for approval.                                                                                                                                                                                                                                                                                                |
| <b>Immune Checkpoint</b>                    | A control mechanism that allows cells, including tumour cells, to inhibit the local activity of the immune system. Analogous to the brake pedal on a car. Examples of immune checkpoints include PD-1, CTLA-4, LAG3, and VISTA.                                                                                                                                                                                                                                               | <b>RECIST / Overall Response Rate (ORR)</b> | A standardised way of measuring the early activity of cancer therapies. A complete response (CR) describes 100% reduction in a specific lesion on MRI or CT scan. A partial response (PR) means a 30% or greater reduction in size. Stable disease (SD) means no material change in the size of the tumour. Progressive disease (PD) occurs when a lesion grows by more than 20%. ORR is traditionally a useful way to assess early-stage cancer therapies but rarely provides a basis for FDA approval and is often less sensitive for targeted therapies such as immune checkpoint inhibitors. |
| <b>Immune Checkpoint Inhibitor (ICI)</b>    | A drug which inhibits an immune checkpoint, releasing the 'brake' on the local activity of the immune system. Examples of immune checkpoint inhibitors include Keytruda(R) (pembrolizumab), Opdivo(R) (nivolumab), Yervoy(R) (ipilimumab), and Tecentriq(R) (atezolizumab).                                                                                                                                                                                                   | <b>Resistance</b>                           | In oncology, a tumour is said to be resistant to a given therapy if it does not meaningfully respond to that therapy. Resistance may be primary, if the tumour is unresponsive from the outset, or secondary / acquired if the tumour becomes unresponsive after a period of initially successful treatment.                                                                                                                                                                                                                                                                                     |
| <b>Ligand</b>                               | Generally, a molecule which connects to another molecule to bring about a biological effect. In the context of immuno-oncology, a ligand is typically the molecule on the immune cell to which the immune checkpoint binds (e.g. PD-1 to PDL-1, CTLA-4 to CD80, LAG3 to Gal3, and VISTA to VSIG-3).                                                                                                                                                                           | <b>T-Cell / T-Lymphocyte</b>                | T-cells are one type of cells involved in the immune system. There are many subtypes, and their effects range from control and coordination ('helper T-cells') to direct attack of infectious organisms and cancer cells ('cytotoxic T-cells').                                                                                                                                                                                                                                                                                                                                                  |
| <b>Monoclonal Antibody</b>                  | A class of genetically engineered drugs which utilise the structure of natural human antibodies to generate new molecules which can either block signalling or attack cells. Approximately 40% of cancer drugs are monoclonal antibodies. Monoclonal antibodies are manufactured in living cells under carefully controlled laboratory conditions. They are more challenging to manufacture than 'small molecule' (chemical) drugs but generally simpler than cell therapies. | <b>Tumour Microenvironment (TME)</b>        | The TME includes the tumour itself, along with the surrounding tissues, including structural support ('stroma'), small blood vessels, etc. The TME is typically also infiltrated with immune cells. When considering the immune cells specifically, it is sometimes referred to as the tumour immune microenvironment (TIME).                                                                                                                                                                                                                                                                    |
| <b>Myeloid Cells</b>                        | Myeloid cells are one type of cells involved in the immune system. They exert a range of effects, some of which can be immunosuppressive.                                                                                                                                                                                                                                                                                                                                     | <b>VISTA</b>                                | V-domain immunoglobulin suppressor of T-cell activation. A novel immune checkpoint, first identified in the 2010s, and the target of HMBD-002.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |