LONG AKTIS ONCOLOGY

Recommendation: Buy	**Date: 10/5/26**
Share Price: $18.52	**Market Capitalization: $1.030B**
Cash & Investments: $517.3M	**Cash Runway: Into 2029**
52-Week Low: $14.72	**52-Week High: $34.19**

Aktis Oncology (NASDAQ: AKTS) is a clinical-stage biotechnology company developing targeted radiopharmaceuticals with the potential to expand precision cancer treatment across a broad range of solid tumors. Its proprietary miniprotein platform uses small, engineered proteins to deliver radiation directly to tumors, combining deep tumor penetration and prolonged retention with rapid clearance from healthy tissues. This approach is designed to address a central challenge in oncology: delivering sufficient treatment to destroy cancer cells while limiting damage to surrounding organs. Aktis is advancing two clinical programs, **AKY-1189** targeting Nectin-4 and **AKY-2519** targeting B7-H3, with potential applications spanning urothelial, breast, prostate, lung, and other cancers. Together, these programs offer multiple opportunities to establish the platform's clinical value and expand its commercial reach.

Aktis enters its next phase of development with substantial financial resources and external support for its technology. The company reported $517.3 million in cash, cash equivalents, and marketable securities as of June 30, 2026, which management expects to fund its operating plan into 2029. Its collaboration with Eli Lilly provided $60 million upfront and includes eligibility for up to $1.2 billion in additional milestone payments, plus royalties, while preserving Aktis' rights to its proprietary pipeline. Preliminary clinical data is expected for AKY-1189 in the first quarter of 2027 and AKY-2519 during 2027, creating identifiable opportunities to assess the platform's therapeutic potential. In our view, the investment opportunity lies in this combination of differentiated drug design, broad development potential, and funding that extends beyond anticipated clinical milestones.

Business Overview

Aktis' proprietary miniprotein radioconjugate platform is designed to deliver actinium-225 (Ac-225), an alpha-emitting radioisotope, to cancer cells to damage their DNA and kill them. Its two lead drug candidates, AKY-1189 and AKY-2519, target the cell-surface proteins Nectin-4 and B7-H3, respectively. In February 2026, the FDA granted Fast Track designation to AKY-1189 for adults with locally advanced or metastatic urothelial cancer who have progressed on or after prior systemic therapies. This designation facilitates closer interaction with the FDA and may help expedite development and review, supporting Aktis's pursuit of a treatment option for patients with limited alternatives.

Aktis has not yet generated revenue from product sales and funds its operations primarily through equity financing and collaboration payments. In January 2026, the company completed its IPO, raising approximately $365.4 million in gross proceeds, including the underwriters' full exercise of their option to purchase additional shares. Its financial backers include MPM BioImpact, Vida Ventures, EcoR1 Capital, Blue Owl Capital, and RA Capital Management. Additionally, Eli Lilly participated as an anchor investor, purchasing approximately $100 million of shares in the IPO, further strengthening its existing relationship with Aktis.

	Milestone	Financing	Key Details
March 2021	Series A	$72M	Co-led by MPM Capital, EcoR1 Capital and Vida Ventures.
August 2022	Series A extension	$84M	Participation from all existing investors; new investors included Merck's MRL Ventures Fund.

May 2024	Eli Lilly Collaboration	$60M upfront	Additional equity investment; eligibility for up to $1.2B in milestone payments and tiered royalties.
September 2024	Series B	$175M	Led by RA Capital; co-led by RTW Investments and Janus Henderson Investors.
January 2026	Initial Public Offering	$365.4M	Gross proceeds at $18 per share, including full exercise of the underwriters' option.

Management

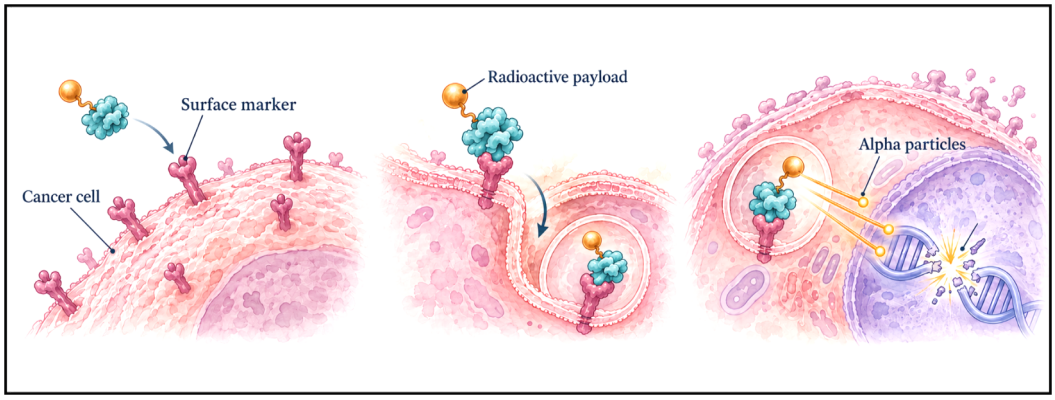
Aktis's team combines experience in drug discovery, clinical development, radiopharmaceutical manufacturing, and biotechnology finance. Members of its leadership have contributed to the approval and commercialization of 14 FDA-approved products. We view this combination as a strength as Aktis advances its pipeline and builds manufacturing capacity. Equity awards held by senior executives also provide incentives tied to shareholder value.

- Matthew Roden, PhD (President and CEO): Previously held senior strategy and business development positions at Bristol Myers Squibb, where he led teams on transactions cumulatively valued at more than $125 billion. Before entering pharmaceutical management, he covered biotechnology as an equity research analyst at UBS and J.P. Morgan. His background brings both scientific and financial expertise to evaluating pipeline opportunities, negotiating partnerships, and communicating Aktis's investment case.
- Kyle Kuvalanka (CFO): Brings more than 20 years of senior leadership experience in biopharmaceuticals. Previously held executive roles at Blueprint Medicines and Syros Pharmaceuticals, where he built finance and business functions and helped guide both companies through their IPOs. His experience is particularly relevant to financing clinical development, managing cash requirements, and evaluating future partnership opportunities.
- Akos Czibere, MD, PhD (Chief Medical Officer): Formerly led Pfizer's hematology-oncology therapeutic area and has been directly involved in the approval of six oncology drugs, including Elrexfio and Talzenna. He oversees Aktis's clinical development activities. His experience leading global registration programs provides a foundation for designing trials and navigating regulatory requirements as Aktis advances its investigational therapies.
- Paul Feldman, PhD (Chief Scientific Officer): Spent more than 27 years at GlaxoSmithKline and contributed to the discovery of five approved drugs. He also co-founded Phoundry Pharmaceuticals, which Intarcia acquired in 2015, and subsequently led discovery and translational medicine at Intarcia. At Aktis, he directs discovery platforms and new radiopharmaceutical candidates, bringing experience in both drug discovery and peptide therapeutics.
- Tyler Benedum, PhD (Chief Technical Officer): Spent more than 16 years at Avid Radiopharmaceuticals, now part of Eli Lilly, ultimately leading chemistry, manufacturing, and controls development and manufacturing. He helped advance the radiopharmaceutical imaging agents Amyvid and Tauvid through approval and commercialization. His experience is particularly relevant to establishing reliable manufacturing and clinical supply for Aktis's radioactive therapies.
- Shulamit Ron-Bigger, PhD (Chief Operating Officer): Previously led strategy and operations for Bristol Myers Squibb's research and early development organization, overseeing portfolio strategy, budgets, and operating models. Her background provides relevant experience for prioritizing programs, coordinating development activities, and allocating resources as Aktis expands its pipeline.

The Science

Miniprotein radioconjugates are small, engineered proteins that carry a radioactive payload to tumors. The miniprotein acts as a delivery vehicle: it recognizes and attaches to a selected protein on cancer cells. The attached radioactive

material then delivers radiation that damages the cells' DNA. Aktis uses actinium-225, which releases powerful alpha particles over a very short distance, only about a few cell widths. This is intended to concentrate cancer-killing radiation around the targeted cells.



Aktis's approach aims to balance three properties: penetrate tumors, remain inside cancer cells, and clear quickly from healthy tissues. Miniproteins are much smaller than antibodies, allowing them to move more readily through tumor tissue. Once they reach their target, they are designed to enter cancer cells and remain there, extending radiation exposure at the tumor while limiting exposure elsewhere. The potential benefit is a more effective treatment at a tolerable dose. Additionally, Aktis can attach an imaging isotope to its miniproteins, allowing doctors to see whether they reach a patient's tumors before therapeutic treatment. This is extremely beneficial as it supports tumor uptake and retention.

Industry Outlook

Oncology remains the pharmaceutical industry's largest therapeutic market, supported by sustained investment in new treatments and expansion into earlier stages of disease. Vision Research Reports estimates that global oncology medicine market reached $356 billion in 2025 and forecasts approximately 10% annual growth over 2026–2034. Innovation is increasingly concentrated in treatments that improve tumor selectivity or engage the immune system, including antibody-drug conjugates, multispecific antibodies, and targeted radiopharmaceuticals. However, at the same time, this expanding opportunity is accompanied by increasingly competitive treatment standards and greater pressure to demonstrate meaningful clinical differentiation.



Aktis operates within several established oncology markets, including urothelial, breast, lung, colorectal, cervical, head and neck, and prostate cancers. Its Nectin-4 program, AKY-1189, benefits from the target validation established by Padcev, while its B7-H3 program, AKY-2519, offers a different targeting approach from PSMA-directed radiopharmaceuticals such as Pluvicto. Pluvicto generated approximately $2.0 billion in 2025 sales, demonstrating the commercial potential of targeted radiotherapy. Aktis has also expanded AKY-2519's clinical development beyond prostate cancer, initiating a second Phase 1b trial in NSCLC and other B7-H3-expressing tumors in October 2026.

In our view, Aktis's commercial opportunity depends on identifying patient populations in which its miniprotein radioconjugates can provide meaningful benefit despite an increasingly effective standard of care. Established drugs demonstrate substantial spending across the company's target indications, but do not establish the size of Aktis's addressable market.

Thesis: Underappreciated Science and Commercial Potential

- We believe Aktis's differentiated tumor targeting and retention justify a more favorable assessment of clinical success than a generic framework would suggest. Our thesis centers on the human evidence already supporting its miniprotein platform: its candidates can reach tumors, remain within them, and clear from healthy tissues. These are essential conditions for delivering an effective radiation dose without unacceptable toxicity. Although therapeutic efficacy remains to be established, treating Aktis solely according to its development stage risks overlooking the uncertainty that its human imaging and dosimetry studies have already reduced.

  AKY-1189 provides the clearest initial evidence. In its first human imaging assessment, all 15 patients evaluable for tumor uptake were uptake-positive, out of 20 patients administered the imaging conjugate. Uptake was observed across urothelial, breast, lung, cervical, and colorectal cancers. Representative imaging with the lutetium-177 conjugate also demonstrated tumor retention through 48 hours, alongside clearance from normal tissues. In eight evaluable patients, median absorbed-dose coefficients were 0.30 Gy/GBq to the kidneys and 0.01 Gy/GBq to bone marrow. These findings support the possibility of maintaining tumor exposure while limiting radiation delivered to organs that could otherwise constrain treatment. The small cohort cannot establish population-wide eligibility or efficacy, but it provides direct human evidence for the drug's intended delivery profile.

  AKY-2519 strengthens this argument by demonstrating a similar delivery profile against a different target, B7-H3. Its initial mCRPC assessment demonstrated tumor retention through at least six days. Using lutetium-177 measurements to model an actinium-225 regimen of four 8 MBq administrations, investigators projected absorbed doses of 1.3 Gy to bone marrow, 4.2 Gy to salivary glands, and 16 Gy to kidneys, with an assumed relative biological effectiveness of five. This separation between tumor retention and normal-organ exposure supports a potential therapeutic window across a second program. These remain surrogate-based projections, but observing favorable delivery characteristics with two different targets strengthens our confidence that the platform's design could have broader application.

  For AKY-1189, the competitive opportunity is particularly compelling in urothelial cancer after existing treatments. Padcev's success has established Nectin-4 as a clinically actionable target, while AKY-1189 introduces a different tumor-killing payload through targeted radiation. We believe this creates a plausible opportunity to treat patients whose tumors remain accessible through Nectin-4 after developing resistance to Padcev's cytotoxic payload. This is a mechanistic hypothesis requiring clinical confirmation, and it makes patients progressing after Padcev a particularly informative population for upcoming studies. Meaningful, durable responses in these patients could establish a differentiated treatment role without requiring immediate displacement of Padcev plus Keytruda in first-line care.

  Patient selection could further improve the development proposition. Aktis's imaging conjugates allow investigators to assess whether the drug reaches a patient's tumors before therapeutic administration. This matters because target expression is heterogeneous: a published study found absent membranous Nectin-4 expression in 39.4% of the metastatic urothelial specimens examined. Imaging offers a way to identify patients with sufficient uptake despite this variability. Our inference is that selecting patients on demonstrated delivery could improve the likelihood of detecting a meaningful therapeutic signal. Such selection would also narrow the eligible population, making observed uptake rates an essential input into commercial forecasts.

  AKY-2519 adds a complementary competitive opportunity because it targets B7-H3, whereas Pluvicto targets PSMA. Aktis is studying AKY-2519 in both Pluvicto-naïve and Pluvicto-experienced patients. Activity following Pluvicto would be particularly valuable evidence that the program can serve a distinct treatment need. We therefore

view the second program as an additional opportunity to establish clinical differentiation, while recognizing that shared platform characteristics also create correlated development risks.

The financial significance lies in the sensitivity of early-stage drug valuations to changing success probabilities. For every $1 billion of commercial present value conditional on success, a five-percentage-point increase in approval probability adds $50 million of risk-adjusted value, before changes in spending assumptions. We believe Aktis's human delivery evidence provides a concrete basis for considering such an upward revision as therapeutic data emerge. Preliminary AKY-1189 results are expected in the first quarter of 2027, followed by preliminary AKY-2519 mCRPC data during 2027. Confirmed, durable responses at repeatable doses would connect the existing targeting evidence to clinical benefit and provide the strongest basis for a higher valuation.

- AI drug discovery research provides an additional reason to examine whether conventional development benchmarks fully capture Aktis's potential. In a 2024 Drug Discovery Today study, Jayatunga and colleagues reported that 21 of 24 AI-discovered molecules completing Phase I were successful (87.5%) compared with historical industry benchmarks of approximately 40–65%. The finding suggests that AI-assisted discovery may help identify molecules with properties favorable to early clinical development.

  The study is relevant as Aktis documents using AI for target selection, miniprotein design, and candidate optimization, integrated with laboratory screening and proprietary experimental data. Our interpretation is that this discovery approach provides supporting context for the platform's scientific differentiation. The study's 87.5% figure should not be assigned directly to Aktis. Instead, it strengthens the rationale for investigating whether Aktis's actual molecular and clinical characteristics support better outcomes than broad historical averages imply.

- Additionally, we believe Aktis's current valuation may understate the commercial implications of its scientific differentiation. If the tumor delivery and retention observed in early human assessments translate into durable responses at tolerable doses, AKY-1189 and AKY-2519 could establish meaningful treatment roles across multiple cancer indications. Our mispricing thesis therefore concerns both the probability of successful development and the revenue opportunity that clinically differentiated therapies could capture. Demonstrating this opportunity requires translating the platform's scientific promise into explicit commercial assumptions. We begin by estimating eligible patient populations, treatment access, market penetration, expected doses, and net pricing under different adoption scenarios. We then apply development probabilities, commercialization timelines, and associated costs to assess the present value attributable to shareholders. This framework allows us to evaluate whether the commercial prospects supported by our interpretation of the science justify a valuation above the current share price.

Modeled Revenues

Our valuation framework begins with an indication-level assessment of Aktis Oncology's commercial opportunity across AKY-1189 and AKY-2519. For each indication, we estimate the population entering the relevant treatment line and apply successive adjustments for clinical eligibility, target expression or tumor uptake, screening, treatment access, and market penetration. We then multiply the resulting treated population by expected doses received and an assumed net price of $45,000 per dose, expressed in 2026 dollars.

- Our price of $45,000 is benchmarked against Pluvicto's published price of approximately $51,168 per dose. Applying a 10–15% discount produces a range of approximately 43,500–46,100, supporting $45,000 as a reasonable central assumption. This approach anchors our forecast to an established radiopharmaceutical while avoiding reliance on a premium price for Aktis's investigational technology. On a six-administration basis, Aktis's drug cost would total $270,000, approximately $37,000 below six doses of Pluvicto at its published list price. Padcev provides an additional benchmark for AKY-1189's potential positioning in advanced urothelial

cancer at approximately $300,424, about $30,000 above the six-dose Aktis course. This potential pricing strengthens Aktis's commercial proposition if AKY-1189 delivers competitive, durable clinical benefit through a limited treatment course. A lower total drug cost can support payer negotiations and adoption in indications and treatment settings where it becomes an approved alternative. Furthermore, this pricing for Aktis's therapy represents a hypothetical full course while our model uses expected doses received, amounts generally lower than the maximum six doses.

The following tables present four commercial adoption scenarios: Conservative, Moderate, Strong, and Exceptional. These scenarios describe market penetration conditional on successful development and approval; they do not represent the probability that approval occurs. Under the supplied assumptions, modeled annual revenue ranges from approximately $813 million to $4.66 billion for second-line and later treatment alone, and from $2.28 billion to $15.52 billion when first-line treatment is included. The combined estimates incorporate the model's adjustment for reduced later-line treatment among patients already treated in first line.

These revenue estimates establish the commercial foundation for the valuation. To translate that opportunity into an investment assessment, we subsequently apply development probabilities, adjust prices to the year in which revenue is generated, and account for the timing and costs of commercialization. This approach distinguishes the potential scale of the portfolio from the portion of that opportunity attributable to shareholders today.

- Treatment lines describe the sequence in which therapies are used within a particular disease setting. First-line treatment (1L) is the initial treatment regimen used in that setting, while second-line and later treatment (2L+) includes subsequent regimens, typically given after an earlier treatment stops working or cannot be tolerated. These terms refer to treatment sequence, rather than cancer stage. The 2L+ table estimates annual revenue assuming Aktis's therapies are approved only for second-line and later use. The combined 1L & 2L+ table estimates the broader opportunity if approval also encompasses first-line treatment, incorporating an adjustment to reduce double counting of patients treated across multiple lines.

Modeled 2L+ Peak Annual Revenue by Commercial Adoption Scenario ($M)

Indication	Conservative	Moderate	Strong	Exceptional
		AKY-1189		
Urothelial	**36**	**72**	**108**	**144**
Breast (TNBC)	**22**	**50**	**79**	**108**
Breast (HR+)	**48**	**121**	**217**	**314**
NSCLC	**102**	**255**	**458**	**662**
Head and neck	**17**	**39**	**61**	**84**
Cervical	**1**	**1**	**2**	**3**
Esophageal	**3**	**6**	**10**	**14**
Colorectal	**46**	**92**	**184**	**277**
		AKY-2519		
mCRPC	**214**	**500**	**785**	**1,070**
NSCLC	**170**	**425**	**764**	**1,104**
SCLC	**31**	**72**	**113**	**154**
Head and neck	**20**	**46**	**72**	**98**
Esophageal	**6**	**13**	**21**	**28**
Colorectal	**100**	**200**	**399**	**599**
Total Modeled Revenue	**813**	**1,891**	**3,274**	**4,657**

Modeled 1L & 2L+ Peak Annual Revenue by Commercial Adoption Scenario ($M)

Indication	Conservative	Moderate	Strong	Exceptional
		AKY-1189		
Urothelial	**117**	**312**	**541**	**726**
Breast (TNBC)	**64**	**153**	**260**	**363**
Breast (HR+)	**120**	**262**	**566**	**934**
NSCLC	**260**	**725**	**1,388**	**2,194**
Head and neck	**70**	**170**	**295**	**418**
Cervical	**2**	**5**	**9**	**13**
Esophageal	**10**	**25**	**43**	**61**
Colorectal	**107**	**213**	**483**	**749**
		AKY-2519		
mCRPC	**630**	**1,505**	**2,532**	**3,504**
NSCLC	**427**	**1,185**	**2,257**	**3,545**
SCLC	**137**	**335**	**582**	**824**
Head and neck	**81**	**199**	**344**	**487**
Esophageal	**20**	**49**	**85**	**120**
Colorectal	**231**	**458**	**1,030**	**1,583**
Total Modeled Revenue	**2,276**	**5,596**	**10,416**	**15,520**

Our valuation incorporates two layers of probability weighting: the likelihood of achieving a particular approval outcome and the distribution of commercial performance conditional on that outcome. For each modeled asset-indication opportunity, we assign a **20% probability to approval limited to second-line and later treatment**, a separate **10% probability to broader approval encompassing first-line and later treatment**, and a **70% probability to neither modeled approval outcome**. Throughout this analysis, "1L+" refers to the combined first-line-and-later opportunity.

These outcomes are mutually exclusive. The 20% weight applies to the 2L+-only revenue opportunity, while the 10% weight applies to the combined 1L+ opportunity. Together, they imply a 30% probability of achieving some form of modeled approval. These are analyst assumptions measured from the current development stage, rather than probabilities conditional on an already successful Phase 1 trial. The odds of approval represent a substantial premium to historical oncology development outcomes. BIO, Informa, and QLS reported a 5.3% probability of approval from Phase 1 for oncology programs during 2011–2020, including 4.6% for solid-tumor programs. The corresponding oncology probability from Phase 2 was 10.8%. These figures provide historical reference points, although they do not separately estimate the likelihood of first-line versus later-line approval. Our assumptions therefore reflect a differentiated investment judgment rather than established industry success rates.

Our rationale for assigning above-average probabilities rests principally on patient selection and evidence of tumor delivery. Aktis' platform allows clinicians to visualize tumor uptake before administering the therapeutic radioisotope, potentially reducing uncertainty about whether treatment reaches its intended target. Historical evidence supports the relevance of patient selection: the same BIO study reported Phase 1-to-approval rates of 15.9% for programs employing patient-preselection biomarkers, compared with 7.6% for programs without them. These results span therapeutic areas and support the direction of our adjustment, while leaving the magnitude of the assumed premium subject to analyst judgment.

Program-specific evidence provides additional support. Nectin-4 is clinically validated as a therapeutic target in urothelial cancer through Padcev, and Aktis has reported human imaging evidence of AKY-1189 tumor uptake. For

AKY-2519, its 2026 ASCO disclosures reported tumor uptake and retention alongside favorable predicted normal-tissue radiation exposure.

The smaller probability assigned to broader first-line approval reflects the additional challenge of competing against effective established regimens. In urothelial cancer, for example, Padcev plus Keytruda demonstrated median overall survival of 31.5 months versus 16.1 months with chemotherapy in its pivotal first-line trial. Moving into this setting requires evidence supporting a compelling role alongside or against existing treatment, making first-line expansion a more demanding development objective.

Within each successful approval outcome, we apply a distinct distribution across the Conservative, Moderate, Strong, and Exceptional commercial adoption scenarios. For 2L+-only approval, the respective weights are 20%, 45%, 25%, and 10%. For combined 1L+ approval, the weights are 5%, 30%, 45%, and 20%.

Commercial adoption scenario	2L+-only annual revenue ($M)	Conditional weight	Combined 1L+ annual revenue ($M)	Conditional weight
Conservative	813.5	20%	2,275.6	5%
Moderate	1,890.8	45%	5,596.3	30%
Strong	3,274.1	25%	10,415.7	45%
Exceptional	4,657.3	10%	15,520.1	20%
Conditional weighted revenue	**2,297.8**	**100%**	**9,583.8**	**100%**

Calculations use the supplied unrounded revenue totals and 2026 prices. Conditional weights describe commercial performance assuming the relevant approval outcome occurs.

The greater weighting toward Strong and Exceptional adoption in the first-line-inclusive scenario reflects our assumption that successful expansion into earlier treatment would be associated with a more compelling clinical profile and stronger competitive positioning. Strong and Exceptional outcomes collectively receive a 65% conditional weight under 1L+ approval, compared with 35% under 2L+-only approval. These distributions represent assumptions about commercial performance following approval; first-line approval itself does not guarantee exceptional uptake.

Applying the commercial scenario weights produces conditional expected annual revenue of approximately $2.30 billion under 2L+-only approval and $9.58 billion under combined 1L+ approval. We then apply the separate approval probabilities:

Expected annual revenue = (20% × $2,297.821 million) + (10% × $9,583.795 million).

The resulting **$1.42 billion in expected annual revenue** incorporates both clinical-development uncertainty and variation in commercial adoption. It preserves the treatment-overlap adjustment already embedded in the combined 1L+ estimates. The higher revenue contribution from the first-line-inclusive outcome reflects its larger commercial opportunity and its greater conditional weighting toward strong adoption.

Pricing represents an additional source of potential revenue growth. The model's $45,000 net price per dose is expressed in 2026 dollars, while commercialization and broader adoption would occur in future years. Pluvicto provides a relevant historical reference: its reported U.S. launch wholesale acquisition cost was $42,500 per dose in March 2022, while Novartis lists a price of $51,168.13 effective January 7, 2026. This represents a cumulative increase of approximately 20.4%, equivalent to roughly 5.0% annually over 3.79 years. However, list-price increases do not necessarily translate into equivalent growth in manufacturer net revenue. Merck's historical disclosures illustrate this distinction:

Year	U.S. portfolio list-price change	U.S. portfolio net-price change
2019	+4.3%	+1.8%
2020	+3.1%	−0.9%
2021	+4.4%	+1.7%
2022	+4.4%	+4.3%
2023	+4.5%	+4.4%

Source: Merck's 2023 Pricing Action. These are portfolio-level observations rather than Keytruda-specific increases.

We assume **3% annual net-price growth**, below Pluvicto's observed list-price growth but above the approximately 2.2% compounded annual increase implied by Merck's reported 2019–2023 net-price changes. This is a modeling judgment informed by historical observations, rather than an established radiopharmaceutical industry average. Before commercialization, it represents escalation of the assumed future launch price; after commercialization, it represents growth in realized net pricing. However, competition, discounts, and Medicare inflation-rebate obligations could restrict actual increases.

Holding patient populations, treatment access, doses, market penetration, and probability weights constant, 3% annual net-price growth increases expected annual revenue from $1.42 billion at 2026 prices to approximately $1.91 billion in 2036:

Under the 3% assumption, price escalation adds approximately **$487.7 million in annual revenue** relative to holding prices flat. This quantifies the potential conservatism of a constant nominal-price forecast while separating the contribution from pricing from changes in clinical success or commercial adoption. The 2036 illustration does not independently establish when the portfolio would achieve the modeled penetration levels.

Risk-Adjusted Net Present Value Calculations

To translate the probability-weighted commercial opportunity into present value, we apply a risk-adjusted net present value framework that incorporates commercialization timing, cash-flow conversion, remaining development expenditure, and the portfolio's modeled economic life. The preceding 2036 pricing illustration represents the mature revenue opportunity expressed at future prices. Our annual cash-flow forecast separately accounts for the time required to launch each indication and achieve the assumed market penetration.

We assume initial later-line commercialization of AKY-1189 in urothelial cancer in 2031 and AKY-2519 in prostate cancer in 2032. Other modeled indications launch in 2033 and 2034, respectively. Under the broader approval outcome, the incremental first-line contribution begins two years after the corresponding later-line launch. These dates are analyst assumptions rather than company guidance.

Following each launch, revenue reaches 5%, 15%, 30%, 50%, 70%, 85%, and 100% of the applicable mature commercial opportunity over seven selling years. The first-line contribution follows its own delayed adoption schedule, bringing the entire modeled portfolio to mature penetration in 2042. The combined 1L+ forecast preserves the treatment-overlap adjustment embedded in the underlying revenue estimates.

The assumed net price of $45,000 per dose increases by 3% annually from its 2026 base (P_t=45,000 x $(1.03)^{t-2026}$).

Here, P_t represents the modeled net price per dose in year t. Before commercialization, this adjustment increases the assumed future launch price; after commercialization, it represents annual growth in realized net pricing. This price escalation is incorporated into the annual revenue forecasts before discounting.

We then convert commercial revenue into cash flow using an assumed **45% after-tax cash-flow margin**. This margin incorporates manufacturing and isotope costs, distribution, selling expenses, royalties, ongoing commercial research and development, and sustaining investment. Separately modeled development expenditure and unallocated corporate overhead are deducted outside this margin.

We extend the forecast through 2047 to capture the portfolio's modeled commercial life. Aktis' disclosures identify expected 2044 expiration dates for relevant AKY-1189 patents and applications, and for AKY-2519 applications if patents are issued, excluding potential patent-term adjustments or extensions. These disclosures provide a reference point for our economic-life assumptions rather than establishing a guaranteed date of competitive entry. We maintain mature penetration through 2044, then apply revenue-retention factors of 50%, 25%, and 10% in 2045, 2046, and 2047, respectively, relative to the otherwise projected revenue in each year. We assign no residual value after 2047. This erosion schedule is an informed assumption.

Next, cash flows are discounted at a **12% nominal annual rate**, using 2026 as the valuation base year. The clinical probabilities account for the expected loss of commercial cash flows from unsuccessful development. The discount rate serves a separate purpose: compensating investors for waiting and for exposure to market-related risks that remain after probability weighting. Clinical failure should therefore not receive a second adjustment through an additional failure premium in the discount rate.

The selection of exactly 12% remains a modeling judgment; it has not been established through an Aktis-specific cost-of-capital calculation. Because both the revenue forecast and discount rate are nominal, the model incorporates 3% price growth in cash flows while retaining the full nominal discount rate.

The pipeline valuation is calculated as:

$$\text{rNPV} = -D_{2026} + \sum_{t=2027}^{2047} \frac{0.20CF_{2L+,t} + 0.10CF_{1L+,t} - \mathbb{E}[Dt]}{(1.12)^{t-2026}}$$

In this equation:

- D_{2026} represents development spending in the starting year, thus why it was subtracted upfront.
- $CF_{2L+,t}$ represents commercial cash flow in year t under the later-line-only outcome, weighted across its commercial adoption scenarios.
- $CF_{1L+,t}$ represents commercial cash flow under the combined first-line-and-later outcome, using its separate commercial scenario weights.
- $\mathbb{E}[D_t]$ represents expected development expenditure in year t, adjusted for the probability of incurring that expenditure.

The commercial cash-flow terms aggregate the modeled asset-indication opportunities and already incorporate launch timing, adoption, price growth, revenue erosion, and the 45% cash-flow margin. The 20% and 10% approval probabilities are applied once. These probabilities operate at the asset-indication level and do not imply that the entire portfolio must succeed or fail together.

The development budget includes $30 million of immediate remaining 2026 expenditure, followed by expected spending of $120 million in 2027, $120 million in 2028, $104.5 million in 2029, $88 million in 2030, $45 million in 2031, and $24 million in 2032. These annual amounts are already probability-weighted. Development spending is

adjusted for the likelihood of reaching the stage at which costs arise, since expenditure can occur even when a program ultimately fails.

At a 12% discount rate, the present value of expected commercial cash flows is approximately **$1,582.4 million**, while the present value of modeled development expenditure, including the immediate 2026 amount, is **$400.8 million**. The resulting pipeline rNPV is approximately $1.182 billion.

To translate pipeline value into equity value, we add $517.3 million of cash, cash equivalents, and marketable securities reported as of June 30, 2026, and subtract a $100 million present-value allowance for unallocated corporate overhead. The cash balance is a dated reported figure and has not yet been reduced for subsequent cash use. No separate value is assigned to additional platform programs or future Lilly collaboration proceeds, all potential sources of significant upside.

Valuation component	Value ($M)
Present value of expected commercial cash flows	1,582.4
Less: present value of expected development expenditure	(400.8)
Pipeline rNPV	**1,181.6**
Add: cash, cash equivalents, and marketable securities	517.3
Less: present value of unallocated corporate overhead	(100.0)
Provisional equity value	**1,598.9**

Under these assumptions, the model indicates a **provisional equity value of approximately $1.60 billion, or $28.75 per share**. The reported 55.62 million outstanding shares were used as the denominator.

Addressing Key Investor Concerns

Concern	Assessment
How defensible is Aktis's intellectual property?	Aktis's IP protection centers on its proprietary molecules and their uses. In its 2025 Form 10-K, the company disclosed one issued U.S. patent covering AKY-1189 and related pending applications, while AKY-2519's applications remained pending as of March 1, 2026. The disclosed patent families have expected expirations in 2044, excluding potential adjustments or extensions.

Could dilution undermine shareholder returns?	Aktis reported $517.3 million in cash, cash equivalents, and marketable securities as of June 30, 2026, with management expecting its operating plan to be funded into 2029. This provides financial flexibility, although the estimate depends on spending assumptions and does not establish that the company is funded through commercialization. Favorable clinical results could allow Aktis to raise a given amount with fewer new shares. Additional non-dilutive funding can also come from milestone payments under Aktis's collaboration with Eli Lilly, contingent on specified development, regulatory, and commercial achievements within the partnered programs.
Could encouraging early data fail to translate into approval?	Yes. Tumor uptake and favorable radiation-distribution measurements help establish whether a radioconjugate reaches its intended target, but they do not independently demonstrate durable tumor responses or improved survival. While Aktis's early AKY-1189 evidence includes preclinical studies and investigator-led human imaging and dosimetry assessments, therapeutic efficacy and repeated-dose safety stand as central uncertainties and highlight the risk that comes along with biotechnology investing.
Can Aktis compete with established treatments?	An initial commercial opportunity does not require Aktis to replace an established first-line regimen. The company is developing AKY-1189 for patients with advanced urothelial cancer, including a setting where patients progressing after therapies such as Padcev have limited options. This creates a potential entry point in later-line disease, provided Aktis demonstrates a clinically meaningful benefit. Its use of a radioactive payload offers a different therapeutic mechanism. Full commercial adoption would depend on efficacy, tolerability, treatment logistics, and the competing options available at launch.
Is isotope supply an issue?	Actinium-225 access is a material operating consideration. Aktis has announced supply agreements with NorthStar, Niowave, and TerraPower, using suppliers with different production approaches. This diversification provides a reasonable basis for reducing dependence on any single source. Furthermore, the company also reported plans for an internal GMP manufacturing facility to become operational in the second half of 2026 as part of its broader manufacturing strategy.

Investment Strategy

Our estimated intrinsic value of $28.75 per share represents approximately 55.2% upside from the $18.52 reference share price used in this report. This estimate reflects the present value of Aktis's future cash flows under our probability-weighted assumptions and provides the valuation basis for our Buy recommendation. We believe the gap between market price and modeled value offers an attractive opportunity to invest ahead of clinical evidence. However, $28.75 is **not** a forecast that the shares will reach that price within a specific timeframe. There remains a high risk and high reward setup, although we believe that this is an opportune time to invest with a positive expected return under our calculations.

The overall investment strategy is to establish a long position in Aktis Oncology ahead of clinical milestones that could prompt investors to reassess its probability of success. The investment rests on the view that Aktis's molecular design, preliminary human delivery evidence, and approach to patient selection justify greater confidence than conventional development-stage benchmarks imply. We seek to capture the difference between the clinical prospects reflected in the share price and our own probability-weighted assessment.

Biotechnology's sensitivity to clinical information creates an additional consideration for implementation. When valuation depends heavily on uncertain future outcomes, changing expectations can produce substantial price movements. Investor enthusiasm, fear, and positioning may amplify these movements, potentially creating temporary discrepancies between market price and fundamental value. However, volatility alone does not establish an investment advantage. Our strategy requires a favorable relationship between the probability and magnitude of potential gains and the corresponding downside.

Within this broader long thesis, we identify a tactical opportunity over the next six months, centered on the preliminary AKY-1189 Phase 1b results expected in the first quarter of 2027. The AI discovery research discussed earlier, which reported Phase I success for 21 of 24 molecules completing that stage, provides supporting context for our confidence. Its observed 87.5% success rate does not establish an Aktis-specific probability but strengthens the rationale for examining whether conventional benchmarks understate the potential of differentiated discovery approaches. Considered alongside Aktis's preliminary human delivery evidence and approach to patient selection, these findings support our conviction in the prospect of favorable early clinical results. A readout demonstrating meaningful antitumor activity and acceptable tolerability would, in our assessment, likely support an upward reassessment of the program's value, particularly if the findings exceed expectations already reflected in the share price.

We would therefore initiate a position ahead of the readout, preserving additional capital as evidence develops. If favorable results produce a meaningful price increase, we would seek to sell a modest portion of the position into that strength, promptly realizing gains while retaining a core holding for subsequent development milestones. The size of this reduction would depend on the magnitude of appreciation relative to the improvement in our valuation, as well as personal risk tolerance. This approach combines participation in a potential near-term repricing with continued exposure to the platform's longer-term clinical and commercial prospects.

Additionally, when making exit decisions after-tax returns must also be considered. For U.S. individual investors in taxable accounts, selling appreciated shares within our proposed six-month window would generally generate short-term capital gains, with net short-term gains taxed at ordinary income rates. Gains on shares held for more than one year generally qualify for potentially lower federal long-term capital-gains rates. Before reducing exposure, we would weigh the potential tax savings from extending the holding period against the expected return and downside risk of continued ownership. This consideration supports selectively realizing gains following a favorable catalyst while retaining a core position when the thesis and valuation remain attractive. Tax efficiency would inform the timing and size of sales but would not justify maintaining an overvalued position or delaying an exit after material deterioration in the clinical outlook. Similarly, tax-lot selection when reducing the position must also be considered to maximize possible returns.

Lastly, following the initial readout, additional investment would depend on response magnitude, durability, repeat-dose tolerability, and the valuation available after the results. Stronger evidence could justify a higher valuation and continued ownership, while market enthusiasm that outpaces improvements in fundamentals would support more substantial profit-taking. However, inadequate therapeutic activity or an unfavorable safety profile would trigger reassessment and potentially an exit. The remaining position would be held according to its prospective return and risk, with partial sales reducing overall exposure without eliminating the downside of the shares retained.

We believe Aktis's breakthrough science and financial foundation position it to advance cancer treatment, create long-term shareholder value, and improve the lives of patients worldwide.

Appendix

The following tables present the assumptions and calculations underlying the modeled revenue opportunities. First-line treatment (1L) and second-line and later treatment (2L+) are calculated separately. Because patients receiving first-line therapy may subsequently enter later treatment lines, simply adding these estimates could count the same patient more than once. The combined estimate therefore reduces later-line revenue to account for assumed prior treatment with the same Aktis therapy:

Combined annual revenue = First-line revenue + [Later-line revenue × (1 − First-line treatment penetration)]

First-line treatment penetration = Clinical/label eligibility × Target/uptake eligibility × Screening/testing rate × Treatment access × Market share

A separate consideration is overlap between AKY-1189 and AKY-2519 in shared modeled indications, including NSCLC, head and neck, esophageal, and colorectal cancers. AKY-1189 and AKY-2519 are modeled separately using drug-specific clinical/label eligibility and target/uptake assumptions. These differences reflect the view that patients within a shared cancer indication are not necessarily eligible for both therapies: a patient who qualifies for one program may not qualify for the other. Accordingly, the model retains these separate eligibility filters without applying an additional cross-drug overlap deduction. This approach assumes that the distinct eligibility requirements meaningfully differentiate the addressable populations. However, different eligibility percentages do not establish that the populations are mutually exclusive.

The percentages in Tables A1–A4 estimate the proportion of patients progressing from the starting population to treatment with Aktis's therapies. They serve as modeling assumptions where definitive data are unavailable.

- Cancer subtype: The share of the starting population belonging to the relevant disease subtype.
- Treatment-line entry: The share receiving 1L or 2L+ treatment, allowing for patients who never begin treatment or do not reach later lines.
- Clinical/label eligibility: A proportion meeting anticipated treatment requirements, including prior therapies, organ function, and overall fitness.
- Target/uptake eligibility: A proportion with sufficient Nectin-4 or B7-H3 availability and tumor uptake, allowing for biological differences across indications.
- Screening/testing: A testing rate that allows for incomplete adoption of diagnostic or imaging assessments.
- Treatment access: An access rate reflecting potential reimbursement, referral, and treatment-center constraints.
- Market share: An adoption rate among eligible, screened, and accessible patients, increasing across scenarios with stronger clinical benefit.

Assumptions were selected to reflect differences in disease biology, treatment progression, anticipated eligibility, and practical access across indications. Where definitive data are unavailable, inputs represent estimates. The four adoption scenarios capture a range of potential commercial outcomes, providing a transparent framework for updating projections as clinical evidence develops.

Annual revenue = Patient population × Subtype percentage × Treatment-line entry × Clinical/label eligibility × Target/uptake eligibility × Screening/testing rate × Treatment access × Market share × Average doses × Net price per dose

Table A1. Estimated U.S. Peak Annual Revenue Assuming Conservative Clinical Benefit

	annual patient population		cancer subtype percentage		percentage starting the modeled treatment line		clinical/label eligbility		target/uptake eligibility	
	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+
AKY-1189										
urothelial	20,000	20000	100.0%	100.0%	70.0%	28.0%	80.0%	70.0%	60.0%	50.0%
breast (TNBC)	53168	53168	15.0%	15.0%	90.0%	50.5%	85.0%	75.0%	50.0%	50.0%
breast (HR+)	53168	53168	70.0%	70.0%	95.0%	61.8%	85.0%	60.0%	30.0%	30.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	40.0%	40.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	40.0%	40.0%
cervical	4991	4991	20.0%	20.0%	75.0%	33.8%	85.0%	75.0%	25.0%	25.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	30.0%	30.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	30.0%	30.0%
AKY-2519										
mCRPC	45613	45613	100.0%	100.0%	90.0%	48.2%	80.0%	70.0%	75.0%	75.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	60.0%	60.0%
SCLC	26244	26244	100.0%	100.0%	85.0%	34.0%	80.0%	65.0%	55.0%	55.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	50.0%	50.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	60.0%	60.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	65.0%	65.0%

screening/testing rate		treatment access		market share		average doses received		net price per dose		annual revenue		
1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L and 2L+
80.0%	80.0%	85.0%	85.0%	10.0%	20.0%	4	3	$45,000.00	$45,000.00	$82,252,800	$35,985,600	$117,063,830
85.0%	80.0%	85.0%	80.0%	10.0%	15.0%	4.3	3.3	$45,000.00	$45,000.00	$42,647,330	$21,526,623	$63,512,951
85.0%	80.0%	85.0%	80.0%	5.0%	10.0%	4.9	4.05	$45,000.00	$45,000.00	$71,817,222	$48,250,892	$119,623,632
80.0%	75.0%	85.0%	80.0%	5.0%	10.0%	4.1	3.07	$45,000.00	$45,000.00	$159,019,245	$101,829,529	$259,948,602
80.0%	75.0%	80.0%	75.0%	10.0%	15.0%	3.8	2.8	$45,000.00	$45,000.00	$53,111,013	$16,767,804	$69,535,413
75.0%	70.0%	75.0%	70.0%	10.0%	15.0%	4	3	$45,000.00	$45,000.00	$1,610,767	$626,778	$2,230,053
75.0%	70.0%	80.0%	75.0%	10.0%	15.0%	3.8	2.72	$45,000.00	$45,000.00	$7,419,288	$2,718,388	$10,100,978
80.0%	75.0%	80.0%	75.0%	5.0%	10.0%	4.2	3.2	$45,000.00	$45,000.00	$61,082,910	$46,084,874	$106,835,973
90.0%	85.0%	90.0%	85.0%	10.0%	15.0%	4.75	3.8	$45,000.00	$45,000.00	$426,455,323	$214,082,151	$630,133,081
85.0%	80.0%	85.0%	80.0%	5.0%	10.0%	4.2	3.2	$45,000.00	$45,000.00	$259,618,310	$169,826,447	$427,052,115
80.0%	70.0%	80.0%	75.0%	10.0%	15.0%	3.8	2.72	$45,000.00	$45,000.00	$107,418,162	$30,748,007	$137,300,305
75.0%	70.0%	80.0%	75.0%	10.0%	15.0%	3.8	2.8	$45,000.00	$45,000.00	$62,239,469	$19,562,438	$81,332,408
75.0%	70.0%	80.0%	75.0%	10.0%	15.0%	3.8	2.82	$45,000.00	$45,000.00	$14,838,576	$5,636,658	$20,323,044
80.0%	75.0%	80.0%	75.0%	5.0%	10.0%	4.2	3.2	$45,000.00	$45,000.00	$132,346,305	$99,850,560	$230,639,197

Table A2. Estimated U.S. Peak Annual Revenue Assuming Moderate Clinical Benefit

	annual patient population		cancer subtype percentage		percentage starting the modeled treatment line		clinical/label eligbility		target/uptake eligibility	
	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+
AKY-1189										
urothelial	20,000	20000	100.0%	100.0%	70.0%	28.0%	80.0%	70.0%	60.0%	50.0%
breast (TNBC)	53168	53168	15.0%	15.0%	90.0%	50.5%	85.0%	75.0%	50.0%	50.0%
breast (HR+)	53168	53168	70.0%	70.0%	95.0%	61.8%	85.0%	60.0%	30.0%	30.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	40.0%	40.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	40.0%	40.0%
cervical	4991	4991	20.0%	20.0%	75.0%	33.8%	85.0%	75.0%	25.0%	25.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	30.0%	30.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	30.0%	30.0%
AKY-2519										
mCRPC	45613	45613	100.0%	100.0%	90.0%	48.2%	80.0%	70.0%	75.0%	75.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	60.0%	60.0%
SCLC	26244	26244	100.0%	100.0%	85.0%	34.0%	80.0%	65.0%	55.0%	55.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	50.0%	50.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	60.0%	60.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	65.0%	65.0%

screening/testing rate		treatment access		market share		average doses received		net price per dose		annual revenue		
1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L and 2L+
80.0%	80.0%	85.0%	85.0%	30.0%	40.0%	4	3	$45,000.00	$45,000.00	$246,758,400	$71,971,200	$311,682,180
85.0%	80.0%	85.0%	80.0%	25.0%	35.0%	4.3	3.3	$45,000.00	$45,000.00	$106,618,324	$50,228,787	$152,991,267
85.0%	80.0%	85.0%	80.0%	10.0%	25.0%	4.9	4.05	$45,000.00	$45,000.00	$143,634,443	$120,627,229	$262,039,266
80.0%	75.0%	85.0%	80.0%	15.0%	25.0%	4.1	3.07	$45,000.00	$45,000.00	$477,057,736	$254,573,824	$724,880,262
80.0%	75.0%	80.0%	75.0%	25.0%	35.0%	3.8	2.8	$45,000.00	$45,000.00	$132,777,533	$39,124,876	$169,899,216
75.0%	70.0%	75.0%	70.0%	25.0%	35.0%	4	3	$45,000.00	$45,000.00	$4,026,918	$1,462,482	$5,445,697
75.0%	70.0%	80.0%	75.0%	25.0%	35.0%	3.8	2.72	$45,000.00	$45,000.00	$18,548,220	$6,342,906	$24,677,053
80.0%	75.0%	80.0%	75.0%	10.0%	20.0%	4.2	3.2	$45,000.00	$45,000.00	$122,165,820	$92,169,748	$213,008,324
90.0%	85.0%	90.0%	85.0%	25.0%	35.0%	4.75	3.8	$45,000.00	$45,000.00	$1,066,138,306	$499,525,020	$1,504,971,036
85.0%	80.0%	85.0%	80.0%	15.0%	25.0%	4.2	3.2	$45,000.00	$45,000.00	$778,854,931	$424,566,116	$1,185,476,230
80.0%	70.0%	80.0%	75.0%	25.0%	35.0%	3.8	2.72	$45,000.00	$45,000.00	$268,545,404	$71,745,350	$335,239,881
75.0%	70.0%	80.0%	75.0%	25.0%	35.0%	3.8	2.8	$45,000.00	$45,000.00	$155,598,671	$45,645,689	$198,505,619
75.0%	70.0%	80.0%	75.0%	25.0%	35.0%	3.8	2.82	$45,000.00	$45,000.00	$37,096,441	$13,152,201	$49,360,869
80.0%	75.0%	80.0%	75.0%	10.0%	20.0%	4.2	3.2	$45,000.00	$45,000.00	$264,692,610	$199,701,121	$458,163,056

Table A3. Estimated U.S. Peak Annual Revenue Assuming Strong Clinical Benefit

	annual patient population		cancer subtype percentage		percentage starting the modeled treatment line		clinical/label eligbility		target/uptake eligibility	
	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+
AKY-1189										
urothelial	20,000	20000	100.0%	100.0%	70.0%	28.0%	80.0%	70.0%	60.0%	50.0%
breast (TNBC)	53168	53168	15.0%	15.0%	90.0%	50.5%	85.0%	75.0%	50.0%	50.0%
breast (HR+)	53168	53168	70.0%	70.0%	95.0%	61.8%	85.0%	60.0%	30.0%	30.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	40.0%	40.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	40.0%	40.0%
cervical	4991	4991	20.0%	20.0%	75.0%	33.8%	85.0%	75.0%	25.0%	25.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	30.0%	30.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	30.0%	30.0%
AKY-2519										
mCRPC	45613	45613	100.0%	100.0%	90.0%	48.2%	80.0%	70.0%	75.0%	75.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	60.0%	60.0%
SCLC	26244	26244	100.0%	100.0%	85.0%	34.0%	80.0%	65.0%	55.0%	55.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	50.0%	50.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	60.0%	60.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	65.0%	65.0%

screening/testing rate		treatment access		market share		average doses received		net price per dose		annual revenue		
1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L and 2L+
80.0%	80.0%	85.0%	85.0%	55.0%	60.0%	4	3	$45,000.00	$45,000.00	$452,390,400	$107,956,800	$540,966,795
85.0%	80.0%	85.0%	80.0%	45.0%	55.0%	4.3	3.3	$45,000.00	$45,000.00	$191,912,983	$78,930,952	$259,937,404
85.0%	80.0%	85.0%	80.0%	25.0%	45.0%	4.9	4.05	$45,000.00	$45,000.00	$359,086,108	$217,129,012	$566,214,293
80.0%	75.0%	85.0%	80.0%	30.0%	45.0%	4.1	3.07	$45,000.00	$45,000.00	$954,115,471	$458,232,883	$1,388,043,682
80.0%	75.0%	80.0%	75.0%	45.0%	55.0%	3.8	2.8	$45,000.00	$45,000.00	$238,999,559	$61,481,949	$294,815,331
75.0%	70.0%	75.0%	70.0%	45.0%	55.0%	4	3	$45,000.00	$45,000.00	$7,248,453	$2,298,186	$9,423,021
75.0%	70.0%	80.0%	75.0%	45.0%	55.0%	3.8	2.72	$45,000.00	$45,000.00	$33,386,797	$9,967,423	$42,748,699
80.0%	75.0%	80.0%	75.0%	25.0%	40.0%	4.2	3.2	$45,000.00	$45,000.00	$305,414,550	$184,339,496	$483,117,824
90.0%	85.0%	90.0%	85.0%	45.0%	55.0%	4.75	3.8	$45,000.00	$45,000.00	$1,919,048,951	$784,967,888	$2,532,344,363
85.0%	80.0%	85.0%	80.0%	30.0%	45.0%	4.2	3.2	$45,000.00	$45,000.00	$1,557,709,862	$764,219,009	$2,257,327,528
80.0%	70.0%	80.0%	75.0%	45.0%	55.0%	3.8	2.72	$45,000.00	$45,000.00	$483,381,727	$112,742,693	$581,837,666
75.0%	70.0%	80.0%	75.0%	45.0%	55.0%	3.8	2.8	$45,000.00	$45,000.00	$280,077,608	$71,728,940	$344,059,823
75.0%	70.0%	80.0%	75.0%	45.0%	55.0%	3.8	2.82	$45,000.00	$45,000.00	$66,773,593	$20,667,745	$84,930,207
80.0%	75.0%	80.0%	75.0%	25.0%	40.0%	4.2	3.2	$45,000.00	$45,000.00	$661,731,525	$399,402,242	$1,029,980,392

Table A4. Estimated U.S. Peak Annual Revenue Assuming Exceptional Clinical Benefit

	annual patient population		cancer subtype percentage		percentage starting the modeled treatment line		clinical/label eligbility		target/uptake eligibility	
	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+
AKY-1189										
urothelial	20,000	20000	100.0%	100.0%	70.0%	28.0%	80.0%	70.0%	60.0%	50.0%
breast (TNBC)	53168	53168	15.0%	15.0%	90.0%	50.5%	85.0%	75.0%	50.0%	50.0%
breast (HR+)	53168	53168	70.0%	70.0%	95.0%	61.8%	85.0%	60.0%	30.0%	30.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	40.0%	40.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	40.0%	40.0%
cervical	4991	4991	20.0%	20.0%	75.0%	33.8%	85.0%	75.0%	25.0%	25.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	30.0%	30.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	30.0%	30.0%
AKY-2519										
mCRPC	45613	45613	100.0%	100.0%	90.0%	48.2%	80.0%	70.0%	75.0%	75.0%
NSCLC	121874	121874	100.0%	100.0%	80.0%	36.0%	65.0%	70.0%	60.0%	60.0%
SCLC	26244	26244	100.0%	100.0%	85.0%	34.0%	80.0%	65.0%	55.0%	55.0%
head and neck	21285	21285	95.0%	95.0%	75.0%	30.0%	80.0%	65.0%	50.0%	50.0%
esophageal	14284	14284	30.0%	30.0%	75.0%	33.8%	75.0%	65.0%	60.0%	60.0%
colorectal	63000	63000	95.0%	95.0%	75.0%	48.8%	75.0%	65.0%	65.0%	65.0%

screening/testing rate		treatment access		market share		average doses received		net price per dose		annual revenue		
1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L	2L+	1L and 2L+
80.0%	80.0%	85.0%	85.0%	75.0%	80.0%	4	3	$45,000.00	$45,000.00	$616,896,000	$143,942,400	$725,601,300
85.0%	80.0%	85.0%	80.0%	65.0%	75.0%	4.3	3.3	$45,000.00	$45,000.00	$277,207,643	$107,633,116	$363,358,198
85.0%	80.0%	85.0%	80.0%	45.0%	65.0%	4.9	4.05	$45,000.00	$45,000.00	$646,354,994	$313,630,795	$933,983,640
80.0%	75.0%	85.0%	80.0%	50.0%	65.0%	4.1	3.07	$45,000.00	$45,000.00	$1,590,192,452	$661,891,942	$2,193,573,146
80.0%	75.0%	80.0%	75.0%	65.0%	75.0%	3.8	2.8	$45,000.00	$45,000.00	$345,221,585	$83,839,021	$417,899,956
75.0%	70.0%	75.0%	70.0%	65.0%	75.0%	4	3	$45,000.00	$45,000.00	$10,469,987	$3,133,890	$13,360,389
75.0%	70.0%	80.0%	75.0%	65.0%	75.0%	3.8	2.72	$45,000.00	$45,000.00	$48,225,373	$13,591,941	$60,624,621
80.0%	75.0%	80.0%	75.0%	40.0%	60.0%	4.2	3.2	$45,000.00	$45,000.00	$488,663,280	$276,509,244	$749,245,592
90.0%	85.0%	90.0%	85.0%	65.0%	75.0%	4.75	3.8	$45,000.00	$45,000.00	$2,771,959,596	$1,070,410,757	$3,504,227,595
85.0%	80.0%	85.0%	80.0%	50.0%	65.0%	4.2	3.2	$45,000.00	$45,000.00	$2,596,183,104	$1,103,871,903	$3,544,533,254
80.0%	70.0%	80.0%	75.0%	65.0%	75.0%	3.8	2.72	$45,000.00	$45,000.00	$698,218,051	$153,740,035	$823,817,510
75.0%	70.0%	80.0%	75.0%	65.0%	75.0%	3.8	2.8	$45,000.00	$45,000.00	$404,556,545	$97,812,191	$487,110,034
75.0%	70.0%	80.0%	75.0%	65.0%	75.0%	3.8	2.82	$45,000.00	$45,000.00	$96,450,746	$28,183,289	$119,687,867
80.0%	75.0%	80.0%	75.0%	40.0%	60.0%	4.2	3.2	$45,000.00	$45,000.00	$1,058,770,440	$599,103,363	$1,583,105,703