Corporate Update

July 2026

Forward-Looking Statements

This presentation contains “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995, as amended (the “Act”). Forward-looking statements are statements that are not of historical fact and include, without limitation, statements regarding future events, our future financial condition, results of operations, business strategy and plans, prospective products (as well as their potential to achieve a differentiated, competitive, or favorable benefit or profile or trend, including on safety, tolerability, improvement, maintenance, clinical response, dosing, efficacy and/or convenience), planned or expected product approval applications or approvals, anticipated milestones, expected data readouts and enrollments, research and development plans and costs, potential future partnerships, expectations about existing partnerships, timing and likelihood of success, objectives of management for future operations, future results of anticipated product development efforts, and adequacy of existing cash and potential partnership funding to fund operations and capital expenditure requirements, as well as statements regarding industry trends. These statements are based on management’s current expectations of future events only as of the date of this presentation and are inherently subject to a number of risks, uncertainties and assumptions, some of which cannot be predicted or quantified and some of which are beyond our control, including, among other things: the ability of our clinical trials to demonstrate safety and efficacy of our product candidates and other positive results; whether we will need expanded or additional trials in order to obtain regulatory approval for our product candidates; our ability to obtain and maintain regulatory approval of our product candidates; existing regulations and regulatory developments in the U.S., the UK, the PRC, Europe and other jurisdictions; the ability of our current cash and investments position to support planned operations; our plans and ability to obtain, maintain, protect and enforce our intellectual property rights and our proprietary technologies, including extensions of existing patent terms where available; our continued reliance on third parties to conduct additional clinical trials of our product candidates, and for the manufacture of our product candidates for preclinical studies and clinical trials; and the degree of market acceptance of our product candidates, if approved, by physicians, patients, healthcare payors and others in the medical community.

Words such as “aim,” “anticipate,” “believe,” “could,” “expect,” “feel,” “goal,” “intend,” “may,” “optimistic,” “plan,” “potential,” “promising,” “will,” and similar expressions are intended to identify forward-looking statements, though not all forward-looking statements necessarily contain these identifying words. The inclusion of forward-looking statements should not be regarded as a representation by Connect that any of its expectations, projections or plans will be achieved. Actual results may differ materially due to the risks and uncertainties inherent in Connect’s business and other risks described in Connect’s filings with the SEC. Further information regarding these and other risks is included under the heading “Risk Factors” in Connect’s annual and periodic reports filed with the SEC. These forward-looking statements should not be taken as forecasts or promises nor should they be taken as implying any indication, assurance or guarantee that the assumptions on which such forward-looking statements have been made are correct or exhaustive or, in the case of the assumptions, fully stated in this presentation. You are cautioned not to place undue reliance on the scientific data presented or these forward-looking statements, which speak only as of the date of this presentation. Except as required by law, Connect undertakes no obligation to publicly update any forward-looking statements, whether because of new information, future events or otherwise. Connect claims the protection of the safe harbor for forward-looking statements contained in the Act for all forward-looking statements.

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A New Chapter in the Connect Biopharma Story

- Connect is advancing rademikibart, a next generation anti-interleukin-4-receptor alpha (IL-4Rα) for treatment of eosinophilic driven respiratory diseases supported by positive results from a Phase 2b 24-week global asthma subcutaneous (SC) study and a Phase 1 single-dose (intravenous) IV study in asthma or COPD patients
  - Rademikibart demonstrated greater FEV_1 response over 24 weeks than seen with other biologics when comparing across studies to patients with similar baseline eosinophils
  - Rademikibart demonstrated rapid onset of action with majority of FEV_1 increase observed within 24 hours of SC dose supporting the potential to use to treat acute exacerbations
  - Rademikibart administered by 2-minute IV push produced increases in FEV_1 of >100 mL within 15 minutes to 4 hours; mean increases of 100 – 300 mL were generally maintained through Day 29
- Rapid onset of effect consistent with preclinical observations that rademikibart appears to directly produce bronchodilation not seen with dupilumab
- Based on the rapid onset of airway improvement with rademikibart, Connect is conducting two Phase 2 studies with rademikibart to treat patients experiencing an acute exacerbation of asthma or COPD
  - Enrollment completed for both studies with topline results planned for September
  - Phase 2 results will help determine Phase 3 endpoint (treatment failure or FEV_1) and sample size
- Goal is to meet with FDA in 4Q2026 to discuss Phase 3 plans for acute indications
  - If both acute exacerbation studies are positive, asthma would likely be prioritized due to the projected faster path to approval for the chronic indication (positive global Phase 2 already completed and Phase 3 chronic study in China completing in 1H2027)

A New Chapter in the Connect Biopharma Story (continued)

- Rademikibart also differentiated from dupilumab by a low risk of hypereosinophilia:
  - Reduces eosinophils in asthma patients vs increases observed with dupilumab, which reduces risk of SAEs associated with hypereosinophilia; this difference appears to be associated with greater internalization of rademikibart/receptor complex due to differential binding to the receptor
- Potential for less frequent dosing - Q4W dosing produced equal benefit versus Q2W dosing in atopic dermatitis (AD) Phase 2b study and single IV dosing showing sustained improvement in FEV_1 through 29 days
- Phase 3 AD study conducted in China at 52-weeks demonstrated:
  - 87.1% IGA 0/1, 96.6% EASI-75 and 85.3% EASI-90 responders
- No important, drug-related safety issues observed in over 1,800 participants in completed studies
  - No difference to placebo in conjunctivitis rates
- Market research shows acute exacerbation indications in asthma and COPD are an important advantage over dupilumab and other biologics and would lead to significantly greater chronic use
  - Dupixent and other biologics are explicitly labelled to not be used to treat acute symptoms or acute exacerbations of asthma or COPD
- Projected base-case worldwide peak sales of >$3B for asthma and >$2B for COPD

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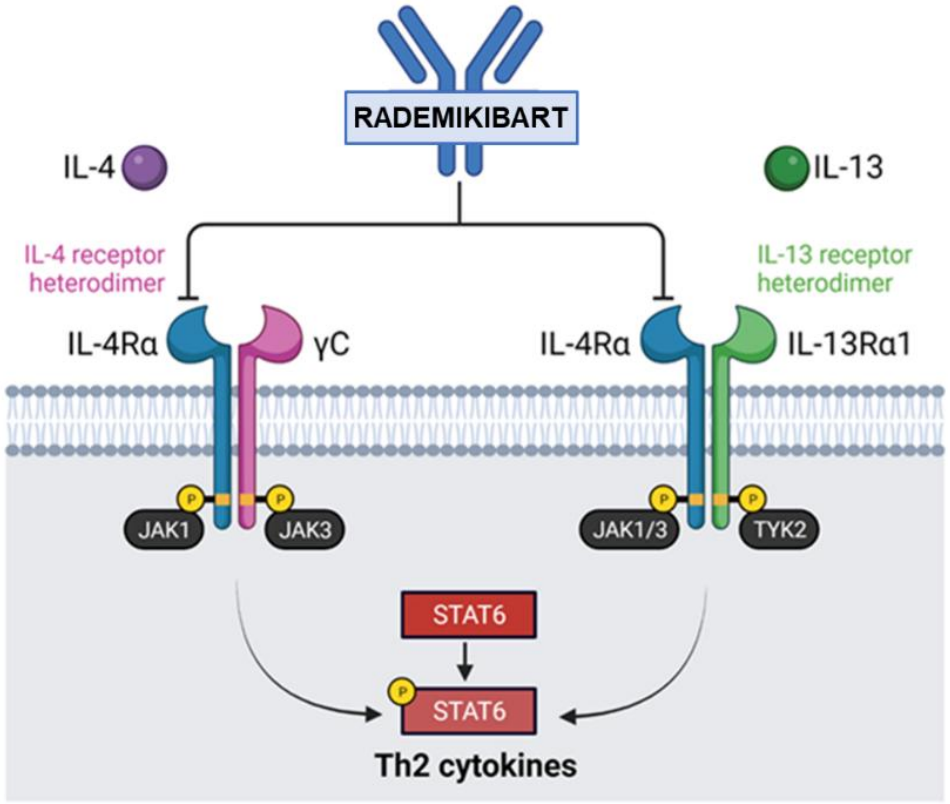
Rademikibart:

A Next Generation Anti-interleukin-4 -receptor alpha (IL-4Rα) Antibody

Rademikibart: Next Gen IL-4Rα Blocker Shows Potential For Less Frequent Dosing, Greater Sustained Efficacy Data, and Faster Onset Observed in Asthma Trials



Rademikibart is a novel, human monoclonal IgG4 antibody directed against IL-4Rα, a common subunit for IL-4 and IL-13 receptors. Blockade of IL-4 and IL-13 binding to IL-4Rα results in inhibition of both IL-4 and IL-13 signaling.

Rademikibart Characteristics

- Engaging with distinct epitopes associated with a higher binding affinity to IL-4Rα[1]
- Highly potent IC_{50} in:
  - Reducing JAK-STAT signaling[1,a]
  - Cell proliferation[1,a]
  - TARC release[1,a]

Clinical Results Demonstrate that Rademikibart has:

- Faster onset of action
- Greater clinical response (FEV_1)
- Potential for less frequent dosing with Q4W dosing producing equal benefit versus Q2W dosing in AD
- Reduction of eosinophils vs increase with dupilumab (reduces risk of SAEs associated with hypereosinophilia)

AD=atopic dermatitis; COPD=chronic obstructive pulmonary disease; IC50=half-maximal inhibitory concentration; IL=interleukin; JAK=janus kinase; STAT=signal transducers and activators of transcription; TARC=thymus- and activation-regulated chemokine.

[a]Based on head-to-head in vitro comparison with dupilumab.

1. Zhang L, et al. Sci Rep. 2023 ;13(1):12411.

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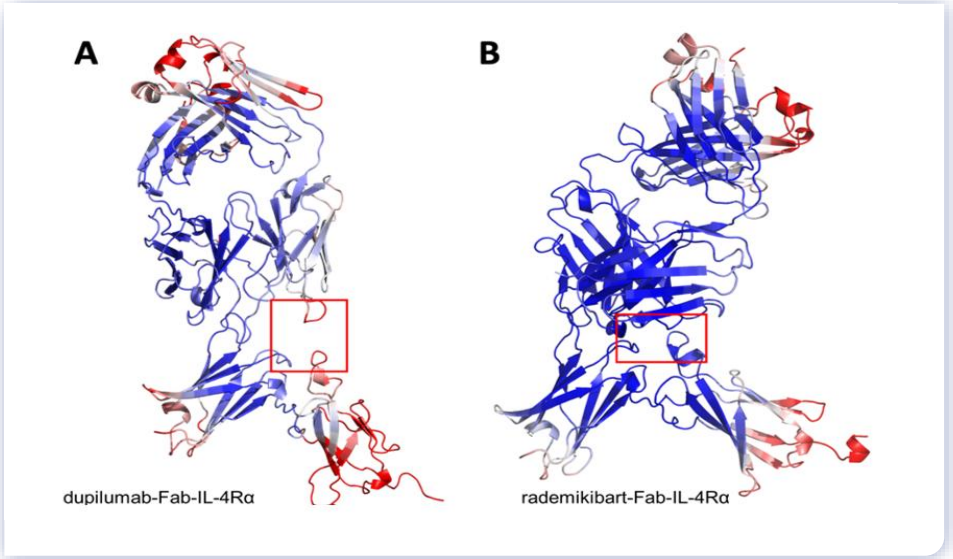
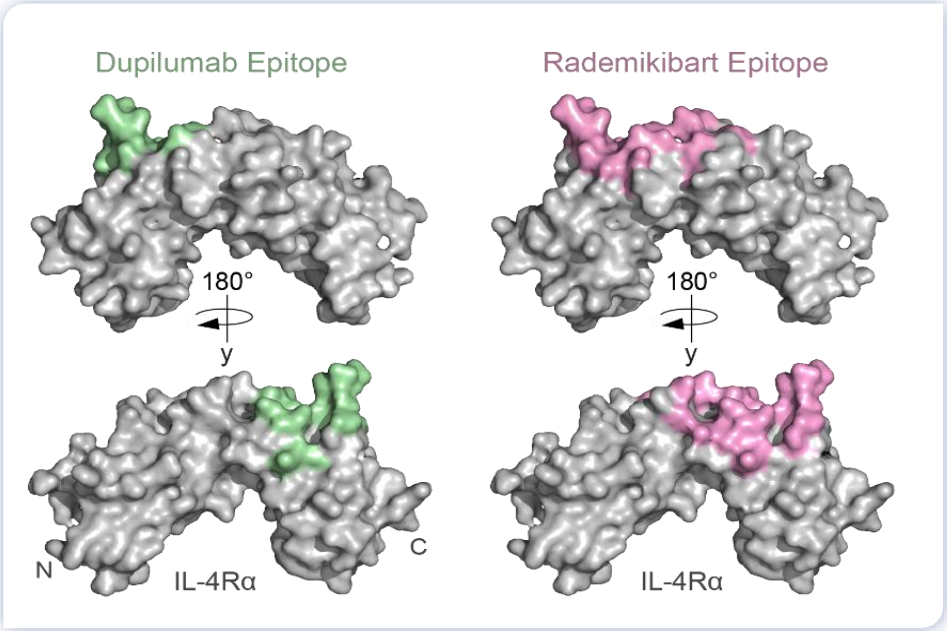
Rademikibart Forms a More Stable Complex with the IL-4Rα subunit

Rademikibart and Dupilumab Have Different Binding Orientation

- Rotation angle between dupilumab and rademikibart bound to IL-4Rα is 59°
- Rademikibart forms a more stable receptor complex
  - Rademikibart binds IL-4Rα across loops 2 and 3 on the D1 domain and loop 5 on the D2 domain (Fig B - red box)
  - Dupilumab binds only D1 (D2 binding is absent – (Fig A - red box)





Rademikibart engages a larger surface on IL-4Rα compared to dupilumab

- The rotation angle enables epitopes of rademikibart to overlap more closely with the conserved binding interface naturally utilized by IL-4 and IL-13 cytokines
  - Rademikibart closely mimics…
    - IL-4 (with 74% overlap) and IL-13 (60% overlap)
  - In contrast, dupilumab mimics…
    - IL-4 (with 47% overlap) and IL-13 (35% overlap)
- Rademikibart's larger binding interface, potentially enhances blockade of IL-4/IL-13 compared to dupilumab

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Rademikibart Has Demonstrated Efficacy & Safety Across Multiple Indications

Connect Biopharma has global development & commercialization rights outside of greater China for rademikibart

	Rademikibart anti-IL-4Rα mAb Indication	Discovery/ Preclinical	Phase 1	Phase 2	Pivotal or Phase 3	Status/Anticipated Milestones
Planned & On-going Studies	Acute COPD - Global			→		Phase 2 studies of rademikibart in acute COPD and asthma exacerbations; enrollment concluded with topline data expected in Sep-2026
	Acute Asthma - Global			→		
	Chronic Asthma – China[a]			→	→	This ongoing study conducted by Simcere at no cost to Connect
Completed Studies	Atopic Dermatitis (AD) – China[b]			→	→	**Simcere[a] filed NDA in China for AD under review**
	Chronic Asthma - Global			→		Based on the results from these studies, the U.S. FDA agreed that rademikibart was ready to move into Phase 3 for chronic treatment of asthma and AD
	Atopic Dermatitis (AD) – Global			→		

[a]Simcere is Connect's partner in Greater China who holds responsibility for future development, including for additional indications; [b] Data presented at 2026 AAD Meeting in Late-Breaking Research Session #79594

mAb = monoclonal antibody; COPD = chronic obstructive pulmonary disease; AD = atopic dermatitis

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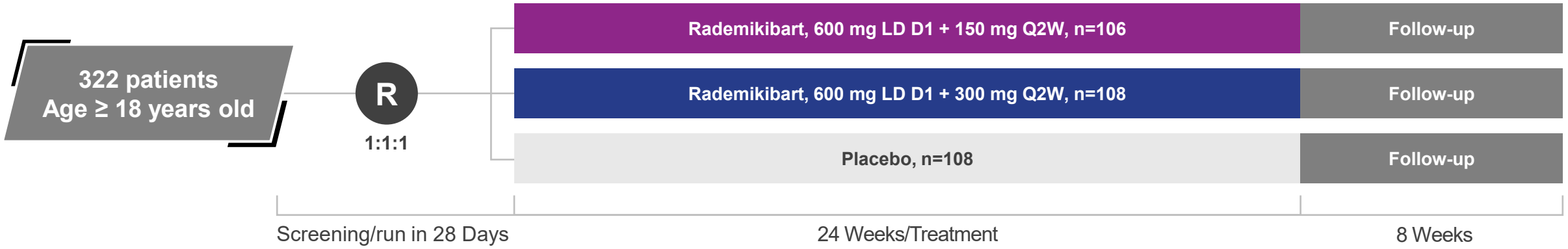
Robust Data from Completed Global Phase 2b Study in Moderate-to-Severe Asthma Patients

Efficacy and Safety Study of CBP-201 (rademikibart) in Patients With Moderate to Severe Persistent Asthma (NCT04773678)



Key Inclusion Criteria:

- Moderate to severe uncontrolled asthma
  - Existing treatment with medium to high dose ICS in combination with a second controller (e.g., LABA, LTRA, or theophylline) for at least 3 months with a stable dose ≥1 month prior to the screening visit.
  - Pre-bronchodilator FEV_1 40 to 85% of predicted normal at Visits 1 and 2, prior to randomization.
  - Screening or historical blood eosinophil count ≥150 cells/μL (amended to ≥300 cells/μL)
    - No eosinophil count requirement for patients on maintenance OCS
  - ACQ score ≥1.5 at Visits 1 and 2, prior to randomization.
  - At least 1 documented asthma exacerbation in the 12 months prior to the date of informed consent that required use of a systemic corticosteroid

Primary Endpoints:

- Change from Baseline in FEV_1 at Week 12 (in clinic with central overread)

Secondary Efficacy Endpoints:

- Change from Baseline in FEV_1 at other timepoints
- Asthma Exacerbations
- PROs (ACQ, symptom diary, at-home lung function)
- PD markers (FENO, eosinophils, ECP, periostin, TARC)
- Rescue medication use

Abbreviations: ACQ=Asthma Control Questionnaire; ECP = eosinophilic cationic protein; FENO = fractional exhaled nitric oxide; FEV_1=Forced expiratory volume at 1 second; ICS = inhaled corticosteroids; LABA = long-acting ß-agonist; LTRA = leukotriene receptor antagonists; OCS = oral corticosteroids; TARC = thymus and activation-regulated chemokine.

https://doi.org/10.1164/rccm.202409-1708OC

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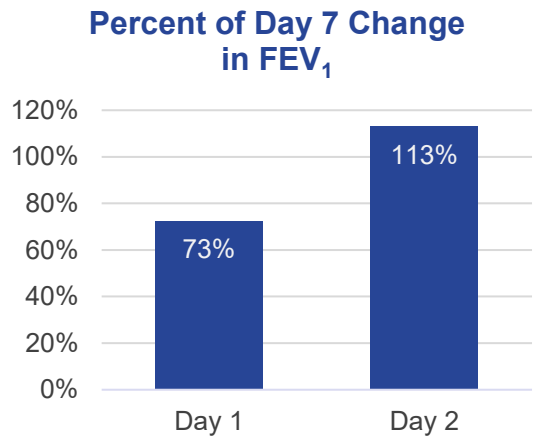
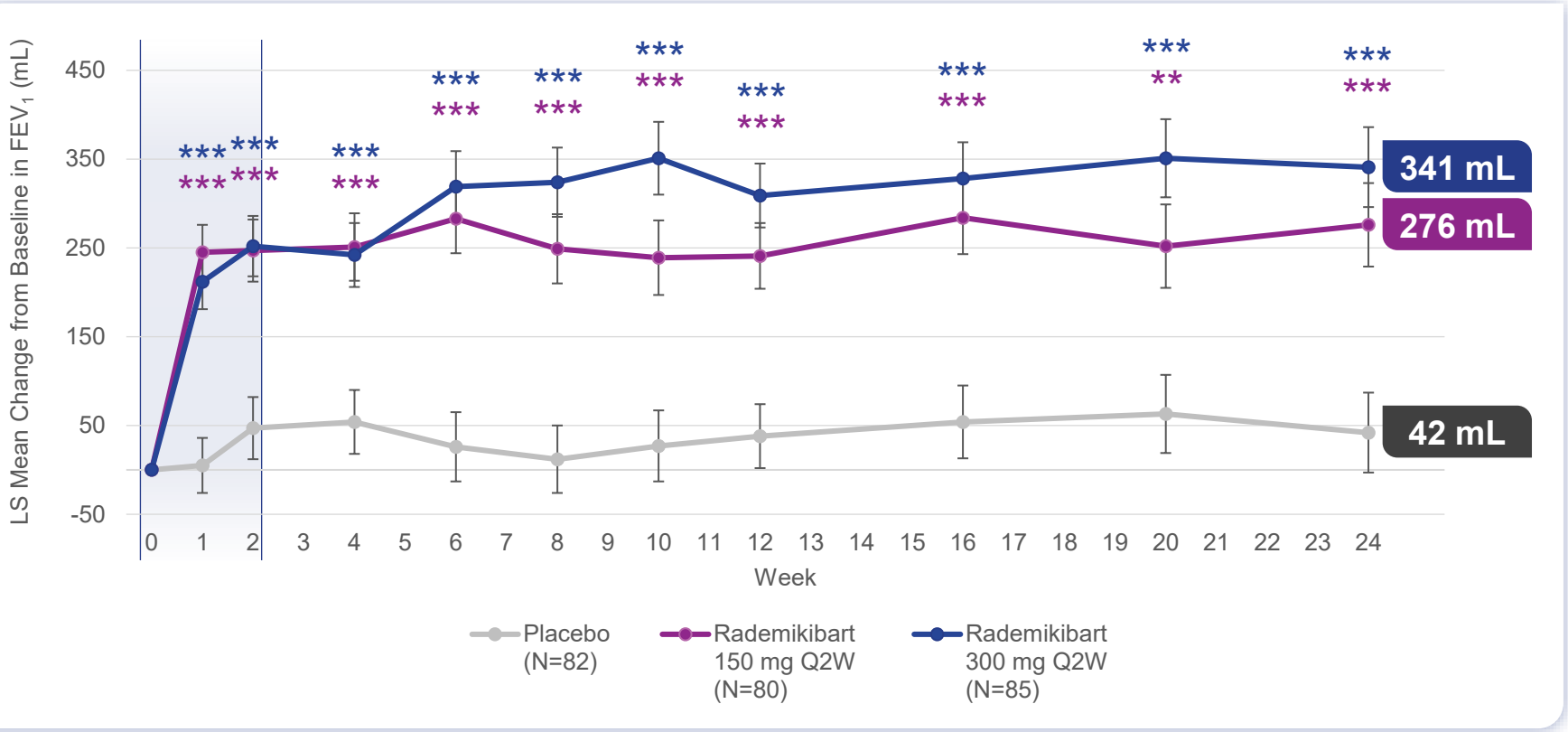
Rapidly Improved and Sustained FEV_1 Values Observed with Rademikibart Treatment in Completed Phase 2b Study

Rademikibart treatment associated with rapid, significant changes in FEV_1 as early as Week 1 clinic visit, which were sustained for the duration of the 24-week study

Home daily lung function data demonstrated 73% of improvement seen on Day 7 was observed by the morning after the first dose, with 113% by Day 2:



Change in Pre-bronchodilator FEV_1 over time in Patients with an Eosinophil Count ≥150 cells/μL at Baseline



***p<0.001, **p<0.01, *p<0.05. Data were analyzed with ANCOVA
FEV_1 = Forced expiratory volume in one second.

Competitive Landscape of Placebo Adjusted Improvement from Baseline In Pre-bronchodilator FEV_1

Rademikibart exhibited best-in-class potential in lung function improvement

Source	MoA	Product	FDA Approv. in last 10 yrs	Study	N (Pbo/Tx)	% patients with EOS ≥300 cells/µL	Week	First response week	Placebo adjusted improvement from baseline in FEV_1	Placebo adjusted improvement from baseline in FEV_1 (*EOS ≥300 cells/µL*)
Phase 2b	IL-4Rα	Rademikibart	--	Phase 2b Asthma	108/108	46.3%	12	1	270 mL*	328 mL
							24		299 mL*	420 mL
				COPD-Like Patients†	27/19	31.6%	12	1	228 mL	500 mL
							24		290 mL	620 mL
Biologic Phase 3 trial results	IL-4Rα	Dupilumab	2018	Asthma: QUEST[1]	231/633	41.8%	12	2	130 mL	240 mL
			2024	COPD: NOTUS[5]	465/470	60.8	12	2	82 mL	113 mL
	IL-5Rα	Benralizumab	2017	SIROCCO[3] Q4W	407/399	68.9%	48	4	--	106 mL
				CALIMA Q4W[6]	440/425	67.5%	56		--	125 mL
	IL-5	Reslizumab	2016	STUDY 1[2]	244/245	--	52	4	126 mL	--
				STUDY 2[2]	232/232	--			90 mL	--
	TSLP	Tezepelumab	2021	NAVIGATOR[4]	528/531	41.5%	52	2	130 mL	230 mL

For Illustrative Purposes Only: **Not a head-to-head trial. Differences exist between trial designs, subject characteristics and geographical regions – caution should be exercised when comparing data across trials**

EOS=eosinophils; FDA=Food and Drug Administration; FEV_1 = Forced expiratory volume in one second; IL=Interleukin; MoA=mechanism of action; Pbo=Placebo; TSLP=thymic stromal lymphopoietin; Tx=treatment group.

*EOS ≥150 cell/µL

†Patients from Phase 2 asthma study with asthma onset age > 40 year and post−bronchodilator FEV_1/forced vital capacity < 0.7 at screening visit

1. QUEST – Castro M et al. N Engl J Med 2018;378:2486-96. **2.** STUDY 1&2- Castro M et al. Lancet Respir Med. 2015 May;3(5):355-66. **3.** SIROCCO – Bleecker ER et al. Lancet. 2016 Oct 29;388(10056):2115-2127. **4.** NAVIGATOR – Menzies-Gow A et al N Engl J Med 2021;384:1800-9. **5.** NOTUS – Bhatt et al N Engl J Med 2024;390:2274-2283; 6. CALIMA – FitzGerald JM et al. Lancet 2016 Sept 5; S0140-6736(16)31322-8

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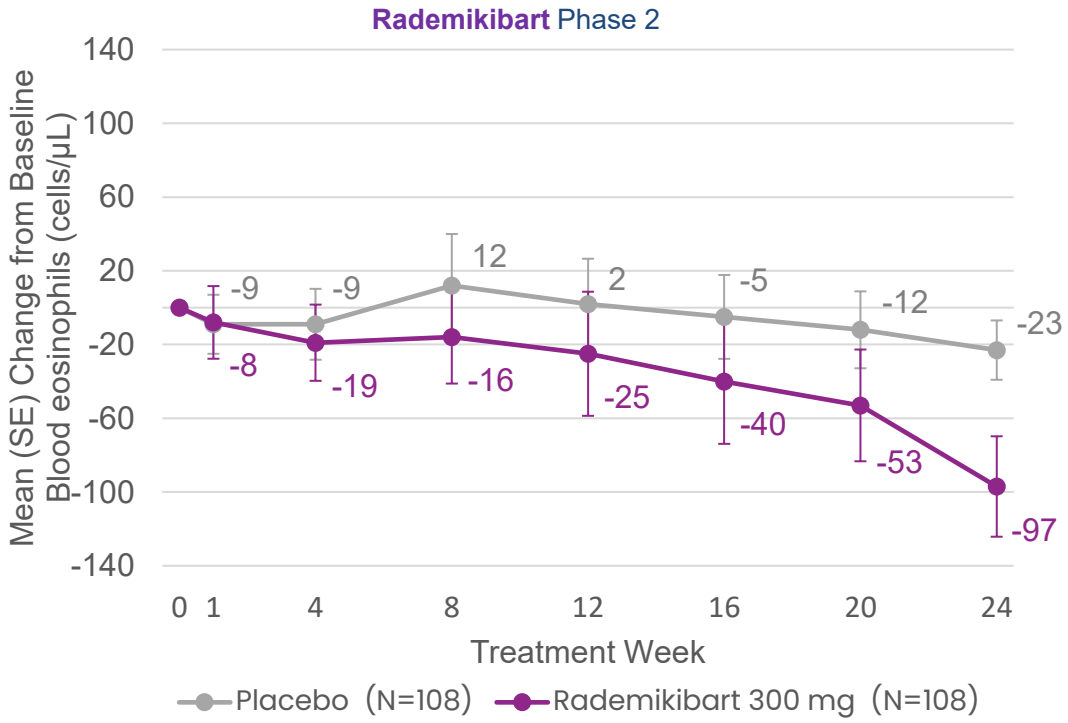
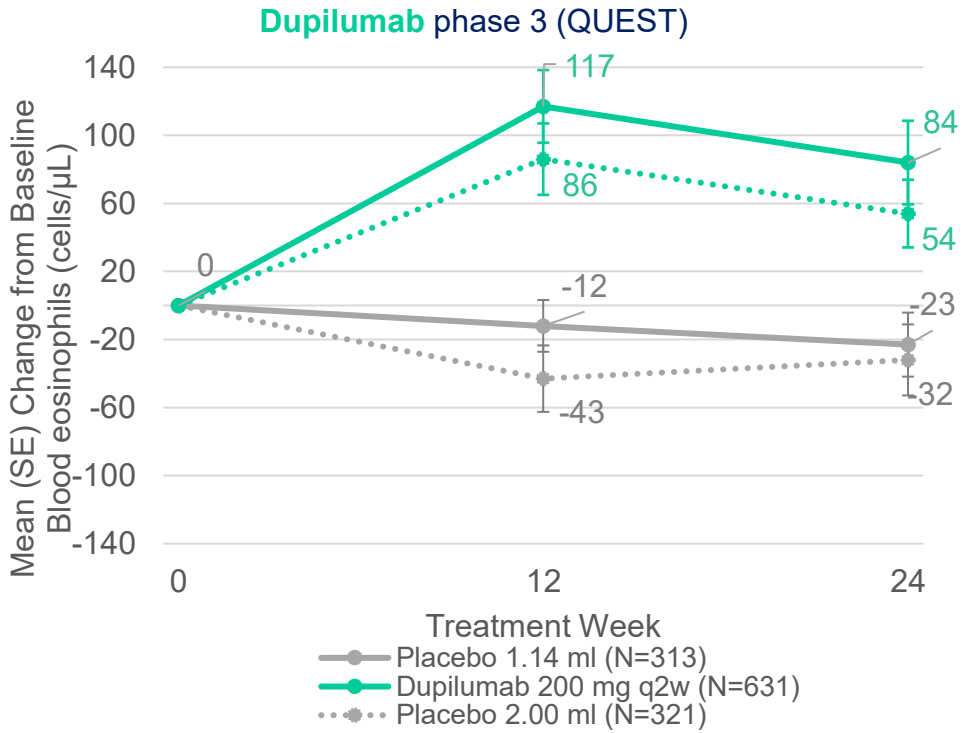
Although Both Target IL-4Rα, Rademikibart Observed to Lower Eosinophils While Dupilumab Increases them in Asthma Patients

Effect of rademikibart on change from baseline in mean eosinophil counts
(patients with eosinophil counts at any point during the treatment period)



At baseline, mean (standard deviation) eosinophil counts = 299 cells/µL (229) for placebo and 320 cells/µL (220) for rademikibart 300 mg.

Effect of dupilumab on change from baseline in mean eosinophil counts
(placebo groups behave similarly to rademikibart phase 2b study above



At baseline, mean±SD eosinophil counts = 370±338 cells/µL (placebo 1.14 ml); 391±419 (placebo 2.00); 349±345 (dupilumab 200 mg) and 351±369 (dupilumab 300 mg).

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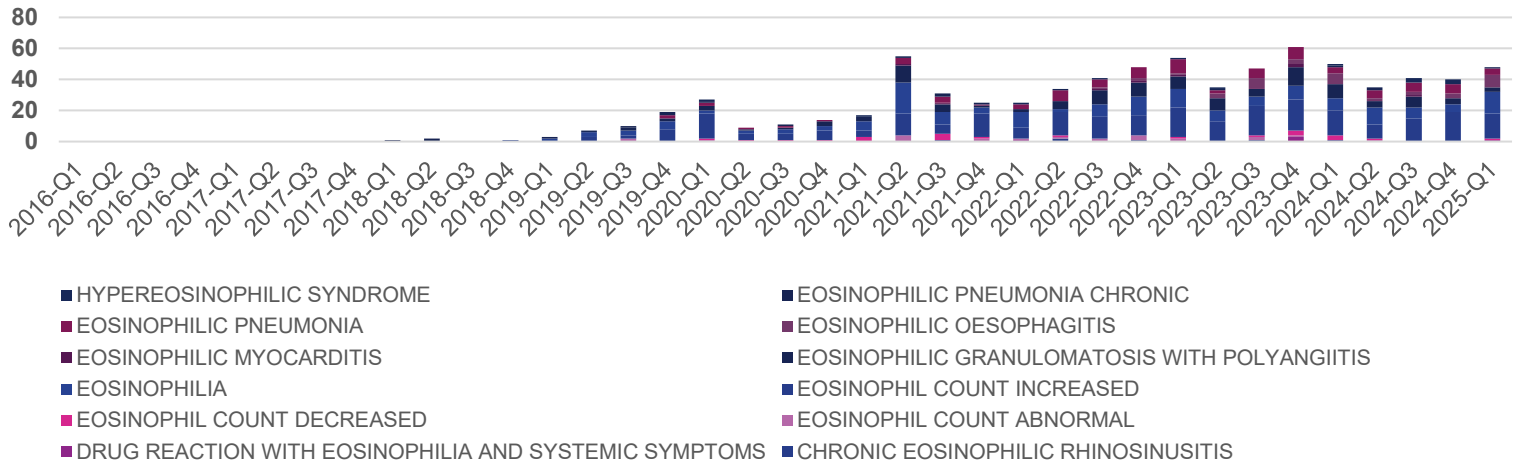
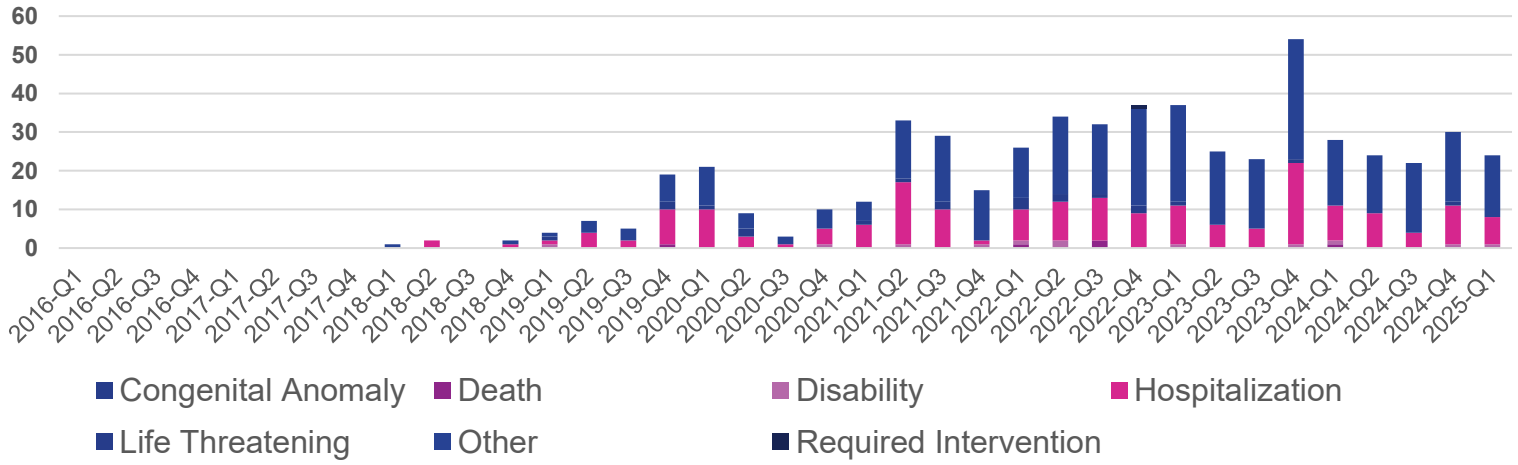
Elevated Eosinophils is Not Just a Lab Abnormality with Dupilumab

All Eosinophilia Primary Terms with >4 Reports by Quarter



All Eosinophilia Serious Outcomes by Quarter



Eosinophilia Related Adverse Events Reported to FDA Safety Database for Dupilumab

- Patients may have more than one adverse event or serious outcome per individual case report
- 676 individual cases with 811 Eosinophilia AEs
- 408 cases with 569 serious outcomes

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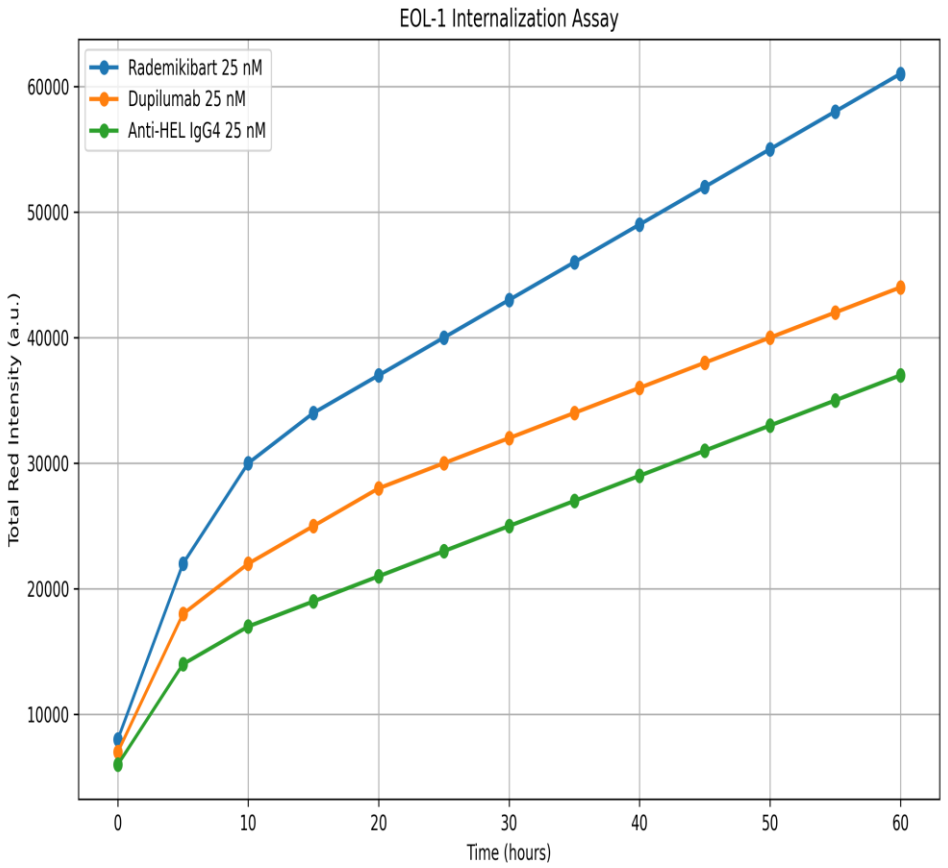
MOA Activities

- Differential effects on eosinophils observed in the clinic are likely due to differential binding leading to greater internalization
- Human airway smooth muscle (HASM) cell experiments indicate that rademikibart directly produces relaxation (cellular marker of bronchodilation)
- Human PCLS experiments from two independent labs show consistent β-agonist augmentation with rademikibart compared to no benefit with dupilumab

Rademikibart Observed to Induce Higher Level of IL-4Rα Internalization Compared to Dupilumab



- Rademikibart can efficiently remove Type I IL-4 receptors from eosinophil cell surface, confirmed by Flow Cytometry and IncuCyte (shown to the left)
- Rademikibart induced stronger apoptosis of EOL-1 than dupilumab
- The effects on internalization and apoptosis are likely the underlying mechanisms of clinical observations:
  - Reduction in EOS compared to increase in EOS with dupilumab
  - Identical results with Q2W and Q4W dosing in AD
- Higher EOS observed with dupilumab is associated with SAEs and may be linked to higher rates of conjunctivitis
  - Dupilumab was associated with 10% conjunctivitis, compared to 2% in the placebo group in Phase 3[1], while only 3-4% conjunctivitis was observed with rademikibart in AD[2]

AD – Atopic Dermatitis; EOS – Eosinophils; SAE – Serious Adverse Event

1. Dupilumab USPI - www.regeneron.com/downloads/dupixent_fpi.pdf. Accessed 1 Jan 2025
2. Silverberg JI et al. J Allergy Clin Immunol 2024;153:1040-9. https://doi.org/10.1016/j.jaci.2023.11.924 and 2026 AAD presentation 79594

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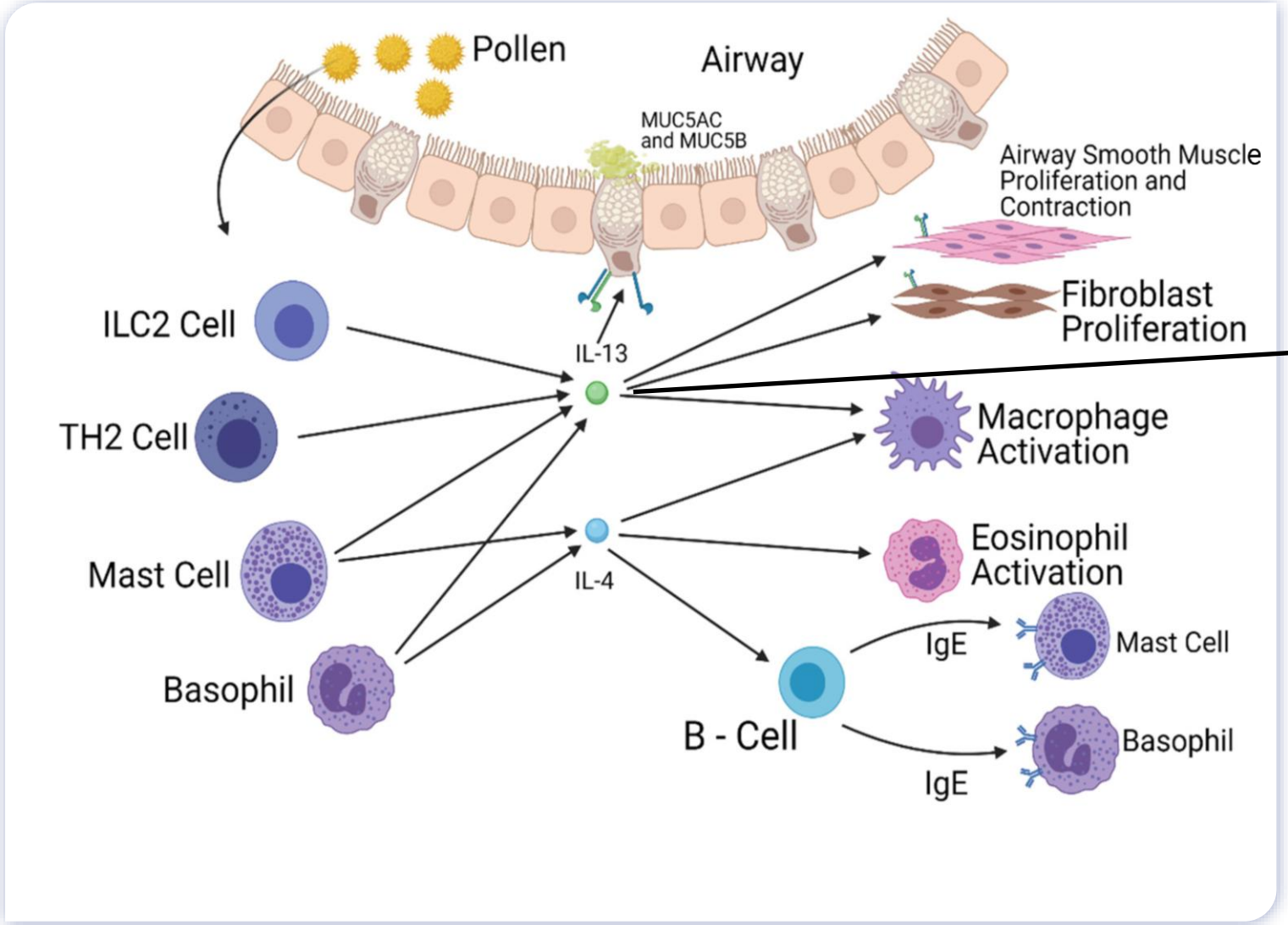
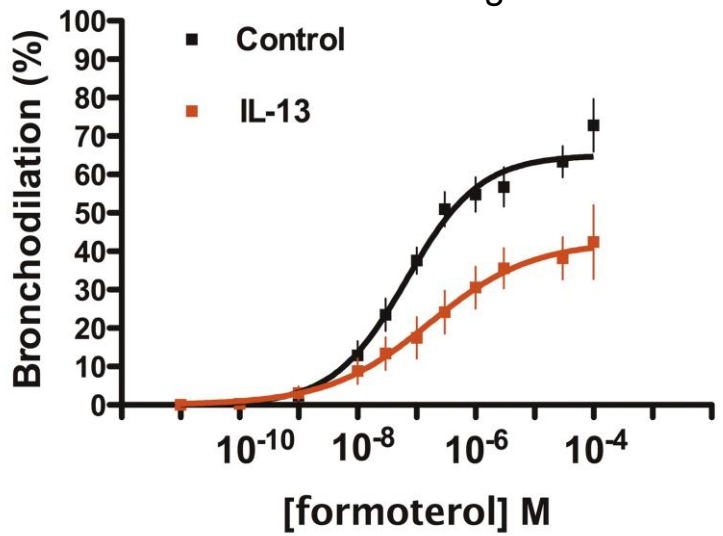
IL-4 and IL-13 Receptors are Expressed on HASM Cells and Play Important Roles in Asthma Exacerbations



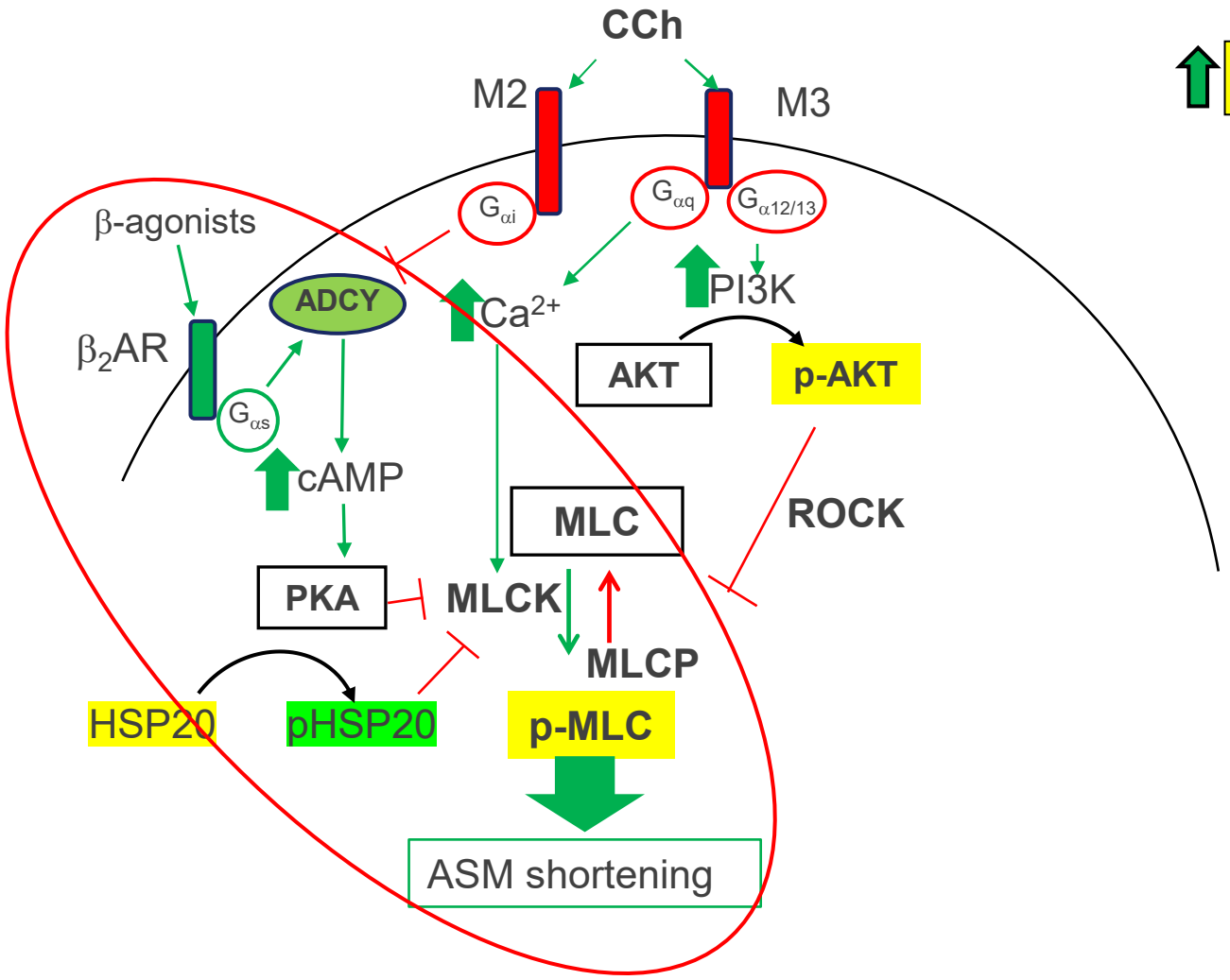
In addition to producing contraction of airway smooth muscle and increasing mucus production, IL-13 also shifts the efficacy curve of β-agonists making them less effective

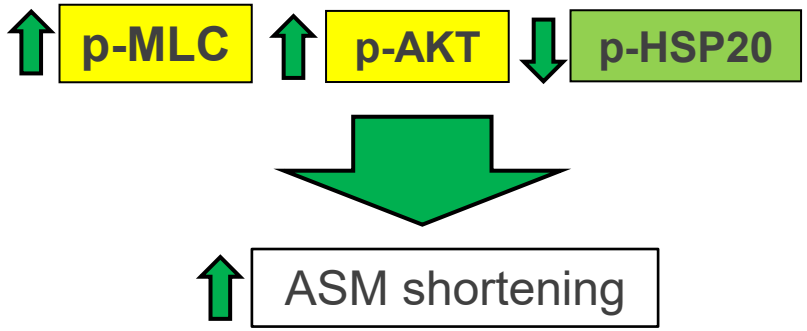
Reduced Bronchodilation in Precision Cut Lung Slice

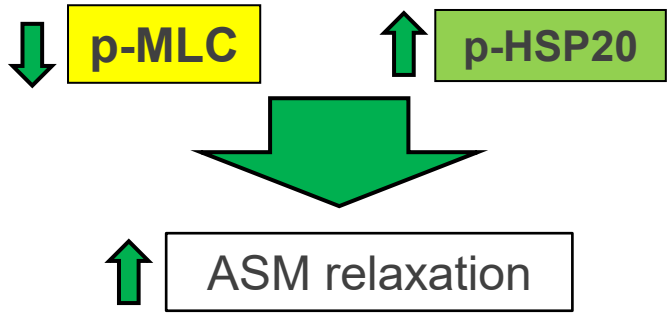


Robinett; Koziol-White et al. Am J Respir Cell Mol Biol . 2013. 50678-683; LePorte, et al. Am J Respir Crit Care Med Vol 164. pp 141–148, 2001 HASM – Human Airway Smooth Muscle.

Inhaled β2-Agonists are SOC for Asthma and COPD Because They Can Rapidly Reverse Airway Hyperreactivity via the HSP20 Pathway



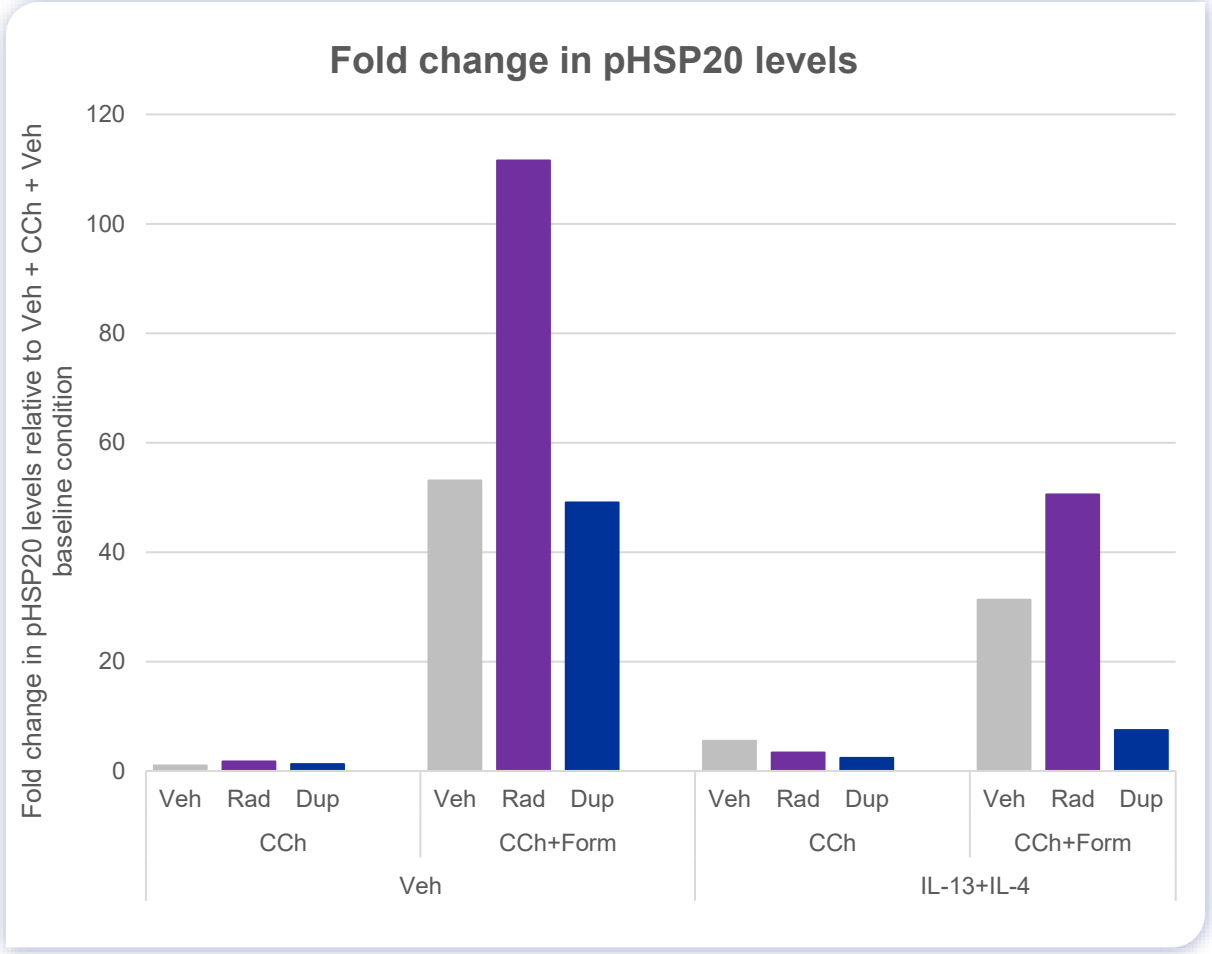




SOC – Standard of care; CCh – Carbochol (muscarinic receptor agonist); ASM – Airway Smooth Muscle; MLC – Myosin Light Chain; HSP – Heat Shock Protein

Increases in β-agonist Induced pHSP20 are Augmented with the Addition of Rademikibart, but Not Dupilumab

- In primary human airway smooth muscle (HASM) cells a potent β–agonist, formoterol, increases pHSP20, consistent with its normal effect on airways
- Addition of rademikibart to formoterol treated cells more than doubled pHSP20 compared to vehicle, and no change observed with the addition of dupilumab
- Addition of IL-4+IL-13 reduced the expected increase in pHSP20 observed with formoterol (consistent with previously demonstrated shift in efficacy of β–agonists in the presence of IL-4/IL-13)
- Rademikibart increased levels of pHSP20 in the presence of IL-4+IL-13, while dupilumab had no beneficial effect on pHSP20
- The enhanced effect of rademikibart compared to dupilumab may explain the faster onset of airway relaxation and greater improvement in FEV_1 observed with rademikibart



Veh - Vehicle; Rad - Rademikibart; Dup - Dupilumab; ASM - Airway Smooth Muscle; MLC - Myosin Light Chain; HSP - Heat Shock Protein; CCh – Carbochol (muscarinic receptor agonist); Form – Fornoterol (β-agonist)

Mean of N=3 donors.

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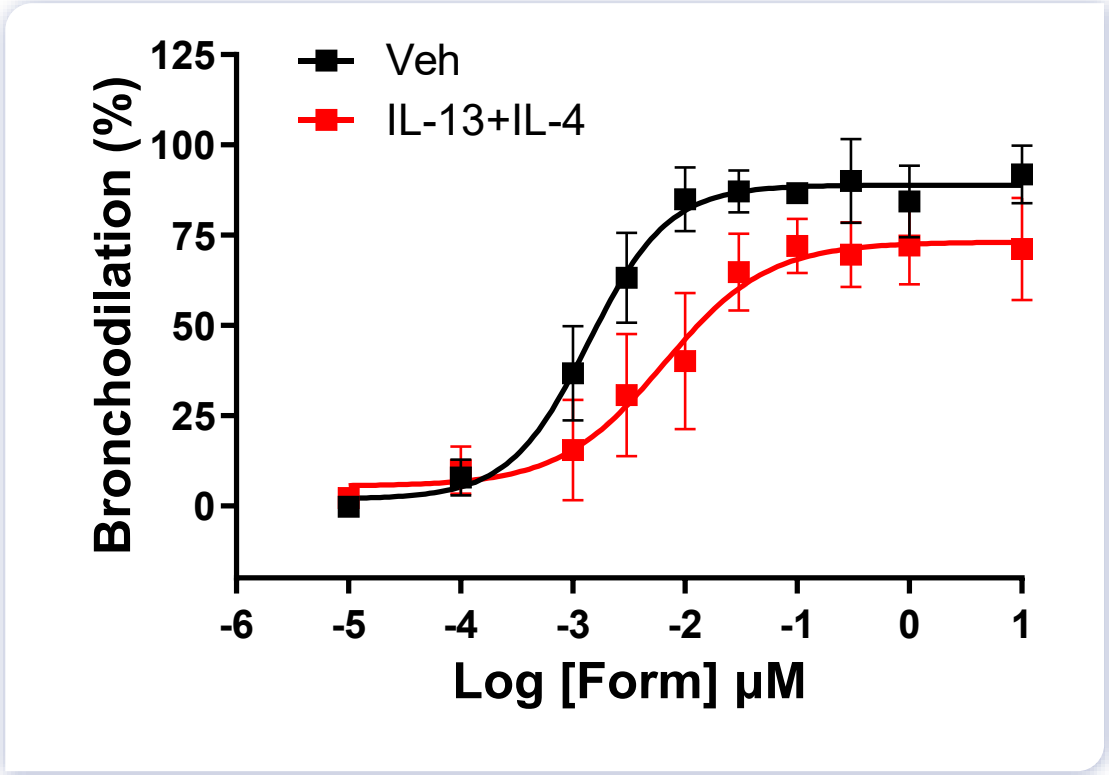
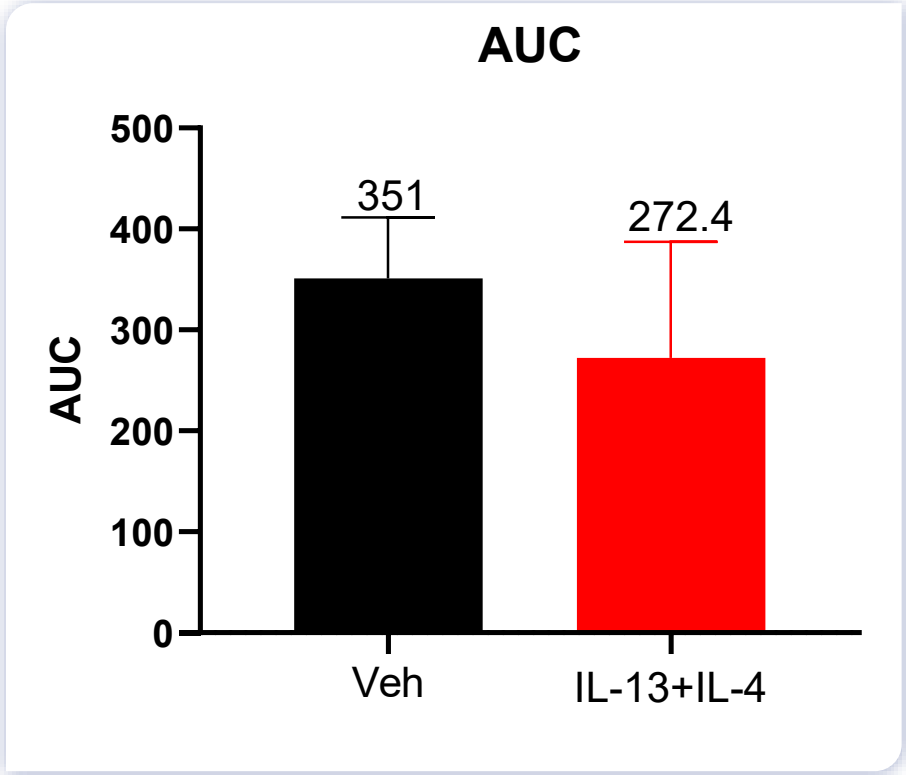
IL-13+IL-4 Reduces the β-Agonist Effect in Human Precision Cut Lung Slice (hPCLS) Model

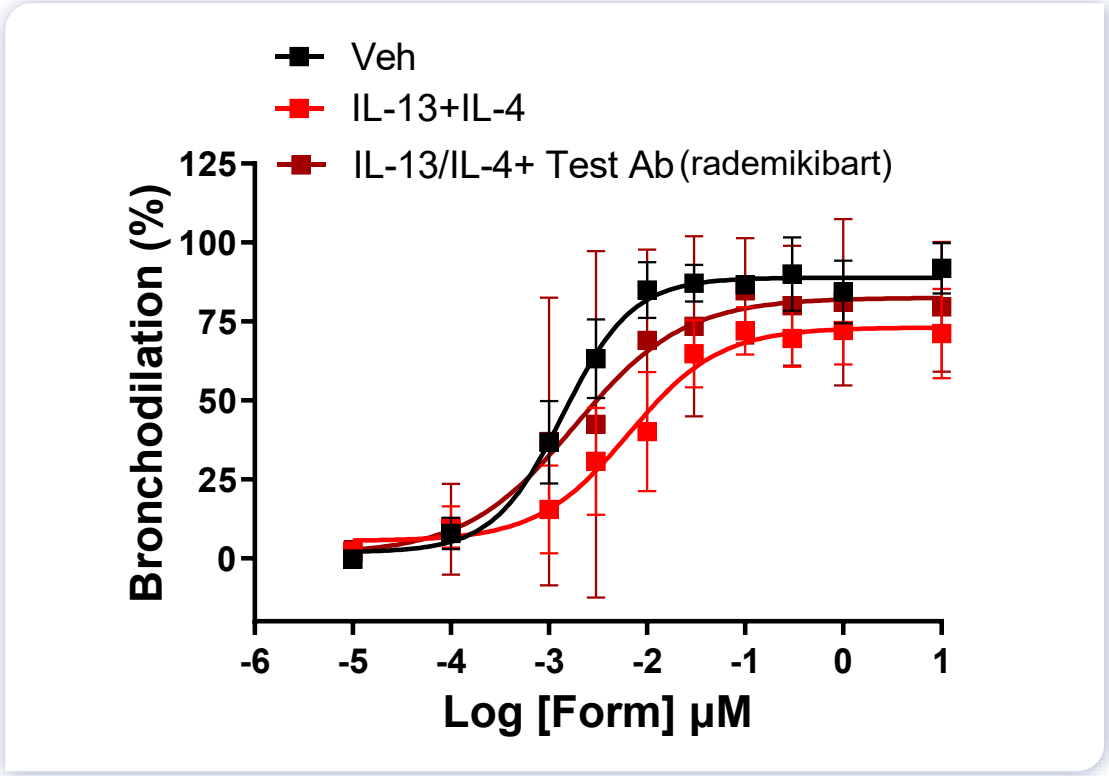


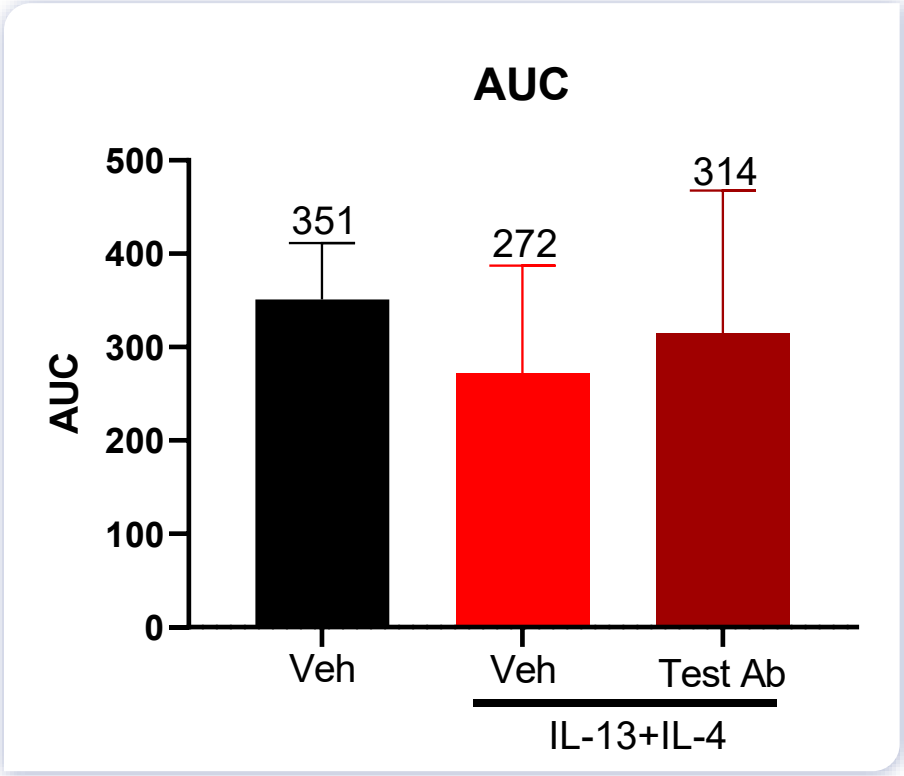


VEH – Vehicle
N= 1 donor, N090425; Mean ±SD of 2-4 slices per condition.

IL-4+IL-13 Mediated Hyporesponsiveness to β-Agonists is Substantially Reversed by Rademikibart in Human Lung Slice Model

Consistent with the HASM cell data rademikibart returned bronchodilation toward baseline in the presence of Th2 cytokines





Veh = Vehicle; Test Ab = Rademikibart; Ref Ab = Dupilumab; HASM – Human Airway Smooth Muscle; hPCLS – human Precision Cut Lung Slice
N= 1 donor, N090425; Mean ±SEM of 2-4 slices per condition.

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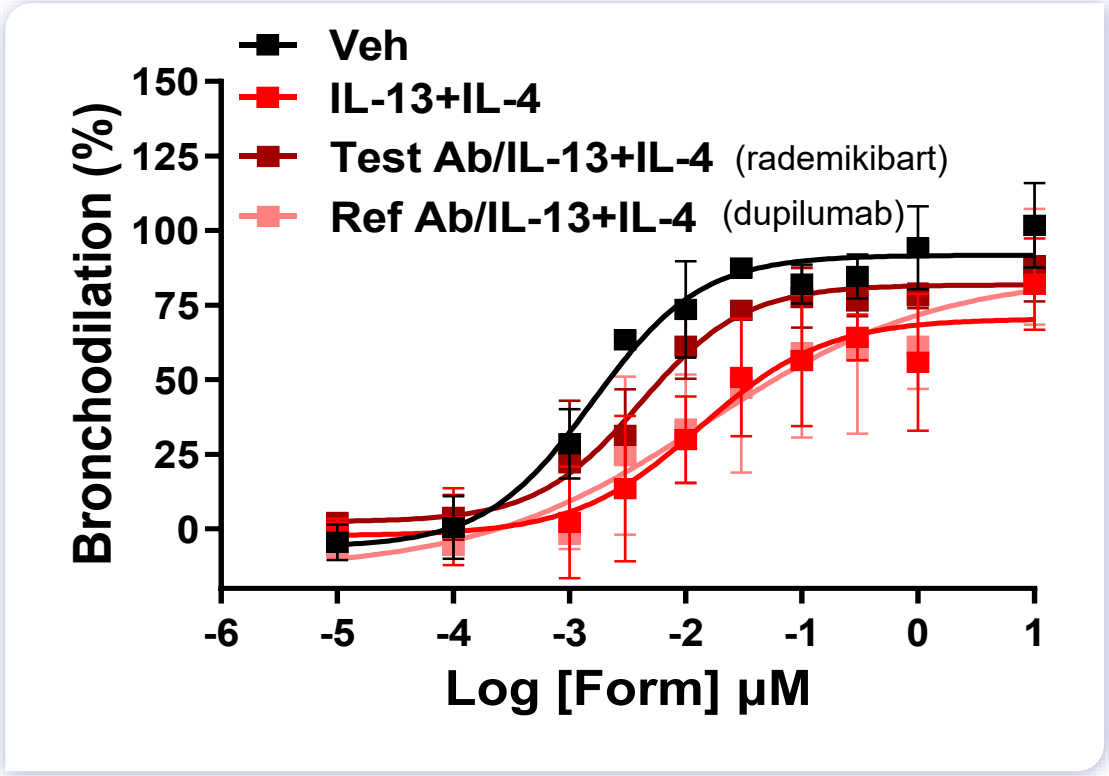
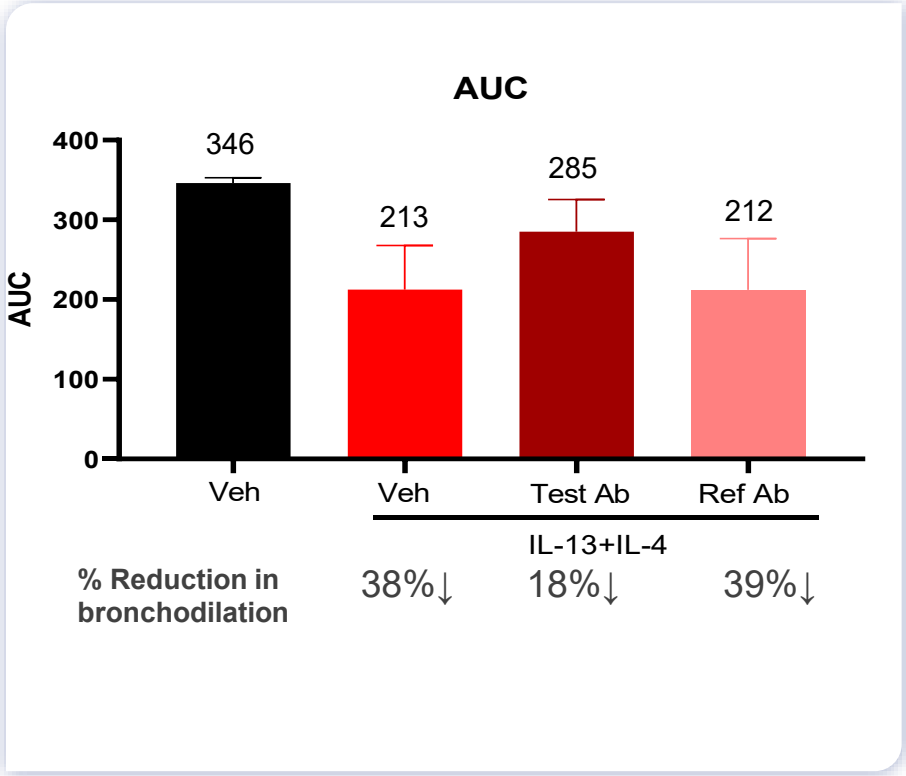
Unlike with Rademikibart, IL-4/IL-13 Mediated Hyporesponsiveness to β-Agonists is *Not* Reversed with Dupilumab

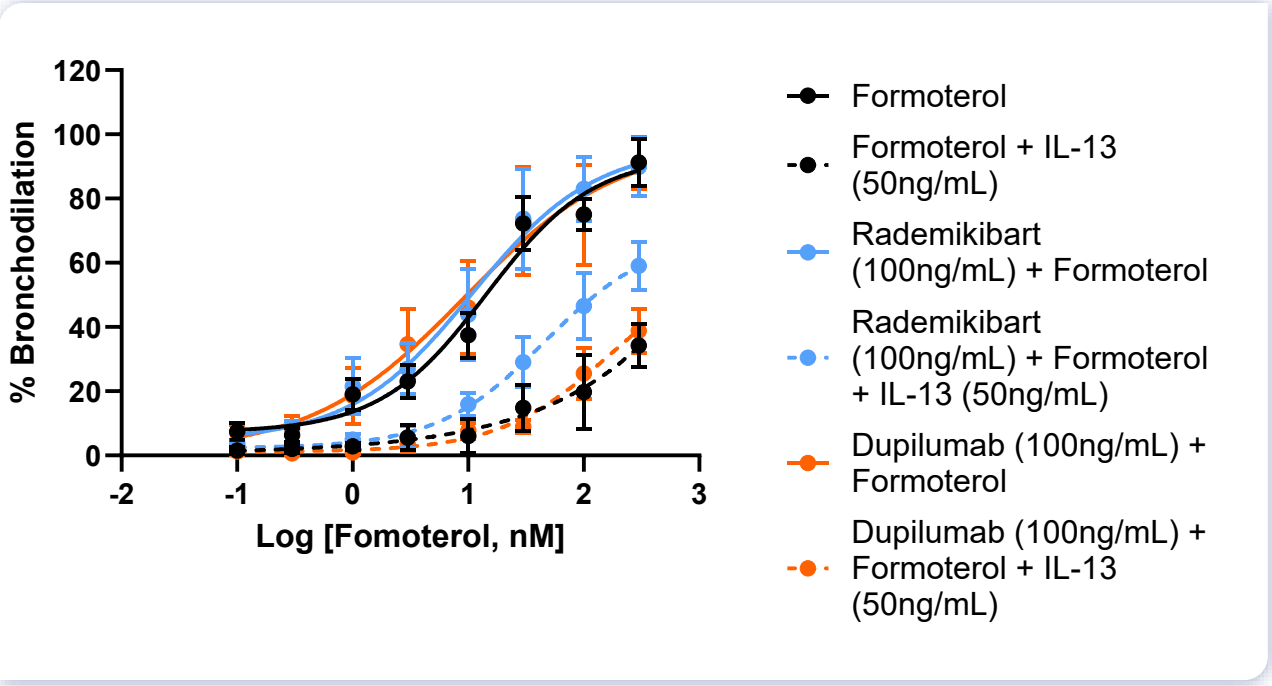
Contrary to rademikibart, and consistent with HASM cell experiments, β2 agonist response is not augmented with dupilumab





Veh = Vehicle; Test Ab = Rademikibart; Ref Ab = Dupilumab; HASM – Human Airway Smooth Muscle; hPCLS – human Precision Cut Lung Slice
N= 2 donors, N090425; Mean ±SEM of 2-4 slices per condition.

PCLS Data from Second Laboratory Confirmed Rademikibart Reverses IL-13 induced Hyporesponsiveness to β-agonist, While Dupilumab had No Effect



Treatment with Rademikibart at doses of 10, 30 and 100ng/mL partially reversed IL-13 induced hyporesponsiveness.

Treatment with dupilumab at the highest concentration tested had no effect.

PCLS – Precision Cut Lung Slices
N = 6 patients

Based on the Rapid Onset of FEV_1 Increases, Current Development of Rademikibart is Focused on Treatment of Acute Exacerbations of Asthma and COPD

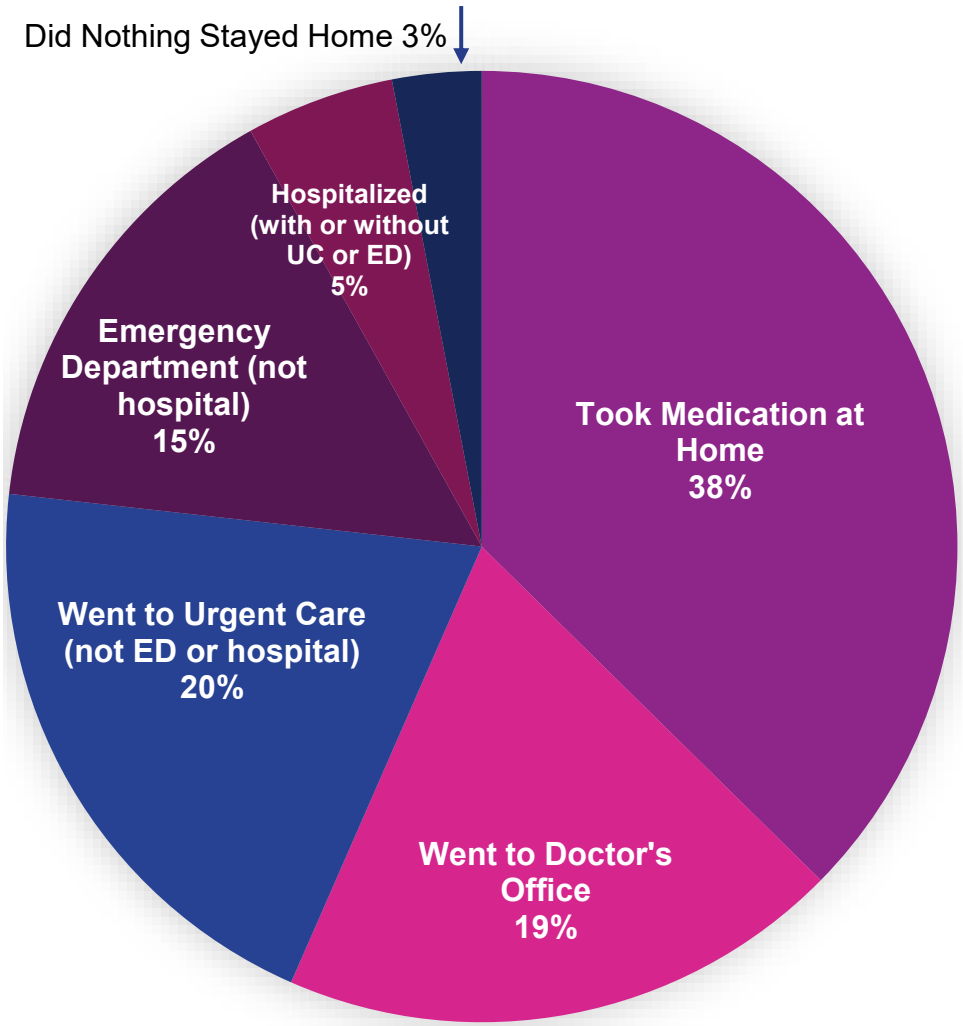
Ultimately the Goal is to have Both Acute and Chronic Indications

Asthma and COPD are Associated with Severe Exacerbations that are Difficult to Treat and Often Require Hospitalization

	Asthma	COPD
POPULATION	**Affects >22M adults in US** with 30-40% having at least one exacerbation per year	**Affects >16M adults in US** with ~30-50% having at least one exacerbation per year
CURRENT SoC	Fast-acting inhaled bronchodilators and oral/IV corticosteroids; severe cases may require IV magnesium sulfate, heliox therapy, and noninvasive ventilation; intubation is considered if patients do not respond to initial therapies. Antibiotics are often added if a bacterial infection is suspected with COPD.	
PROGRESSION	**~50% fail to improve on 1st Line treatments**	**~85% fail to improve on 1st Line treatments**
ADMISSIONS	Persistent hypoxia, severe respiratory distress, poor response to initial treatment, altered mental status and/or a history of exacerbations drive admission decisions	
	~1 million ED visits or hospitalizations/yr **10-30% of Asthma patients are hospitalized** **LOS typically ranges from 2 to 3 days** **~50% meet treatment failure criteria within 4 weeks of an exacerbation, with 20% requiring a re-visit to the ED**	**~1.3 million ED visits or hospitalizations/yr** **~41% of COPD patients are hospitalized** **LOS typically ranges from 4 to 7 days** **~50% fail treatment within 4 weeks of an exacerbation with >10% of patients requiring re-hospitalization**
LONG-TERM CARE	As symptoms improve, hospital physicians coordinate care with PCPs or pulmonologists; asthma patients are most likely to get treated by a PCP in the outpatient setting	COPD patients are typically older and have more comorbidities than asthma patients, and are therefore more likely to be referred to a pulmonologist upon discharge

ED = emergency department; LOS = length of stay; PCP = primary care physician; SoC = standard of care

Treatment Location for Asthma Patients Experiencing an Exacerbation in the U.S.*



Treatment Location	Projected U.S. Patients*
Took Medication at Home	2,466,667**
Went to Doctor's Office	1,266,667
Went to Urgent Care (not ED or hospital)	1,333,333
Emergency Department (not hospital)	1,000,000
Hospitalized (with or without UC or ED)	333,333
Did Nothing and Stayed Home	200,000
*Projections based on 1 million ED visits per year	

Total addressable annual market size for acute asthma exacerbations in U.S.:
>1 million patients

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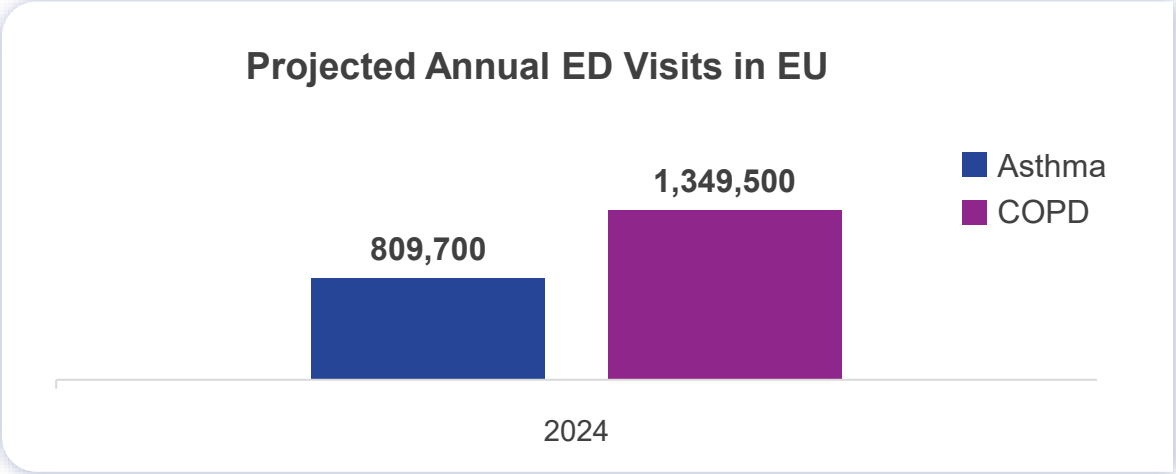
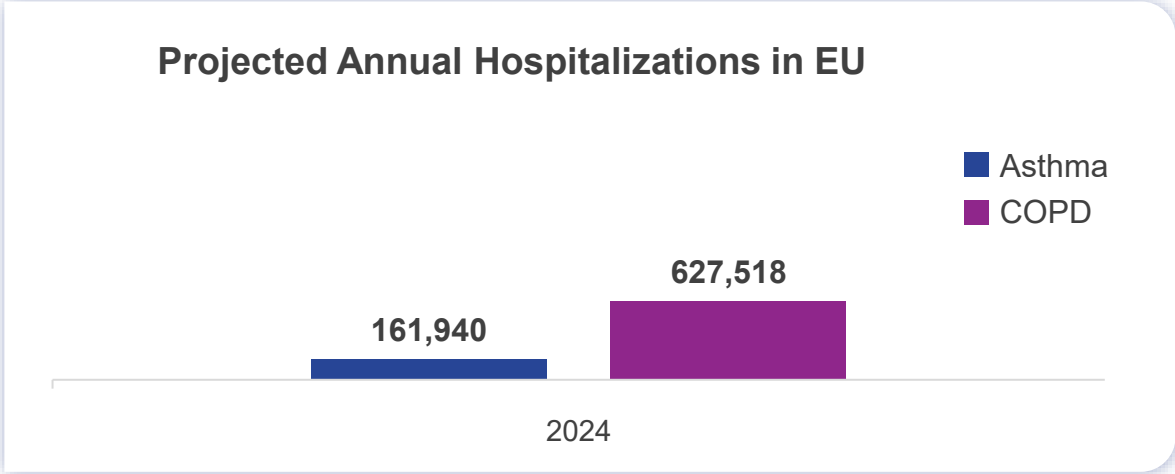
*Gardner, et al. Ann Allergy Asthma Immunol 2025:1-7 **Future upside opportunity for use as rescue treatment at home. ED – Emergency Department; UC – Urgent Care

Asthma and COPD are Global Problems: Projected 2024 European Union Asthma & COPD ED Visits / Hospitalizations

Projected annual ED/hospital visits associated with asthma and COPD exacerbations are similar in the EU and US





Key Statistics and Considerations

- Studies report **~20% of asthma patients are hospitalized, and upwards of ~20% of patients returned to the ED within 30 days**[1-9]
- Studies suggest the **prevalence of COPD exacerbations in the EU closely mirrors that of the US**[10-14]
- **Hospitalization rates for exacerbations among COPD patients range from ~32% to 61% across the EU, with ~24% of patients returning to the ED within 30 days**[10-14]

Sources: **1.** Suruki et al., 2017; **2.** Engelkes et al., 2020; **3.** Mazurek et al., 2018; **4.** OECD 2018; **5.** Mayers et al., 2022; **6.** Skene et al., 2023; **7.** Ayar et al., 2022; **8.** Hardtstock et al., 2022; **9.** Korn et al., 2022; **10.** Kong et al., 2020; **11.** Bergs et al., 2022; **12.** Liew et al., 2023; **13.** Ali et al., 2019; **14.** Rochester et al., 2022.

ED = emergency department

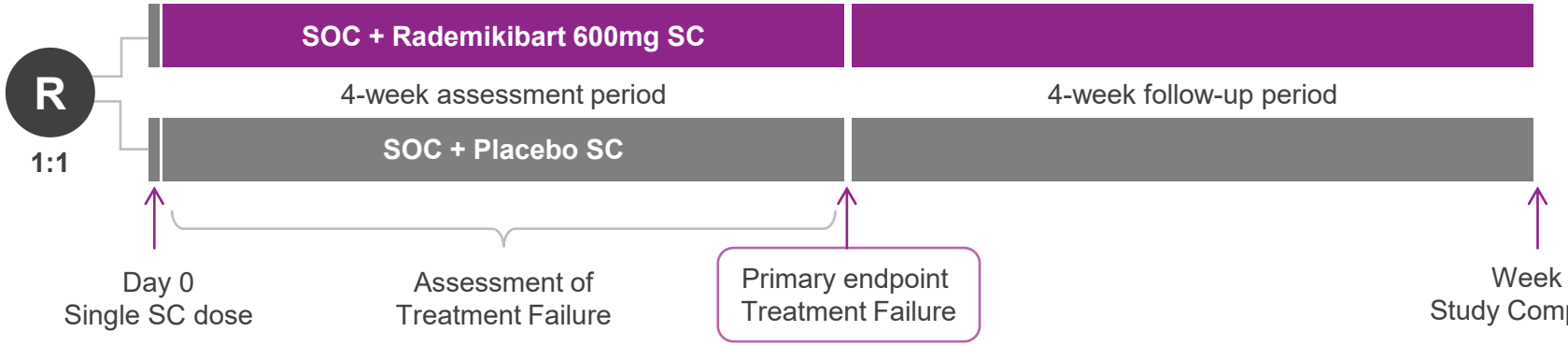
Replicate Phase 2 Clinical Trials of Rademikibart for Treatment of Acute Exacerbations of Chronic Respiratory Disease Initiated

Enrollment Complete in Both Studies; Topline Data in September

Seabreeze

STAT STUDY DESIGN

160 subjects*



	Population		Primary Endpoint	Secondary Endpoints	Key Exploratory Endpoints
Seabreeze STAT Asthma	Adolescents and adults at urgent outpatient visit, ED or hospital	Eosinophil count of ≥ 300 cells/μL and ≥1 exacerbation in prior ~12 months	Treatment Failure (28 days after randomization) includes: • death (any cause), • (re)admission to hospital, • urgent visit to outpatient/ED provider for symptom worsening, or • necessity to intensify pharmacologic treatment.	•**KEY**: Absolute change from baseline in post-bronchodilator (BD) FEV1 at Wk 1; •Rate of exacerbations in 28 days •Time to new exacerbation in 28 days •Absolute change in post-BD FEV1 at Day 3 & Wk 4 •Mean change in respiratory symptoms. •Safety	•Time to ready for discharge in hospitalized patients •Disease specific-PROs
Seabreeze STAT COPD	Adults at urgent outpatient visit, ED or hospital				

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Abbreviations: COPD = Chronic obstructive pulmonary disease; FEV_1 = forced expiratory volume in 1 second; PRO =patient-reported outcome; SC = subcutaneous; SOC = standard of care:

Recent Investigator-Initiated Trial Validated Acute Exacerbation Study Approach and Provides a Roadmap to Improve Our Planned Acute Trials

Treating eosinophilic exacerbations of asthma and COPD with benralizumab (ABRA): a double-blind, double-dummy, active placebo-controlled randomised trial

Sanjay Ramakrishnan, Richard E K Russell, Hafiz R Mahmood, Karolina Krassowska, James Melhorn, Christine Mwasuku, Ian D Pavord, Laura Bermejo-Sanchez, Imran Howell, Mahdi Mahdi, Stefan Peterson, Thomas Bengtsson, Mona Bafadhel

Summary

Background Exacerbations of asthma and chronic obstructive pulmonary disease (COPD) are important events and are associated with critical illness. Eosinophilic inflammation is a treatable trait commonly found during acute exacerbations of asthma and COPD. We hypothesised that for patients with eosinophilic exacerbations, a single injection of benralizumab, a humanised monoclonal antibody against interleukin-5 receptor-α, alone or in combination with prednisolone, will improve clinical outcomes compared with prednisolone, the standard of care.

Methods The Acute exacerbations treated with BenRAlizumab trial (ABRA) was a multicentre, phase 2, double-blind, double-dummy, active placebo-controlled randomised trial completed in the UK at Oxford University Hospitals NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. Patients were recruited from urgent care clinics and emergency departments of these two hospitals. At the time of an acute exacerbation of asthma or COPD, adults with blood eosinophil counts of equal to or more than 300 cells per µL were randomly assigned in a 1:1:1 ratio to receive acute treatment with: prednisolone 30 mg once daily for 5 days and 100 mg benralizumab subcutaneous injection once (BENRA plus PRED group); placebo tablets once daily for 5 days and 100 mg benralizumab subcutaneous injection once (BENRA group); or prednisolone 30 mg once daily for 5 days and placebo subcutaneous injection once (PRED group). Randomisation was performed with a centralised interactive computer randomisation service. All patients and study research staff involved in data collection were masked to study blood results and treatment allocation. The co-primary outcomes were proportion of treatment failures over 90 days and total visual analogue scale (VAS) symptoms at day 28 in the pooled benralizumab groups compared with the prednisolone alone group and analysed in the intention-to-treat population. The trial was registered on Clinicaltrials.gov NCT04098718.

Findings Between May 13, 2021, and Feb 5, 2024, 287 patients were screened for study inclusion. 129 were excluded due to not having an exacerbation captured or not meeting the eosinophil exclusion criteria. 158 patients were randomly assigned at acute eosinophilic exacerbation of asthma or COPD where 86 (54%) patients were female and 72 (46%) were male with a mean age of 57 years (range, 18–84). 53 patients were randomly assigned to the PRED group, 53 were randomly assigned to the BENRA group, and 52 were assigned to the BENRA plus PRED treatment group. At 90 days, treatment failures occurred in 39 (74%) of 53 in the PRED group, and 47 (45%) of 105 in the pooled-BENRA group (OR 0·26 [95% CI 0·13–0·56]; p=0·0005). The 28-day total VAS mean difference was 49 mm (95% CI 14–84; p=0·0065), favouring the pooled-BENRA group. There were no fatal adverse events and benralizumab was well tolerated. Notably, hyperglycaemia and sinusitis or sinus infection adverse events were related to the prednisolone study drug only.

Interpretation Benralizumab can be used as a treatment of acute eosinophilic exacerbations and achieves better outcomes than the current standard of care with prednisolone alone. These results offer a new way of treating eosinophilic endotypes of asthma and COPD exacerbations.

Lancet Respir Med 2024
Published Online November 27, 2024
https://doi.org/10.1016/S2213-2600(24)00299-6
See Online/Comment https://doi.org/10.1016/S2213-2600(24)00323-0

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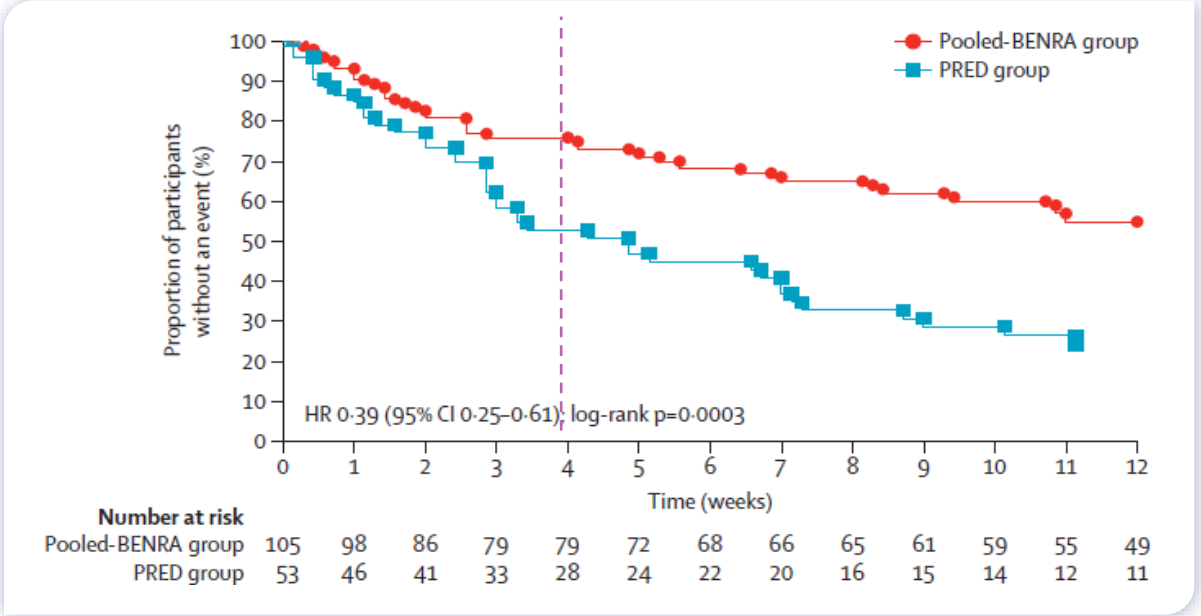
mona.bafadhel@kcl.ac.uk

- ~45% of SOC + placebo experienced treatment failure criteria by 4 weeks
- Benralizumab reduced treatment failure at 30 days by 50%
- Little separation in the first 3-weeks indicating slow onset of effect of benralizumab
- Based on published data, rademikibart may be more effective than benralizumab at improving overall lung function (FEV_1)



New Phase 2 Clinical Trial of Rademikibart via IV Push for Treatment of Acute Exacerbations of Chronic Respiratory Diseases

Seabreeze STAT IV

- **CBP-201-209**: *A Phase 2, Open-Label, Single-Arm Trial to Evaluate IV Rademikibart as an Add-On Treatment for an Acute Exacerbation in Participants With Asthma or COPD With Type 2 Inflammation*
- **Purpose of Study:** *Bridge from IV push to SC administration for treating acute exacerbations*
  - To compare using descriptive statistics to data from Phase 2 acute exacerbation trials evaluating a single 600 mg SC rademikibart dose in asthma (CBP-201-206) or COPD (CBP-201-207) who require an urgent healthcare visit.
    - To assess efficacy of a single 300 mg 2-minute IV push of rademikibart on lung function for acute exacerbation.
    - To evaluate safety, PK, PD, health-related quality of life (HRQoL), and healthcare resource utilization.
    - Trial run for Phase 3 with IV administration
- **Clinical Study Sites:** *Up to 16 sites with good enrollment in SC Phase 2 acute exacerbation trials*
- **Patient Population**:
  - Prior stable participants in Channel 1 of SC Phase 2 trials who had not experienced a qualifying exacerbation prior to randomization closing
  - New stable participants (Chanel 1) are eligible if prior exacerbation ~12 months prior to consent for new trial
  - New participants who experience an exacerbation that requires an urgent healthcare visit for treatment (Chanel 2)

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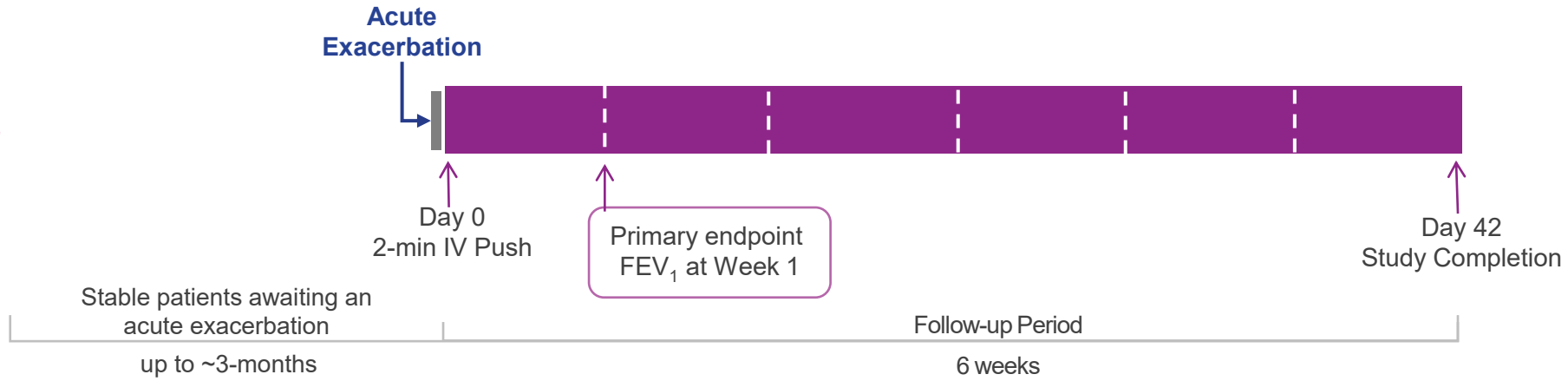
New Phase 2 Clinical Trial of Rademikibart via IV Push Study Design

Seabreeze STAT IV

STUDY DESIGN

Open-label, Single-arm
40 Subjects



	Population		Primary Endpoint	Secondary Endpoints	Key Exploratory Endpoints
Cohort A: ASTHMA N=20	Adults, aged 18 to 75 years	Acute exacerbation requiring an urgent healthcare visit and systemic corticosteroid as standard of care for treatment Eosinophil count of ≥ 300 cells/μL, ≥1 exacerbation in prior ~12 months	Change from baseline in post-BD FEV_1 at Week 1. [NOTE: Key Secondary Endpoint in Seabreeze STAT Asthma and COPD studies.]	Change from baseline in in lung function at scheduled timepoints (Days 1*, 2*, 3 14, 28 and 42). Incidence of treatment-emenrgent adverse events	Rate of new acute exacerbations Disease specific-PROs Use of systemic corticosteroids. Treatment Failure at any time [NOTE: Same definition as in Seabreeze STAT Asthma and COPD studies.] Healthcare resource utilization
Cohort B: COPD N=20	Adults, aged 40 to 85 years				

* Lung function testing on Days 1 & 2 generally preformed for hospitalized participants.

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We Plan to Propose IV Administration for Acute Exacerbations in the ED

- In addition to faster on-set of airway improvement, IV administration also provides a significant financial benefit:
  - Current dose of 300 mg is half of SC loading dose; 150 mg IV dose will also be assessed
  - Different indication, dose and presentation provide the basis for differential pricing in the hospital setting:
    - For example, STELARA is $309.36/ mg for SC and $15.57/ mg for IV dose[1]
- Goal is to meet with FDA in 4Q2026 to discuss Phase 3 plans for acute indications
  - Phase 2 results will help determine phase 3 endpoint (treatment failure or FEV_1) and sample size
- If both Seabreeze Stat Asthma and COPD are positive, we may prioritize asthma for full acute and chronic development based on previously completed positive 24-week Phase 2b asthma study (66% in US patients) and potentially positive Phase 3 52-week chronic asthma study from China (expect topline results 1H2027).

ED: Emergency Department, SC: subcutaneous 1. 2024 Red Book

Preliminary Topline Results from Rademikibart IV Push Study Confirm That:

- The large and rapid improvement in FEV_1 observed in Phase 2 chronic asthma study can be achieved more quickly and maintained through at least 29 days with a single IV administration
- The large increase in FEV_1 observed in COPD-like patients in prior Phase 2 study can rapidly be obtained and maintained in COPD patients with IV administration

Phase 1, Single-dose, Placebo-controlled, 2-Part Study of 300 mg IV Rademikibart (Study CBP-201-105) Preliminary Results

PART A
Healthy Adults

Part A – Evaluation of varying IV infusion rates
- Healthy Volunteers: 3 cohorts evaluating 30-, 15- or 2-minute infusion rates
- Key Endpoints: PK, safety and tolerability
- No differences in safety or pharmacokinetics observed across the 3 infusion rates
- 2-minute IV push selected for Part B

PART B
Stable Patients

Part B1 (asthma) – Evaluation of 2-minute IV push
- Patients: Current or former smoker with EOS ≥200 cells/µL + FeNO ≥25 ppb in non-smokers (smoking lowers FeNO so no lower limit for smokers)
- Key Endpoints: PK, Safety, tolerability, change from baseline in FEV_1 and PD biomarkers
- All patients have completed Day 29

Part B2 (COPD) – Evaluation of 2-minute IV push
- Patients: Current or former smoker with EOS ≥200 cells/µL + FeNO ≥25 ppb in non-smokers (smoking lowers FeNO so no lower limit for smokers)
- Key Endpoints: PK, Safety, tolerability, change from baseline in FEV_1 and PD biomarkers
- All but one patient completed through Day 29

AUC: Area Under the Curve; COPD: Chronic Obstructive Pulmonary Disease; EOS: Eosinophils; FEV1: Forced Expiratory Volume in 1 second; IV: intravenous; PD: Pharmacodynamic; PK: Pharmacokinetic

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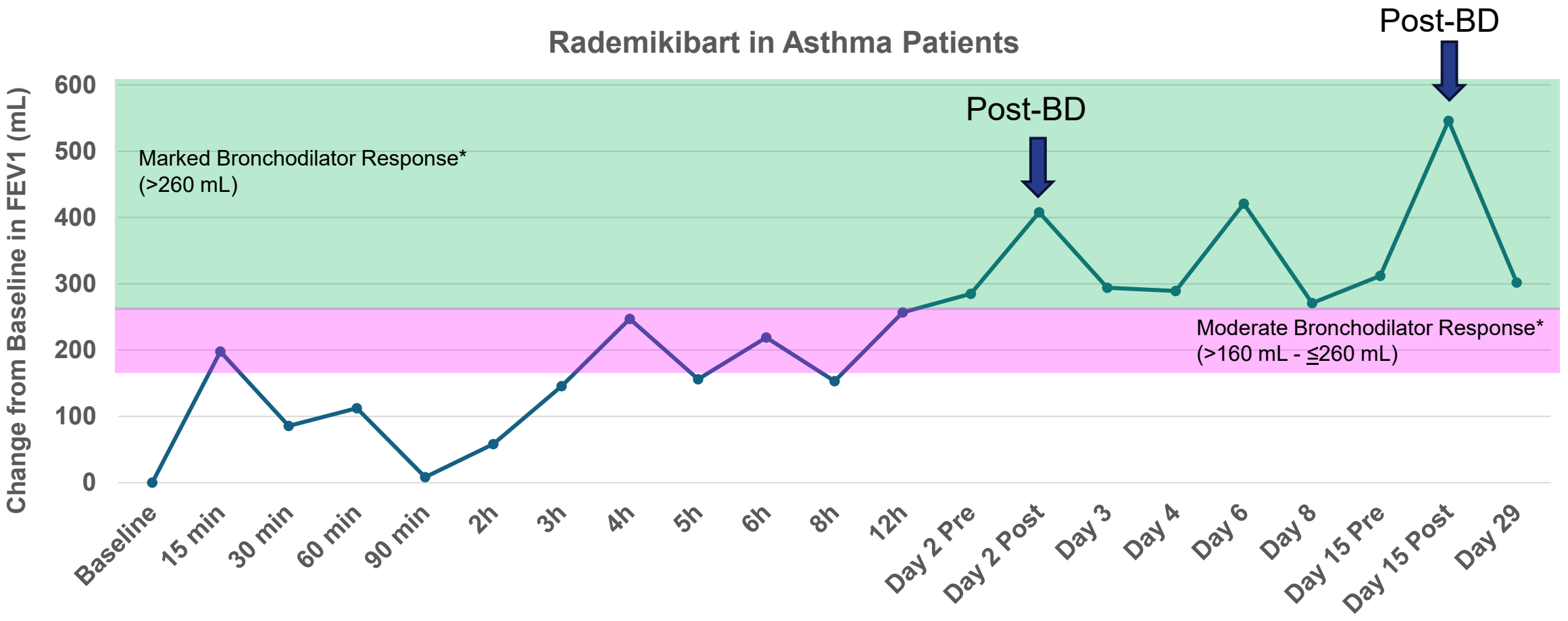
Phase 1 IV Study Participants & Key Demographics

Number of Participants	Part A Healthy Volunteers	Part B1 Stable Asthma	Part B2 Stable COPD
Planned	24	10	10
Randomized	24	12 (10 active:2 placebo)	10 (8 active:2 placebo)
Key Demographics:			
Sex	58.3% male	83.3% female	60% female
Mean Age (years)	34.7	52.0	59.0
Mean FEV_1 at Baseline (Range)	--	1.9 L (0.7 – 3.1 L)	1.55 L (0.76 – 2.13 L)
Race	79.2% Black/20.8% White	75% White/25% Black	90% White/10% Black
Ethnicity	91.7% Non-Hispanic	91.7% Hispanic	100% Hispanic
Current smoker	--	67%	90%
Eosinophil Count	--	330 cells/µL (58% 200-250 cells/µL	330 cells/µL (50% 200-250 cells/µL
FeNO	--	24.2 ppb (50% ≤10 ppb	12 ppb

Study CBP-201-105: Asthma Patients Change from Baseline in FEV_1 Preliminary Topline Results



Placebo-corrected; Preliminary data: all 12 patients have completed Day 29 visit

All time-points are pre-bronchodilator, except as shown: BD = bronchodilator

*Kaminsky DA, Ann Am Thorac Soc Vol 16, No 12, pp 1495–1503, Dec 2019What Is a Significant Bronchodilator Response?

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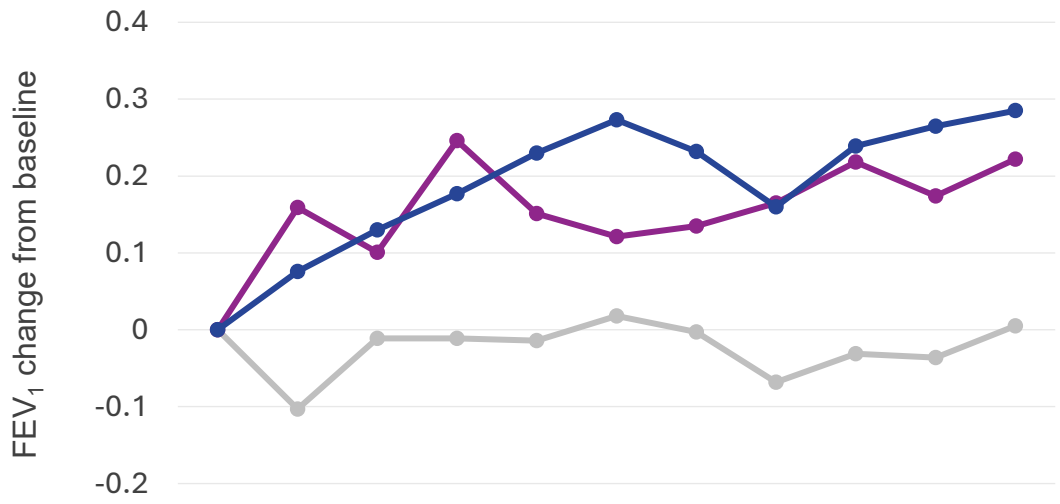
Analysis of COPD-Like Patients from Global Phase 2b Asthma Study

Asthma onset age > 40 year and post−bronchodilator FEV_1/forced vital capacity < 0.7 at screening visit

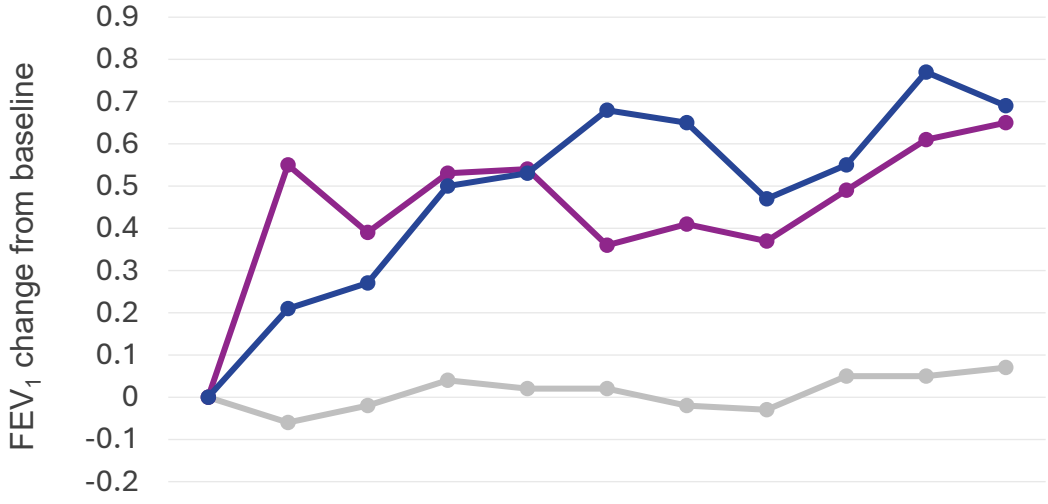
COPD-like Patients
All EOS levels



Week	1	2	4	6	8	10	12	16	20	24
Placebo (N)	27	24	24	26	23	25	26	23	23	22
150 mg (N)	17	16	16	16	15	13	14	17	14	14
300 mg (N)	19	21	19	19	17	20	18	16	19	17

Placebo CBP-201 150 mg CBP-201 300 mg

COPD-like Patients
EOS ≥300 cells/uL

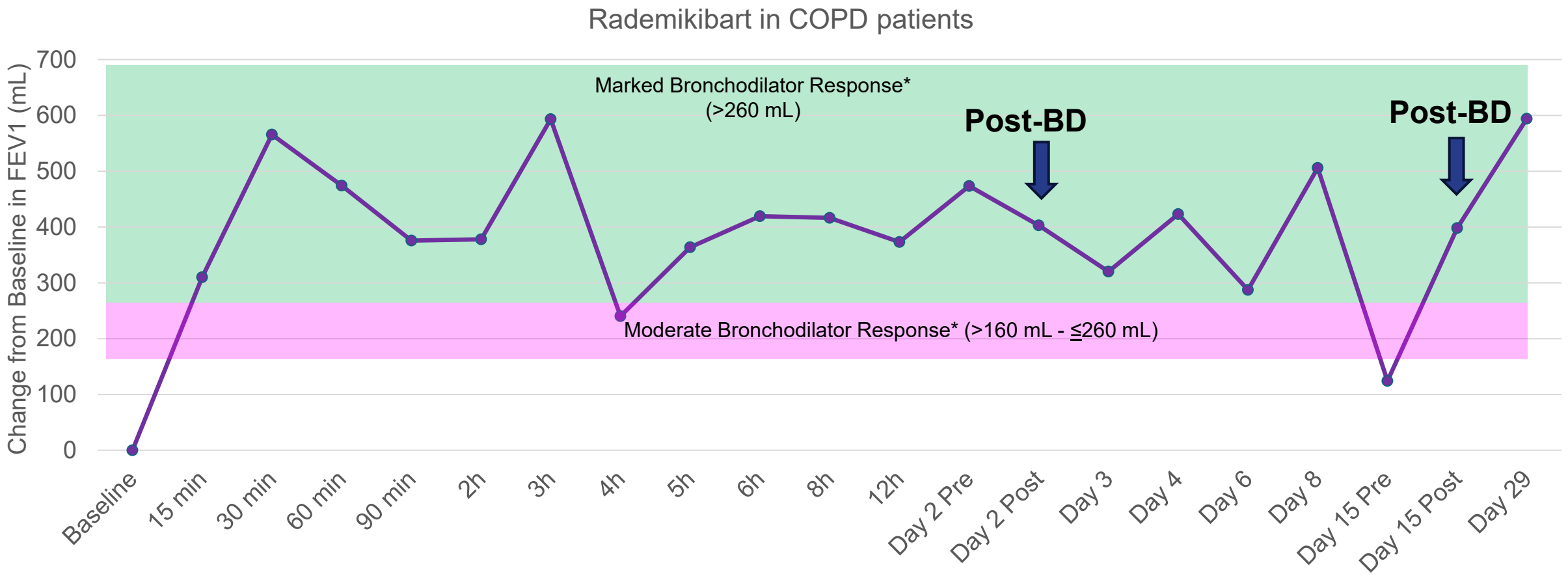


Week	1	2	4	6	8	10	12	16	20	24
Placebo (N)	8	8	7	8	6	8	8	7	7	7
150 mg (N)	5	5	5	4	3	4	4	5	3	3
300 mg (N)	6	7	6	7	6	7	5	6	6	6

Placebo Rademikibart 150 mg Rademikbart 300 mg

EOS = eosinophils. FEV_1 = Forced expiratory volume in one second

Study CBP-201-105: COPD Patients Change from Baseline in FEV_1 Preliminary Topline Results



Placebo-corrected; preliminary results as one of 10 patients has not completed Day 29 visit

All time-points are pre-bronchodilator, except as shown; BD = bronchodilator

*Kaminsky DA, Ann Am Thorac Soc Vol 16, No 12, pp 1495–1503, Dec 2019What Is a Significant Bronchodilator Response?

Comparison of Preliminary Results with IV Rademikibart to Established Therapy in COPD Patients for Change in FEV_1

- FEV_1 increases in COPD patients with established therapy that are considered clinically important:
  - Long-acting β–agonist (LABA) - 100 mL[1]
  - Inhaled corticosteroid (ICS) - 50 mL[1]
  - PDE4 - 45–100 mL[1]
  - Combination ICS/LABA - 100–164 mL[1]
- DUPIXENT – post-bronchodilator change from baseline (placebo-corrected) at Week 2: ~10 mL[2] to ~80 mL[3] increase (compare to 398 mL increase with rademikibart on Day 15 post-bronchodilator)
- OHTUVAYRE[4] – 152-157 mL peak improvement on Day 1 (compared to 590 mL peak increase with rademikibart at 3 hours on Day 1) Average AUC0-12 FEV1 change from baseline was 87-94mL in their two studies; rademikibart is approximately 300 mL on Day 1
- **Rademikibar**t
  - from 15 minutes through Day 28 mean increases from baseline in FEV_1 of approximately ~200 mL - 400 mL were observed at almost all timepoints in patients receiving rademikibart
- Acute treatment is a white space that rademikibart could own as OHTUVAYRE and the biologics for COPD are all approved for chronic maintenance and have explicit warnings to not be used to treat acute exacerbations or bronchospasm (same is true for biologics approved for chronic asthma)

1.James F. Donohue (2005) Minimal Clinically Important Differences in COPD Lung Function, COPD: Journal of Chronic Obstructive Pulmonary Disease, 2:1, 111-124, DOI:10.1081/COPD-200053377; 2. DUPIXENT US Package insert NOTUS Study; 3. DUPIXENT US Package Insert BOREAS Study; 4. Ohtuvayre promotional material

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Phase 1 IV Study Participants Safety & Tolerability Preliminary Results

Number of Participants	Part A Healthy Adults	Part B1 Stable Asthma	Part B2 Stable COPD
Randomized	24	12	10
Serious adverse events	0	0	0
Severe (Grade 3) adverse events	0	0	0
Adverse events leading to early study discontinuation	0	0	0
Adverse events of special interest: • Conjunctivitis • Keratitis • Severe injection site reactions lasting >24 hours • Parasitic and opportunistic infections • Anaphylaxis	 0 0 0 0 0	 0 0 0 0 0	 0 0 0 0 0

US Market Research: Obtaining Acute Treatment Indications Results in Significantly Greater Penetration into Asthma and COPD Markets

Clinician Perspectives Highlight Rademikibart's Potentially Differentiated Profile	• U.S. Clinicians believed the acute indication was a clear differentiator between rademikibart and other biologics approved for patients with eosinophilic phenotype • Once patients were successfully treated with rademikibart acutely, clinicians expected to maintain 75% of these patients on rademikibart chronically
Persistent Unmet Need with Opportunity to Penetrate Acute Setting	• All biologics approved for asthma or COPD and OHTUVAYRE have explicit warnings to not be used for treatment of acute bronchospasm or acute exacerbations* • New high-yield manufacturing process for rademikibart along with IV presentation will allow for hospital-friendly pricing in the acute setting
Significant Commercial Opportunity	• **Acute and chronic asthma and COPD indications resulted in WW peak sales forecast of ~$5B** • Upside opportunities exist for rademikibart to drive revenue even higher (e.g., acute use in clinics, steroid sparing opportunity)
Strong Rationale Supporting Rademikibart	• Rademikibart's rapid improvement of airway function observed in Phase 2 chronic study confirmed in IV study in both asthma and COPD patients; magnitude of FEV_1 improvement consistent across studies • ABRA benralizumab study provides higher level of confidence in obtaining a positive outcome in planned Phase 2 acute asthma and COPD studies**

*Drugs.com ** Ramakrishnan et al; *Lancet Respir Med 2024*; Published Online Nov 27, 2024

COPD=chronic obstructive pulmonary disease; WW = worldwide; EU = European Union; MOA = mechanism of action

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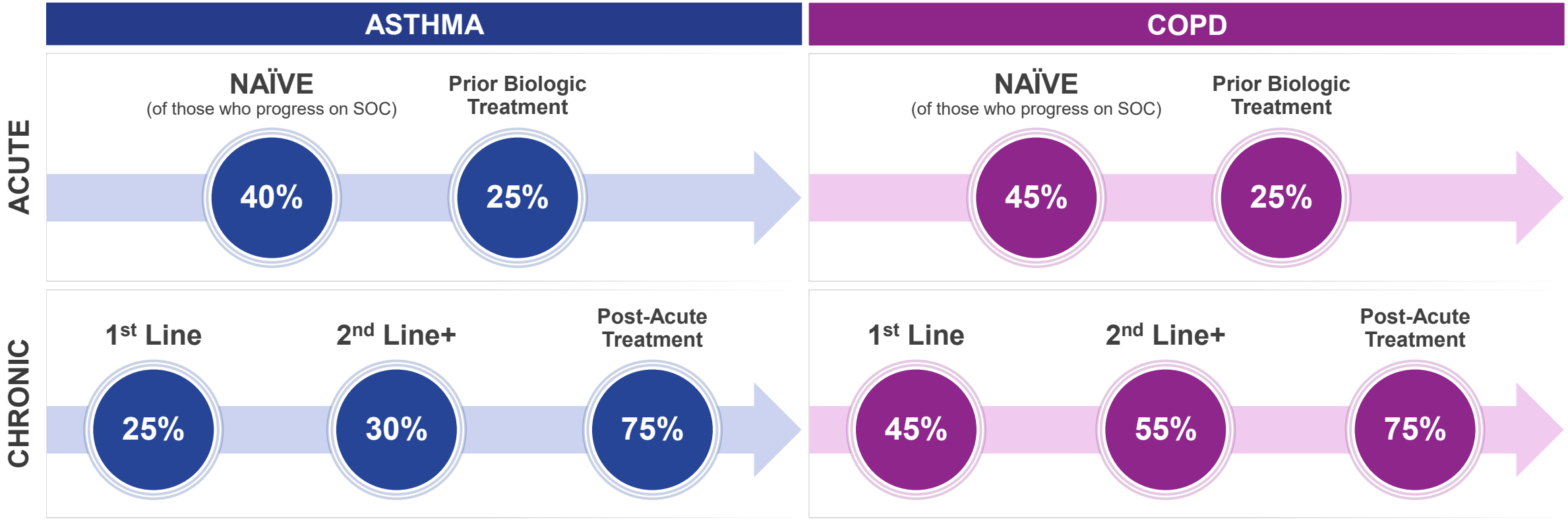
Rademikibart Expected Utilization in Asthma and COPD

Clinicians considered Rademikibart to be differentiated from other biologics by the dual indication



"Steroids and LABAs/LAMAs work well for these acute patients, so I wouldn't really use this up front. But for those patients that are refractory to those options and need something stronger, then I'd definitely use this."

"If a patient was treated with Product X during their acute exacerbation and it worked, then I'd keep them on it for maintenance. If they responded, why would I switch?"

Source: US HCP and Payer Qualitative Primary Research, HCP N=20, Payer N=10, October 2024.
NOTE: Percentages represent brand shares and do not account for earlier population cuts (e.g., pharmacologic treatment rate, biologic class share, progression rates, etc.)
COPD = chronic obstructive pulmonary disease; LABA = long-acting beta-agonist; LAMA = long-acting muscarinic antagonist

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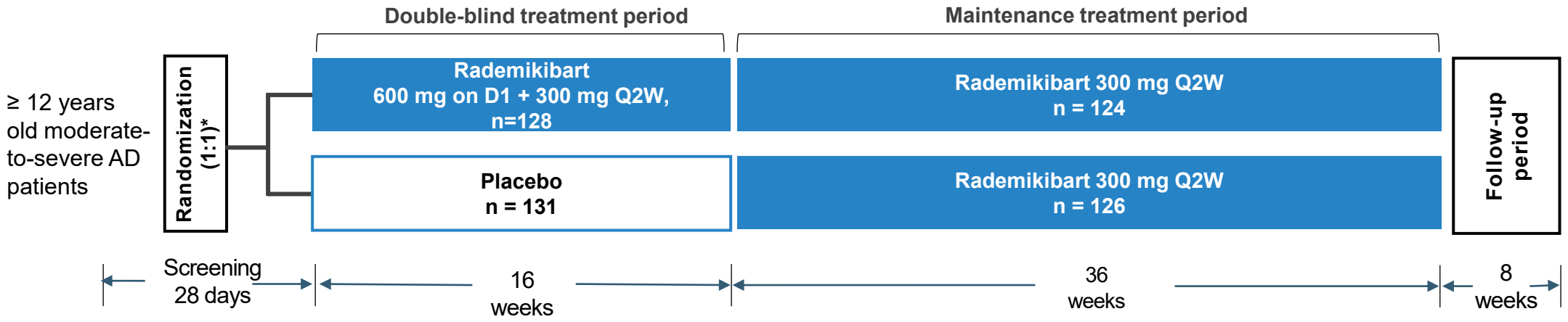
Rademikibart monotherapy in adult and adolescent patients with moderate-to-severe atopic dermatitis (AD): A 1-year, phase III, randomized, double-blinded, placebo-controlled trial (RADIANT-AD)

Title: 79594 – AAD Late-Breaking Research Session March 28

Study conducted by Simcere Pharmaceuticals in China

RADIANT-AD Study Design

- **Design:** a randomized, double-blind, placebo-controlled, phase 3 study at 57 study centers in China (NCT06477835)
- **Eligible patients:** ≥ 12 years old moderate-to-severe atopic dermatitis (AD) patients with EASI ≥ 16, IGA score ≥ 3 (5-point scale [0-4]), ≥ 10% BSA involvement, and weekly average of daily PP-NRS score ≥ 4
- ★ **Co-Primary endpoints:**
  - ① Proportion of subjects achieving IGA score of 0/1 with ≥ 2-point reduction at Week 16
  - ② Proportion of subjects achieving ≥ 75% improvement from baseline in EASI (EASI-75) at Week 16
- **Actual enrollment:** 259 patients (204 adults, 55 adolescents)



*Randomization stratified by: (1) baseline disease severity (IGA=3, IGA=4), (2) age (adult, adolescent)

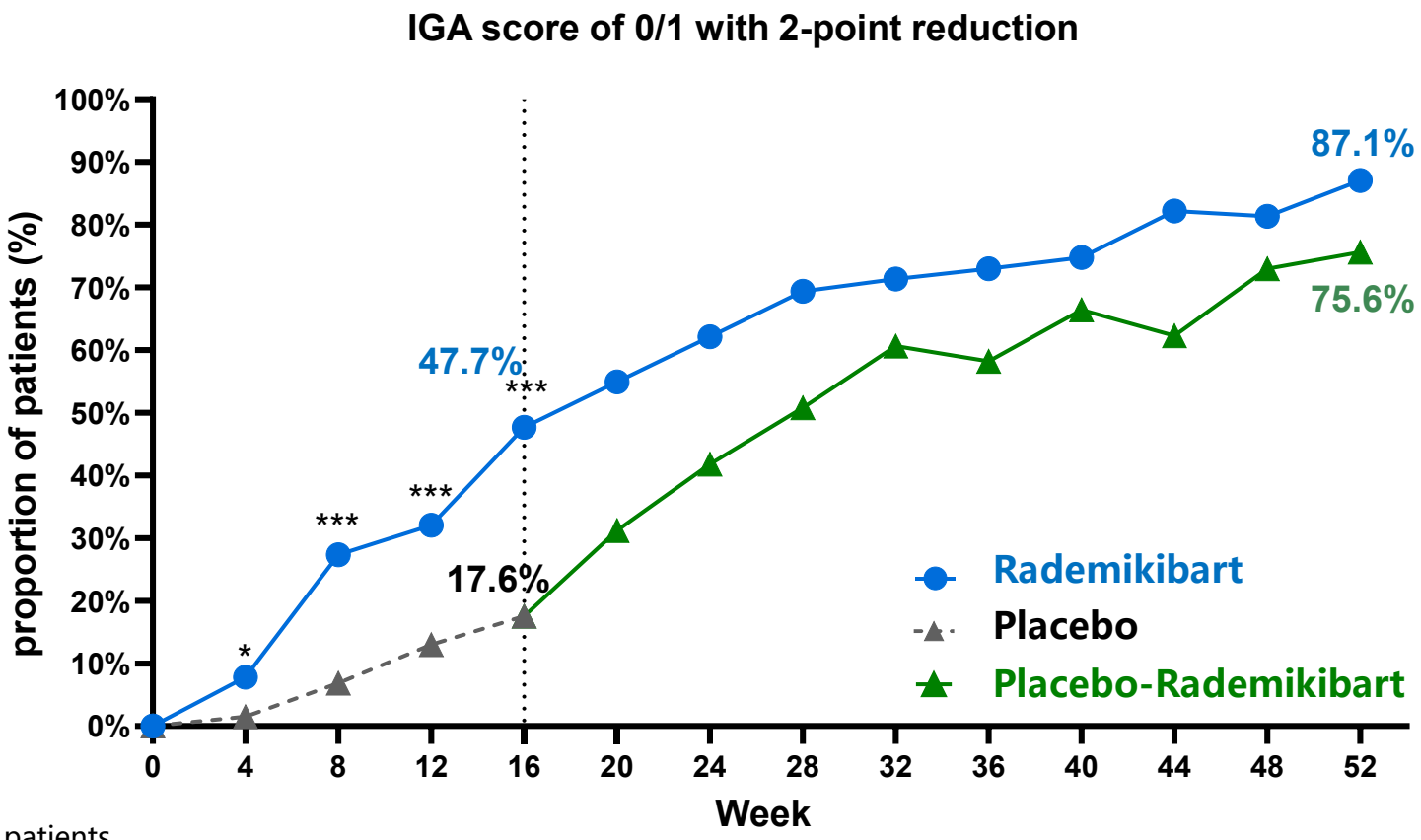
AD: Atopic Dermatitis; BSA: Body Surface Area; EASI: Eczema Area and Severity Index; IGA: Investigator's Global Assessment; PP-NRS: Peak Pruritus Numeric Rating Scale.

Baseline characteristics were generally balanced between Rademikibart and placebo groups

Baseline Characteristics	Rademikibart (N = 128)	Placebo (N = 131)	Overall (N = 259)
Age (y), mean (SD)	33.7 (17.5)	32.7 (16.4)	33.2 (16.9)
Age (y), n (%)			
12 - <18	27 (21.1%)	28 (21.4%)	55 (21.2%)
≥18	101 (78.9%)	103 (78.6%)	204 (78.8%)
Male sex, n (%)	83 (64.8)	85 (64.9)	168 (64.9)
BMI (kg/m^2), mean (SD)	24.1 (4.4)	23.9 (3.9)	24.0 (4.2)
Weight (kg), mean (SD)	68.4 (14.7)	68.1 (15.5)	68.3 (15.1)
Disease duration (y), mean (SD)	9.0 (6.8)	8.9 (6.9)	8.9 (6.8)
Affected BSA, mean (SD)	34.3% (17.7%)	32.9% (16.9%)	33.6% (17.3%)
IGA = 3, n (%)	76 (59.4%)	77 (58.8%)	153 (59.1%)
IGA = 4, n (%)	52 (40.6%)	54 (41.2%)	106 (40.9%)
EASI, mean (SD)	24.1 (9.2)	23.4 (8.8)	23.7 (9.0)
PP-NRS, mean (SD)	7.1 (1.4)	7.3 (1.4)	7.2 (1.4)

AD: Atopic Dermatitis; BMI: Body Mass Index; BSA: Body Surface Area; EASI: Eczema Area and Severity Index; IGA: Investigator's Global Assessment; PP-NRS: Peak Pruritus Numeric Rating Scale.

IGA 0/1 with 2-point reduction was significantly improved by Rademikibart at W16 and continued to rise up to W52



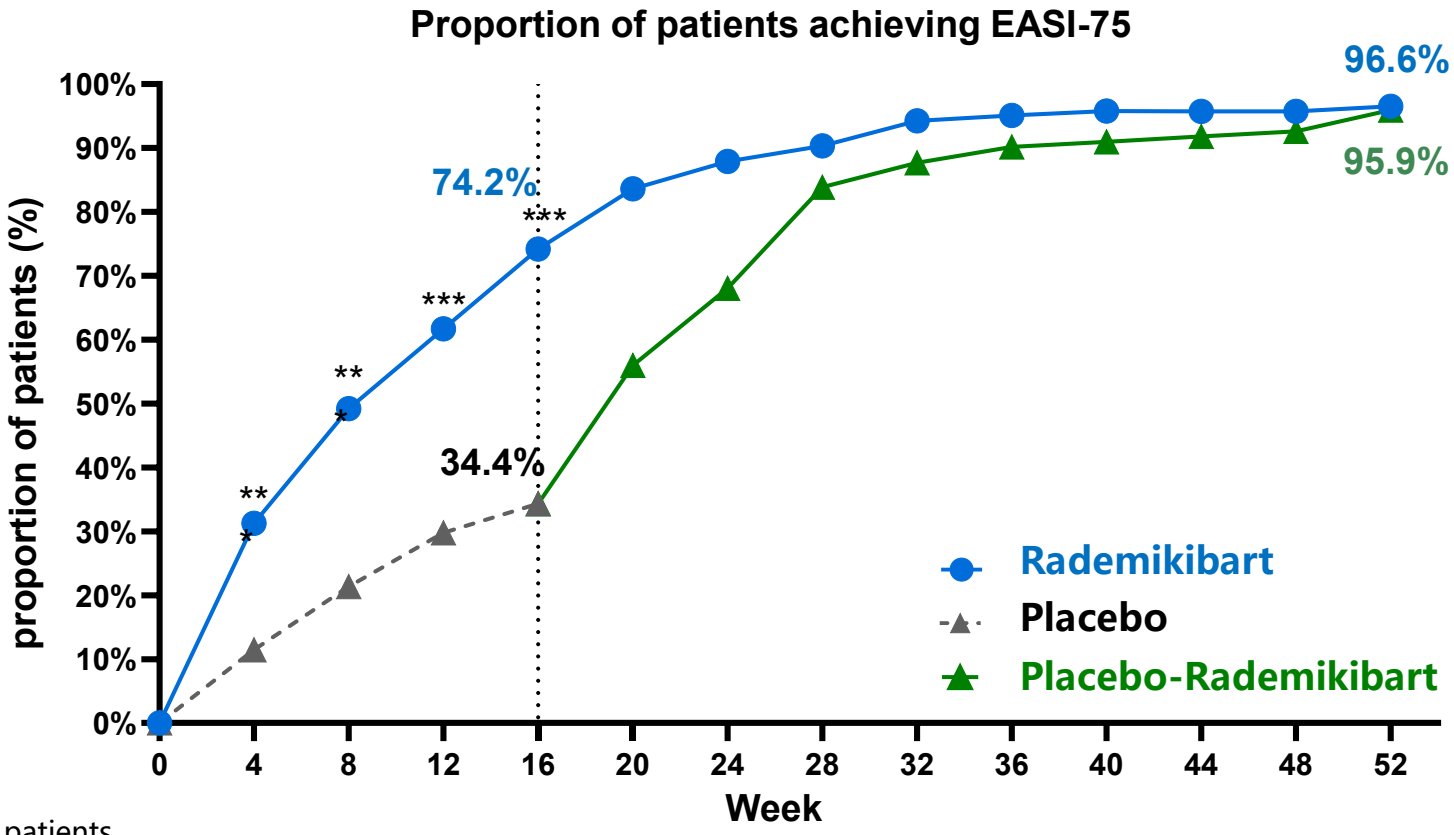
Number of patients							
Week	0	4	8	12	16	20	24	28	32	36	40	44	48	52
Rademikibart	128	128	128	128	124	122	119	116
Placebo	131	131	131	122	122	122	123

- IGA 0/1 response at W16 was statistically significantly higher in Rademikibart group compared to placebo.
- In Rademikibart group, IGA0/1 response demonstrated continued improvement through W52, reaching **87.1%**.
- After switching to Rademikibart treatment, placebo group showed rapid response, reaching 75.6% at W52.

***, **, * represent statistically significant at the one-sided α level of 0.0005, 0.005, and 0.025, respectively. IGA: Investigator's Global Assessment

Note: The summaries for W0-W16 are based on the full analysis set, with missing data handled using non-response imputation; summaries for W16-W52 are based on observed values.

EASI-75 response was significantly improved by Rademikibart at W16 and sustained through W52



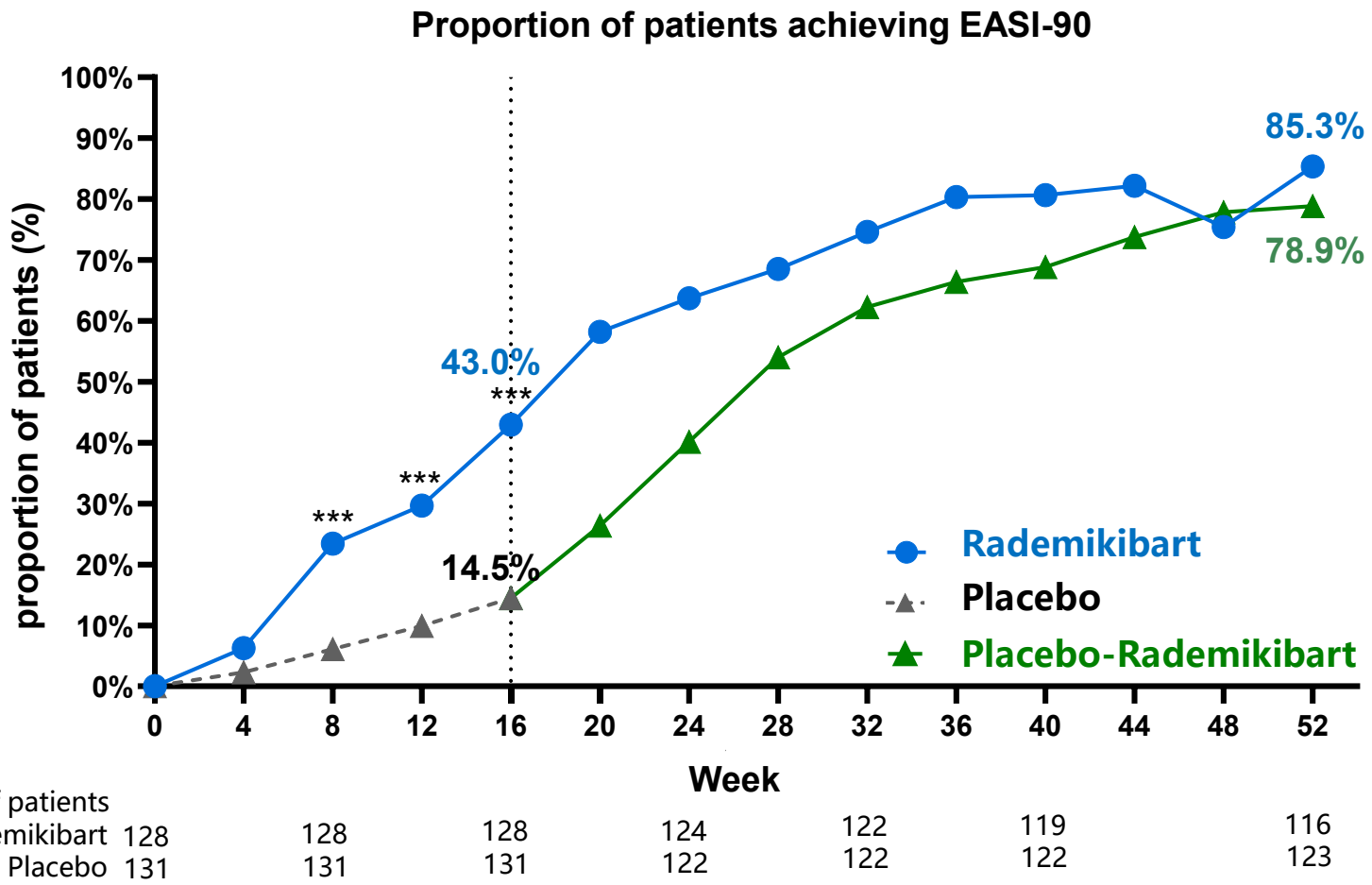
Number of patients													
Rademikibart	128		128		128		124		122		119		116
Placebo	131		131		131		122		122		122		123

- EASI-75 response at W16 was statistically significantly higher in Rademikibart group compared to placebo.
- In Rademikibart group, EASI-75 response demonstrated continued improvement through W52, reaching **96.6%**.
- After switching to Rademikibart treatment, placebo group showed rapid response, reaching 95.9% at W52.

***, **, * represent statistically significant at the one-sided α level of 0.0005, 0.005, and 0.025, respectively. EASI: Eczema Area and Severity Index; EASI-75: patients achieving ≥75% improvements from baseline in EASI score

Note: The summaries for W0-W16 are based on the full analysis set, with missing data handled using non-response imputation; summaries for W16-W52 are based on observed values.

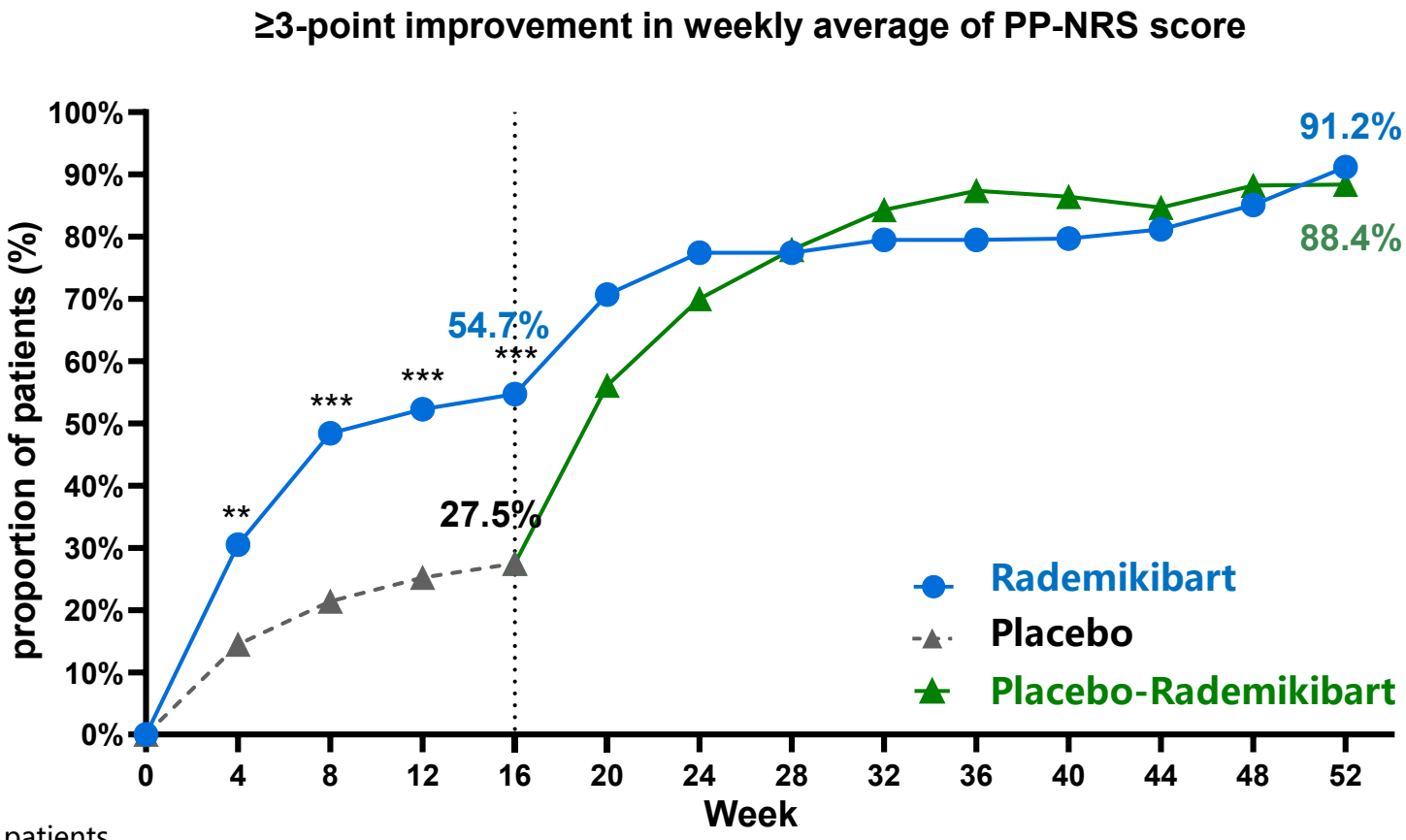
Rademikibart induced and maintained deep clearance of skin lesions compared to placebo



- EASI-90 response at W16 was statistically significant higher in Rademikibart group compared to placebo.
- EASI-90 response continued to rise through W52, reaching **85.3%**.
- After switched to Rademikibart treatment, placebo group showed rapid response, reaching 78.9% at W52.

***, **, * represent statistically significant at the one-sided α level of 0.0005, 0.005, and 0.025, respectively. EASI: Eczema Area and Severity Index; EASI-90: patients achieving ≥90% improvements from baseline in EASI score.
Note: The summaries for W0-W16 are based on the full analysis set, with missing data handled using non-response imputation; summaries for W16-W52 are based on observed values.

Rapid and sustained antipruritic effects of Rademikibart



- PP-NRS≥3 response at W16 in weekly average of PP-NRS score was statistically significantly higher in Rademikibart group compared to placebo.
- In Rademikibart group, PP-NRS≥3 response continued to improve through W52, reaching **91.2%**.
- After switching to Rademikibart treatment, placebo group showed rapid response, reaching 88.4% at W52.

***, **, * represent statistically significant at the one-sided α level of 0.0005, 0.005, and 0.025, respectively. PP-NRS: Peak Pruritus Numeric Rating Scale

Note: The summaries for W0-W16 are based on the full analysis set, with missing data handled using non-response imputation; summaries for W16-W52 are based on observed values.

The safety profile of Rademikibart was comparable to placebo, and remained safe for long-term use

TEAE summary W0-W16

	Rademikibart (N = 128) n (%)	Placebo (N = 131) n (%)
TEAE	78 (60.9%)	85 (64.9%)
Grade 3 TEAE	3 (2.3%)	0
Grade 4 TEAE	0	0
Grade 5 TEAE	0	0
TRAE	24 (18.8%)	35 (26.7%)
SAE*	3 (2.3%)	0
SAE related to study treatment	0	0
TEAE Leading to treatment permanent discontinuation**	1 (0.8%)	0
Injection site reaction	2 (1.6%)	0
Conjunctivitis	5 (3.9%)	4 (3.1%)

*3 SAEs were meniscus injury (D94), pneumonitis (D61, with related medical history at Screening), pulmonary mass/lung adenocarcinoma (D7).
**TEAE leading to treatment permanent discontinuation was pulmonary mass/lung adenocarcinoma (D7)

TEAE summary W0-W52

	Rademikibart (N = 128) W0-W52 n (%)	Placebo-Rademikibart (N = 106) W16-W52 n (%)
TEAE	106 (82.8%)	87 (69.0%)
Grade 3 TEAE	8 (6.3%)	7 (5.6%)
Grade 4 TEAE	0	0
Grade 5 TEAE	0	0
TRAE	40 (31.3%)	30 (23.8%)
SAE	7 (5.5%)	6(4.8%)
SAE related to study treatment*	1 (0.8%)	1 (0.8%)
TEAE Leading to treatment permanent discontinuation**	1 (0.8%)	1 (0.8%)
Injection site reaction	2 (1.6%)	0
Conjunctivitis	8 (6.3%)	7 (5.6%)

*SAE related to study treatment was vasovagal syncope (D154) and vestibular neuronitis (D229).
** pulmonary mass/lung adenocarcinoma (D7) and parotid gland enlargement/lymphadenopathy (D206, with related medical history)

TEAE: Treatment Emergent Adverse Event; TRAE: Treatment Related Adverse Event; SAE: Serious Adverse Event; W: Week.

Conclusions

Rademikibart treatment in patients with moderate-to-severe atopic dermatitis demonstrated:

- ***Rapid and sustained efficacy through 52 weeks***, with minimal plateau and near-maximal response achieved by ~90% of patients
- ***Greater long-term benefit with early initiation***, with higher Week-52 IGA response versus delayed switch from placebo at Week 16
- ***Favorable safety profile***, comparable to placebo and well tolerated with long-term use
- ***Low rates of conjunctivitis***, consistent with prior studies and comparable to placebo

Additional patient-reported outcomes and adolescent-specific analyses from the RADIANT-AD study will be reported separately at a later date

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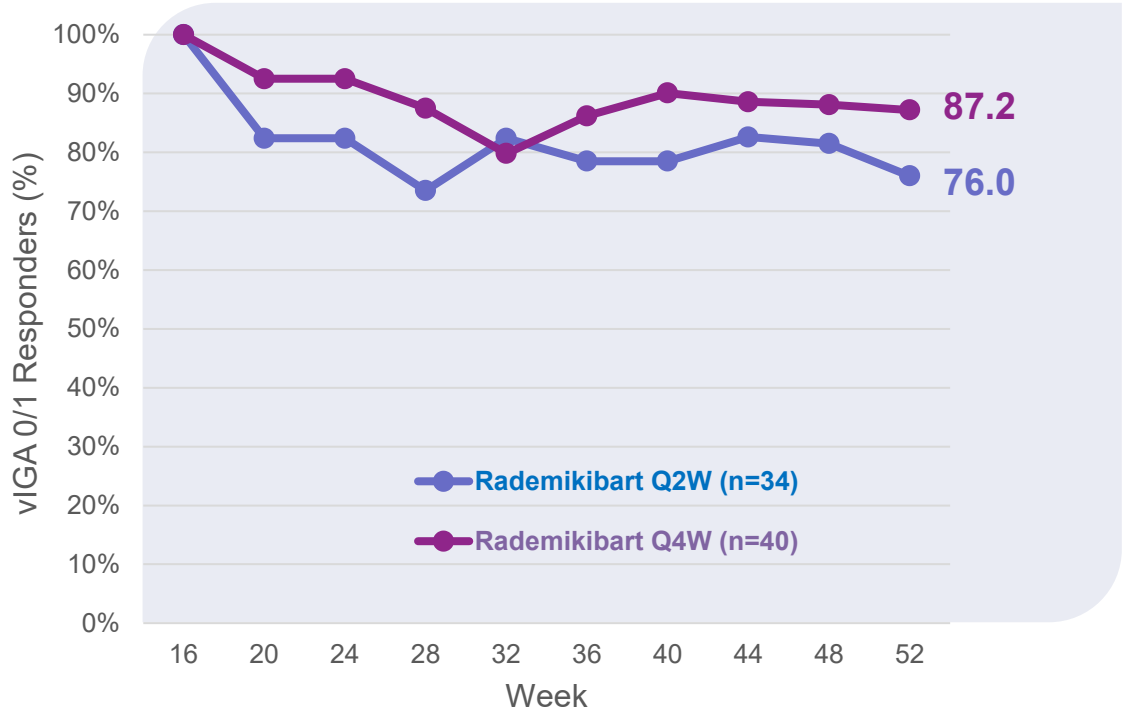
Maintenance of IGA 0/1 and EASI-75 Responses from Week 16 Through Week 52 Demonstrates the Sustained Benefit of Q4W Dosing in AD (Seaside China)

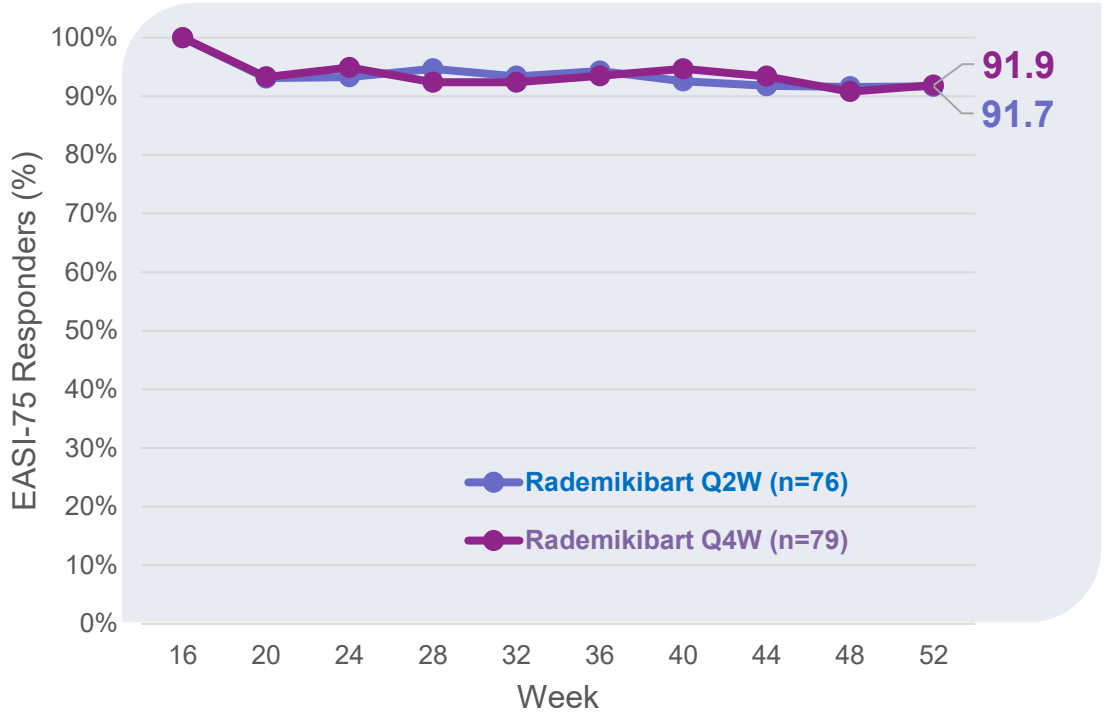
IGA 0/1 and ≥2-Point Reduction

(Percentage of Week 16 vIGA 0/1 responders to rademikibart maintaining response)



EASI-75

(Percentage of Week 16 EASI-75 responders to rademikibart maintaining response)



Q2W = Continued on Q2W dosing from Week 16. Q4W = Switched from Q2W to Q4W dosing at Week 16.

Data were analyzed by NRI-MI (non-responder imputation for rescue medications and multiple imputation for remaining missing data).

Abbreviations: EASI = Eczema Area and Severity Index. EASI-50 = at least 50% decrease from baseline. Q2W = every 2 weeks. Q4W = every 4 weeks. vIGA 0/1 = validated Investigator Global Assessment of 0 (clear skin) or 1 (almost clear).

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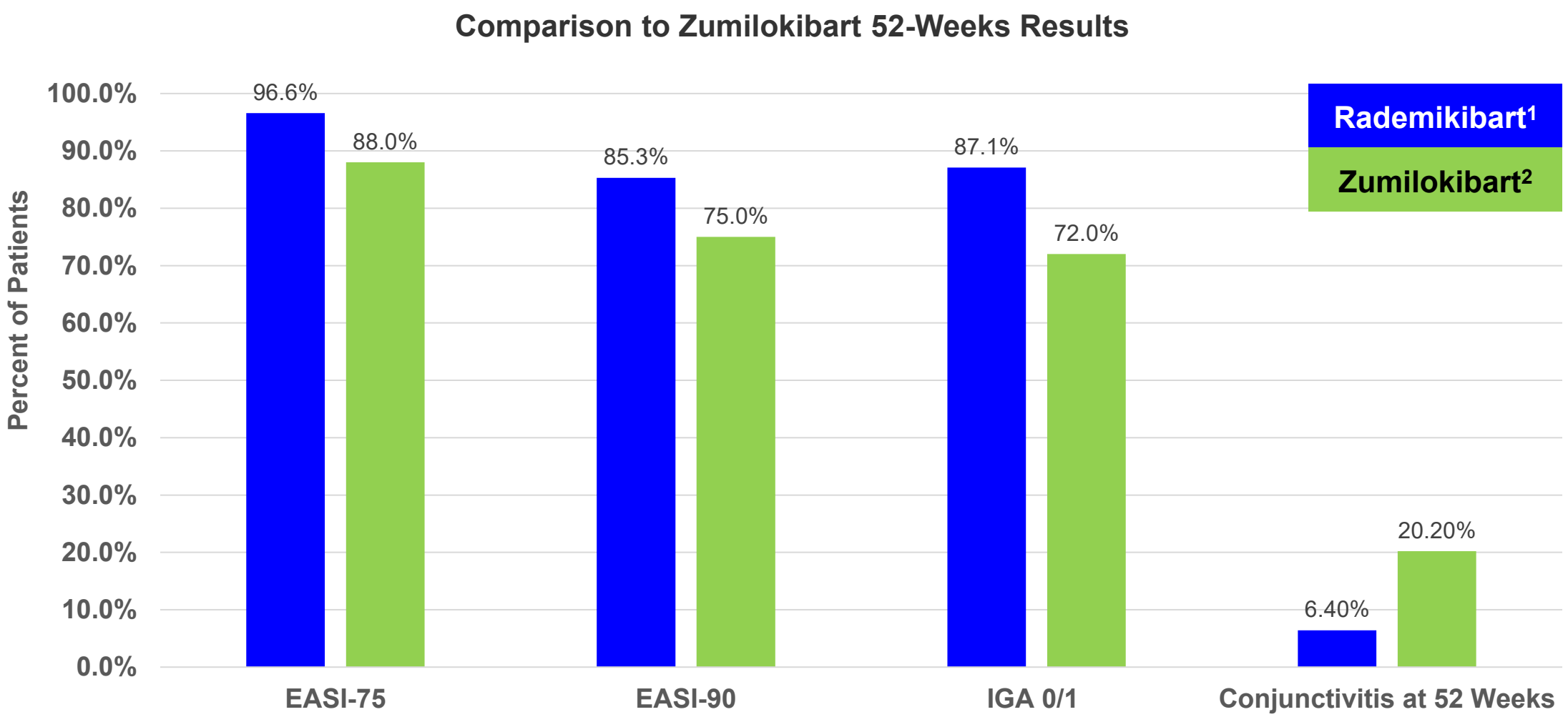
Rademikibart Demonstrates Best-in-Class Potential with Improved Safety Results



IGA 0/1 = Investigator Global Assessment of 0 (clear skin) or 1 (almost clear). EASI: Eczema Area and Severity Index; ; EASI-75: patients achieving ≥75% improvements from baseline in EASI score. EASI-90: patients achieving ≥90% improvements from baseline in EASI score.

1. Radiant-AD 52-week Results Title 79594 2026 AAD Annual Meeting; 2. 52-. March 2026 Apogee Therapeutics Overview Part A 52wk Q12W Dosing;

Potential Differences Between Rademikibart and Dupilumab

Rademikibart has

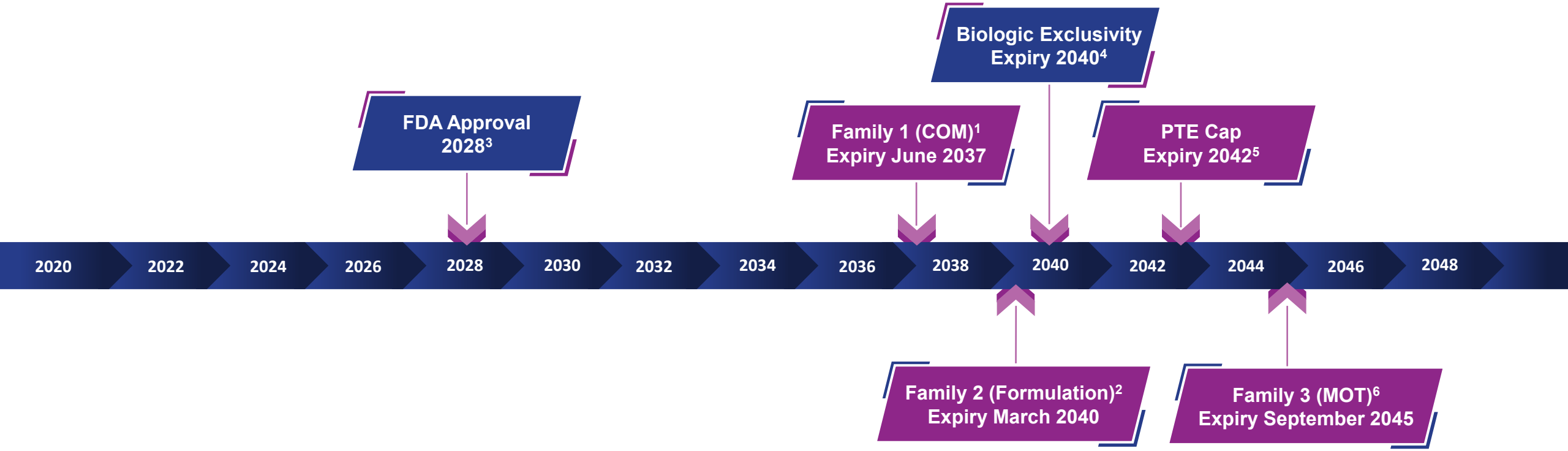
- In asthma and COPD:
  - Differential binding to the receptor resulting in enhanced internalization of drug-receptor complex
  - Demonstrated reductions in eosinophils during chronic dosing vs. significant increases observed with dupilumab
  - Unique mechanism of action of directly increasing pHSP20 in human airway smooth muscle cells and reversing the negative effects of IL-4/IL-13 on the dose response curve of β-agonists in lung slice experiments
  - Rapid onset of effect with subcutaneous dosing, which is accelerated with IV dosing
  - Larger increase in FEV_1 based on Phase 2 chronic asthma study (large increases seen in IV study as well)

- In Atopic Dermatitis[1]
  - Higher response rates with 97% EASI-75 and 85% EASI-90 responders at 52-weeks (also higher response rates than zumilokibart[2])
  - Improved maintenance of response with 87% IGA and 92% EASI-75 16-week responders continuing to respond at 52-weeks in prior 52-week AD study[3] (only 53% of dupilumab IGA responders at 16-weeks in SOLO 1 & 2 continued to respond at 52-weeks)
  - Equal efficacy dosed Q4W vs. Q2W during maintenance phase[3]
  - Potentially lower rate of conjunctivitis based on cross-study comparison of Phase 3 trials

EASI = Eczema Area and Severity Index. EASI-50 = at least 50% decrease from baseline. Q2W = every 2 weeks. Q4W = every 4 weeks. IGA 0/1 = Investigator Global Assessment of 0 (clear skin) or 1 (almost clear). 1. DUPIXENT US Package Insert; 2. March 2026 Apogee Therapeutics Overview Part A 52wk; 3. 52-week safety data from Seaside China Presented at Revolutionizing Atopic Dermatitis (RAD 2024) Conference

Rademikibart Exclusivity Timeline

Exclusive global development & commercialization rights (outside of greater China) **supportive of substantial growth and value creation**



Regulatory Exclusivity

Patent Exclusivity

1 U.S. 10,774,141 & U.S. 11,866,491 **2** Pending U.S. patent application **3** Estimated date of FDA approval **4** 12 years biologic exclusivity **5** 14 years and 5 years maximum PTE **6** Pending U.S. provisional patent applications

Financial Summary

Cash and cash equivalents of $46.0 million as of March 31, 2026. Based on our current operating plan and projections, we expect cash and investments to fund operations into the second half of 2027.

Summary Statement of Operations and Net Cash Used in Operations (In thousands, except per share data)	**Three Months Ended March 31, 2026**
License and collaboration revenues	$169
Operating expenses[1]	($19,776)
Other income, net	257
Income tax expense	(48)
Net loss[1]	($19,398)
Basic and diluted net loss per share[2]	($0.34)
Net cash used in operations	($16,005)
Condensed Balance Sheet Data (In thousands)	**March 31, 2026**
Cash and cash equivalents	$46,034
Total assets	$60,066
Total shareholders' equity	$42,623

[1] Includes $1.2 million of non-cash, share-based compensation expense for the three months ended March 31, 2026.
[2] Based on 56.5 million weighted-average ordinary shares outstanding for the three months ended March 31, 2026.

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Connect is Well Positioned for Success

Rademikibart is Potentially Differentiated from Dupilumab in Asthma, COPD and Atopic Dermatitis

- **Rademikibart SC administration** produced rapid increases in FEV_1 as early as Week 1 clinic **visit in asthma study** sustained for 24-week study
  - Home daily lung function data demonstrated 73% of improvement seen on Day 7 was observed by the morning after the first dose (<24 hours after dose)
- Rademikibart 2-minute IV push produced increases in FEV_1 of >100 mL within 15 minutes to 4 **hours in Phase 1 asthma and COPD study;** mean increases of 100 – 300 mL generally maintained through Day 29 (additional evidence supporting Q4W dosing)
- Rapid onset of effect consistent with preclinical data that rademikibart appears to directly produce bronchodilation not seen with dupilumab
- Phase 3 AD study conducted in China at 52-weeks demonstrated **87.1% IGA 0/1, 96.6% EASI-75 and 85.3% EASI-90 responders**
- No important, drug-related safety issues observed in over **1,800** participants in completed studies

Catalysts

1Q2026
Complete preclinical studies providing the basis for the rapid FEV_1 improvement observed in Phase 2b

1Q2026
Complete IV pharmacology study designed to evaluate time to airway improvement in asthma and COPD

September 2026
Topline results from Phase 2 acute asthma and COPD studies

Late 2026 – 1H2027
Potential for NDA approval in China for AD indication

Confirmation of large, rapid and sustained FEV_1 improvement in both asthma and COPD supporting the likelihood of seeing positive results in ongoing Phase 2 studies. AD data from China supports a potentially best-in-class profile of rademikibart

HASM – human airway smooth muscle; hPCLS – human precision cut lung slice; FEV_1 – forced expiratory volume in one second; COPD = chronic obstructive pulmonary disease; SC – subcutaneous:

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NASDAQ: CNTB