

NeOnc Technologies Holdings, Inc. (NTHI)

NYSE

Rating	Buy
Price (09/23/26)	\$3.22
12-Mo.Price Target	\$20.00

Stock Data

52-Week Range	\$2.99- \$12.09
Shares Out. (mil)	28.81
Mkt. Cap.(mil)	\$99.38
3-Mo. Avg. Vol.	172,745
Cash (mil)¹	\$9.9
Tot. Debt (mil)	\$0.0

¹Pro forma cash of \$9.9M includes \$2M at the end of 2Q26, plus estimated net proceeds of \$13.9M from a 3Q26 equity raise, minus \$6M recently spent to retire all Series A convertible preferred stock.

Rev (\$M)

Yr Dec	Q1	Q2	Q3	Q4	FY
2025A	0.0A	0.0A	0.0A	0.0A	0.0A
2026E	0.0A	0.0A	0.0E	0.0E	0.0E
2027E					0.0E

EPS \$

Yr Dec	Q1	Q2	Q3	Q4	FY
2025A	(1.78)A	(0.30)A	(0.45)A	(0.73)A	(3.20)A
2026E	(0.38)A	(0.58)A	(0.34)E	(0.47)E	(1.77)E
2027E					(1.34)E


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NTHI: Initiating Coverage at Buy; Effective CNS Drug That Chaperones Other Drugs Into CNS

We initiate coverage of NTHI with a Buy rating and \$20 12-month price target (DCF analysis uses 20% discount rate, 5x multiple of our projected \$667M 2033 operating income). We project NEO100 and NEO212 to launch in 2029 and 2030, respectively. Pro forma cash of \$9.9M funds operations through 2026. NTHI intends to develop NEO100 and NEO212 in recurrent grade 4 astrocytoma, and NEO212 in recurrent GBM and brain metastases, with pivotal trials potentially to start by YE26. Based on existing clinical data, key asset perillyl alcohol is both an efficacious therapeutic and drug chaperone.

- A significant near-term value inflection point is the potential for the FDA to agree with the company at its upcoming Type B end-of-Phase 2 meeting (estimated November timing) that both NEO100 and NEO212 are ready for pivotal trials rather than requesting further Phase 2 development. It is plausible to us that the FDA will view the risk/reward with these two drugs to be favorable, especially given the dire unmet medical needs targeted. More specifically, NTHI seeks to further evaluate NEO100 in recurrent IDH1-mutant grade 4 astrocytoma and further evaluate NEO212 in recurrent IDH1-wild-type glioblastoma (GBM), recurrent IDH1-mutant grade 4 astrocytoma, and brain metastases from non-CNS primary tumors. We note the favorable Phase 1/2a efficacy demonstrated for NEO100 thus far (i.e., PFS-6 of 49% versus the historical expectation of about 20%, and median OS of 26.1 months versus the historical expectation of about six-to-nine months), and the highly favorable safety profile for both drugs.
- NEO100 is intranasally administered (via nebulizer/nasal mask) perillyl alcohol. The drug has been shown to kill tumor cells via three likely mechanisms: (1) RAS oncoprotein inhibition, (2) Na/K-ATPase inhibition, and (3) cytoplasmic membrane disruption. NEO100 efficiently enters the CNS most likely via olfactory and trigeminal nerve cells and the nasal mucosa, thereby allowing direct access to cerebrospinal fluid. NEO212 is NEO100 covalently bound to temozolomide via a carbamide linker and given orally (capsule to be replaced by a tablet). Given NEO100's amphipathic nature, it is able to penetrate the blood-brain barrier efficiently enough such that preclinical studies have shown that three times as much temozolomide enters the brain with NEO212 compared to equimolar doses of temozolomide. Thus, lower relative doses of NEO212 should avoid the myelosuppression that often restricts temozolomide dosing. NEO212 has also been shown to inhibit MGMT, which is a key temozolomide resistance pathway, and as such could resensitize tumors to temozolomide. Perillyl alcohol could also have broad utility in efficiently escorting other drugs into the CNS, and to that end NTHI has identified several other product candidates consisting of perillyl alcohol conjugated to various drugs, which could add additional value to the story.
- Near-term catalysts for NTHI include the outcome of the Type B end-of-Phase 2 meeting with the FDA in 4Q26, which will define when pivotal clinical results from both drugs will be available. We note that the company is seeking accelerated approval for each drug based on a single interim analysis, with overall response rate as the endpoint without any survival detriment, which would yield potentially approvable results a couple of years sooner than going straight for full approval based on overall survival. Also, NTHI will present Phase 1/2a NEO100 results and Phase 1 NEO212 results at the SNO annual meeting in mid-November.
- Factors that could impede the achievement of our price target include, but are not limited to: (1) failure and/or setbacks of pipeline candidates in clinical trials; (2) failure of pipeline candidates to gain regulatory approval; and (3) smaller than projected commercial opportunity due to changes in market size, competitive landscape, and product pricing and reimbursement.

Investment Summary

We are initiating coverage of NeOnc Technologies Holdings, Inc. (NTHI) with a Buy rating and a 12-month price target of \$20, based on a DCF analysis using a 20% discount rate that is applied to all cash flows and the terminal value, which is based on a 5x multiple of our projected 2033 operating income of \$667 million. We arrive at this valuation by projecting increasing U.S. and E.U. revenue from NEO100 for the treatment of recurrent high-grade glioma, and from NEO212 in recurrent GBM. We note that successful commercialization of NEO100 in pediatric brain tumors or meningioma, or NEO212 in recurrent high-grade glioma or brain metastases would provide substantial upside to our valuation, but we use a more conservative valuation to illustrate how a compelling value proposition can be made solely upon NEO100 and NEO212 in one indication each. Factors that could impede the achievement of our price target include, but are not limited to: (1) failure and/or setbacks of pipeline candidates in clinical trials; (2) failure of pipeline candidates to gain regulatory approval; and (3) smaller than projected commercial opportunity due to changes in market size, competitive landscape, and product pricing and reimbursement. For our revenue build, P&L, and DCF valuation, please see pages 19-21.

NTHI is a clinical-stage oncology company (formerly known as NAS-ONC, Inc. until 2009 and incorporated in 2008) based in Calabasas, CA, that focuses on developing and eventually commercializing central nervous system therapeutics designed to address persistent challenges in crossing the blood-brain barrier. NTHI went public on the Nasdaq Global Market in late 1Q25 via a direct public listing. In 1Q09, NTHI signed an exclusive, worldwide license agreement with the University of Southern California (USC), pursuant to which USC granted the company a royalty-bearing license to use certain patents and patent applications pertaining to the medical use of NTHI's therapeutic platform. In addition to relatively small fees, there are no future milestone payments, but a 2% or 4% royalty depending on which specific technology is incorporated into a marketed product. NTHI's current pipeline is protected by this licensed intellectual property.

NTHI's lead asset NEO100 is intranasally administered perillyl alcohol that has been shown to promote tumor cell killing through various mechanisms. NEO100 successfully completed both parts of a multi-center Phase 1/2a trial which evaluated the drug in 12 recurrent GBM patients (Phase 1) and subsequently in 24 recurrent IDH1-mutated grade 3/4 glioma patients (three grade 3 and 21 grade 4), with both diseases representing clear unmet medical needs. In Phase 1, NEO100 resulted in an encouraging median OS of 15 months, versus the historical expectation of six to nine months, and exhibited a highly favorable safety profile. In Phase 2a, NEO100 treatment led to an encouraging PFS-6 (49% versus the historical expectation of about 20%) and median OS (26.1 months versus the historical expectation of about six to nine months). In both parts of the trial, there was a tail of patients surviving far longer than expected, namely four of the 12 Phase 1 patients surviving at least two years and eight of the 24 Phase 2a patients surviving at least 20 months. Intranasal delivery was shown to efficiently deliver drug to the CNS, after oral formulations were shown to be ineffective. NTHI intends to ask the FDA at its end-of-Phase 2 Type B meeting in 4Q26 if it can proceed directly to a pivotal NEO100 trial having an interim analysis that could support accelerated approval.

NTHI also completed a successful 14-patient multi-center Phase 1 trial evaluating its second asset NEO212 (perillyl alcohol bound to temozolomide) in recurrent GBM and other solid tumors that metastasized to the brain, which can be given orally due to the comparatively lower perillyl alcohol doses versus NEO100. The drug exhibited a highly favorable safety profile and had measurable efficacy (partial response and stable disease) in two patients. Importantly, preclinical studies have shown that NEO212 effectively inactivates and promotes the degradation of MGMT, which is a crucial DNA repair enzyme causing temozolomide resistance, whereas temozolomide alone does not lower MGMT levels and remains vulnerable to MGMT-driven DNA repair, thereby allowing NEO212 to likely function in patients formerly resistant to temozolomide. NTHI intends to further evaluate NEO212 in recurrent IDH1-wild-type GBM and recurrent IDH1-mutant grade 4 astrocytoma (NEO212 versus standard of care), and in advanced solid tumors with brain metastases (NEO212 plus standard of care versus standard of care). This trial would also be expected to have an interim analysis to potentially support accelerated approval. We expect NTHI to prioritize the Phase 3 NEO100 trial in recurrent IDH1-mutant grade 4 astrocytoma and the Phase 3 NEO212 trial in recurrent IDH1-wild-type GBM, given its expectation to initially raise enough capital to fund those two trials, but raising more capital could allow the company to also pursue the other two indications for NEO212 as well.

Relatively low perillyl alcohol doses could have broad utility in efficiently escorting other drugs into the CNS, essentially acting as a solvent to increase penetration of the blood-brain barrier in oral formulations that could reduce systemic toxicity in the same way that NEO212 reduces temozolomide toxicity by delivering three-fold more temozolomide to the brain than equimolar doses of temozolomide. Although not addressed in this report, to that end NTHI has identified five other product candidates (NEO214, NEO216, NEO2178, NEO400, and NEO412) that consist of perillyl alcohol conjugated to various psychiatric and other drugs.

NTHI's pro forma 2Q26 cash was \$9.9 million (\$2 million end of 2Q26, plus net cash of about \$13.9M raised in 3Q26 via an equity financing, minus \$6 million recently spent to retire all convertible preferred stock), which can fund operations through 2026, as per our projections, and NTHI has no debt. The company has also established an ATM facility (initiated at \$75 million) and an untapped \$10 million line of credit.

Figure 1: Clinical pipeline

Drug Candidate	Application	Indication	Preclinical	IND Enabling*	Phase I	Phase II	Phase III	Commercialization
NEO100-01	Intranasal NEO100	Recurrent Grade III or IV Astrocytoma Brain Tumor w/ IDH1 Mutation	Phase 2a (Completed)					
NEO100-02	Intranasal NEO100	Meningioma Brain Tumors	Phase 2					
NEO100-03	Intranasal NEO100	Pediatric Brain Tumors	Phase 1					
NEO212	Oral NEO212	All Brain Tumors	Phase 2					

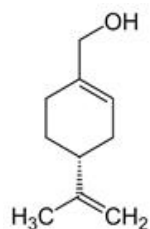
Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

NEO100 description and rationale

NEO100 is an ultrapure, pharmaceutical-grade, intranasally administered perillyl alcohol (POH; p-mentha,1,7-diene-6-ol), a naturally occurring monoterpene related to limonene that can be found in the essential oils of many plants. Preclinical investigation in *in vitro* and *in vivo* studies has determined that POH has antitumor activity. POH inhibits farnesyl-protein transferase, which inhibits the oncogenic activity of Ras protein, given that Ras requires post-translational farnesylation for plasma membrane anchoring and mitogenic activity. In addition, POH inhibits the cytoplasmic sodium/potassium transporter, which triggers proapoptotic endoplasmic reticulum stress due to the ensuing electrolyte imbalances, and inhibition of telomerase, which causes senescence and prevents further cell proliferation. These collective effects of POH cause cell cycle arrest in the G1 phase, tumor growth inhibition, and eventual tumor cell apoptosis. Given that the mechanism for temozolomide resistance is primarily driven by enhanced DNA repair pathways, most notably MGMT and the mismatch repair system, alongside cellular defenses like drug efflux and glioma stem cells, NEO100 is designed to remain active in the temozolomide-resistant recurrent tumor setting.

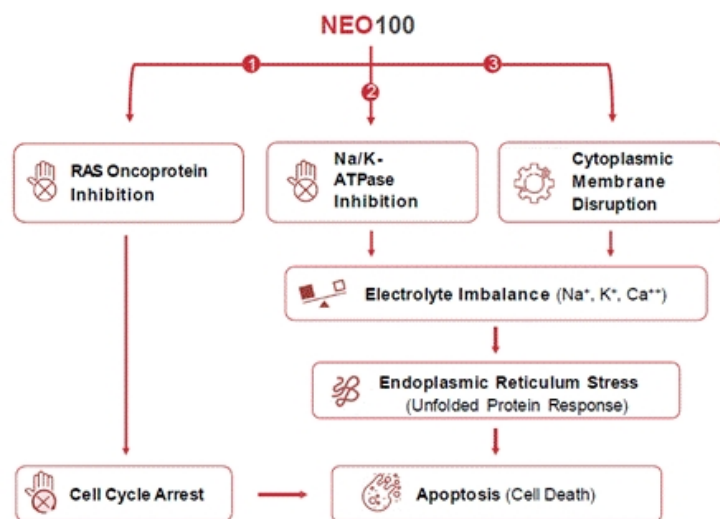
The intranasal formulation was developed because POH was originally formulated for clinical testing as daily oral capsules and administered to cancer patients at high (several grams) doses three or four times a day on a continuous daily basis. However, oral clinical trials in humans yielded disappointing results because the large number of capsules that had to be swallowed caused hard-to-tolerate intestinal side effects, causing high patient withdrawal from treatment due to extensive nausea, fatigue, and vomiting. Also, rapid liver metabolism of POH kept the drug from reaching the tumor. As a result, further clinical development of oral POH was terminated, but clinical trials in Brazil subsequently evaluated comparatively smaller doses of intranasally delivered POH to avoid the gastrointestinal adverse effects of oral POH, and the safety was vastly improved in trials in recurrent malignant gliomas. Nebulized intranasal POH can bypass the protective blood-brain barrier and enter the brain presumably by penetrating olfactory and trigeminal nerve cells and the nasal mucosa, allowing direct access to cerebrospinal fluid and thus the entire CNS. Attributes of POH that further enhance CNS penetration are its small molecular size and amphipathicity. Below we describe NEO100 Phase 1 results in recurrent GBM and Phase 2a results in recurrent IDH1-mutant grade 3/4 glioma and note that NTHI is conducting a 29-patient, multi-site Phase 2a trial in residual, progressive or recurrent high-grade meningioma, and recently began evaluating the drug in a 12-patient, dose escalation Phase 1 trial in pediatric high-grade gliomas. NTHI may also develop NEO100 in combination with other drugs that would benefit from more efficient penetration of the blood-brain barrier, employing the drug essentially as an enhancing solvent for drugs for numerous CNS diseases. NEO100 has Fast Track and Orphan Drug Status for malignant glioma.

Figure 2: NEO100 chemical structure



Source: Wikipedia

Figure 3: NEO100 multiple mechanisms of action



Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

NEO100 Phase 1 trial results

The single-arm, four-site, Phase 1 trial in 12 recurrent GBM patients that progressed after radiation and temozolomide had patients self-administering escalating doses of intranasal NEO100 (four dosing cohorts of 384 to 1,152mg/day total dose, delivered four times daily via nebulizer and nasal mask, 15-20 minutes per treatment) until disease progression, with therapy being generally well tolerated and no dose-limiting toxicities identified. Regarding efficacy, PFS-6 was 33%, OS-12 was 55%, OS-24 was 33%, and median OS was 15 months, compared to a six-to-nine-month historical median OS benchmark. Four of the five patients that were IDH1-mutated survived more than 24 months (Figure 4), potentially because IDH1-mutations naturally alter tumor metabolism and tend to grow less aggressively than IDH wild-type tumors, offering an inherent survival advantage. But the reality is that IDH1-mutant survival is measured in years from initial diagnosis and the years long period of survival is driven by grade 2 disease. Once grade 3/4 IDH1-mutant astrocytoma recurs after standard surgery, radiotherapy, and temozolomide (i.e., the future population targeted by NEO100), the survival advantage conferred by IDH1 mutations has essentially passed. We are highly optimistic about the outcome of NTHI's planned randomized, Phase 3 trial with NEO100, which would exclusively enroll recurrent IDH1-mutant grade 4 astrocytoma patients. As background, the IDH1-mutant produces an abnormal IDH1 enzyme, which overproduces 2-hydroxyglutarate, a molecule that disrupts normal cell functions and greatly reduces glycolysis, which reduces tumor cell growth. Even the seven patients that were IDH1 wild-type had a longer than expected median OS of 11 months. Regarding safety, there were no grade 3 or 4 adverse events, with grade 1 adverse events including nasal soreness or itching, runny nose, skin irritation around the nose, or headache, and one possibly treatment related grade 2 leukopenia. Also, a maximum tolerated dose was not identified, underscoring the drug's safety, and thus the dose used in Phase 2a was 1,152mg/day (the highest dose tested in Phase 1). Adverse event incidence was also not dose proportional, but efficacy as measured by PFS was somewhat dose proportional (Figure 5). Among the 12 patients, four achieved stable disease (including three of the five IDH1-mutated patients) as the best response, with the rest progressing by the first efficacy evaluation, representing a 33% disease control rate.

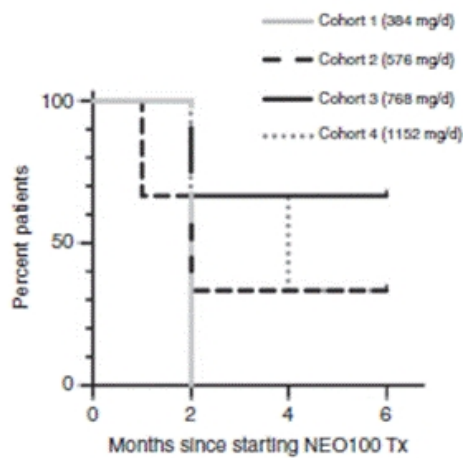
Figure 4: Response results from NEO100 Phase 1 trial

Patient ID	Cohort	Dosage (mg/day)	Completed Number of Cycles ^a	RANO ^b	Survival After Start of NEO100 (Months)	IDH1 Status	Current Status	NEO100Tx Ongoing
104	1	384	2	PD	18	Wild type	Deceased	N/A
105	1	384	2	PD	9	Mutated	Deceased	N/A
106	1	384	2	PD	33	Mutated	Deceased	N/A
202	2	576	33	SD	33	Mutated	Alive	Yes
203	2	576	2	PD	11	Wild type	Deceased	N/A
204	2	576	1	N/A	2	Wild type	Deceased	N/A
301	3	768	24	SD	24	Mutated	Alive	Yes
302	3	768	11	SD	27	Mutated	Alive	No
303	3	768	2	PD	10	Wild type	Deceased	N/A
401	4	1152	4	PD	>4	Wild type	Unknown	No
402	4	1152	2	PD	15	Wild type	Deceased	N/A
403	4	1152	8	SD	9	Wild type	Deceased	N/A

^aEach cycle is 28 days.
^bPerformed at end of even-numbered cycles and 6 month final.

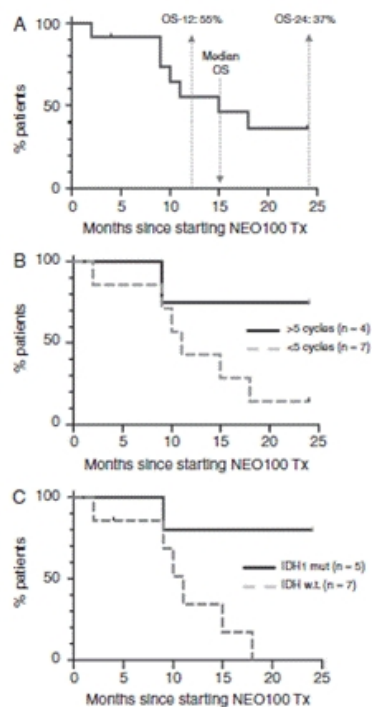
Source: doi:10.1093/noajnl/vdab005

Figure 5: PFS results by dose cohort from NEO100 Phase 1 trial



Source: doi:10.1093/noajnl/vdab005

Figure 6: OS results from NEO100 Phase 1 trial – overall and patient subgroups



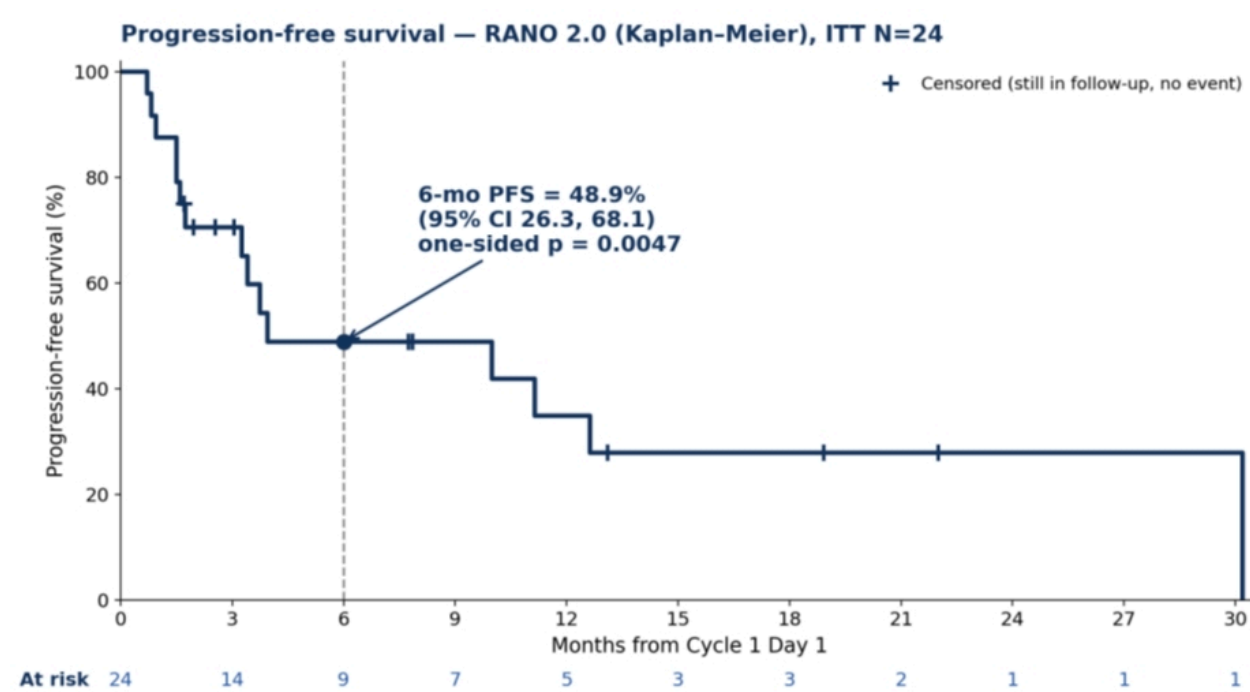
Source: doi:10.1093/noajnl/vdab005

NEO100 Phase 2a trial results

A single-arm Phase 2a trial in 24 patients with recurrent IDH1-mutant grade 3/4 glioma (three grade 3, 21 grade 4) showed that NEO100 self-administered intranasally four times daily (1,152mg/day in total taken as four 288mg doses) delivered highly encouraging PFS-6 (49% versus the historical expectation of about 20%; $p=0.0047$; primary efficacy endpoint) and OS (26.1 months versus the expected OS of about six to nine months in such advanced stage patients) results, with five patients remaining on treatment at last data cut in early August 2026, and with the longest two of the five ongoing treatments out to 20 and 24 months. OS-6, OS-12, and OS-24 were 87%, 61%, and 54%, respectively, with 12 of the 24 patients alive at last data cut. There were also two partial responses (ORR of 8.3%), a rare occurrence in these advanced disease patients, and 14 patients achieving stable disease, with eight patients progressing despite NEO100 treatment, representing an impressive 67% disease control rate. The swimmers plot of the Phase 2a data below (Figure 9) shows a clear tail of patients (eight of the 24) surviving at least 20 months, a highly encouraging result. Although the IDH1-mutant patients are fortunate that they typically live several years from diagnosis after surgery, radiation, and temozolomide treatment, median overall survival upon recurrence is typically only six to nine months.

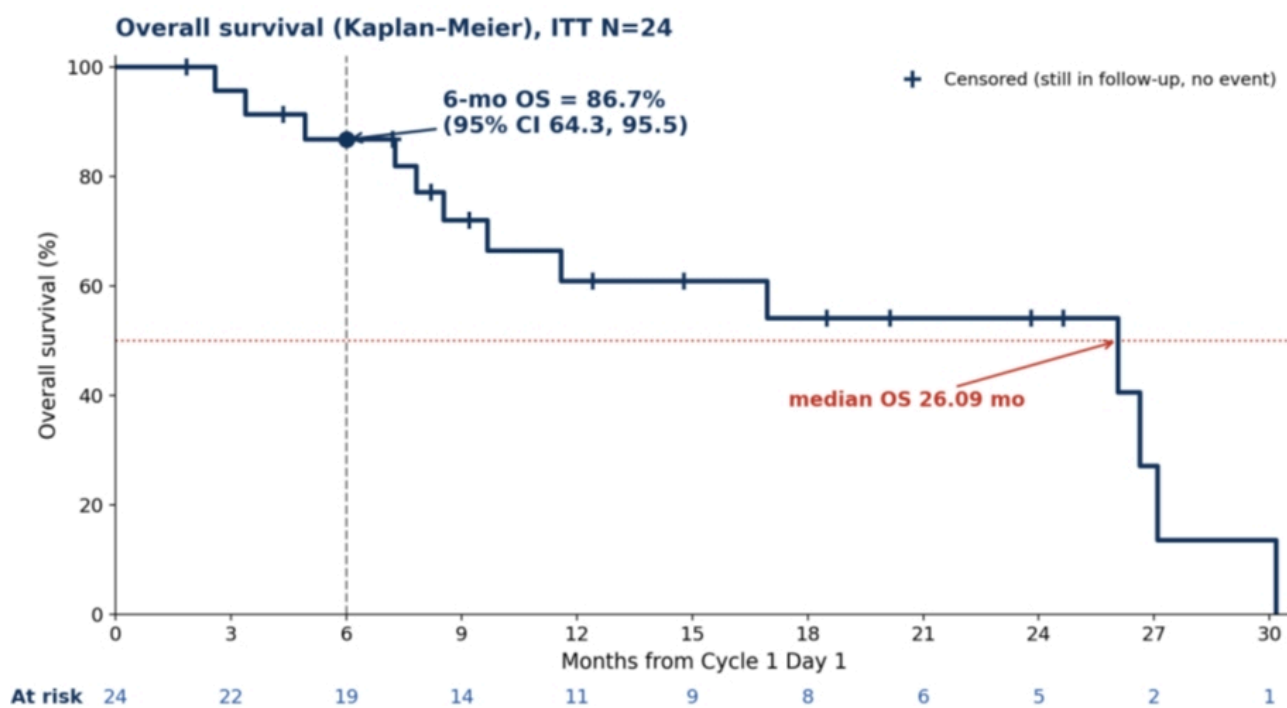
We note that the trial protocol as written used the original RANO criteria for PFS-6, which only delivered a PFS-6 of 25.8% and a nonsignificant $p=0.276$, but when applying the new RANO 2.0 criteria, which is valid since these criteria will be used going forward, the 49% PFS-6 was achieved. RANO 2.0 criteria are considered more forgiving than the original 2010 RANO criteria when calculating PFS-6 primarily because it changes how treatment-related changes are handled in the first few months. Under original RANO, false-positive growth would trigger disease progression, thereby counting as a treatment failure before six months, but RANO 2.0 avoids this. Radiation and chemotherapy typically cause inflammation and breakdown of the blood-brain barrier by four to six weeks, showing up as increased contrast enhancement on a scan that is frequently misidentified as early disease progression. RANO 2.0 criteria mandate a confirmatory scan at least four weeks later if an increase in tumor size ($\geq 25\%$ in 2D area or $\geq 40\%$ in volume) occurs within the first 12 weeks post-radiotherapy, and if the subsequent scan shows the tumor has stabilized or shrunk, the initial judgement of disease progression is downgraded to stable disease, whereas the original RANO criteria would have scored the patient as a progression event.

Figure 7: PFS results from NEO100 Phase 2a trial



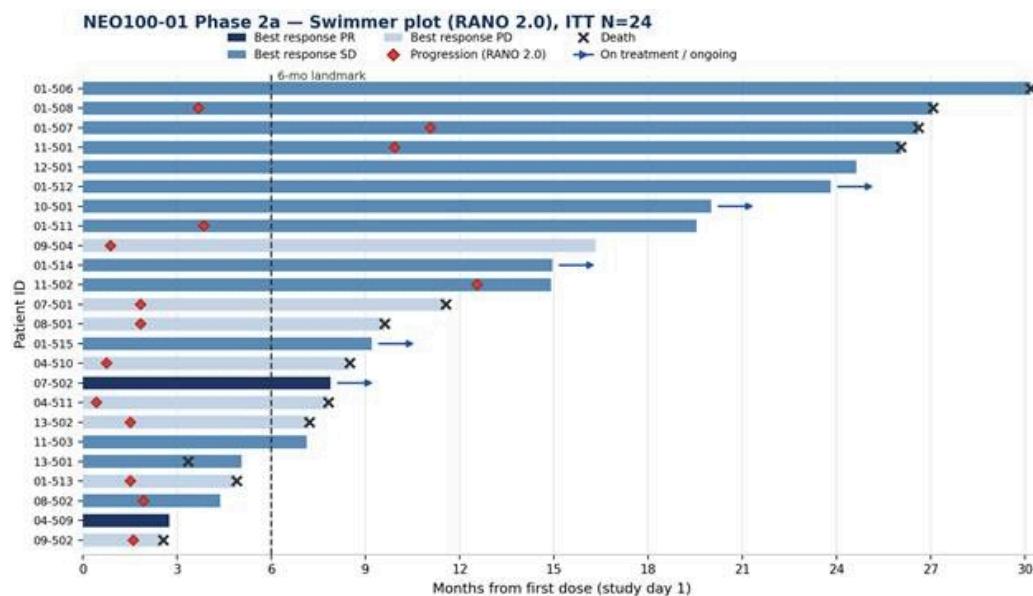
Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

Figure 8: OS results from NEO100 Phase 2a trial



Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

Figure 9: Swimmer plot analysis of NEO100 Phase 2a trial



Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

Preclinical results with POH

POH's antitumor activity overlaps with signaling pathways affected by the Bcr/Abl tyrosine kinase, and thus the antileukemia activity of POH was evaluated *in vitro*. Since Bcr/Abl tyrosine kinase is known to protect leukemia cells from apoptosis that would have otherwise been caused by the removal of growth factors or by cytotoxic agents and ionizing irradiation, inhibiting Bcr/Abl signaling pathways should block the ability of the Bcr/Abl tyrosine kinase to protect tumor cells from apoptosis. POH was able to selectively induce G0/G1 arrest followed by apoptosis in Bcr/Abl-transformed, but not in non Bcr/Abl-transformed myeloid cell lines, thereby supporting one of the ways in which POH has antitumor activity. At the very least, POH activates an apoptotic pathway that is not protected by Bcr/Abl signaling pathways.

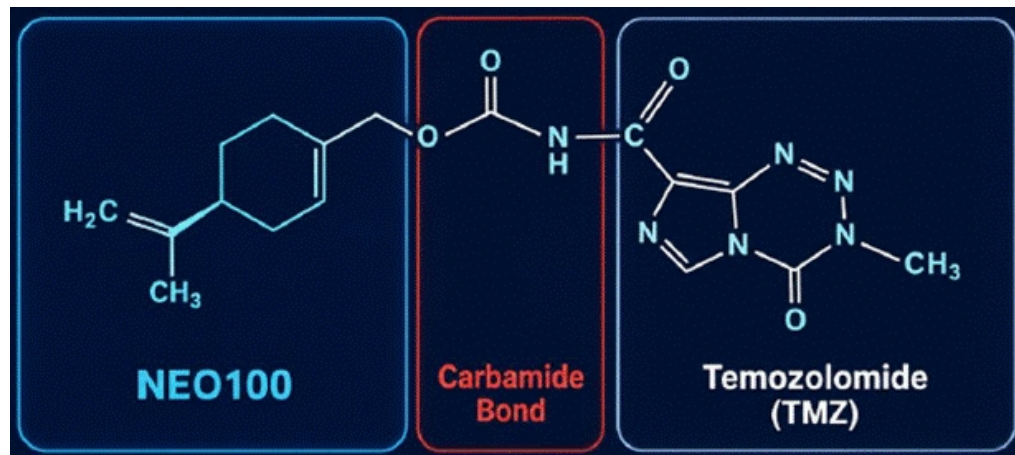
POH was also evaluated in inhibiting liver tumor growth. In an *in vivo* model, diethylnitrosamine was used to induce liver tumors in rats, which were then either treated or not treated with POH. The mean liver tumor weight for the treated rats after 19 weeks of POH treatment was 90% lower compared to untreated rats, specifically by increasing apoptosis by about ten-fold, rather than reducing tumor cell growth. Since mRNA levels for the mannose 6-phosphate/insulin-like growth factor II receptor and the TGF-beta type I, II, and III receptors were significantly increased in the liver tumors of POH-treated animals when compared to the corresponding receptor mRNA levels in the tumors of untreated animals, it can be inferred that POH does not promote the formation of liver tumors, but rather inhibits liver tumor growth by enhancing tumor cell loss through apoptosis.

NEO212 description and rationale

NEO212 is simply NEO100 covalently linked to temozolomide via a carbamide linker (Figure 10) and the drug will initially be evaluated in recurrent GBM as both oral and intranasal, with the oral formulation being preferentially developed. NEO212 is dosed as temozolomide is typically administered, which is five days on and 23 days off, rather than NEO100's four times daily dosing every day, to best align with the optimized temozolomide dosing schedule. Given that MGMT is the main temozolomide-resistance factor in the roughly 40-50% of recurrent GBM patients that actively express MGMT (i.e., temozolomide kills tumor cells by adding a methyl group to DNA at the 6 position of guanine to promote DNA damage and thus inhibit tumor cell division, but MGMT, if actively expressed, directly removes this methyl group, thereby repairing the DNA), it is noteworthy that preclinically NEO212 has been shown to degrade MGMT, thereby allowing its conjugated temozolomide to function in patients formerly resistant to temozolomide. The specific structural conjugation of NEO212 triggers the rapid downregulation of MGMT by routing the protein through the proteasome, thus when cancer cells are treated with NEO212, it induces proteasome-dependent degradation, effectively depleting the cell's pool of MGMT. Preclinical studies have shown that the superior pharmacokinetics of NEO212 allow it to achieve a three-fold higher brain to serum ratio of temozolomide than standard temozolomide (Figure 12), and to favor temozolomide accumulation in brain tumor cells over healthy brain cells (Figure 13). NEO212's enhanced trafficking to brain tumor tissue seen preclinically should reduce systemic toxicity and myelosuppression and reduce MGMT-driven resistance to temozolomide. Simply increasing delivery to the CNS via the amphipathicity of the POH component of NEO212 allows for lower dosing with NEO212 than with temozolomide to achieve the same antitumor effect. Therefore,

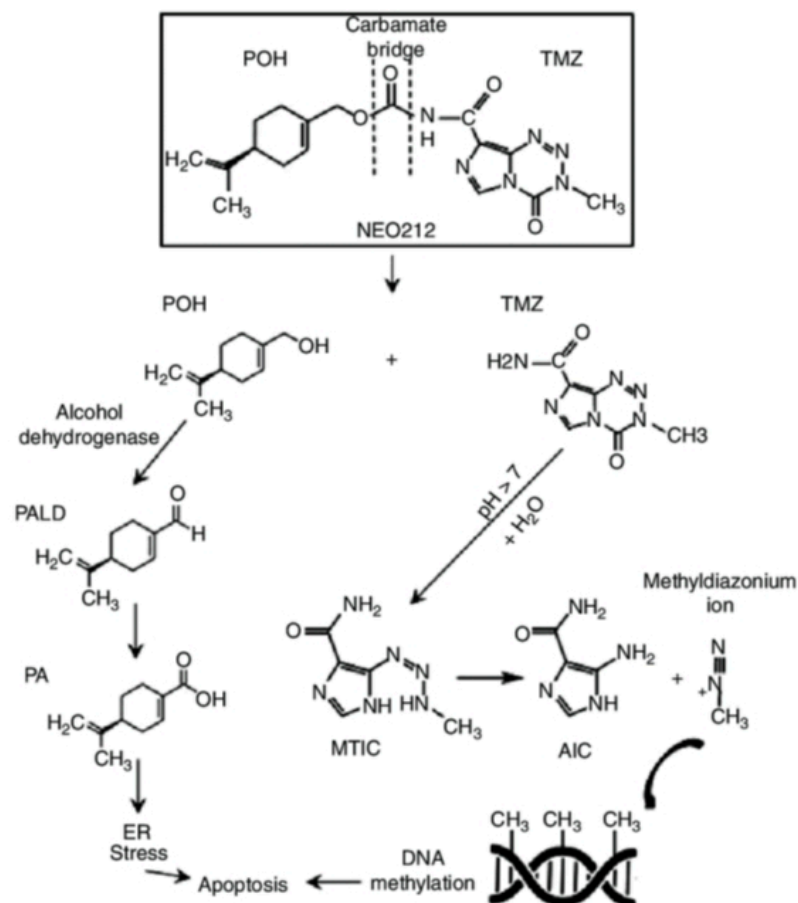
NEO212 combines superior trafficking to tumor cells with delivery of a more effective temozolomide along with POH, potentially enabling patients limited by temozolomide's myelosuppression to safely continue DNA alkylator therapy, and appears to be more effective than combination therapy with POH and temozolomide as separate drugs. Given that about 75% of patients taking temozolomide progress within a year, NEO212 can potentially offer these patients an effective treatment option. NEO212 has Orphan Drug Status for glioma, brain metastases from breast cancer, and nasopharyngeal carcinoma.

Figure 10: NEO212 chemical structure



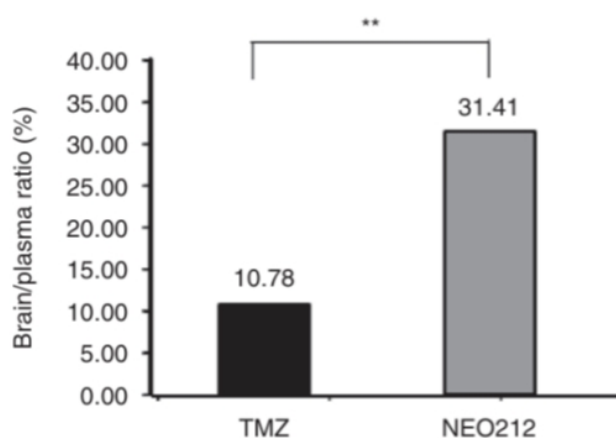
Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

Figure 11: NEO212 – a hybrid therapy having two mechanisms of action



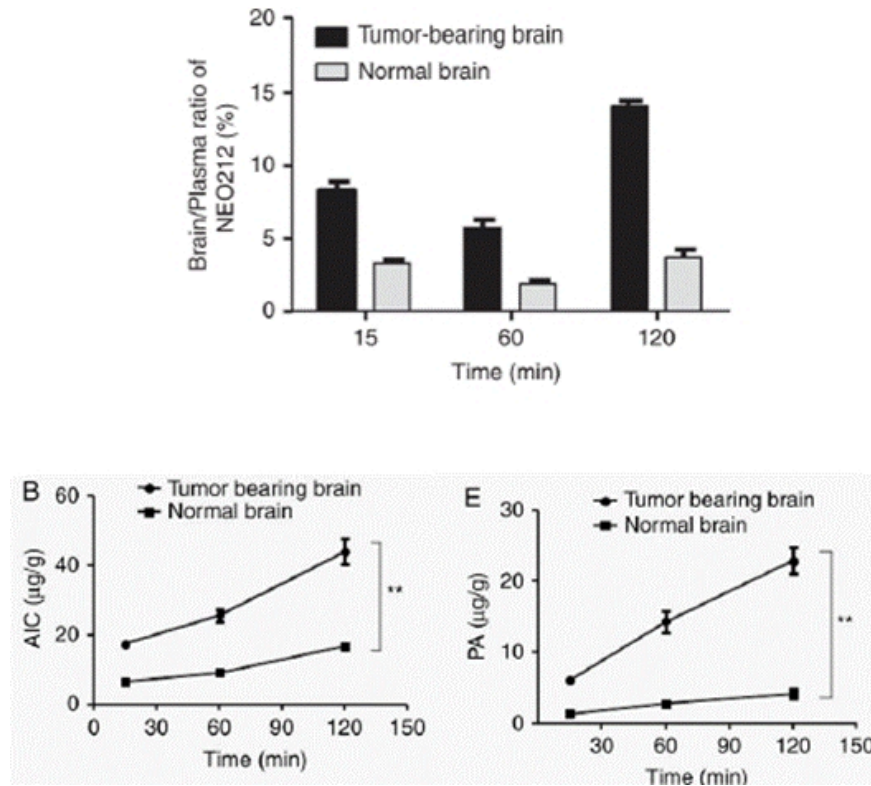
Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

Figure 12: NEO212 achieves a higher brain- to-serum ratio than temozolomide



Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

Figure 13: NEO212 and its metabolites preferentially accumulate in brain tumor tissue

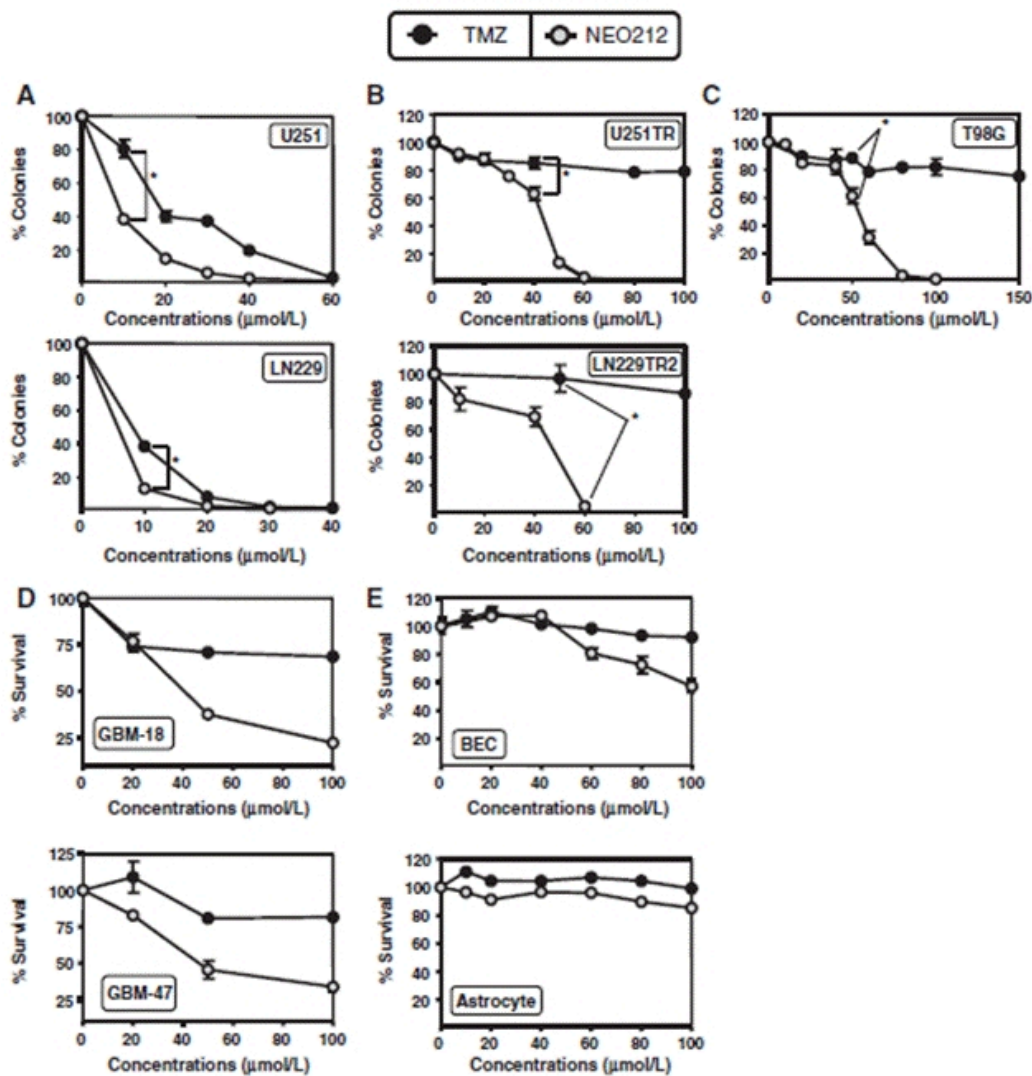


Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

NEO212 kills temozolomide-resistant tumor cells and outperforms its combined components

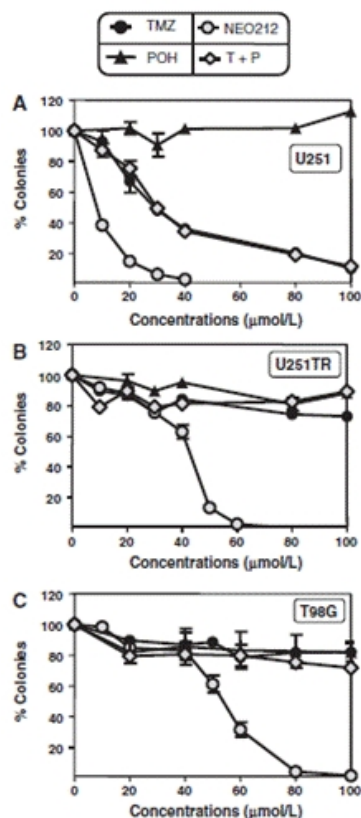
As shown in Figure 14, NEO212 and temozolomide perform similarly, as expected, when given to temozolomide-sensitive cells (U251 and LN229), but NEO212 significantly outperforms temozolomide when given to temozolomide-resistant cells (U251TR and LN229TR). Even more impressive is NEO212's superior performance versus temozolomide against the MGMT-positive temozolomide-resistant glioma cell line T98G, underscoring NEO212's ability to inhibit MGMT from repairing DNA breaks. Cells GBM-18 and GBM-47 are primary tumor cells isolated from GBM patients, against which NEO212 again outperforms temozolomide, but both agents similarly have no significant killing effect on healthy brain cells (BEC and astrocyte), as expected. As shown in Figure 15, NEO212 is superior to temozolomide, POH, and a mixture of the two drugs in temozolomide-sensitive cells (U251), temozolomide-resistant cells (U251TR), and MGMT-positive temozolomide-resistant glioma cells (T98G). Taken together, these results give us a reasonable amount of confidence that a controlled clinical trial with NEO212 in patients that have progressed post-temozolomide will highlight the benefits of this novel treatment and its favorable safety profile.

Figure 14: NEO212 kills temozolomide-resistant cells



Source: *Mol Cancer Ther*; 13(8); 2004–17. _2014 AACR.

Figure 15: NEO212 antitumor activity is superior to the activity of its individual parts



Source: *Mol Cancer Ther*; 13(8); 2004–17. _2014 AACR.

NEO212 Phase 1 results

A Phase 1 trial with NEO212 enrolled 14 patients, 11 that were recurrent GBM IDH1-wildtype, and three that had other solid tumors that metastasized to the brain. For the 11 recurrent GBM patients, two were MGMT+, eight were MGMT-, and one had indeterminate MGMT status. NEO212 was given to five escalating dose cohorts at doses ranging from 170 to 810mg/day. Regarding safety, there was no clinically meaningful myelosuppression, hepatic toxicity, or renal toxicity observed. Evaluation of systemic exposure showed that NEO212 led to a 39-fold reduction in a temozolomide metabolite called 4-amino-5-imidazole carboxamide, compared to equimolar doses of temozolomide, which explains NEO212's superior systemic safety profile. The Phase 1 trial was primarily intended to determine safety, tolerability, maximum tolerated dose, and a recommended Phase 2 dose, and not formally assess efficacy. However, one patient (recurrent GBM IDH1-wildtype, MGMT) had a partial response, which we find to be noteworthy because this patient previously progressed after receiving six cycles of temozolomide. Another patient (NSCLC metastasized to brain) that appeared to have substantial tumor reduction after seven cycles of NEO212 actually achieved prolonged disease control. No more efficacy results were shared from this trial outside these two patients. The trial defined the maximum tolerated dose of 810mg, given the occurrence of two dose-limiting toxicity events, and therefore the recommended Phase 2 dose of 610mg was selected for further evaluation in recurrent GBM, with 400mg chosen as the go forward initial dose in patients with brain metastases from other solid tumors. The lower 400mg dose would be used to evaluate the safety of combining NEO212 with various standards of care in three non-randomized patients, and if none have a dose limiting toxicity, the next three receive 610mg NEO212 plus standard of care. If only one of those three have a dose limiting toxicity at 610mg, then that group will be expanded by six patients, but if two or three have a dose limiting toxicity, NTHI will proceed with the 400mg dose of NEO212 plus standard of care. All subsequently randomized patients would receive 610mg NEO212 along with standard of care if the combination therapy is safe at 610mg, or a lower NEO21 dose if so dictated by dose limiting toxicity. The planned Phase 3 NEO212 trial described below would enroll patients with recurrent IDH1-wild-type GBM and recurrent grade 4 IDH1-mutant astrocytoma (NEO212 versus standard of care), and advanced solid tumors with brain metastases (NEO212 plus standard of care versus standard of care alone).

In late 2Q26, the UAE's Department of Health granted IND status to NEO212, potentially allowing NTHI to conduct a Phase 2 trial in the country while continuing Phase 3 discussions with the FDA, thereby accelerating clinical development. NTHI is also pursuing further clinical development of NEO100 in the UAE.

In early 3Q26, NTHI received written FDA feedback concerning the CMC development program for NEO212, which was clear enough for the company to cancel its July 2026 Type B end-of-Phase 1 meeting with the agency. The feedback specified (1) that NTHI's proposed approach to CMC development appears reasonable, while identifying additional comparative assessments that may be required if the drug-substance manufacturing process or physical characteristics change during development, (2) that the general drug-product development plan may proceed in parallel with NTHI's planned late-stage clinical program, subject to the development and submission of appropriate supporting data, (3) that a staged stability program supporting clinical development, followed by registration stability studies, is a commonly accepted approach, (4) that the transition from the current capsule formulation to a tablet formulation should be supported by an *in vivo* relative bioavailability study, and (5) that the FDA identified CMC work to be completed before representative tablet material is used in a confirmatory clinical trial, including finalization of the tablet formulation and manufacturing process, manufacture of at least one GMP batch, establishment of appropriate in-process controls, solid-state and particle-size characterization, and development of an appropriate dissolution method. NTHI will incorporate the feedback into its NEO212 development plan.

Phase 3 trials for NEO100 and NEO212 that NTHI will request of the FDA

NTHI intends to be able to conduct a single, open-label Phase 3 trial for each drug, expected to start by YE26 should the company persevere in its end-of-Phase 2 Type B meeting with the FDA and be allowed to proceed directly to Phase 3. Successful interim analysis of overall response rate at 50% enrollment, as long as there is no survival detriment, would be expected to drive accelerated approval and a successful final overall survival analysis to drive subsequent full approval. The FDA could of course request more Phase 2 data, but the risk/reward ratio thus far appears to be strikingly positive, in our view, to allow Phase 3 development as the next step. The NEO100 Phase 3 trial would likely enroll about 120 recurrent IDH1-mutant grade 4 astrocytoma (a subset of glioma) patients randomized 2:1 to either 1,152mg NEO100 or physician's choice (most likely lomustine, procarbazine/lomustine/vincristine, or a rechallenge with temozolomide). The NEO212 Phase 3 trial would enroll about 360 total patients (recurrent IDH1-wild-type GBM, recurrent IDH1-mutant grade 4 astrocytoma, and brain metastasis). The GBM and astrocytoma patients would be randomized 2:1 to receive either 610mg NEO212 or the same physician's choice regimen to be used in the NEO100 Phase 3 trial. The brain metastases portion of the NEO212 trial would combine NEO212 with whatever standard of care is best suited to the patient's primary solid tumor and brain metastases, versus that standard of care alone, but only after a non-randomized lead-in study with 12 brain metastasis patients all taking 400mg or 610mg NEO212 plus standard of care to first confirm the safety of the drug combination. Confirmed CNS tumor response from a blinded central reviewer along with no evidence of a survival detriment would be the accelerated approval primary endpoint, with overall survival as the full approval primary endpoint. Standard of care in the NEO100 trial would be expected to yield a median overall survival of six-to-nine months, and we would expect NEO100 to significantly beat that. Likewise, we would expect NEO212 to restore temozolomide sensitivity in enough patients to outperform the expected lackluster results with standard of care. These trials would be conducted at about 40 sites, 30 of which would be in the U.S., with the other 10 in the Middle East (Israel and the UAE), and cost a total of about \$50 million. Should NTHI secure about \$25 million instead of \$50 million, we would expect the company to prioritize the NEO100 trial and the NEO212 trial in recurrent IDN1-wild-type GBM.

Markets targeted by NTHI represent a true unmet medical need

Standard front-line therapy for GBM consists of surgical resection (if possible) followed by repeated radiation and temozolomide, but median PFS is about seven months, with about 75% of patients progressing by one year from initiating treatment. After progression, median survival is a paltry six to nine months. A large factor contributing to these unimpressive results is that temozolomide is administered regardless of the patient's MGMT status, which can significantly affect the treatment outcome, as described above. Temozolomide use is also restricted by grade 3/4 myelosuppression in about 15-20% of patients from branded Temodar, but that percentage is even higher among the numerous generic versions. When patients progress after initial therapy, the options are not that effective, as can be seen in Figure 16, allowing NEO212 to address a dire unmet need, if approved. NEO212 has already been shown to deliver highly encouraging Phase 1 results in recurrent GBM and looks to be able to restore sensitivity to its temozolomide component without promoting myelosuppression or other serious adverse effects.

Figure 16: Competing therapy in second-line recurrent brain tumors

Therapy	Median OS (mo)	OS-12 (%)	Key Trial Context
CCNU (lomustine) alone	5.6–8.6	~20–35%	REGOMA (~20%); EORTC 26101 (~30–35%)
Bevacizumab (Avastin) alone	~9.2	~38–43%	BRAIN Trial
CCNU + Bevacizumab*	~9.1	~35–40%	EORTC 26101
TTFIELDS alone	~6.6	~20–25%	EF-11

Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

With respect to NEO100, NTHI is specifically targeting recurrent IDH1-mutant grade 4 glioma, where it can be seen in Figure 17 that the clinical results are not encouraging and thus represent an open market for a more effective agent, especially one with NEO100's highly favorable safety profile.

Figure 17: Recurrent grade 3/4 brain tumors represent a significant market opportunity

Trial (agent)	Grade 3–4 studied?	Grade 3–4 result	Implication
INDIGO (vorasidenib)	No — grade 2 only	Not studied (mPFS 27.7 mo in grade 2)	Recurrent grade 3–4 unaddressed
STELLAR (eflornithine + lomustine)	Yes — IDH-mut & IDH-wt gr 4	No benefit in grade 4 (OS HR ~1.5); IDH-wt gr4 PFS 3.4 vs 6.8 mo	Grade 4 remains an open failure
Salvage chemo / anti-angiogenics	Recurrent HGG	Median OS ~6–9 mo; low ORR; PFS ≠ OS	No durable survival benefit
NEO100 — Phase 2a	Yes — IDH-mut gr 3–4 (21/24 gr4)	Median OS 26.09 mo; OS-12 60.9%	Durable OS where others fail

Source: NeOnc Technologies Holdings, Inc. corporate presentation September 2026

Intellectual property

NTHI has exclusively licensed a large worldwide patent portfolio from USC consisting of both issued patents and pending patent applications related to NEO100, NEO212 and other products from NTHI's patent family for multiple uses, including oncological and neurological conditions. In the U.S., NTHI has exclusive rights to 28 issued patents and 14 pending patent applications. Internationally, NTHI has 65 patents issued and 28 patent applications pending. The patent families of NTHI's drug candidates are shown in the table below. All patents are owned by USC and exclusively licensed to NTHI from USC, with patent term extension potentially available on certain patents after product approval.

Figure 18. NTHI's patent families licensed from USC

Product Candidate	Title [description]	US Application #	US Patent	Expiration Date	Foreign Counterparts
NEO100	Pharmaceutical Compositions Comprising Monoterpenes [Ultra Pure]	13/040,059 13/939,834 14/817,286 14/843,097 15/040,002 15/220,135 16/575,587 17/749,293	8,507,734 ^{1,2} 9,133,085 ¹ 9,480,659 ¹ 9,498,448 ¹ 9,700,524 ³ 10,457,618 ¹ 10,899,691 ¹ Pending ³	8/29/2031 6/5/2031 3/3/2031 3/3/2031 3/3/2031 3/3/2031 3/3/2031 3/3/2031*	Canada, China, China, EU (France, Germany, United Kingdom, Ireland, and Italy)
NEO212	Pharmaceutical Compositions Comprising POH Derivatives [POH conjugated to temozolomide (TMZ)]	13/566,731 14/455,371 13/818,972 15/408,866	8,916,545 ² 9,580,372 ³ 9,499,461 ^{1,2,3} 10,092,562 ³	8/26/2031 8/26/2031 8/26/2031 8/26/2031	Brazil, China, EU (Germany, Spain, France, United Kingdom, Switzerland, Ireland, Italy, Netherlands, Sweden), Japan, Hong Kong
NEO 214	Pharmaceutical Compositions Comprising POH Derivatives [POH conjugated to rolipram]	16/123,729 16/388,535 17/306,167	11,077,104 ³ 11,013,804 ² pending ^{2,3}	8/26/2031 8/26/2031 8/26/2031*	Japan, EU (Spain, France, United Kingdom, Ireland, Italy, Netherlands, Sweden)
NEO 216	Pharmaceutical Compositions Comprising POH Derivatives and Methods of Use [POH conjugated to valproic acid]	16/606,520 18/150,933	11,559,508 ² pending ³	11/24/2038 4/18/2038*	China, EU (pending in both)
NEO 218	A Perillyl Alcohol-3-Bromopyruvate Conjugate and Methods of Treating Cancer [POH conjugated to 3- Bromopyruvate]	16/465,081	10,858,305 ^{1,2,3}	11/29/2037	China, EU, Japan (pending in all)
NEO 400	Pharmaceutical Compositions Comprising POH Derivatives [POH conjugated with linoleic acid (LA)]	17/251,452 17/313,258 17/573,693	pending ³ pending ³ pending ²	8/26/2031* 8/26/2031* 8/26/2031*	China, EU (pending in both)
NEO 412	Pharmaceutical Compositions Comprising Perillyl Alcohol Derivatives [Triple conjugation of perillyl alcohol, linoleic acid, and temozolomide]	15/041,743 16/126,586	9,522,918 ^{1,2} 10,696,680 ³	2/11/2036 2/11/2036	Australia, China, EU (Germany, France, United Kingdom, Ireland), Japan

¹ Method of making pharmaceutical composition

² Pharmaceutical composition

³ Method of using pharmaceutical composition

* 20 years from the earliest filing date, subject to patent term adjustment

Source: NeOnc Technologies Holdings, Inc. 2025 10-K filed on March 31, 2026

Financial discussion – expecting profitability in 2030

We forecast NEO100 penetrating about 45% of the U.S. recurrent high-grade glioma market by 2033, which would have an annual incidence of about 3,000 cases by then¹. We assume a \$540,000 price per year of therapy, based on the monthly price for glioma drug Voranigo (vorasidenib). We grow the price of NEO100 at 3% per year from launch in 2029.

Taking together our projected growth in both the annual recurrent high-grade glioma patient incidence and NEO100 price, the total addressable annual U.S. market for NEO100 in this indication alone would be about \$1.8 billion, and our 45% market penetration estimate yields peak U.S. revenue of almost \$800 million in 2033. We model NTHI receiving a 25% royalty on U.S. sales, as we assume that the product is partnered prior to commercialization. Our valuation also includes NEO100 commercialization in the largest six E.U. commercial markets, where we also project an annual incidence of about 3,000 cases and a \$324,000 price per year of therapy. Our 2033 EU6 market penetration estimate of 39% yields about \$357 million in revenue, from which we project NTHI to receive a 15% royalty. The aging baby boomer generation inclines us to grow the incidence of recurrent high-grade glioma at a higher rate than the growth of the general population.

We forecast NEO212 penetrating about 42% of the U.S. recurrent GBM market by 2033, which will have an annual incidence of about 12,000 cases by then². We assume a \$240,000 price per year of therapy, based on the monthly price for recurrent GBM drug Gleostine (lomustine). We grow the price of NEO212 at 3% per year from launch in 2030.

Taking together our projected growth in both the annual recurrent GBM patient incidence and NEO212 price, the total addressable annual U.S. market for NEO212 in this indication alone would be about \$3.4 billion, and our 42% market penetration estimate yields peak U.S. revenue of about \$1.4 billion in 2033. We model NTHI receiving a 25% royalty on U.S. sales, as we assume that the product is partnered prior to commercialization. Our valuation also includes NEO212 commercialization in the largest six E.U. commercial markets in recurrent GBM, where we also project an annual incidence of about 12,000 cases and a \$144,000 price per year of therapy. Our 2033 EU6 market penetration estimate of 30% yields about \$534 million in revenue, from which we project NTHI to receive a 15% royalty. The aging baby boomer generation inclines us to grow the incidence of recurrent GBM at a higher rate than the growth of the general population.

NTHI owes a 2% or 4% royalty on any net product sales to USC, depending upon the licensed technology used in creating the product. As we project NEO100 sales for only recurrent IDH1-mutant grade 4 astrocytoma and NEO212 sales for only recurrent IDH1-wild-type GBM to be more conservative in our valuation, successful commercialization of these drugs in other indications, such as brain metastases from non-CNS primary tumors, meningioma, or pediatric high-grade glioma would constitute potential upside to our revenue projections. We have taken this valuation approach to underscore how NTHI is still a compelling story if NEO100 and NEO212 are a commercial success in one indication each.

Since we model NTHI to conduct its pivotal trials prior to licensing its assets to a commercial partner, we have grown our projected R&D expense from its current \$10 million annual run rate to \$36-38 million annually over the next three years to incorporate the cost of pivotal trials. We grow our projected G&A expense at a mid-single-digit rate, given our expectation that NTHI will not have to build out commercial manufacturing and a sales force.

Factors that could impede the achievement of our price target include, but are not limited to: (1) failure and/or setbacks of pipeline candidates in clinical trials; (2) failure of pipeline candidates to gain regulatory approval; and (3) smaller than projected commercial opportunity due to changes in market size, competitive landscape, and product pricing and reimbursement. For our revenue build, income statement, and discounted cash flow valuation, please see pages 19-21.

Bibliography

1. <https://practicalneurology.com/diseases-diagnoses/neuro-oncology/idh-mutant-glioma-clinical-insights-and-emerging-directions/60891/>
2. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10487236/>

NeOnc Technologies Holdings, Inc. - Revenue Build

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NEO100 Revenue Build in IDH1-mutant high-grade glioma

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U.S. recurrent high-grade glioma market	2028E	2029E	2030E	2031E	2032E	2033E
Incidence of recurrent high-grade glioma (000)		2.8	2.9	2.9	2.9	3.0
Percent market penetration		5.0%	20.0%	30.0%	37.5%	45.0%
Number of patients treated (000)		0	1	1	1	1
Annual NEO100 net price		\$540,000	\$556,200	\$572,886	\$590,073	\$607,775
Annual NEO100 net revenue to potential U.S. partner (000)		\$76,623	\$318,844	\$497,541	\$646,989	\$807,676
Royalty rate to NTHI		25%	25%	25%	25%	25%
U.S. NEO100 royalty revenue to NTHI (000)		\$19,156	\$79,711	\$124,385	\$161,747	\$201,919

EU6 recurrent high-grade glioma market	2028E	2029E	2030E	2031E	2032E	2033E
Incidence of recurrent high-grade glioma (000)			2.8	2.8	2.8	2.8
Percent market penetration			5.0%	15.0%	30.0%	39.0%
Number of patients treated (000)			0	0	1	1
Annual NEO100 net price			\$324,000	\$324,000	\$324,000	\$324,000
Annual NEO100 net revenue to potential EU6 partner (000)			\$45,075	\$135,901	\$273,161	\$356,885
Royalty rate to NTHI			15%	15%	15%	15%
EU6 NEO100 royalty revenue to NTHI (000)			\$6,761	\$20,385	\$40,974	\$53,533
Total NEO100 royalty revenue to NTHI (000)		\$19,156	\$86,472	\$144,770	\$202,722	\$255,452

NEO212 Revenue Build in recurrent GBM

U.S. recurrent GBM market	2028E	2029E	2030E	2031E	2032E	2033E
Incidence of recurrent GBM (000)			12	13	13	13
Percent market penetration			5.0%	17.5%	35.0%	42.0%
Number of patients treated (000)			0.62	2.21	4.46	5.40
Annual NEO212 net price			\$240,000	\$247,200	\$254,616	\$262,254
Annual NEO212 net revenue to potential U.S. partner (000)			\$149,734	\$545,191	\$1,134,324	\$1,416,044
Royalty rate to NTHI			25%	25%	25%	25%
U.S. NEO212 royalty revenue to NTHI (000)			\$37,434	\$136,298	\$283,581	\$354,011

EU6 recurrent GBM market	2028E	2029E	2030E	2031E	2032E	2033E
Incidence of recurrent GBM (000)			12	12	12	12
Percent market penetration			4.0%	12.0%	24.0%	30.0%
Number of patients treated (000)			0.5	1.5	3.0	3.7
Annual NEO212 net price			\$144,000	\$144,000	\$144,000	\$144,000
Annual NEO212 net revenue to potential EU6 partner (000)			\$70,117	\$211,402	\$424,917	\$533,802
Royalty rate to NTHI			15%	15%	15%	15%
EU6 NEO212 royalty revenue to NTHI (000)			\$10,517	\$31,710	\$63,738	\$80,070
Total NEO212 royalty revenue to NTHI			\$47,951	\$168,008	\$347,318	\$434,081

Source: SEC filings, company press releases, and ROTH Capital Partners

NeOnc Technologies Holdings, Inc.

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Income Statement

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Fiscal Year ends December

(in \$000, except per share items)

	2024A	1Q25	2Q25	3Q25	4Q25	2025A	1Q26A	2Q26A	3Q26E	4Q26E	2026E	2027E	2028E	2029E	2030E	2031E	2032E	2033E
Revenue	83	40				40					-	-	-	19,156	134,423	312,778	550,040	689,533
Total Revenue	83	40	-	-	-	40	-	-	-	-	-	-	-	19,156	134,423	312,778	550,040	689,533
R&D	3,045	998	677	715	1,248	3,638	1,286	2,650	3,180	7,472	14,588	36,469	37,928	38,307	24,900	17,430	17,604	17,780
Legal & professional fees	2,001	958	520	276	727	2,481	1,188	1,286	1,300	1,300	5,074	5,000	2,500					
G&A	1,680	849	984	903	2,081	4,818	489	896	949	968	3,302	3,500	3,710	3,933	4,168	4,419	4,684	4,965
Stock comp & Advisory fees	500	29,136	3,526	5,040	9,641	47,343	4,092	9,238	3,500	4,000	20,831							
Total Operating Expenses	7,226	31,941	5,708	6,935	13,697	58,280	7,056	14,070	8,929	13,740	43,795	44,969	44,138	42,240	29,068	21,848	22,288	22,745
Operating income	(7,143)	(31,901)	(5,708)	(6,935)	(13,697)	(58,240)	(7,056)	(14,070)	(8,929)	(13,740)	(43,795)	(44,969)	(44,138)	(23,084)	105,355	290,930	527,752	666,788
Other income (expense)	(4,756)	(425)	28	(1,681)	(1,827)	(3,906)	(1,764)	(170)			(1,934)	(2,128)	(2,341)	500	750	1,125	1,688	2,531
Net income (pretax)	(11,898)	(32,326)	(5,680)	(8,616)	(15,524)	(62,146)	(8,820)	(14,240)	(8,929)	(13,740)	(45,729)	(47,097)	(46,479)	(22,584)	106,105	292,055	529,440	669,319
Income tax expense (benefit)						-					-			-	22,282	61,332	111,182	140,557
Net income	(11,898)	(32,326)	(5,680)	(8,616)	(15,524)	(62,146)	(8,820)	(14,240)	(8,929)	(13,740)	(45,729)	(47,097)	(46,479)	(22,584)	83,823	230,723	418,257	528,762
EPS basic	(0.69)	(1.78)	(0.30)	(0.45)	(0.73)	(3.20)	(0.38)	(0.58)	(0.34)	(0.47)	(1.77)	(1.34)	(1.10)	(0.51)	1.81	4.73	8.17	9.84
EPS diluted	(0.69)	(1.78)	(0.30)	(0.45)	(0.73)	(3.20)	(0.38)	(0.58)	(0.34)	(0.47)	(1.77)	(1.34)	(1.10)	(0.51)	1.70	4.47	7.74	9.35
Basic shares outstanding	17,343	18,135	19,027	19,212	21,221	19,399	23,293	24,664	25,972	29,248	25,794	35,097	42,117	44,223	46,434	48,756	51,193	53,753
Diluted shares outstanding	17,343	18,135	19,027	19,212	21,221	19,399	23,293	24,664	25,972	29,248	25,794	35,097	42,117	44,223	49,257	51,579	54,016	56,576

Source: SEC filings, company press releases, and ROTH Capital Partners

NeOnc Technologies Holdings, Inc.
Discounted Cash Flow

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	12/31/2026	12/31/2027	12/31/2028	12/31/2029	12/31/2030	12/31/2031	12/31/2032	12/31/2033
EBITDA	(43,795)	(44,969)	(44,138)	(23,084)	105,355	290,930	527,752	666,788

TP date 9/23/2027

1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00

Discount rate	A	B						C					
	PV of CF's 2024 - 2033	PV of TV as a Multiple of Ebitda						Enterprise Value					
		2	3	4	5	6	7	2	3	4	5	6	7
10.0%	\$ 425,235	514,151	771,227	1,028,303	1,285,379	1,542,454	1,799,530	939,387	1,196,462	1,453,538	1,710,614	1,967,690	2,224,765
15.0%	\$ 268,346	329,640	494,460	659,279	824,099	988,919	1,153,739	597,986	762,806	927,626	1,092,446	1,257,266	1,422,085
20.0%	\$ 169,805	215,380	323,070	430,760	538,450	646,140	753,830	385,185	492,875	600,565	708,255	815,945	923,635
25.0%	\$ 107,000	143,192	214,788	286,383	357,979	429,575	501,171	250,191	321,787	393,383	464,979	536,575	608,171
30.0%	\$ 66,491	96,735	145,103	193,470	241,838	290,205	338,573	163,226	211,593	259,961	308,329	356,696	405,064
	D	Total Equity Value						Value Per Diluted Share					
	Net Debt	2	3	4	5	6	7	2	3	4	5	6	7
10.0%	(9,923)	949,310	1,206,385	1,463,461	1,720,537	1,977,613	2,234,688	\$27.05	\$34.37	\$41.70	\$49.02	\$56.35	\$63.67
15.0%	(9,923)	607,909	772,729	937,549	1,102,369	1,267,189	1,432,008	\$17.32	\$22.02	\$26.71	\$31.41	\$36.10	\$40.80
20.0%	(9,923)	395,108	502,798	610,488	718,178	825,868	933,558	\$11.26	\$14.33	\$17.39	\$20.46	\$23.53	\$26.60
25.0%	(9,923)	260,114	331,710	403,306	474,902	546,498	618,094	\$7.41	\$9.45	\$11.49	\$13.53	\$15.57	\$17.61
30.0%	(9,923)	173,149	221,516	269,884	318,252	366,619	414,987	\$4.93	\$6.31	\$7.69	\$9.07	\$10.45	\$11.82

	PV	2026	2027	2028	2029	2030	2031	2032	2033
NOPAT	\$ 425,235	\$ (32,904)	\$ (30,715)	\$ (27,406)	\$ (13,030)	\$ 42,630	\$ 107,109	\$ 176,666	\$ 202,885
	\$ 268,346	\$ (28,796)	\$ (25,711)	\$ (21,944)	\$ (9,980)	\$ 31,230	\$ 75,056	\$ 118,415	\$ 130,076
	\$ 169,805	\$ (25,344)	\$ (21,687)	\$ (17,738)	\$ (7,731)	\$ 23,184	\$ 53,397	\$ 80,734	\$ 84,989
	\$ 107,000	\$ (22,423)	\$ (18,419)	\$ (14,463)	\$ (6,051)	\$ 17,422	\$ 38,520	\$ 55,911	\$ 56,504
	\$ 66,491	\$ (19,934)	\$ (15,745)	\$ (11,888)	\$ (4,782)	\$ 13,239	\$ 28,146	\$ 39,282	\$ 38,172

	PV	2026	2027	2028	2029	2030	2031	2032	2033
EBITDA	\$ 566,624	\$ (32,904)	\$ (30,715)	\$ (27,406)	\$ (13,030)	\$ 54,064	\$ 135,721	\$ 223,818	\$ 257,076
	\$ 363,121	\$ (28,796)	\$ (25,711)	\$ (21,944)	\$ (9,980)	\$ 39,607	\$ 95,105	\$ 150,020	\$ 164,820
	\$ 234,536	\$ (25,344)	\$ (21,687)	\$ (17,738)	\$ (7,731)	\$ 29,403	\$ 67,661	\$ 102,282	\$ 107,690
	\$ 151,977	\$ (22,423)	\$ (18,419)	\$ (14,463)	\$ (6,051)	\$ 22,095	\$ 48,810	\$ 70,834	\$ 71,596
	\$ 98,240	\$ (19,934)	\$ (15,745)	\$ (11,888)	\$ (4,782)	\$ 16,790	\$ 35,665	\$ 49,767	\$ 48,368

Source: SEC filings, company press releases, and ROTH Capital Partners

Valuation: NeOnc Technologies Holdings, Inc. (NTHI)

Our 12-month price target of \$20 is based on a DCF analysis using a 20% discount rate applied to all cash flows and the terminal value, which is based on a 5x multiple of our projected 2033 operating income of \$667 million.

Factors that could impede the achievement of our price target include, but are not limited to: (1) failure and/or setbacks of pipeline candidates in clinical trials; (2) failure of pipeline candidates to gain regulatory approval; and (3) smaller than projected commercial opportunity due to changes in market size, competitive landscape, and product pricing and reimbursement.

Risks: NeOnc Technologies Holdings, Inc. (NTHI)

- **Clinical risk.** NTHI's clinical staged products could fail to deliver statistically significant results in late-stage clinical trials, substantially reducing the value of NTHI's product candidates and therefore our target price.
- **Regulatory risk.** Even if successful in the clinic, NTHI's products could fail to be approved by domestic and/or foreign regulatory bodies, which would reduce NTHI's value and therefore our target price.
- **Financing risk.** NTHI will need additional capital to fund its operations, and such financing may not occur or it could be substantially dilutive to existing investors.
- **Competitive risk.** For any future approved NTHI products, they may not be well adopted in a competitive marketplace, which would adversely affect NTHI's value and therefore our target price.
- **High stock price volatility.** This issue is common among small-cap biotechnology companies with relatively low trading volumes.

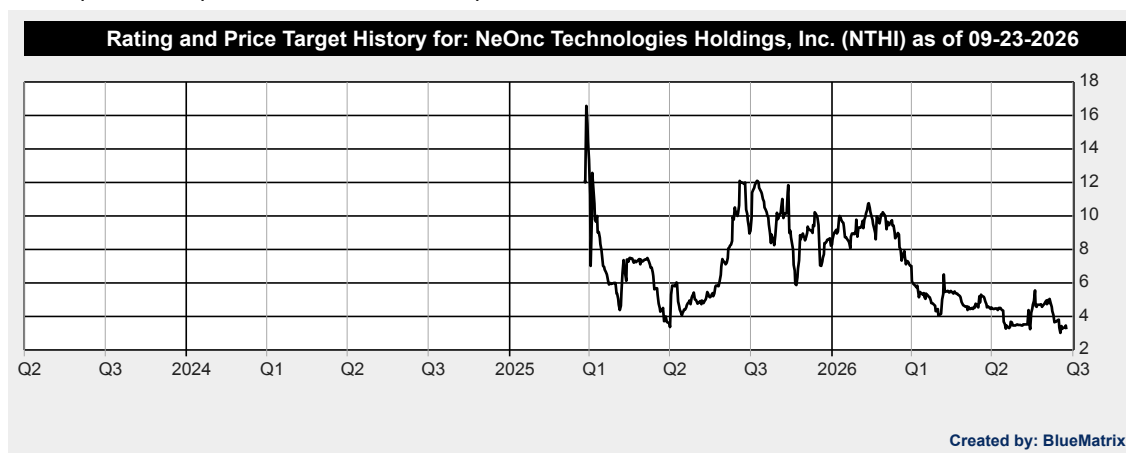
Company Description: NeOnc Technologies Holdings, Inc. (NTHI)

NeOnc Technologies Holdings, Inc. is a clinical-stage life sciences company focused on the development and commercialization of central nervous system therapeutics that are designed to address the persistent challenges in overcoming the blood-brain barrier. The company's NEO drug development platform has produced a portfolio of novel drug candidates and delivery methods with patent protections extending to 2038. These proprietary chemotherapy agents have demonstrated positive effects in laboratory tests on various types of cancers and in clinical trials treating malignant gliomas. NeOnc's NEO100 and NEO212 therapeutics are in Phase II human clinical trials and are advancing under FDA Fast-Track and Investigational New Drug (IND) status. The company has exclusively licensed an extensive worldwide patent portfolio from the University of Southern California consisting of issued patents and pending applications related to NEO100, NEO212, and other products from the NeOnc patent family for multiple uses, including oncological and neurological conditions.

Regulation Analyst Certification ("Reg AC"): The research analyst primarily responsible for the content of this report certifies the following under Reg AC: I hereby certify that all views expressed in this report accurately reflect my personal views about the subject company or companies and its or their securities. I also certify that no part of my compensation was, is or will be, directly or indirectly, related to the specific recommendations or views expressed in this report.

Disclosures:

Shares of NeOnc Technologies Holdings, Inc. may be subject to the Securities and Exchange Commission's Penny Stock Rules, which may set forth sales practice requirements for certain low-priced securities.



Each box on the Rating and Price Target History chart above represents a date on which an analyst made a change to a rating or price target, except for the first box, which may only represent the first note written during the past three years. **Distribution Ratings/IB Services** shows the number of companies in each rating category from which Roth or an affiliate received compensation for investment banking services in the past 12 months.

Distribution of IB Services Firmwide

Rating	Count	Percent	IB Serv./Past 12 Mos. as of September 24, 2026	
			Count	Percent
Buy [B]	404	77.54	114	28.22
Neutral [N]	70	13.44	6	8.57
Sell [S]	1	0.19	0	0
Under Review [UR]	46	8.83	15	32.61

Our rating system attempts to incorporate industry, company and/or overall market risk and volatility. Consequently, at any given point in time, our investment rating on a stock and its implied price movement may not correspond to the stated 12-month price target.

Ratings System Definitions - ROTH Capital employs a rating system based on the following:

Buy: A rating, which at the time it is instituted and or reiterated, that indicates an expectation of a total return of at least 10% over the next 12 months.

Neutral: A rating, which at the time it is instituted and or reiterated, that indicates an expectation of a total return between negative 10% and 10% over the next 12 months.

Sell: A rating, which at the time it is instituted and or reiterated, that indicates an expectation that the price will depreciate by more than 10% over the next 12 months.

Under Review [UR]: A rating, which at the time it is instituted and or reiterated, indicates the temporary removal of the prior rating, price target and estimates for the security. Prior rating, price target and estimates should no longer be relied upon for UR-rated securities.

Not Covered [NC]: ROTH Capital does not publish research or have an opinion about this security.

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