Immix Biopharma

FY25 results

Momentum builds with NEXICART-2 progress

Healthcare

1 April 2026

Immix Biopharma's FY25 results reflect a year in which its investment case shifted from early clinical promise to clearer regulatory progress. Notably, the most recent NEXICART-2 data add confidence to NXC-201 as a potential solution to address unmet needs in relapsed/refractory amyloid light chain amyloidosis (r/r ALA). The company is now approaching a key inflection point, with a biologics licence application (BLA) submission to the FDA anticipated in H226, following the final NEXICART-2 readout expected in Q326. Importantly, the $100m capital raise materially strengthens the balance sheet, mitigating near-term execution risk. Given management's internal cash runway expectations (c 12 months), we infer a growing likelihood of self-commercialisation for NXC-201. While we had previously assumed launch under a licensing partnership in our model, given the strong liquidity position and positive share price momentum, we now update our estimates to reflect this more likely scenario. Our valuation for Immix upgrades to $786.5m or $14.8/share (from $373.2m or $7.2/share).

Year end	Revenue ($m)	PBT ($m)	EPS ($)	DPS ($)	P/E (x)	Yield (%)
12/24	0.0	(18.6)	(0.66)	0.00	N/A	N/A
12/25	0.0	(27.0)	(0.82)	0.00	N/A	N/A
12/26e	0.0	(29.0)	(0.53)	0.00	N/A	N/A
12/27e	38.5	(4.4)	(0.07)	0.00	N/A	N/A

Note: PBT and EPS are normalised, excluding amortisation of acquired intangibles, exceptional items and share-based payments.

Rolling readouts for NXC-201 remain positive

The latest NEXICART-2 data from 20 patients showed positive efficacy and safety, consistent with prior readouts. The complete response (CR) rate was 75%, with 15/20 patients achieving deep haematological responses. Of the five patients without a CR, four were measurable residual disease (MRD) negative, suggesting they may achieve a CR in the coming weeks or months. In terms of safety, there have been no cases of neurotoxicity and cytokine release syndrome (CRS) was considered manageable. In January 2026, Immix received FDA Breakthrough Therapy designation, offering a streamlined review process, adding confidence to the programme. With patient enrolment now complete, the NEXICART-2 readout (on track for Q326) represents the most significant upcoming inflection point for investor attention. If successful, management plans to submit a BLA by end-2026.

Strong liquidity following $100m raise

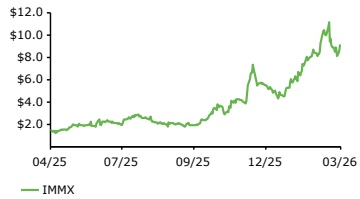
Immix ended FY25 with a strong cash balance of $100.4m, supported by the $100m equity raise ($93.7m net) in December 2025. Management estimates this will support operations through 2026, past top-line readouts from NEXICART-2 and the subsequent BLA filing by end-FY26.

Valuation: $786.5m or $14.8 per share

We update our model to reflect the increased likelihood of self-commercialisation (at least in the US), a higher-reward but higher-risk strategy versus licensing. Our valuation rises to $786.5m ($14.8/share) from $373.2m ($7.2/share). We maintain a 50% probability of success (PoS) and bring forward our estimated time of launch to 2027 (from 2028) following Breakthrough Therapy designation.

Price	**$8.72**
Market cap	**$462m**
Net cash and cash equivalents at 31 December 2025	$100.4m
Shares in issue	53.0m
Free float	60.0%
Code	IMMX
Primary exchange	NASDAQ
Secondary exchange	N/A

Share price performance



%	1m	3m	12m
Abs	1.8	58.0	381.6
52-week high/low		$11.6	$1.3

Business description

Immix Biopharma is a clinical-stage biopharma company developing personalised therapies for oncology and immunology. Lead asset NXC-201 is a BCMA-targeting CAR-T asset, being evaluated for amyloid light chain amyloidosis with plans to expand to autoimmune indications. A Phase I/II trial, NEXICART-2, is ongoing in the US, with top-line results expected from mid-CY26.

Next events

NEXICART-2 final readout	Q326

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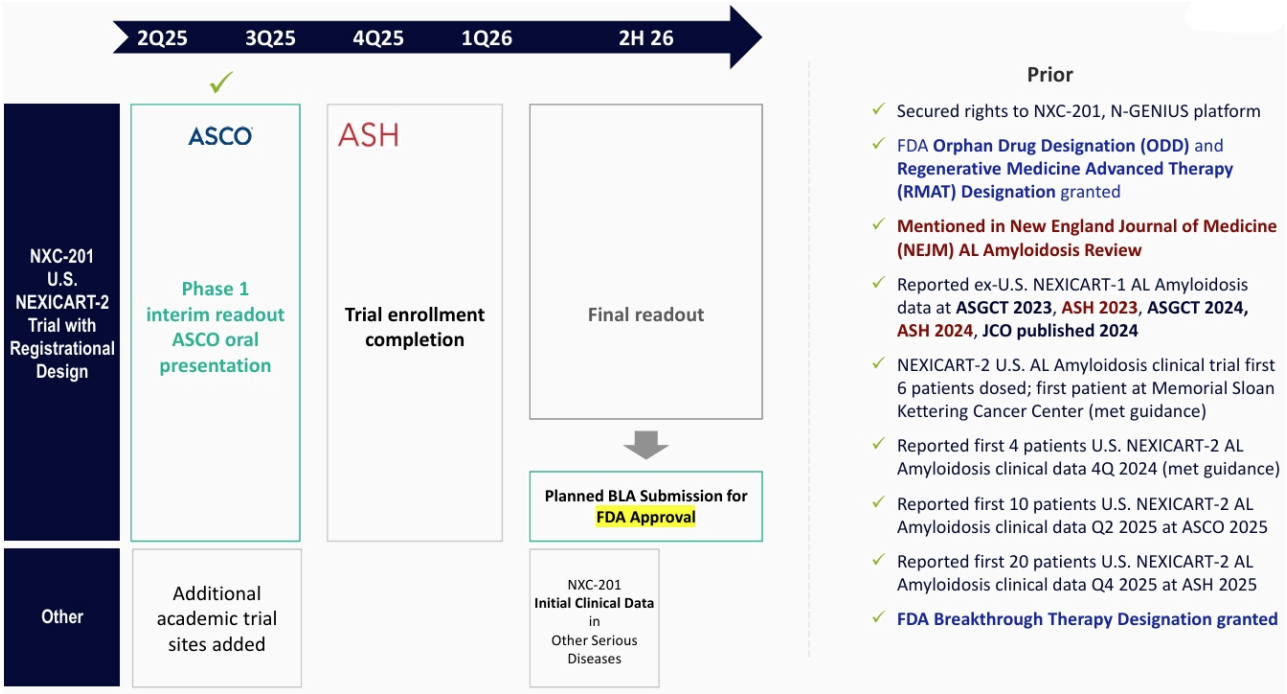
Focused on improving patient outcomes in ALA

Throughout 2025 and early-2026, Immix has made tangible progress in its patient-prioritised approach to developing NXC-201, a sterically-optimised B-cell maturation antigen (BCMA) targeting chimeric antigen receptor T (CAR-T) cell therapy, as an effective new treatment option for patients with relapsed/refractory ALA (Exhibit 1). The latest interim clinical data readout for the registrational NEXICART-2 trial, in December 2025, was particularly encouraging, in our view, bringing the potential for a BLA into clearer view. We recap the most recent clinical data in more detail below, but note here that the results build on earlier readouts from smaller patient cohorts presented in 2024 and mid-2025, which demonstrated similarly high response rates. The consistency across successive datasets provides greater confidence that the efficacy of the CAR-T therapy is reproducible, rather than cohort specific. While the follow-up time remains relatively short, the depth of response and early durability signals support our view that NXC-201 could offer a clinically meaningful benefit in this difficult-to-treat patient population.

From a regulatory perspective, the programme has also gained momentum. In January 2026, NXC-201 received FDA Breakthrough Therapy designation in r/r ALA, reflecting both the seriousness of the condition and the preliminary clinical evidence of improvement over current therapeutic options. While this does not represent a guarantee of regulatory approval, the designation does facilitate closer interactions with the FDA, and may support a more streamlined development and review process.

Taken together, the maturing clinical dataset and strengthening regulatory positioning suggest that Immix is transitioning from an early clinical-stage story to one focused on execution towards registration. The announcement of completed patient enrolment in March 2026 adds confidence to the pace of the programme, and management continues to guide to a final NEXICART-2 readout in Q326. This will be followed by a planned BLA submission by end-2026, representing another key expected milestone this year. In our view though, the next stage of value creation will be driven primarily by confirmation of durability and consistency in the final trial dataset, as well as clarity on the regulatory pathway.

Exhibit 1: Progress for the clinical development of NXC-201



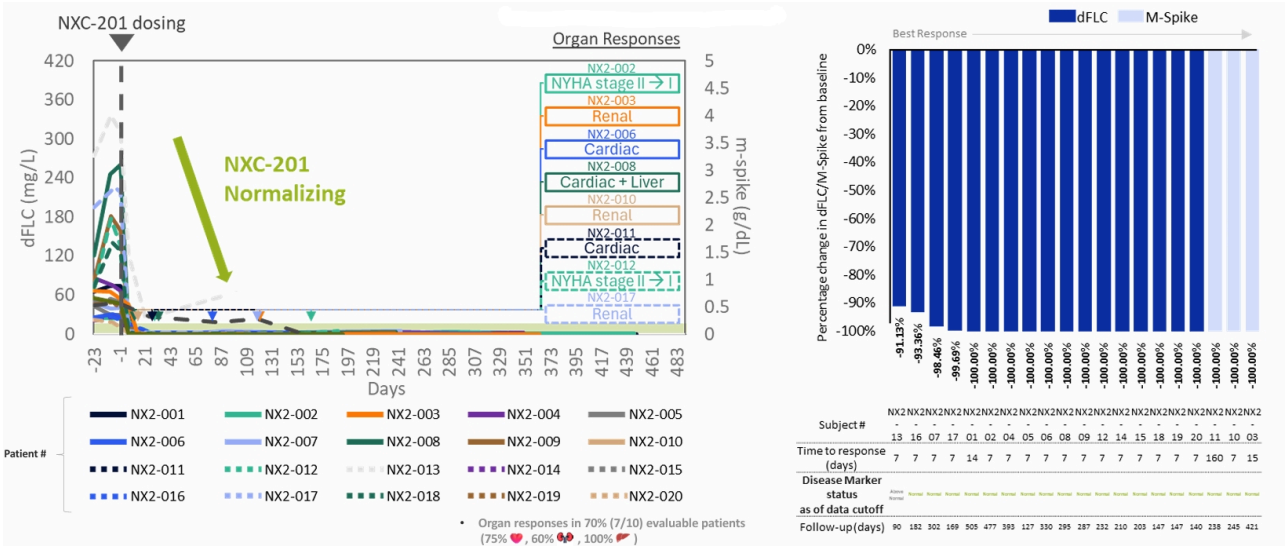
Source: Immix Biopharma corporate presentation (March 2026)

The latest from the clinic: 20-patient NEXICART-2 data presented at ASH 2025

Immix's most recent update from the US-based NEXICART-2 trial was at the American Society of Hematology (ASH) 67th Annual Meeting, in December 2025, corresponding to 20 patients, half the total expected number of participants. This group had a median of four prior lines of therapy (range: 1–10), with 11 patients having had prior stem cell transplants, two of whom had two previous transplants. As part of the trial, disease markers were measured

at enrolment; difference in free light chains (dFLC) was used for 17 of the patients and M-spike levels were used for three who did not display elevated dFLC. As of the 13 November 2025 data cut-off, the median follow-up was 235 days or 7.8 months (range: 90–505 days), and at this stage, 19/20 patients (95%) showed normalised disease markers (15 patients with a CR; four patients deemed MRD negative), within a median of seven days of receiving NXC-201 (Exhibit 2). Disease marker reductions were associated with downstream clinical improvements, including rapid organ responses seen in 7/10 evaluable patients (70%); only 10 patients had organ evaluable disease. In addition to these encouraging results, some patients also saw improvements in their New York Heart Association classifications.

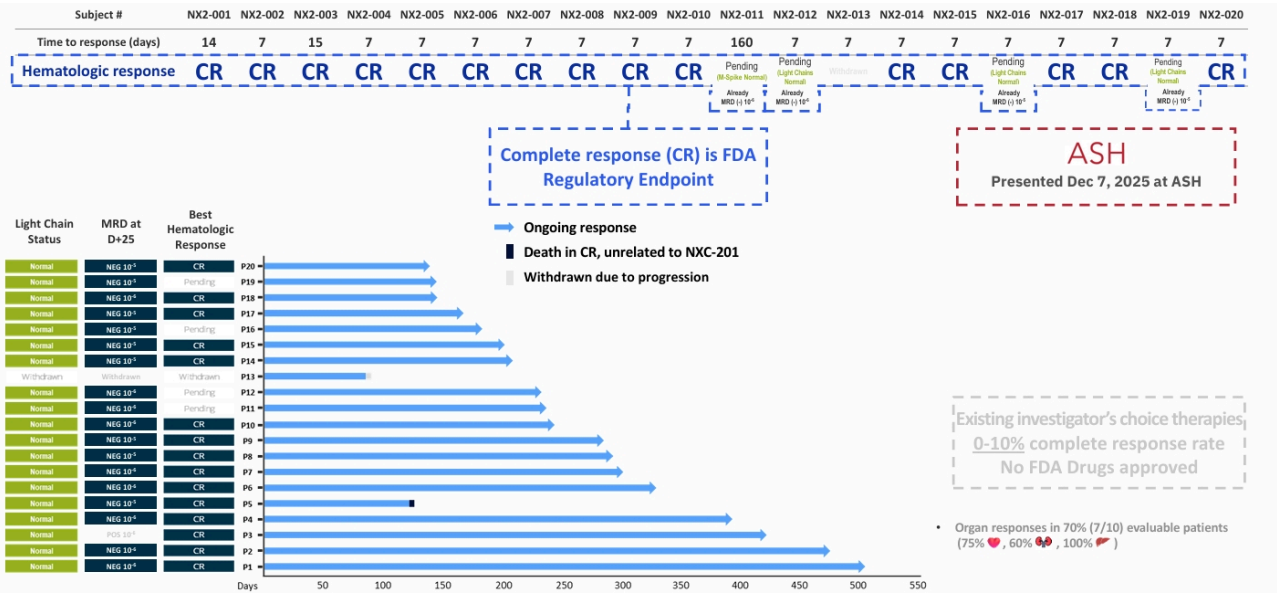
Exhibit 2: Rapid normalisation of disease markers (20-patient NEXICART-2 data)



Source: Immix Biopharma corporate presentation (March 2026)

At this stage in the trial (median follow-up of 7.8 months), 15/20 patients (75%) achieved a CR (Exhibit 3). Further, of the five patients without a CR, four of five were MRD negative, meaning no diseased cells were found on testing 10^6 bone marrow cells. This suggests that they promptly cleared the abnormal plasma cells from their bone marrow and are no longer making the toxic light chains, but have not yet achieved a CR (as it takes some time for existing diseased cells to clear from circulating disease marker measures); these patients may go on to achieve a CR soon. Should this be the case, the CR rate would improve further up to 95%. Unfortunately, the one patient who did not normalise their light chains experienced haematological progression, leading to death at six months (deemed unrelated to NXC-201 treatment). According to the latest update from Immix, 90% of patients remain in the study in haematologic remission. NEXICART-2 is expected to conclude and report a final readout in Q326, representing a major upcoming inflection point for investor attention. Should the data continue to be positive, management intends to submit a BLA to the FDA before end-2026.

Exhibit 3: CR rate of 75% (20-patient NEXICART-2 data)



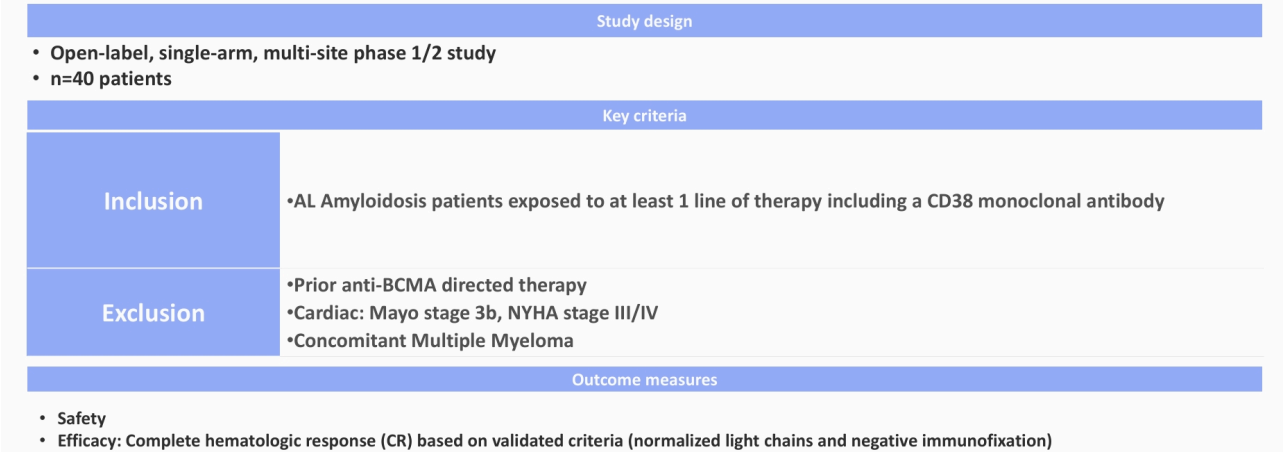
Source: Immix Biopharma corporate presentation (March 2026)

In terms of safety, CRS events were reported in 75% of cases, in line with other approved CAR-Ts. However, with NXC-201, all cases of CRS were low-grade (either grade 1 or grade 2), they all came on predictably (between days one and three) and only lasted for a median of one day, meaning the events were deemed manageable. Further, there were no cases of neurotoxicity, a distinguishing feature of NXC-201 compared to other CAR-Ts, where neurotoxicity is a common challenge. The majority of patients did experience neutropenia, though this was not surprising since the patients had previously undergone lymphodepleting chemotherapy. There was one event of febrile neutropenia, which was in the absence of any infection. One patient with advanced kidney disease did become chemo-dialysis dependent, and, unfortunately, did suffer from a septic event (deemed unrelated to NXC-201). Encouragingly, there was no unexpected or lasting cardiac toxicity, which is impressive given that 11/20 patients had cardiac involvement upon enrolment. In our view, the safety outcomes reflect a net favourable risk-reward profile, especially in light of how fragile the ALA patient population is, with very limited treatment options. The desirable safety profile of NXC-201 may position it as a potential outpatient therapy, where patients may not require hospitalisation or need to stay close to the administering medical centres for long periods for monitoring, as is the case with current CAR-Ts. This could make it a more accessible treatment option for this difficult-to-treat disease.

NEXICART-2 background

As a reminder, NEXICART-2 (NCT06097832) is a US-based, open-label, single-arm, multi-site dose escalation/ expansion, registrational Phase Ib/II trial, with the Memorial Sloan Kettering Cancer Center as one of the main sites. The aim of the study is to evaluate the safety and efficacy of NXC-201 in patients with r/r ALA. This represents an underserved patient population with no FDA-approved drugs. Efficacy measurements for NEXICART-2 are based on haematological responses according to consensus recommendations in ALA. The trial has been designed to recruit 40 participants, the majority of whom are intended to be included in the Phase II portion (the Phase Ib portion included three patients tested at a lower dose and three patients at the target dose). Eligibility criteria for NEXICART-2 are outlined in Exhibit 4.

Exhibit 4: Design of the NEXICART-2 trial



Source: Immix Biopharma corporate presentation (March 2026)

The design of the US-based NEXICART-2 trial differs from that of the prior Israel-based NEXICART-1 trial (NCT04720313), in that NEXICART-2 excludes patients with pre-existing severe cardiac involvement, prior BCMA-targeting therapy exposure and concomitant multiple myeloma. NEXICART-1 also tested three distinct doses of NXC-201 (150m CAR-T cells, 450m CAR-T cells and 800m CAR-T cells, all of which delivered CRs), whereas NEXICART-2 is studying just the first two of these doses, with 450m cells selected as the optimal dose for the Phase II expansion phase, where three patients were tested at 150m cells and three patients were tested at 450m cells in the Phase Ib portion. (Further details on NEXICART-1 can be found in our prior outlook note.) To our knowledge, NEXICART-2 is the only active clinical trial in the US investigating a CAR-T therapy for the treatment of r/r ALA, as of March 2026. Since alternative treatment options for this fragile patient population are limited, it is our opinion that there is a potentially sizeable opportunity for Immix in this space, should the data from NEXICART-2 continue to be positive.

ALA, and potential to expand to additional autoimmune indications

ALA is a rare disease (c 38.5k cases of r/r ALA in the US alone) caused by the abnormal build-up of amyloid proteins in tissues and organs. The disease is driven by the mutation of plasma cells in the bone marrow, which produce non-functional immunoglobulins that misfold to form amyloid light chains. These light chains clump together to form amyloid fibrils that subsequently get deposited in organs, ultimately leading to progressive organ dysfunction.

ALA is the most common type of systemic amyloidosis (accounting for c 70% of all cases), with a high mortality rate if untreated (over 45% within the first year of diagnosis). While ALA can affect almost all organs, the heart, kidneys and liver are the most affected. Notably, over 75% of ALA patients present with cardiomyopathy at the time of diagnosis, with the kidneys and liver involved in 50–60% of cases. ALA most commonly affects the elderly population, with a higher incidence in men. The mean age of diagnosis is c 60 years, and incidence increases with age. Other than genetics and demographics, a key risk factor for ALA is the diagnosis of other plasma cell disorders such as multiple myeloma (c 10% of patients diagnosed with ALA also have multiple myeloma).

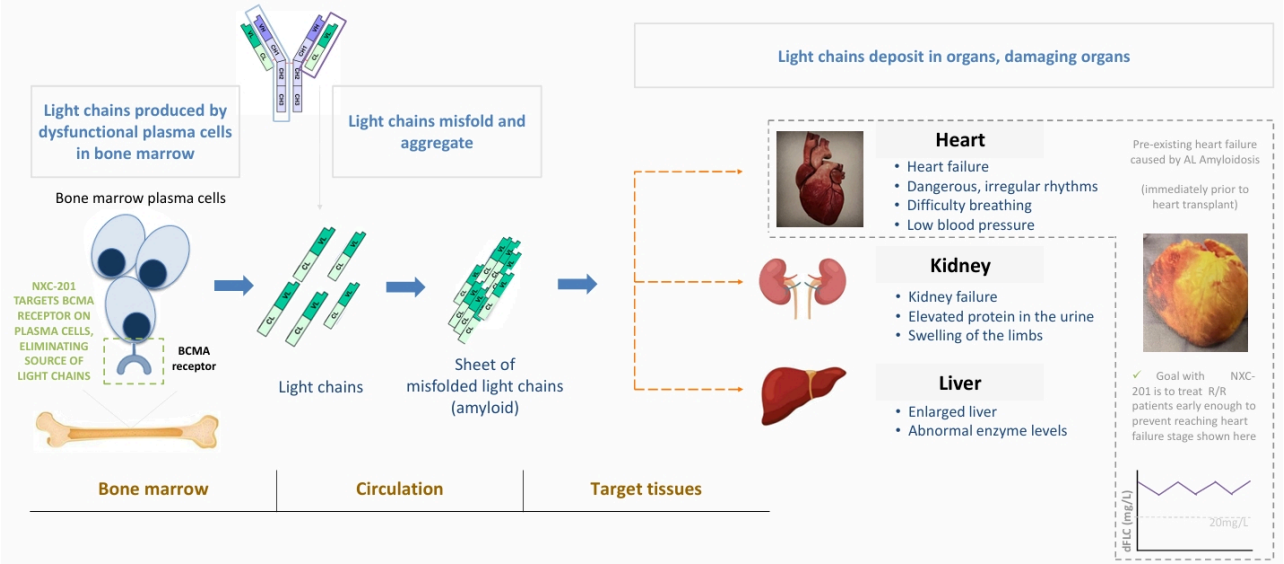
The treatment protocol for ALA aims to reduce amyloid production by targeting aberrant plasma cells, thereby improving organ function. The standard of care induction treatment is a four-drug combination of subcutaneous daratumumab (Darzalex Faspro, Johnson & Johnson) with bortezomib, cyclophosphamide and dexamethasone (Dara CyBorD). Daratumumab is a monoclonal antibody that targets CD38, an antigen expressed on plasma cells, and was approved as a combination treatment by the FDA in 2021, making it the first approved treatment for ALA. For patients achieving a very good partial response (VGPR) after two to four Dara-CyBorD cycles of 28 days each (VGPR = dFLC < 40mg/L), a total of six cycles are completed followed by single agent daratumumab as maintenance treatment for a total of two years, potentially followed by stem cell transplantation as a consolidation treatment. For patients not achieving VGPR, stem cell transplants are suggested for eligible candidates. It is worth noting though that only 20–25% of all patients diagnosed with ALA are eligible for stem cell transplants given the multi-organ involvement and delayed diagnosis.

Despite frontline treatment, ALA is currently considered uncurable and c 75% of patients are believed to be either refractory to frontline treatment (failure to achieve VGPR after two cycles and/or progressive disease while on therapy) or relapse following initial response. Despite ongoing clinical development efforts, there are currently no approved

treatments specifically for r/r ALA (as daratumumab is only approved as a frontline induction treatment).

Immix is pursuing the strategy of a BCMA targeting CAR-T therapy to address the condition; however, given the fragility of the patient population, side effects (mainly neurotoxicity and CRS) remain an ongoing medical concern. In our view, the favourable safety profile of NXC-201 observed in the clinic to date represents a promising opportunity for Immix (Exhibit 5). The ALA treatment market was valued (by Grand View Research) at $5.8bn in 2024 and projected to reach $11.1bn by 2033 (a CAGR of 7.5%). We note that Immix has been awarded Orphan Drug designation for NXC-201 as a potential treatment for ALA by both the FDA and the EMA, alongside a Regenerative Medicine Advanced Therapy (RMAT) designation from the FDA. As mentioned above, it was also recently granted FDA Breakthrough Therapy designation.

Exhibit 5: NXC-201 is designed to target ALA plasma cells that express BCMA



Source: Immix Biopharma corporate presentation (March 2026)

Beyond ALA, Immix has also communicated its plans to expand NXC-201 to other serious diseases (most likely additional autoimmune indications). We expect Immix will likely retain the rights to NXC-201 in ALA, but may potentially seek to out-license the asset in other indications. An announcement with more precise details of these indications, and potentially initial clinical data, could emerge as early as H226. While this may broaden the long-term commercial opportunity, our view remains that the core investment case is centred on execution in r/r ALA.

Financials

Clinical acceleration drives opex expansion

Immix's Q425 and FY25 results reflect a step-up in clinical execution, with a good pace of patient recruitment for the NEXICART-2 trial (completed within Q126, announced shortly after publication of the FY25 annual report, consistent with prior guidance) and top-line readouts expected in Q326. Net R&D expenses (adjusted for the California Institute for Regenerative Medicine (CIRM) grant) for Q425 were recorded at $5.7m, up 24.9% over the Q325 figure of $7.6m. This was expected as the NEXICART-2 trial continues to enrol more patients, with additional sites being onboarded (targeting c 20 sites) ahead of upcoming top-line readouts. We expect R&D spend to stay elevated over the next two to three quarters as clinical activity peaks. G&A expenses in Q425 also rose materially to $5.2m (+67.8% q-o-q), driven by workforce expansion, investor outreach and professional fees as Immix advances towards potential commercialisation of NXC-201. Consequently, the operating loss widened to $10.9m (+42.2% q-o-q).

For FY25, the operating loss increased 32.1% y-o-y to $30.0m, with R&D accounting for 54.3% of total opex (vs 49.8% in FY24). Immix reported $16.3m in R&D expenses (net of the c $2.7m in CIRM grants received during the year), up c 44.0% y-o-y, reflecting the progress with the NEXICART-2 trial. We note that Immix had booked $4.6m of the total $8m CIRM grant income by the end of FY25 ($1.9m in FY24 and $2.7m in FY25) and a further $1.6m has been received in Q126. We model the company reflecting all pending amounts in full in FY26. G&A expenses for the year increased 20.3% y-o-y, reflecting workforce enhancements as well as investor outreach activities. Free cash outflow during the

year was $23.9m, with the impact of the operating performance partially offset by a favourable working capital position (increased accounts payables and accrued expenses).

Estimates revised on commercial build-out

Following Immix's Q425 results, and with greater clarity on the company's commercial strategy for NXC-201, we have made certain adjustments to our near-term forecasts. We raise our R&D estimate for FY26 to $16.6m, from $11.9m. A more material impact comes from G&A expenses, which we now model to be $17.8m in FY26 versus $12.5m previously. This is driven by our understanding that Immix is gearing up its operational team and infrastructure to support its expansion and commercialisation plans. Overall, we now estimate Immix will report an operating loss of $34.4m in FY26, compared to the loss of $24.5m that we had previously expected. We also introduce FY27 estimates and adjust our market launch estimate for NXC-201 to 2027 (previously 2028) following the recent Breakthrough Therapy designation received by the company for NXC-201, which we believe could help accelerate regulatory filing and approval as well as support a priority review. This revised launch timeline in is line with company guidance. We model an operating loss of $9.0m in FY27, assuming product revenues of $38.5m and expenses of $47.5m.

Funded through 2026

Immix ended FY25 with a net cash position of $100.4m (including $93.9m in cash and $6.5m in short-term investments; no debt). This was supported by its December 2025 private placement, raising $100m in gross proceeds ($93.7m net) against an issue of 19.1m shares (at $5.10/share, a discount of c 8% to the prior closing price of $5.56/share) and 490.2k pre-funded warrants at $5.09/unit (exercise price of $0.01/warrant). At current burn rates, funds at hand should support an operating runway through FY27, although management's guidance suggests that further capital will be required in 2027. This leads us to believe that the company is planning significant investments in FY26 and FY27 in building its commercial infrastructure, to potentially support self-commercialisation of NXC-201 (at least in the domestic US market). We await further clarity on this from the company and will revisit our assumptions accordingly. We also note that in March 2026 Immix amended its June 2025 market offering (ATM) agreement with Citizens JMP Securities, increasing the size of the offering to up to $100m, from $50m previously. Under the previous agreement, Immix had raised total net proceeds of $4.4m by 31 December 2025, against the issue of 1.7m shares.

Valuation

Uplift reflects shift to self-commercialisation

We have refreshed our assumptions and valuation for Immix to reflect the increased likelihood of the company self-commercialising NXC-201, should it receive the regulatory green light, backed by the recent appointment of a new commercial-experienced Chief Medical Officer. While we had previously modelled a pre-commercial licensing deal (worth $500m) for NXC-201 in 2027, we now update our model to reflect a fully in-house commercial strategy. Our core assumptions on pricing, penetration and patient population remain broadly unchanged. However, we bring forward the expected launch to 2027 (from 2028 previously) following the recent Breakthrough Therapy designation for NXC-201, which may help accelerate the regulatory process and approval.

We estimate peak sales potential of c $1.2bn for NXC-201, with the PoS maintained at 50% (to reflect the execution risk related to self-commercialisation by a smaller biotech). We assume cost of sales to be 40% of sales at launch and to stabilise over the next few years to 25%, benefiting from scale economies as manufacturing and sales increase. We assume SG&A to be around 25% of sales.

Reflecting the above modifications and the latest net cash position, our valuation for Immix adjusts to $786.5m or $14.8/share, from $373.2m or $7.2/share previously.

Exhibit 6: Immix risk-adjusted net present value

Product	Indication	Launch	Peak	Peak sales (US$m)	Value (US$m)	Probability	rNPV (US$m)	rNPV/share (US$)
NXC-201	AL Amyloidosis	2027	2034	1,169.2	686.1	50%	686.1	13.0
Net cash at 31 December 2025					100.4	100%	100.4	1.9
Valuation					**786.5**		**786.5**	**14.8**

Source: Edison Investment Research

Exhibit 7: Financial summary

Accounts: IFRS; year end 31 December; US$000s	2023	2024	2025	2026e	2027e
PROFIT & LOSS					
Total revenues	0	0	0	0	38,495
Cost of sales	0	0	0	0	(16,124)
Gross profit	0	0	0	0	22,372
Total operating expenses	(16,141)	(22,675)	(29,956)	(34,407)	(31,369)
Research and development expenses	(8,735)	(11,293)	(16,259)	(16,600)	(10,000)
SG&A	(7,406)	(11,382)	(13,698)	(17,807)	(21,369)
EBITDA (normalized)	(16,136)	(22,559)	(29,592)	(33,941)	(8,604)
Operating income (reported)	(16,141)	(22,675)	(29,956)	(34,407)	(8,997)
Finance income/(expense)	572	1,017	556	3,012	2,167
Exceptionals and adjustments	0	0	0	0	0
Profit before tax (reported)	(15,569)	(21,657)	(29,401)	(31,395)	(6,829)
Profit before tax (normalised)	(13,003)	(18,637)	(26,959)	(28,953)	(4,388)
Income tax expense (includes exceptionals)	(26)	(41)	(38)	(40)	683
Net income (reported)	(15,596)	(21,698)	(29,439)	(31,435)	(6,147)
Net income (normalised)	(13,030)	(18,678)	(26,997)	(28,993)	(3,705)
Basic average number of shares, m	17.3	28.3	33.0	54.9	54.9
Basic EPS (US$)	(0.90)	(0.77)	(0.89)	(0.57)	(0.11)
Adjusted EPS (US$)	(0.75)	(0.66)	(0.82)	(0.53)	(0.07)
Dividend per share (US$)	0.00	0.00	0.00	0.00	0.00
BALANCE SHEET					
Property, plant and equipment	50	1,740	2,522	2,056	1,663
Other non current assets	87	20	20	20	20
Total non-current assets	137	1,761	2,542	2,076	1,683
Cash and equivalents	17,510	17,682	100,409	72,249	68,730
Current tax receivables	1,172	1,974	0	0	0
Other current assets	1,106	542	828	542	828
Total current assets	19,788	20,198	101,238	72,790	69,559
Other non-current liabilities	0	0	0	0	0
Long-term debt	0	0	0	0	0
Total non-current liabilities	0	0	0	0	0
Accounts payable	3,722	8,622	9,971	9,878	9,878
Other current liabilities	0	0	0	0	0
Total current liabilities	3,722	8,622	9,971	9,878	9,878
Equity attributable to company	16,203	13,251	93,796	64,803	61,098
CASH FLOW STATEMENT					
Net Income	(15,596)	(21,698)	(29,439)	(31,435)	(6,147)
Depreciation and amortisation	5	33	246	466	393
Share-based payments	2,566	3,021	2,442	2,442	2,442
Other adjustments	0	82	119	80	80
Movements in working capital	1,653	3,967	2,702	193	(287)
Cash from operations (CFO)	(11,371)	(14,595)	(23,930)	(28,254)	(3,519)
Capex	(52)	(1,178)	(733)	0	0
Acquisitions & disposals net	0	0	0	0	0
Other investing activities	0	0	(6,481)	0	0
Cash used in investing activities (CFIA)	(52)	(1,178)	(7,214)	0	0
Capital changes	15,521	15,946	107,393	0	0
Debt Changes	0	0	0	0	0
Other financing activities	(57)	2	(6)	94	0
Cash from financing activities (CFF)	15,464	15,949	107,387	94	0
Cash and equivalents at beginning of period	13,437	17,510	17,682	93,929	65,768
Increase/(decrease) in cash and equivalents	4,040	176	76,243	(28,161)	(3,519)
Effect of FX on cash and equivalents	33	(4)	4	0	1
Cash and equivalents at end of period	17,510	17,682	93,929	65,768	62,250
Net (debt)/cash	17,510	17,682	93,929	65,768	62,250

Source: Company documents, Edison Investment Research

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