Elevating Treatment Outcomes For Patients

NON-CONFIDENTIAL VERSION

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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.

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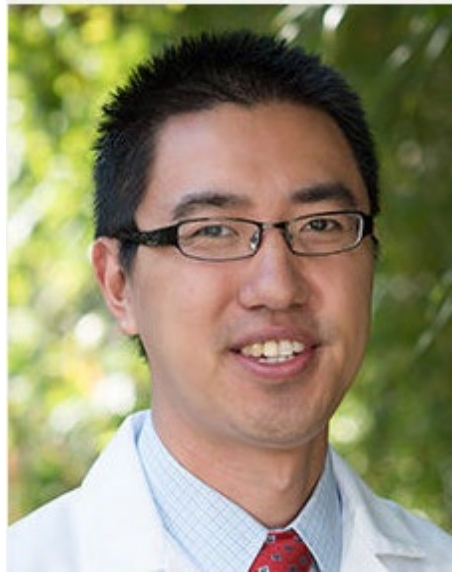

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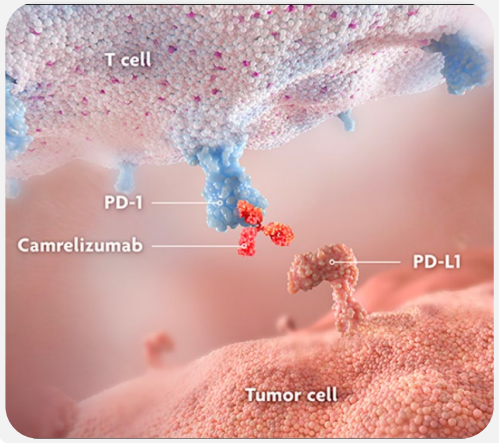
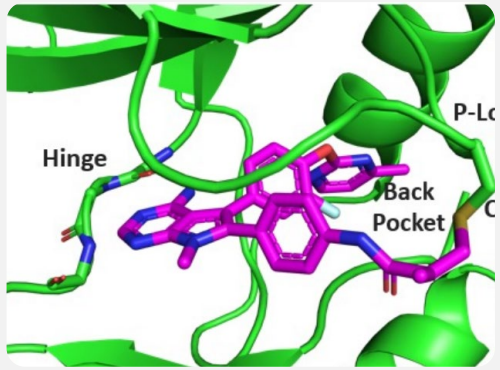
Elevar Therapeutics

An Oncology-Focused, Fully Integrated Biopharmaceutical Company & Portfolio Company of HLB Company, Ltd.



RIVOCERANIB + CAMRELIZUMAB: 1st Line Systemic Treatment for uHCC

- HCC is 2nd leading cause of cancer-related deaths in Asia and the 6th in Western countries[5]
- Approximately ~15,577 patients receiving 1L uHCC treatment yearly in the US[8], with incidence and mortality rates increasing[9,] and 60-70% of patients opting for systemic therapy at some point [6,7]
- CARES-310 study shows mOS of 23.8 months in 1L uHCC* patients, the longest mOS for any treatment in a global Phase 3 trial in uHCC[1,2]
- Current approved combination therapies for uHCC showed mOS of 16.4-19.2 months[3,4]
- Exclusivity on key intellectual property projected through 1H 2038



LIRAFUGRATINIB: Treatment for FGFR2 driven CCA and Tumor Agnostic Fusion Indications

- ReFocus trial demonstrated efficacy improvement compared to current standard of care in 2L CCA with improved safety with low discontinuation rate
- Tumor Agnostic Fusions - a first to market opportunity based on patients accrued to date in ReFocus
- Encouraging FDA feedback - Breakthrough Drug Designation – Accelerated approval opportunity
- Global rights to lirafugratinib for all CCA and tumor agnostic FGFR2 indications through 2040

*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.

Regulatory & Development Key Milestones

RIVOCERANIB + CAMRELIZUMAB

uHCC

- BLA/NDA resubmission in September

RIVOCERANIB + CAMRELIZUMAB

uHCC

- PDUFA date – March 20
- US commercial launch planned Mid-2025
- EU filing 2H 2025

RIVOCERANIB + CAMRELIZUMAB

uHCC

- EU approval 2H 2026

LIRAFUGRATINIB

CCA

- Pre-NDA Meeting 1H 2025
- NDA filing 2H 2025
- Confirmatory Phase 3 patient enrollment 2H 2025

Tumor Agnostic:

- Additional patient enrollment 2H 2025

LIRAFUGRATINIB

CCA

- Potential U.S. approval Mid-2026

LIRAFUGRATINIB

Tumor Agnostic

- File sNDA

Rivoceranib, Camrelizumab & Lirafugratinib Have Been Studied in More Than 6,000 Patients Worldwide for Multiple Oncology Indications[1,2]

Molecule	Therapeutic Area	Indication	Phase 1b	Phase 2	Phase 3	NDA Filed	Approved
Rivoceranib + Camrelizumab	Oncology	Unresectable Hepatocellular Carcinoma (uHCC) 1L (Hengrui Collaboration)*					PDUFA Date March 20, 2025
Rivoceranib	Oncology	Adenoid Cystic Carcinoma (ACC)* Recurrent or Metastatic					
Rivoceranib	Oncology	Gastric Cancer Monotherapy 3L/4L					
Lirafugratinib	Oncology	Intrahepatic Cholangiocarcinoma (CCA) with FGFR fusions 2L					Planned NDA Filing 2H 2025
Lirafugratinib	Oncology	Tumor Agnostic Fusions					

* **Elevar Therapeutics and Jiangsu Hengrui Pharma Announce Global Commercialization Licensing Agreement for PD-1 Inhibitor Camrelizumab in Combination with Rivoceranib for uHCC - Elevar Therapeutics**

* Orphan Drug Designation (ODD).

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/

Near-Term Pipeline Programs

Camrelizumab + Rivoceranib

First line Unresectable Hepatocellular Carcinoma

March 2025 NDA/BLA PDUFA Date

Camrelizumab and Rivoceranib are Proven Therapies with Large Commercial Opportunities

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

COMMERCIAL PRODUCTS AVAILABLE OUTSIDE US

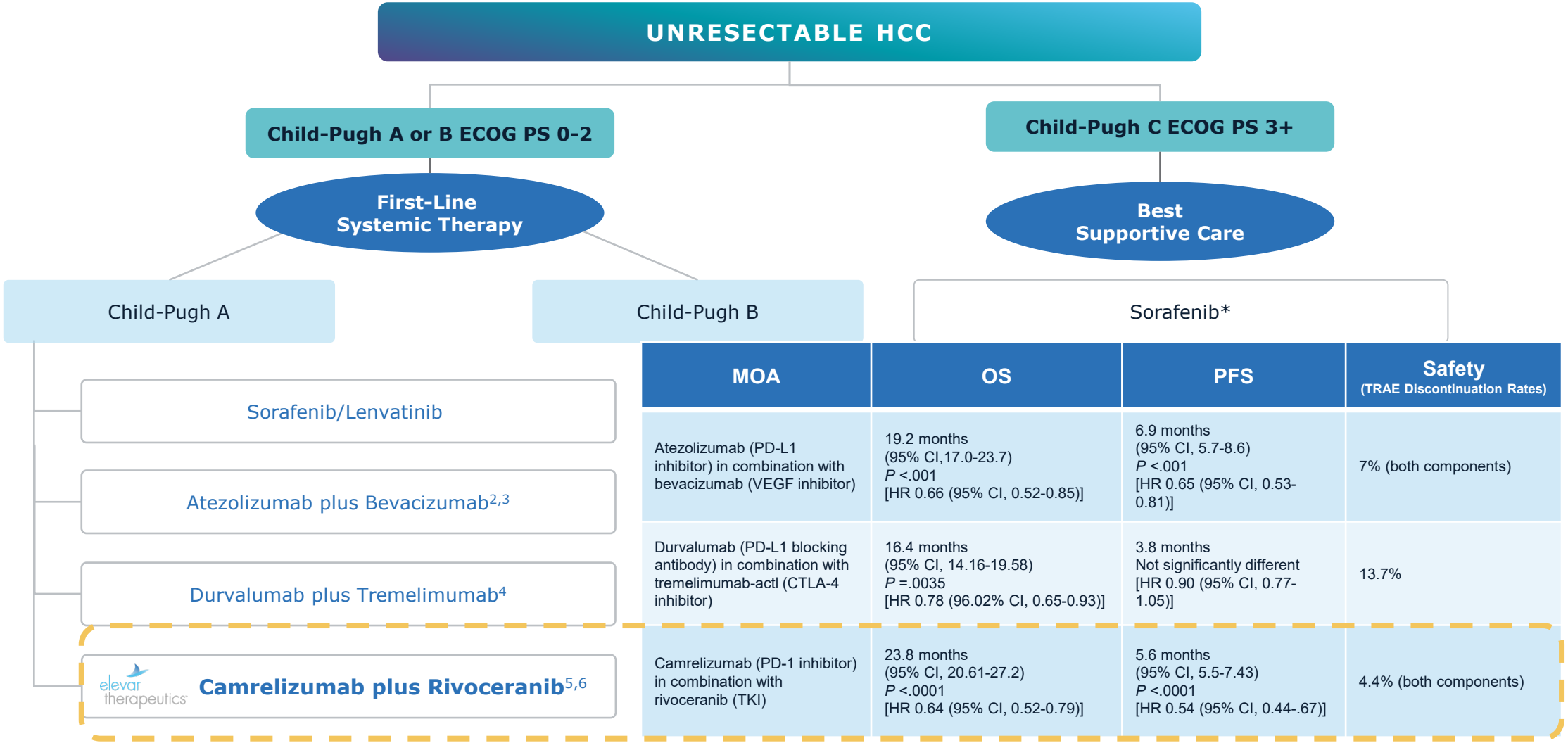
Rivoceranib

- 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)
- 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)

Hepatocellular Carcinoma Systemic Therapy Paradigm[1]



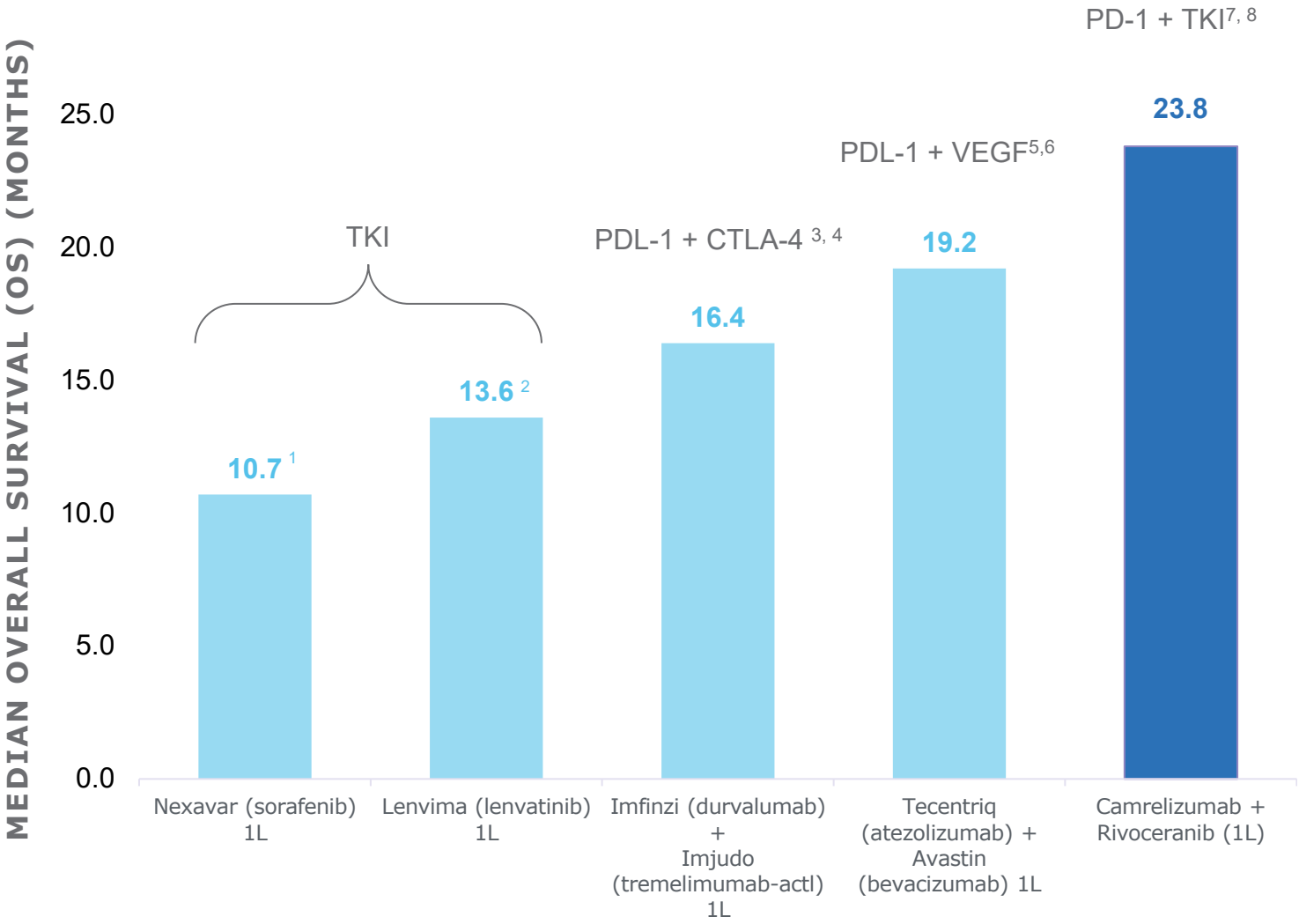
MOA	OS	PFS	Safety (TRAE Discontinuation Rates)
Atezolizumab (PD-L1 inhibitor) in combination with bevacizumab (VEGF inhibitor)	19.2 months (95% CI,17.0-23.7) *P* <.001 [HR 0.66 (95% CI, 0.52-0.85)]	6.9 months (95% CI, 5.7-8.6) *P* <.001 [HR 0.65 (95% CI, 0.53-0.81)]	7% (both components)
Durvalumab (PD-L1 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.

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: Genentench, 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

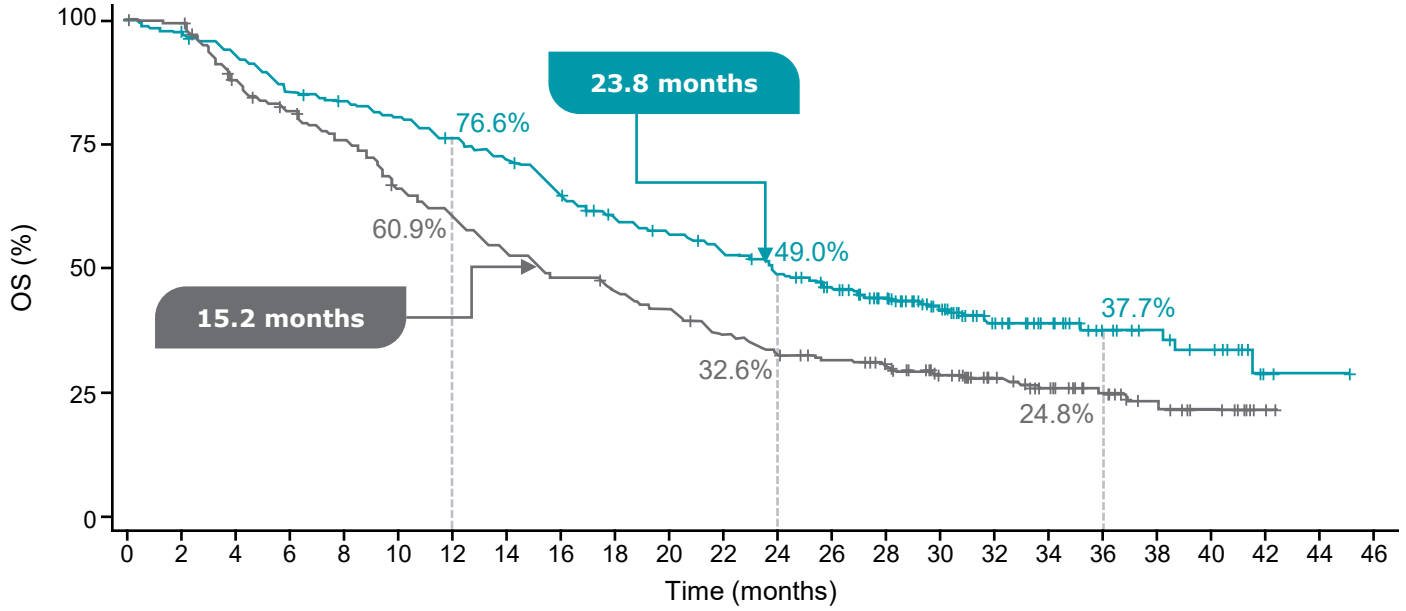
Camrelizumab + Rivoceranib Has the Potential to be a Best-in-Class Treatment Option in uHCC Based on Measurable, Clinically Relevant Data

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. 00 08. Fort Lee, NJ: Elevar Therapeutics; February 14, 2024.

mOS 23.8 Months at Final Study Analysis[1]

OS: FINAL ANALYSIS [1, 2]



No. at risk

Camrelizumab + rivoceranib	272	265	250	231	224	215	204	193	172	156	147	136	124	111	94	73	49	35	24	19	15	3	1	0
Sorafenib	271	268	232	214	198	171	158	138	126	118	108	94	83	78	70	55	43	34	21	14	9	2	0	

	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.

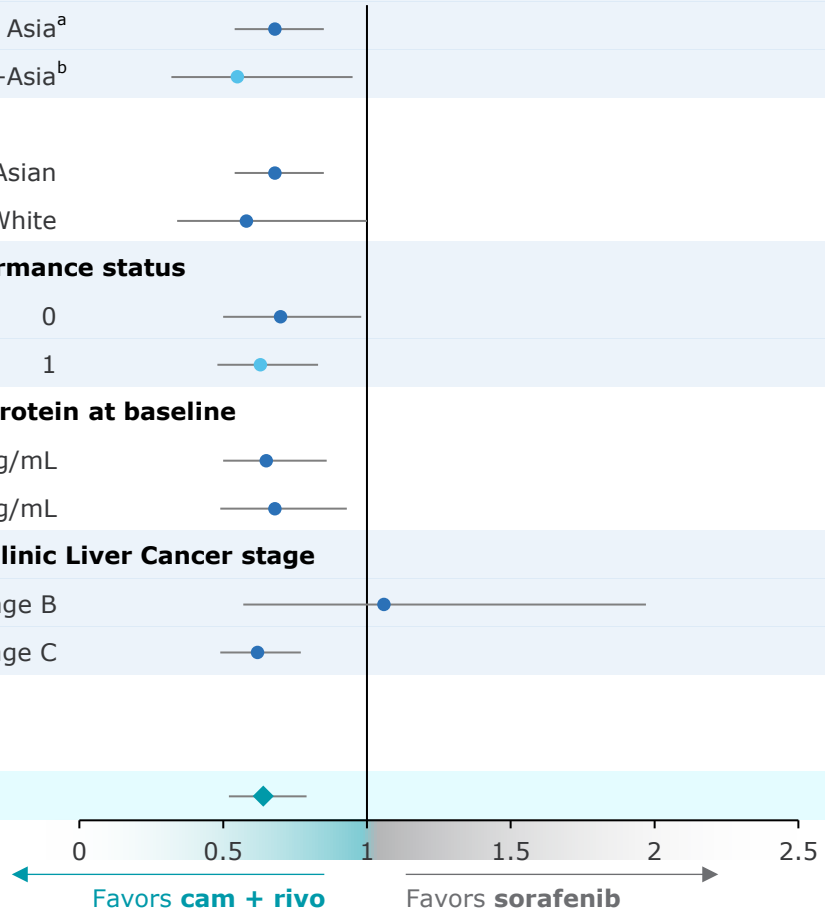
1. Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110.
2. Qin S, et al. *Lancet*. 2023;402(10408):1133-1146.

OS Favored Camrelizumab + Rivoceranib Across Most Subgroups

OS 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

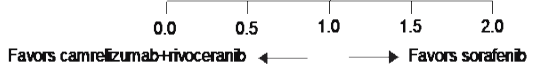
CI=confidence interval; ECOG=Eastern Cooperative Oncology Group; HR=hazard ratio; US=United States.
[a]Includes mainland China, Hong Kong, Taiwan, and South Korea; [b]Includes Belgium, Italy, Germany, Poland, Russia, Spain, Turkey, Ukraine, and the US; [c]Stratified HR.

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.

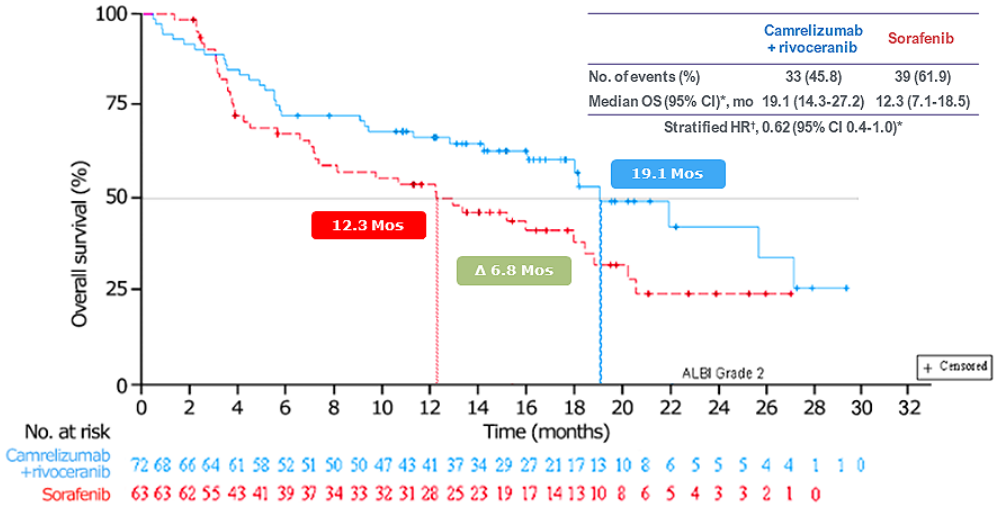
Subgroup Interim Analysis: CARES-310

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)



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.

Final Analysis — Safety[1]

TABLE 2. TRAEs	Cam + Rivo (n=272)		Sorafenib (n=269)	
	ANY GRADE	GRADE ≥3	ANY GRADE	GRADE ≥3
Hypertension	189 (69.5)	104 (38.2)	117 (43.5)	40 (14.9)
AST increased	149 (54.8)	47 (17.3)	101 (37.5)	14 (5.2)
Proteinuria	135 (49.6)	16 (5.9)	73 (27.1)	5 (1.9)
ALT increased	129 (47.4)	38 (14.0)	81 (30.1)	8 (3.0)
Platelet count decreased	126 (46.3)	32 (11.8)	90 (33.5)	4 (1.5)
Blood bilirubin increased	117 (43.0)	24 (8.8)	75 (27.9)	4 (1.5)
PPE syndrome	102 (37.5)	33 (12.1)	164 (61.0)	42 (15.6)
Diarrhoea	84 (30.9)	6 (2.2)	106 (39.4)	14 (5.2)
RCCEP	82 (30.1)	8 (2.9)	0	0
Neutropil count decreased	75 (27.6)	16 (5.9)	28 (10.4)	3 (1.1)
White blood cell count decreased	74 (27.2)	7 (2.6)	38 (14.1)	4 (1.5)
GGT increased	65 (23.9)	26 (9.6)	49 (18.2)	19 (7.1)
Hypothyroidism	58 (21.3)	0	17 (6.3)	0
Fatigue	56 (20.6)	8 (2.9)	21 (7.8)	1 (0.4)

- Safety data aligned with the interim OS analysis,[1] with no new signals noted. TRAE led to discontinuation of camrelizumab in 17.6%, rivoceranib in 16.9% and 4.4% in the combo arm.
- Discontinuation rate of both agents was low, at 4.4%. Sorafenib was discontinued in 4.8% due to TRAE.

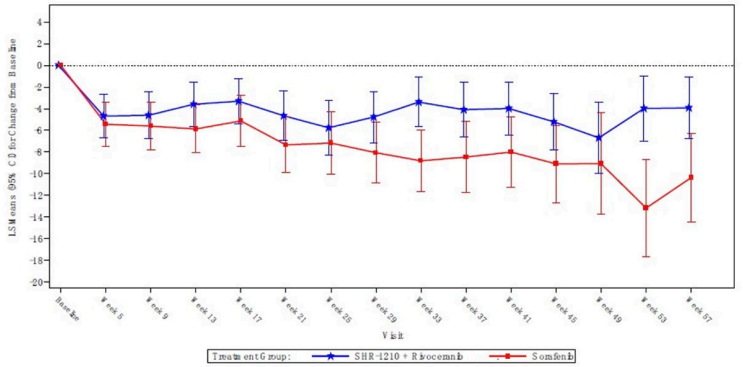
Vogel A et al. Poster presented at: ASCO Annual Meeting; May 31-June 4, 2024; Chicago, IL. *J Clin Oncol*. 2024;42(16)suppl. Abs 4110Data are n (%). *TRAE=treatment adverse event, s of any grade occurring in ≥20% or of grade≥3 occurring in ≥5% of patients in either group are listed. AST. Aspartate aminotransferase; ALT=alanine aminotransferase; GGT, Gamma-glutamyltransferase; PPE, palmar-plantar erythrodysaesthesia; RCCEP, reactive cutaneous capillary endothelial proliferation

Camrelizumab + Rivoceranib Patient-Reported Outcomes[1]

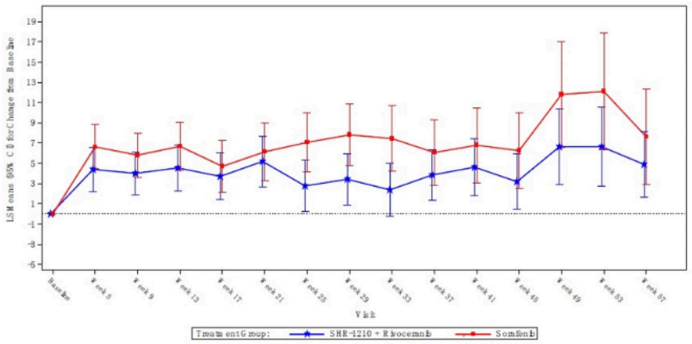
Camrelizumab + rivoceranib demonstrated statistically significant differences in patient-reported outcomes vs sorafenib:

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

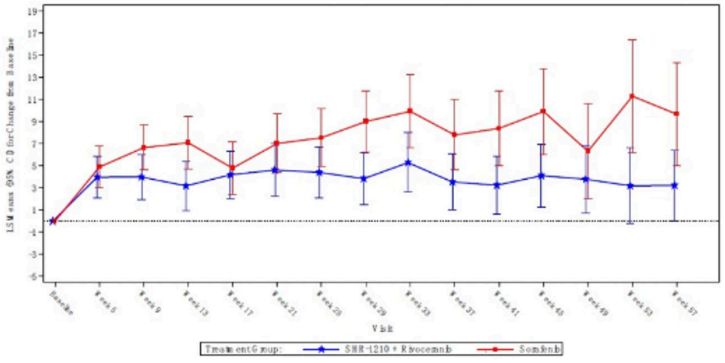
LS Mean (95% CI) for Change from Baseline in Global Health Status/Quality of Life Over Time By Treatment Arm*



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.

Near-Term Pipeline Programs

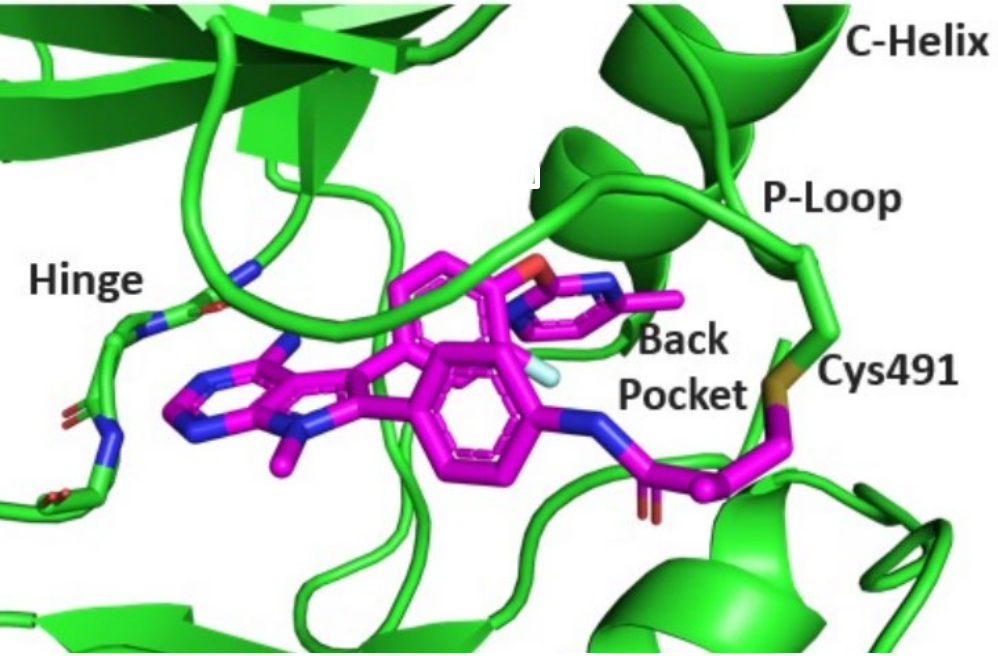
Lirafugratinib

Second Line Intrahepatic Cholangiocarcinoma with FGFR2 Fusions

Second Line Tumor Agnostic FGFR2 Fusions

Lirafugratinib

Potential best-in-class efficacy for FGFR2 CCA with ongoing clinical development in tumor agnostic indication with FGFR2 driven fusions, mutations and amplifications

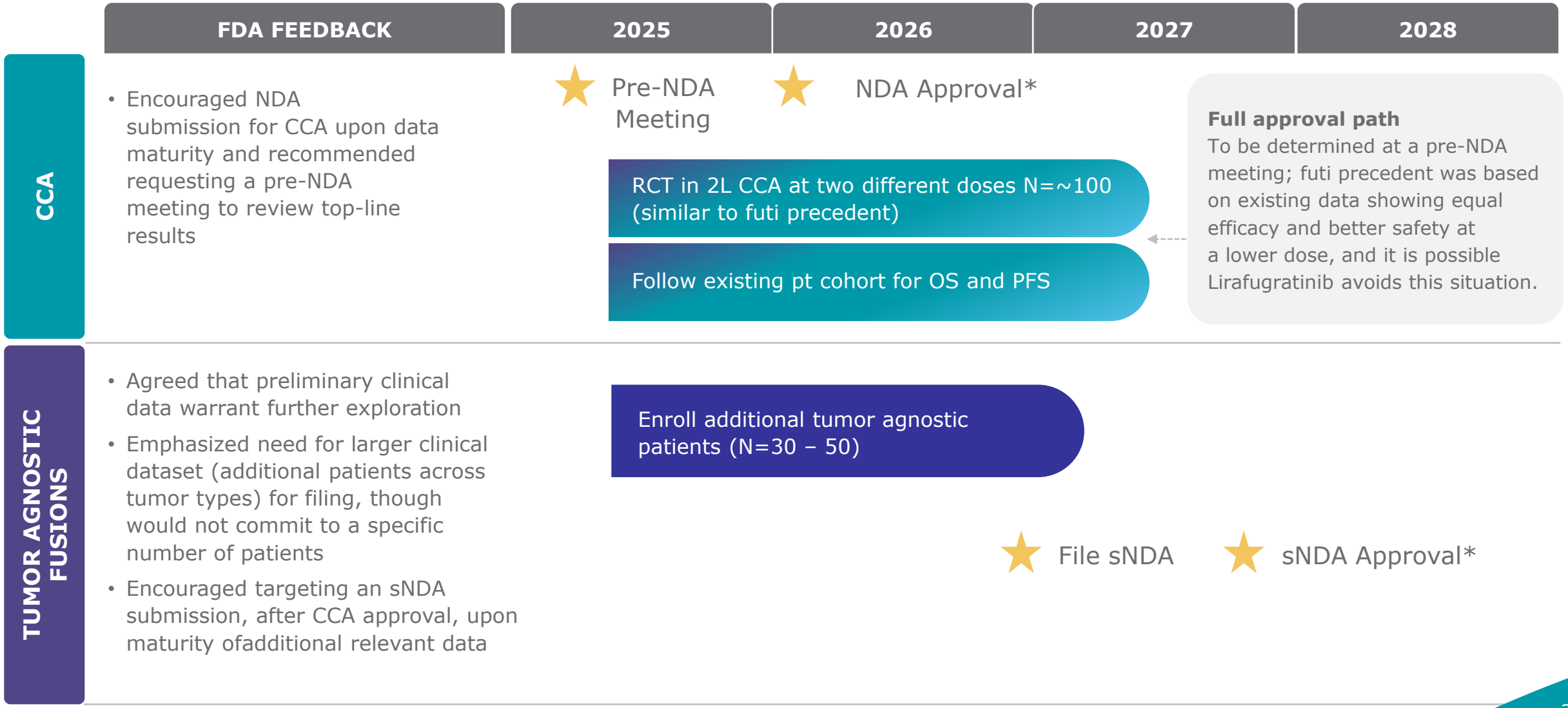


Lirafurgatinib efficacy demonstrates improvement compared to current standard of care across multiple indications and improved safety with low discontinuation rate

Updated CCA, tumor agnostic and indication-specific data highlight lirafugratinib's continued development progress, particularly with encouraging FDA feedback on CCA and tumor agnostic fusion indications

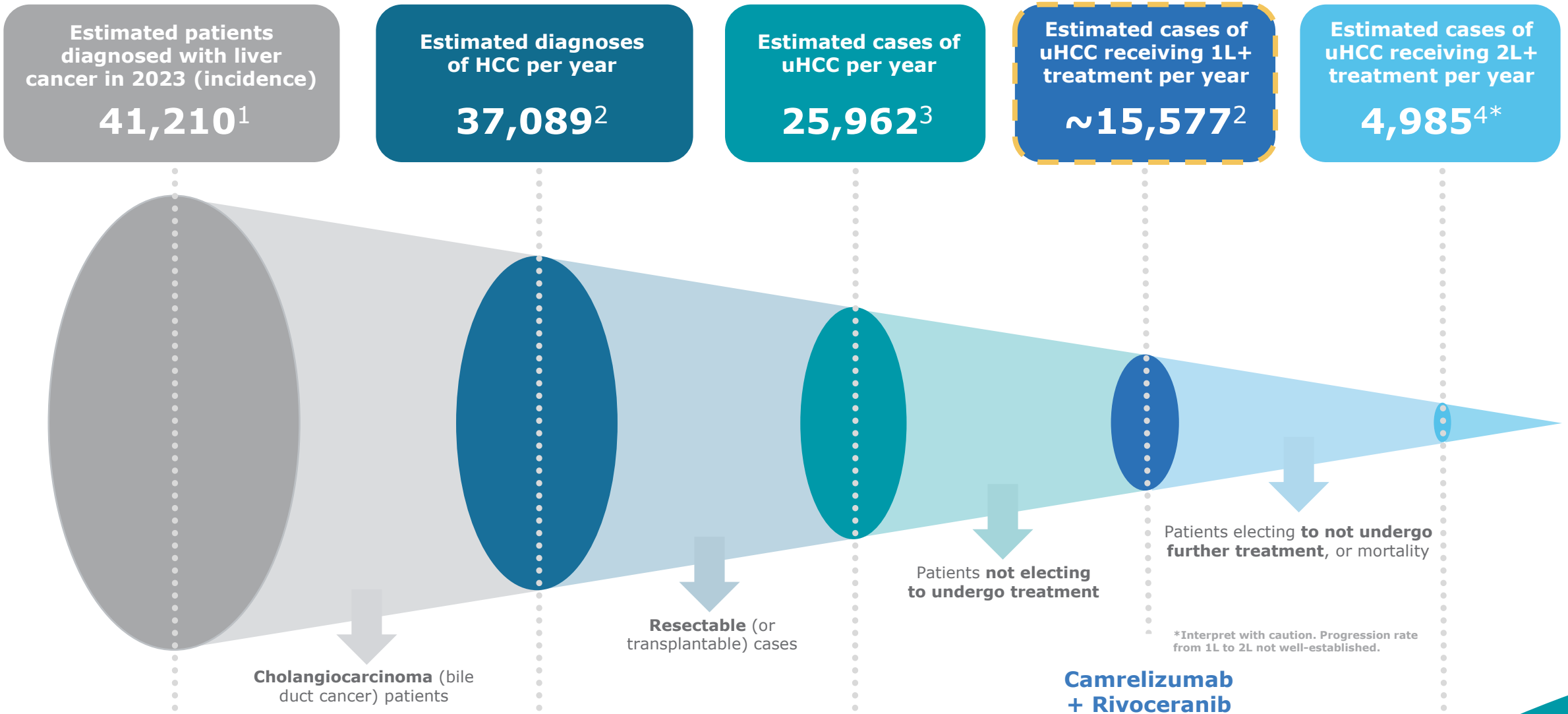
Lirafurgatinib provides potential for global first to market opportunity across high-need solid tumors

Lirafugratinib — Illustrative Near-Term Clinical Development Plans



Commercial Opportunity & Strategy

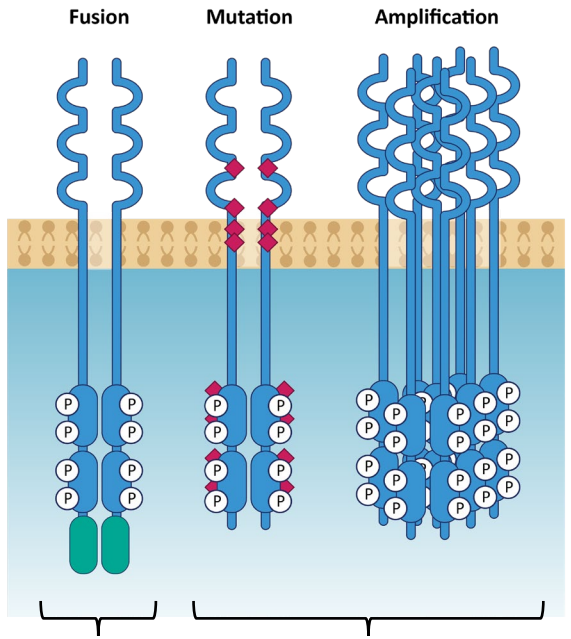
Elevar Is Well Positioned to Treat the US uHCC Patient Population



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.

FGFR2 — Validated Target Present in Several Tumor Types

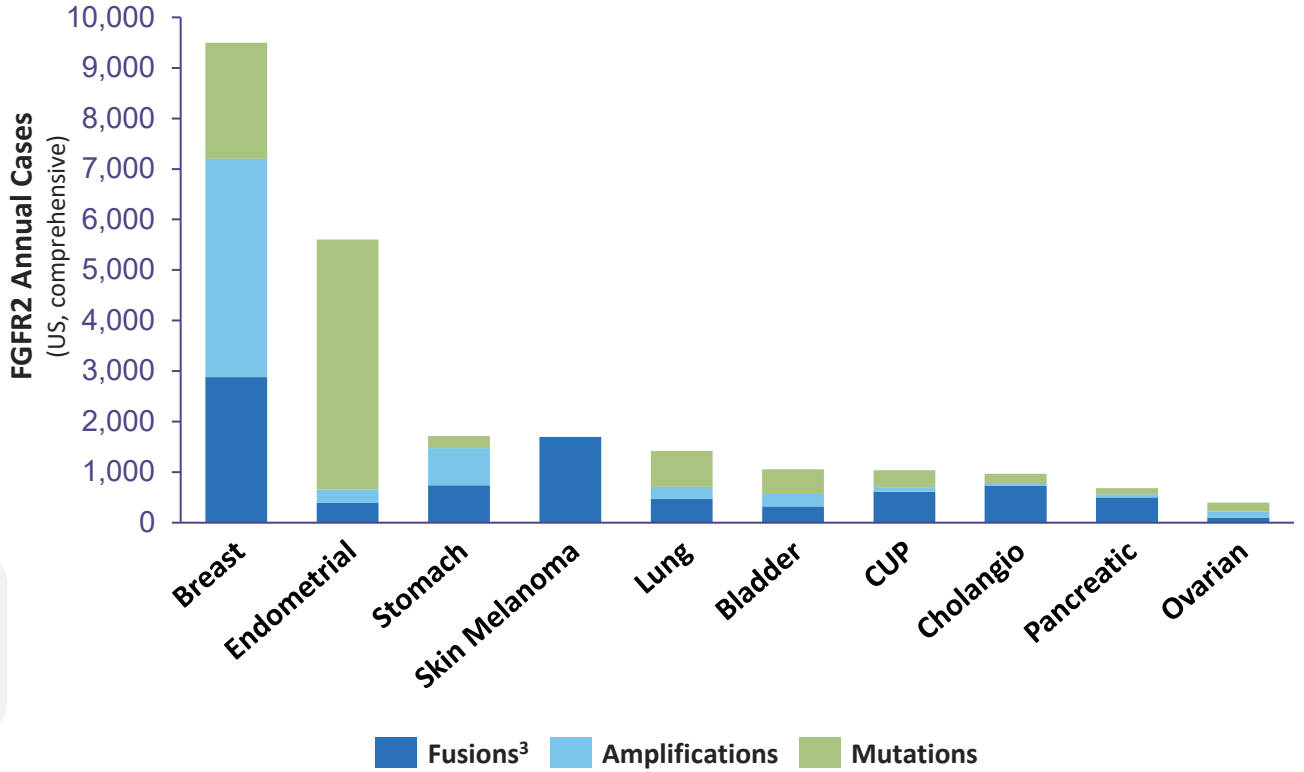
Three classes of driver alterations in FGFR2



Total FGFR2 alterations[1]: ~11-35K patients

Annual US Patient Count[1]

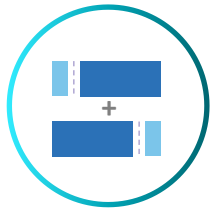
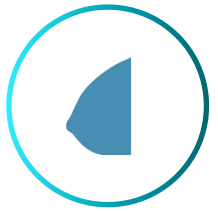
FGFR2 alterations are observed across multiple tumor types[2]



Sources: Image adapted from Babina IS, Turner NC. Nat Rev Cancer 2017;17: 318-332; Internal analysis based on third party industry data

1. All patient #'s refer to total annual number of US patients with late-line cancers vs. comprehensive annual incidence that may be amenable to treatment with our programs including additional FGFR gene fusions and rearrangements resulting from truncation of the protein at exon 18; 2. Cholangio, cholangiocarcinoma (CCA); CUP, carcinoma unknown primary; 3. FGFR2 fusion estimates include del18 truncations;

FGFR2 — Tumor Agnostic Opportunity

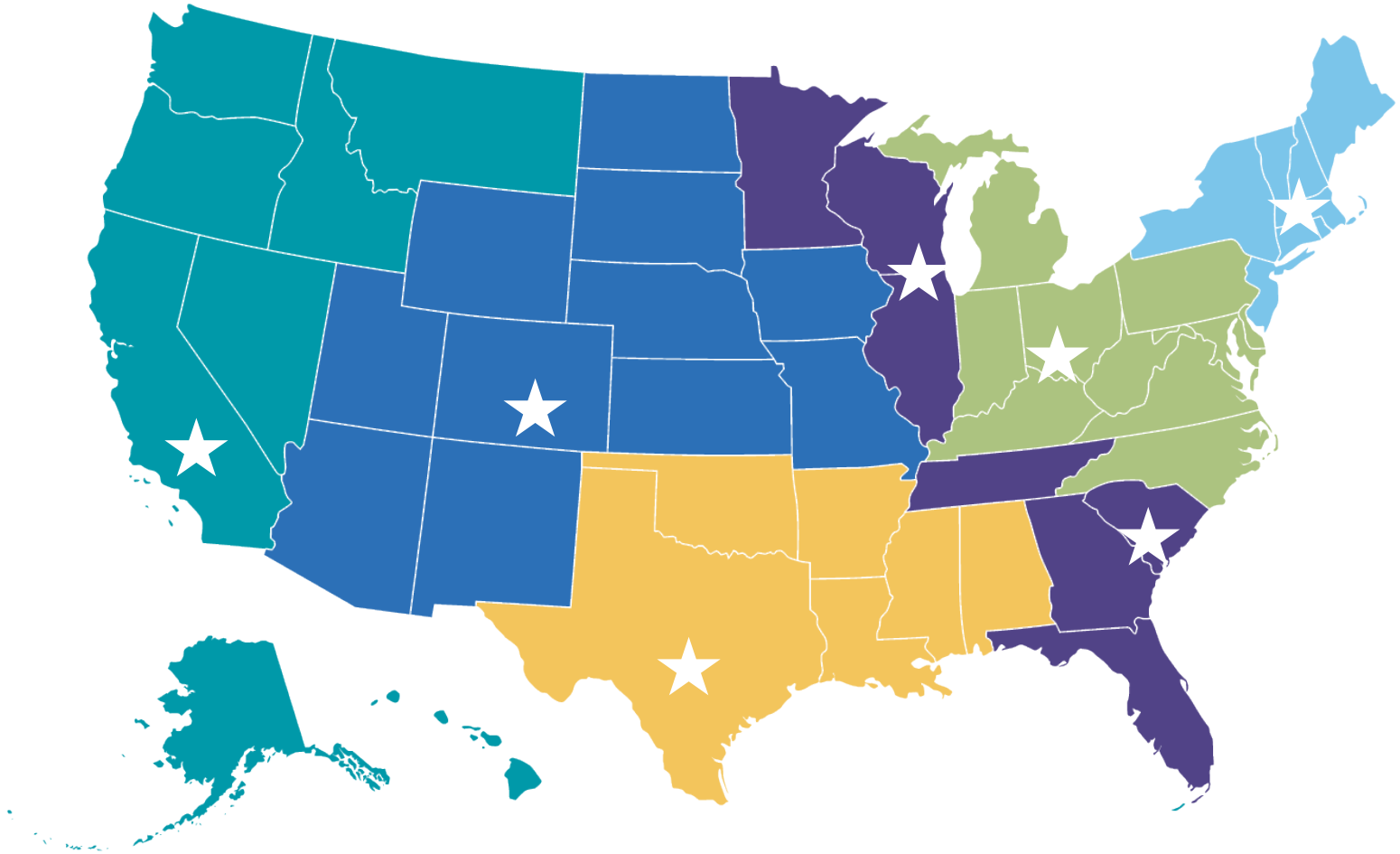
	TUMOR AGNOSTIC		TUMOR SPECIFIC		
					
Indication	**All Solid Tumors: FGFR2 Fusions**	**All Solid Tumors: FGFR2 Amplifications**	**CCA: Fusions**	**HR+ Breast Cancer: All Alterations[2]**	**Gastric Cancer: All Alterations[2]**
US patients per year	**~13k**	**~7k**	**~1k**	**~9k**	**~2k**
Global patients per year[1]	**Up to ~43k**	**Up to ~34k**	**Up to ~6k**	**Up to ~28k**	**Up to ~67k**

Current data suggest potentially large global opportunity

1. Incidence; Global includes US, EU4+UK, Japan, China; 2. Alterations include fusions, amplifications and mutations

Sources: ACS; SEER; Globocan; World Bank; 3rd party sources; Cholangiocarcinoma EU website; Jpn J Clin Oncol 2021, June, Tsujie; CCA News, 2021 Yr in review, "FGFR2 Fusion and/or Rearrangement Profiling in Chinese Patients with Intrahepatic CCA"; Nature, Jan 2012, K Matsumoto; Clin Cancer Res, May 2013, L Xie; Br J Cancer, Feb 2014, X Su; Ann Translational Med, Oct 2020, Yi Sun; Life (Basel), Jan 2022, C Lengyel; Am J Cancer Res, 2021, W Gu

US Commercial footprint after full approvals



- **6** Field Medical Directors
- **1** Medical Resources Director
- **~60** Oncology Account Managers
- **6** Regional Sales Directors
- **3** Field Reimbursement Liaisons
- **12** Marketing, Access, and Comm Ops

Map is a representation. Territory alignment to be finalized prior to FDA approval.
Star represents home-base location of Medical Affairs Team.

Thank You!

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