William Blair

Equity Research
Healthcare | Biotechnology

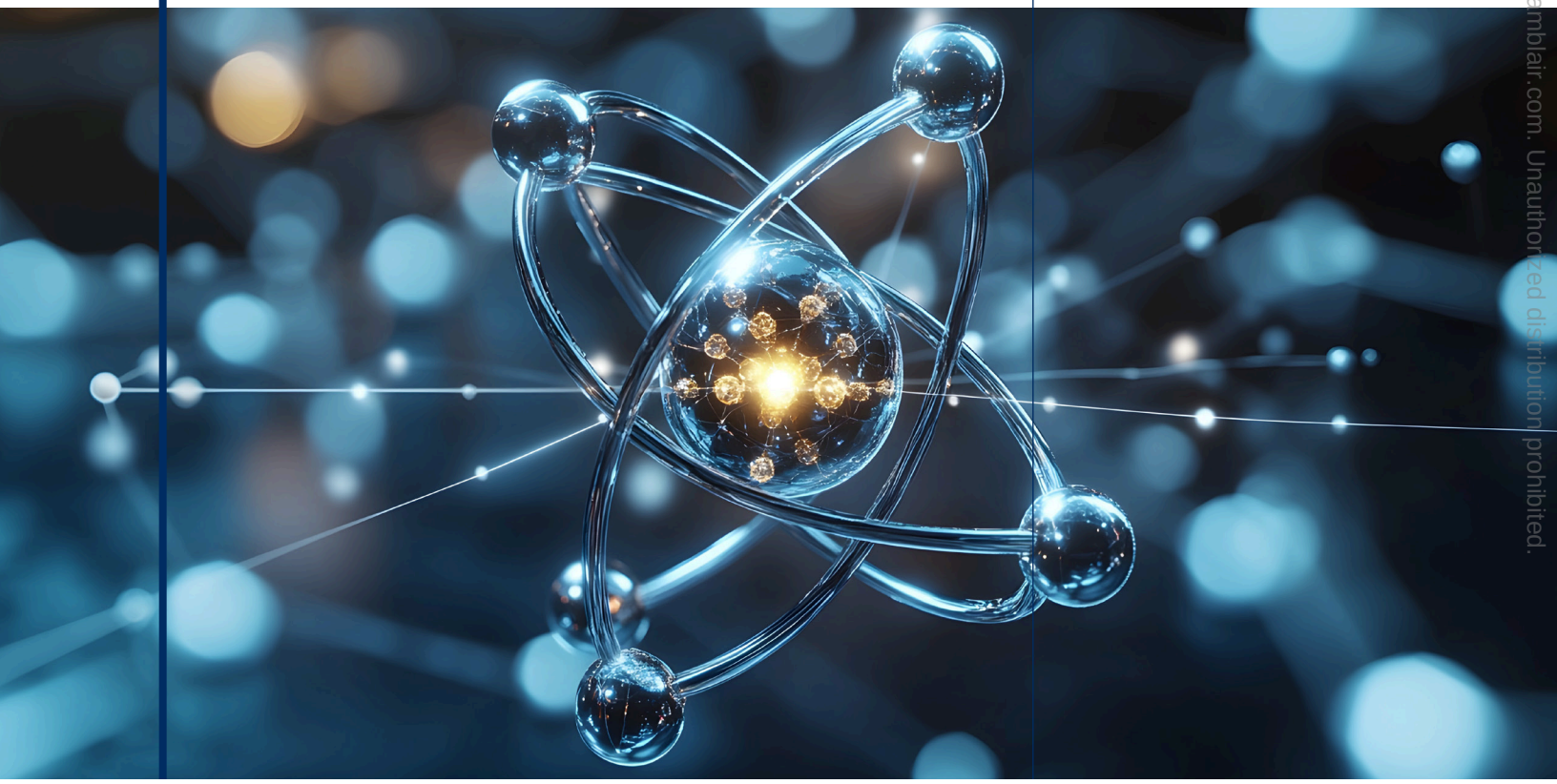
September 1, 2026
Industry Report

Andy T. Hsieh, Ph.D. +1 312 364 5051
ahsieh@williamblair.com

Alexandra V. Ramsey, Ph.D. +1 312 801 7785
aramsey@williamblair.com

Kelsey Lucerne, Ph.D. +1 312 364 8097
klucerne@williamblair.com

Illuminating the Road Less Traveled in Biotech: Radiopharmaceuticals – Fifth Edition



This report is intended for AGraber@williamblair.com. Unauthorized distribution prohibited.

Please refer to important disclosures on pages 46 and 47. Analyst certification is on page 46.
William Blair or an affiliate does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report. This report is not intended to provide personal investment advice. The opinions and recommendations herein do not take into account individual client circumstances, objectives, or needs and are not intended as recommendations of particular securities, financial instruments, or strategies to particular clients. The recipient of this report must make its own independent decisions regarding any securities or financial instruments mentioned herein.

Contents

Introduction 3

Radiopharmaceutical Market Update 4

Private and Public Companies in the Industry 13

Targets and Isotopes of Interest 22

Clinical Trials of Actinium-225, Lead-212, and Terbium-161 26

Recent Datasets in the Radiopharmaceuticals Industry 32

Upcoming Radiopharmaceutical Readouts 41

Outlook 44

Introduction

We believe the radiopharmaceutical industry represents one of the most compelling secular growth opportunities in biotech in the next three to five years. Defying the conventional belief that it remains a niche market, we are optimistic that the recent resurgence in investor and big pharma interest that culminated in four high-profile acquisitions that closed throughout 2023 and 2024 (Point Biopharma by Eli Lilly, RayzeBio by Bristol Myers, Fusion Pharma by AstraZeneca, and Mariana Oncology by Novartis), coupled with Novartis's late-2024 increase in Pluvicto peak sales guidance (to $5 billion, from $3 billion previously), will continue to drive investment in the field. Year-to-date, over $1 billion has been raised in public financing by radiopharmaceutical companies (including the $318 million IPO of Aktis Oncology) and nearly $2 billion has been raised when also including private financing. We believe that over the next few years, the field will reach an inflection point as the therapeutics class emerges from a niche modality to become one of the centerpieces of the cancer treatment paradigm. In our view, Novartis is spearheading that effort, and in the United States, more than 880 sites are administering Pluvicto, representing year-over-year growth of nearly 40%. In addition, Pluvicto is expanding its penetration in the prostate cancer treatment paradigm following its recent approval in the metastatic hormone-sensitive setting.

As the market continues to grow, it is our aim to provide a yearly update on radiopharmaceuticals to serve as a resource for investors who would like to gain knowledge and understanding of this rapidly evolving space that has attracted a significant inflow of investment. Our first edition (see: Bioluminescence—Illuminating the Road Less Traveled in Biotech: Radiopharmaceuticals) provided an in-depth analysis of the field at large, and we refer readers to that report for a historical background on the field and fundamental nuclear chemistry concepts. In our second edition (see: Illuminating the Road Less Traveled in Biotech: Radiopharmaceuticals – Second Edition), we focused on elucidating the supply chain portion of the industry, given that we view this as one of the more obscure and difficult-to-understand and -visualize areas. We also provided an overview of the various medically relevant radioisotopes that are being explored for therapeutic applications, a description of current and future trends, and a comprehensive list of radiopharmaceutical companies in both the therapeutic and diagnostic fields, though we focused our discussion on the therapeutic application. In the third edition (see: Illuminating the Road Less Traveled in Biotech: Radiopharmaceuticals – Third Edition), we provided a brief update on the radiopharmaceutical field, including recent financing, the current company landscape, clinical updates, and targets of interest (again focusing on the therapeutic aspect of the industry).

In the fourth edition (see: Illuminating the Road Less Traveled in Biotech: Radiopharmaceuticals – Fourth Edition), we took a departure from the therapeutic landscape and focused instead on the role of diagnostics. Given that we view the PET imaging market as a promising area of growth for radiopharmaceuticals, we aimed to elucidate the evolving role of PET in the context of diagnosing Alzheimer's disease. We believe this application represents a material use-case for radiopharmaceuticals beyond oncology and provides an example of the diagnostic power of medically relevant radioisotopes.

In this current edition, we again provide a market update, focusing on financings, recent and upcoming clinical data updates, and the current landscape of radiopharmaceutical companies and related assets.

Radiopharmaceutical Market Update

Market Size and Trajectory

Taking into account the increased number of potential addressable oncology indications, owing to the rise in new targets under investigation for radiopharmaceuticals, we have increased our TAM estimate (exhibit 1 and 2). Our base-case assumption is now $35 billion, up from $31 billion previously, while our bull-case assumption is now $68 billion, up from the prior $60 billion. Our bear-case assumption remains roughly the same at $4.6 billion.

Exhibit 1
Radiopharmaceuticals
Potential Future Total Market Size of the Therapeutic Radiopharmaceuticals Industry in the United States

Oncology Indication	Molecular Target (Clinical)	Molecular Target (Preclinical)	Total U.S. Patients*[1]	Net Realized Price*	TAM (mil.)	Market Penetration			Market Size (mil.)		
						Bear	Base	Bull	Bear	Base	Bull
Prostate	PSMA, GRPR, hK2, STEAP2	B7-H3, undisclosed	314	$180	$56,480	7%	14%	25%	$3,954	$7,907	$14,120
Neuroendocrine	SSTR(2), CXCR4	N/A	23	$180	$4,176	15%	30%	50%	$626	$1,253	$2,088
Breast	GRPR, HER2, nectin-4, FAP	Neurotensin, FAP, B7-H3, undisclosed	317	$180	$57,051	0%	10%	20%	$0	$5,705	$11,410
NSCLC	PD-L1, GRPR, nectin-4, FAP	FAP, B7-H3, undisclosed	193	$180	$34,677	0%	10%	20%	$0	$3,468	$6,935
Colon	B7-H3, neurotensin, nectin-4, FAP	Undisclosed	154	$180	$27,769	0%	10%	20%	$0	$2,777	$5,554
Melanoma	MC1R, GD2, undisclosed	Undisclosed	105	$180	$18,893	0%	10%	20%	$0	$1,889	$3,779
Bladder	Nectin-4	N/A	85	$180	$15,277	0%	10%	20%	$0	$1,528	$3,055
Kidney	CAIX	N/A	81	$180	$14,576	0%	10%	20%	$0	$1,458	$2,915
NHL	CD38, lipid rafts	N/A	80	$180	$14,463	0%	10%	20%	$0	$1,446	$2,893
Head and neck	FAP, NTSR1	Undisclosed	73	$181	$13,155	0%	10%	20%	$0	$1,316	$2,631
Pancreatic	Integrins, FAP, undisclosed	B7-H3, neurotensin, integrins, undisclosed	67	$180	$12,139	0%	10%	20%	$0	$1,214	$2,428
Thyroid	FAP	N/A	44	$181	$7,968	0%	10%	20%	$0	$797	$1,594
Liver	GPC3	B7-H3	42	$180	$7,603	0%	10%	20%	$0	$760	$1,521
Multiple Myeloma	SSTR(2), CD38	N/A	36	$180	$6,500	0%	10%	20%	$0	$650	$1,300
SCLC	SSTR(2), DLL3, GD2, B7-H3	CCK2R, DLL3, B7-H3, undisclosed	34	$180	$6,120	0%	10%	20%	$0	$612	$1,224
Gastric	HER2, FAP	N/A	30	$180	$5,454	0%	10%	20%	$0	$545	$1,091
Gastroesophageal	HER2, FAP	N/A	22	$180	$3,973	0%	10%	20%	$0	$397	$795
Ovarian	FRα, FAP	Undisclosed	21	$180	$3,760	0%	10%	20%	$0	$376	$752
Sarcoma	FAP	NTSR1, PDGFRα	17	$180	$3,132	0%	10%	20%	$0	$313	$626
Cervical	Nectin-4	N/A	13	$181	$2,418	0%	10%	20%	$0	$242	$484
Glioblastoma	SSTR(2), GRPR, LAT-1, CAXII	PARP	12	$180	$2,142	0%	10%	20%	$0	$214	$428
Mesothelioma	FAP	Undisclosed	3	$181	$543	0%	10%	20%	$0	$54	$109
Neuroblastoma	SSTR(2)	N/A	1	$180	$135	0%	10%	20%	$0	$14	$27
					Total Addressable Market (mil.)				**$4,600**	**$35,000**	**$67,800**

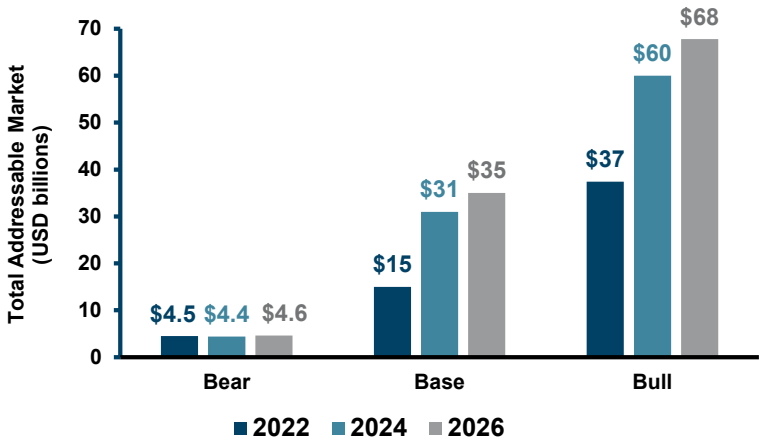
*Patient numbers and price in thousands.

[1]Total U.S. patient numbers are based on yearly incidence.

AML=Acute myeloid leukemia. CAIX=Carbonic anhydrase 9. CCK2R=Cholecystokinin 2 receptor. CAXII=Carbonic anhydrase 12. CXCR4=Chemokine receptor type 4. DLL3=Delta-like ligand 3. FAP=Fibroblast activation protein. FRα=Folate-receptor alpha. GRPR=Gastrin releasing peptide receptor. HER2=Human epidermal growth factor receptor 2. hK2=Human kallikrein-2. IGF-1R=insulin-like growth factor 1 receptor. LAT-1=L-type amino acid transporter 1. MC1R=Melanocortin 1 receptor. NHL=Non-Hodgkin lymphoma. NSCLC=Non–small-cell lung cancer. NTSR1=Neurotensin receptor 1. PARP=Poly (ADP-ribose) polymerase. PDGFRα=Platelet-derived growth factor receptor alpha. PSMA=Prostate-specific membrane antigen. SCLC=Small-cell lung cancer. SSTR=somatostatin receptor.

Sources: The Human Protein Atlas; NIH Surveillance, Epidemiology, and End Results (SEER) Program; William Blair Equity Research

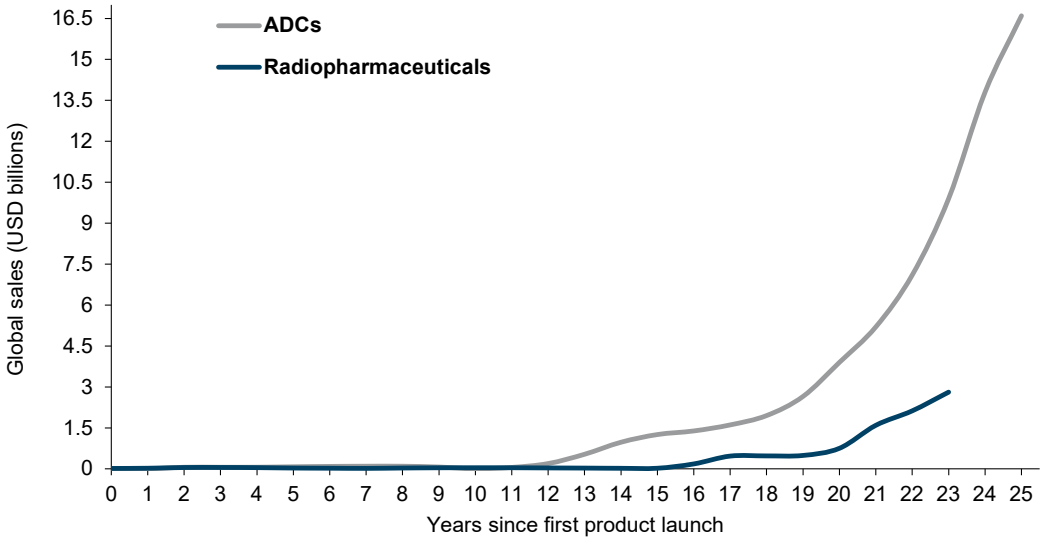
Exhibit 2
Radiopharmaceuticals
Comparison of Changes in U.S. Total Addressable Market Estimates for the Radiopharmaceuticals Industry



Source: William Blair Equity Research

We also conducted an analysis (exhibit 3) of sales for radiopharmaceuticals since the first launch of the modality (Zevalin in 2022) compared to sales of ADCs since the first ADC was launched (Mylotarg in 2000). Given that we view ADCs as an analogous asset to radiopharmaceuticals (essentially replacing the radioisotope with a chemotherapy toxin), our aim was to assess the progress of the radiopharmaceuticals launch trajectory. Similar to ADCs, a notable increase in radiopharmaceuticals sales was not seen until at least a decade after their launch. However, by comparing the trajectories of the two modalities, we believe that radiopharmaceuticals are nearing an inflection point as Pluvicto continues to penetrate deeper into prostate cancer and new therapies are likely to be approved.

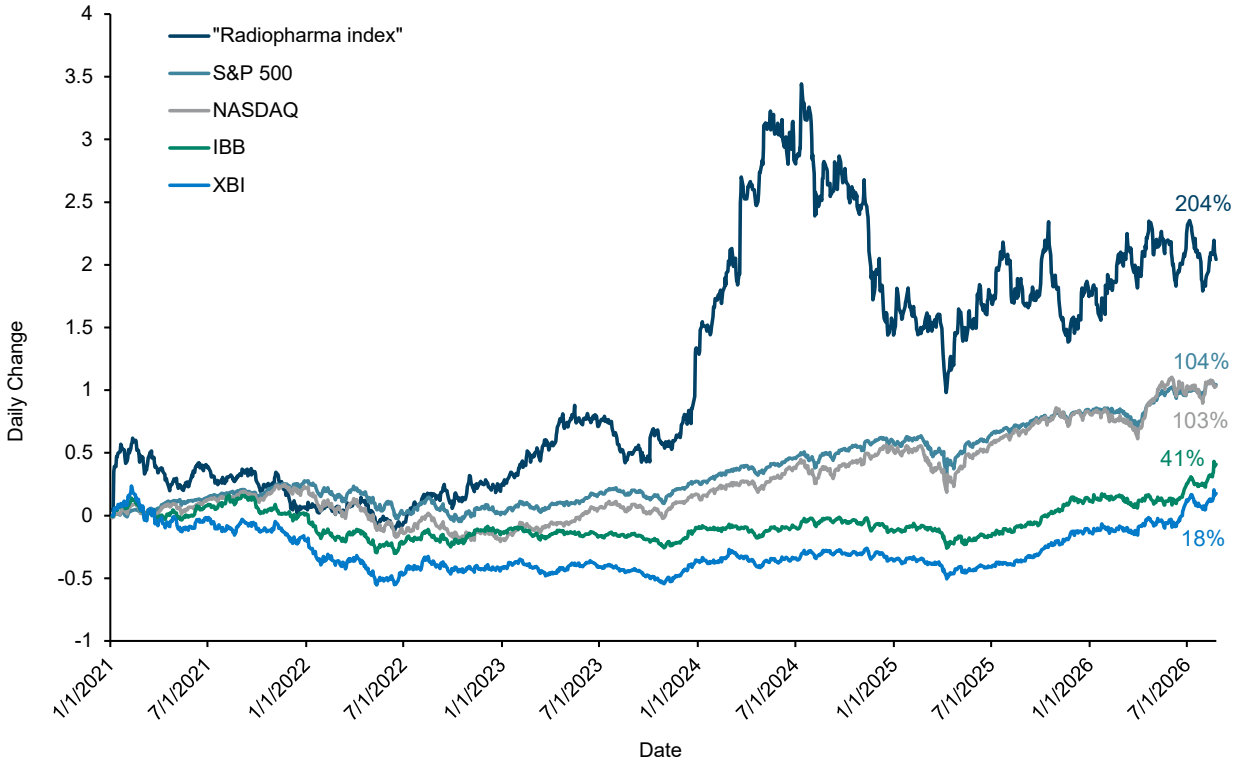
Exhibit 3
Radiopharmaceuticals
Sales Trajectory of Radiopharmaceuticals Compared to ADCs Since Initial Launch (Through 2025)



Sources: Evaluate Pharma, company reports, and William Blair Equity Research

To gauge the performance of radiopharmaceuticals companies, we generated a hypothetical "radiopharma index" and compared it over the past five years to the performance of the S&P 500, Nasdaq, IBB, and XBI. As shown in exhibit 4, investing in our hypothetical index would have provided a return of roughly 200% from early 2021, compared with a return of about 100% for the S&P 500 and Nasdaq or roughly 40% and 20% for the IBB and XBI, respectively. In this case, the "radiopharma index" includes Aktis Oncology, Telix Pharmaceuticals, Lantheus, Actinium Pharmaceuticals, Australia-based Clarity Pharmaceuticals and Radiopharm Theranostics, and previously acquired Fusion, Point, and RayzeBio.

Exhibit 4
Radiopharmaceuticals
Hypothetical "Radiopharma Index" and Performance Benchmarked to Standard Indices and Biotech-Specific Indices



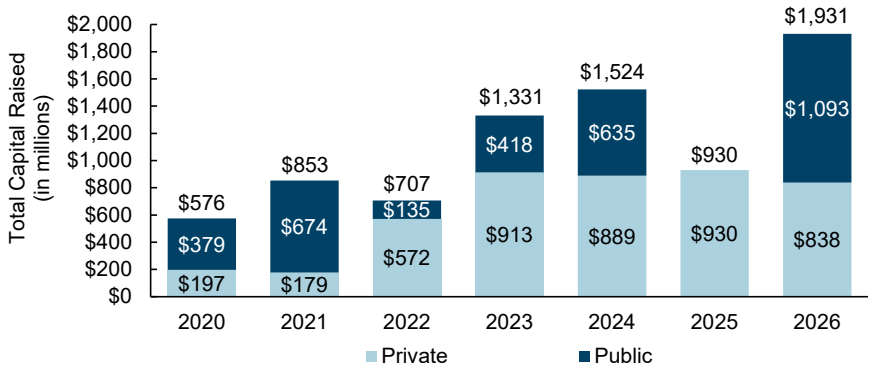
Index includes Aktis Oncology, Telix Pharmaceuticals, Lantheus, Actinium Pharmaceuticals, Australia-based Clarity Pharmaceuticals and Radiopharm Theranostics, and previously acquired Fusion, Point, and RayzeBio.
Source: William Blair Equity Research

Recent Financings in the Sector

Public funding was significant in 2020 and 2021, owing to several IPOs in the space, but in 2023, 2024, and 2025, the majority of funding was from the private sector. Last year, radiopharmaceutical companies raised roughly $930 billion, centered on private funding (exhibit 5). So far in 2026 we have witnessed a rise in public funding, including what we view as a highly successful IPO from Aktis Oncology (described in more detail below). Overall, when considering both public and private investments, 2026 already marks the strongest year in financing since at least 2020 from a total amount raised perspective. This strong funding scene, in our view, demonstrates the sincere interest in and potential of radiopharmaceutical companies in both the near and long term. We would also be remiss to not mention the significant M&A activity that underscored 2023 and 2024.

In our view, the lack of more recent M&A activity is driven by a scarcity of companies focused on the manufacturing and supply chain aspect of the industry, which arguably drove three of the four acquisitions that occurred in 2023 and 2024.

Exhibit 5
Radiopharmaceuticals
Private and Public Capital Raised by Radiopharmaceutical Companies, 2020-2026



Sources: Company reports and BioCentury Inc.

The public debut of Aktis Oncology in early 2026 marked the first radiopharmaceutical IPO since 2023. The public offering was upsized, and gross proceeds were roughly $365 million, including a $100 million investment from Eli Lilly. Aktis is currently trading above its $18 per share IPO price, signaling enthusiasm for the radiopharmaceutical modality, in our view. Aktis's pipeline is built around actinium-225, and the company has developed a class of targeting moiety called miniproteins that aim to bridge favorable characteristics of small molecules or peptides with larger antibody formats. The lead program targets nectin-4, which is a commercially validated target owing to the success of Padcev; Phase Ib dose-escalation data is expected in the first quarter of 2027.

Within private funding, we highlight AdvanCell's $315 million oversubscribed and upsized series D financing from July. We believe the highly successful round of funding from top investors is a testament to AdvanCell's strategy and clinical data (discussed in more detail later in this report) and to the potential of lead-212 as a therapeutic radioisotope. An overview of the radiopharmaceutical financings completed thus far in 2026 is shown in exhibit 6.

Exhibit 6
Radiopharmaceuticals
Financing in the Radiopharmaceuticals Sector During 2026

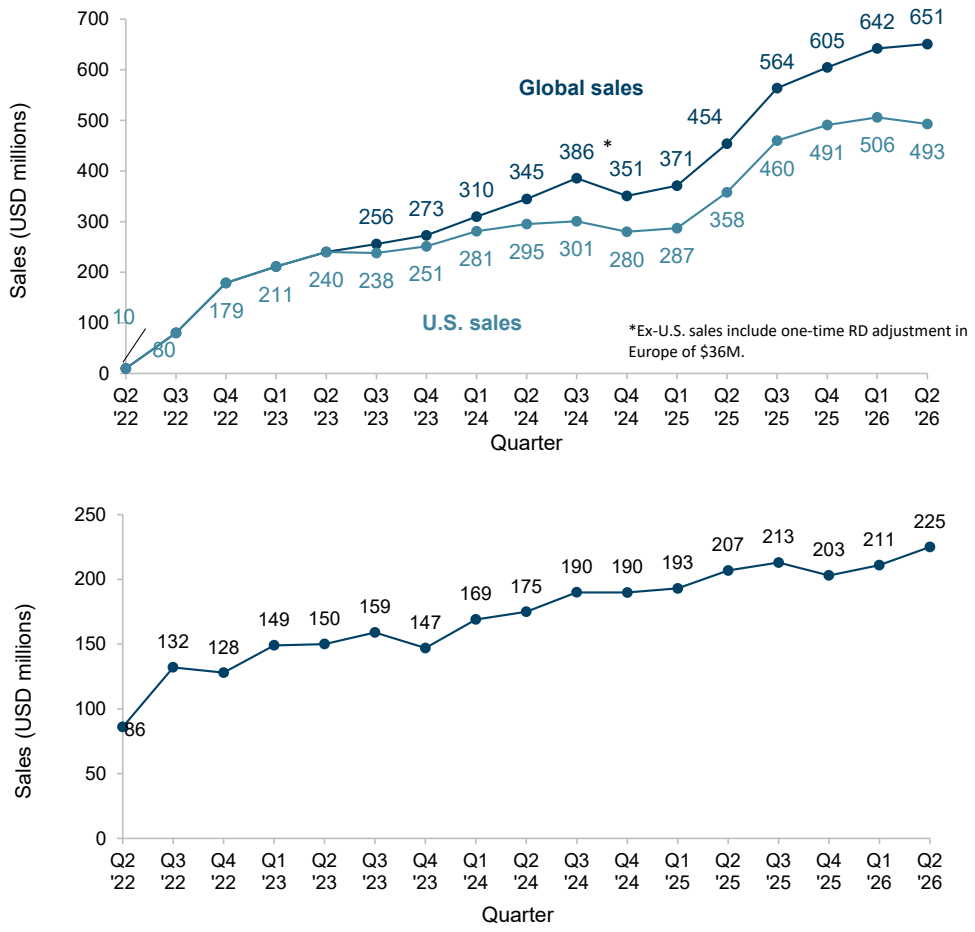
Company	Series/Type	Amount (mil.)	Date	Investors
Ratio Therapeutics	Series C	$70	July 31, 2026	Duquesne Family Office, Bristol Myers Squibb, Catalio Capital Management, Eli Lilly and Company, and Wasatch Group
AdvanCell	Series D	$315	July 15, 2026	Ally Bridge, Alpha Wave, Bain Capital Life Sciences, Fidelity, T. Rowe Price, Eventide Asset Management, Velocity Capital
Orano Med	Debt	$143	July 1, 2026	The European Investment Bank
Nuclidium	Series B	$130	May 27, 2026	Kurma Growth Opportunities Fund, Angelini Ventures, Aurea, Wellington Partners, Neva SGR, DeepTech & Climate Fonds, Bayern Kapital, Vives Partners, NRW.BANK
Full-Life Technologies	Series D / debt	$150 ($109 / $41)	May 19, 2026	SK Biopharmaceuticals, Chengwei Capital, HSG, Junson Capital, Plaisance, Sky9 Capital, Yunion
Ionetix	Go-public transaction	>$30	April 21, 2026	Network 1 Financial Securities (placement agent), consulted by Intuitive Ventures Partners
Telix	Convertible bonds	$600	April 15, 2026	NA
Perspective Therapeutics	Public equity	$175	February 2, 2026	Commodore Capital, TCGX, Spruce Street Capital, Surveyor Capital, Affinity Asset Advisors, HBM Healthcare Investments, Ally Bridge Group
Aktis Oncology	IPO	$318	January 8, 2026	Eli Lilly ($100M), among others

Sources: BioCentury Inc. and company reports

Commercial Highlights

In March 2025, the FDA approved Pluvicto in the pre-taxane setting of mCRPC, based on the Phase III PSMAfore trial. As seen in exhibit 7, this corresponded with a notable increase in sales for Pluvicto. Novartis management disclosed on its fourth quarter 2025 earnings call that it had reached 16% share in the pre-taxane setting, and based on the second quarter of 2026, the pre-taxane setting was driving 70% of new patient starts. The National Comprehensive Cancer Network (NCCN) recently removed androgen receptor pathway inhibitor (ARPI) sequencing recommendations in mCRPC from its guidelines, which management speculated has increased use of Pluvicto in the post-ARPI setting. Global sales during the second quarter of 2026 alone reached $651 million, marking a 43% year-over-year increase. The label for Pluvicto expanded again on July 31, 2026, with approval in metastatic hormone-sensitive prostate cancer (mHSPC), based on the Phase III PSMAddition study. Meanwhile, Lutathera sales remain steady to slightly increasing.

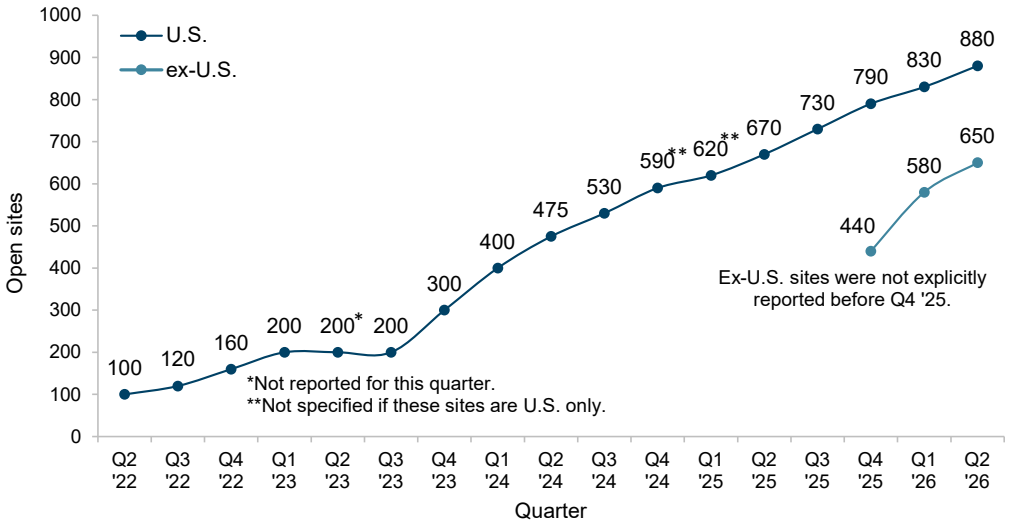
Exhibit 7
Radiopharmaceuticals
Sales of Pluvicto (Top) and Lutathera (Bottom) by Quarter



Sources: Novartis company reports and William Blair Equity Research

According to Novartis management, the mHSPC setting could increase the eligible patient population by 75%, and the company believes that Pluvicto will be rapidly adopted in this setting given that two-thirds of mHSPC patients attend clinics that already use Pluvicto. Novartis previously disclosed that Pluvicto is on track to exceed $5 billion in peak sales (increased in late 2024 from the $2 billion peak potential from the post-chemotherapy VISION population). Given the $651 million in quarterly sales from VISION/PSMAfore alone and the estimated 75% increase from PSMAddition, we agree that $5 billion peak sales is well within reach and could even be an underestimate since it does not include the oligometastatic setting (Phase III PSMA-DC trial). In accordance with Pluvicto's success to date, the number of clinical sites administering Pluvicto has been increasing rapidly, in both the United States and ex-U.S. territories (exhibit 8).

Exhibit 8
Radiopharmaceuticals
Number of Open Clinical Sites Administering Pluvicto



Sources: Novartis company reports and William Blair Equity Research

Novartis's conviction in Pluvicto and the radiopharmaceutical modality as a whole is underscored by its investment in manufacturing facilities. In April 2025, Novartis disclosed a $23 billion investment to expand U.S.-based manufacturing. This includes building two new facilities in Florida and Texas dedicated to manufacturing radioligand therapies and expanding the three existing radioligand therapy facilities in Indiana, New Jersey, and California. The 10,000-square-foot site in Carlsbad, California, is the newest completed site, having come online in November 2025. The new facility in Winter Park, Florida, is expected to encompass 35,000 square feet and open by 2029. The Texas site, to be in the Dallas–Fort Worth area, is expected to be even larger at 46,000 square feet and is slated to be operational in 2028. Characteristics of Novartis's five manufacturing sites for radiopharmaceuticals are summarized in exhibit 9. Based on commentary from Novartis, we expect the facilities to support not only existing products (Pluvicto and Lutathera), but also the company's next wave of radiopharmaceutical therapies.

Exhibit 9
Radiopharmaceuticals
Novartis's Radioligand Therapy (RLT) Manufacturing-Dedicated Facilities in the United States

Site Location	City	Size (square feet)	Initial Operation	Region Serviced	Primary Role
New Jersey	Millburn	Not disclosed[1]	2023	U.S. broadly[2]	Initial U.S. site; Isotope production
Indiana	Indianapolis	70,000[3]	2024	U.S. broadly	Flagship site; First-of-its-kind RLT automation; Isotope production
California	Carlsbad	10,000	2025	Western U.S., Alaska, Hawaii	Increase capacity; Regional manufacturing
Florida	Winter Park	35,000	2029	Southeast U.S.	Increase capacity; Regional manufacturing
Texas	Denton (Dallas–Fort Worth)	46,000	2028	Southern U.S.	Increase capacity; Regional manufacturing

[1]Initial size was 70,000 square feet, but there are plans to roughly double the size by adding a roughly 80,000-square-foot building. Exact timing of expansion completion is uncertain but could occur this year based on estimates from 2024.

[2]May have some kind of regional focus on Northeast.

[3]The size has not been disclosed in detail, but it has been described as small scale and, according to a former unit head at Novartis, is roughly the size of "two one-story single houses."

Source: Novartis reports

Regulatory Impediments

Despite the clinical and regulatory success of Pluvicto and Lutathera, there have been a number of complete response letters (CRLs) in the industry, along with several other regulatory hurdles, in recent years. These include both therapeutic and diagnostic candidates. Deficiencies in CMC and third-party manufacturing are commonly cited, which we believe could be a testament to the complexities of radionuclide production, supply chain logistics, and radiation control requirements. At this time, we do not know whether these manufacturing deficiencies were concentrated in a small number of CDMOs or attributable to the agency's inability to inspect manufacturing facilities on time due to recent reduction-in-force initiatives. We provide a summary of CRLs and other regulatory impediments in exhibit 10.

Despite the setbacks, we highlight a recent approval on the diagnostic side. In mid-August of this year, Tauklarify (previously known as MK-6240) was approved for imaging Alzheimer's disease. The agent targets tau neurofibrillary tangles and incorporates fluroine-18. For more information on this agent and PET imaging of Alzheimer's disease, please refer to the fourth edition of our radiopharmaceuticals report linked to earlier in the report.

Exhibit 10
Radiopharmaceuticals
Summary of Complete Response Letters (CRLs) and Other Regulatory Impediments in the Radiopharmaceuticals Industry

Asset	Company	Original PDUFA	Outcome	Rationale	Current Status
^{177}Lu-edotreotide (ITM-11)	ITM	August 28, 2026	CRL[1]	CMC and third-party manufacturing deficiencies	Plans to resubmit
^{68}Ga-edotreotide (Octevy)	Lantheus	March 29, 2026	Delay, followed by CRL	Further review of manufacturing-related information needed / unresolved third-party manufacturing concerns	Working to address concerns
^{89}Zr-DFO-girentuximab (Zircaix)	Telix	August 27, 2025	CRL[2]	CMC and third-party manufacturing deficiencies; requested bridging study to demonstrate formulation comparability	Resubmission expected in 2026
^{18}F-floretyrosine (Pixclara)	Telix	April 26, 2025	CRL[3]	Additional confirmatory clinical evidence requested given single-center nature and borderline diagnostic performance	Resubmitted with September 11, 2026, PDUFA
^{131}I-apamistamab (Iomab-B)	Actinium Pharmaceuticals	NA	BLA not accepted	Additional head-to-head randomized trial demonstrated overall survival requested	Seeking partner
^{177}Lu-dotatate (Lutathera)	Novartis	December 28, 2016	CRL	Pivotal trial data not complete; requested subgroup analysis, safety update, and addressing of any CMC concerns	Resubmitted and approved on January 26, 2018

[1]https://download.open.fda.gov/crl/CRL_NDA218705_20260807.pdf
[2]https://download.open.fda.gov/crl/CRL_BLA761401_20260410.pdf
[3]https://download.open.fda.gov/crl/CRL_NDA218592_20250425.pdf
Sources: Company websites and the U.S. FDA

Private and Public Companies in the Industry

Taking a broader view, the entrance of new companies into the radiopharmaceuticals industry has been occurring at a rapid pace. According to our research, there are almost 50 therapeutic radiopharmaceuticals companies across both the public (exhibit 11) and private (exhibit 12) sectors (though we note that a few are not radiopharmaceutical pure-plays), with the number increasing on a regular basis. There are also nearly 20 companies operating in the diagnostic space (exhibit 13), with many companies spanning both therapeutics and diagnostics. The programs encompass a range of study phases, from discovery to Phase III, and are investigating a variety of radionuclides, targets, and indications, although we note the large concentration in the PSMA target and prostate cancer indication.

Exhibit 11
Radiopharmaceuticals
Public U.S. Companies Operating in Therapeutics Within the Radiopharmaceuticals Industry

Company	Ticker	Location	Asset	Radionuclide	Targets	Targeting moiety	Indication	Phase
Actinium	ATNM	New York	Iomab-B	I-131	CD45	Antibody	BMC for AML	Seeking partner
			Actimab-A	Ac-225	CD33	Antibody	R/R fit AML	Seeking collaborator
							Frontline AML	Phase I
							Refractory MDS	Phase I
							Other AML/MDS indications	Preclinical
							Solid tumor resistance	Preclinical
			ATNM-400	Ac-225	Not disclosed	Antibody	mCRPC, NSCLC, BC	Phase I
			Iomab-ACT	I-131	CD45	Antibody	Cell conditioning	Phase I
Aktis	AKTS	Boston, MA	AKY-1189	Ac-225	Nectin-4	Miniprotein	Bladder, breast, other solid tumors	Phase Ib
			AKY-2519	Ac-225	B7-H3	Miniprotein	Prostate cancer	Phase Ib
							Lung, colorectal, other solid tumors	Preclinical
Bristol Myers Squibb	BMY	New Jersey	RYZ101	Ac-225	SSTR2	Peptide	NETs	Phase III ACTION-1
							SCLC	Phase Ib
							HR+/HER2- breast cancer	Phase I TRACY-1
			RYZ401	Ac-225	SSTR2	Peptide	SSTR+ solid tumors	Phase I
			RYZ801	Ac-225	GPC3	Macrocyclic peptide	HCC	Phase I
			OncoACP3	Ac-225	ACP3	SM	Prostate cancer	Preclinical
Cellectar	CLRB	New Jersey	Iopofosine	I-131	Lipid rafts	Phospholipid	Waldenstrom macroglobulinemia	Pivotal
							B-cell malignancies, multiple myeloma	Phase II
							pHGG	Phase Ib
							Mycosis fungoides	Unknown status
			CLR 125	I-125	Lipid rafts	Phospholipid	TNBC	Phase I
			CLR 225	Ac-225	Lipid rafts	Phospholipid	Solid tumors	Planned Phase I
Eli Lilly	LLY	Indianapolis, IN	PNT2003	Lu-177	SSTR	Peptide	NETs	Tentative approval
			PNT2001	Ac-225	PSMA	Ligand	Prostate cancer	Phase I ACCEL[1]
			PNT6555	Ac-225	FAP	SM	Solid tumors	Status unknown
			LY4257496	Lu-177	GRPR (antagonist)	Peptide	Advanced cancer	Phase Ia/b OMINRAY
			LY4337713	Lu-177	FAP	SM	FAP-positive solid tumors	Phase Ia/Ib FiREBOLT
Immunome	IMNM	Bothell, WA	IM-3050	Lu-177	FAP	SM	Solid tumors	Phase I
Lantheus[2]	LNTH	Bedford, MA	LNTH-2402	Lu-177	GRPR	Peptide	Prostate cancer	Preclinical
			LNTH-2403	Lu-177	LRRC15	Antibody	Osteosarcoma	Phase I
			LNTH-2404	Not disclosed	TROP2	Nanobody	Solid tumors	Preclinical
			LNTH-2503	Lu-177	CCK2R	Peptide	SCLC	Phase I
			LNTH-2505	Lu-177	Not disclosed	Not disclosed	Glioblastoma	Preclinical
			LNTH-2507	Lu-177	Not disclosed	Not disclosed	PDAC	Preclinical
			LNTH-2509	Lu-177	Not disclosed	Not disclosed	Lobular breast cancer	Preclinical
Perspective Therapeutics	CATX	Richland, WA	^{212}Pb-VMT-α-NET	Pb-212	SSTR2	Peptide	NETs	Phase I/IIa
							Meningioma	Phase I/IIa
			VMT01	Pb-212	MC1R	Peptide	Melanoma	Phase I/IIa
			PSV359	Pb-212	FAP	Peptide	Solid tumors	Phase I/IIa
			PSV594	Pb-212	CCK2R	Peptide	Solid tumors	Preclinical

ACP3=Acid phosphatase 3. AML=Acute myeloid leukemia. BC=Breast cancer. BMC=Bone marrow conditioning. CCK2R=Cholecystokinin 2 receptor. CD=Cluster of differentiation. FAP=Fibroblast activation protein. GPC3=Glypican-3. GRPR=Gastrin-releasing peptide receptor. HCC=Hepatocellular carcinoma. pHGG=Pediatric high-grade gliomas. LRRC15=Leucine-rich repeat containing 15. MC1R=Melanocortin 1 receptor. mCRPC=Metastatic castration-resistant prostate cancer. MDS=Myelodysplastic syndrome. NETs=Neuroendocrine tumors. NSCLC=Non-small-cell lung cancer. PDAC=Pancreatic ductal adenocarcinoma. PSMA=Prostate-specific membrane antigen. R/R=Relapsed/refractory. SCLC=Small-cell lung cancer. SSTR=Somatostatin receptor. TNBC=Triple-negative breast cancer.

[1]Trial is still active on clinicaltrials.gov but has not been recently updated is not listed on Lilly's clinical trial site.

[2]Given the proposed acquisition with Curium, we have limited visibility into recent pipeline development progress for Lantheus and its future plans.

Sources: Company reports and William Blair Equity Research

Exhibit 11 (Continued)
Radiopharmaceuticals
Public International Companies Operating in Therapeutics Within the Radiopharmaceuticals Industry

Company	Ticker	Location	Asset	Radionuclide	Targets	Targeting moiety	Indication	Phase
AstraZeneca	AZN	United Kingdom	Zadavotide guraxetan	Ac-225	PSMA	Ligand	mCRPC	Phase III VECTRA-01
			AZD2284	Ac-255	STEAP2	Antibody	mCRPC	Phase I
Bayer	BAYRY	Germany	Pelivotide mopaxetan	Ac-225	PSMA	Antibody	mCRPC	Phase I PAnTHA
			BAY 3547926	Ac-225	GPC3	Antibody	HCC	Phase I BANTAM-01
Bicycle Therapeutics	BCYC	United Kingdom	BT1702	Pb-212	MT1-MMP	Bi-cyclic peptide	Solid tumors	IND-enabling
			N/A	Not disclosed	EphA2	Bi-cyclic peptide	Solid tumors	Preclinical
Clarity	CU6-AU	Sydney	^{67}Cu-SAR-bisPSMA	Cu-67	PSMA	Ligand	Prostate cancer	Phase I/IIa SECuRE
			^{67}Cu-SAR-Bombesin	Cu-67	GRPR	Ligand	Prostate cancer	Phase I/IIa COMBAT (terminated)
			^{67}Cu-SARTATE	Cu-67	SSTR2	Peptide	Neuroblastoma	Phase I/II CL04 (terminated)
Janssen	JNJ	Belgium	JNJ-69086420	Ac-225	hK2	Antibody	Advanced prostate cancer	Phase I
Novartis	NVS	Switzerland	Pluvicto	Lu-177	PSMA	SM	mCRPC	Approved
							mCRPC (pre chemo)	Approved
							mHSPC	Approved
							Oligometastatic prostate cancer	Phase III PSMA-DC
			Lutathera	Lu-177	SSTR	Peptide	Second-line+ NETs	Approved
							Frontline NETs (G2/G3)	Phase III NETTER-2
							Frontline NETs (G1/G2)	Phase III NETTER-3
							ES-SCLC	Phase II
							Glioblastoma	Phase II
			AAA817	Ac-225	PSMA	Ligand	post-Pluvicto mCRPC	Phase III
			AAA603 (177Lu-NeoB)	Lu-177	GRPR	Ligand	Multiple solid tumors	Phase I NeoRay complete[1]
							Breast cancer	Phase I/II[1]
							Glioblastoma	Phase I[1]
			^{177}Lu-FAP-2286	Lu-177	FAP	Cyclic peptide	Advanced solid tumors	Phase I/II LuMIERE
			AAA802 (225Ac-PSMA-R2)	Ac-225	PSMA	Ligand	Prostate cancer	Phase I/II SatisfACtion[1]
			177Lu-NNS309	Lu-177	FAP	Peptide	Solid tumors	Phase I
			^{177}Lu-DMJ155	Lu-177	HER2	Ligand	Solid tumors	Phase I
			^{225}Ac-ETN029	Ac-225	DLL3	Ligand	Solid tumors	Phase I
Pentixapharm	PTP.F	Germany	PT-002 (PentixaTher)	Lu-177, Y-90	CXCR4	Peptide	CNS lymphoma	Phase I/II
							Acute Myeloid leukemia	Phase I/II IST
			GT-008	Ac-225	CD24	Antibody	Solid female cancers	Preclinical
Philogen	PHIL.MI	Italy	OncoFAP-23	Lu-177	FAP	SM	FAP+ solid tumors	Phase I TheraTri
Radiopharm Theranostics	RAD.AX	Melbourne	RV01	Lu-177	B7H3	Antibody	Solid tumors	Phase I/IIa BetaBart
			RAD204	Lu-177	PD-L1	Nanobody	Solid tumors	Phase I
			RAD202	Lu-177	HER2	Nanobody	Solid tumors	Phase I
			RAD402	Tb-161	KLK3	Antibody	Advanced prostate cancer	Phase I
Roche	RHHBY	Switzerland	^{212}Pb-CEA-PRIT (with Orano Med)	Pb-212	CEA	Antibody[2]	Metastatic CRC	Phase I
StarPharma	SPHRY		DEP HER2	Lu-177	HER2	Nanobody[3]	HER2-expressing cancers	Entering Phase I
Telix	TLX	Melbourne	TLX591	Lu-177	PSMA	Antibody	mCRPC	Phase III ProstACT
			TLX250	Lu-177	CAIX	Antibody	Relapsed ccRCC	Phase II/III LUTEON
							1L ccRCC	Phase Ib/II STARLITE-1
			TLX101	I-131	LAT-1	SM	Recurrent glioblastoma	Phase III IPAX BrIGHT
							1L glioblastoma	Phase I IPAX-2
			TLX597	Lu-177	PSMA	SM	mHSPC	Phase IIa OPTIMAL-E
			TLX66	Y-90	CD66	Antibody	BMC/rare diseases	Phase II
			TLX592	Ac-225	PSMA	Antibody	Prostate cancer	Phase I AlphaPRO initiating 2026
			TLX090	SM-153	N/A	SM	Bone metastases	Phase I SOLACE
			TLX252	Ac-225	CAIX	Antibody	Kidney/other cancers	Phase I ALPHIX initiating 2026
			TLX400	Lu-177	FAP	SM	Pan-cancer	Phase I initiating 2026
			TLX300	Undisclosed	PDGFRα	Antibody	Soft tissue sarcoma	Phase I
			TLX102	At-211	LAT-1	SM	Recurrent glioblastoma	Phase I initiating 2026

CAIX=Carbonic anhydrase IX. ccRCC=Clear-cell renal cell carcinoma. CD=Cluster of differentiation. CEA=Carcinoembryonic antigen. CRC=Colorectal cancer. CSCR4=C-X-C motif chemokine receptor 4. DLL3=Delta-like ligand 3. EphA2=Ephrin type-A receptor 2. ES-SCLC=Extensive stage small-cell lung cancer. FAP=Fibroblast activation protein. GPC3=Glypican-3. GRPR=Gastrin releasing peptide receptor. HCC=Hepatocellular carcinoma. hK2=Human kallikrein 2. KLK3=kallikrein-related peptidase 3. LAT-1=L-type amino acid transporter 1. mCRPC=Metastatic castration-resistant prostate cancer. mHSPC=Metastatic hormone-sensitive prostate cancer. MT1-MMP=Membrane-type 1 matrix metalloproteinase. NETs=Neuroendocrine tumors. PDGFRα=Platelet-derived growth factor receptor alpha. PSMA=Prostate-specific membrane antigen. SM=Small molecule. SSTR=Somatostatin receptor. STEAP2=Six-transmembrane epithelial antigen of the prostate 2.

[1]Still listed on clinicaltrials.gov but not included in Novartis's second-quarter 2026 earnings presentation.
[2]Pre-targeted radio immunotherapy approach.
[3]Incorporates a dendrimer scaffold for conjugating the nanobody and lutetium and controlling overall molecular weight.

Sources: Company reports and William Blair Equity Research

Exhibit 12
Radiopharmaceuticals
Private U.S. and Canadian Companies Operating in Therapeutics Within the Radiopharmaceuticals Industry

Company	Location	Asset	Radionuclide	Targets	Targeting moiety	Indication	Phase
Alpha9 Theranostics	Vancouver	A9-0631	Lu-177	GRPR	Ligand	Breast, prostate, CRC	Phase I/Ib
		A9-0642	Ac-225	GRPR	Ligand	Breast, prostate, CRC	Phase I/Ib
		A9-0941	Ac-225	Undisclosed	Ligand	PDAC, HNSCC	Preclinical
		A9-0731	Lu-177	CCK2R	Ligand	SCLC, NETs	Preclinical
		A9-0741	Ac-225	CCK2R	Ligand	SCLC, NETs	Preclinical
Asta Bio	Boston, MA	Undisclosed	At-211	Undisclosed	Single-domain antibody	Solid tumors	Preclinical
Cancer Targeted Technology	Washington	CTT1403[1]	Lu-177	PSMA	Ligand	mCRPC	Phase I trial completed 2023
Convergent Therapeutics	Cambridge, MA	CONOV1-α	Ac-225	PSMA	Antibody (J591)	mCRPC	Phase II CONVERGE-01
						Progressive mCRPC	Phase I/II
						Non-prostate cancer	IND enabling
dGenThera	Durham, NC	DGT-77	At-211	Undisclosed transporter	SM	Breast cancer	Preclinical
		DGT-207	At-211	Undisclosed receptor	Bioligand	Undisclosed	Preclinical
Fuzionaire Theranostics	Woodlands, TX	FTX-426	Lu-177	GRPR	Ligand	Prostate and breast cancer	First-in-human
		N/A	Tb-161	Not disclosed	Ligand	Not disclosed	Lead optimization
		N/A	Pb-212	Not disclosed	Ligand	Not disclosed	Discovery
Grafton Therapeutics	New York	SMTR-001 to SMTR-005[2]	Not disclosed	SSTR2/SSTR5	Ligand	Not disclosed	Preclinical
Monopar	Wilmette, IL	MNPR-101-Lu	Lu-177	uPAR	Antibody	Advanced solid cancers	Phase Ia
		MNPR-101-Ac	Ac-225	uPAR	Antibody	Advanced solid cancers	Late preclinical
NAYA Therapeutics	Miami, FL	NY-703	At-211	GPC3	Antibody fragment	HCC	Early clinical (China)
		NY-738	At-211	CD38	Antibody fragment	Multiple myeloma	Early clinical
RadioMedix	Houston, TX	RMX-GPC3-VH	Pb-212	GPC3	Vect-Horus vectors	HCC	Preclinical
		RMX-PSMA	Pb-212	PSMA	Not disclosed	Prostate cancer	Preclinical
		RMX-VH	Pb-212	LDLR	Vect-Horus vectors	GBM, PDAC	Preclinical
Radionetics	California	N/A	Alpha and beta	GPCR	SM	Solid cancers	Preclinical
Ratio Therapeutics	Boston, MA	[Ac-225]-RTX-2358	Ac-225	FAP	SM	Advanced sarcoma	Phase I/II ATLAS
		N/A	Lu-177	FAP	SM	Solid tumors	Phase I[3]
		N/A	Not disclosed	SSTR2	SM	NETs	Preclinical
		N/A	Not disclosed	GRPR/GRPR+FAP	SM	Solid tumors	Preclinical
Trevarex	Philly, PA	AlphaPARP	At-211	PARP	SM	Ovarian cancer	Preclinical
Z-Alpha	San Diego, CA	PMI21	At-211	PSMA	Not disclosed	Prostate cancer	IND-enabling[4]
		PMI31	At-211	FAP	Not disclosed	Not disclosed	Not disclosed
		PMI41	At-211	CAIX	Not disclosed	Not disclosed	Not disclosed

CAIX=Carbonic anhydrase 9. CCK2R=Cholecystokinin B receptor. CRC=Colorectal cancer. FAP=Fibroblast activation protein. GBM=Glioblastoma. GPC3=Glypican-3. GPCR=G-protein coupled receptor. GRPR=Gastrin-releasing peptide receptor. HCC=Hepatocellular carcinoma. HNSCC=Head and neck squamous cell carcinoma. LDLR=Low-density lipoprotein receptor. mCRPC=Metastatic castration-resistant prostate cancer. NETs=Neuroendocrine tumors. PARP=Poly(ADP-ribose) polymerase. PDAC=Pancreatic ductal adenocarcinoma. PSMA=Prostate-specific membrane antigen. SCLC=Small-cell lung cancer. SM=Small molecule. SSTR=Somatostatin receptor. uPAR=Urokinase-type plasminogen activator receptor.

[1]Asset available for licensing.
[2]The company has mentioned designing and synthesizing these five agonists but unclear which, if any, are being advanced.
[3]Compassionate use/investigator-initiated trial.
[4]Exact development status of PMI21, along with remaining pipeline assets, is not certain.

Sources: Company reports and William Blair Equity Research

Exhibit 12 (Continued)
Radiopharmaceuticals
Private International Companies Operating in Therapeutics Within the Radiopharmaceuticals Industry

Company	Location	Asset	Radionuclide	Targets	Targeting moiety	Indication	Phase
AdvanCell	Sydney	ADVC001	Pb-212	PSMA	Ligand	mCRPC	Phase I/II TheraPb
		ADVC002	Pb-212	Not disclosed	Ligand[1]	Melanoma	Development candidate
		ADVC003	Pb-212	Not disclosed	Ligand[1]	Ovarian, breast, lung	Lead optimization
		ADVC004	Pb-212	Not disclosed	Ligand[1]	Lung, prostate, head and neck, other	Lead optimization
		ADVC005	Pb-212	Not disclosed	Ligand[1]	Lung, pancreatic	Lead generation
		ADVC006	Pb-212	Not disclosed	Ligand[1]	RCC, ovarian	Lead generation
Affibody	Sweden	ABY-271	Lu-177	HER2	Engineered protein	Breast, GEA, other cancers	First-in-human
		ABY-071	Lu-177	B7-H3	Engineered protein	TNBC, pancreatic, SCLC, NSCLC	Preclinical
Alpha Fusion	Japan	af-001	At-211	Sodium iodide symporter	SM	Thyroid cancer	Phase I
		af-002	At-211	PSMA	SM	Prostate cancer	Phase I
		af-003	At-211	LAT1	SM	Pan-cancer	IND-enabling
		Undisclosed	At-211	Undisclosed	Peptide	Undisclosed	Screening
		Undisclosed	At-211	Undisclosed	SM	Undisclosed	Screening
ArtBio	Norway	AB001	Pb-212	PSMA	Small molecule	mCRPC	Phase I
		ABD	Pb-212	Not disclosed	Not disclosed	TNBC, HNSCC, others	Preclinical
		ABA	Pb-212	Not disclosed	Small molecule	NSCLC, pancreatic, others	Preclinical
		ABC	Pb-212	Not disclosed	Small molecule[1]	Multiple solid tumors	Discovery
Atonco	France	ATO-101	At-211	CAIX	Antibody[2]	Bladder cancer	Phase I (IST)
Blue Earth Therapeutics	UK	^{177}Lu-rhPSMA-10.1	Lu-177	PSMA	Radiohybrid ligand	Prostate cancer	Phase I/II
		^{225}Ac-rhPSMA-10.1	Ac-225	PSMA	Radiohybrid ligand	Prostate cancer	Preclinical
Curium	UK	Lu-177-PSMA-I&T	Lu-177	PSMA	Ligand	mCRPC	Phase III ECLIPSE
Full-Life Technologies	Shanghai, China	FL-020	Ac-225	PSMA	Ligand	Prostate cancer	Phase I ProTACT
		FL-091	Not disclosed	NTSR1	Ligand	GI cancers, SCCHN	First-in-human
		FL-031	Not disclosed	SSTR	Ligand	NETs, SCLC, breast	First-in-human
		FL-802	Not disclosed	B7-H3	Ligand	SCLC, CRC	First-in-human
		FL-261	Not disclosed	c-MET	Ligand	NSCLC, gastric, CRC	First-in-human

CAIX=Carbonic anhydrase 9. CRC=Colorectal cancer. GEA=Gastroesophageal adenocarcinoma. GI=Gastrointestinal. HNSCC=Head and neck squamous cell carcinoma. LAT1=L-type amino acid transporter 1. mCRPC=Metastatic castration-resistant prostate cancer. NETs=Neuroendocrine tumors. NSCLC=Non-small-cell lung cancer. NTSR1=Neurotensin receptor 1. PSMA=Prostate-specific membrane antigen. RCC=Renal cell carcinoma. SCCHN=Squamous cell carcinoma of the head and neck. SCLC=Small-cell lung cancer. SM=Small molecule. SSTR=Somatostatin receptor. TNBC=Triple-negative breast cancer.

[1]Not specifically disclosed.
[2]Administered intravesically.
Sources: Company reports and William Blair Equity Research

Exhibit 12 (Continued)
Radiopharmaceuticals
Private International Companies Operating in Therapeutics Within the Radiopharmaceuticals Industry

Company	Location	Asset	Radionuclide	Targets	Targeting moiety	Indication	Phase
GlyTherix	Sydney, Australia	^{177}Lu-Miltuximab	Lu-177	GPC-1	Antibody	Not disclosed	Planning Phase Ib
ITM	Germany	ITM-11	Lu-177	SSTR	Peptide	GEP-NETs (grade 1 and 2)	Recent CRL
						GEP-NETs (grade 2 and 3)	Phase III COMPOSE
						Lung NETs	Phase III LEVEL
						Pediatric SSTR-positive tumors	Phase I KinLET
		ITM-91	Lu-177	CAIX	Ligand	ccRCC, CAIX-positive tumors	Phase I
		ITM-31	Lu-177	CAXII	Ligand	Glioblastoma	Phase I
		ITM-23	Tb-161	PSMA	Ligand	Prostate	Phase I
		ITM-63	Tb-161	SSTR	Ligand (antagonist)	SSTR-positive tumors	Phase I
		ITM-22	Ac-225	PSMA	Ligand	Prostate	Preclinical
		ITM-51	Lu-177	FRα	Ligand	Ovarian cancer	Preclinical
Molecular Partners	Switzerland	MP0712	Pb-212	DLL3	DARPin	SCLC and NECs	Phase I/IIa (with Orano Med)
		MP0726	Pb-212	Mesothelin	DARPin	Ovarian cancer	FIH initiating 2026
Nuclidium	Switzerland	NU101	Cu-67	PSMA	Ligand	mCRPC	Entering Phase I
		NU201	Cu-67	SSTR	Peptide	HR+/HER2- breast cancer	Preclinical
Orano Med	France	AlphaMedix (with RadioMedix)	Pb-212	SSTR	Peptide	NETs	Phase II ALPHAMEDIX02
		^{212}Pb-GRPR	Pb-212	GRPR	Ligand	Breast and prostate cancer, glioblastoma	Phase I
		^{212}Pb-PSMA	Pb-212	PSMA	Ligand	Prostate cancer	Pre-IND
PeptiDream	Japan	PD-32766	Ac-225	CAIX	Macrocyclic peptide ligand	Renal cell carcinoma	Phase I
		PD-29875	Ac-225	Claudin18.2	Macrocyclic peptide ligand	Gastric cancer	IND-enabling
		N/A	Ac-225, Lu-177	Cadherin 3	Macrocyclic peptide ligand	HNSCC	IND-enabling

CAIX=Carbonic anhydrase 9. CAXII=Carbonic anhydrase 12. ccRCC=Clear cell renal cell carcinoma. CEA=carcinoembryonic antigen. CRL=Complete response letter. DARPin=Designed ankyrin repeat proteins. DLL3=Delta-like ligand 3. FAP=Fibroblast activation protein. FIH=First in-human. FRα=Folate receptor alpha. GEP=Gastroenteropancreatic. GPC-1=Glypican-1. GRPR=Gastrin-releasing peptide receptor. HNSCC=Head and neck squamous cell carcinoma. mCRPC=Metastatic castration-resistant prostate cancer. NECs=Neuroendocrine carcinomas. NETs=Neuroendocrine tumors. PSMA=Prostate-specific membrane antigen. SCLC=Small-cell lung cancer. SSTR=Somatostatin receptor.

[1]Pre-targeted radio immunotherapy approach.
Sources: Company reports and William Blair Equity Research

Exhibit 13
Radiopharmaceuticals
Public Companies Operating in Diagnostics Within the Radiopharmaceuticals Industry

Company	Asset	Radionuclide	Targets	Indication	Phase
Bicycle Therapeutics	N/A	Ga-68	EphA2	Solid tumors	IND-enabling
	N/A	Ga-68	MT1-MMP	Solid tumors	IND-enabling
Clarity	^{64}Cu-SARTATE	Cu-64	SSTR2	NETs	Phase II DISCO complete
	^{64}Cu-SAR-bisPSMA	Cu-64	PSMA	High-risk prostate cancer	Phase III CLARIFY
				Recurrent prostate cancer	Phase I/II COBRA complete
				mCRPC	Phase I/II SECuRE
	^{64}Cu-SAR-Bombesin	Cu-64	GRPR	Recurrent prostate cancer	Phase II SABRE complete
Eli Lilly	Tauvid	F-18	Tau	Alzheimer's disease	Commercialized
	Amyvid	F-18	Amyloid beta	Alzheimer's disease	Commercialized
Lantheus[1]	Pylarify	F-18	PSMA	Prostate cancer	Commercialized
	Tauklarify	F-18	Tau	Alzheimer's disease	Approved
	Octevy/LNTH-2501	Ga-68	SSTR	NETs	Resubmission in progress
	NAV-4694	F-18	Amyloid beta	Alzheimer's disease	Phase III
	LNTH-2515	F-18	Amyloid	Cardiac amyloidosis	Phase III
	LNTH-2620	F-18	Tau	Alzheimer's disease	Phase III
	LNTH-2401	Ga-68	GRPR	Prostate cancer	Phase II
	LNTH-2513	F-18	GPIIb-IIIa	Thromboembolism	Phase II
	LNTH-2503	Ga-68	CCK2R	SCLC	Phase I
	LNTH-1363S	Cu-64	FAP	Tumor/fibrosis assessment	Phase I
	LNTH-2511	F-18	MAO-B	Neuroinflammation	Phase I
	LNTH-2205	Ga-68	Undisclosed	Glioblastoma	Preclinical
	LNTH-2507	Ga-68	Undisclosed	Pancreatic cancer	Preclinical
	LNTH-2509	Ga-68	Undisclosed	Lobular breast cancer	Preclinical
Novartis	Netspot	Ga-68	SSTR	NETs	Commercialized
	Locametz	Ga-68	PSMA	Prostate cancer	Commercialized
	CTT1057	F-18	PSMA	Newly diagnosed high-risk prostate cancer	Phase II/III complete
				Biochemical recurrent prostate cancer	Phase III complete
Pentixapharm	PT-001 (PentixaFor)	Ga-68	CXCR4	Hypertension – primary aldosteronism	Phase III ready
	PT-003	F-18	CXCR4	Cardiovascular, endocrine, and oncology	Preclinical
Philogen	OncoFAP	Ga-68	FAP	Solid tumors	Phase I FAPrimo complete
	OncoACP3	Ga-68	ACP3	Prostate cancer	Phase I complete
	OncoCAIX	Ga-68	CAIX	CAIX-positive cancer	Phase I complete
	OncoFAP-GlyPro-MMAE	Not disclosed	FAP	Solid tumors	Preclinical
Perspective Therapeutics	^{203}Pb-VMT-α-NET	Pb-203	SSTR	NETs	Phase I[2]
	VMT01	Pb-203	MC1R	Melanoma	Phase I[2]
	VMT02	Ga-68	MC1R	Melanoma	Phase I[2]
	PSV377	Pb-203	FAP	Solid tumors	Phase I[2]
	PSV507	Not disclosed	CCK2R	Solid tumors	Initial imaging[2]
Telix	Illuccix/Gozellix	Ga-68	PSMA	Prostate cancer	Commercialized
	Scintimun	Tc-99m	CEA	Suspected osteomyelitis	Commercialized
	TLX599-CDx	Tc-99m	PSMA	Prostate cancer	Noble registry
	Zircaix	Zr-89	CAIX	Kidney cancer	BLA resubmission in progress
	Pixclara	F-18	LAT-1	Brain cancer	September 11 PDUFA
	TLX300-CDx	Zr-89	PDGFRα	Soft tissue sarcoma	Phase I ZOLAR

ACP3=Acid phosphatase 3. CAIX=Carbonic anhydrase IX. CCK2R=Cholecystokinin B receptor. CEA=Carcinoembryonic antigen. CXCR4=C-X-C chemokine receptor type 4. EphA2=Ephrin type-A receptor 2. FAP=Fibroblast activation protein. GRPR=Gastrin releasing peptide receptor. LAT-1=L-type amino acid transporter 1. MC1R=Mitochondrial complex 1 receptor. mCRPC=Metastatic castration-resistant prostate cancer. MOA-B=Monoamine oxidase B. MT1-MMP=Membrane-type 1 matrix metalloproteinase. NETs=Neuroendocrine tumors. PDGFRα=Platelet derived growth factor receptor alpha. PD-L1=Programmed death-ligand 1. PSMA=Prostate-specific membrane antigen. SSTR=Somatostatin receptor. SCLC=Small-cell lung cancer.

[1]Given the proposed acquisition with Curium, we have limited visibility into recent pipeline development progress for Lantheus and its future plans.

[2]Unsure of exact development stage and to what extent this asset is being developed.

Exhibit 13 (Continued)
Radiopharmaceuticals
Private Companies Operating in Diagnostics Within the Radiopharmaceuticals Industry

Company	Asset	Radionuclide	Targets	Indication	Phase
Alpha-9	A9-6217	Ga-68	GRPR	Breast, prostate, colorectal	Phase I/Ib
	A9-0922	Ga-68	Undisclosed	PDAC, HNSCC	Discovery
	A9-0721	Ga-68	CCK2R	SCLC, neuroendocrine	Discovery
Blue Earth Diagnostics	Posluma	F-18	PSMA	Prostate cancer	Commercialized
				Non-prostate cancer	Phase I/II
	BED003	Ga-68	FAP	CRC, gastric, PDAC, breast, ovarian	Phase II
	FPyQCP	F-18	FAP	CRC, gastric, PDAC, breast, ovarian	Phase I/II
Curium	Detectnet	Cu-64	SSTR	NETs	Commercialized
	IASOglio	F-18	LAT1	Gliomas	Commercialized in Poland and France
	Cu-64-PSMA-I&T	Cu-64	PSMA	Intermediate-/high-/very-high- risk prostate cancer	Phase III SOLAR-Stage
				Biochemical recurrent prostate cancer	Phase III SOLAR-Recur completed
Fuzionaire Theranostics	FTX-426	F-18	GRPR	Prostate and breast cancer	First-in-human
	N/A	F-18	Undisclosed	Not disclosed	Lead optimization
	N/A	F-18	Undisclosed	Not disclosed	Discovery
ImaginAb	^{89}Zr-Df-Crefmirlimab	Zr-89	CD8	Melanoma, Merkel cell, renal cell, and NSCLC	Phase II iPREDICT (current status unknown)
				Inclusion body myositis	Phase I
	^{89}Zr-Df-IAB41M2C	Zr-89	CD4	Oncology and autoimmune diseases	Preclinical
ITM	TOCscan	Ga-68	SSTR	NETs	Commercialized[1]
	ITM-94	Ga-68	CAIX	Clear cell renal cell carcinoma	Phase I
	ITM-64	Ga-68	SSTR (antagonist)	SSTR-positive tumors	Phase I
	ITM-74	Ga-68	FAP	Oncology, fibrosis, inflammation	Phase I (compassionate use)
Monopar Therapeutics	MNPR-101	Zr-89	uPAR	Advanced solid cancers	Phase I
Nuclidium	NU101	Cu-61	PSMA	mCRPC	Entering Phase II
	NU201	Cu-61	SSTR	NETs	Phase II
RadioMedix	DetectNET	Cu-64	SSTR	NETs	Commercialized
	PSMA-11	Ga-68	PSMA	Prostate cancer	Approved
	RMX-VH	Pb-203	LDLR	GBM, PDAC	Phase II
Radiopharm Theranostics	RAD101	F-18	Fatty acid synthetase	Brain metastases	Phase IIb complete
	RAD301	Ga-68	αVβ6 integrin	Pancreatic/NSCLC	Phase I

ACP3=Acid phosphatase 3. CAIX=Carbonic anhydrase IX. CCK2R=Cholecystokinin B receptor. CD=Cluster of differentiation. CRC=Colorectal cancer. FAP=Fibroblast activation protein. GBM=Glioblastoma. GRPR=Gastrin releasing peptide receptor. HNSCC=Head and neck squamous cell carcinoma. LAT1=L-type amino acid transporter 1. LDLR=Low density lipoprotein receptor. mCRPC=Metastatic castration-resistant prostate cancer. NSCLC=Non–small-cell lung cancer. NETs=Neuroendocrine tumors. PDAC=Pancreatic ductal adenocarcinoma. PSMA=Prostate-specific membrane antigen. SCLC=Small-cell lung cancer. SSTR=Somatostatin receptor. uPAR=Urokinase-type plasminogen activator receptor.

[1]Curium also has marketing authorization in certain countries, including France, Austria, and Germany.

Sources: Company reports and William Blair Equity Research

A notable development in both the public and private spaces is the roughly $8 billion proposed acquisition of Lantheus (public) by Curium (private), which is expected to close in the first half of 2027. We view Lantheus's U.S.-centric radiodiagnostics business as complementary to Curium's theranostic portfolio. Radiopharmaceutical supply chain is complex and requires impeccable logistics management due to the just-in-time manufacturing model. We are therefore encouraged that the merger could enable an expanded global manufacturing and commercial footprint.

In terms of targeting moieties, both larger antibody formats and small-molecule/peptide ligands are being investigated, although we recognize the consensus in the field that antibodies could impose unique challenges. Specifically, in many cases, employing antibodies requires administration of nonradiolabeled antibodies before administration of the radiopharmaceutical. Infusion with non-radiolabeled antibody has a long record in the field of radiopharmaceuticals, starting with Zevalin and Bexxar, and continuing with some versions of J591, though not all antibody-based

moieties require pre-targeting (including Telix's TLX591). Overall, companies are continuing to explore both types of targeting moieties, and some companies investigating antibody-based therapies are working to more precisely tune the specific characteristics and properties of the antibody portion.

There is also a belief in the field that the half-life of the isotope should roughly match the circulating time of the therapy so that the radiopharmaceutical is not excreted before being taken up in the tumor and having the opportunity to emit cancer-cell-killing radiation. Thus, there could theoretically be opportunities for both types of targeting moieties depending on the chosen isotope. However, we highlight that at the 2024 SNMMI annual meeting, stakeholders engaged in an animated debate over potential safety concerns associated with antibody-based radiopharmaceuticals when combined with actinium-225 (specifically, in the Phase I trial of JNJ-69086420, which employs an antibody targeting human kallikrein 2, four patients died from treatment-related adverse events). In our view, this supports the growing consensus in the field that full antibody modalities may have a limited use-case (especially when combined with actinium-225), even though antibodies have been the modality of choice historically.

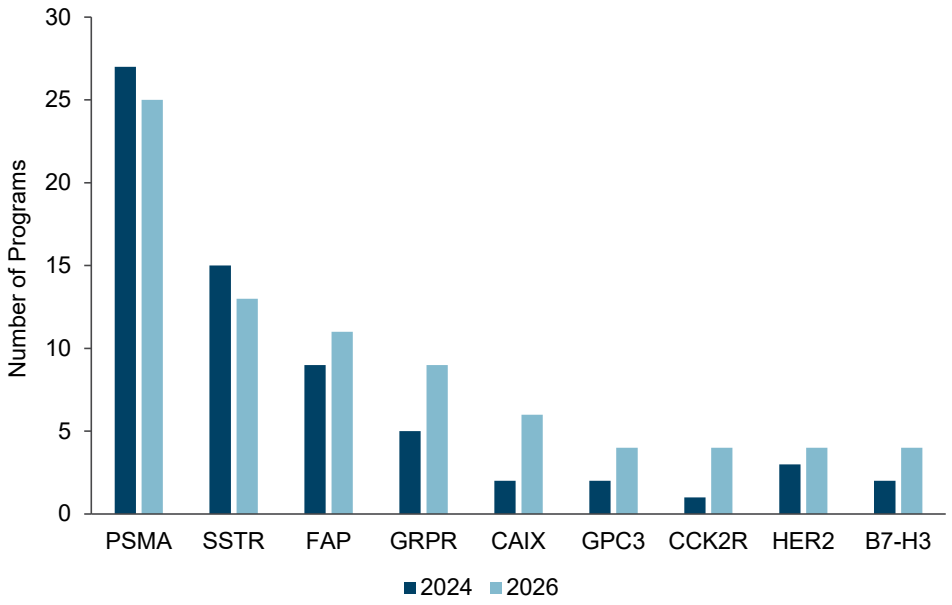
Recognizing both the potential challenges and the benefits (namely, selectivity and specificity) associated with antibodies, there is a trend toward developing targeting moieties that straddle antibodies and smaller-molecule formats. Both small molecules and peptides are recognized for their rapid tumor uptake and quick clearance of excess drug product from the body. Some companies, such as Aktis, are developing targeting moieties that take advantage of key benefits from each type of platform.

The majority of companies currently in operation are more focused on R&D and clinical development than on manufacturing. However, many of the companies that had also been focused on manufacturing, including isotope production, have been previously acquired. Australia-based AdvanCell stands out as being committed to manufacturing, and in June the company announced that U.S. global headquarters had been established. This includes leasing a 128,000-square-foot facility in Andover, part of the Greater Boston area, for U.S.-based manufacturing of lead-212-based ADVC001. AdvanCell will continue building manufacturing capabilities as the company works toward Phase III development and eventual commercialization.

Targets and Isotopes of Interest

While PSMA and SSTR remain the most popular targets in the therapeutic space, we recognize the growing body of targets under investigation across both alpha- and beta-emitting isotopes. In particular, FAP, GRPR, and CAIX are rising as popular targets, and the number of programs pursuing these targets has notably increased in the past several years while the relative proportion of PSMA and SSTR have decreased (exhibit 14). Within alpha-emitters, the greatest variety of targets resides with actinium-225, and there are Phase III programs for both PSMA and SSTR (exhibit 15). PSMA and SSTR are also the most popular for lead-212, supporting the approach of starting with more validated targets when pursuing new isotopes. However, there is still a broad range of targets being evaluated with lead-212. For astatine-211, we have noted an increase in the number of assets investigating the isotope. We have identified 16 assets in this category; in edition 3 of our radiopharmaceuticals report (published in June 2024), we identified only one astatine-211 asset.

Exhibit 14
Radiopharmaceuticals
Number of Assets With Different Targets: 2024 Versus 2026 Comparison



Source: William Blair Equity Research

Exhibit 15
Radiopharmaceuticals
Targets Under Investigation or Being Used in Radiopharmaceuticals With Alpha-Emitting Isotopes (Asset Numbers and Stages Based on Companies Listed in Exhibits 12 and 13)

Isotope	Target	Number of Assets	Most Advanced Stage of Development
Actinium-225	PSMA	10	Phase III
Total assets: 34	SSTR(2)	2	Phase III
	FAP	2	Phase I/II
	CAIX	2	Phase I
	GPC3	2	Phase I
	Not disclosed	2	Phase I
	GRPR	1	Phase I
	Nectin-4	1	Phase I
	B7-H3	1	Phase I
	STEAP2	1	Phase I
	hK2	1	Phase I
	DLL3	1	Phase I
	CD33	1	Phase I
	CCK2R	1	Preclinical
	Cahderin 3	1	Preclinical
	Claudin18.2	1	Preclinical
	Lipid rafts	1	Preclinical
	uPAR	1	Preclinical
	ACP3	1	Preclinical
	CD24	1	Preclinical
Lead-212	Not disclosed	9	Preclinical
Total assets: 25	PSMA	4	Phase I/II
	SSTR(2)	2	Phase II
	MC1R	1	Phase I/II
	FAP	1	Phase I/II
	DLL3	1	Phase I/II
	GRPR	1	Phase I
	CEA	1	Phase I
	CCK2R	1	Preclinical
	Mesothelin	1	Preclinical
	MT1-MMP	1	Preclinical
	LDLR1	1	Preclinical
	GPC3	1	Preclinical
Astatine-211	Not disclosed	5	Preclinical
Total assets: 16	PSMA	2	Phase I
	CAIX	2	Phase I
	LAT-1	2	Preclinical
	GPC3	1	Phase I
	CD38	1	Phase I
	Sodium iodide symporter	1	Phase I
	PARP	1	Preclinical
	FAP	1	Not disclosed

ACP3=Acid phosphatase 3. CAIX=Carbonic anhydrase 9. CCK2R=Cholecystokinin 2 receptor. CEA=Carcinoembryonic antigen. DLL3=Delta-like ligand 3. FAP=Fibroblast activation protein. GPC3=Glypican-3. GRPR=Gastrin releasing peptide receptor. hK2=Human kallikrein-2. LAT-1=L-type amino acid transporter 1. LDLR1=Low-density lipoprotein receptor 1. MC1R=Melanocortin 1 receptor. MT1-MMP=Membrane type-1 matrix metalloproteinase. PARP=Poly-ADP ribose polymerase. PSMA=Prostate-specific membrane antigen. SSTR=Somatostatin receptor. STEAP2=Six-transmembrane epithelial antigen of the prostate 2. uPAR=Urokinase-type plasminogen activator receptor.

Source: William Blair Equity Research

Although there are a number of assets across the three alpha emitters actinium-225, lead-212, and astatine-211, there is a high concentration in lutetium-177 when it comes to beta emitters. Within lutetium-177, FAP actually dominates, though PSMA and GRPR follow closely behind while SSTR lags (exhibit 16). We hypothesize that because lutetium-177 is well established from both clinical and regulatory perspectives, companies are more likely to pursue novel targets within the industry. In these cases, companies avoid the risk of simultaneously exploring uncertain target biology and unvalidated isotope selection. In exhibit 17, we provide a list of targets for which the isotope of interest has not yet been disclosed. Overall, the exact characteristics of what contributes to a "good" target within radiopharmaceuticals remain elusive, but we are encouraged that the target space is expanding. For all our target summary tables and graphs, we note that the exact numbers are based on our research analysis and could differ slightly from the real world but should still illustrate relative numbers and general trends.

Exhibit 16
Radiopharmaceuticals
Targets Under Investigation or Being Used in Radiopharmaceuticals With Beta- or Gamma-Emitting Isotopes (Asset Numbers and Stages Based on Companies Listed in Exhibits 12 and 13)

Isotope	Target	Number of Assets	Most Advanced Stage of Development
Lutetium-177	FAP	7	Phase I/II
Total assets: 43	PSMA	6	Approved
	GRPR	6*	Phase I/II
	HER2	4	Phase I
	SSTR(2)	3	Approved
	Not disclosed	3	Preclinical
	CAIX	2	Phase II/III
	B7H3	2	Phase I/II
	CCK2R	2	Phase I
	CXCR4	1	Phase I/II
	CAXII	1	Phase I
	uPAR	1	Phase I
	LRRC15	1	Phase I
	PD-L1	1	Phase I
	GPC-1	1	Phase I
	FRα	1	Preclinical
	Cadherin 3	1	Preclinical
Copper-67	SSTR(2)	2	Phase I/II
Total assets: 5	PSMA	2	Phase I/II
	GRPR	1	Phase I/II
Iodine-131 (β and γ)	CD45	1	Phase I
	Lipid rafts	1	Phase III
Total assets: 3	LAT-1	1	Phase III
Terbium-161	Not disclosed	1	Preclinical
Total assets: 4	PSMA	1	Phase I
	SSTR(2)	1	Phase I
	KLK3	1	Phase I
Yttrium-90	CD66	1	Phase II
Total assets: 2	CXCR4	1	Phase I/II
Samarium-153	Not disclosed	1	Phase I
Total assets: 1			

*One asset is a GRPR antagonist.

CAIX=Carbonic anhydrase 9. CAXII=Carbonic anhydrase 12. CCK2R=Cholecystokinin 2 receptor. CXCR4=C-X-C chemokine receptor type 4. AP=Fibroblast activation protein. FRα=Folate receptor alpha. GPC-1=Glypican 1. GRPR=Gastrin releasing peptide receptor. HA=Hydroxyapatite. HER2=Human epidermal growth factor receptor 2. KLK3=Kallikrein-related peptidase 3. LAT-1=L-type amino acid transporter 1. LRRC15=Leucine-rich repeat-containing protein 15. PARP=Poly (ADP-ribose) polymerase. PD-L1=Programmed death-ligand 1. PSMA=Prostate-specific membrane antigen. SSTR=Somatostatin receptor. uPAR=Urokinase-type plasminogen activator receptor.

Source: William Blair Equity Research

Exhibit 17
Radiopharmaceuticals
Targets Under Investigation or Being Used in Radiopharmaceuticals With Unspecified Isotopes

Isotope	Target	Number of Assets	Most Advanced Stage of Development
Specific isotope not disclosed	Not disclosed	2	Phase I/II
	SSTR(2)	2	Phase I
Total assets: 12	B7H3	1	Phase I
	NTSR1	1	Phase I
	c-MET	1	Phase I
	PDGFRα	1	Phase I
	EphA2	1	Preclinical
	TROP-2	1	Preclinical
	SSTR2/SSTR5	1	Preclinical
	GRPR	1	Preclinical

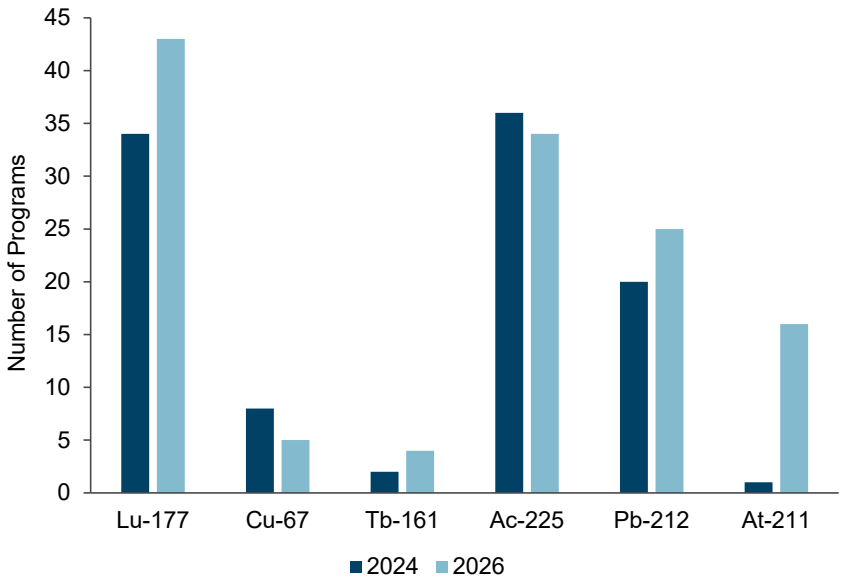
Note: Asset numbers and stages are based on companies listed in exhibits 12 and 13

EphA2=Ephrin type-A receptor 2. GRPR=Gastrin releasing peptide receptor. NTSR1=Neurotensin receptor 1. PDGFRα=Platelet-derived growth factor receptor alpha. SSTR=Somatostatin receptor. TROP-2=Trophoblast cell-surface antigen 2.

Source: William Blair Equity Research

We also conducted an analysis of the number of assets across several of the most investigated isotopes in the industry for both beta and alpha emitters (exhibit 18). Of note, although lead-212 still lags actinium-225, the gap appears to be closing. In addition, as discussed above, we are intrigued by the rapid increase in the number of programs pursuing astatine-211, which is corroborated by the increase in astatine-focused companies.

Exhibit 18
Radiopharmaceuticals
Number of Assets With Different Isotopes: 2024 Versus 2026 Comparison



Source: William Blair Equity Research

Clinical Trials of Actinium-225, Lead-212, and Terbium-161

As alpha-emitting isotopes gain popularity, there are an increasing number of clinical trials evaluating actinium-225 and lead-212. We have summarized ongoing trials in exhibits 19 and 20 based on the ClinicalTrials.gov registry.

Exhibit 19
Radiopharmaceuticals
Ongoing Clinical Trials (Phase I/II Through Phase III) Involving Actinium-225 Assets (Based on ClinicalTrials.gov Registry)

Asset/Regimen	Target	Indication	Phase	Company/ Sponsor	Study Title	Trial ID	Status	Estimated Primary Completion
RYZ101	SSTR2	GEP-NETs with prior Lutathera	III	Bristol Myers Squibb	Study of RYZ101 Compared With SOC in Pts w Inoperable SSTR+ Well-differentiated GEP-NET That Has Progressed Following 177Lu-SSA Therapy (ACTION-1)	NCT05477576	Recruiting	December 2026
^{225}Ac-PSMA-617 (AAA817)	PSMA	mCRPC with prior ARPI[1]	III	Novartis	Study Comparing AAA817+ARPI With Standard of Care in Adult Participants With PSMA-Positive mCRPC (AcTFirst)	NCT06855277	Recruiting	February 2028
^{225}Ac-PSMA-617 (AAA817)	PSMA	mCRPC with prior ARPI, taxane, and 177Lu-PSMA therapy	II/III	Novartis	Open-label Study Comparing AAA817 With Standard of Care in the Treatment of Previously Treated PSMA-Positive mCRPC Adults Who Have Disease Progressed on or After [177Lu]Lu-PSMA Targeted Therapy (PSMAcTION)	NCT06780670	Recruiting	June 2028
^{225}Ac-FPI-2265 (PSMA-I&T)	PSMA	mCRPC	II	AstraZeneca	Targeted Alpha Therapy With 225Actinium-Prostate Specific Membrane Antigen (PSMA)-I&T of Castration-resISTant Prostate Cancer (TATCIST)	NCT05219500	Active, not recruiting	May 2025 (actual)
^{225}Ac-FPI-2265 (PSMA-I&T)	PSMA	mCRPC with prior 177Lu-PSMA	II	AstraZeneca	FPI-2265 (225Ac-PSMA-I&T) for Patients With PSMA-Positive Metastatic Castration-Resistant Prostate Cancer (mCRPC) (AlphaBreak)	NCT06402331	Active, not recruiting	December 2026
CONV01-α (J591 antibody)	PSMA	Progressive CRPC (includes part with prior Pluvicto patients)	II	Convergent Therapeutics	Study Evaluating Dosimetry, Randomized Dose Optimization, Dose Escalation and Efficacy of Ac-225 Rosopatamab Tetraxetan in Participants With PSMA PET-Positive Castration-Resistant Prostate Cancer	NCT06549465	Recruiting	April 2027
^{225}Ac-FPI-2265 (PSMA-I&T)	PSMA	mCRPC (both pre and post 177Lu-PSMA	II	AstraZeneca	FPI-2265 (225Ac-PSMA-I&T) and Olaparib for Patients With Metastatic Castration-Resistant Prostate Cancer (mCRPC)	NCT06909825	Active, not recruiting	January 2030
^{225}Ac-J591	PSMA	mCRPC with prior ARPI	I/II	Cornell	Fractionated and Multiple Dose 225Ac-J591 for Progressive mCRPC	NCT04506567	Active, not recruiting	June 2025 (actual)
^{225}Ac-LNC1011	PSMA	mCRPC	I/II	First Affiliated Hospital of Fujian Medical University	Sequential Study of 225Ac-LNC1011 in the Treatment of Metastatic Castration-Resistant Prostate Cancer	NCT07363486	Recruiting	December 2026
RYZ101	SSTR2	Intracranial meningioma	I/II	Joshua Palmar (Ohio State University)	RYZ101 for the Treatment of Progressive or Recurrent Intracranial Meningioma	NCT07150806	Recruiting	December 2026
^{225}Ac-J591 with Keytruda and ARPI	PSMA	mCRPC with prior ARPI	I/II	Cornell	Phase I/II Trial of Pembrolizumab and Androgen-receptor Pathway Inhibitor With or Without 225Ac-J591 for Progressive Metastatic Castration Resistant Prostate Cancer	NCT04946370	Recruiting	October 2027
^{225}Ac-LNC1011	PSMA	mCRPC	I/II	First Affiliated Hospital of Fujian Medical University	Prospective Clinical Trial of 225Ac-LNC1011 in the Treatment of Metastatic Castration-Resistant Prostate Cancer	NCT07117760	Active, not recruiting	December 2027
RTX-2358	FAP	Sof tissue sarcoma	I/II	Ratio Therapeutics	Actinium Therapy for Late-stage Aggressive Sarcomas (ATLAS)	NCT07156565	Recruiting	January 2028
RYZ101	SSTR2	HER2-negative breast cancer	I/II	Bristol Myers Squibb	Trial of 225Ac-DOTATATE (RYZ101) in Subjects With ER+, HER2-Negative Unresectable or Metastatic Breast Cancer Expressing SSTRs. (TRACY-1)	NCT06590857	Recruiting	October 2028
^{225}Ac-rhPSMA-10.1	PSMA	Prostate cancer	I/II	University College, London	ACTinium in Castrate-RESistant Prostate Cancer After LUTEtium (ACT-RESoLUTE)	NCT07414940	Recruiting	March 2031

[1]No exposure to taxane-based chemotherapy in mCRPC setting.

ARPI=Androgen receptor pathway inhibitor. FAP=Fibroblast activation protein. GEP-NETs=Gastroenteropancreatic neuroendocrine tumors. mCRPC=Metastatic castration-resistant prostate cancer. PSMA=Prostate-specific membrane antigen. SSTR=Somatostatin receptor.
Sources: ClinicalTrials.gov and William Blair Equity Research

Exhibit 19 (Continued)
Radiopharmaceuticals
Ongoing Phase I Clinical Trials Involving Actinium-225 Assets (Based on ClinicalTrials.gov Registry)

Asset/Regimen	Target	Indication	Phase	Company/ Sponsor	Study Title	Trial ID	Status	Estimated Primary Completion
Ac225-DOTA-M5A	CEA	Advanced or metastatic cancer	I	City of Hope	Actinium 225 Labeled Anti-CEA Antibody (Ac225-DOTA-M5A) for the Treatment of CEA Producing Advanced or Metastatic Cancers	NCT05204147	Recruiting	July 2026
^{225}Ac-ABD147	DLL3	SCLC and LCNEC	I	Abdera	Study of 225Ac-ABD147 to Establish Optimal Dose in Patients With SCLC and LCNEC of the Lung That Previously Received Platinum-based Chemotherapy	NCT06736418[1]	Recruiting	August 2026
^{225}Ac-FL-020	PSMA	mCRPC with prior ARPI and taxane	I	Full-Life Technologies	Study With [225Ac]Ac-FL-020 in mCRPC Participants (ProTACT)	NCT06492122	Recruiting	October 2026
^{225}Ac-PSMA-XT	PSMA	mCRPC	I	Xiaorong Sun	A Clinical Study to Evaluate the Safety, Tolerability and Preliminary Efficacy of [225Ac]Ac-PSMA-XT Injection in Patients With Metastatic Castration-resistant Prostate Cancer	NCT07135102	Recruiting	December 2026
^{225}Ac-FAPI-XT	FAP	Advanced solid tumors	I	Xiaorong Sun	A Clinical Study of [225Ac]Ac-FAPI-XT(XT117) Injection in Patients With Advanced Solid Tumors	NCT07135128	Recruiting	December 2026[2]
^{225}Ac-PSMA-617	PSMA	Prostate cancer	I	Endocyte	Study of 225Ac-PSMA-617 in Men With PSMA-Positive Prostate Cancer	NCT04597411	Active, not recruiting	January 2027
^{225}Ac-PSMA-617	PSMA	mCRPC	I	Novartis	Study of 225Ac-PSMA-617 in Men With PSMA-Positive Prostate Cancer	NCT04597411	Recruiting	January 2027
RYZ401	SSTR	Solid tumors	I	Bristol Myers Squibb	Study of RYZ401 in Subjects With Solid Tumors Expressing SSTRs.	NCT07165132	Recruiting	February 2027
^{225}Ac-DOTA-daratumumab	CD38	Multiple myeloma	I	City of Hope Medical Center	Radioimmunotherapy (111Indium/225Actinium-DOTA-daratumumab) for the Treatment of Relapsed/Refractory Multiple Myeloma	NCT05363111	Recruiting	March 2027
^{225}Ac-DOTA-daratumumab	CD38	Multiple myeloma	I	City of Hope	Radioimmunotherapy (111Indium/225Actinium-DOTA-daratumumab) for the Treatment of Relapsed/Refractory Multiple Myeloma	NCT05363111	Recruiting	March 2027
^{225}Ac-MTI-201	MC1R	Uveal melanoma	I	Modulation Therapeutics	Targeted Alpha Particle Radiotherapy for Metastatic Uveal Melanoma	NCT05496686	Recruiting	March 2027
^{177}Lu-PSMA-617 and ^{225}Ac-PSMA-617	PSMA	mCRPC	I	Thomas Hope (UCSF)	Comparison of 177Lu-PSMA-617 and 225Ac-PSMA-617 (LUTACT)	NCT07054346	Recruiting	April 2027
BAY 3563254	PSMA	mCRPC with prior 177Lu-PSMA	I	Bayer	First-in-Human Study of 225Ac-PSMA-Trillium (BAY 3563254) in Participants With Advanced Metastatic Castration-Resistant Prostate Cancer (mCRPC) (PAnTHA)	NCT06217822	Recruiting	June 2027
RYZ101 + carboplatin, etoposide, and Tecentriq	SSTR2	ES-SCLC	I	Bristol Myers Squibb	Study of RYZ101 in Combination With SoC in Subjects With SSTR+ ES-SCLC	NCT05595460	Recruiting	June 2027
BAY3546828	PSMA	mCRPC with prior taxane and some with prior 177Lu-PSMA	I	Bayer	A Study to Learn How Safe the Study Treatment Actinium-225-Macropa-Pelgifatamab (BAY3546828) Is, How it Affects the Body, How it Moves Into, Through and Out of the Body, and About Its Anticancer Activity in Men With Advanced Metastatic Castration-Resistant Prostate Cancer (mCRPC)	NCT06052306	Active, not recruiting	June 2027
^{225}Ac-PSMA-62	PSMA	mCRPC	I	Eli Lilly	[Ac-225]-PSMA-62 Trial in Biochemically Recurrent and Metastatic Castration Resistant Prostate Cancer (ACCEL)	NCT06229366	Active, not recruiting	September 2027
JNJ-69086420	human Kallikrein-2	Prostate cancer	I	Janssen	A Study of JNJ-69086420, an Actinium-225-Labeled Antibody Targeting Human Kallikrein-2 (hK2) for Advanced Prostate Cancer	NCT04644770	Active, not recruiting	October 2027
^{225}Ac-AKY-1189	Nectin-4	Solid tumors	I	Aktis	A Study of [225Ac]Ac-AKY-1189 in Patients With Solid Tumors	NCT07020117	Recruiting	December 2027[3]
^{225}Ac-J591 with ^{177}Lu-PSMA-I&T	PSMA	mCRPC with prior ARPI	I	Weill Medical College of Cornell University	Phase I/II 225Ac-J591 Plus 177Lu-PSMA-I&T for Progressive Metastatic Castration Resistant Prostate Cancer	NCT04886986	Recruiting	December 2027
^{225}Ac-AKY-2519	B7-H3	mCRPC	I	Aktis	A Study of [225Ac]Ac-AKY-2519 in Patients With Metastatic Castration-Resistant Prostate Cancer (BActinium-1)	NCT07581184	Recruiting	December 2027
^{225}Ac-J591 and ^{177}Lu-PSMA	PSMA	mCRPC	I	Weill Medical College of Cornell University	Phase I Study of 225Ac-J591 Plus 177Lu-PSMA Small Molecule for Progressive Metastatic Castration Resistant Prostate Cancer	NCT04886986	Recruiting	December 2027
^{225}Ac-A9-3408	MC1R	Melanoma	I	Alpha-9	A Phase 1-1b Study to Evaluate the Safety, Efficacy and Dosimetry of Study Drug A9-3408 in Subjects With Metastatic Melanoma	NCT07076550[4]	Recruiting	January 2028
FPI-2068	EGFR/cMET	Advanced solid tumors	I	AstraZeneca	A Phase 1, Dose-escalation Study of [225Ac]-FPI-2068 in Adult Patients With Advanced Solid Tumours	NCT06147037	Recruiting	May 2028
^{225}Ac-A9-0642	GRPR	Solid tumors	I	Alpha-9	A Study of [177Lu]Lu-A9-0631 and [225Ac]Ac-A9-0642 With [68Ga]Ga-A9-6217 or [177Lu]Lu-A9-0631 Imaging in GRPR+ Solid Tumors	NCT07661641	Recruiting	December 2028
RYZ801	GPC3	GPC3-positive HCC	I/Ib	Bristol Myers Squibb	Study of the Theranostic Pair RYZ811 (Diagnostic) and RYZ801 (Therapeutic) to Identify and Treat Subjects With GPC3+ Unresectable HCC (GPC3)	NCT06726161	Recruiting	March 2029
AZD2284	STEAP2	mCRPC	I	AstraZeneca	A Phase I Study of [225Ac]-AZD2284 in Patients With Metastatic Castration-Resistant Prostate Cancer	NCT06879041	Recruiting	April 2029
PD-32766	CAIX	Renal cell carcinoma	I	PeptiDream	A Study of Theranostic Pair PD-32766D/T in Participants With Carbonic Anhydrase IX Positive Clear Cell Renal Cell Carcinoma	NCT07688187	Recruiting	May 2029
^{225}Ac-ETN029	DLL3	DLL3-expressing solid tumors	I	Novartis	Phase I Study of [225Ac]Ac-ETN029 in Patients With Advanced DLL3-expressing Solid Tumors	NCT07006727	Recruiting	June 2031
^{225}Ac-PSMA-R2	PSMA	Prostate cancer	I	Novartis	Phase I/II Study of [225Ac]Ac-PSMA-R2 in PSMA-positive Prostate Cancer, With/Without Prior 177Lu-PSMA RLT (SatisfACtion)	NCT05983198	Active, not recruiting	March 2031

[1]Although still listed on clinicaltrials.gov, we are unsure of trial's status given that Abdera is no longer in operation.

[2]Estimated study completion date given that primary completion date has already passed.

[3]Initial data expected in the first quarter of 2027.

[4]Alpha-9 has deprioritized the asset, but the trial is still listed on clinicaltrials.gov.

ARPI=Androgen receptor pathway inhibitor. CAIX=Carbonic anhydrase 9. CEA=Carcinoembryonic antigen. DLL3=Delta-like ligand 3. EGFR=Epidermal growth factor receptor. ES-SCLC=Extensive-stage small-cell lung cancer. GPC-3=Glypican-3. GRPR=Gastrin-releasing peptide receptor. HCC=Hepatocellular carcinoma. LCNEC=Large cell neuroendocrine carcinoma. MC1R=Melanocortin 1 receptor. mCRPC=Metastatic castration-resistant prostate cancer. PSMA=Prostate-specific membrane antigen. RLT=Radioligand therapy. SSTR=Somatostatin receptor.
Sources: ClinicalTrials.gov and William Blair Equity Research

Exhibit 20
Radiopharmaceuticals
Ongoing Clinical Trials Involving Lead-212 Assets (Based on ClinicalTrials.gov Registry)

Asset/Regimen	Target	Indication	Phase	Company/ Sponsor	Study Title	Trial ID	Status	Estimated Primary Completion
^{212}Pb-DOTAMTATE	SSTR2	NETs	II	RadioMedix/ Orano Med	Targeted Alpha-emitter Therapy of PRRT Naïve and Previous PRRT Neuroendocrine Tumor Patients (ALPHAMEDIX02)	NCT05153772	Active, not recruiting	April 2025
[^{212}Pb]VMT01-T101	MC1R	Melanoma	I/II	Perspective Therapeutics	MC1R-Targeted Alpha-Particle Therapy Trial in Adults With Advanced Melanoma	NCT05655312	Recruiting	December 2027
^{212}Pb-ADVC001	PSMA	mCRPC	I/II	AdvanCell	Dose Escalation and Efficacy Study of 212Pb-ADVC001 in Patients With Metastatic Castration Resistant Prostate Cancer	NCT05720130	Recruiting	January 2029
[^{212}Pb]VMT-α-NET	SSTR2	Gastrointestinal NETs and Pheochromocytoma/ Paraganglioma	I/II	National Cancer Institute	Somatostatin-Receptors (SSTR)-Agonist [212Pb]VMT-Alpha-NET in Metastatic or Inoperable SSTR+ Gastrointestinal Neuroendocrine Tumor and Pheochromocytoma/Paraganglioma Previously Treated With Systemic Targeted Radioligand Therapy	NCT06427798	Recruiting	July 2029
[^{212}Pb]PSV359	FAP	Solid tumors	I/IIa	Perspective Therapeutics	Lead-212 PSV359 Therapy for Patients With Solid Tumors	NCT06710756	Recruiting	January 2028
^{212}Pb-MP0712	DLL3	SCLC and other solid tumors	I/IIa	Molecular Partners	Study of [212Pb]Pb-DOTAM-MAM279 ([212Pb]Pb-MP0712) in Patients With Small-Cell Lung Cancer and Other DLL3 Expressing Solid Tumors	NCT07278479	Recruiting	September 2028
[^{212}Pb]VMT-α-NET	SSTR2	NETs	I/IIa	Perspective Therapeutics	Targeted Alpha-Particle Therapy for Advanced SSTR2 Positive Neuroendocrine Tumors (212-Pb-VMT)	NCT05636618	Recruiting	November 2029
^{212}Pb-DOTAM-GRPR1	GRPR	Solid tumors	I	Orano Med	Safety and Tolerability of ^{212}Pb-DOTAM-GRPR1 in Adult Subjects With Recurrent or Metastatic GRPR-expressing Tumors	NCT05283330	Recruiting	January 2027
^{212}Pb-CEA-PRIT	CEA	Colorectal cancer	I	Roche	A Study to Investigate CEA-PRIT 2.0 in Participants With Metastatic Colorectal Cancer (mCRC)	NCT07416552	Recruiting	February 2034
CEA-PRIT 2.0	CEA	Metastatic colorectal cancer	I	Roche	A Study to Investigate CEA-PRIT 2.0 in Participants With Metastatic Colorectal Cancer (mCRC)	NCT07416552	Recruiting	February 2034
[^{212}Pb]VMT-α-NET	SSTR2	NETs	Early Phase I	University of Iowa	A Safety Study of 212Pb-VMT-Alpha-NET in Patients With Neuroendocrine Tumors	NCT06148636	Active, not recruiting	December 2026
^{212}Pb-Pentixather	CXCR4	Lung carcinoid lesions	Early Phase I	University of Iowa	A Safety Study of 212Pb-Pentixather Radioligand Therapy	NCT05557708	Not yet recruiting	June 2028

CEA=Carcinoembryonic antigen. CXCR4=Chemokine receptor type 4. DLL3=Delta-like ligand 3. FAP=Fibroblast activation protein. GRPR=Gastrin-releasing peptide receptor. MC1R=Melanocortin 1 receptor. NETs=Neuroendocrine tumors. mCRPC=Metastatic castration-resistant prostate cancer. PSMA=Prostate specific membrane antigen. SCLC=Small-cell lung cancer. SSTR=Somatostatin receptor.

Sources: ClinicalTrials.gov and William Blair Equity Research

There are several late-stage trials involving actinium-225; one is slated to read out by the end of the year in neuroendocrine tumors (more detail is provided later in this report). Bristol Myers, Novartis, and AstraZeneca are, as expected, sponsoring the majority of the Phase II and later clinical trials, while the earlier-stage studies (Phase I/II or Phase I) are sponsored by a mix of academic centers, smaller biotech, and large pharma. Based on the primary completion dates listed on the clinicaltrials.gov website, most trials complete in 2027 or after; the two late-stage trials from Novartis are slated to read out in 2028.

In our previous analysis of the actinium-225 clinical trial, we highlighted the number of actinium-225 trials employing the J591 antibody, which targets PSMA and to date is one of the most studied targeting moieties for radiopharmaceuticals employing actinium-225. Although J591 is still under investigation in the clinic (including a Phase II trial from Convergent Therapeutics), many of the trials have been previously completed and are not included in the above tables. In our current analysis, we note the increased variety in targets for actinium-225 assets, though PSMA remains the most popular choice, followed by SSTR.

The library of lead-212 trials is notably smaller but, in our view, likely to grow in the coming years as this isotope is being increasingly explored by radiopharmaceutical companies. We also believe that the interest in lead-212 could be bolstered, at least in the short term, by concerns about the actininium-225 supply chain. The potential convenience of producing lead-212 with generators could help combat manufacturing headwinds plaguing the industry. Furthermore, there is increasing enthusiasm about lead-212's simple decay chain, direct imaging through SPECT, and short half-life, which could facilitate fractionated, intensified, and/or adaptive dosing regimens.

The number of trials for terbium-161 is also relatively small but growing (exhibit 21). All but one trial is investigator-sponsored, and the vast majority target PSMA; the PSMA-I&T ligand is particularly popular. However, there are also PSMA assets that incorporate albumin binding or are designed with long-circulating ligands. Beyond prostate cancer, neuroendocrine tumors appear to currently be the only other indication under clinical investigation for terbium-161-based radiopharmaceuticals. We suspect that this is inspired by the success of Pluvicto in prostate cancer and that the indication space could expand in the future pending initial results of terbium-161 in prostate cancer.

Exhibit 21
Radiopharmaceuticals
Ongoing Clinical Trials Involving Terbium-161 Assets (Based on ClinicalTrials.gov Registry)

Asset/Regimen	Target	Indication	Phase	Company/ Sponsor	Study Title	Trial ID	Status	Estimated Primary Completion
^{161}Tb-DOTATATE	SSTR	NETs	II	Tata Memorial Hospital	Study to Assess the Safety and Effectiveness of Novel Radiopharmaceutical Terbium-161 DOTATATE in Metastatic Neuroendocrine Tumors (TENET)	NCT07404176	Recruiting	February 2028
^{161}Tb-PSMA-I&T	PSMA	Pluvicto-Naïve mCRPC	II	Ankara University	Terbium 161 PSMA in Lutetium-177 PSMA Naive Patients (TeLuNa)	NCT07441837	Not yet recruiting	August 2028
^{161}Tb-PSMA-I&T	PSMA	mCRPC	II	National Taiwan University Hospital	Exploring Auger-Enhanced PSMA-Targeted Radioligand Therapy: A First-in-Taiwan Clinical Study of 161Tb-PSMA-I&T	NCT07621692	Recruiting	December 2030
^{161}Tb-PSMA-I&T	PSMA	mCRPC	I/II	Peter MacCallum Cancer Centre	EValuation of radIOLigand Treatment in mEn With Metastatic Castration-resistant Prostate Cancer With [161Tb]Tb-PSMA-I&T (VIOLET)	NCT05521412	Recruiting	December 2026[1]
^{161}Tb-NYM032	PSMA	mCRPC	I/II	Zhengguo Chen	Study on the Safety, Tolerability, and Preliminary Efficacy of 161Tb-NYM032 in Patients With Metastatic Castration-Resistant Prostate Cancer	NCT06827080	Not yet recruiting	December 2026
^{161}Tb-PSMA-I&T	PSMA	Locally advanced prostate cancer	I/II	Rabin Medical Center	Tb-PSMA-I&T Radionuclide Before Radical Prostatectomy in Patients With Locally Advanced Prostate Cancer - TbeforePROST Trial.	NCT07208240	Recruiting	August 2028
^{161}Tb-RAD402	KLK3	CRPC	I/IIa	Radiopharm Theranostics	A Study of Terbium 161 (161Tb)-RAD402 in Participants With CRPC (RAD402)	NCT07259213	Recruiting	November 2028
^{161}Tb-SibuDAB (long-circulating ligand)	PSMA	Metastatic prostate cancer	I	University Hospital, Basel, Switzerland	Targeted Radionuclide Therapy in Metastatic Prostate Cancer Using a New PSMA Ligand Radiolabelled With Terbium-161 (161Tb-SibuDAB) - Dose Identification/Escalation Phase Ia/b Study (PROGNOSTICS)	NCT06343038	Recruiting	June 2028
^{161}Tb-LNC1011 (albumin binding)	PSMA	mCRPC	Early Phase I	Peking Union Medical College Hospital	Safety, Tolerability and Preliminary Efficacy of 161Tb-LNC1011 (PSMA Radioligand) in Patients With Metastatic Castration-Resistant Prostate Cancer (mCRPC) (161Tb-LNC1011)	NCT07381582	Not yet recruiting	October 2027

[1]Estimated study completion date since primary completion date was August 2025.

KLK3=Kallikrein-related peptidase 3. NETs=Neuroendocrine tumors. mCRPC=Metastatic castration-resistant prostate cancer. PSMA=Prostate specific membrane antigen. SSTR=Somatostatin receptor.

Sources: ClinicalTrials.gov and William Blair Equity Research

Recent Datasets in the Radiopharmaceuticals Industry

In our view, the most practice-changing recent dataset was the Phase III PSMAddition trial of Pluvicto in the mHSPC setting, which was presented at ESMO 2025. While we are encouraged that the trial was positive, we recognize that enthusiasm about the results was relatively muted initially, owing to the lack of a significant overall survival (OS) benefit (though the survival data was immature at the time of presentation; a subsequent analysis continued to show a positive trend in OS without statistical significance). Furthermore, the discussant for the presentation highlighted that the trial may never demonstrate a significant survival benefit, owing to the crossover design of the study. When including several additional considerations, the discussant did not believe that the data warranted widespread use of Pluvicto in the tested disease setting and held the view that patients should be carefully selected based on PSMA biomarkers (e.g., PSMA SUV_{mean} and PSMA total tumor volume). Despite mixed views of the results, Pluvicto was approved in the mHSPC setting in July 2026.

Below, we highlight several datasets presented during 2025 and early 2026 that showcase recent advancements in the field. Overall, we are encouraged by the progress in expanding the isotope toolbox, with particular attention drawn to lead-212 and some advancements for both actinium-225 and terbium-161.

Lutetium-177 Updates

Novartis's Phase III PSMAddition Trial in mHSPC

The Phase III PSMAddition trial evaluated Pluvicto (dosed at 7.4 GBq every 6 weeks for 6 cycles) administered in conjunction with standard of care (comprising androgen deprivation therapy and a novel hormone therapy) versus standard of care alone in patients with metastatic hormone-sensitive prostate cancer (HSPC). Patients randomized to standard of care are also allowed to cross over to the Pluvicto-containing arm. Based on top-line results announced in June, the trial met the primary endpoint of radiographic PFS (rPFS) at an interim analysis, and a positive trend in the OS secondary endpoint was also highlighted. Pluvicto was subsequently approved in this setting on July 31, 2026.

A total of 1,144 patients were enrolled in the trial, with 572 randomized to the Pluvicto arm and an additional 572 enrolled to the control arm. Across all patients, the median age was 68 years, the majority (70%) of patients had an ECOG performance status of 0, 70% had a Gleason score of 8-10, and half had de novo disease. Bone metastases were present in 91% of patients, while 41% had visceral metastases and 59% had soft-tissue disease.

Median rPFS was not reached in either arm, and the hazard ratio was 0.72 (p=0.002). All subgroups analyzed favored the Pluvicto arm in terms of rPFS benefit, though in some subgroups, the upper bound of the 95% confidence interval crossed 1. For OS, there was a trend toward favoring the Pluvicto treatment with a hazard ratio of 0.84, but the upper end of the 95% confidence interval was 1.13 (the p-value for OS was 0.125). Once again, median OS was not reached for either arm. The ORR in patients with measurable soft-tissue disease at baseline slightly favored Pluvicto at 85% (57% complete response rate), versus 81% (42% complete response rate) for the control arm.

TRAEs occurring at grade 3 or higher were reported in 23% of patients in the Pluvicto arm and 12% of patients in the control arm. Adverse events leading to discontinuation of any drug treatment occurred in 8.2% and 4.1% of patients in the Pluvicto and control arms, respectively. No treatment-related deaths were reported. Dry mouth occurred in 46% of patients treated with the Pluvicto regimen (versus 3.7% for the control arm), but all cases were grade 1 or 2. Grade 3 or higher adverse events occurring in at least 5% of patients were hypertension (6.0% for the Pluvicto arm versus 6.2% for the control arm), anemia (5.0% versus 2.7%), and decreased lymphocyte count (5.0% versus 1.2%).

The trial results are outlined in exhibit 22. A subsequent updated analysis was conducted, and results were disclosed upon approval in mHSPC. Like the initial data, risk of progression or death was reduced by 28% with a hazard ratio of 0.72, and OS continued to favor Pluvicto with a hazard ratio of 0.80. Although the upper end of the 95% confidence interval was lower compared to the initial data disclosure, it still crossed 1, albeit barely, at 1.01.

Exhibit 22
Novartis AG
Phase III PSMAddition Trial of Pluvicto in Metastatic Hormone-Sensitive Prostate Cancer

Trial Results (NCT04720157)

Mechanism of Action		PSMA-targeting radioligand incorporating lutetium-177	
Enrollment Criteria		ECOG PS 0 to 2 Treatment naïve or minimally treated[1] PSMA-positive by PSMA PET	
Study Arm		Pluvicto (7.4 GBq +/- 10% every 6 weeks for 6 cycles) + ADT + ARPI	ADT + ARPI[2]
Enrollment		572 patients	572 patients
Patient Baseline Characteristics		*Median age* = 68 years *ECOG PS:* 0 / 1 / 2 = 69% / 30% / 0.2% *Gleason score of 8-10:* 68% *Median PSA* = 12.1 µg/L *Site of disease:* soft tissue / bone / visceral = 60% / 91% / 39%	*Median age* = 68 years *ECOG PS:* 0 / 1 / 2 = 71% / 27% / 1.2% *Gleason score of 8-10:* 71% *Median PSA* = 11.6 µg/L *Site of disease:* soft tissue / bone / visceral = 59% / 91% / 42%
Radiographic Progression-Free Survival		**Not reached** **(HR=0.72, *p* =0.002)**	**Not reached**
Overall Survival (intent-to-treat analysis)		Not reached (HR=0.84; *p* =0.125)	Not reached
Objective Response Rate[3]		85% (out of 224 patients) *Complete response rate: 57%*	81% (out of 213 patients) *Complete response rate: 42%*
Grade 3+ Treatment-Related Adverse Events (TRAEs)		23%	12%
Common (≥20%) Treatment-Emergent Adverse Events (TEAEs; all grades)	*Dry mouth*	46%	3.7%
	Fatigue	35%	28%
	Nausea	34%	9.4%
	Hot flash	29%	36%
	Anemia	27%	13%
	Arthralgia	20%	23%
	Back pain	18%	20%
	Constipation	18%	16%
	Asthenia	16%	13%
	Hypertension	14%	17%
Serious Adverse Events (all grades)		32% (treatment-related=6.9%)	29% (treatment-related=2.5%)
Grade 5 TEAEs		2.7% (treatment-related=0%)	2.5% (treatment-related=0%)
TEAEs Leading to Discontinuation		16%	9.0%

ADT=Androgen deprivation therapy. ARPI=Androgen receptor pathway inhibitor. ECOG PS=Eastern Cooperative Oncology Group performance status. HR=Hazard ratio. PSMA=Prostate-specific membrane antigen.

[1]ADT allowed in the neo-adjuvant/adjuvant setting. ADT/ARPI also allowed if used for up to 45 days for metastatic disease.

[2]Can cross over to Pluvicto arm following centrally reviewed radiographic progression. After crossover, ADT/ARPI is not required.

[3]In patients with measurable soft-tissue disease at baseline, accounting for bone disease.

Sources: ESMO 2025

Telix's Phase III ProstACT Trial Part 1 in mCRPC

At ASCO 2026, preliminary results were presented from part 1 of the global Phase III ProstACT trial of TLX591 in mCRPC. The trial randomized 36 patients with mCRPC who progressed following treatment with one prior androgen receptor pathway inhibitor across three dosing cohorts: TLX591 in combination with the standard-of-care treatments Xtandi (cohort 1, n=11) or Zytiga (cohort 2, n=11), or TLX591 dosing followed by docetaxel (cohort 3, n=14). Part 1 of the trial was designed as a safety and dosimetry lead-in to part 2, establishing safety profiles, dosimetry, and pharmacokinetics across the three cohorts.

The enrolled patient population was slightly older compared to other trials (median age 77 years), and the majority of enrolled patients were in the second-line treatment setting. The most common prior androgen receptor pathway inhibitor was Xtandi (47%; 17/36 patients), followed by Zytiga (28%; 10/36 patients), Nubeqa (17%; 6/36 patients), and Erleada (8%; 3/36 patients). Average PSA levels at baseline were 60.3 ng/dL, and we note a higher degree of viscera metastases (36%; 13/36 patients).

The most common treatment-related adverse events were hematological in nature, which included thrombocytopenia in 78% of patients (grade 3=5 patients; grade 4=11 patients), neutropenia in 64% (grade 3=8 patients; grade 4=9 patients), anemia in 44% (grade 3=1 patient; grade 4=0 patients), white blood cell count decrease in 42% (grade 3=6 patients; grade 4=5 patients), and lymphopenia in 56% (grade 3=8 patients; grade 4=7 patients). Of these patients, most self-resolved, with 5.6% receiving red blood cell transfusion, 13.9% receiving platelet transfusion, and 8.3% receiving G-CSF. Hematological profiles were transient, with platelet counts recovering to grade 1 or lower levels over the course of 15 days following treatment. Common nonhematological events included mostly mild to moderate fatigue (53%, grade 3=2 patients), nausea (28%, grade 3=1 patient), and dry mouth (25%). Notably, management previously indicated that investigators did not attribute all cases of dry mouth to TLX591 itself.

Pharmacokinetic profiles appeared to be consistent across cohorts, showing high blood concentrations that slowly decline over the course of 15 days. In parallel, lesion radioactivity gradually increases and plateaus, showing sustained uptake out to 15 days. Organ radiation exposure remained within safe levels, with the highest uptake seen in the liver, left colon, rectum, right colon, spleen, and kidney. Lesion dosimetry across all tumor sites (n=132) was about 4.83 Gy on average. Bone lesions (n=122) had absorbed dose of 5.0 Gy on average, and lymphatic nodes (n=8) and soft tissues (n=2) were 2.01 Gy and 5.73 Gy, respectively.

Part 2 of the ProstACT GLOBAL trial is currently enrolling outside the U.S., and in early July 2026 Telix announced that based on the part 1 safety data and part 2 trial design, it had aligned with the FDA during a Type B meeting. Therefore, Telix plans to submit an IND amendment to officially allow ProstACT to progress to part 2 in the U.S. The company also plans to look at progression-free survival as an exploratory endpoint, with potential for results later this year or early next (once 81 disease progression events have occurred).

The part 1 safety results are outlined in exhibit 23 and are compared to the Phase III PSMAfore trial of Pluvicto.

Exhibit 23
Telix Pharmaceuticals Limited
Comparison of Phase III Part 1 Safety Results of TLX591 Versus Pluvicto in Metastatic Castration-Resistant Prostate Cancer

	ProstACT GLOBAL Trial (NCT06520345) - Part 1	PSMAfore Trial (NCT04689828)	
Mechanism of Action	PSMA-targeting radiolabeled (with lutetium-177) antibody	PSMA-targeting radiolabeled (with lutetium-177) small molecule	
Inclusion Criteria	PSMA-positive tumor by PET scan (gallium-based) Progression after Xtandi or Zytiga plus prednisone (at least 12 weeks of therapy) Chemotherapy-naïve (except in mCSPC setting if ≥ 6 months prior to screening) ECOG PS: 0, 1, or 2	PSMA-positive tumor by PET scan (gallium-based) Progression after Xtandi or Zytiga plus prednisone Taxane-naïve (adjuvant/neoadjuvant setting if >12 months ago) ECOG PS: 0 or 1	
Study Arm	TLX591 (76 mCi every 2 weeks for 2 cycles) + Best standard of care (ARPI or taxane)	Pluvicto (200 mCi every 6 weeks for 6 cycles)	ARPI change
Patient Baseline Characteristics	Median age=77 years Second line=72% Median baseline PSA=18.2 ng/dL ECOG PS 0/1=53%/47% Metastases=lymph node/bone/visceral=39 /47%/36% Prior ARPI=Xtandi/Zytiga/other=47%/28%/25% Prior taxane=25%	Median age=71 years Second-line=82% Median baseline PSA=18.4 ng/dL ECOG PS 0/1=62%/37% Site of disease=lymph node/bone/liver=32%/88%/6% Prior ARPI=Xtandi/Zytiga/other=40%/51%/9%	Median age=72 years Second-line=80% Median baseline PSA=14.9 ng/dL ECOG PS 0/1=50%/49% Site of disease=lymph node/bone/liver=31%/87%/3% Prior ARPI=Xtandi/Zytiga/other=35%/56%/9%
Enrollment	36 patients	227 patients	232 patients
All-Grades (Grade 3/4) Non-Hematologic Treatment-Emergent Adverse Events	Fatigue: 53% (6%) Nausea: 28% (3%) Dry mouth: 25% (0%) Diarrhea: 22% (0%) Back pain: 22% (3%) Headache: 14% (0%)	Fatigue: 23% (<1%) Nausea: 32% (0%) Dry mouth: 58% (0.9%) Diarrhea: 17% (0%) Back pain: 14% (1.3%) Headache: 8.4% (0%)	Fatigue: 25% (1.7%) Nausea: 12% (<1%) Dry mouth: 3% (0%) Diarrhea: 9% (<1%) Back pain: 20% (2.6%) Headache: 4.7% (0%)
All-Grades (Grade 3+) Hematologic Treatment-Emergent Adverse Events	Thrombocytopenia: 78% (45%) Neutropenia: 64% (47%) Anemia: 44% (3%) WBC decrease: 42% (31%) Lymphopenia: 56% (41%)	Thrombocytopenia: 7.5% (2.2%) Neutropenia: 5.7% (1.3%) Anemia: 27% (6.2%) WBC decrease: N/A* Lymphopenia: N/A*	Thrombocytopenia: 3.0% (0.9%) Neutropenia: 0.9% (<1%) Anemia: 19% (6.9%) WBC decrease: N/A* Lymphopenia: N/A*

ARPI=Androgen receptor pathway inhibitor. ECOG PS=Eastern Cooperative Oncology Group performance status. mCi=Millicurie. mCRPC=Metastatic castration-sensitive prostate cancer. PET=Positron emission tomography. PSA=Prostate specific antigen. PSMA=Prostate-specific membrane antigen. WBC=White blood cell.

*Not specifically disclosed (included in broad myelosuppression category).

Sources: Telix reports, Morris, M. et al. *Lancet* (2024), and clinicaltrials.gov

Lead-212 Updates

AdvanCell's Phase I/II TheraPb Trial in mCRPC

In our view, one of the highlights for radiopharmaceuticals during 2025, from a data perspective, was AdvanCell's I/II TheraPb trial data of lead-212-powered ADVC001 in mCRPC, which was presented at ESMO. Despite the early nature of the results, the data marked the first clinical dataset (aside from a previously reported case study) for a lead-212-based therapy that targets PSMA, and we believe it set a new bar for PSMA radioligand therapy in mCRPC. We are impressed by the initial results and believe that they lay the foundation for lead-212 to become an important isotope for radiopharmaceuticals targeting prostate cancer (and potentially additional cancer indications, pending future data).

The Phase Ib dose-escalation portion enrolled 22 patients across 7 dose cohorts (60 MBq, 120 MBq, 160 MBq, and 200 MBq were tested across various administration schedules from once every 6 weeks for 4 cycles to every week for 4-6 cycles). The median age was 73 years, and 77% had an ECOG performance status of 1. The majority (91%) were treated with 1 prior line of androgen receptor pathway inhibitors, and 36% were treated with 1 prior line of chemotherapy (an additional 36% were treated with 2 or 3 lines of prior chemotherapy, while 27% had no prior chemotherapy exposure). Overall, half of the patients had 3 or more prior lines of systemic therapy. Most (86%) had bone metastases, and the median SUV_{mean} was 8.9.

The PSA_{50} was 80% in 15 patients who were treated with a dose of 160 MBq or more of ADVC001, and the PSA_{80} in these patients was 60%. Across all 22 patients, the PSA_{50} was 64%. In six patients with RECIST-measurable lesions at baseline, the ORR was 100%, with two patients (33%) achieving complete responses.

While TheraPb includes patients both with and without prior chemotherapy, we highlight that the PSA_{50} response in patients treated with 160 MBq or higher was notably higher than both the Phase III VISION trial (post-chemotherapy) at 46% and the Phase III PSMAfore trial (pre-chemotherapy) at 51% (though we acknowledge all the caveats and limitations associated with cross-trial comparison, including that the TheraPb data is based on small patient numbers and in an earlier phase of development compared to the Pluvicto studies). While recognizing the small sample size, we also emphasize the impressive ORR, which outperforms both VISION (51%, based on patients with measurable disease at baseline based on RECIST v1.1 criteria) and PSMAfore (50%, again based on measurable disease patients).

The maximum tolerated dose was not reached during dose escalation. In addition, no treatment-related serious adverse events were reported, and there were no discontinuations or dose modifications due to TRAEs. Across the 22 patients enrolled in the study, grade 3 TRAEs occurred in 9% of patients (1 case of anemia and 1 case of hypophosphatemia), and no grade 4 or grade 5 TRAEs were reported. Treatment-related dry mouth at grade 1 and grade 2 occurred in 59% and 23% of patients, respectively.

Based on pharmacokinetic measurements, the blood concentration of ADVC001 rapidly diminished with an elimination half-life of about six hours. We believe this encouraging pharmacokinetic profile could increase the feasibility of incorporating powerful alpha-emitting payloads into the cancer treatment paradigm. Dosimetry measurements also revealed a low radiation absorbed dose to healthy organs. Of particular note, the absorbed dose to the kidneys was estimated to be 1.7 Gy for the 160 MBq dose of ADVC001 and 2.4 Gy for the maximum 200 MBq dose (for reference, the limit for radiation to the kidneys that was set by external beam radiation therapy is 23 Gy to 28 Gy).

The Phase II dose expansion portion of the study will investigate the two highest doses of ADVC001 (160 MBq and 200 MBq) and will incorporate adaptive dosing. In addition to pre-chemotherapy mCPRC, post-^{177}Lu-PSMA mCRPC and mHSPC will also be investigated. We are encouraged to see the broad range of settings being tested as it provides multiple avenues for showcasing the potential power of lead-212.

Orano Med's/RadioMedix's ALPHAMEDIX 02 Trial in GEP-NETs

At ESMO 2025, there were also two datasets presented for Orano Med's/RadioMedix's Phase II ALPHAMEDIX 02 trial of 212Pb-DOTAMTATE in gastroenteropancreatic neuroendocrine tumors (GEP-NETs). The trial includes two cohorts: cohort 1 evaluates the agent in patients naïve to radioligand therapy, while cohort 2 is investigating the post-radioligand setting. In both cohorts, 212Pb-DOTAMTATE was dosed at 67.6 µCi/kg every 8 weeks for up to 4 cycles.

Based on prior data from cohort 1 (presented at the 2024 American Society of Clinical Oncology annual meeting), the ORR was 56% in 36 patients. The 24-month PFS and OS were 74% and 91%, respectively, in patients from both cohort 1 of ALPHAMEDIX 02 and the Phase I ALPHAMEDIX 01 trial. Hematologic toxicity was generally grade 3 or 4 lymphocytopenia that was reversible. This year at ESMO, long-term follow-up of cohort 1 from ALPHAMEDIX 02 was presented.

In 35 patients, the median age was 60 years, 23% had grade 1 disease while 66% had grade 2 (5.7% had grade 3), all had prior somatostatin analog (SSA) therapy, and 83% had prior surgery. With the longer-term follow-up, the ORR increased slightly to 60% (all partial responses). For comparison, the response rate in the Phase III NETTER-1 trial of Lutathera was 18%. Most patients (72%) experienced responses of 2 years or more, and 86% of patients received all 4 doses of treatment. The 36-month PFS and OS rates of 72% and 88%, respectively, were similar to the previously reported 24-month rates. In NETTER-1 the final median OS for Lutathera was 48 months.

Grade 3 and higher TEAEs occurred in 54% of patients, although only one patient (2.9%) discontinued due to TEAEs. The one death due to sepsis was described as likely unrelated to treatment. Grade 3 or higher TEAEs that were reported in at least 5% of patients were lymphopenia (26%), decreased weight (8.6%), chronic kidney disease (8.6%), decreased glomerular filtration rate (8.6%), fatigue (5.7%), and decreased appetite (5.7%). Dysphagia (described as a chronic adverse event) of all grades occurred in 49% (2.9% grade 3) of patients.

Cohort 2 enrolled 26 patients with a mean age of 62 years. Half of the patients had grade 2 disease, while 27% had grade 1 and 12% had grade 3. In addition to prior radioligand therapy, 96% had prior SSA therapy, 89% had prior surgery, 58% had prior chemotherapy, and 58% had prior TKIs. The ORR was 35% (again, all were partial responses), and all patients experienced a duration of response of 18 months or more. Similar to cohort 1, most patients (85%) received all 4 doses of the treatment. The 18-month PFS was 83%, while 18-month OS was 85%.

Grade 3 or higher TEAEs occurred in 42% of patients, and there were no discontinuations or deaths due to TEAEs. Grade 3 or higher TEAEs that were reported in at least 5% of patients were lymphopenia (15%), dysphagia (12%), vomiting (7.7%), and chronic kidney disease (7.7%). Dysphagia (58% all grade) was described as an unexpected side effect that is still under investigation, and it was highlighted that a longer follow-up may be needed to obtain a comprehensive picture of renal toxicity (therefore, the reported renal toxicities from the longer-term follow-up of cohort 1 may be more comprehensive).

Sanofi removed ^{212}Pb-DOTAMTATE from its pipeline in early 2026, although Orano Med is continuing to develop the asset. Although speculation on our part, we believe that Sanofi's decision could be rooted in the high rates of chronic kidney disease (grade 4 or higher requires dialysis or transplant) and other renal events.

Perspective Therapeutics' Update of VMT-α-NET in NETs

Interim data from Perspective's Phase I/IIa trial of [^{212}Pb]VMT-α-NET in NETs was also presented at ESMO 2025, with updated data disclosed at ASCO GI 2026. The study includes three main cohorts in the dose-finding phase: four doses of [^{212}Pb]VMT-α-NET at 2.5 mCi (cohort 1), 5 mCi (cohort 2), or 6 mCi (cohort 3). First disclosed at the American Association for Cancer Research annual meeting in March 2026, another cohort in the trial will test a front-loaded regimen with an initial dose of 6 mCi, followed by two doses of 5 mCi and a final dose of 4 mCi.

The data from ASCO GI included 56 patients across the first three cohorts (2 patients in cohort 2, 46 patients in cohort 2 [split into two halves based on extent of follow up], and 8 patients in cohort 3). The median age range across all patients was 63 years; 23% had an ECOG performance status of 1 (the rest had a status of 0); 59% of the GEP-NET patients (which were 95% of all patients) had non-pancreatic GEP-NETs; and the median number of prior systemic therapies was 1. A total of 11% of patients had grade 3 tumors, while 70% and 20% had grade 2 and grade 1 tumors, respectively.

Focusing on the 23 patients in the first half of cohort 2 (patients with a median follow-up of 11 months), 9 patients (39%) had a partial response (35% confirmed response rate). Of the 16 patients in the first half of cohort 2 who had SSTR2 expression in all tumors, 7 (44%) had a partial response. For the two patients in cohort 1, stable disease has been ongoing for two years.

There were no treatment-related discontinuations, and serious adverse events (none deemed related to treatment) were reported in five patients. Grade 3 or higher adverse events occurred in 38% of patients (no grade 5 events were reported), and the most common grade 3/4 adverse event was decreased lymphocyte count. No serious renal complications were reported.

Additional updated results were presented later in the year at the annual ASCO meeting. Based on an April 17 data cutoff, 68 patients were treated, 46% of which had pancreatic GEP-NETs and 50% of which had non-pancreatic GEP-NETs. The median number of prior systemic therapies was one, and the proportion of patients that were grade 1, grade 2, and grade 3 was 22%, 65%, and 13%, respectively. No dose-limiting toxicities or treatment-related discontinuations were reported. There were also no reports of serious renal complications, clinically meaningful myelosuppression, or dysphagia. In the first half of cohort 2 (5 mCi dose), the confirmed objective response rate was 39% (9 of 23 patients), with an unconfirmed response rate of 43%.

Perspective's Phase I/IIa Trial of ^{212}Pb-VMT01 in Melanoma

At the ASCO 2026 meeting, preliminary results were presented for both part 1 (monotherapy) and part 2 (in combination with Opdivo) of the Phase I/IIa trial. The asset targets MC1R and has been granted fast-track designation by the FDA. Participants received up to three cycles of 212Pb-VMT01 at a dose of 1.5 mCi, 3 mCi, or 5 mCi (only 1.5 mCi or 3 mCi for part 2). As of the data cutoff of March 25 of this year, 27 patients were enrolled with a median of four lines of prior systemic therapy. No treatment-related serious adverse events were reported, and there were no discontinuations due to adverse events. The most common treatment-emergent adverse events were fatigue (52%), nausea (37%), dyspnoea (19%), abdominal pain (15%), anemia (15%), and increased AST (15%). Based on preliminary efficacy data in patients treated with monotherapy, 2 of the 7 patients (29%) treated at the 3 mCi dose achieved a confirmed partial response. No confirmed responses were observed at the other two doses.

Taken together, we believe Perspective's lead-212-based therapies have demonstrated encouraging safety, especially in regard to renal toxicity that could limit other lead-212-based therapies in NETs. From an efficacy perspective, it is our view that more mature data, especially in melanoma, is needed to inform a view on the potential of these assets. We are particularly intrigued by the front-loaded dosing cohort for ^{212}Pb-VMT-α-NET in NETs as we believe it supports the trend of alternative dosing schemes that could ultimately lead to improved patient outcomes.

Actinium-225 Updates

Novartis's Phase I AcTION Trial in mCRPC

At ASCO 2026, Dr. Louise Emmett presented results for Novartis's Phase I AcTION trial of ^{225}Ac-PSMA-617 in mCRPC both with and without prior Pluvicto or other ^{177}Lu-PSMA therapy (abstract 5010). Novartis's ^{225}Ac-PSMA-617 was administered every 8 weeks for up to 6 cycles at a dose of 4 MBq, 6 MBq, 8 MBq, or 10 MBq (dose escalation) or 8 MBq or 10 MBq (dose expansion). Three patient groups were tested: group A patients had prior taxane and ARPI but were naïve to ^{177}Lu-PSMA; group B patients had no prior exposure to taxane, ARPI, or ^{177}Lu-PSMA; and group C patients had exposure to prior ^{177}Lu-PSMA, while prior exposure to taxane and ARPI was not required.

Across all dose levels, PSA_{50} responses in group A (34 patients), B (27 patients), and C (40 patients) were 59%, 85%, and 53%, respectively, while overall PSA_{90} was 44%, 82%, and 18%, respectively. Objective response rate in group A was 43% (of 14 patients), in group B was 33% (of 9 patients), and in group C was 42% (of 12 patients). Treatment-related adverse events of grade 3 or higher occurred in 24% of group A patients, 11% of group B patients, and 15% of group C patients. The rate of treatment-emergent adverse events that led to discontinuation in groups A, B, and C was 2.9%, 0%, and 10%, respectively. Dry mouth (all grade 1 or 2) was the most common adverse event, occurring in 90% to 97% of patients across the three groups. The recommended Phase II dose for all groups was 10 MBq every 8 weeks for up to 6 cycles.

The discussant highlighted the high rates of dry mouth, which can have a significant negative impact on patients' quality of life. However, it was also noted that no cases of grade 3 dry mouth (characterized by lack of ability to swallow and need for a feeding tube) were reported. Meanwhile, the discussant was enthusiastic that PSA_{50} was reported in up to 100% of group B patients at the 10 MBq dose, along with a PSA_{90} of 91% at the same dose and in the same patient group. We are also encouraged to see responses, albeit lower, in the Pluvicto-experienced group C patients, suggesting the ability for alpha therapy to rescue patients who relapse on or who do not respond to beta therapy.

Comparing group A to other trials in prostate cancer with similar patient populations, we highlight that PSA_{50} responses are similar to AdvanCell's Phase Ib TheraPb trial of ^{212}Pb-ADVC001 and Bayer's Phase I PAnTHA trial of ^{225}Ac-PSMA-Trillium. On the safety side, rates of xerostomia were also comparable between the three trials (though numerically higher in AcTION, and the majority of patients did not recover), and hematologic toxicities appear lowest for ^{212}Pb-ADVC001.

There are two ongoing Phase III trials evaluating ^{225}Ac-PSMA-617 in mCRPC. The PSMAcTION is in the post-Pluvicto setting, while AcTFIRST is combining with ARPI in the frontline setting. Both are expected to read out in 2028.

Convergent's Phase II CONVERGE-01 Trial in mCRPC

At ASCO 2026, results from part 3 of the Phase II CONVERGE-01 trial from Convergent Therapeutics were presented. The study is evaluating two doses (45 kBq/kg and 55 kBq/kg) administered two weeks apart of CONV01-α, a PSMA-directed antibody rosopatamab conjugated to actinium-225 (or indium-111 for imaging), in mCRPC. Part 3 of the study is designed to determine the recommended Phase II dose. All patients were exposed to prior ^{177}Lu-PSMA and ARPI therapy, and 80% had prior taxane exposure.

In 25 evaluable patients, PSA_{50} was 40%. At a median follow-up of 8.1 months, preliminary median rPFS was 8.4 months in 11 patients treated at the future fixed target dose of 9 MBq. No dose-limiting toxicities were observed, and no treatment-related adverse events led to discontinuation. The most common treatment-emergent adverse event was dry mouth, all grade 1 or 2 and occurring in 63% of patients, though it was noted that about 49% of patients had experienced dry mouth

previously due to prior treatment with ^{177}Lu-PSMA or had dry mouth at screening. There was also evidence of hematologic toxicity; the most common grade 3 adverse events were decreased lymphocyte count (49%), anemia (26%), decreased platelet count (23%), and decreased neutrophil count (11%). Nephrotoxicity was not observed.

One of the potential advantages of targeting PSMA with an antibody is limited exposure of salivary glands to radiation as PSMA-targeted antibodies are said to be more specific to PSMA expressed on the tumor versus on healthy tissues. Given that a considerable proportion of patients in CONVERGE-01 may have had baseline xerostomia, we concede that it is difficult to fully characterize rates of dry mouth reported in the study given the potentially cumulative effect. Similarly, although rates of grade 3 or higher hematologic adverse events appear to be high, prior radiation exposure could have influenced patients' ability to recover from hematologic toxicity given the cumulative nature of these events. Regarding renal toxicity, we are encouraged that meaningful nephrotoxicity was not observed, supporting the hypothesis that liver-based clearance of antibodies, compared to renally cleared peptides, may help spare the radiation-sensitive kidneys. Regarding efficacy, we are encouraged by the 40% PSA_{50} response given the heavily pretreated nature of the population (all had prior Pluvicto and at least one prior ARPI, and 80% had a prior taxane).

A Phase III trial in Pluvicto-experienced patients is under preparation.

Terbium-161 Updates

First-in-Human Data From Phase I/II VIOLET Trial in mCRPC

Presented at the ASCO 2025 annual meeting, the first-in-human Phase I/II VIOLET study of ^{161}Tb-PSMA-I&T evaluated the radioligand at starting doses of 4.4 GBq, 5.5 GBq, or 7.4 GBq every 6 weeks for up to 6 cycles; the dose was reduced by 0.4 GBq each cycle. Patients with mCRPC were eligible if they had progressed following prior therapy with at least one line of taxane (if suitable) and an androgen receptor pathway inhibitor (ARPI). Tumors were required to be PSMA positive with an SUV_{max} of 20 or higher (no FDG-positive/PSMA-negative disease was allowed). The primary endpoints were maximum tolerated radioactivity and safety.

A total of 30 patients were treated, with 24 patients treated at the highest 7.4 GBq dose, and 70% of patients completed all 6 cycles. Median age was 69 years, and regarding prior therapy, 67% received prior taxane-based chemotherapy (67% docetaxel and 13% cabazitaxel) and all patients received prior ARPI. The PSA level at screening was 27 ng/mL.

A PSA_{50} was achieved in 70% of patients, and the PSA_{90} response rate was 40%. Radiographic PFS at a follow-up of 11.0 months was 11.1 months, while median PSA-PFS was 9.0 months. Mean radiation absorbed dose to normal organs was evaluated in the parotid glands, kidneys, liver, and spleen, and found to be 0.15 Gy/GBq, 0.36 Gy/GBq, 0.08 Gy/GBq, and 0.06 Gy/GBq, respectively.

The majority of adverse events from treatment with ^{161}Tb-PSMA-I&T were grade 1 or 2 and none were grade 4. Grade 3 or 4 TRAEs occurred in 2 patients (7%), which included 1 case of lymphocytopenia and 1 case of pain. No dose-limiting toxicities were observed, and all cases of dry mouth (occurring in 70% of patients) were grade 1.

While acknowledging all the caveats and limitations associated with cross-trial comparison, we highlight that the PSA_{50} is numerically higher than the 46% rate from the Phase III VISION trial of Pluvicto and the 58% reported from the Phase III PSMAfore trial. The rPFS was greater than the 8.8 months from VISION and similar to but numerically lower than the 12.0 months from PSMAfore. While more studies are needed, we view these additional results as encouraging and providing support for expanding the beta-emitting radioisotope toolbox.

Upcoming Radiopharmaceutical Readouts

In this section, we highlight select therapeutic readouts that we expect later this year or next year and that we believe could have important implications for the radiopharmaceuticals field as a whole.

Bristol's Phase III ACTION-1 Trial in GEP-NETs

Perhaps the most anticipated radiopharmaceuticals data update in 2026 is the top-line data from the Phase III portion of ACTION-1, which is evaluating RYZ-101 in GEP-NETs. The results will represent the first Phase III dataset for actinium-225 and therefore could be instrumental in shaping investors' view of the isotope's long-term and commercial potential. The data is slated for release by the end of the year.

Enrollment in ACTION-1 requires prior treatment with Lutathera or another lutetium-177-labeled somatostatin analogue. RYZ101 is being evaluated at 10.2 MBq (the recommended Phase III dose from the Phase Ib portion of the trial) every eight weeks for up to four cycles. The active comparator arm is standard-of-care, which can include Afinitor, Sutent, or a high-dose long-acting somatostatin analogue. Progression-free survival is the primary endpoint, with OS as a secondary endpoint. The trial design is summarized in exhibit 24.

Exhibit 24
Bristol Myers Squibb Company
Phase III ACTION-1 Trial of RYZ101 in Well-Differentiated GEP-NETs

Trial Design (NCT05477576)		
Mechanism of Action	SSTR-targeting radioligand incorporating actinium-225	
Enrollment Criteria	ECOG PS 0 to 2, grade 1 or 2, Ki67 ≤20 SSTR-positive by PET 2-4 cycles prior Lutathera/^{177}Lu-labeled SSA	
Study Arm	RYZ101 (10.2 MBq every 8 weeks for 4 cycles)	Standard of care (Afinitor, Sutent, or high-dose long-acting SSA)
Estimated Enrollment	338 patients (randomized 1:1)	
Primary Endpoint	**Progression-free survival**	
Key Secondary Endpoints	Overall survival Objective response rate Duration of response	
Timeline	Top-line data: 2H 2026	

GEP-NETs=Gastroenteropancreatic neuroendocrine tumors. SSA=Somatostatin analogue.
Sources: clinicaltrials.gov, NANETS 2023 Symposium abstracts

Telix's Phase III ProstACT Trial Part 2 in mCRPC

As reported above, the part 1 safety data from ProstACT has already been disclosed, but we await the part 2 efficacy data to inform our view on the potential of TLX591. We are intrigued by the simplified dosing schedule—two doses administered two weeks apart—but we also recognize investor skepticism about the antibody modality. Therefore, we believe the efficacy data will be critical in defining the role of TLX591 among incumbents like Pluvicto and potentially Curium's ^{177}Lu-PSMA-I&T. Although the exact timing of the initial data release has not been disclosed, we

believe it could occur as early as the end of 2026 (once 81 disease progression events have occurred). Part 2 of the trial has not yet initiated within the U.S., although Telix has aligned with the FDA and expects to submit an IND in the near term.

AstraZeneca's Phase II AlphaBreak Trial in mCRPC

The AlphaBreak trial evaluates zadavotide guraxetan, which AstraZeneca gained access to through its acquisition of Fusion Pharmaceuticals. Zadavotide guraxetan targets PSMA with the PSMA-I&T ligand and incorporates actinium-225. An estimated 110 patients with prior exposure to Pluvicto or other lutetium-PSMA therapy were enrolled and randomized to one of several dosing regimens. The primary endpoints are PSA_{50} response and safety. Zadavotide guraxetan has also advanced to Phase III development in the VECTRA-01 trial in heavily pretreated mCRPC (prior lutetium-PSMA therapy, prior chemotherapy, and prior ARPI).

Aktis's Phase Ib Nectinium-2 Trial in Bladder Cancer

Another potential showcase for actinium-225 could occur in the first quarter of 2027 with Aktis's Phase Ib Nectinium-2 trial of AKY-1189, which targets nectin-4. Although early stage, the data will represent one of the first actinium-225 datasets with a target other than PSMA or SSTR (excluding Johnson & Johnson's human kallikrein-2 targeted asset, which employs an antibody). Given that the asset is being positioned in second-line bladder cancer, we view the objective response rate from post-Padcev chemotherapy (roughly 20%) as the benchmark for initial efficacy results. The trial design is outlined in exhibit 25.

Exhibit 25
Aktis Oncology, Inc.
Phase Ib NECTINIUM-2 Trial of AKY-1189 in Locally Advanced or Metastatic Solid Tumors

Trial Design (NCT07020117)		
Mechanism of Action	Radiopharmaceutical that incorporates actinium-225 and targets nectin-4	
Enrollment Criteria	ECOG PS 0 or 1 No prior radiopharmaceutical treatment No prior nectin-4-targeted therapy (except for Padcev) Nectin-4-positive based on copper-64 imaging	
Enrollment	150 patients	
Study Portion	Part 1: Dose escalation and backfill	Part 2: Dose expansion
Population	Locally advanced or metastatic solid tumors	Cohort 1: Metastatic UC Cohort 2: TNBC Cohort 3: Basket of solid tumors
Treatment Regimen	Up to 6 cycles of AKY-1189 across 5 dose levels	AKY-1189 at the RP2D
Primary Endpoints	Safety and tolerability Determine RP2D	Objective response rate
Secondary Endpoints	Objective response rate Progression-free survival Duration of response	Safety and tolerability Progression-free survival Duration of response
Timing	Initial data: 1Q 2027	NA

ECOG PS=Eastern Cooperative Oncology Group Performance Status. NSCLC=Non-small-cell lung cancer. RP2D=Recommended Phase II dose. TNBC=Triple-negative breast cancer. UC=Urothelial carcinoma.
Sources: Company reports, clinicaltrials.gov

Aktis's Phase Ib BActinium-1 Trial in Prostate Cancer

Although the exact timing of the readout is uncertain, Aktis has guided to initial data from the Phase Ib BActinium-1 trial of AKY-2519 in mCRPC in 2027. AKY-2519 targets B7-H3 and also incorporates actinium-225. Therefore, the initial data will again expand actinium-225's data pool to more novel targets in the radiopharmaceuticals industry. The trial design for the Phase Ib study of AKY-2519 is provided in exhibit 26.

Exhibit 26
Aktis Oncology, Inc.
Phase Ib BActinium-1 Trial of AKY-2519 in mCRPC

Trial Design (NCT07581184)		
Mechanism of Action	Radiopharmaceutical that incorporates actinium-225 and targets B7-H3	
Enrollment Criteria	ECOG PS of 0 or 1 B7-H3-positive[1] Cohort B: ≥2 doses prior Pluvicto	
Cohorts	A: Pluvicto-naive	B: Pluvicto-experienced
Dose Escalation	6 MBq 9 MBq 12 MBq	
Backfill	Selected doses from escalation	
Estimated Enrollment	138 patients	
Initiation	Early May 2026	
Primary Endpoint	**Safety and tolerability** **Occurrence of DLTs**	
Key Secondary Endpoints	Objective response rate Duration of response Progression-free survival PSA_{50} / PSA_{90} responses	
Next Catalyst	Initial data: 2027	

DLTs=Dose-limiting toxicities. ECOG PS=Eastern Cooperative Oncology Group Performance Status. mCRPC=Metastatic castration-resistant prostate cancer.

Molecular Partners' Phase I/IIa Data for DLL3-Targeted Asset

This dataset will likely have read-through to lead-212 more broadly given that MP0712 (developed in collaboration with partner Orano Med) incorporates the isotope. The DLL3-targeting moiety is a designed ankyrin repeat protein (DARPin), and Molecular Partners believes that DARPins are an ideal targeting vector that can be tuned for compatibility with specific targets and cancer biology. The Phase I/IIa study is investigating MP0712 in small-cell lung cancer (SCLC) and other neuroendocrine cancers, and each patient is receiving up to four doses of the radiopharmaceutical. Initial data is expected by the end of the year, while a comprehensive dataset that includes both safety and efficacy is slated for release in 2027. We are particularly intrigued by the DLL3 target given the success of T-cell engagers like Imdelltra, though we also recognize that these agents have raised the bar for efficacy in the SCLC disease setting. Regardless, we view the upcoming dataset as intriguing given that DLL3 is a commercially validated target that remains more novel in radiopharmaceuticals.

Perspective Therapeutics' Phase I/IIa Updates
Expected data updates across Perspective's lead-212-focused pipeline in late 2026 will also have read-through to lead-212. This will include updated Phase I/IIa data in NETs for lead program VMT-α-NET, which targets SSTR; initial Phase I/IIa data in melanoma for VMT01, which targets MC1R; and initial Phase I/IIa data in solid tumors for PSV359, which targets FAP. We look forward to continued data from the lead-212 field, from both safety and efficacy perspectives.

Outlook

Based on our conversations with biotech executives, physicians, and investors, there has been a substantial rise in interest in radiopharmaceuticals over the past several years. Propelled by the highly successful Phase III VISION and PSMAfore trials and the remarkable commercial launch and continued momentum of Pluvicto, we believe it is a watershed moment for the space that will encourage additional investment in R&D and expanded clinical trial activities. This has been bolstered by the investment in, and progress in procurement of, medically relevant radioisotopes and the further advancement of just-in-time manufacturing. This has helped alleviate supply constraints for currently available products and opens avenues for new radionuclides to potentially enter the market in the future. In parallel, clinical trials for assets incorporating a wide variety of novel targets, radionuclides, and targeting moieties continue to propel the industry.

Enthusiasm in the field is exemplified by continued strong funding, and based on year-to-date funding across private and public sectors, 2026 is the strongest year of radiopharmaceuticals financings since at least 2020. Based on our updated analysis, our base-case assumption for the total addressable market for radiopharmaceuticals could reach $35 billion in the United States alone (bull case of $68 billion and a bear case of $4.6 billion). Overall, it is our view that investors should see the market as a budding sector that could benefit from material long-term secular growth. While not without risks, especially pertaining to complicated logistics required for supply chain optimization and limited data outside PSMA- and SSTR-targeted assets, we believe the risk/reward symmetry is skewed to the upside. As the fifth edition in an annual periodical series, this report serves as a continued resource for the investment community interested in conducting due diligence on this exciting and fledgling field in biotech.

The prices of the common stock of other public companies mentioned in this report follow:

Actinium Pharmaceuticals, Inc.	$1.01
Aktis Oncology, Inc. (Outperform)	$25.78
AstraZeneca PLC	$162.70
Bayer AG	$14.02
Bicycle Therapeutics PLC	$4.20
Bristol Myers Squibb Company (Market Perform)	$66.58
Cellectar Biosciences, Inc.	$2.53
Clarity Pharmaceuticals Ltd.	A$2.51
Eli Lilly and Company	$1,174.61
Immunome, Inc.	$27.57
Johnson & Johnson	$268.04
Lantheus Holdings, Inc. (Market Perform)	$100.77
Novartis AG	$153.81
Perspective Therapeutics, Inc.	$3.11
Radiopharm Theranostics Limited	A$0.01
Roche Holdings Ltd.	$55.19
Telix Pharmaceuticals Limited (Outperform)	$11.29

IMPORTANT DISCLOSURES

William Blair or an affiliate is a market maker in the security of Lantheus Holdings, Inc., Telix Pharmaceuticals Limited and Aktis Oncology, Inc.

William Blair or an affiliate expects to receive or intends to seek compensation for investment banking services from Lantheus Holdings, Inc., Telix Pharmaceuticals Limited and Aktis Oncology, Inc. or an affiliate within the next three months.

Officers and employees of William Blair or its affiliates (other than research analysts) may have a financial interest in the securities of Lantheus Holdings, Inc., Telix Pharmaceuticals Limited and Aktis Oncology, Inc.

This report is available in electronic form to registered users via R*Docs™ at https://williamblairlibrary.bluematrix.com or www.williamblair.com.

Please contact us at +1 312 236 1600 or consult https://www.williamblair.com/equity-research/coverage for all disclosures.

Andy T. Hsieh attests that 1) all of the views expressed in this research report accurately reflect his/her personal views about any and all of the securities and companies covered by this report, and 2) no part of his/her compensation was, is, or will be related, directly or indirectly, to the specific recommendations or views expressed by him/her in this report. We seek to update our research as appropriate. Other than certain periodical industry reports, the majority of reports are published at irregular intervals as deemed appropriate by the research analyst.

DOW JONES: 53185.90
S&P 500: 7686.14
NASDAQ: 26370.90



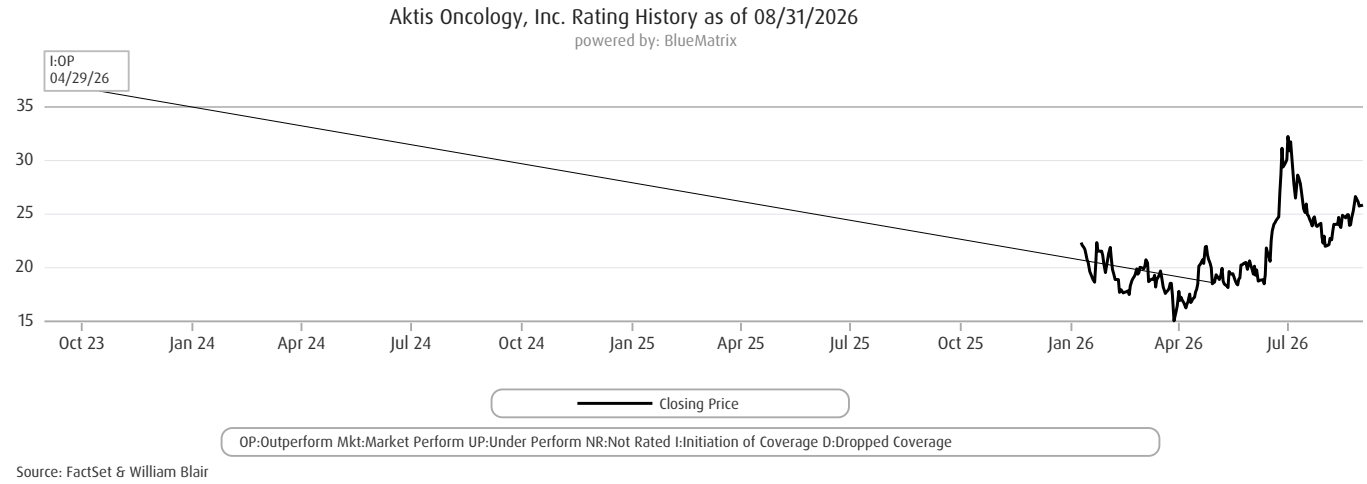
Source: FactSet & William Blair

Current Rating for LNTH: Market Perform



Source: FactSet & William Blair

Current Rating for TLX: Outperform



Source: FactSet & William Blair

Current Rating for AKTS: Outperform

Additional information is available upon request.

Current Rating Distribution (as of September 1, 2026):

Coverage Universe	Percent	Inv. Banking Relationships *	Percent
Outperform (Buy)	72	Outperform (Buy)	14
Market Perform (Hold)	28	Market Perform (Hold)	4
Underperform (Sell)	1	Underperform (Sell)	0

*Percentage of companies in each rating category that are investment banking clients, defined as companies for which William Blair has received compensation for investment banking services within the past 12 months.

The compensation of the research analyst is based on a variety of factors, including performance of his or her stock recommendations; contributions to all of the firm's departments, including asset management, corporate finance, institutional sales, and retail brokerage; firm profitability; and competitive factors.

OTHER IMPORTANT DISCLOSURES

Stock ratings and valuation methodologies: William Blair & Company, L.L.C. uses a three-point system to rate stocks. Individual ratings reflect the expected performance of the stock relative to the broader market (generally the S&P 500, unless otherwise indicated) over the next 12 months. The assessment of expected performance is a function of near-, intermediate-, and long-term company fundamentals, industry outlook, confidence in earnings estimates, valuation (and our valuation methodology), and other factors. Outperform (O) - stock expected to outperform the broader market over the next 12 months; Market Perform (M) - stock expected to perform approximately in line with the broader market over the next 12 months; Underperform (U) - stock expected to underperform the broader market over the next 12 months; not rated (NR) - the stock is not currently rated. The valuation methodologies include (but are not limited to) price-to-earnings multiple (P/E), relative P/E (compared with the relevant market), P/E-to-growth-rate (PEG) ratio, market capitalization/revenue multiple, enterprise value/EBITDA ratio, discounted cash flow, and others. Stock ratings and valuation methodologies should not be used or relied upon as investment advice. Past performance is not necessarily a guide to future performance.

The ratings and valuation methodologies reflect the opinion of the individual analyst and are subject to change at any time.

Our salespeople, traders, and other professionals may provide oral or written market commentary, short-term trade ideas, or trading strategies-to our clients, prospective clients, and our trading desks-that are contrary to opinions expressed in this research report. Certain outstanding research reports may contain discussions or investment opinions relating to securities, financial instruments and/or issuers that are no longer current. Investing in securities involves risks. This report does not contain all the material information necessary for an investment decision. Always refer to the most recent report on a company or issuer. Our asset management and trading desks may make investment decisions that are inconsistent with recommendations or views expressed in this report. We will from time to time have long or short positions in, act as principal in, and buy or sell the securities referred to in this report. Our research is disseminated primarily electronically, and in some instances in printed form. Research is simultaneously available to all clients. This research report is for our clients only. No part of this material may be copied or duplicated in any form by any means or redistributed without the prior written consent of William Blair & Company, L.L.C.

This is not in any sense an offer or solicitation for the purchase or sale of a security or financial instrument.

The factual statements herein have been taken from sources we believe to be reliable, but such statements are made without any representation as to accuracy or completeness or otherwise, except with respect to any disclosures relative to William Blair or its research analysts. Opinions expressed are our own unless otherwise stated and are subject to change without notice. Prices shown are approximate.

This report or any portion hereof may not be copied, reprinted, sold, or redistributed or disclosed by the recipient to any third party, by content scraping or extraction, automated processing, or any other form or means, without the prior written consent of William Blair. Any unauthorized use is prohibited.

If the recipient received this research report pursuant to terms of service for, or a contract with William Blair for, the provision of research services for a separate fee, and in connection with the delivery of such research services we may be deemed to be acting as an investment adviser, then such investment adviser status relates, if at all, only to the recipient with whom we have contracted directly and does not extend beyond the delivery of this report (unless otherwise agreed specifically in writing). If such recipient uses these research services in connection with the sale or purchase of a security referred to herein, William Blair may act as principal for our own account or as riskless principal or agent for another party. William Blair is and continues to act solely as a broker-dealer in connection with the execution of any transactions, including transactions in any securities referred to herein.

For important disclosures, please visit our website at williamblair.com.

This material is distributed in the United Kingdom and the European Economic Area (EEA) by William Blair International, Ltd., authorised and regulated by the Financial Conduct Authority (FCA). William Blair International, Limited is a limited liability company registered in England and Wales with company number 03619027. This material is only directed and issued to persons regarded as Professional investors or equivalent in their home jurisdiction, or persons falling within articles 19 (5), 38, 47, and 49 of the Financial Services and Markets Act of 2000 (Financial Promotion) Order 2005 (all such persons being referred to as "relevant persons"). This document must not be acted on or relied on by persons who are not "relevant persons."

This report is being furnished in Brazil on a confidential basis and is addressed to the addressee personally, and for its sole benefit. This does not constitute an offer or solicitation for the purchase or sale of a security by any means that would constitute a public offering in Brazil under the regulations of the Brazilian Securities and Exchange Commission (*Comissão de Valores Mobiliários*) or an unauthorized distribution under Brazilian laws and regulations. The securities are authorized for trading on non-Brazilian securities markets, and this report and all the information herein is intended solely for professional investors (as defined by the applicable Brazilian regulation) who may only acquire these securities through a non-Brazilian account, with settlement outside Brazil in a non-Brazilian currency.

“William Blair” and “R*Docs” are registered trademarks of William Blair & Company, L.L.C. Copyright 2026, William Blair & Company, L.L.C. All rights reserved.

William Blair & Company, L.L.C. licenses and applies the SASB Materiality Map® and SICSTM in our work.

William Blair

Equity Research Directory

John Kreger, Partner Director of Research +1 312 364 8612

Kyle Harris, CFA, Partner Operations Manager +1 312 364 8230

CONSUMER

Sharon Zackfia, CFA, Partner +1 312 364 5386
Group Head–Consumer
Lifestyle and Leisure Brands, Restaurants, Automotive/E-commerce

Jon Andersen, CFA, Partner +1 312 364 8697
Consumer Products

Phillip Blee, CPA +1 312 801 7874
Home and Outdoor, Automotive Parts and Services, Discount and Convenience

Dylan Carden +1 312 801 7857
E-commerce, Specialty Retail

ECONOMICS

Richard de Chazal, CFA +44 20 7868 4489

ENERGY AND POWER TECHNOLOGIES

Jed Dorsheimer +1 617 235 7555
Group Head–Energy and Power Technologies
Generation, Efficiency, Storage

Neal Dingmann +1 312 801 7835
Oil and Gas, Rare Earth

Tim Mulrooney, Partner +1 312 364 8123
Energy and Environmental Services

Mark Shooter +1 617 235 7593
Generation, Storage

FINANCIAL SERVICES AND TECHNOLOGY

Adam Klauber, CFA, Partner +1 312 364 8232
Group Head–Financial Services and Technology
Financial Analytic Service Providers, Insurance Brokers, Property & Casualty Insurance

Andrew W. Jeffrey, CFA +1 415 796 6896
Fintech

Cristopher Kennedy, CFA +1 312 364 8596
Fintech, Specialty Finance

Jeff Schmitt +1 312 364 8106
Wealthtech, Wealth Management, Capital Markets Technology

GLOBAL SERVICES

Tim Mulrooney, Partner +1 312 364 8123
Group Head–Global Services
Commercial and Residential Services

Andrew Nicholas, CPA +1 312 364 8689
Consulting, HR Technology, Information Services

Trevor Romeo, CFA +1 312 801 7854
Staffing, Waste and Recycling

HEALTHCARE

Biotechnology

Matt Phipps, Ph.D., Partner +1 312 364 8602
Group Head–Biotechnology

Sami Corwin, Ph.D. +1 312 801 7783

Lachlan Hanbury-Brown +1 312 364 8125

Andy T. Hsieh, Ph.D., Partner +1 312 364 5051

Myles R. Minter, Ph.D., Partner +1 617 235 7534

Healthcare Technology and Services

Ryan S. Daniels, CFA, Partner +1 312 364 8418
Group Head–Healthcare Technology and Services
Healthcare Technology, Healthcare Services

Jared Haase, CFA +1 312 364 5135
Healthcare Delivery, Pharmaceutical Outsourcing and Services

Steven Lichtman +1 646 561 9373
Medical Technology

Brandon Vazquez, CFA +1 212 237 2776
Dental, Animal Health, Medical Technology

Life Sciences

Matt Larew, Partner +1 312 801 7795
Life Science Tools, Bioprocessing, Healthcare Delivery

INDUSTRIALS

Brian Drab, CFA, Partner +1 312 364 8280
Co-Group Head–Industrials
Advanced Manufacturing, Industrial Technology

Ryan Merkel, CFA , Partner +1 312 364 8603
Co-Group Head–Industrials
Building Products, Specialty Distribution

Louie DiPalma, CFA, Partner +1 312 364 5437
Aerospace and Defense, Smart Infrastructure

Ross Sparenblek, CFA +1 312 364 8361
Diversified Industrials, Robotics, and Automation

TECHNOLOGY, MEDIA, AND COMMUNICATIONS

Jason Ader, CFA, Partner +1 617 235 7519
Co-Group Head–Technology, Media, and Communications
Infrastructure Software

Arjun Bhatia, Partner +1 312 364 5696
Co-Group Head–Technology, Media, and Communications
Software

Dylan Becker, CFA +1 312 364 8938
Software

Louie DiPalma, CFA, Partner +1 312 364 5437
Government Technology

Jonathan Ho, Partner +1 312 364 8276
Cybersecurity, Security Technology

Patrick McIlwee, CFA +1 312 364 8655
Software

Sebastien Naji +1 212 245 6508
Infrastructure Software, Semiconductor and Infrastructure Systems

Maggie Nolan, CPA, Partner +1 312 364 5090
IT Services

Ralph Schackart III, CFA, Partner +1 312 364 8753
Internet and Digital Media

Stephen Sheldon, CFA, CPA, Partner +1 312 364 5167
Vertical Technology – Real Estate, Education, Restaurant/Hospitality

EDITORIAL AND SUPERVISORY ANALYSTS

Steve Goldsmith, Head Editor and SA +1 312 364 8540
Katie Anderson, Editor and SA +44 20 7868 4451
Audrey Majors, Editor and SA +1 312 364 8992
Beth Pekol Porto, Editor and SA +1 312 364 8924
Lisa Zurcher, Editor and SA +44 20 7868 4549