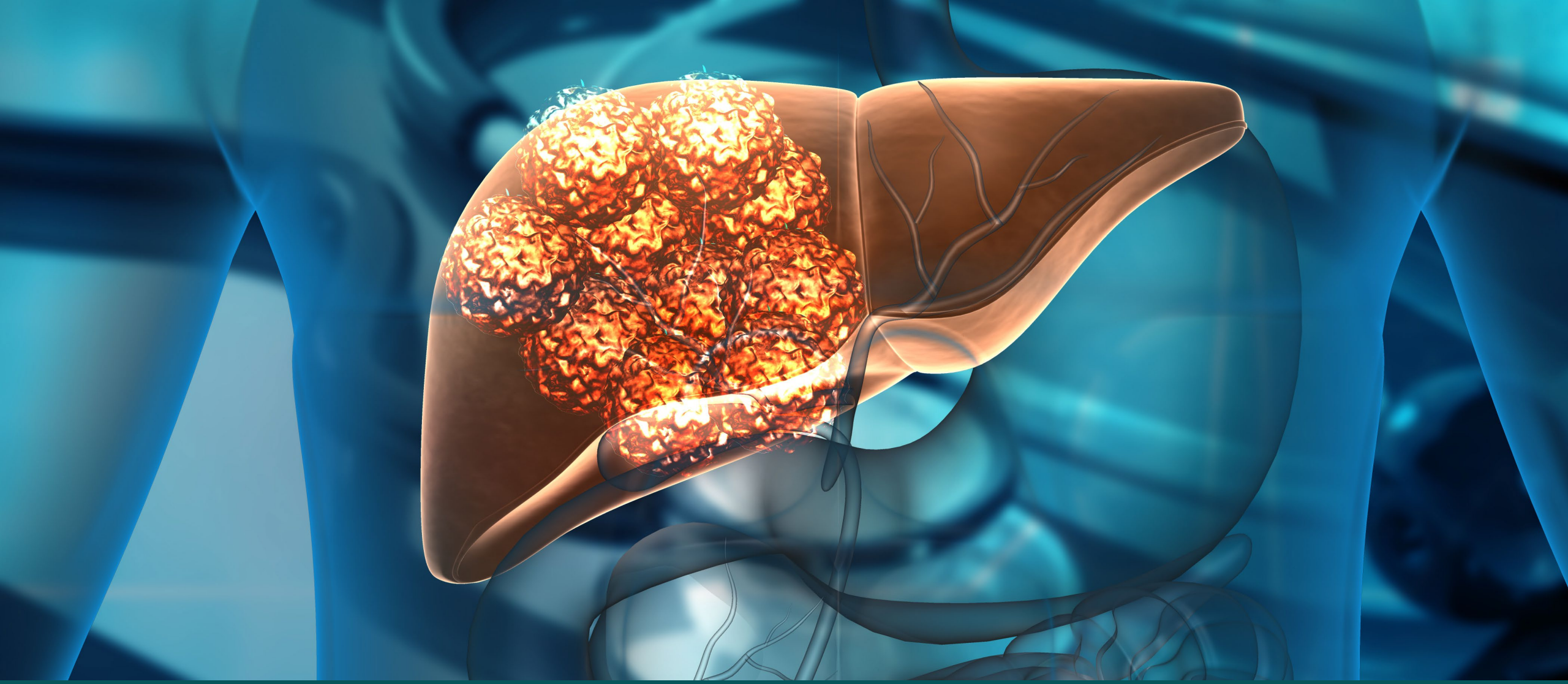

Improving life for advanced liver cancer (HCC) patients

The first oral, targeted treatment for advanced liver cancer

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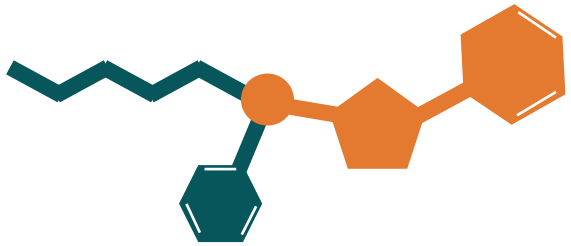
Fostrox (fostroxacitabine bralpamide) – at a glance

Combining 2 proven mechanisms for a liver-targeted efficacy



Liver-guided delivery

Tumor-selective Payload

- Unique liver-activation, for maximum liver exposure, minimizing systemic side effects
- Induces DNA damage selectively in tumor cells, while sparing healthy liver cells
- Exceptional clinical benefit with encouraging safety profile in second line advanced liver cancer
- First-to-market opportunity in second-line liver cancer population worth > $2.5bn

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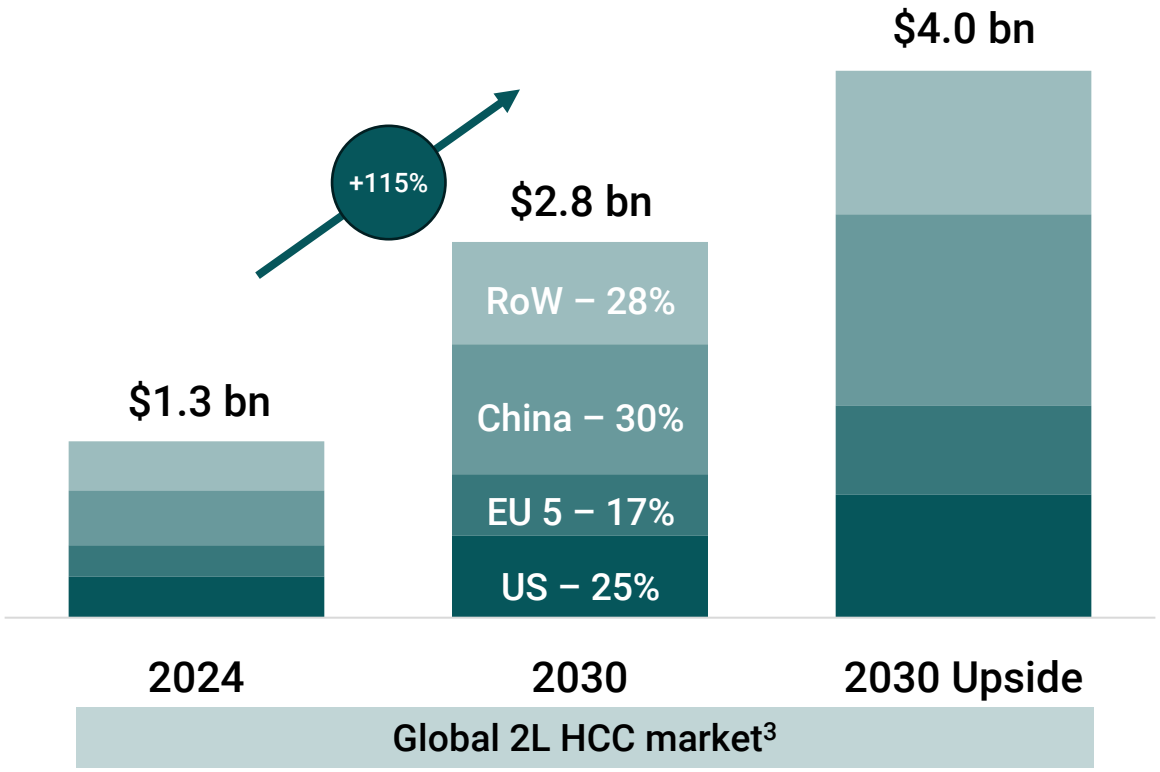
Second line HCC – a large and growing commercial opportunity with significant unmet medical need

Large and rapidly growing commercial market with significant unmet medical need[3]



Growth driven by:

- HCC to increase **+122% in the US** and +**82% in China**[2] by 2030, caused by fatty liver disease
- With improved 1L treatment, more patients will be **fit enough for 2L, 50% → 70%**
- New, approved treatment options increase average **treatment duration to 7 months**
- **2030 Upside –** using average treatment duration of 10 months from fostrox + Lenvima study

[1]Rumguy et al. Journal of Hepatology 2022
[2]Huang et al., Nature Reviews, Gastroenterology & Hepatology, Vol 18, 2021
[3]GlobalData 2021 and internal analysis

Immunotherapy combinations established in 1st line but no effective treatments approved in 2nd line

Advanced Liver cancer (hepatocellular carcinoma, HCC) Treatment Algorithm

1st line treatment

- Tecentriq + Avasting SoC
- (Durva/Treme or Nivo/Ipi)

2nd line treatment

- No approved treatment options
- Lenvatinib mono preferred

"We are getting greedy, trying to have 8 different regimens in the 1L setting and none of us know what to do after.

If I had my way, the focus should really be on 2L treatment and beyond"

Rachna T Schroff, University of Arizona Cancer Center
Discussant in Late Breaking Abstract session at ESMO, September 2024

Fostrox + Lenvatinib, unique combination with novel mechanism at the forefront 2nd line

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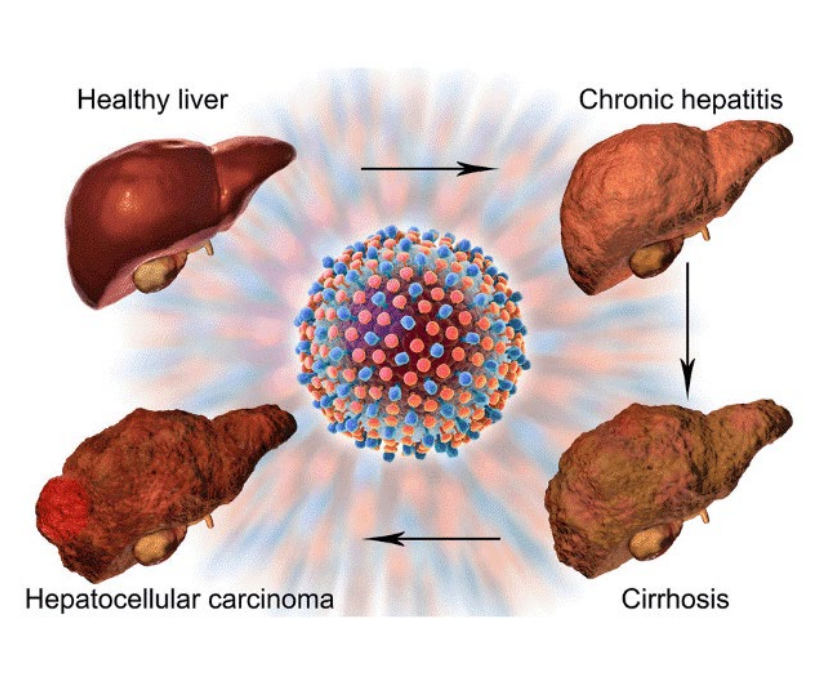
Targeted treatment approach critical in liver cancer (HCC)

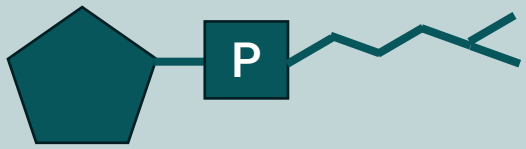


- ~80% of patients have underlying liver disease[1,2]
- Tumor growth primarily occurs locally in the liver[1]
- Critical to achieve selective targeting of tumor cells while sparing healthy cells

[1] Senthilnathan et al., Hepatology, 2012 May; 55(5): 1432-1442
[2] Llovet et al., Nature Reviews Gastroenterology & Hepatology, Vol 20, Aug 2023, 487-503

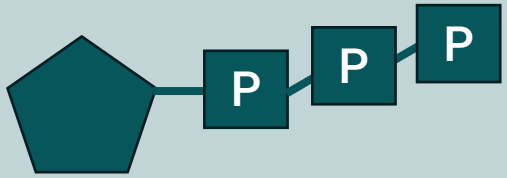
Fostrox – designed to target and kill tumor cells in the liver

Oral drug that remains inactive until it reaches the liver[1]



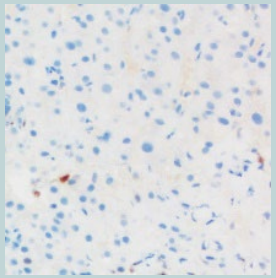
Liver-guided delivery

Absorbed & rapidly activated by enzymes inside liver cells[2]

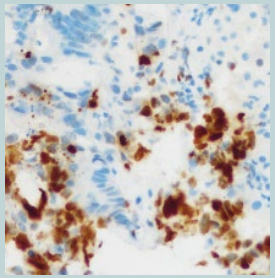


Payload - troxacitabine

Induces DNA damage, selectively kills tumor cells[3,4,5]



Normal liver tissue



Tumor tissue

Based on liver biopsies from patients

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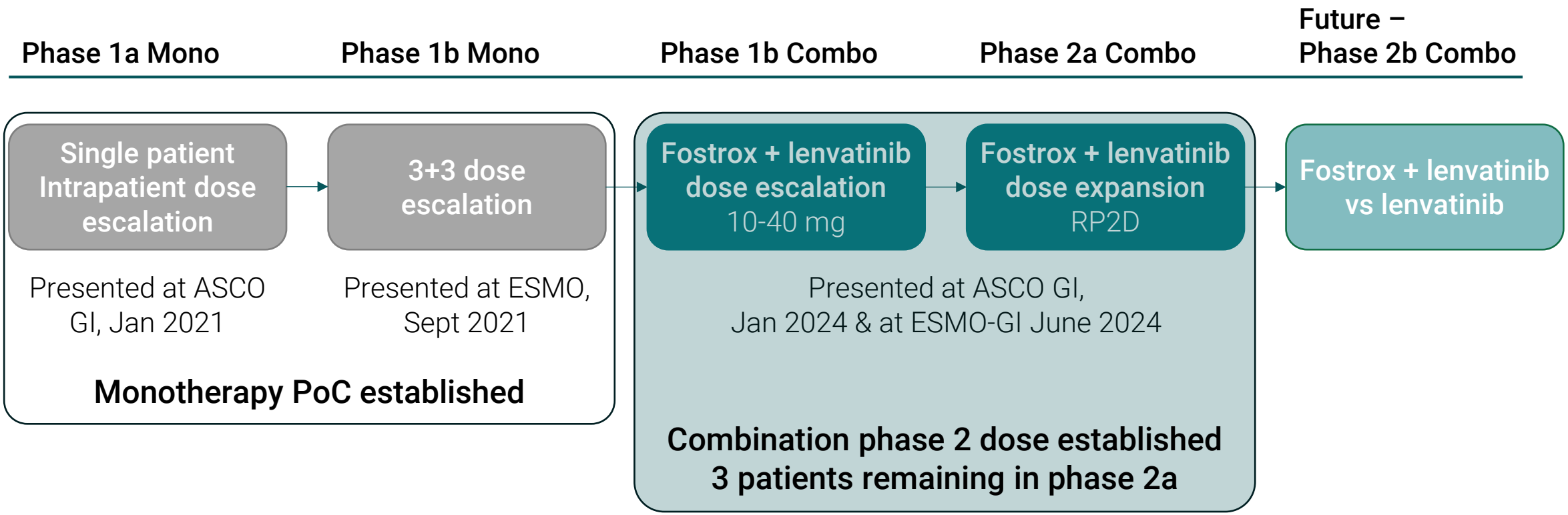
[1]Bethell, R. et al , SAT-123, EASL 2017, [2]Bethell, R. et al P-035, ILCA 2016, [3]Kukhanova, M et al J Biol Chem 1995, [4]Albertella, M. et al EASL Summit P01-05, 2018, [5]Öberg F. et al, EASL PO-221, 2022

Fostrox Clinical Development Program; monotherapy POC established, focus on combination approach in 2nd line HCC



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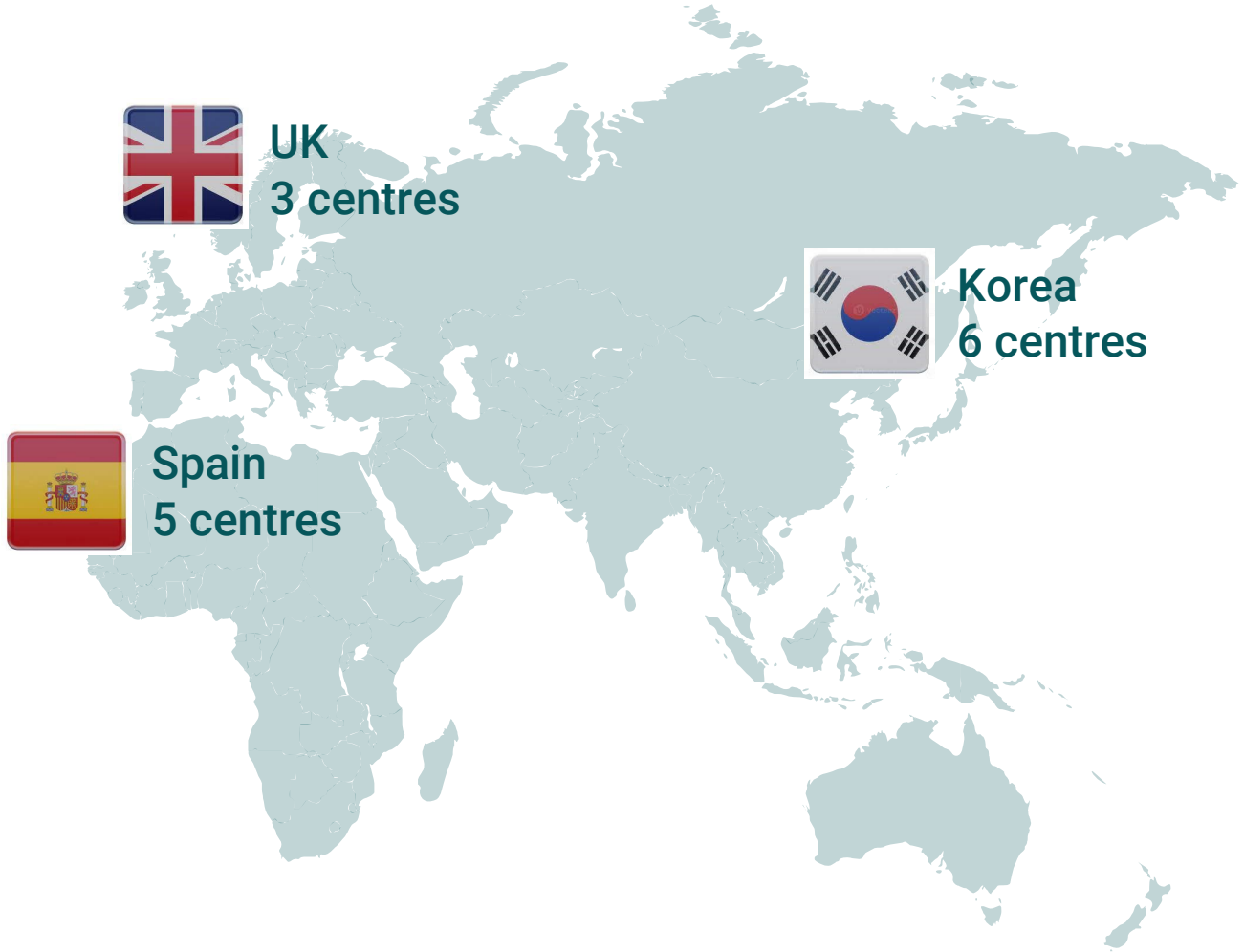
Global phase 1b/2a study with fostrox + lenvatinib (TKI)



Key study features

- Fostrox + lenvatinib in second and third line advanced HCC
- 15 sites in South Korea, Spain and UK
- Median follow-up 10.5 months

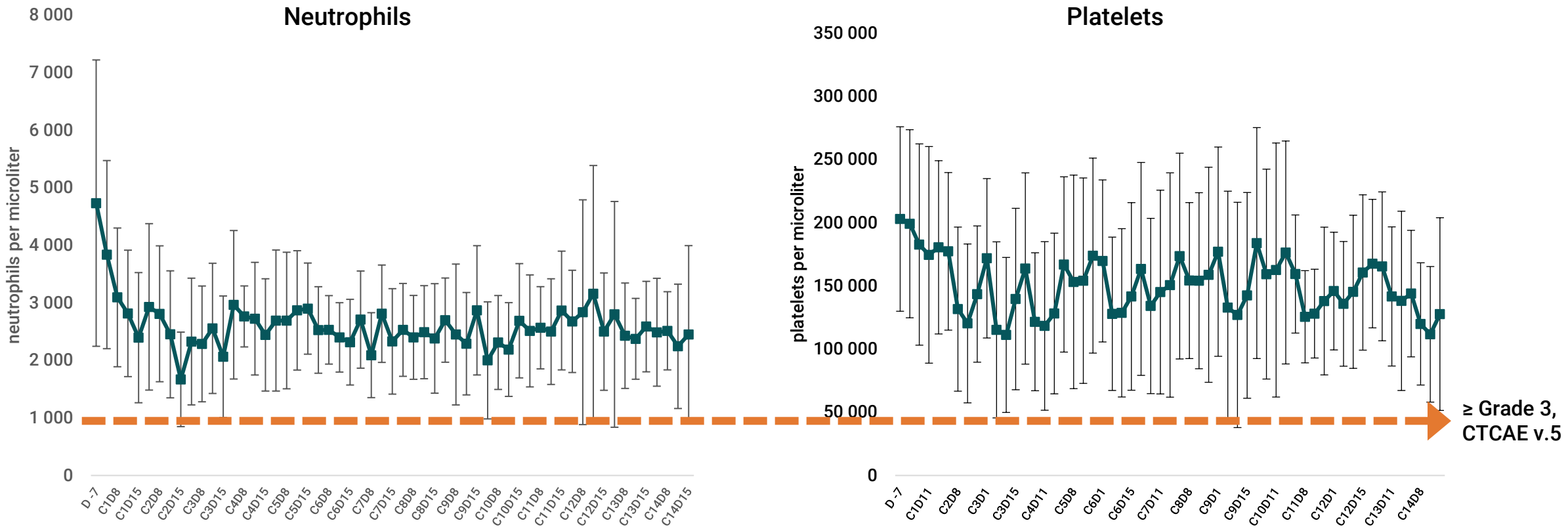
Patient characteristics reflecting generous inclusion criteria

Patient characteristics	N = 21
Mean age (range)	62 yrs (42 - 82)
Gender, Female / Male (%)	24 / 76
ECOG Performance status 0/1 (%)	71 / 29
Child-Pugh A (%)	100
Viral/Non-viral (%)	76* / 24
Extra hepatic lesion(s) Y/N (%)	67 / 33
AFP ≥400 ng/mL at baseline Y/N (%)**	45 / 55
Region, Asia / Europ (%)	67 / 33
Prior treatment lines; 2nd line/3rd line (%)	81 /19
Prior atezolizumab/bevacizumab in 1L (%)	86
Prior local therapy (TACE, RFA etc)	70
PD on prior treatment (%)	100
Primary refractory on prior therapy (%)***	24
Starting dose fostrox, 20mg / 30mg (%)	14 / 86

*HepB-81% and HepC-19%; **AFP- NA for 1 pt; ***Active treatment ≤ 12 weeks. Data NA for 3 patients

Absolute neutrophile and platelet counts were stable over the course of treatment, enabling long-term use[1]

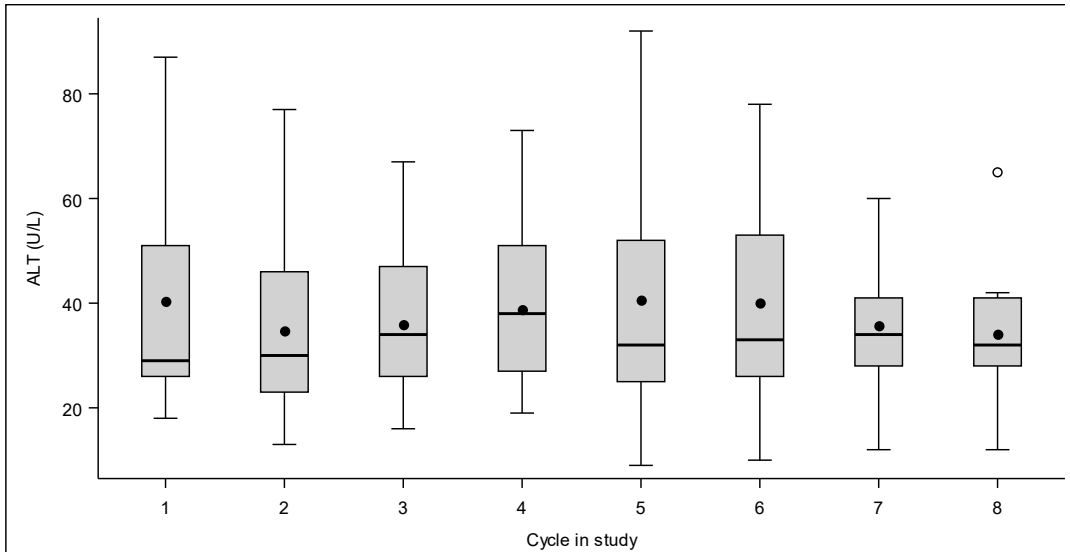
Longitudinal neutrophil & platelet counts, at all time points measured over first 10 months of treatment



[1]Chon et al., ESMO GI 2024, Poster 176.

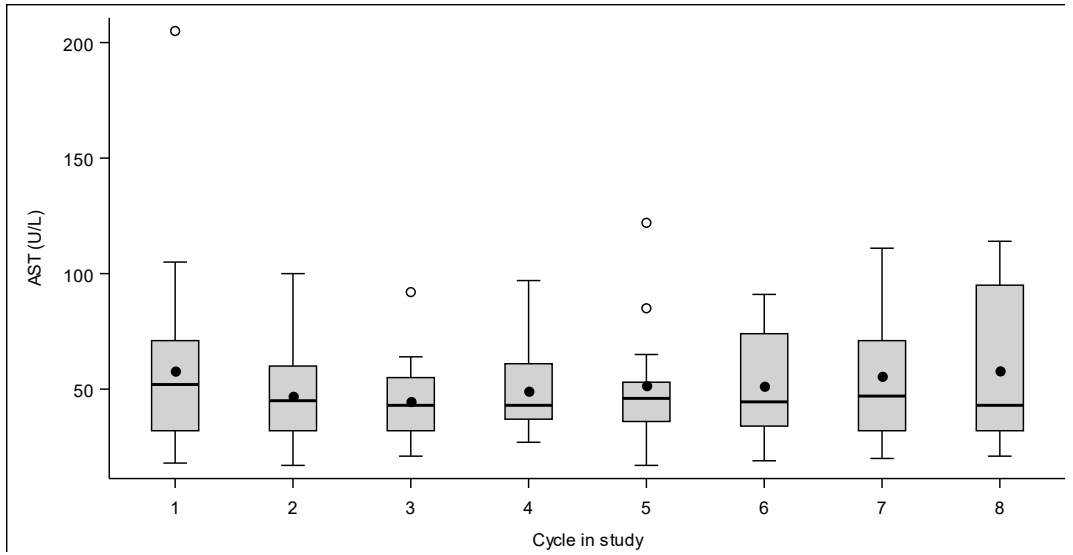
Stable liver function during treatment with fostrox + Lenvima – no deterioration in liver enzymes

ALT change over duration of treatment



Patients At risk	21	21	16	15	14	14	11	10

AST change over duration of treatment



Patients At risk	21	21	16	15	14	14	11	10

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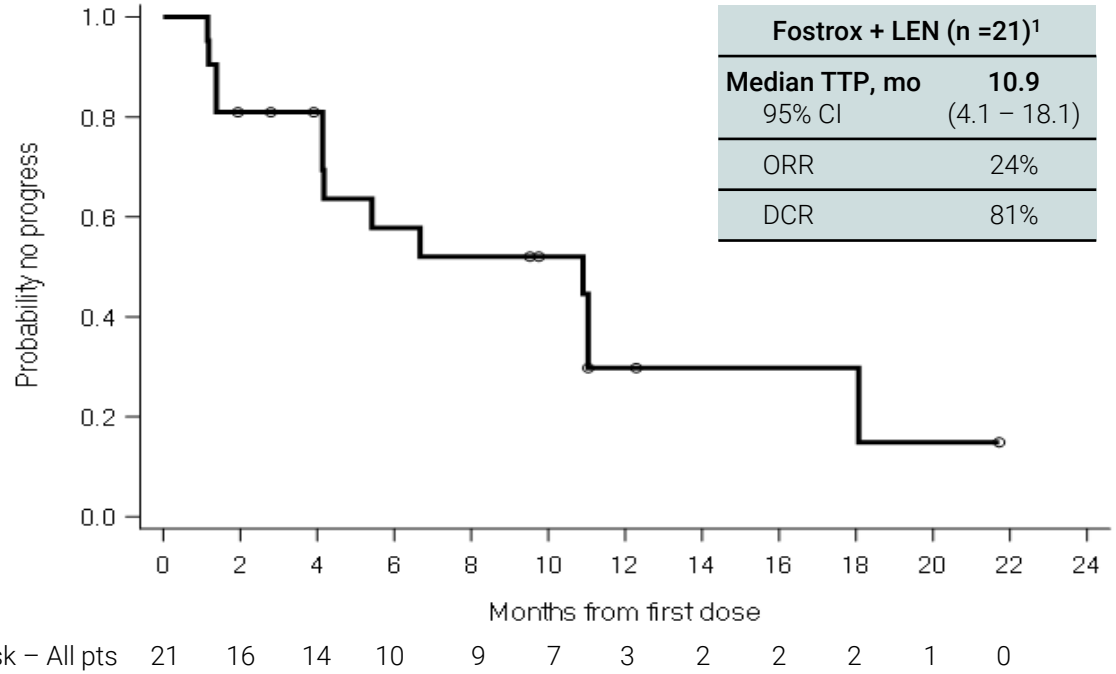
Median TTP 10.9 months, indicating improved efficacy compared with Lenvatinib alone[1]

Median time to progression (TTP) with fostrox + LEN – investigator review, RECISTv1.1



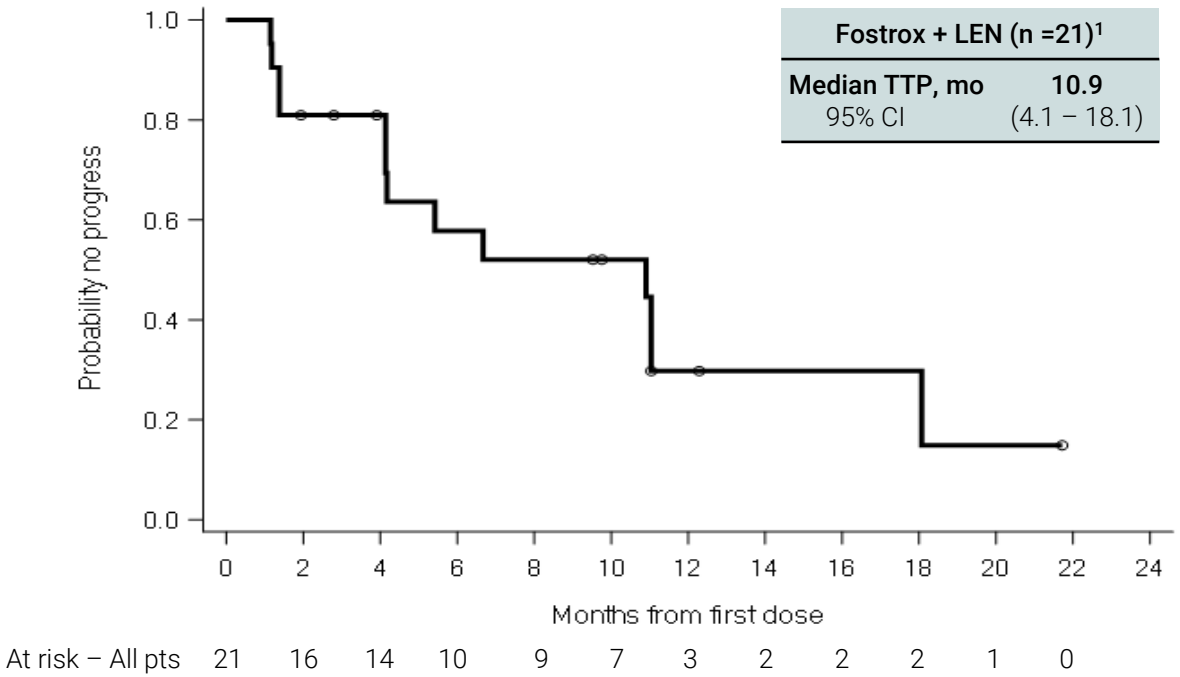
Fostrox + LEN (n =21)[1]	
Median TTP, mo	**10.9**
95% CI	(4.1 – 18.1)
ORR	24%
DCR	81%

- Median time to progression 10.9 months
- Median follow-up of 10.5 months
- Longest running patient still on treatment > 2 years
- 3 patients remaining on treatment at time of data cut (Aug 19, 2024)

[1]Chon et al., ESMO 2024, Poster 986.

Median time to progression (TTP) 10.9 months, substantially longer than Lenvima mono or other 2nd line HCC treatments

Median TTP (Kaplan-Meier) with fostrox + Lenvima



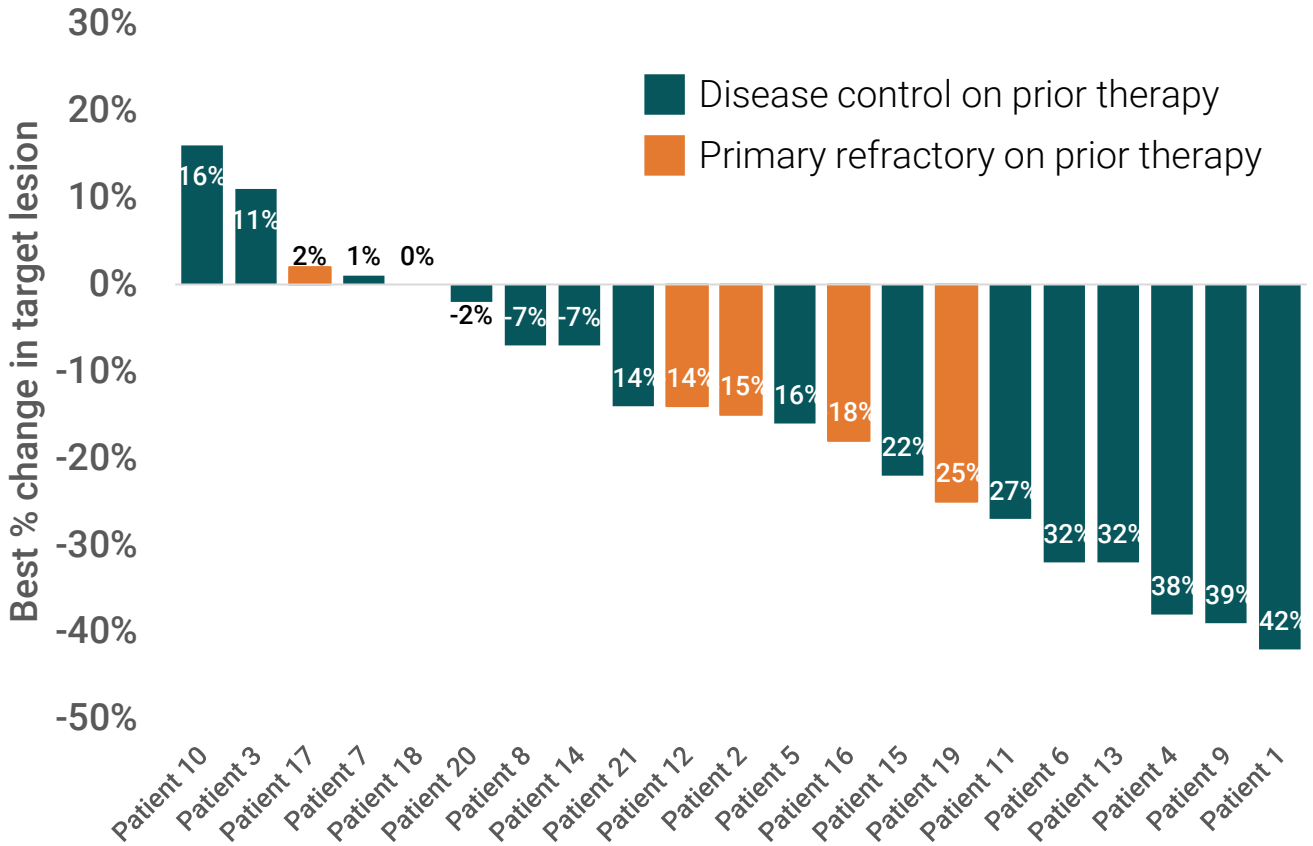
Fostrox + LEN (n =21)[1]	
Median TTP, mo	**10.9**
95% CI	(4.1 – 18.1)

Median TTP/PFS vs previous studies in 2L HCC

[1]Chon et al., ESMO 2024, Poster 986.

Encouraging tumor control with overall response 24% and >75% of patients experiencing tumor shrinkage[1]

Best percentage change in target lesion size related to treatment response in 1st line



- Overall Response 24% with median Duration of Response 7.0 months
- Disease Control Rate 81% with >75% of patients experiencing tumor shrinkage in target lesions
- Patients benefitting from treatment independent of outcome in previous line of therapy

[1]Chon et al., ESMO 2024, Poster 986.

Fostrox + Lenvima data signals superiority compared with Lenvima monotherapy or IO combo treatments in 2nd line HCC

	Lenvima in 2L HCC[1] – Korea	Lenvima in 2L HCC[2] – Japan	Keytruda + TKI in 2L HCC[3]	Fostrox + Lenvima[4]
Median PFS/TTP	3.5 mo	4.4 mo	2.8 mo	**10.9 mo**
Overall Response Rate	7.5%	15.4%	5.9%	**24%**
Disease Control Rate	67.5%	66.2%	54.4%	**81%**

[1]Chon et al. Clinical and Molecular Hepatology 2024 Mar 12
[2]Hiraoka et al., Oncology 2023; 101:624-633
[3]El-Khoueiry et al. ASCO 2024, Abstract 4007
[4]Chon et al, ESMO 2024, Poster 986

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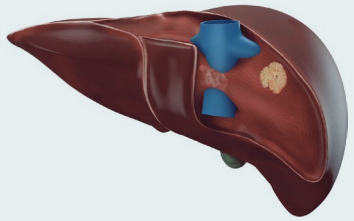
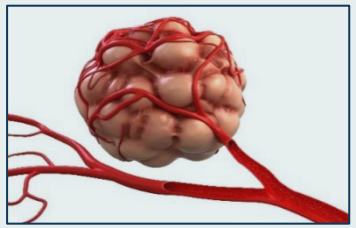
Critical questions to support moving forward



Fostrox

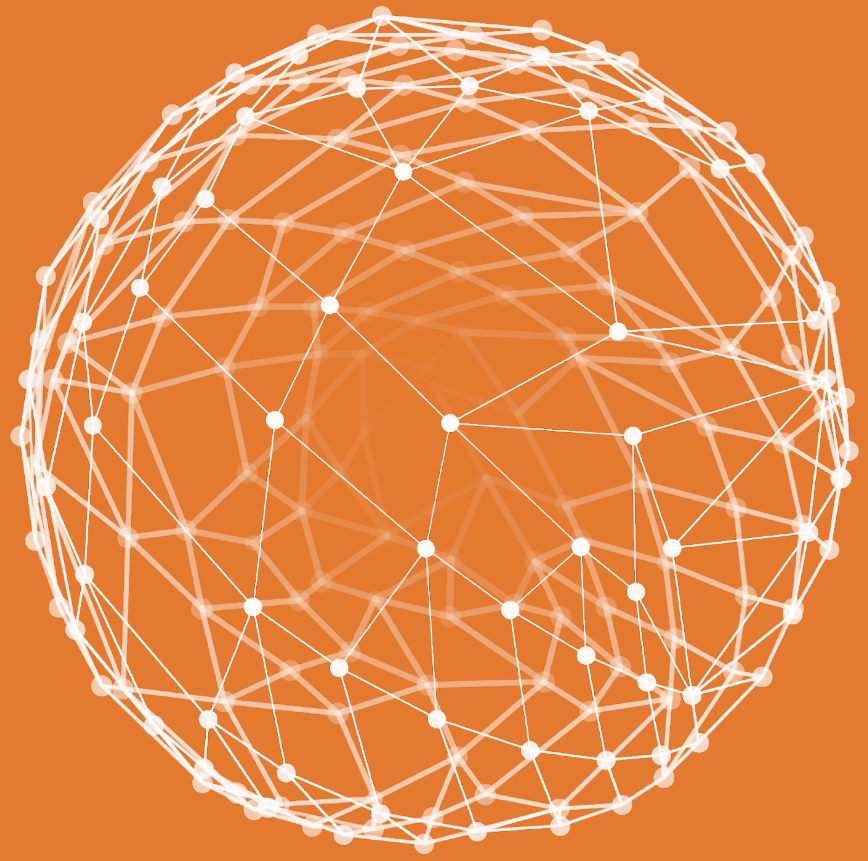
+



Lenvatinib

1. Safety and Tolerability: are the two drugs possible to combine? ✓
2. Efficacy: Does the combination provide meaningful clinical benefit? ✓
3. Contribution of component: Indication that Fostrox + Lenvatinib is better than Lenvima alone? ✓

Moving forward to become the first, approved treatment option in 2L liver cancer



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Distinguished Fostrox Scientific Advisory Council to support shaping the future development of fostrox

Dr. Richard Finn

- Professor of Medicine at the Geffen School of Medicine at UCLA Department of Medicine, Division of Hematology/Oncology.
- Director of the Translational Research Laboratory in the Division of Hematology/Oncology.
- PI of several, ground-breaking studies in HCC, including ImBrave 150 study.

Dr. Jeff Evans

- Professor of Translational Cancer Research in the School of Cancer Sciences, Univ. of Glasgow & honorary Consultant in Medical Oncology at Beatson West of Scotland Cancer Centre
- He is the Lead of the Glasgow Experimental Cancer Medicine Centre (ECMC) and National Clinical Lead of the NHS Scotland Cancer Research Network.
- He is an investigator in the fostrox clinical development program.

Dr. Arndt Vogel

- Managing senior consultant and Prof. in the Department of Gastroenterology, Hepatology and Endocrinology at Hannover Medical School.
- Member and chairman of Hepatobiliary Cancer Study Group of the AIO
- Member of the ESMO Guidelines Steering Committee and coordinator of the ESMO clinical practice guideline on the management of HCC and BTC.

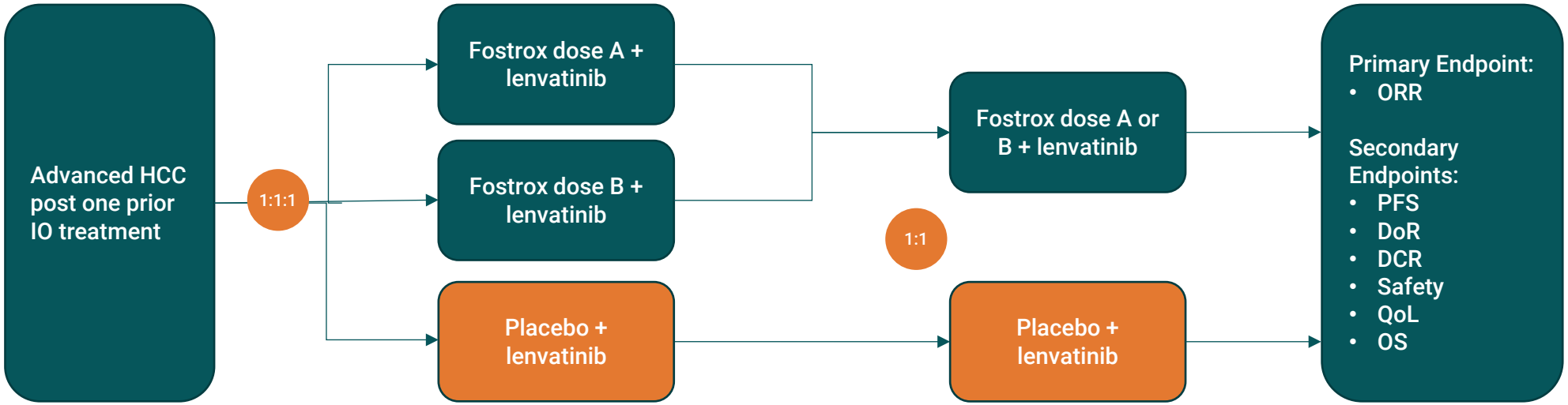
Dr. Maria Reig

- Head of the BCLC and Liver Oncology Unit at Hospital Clinic of Barcelona in Spain.
- Her expertise and area of interest is the development of prognostic models for patients with liver cancer and evaluation of treatment options as well as new research about immune modulation and cancer emergence after antiviral treatment.
- She is an investigator in the fostrox clinical program.

Dr. Jeong Heo

- Professor of Internal Medicine at Pusan National University School of Medicine and Director of Gastroenterology and Hepatology at Pusan National University Hospital.
- Professor Heo has held a number of academic positions, university & hospital appointments and has been PI in many ph. I-IV clinical trials in hepatitis B, C and HCC.
- He is an investigator in the fostrox clinical program.

Next step: randomized phase 2b with dose optimization run-in



Fostrox – first-in-class targeted treatment with potential to transform 2L liver cancer

Liver-targeted MoA achieving a unique anti-tumor activity

- >100-fold increase in liver concentration vs IV admin
- DNA damage induced selectively in tumor cells

Exceptional clinical benefit and encouraging safety profile

- TTP of 10.9 months, substantially longer than current treatment option
- Combination tolerable, enabling treatment long-term

Phase 2b – confirming the activity in a randomized, placebo-controlled trial

- 2L line advanced liver cancer after IO combination
- Global footprint (US/EU/Asia)

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Thank You!