Corporate Presentation

January 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-4Rα) 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

- Plan to initiate parallel acute exacerbation studies in asthma and COPD in 1H2025
- Have sufficient cash to fund these trials with runway to the first half of 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

COPD=chronic obstructive pulmonary disease

Reanalysis of Global Asthma Study CBP-201-WW002 Strongly Supports Rademikibart in Eosinophilic Driven Respiratory Diseases

Robust Efficacy

- Rademikibart demonstrated greater FEV_1 response than seen with approved biologics using protocol specified baseline eosinophils ≥150 cell/µL
- Prespecified analysis of patients with baseline eosinophils ≥300 cell/µL shows greatest efficacy

Rapid Onset of Effect

- Rademikibart demonstrated rapid onset of action with majority of FEV_1 increase observed within 24 hours of SC dose supporting the potential to use to treat acute exacerbations

Sustained FEV_1 Improvement

- Analysis of COPD-like patients in the study demonstrated FEV_1 was improved over baseline beginning at Week 1 and were sustained through 24 weeks of treatment
- 63% average reduction in annual exacerbation rate

Differentiated Safety

- New safety comparison shows clear difference in safety profile of rademikibart compared to dupilumab for hyper-eosinophilia

COPD = chronic obstructive pulmonary disease; SC = subcutaneous; FEV1 = Forced expiratory volume in one second; COPD-like patients had asthma onset age > 40 year and post−bronchodilator FEV1/forced vital capacity < 0.7 at screening visit

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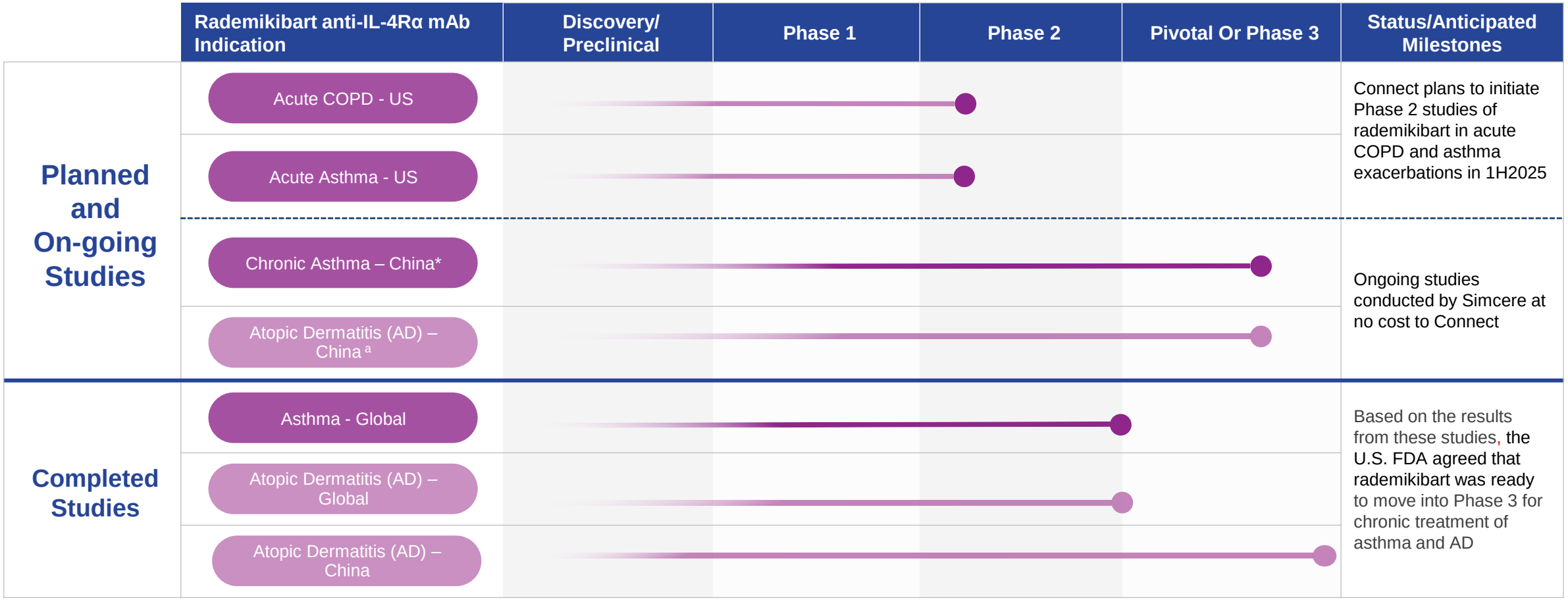
Rademikibart Has Demonstrated Efficacy & Safety Across Multiple Indications

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



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

[a]Simcere is Connect's partner in Greater China who holds responsibility for future development, including for additional indications
mAb = monoclonal antibody; S1P1 = sphingosine-1-phosphate receptor subtype 1; AD = atopic dermatitis

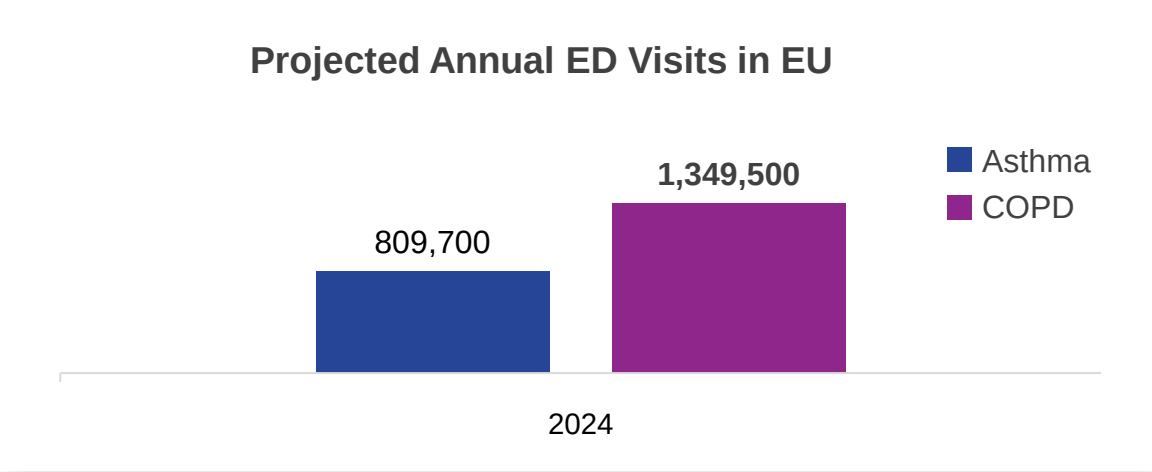
Asthma and COPD are Associated with Severe Exacerbations that are Difficult to Treat and Often Require Hospitalization

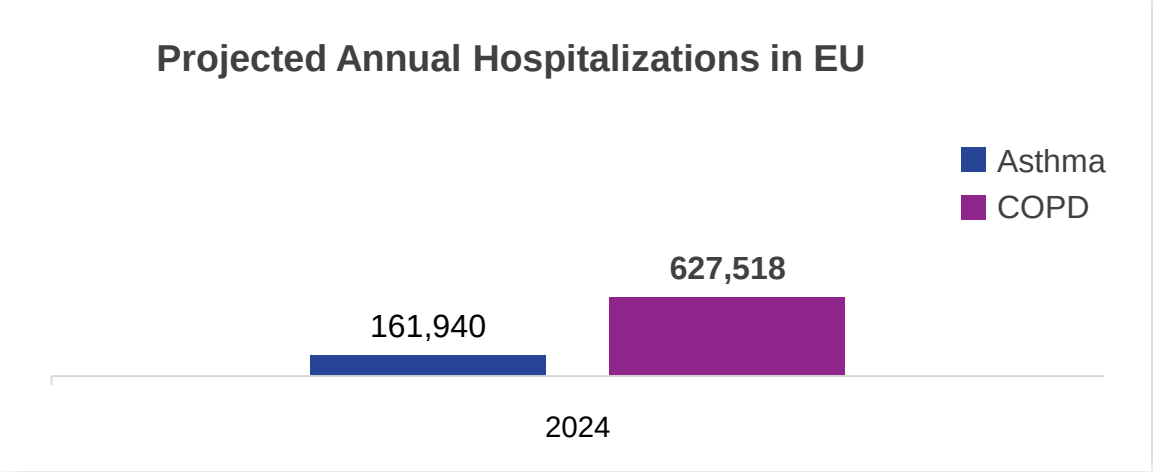
	Asthma	COPD
CURRENT SoC	Fast-acting inhaled bronchodilators and oral/IV corticosteroids; severe cases may require IV magnesium sulfate, heliox therapy, and noninvasive ventilation; intubation is considered if patients do not respond to initial therapies. Antibiotics are often added if a bacterial infection is suspected with COPD	
PROGRESSION	**~50% fail to improve on 1st Line treatments**	**~85% fail to improve on 1st Line treatments**
ADMISSIONS	Persistent hypoxia, severe respiratory distress, poor response to initial treatment, altered mental status and/or a history of exacerbations drive admission decisions	
	~1 million ED visits or hospitalizations/yr **~11% of Asthma patients are hospitalized** **LOS typically ranges from 2 to 3 days** **~50% meet treatment failure criteria within 4 weeks of an exacerbation, with 20% requiring a re-visit to the ED**	**~1.3 million ED visits or hospitalizations/yr** **~41% of COPD patients are hospitalized** **LOS typically ranges from 4 to 7 days** **~50% fail treatment within 4 weeks of an exacerbation with ~11% of patients require re-hospitalization**
LONG-TERM CARE	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

ED = emergency department; LOS = length of stay; PCP = primary care physician; SoC = standard of care

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





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**[1-9]
- Studies suggest the **prevalence of COPD exacerbations in the EU closely mirrors that of the US**[10-14]
- **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**[10-14]

Sources: **1.** Suruki et al., 2017; **2.** Engelkes et al., 2020; **3.** Mazurek et al., 2018; **4.** OECD 2018; **5.** Mayers et al., 2022; **6.** Skene et al., 2023; **7.** Ayar et al., 2022; **8.** Hardtstock et al., 2022; **9.** Korn et al., 2022; **10.** Kong et al., 2020; **11.** Bergs et al., 2022; **12.** Liew et al., 2023; **13.** Ali et al., 2019; **14.** Rochester et al., 2022.

ED = emergency department

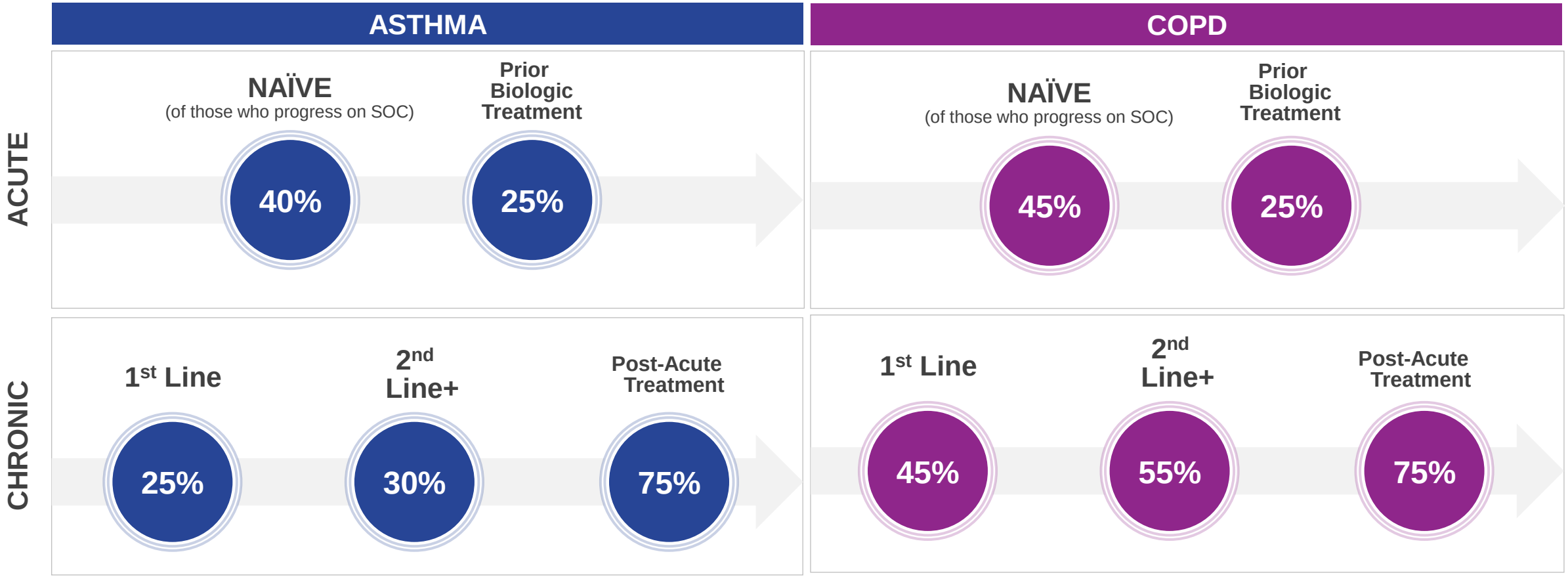
US Market Research: Obtaining Acute Treatment Indications Results in Significantly Greater Penetration into Asthma and COPD Markets

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 FEV1/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

- 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

- >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

- 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

ED = emergency department; COPD = chronic obstructive pulmonary disease; SoC = standard of care

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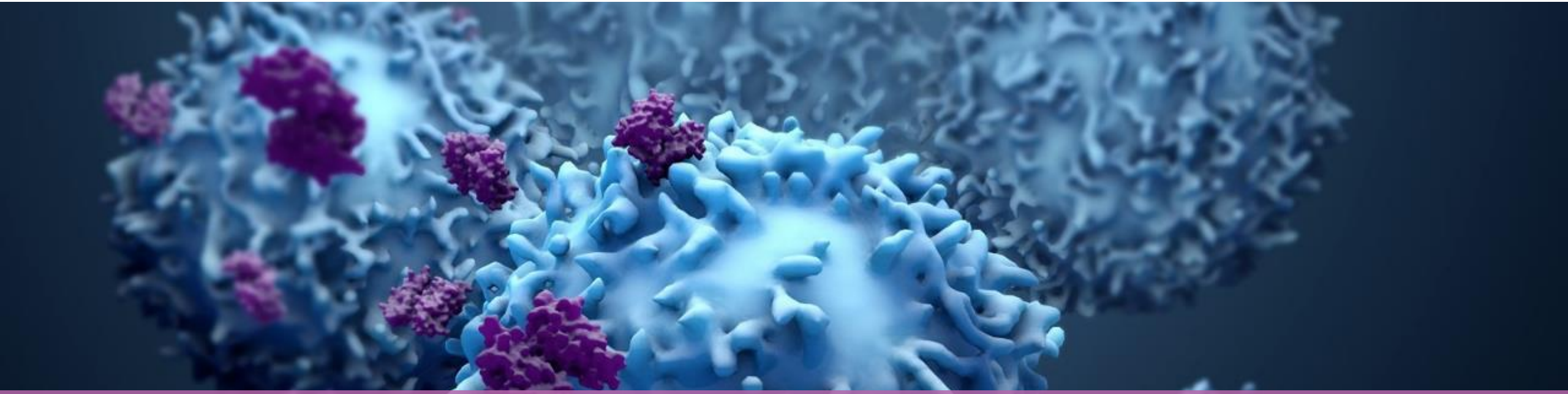
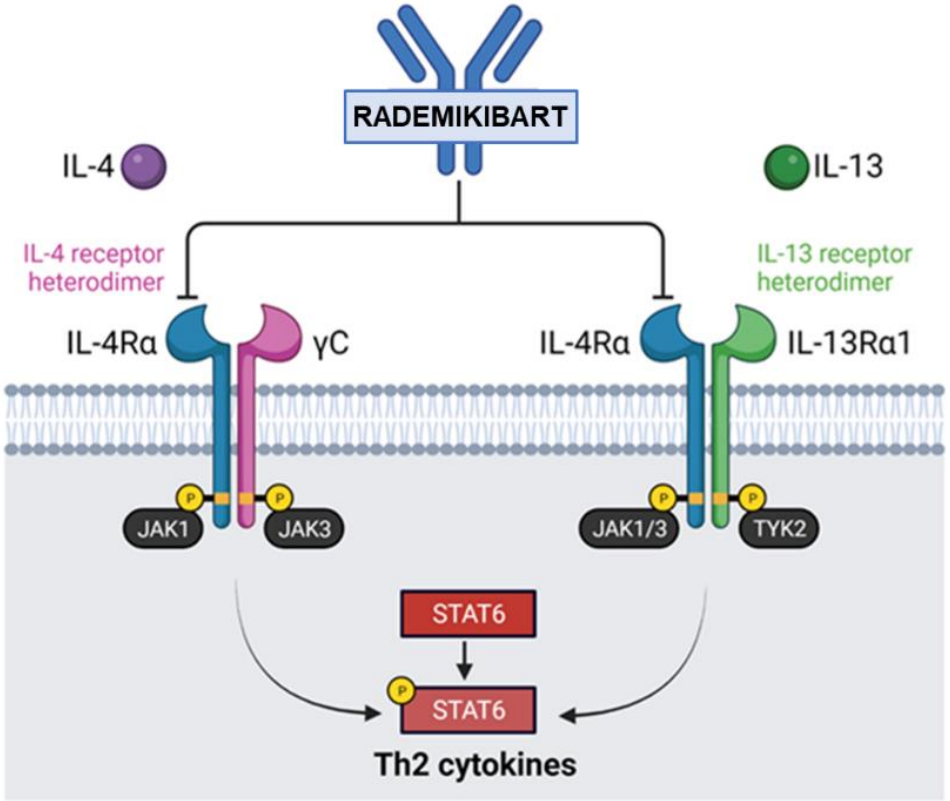


Rademikibart: A Next Generation Anti-interleukin-4-receptor alpha (IL-4Rα) Antibody

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 the IL-4Rα[1]
- Highly potent IC_{50} in:
  - Reducing JAK-STAT signaling[1,a]
  - Cell proliferation[1,a]
  - TARC release[1,a]

Potential Clinical Relevance

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

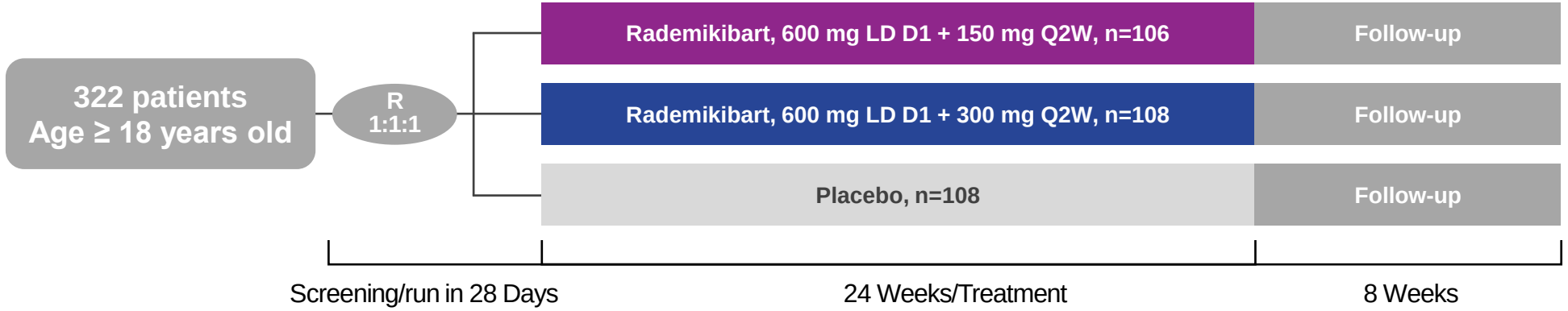
AD=atopic dermatitis; COPD=chronic obstructive pulmonary disease; IC50=half-maximal inhibitory concentration; IL=interleukin; JAK=janus kinase; STAT=signal transducers and activators of transcription; TARC=thymus- and activation-regulated chemokine.

[a]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_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; FEV1=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.

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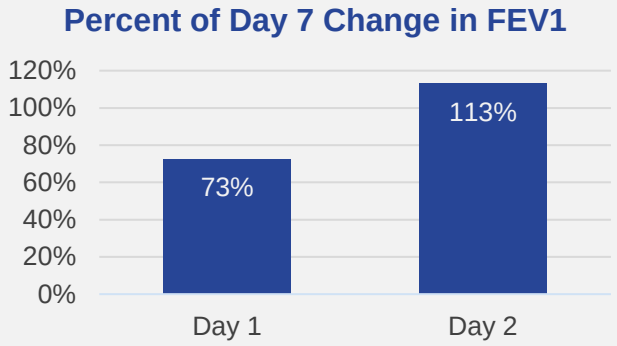
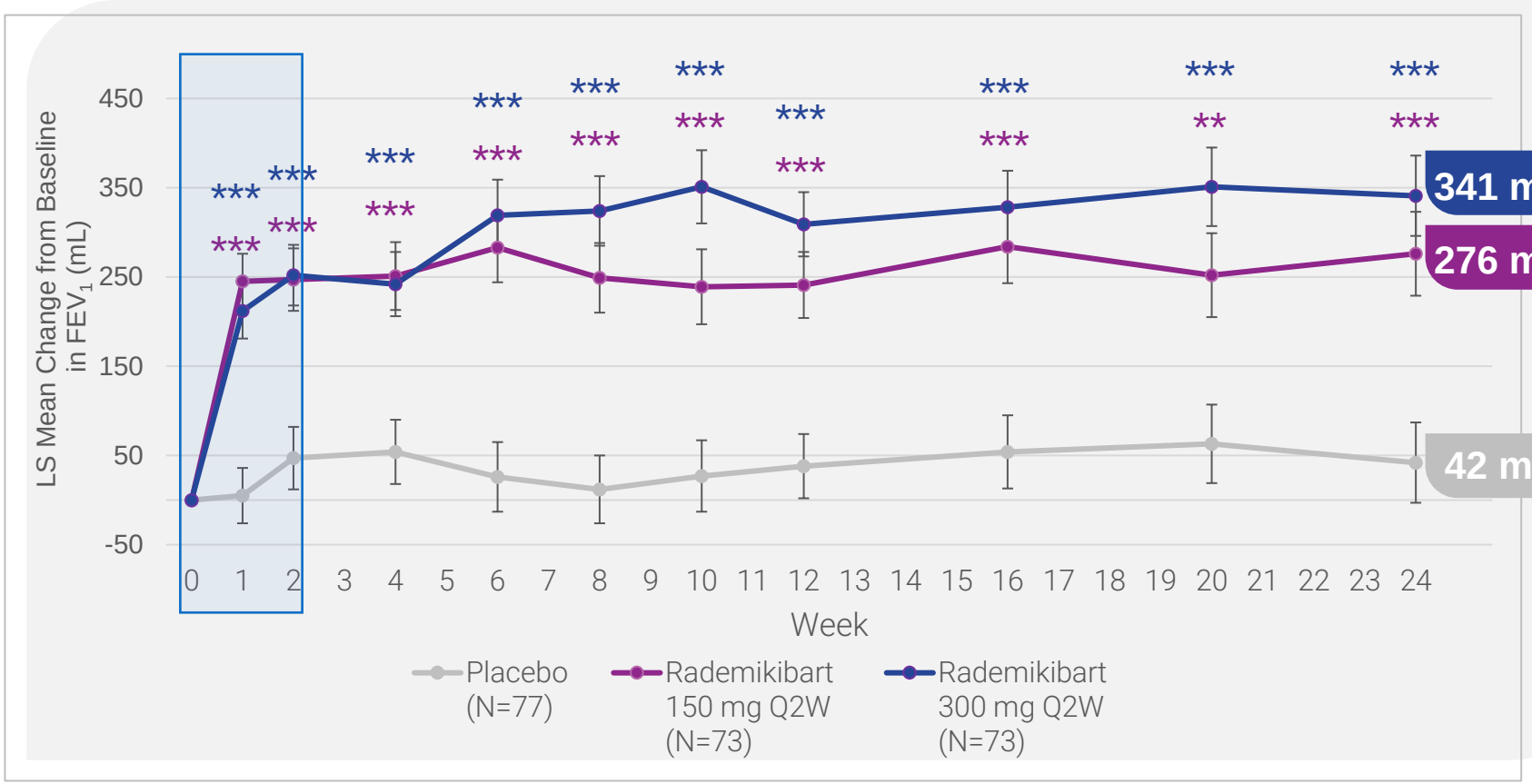
Rapidly Improved and Sustained FEV_1 Values Observed with Rademikibart Treatment

- Rademikibart treatment associated with rapid, significant changes in FEV_1 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:

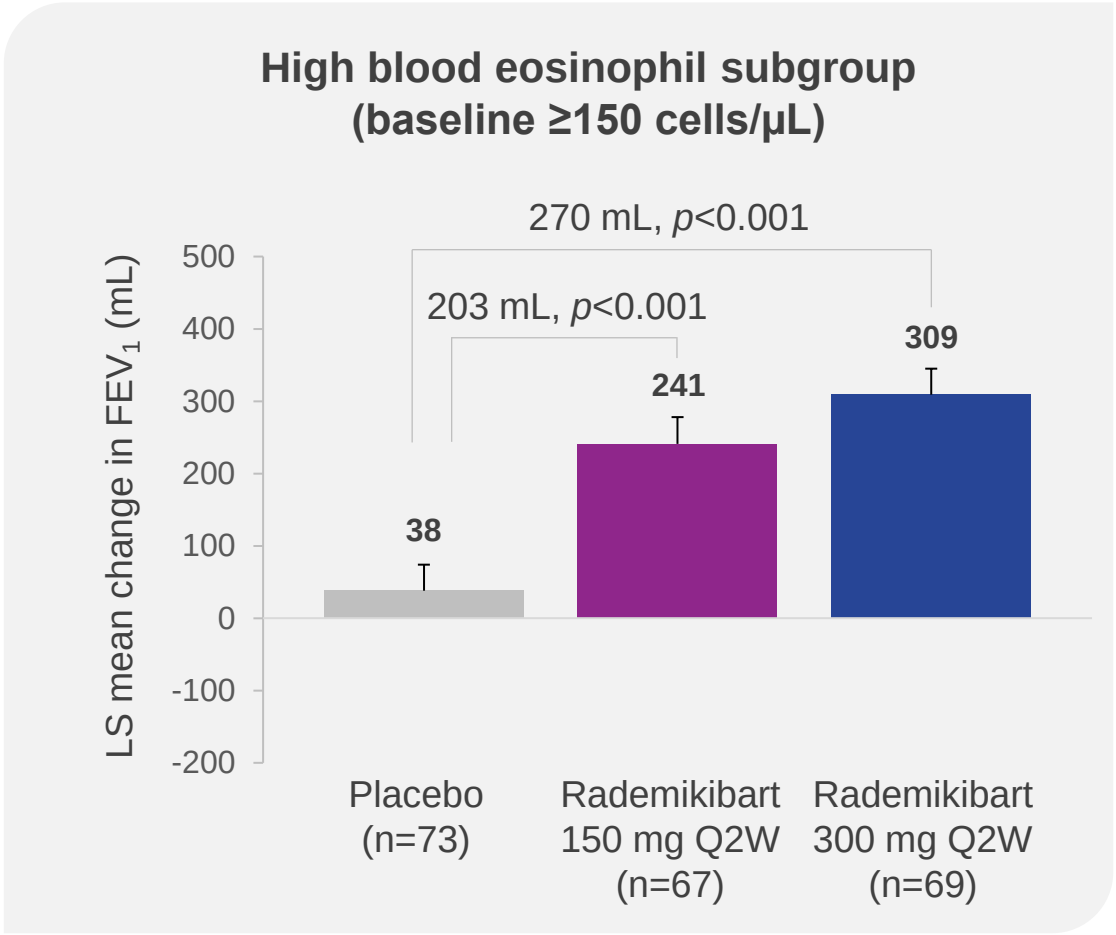


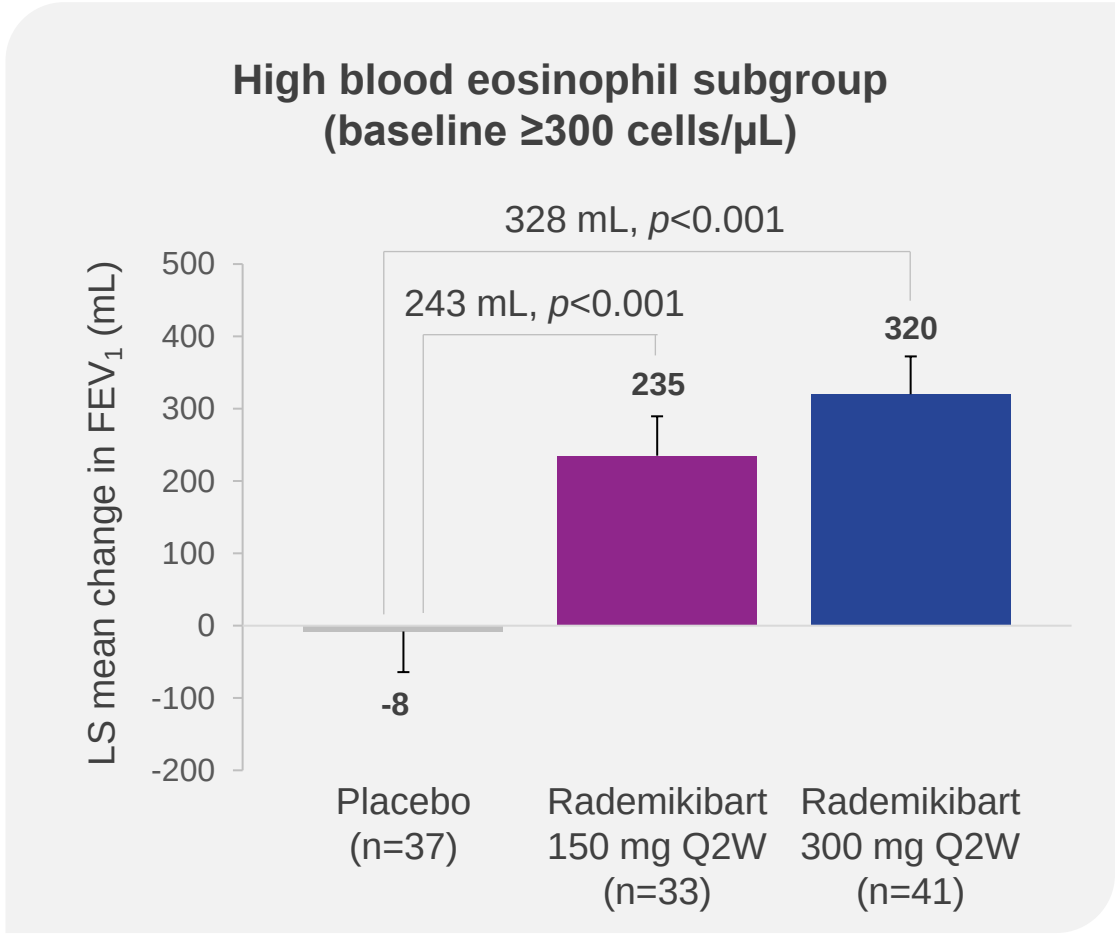
Change in Pre-bronchodilator FEV_1 over time in Patients with an Eosinophil Count ≥150 cells/μL at Baseline



***p<0.001, **p<0.01, *p<0.05. Data were analyzed with ANCOVA
FEV_1 = Forced expiratory volume in one second.

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





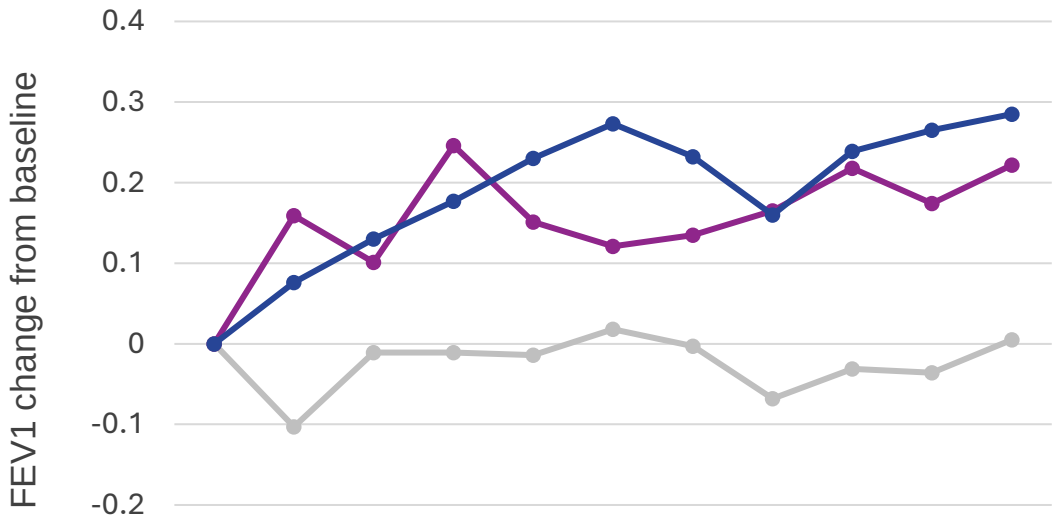
Error bars = standard error.

n, number of patients with data at Week 12. FEV_1 = 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 FEV1/forced vital capacity < 0.7 at screening visit

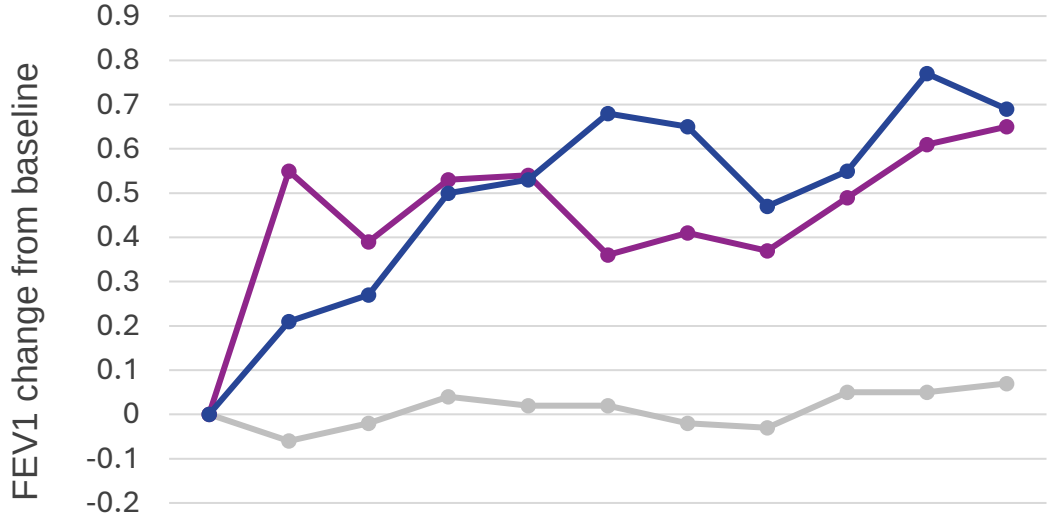
COPD-like Patients
All EOS levels



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

Placebo CBP-201 150 mg CBP-201 300 mg

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

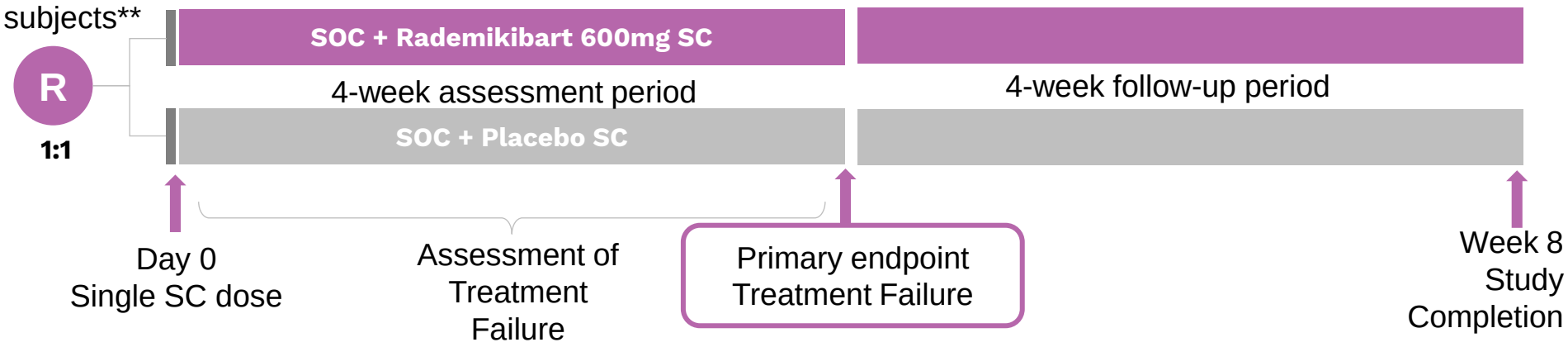
Placebo Rademikibart 150 mg Rademikbart 300 mg

EOS = eosinophils. FEV1 = Forced expiratory volume in one second

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

Seabreeze

STAT STUDY DESIGN*



Seabreeze ASTHMA STAT	Seabreeze COPD STAT
Population	
Adolescents and adults at urgent outpatient visit, ED or hospital	Adults at urgent outpatient visit, ED or hospital
Eosinophil count of ≥ 300 cells/μL, 1 exacerbation in prior 12 mos, No exacerbation in the prior 4 weeks	
Primary Endpoint 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	
Secondary Endpoints Rate of exacerbations and Time to exacerbation	
Key Exploratory Endpoints Time to ready for discharge in hospitalized patients, lung function in the 28 days after randomization, disease specific-PROs	

*Study design pending FDA feedback
**Interim analysis for sample size re-estimation after 80 subjects complete 4-week assessment period

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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

Sanjay Ramakrishnan, Richard E K Russell, Hafiz R Mahmood, Karolina Krassowska, James Melhorn, Christine Mwasuku, Ian D Pavord, Laura Bermejo-Sanchez, Imran Howell, Mahdi Mahdi, Stefan Peterson, Thomas Bengtsson, Mona Bafadhel

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-α, 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 µL 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

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See Online/Comment https://doi.org/10.1016/S2213-2600(24)00323-0

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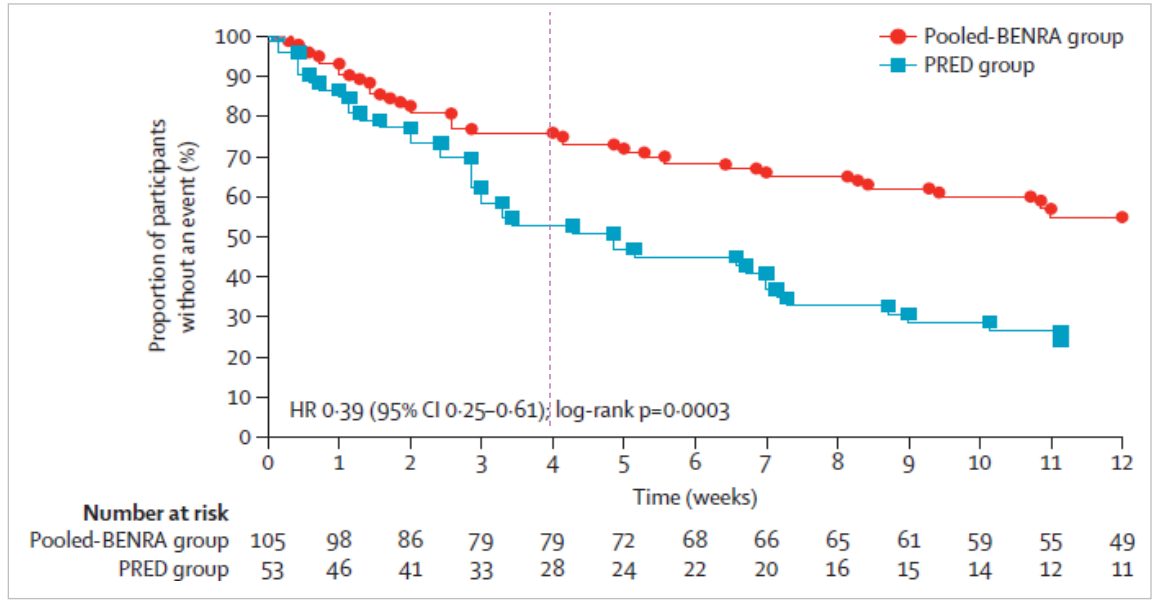
Correspondence to: Prof Mona Bafadhel, King's Centre for Lung Health, School of Immunology and Microbial Sciences, King's College London, London SE1 9RT, UK **mona.bafadhel@kcl.ac.uk**

- ~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_1)



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[2]	231/633	41.8%	12	2	130 mL	240 mL
			2024	COPD: NOTUS[8]	465/470	60.8	12	2	82 mL	113 mL
	IL-5Rα	**Benralizumab**	2017	SIROCCO[6] Q4W	407/399	68.9%	48	4	--	106 mL
				CALIMA Q4WWW002	248/241		56		--	125 mL
	IL-5	**Reslizumab**	2016	STUDY 1[5]	244/245	--	52	4	126 mL	--
				STUDY 2[5]	232/232	--			90 mL	--
	TSLP	**Tezepelumab**	2021	NAVIGATOR[7]	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. †.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

*EOS ≥150 cell/μL

1. ATS/ERS statement – Reddel HK et al. Am J Respir Crit Care Med. 2009 Jul 1;180(1):59-99. **2**. QUEST – Castro M et al. N Engl J Med 2018;378:2486-96. **3**. MENSA – Ortega HG et al. N Engl J Med 2014;371:1198-207.
4. MUSCA – Chupp GL et al. Lancet Respir Med. 2017 May;5(5):390-400. **5**. STUDY 1&2- Castro M et al. Lancet Respir Med. 2015 May;3(5):355-66. **6.** SIROCCO – Bleecker ER et al. Lancet. 2016 Oct 29;388(10056):2115-2127.
7. NAVIGATOR – Menzies-Gow A et al N Engl J Med 2021;384:1800-9. 8. NOTUS – Bhatt et al N Engl J Med 2024;390:2274-2283;

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Substantially Fewer Hyper-Eosinophilia Episodes with Rademikibart than with Dupilumab

	Ph2b Rademikibart Trial		Dupilumab QUEST Trial[1]	
	Placebo (N=108)	Rademikibart (N=108)	Placebo (N=634)	Dupilumab (N=1263)
Baseline EOS <500, n	**91**	**85**	**484**	**497**
Post-baseline peak >1500 **EOS**	1.1%	0%	2.7%	6.6%
Post-baseline peak >3000 **EOS**	0%	0%	0%	1.20%
Baseline EOS ≥500, n	**16**	**20**	**149**	**114**
Post-baseline peak >1500 **EOS**	18.8%	10.0%	17.4%	42.5%
Post-baseline peak >3000 **EOS**	0%	0%	2.7%	12.9%
Safety				
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

Wechsler et al. J Allergy Clin Immunol Pract. 2022;10(10):2695-2709. doi:10.1016/j.jaip.2022.05.019

EOS=eosinophils;

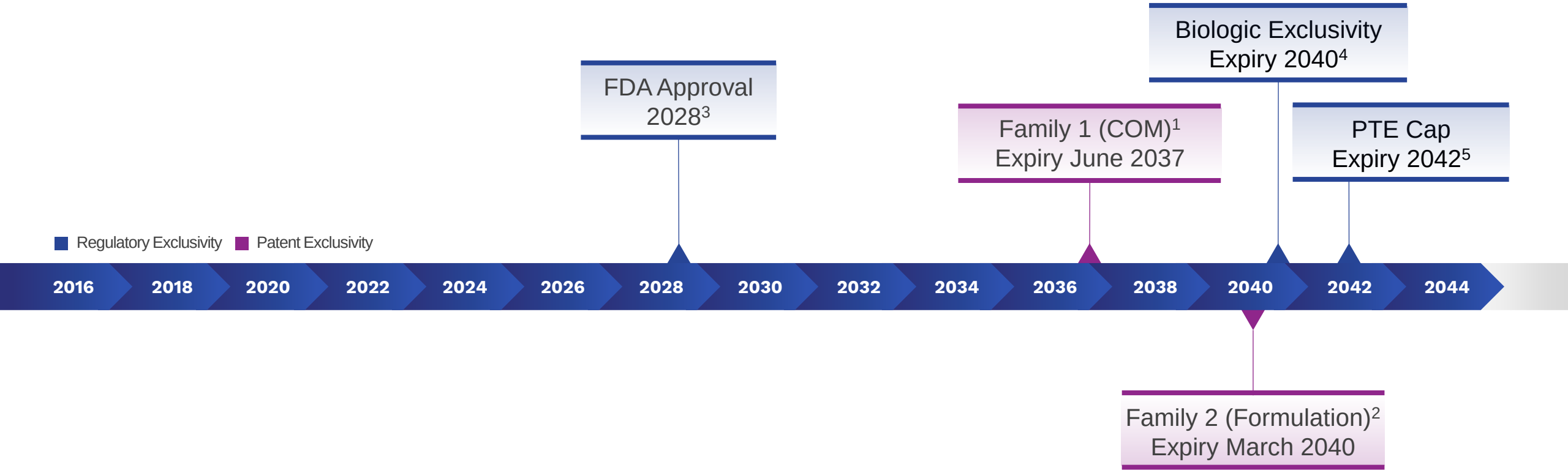
Comprehensive Data Package Sufficient to Move Quickly into Phase 3 Once the Planned Phase 2 Studies are Completed

Study	Status	Outcomes
CMC & Improved Manufacturing Process	Tech Transfer to US CMO Completed	• Initial manufacturing process successfully transferred to US CMO. New high-yield cell-line developed and will be transferred 2H2025
Phase 2b Asthma	Completed	• Significantly improved lung function at week 12 in patients with moderate-to-severe asthma maintained through 24 weeks • Rapidly improved and sustained FEV_1 values observed with rademikibart treatment as early as 24 hours • Rademikibart produced >60% lower annualized rate of exacerbations compared to placebo
Phase 2 Acute Asthma	Planned	• 1-month Phase 2 study evaluating rademikibart + SOC against SOC + placebo that will enroll patients with asthma having an acute exacerbation • Primary Endpoint: treatment failure through 28 days
Phase 2 Acute COPD	Planned	• 1-month Phase 2 study evaluating rademikibart + SOC against SOC + placebo that will enroll patients with COPD having an acute exacerbation • Primary Endpoint: treatment failure through 28 days

CMC = chemistry manufacturing and controls; CMO = contract manufacturing organization; SOC = standard of care; FEV1 = Forced expiratory volume in one second

Rademikibart Exclusivity Timeline

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



[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

Rademikibart has Potential to Transform Patient Outcomes in ED/Hospital Setting Resulting in Substantial WW Revenue

DIFFERENTIATED RAPID EFFICACY, IMPRESSIVE SUSTAINED RESPONSE AND SAFETY

- Rademikibart treatment achieves rapid and significant changes in FEV_1 as early as 24 hours post loading dose
- FEV_1 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**

ED = emergency department; COPD = chronic obstructive pulmonary disease; FEV1 = Forced expiratory volume in one second; WW = worldwide

Well Positioned for Success

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 agreement for acute asthma and COPD studies and for registration pathway

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 and cash equivalents of $110.2 million as of June 30, 2024 expected to support planned operations, including the acute asthma and COPD studies, into at least the first half of 2027

COPD = chronic obstructive pulmonary disease;

Financial Summary

Cash and cash equivalents of $110.2 million expected to support planned operations into at least the first half of 2027

Summary Statement of Operations and Net Cash Used in Operations (In thousands, expect per share data)	Six Months Ended June 30, 2024
Total revenue[1]	$24,116
Operating expenses[2]	16,808
Finance income, net	401
Income tax expense	60
Net income[2]	$7,649
Basic and diluted net income per share[3]	$0.14
Net cash used in operations	$(7,974)
Condensed Balance Sheet Data (In thousands)	**June 30, 2024**
Cash and cash equivalents	$110,174
Total assets	$120,570
Total shareholders' equity	$110,479

[1] Represents revenue recognized under the License Agreement with Simcere.
[2] Includes $1.8 million of non-cash, share-based compensation expense for the six months ended June 30, 2024.
[3] Based on 55.1 million (basic) and 55.6 million (diluted) weighted average ordinary shares outstanding for the six months ended June 30, 2024.

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NASDAQ: CNTB