Elevar Therapeutics

Elevating Treatment Outcomes For Patients

NON-CONFIDENTIAL

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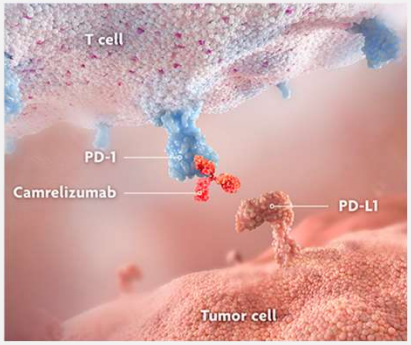
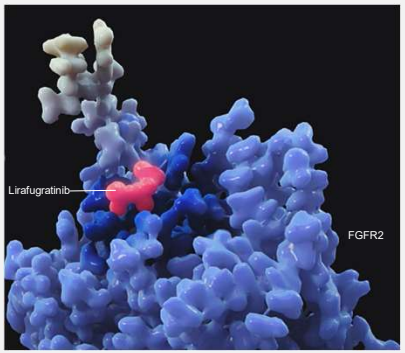
Company Overview

Elevar Therapeutics: delivering late-stage oncology programs with best-in-class potential



RIVOCERANIB + CAMRELIZUMAB: 1st Line Systemic Treatment for uHCC

- VEGFR-2 inhibitor + anti-PD-1 targeting immune checkpoint inhibitor
- **mOS of 23.8 months – the longest for any treatment in a global Phase 3 trial in uHCC**
- BLA/NDA resubmitted in Jan 2026
- EMA MAA preparations ongoing



LIRAFUGRATINIB: FGFR2 inhibitor with tumor-agnostic potential

- **First highly selective FGFR2 inhibitor with minimized off-target toxicity**
- First-to-market opportunity for solid tumor patients with FGFR2 alterations
- NDA submitted for 2L FGFR2 f/r Cholangiocarcinoma in Jan 2026
- **Breakthrough designation** for CCA – accelerated approval opportunity
- Ongoing Phase 2 study for solid tumor patients with FGFR2 f/r
- Orphan drug designation from the FDA

UHCC, unresectable Hepatocellular Carcinoma; CCA, cholangiocarcinoma

References: 1. Rumgay H, et al. J Hepatol 2022;77(6):P1598-1606. 2. Siegel RL, et al. Cancer J Clin 2023;7(1):17-48. 3. Qiu SK, et al. JAMA Netw Open 2024;7(11):e2445525. doi:10.1001. 4. Cerreto M, et al. Curr Oncol 2023;30(10):8774-8792. 5. Llovet JM, et al. Nat Rev Dis Primers. 2021;7(1):7. 6. Qin S, et al. Lancet 2023;402(10408):1133-1146. 7. 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. 8. Finn RS, et al. NEJM 2020;382(20):1894-1905. 9. Abou-Alfa GK, et al. NEJM Evid 2022;1(8):doi:10.1056/EVIDoa2100070. 10. Yau T, et al. Lancet 2025;405(10492):P1851-1864. 11. Borad MJ, et al. J Clin Oncol 2023;41(suppl 16):4009. 12. Hollebecque A, et al. EORTC-NCI-AACR Symposium 2024;PB046.

Regulatory & Development Key Milestones

2025

LIRAFUGRATINIB

CCA FGFR2 f/r

- Pre-NDA Meeting Completed

2026

RIVOCERANIB + CAMRELIZUMAB

uHCC

- BLA/NDA resubmitted in Jan 2026
- EU filing preparations ongoing

LIRAFUGRATINIB

CCA FGFR2 f/r

- NDA submitted in Jan 2026
- Potential U.S. approval 2H 2026
- EU filing Q2-Q3 2026

Tumor Agnostic FGFR2 f/r

- Site open and FPI by Q1 2026

2027 +

LIRAFUGRATINIB

Tumor Agnostic FGFR2 f/r

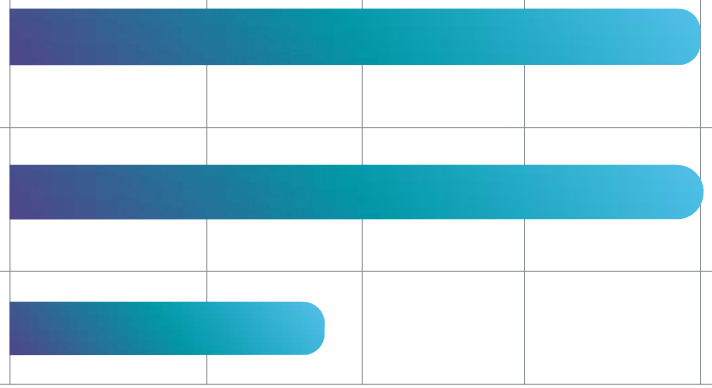
- Complete a global phase 2 study with additional patients
- US and EU Filing

Abbreviations. CCA – cholangiocarcinoma, FGFR2 f/r – fibroblast growth factor receptor 2 fusions/rearrangements, uHCC – unresectable hepatocellular carcinoma

Source:

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)*					
Lirafugratinib	Oncology	FGFR2-altered cholangiocarcinoma, 2L*					
Lirafugratinib	Oncology	Solid tumors with FGFR2 alterations					



[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

Camrelizumab and Rivoceranib are Proven Therapies with Commercial Track Record in China

Elevar plans to leverage the commercial success in China to receive approval for & launch Cam-Rivo for 1L uHCC in the US, EU, and beyond

Camrelizumab plus Rivoceranib

- **Approved in China for 1L Unresectable hepatocellular carcinoma (uHCC)** (Jan 2023); preferred regimen alongside Atezo-Bev Combination
- Elevar has global rights to rivoceranib (excluding Greater China and Korea)
- Elevar has global rights to camrelizumab for HCC with ability to add indications (excluding Greater China and Korea)

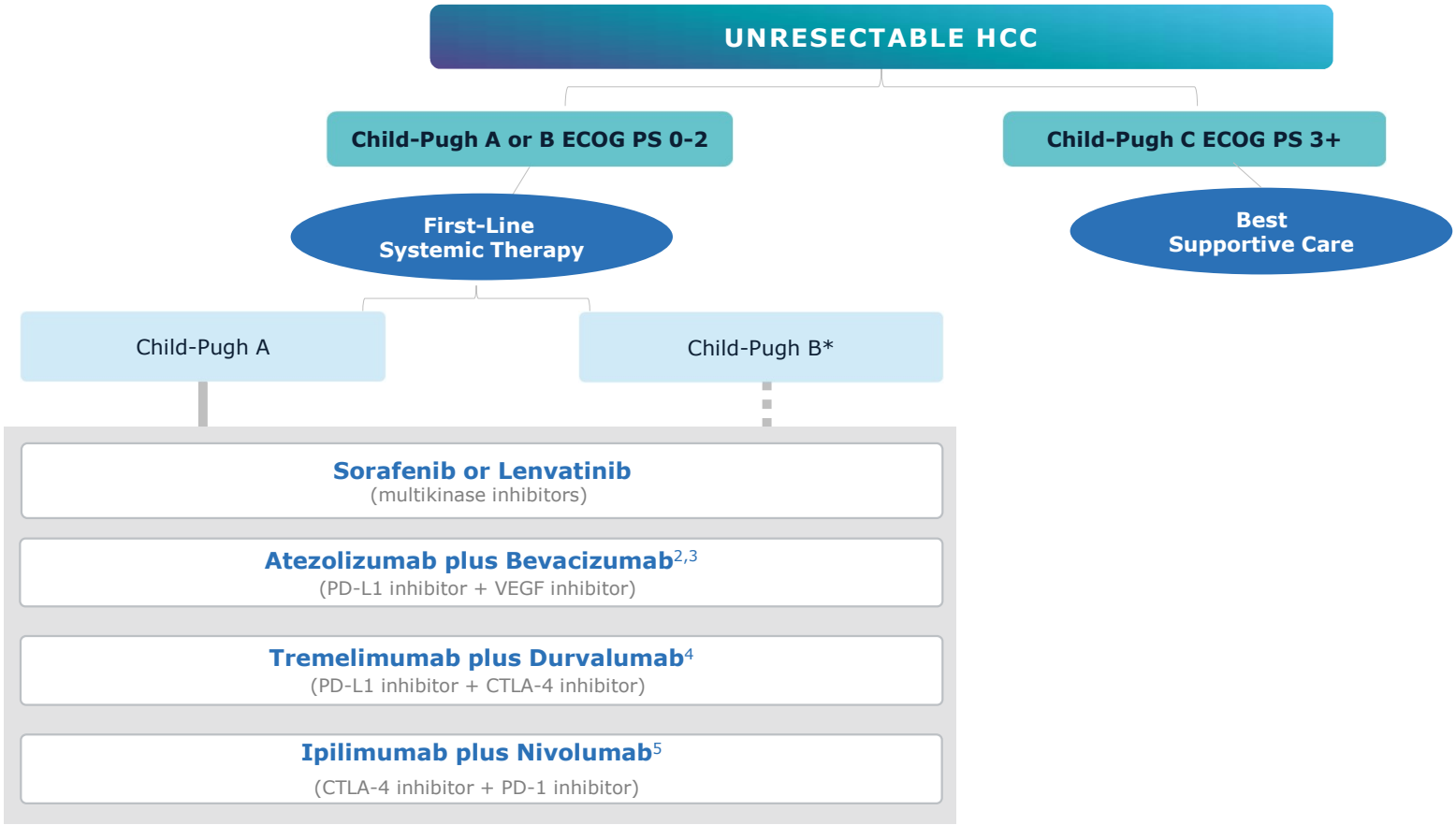
Rivoceranib

- Approved in China (Apatinib®, Hengrui Pharma) for:
  - Gastric cancer 1L monotherapy (2014)
  - Advanced hepatocellular carcinoma (HCC) 2L monotherapy (2020)

Camrelizumab

- Approved in China (AiRuiKa®, Hengrui Pharma) for eight indications (NSCLC 1L, HCC 2L, esophageal SCC 2L etc.)
- **One of the top-selling anti-PD-1s in China**

Hepatocellular Carcinoma Systemic Therapy Paradigm[1]



*Per NCCN Guidelines for 1L uHCC, nivolumab and atezolizumab + bevacizumab are useful in certain circumstances (Child-Pugh Class B); TRAE, treatment related adverse event; Grade 5 refers to death.

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 . Yau T, et al. *Lancet* 2025;405(10492):P1851-1864. 6. Qin S, et al. *Lancet.* 2023;402(10408):1133-1146. 7. 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 plus Rivoceranib shows best-in-class potential with longest mOS and favorable safety (CARES-310)

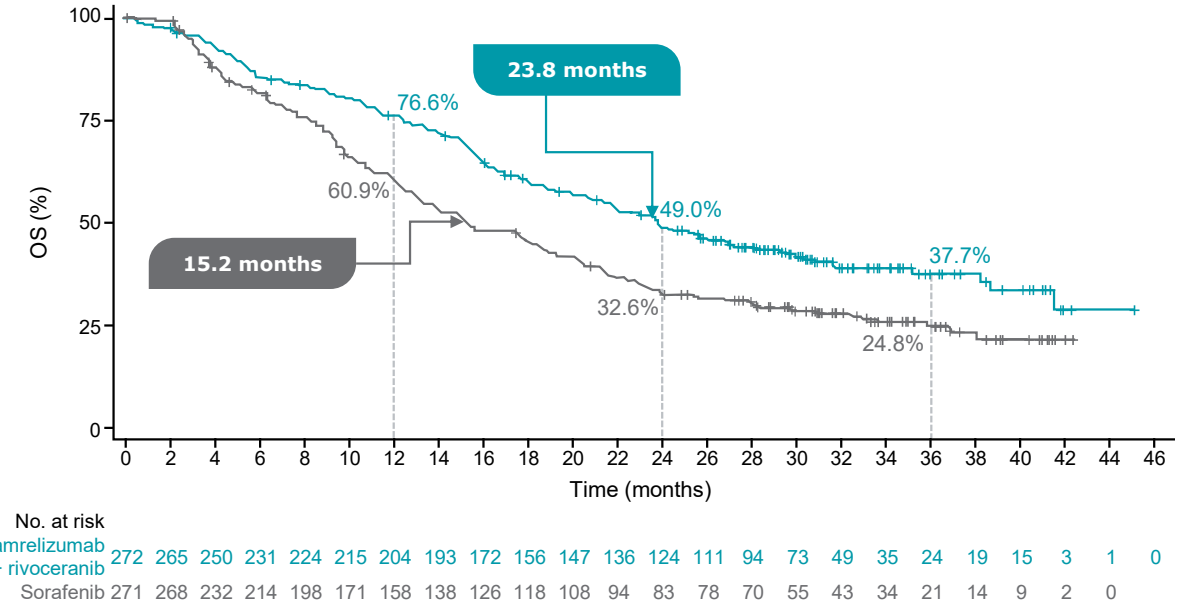
	OS	PFS	Safety (TRAE Discontinuation Rates)	TRAE Grade 5
Camrelizumab plus Rivoceranib[6,7] (PD-1 inhibitor + VEGF 1-3 inhibitor)	**23.8 months** (95% CI, 20.61-27.2) [HR 0.64 (95% CI, 0.52-0.79)]	**5.6 months** (95% CI, 5.5-7.43) [HR 0.54 (95% CI, 0.44-.67)]	**4.4%** (both components)	**0.4%** (1 of 272)
Atezolizumab plus Bevacizumab[2,3] (PD-L1 inhibitor + 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)	1.5% (5 of 336)
Tremelimumab plus Durvalumab[4] (PD-L1 inhibitor + CTLA-4 inhibitor)	16.4 months (95% CI, 14.16-19.58) *P* =.0035 [HR 0.78 (95% CI, 0.65-0.93)]	3.8 months Not significantly different [HR 0.90 (95% CI, 0.77-1.05)]	13.7%	2.3% (9 of 393)
Ipilimumab plus Nivolumab[5] (CTLA-4 inhibitor + PD-1 inhibitor)	23.7 months (95% CI, 18.8-29.4) *P* =.018 [HR 0.79 (95% CI, 0.65-0.96)]	9.1 months PFS was an exploratory endpoint	18%	3.6% (12 of 332)

*Per NCCN Guidelines for 1L uHCC, nivolumab and atezolizumab + bevacizumab are useful in certain circumstances (Child-Pugh Class B); TRAE, treatment related adverse event; Grade 5 refers to death.

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. Yau T, et al. *Lancet* 2025;405(10492):P1851-1864. 6. Qin S, et al. *Lancet.* 2023;402(10408):1133-1146. 7. 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.

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]

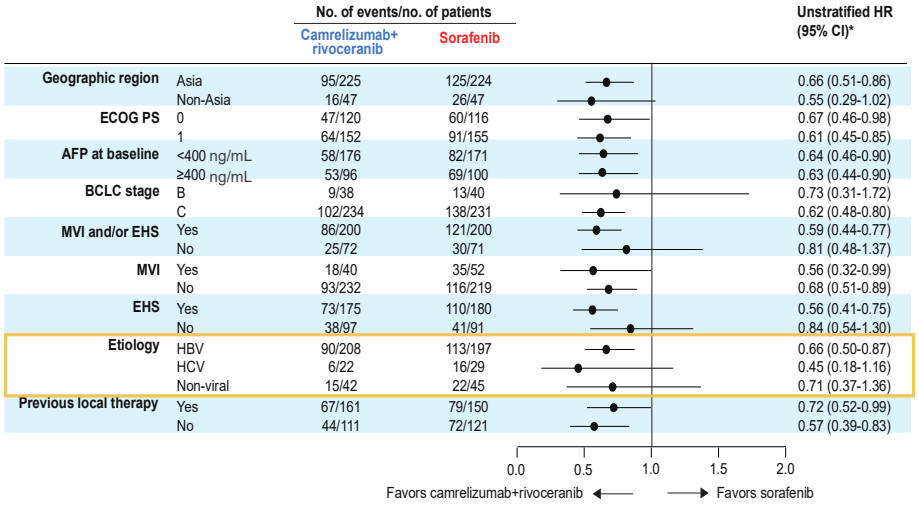
The stratification factors were the randomization strata.
There was very early and durable separation in the KM curves for Cam/Rivo vs Sorafenib.

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.

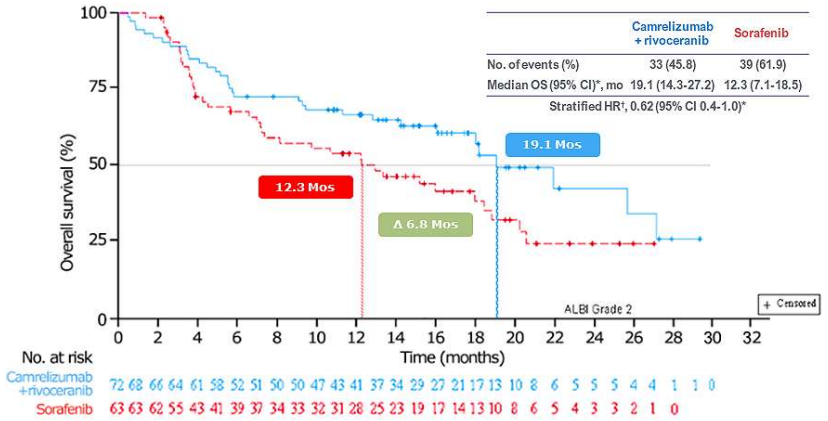
OS survival benefit observed across key subgroups, including baseline ALBI grade, etiology, EHS, and MVI

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]



- 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.

Cam-Rivo was well tolerated, with most common TRAEs being manageable

TRAEs from CARES-310 study	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)
Diarrhea	84 (30.9)	6 (2.2)	106 (39.4)	14 (5.2)
RCCEP	82 (30.1)	8 (2.9)	0	0
Neutrophil 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

Summary – Cam-Rivo has the potential to become a differentiated option in 1L treatment of uHCC

- **Longest mOS** in a global Ph3 study to date; survival benefit consistently observed even in high-risk subgroups
- Well tolerated with **manageable toxicities and low discontinuation rate**
- Commercial success in China by Hengrui Pharma (Elevar's partner) underscores Cam-Rivo's potential to reshape the 1L uHCC treatment landscape
- FDA CRLs were limited to CMC observations; Elevar and Hengrui have resubmitted the NDA/BLA in Jan 2026
- EMA MAA preparations are underway; **Cam-Rivo's inclusion in ESMO treatment guidelines** reflects strong KOL anticipation ahead of market entry

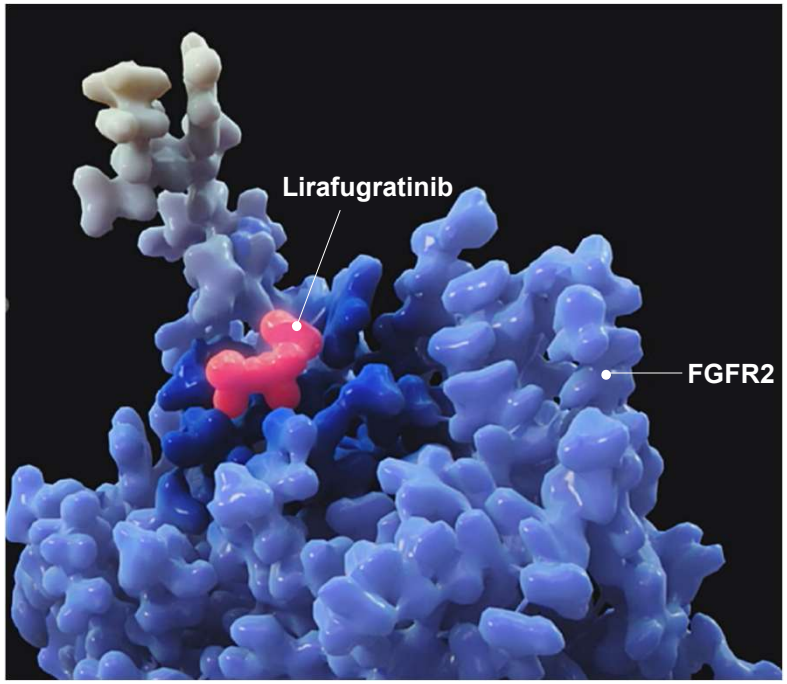
Near-Term Pipeline Programs

Lirafugratinib

Second Line Intrahepatic Cholangiocarcinoma with FGFR2 Fusion and Rearrangement

Second Line Solid Tumors with FGFR2 Fusion and Rearrangement

Lirafugratinib: potential best-in-class efficacy in FGFR2 f/r CCA, under development for tumor-agnostic expansion



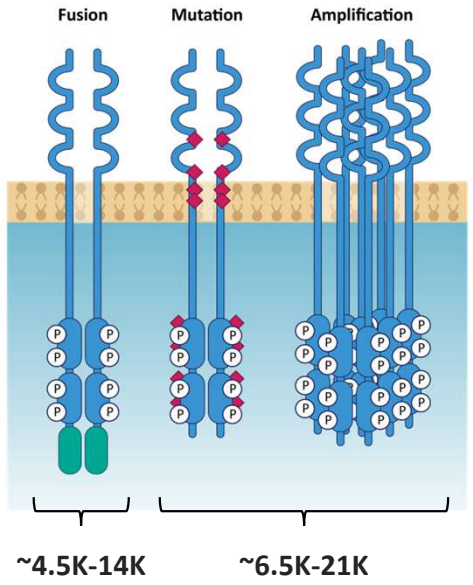
Preliminary data across multiple indications demonstrate **improvement in efficacy and safety with low discontinuation rate**, compared to standard of care

NDA submitted to the FDA for 2L FGFR2 f/r CCA; further clinical development ongoing in non-CCA solid tumors, based on latest clinical data and encouraging FDA feedback

Lirafugratinib has potential for global first-to-market opportunity for **tumor-agnostic treatment of FGFR2 f/r solid tumors**

FGFR2 — Validated Target Present in Several Tumor Types

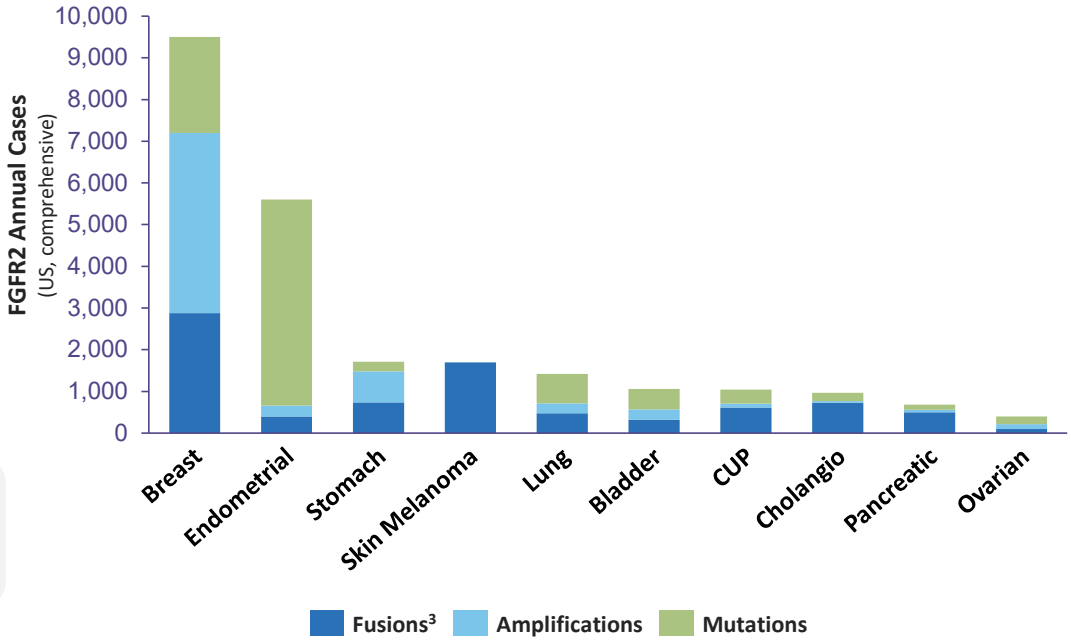
Three classes of driver alterations in FGFR2



Annual US Patient Count[1]

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

FGFR2 alterations are observed across multiple tumor types[2]

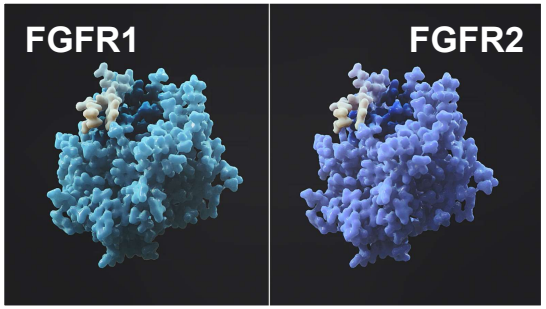


Sources: Image adapted from Babina IS, Turner NC. Nat Rev Cancer 2017;17: 318-332; Internal analysis based on third party industry data

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;

Currently approved FGFR inhibitors are associated with off-target toxicity and limited efficacy

FGFR1-4 static structures look the same



No FGFR2-targeted therapy available

Pan-FGFRi's lead to high rates of off-target toxicity, esp. for FGFR1,4

FDA Approved Compound[1]	% of Patients with Hyperphosphatemia	% of Patients with Diarrhea
Pemigatinib	93%	39%
Futibatinib	88%	33%
Erdafitinib	71%	59%

Chemo and other late line therapies also have high rates of AEs and dose modifications

Efficacy limited by off-target tox

CCA

36-42% ORR in currently approved tx[1]
(in fusion+ CCA, FGFRi-naïve pt)

Non-CCA Solid Tumors

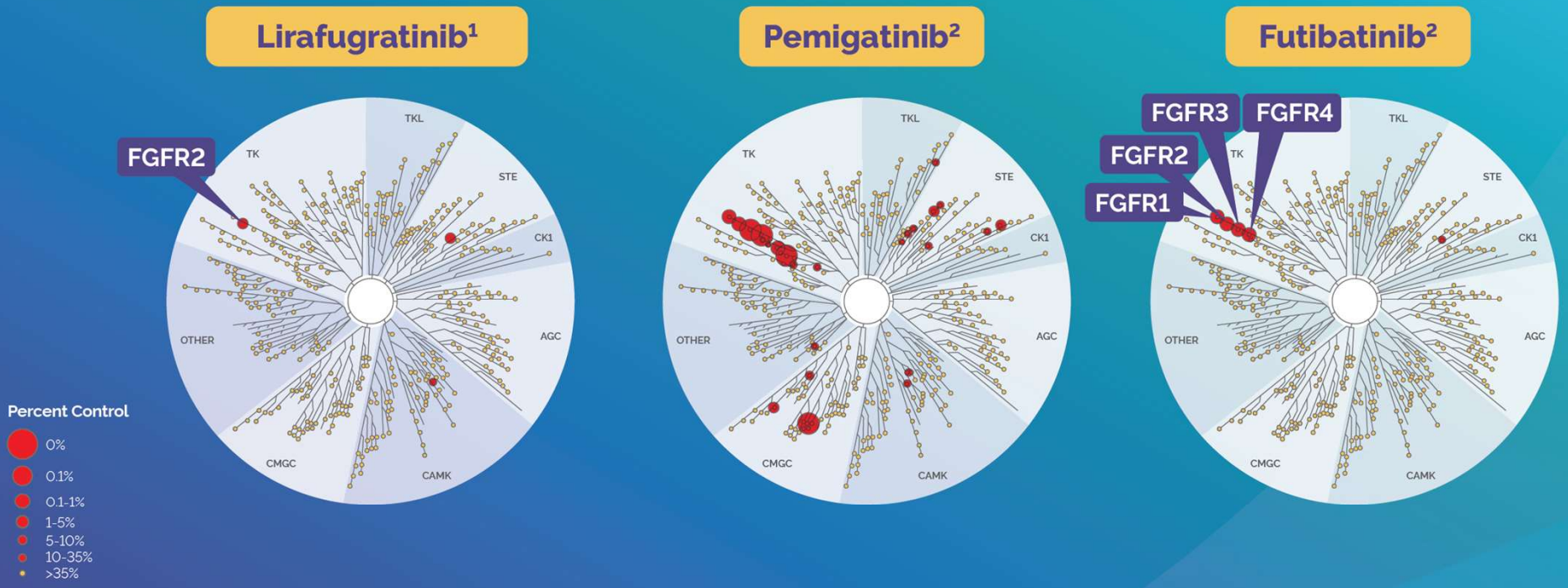
0-15% ORR in approved late-line tx[2]
(based on NCCN guidelines)

mPFS 1-5mo in non-CCA solid tumors

Pan-FGFR inhibitors are often limited by off-target toxicities that prevent dosing at maximum efficacy; selective inhibition of FGFR2 offers the potential to achieve optimal efficacy with an improved safety profile

Sources.: 1. Pemigatinib – prescribing information; futibatinib – prescribing Information; erdafitinib – prescribing information; (note: AEs are reflective of respective label indications); 2. Reflects reported ORRs in key randomized studies evaluating NCCN recommended regimens for recurrent/metastatic patients (second/third line or later) for the following tumor types: HR+ breast cancer, gastric cancer, pancreatic cancer, NSCLC, ovarian cancer, and head and neck

Lirafugratinib demonstrated high selectivity for FGFR2 against 468 kinases screened compared with pan-FGFR inhibitors[1,2]



FGFR-fibroblast growth factor receptor; FGFR1-fibroblast growth factor receptor 1; FGFR2-fibroblast growth factor receptor 2; FGFR3-fibroblast growth factor receptor 3; FGFR4-fibroblast growth factor receptor 4.

References: 1. Subbiah V, et al. *Cancer Discov.* 2023;13(9):2012-2031. **2.** Data on file. Elevar Therapeutics; 2025.

Pivotal data for 2L CCA (FGFR f/r) showed meaningful improvement to efficacy and safety compared to FDA-approved pan-FGFR inhibitors

	ORR	DCR	mOS (months)	mPFS (months)	mDOR (months)	Gr≥3 TEAE	Discontinuation Rate
Lirafugratinib[1] (irreversible FGFR2i)	46.5%	96.5%	22.8	11.3	11.8	62.9% Most common: PPES (20%), stomatitis (12.2%), anaemia (8.3%)	4.9%
Pemigatinib[2] (reversible FGFR1-3i)	36%	82%	17.5	7.0	9.1	68.7% Most common: hypophosphatemia (14.3%), stomatitis (6.8%), arthralgia (6.1%)	9%
Futibatinib[3] (irreversible FGFR1-4i)	42%	83%	21.7	9.0	9.7	77% Most common: hyperphosphatemia (30%), increased AST (10%), fatigue (8%), stomatitis (6%), hyponatremia (11%)	4.9%

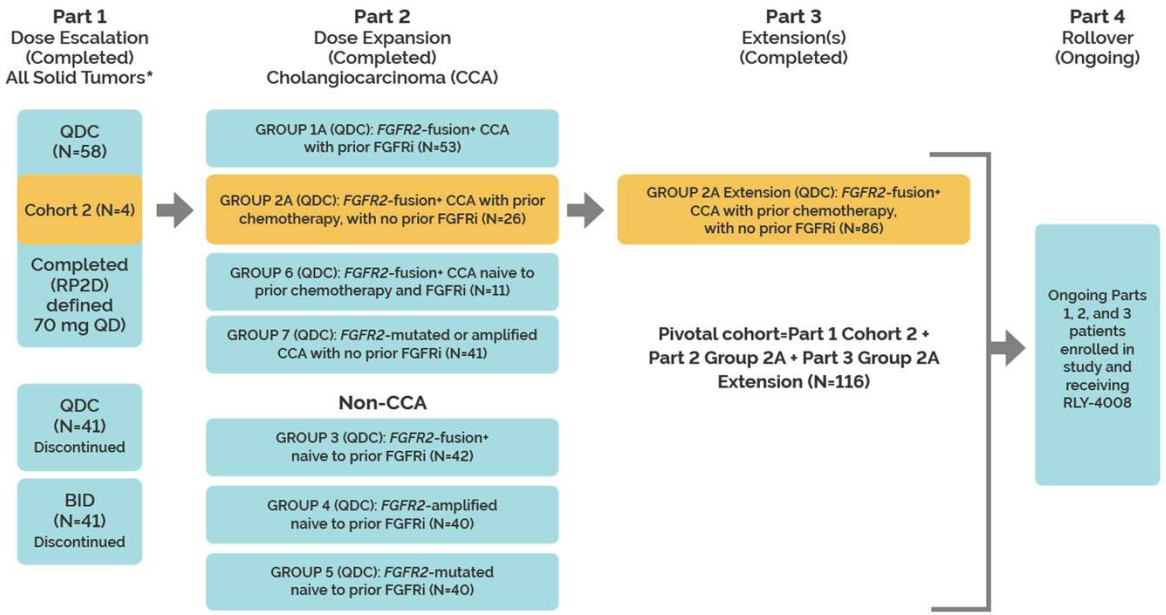
- Lirafugratinib is the first selective FGFR2 inhibitor designed to improve antitumor activity while minimizing FGFR1/3/4 associated toxicities
- Safety data (n=385) showed tolerable safety profile; AEs were manageable and mostly FGFR2-associated toxicities
- **NDA submitted in January 2026; eligible for accelerated approval by the FDA**
- Pivotal Phase 2 study was conducted globally (US, EU4, Netherlands, Sweden, UK, South Korea, Singapore, Australia, Hong Kong)

CCA-cholangiocarcinoma; DCR-disease control rate; FGFR f/r-fibroblast growth factor receptor fusion/rearrangement; mDOR-median duration of response; mOS-median overall survival; mPFS-median progression free survival; ORR-objective response rate; PPES-palmar-plantar erythrodysesthesia; TEAE-treatment emergent adverse event;

References:[1]Data on file from the ReFocus study; [2]Vogel et al. ESMO Open. 2024 Jun;9(6):103488; [3]Pemigatinib FDA prescribing information.

ReFocus study investigated lirafugratinib in 490 solid tumor patients with FGFR2 fusion, amplification, and mutation, with promising initial efficacy and safety

- ReFocus study (by previous sponsor Relay) investigated lirafugratinib across wide range of solid tumors
- Primary and secondary efficacy outcomes demonstrate **meaningful clinical benefit**; safety profile is **manageable and well tolerated**
- Several patients treated with lirafugratinib have transitioned to post-trial supply program



*Including FGFR2 genomic alteration (fusion, amplification, or mutation) or other potentially oncogenic *FGFR2* alterations (eg, *FGFR2* protein or mRNA overexpression) and other tumor types.

BID=twice daily; CCA=cholangiocarcinoma; FGFR2=fibroblast growth factor receptor 2; FGFRi=fibroblast growth factor receptor inhibitor; QD=once daily; QDC=once daily on a continuous dosing schedule; RP2D=recommended phase 2 dose.

References: 1. Hollebecque A, et al. EORTC-NCI-AACR Symposium on Molecular Targets and Cancer Therapeutics 2024. Poster 58 PB046. **2.** REFOCUS: a first-in-human study of highly selective FGFR2 inhibitor, RLY-4008, in patients with ICC and other advanced solid tumors. ClinicalTrials.gov identifier: NCT04526106. Updated January 30, 2025. Accessed April 18, 2025. https://clinicaltrials.gov/study/NCT04526106

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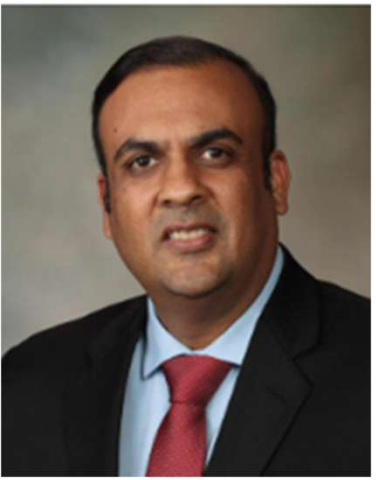

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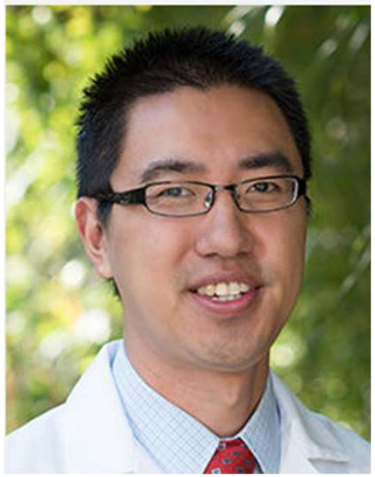

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