DEVELOPING NEXT-GENERATION THERAPEUTICS FOR T CELL DRIVEN INFLAMMATORY DISEASES
Forward-Looking Statements

- This presentation regarding Connect Biopharma Holdings Limited ("Connect," "we," "us" or "our") has been prepared solely for informational purposes.

- Certain information contained in this presentation relates to, or is based on, studies, publications, surveys and other data obtained from third-party sources and Connect's own internal estimates and research. While we believe these third-party sources to be reliable as of the date of this presentation, we have not independently verified, and make no representation as to the adequacy, fairness, accuracy or completeness of, any information obtained from third-party sources. In addition, all of the market data included in this presentation involves a number of assumptions and limitations, and there can be no guarantee as to the accuracy or reliability of such assumptions. Finally, while we believe our own internal research is reliable, such research has not been verified by any independent source.

- This presentation contains forward-looking statements that involve substantial risks and uncertainties. All statements other than statements of historical facts contained in this presentation, including statements regarding our future financial condition, results of operations, business strategy and plans, prospective products and their potential benefits, product approvals, anticipated milestones, expected data readouts and enrollments, research and development plans and costs, future partnerships, timing and likelihood of success, objectives of management for future operations, future results of anticipated product development efforts and adequacy of existing cash to fund operations, as well as statements regarding industry trends, are forward-looking statements. Forward-looking statements can be identified by words such as: "anticipate," "believe," "contemplate," "continue," "could," "estimate," "expect," "intend," "may," "plan," "potential," "predict," "project," "should," "target," "will," or "would" or the negative of these terms or other similar expressions. The forward-looking statements in this presentation are only predictions. We have based these forward-looking statements largely on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. These forward-looking statements 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 United States, the PRC, Europe and other jurisdictions; uncertainties regarding the interpretation and enforcement of PRC laws, rules and regulations; risks associated with the COVID-19 outbreak, which has and may continue to materially and adversely impact our business, preclinical studies and clinical trials; 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 by physicians, patients, healthcare payors and others in the medical community. These risks are not exhaustive.

- 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 from those expectations, projections or plans 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 periodic reports filed with the SEC, including Connect's Annual Report on Form 20-F filed with the SEC on March 31, 2022, and its other reports which are available from the SEC's website (www.sec.gov) and on Connect's website (www.connectbiopharma.com) under the heading "Investors." New risk factors emerge from time to time and it is not possible for our management to predict all risk factors, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in, or implied by, any forward-looking statements. You should not rely upon forward-looking statements as predictions of future events. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance or achievements. Except as required by law, we undertake no obligation to update publicly any forward-looking statements for any reason after the date of this presentation.

- In addition, statements that "we believe" and similar statements reflect our beliefs and opinions on the relevant subject. These statements are based upon information available to us as of the date of this presentation, and while we believe such information forms a reasonable basis for such statements, such information may be limited or incomplete, and our statements should not be read to indicate that we have conducted an exhaustive inquiry into, or review of, all potentially available relevant information. These statements are inherently uncertain and investors are cautioned not to unduly rely upon these statements.

- We have not conducted a head-to-head study of CBP-201 versus dupilumab and have not conducted a head-to-head study of CBP-307 versus Etrasimod or Ozanimod. Comparisons of CBP-201 to dupilumab and comparisons of CBP-307 to Etrasimod or Ozanimod contained herein are based on analysis of data from separate studies. Such data may not be directly comparable due to differences in study protocols, conditions and patient populations. Accordingly, cross-trial comparisons may not be reliable predictors of the relative efficacy or safety of CBP-201 compared to dupilumab or of the relative efficacy or safety of CBP-307 compared to Etrasimod or Ozanimod. The potential benefits of CBP-201 or CBP-307 do not imply an expectation of regulatory approval which is solely within the authority of the FDA (or applicable foreign regulator).
## Company Highlights

<table>
<thead>
<tr>
<th>Large Opportunity</th>
<th>Targeting inflammatory diseases (dermatology, gastroenterology, respiratory) with high unmet need representing multi-billion-dollar global market opportunities</th>
</tr>
</thead>
</table>
| **Late-Stage Pipeline** | **CBP-201**: Interleukin-4-receptor alpha (IL-4Rα) blocker (China Pivotal/Planning Global Phase 3)  
**CBP-307**: Sphingosine 1-phosphate-1 (S1P1) modulator  
**CBP-174**: Peripherally acting histamine-3 receptor (H3R) antagonist |
| **Potential Regulatory Approval** | **CBP-201**: Potential first product approval for AD in China as soon as 2025*; planning Phase 3 for AD outside of China; asthma trial opens door to additional Type II disease indications |
| **Strong Cash Position** | $267.7 million USD in cash and cash equivalents at December 31, 2021, expected to fund operations into at least the second half of 2023 |
| **Multiple Catalysts** | Completed US FDA and China CDE discussions for CBP-201; 3 additional read outs anticipated by end of H1 2023 across 3 disease indications |

*Based on our understanding of standard CDE approval timelines
A robust pipeline of potentially differentiated therapies

Connect Biopharma has Global Development & Commercialization Rights to all Product Candidates

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>PRECLINICAL</th>
<th>PHASE 1</th>
<th>PHASE 2</th>
<th>PIVOTAL OR PHASE 3*</th>
<th>NEXT ANTICIPATED MILESTONE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CBP-201</strong></td>
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<tr>
<td>Antibody targeting IL-4Rα cytokine receptor (Th2 cell modulator)</td>
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<tr>
<td>Atopic Dermatitis (AD) - China Pivotal Trial</td>
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<td>Report pivotal study top-line in 2H2022</td>
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<tr>
<td>Atopic Dermatitis (AD) - Global Trial</td>
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<td></td>
<td></td>
<td></td>
<td>Initiate Global Ph3 in 2H2022</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Report Ph2 top-line in 1H2023</td>
</tr>
<tr>
<td><strong>CBP-307</strong></td>
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<tr>
<td>Small molecule targeting S1P1 (Th1 cell modulator)</td>
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<tr>
<td>Ulcerative Colitis (UC)</td>
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<td></td>
<td>Complete maintenance phase on UC trial in 2H2022. Seek partnerships to advance into future trials for both UC and CD.</td>
</tr>
<tr>
<td>Crohn’s Disease (CD)**</td>
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<tr>
<td><strong>CBP-174</strong></td>
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<td></td>
</tr>
<tr>
<td>Peripherally restricted H3 receptor antagonist</td>
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<td></td>
<td>Report Ph1 top-line data in 2H2022</td>
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<tr>
<td>Pruritus associated with AD</td>
<td></td>
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</tbody>
</table>

*The Company’s clinical trial in China of CBP-201 in patients with AD is included as the Company intends to submit a New Drug Application in China based on the results of this trial, pending pre-NDA discussions with the Chinese Center for Drug Evaluation of the National Medical Products Administration.

**Phase 2 CD trial ended early due to COVID-19-related enrolment challenges.
Multiple Clinical Trial Catalysts Anticipated In Next 12 Months  
(Subject to ongoing Covid-19 restrictions)

Three clinical trial data readouts expected in the next 12 months across up to 3 diseases

<table>
<thead>
<tr>
<th>INDICATION / REGION</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; HALF 2022</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; HALF 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CBP-201</strong></td>
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</tr>
<tr>
<td>Antibody targeting IL-4Ra cytokine receptor (Th2 cell modulator)</td>
<td>Atopic Dermatitis (AD) – Global</td>
<td>Ph3 Initiation</td>
</tr>
<tr>
<td>Atopic Dermatitis (AD) – China</td>
<td>Pivotal Full Enrollment</td>
<td>Pivotal Topline</td>
</tr>
<tr>
<td>Asthma – Global</td>
<td>Ph2 Full Enrollment</td>
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<tr>
<td><strong>CBP-307</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small molecule targeting S1P1 (Th1 cell modulator)</td>
<td>Ulcerative Colitis (UC) – Global*</td>
<td>Complete Ph2 Maintenance Phase</td>
</tr>
<tr>
<td>Crohn's Disease (CD) – Global*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CBP-174</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peripherally restricted H3 receptor antagonist</td>
<td>Pruritus associated with AD - Global</td>
<td>Ph1 Topline</td>
</tr>
</tbody>
</table>

* Company intends to seek partnerships to advance CBP-307 into future trials.
CBP-201: A next generation anti-interleukin-4-receptor alpha (IL-4Rα) antibody in development for type 2 inflammatory diseases
Atopic Dermatitis (AD)

A chronic inflammatory disorder characterized by eczematous skin lesions, itch, localized pain, and sleep disturbances

Large Opportunity with High Unmet Need Despite Advent of Biologics

Current Treatment Limitations
- Limited efficacy with topical corticosteroids and immunosuppressants
- Safety concerns with systemic corticosteroids
- Dupilumab is the only approved biologic agent
  - Sales of $6.2 billion in 2021\(^1\) and expected to grow to $15 billion\(^2\)
  - Unmet efficacy needs remain
  - Q2W administration regimen can be inconvenient for patients

Key Unmet Needs
1. Improved efficacy and sustained efficacy
2. Faster onset of efficacy
3. Reduced adverse events
4. Reduced injection burden frequency with biologic agents

13% AD prevalence in Chinese children aged 1–7 (Clinically diagnosed)\(^3\)
26.1 M People in the United States have AD\(^4\)
6.6 M Adults have moderate-to-severe disease\(^4\)

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1. Regeneron Investor Presentation, February 2022 [https://investor.regeneron.com/static-files/2312f44d-0a3e-47c8d-8a6d9f30a8ed]
2. Gould, Carter, Barclays Equity Research Report, “4Q21 Post-Call Thoughts” on Regeneron, February 6, 2022
CBP-201: A Next Generation IL-4Rα Blocker

Dual inhibition of IL-4 and IL-13 is a validated therapeutic strategy across many Th2-mediated diseases

- CBP-201 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
- Potential for differentiation based on observations of
  1. CBP-201 engages with distinct epitopes and binds with higher affinity to the IL-4Rα target than dupilumab
  2. CBP-201 inhibits IL-4/IL-13-dependent activation of the JAK-STAT pathway and cell proliferation in a concentration-dependent manner
  3. Cytokine-mediated release of TARC, and inflammatory Th2 chemokine, is downregulated in the presence of CBP-201
  4. CBP-201 detected longer in plasma than dupilumab
- Potential for clinical results to show
  - Faster onset of action
  - Greater clinical response
  - Less frequent dosing (Q4W)

1. Yang et al., Society for Investigative Dermatology, Portland, 2022, poster LB945. Observations were made from our in-house preclinical experiments, including all comparisons to dupilumab.
2. Not head-to-head trial results. Differences exist between trial designs and subject characteristics and caution should be exercised when comparing data across trials. Results are from CBP-201 Phase 1 study (AU001) and dupilumab Phase 1 study (Li, Z et al 2020).

A Randomized, Double-blind, Placebo-controlled, Single Ascending Dose Study to Evaluate the Safety, Tolerability, Pharmacokinetics and Pharmacodynamics of CBP-201 Administered to Healthy Adult Subjects (CBP-201AU001)
**Key Inclusion Criteria:**
- Adults with moderate-to-severe AD inadequately controlled with topical corticosteroids and calcineurin inhibitors
- Having atopic dermatitis for ≥ 1 year
- EASI ≥16
- IGA score ≥3 (5-point scale [0-4])
- ≥10% BSA involvement

**Concomitant therapies:**
- TCS, TCI and prescription moisturizers washed out ≥ 1 week prior to Baseline
- OTC emollient used bid for ≥ 1 week prior to Baseline and duration of study
- Medications known to affect AD only used as rescue therapies

**Primary Endpoints**
- Percent change in EASI from Baseline to Week 16

**Key Secondary Efficacy Endpoints**
- Proportion of patients achieving IGA 0,1 at Week 16
- Proportion of patients achieving EASI-75 at Week 16
- Proportion of patients achieving EASI-90 at Week 16
- Change in PP-NRS from Baseline to Week 16

Study conducted in 59 centers in USA (N=38), China (N=9), Australia (N=8) and New Zealand (N=4)
All doses of CBP-201 were statistically significant vs. Placebo, despite high placebo response

EASI % Change from baseline (CFB) at Week 16

CBP-201 WW001, LOCF, FAS

% change in EASI at Week 16

-63.0%***

-57.6%**

-63.5%***

-39.7%

300 mg Q2W (n=49) 150 mg Q2W (n=56) 300 mg Q4W (n=55) Placebo (n=55)

EASI, Eczema Area and Severity Index score. FAS, full analysis set. LOCF, last observation carried forward. LS, least squares. Q2W, every 2 weeks. Q4W, every 4 weeks.

*P<0.05 vs placebo. **P<0.01 vs placebo. ***P<0.001 vs placebo.

1. Strober, B et al. Maui Derm 2022 Abstract and Poster (and reflects additional data analyses conducted by the Company subsequently)
**WW001 – Efficacy Results – Key Secondary Endpoints**

% patients with IGA 0/1, and ≥2-point reduction / EASI-50, -75 or -90 % response vs. baseline at Week 16

CBP-201 300mg Q2W and Q4W delivered highest efficacy responses in the trial\(^1\)

**CBP-201 WW001, NRI, FAS**

% IGA 0/1 responders at Week 16

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Patients with IGA 0/1 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 mg Q2W (n=57)</td>
<td><strong>28.1</strong>% <strong>(\ast)</strong></td>
</tr>
<tr>
<td>150 mg Q2W (n=57)</td>
<td>15.8%</td>
</tr>
<tr>
<td>300 mg Q4W (n=56)</td>
<td>19.6%</td>
</tr>
<tr>
<td>Placebo (n=56)</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

**CBP-201 WW001, NRI, FAS**

% patients with EASI-50, EASI-75, and EASI-90 at Week 16

<table>
<thead>
<tr>
<th>Treatment</th>
<th>EASI-50</th>
<th>EASI-75</th>
<th>EASI-90</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 mg Q2W (n=57)</td>
<td>54% (\ast)**</td>
<td>61% (\ast)**</td>
<td>47% (\ast)**</td>
</tr>
<tr>
<td>150 mg Q2W (n=57)</td>
<td>51% (\ast)**</td>
<td>32%</td>
<td>40% (\ast)**</td>
</tr>
<tr>
<td>300 mg Q4W (n=56)</td>
<td>13%</td>
<td>13%</td>
<td>25% (\ast)**</td>
</tr>
<tr>
<td>Placebo (n=56)</td>
<td>14%</td>
<td>9%</td>
<td>23% (\ast)**</td>
</tr>
</tbody>
</table>

**EASI-50/75/90, Eczema Area and Severity Index score percentage improvement. FAS, full analysis set. IGA, Investigator’s Global Assessment. NRI, non-responder imputation. Q2W, every 2 weeks. Q4W, every 4 weeks. \(\ast\)P<0.05 vs placebo. \(\ast\)P<0.01 vs placebo. \(\ast\)P<0.001 vs placebo.**

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1. Strober, B et al. Maui Derm 2022 Abstract and Poster (and reflects additional data analyses conducted by the Company subsequently)
**WW001 – Efficacy Results – Key Secondary Endpoints**

**Change in weekly average PP-NRS at Week 16**

**CBP-201 300mg Q2W and Q4W delivered statistically significant improvements on itch**

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**CBP-201 WW001, LOCF, FAS**

**Change in PP-NRS at Week 16**

<table>
<thead>
<tr>
<th>Group</th>
<th>LS Mean Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 mg Q2W (n=49)</td>
<td>-3.56**</td>
</tr>
<tr>
<td>150 mg Q2W (n=52)</td>
<td>-2.64</td>
</tr>
<tr>
<td>300 mg Q4W (n=55)</td>
<td>-3.16*</td>
</tr>
<tr>
<td>Placebo (n=51)</td>
<td>-2.24</td>
</tr>
</tbody>
</table>

**Median Baseline PP-NRS**

- Placebo: 7.0
- 300 mg Q4W: 6.7
- 150 mg Q2W: 6.9
- 300 mg Q2W: 7.1

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*P<0.05 vs placebo. **P<0.01 vs placebo.

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1. Strober, B et al. Maui Derm 2022 Abstract and Poster (and reflects additional data analyses conducted by the Company subsequently)
## WW001 - Safety Results

Rates of conjunctivitis, injection site reaction, and herpes virus infections were low with CBP-2011

<table>
<thead>
<tr>
<th>n (%) patients with...</th>
<th>CBP-201 300 mg Q2W N=57</th>
<th>CBP-201 150 mg Q2W N=57</th>
<th>CBP-201 300 mg Q4W N=56</th>
<th>All CBP-201 N=170</th>
<th>Placebo N=56</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any TEAE</td>
<td>26 (45.6%)</td>
<td>24 (42.1%)</td>
<td>32 (57.1%)</td>
<td>82 (48.2%)</td>
<td>30 (55.4%)</td>
</tr>
<tr>
<td>Serious TEAE</td>
<td>0</td>
<td>1 (1.8%)</td>
<td>2 (3.6%)</td>
<td>3 (1.8%)</td>
<td>2 (3.6%)</td>
</tr>
<tr>
<td>Grade ≥3 TEAE</td>
<td>1 (1.8%)</td>
<td>1 (1.8%)</td>
<td>4 (7.1%)</td>
<td>6 (3.5%)</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td>Discontinuation due to TEAE</td>
<td>0</td>
<td>1 (1.8%)</td>
<td>1 (1.8%)</td>
<td>2 (1.2%)</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td>Treatment-related TEAE</td>
<td>6 (10.5%)</td>
<td>6 (10.5%)</td>
<td>8 (14.2%)</td>
<td>20 (11.7%)</td>
<td>5 (8.9%)</td>
</tr>
<tr>
<td>COVID-19 infections</td>
<td>2 (3.5%)</td>
<td>4 (7.0%)</td>
<td>1 (1.8%)</td>
<td>7 (4.1%)</td>
<td>4 (7.1%)</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>2 (3.5%)</td>
<td>2 (3.5%)</td>
<td>1 (1.8%)</td>
<td>5 (2.9%)</td>
<td>0</td>
</tr>
<tr>
<td>Conjunctivitis allergic</td>
<td>0</td>
<td>0</td>
<td>1 (1.8%)</td>
<td>1 (0.6%)</td>
<td>0</td>
</tr>
<tr>
<td>Injection site reaction</td>
<td>1 (1.8%)</td>
<td>1 (1.8%)</td>
<td>1 (1.8%)</td>
<td>3 (1.8%)</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td>Herpes virus infections</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td>Oral herpes</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmic herpes simplex</td>
<td>0</td>
<td>0</td>
<td>1 (1.8%)</td>
<td>1 (%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Q2W, every 2 weeks. Q4W, every 4 weeks. TEAE, treatment-emergent adverse event.

1. Strober, B et al. Maui Derm 2022 Abstract and Poster (and reflects additional data analyses conducted by the Company subsequently)
WW001 – Efficacy Results – Primary & Additional Analyses

Primary Endpoint - EASI % Change from baseline (CFB) to Week 16

CBP-201 300mg Q2W & Q4W efficacy responses appeared at least comparable to dupilumab\(^1,2,3,4\)

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

Data for dupilumab are from two pooled studies. EASI, Eczema Area and Severity Index score. FAS, full analysis set. LOCF, last observation carried forward. LS, least squares. MCMC, Markov Chain Monte Carlo. MI, multiple imputation. QW, every week. Q2W, every 2 weeks. Q4W, every 4 weeks. *P<0.05 vs placebo. **P<0.01 vs placebo. ***P<0.001 vs placebo. P values for dupilumab are not shown.

1. Strober, B et al. Maui Derm 2022 Abstract and Poster (and reflects additional data analyses conducted by the Company subsequently)
2. Silverberg, J et al. Maui Derm 2022 Abstract and Poster (and reflects additional data analyses conducted by the Company subsequently)
• CBP-201 showed significant improvements in skin clearance, disease severity, and itch compared to placebo in adult patients with moderate-to-severe AD\textsuperscript{1,2}

• Cross-trial comparisons to SOLO 1,2 are difficult due to a less severe AD population recruited and higher patient discontinuations due to the impact of the COVID-19 pandemic on trial conduct in WW001

• Additional \textit{a priori} and post-hoc analyses of WW001 trial populations showed
  – As baseline disease severity increased, CBP-201 efficacy response further improved\textsuperscript{1,2,3}
  – With baseline severity that more closely matches SOLO1,2, side by side comparisons of CBP-201 300mg Q2W & Q4W appeared at least comparable, with some endpoints numerically better than dupilumab 300mg Q2W\textsuperscript{1,2,3}
  – CBP-201 300mg has the potential for a differentiated efficacy and safety profile with the convenience of Q4W dosing

• Planning for global phase 3 AD program underway with first patient enrollment estimated in 2H 2022
**CBP-201: Global Phase 2b Asthma Trial Design**

**Key Inclusion Criteria**
- Moderate to severe uncontrolled asthma
  - Existing treatment with medium to high dose inhaled corticosteroids in combination with a second reliever/controller (e.g., LABA, LTRA, LAMA, or theophylline) for at least 3 months with a stable dose ≥1 month prior to the screening visit
  - Pre-bronchodilator FEV1 40 to 85% of predicted normal at Visits 1 and 2, prior to randomization
  - Screening blood eosinophil count ≥150 cells/μL
  - ACQ-6 score ≥1.5 at Visits 1 and 2, prior to randomization
  - At least 1 documented asthma exacerbations in the 12 months prior to the date of informed consent

**Primary Endpoints**
- Change from Baseline in FEV1 at Week 12

**Secondary Efficacy Endpoints**
- Change from Baseline in lung function at other timepoints
- Exacerbation of asthma
- PROs (ACQ-6, symptom diary)
- PD markers (FENO, eosinophils, ECP, periostin, TARC)
- Rescue medication use

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**Trial designed for dose-ranging (NCT04773678)**

**A Multi-center, Randomized, Double-blind, Parallel Group, Placebo-controlled, Efficacy and Safety Study of CBP-201 in Patients With Moderate to Severe Persistent Asthma With Type 2 Inflammation**

<table>
<thead>
<tr>
<th>Randomization</th>
<th>CBP-201, 600 mg LD D1 + 150 mg Q2W, n=102</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1:1 n=306</td>
<td>CBP-201, 600 mg LD D1 + 300 mg Q2W, n=102</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Placebo, n=102</td>
<td>Follow-up</td>
</tr>
</tbody>
</table>

- **Screening/run in 28 Days**
- **24 Weeks/Treatment**
- **8 Weeks**

ACQ-6: Asthma Control Questionnaire 6-question version; FENO: Fractional Exhaled Nitric Oxide; FEV1: Forced expiratory volume at 1 second.
CBP-307: A next generation selective sphingosine 1-phosphate receptor 1 modulator (S1P1) in development for IBD
Ulcerative Colitis (UC)

Large Opportunity where High Unmet Need Remains Despite Treatment Advances

An autoimmune disease that causes inflammation and ulceration of the inner lining of the colon and rectum (the large bowel)

Current Treatment Limitations

• Efficacy
  • Less than half of patients achieve long-term remission, and many drugs lose the initial efficacy response
  • Maximal clinical remission may require up to one year of treatment

• Safety concerns with many treatment options

• Biologics can have complicated administration regimens

Key Unmet Needs

1. Improved efficacy
2. Faster onset of efficacy
3. Reduced adverse events
4. Oral therapies

3 M
IBD patients in the US in 2015

6.8 M
IBD patients worldwide in 2017

 Majority of IBD patients in the US had UC

CBP-307: A Next Generation S1P1 Modulator

• **Blocking T Cell Egress from Lymph Nodes Reduces Inflammation Implicated in Many T cell-mediated diseases**

  - S1P1 mediates T cell movement from lymph nodes into circulation, and hence migration to tissues to release inflammatory mediators
  - CBP-307 internalizes S1P1, trapping T cells inside lymph nodes
  - CBP-307 has molecular design features that offer potential for differentiation
    - **High Potency & Selectivity**
      - Designed to be the most potent modulator of sphingosine 1-phosphate receptor 1 (S1P1)
      - No notable activity observed for S1P3, a receptor subtype associated with known safety concerns
      - Substantially lower potency for S1P4 and S1P5 than S1P1 observed

**Mechanism of Action – S1P1 Modulator – A validated target**

Primary and all secondary endpoints were assessed at Week 12 in the induction phase

A Randomized, Double-blind, Placebo Controlled Trial to Evaluate the Efficacy and Safety of CBP-307 in Patients With Moderate to Severe Ulcerative Colitis (UC)¹

- Primary endpoint: Change from baseline in modified/adapted Mayo Score at Week 12 in 0.2 mg CBP-307 group versus placebo

Select Eligibility Criteria¹
- 8–75 years old with UC, clinically and endoscopically diagnosed ≥3 months before screening, corroborated by a histopathology report
- An adapted Mayo score of 4–9, with an endoscopic subscore of ≥2
- UC extending to the rectum, with ≥15 cm involvement on endoscopy

PO, by mouth; QD, once daily; UC, ulcerative colitis

*For subjects in the group of CBP-307 0.2 mg once daily, a dose of 0.05 mg CBP-307 was given from day 1 to day 4; then, a dose of 0.1 mg CBP-307 was given for later 3 days; from day 8, a target dose (0.2 mg) was administered

**Study amended to modify randomization from 1:1:1 to 1:1 to focus patient enrolment for the 0.2 mg PO QD and placebo groups resulting n=39 patients allocated to the 0.1 mg PO QD group

***Responders at Week 12 without clinical response at Week 24 are withdrawn from treatment

¹ (NCT04700449) - https://clinicaltrials.gov/ct2/show/NCT04700449
CBP-307CN002 Trial - Primary and Secondary Efficacy Endpoints
Change from baseline in Adapted and Complete Mayo score between CBP-307 0.2 mg PO QD and placebo

CBP-307 demonstrated a numerical, non-significant difference vs. placebo on primary efficacy endpoint

Primary Efficacy Endpoint
Change in adapted Mayo score at Week 12 (FAS, MI)

Change in adapted Mayo score at Week 12 (FAS, MI):
- CBP-307 0.2 mg QD PO (n=48) vs. Placebo (n=44)
- CBP-307 demonstrated a numerical, non-significant difference vs. placebo

Secondary Efficacy Endpoint
Change in complete Mayo score at Week 12 (FAS, MI)

Change in complete Mayo score at Week 12 (FAS, MI):
- CBP-307 0.2 mg QD PO (n=48) vs. Placebo (n=44)
- CBP-307 demonstrated a numerical, non-significant difference vs. placebo

FAS, full analysis set; MI, multiple imputation; PO, by mouth; QD, once daily.
Placebo-adjusted data is the difference in score between CBP-307 and placebo.
CBP-307CN002 Trial – Secondary Efficacy Endpoints at Week 12
Clinical Remission based on Adapted and Complete Mayo scores

Proportion of patients achieving Clinical Remission for CBP-307 0.2 mg PO QD was significantly greater than placebo

Clinical remission rate at Week 12 (FAS, NRI) based on **adapted Mayo**

- CBP-307 0.2mg QD PO (N=53): 28.3%
- CBP-307 0.1mg QD PO (N=39): 12.8%
- Placebo (N=52): 9.6%

Δ = 3.5% (p = 0.601)

Clinical remission rate at Week 12 (FAS, NRI) based on **complete Mayo**

- CBP-307 0.2mg QD PO (N=53): 18.9%
- CBP-307 0.1mg QD PO (N=39): 10.3%
- Placebo (N=52): 5.8%

Δ = 4.8% (p = 0.397)

**Clinical Remission by adapted Mayo score** (defined as a rectal bleeding subscore = 0 and stool frequency sub score ≤ 1, with an Endoscopy subscore ≤ 1 [excluding friability])

**Clinical Remission by complete Mayo score** (defined as a total Mayo score of ≤ 2 points with no individual subscore > 1 point)

FAS, full analysis set; NRI, non-responder imputation; PO, by mouth; QD, once daily.
Adapted Mayo scores exclude PGA (Physician’s Global Assessment) score
CBP-307CN002 Trial - Secondary Efficacy Endpoints at Week 12

Clinical Response based on Adapted and Complete Mayo scores

Clinical Response was numerically or significantly greater than placebo based on Adapted or Complete Mayo, respectively

Clinical Response rate at Week 12 (FAS, NRI) based on adapted Mayo numerically (but not significantly) greater than placebo

Clinical Response rate at Week 12 (FAS, NRI) based on complete Mayo was significantly greater than placebo

![Clinical Response rate at Week 12 (FAS, NRI) based on adapted Mayo numerically (but not significantly) greater than placebo](image1)

![Clinical Response rate at Week 12 (FAS, NRI) based on complete Mayo was significantly greater than placebo](image2)

FAS, full analysis set; NRI, non-responder imputation; PO, by mouth; QD, once daily.

Adapted Mayo scores exclude PGA score.
CBP-307CN002 – Secondary Endpoints

Clinical Remission rate based on Adapted and Complete Mayo score

Not head-to-head trial results. Differences exist between trial designs and subject characteristics and caution should be exercised when comparing data across trials.

Phase 2 CBP-307 (FAS, NRI), Phase 2 Etrasimod1 (ITT, MI) and Phase 3 Ozanimod2 Clinical Remission rate based on adapted Mayo score

Week 12*

- CBP-307 0.2 mg PO QD (N=53)
- CBP-307 0.1 mg PO QD (N=39)
- Placebo (N=52)

Δ = 18.7% (p = 0.016)

Δ = 3.5% (p = 0.601)

Δ = 25.8% (p < 0.001)

Δ = 7.1% (p = 0.14)

Δ = 12.4% (p < 0.001)

FAS, full analysis set; ITT, intention-to-treat; MI, multiple imputation; NRI, non-responder imputation; PO, by mouth; QD, once daily

** Remission: Rectal bleeding (RB) = 0; stool frequency (SF) ≤1; endoscopy ≤1
** Remission: RB ≤1; SF ≤1, endoscopy ≤1

Phase 2 CBP-307 (FAS, NRI), Etrasimod1 and Ozanimod2 (ITT, MI) Clinical Remission rate based on complete Mayo score

Week 12†

- CBP-307 0.2 mg PO QD (N=53)
- CBP-307 0.1 mg PO QD (N=39)
- Placebo (N=54)

Δ = 18.7% (p = 0.016)

Δ = 10.0% (p = 0.048)

Δ = 8.0% (p = 0.14)

Week 12**

- CBP-307 0.2 mg PO QD (N=53)
- CBP-307 0.1 mg PO QD (N=39)
- Placebo (N=52)

Δ = 13.1% (p = 0.044)

Δ = 4.8% (p = 0.0397)

Week 10*

- CBP-307 0.2 mg PO QD (N=50)
- Etrasimod 2.0 mg (n=50)
- Etrasimod 1.0 mg (n=52)
- Placebo (n=429)

Δ = 18.7% (p = 0.004)

Δ = 4.8% (p = 0.397)

Week 12†

- CBP-307 0.2 mg PO QD (N=50)
- Etrasimod 2.0 mg (n=50)
- Etrasimod 1.0 mg (n=429)
- Placebo (n=216)

Δ = 25.8% (p < 0.001)

Δ = 7.1% (p = 0.14)

** Remission: Complete/Total Mayo score of ≤ 2 points with no individual subscore > 1 point

CBP-307CN002 Trial - Pharmacodynamic Endpoint
Absolute lymphocyte counts (ALC) and percentage change through Week 12 (FAS)

CBP-307 reduced the peripheral lymphocyte counts during the 12-week study period

Mean values and Percentage changes in Absolute Lymphocyte Count (ALC)
### CBP-307CN002 Trial – Safety Results from 12-week Induction Period

- Overall TEAEs, including drug-related TEAEs and TEAEs of special interest, were more frequent in the CBP-307 groups.
- Most TEAEs were mild and moderate in severity.
- CBP-307 0.2 mg QD showed similar frequencies of SAEs and TEAEs leading to study drug withdrawal as placebo.
- No cases of progressive multifocal leukoencephalopathy and no deaths were reported.

<table>
<thead>
<tr>
<th>Safety Parameter n (%)</th>
<th>CBP-307 Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.1 mg PO QD</td>
</tr>
<tr>
<td></td>
<td>(n=39)</td>
</tr>
<tr>
<td>Any TEAE</td>
<td>37 (94.9%)</td>
</tr>
<tr>
<td>Grade 3 or Higher TEAE</td>
<td>10 (25.6%)</td>
</tr>
<tr>
<td>Drug-Related TEAE</td>
<td>23 (59.0%)</td>
</tr>
<tr>
<td>Drug-Related Grade 3 or Higher TEAE</td>
<td>5 (12.8%)</td>
</tr>
<tr>
<td>Serious TEAE</td>
<td>6 (15.4%)</td>
</tr>
<tr>
<td>Drug-Related Serious TEAE</td>
<td>2 (5.1%)</td>
</tr>
<tr>
<td>TEAE Leading to study Drug Withdrawal</td>
<td>6 (15.4%)</td>
</tr>
<tr>
<td>TEAE Leading to Deaths</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>TEAE of Special Interest</td>
<td>6 (15.4%)</td>
</tr>
</tbody>
</table>

TEAE, treatment-emergent adverse event; UC, ulcerative colitis
CBP-307CN002 Trial – Conclusions from 12 Week Induction Period

Summary

- CBP-307 0.2 mg PO QD decreased disease severity based on adapted Mayo Score after 12 weeks of treatment, although the change did not reach statistical significance.
- CBP-307 0.2 mg PO QD achieved statistical significance on several secondary endpoints including Clinical Remission.
- Clear dose-dependent and rapid pharmacodynamic changes were observed confirming mechanism of action.
- Overall safety results showed CBP-307 to be generally well tolerated in patients with moderate-to-severe UC.
- CBP-307 has the potential to be a competitive asset for further development and a welcome addition to the Gastroenterologist’s treatment armamentarium to benefit patients with IBD.
- Company intends to seek partnerships for CBP-307 to allow strategic focus on ongoing development plans with CBP-201 (IL4Rα antagonist).
Connect Executive Leadership

Zheng Wei, PhD
- Co-Founder, Chief Executive Officer
- > 25 years of experience in discovery of novel therapeutics for autoimmune diseases and inflammation

Wubin (Bill) Pan, PhD, MBA
- Co-Founder, President & Board Chair
- > 25 years of operations, management and fundraising experience

Chin Lee, MD, MPH
- Chief Medical Officer
- > 15 years of clinical research and development experience in the biopharmaceutical industry

Steve Chan, CPA
- Chief Financial Officer
- > 25 years of corporate finance, operations, international management, commercial and fundraising experience

Jiang Bian, JD
- General Counsel & Chief Compliance Officer
- > 10 years of external and in-house counsel to healthcare and biotech companies in areas of licensing, intellectual property and corporate law
Connect Senior Management Team

Malinda Longphre, PhD
EXECUTIVE DIRECTOR, HEAD OF CLINICAL OPERATIONS (US)
> 20 years of research & clinical operations experience, in asthma and atopic dermatitis
  • Novartis
  • Bristol-Myers Squibb
  • Bayer
  • Aerovance

Lei Sun, PhD
VICE PRESIDENT AND HEAD OF BIOLOGICS AND CMC
> 20 years of biologics development focused on process development, CMC, and manufacturing
  • Shire
  • Percivia
  • UCB

Raul Collazo, PhD
VICE PRESIDENT, GLOBAL HEAD OF MEDICAL AFFAIRS
> 20 years of medical/ scientific affairs, compliance, operations, corporate strategy and consulting experience
  • Johnson & Johnson
  • elan
  • Neurocrine Biosciences

Felix Yau, CPA
VICE PRESIDENT, FINANCE
> 25 years of experience in accounting and financial management, corporate finance and investment banking
  • Everbright Water
  • China Strategic Holdings
  • AID Partners

Paul Smith, PhD
VICE PRESIDENT, DISCOVERY BIOLOGY
> 15 years of small molecule and biologics drug discovery experience for inflammatory diseases
  • Incyte
  • Novartis
  • Merck
  • UCB