EDISON

Immutep

Clinical update

AIPAC fully recruited, results due Q120

Pharma & biotech

Immutep's AIPAC Phase IIb study of its antigen-presenting cell activator eftilagimod alpha (efti) plus chemotherapy in breast cancer is fully recruited and expected to report top-line data in Q120. The initial tranche of 17 subjects in the first-line lung cancer arm of the TACTI-002 study of efti plus Keytruda (in collaboration with US Merck) has completed enrolment; the cohort will be expanded to 36 subjects if more than four responses are observed (we expect initial response rate data in Q419). Enrolment in second-line lung and head and neck cancer is ongoing. Positive results in AIPAC or TACTI-002 could be a catalyst for a significant deal with a pharma partner. Our valuation is A$539m or 16c per share.

Year end	Revenue (A$m)	PBT* (A$m)	EPS* (c)	DPS (c)	P/E (x)	Yield (%)
06/17	4.1	(8.4)	(0.4)	0.0	N/A	N/A
06/18	6.9	(10.9)	(0.5)	0.0	N/A	N/A
06/19e	10.9	(6.8)	(0.2)	0.0	N/A	N/A
06/20e	2.8	(14.6)	(0.4)	0.0	N/A	N/A

Note: *PBT and EPS are normalised, excluding exceptional items

AIPAC to report top-line data in Q120

The 226-patient AIPAC study of efti plus paclitaxel in first-line chemotherapy for metastatic breast cancer has completed recruitment. Top-line progression-free survival (PFS) data are expected to report in Q120. Importantly, this will be the first efficacy read-out for efti from a randomised study. The trial could potentially support filing in Europe if it achieves certain (undisclosed) clinical endpoints.

First TACTI-002 cohort recruits initial tranche

We expect the response data from the initial tranche of 17 first-line lung cancer patients in TACTI-002 to mature in Q419 (any earlier would be a very positive sign). The first 17 patients were recruited in about three months; we estimate that if the cohort expansion criterion is met, response rate data for the full 36-patient cohort could mature in mid to late 2020. The other two cohorts (PD1/L1 refractory NSCLC and second-line head and neck cancer) provide additional opportunities to show that efti can increase responses to PD1/L1 immune checkpoint inhibitors (ICIs), as is did in the small Part B cohort of TACTI-mel (three of six subjects responded).

Other programmes provide additional backup

Immutep has other LAG3 programmes that could also create significant value. These include Phase II programmes partnered with Novartis (anti-LAG3 antibody in cancer) and GSK (LAG3 depleting antibody in inflammatory disorders), its pre-clinical LAG3 agonist IMP761 (for inflammatory disorders) and the INSIGHT study of efti plus the PD-L1 blocker avelumab (with Merck KGaA/Pfizer).

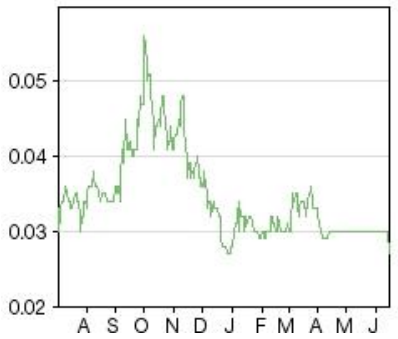
Valuation: A$539m, 16c per share

Our valuation is unchanged at A$539m, or 16c/share (12c/share after diluting for options, warrants and convertible notes). Gross cash at 31 March 2019 was A$21.2m. Our forecasts assume the recent initiation of a Phase II study of GSK'781 (IMP731) will have triggered receipt of a US$6m (A$8m) milestone payment from GlaxoSmithKline (GSK), which would extend Immutep's cash reach to H220.

2 July 2019

Price	**A$0.03**
Market cap	**A$85m**
	US$0.76/A$
Gross cash (A$m) at 31 March 2019	21.2
Shares in issue	3,388.6m
Free float	93%
Code	IMM
Primary exchange	ASX
Secondary exchange	NASDAQ

Share price performance



%	1m	3m	12m
Abs	(7.4)	(21.9)	(16.7)
Rel (local)	(11.8)	(26.9)	(22.3)
52-week high/low		A$0.06	A$0.03

Business description

Immutep is an ASX-listed biotechnology company focused on cancer immunotherapy. Its pipeline is based on four products using a LAG-3 immune control system: IMP321 for cancer chemo-immunotherapy, partnered products IMP731 (GSK) and IMP701 (Novartis) and IMP761 (preclinical).

Next events

Other TACTI-002 cohorts reach initial recruitment target	H219
TACTI-002 1L lung cancer response data	Q419
AIPAC breast cancer Phase II PFS data	Q120

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AIPAC breast cancer Phase II fully recruited; data Q120

The AIPAC Phase IIb breast cancer study is fully recruited, having reached its target of 226 subjects on 25 June. The trial (NCT02614833) is testing the efti soluble LAG-3 fusion protein combined with paclitaxel in women with hormone receptor-positive/HER2-negative metastatic breast cancer (mBC) who have not previously received chemotherapy for metastatic disease. Half of the subjects in the randomised double-blind phase of the study will receive standard paclitaxel chemotherapy plus 30mg of efti, whereas the other half will receive paclitaxel plus placebo. Subjects were recruited at over 30 clinical sites in Belgium, France, the Netherlands, the UK, Poland, Germany and Hungary.

Immutep dosed the first patient in the randomised Phase IIb component of AIPAC in January 2017. The company had originally expected to fully recruit the study in H118, but it believes the widespread use of the recently approved CDK4/6 inhibitor Ibrance (palbociclib, Pfizer) led to a temporary slowdown in recruitment. Ibrance is taken alongside hormone therapy as a first-line treatment to delay the progression of hormone receptor-positive, HER2-negative mBC, prior to the initiation of chemotherapy with paclitaxel. In a pivotal clinical trial, adding Ibrance to hormone therapy increased median PFS from 10.2 months to 20.8 months. Once women who had been treated with Ibrance began to experience disease progression and were then treated with paclitaxel, recruitment in the AIPAC study increased.

The analysis of the PFS primary endpoint of AIPAC will be conducted after 152 PFS events (disease progression or death) have occurred. The company expects to report the top-line PFS data in Q120.

The randomised stage of AIPAC was preceded by a safety run-in study in which 15 women were treated with either 6mg or 30mg of efti in combination with weekly paclitaxel chemotherapy (80mg/m^2 in three weeks out of every four). Both doses of efti were found to be safe and well tolerated when used in combination with paclitaxel. The overall response rate (ORR) for the 15 patients was 47% and the disease control rate (tumour response or stable disease) was 87%. The 47% ORR compares favourably with response rates of 23–41% reported in historical studies.[1,2]

The European Medicines Agency has indicated this trial could be sufficient to support a marketing authorisation if it achieves certain (undisclosed) clinical endpoints. A confirmatory Phase III study would likely be required before filing for approval in the US, but this will not be determined until after the trial results have been discussed with the regulator.

Efti will fit neatly into the breast cancer treatment landscape

Dr Luc Dirix, the principal investigator of the AIPAC trial, reviewed the treatment landscape for hormone receptor positive/HER2-negative mBC on a key opinion leader call hosted by Immutep on 27 June.

About 65% of cases of metastatic breast cancer fall into the hormone receptor positive/HER2-negative category.[3] The foundation of initial systemic therapy for this patient population is endocrine therapy to block the growth-promoting effects of oestrogen and progesterone. Exhibit 1 highlights that after the approval of the CDK 4/6 inhibitor Ibrance (palbociclib, Pfizer) in 2016, many patients now receive endocrine therapy in combination with a CDK 4/6 inhibitor (Ibrance or Kisqali) and/or the mTOR inhibitor Afinitor (everolimus).

1 Gray et al, J Clin Oncol. 2009 Oct 20;27(30):4966–72.

2 Martin et al, Lancet Oncol 2011; 12: 369–76

3 Howlader et al, 2014 JNCI 106(5)

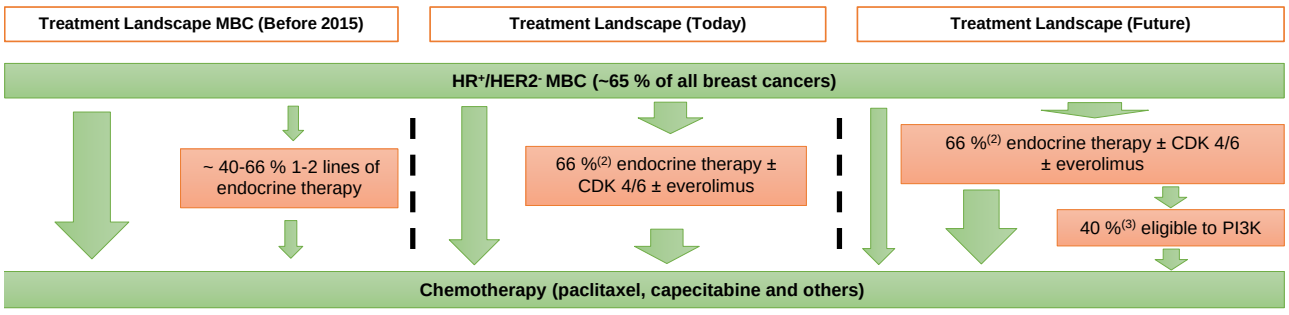
In the near future, around 40% of hormone receptor-positive/HER2-negative patients (those with mutations of the PI3KCA gene) will be eligible for treatment with the PI3K inhibitor Piqray (alpelisib, Novartis) following failure of CDK 4/6 inhibitor therapy, before they progress to chemotherapy treatment. Alpelisib was approved by the FDA in May 2019 and Novartis has filed for approval in Europe.

Another targeted therapy, the AKT inhibitor capivasertib (AstraZeneca) has shown promise in patients who have failed on endocrine therapy, improving median PFS from 4.8 months to 10.3 months in a Phase II study.

Although the targeted therapies described above have proven effective in combination with endocrine therapy, it is notable that the PD1/L1 checkpoint inhibitor immunotherapies that have changed treatment paradigms in diseases such as melanoma and lung cancer have not shown any real promise in hormone receptor positive breast cancer.

Despite the improvements in PFS with the new targeted therapies, mBC remains an incurable disease. Although endocrine therapy and the new targeted therapies can delay disease progression, patients inevitably relapse and become candidates for chemotherapy. Therefore, the new treatments are not expected to significantly reduce the number of patients who eventually receive chemotherapy for mBC. As paclitaxel is a mainstay of first-line chemotherapy, efti/paclitaxel combination therapy, if effective, would be expected to play a significant role in treating this patient population.

Exhibit 1: Treatment landscape for HR$^+$/HER2$^-$ metastatic breast cancer

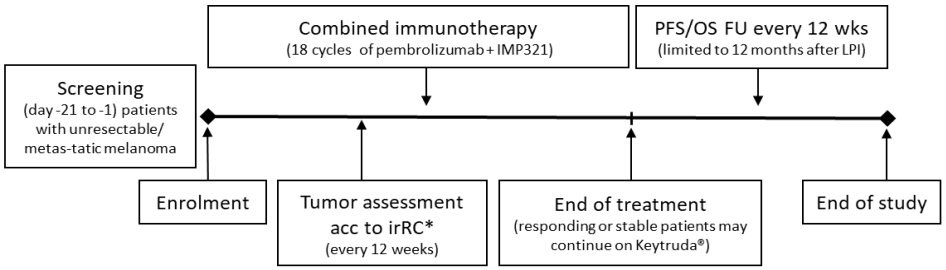


Source: Immutep. Notes: [2]Caldeira et al, Oncology and therapy 2016; 4:189–197; [3]https://www.ascopost.com/News/59389; use to be determined as not yet approved by EMA. HR$^+$= hormone receptor positive; HER2$^-$= HER2 receptor negative.

Ongoing 50% response rate in TACTI-mel Part B

Professor Frederic Triebel, Immutep's chief scientific officer and chief medical officer, presented an update on the TACTI-mel study at the World Advanced Therapies and Regenerative Medicine Congress and Expo 2019 in London on 17 May. The presentation included updated efficacy data from the six-patient cohort, which comprises Part B of TACTI-mel. In this cohort, metastatic melanoma patients were treated with the efti (IMP321) soluble LAG-3 fusion protein in combination with Merck & Co's Keytruda (pembrolizumab), with efti dosing starting at the same time as Keytruda, as shown in Exhibit 2.

Exhibit 2: TACTI-mel Part B study scheme



Source: Immutep. Note: *Eligibility determined according to Response Evaluation Criteria in Solid Tumors (RECIST) 1.1 but treatment decisions based on immune-related Response Criteria (irRC).

Exhibits 3 and 4 show three of the six (50%) subjects have experienced confirmed deep partial responses that are ongoing after at least nine months, including one patient with complete disappearance of all target lesions. A fourth subject who has stable disease has recently experienced minor tumour shrinkage. These four subjects remain on the study and continue to receive efti/Keytruda combination treatment. To highlight the new data, we have added green circles to the response plots for selected patients to show the last data point included in the previous data set reported at the World Immunotherapy Congress in March.

No subjects terminated treatment due to safety issues with efti/Keytruda combination therapy, highlighting the good tolerability of the combination.

Exhibit 3: Updated spider plot from TACTI-mel Part B

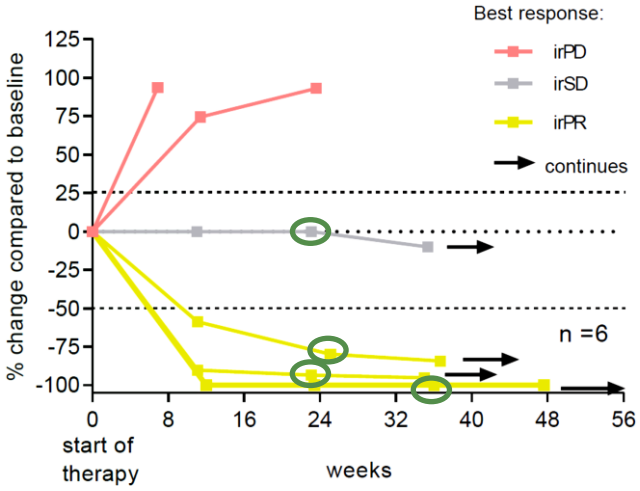
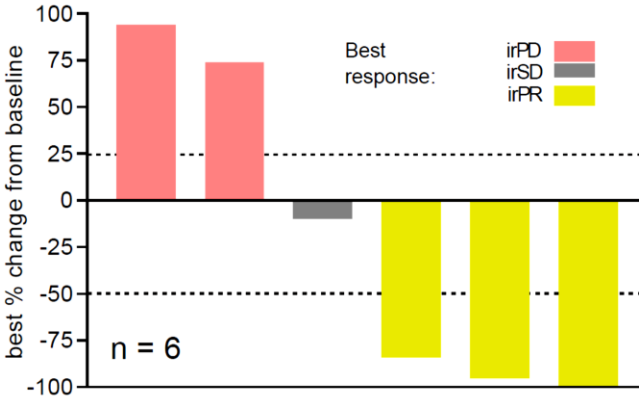


Exhibit 4: Waterfall plot from TACTI-mel Part B



Source: Immutep. Note: Responses are evaluated according to irRC criteria. We have added green ovals to indicate the last data point for selected patients as shown at the World Immunotherapy Congress in March.

In total, 18 subjects were also recruited in Part A of the TACTI-mel study, in which subjects received four cycles of Keytruda monotherapy before subjects who had a suboptimal response to initial treatment with Keytruda were enrolled into the combination therapy study, starting with the fifth cycle of Keytruda.

As previously reported, the ORR from the start of efti/Keytruda combination therapy was 33% (six of 18), including one complete response. In an exploratory post hoc analysis, the ORR was 61% (11/18) when measured from the start of the 12-week Keytruda monotherapy screening period.

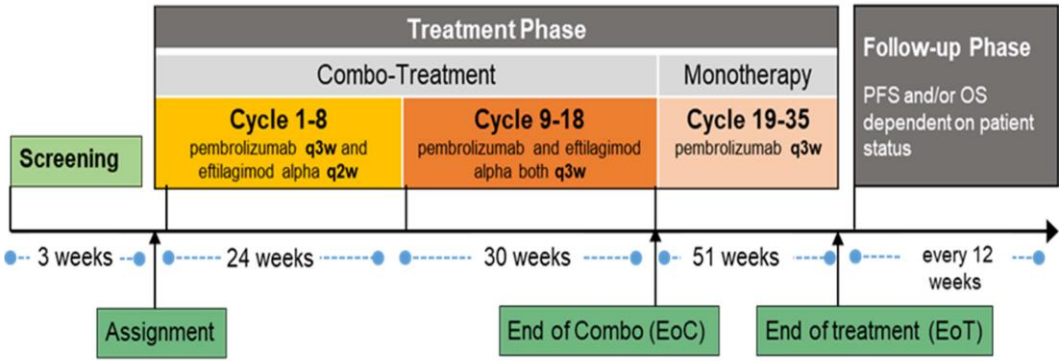
TACTI-002 Part A first cohort fully recruited

Immutep announced on 13 June that the initial cohort of 17 first-line non-small cell lung cancer (NSCLC) patients in Part A of the TACTI-002 study has been fully recruited, a little over three months after the first patient was dosed. The rapid recruitment suggests to us that clinicians believe there is potential for their patients to benefit from enrolling in the study.

The open-label TACTI-002 is evaluating efti plus Keytruda in up to 109 patients in three different cancer indications at up to 13 sites in Europe, the US and Australia. Treatment with efti (30mg by subcutaneous (SC) injection) starts on the same day as Keytruda, just as in TACTI-mel Part B. Immutep is conducting the study in collaboration with Merck & Co.

Patients will receive 12 months of efti/Keytruda combination therapy, followed by a further 12 months of Keytruda monotherapy (Exhibit 5). The primary endpoint will be ORR (as per irRECIST).

Exhibit 5: TACTI-002 trial design



Source: Immutep. Note: One cycle: three weeks; q2w: every two weeks; q3w: every three weeks.

The three patient populations targeted in TACTI-002 are:

- Part A: first-line advanced/metastatic NSCLC patients, who are PD-1/L-1 naive and have not undergone systemic therapy for advanced/metastatic disease.
- Part B: second-line advanced/metastatic NSCLC patients who have experienced treatment failure (disease progression) following treatment with any PD-1/PD-L1 regimen.
- Part C: second-line squamous cell carcinoma of the head and neck (HNSCC) patients who are PD-1/L1 naive.

The TACTI-002 study is using Simon's two-stage design. For each of the three treatment indications, an initial cohort of 17–23 patients will be treated. For each indication, if the number of patients with tumour responses exceeds a pre-specified threshold, additional patients will be recruited to take the total to ~37 for that indication, as shown in Exhibit 6.

Exhibit 6: TACTI-002 trial design and expansion thresholds

Indication	Initial number of patients	Minimum number of responses for cohort expansion#	Minimum ORR for cohort expansion	Additional patients	Total patients	Keytruda monotherapy ORR
Part A: NSCLC 1st line	17	5	29%	19	36	25%*
Part B: NSCLC PD1/L1 refractory 2nd line	23	2	9%	13	36	N/A
Part C: HNSCC PD1/L1 naïve 2nd line	18	3	17%	19	37	16-18%**

Source: Immutep, Edison Investment Research. Note: #The TACTI-002 poster at ASCO 2019 listed the response threshold that needs to be exceeded; to aid clarity we have converted this to the minimum number of responses to be achieved; *Keynote-001 study; **Keynote-012 study.

Part A of the study, which has fully recruited the initial cohort of 17 first-line NSCLC patients, will be enlarged by a further 19 patients if at least five of the 17 patients (29%) respond to efti/Keytruda combo treatment, bringing the total Part A cohort to 36.

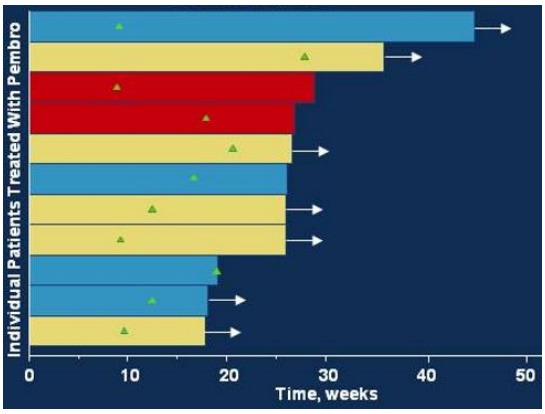
To put this in context, we note that the response rate to Keytruda monotherapy among 101 previously untreated NSCLC patients in the large Keynote-001 Phase I study was 25%.[4]

Therefore it will be a positive signal if the TACTI-002 Part A cohort is expanded to the full size, because it will mean the response rate among the first 17 subjects was at least 29% and therefore was higher than that observed in a similar patient cohort in the Keynote-001 study.

Next we looked at how long we might expect it to take for the threshold of five responses to be reached in the Part A cohort. A presentation of the Keynote-001 NSCLC data at ASCO in 2014 included a swimmer plot showing the time to first response (by RECIST v1.1 criteria) in the study. The swimmer plot showed that among the 11 subjects with tumour responses, 4/11 (36%) had responded by 10 weeks, 9/11 (82%) had responded by 20 weeks and all 11 (100%) had responded by 30 weeks after the start of treatment (Exhibit 7).

This suggests that a median follow-up of 20 to 30 weeks might be needed to observe the required number of responses required to trigger cohort expansion. With the first patient having been dosed on 6 March and the 17th subject recruited on 13 June, we would anticipate the cohort expansion threshold being reached some time in Q419. We would consider it a very encouraging sign if the threshold was reached before Q419, because it would suggest that the eventual final response rate in the tranche was likely to be higher than 29%.

Exhibit 7: Time to response in a subset of first-line NSCLC patients in Keynote-001



Source: Rizvi et al, ASCO 2014 Abstract 8007. Note: Green triangles indicate the onset of tumour response as assessed by independent central review according to RECIST 1.1. Responses were assessed every nine weeks.

In TACTI-002 Part C, in second-line HNSCC patients who are PD-1/L1 naive, the minimum number of responses that needs to be observed to trigger expansion of the cohort is 3/18 (17%). In the Keynote-012 study of Keytruda monotherapy in second-line recurrent or metastatic HNSCC the ORR was reported as 16% (n=174) in the Keytruda prescribing information, and in a subsequent publication as 18% among 192 patients at long-term follow-up (Mehra et al 2018).[5]

Therefore, TACTI-002 Part C needs to at least match the ORR seen with Keytruda monotherapy in second-line HNSCC to progress to recruiting the full cohort.

The swimmer plot of treatment exposure and responses in Keynote-012 showed that among the 26 subjects who achieved a partial response, 50% had responded by three months, 80% after four

4 Garon et al, 2015. Pembrolizumab for the Treatment of Non–Small-Cell Lung Cancer. N Engl J Med; 372:2018-2028

5 Mehra et al, 2018. British Journal of Cancer 119:153–159

months and 85% had responded by six months after the start of Keytruda monotherapy treatment. Therefore, we estimate that if there is a modest 20% increase in ORR from ~18% to ~21%, it might need an average six months follow-up per subject to reach the minimum three responses needed to trigger expansion to the second stage of recruitment for this indication. A larger 50% increase in ORR to ~27% might see the threshold reached after a median follow-up of as little as three or four months.

We could not find any studies of PD1/L1 monotherapy in second-line PD1/L1 refractory NSCLC patients. The minimum response rate for cohort expansion in this patient population in Part B is a modest 9%.

The company has said first data from TACTI-002 are expected in mid-2019, but it is not clear what the nature of these data is likely to be.

INSIGHT testing new administration routes and efti combos

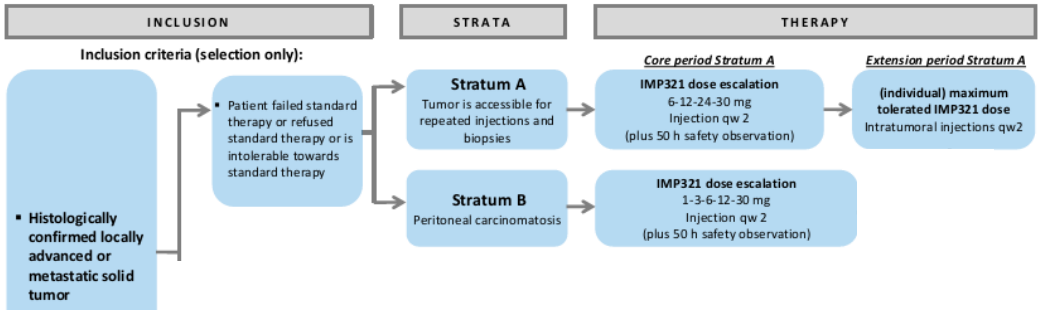
Professor Salah-Eddin Al-Batran, the principal investigator of the INSIGHT investigator initiated trial (NCT03252938), provided an update on the study on the key opinion leader call. INSIGHT contains four strata that are investigating efti in patients with advanced solid tumours in four different settings.

As Exhibit 8 shows, the first two strata are investigating the feasibility of administering efti as a single agent via either intratumoural (IT) injection (Stratum A) or intraperitoneal injection (Stratum B). Each patient receives an escalating dose of efti, ie if the patient tolerates injection of the first, low dose of efti, then two weeks later they will be injected with the next highest dose and so on up to 30mg. Up to nine patients were planned to be treated in each stratum.

Eight patients have already competed the core dose-escalation period for stratum A. No dose-limiting toxicities were observed, confirming the tolerability of 30mg of efti delivered by IT injection in a range of solid tumours (the types of cancers treated have not been disclosed, other than one patient with gastric cancer; see below).

Four patients have completed the core dose-escalation period for stratum B. No dose-limiting toxicities have observed to date.

Exhibit 8: Design of INSIGHT strata A and B



Source: Immutep

Strata C and D are investigating the feasibility of combining SC efti with other drugs in patients with advanced solid tumours (Exhibit 9).

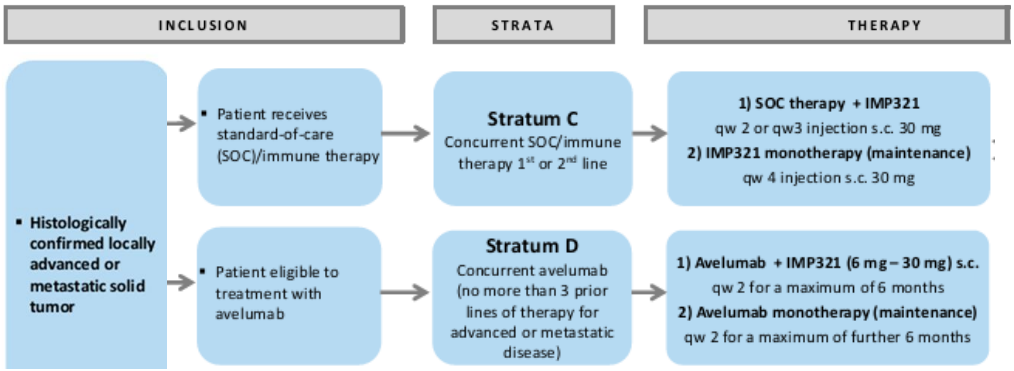
Stratum C, which will combine SC efti with standard of care chemotherapy or immune therapy, is not recruiting subjects, with completion of the other strata having priority. However, we note that the design would appear to allow efti to be added to chemotherapy/immunotherapy combinations. For example, Keytruda plus chemotherapy is approved for treating first- and second-line NSCLC patients. Adding efti to this regimen to form a triple efti/Keytruda/chemo combo would generate data

in a setting where the mechanism of action of efti (antigen-presenting cell activator) suggests it has the potential to significantly increase response rates.

Stratum D, which is combining SC efti with the anti-PD-L1 drug avelumab (Bavencio, Merck KGaA/Pfizer), is being conducted in collaboration with Merck KGaA and Pfizer. Avelumab has been approved by the FDA for treating the skin cancer known as Merkel cell carcinoma, as well as advanced bladder and kidney cancer. Two patients have been enrolled since 1 June and a third is undergoing pre-enrolment screening.

The first data from avelumab combination therapy in stratum D are expected to be reported before the end of 2019.

Exhibit 9: Design of INSIGHT strata C and D



Source: Immutep

Extended post-treatment survival in INSIGHT stratum 1 subject

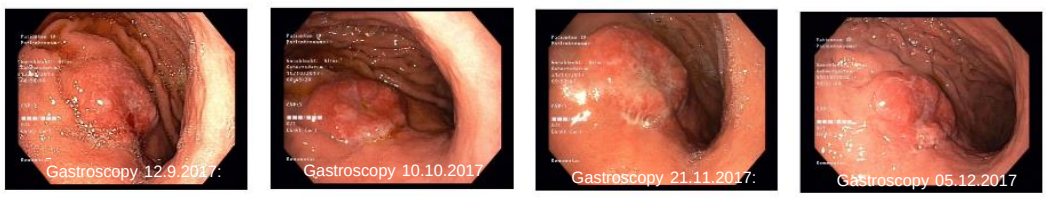
Professor Al-Batran presented a case study of a patient who received IT efti in INSIGHT stratum A. The patient with metastatic gastric cancer had received two lines of intensive chemotherapy before entering the study. The patient received seven IT injections in doses ranging from 6mg to 30mg.

The injected target tumour remained stable over the study, as shown in Exhibit 10. However, the subject was classified as having progressive disease 88 days after entering the study due to the increase in size of a lymph node near the kidney (potential metastatic disease). The patient exited the study, but is still alive almost two years after entering the study in September 2017.

Professor Al-Batran commented that the median survival of metastatic gastric cancer patients in the third-line therapy setting was typically two to four months. Although it is not possible to say whether the lengthy post-treatment survival was a result of the efti therapy, Prof Al-Batran viewed it as an encouraging sign.

Tumour biopsy samples have been collected from subjects in Stratum A before and after IT injection of efti. This will allow the effect that efti has on the immune cell populations in the tumour microenvironment to be investigated (ie can it turn immunologically 'cold' tumours 'hot'?). It is planned to present the results of this analysis at a scientific conference.

Exhibit 10: Third-line gastric cancer patient showed stable disease for 88 days



Source: Immutep

GSK's Phase II study of GSK'781 in ulcerative colitis underway

According to the clinicaltrials.gov registry entry (NCT03893565), GSK started a Phase II study of GSK'781 on 6 May. The study will investigate the safety, tolerability, efficacy and dose response of GSK'781 in up to 280 subjects with moderate to severe ulcerative colitis. The estimated primary completion date is August 2021.

GSK'781, which is based on the IMP731 antibody it licensed from Immutep, is an anti-LAG3 depleting antibody that will kill the few LAG-3 positive activated T-cells that infiltrate autoimmune disease sites.

Our forecasts assume the initiation of the Phase II study will have triggered a US$6m (A$8m) milestone payment from GSK.

Valuation

Our valuation of Immutep is unchanged at A$539m or 16c per share (undiluted). On a fully diluted basis, our valuation is 12c per share, after taking into account the options, warrants and convertible notes in issue. Exhibit 11 summarises the constituent parts of our valuation, which is based on a discount rate of 12.5%. Our valuation assumptions and financial forecasts remain unchanged.

Exhibit 11: DCF valuation of Immutep

Value driver	Launch date	Likelihood of success	Peak sales (US$m)	Royalty	Value (A$m)	Value per share (A$)
efti-mBC*	2021 (EU), 2024 (US)	35%	971	17.5%	223.9	0.07
efti+anti-PD1 ICI melanoma	2025	15%	480	17.5%	34.6	0.01
efti+Keytruda NSCLC	2025	15%	2,300	17.5%	210.1	0.06
efti+Keytruda ovarian	2027	15%	500	17.5%	24.9	0.01
efti+Keytruda head and neck	2025	15%	470	17.5%	33.9	0.01
efti milestones - assume partnered post PII in MBC	US$225m estimated risk-adjusted milestones from out-licensing North American and European rights.				57.8	0.02
IMP731-autoimmune disease	2023	20%	1,079	8%	67.4	0.02
Potential IMP731 milestones from GSK	US$81m of total US$100m in risk-adjusted milestones from GSK				16.5	0.00
IMP701-solid tumours (lung cancer)	2025	20%	2,440	5%	69.8	0.02
Potential IMP701 milestones from Novartis	US$20m in risk-adjusted milestones from Novartis				3.5	0.00
Grants					1.4	0.00
R&D expenses					(12.6)	(0.00)
Admin expenses					(10.7)	(0.00)
Capex					(0.0)	(0.00)
Tax					(193.1)	(0.06)
Net cash	End FY19e net cash (including A$13.75m convertible note at face value)				11.3	0.00
Total					**538.7**	**0.16**

Source: Edison Investment Research. Note: mBC: metastatic breast cancer; ICI: immune checkpoint inhibitor.

Exhibit 12 shows that in addition to the 3,389m Immutep shares in issue, there are a further 1,504m potential shares that could be issued on the exercise of options, warrants, performance rights and convertible notes, all of which would be in the money at our 16c per share undiluted valuation. Exhibit 12 shows that after taking into account these potential shares, our diluted valuation is 12c per share. Depending on trial progress and the timing of milestone payments from partners, Immutep may require additional funding to complete the efti clinical trials; our diluted valuation of 12c per share does not include the potential dilution from any future capital raising.

Exhibit 12: Potential further dilution and value per share

	Average exercise price (A$)	m
Current number of shares		3,389
Ridgeback convertible note potential shares	0.020	688
Ridgeback warrants	0.024	380
Unlisted warrants*	0.033	363
Unlisted options	0.033	2
Performance rights**	0.000	71
Total in-the-money potential shares		1,504
Total potential diluted number of shares		4,892
Net cash raised from options and CN exercise		A$35
Valuation (above plus additional cash)		A$566
Diluted value per share		**A$0.12**

Source: Edison Investment Research. Note: *3.63m ADS warrants converted to ordinary shares at the long-term exchange rate. **Both vested and unvested performance rights have been included.

We include risk-adjusted milestones payable by current partners GSK for IMP731 and Novartis for IMP701, plus milestones from prospective deals for efti. The breadth of the LAG-3 pipeline means there could be further upside if Immutep or its partners launch additional products into the clinic or broaden the indications being studied.

Exhibit 13: Financial summary

A$000s	2016	2017	2018	2019e	2020e
Year end 30 June	IFRS	IFRS	IFRS	IFRS	IFRS
PROFIT & LOSS					
Revenue	1,949	4,117	6,854	10,898	2,778
R&D expenses	(7,060)	(7,526)	(9,990)	(10,990)	(10,440)
SG&A expenses	(6,983)	(4,347)	(7,242)	(7,459)	(7,683)
EBITDA	(12,093)	(7,756)	(11,435)	(7,551)	(15,345)
Operating Profit (before GW and except.)	(12,275)	(7,770)	(11,446)	(7,554)	(15,350)
Intangible Amortisation	(1,993)	(1,688)	(1,798)	(1,650)	(1,501)
Exceptionals	(47,468)	0	0	0	0
Operating Profit	(61,736)	(9,458)	(13,244)	(9,204)	(16,851)
Other	(1,716)	(752)	323	0	0
Net Interest	256	104	177	704	751
Profit Before Tax (norm)	(13,735)	(8,417)	(10,946)	(6,850)	(14,599)
Profit Before Tax (IFRS)	(63,196)	(10,105)	(12,744)	(8,500)	(16,100)
Tax	1,181	737	(2)	0	0
Profit After Tax (norm)	(12,554)	(7,680)	(10,948)	(6,850)	(14,599)
Profit After Tax (IFRS)	(62,015)	(9,368)	(12,746)	(8,500)	(16,100)
Average Number of Shares Outstanding (m)	2,016.6	2,072.5	2,079.7	3,207.3	3,388.6
EPS - normalised (c)	(0.6)	(0.4)	(0.5)	(0.2)	(0.4)
EPS - IFRS (c)	(3.1)	(0.5)	(0.6)	(0.3)	(0.5)
Dividend per share (c)	0.0	0.0	0.0	0.0	0.0
Gross Margin (%)	N/A	N/A	N/A	N/A	N/A
EBITDA Margin (%)	N/A	N/A	N/A	N/A	N/A
Operating Margin (before GW and except.) (%)	N/A	N/A	N/A	N/A	N/A
BALANCE SHEET					
Fixed Assets	20,883	19,045	18,356	16,715	15,223
Intangible Assets	20,852	19,020	18,329	16,680	15,178
Tangible Assets	32	24	26	36	45
Other	0	0	0	0	0
Current Assets	21,671	15,919	28,643	30,203	15,595
Stocks	0	0	0	0	0
Debtors	168	2,194	3,432	3,432	3,432
Cash	20,880	12,237	23,476	25,035	10,428
Other	623	1,488	1,736	1,736	1,736
Current Liabilities	(1,472)	(2,632)	(3,853)	(3,853)	(3,853)
Creditors	(1,444)	(2,589)	(3,664)	(3,664)	(3,664)
Short term borrowings	(0)	(0)	0	0	0
Short term leases	0	0	0	0	0
Other	(28)	(43)	(190)	(190)	(190)
Long Term Liabilities	(5,765)	(5,799)	(9,623)	(9,623)	(9,623)
Long term borrowings incl. conv. note	(5,027)	(5,779)	(6,646)	(6,646)	(6,646)
Long term leases	0	0	0	0	0
Other long term liabilities	(737)	(20)	(2,978)	(2,978)	(2,978)
Net Assets	35,317	26,532	33,522	33,441	17,341
CASH FLOW					
Operating Cash Flow	(11,594)	(8,611)	(7,954)	(7,551)	(15,345)
Net Interest	284	104	177	704	751
Tax	0	0	0	0	0
Capex	(27)	(7)	(12)	(12)	(13)
Acquisitions/disposals	130	0	0	0	0
Financing	27,229	(9)	18,898	8,419	0
Dividends	0	0	0	0	0
Other	0	0	(493)	0	0
Net Cash Flow	16,022	(8,522)	10,616	1,560	(14,607)
Opening net debt/(cash)	(5,251)	(15,852)	(6,458)	(16,830)	(18,389)
HP finance leases initiated	0	0	0	0	0
Other	(5,421)	(872)	(244)	(0)	0
Closing net debt/(cash)	(15,852)	(6,458)	(16,830)	(18,389)	(3,782)

Source: Company accounts, Edison Investment Research

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