



# Corporate Presentation

May 2025

# Forward-Looking Statements

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# A New Chapter in the Connect Biopharma Story

## Experienced U.S. Management Team Assembled in 2H2024

Proven team with deep expertise in drug development with a history of multiple late-stage clinical and regulatory executions

## Focused on Progressing Rademikibart

Advancing next generation anti-interleukin-4-receptor alpha (IL-4R $\alpha$ ) for treatment of eosinophilic driven respiratory diseases supported by reanalysis of global asthma study CBP-201-WW002

## Market Research Supports Commercial Attractiveness

Market research shows acute exacerbation indications in asthma and COPD are an important advantage over dupilumab and other biologics and would lead to significantly greater chronic use

Dupixent and other biologics are explicitly not to be used to treat acute symptoms or acute exacerbations of asthma or COPD

Projected base-case worldwide peak sales of >\$3B for asthma and >\$2B for COPD

## Initiating Rapid Clinical Development Program

Initiating parallel acute exacerbation studies in asthma and COPD with data in 1H2026

Have sufficient cash to fund these trials with runway into 2027

## Expanding US-Centric Footprint

Continue to progress toward becoming more US-centric with reduced footprint in China with 10-Q/K filings planned in 2025

# Connect Biopharma Highlights

## Best-in-Class Next Generation IL-4R $\alpha$ antibody

- Rademikibart shows the largest improvement in FEV<sub>1</sub> observed with a biologic in asthma patients (baseline eosinophils  $\geq 300$  cell/ $\mu$ L FEV<sub>1</sub> increased by 312 mL at 1-week and 420mL at 24-weeks )
- >70% of FEV<sub>1</sub> benefit seen at one week was achieved within 24 hours of dosing demonstrating strong opportunity for acute treatment

## Significant & Persistent Unmet Need

- >1 million asthma patients and >1.3 million COPD patients visit an emergency department (ED) annually for exacerbations and no biologic has been approved or systematically studied for the treatment of acute exacerbations
- In the 4-week period after an exacerbation, ~50% of patients will experience another exacerbation leading to a return visit to the ED, hospital or clinic

## Untapped Market with Significant Commercial Opportunity

- Dupilumab and other biologics excluded the 4-week post-exacerbation period from their clinical trials and are explicitly labelled not to be used to treat acute symptoms or acute exacerbations of asthma or COPD
- Market research shows acute exacerbation indications in asthma and COPD are an important differentiator over dupilumab and other biologics and would lead to significantly greater chronic use; projected worldwide peak sales for rademikibart with acute and chronic indications of >\$3B for asthma and >\$2B for COPD

## Rapid Clinical Development Program with Strong IP & Balance Sheet

- Connect is initiating parallel Phase 2 studies in asthma and COPD patients experiencing acute exacerbations where the endpoint is recurrence of an exacerbation; data expected in 1H2026 with cash runway into 2027
- Rademikibart exclusivity through at least 2040

# Rademikibart Has Demonstrated Efficacy & Safety Across Multiple Indications

*Connect Biopharma has global development & commercialization rights outside of greater China for rademikibart*




	Rademikibart anti-IL-4R $\alpha$ mAb Indication	Discovery/Preclinical	Phase 1	Phase 2	Pivotal or Phase 3	Status/Anticipated Milestones
<b>Planned &amp; On-going Studies</b>	Acute COPD - US		→			Phase 2 studies of rademikibart in acute COPD and asthma exacerbations starting in 1H2025 with data in 1H2026
	Acute Asthma - US		→			
	Chronic Asthma – China <sup>a</sup>			→	→	Ongoing studies conducted by Sincere at no cost to Connect
	Atopic Dermatitis (AD) – China <sup>a</sup>			→	→	
<b>Completed Studies</b>	Asthma - Global			→		Based on the results from these studies, the U.S. FDA agreed that rademikibart was ready to move into Phase 3 for chronic treatment of asthma and AD
	Atopic Dermatitis (AD) – Global			→		
	Atopic Dermatitis (AD) – China				→	

**No further spending on rademikibart in AD or other programs is planned by Connect**

<sup>a</sup>Sincere is Connect's partner in Greater China who holds responsibility for future development, including for additional indications  
 mAb = monoclonal antibody; COPD = chronic obstructive pulmonary disease; AD = atopic dermatitis



# Asthma and COPD are Associated with Severe Exacerbations that are Difficult to Treat and Often Require Hospitalization

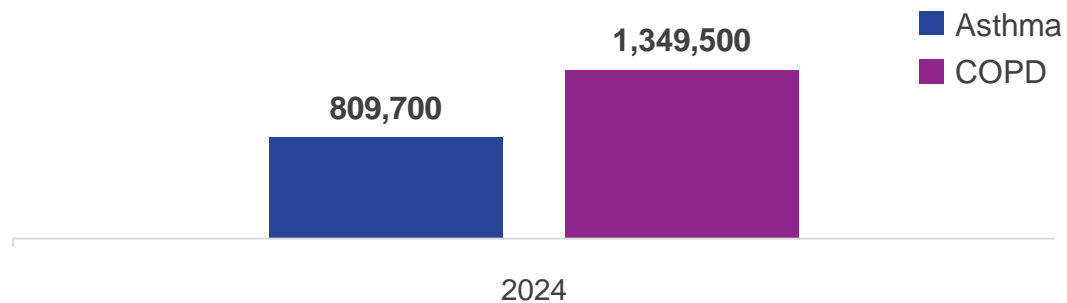
	Asthma	COPD
<b>POPULATION</b>	<b>Affects &gt;22M adults in US</b> with ~40% have at least one exacerbation per year	<b>Affects &gt;16M adults in US</b> with ~30-50% have at least one exacerbation per year
 <b>CURRENT SoC</b>	Fast-acting inhaled bronchodilators and oral/IV corticosteroids; severe cases may require IV magnesium sulfate, heliox therapy, and noninvasive ventilation; intubation is considered if patients do not respond to initial therapies. Antibiotics are often added if a bacterial infection is suspected with COPD	
<b>&gt;&gt;&gt; PROGRESSION</b>	<b>~50% fail to improve on 1<sup>st</sup> Line treatments</b>	<b>~85% fail to improve on 1<sup>st</sup> Line treatments</b>
 <b>ADMISSIONS</b>	Persistent hypoxia, severe respiratory distress, poor response to initial treatment, altered mental status and/or a history of exacerbations drive admission decisions	
	<b>~1 million ED visits or hospitalizations/yr</b> <b>~11% of Asthma patients are hospitalized</b> <b>LOS typically ranges from 2 to 3 days</b> <b>~50% meet treatment failure criteria within 4 weeks of an exacerbation, with 20% requiring a re-visit to the ED</b>	<b>~1.3 million ED visits or hospitalizations/yr</b> <b>~41% of COPD patients are hospitalized</b> <b>LOS typically ranges from 4 to 7 days</b> <b>~50% fail treatment within 4 weeks of an exacerbation with ~11% of patients require re-hospitalization</b>
 <b>LONG-TERM CARE</b>	As symptoms improve, hospital physicians coordinate care with PCPs or pulmonologists; asthma patients are most likely to get treated by a PCP in the outpatient setting	COPD patients are typically older and have more comorbidities than asthma patients, and are therefore more likely to be referred to a pulmonologist upon discharge

# Asthma and COPD are Global Problems Projected 2024 European Union

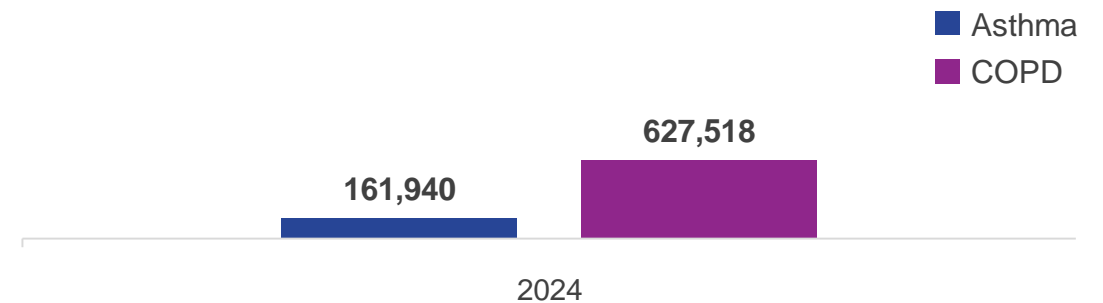
## Asthma & COPD ED Visits / Hospitalizations

*Projected annual ED/hospital visits associated with asthma and COPD exacerbations are similar in the EU and US*

### Projected Annual ED Visits in EU



### Projected Annual Hospitalizations in EU



### Key Statistics and Considerations

- Studies report **~20%** of asthma patients are hospitalized, and upwards of **~20%** of patients returned to the ED within 30 days<sup>1-9</sup>
- Studies suggest the prevalence of COPD exacerbations in the EU closely mirrors that of the US<sup>10-14</sup>
- Hospitalization rates for exacerbations among COPD patients range from **~32% to 61%** across the EU, with **~24%** of patients returning to the ED within 30 days<sup>10-14</sup>

# US Market Research: Obtaining Acute Treatment Indications Results in Significantly Greater Penetration into Asthma and COPD Markets

## Clinician Perspectives Highlight Rademikibart's Differentiated Profile

- U.S. Clinicians believed the acute indication was a clear differentiator between rademikibart and other biologics approved for patients with eosinophilic phenotype
- Once patients were successfully treated with rademikibart acutely, clinicians expected to maintain 75% of these patients on rademikibart chronically

## Persistent Unmet Need with Opportunity to Penetrate Acute Setting

- Dupixent not labeled for treatment of acute symptoms or acute exacerbations of asthma or COPD\*
- New high-yield manufacturing process for rademikibart will allow for hospital-friendly pricing in the acute setting

## Significant Commercial Opportunity

- Acute and chronic asthma indications resulted in WW peak sales forecast of >\$3B (base case)
- Acute and chronic COPD indications resulted in WW peak sales forecast of >\$2B (base case)
- Upside opportunities exist for rademikibart to drive revenue even higher (e.g., steroid sparing opportunity)

## Strong Rationale Supporting Rademikibart

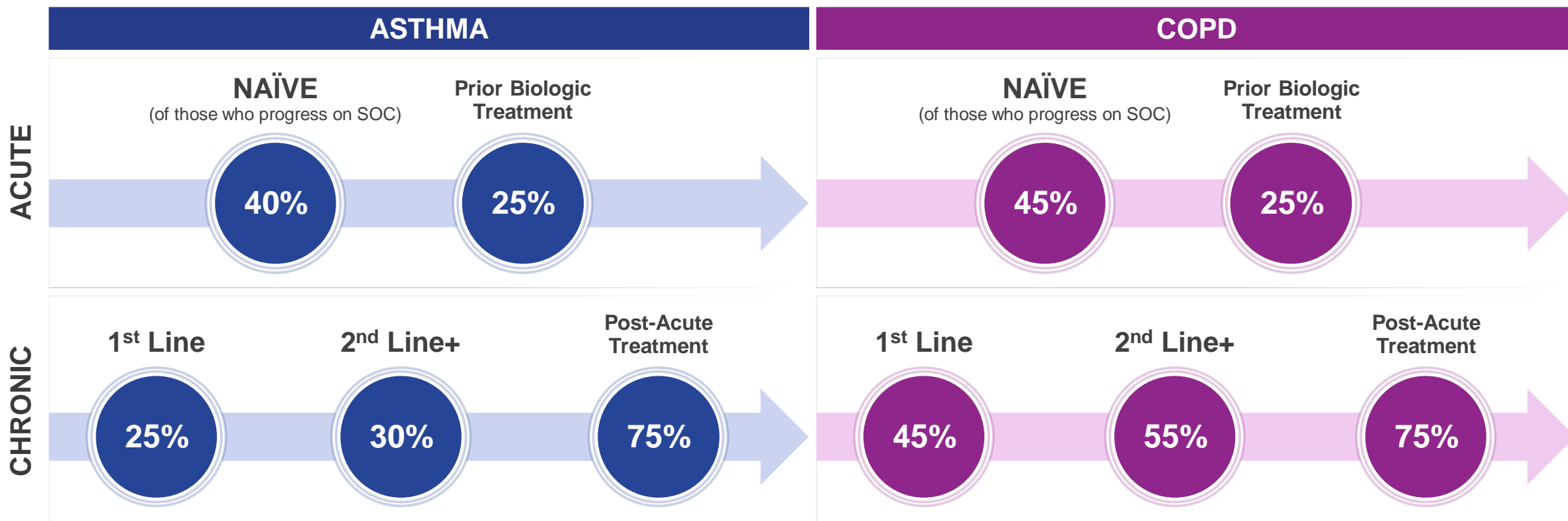
- Approval of dupilumab for chronic treatment of COPD in US and EU provides evidence for rademikibart's MOA to treat chronic COPD, further confirmed in COPD-like patients from global asthma study WW002
- ABRA benralizumab study provides higher level of confidence in obtaining a positive outcome in planned Phase 2 acute asthma and COPD studies\*\*

\*DUPIXENT US Package Insert Revised September 2024, \*\* Ramakrishnan et al; *Lancet Respir Med* 2024; Published Online Nov 27, 2024

COPD=chronic obstructive pulmonary disease; WW = worldwide; EU = European Union; MOA = mechanism of action; COPD-like patients had asthma onset age > 40 year and post-bronchodilator FEV<sub>1</sub>/forced vital capacity < 0.7 at screening visit

# Rademikibart Expected Utilization in Asthma and COPD

Clinicians considered Rademikibart to be differentiated from other biologics by the dual indication



“ Steroids and LABAs/LAMAs work well for these acute patients, so I wouldn't really use this up front. But for those patients that are refractory to those options and need something stronger, then I'd definitely use this. ”

“ If a patient was treated with Product X during their acute exacerbation and it worked, then I'd keep them on it for maintenance. If they responded, why would I switch? ”

Source: US HCP and Payer Qualitative Primary Research, HCP N=20, Payer N=10, October 2024.

NOTE: Percentages represent brand shares and do not account for earlier population cuts (e.g., pharmacologic treatment rate, biologic class share, progression rates, etc.)

COPD = chronic obstructive pulmonary disease; LABA = long-acting beta-agonist; LAMA = long-acting muscarinic antagonist

# There Remains Significant Unmet Need for Better Treatment Options to Improve Patient Outcomes & Reduce Burden on Healthcare Systems

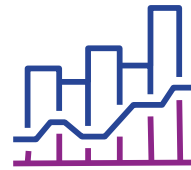


## EXACERBATION RECURRENCE

Reduction in overall frequency of ED visits

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Management of severe exacerbations and the prevention of hospital readmissions remain challenging with ~50% of patients having another exacerbation within 4 weeks of discharge



## HOSPITALIZATION AND RE-ADMISSION RATES

Decrease the Proportion of Patients Admitted

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>100,000 asthma patients and >500,000 COPD patients are hospitalized upon presentation to the ED with an exacerbation in the US annually



## BIOLOGICS / ADVANCED THERAPIES

Deliver Improved Efficacy Over SoC

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There has been a lack of innovation in the acute, inpatient setting with >50% of patients failing to improve on frontline SoC

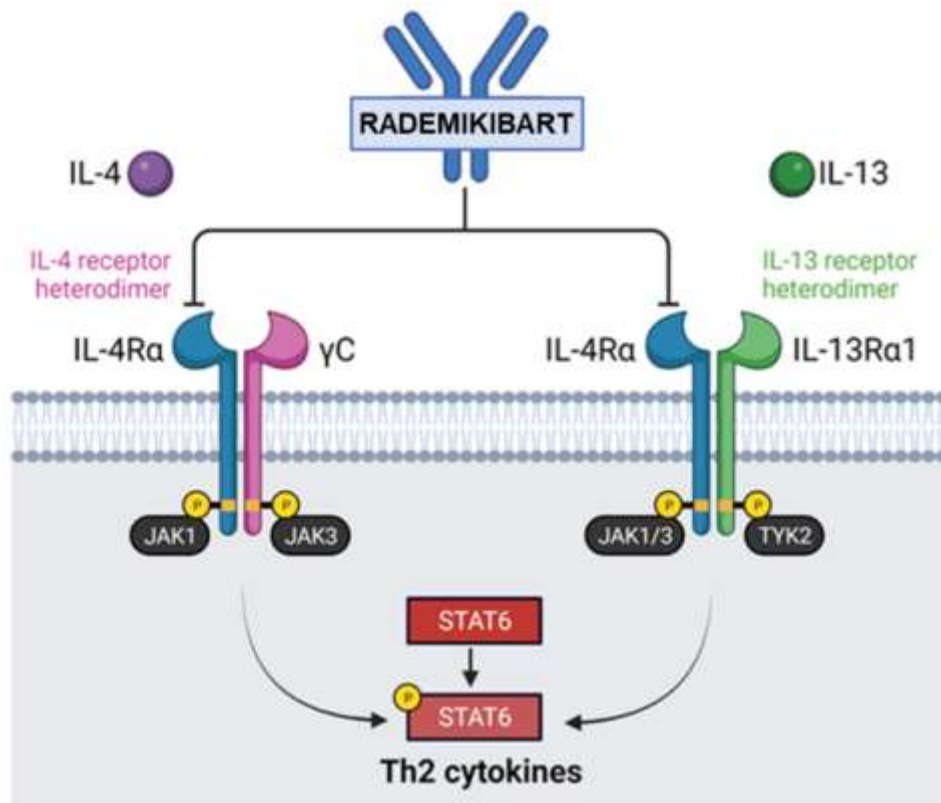
**Rademikibart has the potential to address the unmet needs above resulting in projected peak worldwide sales of: >\$3B for asthma | >\$2B for COPD**



# Rademikibart:

A Next Generation Anti-interleukin-4  
-receptor alpha (IL-4R $\alpha$ ) Antibody

# Rademikibart: Next Gen IL-4R $\alpha$ Blocker Shows Potential For Less Frequent Dosing, Greater Sustained Efficacy Data, and Faster Onset Observed in Asthma Trials



Rademikibart is a novel, human monoclonal IgG4 antibody directed against IL-4R $\alpha$ , a common subunit for IL-4 and IL-13 receptors. Blockade of IL-4 and IL-13 binding to IL-4R $\alpha$  results in inhibition of both IL-4 and IL-13 signaling.

## Rademikibart Characteristics

- Engaging with distinct epitopes associated with a higher binding affinity to the IL-4R $\alpha$ <sup>1</sup>
- Highly potent IC<sub>50</sub> in:
  - Reducing JAK-STAT signaling<sup>1,a</sup>
  - Cell proliferation<sup>1,a</sup>
  - TARC release<sup>1,a</sup>

## Potential Clinical Relevance

- Greater clinical response
- Faster onset of action
- Less frequent dosing

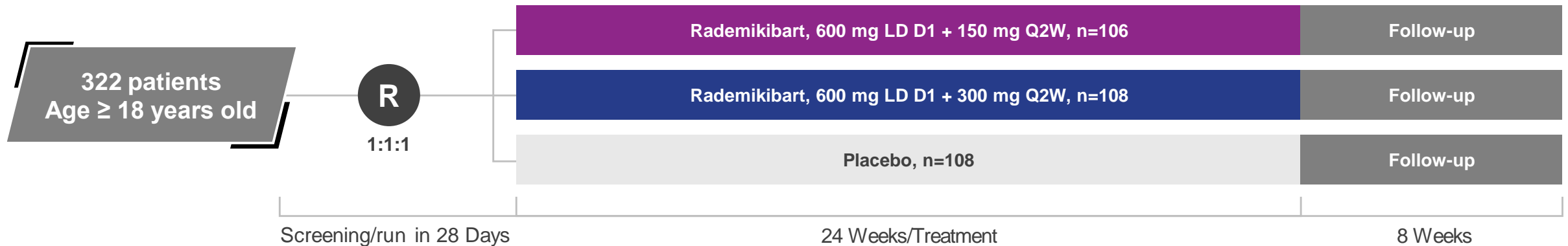
AD=atopic dermatitis; COPD=chronic obstructive pulmonary disease; IC50=half-maximal inhibitory concentration; IL=interleukin; JAK=janus kinase; STAT=signal transducers and activators of transcription; TARC=thymus- and activation-regulated chemokine.

<sup>a</sup>Based on head-to-head in vitro comparison with dupilumab.

1. Zhang L, et al. Sci Rep. 2023 ;13(1):12411.

# Robust Data from Completed Global Phase 2b Study in Moderate-to-Severe Asthma Patients

## Efficacy and Safety Study of CBP-201 (rademikibart) in Patients With Moderate to Severe Persistent Asthma (NCT04773678)



### Key Inclusion Criteria:

- Moderate to severe uncontrolled asthma
  - Existing treatment with medium to high dose ICS in combination with a second controller (e.g., LABA, LTRA, or theophylline) for at least 3 months with a stable dose ≥1 month prior to the screening visit.
  - Pre-bronchodilator FEV<sub>1</sub> 40 to 85% of predicted normal at Visits 1 and 2, prior to randomization.
  - Screening or historical blood eosinophil count ≥150 cells/μL (amended to ≥300 cells/μL)
    - No eosinophil count requirement for patients on maintenance OCS
  - ACQ score ≥1.5 at Visits 1 and 2, prior to randomization.
  - At least 1 documented asthma exacerbation in the 12 months prior to the date of informed consent that required use of a systemic corticosteroid

### Primary Endpoints:

- Change from Baseline in FEV<sub>1</sub> at Week 12 (in clinic with central overread)

### Secondary Efficacy Endpoints:

- Change from Baseline in FEV<sub>1</sub> at other timepoints
- Asthma Exacerbations
- PROs (ACQ, symptom diary, at-home lung function)
- PD markers (FENO, eosinophils, ECP, periostin, TARC)
- Rescue medication use

<https://doi.org/10.1164/rccm.202409-1708OC>

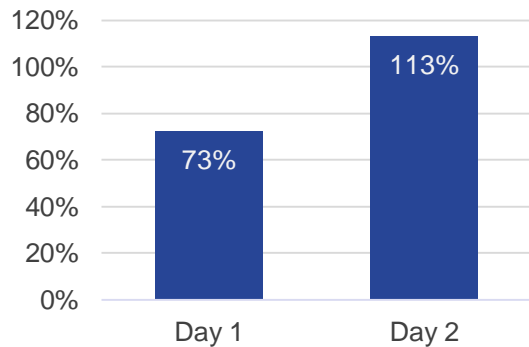
Abbreviations: ACQ=Asthma Control Questionnaire; ECP = eosinophilic cationic protein; FENO = fractional exhaled nitric oxide; FEV<sub>1</sub>=Forced expiratory volume at 1 second; ICS = inhaled corticosteroids; LABA = long-acting β-agonist; LTRA = leukotriene receptor antagonists; OCS = oral corticosteroids; TARC = thymus and activation-regulated chemokine.

# Rapidly Improved and Sustained FEV<sub>1</sub> Values Observed with Rademikibart Treatment

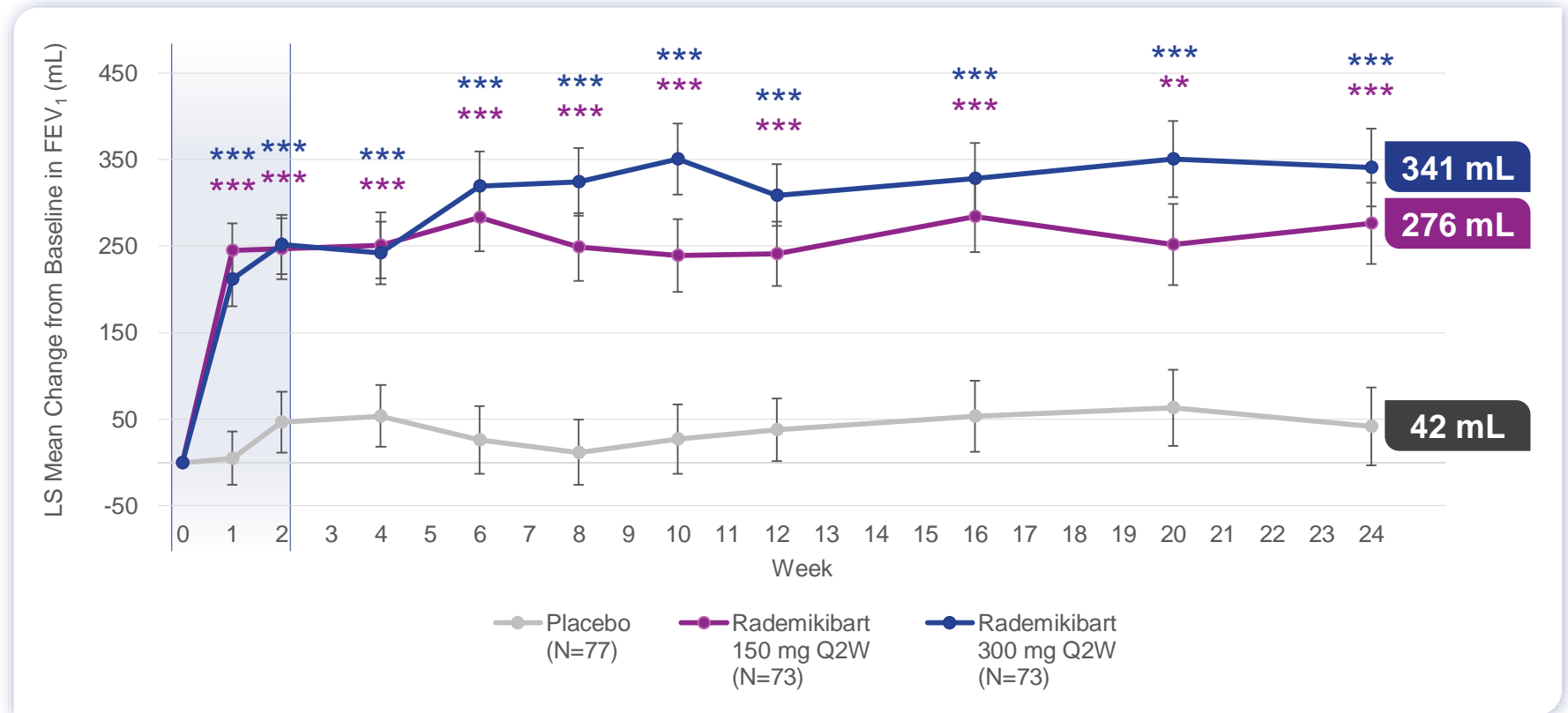
Rademikibart treatment associated with rapid, significant changes in FEV<sub>1</sub> as early as Week 1, which were sustained for the duration of the 24-week study

Home daily lung function data demonstrated 73% of improvement seen on Day 7 was observed by Day 1, with 113% by Day 2:

Percent of Day 7 Change in FEV<sub>1</sub>

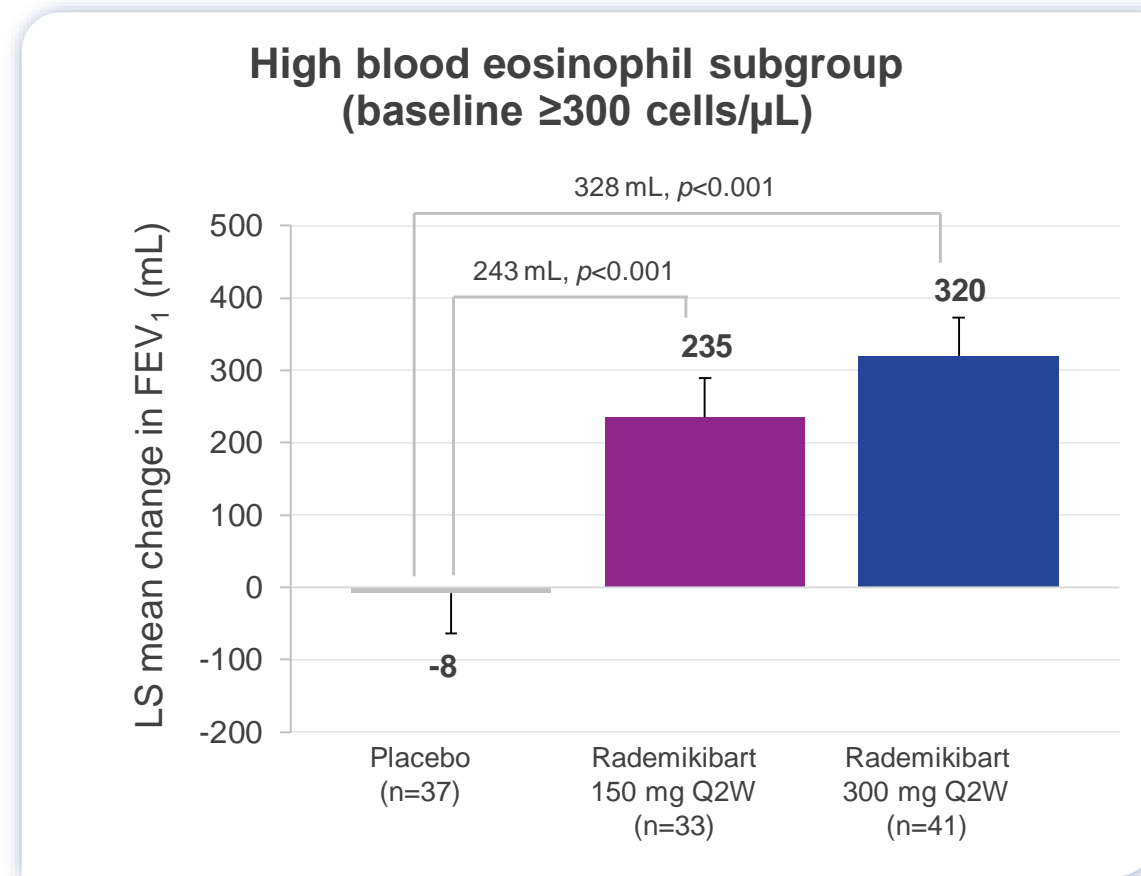
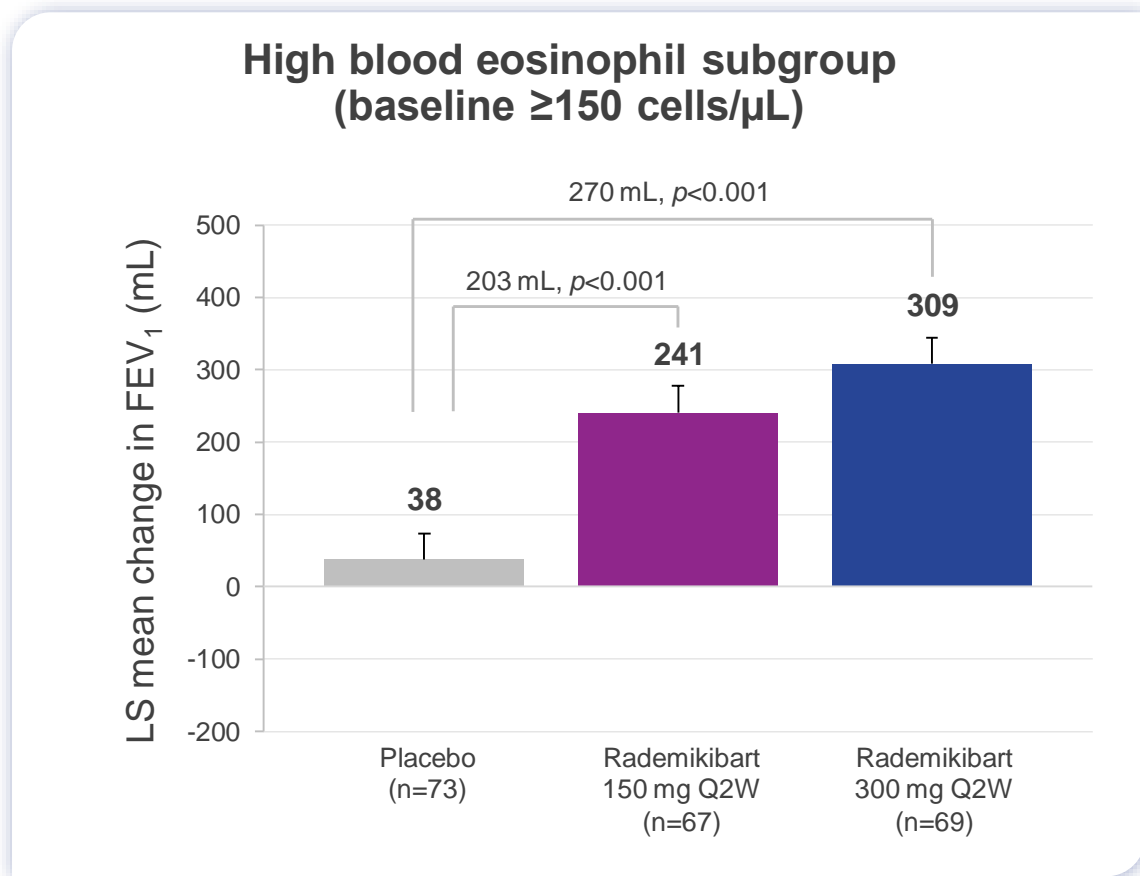


Change in Pre-bronchodilator FEV<sub>1</sub> over time in Patients with an Eosinophil Count ≥150 cells/μL at Baseline



\*\*\*p<0.001, \*\*p<0.01, \*p<0.05. Data were analyzed with ANCOVA  
FEV<sub>1</sub> = Forced expiratory volume in one second.

# Rademikibart Significantly Improved Lung Function at Week 12 with Enhanced Efficacy over Placebo in High Eosinophil Patients



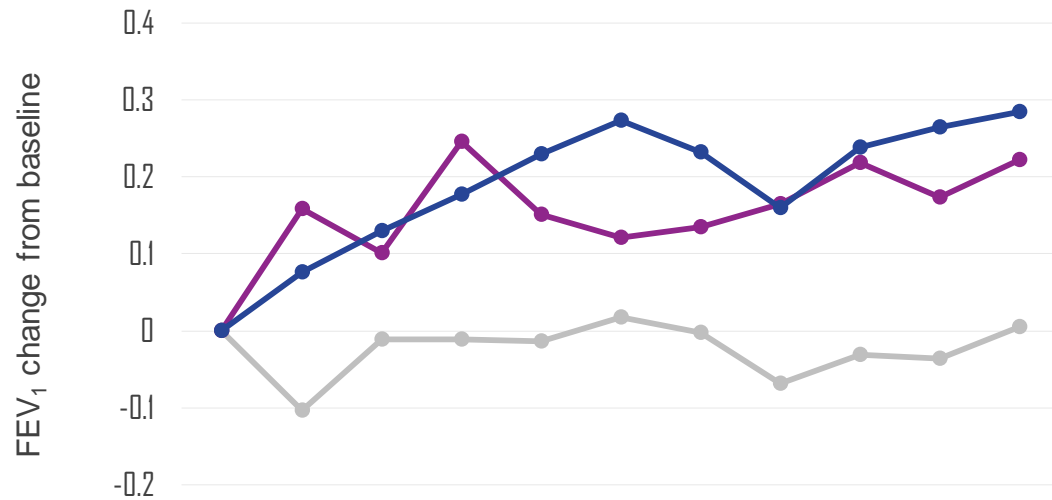
Error bars = standard error.

n, number of patients with data at Week 12. FEV<sub>1</sub> = Forced expiratory volume in one second. Q2W, every other week. Data were analyzed with ANCOVA

# Analysis of COPD-Like Patients from Global Phase 2b Asthma Study

Asthma onset age > 40 year and post-bronchodilator FEV<sub>1</sub>/forced vital capacity < 0.7 at screening visit

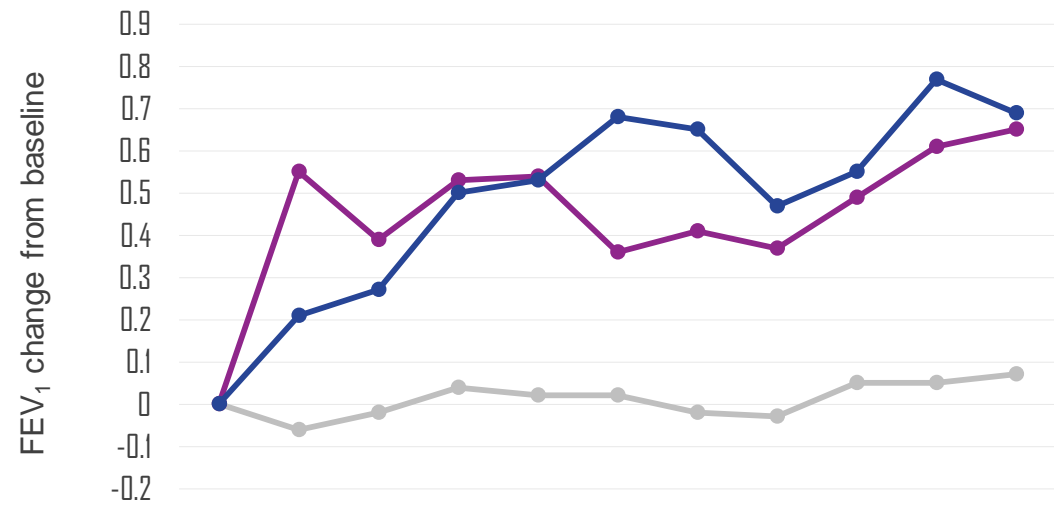
## COPD-like Patients All EOS levels



Week	1	2	4	6	8	10	12	16	20	24
Placebo (N)	27	24	24	26	23	25	26	23	23	22
150 mg (N)	17	16	16	16	15	13	14	17	14	14
300 mg (N)	19	21	19	19	17	20	18	16	19	17

Legend: Placebo (grey), CBP-201 150 mg (purple), CBP-201 300 mg (blue)

## COPD-like Patients EOS ≥300 cells/uL



Week	1	2	4	6	8	10	12	16	20	24
Placebo (N)	8	8	7	8	6	8	8	7	7	7
150 mg (N)	5	5	5	4	3	4	4	5	3	3
300 mg (N)	6	7	6	7	6	7	5	6	6	6

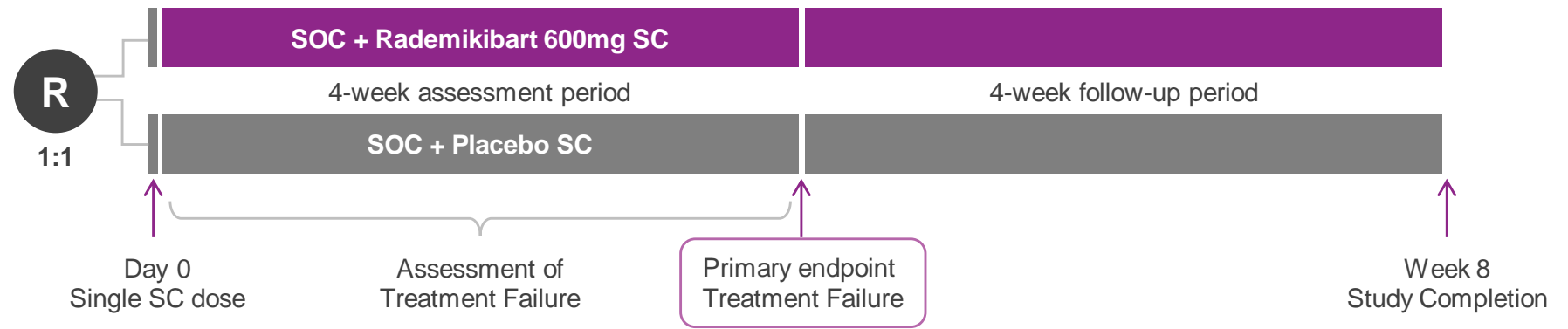
Legend: Placebo (grey), Rademikibart 150 mg (purple), Rademikibart 300 mg (blue)

EOS = eosinophils. FEV<sub>1</sub> = Forced expiratory volume in one second

# Replicate Phase 2 Clinical Trials of Rademikibart for Treatment of Acute Exacerbations of Chronic Respiratory Disease



160 subjects\*\*



	Population		Primary Endpoint	Secondary Endpoints	Key Exploratory Endpoints
<b>Seabreeze ASTHMA STAT</b>	Adolescents and adults at urgent outpatient visit, ED or hospital	Eosinophil count of $\geq 300$ cells/ $\mu$ L, $\geq 1$ exacerbation in prior 12 months	Treatment Failure (28 days after randomization): includes death (any cause), (re)admission to hospital, urgent visit to outpatient/ED provider for symptom worsening, or necessity to intensify pharmacologic treatment.	Rate of exacerbations and Time to new exacerbation; absolute change in post-bronchodilator FEV1; mean change in respiratory symptoms. Safety	Time to ready for discharge in hospitalized patients, disease specific-PROs
<b>Seabreeze COPD STAT</b>	Adults at urgent outpatient visit, ED or hospital				

\*Study design pending FDA feedback

\*\*Interim analysis for sample size re-estimation after 80 subjects complete 4-week assessment period

# Recent Investigator-Initiated Trial Validated Acute Exacerbation Study Approach and Provides a Roadmap to Improve Our Planned Acute Trials

## Treating eosinophilic exacerbations of asthma and COPD with benralizumab (ABRA): a double-blind, double-dummy, active placebo-controlled randomised trial

Sorajy Ramakrishnan, Richard E K Russell, Hafiz R Mahmood, Karolina Krassowska, James McIlham, Christine Mawesuku, Ian D Poyard, Laura Bernabeu-Sanchez, Imran Howel, Mahdi Mahdi, Stefan Petersen, Thomas Bengtsson, Mona Rafiqul

### Summary

**Background** Exacerbations of asthma and chronic obstructive pulmonary disease (COPD) are important events and are associated with critical illness. Eosinophilic inflammation is a treatable trait commonly found during acute exacerbations of asthma and COPD. We hypothesised that for patients with eosinophilic exacerbations, a single injection of benralizumab, a humanised monoclonal antibody against interleukin-5 receptor- $\alpha$ , alone or in combination with prednisolone, will improve clinical outcomes compared with prednisolone, the standard of care.

**Methods** The Acute exacerbations treated with Benralizumab trial (ABRA) was a multicentre, phase 2, double-blind, double-dummy, active placebo-controlled randomised trial completed in the UK at Oxford University Hospitals NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. Patients were recruited from urgent care clinics and emergency departments of these two hospitals. At the time of an acute exacerbation of asthma or COPD, adults with blood eosinophil counts of equal to or more than 300 cells per  $\mu$ L were randomly assigned in a 1:1:1 ratio to receive acute treatment with: prednisolone 30 mg once daily for 5 days and 100 mg benralizumab subcutaneous injection once (BENRA plus PRED group); placebo tablets once daily for 5 days and 100 mg benralizumab subcutaneous injection once (BENRA group); or prednisolone 30 mg once daily for 5 days and placebo subcutaneous injection once (PRED group). Randomisation was performed with a centralised interactive computer randomisation service. All patients and study research staff involved in data collection were masked to study blood results and treatment allocation. The co-primary outcomes were proportion of treatment failures over 90 days and total visual analogue scale (VAS) symptoms at day 28 in the pooled benralizumab groups compared with the prednisolone alone group and analysed in the intention-to-treat population. The trial was registered on ClinicalTrials.gov NCT04098718.

**Findings** Between May 13, 2021, and Feb 5, 2024, 287 patients were screened for study inclusion. 129 were excluded due to not having an exacerbation captured or not meeting the eosinophil exclusion criteria. 158 patients were randomly assigned at acute eosinophilic exacerbation of asthma or COPD where 86 (54%) patients were female and 72 (46%) were male with a mean age of 57 years (range, 18–84). 53 patients were randomly assigned to the PRED group, 53 were randomly assigned to the BENRA group, and 52 were assigned to the BENRA plus PRED treatment group. At 90 days, treatment failures occurred in 39 (74%) of 53 in the PRED group, and 47 (45%) of 105 in the pooled-BENRA group (OR 0.26 [95% CI 0.13–0.56];  $p=0.0005$ ). The 28-day total VAS mean difference was 49 mm (95% CI 14–84;  $p=0.0065$ ), favouring the pooled-BENRA group. There were no fatal adverse events and benralizumab was well tolerated. Notably, hyperglycaemia and sinusitis or sinus infection adverse events were related to the prednisolone study drug only.

**Interpretation** Benralizumab can be used as a treatment of acute eosinophilic exacerbations and achieves better outcomes than the current standard of care with prednisolone alone. These results offer a new way of treating eosinophilic endotypes of asthma and COPD exacerbations.



Lancet Respir Med 2024

Published Online

November 27, 2024

[https://doi.org/10.1016/S2213-2600\(24\)00199-4](https://doi.org/10.1016/S2213-2600(24)00199-4)

[https://doi.org/10.1016/S2213-2600\(24\)00199-4](https://doi.org/10.1016/S2213-2600(24)00199-4)

See Online/Comment

[https://doi.org/10.1016/S2213-2600\(24\)00199-4](https://doi.org/10.1016/S2213-2600(24)00199-4)

[https://doi.org/10.1016/S2213-2600\(24\)00199-4](https://doi.org/10.1016/S2213-2600(24)00199-4)

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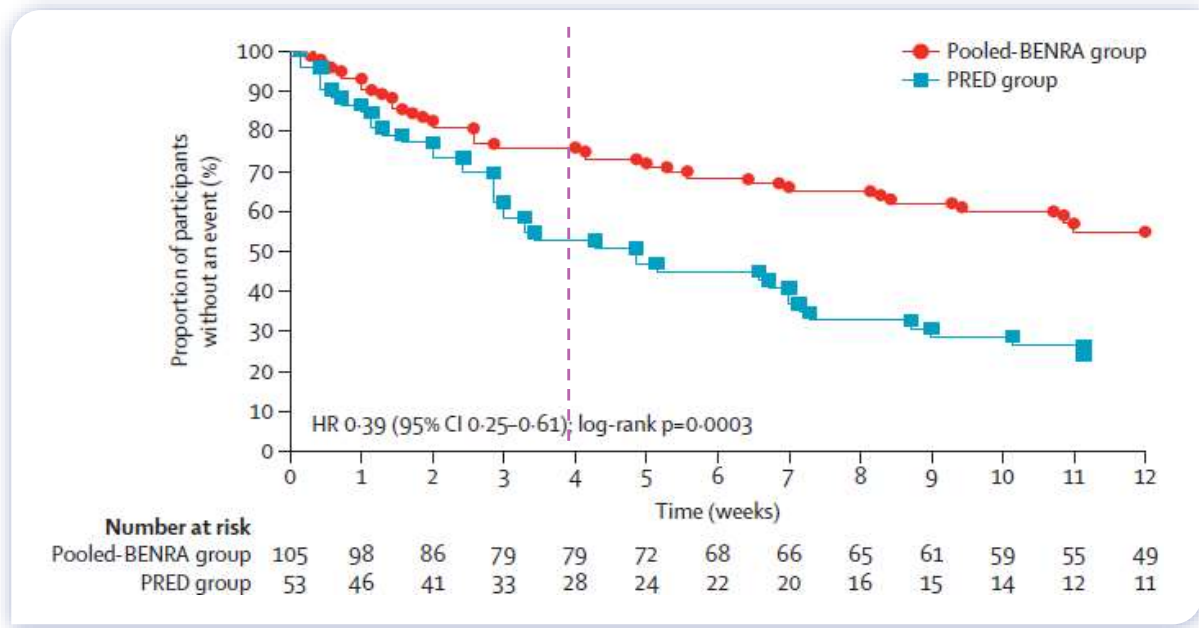
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- ~45% of SOC + placebo experienced treatment failure criteria by 4 weeks
- Benralizumab reduced treatment failure at 30 days by 50%
- Little separation in the first 3-weeks indicating slow onset of effect of benralizumab
- Based on published data, rademikibart may be more effective than benralizumab at improving overall lung function (FEV<sub>1</sub>)



# Competitive Landscape of Placebo Adjusted Improvement from Baseline In Pre-bronchodilator FEV<sub>1</sub>

## Rademikibart exhibited best-in-class potential in lung function improvement

Source	MoA	Product	FDA Approv. in last 10 yrs	Study	N (Pbo/Tx)	% patients with EOS ≥300 cells/μL	Week	First response week	Placebo adjusted improvement from baseline in FEV <sub>1</sub>	Placebo adjusted improvement from baseline in FEV <sub>1</sub> (EOS ≥300 cells/μL)
Phase 2b	IL-4Rα	Rademikibart	--	Phase 2b Asthma	108/108	46.3%	12	1	270 mL*	328 mL
							24		299 mL*	420 mL
				COPD-Like Patients†	27/19	31.6%	12	1	228 mL	500 mL
							24		290 mL	620 mL
Biologic Phase 3 trial results	IL-4Rα	Dupilumab	2018	Asthma: QUEST <sup>1</sup>	231/633	41.8%	12	2	130 mL	240 mL
			2024	COPD: NOTUS <sup>5</sup>	465/470	60.8	12	2	82 mL	113 mL
	IL-5Rα	Benralizumab	2017	SIROCCO <sup>3</sup> Q4W	407/399	68.9%	48	4	--	106 mL
				CALIMA Q4W <sup>6</sup>	440/425	67.5%	56		--	125 mL
	IL-5	Reslizumab	2016	STUDY 1 <sup>2</sup>	244/245	--	52	4	126 mL	--
				STUDY 2 <sup>2</sup>	232/232	--			90 mL	--
	TSLP	Tezepelumab	2021	NAVIGATOR <sup>4</sup>	528/531	41.5%	52	2	130 mL	230 mL

**For Illustrative Purposes Only: Not a head-to-head trial. Differences exist between trial designs, subject characteristics and geographical regions – caution should be exercised when comparing data across trials**

EOS=eosinophils; FDA=Food and Drug Administration; FEV<sub>1</sub> = Forced expiratory volume in one second; IL=Interleukin; MoA=mechanism of action; Pbo=Placebo; TSLP=thymic stromal lymphopietin; Tx=treatment group.

\*EOS ≥150 cell/μL

†Patients from Phase 2 asthma study with asthma onset age > 40 year and post-bronchodilator FEV<sub>1</sub>/forced vital capacity < 0.7 at screening visit

1. QUEST – Castro M et al. N Engl J Med 2018;378:2486-96. 2. STUDY 1&2- Castro M et al. Lancet Respir Med. 2015 May;3(5):355-66. 3. SIROCCO – Bleecker ER et al. Lancet. 2016 Oct 29;388(10056):2115-2127. 4. NAVIGATOR – Menzies-Gow A et al N Engl J Med 2021;384:1800-9. 5. NOTUS – Bhatt et al N Engl J Med 2024;390:2274-2283; 6. CALIMA – FitzGerald JM et al. Lancet 2016 Sept 5; S0140-6736(16)31322-8

# Substantially Fewer Hyper-Eosinophilia Episodes with Rademikibart than with Dupilumab

	Ph2b Rademikibart Trial		Dupilumab QUEST Trial <sup>1</sup>	
	Placebo (N=108)	Rademikibart (N=108)	Placebo (N=634)	Dupilumab (N=1263)
<b>Baseline EOS &lt;500, n</b>	<b>91</b>	<b>85</b>	<b>484</b>	<b>497</b>
<i>Post-baseline peak &gt;1500 EOS</i>	1.1%	0%	2.7%	6.6%
<i>Post-baseline peak &gt;3000 EOS</i>	0%	0%	0%	1.20%
<b>Baseline EOS ≥500, n</b>	<b>16</b>	<b>20</b>	<b>149</b>	<b>114</b>
<i>Post-baseline peak &gt;1500 EOS</i>	18.8%	10.0%	17.4%	42.5%
<i>Post-baseline peak &gt;3000 EOS</i>	0%	0%	2.7%	12.9%
<b>Safety</b>				
Eosinophil related TEAEs	0%	0%	0.6%	4.0%

Rate with rademikibart is lower than placebo

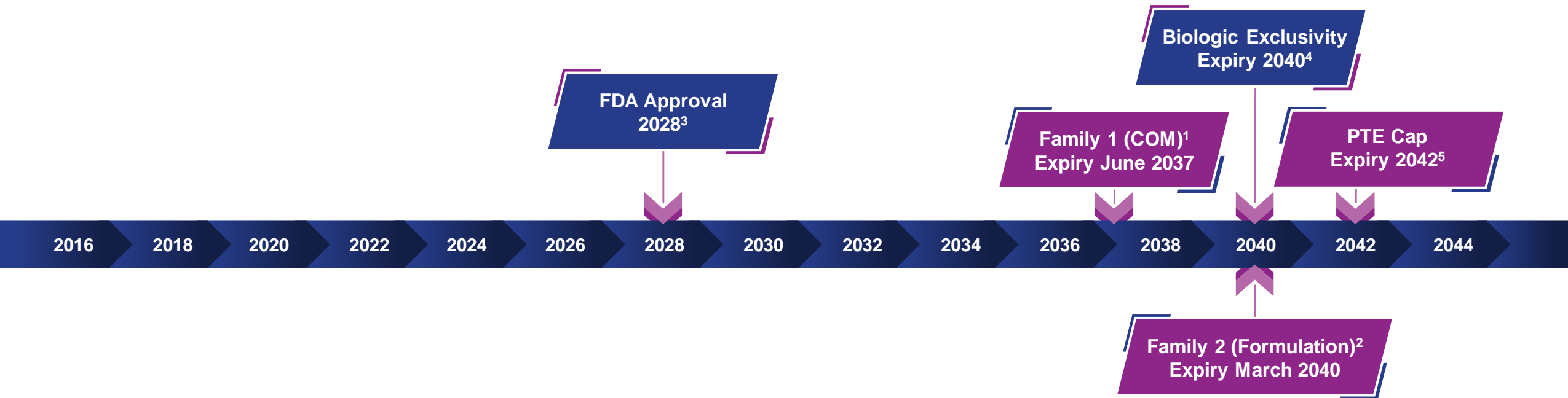
>2x the placebo rate and >4x the rate seen with rademikibart

# Comprehensive Data Package Sufficient to Move Quickly into Phase 3 Once the Planned Phase 2 Studies are Completed

Study	Status	Outcomes
<b>CMC &amp; Improved Manufacturing Process</b>	Tech Transfer to US CMO Completed	<ul style="list-style-type: none"> <li>Initial manufacturing process successfully transferred to US CMO. New high-yield cell-line developed and will be transferred 2H2025</li> </ul>
<b>Phase 2b Asthma</b>	Completed	<ul style="list-style-type: none"> <li>Significantly improved lung function at week 12 in patients with moderate-to-severe asthma maintained through 24 weeks</li> <li>Rapidly improved and sustained FEV<sub>1</sub> values observed with rademikibart treatment as early as 24 hours</li> <li>Rademikibart produced &gt;60% lower annualized rate of exacerbations compared to placebo</li> </ul>
<b>Phase 2 Acute Asthma</b>	Planned	<ul style="list-style-type: none"> <li>1-month Phase 2 study evaluating rademikibart + SOC against SOC + placebo that will enroll patients with asthma having an acute exacerbation</li> <li>Primary Endpoint: treatment failure through 28 days</li> </ul>
<b>Phase 2 Acute COPD</b>	Planned	<ul style="list-style-type: none"> <li>1-month Phase 2 study evaluating rademikibart + SOC against SOC + placebo that will enroll patients with COPD having an acute exacerbation</li> <li>Primary Endpoint: treatment failure through 28 days</li> </ul>

# Rademikibart Exclusivity Timeline

**Exclusive global development & commercialization rights (outside of greater China) supportive of substantial growth and value creation**



- Regulatory Exclusivity
- Patent Exclusivity

1. Granted U.S. Patents (10,774,141 & 11,866,491 (603 days PTA)) 2. Pending U.S. patent application 3. Estimated date of FDA approval 4. 12 years biologic exclusivity 5. 14 years maximum PTE



# There Remains Significant Unmet Need for Better Treatment Options to Improve Patient Outcomes & Reduce Burden on Healthcare Systems

## DIFFERENTIATED RAPID EFFICACY, IMPRESSIVE SUSTAINED RESPONSE AND SAFETY

- Rademikibart treatment achieves rapid and significant changes in FEV<sub>1</sub> as early as 24 hours post loading dose
- FEV<sub>1</sub> response is sustained over 24 weeks
- Rademikibart is generally well tolerated

## SIGNIFICANT COMMERCIAL OPPORTUNITY

- ~1M and ~1.3M ED visits per year and >100K and >500K hospitalizations annually by adult patients with asthma and COPD in the US, respectively
- Rademikibart has the potential to be the first biologic to treat patients with acute asthma and COPD exacerbations
- Potential to drive significant chronic utilization with differentiated acute indications
- Opportunity for significant healthcare cost savings by reducing the number of re-hospitalizations, annualized days of hospitalization and possibly reducing length of stay for both asthma and COPD

## SIGNIFICANT COMMERCIAL OPPORTUNITY

- Based on the Target Product Profile with both acute and chronic indication for both asthma and COPD, rademikibart has the potential to produce substantial revenue. Independent market research projects peak worldwide revenue of:
  - **>\$3B for asthma**
  - **>\$2B for COPD**

## Renewed Focus on U.S. Clinical Execution

- **Announced new U.S.-based leadership** with a history of late-stage clinical and regulatory execution
- **Transforming Connect into a U.S.-centric company**, significantly reducing presence in China
- **Focused clinical development on highest value opportunity** in acute asthma with no competition

## Catalysts

- ✓ Obtain FDA alignment for acute asthma and COPD studies
- ✓ Adopt U.S. filings with the SEC
- Initiate Phase 2 acute asthma and COPD studies
- Complete Phase 2 acute exacerbation studies in 1H2026

**Strong Financial Position:** Cash, cash equivalents, and short-term investments of \$93.7 million as of December 31, 2024 expected to support planned operations, including the acute asthma and COPD studies, into 2027

# Financial Summary

Cash, cash equivalents and short-term investments of \$84.0 million expected to support planned operations into 2027

<b>Summary Statement of Operations and Net Cash Used in Operations</b> (In thousands, expect per share data)	<b>Three Months Ended March 31, 2025</b>
Operating expenses <sup>1</sup>	(\$11,447)
Other income, net	1,229
Income tax expense	(54)
Net loss <sup>1</sup>	(\$10,272)
Basic and diluted net loss per share <sup>2</sup>	(\$0.19)
Net cash used in operations	(\$9,959)
<b>Condensed Balance Sheet Data</b> (In thousands)	<b>March 31, 2025</b>
Cash, cash equivalents and short-term investments	\$83,995
Total assets	\$92,685
Total shareholders' equity	\$82,899

<sup>1</sup> Includes \$0.9 million of non-cash, share-based compensation expense for the three months ended March 31, 2025.

<sup>2</sup> Based on 55.4 million weighted-average ordinary shares outstanding for the three months ended March 31, 2025.



**NASDAQ: CNTB**