EVOLUTION CAPITAL

ATX | UPDATE REPORT | HEALTHCARE

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ACCENT Inflection Point Delivers

Evolution Capital provides an update on Amplia Therapeutics (ASX: ATX), reaffirming our Speculative Buy rating and $0.47 fair valuation. Amplia has released promising topline data from its ACCENT trial, which we believe further de-risks narmafotinib and validates its potential as a "best-in-class" asset capable of redefining the standard of care in pancreatic cancer. The results demonstrate a clinically meaningful improvement (vs. the benchmark) in all core, measurable efficacy endpoints: Progression-Free Survival (PFS); Duration on Trial (DoT); Objective Response Rate (ORR); and Disease Control Rate (DCR). Add the excellent safety and tolerability profile – the final data in Q1 2026 cannot come soon enough.

Durability: How Does the Data Stack Up?

The topline data delivers a powerful efficacy signal on multiple fronts. The interim median PFS of 7.6 months represents a 38% improvement over the 5.5-month benchmark for standard-of-care gem/Abraxane chemotherapy (MPACT study), a clinically significant result that has paved the way for a regulatory approval before: NALIRIFOX, a chemotherapy regimen approved by the FDA in 2024 for treating metastatic pancreatic cancer, exhibited a median PFS of 7.4 months in its pivotal NAPOLI 3 clinical trial. Durability is reiterated with a mean DoT of 202 days (vs. 117 in MPACT). With 17 patients still on trial, the mean DoT will, by definition, end higher upon final data readout in Q1 2026. Median PFS is also likely to increase as 7 patients still on trial are yet to reach the 7.6-month mark since first dose.

Key Metrics Can Only Grow

The results are further bolstered by a superior 31% ORR (vs. 23%) with 16 of 55 patients returning a confirmed Partial Response (PR) (inc. the pCR) and 1 patient seeing an extremely rare confirmed Complete Response (CR), where all target and non-target lesions completely erased, an outcome almost unheard of in pancreatic cancer. For reference, the benchmark study that led to the approval of gem/Abraxane saw one confirmed CR in 431 patients. With 6 of the 17 active patients yet to achieve confirmed PR, there is scope for ORR to reach 42%.

What's more, one of the confirmed PRs had 100% erasure of all target lesions (the 5 measured at baseline) but cannot be classified as a CR due to the presence of non-target lesions. Responses have been rapid: 12/22 PRs (both confirmed and unconfirmed) achieved the feat at first imaging (approx. day 60). Rounding out this strong efficacy bundle is the 73% DCR (vs 50% in MPACT) suggesting the broad applicability of narmafotinib: a significantly greater proportion of patients show some sort of response with narmafotinib added on top.

Our Read

mPDAC is a devastating disease with 5-year overall survival approximately 3%. Amplia is genuinely tackling a titan: all patients enrolled are stage 4, metastatic, and inoperable. Showing tangible superiority in PFS and ORR – with most patients far exceeding the 30% target lesion shrinkage threshold for a PR – patients are far more likely to be deemed operable again, opening the door to surgical resection. The distribution of days on trial has heavy tails – some patients never stood a chance, while 10 patients have surpassed 300 days. What does this tell us? There may be some biological differentiator facilitating a far deeper response in some patients. This validates the pursuit of biomarker research, which the company referenced in the topline data announcement, which will aim to identify a measurable indicator of certain patients' predisposition to treatment response.

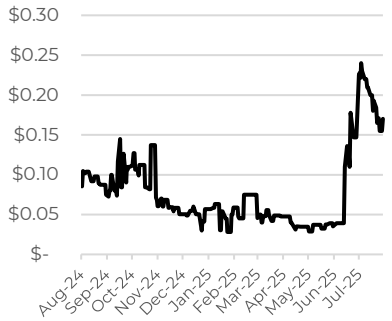
The story is simple: topline data is solid, and it can only get better by Q1 2026. AMPLICITY will begin dosing this quarter. The de-risking is happening; we just await how good it will be.

Recommendation	**Spec Buy**
Share Price	**$0.175**
Fair Valuation	(unch.) **$0.470**
TSR	**169%**

Company Profile

Market Cap	$85.1M
SOI (undiluted)	486.5M
Free Float	87.8%
ADV (3-month)	$340.5k
52-Week Range	$0.049 - $0.425

Price Performance



Company Overview

Amplia Therapeutics (ASX: ATX) is a clinical-stage biotechnology company developing targeted therapies for aggressive, treatment-resistant cancers. Its lead asset, narmafotinib (AMP945), is a next-generation FAK inhibitor designed to enhance the efficacy of chemotherapy by dismantling the tumour's fibrotic and immunosuppressive defences. Currently in a pivotal Phase 2 trial (ACCENT) for first-line metastatic pancreatic cancer, narmafotinib has shown early signs of deep and durable responses, including rare complete remissions. With regulatory designations secured and multiple expansion opportunities in play, Amplia is positioned near a major value inflection point.

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Click here to access Evolution Capital's initiation of coverage published 9 July 2025.

Quality Treatment Response: ORR & DCR

ACCENT's primary efficacy endpoint – Objective Response Rate (ORR) – sits at 31% as at the 20 July 2025 data cut off. 17 of 55 patients have exhibited at least a confirmed PR, defined by the RECIST 1.1 framework as at least a 30% decrease in the sum of diameters of target lesions from baseline. To truly understand what this means, it's important to understand the framework. The Response Evaluation Criteria in Solid Tumours (RECIST) version 1.1 is a standardized framework used globally in clinical trials to objectively measure how solid tumours respond to treatment (see the Appendix for a summary table). At the start of a study (baseline), a patient's tumours are identified and classified into two main groups: target lesions and non-target lesions.

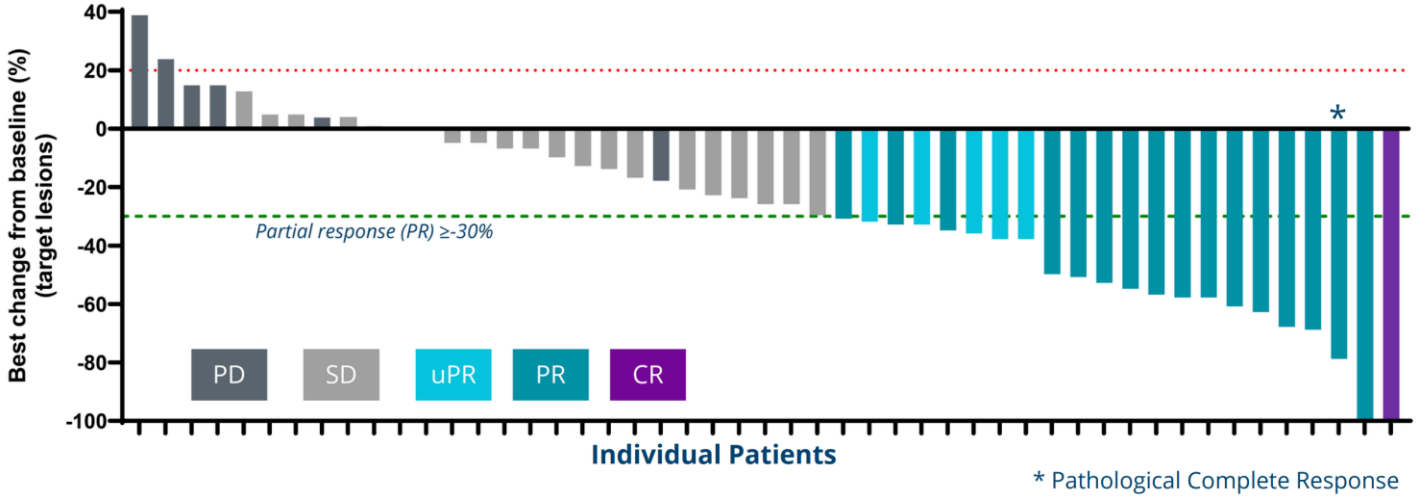
- **Target lesions:** selected, measurable tumours that are followed throughout the trial to assess treatment response. Up to a maximum of 5 are selected in total, with no more than two lesions per organ (note as ACCENT recruited metastatic patients, these lesions are often in the liver, lung, or other organs). Non-nodal lesions must have a longest diameter of at least 10mm while those on lymph nodes are considered measurable if their short axis is 15mm or greater. The sum of diameters is calculated at baseline.

- **Non-target lesions:** all other sites of disease that are not selected. his includes tumours that are too small to be measured accurately and truly non-measurable conditions like pleural effusion, ascites, or widespread inflammatory disease. While not measured, their presence is noted.

- **The role of new lesions:** a critical component of the framework is handling of new lesions. The appearance of one or more new lesions is considered an immediate sign of Progressive Disease (PD). This holds true even if the existing target and non-target lesions are stable or responding to treatment. If a patient achieves a Complete Response (CR) and a lesion later reappears, this is automatically classified as PD. In other scenarios, a reappearing lesion is evaluated like any other.

A deep dive into the data reveals some important and promising findings. Looking at Figure 1, one more patient on top of the confirmed CR exhibited a 100% reduction in target lesions (the bar second from the end on the right). But because non-target lesions remained, this patient is recorded as a confirmed PR rather than a confirmed CR. Nonetheless, another incredible marker of therapeutic efficacy.

Figure 1: Waterfall plot displaying the best response each individual patient achieved during the trial. Each vertical bar is one patient. Source: ATX ASX Release 6 Aug 2025.



Other noteworthy conclusions that can be drawn:

- 6/55 patients' best result was PD (i.e. at no point on trial did they exhibit stable disease or better). This reflects a very strong rate of at least SD at any point – 49/55 (89%). This is a signal that, despite all patients being metastatic, stage 4 cancer at recruitment, gem/abraxane + narmafotinib is efficacious to a degree in most patients. 13/55 patients achieved SD (stable disease).

- Only 9/55 (16%) patients finished with a sum of diameter of target lesions greater than baseline. Again, considering that all patients enrolled were stage 4, metastatic PDAC, it would be reasonable to expect that a greater percentage of patients would have exited the trial with a greater-than-baseline cumulative target lesion size. This data point is quite formidable.

- The disease control rate (DCR), measured as the percentage of patients who achieved CR, PR, or SD is 73%, which is far superior to the 50% figure seen in the benchmark MPACT study of gem/Abraxane alone.

- 22 patients experienced significant tumour shrinkage (≥30%) including 16 confirmed partial responses (including the pathological complete response); a further 5 unconfirmed PRs; and very importantly, one confirmed CR where all target and non-target lesions disappeared. This results in an ORR of 31%, which again, trumps the benchmark MPACT figure of 23%. ACCENT's ORR can only grow from here: of the 17 patients still on trial, 6 are yet to exhibit a confirmed PR.

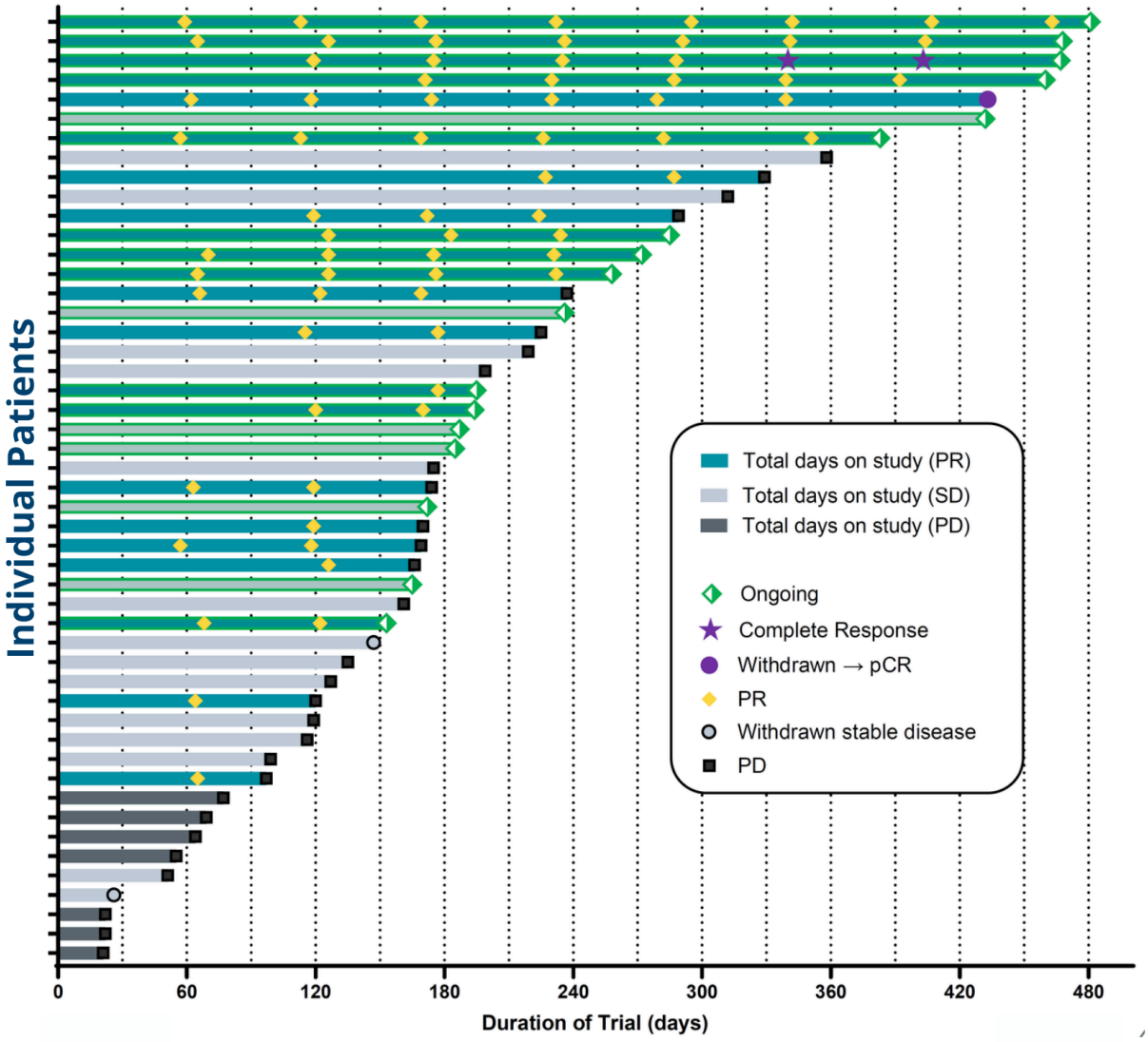
Beyond these rates, the graph highlights the quality and depth of the responses. Many patients in the Partial Response category showed tumour shrinkage far exceeding the required 30% threshold, with several achieving reductions of 60% or more. Moreover, rarity of a confirmed CR outcome cannot be understated. As outlined in our initiation of coverage, the MPACT study featured only 1 confirmed CR out of 431 patients. All in all, this waterfall plot provides strong evidence of narmafotinib's efficacy, showing that it not only controlled the disease in the vast majority but also induced deep and sometimes complete tumour regression.

Repeated Durability: PFS & DoT

Today's data readout gives us the first look at the topline Progression-Free Survival (PFS). The global standard-of-care, gem/Abraxane, in its pivotal MPACT study exhibited a mean PFS of 5.5 months. Many subsequent trials have failed to show a meaningful improvement on this: the NAPOLI 3 trial, which evaluated NALIRIFOX against gem/Abraxane saw a 5.6-month mean PFS for the gem/Abraxane-treated arm. ACCENT achieved a two-month (38%) improvement with a mean PFS of 7.6 months.

Not only does this number beat the gem/Abraxane regimen, but it also surpasses the PFS of FOLFIRINOX (6.4 months), another standard (though more toxic) chemotherapy regimen more commonly used in first-line treatment on mPDAC in the US. Achieving a longer period of disease control with a well-tolerated drug is a major therapeutic goal.

Figure 2: Duration on Trial for Individual Patients in the ACCENT Trial as of July 20, 2025. Source: ATX ASX Release 6 Aug 2025.



Regulators like the FDA often view a significant improvement in PFS as sufficient evidence for drug approval, especially in diseases with high unmet needs like pancreatic cancer. In February 2024, the FDA approved the NALIRIFOX regimen (consisting of irinotecan liposome/Onivyde®, oxaliplatin, fluorouracil, and leucovorin) for first-line treatment of metastatic pancreatic cancer based on the NAPOLI 3 data: the NALIRIFOX arm had a median PFS of 7.4 months, representing a 1.8-month improvement in the time patients lived without their legions progressing. In other words, ACCENT's 2-month improvement would be deemed clinically significant, potentially resulting in sufficient grounds for approval.

This validates Amplia's plan to further de-risk narmafotinib with SoC chemotherapy in pancreatic cancer, including an anticpiated phase 2c/3 clinical trial.

Looking at Figure 2 above, we make further key observations:

- 7 patients have surpassed 12-months on trial, an impressive feat reiterating the tolerability of narmafotinib. Mean DoT for the entire patient pool was 202 days, significantly greater than the benchmark 117 days of MPACT.

- 2 patients were withdrawn despite stable disease – one at less than 30 days, another at just less than 150 days. One of the potential reasons for this is that, while target lesions were not growing, non-target lesions grew, or a new lesion

appeared. Other potential reasons include pain and generally deteriorating health.

- The distribution of days on trial is positively skewed. This can be seen by observing the shape of the data in the graph: there is a large cluster of patients with shorter trial durations and a long tail of patients extending beyond 300 days. The distribution of days on trial is also likely leptokurtic (i.e. there are heavy tails and a sharp peak compared to a normal distribution reflecting distinct “great” and “bad” responders pulling the ends of the distribution curve away from the median).

  What does this mean? The “long tail” is a key indicator of drug targeted drug efficacy – the treatment appears to be exceptionally effective for a subgroup of the patient pool. It also implies durable disease control - for these "exceptional responders”, the drug isn't just delaying progression by a few months, it's controlling the disease for a year or more, which is a remarkable outcome in advanced pancreatic cancer. Notably, this suggests that there may be a specific biological reason that makes these patients respond so well. As outlined in our initiation of coverage, biomarker discovery is a suitable clinical research pathway for Amplia and would help solve the mystery of why certain patients respond so well. Based on the drug’s MOA, the most likely target would be related to the KRAS signalling pathway. It’s important to note however, that the company has not yet identified a definitive biomarker and explicitly states that "Biomarker discovery to be initiated".

- 12/22 partial responders (inc. confirmed and unconfirmed; partial and complete) achieved the 30% shrinkage threshold upon first imaging (at approx. 60-days post first dose). This is indicative of rapid considerable tumour shrinkage. For the patient, this is likely to correlate with fast symptom relief (particularly pain and fatigue) and psychological benefit – seeing tangible proof that the treatment is working on the very first scan provides a powerful morale boost. This early positive feedback can strengthen a patient's resolve to continue with what is often a difficult therapeutic regimen.

  In a real-world setting, an early response provides immediate validation that the chosen therapy is effective for that specific patient. It removes the uncertainty of waiting for multiple cycles to see if a drug is working. For patients with borderline resectable cancer, a strong and rapid response might make them eligible for potentially curative surgery sooner, a key goal in pancreatic cancer treatment. This was demonstrated by the patient in the trial who achieved a pathological Complete Response (pCR) after surgery.

  For a payor (i.e. health insurer, public health system), narmafotinib, despite its likely high upfront cost, has the potential to be cost-effective in the long run. Patients who respond quickly and have their symptoms relieved may require fewer costly supportive care drugs (e.g., opioids), fewer hospital visits for complications, and have a better quality of life, reducing the overall financial burden. It means surgical resection can occur sooner, again resulting in a greater upfront cost, but the potential to eliminate long-run costs. Additionally, payors could quickly identify which patients are benefitting. This opens the door for value-based agreements where treatment is discontinued early for non-responders, preventing wasteful spending.

- 6/17 patients still on trial are yet to exhibit a confirmed PR (the light green bars with no yellow diamond). This opens the door for the ORR figure to increase from 31% to 42% should the conversion rate be 100%. Each PR would represent a 1.8% increase in ORR. Equally as important, the longer the 17 patients stay on trial, the greater the final PFS and DoT figures (expected Q1 2026).

Excellent Tolerability Profile

The tolerability profile for narmafotinib continues to impress, demonstrating a safety profile that outperforms the gemcitabine/Abraxane backbone alone. The rates of severe adverse events are broadly comparable to those from the benchmark MPACT study, reinforcing the view that narmafotinib adds negligible extra patient burden. Most notably, the incidence of severe peripheral neuropathy was significantly lower in the ACCENT trial at just 3.6%, a formidable improvement on the 17% observed in MPACT.

Figure 3: Comparison of safety & tolerability measures between ACCENT and MPACT. Source: ATX ASX Release 6 Aug 2025.

Adverse Event (AE) Grade ≥ 3	Narmafotinib +Gem/Abr (ACCENT; N=55)	Gem/Abr (MPACT; N=421)
Neutropenia	38.2%	38%
Anemia	9.1%	13%
Diarrhea	5.5%	6%
Peripheral neuropathy	3.6%	17%
Vomiting	3.6%	NR
Febrile Neutropenia	5.5%	3%
Thrombocytopenia	NR	13%
Fatigue	NR	17%
Hypokalemia	NR	NR
Nausea	3.6%	NR

What's Next?

Final Data Readout (Exp. Q1 2026)

With mature data from the ACCENT trial expected in Q1 2026, key efficacy and durability metrics are anticipated to strengthen further. As the 17 patients who remain on study continue treatment, the final median PFS and mean DoT figures are expected to improve upon the already impressive interim figures of 7.6 months and 202 days, respectively. The question is, by how much? Furthermore, there is potential for the ORR could increase from its current 31% as 6 patients who are still on trial have yet to record a PR. Worth noting is that 4 of these 6 are at or nearing (< 1 week) imaging – in a highly bullish scenario, we could see another few confirmed PRs in the very short term.

The final data readout will also provide the first Overall Survival figure for the ACCENT trial, where a strong result would be a figure exceeding 11 months, which would compare very favourably against the 8.5-month benchmark from the MPACT study and position it competitively with the 11.1-month survival seen in the PRODIGE trial.

AMPLICITY Trial in mPDAC

With the impressive efficacy and durability signals from the ACCENT trial now in hand, Amplia has a strong foundation for its next clinical study, the AMPLICITY trial, which is set to begin recruitment shortly in the US and Australia. The rationale for this trial is to explore the synergy of narmafotinib with FOLFIRINOX, the other major chemotherapy regimen used in first-line pancreatic cancer. The AMPLICITY trial will also investigate a daily dosing schedule for narmafotinib, a shift from the intermittent schedule used in ACCENT. This Phase 1b/2 study will initially focus on determining the safety, tolerability, and recommended Phase 2 dose (RP2D) of this new combination before proceeding to evaluate efficacy endpoints such as Objective Response Rate (ORR) and Progression-Free Survival (PFS).

Replicating topline ACCENT data would substantially de-risk Amplia's entire investment case. It would directly mitigate the principal risk that these unprecedented early signals might not be reproducible in a final analysis or a larger pivotal study. Furthermore, confirming the high response rate and, critically, the rare Complete Responses (CRs) would validate narmafotinib's potential as a "best-in-class" therapy capable of delivering a paradigm-shifting improvement over the current standard of care. This would fundamentally transform Amplia's negotiating leverage, elevating potential licensing discussions towards the "upper bound" blue-sky scenario outlined in our initiation report and unlocking significant shareholder value.

Figure 4: Table summarising key design parameters for the AMPLICITY trial, a Phase 1b/2a study evaluating narmafotinib with FOLFIRINOX chemotherapy in first-line pancreatic cancer. Source: Company data.

Trial Parameter	Description
Trial Name	AMPLICITY
Phase	Phase 1b/2a
Indication	First-line metastatic pancreatic ductal adenocarcinoma (mPDAC)
Treatment Combination	Narmafotinib + FOLFIRINOX chemotherapy
Narmafotinib Dosing	Daily
Cycle Length	14 days
Locations	USA and Australia
Primary Objective	Initially, to determine safety, efficacy, and the Recommended Phase 2 Dose (RP2D) of the combination.
Primary Endpoints	Safety & Tolerability; RP2D
Secondary Endpoints	Objective Response Rate (ORR); Progression-Free Survival (PFS); Overall Survival (OS); Duration of Response; Disease Control Rate (DCR)

Valuation & Financial Position

Our risk-adjusted fair valuation of $0.47 per share remains unchanged. While the positive interim data significantly de-risks the clinical asset, we await mature survival data before adjusting our probability of success inputs.

Figure 5: Summary table of SOTP valuation. Source: Evolution Capital's analysis.

Asset	Market	Indication	Commercialisation path	NPV12 (A$'000s)	Unrisked $/sh	PoS	rNPV12 (A$'000s)	Risked $/sh
Narmafotinib	US	1L PDAC	Licensee	942,340	$2.168	10%	94,234	$0.217
Narmafotinib	Europe	1L PDAC	Licensee	1,292,153	$2.973	10%	129,215	$0.297

The core assumptions of our model include:

- Post-phase II licensing deal: we model that the company strikes global licensing deal in FY27 on the back of further successful clinical de-risking. US$350m in total deal value including US$50m upfront and tiered royalties starting at 12.5%.

- Regulatory timelines: US FDA approval is forecast for late FY29 for first-line treatment in metastatic pancreatic cancer, followed by European approval in FY30.

- Commercialisation & market penetration: we project an annual price of US$120,000 per annum per patient in the US with market penetration to begin at 5% post launch, growing to a peak TAM penetration of 40% over an 8-year period. This translates to a year 1 number of 884 patients treated, eventually rising to over 7,600. A similar trajectory is expected for Europe though at a lower price point of US$90,000 per patient per annum.

- Expansion in pancreatic cancer: significant upside to the current valuation exists by expanding the label to include patients with earlier, non-metastatic disease, which could effectively double the addressable market. Further growth could be realized through expansion into other jurisdictions not included in the model, like Japan and the Rest of World.

- Future therapeutic opportunities: long-term growth is underpinned by the potential to expand into other FAK-related cancers, with ovarian cancer being a logical next step, and the profound strategic opportunity to become a necessary combination partner for the emerging class of KRAS inhibitors. This is however not factored into the model.

Following a successful $25M capital raise in July 2025, Amplia is in a strong financial position with a cash runway extending into 2027. This new funding provides the necessary capital to not only see the ACCENT trial through to its final data readout but also to fully fund the upcoming AMPLICITY trial. This removes any near-term funding overhang and allows management to execute its clinical strategy from a position of financial strength.

Financial Forecasts

Income Statement					
A$'000s	FY25a	FY26e	FY27e	FY28e	FY29e
Revenue	-	-	50.00	-	100.00
Other Income	4.06	5.66	4.35	3.05	3.05
Total Revenue	**4.06**	**5.66**	**54.35**	**3.05**	**103.05**
Operating expenses	-10.49	-15.75	-13.01	-10.30	-10.03
EBITDA	**-6.43**	**-10.10**	**41.34**	**-7.25**	**93.01**
D&A	-0.09	-0.00	-0.00	-0.00	-0.00
EBIT	**-6.52**	**-10.10**	**41.34**	**-7.25**	**93.01**
Net Interest	-0.06	0.21	0.48	1.37	1.17
NPBT	**-6.57**	**-9.89**	**41.82**	**-5.88**	**94.18**
Tax expense	-	-	-	-	-
Discontinued operations	-	-	-	-	-
NPAT	-6.57	-9.89	41.82	-5.88	94.18

Balance Sheet					
A$'000s	FY25a	FY26e	FY27e	FY28e	FY29e
Cash	10.86	25.22	70.80	65.09	160.34
Receivables	-	-	-	-	-
Inventory	-	-	-	-	-
R&D Incentive Receivable	3.77	5.66	4.35	3.05	3.05
Other	0.29	0.51	0.39	0.27	0.27
Current assets	**14.93**	**31.38**	**75.54**	**68.41**	**163.66**
Intangibles	7.94	7.94	7.94	7.94	7.94
PPE	0.00	0.00	0.00	0.00	0.00
Other	0.07	0.07	0.07	0.07	0.07
Non-current assets	**8.01**	**8.01**	**8.01**	**8.00**	**8.00**
Total Assets	**22.94**	**39.39**	**83.54**	**76.42**	**171.66**
Payables & Accrued Liabilities	1.80	2.72	2.25	1.78	1.73
Borrowings	-	-	-	-	-
Lease Liabilities	0.01	-	-	-	-
Other	0.07	0.36	0.06	-	-
Current liabilities	**1.89**	**3.08**	**2.31**	**1.78**	**1.73**
Borrowings	-	-	-	-	-
Other liability	0.02	0.03	0.03	0.04	0.04
Non current liabilities	**0.02**	**0.03**	**0.03**	**0.04**	**0.04**
Total Liabilities	**1.91**	**3.10**	**2.34**	**1.81**	**1.77**
Net Assets	**21.02**	**36.29**	**81.21**	**74.60**	**169.89**
Contributed Equity	167.39	188.57	194.08	194.89	194.89
Retained earnings	-145.54	-155.43	-113.60	-119.49	-25.31
Reserves/Other	-0.83	3.14	0.73	-0.80	0.28
Total Equity	**21.02**	**36.28**	**81.21**	**74.61**	**169.87**

Statement of Cashflows					
A$'000s	FY25e	FY26e	FY27e	FY28e	FY29e
Net profit for period	-6.57	-9.89	41.82	-5.88	94.18
Depreciation & Amortisation	0.09	0.00	0.00	0.00	0.00
Changes in working capital	-0.82	3.28	-2.19	-1.95	-0.05
Other	-	-	-	-	-
Operating cash flow	**-7.30**	**-6.60**	**39.63**	**-7.83**	**94.13**
	-	-	-	-	0.00
Payments for PPE	-0.00	-	-	-	-
Other payments	-	-	-	-	-
Proceeds from asset sale	-	-	-	-	-
Investing cash flow	**-0.00**	**-**	**-**	**-**	**-**
	-	-	-	-	0.00
Equity raised	17.28	20.00	-	-	-
Transaction costs	-1.33	-1.20	-	-	-
Proceeds from exercise of options	-	2.38	5.51	0.81	-
Net borrowings	-1.47	-	-	-	-
Finance costs	-0.08	-0.05	-0.05	-0.05	-0.05
Other	-0.08	0.21	0.48	1.37	1.17
Financing cash flow	**14.40**	**21.34**	**5.95**	**2.13**	**1.12**
	-	-	-	-	0.00
Free cash flow	**-7.31**	**-6.60**	**39.63**	**-7.83**	**94.13**
Net cash flow	**7.10**	**14.74**	**45.58**	**-5.71**	**95.25**
Effects of exchange rate	-	-	-	-	-
Cash year end	**10.48**	**25.22**	**70.80**	**65.09**	**160.34**

Investment Fundamentals					
	FY25a	FY26e	FY27e	FY28e	FY29e
Liquidity					
Current Ratio	7.9	10.2	32.8	38.5	94.5
Quick Ratio	2.2	2.0	2.1	1.9	1.9
Solvency					
Debt to Equity	0.0	0.0	0.0	0.0	0.0
Debt to Assets	0.0	0.0	0.0	0.0	0.0
LT Debt to Assets	0.0	0.0	0.0	0.0	0.0
Profitability					
Net Margin	n/a	n/a	77%	n/a	91%
ROA	-29%	-25%	50%	-8%	55%
ROE	-31%	-27%	51%	-8%	55%
Valuation					
P/E	n/a	n/a	5.8	n/a	2.6
EV/EBITDA	n/a	n/a	4.1	n/a	0.9
P/B	8.7	6.2	2.9	3.2	1.4

Appendix

RECIST 1.1 Framework

Response Category	Criteria for Target Lesions	Criteria for Non-Target Lesions & New Lesions
Complete Response (CR)	Disappearance of all target lesions. Any pathological lymph nodes must have their short axis reduced to <10 mm.	All non-target lesions must disappear, and tumour marker levels must normalize. No new lesions may appear.
Partial Response (PR)	At least a 30% decrease in the sum of diameters of target lesions, taking the baseline sum as reference.	Non-target lesions must not have progressed.
Progressive Disease (PD)	At least a 20% increase in the sum of diameters of target lesions from the smallest sum recorded during the study (nadir). There must also be an absolute increase of at least 5 mm.	Unequivocal progression of existing non-target lesions or the appearance of one or more new lesions.
Stable Disease (SD)	Neither sufficient shrinkage to qualify for PR nor sufficient increase to qualify for PD.	Non-target lesions must not have progressed.

Key Risks

Clinical development and regulatory risk

Amplia's investment case is heavily reliant on the exceptional early efficacy signals from the Phase 2 ACCENT trial, including multiple, rare Complete Responses (CRs). The primary risk is that these unprecedented results may not be replicated in a larger, randomized, and more stringently controlled pivotal Phase 3 trial. Historically, many promising Phase 2 oncology assets have failed to demonstrate a statistically significant benefit in Phase 3. Metastatic pancreatic ductal adenocarcinoma (mPDAC) is a notoriously difficult-to-treat cancer with a high rate of clinical trial failure. The complex biology, aggressive nature of the disease, and high bar for demonstrating a meaningful survival benefit present significant hurdles for any new therapeutic. While narmafotinib shows a differentiated profile, the broader class of FAK inhibitors has a history of clinical setbacks. The unambiguous failure of GSK's FAK inhibitor in a Phase 2 mPDAC trial serves as a stark reminder that targeting this pathway is not a guaranteed path to success. Like other ATP-competitive kinase inhibitors, narmafotinib only blocks FAK's enzymatic function. This leaves the protein's kinase-independent scaffolding role intact, which can mediate pro-tumorigenic signalling and contribute to adaptive resistance over time.

Competition and market risk

Verastem Oncology represents Amplia's most direct and formidable competitor. Verastem's FAK inhibitor, defactinib, is already FDA-approved for another indication and is being aggressively developed in combination for PDAC. Verastem's significant lead, established manufacturing, and existing relationships with oncologists give it a powerful first-mover advantage that will be difficult to overcome if its combination is approved first. The mPDAC treatment landscape is highly competitive and rapidly evolving. Several other companies (e.g., Arcus Biosciences, Cantargia) are developing novel agents with different mechanisms of action that have shown strong survival data in mid-to-late-stage trials. The success of these competitors could establish a new standard of care, raising the efficacy bar and potentially narrowing the market opportunity for narmafotinib. The recent FDA approval of NALIRIFOX, which demonstrated an 11.1-month median Overall Survival, has already raised the benchmark for new first-line therapies. Narmafotinib will need to demonstrate a clinically meaningful and statistically significant improvement over this new standard to achieve widespread clinical adoption and commercial success.

Partnership and commercialistation risk

Amplia's corporate strategy is predicated on securing a partnership with a major pharmaceutical company to fund the substantial costs of Phase 3 development and global commercialization. The company's ability to negotiate a favourable deal is contingent on the strength of its clinical data. Failure to secure a partner would place the full, significant financial burden on Amplia, a task that would be extremely challenging, if not impossible, to manage independently.

Funding and financial risks
As a clinical-stage biotechnology company with no commercial revenue, Amplia may require additional capital to fund its ongoing operations, including the planned Phase 2 trial of narmafotinib with FOLFIRINOX and any subsequent pivotal studies. Future financing will likely involve the issuance of new equity, which will be dilutive to existing shareholders. The terms of future capital raises will depend on clinical trial progress and prevailing market conditions.

Asset concentration risk
Amplia's valuation and near-term prospects are almost entirely dependent on the clinical and commercial success of a single lead asset, narmafotinib. Any clinical setbacks, safety issues, regulatory delays, or manufacturing problems related to narmafotinib would have a material and disproportionately adverse impact on the company's valuation.

Intellectual property risk
The long-term commercial success of narmafotinib depends on Amplia's ability to obtain, maintain, and defend its patent portfolio. While the company has a multi-layered IP strategy, patents can be challenged by competitors, and there is no guarantee that pending applications will be granted or that existing patents will provide sufficient protection to prevent the entry of competing products.

Board & Management

Chris Burns – CEO & MD
Chris is an experienced drug discovery leader having worked in various roles in pharma, biotech and academia for 25 years.

He has a Ph.D. from the University of Melbourne and undertook postodoctoral studies in the USA before moving to Pfizer UK, as a senior scientist. After 5 years he returned to Australia as a Research Fellow at the University of Sydney and then moved to the biotechnology company Ambri as Head of Chemistry.

Chris joined the Melbourne-based biotech Cytopia as Head of Medicinal Chemistry and later as Research Director. He led teams in the discovery of two anti-cancer agents that entered clinical trial, including the drug momelotinib (Ojjaara) now approved for the treatment of myelofibrosis. Chris then held a Laboratory Head position at the Walter and Eliza Hall Institute of Medical Research (WEHI) before taking on executive and leadership roles with a number of privately-held biotechnology companies in Australia.

Dr Burns is the inventor on over 30 patents and a co-author on over 60 scientific publications. He was co-recipient of the 2024 Prime Minister’s Prize for Innovation and is a Fellow of the Australian Academy of Health and Medical Sciences, the Royal Society of Chemistry (UK) and the Royal Australian Chemical Institute.

Dr Burns was originally appointed as a Non-Executive Director on 4 May 2018 and was subsequently appointed as Chief Executive Officer and Managing Director on 5 December 2022.

Tim Luscombe – CFO
Tim is a highly experienced Chartered Accountant who holds a Bachelor of Commerce from the University of Melbourne and a Certificate in Governance Practice from the Governance Institute of Australia. Tim brings professional skills gained locally and abroad in both public practice accounting and the corporate sector. Tim acts as CFO and Company Secretary for a number of ASX listed healthcare companies, private University spin out companies and Venture Capital investee companies. Tim provides strategic advice to management and boards on financial reporting, cash forecasting, direct and indirect taxes, governance and management matters.

Tim was appointed as Chief Financial Officer of Amplia Therapeutics Limited on 25 September 2023.

Rhiannon Jones – COO
Rhiannon has a background in research operations and project management and more than 10 years of experience in the medical research and biotechnology sector. Rhiannon has previous appointments as Director, Operations and Governance (Cancer Therapeutics CRC), Project Manager (WEHI, Business Development Office), Scientific Coordinator (WEHI, Inflammation Division) and a postdoctoral researcher in organic chemistry (Monash University, Chemistry Department). Her experience includes project management, communications, policy development and oversight, ethics committee submissions, risk management and staff professional development systems.

Rhiannon has a PhD in chemistry and a BSc(Hons) from the University of Adelaide and a Certificate in Governance Practice from the Governance Institute of Australia and is a graduate of the AICD.

Jason Lickliter - CMO
Dr Jason Lickliter trained as a medical oncologist in Australia and at the University of Minnesota and is currently the Chief Medical Officer at Nucleus Network, a multi-centre phase 1 clinical trials organization. He began working with Amplia on the AMP945 phase 1 trial in healthy volunteers and has since become an adviser for the ACCENT trial. Dr Lickliter has extensive experience in designing and implementing early-phase patient and healthy-volunteer clinical trials, including the integration of biomarker studies and advanced imaging into clinical research.

Andrew J. Cooke – Company Secretary
Andrew holds a law degree from Sydney University and has extensive experience in law, corporate finance, governance and compliance. He has over 30 years of boardroom experience and has developed a practical blend of legal and commercial acumen. He has served as a consultant to listed, public and private companies in the biotech, resources, property, mining services and technology sectors focussing on stock exchange, capital raisings, regulatory compliance and a wide range of corporate transactions.

Andrew was appointed as Company Secretary of Amplia Therapeutics Limited on 11 October 2013.

Warwick Tong – Non-Exec Chair
Warwick is a NZ trained physician with more than 25 years' experience in the Pharmaceutical and Biotechnology industry.

After his early career in General Medical Practice Warwick has held a wide variety of roles in the pharmaceutical and biotech industry in NZ (Glaxo) Singapore (GlaxoWellcome) London (GSK), Boston (Surface Logix) and Melbourne (CTx - Cancer Therapeutics CRC). His roles have included; Medical Director, Regional Business Development Director (Asia Pacific), Commercial Strategy Director (International) and SVP Development (USA).

He was CEO and Director of CTx from 2011 until April 2018. He is a member of the SAB of the Maurice Wilkins Centre in Auckland NZ, the Advisory Board of Cortex Health, Melbourne, the Industry Advisory Board, School of Biomedical Sciences, University of Melbourne and a member of the CSIRO Manufacturing, Business Advisory Committee.

Warwick was educated at the University of Auckland and Victoria University, Wellington, New Zealand and is a Graduate of the Australian Institute of Company Directors.

Dr Tong was appointed as a Non-Executive Director on the 4th of May 2018 and Chairman on 25 May 2018. Dr Tong is also a member of the Audit and Risk Committee and a member of the Remuneration Committee.

Jane Bell AM – Independent NED
Jane is a banking and finance lawyer and non-executive director with more than 30 years' experience in leading law firms, financial services and corporate treasury

operations gained living in Melbourne, London, Toronto, San Francisco and Brisbane. Jane has been a non-executive director since 2002, serving on 14 boards including 10 hospital, life sciences, medical research and funds management boards. Jane currently serves as Deputy Chair of Monash Health, Director of Mesoblast Limited (ASX:MSB)(Nasdaq:MESO), Director of Jessie McPherson Private Hospital, and is a Member of the Administrative Appeals Tribunal.

Jane is a former Chair of Melbourne Health (Royal Melbourne Hospital), Chair of Biomedical Research Vic, Deputy Chair of Westernport Water Corporation, Director of U Ethical Funds Management, WorkSafe Victoria, Hudson Institute of Medical Research-Monash Institute of Medical Research-Prince Henry's Institute of Medical Research, Queensland Institute of Medical Research Trust, Australian Red Cross (Qld), Victorian Women's Housing Association.

Jane holds a Master of Laws from Kings College, London, Bachelor of Laws from the University of Melbourne, Bachelor of Economics from Monash University and is a Fellow of the Australian Institute of Company Directors.

Ms Bell was appointed as an Independent Non-Executive Director on 12 April 2021 and is Chair of the Audit and Risk Committee and a member of the Remuneration Committee.

Robert Peach – Independent NED

Dr Peach has over 25 years of drug discovery and development experience in the Pharmaceutical and Biotechnology industry. In 2009 he co-founded Receptos, becoming Chief Scientific Officer and raising $59M in venture capital and $800M in an IPO and three subsequent follow-on offerings. In August 2015 Receptos was acquired by Celgene for $7.8B. Robert held senior executive and scientific positions in other companies including Apoptos, Biogen Idec, IDEC and Bristol-Myers Squibb, supporting in-licensing, acquisition and venture investments. His extensive drug discovery and development experience in autoimmune and inflammatory diseases, and cancer has resulted in multiple drugs entering clinical trials and 3 registered drugs. He is currently on the Scientific Advisory Board of Eclipse Bioinnovations in San Diego and is a consultant for several other biotechnology companies.

Robert is the co-author of 70 scientific publications and book chapters, and 17 patents. He was educated at the University of Canterbury and the University of Otago, New Zealand.

Dr Peach was appointed as an Independent Non-Executive Director on the 2nd of September 2015 and is Chair of the Remuneration Committee and a member of the Audit and Risk Committee.

Evolution Capital Ratings System

Recommendation Structure	• **Buy:** The stock is expected to generate a total return of >10% over a 12-month horizon. For stocks classified as 'Speculative', a total return of >30% is expected. • **Hold:** The stock is expected to generate a total return between -10% and +10% over a 12-month horizon. • **Sell:** The stock is expected to generate a total return of <-10% over a 12-month horizon.
Risk Qualifier	• **Speculative ('Spec'):** This qualifier is applied to stocks that bear significantly above-average risk. These can be pre-cash flow companies with nil or prospective operations, companies with only forecast cash flows, and/or those with a stressed balance sheet. Investments in these stocks may carry a high level of capital risk and the potential for material loss.
Other Ratings:	• **Under Review (UR):** The rating and price target have been temporarily suppressed due to market events or other short-term reasons to allow the analyst to more fully consider their view. • **Suspended (S):** Coverage of the stock has been suspended due to market events or other reasons that make coverage impracticable. The previous rating and price target should no longer be relied upon. • **Not Covered (NC):** Evolution Capital does not cover this company and provides no investment view.

Expected total return represents the upside or downside differential between the current share price and the price target, plus the expected next 12-month dividend yield for the company. Price targets are based on a 12-month time frame.

Disclaimer & Disclosures

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