

Global Science. One Purpose.

Corporate Presentation

March 2026



Forward Looking Statement

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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 topline data 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

~\$530M WITH RUNWAY INTO EARLY 2029*, FUNDED THROUGH KEY MILESTONES



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

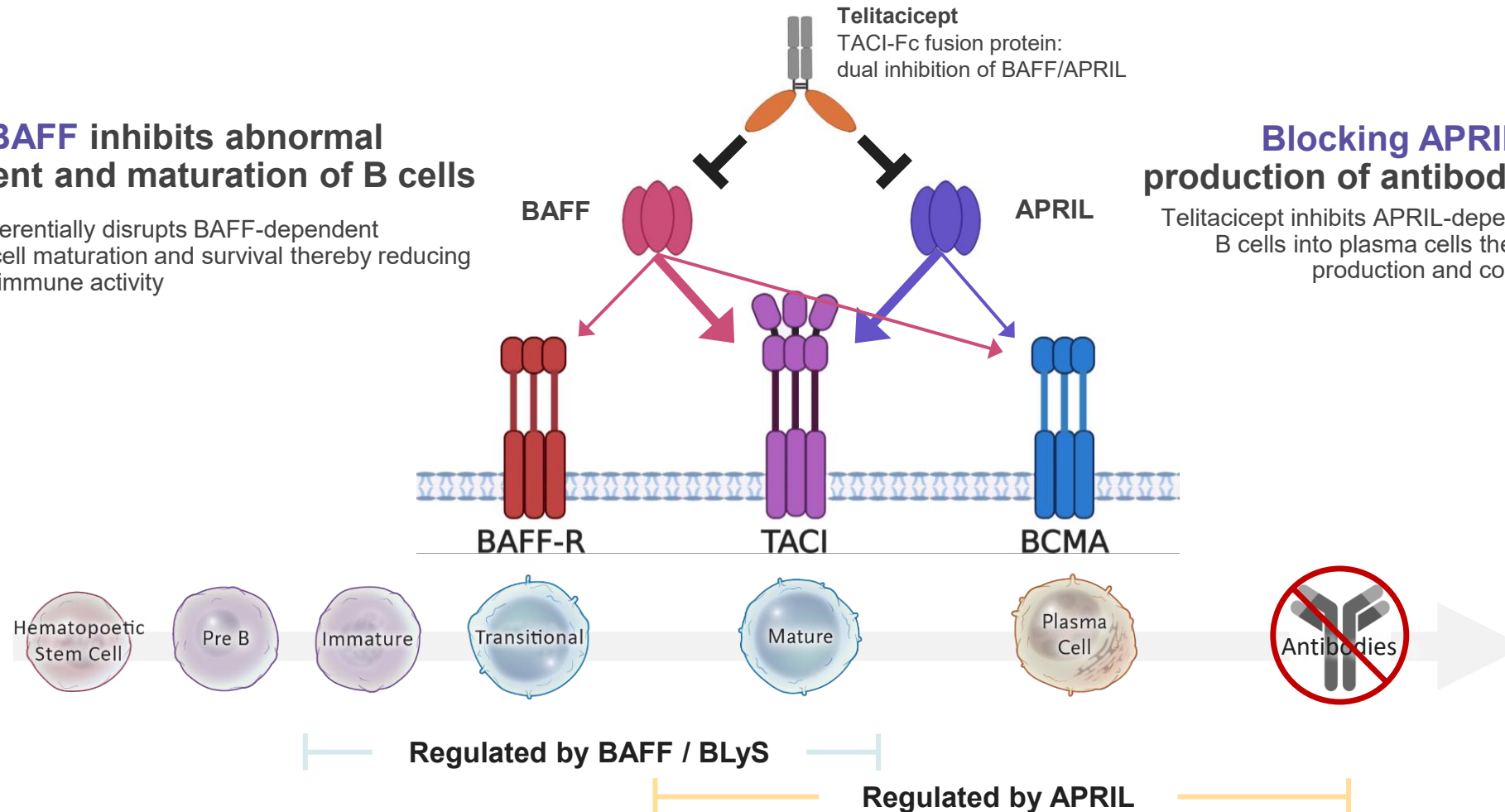
Disease modification through upstream control of B cell survival and downstream antibody production

Blocking BAFF inhibits abnormal development and maturation of B cells

Telitacept 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

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



Established Efficacy in China Across Autoimmune Diseases

3

Commercial Approvals

*Validated Commercial Therapy in China
Across Diverse Autoimmune Diseases*

2021 - Systemic Lupus Erythematosus (SLE)[†]

2024 - Rheumatoid Arthritis (RA)

2025 - Myasthenia Gravis (MG)

2

BLA Submissions

*Poised to Further Expand Telitacicept Footprint
in Large, Underserved Diseases in China*

Filed 2025 – Sjögren's Disease (SjD)

*Filed 2025 – IgA Nephropathy (IgAN)**

3

Best-In-Disease

*Unique Dual BAFF/APRIL Inhibition Drives
Superior Clinical Benefit*

Systemic Lupus Erythematosus

Myasthenia Gravis

Sjögren's Disease



Favorable Safety At Scale

10s of Thousands

Patients Treated Commercially in China

Favorable and Predictable Safety Profile Observed Among ~1,800* 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

	Telitacept (n=1211)	Placebo (n=527)
Upper respiratory tract infection	35	30
Injection site reaction	17	2
Urinary tract infection	10	9
Cough	5	3
Diarrhea	5	5



Advancing the Leading BAFF/APRIL Inhibitor

Strong cash position of ~\$530M 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)
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	OLE 48-wk Data – AANEM (10.29.25)
Primary Sjögren's Disease (pSjD)				BLA Submitted	★	LBA Poster Presentation – ACR (10.28.25)
IgA Nephropathy (IgAN)				BLA Submitted	★	LBA Oral Presentation – ASN (11.8.25)
Systemic Lupus Erythematosus (SLE)					China Marketed	NEJM Publication (10.16.25)
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		





Myasthenia Gravis

Moving Beyond IgG Therapies

A Large and Growing Global Opportunity in Myasthenia Gravis

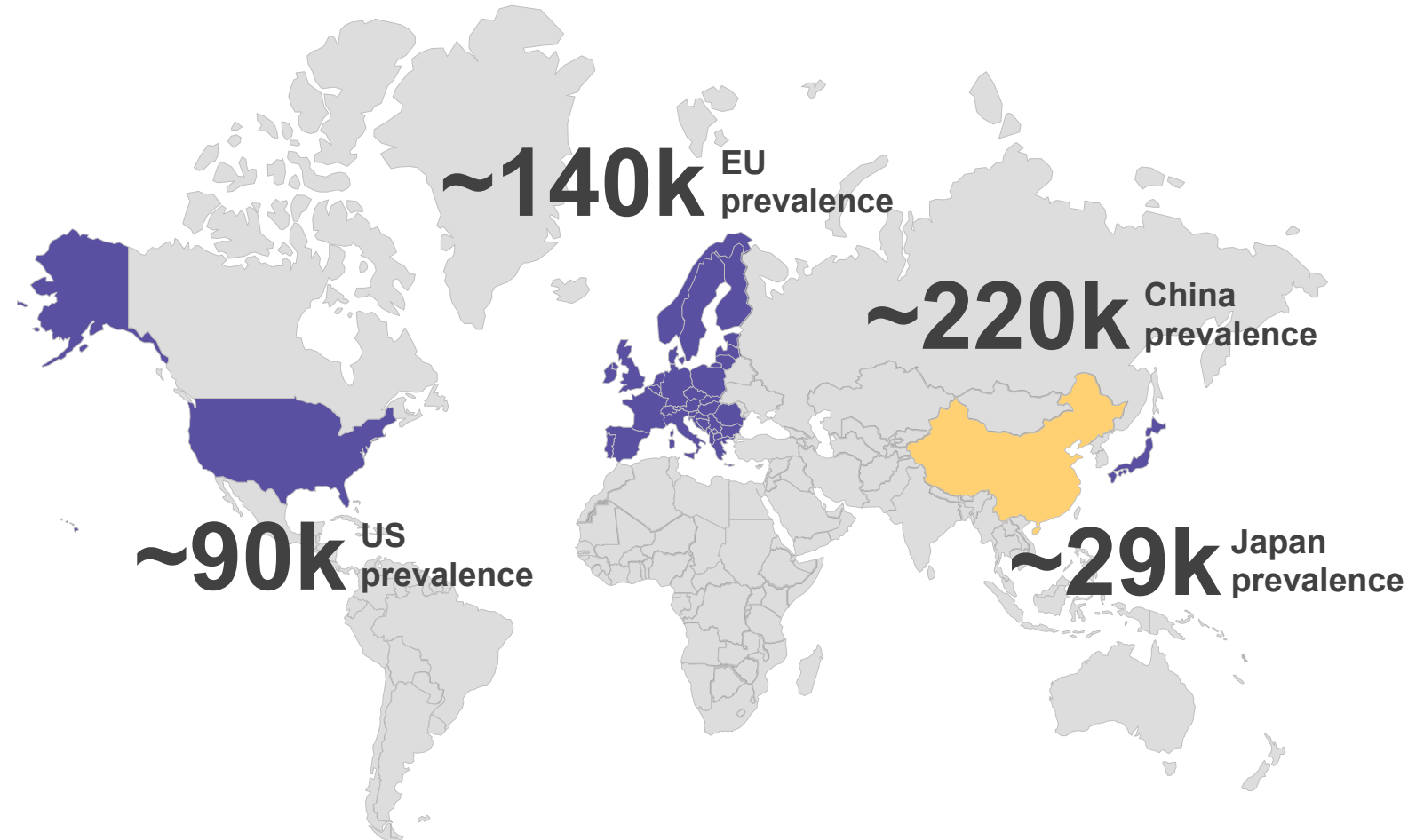
~260,000 diagnosed MG patients across key markets¹

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



MG Market Rapidly Expanding But Lacks Disease-Modifying Treatments

High growth market with underserved patient segments

gMG US Biologic Sales

~90,000

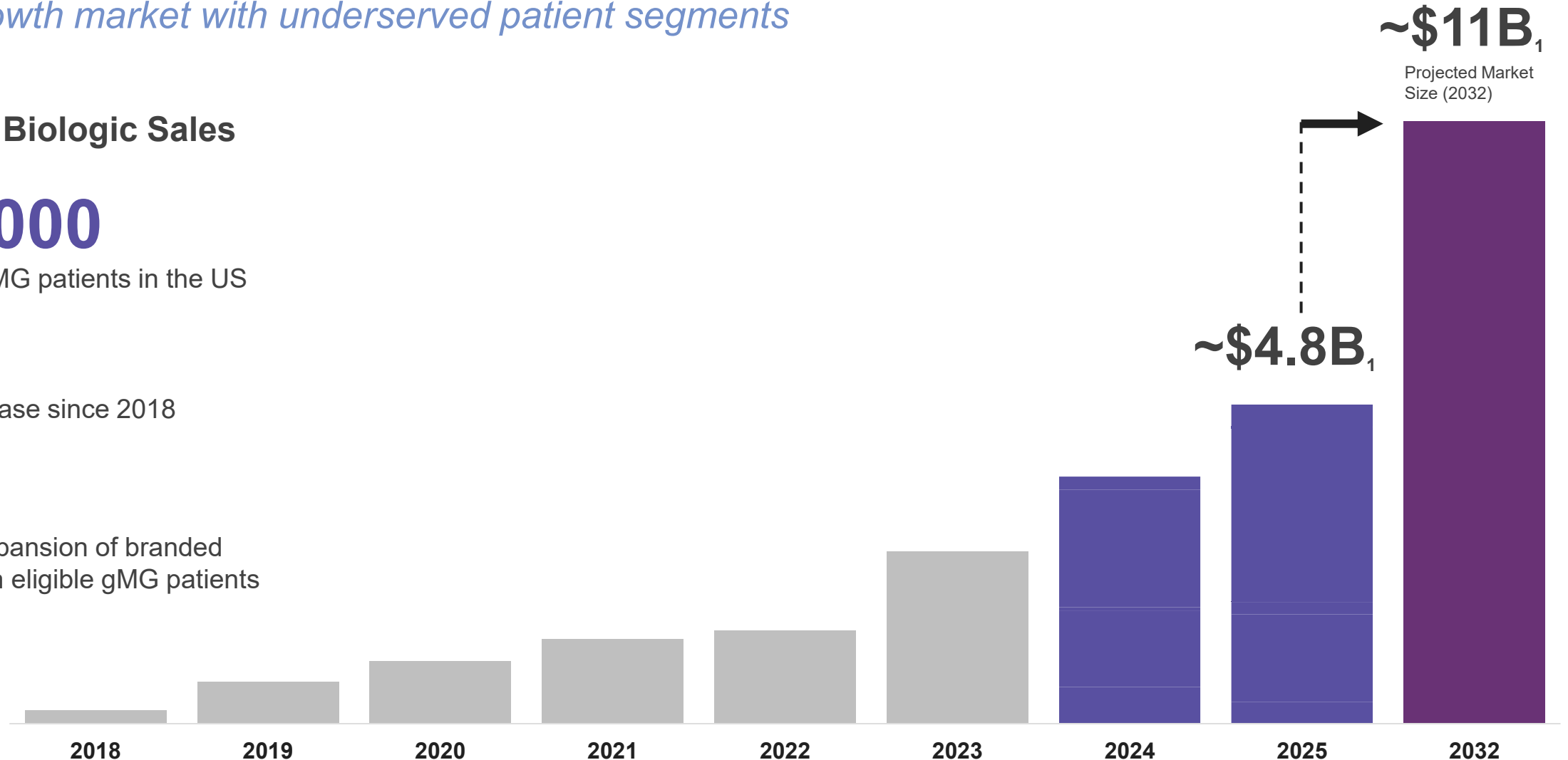
Diagnosed MG patients in the US

57%

CAGR increase since 2018

60%

Potential expansion of branded medicines in eligible gMG patients



Current Myasthenia Gravis Therapies Target Symptoms, Not Disease

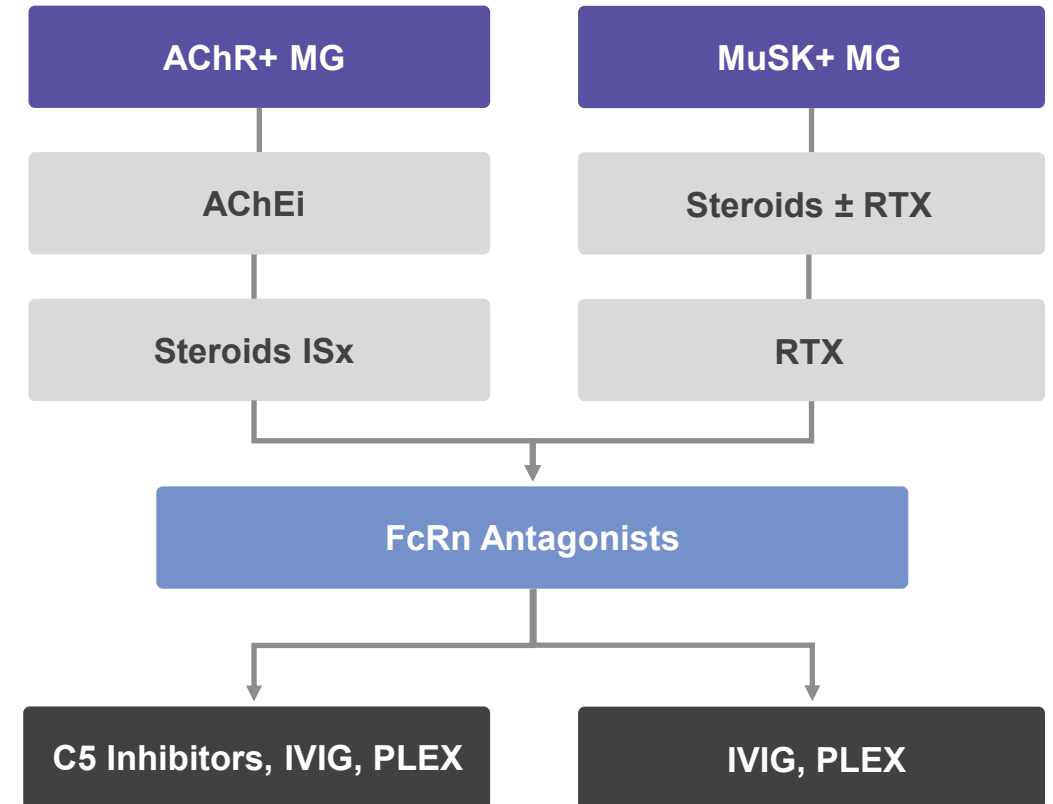
Even with the availability of biologics, unmet need for new therapies remain

Biologic use rising (~35% of gMG patients¹) with choices driven by efficacy, convenience, phenotype, and coverage

FcRn inhibitors dominate but ~20-50% of patients experience insufficient treatment responses²

Complement inhibitors limited by safety, black box warning, and vaccination requirements³

B cell depleting and cell therapies face challenges with efficacy, safety, and logistical limits despite disease-modifying potential⁴



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

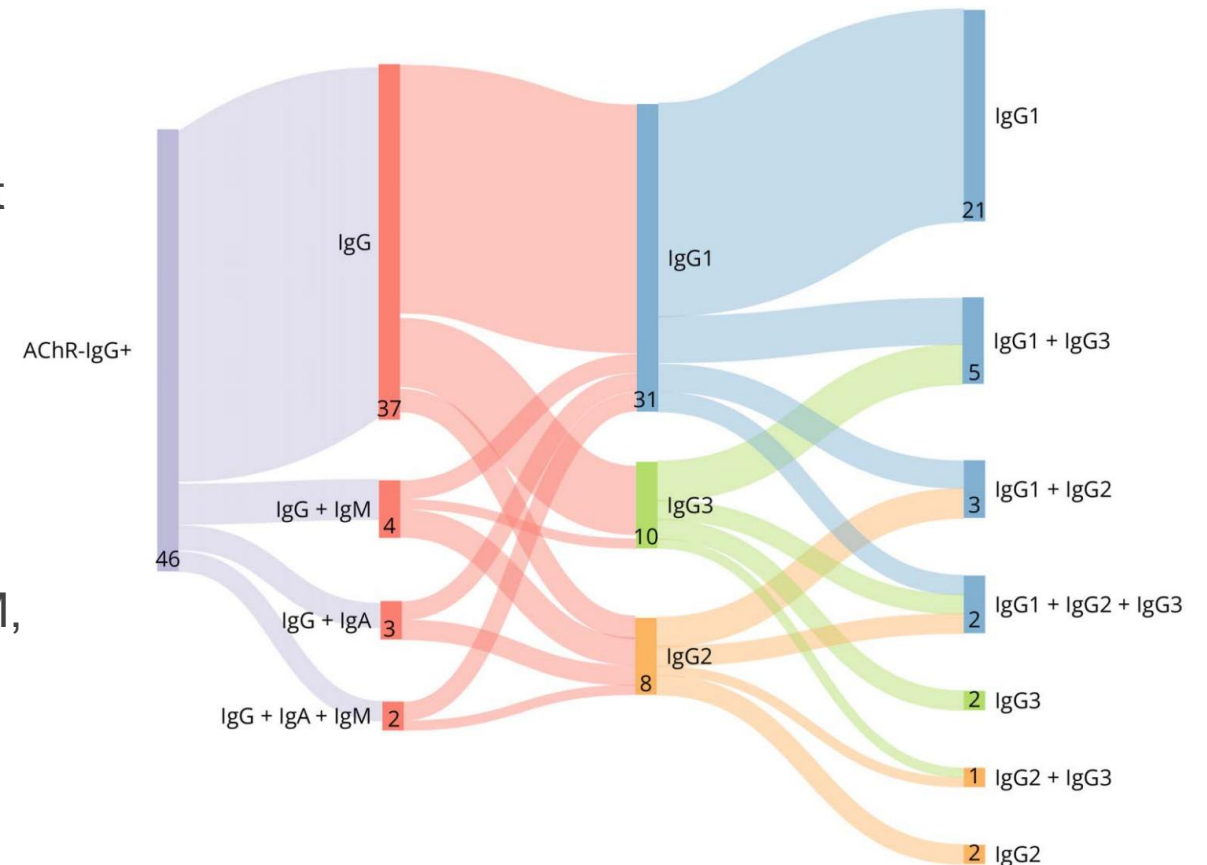
Patients carry different blends of IgG, IgA, and IgM, driving overlapping mechanisms

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



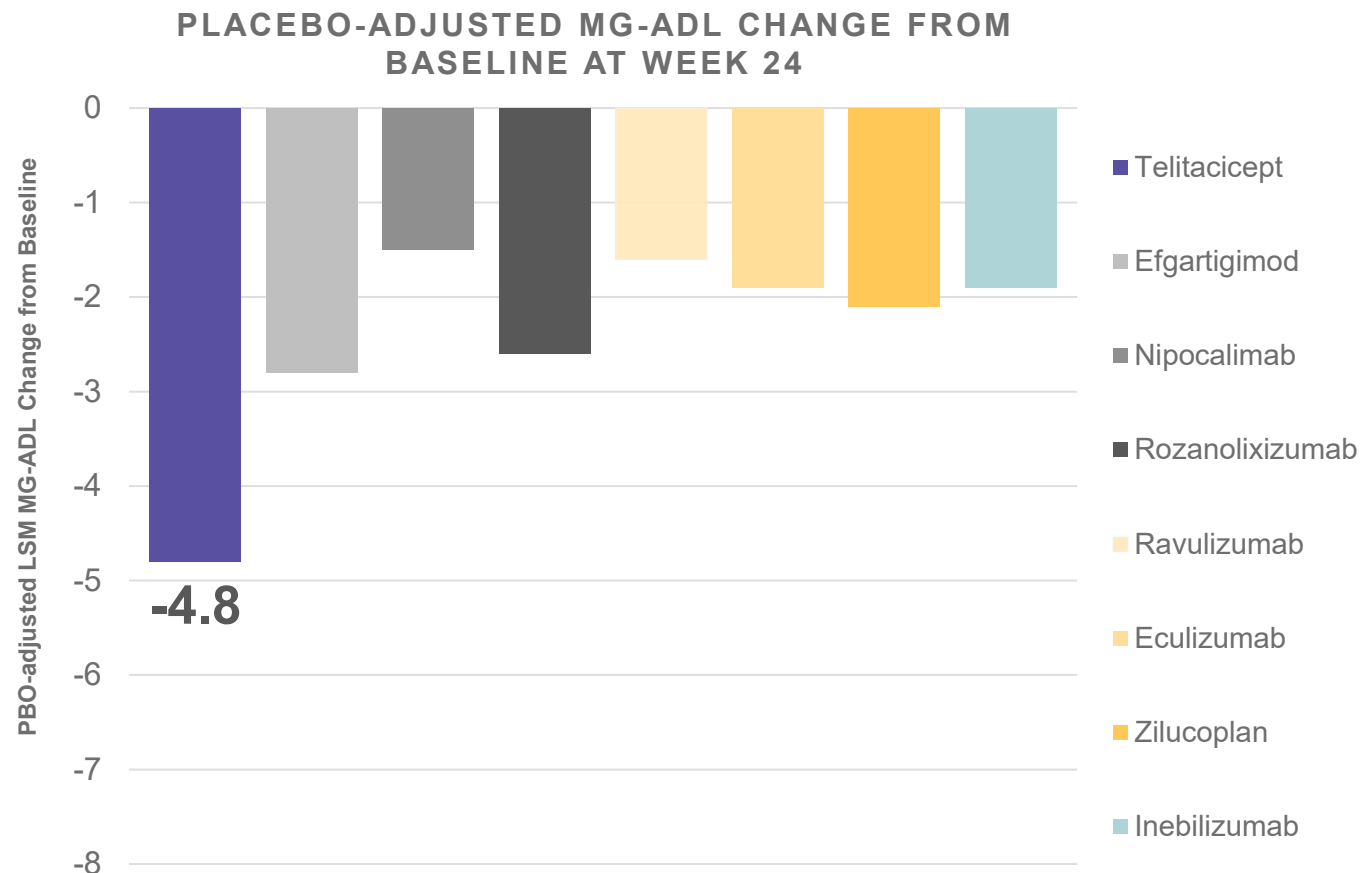
Myasthenia Gravis: The Beachhead Indication

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



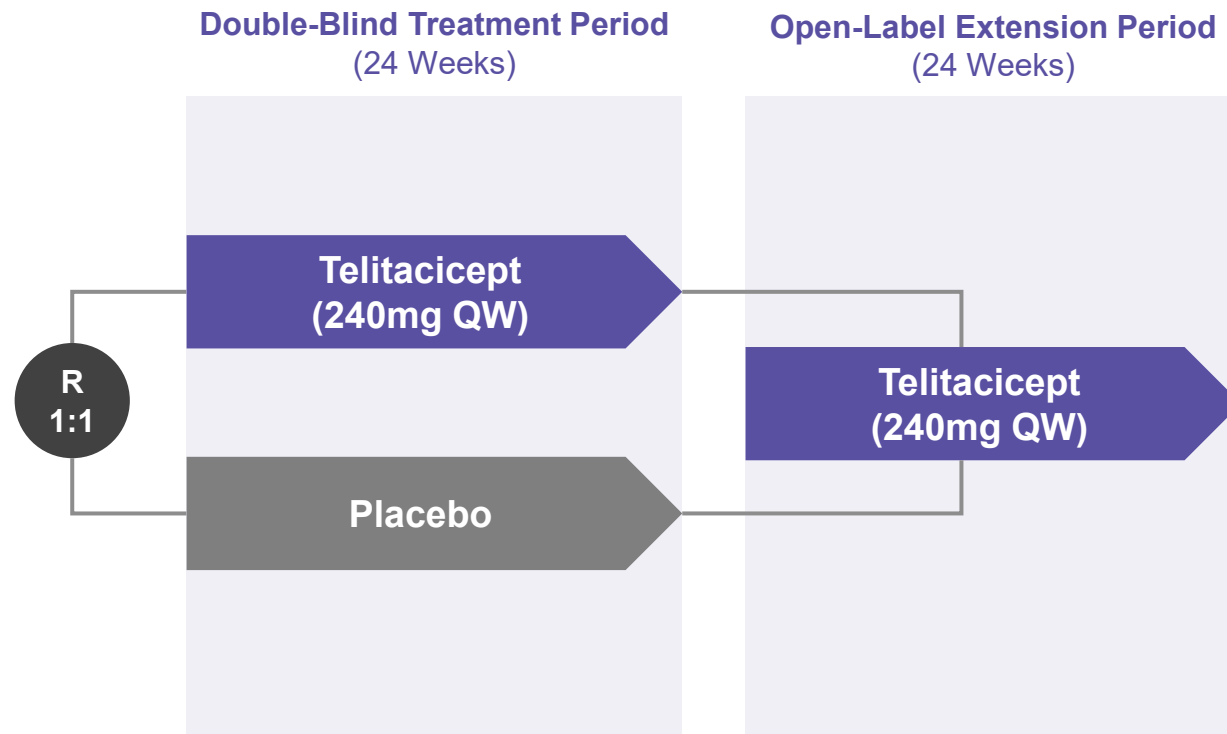
Based on historical clinical data; not a head-to-head trial



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

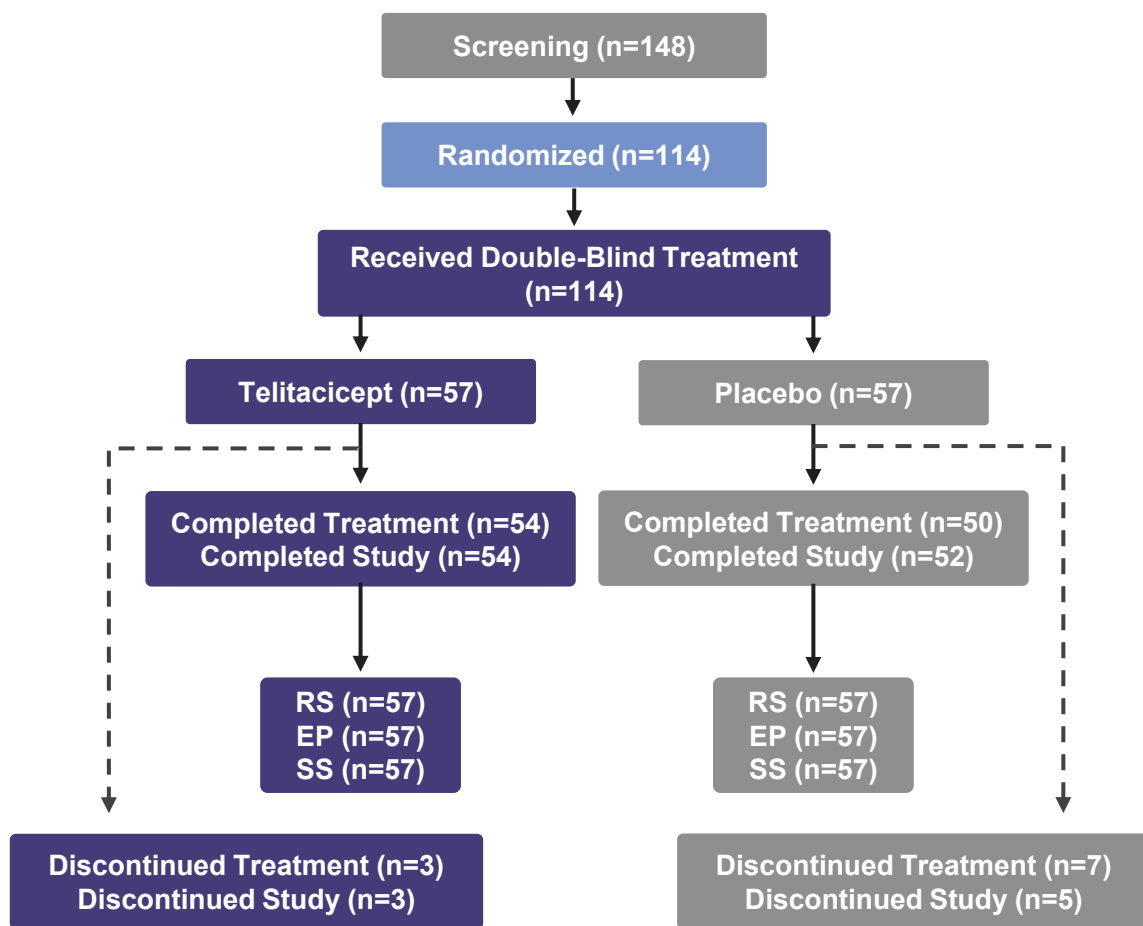
Secondary Endpoints

- 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



Well Balanced Baseline Characteristics

Consistent with recent global Phase 3 populations



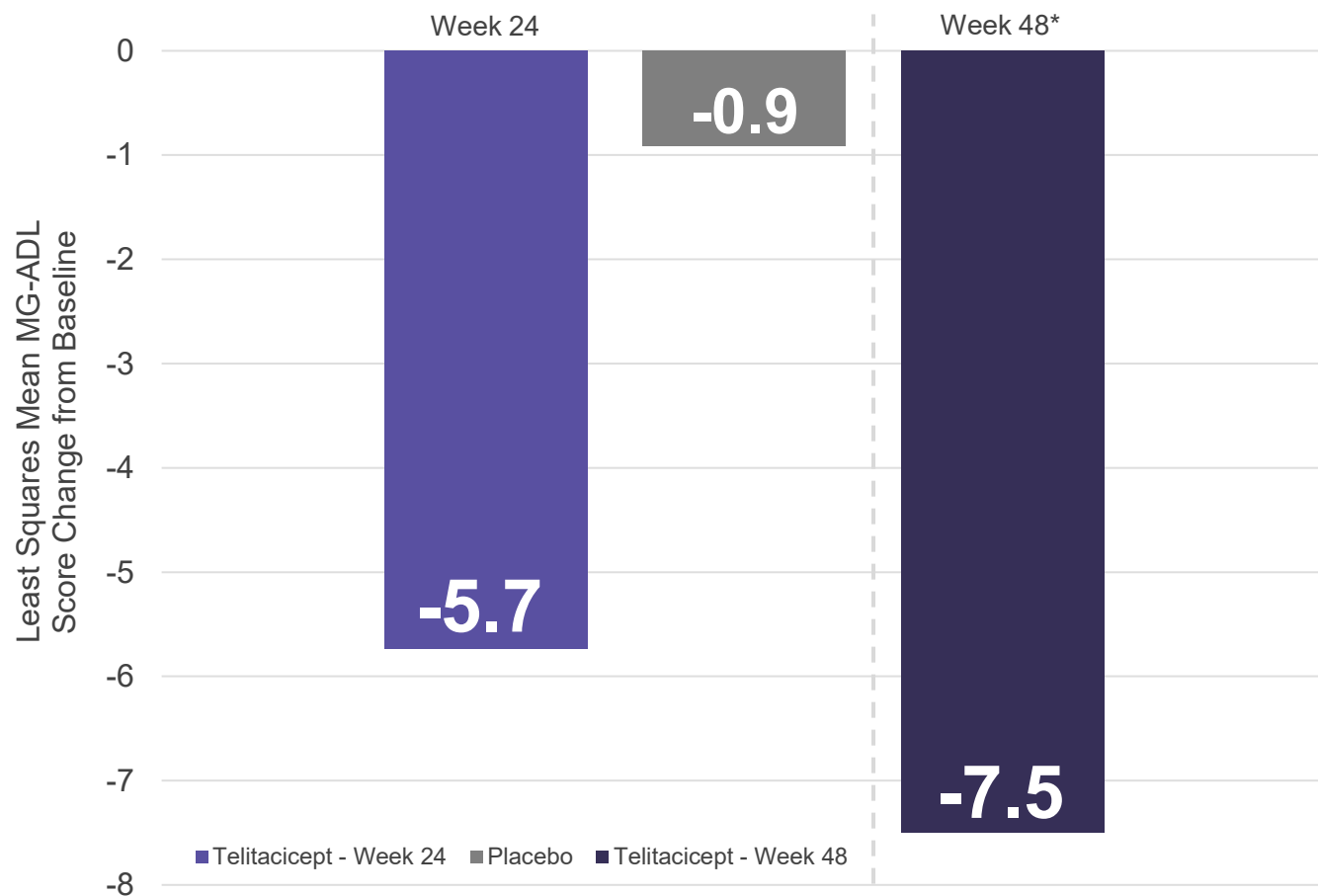
	Telitacicept (N=57)	Placebo (N=57)
Age (yr), mean ± SD	49.1 ± 14.69	49.6 ± 15.03
Sex		
Male, n (%)	30 (52.6)	21 (36.8)
Female, n (%)	27 (47.4)	36 (63.2)
Disease duration (month), mean ± SD	83.09 ± 84.507	76.05 ± 87.817
MGFA classification		
Class IIa, n (%)	3 (5.3)	12 (21.1)
Class IIIb, n (%)	14 (24.6)	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)



MG-ADL Responders - Primary Endpoint Met

Statistically significant and clinically meaningful improvement in activities of daily living

Change from Baseline in MG-ADL at Week 24 and Week 48*



Placebo-adjusted decrease in MG-ADL at Week 24:

-4.8 points

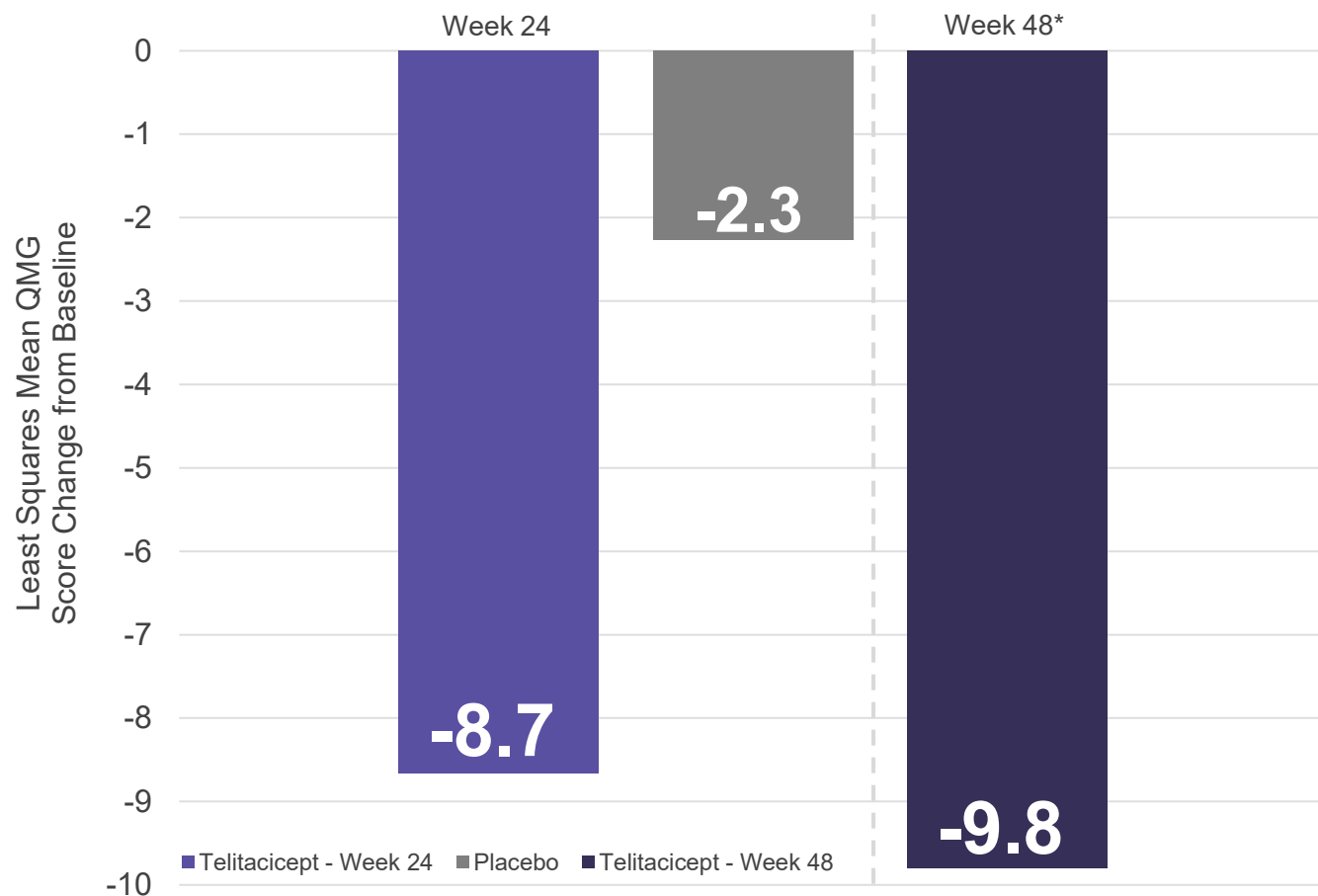
The primary estimate was analyzed using MMRM. Intercurrent event was predefined. Missing data was imputed.



QMG Responders - Secondary Endpoint Met

Statistically significant and clinically meaningful improvement in physician-assessed measure of muscle strength

Change from Baseline in QMG at Week 24 and Week 48*



Placebo-adjusted decrease in QMG at Week 24:

-6.4 points

The data was analyzed using MMRM. Missing data was imputed and as observed (AO) analysis was performed.

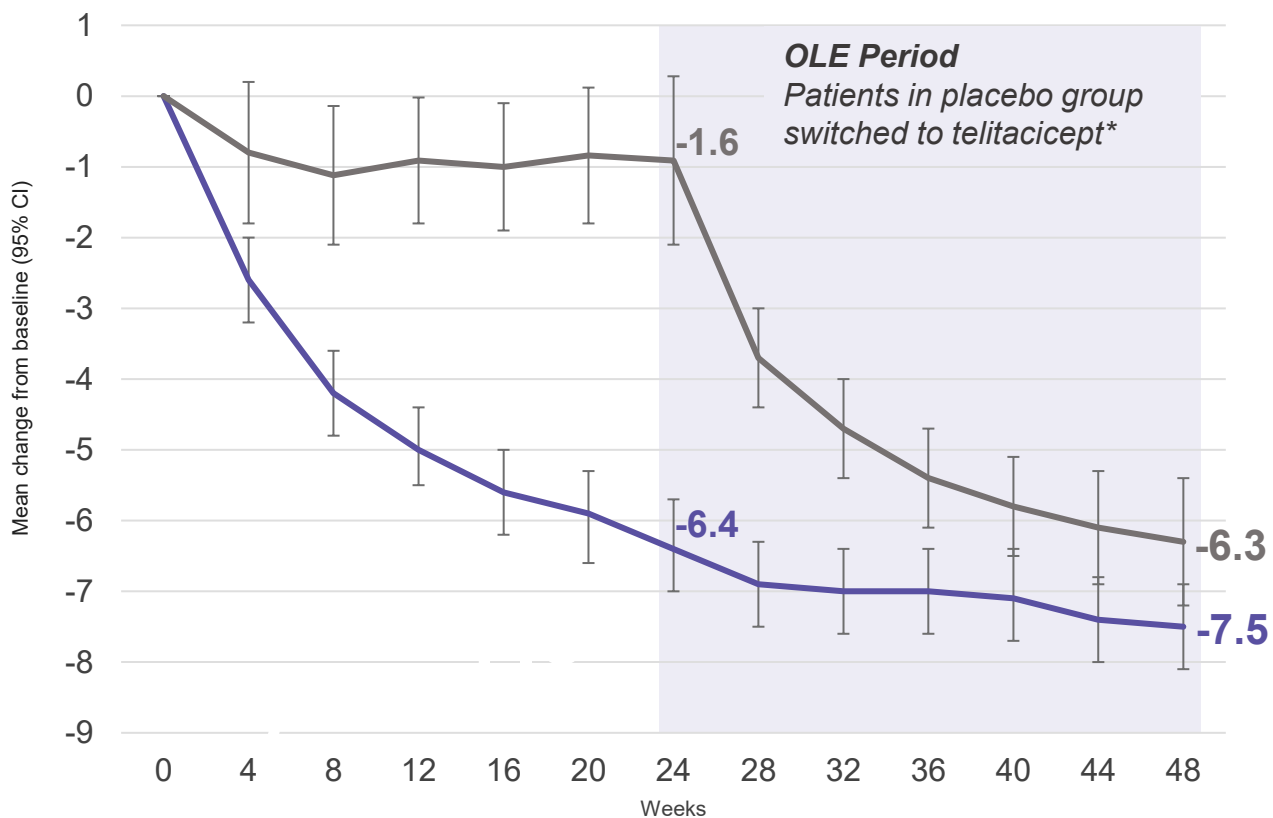
*AANEM 2025 Abstract – not placebo adjusted; QMG, Quantitative Myasthenia Gravis; MMRM, mixed models for repeated measures.



Telitacept Demonstrated Durable MG-ADL Over Time

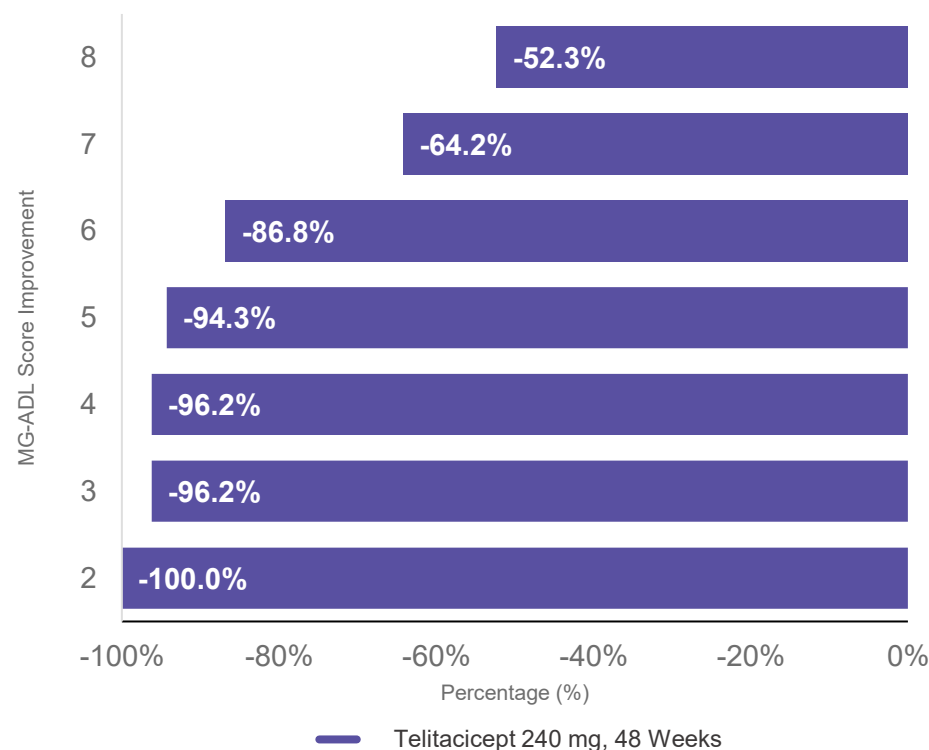
Sustained and deepening functional improvement through 48 weeks

MEAN CHANGE IN MG-ADL SCORE



— Telitacept 240 mg, 24 Weeks → Telitacept 240 mg, 24 Weeks
— Placebo 24, Weeks → Telitacept 240 mg, 24 Weeks

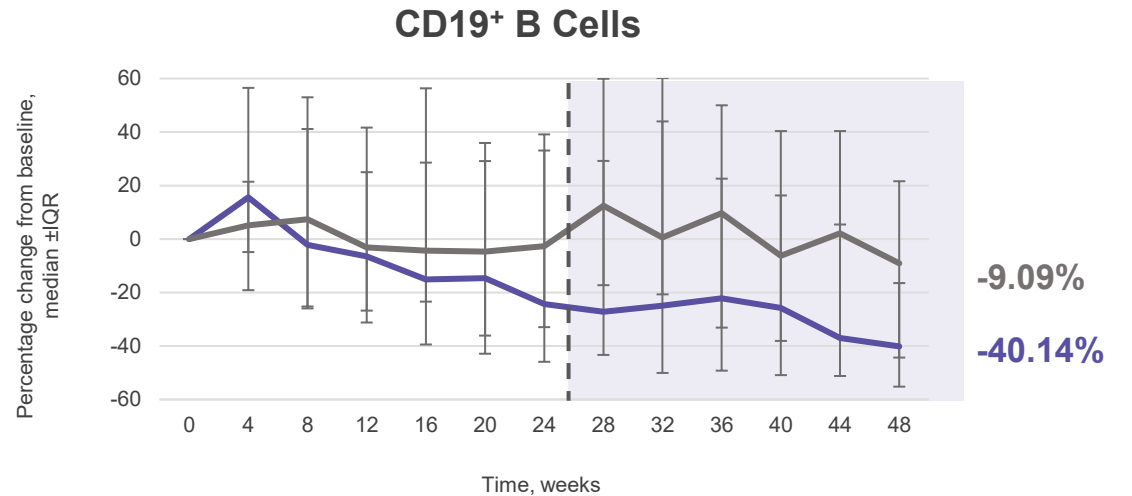
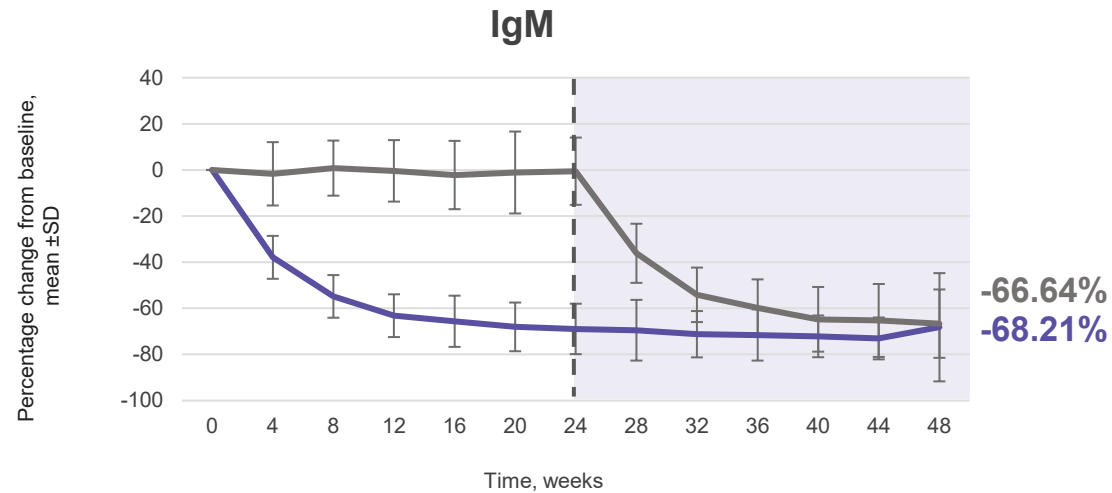
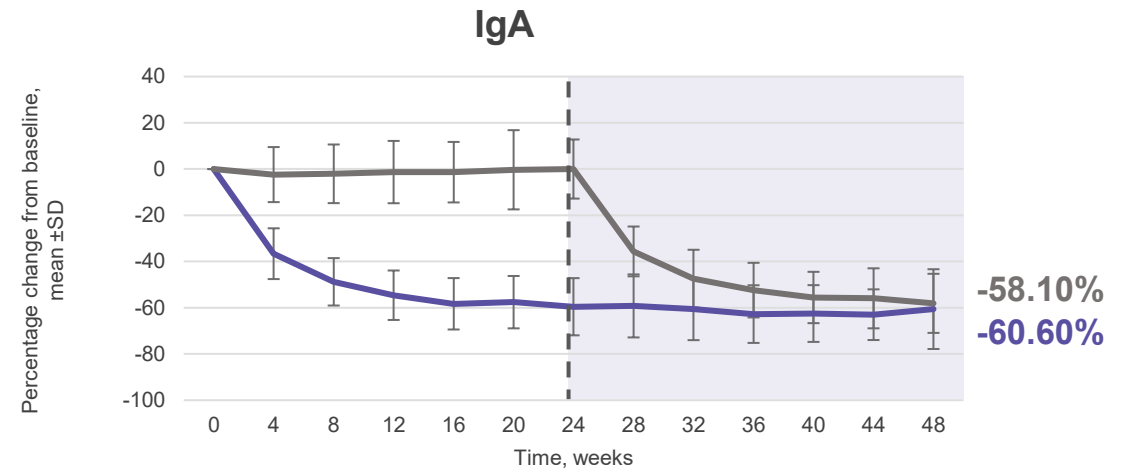
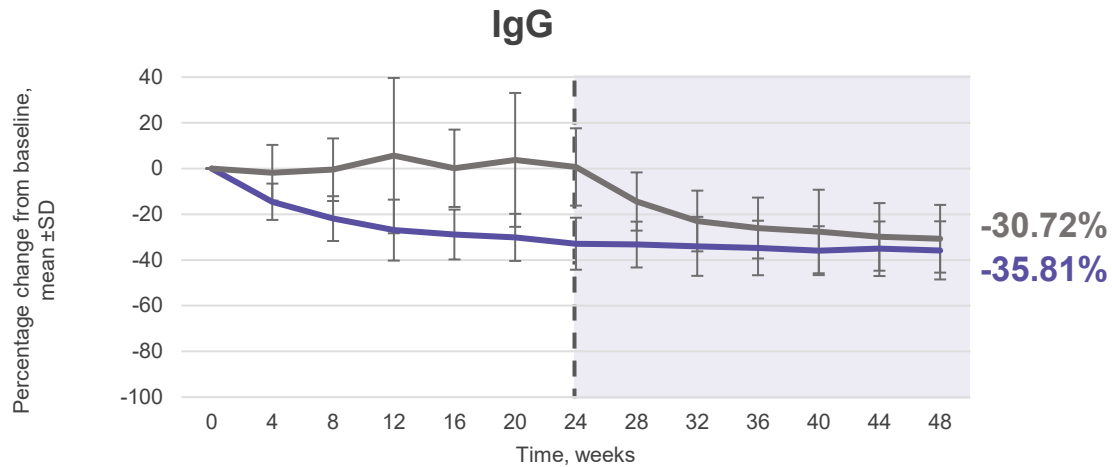
PERCENTAGE OF PATIENTS ACHIEVING IMPROVEMENT IN MG-ADL BY SCORE THRESHOLD AT WEEK 48



* Telitacept arm continue with the same treatment, Placebo arm switched to Telitacept 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.



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



— Telitacept 240 mg, 24 Weeks \rightarrow Telitacept 240 mg, 24 Weeks
 — Placebo 24, Weeks \rightarrow Telitacept 240 mg, 24 Weeks

*Patients in placebo group switched to telitacept. Patients in telitacept arm continued with telitacept 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

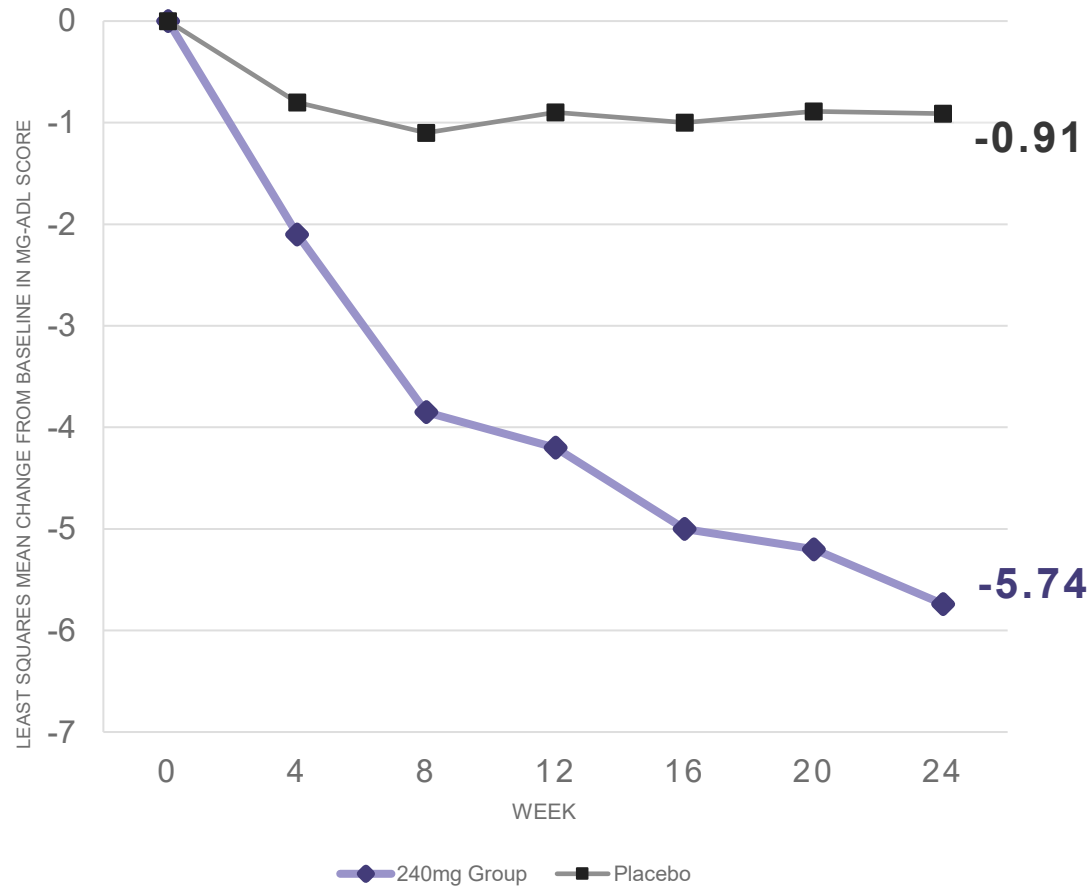
AE, adverse event; gMG, generalized myasthenia gravis; SjD, Sjogren's disease; SLE, systemic lupus erythematosus; RA, rheumatoid arthritis; IgAN, IgA nephropathy



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

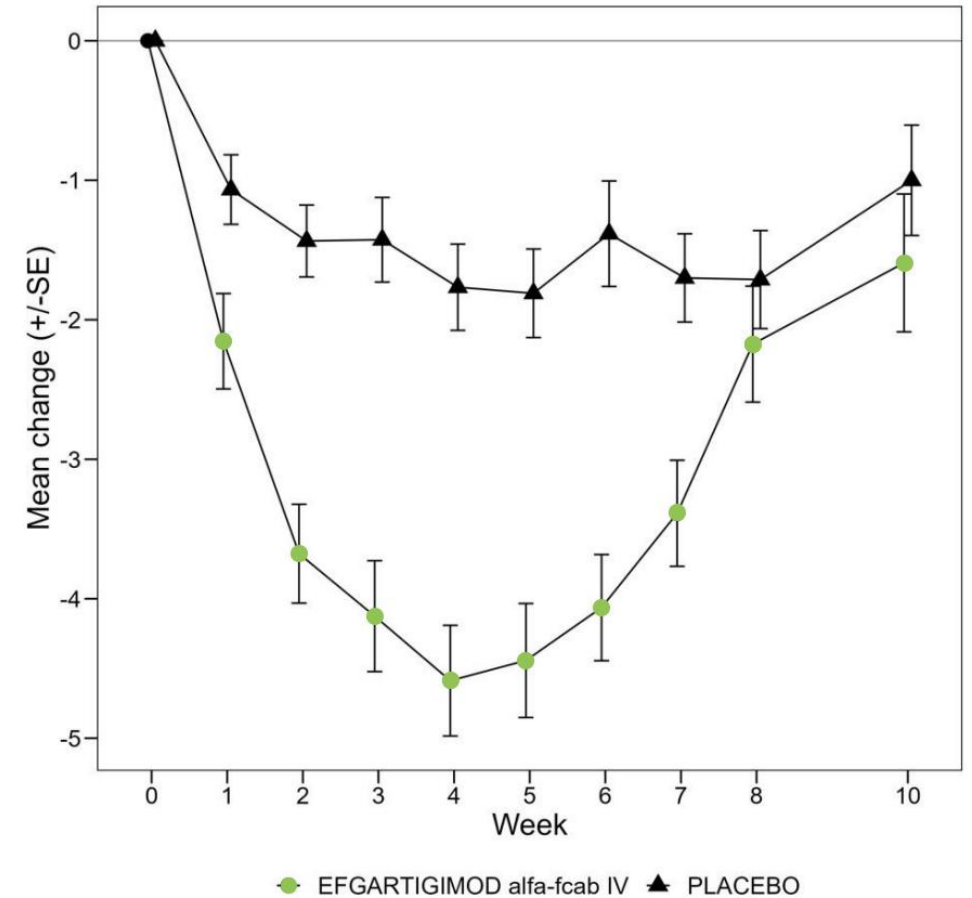
REMEGEN PHASE 3 CHINA TRIAL

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

†Missing data imputed as non-response.
MG-ADL, Myasthenia Gravis - Activities of Daily Living



Telitacicept Targets What Matters and Preserves What Protects

A balanced IgG and B cell reduction allows for superior outcomes

Telitacicept

VYVGART™
(efgartigimod alfa-fcab)

UPLIZNA™
inebilizumab-cdon

MoA	TACI-Fc	Anti-FcRn	Anti-CD19
IgG Reduction	25-35%	60-65%	N/A
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	Week 4	Week 24

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

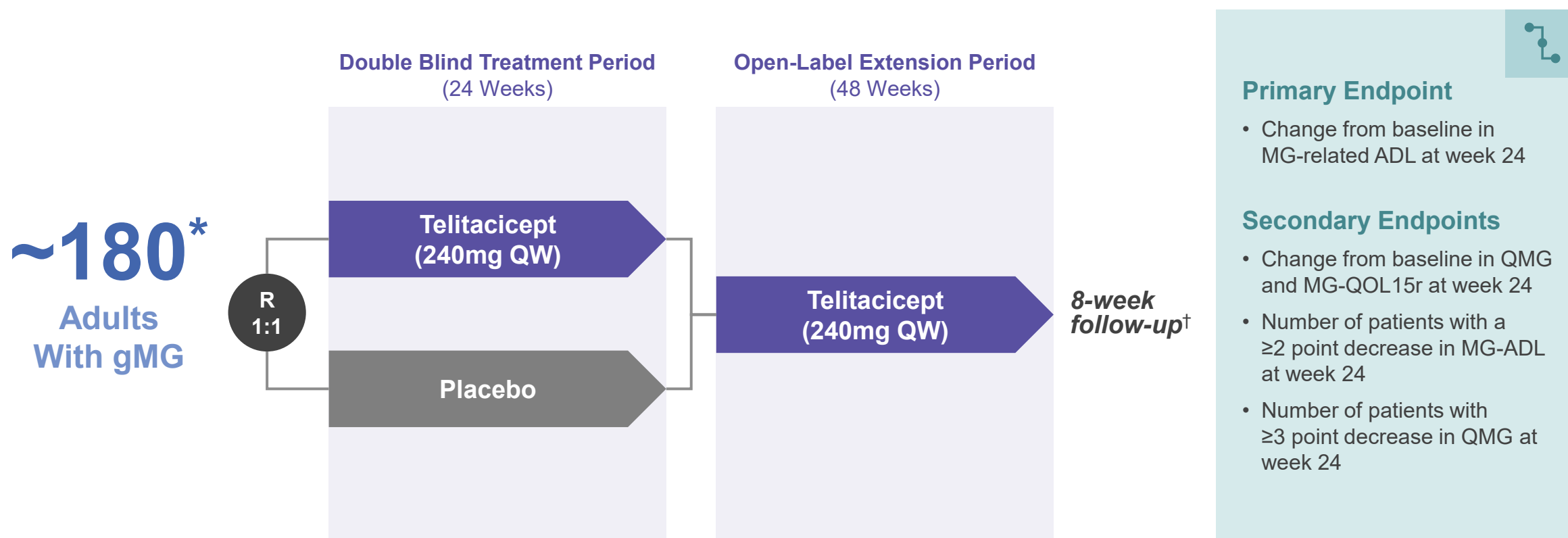
1. Argenx Phase 3 ADAPT Trial
2. Amgen Phase 3 MINT Trial
3. RemeGen China Phase 3 Trial

MoA, mechanism of action; MG-ADL, myasthenia gravis-activities of daily living; QMG, quantitative myasthenia gravis; PBO, placebo



UPSTREAM MG: Global Phase 3 in Generalized Myasthenia Gravis

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



Topline Global Phase 3 Data Anticipated in 1H27





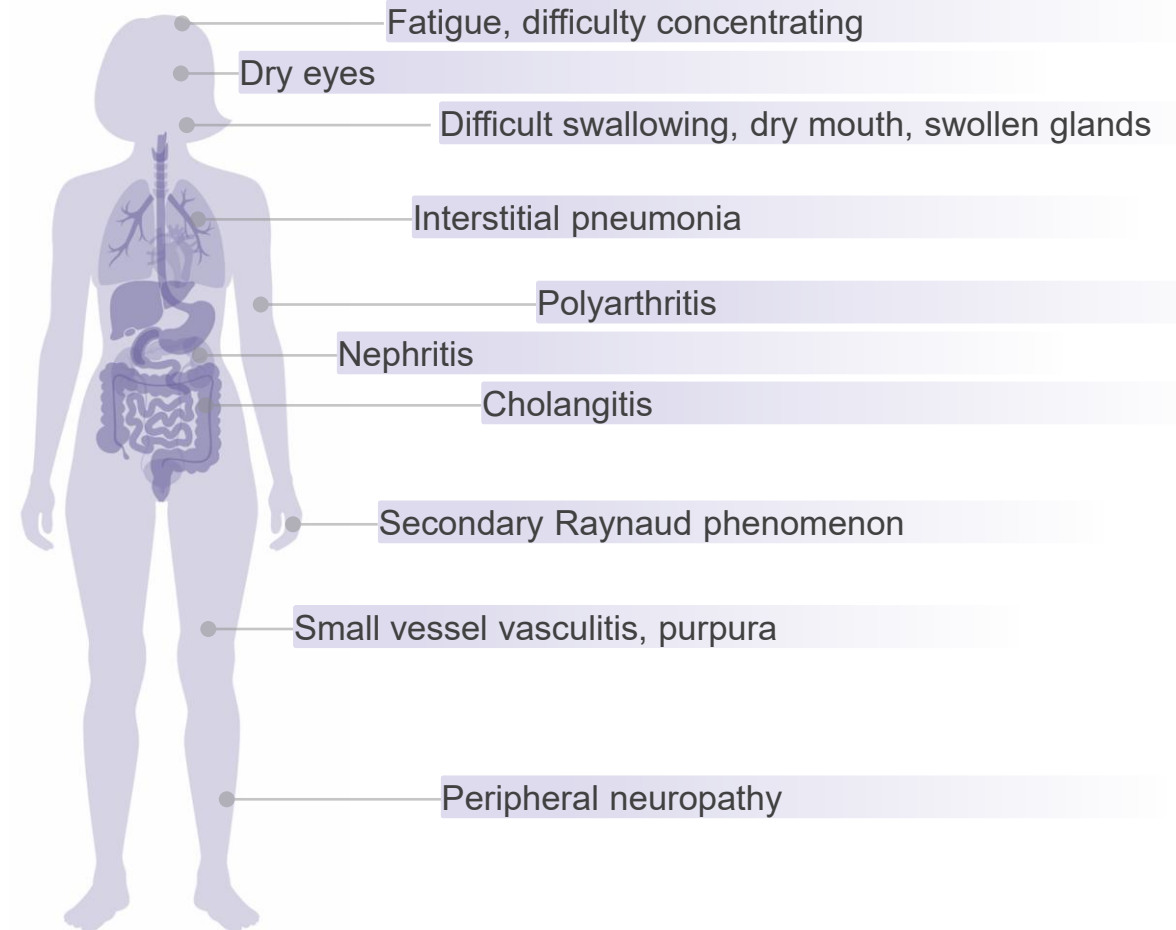
Sjögren's Disease

Moving Beyond Symptom Management

Sjögren's: A Large, Vastly Underserved Autoimmune Disease

Targeting ~100,000¹ addressable patient US opportunity with a potential best-in-disease profile

1	Symptom-Directed Local/topical therapies for dryness	ESSDAI 0
2	Mild-to-Moderate (No Major Organ Involvement) DMARDs (hydroxychloroquine, methotrexate)	ESSDAI 0-4
3	Moderate-to-Severe (Non-Life Threatening) Immunosuppressants (Methotrexate, azathioprine, or cyclosporine)	ESSDAI 5-13
4	Severe Disease (Major Organ Involvement) High potency immunosuppressants, biologics	ESSDAI ≥14



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

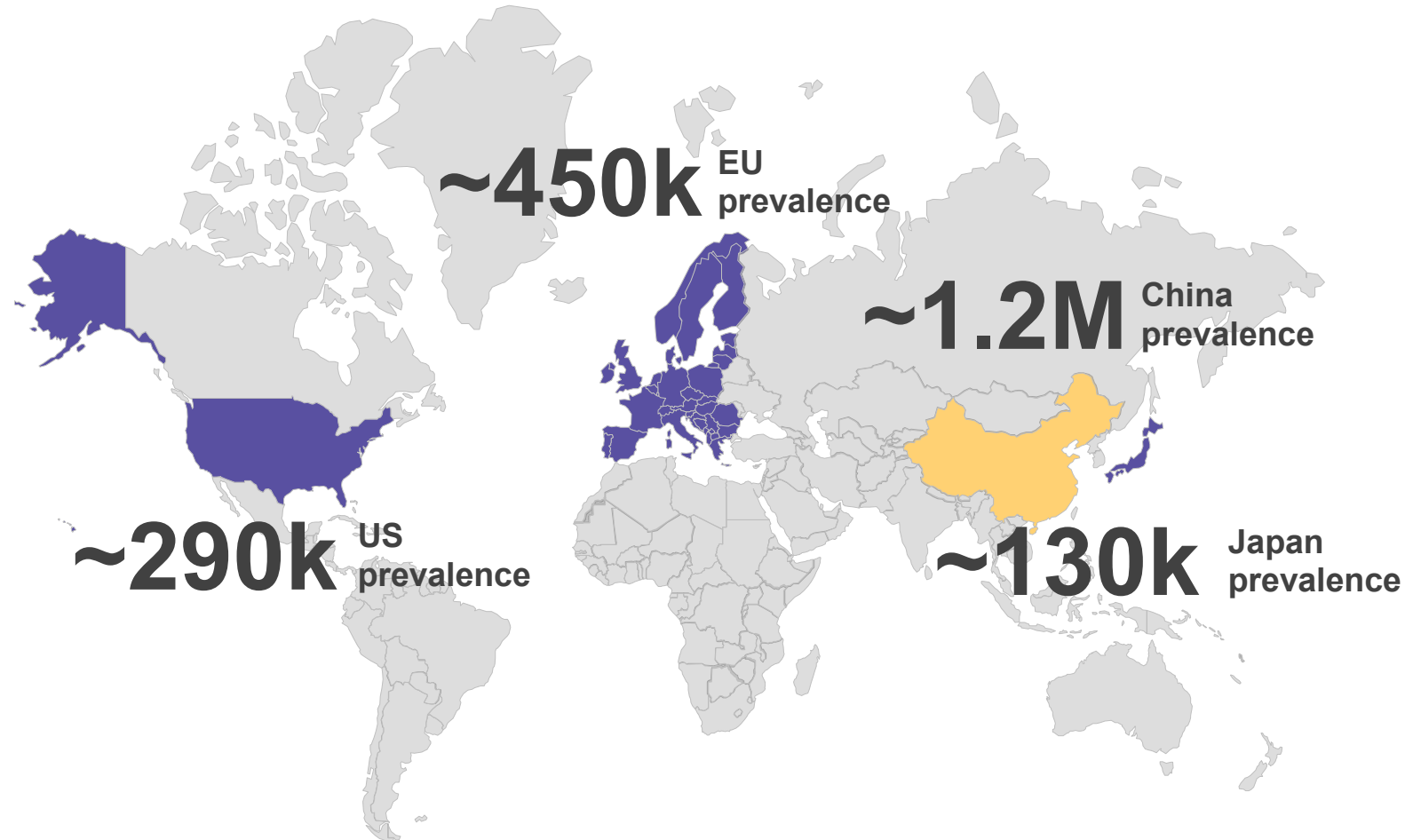
~870,000 diagnosed Sjögren's patients across key markets¹

Favorable Growth Drivers

- Rising diagnosis rates from better awareness and testing

Underpenetrated Market

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



ACR | Potential to Redefine Treatment in SjD

Telitacept showed statistically significant and clinically meaningful improvement in SjD

A True Signal, No Noise

- No DMARDs, no steroids

Clinically Meaningful, Statistically Clear

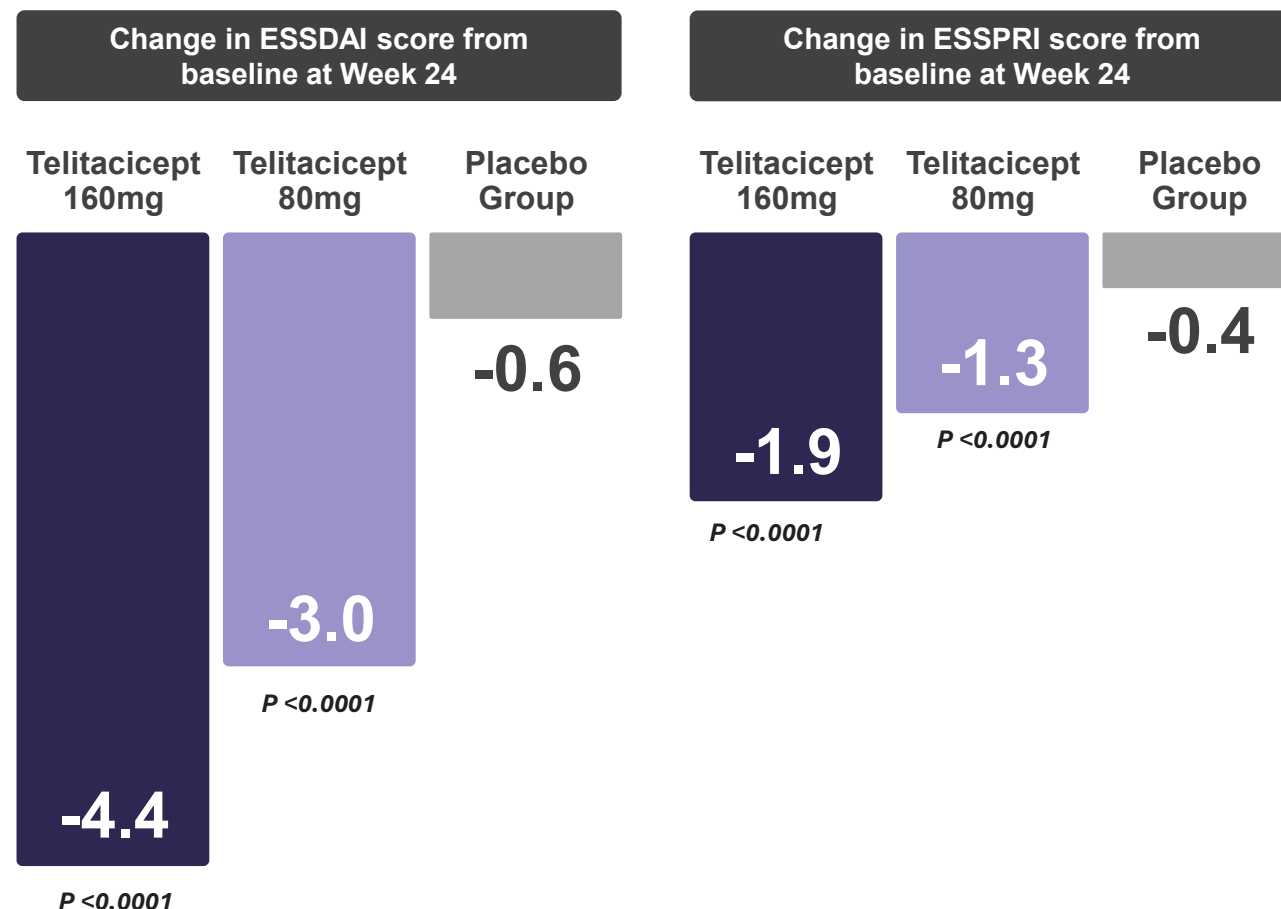
- Robust, dose-dependent improvements across physician- and patient-assessed outcomes

Depth and Durability Across Domains

- Improvement of systemic activity, symptoms, and function

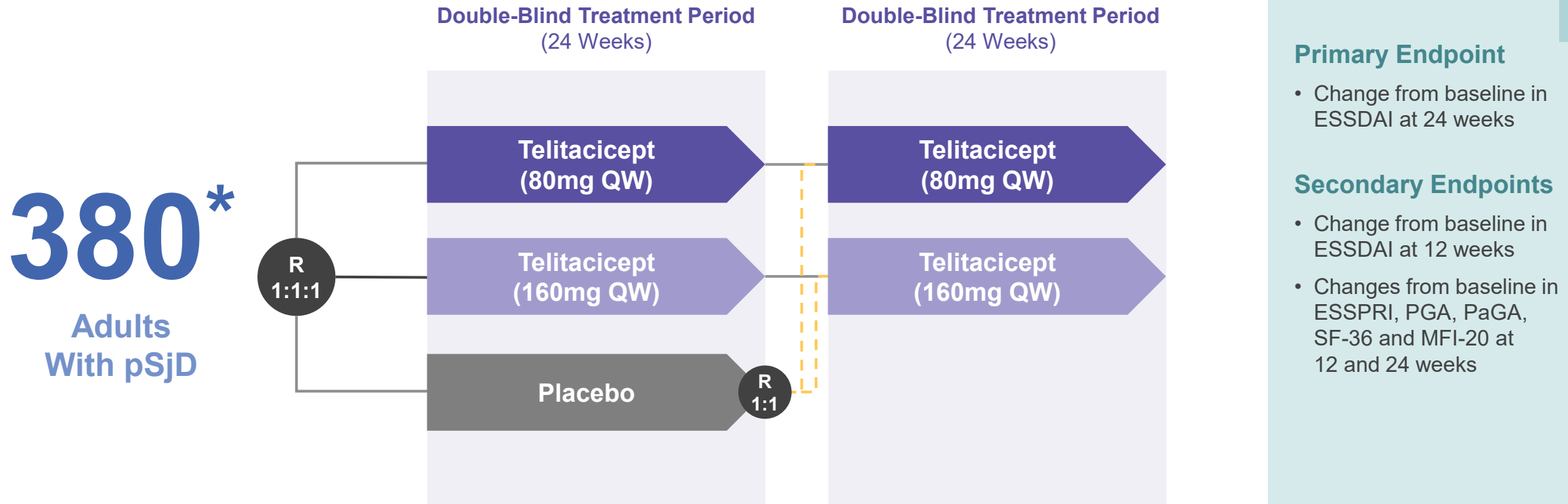
Consistent Safety Profile

- No new safety signals. No opportunistic infection reported.



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

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

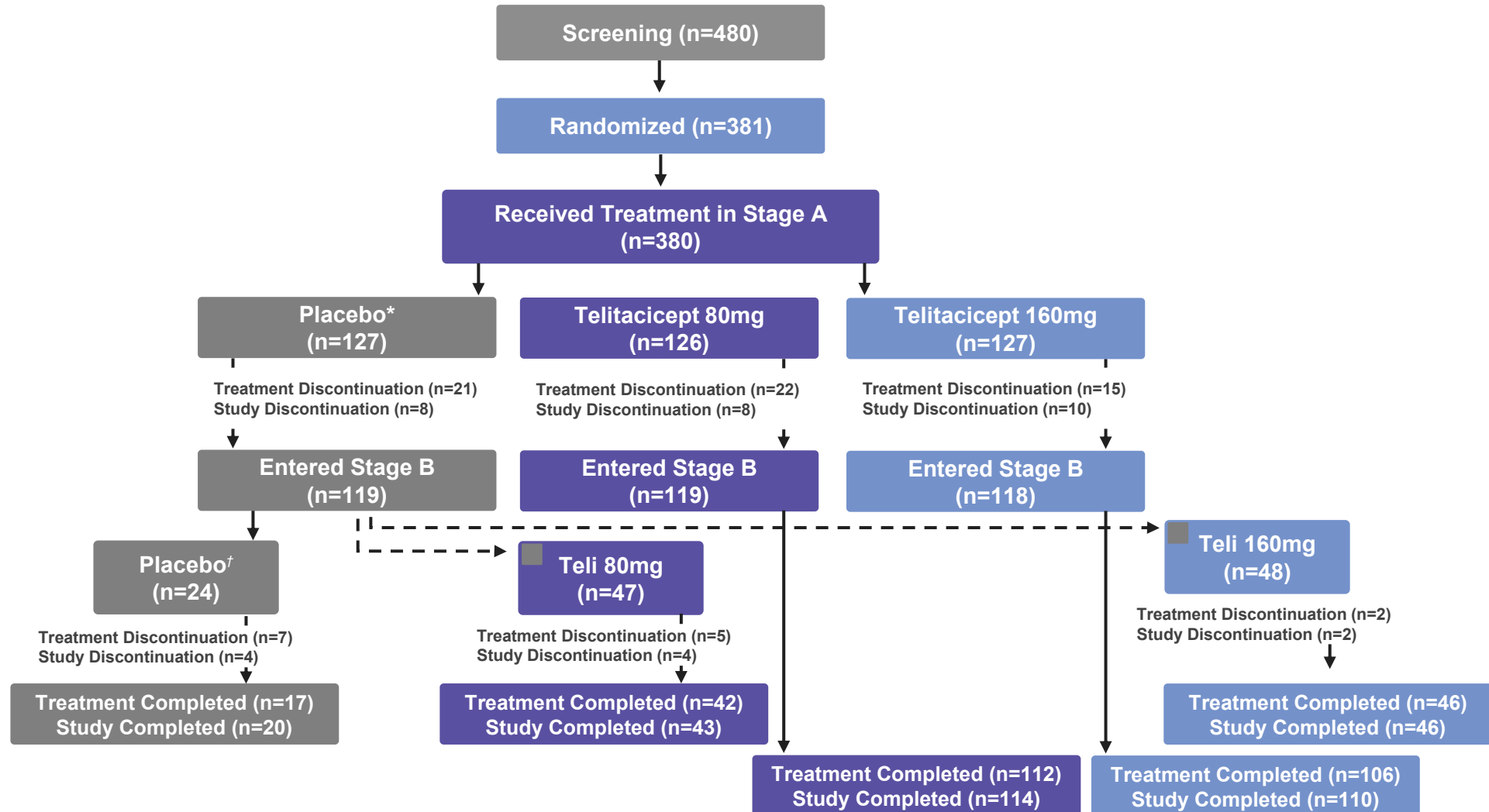


Primary Endpoint Achieved in August 2025



Patient Disposition

Strong study execution across 79 sites in China



Baseline Characteristics

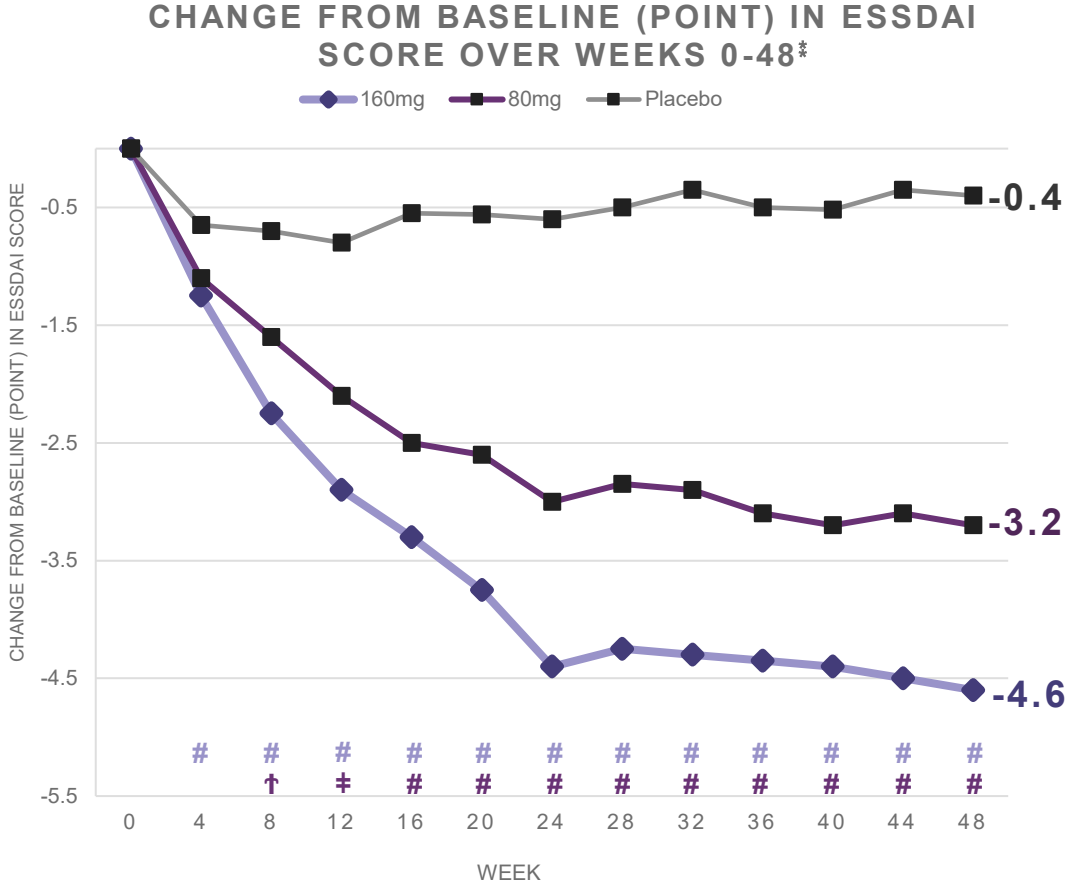
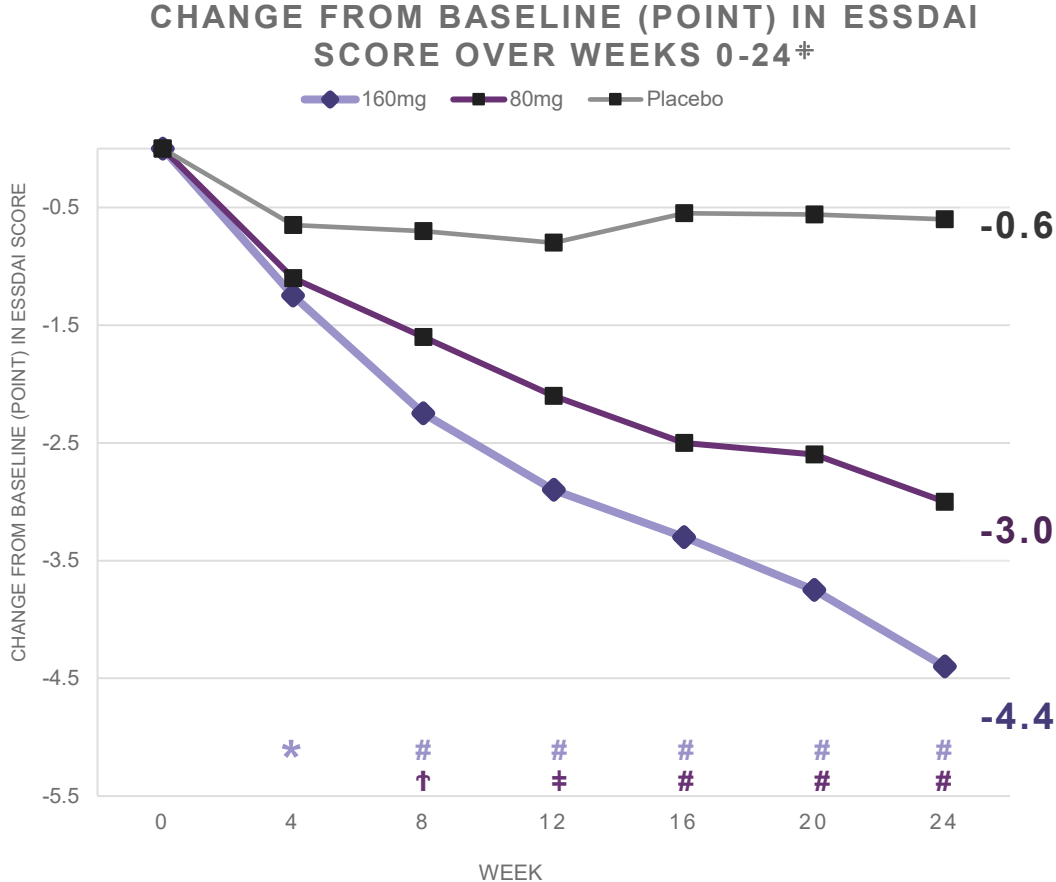
Well-balanced, representative patient population across treatment arms

	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/m²), 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)



Deep, Consistent ESSDAI Reduction Through 48 Weeks

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



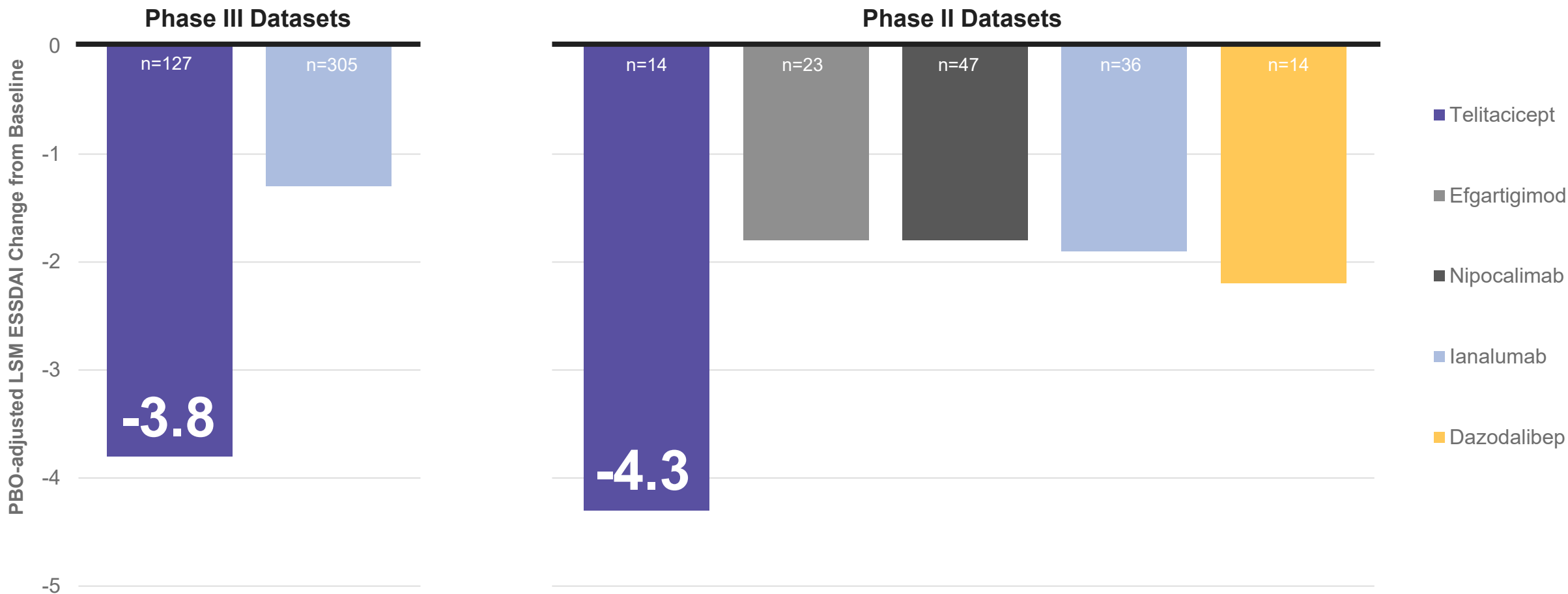
(* $P < 0.05$, † $P < 0.01$, ‡ $P < 0.001$, # $P < 0.0001$)

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 telitacept groups and the placebo group were handled with the RemeGen-sponsored trial LOCF method, i.e. imputing all the post-switching values with the most recent pre-switching results.



Telitacicept: Potential Best-In-Disease Efficacy Globally

Statistically significant and clinically meaningful improvement in ESSDAI



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

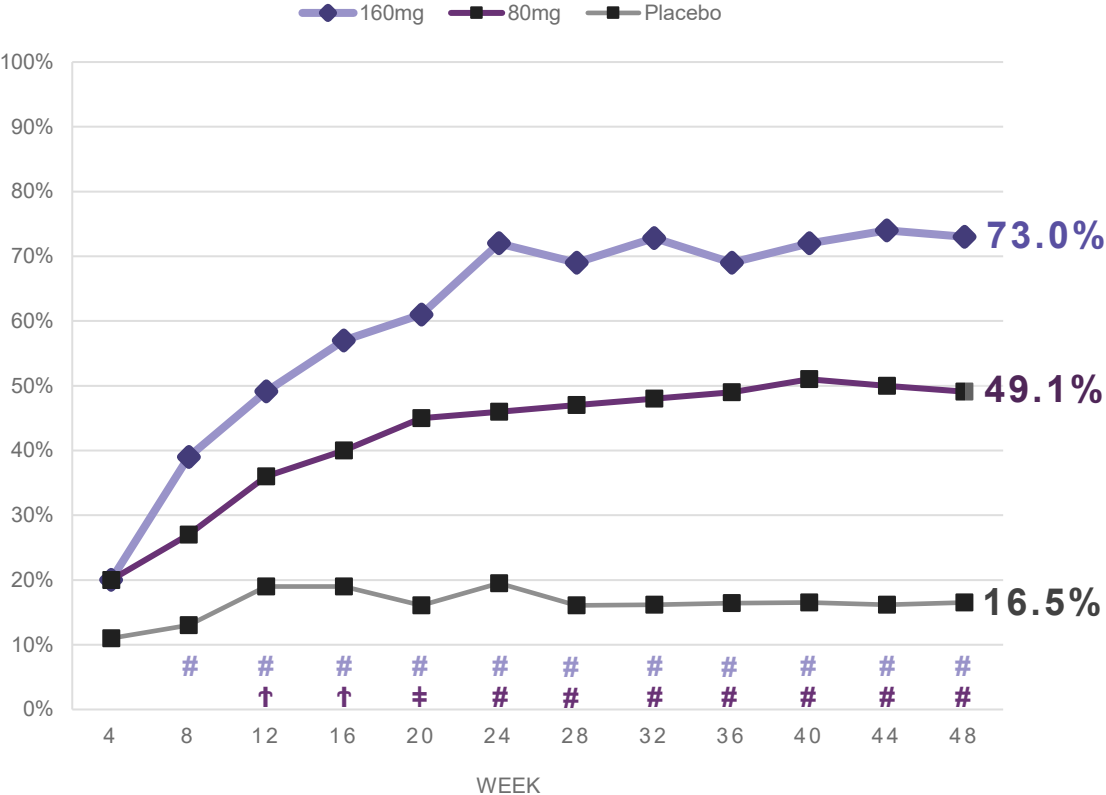
ESSDAI, EULAR Sjögren's syndrome disease activity index



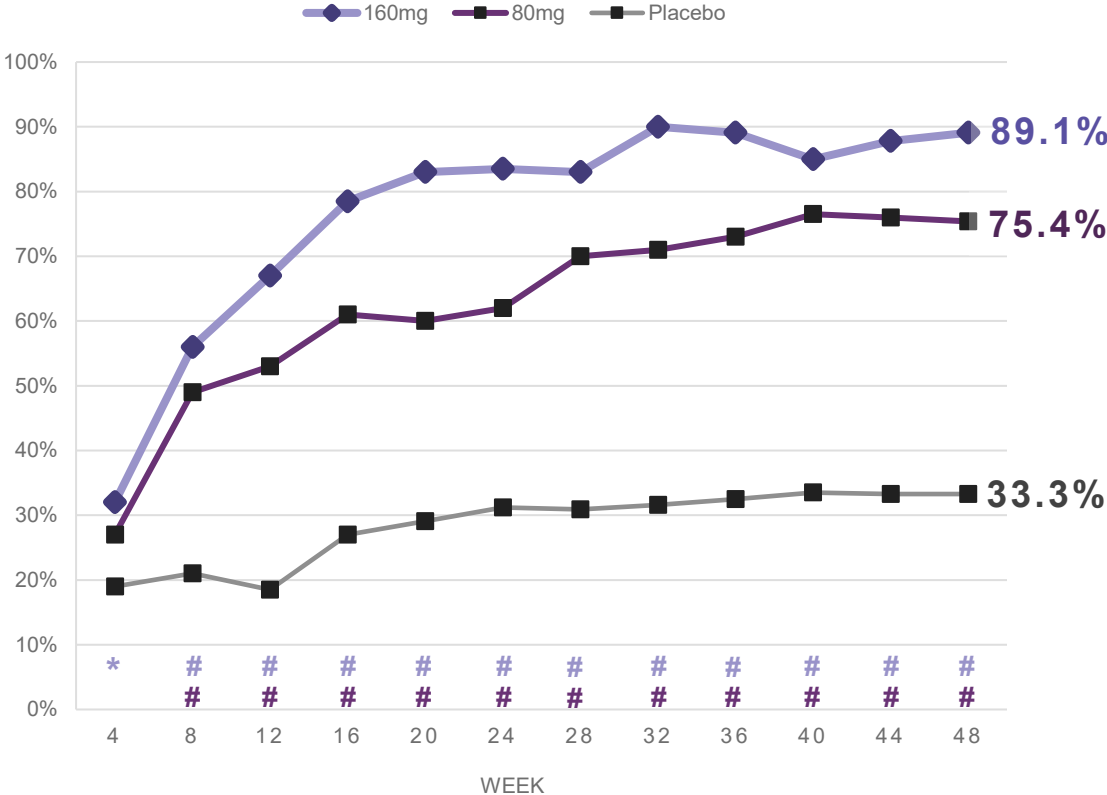
Early, Broad Symptom Improvements Observed with Telitacicept

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**



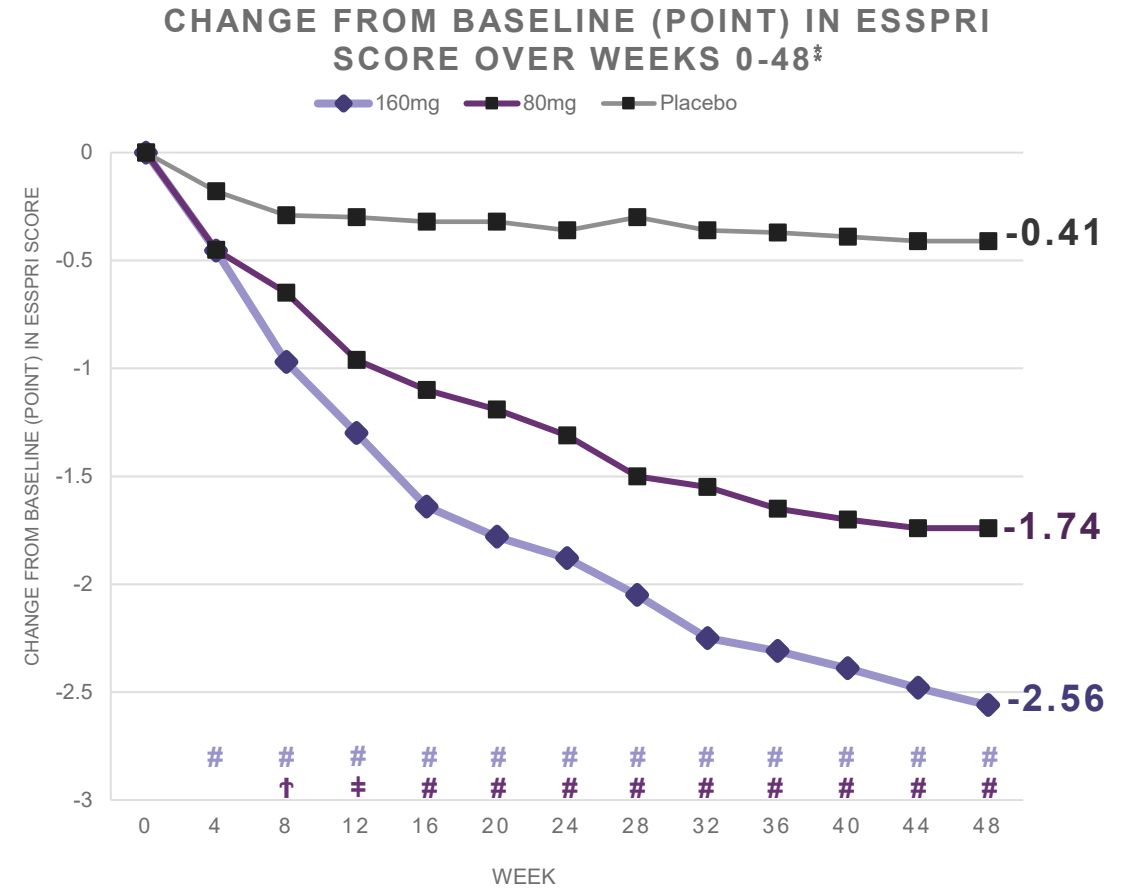
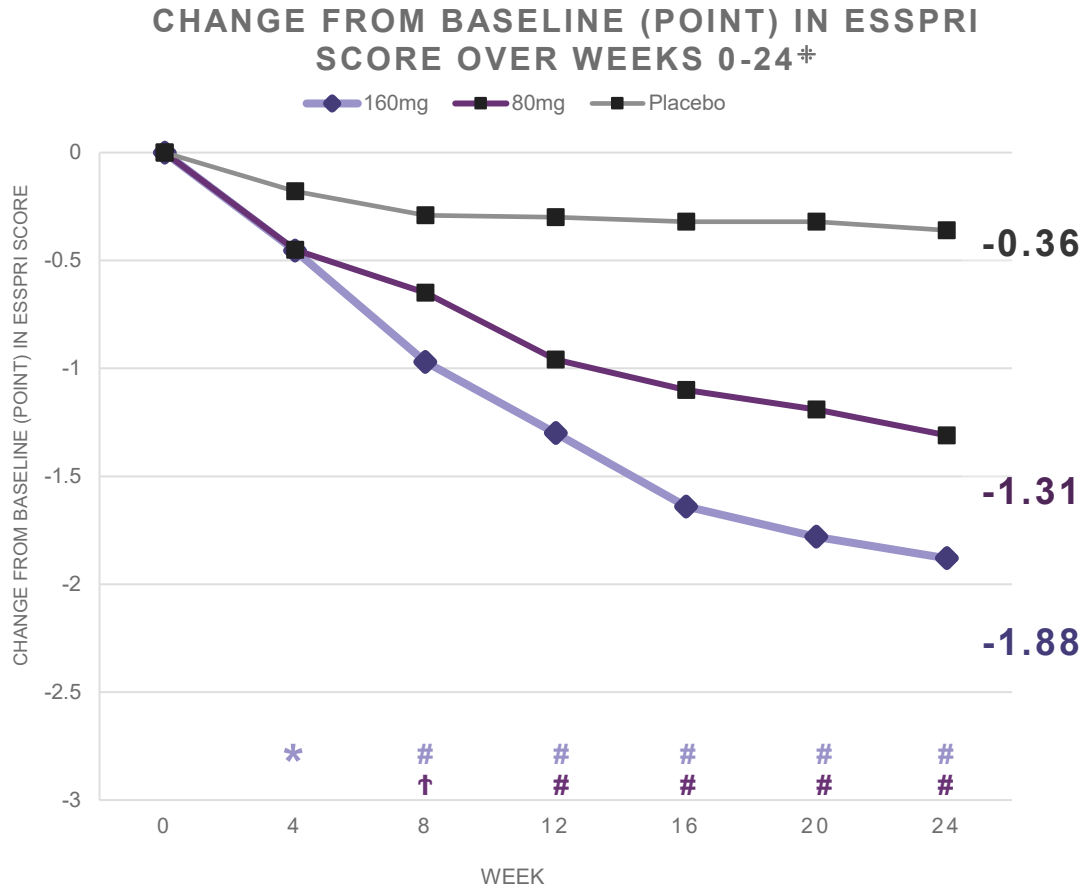
(* P<0.05, † P<0.01, ‡ P<0.001, # P<0.0001)

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.



Sustained Improvement in ESSPRI Through 48 Weeks

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



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

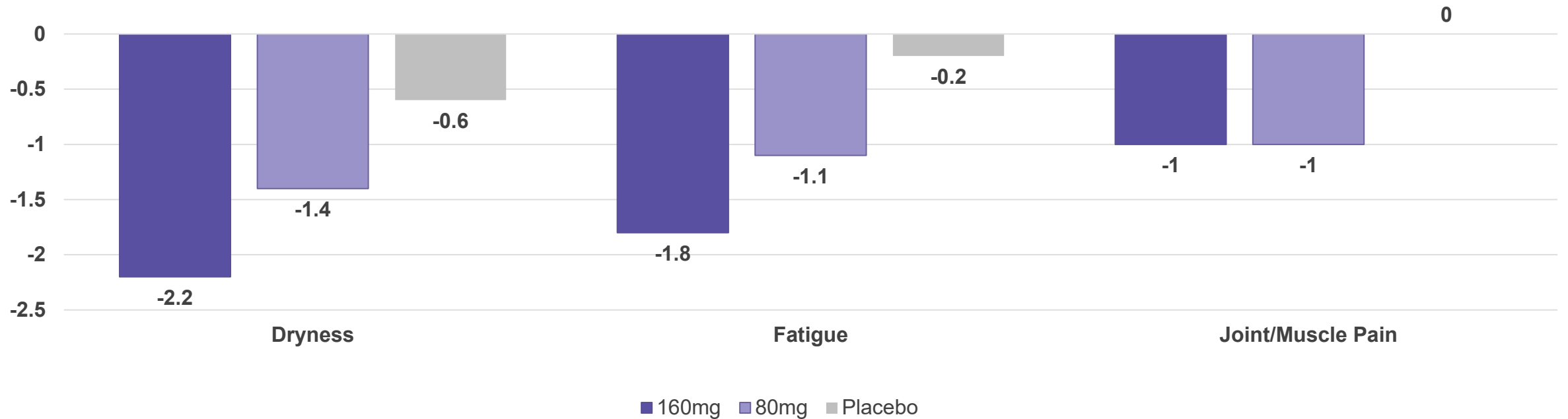
Placebo*: Participants randomized to the placebo group. ‡The analysis of change from baseline in ESSPRI score over Weeks 0-24 was based on the estimate population (EP). The MMRM method was used and missing data were not imputed. †The analysis of change from baseline in ESSPRI score over Weeks 0-48 was based on the estimate population (EP). The post-switching data for the two telitaccept groups and the placebo group were handled with the RemeGen-sponsored trial



BAFF/APRIL MOA Associated With Improvement Across All ESSPRI Domains

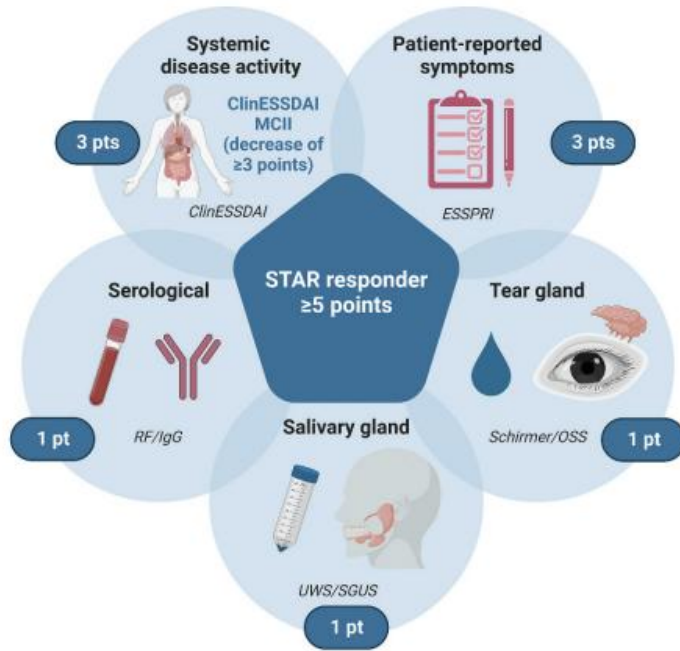
Meaningful improvement across dryness, fatigue, and pain – symptoms that define daily patient life

CHANGE FROM BASELINE IN ESSPRI SCORE BY DOMAIN AT 24 WEEKS



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

Telitacept 160mg

74.8%

Telitacept 80mg

53.2%

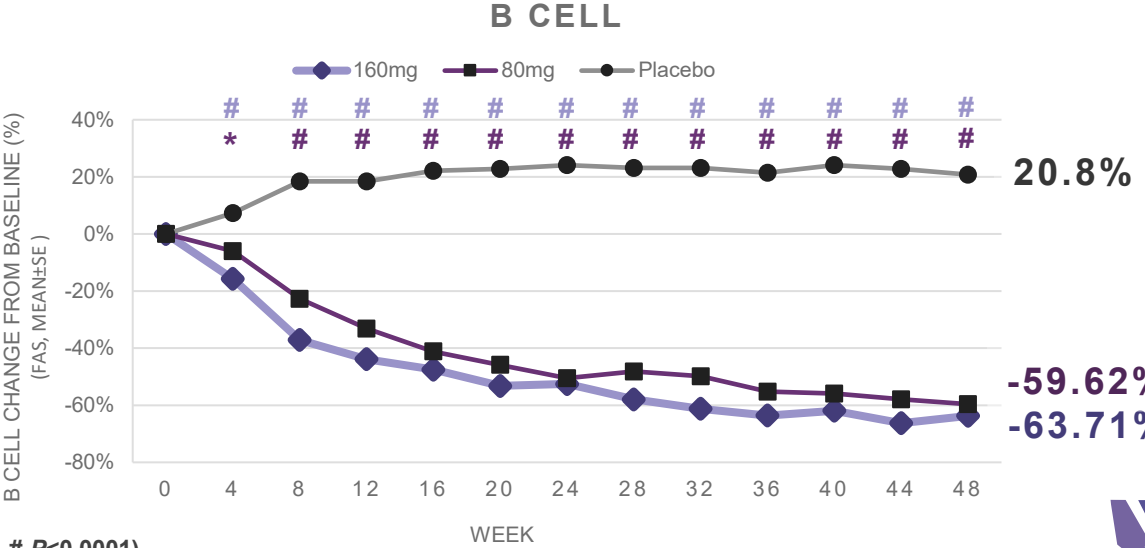
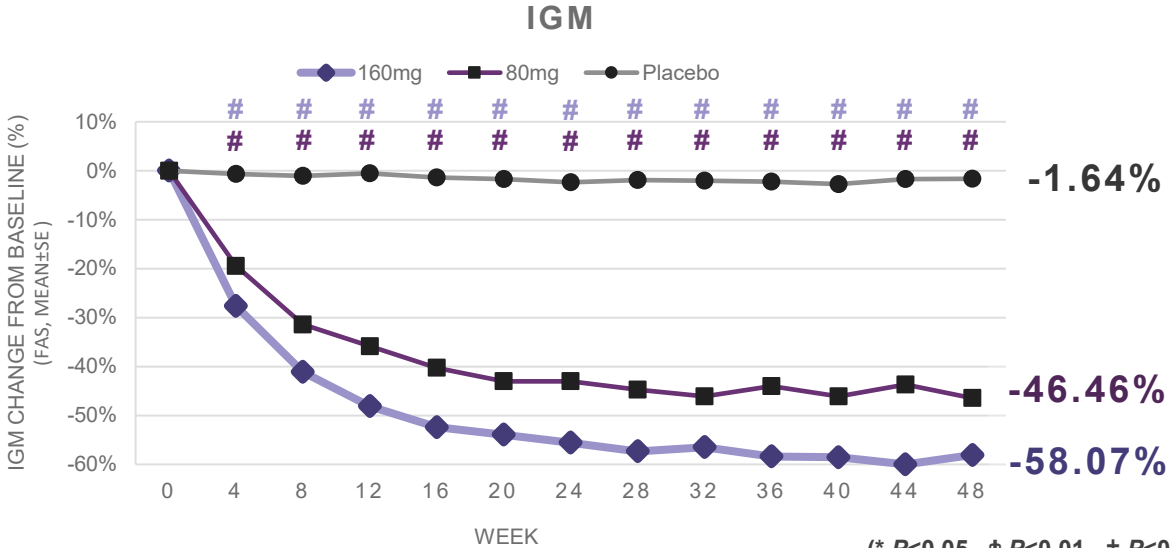
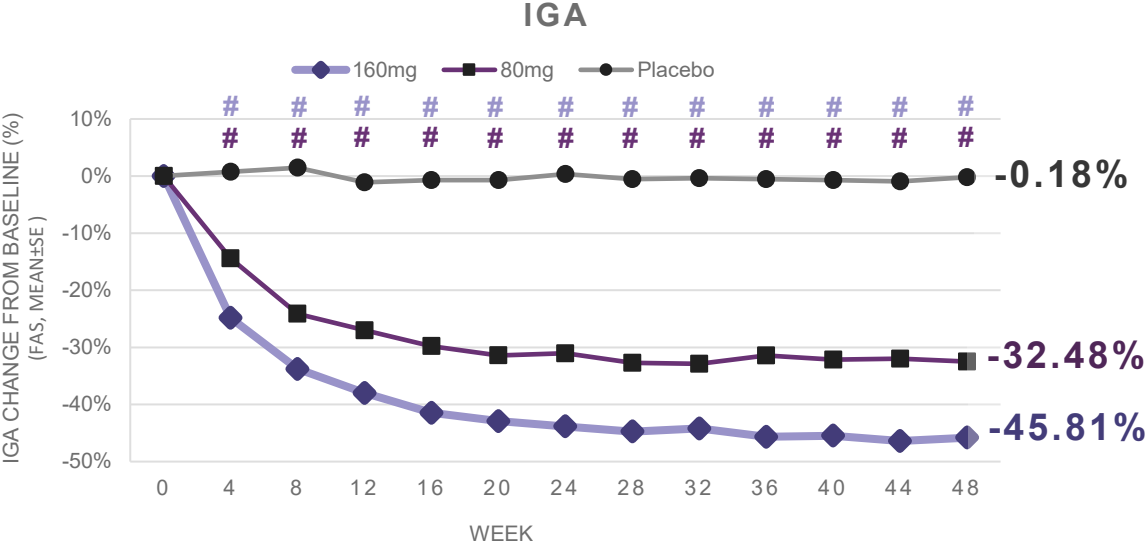
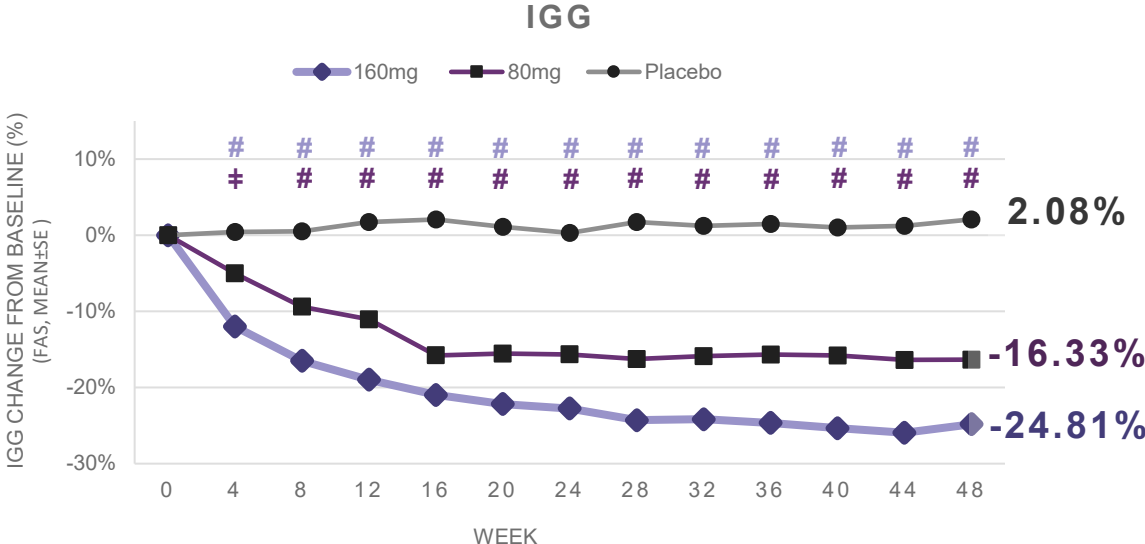
Placebo Group

21.3%

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 telitacept 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)



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)

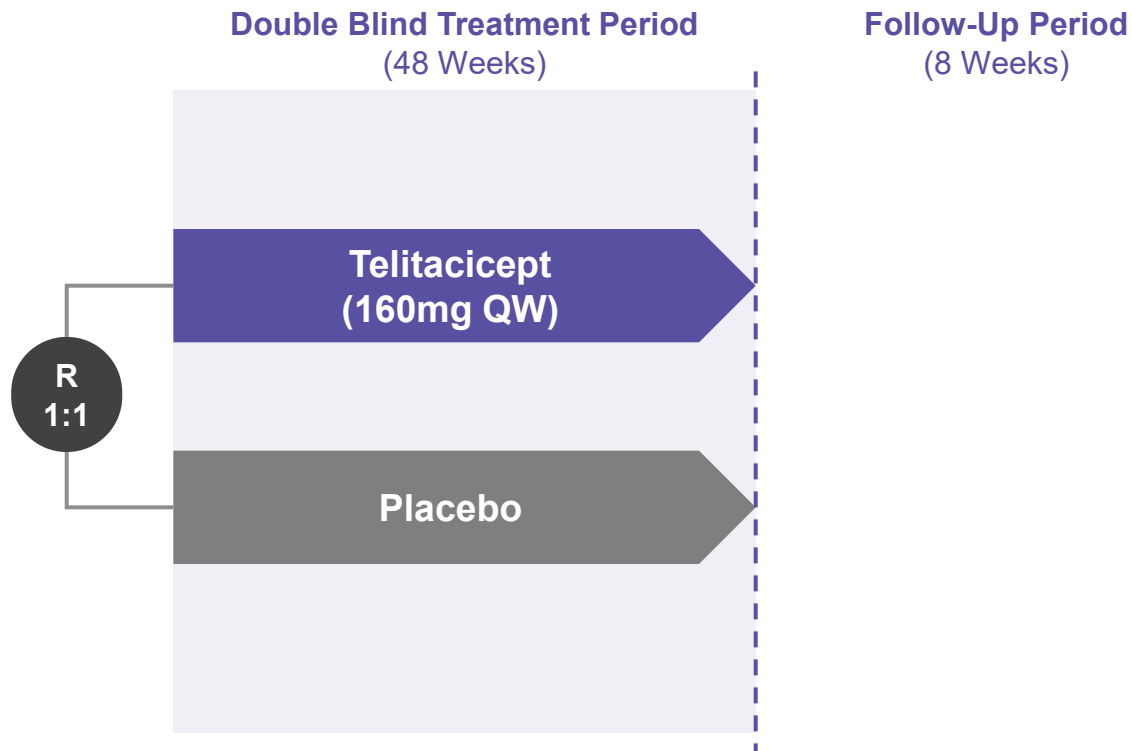


UPSTREAM SjD: Global Phase 3 Trial in Primary Sjögren's Disease

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

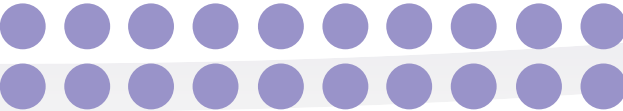
*Estimated. ESSDAI, EULAR Sjögren's syndrome disease activity index; ESSPRI, EULAR Sjögren's Syndrome Patient Reported Index; MFI-20, multidimensional fatigue inventory; PGA, physician's global assessment; PaGA, patient's global assessment; SF-36, 36-item short-form; pSjD, primary Sjögren's disease;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



Significant Near-Term Expansion Opportunities

90k

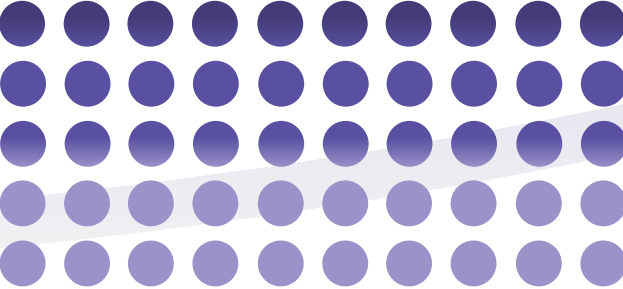
US diagnosed patients with **Myasthenia Gravis**



Beachhead

380k

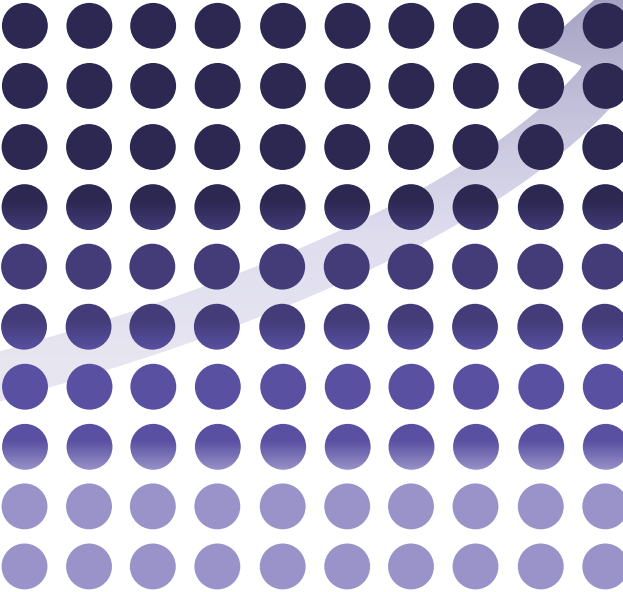
US diagnosed patients with **Myasthenia Gravis** and **Sjögren's Disease**



Follow-On

>1M+

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



Expansion



2026:

Advancing The Leading BAFF/APRIL Inhibitor

~\$530M

Runway into Early 2029*

01

MYASTHENIA GRAVIS

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, BLA Submission Accepted in China

03

EXPANSION OPPORTUNITIES

Broad Potential Across B Cell-Driven Immune Diseases

Indication Focus on High Unmet Need And Clinical Value



Thank You.

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