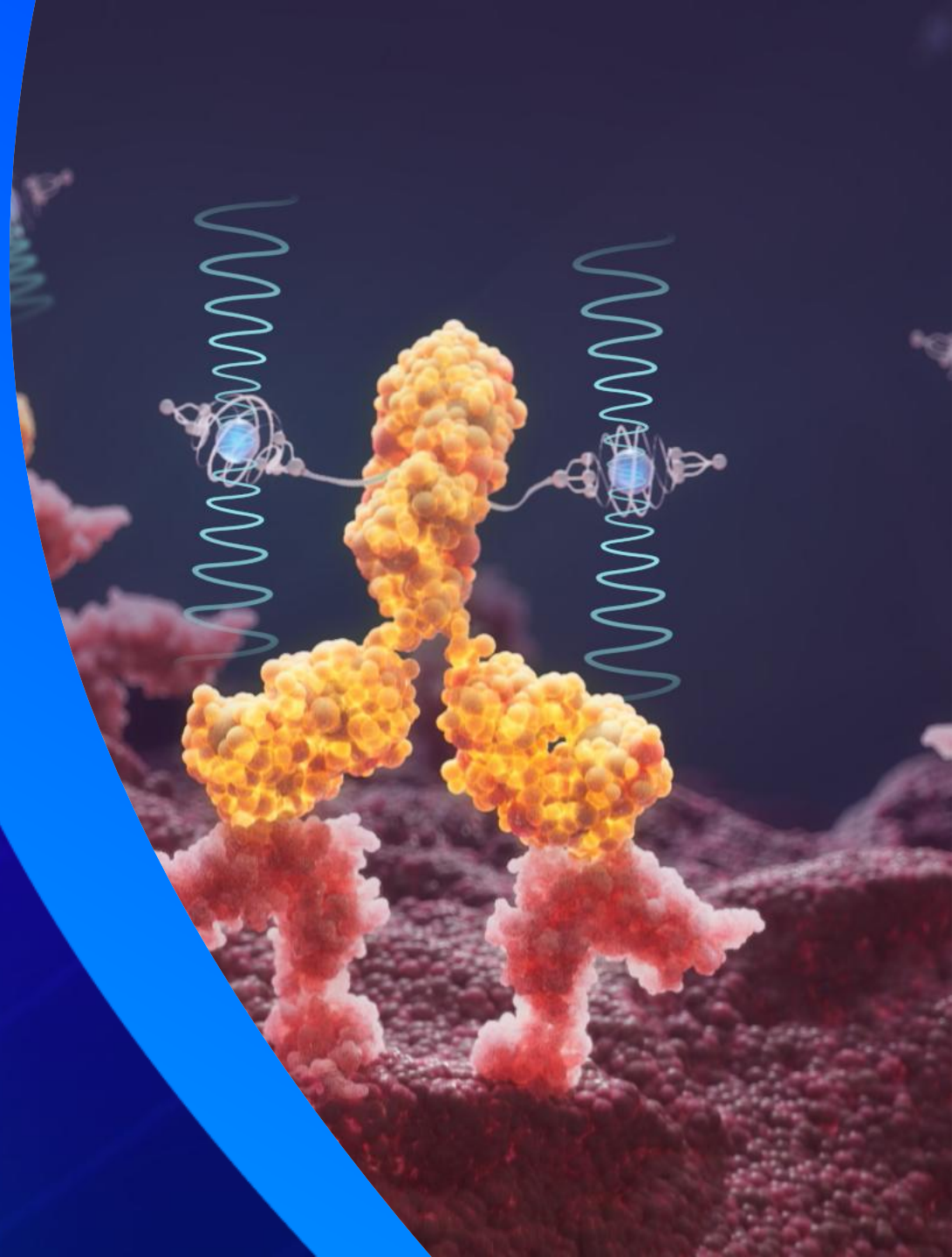
Telix

R&D Day

September 22, 2026

ASX: TLX | NASDAQ: TLX



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Telix’s first generation PSMA-PET 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 in multiple markets globally. Gozellix® (kit for the preparation of gallium-68 (^{68}Ga) gozetotide injection) has been approved by the U.S. Food and Drug Administration (FDA). Telix’s glioma imaging agent, floretyrosine F 18, marketed under the brand name Pixclara®, is also approved by the FDA. 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 EEA. Registrations vary country to country. Refer to your local approved label or regulatory authority status for full information.

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Today’s presenters – Telix management

Dr. Christian Behrenbruch

Managing Director and Group CEO

Mr. Kevin Richardson

CEO, Precision Medicine

Mr. Richard Valeix

CEO, Therapeutics

Dr. David N. Cade, MD

Group Chief Medical Officer

Dr. Michael Wheatcroft

Vice President Discovery Sciences

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Key Opinion Leaders

Dr. Alicia Morgans

Associate Professor of Medicine Harvard Medical School, Director of Adult Survivorship Program, Dana-Farber Cancer Institute, Genitourinary Medical Oncologist

Dr. Varun Sundaram

Surgical Urologist and Advanced Prostate Cancer Specialist with Urology Austin

Dr. Sumanta Pal

Professor and Vice Chair of Academic Affairs, Department of Medical Oncology and Therapeutics Research, Co-director Kidney Cancer Program, City of Hope

Dr. Arthur Braat

Associate Professor Translational Nuclear Oncology and Nuclear Medicine Physician University Medical Center Utrecht

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Views expressed are speakers' own. Any presenter's response during Q&A has not been reviewed in advance by Telix.

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Strategy & overview

Dr. Christian Behrenbruch
Managing Director
and Group CEO

Five pillars defining our competitive leadership in radiopharma

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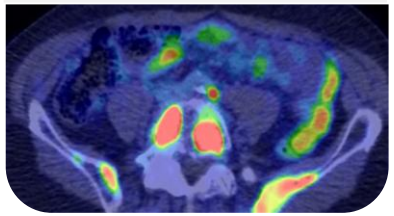
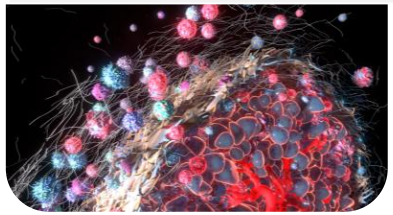
Integrated Theranostic Approach
See It. Treat It.

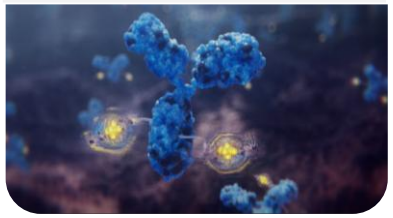
High value therapeutics pipeline



R&D platform for new molecular entities



Precision Medicine portfolio



Specialist commercial organization

Vertically integrated manufacturing and supply chain

Three FDA approvals across prostate and glioma imaging

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

- Launched in **22 countries**[1]
- **17 countries**[1] **in Europe**
- NDA under review by NMPA in **China**[2]
- Registration enabling study in **Japan**[3]

Pixclara®
(floretyrosine F 18)

- First FDA-approved FET-PET imaging drug for glioma[4]
- Included in National Comprehensive Cancer Network (**NCCN®**) **guidelines**
- Inclusion in **International guidelines:** EANM/EANO /RANO/SNMMI

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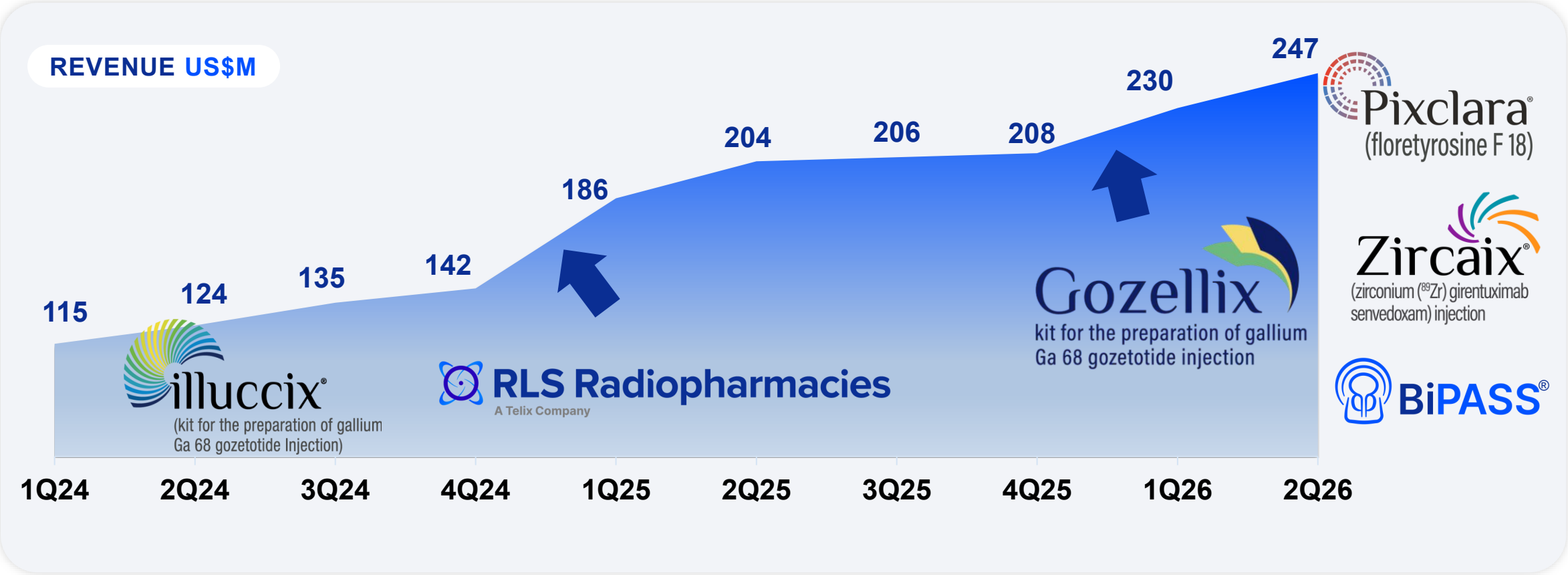
NDA = New Drug Application. NMPA = National Medical Products Administration.
1. Telix ASX disclosure April 6, 2026. 2. Telix ASX disclosure January 20, 2026. 3. Japan Registry of Clinical Trials identifier: JRCT2031250473.
4. Telix ASX disclosure September 14, 2026.

A proven track record of commercial execution

Revenue has more than doubled since 2024

Near-term growth drivers



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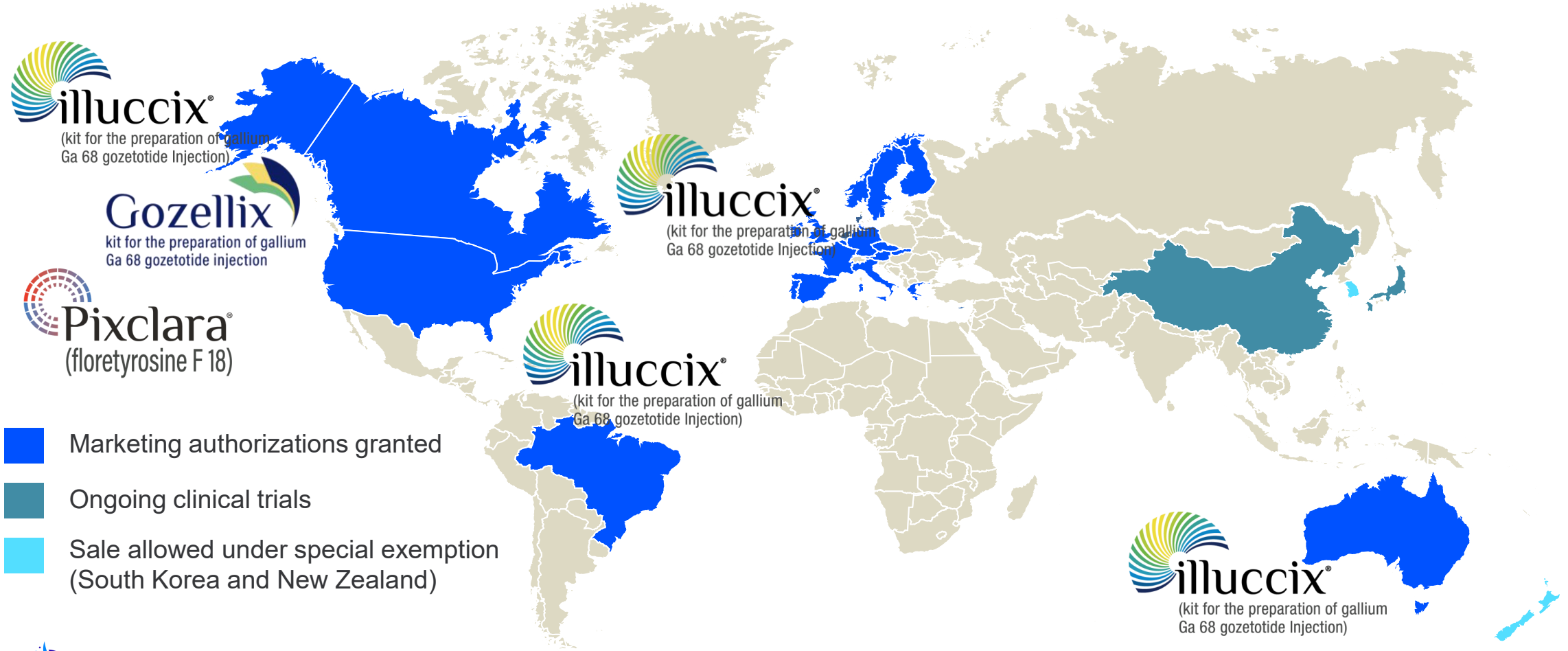
Note: Zircaix and BiPASS have not been evaluated, approved, or cleared by the FDA to diagnose, treat, cure, or prevent any disease. Brand names subject to regulatory approval.

Creating a fully integrated global radiopharma leader

Building on U.S. success to drive global growth



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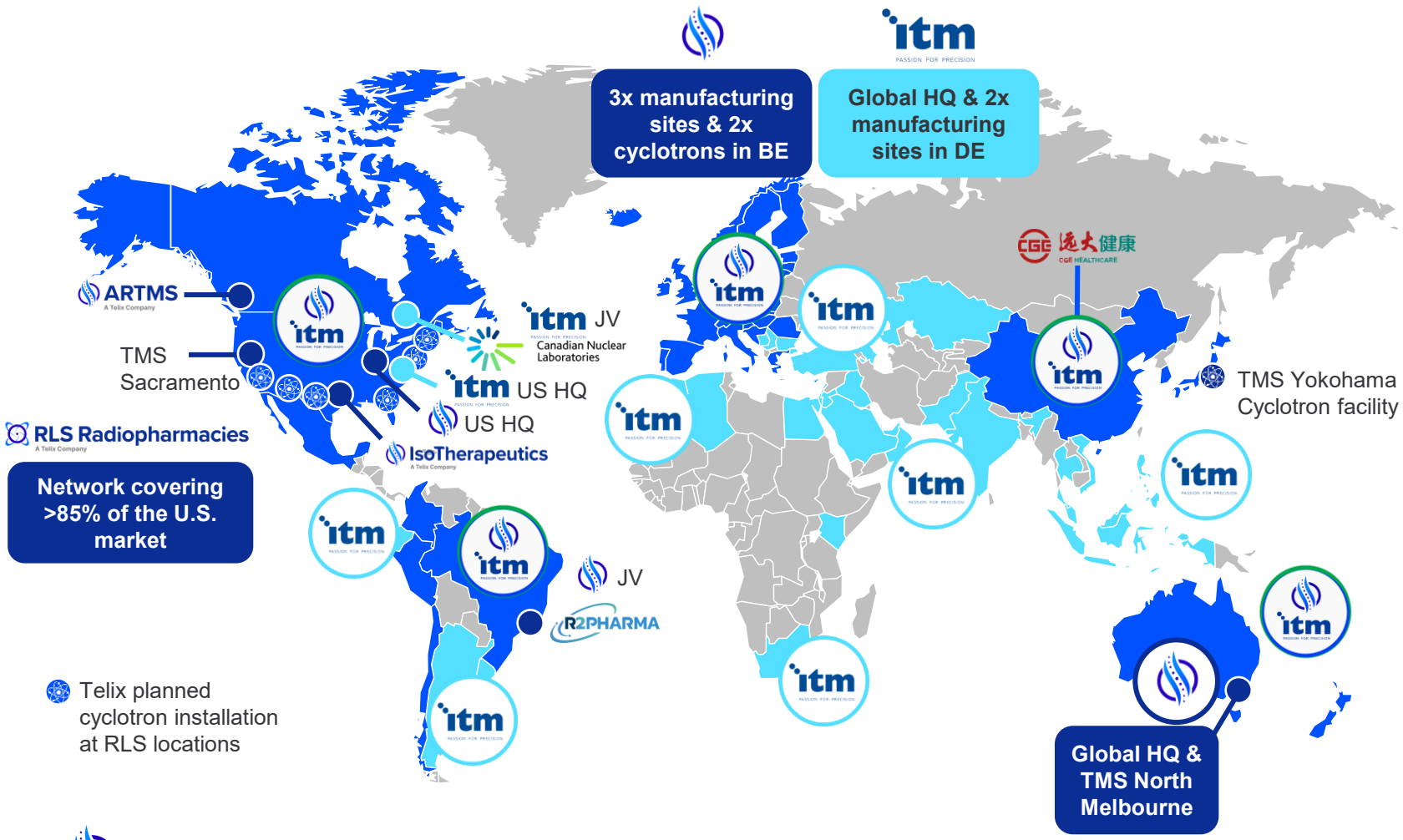
Global network enables just-in-time delivery at commercial scale

Opens new market opportunities for Telix's products



itm[1]

- **>99%** Order fulfillment rate (2025A)
- **Just-in-time delivery:** 24-48hr within EU/US and 72hr across 65 countries worldwide
- **>400[2]** Destinations supplied weekly
- **Partnered reactor network** spanning Europe, Africa, North America, and Australia
- **Exclusive, long-standing distributor partnerships** in key markets

Telix

1. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.
2. Includes direct customer sites, customer sites managed by distributors and B2B customer sites. >1,000 end-market customer sites reached.

Strategic investments and partnerships for long-term growth

Capabilities across manufacturing & supply, R&D and isotope production

Telix

1. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Telix + ITM creates a differentiated and scaled global platform

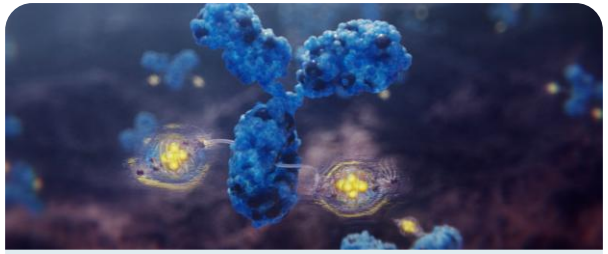
Three complementary growth engines under one platform

Telix + itm[1] PASSION FOR PRECISION

Best-in-class radioisotope manufacturing and supply

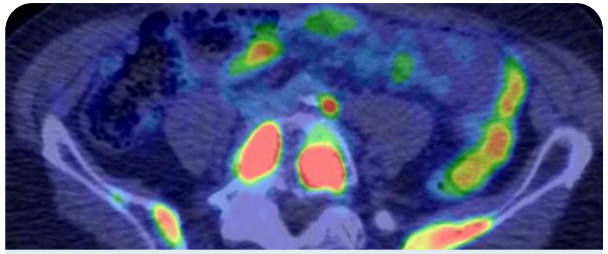
- **Global radioisotope demand** for commercial and clinical use is increasing
- **ITM's high growth**, high-margin radioisotope manufacturing enhances cash generation
- **End-to-end integration of critical global supply chain** derisks supply for future commercial products

Industry's most advanced therapeutic pipeline



- **Potential near-term revenue contribution from ITM-11** with further upside from indication expansion
- Expansion into **commercially validated NET market**
- **Synergies** expected from disciplined capital allocation and optimizing in-house R&D capabilities

Scaled commercial precision medicine



- **Commercially scaled** high growth business
- **Near-term revenue diversification** and growth potential through new products and label expansion
- ITM's complementary pipeline adds **attractive lifecycle management** opportunities

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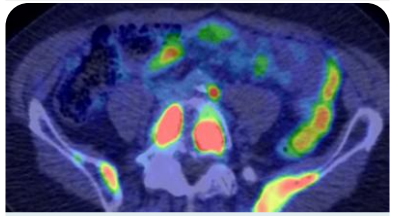
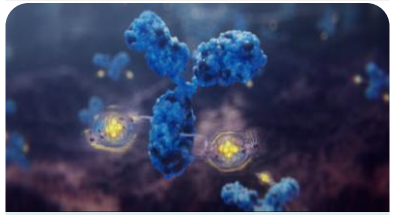
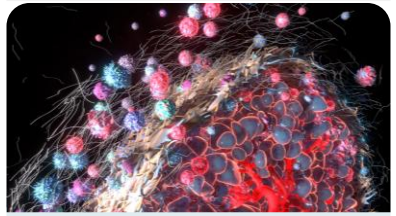
1. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Transaction reinforces Telix's growth strategy

The combination of ITM + Telix enhances our ability to compete

Telix + itm[1] PASSION FOR PRECISION

Vertically integrated manufacturing / supply chain	High value therapeutics pipeline	Precision Medicine portfolio	Specialist commercial organization	R&D platform for new molecular entities
				
Value creation from therapeutic radioisotopes leadership	Accelerates entry into established NET market	Novel product and life-cycle management opportunities	Adds commercial depth and expertise	Enhanced development capabilities
✓	✓	✓	✓	✓

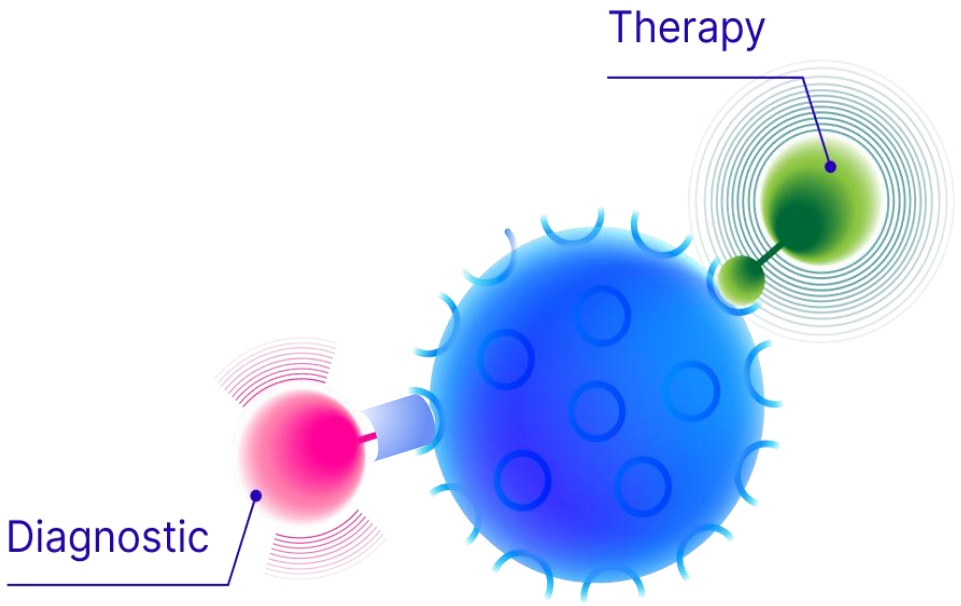
1. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

R&D Strategy

Dr. Michael Wheatcroft

VP, Discovery Sciences

Target selection: Unlocking the advantages of targeted radiation



Our approach to target selection

- **Tumor-specific antigens** that enable a favorable therapeutic window
- **High target prevalence** in the selected indication
- **High expression** to maximize efficient radiation delivery
- **Internalizing targets** supporting sustained intracellular radiation exposure
- **Validated target biology** to inform clinical development
- **Stable, durable target expression** supporting reliable tumor targeting

Established targets in late-stage development (PSMA, CAIX, LAT1); novel targets in early-stage research

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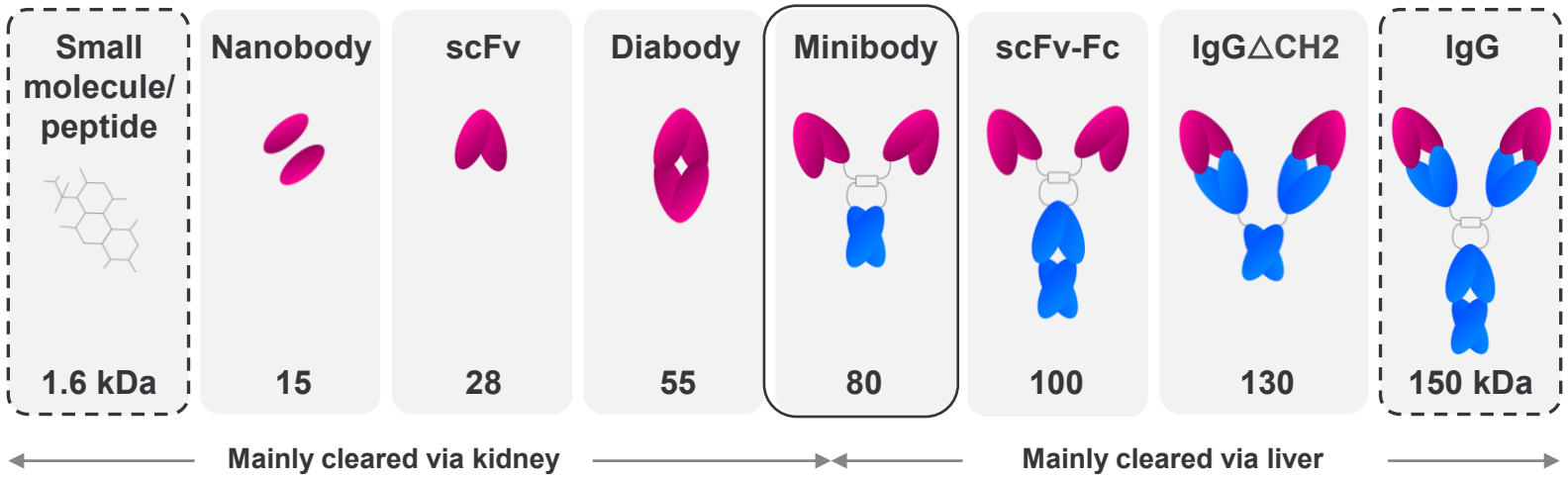
Optimized targeting agents drive next-generation candidates

Different formats offer different features; trade-offs for delivery to and interaction with the cancer cell

Accessing a diversity of formats with different properties supports a range of radioisotopes with differing clinical utilities



Format trade-offs	Small molecule/peptide	Engineered mAb[2]	Full length mAb (IgG)
Time to max. tumor uptake	Fast		Slow
Blood clearance	Fast		Slow
Tumor retention	Low		High
Internalization	Less likely		Highly likely

A modality agnostic approach enables the right candidate for the right clinical need

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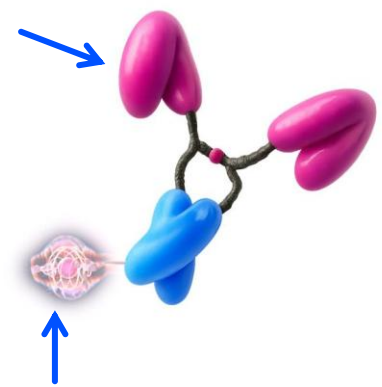
1. Wu et al. *Methods.* 2014; PK: Pharmacokinetics. 2. Monoclonal antibody.
3. Telix ASX disclosure January 31, 2025. Telix acquired a proprietary novel biologics technology platform from ImaginAb, Inc.

Minibody candidates advancing into the clinic



TLR602-Tx [^{212}Pb/^{225}Ac]

Target: αvβ6 Integrin

Potential indications:

Non-Small Cell Lung Cancer, NSCLC

Target Validation

Highly expressed across a range of cancers:

- 90%+ of ovarian cancer[1,4]
- 90%+ of pancreatic cancer[2,4]
- 50%+ of NSCLC[3,4]

Status

Planning FIH imaging study to demonstrate clinical proof of concept utilizing [^{89}Zr]

TLR603-Tx [^{212}Pb/^{225}Ac]

Target: DLL3 (Delta Like Ligand-3)

Potential indications:

Small Cell Lung Cancer, SCLC

Target Validation

Expressed in 85% of SCLC patients[4,6]

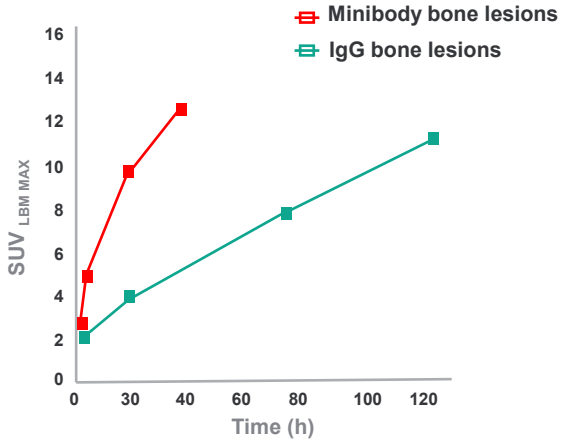
High unmet need: 9% 5-year survival rate[6]

Status

Planning FIH imaging study to demonstrate clinical proof of concept utilizing [^{89}Zr]

Minibody clinical example[7]

(1st Gen. PSMA minibody uptake @MSKCC)



1: Ahmed et al. *Carcinogenesis*. 2002. 2. Sipos et al. *Histopathol*. 2004. 3. Elayadi et al. *Cancer Res.* 2007. 4. American Cancer Society, Key Statistics 2025 https://www.cancer.org/cancer/types.html. 5. Rojo et al. *Lung Cancer.* 2020. 6. American Cancer Society, Key Statistics 2025 https://www.cancer.org/cancer/types.html. 7. Pandit-Taskar N, et al. *J. Nuc. Med.* 2016.

Matching alpha and beta emitters to tumor biology

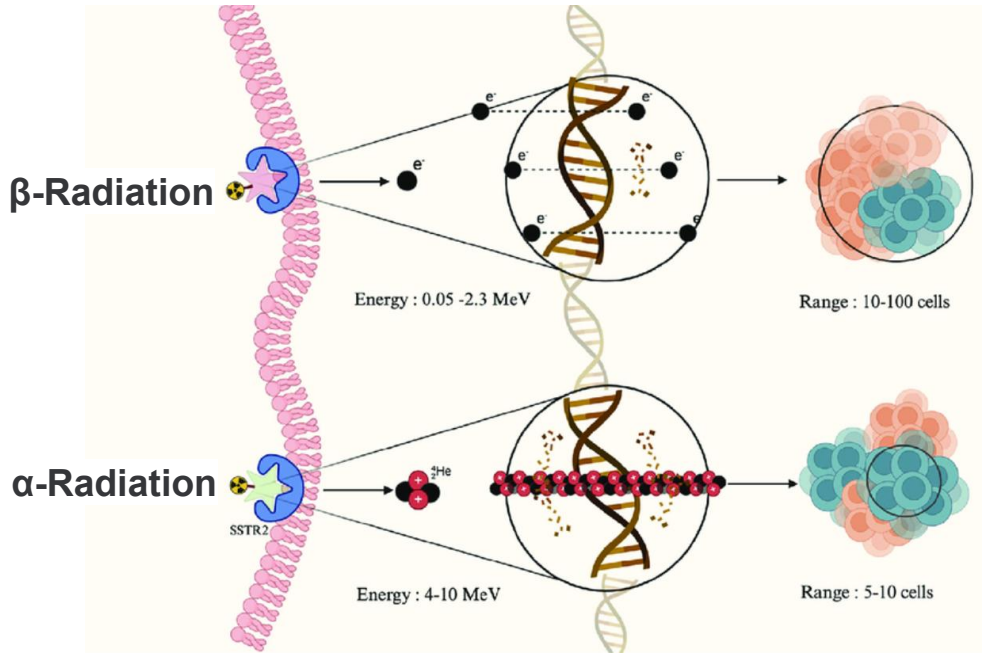
Radioisotope paired to utility

- Emission profile
- Half-life vs pharmacokinetics
- Depth of penetration
- Tumor size / distribution
- Tumor microenvironment & heterogeneity
- Supply chain considerations

Match the radioisotope to targeting agent & use:

- Diagnostic <> Therapeutic utility
- Fast kinetics <> Slow kinetics

α vs β Therapeutic radiation



Isotope selection tailored to biology, target and clinical activity

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Global manufacturing, distribution & clinical support capabilities

ARTMS QIS® technology, enabling highly efficient, cost-effective isotope production

Sacramento, U.S.
Clinical manufacture

Multiple RLS sites in the U.S. with enhanced capabilities and therapy lines being added to selected sites

Seneffe, Belgium
GMP[3] capacity to deliver therapeutics

Yokohama, Japan
ARTMS QIS® for isotope production

New Translational facility in Melbourne, Australia
Clinical manufacturing, radiotracer dosing and SPECT/CT imaging

TMS site

Strategic partner[1,2]

1. Telix Innovations Brazil, Ltda., joint venture with R2PHARMA, a subsidiary of GSH Corp Participações S.A. (Grupo GSH), Telix as 51% owner.
2. Partnership with Grand Pharmaceutical Group Limited (Grand Pharma) for the Greater China region.
3. Good Manufacturing Practice. TMS = Telix Manufacturing Solutions

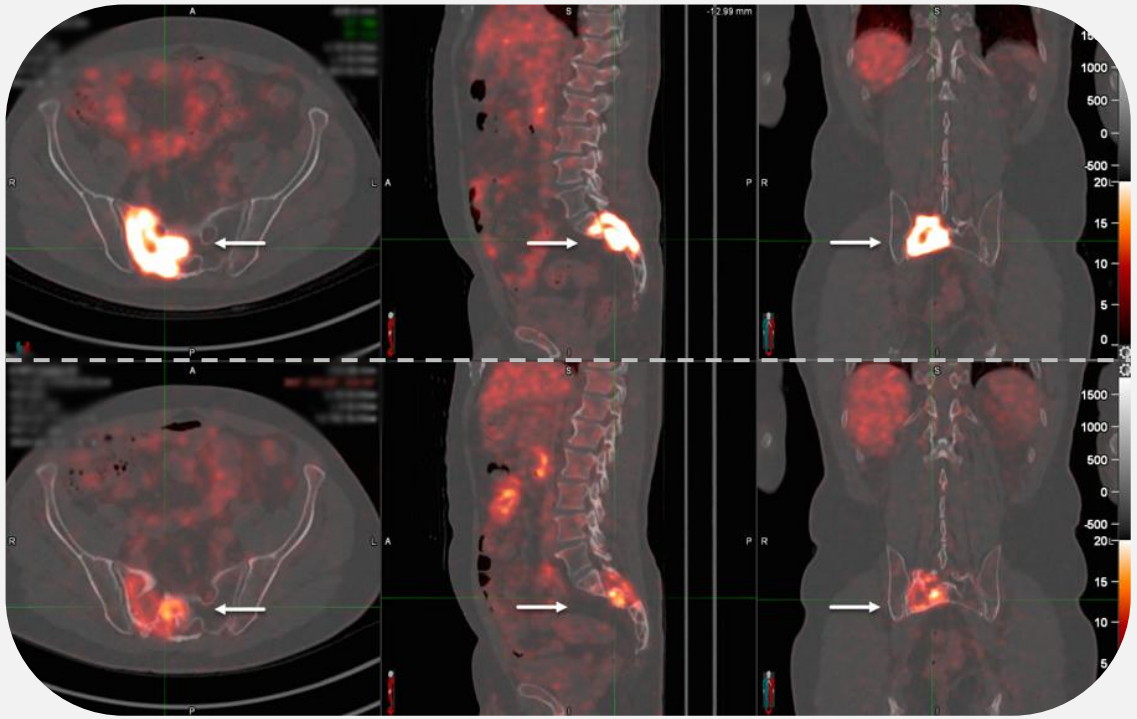
De-risking therapeutic development through early imaging studies

Imaging ⟷ **Therapeutics**

Imaging complements Therapeutic development

- ✓ Confirms clinical proof of concept
- ✓ Provides safety dosimetry estimates to optimize dosing
- ✓ Identifies the right patient population
- ✓ Supports clinical endpoints

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.

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

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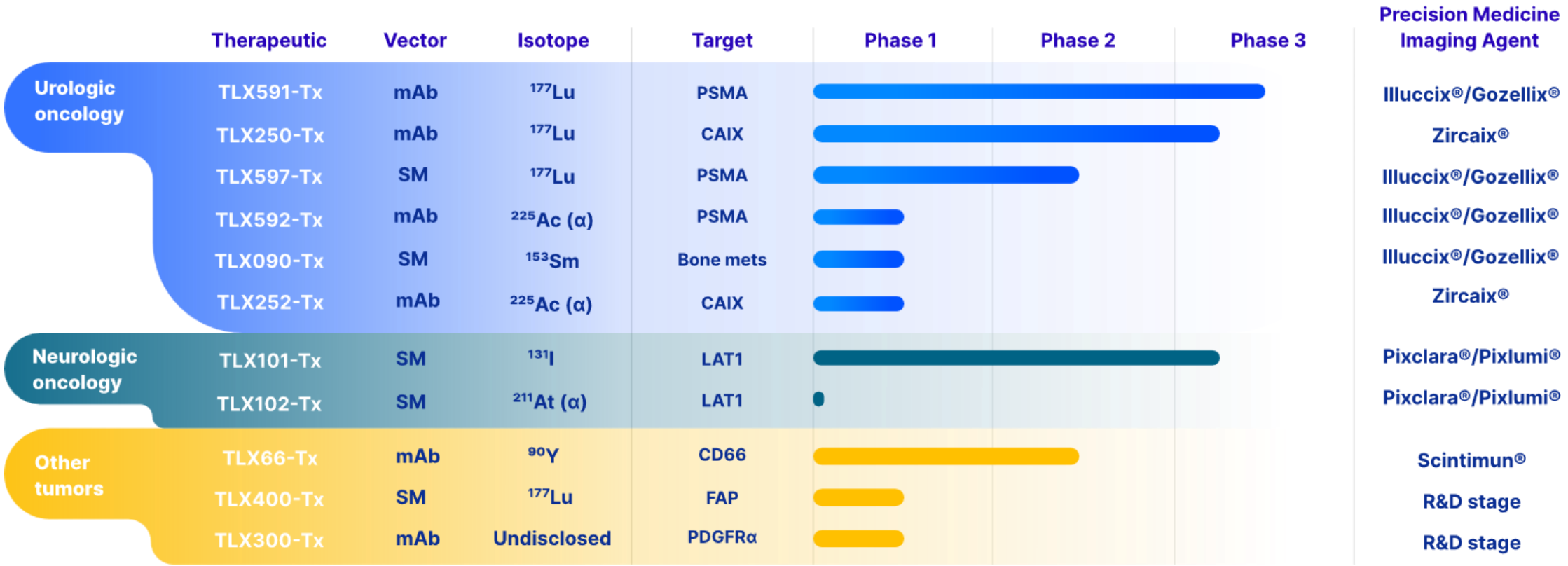
Pipeline Overview

Mr. Richard Valeix

CEO, Therapeutics

Pipeline: Late-stage and “next generation” assets



Pixlumi, Zircaix brand names subject to regulatory approval.

PSMA: Prostate-specific membrane antigen.
CAIX: Carbonic anhydrase IX.
LAT1: L-Type amino acid transporter 1.
CD66: Cluster of differentiation 66.
PDGFRα: Platelet-derived growth factor receptor alpha.
mAb: Monoclonal antibody.
SM: Small molecule.
FAP: Fibroblast activation protein.

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Transformative portfolio expansion across early and late-stage assets

REGENERON
SCIENCE TO MEDICINE®

- Co-development and co-commercialization agreement to develop candidates focused on **alpha therapies**
- **4** initial therapeutic programs, with option for **4 additional programs**
- Up to **$2.1B USD** developmental and commercial milestone payments plus royalties (4 programs), with option for 4 additional programs

itm
PASSION FOR PRECISION

- Adds a complementary therapeutic franchise with **multiple pathways for growth**
- **ITM-11 Phase 3 expansion** programs create meaningful commercial opportunities
- Late-stage pipeline supports **label expansion** into G2/G3 GEP-NETs, plus NETs of lung or thymus origin
- Globally scaled commercial-grade supplier - world's largest **supplier of ^{177}Lu**

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Notes
For Regeneron: Telix ASX disclosure April 13, 2026.
For ITM: Telix ASX disclosure September 21, 2026. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Prostate Cancer Overview

Dr. Alicia Morgans

Associate Professor of Medicine at Harvard Medical School

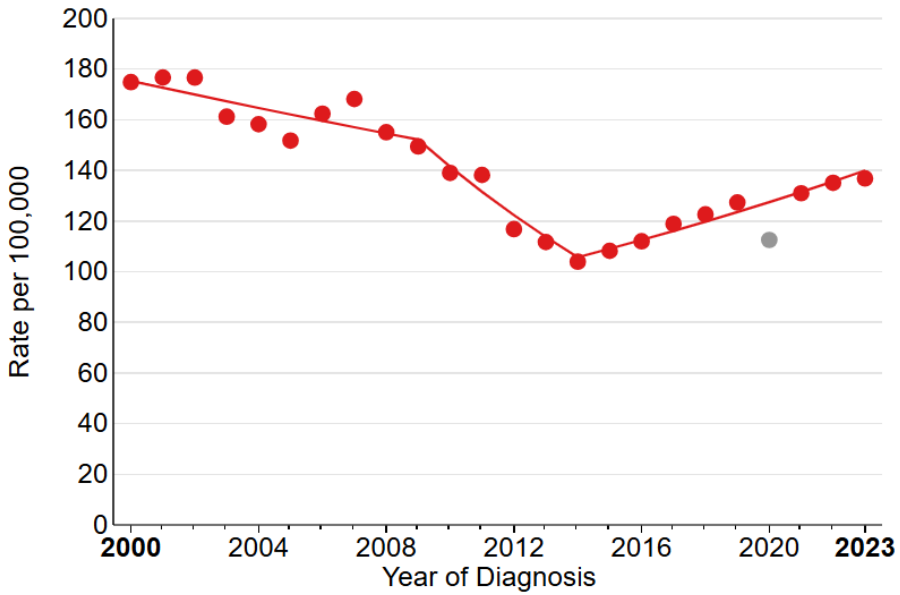
Genitourinary Medical Oncologist at Dana-Farber Cancer Institute

Prostate Cancer: Disease Overview

Most common cancer in men, second leading cause of cancer death in U.S.[1]

- **1 in 8 men diagnosed with prostate cancer during their lifetime, 1 in 44 patients die from it[1]**
- Projected U.S. figures for 2026[1]:
  - **333,830** new prostate cancer diagnosis
  - **36,320** deaths from prostate cancer
- **Metastatic disease** remains associated with substantially poorer outcomes, with a **5-year survival rate of 38%** vs. 90% for earlier disease[2]

Annual Incidence (US)[1]



Despite therapeutic advances, prostate cancer remains a substantial unmet need

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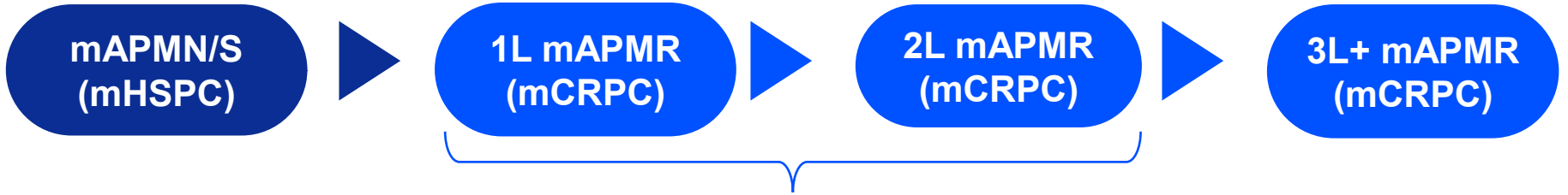
1. American Cancer Society (Cancer Facts & Figures 2025). The American Cancer Society relies on information from SEER (Surveillance, Epidemiology, and End Results) database, maintained by the National Cancer Institute.
2. American Cancer Society, between 2015 – 2021.

Prostate Cancer patient journey

Global Standards of Care (SoC) continue to evolve

Treatment algorithm for metastatic prostate cancer[1]



- **ARPI**
- **Taxane for high volume disease**
- **PARP in BRCA2m only[4]**
- **^{177}Lu-PSMA-617 recent approval[4]**

- **ARPI**
- **Taxane**
- **^{177}Lu-PSMA-617 pre-taxane[3]**
- **^{223}Radium in bone predominant disease only**
- **PARPs in BRCA2m and HRRm only[5]**

- **Taxane**
- **^{177}Lu-PSMA-617 post-taxane[2]**
- **^{223}Radium in bone predominant disease only**
- **PARPs in BRCA2m and HRRm only[5]**

Renal toxicity & QoL considerations increase, especially in earlier disease settings

Prostate Cancer Working Group 4 (PCWG4) Clinical States: mAPMN/S = metastatic androgen pathway modulator naïve / sensitive; mAPMR = metastatic androgen pathway modulator resistant, HRRm = Homologous Recombination Repair Mutation. mHSPC = metastatic hormone resistant prostate cancer. mCRPC = metastatic castration resistant prostate cancer. ARPI = androgen receptor pathway inhibitor. PARP = poly(ADP-ribose) polymerase.

1. Adapted from Calais J. UCLA 2023 EANM 2023; NCCN Guidelines Version 5.2026 Category 1, 2. ClinicalTrials.gov ID: NCT03511664. 3. ClinicalTrials.gov ID: NCT04689828; NCCN Guidelines Version 5.2026 Category 2A. 4. NCCN Guidelines V7.2026: Some Panel members advocate waiting for more mature follow-up before using this regimen in the mCSPC (mAPMN/S) setting given the lack of OS benefit, moderate acute toxicity, and uncertain late toxicity. 5. Homologous recombination repair mutation: e.g. HRR, BRCA2.

Advancing beyond first generation PSMA RLT

Managing xerostomia (dry mouth) and off-target uptake, remains an important unmet need

Select USPI Adverse Reactions in patients treated with 177Lu-PSMA-617	PSMAddition 177Lu-PSMA-617 + ARPI		PSMAfore 177Lu-PSMA-617		VISION 177Lu-PSMA-617 + BSOC	
	All Grades (%)	Grades 3 or 4 (%)	All Grades (%)	Grades 3 or 4 (%)	All Grades (%)	Grades 3 or 4 (%)
Xerostomia	46	0	61	0.9	39	0
Decreased eGFR	43	1.8	41	0.9	42	3.4

Long-Term Nephrotoxicity of ^{177}Lu-PSMA Radioligand Therapy

Lisa Steinhelfer*[1,2], Lukas Lunger*[3], Lisena Cala[1], Chr
Andreas K. Buck[5], Hannah Schäfer[6], Christoph Schmac
Valentin H. Meissner[3], Karina Knorr[1], Wolfgang A. W

Assessment of nephrotoxicity following lutetium-177 PSMA I&T radioligand therapy: a comparative study with docetaxel chemotherapy

Florian P Kirchhoff[1] · Lisa Steinhelfer[2,3] · Christian H. Pfob[4] · Constantin Lapa[4] · Philipp E. Hartrampf[5] · Andreas K. Buck[5] · Robert Tauber[1] · Hannah Schäfer[6] · Christoph Schmaderer[6] · Cornelia Fütterer[7] · Bernhard Haller[7] · Matthias Jahnen[1] · Karina Knorr[2] · Jürgen E. Gschwend[1] · Wolfgang A. Weber[2] · Matthias Eiber[2] · Lukas Lunger[1]

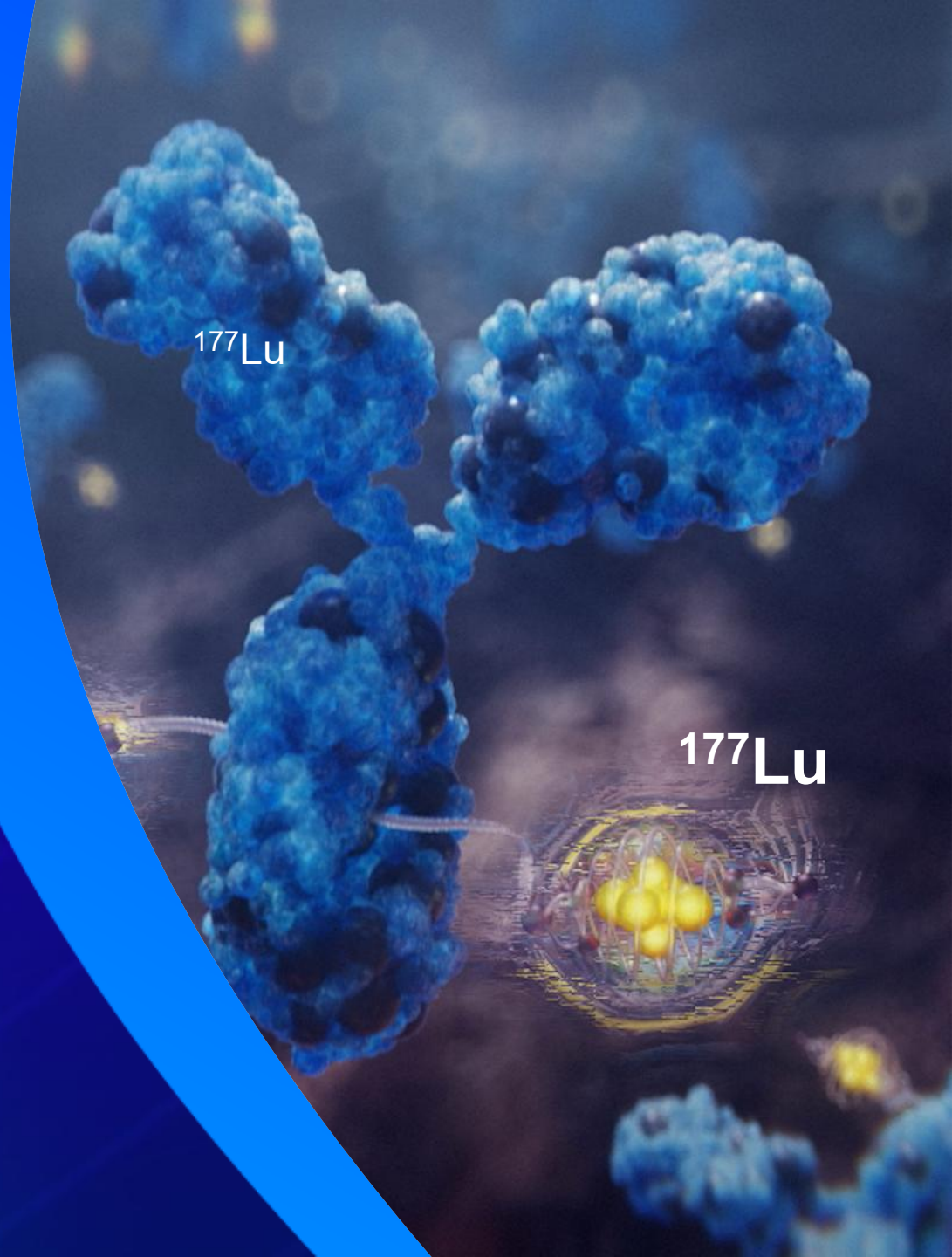
Xerostomia from salivary gland uptake impacts Quality of Life (QOL):

- **Grade 2:** Oral intake alterations
  - Mouth lubricants, saliva substitutes, restricted diet (purees and/or soft moist foods)
- **Grade 3:** Inability to adequately aliment orally
  - Tube feeding or Total Parenteral Nutrition (TPN)- nutrition provided by IV

Risk of acute kidney injury, emerging concerns of long-term renal toxicity as agents move up treatment lines

1. Pluvicto Full Prescribing information, revised 07/2026.
2. National Cancer Institute Common Terminology Criteria for Adverse Events (NCI CTCAE) Version 5.0.

TLX591-Tx

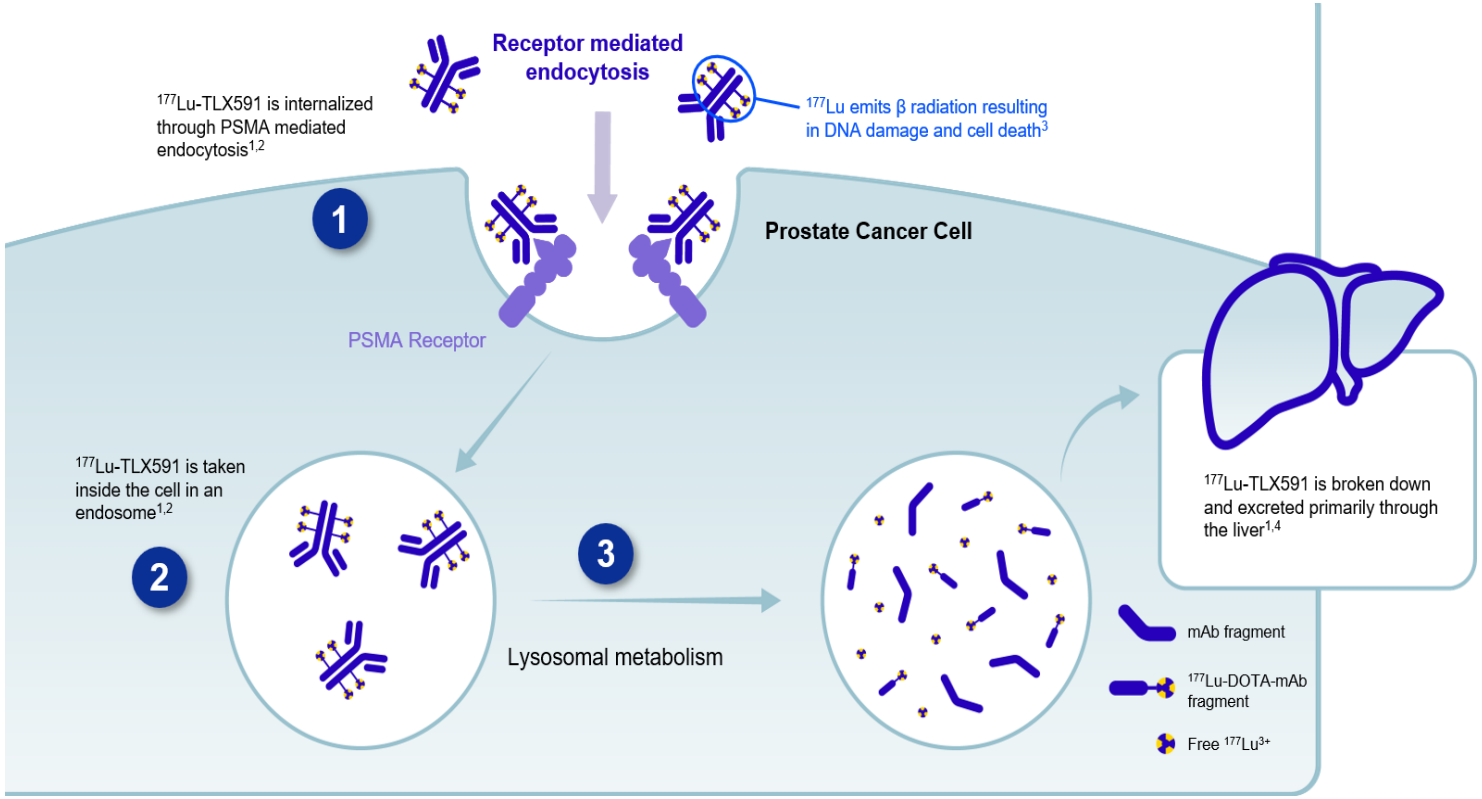


TLX591-Tx is a novel therapy candidate for prostate cancer

Radio antibody-drug conjugate (rADC) approach addresses key unmet needs[1-4]

1. **Patient friendly 2-dose / 2-week regimen:** Supports compliance to treatment and ease of integration with standard of care (SOC)
2. **Safety and tolerability profile:** Low radiation to salivary glands and kidneys, transient and manageable hematologic profile
3. **Internalization and prolonged retention:** Delivering a payload to the tumor, potentially maximizing cell killing effect
4. **Supply, access, and radiation protection:** Potential real-world advantages from lower administered activity (76 mCi per dose)

Mechanism of Action



1. Sartor O, et al. Presented at: American Society of Clinical Oncology Annual Meeting 2024; TPS5115.
2. Sun M, et al. *Curr Oncol Rep.* 2021.
3. Lenzo et al. *Cancers (Basel)* 2026.
4. Tagawa ST, et al. *Cancer.* 2019.

Phase 3 study for TLX591-Tx

Part 1 completed, with FDA alignment to advance to Part 2 in U.S.[1]

Part 1: Safety and dosimetry: completed

- TLX591-Tx (76mCi) x 2 cycles + abiraterone n = 10
- TLX591-Tx (76mCi) x 2 cycles + enzalutamide n = 10
- TLX591-Tx (76mCi) x 2 cycles + docetaxel n = 10

n = 30

Data review

Part 2: Randomized treatment expansion

2:1

- TLX591-Tx + abiraterone/ enzalutamide/ docetaxel
- abiraterone enzalutamide docetaxel

n = ~490

Primary endpoints (Part 1)

- Safety and dosimetry

Primary endpoint (Part 2)

- rPFS[6] by BICR[7]

Global, multi center, open label study

Eligibility: mAPMR[2] patients progressing on first ARPI
Status: Enrolling patients in Part 2 globally[8] (Japan approved for Part 1)

1. Data to be submitted to the FDA following Type B meeting, to seek IND amendment to proceed to Part 2 in the U.S. 2. Metastatic androgen pathway modulation resistant prostate cancer. 3. Safety & tolerability reported as adverse events. 4. Independent Data Monitoring Committee review, October 2025. 5. Japanese regulator has granted approval for a Japan-specific Part 1 in nine patients, prior to commencing Part 2. 6. Radiographic progression-free survival. 7. Blinded independent central review. 8. Australia, New Zealand, Canada, Singapore, South Korea, Türkiye and UK.

Clinicaltrials.gov: NCT06520345

Acceptable safety profile confirmed with no new safety signals

Non-hematologic events were low grade, hematologic events were transient and manageable

Key observations

Treatment emergent adverse events (TEAE)

- Most prevalent non-hematologic adverse events were fatigue (53%), nausea (28%) and dry mouth (25%)
- Almost all TLX591-Tx related non-hematologic events were grade 1 or grade 2[2]
- No treatment-related deaths

Hematologic events: In line with profile expected for this class of therapy

- **Grade 3** thrombocytopenia 5/36 (14%) and neutropenia 8/36 (22%) events in line with profile expected for this class of therapy; single Grade 3 anemia
- **Grade 4** thrombocytopenia 11/36 (31%) and neutropenia 9/36 (25%)

ProstACT Global Part 1 (safety TEAE)[1]

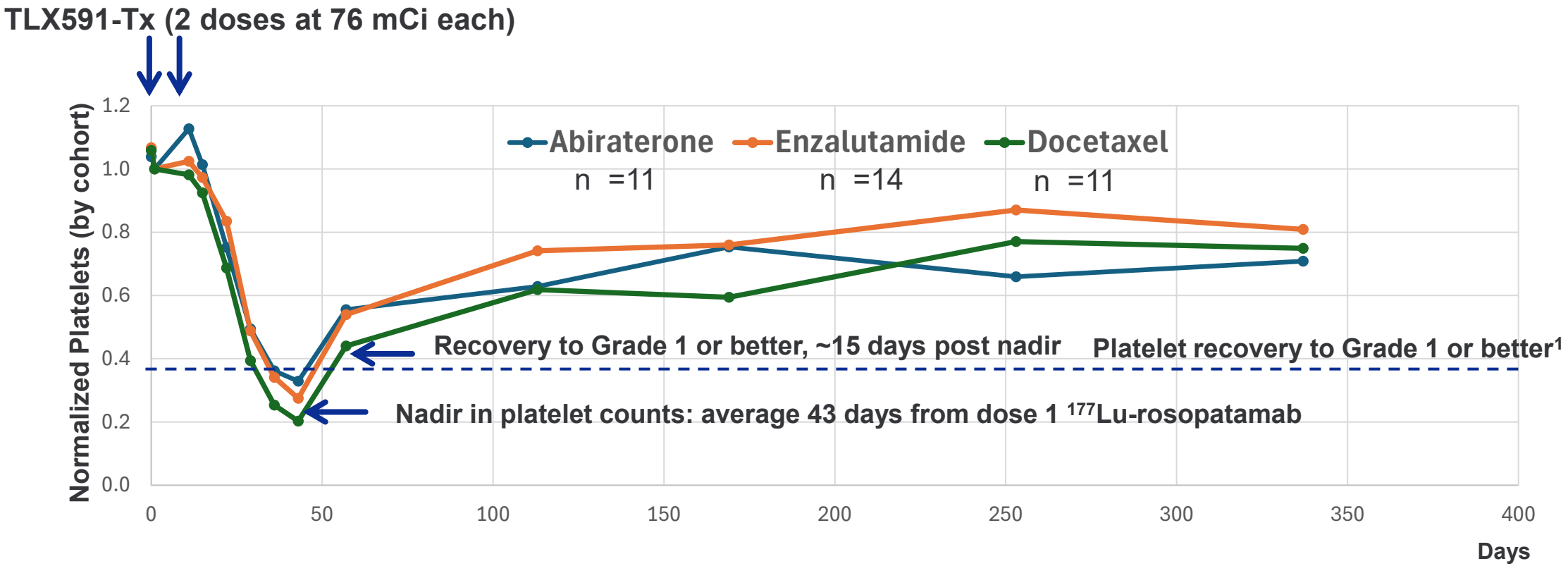
Adverse Event	Grade 1	Grade 2	Grade 3	Grade 4	Total (n)	% of N=36
Non-hematologic events						
Fatigue	10	7	2	0	19	53
Nausea	5	4	1	0	10	28
Dry mouth	9	0	0	0	9	25
Diarrhea	5	3	0	0	8	22
Back pain	4	3	1	0	8	22
Headache	4	1	0	0	5	14
Hematologic events						
Thrombocytopenia	6	6	5	11	28	78
Neutropenia	2	4	8	9	23	64
Anemia	5	10	1	0	16	44
WBC[3] decrease	0	4	6	5	15	42
Lymphopenia	0	5	8	7	20	56

Patients may have experienced more than 1 event or more than 1 grade of the same event.

1. ProstACT Global Part 1 data on file. Telix Pharmaceuticals.
2. One grade 3 dizziness was considered treatment-related.
3. White blood cell.

Hematological events transient and consistent across cohorts

Platelet counts recovered consistently in all three cohorts at ~15 days post nadir



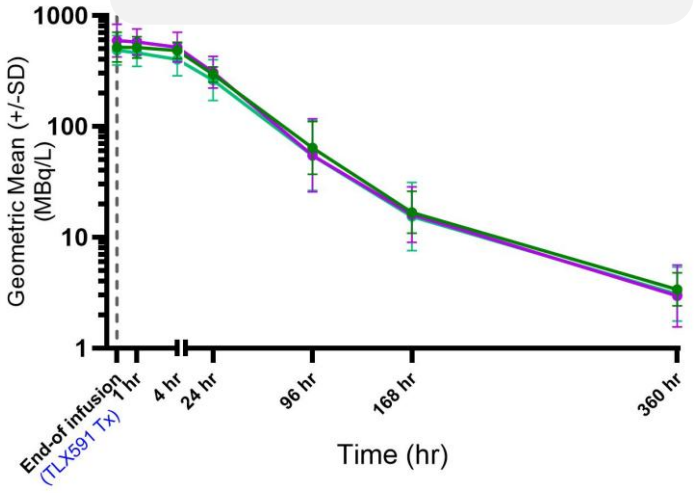
TLX591-Tx, ^{177}Lu-rosopatamab

1. G1 platelets 75,000/µL to 150,000 /µL.
2. ProstACT Global Part 1 data on file. Telix Pharmaceuticals.

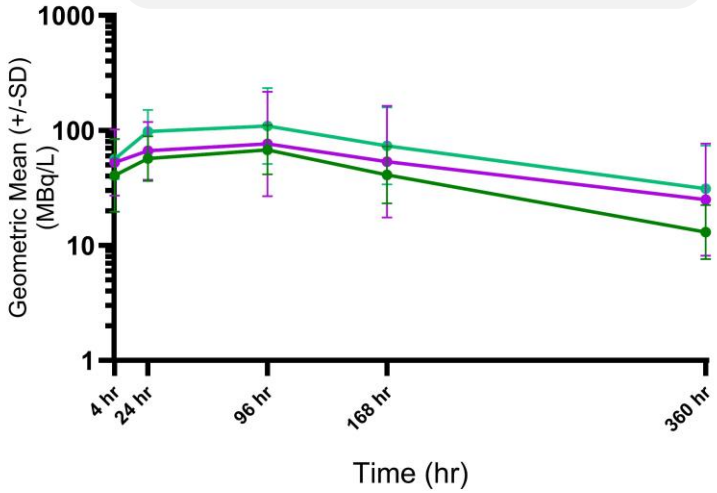
TLX591-Tx demonstrated sustained tumor retention across all cohorts through 15 days

Demonstrates sustained activity, consistent across cohorts[1]

Blood radioactivity
Concentrations-Time Profile



Lesion activity
Concentrations-Time profile



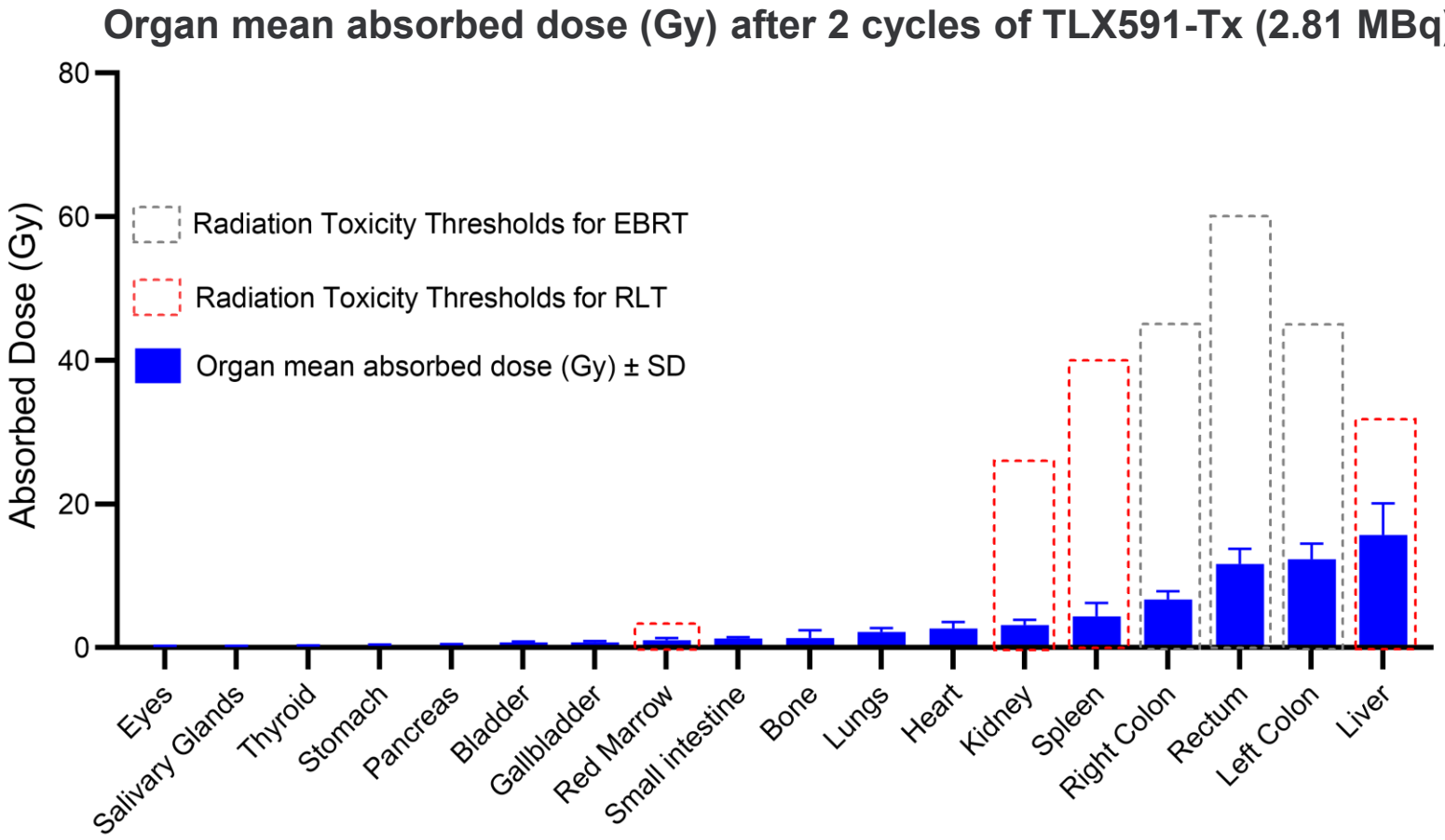
Abiraterone[2,3] Docetaxel[2,3] Enzalutamide[2,3]

Key observations

- **Predictable PK profile:** Low inter-patient variability supports reliable dosing, streamlined clinical development
- **No evidence of drug–drug interaction**: Exposure and washout kinetics were consistent across cohorts
- **Sustained tumor retention**: Lesion activity concentrations remained detectable through 15 days, demonstrating **prolonged radiation exposure to the tumor**

PK and lesion activity analyses are based on imaging datasets provided by the imaging CRO. Demographic and safety summaries are derived from the iQVIA clinical database; differences in patient numbers reflect data availability across datasets.
1. ProstACT Global Part 1 data on file. Telix Pharmaceuticals. 2. Lesion and blood activity concentrations were measured following the first TLX591-Tx dose (2.8 GBq; ~76 mCi). 3. Number of patients in abiraterone cohort (n = 11), Docetaxel (n = 13), Enzalutamide (n = 10).

Organ radiation exposure remained below established safety limits



Key observations

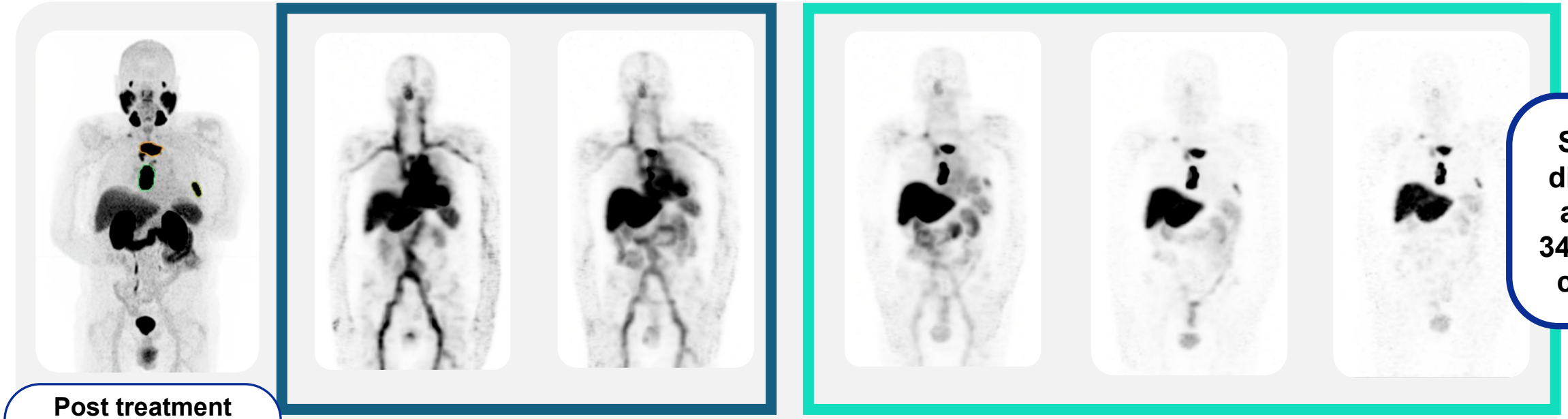
- Liver (clearance organ), colon, rectum, spleen, kidney and red marrow mean absorbed dose (Gy) below threshold for known radiation injury[1,2]
- Dose to organs at risk consistent with ProstACT SELECT data

EBRT: external beam radiation therapy; Gy: Gray; MBq: mega Becquerel; RLT: radioligand therapy; SD: standard deviation; TLX591-Tx, ^{177}Lu-rosopatamab.
Notes: Organ mean absorbed dose reported in (n = 33) patients. Red Marrow dose determined from blood-based assay, 1.03 ± 0.31 Gy for 2 cycles of 2.81 MBq (76 mCi).
1. Wahl RL, et al. *J Nucl Med*. 2021;62(Suppl 3):23S-35S. 2. Emami B, et al. *Int J Radiat Oncol Biol Phys*. 1991;21(1):109-22.

Patient case: TLX591-Tx (2 doses) + docetaxel (6 cycles)

83-year-old patient with bony metastatic lesions[1]

SPECT TLX591-Tx biodistribution: Single dose **Distribution of TLX591-Tx over 15 days[2]**



Post treatment SPECT imaging after one injection of TLX591-Tx

TLX591-Tx seen in the vascular space and liver

TLX591-Tx seen at metastatic sites (and liver)

Stable disease at day 341 (data cutoff)

BASELINE PET	4 hours	1 day	4 days	7 days	15 days*

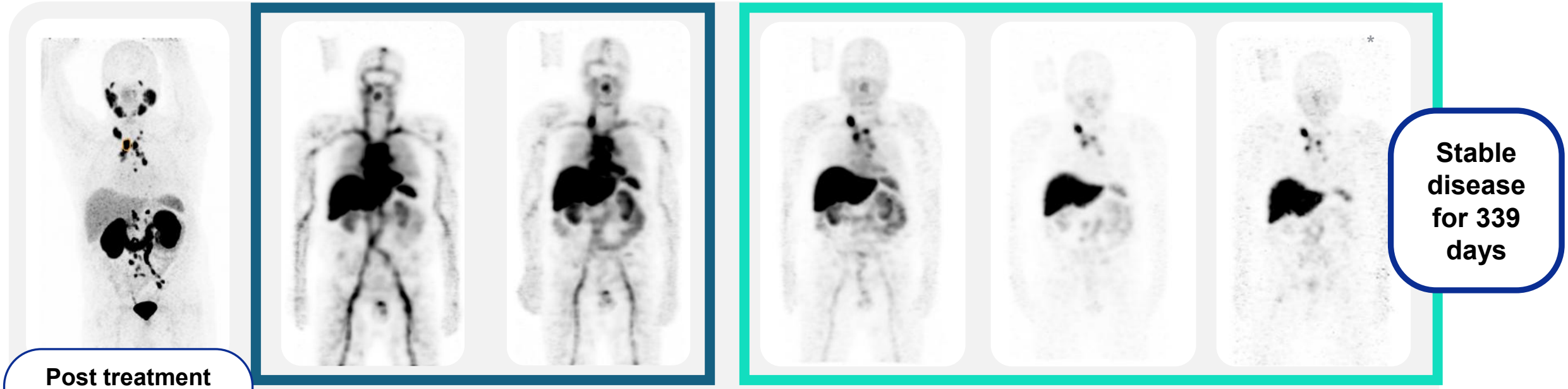
1. Thoracic vertebrae, ribs.
2. ProstACT Global Part 1 data on file. Telix Pharmaceuticals.

Patient representative scans – individual results may vary. Images are non-quantitative.

Patient case: TLX591-Tx (2 doses) + abiraterone

64-year-old patient with metastatic disease in lymph nodes[1]

SPECT TLX591-Tx biodistribution: Single dose distribution of TLX591-Tx over 15 days



Post treatment SPECT imaging after one injection of TLX591-Tx

TLX591-Tx seen in the vascular space and liver

TLX591-Tx seen at metastatic sites (and liver)

Stable disease for 339 days

BASELINE PET	4 hours	1 day	4 days	7 days	15 days*

Telix

TLX591-Tx, ^{177}Lu-rosopatamab

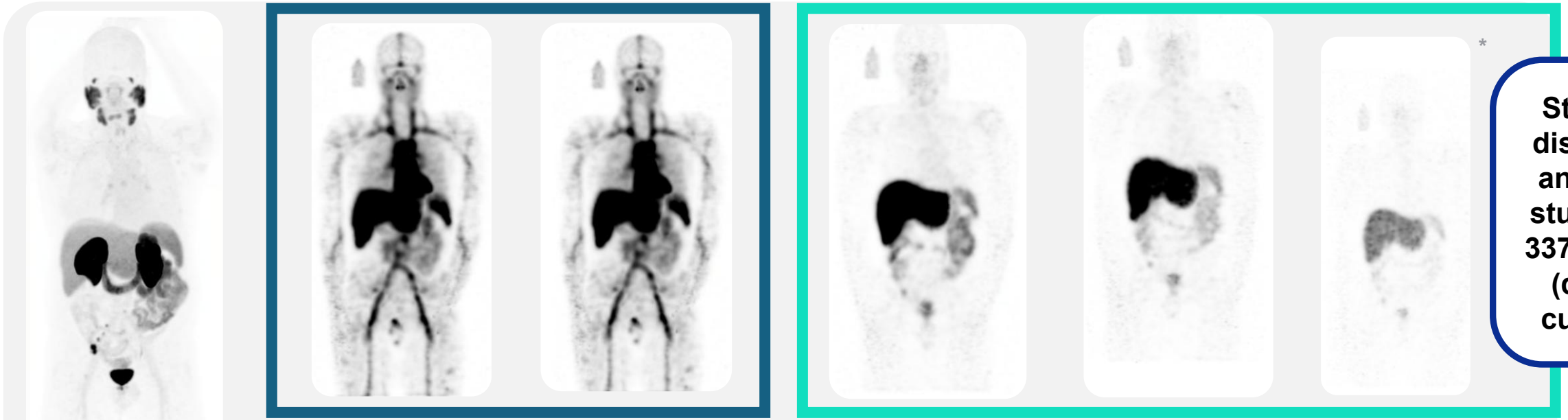
1. Subcarinal, right upper para-tracheal, abdominal, pelvic lymph nodes.

Patient representative scans – individual results may vary. Images are non-quantitative.

Patient case: TLX591-Tx (2 doses) + enzalutamide

62 year-old patient with prior ARPI (darolutamide) and docetaxel[1]

SPECT TLX591-Tx biodistribution: Single dose distribution of TLX591-Tx over 15 days



Administration of first dose of TLX591-Tx

TLX591-Tx seen in the vascular space and liver

TLX591-Tx seen at metastatic sites (and liver)

Stable disease and on study at 337 days (data cutoff)

BASELINE PET	4 hours	1 day	4 days	7 days	15 days*

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TLX591-Tx, ^{177}Lu-rosopatamab

1. Subcarinal, right upper para-tracheal, abdominal, pelvic lymph nodes.

Patient representative scans – individual results may vary. Images are non-quantitative.

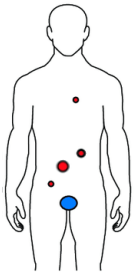
TLX597-Tx

Dr. David N. Cade

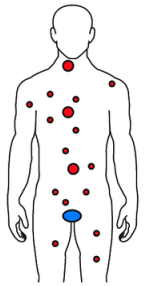
Group Chief Medical Officer, CMO

Disease progression shifts clinical priorities

Distinct prostate cancer disease states bear implications for patient management



Androgen pathway modulator sensitive → **Androgen pathway modulator resistant**



	Androgen pathway modulator sensitive	Androgen pathway modulator resistant
Prognosis and patient profile	• Survival commonly extends beyond 4-5 years[1], generally fitter patients	• Approximately 2-3 years from initiation of 1L therapy[2], greater clinical complexity
Disease biology	• Variable tumor burden, more localized • Responsive to androgen suppression	• Increasing tumor burden • Progressively resistant phenotypes
Clinical implication	• Intensify treatment to delay progression to mAPMR • Preserve long-term quality of life	• Optimize sequencing across limited options • Maximize efficacy at each treatment line

Telix

SOURCES:

1. Kyriakopoulos et al. J Clin Oncol. 2018, Fizazi et al. *Lancet Oncol.* 2019
2. Armstrong et al. Eur Urol. 2020; Ryan et al. Lancet Oncol. 2015

NOTE: Illustrative ranges; outcomes vary by disease volume, prior treatment, patient characteristics and therapy.

Addressing patient needs across the care continuum

TLX597-Tx and TLX591-Tx profiles are adapted to each disease state

	TLX597-Tx: Next gen small molecule[1]	TLX591-Tx: First-in-class rADC[2]
Excretion organ	• Renal excretion BUT with 1/3rd radiation dose to kidney vs PSMA-617	• Liver excretion (radio-tolerant organ) with minimal dose to kidneys
Kidney and salivary gland impact	• Limited kidney dose, radiation to salivary gland 1/5th vs PSMA-617	• Limited kidney dose and negligeable salivary gland uptake
Efficacy signal	• High lesion dosimetry, positive signals from OPTIMAL-PSMA and PTherpan-Lu	• rPFS of 8.8 months in ProstACT SELECT trial
Dosing	• 3-7 doses of 230mCi adaptively administered to limit overtreatment	• 2 doses of 76 mCi enables combination with mAPMR SOC (ARPI and chemo)
	mAPMN/S	**mAPMR**

Telix

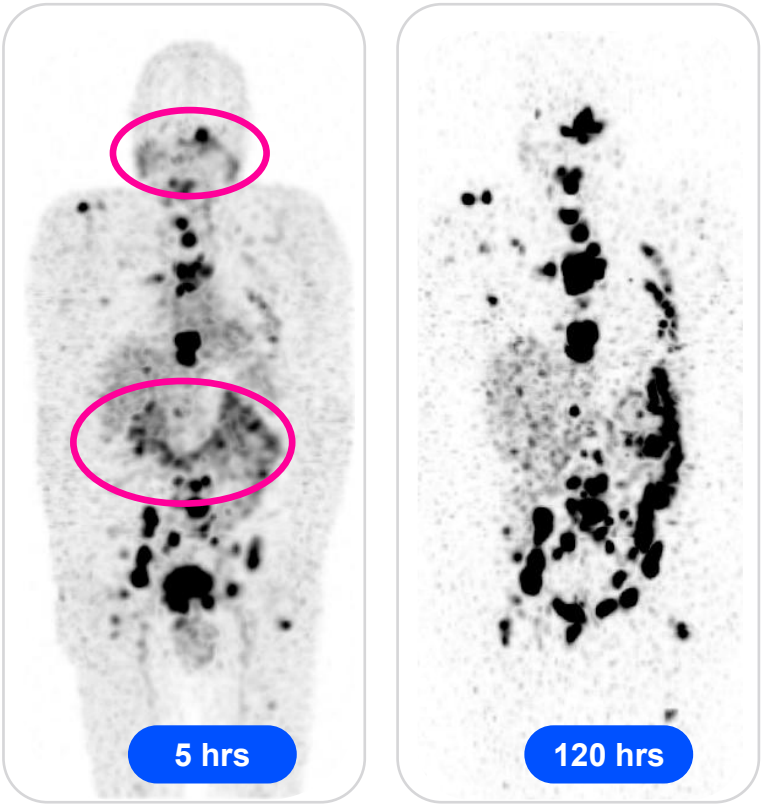
1. Kahn at al. *Dose Optimisation and PSMA Receptor intensification with 177Lu-PSMA-597 in metastatic castration-resistant prostate cancer, the Randomised Phase II OPTIMAL-PSMA trial*, presented at IPCS / APCCC 2026; Omar et al, *[^{177}Lu]Lu-DOTA-HYNIC-panPSMA radioligand therapy for patients with metastatic castration-resistant prostate cancer*, presented at EANM 2025
2. Sartor et al. Presented at: American Society of Clinical Oncology Annual Meeting 2024; TPS5115; Sun et al. *Curr Oncol Rep.* 2021; Lenzo et al. *Cancers (Basel)*. 2026; Tagawa ST, et al. *Cancer.* 2019.

TLX597-Tx early data suggests favorable dosimetry profile

Selective tumor targeting with lower healthy tissue exposure

Gy/GBq	TLX597-Tx (n = 12)[1]		PSMA-617[2] (n = 297)	PSMA-I&T[2] (n = 153)
Kidneys	**0.28**	<	0.58	0.71
Lacrimals	**0.35**	<	1.58	2.83
Submandibular	**0.25**	<	0.74	0.64
Lesions (bone)	**9.74**	>	3.57	4.1
Lesions (soft tissue)	**9.57**	>	4.19	2.94

TLX597-Tx SPECT scan, 5 hrs and 120 hrs



Patient representative scans – individual results may vary.

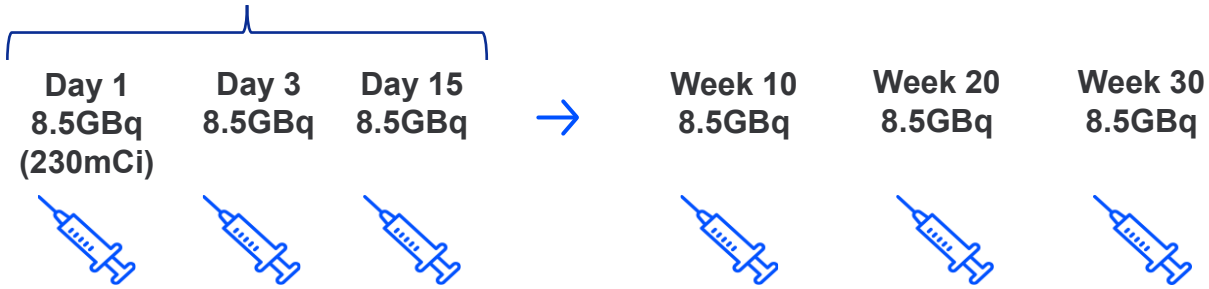
1. Khan et al. *J Nucl Med.* 2026. Final dosimetry report for PSMA-597 (Ascinta Technologies).
2. Ells et al Dosimetry of [177Lu]Lu-PSMA–Targeted Radiopharmaceutical Therapies in Patients with Prostate Cancer: A Comparative Systematic Review and Meta analysis. JNM 2024; 65:1264–1271.

Leveraging dose intensification and higher activity to enhance tumor response

Dose intensification consists of 2 components

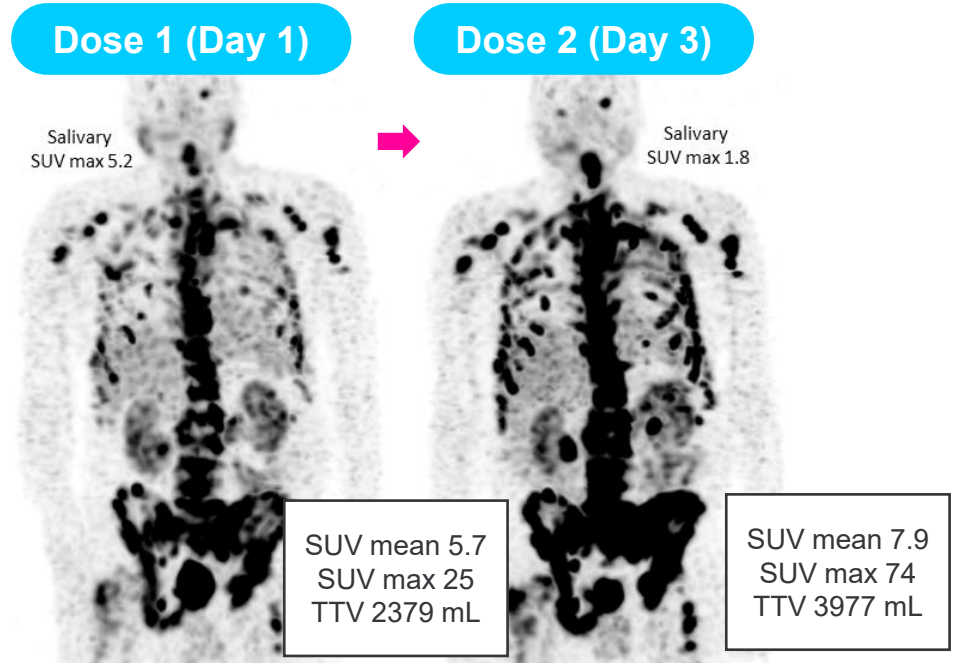
1 **First 3 doses administered** in 15 days

2 **Higher administered activity** of 8.5GBq/dose vs 7.5GBq



Dose intensification and higher activity are enabled by a favorable safety profile and biodistribution

PSMA up-regulation can be seen 3 days after the initial dose through higher TTV



Patient representative scans - individual results may vary.

The rationale is to exploit upregulated PSMA expression and incomplete tumor DNA repair

Telix

1. Crumbaker at al. *Dose Optimisation and PSMA Receptor intensification with 177Lu-PSMA-597 in metastatic castration-resistant prostate cancer, the Randomized Phase II OPTIMAL-PSMA trial*, presented at ASCO GU 2026.

TLX597-Tx, Phase 2 OPTIMAL-PSMA study

Exploring safety and efficacy of dose intensification vs standard treatment

Part B

Majority of patients received prior taxane

Eligibility

- Confirmed mAPMR
- Progressed on prior ARPI
- Baseline ^{68}Ga-PSMA-11 **ENZA-p criteria (SUV max >15 at single site and >10 at larger sites)**

2:1

TLX597-Tx* Dose Intensified

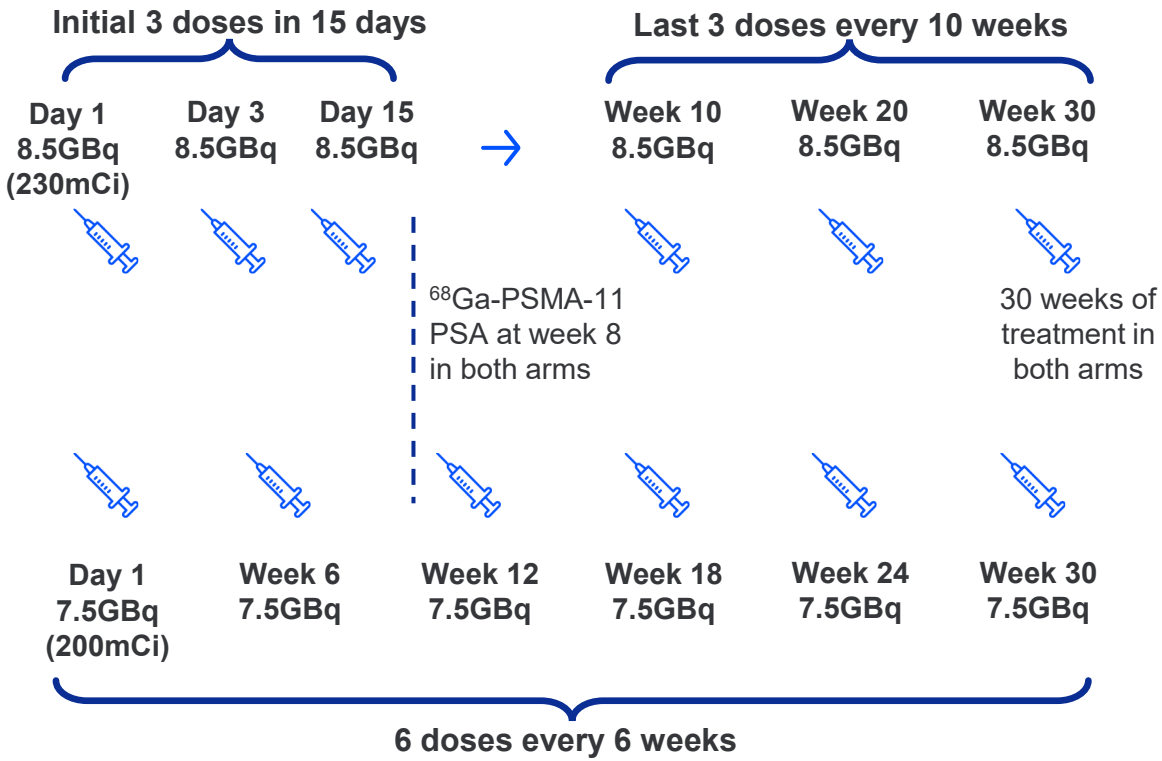
n = 80

TLX597-Tx Standard of Care

n = 40

n= 120

Investigator Initiated Trial (PI: Prof Louise Emmett, St Vincent's Hospital, Sydney)



PSA response as well understood surrogate biomarker for small molecules (not for mAbs)

Primary Endpoints

- PSA90 RR

Secondary Endpoints

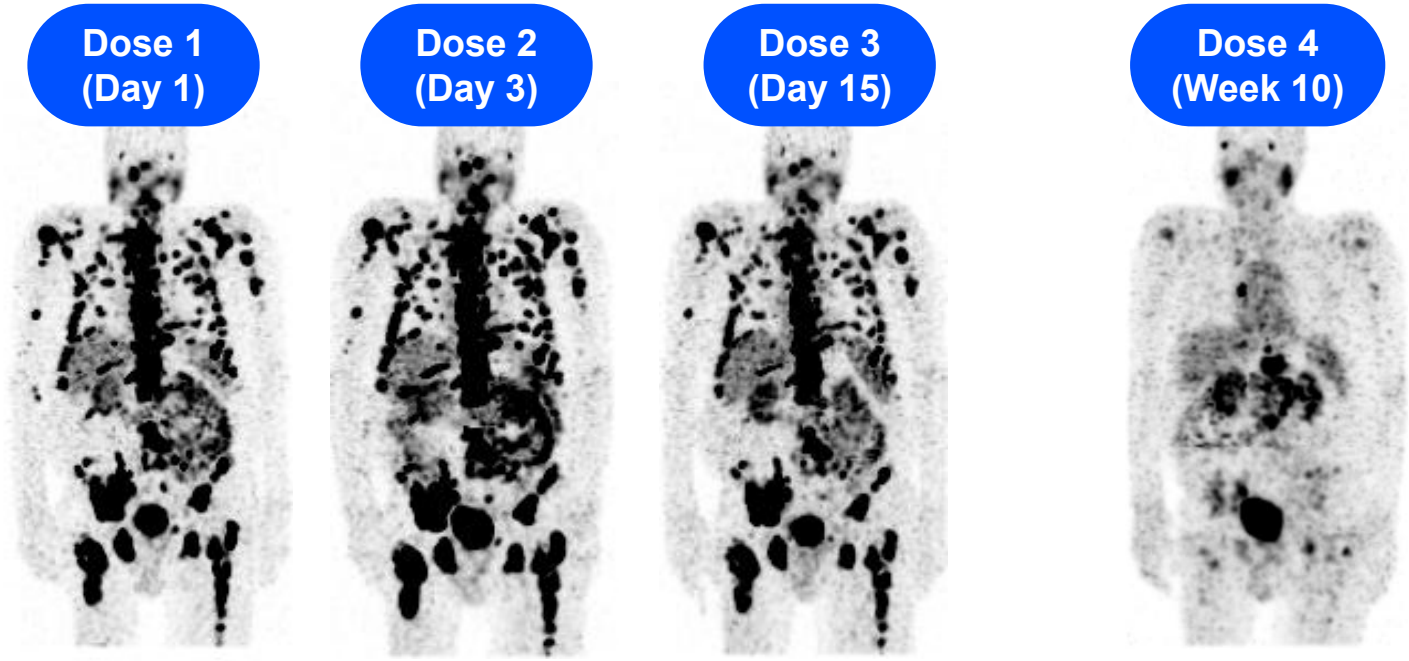
- PSA50 RR
- PSA-PFS
- rPFS
- OS
- ORR
- QoL
- Safety

Telix

ANZCTR Registration Number: ACTRN12625000971437.

1. Pathmanandavel S, et al. *J Nucl Med*. 2022;63:1343-1351.
2. John N, Pathmanandavel S, et al. *J Nucl Med*. 2022;64:410-415.
3. Sheehan B, et al. *Clin Cancer Res*. 2022;28:3104-3115.

Patient case: TLX597-Tx treatment post-chemo (2 lines) and ARPI



	Day 1	Day 3	Day 15	Week 6	Week 10
PSA	1,380	1,480	828	131	40
Hb	112	111	117	116	106
PLT	201	198	217	190	208
eGFR	90	90	90	90	89

71-year-old patient with diffuse bone metastases

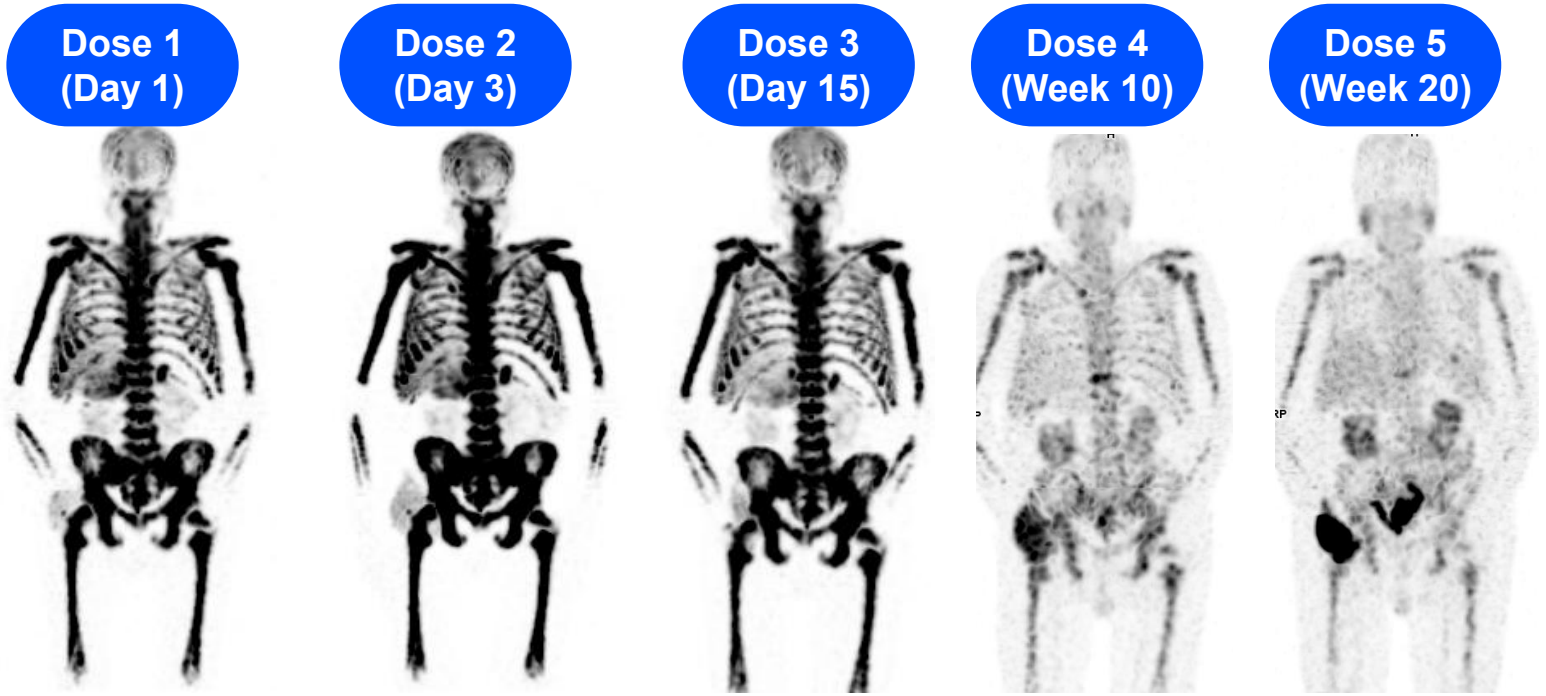
- Normal kidney function
- Substantial shrinkage of lesions
- **97% PSA response at week 10**

Telix

NOTES:
Hb, hemoglobin; PLT, Platelets; eGFR, estimated glomerular filtration rate (renal function).

Patient representative scans - individual results may vary.

Patient case: TLX597-Tx in advanced setting



Extensive skeletal / bone marrow involvement at baseline

- Improvement in hemoglobin
- Normal kidney function
- **99% PSA response**

	Day 1	Day 3	Day 15	Week 10	Week 20
PSA	487	522	358	27	1.9
Hb	81	77	113	67	106
PLT	130	123	109	130	244
eGFR	77	75	81	85	83

Patient representative scans - individual results may vary.

Telix

NOTES:
Hb, hemoglobin; PLT, Platelets; eGFR, estimated glomerular filtration rate (renal function). Advanced setting refer to disease progression post ARPI, received chemotherapy/medically unfit to receive chemotherapy.

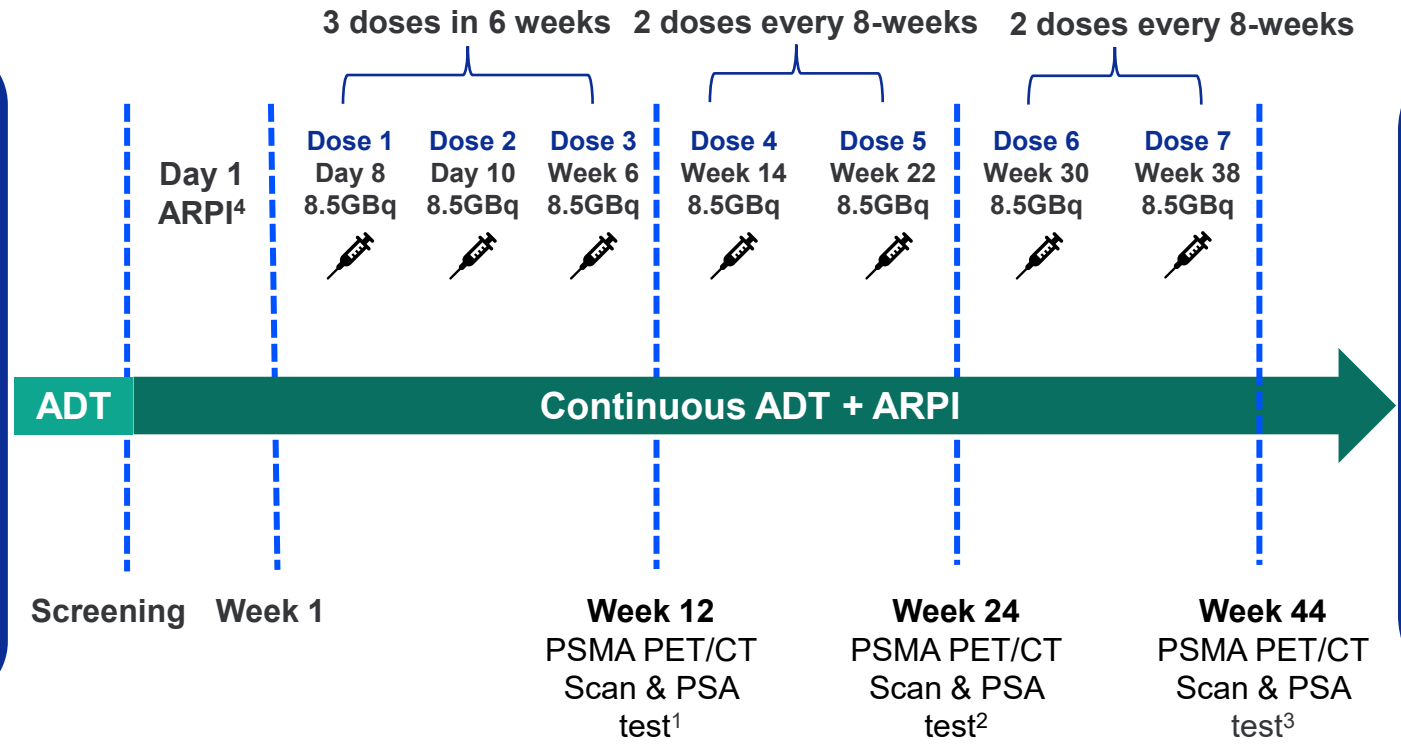
TLX597-Tx, Phase 2 OPTIMAL-e study in mAPMN/S (mHSPC)

Adaptive PSMA targeted radioligand therapy

Eligibility

- Minimally treated mAPMN/S
- High risk metachronous / synchronous
- ADT < 30 days
- Baseline PSMA-PET using VISION Criteria

n= 20



Primary endpoint

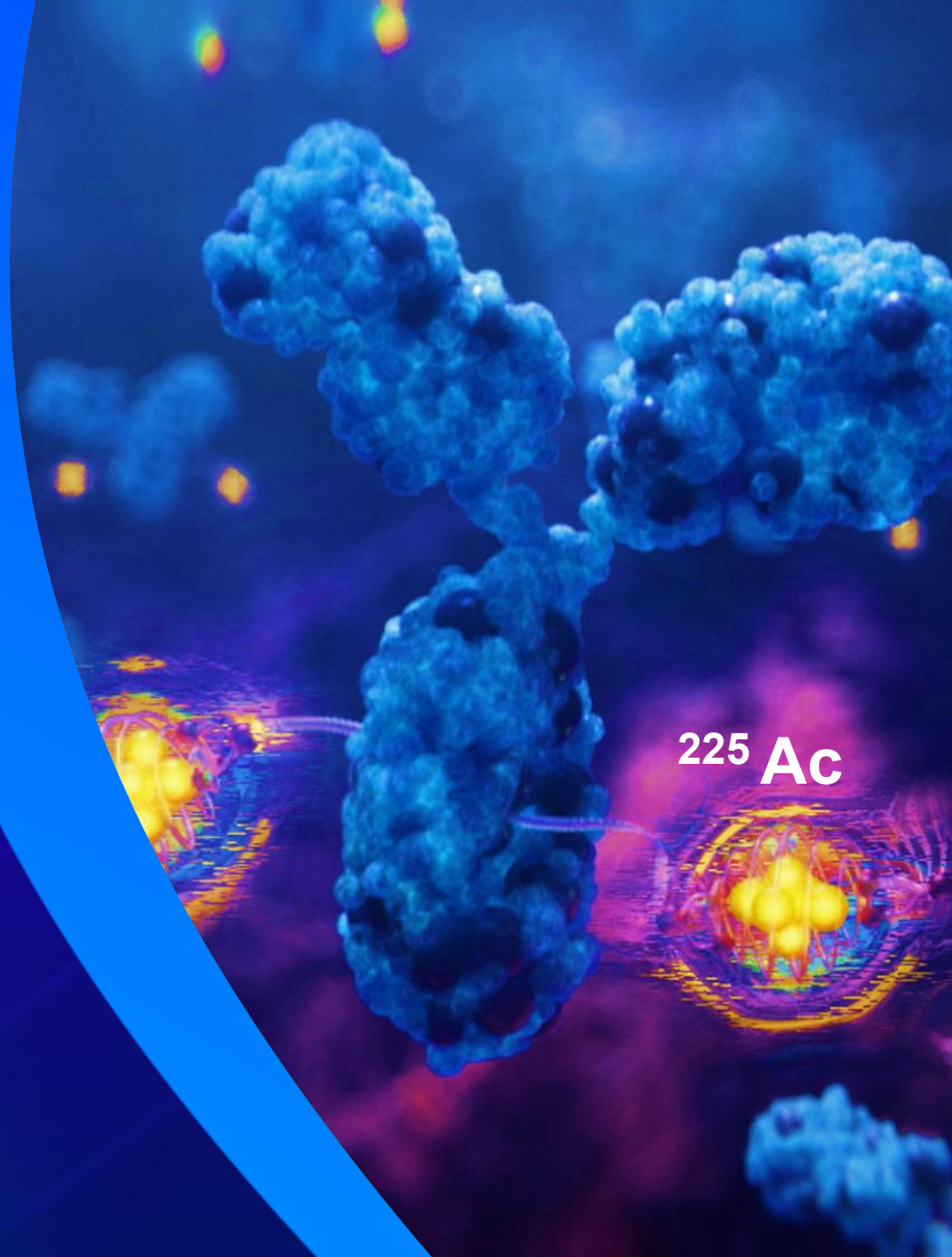
- PSA <0.2ng/mL at 6mo.

Secondary endpoints

- Safety
- PSMA PET response
- PSA 50% & 90% RR
- ORR
- QoL
- Dosimetry

1. After Dose 3, treatment pause is allowed in participants with >90% reduction in volume, no residual large lesions and no new lesions and PSA < 1ng/mL, or in participants with residual PSMA avid disease confined to the prostate only who then receive prostate radiotherapy). 2. After Dose 5, participants who have not had a [177Lu]Lu-PSMA-597 treatment-pause, have a PSA < 1ng/mL, and a >90% reduction in volume, no residual large lesions and no new lesions on the 24-week PSMA PET/CT, will be eligible for a treatment pause. 3. Following 7 doses, an additional 3 doses (7+3) of [177Lu]Lu-PSMA-597 can be given in responding participants at the discretion of the treating investigator. 4. abiraterone, apalutamide, darolutamide, enzalutamide.

Beyond Lu-PSMA in Prostate Cancer



TLX592-Tx: Evaluating two targeting modalities with alpha therapy

Maximizing tumor delivery while limiting off-target uptake

First-generation small molecules

Clinical experience with first-generation ^{225}Ac-PSMA agents identified severe/persistent xerostomia as a key dose-limiting challenge[1]

Antibody-based approach

TLX592 combines the biodistribution advantages of antibody constructs, with minimal salivary gland uptake and predominantly liver clearance, with an engineered accelerated clearance profile that has the potential to further enhance safety and tolerability[2]

Small molecule approach

An optimized small molecule approach aims to combine rapid plasma clearance and low kidney and salivary gland uptake with rapid tumor accumulation and prolonged tumor retention

Telix is exploring antibody- and small molecule-based approaches in parallel for alpha-PSMA therapy

Telix

1. Heynickx et al. *Nuclear Medicine and Biology*. 2021.
2. Refers to CUPID imaging study, using 64Cu-PSMA-RADmAb, presented at ASCO GU, Feb 2025. NCT04726033.

TLX090-Tx: Novel candidate for pain from bone metastasis

Phase 1 data[1] demonstrate encouraging efficacy signal

- Debilitating pain from osteoblastic bone metastases is one of the most common and burdensome complications of advanced prostate and breast cancer
- Up to **90% of patients** with metastatic prostate cancer[3,4] are affected, contributing to reduced quality of life and mental health
- Despite the availability of opioids and external beam radiation therapy (EBRT), many patients remain under-treated, underscoring a critical unmet need for a systemic, targeted, and non-opioid solution that can deliver durable relief

Visual Analogue Scale (VAS) measures pain intensity on a scale of 100
0= no pain, 100 = worst pain

	Dose: 0.5 mCi/kg			Dose: 1 mCi/kg	
Day	**Patient 1**	**Patient 2**	**Patient 3**	**Patient 4**	**Patient 5**
1	18	64	70	50	70
43	17	7	20	30	40
4 months	**0**	**10**	**20**	**30**	

Phase 1 data[1] showed pain reduction scores on the VAS scale using two different doses of TLX090-Tx

Encouraging pain reduction observed in Phase 1 study,[1] supporting potential for clinically meaningful benefit

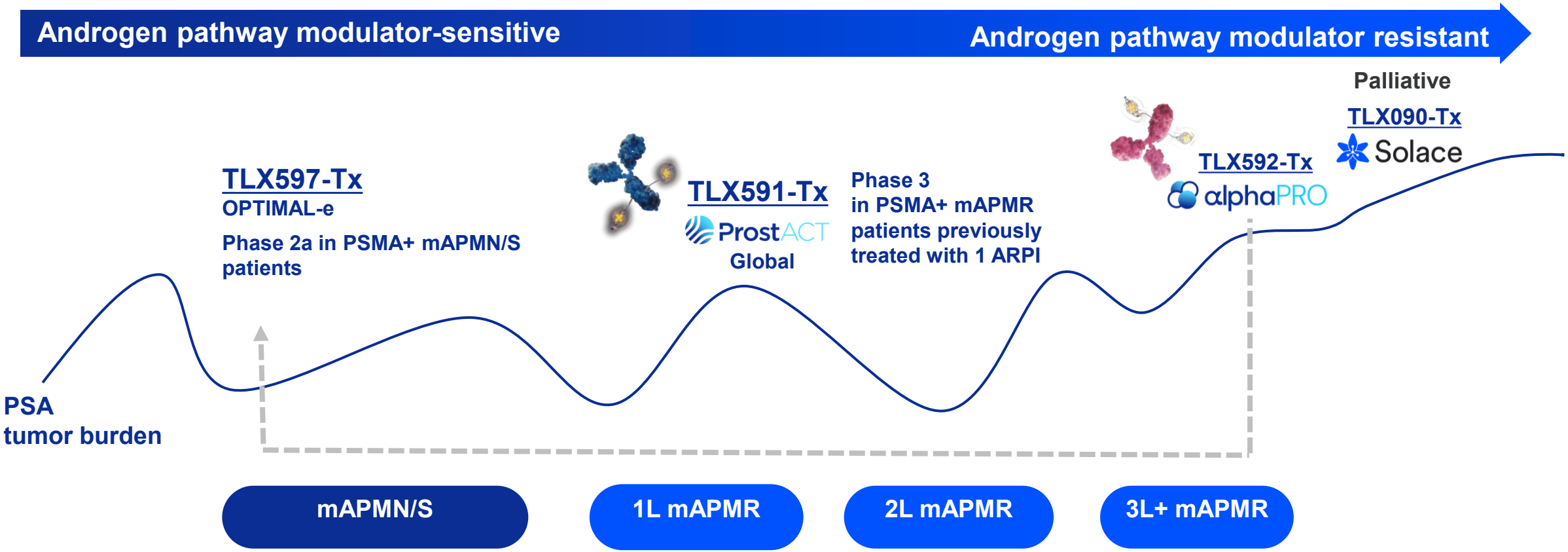
- Consistent pain reduction scores (VAS) observed for all patients
- Anecdotal reports suggest improved mobility

Telix

1. Based on data generated by QSAM Biosciences. Data on file. Clinicaltrials.gov. ID: NCT 06008483, Study conducted under IND 156086.
2. Huang et al. *Ann Transl Med*. 2020.
3. Guo et al. *Skelet Radiol.* 2025.
4. Woolf et al. *Annals of Oncology.* 2015.

Multi-product therapy portfolio in prostate cancer

Aligned to disease state, patient needs and clinical opportunity



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mAPMN/S = metastatic androgen pathway modulation naïve/sensitive; mAPMR = metastatic androgen pathway modulation resistant.

BiPASS®

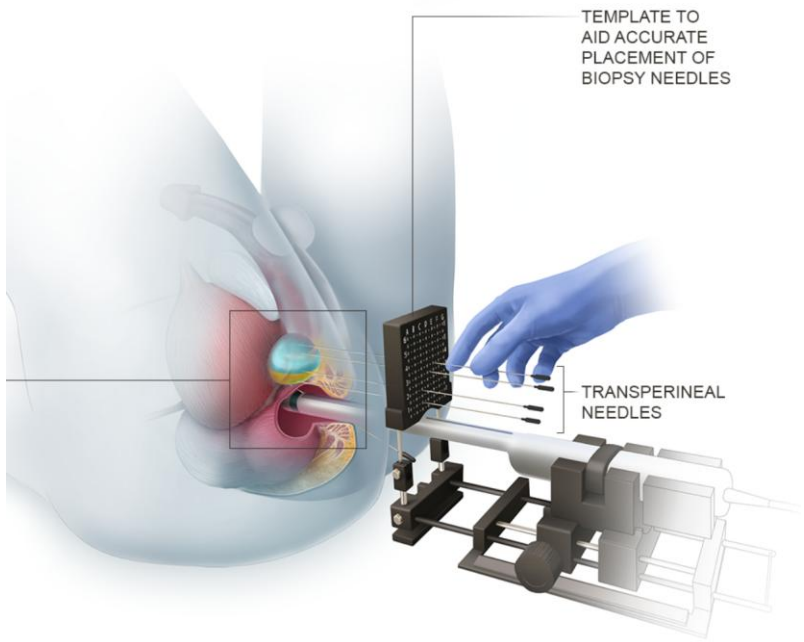
Biopsy of the Prostate Avoidance Stratification Study

Dr. Varun Sundaram

Urology Austin

Current diagnostic pathway for prostate cancer relies on invasive biopsies

Template biopsy



- Template biopsies require 15-20 samples obtained through an invasive procedure under anesthesia
- Sampling limitations may miss disease or fail to characterize tumor burden. Biopsies are blind to the tumor location
- Risks of infection, bleeding, urinary retention, post-procedural complications
- Recovery times may vary from days to weeks
- Multiple biopsies are often required to diagnose, monitor progression or confirm treatment response

Telix

A significant unmet need remains in the diagnostic pathway

Men with elevated PSA values will often be recommended for MRI[1], followed by biopsy

- MRI is not specific and often inconclusive, leading to biopsy

Biopsies carry real risks[4]

- Hematuria, rectal bleeding, hematospermia
- Inconsistent practice around anticoagulants adds complexity

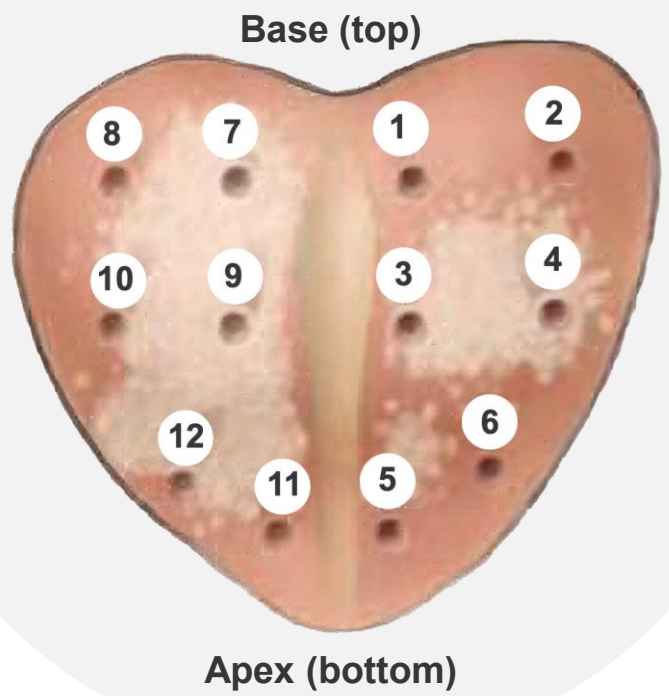
800,000 biopsies performed in the U.S. each year, up to 75% are negative[2]

- Biopsy is blind to the location of cancer in the prostate
- Only ~half of the needles provide useful samples (false negatives)[3]

Up to 25% of patients refuse a recommended biopsy[5]

- Reasons for refusal include fear or pain of complications
- Skepticism about the necessity of the procedure

Areas of biopsy[6]



Biopsy false-negative rates can be as high as 50%[7]

Telix

1. Magnetic resonance imaging. 2. Vickers et al. *J Clin Oncol.* 2010. 3. Ahmed et al. *Lancet. 2017*. 4. https://www.researchgate.net/figure/Complications-of-transrectal-ultrasound-guided-prostate-biopsy_tbl1_10978264
5. Filho et al., 2025. 6. Picture credit: Georgia Radiation Therapy. 7. Schmeusser B, Levin B, Lama D, Sidana A. Hundred years of transperineal prostate biopsy. *Ther Adv Urol.* 2022;14:17562872221100590. Published 2022 May 21. doi:10.1177/17562872221100590.

Key insights from PRIMARY and PRIMARY 2 Investigator Initiated Studies (IITs)

PRIMARY (n = 291)[1]	Ga-PSMA-PET +mpMRA	mpMRI
Sensitivity	97%	83%
Specificity	40%	53%
Negative predictive value	91%	72%
PRIMARY SCORE[2] (analysis)		
Sensitivity	94%	89%
Specificity	68%	74%
P-Score[3] (analysis)		
Sensitivity	94%	89%
Specificity	66%	74%

PRIMARY2[4] (n = 660)	Ga-PSMA-PET +mpMRA
Biopsy reduction	49%
csProstate cancer detected	12% vs 16%

PRIMARY study established proof of concept that Ga-PSMA-11 PET + mpMRI improves the detection of prostate cancer.

PRIMARY 2 study demonstrated that Ga-PSMA-11 PET + mpMRI can safely reduce biopsies while maintaining a clinically significant detection of prostate cancer.

Telix

1. Emmett L, Buteau J, Papa N, et al. *Eur Urol*. 2021, 2. Emmett L, Papa N, Buteau J, et al. *J Nucl Med*. 2022, 3.Emmett L, Papa N, Hope TA, et al. *J. Urol*. 2024, 4. Buteau JP, Moon D, Fahey MT, et al. *Lancet Oncol*. 2026.

BiPASS®, Phase 3 study for detection of prostate cancer

Biopsy of the Prostate Avoidance Stratification Study (BiPASS)

^{68}Ga-PSMA-11 + mpMRI PI-RADS 1-4 → **Template biopsy (targeted biopsy)** → 6- month follow-up (confirm negative findings)

n = 350

Primary Objective:
Detection of clinically significant prostate cancer using mpMRI + ^{68}Ga-PSMA-11 PET[1]

Co-primary endpoints:
Sensitivity and specificity

Global, multi center, open label, single arm study

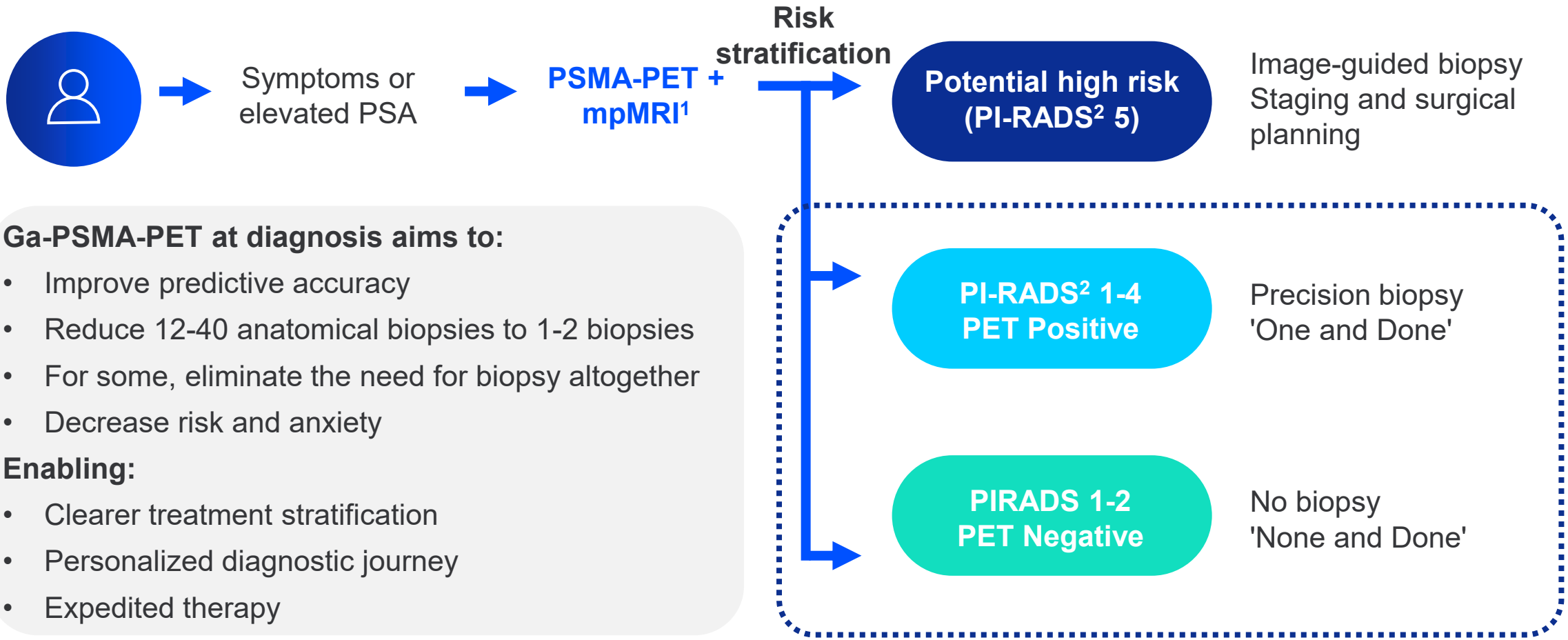
Eligibility: Clinical suspicion of prostate cancer and indicated for template biopsy
Status: Completed patient enrollment

Clinicaltrials.gov: NCT07052214

mpMRI = multiparametric Magnetic Resonance Imaging.
1. Histopathological confirmation will be used to detect prostate cancer.

A personalized diagnostic pathway with Ga-PSMA-PET

Smarter triage BEFORE biopsy. Integrating imaging with biopsy



Ga-PSMA-PET at diagnosis aims to:

- Improve predictive accuracy
- Reduce 12-40 anatomical biopsies to 1-2 biopsies
- For some, eliminate the need for biopsy altogether
- Decrease risk and anxiety

Enabling:

- Clearer treatment stratification
- Personalized diagnostic journey
- Expedited therapy

1. Multiparametric MRI.
2. Prostate Imaging Reporting and Data System, a scoring system used by radiologists to assess the likelihood of prostate cancer based on multiparametric mpMRI findings.

^{68}Ga has a lower propensity for indeterminate bone lesions (IBLs)[1,2]

Gallium-68

Free ^{68}Ga is taken up and metabolized through the liver and does not have an affinity to bone.

Fluorine-18

Free ^{18}F has a naturally high affinity to bone.

Free ^{68}Ga, in contrast to ^{18}F, does not have an affinity to bone

With ^{18}F, a number of benign bone lesions accumulate PSMA and result in false positives on PSMA-PET/CT.

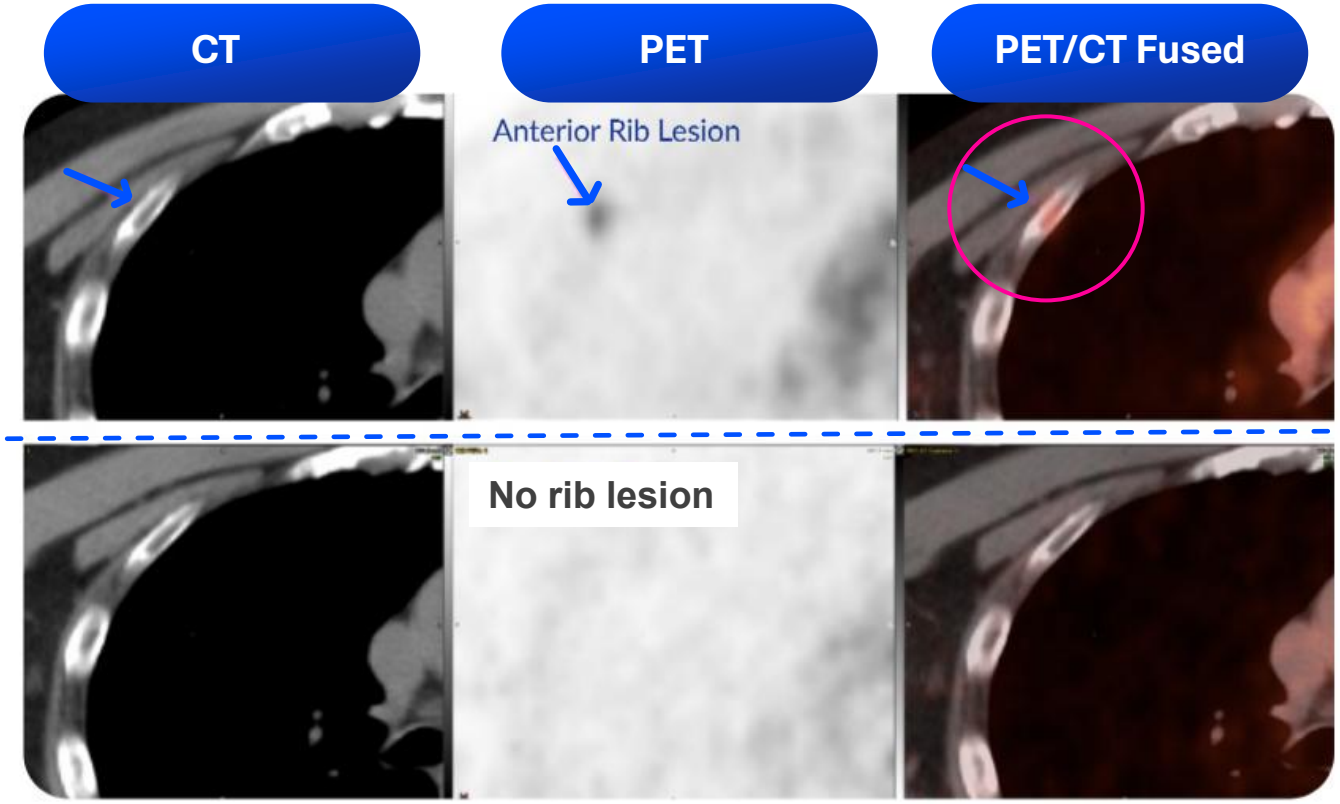
SNMMI Guidelines for Prostate Cancer Imaging

There are numerous advantages of having a more streamlined image pattern that guides you more to where the lesions are and avoids the distractions to where the lesions don't belong. *Dr. Munir Ghesani*

Telix

1. Kuchar M, et al. Molecules. 2015;20(9):16186-16220.
2. Rauscher I, et al. J Nucl Med. 2020;61(1):51-57.

Case study: diagnostic accuracy of ^{68}Ga-PSMA-11



F-18 PSMA PET Scan

PSA 3.4

- Patient on active surveillance
- No active treatment

IBL detected

^{68}Ga-PSMA-11 PET Scan

6 months later

Resolution without interval treatment confirms lesion benignity

Patient representative scans – individual results may vary. Images are non-quantitative.

Interpreting bone lesions with 18F-based PSMA radiotracers can be more challenging compared to 68Ga due to detection of benign bone lesions[1,2]

-SNMMI Guidelines

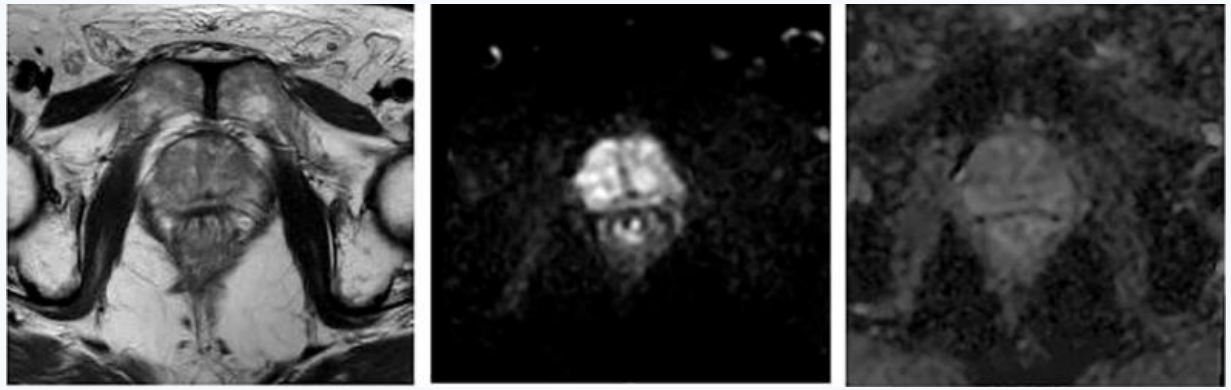
Telix

Patient case study from IIT: Intra-Individual Comparison of ^{68}Ga- and ^{18}F-Labeled PSMA PET for Skeletal Lesion Characterization in Prostate Cancer: A Pilot Feasibility, Study Interim Analysis led by Dr Ghesani.

1. Fendler WP, et al. PSMA PET/CT: joint EANM procedure guideline/SNMMI procedure standard for prostate cancer imaging 2.0. Eur J Nucl Med Mol Imaging, 2023.
2. Lowrance W, et al. Updates to advanced prostate cancer.

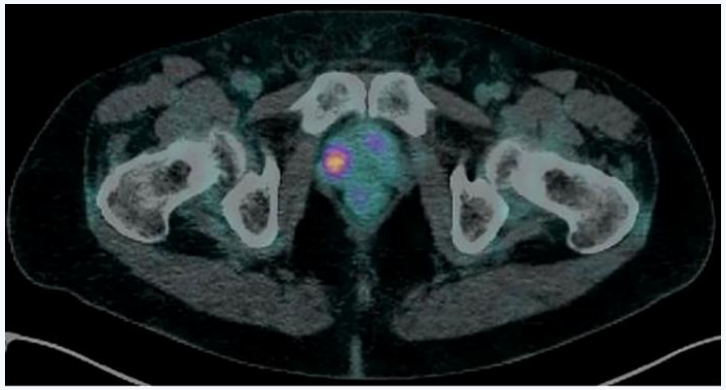
The future of prostate cancer detection

Current state
3 MRI acquisitions



- 72 year old male was negative for suspicious findings (PI-RADS <3)
- PSMA PET detected a focal uptake in the right anterior apex of the prostate[1]

Future state
1 PSMA PET scan



Patient representative scans – individual results may vary. Images are non-quantitative.

1. Celli M, Gunelli R, Ferroni F, Costantini M, Barone D, Fantini L, Fragalà E, Marini I, Di orio V, Foca F, Monti M, Matteucci F and Caroli P (2026) Toward a PSMA PET–mpMRI pathway for biopsy decision-making in men with suspected prostate cancer: interim results from the prospective BIOPSTAGE trial. Front. Oncol. 15:1720861. doi: 10.3389/fonc.2025.1720861.

Mr. Kevin Richardson

CEO of Precision Medicine

Current state: PSMA-PET transformed staging and BCR detection

Initial biopsy protocol has remained unchanged since the addition of MRI

PSMA-PET scans
(in thousands)

Current TAM:
~670,000 scans/year

1M biopsies

Initial staging
151

BCR
460

Response to treatment nmAPMR
143

Monitoring for mAPMR progression
71

RLT selection
58

Monitoring response to RLT
52

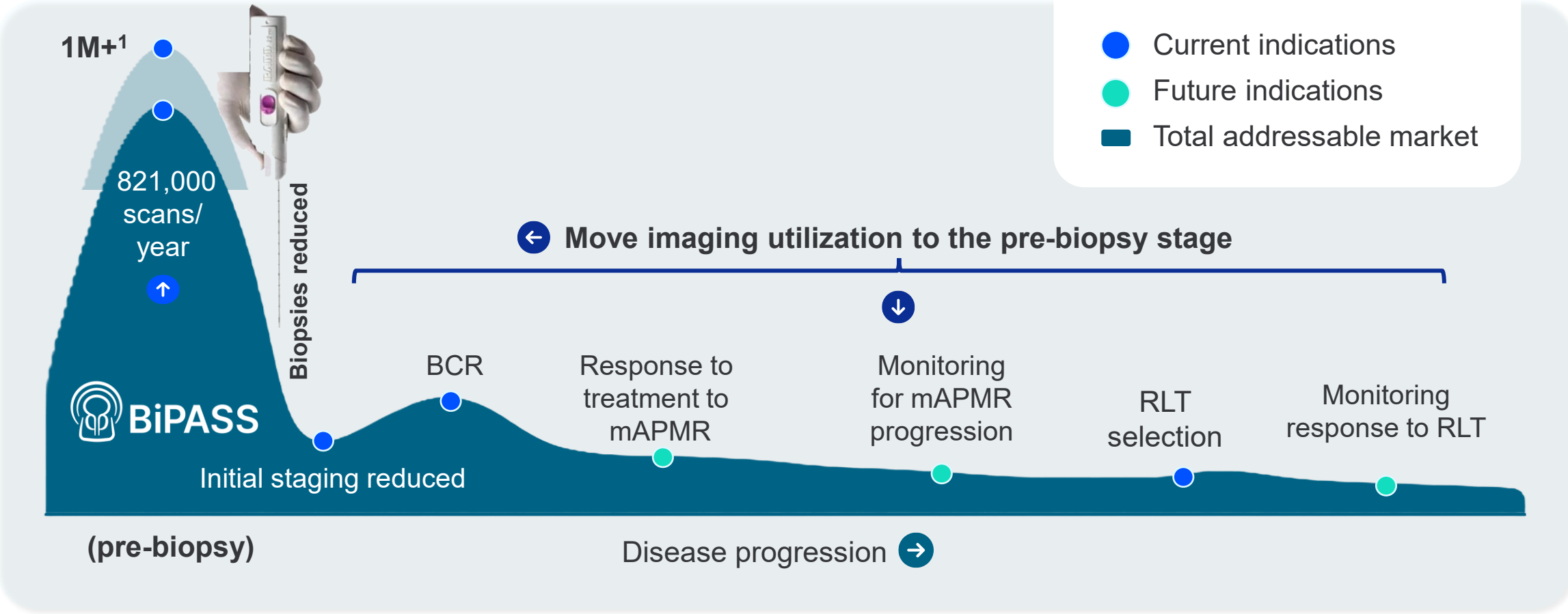
Disease progression

- Current indications
- Future indications
- Total addressable market

TAM = Total addressable market, BCR = Biochemical recurrence, nmAPMR = non-metastatic androgen pathway modulation resistant, RPT = Radiopharmaceutical therapies.
ClinicalTrials.gov: NCT07052214. Annual PSMA-PET scan volume in the U.S. based on internal estimates.

Future state: BiPASS revolutionizes biopsy decision-making

Potential to double the size of the existing PSMA market

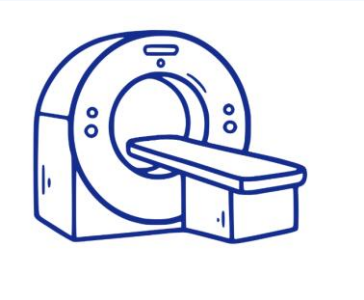


BiPASS = Biopsy of the Prostate Avoidance Stratification Study, TAM = Total addressable market, RPT = Radiopharmaceutical therapies, Annual PSMA-PET scan volume in the U.S. based on internal estimates.

1. Estimate one million biopsies performed in the U.S. each year. Source: Schmeusser et al. Therapeutic Advances in Urology, 2022.
2. ClinicalTrials.gov: NCT07052214.

Patient preference overwhelmingly favors Ga-PSMA PET scan over biopsy

Survey (n = 1,002 patients who had prostate biopsy in the last 6 years)[1]



95% Would have **preferred MRI + PSMA PET** prior to biopsy

93% **Want their doctor to discuss PSMA PET + MRI** in future biopsy decisions

88% **Would bring up PSMA PET + MRI** if their doctor didn't

71% **Chose Imaging-First over Biopsy-First** as their preferred approach

Patient Voice

> *Many **men request unnecessary radical prostatectomies simply to avoid getting another biopsy**, which I thought was ludicrous. But after having two, with another biopsy on the horizon, I now understand.*

> *The **biopsy was a necessary but stressful step**. I strongly support the development of more accurate, less invasive diagnostic tools to reduce patient anxiety and physical complications.*

> ***Non-invasive testing options would be a game changer** for early detection and reducing anxiety.*

Patients show strong preference for a less invasive, imaging-first approach

1. Telix patient survey conducted in collaboration with PCEC, Prostate cancer education council.

$20B opportunity in Prostate Cancer

	U.S. TAM (Patients)	Target Indication	USD $
Precision Medicine	**~670,000** scans (~327k patients)	Illuccix / Gozellix (Initial Staging, BCR, RLT selection)	$2.7B
	~821,000 scans (~821k patients)	BiPASS® (diagnosis of prostate cancer)	$3.3B
	~266,900 scans (~172k patients)	Monitoring RLT therapy, Monitoring for progression in nmAPMR / mAPMR	$1.1B
Therapeutics	**~16,800**	TLX597-Tx: mAPMN/S	$4.2B
	~22,460	TLX591-Tx: mAPMR 1L + 2L	$5.6B
	~12,600	TLX592-Tx: mAPMR 2L+	$3.2B
			$20B

Source: Datamonitor, Clarivate, internal estimates. Total Addressable Market (TAM) for Precision Medicine uses $4,000/scan for modelling purposes. Therapeutics candidates are using $250,000/treatment based on commercial benchmarks/Datamonitor. These price points do not reflect the actual price charged or the price that Telix will charge in the future.

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Note: Intended for investor audience only. The FDA has approved Illuccix for use in initial staging, BCR, and RLT selection. The FDA has approved Gozellix for use in initial staging and BCR. Not intended to advertise or promote any other product or indication. BiPASS has not been accepted by the FDA to diagnose, treat, cure, or prevent any disease. Brand names subject to regulatory approval.

Renal Cancer Overview

Dr. Sumanta (Monty) Pal, MD
City of Hope

Disease overview: Kidney cancer

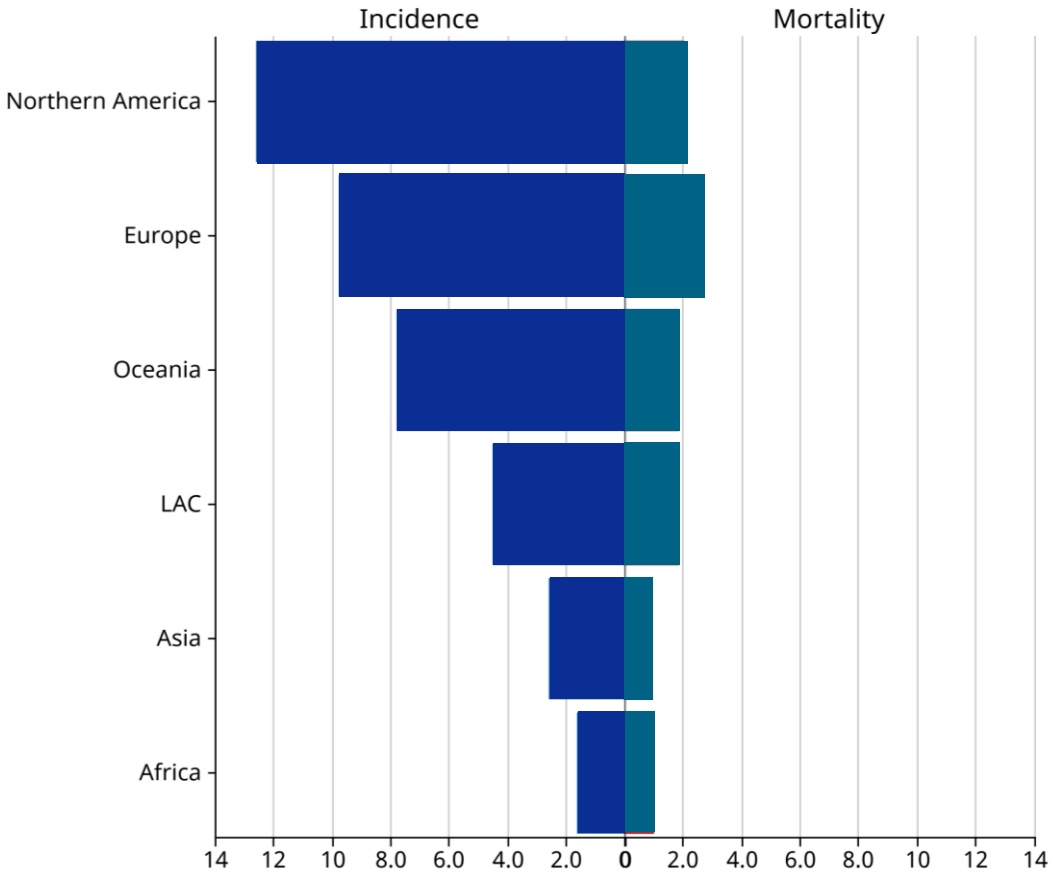
14th most commonly diagnosed cancer worldwide[1]

Age-standardized incidence & mortality highest in **North America & Europe**[1]

Twice as common in men vs women[1]

90% of kidney cancer is RCC, of which ~85% is ccRCC[2,3]

Age-standardized rate per 100,000 (2022)[4]



ccRCC, clear cell renal cell carcinoma; RCC, renal cell carcinoma.

1. Bray F, et al. *CA Cancer J Clin*. 2024;74(3):229-263. 2. Qi X, et al. *Front Oncol*. 2021;11:727778. 3. Alchahin AM, et al. *Nat Commun*. 2022;13(1):5747. 4. Globocan 2022 (version 1.1) - 08.02.2024. https://gco.iarc.who.int.

Significant unmet medical need in ccRCC

Disease Burden

ccRCC is a serious disease with substantial morbidity and mortality[1,2,3,4]

- **Incidence rates are rising** (increased risk factors, incidental detection)[2]
- **~30%** of patients present with **metastatic disease at diagnosis** (5-year survival rate ~20%)[3]
- **~180,000 deaths** annually worldwide from kidney cancer[1]

Treatment Challenges

20–40% of patients with localized ccRCC ultimately progress[5]

- Current ICI- and VEGFR-based therapies achieve durable benefit in only a subset of patients[6]
- Primary and acquired **resistance remain common**[7]
- Treatment sequencing beyond **2nd line remains poorly defined**[8]
- After 2nd line, no improvement in OS (5-year OS ~18%)[8]

Need for Better Tolerated Therapies

4,700 patients/year in the U.S. need third-line therapy options[8]

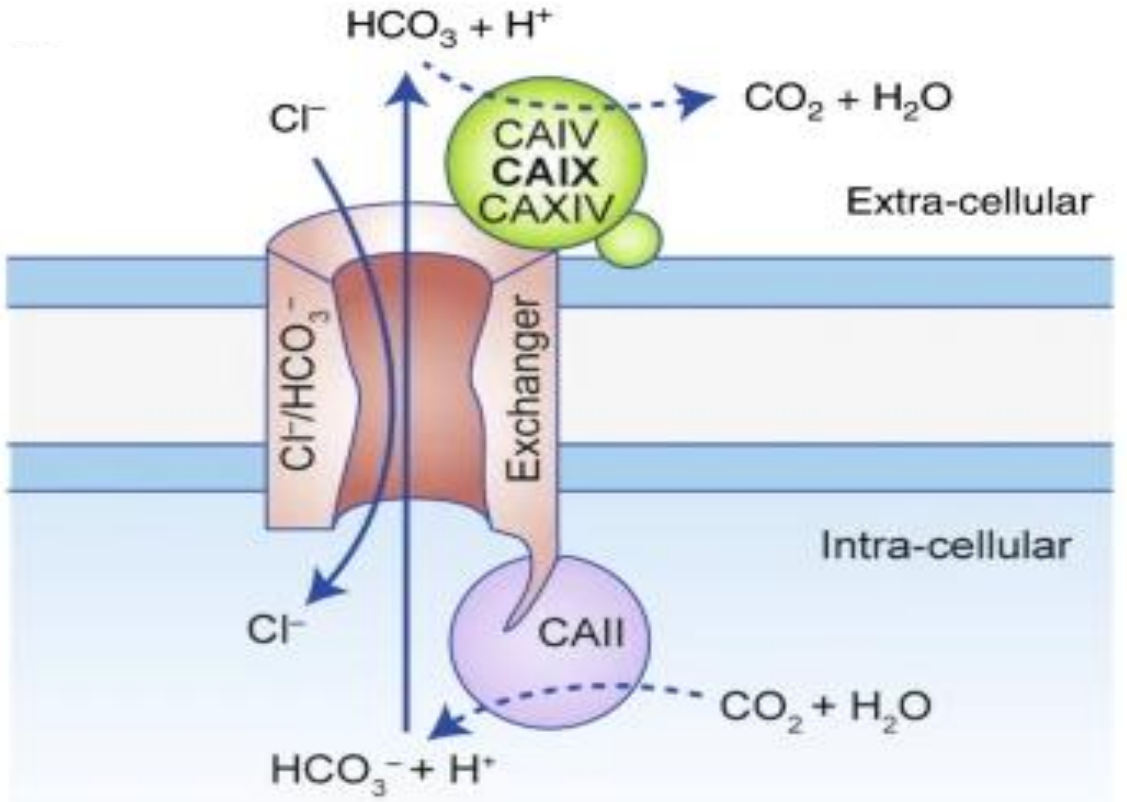
- Disease progression typically occurs with ICI, TKI, belzutifan or everolimus[9]
- Adverse effects frequently lead to **dose reductions, interruptions, or discontinuation**[10]
- Need for targeted therapies that can provide **durable disease control** with **manageable toxicity**[11]

ccRCC remains a high-burden disease with poor long-term outcomes despite recent advances

1. Bray F, et al. CA Cancer J Clin. 2024;74(3):229-263. 2. Bukavina L, et al. Eur Urol. 2022;82(5):529-542. 3. Alchahn AM, et al. Nat Commun. 2022;13(1):5747. 4. National Cancer Institute. Cancer stat facts: kidney and renal pelvis cancer. Updated 2025. 5. Vento JA, et al. Cancers (Basel). 2022;14(20):5005. 6. Rysz J, et al. Int J Mol Sci. 2025;26(12):5577. 7. Schoenfeld A, et al. Cancer Cell. 2020;37(4):443-455. 8. Obeng-Kusi M, et al. Urol Oncol. 2024;42(2):32.e1-32.e8. 9. Rudresha AH, et al. Indian J Cancer. 2017;54(4):626-630. 10. Sunder S, et al. Signal Transduct Target Ther. 2023;8:262. 11. Mielcarek L, et al. Cancer Chemotherapy Pharmacology 2021;87(6):723-742.

Novel target in ccRCC - CAIX

- Transmembrane glycoprotein involved in oxygen-sensing pathways and regulator for pH[1,2]
- Induced by hypoxia or by mutation of the Von Hippel-Lindau tumor suppressor gene[1-4]
- **Expressed in >95% of ccRCC[5-7]**
- Negligible expression in normal kidney tissue[7]



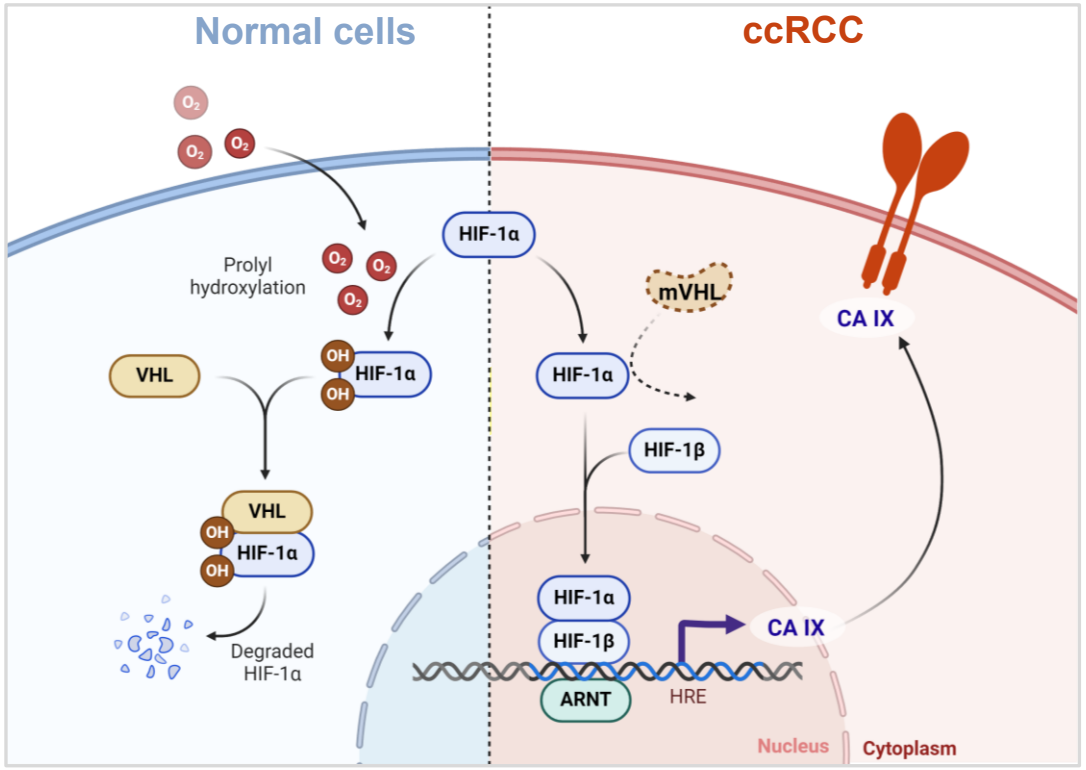
Adapted from Becker HG.[2]

CAIX, carbonic anhydrase IX; ccRCC, clear cell renal cell carcinoma.

1. Aldera AP, et al. *J Clin Pathol*. 2021;74(6):350-354. 2. Becker HM. *Br J Cancer*. 2020;122(2):157-167. 3 3. Wykoff CC, et al. *Cancer Res* 2000;60(24):7075–7083. 4. Maxwell PH, et al. *Nature* 1999;399(6733):271–275. 5. Courcier J, et al. *Int J Mol Sci* 2020;21(19):7146. 6. Bui MHT, et al. *Clin Cancer Res* 2003;9(2):802– 811. 7. Stillebroer AB, et al. *Eur Urol* 2010;58(1):75–83.

CAIX targeting in ccRCC

- VHL mutation is pathognomonic for ccRCC, leading to HIF stabilization, accumulation, and tumor growth[1]
- CAIX is a target of HIF transcriptional activity under hypoxic conditions[2]
- CAIX is a transmembrane protein and a tumor-specific protein important for maintaining pH balance[2]
- CAIX is overexpressed in mVHL ccRCC, but shows only low-level expression in normal kidney[3,4]



CAIX is a highly promising target for ccRCC[5]

Image adapted under a Creative Commons license from Al-Zuaini HH, et al. Front Oncol. 2023. doi:10.3389/fonc.2023.1207253.

ARNT, aryl hydrocarbon receptor nuclear translocator; CAIX, carbonic anhydrase IX; ccRCC, clear cell renal cell carcinoma; HIF, hypoxia-inducible factors; IO, immuno-oncology; mVHL, mutated von Hippel-Lindau; RCC, renal cell carcinoma; VEGF, vascular endothelial growth factor.

1. Chintala S, et al. *BMC Cancer. 2012;12:293.*2. van Kuijk SJ, et al. *Front Oncol. 2016;6:69.* 3. Patard JJ, et al. *Int J Cancer.* 2008;123(2):395-400. 4. Yousef A, et al. *Cancer Diagn Progn.* 2022;2(6):661-667. 5. Muselaers CH, et al. *Eur Urol.* 2016;69(5):767-770.

Monoclonal antibody-based theranostics

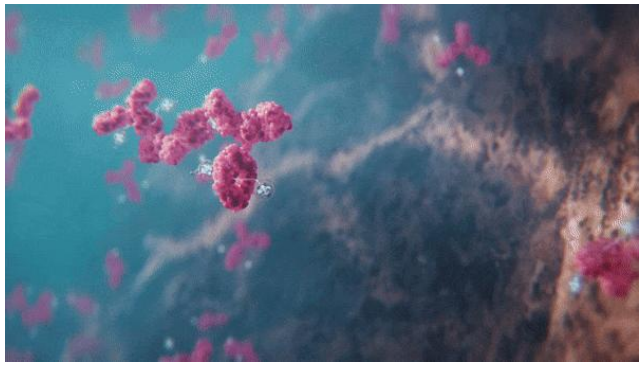
TLX250-Tx for treatment of ccRCC and TLX250-Px for imaging

Girentuximab

- IgG1 kappa light chain chimeric monoclonal antibody
- Girentuximab - highly specific binding to CAIX and internalization
- Safety data from Phase 1-3 clinical studies with girentuximab in RCC, including nearly 500 patients and healthy volunteers[1-4]
- Hepatic clearance

Payload: ^{89}Zr (imaging)

- Positron emitter
- Half-life 3.3 days
- Suitable for antibody-based PET imaging



Payload: ^{177}Lu (therapy)

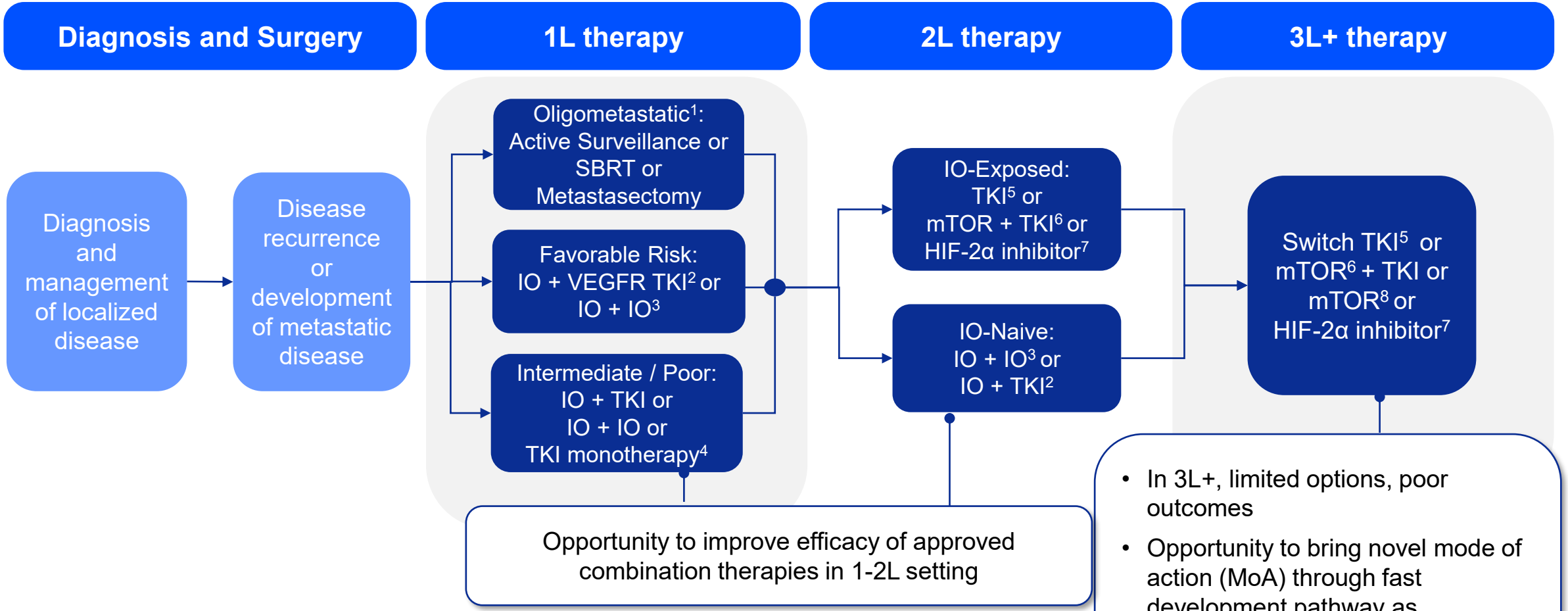
- Medium-energy β-emitter
- Half-life 6.7 days
- Suitable for antibody-based therapy

CAIX, carbonic anhydrase IX; PET, positron emission tomography.

1. Oosterwijk-Wakka et al. Int J Mol Sci. 2013;14(6):11402-23; 2. Kulterer et al. J Nucl Med. 2021;62(3):360-5. 3. Merkx et al. Eur J Nucl Med Mol Imaging. 2021;48(10)3277-85 4. Chamie et al, 2-15.

Patient journey for a metastatic kidney cancer patient

Unmet needs remain in improving efficacy in 1L and 2L treatments and outcomes in 3L+ therapies



- In 3L+, limited options, poor outcomes
- Opportunity to bring novel mode of action (MoA) through fast development pathway as monotherapy

LUTEON / LUTEON ATLAS

SOURCE: NCCN Guidelines, Kidney Cancer.

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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ccRCC administered activity schedule rationale

1 Observations from prior studies (Phase 1, n=23; Phase 2, n=14)[1,2]

- **Patients receiving the maximum number of cycles** (3) were predominantly in the lower administered activity* cohorts (80% at ≤3145 MBq; none >4088 MBq)
- **More treatment cycles correlated with better outcomes** (mOS: 49.3m for 3 cycles, 22.2m for 2 cycles, 18.7m for 1 cycle, respectively)
- **Higher administered activity increased hematological toxicity**; no Gr 3-4 leukocyte or platelet toxicities received in the lowest activity cohort (1887 MBq)
- **Lower administered activity (1887 MBq) was well tolerated and allowed multiple cycles** in a previous study (n=11)[3]

2 Pharmacology rationale

- TLX250-Tx tumor residence time suggests **little/no** relevant therapeutic activity remains in tumor after ~3 weeks
- **Fractionating the administered activity and reducing the interval from 3 months to 1-2 months can enhance efficacy**
- **Each fraction stays low enough to avoid dose-limiting toxicity due to cumulative toxicity**

3

1887 MBq every 2 months x 3 cycles
Based on activity levels administered in previous studies

1258 MBq every month x 6 cycles
Fractionation of 2516 MBq to match tumor exposure window

Lower fractionating enables more cycles with **manageable toxicity**

Telix

1. Stillebroer AB, et al. European Urology. 2013;64:478-485. 2. Muselaers CHJ, et al. European Urology. 2016;69:767-770. 3. Starstruck - Telix and Merck terminated co-developed Ph1b study *BSA= ~ 1.7m^2.

TLX250-Tx: LUTEON (Ph3) and LUTEON-ATLAS (Ph2a) trial design

US/EU: *LUTEON-ATLAS (Ph2a)* — U.S. FDA *'May Proceed'* received / EU under review

AUS: *LUTEON (Ph3)* — HREC approval received[1]

Population:

- Advanced or metastatic ccRCC
- Disease progression on/after 2 to 3 prior systemic lines of therapy
- CAIX-positive by ^{89}Zr-TLX250 PET

Safety Lead-in*

N=3

1,887 MBq

1,258 MBq

RP2a

DR1 = 20

DR2 = 20

1:1

N=3

Part 1: Dose Optimization (Phase 2a)

1887 MBq	1887 MBq	1887 MBq
1258 MBq	1258 MBq	1258 MBq
1258 MBq	1258 MBq	1258 MBq

1 | 2 | 3 | 4 | 5 | 6

Treatment period (months)

Dose administration

- 2-month intervals
- 1-month intervals

Part 2 (Phase 3)

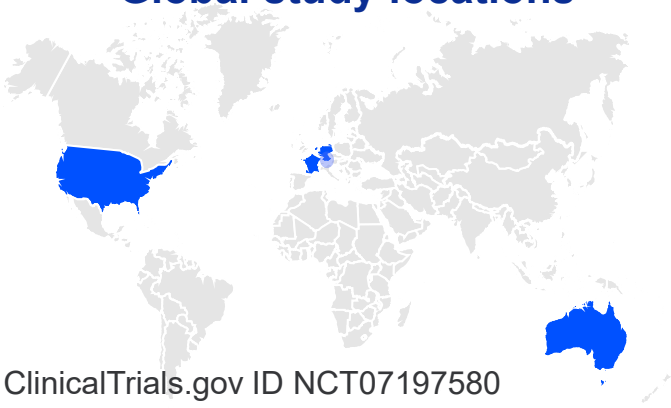
N=TBD

RP3D — 1:1

- ^{177}Lu-TLX250 (RP3D)
- Investigators choice (SOC)

N=TBD

Global study locations[2]



*3 pts in Safety Lead-in included in total 20 pts in Part 1 (Dose Optimization); No Safety Lead-in in AUS

HREC = Human Research Ethics Committee, ccRCC = clear cell renal cell carcinoma, DR1 = Dosing regimen 1, DR2 = Dosing regimen 2, PET = positron emission tomography, R= randomization, RP3D = recommended Phase 3 dose, SoC = Standard of care.

1. ClinicalTrials.gov ID NCT07197580. 2. Australia: recruiting, U.S.: site activation, Europe: application under review.

ClinicalTrials.gov ID NCT07197580

Zircaix (TLX250-Px)[1]

Dr David Cade

Group Chief Medical Officer, CMO

[1] Zircaix brand name subject to regulatory approval.

Unmet need in diagnosis of ccRCC

The most common – and one of the most aggressive – forms of renal cancer

Need for early & accurate diagnosis / treatment

- Up to 85% of RCCs are ccRCC[1,2]
- ccRCC causes ~90% of deaths of all RCC[3,4]
- For patients with small renal masses on active surveillance, ccRCC subtype reported to progress most rapidly[5]

Limitations of renal biopsy

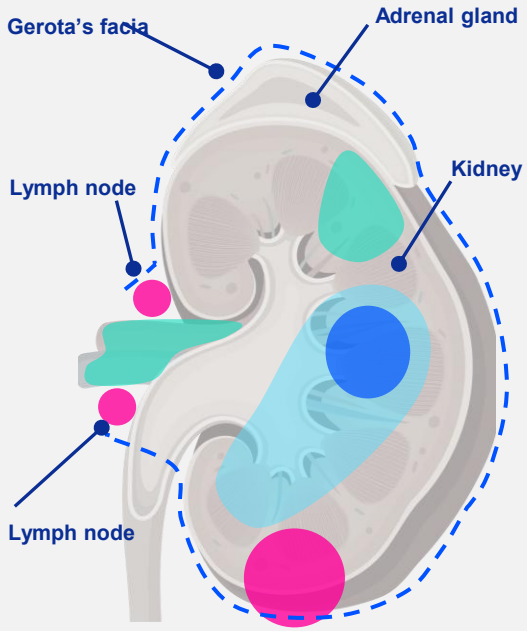
- Non-diagnostic, 10-15%
- Invasive, related risks
- Sampling error, 70% NPV[6]

Limitations of anatomic imaging (CT, MRI)

- Cannot reliably distinguish benign vs malignant

Risk of overtreatment and related complications

- Up to 30% resected small renal masses found to be benign[7]
- 30% complication rate of partial nephrectomy in these patients[8]



Stage I

Tumor <7 cm in greatest dimension and limited to kidney; **5-year survival, 95%**

Stage II

Tumor >7 cm in greatest dimension and limited to kidney; **5-year survival, 88%**

Stage III

Tumor in major veins or adrenal gland, tumor within Gerota's fascia, or 1 regional lymph node involved; **5 year survival, 59%**

Stage IV

Tumor beyond Gerota's fascia, or >1 regional lymph node involved; **5 year survival, 20%**

1. ccRCC, clear cell Renal Cell Carcinoma; CT, computed tomography; MRI, magnetic resonance imaging; NPV, negative predictive value; RCC, Renal Cell Carcinoma.
2. 1. Qi X, et al. Front Oncol. 2021;11:727778. 2. Alchahin AM, et al. Nat Commun. 2022;13(1):5747. 3. Abu Haeyeh Y, et al. Bioengineering (Basel). 2022;9(9). 4. Metin M, et al. Medicina (Kaunas). 2022;58(2). 5. Finelli A, et al. Eur Urol. 2020;78(3):460-467. 6. Patel HD, et al. J Urol. 2016;195(5):1340-1347. 7. Oei T, et al. Imaging in Medicine. 2011;3(2):207-218. 8. Baio R, et al. Diseases. 2023;11(1):27.

TLX250-Px: Highly accurate in detecting ccRCC[1]

Phase 3 ZIRCON trial validates CAIX as a novel target

^{89}Zr-girentuximab

- IgG1 **CAIX-targeting** mAb
- **Payload:** ^{89}Zr, positron emitter with $T_{1/2}$ 3.3 days
- Hepatically cleared
- Demonstrated accuracy and favorable safety profile in **Phase 3 ZIRCON study** and real-world cases[2]

ZIRCON study results summary

Primary endpoints: (n=284)	Sensitivity: 86% | Specificity: 87%
Sensitivity & specificity of small lesions	**≤4 cm (n=145)** • Sensitivity: 85% • Specificity: 90% **≤2 cm (n=20)** • Sensitivity: 97% • Specificity: 97%
Reader agreement	**The Fleiss' κ statistic for inter-reader variability:** 91% Cohen's κ statistic for intrareader **variability:** 100% for each reader
Safety & tolerability	**Favorable profile indicated**

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CAIX, carbonic anhydrase IX; ccRCC, clear cell renal cell carcinoma; mAb, monoclonal antibody; PET, positron emission tomography; rADC, radio antibody-drug conjugate; $T_{1/2}$, half-life.

1. Shuch B, et al. *Lancet Oncol*. 2024;25(10):1277-1287.
2. ZIRCON ClinicalTrials.gov ID: NCT03849118.

TLX250-Px: Patient case study 1

Clinical utility in real-world setting

Clinical background:

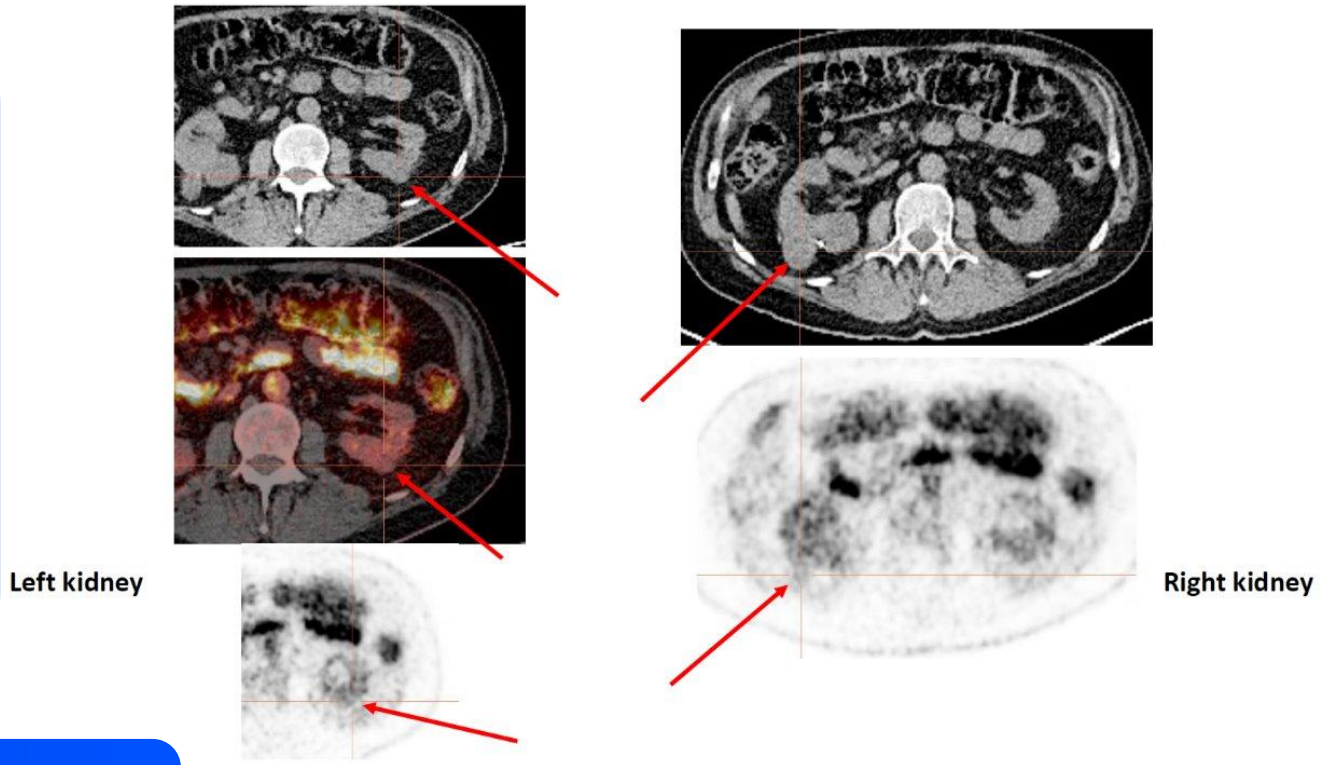
Initial small renal mass detected. CT and MRI demonstrated bilateral masses cT1a (2-4cm), no evidence of extended disease.

Initial plan: partial nephrectomy and radioablation

Negative ^{89}Zr-girentuximab scan

Following negative scan results, decision made to change initial surgical and treatment plan to active surveillance.

Invasive procedure and surgical organ removal avoided.



Patient representative scans – individual results may vary. Images are non-quantitative.

Use of TLX250-Px scan changed clinical management, avoiding unnecessary nephrectomy

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TLX250-Px: Patient case 2

Detection of metastatic ccRCC

Clinical background:

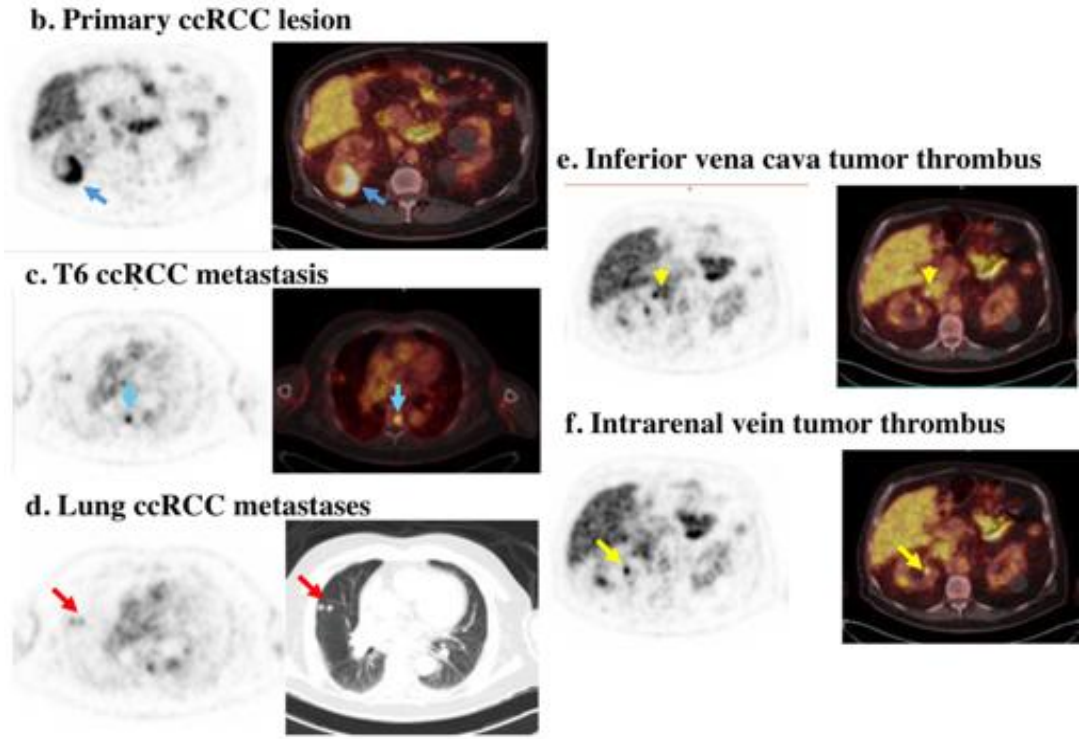
78 year old male with biopsy-confirmed ccRCC and metastases

Clinical challenge:

Patients with ccRCC frequently develop extension of tumor into renal vein and inferior vena cava. Distinguishing tumor thrombus from bland thrombus is critical – however conventional imaging modalities often unable to reliably differentiate

^{89}Zr-girentuximab demonstrated uptake in:

- Primary renal tumor
- Bone metastasis
- Pulmonary metastases
- IVC thrombus consistent with tumor involvement



Patient representative scans – individual results may vary. Images are non-quantitative.

TLX250-Px scan identified metastatic ccRCC and distinguish tumor thrombus from bland thrombus

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Mr. Kevin Richardson

CEO, Precision Medicine

Building on existing relationships with referring physicians

TLX250-Px, Illuccix and Gozellix share common referral stakeholders

Patient

Presentation

- Primary Care Physician

Imaging

- Urologist
- Radiologist /Nuclear Medicine Physician

Treatment/Management

- Urologist
- Medical Oncologist
- Radiation Oncologist
- Interventional radiologist

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$4.5B opportunity in Renal Cell Carcinoma

	U.S. TAM (Patients)	Target Indication	USD $
Precision Medicine	**~116,320** Scans (~116k patients)	Diagnosing indeterminant renal masses	$600M
Precision Medicine	**~56,650** Scans (~23k patients)	Detection of localized and metastatic recurrence of ccRCC	$300M
Therapeutics	**~4,700**	TLX250-Tx: 3rd Line CAIX-positive ccRCC	$1.1B
Therapeutics	**~10,700**	TLX252-Tx: 2nd Line+ CAIX-positive ccRCC	$2.5B
			$4.5B

Source: Datamonitor, Clarivate, internal estimates. Total Addressable Market (TAM) for Precision Medicine uses $5,000/scan for modelling purposes. Therapeutics candidates are using $230,000/treatment based on commercial benchmarks/Datamonitor. These price points do not reflect the price Telix intends to charge in the future.

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Note: Intended for investor audience only. Not intended to advertise or promote any product. TLX-250-Px, TLX-250-Tx, and TLX252-Tx have not been accepted by the FDA to diagnose, treat, cure, or prevent any disease. Not intended to advertise or promote any use or indication.

Brain Cancer overview

Dr. Arthur Braat

University Medical Center Utrecht

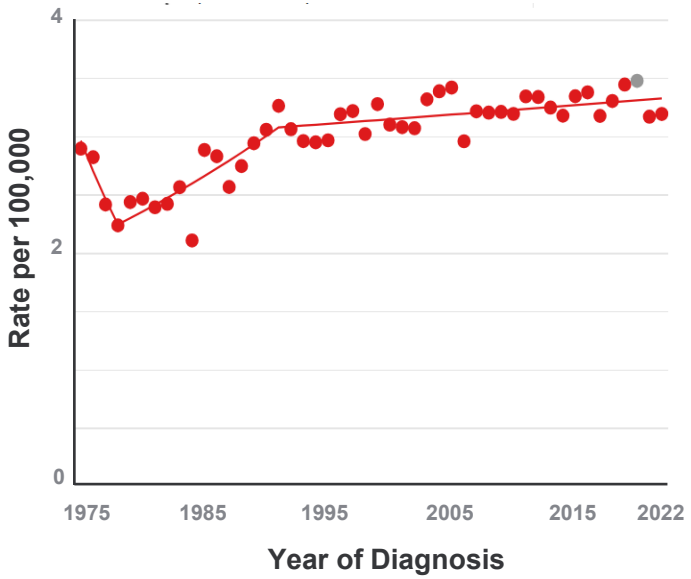
Disease overview: Glioblastoma (GBM)

Burden of GBM is increasing, however survival rates have not improved in 20+ years[1]

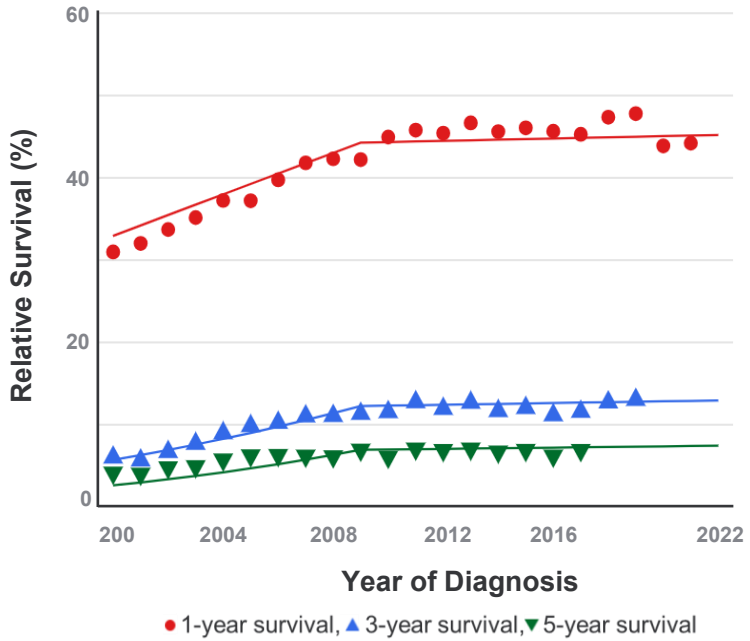
~25k new brain and CNS tumor cases/yr with **~18k** deaths/yr (U.S.)[1]

GBM is the most common and most aggressive type of brain cancer, accounting for **~50%** of all malignant CNS tumors or **~15k+** patients/year[2]

Annual Incidence (US)[1]



Average Survival (US)[1]



Patients with GBM have a median overall survival of 12-15 months[1] from diagnosis and 3-9 months from recurrence[3]

1. American Cancer Society (Cancer Facts & Figures 2025).
2. Grochans S, et al. *Cancers (Basel)*. 2022;14(10):2412.
3. Nahm et al. J Clin Oncol 41, e14057(2023).

Treatment options for GBM remain a significant unmet need

First line GBM treatment includes maximal safe surgical resection followed by radiochemotherapy

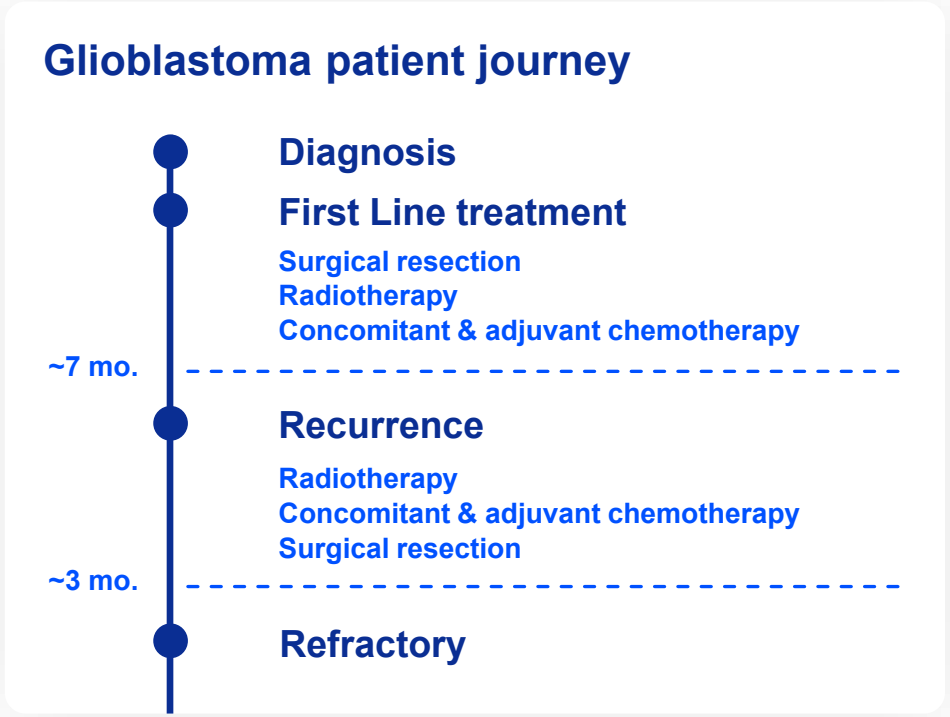
- Most patients progress after ~7 months[1]
- Recurrence occurs in 90% of patients within 2 years[1]

Upon recurrence, patients are treated with systemic therapy, re-resection, re-irradiation or pointed to a clinical trial[2]

- Recommendation by NCCN is participation in a clinical trial[2]

Current imaging modalities (e.g. gold standard MRI) have some limitations[4]

- New imaging modalities have some advantages (FET PET)

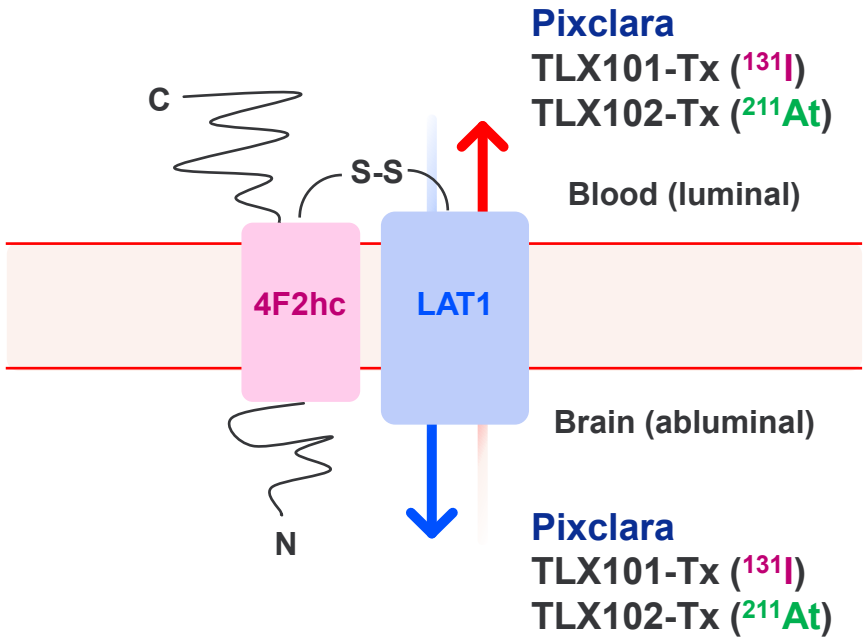


There is currently no established standard of care for recurrent GBM[4]

1. Fisher, J.P.; Adamson, D.C. Current FDA-Approved Therapies for High-Grade Malignant Gliomas. Biomedicines 2021, 9, 324.
2. Vaz-Salgado et al. Cancers (Basel). 2023 Aug 26;15(17):4279.
3. NCCN guidelines for Central Nervous Cancers recommend participation in a clinical trial for recurrent or progressive glioblastoma patients.
4. Bernstock et al. Standard clinical approaches and emerging modalities for glioblastoma imaging, Neuro-Oncology Advances, Volume 4, Issue 1, January-December 2022, vdac080.

A novel mechanism of action overcoming the blood brain barrier

Targeted radiation that provides imaging and therapeutic potential



- Large amino acid transporters, LAT1 and LAT2 are highly expressed in gliomas[1,2] compared to normal tissue
- LAT1 is expressed on both luminal and abluminal membranes, playing a key role in BBB permeation[2,3]
- Pixclara targets LAT1 and LAT2 while TLX101-Tx and TLX102-Tx therapeutic candidates target LAT1

A potential first-in-class theranostic pairing in neuro-oncology

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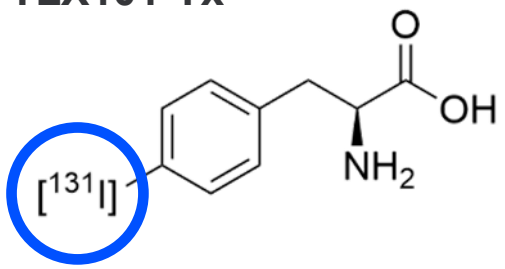
1. Singh N and Ecker GF. *Int J Mol Sci.* 2018;19(5):1278.
2. Haining Z, et al. *BMC Clin Pathol.* 2012;12:4.
3. Ahmed HS. *Mol Neurobiol.* 2025;62(3):3813-3832.

First-in-class, therapeutic candidates in GBM and LMD

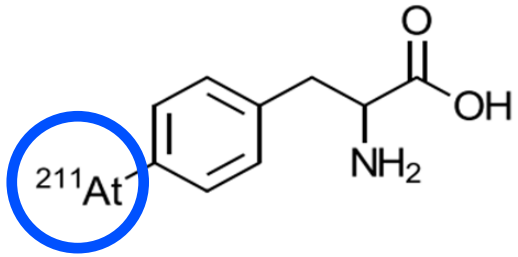
Competitive de-risked portfolio

TLX101-Tx



Orphan Drug Designation, ODD in glioma (U.S. & EU)

TLX102-Tx



Orphan Drug Designation, ODD in glioma (U.S.)

Competitive advantages

- Readily passes blood-brain-barrier, a major challenge in GBM treatment[1,2]
- IV administration vs intracranial administration[3]
- Outpatient setting (U.S.) improving quality of life
- Encouraging safety and tolerability data and compassionate use program[4] (TLX101-Tx)
- Encouraging preliminary efficacy data[5] (TLX101-Tx)
- Clinically validated candidates[5,6,7]

GBM = glioblastoma, LMD = leptomeningeal disease.

1. Samnick S, et al. J Nucl Med. 2009;50(12):2025-2032. Israel I et al. Nucl Med Biol 2011; 38:451-460. 2. Pichler J, et al. Neurooncol Adv. 2024;6(1):vdaw130. 3. Plus Therapeutics website: https://clinicaltrials.gov/study/NCT05533242 using implanted reservoir. 4. El Ghalbouni 2026. 5. IPAX Linz topline data Leibetseder A, et al. Presented at: EANM; 4-8 Oct 2025. Barcelona, Spain. 6. TLX101-Tx: Pitchler 2024 (IPAX-1), Tolboom N, et al. Eur J Nucl Med Mol Imaging. 2024;51(Suppl 1):1-1026. 7. Watabe T et al Oncotarget 2020; 11(15):1388-1398; Bormann N et al Nuklearmedizin 2013; 52: 212-221.

Prior studies have demonstrated favorable safety profile and encouraging efficacy in malignant gliomas

Demonstrated safety and tolerability profile in combination trials with EBRT and TMZ

- IPAX-1 (Phase 1), IPAX Linz1 (Phase 2), IPAX-2 (Phase 1), compassionate use program
- Treated ~60 patients to date, including pediatric patients[2]
- Well tolerated, no DLTs observed in IPAX-2[3]

Demonstrated early efficacy results

- Median OS of 23mo. (IPAX-1) and 32.2mo. (IPAX-Linz1) from initial diagnosis
- Median OS of 13mo. (from initiation of treatment, IPAX-1) and 11.9mo. (from progression prior to start of treatment, IPAX-Linz1)

Ongoing trials

- Phase 3 trial, IPAX™ BrIGHT, in combination with lomustine, first recurrence – dosing patients
- Phase 1 trial, IPAX-2, in newly diagnosed patients – completed enrollment, awaiting readout

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1. Investigator-initiated trial referring to clinical study report (CSR), 2. Across various trials (IPAX-1, IPAX-Linz, IPAX-2, IPAX BrIGHT) and compassionate use program. 3. Telix media release May 19, 2026.

IPAX BrIGHT™, A global Phase 3 study for TLX101-Tx

Part 1: Dose optimization

TLX101-Tx (4 GBq) + Lomustine (90 mg/m²) x 3 cycles n = 3

→

TLX101-Tx (4 GBq) + Lomustine (90 mg/m²) x 3 cycles n = 12

→

If combination dose not tolerated, lower either TLX101-Tx dose and/or Lomustine. Mono therapy is an option n = up to 50

Part 2: Randomized treatment expansion

Data review → 1:1

- **TLX101-Tx + Lomustine**
- **Lomustine**

Conventional MRI and ^{18}F FET PET used for imaging response

Primary endpoints (Part 1)

- Max tolerated dose, MTD and recommended dose for Part 2

Primary endpoint (Part 2)

- Overall survival (OS)

Global, multi center, prospective, open label study

Clinicaltrials.gov: NCT07100730

Eligibility: recurrent GBM (WHO 2021), 18 years+

Status: Study open to enrollment in Austria, Australia, Belgium and Netherlands. Regulatory approval in Denmark, France, Germany, Spain and Singapore. IND filing in U.S. planned next.

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1. Europe includes Austria, Belgium, Denmark, France, Germany, Netherlands, Spain where we have regulatory approvals or filings.
2. IND not yet filed.

TLX101-Tx, Compassionate use experience

UMC Utrecht Real-world data from 14 patients

14 patients with recurrent disease

- 10 Glioblastoma (GBM) patients
- 2 oligodendroglioma patients (WHO G2)
- 1 oligodendroglioma patient (WHO G3)
- 1 astrocytoma patient (WHO G2)

Heavily pretreated patients

- all patients received TMZ, 50% received Lomustine, some patients had re-irradiation, re-debulking

Disease stage:

- 5 at first recurrences
- 9 at second+ recurrences

Median treatment with TLX101-Tx post diagnoses: 22 months (9mo. - 203 mo.)

1. Tolboom N. et al. EANM 2025. 2. El Ghalbouni et al. EANO 2026 / EANM 2026., El Ghalbouni et al. EJNMMI 2025, Tolboom et al, CVIR 2024, El Ghalbouni et al. Manuscript pending submission.

TLX101-Tx, has demonstrated a favorable safety profile, with stable disease observed

Safe and tolerable treatment

- Grade 3 adverse events, cerebral edema (1), common for this condition, judged not likely due to TLX101-Tx
- No Grade 4 adverse events

MRI RANO	Patients
Stable disease (SD)	3 of 12
Progressive disease (PD) not confirmed	7 of 12
Progressive disease (PD) confirmed	2 of 12

PET RANO	Patients
Stable disease (SD)	7 of 7

Overall, over 23 patients have been treated globally with TLX101-Tx in compassionate use in Austria, Australia, Germany and New Zealand with no Grade 4 adverse events reported

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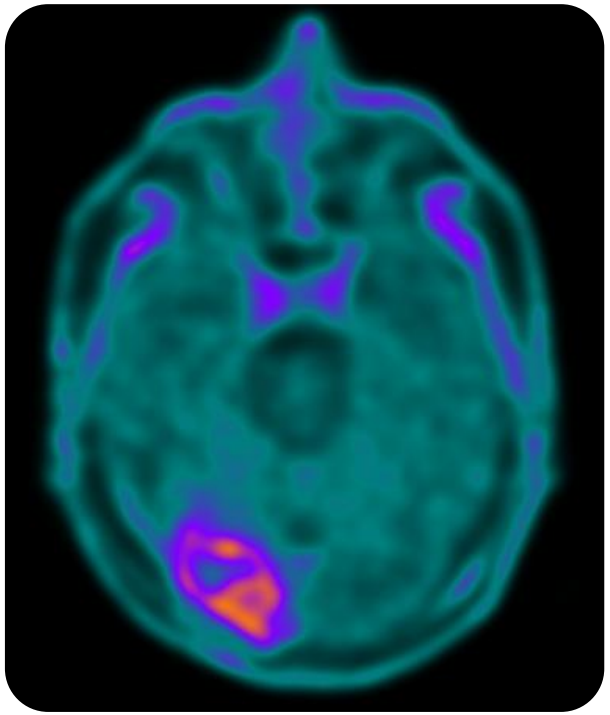
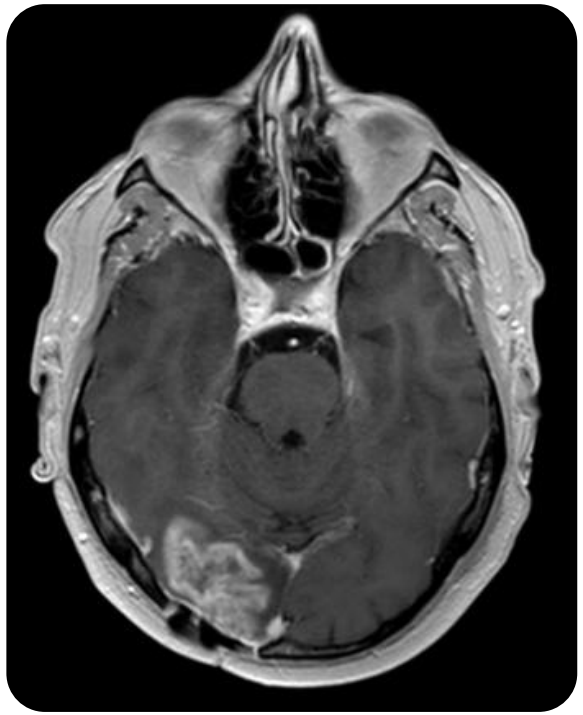
Note: Named patient program, UMC Utrecht.

Case Study 1

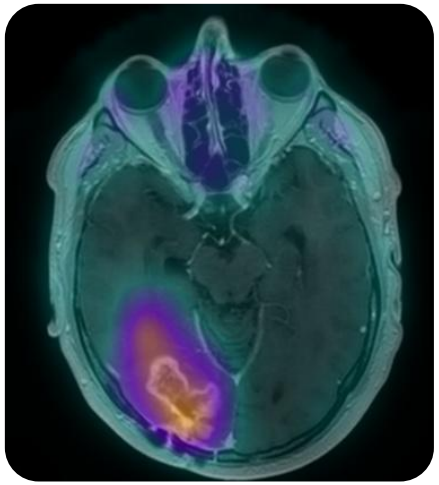
GBM, third recurrence (Stupp, re-debulking and Lomustine)

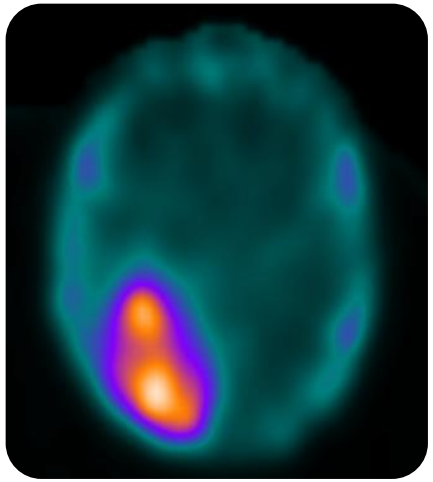
UMC Utrecht



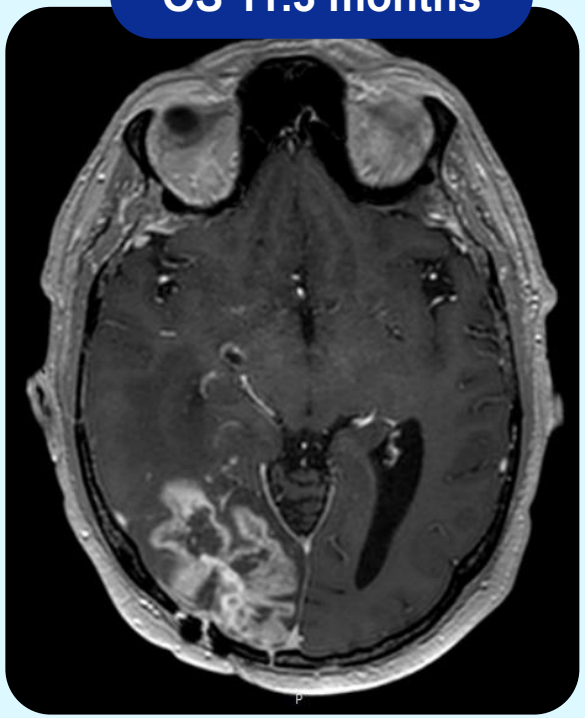


Baseline MRI





OS 11.3 months



MRI after 2 cycles

MR RANO unconfirmed Progressive Disease

No [^{18}F]FET performed

Patient representative scans – individual results may vary.

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El Ghalbouni et al. Manuscript pending submission.

Case study 2: Near complete response

Patient with recurrent glioblastoma treated with TLX101-Tx

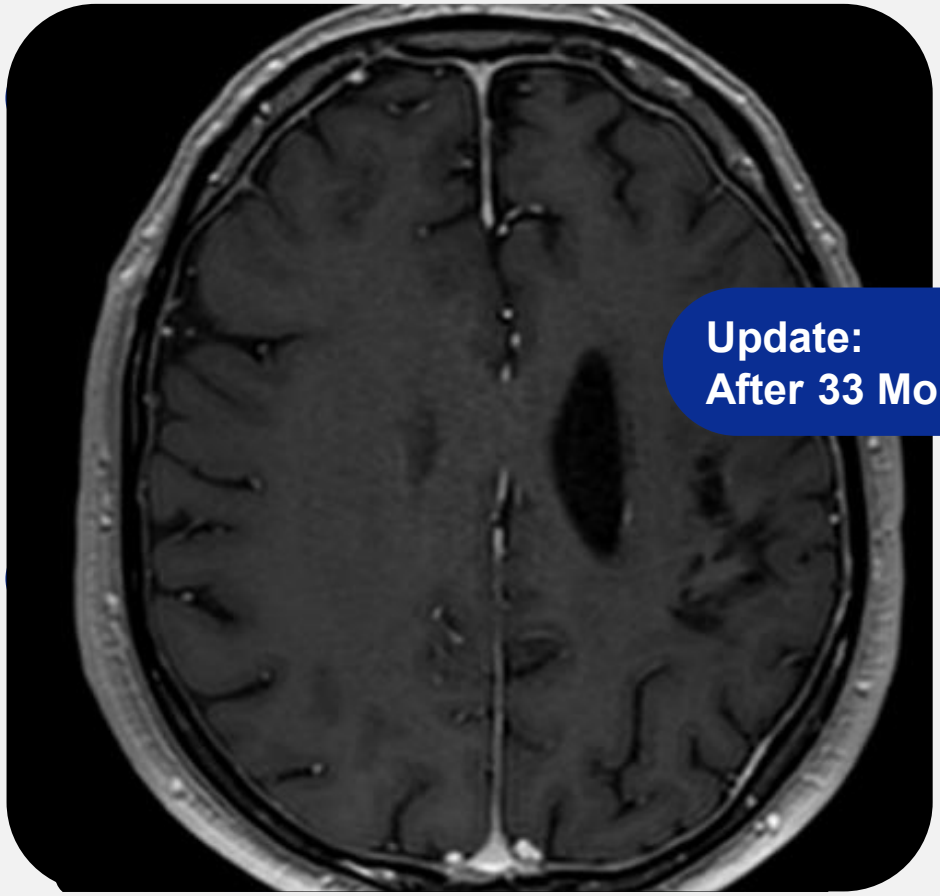
UMC Utrecht

Patient

- 56 year old male, with progressive, treatment refractory glioblastoma
- Inoperable due to its location
- Treatment with TLX101-Tx initiated with 2 cycles of 5 GBq with 3 cycles of Lomustine as bridging therapy and 2 cycles of TLX101-Tx 5 GBq

Key results

- Treatment was well tolerated, with no effects on kidney, liver, or bone marrow functions
- Tumor response demonstrated ongoing regression
- To date, 31mo since biopsy, 23mo since starting treatment with TLX101-Tx, his treatment response is ongoing



Patient representative scans – individual results may vary.

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Ghalbouni et al. EJNMMI. 2026. https://doi.org/10.1007/s00259-025-07742-w.

Case study 3: Oligodendroglioma

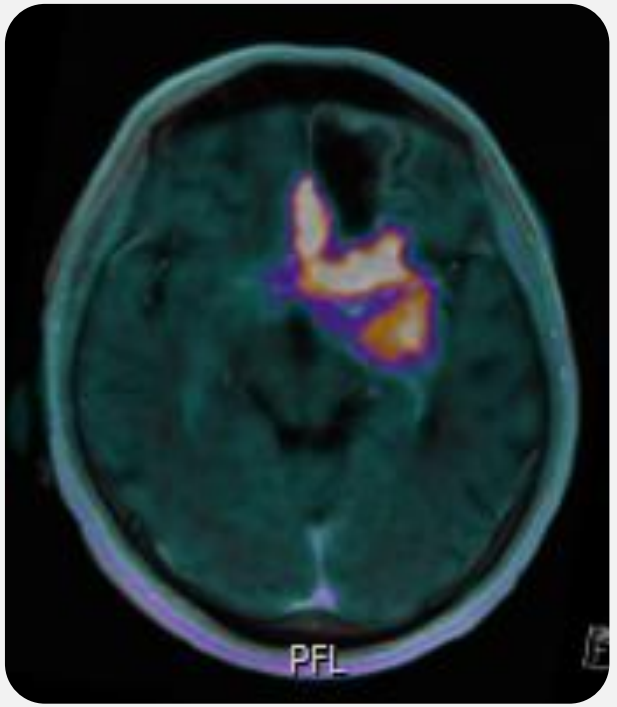
UMC Utrecht

Patient

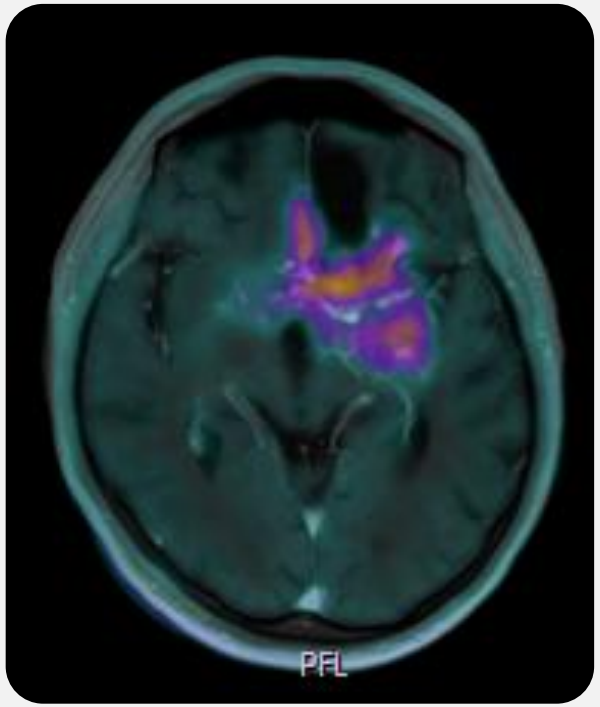
- 38-year-old male
- Diagnosed 4 years ago
- After resection, EBRT+TMZ, PVC and Lomustine
- Treatment holiday, due to new seizures

Key results

- Significant reduction of tumor after 10 months
- TLX101-Tx utility is not just limited to glioblastoma



Baseline [^{18}F] FET



[^{18}F] FET 10 months later
After 3x 5 GBq TLX101

Patient representative scans – individual results may vary.

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IPAX-2, Phase 1 study for TLX101-Tx (newly diagnosed GBM)

Met Primary endpoint: Max Tolerated Dose (MTD) of 5GBq x 2cycles + SoC achieved

Dose escalation

TLX101-Tx (3 GBq) x 2 cycles + SoC → **TLX101-Tx (4 GBq) x2 cycles + SoC** → **TLX101-Tx (5 GBq) x2 cycles + SoC**

SoC = Maximal safe resection followed by concomitant EBRT + TMZ and adjuvant TMZ

n = 12

Conventional MRI and [^{18}F]FET PET used for imaging

Eligibility: newly diagnosed glioblastoma patients[1]
Status: Study completed
Results: **no dose limiting toxicities observed at maximum dose of (5 GBq) x 2 cycles within DLT window (63 days)**
Next steps: **data supports advancement into Phase 2 study**

Primary endpoints

- Safety and tolerability
- Max tolerated dose and recommended dose

Global, multi center, open label, single arm study

Clinicaltrials.gov: NCT05450744

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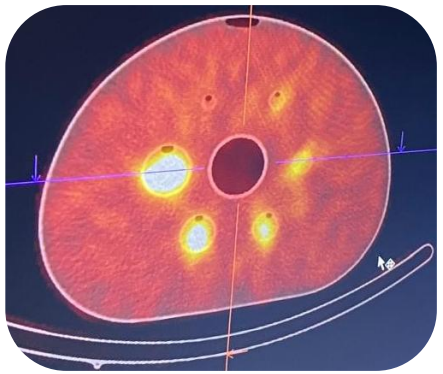
EBRT = external beam radiation therapy, TMZ = temozolomide.
1. Post surgical resection and prior to systemic therapy or radiation therapy for GBM.

TLX102-Tx

I-APACHE – FIH Study of TLX102-Tx in recurrent GBM

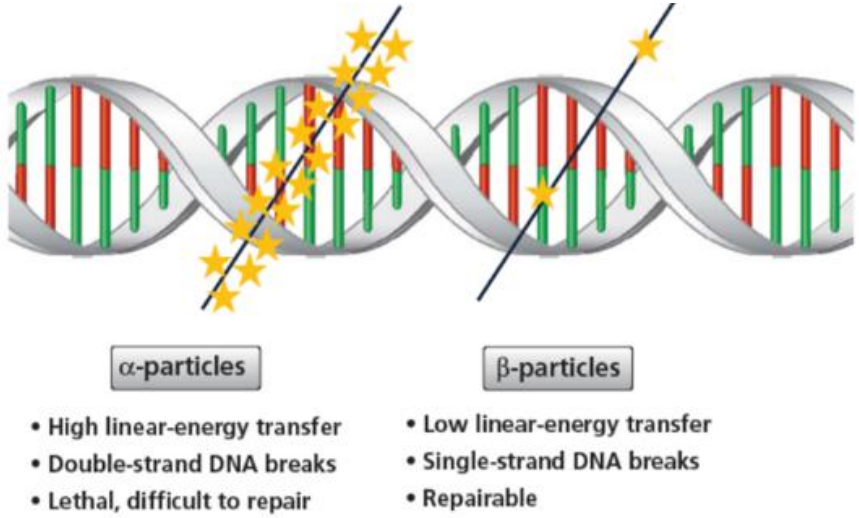
An Investigator Lead Trial (led by Dr. Braat) - Phase 1 Dose Escalation trial



^{211}At can be easily imaged compared to other α-emitters
(SPECT phantom of ^{211}At)

UMC Utrecht

Intra-arterial TLX102-Tx (^{211}At) Phase 1 dose escalation in [^{18}F]FET positive first recurrence GBM



Funding support provided by KWF (Dutch Cancer Society)

Unmet medical need in Leptomeningeal Disease (LMD)

A rapidly progressive disease with limited treatment options

Rapidly progressive and uniformly fatal condition:

Leptomeningeal disease is an aggressive complication of cancer with a median survival typically measured in weeks to a few months, even with available interventions

Severe neurological morbidity:

Diffuse involvement of the leptomeninges leads to multifocal neurological deficits including cognitive decline, cranial nerve dysfunction, seizures, and loss of functional independence

Limited and poorly effective treatment options:

Current approaches (intrathecal chemotherapy, focal radiotherapy, or systemic therapy) provide modest and transient benefit, are often poorly tolerated, and rarely achieve durable disease control

Biological and anatomical barriers to effective therapy:

The blood–CSF barrier, diffuse tumor spread, and microscopic disease burden limit drug delivery and therapeutic efficacy, highlighting the need for targeted, CNS-penetrant treatment strategies

Median survival estimated at 3.8-5.4 months for LMD from breast cancer, 3-8.7 months for LMD from lung cancer, and ~5.2 months for LMD from melanoma

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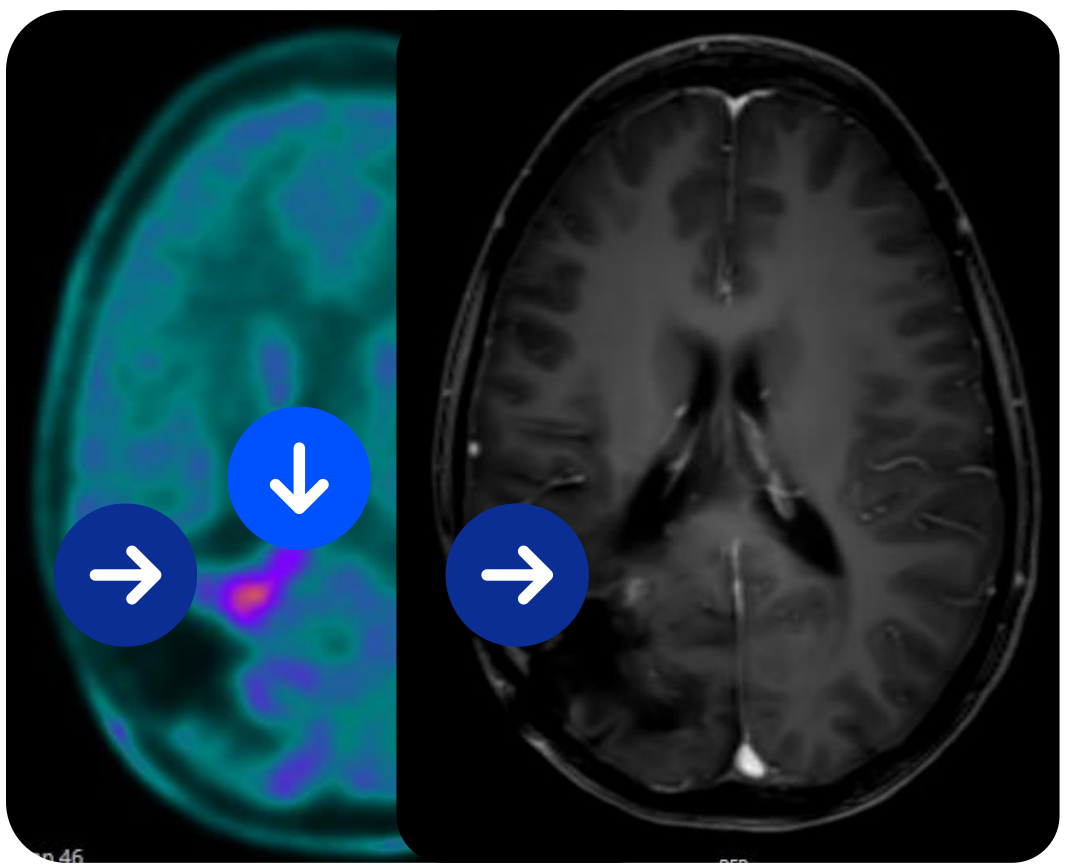
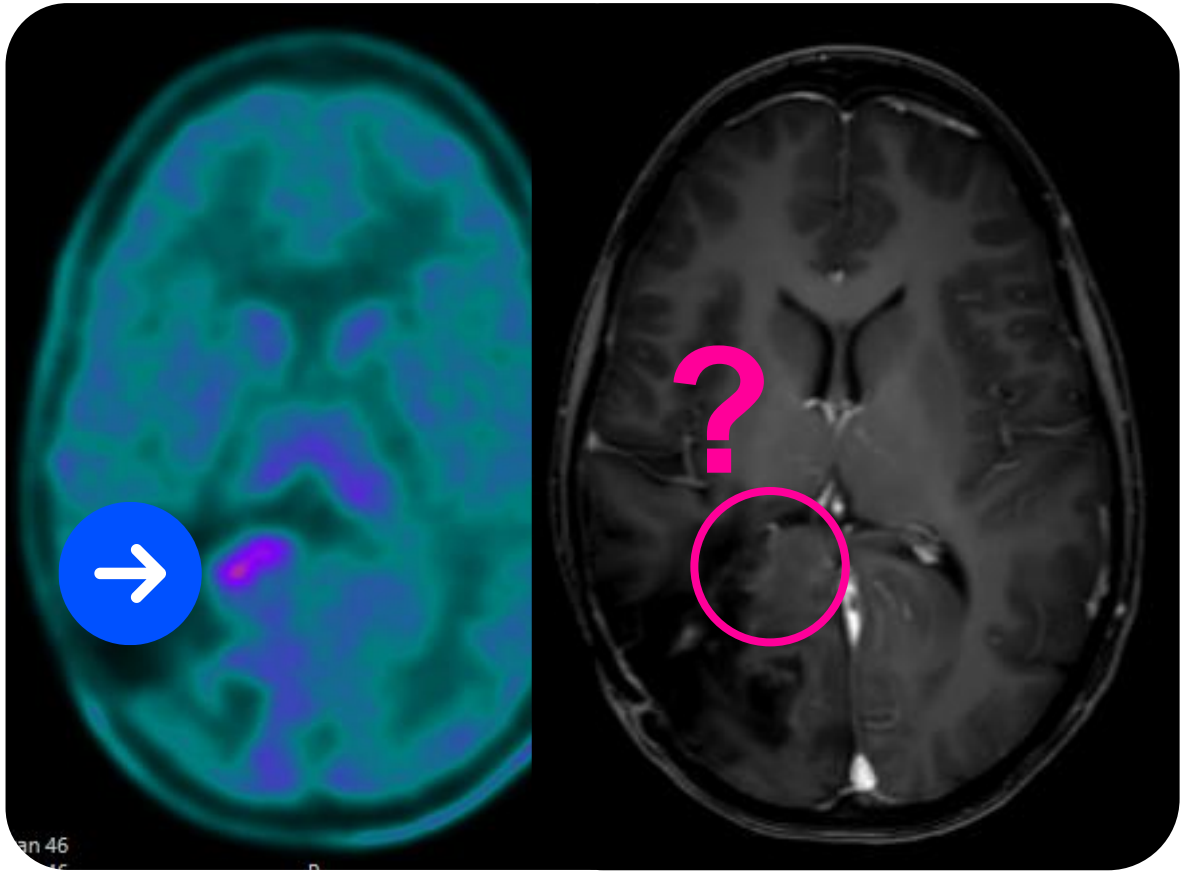
Leptomeningeal disease – LAT-1 expression confirmed with [18F]-FET

4th recurrence PXA in 16 year old girl with leptomeningeal spread





Patient representative scans – individual results may vary.

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Pixclara

Mr. Kevin Richardson

CEO, Precision Medicine

First FDA approved imaging agent for gliomas (U.S.)

Pixclara®
(floretyrosine F 18)

- Pixlumi®[1] **MAA accepted** in Europe
- Included in National Comprehensive Cancer Network **(NCCN®) guidelines**
- Inclusion in **International guidelines:** EANM/EANO/RANO/SNMMI
- Expanding into new indication: **brain metastases**[2]
- Addresses high unmet need – helps to differentiate tumor progression vs. treatment effects[3]
- Granted orphan drug designation[4]

First-in-class imaging agent approved for glioma[1]

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MAA = Marketing authorization application. EANM = European Association of Nuclear Medicine. EANO = European Association of Neuro-Oncology. RANO = Response Assessment in Neuro-Oncology. SNMMI = Society of Nuclear Medicine and Molecular Imaging.
1. Launch and brand names subject to final regulatory approval. 2. ASX release July 20, 2026. 3. Telix ASX disclosure September 14, 2026. 4. Telix ASX disclosure October 6, 2020.

Pixclara positioned for successful launch

Strong existing awareness of Pixclara among prescribers

~70%

of physicians surveyed indicated they are ready to prescribe Pixclara upon FDA approval

~80%

of referrers rely on NCCN guidelines when ordering imaging for glioma

Key Market Insights

>90%

availability of PET scanners in-house

Majority of referrers rank high differential uptake in glioma and high image quality
as the most important features of a PET radio tracer

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Insights based Shoreline Research, Awareness trial and utilization report, January 2026.

$3.5B opportunity in Neuro-Oncology

	U.S. TAM (Patients)	Target Indication	USD $
Precision Medicine	**21,200** Scans (11k patients)	Characterization of Progression in Glioma Patients	$106M
	16,800 Scans (16k patients)	Radiation Planning in adult Glioma Patients	$84M
	100,000 Scans (49k patients)	Characterization of Brain Metastasis	$500M
Therapeutics	**8,100**	Second line recurrent IDH-wild type glioblastoma	$1.2B
	10,910	First-line IDH-wild type glioblastoma	$1.6B
			$3.5B

Source: Datamonitor, Clarivate, internal estimates. Total Addressable Market (TAM) for Precision Medicine uses $5,000/scan for modelling purposes. Therapeutics candidates are using $150,000/treatment based on commercial benchmarks/Datamonitor. These price points do not reflect the actual price charged or the price that Telix will charge in the future.

Note: Intended for investor audience only. The FDA has approved Pixclara for use in positron emission tomography (PET) to differentiate recurrent or progressive glioma from treatment-related change, in conjunction with other diagnostic evaluations, in adults and pediatric patients 1 month of age and older. Not intended to advertise or promote this indication, or any other use or indication.

Telix

TLX400-Tx

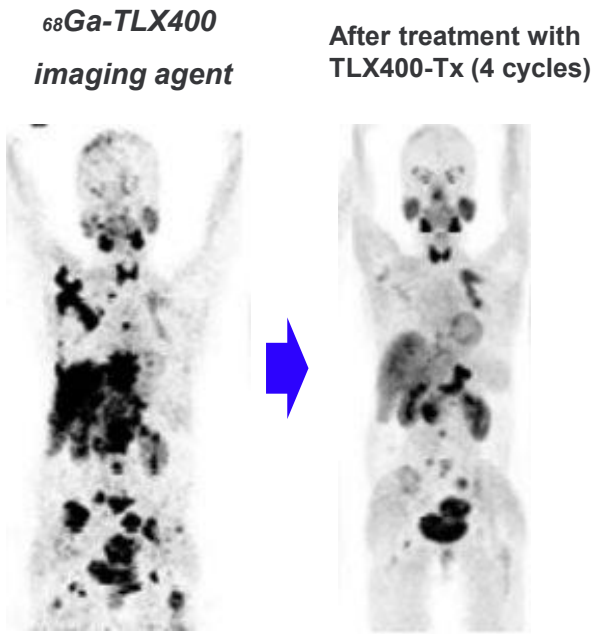
Dr. David N. Cade

Group Chief Medical Officer, CMO

TLX400-Tx- Broad FAP expression supports pan-cancer potential

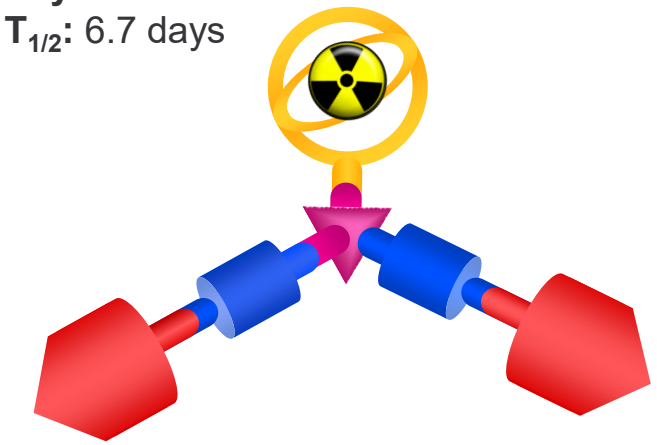
- FAP present on more than 90% of epithelial cancers, **identified as a potential target for molecular imaging and therapy**
- **Broad expression on tumor stroma across solid tumors** (including pancreatic, colorectal, breast, bladder) suggests pan-tumor potential
- In certain cancers (e.g., sarcoma, ovarian, pancreatic) FAP also expressed on cell surface, potentially enhancing efficacy
- **Not expressed in most normal adult tissues**

TLX400-Tx



Patient representative scan – individual results may vary.

Payload: ^{177}Lu
$T_{1/2}$: 6.7 days



Source: Kratochwil et al. *J Nucl Med.* 2019.

TLX400-Tx: High level of clinical confidence

Clinical benefit reported across multiple indications and in treatment refractory patients

Dataset: Clinical data available in patients across multiple cancer types

Safety: Treatment is well tolerated even in late-stage patients with poor prognosis

Low Normal Organ Uptake: Dosimetry data[7] shows low normal organ uptake which enables the administration of higher radiation doses than most competitor products

Efficacy:

- Encouraging tumor responses (>50% disease control rate across multiple tumor types)
- Encouraging overall survival (OS) and progression free survival (PFS) that compare favorably to existing standard of care treatments in earlier stage patients

Cancer	Patients (#)	Median OS/PFS		Tumour Response			
RR-Thyroid Cancer[1]	15	OS	PFS	CR	PR	SD	N/A
		NR	NR	0%	27%	20%	53%
Medullary Thyroid[2]	19	OS	PFS	CR	PR	SD	PD
		42 mo	26 mo	0%	33%	47%	20%
RAI-R Follicular Thyroid carcinoma (FTC)[3,5]	73	OS	PFS	CR	PR	SD	PD
		32 mo	29 mo	0% (0/36)	50% (18/36)	25% (9/36)	25% (9/36)
Breast[4,6]	19	OS	PFS	CR	PR	SD	PD
		12 mo	8.5 mo	0%	25%	37%	37%
Sarcoma[8]	10	OS	PFS	CR	PR	SD	PD
		7 mo	6 mo	0%	20%	40%	40%

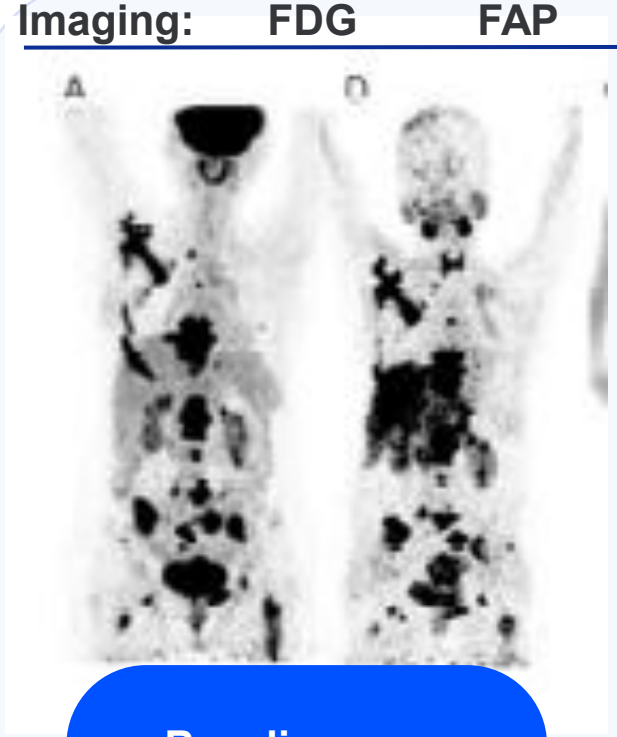
NR = Not reached, CR = Complete response, PR = Partial response, SD = Stable disease, PD = Progressive disease

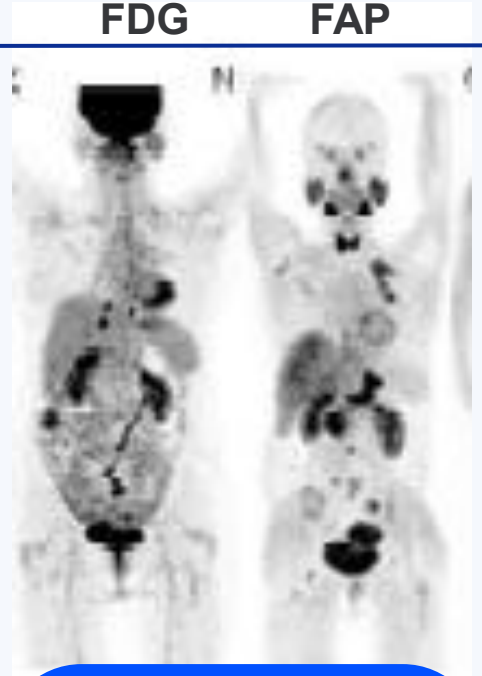
1. Ballal et al., *Thyroid,* 2022. 2. S. Ballal, ICPO Theranostics Summit 2024 & Ballal et al., EJNMMI 2026. 3. Ballal et al, Thyroid 2025. 4. Yadav et al, 2023 EJNMMI. 5. Molecular response using [68Ga]Ga-DOTA.SA.FAPi was assessed in 36 of the 73 patients. 6. Molecular response using [68Ga]Ga-DOTA.SA.FAPi was assessed in 16 of the 19 patients. 7. Kurth el a., SNMMI 2024 Poster No. 242022. 8. Ballal et al., J. Nuc. Med. 2025.

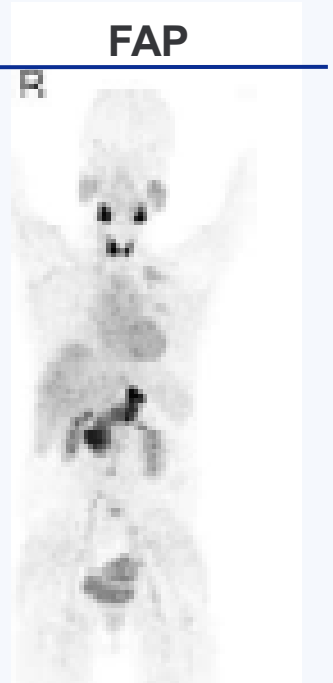
TLX400-Tx, Case study in breast cancer

Clinical data

Imaging:	FDG	FAP	FDG	FAP	FAP







Baseline scan

Follow up scan post 4 cycles of TLX400-Tx

Follow up scan post 5 cycles of TLX400-Tx

Significant reduction in disease burden

Patient

54-year-old breast cancer patient treated with TLX400-Tx after multiple lines of prior therapy[1]

Patient representative images, individual results may vary.

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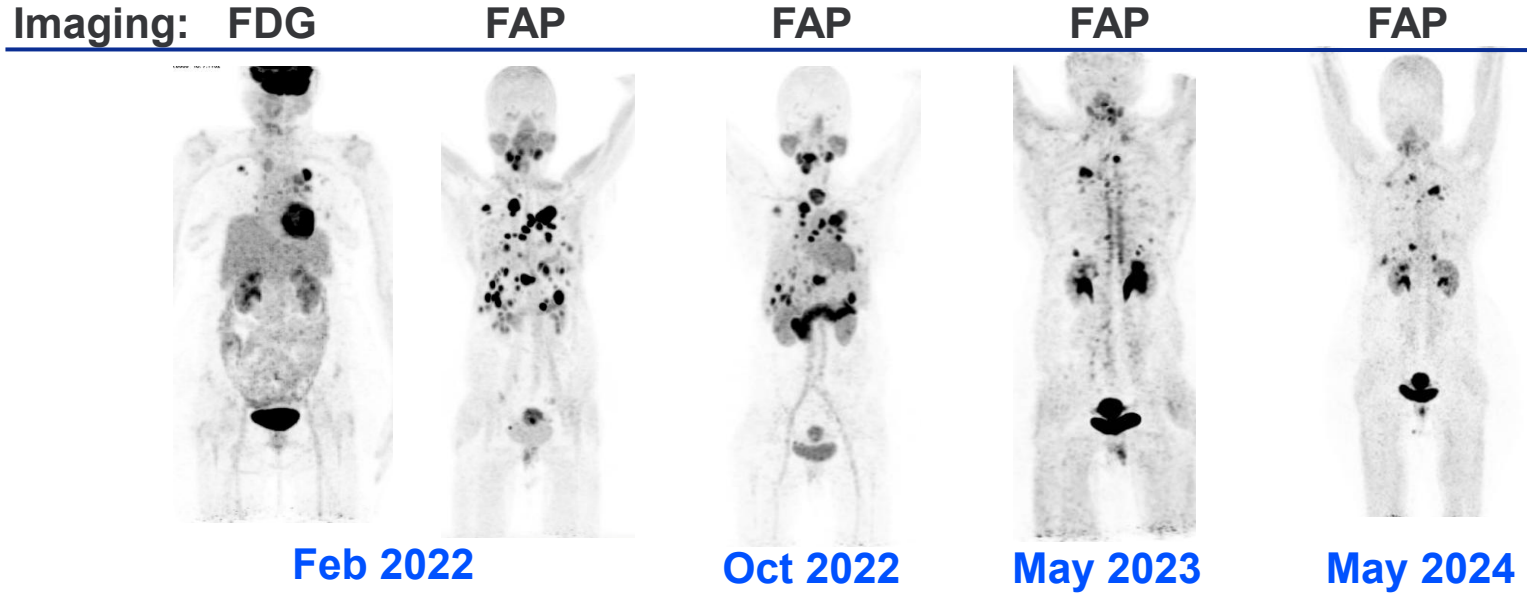
1. Source: Yadav et al. Eur J Nucl Med Mol Imaging. 2024.

TLX400-Tx, in 19 patients with thyroid cancer[1]

Partial Response in patient treated with TLX400-Tx[2]



Patient representative images, individual results may vary.

Outcome	Result
Medullary thyroid cancer (total)	**19 patients**
Assessable for radiological response[3]	**15 patients**
Partial response (PR)	**5 patients (33%)**
Stable disease (SD)	**7 patients (47%)**
Progressive disease (PD)	**3 patients (20%)**
Disease control rate (DCR)	**80%**
Median PFS	**26 months**
Median OS	**42 months**

Eligibility: FAP positive medullary thyroid cancer (MTC)

Treatment: ^{177}Lu LuDOTAGA.Glu.$(FAPi)_2$ or ^{225}Ac-DOTAGA.Glu.$(FAPi)_2$, receiving a median of 5 cycles

EJNMMI Research https://doi.org/10.1186/s13550-026-01474-0
Article in Press

Long-term outcomes in medullary thyroid cancer patients treated with [^{177}Lu]Lu-DOTAGA.FAPi dimer therapy

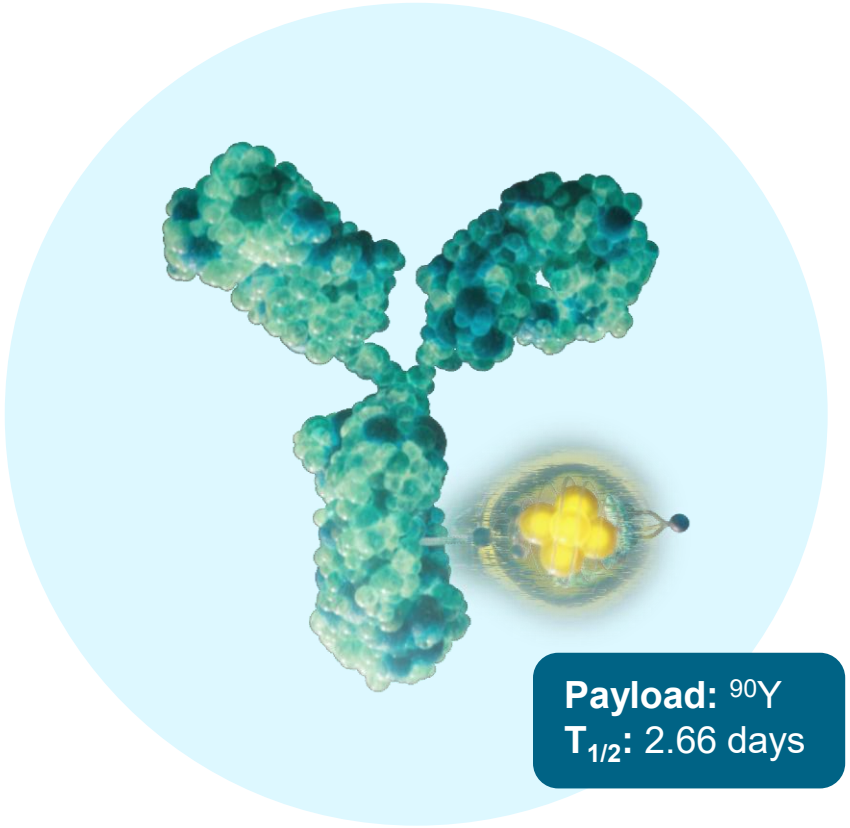
Telix

1. Ballal S., Priyanka G.B., Yadav M.P. et al. Longterm outcomes in medullary thyroid cancer patients treated with [177Lu] Lu-DOTAGA.FAPi dimer therapy. EJNMMI Res (2026).
2. Adapted from Sanjana Ballal, ICPO Theranostics Summit 2024 using RECIST 1.1.
3. Radiological and molecular imaging response was assessed in 15 out of 19 patients, as four patients did not have follow-up imaging available for evaluation.

TLX66-Tx
TLX300-Tx

Mr. Richard Valeix
CEO, Therapeutics

TLX66-Tx: Investigator Initiated Trial



TLX66-Tx, ^{90}Y-DTPA-besilesomab

Targeting molecule / target:
Monoclonal Antibody / CD66

Mechanism of Action
- ^{90}Y-DTPA-besilesomab binds myeloid precursors expressing CD66 in the marrow
- Mid-to-long range beta crossfire ablates the adjacent stem-cell niche
- May directly contribute to anti-tumor activity

Potential indication(s)
Bone marrow conditioning for HSCT; priority indication: alloHSCT in high risk acute myeloid leukemia (AML) patients

Value to patients
Targeted conditioning with TLX66-Tx will enable myeloablation for HSCT without high intensity chemo (HIC) regimen

Strategic ambition
Replace HIC as the standard conditioning regimen across HSCT – from high-risk AML to non-malignant and non-oncology indications

Ongoing IIT clinical activities
Phase 2 Investigator Initiated Trial in pediatric high-risk leukemia at Great Ormond Street Hospital in London, UK

Telix

FDA and EMA Orphan Drug Designation granted forTLX66-Tx for bone marrow conditioning.

1. ClinicalTrials.org: NCT0485621.

Extensive clinical data in >90 patients across multiple malignancies

Excellent safety profile and encouraging long-term efficacy signals

TLX66-Tx has been tested in >90 patients (including pediatric patients) across a range of hematological malignancies. Completed studies include:

- *Phase 1*: Dose-escalation study in hematological malignancies (n=55 pts)
- *Phase 1:* Study in pediatric relapsed/refractory leukemia (n=9 pts)
- *Phase 2*: A randomized Ph2 study in multiple myeloma (n=24 pts)

Safety

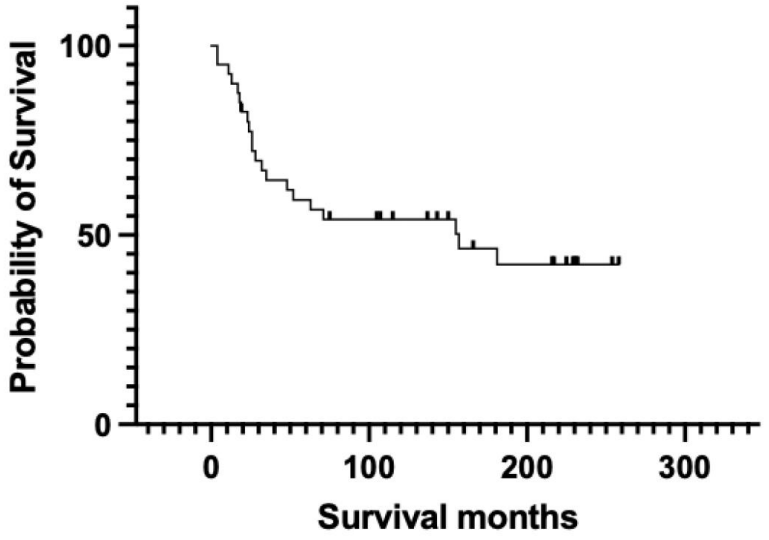
- TLX66 was well tolerated in adult patients across multiple haematological malignancies, with no detectable non-hematological toxicities (eg mucositis/colitis)
- In pediatric patients (aged 4 – 16 years), TLX66-Tx was well-tolerated with no serious toxicities

Efficacy

- All patients engrafted
- Encouraging increases in relapse free and overall survival were observed relative to historical data. Overall survival >10 years was seen in most adult patients[1]

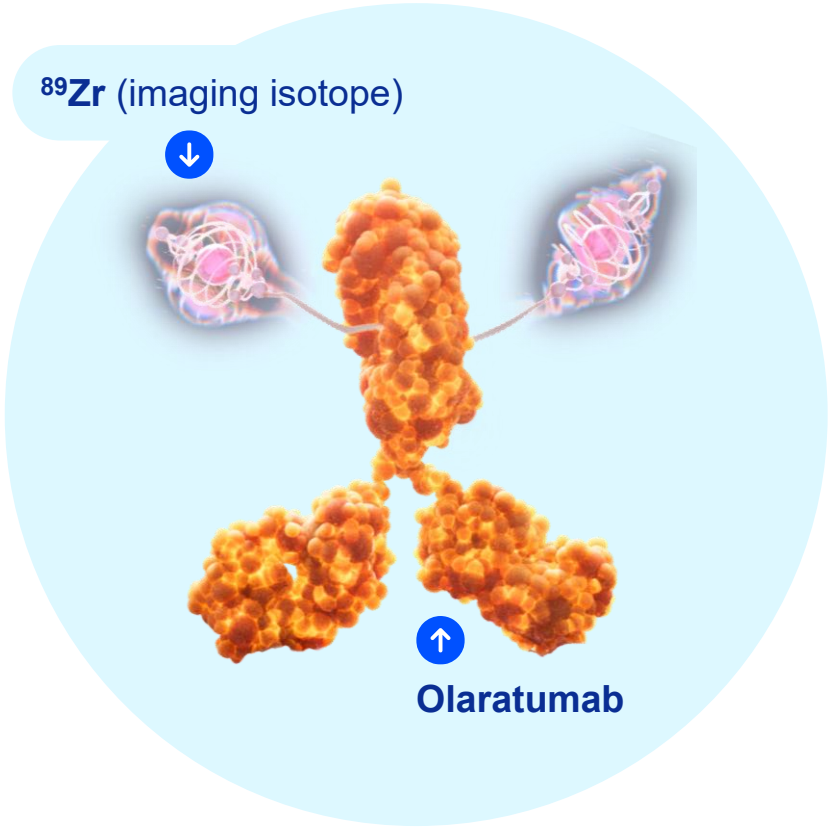
Encouraging long-term survival in high-risk AML, MM, CML and B-ALL patients

(*OS >10 years in most patients*)[1]



1. Orchard EBMT Presentation 2026.

TLX300-Tx: Program overview



ClinicalTrials.gov ID: NCT06537596

TLX300-Tx

Targeting molecule / target:
- Antibody (olaratumab)/
- Platelet-derived Growth Factor Receptor alpha (PDGFRα)

Potential indication(s)
Advanced metastatic Soft Tissue Sarcoma (STS), other PDGFRα expressing tumors

Clinical experience
- Olaratumab was in-licensed from Eli Lilly and Company with exclusive rights to develop as a radiopharmaceutical[1]
- 657 STS patients have been treated with olaratumab (across Ph 1b/2 and Ph 3 trials). Clinical safety profile was favorable[2]

Clinical Trial

Name: ZOLAR imaging study

Description:
Evaluate the safety, pharmacokinetics, biodistribution and dosimetry of ^{89}Zr-labelled-olaratumab

Phase: 1 (dosimetry)
Primary endpoints:
- Adverse events (AEs), /Serious Adverse events (SAEs)
- Evaluate uptake of 89Zr-labelled-olaratumab within tumors and normal organs

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1. Telix ASX disclosure April 11, 2022.
2. Tap W.D., Jones R.L., Van Tine B.A., et al. Olaratumab plus doxorubicin versus doxorubicin alone for treatment of soft-tissue sarcoma: an open-label phase 1b and randomized phase 2 trial. Lancet. 2016.

Closing Remarks

Dr. Christian Behrenbruch
Managing Director and Group CEO

A proven leader in Radiopharma innovation and execution

~$1B
Estimated 2026 sales

3
Approved products on market

22 countries
Illuccix available

4
Pivotal trials near readout

Diversified, de-risked pipeline

- PSMA, CAIX, LAT1 and FAP targets
- New targets in GEP-NETs,[1] lung and other areas
- R&D platform leading next-generation targeting

Vertically integrated leadership

- Established a vertically integrated radiopharma industry leader
- World-class radioisotope production secures supply at scale
- Global footprint supporting commercial delivery worldwide

Transformational growth engine

- Transactions and partnerships accelerating entry into therapeutics
- Proven ability to advance assets from **development to regulatory approval**
- Radiopharmaceuticals positioned to transform standards of care

Proven **commercial execution**, a deep and diversified pipeline and integrated supply **— positioned to lead the next decade of radiopharmaceuticals**

Telix

1. Subject to close of transaction, the transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.