Telix Therapeutics

Unlocking the Potential of PSMA Therapy: A Next Generation Portfolio Approach

Scientific Update

April 2026

Forward-looking statements

This presentation should be read together with our risk factors, as disclosed in our most recently filed reports with the Australian Securities Exchange (ASX), U.S. Securities and Exchange Commission (SEC), including our Annual Report on Form 20-F filed with the SEC, or on our website.

The information contained in this presentation is not intended to be an offer for subscription, invitation or recommendation with respect to shares of Telix Pharmaceuticals Limited (Telix) in any jurisdiction, including the United States. The information and opinions contained in this presentation are subject to change without notification. To the maximum extent permitted by law, Telix disclaims any obligation or undertaking to update or revise any information or opinions contained in this presentation, including any forward-looking statements (as referred to below), whether as a result of new information, future developments, a change in expectations or assumptions, or otherwise. No representation or warranty, express or implied, is made in relation to the accuracy or completeness of the information contained or opinions expressed in this presentation.

This presentation may contain forward-looking statements, including within the meaning of the U.S. Private Securities Litigation Reform Act of 1995, that relate to anticipated future events, financial performance, plans, strategies or business developments. Forward-looking statements can generally be identified by the use of words such as “may”, “expect”, “intend”, “plan”, “estimate”, “anticipate”, “believe”, “outlook”, “forecast” and “guidance”, or the negative of these words or other similar terms or expressions. Forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause Telix’s actual results, levels of activity, performance or achievements to differ materially from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. Forward-looking statements are based on Telix’s good-faith assumptions as to the financial, market, regulatory and other risks and considerations that exist and affect Telix’s business and operations in the future and there can be no assurance that any of the assumptions will prove to be correct. In the context of Telix’s business, forward-looking statements may include, but are not limited to, statements about: the initiation, timing, progress, completion and results of Telix’s preclinical and clinical trials, and Telix’s research and development programs; Telix’s ability to advance product candidates into, enroll and successfully complete, clinical studies, including multi-national clinical trials; the timing or likelihood of regulatory filings and approvals for Telix’s product candidates, manufacturing activities and product marketing activities; Telix’s sales, marketing and distribution and manufacturing capabilities and strategies; the commercialization of Telix’s product candidates, if or when they have been approved; Telix’s ability to obtain an adequate supply of raw materials at reasonable costs for its products and product candidates; estimates of Telix’s expenses, future revenues and capital requirements; Telix’s financial performance; developments relating to Telix’s competitors and industry; the anticipated impact of U.S. and foreign tariffs and other macroeconomic conditions on Telix’s business, including as a result of war or other geopolitical conflicts; and the pricing and reimbursement of Telix’s product candidates, if and after they have been approved. Telix’s actual results, performance or achievements may be materially different from those which may be expressed or implied by such statements, and the differences may be adverse. Accordingly, you should not place undue reliance on these forward-looking statements.

This presentation also contains estimates and other statistical data made by independent parties and by Telix relating to market size and other data about its industry. This data involves a number of assumptions and limitations, and you are cautioned not to give undue weight to such data and estimates. In addition, projections, assumptions and estimates of Telix’s future performance and the future performance of the markets in which it operates are necessarily subject to a high degree of uncertainty and risk.

Telix’s first generation PSMA-PET imaging product, gallium-68 (^{68}Ga) gozetotide injection (also known as ^{68}Ga PSMA-11 and marketed under the brand name Illuccix®), has been approved in multiple markets globally. Gozellix® (kit for the preparation of gallium-68 (^{68}Ga) gozetotide injection) has been approved by the U.S. FDA. Telix’s osteomyelitis (bone infection) imaging agent, technetium-99m (^{99m}Tc) besilesomab (marketed under the brand name Scintimun®) is approved in 32 European countries and Mexico. Telix’s miniaturized surgical gamma probe, SENSEI®, for minimally invasive and robotic-assisted surgery, is registered with the FDA for use in the U.S. and has attained a Conformité Européenne (CE) Mark for use in the EEA. Registrations vary country to country. Refer to your local approved label or regulatory authority status for full information.

No other Telix drug or device has received marketing authorization in any jurisdiction. Any other Telix drug or device that is discussed in this presentation, including Zircaix and Pixclara, is investigational or under development and not approved by any regulatory authority. The efficacy or safety profile of any unapproved drug or device has not been determined by any regulatory authority. In addition, Zircaix and Pixclara brand names and launch are subject to final regulatory approval.

All trademarks and trade names referenced in this press release are the property of Telix Pharmaceuticals Limited (Telix) or, where applicable, the property of their respective owners. For convenience, trademarks and trade names may appear without the ® or ™ symbols. Such omissions are not intended to indicate any waiver of rights by Telix or the respective owners. Trademark registration status may vary from country to country. Telix does not intend the use or display of any third-party trademarks or trade names to imply any affiliation with, endorsement by, or sponsorship from those third parties.

Telix Therapeutics

Presenters

David N. Cade, MBBS

Group Chief Medical Officer
Telix Pharmaceuticals

Louise Emmett, MD[1]

Director of Theranostics and Nuclear Medicine
St Vincent's Hospital, Sydney, Australia

Agenda

1. Telix PSMA Portfolio
2. Experience with TLX597-Tx: OPTIMAL-PSMA
3. Summary and Q&A

1. Prof. Emmett is an independent expert speaker and is not an employee or consultant of Telix. Views expressed are the speaker's own.

Telix

Telix Therapeutics

Telix PSMA Portfolio

Dr. David N. Cade

Executive Summary

A next generation portfolio overcomes limitations of first generation RLTs

1. ^{177}Lu-PSMA small molecule radioligand therapy (RLT) is established in **advanced prostate cancer** (e.g. PSMA-617/I&T)
2. However, use of first generation RLT in **early prostate cancer** has proven challenging, due to worsened **quality of life (QOL)** and **renal toxicity** (e.g. PSMAddition[1] and SPLASH[2] trials)

Telix has two advanced-stage PSMA-targeting programs with distinct MOAs, tailored to the disease state

- **TLX591-Tx in mCRPC:** Radio antibody-drug conjugate (rADC)
  - Antibody advantage is selectivity for tumor-expressed PSMA and long retention / residualization times
  - Two-dose regimen intended to be combined with standard of care (SOC) (Phase 3 ProstACT Global trial[3])
- **TLX597-Tx in mHSPC:** Highly targeted “next generation” small molecule RLT with favorable dosimetry
  - Minimal salivary gland and kidney uptake suggests best-in-class small molecule profile
  - Biodistribution supports dose intensification, improved efficacy, and potentially QOL in mHSPC

Proof-of-concept data from OPTIMAL-PSMA[4] Ph 2 RCT reported at ICPS 2026, Lugano, Switzerland

Telix Therapeutics

NOTES:
PSMA = prostate-specific membrane antigen.
MOA = mode of action.
mHSPC = hormone-sensitive prostate cancer.
mCRPC = metastatic castration-resistant prostate cancer.
RCT = randomized controlled trial.

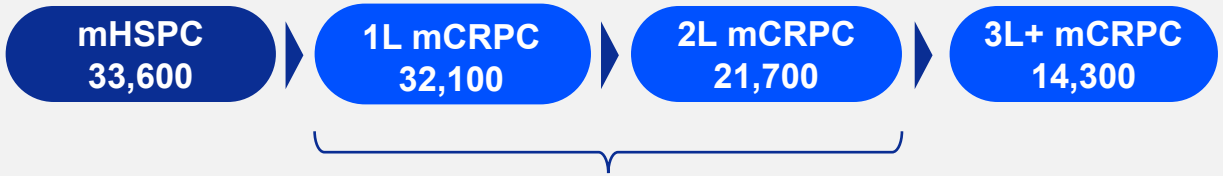
SOURCES:
1. ClinicalTrials.gov ID NCT04720157.
2. ClinicalTrials.gov ID NCT04647526.
3. ClinicalTrials.gov ID: NCT06520345.
4. Australian New Zealand Clinical Trials Registry ID: ACTRN12625000971437.

Key considerations as PSMA RLT moves into earlier settings

Quality of life and tailored dosing are critical

Treatment algorithm for metastatic prostate cancer[1]

Estimated U.S. incidence[2], 2026



- **ADT**
- **ARPI**
- **High volume disease: Taxane**

- **ARPI**
- **Taxane**

- **Taxane**
- **^{177}Lu-PSMA-617 (VISION trial)[3]**

QOL & renal toxicity considerations increase in earlier, healthier patients

- **First generation ^{177}Lu-PSMA-617 / I&T** established as a treatment for advanced prostate cancer
- **Emerging concerns as first generation agents attempt to move up treatment lines** to earlier, healthier patients
  - Risk from radiation to salivary glands and kidneys leading to **dry mouth** and **renal toxicity[4]**
  - **Over-treatment with fixed 6-dose regimen** (PSMAddition trial)[5]

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

Lisa Steinhelfer*[1,2], Lukas Lunger*[3], Lisena Cala[1], Christian H. Pfob[4], Constantin Lapa[4], Philipp E. Hartrampf[5], Andreas K. Buck[5], Hannah Schäfer[6], Christoph Schmaderer[6], Robert Tauber[3], Julia Brosch-Lenz[1], Bernhard Haller[7], Valentin H. Meissner[3], Karina Knorr[1], Wolfgang A. Weber[1], and Matthias Eiber[1]

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

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

1. Adapted from Calais J. UCLA 2023 EANM 2023; NCCN Guidelines Version 5.2026 Category 1 Preferred.
2. Clarivate Market Forecast, published July 2025.
3. ClinicalTrials.gov ID: NCT03511664.
4. Steinhelfer et al. J Nucl Med. 2024; Kirchloff et al. EJNM 2026.
5. Azad, *Discussant – Phase III Trial of [177Lu]Lu-PSMA-617 Combined with ADT + ARPI in Patients with PSMA-Positive Metastatic Hormone-Sensitive Prostate Cancer (PSMAddition)*, presented at ESMO 2025. ClinicalTrials.gov ID: NCT04720157.

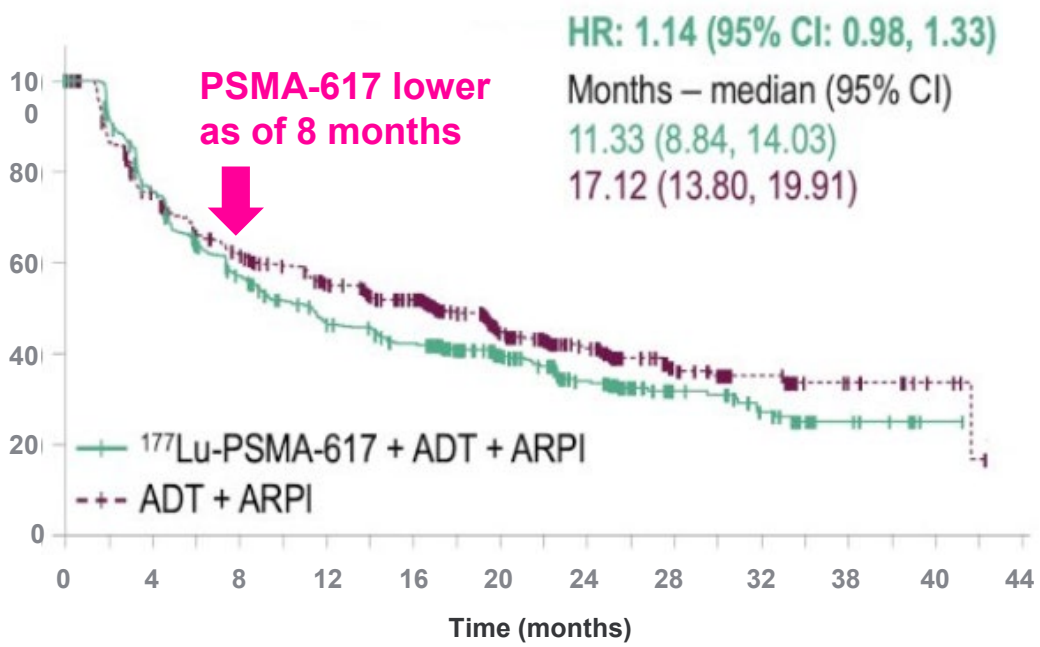
Telix Therapeutics

QOL learnings from ^{177}Lu-PSMA-617 in hormone sensitive setting

Challenges in healthier patients may limit potential clinical utility

PSMAddition Ph 3 showed limited improvement in QOL with PSMA-617[1]…

FACT-P Total Score (QOL metric)



… leading to clinicians expressing concern about utility and level of adoption[2]

Concluding thoughts from Prof Azad's discussion of PSMAddition at ESMO 2025

- **The goal of any anti-cancer treatment is to make patients live longer and live better**
  - This goal has not been achieved in PSMAddition
- **I would not recommend widespread use of Lu-PSMA-617 in mHSPC at this stage**
  - Would consider using if "bad" disease (e.g. de novo high volume) or "bad" scans (e.g. very high PSMA SUVmean and/or total tumour volume)
  - I have concerns about patient selection, overtreatment and impact of toxicity

BERLIN 2025 ESMO congress

Telix Therapeutics

SOURCES:

1. Tagawa, *Phase III Trial of [177Lu]Lu-PSMA-617 Combined with ADT + ARPI in Patients with PSMA-Positive Metastatic Hormone-Sensitive Prostate Cancer (PSMAddition)*, presented at ESMO 2025. ClinicalTrials.gov ID NCT04720157.
1. Azad, *Discussant – Phase III Trial of [177Lu]Lu-PSMA-617 Combined with ADT + ARPI in Patients with PSMA-Positive Metastatic Hormone-Sensitive Prostate Cancer (PSMAddition)*, presented at ESMO 2025.

What does the “next generation” need to look like to succeed?

Moving the needle on PSMA theranostics

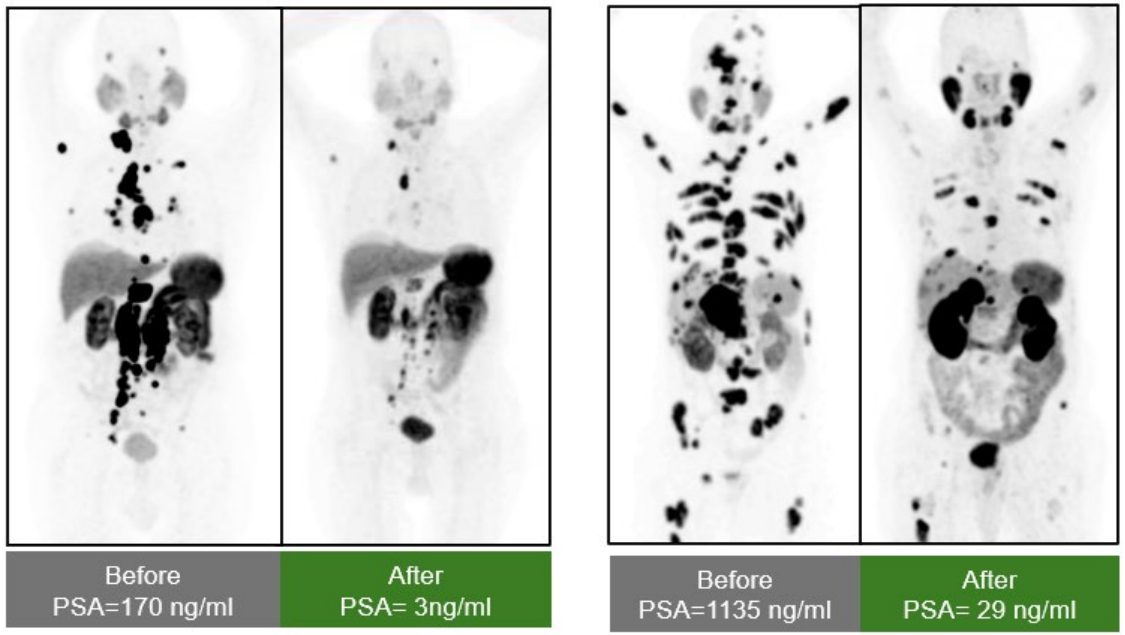
- Greater consideration around clearance organ dosimetry (hepatic clearance or very low renal imparted dose)
- Avoidance of exocrine gland irradiation
- Higher tumor retention / residualization, especially given the typically short retention and pharmacokinetics of small molecules
- Dosing regimens that maximize patient benefit
- More intensive treatment regimens that may benefit patient compliance
- Better integration with standard of care
- Potential to flexibly incorporate alpha-emitters

Telix Therapeutics

TLX597-Tx (^{177}Lu-DOTA-HYNIC-panPSMA)

Highly targeted small molecule agent optimized for early prostate cancer

Representative images from 2 different patients who achieved ≥85% decrease from baseline PSA level following treatment with TLX597-Tx[1]



Patient representative scans – individual results may vary.

- **Current status:**
  - Exploratory Phase 1 investigator-initiated trial (IIT) with adjusted formulation showed promising dosimetry (low kidney, salivary gland irradiation) and PSA reduction[1]
  - OPTIMAL-PSMA[2] Phase 2 study with over 85 patients dosed trialing novel dosing regimen, promising efficacy signals
  - Early access in select geographies

- **Highly targeted biodistribution with minimal salivary gland and kidney uptake supports**
  - Dose intensification to improve efficacy
  - Potential suitability in earlier prostate cancer (mHSPC)[2]

Telix Therapeutics

SOURCES:
1. Omar et al, [177Lu]Lu-DOTA-PSMA radioligand therapy for patients with metastatic castration-resistant prostate cancer, presented at EANM 2025.
2. Crumbaker at al. Dose Optimisation and PSMA Receptor intensification with 177Lu-PSMA-597 in metastatic castration-resistant prostate cancer, the Randomised Phase II OPTIMAL-PSMA trial, presented at ASCO GU 2026; data on file. Australian New Zealand Clinical Trials Registry ID: ACTRN12625000971437.

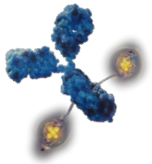
Portfolio to address early and late stage prostate cancer

Hormone-sensitive → **Castration-resistant**

Metastatic hormone-sensitive

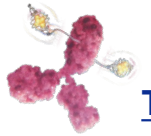
TLX597-Tx
OPTIMAL-E
Phase 2a in PSMA+ mHSPC patients

Metastatic castration-resistant



TLX591-Tx
ProstACT Global
Phase 3 in PSMA+ mCRPC patients previously treated with 1 ARPI

Palliative



TLX592-Tx
TLX090-Tx
Solace

PSA tumor burden

Annual incidence, U.S. patients

mHSPC	1L mCRPC	2L mCRPC	3L+ mCRPC
33,600[1]	32,100[1]	21,700[1]	14,300[1]
PSMAddition	PSMAfore		VISION

Telix Therapeutics

SOURCES:
Adapted from Calais J. UCLA 2023 EANM 2023.
All figures are 2026. Clarivate Market Forecast, published July 2025.

Telix Therapeutics

Experience with TLX597-Tx: OPTIMAL-PSMA

Prof. Louise Emmett

OPTIMAL-PSMA: POC for novel dosing with next gen agent

Phase 2 IIT at St Vincent's Hospital has dosed over 85 patients with TLX597-Tx

- VISION[1] and TheraP[2] trials demonstrated that **^{177}Lu-PSMA-617 improves QOL, but OS benefit is modest**
- **Evidence suggests underdosing of patients with PSMA therapy**
  - Standard 7.5GBq (200mCi) dosing based on external beam radiation limits to kidneys
  - Clinical experience shows patients can tolerate higher doses
  - SPLASH[3] trial of PSMA-I&T suggested decreasing administered activity reduces tumor dose and efficacy
- **OPTIMAL-PSMA[4] aims to improve response and survival** by
  1) **Using agent with highly favorable biodistribution** enabling dose intensification, TLX597-Tx
  2) **Optimizing dosing by intensifying administered activity** to maximize radiation dose when the cancer cell is most vulnerable to damage

Telix Therapeutics

NOTES:
POC = Proof-of-Concept; OS = overall survival.

SOURCES:
1. ClinicalTrials.gov ID: NCT03511664.
2. ClinicalTrials.gov ID: NCT03392428.
3. ClinicalTrials.gov ID: NCT04647526.
4. Australian New Zealand Clinical Trials Registry ID: ACTRN12625000971437.

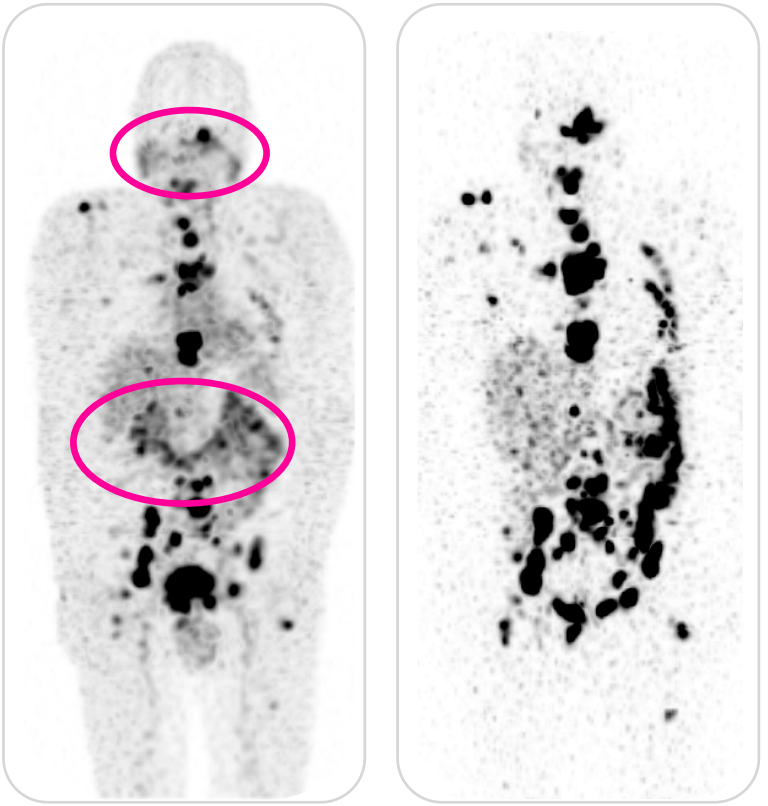
ST VINCENT'S HOSPITAL SYDNEY

TLX597-Tx dosimetry: Favorable profile vs available agents

Dosimetry enables dose intensification

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

TLX597-Tx SPECT scan, 5 and 120 hr



Patient representative scans – individual results may vary.

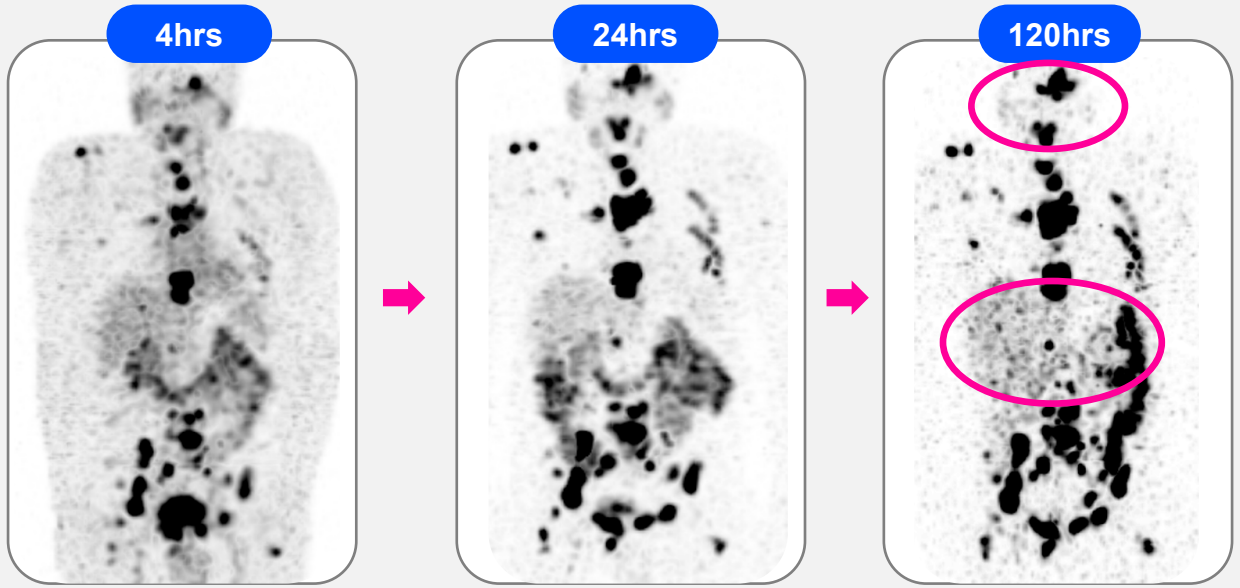
Telix Therapeutics

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

TLX597-Tx uptake profile compared to PSMA-617

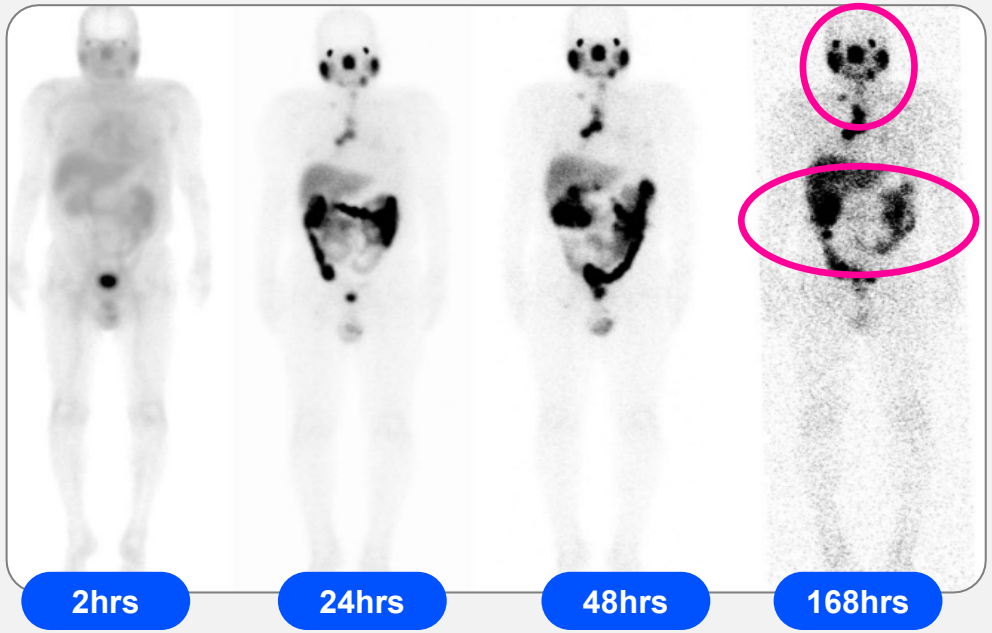
Long tumor retention even at 120 hours, limited salivary gland and kidney uptake

TLX597-Tx SPECT biodistribution[1]



Dosimetry demonstrates low salivary gland and renal doses, high persistence of tumor radiation activity on the 120-hour imaging. The dose delivered to salivary glands is 0.25Gy/GBq (2.15Gy/7.4Gbq), to kidneys is 0.28Gy/GBq (2.05Gy/7.4Gbq) and to tumor is 9.74Gy/GBq (72Gy/7.4Gbq). Patient representative scans – individual results may vary.

PSMA-617 SPECT biodistribution[2]



Patient representative scans – individual results may vary.

Telix Therapeutics

SOURCES:
1. Crumbaker at al. *Dose Optimisation and PSMA Receptor intensification with 177Lu-PSMA-597 in metastatic castration-resistant prostate cancer, the Randomised Phase II OPTIMAL-PSMA trial*, presented at ASCO GU 2026
2. Annals of Nuclear Medicine (2025) 39:1201–1212

TLX597-Tx proof-of-concept: Phase 2 OPTIMAL-PSMA study

Exploring safety, dosimetry, and efficacy of short-interval dose intensification

Aim: To see whether giving ^{177}Lu-PSMA more frequently at the start of treatment can overcome early resistance and improve outcomes.

Part B: Pt 41-120

Majority of patients received prior taxane

Eligibility

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

2:1

TLX597-Tx* Dose Intensified

ARM 1
N = 80

TLX597-Tx Standard of Care

ARM 2
N = 40

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

Initial 3 doses in 15 days

Day 1 8.5GBq (230mCi) | **Day 3** 8.5GBq | **Day 15** 8.5GBq

Last 3 doses every 10 weeks

Week 10 8.5GBq | **Week 20** 8.5GBq | **Week 30** 8.5GBq

^{68}Ga-PSMA-11 PSA at week 8 in both arms

30 weeks of treatment in both arms

Day 1 7.5GBq (200mCi) | **Week 6** 7.5GBq | **Week 12** 7.5GBq | **Week 18** 7.5GBq | **Week 24** 7.5GBq | **Week 30** 7.5GBq

6 doses every 6 weeks

Primary EP

- PSA90 RR

Secondary EPs

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

Telix Therapeutics

ANZCTR Registration Number: ACTRN12625000971437

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

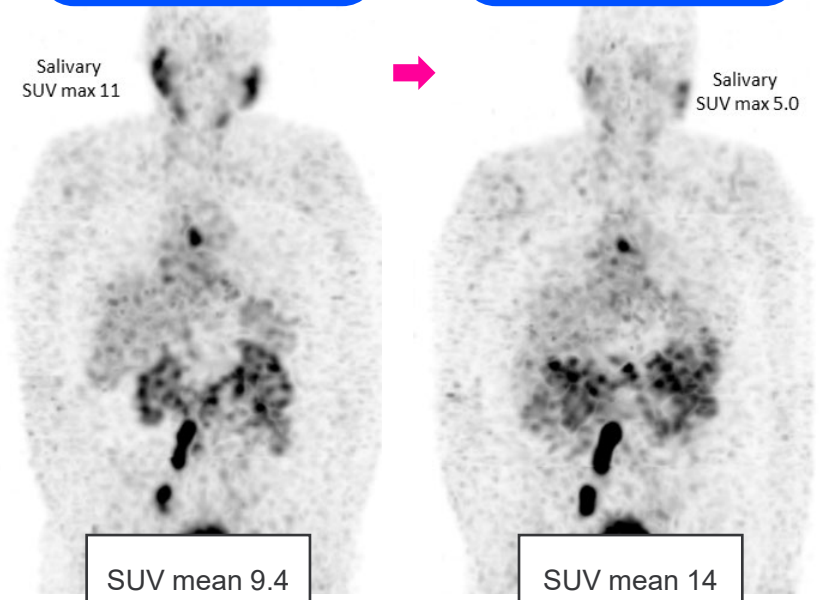
Why is up-front dose intensification effective?

Dose 1 induces PSMA expression in tumors, potentially increasing uptake of doses 2 and 3

Day 3 scans show increase in TTV from higher PSMA expressions

Patient Case A

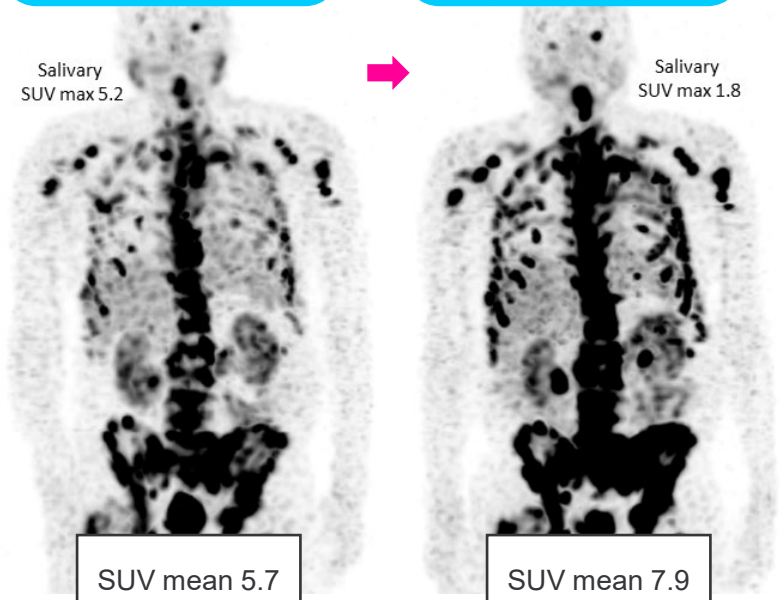
Dose 1 (Day 1) → **Dose 2 (Day 3)**



Dose 1 (Day 1)	Dose 2 (Day 3)
SUV mean 9.4	SUV mean 14
SUV max 51	SUV max 124
TTV 84 mL	TTV 133 mL

Patient Case B

Dose 1 (Day 1) → **Dose 2 (Day 3)**



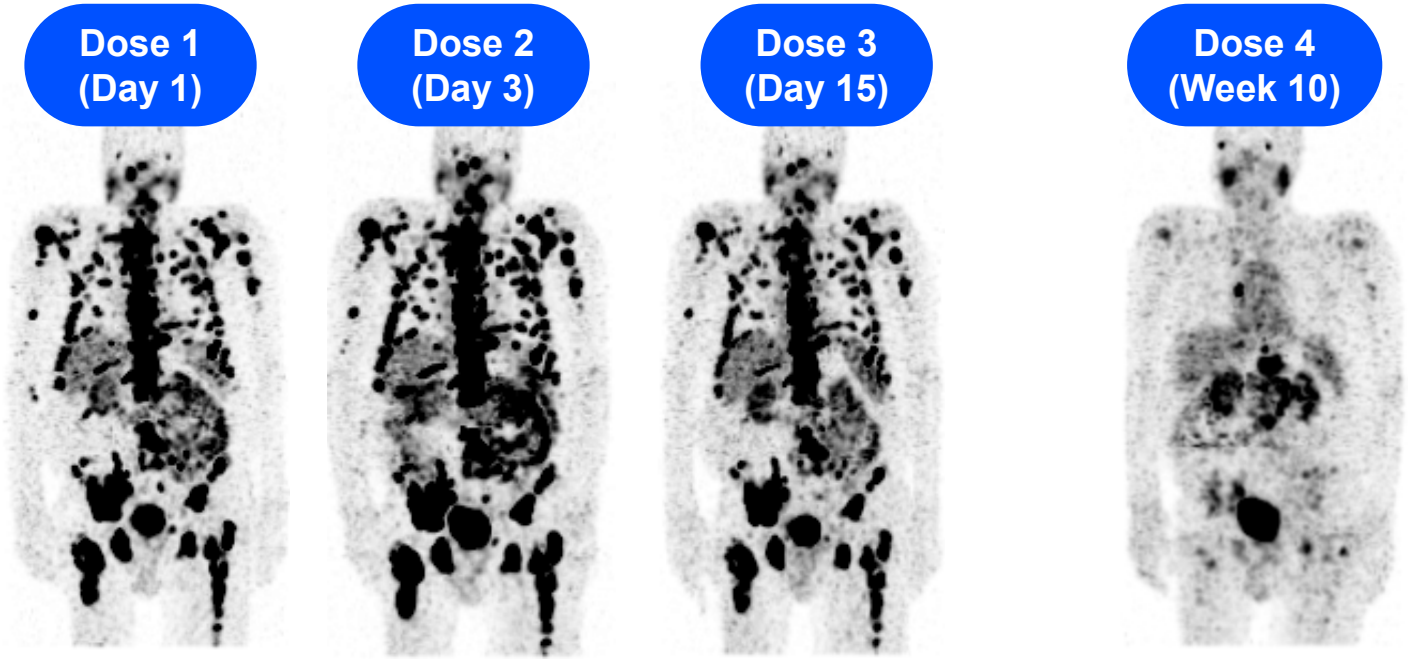
Dose 1 (Day 1)	Dose 2 (Day 3)
SUV mean 5.7	SUV mean 7.9
SUV max 25	SUV max 74
TTV 2379 mL	TTV 3977 mL

- 3 doses upfront maximize cell kill effect when PSMA expression is the highest
- Initial dose induces PSMA up-regulation (increased tumor volume on day 3 imaging), doses 2-3 increase radiation dose rate in cancer cells

NOTES:
Patient representative scans - individual results may vary.
Data from ASCO-GU 2026; Megan Crumbaker.

Telix Therapeutics

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



	Day 1	Day 3	Day 15	Week 6	Week 10
PSA	1380	1480	828	131	40
Hb	112	111	117	116	106
PLT	201	198	217	190	208
eGFR	90	90	90	90	89

71-year-old patient with diffuse bone metastases

- Blood platelets lower but stable
- Normal kidney function
- Substantial shrinkage of lesions
- 97% PSA response at week 10

Telix Therapeutics

NOTES:
Hb, hemoglobin; PLT, Platelets; eGFR, estimated glomerular filtration rate (renal function).
Patient representative scans – individual results may vary.

Early data warrants exploring TLX597-Tx in the mHSPC setting

Biodistribution, flexible dosing regimen, favorable safety suggest promising profile

Safety profile

Low renal and salivary gland uptake, limited AEs

Pharmacokinetic (PK) profile

Long tumor retention, high lesion dose vs other small molecules

Biodistribution

Enables intensified regimen to maximize efficacy

Adaptive dosing

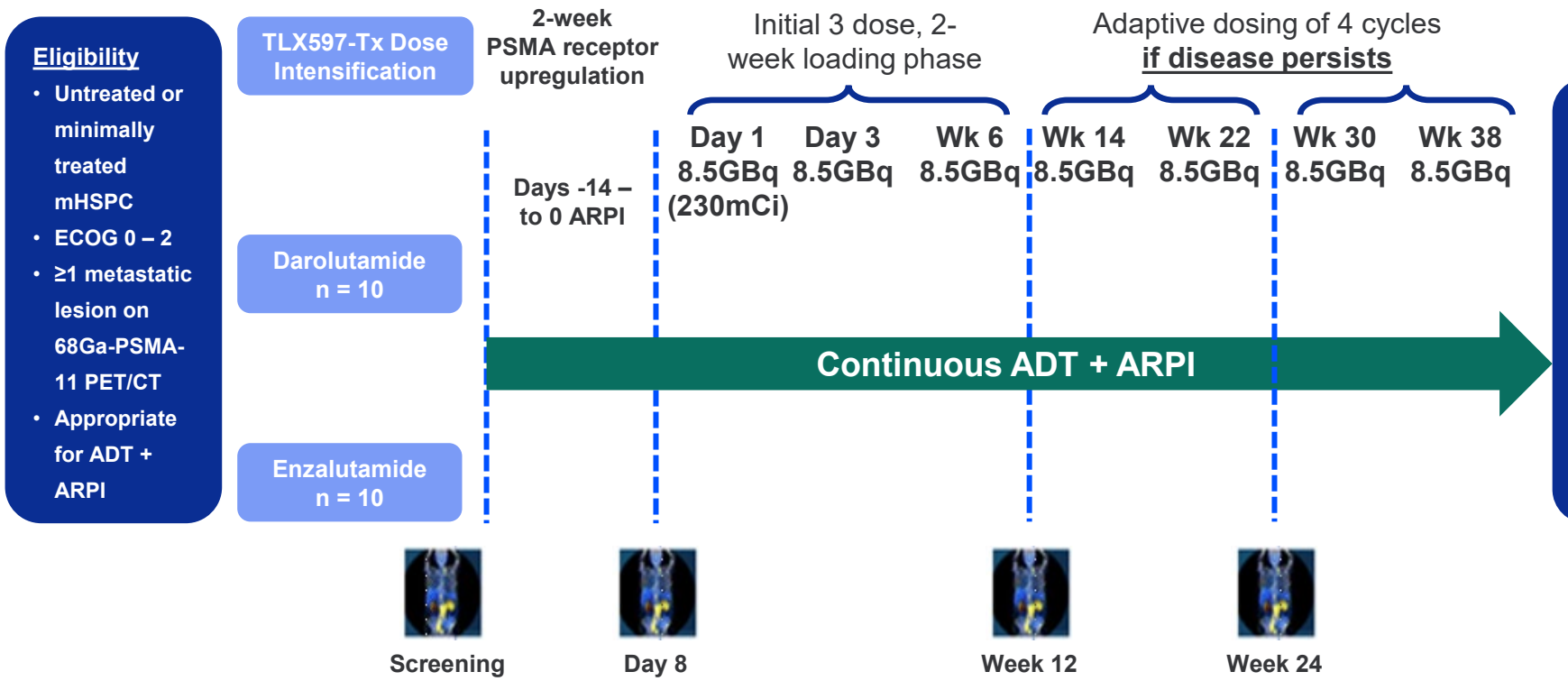
Maximize therapeutic effect in strong responders

- **Quality of life characteristics suggest high potential in mHSPC**
- **Additional future potential with novel isotopes e.g., alpha emitters including ^{225}Actinium**

Telix Therapeutics

OPTIMAL-E: TLX597-Tx proof-of-concept in mHSPC (n=20)

Ph 2a exploring adaptive dosing with 3, 5, or 7 doses depending on response



- 3 dose loading phase maximizes radiation to lesions when they are most sensitive
- Doses 4-7 are given if PSMA target is persistent to avoid overtreating
- Clinical data supportive of disease stabilization approach

ADT in the neo-adjuvant setting and / or up to 45 days of ADT/ARPI for metastatic disease allowed before study entry I Any ARPI with one switch allowed I BRIC, blinded independent review committee; ECOG PS, Easter Cooperative Oncology Group performance status; mHSPC, metastatic hormone-sensitive prostate cancer; OS, overall survival; PET/CT, positron-emission tomography / computed tomography; rPFS, radiographic progression free survival.

Telix Therapeutics

Telix Therapeutics

Summary

Telix Therapeutics

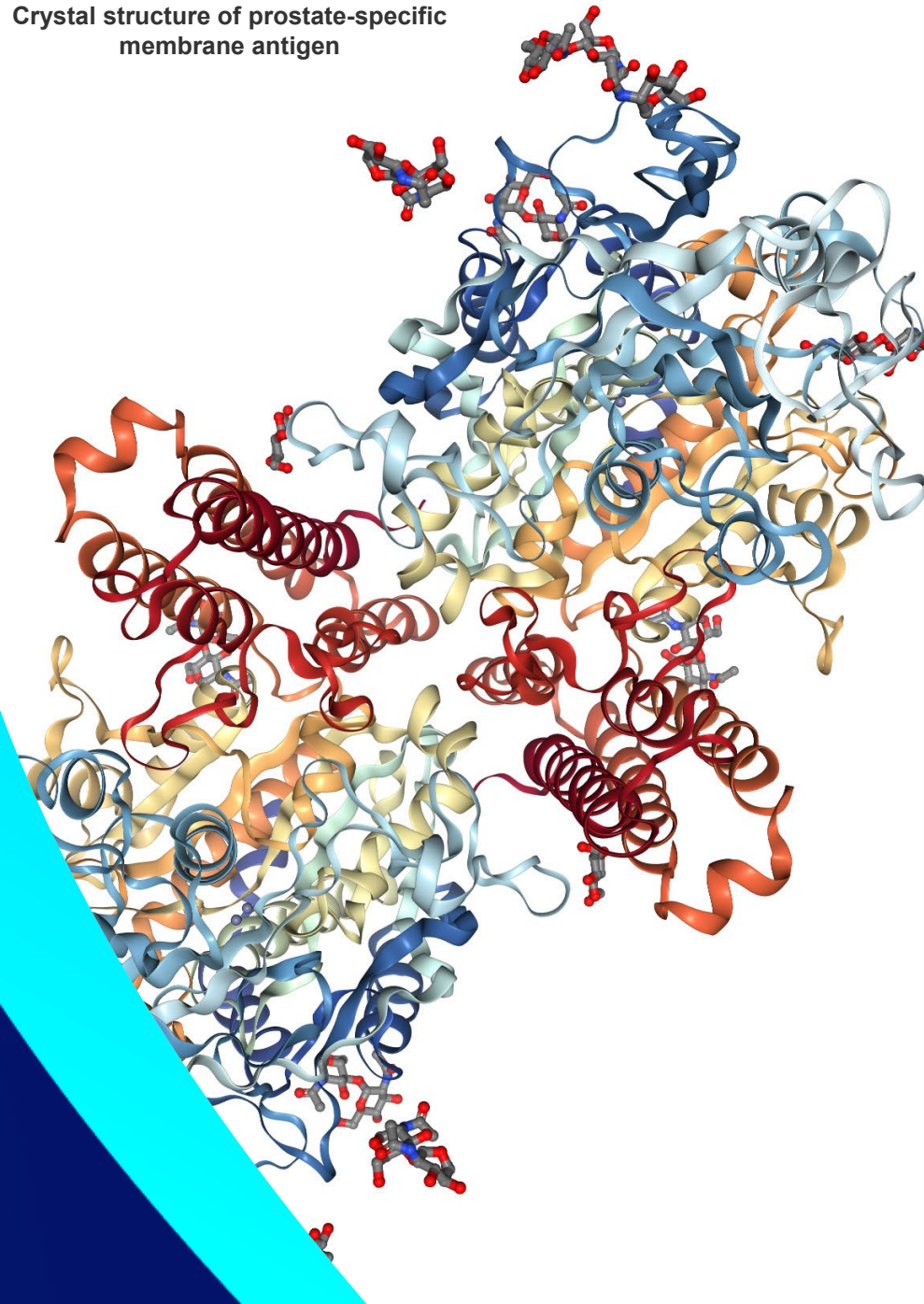
Q&A

Telix Contacts:

Kyahn Williamson (Global)
SVP Investor Relations and Corporate Communications
kyahn.williamson@telixpharma.com

Telix Investor Relations (U.S.)
Ms. Annie Kasparian
Director Investor Relations and Corporate Communications
annie.kasparian@telixpharma.com

Telix Investor Relations (Australia)
Ms. Charlene Jaw
Associate Director Investor Relations
charlene.jaw@telixpharma.com



Crystal structure of prostate-specific membrane antigen