Corporate Update

September 2026

Forward-Looking Statements

This presentation contains “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995, as amended (the “Act”). Forward-looking statements are statements that are not of historical fact and include, without limitation, statements regarding future events, our future financial condition, results of operations, business strategy and plans, prospective products (as well as their potential to achieve a differentiated, competitive, or favorable benefit or profile or trend, including on safety, tolerability, improvement, maintenance, clinical response, dosing, efficacy and/or convenience), planned or expected product approval applications or approvals, anticipated milestones, expected data readouts and enrollments, research and development plans and costs, potential future partnerships, expectations about existing partnerships, timing and likelihood of success, objectives of management for future operations, future results of anticipated product development efforts, and adequacy of existing cash and potential partnership funding to fund operations and capital expenditure requirements, as well as statements regarding industry trends. These statements are based on management’s current expectations of future events only as of the date of this presentation and are inherently subject to a number of risks, uncertainties and assumptions, some of which cannot be predicted or quantified and some of which are beyond our control, including, among other things: the ability of our clinical trials to demonstrate safety and efficacy of our product candidates and other positive results; whether we will need expanded or additional trials in order to obtain regulatory approval for our product candidates; our ability to obtain and maintain regulatory approval of our product candidates; existing regulations and regulatory developments in the U.S., the UK, the PRC, Europe and other jurisdictions; the ability of our current cash and investments position to support planned operations; our plans and ability to obtain, maintain, protect and enforce our intellectual property rights and our proprietary technologies, including extensions of existing patent terms where available; our continued reliance on third parties to conduct additional clinical trials of our product candidates, and for the manufacture of our product candidates for preclinical studies and clinical trials; and the degree of market acceptance of our product candidates, if approved, by physicians, patients, healthcare payors and others in the medical community.

Words such as “aim,” “anticipate,” “believe,” “could,” “expect,” “feel,” “goal,” “intend,” “may,” “optimistic,” “plan,” “potential,” “promising,” “will,” and similar expressions are intended to identify forward-looking statements, though not all forward-looking statements necessarily contain these identifying words. The inclusion of forward-looking statements should not be regarded as a representation by Connect that any of its expectations, projections or plans will be achieved. Actual results may differ materially due to the risks and uncertainties inherent in Connect’s business and other risks described in Connect’s filings with the SEC. Further information regarding these and other risks is included under the heading “Risk Factors” in Connect’s annual and periodic reports filed with the SEC. These forward-looking statements should not be taken as forecasts or promises nor should they be taken as implying any indication, assurance or guarantee that the assumptions on which such forward-looking statements have been made are correct or exhaustive or, in the case of the assumptions, fully stated in this presentation. You are cautioned not to place undue reliance on the scientific data presented or these forward-looking statements, which speak only as of the date of this presentation. Except as required by law, Connect undertakes no obligation to publicly update any forward-looking statements, whether because of new information, future events or otherwise. Connect claims the protection of the safe harbor for forward-looking statements contained in the Act for all forward-looking statements.

This presentation discusses product candidates that are under clinical study, and which have not yet been approved for marketing by the U.S. Food and Drug Administration, the National Medical Products Administration or by any other regulatory agency. No representation is made as to the safety or effectiveness of these product candidates for the use for which such product candidates are being studied. The trademarks included herein are the property of the owners thereof and are used for reference purposes only. Such use should not be construed as an endorsement of such products.

A New Chapter in the Connect Biopharma Story

- Connect is advancing rademikibart, a next generation anti-interleukin-4-receptor alpha (IL-4Rα) for treatment of eosinophilic driven respiratory diseases, supported by positive results from a Phase 2b 24-week global asthma subcutaneous (SC) study and a Phase 1 single-dose (intravenous) IV study in asthma and COPD patients
- Topline results from Study 206 with patients experiencing an acute exacerbation of asthma showed:
  - 66% reduction in Treatment Failure (TxF) events compared to placebo by Day 28 (p=0.153)
  - Rapid, statistically significant increase in post-bronchodilator FEV_1 compared to placebo despite participants receiving maximal treatment (bronchodilator and systemic steroids) for exacerbations
  - Favorable safety profile
- Phase 2 asthma results provide a roadmap for Phase 3 development
- Goal is to meet with FDA in 4Q2026 to discuss Phase 3 plans for acute indications

A New Chapter in the Connect Biopharma Story (continued)

- Rademikibart also differentiated from dupilumab by a low risk of hypereosinophilia:
  - Reduces eosinophils in asthma patients vs increases observed with dupilumab, which reduces risk of SAEs associated with hypereosinophilia; this difference appears to be associated with greater internalization of rademikibart/receptor complex due to differential binding to the receptor
- Potential for less frequent dosing - Q4W dosing produced equal benefit versus Q2W dosing in atopic dermatitis (AD) Phase 2b study and single IV dosing showing sustained improvement in FEV_1 through 29 days
- Phase 3 AD study conducted in China at 52-weeks demonstrated:
  - 87.1% IGA 0/1, 96.6% EASI-75 and 85.3% EASI-90 responders
  - No difference to placebo in conjunctivitis rates
- No important, drug-related safety issues observed in over 2,000 participants in completed studies
- 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 labelled to not 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

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CBP-201-206

Rademikibart Add-on Treatment of an Acute Asthma Exacerbation (Seabreeze STAT Asthma)

Study 206 Preliminary Topline Results

- 66% reduction in Treatment Failure (TxF) events compared to placebo by Day 28
  - Although reduction in TxF observed with rademikibart was approximately 50% greater than projected, statistical significance not achieved (p=0.153) due to much lower overall rate of TxF events than projected from ABRA study* used to power Study 206
    - 45% TxF rate in ABRA control arm and 50% reduction in benralizumab arm used to power Study 206
    - TxF rate in placebo control arm in Study 206 was 7.4%; rademikibart arm TxF rate of 2.5% is 66% lower than placebo arm (50% greater difference than seen with benralizumab in ABRA at 28 days)
- Rapid, statistically significant increase in post-bronchodilator FEV_1 compared to placebo despite participants receiving maximal treatment (bronchodilator and systemic steroids) for exacerbations
- Favorable safety profile with low overall incidence of adverse events and no individual adverse event occurring in more than 2 participants.

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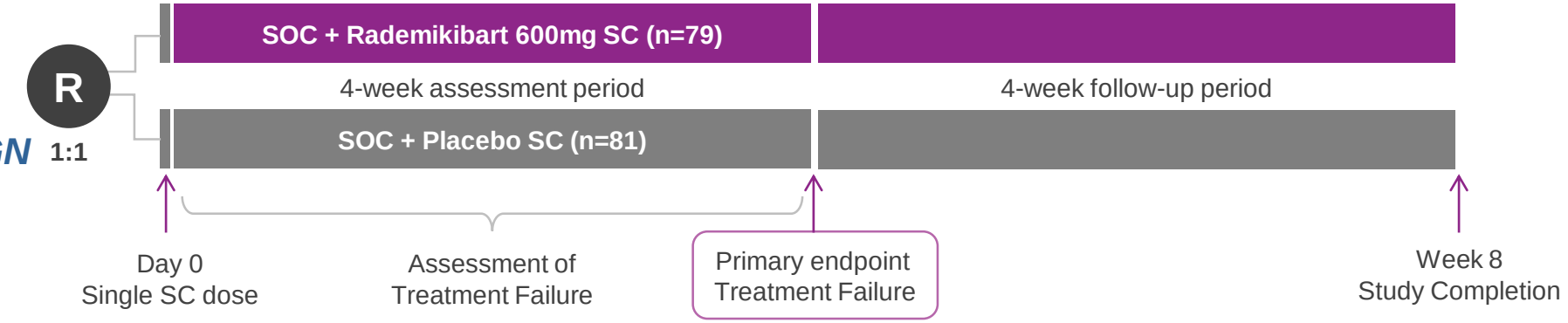
* Treating eosinophilic exacerbations of asthma and COPD with benralizumab (ABRA): double-blind, double-dummy, active placebo-controlled randomised trial

Phase 2 Clinical Trial of Rademikibart for Treatment of Acute Asthma Exacerbations

Seabreeze

STAT ASTHMA STUDY DESIGN



	Population		Primary Endpoint	Secondary Endpoints	Key Exploratory Endpoints
Seabreeze STAT Asthma	Adolescents and adults at urgent outpatient visit, ED or hospital	Eosinophil count of ≥ 300 cells/μL and ≥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.	•**KEY**: Absolute change from baseline in post-bronchodilator (BD) FEV1 at Wk 1; •Rate of exacerbations in 28 days •Time to new exacerbation in 28 days •Absolute change in post-BD FEV1 at Day 3 & Wk 4 •Mean change in respiratory symptoms. •Safety	•Time to ready for discharge in hospitalized patients •Disease specific-PROs

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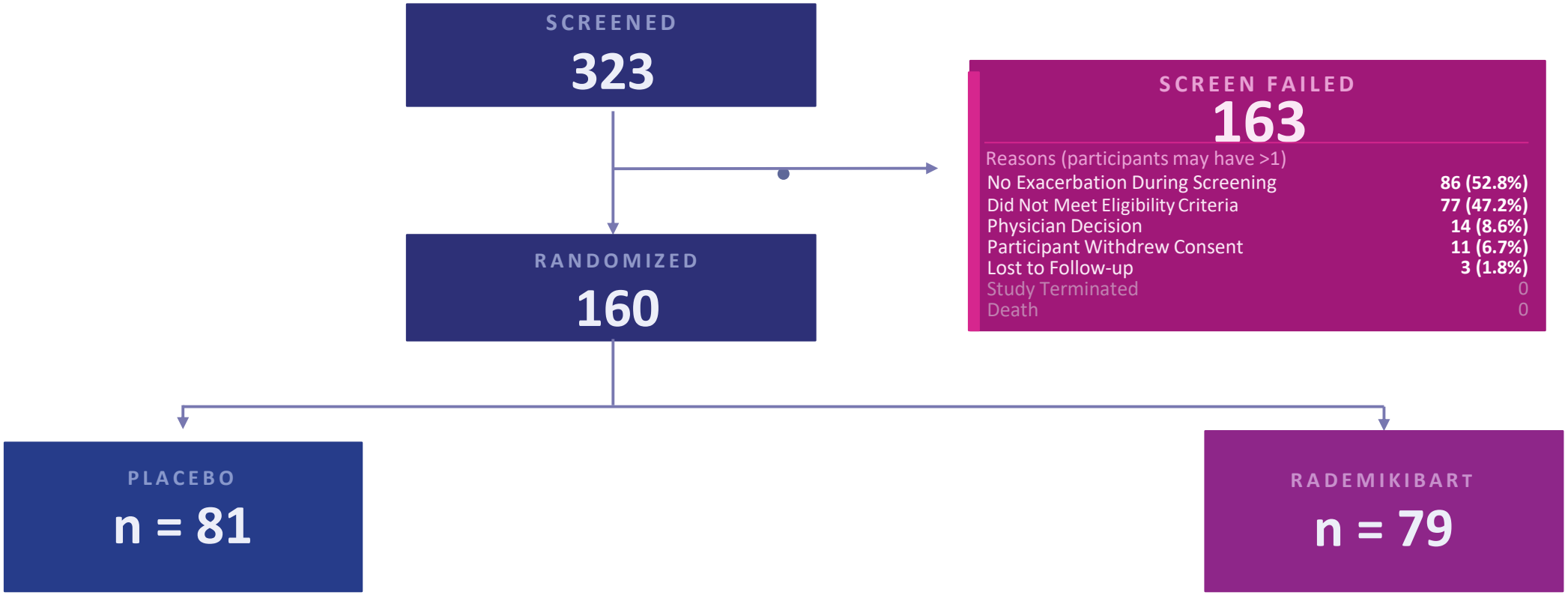
Abbreviations: COPD = Chronic obstructive pulmonary disease; FEV_1 = forced expiratory volume in 1 second; PRO =patient-reported outcome; SC = subcutaneous; SOC = standard of care:

Phase 2 Seabreeze STAT Asthma Study
Participant Disposition



Phase 2 Seabreeze STAT Asthma Demographics and Baseline Characteristics

		Placebo (N=81) n (%)	Rademikibart (N=79) n (%)
Age (years):	Mean (SD); Min, Max	57.1 (12.86); 13, 74	53.0 (13.01); 23, 73
Sex:	Female Male	45 (55.6%) 36 (44.4%)	53 (67.1%) 26 (32.9%)
Ethnicity:	Not Hispanic	69 (85.2%)	71 (89.9%)
Race:	White Black Asian & Other	80 (98.8%) 0 2 (2.5%)	73 (92.4%) 4 (5.1%) 2 (2.5%)
Smoking Status:	Former/Nonsmoker Current	79 (97.5%) 2 (2.5%)	77 (97.5%) 2 (2.5%)
Exacerbations in Prior 12 mos:	Mean (SD)	1.6 (0.97)	1.6 (0.88)
Baseline Eosinophil Count (cells/µL):	Mean (SD)	500 (300)	600 (460)
Baseline FeNO (ppb):		45.5 (51.88)	45.9 (43.58)
Country:	Serbia Georgia USA Argentina Great Britain Australia	41 (50.6%) 23 (28.4%) 5 (6.2%) 9 (11.1%) 2 (2.5%) 1 (1.2%)	40 (50.6%) 23 (29.1%) 9 (11.4%) 4 (5.1%) 2 (2.5%) 1 (1.3%)

Treatment Failure (TxF) Rate in Trial Lower than Projected
66% Reduction in TxF with Rademikibart 50% Greater Than Projected

	Placebo (n=81)	Rademikibart (n=79)	P-value
Treatment Failure Rate	6 (7.4%)	2 (2.5%) 66% reduction*	0.153
Death	0	0	
~~A~~dmission or readmission to hospital for asthma	0	0	
ED visit or unscheduled medical visit for worsening asthma symptoms	4 (4.9%)	2 (2.5%) 50% reduction	
Intensified pharmacologic treatment without hospital admission or ED/unscheduled medical visit	2 (2.5%)	0	

* Study 206 was powered based on 45% placebo arm TxF rate and approximately a 50% reduction observed for benralizumab arm in ABRA study
ED – Emergency Department.

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Number of New Exacerbations Also Lower in Study 206

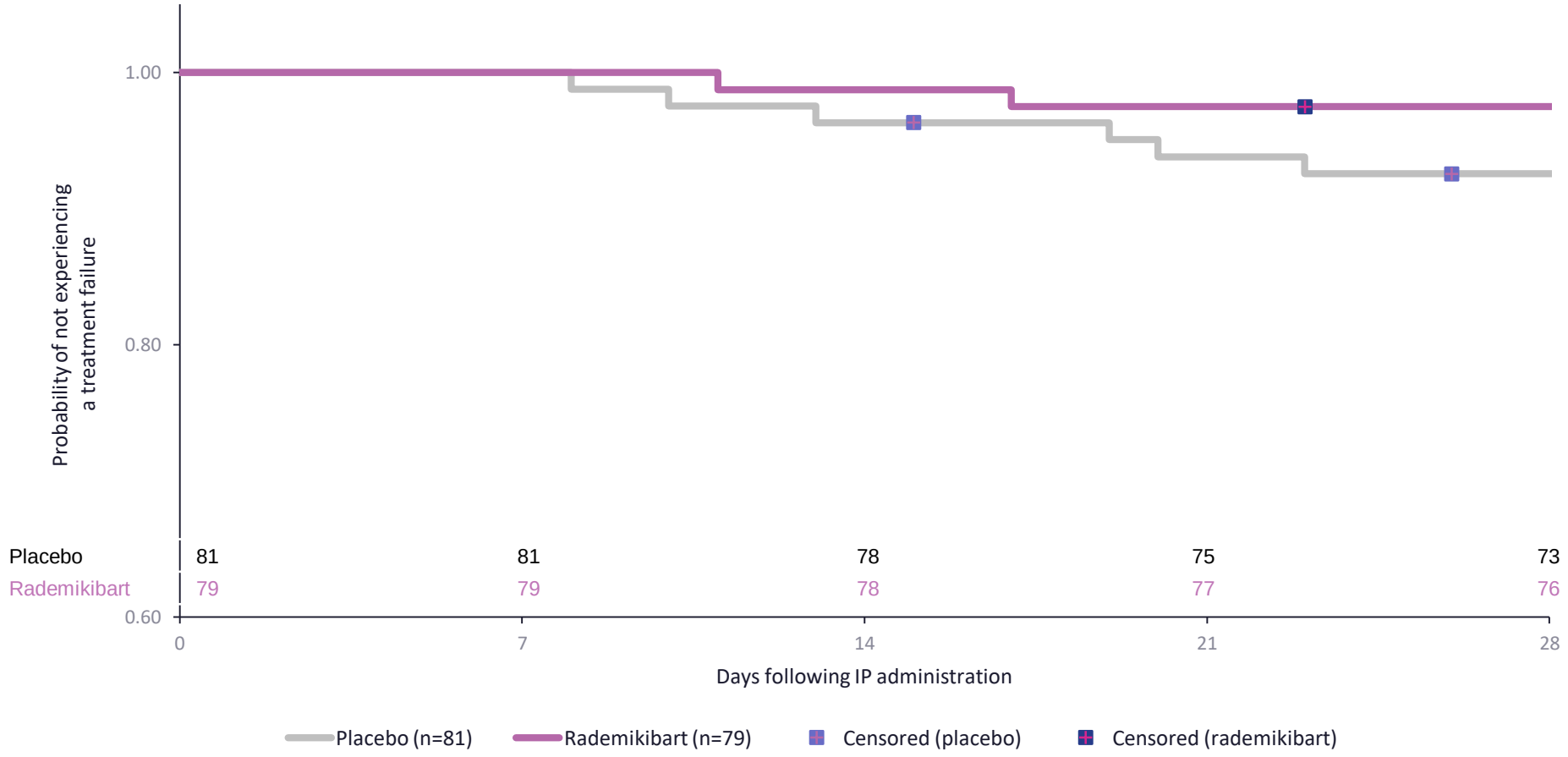
	Placebo (n=81)	Rademikibart (n=79)	P-value
Number of new exacerbations through Week 4 visit	5 (6.2%)	2 (2.5%)	N/A

Due to the low number or exacerbations, the other secondary endpoints of rate of new asthma exacerbations in 28 days after randomization and time to the first new asthma exacerbation in the 28 days after randomization could not be calculated.

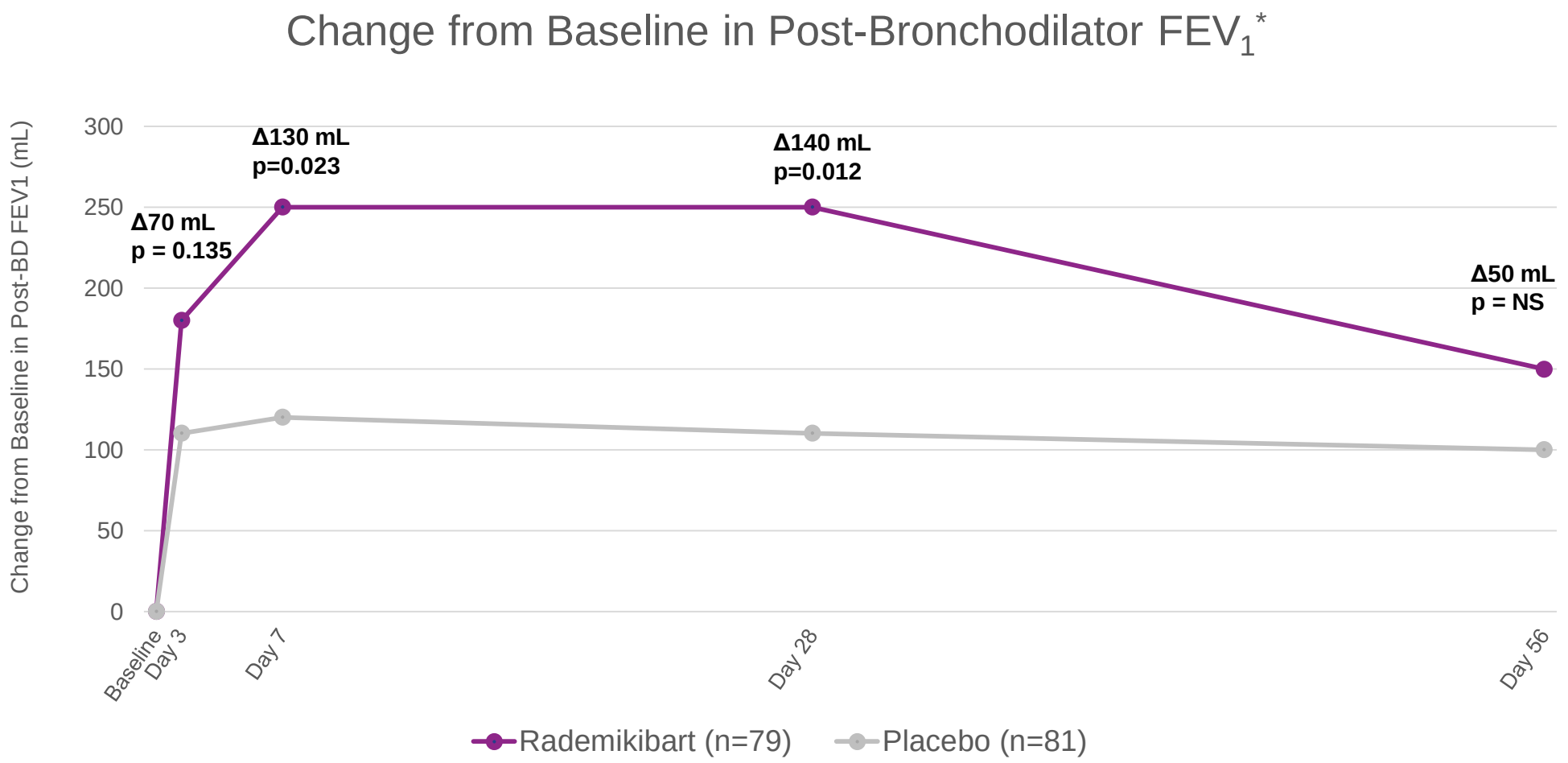
* Study 206 was powered based on 45% placebo arm TxF rate and approximately a 50% reduction observed for benralizumab arm in ABRA study
ED – Emergency Department.

Time to Treatment Failure

Time to Treatment Failure Through Day 28



Key Secondary Endpoint – Significant Increase in Post-Bronchodilator FEV_1 on Day 7 (Day 28 also Significant Change from Baseline vs Placebo) Preliminary Topline Results



BD – Bronchodilator
*LSM change from baseline

Phase 2 Seabreeze STAT Asthma Study Adverse Event Summary

	Placebo (N=81) n (%)	**Rademikibart** (N=79) n (%)
Any TEAE	16 (19.8%)	13 (16.5%)
SAE	3 (3.7%)	1 (1.3%)
TEAEs possibly related to IP	1 (1.2%)	2 (2.5%)
TEAEs ≥Grade 3	2 (2.5%)	2 (2.5%)
AESIs	0	1 (1.3%)
TEAEs of DILI	0	0
TEAEs leading to IP discontinuation	0	0
TEAEs leading to trial withdrawal	0	0

Note: AESIs include conjunctivitis, keratitis, severe (Grade 3) injection site reactions persisting > 24 hrs, parasitic and opportunistic infections, and anaphylaxis

Abbreviations: AESI, adverse event of special interest; CPK, creatine phosphokinase; DILI, drug-induced liver injury; GFR, glomerular filtration rate; IP, investigational product; SAE, serious adverse event; TEAE, treatment-emergent adverse event.

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Phase 2 Seabreeze STAT Asthma Study
Adverse Event Details

Placebo (N=81)		**Rademikibart** (N=79)	
Abdominal pain (n=1)	✓ SAE	Asthma (n=1; exacerbation - Day 42)	✓ SAE ✓ Grade 3 TEAE
Cholangitis (n=1) Drug hypersensitivity (n=1)	✓ SAE ✓ Grade 3 TEAE	Injection site erythema (n=1; left upper arm)	✓ Grade 3 TEAE ✓ AESI
Vertigo (n=1)	✓ Possibly related TEAE	Injection site erythema (n=2; multiple locations)	✓ Possibly related TEAE
Asthma (n=2; exacerbation) Diarrhea (n=2) Urinary tract infection (n=2)	✓ Most common TEAE	Injection site erythema (n=2) Blood triglycerides increased (n=2) Urinary tract infection (n=2)	✓ Most common TEAE

Abbreviations: AESI, adverse event of special interest; SAE, serious adverse event; TEAE, treatment-emergent adverse event

Notes:
No AEs of ‘eosinophil count increased’ or ‘eosinophilia’ reported in the study. The protocol required eosinophil counts ≥1500 cells/μL or if symptomatic to be reported as an AE. Asthma exacerbations reported as an Adverse Event only if more severe than Index Exacerbation or more frequent than expected for participant.

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Study 206 Topline Results - Conclusions

- Clinically meaningful 66% reduction in Treatment Failure (TxF) observed through Day 28
- Rapid, statistically significant and clinically meaningful increase in post-bronchodilator FEV_1 compared to placebo observed at Day 7
  - Day 7 FEV_1 improvement is Key Secondary Endpoint, which we plan to propose to FDA as Phase 3 endpoint
  - FDA has previously indicated they prefer an endpoint showing rapid benefit
- Favorable safety profile

Snapshot of the Asthma Market

- Based on the rapid onset of FEV1 increases, current development of rademikibart is focused on treatment of acute exacerbations of asthma and COPD
- Updated market research indicates that there were approximately 1.6M ED visits in the US for acute asthma attacks in T2 high patients in 2025*
  - Penetration of biologics into the asthma market is very low: 2.26% of all asthma patients (288,683 of 12.7M) received an asthma biologic in 2025, rising to 3.44% among the type-2-high subset leaving a large untapped market
- Ultimately, goal is to have both acute and chronic indications for rademikibart
  - Market research indicates that acute use will drive significant chronic use

*Komodo 2025 Asthma Biologic Penetration
ED – Emergency Department

Real-World Claims Data

How we measure disease burden at national scale

Every time a patient is treated, a billing claim is created. Aggregated across payers, those claims show how care is actually delivered in the United States.

WHAT IS CAPTURED

Diagnosis, procedure, prescription, site of care, and amount paid, for every billed encounter.

WHAT WE DO WITH IT

Size the patient population, quantify the cost of uncontrolled disease, and design better trials.

THE DATA SOURCE: KOMODO HEALTH HEALTHCARE MAP

330M+	160M	60+	1T+	Daily
de-identified U.S. patient journeys	closed, linkable lives per year	contributing data sources	linked patient records	refresh of the underlying map

Claims are coded for billing, not for research, so cohorts are pre-specified and validated before any figure is reported.

Source: Komodo Health, Healthcare Map product overview and company press materials (komodohealth.com), accessed September 2026; figures as reported by the vendor. All analyses use HIPAA-compliant de-identified data. HIPAA, Health Insurance Portability and Accountability Act.

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2025 US National Claims Data Patients Aged 12 and Over Distribution of Emergency Visits for Asthma with Costs

Acute asthma attack
2,158,005 ER visits/yr

Not type 2–high · 565,397 · 26.2% *not carried forward*

Type 2–high **1,592,608** 73.8%

76% of the 90-day spend lands in the first month.

HOW THE VISIT ENDS…	Treat + Release discharged from the ER		Observation held, not admitted		Admitted inpatient stay	
Type 2–high visits a year †	**1,138,353**	71.5%	**144,783**	9.1%	**309,472**	19.4%
WHAT HAPPENS IN THE FIRST 30 DAYS…						
Returned to ER or was admitted ≤30 days	**194,658**	**17.1%**	**22,441**	**15.5%**	**64,061**	**20.7%**
↳ extra cost those returns drive per patient	**$4,992**		**$11,249**		**$19,572**	
30-day cost for returning patients	**$971M**		**$253M**		**$1,254M**	
Cost savings with 66% reduction in 30-day returns	**$641M**	**$563 per Treated and Released visits**	**$167M**	**$1,153 per Observed visits**	**$828M**	**$2,674 per Admitted visits**

ER = emergency room; type 2–high = elevated eosinophils, IgE or a documented atopic condition; allowed amount = billed and allowed by the plan, before the plan's share is netted out
Visit volume: Komodo Healthcare Map, age 12+, CY2025, standardised for age and payer mix — 2,158,005 is the projection of 1,087,531 observed ER episodes.

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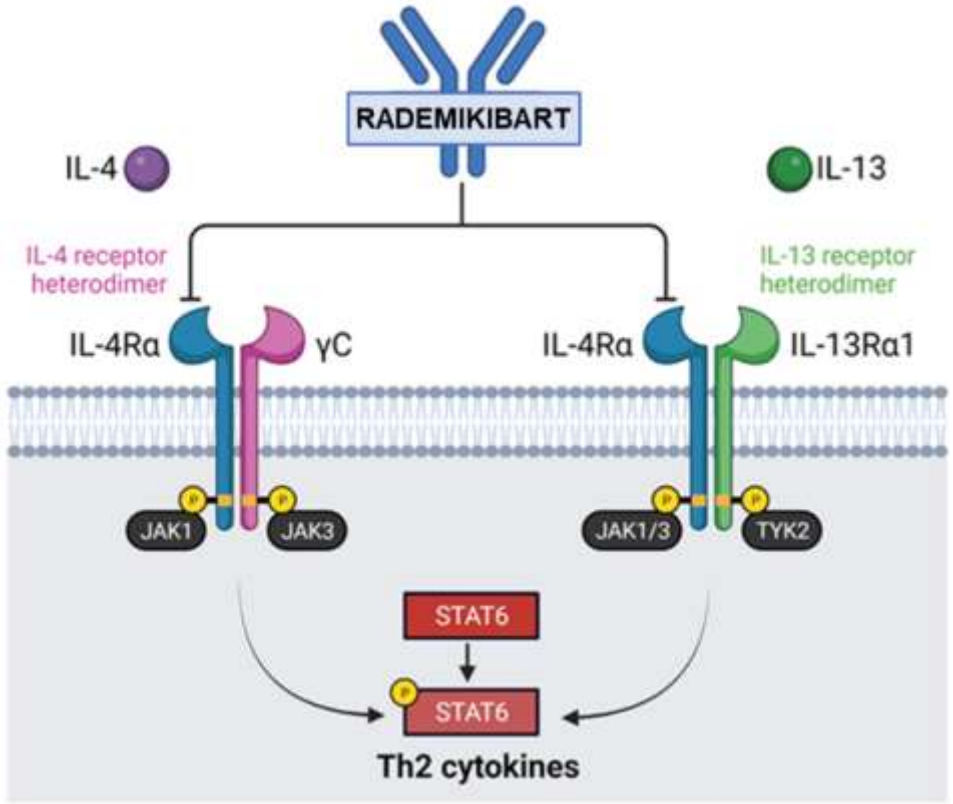
Rademikibart:

A Next Generation Anti-interleukin-4 -receptor alpha (IL-4Rα) Antibody

Rademikibart: Next Gen IL-4Rα 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-4Rα, a common subunit for IL-4 and IL-13 receptors. Blockade of IL-4 and IL-13 binding to IL-4Rα results in inhibition of both IL-4 and IL-13 signaling.

Rademikibart Characteristics

- Engaging with distinct epitopes associated with a higher binding affinity to IL-4Rα[1]
- Highly potent IC_{50} in:
  - Reducing JAK-STAT signaling[1,a]
  - Cell proliferation[1,a]
  - TARC release[1,a]

Clinical Results Demonstrate that Rademikibart has:

- Faster onset of action
- Greater clinical response (FEV_1)
- Potential for less frequent dosing with Q4W dosing producing equal benefit versus Q2W dosing in AD
- Reduction of eosinophils vs increase with dupilumab (reduces risk of SAEs associated with hypereosinophilia)

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.

[a]Based on head-to-head in vitro comparison with dupilumab.

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

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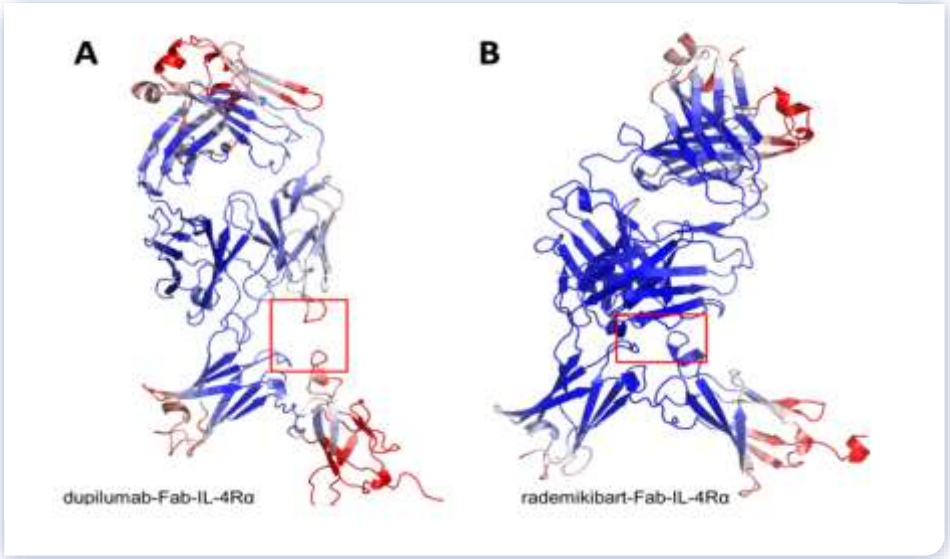
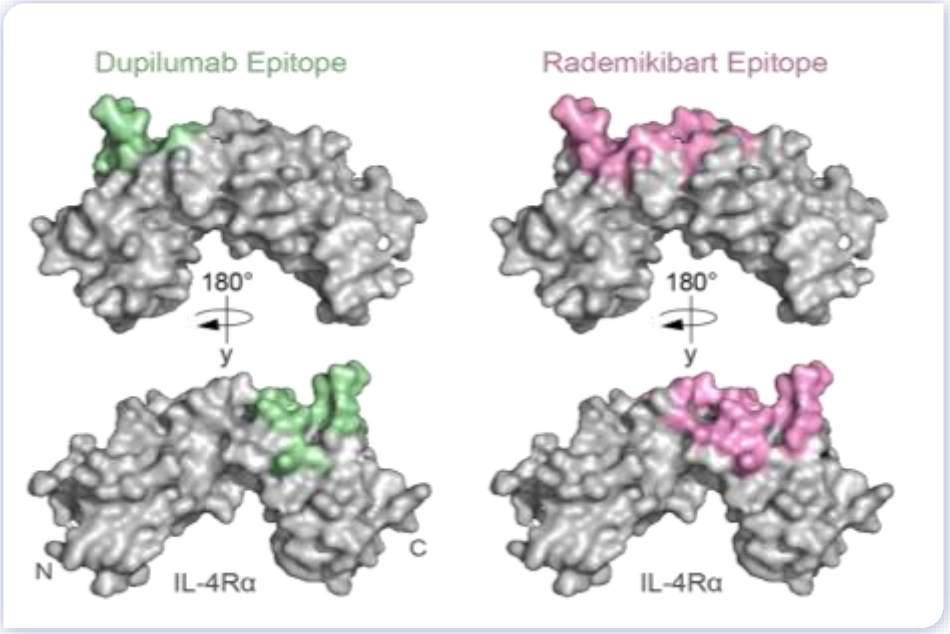
Rademikibart Forms a More Stable Complex with the IL-4Rα subunit

Rademikibart and Dupilumab Have Different Binding Orientation

- Rotation angle between dupilumab and rademikibart bound to IL-4Rα is 59°
- Rademikibart forms a more stable receptor complex
  - Rademikibart binds IL-4Rα across loops 2 and 3 on the D1 domain and loop 5 on the D2 domain (Fig B - red box)
  - Dupilumab binds only D1 (D2 binding is absent – (Fig A - red box)





Rademikibart engages a larger surface on IL-4Rα compared to dupilumab

- The rotation angle enables epitopes of rademikibart to overlap more closely with the conserved binding interface naturally utilized by IL-4 and IL-13 cytokines
  - Rademikibart closely mimics…
    - IL-4 (with 74% overlap) and IL-13 (60% overlap)
  - In contrast, dupilumab mimics…
    - IL-4 (with 47% overlap) and IL-13 (35% overlap)
- Rademikibart's larger binding interface, potentially enhances blockade of IL-4/IL-13 compared to dupilumab

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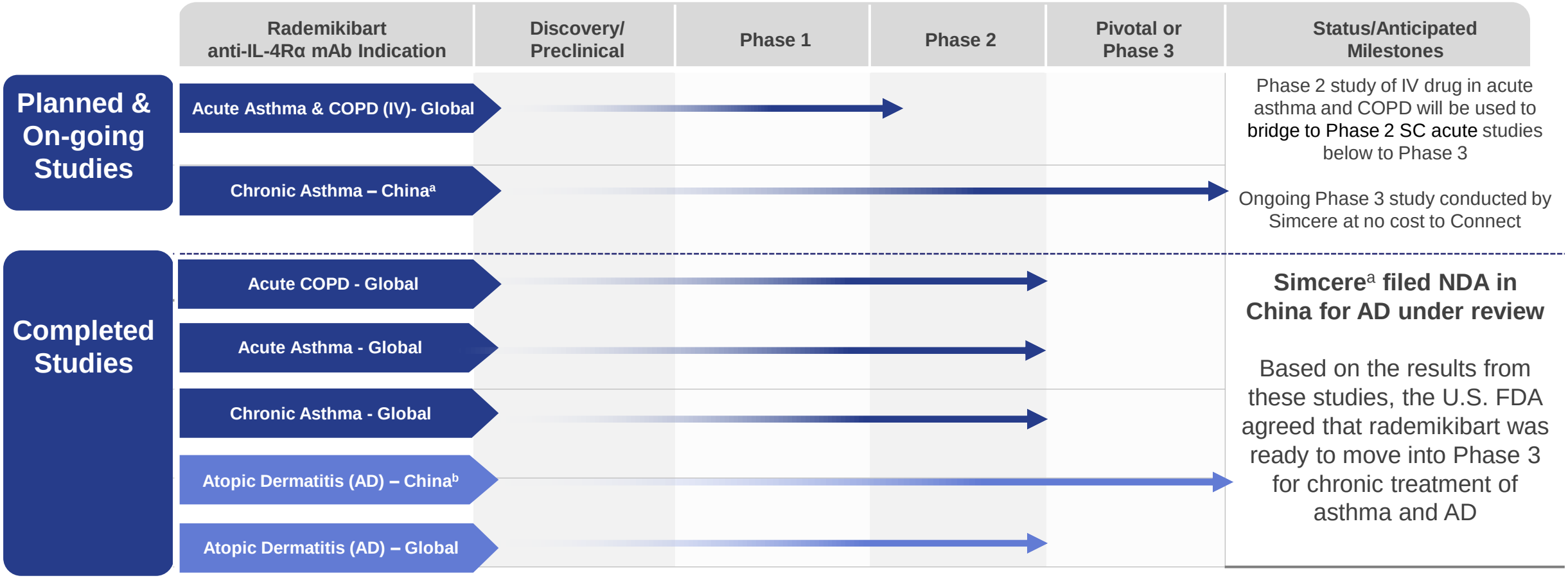
Rademikibart Has Demonstrated Efficacy & Safety Across Multiple Indications

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

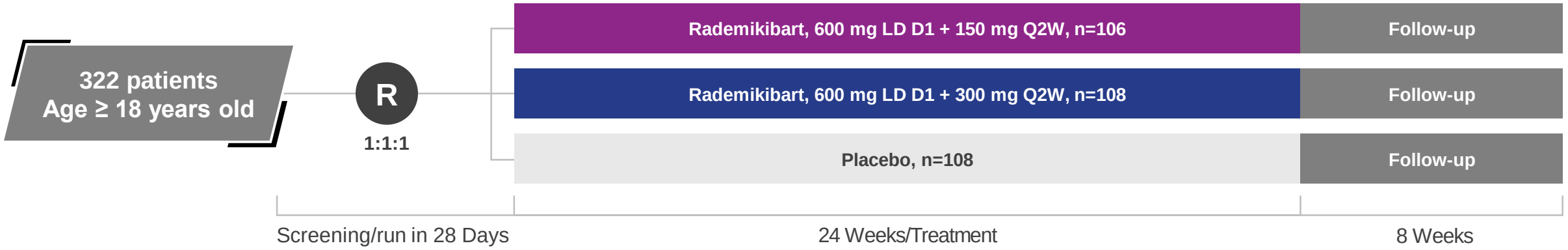


[a]Simcere is Connect's partner in Greater China who holds responsibility for future development, including for additional indications; [b] Data presented at 2026 AAD Meeting in Late-Breaking Research Session #79594

Abbreviations: AD = atopic dermatitis; COPD = chronic obstructive pulmonary disease; IV = intravenous; mAb = monoclonal antibody; SC = subcutaneous

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_1 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_1 at Week 12 (in clinic with central overread)

Secondary Efficacy Endpoints:

- Change from Baseline in FEV_1 at other timepoints
- Asthma Exacerbations
- PROs (ACQ, symptom diary, at-home lung function)
- PD markers (FENO, eosinophils, ECP, periostin, TARC)
- Rescue medication use

Abbreviations: ACQ=Asthma Control Questionnaire; ECP = eosinophilic cationic protein; FENO = fractional exhaled nitric oxide; FEV_1=Forced expiratory volume at 1 second; ICS = inhaled corticosteroids; LABA = long-acting ß-agonist; LTRA = leukotriene receptor antagonists; OCS = oral corticosteroids; TARC = thymus and activation-regulated chemokine.

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

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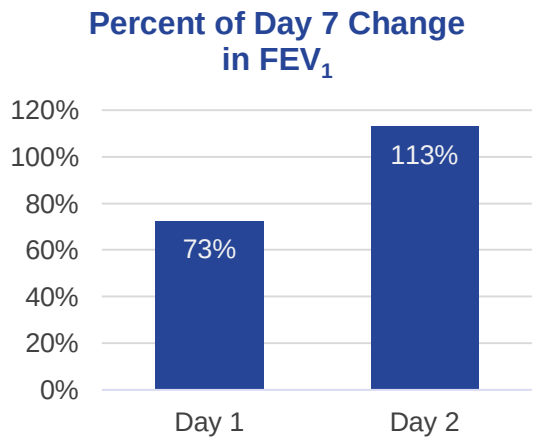
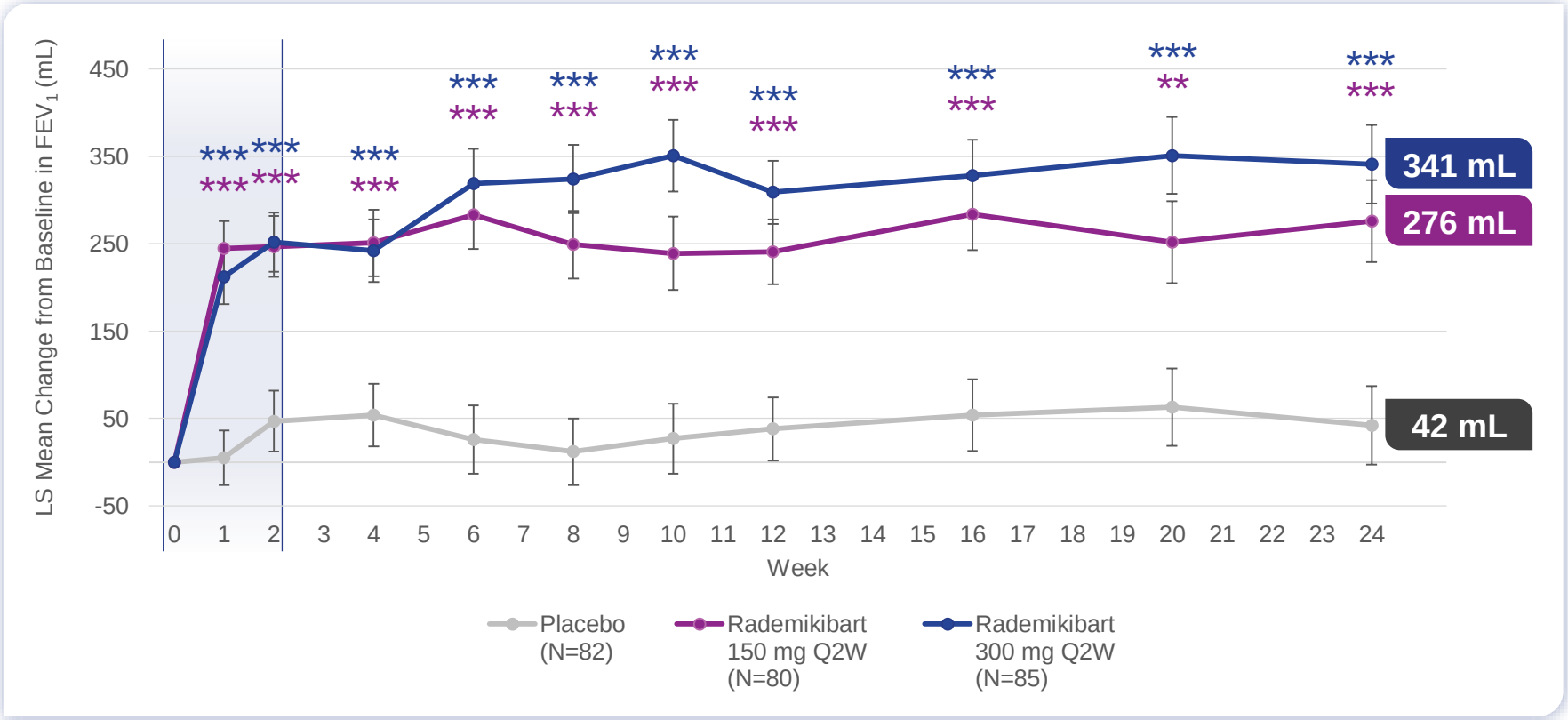
Rapidly Improved and Sustained FEV_1 Values Observed with Rademikibart Treatment in Completed Phase 2b Study

Rademikibart treatment associated with rapid, significant changes in FEV_1 as early as Week 1 clinic visit, 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 the morning after the first dose, with 113% by Day 2:



Change in Pre-bronchodilator FEV_1 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_1 = Forced expiratory volume in one second.

Competitive Landscape of Placebo Adjusted Improvement from Baseline In Pre-bronchodilator FEV_1

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_1	Placebo adjusted improvement from baseline in FEV_1 (*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[1]	231/633	41.8%	12	2	130 mL	240 mL
			2024	COPD: NOTUS[5]	465/470	60.8	12	2	82 mL	113 mL
	IL-5Rα	**Benralizumab**	2017	SIROCCO[3] Q4W	407/399	68.9%	48	4	--	106 mL
				CALIMA Q4W[6]	440/425	67.5%	56		--	125 mL
	IL-5	**Reslizumab**	2016	STUDY 1[2]	244/245	--	52	4	126 mL	--
				STUDY 2[2]	232/232	--			90 mL	--
	TSLP	**Tezepelumab**	2021	NAVIGATOR[4]	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_1 = Forced expiratory volume in one second; IL=Interleukin; MoA=mechanism of action; Pbo=Placebo; TSLP=thymic stromal lymphopoietin; Tx=treatment group.

*EOS ≥150 cell/µL

†Patients from Phase 2 asthma study with asthma onset age > 40 year and post−bronchodilator FEV_1/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

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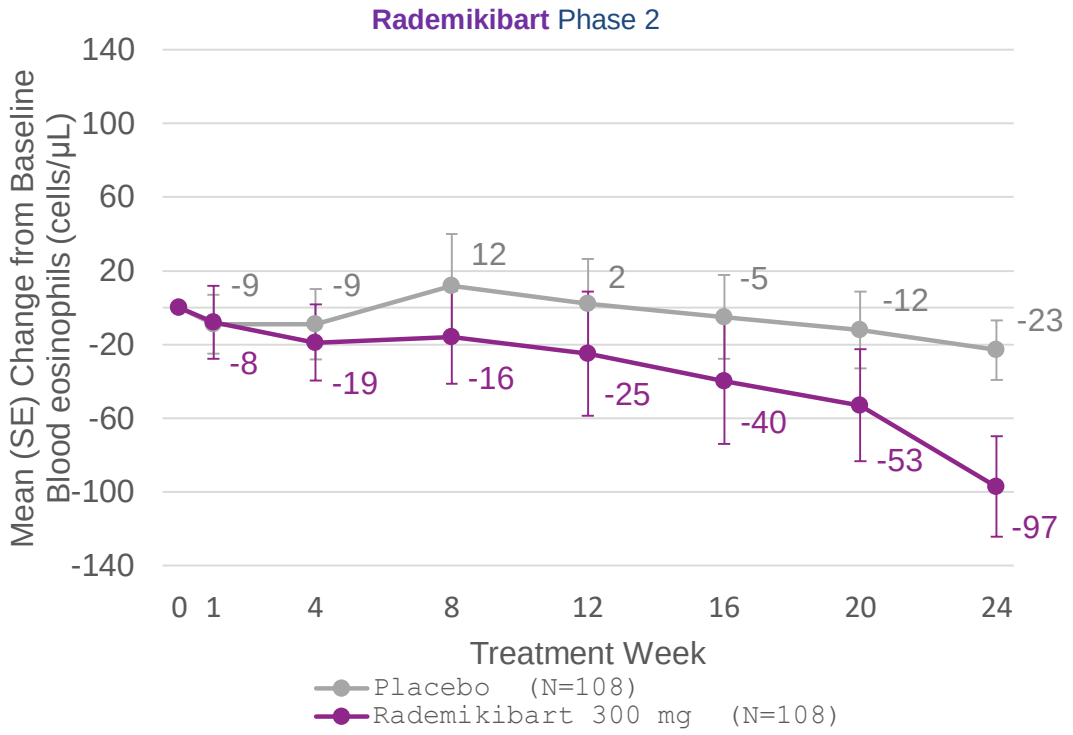
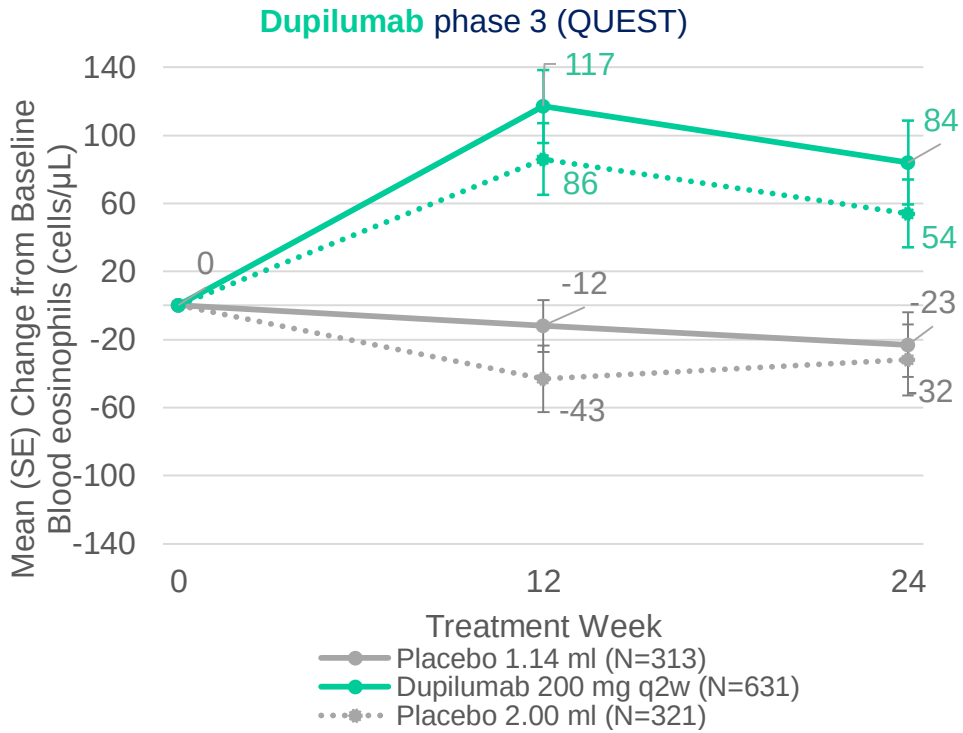
Although Both Target IL-4Rα, Rademikibart Observed to Lower Eosinophils While Dupilumab Increases them in Asthma Patients

Effect of rademikibart on change from baseline in mean eosinophil counts
(patients with eosinophil counts at any point during the treatment period)



At baseline, mean (standard deviation) eosinophil counts = 299 cells/µL (229) for placebo and 320 cells/µL (220) for rademikibart 300 mg.

Effect of dupilumab on change from baseline in mean eosinophil counts
(placebo groups behave similarly to rademikibart phase 2b study above



At baseline, mean±SD eosinophil counts = 370±338 cells/µL (placebo 1.14 ml); 391±419 (placebo 2.00); 349±345 (dupilumab 200 mg) and 351±369 (dupilumab 300 mg).

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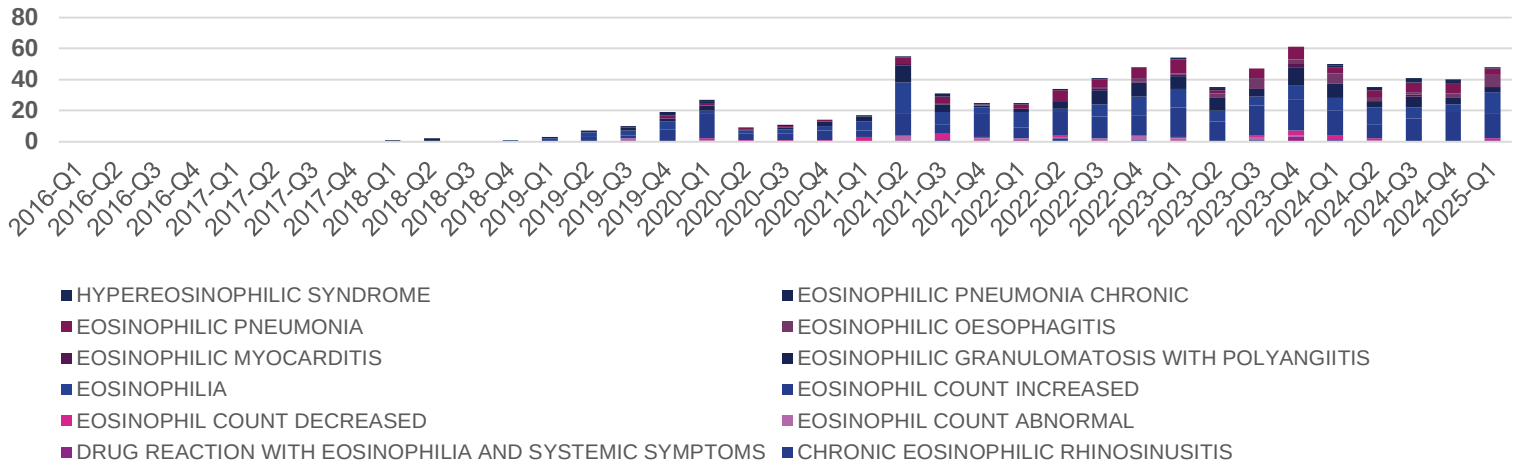
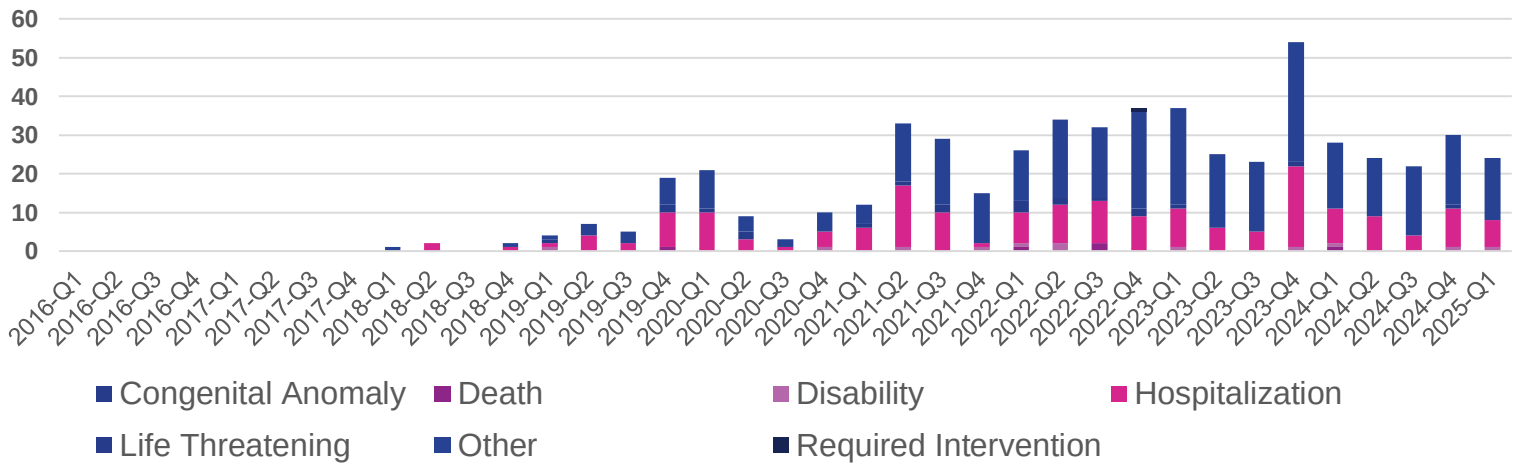
Elevated Eosinophils is Not Just a Lab Abnormality with Dupilumab

All Eosinophilia Primary Terms with >4 Reports by Quarter



All Eosinophilia Serious Outcomes by Quarter



Eosinophilia Related Adverse Events Reported to FDA Safety Database for Dupilumab

- Patients may have more than one adverse event or serious outcome per individual case report
- 676 individual cases with 811 Eosinophilia AEs
- 408 cases with 569 serious outcomes

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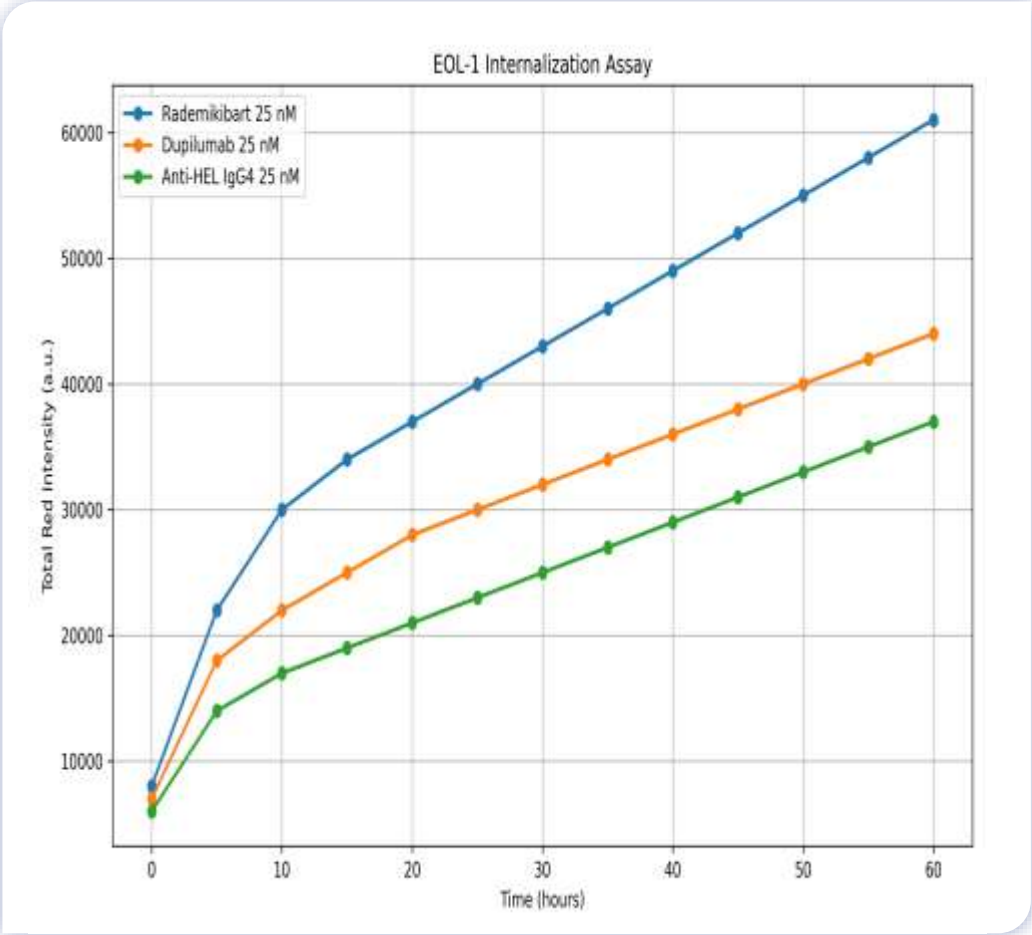
MOA Activities

- Differential effects on eosinophils observed in the clinic are likely due to differential binding leading to greater internalization
- Human PCLS experiments from two independent labs show consistent β-agonist augmentation with rademikibart compared to little to no benefit with dupilumab and benralizumab

Rademikibart Observed to Induce Higher Level of IL-4Rα Internalization Compared to Dupilumab

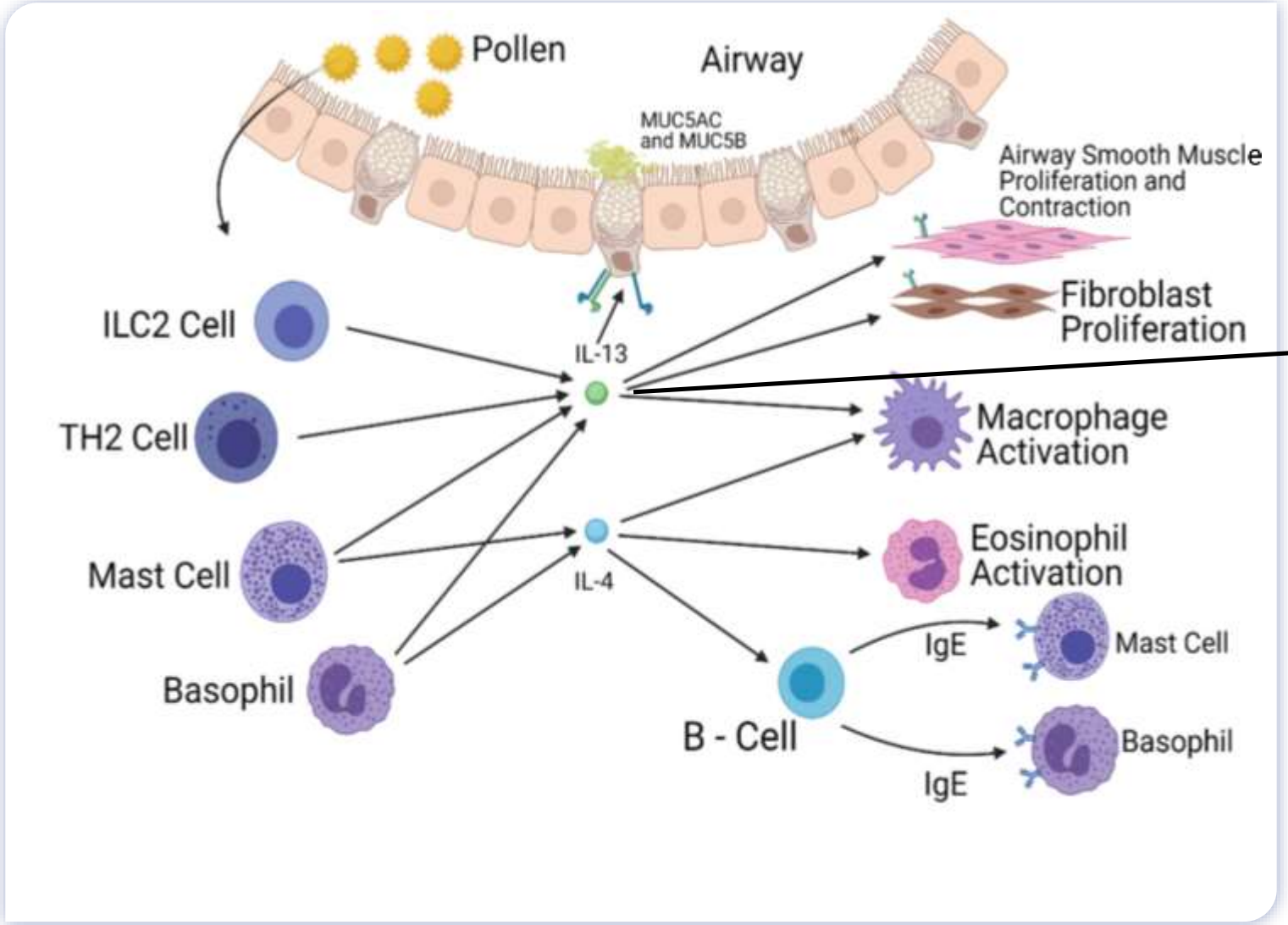


- Rademikibart can efficiently remove Type I IL-4 receptors from eosinophil cell surface, confirmed by Flow Cytometry and IncuCyte (shown to the left)
- Rademikibart induced stronger apoptosis of EOL-1 than dupilumab
- The effects on internalization and apoptosis are likely the underlying mechanisms of clinical observations:
  - Reduction in EOS compared to increase in EOS with dupilumab
  - Identical results with Q2W and Q4W dosing in AD
- Higher EOS observed with dupilumab is associated with SAEs and may be linked to higher rates of conjunctivitis
  - Dupilumab was associated with 10% conjunctivitis, compared to 2% in the placebo group in Phase 3[1], while only 3-4% conjunctivitis was observed with rademikibart in AD[2]

AD – Atopic Dermatitis; EOS – Eosinophils; SAE – Serious Adverse Event

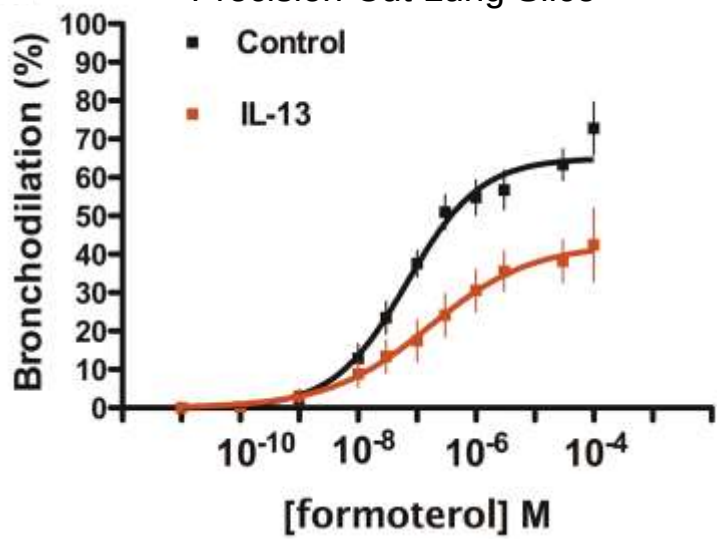
1. Dupilumab USPI - www.regeneron.com/downloads/dupixent_fpi.pdf. Accessed 1 Jan 2025
2. Silverberg JI et al. J Allergy Clin Immunol 2024;153:1040-9. https://doi.org/10.1016/j.jaci.2023.11.924 and 2026 AAD presentation 79594

IL-4 and IL-13 Receptors are Expressed on HASM Cells and Play Important Roles in Asthma Exacerbations



In addition to producing contraction of airway smooth muscle and increasing mucus production, IL-13 also shifts the efficacy curve of β-agonists making them less effective

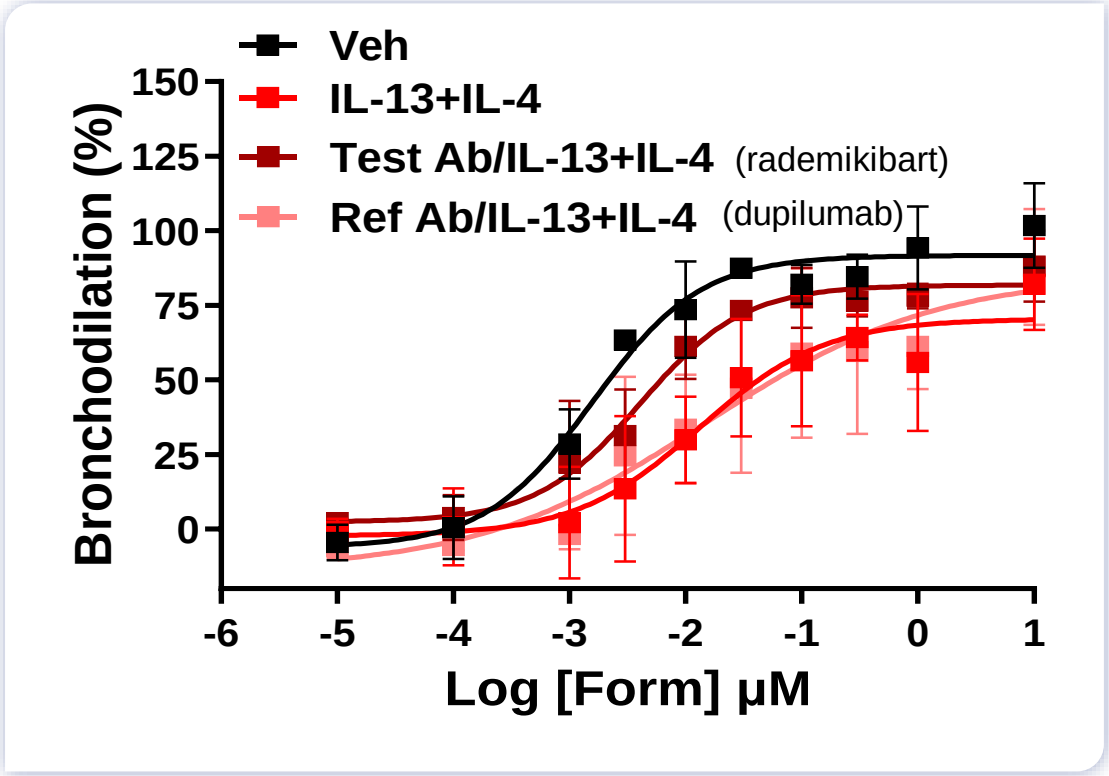
Reduced Bronchodilation in Precision Cut Lung Slice

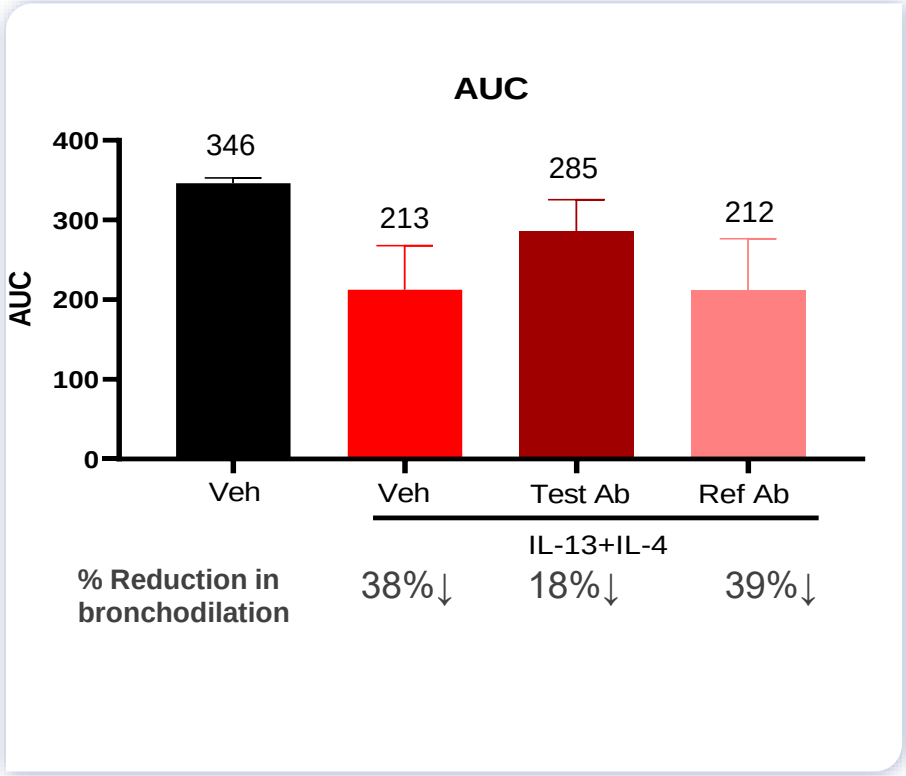


Robinett; Koziol-White et al. Am J Respir Cell Mol Biol . 2013. 50678-683; LePorte, et al. Am J Respir Crit Care Med Vol 164. pp 141–148, 2001 HASM – Human Airway Smooth Muscle.

Unlike with Rademikibart, IL-4/IL-13 Mediated Hyporesponsiveness to β-Agonists is *Not* Reversed with Dupilumab

Contrary to rademikibart, and consistent with HASM cell experiments, β2 agonist response is not augmented with dupilumab





Veh = Vehicle; Test Ab = Rademikibart; Ref Ab = Dupilumab; HASM – Human Airway Smooth Muscle; hPCLS – human Precision Cut Lung Slice
N= 2 donors, N090425; Mean ±SEM of 2-4 slices per condition.

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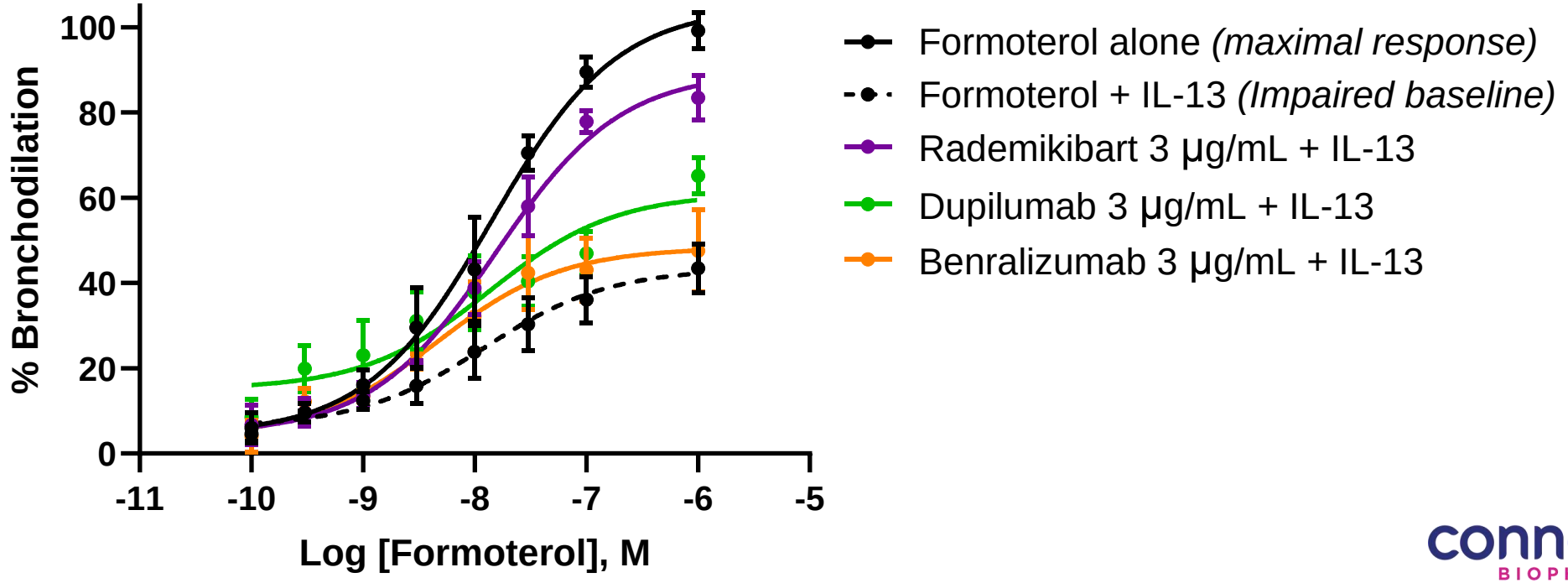
Unlike with Rademikibart, IL-13 Mediated Hyporesponsiveness to β-Agonists is *Not* Significantly Reversed with Either Dupilumab or Benralizumab

Formoterol concentration-response curves for bronchodilation in IL-13-challenged PCLS

- rademikibart (3 µg/mL) produced the most complete recovery of β-agonist responsiveness, approaching the IL-13-free maximal response, while dupilumab and benralizumab conferred only partial and minimal recovery, respectively.



Preliminary Topline Results from Rademikibart IV Push Study Confirm That:

- The large and rapid improvement in FEV_1 observed in Phase 2 chronic asthma study can be achieved more quickly and maintained through at least 29 days with a single IV administration
- The large increase in FEV_1 observed in COPD-like patients in prior Phase 2 study can rapidly be obtained and maintained in COPD patients with IV administration

Phase 1, Single-dose, Placebo-controlled, 2-Part Study of 300 mg IV Rademikibart (Study CBP-201-105) Preliminary Results

PART A
Healthy Adults

Part A – Evaluation of varying IV infusion rates
- Healthy Volunteers: 3 cohorts evaluating 30-, 15- or 2-minute infusion rates
- Key Endpoints: PK, safety and tolerability
- No differences in safety or pharmacokinetics observed across the 3 infusion rates
- 2-minute IV push selected for Part B

PART B
Stable Patients

Part B1 (asthma) – Evaluation of 2-minute IV push
- Patients: Current or former smoker with EOS ≥200 cells/µL + FeNO ≥25 ppb in non-smokers (smoking lowers FeNO so no lower limit for smokers)
- Key Endpoints: PK, Safety, tolerability, change from baseline in FEV_1 and PD biomarkers
- All patients have completed Day 29

Part B2 (COPD) – Evaluation of 2-minute IV push
- Patients: Current or former smoker with EOS ≥200 cells/µL + FeNO ≥25 ppb in non-smokers (smoking lowers FeNO so no lower limit for smokers)
- Key Endpoints: PK, Safety, tolerability, change from baseline in FEV_1 and PD biomarkers
- All but one patient completed through Day 29

AUC: Area Under the Curve; COPD: Chronic Obstructive Pulmonary Disease; EOS: Eosinophils; FEV1: Forced Expiratory Volume in 1 second; IV: intravenous; PD: Pharmacodynamic; PK: Pharmacokinetic

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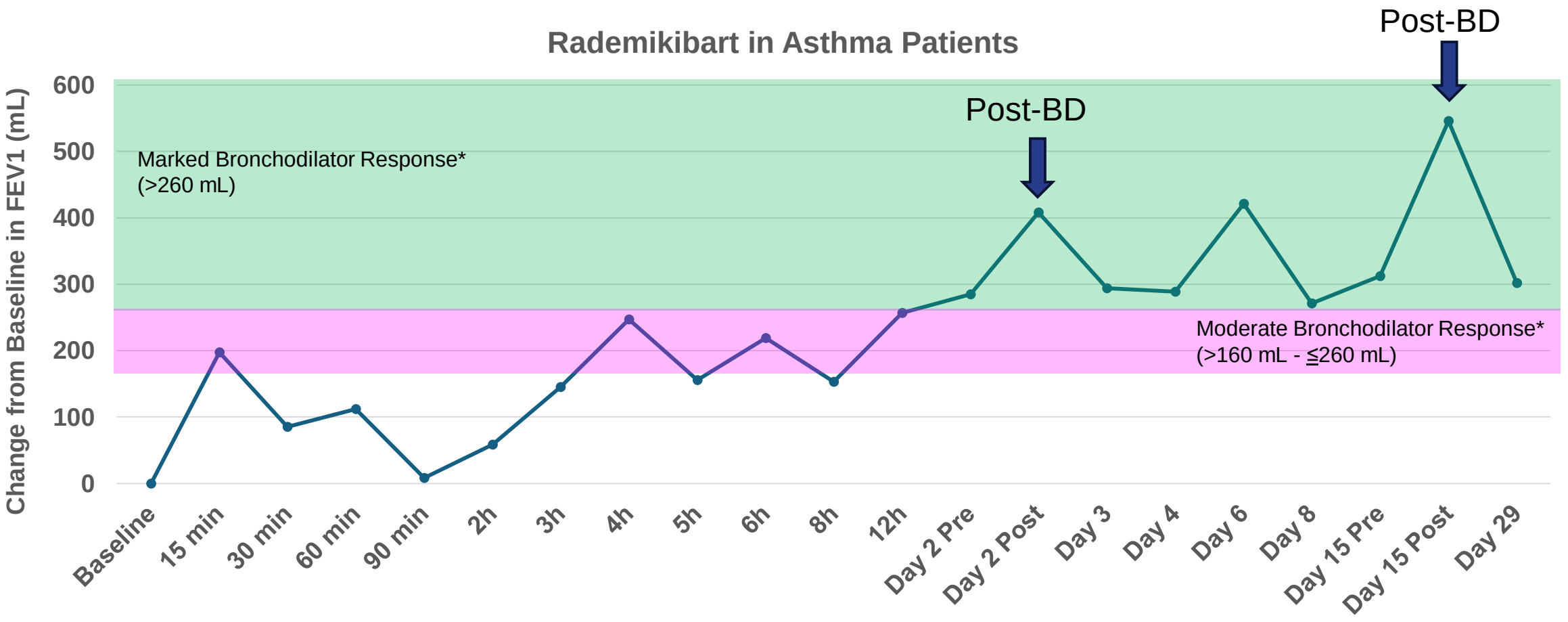
Phase 1 IV Study Participants & Key Demographics

Number of Participants	Part A Healthy Volunteers	Part B1 Stable Asthma	Part B2 Stable COPD
Planned	24	10	10
Randomized	24	12 (10 active:2 placebo)	10 (8 active:2 placebo)
Key Demographics:			
Sex	58.3% male	83.3% female	60% female
Mean Age (years)	34.7	52.0	59.0
Mean FEV_1 at Baseline (Range)	--	1.9 L (0.7 – 3.1 L)	1.55 L (0.76 – 2.13 L)
Race	79.2% Black/20.8% White	75% White/25% Black	90% White/10% Black
Ethnicity	91.7% Non-Hispanic	91.7% Hispanic	100% Hispanic
Current smoker	--	67%	90%
Eosinophil Count	--	330 cells/µL (58% 200-250 cells/µL	330 cells/µL (50% 200-250 cells/µL
FeNO	--	24.2 ppb (50% ≤10 ppb	12 ppb

Study CBP-201-105: Asthma Patients Change from Baseline in FEV_1 Preliminary Topline Results



Placebo-corrected; Preliminary data: all 12 patients have completed Day 29 visit

All time-points are pre-bronchodilator, except as shown: BD = bronchodilator

*Kaminsky DA, Ann Am Thorac Soc Vol 16, No 12, pp 1495–1503, Dec 2019What Is a Significant Bronchodilator Response?

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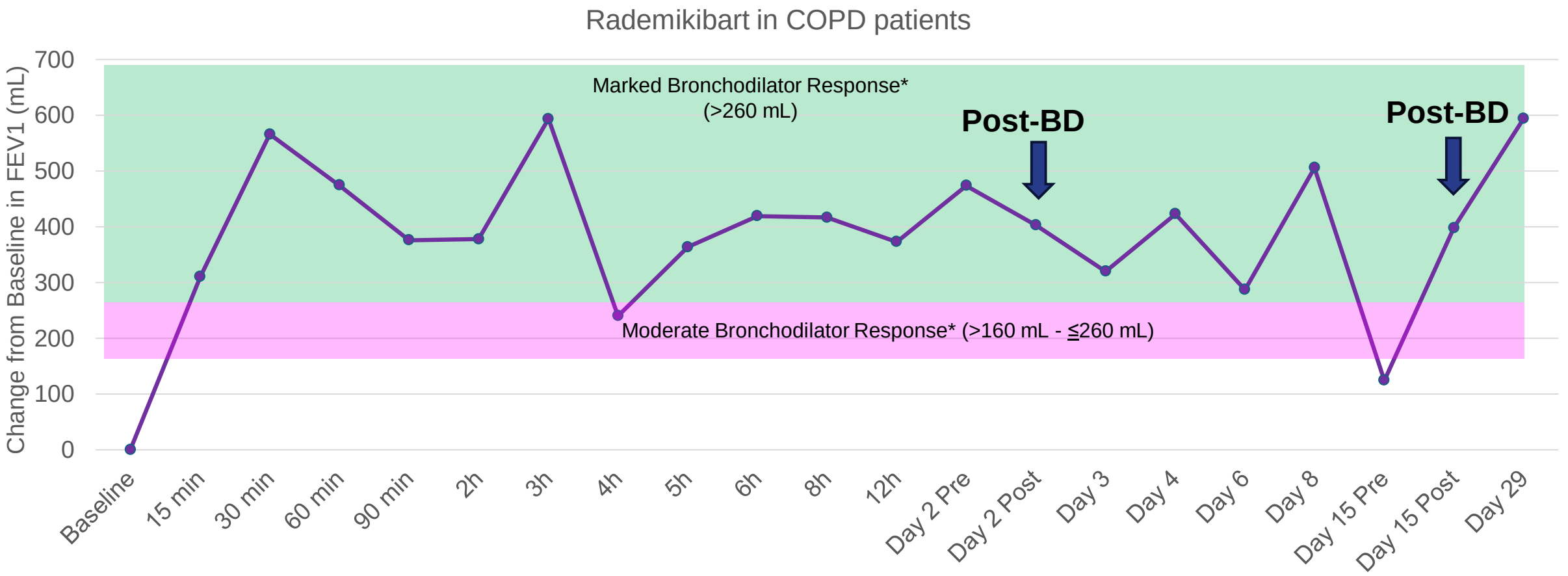
Study CBP-201-105: COPD Patients Change from Baseline in FEV_1 Preliminary Topline Results



Placebo-corrected; preliminary results as one of 10 patients has not completed Day 29 visit

All time-points are pre-bronchodilator, except as shown; BD = bronchodilator

*Kaminsky DA, Ann Am Thorac Soc Vol 16, No 12, pp 1495–1503, Dec 2019What Is a Significant Bronchodilator Response?

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Phase 1 IV Study Participants Safety & Tolerability Preliminary Results

Number of Participants	Part A Healthy Adults	Part B1 Stable Asthma	Part B2 Stable COPD
Randomized	24	12	10
Serious adverse events	0	0	0
Severe (Grade 3) adverse events	0	0	0
Adverse events leading to early study discontinuation	0	0	0
Adverse events of special interest: • Conjunctivitis • Keratitis • Severe injection site reactions lasting >24 hours • Parasitic and opportunistic infections • Anaphylaxis	 0 0 0 0 0	 0 0 0 0 0	 0 0 0 0 0

New Phase 2 Clinical Trial of Rademikibart via IV Push for Treatment of Acute Exacerbations of Chronic Respiratory Diseases

Seabreeze STAT IV

- **CBP-201-209**: *A Phase 2, Open-Label, Single-Arm Trial to Evaluate IV Rademikibart as an Add-On Treatment for an Acute Exacerbation in Participants With Asthma or COPD With Type 2 Inflammation*
- **Purpose of Study:** *Bridge from IV push to SC administration for treating acute exacerbations*
  - To compare using descriptive statistics to data from Phase 2 acute exacerbation trials evaluating a single 600 mg SC rademikibart dose in asthma (CBP-201-206) or COPD (CBP-201-207) who require an urgent healthcare visit.
    - To assess efficacy of a single 300 mg 2-minute IV push of rademikibart on lung function for acute exacerbation.
    - To evaluate safety, PK, PD, health-related quality of life (HRQoL), and healthcare resource utilization.
    - Trial run for Phase 3 with IV administration
- **Clinical Study Sites:** *Up to 16 sites with good enrollment in SC Phase 2 acute exacerbation trials*
- **Patient Population**:
  - Prior stable participants in Channel 1 of SC Phase 2 trials who had not experienced a qualifying exacerbation prior to randomization closing
  - New stable participants (Chanel 1) are eligible if prior exacerbation ~12 months prior to consent for new trial
  - New participants who experience an exacerbation that requires an urgent healthcare visit for treatment (Chanel 2)

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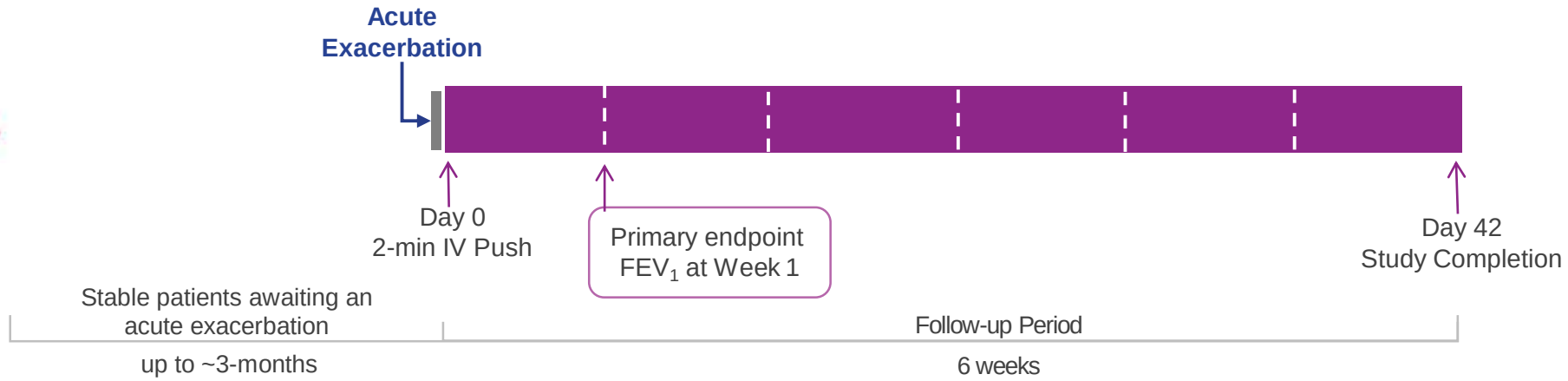
Abbreviations: COPD = chronic obstructive pulmonary disease; IV = intravenous; SC = subcutaneous

New Phase 2 Clinical Trial of Rademikibart via IV Push Study Design

Seabreeze STAT IV

STUDY DESIGN

Open-label, Single-arm
40 Subjects



	Population		Primary Endpoint	Secondary Endpoints	Key Exploratory Endpoints
Cohort A: ASTHMA N=20	Adults, aged 18 to 75 years	Acute exacerbation requiring an urgent healthcare visit and systemic corticosteroid as standard of care for treatment Eosinophil count of ≥ 300 cells/μL, ≥1 exacerbation in prior ~12 months	Change from baseline in post-BD FEV_1 at Week 1. [NOTE: Key Secondary Endpoint in Seabreeze STAT Asthma and COPD studies.]	Change from baseline in in lung function at scheduled timepoints (Days 1*, 2*, 3, 14, 28 and 42). Incidence of treatment-emergent adverse events	Rate of new acute exacerbations Disease specific-PROs Use of systemic corticosteroids. Treatment Failure at any time [NOTE: Same definition as in Seabreeze STAT Asthma and COPD studies.] Healthcare resource utilization
Cohort B: COPD N=20	Adults, aged 40 to 85 years				

* Lung function testing on Days 1 & 2 generally preformed for hospitalized participants.

Abbreviations: BD = bronchodilator; COPD = chronic obstructive pulmonary disease; FEV_1= Forced expiratory volume at 1 second; ; IV = intravenous; PRO = patient-reported outcome

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We Plan to Propose IV Administration for Acute Exacerbations in the ED

- In addition to faster on-set of airway improvement, IV administration also provides a significant financial benefit:
  - Current dose of 300 mg is half of SC dose
  - Different indication, dose and presentation provide the basis for differential pricing in the hospital setting:
    - For example, STELARA is $309.36/ mg for SC and $15.57/ mg for IV dose[1]
- Goal is to meet with FDA in 4Q2026 to discuss Phase 3 plans for acute indications

ED: Emergency Department, SC: subcutaneous 1. 2024 Red Book

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

Clinician Perspectives Highlight Rademikibart's Potentially 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	• All biologics approved for asthma or COPD and OHTUVAYRE have explicit warnings to not be used for treatment of acute bronchospasm or acute exacerbations* • New high-yield manufacturing process for rademikibart along with IV presentation will allow for hospital-friendly pricing in the acute setting
Significant Commercial Opportunity	• **Acute and chronic asthma and COPD indications resulted in WW peak sales forecast of ~$5B** • Upside opportunities exist for rademikibart to drive revenue even higher (e.g., acute use in clinics, steroid sparing opportunity)
Strong Rationale Supporting Rademikibart	• Rademikibart's rapid improvement of airway function observed in Phase 2 chronic study confirmed in IV study in both asthma and COPD patients; magnitude of FEV_1 improvement consistent across studies • ABRA benralizumab study provides higher level of confidence in obtaining a positive outcome in planned Phase 2 acute asthma and COPD studies**

*Drugs.com ** 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

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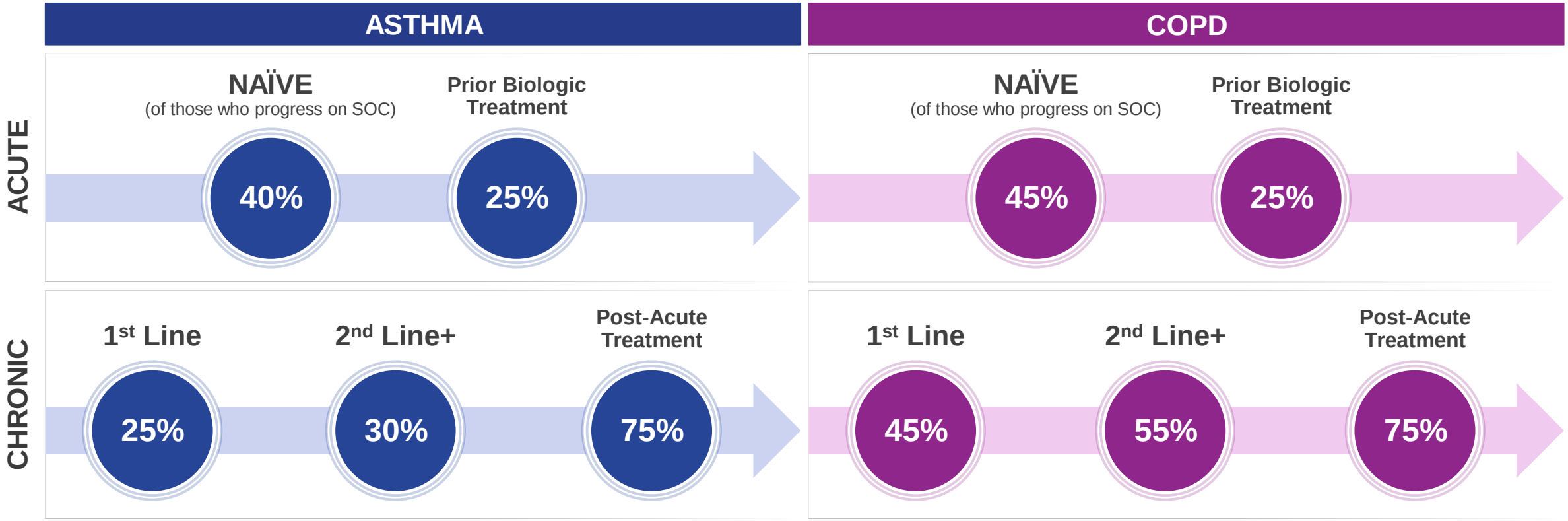
Rademikibart Expected Utilization in Asthma and COPD

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

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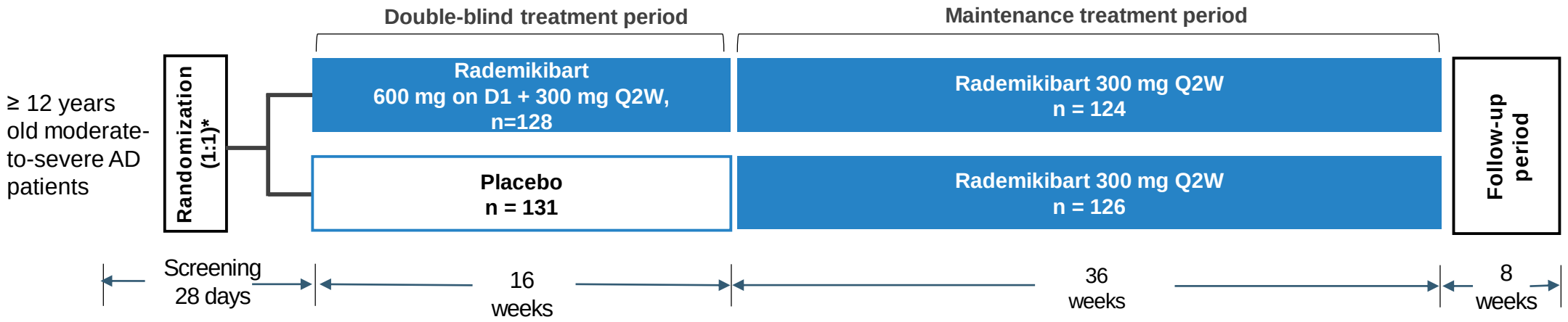
Rademikibart monotherapy in adult and adolescent patients with moderate-to-severe atopic dermatitis (AD): A 1-year, phase III, randomized, double-blinded, placebo-controlled trial (RADIANT-AD)

Title: 79594 – AAD Late-Breaking Research Session March 28

Study conducted by Simcere Pharmaceuticals in China

RADIANT-AD Study Design

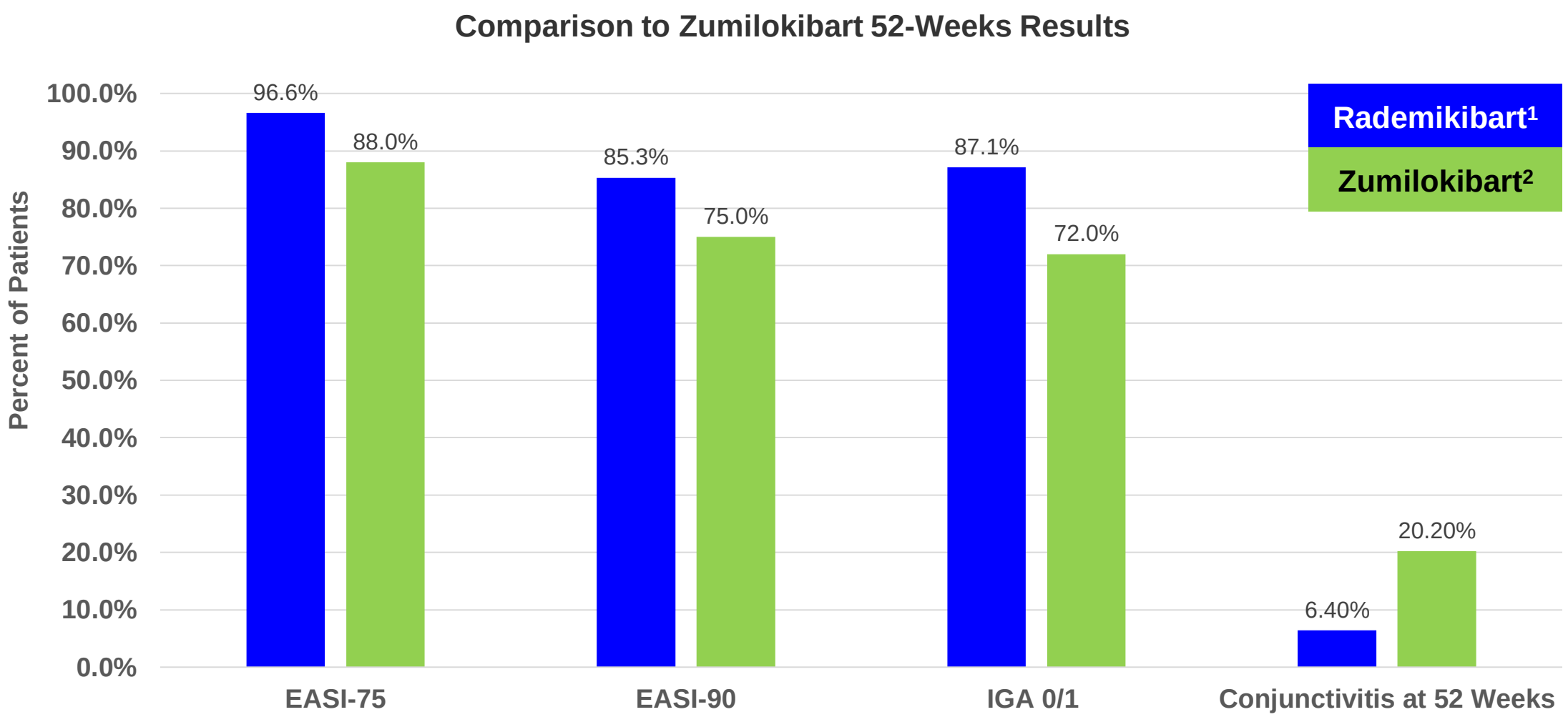
- **Design:** a randomized, double-blind, placebo-controlled, phase 3 study at 57 study centers in China (NCT06477835)
- **Eligible patients:** ≥ 12 years old moderate-to-severe atopic dermatitis (AD) patients with EASI ≥ 16, IGA score ≥ 3 (5-point scale [0-4]), ≥ 10% BSA involvement, and weekly average of daily PP-NRS score ≥ 4
- ★ **Co-Primary endpoints:**
  - ① Proportion of subjects achieving IGA score of 0/1 with ≥ 2-point reduction at Week 16
  - ② Proportion of subjects achieving ≥ 75% improvement from baseline in EASI (EASI-75) at Week 16
- **Actual enrollment:** 259 patients (204 adults, 55 adolescents)



*Randomization stratified by: (1) baseline disease severity (IGA=3, IGA=4), (2) age (adult, adolescent)

AD: Atopic Dermatitis; BSA: Body Surface Area; EASI: Eczema Area and Severity Index; IGA: Investigator's Global Assessment; PP-NRS: Peak Pruritus Numeric Rating Scale.

Rademikibart Demonstrates Best-in-Class Potential with Improved Safety Results



IGA 0/1 = Investigator Global Assessment of 0 (clear skin) or 1 (almost clear). EASI: Eczema Area and Severity Index; ; EASI-75: patients achieving ≥75% improvements from baseline in EASI score. EASI-90: patients achieving ≥90% improvements from baseline in EASI score.

1. Radiant-AD 52-week Results Title 79594 2026 AAD Annual Meeting; 2. 52-. March 2026 Apogee Therapeutics Overview Part A 52wk Q12W Dosing;

Potential Differences Between Rademikibart and Dupilumab

Rademikibart has

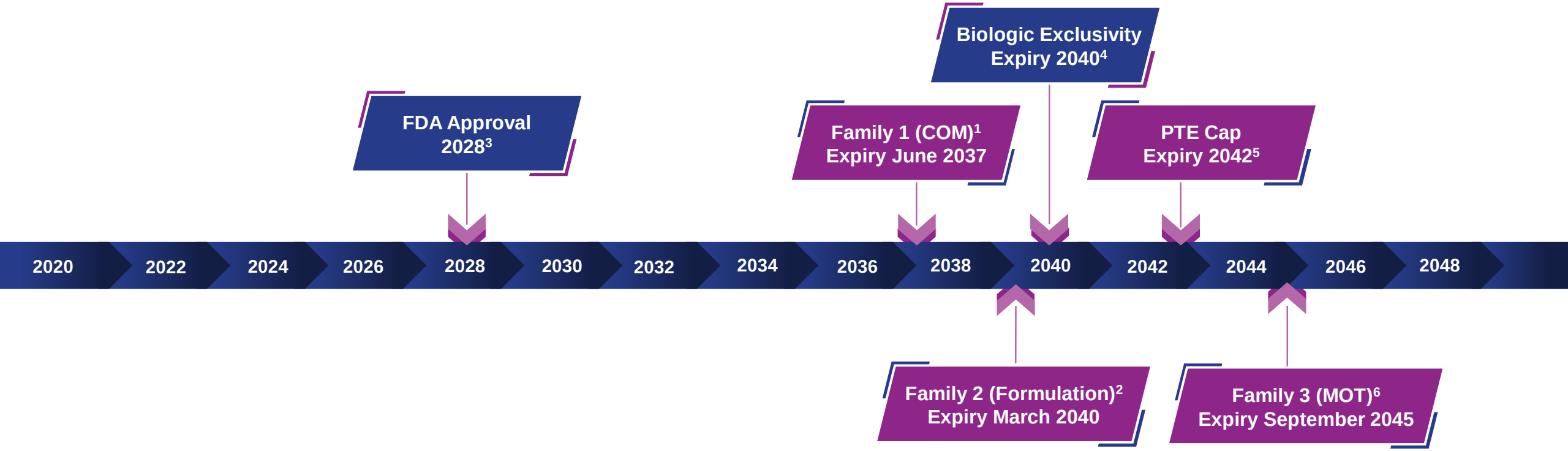
- In asthma and COPD:
  - Differential binding to the receptor resulting in enhanced internalization of drug-receptor complex
  - Demonstrated reductions in eosinophils during chronic dosing vs. significant increases observed with dupilumab
  - Unique mechanism of action of directly increasing pHSP20 in human airway smooth muscle cells and reversing the negative effects of IL-4/IL-13 on the dose response curve of β-agonists in lung slice experiments
  - Rapid onset of effect with subcutaneous dosing, which is accelerated with IV dosing
  - Larger increase in FEV_1 based on Phase 2 chronic asthma study (large increases seen in IV study as well)

- In Atopic Dermatitis[1]
  - Higher response rates with 97% EASI-75 and 85% EASI-90 responders at 52-weeks (also higher response rates than zumilokibart[2])
  - Improved maintenance of response with 87% IGA and 92% EASI-75 16-week responders continuing to respond at 52-weeks in prior 52-week AD study[3] (only 53% of dupilumab IGA responders at 16-weeks in SOLO 1 & 2 continued to respond at 52-weeks)
  - Equal efficacy dosed Q4W vs. Q2W during maintenance phase[3]
  - Potentially lower rate of conjunctivitis based on cross-study comparison of Phase 3 trials

EASI = Eczema Area and Severity Index. EASI-50 = at least 50% decrease from baseline. Q2W = every 2 weeks. Q4W = every 4 weeks. IGA 0/1 = Investigator Global Assessment of 0 (clear skin) or 1 (almost clear). 1. DUPIXENT US Package Insert; 2. March 2026 Apogee Therapeutics Overview Part A 52wk; 3. 52-week safety data from Seaside China Presented at Revolutionizing Atopic Dermatitis (RAD 2024) Conference

Rademikibart Exclusivity Timeline

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



Regulatory Exclusivity

Patent Exclusivity

1 U.S. 10,774,141 & U.S. 11,866,491 **2** Pending U.S. patent application **3** Estimated date of FDA approval **4** 12 years biologic exclusivity **5** 14 years and 5 years maximum PTE **6** Pending U.S. provisional patent applications

Financial Summary

Cash, cash equivalents and short-term investments of $31.5 million as of June 30, 2026. Based on our current operating plan and projections, we expect cash and investments to fund operations for at least one year from August 12, 2026 (expected filing date of our Q2 2026 Form 10-Q).

Summary Statement of Operations and Net Cash Used in Operations (In thousands, except per share data)	**Three Months Ended June 30, 2026**	**Six Months Ended June 30, 2026**
License and collaboration revenues	$2,768	$2,937
Operating expenses[1]	($20,372)	($40,148)
Loss from operations[1]	($17,604)	($37,211)
Other income, net	380	637
Income tax expense	(60)	(108)
Net loss[1]	($17,284)	($36,682)
Basic and diluted net loss per ordinary share[2]	($0.27)	($0.61)
Net cash used in operations	($15,922)	($31,927)
Condensed Balance Sheet Data (In thousands)	**June 30, 2026**	
Cash, cash equivalents and short-term investments		$31,486
Total assets		$43,472
Total shareholders' equity		$26,861

[1] Includes $1.3 million and $2.5 million, respectively, of non-cash, share-based compensation expense for the three and six months ended June 30, 2026.
[2] Based on 62.9 million and 59.7 million, respectively, weighted-average ordinary shares outstanding for the three and six months ended June 30, 2026.

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Connect is Well Positioned for Success

Rademikibart is Potentially Differentiated from Dupilumab in Asthma, COPD and Atopic Dermatitis

- **Rademikibart SC administration** produced rapid increases in FEV_1 as early as Week 1 clinic **visit in asthma study** sustained for 24-week study
  - Home daily lung function data demonstrated 73% of improvement seen on Day 7 was observed by the morning after the first dose (<24 hours after dose)
- Phase 2 acute exacerbation study showed rademikibart reduced treatment failure by 66% at one month and significantly increased post-bronchodilator FEV1 by Day 7
- Rapid onset of effect consistent with preclinical data that rademikibart appears to directly produce bronchodilation not seen with dupilumab
- Phase 3 AD study conducted in China at 52-weeks demonstrated **87.1% IGA 0/1, 96.6% EASI-75 and 85.3% EASI-90 responders**
- No important, drug-related safety issues observed in over **1,800** participants in completed studies

Catalysts

1Q2026
Complete preclinical studies providing the basis for the rapid FEV_1 improvement observed in Phase 2b

1Q2026
Complete IV pharmacology study designed to evaluate time to airway improvement in asthma and COPD

September 2026
Topline results from Phase 2 acute asthma and COPD studies

Late 2026 – 1H2027
Potential for NDA approval in China for AD indication

Large, rapid and sustained FEV_1 improvement in acute asthma study 206 confirms the utility of rademikibart for treatment of patients experiencing an acute exacerbations and provide a roadmap for Phase 3 development. AD data from China supports a potentially best-in-class profile of rademikibart

HASM – human airway smooth muscle; hPCLS – human precision cut lung slice; FEV_1 – forced expiratory volume in one second; COPD = chronic obstructive pulmonary disease; SC – subcutaneous:

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