# Elicera Therapeutics

Sector: Biotech

## Tackling Tumour Heterogeneity

*Redeye initiates coverage of Elicera Therapeutics, a Swedish clinical-stage biotech company focusing on cell and gene therapies for cancer treatment. Thanks to its promising focus on CAR-T – a modality we find highly promising – and its iTANK platform, aiming to broaden the use of CAR-T to solid tumours, we see good prospects for Elicera if it can demonstrate positive clinical results, potentially as early as next year.*

### A Swedish shot at CAR-T therapy

Despite its early stage, Elicera Therapeutics demonstrates high quality with its iTANK platform, designed to broaden and enhance CAR-T therapies, a promising but today relatively limited immune-oncology modality on a broader scale. This platform underpins its lead drug candidate, ELC-301 (currently in a recently initiated phase I/IIa study funded by EIC), as well as two preclinical projects, ELC-201 and ELC-401. Elicera is also advancing ELC-100, an externally funded oncolytic virus through an ongoing phase I/IIa trial. We favour the company's ability to finance projects partly/fully via external means, allowing for a cost-conscious yet broad approach versus most peers.

### Financed phase I/IIa study with near term triggers

The company's cash runway extends into mid-2026, providing sufficient funds to reach an important readout from the ongoing phase I/IIa study of ELC-301 in diffuse large B-cell lymphoma. If positive, this could lay the foundation for Elicera securing a licensing agreement. Additionally, the ELC-100 study should report results in early 2025, and we anticipate further optionality in the company's iTANK platform, which could be non-exclusively outlicensed at an early stage.

### Base case of SEK2.4 per share

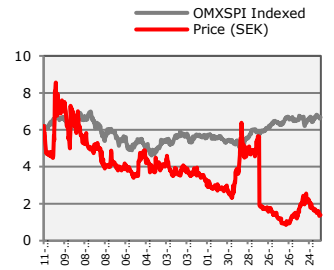
We base our valuation of Elicera on a risk-adjusted DCF model of its current pipeline where we apply a WACC of 19% and an estimate period between 2024e-2042e. We initiate coverage with a base case of SEK2.4 per share, with respective bull and bear cases of SEK5.5 and SEK0.4 per share. We think that the current valuation is undemanding for a clinical stage company with an attractive platform, and the implicit expectations in the share price are very low on a fundamental level (Enterprise value around SEK20m), but also note that it reflects the tough sentiment around early-stage biotech companies. Given the early stage of the company's drug candidates, the risk is high (8-12% likelihood of success), and clinical progress and successfully navigating potential financing needs, hopefully through partnerships, will be key for the share price going forward.

| Key Financials (SEKm) | 2022 | 2023 | 2024e | 2025e | 2026e |
|---|---|---|---|---|---|
| Net sales | 0 | 0 | 0 | 0 | 0 |
| Sales growth | nm | nm | nm | nm | nm |
| EBITDA | -19 | -17 | -20 | -17 | 44 |
| EBIT | -19 | -17 | -20 | -17 | 44 |
| Net Income | -19 | -16 | -20 | -17 | 35 |

**FAIR VALUE RANGE**

| BEAR | BASE | BULL |
|---|---|---|
| 0.4 | 2.4 | 5.5 |

**Elicera VERSUS OMXSPI**




**REDEYE RATING**




**KEY STATS**

| | |
|---|---|
| Ticker | ELIC |
| Market | First North |
| Share Price (SEK) | 1.6 |
| Market Cap (SEKm) | 48 |
| Free Float (%) | 71% |
| Avg. daily volume ('000) | 415 |

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**Important information:** All information regarding limitation of liability and potential conflicts of interest can be found at the end of the report
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# Investment Thesis

**Case: Quality research at a discount**

We recognise, despite its early stage, the high quality in Elicera's iTANK platform and research, which aims to broaden and enhance the use of CAR-T therapies and serves as the foundation for its leading drug candidate, ELC-301, plus two preclinical platforms (ELC-201 and ELC 401). Our DCF model and peer analysis suggest that the share's current valuation is undemanding, partly due to an overhang from a recent rights issue but also affected by the current sentiment for early-stage biotech companies. The company's cash runway extends into mid-2026, providing sufficient funds for it to reach an important readout in the ongoing phase I/IIa study of ELC-301 in diffuse large B-cell lymphoma – which, if positive, could be the foundation for the company to land a licensing agreement – two significant catalysts for the share.

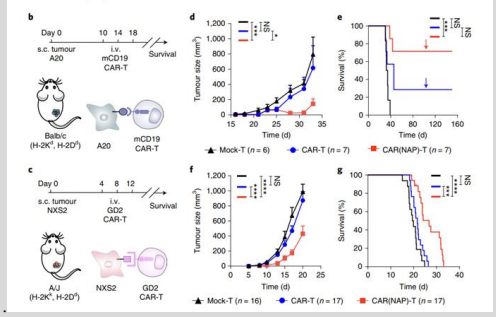
**Evidence: iTANK platform offers plenty of optionality**

Elicera's CAR-T drug candidates, ELC-301 and ELC-401, utilise the iTANK platform and offer an optimised version of the fourth-generation CAR T-cells. They have been genetically modified with a transgene that codes for a neutrophil-activating protein (NAP) rather than single cytokines, which is a strong immune stimulator. Today's CAR-T therapies focus on blood cancers, with no currently approved CAR-T therapies targeting a solid tumour.

iTANK focuses on solving two key issues in solid tumours: tumour heterogeneity and immunosuppressive tumour environment. According to a survey by Global Data, these are the two most challenging aspects of optimising cell therapies and would thus be very beneficial if replicated in clinical trials. This could potentially broaden the application of CAR-T to solid tumours, a significantly more prevalent cancer form – thus highly attractive from a commercial perspective. We also believe that ELC-301, which targets diffuse large B-cell lymphoma through a combination of CD20 targeting and iTANK armouring, could potentially improve efficacy compared with previous generations of CAR-T therapies. This combination makes ELC-301 an attractive therapy option if results from upcoming clinical trials are positive.

**Pre-clinical rationale**

A pre-clinical study (Jin et al) published in 2022 evaluated the efficacy of Elicera's CAR(NAP) T -cells in murine models with subcutaneous pancreatic ductal adenocarcinomas, neuroblastomas, and colon carcinomas. The study found that CAR(NAP) T- cells slowed tumour growth and improved survival rates compared to with conventional mouse CAR- T cells, irrespective of the target antigen, tumour type, or mouse model. In tumours with heterogeneous antigen expression, NAP secretion was associated with the development of an immunologically hot tumour microenvironment, promoting dendritic cell maturation and bystander immune responses, as evidenced by epitope spreading and increased infiltration of cytotoxic CD8+ T- cells targeting tumour-associated antigens beyond the CAR-specific target. The study also noted that CAR T- cells with NAP did not increase off-tumour toxicity or compromise CAR- T cell efficacy, which the authors suggested indicates potential advantages for future clinical applications



Challenge: **Inherent high risk due to early clinical stage**

As with all early-stage biotech companies, Elicera faces significant development risks, and we estimate the likelihood of approval for its clinical candidates to be between 8% and 12%. On a positive note, we like that Elicera has multiple opportunities for success through two immuno-oncology modalities: CAR-T therapies and oncolytic viruses. Additionally, the company could non-exclusively outlicense its iTANK platform to other pharmaceutical companies.

Challenge: **Dependent on partnerships**

As is typical for biotech companies, Elicera will depend on future partnerships to bring its clinical candidates to market, as we do not consider it feasible for the company to finance pivotal trials in-house. Given the company's low valuation, it would also be difficult to raise a significant sum at the moment.

**Valuation: Undemanding valuation**

We base our valuation of Elicera on a risk-adjusted DCF model of its current pipeline where we apply a WACC of 19% and an estimate period between 2024e-2042e. We initiate coverage with a base case of SEK2.4 per share, with respective bull and bear cases of 5.5 and 0.4 per share. We think that the current valuation is undemanding for a clinical stage company with an attractive platform, and the implicit expectations in the share price are very low on a fundamental level (EV around SEK20m), but also note that it reflects the tough sentiment around early-stage biotech companies. Given the early stage of the company's drug candidates, the risk is high (8-12% likelihood of success), and clinical progress and successfully navigating potential financing needs will be key for the share price going forward.

## Counter thesis

Development risk

Financial risk

Key personnel

# Catalysts

**ELC-301 readouts**

Elicera has stated that interim data from the first dosage group will be presented in early 2025, with the complete results from the dose-escalation phase presented by the end of 2025. It also says results from the second part will be presented six to 12 months after that, i.e. mid- to late 2026, depending on recruitment pace. Patients will subsequently be followed for two years, mainly for safety.

*Time horizon: 6 -24 months*

*Impact: High*

**ELC-100 phase I/IIa readout**

As of the Q2 2024 report, one patient remains to be treated and the company expects to conclude and report results in H1 2025

Time *horizon: 6 - 12 months*

*Impact: Medium*

**Potential licensing agreement**

If results are positive following the company's two ongoing clinical studies, we expect Elicera will aim to outlicense its candidates. Furthermore, the company has a platform (iTANK) that it could outlicense potentially earlier than that.

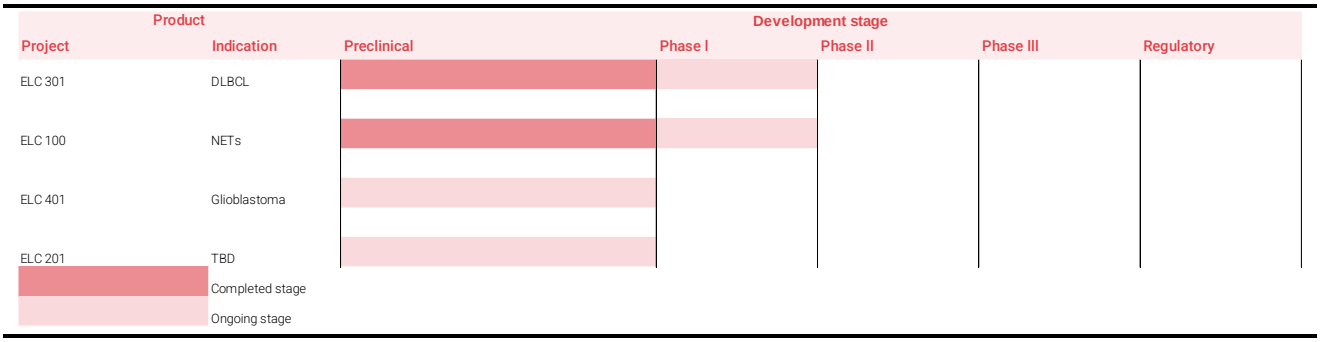
*Time horizon: 12 months and onward*

*Impact: High*

# Background

## Company history and business model

Elicera Therapeutics is a Swedish biotech company based in Gothenburg and focused on cell and gene therapies to treat cancer. The company was founded in 2014, with operations as of 2020, building on research from Uppsala University and co-founders Magnus Essand and Di Yu. The company has a platform, iTANK, and two clinical-stage candidates: the oncolytic virus ELC 100, (ongoing phase I/IIa clinical trial) and ELC 301, a CAR-T therapy (phase I/IIa clinical trial in the recruiting phase). Elicera also has two preclinical drug candidates: the next-generation oncolytic virus ELC-201 for treatment of solid tumours, and ELC-401, a CAR-T therapy for treatment of glioblastoma. The company is led by CEO Jamal El-Mosleh.




*Source: Elicera; Redeye Research*

## Major events

| Year | Event | |
|---|---|---|
| 2021 | - | IPO on Nasdaq First North |
| | - | Partners with BioNTech for contract manufacturing of viral vectors |
| 2022 | - | Strengthens IP protection of ELC-100 through acquisition of patent from Immunicum |
| | - | Secures SEK5m in funding from Vinnova regarding automated CAR-T Cell manufacturing process |
| | - | Publishes scientific publication about iTANK inhigh impact scientific journal Nature Biomedical Engineering |
| | - | Receives EIC grant of EUR2.5m to finance ELC-301 phase I/IIa trial |
| | - | Co-founders receive SEK7.65m in research grants from Swedish Cancer Society |
| | - | Reports signals of clinical activity in two patients from ongoing ELC-100 study |
| 2023 | - | Receives conditional approval to start clinical trial with ELC-301 |
| | - | Receives notice of allowance for European iTANK patent |
| | - | Submits GMP validation data to supplement conditional approval for ELC 301 clinical study |
| | - | Co-founder receives grant of SEK4.8m from Swedish Childhood Cancer Fund to support CAR-T research |
| 2024 | - | Magnus Essand presents Elicera's CAR-T cell projects at CICON, the largest cancer immunotherapy conference |
| | - | Announces rights issue of SEK64m |
| | - | Receives approval to start clinical phase I/IIa ELC-301 study (CARMA) |
| | - | Enters into agreement with a prominent US cancer centre to evaluate use of iTANK |
| | - | Enters a pre-clinical collaboration with China Medical University for development of ELC-201 |

# Leadership and holdings

## Top shareholders

| | No. of shares | SEK | Capital (%) | Votes (%) |
|---|---|---|---|---|
| Nordnet Pensionsförsäkring | 4145261 | 5575376 | 11,81% | 11,81% |
| Di Yu | 3423705 | 4604883 | 9,76% | 9,76% |
| Magnus Essand | 3370032 | 4532693 | 9,60% | 9,60% |
| Jamal El-Mosleh | 2945300 | 3961429 | 8,39% | 8,39% |
| Tuvedalen Ltd | 1206747 | 1623075 | 3,44% | 3,44% |
| Avanza Pension | 1144844 | 1539815 | 3,26% | 3,26% |
| Victory NET Foundation | 619300 | 832959 | 3,13% | 3,13% |
| Göran Persson | 1000000 | 1345000 | 2,85% | 2,85% |
| Kaj Johan Rintala | 474000 | 637530 | 1,35% | 1,35% |
| Sc Holding AB | 426000 | 572970 | 1,21% | 1,21% |
| Söderfors Data AB | 420000 | 564900 | 1,20% | 1,20% |

Source: *Holdings/Modular Finance: Redeye Research * Latest verification of Victory NET Foundations is from 2021, leading the % share of capital to be inactual.*

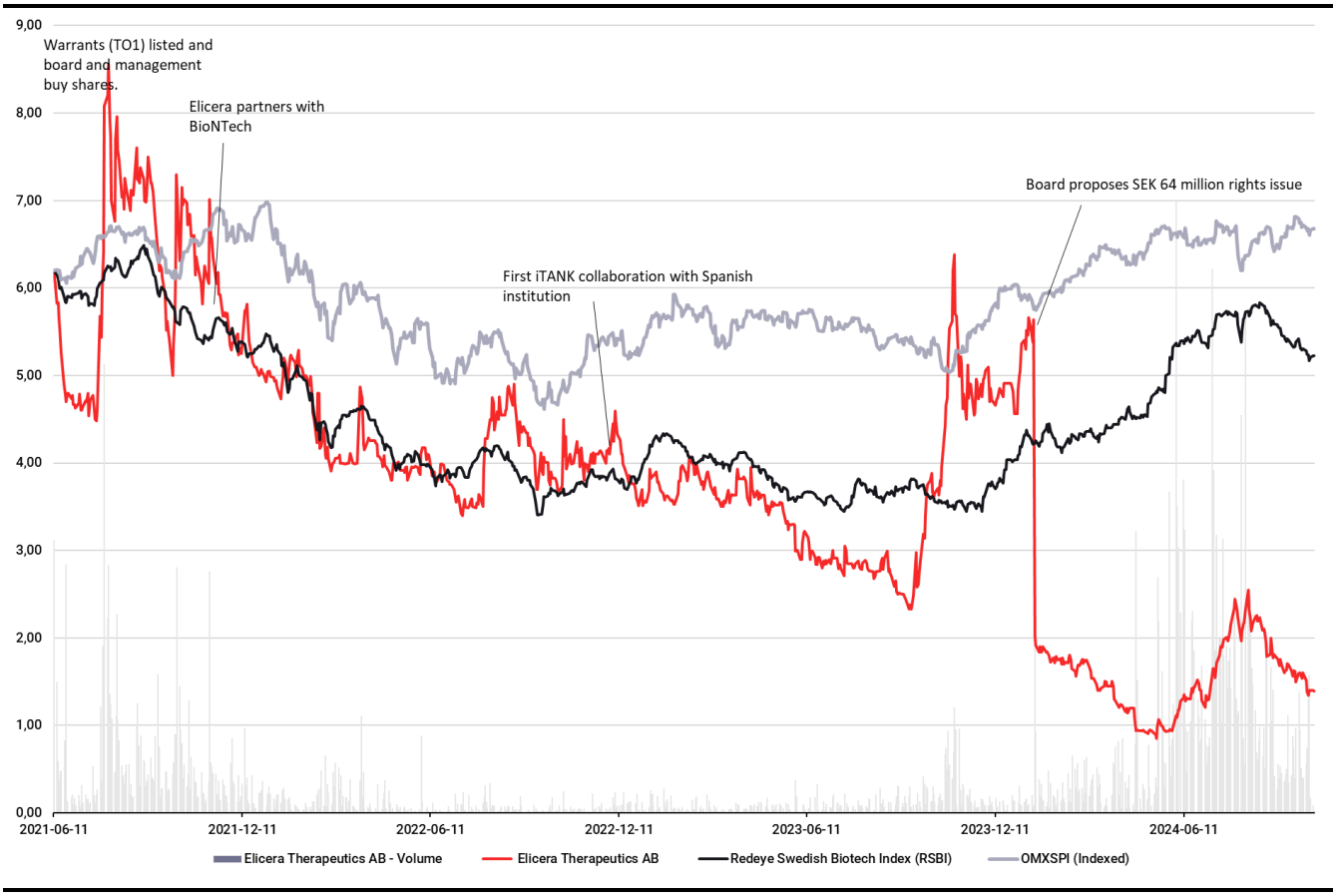
Elicera has a quite typical ownership list for an early-stage biotech company, largely without specialist investors and institutions, with most long-term-oriented investors being private individuals. On a positive note, insiders own some 30% of the outstanding shares, mainly the three co-founders, indicating significant skin in the game. Victory NET Foundation, with a relatively significant holding, is a foundation focused on research into neuroendocrine tumours, and it has funded the ongoing phase I/IIa trial in NETs with ELC 100.

| Management | Position | Shares | Warrants |
|---|---|---|---|
| Jamal El-Mosleh | CEO and co-founder | 2 945 300 | 151 900 |
| Ingvar Karlsson | Chief Financial Officer | 79 200 | 33 600 |
| Magnus Essand | Chief Scientific Officer and co-founder | 3 370 031 | 43 211 |
| Di Yu | Head of Translational Research and co-founder | 3 423 705 | 86 415 |
| Anna Koptina Gültekin | Head of Regulatory Affairs | 0 | 0 |
| | | **9 768 236** | **315 126** |

*Source: Holdings*

Elicera boasts a well-assembled team for its stage, we argue, with Jamal El Mosleh as a CEO (experience from several listed biotechs such as Annexin and Immunicum) and strong scientific backgrounds from co-founders Magnus Essand and Di Yu, a professor and a researcher from Uppsala University, respectively. Insider ownership is notably high (around 30%) versus other biotech firms at a similar stage.

## Share price development




*Source: Factset (data); Redeye Research (graph and RSBI index)*

Elicera's share price development has been relatively volatile, mostly downward since its IPO in 2021, largely reflecting the tough sentiment for biotech companies over this time. At the end of 2023, the board proposed a rights issue of some SEK64m, which had a negative impact on the share price. Now in H2 however, the share price has rebounded somewhat and traded in a quite broad range. Looking ahead, we see progress with the ELC 301 study as the key catalyst, followed by a readout in the ELC 100 clinical trial. We see good potential for an upward trend in the share, pending good clinical progress.

# Table of content

Company history and business model ..... 5
Major events ..... 5
Leadership and holdings ..... 6
Top shareholders ..... 6
Share price development ..... 7
Overview – immuno-oncology ..... 9
Cell therapy ..... 9
CAR-T ..... 12
Elicera's iTANK platform ..... 13
Today's treatments and pipeline ..... 18
ELC-100 and oncolytic viruses ..... 23
Neuroendocrine tumours ..... 24
Financials and business model ..... 27
Financing and OPEX Review (mSEK) ..... 27
Key Assumptions ..... 28
Likelihood of approval ..... 28
Deal Assumptions ..... 29
Patent portfolio ..... 30
ELC-301 in DLBCL ..... 31
ELC 100 in NETs ..... 32
Valuation Summary ..... 33

# Overview – immuno-oncology

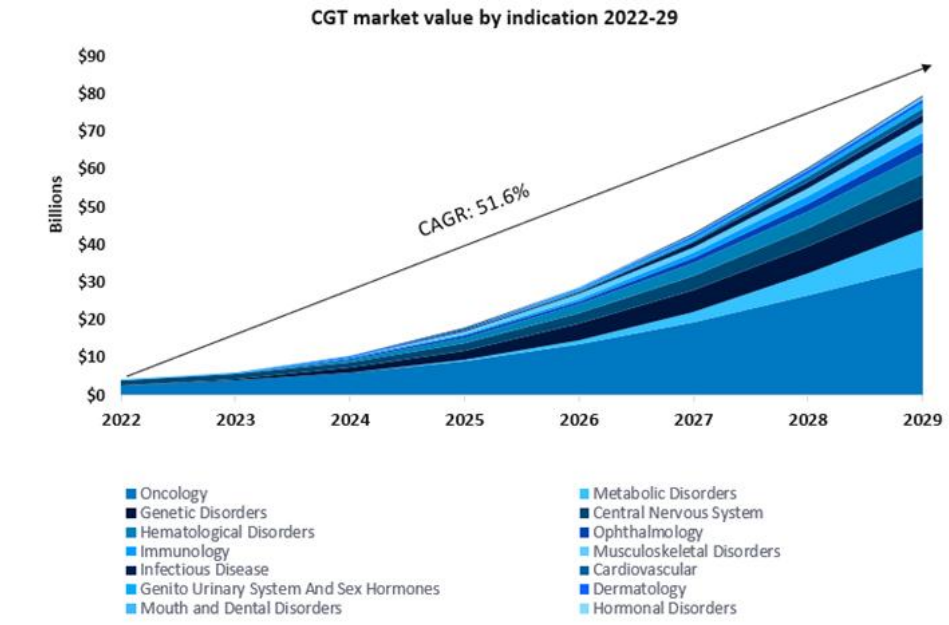
Immuno-oncology is a broad term for oncology therapies using the body's immune response, either via the patient's own immune system or via modified products. There are several different classes of drugs, such as checkpoint inhibitors, cytokines, cell therapies, vaccines, oncolytic viruses and bispecific antibodies. The most utilised class is checkpoint inhibitors, with Keytruda being the bestselling of these pharmaceuticals, supported by approvals in many cancer indications and forming the backbone of many cancer treatments. Checkpoint inhibitors are, for example, used in melanoma, bladder, lung, kidney cancer and for typical cases of Hodgkin's lymphoma. Elicera focuses on cell therapy and oncolytic viruses, which we will discuss further below.

According to Global Data, the immuno-oncology market was worth around USD48bn in 2022 and is expected to reach USD150bn by 2028 – in other words, it is a very significant market and one of the most important pharmaceutical markets overall. Checkpoint inhibitors are projected to reach approximately USD102bn by 2028. However, as key patents expire towards the end of this period, patients are expected to shift towards biosimilars, which could result in a lower market value.

### Cell therapy

Cell therapy is a modality within oncology, where modified immune cells are administered into the patient's body to prompt a direct or indirect anti-tumour effect. However, it is also a modality used in a wide range of indication areas, as seen below. In this report, our focus will be on its applications within oncology.

**Cell and gene therapy market value by indication**




*Source: Global Data*

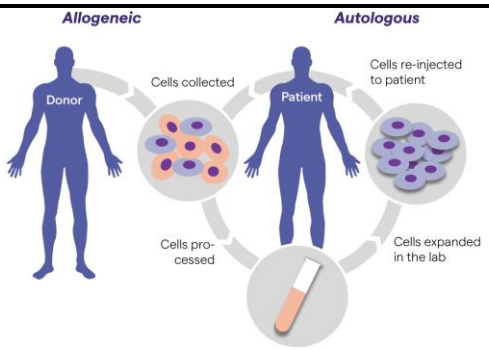
Cell therapy is typically divided into two groups: autologous, where cells from the patient's own body are removed, modified and then reinfused; and allogeneic, where a donor's cells are used.

Autologous cell therapy is patient-specific, meaning the cells come from the same person who will receive the treatment. This approach reduces the chances of immune rejection and graft-versus-host disease (GVHD), making it safer for repeated doses and longer-term treatments. However, autologous therapies face challenges such as high manufacturing and quality testing costs due to small batch sizes, variability in the starting material because of donor differences, and limited re-dosing options due to the limited number of cells available. Additionally, the patient's cells may be more fragile than those of healthy donors.

Allogeneic cell therapy involves donor cells, allowing for larger-scale, more cost-effective manufacturing. The manufacturing process is more reproducible due to less variability in donor material, and cell banking is possible, providing immediate availability for treatment – meaning it works better for acute disorders. Donors can also be screened for desirable characteristics, enabling treatment for multiple patients. However, allogeneic therapies also have challenges, including the need for additional gene editing to reduce the risk of GVHD, which increases costs. There is also a higher risk of rapid rejection because the cells are recognised as foreign, leading to short cell persistence and limiting the possibility of multiple doses.

Autologous cell therapy, which is also Elicera's focus, is the most common approach today.

**Allogenic versus autologous cell therapy**

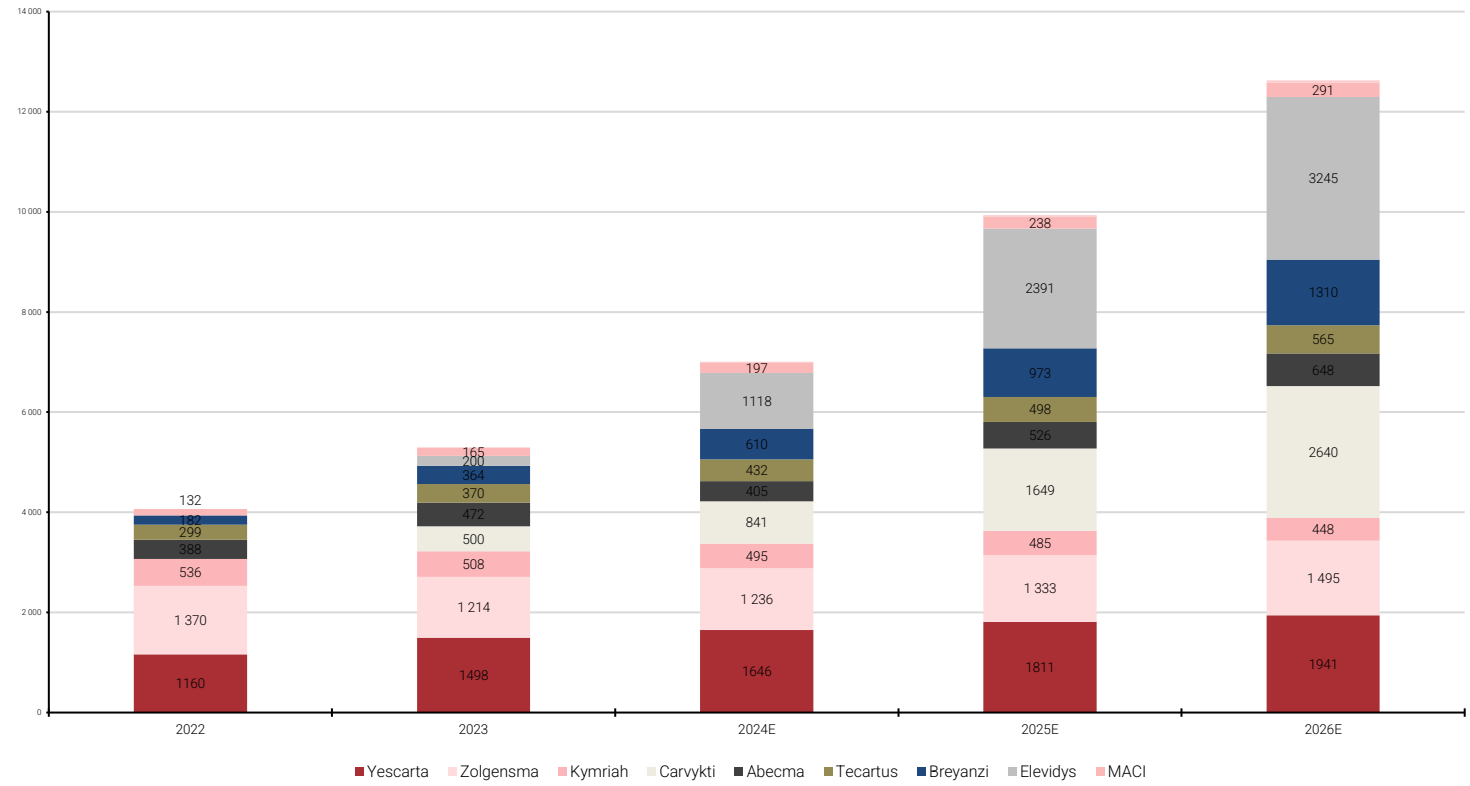



*Source: Lonza*

According to Global Data, cell therapies are also expected to experience robust growth with USD29bn by 2029, driven by new generations of therapies as well as by label expansion to new indications/moving to earlier lines of treatment.

Today's market leaders are Gilead (Yescarta and Tecartus), Novartis (Zolgensma and Kymriah), BMS (Abecma and Breyanzi) and Johnsson and Johnsson (Carvykti). As seen below, Yescarta, a CD19 targeting CAR-T therapy for large B-cell lymphoma, is the bestselling cell therapy today and is expected to grow further in the coming years. Based on our analysis of Factset consensus, Sarepta Therapeutics' Elevidys, targeting Duchenne muscular dystrophy, is expected to become the top-selling cell therapy among currently approved treatments. However, as illustrated below, CD19-targeting CAR-T therapies currently dominate the cell therapy landscape and target various B-cell malignancies.

**Best selling cell terapies (USDm)**




*Source: Factset (data) Redeye (compiling)*

**Categorisation of top cell therapies (selection)**

| Drug Name | Modality | Target | Indications | Approved |
|---|---|---|---|---|
| Yescarta | CAR-T | CD19 | Large B-cell Lymphoma, Follicular Lymphoma | 2017 |
| Kymriah | CAR-T | CD19 | Acute Lymphoblastic leukemia, Large B-cell Lymphoma, Follicular Lymphoma | 2017 |
| Tecartus | CAR-T | CD19 | Mantle cell lymphoma, Acute lymphoblastic leukemia | 2020 |
| Breyanzi | CAR-T | CD19 | Mantle cell lymphoma, Acute Lymphoblastic leukemia, Large B-cell Lymphoma, Follicular Lymphoma | 2021 |
| Carvykti | CAR-T | BCMA | Multiple Myeloma | 2022 |
| Abecma | CAR-T | BCMA | Multiple Myeloma | 2021 |
| Elevidys | AAV | ELEVIDYS micro-dystrophin | Duchenne Muscular Dystrophy | 2023 |
| Zolgensma | AAV | survival motor neuron 1 (SMN1) | Spinal Muscular Atrophy | 2019 |

*Source: Global Data; Redeye Research*

# CAR-T

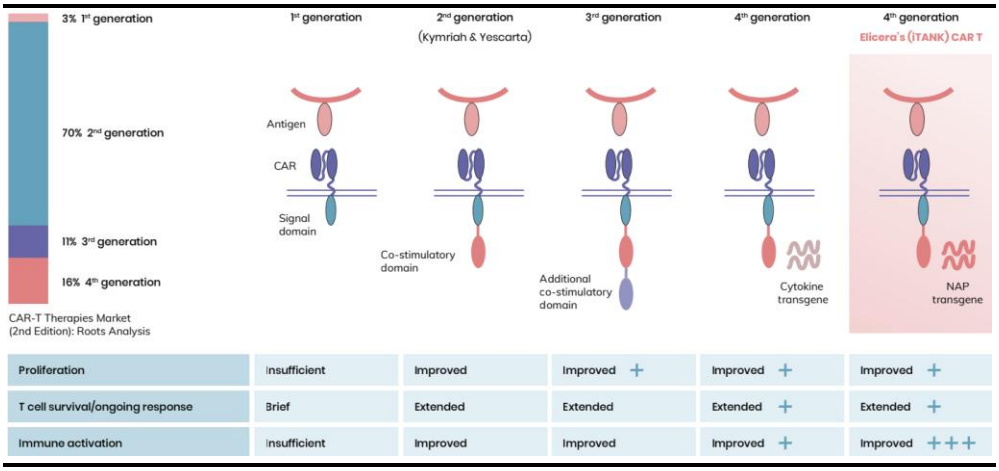
CAR T-cell therapy is a type of immunotherapy where a patient's T-cells are collected, re-engineered in a lab to produce chimeric antigen receptors (CARs) on their surface, and infused back into the patient. The CARs help the T-cells recognise and attack cancer cells by targeting specific antigens on the cancer cell's surface.

There have been several generations of CAR-T therapies, spanning more than 30 years, with each generation improving survival and persistence. However, as noted above, the first approval was in 2017.

First-generation CAR T-cells often demonstrated poor efficacy due to insufficient proliferation and survival after infusion. The second- and third-generation CAR T-cells incorporated one and two extra co-stimulatory domains, improving their function, survival and immunogenicity. According to Elicera, some 70% of all CAR T-cells under development belong to the third generation.

Fourth-generation CAR T-cells build upon previous generations by adding a transgene that codes for single immune-stimulating substance, such as a cytokine. These are intended to trigger the innate immune system, which then activates the patient's killer T-cells.

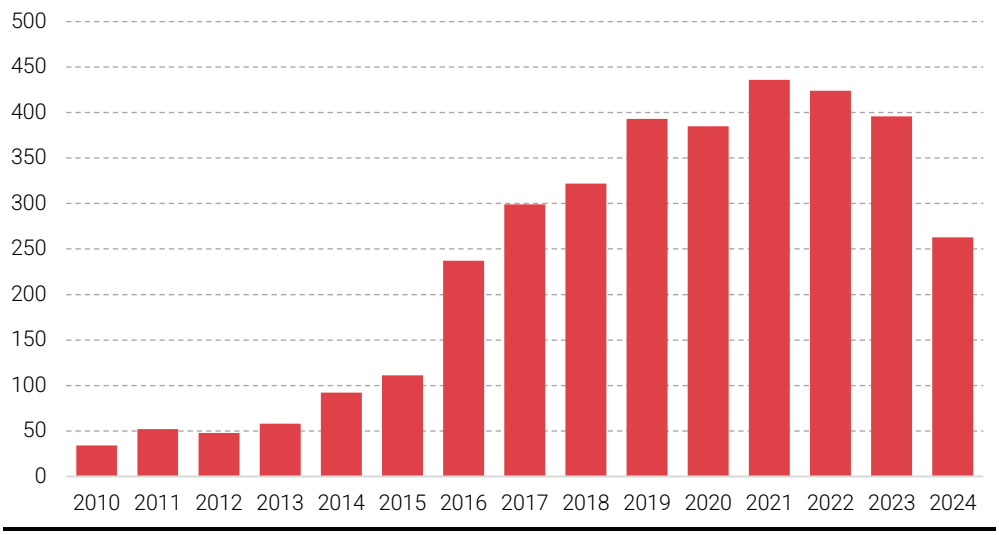
**Generations of cell therapies**




*Source: Elicera Therapeutics*

Cell therapy and CAR-T therapies are a rapidly developing field, with a significant increase in the number of clinical trials since 2010. Among the slightly broader definition of adoptive cell therapies (including CAR-T, tumour-infiltrating lymphocyte immunotherapy (TIL) and NK cell therapy), the number of clinical trials peaked in 2021, before seeing a downward trend affected by COVID-19 and lower investments due to the weakened macroeconomic environment. This trend appears to have reversed this year, however, with 60%+ of the number seen in 2023 by May 2024. Most clinical trials in cell therapy are currently ongoing, and China is the single most popular country in which to conduct a trial, followed by the US, according to Global Data. Most studies are in the early stages of development, with phase I being the most common ongoing phase. As with many other modalities, this indicates that CAR-T and cell therapies remain a fledgling area for clinical development and, potentially, that safety could remain an obstacle for some candidates.

**Adoptive cell therapy – development of clinical studies**

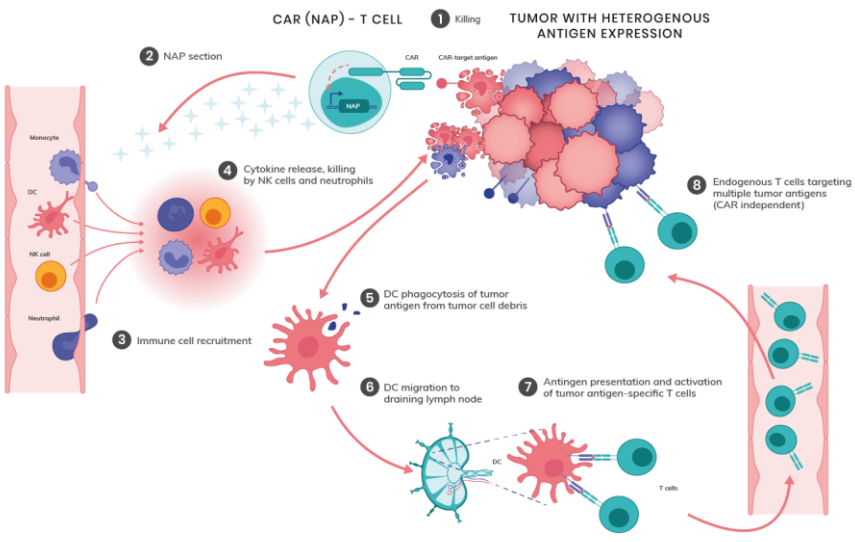



Source: Global Data (data); Redeye Research (compiling) (2024 through May)

## Elicera's iTANK platform

Elicera's CAR-T drug candidates, ELC-301 and ELC-401, utilise the iTANK platform with an optimised version of the fourth-generation CAR T-cells. They have been genetically modified with a transgene that codes for a neutrophil-activating protein (NAP), which is a strong immune stimulator, instead of single cytokines. Today's CAR-T therapies focus on blood cancers, with no currently approved CAR-T therapies targeting a solid tumour. iTANK focuses on solving two key issues within solid tumours: tumour heterogeneity and immunosuppressive tumour environment. According to a survey by Global Data, these are the two most challenging aspects of optimising cell therapies and would thus be very beneficial if replicated in clinical trials. This could potentially broaden the application of CAR-T to solid tumours, a significantly more prevalent cancer form.

**Mode of action**




*Source: Elicera*

Cancer cells in solid tumours often exhibit a variety of antigens on their surfaces, a phenomenon known as tumour antigen heterogeneity. This diversity makes it challenging for today's CAR T-cell therapies – which target a single specific antigen – to eliminate all cancer cells effectively. Elicera has developed CAR (NAP) T-cells, which are engineered CAR-T cells armed with NAP, an immune activator derived from the bacterium *helicobacter pylori*, that can induce bystander immunity. This means cells from the innate immune system activated by NAP destroy cancer cells, which then leak molecules (neo-antigens) that are recognised by the adaptive immune system. T-cells from the adaptive immune system can learn to identify and kill the cancer cells. This is similar to vaccinating a patient against the cancer (specifically the neo-antigens).

NAP has been shown to substantially enhance the immunogenicity of poor immunogens through this mode of action in other studies. By engaging both innate and adaptive immune responses, Elicera's CAR(NAP) T-cell therapy can address the challenge of antigen heterogeneity within solid tumours. It targets specific tumour cells like standard CAR-T therapy and stimulates a robust immune response that can eliminate adjoining cancer cells lacking the original target antigen, leading to a more comprehensive eradication of the tumour if replicated in the clinic.

### Proposed chain of events (adapted from Jin et al 2022)

Chimeric antigen receptor (CAR) T-cell therapy is a cancer treatment in which patient-derived T-cells are genetically engineered in a laboratory to recognise an antigen (unique structure) on the surface of tumour cells. When the CAR molecule interacts with their target antigen, the CAR-T cell is activated and kills the tumour cell. CAR-T cell therapy is an effective and approved treatment for haematological cancers but is not currently effective against solid tumours. The main reason for this is that antigen expression is heterogenous in solid tumours and CAR-T cells targeting a single antigen thereby fail to eradicate all tumour cells, leading to regrowth of a tumour clone that no longer responds to the CAR-T cell therapy.

CAR(NAP)-T cells are CAR-T cells armed with a neutrophil-activating protein (NAP) from the bacteria *helicobacter pylori*. When CAR(NAP)-T cells encounter tumour cells, they kill them in the same way as conventional CAR-T cells do and also release immune-boosting NAP protein locally in the tumour microenvironment.

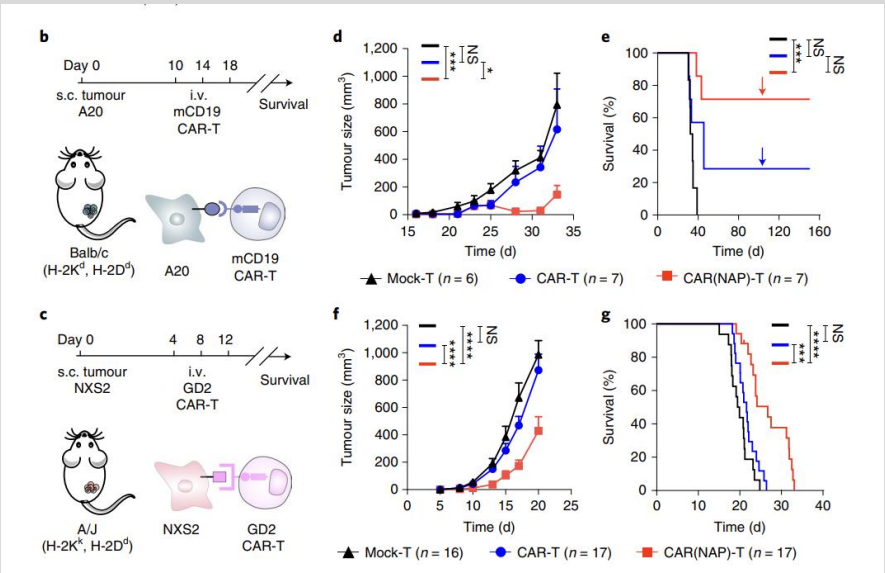
By being a recruiter and activator of innate immune cells (neutrophils, NK cells monocytes and dendritic cells), NAP induces a bystander innate immune response against the cancer. Furthermore, NAP instructs dendritic cells, which are the educators of adaptive immune cells (T-cells and B-cells), to take up antigens, including tumour-specific neoantigens from killed tumour cells, and present these antigens to naïve T-cells. T-cells with a T-cell receptor (TCR) that recognises neoantigens will be activated and mount an attack on tumour cells. As this attack is directed against the neoantigens, it does not depend on whether the tumour cells have the CAR target antigen or not. This adaptive bystander immune response is also referred to as epitope spread, and it has the possibility to help clear solid tumours with a heterogenous antigen expression. CAR(NAP)-T cells thus have the potential to be more active than the CAR-T cells on the market today.

### Pre-clinical evidence

A pre-clinical study (Jin et al) published in 2022 evaluated the efficacy of Elicera's CAR(NAP) T cells in murine models with subcutaneous pancreatic ductal adenocarcinomas, neuroblastomas, and colon carcinomas. The study found that CAR(NAP) T cells slowed tumor

growth and improved survival rates compared with conventional mouse CAR T cells, irrespective of the target antigen, tumor type, or mouse model. In tumours with heterogeneous antigen expression, NAP secretion was associated with the development of an immunologically hot tumor microenvironment, promoting dendritic cell maturation and bystander immune responses, as evidenced by epitope spreading and increased infiltration of cytotoxic CD8+ T cells targeting tumor-associated antigens beyond the CAR-specific target. The study also noted that CAR T cells with NAP did not increase off-tumor toxicity or compromise CAR T cell efficacy, which the authors suggested indicates potential advantages for future clinical applications.

**Tumour size and survival**




*Source: Jin et al (2022)*

**Collaborations**

Earlier this year, Elicera announced it had entered into a material transfer agreement with a prominent academic US cancer centre to evaluate the enhancing effects of the iTANK platform in a novel T-cell receptor (TCR) therapy in a pre-clinical setting. The therapy targets CD4 and focuses on the skin and lung cancer indications. The studies will be conducted and funded by the centre, and Elicera has the right to use the results for internal and commercial use. The name of the centre will be disclosed when the results are published. Elicera has previously announced a similar agreement with a Spanish institute, Josep Carreras Leukaemia Research Institute, using iTANK to arm CAR-T cells for treating Ewing sarcoma.

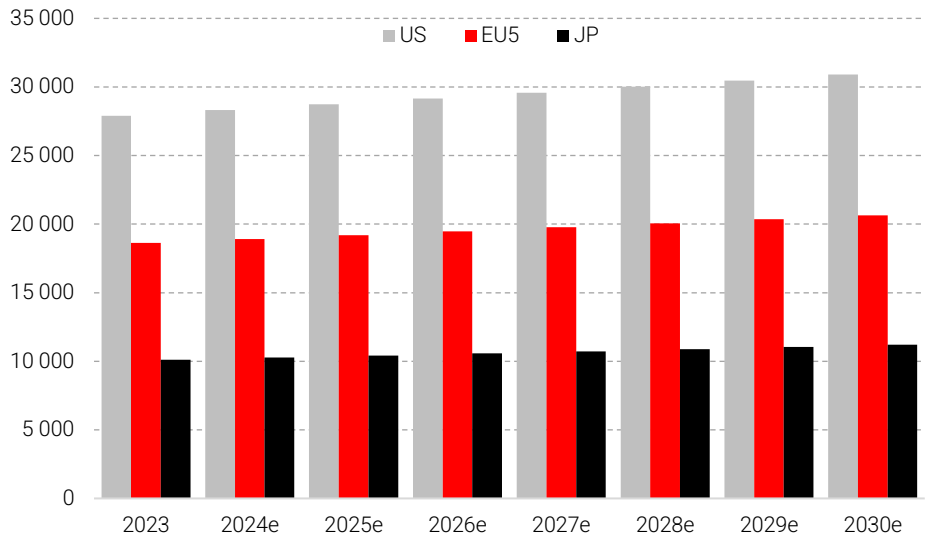
In June 2024, Elicera also announced a preclinical collaboration with the Fourth Affiliated Hospital of Chinese Medical University to evaluate ELC-201, armed with the iTANK-platform, in a number of solid tumours identified as most relevant for that drug candidate based on a comprehensive indication analysis, taking into consideration both commercial and scientific parameters.

We think such collaborations could improve the scientific understanding of the platform further and, if successful, potentially increase the odds for commercial licensing deals further on.

## Diffuse large B-cell lymphoma

Diffuse large B-cell lymphoma (DLBCL) is the most common form of non-Hodgkin's lymphoma (a broad category of lymphoma) and comprises about one-third of NHL cases. There are around 350,000 prevalent cases in the US, EU4+UK and Japan, and the incidence is around 55,000 annually, affecting mainly elderly people (median age of occurrence is around 67 years).

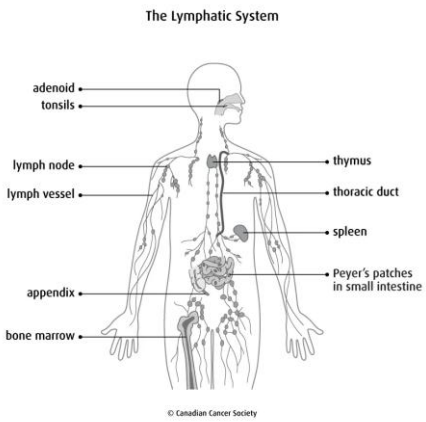
**Incidence - diagnosed patients with DLBCL**




*Source: Global data (data); Redeye Research (compiling)*

The cancer form starts in the lymphatic system, which is an essential part of the immune system, and develops from a type of white blood cell called a lymphocyte. Lymphocytes grow in the body to fight infections or inflammation but can also develop into lymphoma when growing unregulated.

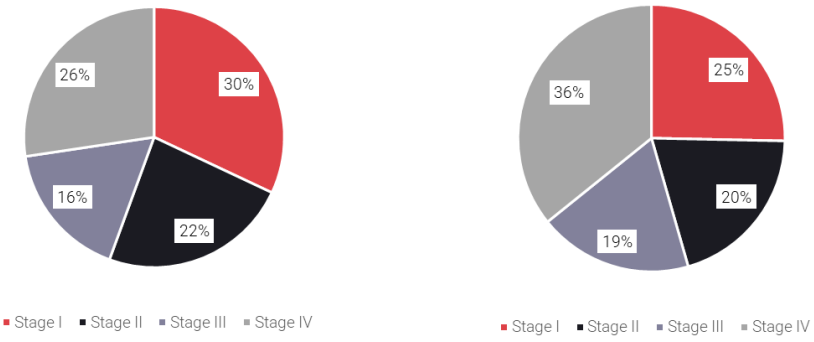
**Lymphatic system - overview**




*Source: Canadian Cancer Society*

As indicated by its name, DLBCL starts in B-cells, and the tumours consist of large, fast-growing B-cells typically found in lymph nodes and extranodal sites, such as the spleen, bone marrow, liver and other tissues/organs. Although aggressive, DLBCL is considered a treatable cancer form, and the ambition is to reach complete remission.

**Diagnosed prevalence proportion (left) and incidence proportion (right) of DLBCL by stage (2024 estimate)**




*Source: Global data (data); Redeye Research (compiling)*

**Lugano staging of DLBLC**

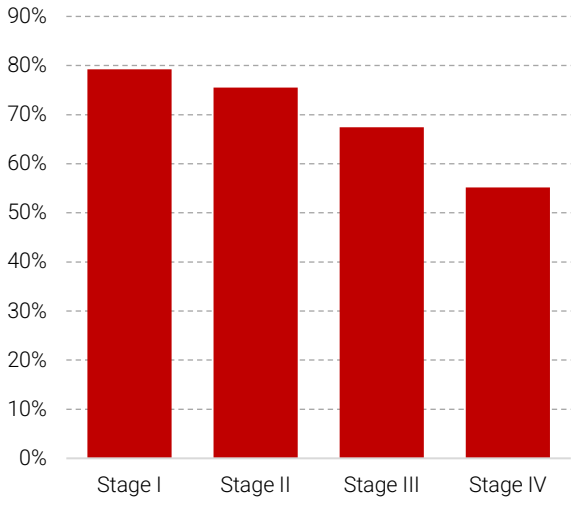
| Stage | Area of Involvement | Extranodal (E) Status |
|---|---|---|
| Stage I | One node or a group of adjacent nodes | Single extranodal lesions without nodal involvement |
| Stage II | Two or more nodal groups on the same side of the diaphragm | Stage I or II by nodal extent with limited contiguous extranodal involvement |
| Stage II bulky | Two or more nodal groups on the same side of the diaphragm with 'bulky' disease | Not applicable |
| Stage III | Nodes on both sides of the diaphragm and nodes above the diaphragm with spleen involvement. | Not applicable |
| Stage IV | Additional non-contiguous extralymphatic involvement | Not applicable |

Bulky disease: >7.5 cm maximum diameter of nodal mass

*Source: Global Data, NCCN (information); Redeye Research (compiling)*

Patients with DLBLC are staged using the Lugano staging system into four categories: I (limited disease) through to IV (advanced disease). As seen above, the most prevalent stage is stage I, but from an incidence perspective, stage IV is the most common, also reflecting the reduced survival odds of being in stage IV, down from 79% to 55%, as seen below.

**Five year survival according to Lugano staging, 2014-2020**




*Source: National Cancer Institute (Data); Redeye Research (compiling)*

## Today's treatments and pipeline

There is a relatively elaborate treatment algorithm for DLBCL, which depends on staging. The standard first-line treatment combines Rituximab (an antibody that targets CD20) with chemotherapies cyclophosphamide, doxorubicin, vincristine, and the steroid prednisolone, called R-CHOP. It is an effective treatment, and 50–70% of treated patients are cured. A combination of Polivy (an ADC targeting CD79b from Genentech) and R-CHP is also approved for patients with higher tolerability for toxicity. It will likely challenge R-CHOP as the first-line standard of care (SOC). Several label expansions and new therapies are also expected to target the first-line setting, such as bispecific antibodies (CD20 x CD3) combined with chemotherapy.

About 10–15% of patients experience primary refractory disease, i.e. relapse within three months, or non-response, and about 20–25% of patients relapse after an initial response to treatment, typically within two years. The following treatment option is based on the time since their last treatment: if the cancer returns less than a year after the last treatment ended, a patient's treatment will be based on whether CAR-T therapy is planned, and if the cancer returns after more than 12 months, treatment is based on whether haematopoietic cell transplant (HCT) is planned. According to Datamonitor, about 50% of patients are fit for Rituximab and platinum-based chemotherapy followed by treatment with high-dose chemotherapy and autologous stem cell transplantation, and only half of these patients will respond to chemotherapy and then move on to transplantation, leading to a relatively narrow patient population.

We also understand that CAR-T increasingly challenges stem cell therapy for high-risk relapsing/refractory patients. Approved CAR-T therapies Yescarta and Breyanzi were initially approved for relapsing/refractory patients after two or more lines of treatment (3L+) but were later approved for refractory patients after chemoimmunotherapy (R-CHOP) or relapsing patients within 12 months (2L+). Kymriah, while initially approved for 3L+, did not achieve its goal in a follow-up phase III trial in 2l+ and is seldom used in DLBCL patients, indicating that the CAR-T therapies mainly are used in the 2L+ setting.

Looking at the clinical effect of the CD-19 Yescarta and Breyanzi, the median EFS (event-free survival) was 8.3 and 10.1 months, respectively, for the drugs in their pivotal trials. EFS was defined as *"the time from randomization to death from any cause, progressive disease, failure to achieve CR or PR by 9 weeks after randomization (evaluated after 3 cycles of SOC and 5 weeks after liso-cel infusion), or the start of new antineoplastic therapy because of efficacy concerns, whichever occurred first"*.

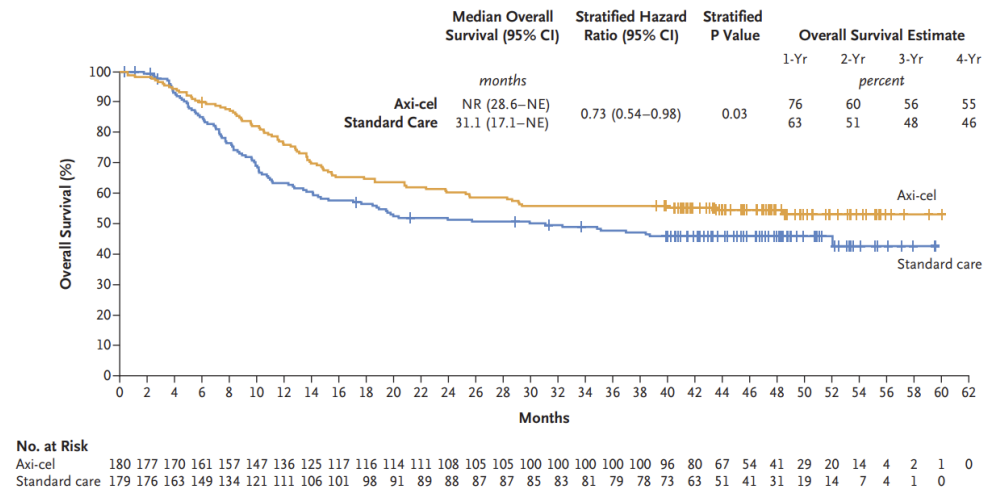
**Clinical results: Positive phase III studies in DLBCL 2L+**

| Therapy | Trial Name | Median EFS, months (placebo) | Median Follow-Up (Months) | 36-Month PFS (%) | 36-Month OS (%) | 48-Month PFS (%) | 48-Month OS (%) |
|---|---|---|---|---|---|---|---|
| Yescarta | ZUMA-7 | 8,3 (2) | 48 | NA | NA | 42% (24%) | 55% (46%) |
| Breyanzi | TRANSFORM | 10,1 (2,3) | 33,1 | 51% (26%) | 63% (52%) | | |

Source: Kite Pharma, Bristol Myers Squibb; Redeye Research (compiling)

Only Yescarta showed a statistically significant effect on overall survival, which can be considered a competitive advantage. However, it is not fully clear to us whether this related to efficacy or study design. Breyanzi is often perceived as safer than Yescarta. According to Factset consensus, Yescarta is estimated to be the better-selling drug of the two.

**Overall survival: Yescarta (Axi-cel) in DLBCL 2L+**




*Source: Abramson et al 2023*

## Phase I/II trials (3L+)

| Study (year of publication) | CAR product and trial phase | Cancer types (n) | Median follow-up (range) | ORR and CRR | PFS or EFS |
|---|---|---|---|---|---|
| ZUMA 1 - Jacobson et al. (2021) | Yescarta, multicentre phase I/II | DLBCL (77); PMBCL (8); t-FL (16) | 51 months | ORR: 74%; CRR: 54% | Median EFS: 5.7 months, with 24-month EFS of 38% |
| JULIET - Schuster et al. (2021) | Kymriah, multicentre phase II | DLBCL, HGBCL or tFL (115) | 40 months (IQR 38–44 months) | ORR: 53%; CRR: 39% | Median PFS: 2.9 months; median EFS: 2.8 months |
| TRANSCEND - Abramson et al. (2021) | Breyanzi, multicentre phase I | LBCL (270) | All patients had ≥24 months of follow-up data; median NR | ORR: 73%; CRR: 53% | Median PFS: 6.8 months |

*Source: Cappell & Kochenderfer 2023, company presentations (data); Redeye Research (compiling)*

Looking at the long-term outcomes of the phase I/II trials of Kymriah, Yescarta and Bretanzi, the ORR ranged between 53% and 74% and CRR between 39% and 54%, which should give some indication of the efficacy that we would want to see with ELC-301.

Even though the CD-19 targeting CAR-T therapies are effective, 30–60% of patients eventually relapse – and the prognosis for these patients is typically poor. We have seen some numbers indicating that 10–20% of relapsing patients experience CD19-negative relapse – i.e. a relapse where cancer cells no longer express the CD19 antigen on their surface and thus cannot be targeted.

One safety concern has been that CAR-T therapies overactivate the patient's immune system, which can lead to serious adverse effects – in the worst case, death – that differ from other cancer therapies. Typical adverse effects that are unique to CAR-T are cytokine release syndrome (CRS) and *immune effector cell associated neurotoxicity syndrome (*ICANS).

The onset of CRS typically occurs in the first week of treatment and is generally seen in the first two weeks. CRS always includes fever but can also affect other systems. It should be monitored closely, is graded on a scale of 1–4, and can typically be treated symptomatically and with anti-IL6 therapy tocilizumab. Co-morbidities and early onset of CRS are associated with higher risks of CRS.

ICANS typically manifests via symptoms such as diminished attention, confusion and language disturbance. It can also present in a biphasic manner, and around 10% of patients experience delayed neurotoxicity, such as seizures or confusion, during the third or fourth week after CAR-T cell therapy. While anti-IL-6 treatment is effective in treating ICANS during the first phase, it is generally less effective in the second phase, where corticosteroids are the preferred treatment.

For now, the high need for monitoring and remaining risk for adverse effects are key reasons why CAR-T to likely remain a second- or third-line treatment, in combination with the high cost of treatment and production. Furthermore, the administration in patients is currently limited to specialist clinics. Beyond efficacy, treatments with less adverse effects that could be administered in outpatient clinics are highly sought after.

Overall, we argue that the unmet medical need is high in DLBCL, and we believe a CD20-targeting CAR-T therapy that is also armed with the iTANK technology could have the potential to complement existing CAR-T therapies at least initially as a treatment for non-responders. As previously mentioned, CD-20 is a primary target in DLBCL, including Rituximab, and also includes bispecific antibodies. To our knowledge, there are a handful of companies with a CD20 target, including bispecific targeting on CD19/CD20, but also a few bispecific antibodies, as previously mentioned.

Still, we argue that CD20 is a relatively underexplored target for CAR-T compared with CD19. In the long run, we do not see the target as the key competitive advantage necessarily, but CD20-targeting could, in combination with iTANK armouring, potentially improve efficacy compared with the previous generation of CAR-T therapies regardless of target, and that in combination could make ELC-301 an attractive therapy.

### ELC 301 and the CARMA trial

CARMA is the first clinical study with Elicera's drug candidate ELC-301, its CD20, targeting CAR-T therapy armed with the iTANK technology. The trial is open-label, single-arm and multicentre. It will evaluate the safety and treatment effect after a single dose of ELC-301 in patients with challenging cases of CD20-positive B-cell lymphoma, mantle cell lymphoma or indolent lymphoma, including those who have experienced disease relapse.

The study will evaluate anti-tumour efficacy, toxicity and tolerability and is divided into two sections: a dose escalation phase (I) with a maximum of 12 patients to establish optimal dose, followed by a dose expansion phase (phase IIa) with up to six patients receiving the maximum tolerated dose. In total, 12 patients are planned to receive the maximum tolerated dose. The study is conducted at Sweden's Uppsala University and Karolinska University Hospital in Huddinge.

In its Q2 report, Elicera states that interim data from the first dosage group will be presented in early 2025, with complete results from the dose-escalation phase to be presented by the end of 2025. Results from the second part will be presented six to 12 months after that, i.e. mid- to late 2026, depending on recruitment pace. Patients will subsequently be followed for two years, mainly for safety.

Compared to the typical biotech case, we believe the phase I/IIa trial will hold more importance clinically but also from a share price perspective – both as safety is essential for CAR-T therapies, and also as the company likely would only need one more clinical trial from approval.

The CARMA study is financed by an EIC grant of EUR2.5m, with two remaining outstanding payments.

**Study design – CARMA**

| | |
|---|---|
| Subjects | • Patients with r/r B-cell lymphoma in third line setting |
| Trial Arm Design | • Open study with 18 subjects (12 in phase I dose escalation and 6 in phase II)<br>• 1 dose of ELC-301 (CD20 CAR(NAP)T-cell)<br>• Dose levels of $2x10^5$, $6x10^5$, $2x10^6$ |
| Primary Endpoints | • Incidence of dose limiting toxicity (DLT) |
| Secondary Endpoints | • ORR, PFS, OS, DoR<br>• Additional efficacy endpoints including CAR-T cell persistence and immune status profiling |

Source: Elicera

## ELC-401

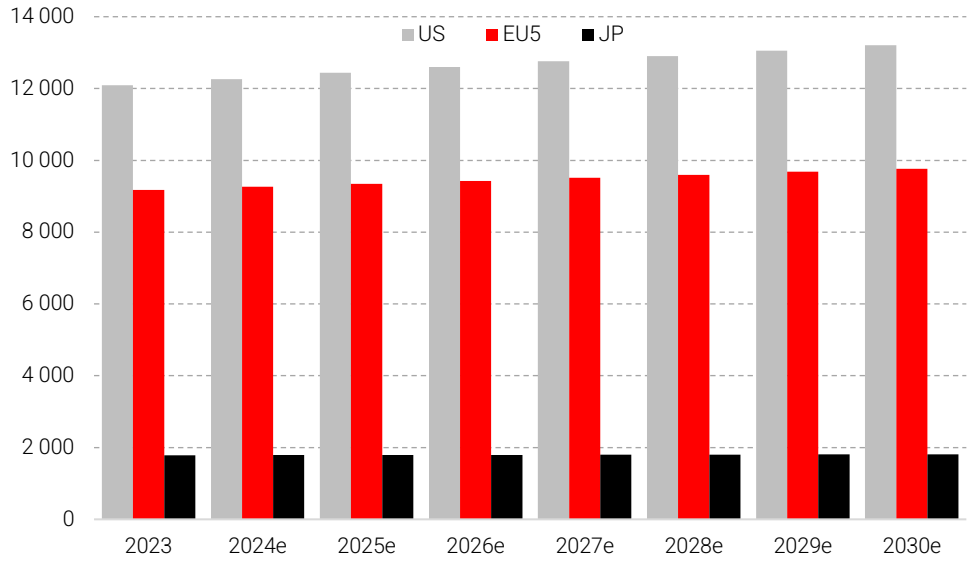
Elicera has a second CAR-T therapy armoured with the iTANK technology, namely ELC-401, focusing on the aggressive and highly deadly brain cancer form glioblastoma. It targets the tumour antigen IL13Ra2 – an overrepresented receptor protein in glioblastoma.

Glioblastoma typically manifests rapidly and the limited efficacy of available treatments results in a median survival rate of about 15 months. Gliomas are generally classified based on their cell of origin into astrocytomas, oligodendrogliomas, ependymomas and mixed gliomas. The World Health Organization (WHO) further grades astrocytomas by evaluating factors that indicate tumour aggressiveness, such as mitotic activity, vascular proliferation and necrosis. This classification system identifies glioblastoma multiforme (GBM) as a grade IV astrocytoma.

Glioblastoma patients often report a clinical history spanning three to six months. It is localised in the brain, predominantly in the supratentorial region (encompassing the temporal, frontal, occipital and parietal lobes), but it can also emerge in other central nervous system (CNS) areas.

It is a very aggressive disease, and the development of drug resistance over time makes it particularly difficult to treat. As a result, survival rates and mortality figures for GBM have remained essentially unchanged for years. Palliative treatments such as surgery, radiation and chemotherapy can help manage the disease. Surgery is the primary treatment for GBM, followed by radiation and chemotherapy. The main goal of surgery is to remove as much of the tumour as possible without damaging the adjacent healthy brain tissue essential for normal neurological functions; this process is known as debulking. However, GBMs have infiltrative tumour cells that spread into nearby tissue, making complete removal unattainable.

**Incidence of glioblastoma**




*Source: Datamonitor; Redeye Research*

In a pre-clinical study published in Nature Communications (Sarén et al., 2023), the researchers showed, amongst other things, that IL13Ra2 is an effective target for iTANK armoured CAR-T cells as it prolongs survival and has a strong killing effect. ELC-401 is in the late pre-clinical stage, and the company is currently evaluating the optimal route of administration for the CAR T-cell therapy. The company has communicated its aim to finance the ELC-401 clinical trial via soft funding or a partnership. We will discuss ELC-401 in more depth once it nears the clinic. However, note that the unmet need in glioblastoma is enormous, and that promising results here would further validate the iTANK platform and its potential in solid cancers.

Although CAR-T cells are typically the most common cell/gene modality under development, they are not as common in glioblastoma, reflecting CAR-T's difficulties in tumour heterogeneity and antigen escape. According to our research, we have seen two studies focusing on CAR-T therapy targeting IL13Ra2, with one study publishing phase I results (n=65) recently in Nature Medicine (Brown et al. 2024), with early but promising (although somewhat varied) results. The CAR-T cells were administered locoregionally. Another study (n=6), also published in Nature Medicine (Bagley et al 2024), looked at bivalent CAR-T cells targeting both EGFR and IL13Ra2 and administered intrathecally. We mainly see it as a positive that other companies evaluate this target as well, which can benefit Elicera in designing an upcoming clinical study.

In January this year, Elicera announced its participation in a collaboration with Vecura at Karolinska University Hospital, being awarded SEK0.85m from Center for Advanced Medical Products (CAMP) to develop an automated CAR-T cell production process. In late 2023, co-founder Magnus Essand also received SEK4.8m over three years to evaluate the ability of CAR-T cells, including ELC-401, to treat brain tumours in children.

## ELC-100 and oncolytic viruses

Elicera's second clinical-stage drug candidate, which is also its most advanced project, is ELC-100 –an oncolytic virus and Elicera's only drug candidate not armed with the iTANK technology. Elicera also has a second project, a next-generation oncolytic virus that is armed with iTANK, called ELC-201, which it recently announced will be evaluated in several cancers in a pre-clinical collaboration with Chinese Medical University. While it is very promising, we will return to ELC-201 once it gets closer to the clinic and we know more about the target indication.

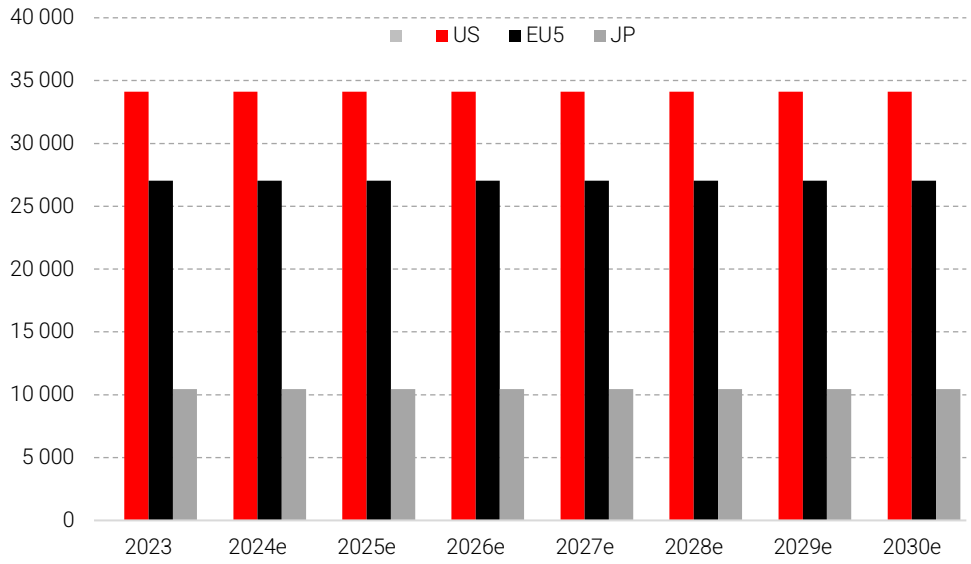
Oncolytic viruses are genetically engineered viruses with the aim of targeting a tumour cell selectively. They are typically classified by their route of administration: systemic or intratumorally. There are thousands of viruses, but not all are oncolytic viruses: the oncolytic virus should be non-pathogenic, have an inherent tumour-specific killing capacity, or otherwise be genetically modified. A few commonly used viruses are measles morbillivirus, human enterovirus A/B, herpes simplex virus and adenovirus. ELC-100 is an adenovirus.

Currently, oncolytic viruses are relatively rare compared with other immuno-oncology modalities, with only a handful of approvals around the world, mostly regionally. To our understanding, Amgen's T-VEC is the only approved drug in the EU and US and has seen relatively low revenues since approval. According to Global Data, the most promising pipeline drugs are expected to be RP-1 and RP-2 from Replimune and CAN-3110 from Candel Therapeutics, with estimated sales in 2028 of USD1,071m, USD193m and USD56m, respectively – indicating relatively low activity versus cell therapy, for example. However, we have learned that interest in cancer modalities can shift rapidly after a breakthrough, as seen recently with ADCs.

## Neuroendocrine tumours

Neuroendocrine tumours (NETs) originate in the body's neuroendocrine system, a network of nerve and endocrine (hormone-producing) cells. These cells are distributed throughout the body but are most common in the gastrointestinal (GI) tract and other parts of the body, such as the lungs and pancreas. There is considerable variability between patients, ranging from indolent (slow growing) to highly aggressive.

**Estimated incidence of NETs**




*Source: Global data (data), Redeye Research (graph)*

Various factors are considered when diagnosing NETs, such as the specific type of tumour, patient age, overall health, symptoms presented and results from medical tests. Known prognostic factors include the origin of the primary tumour, whether there are metastases, tumour morphology and proliferation activity using the biomarker Ki-67, which is also the basis for the WHO's classification of the disease. This is determined via a biopsy or a surgically resected tumour. However, there are difficulties with the measure and intratumoural heterogeneity, which could lead to a misleading interpretation of the severity of the disease.

NET G1: Ki-67 < 3%

NET G2: Ki-67 3-20%

NET G3: Ki-67 > 20% (well-differentiated)

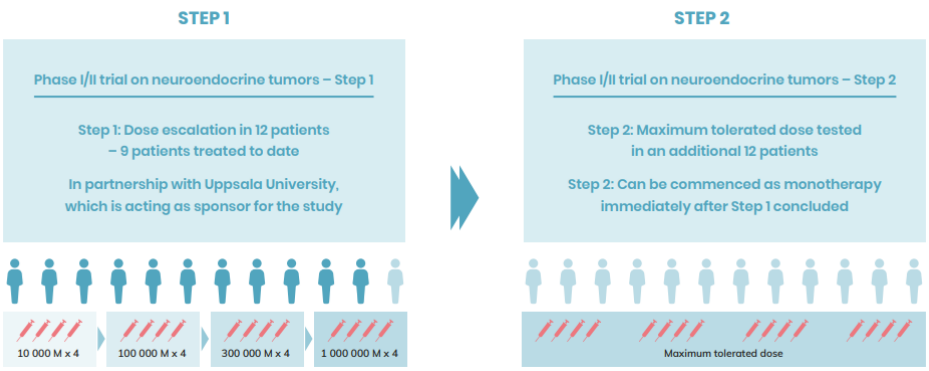
NEC (neuroendocrine carcinoma) Ki-67 > 20% (poorly differentiated)

ELC-100 is "*targeted at patients who have a confirmed expression of somatostatin receptors and have suffered a relapse after standard treatment*," which, according to Elicera's estimates, amounts to about 2,000 patients annually in the EU and the US. Today's standard of care includes surgery, chemotherapy and, in later stages, targeted therapies such as targeted radiotherapy (radioligand).

### The clinical study

Elicera has an ongoing phase I/IIa trial with AdVince. Included patients should have progressive liver-dominant neuroendocrine cancer (NET or NEC), i.e. with multiple metastases in the liver. They have to have relapsed from standard treatment. AdVince is administered in the hepatic artery.

### Study design

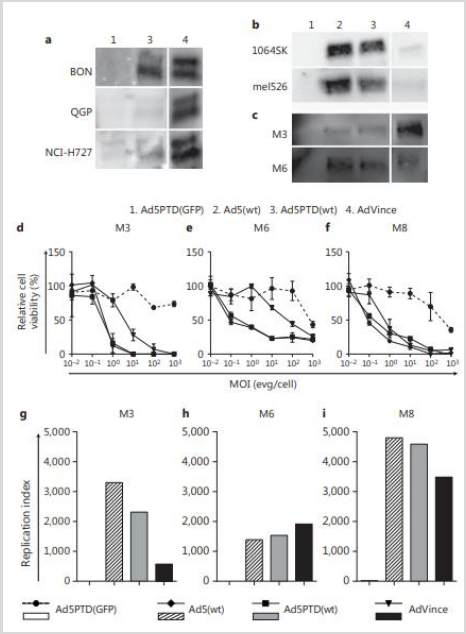



*Source: Elicera*

In 2022, Elicera presented indications of clinical activity in two patients from the dose-escalation part of the trial. The company reported in 2023 that it had received approval to continue with the last cohort of three patients, as no dose-related adverse effects were reported. As of its Q2 2024 report, one patient remains to be treated, and the company expects to conclude and report results in H1 2025. As previously mentioned, the Victory NET Foundation fully funds the study, and Elicera has communicated that it will focus on partnering for the next clinical study.

### Pre-clinical data

In a 2016 pre-clinical study, researchers evaluated AdVince, an oncolytic adenovirus designed to target liver metastases from neuroendocrine tumours (NETs). According to the paper, *"AdVince includes the gene promoter from human chromogranin A for selective replication in neuroendocrine cells, miR122 target sequences for reduced liver toxicity, and a cell-penetrating peptide in the capsid for increased infectivity of tumor cells and optimized spread within tumors."* The study used newly isolated human gastrointestinal NET cells resected from liver metastases. Findings revealed that *"AdVince selectively replicates in and kills NET cells,"* and it did not induce considerable cytokines or chemokines in human blood, indicating that it can be evaluated safely in a clinical trial.




*Source: Yu et al (2016)*

# Financials and business model

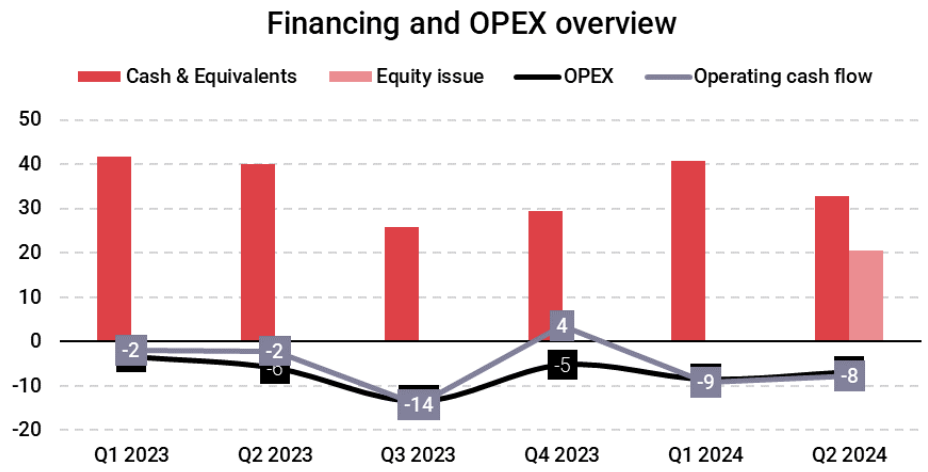
Elicera is research company and the company's business model revolve around finding strategic partnerships for its platforms iTANK and its clinical candidates. It other words, we don't expect the company to significantly increase its organization and investments over time.

**Key figures from the Q2 report:**

- Net sales for the period amounted to SEK0m (0m)
- Operating loss amounted to SEK-6.8m (-6.2m)
- Cash and cash equivalents at the end of the quarter amounted to SEK32.9m (40.1m)

(The numbers in parenthesis refer to the corresponding quarter of last year)

**Financing and OPEX Review (mSEK)**




*Source: Elicera (historical numbers) and Redeye Research (estimates)*

In Q2, Elicera reported an OPEX at SEK-6.8m for the quarter, somewhat higher than the previous year. The company also finalized a rights issue during the quarter, netting the company cSEK20m. According to the company's guidance, it should last until mid-2026 – beyond at least two readouts with the company's clinical candidate ELC-301. As we have discussed further below, we have a risk-adjusted a deal for ELC-301 in late 2026, and also include a rights issue in our model to stay conservative, also as its common to proactively raise cash in order to get a better bargaining position.

The company also has a warrant program: *"Each warrant entitles the holder to subscribe for one (1) share in the Company at a subscription price corresponding to 70 percent of the volume-weighted average trading price of the Company's share during the period from 11 February, 2025, up to and including 24 February, 2025, however, not less than SEK 1.24 and not more than SEK 2.70. The amount that exceeds the quota value of the shares shall be transferred to the unrestricted premium reserve".* This would mean that the share price exceeds SEK 1.78 per share – which is higher than today's share price (1.6 per share), but relatively close. We currently assume that the company receives some proceeds from the program, but will adjust more once we get closer to the subscription period. More proceeds from the warrant program would reduce the need for additional capital, we judge.

**Elicera Therapeutics: Key Financials**

| | 2021 | 2022 | 2023 | 2024e | 2025e | 2026e |
|---|---|---|---|---|---|---|
| Revenues | 0,0 | 1,3 | 11,2 | 9,0 | 3,6 | 64,5 |
| Gross profit | 0,0 | 1,3 | 11,2 | 9,0 | 3,6 | 64,5 |
| EBIT | -13,1 | -19,4 | -17,1 | -20,1 | -17,4 | 43,5 |
| EBITDA | -13,1 | -19,4 | -17,1 | -20,1 | -17,4 | 43,5 |
| EPS | -0,7 | -1,0 | -0,8 | -0,6 | -0,5 | 1,0 |

*Source: Elicera (historical data); Redeye Research (estimates and table)*

In our forecast (risk-adjusted) above, we focus mainly on the company's clinical studies with ELC-301 and ELC-100, both of which are mostly/fully funded by external parties, and also included in our SOTP-valuation of Elicera. In other words, if the company were to initiate further studies, such as with ELC-401 and/or ELC-201, we will have to adjust our forecasts – although we mainly expect the company to do so if the studies are externally financed. This as we believe it to be important for the company to reach as many readouts as possible, especially with ELC-301, with the company's current cash in order to the maximize shareholder valoue. Overall, we think that the management team has prioritized the right projects so far and expect this to continue.

We have assumed that the company could outlicense ELC-301 and ELC-100 in 2026 if results from the trials are positive, which we then risk adjust. Therefore, we have not modeled costs for clinical trials/in-house development of these candidates beyond 2026. This is because Elicera plans to outlicense them, and we also believe it is not feasible for the company to conduct pivotal trials internally due to the significant costs and organizational resources required.

# Key Assumptions

**Likelihood of approval**

| Likelihood of success | Indication | Phase I PoS | Phase II PoS | Phase III PoS | Regulatory PoS | Total LoA |
|---|---|---|---|---|---|---|
| ELC 301 | DLBCL | 73% | 30% | 48% | 78% | 8% |
| ELC 100 | NETs | 74% | 27% | 75% | 83% | 12% |
| Oncology | | 69% | 39% | 45% | 83% | 10% |

*Source: Global Data (baseline data); Redeye Research (assumptions)*

There are high risks involved in clinical stage biotech companies, including with Elicera's core projects, and we note that the company's both clinical trials are first-in-human phase I/IIa trials – ie we have no clinical data to analyze so far.

We have used historical approval data from Global Data to form our estimates for likelihood of approval for ELC-301 and ELC-100. We chose to more or less fully follow the historical numbers, as we mainly want to see clinical data to deviate. However, as previously stated, we see potential for revisions already in 2025 when the first cohort is readout in the ELC-301 study early in the year, and dose-escalation later during the year. Furthermore, the company can combine phase I and II as the study is done in patients and can likely move directly into a pivotal trial. In other words, updates from the CARMA study with ELC-301 will likely more gradually raise our probability of success, not necessarily only at one time, which we have accounted for.

### Deal Assumptions

For ELC-301, we have primarily focused on global CAR-T deals, as we consider this modality crucial, particularly given its significant relevance to major pharmaceutical companies. We conclude that there is a lot of activity in the area and include some notable deals below, both platform-oriented deals and with more specific focuses. We conclude that candidates/platforms that are well positioned could be out licensed relatively early – including in the preclinical stage – but also significantly later. We think that the two included deals with Noile-Immune's platform, with similarities to Elicera's iTANK platform, could give some indications of the value of a potential iTANK deal.

### Selection of deals – CAR-T

| Year | Originator | Sponsor | Type of asset | Upfront (USDm) | Total (USDm) | Comment |
|---|---|---|---|---|---|---|
| 2023 | Legend Biotech | Novartis | CAR-T targeting FLL3, including LB2102 | 100 | 1110 | Armed treatment, targeting solid tumours |
| 2022 | Poseida | Roche | Several | 110 | 6135 | Allogeneic CAR-T, complex deal structure |
| 2022 | Century Therapeutics | BMS | Both NK and T-cell based programs | 100 | 3000 | Allogeneic programs. Also USD50m investment |
| 2018 | Sangamo Therapeutics Inc | Kite (Gilead) | Platform | 150 | 3160 | Preclinical. Included Kite-037, an allogeneic CD-19 CAR-T the |
| 2019 | Noile-Immune | Adaptimmune | Platform | 3 | 312 | Platform technology with similarities to Elicera |
| 2023 | CBMG | Janssen | Two programs | 245 | undisclosed | CD20 targeting CAR-T |
| 2022 | Noile-Immune | Chugai | Platform | undisclosed | 146 | Platform technology with similarities to Elicera |

*Source: Global Data (data); Redeye Research (compiling and comments)*

When it comes to ELC-100, we have looked at deals mainly related to oncolytic viruses. We conclude that the deal potential is a bit lower than that of CAR-T, and also that it has reduced in pace compared to a few years ago. Furthermore, most of the top deals have in recent years been terminated. We conclude that several of the more significant have been regional – an indication of higher use/interest in for example Asia/China.

### Selection of deals – Oncolytic Viruses

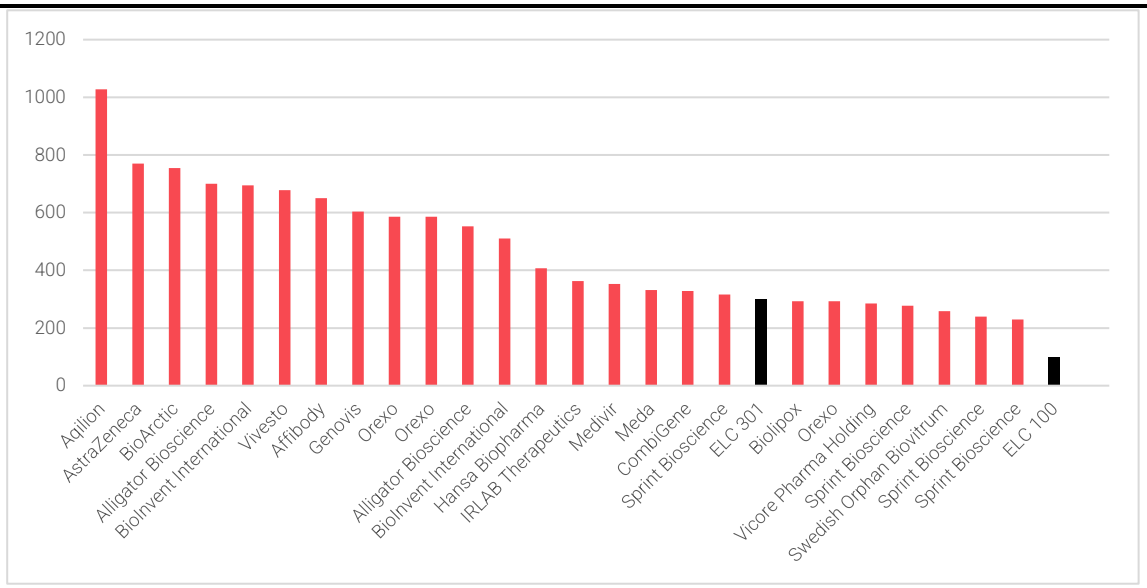
| Year | Originator | Sponsor | Type of asset | Upfront (USDm) | Total (USDm) | Comment |
|---|---|---|---|---|---|---|
| 2019 | Turnstone Biologics | Takeda | Platform | 120 | 1020 | Terminated lead drug of collaboration |
| 2016 | PsiOxus Therapeutics | BMS | NG-348 | 50 | 936 | As we understand it terminated |
| 2019 | Oncolys BioPharma | Chugai Pharmaceutical | OBP-301 | 4 | 462 | As we understand it terminated |
| 2021 | Genelux Corp | Newsoara Biopharma Co Ltd | Ivi-Vec and other oncolytic viruses. | 11 | 172 | China, Hong Kong and Macau |
| 2018 | ViraTherapeutics | Boehringer Ingelheim | All assets | 230 | - | Aquisition |
| 2018 | Viralytics | Merck | All assets | 394 | - | Aquisition |
| 2017 | Oncolytics Biotech Inc | Adlai Nortye Biopharma Co Ltd | REOLYSIN | 5 | 87 | Regional to parts of Asia |
| 2019 | CG Oncology Inc | Lepu Biopharma Co Ltd | CG0070 | 5 | 65 | China, Hong Kong and Macau |
| 2019 | Transgene | Astra Zeneca | Five oncolytic viruses | 10 | - | More of an option/research collaboration; Later terminated |

*Source: Global Data (data); Redeye Research (compiling and comments)*

As illustrated, the majority of deals occur outside of Sweden, and we generally observe that deals with Swedish companies tend to be smaller, particularly when compared to those in the US. This has prompted us to also look at historical Swedish biotech deals on a broader scale as well for comparison.

In our base case, we have assumed that Elicera could outlicense ELC-301 and ELC-100 in relation to their phase I/II studies: We pencil in a deal for ELC-301 in late 2026, ie after initial efficacy data from the second part. We assume an upfront payment of USD10m and a total deal value of USD300m, which would be a significant deal by historic standards in a Swedish context (see graph on next page). For ELC-100, we assume an upfront payment of USD5m and total deal value of USD100m, also in 2026. We choose to be more conservative to ELC-100 given the current deal activity. We currently see an iTANK deal as optionality in the case but do not include a deal in our valuation as of today, as we don't have any insight into timeline, choice of indication etc.

**25 largest deals on Swedish market and our assumptions (black bars) (USDm)**




*Source: Global Data: Redeye Research*

### Pricing

When it comes to pricing of ELC-301, we have looked at the price of other CAR-T therapies in DLBCL. The average cost of treatment/patient for Yescarta and Breyanzi is around USD400 000-450 000 in the US, according to Global Data. Given that we position ELC-301 as a third-line treatment, and that it also is a newer generation with potentially more potent effect, we assume a gross price in the upper range of this interval, ie. USD450 000 per patient in the US, and then, around 70% of the US price in EU4+UK and 50% of the US price in Japan (based how Yescarta and Breyanzi are priced in these markets).

For ELC-100, we base our assumptions on the pricing of Imlygic, the only relevant peer drug when it comes to oncolytic viruses, which is priced around USD70 000 per patient and targets unresectable melanoma, and specifically patients with melanoma lesions in the skin and lymph nodes. We think that this is relevant peer drug both in terms of indication and modality and thus assume the price to USD70 000 per patient in the US, and 50% of the US price in EU4+UK and Japan. However, we think that there is potential for higher pricing depending on the effect that can be shown.

### Patents

For ELC-301, the patent is expected to expire in 2036 (not including a potential extension). We also expect that the company can receive an orphan drug designation for most of its candidates, including ELC-301 and ELC-100, which would grant market exclusivity in the US for 7 years and 10 years in the EU and Japan. In the case of ELC-100, which patent expires in 2033, we mainly rely on orphan drug protection.

### Patent portfolio

| Drug Candidate | Title | Year of application | Patent approved | Expiration date |
|---|---|---|---|---|
| ELC-100/AdVince | Hexon TAT-PTD Modified Adenovirus and uses thereof | 2013 | USA | 2033 |
| ELC-201 | Adenovirus for treatment of cancer | 2021 | - | 2041 |
| ELC-301 and ELC-001 (the iTANK-platform) | T-Cell Immunotherapy | 2016 | Turkey, the United Kingdom, Switzerland, Europe (with the exception of Cyprus, Greece, Ireland, Croatia, Romania, Slovakia, the Czech Republic, and Hungary) | 2036 |
| ELC-401 | CAR T IL-13Ra2 | 2020 | - | 2040 |

*Source: Elicera Therapeutics *expiration date does not including extensions*

# ELC-301 in DLBCL - assumptions

- We base our model on incidence of DLBCL in the US, EU4+UK and Japan
- We assume that ELC-301 will be used as a third-line treatment – ie. r/r to today's approved CAR-T therapies Yescarta and Breyanzi.
- ELC-301 is outlicensed in late 2026/early 2027 if initial safety and efficacy data is positive
- We assume that the company in collaboration with a partner will initiate a pivotal trial of c.300 patients in 2028 and that ELC-301 could be approved in 2030/2031
- As previously stated, we assume a gross price of USD450 000 per patient in the US, and then, around 70% of the US price in EU4+UK and 50% of the US price in Japan (based how Yescarta and Breyanzi are priced in these markets).
- Likelihood of approval at 8%
- Assume a royalty rate of 15%
- Assuming a peak market penetration of 15%, we see strong commercial potential for ELC-301. However, it's important to note the presence of competing drugs and treatment modalities, We will revise our market outlook as we learn more about the clinical characteristics of the drug candidate.
- Sales starts to erode in 2038 in the US and 2041 in the EU4+UK and Japan

| ELC 301 | | 2031e | 2032e | 2033e | 2034e | 2035e | 2036e | 2037e | 2038e | 2039e |
|---|---|---|---|---|---|---|---|---|---|---|
| Development stage | | Market | Market | Market | Market | Market | Market | Market | Market | Market |
| Probability | | 8% | 8% | 8% | 8% | 8% | 8% | 8% | 8% | 8% |
| Disease incidence | US | 31 364 | 31 825 | 32 293 | 32 767 | 33 249 | 33 738 | 34 234 | 34 737 | 35 248 |
| | EU5 | 20 952 | 21 260 | 21 572 | 21 889 | 22 211 | 22 537 | 22 869 | 23 205 | 23 546 |
| | JP | 11 375 | 11 543 | 11 712 | 11 884 | 12 059 | 12 236 | 12 416 | 12 599 | 12 784 |
| Addressable patients (TAM) | US | 4 391 | 4 456 | 4 521 | 4 588 | 4 655 | 4 723 | 4 793 | 4 863 | 4 935 |
| | EU5 | 2 933 | 2 976 | 3 020 | 3 064 | 3 110 | 3 155 | 3 202 | 3 249 | 3 296 |
| | JP | 1 592 | 1 616 | 1 640 | 1 664 | 1 688 | 1 713 | 1 738 | 1 764 | 1 790 |
| Penetration | US | 1,4% | 3,8% | 6,9% | 9,9% | 12,0% | 13,5% | 15,0% | 15,0% | 9,0% |
| | EU5 | 1,4% | 3,8% | 6,9% | 9,9% | 12,0% | 13,5% | 15,0% | 15,0% | 15,0% |
| | JP | 1,4% | 3,8% | 6,9% | 9,9% | 12,0% | 13,5% | 15,0% | 15,0% | 15,0% |
| Adherent treated patients | US | 59 | 167 | 312 | 454 | 559 | 638 | 719 | 729 | 444 |
| | EU5 | 40 | 112 | 208 | 303 | 373 | 426 | 480 | 487 | 494 |
| | JP | 21 | 61 | 113 | 165 | 203 | 231 | 261 | 265 | 269 |
| Net price | US | 405 000 | 413 100 | 421 362 | 429 789 | 438 385 | 447 153 | 456 096 | 465 218 | 474 522 |
| | EU5 | 283 500 | 289 170 | 294 953 | 300 852 | 306 870 | 313 007 | 319 267 | 325 652 | 332 165 |
| | JP | 202 500 | 206 550 | 210 681 | 214 895 | 219 193 | 223 576 | 228 048 | 232 609 | 237 261 |
| Product Sales (USDm) | US | 24 | 69 | 131 | 195 | 245 | 285 | 328 | 339 | 211 |
| | EU5 | 11 | 32 | 61 | 91 | 114 | 133 | 153 | 159 | 164 |
| | JP | 4 | 13 | 24 | 35 | 44 | 52 | 60 | 62 | 64 |
| Worldwide product sales (USDm) | | 39 | 114 | 217 | 322 | 404 | 470 | 541 | 559 | 439 |

*Source: Redeye Research*

## ELC 100 in NETs - assumptions

- We base our model on the incidence of neuroendocrine tumors in the US, EU4+UK and Japan
- We base our assumption of addressable market based on the rate of diagnosed patient with liver metastasis, and also focus on patients that have tried previous treatments.
- 20% market penetration
- Gross price of USD70 000 per patient in the US, and 50% of the US price in EU4+UK and Japan
- We assume that the company in collaboration with a partner will initiate a pivotal trial and that ELC-100 could be approved in 2030/2031
- Likelihood of approval at 12%
- Royalty rate of 12%
- Sales starts to erode in 2036 in the US and 2039 in the EU4+UK and Japan

| ELC 100 | | 2030e | 2031e | 2032e | 2033e | 2034e | 2035e | 2036e | 2037e | 2038e | 2039e |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Development stage | | Market | Market | Market | Market | Market | Market | Market | Market | Market | Market |
| Probability | | 12% | 12% | 12% | 12% | 12% | 12% | 12% | 12% | 12% | 12% |
| Disease incidence | US | 34 116 | 34 116 | 34 116 | 34 116 | 34 116 | 34 116 | 34 116 | 34 116 | 34 116 | 34 116 |
| | EU5 | 27 037 | 27 037 | 27 037 | 27 037 | 27 037 | 27 037 | 27 037 | 27 037 | 27 037 | 27 037 |
| | JP | 10 444 | 10 444 | 10 444 | 10 444 | 10 444 | 10 444 | 10 444 | 10 444 | 10 444 | 10 444 |
| Addressable patients (TAM) | US | 10 917 | 10 917 | 10 917 | 10 917 | 10 917 | 10 917 | 10 917 | 10 917 | 10 917 | 10 917 |
| | EU5 | 8 652 | 8 652 | 8 652 | 8 652 | 8 652 | 8 652 | 8 652 | 8 652 | 8 652 | 8 652 |
| | JP | 3 342 | 3 342 | 3 342 | 3 342 | 3 342 | 3 342 | 3 342 | 3 342 | 3 342 | 3 342 |
| Penetration | US | 1,8% | 5,0% | 9,2% | 13,2% | 16,0% | 18,0% | 20,0% | 12,0% | 7,2% | 4,3% |
| | EU5 | 1,8% | 5,0% | 9,2% | 13,2% | 16,0% | 18,0% | 20,0% | 20,0% | 20,0% | 20,0% |
| | JP | 1,8% | 5,0% | 9,2% | 13,2% | 16,0% | 18,0% | 20,0% | 20,0% | 20,0% | 20,0% |
| Adherent treated patients | US | 158 | 437 | 803 | 1 153 | 1 398 | 1 572 | 1 746 | 1 048 | 629 | 378 |
| | EU5 | 125 | 346 | 637 | 914 | 1 107 | 1 246 | 1 384 | 1 384 | 1 384 | 1 384 |
| | JP | 48 | 134 | 246 | 353 | 428 | 482 | 534 | 534 | 534 | 534 |
| Net price | US | 56 560 | 57 126 | 57 697 | 58 274 | 58 857 | 59 445 | 60 040 | 60 640 | 61 246 | 61 859 |
| | EU5 | 28 280 | 28 563 | 28 848 | 29 137 | 29 428 | 29 723 | 30 020 | 30 320 | 30 623 | 30 929 |
| | JP | 28 280 | 28 563 | 28 848 | 29 137 | 29 428 | 29 723 | 30 020 | 30 320 | 30 623 | 30 929 |
| Product Sales (USDm) | US | 9 | 25 | 46 | 67 | 82 | 93 | 105 | 64 | 39 | 23 |
| | EU5 | 4 | 10 | 18 | 27 | 33 | 37 | 42 | 42 | 42 | 43 |
| | JP | 1 | 4 | 7 | 10 | 13 | 14 | 16 | 16 | 16 | 17 |
| Worldwide product sales (USDm) | | 14 | 39 | 72 | 104 | 127 | 145 | 162 | 122 | 97 | 83 |

*Source: Redeye Research*

# Valuation Summary

In total, we land a base case of SEK2.4 per share, and we see upside potential of some 50% from today's levels (SEK1.6). However, we want to highlight that our valuation can rapidly change following clinical development and potential capital injections. On the next page, we also present our bear- and bull scenarios.

### Model assumptions:

- We assume the USD/SEK exchange rate to 10.4
- Assume a capital injection of SEK20m in 2026
- Assume a WACC ("weighted average cost of capital") at 19%, including 3% risk-free rate, per Redeye's rating model 2.3
- Estimate period between 2024e-2042e

### Sum-of-the-parts: Elicera

| Project | Indication | Est. Launch | Deal size (USDm) | Peak sales (USDm) | LoA | rNPV (SEKm) |
|---|---|---|---|---|---|---|
| **ELC 301** | DLBCL | 2031 | 300 | 559 | 8% | **72** |
| **ELC 100** | NETs | 2030 | 100 | 162 | 12% | **35** |
| Technology value (SEKm) | | | | | | **108** |
| Assumed Net cash (SEKm)* | | | | | | **55** |
| Shared costs (SEKm) | | | | | | **-19** |
| Equity value (SEKm) | | | | | | **144** |
| Shares outstanding (million) | | | | | | **35** |
| Diluted shares outstanding (million) | | | | | | **60** |
| Equity value per share (SEK) | | | | | | **2,4** |

*Source: Redeye Research *includes assumed net proceeds from warrant program and future capital injection*

**Sensitivity analysis: Stock price/raised funds and our base case (up), WACC/LoA for ELC-301 (down)**

| Subscription price | Capital need 40 | 30 | 20 | 10 | 0 |
|---|---|---|---|---|---|
| 1,3 | 2,36 | 2,50 | 2,68 | 2,93 | 3,26 |
| 1,1 | 2,19 | 2,35 | 2,56 | 2,85 | 3,26 |
| 0,9 | 1,99 | 2,17 | 2,4 | 2,74 | 3,26 |
| 0,7 | 1,75 | 1,93 | 2,19 | 2,59 | 3,26 |
| 0,5 | 1,44 | 1,63 | 1,91 | 2,37 | 3,26 |

| wacc | Likelihood of approval ELC-301 0% | 4% | 8% | 12% | 16% |
|---|---|---|---|---|---|
| 17% | 0,9 | 1,8 | 2,7 | 3,6 | 4,5 |
| 18% | 0,8 | 1,7 | 2,5 | 3,4 | 4,2 |
| 19% | 0,8 | 1,6 | 2,4 | 3,2 | 3,9 |
| 20% | 0,8 | 1,6 | 2,3 | 3,0 | 3,7 |
| 21% | 0,8 | 1,5 | 2,2 | 2,8 | 3,5 |

*Source: Redeye Research*

Given the company's current low valuation, our base case is heavily dependent on whether Elicera will need to raise additional capital and at what price. Maintaining momentum in ongoing clinical trials is crucial, as timely data readouts will be key for potential share price appreciation or securing a deal before the company's cash runway expires. In line with Redeye's policy, our assumptions regarding a rights issue are based on the current share price; however, as shown, these assumptions significantly impact our base case projections.

## Bear case: SEK0.4 per share

We base our pessimistic scenario on the possibility that the company's ongoing phase I/IIa trial with ELC-301 fails, potentially due to safety concerns. In this case, the remaining assets would consist of ELC-100 and the iTANK platform. As a result, the company would likely need to raise additional funds at a lower share price.

## Bull case: SEK5.5 per share

We base our optimistic scenario on the assumption that the company successfully advances ELC-301 through the dose-escalation phase and achieves positive initial efficacy results, expected by mid-2026. This would increase the likelihood of approval to 22%. Additionally, we have removed our previous assumption regarding a rights issue.

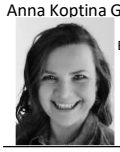
**Peer Valuation**

| Company | EV (SEKm) | Lead indication | Phase |
|---|---|---|---|
| NextCell Pharma AB | 46 | T1D | II |
| Alzinova AB | 156 | Alzheimer's disease | Ib |
| Dicot Pharma AB | 161 | Erectile Dysfunction | I (soon II) |
| Xintela AB | 260 | Osteoarthritis | I/Iia |
| Spago Nanomedical AB | 12 | Oncology | I (Tumorad) |
| Lipigon Pharmaceuticals AB | 3 | Elevated triglyceride levels | II |
| Modus Therapeutics Holding AB | 39 | Sepsis | I |
| Median | 46 | | |
| **Elicera Therapeutics** | **22** | **DLBCL** | **I/IIa** |

*Source: Factset; Redeye Research*

There is considerable variability among clinical-stage biotech companies, making it challenging to identify exact peers. This is further complicated by the fact that some companies have multiple clinical drug candidates and/or a platform. However, when we compare a mix of early-stage oncology companies and those in Phase I, it becomes evident that Elicera is trading at a low levels. This is particularly notable given that Elicera has two clinical-stage assets and a platform. Additionally, companies like Alzinova and Dicot, which have released some Phase I data, command significantly higher EVs. This may reflect the premium associated with presenting clinical data and could provide an indication of Elicera's potential valuation post-readouts.

# Management and Board

| Name | Position | Shares | Options |
|---|---|---|---|
| Jamal El-Moshleh | Chief Executive Officer | | |
|  | Jamal El-Mosleh, born in 1981, is the CEO and co-founder of Elicera AB since 2020. He holds an MSc in Industrial Engineering and Management with a focus on Biotech from Chalmers University of Technology and a Master's in Innovation and Entrepreneurship from Chalmers School of Entrepreneurship (Biotech), obtained in 2006. Previously, he served as CEO of Annexin Pharmaceuticals AB (2017-2019) and spent nearly a decade as CEO of Immunicum AB (2007-2017), where he co-founded the company and led its listing on NASDAQ First North in 2013. He also served as a board member of Elypta AB from 2017 to 2020. | 2 895 300 | 151 900 |
| Ingvar Karlsson | Chief Financial Officer | | |
|  | Ingvar Karlsson, born in 1956, has been the Chief Financial Officer of Elicera AB since 2021. He holds a Master's degree in Economics from Lund University. With extensive experience in various companies, Ingvar has been a consultant since 2014, focusing on life sciences. He is currently a part-time CFO at Amferia AB and a board member of Oxcia AB (publ). Before joining Elicera, he was CFO at Idogen and previously held CFO positions at Lekolar Group, Doro AB, and various roles within Gambro Group and Perstorp AB. | 79 200 | 33 600 |
| Magnus Essand | Chief Scientific Officer | | |
|  | Magnus Essand, born in 1964, is the Chief Scientific Officer and co-founder of Elicera AB since 2020. He is a Professor of Gene Therapy and an Associate Professor of Immunology at Uppsala University. Magnus has been a professor at Uppsala University since 2009, following his tenure at the American National Cancer Institute (NCI). He has published 95 scientific articles, serving as the lead author on 53. He has received numerous awards and significant research grants from prestigious institutions such as the Swedish Research Council, Horizon 2020, and the Sjöberg Foundation. Currently, he sponsors two clinical studies in immunology. | 3 370 031 | 43 211 |
| Di Yu | Head of Translational Research | | |
|  | Di Yu, born in 1985, is the Head of Translational Research and co-founder of Elicera AB since 2020. He is a researcher in immuno-oncology at Uppsala University, holding a Ph.D. in Medical Science from Uppsala University and a B.Sc. in Life Sciences and Biotechnology from Shaanxi Normal University in China. Di Yu conducts research at the Department of Immunology, Genetics, and Pathology at Uppsala University. He is a co-inventor of Elicera's patents and has received numerous awards and grants from institutions such as the Sjöberg Foundation, Vinnova, Cancerfonden, and Barncancerfonden. In 2020, he was awarded the Göran Gustavsson Prize by the Royal Swedish Academy of Sciences. | 3 423 705 | 86 415 |
| Anna Koptina Gultekin | Chief Regulatory Officer | | |
|  | Anna Koptina Gültekin has been the Head of Regulatory Affairs at Elicera AB since 2023. She holds a PhD in Biotechnology from the All-Russian Research and Technological Institute of Biological Industry (2010) and an MSc from Kazan State Technological University (2005). With extensive experience in regulatory affairs for cell and gene therapies in the US and EU, Anna has worked with FDA, EMA, and other regulatory bodies. She runs Exellerium AB as an independent consultant and is also Head of Regulatory Affairs at Mendus AB. Previously, she worked at Galderma, leading regulatory projects globally. Her academic background includes post-doctoral research at Uppsala University and Bonn University. | 0 | 0 |

*Source: Redeye research*

| Name | Position | Shares | Options |
|---|---|---|---|
| Agneta Edberg | Chairman of the Board | | |
|  Born in 1956, Agneta Edberg holds degrees in health economics from Stockholm School of Economics and biomedical sciences from the University of Sundsvall. With over 25 years in life sciences, she has held senior roles at Mylan AB, LFF Service AB, and NM Pharma AB. Her board experience includes Immunicum AB (Mendus) and Likvor AB. Currently, she chairs CathPrint AB, Amferia AB, and A Edberg Consulting AB, and is a board member of CAMP and NextGenNK. | | 160 953 | 31 626 |
| Christina Herder | Member of the Board | | |
|  Born in 1961, Christina Herder holds a PhD from the Royal Institute of Technology in Stockholm and an Executive MBA from Stockholm University. With 30 years of experience in pharmaceutical development and business development in the life science industry, she has held senior roles at SOBI, Biovitrum, Modus Therapeutics, Medivir, and Idogen. Currently, she is a board member at Beactica Therapeutics. | | 84 400 | 21 700 |
| Margareth Jorvid | Member of the Board | | |
|  Born in 1961, Margareth Jorvid has over 30 years of experience in regulatory affairs for pharmaceuticals. She has worked at the Medical Products Agency (MPA) and in various pharmaceutical companies, including Roussel Nordiska, Hoechst Marion Roussel, and Neopharma. Since 2006, she has been a consultant in regulatory affairs and quality assurance, focusing on pharmaceuticals, biologics, cell and gene therapies, medical devices, and drug-device combination products as CEO of Methra Uppsala AB, LSM group. She is a Fellow and Honorary Life Member of TOPRA and served as TOPRA President from 2005 to 2006. | | 96 500 | 21 700 |
| Magnus Essand | Member of the Board | | |
|  Born in 1964, Magnus Essand has been a Professor of Gene Therapy at Uppsala University since 2009 and was an Associate Professor in Immunology there from 2000 to 2009. He previously worked at the US National Cancer Institute. With 98 scientific articles (48 as lead author) and 14 reviews on cancer immunotherapy, he has received numerous awards and major research grants from various prestigious institutions. Currently, he sponsors two clinical trials for advanced cancer treatments from his lab and is a co-founder of Elicera AB | | 3 370 031 | 43 211 |
| Sharon Longhurst | Member of the Board | | |
|  Sharon Longhurst, born in 1969, holds a PhD in Virology from the University of Warwick and a BSc in Biochemistry from the University of Surrey. With over 20 years in CMC development for biological medicinal products, she specializes in Advanced Therapy Medicinal Products (ATMP). She has been VP of Development at Gadeta BV, Head of CMC at Immunium AB (now Mendus), and Akari Therapeutics, and a Senior Pharmaceutical Assessor at the MHRA. Currently, she is the Director of Advanced Biologics Consulting Ltd, offering CMC consulting services to biotech companies. | | 0 | 0 |

*Source: Redeye research*

# Summary Redeye Rating

**People:** 3

Elicera boasts a well-assembled team for its stage, we argue, with Jamal El Mosleh as a CEO (experience from several listed biotechs such as Annexin and Immunicum) and strong scientific backgrounds from co-founders Magnus Essand and Di Yu, a professor and a researcher from Uppsala University, respectively. Insider ownership is notably high (around 30%) versus other biotech firms at a similar stage.

**Business:** 3

Elicera is a pre-revenue company and has no established position in the market. However, success in the development and commercialization of its drug candidates could provide the company with strong protective barriers surrounding its business, protected by patents and rigid guidelines, ensuring stability. Furthermore, if the company is successful with outlicensing, we expect an asset light business model that could be profitable.

**Financials:** 0

Elicera is a pre-revenue biotech company that has not historically achieved profitability, which is a requirement to receive a high score.

| | 2023 | 2024e | 2025e | 2026e |
|---|---|---|---|---|
| **INCOME STATEMENT** | | | | |
| Revenues | 11 | 9 | 4 | 65 |
| Cost of Revenues | 0 | 0 | 0 | 0 |
| Gross Profit | 11 | 9 | 4 | 65 |
| Operating Expenses | -28 | -29 | -21 | -21 |
| **EBITDA** | -17 | -20 | -17 | 44 |
| D&A | 0 | 0 | 0 | 0 |
| **EBIT** | -17 | -20 | -17 | 44 |
| Net Financial Items | 1 | 0 | 0 | 0 |
| EBT | -16 | -20 | -17 | 44 |
| Income Tax Expenses | 0 | 0 | 0 | -9 |
| Non-Controlling Interest | 0 | 0 | 0 | 0 |
| **Net Income** | -16 | -20 | -17 | 35 |
| **BALANCE SHEET** | | | | |
| **Assets** | | | | |
| Current assets | | | | |
| Cash & Equivalents | 29 | 30 | 17 | 69 |
| Inventories | 0 | 0 | 0 | 0 |
| Accounts Receivable | 0 | 0 | 0 | 0 |
| Other Current Assets | 1 | 1 | 1 | 1 |
| **Total Current Assets** | 30 | 31 | 18 | 70 |
| Non-current assets | | | | |
| Property, Plant & Equipment | 0 | 0 | 0 | 0 |
| Goodwill | 0 | 0 | 0 | 0 |
| Intangible Assets | 0 | 0 | 0 | 0 |
| Right-of-Use Assets | 0 | 0 | 0 | 0 |
| Shares in Associates | 0 | 0 | 0 | 0 |
| Other Long-Term Assets | 0 | 0 | 0 | 0 |
| **Total Non-Current Asset** | 0 | 0 | 0 | 0 |
| **Total Assets** | 30 | 31 | 18 | 70 |
| **Liabilities** | | | | |
| Current liabilities | | | | |
| Short-Term Debt | 0 | 0 | 0 | 0 |
| Short-Term Lease Liabilities | 0 | 0 | 0 | 0 |
| Accounts Payable | 1 | 1 | 1 | 1 |
| Other Current Liabilities | 13 | 13 | 13 | 13 |
| **Total Current Liabilities** | 14 | 14 | 14 | 14 |
| Non-current liabilities | | | | |
| Long-Term Debt | 0 | 0 | 0 | 0 |
| Long-Term Lease Liabilities | 0 | 0 | 0 | 0 |
| Other Long-Term Liabilities | 0 | 0 | 0 | 0 |
| **Total Non-current Liabil** | 0 | 0 | 0 | 0 |
| Non-Controlling Interest | 0 | 0 | 0 | 0 |
| Shareholder's Equity | 16 | 17 | 4 | 56 |
| **Total Liabilities & Equity** | 30 | 31 | 18 | 70 |
| **CASH FLOW** | | | | |
| EBT | -16 | -20 | -17 | 44 |
| Cash Flow from changes in | 1 | 0 | 0 | 0 |
| Operating Cash Flow | -15 | -20 | -17 | 35 |
| Capital Expenditures | 0 | 0 | 0 | 0 |
| Investment in Intangible Ass | 0 | 0 | 0 | 0 |
| Investing Cash Flow | 0 | 0 | 0 | 0 |
| Financing Cash Flow | 0 | 21 | 4 | 17 |
| Free Cash Flow | -15 | -20 | -17 | 35 |

| DCF Valuation Metrics | Sum FCF (SEKm) |
|---|---|
| ELC 301 | 72,1 |
| ELC 100 | 34,4 |
| Technology value (SEKm) | 107 |
| Net cash (SEKm) | 55 |
| Shared costs (SEKm) | -19 |
| Equity value (SEKm) | 142 |
| Shares outstanding (million) | 35 |
| Diluted shares outstanding (million) | 60 |
| Fair Value per Share | 2,4 |

| SHAREHOLDER STRUCTURE | CAPITAL % | VOTES % |
|---|---|---|
| Nordnet Pensionsförsäkring | 11,8% | 11,8% |
| Di Yu | 9,8% | 9,8% |
| Magnus Essand | 9,6% | 9,6% |
| Jamal El-Mosleh | 8,4% | 8,4% |
| Tuvedalen Ltd | 3,4% | 3,4% |

| SHARE INFORMATION | |
|---|---|
| Reuters code | |
| List | |
| Share price | 1,6 |
| Total shares, million | 35,1 |
| Total shares, million (diluted) | 59,8 |

| MANAGEMENT & BOARD | |
|---|---|
| CEO | Jamal El-Mosleh |
| CFO | Ingvar Karlsson |
| Chairman | Agneta Edberg |

| ANALYSTS | Redeye AB |
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# Redeye Rating and Background Definitions

### Company Quality

Company Quality is based on a set of quality checks across three categories; PEOPLE, BUSINESS, FINANCE. These are the building blocks that enable a company to deliver sustained operational outperformance and attractive long-term earnings growth.

Each category is grouped into multiple sub-categories assessed by five checks. These are based on widely accepted and tested investment criteria and used by demonstrably successful investors and investment firms. Each sub-category may also include a complementary check that provides additional information to assist with investment decision-making.

If a check is successful, it is assigned a score of one point; the total successful checks are added to give a score for each sub-category. The overall score for a category is the average of all sub-category scores, based on a scale that ranges from 0 to 5 rou nded up to the nearest whole number. The overall score for each category is then used to generate the size of the bar in the Company Quality graphic.

### People

At the end of the day, people drive profits. Not numbers. Understanding the motivations of people behind a business is a significant part of understanding the long-term drive of the company. It all comes down to doing business with people you trust, or at least avoiding dealing with people of questionable character.

The People rating is based on quantitative scores in seven categories:

- Passion, Execution, Capital Allocation, Communication, Compensation, Ownership, and Board.

### Business

If you don't understand the competitive environment and don't have a clear sense of how the business will engage customers, create value and consistently deliver that value at a profit, you won't succeed as an investor. Knowing the business model inside out will provide you some level of certainty and reduce the risk when you buy a stock.

The Business rating is based on quantitative scores grouped into five sub-categories:

- Business Scalability, Market Structure, Value Proposition, Economic Moat, and Operational Risks.

### Financials

Investing is part art, part science. Financial ratios make up most of the science. Ratios are used to evaluate the financial soundness of a business. Also, these ratios are key factors that will impact a company's financial performance and valuation. However, you only need a few to determine whether a company is financially strong or weak.

The Financial rating is based on quantitative scores that are grouped into five separate categories:

- Earnings Power, Profit Margin, Growth Rate, Financial Health, and Earnings Quality.

# Redeye Equity Research team

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**Redeye Rating (2024-10-17)**

| Rating | People | Business | Financials |
|---|---|---|---|
| 5p | 32 | 16 | 4 |
| 3p - 4p | 130 | 115 | 42 |
| 0p - 2p | 5 | 36 | 121 |
| Total | 167 | 167 | 167 |

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**CONFLICT OF INTERESTS**

Fredrik Thor owns shares in the company : No
Richard Ramanius owns shares in the company : No
Redeye performs/have performed services for the company and receives/have received compensation from the company in connection with this.