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QBIOTICS GROUP

INTRATUMOURAL ONCOLOGY WITH PLATFORM OPTIONALITY

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QBiotics Group

Valuation research

Intratumoural oncology with platform optionality

Pharma and biotech

QBiotics is a clinical-stage biotechnology company developing novel small molecules derived from natural sources, with the potential to access multiple blockbuster markets. Lead asset, tigilanol tiglate (TT), is an intratumoural therapy involved in three Phase II trials, in soft tissue sarcoma (STS), for which the FDA has granted Orphan Drug Designation (ODD); head and neck cancer (HNC); and breast cancer, the latter of which is 90% backed by a strategic partner. Early clinical data have been promising, in our view, with high response rates and durable tumour control, providing a robust foundation for further development. Beyond oncology, QBiotics has programmes in wound healing and antibiotics, giving additional optionality from its underlying discovery platform, capable of generating multiple drug candidates. QBiotics is planning a capital raise (seeking up to c A$40m), with the proceeds to be used to augment the oncology programme for a commercial partnership with a big pharmaceutical company, and to extend the company's operating runway ahead of a potential Australian Securities Exchange (ASX) IPO in 2027.

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Differentiated oncology asset with early validation

TT represents a differentiated approach in oncology, targeting tumours through direct injection rather than systemic exposure. This localised delivery allows for rapid tumour destruction at the injection site. In Phase IIa STS studies, TT has shown high objective response rates (ORR) and durable ablation, with no recurrence observed in fully responding lesions over follow-up periods. Emerging translational data also show signs of systemic immune responses after local treatment, suggesting broader therapeutic relevance. While these findings remain early, we believe they provide encouraging initial validation of this asset and the platform. We note that TT has already been marketed as a veterinary formulation (Stelfonta), providing evidence of real-world safety and activity in live disease settings across >30k dogs, somewhat de-risking the human oncology programme.

Platform optionality provides longer-term upside

QBiotics' pipeline is powered by its discovery platform, EcoLogic, based on the development of bioactive molecules from natural sources. This approach generates chemical platforms such as the current epoxytiglianes platform, which is producing multiple programmes extending into wound healing and antibiotics, providing longer-term optionality beyond the core oncology focus. In our view, the company's ability to translate platform-derived molecules into clinically validated drug candidates supports the credibility of the approach. Over time, successful creation of additional assets could diversify the pipeline and unlock further partnering opportunities.

Enterprise value assessed at A$361m

We value QBiotics at A$361m (73.7c/share), with TT representing the primary value driver across STS, HNC and breast cancer, underpinning the bulk of risk-adjusted returns. EBC-1013 and Stelfonta offer additional diversification and medium-term upside. We note that, given the early stage of clinical development, our valuation is highly sensitive to clinical readouts, regulatory execution and the scalability of intratumoral delivery, as well as the successful translation of TT's combination potential within immuno-oncology settings.

QBiotics is a research client of Edison Investment Research Limited

Investment case and use of proceeds

Why invest now?

QBiotics presents an opportunity to invest in a differentiated oncology asset at a stage where early clinical validation is established, yet potentially significant value inflection points remain ahead. The company is targeting areas of high unmet medical need, including STS, HNC and breast cancer, all of which have the potential to translate to lucrative commercial opportunities. TT offers a relatively underexplored intratumoural approach, combining direct tumour ablation with broader immune-mediated effects, differentiating the asset from current treatment options. While the therapy may be positioned as a monotherapy, we see potentially greater opportunities in combination approaches, which are becoming increasingly prevalent in modern cancer treatment regimens, and, hence, of interest to prospective pharma partners.

Clinical traction is already evident. Early studies have shown encouraging response rates across multiple tumour types, all while showcasing a favourable safety profile. Programmes in STS and HNC are progressing through Phase II, with an additional Phase II study in breast cancer in planning, supported largely by non-dilutive external funding, and is expected to broaden the dataset. Further opportunities also exist in additional solid tumour settings, including liver cancer and melanoma based on preclinical and early clinical data, respectively, offering multiple shots at goal. We believe that the human oncology programme is somewhat de-risked by the successful development and commercialisation of Stelfonta. These achievements highlight TT's safety and activity in live disease settings, while demonstrating QBiotics' capabilities in manufacturing and providing the company with learnings to support the current human oncology focus.

In parallel, management is actively engaging potential pharma partners, suggesting the asset is approaching a stage where its robust scientific backing can translate into a commercial transaction. As such, any further developments may help secure a partner under more attractive deal terms.

Use of proceeds and path to value inflection

The proposed fundraise (seeking up to c A$40m) has been planned with the clear objective of augmenting the oncology programme for a commercial partnership, and we understand that management is already in discussions with prospective pharma partners. Most of the proceeds will be allocated to progressing TT through ongoing and planned clinical development efforts, generating important data to enhance both partnering discussions and the overall value proposition. This includes completing key Phase II studies and expanding the clinical evidence base across all relevant oncology indications.

A secondary component of the funding will support preparations for a potential ASX IPO. Importantly, the use of proceeds is tightly aligned with near-term value creation, providing investors with a clear line of sight between capital deployment and milestone delivery.

The wound healing drug candidate (EBC-1013) is expected to progress independent of newly raised capital. The programme is already funded through its current stage of development, and management is exploring non-dilutive funding opportunities, including grants and strategic partnership opportunities, to support further advancement. As such, investors in QBiotics may gain exposure to this additional opportunity without a meaningful increase in near-term funding requirements. We highlight that QBiotics also has a novel antibiotics programme (preclinical), but since this represents a longer-term opportunity, we do not discuss it in detail in this report.

Overall, the investment case is underpinned by a disciplined capital strategy: deploying capital into the highest-value programme, targeting a defined partnering inflection point, while maintaining optionality across the broader pipeline with limited incremental spend.

Company overview

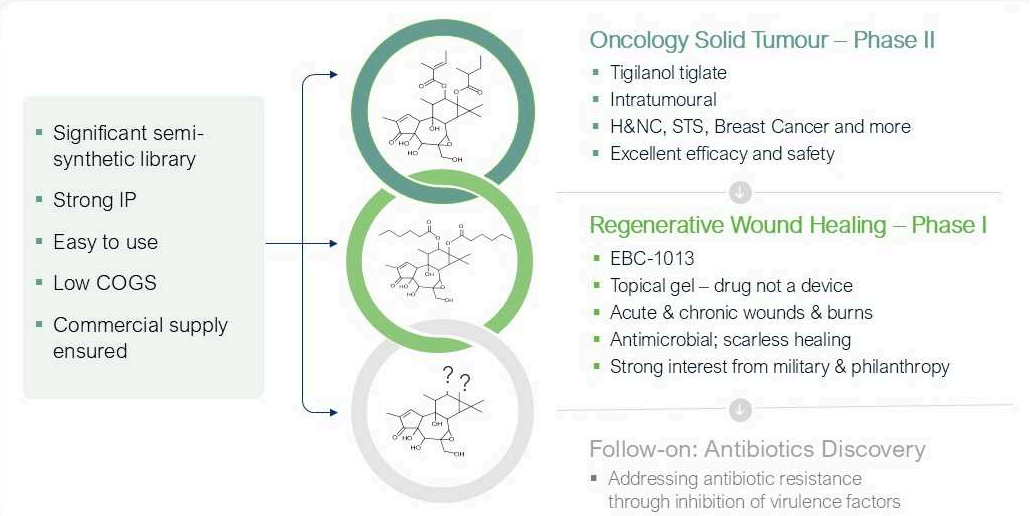
Translating natural molecules into clinical assets

QBiotics is a clinical-stage biotechnology company headquartered in Brisbane, Australia. It is a public unlisted company, having historically funded its operations through private capital. Its operating model spans early-stage drug discovery, through clinical development, to marketed products. The leadership team brings a diverse mix of scientific, clinical and commercial experience, with recent changes reflecting a renewed focus on capital discipline, clinical execution and strategic positioning. This includes a reconstituted board and management structure, aligning the organisation more closely with its next stage of development and funding objectives.

At the core of QBiotics' approach is its EcoLogic platform that produces novel biologically active chemical platforms sourced from botanical origins, drug candidates from which are subsequently optimised for therapeutic use (Exhibit 1). The current epoxytiglianes platform is derived from *Fontainea picrosperma* (a rainforest tree endemic to the Atherton Tablelands in North Queensland, Australia), exemplifying this approach.

Natural products have historically played an important role in drug discovery, offering structurally diverse and biologically active molecules that can interact with complex disease pathways. Key successful examples include quinine for malaria, paclitaxel in oncology and the penicillin class of antibiotics. QBiotics' platform seeks to harness these properties, identifying molecules with inherent biological activity and translating them into clinically viable therapies. The epoxytiglianes class is of particular interest due to its ability to induce rapid, localised and systemic biological effects, which can be leveraged in settings such as tumour destruction and tissue regeneration. This discovery strategy differentiates QBiotics from many small biotechnology companies, which often focus on synthetic or highly targeted molecular approaches, which can be complex and expensive.

Exhibit 1: QBiotics' epoxytiglianes platform is a source of potential therapeutics across a range of disease areas



Source: QBiotics corporate presentation (April 2026)

Corporate strategy

QBiotics' epoxytiglianes platform has given rise to a pipeline spanning oncology, wound healing and antibiotics, with each programme reflecting a different application of its underlying chemistry (Exhibit 2). The lead oncology asset, TT, is being developed as an intratumoural therapy for solid tumours, with active programmes in STS and HNC. Additional exploratory work is ongoing in other

tumour types, including breast cancer, supported in part by external funding, highlighting TT's 'pipeline-in-a-product' potential.

The company's second clinical-stage asset, EBC-1013, is being developed for chronic wound healing, with additional potential in acute wounds and burns. This programme targets conditions where tissue repair represents a medical challenge, with early clinical work suggesting potential to accelerate healing through localised biological activity. In parallel, QBiotics maintains a preclinical antibiotics programme, although this remains a longer-term opportunity. Together, these programmes illustrate the breadth of the epoxytiglianes platform and its potential to generate multiple assets across distinct therapeutic areas. While oncology is deliberately the primary focus, the broader pipeline provides strategic optionality, with scope to expand into additional indications over time as new candidates are identified.

Management is prioritising the clinical development of TT in oncology, with the objective of generating robust data to augment a commercial partnership to support subsequent development efforts and eventual potential commercialisation. This reflects a disciplined approach to capital allocation, concentrating resources on the programme with the clearest path to near-term value realisation, while maintaining longer-term upside through the broader platform. As an example of an oncology deal involving the intratumoral delivery approach, French biotech Nanobiotix secured a $2.6bn licence agreement with Janssen (a Johnson & Johnson company), including a $60m upfront payment for its intratumoral candidate, highlighting the big pharma interest in this space.

Exhibit 2: QBiotics' clinical development pipeline

Source: QBiotics corporate presentation (April 2026)

Lead asset: Tigilanol tiglate

Mode of action and positioning

TT is QBiotics' lead oncology asset and represents a novel approach to cancer treatment based on intratumoural delivery. Unlike conventional anti-cancer therapies, which typically circulate throughout the body, TT is administered directly into the tumour site. This localised approach is designed to enable targeted tumour destruction while limiting systemic exposure.

As characterised by Johnson & Johnson, such intratumoural treatments offer the potential to:

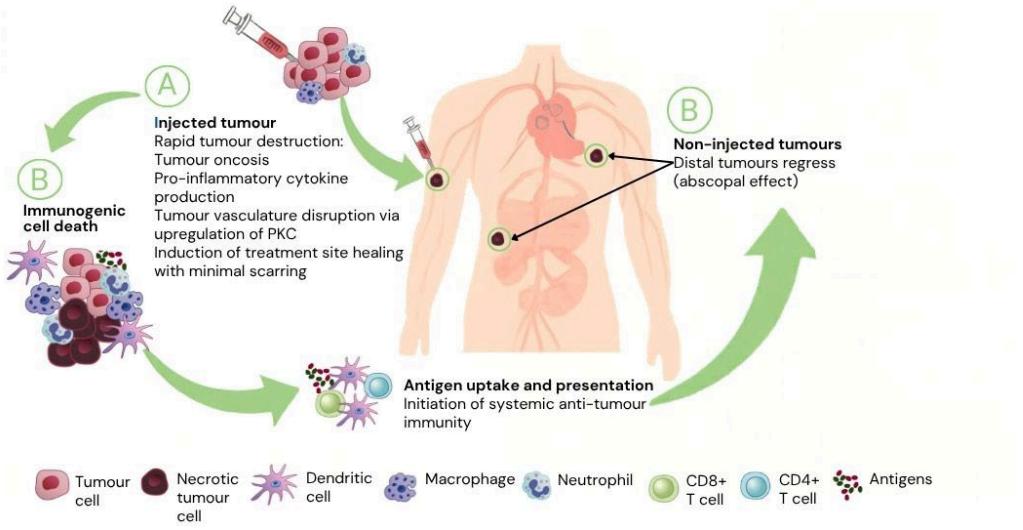
- Minimise toxicity: offering more favourable risk-benefit profiles, in particular for earlier-stage cancers.
- Increase efficacy: expose tumours to higher concentrations of therapy and activate anti-tumour immunity.

- Unlock new therapies: enable use of immunotherapeutic agents that otherwise may not be usable via systemic delivery.

Following injection, TT induces a localised biological response within the tumour microenvironment. This includes disruption of tumour vasculature (disrupting the blood vessels supplying the tumour) and oncosis (activation of cellular processes that lead to tumour cell death), leading to rapid tumour ablation. TT also stimulates healing of the site post tumour destruction. By concentrating activity at the tumour site, the therapy achieves meaningful local control while reducing off-target effects associated with systemic therapies.

Beyond this local effect, there is emerging evidence of TT having broader biological implications. The destruction of tumour tissue can release tumour-specific antigens (proteins that our immune systems can recognise), stimulating systemic immunological responses. While these distal effects remain under investigation, they support the potential for QBiotics' lead asset to act as a local therapy as well as for wider anti-cancer activity (Exhibit 3).

Exhibit 3: TT's mode of action



Source: QBiotics resources

This mode of action positions TT as a flexible component within the evolving oncology treatment landscape. Standards of care are increasingly incorporating synergistic combination approaches, especially in immuno-oncology (as discussed in our recent thematic report), where therapies are used together to improve response rates and durability. Intratumoural therapies such as TT may complement these approaches by improving both tumour accessibility and immune recognition (as demonstrated in mouse studies), potentially enhancing responses to existing therapies (immune checkpoint inhibitors (ICIs) response rates are only 15–30% in solid tumours, and the market is still currently valued at c $50bn, according to Grand View Research). This means that while TT could be initially developed as a monotherapy, combination strategies may provide a greater value proposition, in our view.

Preclinical development

QBiotics has progressed TT through a structured development path, including preclinical research, veterinary clinical development, a Phase I study and ongoing Phase II programmes across multiple tumour types. Preclinical and veterinary clinical work showed the molecule's ability to induce the rapid destruction of tumour cells after local dosing, alongside evidence of vascular disruption and immune activation. These findings provided the rationale for advancing into human studies.

Early clinical development

Early clinical development focused on establishing safety, tolerability and signals of efficacy in nine different solid tumour types. The Phase I study (EBC46-H01/2) assessed TT in 22 patients with advanced solid tumours, including STS, HNC, as well as other accessible lesions, such as breast cancer, melanoma and squamous cell carcinoma. The therapy was generally well tolerated, with no maximum tolerated dose identified and a safety profile characterised primarily by localised, manageable effects at the injection site, normal for this type of administration. While the study was not powered to test efficacy, early signals of anti-tumour activity were observed across multiple tumour types. Encouragingly, 6/22 patients (27%) experienced a treatment response, with 4/22 (18%) achieving a complete response. Furthermore, abscopal responses were observed in two patients, meaning that tumour responses were recorded in distal (non-injected) tumour sites in two cases. Collectively, an overall injected-tumour response rate of 60% was reported following single injections of TT, providing early validation of the mode of action. However, we highlight that the data here correspond to a relatively small sample size. (See Exhibit 14 in the appendix for a supplementary figure relating to the Phase I study.)

Building on these findings, QBiotics advanced TT into Phase II development with larger cohorts, with an initial focus on STS and HNC. These indications were selected based on a combination of clinical need, accessibility of tumours for injection and compelling early signals of efficacy.

Phase IIa in STS, programme supported by ODD

The Phase IIa study (QB46C-H07) in STS represents the most advanced clinical programme and is a key driver of the current investment case. QB46C-H07, being undertaken at the recognised site Memorial Sloan Kettering Cancer Center in the US, is designed as an open-label study, evaluating both the safety and efficacy of intratumoural TT in patients with a range of accessible STS lesions. The study is being conducted in stages, the first of which is a pilot in 10 patients, while the second is the expansion portion of the trial. The primary efficacy endpoint is based on ORR of injected tumours compared to baseline, defined as the portion of patients who achieve complete (100% reduction in volume) or partial (at least 30% reduction) ablation of tumours and/or tumour segments. Secondary endpoints are based on safety and tolerability, alongside pharmacokinetics. Exploratory endpoints include local rate of recurrence at the injection site at six months after initial injection and assessment of tumour responses in biopsy samples. Initial results have been reported from the first stage of the trial, and the expansion stage is ongoing.

The data from the first stage (announced in June 2025) were encouraging, in our view. The study reported an ORR of 80% in injected tumours (8/10 patients), with 22 of the 27 tumours treated (81%) across the 10 participants showing complete or partial ablation (Exhibit 4). This comprised 14/27 (52%) cases of complete ablation and 8/27 (30%) cases of partial ablation. Notably, in the 14 tumours that were fully ablated, no recurrence was observed over a six-month follow-up period, suggesting that TT delivers durable local tumour control in settings where treatment options are often limited and outcomes can be poor. In addition, TT efficacy response was consistent across six STS subtypes. Encouragingly, it has also been reported that three patients exhibited better-than-expected responses to subsequent systemic therapy, despite previously being refractory to such treatments, highlighting the promise for potential future combination treatment approaches. In terms of safety, the drug candidate was well tolerated, consistent with prior data, adding to a robust data package. (See Exhibit 15 in the appendix for a supplementary figure relating to QB46C-H07, showing an angiosarcoma patient achieving a complete response.)

The second stage of QB46C-H07 is underway with the aim of expanding the dataset and further validating the findings; management has communicated it will provide an update once this stage has been completed. It is our opinion that the results to date represent a meaningful signal of efficacy for a therapy at this stage of development.

We note that TT has received ODD in STS from the FDA, providing validation that the regulators see TT as a potentially viable product in this indication. Benefits of ODD include tax credits for qualified clinical trials and exemption from user fees, which may support an accelerated regulatory pathway. ODD also allows for a minimum of seven years of market exclusivity, enhancing the commercial attractiveness of the programme to prospective partners.

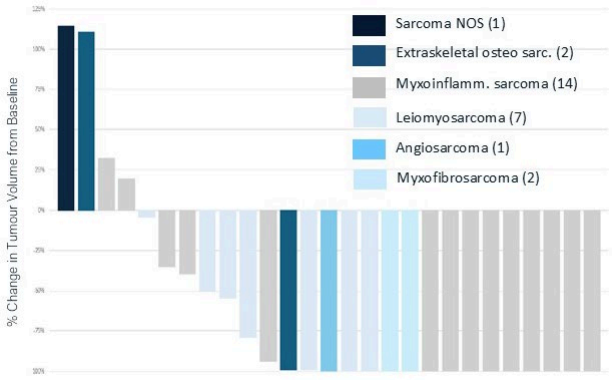
Phase I/II in HNC

QBiotics has conducted a Phase I/IIa study (QB46C-H03) and is conducting a Phase II study (QB46C-H08) in HNC, another indication characterised by significant unmet need and where local tumour control may have a meaningful effect on patient outcomes. These studies have explored the use of TT in accessible tumours, with a focus on safety, tolerability and preliminary efficacy.

QB46C-H03 was a dose-escalation safety study, for which results were announced in August 2023. It treated 19 patients in a window-of-opportunity before-surgery study, meeting its primary endpoint of safety and tolerability. It was not designed to generate efficacy data but focussed on exploring the immunological response of TT treatment. Study outcomes confirmed the induction of immunological cell death and tumour immune cell infiltration.

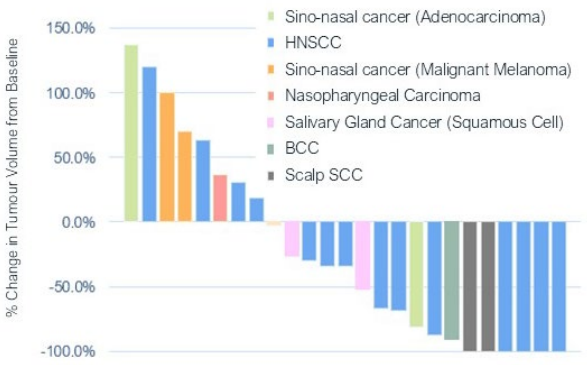
QB46C-H08 is designed as an open-label trial in up to 37 HNC patients, based at sites in Australia and the UK. The primary objective is to evaluate local control through tumour ablation, while secondary objectives focus on safety and tolerability, alongside time to local disease recurrence, recurrence rates at injected tumour sites and progression-free survival. As announced in March 2026, recruitment for QB46C-H08 has been completed and a readout is anticipated in Q2 or Q3 CY26. Management has communicated that early efficacy signals have been supportive, including interim data showing a 71% ORR across 25 tumours in 16 HNC patients (Exhibit 5). We expect the final data package will provide greater clarity on the clinical potential of the drug candidate in this indication.

Exhibit 4: QB46C-H07 (first stage) data in STS – change in tumour volume



Source: QBiotics corporate presentation (April 2026)

Exhibit 5: QB46C-H08 (interim) data in HNC – change in tumour volume



Source: QBiotics corporate presentation (April 2026)

Plans for Phase II in breast cancer, 90% collaborator-funded

Beyond STS and HNC, QBiotics is exploring broader applicability across additional solid tumours, including breast cancer, as reflected in the March 2026 announcement that QBiotics and Unicancer France (a French hospital network specialised in oncology that coordinates research and treatment across the country, and a recognised organisation for conducting oncology trials and advancing new cancer therapies) have signed a letter of intent to establish a collaborative partnership, looking at breast cancer recurrence. This will involve a Phase II, multi-centre, open-label, single-arm, investigator-initiated clinical trial (expected n=50) assessing intratumoural TT for loco-regional and

superficial breast cancer recurrences. Management is finalising a definitive collaboration agreement, where Unicancer is expected to fund 90% of the programme, serving as an encouraging form of external validation, in our view. Overall, we believe this programme has the potential to expand the clinical utility of TT to another cancer type where effective new treatment options are needed. We note that Unicancer's interest in the programme stemmed from some encouraging case studies as part of a compassionate use scheme with the Gustave Roussy Cancer Centre in Paris. (See Exhibit 16 in the appendix for a supplementary figure relating to a case study, showing a metastatic breast angiosarcoma patient achieving a complete response.)

Clinical strategy and next steps

Taken together, the clinical data to date provide supportive evidence of TT's therapeutic potential. However, it is important to note that these findings are based on early-stage studies with limited patient numbers. As such, further validation in larger, more comprehensive trials will be critical to confirm the prior observed outcomes. Looking ahead, QBiotics' clinical strategy remains focused on advancing TT through its three Phase II programmes. Beyond these, where TT targets external solid tumours, we understand that QBiotics is also exploring the potential of TT to address internal tumours, with an initial focus on liver cancer. We note that this is in the preclinical stages of development; hence, we do not include it in our valuation. Nevertheless, positive progression on that front may enhance discussions with prospective pharma partners. Other expandable opportunities include indications such as melanoma, where QBiotics generated encouraging Phase I clinical data, highlighting the company's potential to have multiple shots at goal.

Target markets: STS, HNC and beyond

Oncology remains the largest, fastest growing and most innovation-intensive therapeutic area globally, reflecting both the scale of the unmet medical need and the commercial value associated with improved patient outcomes. Within this, immuno-oncology (harnessing the body's own immune system) has transformed many treatment paradigms over the past decade (ICIs in particular), although response rates to these therapies remain limited in some specific cancers.

The field of immuno-oncology now has a growing interest in combination treatment regimens, as well as novel modes of action, intended to enhance efficacy and minimise the risk of resistance, all while improving or maintaining favourable safety profiles.

Soft tissue sarcoma

STS is a rare and heterogeneous group of cancers that arise from connective tissues (such as muscle, fat, nerves and blood vessels). This encompasses over 50 subtypes, contributing to complexities in diagnosis and treatment. It is estimated that there are c 14k new cases of STS each year in the US alone, with many patients expected to present with advanced or unresectable disease. Standard of care typically involves a combination of surgery, radiotherapy and chemotherapy, although outcomes remain variable and recurrence rates can be high. Systemic therapies are often associated with limited durability of response and significant side effects (immunotherapies such as ICIs struggle in STS, achieving only low ORR), while surgical options are invasive and not always feasible, meaning treatment options are often limited.

From a commercial perspective, STS represents a relatively small, but underserved market, with high unmet needs creating the potential for premium pricing for therapies that improve local tumour control. The competitive landscape is relatively sparse, with few targeted therapies and modest innovation beyond chemotherapy. Within the field, Immunome's varegacestat (a small molecule drug candidate) garnered attention in December 2025 after meeting the primary endpoint in its registrational Phase III trial (n=156) in desmoid tumours (a specific STS), delivering an ORR of 56%

as a monotherapy and a statistically significant benefit in progression-free survival compared to placebo; FDA submission is planned within Q2 CY26. Other emerging approaches, including next-generation immunotherapies, have shown some activity, but response rates remain inconsistent across subtypes and durability is often limited. As a result, there remains scope for differentiated therapies to establish a role in selected populations.

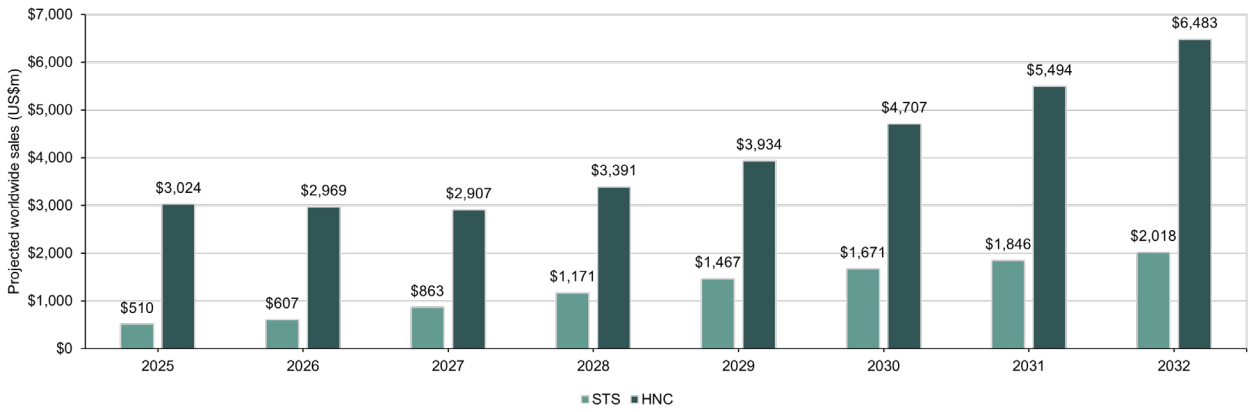
In this setting, TT may be positioned to address specific gaps in this market. Its intratumoural approach enables direct and rapid tumour ablation, which could be particularly relevant where local control is clinically meaningful. As discussed previously, early clinical data suggest high response rates and potential durability in treated tumours. To capture meaningful market share, the asset will need to demonstrate reproducible outcomes in larger cohorts, sustained durability and a clear role in clinical practice. If achieved, it may offer an alternative to more invasive or systemic approaches, supporting its commercial potential within this niche indication.

Head and neck cancer

HNC refers to a group of malignancies that originate in the oral cavity, throat and larynx, commonly associated with tobacco and alcohol use, or caused by human papillomavirus infection. It is significantly more prevalent than STS, with c 73k new cases of HNC in the US each year. Despite advances in treatment, outcomes remain challenging, particularly in recurrent or metastatic disease. Standard of care typically includes surgery and systemic therapies, often alongside radiotherapy. Unlike STS, immunotherapies have been more promising in HNC, although these approaches can be associated with substantial toxicity and high recurrence rates.

The commercial landscape for HNC is correspondingly larger and more competitive than in STS (Exhibit 6). Immunotherapies, particularly ICIs, have improved outcomes in some patient populations, but response rates remain modest, and many patients either do not respond or relapse. As a result, there is a continued focus on combination strategies and novel modes of action to improve efficacy. The size of the market and ongoing unmet need have attracted notable investment from big pharmaceutical companies. Key recent transactions include Genmab's acquisition of Merus for c $8bn (announced in September 2025) and Galapagos's license deal with Adaptimmune for $100m upfront and up to $465m in milestones (announced in June 2024). The target of Genmab's acquisition was petosemtamab (a bispecific antibody), which has been granted Breakthrough Therapy designation by the FDA for two HNC settings; it is currently in Phase III development across both these settings and updates are expected within 2026. Compelling prior clinical data showed that petosemtamab in combination with the ICI pembrolizumab delivered an ORR of 63% in a Phase II trial (among 43 evaluable patients), alongside a 79% overall survival rate at 12 months.

Exhibit 6: Projected worldwide drug sales for STS and HNC, reaching over $2.0bn and $6.4bn, respectively, by 2032 (according to Evaluate Pharma)



Source: Evaluate Pharma, Edison Investment Research

As discussed above, TT's intratumoural approach offers a differentiated modality that may complement existing therapies. Early studies have shown a favourable safety profile and initial signs of efficacy. To establish a meaningful position, QBiotics will need to demonstrate consistent and durable responses in larger trials, alongside clear positioning relative to existing therapies.

We discuss some scenarios within the STS and HNC treatment landscapes, where TT may find clinical utility, below (see the Valuation section of this report).

Breast cancer

Beyond the two priority indications, QBiotics is also exploring breast cancer. This is the second most commonly diagnosed cancer globally, arising from malignant cells in breast tissue, with a sizable c 2.3 million new cases reported each year. This makes it significantly more prevalent, and commercially larger, than both STS and HNC (the global breast cancer treatment market is projected to exceed $60bn by 2032, according to Evaluate Pharma). As mentioned above, QBiotics is currently exploring TT in breast cancer in collaboration with Unicancer France, although Phase II data are yet to be generated. Nevertheless, if clinical results are supportive, this indication could meaningfully broaden the asset's applicability and enhance its long-term value proposition.

Pipeline optionality beyond human oncology

As a reminder, QBiotics' broader pipeline is underpinned by its epoxytiglianes platform, which has generated multiple programmes across oncology, wound healing and anti-infectives. While TT in human oncology represents the primary near-term value driver, the platform offers longer-term optionality, through additional therapeutic applications.

One component of this broader portfolio is Stelfonta, the veterinary formulation of TT, approved for the treatment of mast cell tumours in dogs. It has been commercialised across multiple regions, including the US, Europe and Australia. Beyond generating a modest revenue stream, this programme is strategically relevant as it demonstrates the molecule's clinical activity and safety in real-world disease settings, having been tested in >30k dogs, while also showcasing manufacturability. While not directly translatable to human oncology, we believe it somewhat de-risks the programme, as it provides supporting evidence for the underlying mode of action and the company's ability to advance assets from discovery through to approval.

Non-oncology pipeline

Beyond oncology, QBiotics is advancing EBC-1013 as a topical gel for wound healing, targeting chronic wounds such as venous leg ulcers (VLUs), as well as acute wounds and burns. It is already funded through the ongoing Australia-based Phase I study in VLU patients, for which a clinical update is anticipated within 2026. Management has highlighted diabetic foot ulcers as a potentially lucrative expandable opportunity. The programme is designed to leverage the anticipated ability of epoxytiglianes to stimulate local biological responses, including immune activation and tissue repair, with the aim of promoting effective healing in conditions where this process is impaired. The programme has been supported by encouraging results in veterinary models, showing accelerated closure of infected wounds compared to control treatments. The company has highlighted potential applications across both civilian and military settings, alongside opportunities for non-dilutive funding and partnerships. (See Exhibit 17 in the appendix for a supplementary figure relating to vet case studies, showcasing the benefit of EBC-1013 gel across various wound types.)

QBiotics also maintains an earlier-stage antibiotics programme, focused on addressing antimicrobial resistance. This work explores molecules that target bacterial virulence pathways, with the aim of reducing the development of resistance. While still preclinical, it reflects the broader versatility of the platform, although it is not expected to contribute to near-term value inflection.

Implications

From a capital allocation perspective, the company remains focused on advancing TT in human oncology, with the planned fundraise (seeking up to c A$40m) directed towards this programme. The wound healing asset is expected to progress through its current stage with existing resources and potential external non-dilutive funding, while the antibiotics programme remains longer term. As a result, investors gain exposure to these additional programmes alongside the core oncology opportunity, providing incremental upside without a corresponding increase in near-term funding requirements.

Key upcoming milestones and catalysts

- **Expansion data from Phase II trial (throughout 2026).** Clinical updates are anticipated in STS and HNC, from the QB46C-H07 and QB46C-H08 trials, respectively.
- **Additional indication entry (2026 and beyond).** Plans have already been announced for a Phase II trial in breast cancer. Beyond this, liver cancer represents an internal tumour opportunity, though this is in the earlier planning stages.
- **Strategic partnerships (timing difficult to predict).** While it is feasible that QBiotics may already be able to engage a pharma partner, it is currently augmenting its offering by generating incremental data for TT. Any further developments may enable management to secure a partner under more attractive deal terms.
- **Capital raise and IPO (planned for 2026 and 2027 respectively).** As discussed, the capital raise planned for this year is intended to augment the oncology programme for a commercial partnership and extend the company's operating runway ahead of a potential ASX IPO in 2027.

Financial overview

Being a clinical-stage biotech, QBiotics does not generate any meaningful recurring revenues from its core human therapeutics pipeline, and as such is currently reliant on external funding to support operations, with a high degree of forward-looking execution risk. Historically, the company has benefited from a veterinary revenue stream via Stelfonta (TT for veterinary use; FDA approved in

late 2020), which has generated product sales and milestone revenues through a commercial partnership with Virbac. QBiotics reported A$1.3m in revenues in FY24 (the period ended June 2024) and A$0.8m in FY25. Management had noted sales had underperformed expectations and, more recently, the distribution arrangement has been disrupted (both QBiotics and Virbac agreed not to renew for a second term), resulting in an absence of any product-related revenues in H126 (the six-month period ended December 2025). Pending a new commercial agreement, we expect modest top-line contribution from Stelfonta in FY26 (we currently model A$1.2m in product revenues in FY26 based on management guidance of the last 5,000 doses of Stelfonta to be shipped to Virbac in May 2026).

The company also benefits from Australia's R&D Tax Incentive, which provides a cash rebate of up to 43.5% on eligible R&D expenditure, offering a meaningful source of non-dilutive funding and partially offsetting operating cash burn. QBiotics reflects these R&D tax credits as revenues in its P&L statement. In FY25, the company reported A$6.5m as R&D credits (A$7.4m in FY24). Note that the R&D credit figure tends to vary with underlying R&D expenses for a particular period. In FY25, QBiotics recorded A$11.7m as R&D expenses (FY24: A$11.7m), which we attribute to the ongoing clinical programmes as well as other R&D activities. In addition, the company reported A$15.2m as general and administrative expenses, broadly in line with the FY24 figure of A$14.8m. Overall, QBiotics booked an operating loss of A$22.6m in FY25 versus A$19.5m in FY24. This translated to operating cash outflows of A$18.9m and A$17.2m in FY25 and FY24, respectively.

While management has emphasised disciplined cost control and capital allocation, the business remains structurally dependent on capital markets and non-dilutive funding sources ahead of commercialisation of its ongoing clinical programmes. At the end of December 2025, the company had a cash balance of A$13.5m, bolstered by another c A$7.7m in R&D tax credits received in May 2026. Based on our cash burn rates, we expect these pro-forma funds to provide the company with headroom into H2 CY26, with another c A$20m required in H2 to support operations into CY27 (we reflect this as illustrative debt in our model). Considering these requirements QBiotics is seeking to raise up to c A$40m in bridging capital, which is expected to support ongoing clinical development activities, including progression of key trials across its oncology programmes, while positioning the company for a potential IPO on the ASX in 2027. Should the company be successful in raising the planned funds, we estimate these, along with existing cash on hand, will be sufficient to fund operations to the planned IPO in 2027. We note that proceeds from the planned fundraise have been earmarked for the oncology programme, with the wound healing clinical development to be supported by non-dilutive government funding and grants.

We therefore view the planned raise as a critical near-term financing event, effectively serving as a bridge to a larger liquidity event (ASX IPO). As such, execution risk is twofold: successful completion of the capital raise itself and delivery of further clinical and strategic milestones to augment a partnership and/or credible public market listing within the targeted time frame.

Given the scenario, we believe that capital efficiency will remain a key variable. QBiotics' approach to clinical development, including trial design, use of investigator-sponsored studies and prioritisation across indications, will materially affect cash burn. The company has indicated ongoing efforts to explore partnering opportunities, particularly for later-stage development and commercialisation, which could enable the sharing of costs, de-risking the funding profile.

Valuation framework: Risk-adjusted NPV

Business case anchored by tigilanol tiglate

While QBiotics maintains a diversified pipeline across oncology (human and veterinary), wound management and antibiotics, TT remains the primary value driver underpinning the investment

case. As an intratumoral small molecule with a potential dual mode of action, TT is building a differentiated position within oncology, straddling both local tumour control and systemic immuno-oncology potential across a range of solid tumours.

Clinical validation to date supports TT's potential role as a local tumour control agent, evidenced by Stelfonta (FDA-approved for non-metastatic mast cell tumours in dogs) and early clinical studies in STS and HNC. This provides a clear and tangible near-term commercial opportunity. In parallel, combination strategies, particularly within immuno-oncology, offer another promising avenue for future growth. While evidence of synergy with ICIs is still emerging, early observations point to the potential for immune-mediated abscopal effects. We note that in an earlier Phase I/IIa combination study in melanoma with pembrolizumab, one of the three patients dosed achieved a complete response with the injected tumours, with a non-injected distal tumour showing a partial response. However, the trial was terminated prematurely (planned n=40), with the company citing enrolment-related challenges due to COVID-19. Materially larger trials will be required to establish efficacy and TT's role as an immune primer, unlocking additional therapeutic impact.

The valuation of TT is therefore best approached through a risk-adjusted net present value (rNPV), sum-of-the-parts framework, separating near-term, more de-risked settings from longer-term platform optionality.

Valuation scope by indication and treatment setting

In line with management's stated clinical development priorities, our valuation of TT focuses on a defined set of oncology indications and settings where there is both a clear rationale and near- to medium-term development visibility. Specifically, we model TT across selected settings in STS, HNC and breast cancer, reflecting current pipeline focus and potential pathways to value inflection. QBiotics had previously evaluated TT in melanoma (two Phase I/II clinical trials discontinued in late 2022 due to recruitment challenges during COVID-19) and is currently collaborating with the University of Edinburgh in its cancer research project in oronasal mucosal melanoma. However, given the early stages of these activities, we currently exclude melanoma from our projections but note the upside potential with clinical progression.

Note that all our assumptions are contingent on the clinical development pathways ultimately selected by management, and that not all of these pathways may be pursued.

Within STS, which represents the most advanced and de-risked opportunity, we include:

- Advanced unresectable STS as an adjunct to first-line doxorubicin.
- Advanced unresectable STS in the second-line setting in combination with ICIs.
- Early-stage STS in the neoadjuvant setting for localised, accessible tumours.

In HNC, we capture both monotherapy and combination approaches:

- Locally advanced HNC as a monotherapy.
- Recurrent/metastatic HNC in first-line combination with ICIs.

In breast cancer, which reflects a key platform expansion opportunity, we include:

- Recurrent breast cancer, particularly skin and chest wall recurrence.
- Metastatic breast cancer in combination with ICIs.

We believe that this indication set captures a balance between nearer-term, clinically tangible applications (eg STS and accessible tumours) and higher-upside combination strategies in larger markets, particularly in immuno-oncology. Our approach therefore aligns with management's strategy of advancing TT both as a local tumour control agent and as a potential immune-priming therapy in combination settings.

Across all the target indications and settings, we use certain broad assumptions to model the market opportunity (discussed below):

- We explicitly model the US market opportunity, forecasting indication-specific cash flows through to 2045. No terminal value is applied, reflecting our assumption that revenues decline to negligible levels thereafter.
- Global commercial potential is derived by extrapolating from US forecasts, assuming a 50:50 revenue split between the US and the rest of the world (RoW). This assumption is informed by our analysis of ICI sales, where the US typically accounts for approximately 50–60% of global revenues.
- Given the early stage of development and as yet limited public visibility on the timing and structure of a potential licensing agreement, identified by management as the preferred exit route, we assume self-commercialisation across all modelled indications, incorporating both revenue and cost profiles at the indication level.
- We assume a realisable price of US$50,000 per dose of TT, based on management guidance.
- A flat discount rate of 15% is applied across all indications. This includes a 2.5% illiquidity premium over the standard Edison discount rate of 12.5% for clinical-stage biotechs, reflecting QBiotics' private company status and the associated liquidity and execution risks.
- We assume a combined COGS and SG&A of 20% of product revenues. These ratios are widely accepted standards for small molecule drugs.

STS opportunity overview

We believe that STS represents one of the most advanced and clinically validated opportunities for TT, with the highest contribution to our current investment case for QBiotics. We value the STS opportunity across multiple settings, including neoadjuvant, first-line adjunct and second-line combination use, where we believe that TT is well positioned to address a defined sub-set of patients with accessible tumours (palpable or visible), where its intratumoral injectable delivery and rapid tumour ablation mode of action offer clear clinical utility. While the overall market remains relatively small, it is characterised by high unmet need, and favourable orphan-like pricing and commercial dynamics. We remind readers that TT holds ODD in STS, providing seven years of market exclusivity following regulatory approval.

Indication specific assumptions for STS are detailed below:

Exhibit 7: Assumptions for STS rNPV

Treatment setting	Assumptions
Adjunct to first-line doxorubicin (advanced or metastatic STS)	**Target population:** US STS incidence (c 14k, 1.5% y-o-y growth), filtered for extremity/trunk tumours (80%), advanced/progressed patients (40%) and clinical eligibility (systemic treatment, progression, accessibility, injectability), resulting in a target population of c 1.5k patients/year. **Commercial assumptions:** Most immediate commercial opportunity for TT given existing clinical data. Launch assumed in 2032, peak penetration of 50% by 2038 (c 870 patients) given the material unmet need and lack of effective options other than chemotherapy. Pricing at $50k/dose, three doses per patient ($150k), with 2% annual price growth. **Revenue potential:** Peak US sales of c $150m; global peak of c $300m (50:50 US:RoW split). Positive operating leverage post-launch with strong margin expansion. **Cost and development assumptions:** Clinical costs assumed to be $100k per patient, with Phase IIb (40 patients) and Phase III (150 patients given the limited target patient population). R&D partially offset by tax incentives; 25% tax rate applied (Australia corporate tax rate). **Valuation output:** NPV: c $203m; applying 20% probability of success (PoS) and a 15% discount rate → rNPV $41m (A$57m). **Conclusion:** Represents a core, near-term, relatively de-risked indication underpinning base-case valuation.
Combination with checkpoint inhibitors	**Target population:** US STS incidence (c 14k, 1.5% growth) filtered for advanced patients progressing post-1L chemo (85%), 2L treatment uptake (90%), tumour accessibility (40%) and ECOG ≤2 (80%), yielding a target population of c 2.4k patients/year. **Commercial assumptions:** Launch 2033; peak penetration 50% by 2038 (c 1,460 patients). Pricing at $50k/dose, three doses (c $150k/patient), with 2% annual price growth. **Cost and development assumptions:** Clinical costs assume c $150k per patient (higher than the previous setting due to increased complexity of administration in combination with ICIs), with Phase II (c 50 patients) and Phase III (c 200 patients). R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of c $250m; global peak of c $500m (50:50 US:RoW). **Valuation output:** NPV $324m; applying 10% PoS (lower than first line due to higher risk and lack of prior data) and a 15% discount rate → rNPV $32m (~A$45m). **Conclusion:** Represents a higher-risk, higher-reward expansion versus first-line STS, driven by larger patient pool and combination with ICIs.
Neoadjuvant setting for localised, accessible tumours	**Target population:** US STS incidence (c 14k, 1.5% growth) filtered for early-stage patients eligible for neoadjuvant therapy (35%), tumour accessibility (60%), ECOG ≤2 (80%) and uptake of local intratumoral treatment (85%), resulting in a target population of c 2.0k patients/year. **Commercial assumptions:** Launch 2034; peak penetration 50% by 2039 (1,200 patients). Pricing at $50k/dose, two doses (~$100k/patient), with 2% annual price growth. **Cost and development assumptions:** Clinical costs assumed at $100k per patient, with Phase IIb (50 patients) and Phase III (200 patients). R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of $140m; global peak of $280m (50:50 US:RoW). **Valuation output:** NPV $152m; applying 10% PoS (based on our assumption that this setting will be pursued last by the company) and 15% discount rate → rNPV $15m (A$21m). **Conclusion:** Represents a moderate-risk, mid-sized opportunity, bridging core STS value and broader platform expansion.

Source: Edison Investment Research

Overall, we view the STS franchise as a core, partially de-risked value driver, with multiple potential clinical entry points. While individual indications are modest in scale, together they provide a meaningful revenue base. More importantly, we believe that success in STS would help solidify TT's utility in solid tumours, supporting broader expansion into larger oncology indications and higher-value combination strategies.

HNC opportunity overview

HNC represents a significant step-up opportunity for TT, leveraging its intratumoral delivery in a large and accessible tumour setting (cutaneous and subcutaneous tumours that are either visible or palpable). In this indication, we believe the opportunity landscape for TT spans both locally advanced and recurrent/metastatic settings, particularly where tumours are accessible, injectable and amenable to local control strategies. We note that compared to STS, HNC offers a materially larger addressable population, supporting meaningful commercial upside.

Indication specific assumptions for HNC are detailed below:

Exhibit 8: Assumptions for HNC rNPV

Treatment setting	Assumptions
Monotherapy – locally advanced HNC	**Target population:** US HNC incidence (c 73k, ~1% growth), filtered further for locally advanced/regional patients plus progression from early-stage (c 60%), then unresectable (50%), accessible/palpable (60%) and eligible for intratumoural delivery based on size and location of the tumour (70%), yielding a target population of c 9.6k patients/year. **Commercial assumptions:** Launch in 2033; peak penetration 25% by 2037 (c 2,677 patients), lower than STS due a more competitive market. Pricing at $50k/dose, two doses (c $100k/patient), with 2% annual price growth. **Cost and development assumptions:** Clinical costs assumed to be $100k per patient, with Phase IIb (60 patients) and Phase III (300 patients). R&D partially offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of $250m; global peak of $500m. Strong operating leverage post-launch. **Valuation output:** NPV $382m; applying 20% PoS (based on supportive Phase II interim data demonstrating a 71% ORR) and 15% discount rate → rNPV $77m (A$106m). **Conclusion:** Represents a major medium-term value contributor, driven by large accessible population and monotherapy positioning.
Recurrent/metastatic HNC – combination with checkpoint inhibitors	**Target population:** US HNC incidence filtered for advanced/metastatic patients plus progression (42%), ICI-treated population (80%), refractory/relapsed (70%), with accessible (60%) and eligible for intratumoural injections (70%), yielding a target population of c 7.2k patients/year. **Commercial assumptions:** Launch 2034; peak penetration 25% by 2038 (2,040 patients). Pricing at $50k/dose, two doses (~$100k/patient), with 2% annual price growth. **Cost and development assumptions:** Higher clinical cost assumed at ~$150k per patient, reflecting larger trials (Phase IIb/III; 100 and 400 patients, respectively) and combination with ICIs. R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of $235m; global peak of $470m. Strong margin profile post-launch. **Valuation output:** NPV $245m; applying 10% PoS and a 15% discount rate → rNPV $24m (A$34m). **Conclusion:** Represents a higher-risk, combination-driven opportunity, with upside linked to ICI-refractory positioning.

Source: Edison Investment Research

Overall, we view HNC as a key value driver beyond STS, with the locally advanced setting contributing the majority of risk-adjusted value, supported by a large patient population and clearer clinical positioning. The recurrent/metastatic setting provides additional upside, albeit with higher clinical risk given its reliance on combination strategies and refractory populations.

Breast cancer opportunity overview

While breast cancer is QBiotics' most recent, and still early-stage, oncology focus, we view it as a potentially meaningful commercial opportunity for TT, supported by the high prevalence of the disease and the subset of patients presenting with accessible cutaneous or chest wall lesions. The indication may offer a logical expansion pathway, given the intratumoral mode of action, which appears conceptually suited to localised recurrence settings.

That said, while there have been some encouraging case studies under compassionate use (an example shared by the company shows one complete response, refer to Exhibit 16), the programme is yet to generate controlled clinical trial data and, therefore, carries a significant degree of development risk. The planned clinical evaluation is expected to be conducted as an investigator-sponsored study (Unicancer France), which may introduce additional variability in execution and timelines relative to company-sponsored trials.

Over the longer term, there may be scope to explore use in broader metastatic disease, including in combination with ICIs, an approach management has indicated interest in pursuing. However, ICI use in breast cancer remains relatively limited, primarily confined to certain subtypes such as triple-negative breast cancer. As such, the nearer-term opportunity is likely more concentrated in accessible recurrence settings, with any combination-driven expansion representing longer-term and less certain optionality.

Indication specific assumptions for breast cancer are detailed below:

Exhibit 9: Assumptions for breast cancer rNPV

Treatment setting	Assumptions
Monotherapy – recurrent breast cancer, particularly skin and chest wall recurrence	**Target population:** US breast cancer prevalence (c 4m) with annual chest wall recurrence (c 0.8%; this is extrapolated from the information that 5–10% of the patients with operable breast cancer develop a chest wall recurrence within 10 years). Further filtered for local node disease (35%) and accessible tumours (70%), yielding a target population of c 7.9k patients/year. **Commercial assumptions:** Launch in 2034; peak penetration of 20% by 2039 (3,100 patients). Pricing at $100k per patient (two doses), with 2% annual price growth. **Cost and development assumptions:** Clinical costs assumed to be $100k per patient, with Phase IIb/III studies required (Phase IIb: 100 patients Phase III: 300 patients). R&D partly offset by tax incentives; 25% tax rate applied. Planned Phase II trial (n=50) to be majorly (c 90%) sponsored by partner Unicancer. **Revenue and profitability:** Peak US sales of $360m; global peak of $720m. Strong operating leverage with high-margin profile post-launch. **Valuation output:** NPV $344m; applying 7.5% PoS (conservative given investigator-sponsored Phase II study still to initiate) and 15% discount rate → rNPV $26m (A$36m). **Conclusion:** Represents a large, relatively accessible expansion opportunity, driven by high prevalence and feasibility of intratumoral delivery. However, it remains very early-stage for now.
Metastatic breast cancer – combination with checkpoint inhibitors	**Target population:** US breast cancer incidence (c 325k cases) filtered for advanced/metastatic patients plus progression (c 50%), ICI-treated population (10%), progression (40%), accessible/palpable tumours (40%) and injectability, based on size and tumour position (70%), yielding a target population of c 1.8k patients/year. **Commercial assumptions:** Launch in 2035; peak penetration of 40% by 2040 (880 patients). Pricing at $100k per patient, with 2% annual price growth. **Cost and development assumptions:** Higher clinical cost assumed at ~$150k per patient, reflecting combination with ICIs. R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of c $105m; global peak of c $210m. Positive operating leverage, though smaller scale versus recurrence setting. **Valuation output:** NPV $79m; applying a conservative 5% PoS and a 15% discount rate → rNPV $4m (A$6m). **Conclusion:** Represents a high-risk, combination-driven opportunity, with value contingent on ICI synergy and clinical validation.

Source: Edison Investment Research

Overall, we view breast cancer as a potential long-term value driver, with the recurrence setting underpinning the majority of risk-adjusted value due to its scale and feasibility. The metastatic combination setting provides additional upside, albeit with higher clinical risk given ICI use in breast cancer remains relatively limited. While TT's mode of action indicates a potential ability to stimulate an immune response and potentially modulate the tumour microenvironment, any hypothesis around converting immunologically 'cold' tumours into 'hot' tumours will require substantial clinical work and validation.

Upside optionality from EBC-1013 in wound healing

While the clear focus for QBiotics is on TT, we believe that EBC-1013 represents an incremental medium-term diversification opportunity for the company, supported by a large addressable population and relatively lower development costs. As previously highlighted, QBiotics is evaluating EBC-1013 as a novel topical pharmacological wound care treatment, with an initial focus on VLUs.

A Phase I, multi-centre, dose-escalation study is underway to evaluate the safety and tolerability of EBC-1013 gel in patients with VLUs, with planned enrolment of approximately 21–33 participants. Wound healing and quality of life measures are expected to be assessed as exploratory endpoints. At this stage, no human clinical efficacy data are available, and the programme remains early and high risk. While supportive findings have been reported from veterinary case studies, suggesting potential wound-healing activity, the extent to which these observations translate into human clinical outcomes remains to be confirmed.

We note that there are currently no approved topical treatments for VLUs, with the segment dominated by compression therapy and wound dressings that primarily serve supportive functions rather than actively drive healing. As a result, clinical outcomes remain suboptimal, with a large proportion of patients experiencing chronic, slow-healing wounds, highlighting a clear unmet need for therapies that can accelerate tissue repair.

QBiotics is positioning EBC-1013 as an active treatment applied topically, with the potential to enhance wound healing rather than simply maintain a favourable environment. We believe this

positions EBC-1013 favourably, as a complement to the existing standard of care, potentially allowing for easier integration into the treatment pathway. We believe that the most relevant patient group will be patients with hard-to-heal or non-responsive ulcers, where incremental clinical benefit can be clearly demonstrated.

From a modelling perspective, we assume a US VLU population of c 600,000 patients annually seeking treatment (1% y-o-y growth), with EBC-1013 achieving peak penetration of 10%, reflecting its adjunctive use in a subset of patients. We assume a per patient treatment cost of c $1,500, supporting accessibility while maintaining attractive unit economics. This results in peak global revenues of c $260m, which we believe will be achieved in 2041, following launch in 2035. This translates to an NPV of $122.3m or an rNPV of $12.2m (A$17.1m), assuming a 10% probability of success (given the early stage of clinical development) and a 15% discount rate.

If QBiotics successfully establishes proof of concept in VLUs, we believe this could materially de-risk EBC-1013's broader applicability across other hard-to-treat wounds and burns. Management has specifically highlighted diabetic foot ulcers (DFUs) as a key adjacent indication. The global DFU treatment market was valued at $9.4bn in 2025 and is projected to reach $16.4bn by 2034 (6.4% CAGR, according to Fortune Business Insights), underscoring a meaningful commercial opportunity. Notably, the current treatment landscape remains limited, with becaplermin representing the only approved topical gel therapy. In our view, an effective topical agent with differentiated efficacy could capture significant share in this underserved market. That said, in the absence of clinical data in DFUs, we do not currently incorporate this indication into our valuation framework for QBiotics.

Stelfonta: Commercial-stage with potential to be unlocked

Stelfonta represents the veterinary oncology analogue of TT, providing a useful proof-of-concept for the mode of action in a commercial setting. Developed for the treatment of canine, non-metastatic mast cell tumours, Stelfonta was commercialised via a partnership with Virbac (launched in 2020/21), leveraging its established global animal health distribution network. The agreement concluded in early 2026 and QBiotics is in the process of finalising a new distribution partnership before recommencing sales. While we note that initial sales for the product have been modest, management remains confident in the treatment's potential (treatment efficacy has been encouraging) and will continue to pursue this market opportunity. We model Stelfonta achieving a peak market penetration of 10%, which equates to a treatment pool of c 25,000 dogs with localised, mast cell tumours per year. Assuming an effective treatment price of $1,500/patient, we project peak sales potential of c $40m in the US and c $70m globally for the treatment, to be achieved in 2031. Assuming a transfer pricing model with the new partner, we model an economic share of 20% of sales for Stelfonta. Although Stelfonta is a commercial-stage asset, we apply an 80% PoS to reflect current uncertainty around the re-establishment of distribution. This yields an NPV of $16.4m or an rNPV of $13.2m (A$18.4m).

Valuation: enterprise value assessed at A$361m

Incorporating our core pipeline assumptions and the latest net cash position, we derive a base-case valuation for QBiotics of A$361m or 73.7c/share. Exhibit 10 presents a breakdown of our valuation for the company by indication.

Exhibit 10: QBiotics risk-adjusted NPV valuation

Product	Indication	Treatment positioning	Expected launch	Global peak sales ($m)	NPV (A$m)	PoS	rNPV (A$m)	rNPV/share (Ac)
TT	Soft tissue sarcomas (STS)	Advanced unresectable STS (adjunct to first-line doxorubicin)	2032	300	284.7	20%	56.5	11.5
		Advanced unresectable STS (second-line combination with checkpoint inhibitors)	2033	503	453.1	10%	45.0	9.2
		Early-stage STS (neoadjuvant for localised/accessible tumours)	2034	282	212.4	10%	21.1	4.3
	Head and neck cancer (HNC)	Locally advanced HNC (monotherapy)	2033	603	535.2	20%	106.3	21.7
		Recurrent/metastatic HNC (first-line combination with checkpoint inhibitors)	2034	469	342.3	10%	34.0	6.9
	Breast cancer (BC)	Recurrent BC (skin and chest wall recurrence)	2034	727	480.9	7.5%	35.8	7.3
		Metastatic BC (combination with checkpoint inhibitors)	2035	210	110.7	5%	5.5	1.1
EBC-1013	Venous leg ulcers (VLU)	Topical treatment for wound healing	2035	257	171.3	10%	17.1	3.5
Stelfonta	Mast cell tumours (MCT)	Non-metastatic cutaneous and subcutaneous MCTs	On market	68	23.0	80%	18.4	3.8
Pro-forma net cash at end-December 2025					21.2	100%	21.2	4.3
Valuation				**3,418**	**2,635**		**361**	**73.7**

Source: Edison Investment Research

Our base case rNPV valuation for QBiotics, as presented above, is heavily reliant on our market estimates, risk adjustments and discount rates. Given that these are subject to variability, we also present a sensitivity table that provides the range of valuations, based on different success probabilities and discount rates. We use only the most clinically advanced clinical programme for this exercise: advanced unresectable STS (adjunct to first-line doxorubicin) (Exhibit 11).

Exhibit 11: Sensitivity of rNPV/share (Ac) to success probabilities and discount rates

		Discount rates						
		7.5%	10.0%	12.5%	15.0%	17.5%	20.0%	22.5%
Probability of Success	5.0%	151.7	112.7	85.0	65.0	50.4	39.7	31.7
	10.0%	158.5	117.8	88.8	67.9	52.6	41.4	33.0
	15.0%	165.4	122.9	92.6	70.8	54.8	43.1	34.3
	20.0%	172.3	128.0	96.4	**73.7**	57.0	44.8	35.6
	30.0%	186.0	138.2	104.1	79.4	61.4	48.2	38.3
	40.0%	199.8	148.4	111.7	85.2	65.9	51.6	40.9
	50.0%	213.6	158.6	119.4	91.0	70.3	54.9	43.5

Source: Edison Investment Research

The table above demonstrates the meaningful sensitivity of our valuation for QBiotics to both PoS and the applied discount rate. The valuation expands materially at higher PoS assumptions (A$0.91/share at a 50% PoS), reflecting the binary and step-change nature of clinical de-risking. Conversely, increases in the discount rate have a dampening effect, compressing the valuation as future cash flows are more heavily discounted. The interaction of these variables produces a broad valuation range, reinforcing that our base-case should be viewed as one point within a wider, risk-adjusted spectrum of potential outcomes.

Partnering potential

While our base-case valuation assumes self-commercialisation of QBiotics' lead assets, we acknowledge that a licensing or co-development partnership with a larger pharmaceutical player represents a more realistic and preferred route to market, particularly given the capital intensity and

infrastructure required to commercialise oncology therapeutics globally. Such a structure involves upfront payments, development and commercial milestones and royalties, and while this may reduce peak revenue capture relative to full commercialisation, it would also lower funding requirements and execution risk and could provide external validation of the TT platform.

To contextualise potential partnering outcomes for QBiotics, we highlight a selection of precedent transactions involving intratumoral and locally delivered oncology assets (Exhibit 12).

Exhibit 12: Select intratumoral licensing deals

Date	Acquirer/ partner	Target/ licensor	Asset	Modality	Stage at deal	Deal value	Upfront	Key details/strategic context	Relevance to QBiotics
Mar-11	Amgen	BioVex (private)	T-VEC (OncoVEX GM-CSF)	Oncolytic virus (intratumoral)	Phase III	Up to ~$1.0bn	~$425m	Milestone-heavy (~US$575m); late-stage asset; FDA approved in 2015; only approved oncolytic virus in US/EU	Demonstrates significant valuation uplift at late stage; validates intratumoral IO modality and regulatory pathway
Feb-18	Merck	Viralytics	CAVATAK (CVA21)	Oncolytic virus (intratumoral/systemic)	Phase I/II	~$394m (A$502m)	100% acquisition	~160% premium to pre-bid market cap (~A$190–200m); evaluated with pembrolizumab; early clinical efficacy	Relevant mid-stage precedent; highlights strategic value of Phase I/II intratumoral assets with IO combination potential
Aug-23	Johnson & Johnson (Janssen)	Nanobiotix	NBTXR3	Radioenhancer (intratumoral adjunct)	Phase II/III	Up to ~$2.6bn	~$60m	Global licensing deal; multi-indication platform; strong combination potential with radiotherapy/IO	Highlights premium for platform assets with broad applicability; relevant for TT's multi-indication potential

Source: EvaluatePharma, Edison Investment Research

While deal activity in this niche remains relatively limited, these deals demonstrate the significant step-up in value associated with clinical proof-of-concept, as well as strong strategic interest from large pharmaceutical companies. In particular, these transactions demonstrate that differentiated platforms with combination potential and applicability across multiple tumour types can attract substantial upfront payments and milestone-driven deal structures. In our view, a successful Phase II readout for QBiotics' TT platform could position the company to pursue a similar licensing or strategic transaction, providing a meaningful valuation inflection beyond our base-case assumptions.

Risks and sensitivities

As a clinical-stage biotech, QBiotics is subject to risks typical of early-stage drug development, with clinical outcomes representing the most significant inflection points. While TT has shown encouraging early efficacy signals, these findings are based on limited patient cohorts and require validation in larger, more diverse populations. Clinical development inherently carries uncertainty, including binary event risks, and future trials may not replicate the response rates or durability observed to date. While TT's 'pipeline-in-a-product' potential somewhat mitigates the binary event risk, the investment case remains closely tied to the successful progression of the lead programme.

Regulatory risk is also a key consideration. The clinical study design pathway to approval for TT is yet to be defined, and its intratumoural mode of delivery may be a key consideration. While such therapies can offer potential advantages, their adoption has historically been limited, reflecting considerations such as tumour accessibility and clinical practice integration; though we note that clinical feedback thus far for TT has been supportive. While designations such as ODD may support expedited pathways, approval will ultimately depend on demonstrating clear clinical benefit in well-controlled studies (ie randomised, double-blind, placebo-controlled). The design and execution of these trials will be critical in determining regulatory outcomes.

From a commercial perspective, QBiotics will need to establish a clear positioning for TT within increasingly competitive (for HNC, less so for STS) and rapidly evolving oncology landscapes. While the asset may offer complementary benefits, particularly alongside systemic therapies, its role in clinical practice remains to be defined. Adoption will depend on not only showing efficacy and safety, but also practical advantages relative to existing treatments, including ease of use and impact on quality of life. These considerations apply regardless of whether development is undertaken independently or in partnership.

Financing risk remains a crucial factor. As a pre-revenue company (except for Stelfonta), QBiotics relies largely on external capital to fund operations and clinical development. While the planned fundraise is expected to extend the company's cash runway, additional funding may be required to support later-stage development, particularly in the absence of a strategic partnership. The timing and terms of future financing, including any potential partnership agreements, may affect shareholder value and are inherently challenging to predict.

Execution risk spans all aspects of the development process, including trial design, patient recruitment and operational timelines. Delays or challenges in any of these areas could affect the pace of development and, consequently, the timing of key value inflection points. More broadly, QBiotics must demonstrate that TT can deliver consistent and scalable outcomes across indications, while establishing a clear role within the treatment paradigm.

Conclusion and outlook

QBiotics presents a differentiated clinical-stage opportunity, centred on TT and its novel intratumoural approach. The asset has demonstrated encouraging early clinical activity, and its positioning alongside existing treatment regimens may support future adoption and partnering interest.

In our view, the characteristics that may enable QBiotics to move beyond a typical small-cap biotech profile include:

- a differentiated intratumoural modality that has the potential to complement existing therapies;
- early clinical data that are both visible and indicative of potential durability;
- a platform with demonstrated biological breadth and translational validation; and
- a development strategy aligned with anticipated partner expectations, with promise in combination treatment regimens, a highly sought after approach.

Looking ahead, value creation is expected to be driven by continued clinical progress and strategic execution, including advancement through key development milestones and potential partnering activity. While risks remain inherent, particularly around clinical validation and positioning, it is our opinion that successful delivery could support meaningful value creation.

Appendix

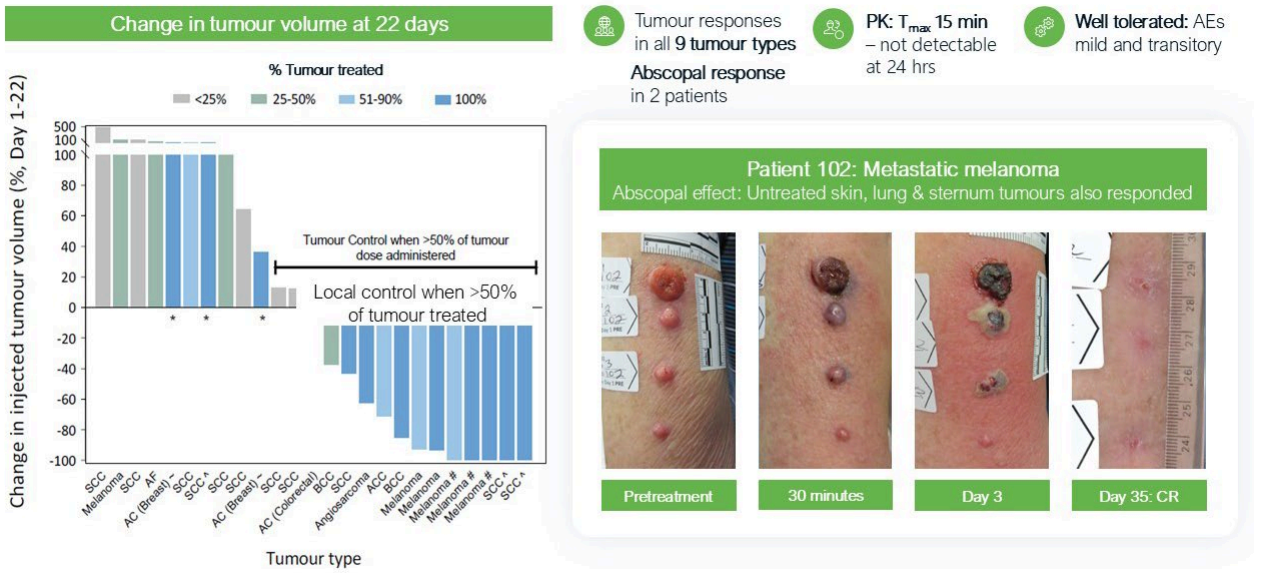
Supplementary figures

Exhibit 13: Financial Summary

A$'000s	2023	2024	2025	2026e	2027e
Year-end 30 June	IFRS	IFRS	IFRS	IFRS	IFRS
PROFIT & LOSS					
Revenue	11,146.9	8,702.1	7,331.6	8,238.8	6,510.6
Product sales	2,508.4	1,284.8	838.5	1,223.1	0.0
R&D tax credit	8,631.7	7,402.0	6,476.5	7,000.7	6,510.6
Others	6.8	15.4	16.5	15.0	0.0
Cost of Sales	(1,817.8)	(546.1)	(1,755.0)	(764.9)	(153.0)
Gross Profit	9,329.1	8,156.0	5,576.6	7,473.9	6,357.6
R&D expenses	(14,388.6)	(11,695.5)	(11,667.8)	(13,021.2)	(18,765.0)
G&A expenses	(17,845.2)	(14,830.2)	(15,223.5)	(16,362.5)	(15,544.3)
Other expenses	(352.2)	(279.8)	(341.4)	(267.5)	(267.5)
EBITDA	(23,256.9)	(18,649.5)	(21,656.1)	(22,177.3)	(28,219.2)
Operating Profit/ (loss)(before amort. and except.)	(23,975.5)	(19,507.2)	(22,543.9)	(23,173.0)	(29,314.6)
Intangible Amortisation	(34.1)	(38.9)	(36.5)	(37.2)	(38.0)
Exceptionals	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0
Operating Profit	(24,009.6)	(19,546.1)	(22,580.4)	(23,210.3)	(29,352.6)
Net Interest	2,387.8	2,035.3	1,947.0	742.5	589.0
Profit Before Tax (norm)	(21,587.7)	(17,472.0)	(20,596.9)	(22,430.5)	(28,725.6)
Profit Before Tax	(21,621.8)	(17,510.9)	(20,633.4)	(22,467.8)	(28,763.6)
Tax	0.0	0.0	0.0	0.0	0.0
Profit After Tax (norm)	(21,587.7)	(17,472.0)	(20,596.9)	(22,430.5)	(28,725.6)
Profit After Tax	(21,621.8)	(17,510.9)	(20,633.4)	(22,467.8)	(28,763.6)
Average Number of Shares Outstanding (m)	488.0	488.2	488.5	489.7	489.7
EPS - normalised (c)	(4.42)	(3.58)	(4.22)	(4.58)	(5.87)
EPS - (IFRS) (c)	(4.43)	(3.59)	(4.22)	(4.59)	(5.87)
BALANCE SHEET					
Fixed Assets	8,887.5	8,078.3	3,918.4	3,085.4	2,152.1
Intangible Assets	433.5	394.6	358.1	320.9	282.9
Tangible Assets	4,325.5	4,036.4	3,407.4	2,611.6	1,716.3
Others	4,128.5	3,647.3	152.9	152.9	152.9
Current Assets	71,688.4	54,407.8	36,619.3	35,602.8	33,938.2
Stocks	1,453.7	839.0	589.8	118.0	23.6
Debtors	9,682.1	8,196.5	7,005.8	12,610.4	22,698.7
Cash	6,130.2	6,927.3	10,293.6	20,047.1	9,121.0
Term deposits	52,966.0	36,552.0	15,461.1	0.0	0.0
Other	1,456.5	1,893.1	3,269.0	2,827.3	2,094.9
Current Liabilities	6,412.0	5,891.8	4,146.4	4,872.2	6,036.9
Creditors	3,977.2	3,231.5	2,227.1	3,117.9	4,365.0
Short-term borrowings	0.0	0.0	0.0	0.0	0.0
Lease liabilities and others	2,434.8	2,660.3	1,919.4	1,754.4	1,671.9
Long-Term Liabilities	1,435.7	852.0	423.5	20,315.9	45,316.9
Long-term borrowings	0.0	0.0	0.0	20,000.0	45,000.0
Lease liabilities and other long-term liabilities	1,435.7	852.0	423.5	315.9	316.9
Net Assets	72,728.2	55,742.3	35,967.8	13,500.0	(15,263.6)
CASH FLOW					
Operating Cash Flow	(25,372.5)	(17,223.6)	(18,864.8)	(25,235.0)	(35,644.6)
Net interest	1,362.8	2,551.6	1,925.3	0.0	0.0
Tax	0.0	0.0	0.0	0.0	0.0
Capex	(772.8)	(343.1)	(190.7)	(200.0)	(200.0)
Proceeds from term deposits	12,953.7	16,414.0	21,090.8	15,461.1	0.0
Financing	169.2	0.0	0.0	20,000.0	25,000.0
Others	(488.7)	(601.8)	(594.3)	(272.6)	(81.5)
Net Cash Flow	(12,148.2)	797.1	3,366.3	9,753.5	(10,926.1)
Opening net debt/(cash)	(18,278.4)	(6,130.2)	(6,927.3)	(10,293.6)	(20,047.1)
HP finance leases initiated	0	0	0	0	0
Other	0	0	0	0	0
Closing net debt/(cash)	(6,130.2)	(6,927.3)	(10,293.6)	(20,047.1)	(9,121.0)

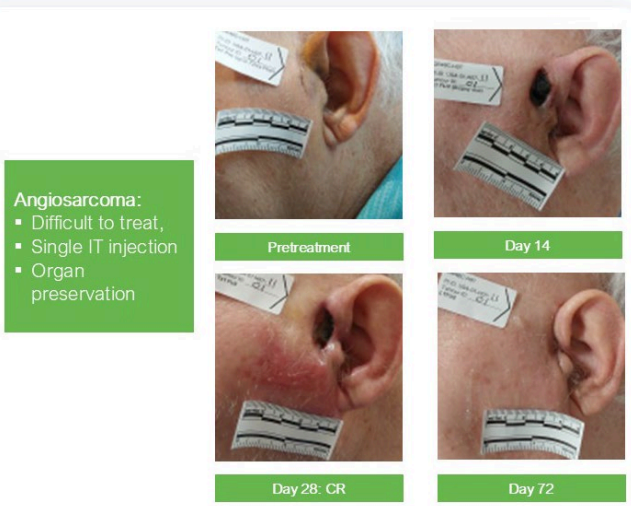
Source: Company data, Edison Investment Research

Exhibit 14: Phase I outcomes for TT



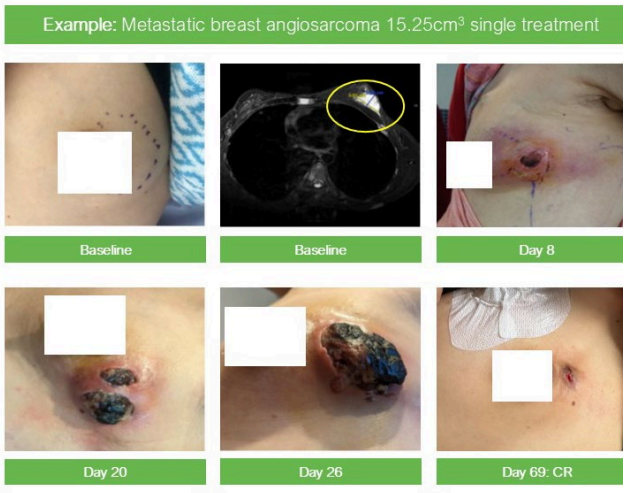
Source: QBiotics corporate presentation (April 2026)

Exhibit 15: QB46C-H07 outcome for an angiosarcoma patient with a complete response by day 28



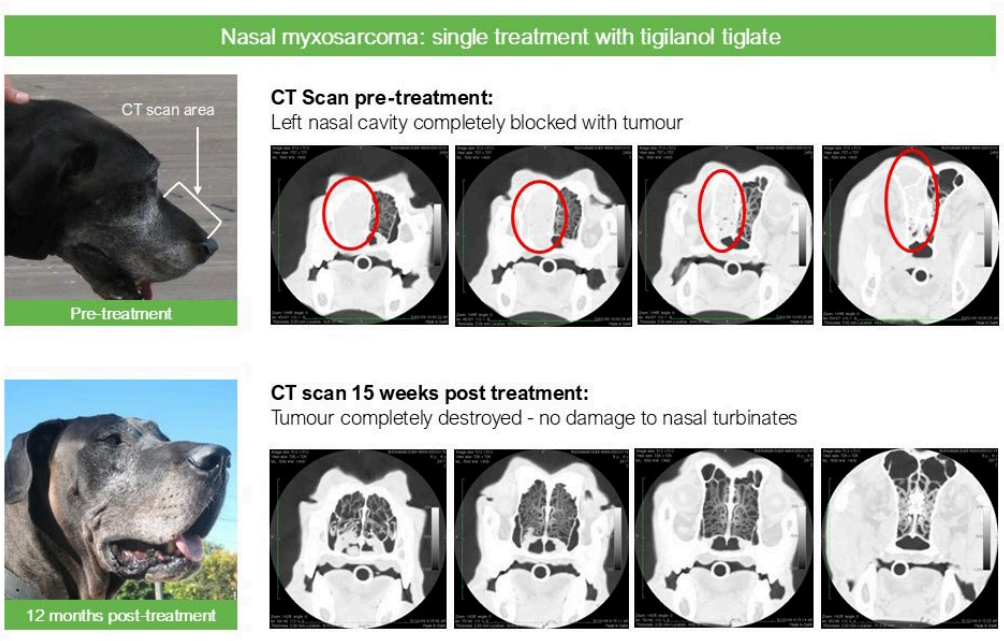
Source: QBiotics corporate presentation (April 2026)

Exhibit 16: Metastatic breast angiosarcoma patient case study with a complete response by day 69



Source: QBiotics corporate presentation (April 2026)

Exhibit 17: Vet case study of solid tumour single treatment with tigilanol tiglate



Source: QBiotics resources

Exhibit 18: Vet case studies of wound healing treatment with EBC-1013 gel

Source: QBiotics corporate presentation (April 2026)

Board of directors and executive leadership team

The board and executive management of QBiotics comprise an experienced leadership team with backgrounds across biotechnology, drug development, commercialisation, capital markets and corporate governance. Collectively, the team brings robust scientific, clinical, operational, financial and partnering capability, supporting the company's strategy from early-stage research through to advanced development and commercialisation. Consistent with its focus on best-practice governance and continuous board renewal, the company has identified the need to further strengthen the board through the appointment of independent non-executive directors and is already in active discussions with suitably qualified candidates.

The board currently consists of Simon Pollard as non-executive chairman, together with three executive directors: co-founders Dr Victoria Gordon and Dr Paul Reddell, and interim chief executive officer Ebru Davidson.

Non-executive chairman: Simon Pollard. Mr Simon Pollard is an experienced director and senior executive with a background in strategy, governance, capital markets and global commercialisation. He is a long-term QBiotics investor and served as chief commercial officer from 2016–2019. Over 25 years, he has held senior roles at Macquarie Group, IBM and HSBC, leading large-scale operations and driving revenue growth across Asia-Pacific, Europe and the US. He has extensive board, chair and advisory experience across public and private companies, with a track record in capital raising, M&A, partnerships and commercialisation of healthcare, life sciences and technology assets. More recently, he has focused on non-executive director roles, mentoring and investing in biotech, software and AI startups. He is chairman of Yarken and Valorica. Earlier, he was partner and co-head of technology law at Gilbert+Tobin. He holds a BA in economics, an LLB and an LLM.

Executive director, chief strategy officer and co-founder: Dr Victoria Gordon, PhD, FTSE. Dr Victoria Gordon has 25+ years' experience in biotechnology with extensive executive and governance experience across drug discovery and development, investment, commercialisation, investor relations and strategic partnerships. She founded EcoBiotics in 2000 and QBiotics in 2010, leading the merger forming QBiotics Group in 2017 and serving as CEO and managing director from 2000 to 2023 before transitioning to chief strategy officer and executive director. She was elected a fellow of the Australian Academy of Technological Sciences and Engineering in 2025 for contributions to medical innovation. Prior to founding EcoBiotics, she was a research scientist with the CSIRO. Relevant board and advisory roles include Biopharmaceuticals Australia, the Australian Rainforest Foundation, the QLD Government Biotechnology Advisory Council and Federal Government Expert Forums on Biomedicine and Environmental Biotechnology. She holds a PhD in microbiology, a BAppSc (Hons) in chemistry and biology and is a Graduate of the Australian Institute of Company Directors.

Executive director, chief scientific officer and co-founder: Dr Paul Reddell, PhD. Dr Paul Reddell is a biotechnology executive and co-founder of EcoBiotics, QBiotics and the QBiotics Group, serving as chief scientific officer since 2000. He has extensive experience in scientific leadership, translational research and complex multi-institutional research and development projects, leading drug discovery and development initiatives and strategic scientific partnerships to advance novel therapeutics. Prior to EcoBiotics, he held senior leadership roles at CSIRO, including senior principal research scientist and programme leader at the Tropical Forest Research Centre, and he later served as principal plant ecologist within a Rio Tinto Group environmental consulting business. He holds a PhD in forest ecology and a BSc (Hons) from the University of Western Australia and has been a fellow of the Australian Institute of Company Directors since 2007.

Interim CEO and managing director: Ms Ebru Davidson. Ms Ebru Davidson brings 17+ years' experience in commercial law, governance, equity capital markets, M&A, corporate transactions and regulatory matters across listed and unlisted companies. She advised QBiotics from 2015–21 and joined as general counsel in 2021, where she supported board matters, investor engagement and corporate governance to advance the company's strategic and capital markets objectives. Previously, she was a partner in Thomson Geer's equity capital markets team. She holds a BSc from the University of Melbourne and a Juris Doctor (Hons) from Bond University. She is an associate member of the Governance Institute of Australia, a graduate of the Australian Institute of Company Directors, and she serves as a non-executive director of Kazia Therapeutics (NASDAQ: KZIA) and the Centre for Eye Research Australia.

Chief operating officer: Dr Peter Schmidt, PhD. Dr Peter Schmidt has extensive experience in developing drug candidates for TGA and FDA submissions through to clinical phase III, including preparation of chemistry, manufacturing and controls (CMC) and preclinical data packages for Investigational New Drug applications and support of clinical Phase I and II programmes. His human drug development experience strengthens QBiotics' veterinary drug development team. Prior to joining QBiotics, he was director of CMC and preclinical drug development at Xenome for six years. Earlier roles included senior scientist at Agen Biomedical and professional officer at the Australian Nuclear Science and Technology Organisation. He holds a PhD in experimental medicine and a BSc (Hons).

Global investor relations officer: Mr Andrew Craig. Mr Andrew Craig is an investment banker with nearly 30 years' experience in global capital markets, beginning at SBC Warburg (now UBS) and later holding senior equity roles in London and New York, advising institutional investors and public company leadership teams. From 2015–21, he was partner at life sciences investment bank WG Partners, advising 60+ biotechnology companies. He has met with senior management teams from 1,000+ companies, contributing to transactions including Sweden's US$7.6bn selldown of Nordea Bank AB and IPOs for easyJet, Burberry, Campari and lastminute.com. He is a bestselling author of *How to Own the World* and *Our Future is Biotech* (2024), focused on biotechnology's role in health, sustainability and economic development. He founded Plain English Finance and is a UK media commentator. He holds a bachelor of social science (economics and politics) from the University of Birmingham and is a chartered member of the CISI.

Chief financial officer: Mr Brendan Brown. Mr Brendan Brown is a partner and director at Prime Accounting & Business Advisory, part of the Prime Financial Group. He is a chartered accountant (CA ANZ) and registered tax agent with more than 20 years' experience. With a background in accounting and business advisory (particularly in the life sciences sector), he brings significant experience to QBiotics' financial strategy and operations. He has a strong track record in supporting executive teams through growth, operational scaling and capital market engagement, with responsibility for financial governance, risk management and performance optimisation. He is recognised in the Research & Development Tax Incentive and other Australian government funding programmes. He holds a bachelor of business (accounting) from La Trobe University.

Clinical advisory board

Prof Alexander Eggermont, MD, PhD (board chairperson). Professor Alexander Eggermont is a recognised oncology key opinion leader with more than 37 years' experience in clinical immunotherapy, melanoma, sarcoma, drug development and translational tumour immunology. He is chief scientific officer at the Princess Máxima Center for Paediatric Oncology, professor of clinical and translational immunotherapy at University Medical Center Utrecht, and coordinator of the Comprehensive Cancer Center Program Deutsche Krebshilfe. He holds board roles with the Comprehensive Cancer Center Munich, Technical University Munich and Ludwig Maximilians University, and is strategic adviser for DKFZ-NCT Heidelberg within Germany's National Center for

Tumours Program. Previously director general of Gustave Roussy Cancer Campus Grand Paris, he has served as president of ECCO and EORTC, board director of ASCO, and held editorial roles with the *Journal of Clinical Oncology*. He is currently editor-in-chief of the *European Journal of Cancer*. He has authored 1,000+ peer-reviewed publications and received international awards, including Chevalier of the Légion d'Honneur (2015).

Prof Kevin Harrington, FRCP, FRCR, FRSB, PhD. Professor Kevin Harrington is a senior investigator at the National Institute for Health and Care Research and head of radiotherapy and imaging at the Institute of Cancer Research (ICR)/Royal Marsden Hospital (RMH). He is director of the ICR/RMH CRUK RadNet Centre of Excellence and a leading international key opinion leader in oncology and drug development. His research spans immunotherapy, targeted radiation sensitisers and oncolytic virotherapy, including DNA and RNA viral platforms such as HSV-based agents (talimogene laherparepvec, RP1, RP2, RP3), vaccinia, reovirus, coxsackievirus A21, Maraba and Newcastle Disease virus across translational and clinical development. He has received major honours including the 2019 British Association of Head and Neck Oncology President's Award and lectureships in 2021 (Semon), 2023 (Elia) and 2024 (Tata). He has authored 600+ peer-reviewed publications and 50+ book chapters and is a Clarivate Highly Cited Researcher (2021–23).

Prof Aurelien Marabelle, MD, PhD. Professor Aurelien Marabelle is a senior oncologist and an internationally recognised key opinion leader in oncology and drug development at Gustave Roussy Cancer Center, Paris, within the drug development department. He is also professor of clinical immunology at the University of Paris-Saclay, with a clinical focus on early-phase cancer immunotherapy trials across tumour types. He directs the Clinical Investigation Centre BIOTHERIS, specialising in intratumoural immunotherapies. He trained at École Normale Supérieure de Lyon, King's College London and Léon Bérard Cancer Center, and completed a postdoctoral fellowship with Professor Ronald Levy at Stanford University, where he returned as visiting professor in 2021. He is an active member of ESMO, ASCO, AACR, SITC and EATI, and he co-founded and serves as vice-president of the French Society for Cancer Immunotherapies (FITC). He has published 250+ peer-reviewed papers with an h-index of 62.

Prof Ignacio Melero, MD, PhD. Professor Ignacio Melero is an internationally recognised key opinion leader in oncology and drug development with more than 36 years' experience in immunology and immunotherapy. Since 2015, he has been co-director of the immunology and immunotherapy service at the University of Navarra, with a translational research focus spanning experimental models through to clinical trials in cancer immunology. He also holds senior editorial roles, including senior editor of *Clinical Cancer Research*, scientific editor of *Cancer Discovery*, associate editor of *Frontiers in Immunology*, and section editor of the *Journal for Immunotherapy of Cancer*. He sits on multiple editorial boards, including *Immunotherapy*, *Oncoimmunology*, *Cancer Immunology Research* and *Cancer Research*. He is a member of external advisory boards for the Curie Institute, Gustave Roussy Institute, Biomedical Research Institute of Granada and the Netherlands Cancer Institute.

Assoc Prof Jason Luke MD, FACP. Dr Jason Luke is one of the noteworthy clinical-translational investigators in immuno-oncology and an associate professor of medicine at the University of Pittsburgh, director of the Immunotherapy and Drug Development Center and associate director for clinical research at the UPMC Hillman Cancer Center. He has been a lead investigator on clinical trials of immunotherapy agents, including but not limited to novel immune checkpoints, bispecific antibodies, innate immune-modifiers and oncolytic viruses, immune-metabolism and cellular therapies in solid tumours. He conceived of and was the principal investigator for the KEYNOTE-716 trial that changed the landscape of stage II melanoma oncology and underpinned the FDA and EMA approval of pembrolizumab in this setting.

Dr Edmund Bartlett, MD. Dr Edmund Bartlett is an assistant attending surgeon in the gastric and mixed tumour service at Memorial Sloan Kettering Cancer Center in New York City, specialising in

cutaneous malignancies and sarcoma. He is a clinical and translational surgeon-scientist focused on improving the efficacy of oncology drug development, particularly immunotherapeutics in sarcoma. He is co-principal investigator on a trial combining PD-1 and adenosine receptor inhibition in dedifferentiated liposarcoma, principal investigator on a study combining pembrolizumab with isolated limb infusion of melphalan and dactinomycin in extremity sarcoma (NCT04332874), and principal investigator on a trial evaluating intratumoural tigilanol tiglate in soft tissue sarcoma (NCT05755113).

Dr Alan Barge, MBBS, MRCP. Dr Alan Barge trained in medicine at Oxford and London, specialising in leukaemia and bone-marrow transplantation. He joined Amgen in 1990 as European medical director, leading global development of Neupogen (filgrastim) across cancer, leukaemia, HIV and infectious disease indications. In 1999, he joined AstraZeneca, overseeing early-phase oncology development and advancing multiple first-in-human programs, including Gefitinib (Iressa) and Olaparib (Lynparza). In 2003 he became vice president of clinical development and head of oncology and infection, leading global execution of AstraZeneca's oncology portfolio. He left AstraZeneca in 2011 to co-found ASLAN Pharmaceuticals, focused on Asia-prevalent cancers, and in 2016 co-founded Carrick Therapeutics, specialising in early-stage oncology assets.

Scientific advisory board

Prof David Thomas BDS, FDSRCS, FDSRCSEng (ad eundem), PhD (board chairperson). Professor David Thomas is a leading scientist and clinician with more than 40 years' experience in oral and maxillofacial surgery, with research spanning wound healing, nanomedicines, tissue engineering and antimicrobial therapies. He is professor and honorary consultant at Cardiff University and leads the advanced therapies group. His work has advanced understanding of microbiome, biofilms and chronic wound biology, supported by more than £15m in funding. He co-founded the Cardiff Institute of Tissue Engineering and Repair and has advanced polymer therapies to Phase II trials, including OligoG, which received US FDA Orphan Drug Status. He also collaborates with QBiotics on rainforest-derived antimicrobials targeting multidrug-resistant infections. He has held senior leadership roles including president of the Academic Association of British Oral and Maxillofacial Surgeons and innovation lead at Cardiff University. He has an h-index of 53 with 8,500+ citations and holds honours including the King James IV Professorship and Fellowship of the Learned Society of Wales.

Prof Timothy Walsh, PhD, DSc, MAE, OBE. Professor Timothy Walsh OBE is professor of medical microbiology and antimicrobial resistance and director of biology at the Ineos Oxford Institute for Antimicrobial Research, University of Oxford. He is a globally recognised leading scientist with more than 30 years' experience in antimicrobial resistance (AMR). He discovered and named two major resistance genes: NDM, now a dominant global carbapenemase, and MCR-1, a plasmid-mediated colistin resistance gene co-discovered in 2015. He also co-discovered TetX, a key tigecycline resistance mechanism. Through unique models with collaborators, he has shown that microplastics and rising temperatures accelerate AMR spread, reshaping global intervention approaches. He currently leads two major AMR burden studies in LMICs - BARNARDS (neonates) and BALANCE (adults). He contributed to China's 2017 ban on colistin in agriculture and advises the WHO, national health ministries, the Chinese CDC and ENABLE 2. He was appointed OBE in 2020 for services to microbiology and international development, was awarded his DSc in 2022, and is a member of Academia Europaea (2023).

Prof Aurelien Marabelle, MD, PhD. Professor Aurelien Marabelle is a senior oncologist and an internationally recognised key opinion leader in oncology and drug development at Gustave Roussy Cancer Center, Paris, within the drug development department. He is also professor of clinical immunology at the University of Paris-Saclay, with a clinical focus on early-phase cancer immunotherapy trials across tumour types. He directs the Clinical Investigation Centre BIOTHERIS,

specialising in intratumoural immunotherapies. He trained at École Normale Supérieure de Lyon, King's College London and Léon Bérard Cancer Center, and completed a postdoctoral fellowship with Professor Ronald Levy at Stanford University, where he returned as visiting professor in 2021. He is an active member of ESMO, ASCO, AACR, SITC and EATI, and he co-founded and serves as vice-president of the French Society for Cancer Immunotherapies (FITC). He has published 250+ peer-reviewed papers with an h-index of 62.

Prof Thomas Wishart, BSc, MBA, PhD, FRSB, FAS. Professor Thomas Wishart is a leading scientist in molecular anatomy. Formerly co-head of Translational Biomarker Discovery at the Centre for Dementia Prevention and deputy director of the Roslin Institute (University of Edinburgh), he currently leads neuroscience activity at the School of Science and Technology, Nottingham Trent University. He also leads the ALLMoND programme (Academic Led Livestock Models of Neurological Disorders) at the Roslin Institute. His research focuses on neurodegenerative disease mechanisms, including synaptic vulnerability, multi-omics biomarkers and clinically relevant animal models. He is well known for his research advancing understanding of conditions such as motor neurone disease – both adult onset (ALS) and childhood onset (ie SMA with patent applications for therapeutics). He is also an expert in dementia, again including both adult onset forms such as Alzheimer's disease, and childhood dementias (such as Batten disease) with expertise in therapeutic assessments including cross-species efficacy of enzyme replacement therapy (JCI, 2022) and viral interventions (Molecular Therapies, 2025) for CLN1 disease in mouse and sheep models. He has 80+ peer-reviewed publications and an h-index of 38. Professor Wishart has secured millions of pounds in competitive funding, including NIH R01 support and industry partnerships. He is a fellow of the Royal Society of Biology (2021) and the Anatomical Society (2018).

Prof Andrew Sewell, BPharm, PhD, FBPhS. Professor Andrew Sewell is a leading scientist and distinguished research professor at Cardiff University, specialising in T-cell biology and cancer immunotherapy. With more than 30 years' experience in viral immunology, autoimmunity and translational oncology, he is internationally recognised for experience in T-cell receptor biology and therapeutic application. His work includes landmark discoveries in HIV immune escape, T-cell cross-reactivity and epitope recognition, including showing that a single T-cell receptor can recognise more than 1m peptides. He pioneered combinatorial peptide library approaches for epitope mapping and co-developed VDJdb, a leading T-cell receptor specificity database. His group also demonstrated that CRISPR-mediated TCR replacement can generate highly sensitive anticancer T-cells, advancing next-generation immunotherapy. His research has strong translational impact, contributing to spinouts including Avidex, Adaptimmune and Immunocore, the latter achieving FDA approval of tebentafusp for metastatic uveal melanoma. He holds a Wellcome Trust Senior Investigator Award and received the Genentech Distinguished Research Award (2023).

Prof Giovanni Appendino, PhD. Professor Giovanni Appendino is a leading scientist and emeritus professor of organic chemistry at the Università del Piemonte Orientale, Italy, where he served as full professor until 2022. He is a highly distinguished natural products chemist with a four-decade career spanning organic chemistry, pharmacology and chemical biology. His work focuses on natural product discovery and synthesis, including isolation of more than 200 novel compounds and development of new synthetic methodologies. Key areas include cannabinoids, taxoids and isoprenoids, with translational work in collaboration with the University of Córdoba producing clinical candidates VCE-004.8 and VCE-003.2 with Orphan Drug Status in the EU and USA. He has authored 429 publications with 16,505+ citations, an h-index of 65 and 14 patents, placing him among the world's top 2% of scientists. He has received major international honours including the Egon Stahl Gold Award (2023) and held senior editorial roles, including editor-in-chief of *Fitoterapia* (2009–22).

Prof Kelly Blacklock, BVM&S PhD, DipECVS, FRCVS. Professor Kelly Blacklock is a leading scientist in small animal soft tissue surgery at the Royal (Dick) School of Veterinary Studies, University of Edinburgh, and a fellow of the Royal College of Veterinary Surgeons. Her research spans translational oncology, mucosal melanoma, surgical infection control and surgical education. She established the dog as a natural immunocompetent model of human oronasal mucosal melanoma, generating multi-omics datasets that demonstrate shared tumour biology and provide a translational platform for drug discovery. This work, supported by the Wellcome Trust and QBiotics Group, underpins ongoing canine clinical trials and organoid-based melanoma research. Her infection control research has influenced global veterinary practice and contributed to *Infection Control in Small Animal Practice* (CABI, 2023). She holds a PhD from the University of Liverpool and collaborates internationally across veterinary, surgical and bioinformatics networks. In 2024 she was awarded a personal chair for her clinical and research leadership.

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QBiotics Group – Intratumoural oncology with platform optionality

QBiotics is a clinical-stage biotechnology company developing novel small molecules derived from natural sources, with the potential to access multiple blockbuster markets. Lead asset, tigilanol tiglate (TT), is an intratumoural therapy involved in three Phase II trials, in soft tissue sarcoma (STS), for which the FDA has granted Orphan Drug Designation (ODD); head and neck cancer (HNC); and breast cancer, the latter of which is 90% backed by a strategic partner. Early clinical data have been promising, in our view, with high response rates and durable tumour control, providing a robust foundation for further development. Beyond oncology, QBiotics has programmes in wound healing and antibiotics, giving additional optionality from its underlying discovery platform, capable of generating multiple drug candidates. QBiotics is planning a capital raise (seeking up to c A$40m), with the proceeds to be used to augment the oncology programme for a commercial partnership with a big pharmaceutical company, and to extend the company's operating runway ahead of a potential Australian Securities Exchange (ASX) IPO in 2027.

Pharma and biotech

12 May 2026

Edison themes

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Differentiated oncology asset with early validation

TT represents a differentiated approach in oncology, targeting tumours through direct injection rather than systemic exposure. This localised delivery allows for rapid tumour destruction at the injection site. In Phase IIa STS studies, TT has shown high objective response rates (ORR) and durable ablation, with no recurrence observed in fully responding lesions over follow-up periods. Emerging translational data also show signs of systemic immune responses after local treatment, suggesting broader therapeutic relevance. While these findings remain early, we believe they provide encouraging initial validation of this asset and the platform. We note that TT has already been marketed as a veterinary formulation (Stelfonta), providing evidence of real-world safety and activity in live disease settings across >30k dogs, somewhat de-risking the human oncology programme.

Platform optionality provides longer-term upside

QBiotics' pipeline is powered by its discovery platform, EcoLogic, based on the development of bioactive molecules from natural sources. This approach generates chemical platforms such as the current epoxytiglianes platform, which is producing multiple programmes extending into wound healing and antibiotics, providing longer-term optionality beyond the core oncology focus. In our view, the company's ability to translate platform-derived molecules into clinically validated drug candidates supports the credibility of the approach. Over time, successful creation of additional assets could diversify the pipeline and unlock further partnering opportunities.

Enterprise value assessed at A$361m

We value QBiotics at A$361m (73.7c/share), with TT representing the primary value driver across STS, HNC and breast cancer, underpinning the bulk of risk-adjusted returns. EBC-1013 and Stelfonta offer additional diversification and medium-term upside. We note that, given the early stage of clinical development, our valuation is highly sensitive to clinical readouts, regulatory execution and the scalability of intratumoral delivery, as well as the successful translation of TT's combination potential within immuno-oncology settings.

Investment case and use of proceeds

Why invest now?

QBiotics presents an opportunity to invest in a differentiated oncology asset at a stage where early clinical validation is established, yet potentially significant value inflection points remain ahead. The company is targeting areas of high unmet medical need, including STS, HNC and breast cancer, all of which have the potential to translate to lucrative commercial opportunities. TT offers a relatively underexplored intratumoural approach, combining direct tumour ablation with broader immune-mediated effects, differentiating the asset from current treatment options. While the therapy may be positioned as a monotherapy, we see potentially greater opportunities in combination approaches, which are becoming increasingly prevalent in modern cancer treatment regimens, and, hence, of interest to prospective pharma partners.

Clinical traction is already evident. Early studies have shown encouraging response rates across multiple tumour types, all while showcasing a favourable safety profile. Programmes in STS and HNC are progressing through Phase II, with an additional Phase II study in breast cancer in planning, supported largely by non-dilutive external funding, and is expected to broaden the dataset. Further opportunities also exist in additional solid tumour settings, including liver cancer and melanoma based on preclinical and early clinical data, respectively, offering multiple shots at goal. We believe that the human oncology programme is somewhat de-risked by the successful development and commercialisation of Stelfonta. These achievements highlight TT's safety and activity in live disease settings, while demonstrating QBiotics' capabilities in manufacturing and providing the company with learnings to support the current human oncology focus.

In parallel, management is actively engaging potential pharma partners, suggesting the asset is approaching a stage where its robust scientific backing can translate into a commercial transaction. As such, any further developments may help secure a partner under more attractive deal terms.

Use of proceeds and path to value inflection

The proposed fundraise (seeking up to c A$40m) has been planned with the clear objective of augmenting the

oncology programme for a commercial partnership, and we understand that management is already in discussions with prospective pharma partners. Most of the proceeds will be allocated to progressing TT through ongoing and planned clinical development efforts, generating important data to enhance both partnering discussions and the overall value proposition. This includes completing key Phase II studies and expanding the clinical evidence base across all relevant oncology indications.

A secondary component of the funding will support preparations for a potential ASX IPO. Importantly, the use of proceeds is tightly aligned with near-term value creation, providing investors with a clear line of sight between capital deployment and milestone delivery.

The wound healing drug candidate (EBC-1013) is expected to progress independent of newly raised capital. The programme is already funded through its current stage of development, and management is exploring non-dilutive funding opportunities, including grants and strategic partnership opportunities, to support further advancement. As such, investors in QBiotics may gain exposure to this additional opportunity without a meaningful increase in near-term funding requirements. We highlight that QBiotics also has a novel antibiotics programme (preclinical), but since this represents a longer-term opportunity, we do not discuss it in detail in this report.

Overall, the investment case is underpinned by a disciplined capital strategy: deploying capital into the highest-value programme, targeting a defined partnering inflection point, while maintaining optionality across the broader pipeline with limited incremental spend.

Company overview

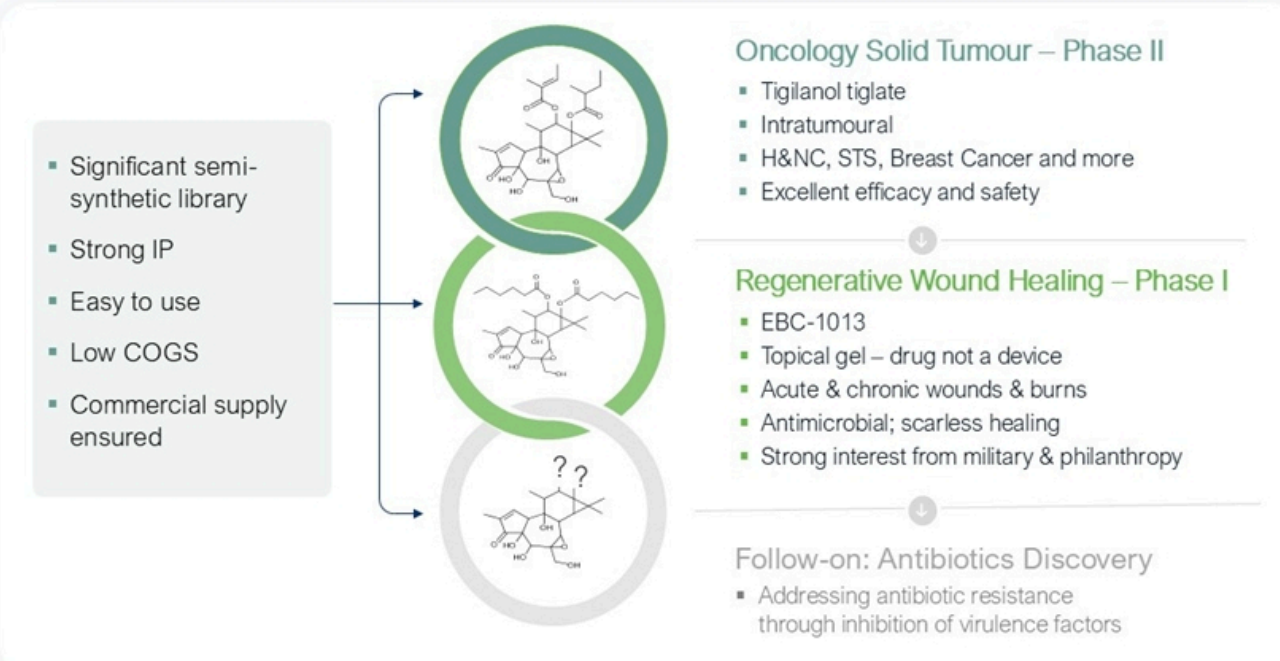
Translating natural molecules into clinical assets

QBiotics is a clinical-stage biotechnology company headquartered in Brisbane, Australia. It is a public unlisted company, having historically funded its operations through private capital. Its operating model spans early-stage drug discovery, through clinical development, to marketed products. The leadership team brings a diverse mix of scientific, clinical and commercial experience, with recent changes reflecting a renewed focus on capital discipline, clinical execution and strategic positioning. This includes a reconstituted board and management structure, aligning the organisation more closely with its next stage of development and funding objectives.

At the core of QBiotics' approach is its EcoLogic platform that produces novel biologically active chemical platforms sourced from botanical origins, drug candidates from which are subsequently optimised for therapeutic use (Exhibit 1). The current epoxytiglianes platform is derived from *Fontainea picrosperma* (a rainforest tree endemic to the Atherton Tablelands in North Queensland, Australia), exemplifying this approach.

Natural products have historically played an important role in drug discovery, offering structurally diverse and biologically active molecules that can interact with complex disease pathways. Key successful examples include quinine for malaria, paclitaxel in oncology and the penicillin class of antibiotics. QBiotics' platform seeks to harness these properties, identifying molecules with inherent biological activity and translating them into clinically viable therapies. The epoxytiglianes class is of particular interest due to its ability to induce rapid, localised and systemic biological effects, which can be leveraged in settings such as tumour destruction and tissue regeneration. This discovery strategy differentiates QBiotics from many small biotechnology companies, which often focus on synthetic or highly targeted molecular approaches, which can be complex and expensive.

Exhibit 1: QBiotics' epoxytiglianes platform is a source of potential therapeutics across a range of disease areas



Source: QBiotics corporate presentation (April 2026)

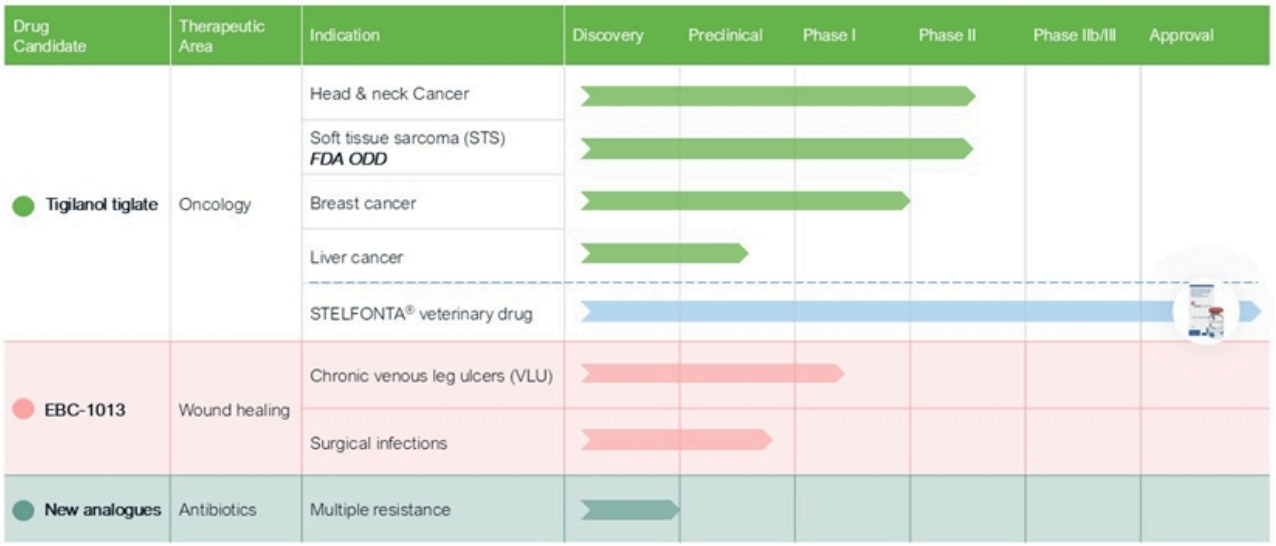
Corporate strategy

QBiotics' epoxytiglianes platform has given rise to a pipeline spanning oncology, wound healing and antibiotics, with each programme reflecting a different application of its underlying chemistry (Exhibit 2). The lead oncology asset, TT, is being developed as an intratumoural therapy for solid tumours, with active programmes in STS and HNC. Additional exploratory work is ongoing in other tumour types, including breast cancer, supported in part by external funding, highlighting TT's 'pipeline-in-a-product' potential.

The company's second clinical-stage asset, EBC-1013, is being developed for chronic wound healing, with additional potential in acute wounds and burns. This programme targets conditions where tissue repair represents a medical challenge, with early clinical work suggesting potential to accelerate healing through localised biological activity. In parallel, QBiotics maintains a preclinical antibiotics programme, although this remains a longer-term opportunity. Together, these programmes illustrate the breadth of the epoxytiglianes platform and its potential to generate multiple assets across distinct therapeutic areas. While oncology is deliberately the primary focus, the broader pipeline provides strategic optionality, with scope to expand into additional indications over time as new candidates are identified.

Management is prioritising the clinical development of TT in oncology, with the objective of generating robust data to augment a commercial partnership to support subsequent development efforts and eventual potential commercialisation. This reflects a disciplined approach to capital allocation, concentrating resources on the programme with the clearest path to near-term value realisation, while maintaining longer-term upside through the broader platform. As an example of an oncology deal involving the intratumoral delivery approach, French biotech Nanobiotix secured a $2.6bn licence agreement with Janssen (a Johnson & Johnson company), including a $60m upfront payment for its intratumoral candidate, highlighting the big pharma interest in this space.

Exhibit 2: QBiotics' clinical development pipeline



Source: QBiotics corporate presentation (April 2026)

Lead asset: Tigilanol tiglate

Mode of action and positioning

TT is QBiotics' lead oncology asset and represents a novel approach to cancer treatment based on intratumoural delivery. Unlike conventional anti-cancer therapies, which typically circulate throughout the body, TT is administered directly into the tumour site. This localised approach is designed to enable targeted tumour destruction while limiting systemic exposure.

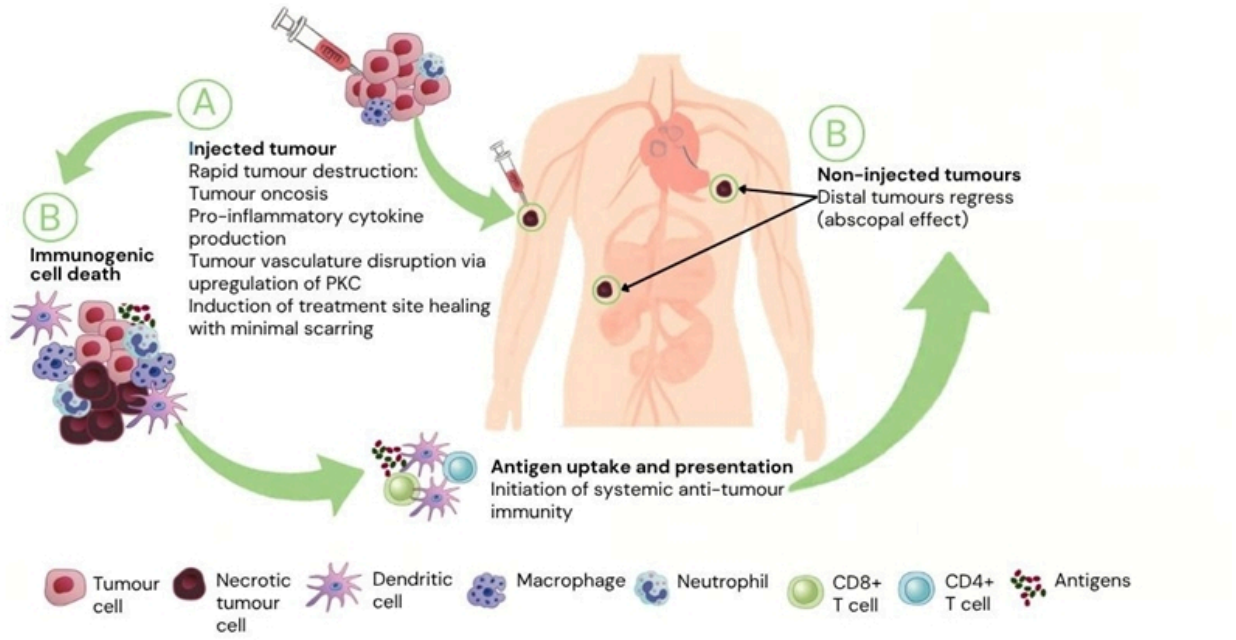
As characterised by Johnson & Johnson, such intratumoural treatments offer the potential to:

- Minimise toxicity: offering more favourable risk-benefit profiles, in particular for earlier-stage cancers.
- Increase efficacy: expose tumours to higher concentrations of therapy and activate anti-tumour immunity.
- Unlock new therapies: enable use of immunotherapeutic agents that otherwise may not be usable via systemic delivery.

Following injection, TT induces a localised biological response within the tumour microenvironment. This includes disruption of tumour vasculature (disrupting the blood vessels supplying the tumour) and oncosis (activation of cellular processes that lead to tumour cell death), leading to rapid tumour ablation. TT also stimulates healing of the site post tumour destruction. By concentrating activity at the tumour site, the therapy achieves meaningful local control while reducing off-target effects associated with systemic therapies.

Beyond this local effect, there is emerging evidence of TT having broader biological implications. The destruction of tumour tissue can release tumour-specific antigens (proteins that our immune systems can recognise), stimulating systemic immunological responses. While these distal effects remain under investigation, they support the potential for QBiotics' lead asset to act as a local therapy as well as for wider anti-cancer activity (Exhibit 3).

Exhibit 3: TT's mode of action



Source: QBiotics resources

This mode of action positions TT as a flexible component within the evolving oncology treatment landscape. Standards of care are increasingly incorporating synergistic combination approaches, especially in immuno-oncology (as discussed in our recent thematic report), where therapies are used together to improve response rates and durability. Intratumoural therapies such as TT may complement these approaches by improving both tumour accessibility and immune recognition (as demonstrated in mouse studies), potentially enhancing responses to existing therapies (immune checkpoint inhibitors (ICIs) response rates are only 15–30% in solid tumours, and the market is still currently valued at c $50bn, according to Grand View Research). This means that while TT could be initially developed as a monotherapy, combination strategies may provide a greater value proposition, in our view.

Preclinical development

QBiotics has progressed TT through a structured development path, including preclinical research, veterinary clinical development, a Phase I study and ongoing Phase II programmes across multiple tumour types. Preclinical and veterinary clinical work showed the molecule's ability to induce the rapid destruction of tumour cells after local dosing, alongside evidence of vascular disruption and immune activation. These findings provided the rationale for advancing into human studies.

Early clinical development

Early clinical development focused on establishing safety, tolerability and signals of efficacy in nine different solid tumour types. The Phase I study (EBC46-H01/2) assessed TT in 22 patients with advanced solid tumours, including STS, HNC, as well as other accessible lesions, such as breast cancer, melanoma and squamous cell carcinoma. The therapy was generally well tolerated, with no maximum tolerated dose identified and a safety profile characterised primarily by localised, manageable effects at the injection site, normal for this type of administration. While the study was not powered to test efficacy, early signals of anti-tumour activity were observed across multiple tumour types. Encouragingly, 6/22 patients (27%) experienced a treatment response, with 4/22 (18%) achieving a complete response. Furthermore, abscopal responses were observed in two patients, meaning that tumour responses were recorded in distal (non-injected) tumour sites in two cases. Collectively, an overall injected-tumour response rate of 60% was reported following single injections of TT, providing early validation of the mode of action. However, we highlight that the data here correspond to a relatively small sample size. (See Exhibit 14 in the appendix for a supplementary figure relating to the Phase I study.)

Building on these findings, QBiotics advanced TT into Phase II development with larger cohorts, with an initial focus on STS and HNC. These indications were selected based on a combination of clinical need, accessibility of tumours for

injection and compelling early signals of efficacy.

Phase IIa in STS, programme supported by ODD

The Phase IIa study (QB46C-H07) in STS represents the most advanced clinical programme and is a key driver of the current investment case. QB46C-H07, being undertaken at the recognised site Memorial Sloan Kettering Cancer Center in the US, is designed as an open-label study, evaluating both the safety and efficacy of intratumoural TT in patients with a range of accessible STS lesions. The study is being conducted in stages, the first of which is a pilot in 10 patients, while the second is the expansion portion of the trial. The primary efficacy endpoint is based on ORR of injected tumours compared to baseline, defined as the portion of patients who achieve complete (100% reduction in volume) or partial (at least 30% reduction) ablation of tumours and/or tumour segments. Secondary endpoints are based on safety and tolerability, alongside pharmacokinetics. Exploratory endpoints include local rate of recurrence at the injection site at six months after initial injection and assessment of tumour responses in biopsy samples. Initial results have been reported from the first stage of the trial, and the expansion stage is ongoing.

The data from the first stage (announced in June 2025) were encouraging, in our view. The study reported an ORR of 80% in injected tumours (8/10 patients), with 22 of the 27 tumours treated (81%) across the 10 participants showing complete or partial ablation (Exhibit 4). This comprised 14/27 (52%) cases of complete ablation and 8/27 (30%) cases of partial ablation. Notably, in the 14 tumours that were fully ablated, no recurrence was observed over a six-month follow-up period, suggesting that TT delivers durable local tumour control in settings where treatment options are often limited and outcomes can be poor. In addition, TT efficacy response was consistent across six STS subtypes. Encouragingly, it has also been reported that three patients exhibited better-than-expected responses to subsequent systemic therapy, despite previously being refractory to such treatments, highlighting the promise for potential future combination treatment approaches. In terms of safety, the drug candidate was well tolerated, consistent with prior data, adding to a robust data package. (See Exhibit 15 in the appendix for a supplementary figure relating to QB46C-H07, showing an angiosarcoma patient achieving a complete response.)

The second stage of QB46C-H07 is underway with the aim of expanding the dataset and further validating the findings; management has communicated it will provide an update once this stage has been completed. It is our opinion that the results to date represent a meaningful signal of efficacy for a therapy at this stage of development.

We note that TT has received ODD in STS from the FDA, providing validation that the regulators see TT as a potentially viable product in this indication. Benefits of ODD include tax credits for qualified clinical trials and exemption from user fees, which may support an accelerated regulatory pathway. ODD also allows for a minimum of seven years of market exclusivity, enhancing the commercial attractiveness of the programme to prospective partners.

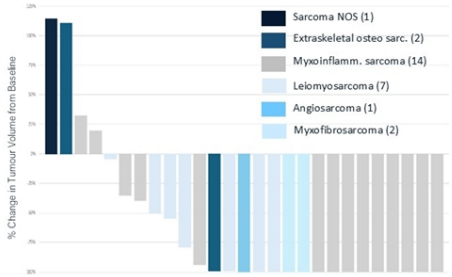
Phase I/II in HNC

QBiotics has conducted a Phase I/IIa study (QB46C-H03) and is conducting a Phase II study (QB46C-H08) in HNC, another indication characterised by significant unmet need and where local tumour control may have a meaningful effect on patient outcomes. These studies have explored the use of TT in accessible tumours, with a focus on safety, tolerability and preliminary efficacy.

QB46C-H03 was a dose-escalation safety study, for which results were announced in August 2023. It treated 19 patients in a window-of-opportunity before-surgery study, meeting its primary endpoint of safety and tolerability. It was not designed to generate efficacy data but focussed on exploring the immunological response of TT treatment. Study outcomes confirmed the induction of immunological cell death and tumour immune cell infiltration.

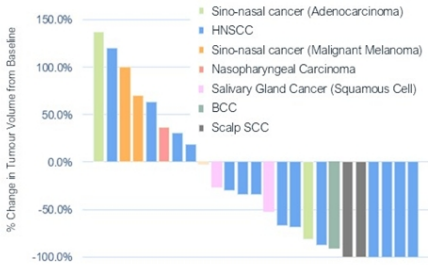
QB46C-H08 is designed as an open-label trial in up to 37 HNC patients, based at sites in Australia and the UK. The primary objective is to evaluate local control through tumour ablation, while secondary objectives focus on safety and tolerability, alongside time to local disease recurrence, recurrence rates at injected tumour sites and progression-free survival. As announced in March 2026, recruitment for QB46C-H08 has been completed and a readout is anticipated in Q2 or Q3 CY26. Management has communicated that early efficacy signals have been supportive, including interim data showing a 71% ORR across 25 tumours in 16 HNC patients (Exhibit 5). We expect the final data package will provide greater clarity on the clinical potential of the drug candidate in this indication.

Exhibit 4: QB46C-H07 (first stage) data in STS – change in tumour volume



Source: QBiotics corporate presentation (April 2026)

Exhibit 5: QB46C-H08 (interim) data in HNC – change in tumour volume



Source: QBiotics corporate presentation (April 2026)

Plans for Phase II in breast cancer, 90% collaborator-funded

Beyond STS and HNC, QBiotics is exploring broader applicability across additional solid tumours, including breast cancer, as reflected in the March 2026 announcement that QBiotics and Unicancer France (a French hospital network specialised in oncology that coordinates research and treatment across the country, and a recognised organisation for conducting oncology trials and advancing new cancer therapies) have signed a letter of intent to establish a collaborative partnership, looking at breast cancer recurrence. This will involve a Phase II, multi-centre, open-label, single-arm, investigator-initiated clinical trial (expected n=50) assessing intratumoural TT for loco-regional and superficial breast cancer recurrences. Management is finalising a definitive collaboration agreement, where Unicancer is expected to fund 90% of the programme, serving as an encouraging form of external validation, in our view. Overall, we believe this programme has the potential to expand the clinical utility of TT to another cancer type where effective new treatment options are needed. We note that Unicancer's interest in the programme stemmed from some encouraging case studies as part of a compassionate use scheme with the Gustave Roussy Cancer Centre in Paris. (See Exhibit 16 in the appendix for a supplementary figure relating to a case study, showing a metastatic breast angiosarcoma patient achieving a complete response.)

Clinical strategy and next steps

Taken together, the clinical data to date provide supportive evidence of TT's therapeutic potential. However, it is important to note that these findings are based on early-stage studies with limited patient numbers. As such, further validation in larger, more comprehensive trials will be critical to confirm the prior observed outcomes. Looking ahead, QBiotics' clinical strategy remains focused on advancing TT through its three Phase II programmes. Beyond these, where TT targets external solid tumours, we understand that QBiotics is also exploring the potential of TT to address internal tumours, with an initial focus on liver cancer. We note that this is in the preclinical stages of development; hence, we do not include it in our valuation. Nevertheless, positive progression on that front may enhance discussions with prospective pharma partners. Other expandable opportunities include indications such as melanoma, where QBiotics generated encouraging Phase I clinical data, highlighting the company's potential to have multiple shots at goal.

Target markets: STS, HNC and beyond

Oncology remains the largest, fastest growing and most innovation-intensive therapeutic area globally, reflecting both the scale of the unmet medical need and the commercial value associated with improved patient outcomes. Within this, immuno-oncology (harnessing the body's own immune system) has transformed many treatment paradigms over the past decade (ICIs in particular), although response rates to these therapies remain limited in some specific cancers.

The field of immuno-oncology now has a growing interest in combination treatment regimens, as well as novel modes of action, intended to enhance efficacy and minimise the risk of resistance, all while improving or maintaining favourable safety profiles.

Soft tissue sarcoma

STS is a rare and heterogeneous group of cancers that arise from connective tissues (such as muscle, fat, nerves and blood vessels). This encompasses over 50 subtypes, contributing to complexities in diagnosis and treatment. It is estimated that there are c 14k new cases of STS each year in the US alone, with many patients expected to present with advanced or unresectable disease. Standard of care typically involves a combination of surgery, radiotherapy and chemotherapy, although outcomes remain variable and recurrence rates can be high. Systemic therapies are often associated with limited durability of response and significant side effects (immunotherapies such as ICIs struggle in STS, achieving only low ORR), while surgical options are invasive and not always feasible, meaning treatment options are often limited.

From a commercial perspective, STS represents a relatively small, but underserved market, with high unmet needs creating the potential for premium pricing for therapies that improve local tumour control. The competitive landscape is relatively sparse, with few targeted therapies and modest innovation beyond chemotherapy. Within the field, Immunome's varegacestat (a small molecule drug candidate) garnered attention in December 2025 after meeting the primary endpoint in its registrational Phase III trial (n=156) in desmoid tumours (a specific STS), delivering an ORR of 56% as a monotherapy and a statistically significant benefit in progression-free survival compared to placebo; FDA submission is planned within Q2 CY26. Other emerging approaches, including next-generation immunotherapies, have shown some activity, but response rates remain inconsistent across subtypes and durability is often limited. As a result, there remains scope for differentiated therapies to establish a role in selected populations.

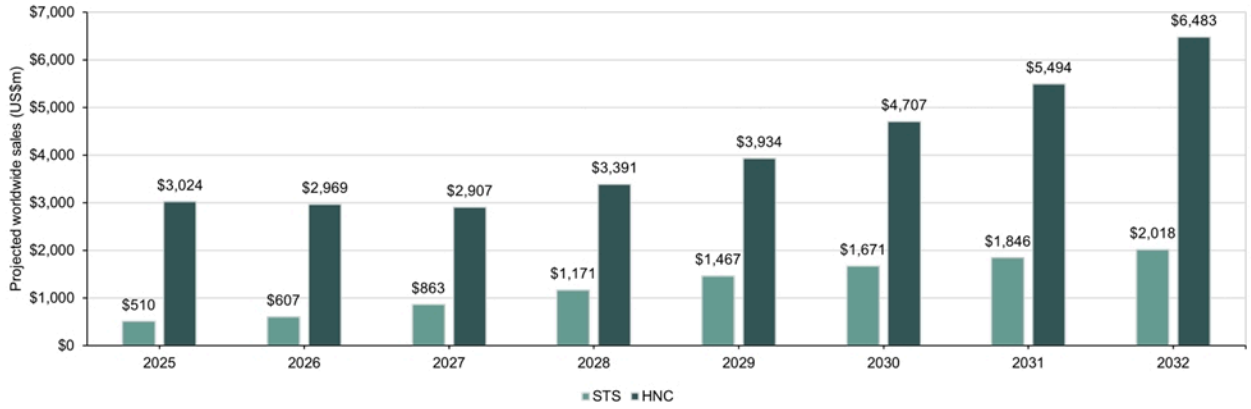
In this setting, TT may be positioned to address specific gaps in this market. Its intratumoural approach enables direct and rapid tumour ablation, which could be particularly relevant where local control is clinically meaningful. As discussed previously, early clinical data suggest high response rates and potential durability in treated tumours. To capture meaningful market share, the asset will need to demonstrate reproducible outcomes in larger cohorts, sustained durability and a clear role in clinical practice. If achieved, it may offer an alternative to more invasive or systemic approaches, supporting its commercial potential within this niche indication.

Head and neck cancer

HNC refers to a group of malignancies that originate in the oral cavity, throat and larynx, commonly associated with tobacco and alcohol use, or caused by human papillomavirus infection. It is significantly more prevalent than STS, with c 73k new cases of HNC in the US each year. Despite advances in treatment, outcomes remain challenging, particularly in recurrent or metastatic disease. Standard of care typically includes surgery and systemic therapies, often alongside radiotherapy. Unlike STS, immunotherapies have been more promising in HNC, although these approaches can be associated with substantial toxicity and high recurrence rates.

The commercial landscape for HNC is correspondingly larger and more competitive than in STS (Exhibit 6). Immunotherapies, particularly ICIs, have improved outcomes in some patient populations, but response rates remain modest, and many patients either do not respond or relapse. As a result, there is a continued focus on combination strategies and novel modes of action to improve efficacy. The size of the market and ongoing unmet need have attracted notable investment from big pharmaceutical companies. Key recent transactions include Genmab's acquisition of Merus for c $8bn (announced in September 2025) and Galapagos's license deal with Adaptimmune for $100m upfront and up to $465m in milestones (announced in June 2024). The target of Genmab's acquisition was petosemtamab (a bispecific antibody), which has been granted Breakthrough Therapy designation by the FDA for two HNC settings; it is currently in Phase III development across both these settings and updates are expected within 2026. Compelling prior clinical data showed that petosemtamab in combination with the ICI pembrolizumab delivered an ORR of 63% in a Phase II trial (among 43 evaluable patients), alongside a 79% overall survival rate at 12 months.

Exhibit 6: Projected worldwide drug sales for STS and HNC, reaching over $2.0bn and $6.4bn, respectively, by 2032 (according to Evaluate Pharma)



Source: Evaluate Pharma, Edison Investment Research

As discussed above, TT's intratumoural approach offers a differentiated modality that may complement existing therapies. Early studies have shown a favourable safety profile and initial signs of efficacy. To establish a meaningful position, QBiotics will need to demonstrate consistent and durable responses in larger trials, alongside clear positioning relative to existing therapies.

We discuss some scenarios within the STS and HNC treatment landscapes, where TT may find clinical utility, below (see the Valuation section of this report).

Breast cancer

Beyond the two priority indications, QBiotics is also exploring breast cancer. This is the second most commonly diagnosed cancer globally, arising from malignant cells in breast tissue, with a sizable c 2.3 million new cases reported each year. This makes it significantly more prevalent, and commercially larger, than both STS and HNC (the global breast cancer treatment market is projected to exceed $60bn by 2032, according to Evaluate Pharma). As mentioned above, QBiotics is currently exploring TT in breast cancer in collaboration with Unicancer France, although Phase II data are yet to be generated. Nevertheless, if clinical results are supportive, this indication could meaningfully broaden the asset's applicability and enhance its long-term value proposition.

Pipeline optionality beyond human oncology

As a reminder, QBiotics' broader pipeline is underpinned by its epoxytiglianes platform, which has generated multiple programmes across oncology, wound healing and anti-infectives. While TT in human oncology represents the primary near-term value driver, the platform offers longer-term optionality, through additional therapeutic applications.

One component of this broader portfolio is Stelfonta, the veterinary formulation of TT, approved for the treatment of mast cell tumours in dogs. It has been commercialised across multiple regions, including the US, Europe and Australia. Beyond generating a modest revenue stream, this programme is strategically relevant as it demonstrates the molecule's clinical activity and safety in real-world disease settings, having been tested in >30k dogs, while also showcasing manufacturability. While not directly translatable to human oncology, we believe it somewhat de-risks the programme, as it provides supporting evidence for the underlying mode of action and the company's ability to advance assets from discovery through to approval.

Non-oncology pipeline

Beyond oncology, QBiotics is advancing EBC-1013 as a topical gel for wound healing, targeting chronic wounds such as venous leg ulcers (VLUs), as well as acute wounds and burns. It is already funded through the ongoing Australia-based Phase I study in VLU patients, for which a clinical update is anticipated within 2026. Management has highlighted diabetic foot ulcers as a potentially lucrative expandable opportunity. The programme is designed to leverage the anticipated ability of epoxytiglianes to stimulate local biological responses, including immune activation and tissue repair, with the aim of promoting effective healing in conditions where this process is impaired. The programme has been

supported by encouraging results in veterinary models, showing accelerated closure of infected wounds compared to control treatments. The company has highlighted potential applications across both civilian and military settings, alongside opportunities for non-dilutive funding and partnerships. (See Exhibit 17 in the appendix for a supplementary figure relating to vet case studies, showcasing the benefit of EBC-1013 gel across various wound types.)

QBiotics also maintains an earlier-stage antibiotics programme, focused on addressing antimicrobial resistance. This work explores molecules that target bacterial virulence pathways, with the aim of reducing the development of resistance. While still preclinical, it reflects the broader versatility of the platform, although it is not expected to contribute to near-term value inflection.

Implications

From a capital allocation perspective, the company remains focused on advancing TT in human oncology, with the planned fundraise (seeking up to c A$40m) directed towards this programme. The wound healing asset is expected to progress through its current stage with existing resources and potential external non-dilutive funding, while the antibiotics programme remains longer term. As a result, investors gain exposure to these additional programmes alongside the core oncology opportunity, providing incremental upside without a corresponding increase in near-term funding requirements.

Key upcoming milestones and catalysts

- **Expansion data from Phase II trial (throughout 2026).** Clinical updates are anticipated in STS and HNC, from the QB46C-H07 and QB46C-H08 trials, respectively.
- **Additional indication entry (2026 and beyond).** Plans have already been announced for a Phase II trial in breast cancer. Beyond this, liver cancer represents an internal tumour opportunity, though this is in the earlier planning stages.
- **Strategic partnerships (timing difficult to predict).** While it is feasible that QBiotics may already be able to engage a pharma partner, it is currently augmenting its offering by generating incremental data for TT. Any further developments may enable management to secure a partner under more attractive deal terms.
- **Capital raise and IPO (planned for 2026 and 2027 respectively).** As discussed, the capital raise planned for this year is intended to augment the oncology programme for a commercial partnership and extend the company's operating runway ahead of a potential ASX IPO in 2027.

Financial overview

Being a clinical-stage biotech, QBiotics does not generate any meaningful recurring revenues from its core human therapeutics pipeline, and as such is currently reliant on external funding to support operations, with a high degree of forward-looking execution risk. Historically, the company has benefited from a veterinary revenue stream via Stelfonta (TT for veterinary use; FDA approved in late 2020), which has generated product sales and milestone revenues through a commercial partnership with Virbac. QBiotics reported A$1.3m in revenues in FY24 (the period ended June 2024) and A$0.8m in FY25. Management had noted sales had underperformed expectations and, more recently, the distribution arrangement has been disrupted (both QBiotics and Virbac agreed not to renew for a second term), resulting in an absence of any product-related revenues in H126 (the six-month period ended December 2025). Pending a new commercial agreement, we expect modest top-line contribution from Stelfonta in FY26 (we currently model A$1.2m in product revenues in FY26 based on management guidance of the last 5,000 doses of Stelfonta to be shipped to Virbac in May 2026).

The company also benefits from Australia's R&D Tax Incentive, which provides a cash rebate of up to 43.5% on eligible R&D expenditure, offering a meaningful source of non-dilutive funding and partially offsetting operating cash burn. QBiotics reflects these R&D tax credits as revenues in its P&L statement. In FY25, the company reported A$6.5m as R&D credits (A$7.4m in FY24). Note that the R&D credit figure tends to vary with underlying R&D expenses for a particular period. In FY25, QBiotics recorded A$11.7m as R&D expenses (FY24: A$11.7m), which we attribute to the ongoing clinical programmes as well as other R&D activities. In addition, the company reported A$15.2m as general and administrative expenses, broadly in line with the FY24 figure of A$14.8m. Overall, QBiotics booked an operating loss of A$22.6m in FY25 versus A$19.5m in FY24. This translated to operating cash outflows of A$18.9m and A$17.2m in FY25

and FY24, respectively.

While management has emphasised disciplined cost control and capital allocation, the business remains structurally dependent on capital markets and non-dilutive funding sources ahead of commercialisation of its ongoing clinical programmes. At the end of December 2025, the company had a cash balance of A$13.5m, bolstered by another c A $7.7m in R&D tax credits received in May 2026. Based on our cash burn rates, we expect these pro-forma funds to provide the company with headroom into H2 CY26, with another c A$20m required in H2 to support operations into CY27 (we reflect this as illustrative debt in our model). Considering these requirements QBiotics is seeking to raise up to c A$40m in bridging capital, which is expected to support ongoing clinical development activities, including progression of key trials across its oncology programmes, while positioning the company for a potential IPO on the ASX in 2027. Should the company be successful in raising the planned funds, we estimate these, along with existing cash on hand, will be sufficient to fund operations to the planned IPO in 2027. We note that proceeds from the planned fundraise have been earmarked for the oncology programme, with the wound healing clinical development to be supported by non-dilutive government funding and grants.

We therefore view the planned raise as a critical near-term financing event, effectively serving as a bridge to a larger liquidity event (ASX IPO). As such, execution risk is twofold: successful completion of the capital raise itself and delivery of further clinical and strategic milestones to augment a partnership and/or credible public market listing within the targeted time frame.

Given the scenario, we believe that capital efficiency will remain a key variable. QBiotics' approach to clinical development, including trial design, use of investigator-sponsored studies and prioritisation across indications, will materially affect cash burn. The company has indicated ongoing efforts to explore partnering opportunities, particularly for later-stage development and commercialisation, which could enable the sharing of costs, de-risking the funding profile.

Valuation framework: Risk-adjusted NPV

Business case anchored by tigilanol tiglate

While QBiotics maintains a diversified pipeline across oncology (human and veterinary), wound management and antibiotics, TT remains the primary value driver underpinning the investment case. As an intratumoral small molecule with a potential dual mode of action, TT is building a differentiated position within oncology, straddling both local tumour control and systemic immuno-oncology potential across a range of solid tumours.

Clinical validation to date supports TT's potential role as a local tumour control agent, evidenced by Stelfonta (FDA-approved for non-metastatic mast cell tumours in dogs) and early clinical studies in STS and HNC. This provides a clear and tangible near-term commercial opportunity. In parallel, combination strategies, particularly within immuno-oncology, offer another promising avenue for future growth. While evidence of synergy with ICIs is still emerging, early observations point to the potential for immune-mediated abscopal effects. We note that in an earlier Phase I/IIa combination study in melanoma with pembrolizumab, one of the three patients dosed achieved a complete response with the injected tumours, with a non-injected distal tumour showing a partial response. However, the trial was terminated prematurely (planned n=40), with the company citing enrolment-related challenges due to COVID-19. Materially larger trials will be required to establish efficacy and TT's role as an immune primer, unlocking additional therapeutic impact.

The valuation of TT is therefore best approached through a risk-adjusted net present value (rNPV), sum-of-the-parts framework, separating near-term, more de-risked settings from longer-term platform optionality.

Valuation scope by indication and treatment setting

In line with management's stated clinical development priorities, our valuation of TT focuses on a defined set of oncology indications and settings where there is both a clear rationale and near- to medium-term development visibility. Specifically, we model TT across selected settings in STS, HNC and breast cancer, reflecting current pipeline focus and potential pathways to value inflection. QBiotics had previously evaluated TT in melanoma (two Phase I/II clinical trials discontinued in late 2022 due to recruitment challenges during COVID-19) and is currently collaborating with the University of Edinburgh in its cancer research project in oronasal mucosal melanoma. However, given the early stages of these activities, we currently exclude melanoma from our projections but note the upside potential with clinical

progression.

Note that all our assumptions are contingent on the clinical development pathways ultimately selected by management, and that not all of these pathways may be pursued.

Within STS, which represents the most advanced and de-risked opportunity, we include:

- Advanced unresectable STS as an adjunct to first-line doxorubicin.
- Advanced unresectable STS in the second-line setting in combination with ICIs.
- Early-stage STS in the neoadjuvant setting for localised, accessible tumours.

In HNC, we capture both monotherapy and combination approaches:

- Locally advanced HNC as a monotherapy.
- Recurrent/metastatic HNC in first-line combination with ICIs.

In breast cancer, which reflects a key platform expansion opportunity, we include:

- Recurrent breast cancer, particularly skin and chest wall recurrence.
- Metastatic breast cancer in combination with ICIs.

We believe that this indication set captures a balance between nearer-term, clinically tangible applications (eg STS and accessible tumours) and higher-upside combination strategies in larger markets, particularly in immuno-oncology. Our approach therefore aligns with management's strategy of advancing TT both as a local tumour control agent and as a potential immune-priming therapy in combination settings.

Across all the target indications and settings, we use certain broad assumptions to model the market opportunity (discussed below):

- We explicitly model the US market opportunity, forecasting indication-specific cash flows through to 2045. No terminal value is applied, reflecting our assumption that revenues decline to negligible levels thereafter.
- Global commercial potential is derived by extrapolating from US forecasts, assuming a 50:50 revenue split between the US and the rest of the world (RoW). This assumption is informed by our analysis of ICI sales, where the US typically accounts for approximately 50–60% of global revenues.
- Given the early stage of development and as yet limited public visibility on the timing and structure of a potential licensing agreement, identified by management as the preferred exit route, we assume self-commercialisation across all modelled indications, incorporating both revenue and cost profiles at the indication level.
- We assume a realisable price of US$50,000 per dose of TT, based on management guidance.
- A flat discount rate of 15% is applied across all indications. This includes a 2.5% illiquidity premium over the standard Edison discount rate of 12.5% for clinical-stage biotechs, reflecting QBiotics' private company status and the associated liquidity and execution risks.
- We assume a combined COGS and SG&A of 20% of product revenues. These ratios are widely accepted standards for small molecule drugs.

STS opportunity overview

We believe that STS represents one of the most advanced and clinically validated opportunities for TT, with the highest contribution to our current investment case for QBiotics. We value the STS opportunity across multiple settings, including neoadjuvant, first-line adjunct and second-line combination use, where we believe that TT is well positioned to address a defined sub-set of patients with accessible tumours (palpable or visible), where its intratumoral injectable delivery and rapid tumour ablation mode of action offer clear clinical utility. While the overall market remains relatively small, it is characterised by high unmet need, and favourable orphan-like pricing and commercial dynamics. We remind readers that TT holds ODD in STS, providing seven years of market exclusivity following regulatory approval.

Indication specific assumptions for STS are detailed below:

Exhibit 7: Assumptions for STS rNPV

Treatment setting	Assumptions
Adjunct to first-line doxorubicin (advanced or metastatic STS)	**Target population**: US STS incidence (c 14k, 1.5% y-o-y growth), filtered for extremity/trunk tumours (80%), advanced/progressed patients (40%) and clinical eligibility (systemic treatment, progression, accessibility, injectability), resulting in a target population of c 1.5k patients/year. **Commercial assumptions**: Most immediate commercial opportunity for TT given existing clinical data. Launch assumed in 2032, peak penetration of 50% by 2038 (c 870 patients) given the material unmet need and lack of effective options other than chemotherapy. Pricing at $50k/dose, three doses per patient ($150k), with 2% annual price growth. **Revenue potential**: Peak US sales of c $150m; global peak of c $300m (50:50 US:RoW split). Positive operating leverage post-launch with strong margin expansion. **Cost and development assumptions**: Clinical costs assumed to be $100k per patient, with Phase IIb (40 patients) and Phase III (150 patients given the limited target patient population). R&D partially offset by tax incentives; 25% tax rate applied (Australia corporate tax rate). **Valuation output**: NPV: c $203m; applying 20% probability of success (PoS) and a 15% discount rate → rNPV $41m (A$57m). **Conclusion**: Represents a core, near-term, relatively de-risked indication underpinning base-case valuation.
Combination with checkpoint inhibitors	**Target population**: US STS incidence (c 14k, 1.5% growth) filtered for advanced patients progressing post-1L chemo (85%), 2L treatment uptake (90%), tumour accessibility (40%) and ECOG ≤2 (80%), yielding a target population of c 2.4k patients/year. **Commercial assumptions**: Launch 2033; peak penetration 50% by 2038 (c 1,460 patients). Pricing at $50k/dose, three doses (c $150k/patient), with 2% annual price growth. **Cost and development assumptions**: Clinical costs assume c $150k per patient (higher than the previous setting due to increased complexity of administration in combination with ICIs), with Phase II (c 50 patients) and Phase III (c 200 patients). R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability**: Peak US sales of c $250m; global peak of c $500m (50:50 US:RoW). **Valuation output**: NPV $324m; applying 10% PoS (lower than first line due to higher risk and lack of prior data) and a 15% discount rate → rNPV $32m (~A$45m). **Conclusion**: Represents a higher-risk, higher-reward expansion versus first-line STS, driven by larger patient pool and combination with ICIs.
Neoadjuvant setting for localised, accessible tumours	**Target population**: US STS incidence (c 14k, 1.5% growth) filtered for early-stage patients eligible for neoadjuvant therapy (35%), tumour accessibility (60%), ECOG ≤2 (80%) and uptake of local intratumoral treatment (85%), resulting in a target population of c 2.0k patients/year. **Commercial assumptions**: Launch 2034; peak penetration 50% by 2039 (1,200 patients). Pricing at $50k/dose, two doses (~$100k/patient), with 2% annual price growth. **Cost and development assumptions**: Clinical costs assumed at $100k per patient, with Phase IIb (50 patients) and Phase III (200 patients). R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability**: Peak US sales of $140m; global peak of $280m (50:50 US:RoW). **Valuation output**: NPV $152m; applying 10% PoS (based on our assumption that this setting will be pursued last by the company) and 15% discount rate → rNPV $15m (A$21m). **Conclusion**: Represents a moderate-risk, mid-sized opportunity, bridging core STS value and broader platform expansion.

Source: Edison Investment Research

Overall, we view the STS franchise as a core, partially de-risked value driver, with multiple potential clinical entry points. While individual indications are modest in scale, together they provide a meaningful revenue base. More importantly, we believe that success in STS would help solidify TT's utility in solid tumours, supporting broader expansion into larger oncology indications and higher-value combination strategies.

HNC opportunity overview

HNC represents a significant step-up opportunity for TT, leveraging its intratumoral delivery in a large and accessible tumour setting (cutaneous and subcutaneous tumours that are either visible or palpable). In this indication, we believe the opportunity landscape for TT spans both locally advanced and recurrent/metastatic settings, particularly where tumours are accessible, injectable and amenable to local control strategies. We note that compared to STS, HNC offers a materially larger addressable population, supporting meaningful commercial upside.

Indication specific assumptions for HNC are detailed below:

Exhibit 8: Assumptions for HNC rNPV

Treatment setting	Assumptions
Monotherapy – locally advanced HNC	**Target population:** US HNC incidence (c 73k, ~1% growth), filtered further for locally advanced/regional patients plus progression from early-stage (c 60%), then unresectable (50%), accessible/palpable (60%) and eligible for intratumoural delivery based on size and location of the tumour (70%), yielding a target population of c 9.6k patients/year. **Commercial assumptions:** Launch in 2033; peak penetration 25% by 2037 (c 2,677 patients), lower than STS due a more competitive market. Pricing at $50k/dose, two doses (c $100k/patient), with 2% annual price growth. **Cost and development assumptions:** Clinical costs assumed to be $100k per patient, with Phase IIb (60 patients) and Phase III (300 patients). R&D partially offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of $250m; global peak of $500m. Strong operating leverage post-launch. **Valuation output:** NPV $382m; applying 20% PoS (based on supportive Phase II interim data demonstrating a 71% ORR) and 15% discount rate → rNPV $77m (A$106m). **Conclusion:** Represents a major medium-term value contributor, driven by large accessible population and monotherapy positioning.
Recurrent/metastatic HNC – combination with checkpoint inhibitors	**Target population:** US HNC incidence filtered for advanced/metastatic patients plus progression (42%), ICI-treated population (80%), refractory/relapsed (70%), with accessible (60%) and eligible for intratumoural injections (70%), yielding a target population of c 7.2k patients/year. **Commercial assumptions:** Launch 2034; peak penetration 25% by 2038 (2,040 patients). Pricing at $50k/dose, two doses (~$100k/patient), with 2% annual price growth. **Cost and development assumptions:** Higher clinical cost assumed at ~$150k per patient, reflecting larger trials (Phase IIb/III; 100 and 400 patients, respectively) and combination with ICIs. R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of $235m; global peak of $470m. Strong margin profile post-launch. **Valuation output:** NPV $245m; applying 10% PoS and a 15% discount rate → rNPV $24m (A$34m). **Conclusion:** Represents a higher-risk, combination-driven opportunity, with upside linked to ICI-refractory positioning.

Source: Edison Investment Research

Overall, we view HNC as a key value driver beyond STS, with the locally advanced setting contributing the majority of risk-adjusted value, supported by a large patient population and clearer clinical positioning. The recurrent/metastatic setting provides additional upside, albeit with higher clinical risk given its reliance on combination strategies and refractory populations.

Breast cancer opportunity overview

While breast cancer is QBiotics' most recent, and still early-stage, oncology focus, we view it as a potentially meaningful commercial opportunity for TT, supported by the high prevalence of the disease and the subset of patients presenting with accessible cutaneous or chest wall lesions. The indication may offer a logical expansion pathway, given the intratumoral mode of action, which appears conceptually suited to localised recurrence settings.

That said, while there have been some encouraging case studies under compassionate use (an example shared by the company shows one complete response, refer to Exhibit 16), the programme is yet to generate controlled clinical trial data and, therefore, carries a significant degree of development risk. The planned clinical evaluation is expected to be conducted as an investigator-sponsored study (Unicancer France), which may introduce additional variability in execution and timelines relative to company-sponsored trials.

Over the longer term, there may be scope to explore use in broader metastatic disease, including in combination with ICIs, an approach management has indicated interest in pursuing. However, ICI use in breast cancer remains relatively limited, primarily confined to certain subtypes such as triple-negative breast cancer. As such, the nearer-term opportunity is likely more concentrated in accessible recurrence settings, with any combination-driven expansion representing longer-term and less certain optionality.

Indication specific assumptions for breast cancer are detailed below:

Exhibit 9: Assumptions for breast cancer rNPV

Treatment setting	Assumptions
Monotherapy – recurrent breast cancer, particularly skin and chest wall recurrence	**Target population:** US breast cancer prevalence (c 4m) with annual chest wall recurrence (c 0.8%; this is extrapolated from the information that 5–10% of the patients with operable breast cancer develop a chest wall recurrence within 10 years). Further filtered for local node disease (35%) and accessible tumours (70%), yielding a target population of c 7.9k patients/year. **Commercial assumptions:** Launch in 2034; peak penetration of 20% by 2039 (3,100 patients). Pricing at $100k per patient (two doses), with 2% annual price growth. **Cost and development assumptions:** Clinical costs assumed to be $100k per patient, with Phase IIb/III studies required (Phase IIb: 100 patients Phase III: 300 patients). R&D partly offset by tax incentives; 25% tax rate applied. Planned Phase II trial (n=50) to be majorly (c 90%) sponsored by partner Unicancer. **Revenue and profitability:** Peak US sales of $360m; global peak of $720m. Strong operating leverage with high-margin profile post-launch. **Valuation output:** NPV $344m; applying 7.5% PoS (conservative given investigator-sponsored Phase II study still to initiate) and 15% discount rate → rNPV $26m (A$36m). **Conclusion:** Represents a large, relatively accessible expansion opportunity, driven by high prevalence and feasibility of intratumoral delivery. However, it remains very early-stage for now.
Metastatic breast cancer – combination with checkpoint inhibitors	**Target population:** US breast cancer incidence (c 325k cases) filtered for advanced/metastatic patients plus progression (c 50%), ICI-treated population (10%), progression (40%), accessible/palpable tumours (40%) and injectability, based on size and tumour position (70%), yielding a target population of c 1.8k patients/year. **Commercial assumptions:** Launch in 2035; peak penetration of 40% by 2040 (880 patients). Pricing at $100k per patient, with 2% annual price growth. **Cost and development assumptions:** Higher clinical cost assumed at ~$150k per patient, reflecting combination with ICIs. R&D partly offset by tax incentives; 25% tax rate applied. **Revenue and profitability:** Peak US sales of c $105m; global peak of c $210m. Positive operating leverage, though smaller scale versus recurrence setting. **Valuation output:** NPV $79m; applying a conservative 5% PoS and a 15% discount rate → rNPV $4m (A$6m). **Conclusion:** Represents a high-risk, combination-driven opportunity, with value contingent on ICI synergy and clinical validation.

Source: Edison Investment Research

Overall, we view breast cancer as a potential long-term value driver, with the recurrence setting underpinning the majority of risk-adjusted value due to its scale and feasibility. The metastatic combination setting provides additional upside, albeit with higher clinical risk given ICI use in breast cancer remains relatively limited. While TT's mode of action indicates a potential ability to stimulate an immune response and potentially modulate the tumour microenvironment, any hypothesis around converting immunologically 'cold' tumours into 'hot' tumours will require substantial clinical work and validation.

Upside optionality from EBC-1013 in wound healing

While the clear focus for QBiotics is on TT, we believe that EBC-1013 represents an incremental medium-term diversification opportunity for the company, supported by a large addressable population and relatively lower development costs. As previously highlighted, QBiotics is evaluating EBC-1013 as a novel topical pharmacological wound care treatment, with an initial focus on VLUs.

A Phase I, multi-centre, dose-escalation study is underway to evaluate the safety and tolerability of EBC-1013 gel in patients with VLUs, with planned enrolment of approximately 21–33 participants. Wound healing and quality of life measures are expected to be assessed as exploratory endpoints. At this stage, no human clinical efficacy data are available, and the programme remains early and high risk. While supportive findings have been reported from veterinary case studies, suggesting potential wound-healing activity, the extent to which these observations translate into human clinical outcomes remains to be confirmed.

We note that there are currently no approved topical treatments for VLUs, with the segment dominated by compression therapy and wound dressings that primarily serve supportive functions rather than actively drive healing. As a result, clinical outcomes remain suboptimal, with a large proportion of patients experiencing chronic, slow-healing wounds, highlighting a clear unmet need for therapies that can accelerate tissue repair.

QBiotics is positioning EBC-1013 as an active treatment applied topically, with the potential to enhance wound healing rather than simply maintain a favourable environment. We believe this positions EBC-1013 favourably, as a complement to the existing standard of care, potentially allowing for easier integration into the treatment pathway. We believe that the

most relevant patient group will be patients with hard-to-heal or non-responsive ulcers, where incremental clinical benefit can be clearly demonstrated.

From a modelling perspective, we assume a US VLU population of c 600,000 patients annually seeking treatment (1% y-o-y growth), with EBC-1013 achieving peak penetration of 10%, reflecting its adjunctive use in a subset of patients. We assume a per patient treatment cost of c $1,500, supporting accessibility while maintaining attractive unit economics. This results in peak global revenues of c $260m, which we believe will be achieved in 2041, following launch in 2035. This translates to an NPV of $122.3m or an rNPV of $12.2m (A$17.1m), assuming a 10% probability of success (given the early stage of clinical development) and a 15% discount rate.

If QBiotics successfully establishes proof of concept in VLUs, we believe this could materially de-risk EBC-1013's broader applicability across other hard-to-treat wounds and burns. Management has specifically highlighted diabetic foot ulcers (DFUs) as a key adjacent indication. The global DFU treatment market was valued at $9.4bn in 2025 and is projected to reach $16.4bn by 2034 (6.4% CAGR, according to Fortune Business Insights), underscoring a meaningful commercial opportunity. Notably, the current treatment landscape remains limited, with becaplermin representing the only approved topical gel therapy. In our view, an effective topical agent with differentiated efficacy could capture significant share in this underserved market. That said, in the absence of clinical data in DFUs, we do not currently incorporate this indication into our valuation framework for QBiotics.

Stelfonta: Commercial-stage with potential to be unlocked

Stelfonta represents the veterinary oncology analogue of TT, providing a useful proof-of-concept for the mode of action in a commercial setting. Developed for the treatment of canine, non-metastatic mast cell tumours, Stelfonta was commercialised via a partnership with Virbac (launched in 2020/21), leveraging its established global animal health distribution network. The agreement concluded in early 2026 and QBiotics is in the process of finalising a new distribution partnership before recommencing sales. While we note that initial sales for the product have been modest, management remains confident in the treatment's potential (treatment efficacy has been encouraging) and will continue to pursue this market opportunity. We model Stelfonta achieving a peak market penetration of 10%, which equates to a treatment pool of c 25,000 dogs with localised, mast cell tumours per year. Assuming an effective treatment price of $1,500/patient, we project peak sales potential of c $40m in the US and c $70m globally for the treatment, to be achieved in 2031. Assuming a transfer pricing model with the new partner, we model an economic share of 20% of sales for Stelfonta. Although Stelfonta is a commercial-stage asset, we apply an 80% PoS to reflect current uncertainty around the re-establishment of distribution. This yields an NPV of $16.4m or an rNPV of $13.2m (A$18.4m).

Valuation: enterprise value assessed at A$361m

Incorporating our core pipeline assumptions and the latest net cash position, we derive a base-case valuation for QBiotics of A$361m or 73.7c/share. Exhibit 10 presents a breakdown of our valuation for the company by indication.

Exhibit 10: QBiotics risk-adjusted NPV valuation

Product	Indication	Treatment positioning	Expected launch	Global peak sales ($m)	NPV (A$m)	PoS	rNPV (A$m)	rNPV/share (Ac)
TT	Soft tissue sarcomas (STS)	Advanced unresectable STS (adjunct to first-line doxorubicin)	2032	300	284.7	20%	56.5	11.5
		Advanced unresectable STS (second-line combination with checkpoint inhibitors)	2033	503	453.1	10%	45.0	9.2
		Early-stage STS (neoadjuvant for localised/accessible tumours)	2034	282	212.4	10%	21.1	4.3
	Head and neck cancer (HNC)	Locally advanced HNC (monotherapy)	2033	603	535.2	20%	106.3	21.7
		Recurrent/metastatic HNC (first-line combination with checkpoint inhibitors)	2034	469	342.3	10%	34.0	6.9
	Breast cancer (BC)	Recurrent BC (skin and chest wall recurrence)	2034	727	480.9	7.5%	35.8	7.3
		Metastatic BC (combination with checkpoint inhibitors)	2035	210	110.7	5%	5.5	1.1
EBC-1013	Venous leg ulcers (VLU)	Topical treatment for wound healing	2035	257	171.3	10%	17.1	3.5
Stelfonta	Mast cell tumours (MCT)	Non-metastatic cutaneous and subcutaneous MCTs	On market	68	23.0	80%	18.4	3.8
Pro-forma net cash at end-December 2025					21.2	100%	21.2	4.3
Valuation				**3,418**	**2,635**		**361**	**73.7**

Source: Edison Investment Research

Our base case rNPV valuation for QBiotics, as presented above, is heavily reliant on our market estimates, risk adjustments and discount rates. Given that these are subject to variability, we also present a sensitivity table that provides the range of valuations, based on different success probabilities and discount rates. We use only the most clinically advanced clinical programme for this exercise: advanced unresectable STS (adjunct to first-line doxorubicin) (Exhibit 11).

Exhibit 11: Sensitivity of rNPV/share (Ac) to success probabilities and discount rates

		Discount rates						
		7.5%	10.0%	12.5%	15.0%	17.5%	20.0%	22.5%
Probability of Success	5.0%	151.7	112.7	85.0	65.0	50.4	39.7	31.7
	10.0%	158.5	117.8	88.8	67.9	52.6	41.4	33.0
	15.0%	165.4	122.9	92.6	70.8	54.8	43.1	34.3
	20.0%	172.3	128.0	96.4	**73.7**	57.0	44.8	35.6
	30.0%	186.0	138.2	104.1	79.4	61.4	48.2	38.3
	40.0%	199.8	148.4	111.7	85.2	65.9	51.6	40.9
	50.0%	213.6	158.6	119.4	91.0	70.3	54.9	43.5

Source: Edison Investment Research

The table above demonstrates the meaningful sensitivity of our valuation for QBiotics to both PoS and the applied discount rate. The valuation expands materially at higher PoS assumptions (A$0.91/share at a 50% PoS), reflecting the binary and step-change nature of clinical de-risking. Conversely, increases in the discount rate have a dampening effect, compressing the valuation as future cash flows are more heavily discounted. The interaction of these variables produces a broad valuation range, reinforcing that our base-case should be viewed as one point within a wider, risk-adjusted spectrum of potential outcomes.

Partnering potential

While our base-case valuation assumes self-commercialisation of QBiotics' lead assets, we acknowledge that a licensing or co-development partnership with a larger pharmaceutical player represents a more realistic and preferred route to market, particularly given the capital intensity and infrastructure required to commercialise oncology therapeutics

globally. Such a structure involves upfront payments, development and commercial milestones and royalties, and while this may reduce peak revenue capture relative to full commercialisation, it would also lower funding requirements and execution risk and could provide external validation of the TT platform.

To contextualise potential partnering outcomes for QBiotics, we highlight a selection of precedent transactions involving intratumoral and locally delivered oncology assets (Exhibit 12).

Exhibit 12: Select intratumoral licensing deals

Date	Acquirer/ partner	Target/ licensor	Asset	Modality	Stage at deal	Deal value	Upfront	Key details/strategic context	Relevance to QBiotics
Mar-11	Amgen	BioVex (private)	T-VEC (OncoVEX GM-CSF)	Oncolytic virus (intratumoral)	Phase III	Up to ~$1.0bn	~$425m	Milestone-heavy (~US$575m); late-stage asset; FDA approved in 2015; only approved oncolytic virus in US/EU	Demonstrates significant valuation uplift at late stage; validates intratumoral IO modality and regulatory pathway
Feb-18	Merck	Viralytics	CAVATAK (CVA21)	Oncolytic virus (intratumoral/systemic)	Phase I/II	~$394m (A$502m)	100% acquisition	~160% premium to pre-bid market cap (~A$190–200m); evaluated with pembrolizumab; early clinical efficacy	Relevant mid-stage precedent; highlights strategic value of Phase I/II intratumoral assets with IO combination potential
Aug-23	Johnson & Johnson (Janssen)	Nanobiotix	NBTXR3	Radioenhancer (intratumoral adjunct)	Phase II/III	Up to ~$2.6bn	~$60m	Global licensing deal; multi-indication platform; strong combination potential with radiotherapy/IO	Highlights premium for platform assets with broad applicability; relevant for TT's multi-indication potential

Source: EvaluatePharma, Edison Investment Research

While deal activity in this niche remains relatively limited, these deals demonstrate the significant step-up in value associated with clinical proof-of-concept, as well as strong strategic interest from large pharmaceutical companies. In particular, these transactions demonstrate that differentiated platforms with combination potential and applicability across multiple tumour types can attract substantial upfront payments and milestone-driven deal structures. In our view, a successful Phase II readout for QBiotics' TT platform could position the company to pursue a similar licensing or strategic transaction, providing a meaningful valuation inflection beyond our base-case assumptions.

Risks and sensitivities

As a clinical-stage biotech, QBiotics is subject to risks typical of early-stage drug development, with clinical outcomes representing the most significant inflection points. While TT has shown encouraging early efficacy signals, these findings are based on limited patient cohorts and require validation in larger, more diverse populations. Clinical development inherently carries uncertainty, including binary event risks, and future trials may not replicate the response rates or durability observed to date. While TT's 'pipeline-in-a-product' potential somewhat mitigates the binary event risk, the investment case remains closely tied to the successful progression of the lead programme.

Regulatory risk is also a key consideration. The clinical study design pathway to approval for TT is yet to be defined, and its intratumoural mode of delivery may be a key consideration. While such therapies can offer potential advantages, their adoption has historically been limited, reflecting considerations such as tumour accessibility and clinical practice integration; though we note that clinical feedback thus far for TT has been supportive. While designations such as ODD may support expedited pathways, approval will ultimately depend on demonstrating clear clinical benefit in well-controlled studies (ie randomised, double-blind, placebo-controlled). The design and execution of these trials will be critical in determining regulatory outcomes.

From a commercial perspective, QBiotics will need to establish a clear positioning for TT within increasingly competitive (for HNC, less so for STS) and rapidly evolving oncology landscapes. While the asset may offer complementary benefits, particularly alongside systemic therapies, its role in clinical practice remains to be defined. Adoption will depend on not only showing efficacy and safety, but also practical advantages relative to existing treatments, including ease of use and impact on quality of life. These considerations apply regardless of whether development is undertaken independently or in partnership.

Financing risk remains a crucial factor. As a pre-revenue company (except for Stelfonta), QBiotics relies largely

on external capital to fund operations and clinical development. While the planned fundraise is expected to extend the company's cash runway, additional funding may be required to support later-stage development, particularly in the absence of a strategic partnership. The timing and terms of future financing, including any potential partnership agreements, may affect shareholder value and are inherently challenging to predict.

Execution risk spans all aspects of the development process, including trial design, patient recruitment and operational timelines. Delays or challenges in any of these areas could affect the pace of development and, consequently, the timing of key value inflection points. More broadly, QBiotics must demonstrate that TT can deliver consistent and scalable outcomes across indications, while establishing a clear role within the treatment paradigm.

Conclusion and outlook

QBiotics presents a differentiated clinical-stage opportunity, centred on TT and its novel intratumoural approach. The asset has demonstrated encouraging early clinical activity, and its positioning alongside existing treatment regimens may support future adoption and partnering interest.

In our view, the characteristics that may enable QBiotics to move beyond a typical small-cap biotech profile include:

- a differentiated intratumoural modality that has the potential to complement existing therapies;
- early clinical data that are both visible and indicative of potential durability;
- a platform with demonstrated biological breadth and translational validation; and
- a development strategy aligned with anticipated partner expectations, with promise in combination treatment regimens, a highly sought after approach.

Looking ahead, value creation is expected to be driven by continued clinical progress and strategic execution, including advancement through key development milestones and potential partnering activity. While risks remain inherent, particularly around clinical validation and positioning, it is our opinion that successful delivery could support meaningful value creation.

Appendix

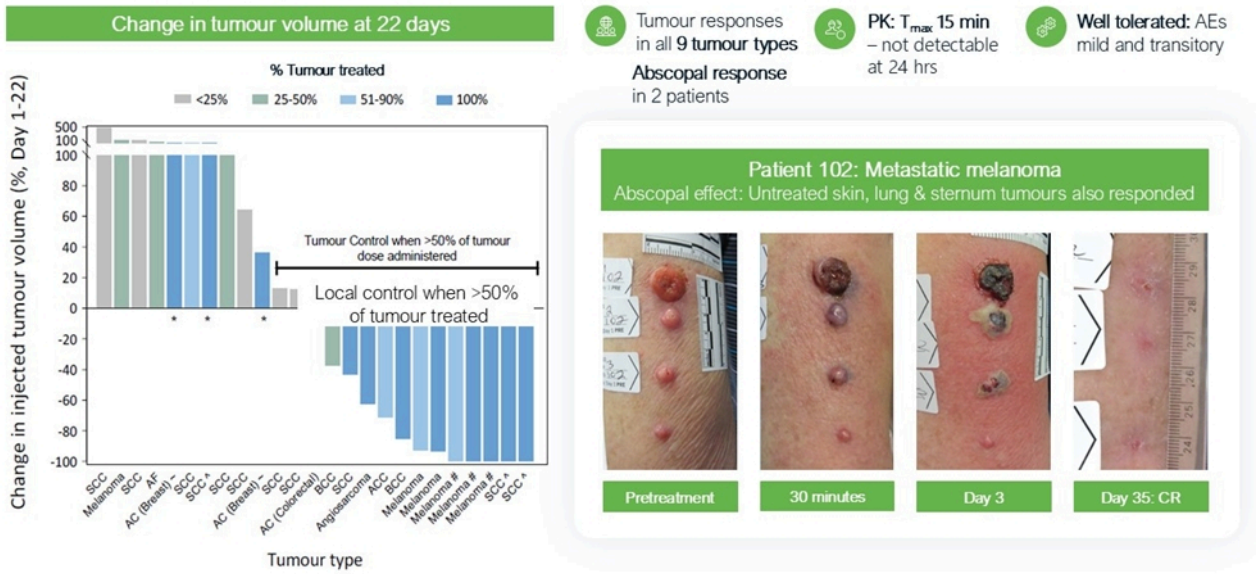
Supplementary figures

Exhibit 13: Financial Summary

A$'000s	2023	2024	2025	2026e	2027e
Year-end 30 June	IFRS	IFRS	IFRS	IFRS	IFRS
PROFIT & LOSS					
Revenue	11,146.9	8,702.1	7,331.6	8,238.8	6,510.6
Product sales	2,508.4	1,284.8	838.5	1,223.1	0.0
R&D tax credit	8,631.7	7,402.0	6,476.5	7,000.7	6,510.6
Others	6.8	15.4	16.5	15.0	0.0
Cost of Sales	(1,817.8)	(546.1)	(1,755.0)	(764.9)	(153.0)
Gross Profit	9,329.1	8,156.0	5,576.6	7,473.9	6,357.6
R&D expenses	(14,388.6)	(11,695.5)	(11,667.8)	(13,021.2)	(18,765.0)
G&A expenses	(17,845.2)	(14,830.2)	(15,223.5)	(16,362.5)	(15,544.3)
Other expenses	(352.2)	(279.8)	(341.4)	(267.5)	(267.5)
EBITDA	(23,256.9)	(18,649.5)	(21,656.1)	(22,177.3)	(28,219.2)
Operating Profit/ (loss)(before amort. and except.)	(23,975.5)	(19,507.2)	(22,543.9)	(23,173.0)	(29,314.6)
Intangible Amortisation	(34.1)	(38.9)	(36.5)	(37.2)	(38.0)
Exceptionals	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0
Operating Profit	(24,009.6)	(19,546.1)	(22,580.4)	(23,210.3)	(29,352.6)
Net Interest	2,387.8	2,035.3	1,947.0	742.5	589.0
Profit Before Tax (norm)	(21,587.7)	(17,472.0)	(20,596.9)	(22,430.5)	(28,725.6)
Profit Before Tax	(21,621.8)	(17,510.9)	(20,633.4)	(22,467.8)	(28,763.6)
Tax	0.0	0.0	0.0	0.0	0.0
Profit After Tax (norm)	(21,587.7)	(17,472.0)	(20,596.9)	(22,430.5)	(28,725.6)
Profit After Tax	(21,621.8)	(17,510.9)	(20,633.4)	(22,467.8)	(28,763.6)
Average Number of Shares Outstanding (m)	488.0	488.2	488.5	489.7	489.7
EPS - normalised (c)	(4.42)	(3.58)	(4.22)	(4.58)	(5.87)
EPS - (IFRS) (c)	(4.43)	(3.59)	(4.22)	(4.59)	(5.87)
BALANCE SHEET					
Fixed Assets	8,887.5	8,078.3	3,918.4	3,085.4	2,152.1
Intangible Assets	433.5	394.6	358.1	320.9	282.9
Tangible Assets	4,325.5	4,036.4	3,407.4	2,611.6	1,716.3
Others	4,128.5	3,647.3	152.9	152.9	152.9
Current Assets	71,688.4	54,407.8	36,619.3	35,602.8	33,938.2
Stocks	1,453.7	839.0	589.8	118.0	23.6
Debtors	9,682.1	8,196.5	7,005.8	12,610.4	22,698.7
Cash	6,130.2	6,927.3	10,293.6	20,047.1	9,121.0
Term deposits	52,966.0	36,552.0	15,461.1	0.0	0.0
Other	1,456.5	1,893.1	3,269.0	2,827.3	2,094.9
Current Liabilities	6,412.0	5,891.8	4,146.4	4,872.2	6,036.9
Creditors	3,977.2	3,231.5	2,227.1	3,117.9	4,365.0
Short-term borrowings	0.0	0.0	0.0	0.0	0.0
Lease liabilities and others	2,434.8	2,660.3	1,919.4	1,754.4	1,671.9
Long-Term Liabilities	1,435.7	852.0	423.5	20,315.9	45,316.9
Long-term borrowings	0.0	0.0	0.0	20,000.0	45,000.0
Lease liabilities and other long-term liabilities	1,435.7	852.0	423.5	315.9	316.9
Net Assets	72,728.2	55,742.3	35,967.8	13,500.0	(15,263.6)
CASH FLOW					
Operating Cash Flow	(25,372.5)	(17,223.6)	(18,864.8)	(25,235.0)	(35,644.6)
Net interest	1,362.8	2,551.6	1,925.3	0.0	0.0
Tax	0.0	0.0	0.0	0.0	0.0
Capex	(772.8)	(343.1)	(190.7)	(200.0)	(200.0)
Proceeds from term deposits	12,953.7	16,414.0	21,090.8	15,461.1	0.0
Financing	169.2	0.0	0.0	20,000.0	25,000.0
Others	(488.7)	(601.8)	(594.3)	(272.6)	(81.5)
Net Cash Flow	(12,148.2)	797.1	3,366.3	9,753.5	(10,926.1)
Opening net debt/(cash)	(18,278.4)	(6,130.2)	(6,927.3)	(10,293.6)	(20,047.1)
HP finance leases initiated	0	0	0	0	0
Other	0	0	0	0	0
Closing net debt/(cash)	(6,130.2)	(6,927.3)	(10,293.6)	(20,047.1)	(9,121.0)

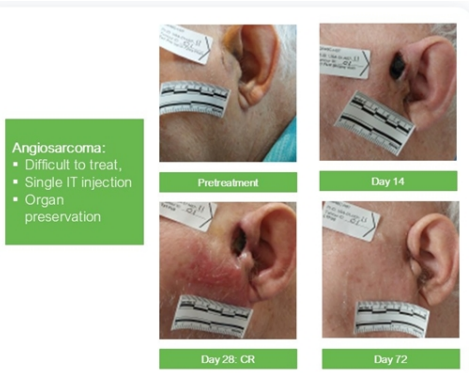
Source: Company data, Edison Investment Research

Exhibit 14: Phase I outcomes for TT



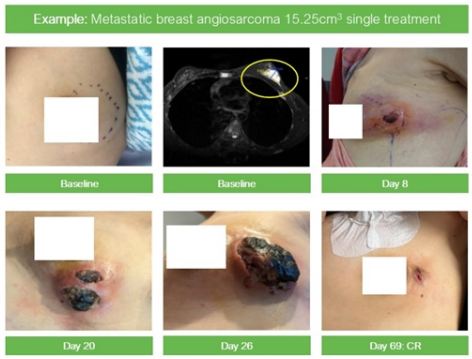
Source: QBiotics corporate presentation (April 2026)

Exhibit 15: QB46C-H07 outcome for an angiosarcoma patient with a complete response by day 28



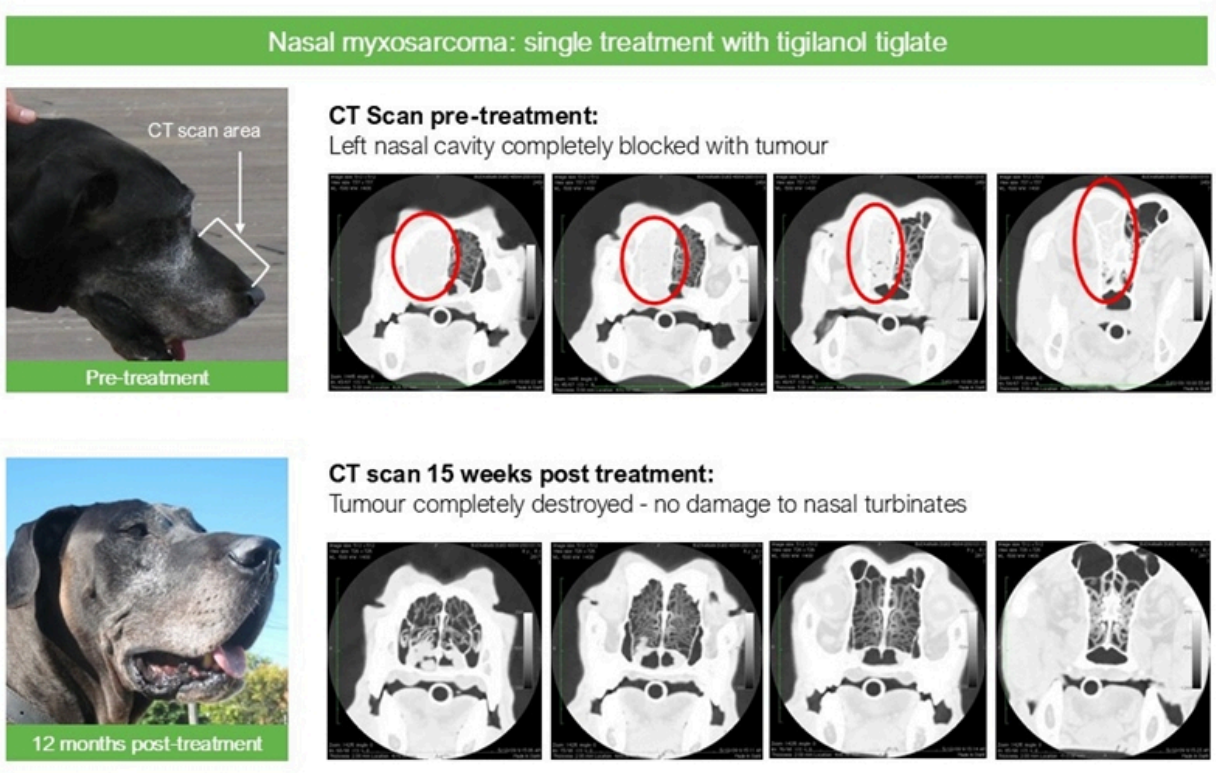
Source: QBiotics corporate presentation (April 2026)

Exhibit 16: Metastatic breast angiosarcoma patient case study with a complete response by day 69



Source: QBiotics corporate presentation (April 2026)

Exhibit 17: Vet case study of solid tumour single treatment with tigilanol tiglate



Source: QBiotics resources

Exhibit 18: Vet case studies of wound healing treatment with EBC-1013 gel

Source: QBiotics corporate presentation (April 2026)

Board of directors and executive leadership team

The board and executive management of QBiotics comprise an experienced leadership team with backgrounds across biotechnology, drug development, commercialisation, capital markets and corporate governance. Collectively, the team

brings robust scientific, clinical, operational, financial and partnering capability, supporting the company's strategy from early-stage research through to advanced development and commercialisation. Consistent with its focus on best-practice governance and continuous board renewal, the company has identified the need to further strengthen the board through the appointment of independent non-executive directors and is already in active discussions with suitably qualified candidates.

The board currently consists of Simon Pollard as non-executive chairman, together with three executive directors: co-founders Dr Victoria Gordon and Dr Paul Reddell, and interim chief executive officer Ebru Davidson.

Non-executive chairman: Simon Pollard. Mr Simon Pollard is an experienced director and senior executive with a background in strategy, governance, capital markets and global commercialisation. He is a long-term QBiotics investor and served as chief commercial officer from 2016–2019. Over 25 years, he has held senior roles at Macquarie Group, IBM and HSBC, leading large-scale operations and driving revenue growth across Asia-Pacific, Europe and the US. He has extensive board, chair and advisory experience across public and private companies, with a track record in capital raising, M&A, partnerships and commercialisation of healthcare, life sciences and technology assets. More recently, he has focused on non-executive director roles, mentoring and investing in biotech, software and AI startups. He is chairman of Yarken and Valorica. Earlier, he was partner and co-head of technology law at Gilbert+Tobin. He holds a BA in economics, an LLB and an LLM.

Executive director, chief strategy officer and co-founder: Dr Victoria Gordon, PhD, FTSE. Dr Victoria Gordon has 25+ years' experience in biotechnology with extensive executive and governance experience across drug discovery and development, investment, commercialisation, investor relations and strategic partnerships. She founded EcoBiotics in 2000 and QBiotics in 2010, leading the merger forming QBiotics Group in 2017 and serving as CEO and managing director from 2000 to 2023 before transitioning to chief strategy officer and executive director. She was elected a fellow of the Australian Academy of Technological Sciences and Engineering in 2025 for contributions to medical innovation. Prior to founding EcoBiotics, she was a research scientist with the CSIRO. Relevant board and advisory roles include Biopharmaceuticals Australia, the Australian Rainforest Foundation, the QLD Government Biotechnology Advisory Council and Federal Government Expert Forums on Biomedicine and Environmental Biotechnology. She holds a PhD in microbiology, a BAppSc (Hons) in chemistry and biology and is a Graduate of the Australian Institute of Company Directors.

Executive director, chief scientific officer and co-founder: Dr Paul Reddell, PhD. Dr Paul Reddell is a biotechnology executive and co-founder of EcoBiotics, QBiotics and the QBiotics Group, serving as chief scientific officer since 2000. He has extensive experience in scientific leadership, translational research and complex multi-institutional research and development projects, leading drug discovery and development initiatives and strategic scientific partnerships to advance novel therapeutics. Prior to EcoBiotics, he held senior leadership roles at CSIRO, including senior principal research scientist and programme leader at the Tropical Forest Research Centre, and he later served as principal plant ecologist within a Rio Tinto Group environmental consulting business. He holds a PhD in forest ecology and a BSc (Hons) from the University of Western Australia and has been a fellow of the Australian Institute of Company Directors since 2007.

Interim CEO and managing director: Ms Ebru Davidson. Ms Ebru Davidson brings 17+ years' experience in commercial law, governance, equity capital markets, M&A, corporate transactions and regulatory matters across listed and unlisted companies. She advised QBiotics from 2015–21 and joined as general counsel in 2021, where she supported board matters, investor engagement and corporate governance to advance the company's strategic and capital markets objectives. Previously, she was a partner in Thomson Geer's equity capital markets team. She holds a BSc from the University of Melbourne and a Juris Doctor (Hons) from Bond University. She is an associate member of the Governance Institute of Australia, a graduate of the Australian Institute of Company Directors, and she serves as a non-executive director of Kazia Therapeutics (NASDAQ: KZIA) and the Centre for Eye Research Australia.

Chief operating officer: Dr Peter Schmidt, PhD. Dr Peter Schmidt has extensive experience in developing drug candidates for TGA and FDA submissions through to clinical phase III, including preparation of chemistry, manufacturing and controls (CMC) and preclinical data packages for Investigational New Drug applications and support of clinical Phase I and II programmes. His human drug development experience strengthens QBiotics' veterinary drug development team. Prior to joining QBiotics, he was director of CMC and preclinical drug development at Xenome for six years. Earlier roles included senior scientist at Agen Biomedical and professional officer at the Australian Nuclear Science and Technology Organisation. He holds a PhD in experimental medicine and a BSc (Hons).

Global investor relations officer: Mr Andrew Craig. Mr Andrew Craig is an investment banker with nearly 30 years' experience in global capital markets, beginning at SBC Warburg (now UBS) and later holding senior equity roles in London and New York, advising institutional investors and public company leadership teams. From 2015–21, he was

partner at life sciences investment bank WG Partners, advising 60+ biotechnology companies. He has met with senior management teams from 1,000+ companies, contributing to transactions including Sweden's US$7.6bn selldown of Nordea Bank AB and IPOs for easyJet, Burberry, Campari and lastminute.com. He is a bestselling author of *How to Own the World* and *Our Future is Biotech* (2024), focused on biotechnology's role in health, sustainability and economic development. He founded Plain English Finance and is a UK media commentator. He holds a bachelor of social science (economics and politics) from the University of Birmingham and is a chartered member of the CISI.

Chief financial officer: Mr Brendan Brown. Mr Brendan Brown is a partner and director at Prime Accounting & Business Advisory, part of the Prime Financial Group. He is a chartered accountant (CA ANZ) and registered tax agent with more than 20 years' experience. With a background in accounting and business advisory (particularly in the life sciences sector), he brings significant experience to QBiotics' financial strategy and operations. He has a strong track record in supporting executive teams through growth, operational scaling and capital market engagement, with responsibility for financial governance, risk management and performance optimisation. He is recognised in the Research & Development Tax Incentive and other Australian government funding programmes. He holds a bachelor of business (accounting) from La Trobe University.

Clinical advisory board

Prof Alexander Eggermont, MD, PhD (board chairperson). Professor Alexander Eggermont is a recognised oncology key opinion leader with more than 37 years' experience in clinical immunotherapy, melanoma, sarcoma, drug development and translational tumour immunology. He is chief scientific officer at the Princess Máxima Center for Paediatric Oncology, professor of clinical and translational immunotherapy at University Medical Center Utrecht, and coordinator of the Comprehensive Cancer Center Program Deutsche Krebshilfe. He holds board roles with the Comprehensive Cancer Center Munich, Technical University Munich and Ludwig Maximilians University, and is strategic adviser for DKFZ-NCT Heidelberg within Germany's National Center for Tumours Program. Previously director general of Gustave Roussy Cancer Campus Grand Paris, he has served as president of ECCO and EORTC, board director of ASCO, and held editorial roles with the *Journal of Clinical Oncology*. He is currently editor-in-chief of the *European Journal of Cancer*. He has authored 1,000+ peer-reviewed publications and received international awards, including Chevalier of the Légion d'Honneur (2015).

Prof Kevin Harrington, FRCP, FRCR, FRSB, PhD. Professor Kevin Harrington is a senior investigator at the National Institute for Health and Care Research and head of radiotherapy and imaging at the Institute of Cancer Research (ICR)/Royal Marsden Hospital (RMH). He is director of the ICR/RMH CRUK RadNet Centre of Excellence and a leading international key opinion leader in oncology and drug development. His research spans immunotherapy, targeted radiation sensitisers and oncolytic virotherapy, including DNA and RNA viral platforms such as HSV-based agents (talimogene laherparepvec, RP1, RP2, RP3), vaccinia, reovirus, coxsackievirus A21, Maraba and Newcastle Disease virus across translational and clinical development. He has received major honours including the 2019 British Association of Head and Neck Oncology President's Award and lectureships in 2021 (Semon), 2023 (Elia) and 2024 (Tata). He has authored 600+ peer-reviewed publications and 50+ book chapters and is a Clarivate Highly Cited Researcher (2021–23).

Prof Aurelien Marabelle, MD, PhD. Professor Aurelien Marabelle is a senior oncologist and an internationally recognised key opinion leader in oncology and drug development at Gustave Roussy Cancer Center, Paris, within the drug development department. He is also professor of clinical immunology at the University of Paris-Saclay, with a clinical focus on early-phase cancer immunotherapy trials across tumour types. He directs the Clinical Investigation Centre BIOTHERIS, specialising in intratumoural immunotherapies. He trained at École Normale Supérieure de Lyon, King's College London and Léon Bérard Cancer Center, and completed a postdoctoral fellowship with Professor Ronald Levy at Stanford University, where he returned as visiting professor in 2021. He is an active member of ESMO, ASCO, AACR, SITC and EATI, and he co-founded and serves as vice-president of the French Society for Cancer Immunotherapies (FITC). He has published 250+ peer-reviewed papers with an h-index of 62.

Prof Ignacio Melero, MD, PhD. Professor Ignacio Melero is an internationally recognised key opinion leader in oncology and drug development with more than 36 years' experience in immunology and immunotherapy. Since 2015, he has been co-director of the immunology and immunotherapy service at the University of Navarra, with a translational research focus spanning experimental models through to clinical trials in cancer immunology. He also holds senior editorial roles, including senior editor of *Clinical Cancer Research*, scientific editor of *Cancer Discovery*, associate editor of *Frontiers in Immunology*, and section editor of the *Journal for Immunotherapy of Cancer*. He sits on multiple editorial boards, including *Immunotherapy*, *Oncoimmunology*, *Cancer Immunology Research* and *Cancer Research*. He is a member of external advisory boards for the Curie Institute, Gustave Roussy Institute, Biomedical Research Institute of

Granada and the Netherlands Cancer Institute.

Assoc Prof Jason Luke MD, FACP. Dr Jason Luke is one of the noteworthy clinical-translational investigators in immuno-oncology and an associate professor of medicine at the University of Pittsburgh, director of the Immunotherapy and Drug Development Center and associate director for clinical research at the UPMC Hillman Cancer Center. He has been a lead investigator on clinical trials of immunotherapy agents, including but not limited to novel immune checkpoints, bispecific antibodies, innate immune-modifiers and oncolytic viruses, immune-metabolism and cellular therapies in solid tumours. He conceived of and was the principal investigator for the KEYNOTE-716 trial that changed the landscape of stage II melanoma oncology and underpinned the FDA and EMA approval of pembrolizumab in this setting.

Dr Edmund Bartlett, MD. Dr Edmund Bartlett is an assistant attending surgeon in the gastric and mixed tumour service at Memorial Sloan Kettering Cancer Center in New York City, specialising in cutaneous malignancies and sarcoma. He is a clinical and translational surgeon-scientist focused on improving the efficacy of oncology drug development, particularly immunotherapeutics in sarcoma. He is co-principal investigator on a trial combining PD-1 and adenosine receptor inhibition in dedifferentiated liposarcoma, principal investigator on a study combining pembrolizumab with isolated limb infusion of melphalan and dactinomycin in extremity sarcoma (NCT04332874), and principal investigator on a trial evaluating intratumoural tigilanol tiglate in soft tissue sarcoma (NCT05755113).

Dr Alan Barge, MBBS, MRCP. Dr Alan Barge trained in medicine at Oxford and London, specialising in leukaemia and bone-marrow transplantation. He joined Amgen in 1990 as European medical director, leading global development of Neupogen (filgrastim) across cancer, leukaemia, HIV and infectious disease indications. In 1999, he joined AstraZeneca, overseeing early-phase oncology development and advancing multiple first-in-human programs, including Gefitinib (Iressa) and Olaparib (Lynparza). In 2003 he became vice president of clinical development and head of oncology and infection, leading global execution of AstraZeneca's oncology portfolio. He left AstraZeneca in 2011 to co-found ASLAN Pharmaceuticals, focused on Asia-prevalent cancers, and in 2016 co-founded Carrick Therapeutics, specialising in early-stage oncology assets.

Scientific advisory board

Prof David Thomas BDS, FDSRCS, FDSRCSEng (ad eundem), PhD (board chairperson). Professor David Thomas is a leading scientist and clinician with more than 40 years' experience in oral and maxillofacial surgery, with research spanning wound healing, nanomedicines, tissue engineering and antimicrobial therapies. He is professor and honorary consultant at Cardiff University and leads the advanced therapies group. His work has advanced understanding of microbiome, biofilms and chronic wound biology, supported by more than £15m in funding. He co-founded the Cardiff Institute of Tissue Engineering and Repair and has advanced polymer therapies to Phase II trials, including OligoG, which received US FDA Orphan Drug Status. He also collaborates with QBiotics on rainforest-derived antimicrobials targeting multidrug-resistant infections. He has held senior leadership roles including president of the Academic Association of British Oral and Maxillofacial Surgeons and innovation lead at Cardiff University. He has an h-index of 53 with 8,500+ citations and holds honours including the King James IV Professorship and Fellowship of the Learned Society of Wales.

Prof Timothy Walsh, PhD, DSc, MAE, OBE. Professor Timothy Walsh OBE is professor of medical microbiology and antimicrobial resistance and director of biology at the Ineos Oxford Institute for Antimicrobial Research, University of Oxford. He is a globally recognised leading scientist with more than 30 years' experience in antimicrobial resistance (AMR). He discovered and named two major resistance genes: NDM, now a dominant global carbapenemase, and MCR-1, a plasmid-mediated colistin resistance gene co-discovered in 2015. He also co-discovered TetX, a key tigecycline resistance mechanism. Through unique models with collaborators, he has shown that microplastics and rising temperatures accelerate AMR spread, reshaping global intervention approaches. He currently leads two major AMR burden studies in LMICs - BARNARDS (neonates) and BALANCE (adults). He contributed to China's 2017 ban on colistin in agriculture and advises the WHO, national health ministries, the Chinese CDC and ENABLE 2. He was appointed OBE in 2020 for services to microbiology and international development, was awarded his DSc in 2022, and is a member of Academia Europaea (2023).

Prof Aurelien Marabelle, MD, PhD. Professor Aurelien Marabelle is a senior oncologist and an internationally recognised key opinion leader in oncology and drug development at Gustave Roussy Cancer Center, Paris, within the drug development department. He is also professor of clinical immunology at the University of Paris-Saclay, with a clinical focus on early-phase cancer immunotherapy trials across tumour types. He directs the Clinical Investigation Centre BIOTHERIS, specialising in intratumoural immunotherapies. He trained at École Normale Supérieure de Lyon, King's College London and Léon Bérard Cancer Center, and completed a postdoctoral fellowship with Professor

Ronald Levy at Stanford University, where he returned as visiting professor in 2021. He is an active member of ESMO, ASCO, AACR, SITC and EATI, and he co-founded and serves as vice-president of the French Society for Cancer Immunotherapies (FITC). He has published 250+ peer-reviewed papers with an h-index of 62.

Prof Thomas Wishart, BSc, MBA, PhD, FRSB, FAS. Professor Thomas Wishart is a leading scientist in molecular anatomy. Formerly co-head of Translational Biomarker Discovery at the Centre for Dementia Prevention and deputy director of the Roslin Institute (University of Edinburgh), he currently leads neuroscience activity at the School of Science and Technology, Nottingham Trent University. He also leads the ALLMoND programme (Academic Led Livestock Models of Neurological Disorders) at the Roslin Institute. His research focuses on neurodegenerative disease mechanisms, including synaptic vulnerability, multi-omics biomarkers and clinically relevant animal models. He is well known for his research advancing understanding of conditions such as motor neurone disease – both adult onset (ALS) and childhood onset (ie SMA with patent applications for therapeutics). He is also an expert in dementia, again including both adult onset forms such as Alzheimer's disease, and childhood dementias (such as Batten disease) with expertise in therapeutic assessments including cross-species efficacy of enzyme replacement therapy (JCI, 2022) and viral interventions (Molecular Therapies, 2025) for CLN1 disease in mouse and sheep models. He has 80+ peer-reviewed publications and an h-index of 38. Professor Wishart has secured millions of pounds in competitive funding, including NIH R01 support and industry partnerships. He is a fellow of the Royal Society of Biology (2021) and the Anatomical Society (2018).

Prof Andrew Sewell, BPharm, PhD, FBPhS. Professor Andrew Sewell is a leading scientist and distinguished research professor at Cardiff University, specialising in T-cell biology and cancer immunotherapy. With more than 30 years' experience in viral immunology, autoimmunity and translational oncology, he is internationally recognised for experience in T-cell receptor biology and therapeutic application. His work includes landmark discoveries in HIV immune escape, T-cell cross-reactivity and epitope recognition, including showing that a single T-cell receptor can recognise more than 1m peptides. He pioneered combinatorial peptide library approaches for epitope mapping and co-developed VDJdb, a leading T-cell receptor specificity database. His group also demonstrated that CRISPR-mediated TCR replacement can generate highly sensitive anticancer T-cells, advancing next-generation immunotherapy. His research has strong translational impact, contributing to spinouts including Avidex, Adaptimmune and Immunocore, the latter achieving FDA approval of tebentafusp for metastatic uveal melanoma. He holds a Wellcome Trust Senior Investigator Award and received the Genentech Distinguished Research Award (2023).

Prof Giovanni Appendino, PhD. Professor Giovanni Appendino is a leading scientist and emeritus professor of organic chemistry at the Università del Piemonte Orientale, Italy, where he served as full professor until 2022. He is a highly distinguished natural products chemist with a four-decade career spanning organic chemistry, pharmacology and chemical biology. His work focuses on natural product discovery and synthesis, including isolation of more than 200 novel compounds and development of new synthetic methodologies. Key areas include cannabinoids, taxoids and isoprenoids, with translational work in collaboration with the University of Córdoba producing clinical candidates VCE-004.8 and VCE-003.2 with Orphan Drug Status in the EU and USA. He has authored 429 publications with 16,505+ citations, an h-index of 65 and 14 patents, placing him among the world's top 2% of scientists. He has received major international honours including the Egon Stahl Gold Award (2023) and held senior editorial roles, including editor-in-chief of *Fitoterapia* (2009–22).

Prof Kelly Blacklock, BVM&S PhD, DipECVS, FRCVS. Professor Kelly Blacklock is a leading scientist in small animal soft tissue surgery at the Royal (Dick) School of Veterinary Studies, University of Edinburgh, and a fellow of the Royal College of Veterinary Surgeons. Her research spans translational oncology, mucosal melanoma, surgical infection control and surgical education. She established the dog as a natural immunocompetent model of human oronasal mucosal melanoma, generating multi-omics datasets that demonstrate shared tumour biology and provide a translational platform for drug discovery. This work, supported by the Wellcome Trust and QBiotics Group, underpins ongoing canine clinical trials and organoid-based melanoma research. Her infection control research has influenced global veterinary practice and contributed to *Infection Control in Small Animal Practice* (CABI, 2023). She holds a PhD from the University of Liverpool and collaborates internationally across veterinary, surgical and bioinformatics networks. In 2024 she was awarded a personal chair for her clinical and research leadership.

Prof Gian Cesare Tron PhD. Professor Gian Cesare Tron is a leading scientist and full professor of medicinal chemistry at the Università del Piemonte Orientale, Italy, with a career at the forefront of synthetic medicinal chemistry and drug discovery. His research focuses on novel multicomponent reactions, isocyanide chemistry and the development of new anticancer agents. He has completed research placements at leading global institutions including the University of Bristol, Institut de Chimie des Substances Naturelles (France) and The Scripps Research Institute (the US), shaping an internationally recognised research programme. He has authored 122 peer-reviewed publications, holds five patents,

and has an h-index of 39, with recognition among the World's Top 2% Scientists (2022–23). His work has strong translational impact through collaborations with pharmaceutical and biotech companies including QBiotics Group and others. He has received competitive funding from MIUR and AIRC and was awarded the Farmindustria Prize (2007).

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