Global Science.
One Purpose.

Corporate Presentation

September 2026

Forward Looking Statement

This presentation (the “Presentation”) contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 about Vor Biopharma Inc. (“Vor,” “Vor Bio” or the “Company”). The words “aim,” “anticipate,” “believe,” “can,” “could,” “design,” “enable” “estimate,” “expect,” “intend,” “may,” “ongoing,” “plan,” “potential,” “project,” “should,” “target,” “towards,” “will,” and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. Forward-looking statements in this Presentation include those regarding Vor Bio's plans for development and commercialization of telitacicept, including expected milestones such as MG data readout in 1H27 and doing the first patient in the oMG global Phase 3 trial in 1H27; the potential of telitacicept in various indications including generalized myasthenia gravis (gMG) and primary Sjögren's disease; the Company’s ambition to transform the approach to B cell-driven autoimmune disease; the potential of telitacicept to be a best- and first-in-class BAFF/APRIL inhibitor; the expected safety profile of telitacicept; the market opportunities for telitacicept; the addressable patient populations in the indications Vor Bio intends to treat; Vor Bio's cash runway; and other statements that are not historical fact.

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Immune Remodulation Through BAFF/APRIL Inhibition

OUR AMBITION

To Transform the Approach to B Cell-Driven Autoimmune Disease

TELITACICEPT

- Selective BAFF/APRIL inhibitor designed to reduce pathogenic B cells and antibodies while preserving immune protection
- Clinically validated in 8+ autoimmune indications in China
- Manageable safety and tolerability in tens of thousands of patients

LEAD AUTOIMMUNE PROGRAMS

- *Myasthenia Gravis*: Global Phase 3 enrollment completed; topline data in 1H27
- *Ocular Myasthenia Gravis*: Global Phase 3 first patient dosed in 1H27
- *Sjögren's Disease*: Global Phase 3 enrollment ongoing; first patient dosed in 1Q26

NEAR-TERM EXPANSION OPPORTUNITIES

- Broad applicability across B cell-mediated autoimmune diseases

~$515M WITH RUNWAY INTO EARLY 2029*, FUNDED THROUGH KEY MILESTONES

Proforma cash, cash equivalents, and short-term investments as of June 30, 2026

Dual BAFF/APRIL Inhibition Targets Autoreactive B Cells and Plasma Cells

Disease modification through upstream control of B cell survival and downstream antibody production

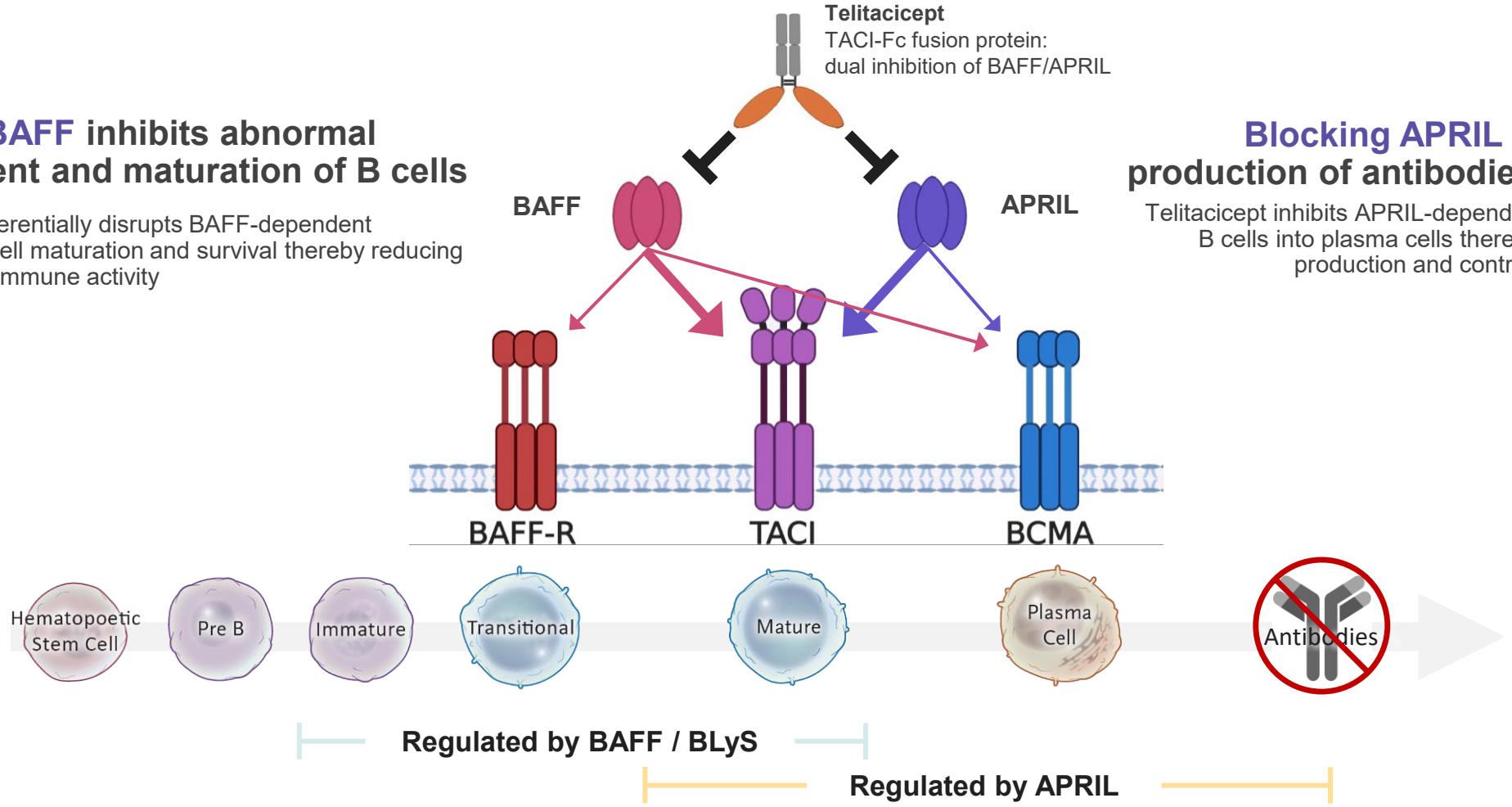
Telitacicept
TACI-Fc fusion protein:
dual inhibition of BAFF/APRIL

Blocking BAFF inhibits abnormal development and maturation of B cells

Telitacicept preferentially disrupts BAFF-dependent autoreactive B-cell maturation and survival thereby reducing disease-driving immune activity

Blocking APRIL inhibits abnormal production of antibodies by plasma cells

Telitacicept inhibits APRIL-dependent differentiation of mature B cells into plasma cells thereby minimizing autoantibody production and contributing to control of disease



doi.org/10.3390/cancers12041045

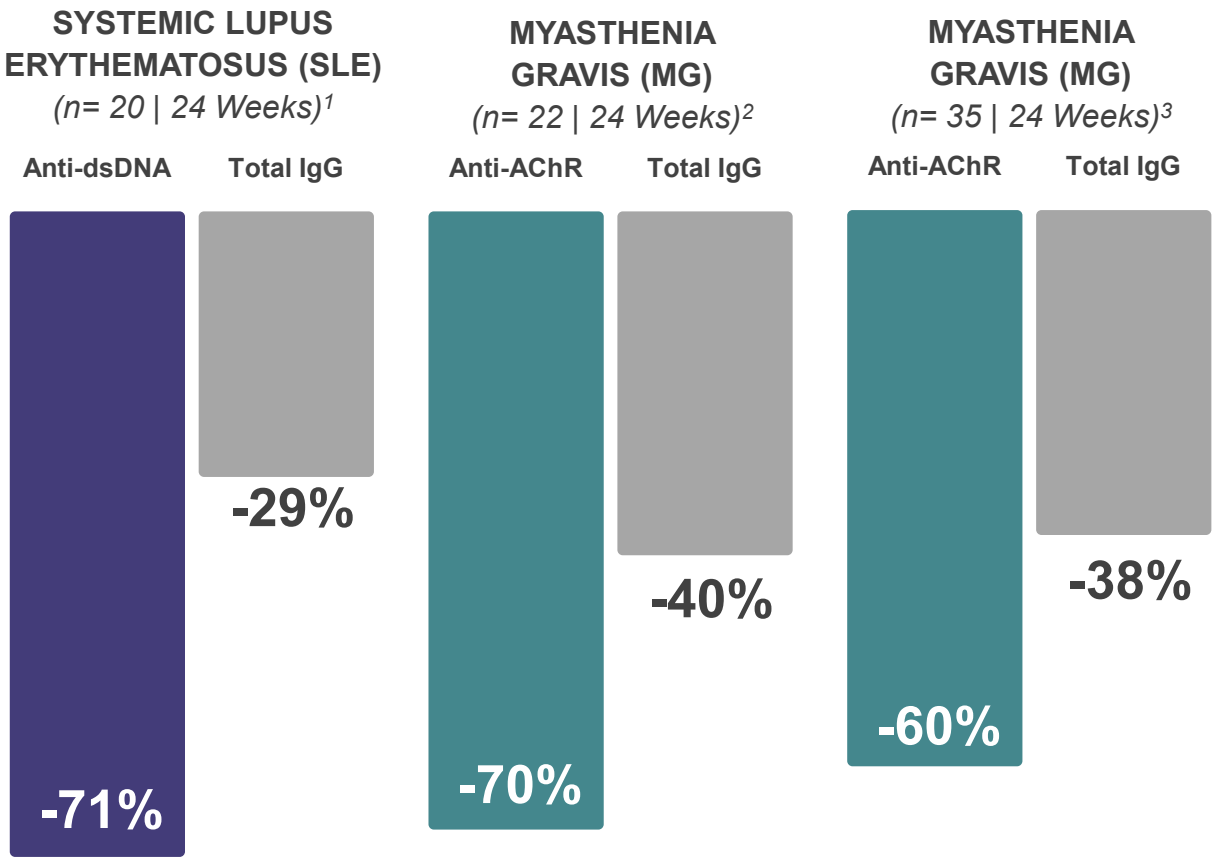
BAFF, B-cell activating factor; BLyS, B Lymphocyte Stimulator; APRIL, a proliferation inducing ligand

TELITACICEPT PREFERENTIALLY DEPLETES PATHOGENIC CELLS WHILE PRESERVING HUMORAL IMMUNITY

Pathogenic autoantibodies fell ~1.6-2.4x more than total IgG pool in SLE and MG patients treated with telitacicept[1,2]

Telitacicept removes BAFF/APRIL survival signals that pathogenic long-lived plasma cells depend on without depleting the immune system[1,4]

Functional B cell reservoir were retained with CD4 T cell immunity unaffected, protective IgG pool largely spared, and a proportion of regulatory B cells restored to healthy-control levels[1,4]



1. DOI: 10.1186/s13075-025-03584-x; 2. DOI: 10.1007/s11481-025-10272-9 (overall mean excludes subject 16); 3. DOI: 10.2147/ITT.S616114.; 4.DOI:10.1016/j.autrev.2026.104042

Established Efficacy in China Across Autoimmune Diseases

5

Commercial Approvals

Validated Commercial Therapy in China Across Diverse Autoimmune Diseases

2021 - Systemic Lupus Erythematosus (SLE)†

2024 - Rheumatoid Arthritis (RA)

2025 - Myasthenia Gravis (MG)

2026 – Sjögren's Disease (SjD)

2026 – IgA Nephropathy (IgAN)*

3

Best-In-Disease

Unique Dual BAFF/APRIL Inhibition Drives Superior Clinical Benefit

Systemic Lupus Erythematosus

Myasthenia Gravis

Sjögren's Disease

†Conditional Approval, Full Approval in 2023; *Conditional Approval

Favorable Safety At Scale

10s of Thousands Patients Treated Commercially in China

Favorable and Predictable Safety Profile Observed Among ~2,400* Patients Studied in Clinical Trials

- **No Burdensome Vaccination Requirements**
- **No Signature B Cell Depletion Associated SAEs**
- **Mild to Moderate AEs**

Frequency (%) of safety events reported in clinical trials

	Telitacicept (n=1669)	Placebo (n=711)
Upper respiratory tract infection	39	36
Injection site reaction	21	2
Urinary tract infection	10	8
Cough	5	3
Diarrhea	5	5

*Pooled safety analysis across 14 completed telitacicept clinical studies; data cutoff December 1, 2025
AEs, adverse events; SAEs, serious adverse events.

Advancing the Leading BAFF/APRIL Inhibitor

Strong cash position of ~$515M with runway into early 2029 expected to cover key milestones*

Vor Indications	Preclinical	Phase 1	Phase 2	Phase 3	Marketing Approval	Milestones
Generalized Myasthenia Gravis (gMG)				Phase 3		Global Phase 3 Topline Data (1H27)
Ocular Myasthenia Gravis (oMG)				Phase 3 Planned		FPD (1Q27)
Primary Sjögren's Disease (pSjD)				Phase 3		FPD (1Q26); Enrollment Ongoing

RemeGen Indications	Preclinical	Phase 1	Phase 2	Phase 3	Marketing Approval	Milestones
Generalized Myasthenia Gravis (gMG)					China Marketed	
Primary Sjögren's Disease (pSjD)					China Marketed	
IgA Nephropathy (IgAN)					Conditional Approval	
Systemic Lupus Erythematosus (SLE)					China Marketed	
Rheumatoid Arthritis (RA)					China Marketed	
Connective Tissue Disease-Associated Interstitial Lung Disease (CTD-ILD)				Phase 3		
Ocular Myasthenia Gravis (oMG)				Phase 3		
Membranous Nephritis (MN)				Phase 3 Planned		
Pediatric Systemic Lupus Erythematosus (pSLE)				Phase 3 Planned		
Autoimmune Encephalitis (AE)				Phase 3 Planned		
Pediatric IgA Nephropathy (pIgAN)				Phase 3 Planned		

FPD, first patient dosed; *Proforma cash, cash equivalents, and short-term investments as of June 30, 2026

Vor – Global Trial RemeGen – China Trial Primary Endpoint Achieved

Myasthenia Gravis

Moving Beyond Complement and
IgG Therapies

A Large and Growing Global Opportunity in Myasthenia Gravis

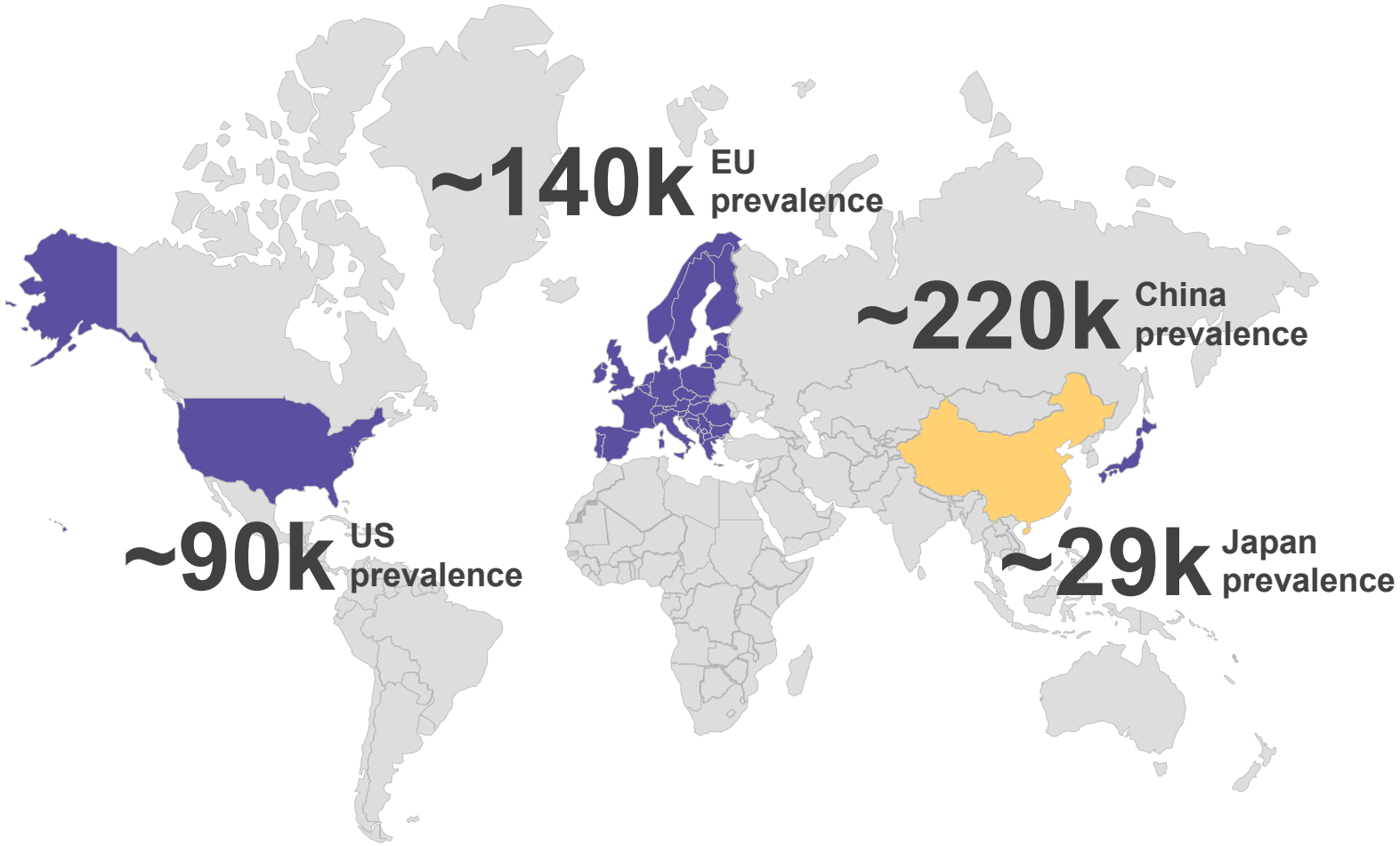
~260,000 diagnosed MG patients across key markets[1]

Significant Burden

- A large, diagnosed patient population across key markets establishes a substantial initial opportunity

Favorable Growth Drivers

- Prevalence is growing due to increased awareness, improved diagnostics, and an aging population



1. Vor metanalysis and estimates; excludes Chinese market

MG, myasthenia gravis

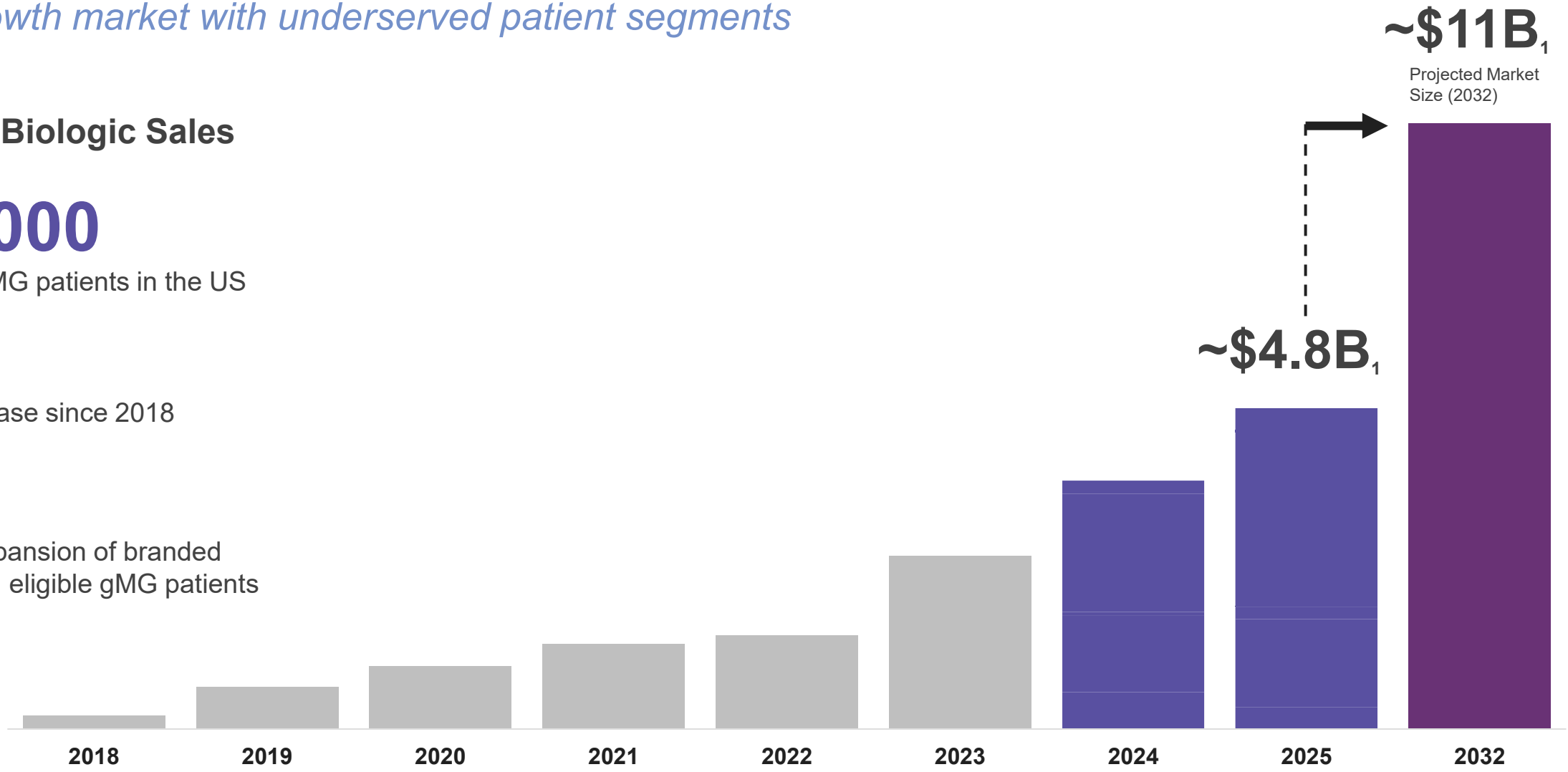
MG Market Rapidly Expanding But Lacks Disease-Modifying Treatments

High growth market with underserved patient segments

~90,000
Diagnosed MG patients in the US

57%
CAGR increase since 2018

60%
Potential expansion of branded medicines in eligible gMG patients



MG, myasthenia gravis; gMG: generalized myasthenia gravis; 1. EvaluatePharma and GlobalData sales and consensus

Current Myasthenia Gravis Therapies Target Symptoms, Not Disease

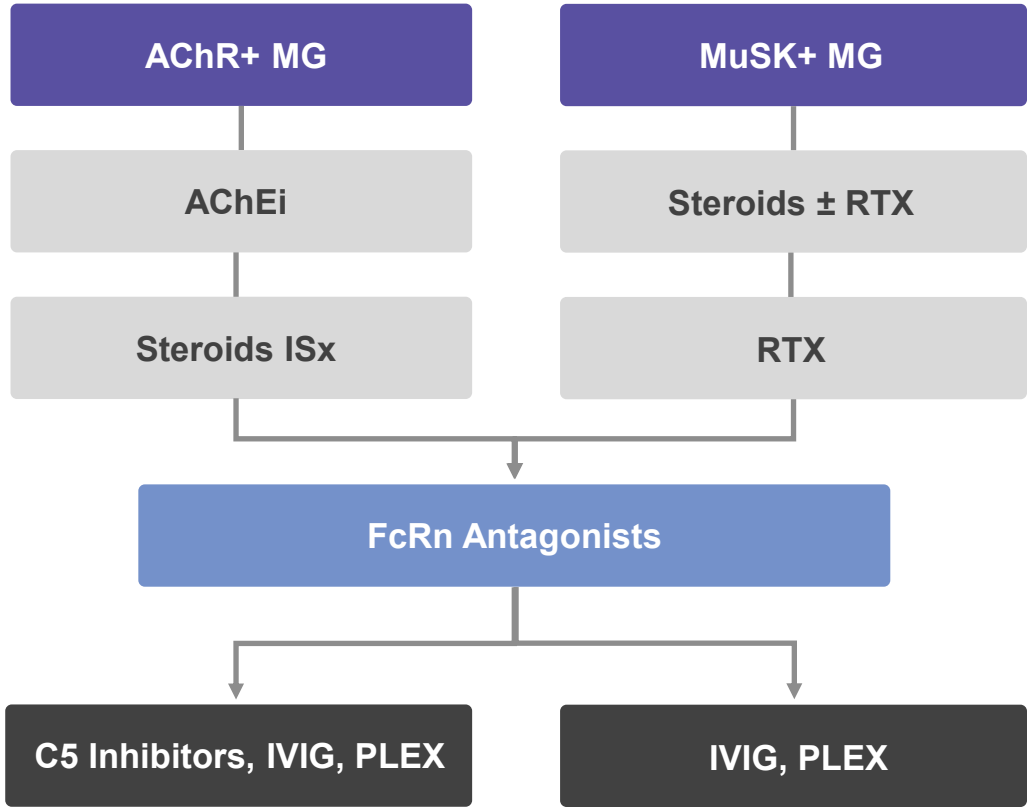
Even with the availability of biologics, unmet need for new therapies remain

Biologic use rising (~35% of gMG patients[1]) with choices driven by efficacy, convenience, phenotype, and coverage

FcRn inhibitors dominate but ~20-50% of patients experience insufficient treatment responses[2]

Complement inhibitors limited by safety, black box warning, and vaccination requirements[3]

B cell depleting and cell therapies face challenges with efficacy, safety, and logistical limits despite disease-modifying potential[4]



1. Wedbush Neurologist Surveys
2. doi: 10.1136/jnnp-2024-334404
3. ULTOMIRIS, SOLIRIS label
4. doi: 10.1007/s40259-020-00443-w

AChEI, acetylcholinesterase inhibitors; AChR, acetylcholine receptor; FcRn, neonatal Fc receptor; IVIG, intravenous immune globulin; MuSK, muscle-specific tyrosine kinase; PLEX, plasma exchange; RTX, rituximab; ISx, immunosuppressants.

The Need for Therapies to Go Beyond IgG in Myasthenia Gravis

New evidence shows IgA and IgM drive pathology, demanding broader therapeutic strategies

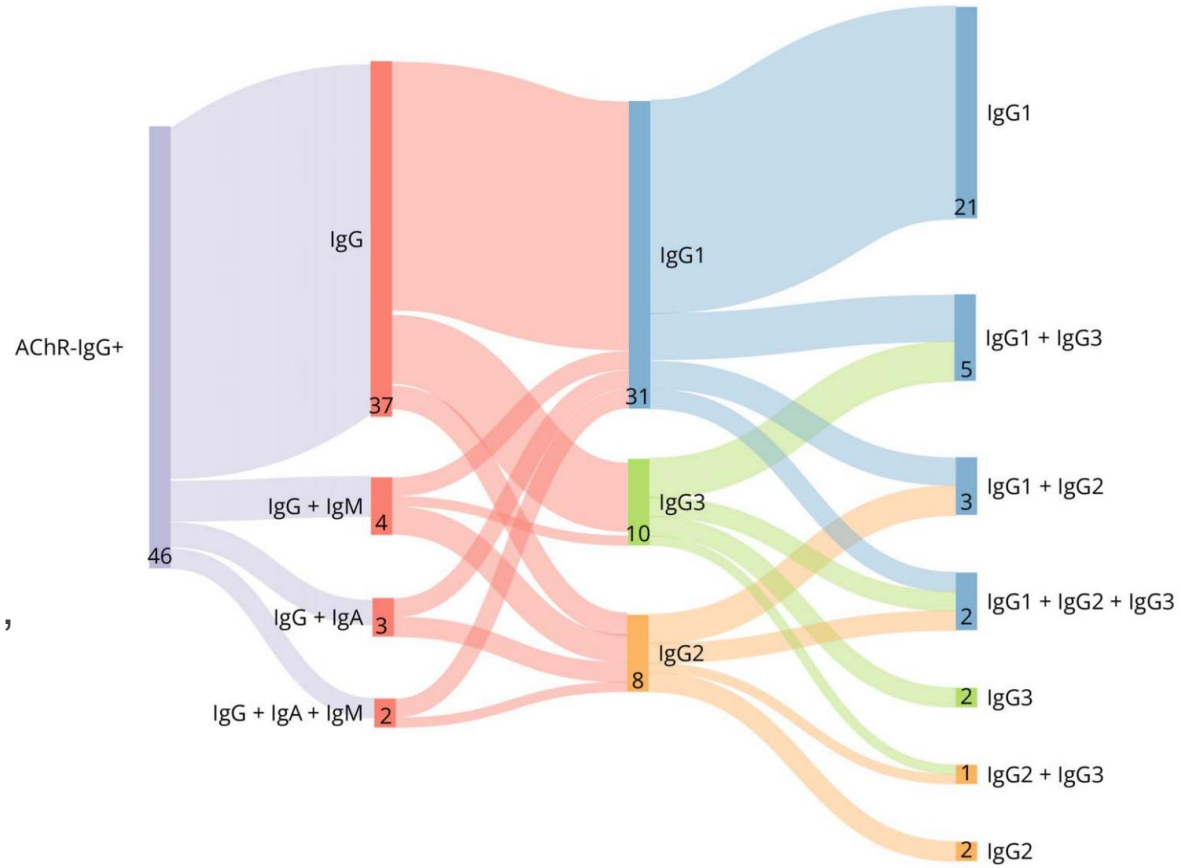
Patients carry different blends of IgG, IgA, and IgM, driving overlapping mechanisms

Greater than 1 in 5 patients have IgA and/or IgM as part of their autoantibody profile

MG patient autoantibody profiles shift over time, sometimes tied to relapse

Current MG therapies only hit IgG, missing IgA and IgM, which drive disease and are present in a meaningful subset of patients

Distribution of AChR Autoantibody Isotypes and IgG Subclasses in MG



MG, myasthenia; doi:10.1212/NXI.0000000000200436

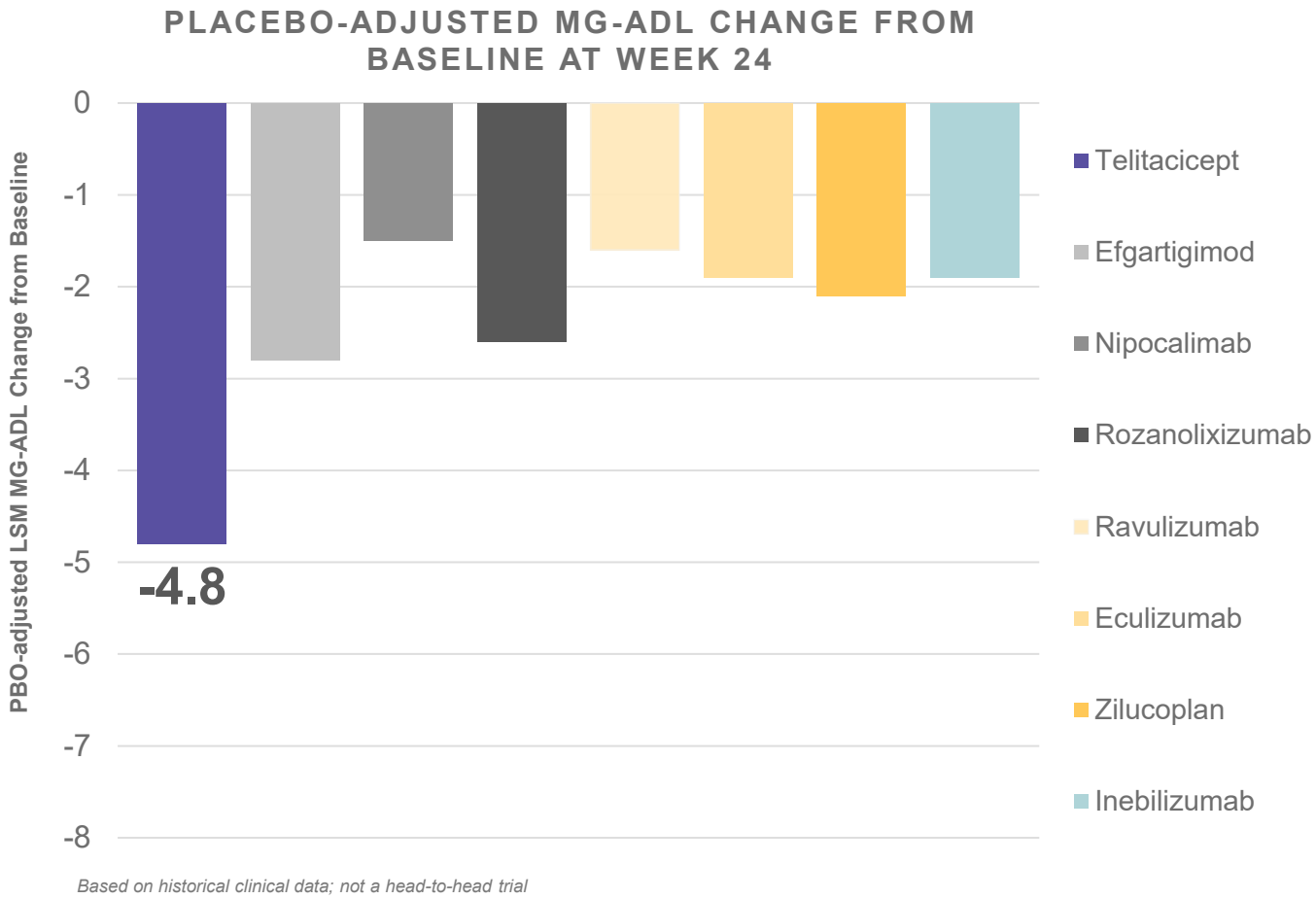
Myasthenia Gravis: The Beachhead Indication

Telitacicept demonstrated depth, durability, and a differentiated upstream mechanism

Across leading mechanisms, telitacicept demonstrates **largest placebo-adjusted MG-ADL improvement**

24- and 48-week data show continued improvement, suggesting patient benefit deepens over time

Upstream disease control with consistent safety and tolerability over one year of therapy



Based on historical clinical data; not a head-to-head trial

MG-ADL; Myasthenia Gravis Activities of Daily Living; gMG, generalized myasthenia gravis; Efgartigimod - ADAPT; Nipocalimab - Vivacity-MG3; Rozanolixizumab – MycarinG; Ravulizumab – CHAMPION-MG; Eculizumab – REGAIN; Zilucoplan – RAISE; Inebilizumab - MINT

RemeGen-sponsored trial

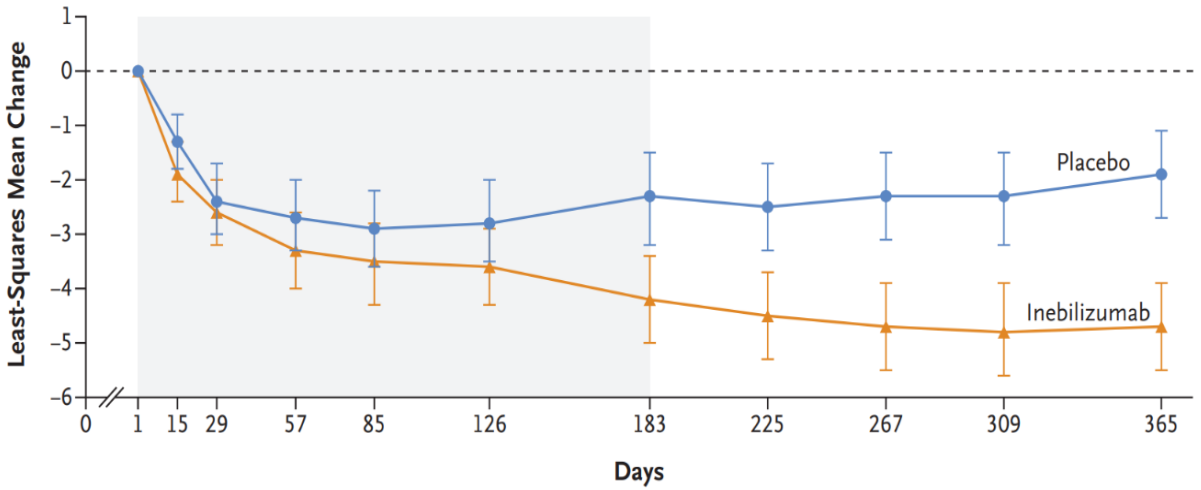
Durability in Myasthenia Gravis | Upstream vs Downstream Agents

How a therapy acts on antibody production and clearance yields different durability profiles

UPSTREAM

AMGEN PHASE 3 MINT TRIAL

UPLIZNA | Least Square Mean Change From Baseline in MG-ADL Score,
AChR-Ab+ Population



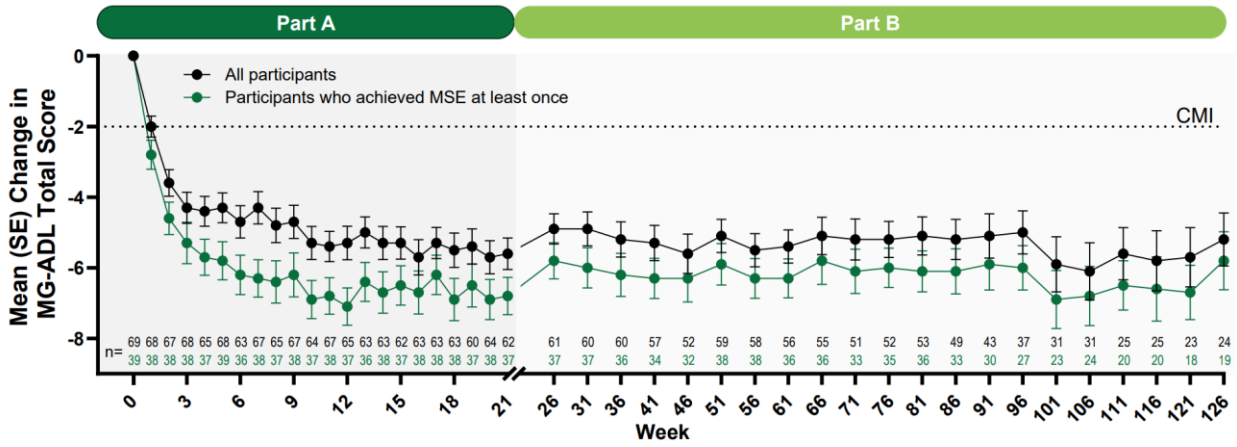
Breadth:
- ⊗ Indiscriminately, broadly depletes CD19+ B cell lineage
- ⊗ Slightly reduces IgG

Durability:
- ☑ MG-ADL response deepens over time
- ⊗ Depth of response accrues slowly

DOWNSTREAM

ARGENX PHASE 3B ADAPT NXT TRIAL

VYVGART | Mean (SE) Change From in MG-ADL Total Score
AChR-Ab+ Population



Breadth:
- ⊗ Pathogenic B cells left intact
- ⊗ Indiscriminately, broadly depletes circulating IgG only; no effect on IgM, IgA

Durability:
- ⊗ MG-ADL plateaus within the first 12 weeks; no further deepening with time
- ☑ Rapid onset by targeting IgG

DOI:10.1016/j.autrev.2026.104042; UPLIZNA – Phase 3 MINT – NEJM; VYVGART – Phase 3B ADAPT NXT - AAN 2025

Even At MG-ADL Parity, Telitacicept Still Competes

Physician research suggests a meaningful commercial floor for telitacicept at a parity MG-ADL, while UPLIZNA uptake validates B-cell demand in real time

9.4%

EXPECTED UPLIZNA GMG SHARE BY 1Q27

Up from 3.6% in April 2026[b]

Rapid uptake suggests demand for novel upstream B-cell mechanisms

69%

PREFERRED BAFF/APRIL MODULATION

For long-term suitability vs 2% for CD19 depletion[c]

21%

PHYSICIAN-ALLOCATED BIOLOGIC-TREATED PATIENT SHARE

Physician assessed simulation where telitacicept matches a ~2-point placebo-adjusted MG-ADL[a]

~37% share in 2L post-FcRn setting

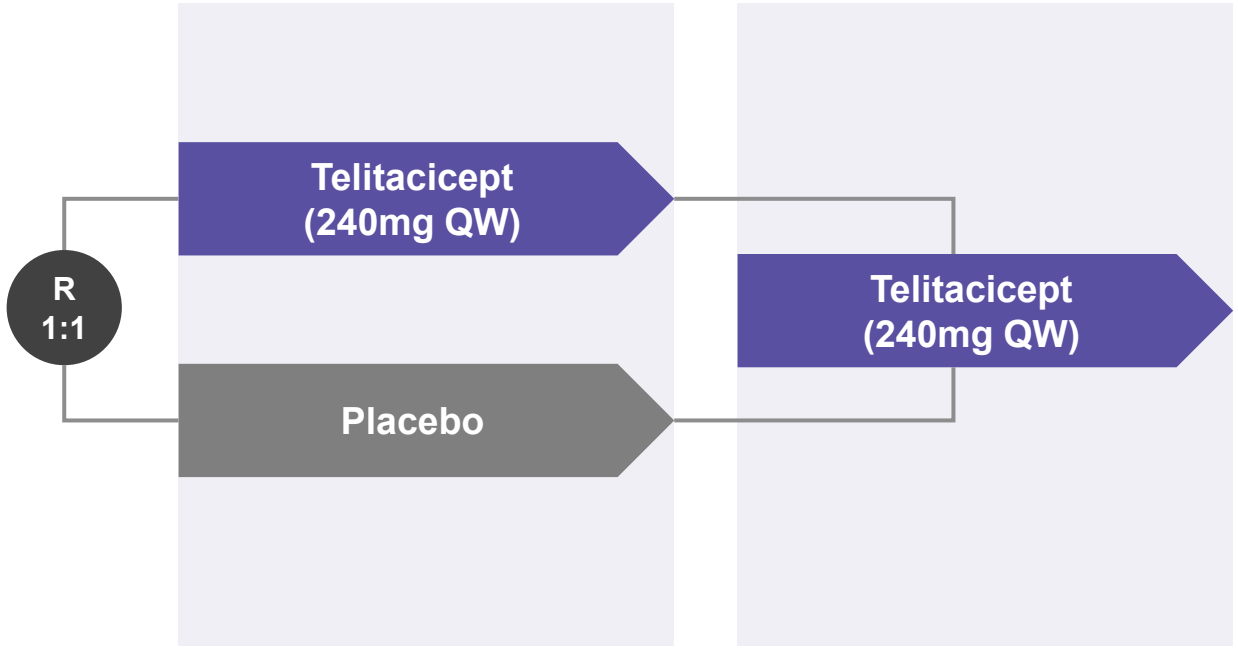
a. Guidepoint quick poll, n=30 US neurologists, 19-Mar-2026, FcRn 28%, complement 27%, and UPLIZNA 24%, Q4 asked under the parity profile (~2-pt pbo-adj MG-ADL, QW SQ, no vaccine requirement / no boxed warning); shares computed as each option's sum of allocated patients across all respondents; b. Citi Research, Global Biotechnology: US Neurologist Survey, July 21, 2026. Survey of N=103; c. MG Pulse Survey, September 2026, n=75.

Phase 3 Trial in Generalized Myasthenia Gravis Completed in China

Best-in-disease profile in China; randomized, double-blind, placebo-controlled study

114

Adults With gMG



Primary Endpoint

- Change from baseline in MG-ADL at 24 weeks

Secondary Endpoints

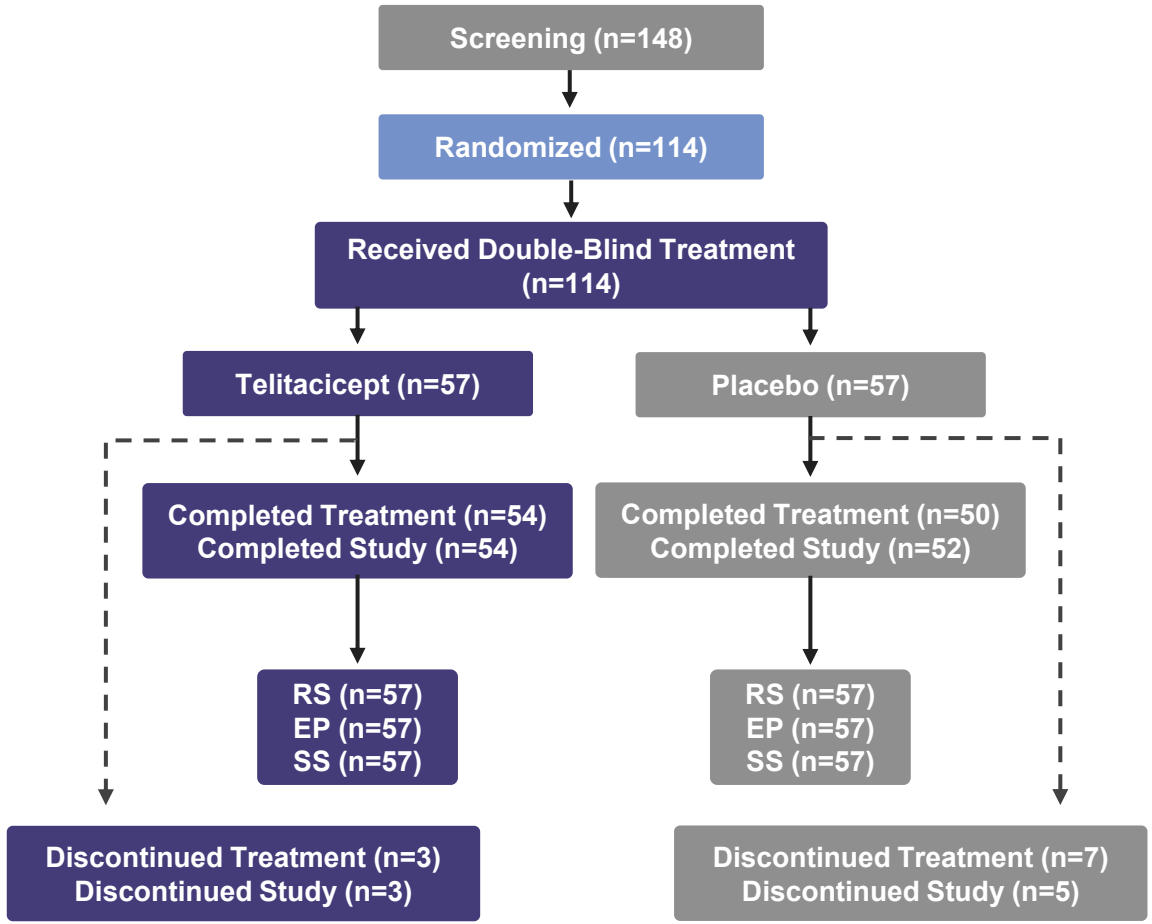
- Change from baseline in MG-ADL at 12, 36, and 48 weeks
- Change from baseline in QMG at 12, 24, 36, and 48 weeks
- Number of patients with ≥3 point decrease in MG-ADL, ≥5 point decrease in QMG at 24 and 48 weeks

MG-ADL; Myasthenia Gravis Activities of Daily Living; QMG, Quantitative Myasthenia Gravis; QW, per week.
ClinicalTrials.gov. NCT05737160. Updated May 5, 2025. Accessed August 19, 2025. https://clinicaltrials.gov/study/NCT05737160

RemeGen-sponsored trial

Well Balanced Baseline Characteristics

Consistent with recent global Phase 3 populations



	Telitacicept (N=57)	Placebo (N=57)
Age (yr), mean ± SD	49.1 ± 14.69	49.6 ± 15.03
Sex		
Male, n (%)	30 (52.6)	21 (36.8)
Female, n (%)	27 (47.4)	36 (63.2)
Disease duration (month), mean± SD	83.09 ± 84.507	76.05 ± 87.817
MGFA classification		
Class IIa, n (%)	3 (5.3)	12 (21.1)
Class IIb, n (%)	14 (24.6)	9 (15.8)
Class IIIa, n (%)	25 (43.9)	23 (40.4)
Class IIIb, n (%)	11 (19.3)	12 (21.1)
Class IVa, n (%)	4 (7.0)	1 (1.8)
Baseline MG-ADL score, mean ± SD	10.0 ± 2.60	9.9 ± 2.62
Baseline QMG score, mean ± SD	17.9 ± 3.43	18.8 ± 3.65
Antibody-positive at screening		
AChR, n (%)	55 (96.5)	55 (96.5)
MuSK, n (%)	2 (3.6)	2 (3.5)
Standard-of-care therapy		
Anticholinesterase inhibitors, n (%)	53 (93.0)	52 (91.2)
Steroids, n (%)	36 (63.2)	34 (59.6)
Immunosuppressants, n (%)	34 (59.6)	34 (59.6)

AE, adverse event; AChR, acetylcholine receptor; EP, efficacy population; MG-ADL, Myasthenia Gravis-Activities of Daily Living; MGFA, Myasthenia Gravis Foundation of America; MuSK, muscle-specific tyrosine kinase; QMG, Quantitative Myasthenia Gravis; SD, standard deviation; RS, randomized set; SS, safety set

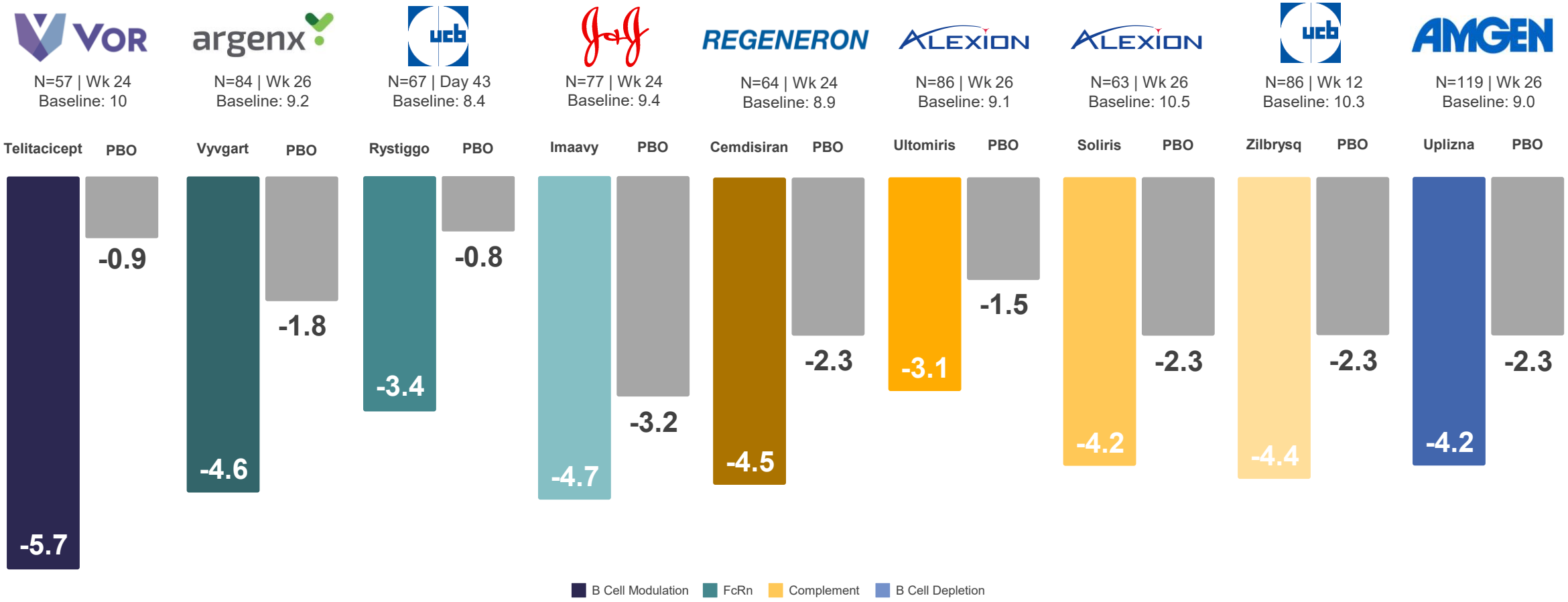
RemeGen-sponsored trial

Telitacicept Shows Potential Best-In-Disease Profile in gMG

Telitacicept delivered 4.8-point MG-ADL separation from placebo, the largest reported in gMG

Change in MG-ADL Score from Baseline

Based on historical clinical data; not a head-to-head trial



MG-ADL; Myasthenia Gravis Activities of Daily Living; gMG, generalized myasthenia gravis; Efgartigimod - ADAPT; Nipocalimab - Vivacity-MG3; Rozanolixizumab – MycarinG; Cemdisiran – NIMBLE; Ravulizumab – CHAMPION-MG; Eculizumab – REGAIN; Zilucoplan – RAISE; Inebilizumab - MINT

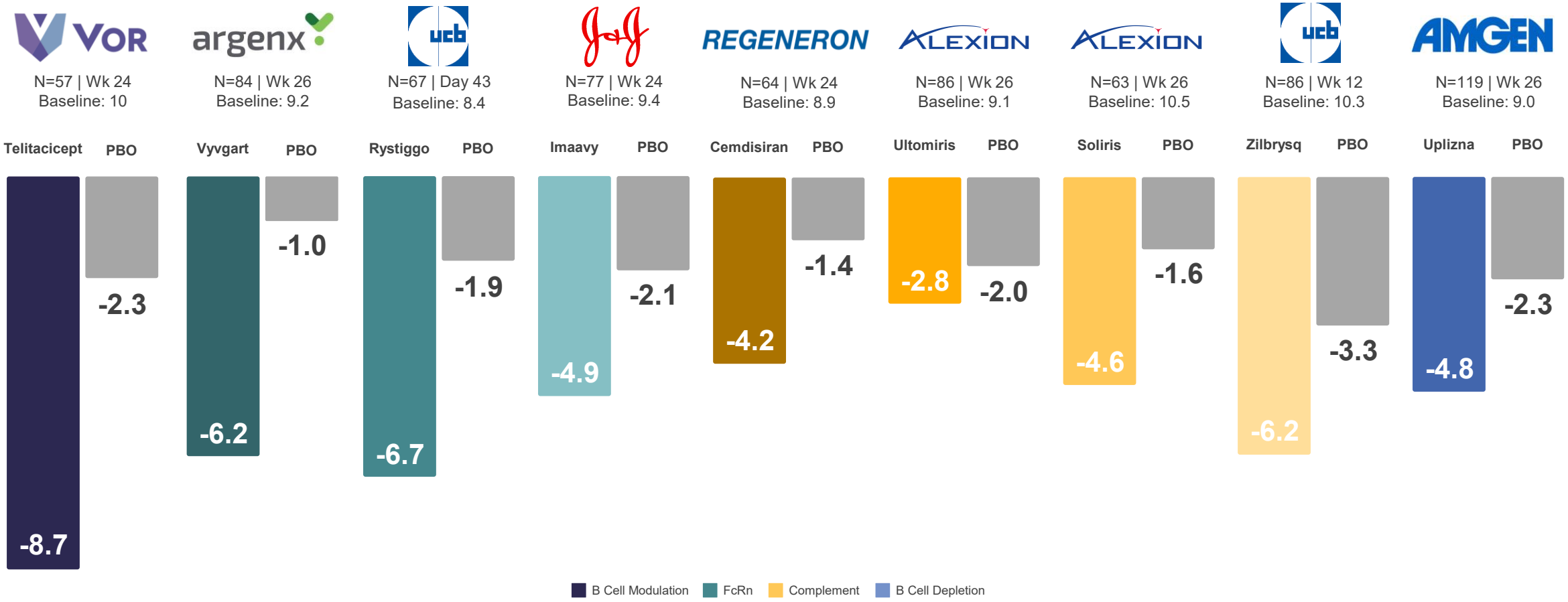
RemeGen-sponsored trial

Telitacicept Shows Potential Best-In-Disease Profile in gMG

Telitacicept delivered 6.4-point QMG separation from placebo, the largest reported in gMG

Change in QMG Score from Baseline

Based on historical clinical data; not a head-to-head trial

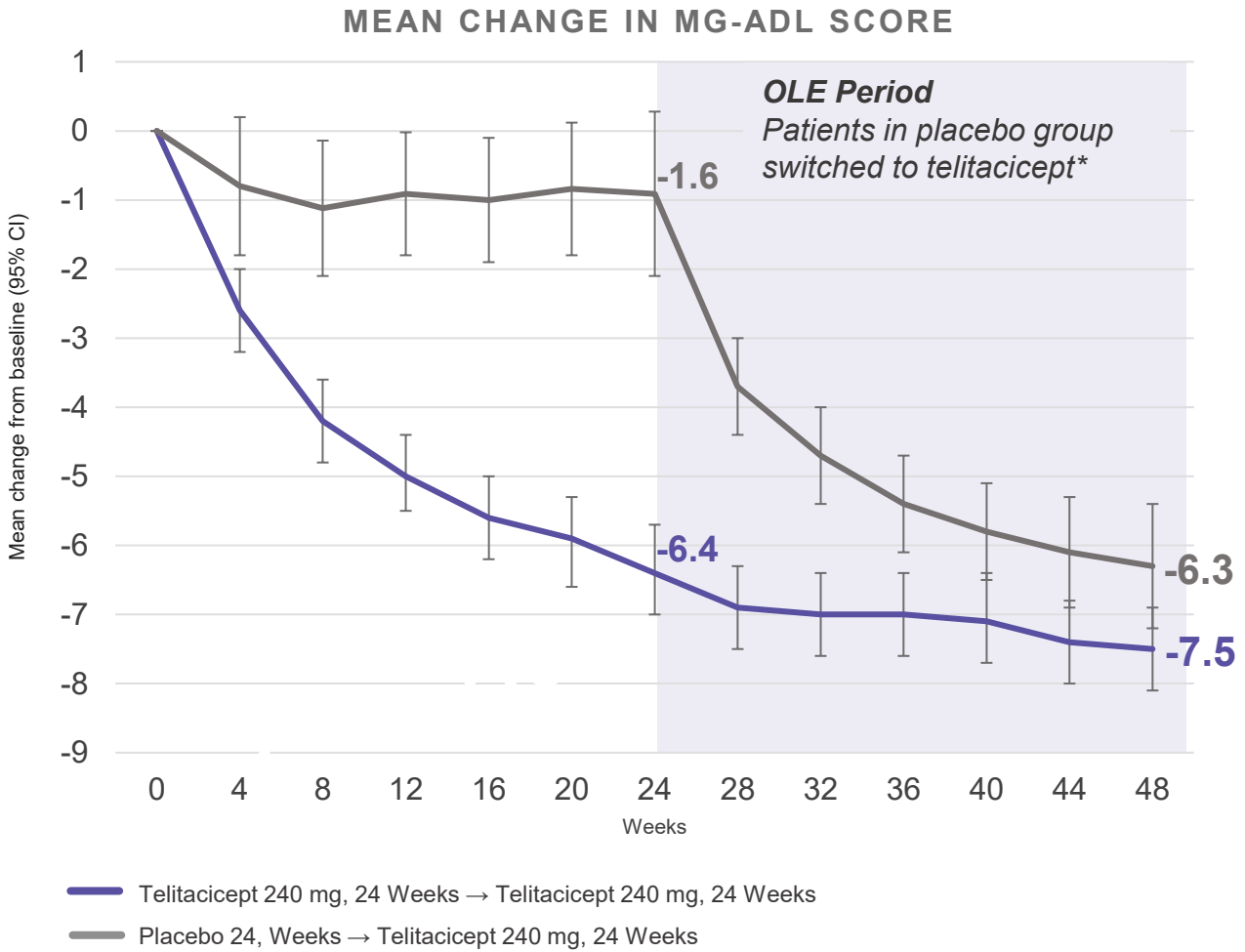


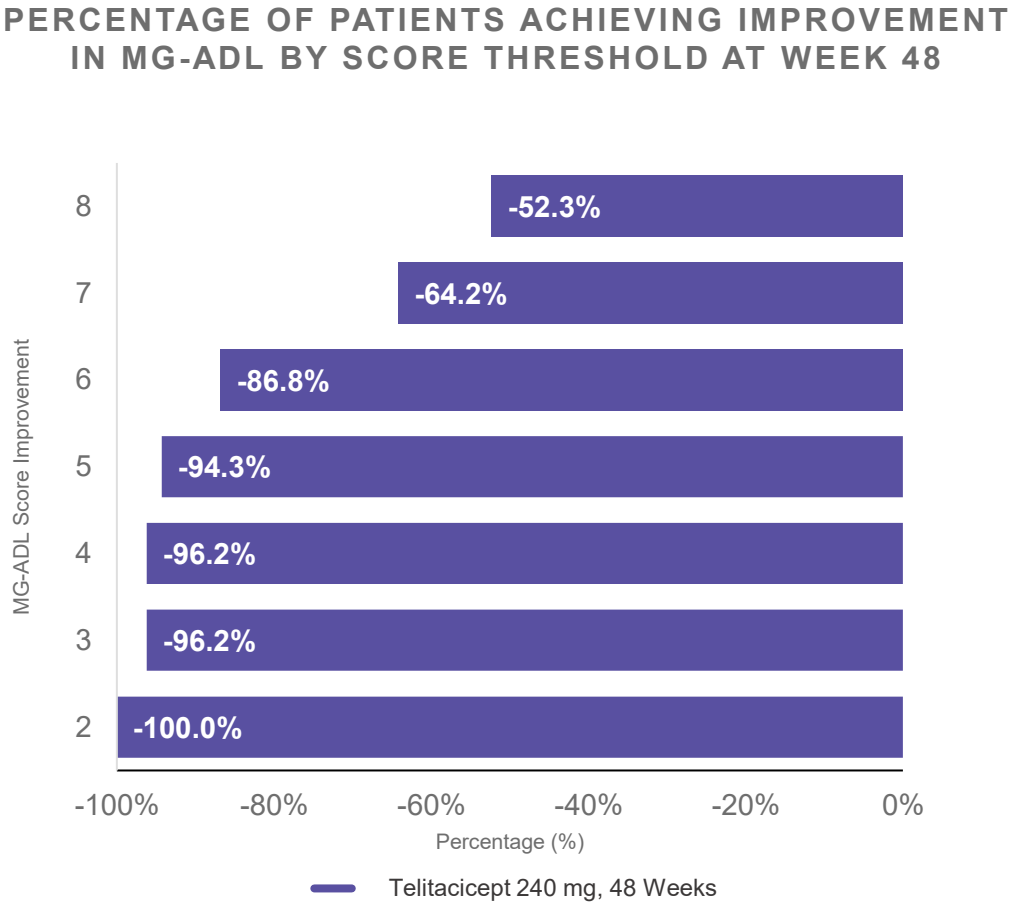
QMG, Quantitative Myasthenia Gravis; gMG, generalized myasthenia gravis; Efgartigimod - ADAPT; Nipocalimab - Vivacity-MG3; Rozanolixizumab – MycarinG; Cemdisiran – NIMBLE; Ravulizumab – CHAMPION-MG; Eculizumab – REGAIN; Zilucoplan – RAISE; Inebilizumab - MINT

RemeGen-sponsored trial

Telitacicept Demonstrated Durable MG-ADL Over Time

Sustained and deepening functional improvement through 48 weeks



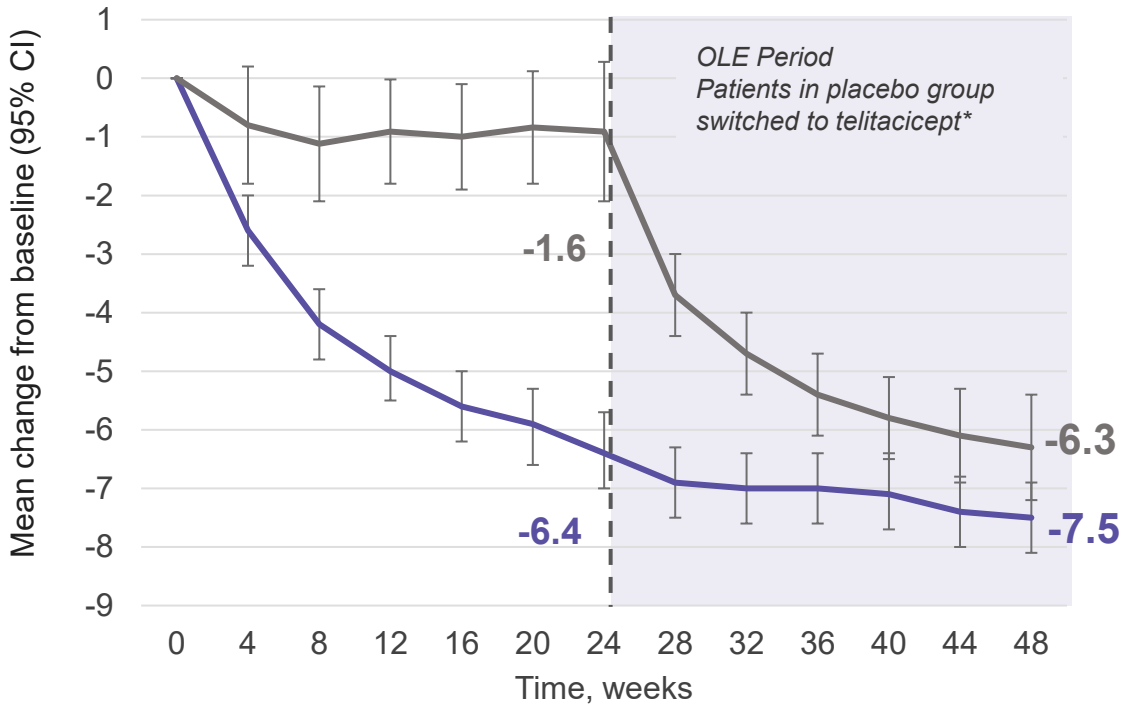


* Telitacicept arm continue with the same treatment, Placebo arm switched to Telitacicept during OLE period. The efficacy analysis was based on descriptive statistical analysis of the actual data in the full analysis set (FAS), and missing data were not filled.

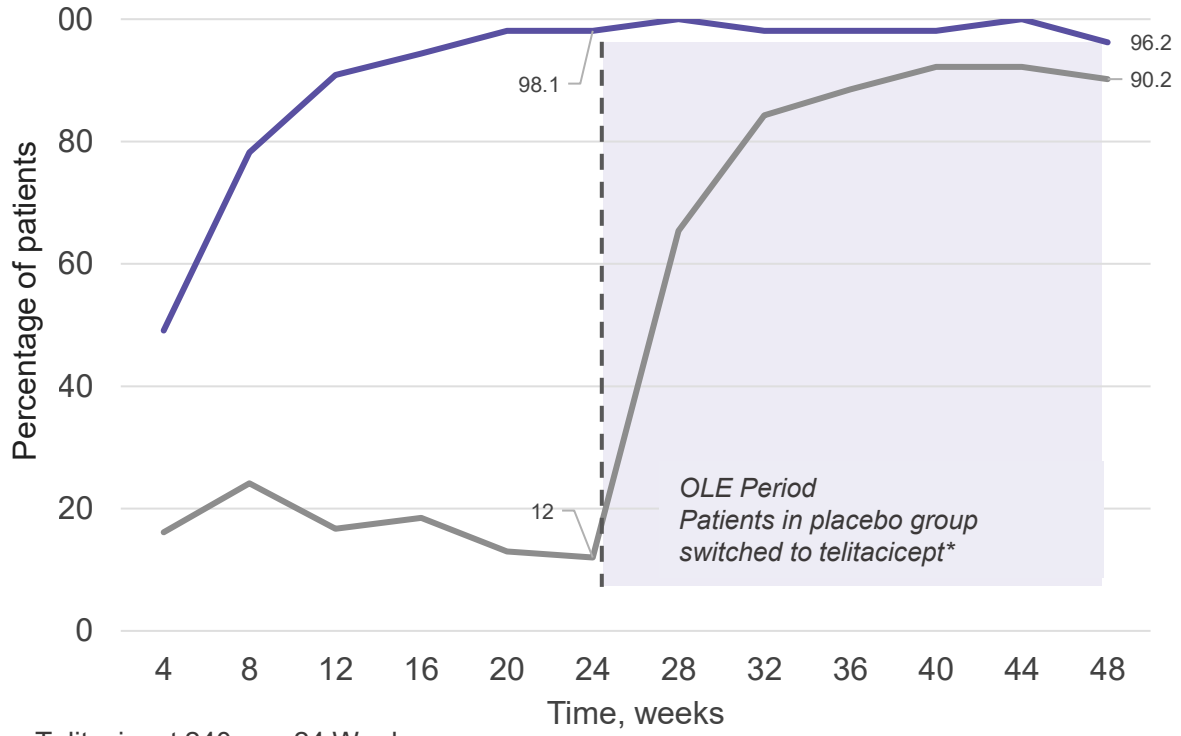
RemeGen-sponsored trial

OLE Data Highlight the Significant Change in MG-ADL Scores Seen With Telitacicept vs Placebo

Mean Change in MG-ADL Score



Percentage of Patients With ≥3-Point Reduction in MG-ADL Score from Baseline



Telitacicept 240 mg, 24 Weeks → Telitacicept 240 mg, 24 Weeks

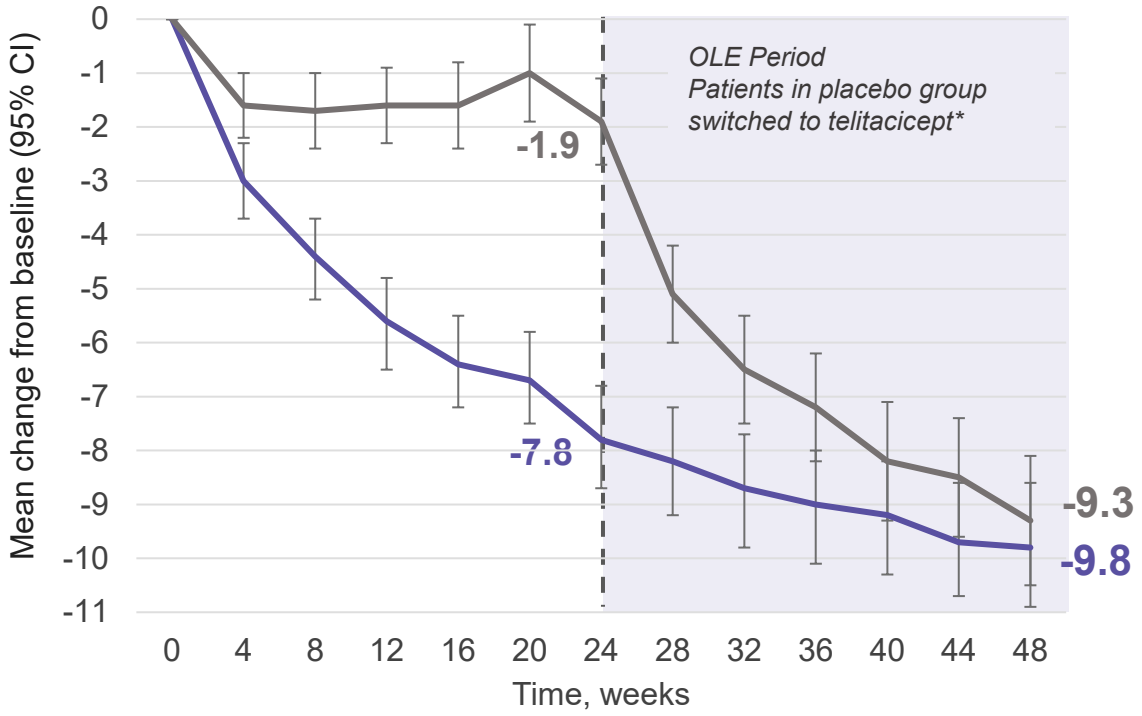
Placebo 24, Weeks → Telitacicept 240 mg, 24 Weeks

Non-adjusted data presented. The efficacy analysis was based on descriptive statistical analysis of the actual data in the full analysis set (FAS), and missing data were not filled.
*Patients in placebo group switched to telitacicept 240 mg. Patients in telitacicept arm continued with telitacicept 240 mg QW.
Li G, et al. Presented at: American Association of Neuromuscular & Electrodiagnostic Medicine Annual Meeting; October 29-November 1, 2025; San Francisco, CA.

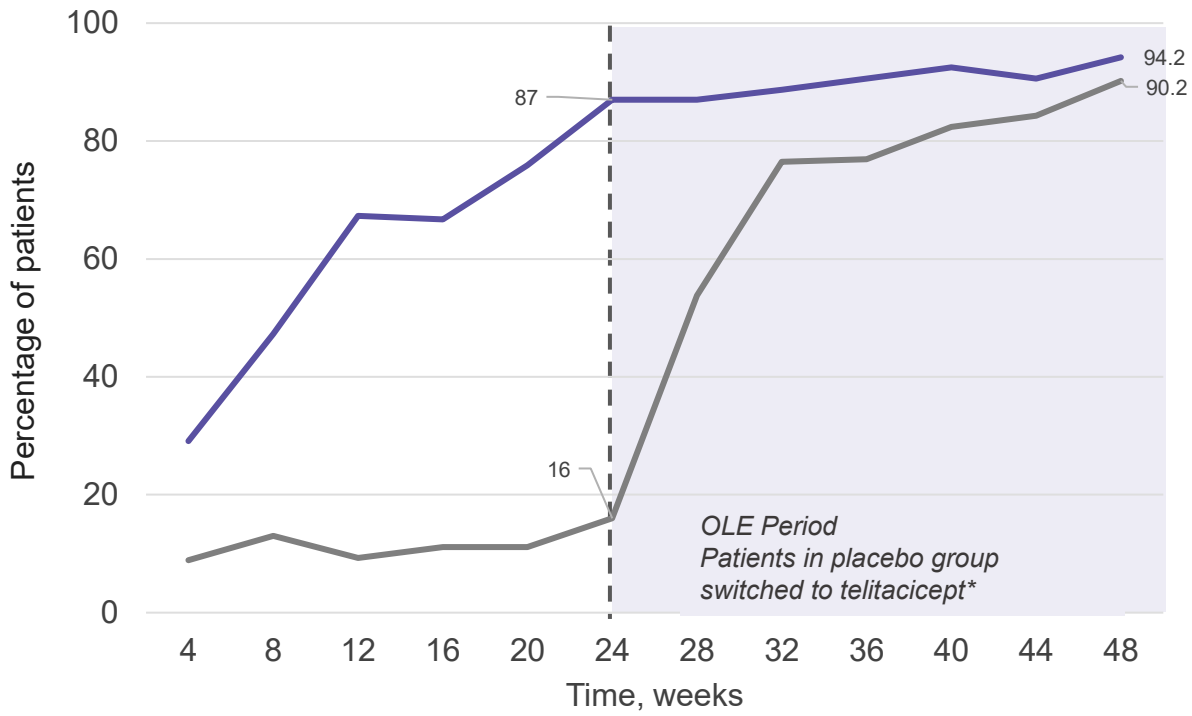
RemeGen-sponsored trial

OLE Data Highlight the Significant Change in QMG Scores Seen With Telitacicept vs Placebo

Mean Change in QMG Score



Percentage of Patients With ≥5-Point Reduction in QMG Score from Baseline



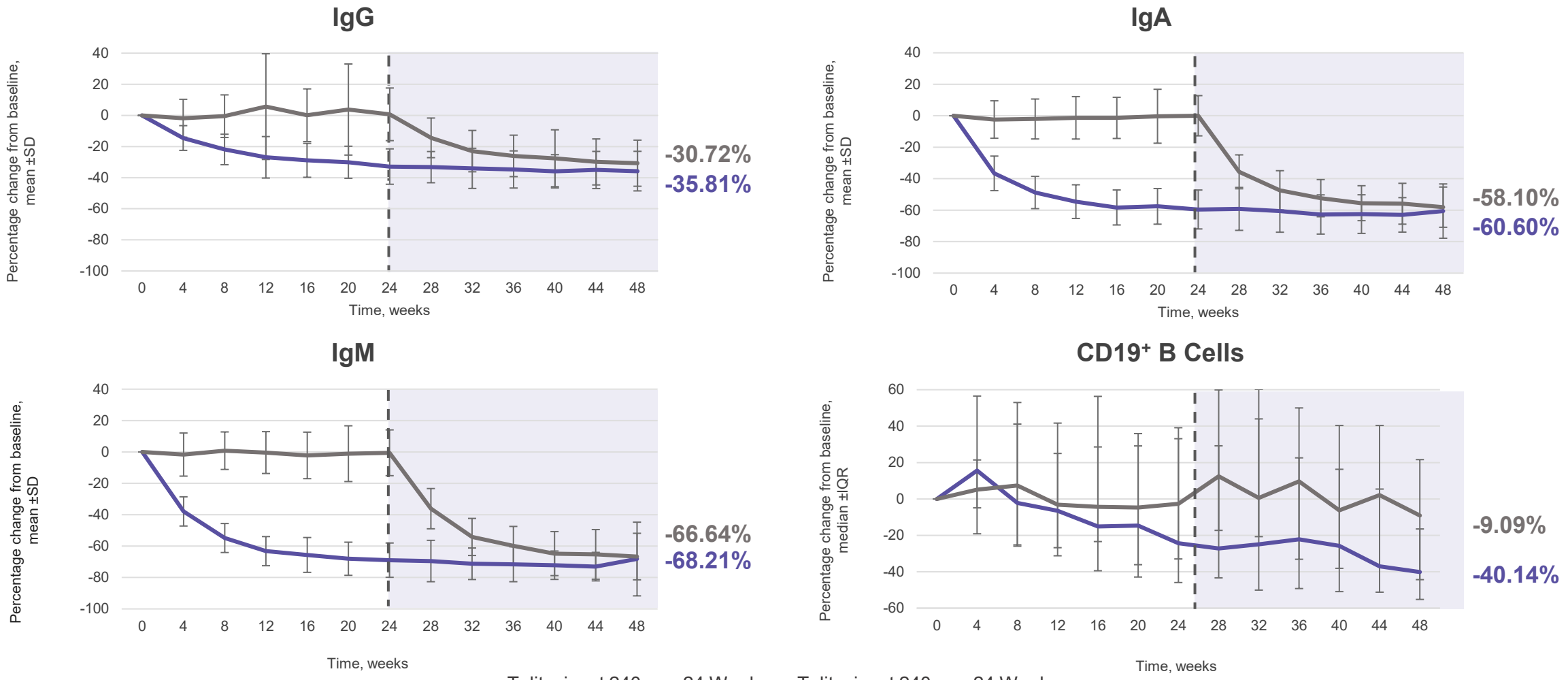
Telitacicept 240 mg, 24 Weeks → Telitacicept 240 mg, 24 Weeks

Placebo 24, Weeks → Telitacicept 240 mg, 24 Weeks

Non-adjusted data presented. The efficacy analysis was based on descriptive statistical analysis of the actual data in the full analysis set (FAS), and missing data were not filled.
*Patients in placebo group switched to telitacicept 240 mg. Patients in telitacicept arm continued with telitacicept 240 mg QW.
Li G, et al. Presented at: American Association of Neuromuscular & Electrodiagnostic Medicine Annual Meeting; October 29-November 1, 2025; San Francisco, CA.

RemeGen-sponsored trial

Consistent Reduction in IgG, IgA, IgM, and B Cells



*Patients in placebo group switched to telitacicept. Patients in telitacicept arm continued with telitacicept 240 mg QW.

Li G, et al. Presented at: American Association of Neuromuscular & Electrodiagnostic Medicine Annual Meeting; October 29-November 1, 2025; San Francisco, CA.

Favorable Safety Profile in gMG

Consistent with data from clinical trials in SLE, RA, SjD, and IgAN, and post-marketing data

	Randomized Control Period (Baseline to Week 24)[1]			
	Telitacicept (n=57)		Placebo (n=57)	
	n (%)	Events	n (%)	Events
Infections and infestations	26 (45.6)	46	34 (59.6)	50
Upper respiratory tract infection	12 (21.1)	17	20 (35.1)	24
Urinary tract infection	9 (15.8)	11	6 (10.5)	6
Pneumonia	1 (1.8)	1	6 (10.5)	6
Respiratory tract infection	1 (1.8)	1	2 (3.5)	2
Influenza	0 (0)	0	3 (5.3)	3

	OLE Period (Weeks 24-48)[2]			
	Telitacicept 240 mg (n=54)		Placebo → Telitacicept 240 mg (n=53)	
	n (%)†	Events‡	n (%)†	Events‡
Infections and infestations	27 (50.0)	33	21 (39.6)	29
Upper respiratory tract infection	14 (25.9)	15	11 (20.8)	12
Urinary tract infection	8 (14.8)	10	5 (9.4)	7
Pneumonia	1 (1.9)	1	0 (0)	0
Respiratory tract infection	1 (1.9)	1	0 (0)	0
Nasopharyngitis	1 (1.9)	1	1 (1.9)	1
Gastroenteritis	1 (1.9)	1	1 (1.9)	1
Herpes zoster	0 (0)	0	3 (5.7)	3
COVID-19	0 (0)	0	2 (3.8)	2
Pharyngitis	0 (0)	0	0 (0)	0
Vaginal infection	0 (0)	0	2 (3.8)	2
Oral herpes	1 (1.9)	1	0 (0)	0

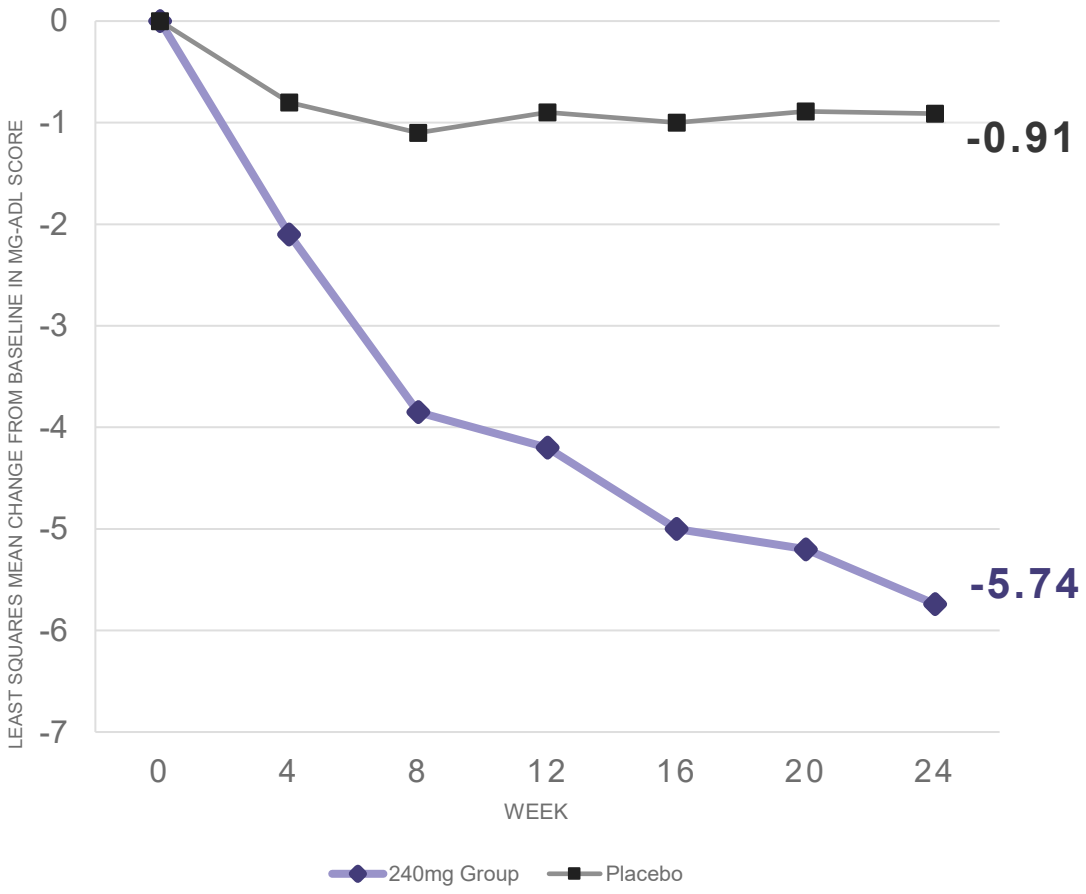
AE, adverse event; gMG, generalized myasthenia gravis; SjD, Sjogren's disease; SLE, systemic lupus erythematosus; RA, rheumatoid arthritis; IgAN, IgA nephropathy

RemeGen-sponsored trial

Telitacicept Delivers Lasting Disease Control vs. Cyclic Relapse from FcRn Inhibitors

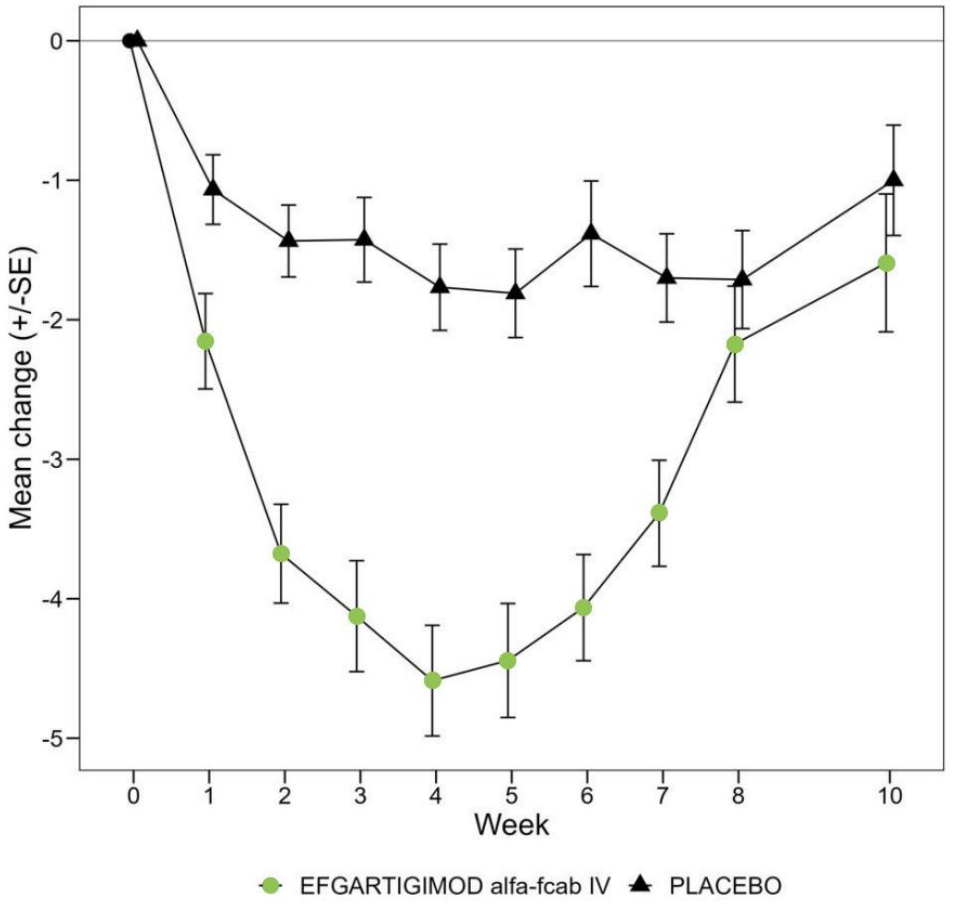
REMEGEN PHASE 3 CHINA TRIAL

Mean Change in MG-ADL Score†



ARGENX PHASE 3 ADAPT TRIAL

Mean Change in Total MG-ADL From Cycle 1 Baseline Over Time in AChR-Ab Positive Patients (mITT Analysis Set)



Based on historical clinical data; not a head-to-head trial

RemeGen-sponsored trial

†Missing data imputed as non-response.

MG-ADL, Myasthenia Gravis - Activities of Daily Living

BAFF/APRIL Inhibition Creates the Potential for a Better Clinical Profile

Telitacicept avoiding extreme IgG lowering and B cell depletion supporting depth, breadth and durability

	Telitacicept	VYVGART™ (efgartigimod alfa-fcab)	UPLIZNA® inebilizumab-cdon
MoA	**TACI-Fc**	**Anti-FcRn**	**Anti-CD19**
IgG Reduction	25-35%	60-65%	~9%[a]
AutoAb Reduction	~65%†	~57%‡	~10%*
Selectivity (AutoAb : IgG)	~2 : 1	~1 : 1	~1 : 1
CD19+ B cell reduction	20-40%	NA	100%
ΔMG-ADL vs. PBO	**-4.8**	**-2.8**	**-1.9**
ΔQMG vs. PBO	**-6.4**	**-5.2**	**-2.5**
Data readout	Week 24[1]	Week 4[2]	Week 24[3]

Based on historical clinical data; not a head-to-head trial

1. RemeGen China Phase 3 Trial; 2. Argenx Phase 3 ADAPT Trial; 3. Amgen Phase 3 MINT Trial; MoA, mechanism of action; AutoAb, autoantibody; MG-ADL, myasthenia gravis-activities of daily living; QMG, quantitative myasthenia gravis; PBO, placebo; [a]EMA Uplizna EPAR Assessment Report; †Based on the average from DOI: 10.1007/s11481-025-10272-9 (overall mean excludes subject 16) and DOI: 10.2147/ITT.S616114; ‡ DOI: 10.1080/08916934.2022.2104261; *Anti-AChR autoantibody reduction not directly quantified; inferred from EMA assessment noting IgG subclass changes consistent with total IgG and implying reduction of AChR-specific autoantibodies.

gMG Has 7 Approved Therapies. *Predictability Is Still An Issue.

China Phase 3 data suggest telitacicept may offer broad, deep, and durable responses that could support more consistent disease control

BREADTH

~94%

Achieved ≥5-point MG-ADL improvement at Week 48

DEPTH

1 in 2

Patients with baseline of MG-ADL 6-10 who achieved MSE

1 in 5

Patients with baseline of MG-ADL ≥11 who achieved MSE

DURABILITY

~83%

Remaining observed follow-up time spent in MSE after initial achievement

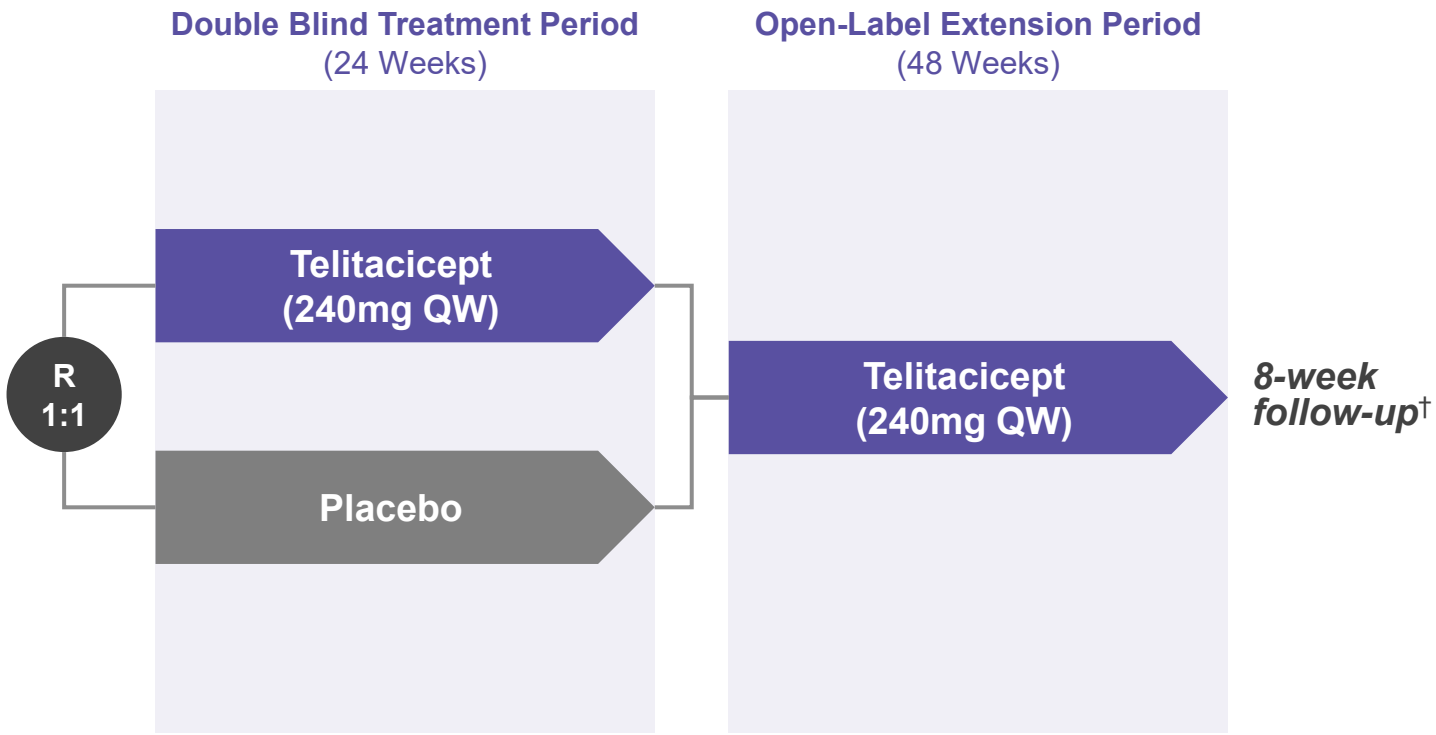
RemeGen-sponsored trial

*Predictability of FcRn and complement inhibitors based on publications including: DOI:10.1212/NXI.0000000000200436; DOI:10.1111/nyas.13522; DOI:10.1016/bs.irn.2025.04.031; DOI:10.1212/WNL.0000000000205274; DOI:10.1016/S1474-4422(21)00159-9; Zhao M, et al. MGFA Scientific Session at AANEM Annual Meeting 2026

UPSTREAM MG: Global Phase 3 in Generalized Myasthenia Gravis

Potential best- and first-in-class BAFF/APRIL inhibitor; randomized, double-blind, placebo-controlled study

~180*
Adults With gMG



Primary Endpoint

- Change from baseline in MG-related ADL at week 24

Secondary Endpoints

- Change from baseline in QMG and MG-QOL15r at week 24
- Number of patients with a ≥2 point decrease in MG-ADL at week 24
- Number of patients with ≥3 point decrease in QMG at week 24

Enrollment Complete; Topline Global Phase 3 Data Anticipated in 1H27

MG-ADL, Myasthenia Gravis-Activities of Daily Living; QMG, Quantitative Myasthenia Gravis; QW, per week. *Estimated. †For patients who discontinue treatment before the open-label extension (OLE) period, end of treatment (EOT) and end of study (EOS) time points are at 24 and 32 weeks respectively. For those continuing with the OLE, EOT and EOS time points are at 72 and 80 weeks respectively. ClinicalTrials.gov. NCT05737160. Updated May 5, 2025. Accessed August 19, 2025. https://clinicaltrials.gov/study/NCT05737160

Sjögren's Disease

Moving Beyond Symptom Management

Sjögren's: A Large, Vastly Underserved Autoimmune Disease

Targeting ~100,000[1] addressable patient US opportunity with a potential best-in-disease profile

ESSDAI 0

1 **Symptom-Directed**

Local/topical therapies for dryness

ESSDAI 0-4

2 **Mild-to-Moderate (No Major Organ Involvement)**

DMARDs (hydroxychloroquine, methotrexate)

ESSDAI 5-13

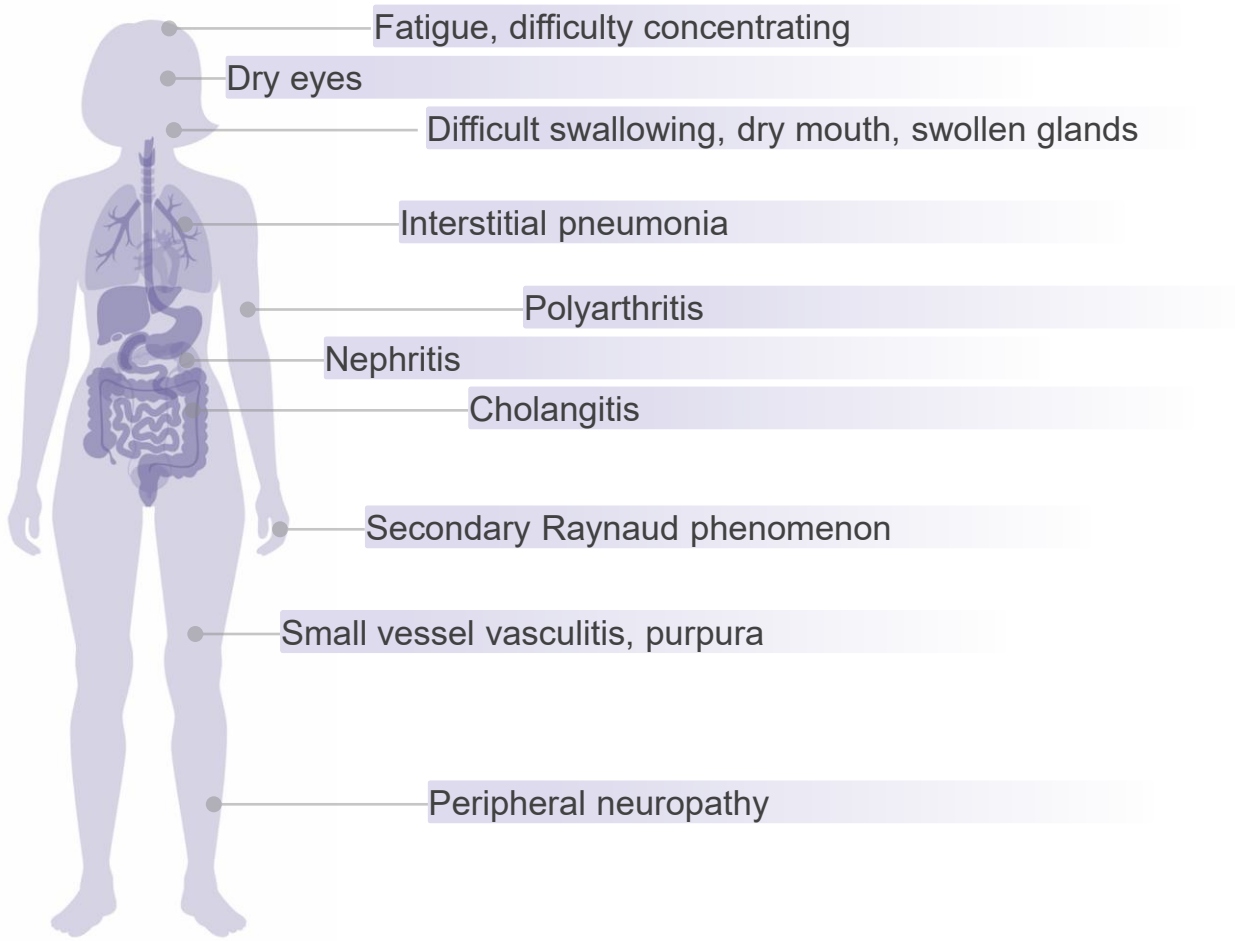
3 **Moderate-to-Severe (Non–Life Threatening)**

Immunosuppressants (Methotrexate, azathioprine, or cyclosporine)

ESSDAI ≥14

4 **Severe Disease (Major Organ Involvement)**

High potency immunosuppressants, biologics



1. Vor metanalysis and estimates

DMARDs, disease-modifying anti-rheumatic drugs; ESSDAI, EULAR Sjögren's syndrome disease activity index

Sjögren's: One of the Most Common Systemic Autoimmune Diseases Globally

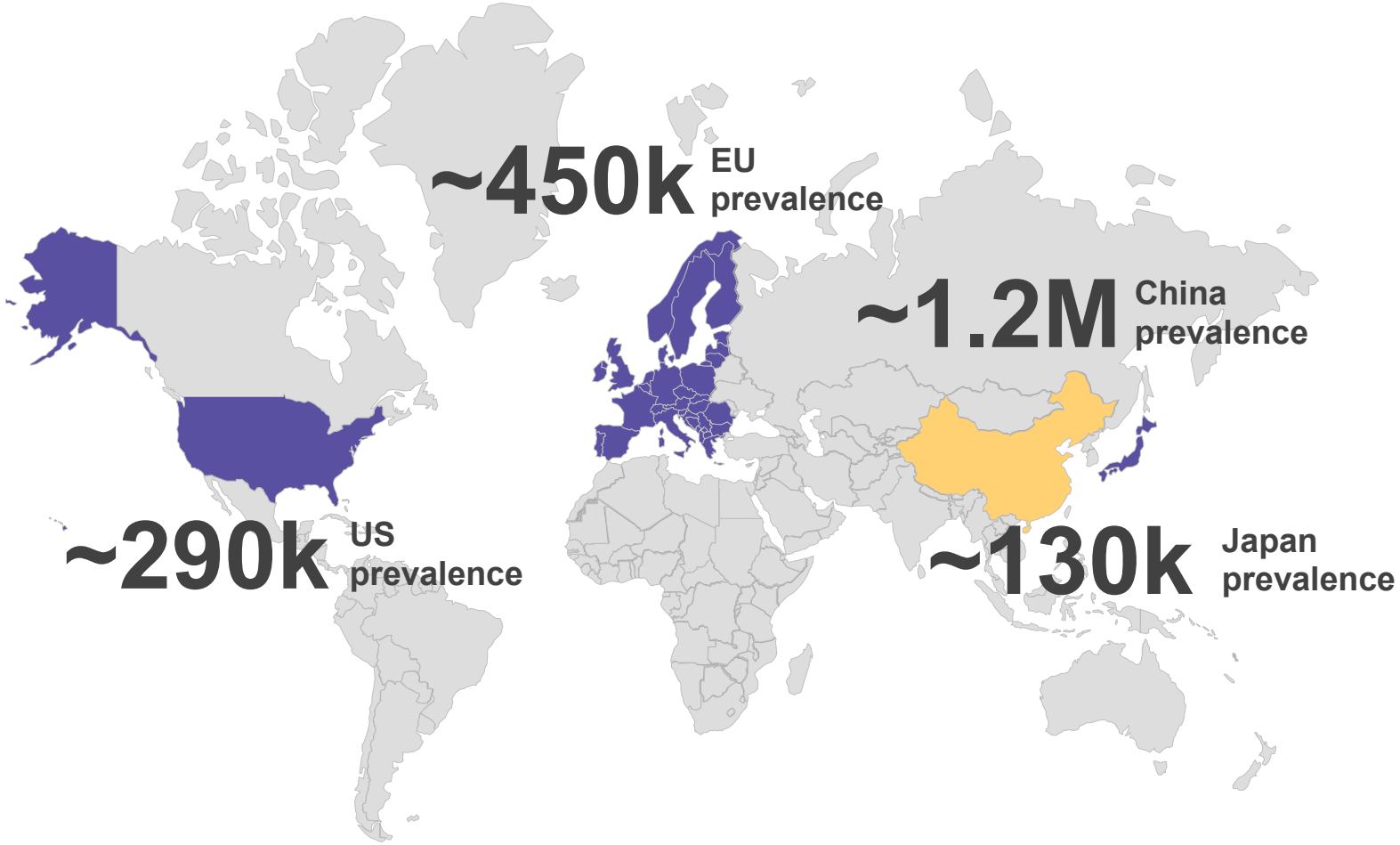
~870,000 diagnosed Sjögren's patients across key markets[1]

Favorable Growth Drivers

- Rising diagnosis rates from better awareness and testing

Underpenetrated Market

- No approved disease-modifying systemic therapies
- Patients managed with symptomatic treatments



1. Vor metanalysis and estimates; excludes Chinese market

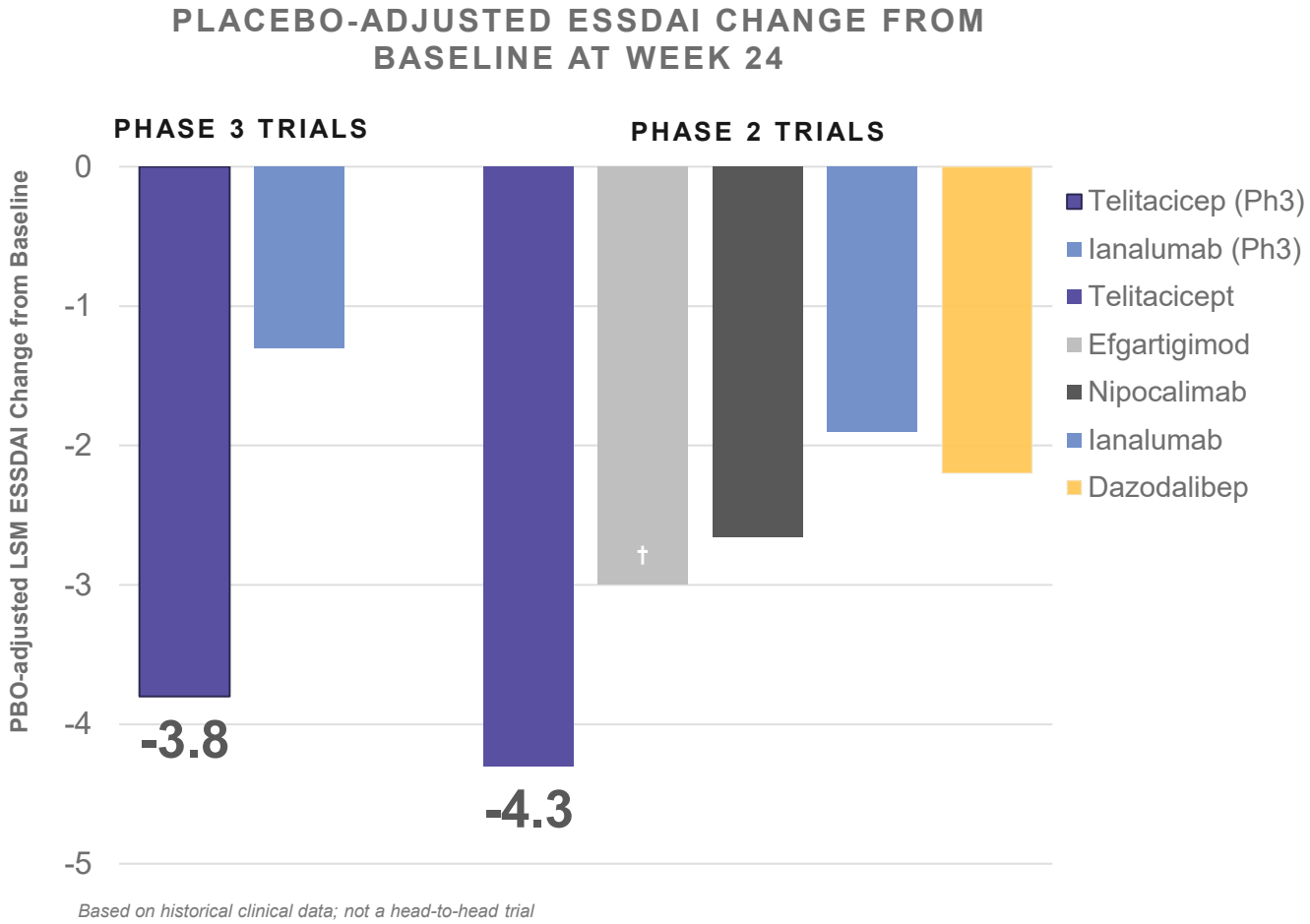
Sjögren's Disease: The White Space Expansion Opportunity

Telitacicept demonstrated depth, durability, and a differentiated upstream mechanism

Across leading mechanisms, telitacicept demonstrates **largest placebo-adjusted ESSDAI improvement**

Response deepens through week 48, with 73% of patients achieving ≥3-point ESSDAI reduction vs 16.5% for placebo

Upstream disease control with consistent safety and tolerability over one year of therapy



Based on historical clinical data; not a head-to-head trial

Efgartigimod - RHO; Nipocalimab - Bowman 2022, Lancet; Ianalumab - St. Clair 2024, Nature and Grader-Beck 2025 ACR; Dazodalibep - Xu 2024 Rheumatology; Ianalumab Phase 3 – ACR 2025; ESSDAI, EULAR Sjögren's syndrome disease activity index; †Median clinESSDAI reported

RemeGen-sponsored trial

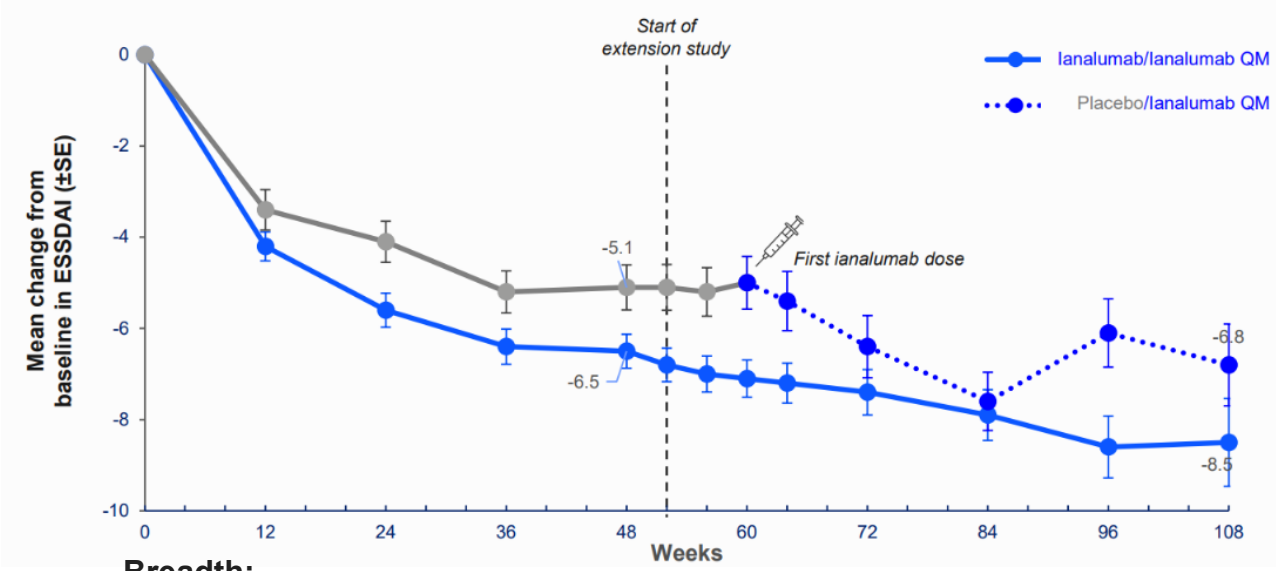
Durability in Sjögren's Disease | Upstream vs Downstream Agents

How a therapy acts on antibody production and clearance yields different durability profiles

UPSTREAM

NOVARTIS PHASE 3 NEPTUNUS TRIAL

Ianalumab | Mean Change from Baseline ESSDAI (±SE)



Breadth:

- ⊗ Indiscriminately, broadly depletes BAFF-R+ B cell lineage
- ⊗ Modestly reduces IgG; no reported effect on IgA or IgM

Durability:

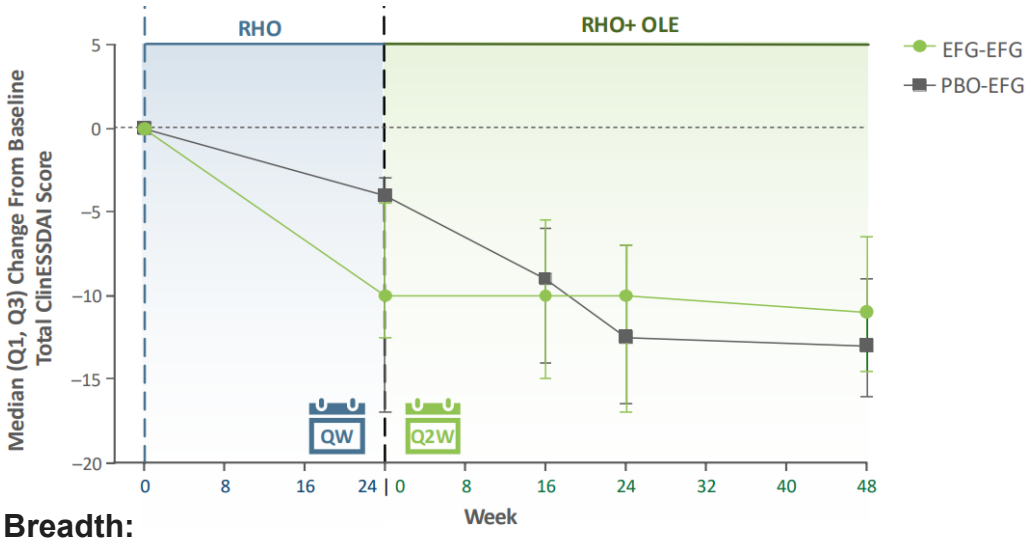
- ☑ ESSDAI response deepens over time
- ⊗ Depth of response accrues slowly

DOWNSTREAM

ARGENX PHASE 2 RHO+ OPEN-LABEL EXTENSION TRIAL

VYVGART | Median (Q1,Q3) Change* From Baseline Total ClinESSDAI Score

*Calculated relative to RHO study baseline (post hoc analyses); participants that rolled over into the OLE study



Breadth:

- ⊗ Pathogenic B cells left intact
- ⊗ Indiscriminately, broadly depletes circulating IgG only; no effect on IgM, IgA

Durability:

- ⊗ Plateaued clinESSDAI
- ☑ Benefit maintained after responders moved to Q2W dosing

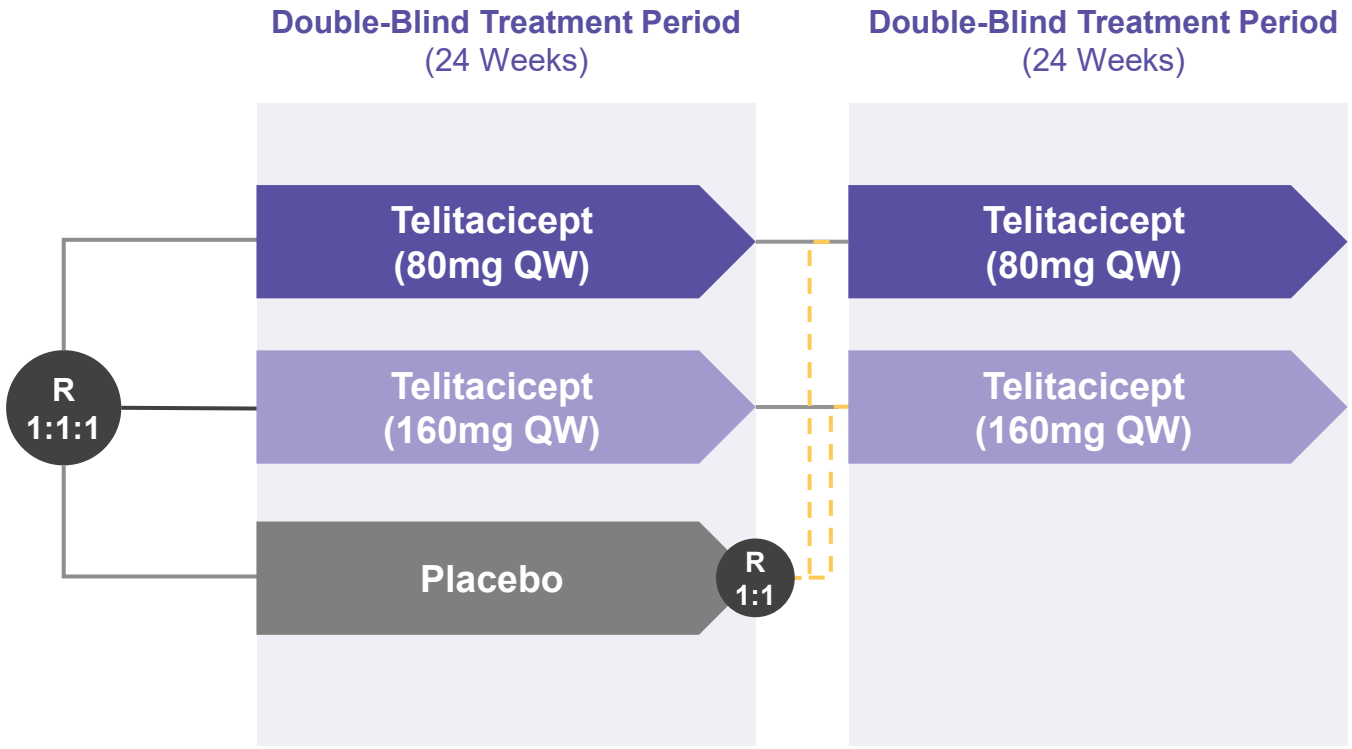
DOI:10.1016/j.autrev.2026.104042; Ianalumab - NEPTUNUS Phase 3 – EULAR 2026; Vyvgart – RHO+ OLE Study – EULAR 2026

Phase 3 Trial in Primary Sjögren's Disease Completed in China

Best-in-disease profile in China; randomized, double-blind, placebo-controlled study

380*

Adults With pSjD



Primary Endpoint

- Change from baseline in ESSDAI at 24 weeks

Secondary Endpoints

- Change from baseline in ESSDAI at 12 weeks
- Changes from baseline in ESSPRI, PGA, PaGA, SF-36 and MFI-20 at 12 and 24 weeks

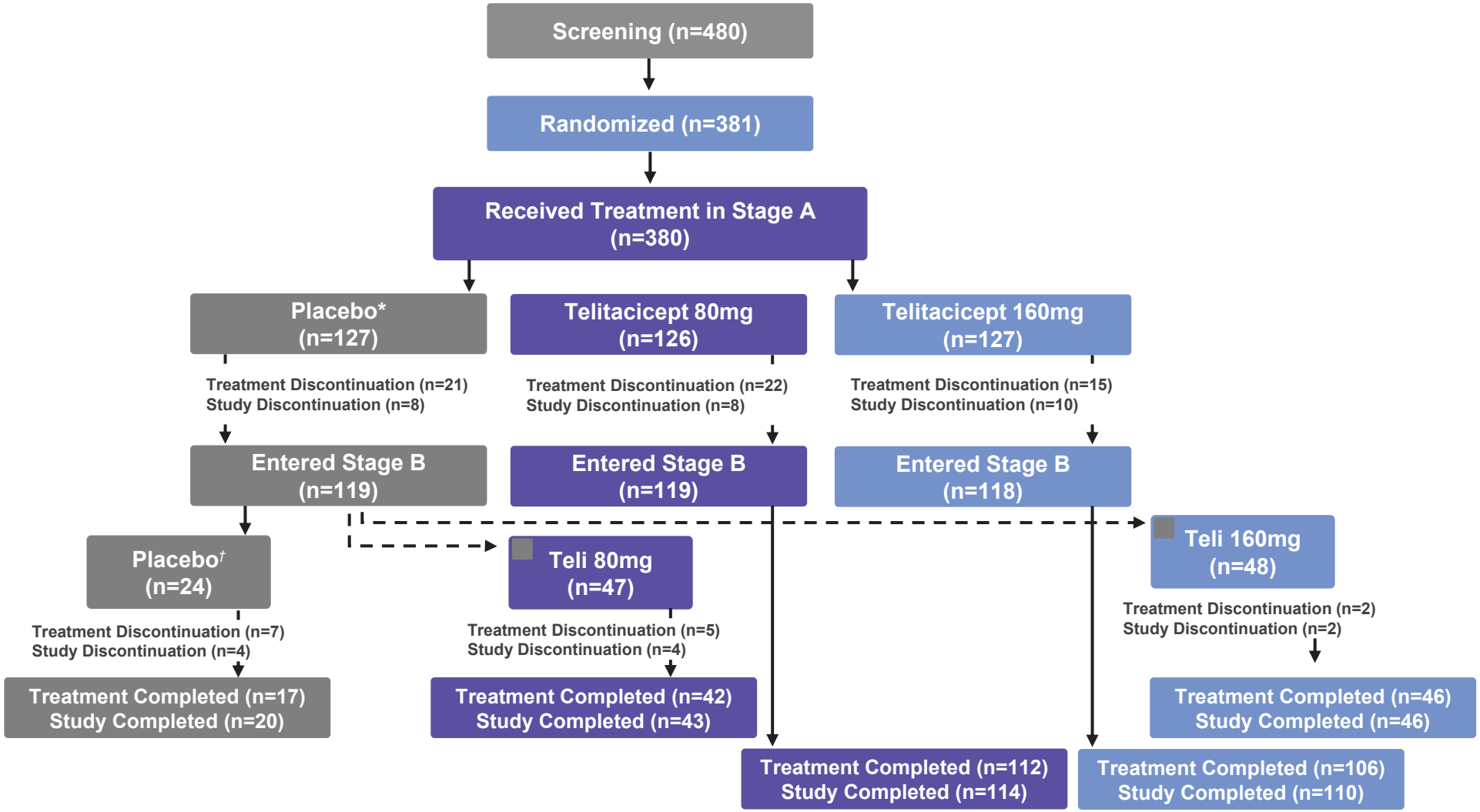
Primary Endpoint Achieved in August 2025

*Estimated. ESSDAI, EULAR Sjögren's syndrome disease activity index; ESSPRI, EULAR Sjögren's Syndrome Patient Reported Index; MFI-20, multidimensional fatigue inventory; PGA, physician's global assessment; PaGA, patient's global assessment; SF-36, 36-item short-form; pSjD, primary Sjögren's disease; QW, per week.

RemeGen-sponsored trial

Patient Disposition

Strong study execution across 79 sites in China



*Participants randomized to the placebo group; †Participants who did not switch treatment throughout the trial; Teli, telitacicept

RemeGen-sponsored trial

Baseline Characteristics

Well-balanced, representative patient population across treatment arms

	Telitacicept 160mg (n=127)	Telitacicept 80mg (n=127)	Placebo (n=127)	Total (n=381)
Age (yr), Mean (SD)	45.9 (12.29)	44.6 (12.06)	47.3 (12.75)	46.0 (12.39)
Body Weight (kg), Mean (SD)	55.89 (9.04)	56.88 (8.71)	56.99 (11.08)	56.58 (9.65)
BMI (kg/m^2), Mean (SD)	22.03 (3.16)	22.31 (3.19)	22.24 (3.58)	22.19 (3.31)
Sex, n (%), Female	124 (97.6)	124 (97.6)	123 (96.9)	371 (97.4)
pSD Duration (mon), Mean (SD)	21.388 (36.32)	25.831 (46.90)	19.930 (39.57)	22.383 (41.14)
ESSDAI Score, Mean (SD)	10.0 (3.77)	9.8 (3.52)	10.2 (4.17)	10.0 (3.82)
ESSDAI ≥10 points, n (%)	63 (49.6)	61 (48.0)	63 (49.6)	187 (49.1)
ESSPRI Score, Mean (SD)	5.07 (1.60)	4.91 (1.72)	5.08 (1.76)	5.02 (1.69)
MFI-20 Total Score, Mean (SD)	56.8 (12.08)	56.8 (12.50)	58.1 (13.07)	57.2 (12.54)
Baseline Hydroxychloroquine Use, n (%)	87 (68.5)	97 (76.4)	99 (78.0)	283 (74.3)
IgG (g/L), Mean (SD)	21.459 (7.43)	22.429 (7.95)	22.297 (7.21)	22.062 (7.53)
IgA (g/L), Mean (SD)	3.435 (1.63)	3.637 (1.86)	3.154 (1.68)	3.409 (1.73)
IgM (g/L), Mean (SD)	1.458 (0.64)	1.372 (0.92)	1.274 (0.70)	1.368 (0.77)
CD19$^+$ B Cell (cells/μL), Mean (SD)	209.412 (129.10)	183.993 (109.52)	266.902 (726.52)	220.102 (430.96)

SD: standard deviation; BMI: body mass index; Mon, months; ESSDAI, EULAR Sjögren's syndrome disease activity index; ESSPRI, EULAR Sjögren's Syndrome Patient Reported Index; MFI-20, multidimensional fatigue inventory; RemeGen-sponsored trial

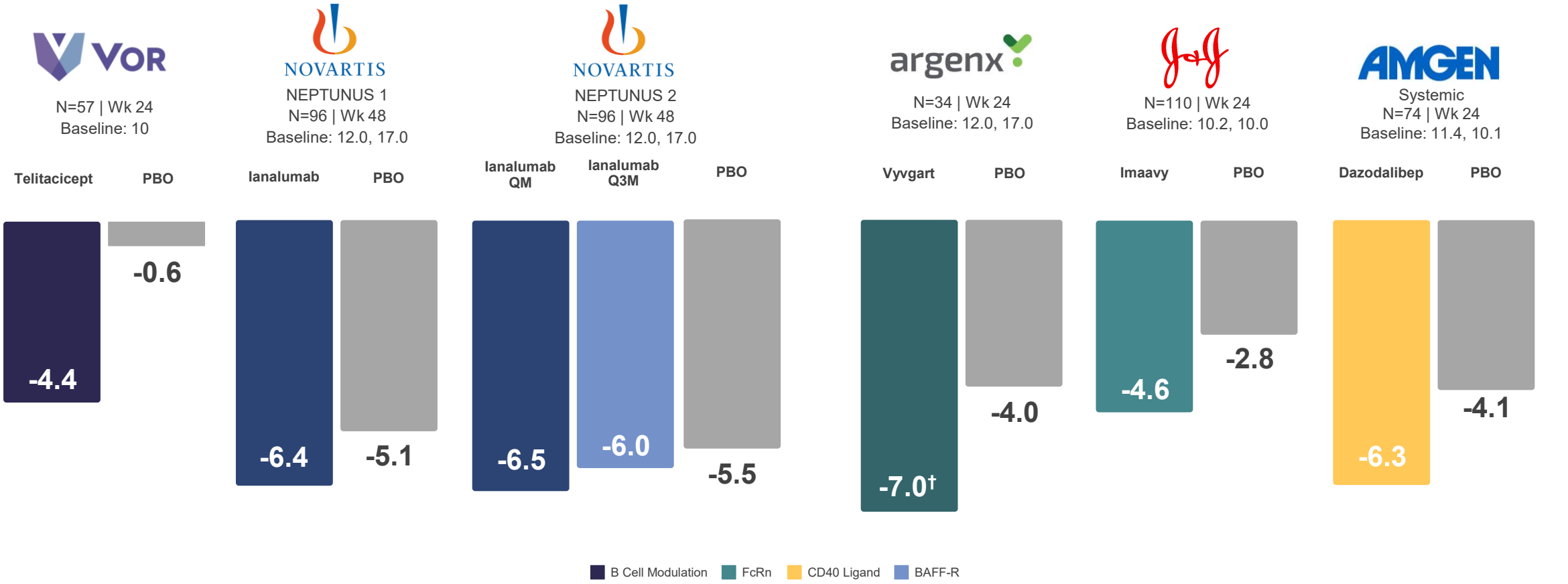
Telitacicept Shows Potential Best-In-Disease Profile in pSjD

Telitacicept delivered 3.8-point ESSDAI separation from placebo, the largest reported in SjD

Change in ESSDAI Score from Baseline

Based on historical clinical data; not a head-to-head trial

PHASE 3 TRIALS | **PHASE 2 TRIALS**



ESSDAI, EULAR Sjögren's syndrome disease activity index; pSjD, primary Sjögren's disease; Efgartigimod - RHO; Nipocalimab - Bowman 2022, Lancet; Ianalumab - St. Clair 2024, Nature and Grader-Beck 2025 ACR; Dazodalibep - Xu 2024 Rheumatology; Ianalumab Phase 3 – ACR 2025; †Median clinESSDAI reported

RemeGen-sponsored trial

Telitacicept Shows Potential Best-In-Disease Profile in pSjD

Telitacicept delivered 1.5-point ESSPRI separation from placebo, the largest reported in SjD

Change in ESSPRI Score from Baseline

Based on historical clinical data; not a head-to-head trial

PHASE 3 TRIALS

VOR

N=57 | Wk 24
Baseline: 10

Telitacicept: -1.88
PBO: -0.36

NOVARTIS

NEPTUNUS 1
N=96 | Wk 48
Baseline: 12.0, 17.0

Ianalumab | PBO: Not Reported

NOVARTIS

NEPTUNUS 2
N=96 | Wk 48
Baseline: 12.0, 17.0

Ianalumab QM | Ianalumab Q3M | PBO: Not Reported

PHASE 2 TRIALS

argenx

N=34 | Wk 24
Baseline: 12.0, 17.0

Vyvgart | PBO: Not Reported

J&J

N=110 | Wk 24
Baseline: 10.2, 10.0

Imaavy: -2.32
PBO: -1.91

AMGEN

Systemic
N=74 | Wk 24
Baseline: 11.4, 10.1

Dazodalibep: -1.80
PBO: -1.12

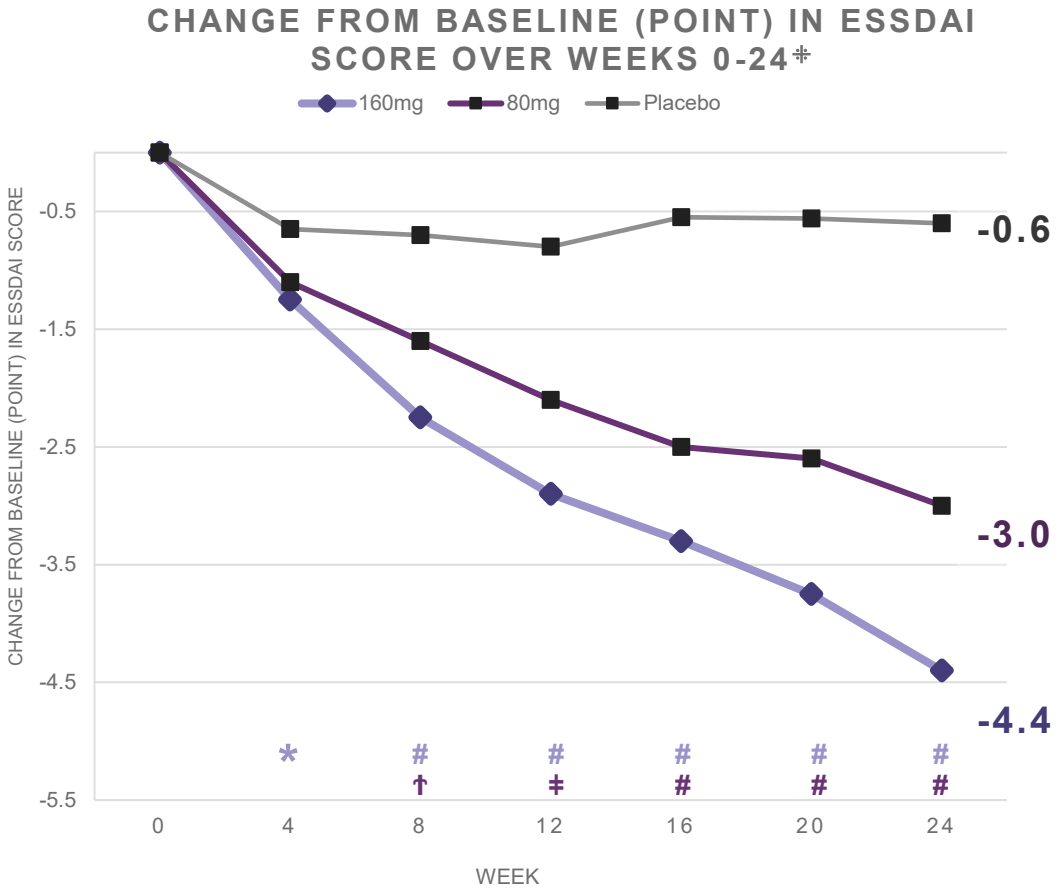
B Cell Modulation | FcRn | CD40 Ligand | BAFF-R

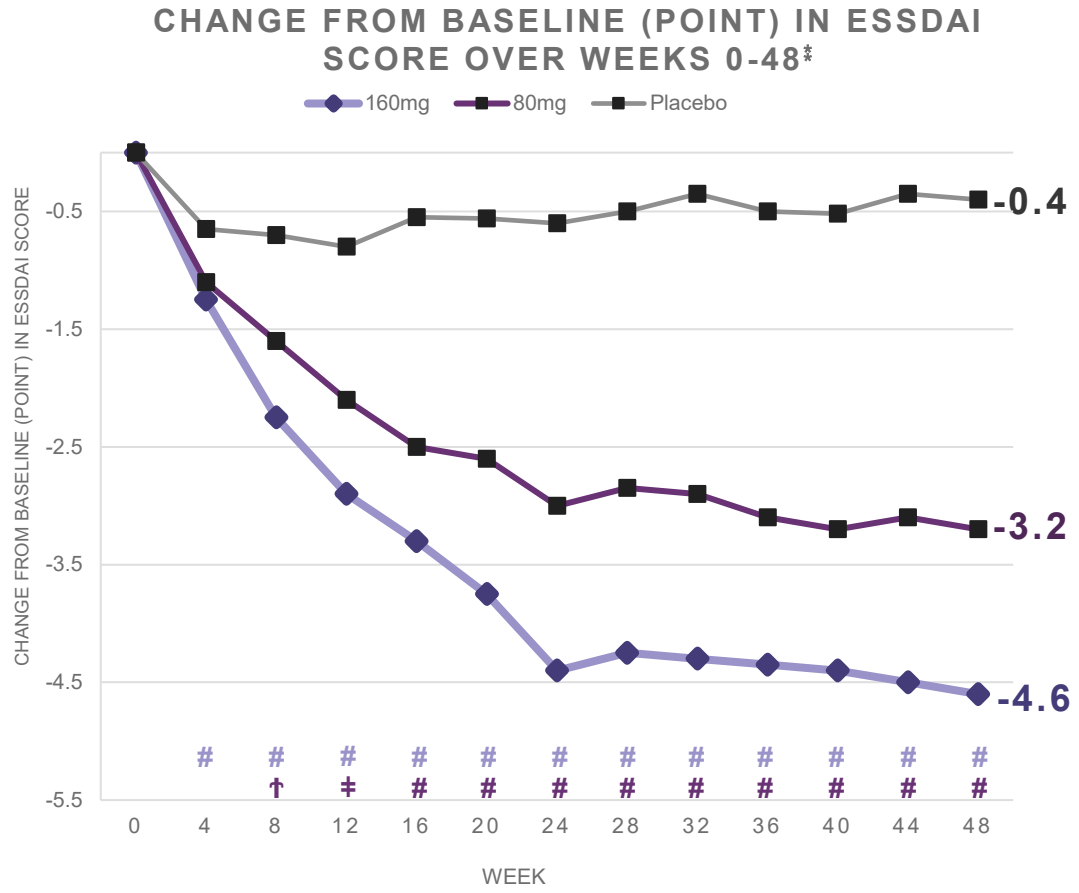
ESSPRI, EULAR Sjögren's Syndrome Patient Reported Index; pSjD, primary Sjögren's disease; Efgartigimod - RHO; Nipocalimab - Bowman 2022, Lancet; Ianalumab - St. Clair 2024, Nature and Grader-Beck 2025 ACR; Dazodalibep - Xu 2024 Rheumatology; Ianalumab Phase 3 – ACR 2025; †Median clinESSDAI reported

RemeGen-sponsored trial

Deep, Consistent ESSDAI Reduction Through 48 Weeks

7x greater improvement means fewer active symptoms and broader systemic relief for patients





(* *P*<0.05, † *P*<0.01, ‡ *P*<0.001, # *P*<0.0001)

Placebo*: Participants randomized to the placebo group. ⁜The analysis of change from baseline in ESSDAI score over Weeks 0-24 was based on the estimate population (EP). The MMRM method was used and missing data were not imputed. ⁑The analysis of change from baseline in ESSDAI score over Weeks 0-48 was based on the estimate population (EP). The post-switching data for the two telitacicept groups and the placebo group were handled with the LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.

RemeGen-sponsored trial

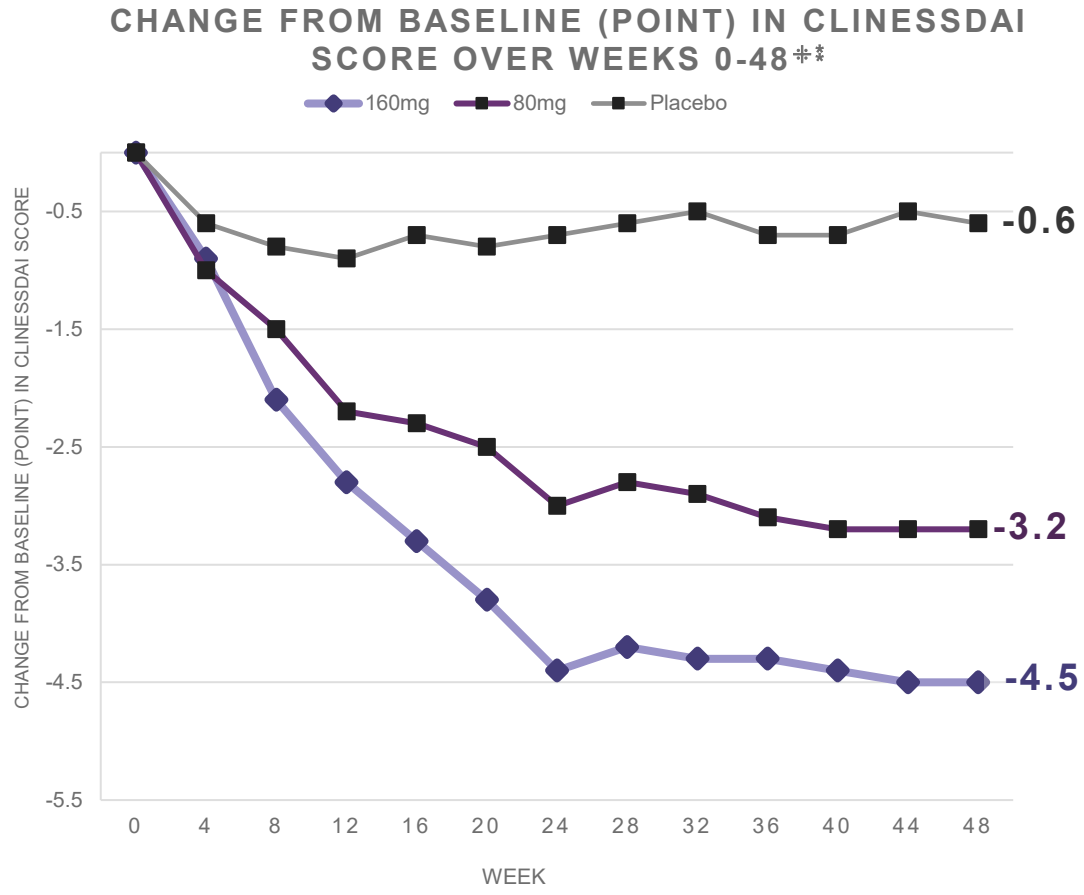
Deep, Consistent ClinESSDAI Reduction Through 48 Weeks

Sustained improvement in clinical benefit beyond serologic change

ESSDAI and ClinESSDAI remain nearly identical at week 48

-4.6 vs -4.5

ClinESSDAI excludes biological domain (IgG, complement), representing a more sensitive measure of pure clinical disease activity

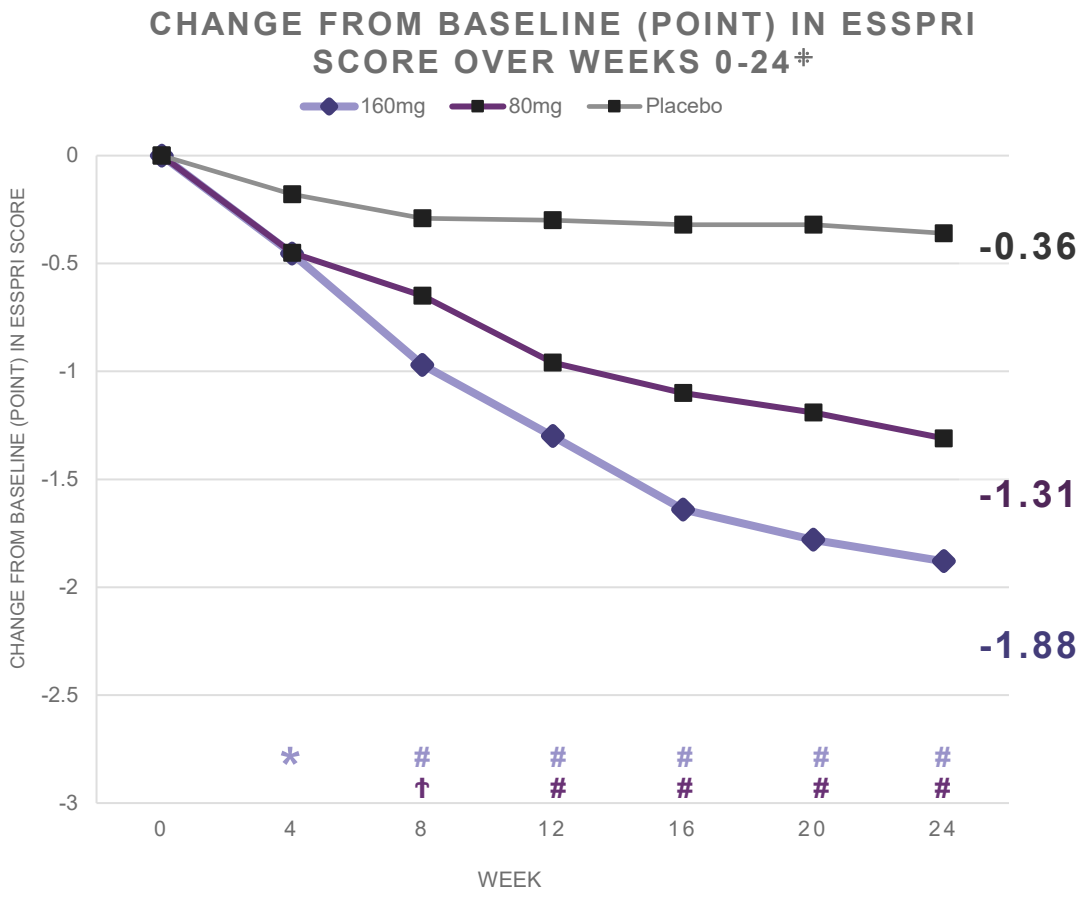


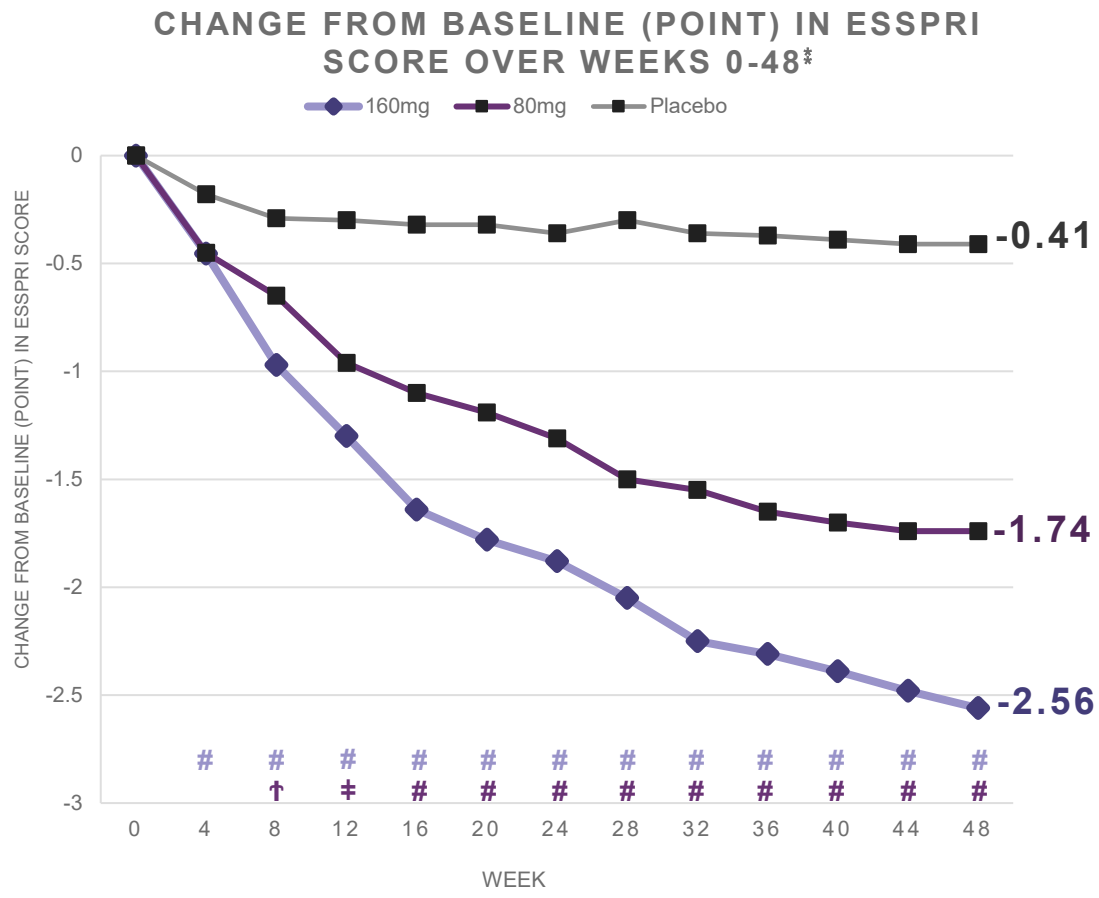
ClinESSDAI, clinical ESSDAI; Placebo*: Participants randomized to the placebo group. ⁜The analysis of change from baseline in ClinESSDAI score over Weeks 0-24 was based on the estimate population (EP). The MMRM method was used and missing data were not imputed. ‡The analysis of change from baseline in ClinESSDAI score over Weeks 0-48 was based on the estimate population (EP). The post-switching data for the two telitacicept groups and the placebo group were handled with the LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.

RemeGen-sponsored trial

Sustained Improvement in ESSPRI Through 48 Weeks

Reduction in patient-reported fatigue, pain, and dryness by ~2.6 points at one year





(* *P*<0.05, † *P*<0.01, ‡ *P*<0.001, # *P*<0.0001)

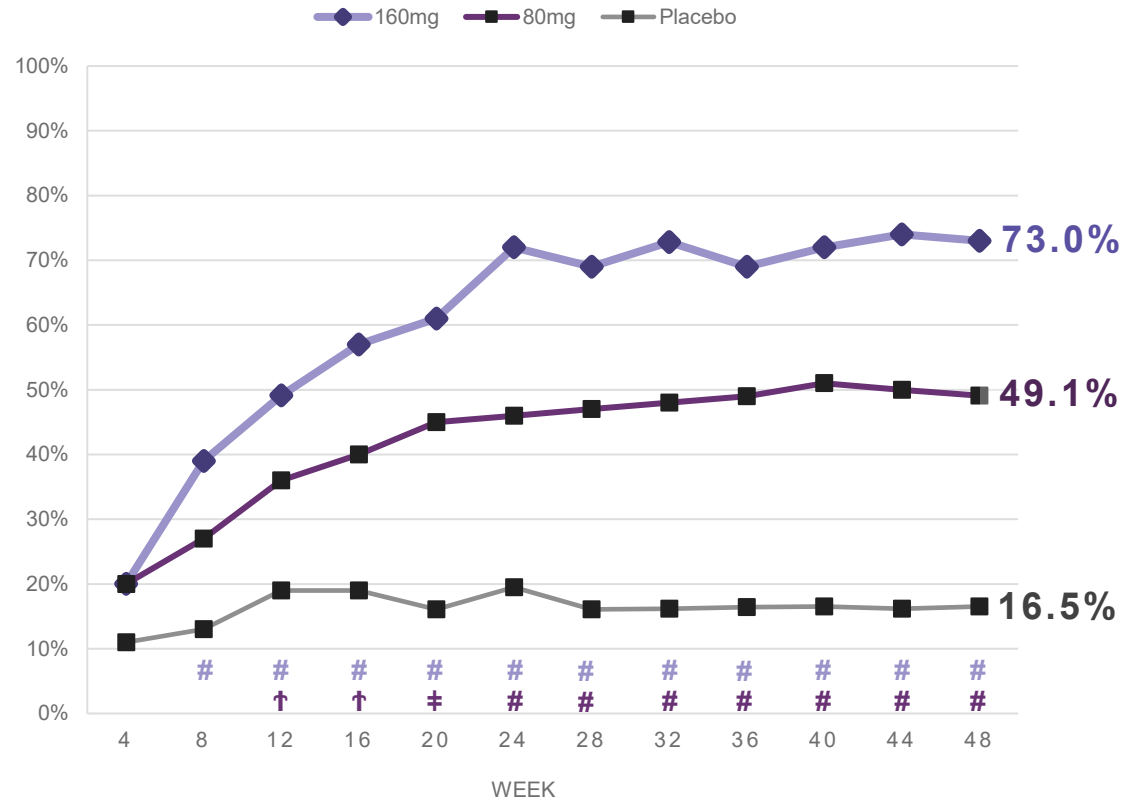
Placebo*: Participants randomized to the placebo group. ⁜The analysis of change from baseline in ESSPRI score over Weeks 0-24 was based on the estimate population (EP). The MMRM method was used and missing data were not imputed. ⁑The analysis of change from baseline in ESSPRI score over Weeks 0-48 was based on the estimate population (EP). The post-switching data for the two telitacicept groups and the placebo group were handled with the LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.

RemeGen-sponsored trial

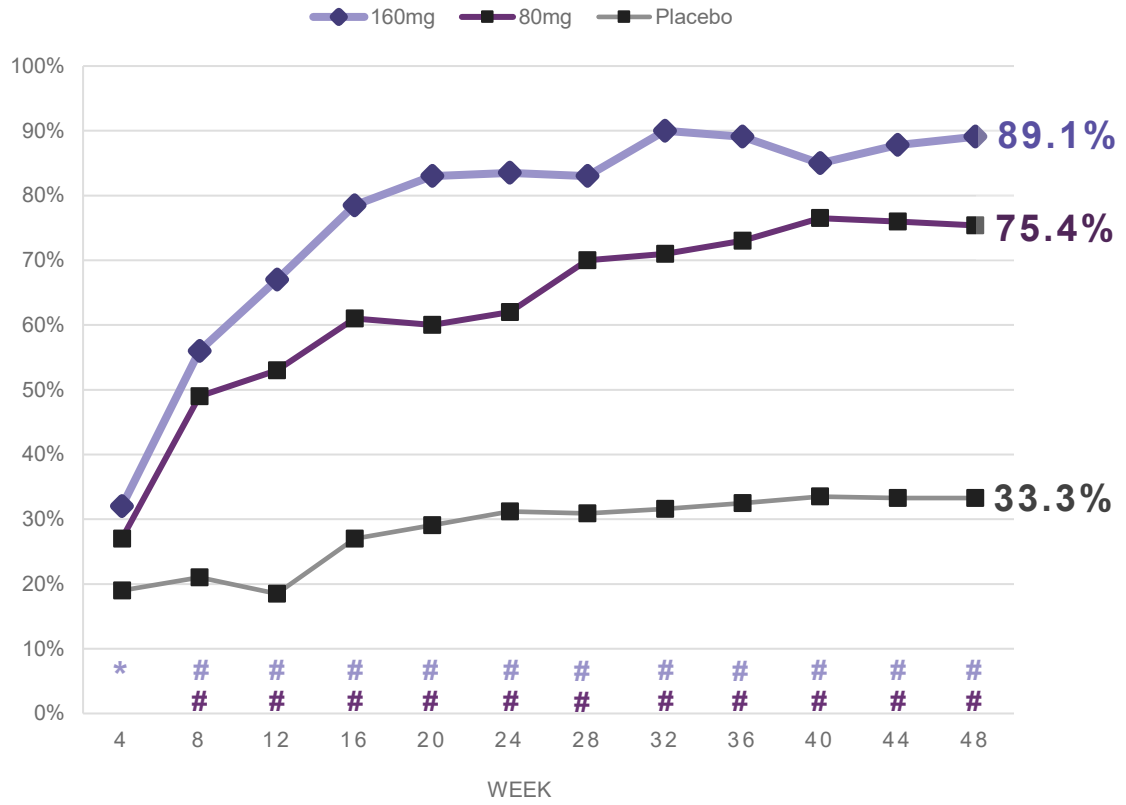
Early, Broad Symptom Improvements Observed with Telitacicept

Nearly 90% of patients report improvement as physicians confirm disease control in 3 out of 4 patients

PROPORTION OF PARTICIPANTS WITH ≥3-POINT REDUCTION FROM BASELINE IN ESSDAI SCORE OVER TIME⁜‡



PROPORTION OF PARTICIPANTS WITH ≥1-POINT OR ≥15% REDUCTION FROM BASELINE IN ESSPRI SCORE OVER TIME⁜‡



(* *P*<0.05, † *P*<0.01, ‡ *P*<0.001, # *P*<0.0001)

Placebo*: Participants randomized to the placebo group. ⁜The analysis of change from baseline in ESSDAI and ESSPRI score over Weeks 0-24 was based on the estimate population (EP). The MMRM method was used and missing data were not imputed. ‡The analysis of change from baseline in ESSDAI and ESSPRI score over Weeks 0-48 was based on the estimate population (EP). The post-switching data for the two telitacicept groups and the placebo group were handled with the LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.

RemeGen-sponsored trial

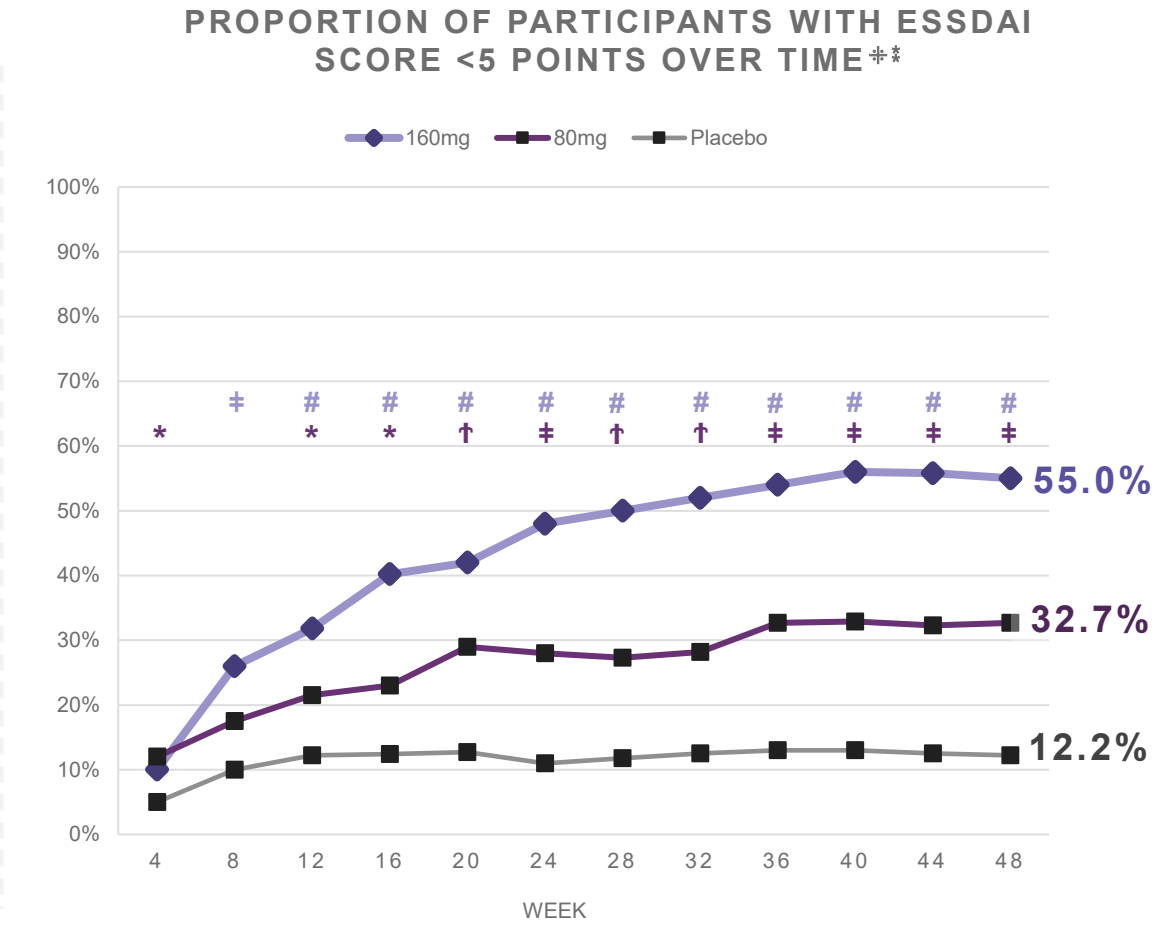
More Than Half of Patients Achieve Low Disease Activity

Nearly 5x more patients on 160mg vs placebo achieved this threshold

Low Disease Activity (ESSDAI <5) Represents Minimal Systemic Involvement

55% vs 12%

Consistent improvement sustained through 48 weeks, indicating durable immune stabilization



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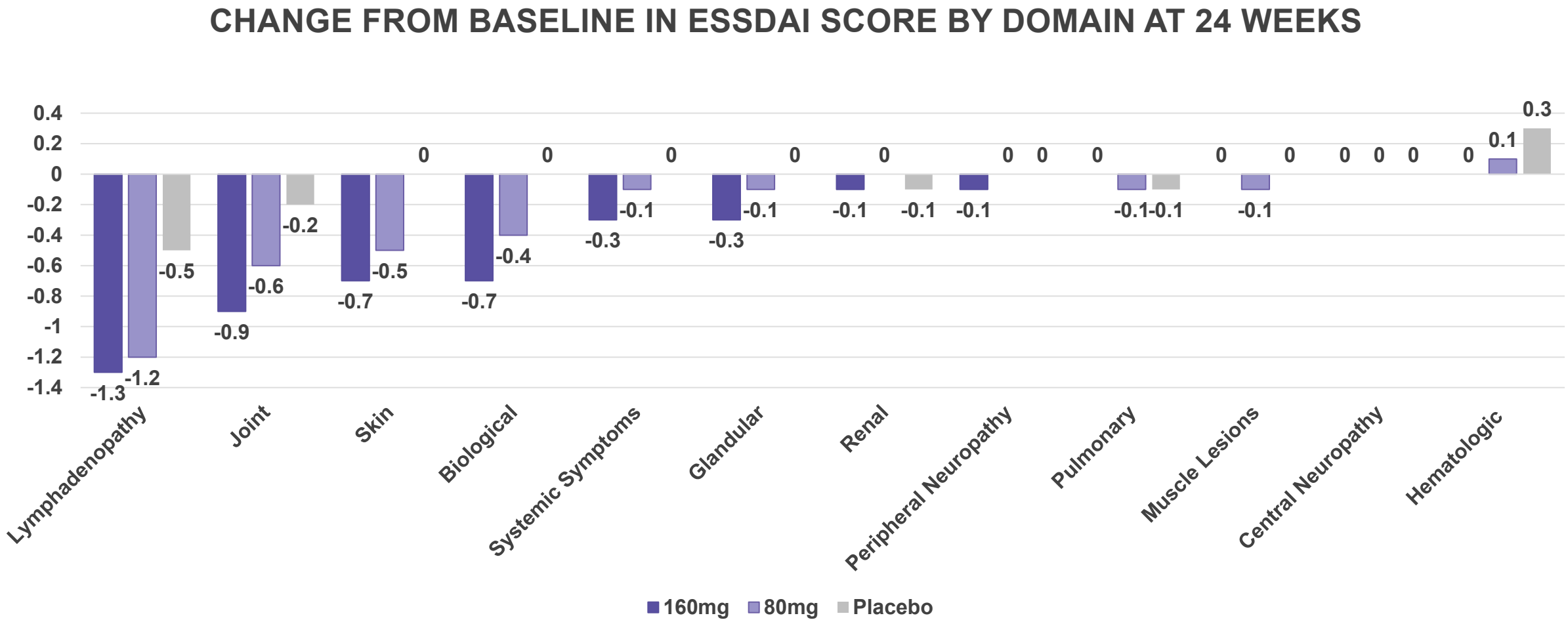
Placebo*: Participants randomized to the placebo group. ⁜The analysis of change from baseline in ESSDAI score over Weeks 0-24 was based on the estimate population (EP). The MMRM method was used and missing data were not imputed. ‡The analysis of change from baseline in ESSDAI score over Weeks 0-48 was based on the estimate population (EP). The post-switching data for the two telitacicept groups and the placebo group were handled with the LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.

BAFF/APRIL MOA Yields Improvement Across Key ESSDAI Domains

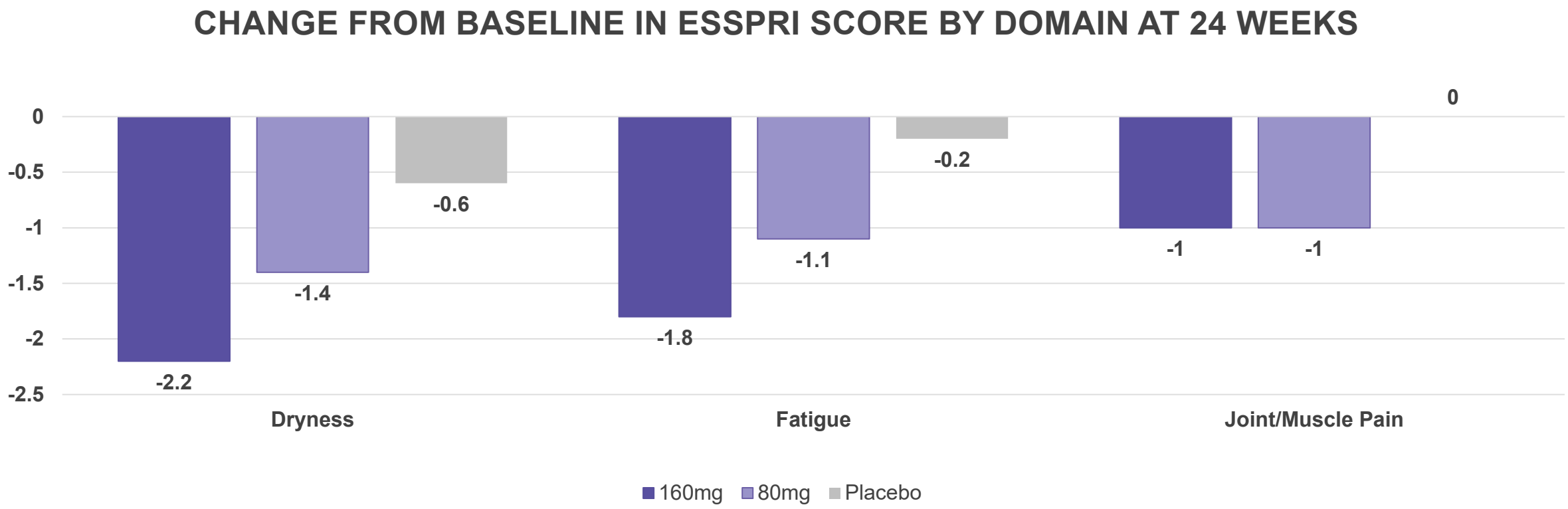
Lack of domain worsening supports balanced B cell modulation without over-suppression



MOA, mechanism of action

BAFF/APRIL MOA Associated With Improvement Across All ESSPRI Domains

Meaningful improvement across dryness, fatigue, and pain – symptoms that define daily patient life

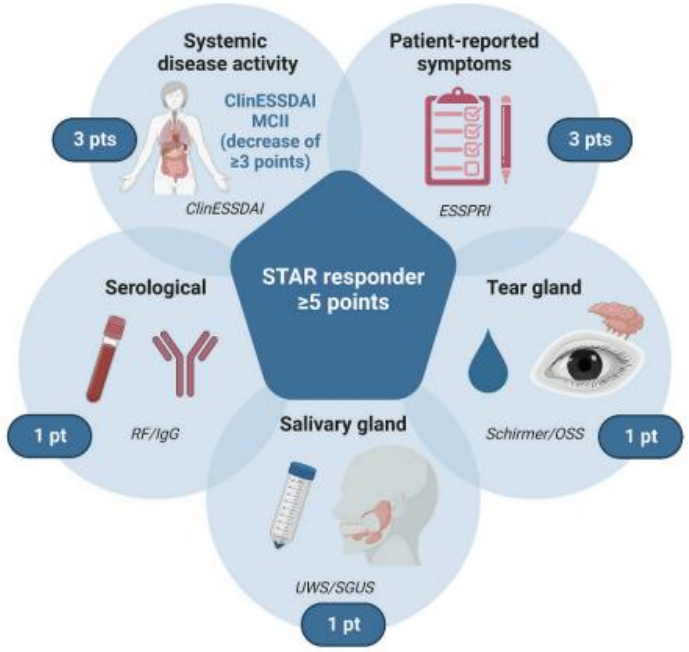


RemeGen-sponsored trial

MOA, mechanism of action

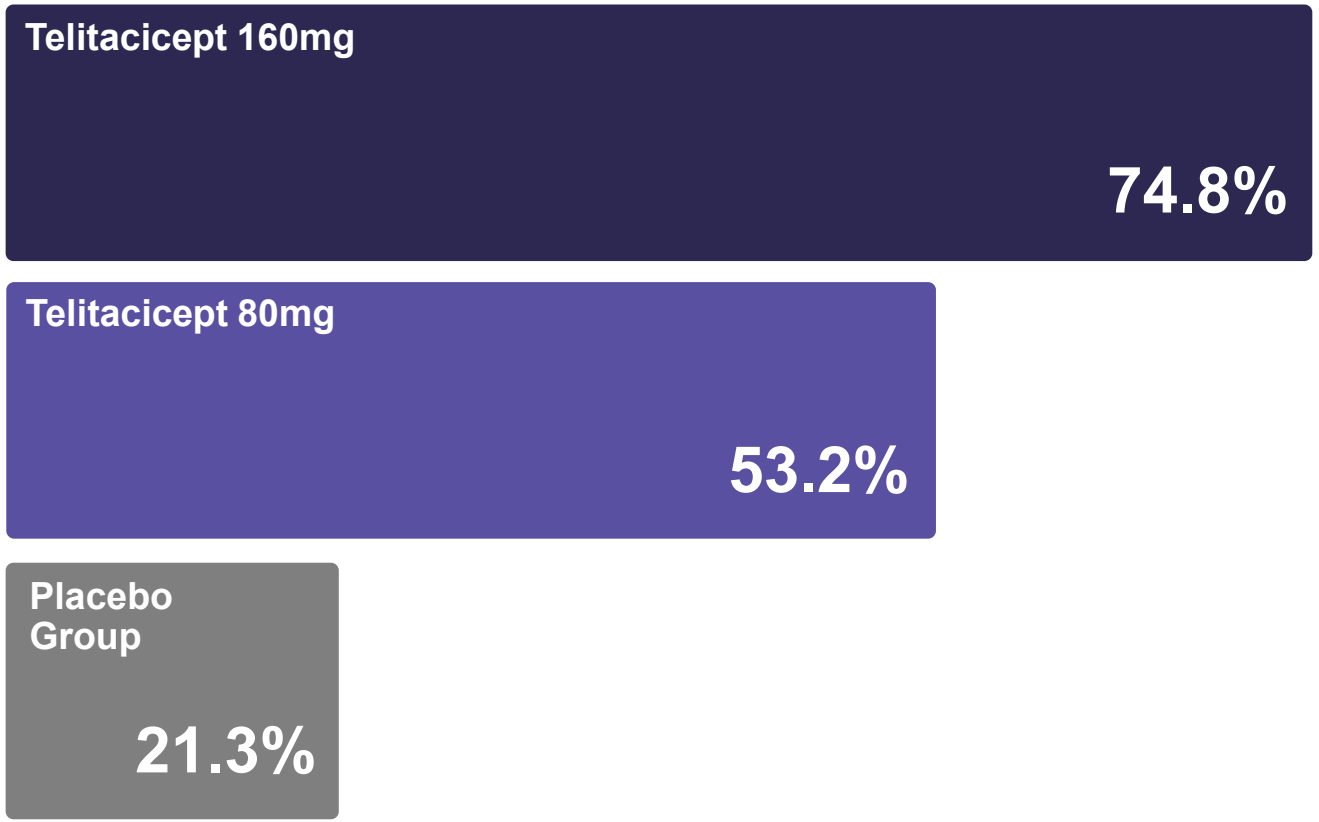
STAR: Exploratory Endpoint Demonstrates Multi-Domain Improvement

Nearly 3 in 4 patients achieved ≥5 point response



- STAR integrates systemic disease activity (ClinESSDAI), symptoms (ESSPRI), and glandular function (Schirmer's / salivary flow)
- Systemic disease activity and patient-reported symptoms are considered as major items (3 points per item) and the rest as minor items (1 point per item)
- Patients are classified as STAR responders when they reach ≥ 5 of 9 points

STAR Responders (%) at Week 24

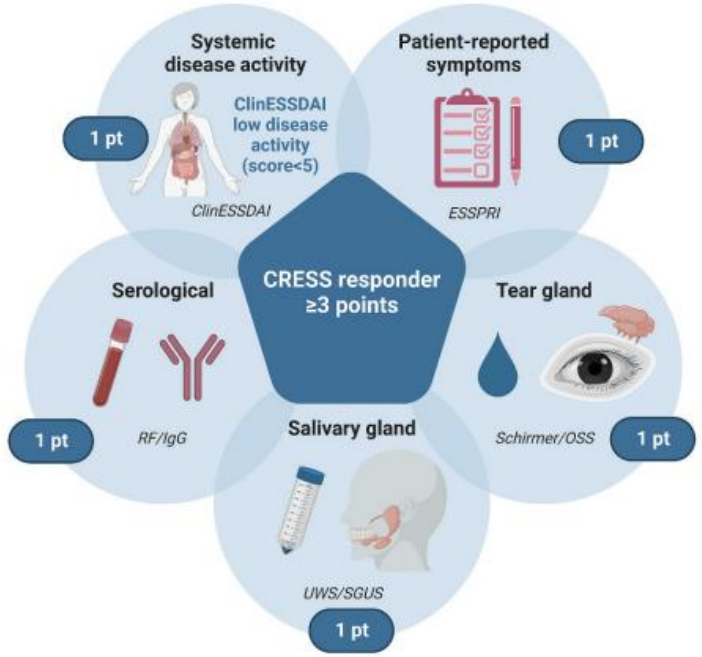


Placebo*: Participants randomized to the placebo group. A STAR responder was defined as a participant with a total STAR score of ≥5 points. Participants with missing scores in any domain (except those with a total STAR score of ≥5 points despite missing scores in some domains) were imputed as "non-responders". The responder proportion analysis for Weeks 0-24 was based on estimate population (EP). The stratum-adjusted between-group difference was tested with the CMH method. The responder proportion analysis for Weeks 28-48 was based on the estimate population (EP). The stratum-adjusted between-group difference was tested with the CMH method. The post-switching data for the two telitacicept groups and the placebo group were handled with the LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.

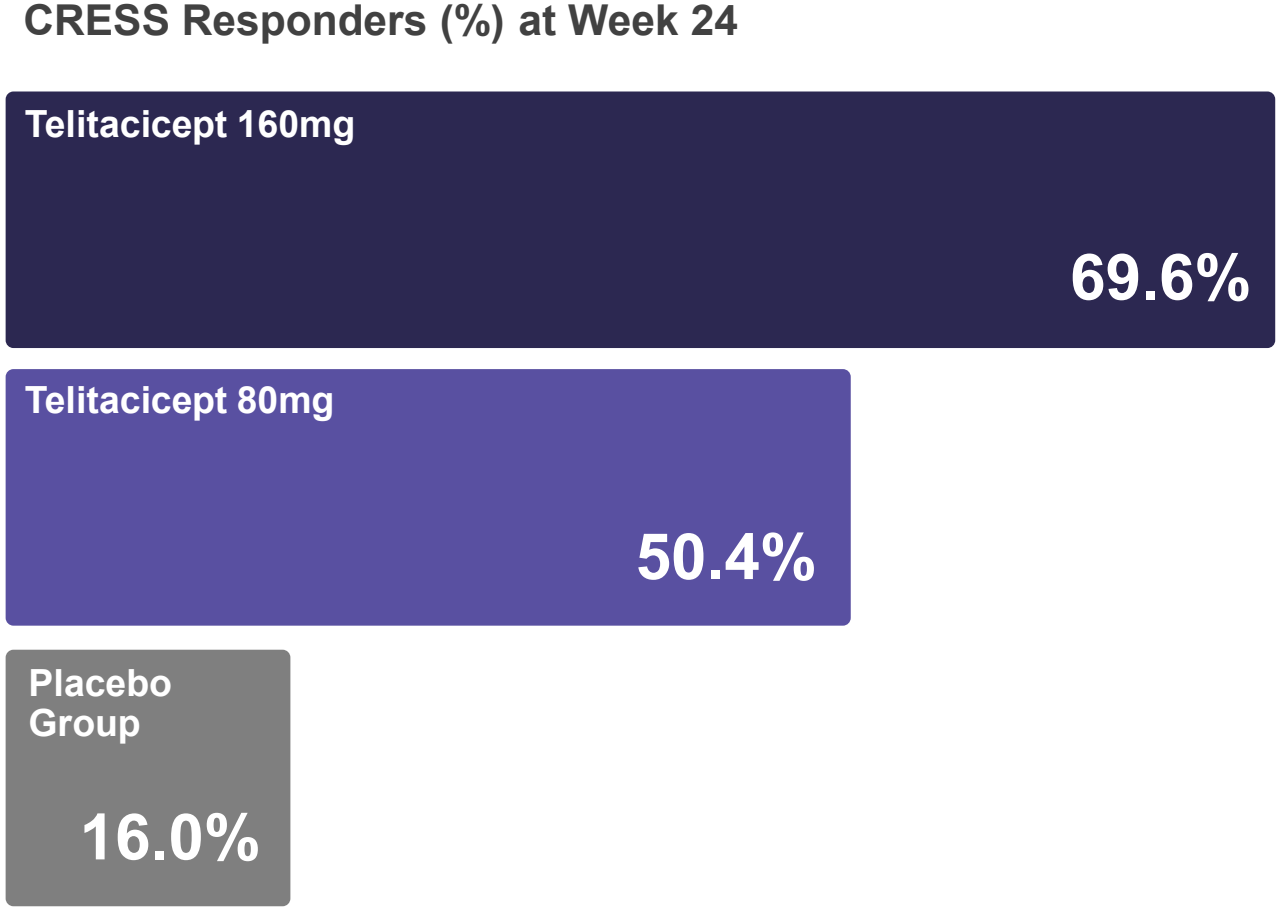
RemeGen-sponsored trial

CRESS: Exploratory Endpoint Demonstrates Broad, Balanced Efficacy

Nearly 7 in 10 patients achieved ≥3 point response

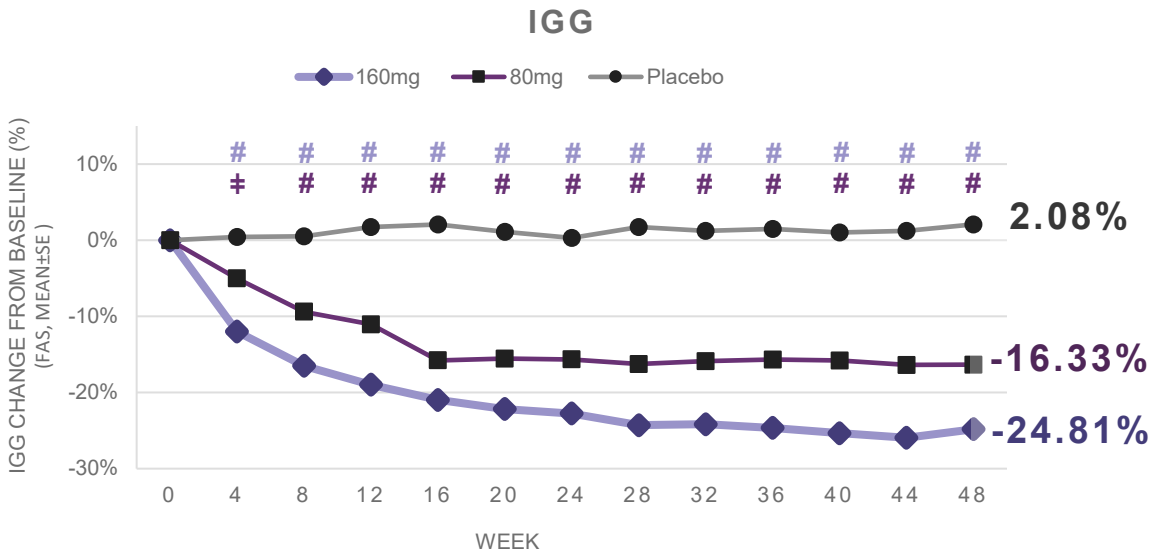


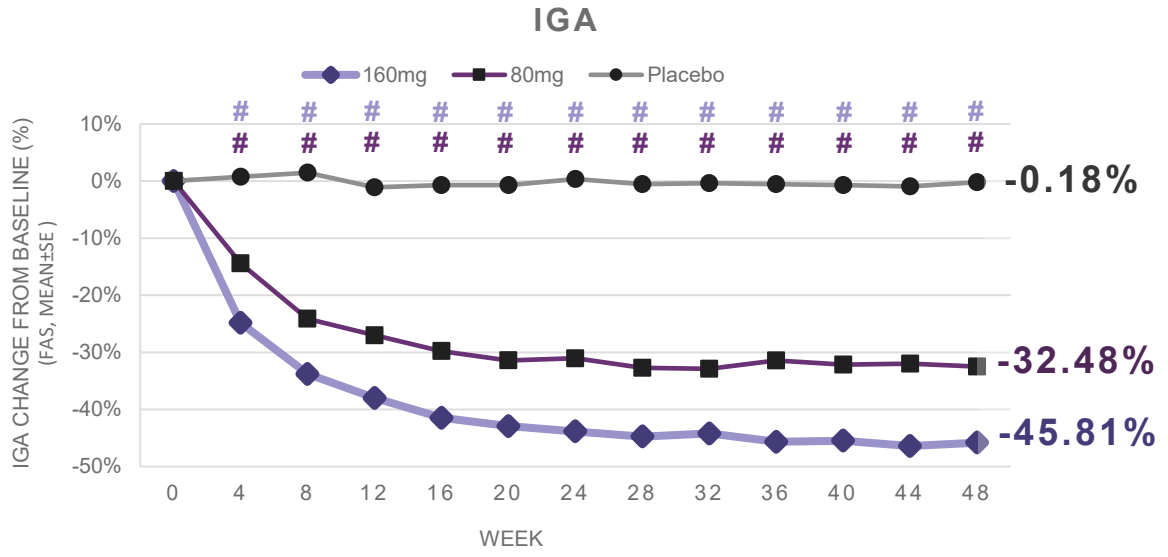
- Response in the systemic disease activity domain is defined as low disease activity at follow-up (ClinEssdai <5)
- All domains are equally balanced,1 point each
- Patients are classified as CRESS responders when they reach ≥ 3 of 5 points

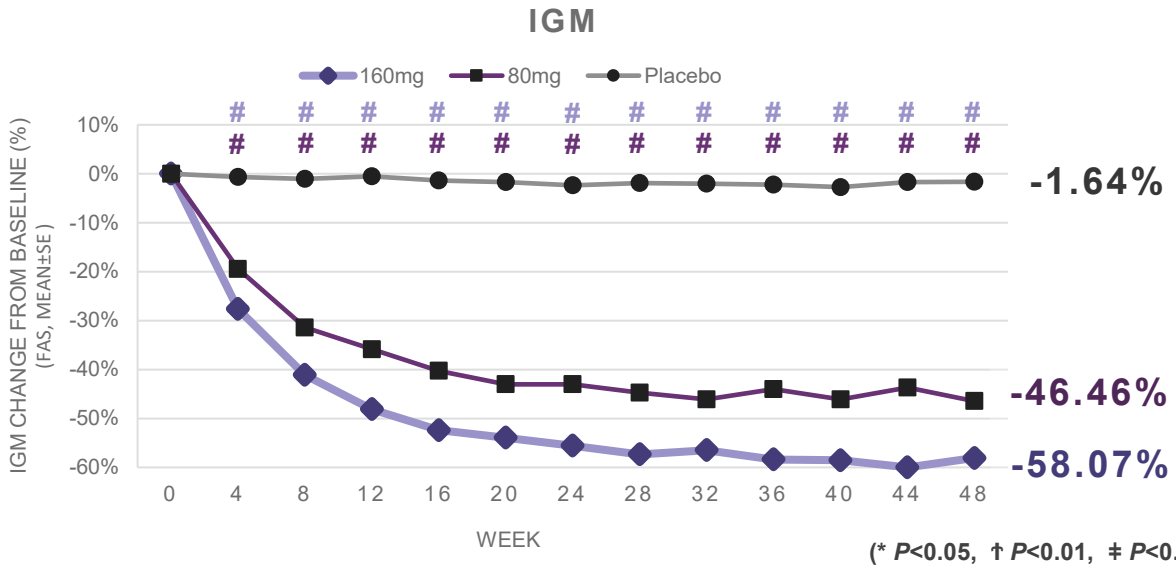


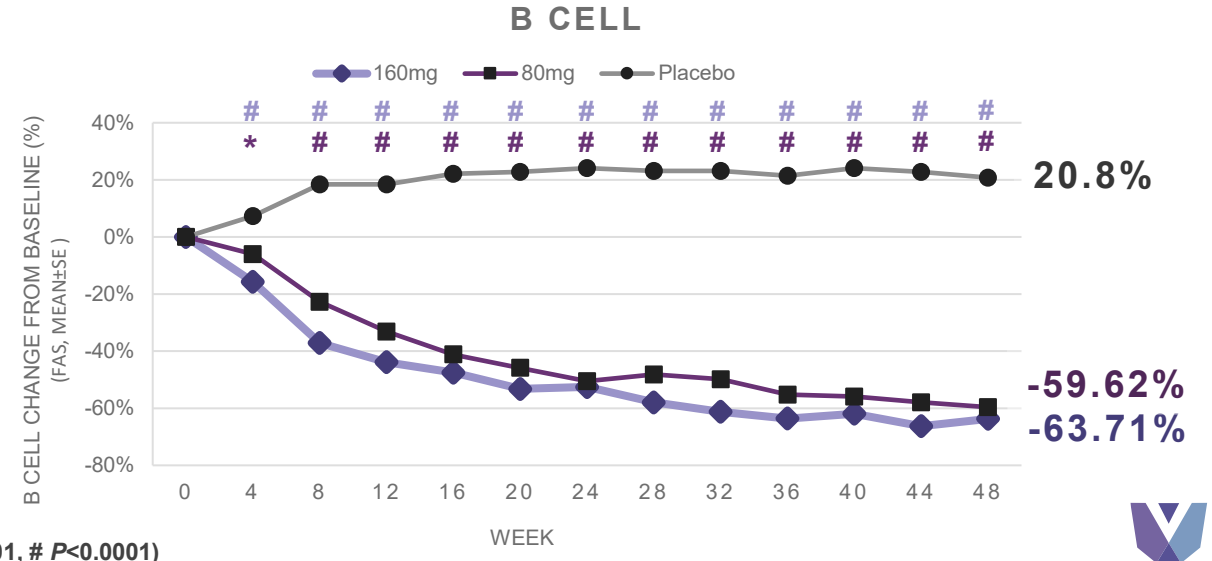
Placebo*: Participants randomized to the placebo group. A CRESS responder was defined as a participant with a total CRESS reduction score of ≥3 points. Participants with missing scores in any domain (except those with a total CRESS score of ≥3 points despite missing scores in some domains) were imputed as "non-responders". The responder proportion analysis for Weeks 0-24 was based on estimate population (EP). The stratum-adjusted between-group difference was tested with the CMH method. The responder proportion analysis for Weeks 28-48 was based on the estimate population (EP). The stratum-adjusted between-group difference was tested with the CMH method. The post-switching data for the two telitacicept groups and the placebo group were handled with the LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.

Consistent Reduction in IgG, IgA, IgM, and B Cells









(* *P*<0.05, † *P*<0.01, ‡ *P*<0.001, # *P*<0.0001)

RemeGen-sponsored trial

Favorable Safety Profile in pSjD

Consistent with data from clinical trials in SLE, RA, gMG, and IgAN, and post-marketing data

	Telitacicept 160mg (N=127)	Telitacicept 80 mg (N=126)	Placebo Group (N=127)
TEAE, n(%)	122 (96.1)	119 (94.4)	112 (88.2)
TRAE, n(%)	107 (84.3)	106 (84.1)	74 (58.3)
TESAE, n(%)	11 (8.7)	14 (11.1)	10 (7.9)
TRSAE, n(%)	2 (1.6)	5 (4.0)	4 (3.1)
Severe TEAE, n(%)	3 (2.4)	5 (4.0)	3 (2.4)
Severe TRAE, n(%)	0	1 (0.8)	1 (0.8)
Death, n(%)	0(0)	0(0)	0(0)
Common TEAE (incidence ≥10% in any group)			
Upper respiratory tract infections, n(%)	80 (63.0)	85 (67.5)	74 (58.3)
Urinary tract infection, n(%)	8 (6.3)	15 (11.9)	7 (5.5)
Cough, n(%)	11 (8.7)	14 (11.1)	8 (6.3)
Hepatic function abnormal, n(%)	7 (5.5)	16 (12.7)	7 (5.5)
Injection site reaction, n(%)	53 (41.7)	51 (40.5)	5 (3.9)
Pyrexia, n(%)	4 (3.1)	14 (11.1)	4 (3.1)

RemeGen-sponsored trial

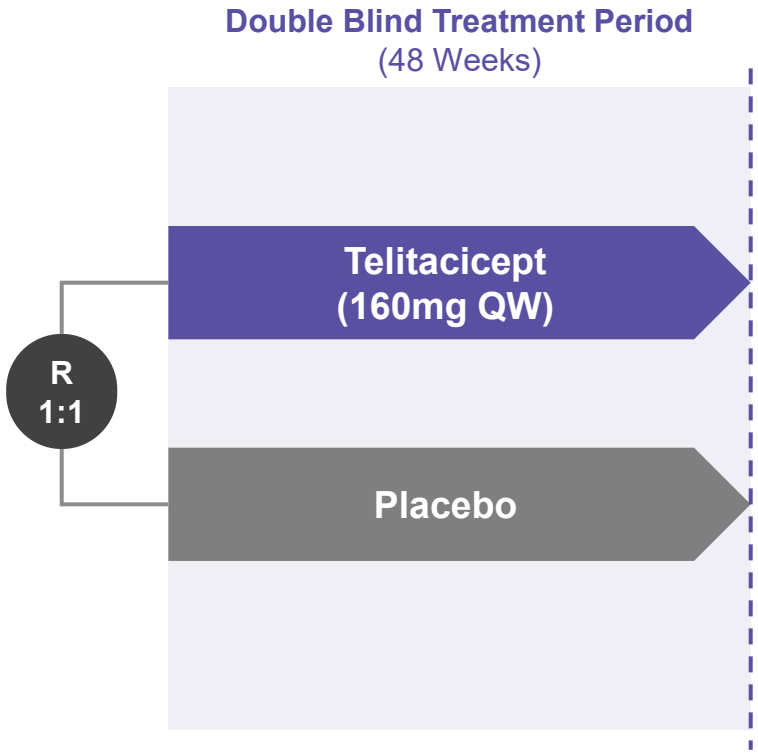
TEAE, treatment emergent adverse event; TRAE, treatment related adverse event; TESAE, treatment emergent serious adverse event; TRSAE, treatment related serious adverse event; pSjD, primary Sjogren's disease SLE, systemic lupus erythematosus; RA, rheumatoid arthritis; gMG, generalized myasthenia gravis; IgAN, IgA nephropathy

UPSTREAM SjD: Global Phase 3 Trial in Primary Sjögren's Disease

Potential best- and first-in-class BAFF/APRIL inhibitor; randomized, double-blind, placebo-controlled study

250*

Adults With pSjD



Primary Endpoint

- Change from baseline in ESSDAI at 48 weeks

Secondary Endpoints

- Changes from baseline in ESSPRI, Whole Salivary Flow, Unstimulated Whole Salivary Flow, Schirmer's Test, SF-36, FACIT-F, and MFI-20 at 48 weeks
- Proportion of patients who achieve >3 domains of CRESS and ≥5 domains of STAR

Enrollment Ongoing; First Patient Dosed in 1Q26

*Estimated. ESSDAI, EULAR Sjögren's syndrome disease activity index; ESSPRI, EULAR Sjögren's Syndrome Patient Reported Index; MFI-20, multidimensional fatigue inventory; PGA, physician's global assessment; PaGA, patient's global assessment; SF-36, 36-item short-form; pSjD, primary Sjögren's disease; QW, per week.

Global Precedents for China-to-Global Translatability

Moving Beyond Geographic Boundaries

MG: Batoclimab Shows Consistent MG-ADL Improvement Independent of Region

PBO-adjusted MG-ADL Δ: −1.9 China vs −2.0 Global

Metric	China n=131 | 6 weeks *(JAMA Neurol 2024)*	Global n=164 | 12 weeks *(Immunovant 2025)*	What It Means
Baseline MG-ADL (PBO)	8.4 (8.5)	8.8 (8.7)	Similar disease severity
PBO MG-ADL Absolute Δ	-1.7	-3.6	Global placebo more active
Drug MG-ADL Absolute Δ	-3.6	-5.6	Meaningful performance in both
PBO-Adjusted MG-ADL Δ	**-1.9**	**-2.0**	**Similar contribution**
IgG Reduction	~75% (max)	74% (mean)	Similar pharmacodynamics
Sustained Responder Rate (PBO)	58.2% (31.3%)*	93%†	Consistent or stronger globally
MSE Rate	25.4% (4.7%)	42% (7.0%)	MSE numerically higher globally

Based on historical clinical data; not a head-to-head trial

DOI:10.1001/jamaneurol.2024.0044; MG – myasthenia gravis; *58.2% in China uses a ≥3-point MG-ADL threshold; † 93% globally uses a ≥2-point threshold.; PBO, placebo; MSE, minimal symptom expression

MG: Nipocalimab Shows Consistent MG-ADL Improvement Independent of Region

PBO-adjusted MG-ADL Δ: −1.25 East Asia vs −1.30 EU / Rest of World

Subgroup	Treatment Arm	No. of Subjects at Baseline (n)	LS Mean Difference from Placebo (95% CI)
Region			
East Asia	Placebo	24	--
	Nipocalimab	24	**-1.251** (-2.904,0.402)
European Union/Rest of World[a]	Placebo	43	--
	Nipocalimab	44	**-1.302** (-2.541,-0.062)
United States	Placebo	9	--
	Nipocalimab	9	-2.451 (-5.297, 0.0395)

FDA, Integrated Review: IMAAVY (nipocalimab-aahu), BLA 761430, April 29, 2025, regional subgroup analysis of VIVACITY-MG3 (NCT04951622)
MG – myasthenia gravis; [a]The Rest of World includes Canada (CAN), Germany (DEU), Spain (ESP), France (FRA), South Korea (KOR), Taiwan (TWN); CI, confidence interval

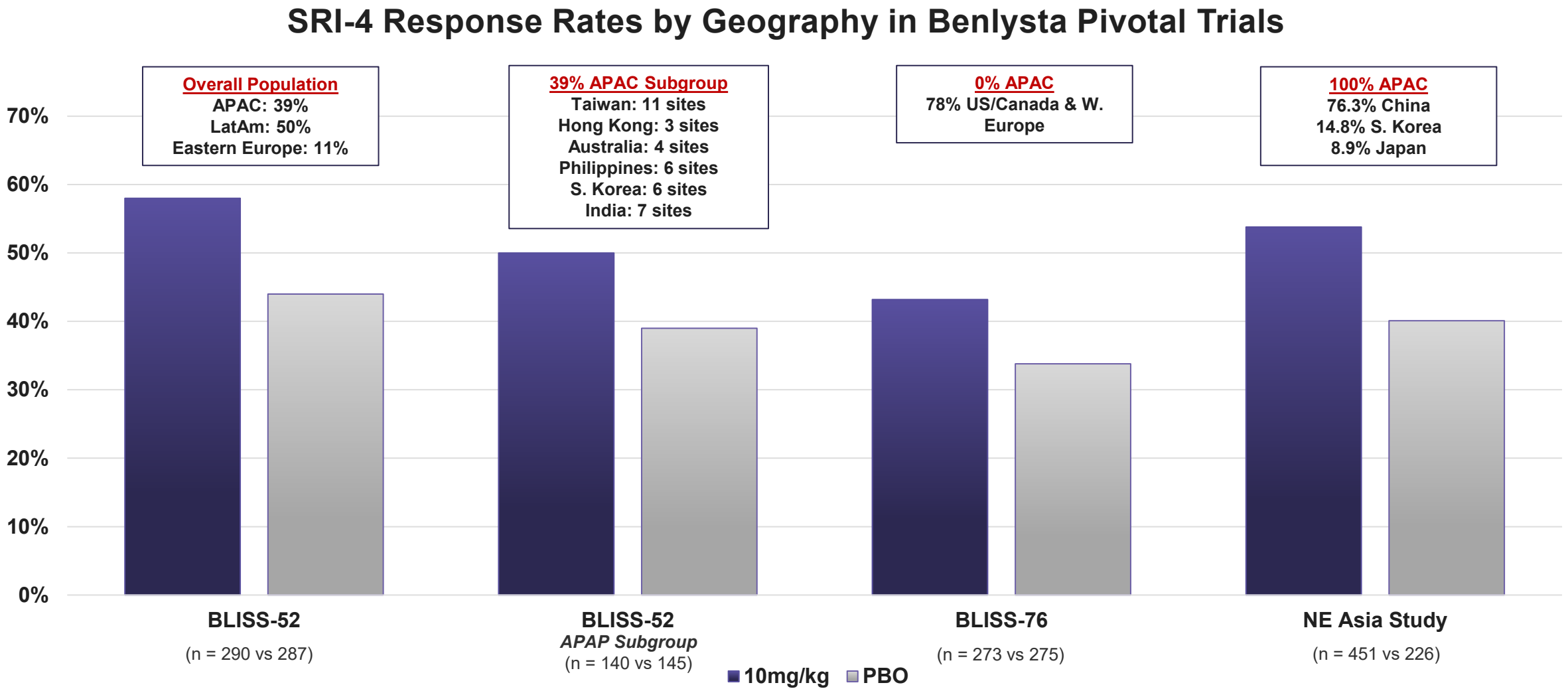
Sjögren's: Ianalumab Shows Consistent Activity Independent of Region

No signal of reduced effect in Novartis NEPTUNUS China subgroup

		Ianalumab				Telitacicept	
		Global		China Subgroup		China Phase 3	
		300mg QM N=305	Placebo N=307	300mg QM N=29	Placebo N=36	160mg N=127	Placebo N=127
ESSDAI	Mean Change from Baseline	-6.5	-5.3				
	Δ vs Placebo	-1.2		-1.4		-3.8	
	ESSDAI <5	53.4%	45.1%	42.7%	30.3%	49.6%	10.9%
ESSPRI	Mean Change from Baseline	-1.73	-1.47	-0.62	-0.83	-1.88	-0.36
	Δ vs Placebo	-0.26		0.21		-1.52	
SSSD	Mean Change from Baseline	-1.52	-1.29	-0.75	-0.71		
	Δ vs Placebo	-0.23		-0.04			
PaGA	Mean Change from Baseline	-13.5	-8.7	-7.9	-4		
	Δ vs Placebo	-4.9		-3.9			
PhGA	Mean Change from Baseline	-29.2	-25.9	-17.1	-16.5		
	Δ vs Placebo	-3.3		-0.6			
Safety (Week 52)	Any Adverse Event (%)	85.9%	83.4%	100.0%	97.2%	96.1%	88.2%
	Series Adverse Events (%)	6.9%	9.8%	6.9%	11.1%	2.4%	2.4%
	AEs Leading to Discontinuation	6.2%	3.6%	3.4%	2.8%	3.1%	3.9%
	Deaths	0	1	0	0		

Ianalumab - NEPTUNUS Phase 3 – EULAR 2026; ESSDAI, EULAR Sjögren's syndrome disease activity index; ESSPRI, EULAR Sjögren's Syndrome Patient Reported Index; SSSD, Sjögren's Syndrome Symptom Diary; PaGA, Patient Global Assessment; PhGA, Physician Global Assessment

SLE: Benlysta Shows Consistent SRI-4 Treatment Effect Despite Varying APAC Enrollment Across Multiple Phase 3 Trials



GSK – BLISS-52 Phase 3 Trial, BLISS-76 Phase 3 Trial, Northeast Asia Trial (Japan, China, S. Korea)

IgAN: BAFF/APRIL Assets Show Consistent Activity Independent of Region

Objective endpoints, quantitative biomarkers, and limited placebo sensitivity concern

Why IgAN Is The Benchmark

Limited Placebo Sensitivity: UPCR reduction is a direct biological readout, with limited placebo impact on proteinuria

Conserved Pathophysiology: all studies demonstrated meaningful UPCR reductions supporting IgAN consistent MoA across populations

Low Regional Bias Risk: UPCR, Gd-IgA1, eGFR are quantitative, validated, and globally standardized, not subjective endpoints

Biomarker Bridge: Consistent Gd-IgA1 reduction across agents support target engagement and biological comparability

Agent	Region	Baseline UPCR (g/g)	PBO-Adjusted UPCR Reduction	PBO UPCR Reduction	Gd-IgA1 Reduction	AEs Leading to Discontinuation
Telitacicept *BAFF/APRIL*	China	1.23	**-55%**	-9%	61%	1%
Povetacicept *BAFF/APRIL*	Global	-	**-49.8%**	-4.3%	77.4%	3.8%
Atacicept *BAFF/APRIL*	Global	1.7	**-42%**	-7%	68%	1%
Sibeprenlimab *APRIL-Only*	Global	1.33	**-51%**	+2%	67%	<1%

Telitacicept – TELIGAN China Phase 3 Trial; Povetacicept – RAINIER Phase 3 Trial; Atacicept – Origin 3 Phase 3 Trial; Sibeprenlimab – VISIONARY Phase 3 Trial

Significant Near-Term Expansion Opportunities

90k

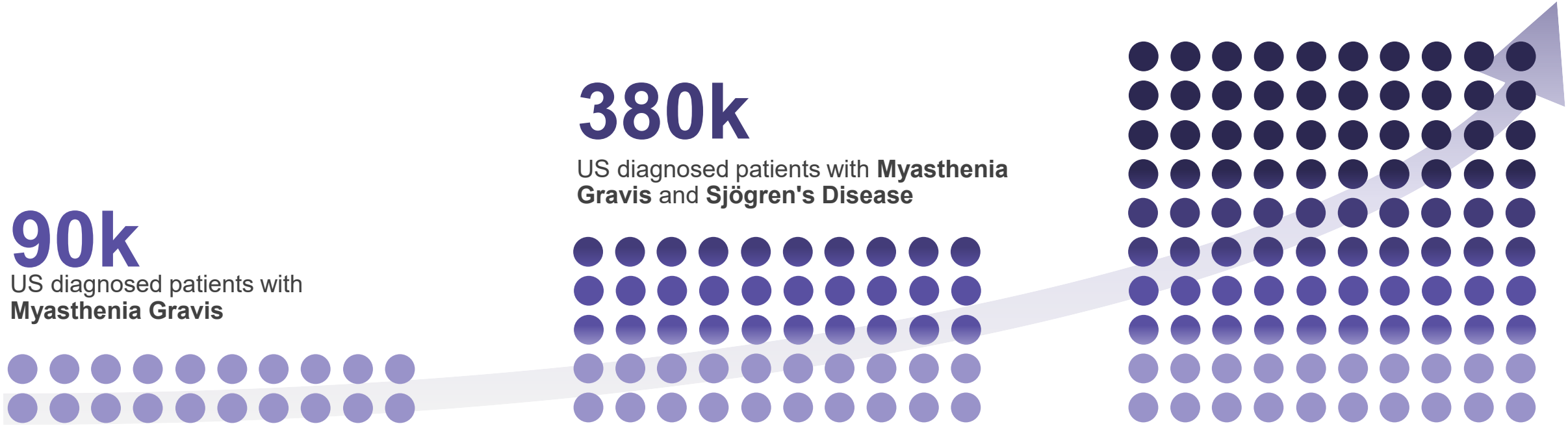
US diagnosed patients with **Myasthenia Gravis**

380k

US diagnosed patients with **Myasthenia Gravis** and **Sjögren's Disease**

>1M+

US diagnosed patients with **Myasthenia Gravis**, **Sjögren's Disease**, and **other B-cell mediated autoimmune disease**



Beachhead | **Follow-On** | **Expansion**

1. Vor metanalysis and estimates

2026:

Advancing The Leading BAFF/APRIL Inhibitor

~$515M

Runway into Early 2029*

01 MYASTHENIA GRAVIS

Enrollment Complete; Global Phase 3 Topline Data in 1H27
Best-in-Disease, Commercially Approved in China

02 SJÖGREN'S DISEASE

Global Phase 3 Initiated; FPD in 1Q26
Best-in-Disease, Commercially Approved in China

03 EXPANSION OPPORTUNITIES

Broad Potential Across B Cell-Driven Immune Diseases
Indication Focus on High Unmet Need And Clinical Value

FPD, first patient dosed; *Proforma cash, cash equivalents, and short-term investments as of June 30, 2026

Thank You.

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