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OVERVIEW OF THE CANCER TREATMENT LANDSCAPE

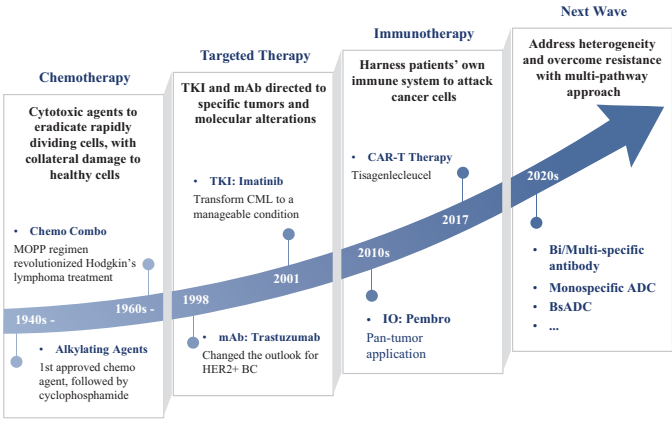
Overview

Cancer treatment has evolved from broadly cytotoxic chemotherapy towards increasingly targeted approaches, beginning with monoclonal antibodies and tyrosine kinase inhibitors ("**TKIs**") and extending to antibody-drug conjugates ("**ADCs**"). In parallel, immuno-oncology therapies have broadened treatment options. Despite these advances, many cancers continue to evade treatment through intratumoral heterogeneity, antigen or target loss, compensatory pathway activation, inefficient internalization and acquired resistance. These challenges can limit the durability of response to therapies that depend on a single target, pathway or mode of action.

The cancer treatment field is now advancing toward the next generation of targeted and immune-based modalities, including sophisticated monospecific and bispecific ADCs, bi- and multi-specific antibodies, T-cell engagers and ADC-based combination therapies. Monospecific ADCs enable the targeted delivery of cytotoxic payloads, while advances in payload technologies may further enhance antitumor potency, broaden the therapeutic window and help address payload-specific resistance. Bispecific ADCs simultaneously engage two antigens to enhance tumor selectivity and address antigen heterogeneity and loss. Multi-specific antibodies can block redundant or compensatory signaling pathways within a single molecule, while T-cell engagers redirect cytotoxic immune cells to tumors that respond poorly to checkpoint inhibition.

Among these emerging modalities, bispecific ADCs represent a compelling shift from single target oncology toward multi-dimensional precision therapeutics designed to deliver deeper, broader and more durable anti-tumor activity. As of the Latest Practicable Date, iza-bren was the world's first and only bispecific ADC approved for commercialization, following its marketing approvals in China for nasopharyngeal carcinoma ("**NPC**") in June 2026 and for esophageal squamous cell carcinoma ("**ESCC**") in July 2026. With one additional NDA filing accepted by the NMPA and a broad clinical development program across multiple tumor types, iza-bren is positioned to define the emerging bispecific ADC category.

The following diagram illustrates the evolution of cancer treatment to date.



Leading Approach	Improvement
Bi/multi-specific antibodies	• Block two/multiple signaling axes simultaneously • Improve selectivity • Shift from "biomarker-fragile" to "heterogeneity-tolerant therapies"
Multi-specific CD3 TCEs	• Reduced antigen-loss resistance • Broader eligible patient population
Monospecific ADC	• Direct cytotoxicity independent of signaling/immune pathways
BsADC	• Exploit avidity effects (tumor cells bind strongly and enable previously undruggable target e.g. EGFR) • Reduce off-tumor binding
Novel-payload	• Hedge against payload-specific resistance
IO+ADC	• Spatially restricted immune modulation • Reduced systemic immune toxicity

Source: CIC

Beyond ADCs, antibody-radionuclide conjugates ("**ARCs**"), a sub-category of radioligand drug conjugates ("**RDCs**"), represent a complementary modality that uses an antibody scaffold to deliver therapeutic radionuclides selectively to tumors. Unlike ADCs, RDCs exert anti-tumor activity through localized radiation and generally do not require cellular internalization or linker cleavage for activation. This makes ARCs well suited to targets with suboptimal internalization and to tumors with heterogeneous antigen expression, where radiation crossfire effects may help eliminate neighboring tumor cells with low or absent target expression. As of the Latest Practicable Date, BL-ARC001 and BL-ARC002 were the only two domestically developed ARCs in China that had entered clinical stage.

Market Size of the Oncology Drug Market

Cancer is a leading cause of death globally. The number of new cases has continued to rise, reaching 21.3 million worldwide, 5.3 million in China and 2.5 million in the U.S. in 2025, driving the continued growth of the oncology drug market. The global cancer drug market grew from US$167.0 billion in 2020 to US$304.1 billion in 2025 at a compound annual growth rate ("**CAGR**") of 12.7%, and is expected to increase to US$729.2 billion in 2035, representing a CAGR of 9.1% from 2025 to 2035. Over the same period, the cancer drug markets in China and the U.S. grew from US$25.8 billion and US$71.0 billion in 2020 to US$39.1 billion and US$134.4 billion in 2025, respectively, and are expected to reach US$131.2 billion and US$333.6 billion by 2035, representing CAGRs of 12.9% and 9.5%, respectively, from 2025 to 2035.

Next-Generation Oncology Therapeutics

ADCs

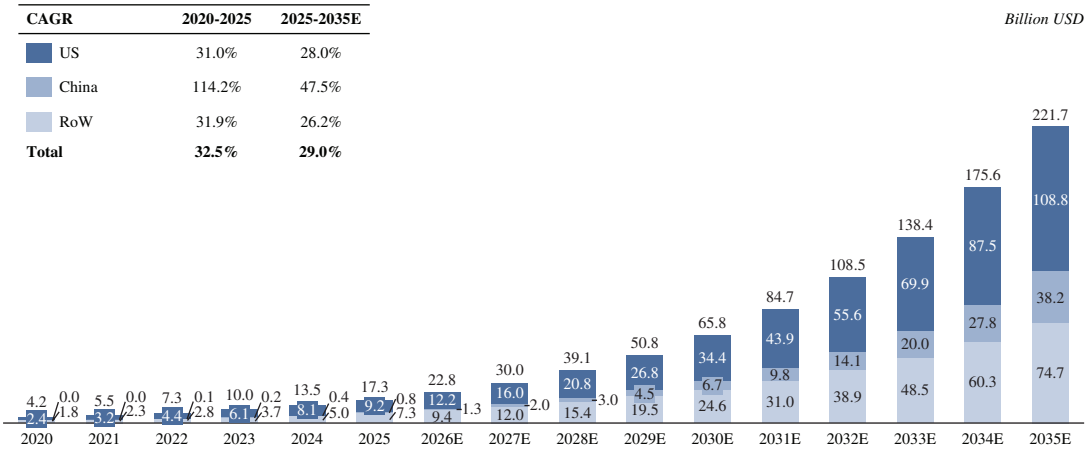
An ADC consists of an antibody connected through a chemical linker to a cytotoxic payload. The antibody binds to target antigen(s) expressed on tumor cells and is internalized, releasing the payload intracellularly to induce tumor cell death. By combining the target specificity of antibodies with potent cytotoxic payloads, ADCs enable selective delivery of cancer-killing agents to tumor cells while reducing the systemic exposure and off-target toxicity associated with conventional chemotherapy. ADCs have demonstrated anti-tumor activity in patients who are unresponsive to, or have progressed after, immune checkpoint inhibitors ("**ICIs**") or targeted therapies such as TKIs, while advances in drug-to-antibody ratio, linker stability and payload selection have further broadened the therapeutic window. Building on this foundation, bispecific and multi-specific antibody scaffolds can be incorporated into next-generation ADCs that address limitations of conventional monospecific ADCs, including heterogeneous antigen expression, antigen loss and single-pathway resistance, as exemplified by iza-bren. These advantages have established ADCs as a clinically validated and rapidly growing oncology modality across a broad range of solid tumors and hematologic malignancies.

ADCs have evolved from late-line therapies with relatively narrow indications into an increasingly important oncology modality, with expanding use across multiple tumor types and earlier lines of treatment, progressively being incorporated into frontline standards of care as monotherapy or in combination with established agents such as PD-1/PD-L1 inhibitors. To date, innovation has centered on the expansion to novel targets (such as B7-H3, human epidermal growth factor receptor 3 ("**HER3**"), TROP2 and Claudin 6), site-specific conjugation, cleavable linkers and differentiated payloads (including topoisomerase I inhibitors, microtubule inhibitors and immune modulators). As these approaches have become widely adopted and competition has intensified, development is increasingly shifting toward next-generation, multi-target and structurally complex designs intended to overcome tumor heterogeneity and drug resistance.

The ADC market has grown significantly. In 2025, the global ADC market reached US$17.3 billion and is expected to reach US$221.7 billion by 2035, and its share of the overall oncology market is expected to increase from 5.7% to 30.4% over the same period. The ADC markets in

China and U.S. reached US$0.8 billion and US$9.2 billion in 2025, respectively, and are expected to grow to reach US$38.2 billion and US$108.8 billion in 2035, respectively. The following diagram sets forth the size of the ADC market globally, in China, the U.S. and the rest of the world for the periods indicated:

Global ADC Market Size, 2020-2035E



Source: Annual reports, CIC

The significant potential of the ADC market has attracted substantial investments. In the past five years, total ADC deals reached approximately US$261.7 billion. In 2024 and 2025, the sector witnessed 147 collaboration transactions for ADC assets, cumulatively valued at over US$65.3 billion. Notably, our global strategic license and collaboration agreement for iza-bren with BMS carries a total deal value of up to US$8.4 billion.

Major ADC Transactions by Global Pharmaceutical Companies

Date	Transferor	Transferee	Transaction Details	Target	Initial upfront payment, Million US$	Transaction Amount, Million US$
2023/12/12	Our Group	BMS	iza-bren	EGFR/HER3	800	8,400
2023/10/19	Daiichi Sankyo	Merck	DS-7300a	B7H3	1,500*	7,500
2023/10/19	Daiichi Sankyo	Merck	U3-1402	HER3	750*	7,500
2023/10/19	Daiichi Sankyo	Merck	DS-6000	CDH6	750*	7,000
2019/03/28	Daiichi Sankyo	AstraZeneca	DS-8201	HER2	1,350	6,900
2020/07/27	Daiichi Sankyo	AstraZeneca	DS-1062	TROP2	1,000	6,000
2020/09/14	Seagen	Merck	SGN-LIV1A	LIV-1	600	3,200
2021/08/09	Remegen	Seagen	RC48	HER2	200	2,600
2017/02/10	Immunomedics	Seagen	IMMU-132	TROP2	250	2,000
2023/12/20	Hansoh	GSK	HS-20093	B7H3	185	1,710

* From the Daiichi Sankyo official website, not including payments due 12/24 months after contract execution.

Source: Public disclosure, CIC

Bispecific and Multi-specific Antibodies

Bispecific and multi-specific antibodies represent an important class of next-generation therapeutics that incorporate two or more binding specificities within a single molecule to coordinate multiple therapeutic mechanisms. By simultaneously engaging different targets, signaling pathways or cell populations, these molecules are designed to achieve effects that are difficult for monospecific antibodies to deliver, including dual pathway blockade, immune-cell redirection and more selective targeting of cells defined by specific antigen-expression profiles. By coordinating multiple mechanisms within a single molecule, these formats are designed to address key limitations of single-target therapies, such as tumor heterogeneity, pathway redundancy, compensatory signaling and acquired resistance.

CD3-mediated T-cell engagement is a key application of bispecific and multi-specific antibody design. By binding CD3 on T cells and one or more tumor-associated antigens on cancer cells, these antibodies are designed to redirect T cells toward tumor cells and promote targeted tumor-cell killing without relying on tumor antigen recognition through the native TCR-pMHC interaction. Multi-specific formats further incorporate additional binding domains to enhance tumor selectivity and coordinate immune-related mechanisms within a single molecule.

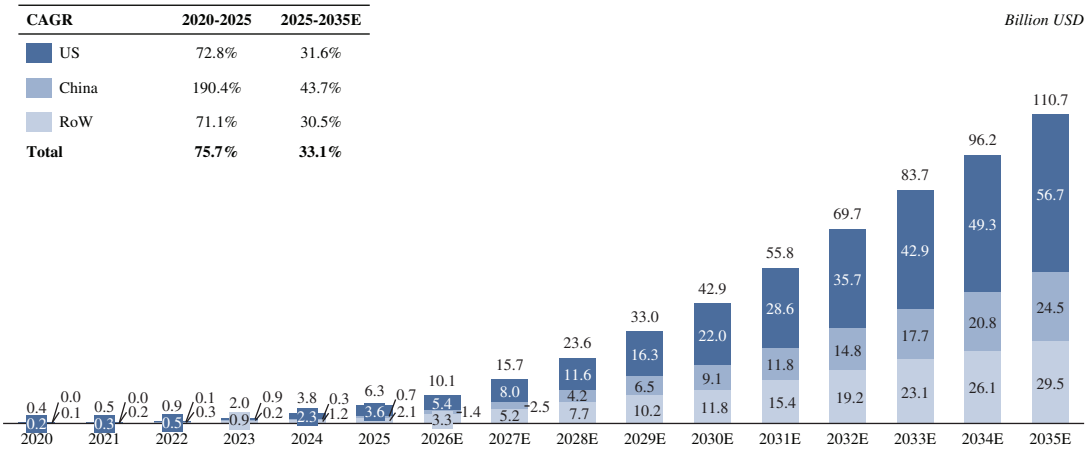
The integration of multiple mechanisms into one molecule carries both clinical and commercial significance. By engaging several disease-driving pathways concurrently, these agents are designed to mitigate the resistance that limits single-target therapies, while precise engineering of target combination, valency, affinity and binding geometry can sharpen selectivity for tumor cells carrying a defined antigen profile, thereby widening the therapeutic window. From a commercial perspective, a single agent delivering combination-like activity may broaden the eligible patient population, support use in earlier lines of therapy and extend duration of treatment. The engineering complexity and manufacturing expertise these formats demand also create meaningful barriers to entry that conventional antibodies and biosimilars do not face.

However, this complexity renders bispecific and multi-specific antibodies inherently difficult to design and manufacture. Developers must address challenges including correct chain pairing, molecular stability, aggregation, expression yield and pharmacokinetics ("**PK**"). For CD3- or other immune-cell-engaging formats, potency must also be carefully balanced against risks of off-tumor activity, systemic immune activation and cytokine release syndrome. The ability to integrate multiple binding domains while maintaining developability, manufacturability and an acceptable safety profile is therefore central to competitiveness in this field. Our proprietary GNC platform is designed to support the development of differentiated multi-specific antibody candidates.

The global bispecific and multi-specific antibody drug market grew rapidly from US$0.4 billion in 2020 to US$6.3 billion in 2025 at a CAGR of 75.7%, and is expected to increase to US$110.7 billion in 2035, representing a CAGR of 33.1% from 2025 to 2035. The following diagram sets forth the size of the bispecific and multi-specific antibody drug market.

Global Bispecific and Multi-Specific Antibody Drug Market Size, 2020-2035E

CAGR	2020-2025	2025-2035E
US	72.8%	31.6%
China	190.4%	43.7%
RoW	71.1%	30.5%
Total	**75.7%**	**33.1%**



Source: Annual reports, CIC

"X" drug conjugates

Beyond conventional antibody modifications, conjugate innovation is rapidly evolving across "X" drug conjugates ("**XDC**") platforms, with development focus shifting toward novel conjugate classes such as radionuclides, peptides, or nucleotides. RDCs represent the promising XDC subclass that delivers therapeutic radionuclides selectively to tumors. ARCs are a differentiated sub-category of RDCs. They use an antibody as the tumor-targeting scaffold and link it to a therapeutic radionuclide, typically an α- or β-emitting isotope. Compared with peptide-based radioligand therapies, ARCs generally have a larger molecular size, higher target-binding specificity and longer circulating half-life, which may support prolonged tumor exposure and greater tumor accumulation in tumors with clear antigen expression. Depending on the radionuclide selected, ARCs deliver localized radiation to tumor cells through different mechanisms: β-emitters such as Lu-177 can provide a longer tissue penetration range and potential cross-fire effect in tumors with heterogeneous target expression, while α-emitters such as Ac-225 can deliver high linear energy transfer over a short range and induce potent localized DNA damage. In addition, ARCs may enable theranostic approaches through pairing of diagnostic and therapeutic radionuclides

ADCs and ARCs represent complementary modalities suited to different target profiles and tumor biology. ADCs are well established in chemosensitive solid tumors with favorable internalization characteristics, such as breast, urothelial, ovarian and lung cancers. ARCs, by contrast, are particularly well suited to targets exhibiting high tumor expression, low normal-tissue background and imageability, with potential advantages in disease settings characterized by multiple systemic lesions. Three specific scenarios illustrate where ARCs provide differentiated treatment relative to ADCs: (i) targets with low internalization efficiency (e.g., SSTR in neuroendocrine tumors) — ARCs kill tumor cells through physical radiation without requiring intracellular payload release, overcoming a key ADC limitation; (ii) tumors with high intratumoral antigen heterogeneity — the physical crossfire effect of β-emitters (Lu-177, ~2mm tissue range) and α-emitters (Ac-225, ~50-80μm range) can eliminate neighboring tumor cells that do not express the target antigen, a coverage mechanism distinct from ADC bystander killing; and (iii) theranostic pairing — the same antibody scaffold can be paired with a diagnostic radionuclide (e.g., Ga-68 for PET imaging) to screen patients before switching to a therapeutic radionuclide, a closed-loop diagnostic-therapeutic approach that ADCs cannot replicate.

The landscape for ARCs has seen dynamic transaction activity in recent years. Approximately 25 ARC-related deals were recorded from 2020 to 2025. With a total disclosed value of US$1.03 billion across six major agreements, this strong market interest highlights ARCs as a critical area of development in radiopharmaceuticals. In 2025, the size of the global RDC market was US$2.8 billion and is expected to reach US$22.6 billion by 2035, representing a CAGR of 23.2% from 2025 to 2035. Within the RDC market, the size of the global ARC market is expected to increase from US$0.2 billion in 2029 to US$5.6 billion in 2035 at a CAGR of 82.7%. As of the Latest Practicable Date, there was no ARC approved for marketing and over 20 ARC candidates were under clinical development globally. Notably, our BL-ARC001 and BL-ARC002 were the only two domestically developed ARCs in China to enter clinical stage, targeting advanced solid tumors.

THE ONCOLOGY DRUG MARKET

Lung Cancer

Lung cancer represents the leading type among solid tumors, with more than 2.6 million new cases worldwide in 2025 — approximately 46% occurring in China, where incidence was approximately two-fold higher than the next most common cancer. The five-year overall survival ("**OS**") rates remain modest, at 20.5% in the U.S. and 19.7% in China. Lung cancer is primarily classified into two types: non-small cell lung cancer ("**NSCLC**") and small cell lung cancer ("**SCLC**"). As the most prevalent cancer indication globally, the size of the global lung cancer drug market was US$60.1 billion in 2025, including US$8.5 billion in China and US$24.7 billion in the U.S. It is expected to reach US$127.9 billion globally by 2035, including US$25.3 billion in China and US$43.5 billion in the U.S.

NSCLC

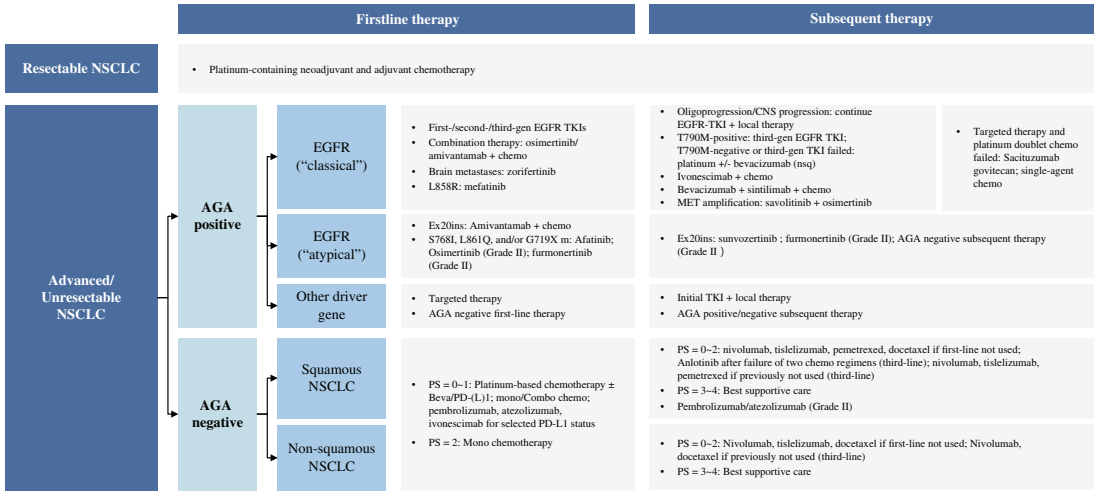
Overview

NSCLC accounts for approximately 85% of lung cancer cases globally. The incidence of NSCLC worldwide is expected to grow from approximately 1.9 million cases in 2020 to 3.0 million cases in 2035. China is expected to contribute substantially to such growth, with the incidence of NSCLC in China projected to increase from approximately 0.8 million cases in 2020 to 1.5 million cases in 2035. To guide treatment selection, NSCLC is increasingly stratified by the presence of actionable genomic alterations ("**AGAs**"), identifiable tumor alterations for which matched targeted therapies exist. AGA-positive NSCLC harbors targetable oncogenic drivers, whereas AGA-negative NSCLC lacks such alterations. Among the common AGAs in NSCLC, epidermal growth factor receptor ("**EGFR**") mutations are the most prevalent driver globally, with particularly high frequency in Asian patients (approximately 54.4% of cases), and meaningful prevalence in Western patients (approximately 25.0% of cases). Other clinically important AGAs in NSCLC include KRAS, anaplastic lymphoma kinase ("**ALK**"), ROS1, human epidermal growth factor receptor 2 ("**HER2**") and RET alterations. Independent of the broader AGA classification, tumors lacking activating EGFR mutations are specifically referred to as EGFR wild-type NSCLC.

Treatment Paradigm and Unmet Needs

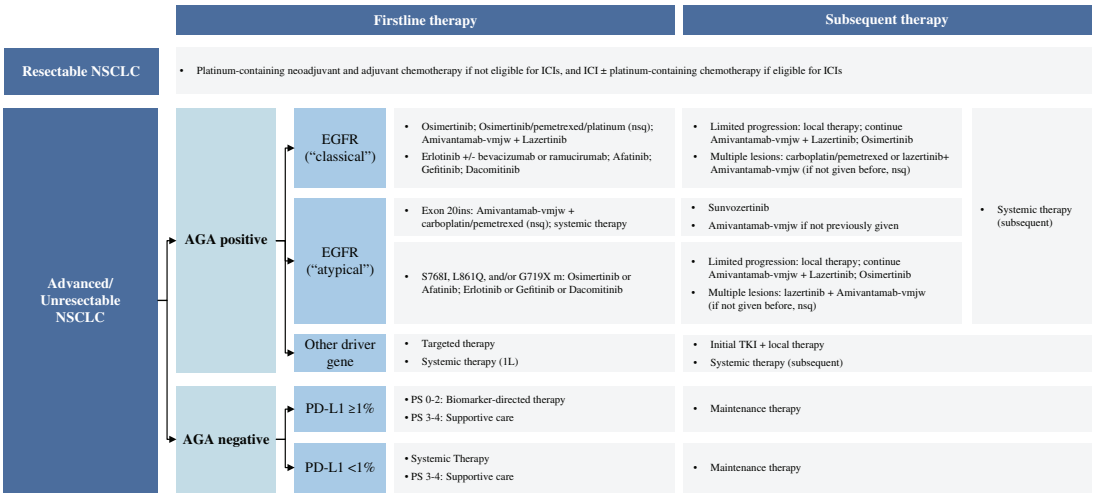
The treatment paradigm for NSCLC is determined by disease stage and molecular profile. For early-stage and resectable disease, surgical resection is the mainstay, increasingly combined with neoadjuvant or adjuvant chemotherapy, immunotherapy or, for patients harboring targetable drivers such as EGFR mutations, adjuvant targeted therapy. For advanced disease, treatment is guided by AGA status: AGA-positive patients receive molecularly matched targeted therapies as first-line treatment, whereas AGA-negative patients are treated based on histology and PD-L1 expression with platinum-based chemotherapy, immunotherapy, or a combination thereof. The following charts set forth the treatment paradigm for NSCLC recommended by CSCO and NCCN, respectively.

Treatment Paradigm for NSCLC, CSCO (China)



Source: CSCO 2025, CIC

Treatment Paradigm for NSCLC, NCCN (the U.S.)



Source: NCCN 2025, CIC

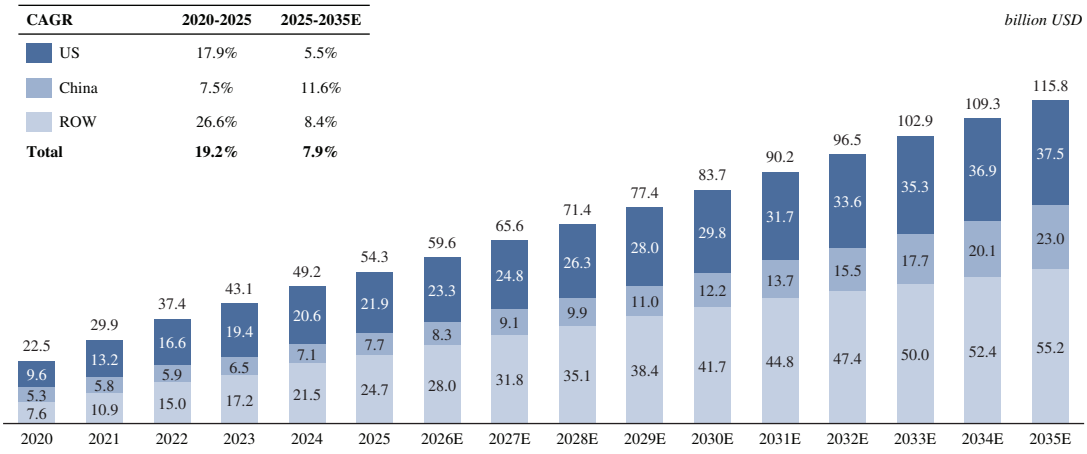
Despite significant advances in NSCLC treatment, substantial unmet medical needs currently concentrate in the advanced/metastatic setting across both AGA-positive and AGA-negative diseases. In AGA-positive NSCLC, particularly EGFR-mutant disease, acquired resistance to first-line EGFR-TKIs such as osimertinib is near-universal and molecularly heterogeneous, encompassing MET amplification, secondary EGFR mutations (e.g., C797S), bypass pathway activation and histologic transformation. As a result, most patients cannot be matched to a single resistance-directed therapy following TKI failure. In AGA-negative NSCLC, only approximately 27% to 46% of patients respond initially to first-line immunotherapy-based regimens, and approximately 80% do not achieve durable benefit from ICIs due to primary or acquired resistance. Second-line options remain largely limited to chemotherapy- or anti-angiogenic chemotherapy-based regimens with modest durability.

An increasing number of ADCs are being developed to address these unmet needs by leveraging broadly expressed tumor-associated antigens to deliver potent cytotoxic payloads independent of a single oncogenic driver or immune-response status, rendering them applicable across both AGA-positive and AGA-negative populations. ADC development in NSCLC is further evolving along two key dimensions. First, from monospecific toward bispecific ADCs that simultaneously recognize two antigens to broaden patient coverage, improve tumor selectivity and mitigate reliance on a single target. For instance, EGFR and HER3 are broadly co-expressed across NSCLC tumors irrespective of oncogenic driver mutation status, providing a target foundation that transcends individual molecular subtype and covers both AGA-positive and AGA-negative disease. Second, from late-line monotherapy toward earlier-line and combination settings. These converging trends position ADCs — and bispecific ADCs in particular — as potential core components of future NSCLC treatment paradigms, extending their role well beyond chemotherapy substitution in heavily pretreated patients.

Market Opportunity for NSCLC

The global NSCLC drug market grew rapidly from US$22.5 billion in 2020 to US$54.3 billion in 2025 at a CAGR of 19.2%, and is expected to increase to US$115.8 billion in 2035, representing a CAGR of 7.9% from 2025 to 2035. The following diagram sets forth the size of the NSCLC drug market.

Global NSCLC Drug Market Size, 2020-2035E



Source: GLOBOCAN, WHO, CIC

Competitive Landscape for NSCLC

Established pharmaceutical therapies for NSCLC primarily include targeted therapies directed at actionable driver alterations such as EGFR, ALK, ROS1, RET, MET, KRAS (G12C) and BRAF, together with PD-1/PD-L1 ICIs, platinum-based chemotherapy and anti-angiogenic agents. As of the Latest Practicable Date, there were over 80 targeted therapies approved and over 90 candidates in Phase III or beyond for NSCLC, of which EGFR-TKIs accounted for 19 approved agents and 11 candidates in Phase III or beyond. As of the same date, over 16 PD-1/PD-L1 inhibitors were approved and 24 candidates in Phase III or beyond were under development for NSCLC. More recently, ADCs have emerged as a rapidly growing modality, with five ADCs approved and 13 candidates in Phase III or beyond for NSCLC. Notably, iza-bren is the world's first and only bispecific ADC to have entered into Phase III clinical development for NSCLC. The following table sets forth a pipeline of ADC drug candidates targeting NSCLC in China and/or the U.S., in Phase III clinical development or beyond.

Competitive Landscape of ADCs for NSCLC

Drug name	Target	Company	EGFRmt NSCLC, 1L	EGFRmt NSCLC, post EGFR-TKI	Other AGA-positive NSCLC	AGA-negative NSCLC, 1L	AGA-negative NSCLC, 2L+
Iza-bren	EGFR HER3	Our Company	Regimen: Combo Ph III, PFD: 2025-02-17 Location: China	Mono Ph II/III, 2025-08-03 China, US, others			Mono Ph III, 2024-04-24 China
Trastuzumab deruxtecan	HER2	Daiichi Sankyo			Mono (For HER2mt NSCLC), 2L Approved, 2024-10-09, NMPA Approved, 2022-08-11, FDA		
Sacituzumab tirumotecan	TROP2	Sichuan Kelun-Biotech/Merck	Combo Trial phase: Ph III, FPD: 2024-10-28 Trial location: China	Regimen: Mono Approved, 2025-03-04 NMPA		Combo Ph II, 2022-04-28 China	Mono/Combo Ph II, 2023-03-17 China, others
Telisotuzumab Vedotin	c-Met	AbbVie			Mono (For c-Met overexpression NSCLC), 2L Approved, 2025-05-14, FDA		
trastuzumab rezetecan	HER2	Jiangsu Hengrui			Mono (For HER2mt NSCLC), 2L Approved, 2025-05-27, NMPA		
Datopotamab deruxtecan	TROP2	Daiichi Sankyo	Combo Ph III, 2024-04-05 China, US, others	Mono Approved, 2025-06-23 FDA		Combo Ph III, 2022-08-23 China, US, others	
Sacituzumab govitecan	TROP2	Gilead Sciences		Mono Ph III, 2021-10-22 US, others		Combo Ph II, 2022-01-11 US, others	
Patritumab deruxtecan	HER3	Daiichi Sankyo/ Merck		Mono Ph III, 2022-04-14 China, US, others		Combo Ph I/II, 2019-11-15 US, others	
CPO301	EGFR	CSPC PHARM/ Conjupro	Combo Ph III, 2024-08-26 China	Mono Ph III, 2025-03-18 China			Combo Ph I/II, 2024-09-08 China
ruzaltatug rezetecan	HER3	Jiangsu Hengrui	Combo Ph III, 2025-09-19 China	Mono Ph III, 2024-11-01 China			
Sigvotatug vedotin	ITGB6	Pfizer				Combo (For PD-L1 TPS ≥50% NSCLC) Ph III, 2025-01-03 China, US, others	
PF-08046054	PD-L1	Pfizer/Seagen				Combo Ph I/II, 2025-11-12 China, US, others	Mono (For PD-L1 expression ≥ 1% NSCLC)* Ph III, 2025-08-27 China, US, others
T-Bren	HER2	Our Company			Mono (For HER2mt NSCLC), 1L Ph III, 2025-09-11 China		
YL202	HER3	MediLink Therapeutics		Mono Ph III, 2026-02-18 China		Combo Ph I/II, 2025-08-08 China, US, others	Mono Ph II, 2023-10-20 China
Risvutatug rezetecan	B7-H3	Hansoh Pharma				Combo Ph I, 2024-03-18 China	Combo Ph III, 2026-03-09 China
AMT-116 ADC	CD44	Multitude Therapeutics					Mono (For EGFR wildtype NSCLC) Ph III, 2026-07-22 Others
telisotuzumab adizutecan	c-Met	AbbVie	Combo Ph II/III, 2025-06-05 China, US, others	Mono Ph II/III, 2025-09-04 China, US, others		Combo Ph I/II, 2025-01-13 China, US, others	
HLX43	PD-L1	MediLink Therapeutics					Mono/Combo (For Squamous NSCLC) Ph II/III, 2026-03-10 China, others

Approved | Phase III & Phase II/III | Phase II & Phase I/II | Phase I

* Participants who have NSCLC with known AGAs are permitted.

Notes:

1. Only active pipelines are included. Programs that have been completed, suspended, terminated, or withdrawn prior to recruitment are generally excluded, unless they represent the only or most advanced program available.
2. Indications are not exhaustively listed. For each indication, only the most advanced and earliest-disclosed pipeline is presented, with regional distinctions drawn where applicable (for example, between China and the U.S.).
3. Only approved drugs and drug candidates that have advanced to Phase III or beyond clinical development are included.

Source: ClinicalTrials.gov, CDE, CIC

SCLC

Small-cell lung cancer (**"SCLC"**) is a high-grade neuroendocrine carcinoma ("**NEC**") that arises predominantly in current or former smokers and is characterized by an exceptionally poor prognosis. SCLC is classified into limited-stage disease (**"LS-SCLC"**) and extensive-stage disease ("**ES-SCLC**"), with the latter accounting for approximately 70% of cases. While the median survival time for patients with LS-SCLC has reached up to 55.9 months, that for patients with ES-SCLC is only approximately 12 to 13 months, with approximately 60% of patients relapsing within three months. The global incidence of SCLC is expected to grow from approximately 316.6 thousand cases in 2020 to 560.9 thousand cases in 2035. The global SCLC drug market grew rapidly from US$3.1 billion in 2020 to US$5.8 billion in 2025 at a CAGR of 13.7%, and is expected to increase to US$12.1 billion in 2035, representing a CAGR of 7.6% from 2025 to 2035.

Established pharmaceutical therapies for SCLC primarily consist of platinum-based chemotherapy, commonly used in combination with PD-1/PD-L1 ICIs. As of the Latest Practicable Date, there were 10 approved PD-1/PD-L1 inhibitors and five candidates in Phase III or beyond for SCLC. Although no ADC had been approved for SCLC as of the Latest Practicable Date, there were nine candidates in Phase III or beyond as of the same date.

Breast Cancer

Breast cancer ("**BC**") is the second most common cancer type with an incidence of approximately 2.5 million cases globally in 2025, of which 0.4 million were recorded in China and 0.3 million in the U.S. BC is primarily classified based on hormone receptor ("**HR**") and HER2 status into three major clinical subtypes: HR-positive/HER2-negative (HR+/HER2-) BC, HER2-positive (HER2+) BC and triple-negative breast cancer ("**TNBC**"), which account for approximately 70%, 15% and 15% of BC cases, respectively. HER2 status is commonly determined by immunohistochemistry ("**IHC**"), with equivocal IHC 2+ results further assessed by in situ hybridization ("**ISH**"). Specifically, HER2-positive BC is defined as IHC 3+ or IHC 2+/ISH-positive, whereas HER2-negative BC includes IHC 0, IHC 1+ and IHC 2+/ISH-negative disease. Driven by recent therapeutic advancements, HER2-negative BC is now increasingly subclassified to identify HER2-low BC, defined as IHC 1+ or IHC 2+/ISH-negative, distinguishing it from tumors with no detectable expression (HER2 IHC 0).

Treatment Paradigm and Unmet Needs

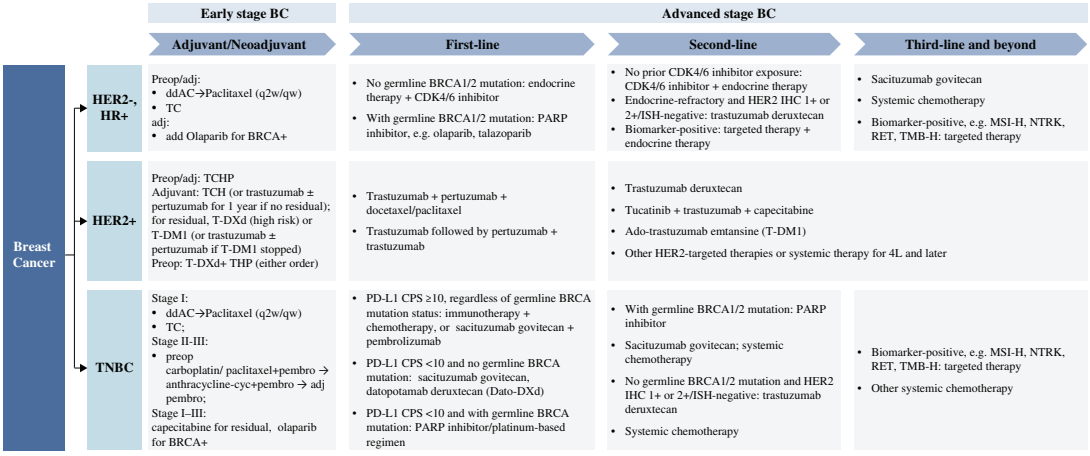
The treatment of BC is guided by molecular subtyping based on HR and HER2 expression status, and generally advances through successive lines of therapy upon disease progression. For early-stage disease, adjuvant or neoadjuvant regimens combining chemotherapy, endocrine therapy, anti-HER2 targeted agents and immune checkpoint inhibitors are administered preoperatively or postoperatively based on molecular subtypes. In HR+/HER2- disease, endocrine therapy combined with CDK4/6 inhibitors constitutes the preferred first-line regimen for advanced disease; upon progression, PI3K/AKT/mTOR pathway inhibitors and selective estrogen receptor degraders provide options for biomarker-defined patients, while those who exhaust endocrine-based therapies typically transition to single-agent chemotherapy in later lines. In HER2+ disease, first-line treatment is anchored by dual HER2 blockade with trastuzumab and pertuzumab in combination with taxane-based chemotherapy, followed upon progression by HER2-directed ADCs, HER2 TKIs and other HER2-targeted regimens. In TNBC, treatment remains primarily chemotherapy-based, augmented by PD-1 inhibitor-based chemoimmunotherapy for PD-L1-positive tumors and PARP inhibitors for patients with germline breast cancer susceptibility genes 1 and 2 ("**BRCA1/2**") mutations. The following tables set forth the treatment paradigm for BC recommended by CSCO and NCCN, respectively.

Treatment Paradigm for BC, CSCO (China)

		Early stage BC	Advanced stage BC		
		Adjuvant/Neoadjuvant	First-line	Second-line and beyond	
Breast Cancer	HER2-, HR+	Neoadjuvant therapy: • A+T • Neoadjuvant endocrine therapy Adjuvant chemotherapy/endocrine therapy	Endocrine therapy-naive (Grade I recommendation): • Aromatase inhibitor (AI) + CDK4/6 inhibitor Failure of tamoxifen (TAM) therapy (Grade I recommendation): • Aromatase inhibitor (AI) + CDK4/6 inhibitor • Palbociclib + fulvestrant	Failure of non-steroidal/steroidal aromatase inhibitor therapy (Grade I recommendation): • Fulvestrant + CDK4/6 inhibitor • Capivasertib + fulvestrant	Failure of CDK4/6 inhibitor therapy (Grade I recommendation): • Capivasertib + fulvestrant HER2-low expression, failure of CDK4/6 inhibitor therapy (Grade I recommendation): • Trastuzumab deruxtecan
	HER2+	Neoadjuvant therapy: • TCbHP • THP×6 Adjuvant therapy (node-positive): • AC-THP • TCbHP	Trastuzumab-sensitive (Grade I recommendation): • Taxane + anti-HER2 monoclonal antibody + pertuzumab • Taxane + anti-HER2 monoclonal antibody + pyrotinib	Failure of trastuzumab therapy (Grade I recommendation): • Trastuzumab deruxtecan	Failure of TKI therapy (Grade I recommendation): • Trastuzumab deruxtecan
	TNBC	Neoadjuvant: • PD-1+TP-AC/TP (no contraindication) • AT/AP adjuvant: • continue PD-1 • olaparib (BRCA+) or capecitabine for non-pCR; postoperative adjuvant： ddAC-TP/ddT (node-positive)	Taxane-sensitive (Grade I recommendation): • Nab-paclitaxel + PD-1 inhibitor • Taxane + capecitabine; taxane + gemcitabine; taxane + platinum	Failure of taxane therapy (Grade I recommendation): • Monotherapy: sacituzumab tirumotecan; sacituzumab govitecan • Combination therapy: • With BRCA mutation: fluzoparib + apatinib • GP + PD-1 inhibitor; vinorelbine + platinum; gemcitabine + platinum; capecitabine + utidelone; capecitabine + vinorelbine	

Source: CSCO 2025, CIC

Treatment Paradigm for BC, NCCN (the U.S.)



Source: NCCN 2025, CIC

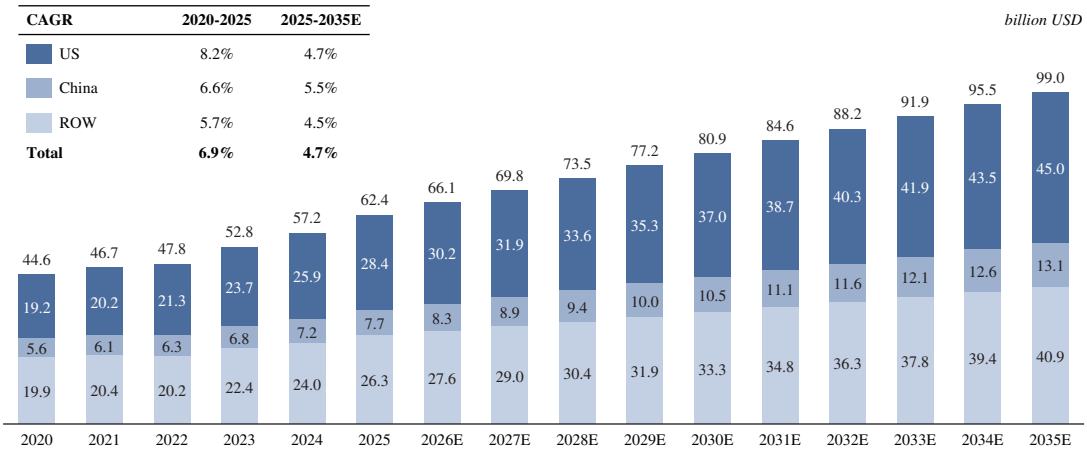
Notwithstanding this well-established biomarker-driven treatment paradigm, material unmet medical needs remain across major BC subtypes. In HR+/HER2- advanced or metastatic BC, most metastatic patients on endocrine therapy combined with CDK4/6 inhibitors eventually develop acquired resistance. In HER2+ BC, HER2-directed antibodies, ADCs and TKIs have materially improved patient outcomes, yet patients may still experience disease progression after sequential HER2-directed regimens, including progression involving the central nervous system ("**CNS**"), and optimal treatment sequencing remains complex. In TNBC, the lack of HR and HER2 expression limits the use of endocrine and HER2-directed therapies, while ICIs are applicable only to selected patients and many patients continue to rely on chemotherapy-based regimens. Across subtypes, later-line single-agent chemotherapy is generally associated with limited durability of disease control and cumulative toxicity, which may adversely affect patients' quality of life.

ADCs represent an important and evolving therapeutic modality in BC. ADCs provide a mechanism distinct from endocrine pathway suppression, HER2 receptor blockade and HER2 TKI inhibition, supporting activity after prior resistance, as reflected by the FDA approvals of sacituzumab govitecan in 2023 and datopotamab deruxtecan in 2025 in pretreated HR+/HER2- BC. Certain ADCs are also designed with cleavable linkers and membrane-permeable payloads, which may enable bystander killing and support activity in tumors with heterogeneous or lower antigen expression, including HER2-low and HER2-ultralow tumors. This momentum is now reaching the frontline: T-DXd plus pertuzumab was approved as first-line HER2+ therapy in December 2025, and datopotamab deruxtecan entered first-line TNBC in patients ineligible for PD-1/PD-L1 therapy in May 2026. Continued innovation in ADC targets, payloads and linker technologies, including bispecific ADCs, together with their movement into earlier lines of therapy, are expected to further expand treatment options for patients with BC.

Market Opportunity for BC

The global BC drug market grew rapidly from US$44.6 billion in 2020 to US$62.4 billion in 2025 at a CAGR of 6.9%, and is expected to increase to US$99.0 billion in 2035, representing a CAGR of 4.7% from 2025 to 2035. The following diagram sets forth the size of the BC drug market.

Global BC Drug Market Size, 2020-2035E



Source: CSCO, NCCN, CIC

Competitive Landscape for BC

The pharmaceutical treatment of BC is organized around its major molecular subtypes and comprises several therapeutic classes: endocrine therapy targeting hormone receptor signaling; targeted therapies against defined molecular dependencies, such as CDK4/6 inhibitors, PI3K/AKT/mTOR pathway inhibitors, PARP inhibitors for germline BRCA-mutated tumors, and HER2-directed monoclonal antibodies and TKIs; as well as platinum-based and other chemotherapy and ICIs. As of the Latest Practicable Date, there were over 50 targeted therapies approved and over 40 candidates in Phase III or beyond for BC, of which CDK4/6 inhibitors accounted for 10 approved agents and four candidates in Phase III or beyond, and HER2-directed therapies accounted for 17 approved agents and 16 candidates in Phase III or beyond. Among HER2-directed therapies, monoclonal antibodies accounted for six approved agents and three candidates in clinical development for BC. More recently, ADCs have emerged as a rapidly growing modality, with eight ADCs approved and 17 candidates in Phase III or beyond for BC. The following table sets forth a pipeline of ADC drug candidates targeting BC in China and/or the U.S.

Competitive Landscape of ADCs for BC

Drug name	Target	Company	HR+/HER2- 1L	HR+/HER2- 2L+	HER2+ 1L	HER2+ 2L+	TNBC 1L	TNBC 2L+
Iza-bren	EGFR HER3	Our Company	Regimen: Mono* Ph II/III, FPD: 2025-04-15 Location: China, US, Others	Mono Ph III, 2024-04-03 China			Mono Ph II/III, 2025-04-15 China, US, Others	Mono Ph III, 2024-04-24 China
Trastuzumab Emtansine	HER2	ImmunoGen/ Roche		Combo Ph I, 2015-11-16 US	Combo Ph III, 2010-03-23 US, others	Mono Approved, 2021-06-22, NMPA Approved, 2013-02-22, FDA		
Sacituzumab govitecan	TROP2	Gilead Sciences/ Immunomedics	Mono* Ph III, 2023-05-03 China, US, others,	Mono* Approved, 2025-03-18, NMPA Approved, 2023-02-03, FDA			Mono Ph III, 2022-02-16 China, US, others	Mono Approved, 2022-06-07 NMPA Approved, 2021-04-07 FDA
Trastuzumab deruxtecan	HER2	Daiichi Sankyo	Mono/Combo Ph I/II, 2020-11-25 China, US, others	Mono* Approved, 2023-07-11, NMPA Approved, 2022-08-05, FDA	Combo Approved, 2025-12-15 FDA	Mono Approved, 2023-02-21, NMPA Approved, 2022-05-04, FDA		
Trastuzumab botidotin	HER2	Sichuan Kelun Pharma		Mono* Ph I/II, 2018-07-26 US		Mono Approved, 2025-10-14 NMPA		
Disitamab vedotin	HER2	Remegen Co., Ltd.	Combo* Ph II, 2024-09-30 China	Mono* (Liver mets) Approved, 2026-03-17 NMPA		Mono (Liver mets) Approved, 2025-04-30 NMPA		
Sacituzumab tirumotecan	TROP2	Merck/Sichuan Kelun-Biotech	Mono/Combo Ph III, 2024-03-15 US, others	Mono Approved, 2026-02-02 NMPA			Mono Ph III, 2024-02-05 China	Mono Approved, 2024-11-22 NMPA
trastuzumab rezetecan	HER2	Jiangsu Hengrui		Mono* Ph III, 2023-04-12 China	Mono/Combo Ph III, 2023-09-15 China	Mono Approved, 2026-03-17 NMPA	Combo Ph III, 2025-08-05 China	Combo Ph I/II, 2023-12-05 China
Datopotamab deruxtecan	TROP2	Daiichi Sankyo	Mono Ph III, 2025-10-03 China, US, Others	Mono* Approved, 2025-01-17, FDA Approved, 2025-08-19, NMPA			Mono Approved, 2026-05-22 FDA	Mono/Combo Ph I/II, 2022-05-12 US, others
Trastuzumab pamirtecan	HER2	Duality Biologics Pharma	Mono* Ph III, 2023-08-30 China, US, others	Mono* Ph III, 2023-08-30 China, US, others	Mono Ph I/II, 2021-12-09 China, US, others	Mono NDA, 2026-04-09 NMPA		Combo Ph I/II, 2025-02-14 China, US, others
T-Bren	HER2	Our Company		Mono* Ph III, 2025-04-28 China	Combo Ph III, 2026-04-03 China	Mono Ph III, 2024-03-14 China		Mono Ph I, 2022-07-18 China
Caxmotabart Entudotin	HER2	LegoChem Biosciences		Mono* Ph I, 2023-05-24 US, others		Mono Ph III, 2023-02-27 China		
Anbenitamab repodatecan	HER2	Alphamab Oncology		Mono* Ph III, 2023-10-07 China	Mono Ph II, 2026-04-22 China	Mono Ph III, 2025-02-05 China		
DP303C	HER2	CSPC PHARMA		Combo* Ph I/II, 2024-08-22 China		Mono Ph III, 2024-01-25 China		
FDA018	TROP2	Shanghai Fudan-Zhangjiang Bio.						Mono Ph III, 2024-07-22 China
TQB2102	HER2	Chia Tai-tianqing Pharma	Mono* Ph III, 2024-08-19 China	Mono Ph II, 2024-03-25 China	Mono Ph III, 2025-05-30 China	Mono Ph III, 2025-05-15 China		Mono Ph II, 2024-03-25 China
GQ1005	HER2	Qide Medical Technology		Mono* Ph I, 2023-02-21 China	Combo Ph II/III China, 2025-12-10	Mono Ph III, 2024-12-24 China		
Patritumab deruxtecan	HER3	Daiichi Sankyo		Mono Ph III, 2025-07-11 China, US, others		Combo Ph I/II, 2024-11-13 US, others		Mono Ph II, 2021-01-07 US
IBI354	HER2	Innovent		Mono Ph I/II, 2022-12-05 China, others	Combo Ph III, 2026-01-26 China	Mono Ph I/II, 2022-12-05 China, others		
CPO301	EGFR	CSPC PHARMA		Mono Ph III, 2026-02-12 China		Combo Ph I/II, 2025-10-24 China		Mono Ph III, 2026-02-12 China
YL202	HER3	MediLink Therapeutics		Mono* Ph III, 2026-02-28 China				Mono Ph II, 2024-04-15 China
JSKN-016	HER3 TROP2	Alphamab Oncology/Jiangsu Alphamab Bio		Combo Ph I/II, 2025-04-24 China			Combo Ph I/II, 2025-04-24 China	Mono Ph III, 2026-03-09 China
Bulumtatug Fuvedotin	Nectin-4	Mabwell/Jiangsu Maiweikang					Combo Ph II, 2025-06-26 China	Mono Ph III, 2026-04-22 China
Trastuzumab vedotin	HER2	Lepu Biopharma/Shanghai Miracogen		Mono* Ph II, 2021-02-05 China		Mono Ph II/III, 2021-05-31 China		
Anvatabart opadotin	HER2	J&J/Ambrx Biopharma		Mono Ph I, 2017-08-21 US, others		Mono Ph II/III, 2020-06-30 China		

Approved | Phase III & Phase II/III | Phase II & Phase I/II | Phase I

* HER2-low status specified where applicable.

Notes:

1. Only active pipelines are included. Programs that have been completed, suspended, terminated, or withdrawn prior to recruitment are generally excluded, unless they represent the only or most advanced program available.

2. Indications are not exhaustively listed. For each indication, only the most advanced and earliest-disclosed pipeline is presented, with regional distinctions drawn where applicable (for example, between China and the U.S.).

3. Only approved drugs and drug candidates that have advanced to Phase III or beyond clinical development are included.

Source: ClinicalTrials.gov, CDE, CIC

NPC

NPC is a type of epithelial tumor originating from the nasopharyngeal epithelial cells in the upper throat. Due to the limitations of specific early diagnostic tools and a lack of widespread screening, less than 20% of NPC cases are diagnosed at an early stage, with the vast majority detected only at mid-to-late stages. The incidence of NPC is notably higher in Asia than in Western countries. In 2024, the global crude incidence rate of NPC was 1.48 per 100,000 person-years, whereas it exceeded 3.51 per 100,000 person-years in China.

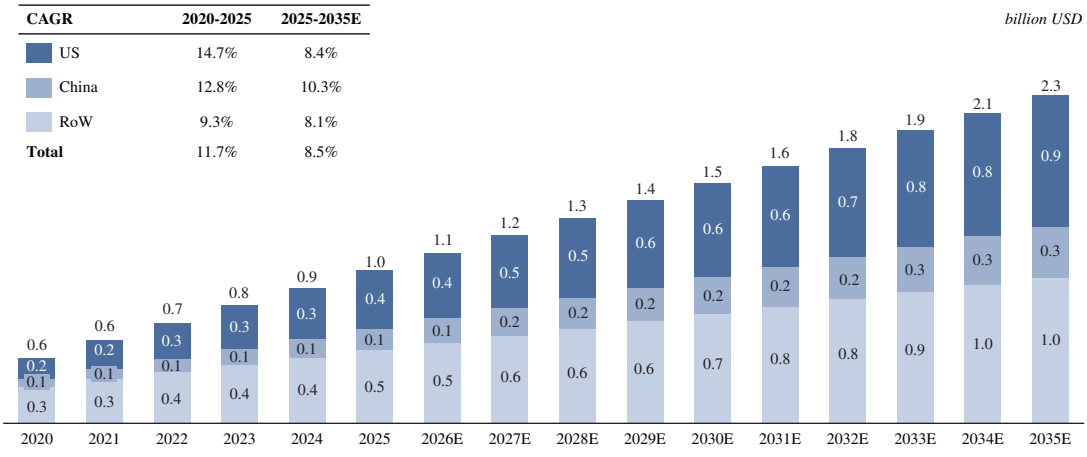
Treatment Paradigm and Unmet Needs

For early-stage and locoregionally advanced NPC, definitive intensity-modulated radiotherapy, with or without concurrent platinum-based chemoradiotherapy and induction chemotherapy, constitutes the standard curative-intent treatment. For recurrent or metastatic (R/M) NPC, first-line treatment consists of gemcitabine plus cisplatin in combination with a PD-1 inhibitor. Upon first-line progression, second-line options are largely limited to single-agent chemotherapy, while third-line and beyond options include PD-1 monotherapy (for patients without prior checkpoint inhibitor exposure) and, more recently, ADCs. The current standard of care for late-line R/M NPC offers only modest therapeutic benefit, with PD-1 monotherapy achieving response rates of only approximately 20% to 30%. This represents a significant unmet medical need, as patients with R/M NPC who have progressed after platinum-based chemotherapy and immunotherapy have a five-year survival rate of only 25% and face few effective treatment options. ADCs offer a differentiated mechanism that may address this gap by delivering potent cytotoxic payloads through antigen-directed targeting, independent of PD-L1-mediated immune activation, thereby providing clinical benefit in patients who are unresponsive to or have progressed after ICI therapy. Notably, CSCO guidelines have incorporated iza-bren as a recommended treatment option for late stage R/M NPC.

Market Opportunity for NPC

The global NPC drug market grew rapidly from US$0.6 billion in 2020 to US$1.0 billion in 2025 at a CAGR of 11.7%, and is expected to increase to US$2.3 billion in 2035, representing a CAGR of 8.5% from 2025 to 2035. The following diagram sets forth the size of the NPC drug market.

Global NPC Drug Market Size, 2020-2035E



Source: CSCO, NCCN, CIC

Competitive Landscape for NPC

The pharmaceutical treatment of R/M NPC comprises PD-1/PD-L1 ICIs, which form the backbone of first-line therapy in combination with chemotherapy and are also used as monotherapy in later lines; conventional cytotoxic chemotherapy administered across treatment lines; and, more recently, ADCs. As of the Latest Practicable Date, there were 12 drugs approved for NPC, including five PD-1/PD-L1 inhibitors. As of the same date, there were two ADCs approved for NPC in China and/or the U.S., as set forth below. Notably, iza-bren was the world's only approved EGFR × HER3 bispecific ADC.

Approved ADC Drugs for NPC

INN[1]	Brand name	Drug type	Company	Indication	NMPA approval	NRDL status	Target	Dosage	Efficacy[2]
Izalontamab brengitecan	宜泽康	Bispecific ADC	Our Company	R/M NPC after ≥ 2L systemic chemotherapy and PD-1/PD-L1 inhibitors	2026-06	Not included	EGFR, HER3	IV infusion Q3W	• ORR: 54.6% vs. 27.0% • mPFS: 8.38 m vs. 4.34 m
Becotatug vedotin	美佑恒	ADC	Lepu Biopharma	R/M NPC after ≥ 2L systemic chemotherapy and PD-1/PD-L1 inhibitors	2025-10	Not included	EGFR	IV infusion Q3W	• ORR: 42.0% • mPFS: 5.8 m

Notes:

1 International Nonproprietary Name;

2 Efficacy data for iza-bren are from a randomized phase III study versus treatment of physician's choice (TPC) (NCT06118333); efficacy data for MRG003 are from a single-arm phase IIa study (NCT05126719);

Source: NMPA, Drug labels, The Lancet, Med, CIC

Esophageal Squamous Cell Carcinoma

Esophageal squamous cell carcinoma ("**ESCC**") is the predominant histological subtype of esophageal cancer ("**EC**"), accounting for approximately 90% of cases in China. ESCC is often asymptomatic at an early stage, and approximately 70% of patients are estimated to experience advanced disease over the course of their disease. The incidence of ESCC is notably higher in Asia than in Western countries. In 2025, the global crude incidence rate of ESCC was over 5 per 100,000 person-years, whereas it exceeded 11 per 100,000 person-years in China.

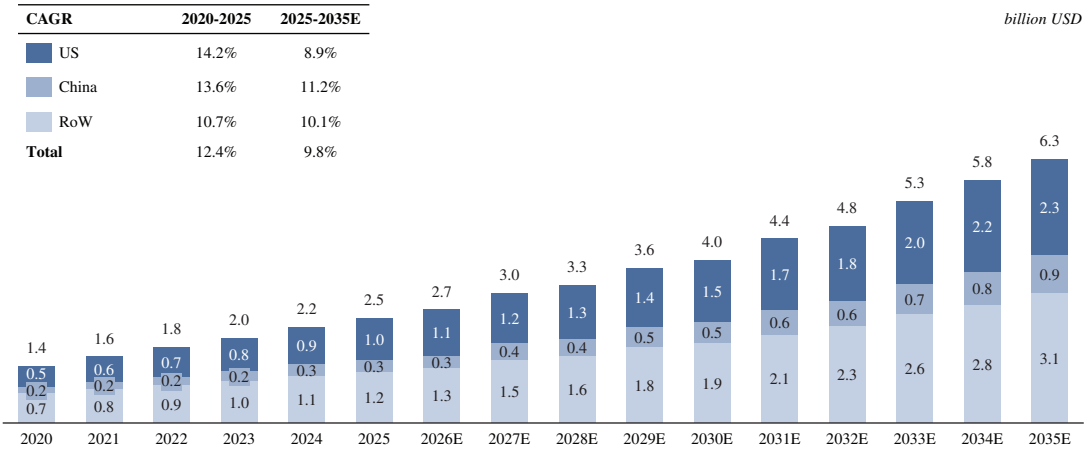
Treatment Paradigm and Unmet Needs

For early-stage and locoregionally advanced ESCC, local and curative-intent modalities — including endoscopic resection, ablation therapy, and esophagectomy, as well as preoperative or definitive concurrent chemoradiation — constitute the standard treatment. For unresectable, recurrent, or metastatic ESCC, first-line treatment consists of platinum-based chemotherapy in combination with a PD-1/PD-L1 inhibitor. Upon first-line progression, second-line and beyond options are largely limited to single-agent chemotherapy and PD-1/PD-L1 monotherapy for patients without prior checkpoint inhibitor exposure. This represents a significant unmet medical need, as patients with ESCC who have progressed after platinum-based chemotherapy and immunotherapy have a five-year survival rate of less than 8% and face few effective treatment options. ADCs offer a differentiated mechanism that may address this gap, providing clinical benefit in patients who are unresponsive to or have progressed after ICI therapy.

Market Opportunity for ESCC

The global ESCC drug market grew rapidly from US$1.4 billion in 2020 to US$2.5 billion in 2025 at a CAGR of 12.4%, and is expected to increase to US$6.3 billion in 2035, representing a CAGR of 9.8% from 2025 to 2035. The following diagram sets forth the size of the ESCC drug market.

Global ESCC Drug Market Size, 2020-2035E



Source: CSCO, NCCN, CIC

Competitive Landscape for ESCC

The pharmaceutical treatment of ESCC comprises PD-1/PD-L1 ICIs, which form the backbone of first-line therapy in combination with chemotherapy and are also used as monotherapy in later lines; conventional cytotoxic chemotherapy administered across treatment lines; and, more recently, ADCs. As of the Latest Practicable Date, there were 12 drugs approved for ESCC, including 10 PD-1/PD-L1 inhibitors. As of the same date, iza-bren was the only ADC approved for ESCC in China and/or the U.S.

Other Cancer Types

Unlike targeted therapies that require specific oncogenic drivers, certain next-generation ADCs, including EGFR×HER3 bispecific ADCs, target antigen pairs that are broadly co-expressed across multiple solid tumor types. EGFR and HER3 are co-expressed in a range of epithelial cancers beyond NSCLC and BC, including gastric cancer ("**GC**"), head and neck squamous cell carcinoma ("**HNSCC**"), colorectal cancer ("**CRC**") and biliary tract cancers ("**BTCs**"), creating a pan-tumor opportunity. This pan-tumor activity profile is further supported by the bystander killing mechanism of modern ADC payloads, which enables anti-tumor activity even in cells with heterogeneous or lower antigen expression. These innovative modalities are expected to become promising cancer therapies, potentially replacing conventional chemotherapy as the pan-tumor standard of care. The following chart summarizes the incidence of major cancer indications addressed by these anti-tumor therapies.

Epidemiology of the Selected Cancers

Cancer type	Global			The U.S.			China		
	2025	2030E	2035E	2025	2030E	2035E	2025	2030E	2035E
Solid tumor	**Incidence (thousand people)**								
CRC	2,064	2,361	2,674	170	183	195	584	689	784
Prostate Cancer	1,570	1,830	2,098	245	263	275	179	246	298
GC	1,037	1,190	1,351	27	30	32	335	309	290
HNSCC	907	1,011	1,114	60	64	68	134	142	150
Liver cancer	917	1,007	1,100	46	50	52	355	359	363
CC	703	760	815	14	15	15	146	152	157
Urothelial Carcinoma	638	743	856	84	96	106	101	115	127
Esophageal Cancer	547	623	702	20	22	23	193	166	147
RCC	394	443	493	64	69	73	69	75	80
OC	347	382	416	22	24	25	62	65	67
BTC	315	352	391	14	16	17	104	101	99
NPC	122	133	143	2	2	2	50	53	55
Blood cancer	**Incidence (thousand people)**								
NHL	590	664	740	83	91	98	84	89	93
ALL	111	123	136	5	5	6	40	42	43
AML	155	172	190	23	26	28	19	19	20

Source: GLOBOCAN; NCC; IARC; GHDx; CIC

MNC CAPABILITY STANDARDS FOR GLOBAL BIOPHARMA

To successfully develop and commercialize innovative therapies and compete effectively on a global scale, leading multinational pharmaceutical corporations ("**MNCs**") are evaluated against a comprehensive capability framework encompassing several core dimensions: (i) global innovation capability, driven by proprietary discovery platforms and deep-rooted scientific expertise, generating first-/best-in-class assets across multiple modalities; (ii) cross-continental integrated R&D capability, often facilitated by integrated R&D hubs across different regions to optimize global development; (iii) multi-regional clinical execution, accelerated by direct engagement with major regulators such as the FDA; (iv) multi-jurisdictional Good Manufacturing Practice ("**GMP**")-compliant manufacturing to support global commercialization; and (v) global commercialization capability, encompassing cross-border launch of innovative products and global market-access ability. As China's innovative drug industry transitions from a "fast-follower" strategy to "first-in-class" innovation, platform-driven companies with global execution capabilities are uniquely positioned to lead the charge and evolve into globally competitive MNCs. The chart below sets forth the capability framework and key benchmarks for MNCs.

MNC Capability Framework

Capability Dimensions	Global Biopharma Benchmark	Representative Evidence	Biokin Evidence
Global Innovation Capability	Ability to continuously generate first-/best-in-class assets across multiple modalities through proprietary technology platforms and leverage scientific expertise to drive global innovation	• Multiple internally originated clinical-stage assets • Strategic collaborations and out-licensing of internally generated assets • Identification and integration of external innovation opportunities	• Proprietary ADC, BsAb and ARC platforms • >10 clinical-stage assets • Iza-bren achieved a global strategic licensing transaction valued at up to US$8.4 billion • Multiple internally discovered assets advanced into clinical development
Cross-Continental Integrated R&D	Integrated R&D organizations spanning major innovation hubs and enabling efficient global development	• Global research footprint • Cross-regional project teams • Coordinated regulatory strategy	• U.S.–China dual-center R&D model • Integrated discovery, translational and clinical development teams supporting global programs
Multi-Regional Clinical Execution	Capability to conduct MRCTs and engage directly with major regulators	• FDA/EMA/NMPA interactions • Global trial execution • Multi-country enrollment	• Clinical trials conducted across China, U.S. and other regions • Direct FDA engagement • Global development strategy for Iza-bren and other key assets
Multi-Jurisdictional Manufacturing	GMP-compliant manufacturing capable of supporting clinical and commercial supply across jurisdictions	• Commercial-scale biologics/ADC manufacturing • Quality systems aligned with global standards	• ADC manufacturing facilities and capacity expansion under build-out • Manufacturing systems designed to support global development and commercialization
Global Commercialization Capability	Ability to establish commercial infrastructure and successfully launch innovative products across global markets	• Product launches across major markets • Global market access and commercialization capabilities	• Established oncology commercialization capabilities in China • Commercial launch of iza-bren in China and preparation for overseas commercialization

Source: FDA, NMPA, Annual reports, Official Websites, CIC

GENERICS AND TRADITIONAL CHINESE MEDICINES

Generic Medicines

Anesthesia

Anesthesia drugs induce a temporary loss of sensation or awareness, and are essential in medical practice. According to CIC, the number of inpatient surgeries in China is expected to increase from 104.3 million in 2024 to 156.1 million in 2035. In addition, the number of diagnostic endoscopic procedures under general anesthesia in China is expected to grow from 19.0 million in 2025 to 30.7 million in 2035, with anesthesia drugs playing a crucial role in stabilizing patients to enhance diagnostic accuracy. The anesthesia drug market in China grew from RMB16.0 billion in 2020 to RMB20.2 billion in 2025 at a CAGR of 4.8%, and is projected to reach RMB34.0 billion in 2035, representing a CAGR of 5.2% from 2025 to 2035. Such growth is primarily driven by the rising prevalence of chronic diseases requiring surgical intervention and continuous R&D investments yielding safer, more effective drugs.

As of the Latest Practicable Date, there were over 40 propofol emulsion injection, over 60 propofol medium and long chain fat emulsion injection products, over 30 dexmedetomidine hydrochloride injection products, and over 15 sevoflurane for inhalation products in China. According to CIC, Leweijing 乐维静® (propofol emulsion injection) ranked fourth with a market share of 12.4%; Leweitai 乐维泰® (propofol medium and long chain fat emulsion injection) ranked second with a market share of 17.3%; and Shuweijing 舒维静® (sevoflurane for inhalation) ranked sixth with a market share of 1.6% in each product's respective market in China in 2025.

Parenteral Nutrition

Parenteral nutrition is a life-sustaining therapy that offers nutritional support to patients who are unable to meet their nutritional needs through oral or enteral routes, with medium and long chain fat emulsion injections serving as a critical component. The market size for medium and long chain fat emulsion in China was RMB1.0 billion in 2025, according to CIC. The parenteral nutrition drug market in China grew from RMB14.4 billion in 2020 to RMB16.9 billion in 2025 at a CAGR of 3.1%, and is projected to reach RMB24.0 billion in 2035, representing a CAGR of 3.6% from 2025 to 2035. Such growth is primarily driven by continuous formulation advancements, diversified product specifications, and the adoption of user-friendly multi-chamber bag products. As of the Latest Practicable Date, there were over 50 medium and long chain fat emulsion injection products in China. According to CIC, Tianze 天泽® (medium and long chain fat emulsion injection) ranked ninth in China's medium and long chain fat emulsion injection market, with a market share of 3.3%, and Bailineng （百利能®, structural fat emulsion injection) ranked second with a market share of 3.1% in each product's respective market in China in 2025.

Pediatric Drugs

Pediatric drugs, including racecadotril and glucose electrolyte solutions, play a vital role in managing common childhood conditions such as acute diarrhea and dehydration. As an enkephalinase inhibitor, racecadotril effectively reduces intestinal fluid secretion without altering gut motility. Similarly, glucose electrolyte solutions serve as a fundamental therapy for treating dehydration caused by diarrhea or vomiting and promote efficient intestinal absorption of sodium and water. In 2025, the market size for racecadotril granule in China was RMB29.4 million and the market size for glucose electrolyte effervescent tablet in China was RMB25.4 million.

The pediatric drug market in China rose from RMB83.5 billion in 2020 to RMB125.3 billion in 2025 at a CAGR of 8.5% and is projected to reach RMB234.7 billion in 2035, representing a CAGR of 6.3% from 2025 to 2035. Such growth is primarily driven by the widespread prevalence of pediatric diarrhea and dehydration globally, as well as supportive domestic policies for pediatric medicine R&D in China. As of the Latest Practicable Date, we were the only manufacturer of glucose electrolyte products in China.

Challenges of the Generic Drug Market

The generic drug market faces several significant challenges. A primary concern is the price pressure from the VBP policy. As of the Latest Practicable Date, a number of anesthetic and parenteral nutrition drugs had already been included in VBP schemes, experiencing deep price cuts, according to CIC. A broader range of drugs may be affected in the future, leading to market volatility as prices drop. Additionally, the regulatory framework for anesthetics and other drugs is becoming increasingly stringent, covering aspects from manufacturing to distribution and consumption, complicating market entry for new drugs. Furthermore, the strict supervision of anti-infective drug use in hospitals, driven by concerns over drug abuse, poses a challenge to market growth. In the pediatric sector, high requirements for flavor and drug form are necessary to address poor compliance in children, necessitating additional R&D efforts and significant investment in capital and talent.

Traditional Chinese Medicine

Overview of Astragalus and Chaihuang

Huangqi (黄芪), also known as astragalus, and chaihuang (柴黄), a formulation combining Bupleurum (Chaihu) and astragalus, are integral components of traditional Chinese medicine with a long history of use. Astragalus is renowned for its immunomodulatory and anti-inflammatory properties, and is traditionally used to enhance immune function. It is prescribed for chronic fatigue, respiratory infections, and as an adjunct therapy in cancer treatment. Meanwhile, chaihuang

is valued for its heat-clearing and detoxifying properties, and is effective in treating fever, inflammation, and liver disorders. It is commonly used for upper respiratory tract infections, hepatitis, and digestive issues, working by modulating the immune response and exerting anti-inflammatory effects.

Market Size and Competitive Landscape of Traditional Chinese Medicine in China

The traditional Chinese medicine market in China grew from RMB355.1 billion in 2020 to RMB435.3 billion in 2025 at a CAGR of 4.2%, and is projected to reach RMB545.7 billion in 2035, representing a CAGR of 2.2% from 2025 to 2035. Such growth is primarily driven by (i) robust government policy support, such as the *State Council General Office Notice on Improving the Quality of TCM and Promoting High-Quality Development of the TCM Industry (*國務院辦公廳關於提升中藥質量促進中醫藥產業高質量發展的意見) and the *Special Provisions on the Management of TCM Standards* (《中藥標準管理專門規定》); (ii) increasing consumer demand for natural, holistic health solutions integrated with modern healthcare; and (iii) the growing acceptance of astragalus and chaihuang, backed by modern pharmacological studies and a long history of safe usage.

As of the Latest Practicable Date, there were over 60 approved medicines containing astragalus and over 30 approved medicines containing chaihuang in China. According to CIC, our astragalus granule (黃芪顆粒) ranked first in China's astragalus market, with a market share of approximately 36.8% in 2025, and our chaihuang granule (柴黃顆粒) also ranked first in China's chaihuang market, with a market share of approximately 75.7% in 2025.

Challenges of Traditional Chinese Medicine Market

The traditional Chinese medicine market is also characterized by several entry barriers such as brand loyalty. Additionally, new entrants to the traditional Chinese medicine must also establish a reliable supply chain to be able to source the required raw medicinal materials. The market also faces significant challenges, primarily due to difficulties in quality control and standardization. Since traditional Chinese medicines are made from herbs and are not standardized products, maintaining consistent quality requires considerable effort. This lack of standardization can hinder the ability to meet market demand reliably. Additionally, there is a shortage of valid clinical evidence supporting the efficacy of some traditional Chinese medicines, as many do not have sufficient data from well-designed clinical trials. Conducting such trials demands substantial capital and talent, which can impact market growth.

SOURCE OF INFORMATION

In connection with the [**REDACTED**], we have engaged CIC to conduct a detailed analysis and prepare an industry report on the major markets for which our drug candidates are positioned. CIC is an independent global market research and consulting company that provides market research on a variety of industries including biotechnology. We have agreed to pay CIC a total fee of RMB0.7 million for the preparation of the CIC Report, and we believe that such fees are consistent with the market rate. The payment of such amount was not contingent upon our successful [**REDACTED**] or on the results of the CIC Report. Except for the CIC Report, we did not commission any other industry report in connection with the [**REDACTED**]. The market projections in the CIC Report were based on the following key assumptions: (i) the overall social, economic and political environment globally and in China is expected to remain stable during the forecast period; (ii) the global and China's economic and industrial development is likely to maintain a steady growth trend over the next decade; (iii) related key industry drivers are likely to continue driving the growth of the market during the forecast period; and (iv) there is no extreme force majeure or industry regulation in which the market may be affected dramatically or fundamentally. The reliability of the CIC Report may be affected by the accuracy of the foregoing key assumptions.