A ROYALTY LENS ON 2026

Three ideas I have been watching

A point of view I've been developing as I follow the space, shared here as an exploratory read.

Exploratory, not a recommendation.

- Built as a portfolio across three risk tiers
- Public sources, cited throughout

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HOW I SCREENED

I screen for the royalty, not the drug.

Four questions, in the order I run them, close to the order most royalty investors use.

01 / Durability

Will demand still be here in ten years? I want revenue with a long half-life, the kind that outlasts the launch.

02 / Risk stage

How proven is the drug: approved and selling, or still in the clinic? That sets the price of admission.

03 / Structure fit

Match the instrument to the stage: a synthetic royalty plus a loan for clinical assets, co-funding at early launch, buying an existing royalty once it is proven.

04 / Where the royalty sits

Who actually needs capital? The originator rarely sells; the opening is usually one step to the side.

Non-dilutive royalty financing has gone mainstream: roughly **$29B** changed hands from 2020 to 2024, about double the prior five years. Royalty Pharma deployed **$2.6B** in 2025, including a record **~$2.1B** of synthetic royalties, up from $375M in 2020. The opportunity set is widening faster than the number of good places to point it.

Sources: Goodwin (2025); Royalty Pharma FY2025 results.

IDEA 01 / RISK: HIGHER

Radiopharmaceuticals

The modality every major raced to own.

Thesis Every major has bought in, and the first radioligands are already selling at scale. Today's proof is in lutetium-177 beta-emitters; the frontier is alpha-emitters, where the science runs ahead of the supply.

Royalty angle The majors bought the leaders, so the opening lies with independent alpha developers that need capital. I would place a synthetic royalty plus a loan only on developers whose isotope supply is already secured, like Ratio Therapeutics, or move up to the isotope producers.

The catch A royalty only pays if the drug ships. For the next-generation alpha-emitters, actinium-225 supply is the binding constraint, and it is physical and hard to hedge, so it belongs in the underwriting itself.

$9B+	**Radiopharma M&A since 2023** BMS · AstraZeneca · Novartis · Lilly
$2.0B	**Pluvicto (Lu-177) sales in 2025, up 42%** Novartis FY2025
Ac-225	**Alpha-emitter supply: the forward chokepoint**

Higher risk. Clinical-stage, priced for growth; a marquee radiopharma royalty is still open ground for RP.

IDEA 02 / RISK: MEDIUM

Non-opioid pain

The first new pain mechanism in a generation just cleared.

Thesis Vertex's Journavx (a Nav1.8 inhibitor) won FDA approval in January 2025, the first new class of pain medicine in over twenty years. Post-crisis, payers and policy now point the same way, toward non-cyclical demand.

Royalty angle There is no clean royalty to buy here yet. Vertex will not sell Journavx, and the fast-followers are either venture-funded (Latigo) or already bought (SiteOne, by Lilly in 2025). The entry opens when the next Nav1.8 asset reaches Phase 3 and needs capital to finish; that is the trigger I would wait for.

The catch Launch is young, so the durable bet is the category itself, before any single asset proves out. And the clearest policy support, the NOPAIN Act's separate Medicare payment, is written to expire at the end of 2027.

Jan 2025	**Journavx approved; first new pain class in 20+ years** Vertex / FDA
$150M	**Latigo Series B, led by Blue Owl** Mar 2025
2025–27	**NOPAIN Act Medicare payment window** CMS

Medium risk. An approved category, but no royalty to buy yet; I would pre-position and watch the 2027 policy cliff.

IDEA 03 / RISK: LOWER

Cardiometabolic durability

Obesity is becoming a chronic, outcomes-backed franchise.

Thesis GLP-1 and the next wave are becoming long-duration franchises. In SELECT, semaglutide cut cardiovascular events by 20% in obese patients with established heart disease and no diabetes, turning a lifestyle drug into lifelong, reimbursed therapy.

Royalty angle Novo and Lilly will not sell, so I would work two angles. Buy an existing royalty on an approved, outcomes-backed asset, the AMVUTTRA structure RP just used ($310M). Or place a synthetic royalty on an independent Phase 3 developer, Viking (VK2735) or Structure, that needs capital and will not sell cheaply.

The catch The durability is clear; the entry price is the question. The top is crowded and richly priced, and the periphery is catching the same bid. Roche committed up to $5.3B to partner on Zealand's amylin drug in March 2025, so this wave is expensive too.

−20%	**SELECT: MACE cut (obesity + prior CVD)** NEJM 2023
$5.3B	**Roche–Zealand amylin deal** Mar 2025 (up to)
$310M	**RP's existing-royalty precedent** AMVUTTRA, Nov 2025

Lower risk. The de-risked anchor; RP already runs this play with AMVUTTRA, and I would look for the next one.

THE PORTFOLIO VIEW

One sleeve, deliberately spread

One balanced sleeve, with each idea in a different seat. Risk rises to the right; proven durability rises upward.

Cardiometabolic

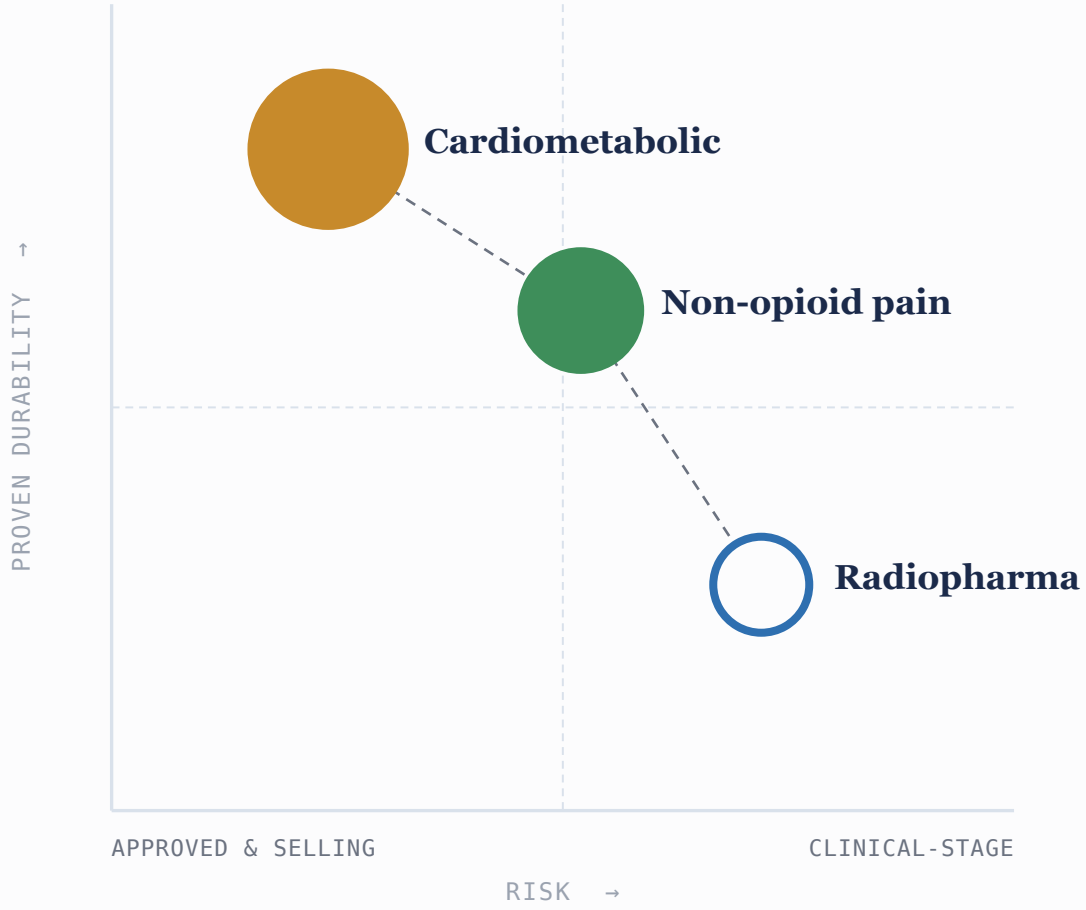
Lower risk, proven durability. The de-risked anchor that carries the sleeve.

Non-opioid pain

Medium risk, high durability. The policy-tailwind grower in the middle.

Radiopharma

Higher risk, durability still unproven. Drawn as a small ring: a starter position, deliberately kept light.



WHAT I WOULD PRESSURE-TEST

Where I am least certain

I am more sure of the framework than of any single name, so these are the questions I would pressure-test first.

01

Which idea dies first?

If the cycle turns, which of the three breaks soonest, and what breaks it?

02

Can radiopharma's supply risk be underwritten at all?

The isotope constraint is real. Is bearing it the mistake, or is it exactly where the return lives?

03

Does a policy tailwind count as durability?

The NOPAIN Act support sunsets in 2027. Am I underwriting durable demand, or a subsidy that could lapse?

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The open questions

The approach here weighs drugs by how proven they are. Where might that reasoning bend the wrong way?

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Every figure in these pages is public and cited on the final slide. Nothing here draws on internal or non-public data.

APPENDIX

Sources

All public. Figures as reported by companies, regulators, or peer-reviewed journals; nothing internal or under NDA.

SCREENING

- Goodwin, “The Continued Rise of Royalty Deals in Life Sciences” (2025)
- Royalty Pharma, Q4 & Full-Year 2025 results (Feb 2026)

RADIOPHARMACEUTICALS

- Novartis FY2025 results: Pluvicto net sales
- Deal announcements: BMS–RayzeBio ($4.1B, 2023); AstraZeneca–Fusion (up to $2.4B, 2024); Novartis–Mariana (up to $1.75B, 2024); Eli Lilly–POINT ($1.4B, 2023)
- Royalty Pharma / Revolution Medicines (up to $2B, Jun 2025)
- Ratio Therapeutics: Ac-225 program; supply deals with Niowave, PanTera (2025–26)

NON-OPIOID PAIN

- Vertex / FDA: Journavx (suzetrigine) approval, Jan 30, 2025
- Latigo Biotherapeutics: $150M Series B (Blue Owl), Mar 2025
- CMS: NOPAIN Act separate Medicare payment, 2025–27
- SiteOne Therapeutics: acquired by Eli Lilly (2025)

CARDIOMETABOLIC

- NEJM: SELECT trial, semaglutide CV outcomes (2023)
- Roche / Zealand: petrelintide amylin agreement (up to $5.3B, Mar 2025)
- Royalty Pharma / Blackstone Life Sciences: AMVUTTRA royalty on Alnylam’s product ($310M, Nov 2025)
- Viking Therapeutics (VK2735, Phase 3) & Structure Therapeutics (aleniglipron); Metsera acquired by Pfizer (2025)