Good morning Chair, members of the Board, and members of the ICOC Science Subcommittee. Thank you for the opportunity to speak today.

My name is Dr. Theodore Scott Nowicki. I am a California resident, a pediatric oncologist at UCLA, and a physician-scientist who treats children and young adults with aggressive cancers using cell and gene therapies, many of which were made possible through CIRM support. I want to begin by sincerely thanking the CIRM team and this Board for your long-standing commitment to patients across California.

In my clinical practice, I care for children with cancers that have exhausted standard therapies. Recently, I treated a teenager with a relapsed sarcoma whose family asked a simple question: *"Is there anything left?"* The only honest answer I could offer was an experimental cell therapy - one that exists because of years of CIRM-funded academic work. Unfortunately, the current scoring rubric of CIRM grants has made literally any of these cancer treatments' consideration for funding ***mathematically impossible,*** excluding them even without any scientific review whatsoever. For families like this, policy decisions are not abstract. They determine whether hope exists at all.

With that perspective, I would like to offer three observations regarding the implementation of the Strategic Allocation Framework.

First, the current preference-based selection process appears, intentionally or not, to exclude many cell and gene therapy approaches that have already demonstrated safety and clinical efficacy. Physician-scientists who have spent years translating CIRM-funded discoveries into INDs and early-phase trials are now finding their applications halted before scientific review. These are not speculative projects. They are programs with patients enrolled, data generated, and real clinical consequences if momentum is lost.

Second, there is a practical reality that deserves explicit consideration. Academic cell-therapy programs that are meeting milestones often have no viable alternative funding pathways outside of CIRM to advance into clinical trials. This is especially true in the current national funding environment, which is far more constrained than when this framework was developed. For many programs, CIRM is not one option among many, it is the only bridge between discovery and patient care.

Finally, as a California taxpayer and a public physician, I am concerned that aspects of the current preference criteria disproportionately favor private companies over academic investigators. In CLIN2, two of eight required criteria for scientific review (an accelerated FDA designation or a pivotal trial) typically require commercial participation. That weighting meaningfully shifts public funds toward private entities rather than toward applications selected primarily on scientific and clinical merit.

CIRM was created to serve patients first, especially those with life-threatening diseases who cannot wait for the market to mature. I respectfully urge the Board to ensure that implementation of this framework continues to support proven, patient-ready cancer cell and gene therapies, consistent with CIRM's mission and public trust.

Thank you very much for your time and consideration.