Elevating
Treatment Outcomes For Patients

elevar therapeutics

CONFIDENTIAL

Company Overview

ELEVAR THERAPEUTICS: An Oncology-Focused, Fully Integrated Biopharmaceutical Company

PHASE 3 CARES-310 STUDY WITH POTENTIAL FDA APPROVAL IN MARCH 2025[1,2]

- CARES-310 study shows industry leading mOS of 23.8 months in 1L uHCC* patients[1,2]
- Current approved combination therapies for uHCC showed mOS of 16.4-19.2 months[3,4]

uHCC REPRESENTS A $10B+ MARKET OPPORTUNITY

- 60-70% of patients opt for systemic therapy at some point[6,7]
- Approximately ~15,577 patients receiving 1L uHCC treatment yearly in the US[8], with incidence and mortality rates increasing[9]
- HCC is 2nd leading cause of cancer-related deaths in Asia and the 6th in Western countries[5]

EXPERIENCED MANAGEMENT TEAM

- Extensive global leadership experience in clinical development, regulatory and commercial
- Proven oncology launch footprint plans developed to support optimal target reach

WELL-CAPITALIZED WITH STRONG INTELLECTUAL PROPERTY PROTECTION

- A subsidiary of HLB Co., Ltd. (KOSDAQ:028300)
- Exclusivity on key intellectual property projected through 1H 2038
- Global rights to camrelizumab and rivoceranib for HCC (excluding Greater China and Korea)

*uHCC - unresectable Hepatocellular Carcinoma

References: 1. Qin S, et al. Lancet. 2023;402(10408):1133-1146. 2. Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. J Clin Oncol. 2024;42(16)suppl. Abs 4110. 3. Cheng A-I, et al. J Hepatol. 2022;76(4):862-873. 4. Abou-Alfa GK, et al. NEJM Evid.2022;1(8):doi:10.1056/EVIDoa2100070. 5. Rawla P, et al. Contemp Oncol (Pozn). 2018;22(3):141-150. 6. Llovet JM, et al. Nat Rev Dis Primers. 2021;7(1):6. 7. Yoo JJ, et al. Sci Rep. 2023;13(1):14584. 8. Llovet, J.M., Kelley, R.K., Villanueva, A. *et al.* Hepatocellular carcinoma. *Nat Rev Dis Primers* **7**, 6 (2021).9. Golabi P, et al. Medicine (Baltimore). 2017;96(9):e5904.

Leadership Team

Saeho Chong, PhD
Chief Executive Officer

Alnylam PHARMACEUTICALS · FDA · Bristol Myers Squibb

Jacqueline Blazek
Head, Human Resources

MIRATI THERAPEUTICS · ARENA PHARMACEUTICALS · Catalent

Seong Jang, PhD
Chief Operating Officer

FDA

Wade Smith
Chief Financial & Business Officer

Mylan · VIATRIS · DRA

Chris Galloway, MD
SVP, Clinical Development/Medical Affairs

Diffusion Pharmaceuticals Inc. · La Jolla Pharmaceutical · Rakuten Medical

Jeanette Bressi
Head, Corporate Communications

Johnson & Johnson · Bristol Myers Squibb · MERCK

Elevar Key Milestones for Camrelizumab + Rivoceranib

- ☐ **Japan filing and approval**
  2026+
- ☐ **EU filing and approval**
  2H 2025+
- ☐ **US commercial launch planned**
  Mid-2025
- ☑ **PDUFA date**
  March 20, 2025
- ☑ **BLA/NDA filings**
  Resubmission September 2024

Camrelizumab and Rivoceranib are Proven Therapies with Large Commercial Opportunities

Camrelizumab and rivoceranib being developed for HCC and uHCC – areas of large unmet medical need representing a $10B+ global potential market opportunity

Commercial Products Available Outside US

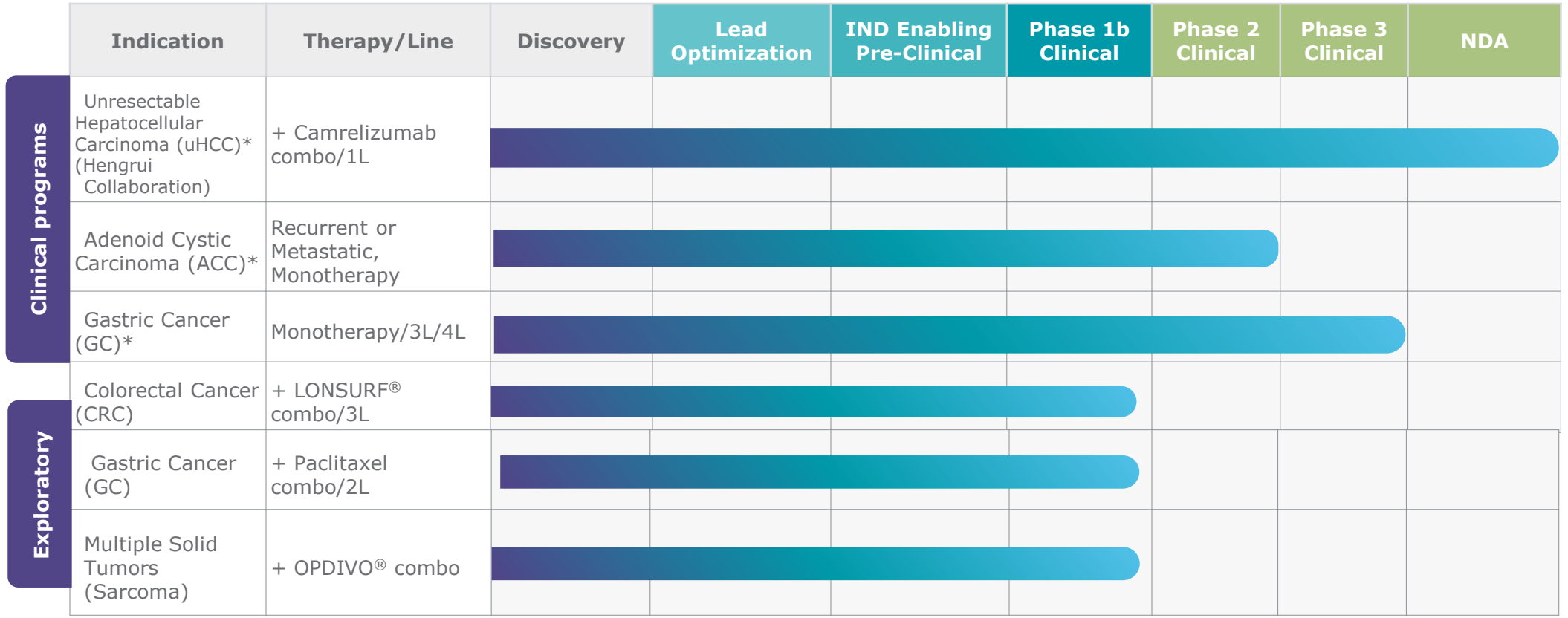
Rivoceranib

- Commercialized by Hengrui Pharma in China as Apatinib®
- Approved in China for:
  - Gastric cancer 1L monotherapy (2014)
  - Advanced hepatocellular carcinoma (HCC) 2L monotherapy (2020)
  - Unresectable hepatocellular carcinoma (uHCC) in combination with Hengrui Pharma's camrelizumab 1L (January 2023)
- Potential to be a best-in-class small molecule, TKI selective for the VEGF receptor; orally administered
- Elevar has global rights to rivoceranib (excluding Greater China and Korea)

Camrelizumab

- Commercialized by Hengrui Pharma in China as AiRuiKa®
- One of the top-selling anti-PD-1s in China with eight approved indications; administered by IV infusion
- Elevar has global rights to camrelizumab for HCC with ability to add indications (excluding Greater China and Korea

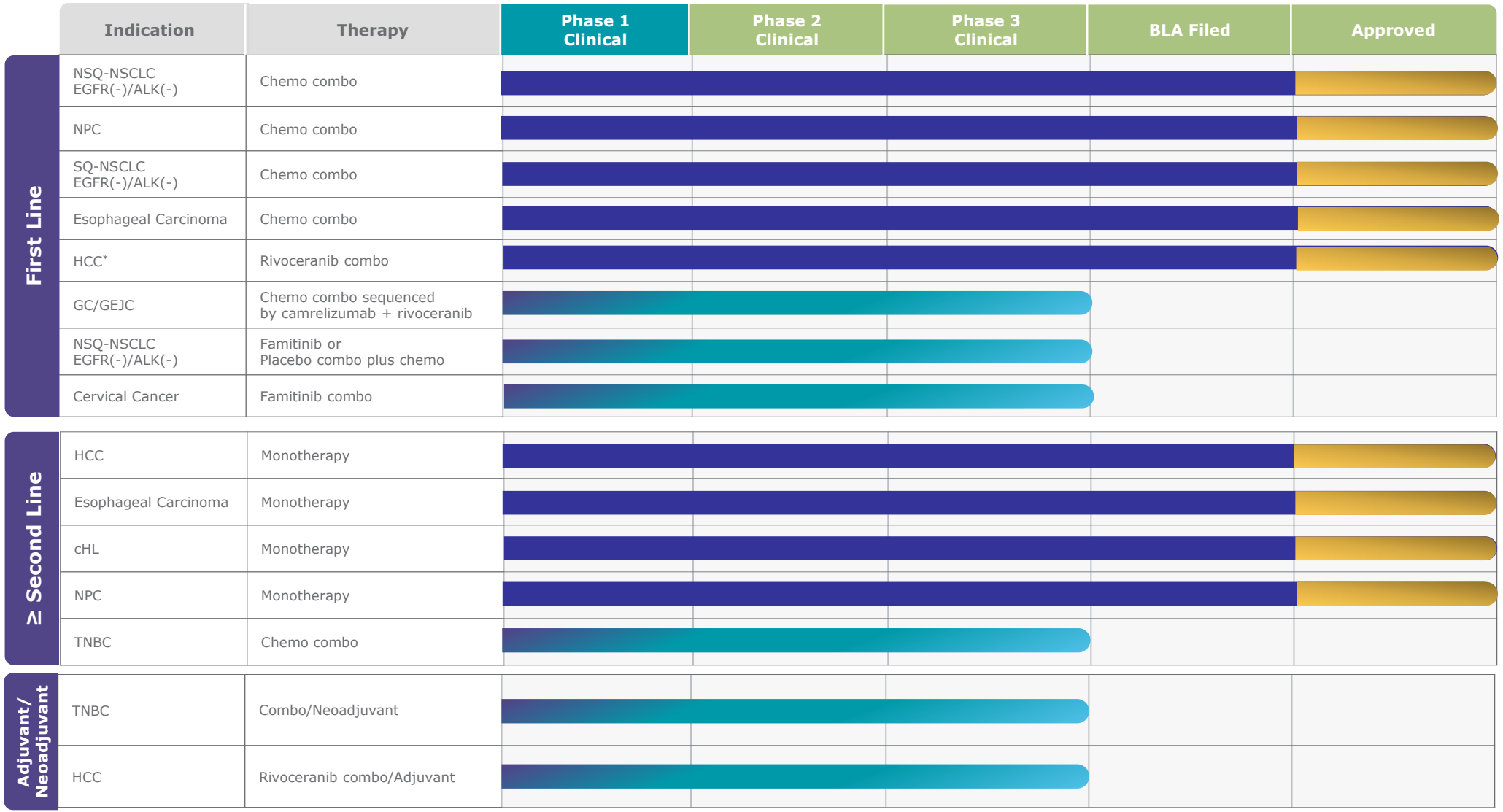
Rivoceranib Has Been Studied in More Than 6,000 Patients Worldwide for Multiple Indications[1,2]



*Orphan Drug Designation (ODD).
All product and company names are trademarks™ or registered® trademarks of their respective holders. Use of them does not imply any affiliation with or endorsement by them.
uHCC=unresectable hepatocellular carcinoma; ACC=adenoid cystic carcinoma; GC=gastric cancer; CRC=colorectal cancer

References: 1. Elevar Therapeutics. Press release. Accessed September 13, 2023. https://elevartherapeutics.com/2023/08/03/elevar-therapeutics-to-host-august-10-virtual-kol-event-on-phase-3-study-of-rivoceranib-in-combination-with-camrelizumab-in-unresectable-hepatocellular-carcinoma-uhcc/ **2.** Elevar Therapeutics. Press release. Accessed September 14, 2023. https://elevartherapeutics.com/2023/07/17/elevar-therapeutics-announces-fda-acceptance-for-filing-of-new-drug-application-for-rivoceranib-in-combination-with-camrelizumab-as-a-first-line-treatment-for-unresectable-hepatocellular-carcinoma/

Camrelizumab Has Been Studied in More Than 5,000 Patients Worldwide Across Multiple Indications Outside the United States[1]



Reference: 1. Elevar Therapeutics. Press release. Accessed September 14, 2023. https://elevartherapeutics.com/2023/07/17/elevar-therapeutics-announces-fda-acceptance-for-filing-of-new-drug-application-for-rivoceranib-in-combination-with-camrelizumab-as-a-first-line-treatment-for-unresectable-hepatocellular-carcinoma/

*1L treatment for HCC approved in China.
Note: All approved treatments are approved in China only, not U.S. or E.U.
Note: Hengrui's pipeline is shown, Elevar only has the HCC combination therapy rights globally ex Greater China and South Korea.

Camrelizumab cohort only.

ALK=anaplastic lymphoma kinase; cHL=classic Hodgkin lymphoma; EGFR=epidermal growth factor receptor; GC=gastric cancer; GEJC=gastroesophageal junction cancer; HCC=hepatocellular carcinoma; NPC=nasopharyngeal cancer; NSCLC=non small-cell lung cancer; NSQ=non-squamous; SQ=squamous; TNBC=triple-negative breast cancer.

Product Candidates

Opportunity in unresectable Hepatocellular Carcinoma (uHCC)

1. With ~15,577 patients[1-3] receiving 1L uHCC treatment yearly in the US with incidence and mortality rates increasing, **HCC represents the fastest-rising cause** of cancer-related deaths in the US[4,5]

2. Typically diagnosed late in its course when **liver function is already severely declining**, survival at diagnosis is only ~6-20 months with very low five-year survival rates[4]

3. HCC is currently the **2nd leading cause of cancer-related death** in Asia and the 6th most common in Western countries[5] with ~60-70% of patients being exposed / opting to systemic therapy at some point,[2,6] the number of which should increase with **safer and more tolerable treatment options**

Available Treatment

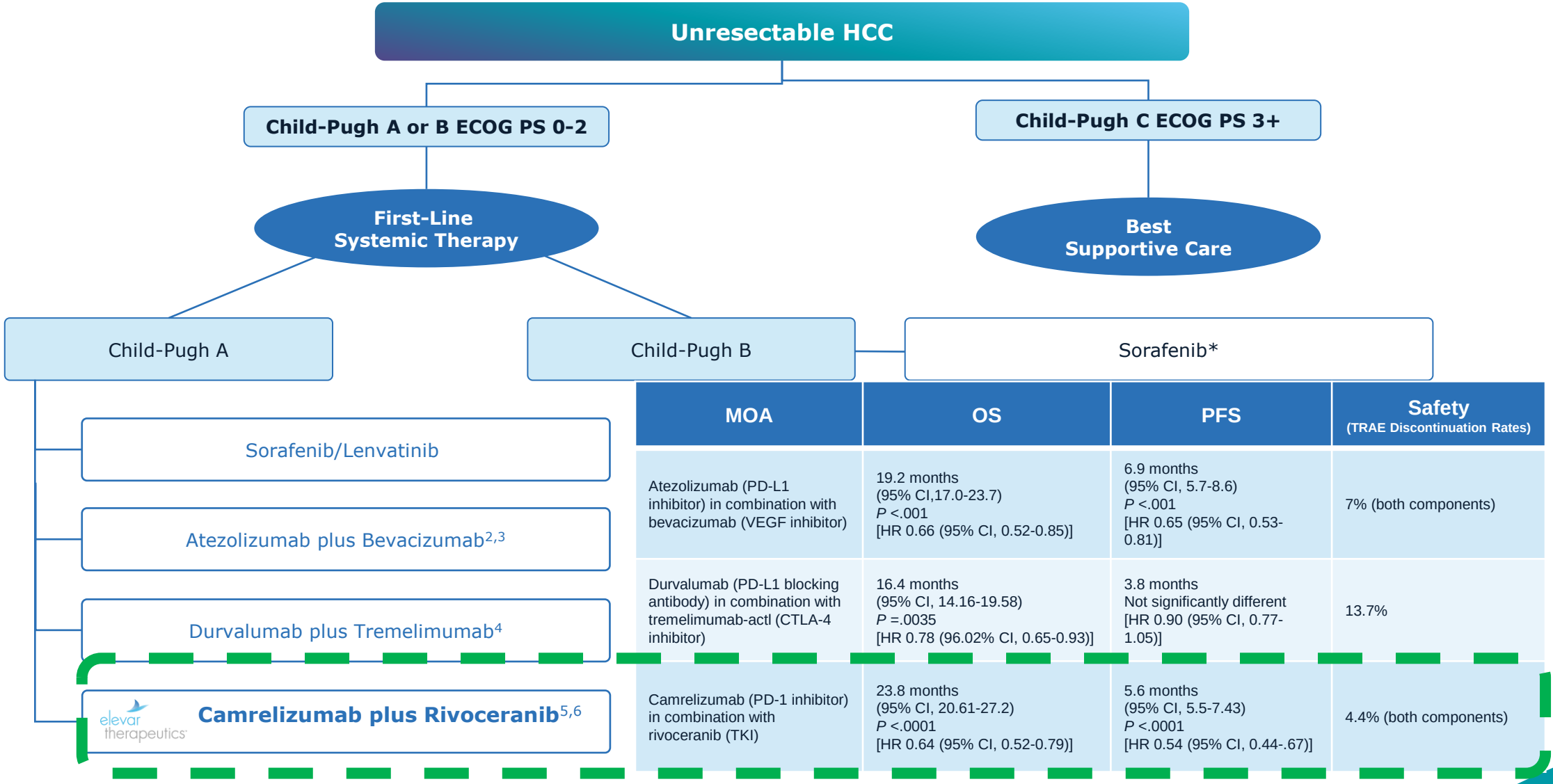
40+% of patients are expected to receive an angiogenesis inhibitor in combination with an immune checkpoint inhibitor (ICI), such as atezolizumab + bevacizumab (VEGF-A)[7,8]

ICI and angiogenic inhibitor combinations offer promise because toxicity profiles do not overlap[9]

Despite the latest advancements in HCC treatments, an urgent need remains for more efficacious, tolerable treatments due to the disease's severity and low survival rates

References: 1. Siegel RL, et al. *CA Cancer J Clin*. 2023;73(1):17-48. **2.** Llovet JM, et al. *Nat Rev Dis Primers*. 2021;7(1):6. **3.** Wang EA, et al. *Int J Clin Pract*. 2017;71(11). **4.** Golabi P, et al. *Medicine (Baltimore)*. 2017;96(9):e5904. **5.** Rawla P, et al. *Contemp Oncol (Pozn)*. 2018;22(3):141-150. **6.** Yoo JJ, et al. *Sci Rep*. 2023;13(1):14584. **7.** Data on file. 0001. Fort Lee, NJ: Elevar Therapeutics; February 1, 2024. **8.** Sadhu A, Blandy O. Decisions Resources Group. *Disease Landscape & Forecast: Hepatocellular Carcinoma*. Published November 20, 2020. **9.** Zhu XD, et al. *Genes Dis*. 2020;7(3):328-335.

Hepatocellular Carcinoma Systemic Therapy Paradigm[1]

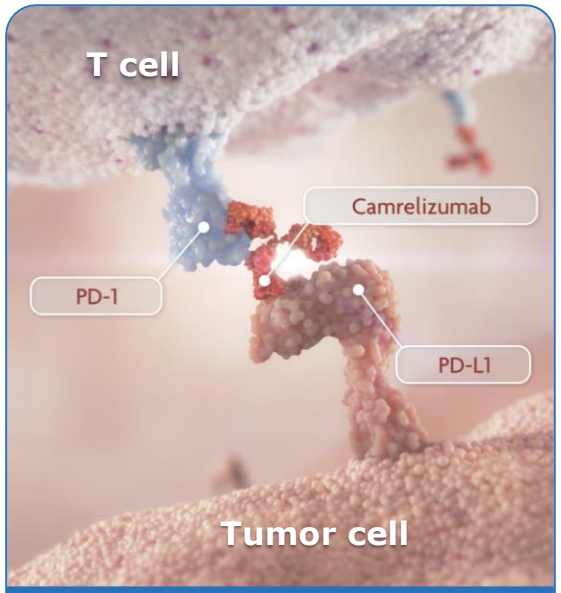


MOA	OS	PFS	Safety (TRAE Discontinuation Rates)
Atezolizumab (PD-L1 inhibitor) in combination with bevacizumab (VEGF inhibitor)	19.2 months (95% CI,17.0-23.7) *P* <.001 [HR 0.66 (95% CI, 0.52-0.85)]	6.9 months (95% CI, 5.7-8.6) *P* <.001 [HR 0.65 (95% CI, 0.53-0.81)]	7% (both components)
Durvalumab (PD-L1 blocking antibody) in combination with tremelimumab-actl (CTLA-4 inhibitor)	16.4 months (95% CI, 14.16-19.58) *P* =.0035 [HR 0.78 (96.02% CI, 0.65-0.93)]	3.8 months Not significantly different [HR 0.90 (95% CI, 0.77-1.05)]	13.7%
Camrelizumab (PD-1 inhibitor) in combination with rivoceranib (TKI)	23.8 months (95% CI, 20.61-27.2) *P* <.0001 [HR 0.64 (95% CI, 0.52-0.79)]	5.6 months (95% CI, 5.5-7.43) *P* <.0001 [HR 0.54 (95% CI, 0.44-.67)]	4.4% (both components)

*Per NCCN Guidelines for 1L uHCC, nivolumab and atezolizumab+bevacizumab are useful in certain circumstances (Child-Pugh Class B only).

References: 1. Leowattana W, et al. *World J Gastroenterol.* 2023;29(10):1551-1568. **2.** Cheng A-l, et al. *J Hepatol.* 2022;76(4):862-873. **3.** Finn RS, et al. *N Engl J Med.* 2020;382(20):1894-1905. **4.** Abou-Alfa GK, et al. *NEJM Evid.* 2022;1(8):doi: 10.1056/EVIDoa2100070 **5.** Qin S, et al. *Lancet.* 2023;402(10408):1133-1146. **6.** Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol.* 2024;42(16)suppl. Abs 4110.

Complementary Mechanism of Actions (MOAs) of Camrelizumab + Rivoceranib



Click to View the Camrelizumab MOA Video

Camrelizumab

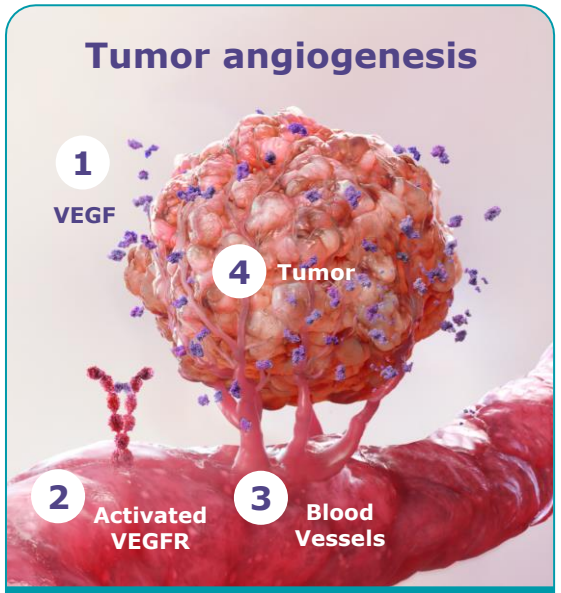
Camrelizumab is a **monoclonal antibody** that targets the programmed cell death protein 1 (PD-1) receptor.

In cancer cells, the programmed cell death ligand 1 (PD-L1) protein binds to the PD-1 receptor, effectively allowing tumor cells to escape immunosurveillance. This is referred to as the PD-1/PD-L1 pathway. By targeting the PD-1 receptor, **camrelizumab blocks this binding** and allows T cells to start attacking tumor cells, boosting **immune response**.

Rivoceranib

Rivoceranib is a **small-molecule tyrosine kinase inhibitor** (TKI) that works to **inhibit** the vascular endothelial growth factor receptor (VEGFR), a primary pathway for tumor angiogenesis (*see illustration*).

By inhibiting VEGFR, rivoceranib helps **restrict blood vessels** used in supplying nutrients to the tumor which leads to the **death of tumor cells** and **slows further cancer growth.**



Click to view the Rivoceranib MOA Video

Camrelizumab + Rivoceranib

Camrelizumab and rivoceranib, designated as a targeted combination therapy, is designed to **disrupt cancer cell** pathogenesis at **specific biological points and distinct pathways** that are essential to tumor development as outlined above, via a two-pronged approach.

Camrelizumab **reinvigorates the body's immune response** by allowing T cells to attack malignant cancer cells,[1] while rivoceranib targets the VEGFR pathway to **restrict the supply** of blood vessels and nutrients to the tumor.[2,3]

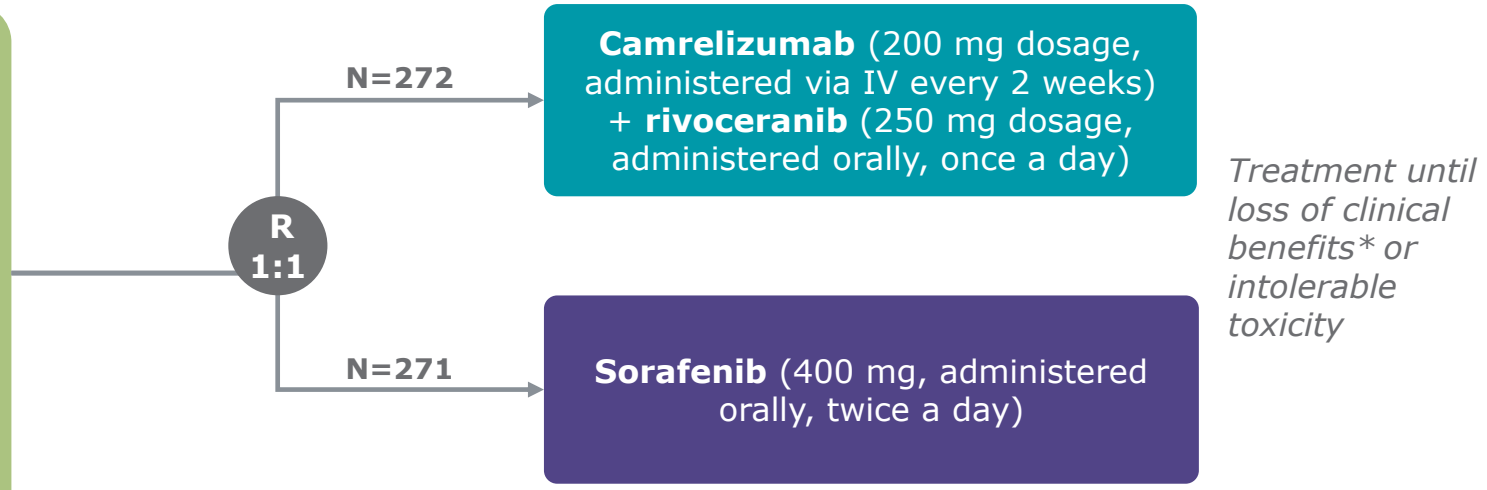
References: 1. Data on file. 0005. Fort Lee, NJ: Elevar Therapeutics; February 14, 2024. **2.** Data on file. 0006. Fort Lee, NJ: Elevar Therapeutics; February 14, 2024.
3. Jang S, et al. *Cancer Chemother Pharmacol*. 2023;91(6):491-499.

CARES-310 Phase 3 Trial Design

International, Randomized Open-Label Phase 3 Trial[1]

Key Eligibility Criteria

- Unresectable or metastatic HCC
- BCLC Stage B (unsuitable for radical surgery and/or locoregional treatment) or C
- No prior systemic therapy
- ECOG PS 0 or 1
- Child-Pugh A
- At least one measurable lesion per RECIST v1.1



Stratification Factors

- MVI and/or EHS (yes vs no)
- Geographical region (Asia vs non-Asia)
- Baseline serum AFP (<400 vs ≥400 ng/mL)

Primary Endpoints

- PFS†
- OS

Key Secondary Endpoint

- Objective response rate (ORR)†

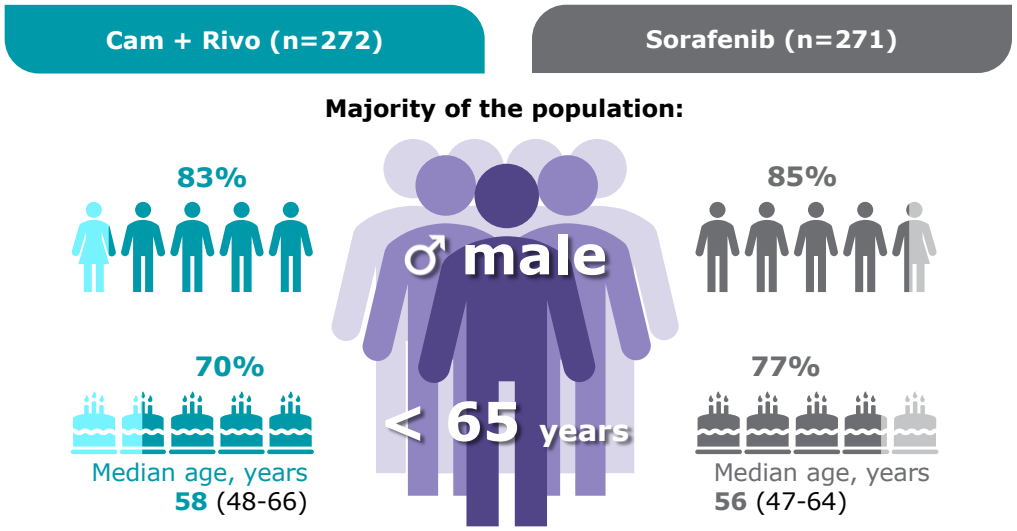
AFP=alpha-fetoprotein; BCLC=Barcelona Clinic Lever Cancer; BIRC=blinded independent review committee; CARES-310=Camrelizumab plus rivoceranib vs sorafenib as first-line therapy for unresectable hepatocellular carcinoma; ECOG PS=Eastern Cooperative Oncology Group performance status; EHS=extrahepatic spread; HCC=hepatocellular carcinoma; IV=intravenous; MVI=macrovascular invasion; OS=overall survival; PFS=progression-free survival; RECIST=Response Evaluation Criteria in Solid Tumors.

*Treatment beyond progression allowed if there was evidence of clinical benefits per investigator.

†By BIRC per RECIST v1.1.

Reference: 1. Qin S, et al. *Lancet*. 2023;402(10408):1133-1146.

Baseline Characteristics



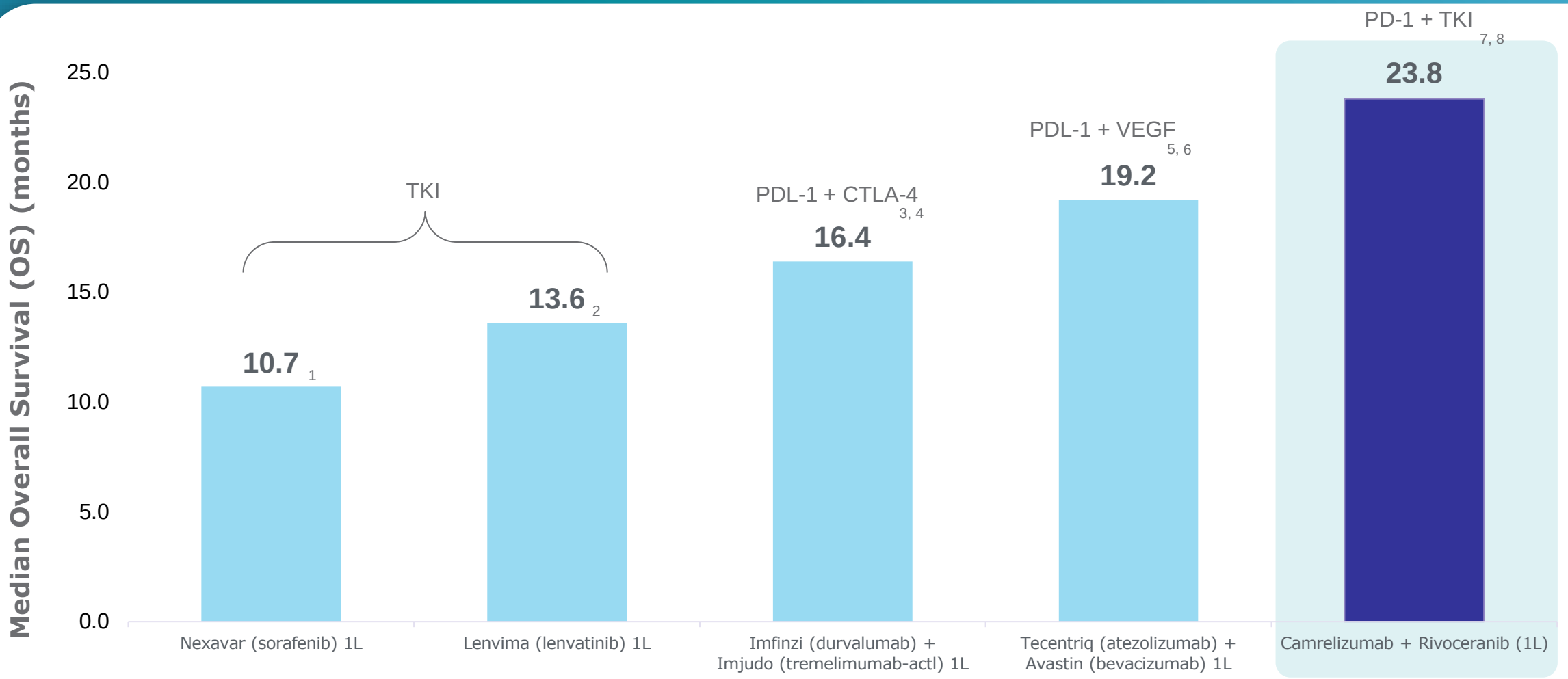
- Geographical area: Asia[a] (83%) and Non-Asia[a] (17%)
- Ethnicity: Asian (83%) and non-Asian (17%)
- More than half had previous local therapy for HCC
  - 59% vs. 55%

n (%)	Cam + Rivo n=272	Sorafenib n=271
ECOG PS, 0 or 1		
1	152 (56)	155 (57)
AFP		
<400 ng/mL	176 (65)	171 (63)
BCLC stage, B or C		
Stage C	234 (86)	231 (85)
Child-Pugh score		
Class A (5 points)	236 (87)	230 (85)
Class A (6 points)	36 (13)	41 (15)
Albumin-bilirubin grade		
1	200 (74)	208 (77)
2	72 (26)	63 (23)
MVI, EHS, or both	200 (74)	200 (74)
MVI[b]	40 (15)	52 (19)
EHS	175 (64)	180 (66)
Etiology[c]		
Hepatitis B virus	208 (76)	197 (73)
Hepatitis C virus	22 (8)	29 (11)
Non-viral[d]	42 (15)	45 (17)
PD-L1 expression		
TPS <1%	220 (81)	212 (78)
TPS ≥1%	32 (12)	39 (14)
CPS <1	190 (70)	180 (66)
CPS ≥1	62 (23)	71 (26)
Unknown	20 (7)	20 (7)

AFP=alpha-fetoprotein; BCLC=Barcelona Clinic Liver Cancer; CPS=combined positive score; ECOG PS=Eastern Cooperative Oncology Group performance status; EHS=extrahepatic spread; HCC=hepatocellular carcinoma; MVI=macrovascular invasion; TPS=tumor proportion score' US=United States.
[a]Includes mainland China, Hong Kong, Taiwan, and South Korea. Non-Asia includes Belgium, Italy, Germany, Poland, Russia, Spain, Turkey, Ukraine, and the US. [b]Patients with invasion of - or tumor t hrombus in - the main trunk of the portal vein (partial occlusion only), contralateral portal vein branch, or both, were included. [c]Main underlying cause of hepatocellular carcinoma per investigator. [d]Includes non-alcoholic fatty liver disease, alcohol cirrhosis, aflatoxin exposure, and other non-hepatitis B virus and non-hepatitis C virus causes (known or unknown).

Qin S, et al. *Lancet*. 2023;402(10408):1133-1146.

Camrelizumab + Rivoceranib Demonstrated Notable mOS vs Sorafenib as First-Line Treatment for unresectable Hepatocellular Carcinoma (uHCC)



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

References: 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.** TECENTRIQ (atezolizumab) (Prescribing Information). South San Francisco, CA: Genentech; 2024. **6.** AVASTIN (bevacizumab) (Prescribing information. South San Francisco, CA: Genentech, Inc.; May 2022. **7.** Qin S, et al. *Lancet*. 2023;402(10408):1133-1146. doi:10.1016/S0140-6736(23)00961-3; 8. Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110.

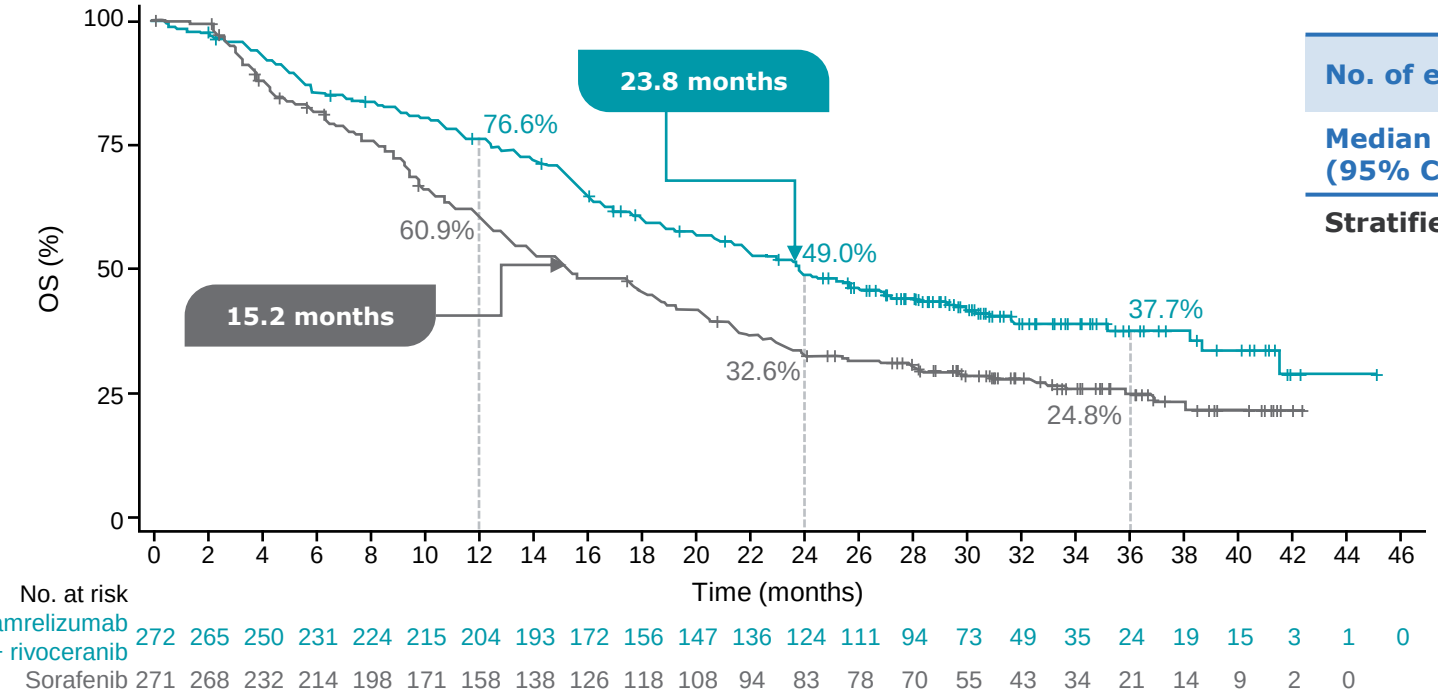
Camrelizumab + Rivoceranib Has the Potential to be a Best-in-Class Treatment Option in uHCC Based on Measurable, Clinically Relevant Data

Median Overall Survival (mOS)	**23.8 months**[1,2]
Median Progression Free Survival (mPFS)	**5.6**[1,2] HR, 0.54 (95% CI; 0.44-0.67)
Stable Disease (SD)	**51.1%**[1,2]
Progressive Disease (PD)	**16.5%**[1,2]
Viral and Non-Viral Etiology	**55% and 29% reduction in the risk for mortality for patients with HCV and non-viral etiology, respectively**[1,2]
Albumin-Bilirubin (ALBI) Impact *Post-Hoc analysis*	**No significant change over time to ALBI Score**[1,2] **Similar mOS for patients with Grade 1 or Grade 2 ALBI Score**[3]
Discontinuation Rate	**4.4%**[1,2]
Grade 3-4 Hemorrhage	**3.3% rate**[1]
Half-life (mean, steady state)	**Rivoceranib: 7.0 hours to 16.3 hours**[4] (allows for rapid elimination of VEGFR blockade) **Camrelizumab: 17 days**[5]

1. Qin S, et al. *Lancet*. 2023;402(10408):1133-1146. **2.** Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110. **3.** Vogel A, et al. *J Clin Oncol*. 2024;42(3 suppl):abstract 509. **4.** Data on file. 0007. Fort Lee, NJ: Elevar Therapeutics; February 14, 2024. 5. Data on file. 0008. Fort Lee, NJ: Elevar Therapeutics; February 14, 2024.

Patients Treated With Camrelizumab + Rivoceranib Performed Better Compared to Sorafenib Monotherapy[1]

OS: Final Analysis[1,2]



	Cam + Rivo n = 272	Sorafenib n = 271
No. of events (%)	159 (59)	192 (71)
Median OS, months (95% CI)	23.8 (20.6-27.2)	15.2 (13.2-18.5)

Stratified HR, 0.64 (95% CI, 0.52-0.79)[a], p < 0.0001[b]

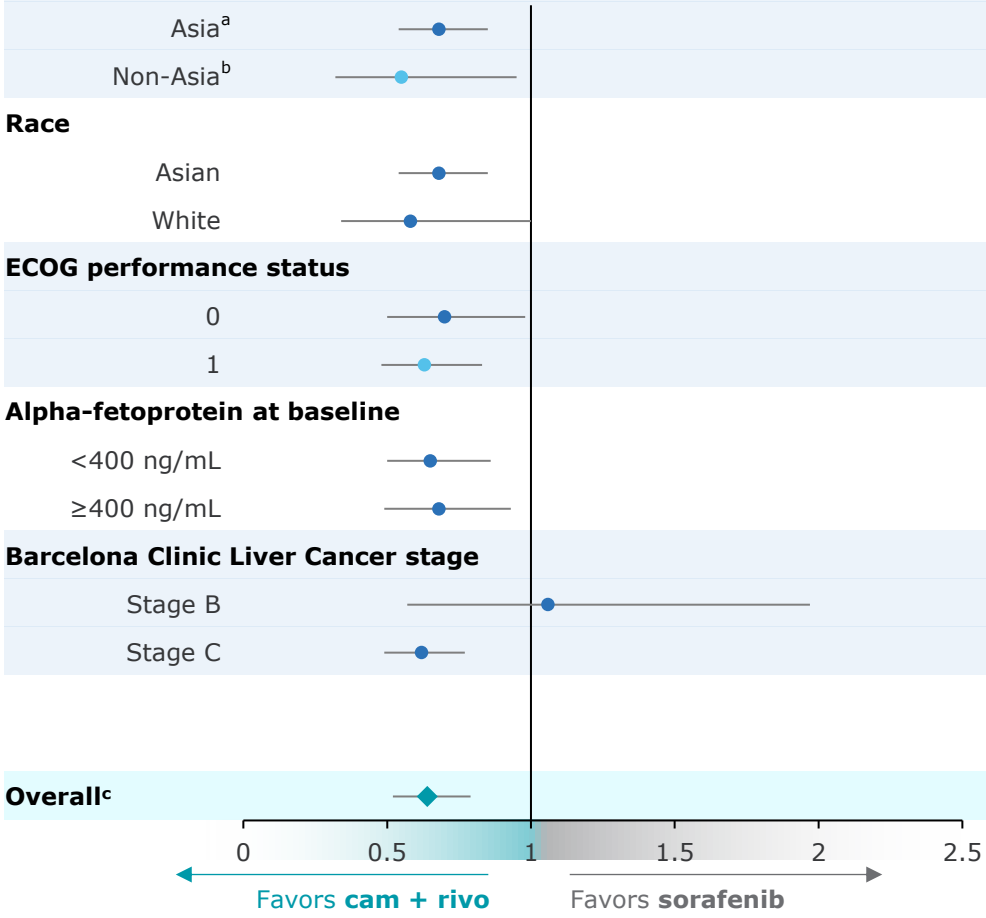
The stratification factors were the randomization strata.

There was very early and durable separation in the KM curves for Cam/Rivo vs Sorafenib.

CI=confidence interval; HR=hazard ratio; ITT=intent to treat; OS=overall survival.
[a]Stratified Cox proportional hazards model. [b]One-sided based on the stratified log-rank test.

1. Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110.
2. Qin S, et al. *Lancet*. 2023;402(10408):1133-1146.

Overall Survival by Prespecified Subgroups: Final Analysis



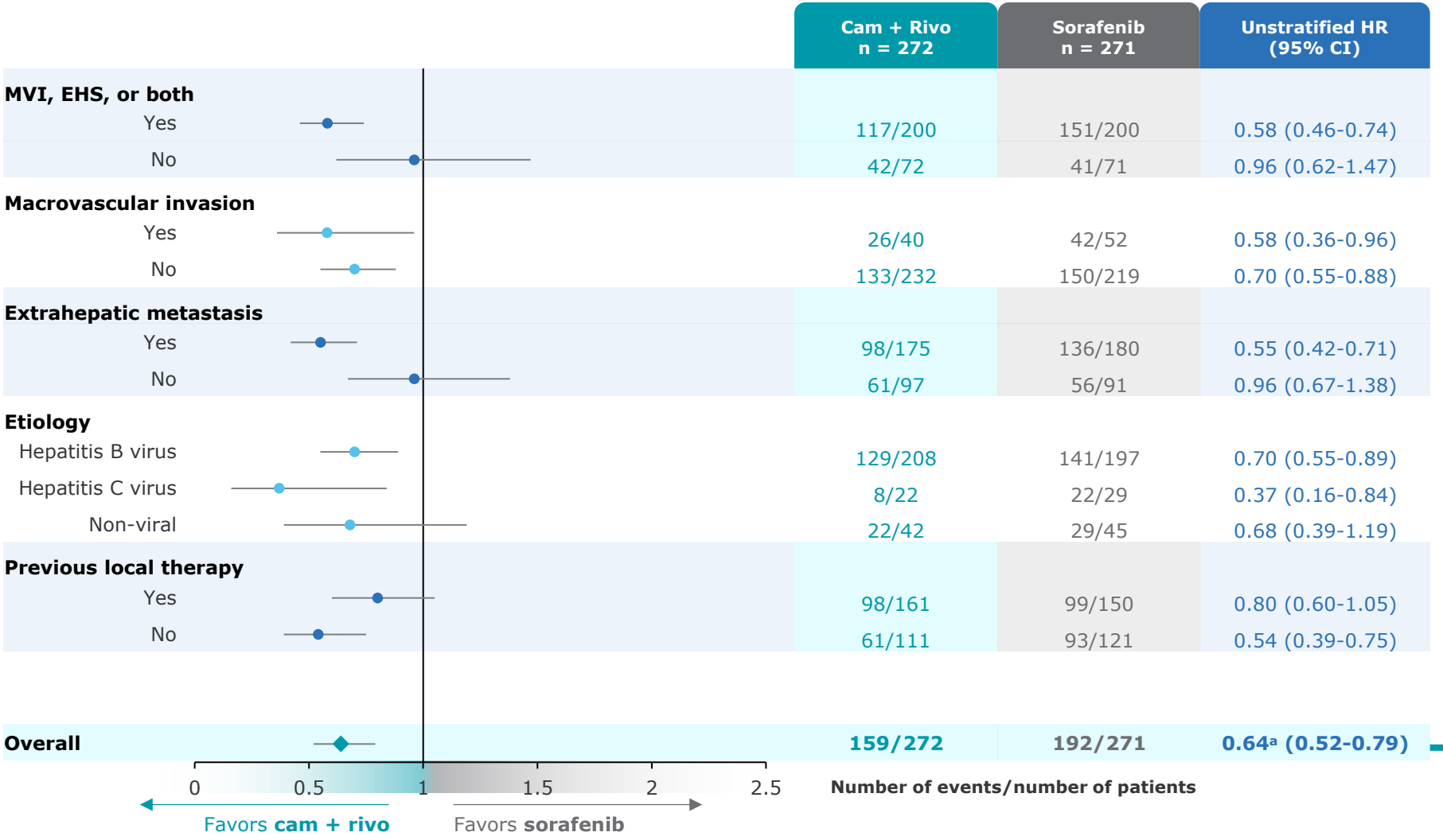
	Cam + Rivo n = 272	Sorafenib n = 271	Unstratified HR (95% CI)
Geographical region			
Asia[a]	134/225	160/224	0.68 (0.54-0.85)
Non-Asia[b]	25/47	32/47	0.58 (0.34-1.00)
Race			
Asian	135/226	160/224	0.68 (0.54-0.85)
White	24/44	32/46	0.55 (0.32-0.95)
ECOG performance status			
0	65/120	75/116	0.70 (0.50-0.98)
1	94/152	117/155	0.63 (0.48-0.83)
Alpha-fetoprotein at baseline			
<400 ng/mL	90/176	112/171	0.65 (0.50-0.86)
≥400 ng/mL	69/96	80/100	0.68 (0.49-0.93)
Barcelona Clinic Liver Cancer stage			
Stage B	20/38	20/40	1.06 (0.57-1.97)
Stage C	139/234	172/231	0.62 (0.49-0.77)
Overall[c]	**159/272**	**192/271**	**0.64 (0.52-0.79)**

OS favored cam+rivo across most subgroups reported in the final analysis

CI=confidence interval; ECOG=Eastern Cooperative Oncology Group; HR=hazard ratio; US=United States.
[a]Includes mainland China, Hong Kong, Taiwan, and South Korea; [b]Includes Belgium, Italy, Germany, Poland, Russia, Spain, Turkey, Ukraine, and the US; [c]Stratified HR.

Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110.

Patients Treated With Camrelizumab + Rivoceranib Performed Better Compared to Sorafenib Monotherapy: OS by Prespecified Subgroups: Final Analysis



	Cam + Rivo n = 272	Sorafenib n = 271	Unstratified HR (95% CI)
MVI, EHS, or both			
Yes	117/200	151/200	0.58 (0.46-0.74)
No	42/72	41/71	0.96 (0.62-1.47)
Macrovascular invasion			
Yes	26/40	42/52	0.58 (0.36-0.96)
No	133/232	150/219	0.70 (0.55-0.88)
Extrahepatic metastasis			
Yes	98/175	136/180	0.55 (0.42-0.71)
No	61/97	56/91	0.96 (0.67-1.38)
Etiology			
Hepatitis B virus	129/208	141/197	0.70 (0.55-0.89)
Hepatitis C virus	8/22	22/29	0.37 (0.16-0.84)
Non-viral	22/42	29/45	0.68 (0.39-1.19)
Previous local therapy			
Yes	98/161	99/150	0.80 (0.60-1.05)
No	61/111	93/121	0.54 (0.39-0.75)
Overall	**159/272**	**192/271**	**0.64[a] (0.52-0.79)**

Number of events/number of patients

OS favored cam+rivo across most subgroups reported in the final analysis

CI=confidence interval; EHS=extrahepatic spread; HR=hazard ratio; MVI=macrovascular invasion; US=United States.
[a]Stratified HR.

Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110.

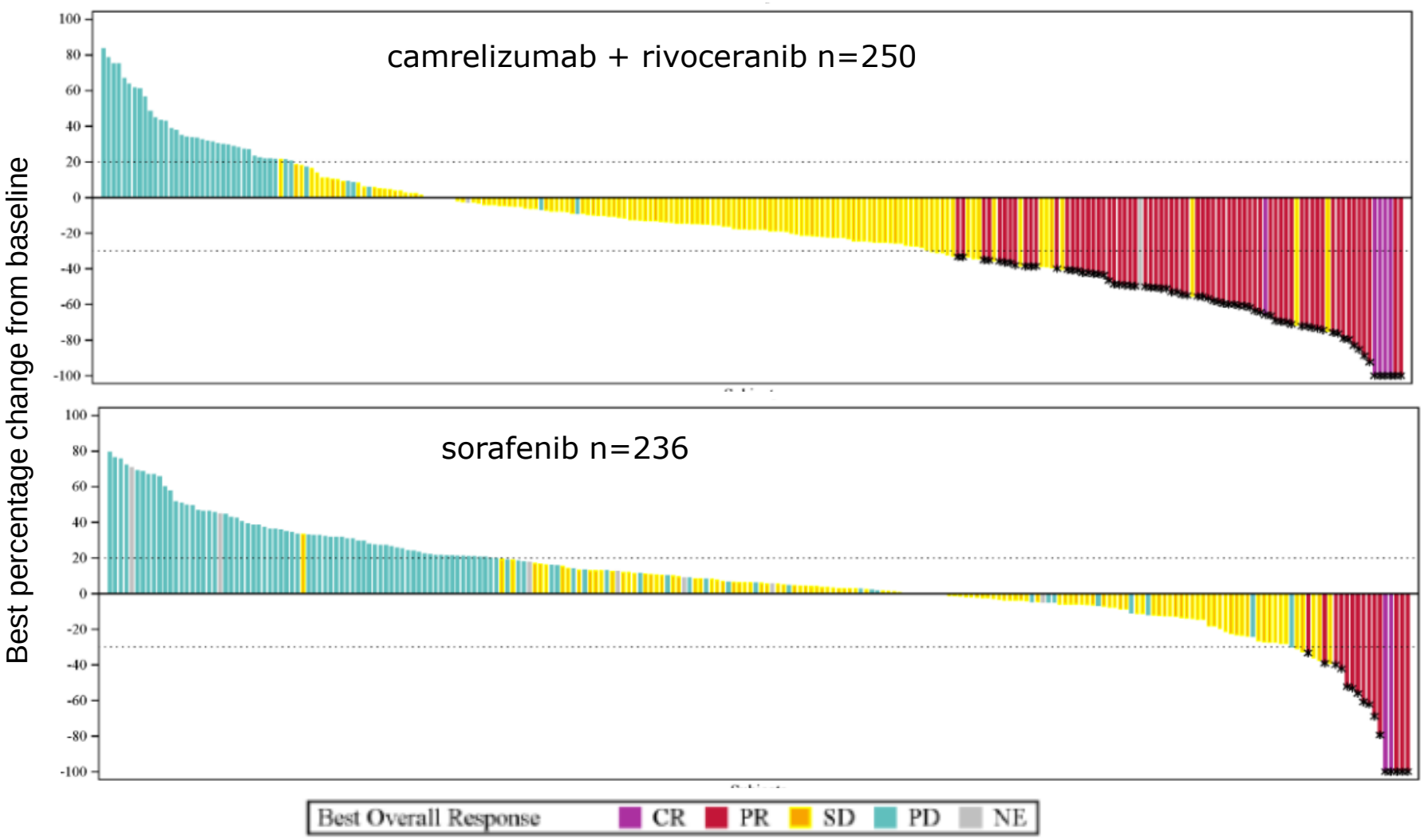
Safety Summary:

Safety Analysis Set at Final Analysis[1]

	Cam + Rivo n=272	Sorafenib n=269
Median duration of treatment (IQR), months	**Cam**: 6.9 (3.6-14.7) **Rivo**: 6.9 (3.5 – 14.2)	3.9 (1.9-7.6)
Any TRSAE	69 (25.4)	18 (6.7)
TRAEs leading to discontinuation of any study drug	74 (27.2)	13 (4.8)
TRAEs leading to discontinuation of all study drugs	12 (4.4)	13 (4.8)
TRAEs leading to discontinuation of study drugs	**Cam**: 48 (17.6) **Rivo**: 46 (16.9)	13 (4.8)
TRAEs leading to discontinuation of any study drug[a]		
ALT increased	10 (3.7)	4 (1.5)
Blood bilirubin increased	8 (2.9)	2 (0.7)
Hypertension	8 (2.9)	1 (0.4)
AST increased	8 (2.9)	3 (1.1)
Platelet count decreased	6 (2.2)	0
Bilirubin conjugate increased	3 (1.1)	2 (0.7)
Gamma-glutamyl transferase increased	3 (1.1)	3 (1.1)
Upper GI hemorrhage	3 (1.1)	0
Autoimmune hepatitis	3 (1.1)	0
Immune-mediated hepatitis	3 (1.1)	0
Fatigue	3 (1.1)	0

Data are n (%), unless otherwise noted.
ALT=alanine aminotransferase; AST=aspartate aminotransferase; GI=gastrointestinal; IQR=interquartile range; TRAE=treatment-related adverse event; TRSAE=treatment-related serious adverse event.
[a]At final data cutoff, TRAE led to discontinuation of cam in 17.6% of patients, rivo in 16.9%; TRAE led to discontinuation of sorafenib in 4.8%.
1. Data on File

Camrelizumab + Rivoceranib is Highly Effective for Tumor Reduction[a,1,2]



72.8% of patients had a reduction in lesion diameter

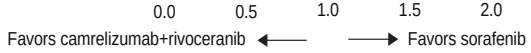
36.4% of patients had at least a 30% reduction in lesion diameter

BIRC=blinded independent review committee; CR=complete response; HR=hazard ratio; ITT=intention-to-treat; NE=not evaluable; PD=progressive disease; PFS=progression-free survival; PR=partial response; RECIST=Response Evaluation Criteria in Solid Tumors; SD=stable disease.
*Patient with confirmed response.
[a]Per RECIST 1.1 by BIRC at the overall survival interim analysis (ITT set).
1. Qin S, et al. *Lancet*. 2023;402(10408):1133-1146. **2.** Qin S, et al. *Lancet.* 2023;Appendix:1-227.

Subgroup Interim Analysis: CARES-310

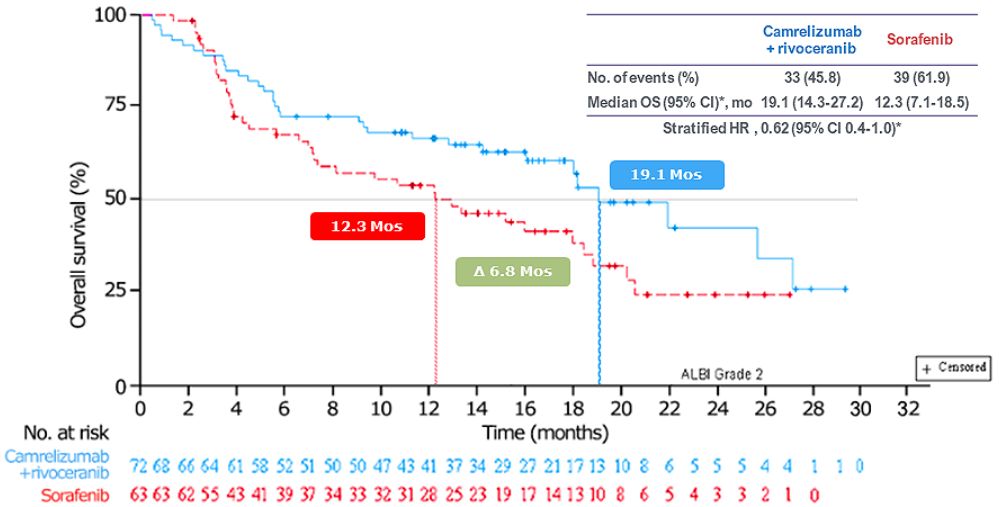
OS SUBGROUP ANALYSIS[1]

		No. of events/no. of patients		Unstratified HR (95% CI)*
		Camrelizumab+ rivoceranib	Sorafenib	
Geographic region	Asia	95/225	125/224	0.66 (0.51-0.86)
	Non-Asia	16/47	26/47	0.55 (0.29-1.02)
ECOG PS	0	47/120	60/116	0.67 (0.46-0.98)
	1	64/152	91/155	0.61 (0.45-0.85)
AFP at baseline	<400 ng/mL	58/176	82/171	0.64 (0.46-0.90)
	≥400 ng/mL	53/96	69/100	0.63 (0.44-0.90)
BCLC stage	B	9/38	13/40	0.73 (0.31-1.72)
	C	102/234	138/231	0.62 (0.48-0.80)
MVI and/or EHS	Yes	86/200	121/200	0.59 (0.44-0.77)
	No	25/72	30/71	0.81 (0.48-1.37)
MVI	Yes	18/40	35/52	0.56 (0.32-0.99)
	No	93/232	116/219	0.68 (0.51-0.89)
EHS	Yes	73/175	110/180	0.56 (0.41-0.75)
	No	38/97	41/91	0.84 (0.54-1.30)
Etiology	HBV	90/208	113/197	0.66 (0.50-0.87)
	HCV	6/22	16/29	0.45 (0.18-1.16)
	Non-viral	15/42	22/45	0.71 (0.37-1.36)
Previous local therapy	Yes	67/161	79/150	0.72 (0.52-0.99)
	No	44/111	72/121	0.57 (0.39-0.83)



CARES-310

ALBI Grade 2[2]



OS outcomes favored the cam + rivo arm regardless of baseline ALBI scores

- HR 0.62 (0.47-0.83) for ALBI grade 1
- HR 0.62 (0.4-1.0) for ALBI grade 2

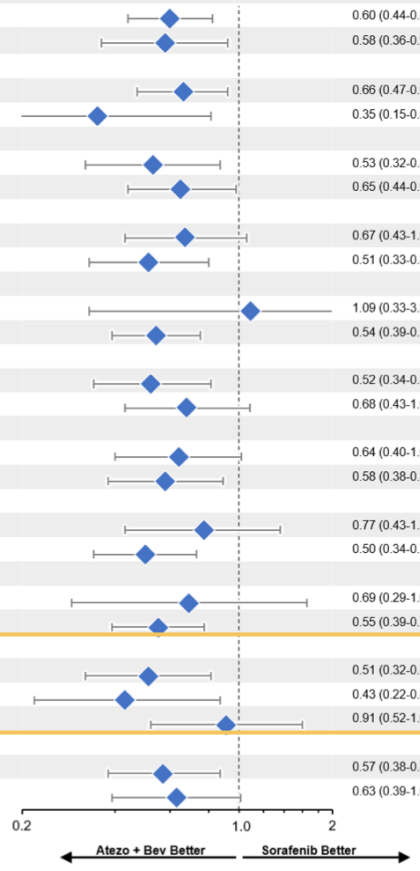
*Cox proportional hazards model.

References: 1. Qin S, Chan SL, Gu S, et al. *Lancet*. 2023;402(10408):1133-1146. **2.** Vogel A, et al. *J Clin Oncol*. 2024;42(3 suppl):abstract 509.

Subgroup Analysis: IMbrave150 (Roche/Genentech)

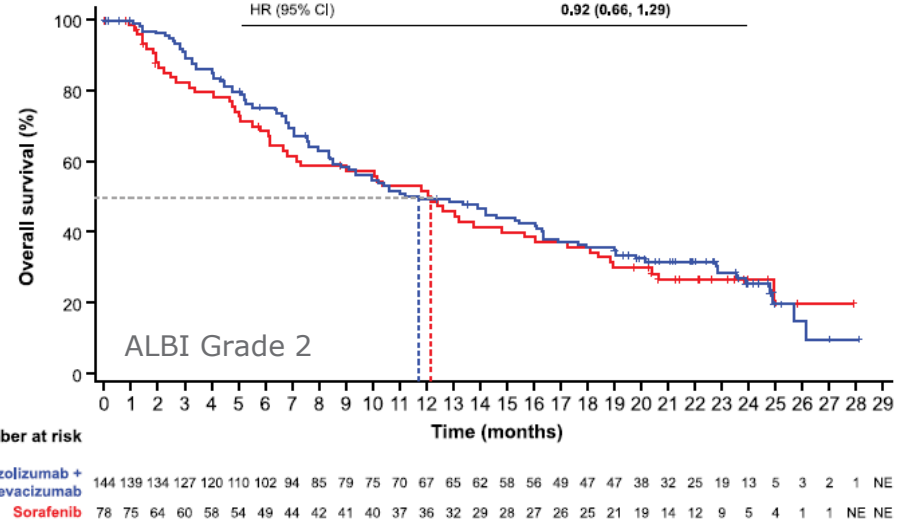
OS SUBGROUP ANALYSIS[1]

Subgroup	No. of Patients	No. of Events Atezo + Bev	No. of Events Sorafenib	Hazard Ratio for Death (95% CI)
All patients	501	96	65	0.60 (0.44-0.82)
Age ≥65 years	252	39	32	0.58 (0.36-0.92)
Sex				
Male	414	86	53	0.66 (0.47-0.92)
Female	87	10	12	0.35 (0.15-0.81)
Geographic region				
Asia (excluding Japan)	201	34	27	0.53 (0.32-0.87)
Rest of world	300	62	38	0.65 (0.44-0.98)
ECOG performance status score				
0	312	50	31	0.67 (0.43-1.06)
1	189	46	34	0.51 (0.33-0.80)
Barcelona Clinic liver cancer stage				
B	78	9	4	1.09 (0.33-3.53)
C	409	86	61	0.54 (0.39-0.75)
AFP category				
<400 ng/ml	314	45	36	0.52 (0.34-0.81)
≥400 ng/ml	187	51	29	0.68 (0.43-1.08)
MVI at study entry				
No	301	47	29	0.64 (0.40-1.02)
Yes	200	49	36	0.58 (0.38-0.89)
Extrahepatic spread at study entry				
No	196	29	20	0.77 (0.43-1.36)
Yes	305	67	45	0.50 (0.34-0.73)
MVI and/or EHS at study entry				
No	123	12	9	0.69 (0.29-1.65)
Yes	378	84	56	0.55 (0.39-0.77)
Etiology				
Hepatitis B	240	44	31	0.51 (0.32-0.81)
Hepatitis C	108	18	15	0.43 (0.22-0.87)
Nonviral	153	34	19	0.91 (0.52-1.60)
Prior local therapy				
No	255	55	37	0.57 (0.38-0.87)
Yes	246	41	28	0.63 (0.39-1.01)



IMbrave150[2]

	Atezolizumab + bevacizumab (n=144)	Sorafenib (n=78)
Patients with events, n (%)	100 (69)	53 (68)
Median OS, months (95% CI)	11.7 (9.1, 16.1)	12.2 (7.2, 16.1)
HR (95% CI)	**0.92 (0.66, 1.29)**	



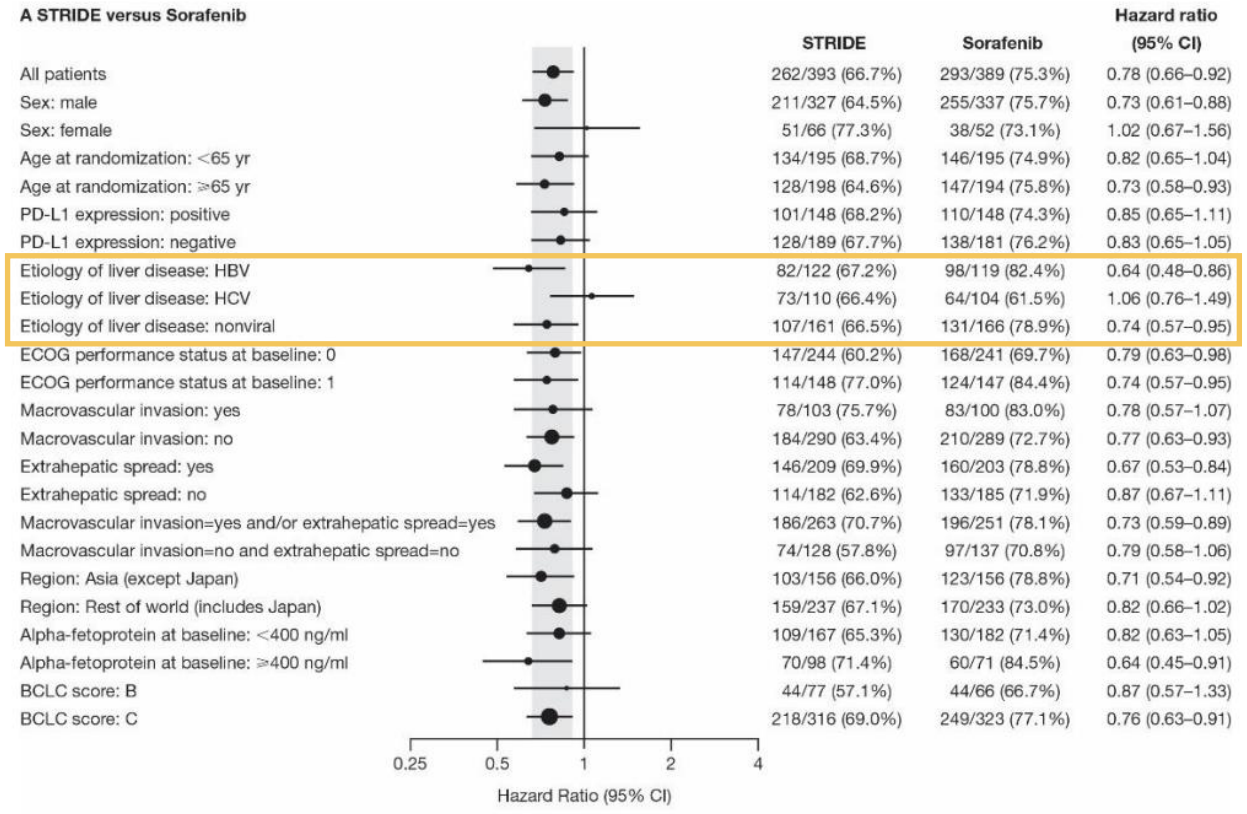
No OS benefit seen in ALBI grade 2 (or mALBI 2a and mALBI 2b) patients treated with atezo-bev vs sorafenib:

- ALBI 1: HR 0.50 (0.35-0.72)
- ALBI 2: HR 0.92 (0.66-1.29)
- mALBI 2a: HR 0.97 (0.59-1.59)
- mALBI 2b: HR 0.85 (0.54-1.34)

References: 1. Finn RS, et al. *N Engl J Med*. 2020;382(20):1894-1905. **2.** Kudo M, et al. *Liver Cancer*. doi: 10.1159/000529996.

Subgroup Analysis: HIMALAYA (AstraZeneca)

OS SUBGROUP ANALYSIS[1]



ALBI SUBGROUP ANALYSIS[1,2]

ALBI grade 1:

- mOS was 23.4 months with STRIDE vs 19.02 months with sorafenib
- OS HR (95% CIs) was 0.79 (0.62-1.01) for STRIDE vs sorafenib, consistent with full analysis set (0.78 [96% CI, 0.65-0.93])

ALBI grade 2/3:

- mOS was 11.3 months with STRIDE vs 9.7 months with sorafenib
- OS HR (95% CIs) was 0.83 (0.65-1.05) for STRIDE vs sorafenib

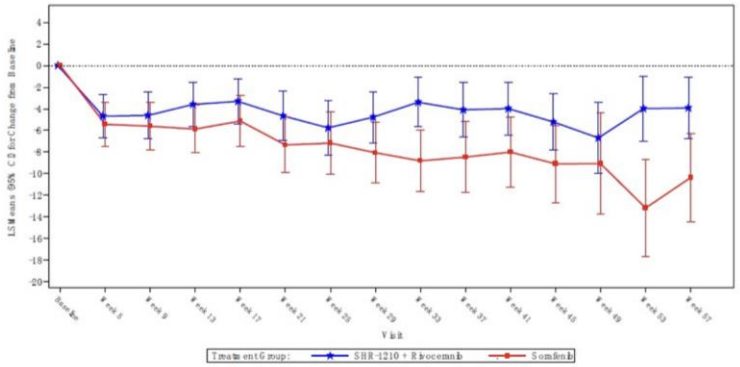
References: 1. Abou-Alfa GK, et al. *NEJM*. 2022;1(8). **2.** Vogel A, et al. *Ann Oncol*. 2022;33(suppl_9):abstract 79P.

Camrelizumab + Rivoceranib Patient-Reported Outcomes[1]

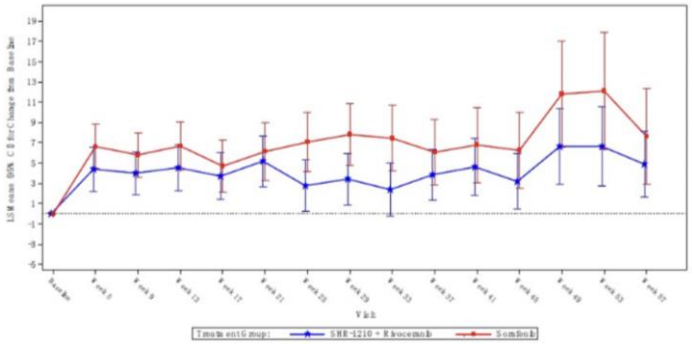
Camrelizumab + rivoceranib demonstrated statistically significant differences in patient-reported outcomes vs sorafenib:

- Less deterioration in global health status/quality of life (*P*=0.012)
- Decreased pain (*P*=0.045)
- Decreased fatigue (*P*=0.007)

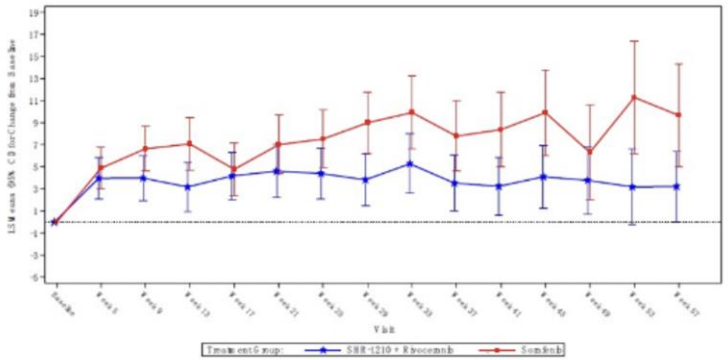
LS Mean (95% CI) for Change from Baseline in Global Health Status/Quality of Life Over Time By Treatment Arm*



LS Mean (95% CI) for Change from Baseline in Pain Over Time By Treatment Arm†



LS Mean (95% CI) for Change from Baseline in Fatigue Over Time By Treatment Arm†



CI=confidence interval; EORTC=European Organization for Research and Treatment of Cancer; LS=least squares; QLQ-C30=Quality-of-life Questionnaire Core 30.
*Measured by EORTC QLQ-C30 using data up to week 57. An increase in scores from baseline indicates improvement.
†Measured by EORTC QLQ-C30 using data up to week 57. A decrease in scores from baseline indicates improvement.

Reference: 1. Data on file. 0004. Fort Lee, NJ: Elevar Therapeutics; February 12, 2024.

Camrelizumab + Rivoceranib Expands First Line uHCC Treatment Options

CARES-310

- First Phase III trial to report **significant OS and PFS** with PD-1 antibody (camrelizumab) + an oral small molecule anti-angiogenic drug (rivoceranib) in uHCC first-line setting vs sorafenib
- CARES-310 study shows industry leading mOS of 23.8 months in 1L uHCC patients[1,2]
- CARES-310 post-hoc final analysis in non-hepatitis B etiology: mOS 31.7 mos for camrelizumab + rivoceranib vs 13.3 mos for sorafenib[1]

- Longest mOS: **23.8 mos** vs 15.2 mos for sorafenib[1]
- Higher ORR: **26.8%** vs sorafenib (5.9%)[a,1]
- Higher DCR: **77.9%** vs sorafenib (53.5%)[1]
- Longer DoR: **17.5 mo** (95% CI, 9.3-NR) vs 9.2 mos (95% CI, 5.3-NR for sorafenib)[a,1]

Safety and tolerability profiles of cam + rivo were consistent with the known safety profiles of each agent and underlying HCC disease. No new safety signals were identified.[1]

mOS =median overall survival; ORR=objective response rate; DCR=disease control rate; DoR=duration of response

[a]BIRC-assessed per RECIST 1.1.

1. Data on file; 2. Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110.

Commercial Opportunity & Strategy

Top Unmet Needs in uHCC Today

Low Overall Survival[1-3]

With a 5Y overall survival (OS) rate at 18% in the US, **uHCC has one of the lowest OS rates** of all cancers. Many patients when diagnosed with HCC see this as **"depressing," "living a nightmare," and a "death sentence."** Improved HCC treatment to extend life is needed.

Treatment for Patients With Impaired Liver Function[5]

Improved treatment for those with higher levels of liver dysfunction (as determined by Child-Pugh or ALBI) is needed, as these **patients are the most underserved**, leading some patients to opt for hospice instead of treatment.

Quality of Life[3,4]

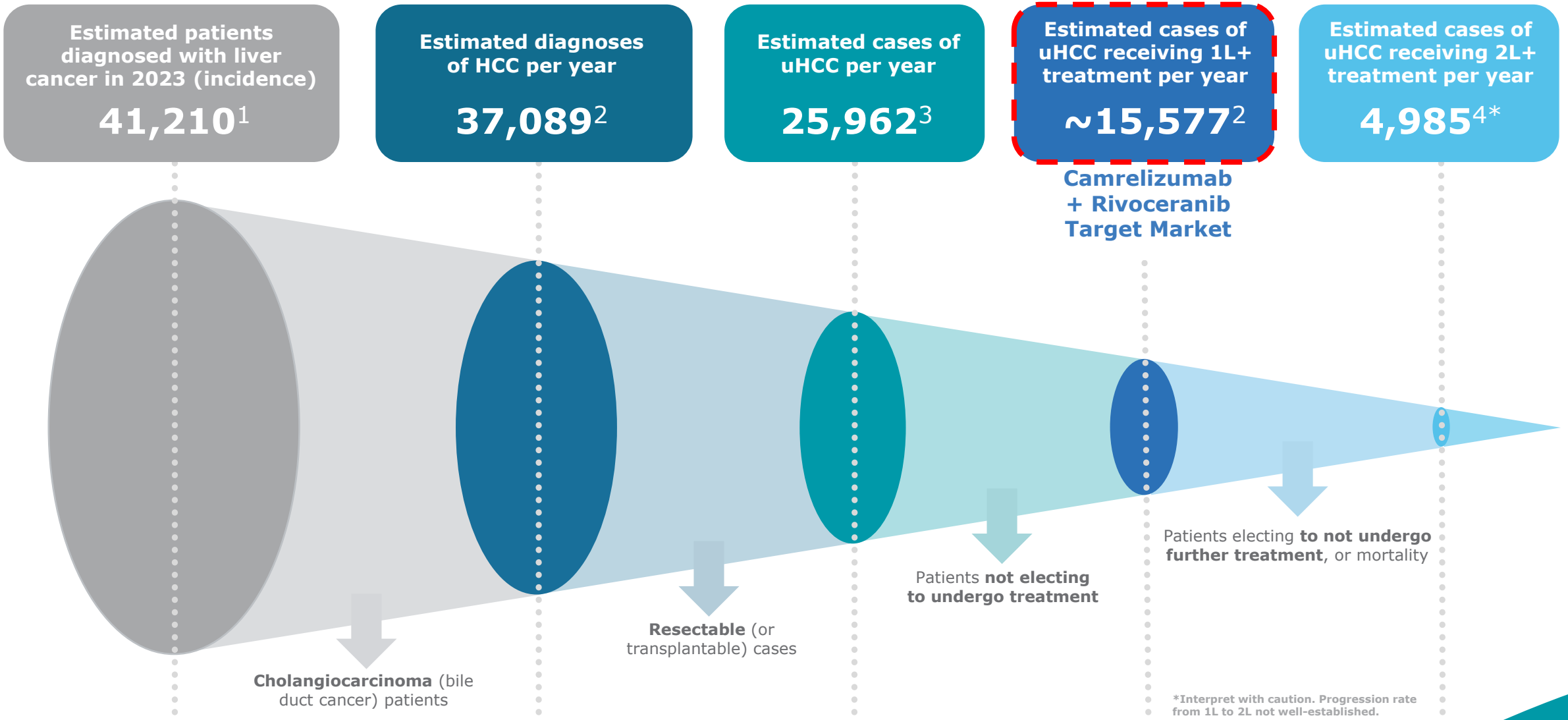
Severe liver dysfunction because of HCC conjoined with treatment **side effects** (weight loss, fatigue, nausea, etc.) **make quality of life poor for patients.** HCC also can take a severe toll on caregivers and their quality of life–a need for safer and more efficacious therapy is needed.

Optimal Treatment Selection[6]

With more novel HCC treatments available (and more clinical trials ongoing), there is an increasing need to understand how to **best optimize treatment choice by patient type**, including factors like biomarkers, liver function, disease etiology, etc., both in 1L and sequencing across lines of therapy.

References: 1. Decisions Resources Group – HCC Survival Rate (Accessed 9/30/23). **2.** Vogel A, et al. *Lancet*. 2022;400(10360):1345-1362. **3.** Data on file. 0003. Fort Lee, NJ: Elevar Therapeutics; February 1, 2024. **4.** American Cancer Society. Treating liver cancer. https://www.cancer.org/cancer/types/liver-cancer/treating.html Accessed January 31, 2024. **5.** NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Hepatocellular Carcinoma V.2.2023. **6.** Rai V, et al. *Hepatobiliary Surg Nutr*. 2022;11(4):629-631.

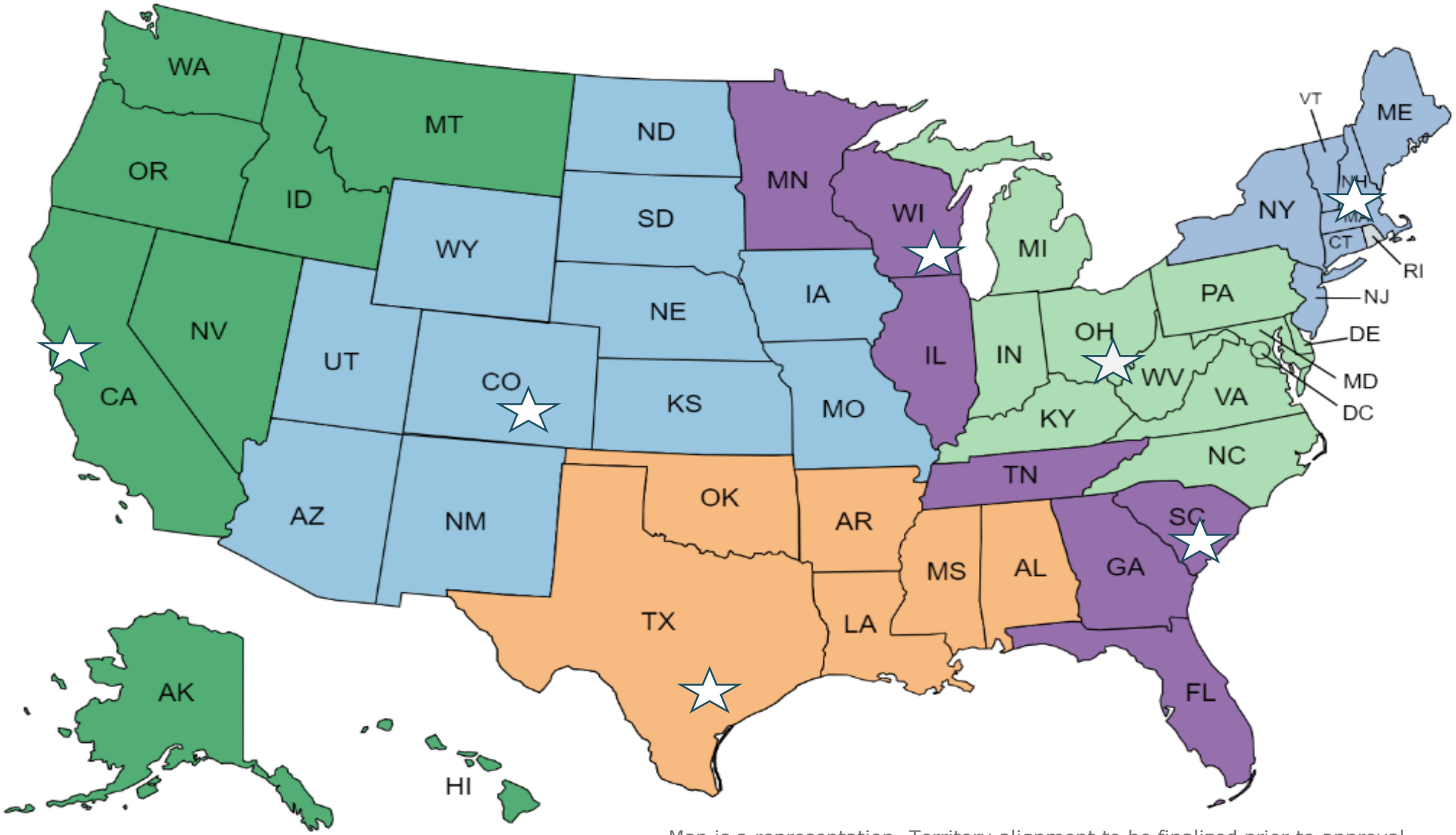
Elevar Is Well Positioned to Treat the US uHCC Patient Population



References: 1. Siegel RL, et al. *CA Cancer J Clin*. 2023;73(1):17-48. **2.** Llovet JM, et al. *Nat Rev Dis Primers*. 2021;7(1):6. **3.** Wang EA, et al. *Int J Clin Pract*. 2017;71(11). **4.** Klink AJ, et al. *Oncologist*. 2022;27.

Experienced Oncology Medical Affairs and Field Medical Team

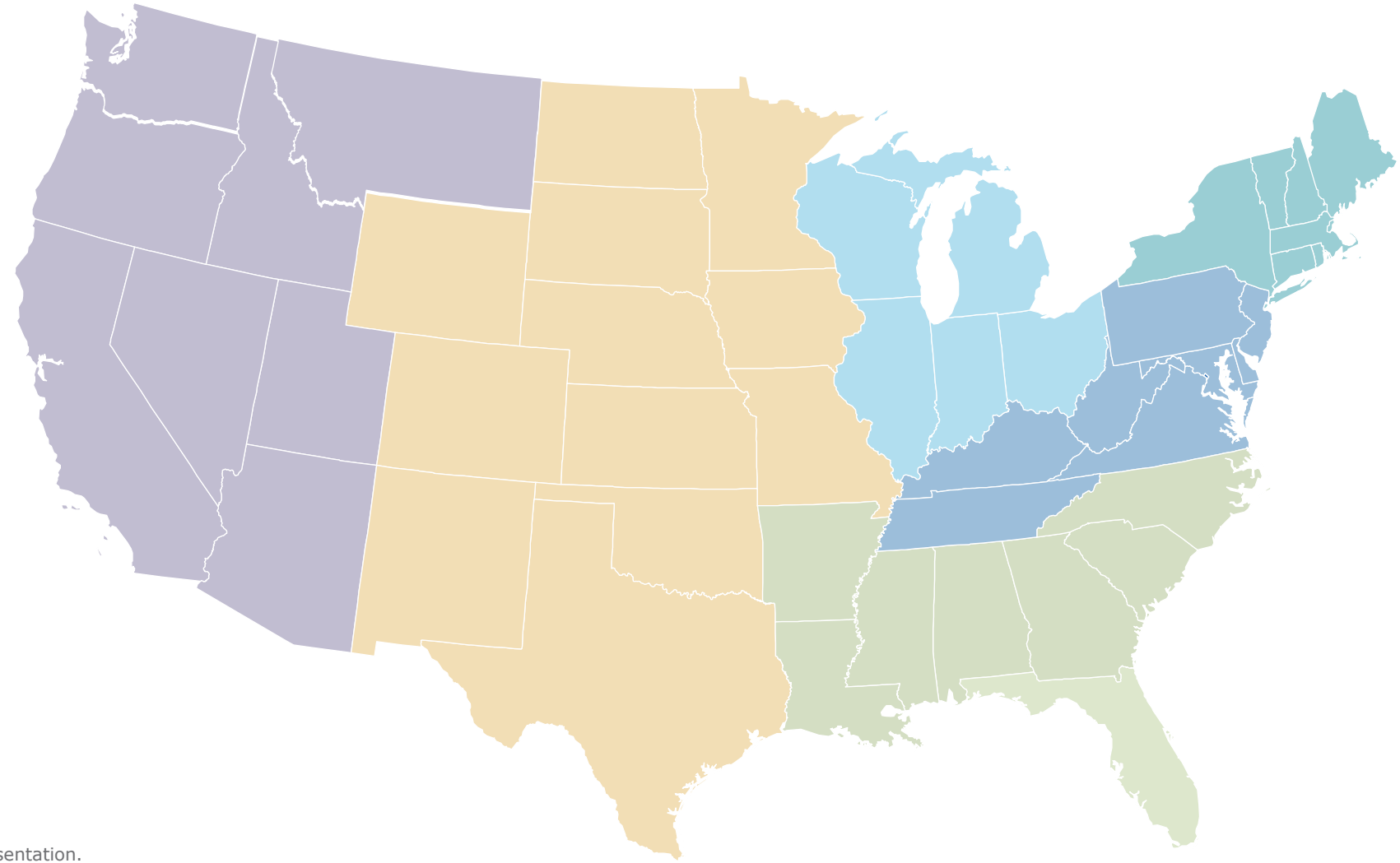
6 Field Medical Directors | **1** Medical Resources Director



Map is a representation. Territory alignment to be finalized prior to approval.
Star represents home-base location

Anticipated Oncology Sales Force With Ability to Expand

~60 Oncology Account Managers | **6** Regional Sales Directors | **3** Field Reimbursement Liaisons | **12** Field Medical Directors



Note: Map is a representation.
Territory alignment to be finalized prior to approval.

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This presentation contains forward-looking statements about Elevar Therapeutics Inc. ("Elevar Therapeutics" or the "Company"). Forward-looking statements are based on our management's beliefs and assumptions and on information currently available to our management, including those described in the forward-looking statements.

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.

Except as required by law, we assume no obligation to update these forward-looking statements publicly, or to update the reasons why actual results could differ materially from those anticipated in the forward-looking statements, even if new information becomes available in the future.

The market data and certain other statistical information used throughout this presentation are based on independent industry publications, governmental publications, reports by market research firms or other independent sources. Some data are also based on our good faith estimates. Although we believe these third-party sources are reliable, we have not independently verified the information attributed to these third-party sources and cannot guarantee its accuracy and completeness. Similarly, our estimates have not been verified by any independent source.

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.

Appendix

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

Corporate Timeline

2005 — Company founded as LSK BioPharma

2007 — Initial HLB investment of $1.3 million LSK BioPharma via a licensing agreement

2014 — Rivoceranib is approved in China as a single agent for the treatment of gastric cancer in November

2019 — LSK BioPharma changes its name to Elevar Therapeutics

HLB acquired LSK for $440 million; became a majority-owned subsidiary of HLB

2020 — Rivoceranib is approved in China as a single agent for second-line advanced HCC

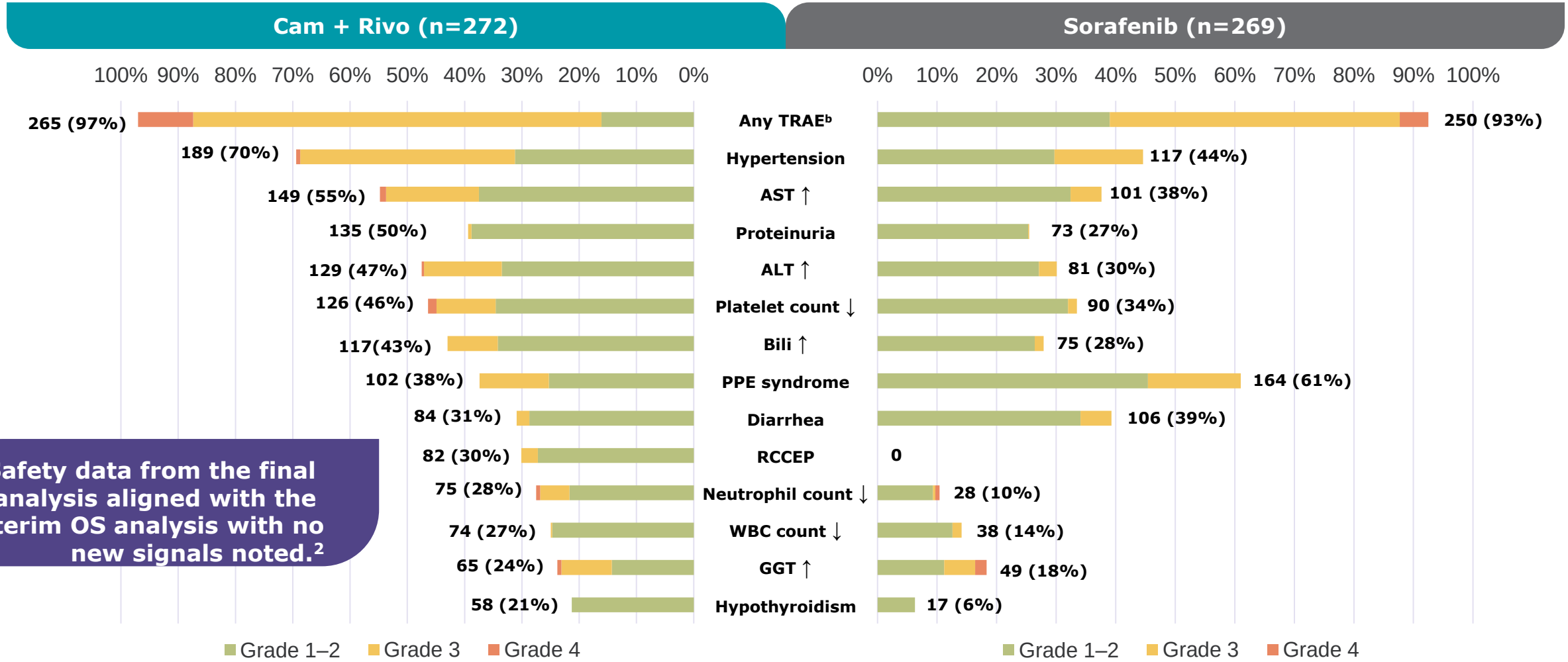
2021 — Rivoceranib received Orphan Drug Designation from the FDA for the treatment of ACC and HCC

2023 — BLA/NDA submission and acceptance in July; announced global licensing agreement with Hengrui to commercialize camrelizumab in combination with rivoceranib for uHCC in October

2024 — FDA resubmission Sept. for rivo + cam PDUFA date of March 2025

Treatment Related Adverse Events (TREAs) are manageable with Camrelizumab + Rivoveranib[1,2,a]

Safety Analysis Set at Final Analysis for OS



Safety data from the final analysis aligned with the interim OS analysis with no new signals noted.[2]

ALT=alanine aminotransferase; AST=aspartate aminotransferase ; Bili=blood bilirubin; GGT=gamma-glutamyltrasferase; OS=overall survival; PPE=palmar-plantar erythrodysaesthesia; RCCEP=reactive cutaneous capillary endothelial proliferation; TRAE=treatment-related adverse event; WBC=white blood cell.

[a]Data are n (%). Treatment-related adverse events of grade 1-2 occurring in at least 10% of patients or of grade 3-5 occurring in at least 2% of paitents in either group are reported.

[b]There was one treatment-related death in each arm (multiple organ dysfunction syndrome in cam + rivo arm; respiratory failure and circulatory collapse in sorafenib arm).

1. Qin S, et al. *Lancet*. 2023;402(10408):1133-1146. 2. Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110

Well-Tolerated Safety Profile With Low TRAE-Related Discontinuations[1,2]

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	128 (47)	87 (32)
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. IQR=interquartile range; mo=months; TRAE=treatment-related adverse event.

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. ALT=alanine aminotransferase; AST=aspartate aminotransferase; GGT=gamma-glutamyl transferase; PPE=palmar-plantar erythrodysesthesia; RCEP=reactive capillary endothelial proliferation; TRAE=treatment-related adverse event.

References: 1. Qin S, et al. *Lancet*. 2023;402(10408):1133-1146. **2.** Data on file. 0002. Fort Lee, NJ: Elevar Therapeutics; February 8, 2024.

CARES-310: first Phase III trial to report **significant OS and PFS** with the co mbination of a PD-1 antibody (camrelizumab) + an oral small molecule anti-a ngiogenic drug (rivoceranib) compared with sorafenib in patients with unresect able and metastatic HCC in the first-line setting

Median OS
23.8 mos for cam + rivo vs
15.2 mos for sorafenib
HR, 0.64 (95% CI, 0.52-0.79)
p<0.0001[1]

Median PFS
5.6 mos for cam + rivo vs
3.7 mos for sorafenib
HR, 0.54 (95% CI, 0.44-0.66)
p<0.0001[1]

Higher ORR
with cam + rivo (26.8%) vs
sorafenib (5.9%)[a,1]

Higher % of patients with **reduction in tumor size** for cam + rivo (**72.8%**) vs sorafenib (36.4%)

Higher DCR
with cam + rivo (**77.9%**) vs
sorafenib (53.5%)[1]

Median DoR
17.5 mos (95% CI, 9.3-NR)
for cam + rivo vs
9.2 mos (95% CI, 5.3-NR
for sorafenib[a,1]

Safety and tolerability profiles of cam + rivo were consistent with the known safety profiles of each agent and underlying HCC disease. No new safety signals were identified.[1]

AE=adverse event; BIRC=blinded independent review committee; DCR=disease control rate; DoR=duration of response; HCC=hepatocellular carcinoma; mos=months; NR=not reached; ORR=objective response rate; OS=overall survival; PD-1=programmed death receptor-1; PFS=progression-free survival; RECIST=Response Evaluation Criteria in Solid Tumors.
[a]BIRC-assessed per RECIST 1.1.

1. Data on File