Venn Brown
Investment Research

One to Watch

Racura Oncology

One drug, three shots

3rd August 2026

Venn Brown sat down with Daniel Tillett, CEO of Racura Oncology, to discuss the three potential applications for RC220, their potential market size, the status of its clinical trials, funding, and what the market doesn't understand.

Old drug, new delivery:

RC220 reformulates bisantrene, an effective cancer drug developed in the 1980s but constrained by poor solubility and crystallisation in the blood. Racura's formulation is designed to enable safer, more practical administration while preserving the drug's underlying properties. Unlike many early-stage oncology assets, bisantrene also brings historical human efficacy data and subsequent clinical validation in acute myeloid leukaemia.

Three paths from one compound:

Racura is developing RC220 across acute myeloid leukaemia (AML), EGFR-mutant[2] lung cancer and cardioprotection during chemotherapy. Each program carries a different balance of risk, timing and commercial potential, giving the company several routes to value creation from one core asset. Together, the targeted cancers represent an addressable population of approximately six to seven million people diagnosed annually in the OECD.

Cardioprotection during chemo is a massive opportunity:

Cardioprotection is potentially RC220's largest application, targeting heart damage associated with widely used anthracycline chemotherapy while also seeking to improve cancer treatment. The trial is progressing through dose escalation across Australia, Hong Kong and South Korea. The opportunity could extend across multiple solid tumours, although management acknowledges it has the least human data & will take the longest to establish.

Funded through the trials:

Racura reported $34 million in cash at the end of June after raising more than $24 million through exercised piggyback options. Management says this leaves all three clinical programs fully funded to completion. Historical annual cash burn has been $10–12 million, of which $8-10 million has been eligible for the Federal Government's R&D tax rebate.

A different company today:

Racura's current strategy bears little resemblance to the business many longer-standing investors may remember. Racura has reformulated the drug, identified its MYC-related mechanism and built a new clinical and patent strategy around RC220 with funding through to trial completion.

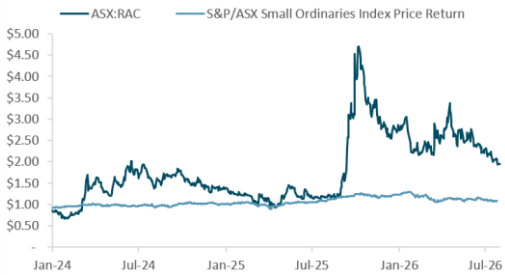
Racura Oncology

ASX:RAC

Sector	Pharmaceuticals
Date	3-Aug-26
Share price	$1.95
52-week range	$1.13 / $4.90
Market cap	$366m
Free float	69.5%
Dividend	-
Yield	-

Year-end 30 June	FY22	FY23	FY24	FY25
Revenue	$0.7m	$3.1m	$4.0m	$5.3m
EBITDA	-$11.5m	-$10.8m	-$14.9m	-$5.9m
EBIT	-$11.3m	-$10.5m	-$14.7m	-$5.6m
Net profit	-$11.2m	-$9.9m	-$13.8m	-$4.8m
Earnings per share	-$7.31	-$6.17	-$8.40	-$2.78
Operating cash flow	-$6.3m	-$10.7m	-$9.5m	-$4.6m
Free cash flow	-$6.3m	-$10.7m	-$9.5m	-$4.6m
Cash & equiv	$33.5m	$21.5m	$17.2m	$13.7m
Net debt	-$33.5m	-$21.5m	-$17.2m	-$13.7m
Net debt / EBITDA	-	-	-	-

3-year Price Chart



Analysts

Andrew Wilkinson awilkinson@vennbrown.com

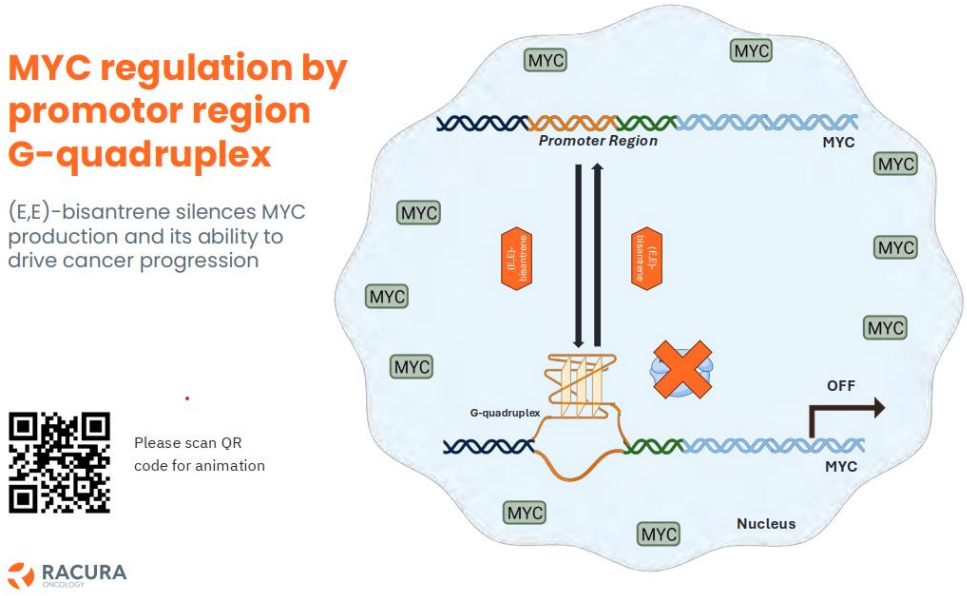
Thanks for being with us today, Daniel. First, can you give us a brief overview of Racura Oncology?

Racura Oncology is built around RC220, a reformulated version of an older cancer drug based on the chemical bisantrene. The original drug was developed in the 1980s and was efficacious, but it was ultimately dropped because it could not be delivered safely or efficiently. The problem was solubility: once exposed to the neutral conditions of blood, the drug crystallises, causing severe pain and making IV delivery impractical outside a narrow set of leukaemia applications.

There are three key steps to our work:

1. **Drug delivery problem:** Racura's first key development was to fix the drug delivery problem through reformulation. RC220 is the new drug formulation designed to allow bisantrene to be administered to patients without crystallising in the blood.
2. **How RC220 works:** The second development was understanding how the drug works, which no one had done until now. We knew bisantrene worked, but we didn't know how. It turns out that RC220 acts on MYC[1], which is one of oncology's "holy grail" targets. Rather than directly binding to the MYC protein, RC220 appears to switch off the gene that produces it, producing a similar effect to turning off the protein itself in the cancer cell. This discovery has helped Racura understand where the drug should be used, which cancers to target, and which other drugs it should be combined with.

Figure 1: RC220 acts on the gene that produces MYC, the holy grail of oncology therapies

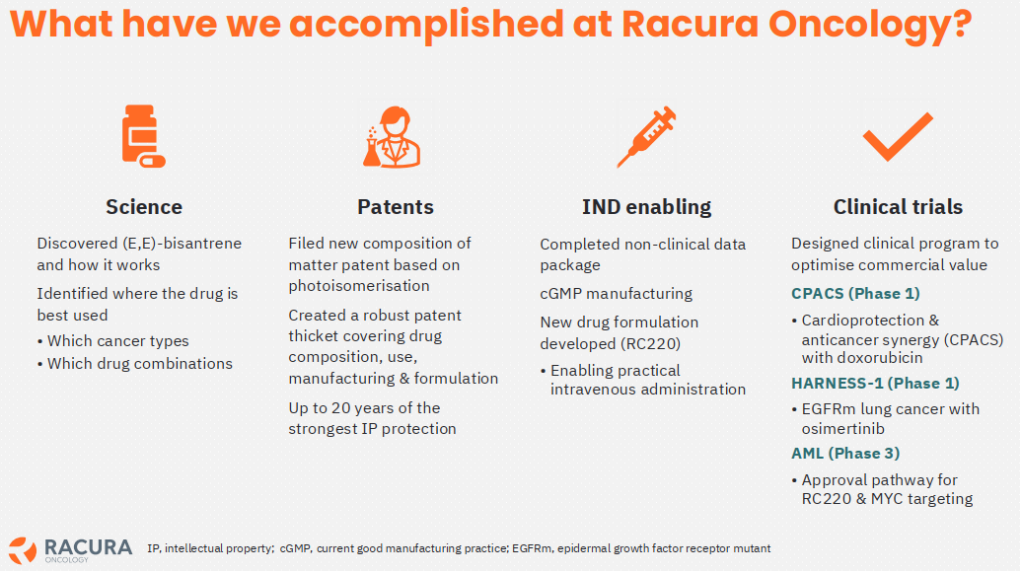


Source: Racura Oncology

[1] MYC is a cancer-related gene/protein pathway that helps control cell growth and proliferation. In cancer, MYC can become overactive, helping tumour cells grow, divide and survive more aggressively.

3. **New applications:** The third part of the story is intellectual property. We've made new discoveries about the molecule that have allowed us to file new patents. While those patents are not yet granted, the objective is to create a patent "thicket" that makes it difficult for generic competitors to manufacture or sell the drug, potentially giving us long-term commercial protection.

Figure 2: Racura is making progress in all three applications of RC220



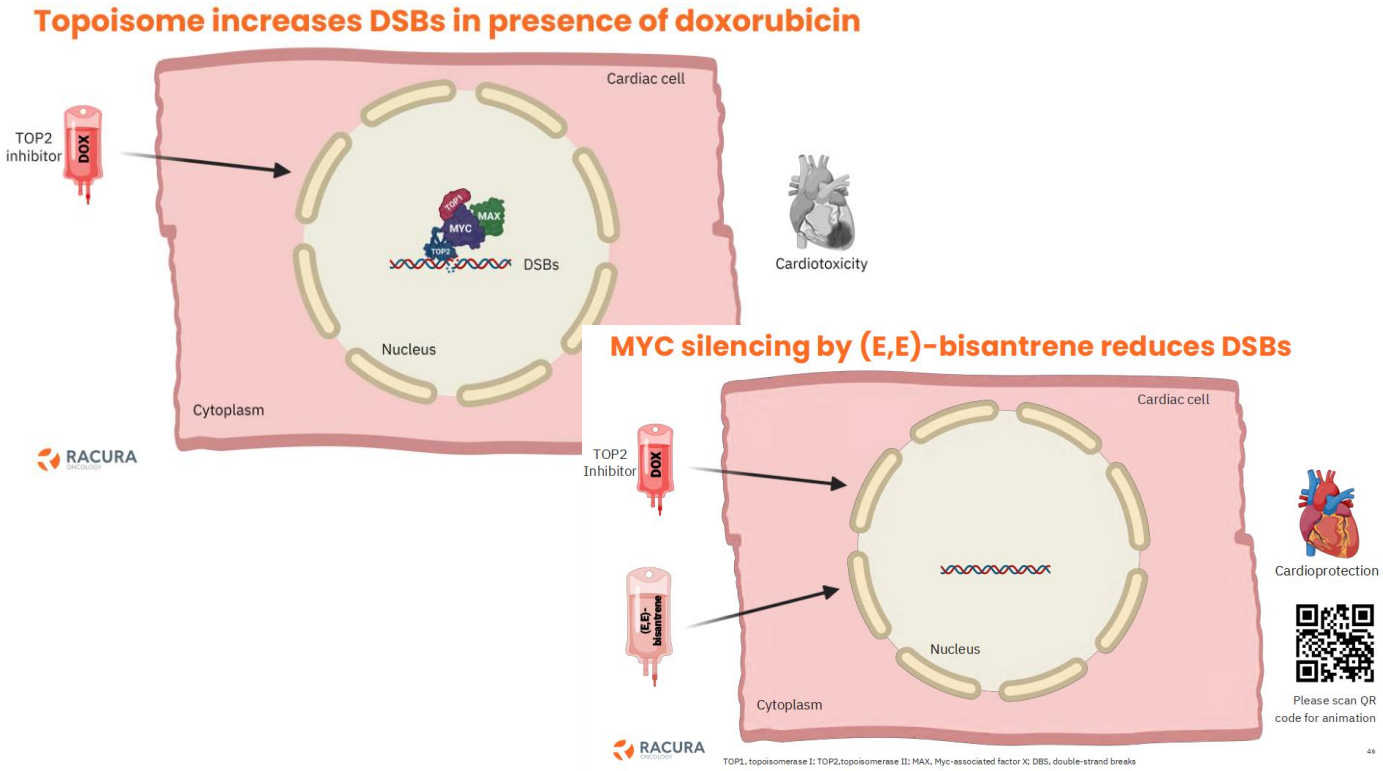
Source: Racura Oncology

Where do you see the opportunities for RC220?

Racura is currently targeting three main opportunities:

1. **Acute myeloid leukaemia (AML):** The early formulations of bisantrene were a highly effective treatment for acute myeloid leukaemia (AML), but was abandoned for commercial reasons – simply AML was too small a market back in the 1980s to support continued marketing of bisantrene given it had to be given using a central line catheter. RC220 still has the same drug properties as the original bisantrene, but without having to be given only by a central line. We know it works and we are currently preparing a phase three trial in AML which will start in 2026.
2. **Lung cancer:** We're testing RC220 in combination with an existing treatment known as osimertanib, which is highly effective, but resistance always arise and the patient relapse after around 18 months. Once the cancer comes back, the prognosis is grim. We are aiming to show that RC220 can extend the life of the existing treatment. Globally, lung cancer is the most common cancer, and there might be a path to gain accelerated approval that allows us to commence selling the drug in parallel to completing the required phase three trials.
3. **Cardioprotection**: RC220 may help reduce chemotherapy-related heart damage, which occurs in almost all chemotherapy patients, while also improving the treatment of the cancer. This a very large opportunity as chemotherapy is still the backbone of most cancer treatments and thereby offering a massive market opportunity.

Figure 3: 6-7 million people each year are diagnosed with addressable cancers



Source: Racura Oncology

What is the potential market opportunity for the three RC220 applications

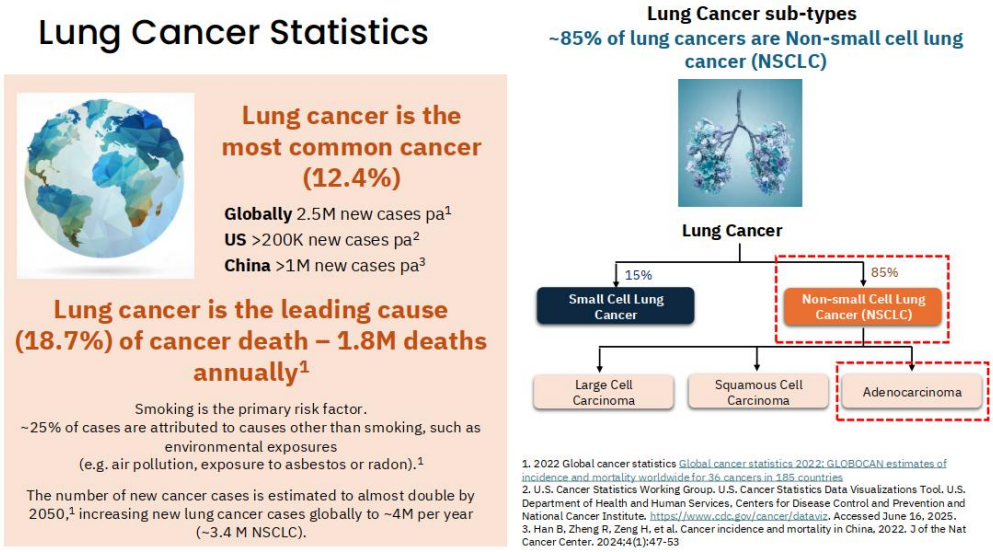
1. **AML ~US$1b/yr:** AML is the smallest but most certain of the three, but it is still commercially meaningful because orphan oncology drugs command very high prices. There are roughly 120,000 new AML patients a year worldwide, although only a fraction would be suitable and captured.

   In the US, comparable new AML drugs can be priced around US$300,000 to US$500,000 per patient per year, with Europe typically around half that and Australia around one-third after PBS pricing. Even capturing 5,000 patients a year at US$200,000 to US$250,000 per patient would create substantial sales [US$1-1.25 billion a year].

2. **Lung cancer >US$5b/yr:** The lung cancer opportunity is much larger. Lung cancer is the most common cancer globally, and while we are targeting a specific EGFR-mutant[2] subtype, the existing EGFR drug market generates around US$15 billion a year. Tagrisso (osimertanib) alone generated just under US$7.5 billion in worldwide sales last year, so this is already a very large, well-established market. The commercial logic is that our drug would be used in combination with current EGFR treatments to delay resistance and keep patients on a therapy that is working for longer. Hence, the success and use of RC220 actually benefit makers of existing treatments, providing a great opportunity for commercial partnerships.

[2] EGFR = Epidermal growth factor receptor

Figure 4: RC220 could meaningfully extend the life of lung cancer patients



Source: Racura Oncology

3. **Cardioprotection - the largest market:** The cardioprotection market is potentially the largest, but also the hardest to size. The chemotherapy we are pairing with is widely used across solid tumours, and the heart damage occurs independently of the cancer type.

   Every year, approximately 6-7 million people in the OECD are diagnosed with a cancer that's addressible by RC220. In market terms, this is potentially tens of billions of dollars, essentially as big as oncology markets get, but pricing will be the key constraint, and payers are likely to push back. It is also the least supported by human data today, so it's also the least certain application.

What is the current status of these three applications?

We're working on all three applications in parallel, with each in different stages:

1. **AML:** This is the lowest risk program. We have already run two phase two trials, which reproduced the historical, highly effective treatment results. We are about to start a phase three trial using the new formulation under modern FDA conditions. We have not started recruitment yet, but the first 60 patients should give us a good read. Once started, I would expect the trial to take around 18 months to two years, followed by the FDA process, which is typically six to nine months.

   Clinicians are now much more interested in working with us and RC220, now that we understand how it works, which will help us recruit clinicians and sites for the trials.

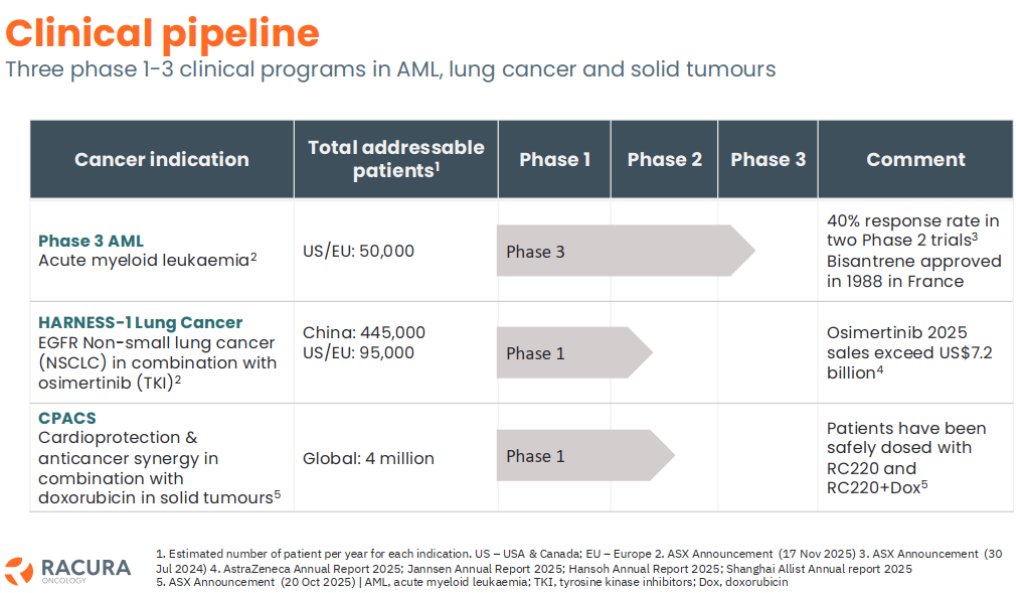
2. **Lung cancer:** It's a phase one/two trial that started at the end of March, and I expect initial data by the end of the year. A huge opportunity for us is that the approval pathway could look very different if the phase one data is strong. Lung cancer is an area of very high clinical need, and the regulators have recently been aggressive in approving lung cancer drugs early. The last three recently approved lung cancer drugs were essentially approved from on phase one data, with fewer than 100 patients treated.

If you bring the FDA a compelling data package, they can grant accelerated approval, allowing the drug onto the market early, and allow the phase three trial to be run afterwards. The logic is that these patients do not have time to wait; once resistance develops, survival is often only six to nine months. If the drug shows a large enough effect, you do not need thousands of patients to prove it statistically. That is what could change the whole timeline – instead of waiting years for phase three readouts, the drug could potentially reach market much earlier, although that decision ultimately sits with the regulator.

Regardless of whether we get accelerated approval, we'll still need the phase three trials, which will typically take around 3-4 years. Without acceleration, FDA approval is probably 3-4 years away.

3. **Cardioprotection:** This is by far the largest opportunity for RC220. The trial has been running for about 12 months in Australia, Hong Kong and South Korea. It is still in the dose-escalation stage, with what we think is likely two more steps to go. I can't give you a completion date though. This application will take the longest to prove out, but is also the biggest market opportunity, given that it's applicable to all cancers where anthracycline chemotherapy drugs are used.

Figure 5: All studies are now fully funded and are progressing



Source: Racura Oncology

What's Racura's cash position?

We're in a very strong position. At the end of June we reported $34 million on our balance sheet. Historically, our burn rate has been between $10-12 million a year, with $8-10 million of that being eligible for the government's R&D tax rebate.

In early June we raised just over $24 million through the exercising of our piggyback options offering. As a result of the raise, we are now fully funded to complete our clinical trials. We have a very supportive shareholder base. Over the last two years, we've raised $34 million from new and existing shareholders.

What do you think is the most misunderstood part of the company?

The most misunderstood part of Racura is its historical aspect. Before the current management team came in, Racura Oncology was a very different company with a very different story. Many investors still remember the old story, and in many cases, they dismissed it – probably rightly.

The problem is that once someone thinks they already know a company, it is much harder to change their mind than it is to explain the story to someone new. The old company had no real IP position, no understanding of how the drug worked, was trying to advance the old formulation that crystallised in the blood, and had what I would call a very unusual strategy to get to market through named-patient use, which was not realistic for cancer like AML.

Today the story is completely different: we have a new formulation, we understand the mechanism, we know it targets MYC, and we have built a robust new IP strategy around the molecule.

What do you wish more investors knew?

I wish more investors understood how unusual this story is. Most modern drug development starts with a scientific mechanism: you make thousands of chemical compounds which you screen in cells and animals to see if you can affect the mechanism with a possible drug, and then you spend years trying to find out if your new drug actually works in humans. We are running almost the reverse process.

In AML, we already know the drug works in humans. It worked historically and was even approved in France, and we have since run two AML trials where it still worked. What we have done is start at the end by beginning with a drug we know works and then spent our time understanding why it works, improve the formulation, and building a viable development and IP strategy.

I think many investors apply the usual very high biotech discount rate to us, where most drugs fail in clinical developement. That is fair for a normal early-stage oncology drug, but in AML RC220 is different. For this indication, the probability of success should be much closer to 100% than the ususal 3% for most new oncology drugs.

Is there anything we haven't touched on that you'd like to cover?

The one thing I would add is that timelines in biotech can change very quickly if a larger pharmaceutical company decides the asset is strategically important. There are a lot of early-stage deals happening at the moment, including very large transactions on very small datasets. In lung cancer, we are using a EGFR TKI (osmertanib) for commercial reasons, but if our drug works with EGFR therapies, it may also work with other drugs in the same TKI class. A company like AstraZeneca that owns osimertanib could decide it does not want that risk sitting in the hands of a competitor, particularly if the drug could protect or extend the value of it major franchise in this area. This kind of strategic move is entirely up to those companies, but it can completely change the timeline to a return.

Share price performance

Source: Yahoo Finance

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