Telix Therapeutics Urology Showcase and Expert Forum

March 12, 2025

ASX: TLX | Nasdaq: TLX

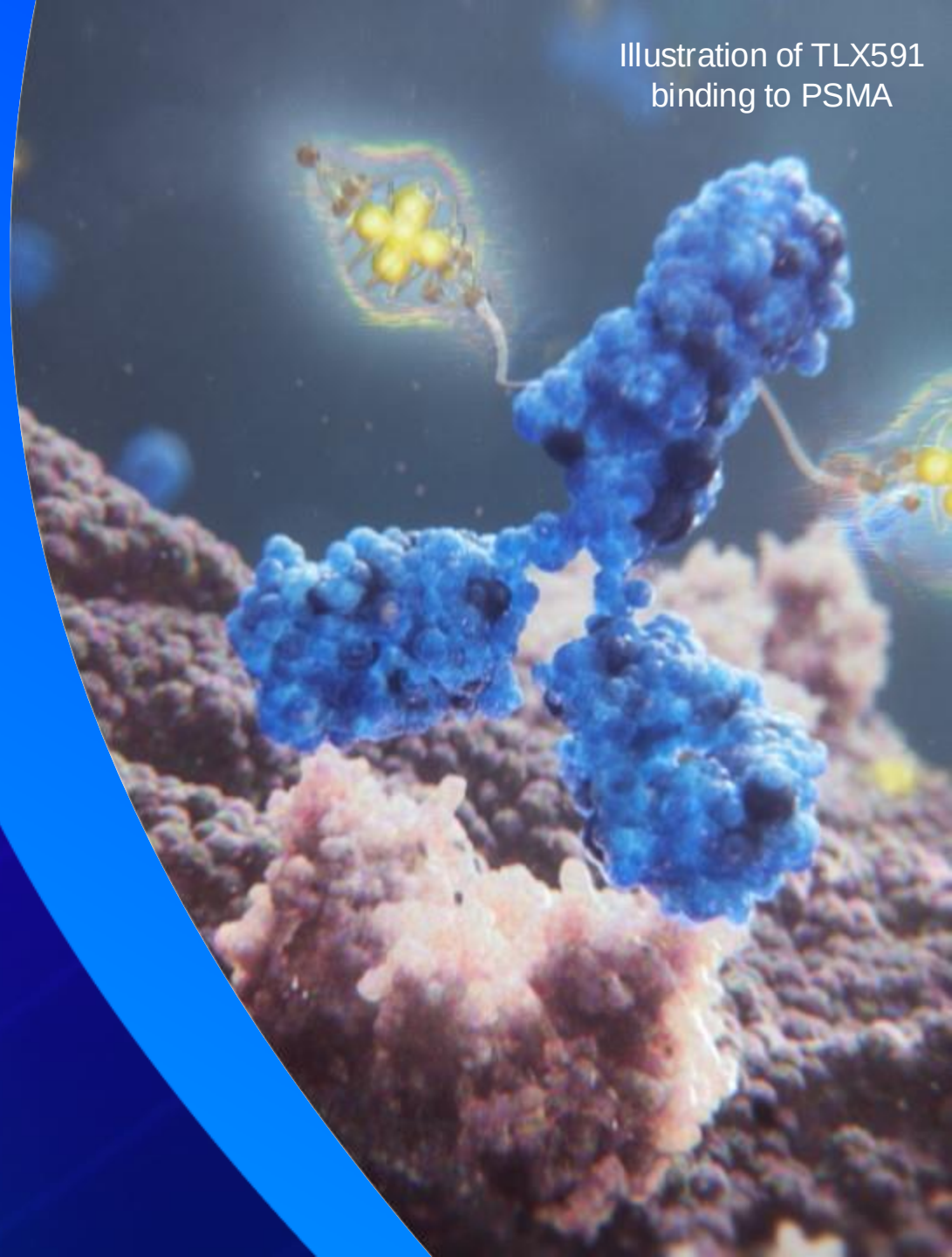

Illustration of TLX591 binding to PSMA

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Telix’s lead imaging product, gallium-68 (^{68}Ga) gozetotide injection (also known as ^{68}Ga PSMA-11 and marketed under the brand name Illuccix®), has been approved by the U.S. Food and Drug Administration (FDA), by the Australian Therapeutic Goods Administration (TGA), by Health Canada, by the UK MHRA, and approved or in national approval review in 19 European countries following a positive decentralized procedure (DCP) opinion by BfArM. Telix’s osteomyelitis (bone infection) imaging agent, technetium-99m (^{99m}Tc) besilesomab, marketed under the brand name Scintimun®, is approved in 32 European countries and Mexico. Telix’s miniaturized surgical gamma probe, SENSEI®, for minimally invasive and robotic-assisted surgery, is registered with the FDA for use in the U.S. and has attained a Conformité Européenne (CE) Mark for use in the European Economic Area. No other Telix products have received a marketing authorization in any jurisdiction.

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Introduction

Kyahn Williamson

SVP Investor Relations and Corporate Communications

Telix

Presenters

Kyahn Williamson

SVP Investor Relations
and Corporate Communications

Richard Valeix

CEO, Telix Therapeutics

David N. Cade, MD

Telix Group Chief
Medical Officer

Pamela Habib, MD

Chief Medical Officer -
Therapeutics

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Cancer Center, Houston, TX

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Professor of Medicine, University of
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Chair, and Chief Medical Officer at MTIC,
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Neeraj Agarwal, MD*

Professor of Medicine and
Presidential Endowed Chair of Cancer
Research at Huntsman Cancer
Institute, Salt Lake City, UT

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* Independent expert speakers are not employees of Telix.

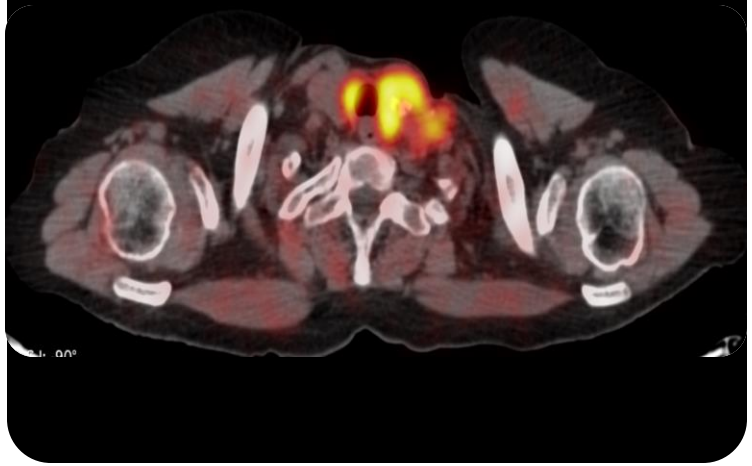
Telix: Defining the future of radiopharma

We are a global leader in theranostics for oncology and rare diseases

A global radiopharmaceutical company with:

Established footprint in urology with Illuccix®, leading ^{68}Ga-PET prostate cancer imaging agent in U.S.

Deep theranostic pipeline – multiple near-term catalysts plus next-generation assets



Manufacturing, isotope and distribution partnerships **delivering to patient**s

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Patient representative scans – individual results may vary.

Agenda: Focus for today

1. Telix's vision for urology
2. TLX250: CAIX-targeted radiotherapeutic
3. Physician perspective on kidney cancer therapy
4. TLX591 and TLX592 for prostate cancer therapy
5. Radiolabelled antibodies: A novel approach for PSMA therapy
6. Physician perspective on TLX591
7. Role of alpha emitters

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Telix's vision for urology

Richard Valeix

CEO, Telix Therapeutics

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Urology is a significant clinical and commercial opportunity

Large indications with high unmet need

	Prostate cancer	Kidney cancer	Bladder cancer
2025 U.S. incidence[1]	313,780	81,610	84,870
2025 U.S. therapeutic market size[2-4]	US$ 12.9B	US$ 7.5B	US$ 5.4B

1. American Cancer Society, Key Statistics for Prostate Cancer, Kidney Cancer, Bladder Cancer; March 2025.
2. Datamonitor Prostate Cancer Patient-Based Forecast; December 2023.
3. Datamonitor Renal Cell Carcinoma Patient-Based Forecast; July 2024.
4. Datamonitor Bladder Patient Based-Forecast; February 2024.

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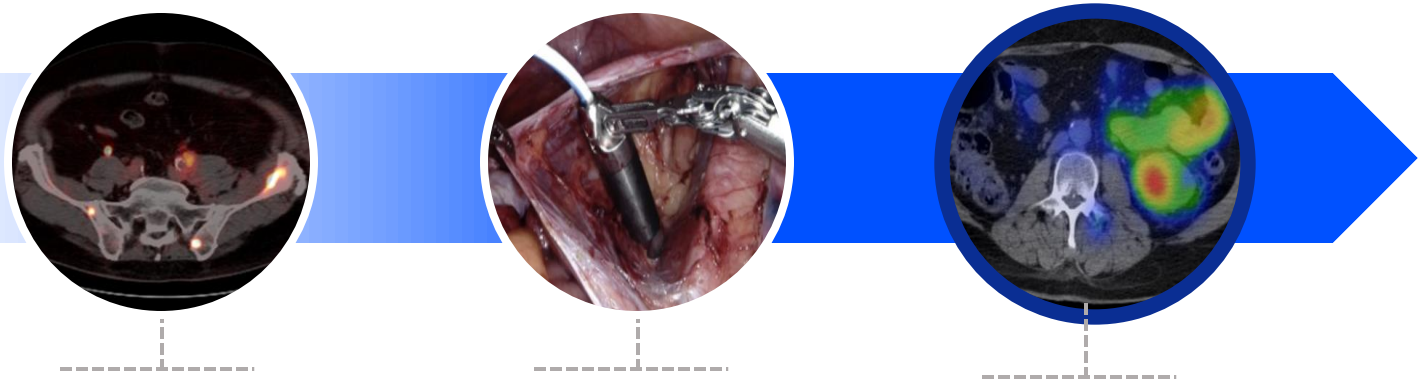
Uniquely positioned in urologic oncology

Leading innovation across the patient journey



Diagnosis & Staging

illuccix® (kit for the preparation of gallium Ga 68 gozetotide Injection)

Gozellix[1] kit for the preparation of gallium Ga 68 gozetotide injection

Zircaix[1] (zirconium Zr 89 girentuximab senvedoxam-crdi)

TLX400-CDx

Surgical Technologies

SENSEI®

Therapy

ProstACT

STARLITE

TLX090 **TLX400**

Software and AI Platforms

SUBTLE MEDICAL

Telix AI™

QDOSE®

- Differentiated therapies with clear benefits for physicians and patients
- Clinical trial designs with real-world standard of care
- Innovative solutions at every step of patient journey, driving clinician engagement from urologist to oncologist
- Commitment to service and innovation

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1. Product launches and brand names subject to regulatory approval.

Telix has a broad and deep urology portfolio

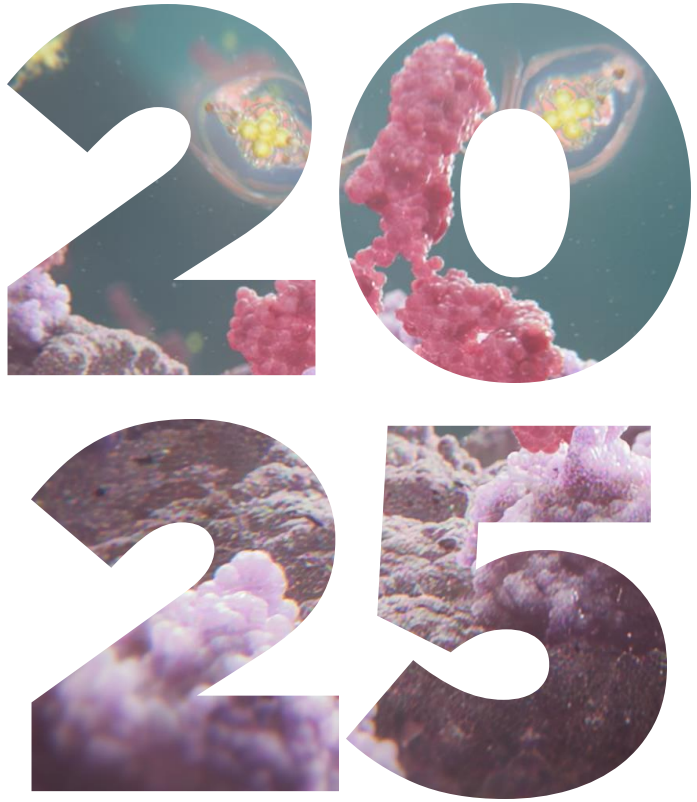
Commercial diagnostics and a pipeline of differentiated therapeutics

	Targeting agent	Isotope	Px / Tx[1]	Pre-clinical	Phase 0/1	Phase 2	Phase 3	Commercial
Prostate PSMA	Antibody	^{177}Lu	Tx	TLX591 (^{177}Lu rosopatamab tetraxetan)				
	Antibody	^{225}Ac (alpha)	Tx	TLX592 (^{225}Ac-RADmAb®)				
	Small molecule	^{68}Ga	Px	Illuccix® (^{68}Ga-PSMA-11)				
	Small molecule	^{68}Ga	Px	TLX007-CDx, Gozellix® (^{68}Ga-PSMA-11)				
Kidney + other CAIX	Antibody	^{177}Lu	Tx	TLX250 (^{177}Lu-girentuximab)				
	Antibody	^{225}Ac (alpha)	Tx	TLX252 (^{225}Ac-girentuximab)				
	Antibody	^{89}Zr	Px	TLX250-CDx, Zircaix® (^{89}Zr-girentuximab)				
Bladder FAP	Small molecule	Undisclosed	Tx	TLX400 (new in-license)				
Musculo-skeletal	Small molecule	^{153}Sm	Tx	TLX090 (^{153}Sm-DOTMP), bone-seeking candidate for bone metastases and pain palliation				

1. Px = precision medicine (diagnostic); Tx = therapeutic.

Our strategy and focus for 2025

Targeting three late-stage therapeutics in pivotal trials



Progress late-stage therapeutic pipeline

- Accelerate ProstACT Global[1] Phase 3 trial of TLX591, first rADC[2] in 1L/2L mCRPC[3]
- Submit Investigational New Drug (IND) application to progress TLX250 in ccRCC[4], fast-to-market opportunity in late-line setting with limited treatment options

Advance next-generation therapeutic programs

- Expand in prostate cancer with ^{225}Ac-TLX592 alpha emitter
- Complement prostate portfolio with TLX090 for bone pain in end-of-life setting
- Explore multi-indication asset strategy with TLX252 targeting CAIX[5], expressed in a range of solid hypoxic tumors

1. ClinicalTrials.gov ID: NCT06520345.
2. Radio antibody-drug conjugate.
3. Metastatic castrate resistant prostate cancer.
4. Clear cell renal cell carcinoma – most common form of kidney cancer.
5. Carbonic anhydrase IX.

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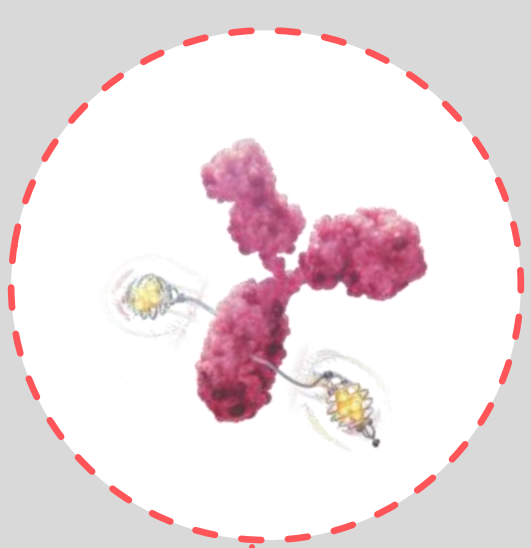
A “double hit” at the tumor microenvironment (TME)

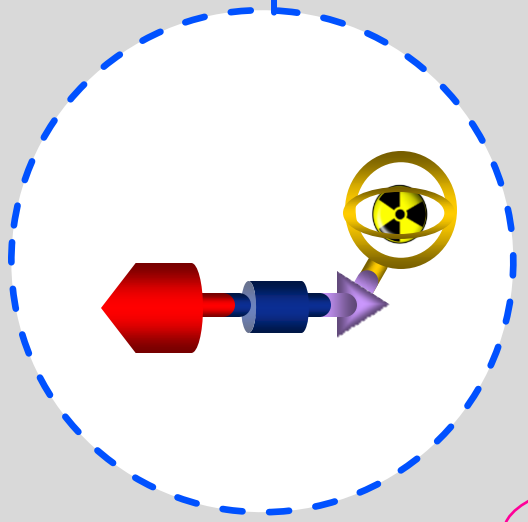
Hypoxia and the stromal compartment, a complementary approach

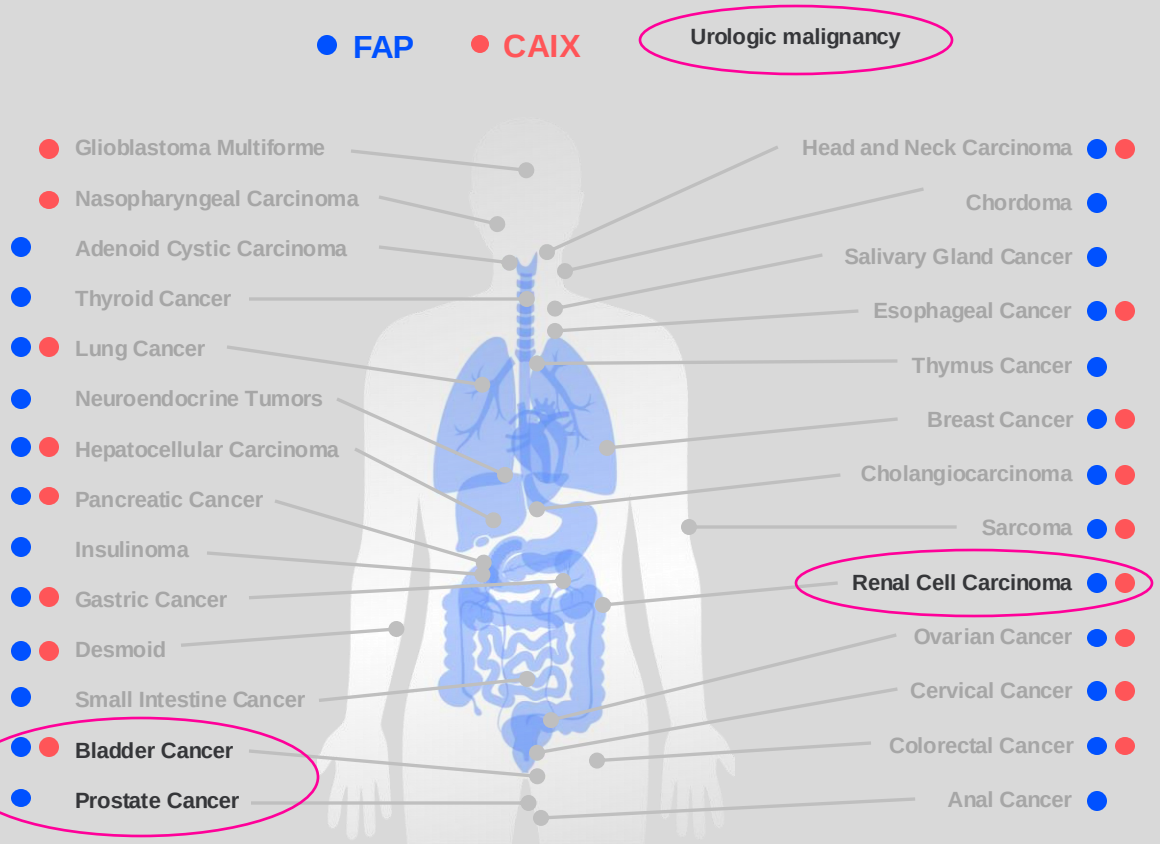
Two well validated targets with pan-cancer potential[1, 2] – potential boost to immuno-oncology



CAIX targeting antibody (hypoxia)

FAP targeting small molecule (fibrosis / stroma)





1. Literature reports of CAIX expression.
2. Giesel et al. *J Nucl Med.* 2019.

TLX250: CAIX-targeted radiotherapeutic

David N. Cade, MD

Telix Group Chief Medical Officer

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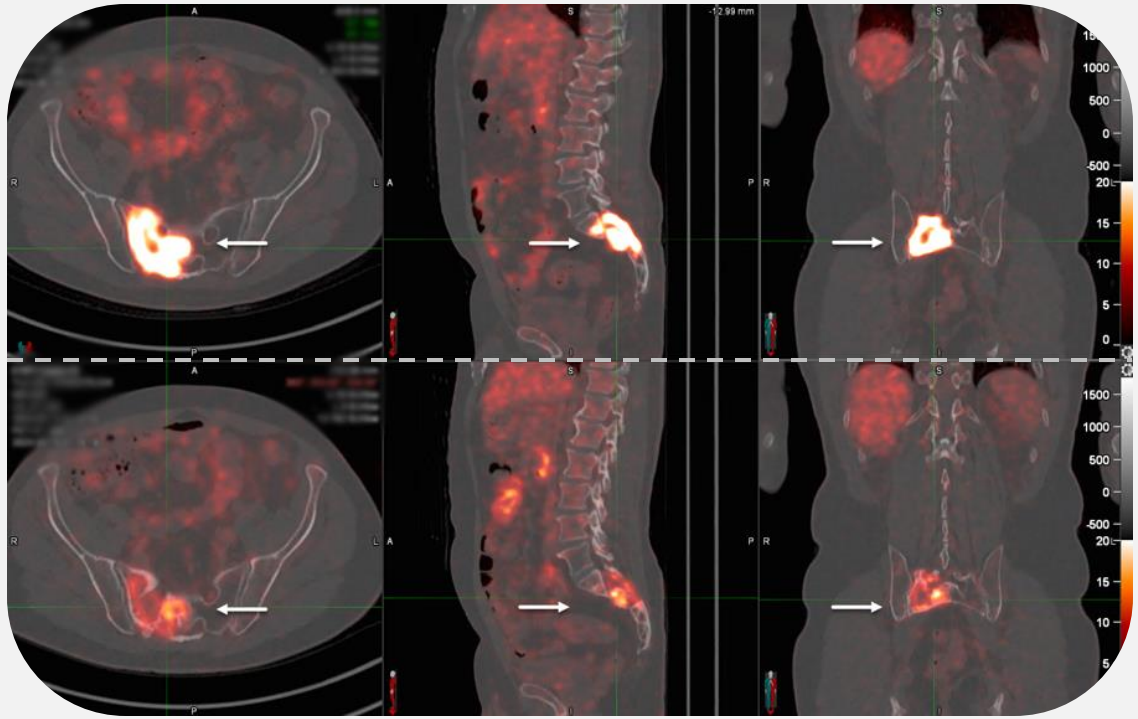
TLX250: Validated in ccRCC, pan-cancer potential

Positioned to be first CAIX-targeting rADC to market

TLX250 (^{177}Lu-girentuximab)

- Monoclonal antibody targeting Carbonic Anhydrase IX (CAIX), **a validated target expressed in >90% of ccRCC and range of solid tumors**[1]
- **Ability to image CAIX with Zircaix®**[2], use of extensively studied 177-Lutetium payload de-risks clinical program[3]
- **Demonstrated durable disease control in** a **Phase 1 and a Phase 2 RCC study** with a manageable safety profile[4,5]
- **Fast-to-market opportunity in late-line RCC,** with expansion potential to other solid tumors

TOP: ^{89}Zr-girentuximab PET/CT at baseline showing uptake in a sacral metastatic lesion in a patient with ccRCC.



BOTTOM: ^{89}Zr-girentuximab PET/CT after three cycles of therapy.

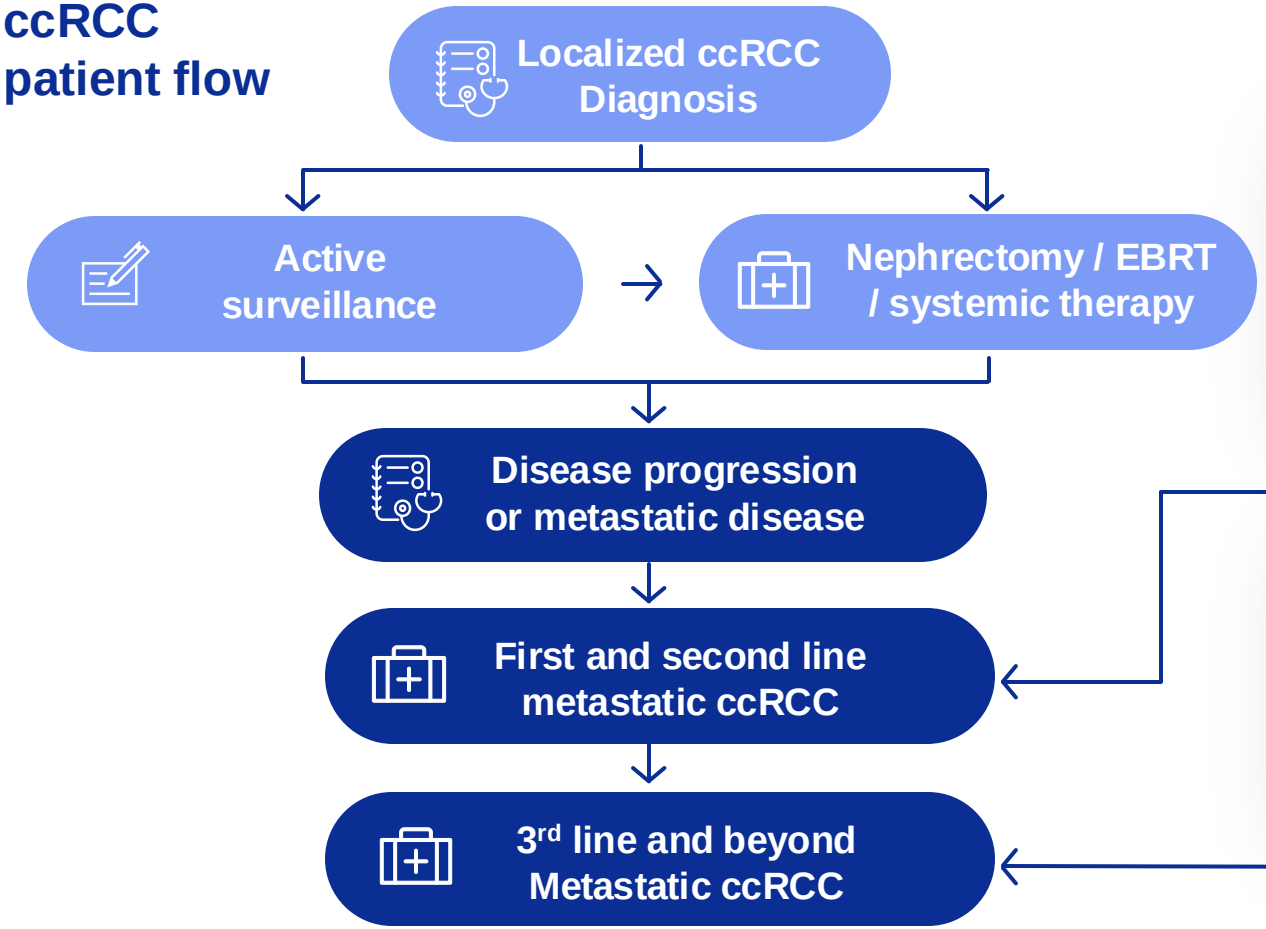
1. Pastorekova S and Gillies RJ. Cancer Metastasis Rev. 2019;38:65-77.
2. Brand name subject to final regulatory approval.
3. Shuch et al. *Lancet Oncology* 2024.
4. Stillbroer et al. *European Urology*. 2013.
5. Muselaers et al. *European Urology*. 2015.

Images from Telix's STARSTRUCK study, data on file.
Patient representative scans - individual results may vary.

Multiple opportunities in the current treatment landscape

Entry point in late-stage disease as monotherapy, expansion to earlier lines in combination

ccRCC patient flow



Opportunities to impact patient outcomes in advanced disease with TLX250

- Patients typically receive combination or sequence of IOs and TKIs
- Opportunity to improve on efficacy of combinations
- POC on-going through STARLITE program

STARLITE

- Limited treatment options (TKI, mTOR or HIF-2α inhibitor), poor outcomes
- Opportunity to bring novel MOA through fast development pathway as monotherapy

TLX250 PIVOTAL TRIAL

Telix

Source: NCCN Guidelines, Kidney Cancer.

Initiating TLX250 monotherapy pivotal trial in late line setting

Fast-to-market opportunity in setting w/ limited treatment options as entry point to RCC

Indicative Phase 3 trial design summary

Part 1

- Dose escalation
- Safety and radiation exposure
- Efficacy

Part 2

- Unresectable, locally advanced or metastatic ccRCC
- Disease progression after 2-3 lines of prior therapy
- PFS as primary endpoint
- 1:1 monotherapy vs SOC
- Prior EBRT patients eligible

Upcoming inflection points

- ✓ FDA pre-IND meeting completed
- IND submission planned in mid-2025
- First patient dosed in H2 2025

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Physician perspective on kidney cancer therapy

Eric Jonasch, MD
Professor of Medicine, MD Anderson Cancer Center, Houston, TX

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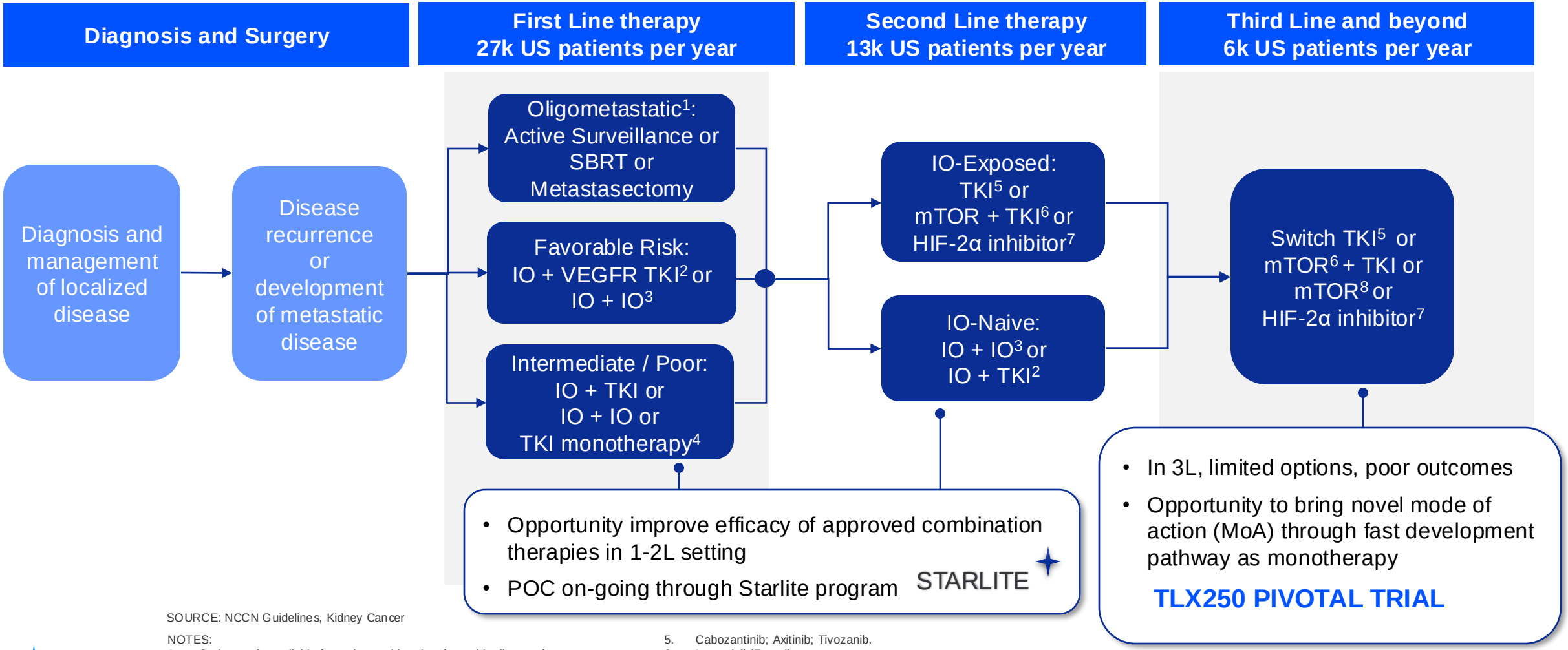
Views are speaker's own.

Typical patient journey for a metastatic kidney cancer patient

Major unmet needs include enhancing efficacy of combination treatments and late-line treatment



SOURCE: NCCN Guidelines, Kidney Cancer

NOTES:
1. Options only available for patients with select favorable disease features.
2. Axitinib/Pembrolizumab; Cabozantinib/Nivolumab; Lenvatinib/Pembrolizumab.
3. Ipilumumab/Nivolumab.
4. Cabozantinib only.
5. Cabozantinib; Axitinib; Tivozanib.
6. Lenvatinib/Everolimus.
7. Belzutifan.
8. Everolimus.

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Radionuclide therapy is synergistic with immune checkpoint inhibitors (ICIs)

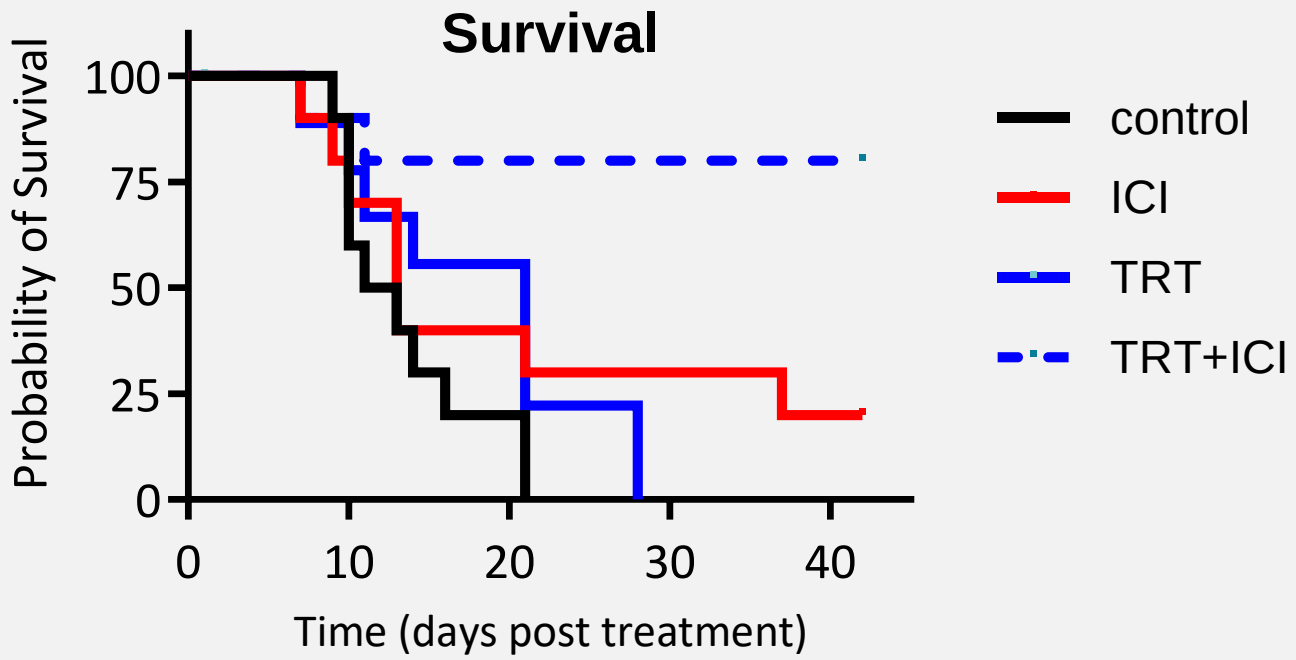
Clinical evidence supports combination, suggesting opportunity in earlier lines of ccRCC

Strong scientific rationale for combining systemic radiation with immunotherapy

- Proportion of patients do not respond to checkpoint inhibitors, fail to generate effective antitumor immune response[1]
- Evidence suggests **radiation of tumor cells** can activate immune system in manner **synergistic with immunotherapy**[1-4]

Data from several clinical trials supporting combination[5-8]

Mouse RCC models show survival benefit of TLX250 + IO combination therapy[10]



STARLITE-1 investigating TLX250 with nivolumab and cabozantinib in RCC[9]

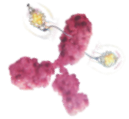
1. Esfahani, et al. *Curr Oncol.* 2020.
2. Kong Y, et al. *Front Oncol.* 2021.
3. Golden E. et al. *Semin Radiat Oncol*. 2015.
4. Ochoa de Olza M. et al *Lancet Oncol*. 2020.
5. Jagodinsky JC, et al. *Int J Radiat Oncol Biol Phys*. 2020.
6. Antonia SJ, et al. *N Engl J Med*. 2017.
7. Zhang Z, et al. *Signal Transduction and Targeted Therapy*. 2022.
   Kim C, et al. *J Immunother Cancer*. 2020.
8. https://www.urotoday.com/video-lectures/psma-ucsf-ucla-2024/video/3880-psma-directed-radioligand-therapy-in-combination-with-immunotherapy-presentation-rahul-aggarwal.html,
9. ASCO GU 2023: STARLITE 1: Phase 1b/2 Study of Combination 177Lu Girentuximab plus Cabozantinib and Nivolumab in Treatment Naïve Patients with Advanced Clear Cell RCC
10. Kleinendorst et al. *Theranostics.* 2024.

Treatment synergies are also observed on tumor growth inhibition

Combining with TLX250 improved tumor control vs ICIs alone

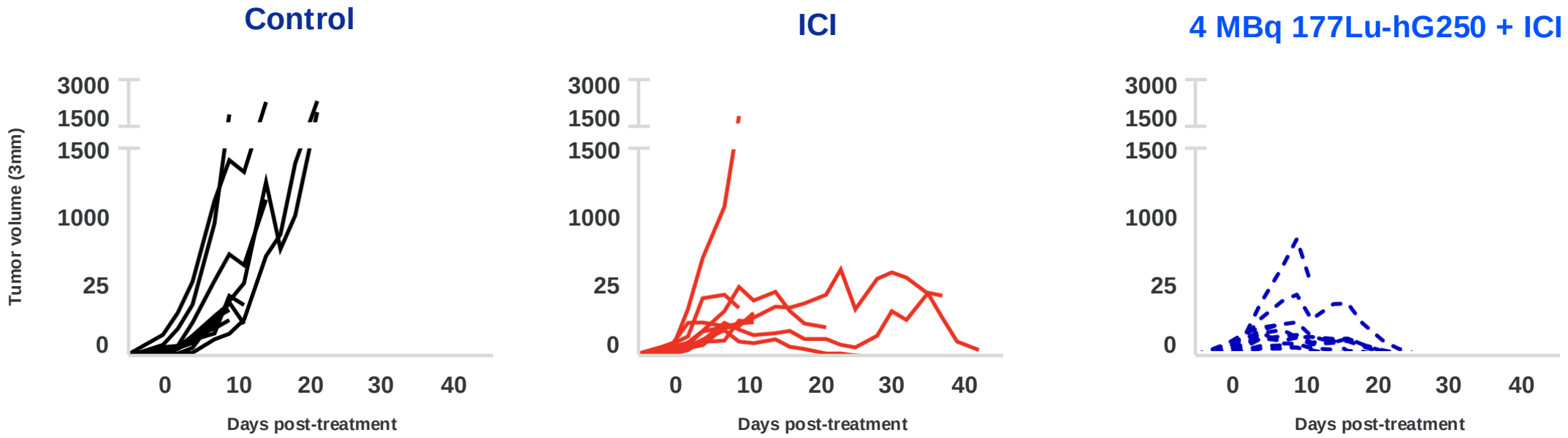
Mouse Tumor Model Renca-hCAIX

Treatment



TLX250

aPD-1 + aCTLA-4 (ICI)



1. Kleinendorst et al. *Theranostics.* 2024.

Two studies exploring potential new combinations in ccRCC with TLX250

Combination I-O therapy studies (IITs)

	STARLITE-1[1]	STARLITE-2[2]
Trial setup	• Open-label single-arm Phase 2 • PI: Eric Jonasch, MD	• Open-label single-arm Phase 2 • PI: Darren R. Feldman, MD
Therapeutic combination	• TLX250 + cabozantinib + nivolumab	• TLX250 + nivolumab
Positioning	• Treatment-naïve ccRCC patients with biopsy-proven advanced disease	• Recurrent ccRCC patients that have progressed on I-O therapy
Primary endpoints	• Safety • Complete response	• Maximum tolerated dose • Overall response rate

1. ClinicalTrials.gov ID: NCT05663710.
2. ClinicalTrials.gov ID: NCT05239533.

Q&A

Eric Jonasch, MD and Pamela Habib, MD

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Views are external speaker's own.

TLX591 and TLX592 for prostate cancer therapy

David N. Cade, MD

Telix Group Chief Medical Officer

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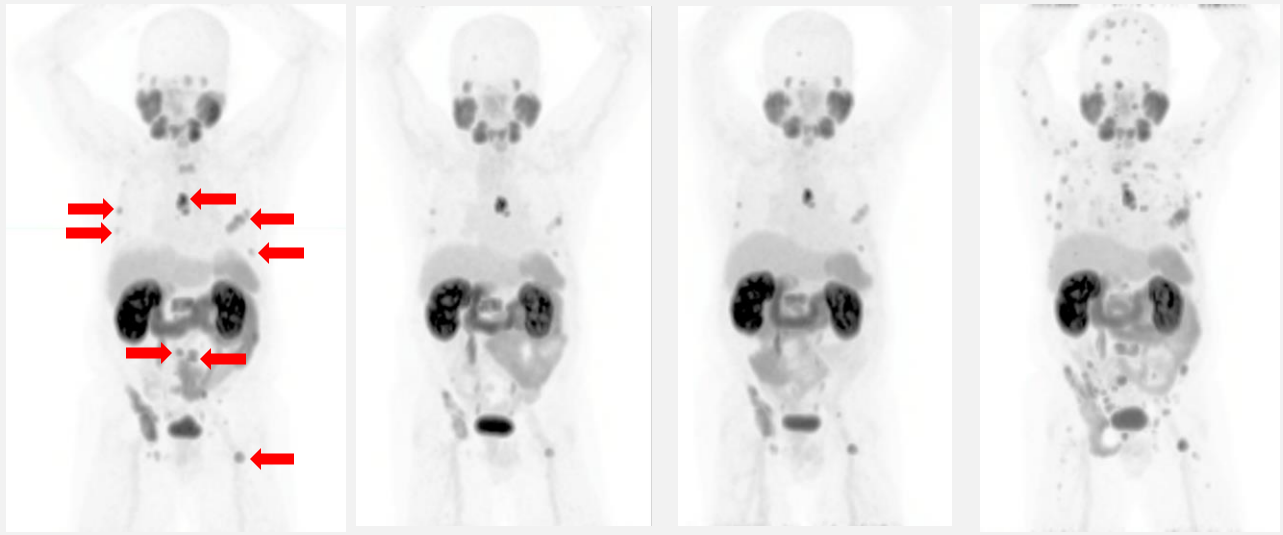
TLX591: A highly differentiated approach to ^{177}Lu-PSMA therapy

Established safety profile and potential to improve efficacy

- Antibody approach enables high internalization, retention, and selectivity for tumor-expressed PSMA
- ProstACT Select[1] study demonstrated safety and median rPFS[2] of 8.8 months[3]
- Patient-friendly dosing regimen (2 doses, 2 weeks apart), manageable safety profile
- Lower cumulative radiation exposure vs approved PSMA therapy

ProstACT



Baseline PET/CT | 2 months | 4 months | 9 months

ProstACT Select: ^{68}Ga-PSMA-11 PET/CT with Illuccix® demonstrates multiple sites of metastatic disease (red arrows) which remained stable until the 9 month scan[4]

Patient representative scans - individual results may vary.

Telix

1. ClinicalTrials.gov ID: NCT04786847.
2. Radiographic progression free survival.
3. Telix ASX disclosure 31 May 2024.
4. ProstACT Select data on file.

TLX591: Novel PSMA Therapy Addressing Key Unmet Needs

Potential to overcome limitations of small molecule approach

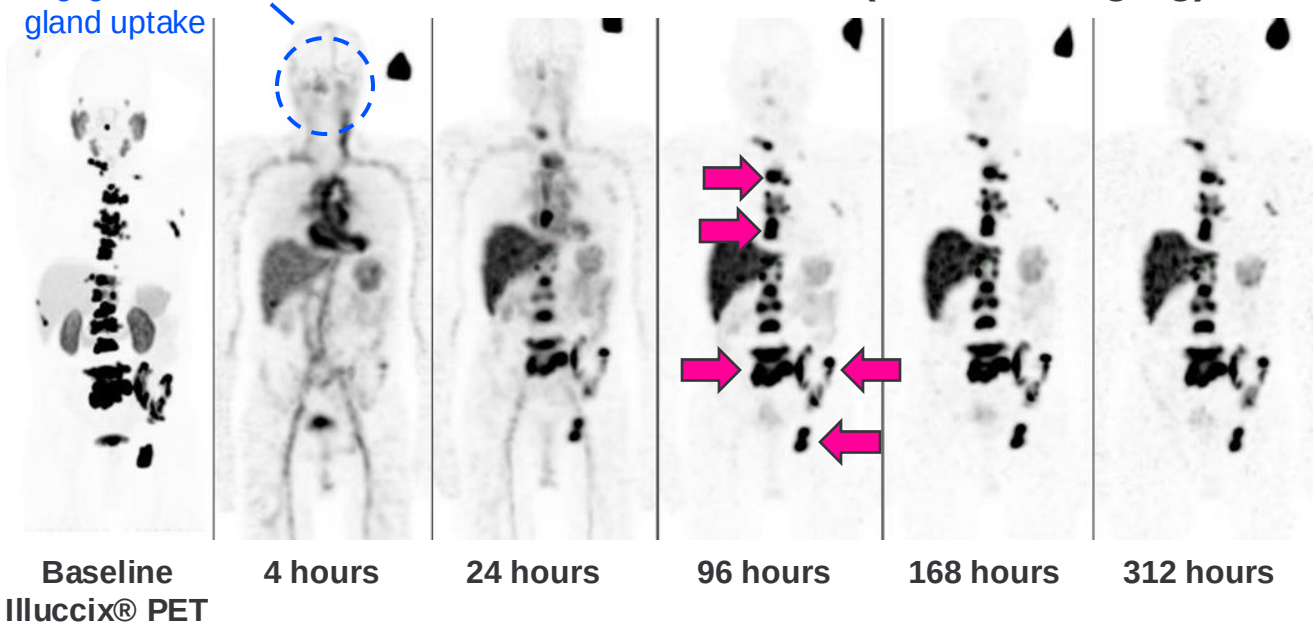
ProstACT™

SURVIVAL Promising overall survival demonstrated in early studies, median OS 42.3 months[1]

DOSING Simple 2-dose regimen
Lower cumulative radiation exposure (152 mCi v 1200 mCi)

QoL[2] Limited off target side effects: renal toxicity, dry mouth, dry eye, ganglia irritation. Predictable hematological response

TLX591 biodistribution (SPECT imaging)[3]



Key near-term catalyst

ProstACT Global Phase 3 study dosing patients.
Interim readout H1 2025 – Part 1 combination safety and dosimetry

Telix

1. Tagawa, et al. *Cancer*. 2019 (Open label, single-arm Phase 1/2 clinical trial in 17 patients with advanced mCRPC).
2. Quality of life.
3. ProstACT SELECT data on file.

Patient representative scans - individual results may vary.

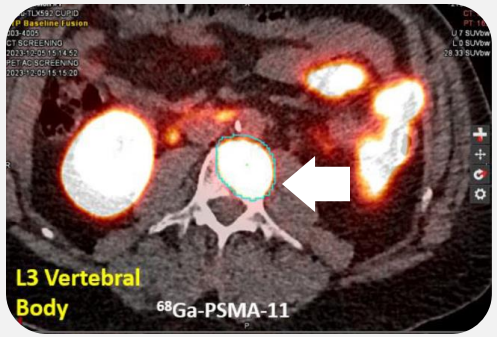
TLX592: ^{225}Ac-PSMA therapy leveraging next generation antibody

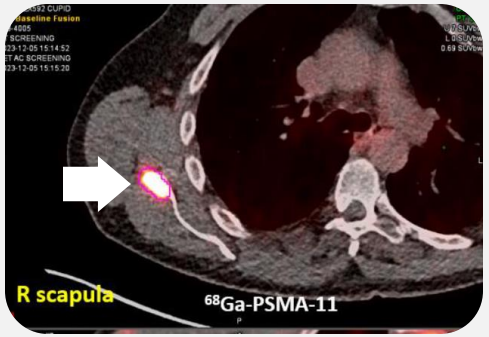
Safety, PK and Dosimetry demonstrated in the CUPID trial[1]

- **Engineered antibody for fast elimination from circulation, high tumor:blood ratios**
  - Retains tumor-targeting and retention
  - Liver-cleared, no exocrine (salivary) gland uptake
- **Highly potent ^{225}Actinium isotope** enabling treatment of ^{177}Lutetium refractory / resistant patients
- **Demonstrated proof-of-concept** in CUPID trial[2], Phase 1/2 therapeutic study to commence in H2 2025

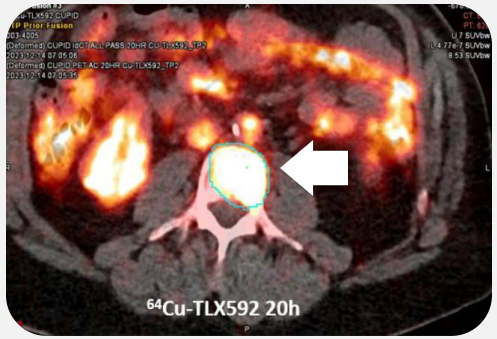
Confirmation of Tumor Targeting compared to Illuccix®

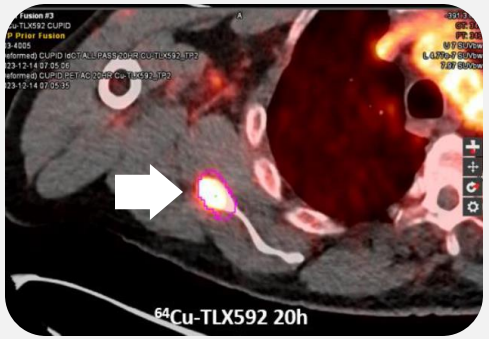
^{68}Ga-PSMA-11





^{64}Cu-TLX592





Patient representative scans - individual results may vary.

1. ClinicalTrials.gov ID: NCT04726033.
2. Telix ASX disclosure 21 May 2024.

Radiolabelled antibodies: A novel approach for PSMA therapy

Rodney Hicks, MD
Professor of Medicine, University of Melbourne and Monash University; Founder, Chair, and Chief Medical Officer at MTIC, Melbourne, Australia

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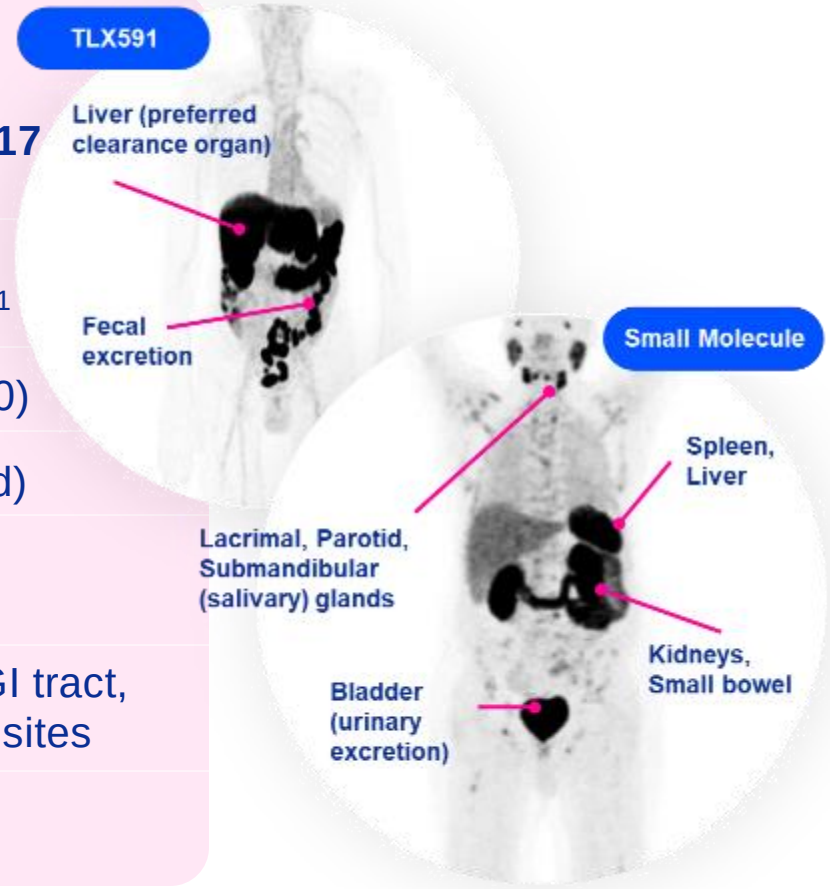
Views are speaker's own.

Mechanism of action: antibody vs small molecule

Key differences underpin tumor targeting, uptake and retention

	rADC TLX591	Radio-Peptide Eg ^{177}Lu-PSMA-617
Radiopharmaceutical description		
Recommended adult dose	2 x 76 mCi (14 days apart)	6 x 200 mCi (6 weeks apart)[1]
Molecule size	Large (mw 150,000)	Small (mw 1400)
Clearance time	Days (slow)	2.5 hours (rapid)
PSMA on-target binding specificity	High	Medium
Off-tumor organ diffusion exposure	Liver, spleen	Salivary glands, GI tract, kidneys + other sites
Excretion	Hepatic	Renal



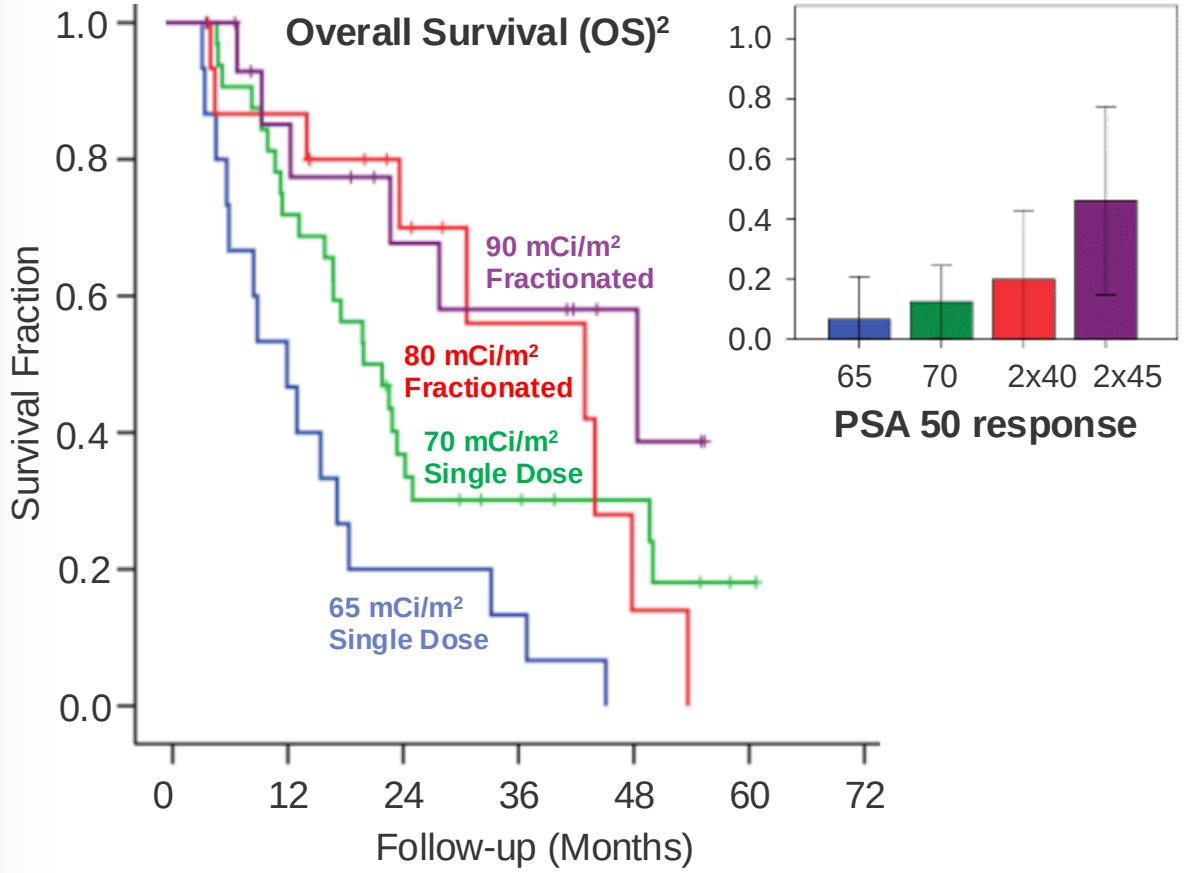
1. Pluvicto® prescribing information. Administered every six weeks for up to six treatments, solution for injection contains 200 mCi (7.4 GBq) at time of use.

Demonstrated anti-tumor effect and overall survival benefit[1,2]

Clinical development and current efficacy data

- To date: evaluated in 242 prostate cancer patients in eight Ph1/2 studies
- Evidence of anti-tumor effect and a clear dose-response profile for key measures of efficacy
  - Prostate-specific antigen (PSA) response
  - Overall survival (OS) – **published 42.3 months** median survival in end-stage (heavily pre-treated) patients[1]
- Well-tolerated with predictable and transient hematological toxicity, with subsequent recovery

Fractionated dosing manages hematologic safety while delivering a highly targeted and potent radiation dose to prostate cancer metastases

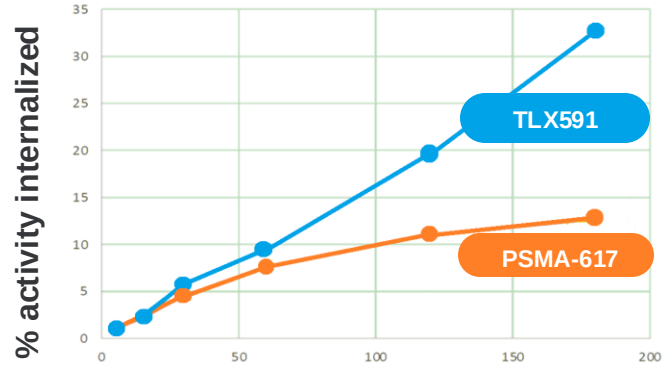


1. Tagawa et al, *Cancer*. 2019.
2. Vallabhajosula et al. *Curr Radiopharm.* 2016.

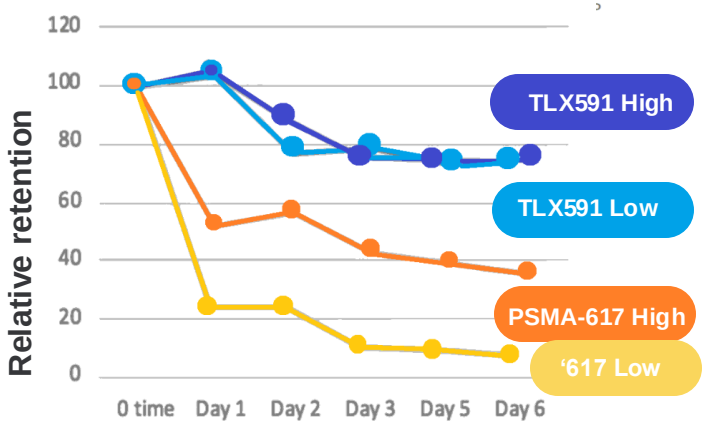
Internalization and retention of antibodies vs peptides

ProstACT Global dosimetry validating higher TLX591 tumor-dose with lower injected activity

Internalization efficiency comparison between TLX591 and PSMA-617 in LNCaP cell lines[2]

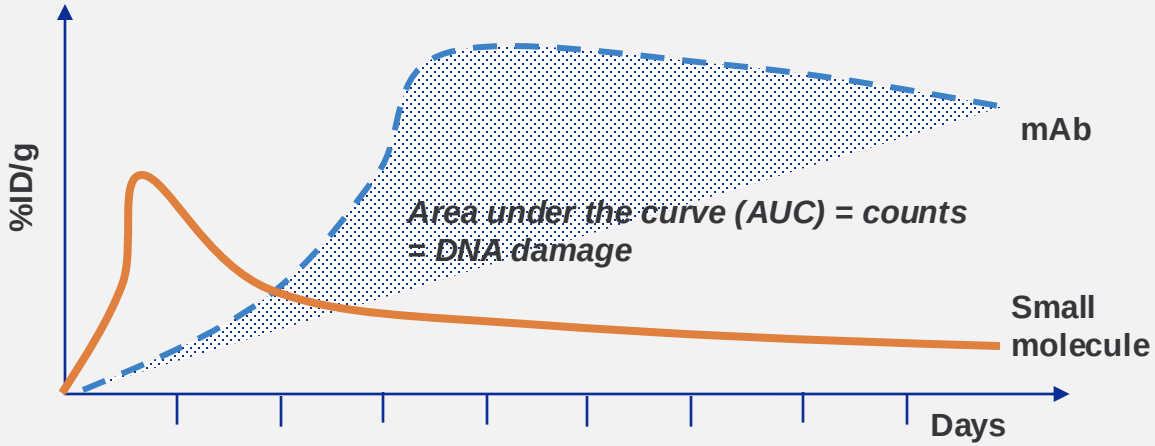


Relative retention in low / high expressing cell lines, suggesting superiority of TLX591 in low-PSMA expressing disease (i.e. late-stage metastatic disease)



Courtesy of Prof. Neill Bander (Weill Cornell) unpublished data.

Antibody-delivered radiation accumulates in the tumor to have more impact (idealized)



The combination of long internalization / accumulation of 177-Lutetium plus far higher (relative) retention in the cytoplasm means that the total count (decay) events causing DNA damage is significantly higher, despite a lower injected dose

1. Uptake per gram of organ.
2. Human prostate cancer cell line.

Sources: Besova et al (J Nuc Med 2015; 56:56:914-920); Wustemannet al (Theranostics, 2016); Shäfer et al (EJNMMI Research 2012, 2:23); Umbricht et al (EJNMMI Research (2017) 7:9

Physician perspective on TLX591

Neeraj Agarwal, MD

Professor of Medicine and Presidential Endowed Chair of Cancer Research at Huntsman Cancer Institute, Salt Lake City, UT

Telix

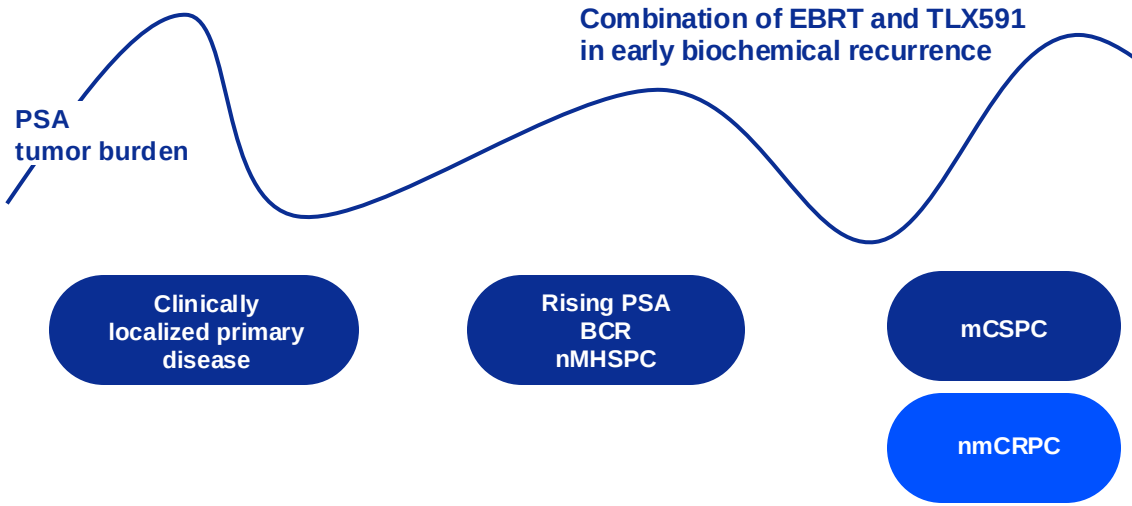
Views are speaker's own.

TLX591 can address unmet needs for 1L/2L mCRPC Patients

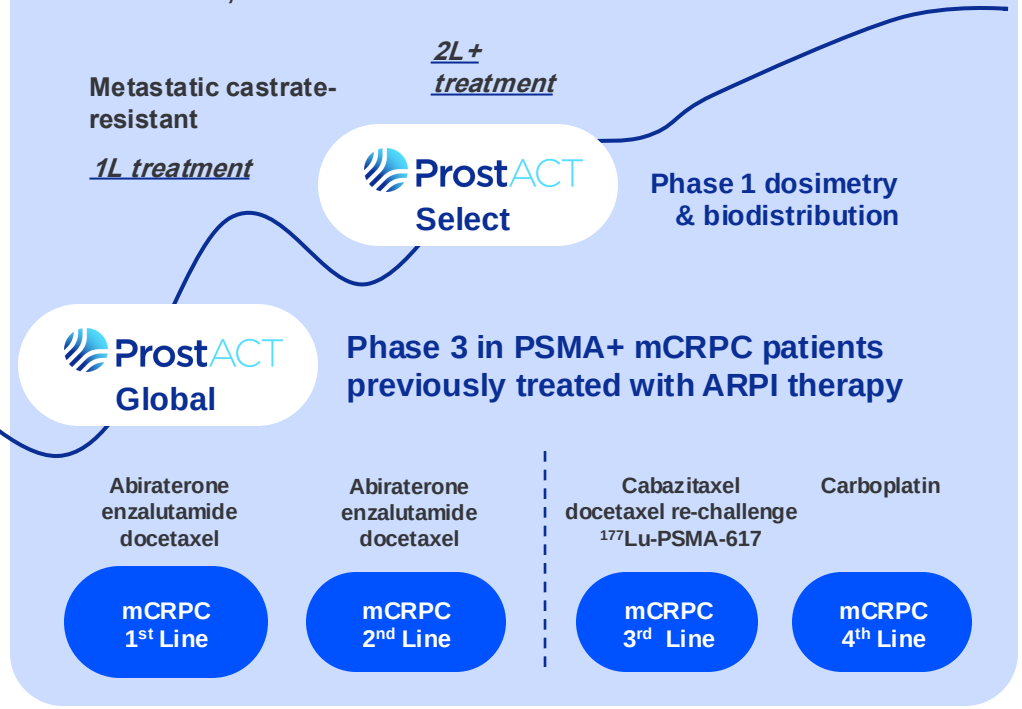
Hormone sensitive → **Castration resistant**

^{177}Lu-PSMA peptide therapy approved but …

- Opportunity to improve on efficacy
- Opportunity to reduce off-target organ diffusion to improve tolerability
- Opportunity to improve patient dosing regimen and radiation exposure



TLX591 target initial patient population:
51k incident U.S. mCPRC patients per annum[1], ARPI and taxanes as current SoCs



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Adapted from Calais J. UCLA 2023 EANM 2023; NCCN Guidelines Version 4.2023 Category 1 Preferred Scher 2015, PLoS1; Nezolosky 2018, Journal of Clinical Oncology; ASCO Cancer.NET, Prostate Cancer Statistics, accessed November 2023.

Docetaxel + TLX591: supports Global SoC arm / docetaxel optionality

Demonstrates utility of docetaxel in combination with TLX591

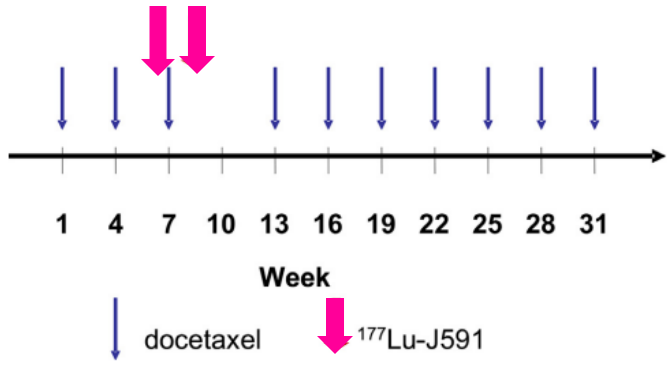

Fig. 1. Treatment schema.

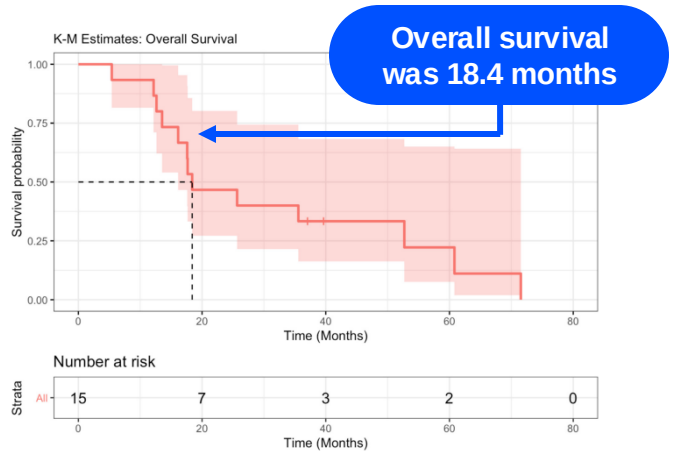

Fig. 4. Kaplan-Meier curve for OS.

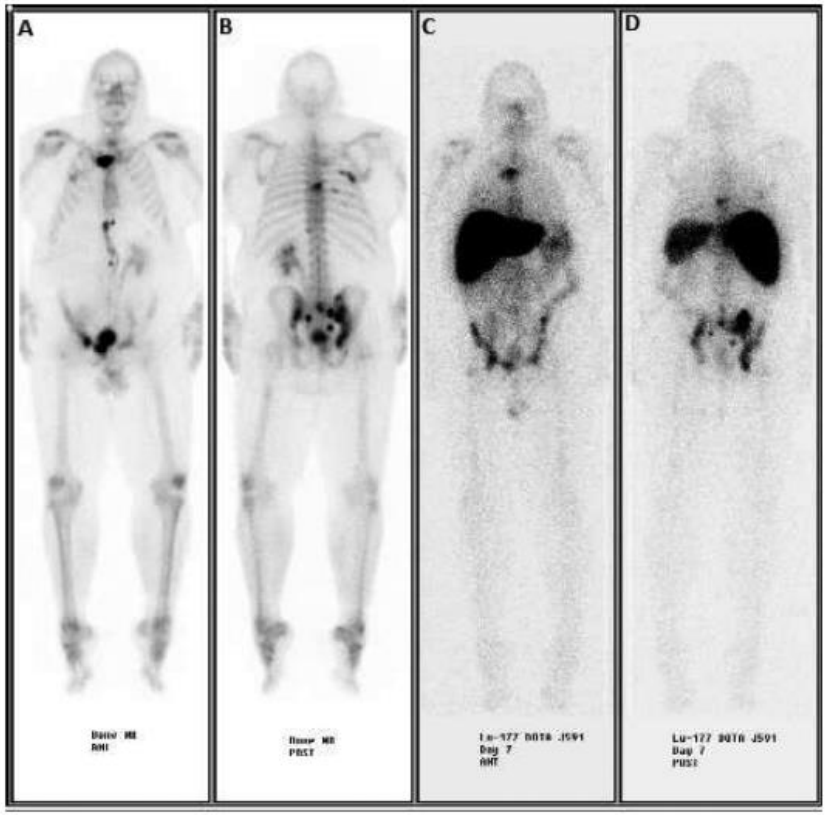

Fig. 2. A 49-year-old man with mCRPC with intact primary prostatic tumor. Multiple bone metastases are seen on pre 177Lu-J591 treatment bone scan (A, B). Whole body planar scan 7 days after 177Lu-J591 (C, D) demonstrate the accurate targeting of known disease sites (visual score 3), as seen on the bone scintigraphy. Physiologic uptake can be seen in liver on planar scans in image C and D.

Median OS was 18.4 months, slightly higher than similar (average) monotherapy dosing (16.7mo), with no DLT seen.

Ph1 trial of docetaxel + TLX591 also correlated with dose dependent % decrease of CTC

1. Betra 2020: Phase 1 trial of docetaxel plus lutetium-177-J591.

ProstACT Global trial design[1]

Designed to integrate with current standard of care

ProstACT

Part 1: Dosimetry & Safety Lead-In (n = 30)

Eligibility
- Confirmed mCRPC
- Progressed once on prior 2nd generation ARPI
- Docetaxel in mCSPC if >6 months prior

76mCi ← 2 weeks → 76mCi

Fractionated dosing

TLX591 + SOC
- abiraterone (10)
- enzalutamide (10)
- docetaxel (10)

N = 30

Primary
- Dosimetry
- AEs/SAEs

Secondary
- rPFS
- ORR
- PSA reduction

Characterize biodistribution & safety profiles of TLX591 + SOC combinations

Part 2: Randomized Treatment Expansion (n = 490)

2:1

TLX591 + SOC
- abiraterone
- enzalutamide
- docetaxel

N = 327

SOC
- **abiraterone**
- **enzalutamide**
- **docetaxel**

N = 163

Interim Analysis

Primary
- rPFS

Key Secondary
- OS

Other Secondary
- ORR
- SSE
- PSA Resp
- HRQoL

Phase 3 trial in patients with mCRPC progressing on 1st line androgen agents or docetaxel

Product designed to be "patient-centric", only requires two treatments with TLX591, potential for less off-target toxicity

Interim readout expected H1 2025

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1. ClinicalTrials.gov ID: NCT06520345.

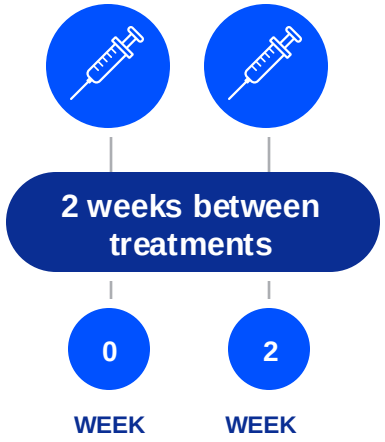
Dosing flexibility is a key differentiator

Simple, short dosing regimen with lower accumulated radiation to patient

2 weeks

TLX591

- Administered every 2 weeks for up to 2 treatments
- Solution for injection contains 76 mCi at time of use



Cumulative radiation exposure comparison

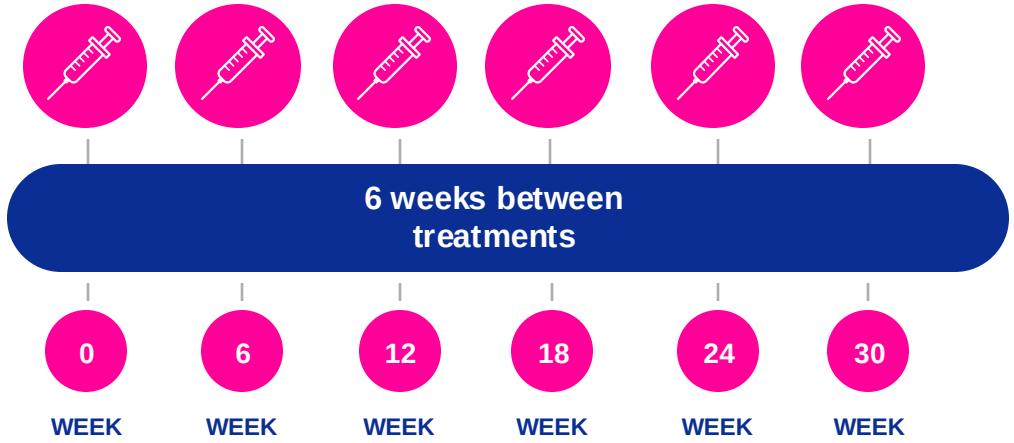
152 mCi

VS

30 weeks

^{177}Lu-PSMA-617 / PSMA I&T

- Administered every 6 weeks for up to 6 treatments
- Solution for injection contains 200 mCi at time of use



1,200 mCi

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Role of alpha emitters

Rodney Hicks, MD
Professor of Medicine, University of Melbourne and Monash University; Founder, Chair, and Chief Medical Officer at MTIC, Melbourne, Australia

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Views are speaker's own.

Alpha emitters create new possibilities for radionuclide therapy

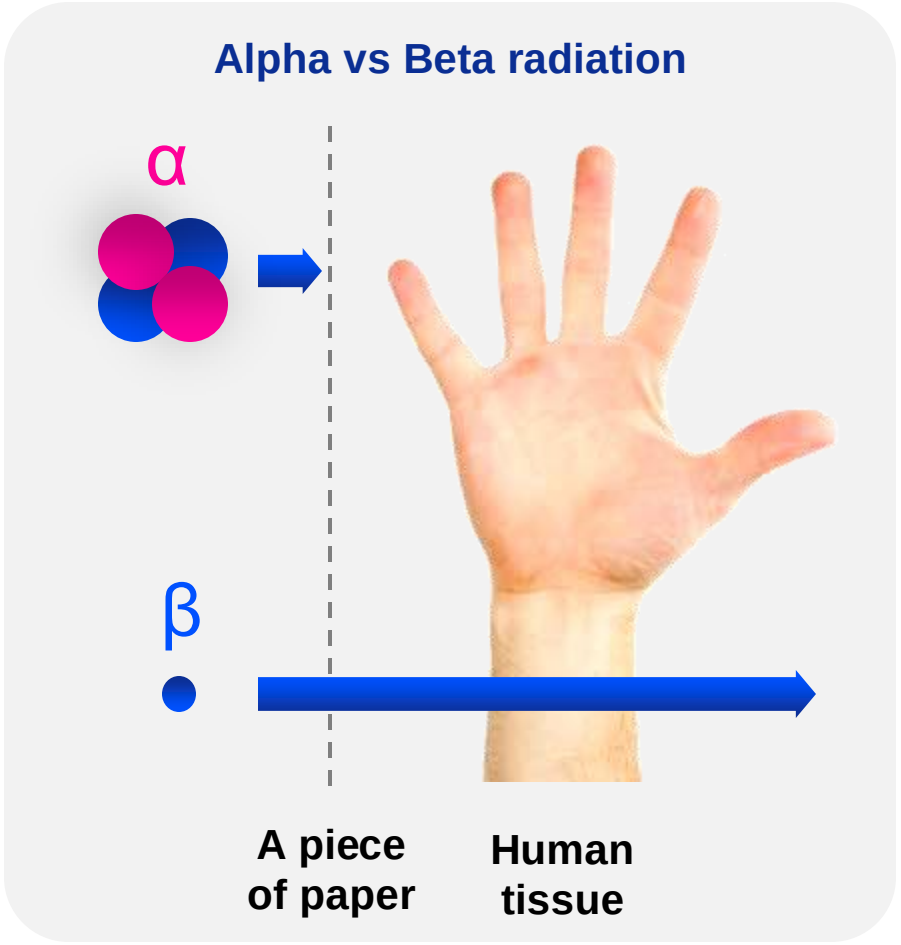
Potential to deliver high amounts of energy to lesions but need to manage safety

Why alpha emitters?

- Highly potent w/ data suggesting efficacy in ^{177}Lu resistant patients
- Shorter decay path but need to manage safety
- Advantage in terms of radioprotection with less shielding required

What are optimal properties for a targeting vector?

- High-specificity targeting agents to limit off-target radiation
- Hepatic clearance (radioresistant organ) to limit kidney toxicity
- Alignment of isotope half-life with targeting agent residence time



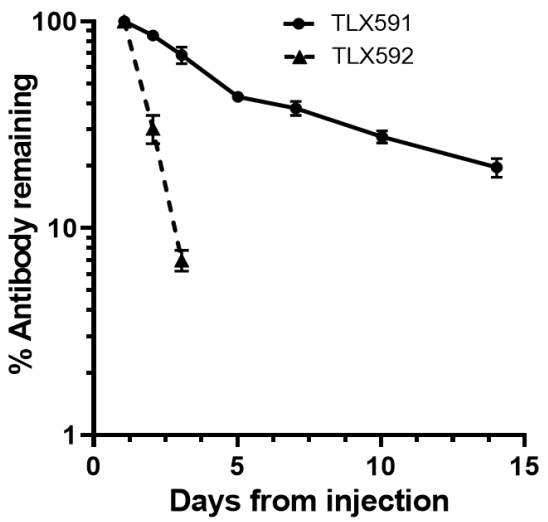
1. Wild et al. *Cancer Research*. 2011.
2. Kratochwil et al. *J Nucl Med*. 2018.
3. Satapathy et al. *Prostate Cancer*. 2021.

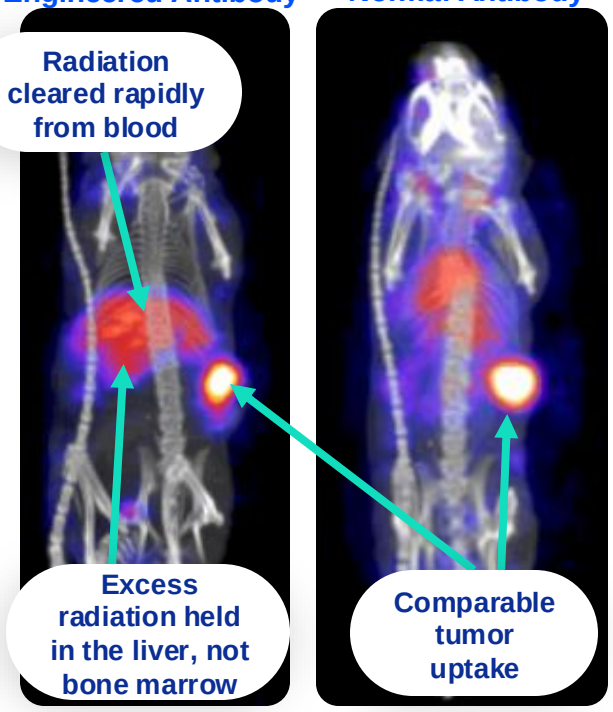
A tailored approach for alpha emitters with TLX592

Engineered for speed, designed for specificity: Pre-clinical

- Proprietary changes to antibody Fc-region significantly alter its pharmacokinetic clearance without altering targeting or stability properties
- TLX591 (normal IgG1) and TLX592 (RADmAb) antibodies dosed in a humanized FcRn mouse model to simulate clinical pharmacokinetics
  - TLX591 half llfe = **133.4** ± 6.8
  - TLX592 half life = **13.3** ± 0.4
- Fast clearance of RADmAb®, but retention in the tumor leads to very high tumor:blood ratios
- **Highly desirable attribute** for alpha-emitting radiopharmaceuticals: radiation is contained within the tumor or excreted.

Clearance of the TLX592 mAb is much quicker than TLX591 in a humanised FcRn mouse





In vivo performance of TLX592 vs TLX591 imaged 48 hours after dosing

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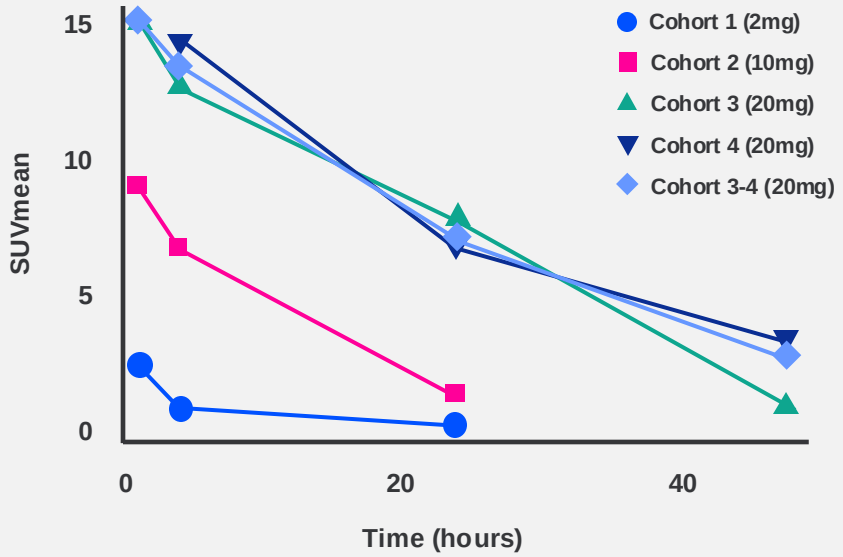
Safety, pharmacokinetics and dosimetry confirmed in human

CUPID study data presented at ASCO-GU

Pharmacokinetics

- ^{64}Cu-PSMA-RADmAb blood clearance rate: **T½=19.86+1.96h at 20 mg**
- ^{64}Cu-PSMA-RADmAb biological half-life in blood showed a clear mass dose response

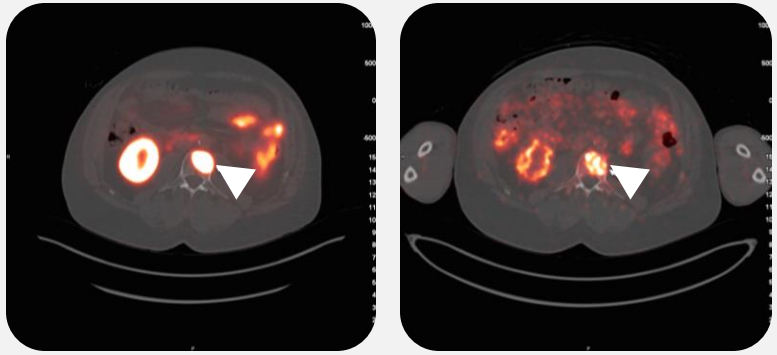


Absorbed radiation doses

- Whole-body effective dose (mean ± SD mSv/MBq):
  - *Group 3*: 0.043 ± 0.007
  - *Group 4*: 0.042 ± 0.002
- ^{64}Cu-PSMA-RADmAb uptake in bone lesions in Group 4 **correlated with ^{68}Ga-PSMA-11 uptake (r=0.756, *P*=0.003)** at 20h timepoint

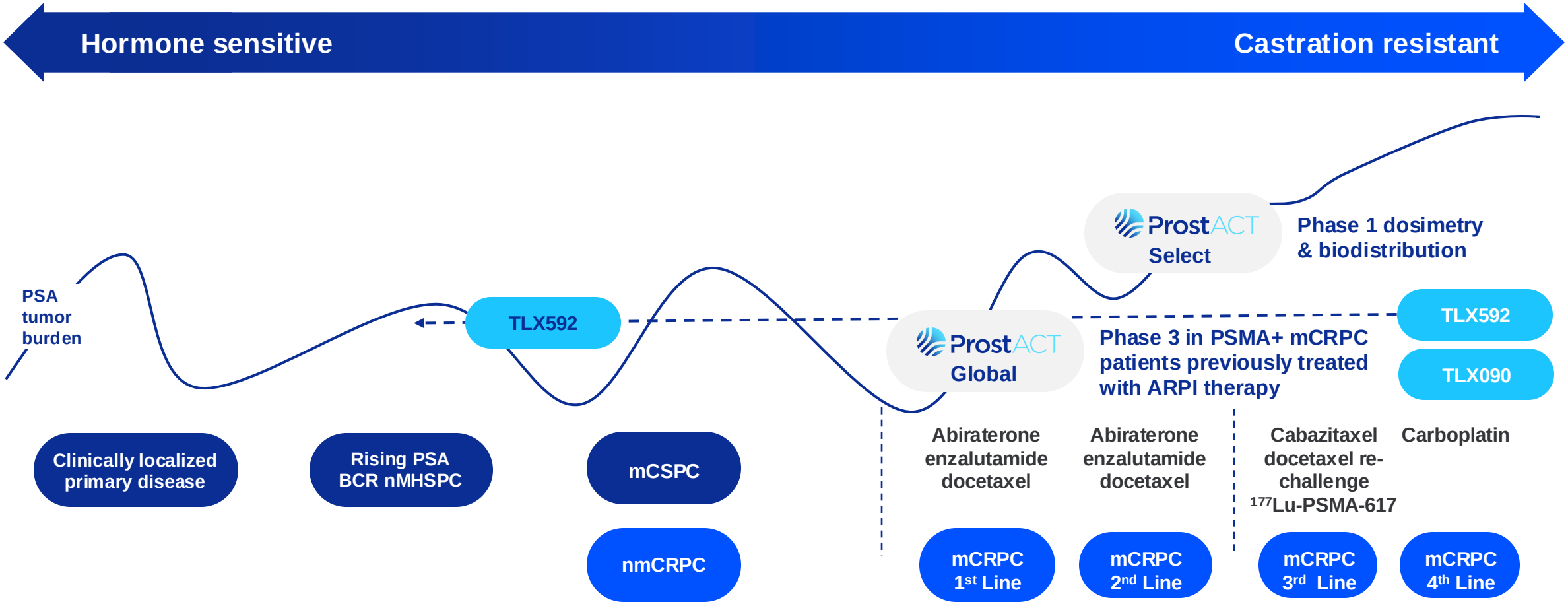
PET targeting of PC metastasis in L3 lumbar vertebral body (arrow)

^{68}Ga-PSMA-11 | ^{64}Cu-PSMA-RADmAb (20mg)



1. ASCO GU conference presentation, February 2025.

Developing treatments across the prostate cancer continuum



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Adapted from Calais J. UCLA 2023 EANM 2023; NCCN Guidelines Version 4.2023 Category 1 Preferred

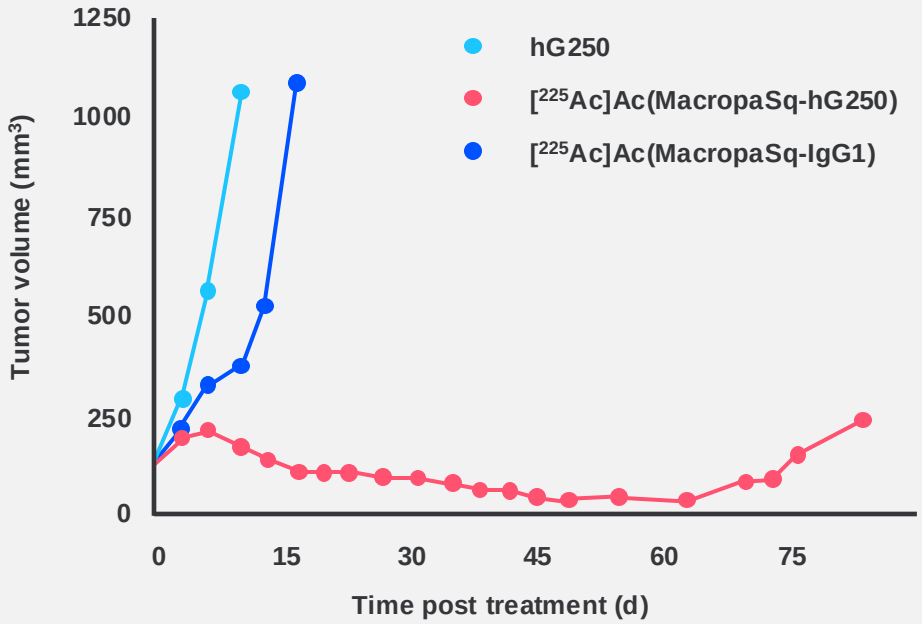
Alpha therapy candidate: TLX252 targeting CAIX

Higher potency isotope with shorter path length provides potential to expand adoption

Proof of concept for ^{225}Ac-labelled rADC in RCC and other CAIX-expressing tumors

- Preclinical data in RCC models indicate approach may lead to tumor growth delay without short-term toxicity[2], with efficacy similar to TLX250[3]
- Telix-sponsored and investigator-initiated trials demonstrated proof-of-concept for CAIX-targeted alpha therapy in triple-negative breast cancer, and non-muscle-invasive bladder cancer[4,5]

TLX252 surrogate prolonged survival in mouse model[1]



1. Morgan et al. *Chemical Science.* 2024.
2. Proceedings from the TAT11/*Journal of Medical Imaging and Radiation Sciences* 50 (2019) S1-S42
3. Merkx et al. *Pharmaceuticals.* 2022.
4. ClinicalTrials.gov ID: NCT04758780. Positive topline results presented at SABCS in December 2023, Telix media release 7 December 2023.
5. ClinicalTrials.gov ID: NCT04897763.

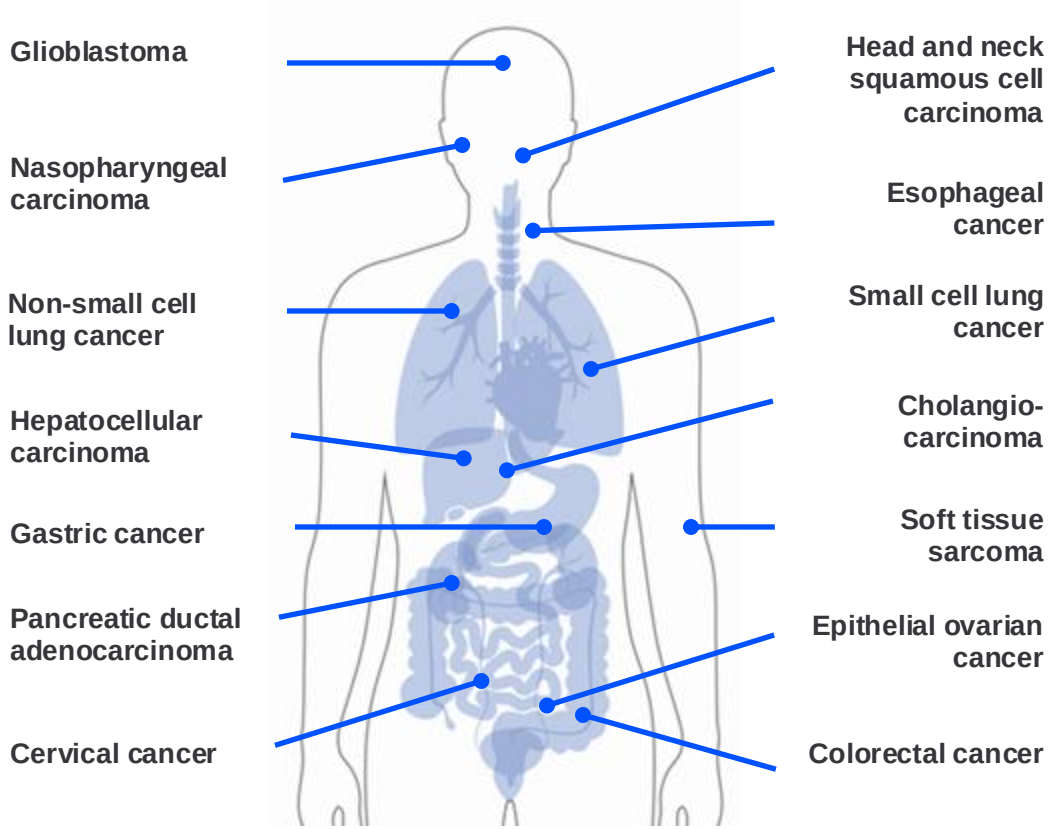
Beyond ccRCC: TLX252 multi-indication basket study

^{225}Ac-labelled antibody for the treatment of CAIX-expressing tumors

Scientific rationale supports multi-indication basket study…

- Use of **alpha emitter may help overcome radio-resistance** in CAIX-expressing lesions[1-3]
- **Demonstrated pre-clinical proof-of-concept** of CAIX-targeted radiation in four non-RCC models
- **Initiating dose-escalation/expansion** to evaluate safety, tolerability, biodistribution, preliminary activity
- Study will enroll **CAIX-positive patients in a number of solid tumours**

… with potential application in range of CAIX-expressing cancers



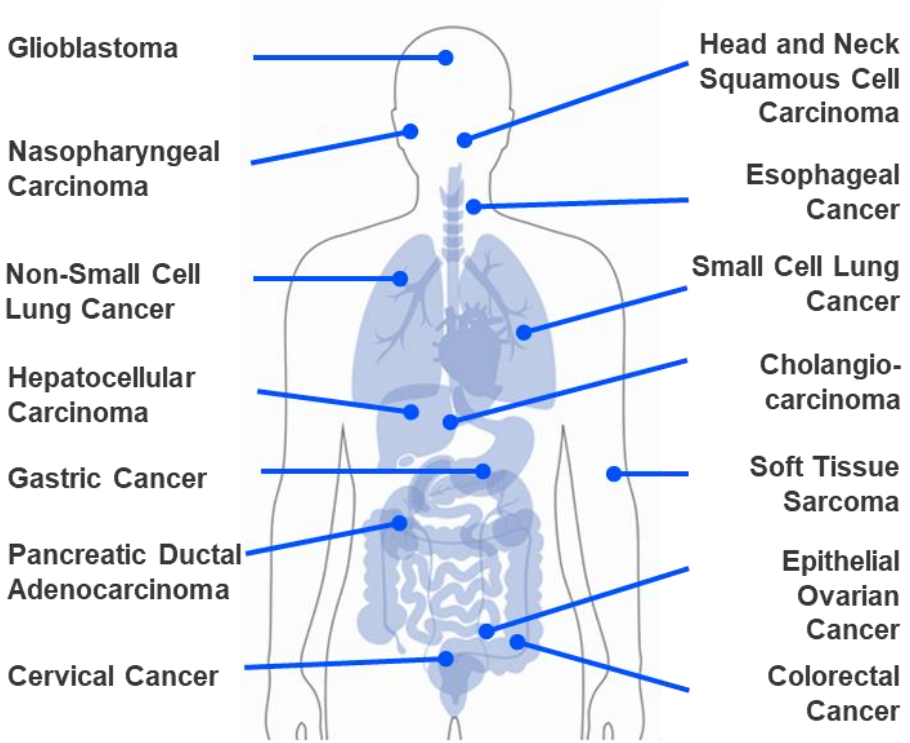
Literature reports of CAIX expression

1. Gillies et al. *Cancer and Metastasis Rev.* 2019.
2. Magne et al. *Med Sci Monit.* 2021.
3. Gourgos et al. *Cancer Res.* 2019.

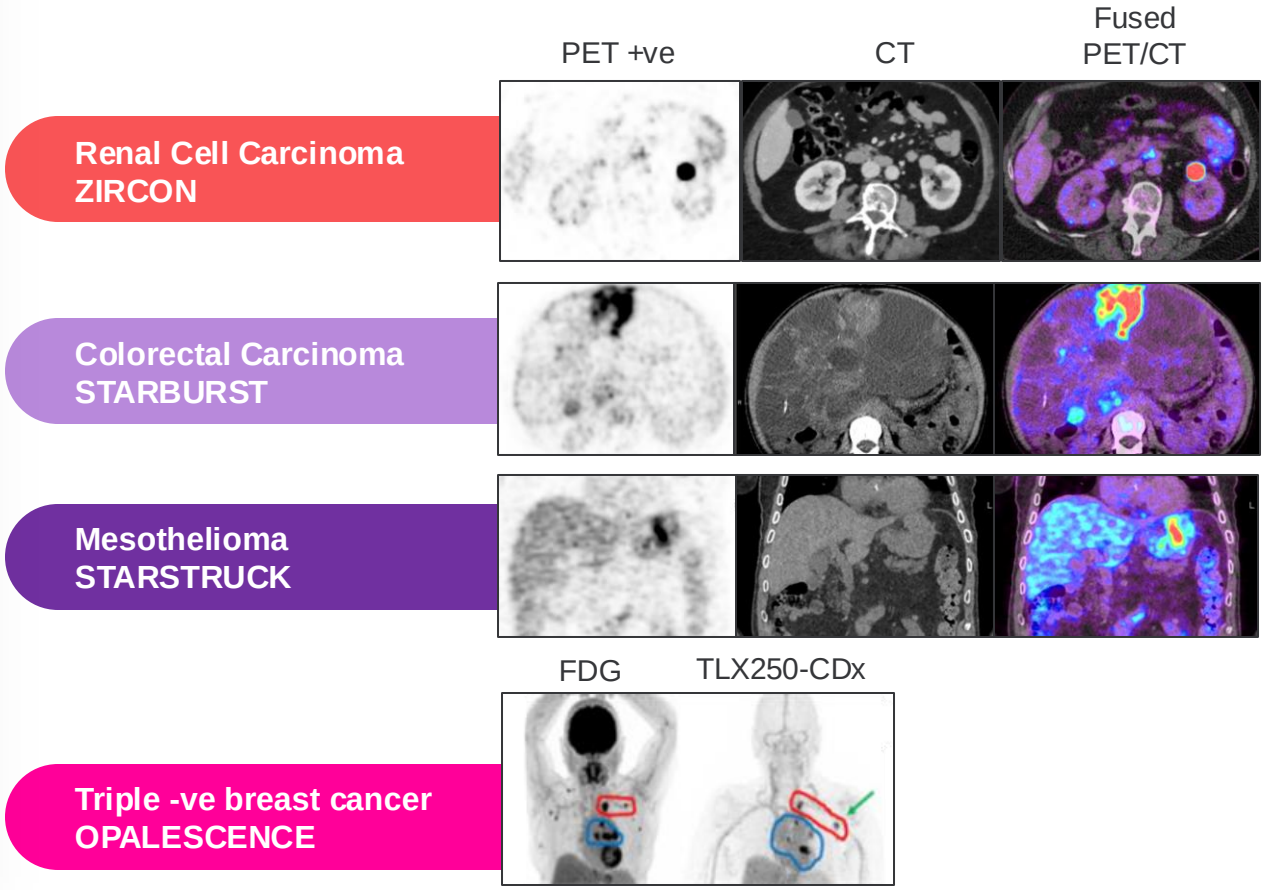
CAIX expression is associated with poor clinical outcomes

Strong rationale for exploring CAIX across multiple indications

CAIX expression[1]



TLX250-CDx detection of CAIX expressing tumors



1. Literature reports of CAIX expression.

Patient representative scans - individual results may vary.

Q&A

Neeraj Agarwal, MD
Rodney Hicks, MD
and Pamela Habib, MD

Telix

Views are external speakers' own.

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SVP Investor Relations and Corporate Communications

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Illustration showing TLX250 binding to CAIX and internalization