City of Hope

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January 27, 2026

Re: CIRM Board Meeting Public Statement

Dear CIRM Board,

My name is Christine Brown. I am a Professor at City of Hope in Duarte, California, and I lead a translational research program focused on clinically advancing CAR T cell therapies for solid tumors, with an emphasis on incurable brain tumors.

I want to thank the CIRM Board for the opportunity to speak today. My goal is to share three points based on recent experiences, because I am concerned that some of the new preference selection processes, however well-intended, may be drifting from CIRM's core purpose of accelerating therapies that change lives for Californians.

First, I would like to comment on the new pre-submission review process. I recently submitted a DISC4 pre-application that strongly aligned with all published CIRM preference topics, including neurological disease. The project proposed a cross-disciplinary systems biology approach to understand the complex immunobiology of brain tumors by interrogating unique patient samples from multiple brain tumor CAR-T cell clinical trials, including those developed and executed with CIRM funding. Despite this alignment, our pre-submission application was administratively triaged without evaluation comments. CIRM noted that only 24 of 138 applications were invited forward to full review. This raises questions as to the administrative criteria used, without independent scientific review, to select only 17% of the submitted applications. Providing greater transparency on the objective criteria used for administrative triage, including scoring algorithms, would allow teams to better align grant applications with CIRM priorities.

Second, I would like to comment on CIRM's prioritization of access and affordability. While affordability and accessibility are important, an affordable therapy that is not efficacious, or that is delayed by forced platform changes to fit CIRM's new priorities, such as non-viral gene editing, doesn't best serve CIRM's mission. For example, shifting a clinically validated program to an unvalidated engineering modality can slow timelines, raise costs, and add risk without improving patient outcomes. I respectfully request that the CIRM Board review whether current prioritizations may be unintentionally excluding proven modalities with demonstrated patient impact.

Third, I would like to comment on the important clinical impact CIRM has achieved. Our success in advancing CAR T cell therapies for incurable brain tumors would not have been possible without CIRM's partnership. Our project was the first CAR T cell therapy supported by CIRM. We treated our first patient within three years of a TRAN1 award; we demonstrated that CAR T cells can mediate a complete response against glioblastoma; and we have patients living years later because CIRM took that risk. My worry is that today, the same kind of clinically focused program would be administratively triaged without scientific review, a concern I am hearing broadly from my colleagues.

Thank you to the CIRM Board for your time and your consideration.

City of Hope

Sincerely,

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