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Dear Independent Citizens' Oversight Committee,

I would like to thank the Board as well as the CIRM staff for all your effort in guiding and executing the missions of CIRM. I am a California resident, a professor of Microbiology, Immunology & Molecular Genetics at UCLA, and a translational researcher who develops novel cell-based therapies for advanced cancers. I am writing today to bring to your attention an important consequence of the new preference system that is currently in place for PDEV and CLIN2. This is what Dr. Rosa Canet-Aviles described as "perception of modality bias" on slide 5 of the presentation scheduled to be delivered on January 29, 2026. I would like to discuss why this is not simply a perception but a reality.

I will focus this discussion on PDEV, but CLIN2 faces the same challenges. By virtue of listing specific preferences and triaging applications based on how many boxes one could check, the preference system effectively eliminates certain treatment modalities from consideration. For example, for an *ex vivo*, virally transduced CAR-T cell therapy—the same modality that has been approved by the FDA and has transformed treatment for cancers such as B-cell lymphoma and multiple myeloma—there are 3 preference boxes that can never be checked. These are: *in vivo*, non-viral, and pluripotent stem cells.

PDEV has a total of 6 preference boxes, so being categorically unable to check 3 of those boxes puts a therapy at a disadvantage that can never be overcome, regardless of how strong the science is.

Furthermore, if the therapy is for any non-CNS disease, even if it is for a significant unmet medical need—such as lung cancer or pancreatic cancer—then there is a 4th box that can never be checked. When 4 out of 6 boxes are denied, the maximum score is a 2, meaning such a therapy will never make it past triage based on statistics from the first two PDEV and CLIN2 cycles. I would like to emphasize that **we have not considered the scientific merit at all; instead, these applications are being blocked by simple box-checking arithmetic**.

If we look at the list of PDEV and CLIN2 applications that were funded in the first cycle, we see a complete absence of CAR-T cell therapies. In fact, there is **not a single funded project focusing on cancer**. As a personal example, I submitted a PDEV application on a CAR-T cell therapy for glioblastoma—a CNS cancer—and it was triaged without scientific review in both cycles. This application was a more advanced version of a proposal that **had been recommended by the CIRM Grants Working Group for TRAN1 funding in 2024**. The proposal was deemed scientifically meritorious, but it was not funded because the TRAN1 mechanism had exhausted its budget allocation. Since 2024, we have completed a successful pre-IND meeting with the FDA, and despite this being a proposal focused on CNS cancer, it has repeatedly been triaged without scientific review.

I understand resources are limited, and it is the CIRM Board's discretion to decide how to focus resources. However, I would like to bring the Board's attention to the fact that by using this

preference system, CIRM is excluding scientifically rigorous, potentially life-saving modalities, even if the word “exclusion” is never mentioned.

CIRM has been a critical resource to bring novel cancer therapies to the clinic in California, and it has become even more important given recent changes in our nation’s research-funding landscape. I am grateful for your service to CIRM, and thank you for your attention to this critical topic.

Sincerely,

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