EDISON

Percheron Therapeutics

Resetting the narrative with a VISTA focus

Initiation of coverage

Pharma and biotech

17 September 2025

Percheron Therapeutics is an emerging immuno-oncology-focused biotech with a business case anchored on its recent in-licensing of HMBD-002, a Phase II-ready, potentially first-in-class anti-VISTA immune checkpoint inhibitor. HMBD-002's prospects are underpinned by wide expression of VISTA on tumour cells and a mechanistically distinct IgG4 backbone, allowing for non-depleting VISTA inhibition, overcoming a key limitation of other IgG1 anti-VISTA antibodies. Supported by encouraging preclinical and Phase I data, management plans to commence Phase II trials in CY26, a key upcoming catalyst for a share price re-rating. We view Percheron as high-risk, high-reward, with potentially sizeable upside optionality from broad labelling potential. Cash reserves of A$10.2m should provide a runway into FY27. We initiate coverage with a valuation of A$66.7m or 6.1c/share.

Year end	Revenue (AUDm)	PBT (AUDm)	EPS (AUD)	DPS (AUc)	P/E (x)	Yield (%)
6/24	2.4	(11.7)	(1.33)	0.00	N/A	N/A
6/25e	1.4	(13.4)	(1.31)	0.00	N/A	N/A
6/26e	2.4	(10.5)	(0.97)	0.00	N/A	N/A
6/27e	5.8	(18.9)	(1.73)	0.00	N/A	N/A

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

HMBD-002: A novel drug with multi-cancer potential

HMBD-002, acquired by Percheron in June 2025, inhibits VISTA, a promising target with wide expression across tumour cells (believed to be upregulated in over 30% of tumours) and possible synergies with anti-PD-1s given its role as a resistance pathway to PD-1 inhibition. Drugging VISTA has been a challenge historically due to concerns around off-target toxicities and cytokine release syndrome (CRS). HMBD-002, an IgG4 isotype (other anti-VISTA antibodies in development are IgG1, to our knowledge), is engineered to overcome this limitation by blocking the checkpoint-ligand interaction on tumour cells without wider systemic VISTA depletion. Phase I data indicate a favourable safety profile with optionality as monotherapy or combination treatment across a range of cancers. Efficacy signals in more advanced studies will now be required to validate HMBD-002's potential.

Phase II commencement a key upcoming catalyst

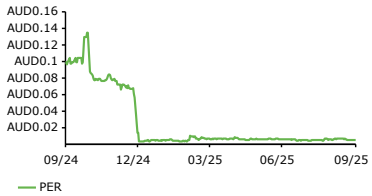
With full Phase I data expected in Q4 CY25, Percheron plans to commence Phase II studies in CY26. While the Phase II plans and design are yet to be disclosed, we see the highest prospects in testing HMBD-002 in combination with Keytruda across multiple indications. The immune checkpoint inhibitor (ICI) market is touted to reach US$150bn by 2030, and even a modest share of this market could mean blockbuster sales potential for HMBD-002 if clinical development is successful.

Valuation: A$66.7m or 6.1c per basic share

Percheron is currently trading below cash, suggesting material value accretion potential with HMBD-002's clinical progression. We value Percheron at A$66.7m or 6.1c/share using a risk-adjusted NPV approach, assuming three target indications, NSCLC, HNSCC and melanoma, a 10% probability of success, and out-licensing before Phase III. This is subject to modification with clarity on the Phase II plans.

Price	**AUD0.009**
Market cap	**AUD10m**
	US$0.65/A$
Net cash/(debt) as at 30 June 2025	AUD10.2m
Shares in issue	1,087.4m
Code	PER
Primary exchange	ASX
Secondary exchange	N/A

Share price performance



%	1m	3m	12m
Abs	0.0	(10.0)	(87.8)
52-week high/low		AUD0.1	AUD0.0

Business description

Percheron Therapeutics is a clinical-stage biotech advancing HMBD-002, a differentiated VISTA-targeting checkpoint inhibitor with potential to address PD-1 resistance across a range of cancer indications. HMBD-002 has completed a Phase I clinical trial in patients with advanced cancer, with favourable safety and tolerability. Phase II trials are expected to commence in 2026.

Next events

HMBD-002 Phase I full data release	Q4 CY25
Phase II trial initiation	CY26

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Investment summary

Company description: Staking a claim to the VISTA opportunity

Percheron Therapeutics is an ASX-listed clinical-stage biotech. It recently pivoted into immuno-oncology after discontinuing its prior lead programme, avicursen (ATL1102), in Duchenne muscular dystrophy (DMD) following an unsuccessful Phase IIb trial in late 2024. With the acquisition of the global licensing rights to HMBD-002 in June 2025 from Hummingbird Biosciences, the company has now reset its pipeline, with a potentially first-in-class VISTA-targeting antibody. Deal terms included a US$3m upfront payment, up to US$287m in milestones and tiered royalties starting at 12.5%. VISTA is an emerging immune checkpoint implicated in resistance to PD-1/PD-L1 therapies, with wide expression across immune cells and a range of certain solid tumours, offering potential differentiation. Early data suggest favourable safety and tolerability, immune activation and synergies with PD-1 and potentially EGFR inhibitors. Percheron plans to begin Phase II proof-of-concept trials in CY26, with trial design details expected in Q4 CY25. While VISTA remains a nascent, high-risk target, HMBD-002 provides first-mover potential in an ICI space expected to reach US$150bn by 2030, with value inflection tied to upcoming trial readouts.

Valuation: A$66.7m or 6.1c per share in the base case

Percheron's valuation rests on HMBD-002, its Phase II-ready, potentially first-in-class anti-VISTA ICI. We employ a risk-adjusted net present value (rNPV) framework as our primary valuation methodology, supplemented by peer benchmarking and market-based methods, as a tool to validate our rNPV projections. While the exact Phase II target indications have not been disclosed, our base case assumes combination with Keytruda across non-small cell lung cancer (NSCLC), head and neck squamous cell carcinoma (HNSCC) and melanoma, with Phase II costs of c US$15m per indication for a total outlay of c US$45m. We model US pricing at US$90k/year, peak penetration of 20–30% across indications and global peak sales of US$3.0bn by 2045, with 12 years' market exclusivity in the US, in line with novel biologics. Assuming a 10% probability of success (PoS) and out-licensing in 2029 at US$750m total deal value, we derive an rNPV valuation of A$66.7m (6.1c/share) for Percheron.

Financials: Funded into FY27

As a pre-revenue biotech, Percheron relies on external capital raises (primarily in the form of equity issues) and Australia's R&D tax rebate (A$1.4m in FY25 and A$2.4m in FY24) to support clinical and operational efforts. Operating expenses rose 12% y-o-y to A$16.6m in FY25, driven by avicursen Phase IIb costs, higher staff costs and share-based payments. Supported by an A$15m equity raise in late CY24, end-FY25 cash stood at A$10.2m, providing a runway into FY27 according to our estimates. We forecast higher R&D expenses in FY26 and FY27 as HMBD-002 Phase II trials commence and estimate an additional capital requirement of c A$40m before out-licensing in FY29.

Sensitivities: Clinical execution will be key

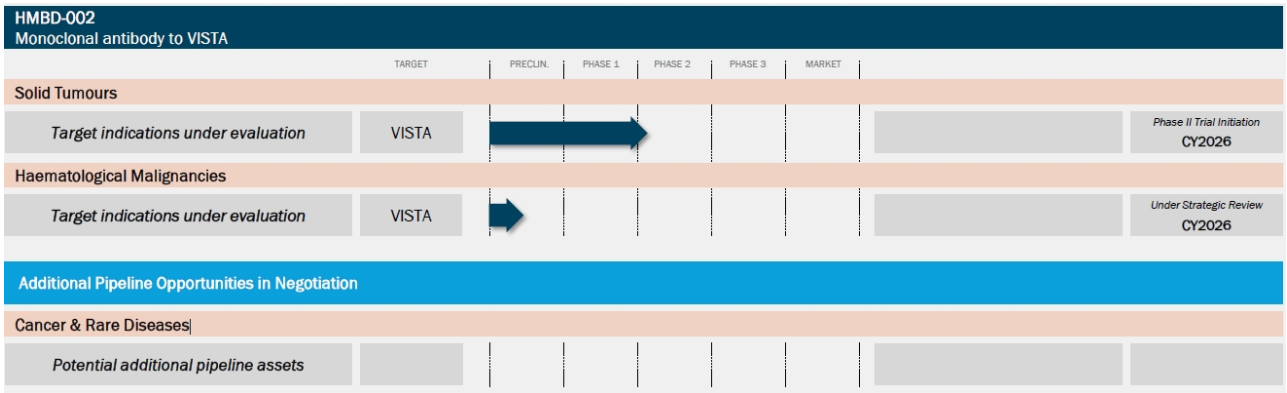
Percheron Therapeutics has the typical high-risk, high-reward profile of clinical-stage biotechs. With HMBD-002, its sole pipeline asset currently, the company has a high product concentration risk and is also exposed to binary risk events. However, we believe that HMBD-002's broad application potential across a range of indications mitigates some of these risks. The key sensitivities for Percheron will be clinical execution with the Phase II trial design, patient recruitment and dose optimisation, which is critical to establishing proof-of-concept. Target validation remains a core uncertainty. Although VISTA is supported by a strong preclinical rationale, human evidence is limited. Demonstrating consistent immune activation and efficacy in VISTA-high tumours is critical, while immune-related safety events could restrict dose levels and narrow the patient population. Percheron believes HMBD-002's IgG4 design provides an edge over IgG1 competitors by blocking VISTA's immunosuppressive function without depleting VISTA-expressing cells, but this still requires clinical confirmation. Strategic choices around trial design and indication selection, including whether to pursue monotherapy or PD-1 combinations, will shape the asset's trajectory and costs. Financing adds another layer of risk. With A$10.2m in cash at FY25, Percheron is funded into FY27 but will need additional capital to complete Phase II. Equity raises are likely, with dilution a concern, though tax credits and partnerships could extend the runway. Furthermore, competitive dynamics and partnering are crucial, as HMBD-002 must differentiate itself in a competitive ICI landscape and field challenges from other next-generation ICI combinations and bispecifics. Attractive deal terms (≥20% royalties) will be vital for future partnerships and commercialisation.

A refreshed pipeline with HMBD-002

Percheron Therapeutics is a clinical-stage biotech repositioning its strategy to immuno-oncology from neuromuscular diseases following the discontinuation of its prior lead clinical programme, avicursen (ATL1102), in DMD. Avicursen is an oligonucleotide inhibitor of CD49d (a cell surface receptor on white blood cells), inhibition of which had shown immunomodulatory activity in inflammatory disease models. Despite positive early signals, the company's Phase IIb trial failed to meet efficacy endpoints (results were reported in December 2024), prompting a pipeline reset and capital redeployment. The readout highlighted the inherent risks with drug development and the challenges in translating early promise into late-stage functional outcomes.

Percheron has since pivoted its focus towards immuno-oncology, a field with significant commercial opportunities and a broader set of validated clinical development pathways, albeit with a more competitive landscape. The cornerstone of this transition was the acquisition of global licensing rights in June 2025 to HMBD-002, a first-in-class monoclonal antibody targeting VISTA (V-domain Ig suppressor of T-cell activation). The licence was acquired from Hummingbird Biosciences, a Singapore-based precision biotherapeutics company focused on the discovery and early development of biologics, with a strategy to out-license following early-stage development. Hummingbird was founded in 2015 and its licensing partners include Endeavor BioMedicines, Callio Therapeutics, Synaffix and Caris Life Sciences. The deal terms for HMBD-002 included an upfront payment of US$3m (of which US$2m has been paid to date and the remaining US$1m due within 20 days of Hummingbird supplying the initial batch of HMBD-002 drug substance to the company), development and commercial milestones of up to US$287m and tiered royalties starting at 12.5%. VISTA is a new-generation immune checkpoint receptor believed to play a key role in T-cell suppression and resistance to existing anti-PD-1/PD-L1 therapies. Unlike conventional checkpoints, VISTA is highly expressed in myeloid-derived suppressor cells (MDSCs) and multiple solid tumours, offering the potential for differentiated activity in patient populations underserved by current immunotherapies. We present a schematic of Percheron's current pipeline priorities in Exhibit 1.

Exhibit 1: Percheron Therapeutics' development pipeline



Source: Percheron Therapeutics corporate presentation, June 2025

Preclinical and early Phase I data on HMBD-002 have shown favourable safety, tolerability and preliminary signs of immune activation. Importantly, the candidate has demonstrated potential synergy with both checkpoint inhibitors (such as anti-PD-1s) and targeted therapies (such as EGFR inhibitors) in preclinical models, creating scope for varied combination strategies. Percheron plans to advance the candidate through Phase II proof-of-concept before seeking out-licensing opportunities. Details on the Phase II plans and study design are expected to be released in Q4 CY25, and we believe that possible development strategies could include basket or standalone trials across multiple solid tumour types.

From an investment perspective, Percheron represents a high-risk, high-reward story, in our view. While the acquisition of HMBD-002 aligns the company with one of the most active and commercially attractive areas of drug development, the risks stem from VISTA being a relatively new and unexplored target and early challenges with VISTA drugging (as seen by previously developed anti-VISTA antibodies). However, with its optimised IgG4 backbone and positive clinical data to date, HMBD-002 offers potential first-mover opportunities and differentiation in the ICI space, currently dominated by anti-PD-1/PD-L1 and anti-CTLA-4 drugs. Key catalysts include readouts from the upcoming Phase II clinical trials, progress with combination strategies and clarity on the regulatory path forward. Execution risk remains high, but this pivot builds a defined strategic narrative with the potential to rebuild long-term value. We explore our investment case for Percheron in more detail below.

Immuno-oncology: Transforming the cancer treatment landscape

The immune system is naturally built to detect and eliminate abnormal cells while sparing healthy tissue. Cancer, however, has evolved ways to evade immune recognition, allowing unchecked tumour growth. While traditional treatments like chemotherapy and radiation can be effective, they are associated with significant side effects. In contrast, immuno-oncology (immunotherapy) harnesses and enhances natural defence mechanisms, effectively removing the 'brakes' that cancer places on the immune system. This offers a considerably more desirable risk-reward profile from a safety perspective. The field is regarded as a key pillar of innovation, having provided meaningful and beneficial treatment outcomes across a broad range of cancer indications over the past 10–15 years.

There are four main categories of immuno-oncology treatments currently on the market: chimeric antigen receptor T-cell therapies (CAR-Ts); cancer vaccines; oncolytic viral therapies; and ICIs. Of these, ICIs have had the broadest benefit and are the main focus of Percheron. Immune checkpoints (such as PD-1 and CTLA-4) are regulators of the immune system and play a key role in maintaining immune homeostasis and preventing abnormal immune activity. Cancer cells exploit this property of checkpoints, dampening T-cell activity and allowing tumours to grow unchecked. ICIs are biological treatments (monoclonal antibodies) that disrupt these interactions, thereby reactivating cytotoxic T-cells against cancer. In effect, ICIs switch the tumour micro-environment (TME) from 'cold' (ie immunosuppressive) to 'hot' (ie vulnerable to the immune system).

Shifting regimes: From later- to earlier-line settings for various cancers

Over the past decade, ICIs have reshaped cancer therapy, offering durable responses and broad applicability across cancers, including in patient groups with historically poor prognoses. Their clinical success has prompted a paradigm shift, with ICIs being increasingly utilised in earlier-line treatment settings (either as monotherapies or in combination with chemotherapy or other immunotherapies) in advanced-stage cancers. For example, ICIs have progressed from late-line to first-line therapy in advanced melanoma, where PD-1 inhibitors such as Keytruda (generic name: pembrolizumab) and Opdivo (generic name: nivolumab) have significantly improved overall survival. In NSCLC, ICIs are now standard in both metastatic and locally advanced settings. Similarly, in HNSCC, ICIs such as Opdivo have moved into earlier treatment lines, reflecting a growing confidence in their safety profiles, as well as their durability and efficacy profiles.

Current approved ICIs have a range of mechanisms

Many types of tumours can evade immune attack by expressing PD-L1, which binds to PD-1 receptors on T-cells and suppresses their activity. Drugs that block the PD-1/PD-L1 interactions help to 'reactivate' the immune system against cancer cells. This is by far the most prevalent mechanistic approach for currently approved ICIs. Merck's blockbuster Keytruda dominates this class, with FDA approval for 21 cancer types and an additional 23 in the pipeline (across Phase II and Phase III, according to Evaluate Pharma). The first approved ICI, BMS's Yervoy (generic name: ipilimumab; approved in 2011), however, has a different mechanism of action, targeting cytotoxic T lymphocyte-associated protein 4 (CTLA-4). Yervoy has been approved for seven indications and has 18 in the pipeline. More recently, Opdualag (2022), a combination of Opdivo (PD-1) and relatlimab (LAG-3), introduced dual checkpoint inhibition, offering another strategy to overcome immune resistance. Opdivo was first approved in 2014, while relatlimab is the first approved LAG-3 inhibitor.

Market size: Impressive revenue performances to date across the major ICIs

ICIs are the largest contributor to immuno-oncology product sales worldwide (Exhibit 2). According to Grandview Research, the market size for ICIs was estimated at c US$50bn in 2023, and is projected to reach c US$150bn by 2030. This corresponds to a CAGR of 17.9% across this period, reflecting both the lucrative nature of the field and the potential for it to continue to grow in size.

While significant investments and strides have been made with the development of ICIs for various cancers, recent thinking has evolved to suggest that such approaches are not a long-term, standalone solution. Despite the success ICIs have seen, both pharmacologically and economically, their use as monotherapies has limitations, such as low response rates in certain indications, as well as observations of tumour resistance.

Exhibit 2: Approved ICIs

ICI	Company	Target	Launch year	First patent expiry year	Number of marketed indications	Estimated sales 2028 (US$)
Yervoy (ipilimumab)	Bristol Myers Squibb	CTLA-4	2011	2025	7	1.9bn
Opdivo (nivolumab)	Bristol Myers Squibb	PD-1	2014	2028	12	9.2bn
Keytruda (pembrolizumab)	Merck	PD-1	2014	2028	21	28.5bn
Tecentriq (atezolizumab)	Roche	PD-L1	2016	2032	8	4.5bn
Bavencio (avelumab)	EMD Serono/Merck	PD-L1	2017	2033	3	769m
Imfinzi (durvalumab)	AstraZeneca	PD-L1	2017	2031	8	7.3bn
Libtayo (cemiplimab)	Regeneron/Sanofi	PD-1	2018	2035	6	2.0bn
Jemperli (dostarlimab)	GSK	PD-1	2021	2034	2	1.4bn
Opdualag (nivolumab & relatlimab)	Bristol Myers Squibb	PD-1 & LAG-3	2022	2034	1	1.6bn

Source: Edison Investment Research, Evaluate Pharma

Immunotherapy combinations: The ideal doubles partner?

ICIs may fall short (on their own)

Depending on the precise indication and agent, the effectiveness of ICIs can be limited, with typically only c 20–40% of patients experiencing significant and durable benefits. This limited efficacy is often attributed to either innate resistance or acquired resistance. Innate resistance refers to a pre-existing, intrinsic lack of responsiveness to immune checkpoint blockade (before any treatment is initiated). This may be due to naturally 'cold' TMEs, which lack pre-existing cytotoxic T lymphocytes (CTLs) and/or have low PD-1/PD-L1 expression, meaning that blocking such checkpoints will have little biological effect. Conversely, acquired resistance occurs when a tumour that initially responds to an ICI later progresses due to newly evolved mechanisms of immune escape.

A key driver of acquired resistance is believed to be the upregulation of alternative checkpoints. For example, in response to PD-1 blockade, tumours may upregulate other inhibitory pathways, such as LAG-3, TIGIT, TIM-3 and VISTA. This understanding led to the development and approval of Opdualag, which, as discussed above, is a combination therapy in itself, combining the PD-1 inhibitor Opdivo with the LAG-3 inhibitor relatlimab. In its registrational trial, at the 13.2 month primary analysis, it was found that Opdivo/relatlimab reduced the risk of cancer growing, spreading, or getting worse by 25% compared to Opdivo alone, when tested across 714 patients with advanced melanoma.

Combination with other checkpoints may improve patient outcomes

To address these challenges, combination therapies are fast emerging as an important strategy to provide more desirable and durable patient outcomes compared to monotherapy approaches, pairing ICIs with chemotherapy, targeted treatments, or other checkpoint inhibitors. Such approaches, which aim to create synergistic effects and overcome resistance will likely be key for developing new treatment protocols involving ICIs to disrupt existing standards of care in cancer treatments.

ICI combinations have proved to be an effective strategy for BMS for the treatment of melanoma, highlighting a viable strategy to maximise the potential of such treatments. While blocking only one pathway often allows tumours to escape via others, this dual-inhibition approach appears to help overcome acquired resistance, as it acts on non-overlapping inhibitory mechanisms. Percheron is looking to exploit a similar strategy with its novel ICI candidate, HMBD-002, which targets the immune checkpoint VISTA. We discuss VISTA as a therapeutic target in more detail below.

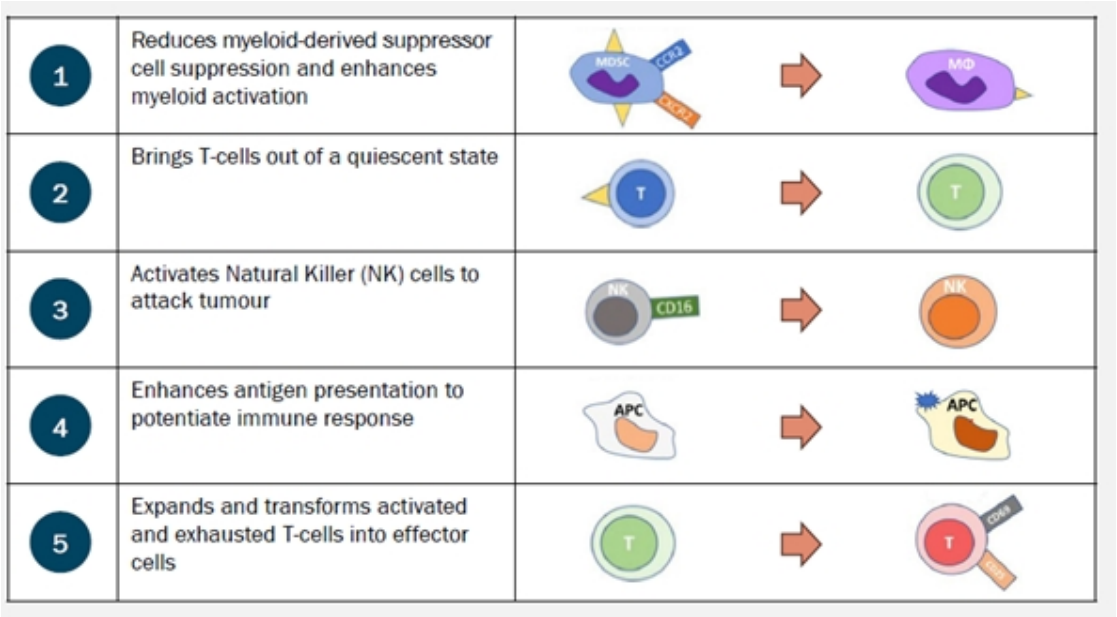
VISTA: A compelling target

Distinct mechanism of action

While several next-generation ICIs are under development (targeting checkpoints such as TIGIT, TIM-3, LAG-3), VISTA is one of the newest targets and is differentiated by its broad expression across lymphoid (such as naïve and regulatory T-cells) and myeloid cells (mainly MDSCs, dendritic cells and macrophages in the case of cancer) and its role as a compensatory pathway driving resistance to PD-1/CTLA-4 blockade. Unlike PD-1 or CTLA-4, which primarily regulate effector T-cell activation, VISTA is unique due to its ability to act as both a receptor (on T-cells) and a ligand (on antigen-

presenting cells (APCs)). As a receptor on naive T-cells, it directly transmits signals that sustain quiescence (restraining the immune system) and prevent excessive activation. As a ligand on APCs, VISTA can deliver inhibitory signals to T-cells, dampening their activation threshold and contributing to immune evasion by tumour cells. VISTA also plays a crucial role in the differentiation and expansion of MDSCs, which are key regulators of immune evasion in cancer. This can further contribute to immune suppression in the TME. VISTA is also expressed at lower levels on natural killer (NK) cells, where it acts as a regulator to control NK cell activation. While VISTA's influence on NK cells is less direct compared to its more prominent role in MDSCs and T-cells, it is still significant, contributing to the overall balance of the immune response within the TME. Targeting VISTA with VISTA-blocking antibodies such as HMBD-002 is therefore believed to be a promising therapeutic strategy to reduce MDSC accumulation (diminishing its inhibitory effects on T-cells), enhance anti-tumour T-cell responses and improve cancer immunotherapy outcomes (Exhibit 3).

Exhibit 3: Anti-VISTA mechanism of action



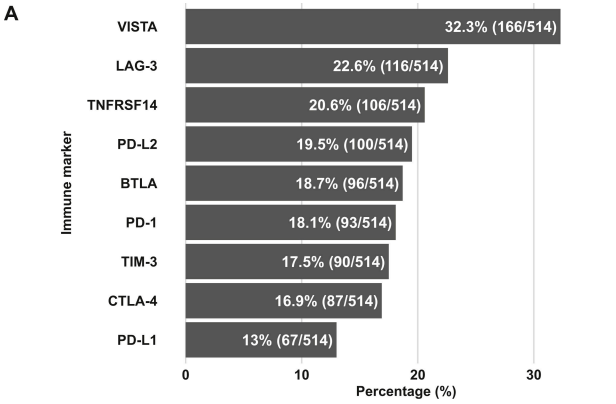
Source: Percheron Therapeutics corporate presentation, June 2025

High expression across tumour types

VISTA is highly expressed across a broad range of solid tumours, underscoring its potential role as a next-generation immunotherapy target. Scientific and preclinical studies have shown that VISTA is upregulated in several solid tumours, including NSCLC, HNSCC, colorectal, ovarian, breast, gastric and pancreatic cancer. As an example, a study comparing expression of nine protein checkpoints in a sample of 514 tissues noted that VISTA was the most commonly expressed checkpoint among the nine assessed (observed in 32% of the tumours), although the expression levels varied by cancer type and cell type within the TME (Exhibits 4 and 5). In another study testing 324 human breast cancer samples, expression of immune checkpoint molecules (VISTA, PD-1, PD-L1, TIGIT, TIM3, and LAG3) observed that VISTA had the highest expression among all checkpoints.

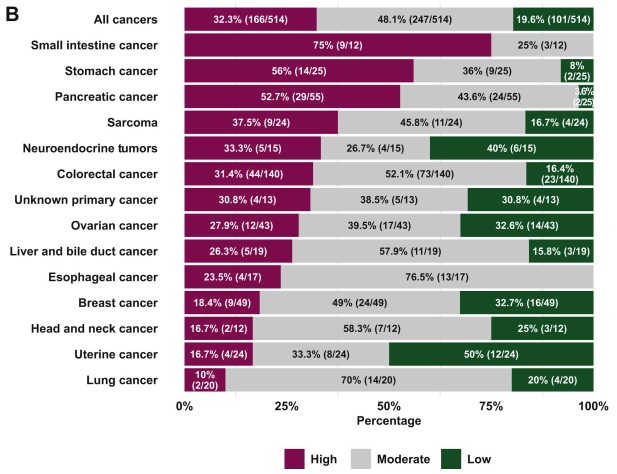
Notably, a study evaluating 85 primary melanoma specimens observed that the presence of VISTA was associated with a significantly worse disease-specific survival (Exhibit 6). A meta-analysis of solid tumours concluded that high VISTA expression has been linked to poor prognosis in cancers such as melanoma, gliomas and pancreatic cancer, reflecting its role in reinforcing immune evasion. We believe this highlights the potential utility of VISTA as a therapeutic target and biomarker in several cancers.

Exhibit 4: VISTA tumour expression versus other checkpoints



Source: Nishizaki D et al. VISTA: landscape and outcomes across cancers. ESMO Open. 2024.

Exhibit 5: VISTA expression by tumour type

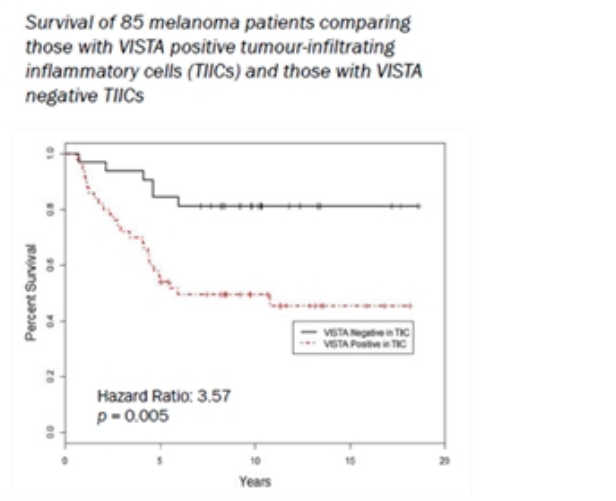


Source: Nishizaki D et al. VISTA: landscape and outcomes across cancers. ESMO Open. 2024.

Synergy with PD-1/PD-L1 blockade

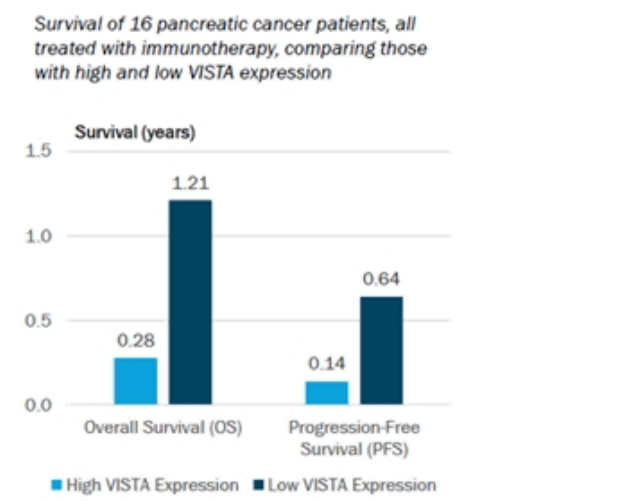
Both VISTA and PD-1 are negative regulators of T-cell responses and are frequently co-expressed on tumour and immune cells. Some studies have also reported the overexpression of VISTA following treatment with PD-1 inhibitors, suggesting that it may act as a compensatory immune escape pathway. In one study, 34 metastatic melanoma samples were collected from 16 patients who had initially responded to either anti-PD-1 (n=13) alone or a combination of anti-PD-1 and anti-CTLA4 (n=3) and then progressed. Biopsies were taken before treatment (n=12) and following disease progression (n=22). It was observed that VISTA expression was increased in 67% of the samples (p=0.009), post disease progression. Moreover, in the previously cited study testing 514 samples of checkpoint expression, it was noted that of the 16 ICI-treated pancreatic cancer samples, median overall survival (OS) and median progression-free survival (PFS) were significantly shorter for the high-VISTA groups compared to the low-VISTA groups, with an OS of 0.28 years versus 1.21 years and a PFS: 0.14 years versus 0.64 years (Exhibit 7). We believe this further builds the case for VISTA to be explored as a next-generation checkpoint to target patients who relapse or fail to respond to PD-1/PD-L1 therapy or as a combination treatment. Preclinical data demonstrate strong synergy between VISTA and PD-1/PD-L1 blockade, with combination therapy restoring T-cell activation more effectively than either monotherapy. Given that anti-PD-1 therapies like Keytruda already anchor the oncology landscape, we believe that the rationale for developing VISTA inhibitors as combination agents is commercially and clinically compelling.

Exhibit 6: High expression of VISTA associated with worse prognosis



Source: Percheron Therapeutics corporate presentation, June 2025

Exhibit 7: High VISTA expression is associated with resistance to PD-1 inhibition



Source: Percheron Therapeutics corporate presentation, June 2025

VISTA inhibition: Competitive landscape

HMBD-002: Leading anti-VISTA antibody targeting solid tumours

While the ICI development landscape is fairly crowded with several novel ICIs in clinical development, because VISTA is a relatively new checkpoint, the competitive intensity around this target remains more modest and at an early stage, compared with PD-1/PD-L1 or other more advanced proteins such as LAG-3 and TIGIT. With only a limited number of programmes in clinical testing (Exhibit 8), the space is dominated by small biotech players, which provides a meaningful first-mover opportunity for successful programmes, including potentially HMBD-002, which is one of the most clinically advanced active programmes.

Exhibit 8: Anti -VISTA competitive landscape

Programme/asset	Parent company	Isotype	Monotherapy/combination	Stage	Current status	Notes
HMBD-002	Hummingbird Biosciences/ Percheron Therapeutics	IgG4	Monotherapy and in combination with pembrolizumab (Keytruda)	Phase I (n=48)	Phase II to commence in 2026	Percheron in-licensed rights in June 2025. Only IgG4 antibody targeting VISTA in clinical development.
Solnerstotug (SNS-101)	Sensei Bio	IgG1	Monotherapy and in combination with cemiplimab (Libtayo)	Phase I (n=94)	Phase II to commence in 2026	Phase I dose expansion data expected by end-2025.
Onvatilimab/CI-8993/ JNJ-61610588	Curis/ImmuNext/formerly Janssen	IgG1	Monotherapy	Phase I (n=12;26)	Programme terminated/on hold	First VISTA mAb to enter clinical trials, discontinued first by Janssen (CRS-related encephalopathy) and subsequently put on hold by acquirer, Curis.
KVA12123/TBS-2025	Kineta/TuHURA Biosciences	IgG1	Monotherapy and in combination with pembrolizumab (Keytruda)	Phase I (n=40)	Phase II trial planned in combination with a menin inhibitor in NPM1 mutated AML	TuHURA Biosciences completed acquisition of Kineta in June 2025.
W0180/ K01401	Pierre Fabre	IgG1	Monotherapy and in combination with pembrolizumab (Keytruda)	Phase I (n=33)	Programme terminated	The programme was terminated in late 2023 after two dose-limiting toxicities and 23 of the 33 patients treated reporting grade three and four treatment-emergent adverse events. Non-linear pharmacokinetics, consistent with the 'VISTA sink' were also observed.
PMC-309	PharmAbcine	IgG1	Monotherapy and in combination with pembrolizumab (Keytruda)	Phase I (n=67)	Ongoing	Total 67 patients to be enrolled in Phase I undertaken in Australia. Phase Ia to evaluate maximum tolerated dose and recommended Phase II dose ongoing.

Source: Company documents, Edison Investment Research

The first VISTA targeting antibody to enter human trials was JNJ-61610588/CI-8993/onvatilimab, although its clinical progress has been hit by various roadblocks. It was originally developed by ImmuNext/Janssen, but the Phase I trial (initiated in 2016 in advanced solid tumours) was terminated prematurely following safety issues related to one dose-limiting CRS event and Grade 3 CRS-associated encephalopathy (affecting brain functioning) at a 0.3mg/kg dose. In 2020 the licence was acquired by Curis, which commenced a Phase I dose-escalation trial with an optimised formulation in refractory solid tumours in September 2020. However, according to our understanding, further development has been put on hold as Curis has prioritised its lead programme, emavusertib in AML. A few other VISTA-targeting programmes have since been terminated or put on hold, such as Pierre Fabre W0180 (following Phase I) and Apexigen APX201 (during preclinical development). Note that another anti-VISTA asset under development, Kineta's KVA12123 (which was previously tested in a Phase I trial as monotherapy and in combination with Keytruda), has been revived following the company's acquisition by TuHURA Biosciences in June 2025; TuHURA now plans to initiate a Phase II randomised study for the asset (rebranded as TBS-2025) in combination with a menin inhibitor in NPM1 mutated AML.

The most clinically advanced anti-VISTA antibodies targeting solid tumours are Sensei Bio's solnerstotug (SNS-101) and Percheron's HMBD-002. Solnerstotug is expected to report complete data from the expansion part of a Phase I study by end-CY25, with Phase II expected to initiate in 2026. Solnerstotug has a distinct mechanism of action compared to other IgG1 isotypes, being a pH-dependent monoclonal antibody designed to target and block VISTA specifically at acidic pH levels seen in the TME, while sparing the pH neutral immune cells. HMBD-002 is an IgG4 isotype and full Phase I data are expected in Q4 CY25, with Phase II to commence in 2026.

Note that HMBD-002 is the only IgG4 antibody targeting VISTA in a playing field otherwise dominated by IgG1 isotypes. This differentiation is what equips it to meet some of the challenges faced by previous anti-VISTA antibodies. We discuss the significance of this in the section below.

Designed to overcome early challenges with VISTA drugging

VISTA's wide expression across different immune cells and its ability to function as both a receptor and ligand, the features that make it a compelling target, have also been a key challenge in utilising it as a target. Unlike PD-1/PD-L1, which are more restricted to activated T-cells, VISTA is expressed across multiple immune subsets (myeloid cells, T-cells, MDSCs), making it more difficult to selectively target tumour cells without affecting peripheral immune homeostasis. This increases the risk of off-target systemic immune activation and unwanted inflammatory reactions.

Another issue has been non-linear pharmacokinetics and a pharmacological 'sink' effect seen with VISTA drugging. As noted above, VISTA is widely expressed in immune cells and off-target binding to these cells allows the drug to be quickly expelled from the body, limiting distribution within the tumour cells in a phenomenon called target-mediated drug disposition. This results in higher dosing being required to reach biologically active concentration within the tumour, increasing the likelihood of dose-limiting toxicities. An additional challenge faced particularly by previous-generation IgG1 antibodies is driven by antibody-dependent cellular cytotoxicity (ADCC). An antibody has a Y-shaped structure composing two antigen-binding fragment (Fab) arms and a crystallisable fragment (Fc). While the Fab arms binds to the target protein/antigen, the Fc arm binds to the Fc receptors on the surface of immune effector cells, such as NK cells, allowing the immune cells to recognise and kill the antibody-coated target cells in a process called ADCC. While this in itself is an effective approach to target cancer, in the case of IgG1 anti-VISTA antibodies, the strong Fc-mediated effector function also results in the elimination/depletion of VISTA-expressing immune cells (which are required to maintain immune homeostasis), increasing the chances of CRS and off-target toxicity.

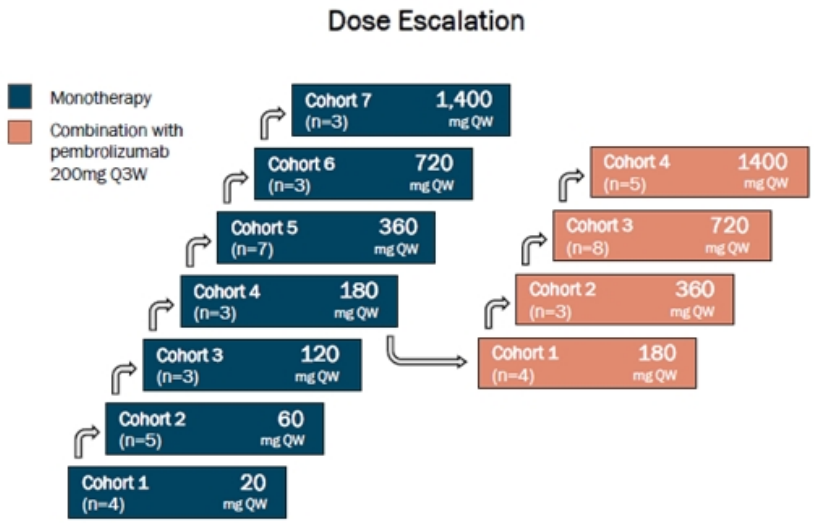
HMBD-002, an IgG4 antibody, has been designed to overcome these limitations. In contrast to IgG1 antibodies, it has been engineered to minimise Fc receptor binding, reducing the effector function and allowing it to neutralise VISTA immunosuppressive activity (by blocking ligand/receptor interactions) without depleting healthy VISTA expressing cells. The strategy aims to decouple efficacy from toxicity, allowing for the higher and more sustained dosing needed to overcome the VISTA sink. Keytruda and Opdivo are both IgG4 antibodies, meaning that this intended mechanism has been demonstrated to not impact treatment efficacy while maintaining a more favourable safety and toxicity profile.

HMBD-002: Potential backed by supportive data

Phase I results encouraging; full data expected in Q4 CY25

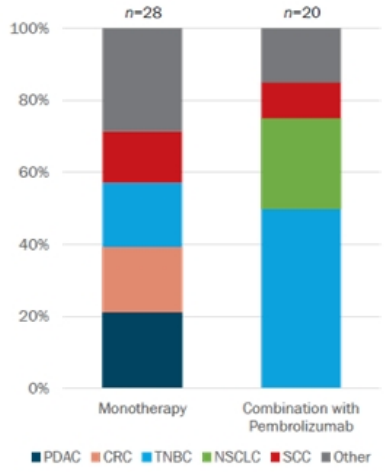
HMBD-002 has successfully completed a Phase I safety study in the US, which showed the drug to be pharmacologically active and generally safe and well-tolerated. The trial was an open-label, multi-centre study evaluating HMBD-002 as monotherapy and in combination with Keytruda in 48 patients with advanced solid tumours (locally advanced and unresectable, or metastatic). The study had a 3+3 dose escalation design with a 21-day observation period for dose-limiting toxicities (Exhibit 9). A total of seven cohorts were included in the monotherapy arm (n=28) and four in the combination arm (n=20). The tested doses ranged from 20mg (once-weekly IV infusion) to 1,400mg, administered for a period of up to one year (Exhibit 10).

Exhibit 9: HMBD-002 Phase I trial design



Source: Percheron Therapeutics corporate presentation, June 2025

Exhibit 10: Patient breakdown by treatment arms

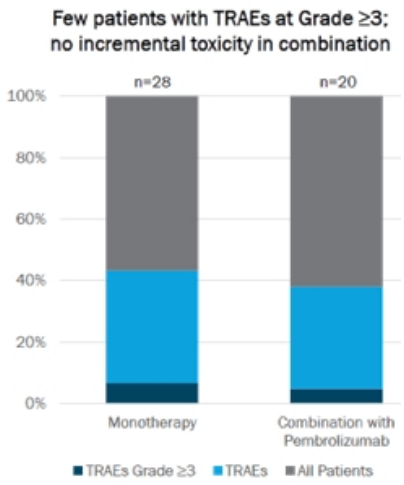


Source: Percheron Therapeutics corporate presentation, June 2025

At the end of the treatment period, the maximum tolerated dose was not reached, reflecting HMBD-002's favourable safety and tolerability profile to date. While the study was not powered to test efficacy, management noted an increased duration of response in several patients. Only one case with dose-limiting toxicity was observed at a dose of 360mg with a single treatment-related discontinuation in the combination arm (Exhibit 11). Importantly no cases of CRS were observed either in the monotherapy or in the combination arm. We believe this is a very positive signal given the previous challenges with VISTA drugging and in light of the treated population, which included patients who had received up to six prior lines of treatment (Exhibit 12).

The full data from the Phase I study are expected in Q4 CY25. The company also plans to focus on manufacturing the drug substance for the clinical trial (Hummingbird will provide the initial batch) and determining the Phase II plans for HMBD-002 (following discussions with a clinician advisory board) in H2 CY25, before commencing the efficacy studies in H1 CY26.

Exhibit 11: Treatment-related adverse events in Phase I



Source: Percheron Therapeutics corporate presentation, June 2025

Exhibit 12: Selected Phase I patient profile

Pathology	Dose	Prior History	Time on Study
Monotherapy			
Dedifferentiated lipscarcoma	360mg	2 prior lines of treatment, including nivolumab + ipilimumab	18 cycles
Triple-negative breast cancer	360mg	Previous progression on pembrolizumab	10 cycles
Melanoma	360mg	6 prior lines of treatment, including nivolumab + ipilimumab	5 cycles
Combination Therapy			
Non-small-cell lung cancer	360mg	4 prior lines of treatment, including pembrolizumab, nivolumab + ipilimumab	10 cycles
Non-small-cell lung cancer	720mg	2 prior lines of treatment, including osimertinimb, bevacizumab	6 cycles

Source: Percheron Therapeutics corporate presentation, June 2025

Broad potential highlighted by preclinical data

HMBD-002 has previously shown efficacy signals in preclinical animal models as both a monotherapy and in combination with other ICIs in a range of cancer indications. In two murine models of colon cancer (CT26 and HCT15), HMBD-002 as monotherapy demonstrated c 84% and c 65% inhibition of tumour growth, respectively compared to control. When combined with PD-1 (CT26 model) the tumour inhibition rates improved further to c 94%, supporting the potential for HMBD-002 to be developed as a combination treatment. In another mesothelioma model, treatment with HMBD-002 resulted in a c 40% tumour growth inhibition.

More recently, Percheron reported new preclinical data in triple-negative breast cancer (TNBC) and in HNSCC (in combination with radiotherapy). In a mouse model of TNBC, HMBD-002 substantially blocked tumour growth in VISTA + animals: $p < 0.0001$ (VISTA is expressed in 25–35% of all TNBC tumours). The study also identified a four-amino-acid motif, which may potentially be used as a biomarker for future patient selection. The data also highlighted that HMBD-002's activity may be related to modulation of growth signals such as epidermal growth factor receptor (EGFR), providing early signals of a potential VISTA/EGFR combination treatment. In a preclinical MOC2 model of HNSCC, it was observed that upregulation of VISTA represents an important resistance mechanism to radiotherapy, which is one of three primary treatment modalities for the indication, alongside surgery and chemotherapy. The addition of HMBD-002 extended median survival to 35.5 days, versus 27 days with radiotherapy alone ($p < 0.05$).

We believe that the favourable safety profile and early efficacy signals from preclinical trials are indicative of the applicability of HMBD-002 across multiple indications and support continued development into more advanced clinical studies.

Phase II plans to become clear in Q4 CY25

We expect Percheron's focus over the next few months will be on analysing the Phase I trial data and subsequently cementing the Phase II plans for HMBD-002. Given the scope of the immuno-oncology landscape and the expanse of potential target indications, we believe that the company may need to be strategic when choosing both the target indication(s) and the Phase II design. Management has communicated that the potential Phase II strategy could include testing HMBD-002 either as a monotherapy or in combination with PD-1 checkpoint inhibitors or other emerging combinations such as EGFR inhibitors (in indications with high EGFR expression). Several clinical trials are underway testing PD-1/PD-L1s in combination with EGFR in indications such as NSCLC and HNSCC, although all of these are early-stage at present (Phase I and II).

In terms of the Phase II design, we speculate that the company may decide to run a basket study, a common strategy in oncology that enables a single agent to be evaluated across multiple tumour types. While efficient in hypothesis generation, this approach may result in underpowered cohort arms, limiting statistical confidence in efficacy readouts. Management could also adopt a two-part Phase II strategy: (i) a Phase IIa dose-expansion segment (likely open-label) to refine safety and dosing parameters, followed by (ii) a Phase IIb randomised component aimed at generating efficacy signals. The target indications could be equally variable, ranging from large, competitive markets (such as NSCLC, where commercial potential is significant, but differentiation is challenging) and smaller, niche opportunities (such as gastric cancer, where competitive intensity is lower, and market share capture could be more meaningful).

While more clarity on the Phase II plans will come in Q4 CY25, we believe that combination treatment with PD-1 may be the most practical and de-risked approach for Percheron, given the preclinical and Phase I observations. We present our view on the potential target indications and other Phase II assumptions in the Valuation section.

Leadership team and board

CEO and managing director: Dr James Garner. Dr James Garner is an experienced life sciences executive, whose career has focused on the development and commercialisation of novel therapeutics for diseases with high unmet medical need. Over his 21-year career in the industry, James has worked principally with Biogen (NASDAQ: BIIB), Takeda (NYSE: TAK) and Sanofi (NASDAQ: SNY), in regional and global roles. He has overseen more than 30 national product approvals, more than a dozen multinational clinical trials, several partnering transactions and numerous scientific collaborations. His experience spans multiple therapeutic areas, including oncology, immunology, CNS and orphan diseases. In his seven-year tenure as CEO and managing director of Kazia Therapeutics (NASDAQ: KZIA), James drove a transformation of the company's pipeline by in-licensing clinical-stage assets from Genentech and Evotec, deployed an extensive pipeline of more than a dozen clinical trials across multiple oncology indications and signed partnering deals with Simcere (HKSE:2096) and Vivesto (STO: VIVE). James raised c US$40m in equity

financing for Kazia, and the company also benefited significantly from non-dilutive opportunities. In addition to his medical qualifications and MBA, James holds a master's degree in continental philosophy and a bachelor's degree in the history of medicine, and is a member of the Australian Institute of Company Directors (AICD) and the American Society for Clinical Oncology (ASCO).

See below for an Edison TV executive interview we recently conducted with Dr James Garner.

CFO and company secretary: Ms Deborah Ambrosini. Deborah Ambrosini's qualifications include BCom (accounting and business law), FCA and GIA (cert). She is a highly experienced CFO and company secretary, having previously served as CFO at the Cann Group and Acrux. She is a fellow of Chartered Accountants Australia and New Zealand with over 20 years' experience in leading financial strategies to facilitate growth plans. Her experience spans the biotechnology, mining, IT communications and financial services sectors. Deborah possesses extensive experience in debt and equity capital raising activities, regulatory compliance, process improvement, investor relations, large contract management and leading all aspects of accounting, budgeting, forecasting and financial analysis. She also has significant experience both nationally and internationally in financial and business planning, compliance and taxation. Deborah has held director roles in both listed and unlisted entities. Deborah has been a state finalist in the Telstra Business Woman Awards. She was also named as one of the top 40 pre-eminent business leaders in the highly prestigious WA Business News 40 under 40 awards.

Non-executive chair: Dr Charmaine Gittleson. Dr Gittleson is an experienced pharmaceutical physician with over 15 years of global leadership in drug development, governance and risk management at CSL (ASX: CSL). At CSL (2005–20), she held senior roles spanning clinical research, medical safety and patient ethics, contributing to strategic development across multiple therapeutic and rare disease areas. Her leadership positions included senior director, head safety and clinical development (2006–10) in Melbourne, vice president clinical strategy (2010–13) and senior vice president clinical development (2013–17) in the US, and CMO in Melbourne, a role she held until retiring from corporate leadership in 2020.

Non-executive director: Dr Gil Price. Dr Price is a seasoned biotech executive and entrepreneur with extensive experience across clinical asset investment strategy, evaluation, financing and execution. Between 2017 and 2020, Dr Price served as CMO of ProPharma Group following its acquisition of Drug Safety Solutions, where he was the CEO and CMO. From 2007 to 2016, Dr Price served on the board of directors of Sarepta Therapeutics during its growth into a multibillion-dollar company. He has held senior clinical roles at MedImmune and contract research organisations overseeing trials, from first-in-human to Phase IV. As a non-executive director at Percheron Therapeutics, he brings expertise in safety oversight, clinical strategy and governance across oncology, rare disease and infectious diseases.

Percheron Therapeutics – Edison executive interview

Source: Edison Investment Research

Sensitivities

The biotech sector is uniquely characterised by a high risk-reward trade-off, with material upfront outlays and significant lead times to binary outcomes. As a clinical-stage biotech with a concentrated development pipeline, Percheron is exposed to the common risks associated with drug discovery and development, such as outcomes of clinical trials, regulatory decision-making, the competitive landscape, partnering success and capital access. In particular, we believe Percheron is most sensitive to the following risks:

Clinical execution: given that HMBD-002 is Percheron's only active clinical programme at present, the company's investment case and valuation are tied directly to the progress of the programme, which remains in early clinical development. Ahead of establishing human proof-of-concept, this exposes Percheron to high concentration and binary risks, particularly in relation to the upcoming Phase II trials. Trial design, patient recruitment, and dose optimisation will be critical sensitivities, in our view. The strategic pivot from rare diseases to immuno-oncology may also invite increased scrutiny around the clinical and operational expertise required to develop novel checkpoint inhibitors. Percheron will have to demonstrate its ability to engage with relevant key opinion leaders and clinical research organisations (CROs) to effectively advance its programme.

Target validation: VISTA is an emerging checkpoint with limited clinical evidence in humans. While the preclinical rationale is strong, the biology still needs to be de-risked in human studies. Failure to demonstrate consistent immune activation or efficacy in VISTA-high tumours could affect the asset's commercial potential. Moreover, given VISTA's role in immune homeostasis, VISTA inhibition raises the risks of immune-related adverse events, which could restrict dose optimisation and potentially reduce the addressable patient population. Percheron believes it has mitigated this risk with HMBD-002 because it is an IgG4 antibody that blocks VISTA's immunosuppressive function without depleting VISTA-expressing cells, which is the case with competing VISTA treatments under development, which are all IgG1 isotypes.

Clinical trial design: while Percheron management has communicated that its Phase III strategy could include testing HMBD-002 as either monotherapy or in combination (with checkpoint inhibitors or other treatment types), choosing the right strategy and trial design will be crucial for its success. While monotherapy promises the maximum commercial potential, we believe the more practical approach would be a combination treatment with a PD-1 checkpoint inhibitors. Choosing the right indication(s) to target would also be key, given VISTA's broad expression across tumour types and thereby its widespread applicability. Note that if the Phase II trials are conducted in combination with PD-1, Percheron may be required to purchase the drug, which could add to the trial costs. The company could mitigate this by either collaborating with the IP owner Merck (similar to Hummingbird Biosciences) or choosing patients already under treatment with PD-1s.

Financing and dilution: clinical development is a capital-intensive exercise, with oncology trials in particular requiring large outlays. Percheron ended FY25 with a cash balance of A$10.2m, which we estimate will fund the company into FY27. To preserve capital the company would need to optimise the design for the Phase II trial. We believe Percheron may look at splitting the Phase II trial for the target indication(s) between Phase IIa and Phase IIb in an effort to maximise its cash runway. While we expect support in the form of R&D tax credits and anticipate the company securing an out-licensing partnership following Phase II (should data be encouraging), it will be required to raise additional capital to complete the Phase II clinical development. This will likely be secured through equity issues, which could be dilutive to existing shareholders.

Competition and partnering: immuno-oncology is a highly competitive space, with big pharma dominating the landscape and several speciality biotechs developing novel treatments. Moreover, bispecific antibodies, in particular dual checkpoints (PD-1/CTLA-4, PD-1/LAG-3 and PD-1/TIM-3) and checkpoint-targeted treatment (such as PD-1/VEGF) have also been gaining prominence. HMBD-002 would have to show tangible benefits over existing treatments to secure its place in the treatment algorithm for the target indications. Partnering is another key sensitivity for Percheron and is crucial for timely late-stage clinical development and subsequent commercialisation of HMBD-002. We note that the deal terms for any future partnership would have to be fairly attractive (including a royalty rate of over 20%, given the 12.5% pay away to Hummingbird) for it to make economic sense for Percheron. This could mean a more back-end loaded deal, which should not be a material concern given the ability to participate in the upside. Should the Phase II data for HMBD-002 be compelling, we do not foresee any major challenges to Percheron securing such a deal. For reference, the Incyte MacroGenics deal for the PD-1 asset retifanlimab in October 2017 included tiered royalties ranging from 15% to 24% and the Coherus Junshi deal for the TIGIT asset in January 2022 came with 18% royalties (refer to Exhibit 13 for more details).

Valuation

Percheron Therapeutics' valuation is inherently complex at this stage, given HMBD-002's novelty as a VISTA-targeting checkpoint inhibitor and the limited visibility on indication selection and trial design for the planned Phase II studies (expected initiation in CY26). While a risk-adjusted net present value remains our primary framework for valuing clinical-stage biotechs, in this case we believe it prudent to validate outcomes using complementary methodologies including peer benchmarking and a top-down market-based approach.

Methodology 1: Risk-adjusted NPV

Risk-adjusted NPV (rNPV) is a bottom-up approach most commonly employed to value clinical-stage biotechs. It involves forecasting future cash flows from each clinical asset to the end of market exclusivity/patent life and discounting them using appropriate discount rates (the standard Edison discount rate is 12.5%). We believe that the rNPV approach is most representative of the long-term value creation potential for Percheron, although it requires us to make several key assumptions, given the widespread expression of VISTA across tumour types and the current lack of visibility around target indication(s) for Phase II. We list below the underlying assumptions for our rNPV valuation for HMBD-002. Note that these assumptions are subject to change as we gain more clarity on the company's Phase II plans in the coming months, which may require a reassessment of our valuation for HMBD-002.

Combination strategy: as highlighted previously, we believe that the most practical approach for HMBD-002 will be to develop it as a combination treatment with a PD-1 inhibitor, given the favourable safety and toxicity profile and synergistic results seen in preclinical studies. Our model assumes that the Phase II trials will test HMBD-002 in combination with Merck's Keytruda.

Indication focus: we assume that the HMBD-002-Keytruda combination will be evaluated in three sperate indications as a first-line treatment in metastatic NSCLC, HNSCC and melanoma. These were selected based on VISTA expression, large addressable patient populations and overlap with Keytruda's strongest commercial franchises (top three indications, accounting for c 50% of its annual sales). Note that this is subject to modification as the company's Phase II plans become clearer.

Trial design and costs: immuno-oncology trials are associated with large capital outlays. In an effort to optimise capital usage and maximise the runway, we model Percheron undertaking a two-step Phase II programme (IIa and IIb). We assume each Phase IIa and Phase IIb trial enrols around 30 and 75 patients, respectively. We calculate a Phase IIa trial cost of US$4.5m and Phase IIb trial cost of US$11m, based on a per patient cost of US$150k. Note that this does not include any incremental costs related to Keytruda on the assumption that the trials will either include patients already eligible to receive Keytruda or be undertaken in collaboration with Merck. We assume the first Phase IIa trial to commence in H1 CY26 in NSCLC, with HNSCC and melanoma following at six-month intervals.

Drug pricing: we model an annual treatment cost of US$130,000 for HMBD-002 (list price), with an effective price of US$90,000 assuming a 30% payor discount. The pricing is benchmarked (with a slight discount) to the average US $150,000–200,000 price tags carried by the approved PD-1 inhibitors. This assumption is also validated by Bristol Myers Squibb's Opdualag (a combination of the PD-1 inhibitor nivolumab/Opdivo and the novel LAG-3 antibody relatlimab), which was launched in March 2022 with an annual treatment cost of c US$360,000 (per vial cost or c US$15,000; two vials administered every four weeks).

Market opportunity: we estimate US target populations of 80,000 in NSCLC, 8,000 in HNSCC and 4,000 in melanoma, assuming only locally advanced, metastatic cases. For our base case, we assume a 20% peak market penetration for HMBD-002 in NSCLC (due to the space being highly competitive) and a higher 30% in HNSCC and melanoma. Based on the global revenue performance of approved ICIs, we assume the US accounts for c 60% of HMBD-002's commercial market, with Europe and other international markets contributing the remaining 40%.

Timelines: we model that the combined Phase IIa and Phase IIb studies across all three target indications will complete by 2028 and will cost the company a total of around US$45m in R&D. This excludes any potential development milestone payments due to Hummingbird Biosciences related to the Phase II trials. We assume the Phase III trials commence in 2029 under an out-licensing partnership (discussed in more detail below) with a Biologics Licence Application (BLA) filing in 2031 and launch in 2032.

Peak sales potential: we model 12 years of market exclusivity in the US following approval (in line with the FDA guidelines for biologics) with a steady decline in sales assumed thereafter. Our base case estimates peak sales of US $3.0bn for HMBD-002, to be achieved in 2045. Given the early stage of clinical development, uncertainty on the Phase II design and limited human efficacy data to date, we assume a conservative 10% PoS. This is subject to revision with

further clarity on the company's Phase II plans and chosen indications. If early trial results are positive, we highlight the possibility of label expansion to other oncology indications, which would add to the upside potential.

Licensing economics: we expect the company to seek partnership opportunities before commencement of Phase III studies in 2029. Based on our assessment of previous licensing deals in the ICI space (Exhibit 13) and taking directional guidance from the in-licensing terms with Hummingbird Biosciences, we estimate a total deal value of US$750m for HMBD-002 in 2029, with an upfront payment of US$75m. We also assume tiered royalty rates starting at 20% (as noted previously, this would be crucial for the deal to make economic sense for Percheron given the royalty payout terms to Hummingbird Biosciences) and the remaining milestone payments of US$675m will be split 30:70 between development and sales milestone payments, which we have accounted for over the course of clinical development and subsequent commercialisation of HMBD-002. We also highlight that the assumed deal dynamics are subject to revision, based on the strength of the data presented by the company on HMBD-002 as clinical development progresses.

Exhibit 13: Selected licensing deals in the ICI landscape

Deal date	Licensor	Licensee	Asset	Target	Status on deal date	Upfront payment	Milestones/royalties	Notes
Jan-22	Junshi Biosciences	Coherus BioSciences	JS006 /CHS-006	TIGIT	Phase I	US$35m	Up to US$255m +18% royalties	Programme terminated by Coherus in January 2024 (for North American rights).
Dec-21	BeOne Medicines (formerly BeiGene)	Novartis	Ociperlimab (BGB-A1217)	TIGIT	Phase III	US$300m	Up to US$700m + tiered royalties	Programme terminated in July 2023 by Novartis; rights retuned to BeOne who stopped further clinical development in May 2025.
Jun-21	iTeos Therapeutics	GSK	Belrestotug (EOS-448)	TIGIT	Phase I/II	US$625m	Up to US$1.45bn + royalties	Programme terminated in May 2025 by GSK.
May-21	Agenus	Bristol Myers Squibb	AGEN1777/ BMS-986442	TIGIT/CD96	Late preclinical	US$200m	Up to $1.36bn + tiered double-digit royalties	Programme terminated in 2024; rights returned to Agenus and the company plans to continue development independently.
Jan-21	BeOne Medicines (formerly BeiGene)	Novartis	Tislelizumab	PD-1	Phase II	US$650m	Up to US$1.55bn + royalties	Ex-China rights. Agreement terminated by Novartis in September 2023. Right returned to BeiGene. Tislelizumab subsequently approved in the US in 2024.
Dec-20	Surface Oncology	GSK	GSK4381562/ SRF813	PVRIG	IND-enabling studies	US$85m	Up to US$730m + tiered royalties	Being studied as a combination treatment with Jemperli and belrestotug in Phase II studies in solid cancers.
Sep-20	I-Mab	AbbVie	Lemzoparlimab (TJC4)	SIRP?/anti-CD47	Phase I	US$180m	Up to US$1.74bn + low-to-mid-teens royalties	Ex-China rights. Programme terminated by AbbVie in 2023; rights returned to I-Mab.
Jan-20	Curis	ImmuNext	CI-8993	VISTA	Phase I	N/A	N/A	Phase I trial commenced in September 2020 but subsequent development has been halted.
Apr-18	Compugen	AstraZeneca	COM902/COM701	TIGIT/ PVRIG	Late preclinical	US$10m	Up to US$200m + tiered royalties	Several Phase III trials ongoing including in metastatic squamous NSCLC (ARTEMIDE-Lung02), biliary tract cancer (ARTEMIDE-Bil01) and hepatocellular carcinoma (ARTEMIDE-HCC01).
Oct-17	MacroGenics	Incyte	Retifanlimab (MGA012)	PD-1	Phase I	US$150m	Up to US$750m + tiered royalties (15-24%)	First US FDA approval received in March 2023.
Aug-17	WuXi Biologics/Harbin Gloria Pharmaceuticals	Arcus Biosciences	Zimberelimab (GLS-010)	PD-1	Phase I	US$18.5m	Up to US$816m + tiered royalties (high single-digit to low double digit)	Ex-China rights. Several registrational Phase III studies ongoing in NSCLC and upper gastrointestinal cancers.
Apr-15	Innate Pharma	AstraZeneca	Monalizumab (IPH2201)	NKG2A	Phase II	US$250m	Up to US$1.254bn + double-digit royalties+ EU 50% profit-share	US$450m in upfront and milestone payments received to date. Active global programme; Phase II/III trials ongoing in NSCLC.

Source: Company documents, Edison Investment Research

Reflecting the aforementioned assumptions and estimates and incorporating the latest net cash figure (A$10.2m at end-FY25), we derive an rNPV valuation of A$66.7m or 6.1c/share for Percheron. A breakdown of our valuation by indication is presented in Exhibit 14.

Exhibit 14: Percheron Therapeutics rNPV valuation

Product	Indication	Expected launch	Peak sales (US$m)	NPV (A$m)	Probability	rNPV (A$m)	rNPV/share (Ac)
HMBD-002	1st line metastatic NSCLC	2032	1,900	546.5	10%	44.4	4.1
	1st line metastatic HNSCC	2032	700	141.1	10%	9.0	0.8
	1st line unresectable, locally advanced or metastatic melanoma	2032	400	78.6	10%	3.1	0.3
Net cash at end-June 2025				10.2		10.2	0.9
Valuation				**776.4**		**66.7**	**6.1**

Source: Edison Investment Research

Our base case rNPV valuation for Percheron as defined above aligns with our central assumptions, but we highlight that it is highly sensitive to assumptions on market penetration, given the competitive nature of the ICI landscape. We therefore present bull and bear case scenarios below, reflecting varying penetration assumptions across NSCLC, HNSCC, and melanoma (Exhibit 15). While the bull case valuation accounts for upside optionality if HMBD-002 demonstrates strong efficacy across multiple tumour types, the bear case valuation illustrate the downside if competitive pressures or trial design limit adoption. We note that the broad valuation range across the three scenarios (A$47.1–88.3m) reflects early-stage uncertainties and potential variabilities in outcomes.

Exhibit 15: rNPV scenarios

Scenario	Penetration assumptions	Peak sales (US$bn)	Probability of success	rNPV (A$m)	Value/share (Ac)
Bull	30% NSCLC, 50% HNSCC, 50% melanoma	4.7	10%	88.3	8.1
Base	20% NSCLC, 30% HNSCC, 30% melanoma	3.0	10%	66.7	6.1
Bear	10% NSCLC, 15% HNSCC, 15% melanoma	1.5	10%	47.1	4.3

Source: Edison Investment Research

Methodology 2: Peer-based valuation

Given Percheron's early-stage clinical profile, peer benchmarking provides an important sense-check. While a comparative peer-based valuation typically focuses on trading multiples, this is inapplicable for Percheron, as its pre-revenue at present. Instead, we benchmark the company against the market caps and enterprise values of oncology-focused clinical-stage peers in Australia and Europe at similar stages of development (Exhibit 16).

Exhibit 16: Selected oncology peers

Company	Market cap (A$m)	Enterprise value (A$m)	Target indications	Stage of development
ASX listed				
Immutep	382	254	Cancer (NSCLC, HNSCC, breast, STS) via LAG-3 programmes	Phase III
Race Oncology	313	299	AML	Phase Ib/II
Arovella Therapeutics	95	74	CAR19-iNKT (CD19+ cancers), CLDN18.2-iNKT (targeted solid tumours)	Phase I ready (IND-enabling)
Amplia Therapeutics	85	74	Pancreatic cancer, ovarian cancer, fibrotic diseases	Phase IIa
Imugene	87	75	Azer-Cel CAR-T	Phase Ib
Radiopharm Theranostics	73	42	Solid tumour-targeted radiopharmaceuticals (PD-L1, HER2, B7H3)	Phase I
Prescient Therapeutics	42	35	Targeted therapy (cutaneous T-cell lymphoma)	Phase IIa
Syntara	41	26	Myelofibrosis (SNT-5505), fibrotic/blood disorders	Phase II
Median	**86**	**74**		
Other exchange listed				
Faron Pharmaceuticals	430	445	Hematological cancers (anti–Clever-1 antibody)	Phase II
BioInvent International	290	165	Immuno-modulatory antibodies for cancer	Phase II
Innate Pharma	297	208	Anti-NKG2A mAb targeting NSCLC, lymphoma and other solid tumours and haematological cancers	Phase III
Transgene	271	260	Therapeutic vaccines – head and neck cancer	Phase II
OSE Immunotherapeutics	241	218	Therapeutic vaccines – NSCLC	Phase III
Agenus	251	396	Colorectal, pancreatic cancer (checkpoint modulators)	Phase II
Cantargia AB	105	96	Antibody treatments based on the IL1RAP protein	Phase II
Ascelia Pharma	73	64	Gastric cancer	Phase II-ready
Hemogenyx Pharmaceuticals	138	143	AML – anti-FLT3 CAR-T and CDX bispecific antibodies	Phase I
Mendus AB	60	54	Cell-based therapy for AML	Phase II
Median	**246**	**187**		

Source: Company documents, Edison Investment Research. Note: Market caps and enterprise values for companies converted from reporting currencies to Australian dollars using prevailing forex rates.

While it is clear from the exhibit above that oncology-focused, clinical-stage biotechs (preclinical to Phase II) trade across a broad market cap range (from A$40m to A$400m), looking at the median enterprise valuation of similar ASX-listed peers (A$74m) and adjusting for Percheron's net cash position, we would derive an implied equity value of c A$84.2m or 7.8c/share for Percheron. Also evident from the table is that European peers tend to command higher valuations (median c A$200m), likely reflecting greater capital access and broader/more advanced pipelines. This wide range of valuations also highlights the upside potential for Percheron.

Note that the peer valuations are a factor of the breadth and clinical stage of the individual company's pipeline, target indications, variability and depth of clinical data as well as partnerships and capital access, and are therefore not strictly comparable. However, they do provide us with a broad tool to help validate the outcome from our core rNPV approach, although we stress that the rNPV remains a more comprehensive and specific valuation approach and is the core underlying methodology for our valuation.

Immutep's journey offers important read across for Percheron

As Immutep is a fellow ASX-listed, clinical-stage immuno-oncology player developing novel checkpoint inhibitors, we believe that it offers a particularly useful case study and read-across for Percheron. Similar to Percheron, Immutep is developing novel ICIs (targeting LAG-3, an immune checkpoint protein that acts as an inhibitory receptor on T-cells, NK cells and B cells). Its lead asset, eftilagimod alpha, is currently being evaluated in combination with Keytruda across several Phase II/III studies, including a Phase III trial in NSCLC and a Phase II trial in HNSCC. We note that before initiating its Phase II basket study TACTI-002 in March 2019, Immutep's market cap was c A$80m. Its subsequent trajectory to c A$360m today (a 30% CAGR) underscores the value accretion possible for innovative checkpoint inhibitors, providing a credible benchmark for Percheron as HMBD-002 advances.

Methodology 3: Market context

We also assess HMBD-002's potential from a top-down market perspective. The global ICI market was valued at c US $50bn in 2023 and is projected to grow to US$155bn by 2030 (according to Grandview Research), led by Keytruda's >US$25bn in sales. Based on these numbers, even if we were to assume only a modest market share for HMBD-002, it has the potential to translate to a sizeable commercial opportunity. In Exhibit 17 below we provide a few revenue scenarios for Percheron, based on penetration and market share assumptions.

Exhibit 17: HMBD-002's commercial potential scenarios

Scenario	Assumption	Estimated annual peak sales
Conservative (1% of ICI market)	Small indication, limited uptake	US$1.5bn
Mid-range (3%)	Multiple niche indications or PD-1 combination in large indications such as NSCLC	US$4.5bn
Aggressive (5%)	Broad label expansion, global rollout	US$7.5bn

Source: Edison Investment Research

With the ICI market on a steep growth trajectory, it is clear that even a modest 1% market share could equate to blockbuster revenues for HMBD-002. While we caution that such projections are contingent on successful clinical development, regulatory approval, label expansion and commercial execution, we believe the broader market dynamics illustrate the scale of the opportunity.

Note that following the Phase IIb setback for avicursen and notwithstanding the acquisition of HMBD-002, Percheron continues to trade below cash levels, at a market cap of A$9.8m (versus a cash balance of A$10.2m at end-FY25). We view this as evidence that the market is yet to price in any potential value from HMBD-002, leaving scope for a significant re-rating as clinical catalysts emerge, most notably disclosure of Phase II trial design and target indications. We believe Percheron's valuation case, while assumption-heavy at this stage, is supported by a combination of rNPV fundamentals, peer benchmarking and the rapidly expanding ICI market opportunity.

Financials

Operating performance: In line with pre-revenue biotech development

Percheron recently reported its FY25 results (for the 12-month period ended June 2025), a year marked by strategic re-prioritisation and subsequent operational management. Typical of an early, clinical-stage biotech, Percheron is pre-revenue, with the primary source of capital being external financing in the form of capital raises and R&D tax rebates from the Australian government. We highlight that Australia's R&D tax incentive programme allows companies (with revenues <A$20m) to receive a tax rebate of up to 43.5% on clinical trial related R&D costs. This covers direct R&D costs (clinical trials, lab work, contract research, salaries, consumables) as a portion of overheads. For pre-revenue companies, such as Percheron, this credit is paid as a cash refund by the Australian Tax Office (ATO). Note that while the 43.5% refundable R&D offset only typically applies to activities conducted in Australia, in exception circumstances overseas expenses can also be claimed (such as in cases where such activities are crucial to the project or cannot be conducted in Australia). In FY25 Percheron reported A$1.4m in R&D tax credits, which the company reflects in the income statement as revenues and as current receivables in the balance sheet (received in August 2025). In FY24 the corresponding figure was A$2.4m.

Operating expenses for the year were reported to be A$16.6m, up 12.4% from A$14.8m in FY24. As expected, R&D-related costs accounted for the bulk of the opex at A$10.8m (64.7% opex vs 72.3% in FY24). These primarily related to the Phase IIb trials for the company lead programme at the time, avicursen (ATL1102) in DMD, which has now been de-prioritised. While administrative expenses stayed broadly flat at A$1.9m, employee expenses increased by 19.0% y-o-y to A$2.3m (FY24: A$1.9m). In addition, the company recognised A$1.6m in share-based payment expenses in FY25 (FY24: A$0.2m). Overall Percheron recorded operating and net losses of A$15.3m and A$14.9m, respectively in FY25, versus A$12.5m and A$11.9m in FY24.

Near-term estimates: Driven by HMBD-002 Phase II plans

Our FY26 and FY27 estimates are based on our aforementioned assumptions for Percheron's Phase II plans for HMBD-002. We expect the first Phase IIa trial in NSCLC to commence in H2 FY26/H1 CY26 and estimate the company to book total trial costs of A$3.5m in FY26. We also highlight the A$4.6m (US$3m) upfront payment to be made to Hummingbird Biosciences in FY26 (US$2m was paid on 10 July and the remaining US$1m becomes due within 20 days

of Hummingbird supplying Percheron with the HMBD-002 drug substance), which we assume the company will include in total R&D expenses. Combining the above, we forecast R&D expenses to be A$8.6m in FY26 and A$19.7m in FY27. We also assume that 30% of R&D expenses related to HMBD-002 will be reimbursed by the Australian government as R&D tax credits (this is lower than the 43.5% benchmark based on the assumption that at least some part of the R&D efforts will be undertaken overseas and therefore may not fully qualify for reimbursement). We reflect these R&D tax credits as revenues in FY26 (A$2.4m) and FY27 (A$5.8m). We also estimate general and administrative expenses of A $2.0m in FY26 and A$2.2m in FY27 and personnel expenses of A$2.4m and A$2.5m in FY26 and FY27, respectively. Overall, we project operating losses of A$11.0m in FY26 and A$19.1m in FY27.

Balance sheet: Cash position strengthened with A$15m raise

The FY25 free cash outflow from operations was A$15.7m (FY24: A$10.1m) reflecting the company's operating performance. Note that Percheron fully expenses its R&D costs and has limited capex (being clinical stage) and therefore free cash flows tend to mirror operating cash flows. In October 2024, the company raised A$13m in gross proceeds against the issue of 162.7m new shares to institutional investors and a further A$1.85m under a share purchase programme to eligible existing shareholders, bolstering its capital position. This has allowed Percheron to close FY25 with gross cash on its books of A$10.2m. Based on our projections for the clinical plans for HMBD-002 and taking into account the US$3m upfront payment to Hummingbird Biosciences, we expect the company to be funded into FY27. We estimate the company will need to raise A$20m each in FY27 and FY28 (total A$40m) before out-licensing HMBD-002 in FY29 for Phase III clinical development and subsequent commercialisation.

Exhibit 18: Financial summary

A$'000s	2023	2024	2025e	2026e	2027e
Y/e June	**IFRS**	**IFRS**	**IFRS**	**IFRS**	**IFRS**
PROFIT & LOSS					
Revenue	**1,579.8**	**2,352.7**	**1,430.0**	**2,441.3**	**5,754.4**
R&D tax credit	1,579.8	2,352.0	1,430.0	2,441.3	5,754.4
Government and other grants	0.0	0.7	0.0	0.0	0.0
Cost of Sales	0.0	0.0	0.0	0.0	0.0
Gross Profit	**1,579.8**	**2,352.7**	**1,430.0**	**2,441.3**	**5,754.4**
R&D expenses	(10,162.5)	(10,699.5)	(10,766.9)	(8,637.5)	(19,681.3)
G&A expenses	(1,854.9)	(1,927.5)	(1,876.0)	(2,002.9)	(2,203.1)
Personnel expenses	(982.3)	(1,910.7)	(2,274.0)	(2,387.7)	(2,507.1)
Other expenses	(36.0)	(64.6)	(167.3)	(175.6)	(184.4)
EBITDA	**(11,455.9)**	**(12,249.6)**	**(13,654.2)**	**(10,762.5)**	**(18,821.5)**
Operating Profit (before amort. and except.)	**(11,551.1)**	**(12,329.0)**	**(13,722.2)**	**(10,820.8)**	**(18,873.5)**
Intangible Amortisation	0.0	0.0	0.0	0.0	0.0
Share-based payments	(214.1)	(198.4)	(1,555.9)	(200.0)	(200.0)
Exceptionals and other	0.0	0.0	0.0	0.0	0.0
Operating Profit	**(11,765.1)**	**(12,527.4)**	**(15,278.1)**	**(11,020.8)**	**(19,073.5)**
Net Interest	385.3	608.2	356.2	302.5	11.8
Profit Before Tax (norm)	**(11,165.8)**	**(11,720.8)**	**(13,366.0)**	**(10,518.3)**	**(18,861.8)**
Profit Before Tax	**(11,379.8)**	**(11,919.2)**	**(14,921.9)**	**(10,718.3)**	**(19,061.8)**
Tax	0.0	0.0	0.0	0.0	0.0
Profit After Tax (norm)	**(11,165.8)**	**(11,720.8)**	**(13,366.0)**	**(10,518.3)**	**(18,861.8)**
Profit After Tax	**(11,379.8)**	**(11,919.2)**	**(14,921.9)**	**(10,718.3)**	**(19,061.8)**
Average Number of Shares Outstanding (m)	668.8	881.1	1,024.1	1,087.4	1,087.4
EPS - normalised (c)	(1.67)	(1.33)	(1.31)	(0.97)	(1.73)
EPS - reported (c)	(1.70)	(1.35)	(1.46)	(0.99)	(1.75)
BALANCE SHEET					
Fixed Assets	**150.8**	**56.9**	**35.3**	**32.4**	**31.3**
Intangible Assets	0.0	0.0	0.0	0.0	0.0
Tangible Assets	150.8	56.9	35.3	32.4	31.3
Investments	0.0	0.0	0.0	0.0	0.0
Current Assets	**12,692.2**	**14,473.4**	**12,400.8**	**3,607.6**	**6,569.9**
Cash	10,967.3	11,866.7	10,167.9	550.7	327.1
Trade and other receivables	1,658.5	2,568.5	1,582.5	2,601.6	5,924.1
Prepayments	66.5	38.3	650.4	455.3	318.7
Other current assets	0.0	0.0	0.0	0.0	0.0
Current Liabilities	**(2,812.3)**	**(5,152.0)**	**(2,432.3)**	**(2,720.7)**	**(3,028.4)**
Trade and other payables	(2,532.3)	(4,865.8)	(2,244.5)	(2,468.9)	(2,715.8)
Short-term borrowings	0.0	0.0	0.0	0.0	0.0
Lease liabilities and others	(280.0)	(286.2)	(187.8)	(251.8)	(312.6)
Long-Term Liabilities	**(55.1)**	**(15.2)**	**0.0**	**0.0**	**0.0**
Long-term borrowings	0.0	0.0	0.0	0.0	0.0
Lease liabilities and other long-term liabilities	(55.1)	(15.2)	0.0	0.0	0.0
Net Assets	**9,975.7**	**9,363.1**	**10,003.9**	**919.3**	**3,572.9**
CASH FLOW					
Operating Cash Flow	**(8,151.3)**	**(10,115.9)**	**(15,643.3)**	**(9,609.6)**	**(20,215.6)**
Net interest	0.0	0.0	0.0	0.0	0.0
Tax	0.0	0.0	0.0	0.0	0.0
Capex	(29.3)	(3.6)	(7.2)	(7.6)	(8.0)
Acquisitions/disposals	0.0	0.0	0.0	0.0	0.0
Financing	0.0	11,611.5	14,871.5	0.0	20,000.0
Others	(85.3)	(592.7)	(919.7)	0.0	0.0
Net Cash Flow	(8,265.9)	899.4	(1,698.8)	(9,617.2)	(223.6)
Opening net debt/(cash)	**(19,233.2)**	**(10,967.3)**	**(11,866.7)**	**(10,167.9)**	**(550.7)**
Other	0.0	0.0	0.0	0.0	0.0
Closing net debt/(cash)	**(10,967.3)**	**(11,866.7)**	**(10,167.9)**	**(550.7)**	**(327.1)**

Source: company accounts, Edison Investment Research

Contact details	Revenue by geography
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Management team

CEO and managing director: Dr James Garner

Dr James Garner is an experienced life sciences executive with over 20 years of experience in the development and commercialisation of novel therapeutics for diseases with high unmet medical need. He joined Percheron as CEO in August 2023 from Kazia Therapeutics, where he served as CEO and managing director for seven years. Dr Garner has been previously associated with big pharma companies such as Biogen, Takeda and Sanofi in regional and global roles. His experience spans multiple therapeutic areas, including oncology, immunology, CNS and orphan diseases. In addition to his medical qualifications and MBA, James holds a master's degree in continental philosophy and a bachelor's degree in the history of medicine, and is a member of the Australian Institute of Company Directors (AICD) and the American Society for Clinical Oncology (ASCO).

CFO and company secretary: Ms Deborah Ambrosini

Deborah Ambrosini joined as CFO and company secretary of Percheron Therapeutics in June 2024. She previously served as CFO at the Cann Group and Acrux. She is a fellow of Chartered Accountants Australia and New Zealand with over 20 years' experience in leading financial strategies to facilitate growth plans. Her experience spans the biotechnology, mining, IT communications and financial services sectors. She holds a BCom (accounting and business law), FCA and GIA (Cert). Deborah possesses extensive experience in debt and equity capital raising activities, regulatory compliance, process improvement, investor relations, large contract management and leading all aspects of accounting, budgeting, forecasting and financial analysis.

Non-executive chair: Dr Charmaine Gittleson

Dr Gittleson has extensive international experience as a pharmaceutical physician and enterprise leader in pharmaceutical drug development, governance and risk management gained during her 15-year tenure (2005–20) with global specialty biotechnology company CSL Limited (ASX: CSL). During her time at CSL, she had at various times accountability for clinical research, medical safety, medical and patient related ethics for development and on market programmes, providing leadership in strategic product development, planning and implementation across multiple therapeutic and rare disease areas. Dr Gittleson held the key leadership roles of: senior director, head safety and clinical development (2006–10) in Melbourne, Australia; vice president clinical strategy (2010–13) and senior vice president clinical development (2013–17) in Pennsylvania, US; and chief medical officer in Melbourne from 2017 until her retirement from corporate roles in 2020.

Non-executive director: Dr Gil Price

Dr Price is a seasoned biotech executive and entrepreneur with extensive experience across clinical asset investment strategy, evaluation, financing and execution. From 2017-20, Dr Price served as CMO of ProPharma Group following its acquisition of Drug Safety Solutions, where he was the CEO and CMO. From 2007 to 2016, Dr Price served on the board of directors of Sarepta Therapeutics during its growth into a multibillion-dollar company. He has held senior clinical roles at MedImmune and CROs, overseeing trials from First-in-Human to Phase IV. As a non-executive director at Percheron Therapeutics, he brings deep expertise in safety oversight, clinical strategy and governance across oncology, rare disease and infectious diseases.

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Citicorp Nominees Pty	6.9%
James Garner	4.8%
Non Correlated Capital	4.6%
Powerhouse Ventures	4.3%
Glen Corby Bull	3.3%
BNP Paribas	2.4%
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