Scancell Holdings plc (SCLP.L)
Rating: Buy

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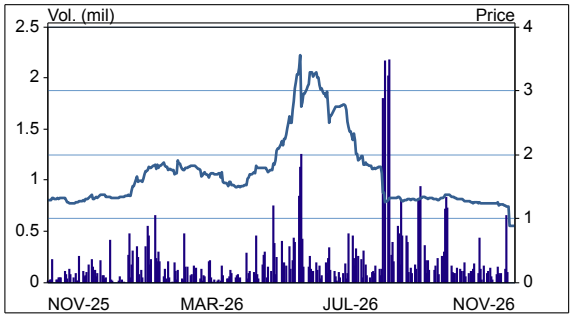
Cancer Vaccines Take Another Shot with a Stronger Hand; Initiating at Buy and 330p PT

Stock Data	10/30/2026
Price	£0.87
Exchange	LSE
Price Target	£3.30
52-Week High	£2.95
52-Week Low	£0.86
Enterprise Value (M)	£102
Market Cap (M)	£106
Shares Outstanding (M)	121.2
3 Month Avg Volume	244,720
Balance Sheet Metrics	
Cash (M)	£21.0
Total Debt (M)	£16.8
Total Cash/Share	17.32p

Cash (M): Pro forma cash includes £15.7M gross proceeds from July 2026 U.K. offerings.

EPS (GBp) Diluted			
Full Year - Apr	2025A	2026A	2027E
1st Half	(13.45)	(6.37)	(9.07)
2nd Half	(2.20)	(11.72)	(8.20)
FY	(12.65)	(17.25)	(17.09)

Revenue (£M)			
Full Year - Apr	2025A	2026A	2027E
1st Half	0.0	0.0	0.0
2nd Half	4.7	0.0	2.0
FY	4.7	0.0	2.0



Future Nasdaq listing and strengthened balance sheet bring Scancell into focus. We are initiating coverage of Scancell with a Buy rating and 330p price target. Scancell is pursuing an all-share reverse merger with Neuphoria Therapeutics (NEUP; Neutral) following the Phase 3 failure of Neuphoria's lead asset in October 2025. The transaction, expected to close in late 4Q26 or early 1Q27, provides Scancell with a path to establish a Nasdaq listing under the symbol SCLT while retaining its AIM listing. We view the decision to retain AIM positively given Scancell's established U.K. shareholder base and active trading market. Scancell has also lined up a $39.1M PIPE, recent U.K. equity raises, and debt financing from BlackRock-managed Kreos Capital. We project ~$75M in total proceeds from the U.K. offerings, PIPE, and initial $15M of debt financing, with at least $10M of additional cash expected from Neuphoria. We believe the transaction should increase Scancell's visibility among U.S. healthcare investors and provide funding through the targeted 2H28 Phase 3 PFS readout for lead asset iSCIB1+.

iSCIB1+ is an off-the-shelf DNA cancer vaccine entering Phase 3 in advanced melanoma. Scancell's second-generation ImmunoBody melanoma vaccine is designed to generate T-cell responses against the melanoma-associated antigens gp100 and TRP-2. In combination with checkpoint inhibitors, iSCIB1+ aims to generate more melanoma-specific T-cells while checkpoint inhibition helps keep them active. iSCIB1+ builds on first-generation SCIB1 through two modifications: the "i" reflects an Fc-engineering change to improve antigen uptake and presentation, while the "+" adds peptide epitopes that broaden human leukocyte antigen (HLA) coverage beyond HLA-A2. HLA molecules determine which epitopes can be presented to T-cells, and iSCIB1+ targets HLA types representing approximately 80% of melanoma patients. A randomized Phase 3 study in first-line unresectable stage III/IV melanoma is expected to enroll its first patient in December 2026. Despite advances with checkpoint inhibitors, many patients still fail to achieve durable disease control.

We believe investors may be underappreciating several aspects of the Scancell story:

1. **iSCIB1+ enters Phase 3 with meaningful clinical, biological, and regulatory de-risking.** Scancell's Phase 2 melanoma study, known as SCOPE, evaluated first-generation SCIB1 and subsequently second-generation iSCIB1+ in combination with nivolumab/ipilimumab and generated encouraging response, PFS, immune-response, and safety data. Importantly, activity was stronger among patients whose HLA types matched those targeted by the vaccine, providing additional biological support that iSCIB1+ is contributing to the observed activity. Phase 3 carries forward key learnings from SCOPE, while the FDA has cleared the study under Scancell's U.S. IND and granted iSCIB1+ Fast Track designation. See below for a closer look at the SCOPE data and Phase 3 design.

2. **Cancer vaccines are seeing renewed interest after years of disappointing development.** Improved vaccine technologies and combination with checkpoint inhibitors have generated renewed momentum, with Merck (MRK; not rated) and Moderna (MRNA; not rated) providing important Phase 3 validation through their personalized cancer-vaccine program in melanoma, with the latest detailed results presented at ESMO 2026. We believe this could bring greater investor attention back to the cancer-vaccine space as iSCIB1+ enters Phase 3.

3. **iSCIB1+ could offer meaningful practical and economic advantages vs. personalized vaccines.** Unlike individualized approaches, iSCIB1+ does not require patient-specific tumor sequencing or manufacture of a unique vaccine for each patient and can instead be produced in larger batches, undergo standardized quality-control testing, and be manufactured in advance. It is administered using PharmaJet's Stratis needle-free intramuscular system under a long-term license and supply agreement that includes a mid-single-digit royalty on commercial sales where Stratis is used. We believe lower manufacturing complexity, potentially lower cost of goods sold, product availability in advance, and an established needle-free delivery system could provide meaningful practical differentiation.

4. **The commercial opportunity extends beyond advanced melanoma.** We project approximately $680M in U.S. peak sales for iSCIB1+ in advanced melanoma and assign a 65% probability of success, with launch modeled in 2029. Earlier-stage, resectable melanoma represents an additional approximately $620M U.S. peak-sales opportunity in our model, although we currently assign only a 15% probability of success ahead of the planned Phase 2 study given the program's earlier stage of development.

5. **We believe investors are heavily focused on iSCIB1+, with less attention paid to Scancell's broader pipeline.** Modi-1 provides a second clinical-stage cancer-vaccine opportunity, while Scancell's GlyMab antibody platform has received external validation through two licensing agreements with Genmab (GMAB; Buy; Selvaraju). The company also retains several earlier-stage ImmunoBody and proprietary GlyMab programs. We currently assign no value to these programs given their earlier stage of development and/or limited visibility into future economics, but believe they represent meaningful upside as the programs advance. We believe investors should take a closer look at these assets given their potential to provide additional value beyond iSCIB1+.

SCOPE provides clinical and biological support for iSCIB1+ ahead of Phase 3. The open-label, non-randomized Phase 2 study evaluated different versions of Scancell's ImmunoBody melanoma vaccine with nivolumab/ipilimumab in previously untreated patients with first-line unresectable stage III/IV melanoma. Cohort 1 evaluated first-generation SCIB1 in HLA-A2-positive patients, Cohort 3 moved to second-generation iSCIB1+ and included 39 evaluable patients whose HLA types matched those targeted by the vaccine and 10 whose HLA types did not, and Cohort 4 evaluated iSCIB1+ using an accelerated priming schedule in 24 patients with matching HLA types. Across 104 patients with vaccine-matched HLA types from Cohorts 1, 3, and 4, SCIB1/iSCIB1+ + nivolumab/ipilimumab achieved a 62% objective response rate (ORR) and 81% disease control rate (DCR), while Cohort 4 achieved a 70% ORR and 83% DCR. Importantly, within Cohort 3, patients with matching HLA types achieved a 56% ORR and 79% DCR vs. 20% and 40%, respectively, among patients without matching HLA types, with PFS of 74% at 16 months vs. 20% at 14 months. PFS among the matching-HLA patients also remained 77% at 22 months vs. ~43% historically for nivolumab/ipilimumab in CheckMate 067. Separately, 94% of evaluated patients generated T-cell responses to iSCIB1+ peptides, with stronger and broader immune responses associated with higher clinical response rates. Although SCOPE was non-randomized and the non-matching HLA population was small, we believe the consistency across clinical activity, HLA status, and immune response provides meaningful evidence that iSCIB1+ is contributing to the observed activity. Safety has also remained favorable, with predominantly low-grade vaccine-attributed adverse events and infrequent Grade ≥3 events.

Phase 3 appears thoughtfully designed around the lessons from SCOPE. The global, double-blind, placebo-controlled study is expected to enroll approximately 550 patients randomized 1:1 to iSCIB1+ + nivolumab/ipilimumab or placebo + nivolumab/ipilimumab. The study carries forward the HLA-selected population, optimized 8 mg dose, and accelerated priming schedule selected through SCOPE. The accelerated schedule administers iSCIB1+ at Weeks 0, 1, 3, 7, and 13 before moving to every-12-week dosing, with the goal of establishing vaccine-specific immunity earlier and better aligning vaccine priming with the initial nivolumab/ipilimumab treatment period. Management has indicated that the study is powered around an approximately 15-percentage-point difference in PFS between treatment arms, substantially below the approximately 34-percentage-point historical difference observed between the matching-HLA patients treated with iSCIB1+ in SCOPE and CheckMate 067 at 22 months. PFS is the primary endpoint and is designed to potentially support accelerated approval, with subsequent overall survival follow-up intended to support full approval. We believe the Phase 3 design, encouraging Phase 2 data, and regulatory progress support our confidence in the program.

Earlier-stage melanoma could materially expand the iSCIB1+ opportunity. Scancell plans to initiate a randomized two-arm Phase 2 study in HLA-matched patients with resectable stage III/IV melanoma in 1H27, evaluating pembrolizumab alone vs. pembrolizumab + iSCIB1+, with treatment administered before surgery and, for patients who do not achieve a pathological complete response (pCR), continued after surgery. The study will assess pCR following neoadjuvant therapy and event-free survival, with initial data targeted for 2H27. Earlier clinical experience with first-generation SCIB1 provides initial support for development in this setting. In a Phase 1 study that included patients with resected stage III/IV melanoma, 10/16 evaluable patients remained disease free at 60 months, although the dataset was small and predates the optimized iSCIB1+ construct.

While the addressable population in resectable melanoma is considerably larger than in advanced disease, we conservatively project approximately $620M in U.S. peak sales in the neoadjuvant/adjuvant setting given the earlier stage of the program, with launch modeled in 2032. We currently assign a 15% probability of success ahead of the planned Phase 2 study.

The broader pipeline deserves greater investor attention, in our view. Modi-1 provides Scancell with a second clinical-stage cancer-vaccine program and is designed to generate T-cell responses against citrullinated peptides that can arise in stressed tumor cells. Early data in HPV-negative head-and-neck squamous cell carcinoma (HNSCC) showed three partial responses among seven patients evaluated at Week 25. Scancell's GlyMab antibody platform has also received external validation through two licensing agreements with Genmab, while the company retains several earlier-stage ImmunoBody and proprietary GlyMab programs. We currently assign no value to these programs given their earlier stage of development and/or limited visibility into future economics. However, we believe positive Modi-1 data, advancement of the Genmab-partnered programs, or progress across the earlier-stage pipeline could provide meaningful additional upside beyond iSCIB1+.

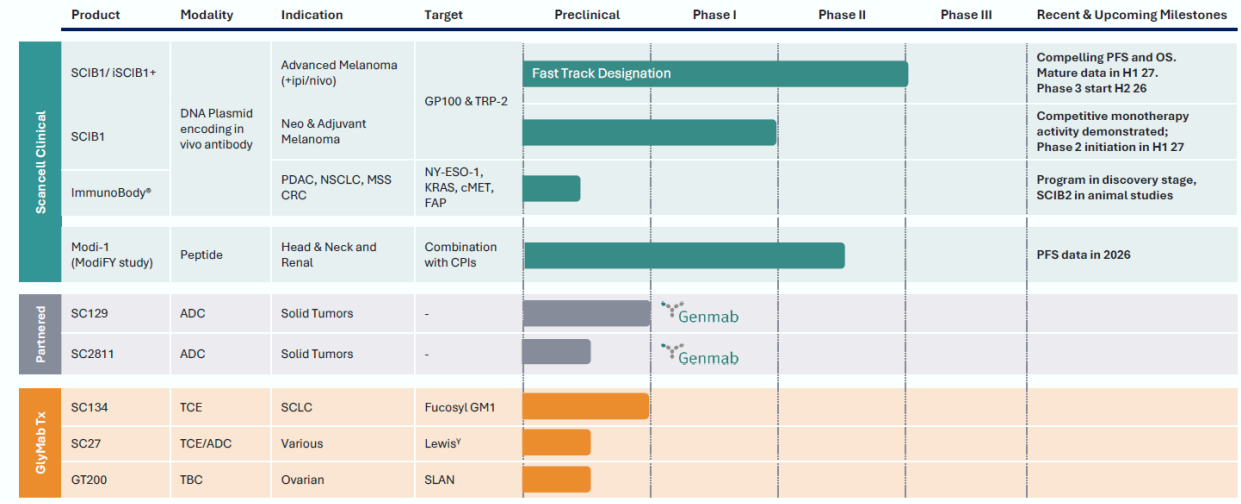
Valuation and risks to price target achievement. We are initiating coverage of Scancell with a Buy rating and 330p price target. We base our valuation on our probability-weighted clinical net present value (NPV) valuation model, which allows us to flex multiple assumptions affecting a drug's profile. We value Scancell based on the U.S. opportunities for iSCIB1+ in advanced and earlier-stage melanoma, assigning 65% and 15% probabilities of success and approximately $680M and $620M in U.S. peak sales, respectively. These peak-sales estimates are before PharmaJet royalty payments, and we model a 5% royalty in both indications, consistent with management's indication of a mid-single-digit royalty on commercial iSCIB1+ sales where the Stratis system is used. Moving forward, we believe additional upside potential exists from ex-U.S. iSCIB1+ sales, Modi-1, earlier-stage ImmunoBody programs, Genmab-partnered GlyMab economics, and Scancell's proprietary GlyMab pipeline, none of which are currently reflected in our valuation. Risk factors that could impede the stock from reaching our PT include failed or inconclusive clinical trials, unfavorable regulatory or competitive developments, lower-than-expected commercial adoption, or the occurrence of additional dilutive capital raises.

Company Background

Scancell Holdings plc is a late-stage clinical biotechnology company developing targeted, off-the-shelf immunotherapies designed to enhance anti-tumor immune responses in difficult-to-treat cancers. The company currently trades on the Alternative Investment Market of the London Stock Exchange under the ticker "SCLP." In July 2026, Scancell entered into a definitive all-share merger agreement to acquire Neuphoria Therapeutics (NEUP; Neutral). Upon completion of the transaction, which is expected in late 4Q26 or early 1Q27, the combined company plans to continue operating under the Scancell name and apply to list its American Depositary Shares on Nasdaq under the symbol "SCLT." In our opinion, the transaction is intended primarily to establish a U.S. public listing following the Phase 3 failure of Neuphoria's lead asset in October 2025 and help secure capital needed to advance Scancell's lead program. We believe the planned Nasdaq listing, alongside Scancell's existing AIM listing, could increase the company's visibility among U.S. healthcare investors and potential partners as iSCIB1+ advances through Phase 3.

Scancell's primary value driver is iSCIB1+, a second-generation DNA ImmunoBody immunotherapy encoding melanoma-specific gp100 and TRP-2 epitopes and designed to generate potent anti-tumor T-cell responses. iSCIB1+ is advancing into a global, randomized, Phase 3 study in combination with ipilimumab and nivolumab in first-line unresectable stage III or stage IV melanoma. The company received FDA clearance in January 2026 to move forward with the Phase 3 study under its U.S. IND, and iSCIB1+ received Fast Track designation in April 2026. Management expects the first patient in during December 2026. Beyond iSCIB1+, Scancell has additional ImmunoBody programs, the Moditope platform (led by Phase 2 candidate Modi-1 in HPV-negative head-and-neck squamous cell carcinoma [HNSCC] and renal-cell carcinoma [RCC]), and the GlyMab antibody platform, which includes two Genmab (GMAB; Buy; Selvaraju) licensing deals and early-stage proprietary antibody and T-cell engager programs. We currently value Scancell based on iSCIB1+ in advanced and earlier-stage melanoma in the U.S., while treating ex-U.S. sales, Modi-1, and the other pipeline assets as potential additional upside. We believe this provides a conservative base case while preserving meaningful upside as the additional programs progress and mature. Altogether, Scancell is anchored by its lead program, iSCIB1+, with meaningful long-term optionality from its broader clinical pipeline and partnered assets, providing multiple avenues for value creation.

Scancell Pipeline



Source: Company documents. ADC, antibody-drug conjugate; CPI, checkpoint inhibitors; CRC, colorectal cancer; Ipi, ipilimumab; MSS, microsatellite stable cancer; Nivo, nivolumab; NSCLC, non-small cell lung cancer; PDAC, pancreatic ductal adenocarcinoma; SCLC, small cell lung cancer; TCB, T-cell-redirecting bispecific antibody; TCE, T-cell engager.

Upcoming Company Catalysts

Drug Name	Indication	Timeline	Milestone	Impact
Modi-1	HNSCC/RCC	Nov 2026	New Phase 2 ModiFY data	Medium
GlyMab	Solid tumors	4Q26	Partnered-program update; potential development milestones	Medium
iSCIB1+	1L unresectable/metastatic melanoma	Dec 2026	First patient expected in global Phase 3 trial	Medium
SCIB1 / iSCIB1+ (SCOPE)	1L unresectable/metastatic melanoma	1H27	Mature Phase 2 PFS and early OS data	High
iSCIB1+	Resectable melanoma	1H27	Initiation of Phase 2 neoadjuvant/adjuvant study	Medium
iSCIB1+	Resectable melanoma	2H27	Interim Phase 2 readout	High
iSCIB1+	Resectable melanoma	1H28	Additional Phase 2 neoadjuvant/adjuvant readout	Medium
iSCIB1+	1L unresectable/metastatic melanoma	2H28	Initial Phase 3 PFS readout	High

Source: H.C. Wainwright research.

We are Bullish on the Shares of Scancell Based on the Following 6 Factors:

1. **Advanced melanoma remains a significant unmet need despite major advances with checkpoint inhibitors.**

Melanoma outcomes fall sharply once disease becomes advanced. Melanoma is an aggressive malignancy arising from melanocytes that is highly curable when detected early but remains substantially more difficult to treat once it spreads. About 112,000 new cases of cutaneous melanoma and 8,510 melanoma-related deaths are expected in the U.S. in 2026. While 5-year relative survival approaches 100% for localized disease, survival declines to 76% for regional disease and 34% for patients with distant metastatic melanoma (*NCI SEER Cancer Stat Facts*). In our opinion, although treatment advances have dramatically improved outcomes, advanced melanoma remains a serious disease in which achieving durable systemic disease control continues to be the main therapeutic challenge.

Checkpoint inhibitors transformed advanced melanoma, but benefit is not universal. The introduction of PD-1-directed therapies such as nivolumab and pembrolizumab, followed by combination checkpoint inhibition with nivolumab and the CTLA-4 inhibitor ipilimumab, fundamentally changed the treatment landscape. We highlight the fact that checkpoint blockade demonstrated for the first time that a sufficiently strong anti-tumor immune response can translate into extremely durable disease control in metastatic melanoma. However, it is important to note that at the same time, a meaningful proportion of patients either fail to respond initially or eventually develop progressive disease, leaving considerable room to improve upon current outcomes.

CheckMate 067 established nivolumab + ipilimumab as an important first-line efficacy benchmark. The Phase 3 CheckMate 067 study enrolled 945 previously untreated patients with unresectable stage III or stage IV melanoma and evaluated nivolumab + ipilimumab, nivolumab alone, and ipilimumab alone. Nivolumab + ipilimumab produced an objective response rate (ORR) of 57.6% and median progression-free survival (PFS) of 11.5 months, while 5-year PFS and overall survival (OS) rates reached 36% and 52% respectively. With approximately 10 years of follow-up, 43% of patients randomized to the combination remained alive and melanoma-specific survival reached 52%, demonstrating strong durability that can be achieved when checkpoint inhibition successfully establishes long-term tumor control (*Larkin et al., NEJM 2019; Wolchok et al., NEJM 2025*).

Despite these impressive results, a substantial proportion of patients still do not achieve durable disease control. While nivolumab/ipilimumab produces an ORR of 57.6%, a meaningful subset of patients derives no objective response, and long-term follow-up shows that a majority ultimately experience disease progression. Real-world data similarly show that a substantial proportion of patients either fail to respond or experience disease progression despite checkpoint-based therapy. Post-progression treatment options also remain limited, with responses to later-line therapies generally modest and rarely durable. In our view, there is a need for therapies that can both increase the proportion of patients achieving an initial response and deliver responses that are deep, robust, and long-lasting.

LAG-3 inhibition expanded treatment options but did not eliminate the treatment gap. The Phase 2/3 RELATIVITY-047 study subsequently established nivolumab + the LAG-3 inhibitor relatlimab (Opdualag) as another first-line option for unresectable or metastatic melanoma. At five years, nivolumab/relatlimab demonstrated an ORR of 44%, median PFS of 10.2 months, and 5-year PFS and OS rates of 29% and 48%, respectively. However, more than half of patients still failed to achieve an objective response and ~71% had progressed or died by five years. In our opinion, the addition of LAG-3 blockade broadened the first-line armamentarium, but it did not solve the problem of primary and acquired resistance to checkpoint inhibition (*Tawbi et al., NEJM, 2022; RELATIVITY-047 5-year update, JCO, 2026*).

A Substantial Unmet Need Persists Despite Modern Dual-Checkpoint Therapy

Regimen	ORR	Patients without objective response	5-year PFS	Progressed/dead by 5 years
Nivolumab + Ipilimumab	57.6%	~42%	36%	~64%
Nivolumab + Relatlimab	44%	~56%	29%	~71%

Source: CheckMate 067 and RELATIVITY-047.

Therapeutic cancer vaccines represent another strategy for extending the benefit of checkpoint inhibition. Historically, therapeutic cancer vaccines have faced considerable challenges, with numerous programs failing to demonstrate meaningful clinical benefits despite promising early results, leading to declining enthusiasm for the approach. Rather than just adding another inhibitory checkpoint target, cancer vaccines are designed to stimulate the immune system by generating or expanding tumor-specific T-cells, which can then be further activated and sustained by checkpoint blockade. For example, IO Biotech's (IOBTQ; not rated) Cylembio (IO102-IO103) provides a relevant precedent in advanced melanoma. In the 407-patient Phase 3 IOB-013/KEYNOTE-D18 study, IO102-IO103 + pembrolizumab produced median PFS of 19.4 months vs. 11 months with pembrolizumab alone. However, the study narrowly missed statistical significance for its primary endpoint, PFS, with p=0.0558 vs. the required p≤0.045 (Hassel et al., *Annals of Oncology*, 2026). Grade ≥3 treatment-related adverse events were similar between the combination and pembrolizumab-alone arms. More recently, at ESMO 2026, Merck (MRK; not rated) and Moderna (MRNA; not rated) reported detailed Phase 3 INTerpath-001 results with their personalized mRNA-based cancer vaccine intismeran autogene + pembrolizumab in completely resected stage IIB-IV melanoma. At two years, recurrence-free survival (RFS) was 82.2% with intismeran + pembrolizumab vs. 70.0% with pembrolizumab alone, while distant metastasis-free survival (DMFS) was 88.5% vs. 80.2%, respectively. Grade 3-5 treatment-related adverse events occurred in 14.2% vs. 13.4% of patients, while pyrexia, injection-site pain, and fatigue were common with the combination. While intismeran is an individualized neoantigen therapy being developed in the adjuvant setting and therefore does not directly overlap with iSCIB1+ in first-line unresectable advanced melanoma, we view the positive Phase 3 result as meaningful validation for the broader cancer-vaccine + checkpoint-inhibitor strategy. Scancell management also views the programs as potentially complementary given the different disease settings and iSCIB1+'s off-the-shelf profile. In our opinion, the INTerpath results could reignite enthusiasm for therapeutic cancer vaccines following years of disappointing clinical outcomes, demonstrating the potential for a vaccine-based approach to improve upon checkpoint inhibition alone. At the same time, the IO102-IO103 experience highlights the continued challenge of translating encouraging vaccine activity into a statistically successful Phase 3 study.

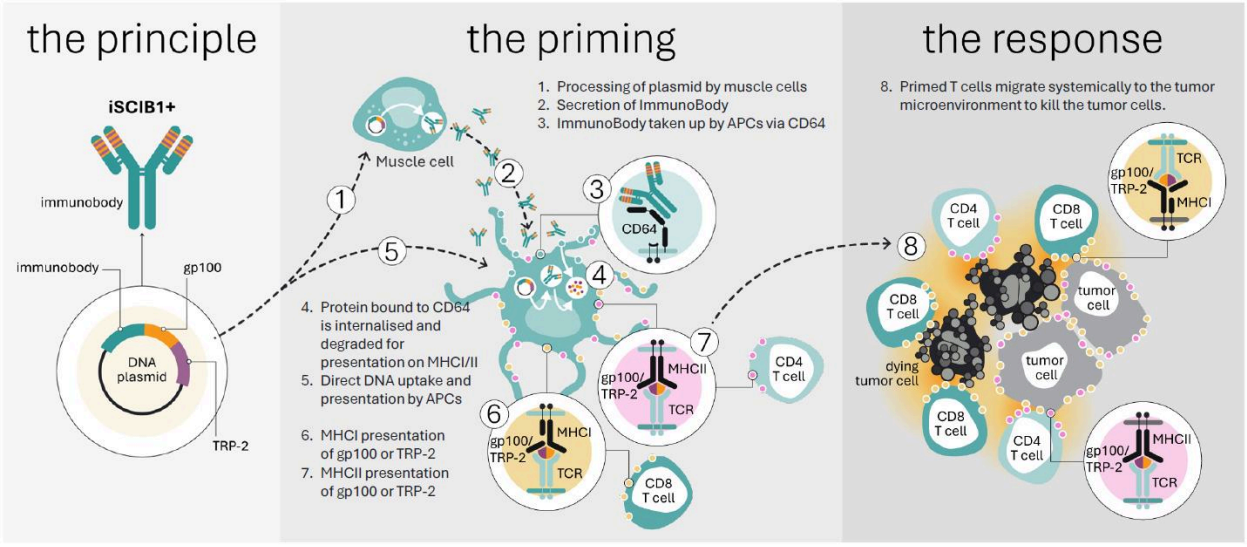
The remaining treatment gap creates room to further improve upon an already effective checkpoint backbone. Altogether, checkpoint therapy has shown durable immune control and improved prognosis of advanced melanoma; however, approximately 40-55% of patients treated with checkpoint combinations do not achieve an objective response and a majority ultimately experience progression. With recent Phase 3 data potentially renewing enthusiasm for therapeutic cancer vaccines following years of disappointing clinical outcomes, we believe there is an important opportunity to build upon existing checkpoint regimens. Specifically, combining cancer vaccines that expand the pool of tumor-specific T-cells with checkpoint inhibitors that help keep those T-cells active could increase the proportion of patients achieving deep and durable responses. We believe this creates a compelling rationale for the continued development of Scancell's iSCIB1+ in advanced melanoma.

2. iSCIB1+ is a DNA cancer vaccine designed to enhance checkpoint inhibitor efficacy in melanoma.

DNA cancer vaccines are not a new concept, but technological and therapeutic advances have renewed interest in the approach. DNA vaccines have been studied for several decades and historically generated considerable enthusiasm. However, early clinical development frequently failed to reproduce the strong immunogenicity observed in preclinical models, with inefficient DNA uptake, inadequate antigen presentation, immune tolerance to tumor-associated antigens, and the immunosuppressive tumor microenvironment limiting clinical activity. More recently, improvements in vaccine design and antigen delivery, together with the emergence of checkpoint inhibitors capable of sustaining vaccine-induced T-cell responses, have generated renewed interest in DNA-based cancer immunotherapy. We believe this is particularly relevant to Scancell, as its ImmunoBody DNA cancer vaccine platform was specifically designed to enhance antigen presentation and tumor-specific T-cell responses, with iSCIB1+ being developed in combination with checkpoint inhibitors to help overcome the immune suppression that limited many earlier cancer-vaccine approaches.

ImmunoBody uses a DNA-based vaccine approach to generate tumor-specific T-cells. Scancell's ImmunoBody platform is designed to generate potent T-cell responses against selected tumor antigens by delivering those antigens to antigen-presenting cells (APCs), particularly dendritic cells. Each ImmunoBody consists of a DNA plasmid encoding a modified human IgG1 antibody in which tumor-specific T-cell epitopes are incorporated into the antibody structure. In the case of iSCIB1+, the encoded epitopes are derived from the melanoma-associated antigens glycoprotein 100 (gp100) and tyrosine-related protein-2 (TRP-2), enabling the immune system to specifically recognize and target melanoma cells expressing these proteins. Following intramuscular administration, muscle cells can take up the DNA plasmid and produce and secrete the ImmunoBody protein, which is then captured by antigen-presenting cells (APCs), including dendritic cells, through the high-affinity Fc receptor CD64. The APCs process the encoded tumor antigens and present them through both MHC class I and class II, activating cytotoxic CD8+ and helper CD4+ T-cells. Separately, APCs can also directly take up the DNA plasmid and produce and present the encoded tumor antigens themselves, providing a second route of immune priming. This "dual-presentation" mechanism should substantially increase the potency of the resulting T-cell response.

iSCIB1+ Uses Dual Antigen Presentation to Generate Melanoma-Specific T-cell Responses



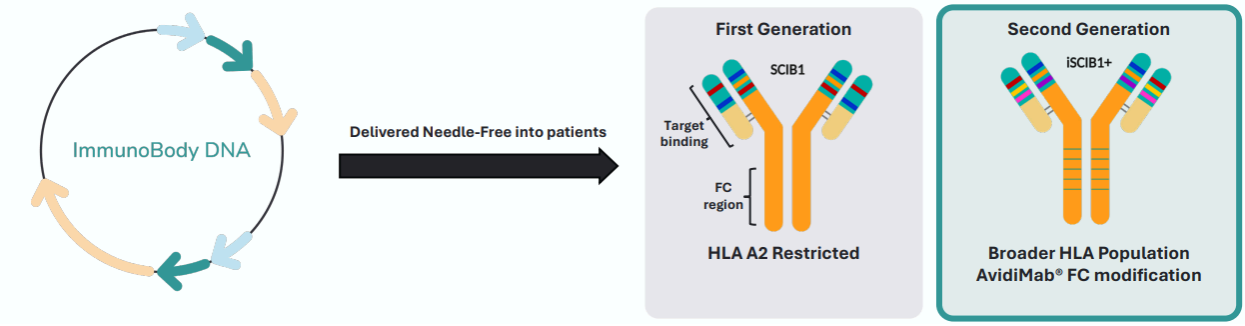
Source: Scancell July 2026 corporate presentation.

iSCIB1+ applies the ImmunoBody platform to melanoma. iSCIB1+ incorporates epitopes derived from gp100 and TRP-2, two melanoma-associated differentiation antigens capable of being recognized by

tumor-reactive T-cells. iSCIB1+ is intended to teach the immune system to recognize melanoma cells displaying these antigens and generate a pool of high-avidity melanoma-specific T-cells capable of attacking the tumor. Nivolumab and ipilimumab then provide a complementary function by blocking inhibitory immune checkpoints that can suppress or limit the activity of these vaccine-generated T-cells. In our opinion, this combination approach makes sense, as iSCIB1+ attempts to increase the number and breadth of tumor-specific T-cells available to fight the cancer, while checkpoint inhibition helps keep those cells active once they encounter the tumor.

iSCIB1+ represents an important evolution from first-generation SCIB1. SCIB1 incorporated CD4+ and CD8+ epitopes from gp100 and TRP-2 but principally targets HLA-A2 patients. Management described the "i" modification as an Fc engineering change intended to improve binding to CD64 on activated dendritic cells, thereby enhancing antigen uptake and presentation, while the "+" reflects the addition of further peptide epitopes to broaden HLA coverage. Accordingly, iSCIB1+ incorporates Scancell's AvidiMab Fc modification and additional epitopes that expand coverage to HLA-A2, A3, A31, Bw4, B35, and B44, with these HLA haplotypes collectively representing ~80% of the melanoma population. In our opinion, the two modifications address distinct limitations of the first-generation construct: (1) the Fc change is intended to improve immune potency, while (2) the additional epitopes substantially expand the addressable patient population. We believe this evolution is important because iSCIB1+ expands the eligible population well beyond the HLA-A2 restriction of first-generation SCIB1, which should improve its scalability as a potential front-line therapy.

iSCIB1+ Broadens the Target HLA Population and Incorporates an Fc Modification



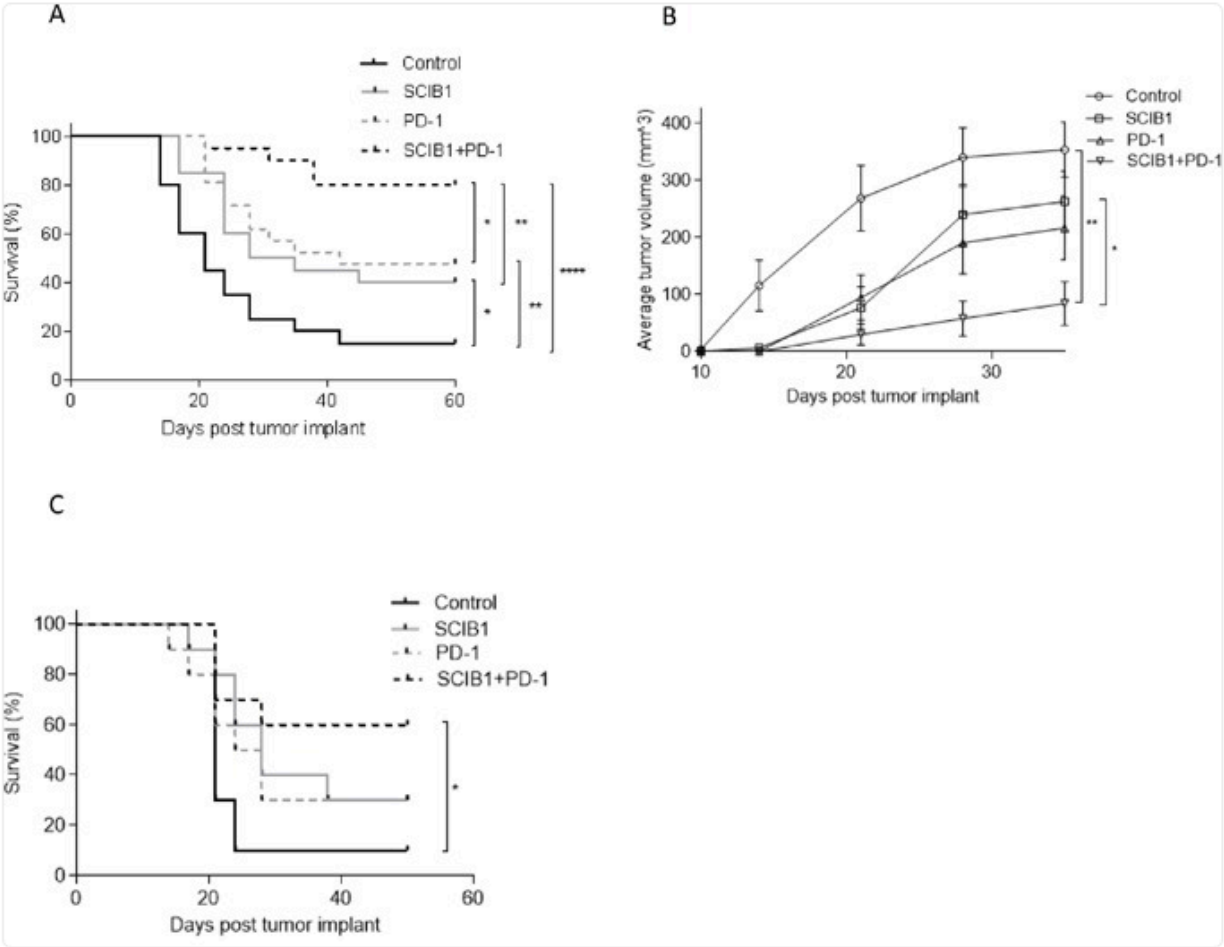
Source: Scancell FY26 interim presentation.

SCIB1 provided the initial human validation for the ImmunoBody platform. In a Phase 1/2 study, 35 patients with stage III/IV melanoma received SCIB1 at doses ranging from 0.4 mg to 8 mg, including 15 patients with tumor present at study entry and 20 patients with fully resected disease. SCIB1 induced dose-dependent T-cell responses in 88% of patients, with no serious treatment-related adverse events or dose-limiting toxicities reported. Among the 15 patients with measurable disease, 1/15 (7%) achieved an objective tumor response and 7/15 (47%) achieved stable disease (SD). Importantly, patients receiving 8 mg generated significantly stronger T-cell responses than those receiving 4 mg ($p<0.03$), providing early evidence that vaccine exposure influenced the magnitude of immune priming (*Patel et al., OncoImmunology, 2018*). Although the study was small and was conducted before checkpoint inhibitors were used in combination with SCIB1, we believe it demonstrated that the ImmunoBody platform could generate strong antigen-specific T-cell responses in humans and provided evidence of clinical activity.

Preclinical data provided the rationale for combining ImmunoBody vaccination with checkpoint blockade. SCIB1 generated high-avidity melanoma-specific T-cells; however, preclinical work showed that these activated T-cells also express PD-1 and can encounter increased PD-L1 within the tumor microenvironment. This can potentially limit their proliferation and anti-tumor activity. To test whether

checkpoint blockade could overcome this adaptive resistance, Xue et al. evaluated SCIB1 alone, anti-PD-1 alone, or the combination in HLA-DR4 transgenic mice bearing B16F1-DR4 melanoma tumors (*Xue et al., Oncotarget, 2016*). In these mice, SCIB1 monotherapy resulted in long-term survival in 40% of mice and PD-1 blockade in 50%, while combining SCIB1 with PD-1 blockade increased long-term survival to 80% and significantly improved survival compared with either treatment alone (Panel A). Tumor growth was also delayed with SCIB1 and further suppressed with the combination (Panel B). The experiment was also repeated using a six-fold higher tumor-cell challenge vs. Panel A. In this setting, only the SCIB1/PD-1 combination produced a statistically significant survival benefit vs. control (p=0.0126), reinforcing the benefit of combining vaccine-driven T-cell priming with checkpoint blockade (Panel C).

SCIB1 + PD-1 Blockade Showed Enhanced Anti-Tumor Activity in Preclinical Melanoma Models

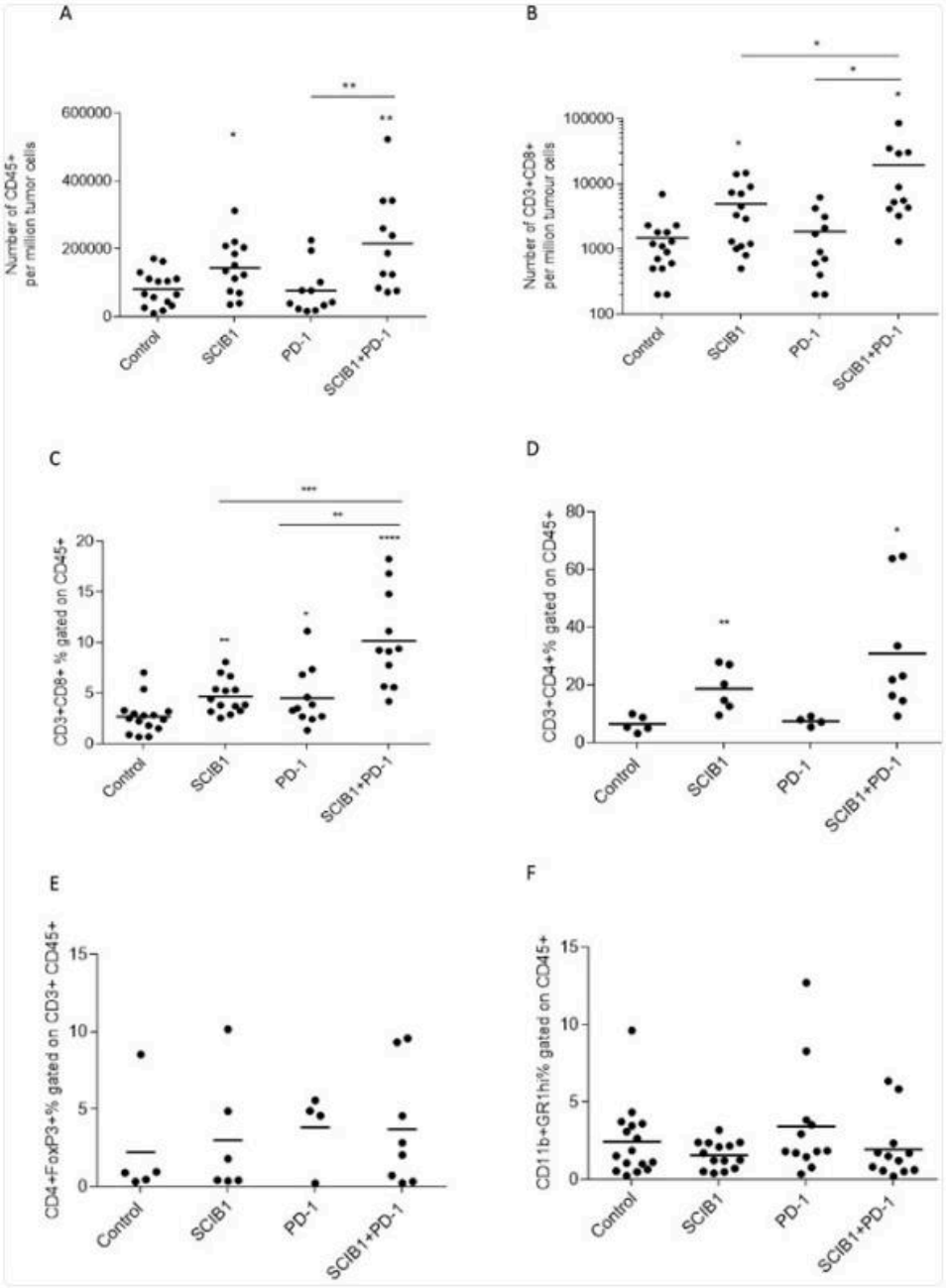


Source: Xue et al., Oncotarget, 2016

Mechanistically, Xue et al. looked at immune-cell infiltration within B16F1-DR4 tumors following treatment with SCIB1, PD-1 blockade, or the combination. SCIB1 alone significantly increased total leukocyte infiltration and produced an ~3x increase in intratumoral CD8+ T-cells vs. control (p=0.0157; Panels A and B). Adding PD-1 blockade further increased CD8+ T-cell infiltration to ~10x above control (p=0.0468; Panel B), with the proportion of CD8+ cells among tumor-infiltrating immune cells significantly greater with the combination than with either PD-1 blockade alone (p=0.0026) or SCIB1 alone (p=0.0004; Panel C). SCIB1 alone and in combination with PD-1 blockade also significantly increased CD4+ T-cell infiltration (Panel D). Importantly, the increase in effector T-cell infiltration was not accompanied by an increase in

immunosuppressive cell population. Neither SCIB1 nor the combination significantly increased FoxP3+ regulatory T-cells (Panel E), while myeloid-derived suppressor cells (MDSCs) were numerically reduced with SCIB1-containing treatment, although the difference was not statistically significant (Panel F). We believe this is important because it suggests that SCIB1 + PD-1 blockade shifts the tumor microenvironment toward anti-tumor immunity by increasing CD8+ and CD4+ effector T-cell infiltration without simultaneously expanding the suppressive Treg or MDSC populations that could counteract those responses. We believe these findings provide nice mechanistic support for the complementary activity observed in the survival studies.

SCIB1 + PD-1 Blockade Substantially Increased T-cell Infiltration into Tumors



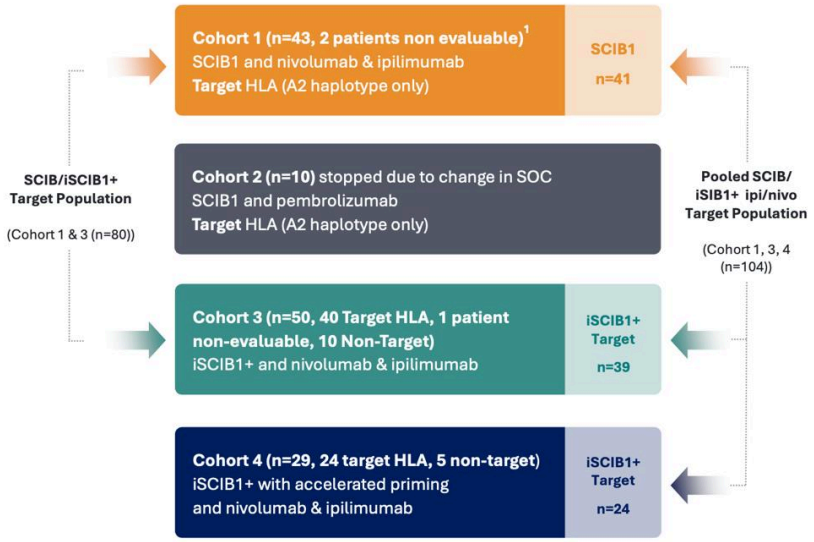
Source: Xue et al., Oncotarget, 2016.

The preclinical rationale was then translated into the clinic through SCOPE. The preclinical studies discussed above established a clear biological rationale for combining ImmunoBody vaccination with checkpoint inhibition. The obvious next question was whether this could be translated into improved outcomes in patients. This led to the SCOPE trial, a multi-cohort Phase 2 study evaluating SCIB1 and ultimately the second-generation iSCIB1+ construct in combination with standard-of-care checkpoint inhibitors in first-line advanced melanoma.

SCOPE was designed to optimize the ImmunoBody strategy in first-line advanced melanoma. The open-label, non-randomized Phase 2b study enrolled 132 patients across 16 UK sites with previously untreated unresectable stage III or stage IV melanoma and was designed to select the ImmunoBody construct, target population, dosing schedule, and endpoints to advance into Phase 3. Rather than randomizing patients between treatment arms, SCOPE evolved through sequential cohorts that evaluated different iterations of the ImmunoBody strategy, with Cohort 4 added in June 2025 following completion of enrollment in Cohort 3. Eligible patients had ECOG performance status 0-1, measurable disease under RECIST 1.1, and known HLA status; key exclusions included acral, ocular, and mucosal melanoma, CNS metastases, and checkpoint therapy in the adjuvant setting in the previous six months. Each cohort is outlined below:

- **Cohort 1:** Enrolled 43 patients and evaluated first-generation SCIB1 + nivolumab/ipilimumab in HLA-A2-positive patients, with 41 ultimately evaluable.
- **Cohort 2:** Enrolled 10 patients and evaluated first-generation SCIB1 + pembrolizumab in HLA-A2-positive patients; the cohort was subsequently stopped following a change in the standard of care.
- **Cohort 3:** Enrolled 50 patients and evaluated second-generation iSCIB1+ + nivolumab/ipilimumab, including 40 target-HLA and 10 non-target-HLA patients; one target-HLA patient was considered non-evaluable, leaving 39 evaluable target-HLA patients.
- **Cohort 4:** In June 2025, following completion of enrollment in Cohort 3, Scancell initiated Cohort 4 to further optimize iSCIB1+ administration and dosing ahead of registrational development. The cohort ultimately enrolled 29 patients and evaluated iSCIB1+ using an accelerated priming schedule + nivolumab/ipilimumab, including 24 target-HLA and five non-target-HLA patients.

Phase 2b SCOPE Cohorts



Source: Scancell July 2026 corporate presentation.

The SCOPE population appears broadly comparable with key first-line advanced melanoma trials. Cohort 3 had fewer patients with M1c/M1d disease (subcategories of stage IV melanoma) than CheckMate 067 but had a similar overall tumor burden and prevalence of liver metastases, a higher proportion of BRAF-mutated disease, and included patients who had previously received adjuvant anti-PD-1 therapy. In our opinion, while there are differences across studies, the SCOPE population does not appear obviously skewed toward patients with more favorable disease characteristics.

SCOPE Baseline Characteristics Were Broadly Comparable with Key First-Line Melanoma Trials

	SCIB1 (n=43)	iSCIB1+ (n=50)
Gender		
Male	65%	42%
Female	35%	58%
Age		
<65	47%	66%
≥65 - <75	25%	30%
≥75	28%	4%
Stage of Disease at Study Entry IIIB/IIIC/IV	1 IIIB / 42 IV	1 IIIC / 49 IV
M0, M1a or M1b	64%	58%
M1c, M1d	36%	42%
BRAF		
Mutation	49%	50%
Wildtype	51%	50%
Lactate Dehydrogenase		
>Upper limit of normal (ULN)	33%	38%
≤ULN	67%	62%
Prior treatment in the adjuvant setting		
Anti-PD-1	26%	10%
Baseline Tumor Burden		
<100mm/>100mm	19/81%	
Liver mets	27.5%	

	ipi + nivo Checkmate 067	Nivo+rela Relativity 047	IO102/103-pembro
Gender			
Male	65%	59%	67%
Female	35%	41%	33%
Age			
<65	60%	59%	38%
≥65 - <75	28%	29%	26%
≥75	13%	12%	36%
Stage of Disease at Study Entry IIIB/IIIC/IV	1 IIIB / 42 IV	1 IIIC / 49 IV	
M0, M1a or M1b	42%	59%	60%
M1c, M1d	58%	41%	40%
BRAF			
Mutation	32%	39%	41%
Wildtype	68%	61%	59%
Lactate Dehydrogenase			
>Upper limit of normal (ULN)	36%	36%	35%
≤ULN	64%	64%	65%
Prior treatment in the adjuvant setting			
Anti-PD-1	0	8.4%	10.3%
Baseline Tumor Burden			
<100mm/>100mm			16/84%
Liver mets	28%	40%	18.1%

Source: Scancell July 2026 corporate presentation.

Clinical outcomes favored patients capable of presenting the iSCIB1+ epitopes. Cohort 3 included 39 evaluable patients carrying one of the target HLA types (A2, A3, A31, B35, B44, or Bw4) and 10 patients outside this target-HLA population. Target-HLA patients achieved a 56% ORR and 79% disease control rate (DCR), compared with 20% and 40%, respectively, in the non-target population, while PFS was 74% at 16 months vs. 20% at 14 months. Although the non-target group was small and the HLA comparison was not randomized, with patients grouped according to their naturally occurring HLA status, we believe the split provides an important piece of biological validation for iSCIB1+. Both populations received iSCIB1+ with the same nivolumab/ipilimumab backbone, while the key biological difference was whether patients carried HLA types expected to present the encoded gp100 and TRP-2 epitopes. In our opinion, the substantially better outcomes observed in the target-HLA population are therefore consistent with iSCIB1+'s mechanism and support the view that the vaccine is contributing to the clinical activity observed in SCOPE rather than the data simply reflecting the checkpoint-inhibitor backbone.

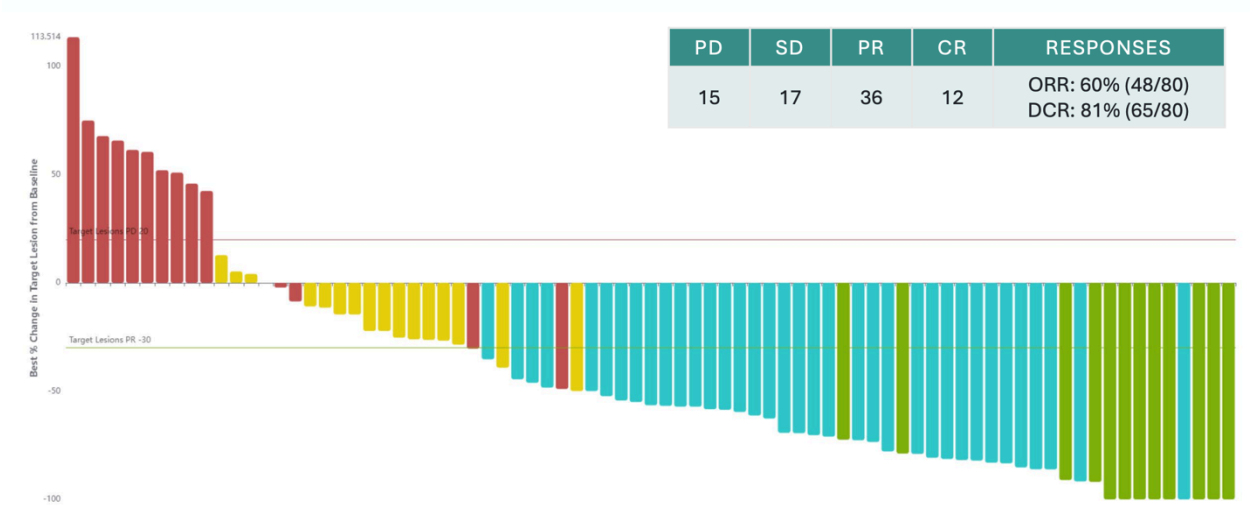
iSCIB1+ Clinical Activity was Concentrated in the Target-HLA Population

Cohort 3	Target HLA	Non-Target HLA
Patients	39	10
ORR	56%	20%
DCR	79%	40%
PFS	74% at 16 months	20% at 14 months

Source: H.C. Wainwright research; data from Scancell.

The depth of tumor reduction provides another view of the clinical activity observed in SCOPE. In the December 2025 analysis of 80 target-HLA patients across SCIB1 Cohort 1 and iSCIB1+ Cohort 3, 48 patients achieved an objective response, including 36 partial responses (PRs) and 12 complete responses (CRs), resulting in a 60% ORR; an additional 17 patients achieved SD, producing an 81% DCR. While these data represent an earlier pooled analysis that includes both SCIB1 and iSCIB1+, we believe the waterfall plot below is useful because it shows the depth of response on a patient-by-patient basis. Many patients experienced deep reductions in target-lesion burden and multiple patients achieved CRs. Importantly, although the pooled analysis cannot isolate the incremental contribution of iSCIB1+ over first-generation SCIB1, both constructs are based on the same ImmunoBody approach and target gp100 and TRP-2. In our opinion, the consistency of anti-tumor activity across both generations provides additional support for the underlying ImmunoBody cancer-vaccine strategy.

Deep Tumor Reductions Observed Across the Target-HLA SCOPE Population



Source: Scancell December 2025 SCOPE data update.

The updated SCOPE data have continued to demonstrate encouraging clinical activity as the pooled analysis has expanded. The initial pooled target-HLA efficacy analysis included 80 evaluable patients from Cohorts 1 and 3. By July 2026, the 24 target-HLA patients from Cohort 4 were also incorporated, which increased the pooled population to 104 patients. Across these 104 patients, SCIB1/iSCIB1+ + nivolumab/ipilimumab demonstrated a 62% ORR and 81% DCR, while the 24 target-HLA patients in Cohort 4 receiving iSCIB1+ under the accelerated priming schedule achieved a 70% ORR and 83% DCR. Comparing these response rates with other first-line melanoma regimens, we see that the SCOPE ORR and DCR compare favorably with the historical benchmarks shown below. We believe the consistency of the response profile as additional patients have been incorporated is encouraging. However, it is important to note these are not head-to-head and should be interpreted cautiously given differences in study design, patient population, sample size, eligibility criteria, etc.

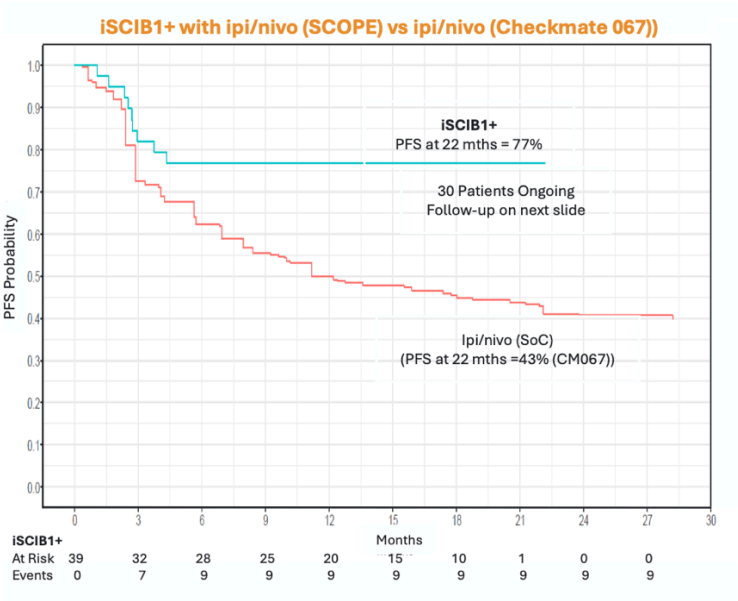
SCOPE Response Rates Compare Favorably with Other First-Line Melanoma Regimens

	Scancell	Scancell	BioNTech	IO Biotech	BMS	BMS	Real World
Study[1]	SCOPE (combined)	SCOPE (iSCIB1+ accel dosing)	IMCODE-001 (control arm)	Phase 3 NCT05155254	Relativity 047	Checkmate 067	NA
No of Patients	104	24	41	203	355	314	NA
Agent	iSCIB1+ / SCIB1 Nivolumab + Ipilimumab	iSCIB1+ Nivolumab + Ipilimumab	Pembro	IO102-IO103 + Pembro	Anti-LAG-3 + nivo	Nivo + ipi	Nivo + ipi
ORR	**62%**	**70%**	49%	44.8%	43.9%	50% (confirmed)	48%
DCR	**81%**	**83%**		65.5%		63%	58%

Source: Scancell July 2026 corporate presentation.

We find the PFS data encouraging. Among the 39 evaluable target-HLA patients in iSCIB1+ Cohort 3, PFS remained at 77% at 22 months in the July 2026 analysis, with only nine progression events reported and 30 patients remaining ongoing. It is important to note however that the number of patients remaining at risk declines substantially toward the tail of the curve (from 20 patients at 12 months to only one at 21 months), reflecting the still-maturing follow-up. We therefore view the 77% PFS as encouraging but still immature, especially at the later timepoints. Regardless, the PFS curve does remain favorable to date and compares favorably to the historical comparison of ~43% PFS at 22 months for nivolumab/ipilimumab in CheckMate 067.

iSCIB1+ PFS Compares Favorably with Historical CheckMate 067

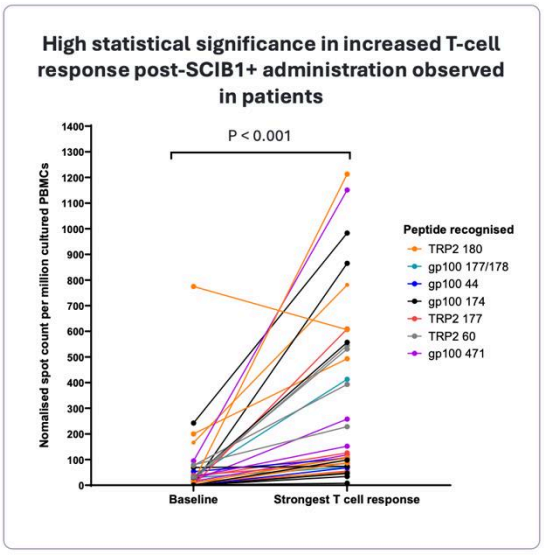


Source: Scancell July 2026 corporate presentation.

Early OS data also remain encouraging, although still immature. The July 2026 update provided more mature PFS data but did not include an updated OS analysis. The latest OS data cutoff is from May 22, 2026. At that time, OS was 87.4% at 22 months in the 39-patient iSCIB1+ Cohort 3 target-HLA population and 80.6% at 24 months across the combined 80-patient target-HLA population from Cohorts 1 and 3, compared with approximately 63% at 24 months for nivolumab/ipilimumab in CheckMate 067. However, 35 of 39 patients in Cohort 3 and 67 of 80 patients in the combined analysis were censored, highlighting the immaturity of the OS data. We therefore view the early OS trend as supportive but place greater weight on the more mature PFS data at this stage. More mature PFS and early OS data are expected in 1H27.

The immune-response data provide a link between iSCIB1+'s mechanism and the clinical activity observed in SCOPE. The latest analysis showed a significant increase in antigen-specific T-cell responses following treatment ($p<0.001$), with 94% of evaluated patients generating T-cell responses to iSCIB1+ peptides. Among patients generating a high-magnitude T-cell response, 22/30 (73%) achieved a CR or PR, while 28/39 (72%) patients generating responses against both gp100 and TRP-2 achieved a CR or PR. Further, SCIB1/iSCIB1+-specific CD8+ T cells demonstrated cytotoxic and chemokine signatures as well as a stem-like Tpex phenotype, consistent with tumor-specific T cells capable of being reactivated and expanding to mount an anti-tumor response. In our opinion, these findings provide an important biological link between administration of iSCIB1+, generation of melanoma-specific T-cell responses, and the clinical activity observed in SCOPE. Looking ahead, we would be particularly interested in whether the magnitude and breadth of the T-cell response also correlate with PFS, which could provide further support for the durability observed to date.

Strong iSCIB1+-Induced T-Cell Responses Correlated with Clinical Response



Patients with broad T-cell responses had better clinical responses

Clinical response	Number of patients	High magnitude T cell response (n=30)*	Response to both gp100 and TRP2 (n=39)
CR/PR	**41**	**22/30 (73%)**	**28/39 (72%)**
SD	17	5/30 (17%)	7/39 (18%)
PD	8	3/30 (10%)	4/39 (10%)
Overall:	66*	30	39

**94% patients generated T-cell responses to the iSCIB1+ peptides*

Cells with CD8 SCIB1/iSCIB1+ specific TCRs have:

- Strong signal of tumor cell killing and immune cell recruitment (cytotoxic and chemokine signature)
- Tumor-specific stem-like T cells that **can be reactivated and expand to mount an anti-tumor response** (Tpex phenotype)

Source: Scancell July 2026 corporate presentation.

Safety has continued to look favorable despite the addition of SCIB1/iSCIB1+ to checkpoint inhibitors. Safety data from 104 HLA-matched evaluable patients across Cohorts 1, 3, and 4 show that adverse events attributed to SCIB1/iSCIB1+ were predominantly low grade, with injection-site reactions and fatigue among the more commonly reported events. There was also no potentiation of toxicities associated with nivolumab/ipilimumab, while Grade ≥3 adverse events attributed to SCIB1/iSCIB1+ were infrequent. One patient discontinued treatment due to posterior uveitis, which fully resolved following discontinuation. We believe the overall safety profile is encouraging, particularly because nivolumab/ipilimumab is already associated with substantial immune-related toxicity. If iSCIB1+ can

improve the depth or durability of response without materially worsening the safety profile of the checkpoint-inhibitor backbone, we believe that would represent an attractive product profile for physicians and patients.

SCIB1/iSCIB1+ Maintains Favorable Safety Profile with Checkpoint Inhibitors

TEAEs, n(%)	Related to: SCIB1/iSCIB1+		Related to CPI		Dually Related (CPI + IMP)	
	All grades	Grade ≥3	All grades	Grade ≥3	All grades	Grade ≥3
Endocrine disorders						
Hypophysitis	5 (4)	3 (3)	11 (10)	5 (5)	5 (4)	3 (3)
Adrenal Insufficiency	5(5)	0 (0)	13(13)	1(1)	3(3)	0(0)
Thyroid Disorders	2 (2)	0(0)	18 (14)	2(1)	0(0)	0(0)
Eye disorders						
Dry Eye*	1 (1)	0 (0)	5 (5)	0 (0)	1 (1)	0 (0)
Uveitis*	2 (2)	0 (0)	2 (2)	0 (0)	0 (0)	0 (0)
Vision Blurred*	3 (2)	0 (0)	2 (2)	0 (0)	1 (1)	0 (0)
Gastrointestinal disorders						
Colitis	5 (3)	1 (1)	22 (21)	15 (14)	5 (3)	1 (1)
Diarrhoea	9 (8)	0 (0)	50 (32)	6 (5)	9 (8)	0 (0)
Decreased Appetite	5 (5)	0 (0)	21 (14)	1 (1)	5 (5)	0 (0)
Nausea	10 (5)	1 (1)	32 (20)	2 (2)	9 (4)	1 (1)
Injection Site Reactions	42 (16)	0 (0)	3 (3)	0 (0)	0 (0)	0 (0)
Fatigue	22 (20)	0 (0)	56 (44)	1 (1)	18 (16)	0 (0)
Headache	7 (5)	0 (0)	22 (17)	0 (0)	6 (4)	0 (0)
Hepatitis	3 (3)	1 (1)	24 (11)	6 (6)	3 (3)	1 (1)
Transaminases Increased	29 (11)	6 (4)	76 (4)	18 (15)	28 (11)	6 (4)
Arthralgia	0 (0)	0 (0)	19 (9)	0 (0)	0 (0)	0 (0)
Vitiligo*	5 (2)	0 (0)	13 (13)	0 (0)	4 (4)	0 (0)
Pruritus	5 (5)	0 (0)	37 (23)	1 (1)	5 (5)	0 (0)
Rash	22 (16)	2 (2)	91 (54)	6 (6)	21 (15)	2 (2)

Source: Scancell July 2026 corporate presentation.

Overall, we believe SCOPE provides strong Phase 2 validation for iSCIB1+. While we recognize the limitations of these data, including the open-label, non-randomized study design, relatively small target-HLA population, immature later portions of the PFS curve, and reliance on historical comparisons, we are encouraged by several aspects of the data:

- Response rates have remained encouraging as the dataset has expanded.
- PFS continues to compare favorably with historical nivolumab/ipilimumab.
- Vaccine-induced T-cell responses appear to track with clinical response, with stronger and broader responses associated with higher CR/PR rates.
- Safety has remained favorable despite the addition of SCIB1/iSCIB1+ to checkpoint inhibitors.

In our opinion, the consistency across the efficacy, immune-response, and safety data provides meaningful support for iSCIB1+ ahead of registrational development. The key remaining question is whether this signal can be reproduced in a randomized setting. In the next section, we discuss how these Phase 2 learnings informed the Phase 3 design and our thoughts on how they could help improve the chances of a positive Phase 3 readout.

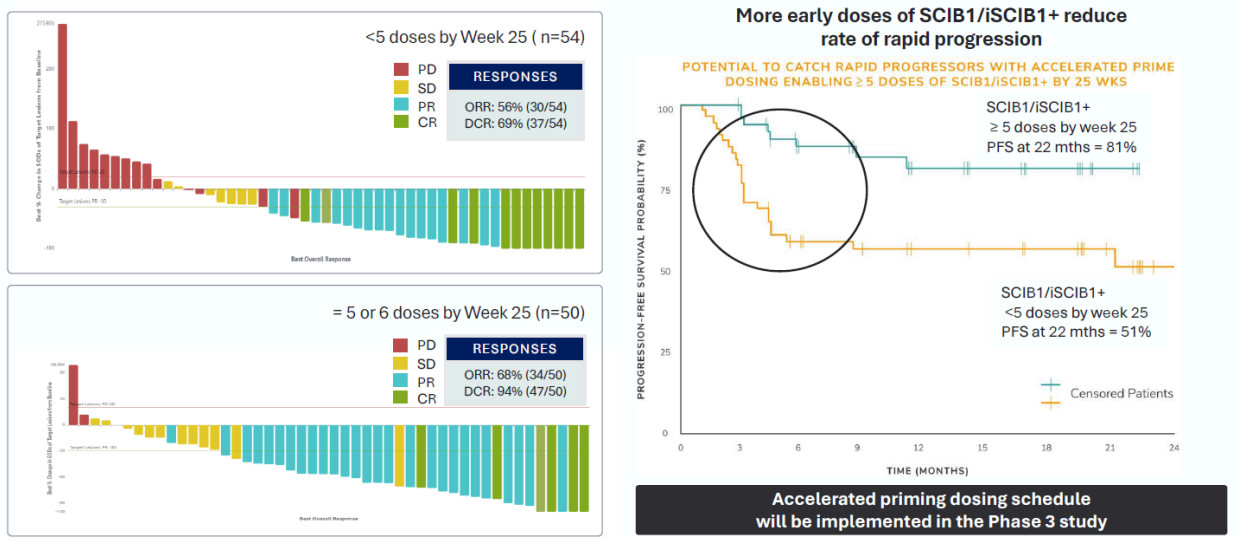
3. iSCIB1+ Phase 3 incorporates key SCOPE learnings which should improve its success.

The Phase 3 study incorporates several key learnings from SCOPE. As discussed above, SCOPE was designed to evaluate clinical activity but to also help with selection of product, target population, dosing schedule, and endpoints to bring into Phase 3. The Phase 2 helped with selecting iSCIB1+, defining the target-HLA population, establishing the 8 mg intramuscular dose, moving to an accelerated priming schedule, and identifying PFS as the primary registrational endpoint. We believe these decisions provide a

good setup for Phase 3, although the randomized study remains the important test of whether the SCOPE signals can be reproduced.

SCOPE suggested that getting sufficient vaccine exposure into patients early could be important. As mentioned earlier, cohort 4 was used to test an accelerated priming schedule that brought the initial iSCIB1+ doses closer together, with the goal of establishing the melanoma-specific T-cell response earlier and increasing the likelihood that patients receive sufficient vaccine exposure before progression or treatment interruption. Management also explained to us that the faster schedule should better align vaccine priming with the early administration of nivolumab/ipilimumab. Supporting this approach, a pooled analysis of 104 patients treated with SCIB1/iSCIB1+ showed that the 50 patients receiving five or six doses by Week 25 achieved a 68% ORR and 94% DCR vs. 56% ORR and 69% DCR among the 54 patients receiving fewer than five doses, while PFS at 22 months was 81% vs. 51%, respectively. However, it's important not to overinterpret these data. Patients who progressed early were less likely to remain on study long enough to receive five or six doses, so we can't conclude that receiving doses itself leads to better outcomes. But we believe these findings help support the rationale for moving more doses earlier through the accelerated priming schedule. The accelerated schedule has now been carried into Phase 3, where patients will receive 8 mg iSCIB1+ intramuscularly at Weeks 0, 1, 3, 7, and 13, followed by dosing every 12 weeks for 11 doses in total.

Greater Early Vaccine Exposure Supported the Phase 3 Accelerated Priming Schedule



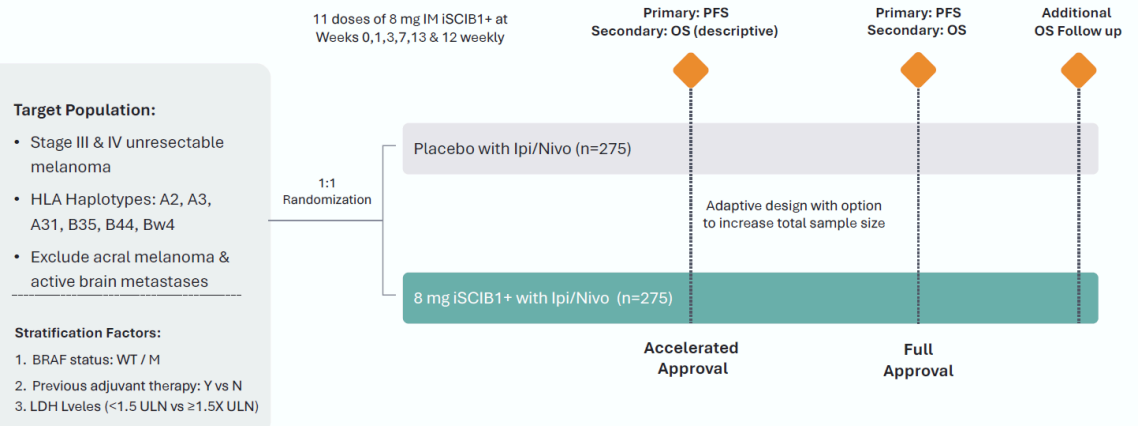
Source: Scancell October 2026 corporate presentation.

Phase 3 will also focus enrollment on the HLA population most likely to benefit. As discussed earlier, efficacy in SCOPE was substantially greater in target-HLA patients than in non-target-HLA patients. Therefore, the Phase 3 study will enroll patients carrying HLA-A2, A3, A31, B35, B44, or Bw4, which collectively represent ~80% of the melanoma population. Management also told us that A1 was not carried forward following weaker activity during Phase 2. We believe this approach should enrich the study for patients most likely to benefit from iSCIB1+ while still maintaining a broad addressable population.

The randomized Phase 3 study should provide a cleaner view of iSCIB1+'s contribution. The global, double-blind, placebo-controlled study is designed to enroll 550 patients across ~90 sites. Patients will be randomized 1:1 to 8 mg iSCIB1+ + nivolumab/ipilimumab or placebo + nivolumab/ipilimumab. The placebo consists of Dulbecco's phosphate-buffered saline (D-PBS), an inactive solution that does not contain iSCIB1+ plasmid DNA. It is formulated to be visually and physically indistinguishable from iSCIB1+ and

administered via intramuscular injection using the same procedures to maintain study blinding. PFS is the primary endpoint and OS is the secondary endpoint. Patients will be stratified by BRAF status, prior adjuvant therapy, and lactate dehydrogenase (LDH) levels. The study is designed for the PFS analysis to potentially support accelerated approval, while subsequent OS follow-up is intended to support full approval. We believe that this randomized design is the most important next step for the program because it will directly determine whether adding iSCIB1+ improves outcomes over nivolumab/ipilimumab alone.

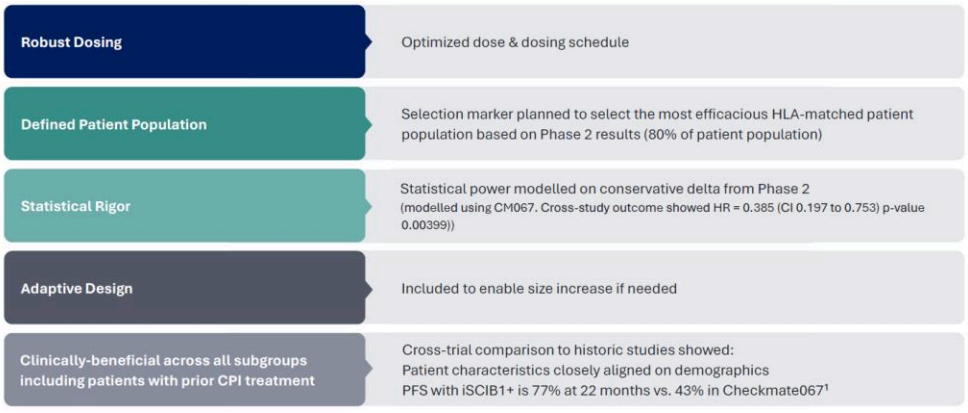
Phase 3 will Directly Test the Incremental Benefit of iSCIB1+



Source: Scancell October 2026 corporate presentation.

The Phase 3 design incorporates several features to mitigate statistical risk. As discussed earlier, Cohort 3 showed 77% PFS at 22 months vs. ~43% historically for nivolumab/ipilimumab in CheckMate 067, representing an approximately 34-percentage-point difference. Management noted that the Phase 3 study is powered around an approximately 15-percentage-point difference in PFS between treatment arms, substantially below the benefit observed in the cross-trial Phase 2 comparison. The protocol also includes an adaptive option to increase the total sample size if needed, with management indicating that roughly 100 additional patients per arm could be added (although this would delay the readout). We believe this sets a reasonable bar for Phase 3 to clear while providing additional flexibility if the treatment benefit in a randomized study is smaller than that observed in the non-randomized SCOPE trial. The figure below summarizes how the key learnings from SCOPE have been incorporated into the Phase 3 design to help mitigate clinical and statistical risk.

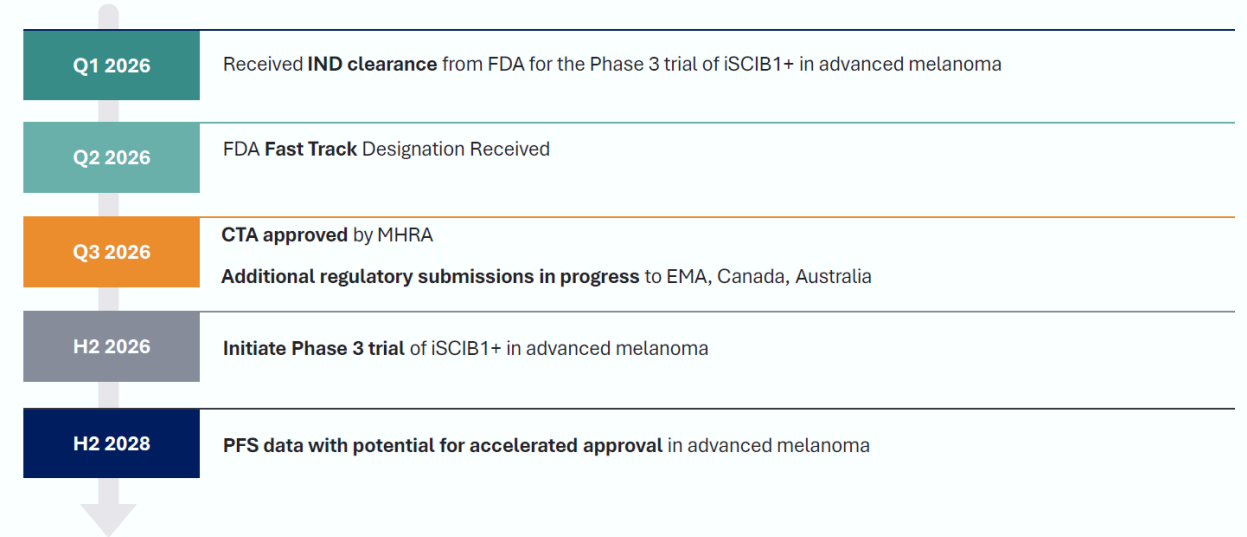
Phase 3 Design Incorporates Multiple Features to Mitigate Pivotal-Study Risk



Source: Scancell October 2026 corporate presentation.

Regulatory progress also supports Phase 3 readiness. The FDA cleared the Phase 3 IND in January 2026 and granted Fast Track designation in April, followed by UK MHRA Clinical Trial Authorization in August 2026. Regulatory submissions in the E.U., Canada, and Australia are also in progress. Management is targeting first patient in during December 2026, with initial PFS data expected in 2H28.

iSCIB1+ Regulatory Milestones and Development Timeline



Source: Scancell October 2026 corporate presentation.

Scancell has also addressed several operational requirements ahead of Phase 3. The FDA accepted the proposed 8 mg intramuscular dose under Project Optimus and provided alignment on the CMC manufacturing process and non-clinical package. The FDA also agreed that a developmental and reproductive toxicology (DART) study would not be required, while additional comparability testing requested as part of the IND was subsequently completed. We believe addressing these requirements ahead of Phase 3 reduces execution risk as the study begins.

Overall, we believe iSCIB1+ is well positioned entering Phase 3. In our opinion, Scancell has used the SCOPE study effectively to optimize target population, dosing schedule, statistical assumptions, and overall registrational strategy, while also addressing key regulatory, manufacturing, and non-clinical requirements ahead of study initiation. We view the randomized Phase 3 study as the next major value-defining step for the program and currently assign iSCIB1+ a 65% probability of success in advanced melanoma in our valuation. We believe this appropriately reflects the encouraging Phase 2 efficacy, favorable safety profile, and well-designed Phase 3 design, while recognizing that SCOPE was non-randomized and the incremental benefit of iSCIB1+ still needs to be confirmed prospectively.

4. **iSCIB1+ addresses a sizeable commercial opportunity in advanced melanoma, with earlier-stage disease offering additional upside.**

We see a sizeable addressable population for iSCIB1+ in advanced melanoma. Based on our assumptions for the addressable first-line population, HLA eligibility, pricing, and market penetration (detailed later in valuation section), we project U.S. peak sales of approximately $680M (before PharmaJet royalty payment). We view our assumptions as a relatively conservative base case, with potential upside if iSCIB1+ achieves broader uptake or longer treatment duration than we currently assume.

We view iSCIB1+'s off-the-shelf profile as an important potential commercial advantage. Unlike personalized cancer vaccines, which require tumor sequencing to design a unique vaccine for each patient, iSCIB1+ is a standardized product that does not require patient-specific tumor sequencing for vaccine design. This allows iSCIB1+ to be manufactured in larger batches for multiple patients, with standardized batch-level quality-control testing rather than separate manufacturing and testing for each individual. We believe these differences could translate into substantially lower cost of goods sold (COGS) compared with personalized vaccines, while also allowing iSCIB1+ to be manufactured and made available in advance without requiring patients to wait for a customized product. Also, Scancell has a long-term license and supply agreement with PharmaJet covering use of the Stratis needle-free intramuscular delivery system for both clinical development and commercialization of iSCIB1+. Management noted that the agreement includes a milestone payment at initiation of the Phase 3 trial and a mid-single digit royalty on commercial sales of iSCIB1+ where Stratis is used. Stratis is FDA 510(k)-cleared and CE-marked, requires minimal training, and delivers treatment in approximately one-tenth of a second. We believe the combination of lower manufacturing complexity, potentially more favorable COGS, and an established commercial delivery system could support broad use.

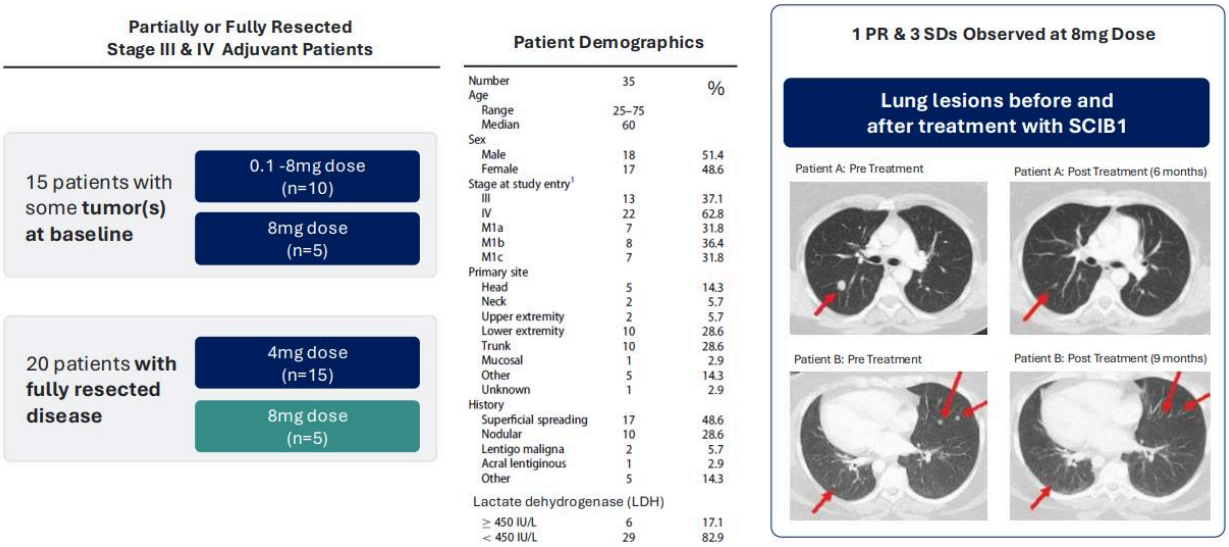
We do not view personalized cancer vaccines as a winner-take-all threat to iSCIB1+. As discussed earlier, the positive Phase 3 Merck/Moderna data provide further validation of therapeutic cancer vaccination in melanoma. However, the approaches differ meaningfully: intismeran is individualized and being developed in resected melanoma, while iSCIB1+ is off the shelf and is entering Phase 3 in first-line unresectable advanced melanoma. Management sees no direct impact on iSCIB1+'s current market opportunity and believes the programs could ultimately be complementary across the melanoma treatment continuum. We also believe iSCIB1+ could offer a favorable practical and tolerability profile if its existing safety experience is maintained, as no flu-like syndrome has emerged as a characteristic toxicity to date, whereas pyrexia was common in INTerpath-001. In our opinion, there is room for multiple approaches if each demonstrates meaningful clinical benefit.

Earlier-stage melanoma could substantially expand the opportunity for iSCIB1+. The addressable population in resectable melanoma is considerably larger than in advanced disease, and Scancell plans to begin evaluating iSCIB1+ in this setting in 1H27. While first-generation SCIB1 has provided initial clinical support for the ImmunoBody approach in resectable disease, the randomized two-arm iSCIB1+ Phase 2 study has not yet started and the existing data come from a small, early-stage study of the first-generation construct. We therefore assign the neoadjuvant/adjuvant opportunity with a relatively low 15% probability of success in our model. We look forward to the planned Phase 2 study, particularly the initial pathological response readout targeted for 2H27, to reassess the opportunity. See below for a closer look at the earlier SCIB1 data and the planned Phase 2 study.

First-generation SCIB1 provided the initial clinical rationale for expansion into earlier-stage melanoma. The Phase 1 study evaluated SCIB1 monotherapy in patients with partially or fully resected stage III/IV melanoma. 15 patients entered the study with tumor present at baseline, while 20 patients had fully resected disease. Among patients treated at the 8 mg dose, one PR and three cases of SD were observed. While the study was small, we believe these findings provided early evidence that the ImmunoBody approach could generate clinical activity as monotherapy.

- **Left:** 15 patients had tumor present at baseline; 20 patients had fully resected disease.
- **Right:** The CT images on the right show lung lesions before and after SCIB1 treatment in two patients. The red arrows identify the lesions, with visible reductions after six months in Patient A and nine months in Patient B.

SCIB1 Monotherapy Demonstrated Early Activity in Stage III/IV Melanoma

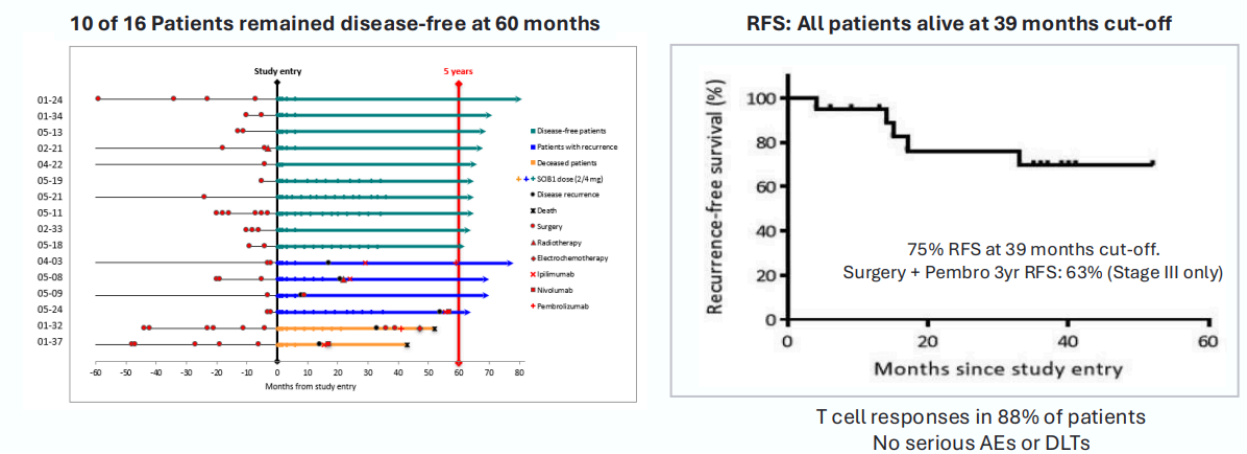


Source: Scancell August 2026 corporate presentation.

Long-term follow-up provided additional support for the approach in resected disease. Among evaluable patients, 10/16 remained disease free at 60 months, while RFS was 75% at the 39-month cutoff. T-cell responses were observed in 88% of patients, with no serious adverse events or dose-limiting toxicities reported. Although these data come from a small study of first-generation SCIB1, we believe the durability and immune responses provide additional rationale for evaluating the optimized iSCIB1+ construct in earlier-stage melanoma.

- The left panel shows individual patient follow-up, with the majority remaining disease free for several years and 10/16 patients still disease free at 60 months.
- The right panel shows that most recurrences occurred relatively earlier, after which the RFS curve plateaued at ~75% through the later follow-up shown. Comparing this with the 63% three-year RFS reported for surgery + pembrolizumab in stage III disease, the SCIB1 outcome appears encouraging, although note that this is a cross-trial comparison.

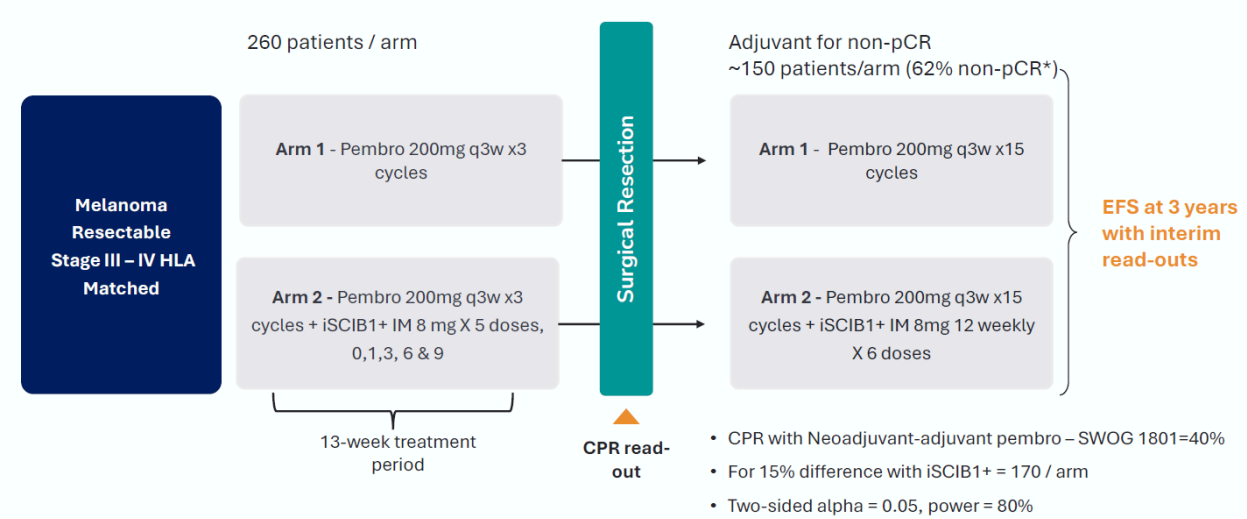
Long-Term SCIB1 Activity Supports Earlier-Stage Development



Source: Scancell August 2026 corporate presentation.

The planned Phase 2 study will provide the first test of iSCIB1+ in resectable melanoma. Scancell is planning a two-arm study in HLA-matched patients with resectable stage III/IV melanoma comparing pembrolizumab alone vs. pembrolizumab + iSCIB1+. During a 13-week neoadjuvant period, both groups will receive pembrolizumab 200 mg every three weeks for three cycles, with patients in the combination arm also receiving five 8 mg intramuscular doses of iSCIB1+ at Weeks 0, 1, 3, 6, and 9. Following surgical resection, patients without a pathological complete response (pCR) will enter the adjuvant phase, with both arms receiving pembrolizumab 200 mg every three weeks for 15 cycles and the combination arm also receiving six additional 8 mg doses of iSCIB1+ every 12 weeks. The study will assess pCR following neoadjuvant therapy and event-free survival (EFS) at three years, with interim readouts planned. Phase 2 initiation is targeted for 1H27, with interim data expected in 2H27 and a further study readout in 1H28. We believe the randomized comparison against pembrolizumab should provide an important early indication of iSCIB1+'s potential to improve outcomes in earlier-stage melanoma.

Planned Phase 2 Study Evaluating iSCIB1+ in Resectable Melanoma



Source: Scancell October 2026 corporate presentation.

5. **Modi-1 provides a second clinical-stage value driver, while the broader platforms and partnerships provide longer-term optionality.**

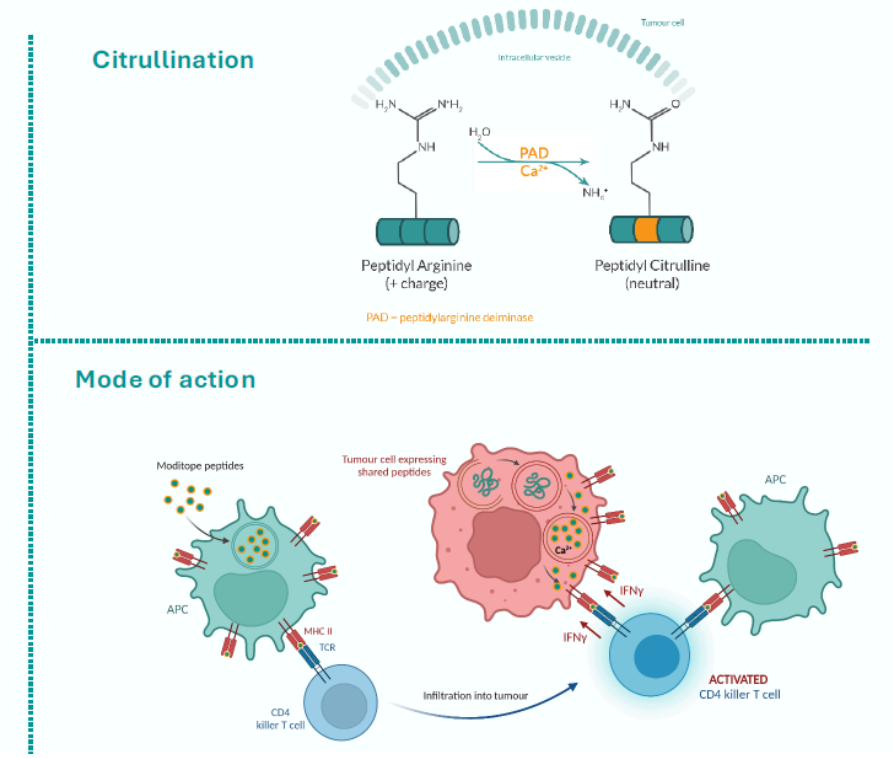
We believe Scancell's broader pipeline receives relatively little investor attention today. Management has indicated to us that investor discussions remain heavily focused on iSCIB1+, while Modi-1 and the company's earlier-stage platforms receive substantially less attention. We think that is understandable given the importance of the upcoming iSCIB1+ Phase 3 study, but Scancell is not a single-asset company. Modi-1 provides a second clinical-stage program, while the broader ImmunoBody and GlyMab platforms offer additional opportunities for internal development and partnering.

Modi-1 uses a different approach to help the immune system recognize stressed tumor cells. When cancer cells are under stress, they increase the cellular recycling process known as autophagy. During this process, proteins can undergo citrullination, a chemical modification in which the amino acid arginine is converted to citrulline. This can create altered peptides that look different to the immune system and provide potential targets for an anti-tumor immune response. Modi-1 is essentially a vaccine containing three of these citrullinated peptide targets: two derived from vimentin (structural protein involved in maintaining cell shape and organization), and one derived from enolase (enzyme involved in cellular energy metabolism).

After vaccination, antigen-presenting cells take up these peptides and present them to CD4+ T-cells, training the immune system to recognize the same citrullinated targets present on stressed tumor cells. The peptides are also linked to AMPLIVANT, a synthetic Toll-like receptor 1/2 (TLR1/2) agonist that acts as an adjuvant to enhance dendritic-cell antigen processing and T-cell priming. Preclinical data showed that conjugating Modi-1 peptides to AMPLIVANT increased anti-tumor immune responses by about 10- to 100-fold. Both vimentin and enolase are expressed across several solid tumors, including head and neck, renal, ovarian, and triple-negative breast cancers. Importantly, Scancell acquired the AMPLIVANT patent rights following ISA Pharmaceuticals' bankruptcy. Management noted that, other than ongoing patent-maintenance costs, Scancell has no further financial obligations related to AMPLIVANT.

- The top portion shows the concept of citrullination, where stress and autophagy can chemically modify proteins and create new epitopes that the immune system can recognize.
- Bottom: Modi-1 contains three of these citrullinated targets, two derived from vimentin and one from enolase, which antigen-presenting cells display to CD4+ T-cells. These activated CD4+ T-cells are then intended to recognize the same citrullinated targets on stressed tumor cells, while AMPLIVANT is used to strengthen antigen presentation and T-cell priming.

Modi-1 Trains CD4+ T-cells to Recognize Citrullinated Targets on Stressed Tumor Cells



Source: Scancell August 2026 corporate presentation.

Early HPV-negative HNSCC data provide a strong clinical signal for Modi-1 to date. The Phase 1/2 ModiFY basket study has enrolled more than 120 patients across 16 UK sites, with safety and dose selection established in more than 50 patients. In the HPV-negative HNSCC cohort, 3/7 patients achieved a partial response at their Week 25 scan, corresponding to a 43% ORR. This compares favorably with historical ORRs of 19% for pembrolizumab and 13% for nivolumab. While the early activity appears encouraging, we note that the dataset is small, and the comparison is historical. ModiFY is also evaluating Modi-1 with nivolumab/ipilimumab in RCC. Management expects to provide a pipeline update in November

2026 that includes new Phase 2 ModiFY data, representing the first new clinical update since the HNSCC non-futility disclosure in January 2025. We view the upcoming data as the next important look at Modi-1 and its potential as a broader pan-cancer program.

We currently assign no value to Modi-1 in our valuation. Although the early HNSCC response data are encouraging, the efficacy data remain limited to a small number of patients and mature PFS data are not yet available. We therefore view Modi-1 as potential upside to our current valuation and look toward the upcoming Phase 2 update as the next step to reassess the program.

SCIB2/iSCIB2+ extends the ImmunoBody approach beyond melanoma through NY-ESO-1. SCIB2 is Scancell's second ImmunoBody cancer vaccine and consists of a DNA plasmid encoding a modified human IgG1 antibody containing 16 T-cell epitopes from NY-ESO-1, a cancer-testis antigen expressed across a range of solid tumors but with limited expression in normal tissue. The selected epitopes cover more than 80% of HLA phenotypes and are designed to generate high-avidity NY-ESO-1-specific CD4+ and CD8+ T-cell responses through the same antigen-presentation mechanism underlying the broader ImmunoBody platform. Preclinically, SCIB2 demonstrated anti-tumor activity both alone and in combination with checkpoint inhibition, with PD-1 blockade substantially enhancing activity. Cancer Research UK subsequently planned a Phase 1/2 study of SCIB2 + checkpoint inhibition in solid tumors, initially focused on NSCLC, although the partnership was terminated in 2021 before the study began and rights reverted to Scancell. Scancell has since incorporated its AvidiMab Fc modification into the construct to create iSCIB2+, which is intended to enhance targeting to activated dendritic cells and increase the resulting T-cell response. iSCIB2+ remains in preclinical development for solid tumors.

The broader ImmunoBody platform includes several earlier-stage programs targeting additional tumor antigens. iSCIB3+, which is being developed for ovarian cancer, targets aspartate beta-hydroxylase (ASPH) and fibroblast activation protein (FAP), while iSCIB4+, being evaluated across PDAC, NSCLC, and MSS colorectal cancer, includes programs targeting mutant KRAS + cMET and GPC3 + ASPH. These programs provide additional opportunities to apply the ImmunoBody platform beyond melanoma, although they remain early stage and we currently assign no value to them in our valuation.

GlyMab provides another source of optionality and has already generated external validation through two Genmab partnerships. Glycans are sugar structures attached to proteins and lipids on the surface of cells, and cancer cells can display abnormal glycan patterns that distinguish them from normal tissue. Scancell's GlyMab platform is designed to generate high-affinity, tumor-specific IgG1 monoclonal antibodies that recognize these glycan motifs rather than conventional peptide epitopes. This expands the potential target space to the glycoproteome, including changes in sialylation, sulfation, fucosylation, and glycopeptides, which we believe can provide access to otherwise difficult targets while potentially improving tumor specificity. The company has identified targets including SLAN and protein-glycan combinations, as well as more tumor-specific glycans such as sialyl-di-Lewis A, Fucosyl-GM1, and Lewis Y. The resulting antibodies can potentially be developed directly or incorporated into other therapeutic formats, including ADCs and T-cell engagers.

Two GlyMab antibodies have already been licensed to Genmab. The first, SC129, was licensed to Genmab in 2022, with Scancell receiving a $6M upfront payment and becoming eligible for up to $208M for each product developed and commercialized (up to $624M in total), plus low-single-digit royalties on net sales. Genmab then paid $1M in June 2024 for the exclusive right to evaluate a second antibody, SC2811, and exercised its option in December 2024, paying an additional $5M for the worldwide exclusive license. Under the SC2811 agreement, Scancell is eligible for up to $630M in development, regulatory, and commercial milestones plus low-single-digit royalties on net sales. Scancell has guided to additional

Genmab development milestones in 2026 and management expects to provide an update on the license as part of its upcoming pipeline update, which could provide a nearer-term indication of progress across the partnered programs.

Scancell also retains several proprietary GlyMab programs for internal development or future partnering. These include SC134, a T-cell engager targeting Fucosyl-GM1 in SCLC; SC27, which targets Lewis Y and is being explored as a T-cell engager or ADC; and GT200, which targets SLAN in ovarian cancer. Given their early stage of development, we currently assign no value to these programs.

We view the broader pipeline as upside to our current valuation. Overall, we currently assign no value to Modi-1, the earlier-stage ImmunoBody programs, the Genmab-partnered GlyMab economics, or Scancell's proprietary GlyMab pipeline. Regardless, Modi-1 provides a second clinical-stage opportunity, while the two Genmab agreements provide external validation of GlyMab and the earlier ImmunoBody programs provide additional opportunities to apply the ImmunoBody platform to cancers beyond melanoma. We believe positive Modi-1 PFS data, progress from the Genmab-partnered programs, or advancement of the earlier-stage pipeline could provide additional value beyond the core iSCIB1+ story.

6. **The proposed Neuphoria merger and financing package could support operations through multiple milestones into 2029.**

We view the proposed Neuphoria merger and financing package as an important potential de-risking event for Scancell. We believe completion of the proposed financing transactions could support operations through multiple milestones in 2029, including the targeted 2H28 Phase 3 PFS readout. We also believe the planned Nasdaq listing could increase Scancell's visibility among U.S. healthcare investors and potential partners as iSCIB1+ advances through late-stage development.

Scancell's current liquidity position underscores the importance of the proposed financing transactions. As of April 30, 2026, Scancell held £5.3M in cash vs. £16.9M a year earlier, while net operating cash use increased to £10.8M in FY26 from £6.4M in FY25. Scancell also noted that its existing funding would not cover projected cash needs over the next 12 months without proceeds from the proposed financing transactions. Additionally, the company has £18.2M in outstanding convertible notes held by Redmile, which are expected to convert into equity upon completion of the merger and financing. We believe successful completion of these transactions is important, as it would bring in new capital to support the continued development of iSCIB1+ while eliminating a significant existing debt obligation through conversion into equity.

The BlackRock debt facility provides additional financing flexibility for Phase 3. On September 24, 2026, Scancell entered into an agreement with Kreos Capital, a fund managed by BlackRock, for up to $25M in secured debt financing across four tranches. The initial $7M tranche became available following shareholder approval on October 20, while a further $8M is available subject to fundraising and Phase 3 site-opening conditions. The remaining $10M may be drawn through December 31, 2027, subject to Scancell having raised at least $75M in cumulative equity funding and receiving an additional $10M investment from an acceptable specialist life-sciences investor. The facility carries a 10.50% annual cash interest rate on the term-loan portions and 10.95% payment-in-kind interest on the convertible portions. Up to $5M of the first three tranches is convertible into equity, while warrants are also issued on amounts drawn. We believe the facility provides additional financial flexibility as Scancell advances iSCIB1+ into Phase 3, although the associated interest obligations and potential shareholder dilution remain important considerations.

The proposed merger and PIPE financing could substantially strengthen Scancell's financial position. Scancell raised £15.7M (approximately $21M) through U.K. offerings in July 2026. In October, management projected approximately $75M in total proceeds from the completed UK offerings, the $39.1M PIPE expected upon completion of the Neuphoria merger, and the initial $15M of BlackRock debt financing. The merger would also bring at least $10M in additional cash from Neuphoria, with the transactions expected to close in late 4Q26 or early 1Q27. Scancell shareholders approved the transaction-related resolutions on October 20, including the one-for-ten share consolidation that took effect October 21, while completion of the merger remains subject to Neuphoria shareholder approval and remaining regulatory and Nasdaq listing requirements. We believe successful completion of the transactions could extend Scancell's cash runway through the anticipated 2H28 Phase 3 PFS readout, providing the company with funding to advance its lead program through this important clinical milestone.

Scancell Valuation

We are initiating coverage of Scancell with a Buy rating and 330p price target. We base our valuation on our probability-weighted clinical net present value (NPV) valuation model. This is an independent, fully taxed snapshot of each drug's perceived value. We believe this method is appropriate in capturing the value of the clinical stage pipeline by allowing us to flex multiple assumptions, including chance of success, peak sales estimates, and year of commercial launch.

Our peak sales estimates are found by looking out approximately five to six years from projected product launch. Per our market models below, and incorporating the vagaries, and timing of new drug launches, we believe a rough estimate of the market model sales in year five and year six best represent our view of peak. We believe a level of conservatism exists in our valuation model based on our assigned multiple of 17.0x, rather than the sometimes-inflated non-profitable biotech multiples in the 30-40x range. Our rationale for using Big Pharma multiples, plus a discount, is based on the potential acquisition metrics utilized by Big Pharma in valuing the smaller biotech as part of its overall portfolio. We are currently assigning a 15% discount rate, which is in line for the majority of our covered companies, except for those with higher perceived risks. Our valuation is also based on fully diluted share count.

Our clinical NPV valuation is based on the contribution of iSCIB1+ in U.S. advanced melanoma and earlier-stage melanoma. We currently assign a 65% probability of success to iSCIB1+ in advanced melanoma and a 15% probability of success in earlier-stage melanoma. We currently omit Modi-1, the preclinical ImmunoBody programs, the Genmab-partnered GlyMab economics, and Scancell's GlyMab programs from our valuation given their earlier stage of development and/or limited visibility into future economics. We also currently exclude ex-U.S. iSCIB1+ sales. We look to reassess the potential upside from these programs as they advance, and greater visibility emerges. In our belief, this represents an additional layer of conservatism while also providing meaningful long-term upside potential as the broader pipeline progresses.

Currently, we project U.S. peak net sales of $680M for iSCIB1+ in 1L unresectable/metastatic melanoma and $620M in the earlier-stage neoadjuvant/adjuvant setting, before our assumed PharmaJet royalty. We take a relatively conservative approach to our forecasts, considering the need to demonstrate a meaningful benefit over nivolumab/ipilimumab alone, the target-HLA population, and gradual physician adoption of a vaccine-based add-on therapy.

- In advanced melanoma, we derive an unresectable/metastatic population representing approximately 16.2% of diagnosed melanoma patients based on Scancell's estimates of approximately 117,000 U.S. melanoma diagnoses and approximately 98,000 patients with resectable disease. We apply approximately 80% target-HLA eligibility and assume gradual commercial uptake following our assumed 2029 launch. We assume a U.S. net price of $150,000 per complete 11-dose treatment course at launch, increasing 3% annually, rather than recurring annual revenue from each patient. While treatment may extend across multiple calendar years, we attribute the full course value to the year treatment begins for modeling purposes.
- In earlier-stage melanoma, we assume approximately 84% of diagnosed patients have potentially resectable disease, of whom 35% are candidates for neoadjuvant/adjuvant therapy. We apply the same 80% HLA eligibility and assume gradual uptake following our 2032 launch. The perioperative Phase 2 design includes five preoperative doses, with six additional doses administered only to patients who do not achieve a pCR. To estimate average dosing, we assume a 38% pCR rate based on published neoadjuvant pembrolizumab experience in resectable melanoma (*Patel et al., Annals of Oncology, 2023*), implying that 38% of patients receive five doses and the remaining 62% receive all 11 doses. This results in a weighted average of 8.72 doses per patient [(38% × 5) + (62% × 11)]. We view this as a reasonable starting point given that these data reflect checkpoint

therapy without iSCIB1+. If the addition of iSCIB1+ ultimately produces a higher pCR rate, the average number of doses administered could be lower. Using the same per-dose economics as the advanced setting and our weighted-average assumption of 8.72 doses per patient, we model an approximately $119,000 launch-year treatment value, increasing 3% annually thereafter.

For both market models, we also deduct a modeled 5% royalty to PharmaJet, consistent with management's indication of a mid-single-digit royalty on commercial sales where Stratis is used. We believe compelling randomized Phase 3 data could support greater uptake, while the earlier-stage opportunity remains less de-risked given that its Phase 2 study has yet to begin.

The overall assumptions are outlined in our clinical NPV model and U.S. market tables below. We believe significant upside potential exists to our valuation based on: (1) positive randomized Phase 3 PFS data supporting a meaningful clinical benefit from adding iSCIB1+ to nivolumab/ipilimumab; (2) greater commercial penetration or pricing than reflected in our projections; (3) partnerships supporting development and commercialization in ex-U.S. markets; (4) favorable results supporting iSCIB1+ development in earlier-stage melanoma or additional settings; and (5) progress across Modi-1, ImmunoBody, and GlyMab programs currently excluded from our valuation.

Scancell NPV Valuation Model

Drug name	Indication	Status	Launch	Success	Peak Sales (US$m)	Economics	Profitability	NPV (US$)
iSCIB1+ - U.S.	1L unresectable/metastatic melanoma	Phase 3	2029	65%	680	95%	30%	3.88
iSCIB1+ - U.S.	Earlier-stage melanoma	Phase 2	2032	15%	620	95%	30%	0.54
							Total	**4.41**
								329.96p

Source: H.C. Wainwright estimates. Peak sales estimates reflect net product revenue before PharmaJet royalty payments. GBP/USD conversion based on £1.00 = $1.33745.

Scancell 1L Advanced Melanoma Market Model

iSCIB1+ Revenue Forecast & Royalty Model in 1L Advanced Melanoma							
Year	**2029 (Launch)**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**
U.S. Diagnosed Melanoma Patients	115,737	117,010	118,297	119,598	120,914	122,244	123,589
Unresectable/Metastatic Melanoma Share (%)	16.2%	16.2%	16.2%	16.2%	16.2%	16.2%	16.2%
Total 1L Unresectable/Metastatic Melanoma Patients	**18,749**	**18,956**	**19,164**	**19,375**	**19,588**	**19,804**	**20,021**
Target HLA Prevalence (%)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
HLA-Addressable 1L Unresectable/Metastatic Melanoma Pool	**14,999**	**15,164**	**15,331**	**15,500**	**15,670**	**15,843**	**16,017**
iSCIB1+ Market Penetration (%)	3.0%	6.0%	10.0%	16.0%	22.0%	26.0%	28.0%
Annual Patients on Therapy	450	910	1,533	2,480	3,447	4,119	4,485
Net Price per 11 Dose Treatment Course	$150,000	$154,500	$159,135	$163,909	$168,826	$173,891	$179,108
Net Product Revenue (US)	**$67,497,705**	**$140,574,770**	**$243,974,542**	**$406,492,815**	**$582,028,099**	**$716,280,288**	**$803,259,856**
Royalties Payments							
PharmaJet Royalty Rate (%)	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Annual Royalty Expense to PharmaJet	$3,374,885	$7,028,738	$12,198,727	$20,324,641	$29,101,405	$35,814,014	$40,162,993
Total Royalty Payments	$3,374,885	$7,028,738	$12,198,727	$20,324,641	$29,101,405	$35,814,014	$40,162,993
Net Revenue to Scancell	**$64,122,819**	**$133,546,031**	**$231,775,814**	**$386,168,174**	**$552,926,694**	**$680,466,273**	**$763,096,863**

Source: H.C. Wainwright estimates. Figures in U.S. dollars.

Scancell Earlier-Stage Melanoma Market Model

iSCIB1+ Revenue Forecast & Royalty Model in Earlier-Stage Melanoma							
	2032 (Launch)	2033	2034	2035	2036	2037	2038
U.S. Diagnosed Melanoma Patients	119,598	120,914	122,244	123,589	124,948	126,323	127,712
Potentially Resectable Share (%)	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%
Potentially Resectable Melanoma Patients	**100,463**	**101,568**	**102,685**	**103,814**	**104,956**	**106,111**	**107,278**
Neo/Adjuvant Eligible Share (%)	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%
Neo/Adjuvant Eligible Patients	**35,162**	**35,549**	**35,940**	**36,335**	**36,735**	**37,139**	**37,547**
Target HLA Prevalence (%)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
HLA-Addressable Earlier-Stage Pool	**28,130**	**28,439**	**28,752**	**29,068**	**29,388**	**29,711**	**30,038**
iSCIB1+ Market Penetration (%)	2.0%	5.0%	9.0%	12.0%	15.0%	16.0%	16.5%
Annual Patients on Therapy	563	1,422	2,588	3,488	4,408	4,754	4,956
Net Price per Treatment Course	$118,909	$122,476	$126,151	$129,935	$133,833	$137,848	$141,984
Net Product Revenue (US)	**$66,897,106**	**$174,154,908**	**$326,434,914**	**$453,235,292**	**$589,959,383**	**$655,298,564**	**$703,706,493**
Royalties Payments							
PharmaJet Royalty Rate (%)	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Annual Royalty Expense to PharmaJet	$3,344,855	$8,707,745	$16,321,746	$22,661,765	$29,497,969	$32,764,928	$35,185,325
Total Royalty Payments	$3,344,855	$8,707,745	$16,321,746	$22,661,765	$29,497,969	$32,764,928	$35,185,325
Net Revenue to Scancell	**$63,552,250**	**$165,447,162**	**$310,113,168**	**$430,573,527**	**$560,461,414**	**$622,533,636**	**$668,521,169**

Source: H.C. Wainwright estimates. Figures in U.S. dollars.

Risks

Clinical development risk. Scancell is a clinical-stage biotechnology company, and our valuation is primarily dependent on iSCIB1+. Although the Phase 2 SCOPE data have shown encouraging efficacy and tolerability, the study was non-randomized and comparisons with nivolumab/ipilimumab are historical. The planned randomized Phase 3 study may not reproduce the observed benefit or could identify safety concerns not apparent in smaller cohorts. Delays in enrollment or an unsuccessful PFS readout would materially affect our investment thesis. The neoadjuvant/adjuvant opportunity carries further uncertainty because the planned iSCIB1+ Phase 2 study has not yet begun.

Regulatory risk. Scancell has no approved products, and future approvals remain subject to regulatory review. Although iSCIB1+ has received Fast Track designation and the Phase 3 design has been discussed with the FDA, positive PFS data may not necessarily support accelerated approval. Regulators could require additional follow-up, mature overall survival data, or further studies before approving the product or granting a broad label.

Competitive and commercial risk. The melanoma treatment landscape continues to evolve, with established checkpoint-inhibitor combinations and additional vaccine and immunotherapy programs in development. If approved, iSCIB1+ will need to demonstrate sufficient efficacy, durability, and tolerability to support physician adoption as an add-on to nivolumab/ipilimumab. The requirement for target-HLA eligibility, the multi-dose treatment schedule, reimbursement, and the ultimate net price could also limit uptake relative to our forecasts.

Financing risk. Scancell is not yet generating recurring commercial product revenue and is expected to require significant investment to complete registrational development. The proposed Neuphoria merger, U.S. PIPE, and staged BlackRock facility could materially improve liquidity, but the merger-linked transactions remain subject to closing conditions. Delays or failure to complete those transactions could constrain the Phase 3 program and require alternative funding. Additional equity issuance, debt financing, or strategic transactions could also result in shareholder dilution or other financing costs.

(£ in millions except basic and diluted loss per share, which is in pence)

Profit & Loss	2025A	2026A	2027E	2028E	2029E	2030E
Licensing and R&D revenue	4.7	0.0	2.0	0.0	0.0	0.0
Net product revenue	0.0	0.0	0.0	0.0	47.9	99.9
Royalties and other revenue	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
Revenues	**4.7**	**0.0**	**2.0**	**0.0**	**47.9**	**99.9**
CoGS	0.2	0.0	0.1	0.0	3.0	9.0
Gross Profit	**4.5**	**0.0**	**1.9**	**0.0**	**44.9**	**90.9**
Gross margin	*95%*	*0%*	*95%*	*0%*	*94%*	*91%*
G&A	4.8	5.4	6.5	7.3	8.2	9.4
R&D	14.7	12.0	22.4	24.9	27.4	30.4
Other op ex	0.0	0.0	0.0	0.0	0.0	0.0
EBIT	**(15.0)**	**(17.4)**	**(27.0)**	**(32.2)**	**9.4**	**51.1**
EBIT margin	*nm*	*nm*	*nm*	*nm*	*20%*	*51%*
Depreciation	0.0	0.0	0.0	0.0	0.0	0.0
Amortization Intangibles	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**(15.0)**	**(17.4)**	**(27.0)**	**(32.2)**	**9.4**	**51.1**
EBITDA margin	*nm*	*nm*	*nm*	*nm*	*20%*	*51%*
Non operating expenses	0.0	0.0	0.0	0.0	0.0	0.0
Net Interest Income/Other	1.4	(0.8)	0.5	1.5	0.8	0.3
Interest expense	1.7	2.0	1.8	1.3	0.9	0.4
EBT	**(15.3)**	**(20.2)**	**(28.3)**	**(32.0)**	**9.3**	**51.0**
EBT margin	*nm*	*nm*	*nm*	*nm*	*19%*	*51%*
Provision for taxes	(3.0)	(2.3)	(4.2)	(4.7)	(5.2)	(5.8)
Net Income	**(12.3)**	**(17.9)**	**(24.1)**	**(27.3)**	**14.5**	**56.8**
Participation of preferred stock	0.0	0.0	0.0	0.0	0.0	0.0
Net Income to common	**(12.3)**	**(17.9)**	**(24.1)**	**(27.3)**	**14.5**	**56.8**
net margin	*nm*	*nm*	*nm*	*nm*	*30%*	*57%*
Number of shares - basic	97.03	103.76	141.00	193.20	195.20	197.20
Number of shares - diluted	97.03	103.76	141.00	193.20	195.20	197.20
EPS - basic	**(12.65)**	**(17.25)**	**(17.09)**	**(14.14)**	**7.41**	**28.81**
EPS - diluted	**(12.65)**	**(17.25)**	**(17.09)**	**(14.14)**	**7.41**	**28.81**

Source: Company filings and H.C. Wainwright estimates.

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Semiannual P&L

April Fiscal (£ in millions, except per-share data in pence)	H1'25A	2H'25A	FY'25A	H1'26A	2H'26A	FY'26A	H1'27E	2H'27E	FY'27E
Licensing and R&D revenue	0.00	4.71	4.71	0.00	0.00	0.00	0.00	2.00	2.00
Net product revenue	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Royalties and other revenue	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Revenues	**0.00**	**4.71**	**4.71**	**0.00**	**0.00**	**0.00**	**0.00**	**2.00**	**2.00**
CoGS	0.00	0.24	0.24	0.00	0.00	0.00	0.00	0.10	0.10
Gross Profit	**0.00**	**4.47**	**4.47**	**0.00**	**0.00**	**0.00**	**0.00**	**1.90**	**1.90**
Gross margin	*nm*	nm	*0.95*	*nm*	nm	*0.00*	*nm*	nm	*0.95*
G&A	2.50	2.29	4.79	2.75	2.64	5.39	3.00	3.50	6.50
R&D	8.04	6.64	14.69	6.15	5.89	12.03	7.90	14.50	22.40
Other op ex	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
EBITDA	**(10.55)**	**(4.46)**	**(15.00)**	**(8.89)**	**(8.53)**	**(17.42)**	**(10.90)**	**(16.10)**	**(27.00)**
EBITDA margin			*nm*			*nm*			*nm*
Non operating expenses	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net Interest Income/Other	(2.50)	3.91	1.42	3.06	(3.91)	(0.84)	0.15	0.35	0.50
Interest expense	0.79	0.92	1.72	0.98	0.98	1.96	1.00	0.80	1.80
EBT	**(13.84)**	**(1.47)**	**(15.30)**	**(6.81)**	(13.42)	**(20.23)**	**(11.75)**	**(16.55)**	**(28.30)**
EBT margin			*nm*			*nm*			*nm*
Provision for taxes	(1.33)	(1.70)	(3.03)	(1.07)	(1.26)	(2.33)	(1.50)	(2.70)	(4.20)
Participation of preferred stock									
Net Income to common	**(12.50)**	**0.23**	**(12.27)**	**(5.74)**	(12.16)	**(17.90)**	**(10.25)**	**(13.85)**	**(24.10)**
net margin			*nm*			*nm*			*nm*
NoSH - basic	92.94	101.12	97.03	103.74	103.78	103.76	113.00	169.00	141.00
NoSH - diluted	92.94	117.32	97.03	119.94	103.78	103.76	113.00	169.00	141.00
EPS - basic	**(13.45)**	**0.23**	**(12.65)**	**(5.53)**	**(11.72)**	**(17.25)**	**(9.07)**	**(8.20)**	**(17.09)**
EPS - diluted	**(13.45)**	**(2.20)**	**(12.65)**	**(6.37)**	**(11.72)**	**(17.25)**	**(9.07)**	**(8.20)**	**(17.09)**

Source: Company filings and H.C. Wainwright estimates.

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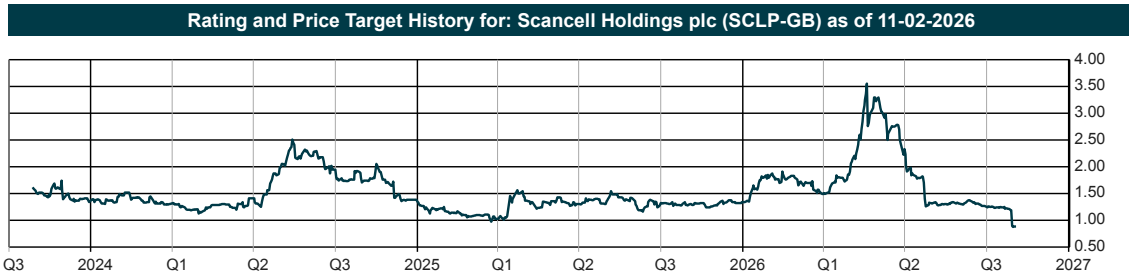
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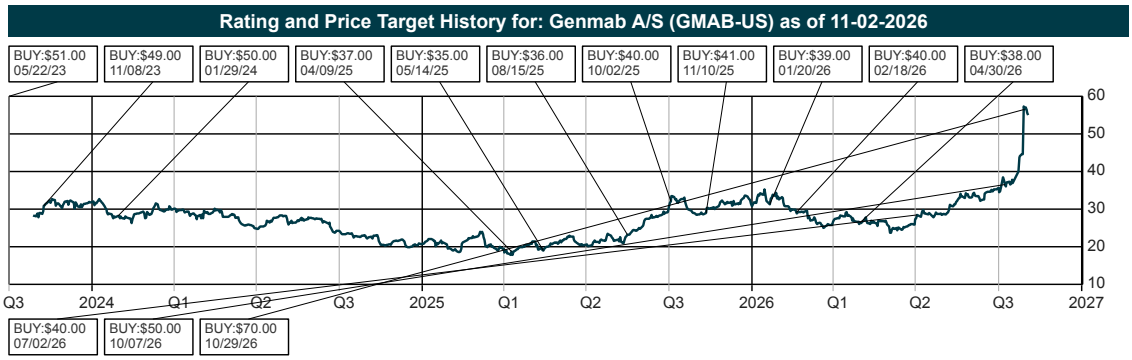
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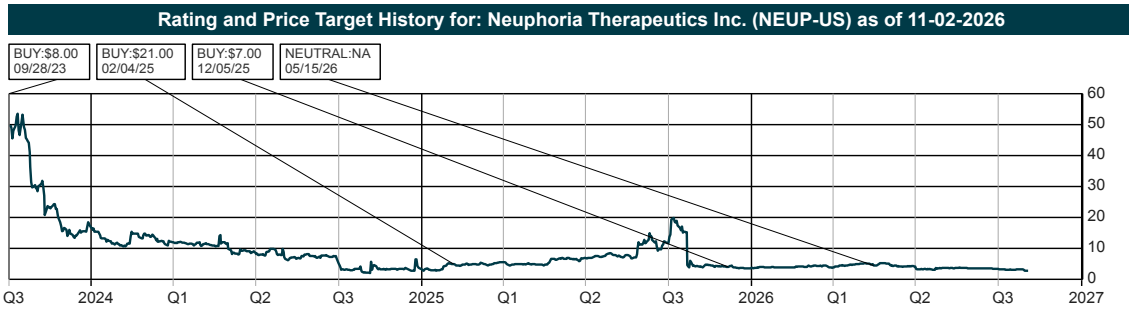
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Related Companies Mentioned in this Report as of November/2/2026					
Company	Ticker	H.C. Wainwright Rating	12 Month Price Target	Price	Market Cap
Neuphoria Therapeutics Inc.	NEUP-US	Neutral	$NA	$3.04	$16
Genmab A/S	GMAB	Buy	$70.00	$54.92	$34273

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Distribution of Ratings Table as of November 2, 2026				
			IB Service/Past 12 Months	
Ratings	Count	Percent	Count	Percent
Buy	529	81.13%	153	28.92%
Neutral	52	7.98%	13	25.00%
Sell	2	0.31%	0	0.00%
Under Review	69	10.58%	22	31.88%

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