Elevating
Treatment Experiences and Outcomes for Patients

February 2023

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Such statements are subject to known and unknown risks, uncertainties, and other factors that may cause our or our industry's actual results, levels of activity, performance, or achievements to be materially different from those anticipated by such statements. In some cases, you can identify forward-looking statements by terminology such as "may," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "predicts," "potential," "intends," or "continue," or the negative of these terms or other comparable terminology. Forward-looking statements contained in this presentation include, but are not limited to, (i) statements regarding the timing of anticipated clinical trials for our product candidates and our research and development programs; (ii) the timing of receipt of clinical data for our product candidates; (iii) our expectations regarding the potential safety, efficacy, or clinical utility of our product candidates; (iv) the size of patient populations targeted by our product candidates and market adoption of our product candidates by physicians and patients; and (v) the timing or likelihood of regulatory filings and approvals.

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Chief Executive Officer

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Wade Smith
Chief Financial Officer

Mylan · VIATRIS · DRA

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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

We are a rapidly growing, fully integrated biopharmaceutical company developing therapeutics for cancer

Engage

established partners to co-develop and/or commercialize rivoceranib

RESOURCES

- Wholly owned and funded by HLB Co, LTD., a publicly traded company on the Korean KOSDAQ exchange (028300.KQ)
- Strong intellectual property protection
- Demonstrated success with existing partners

Evolve

the treatment potential of rivoceranib across multiple indications

LEAD ASSET

- Rivoceranib: lead asset with multiple inflection points as 1L+, as both monotherapy and in combination with chemo and IO
- 4 later-stage clinical studies ongoing with filing in 2023
- Global orphan drug designation for multiple indications (ACC, HCC, GC)
- Rivoceranib studied in >6000 patients worldwide; development driven by patient need for improved clinical outcome
- Robust and repeatable manufactured product with excellent purity, high yields, and 3-year shelf-life

Elevate

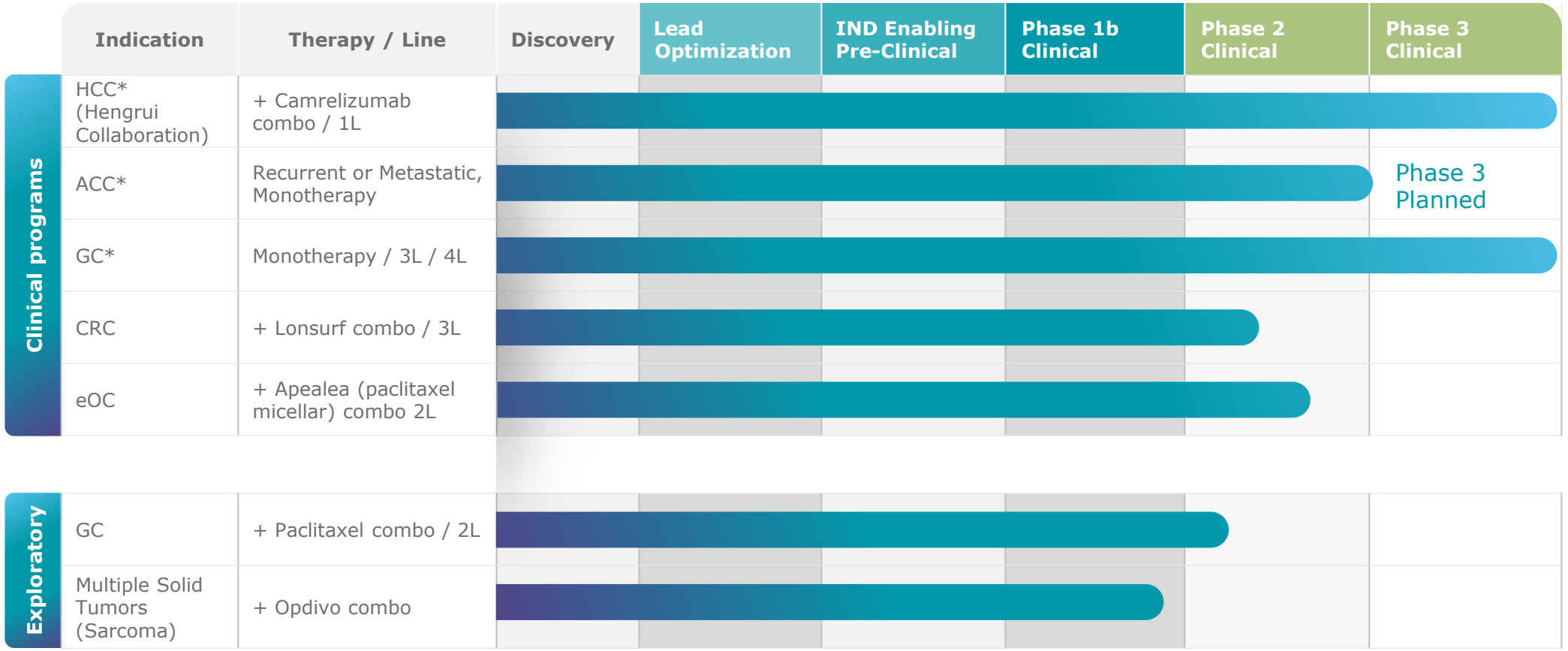
clinical outcomes and set new standards of care that improve treatment experiences

CORE SCIENCE

- Rivoceranib is 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 (excluding China)

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

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



* Orphan Drug Designation (ODD)

Rivoceranib

A more selective anti-VEGF-2 TKI

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Rivoceranib: A pipeline in a product

Providing the Foundation for Future Growth and Diversification

Multiple Therapeutic Opportunities

- Positive data with largest study in ACC patients
- Clinical studies in multiple tumor types including a phase 3 HCC study in combination with immunotherapy (PD-1)
- Anticipate NDA filing with FDA in 2023
- VEGF TKIs are indicated for more than 15 different type of cancers

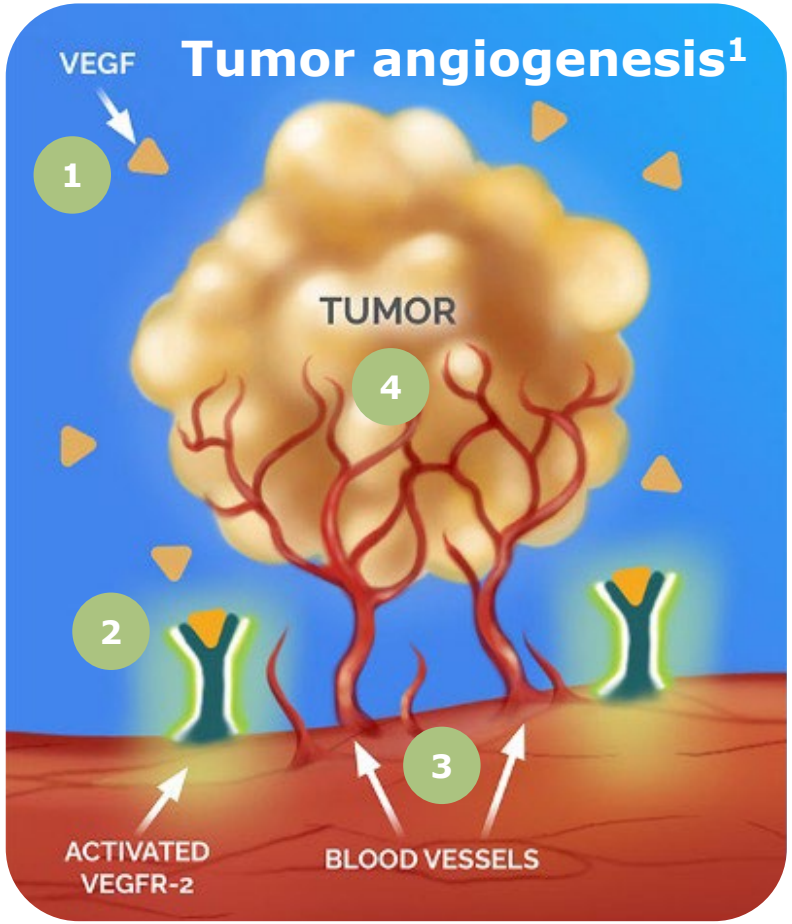
Strong Safety Profile

- 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 worldwide with favorable tolerability and acceptable safety profile

Opportunities for Growth

- Synergy with immuno-oncology therapy and chemotherapy
- Anti-VEGF TKIs have shown positive results in solid tumors
- Market is large (approximately $10B) and growing at a compound annual growth rate (CAGR) of approximately 10%
- Oral TKI anti-VEGF market is approximately $3.7B and growing at approximately 30% CAGR

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

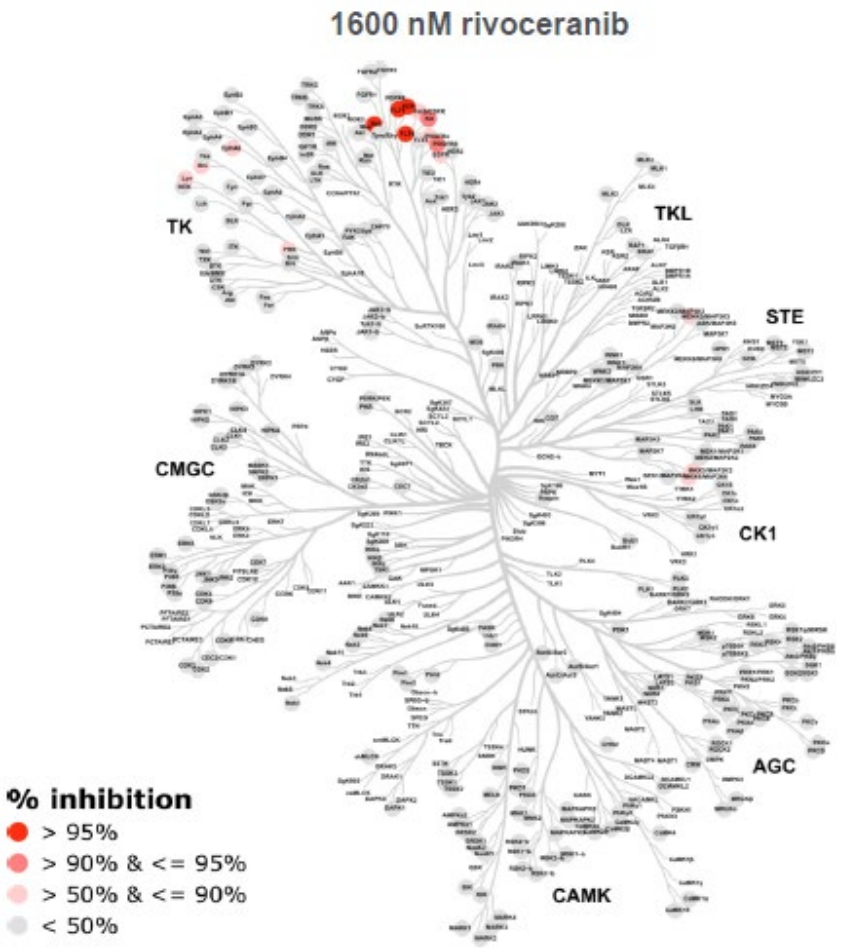
VEGFR-2 activation causes new blood vessels to sprout, supplying nutrients for tumor growth[2]

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	101
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

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%

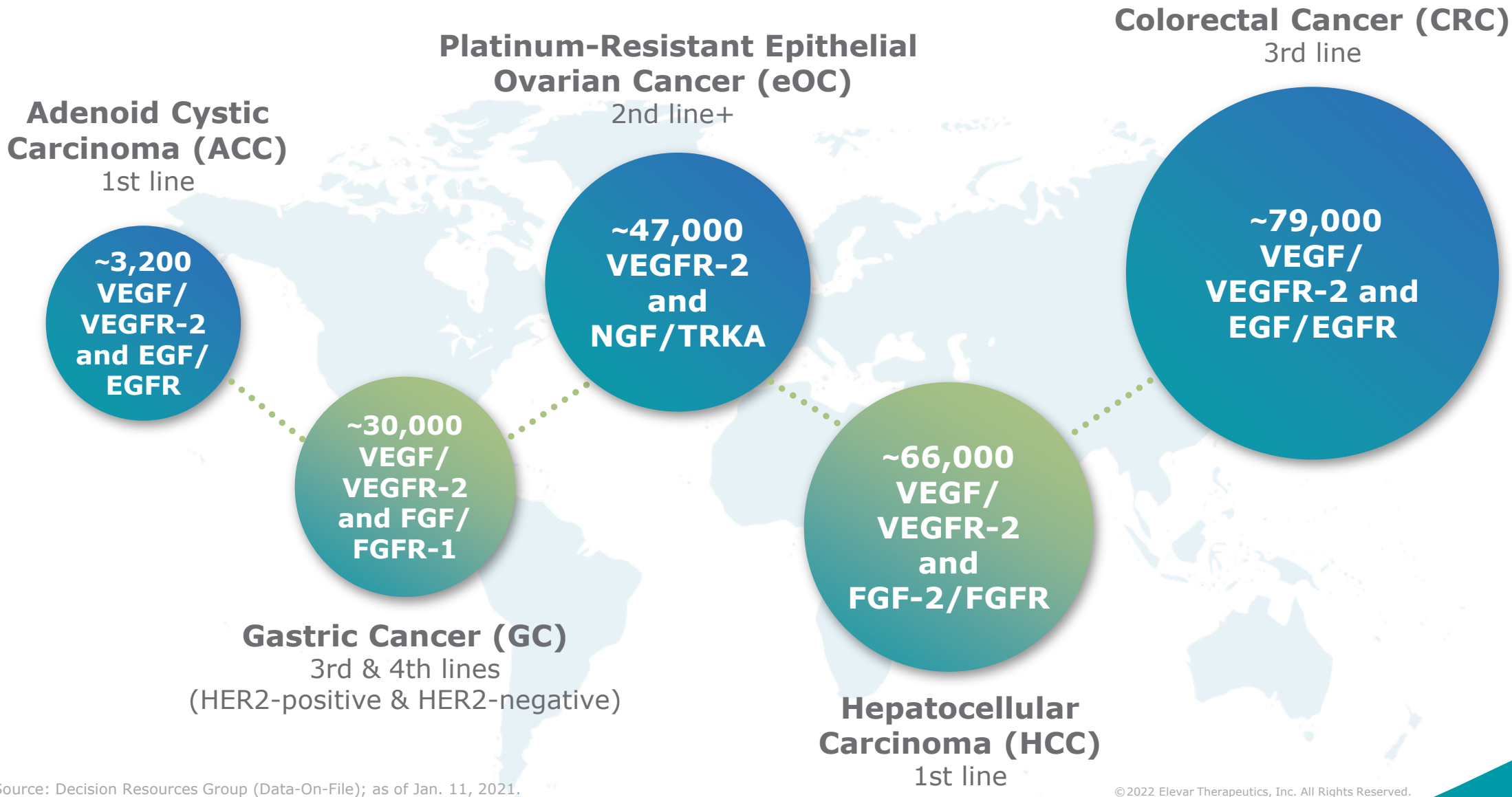
* Black-box warning

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.

2021 Global incidence in US, EU-5, and Japan



Source: Decision Resources Group (Data-On-File); as of Jan. 11, 2021.

Rivoceranib is an extensively-studied TKI, and more clinical studies are currently underway

Elevar and its collaborators have studied rivoceranib in

OVER 6000 PATIENTS

WORLDWIDE

Number of Studies	Disease State	Region	Number of Subjects	Phase
1	ACC	USA/Korea	80	2
2	Solid Tumors	USA/Korea	85	1/2a
2	GC	USA/Global	470 +	1/2, 3
1	CRC	US/Korea	20 +	1/2
7	Clinical Pharmacology	USA	250	1
1	HCC	USA/Global	543	3
47	Multiple	China/Global	4770+	1-3

Source: Data on file.

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

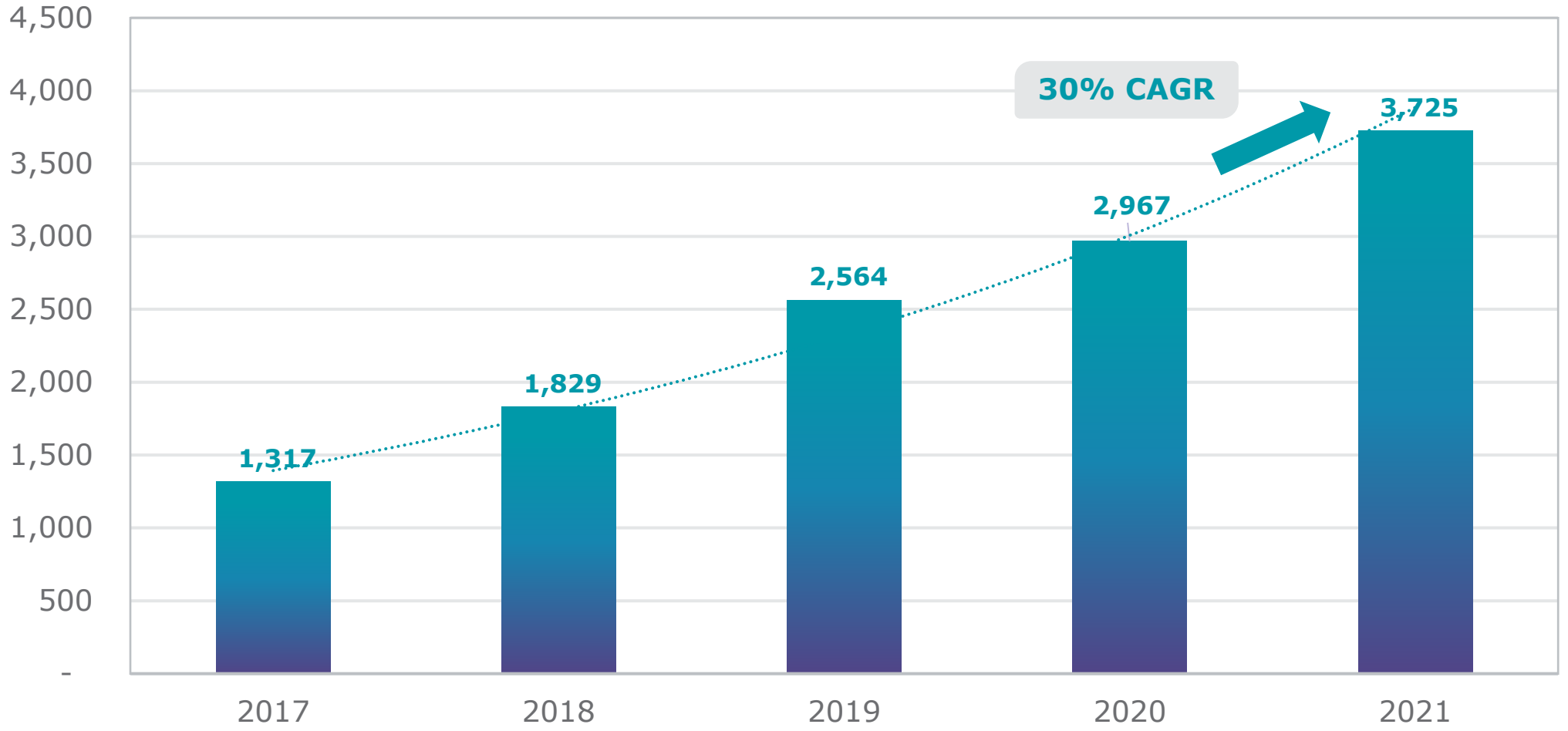
	Rivoceranib	Bevacizumab	Ramucirumab	Regorafenib	Sorafenib	Lenvatinib	Cabozantinib
Target	VEGFR-2	VEGF-A	VEGFR-2	• VEGFR • PDGFR • TIE2 • FGFR	• VEGFR • PDGFR • c-RAF	• VEGFR • FGFR • RET	• VEGFR • cKIT • RET
Indication(s)	• HCC (1st/C)** • HCC (mono)† • ACC (1st)** • GC (3rd/4th)* • CRC (3rd/C)** • OC (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
2021 Revenue	$505 (Hengrui, China)‡	$4.62b	$1.033b	$565m	$515m	$1.73b	$1.077b

* Approved in GC (China) † Approved in HCC as monotherapy (China)
** Not approved

Source: Evaluate Pharma July 2022., Company 2021 Annual Reports

Oral TKI Anti-VEGF global sales 2017-2021 *(USD $mm)*

Regorafenib, Sorafenib, Lenvatinib, Cabozantinib



Source: MIDAS Global data.

Hepatocellular Carcinoma (HCC)

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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 (atezo-bev, atezo-cabozantinib, and lenvatinib-pembro)[5]

Checkpoint inhibitor and TKI combinations offer 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.

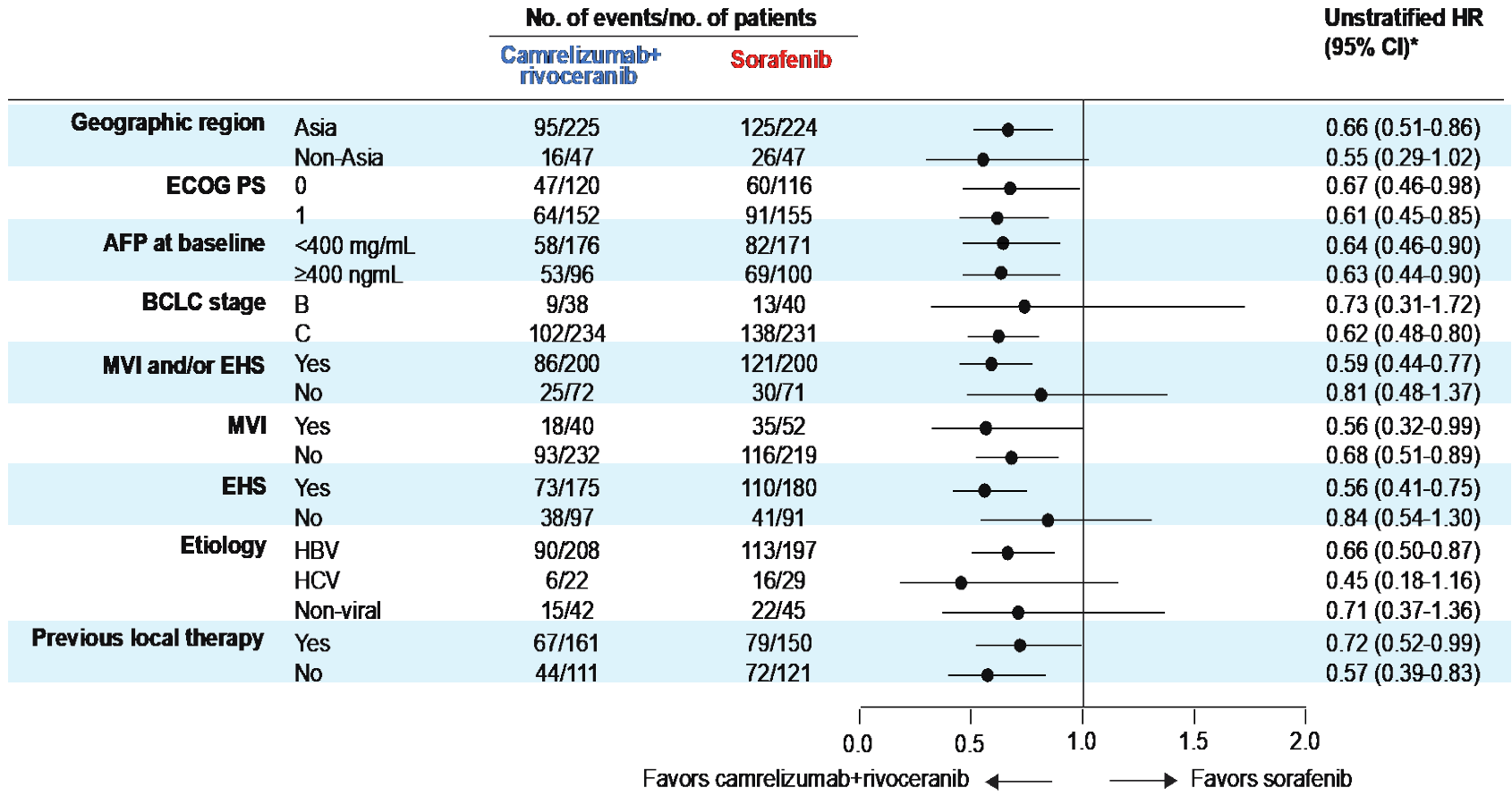
Rivoceranib study SHR-1210-III-310 shows significant improvement in outcomes for HCC patients[1]

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

Overall Survival favored Rivoceranib + Camrelizumab across subgroups compared with sorafenib monothearpy



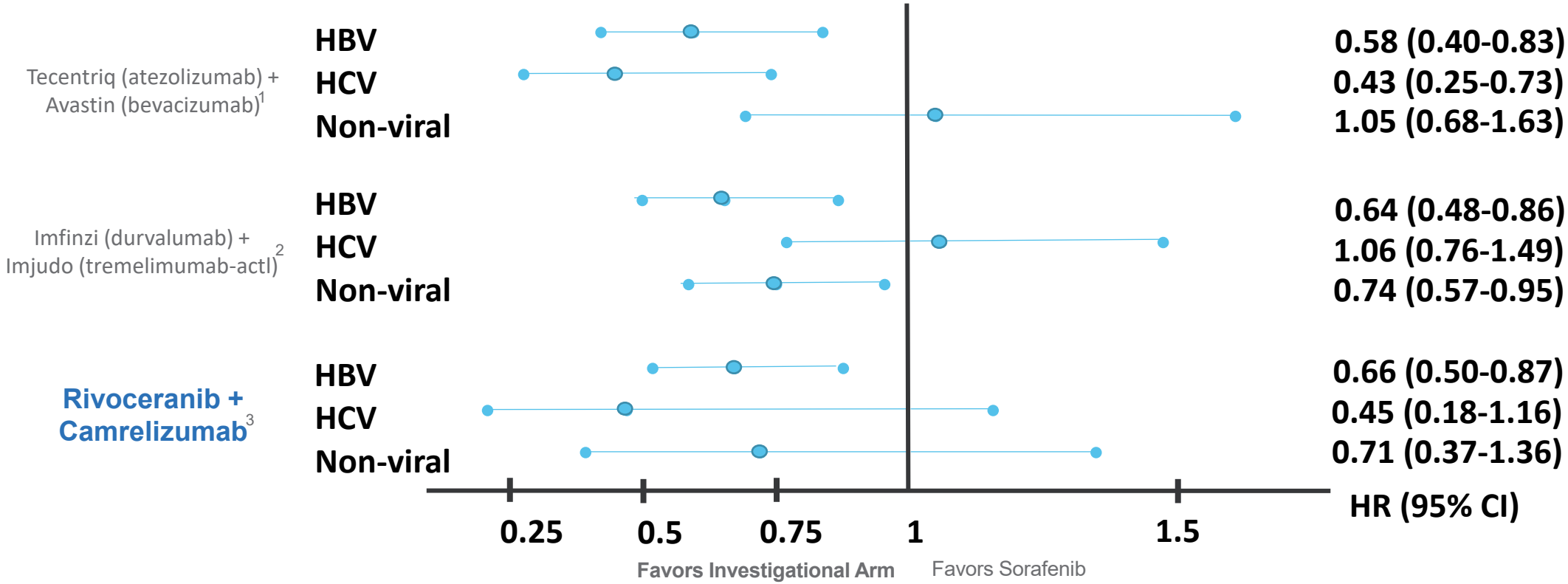
- 17.2% of total study patient population were Western
- Regardless of region, hazard ratios (HRs) of OS favored Cam + Rivo over sorafenib in the majority of subgroups

*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 consistent OS benefit across viral and non-viral etiologies

Indirect comparison of OS in prespecified subgroups across HCC trials

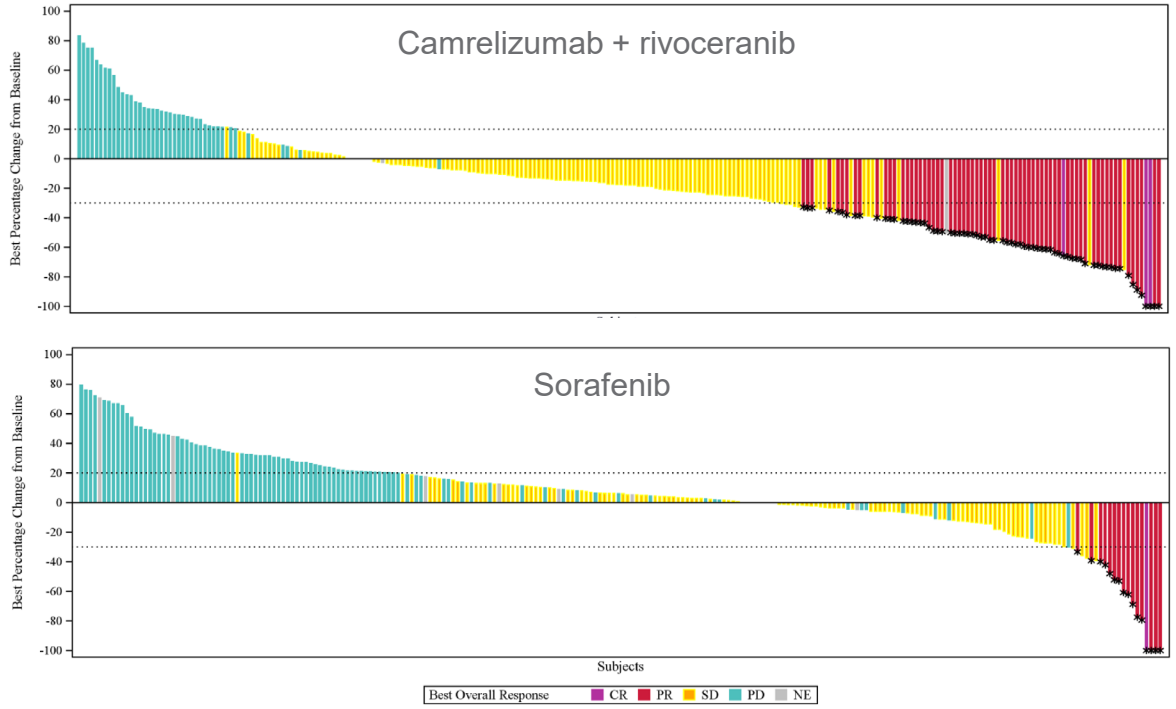


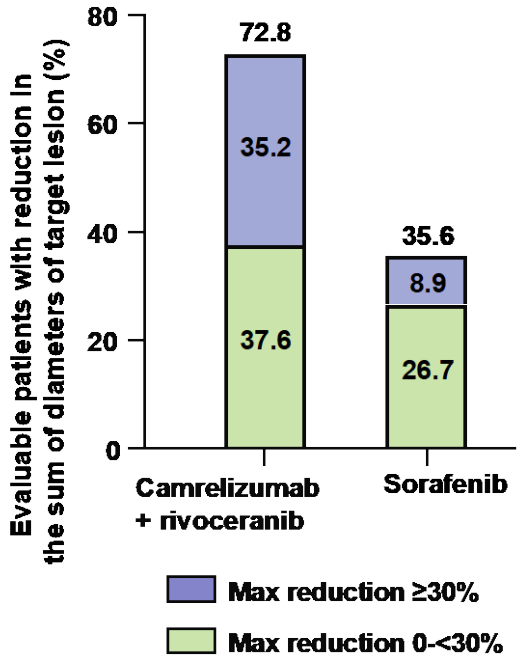
Please note that head-to-head studies were not conducted between these products. This data is for information purposes only and no comparative claims of non-inferiority or superiority in terms of efficacy or safety are implied or intended.

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. 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 is highly effective for tumor reduction

Best change from baseline in sum of diameters of target lesion



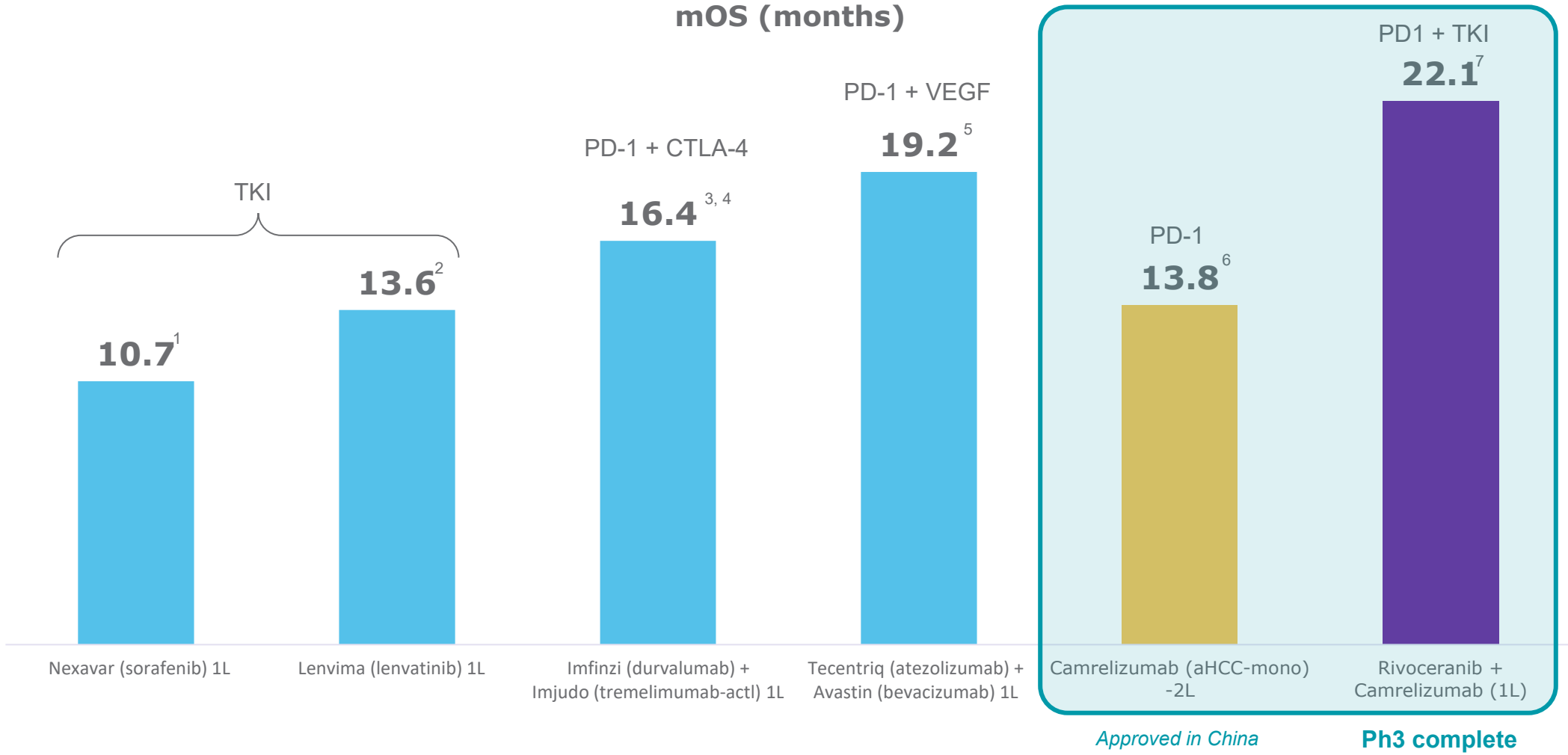


33.1% of patients had a 30% reduction in lesion diameter

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

Rivoceranib + camrelizumab demonstrated significant mOS in 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

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

Rivoceranib when combined with Camrelizumab may be poised to treat HCC, a rapidly growing disease

HCC incidence projected to increase by 137% over the next decade[1]

Antiangiogenic therapy in combination with Immune Checkpoint Inhibitors expected to become dominant class with an expected 25% annual growth to $6.7B (2029)[2]

Median survival now longer than a year[3]

~50% of patients expected to receive a TKI in combination with an ICI[4]

ICI and TKI combinations offer promise because toxicity profiles do not overlap[5]

Camrelizumab and rivoceranib are both approved in China as monotherapy

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

Sources: 1. Weinfurtner K, et al. *Transplant Direct*. 2020;6(10):e605. 2. Decision Resources Group (Data-On-File); as of Jan. 11, 2021. 3. Raybould, Alison L, and Hanna S anoff. "Combination Antiangiogenic and Immunotherapy for Advanced Hepatocellular Carcinoma: Evidence to Date." Journal of hepatocellular carcinoma vol. 7 133-142. 15 Sep. 2020, doi:10.2147/JHC.S224938. 4. Decision Resources Disease Landscape and Forecast, Hepatocellular Carcinoma January 2021 (Internal-on-file). 5. Zhu, Xiao-D ong 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. 6. Xu, Jianming et al. Camrelizumab in Combination with Apatinib in Patients with Advanced Hepatocellular Carcinoma (RESCUE): A Nonrandomized, Open-label, Phase II Trial. Clin Cancer Res February 15 2021 (27) (4) 1003-1011; DOI: 10.1158/1078-0432.CCR-20-257.

Adenoid Cystic Carcinoma (ACC)

CONFIDENTIAL

Potential opportunity in adenoid cystic carcinoma[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]

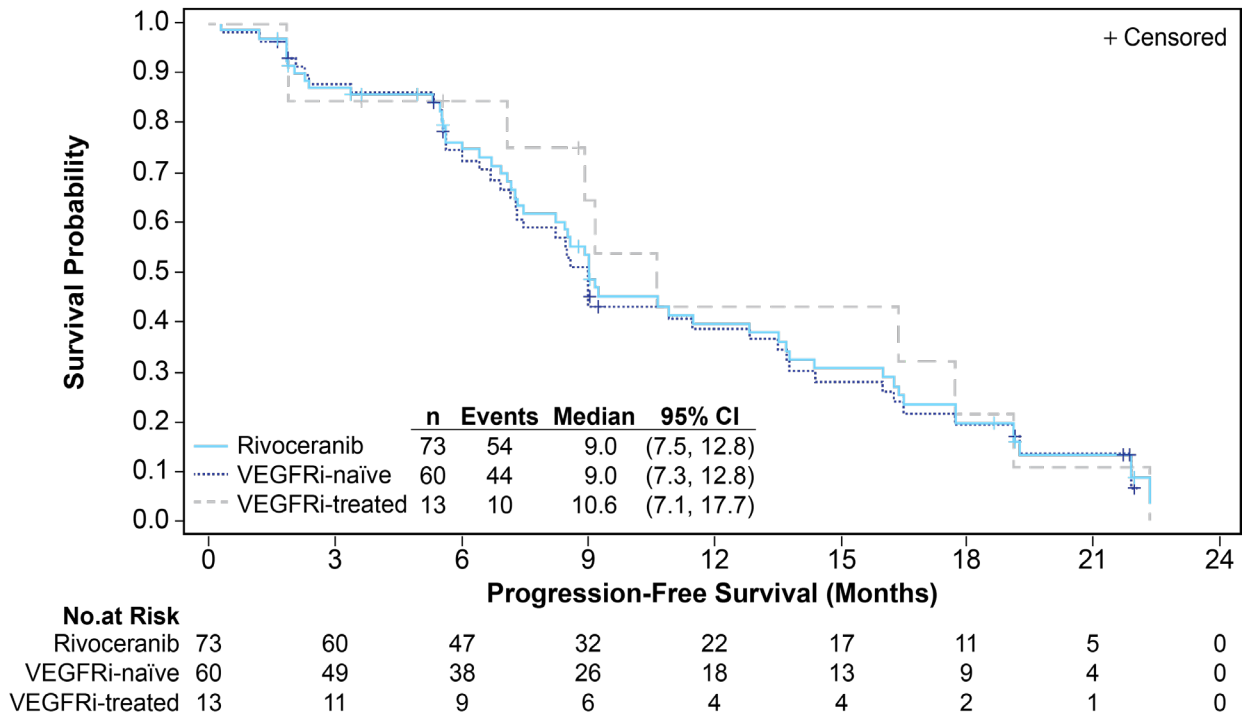
Urgent unmet medical needs remain for a rare cancer that currently has no approved treatment options

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



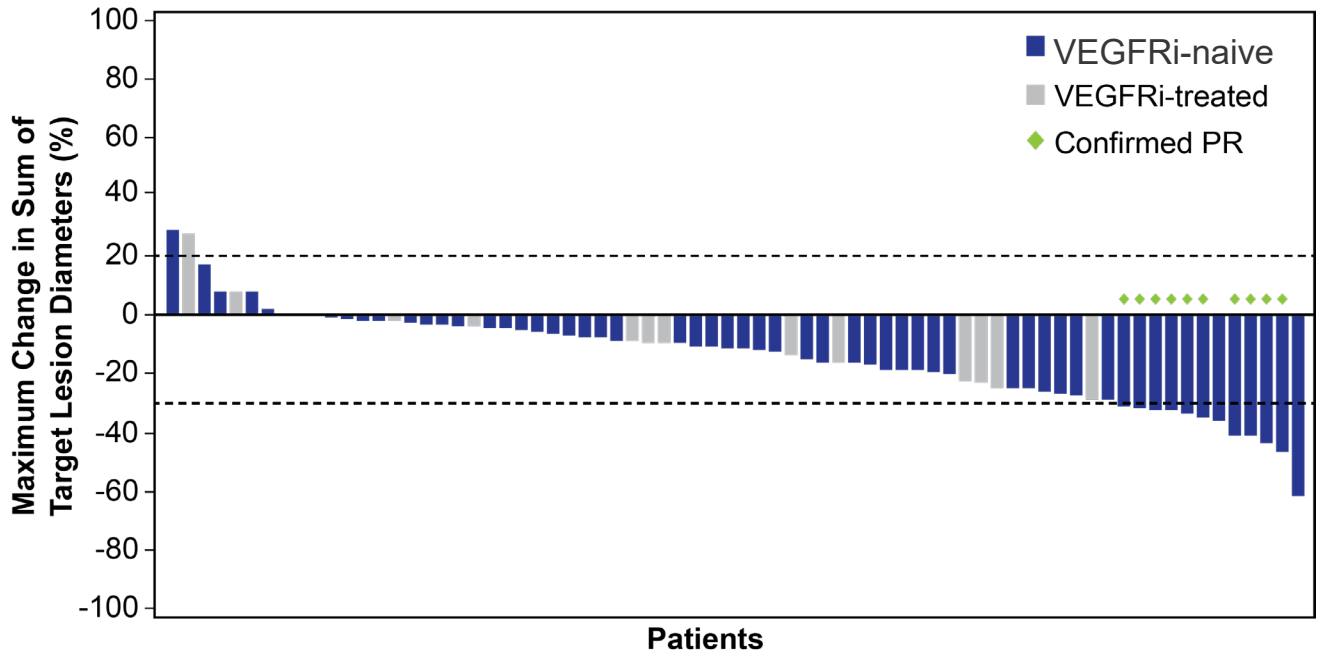
Rivoceranib demonstrated a **PFS rate of 9.0 months** (per RECIST)

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

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

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, Ah n MJ, Ock CY, et al. *Clin Cancer Res*. 2021;27(19):5272-5279.

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.

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

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/