Elevating
Treatment Experiences and Outcomes for Patients

May 2023

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By attending or receiving this presentation and viewing the related video, you acknowledge that you will be solely responsible for your own assessment of the market and our market position and that you will conduct your own analysis and be solely responsible for forming your own view of the potential future performance of our business.

Visionary management team

Saeho Chong, Ph.D.
Chief Executive Officer

Alnylam PHARMACEUTICALS · FDA · Bristol Myers Squibb

Wade Smith
Chief Financial Officer

Mylan · VIATRIS · DRA

Paul Friel
Chief Commercial Officer

Takeda · vyaire MEDICAL · BeyondSpring PHARMACEUTICALS

Gordon Schooley, Ph.D.
Chief Regulatory Officer

Pfizer · BeyondSpring PHARMACEUTICALS · Allergan

Seong Jang Ph.D.
Chief Operating Officer

FDA

Tyler Wiseman
Chief Legal Officer

PRAXIS · VERTEX · WILMERHALE

Jenny Gizzi
Chief of Staff

MIRATI THERAPEUTICS · ARENA PHARMACEUTICALS · Bristol Myers Squibb

Phillip J Stevens, Ph.D.
Executive Director Business Development

ACROTECH BIOPHARMA · SPECTRUM PHARMACEUTICALS Redefining Cancer Care · APTALIS

60+ global pharma experiences	**50+** partnerships/ alliances	**30+** startups	**20+** billion financing experience	**70+** approvals and launches	**20+** initial public offerings (IPOs)

Corporate Highlights

Elevar is a rapidly growing, fully integrated biopharmaceutical company built on the promise of elevating treatment experiences and outcomes for patients who have limited or inadequate therapeutic options

Resourced

for the evolution to commercialization in the US, and seeking partners to co-develop rivoceranib

- Elevar Therapeutics is a majority-owned subsidiary of HLB Co, LTD., a publicly traded company on the Korean KOSDAQ exchange (028300.KQ)
- Strong intellectual property protection
- Demonstrated success with existing partners

Experienced

in clinical and commercial development and launch experience

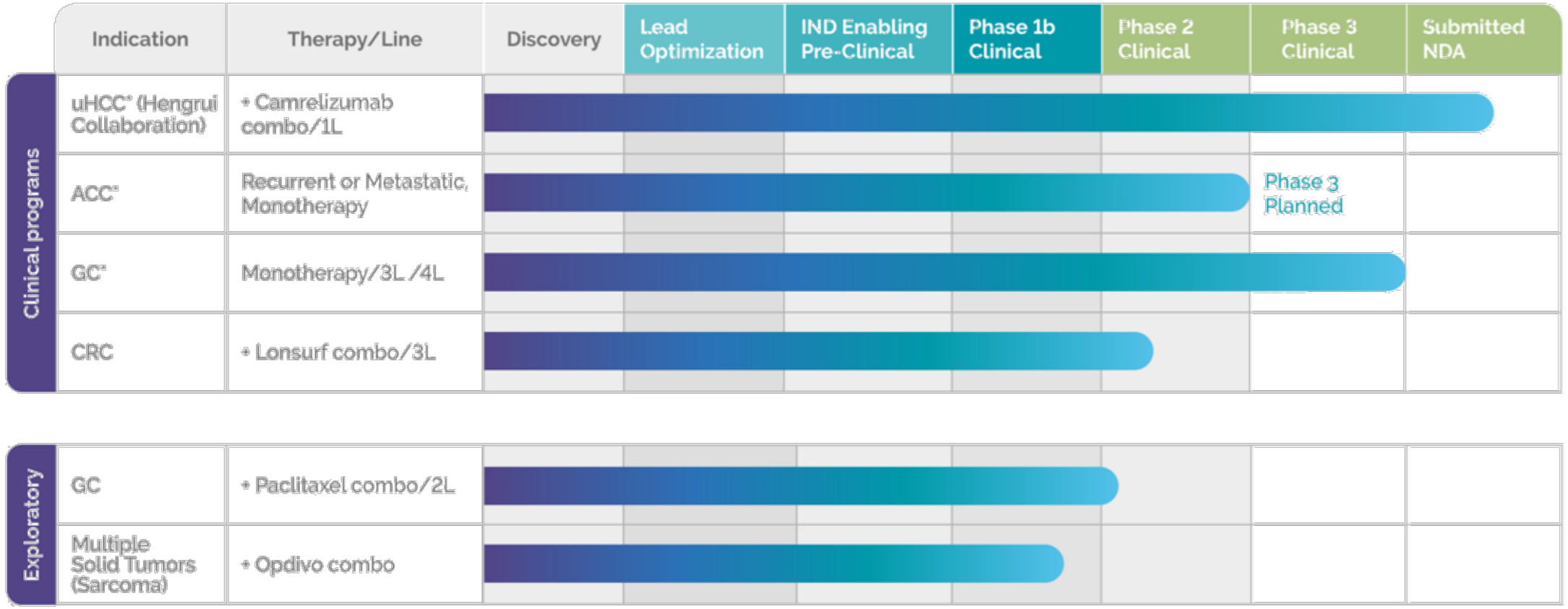
- Executive Leadership Team with extensive Global Experience in both Big and Small Biotech
- Experienced in building/scaling organizations with more than 70 FDA Approvals and Launches
- Plans developed for proven Oncology Launch footprint to support optimal targeted reach

Focused

on solid tumors that respond to Anti-VEGF TKIs that are effective as mono or combination therapy

- Rivoceranib has the potential to be a best-in-class small molecule, highly selective anti-VEGFR-2 TKI; orally administered
- Complementary MOA tumor angiogenesis inhibition with excellent tolerability
- Elevar has global rights to rivoceranib (excluding China)

Rivoceranib: Focused pipeline with multiple near-term value inflection points



* Orphan Drug Designation (ODD)

Rivoceranib

A more selective anti-VEGF-2 TKI

Rivoceranib: A Pipeline in a Product

Providing the Foundation for Future Growth and Diversification

Multiple Therapeutic Opportunities

- Clinical studies in multiple solid tumor types including a phase 3 HCC study in combination with immunotherapy (PD-1)
- NDA filed with US FDA May 16, 2023
  - Approved Ex-US for same indication in uHCC*
- Additional Positive data in largest study of ACC patients, where no approved therapy exists
- Global orphan drug designation for multiple indications (ACC, HCC, GC)

Strong Safety Profile

- Rivoceranib is a more selective inhibitor of VEGFR-2 and is generally well tolerated
- Rivoceranib has shown potential to improve outcomes as a monotherapy and in combination with immunotherapy
- Over 6000 patients treated in more than 60 clinical trials worldwide with favorable tolerability and acceptable safety profile

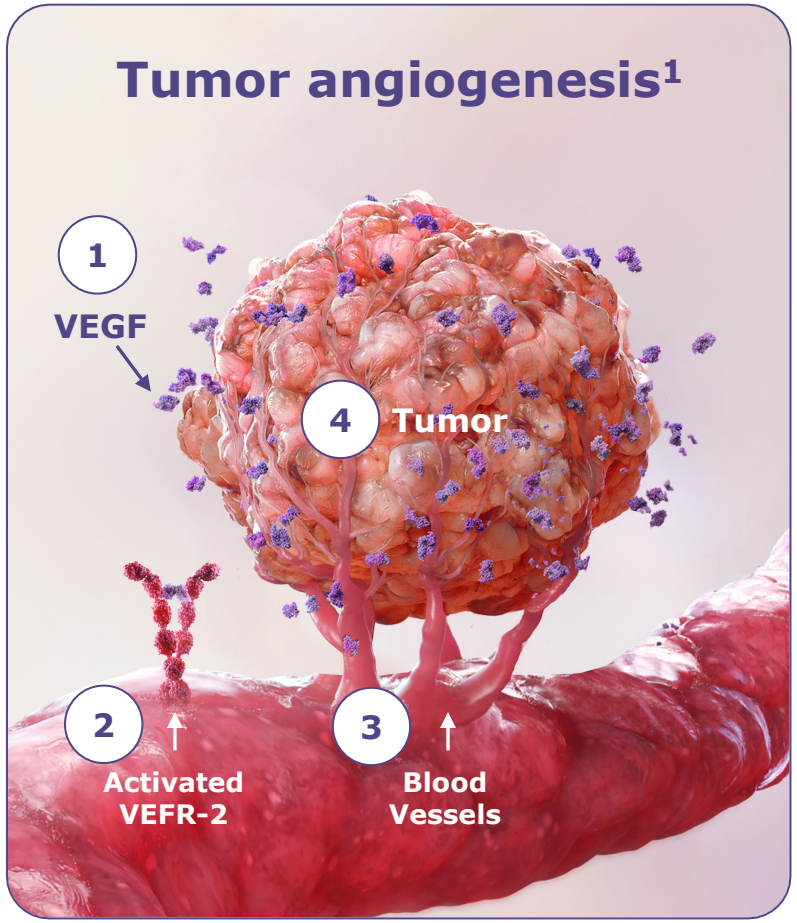
Opportunities for Growth

- Anti-VEGF TKIs have shown positive results in solid tumors and are indicated for more than 15 different type of cancers
- Synergy with immuno-oncology therapy and chemotherapy
- Oral TKI anti-VEGF market is approximately $4.6B and growing at approximately 15% CAGR

Rivoceranib: Highly differentiated product, best-in-class molecule, in a large growing market with multiple near-term inflection points

*Approved in China as apatanib (Aitan®)

VEGF activated tumor angiogenesis is essential in the growth of solid tumors



1. Tumor releases vascular endothelial growth factor (VEGF)
2. VEGF binds to VEGFR-2 receptors on existing blood vessels
3. New blood vessels sprout
4. Nutrients are supplied to tumor, allowing for rapid growth

VEGFR-2 activation causes new blood vessels to sprout, supplying nutrients for tumor growth[2]

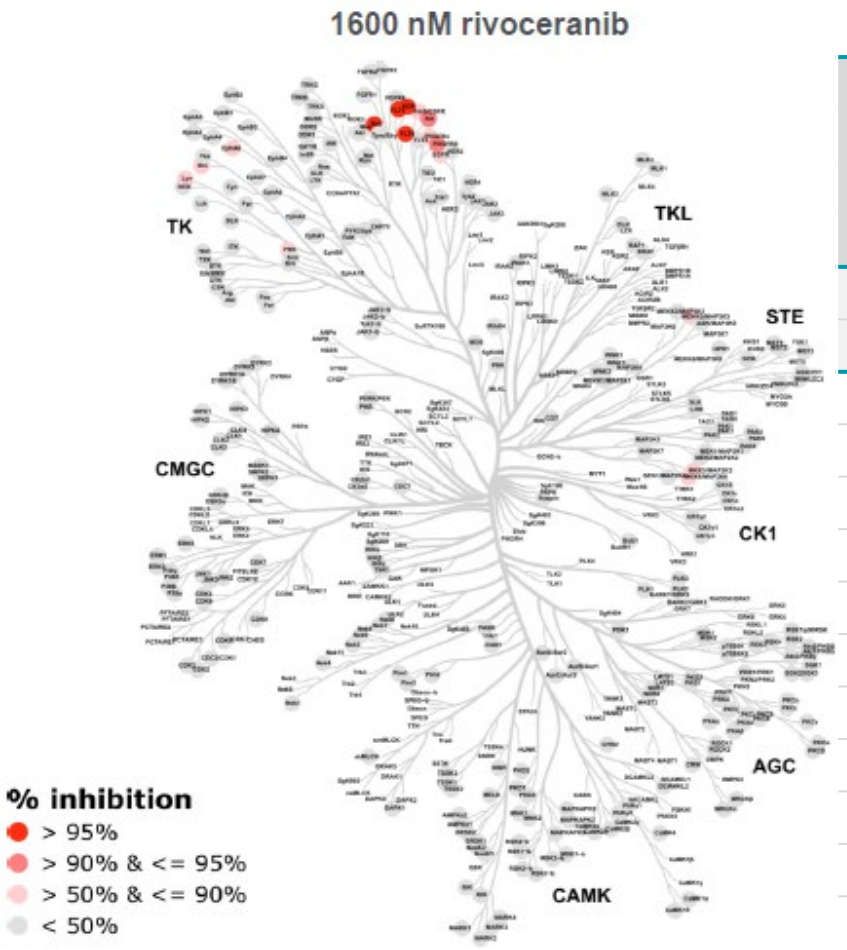
Click to view the Rivoceranib MOA Video

Sources: 1. Feng G, Chun Y. Current Cancer Drug Targets. Anti-VEGF/VEGFR2 Monoclonal Antibodies and their Combinations with PD-1/PD-L1 Inhibitors in Clinic. Volume 20, Issue 1, 2020. DOI : 10.2174/1568009619666191114110359, 2. Hicklin, D.J., et al. Journal of Clinical Oncology. Role of the Vascular Endothelial Growth Factor Pathway in Tumor Growth and Angiogenesis. Vol. 23, No. 5 (2005) 1011-1027. DOI: 10.1200/JCO.2005.06.081

Rivoceranib is more selective for the VEGF-2 receptor, potentially resulting in reduced off-target effects

The VEGFR-2, aka KDR, tyrosine kinase receptor plays a pivotal role in the regulation of angiogenesis, mitogenic signaling, and vascular permeability

Kinome tree analysis shows rivoceranib is more selective for receptors that impact tumor angiogenesis*



Protein	HGNC	% inhibition*
KDR (VEGFR-2)	KDR	100
FLT1	FLT1	100
FLT4	FLT4	99
RET	RET	98
PDGFRβ	PDGFRB	95
KIT	KIT	93
LYNb		90
PDGFRα	PDGFRA	88
LYNa	LYN	88
EGFR	EGFR	80
FMS	CSF1R	78
FRK	FRK	60
MAP2K6_Cascade	MAP2K6	60
MAP2K3_Cascade	MAP2K3	58
EPHA6	EPHA6	58
SRC	SRC	58
MAP3K3_Cascade	MAP3K3	57

*The % inhibition of the enzyme activity is related to controls, according to the following formula:
Inhibition (%) = [1-(A-B)/(C-B)] x 100 where A is the response with compound, B is the background response with no kinase, and C is the response with vehicle (1% DMSO).
Thus, the short answer is that the % activity is related to signal of the assay without addition of enzyme to the reaction, that is, 'background' signal of the reagents.

* Oncolines. Comparison of the biochemical activity and selectivity of KDR inhibitors. 2022

Tolerability & rates of adverse events based upon published data[1]

	Rivoceranib[2]	Regorafenib*	Sorafenib	Lenvatinib	Cabozantinib
Hypertension	<35%	20–50%	<20%	>50%	20–50%
Fatigue	<15%	15–30%	<15%	>30%	<15%
Nausea	<10%	<10%	<10%	>20%	>20%
Diarrhea	<10%	20–40%	20–40%	>40%	>40%
Stomatitis	<20%	15–30%	<15%	>30%	15–30%
Rash	<10%	15–30%	15–30%	15–30%	<15%
HFS	<25%	>40%	>40%	<20%	20–40%
Hepatotoxicity	<10%	<20%	<20%	20–40%	>40%
Neutropenia	<10%	<20%	<20%	<20%	20–40%

Legend

- <10%
- <20%
- <30%
- >30%

* Black-box warning

Please note that head-to-head studies were not conducted between these products. This data is for information purposes only and no comparative claims of non-inferiority or superiority in terms of efficacy or safety are implied or intended.

- **Fatigue** and **diarrhea** are common reasons for discontinuation of treatment
- Percentages represent absolute difference in toxicity between treatment and placebo arm

Source: 1. Table adapted from Gougis P, et al. "Clinical pharmacology of anti-angiogenic drugs in oncology." Crit Rev Oncol Hematol. 2017 Nov; 119:75-93. DOI: 10.1016/j.critrevonc.2017.08.010. 2. Data on File.

Anti-VEGFs market is approximately $10b+ growing at a CAGR of approximately 10%

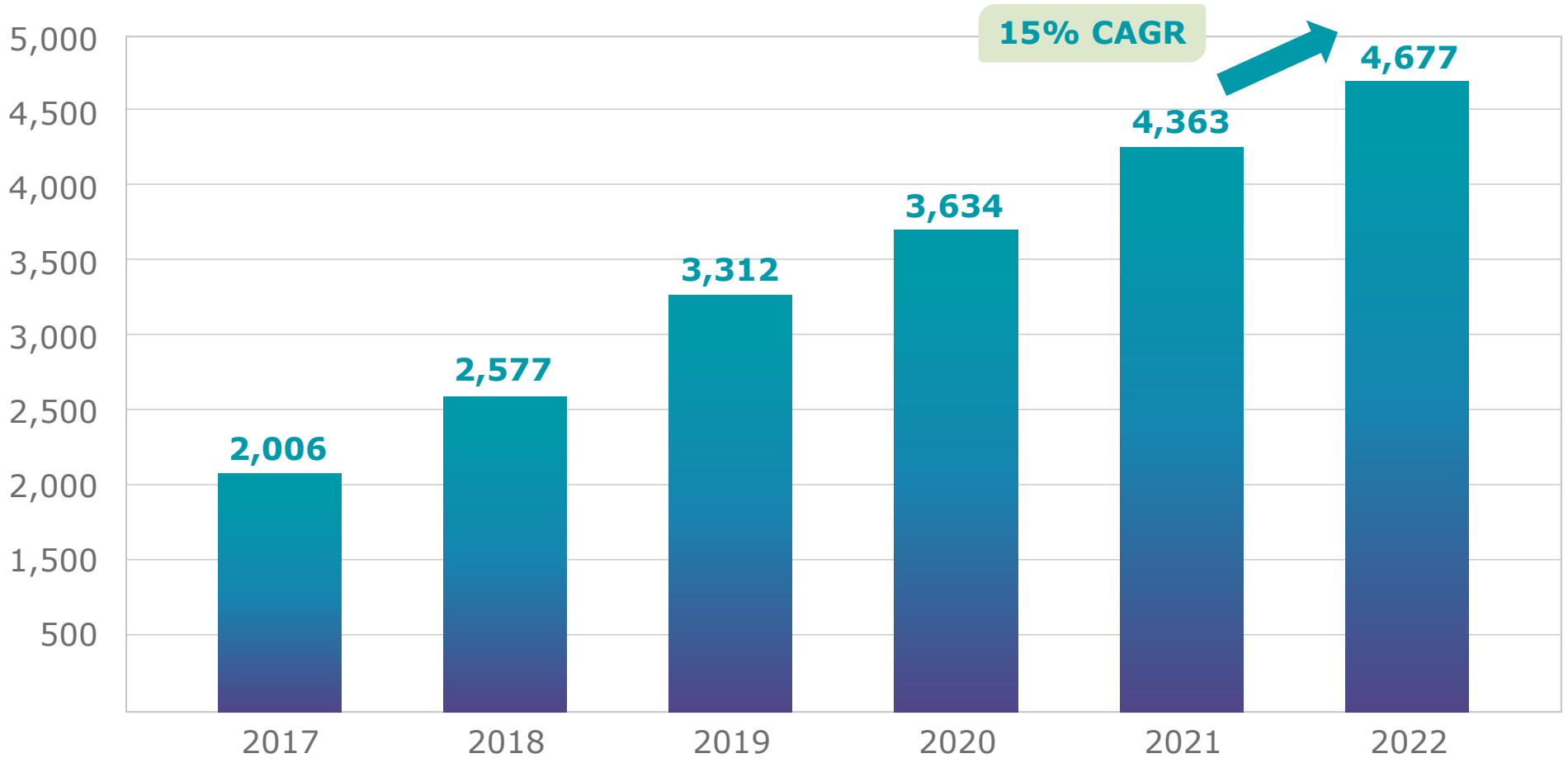
	Rivoceranib	Bevacizumab	Ramucirumab	Regorafenib	Sorafenib	Lenvatinib	Cabozantinib
Target	VEGFR-2	VEGF-A	VEGFR-2	• VEGFR • PDGFR • TIE2 • FGFR	• VEGFR • PDGFR • c-RAF	• VEGFR • FGFR • RET	• VEGFR • cKIT • RET
Indication(s)	• HCC (1st/C)* • GC (3rd/4th)* • ACC (1st)** • CRC (3rd/C)** • OC (2nd/C)**	• CRC (1st/C) • NSCLC (1st/C) • GBM (2nd) • RCC (1st/C) • OC (1st/C) • CC (1st/C) • HCC (1st/C)	• GC (2nd/C) • NSCLC (1st/C) • NSCLC (2nd/C) • CRC (2nd/C) • AFP-HCC (2nd)	• HCC (2nd) • CRC (3rd) • GIST (3rd)	• HCC (1st) • RCC (2nd) • DTC (1st)	• HCC (1st) • RCC (1st/C) • RCC (2nd/C) • DTC (2nd) • EC (2nd/C)	• HCC (2nd) • RCC (1st/C) • DTC (2nd)
Administration	Oral	Injectable mAb	Injectable mAb	Oral	Oral	Oral	Oral
2022‡ Revenue	$577m (Hengrui, China)‡	$3.59b	$971m	$654m	$285m	$1.90b	$1.94b

* Approved in China
** Not approved
C = combination use

Source: Evaluate Pharma May 2023., Company 2021 Annual Reports

Oral TKI Anti-VEGF global sales 2017-2022 *(USD $mm)*

Regorafenib, Sorafenib, Lenvatinib, Cabozantinib



Source: Evaluate Ltd. May 2023 WW Sales of Regorafenib, Sorafenib, Lenvatinib and Cabozantinib

Hepatocellular Carcinoma (HCC)

Potential opportunity in hepatocellular carcinoma

1. The fifth most common type of primary liver cancer[1]
   - 75%-90% of cases
   - Most cases develop in the setting of liver cirrhosis[2]

   ▶ HCC represents the fastest rising cause of cancer-related death in the US and remains difficult to manage[4]

2. Typically diagnosed late in its course, survival at diagnosis is only ~6-20 months with a 10% five-year survival rate[1]

   ▶ It is the 2nd leading cause of cancer death in East Asia and the 6th most common in western countries[4]

3. US incidence & mortality has been increasing for decades[1]

   ▶ 50%-60% of patients will be exposed to systemic therapy at some point in the disease process[3]

Available Treatment

~50% of patients are expected to receive an angiogenesis inhibitor in combination with an ICI, such as atezolizumab+bevacizumab[5]

Checkpoint inhibitor and TKI combination offers promise because toxicity profiles do not overlap[6]

! *Despite emerging therapies, an urgent need remains for new effective, tolerable treatments due to disease severity and low survival rates*

Sources: 1. Golabi, Pegah et al. "Mortality assessment of patients with hepatocellular carcinoma according to underlying disease and treatment modalities." Medicine vol. 96,9 (2017): e5904. doi:10.1097/MD.0000000000005904. Accessed at https://www.ncbi.nlm.nih.gov/pmc/ articles/PMC5340426/. 2. Decision Resources Group (Data-On-File); as of Jan. 11, 2021. 3. Llovet JM, et al. Nat Rev Gastroenterol Hepatol. 2021;18(5):293-313. 4. Rawla, Prashanth et al. "Update in global trends and aetiology of hepatocellular carcinoma." Contemporary oncology (Poznan, Poland) vol. 22,3 (2018): 141-150. doi:10.5114/wo.2018.78941 (link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6238087/). 5. Decision Resources Disease Landscape and Forecast, Hepatocellular Carcinoma January 2021 (Internal-on-file). 6. Zhu, Xiao-Dong et al. "Targeting angiogenesis for liver cancer: Past, present, and future." Genes & diseases vol. 7,3 328-335. 7 Apr. 2020, doi:10.1016/j.gendis.2020.03.010.

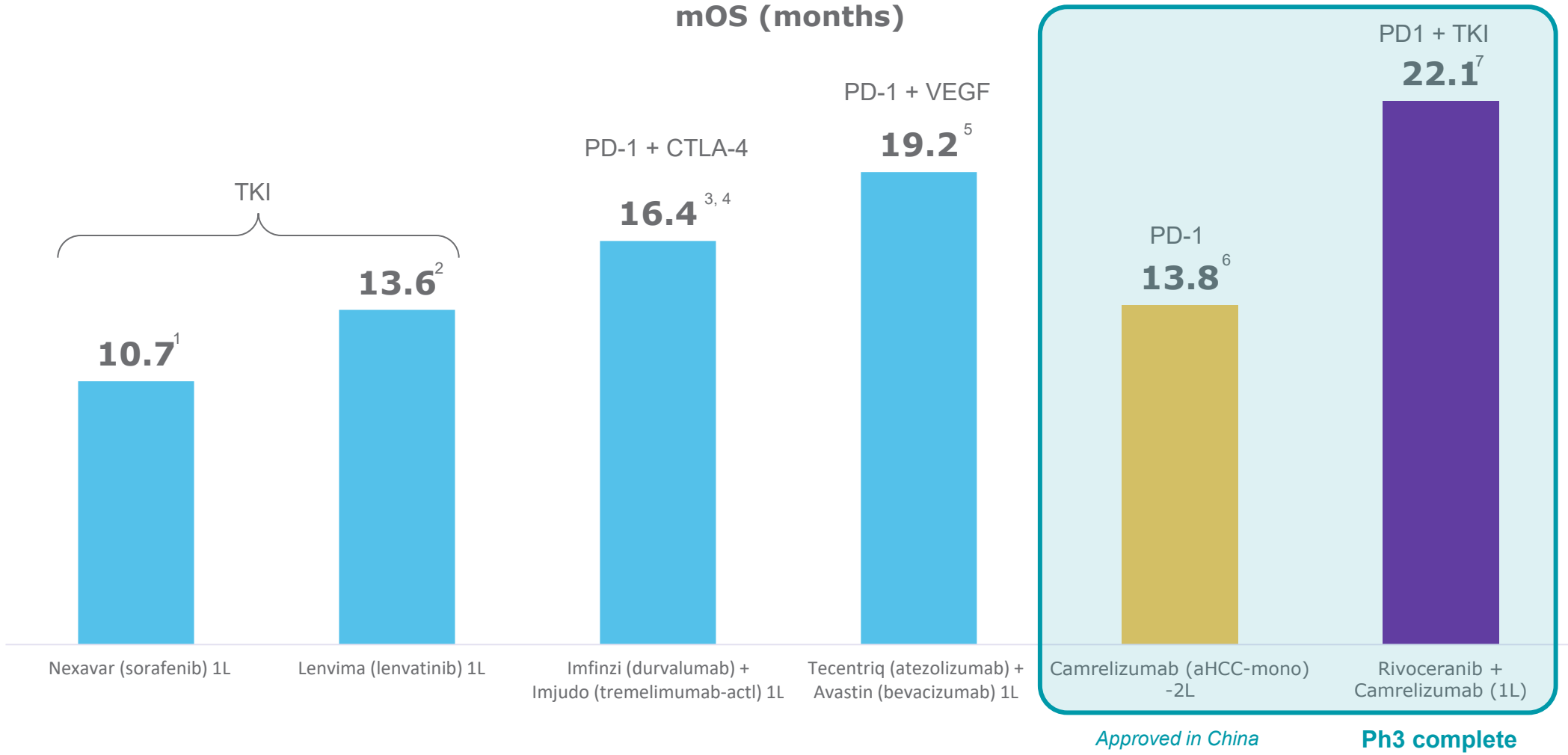
Rivoceranib CARES 310 Study shows significant improvement in outcomes in first line HCC patients[1]

First phase 3 study to demonstrate significant OS and PFS benefits with the combination of a PD-1 antibody and an orally administered small molecule anti-angiogenic drug over sorafenib as first-line treatment for advanced HCC

OS of 22.1 months and PFS of 5.6 months versus sorafenib at 15.2 and 3.7 months	ORR of 25.4% versus 5.9%; **72.8% of patients saw a reduction in tumor size**	Combination is **generally well tolerated** with AE profile similar to each agent and underlying disease

Sources: 1. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepatocellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35

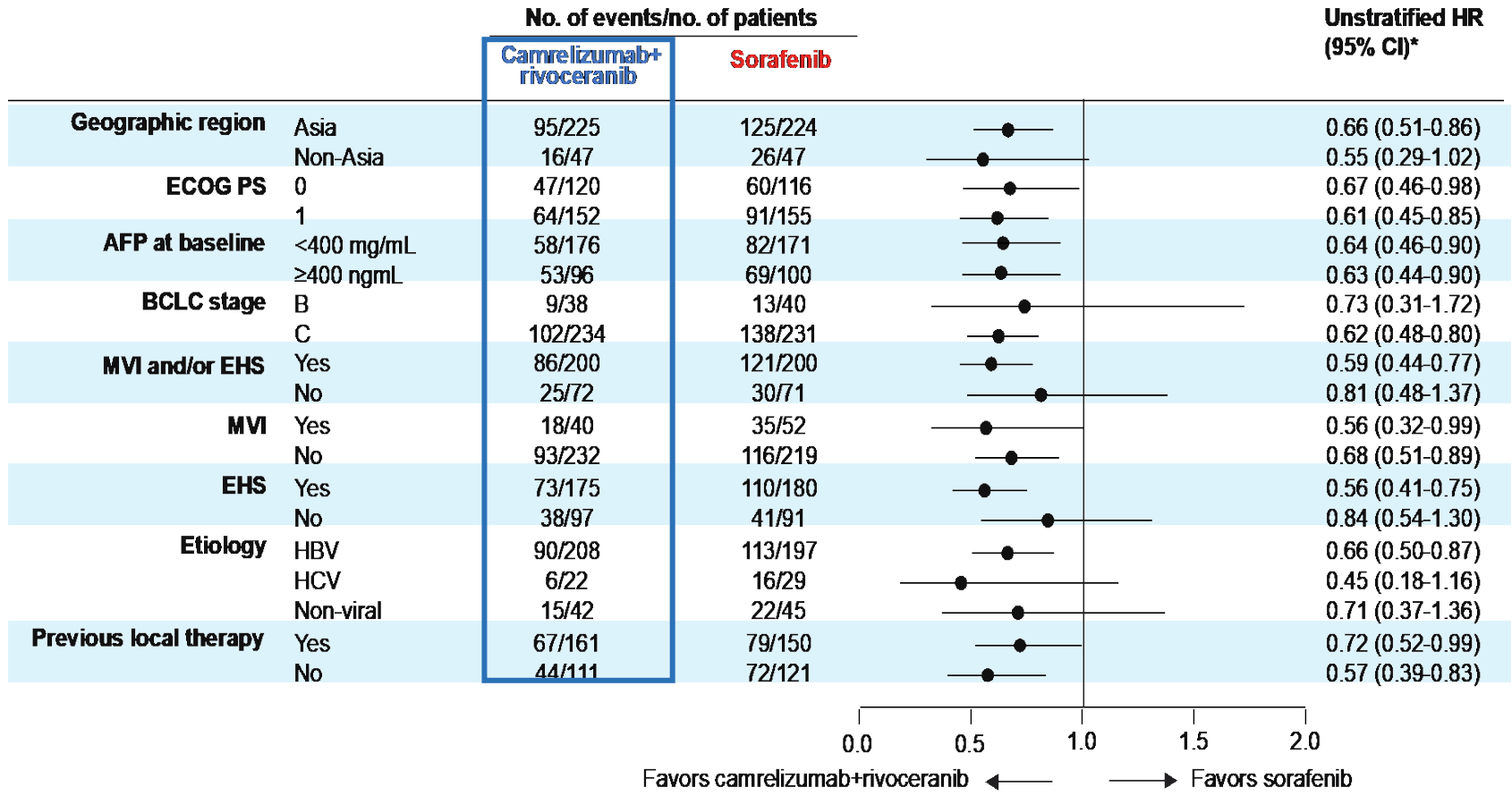
Rivoceranib + camrelizumab demonstrated significant mOS in a Phase 3 study vs. sorafenib as 1st line treatment for advanced HCC



Please note that head-to-head studies were not conducted between these products. This data is for information purposes only and no comparative claims of non-inferiority or superiority in terms of efficacy or safety are implied or intended.

1. NEXAVAR. Prescribing information. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc; July 2020; 2. LENVIMA [package insert]. Nutley, NJ: Eisai Inc.; 3. IMFINZI® (durvalumab) [Prescribing Information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2022.
4. IMJUDO® (tremelimumab-actl) [Prescribing Information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; 2022.; 5. Finn RS, Qin S, Ikeda M, et al. IMbrave150: updated efficacy and safety by risk status in patients (pts) receiving atezolizumab (atezo) + bevacizumab (bev) vs sorafenib (sor) as first-line treatment for unresectable hepatocellular carcinoma (HCC). Paper presented at: 2021 American Association for Cancer Research (AACR) Annual Meeting; April 10-15, 2021; virtual conference.; 6. . Shukui Q, Zhenggang R., et al Camrelizumab in patients with previously treated advanced hepatocellular carcinoma: a multicentre, open-label,parallel-group, randomised, phase 2 trial Lancet Oncology, Feb 26, 2020, https://doi.org/10.1016/S1470-2045(20)30011-5; 7. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepato cellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35

Patients treated with Camrelizumab + Rivoceranib performed better compared with sorafenib monotherapy



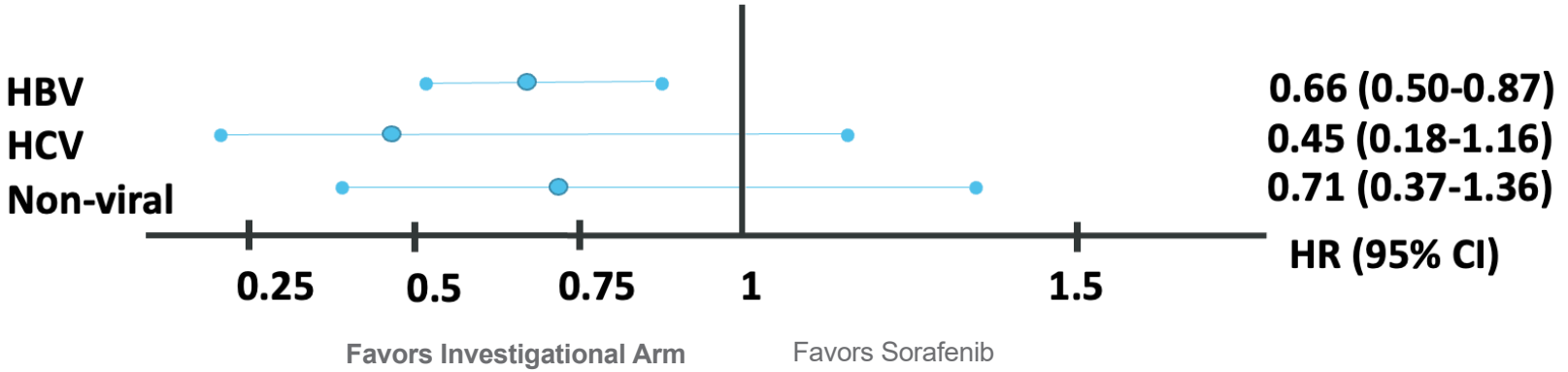
- 17.2% of total study patient population were Western
- Regardless of region, hazard ratios (HRs) of OS favored Cam + Rivo over sorafenib in the majority of subgroups

*Cox proportional hazards model. Data cutoff: Feb. 8, 2022.

Sources: 1. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepatocellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35

Rivoceranib + Camrelizumab provides a statistically significant OS benefit for patients with HBV, and data suggests potential efficacy in HCV and non-viral etiologies

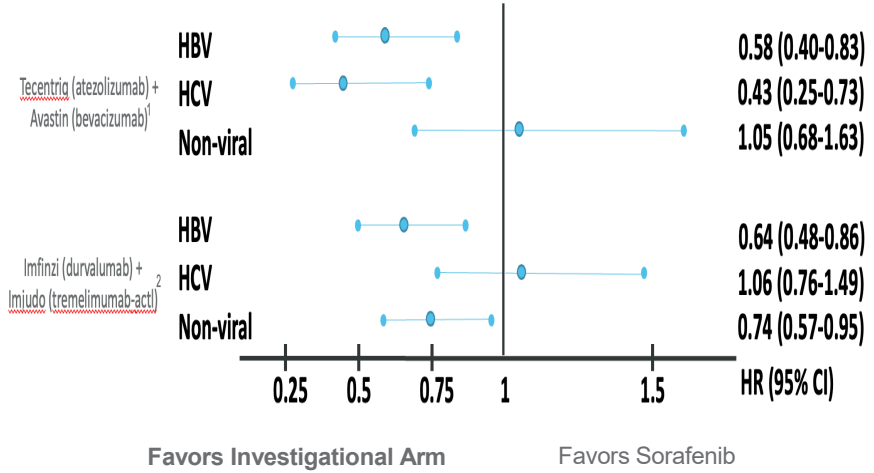
Rivoceranib + Camrelizumab[1]



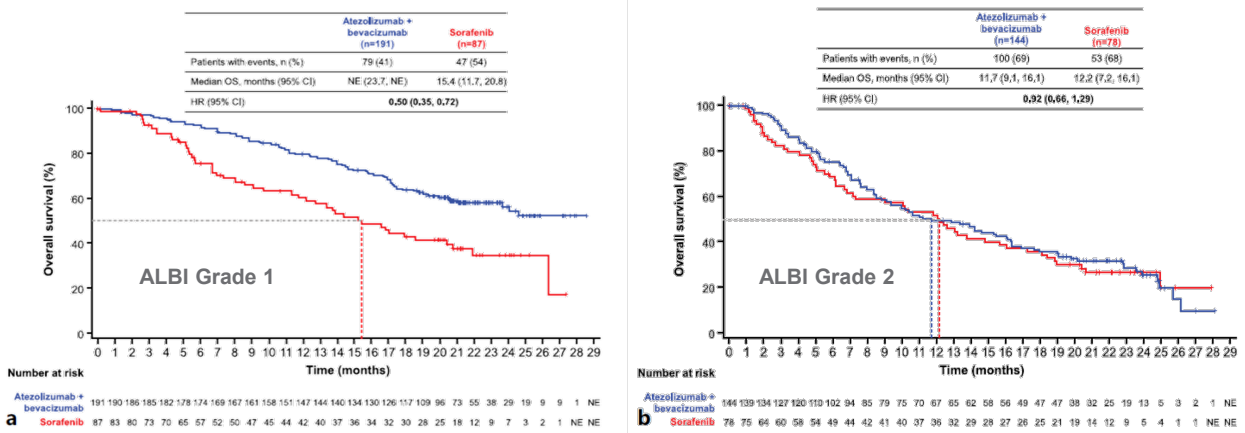
Sources: 1. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepatocellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35

Current uHCC regimens offer benefit in HBV, but can be mixed for those with HCV, non-viral etiology or Grade 2 ALBI

Indirect comparison of OS in prespecified subgroups across HCC trials



Post-hoc analysis of OS based on ALBI score from IMBrave 150[3]*



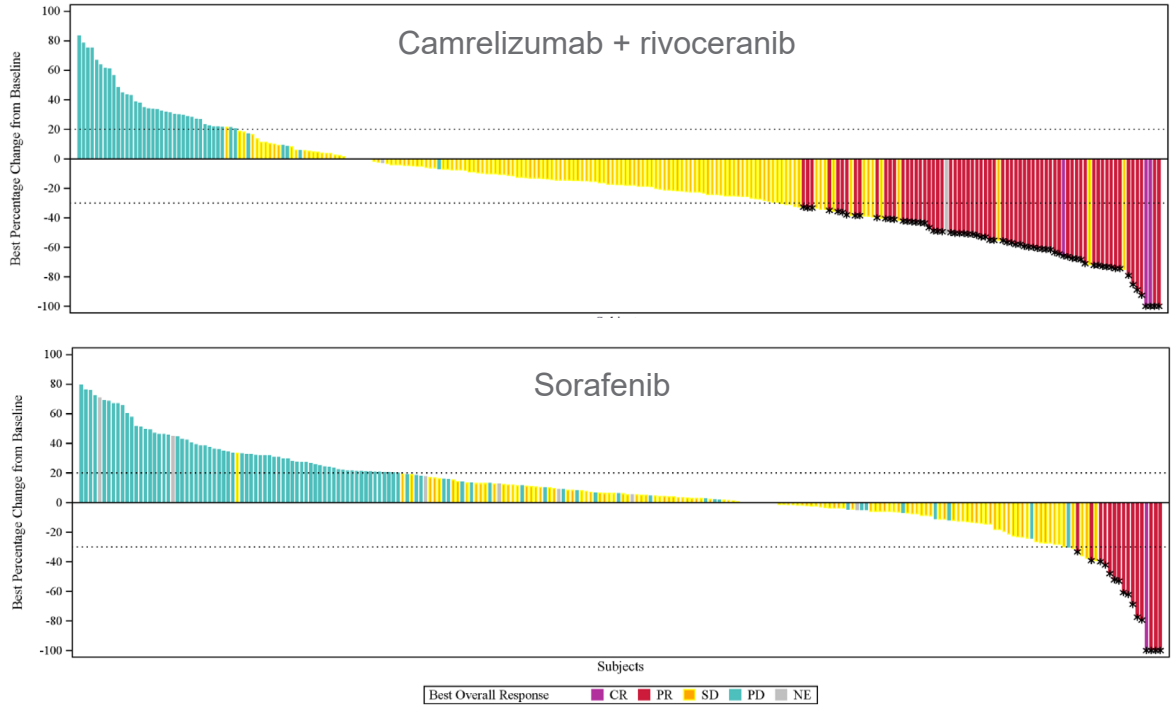
*ALBI= Albumin + Bilirubin grade, calculated = (log10 bilirubin [µmol/L] × 0.66) + (albumin [g/L] × −0.0852)

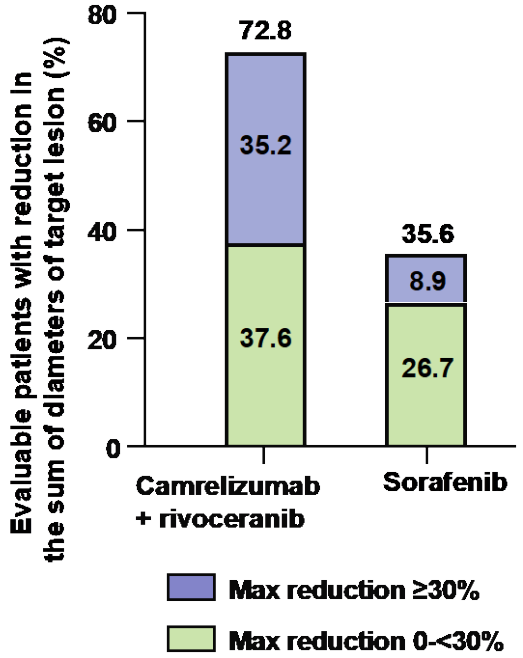
Please note that head-to-head studies were not conducted between these products. This data is for information purposes only and no comparative claims of non-inferiority or superiority in terms of efficacy or safety are implied or intended.

Sources: 1. Updated efficacy and safety data from IMbrave150: Atezolizumab plus bevacizumab vs. sorafenib for unresectable hepatocellular carcinoma; Journal of Hepatology 2022 vol 76 https://doi.org/10.1016/j.jhep.2021.11.030; 2. Phase 3 randomized, open-label, multicener stury of tremelimumab and durvalumab as first-line therapy in patients with unresectable hepatocellular carcinoma HIMALAYA. Ghassan K About-Alfa, et al. Presented at ASCO GI 2022; 3. Kudo M, Finn R, et al. Albumin-Bilirubin Grade Analyses of Atezolizumab plus Bevacizumab versus Sorafenib in Patients with Unresectable Hepatocellular Carcinoma: A Post Hoc nalysis of the Phase III IMbrave150 Study, Liver Cancer March 4, 2023

Rivoceranib + Camrelizumab is highly effective for tumor reduction

Best change from baseline in sum of diameters of target lesion





35.2% of patients had a 30% reduction in lesion diameter

72.8% of patients had a reduction in lesion diameter

Sources: 1. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepatocellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35

Safety summary

	Camrelizumab + rivoceranib (N=272)	Sorafenib (N=269)
Median exposure of treatment (IQR), mo		
Camrelizumab	6.9 (3.6-13.4)	–
Rivoceranib/sorafenib	6.5 (3.4-11.9)	3.8 (1.9-7.4)
Any TRAE*	265 (97.4)	249 (92.6)
Grade 3/4	219 (80.5)	140 (52.0)
Grade 5	1 (0.4)†	1 (0.4)‡
Serious TRAE	66 (24.3)	16 (5.9)
TRAEs leading to dose modification or interruption of any treatment component	219 (80.5)	135 (50.2)
TRAEs leading to discontinuation of any treatment component	66 (24.3)	12 (4.5)
TRAEs leading to discontinuation of all treatment components	10 (3.7)	12 (4.5)

Data are n (%) or otherwise indicated. *Causality to treatment was determined by the investigator. †Multiple organ dysfunction syndrome. ‡Respiratory failure and circulatory collapse. Data cutoff: Feb. 8, 2022. TRAE=treatment-related adverse event

Sources: 1. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepatocellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35

TRAEs with incidence of ≥20%*

Preferred term	Camrelizumab + rivoceranib (N=272)		Sorafenib (N=269)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Hypertension	189 (69.5)	102 (37.5)	116 (43.1)	40 (14.9)
AST increased	147 (54.0)	45 (16.5)	99 (36.8)	14 (5.2)
Proteinuria	134 (49.3)	16 (5.9)	72 (26.8)	5 (1.9)
ALT increased	127 (46.7)	35 (12.9)	80 (29.7)	8 (3.0)
Platelet count decreased	126 (46.3)	32 (11.8)	89 (33.1)	4 (1.5)
Blood bilirubin increased	116 (42.6)	24 (8.8)	75 (27.9)	4 (1.5)
PPE syndrome	102 (37.5)	33 (12.1)	163 (60.6)	41 (15.2)
Diarrhea	83 (30.5)	6 (2.2)	105 (39.0)	14 (5.2)
RCEP	79 (29.0)	7 (2.6)	0	0
Neutrophil count decreased	73 (26.8)	16 (5.9)	27 (10.0)	3 (1.1)
White blood cell count decreased	73 (26.8)	7 (2.6)	38 (14.1)	3 (1.1)
GGT increased	66 (24.3)	27 (9.9)	49 (18.2)	20 (7.4)
Hypothyroidism	58 (21.3)	0	16 (5.9)	0

Data are n (%). *TRAEs of any grade occurring in ≥20% or of grade ≥3 occurring in ≥5% of patients in either group are listed.
Data cutoff: Feb. 8, 2022. AST=aspartate aminotransferase; ALT=alanine aminotransferase; GGT=Gamma-glutamyl transferase; PPE=palmar-plantar erythrodysaesthesia; RCEP=reactive capillary endothelial proliferation

Sources: 1. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepatocellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35

The combination of Rivoceranib + Camrelizumab has the potential to be a Best-in-Class treatment option in uHCC based on measurable clinically meaningful data points

mOS	**22.1 months[1]**
Relative Risk Reduction (PFS)	**48%[1]** HR, 0.52 (95% CI; 0.41-0.65)
Partial Response	**Highest: 24.3%[1]** 72.8% of patients had a reduction in lesion diameter
Stable Disease	**Highest: 52.9%[1]**
Progressive Disease	**Lowest: 16.2%[1]**
Viral and Non-Viral Etiology	**55% and 29% Reduction in the Risk for Mortality for patients with HCV and non-Viral Etiology, respectively[1]**
Albumin-Bilirubin (ALBI) Impact *Post-Hoc analysis*	• **No significant change over time to ALBI Score[2]** • **Similar mOS for patients with Grade 1 or Grade 2 ALBI Score[2]**
Discontinuation Rate	**Lowest: 3.7%[1]**
Grade 3-4 Hemorrhage	**3.3% rate[1]**
Half-life (mean, at steady state)	**11 hours [3]** Allows for rapid withdrawal of VEGFR-2 blockade

Sources: 1. Shukui Q, Chan SL, Gu Shanzhi, et al. Camrelizumab plus rivoceranib vs. sorafenib as first-line therapy for unresectable hepatocellular carcinoma: a randomized, phase 3 trial. Presented at ESMO 2022. Abstract #LBA35; 2. Data of File, Elevar Therautics; 3. Li et al. Safety and pharmacokinetics of novel selective vascular endothelial growth factor receptor-2 inhibitor YN968D1 in patients with advanced malignanciesBMC Cancer 2010, 10:529 http://www.biomedcentral.com/1471-2407/10/529

Rivoceranib Summary

- Highly Differentiated Best-in-Class Molecule
- Large and Growing Market
- Near-Term Inflection Points
- 4 Later Stage Clinical Studies
- Well Funded Through HLB Co., Ltd.

Thank you!

For more information, please visit https://elevartherapeutics.com/

Adenoid Cystic Carcinoma (ACC)

Potential opportunity in adenoid cystic carcinoma (ACC)[1-3]

1	Incurable disease with no approved treatment[1]	US: ~1328-1500 new cases per year • 4.3% of cases are metastatic at diagnosis[3] • ~50% of cases are recurrent/metastatic over 3-8 years
2	Rare tumor arising from secretory glands, most commonly salivary glands,[2] accounts for 5%-7% of all head/neck malignancies[2]	ACC mOS ~17 years[1] R/M mOS ~2 years[4]
3	Ultra-orphan indication with ~3000 new patients annually between US, EU-5, and Japan	Half of all patients with ACC experience recurrence of metastatic disease over 3-8 years with no approved systemic treatment

Available Treatment

No approved agents worldwide

Limited use of levantinib based on a small single site study and NCCN Guideline Category 2B

More than half of the patients discontinue other treatments due to drug toxicity[1-3]

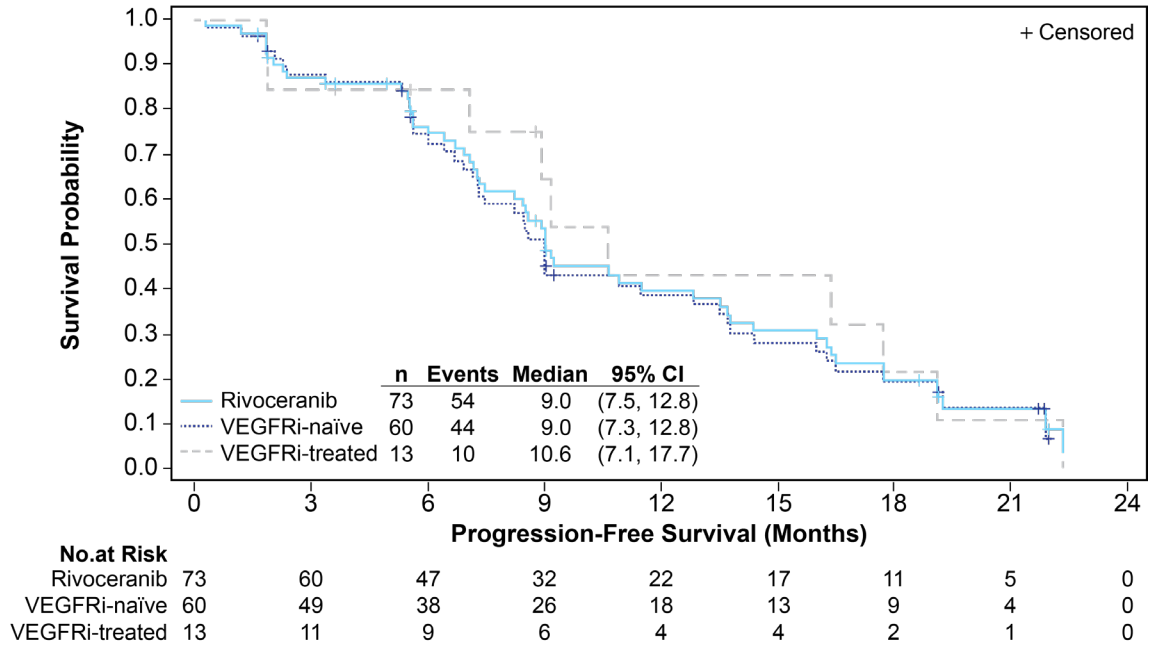
Urgent unmet medical needs remain for a rare cancer that currently has no approved treatment options

Sources: 1. Hanna GJ, et al. Oral Oncol. 2020;106:104690. 2. Adenoid Cystic Carcinoma Research Foundation. https://accrf.org/living-with-acc/understanding-acc/. 3. Feeney L, et al. Cancers. 2021;13:4336. 4. van Weert S, et al. Head Neck. 2017;39(3):456.

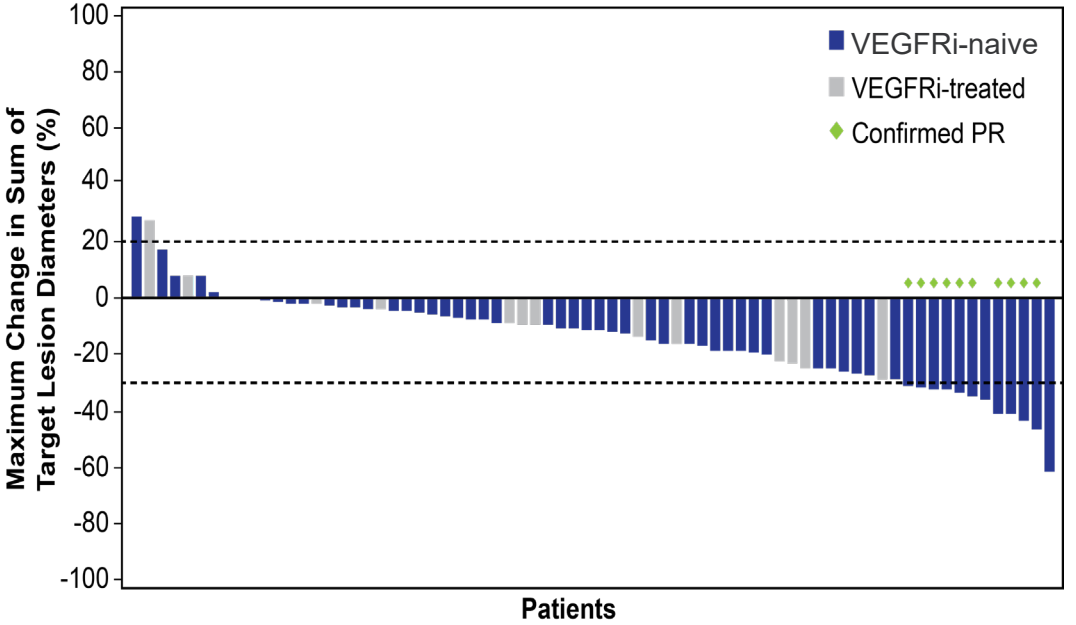
Rivoceranib study RM-202 shows significant improvement in outcomes for ACC patients[1,2]

Largest study of a TKI in R/M ACC (N=80) with **66% (n=53) of patients in the United States[1]**

Investigator assessed PFS



Rivoceranib effect on tumor size



All patients entering the trial had growing tumors 6 months prior to the trial. Maximum change in sum of target lesions assessed by investigator in the efficacy evaluable population.

Rivoceranib demonstrated a **PFS rate of 9.0 months** (per RECIST)

Published historical data of 2.8 months for R/M ACC[2]

Median PFS was **consistent** regardless of prior VEGFRi

15.1% of patients had a 30% reduction in lesion diameter

27% of patients had a 25% reduction in lesion diameter

85% of patients had a reduction in lesion diameter

Sources: 1. Kang H, Ahn MJ, Keam B, et al. A phase 2 study of the oral vascular endothelial growth factor receptor 2 (VEGFR2) Inhibitor Rivoceranib, for recurrent or metastatic (R/M) adenoid cystic carcinoma (ACC). Presented at ASCO 2022. Abstract #6020.
2. Kang EJ, Ahn MJ, Ock CY, et al. *Clin Cancer Res*. 2021;27(19):5272-5279.

Rivoceranib has a tolerable safety profile

All patients received at least 1 dose of study drug and were analyzed for safety

- The median actual dose intensity was 421.0 mg/day

Overall, 68 patients (85.0%) required one or more dose modifications (reduction or interruption) due to an adverse event

- The median time to first dose reduction was 4.1 weeks (range, 1–40)

Sixteen patients (20.0%) discontinued rivoceranib

- The median duration of treatment was 31.1 weeks (range, 0.6–103.0)

Grade ≥3 AEs were observed in 64 patients (80.0%)

- The most common Grade ≥3 AEs were hypertension, stomatitis, anemia, and fatigue